NHS
University Hospitals Tees

# Board of Directors Meeting

## Thursday, 3 September 2026, 13:00

Health and Social Care Academy, 2nd floor,
University Hospital of Hartlepool

Caring
Better
Together

University Hospitals Tees

**MEETING OF THE BOARD OF DIRECTORS TO BE HELD IN PUBLIC**
**ON THURSDAY 3 SEPTEMBER 2026 AT 1:00pm**
**HEALTH AND SOCIAL CARE ACADEMY,**
**2ND FLOOR, UNIVERSITY HOSPITAL OF HARTLEPOOL**

**AGENDA**

| | ITEM | PURPOSE | LEAD | FORMAT | TIME |
|---|---|---|---|---|---|
| **1. CHAIR'S BUSINESS** | | | | | |
| 1.1 | Patient/Staff Story | Information | Chair | Verbal | 13:00 |
| 1.2 | Welcome and Introductions | Information | Chair | Verbal | 13:20 |
| 1.3 | Apologies for Absence | Information | Chair | Verbal | 13:20 |
| 1.4 | Quorum and Declarations of Interest | Information | Chair | ENC | 13:20 |
| 1.5 | Minutes of the last meeting held on 2 July 2026 | Approval | Chair | ENC | 13:25 |
| 1.6 | Matters Arising and Action Log | Information | Chair | ENC | 13:30 |
| 1.7 | Chair's Report | Information | Chair | ENC | 13:35 |
| 1.8 | Chief Executive's Report | Information | Chief Executive | ENC | 13:45 |
| 1.9 | UHT Management Team Chairs Log: 23 July 2026 & 20 August 2026 | Information | Chief Executive | ENC | 14:00 |
| 1.10 | Board Assurance Framework | Assurance | Director of Assurance & Deputy Managing Director | ENC | 14:05 |
| **2. QUALITY AND SAFETY** | | | | | |
| 2.1 | Quality Committee Chairs Log: 27 July 2026 & 14 August 2026 | Assurance | Chair of Committee | ENC | 14:15 |

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

| | ITEM | PURPOSE | LEAD | FORMAT | TIME |
|---|---|---|---|---|---|
| 2.2 | Maternity and Neonatal Improvement Plan:<br>• Perinatal 10 Urgent Actions 2026<br>• Maternity Triage Specification 2026 | Assurance | Director of Midwifery | ENC | 14:25 |
| 2.3 | Perinatal Quality and Safety Report Quarter 1: 2026/27 | Assurance | Director of Midwifery | ENC | 14:35 |
| 2.4 | Perinatal Staffing Report Quarter 1: 2026/27 | Assurance | Director of Midwifery | ENC | 14:40 |
| 2.5 | Monthly Nurse Safer Staffing Report | Assurance | Chief Nursing Officer | ENC | 14:45 |
| 2.6 | Safer Staffing Bi-Annual Overview and Emerging Themes | Assurance | Chief Nursing Officer | ENC | 14:50 |
| 2.7 | Infection, Prevention & Control Annual Report 2025-26 | Assurance | Chief Nursing Officer | ENC | 14:55 |
| **3. PEOPLE** | | | | | |
| 3.1 | People Committee Chairs Log: 28 July 2026 | Assurance | Chair of Committee | ENC | 15:00 |
| 3.2 | WRES Report | Approval | Chief People Officer | ENC | 15:10 |
| 3.3 | WDES Report | Approval | Chief People Officer | ENC | 15:15 |
| **4. FINANCE & PERFORMANCE** | | | | | |
| 4.1 | Resources Committee Chairs Log: 29 July 2026 & 26 August 2026 | Assurance | Chair of Committee | ENC | 15:20 |
| 4.2 | Finance Report - Month 4: 2026/27 | Assurance | Chief Finance Officer | ENC | 15:30 |

| | ITEM | PURPOSE | LEAD | FORMAT | TIME |
|---|---|---|---|---|---|
| 4.3 | Integrated Performance Report | Assurance | Chief Operating Officer | ENC | 15:35 |
| 4.4 | Sustainability Plan Update | Assurance | Director of Estates | ENC | 15:45 |
| 4.5 | Winter Plan Board Assurance Statements 2026/27 | Approval | Chief Operating Officer | ENC | 15:50 |
| **5. SOUTH TEES HOSPITALS NHS TRUST UNITARY BOARD** | | | | | |
| 5.1 | Audit Committee Chairs Log: 16 July 2026 | Assurance | Chair of Committee | ENC | 16:00 |
| 5.2 | Charitable Funds Committee in Common Chairs Log: 5 August 2026 | Assurance | Chair of Committee | ENC | 16:05 |
| **6. NORTH TEES & HARTLEPOOL NHS TRUST UNITARY BOARD** | | | | | |
| 6.1 | Audit Committee Chairs Log: 16 July 2026 | Assurance | Chair of Committee | ENC | 16:10 |
| 6.2 | Charitable Funds Committee in Common Chairs Log: 5 August 2026 | Assurance | Chair of Committee | ENC | 16:15 |
| 6.3 | Appointment of Independent Chair of North Tees & Hartlepool Solutions LLP | Approval | Chief Executive | ENC | 16:20 |
| 6.4 | Any Other Business | Information | Chair | Verbal | 16:30 |
| **CLOSE** | | | | | |
| | **DATE OF NEXT MEETING**<br>The next meeting of the Board of Directors will take place on 3 December 2026 in Rooms 3&4 STRIVE, Friarage Hospital, Northallerton | | | | |

University Hospitals Tees

# Register of members interests

**Meeting date:** 3 September 2026

**Reporting to:** Board of Directors

**Agenda item No:** 1.4

**Report author:** Sarah Hutt, Assistant Company Secretary

**Executive director sponsor:** Jackie White, Director of Corporate Affairs

**Action required:** Information

**Delegation status:** Jointly delegated item to Group Board

**Previously presented to:** N/A

## UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

## CQC domain link:

Well-led

## Board assurance / risk register this paper relates to:

All BAF risks

## Key discussion points and matters to be escalated from the meeting

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

The report sets out membership of the 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 Trust and Director of South Tees Hospitals NHS Trust Board |
| | | | | Non-Executive Director, Leazes Homes |
| | | | | Member of the Karbon Group Audit and Risk Committee, Karbon Homes |
| | | July – November 2026 | | Self-employed Consultancy work in the third-sector |
| **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 | Board 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 |
| | | | Ongoing | Chair of Universities for North East England |
| | | | Ongoing | Board member, 4th Generation University Community Board (4GU) |
| **Chris Hand** | Chief Finance Officer | 2 July 2021 | Ongoing | Director of South Tees Healthcare Management Limited - Company number 10166808 |
| | | | Ongoing | Client Representative ELFS Shared Services Management Board |
| | | April 2024 | Ongoing | Representation on behalf of South Tees Hospitals NHS Trust on NTH Solutions LLP – Company Number OC419412 |
| | | June 2024 | Ongoing | Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board |

| Board Member | Position | Relevant Dates From | to | Declaration Details |
|---|---|---|---|---|
| **David Redpath** | Non-Executive Director | 1 January 2021 | Ongoing | Director of DGR Consultancy - Company number 10340661 |
| | | September 2022 | Ongoing | South Tees Healthcare Management Limited - Company number 10166808. |
| | | September 2017 | Ongoing | Vice President Senior Executive Partner – Gartner |
| | | July 2022 | Ongoing | Deputy Chairman – Seaton Delaval Football Club |
| | | 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 – Company Number 17129251 |
| **Emma Nunez** | Chief Nursing Officer | April 2025 | Ongoing | Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board |
| **Fay Scullion** | Non-Executive Director | October 2024 | Ongoing | Chief Executive, Age UK North Yorkshire & Darlington |
| | | April 2024 | Ongoing | Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board |
| **Jackie White** | Director of Corporate Affairs & Company Secretary | March 2013 | Ongoing | Registered with IMAS (NHS Interim Management & Support) |
| | | March 2023 | Ongoing | Company Secretary of South Tees Healthcare Management Limited - Company number 10166808 |
| | | March 2023 | Ongoing | Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board |
| | | | Ongoing | Daughter and Daughter in law employees of South Tees Hospitals NHS Foundation Trust |
| **Ken Anderson** | Chief Information Officer | May 2024 | Ongoing | Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board |
| **Kenneth Readshaw** | Non-Executive Director | 2016 | Ongoing | Treasurer – Leyburn Community Leisure Club |
| | | 2018 | Ongoing | Chair – Health Accommodation Trust |
| | | 2000 | Ongoing | Chair – Horsehouse School Charity - Charity number: 513060 |
| | | April 2024 | Ongoing | Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board |

| Board Member | Position | Relevant Dates From | to | Declaration Details |
|---|---|---|---|---|
| **Matt Neligan** | Deputy Chief Executive / Chief Strategy Officer | October 2024 | Ongoing | Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board |
| | | May 2025 | Ongoing | Founding member, Evolve Collaborative (supported by NHS Confederation and Beamtree) |
| **Mark Dias** | Non-Executive Director | 20 July 2015 | Ongoing | Director of Be The Change HR Ltd – Company No. 9694576 |
| | | September 2023 | Ongoing | Permanent Deacon in Formation (Voluntary Position). Roman Catholic Diocese of Middlesbrough |
| | | April 2024 | Ongoing | Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board |
| | | March 2025 | Ongoing | Chair of Board of Nicholas Postgate Catholic Academy Trust |
| **Michael Stewart** | Chief Medical Officer | April 2024 | Ongoing | Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board |
| **Miriam Davidson** | Non-Executive Director | April 2024 | Ongoing | Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board |
| | | | Ongoing | Local Government Association Associate, occasional work with English councils on Public Health Peer Reviews and facilitation of relevant workshops |
| **Neil Atkinson** | Managing Director | April 2024 | Ongoing | Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board |
| | | June 2024 | Ongoing | Representation on behalf of North Tees & Hartlepool NHS Foundation Trust on NTH Solutions LLP – Company Number OC419412 |
| | | October 2025 | Ongoing | Director of South Tees Healthcare Management Limited - Company number 10166808 |
| | | 1 November 2025 | Ongoing | Trustee, Age UK |
| **Derek Bell** | Chair | April 2020 | Ongoing | Trustee Royal Medical Benevolent Fund – no remuneration |
| | | April 2018 | Ongoing | Chair and Trustee Tenovus Scotland (Edinburgh) – no remuneration |
| | | April 2021 | Ongoing | Centre for Quality in Governance |
| | | July 2022 | Ongoing | NHS South East London Chair of SEL SEEC |
| | | March 2024 | Ongoing | Member of the Council for Newcastle University. No remuneration. |
| | | April 2024 | Ongoing | Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board |
| **Rachael Metcalf** | Chief People Officer | December 2020 | Ongoing | Role of School Governor at High Tunstall College of Science |

| Board Member | Position | Relevant Dates From | to | Declaration Details |
|---|---|---|---|---|
| | | April 2024 | Ongoing | Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board |
| **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 | April 2024 | Ongoing | Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board |
| | | | Ongoing | Trustee of Hospitals Trust of the Hartlepool |
| | | | Ongoing | Sons (x2) are employees at Hartlepool College of Further Education |
| | | | Ongoing | Wife employed by University Hospitals Tees |
| **Russell Nightingale** | Chief Delivery Officer | May 2026 | Ongoing | Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board |

University Hospitals Tees

**Minutes of a meeting of the University Hospitals Tees Board held in Public at 9:45am on Thursday, 2 July 2026 in Boardroom, 2nd floor, Murray Building, James Cook University Hospital**

**Present:**
Professor Derek Bell, Chair (Chair)
Ali Wilson, Vice Chair/Non-Executive Director
Fay Scullion, Non-Executive Director
Miriam Davidson, Non-Executive Director & Maternity Champion
Celia Weldon, Non-Executive Director
Professor Chris Day, Non-Executive Director
Ken Readshaw, Non-Executive Director / Senior Independent Director
Stacey Hunter, Chief Executive
Matt Neligan, Deputy Chief Executive / Chief Strategy Officer
Neil Atkinson, Managing Director
Mike Stewart, Chief Medical Officer
Rachael Metcalf, Chief People Officer
Paul Mullins, Deputy Director of Finance on behalf of Chris Hand, Chief Finance Officer

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

**In Attendance:**
Sarah Hutt, Assistant Company Secretary (note taker)
Richard Scott and Marie Levy (Shadow Board observers)
Gareth Lightfoot, Press

## GB26/050 Welcome and Introductions

The Chair welcomed members to the meeting and the participants of the Shadow Board programme who were attending the meeting as observers.

## GB26/051 Apologies for Absence

Apologies for absence were reported from Mark Dias, Non-Executive Director, David Redpath, Non-Executive Director, Emma Nunez, Chief Nursing Officer and Chris Hand, Chief Finance Officer.

**Resolved:** that, the verbal update be noted.

## GB26/052 Quorum and Declaration of Interests

The meeting was confirmed as quorate.

No perceived conflicts of interest

The Chair of the meeting referred to the Trust's declaration of interest register for board members. There were no perceived conflicts of interest from the agreed agenda. Should a conflict arise during the course of the meeting, affected individuals should raise the conflict and a decision would be made to ensure appropriate action was taken.

**GB26/053 Minutes of the last meeting held on, 7 May 2026**

The minutes of the last meeting held on, 7 May 2026 were accepted as a true and accurate record.

**Resolved:** that, the minutes of the meeting held on, 7 May 2026 be confirmed as a true and accurate record.

**GB26/054 Matters Arising and Action Log**

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

**Resolved:** that, the verbal update be noted.

**GB26/055 Chair's Report**

The Chair presented the Chair's Report that included national, regional and local matters taking the information as read and highlighting key points.

- NHS Confed Expo - Main topic of discussion was the increase in reported violence and aggression against NHS staff, noting the increase was internationally as well as nationally.
- STHFT Covid Memorial Launch – Unveiling of the Covid memorial artwork took place on 24 June 2026 at both James Cook University Hospital (JCUH) and Friarage Hospital Northallerton (FHN), with the winning entries being from local schools. It was a good example of engaging with communities as part of being an anchor organisation.
- Council of Governors – Development day on 20 May and follow-up sessions supported by Healthwatch looking at the future for patient and public engagement. A formal Council of Governors Meeting in common took place on 25 June 2026.
- Trust Charities – The Charities of both North Tees and Hartlepool NHS Foundation Trust (NTHFT) and South Tees Hospitals NHS Foundation Trust (STHFT) were working together and funded over £150K of staff generated ideas to support health and wellbeing, education and research. A paper regarding proposals for the charities to work closer together was on the agenda of the Private Board.
- Non-Executive Director (NED) Appraisals – The 2025/26 round of appraisals for NEDs was almost complete and a summary would be submitted to NHSE by the deadline of 30 September 2026.
- Ockenden / Amos Reports – The final reports regarding Maternity services were published on 23 June and 30 June 2026 respectively. A significant amount of work had been undertaken internally and an update would be included in the Chief Executive's Report.

The Chair sought an update regarding patient and staff stories to be included at Board meetings. Jackie White, Director of Corporate Affairs & Company Secretary confirmed that a review of the format was being undertaken in conjunction with the Chief Nursing Officer and Chief People Officer and it was anticipated to introduce the new format after the summer.

**Resolved:**
(i) that, the content of the report be noted; and
(ii) that, the new programme regarding patient and staff stories to be introduced to Board after the summer.

**GB26/056 Chief Executive's Report**

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

areas of Alert were relevant at the time of writing the report.

- Remedial work continued to a number of theatres at the University Hospital North Tees (UHNT) following damage caused by flooding, with over 400 patients identified to have procedures re-arranged. Urgent cases were accommodated elsewhere across the organisation and the other cases were being re-appointed. There was an impact to the capital budget for the repairs and revenue budgets to re-appoint. The issue had been escalated to the NENC regional team, which reflected the ageing estate. Thanks were placed on record to the Estates and Facilities and Clinical operational teams.
- The Resident Doctor industrial action planned for June was called off 36 hours prior to the start of the strikes following a revised offer from government, which had subsequently been accepted by the BMA. The Chief Medical Officer would review the specifics of the agreement to understand considerations for University Hospitals Tees (UHT).
- The final Ockenden Report into Maternity Services at Nottingham University Hospitals NHS Trust and the Baroness Amos Report into Maternity and Neonatal Services in England were published on 23 June and 30 June 2026 respectively. The profound and devastating impact on the lives of the families involved was acknowledged and should not be underestimated. The findings provided an opportunity to pause and reflect. It was noted that both NTHFT and STHFT had been supported by the national maternity team as part of the Maternity and Neonatal Improvement Support Team (MNIST) framework, with NTHFT having exited the programme and STHFT commencing 12 months ago, which provided valuable external assurance regarding the services being provided. Work would remain ongoing internally with the maternity leadership teams to review the agreed ten-point plan that set out a number of urgent actions in response to the recommendations in both reports for trusts and the wider system to prioritise, with some actions requiring an update to be reported to Board in 3 months-time. It was positive to note that as a Board a significant amount of time was already spent around leadership, governance and culture collectively.
- Notification had been received regarding potential boundary changes for the NENC ICB footprint, which NHS England (NHSE) were consulting on, following the recently passed English Devolution and Community Empowerment Act 2026 legislation. Feedback was to be submitted by the ICB to NHSE by 14 July 2026 and the Chief Executive confirmed she had responded on behalf of the organisation, highlighting that the view was for the current footprint to remain unchanged.
- Sam Allen, Chief Executive, NENC ICS, would also be undertaking the role of Regional Director, following the previous incumbent stepping down.
- Progress of the Voluntary Redundancy (VR) would be discussed in the Private Board, recognising the sensitive nature.

Miriam Davidson, Non-Executive Director / Maternity Champion reflecting on elements of the Maternity ten-point plan posed the question what other avenues and methods were there within the organisation to ensure the lived experience and patient/families voices were heard, in addition to things like the Maternity Voice Partnership (MVP) and highlighted that there had been discussion at the recent Council of Governors meeting regarding feedback and engagement channels as well as the strands of external oversight in place. Miriam also suggested that a Board Development session be held in relation to Maternity and Perinatal services to further strengthen Board governance and oversight. It was pleasing to note that Kate Brintworth, Chief Midwifery Officer was visiting the organisation that day to present awards as part of the Heart of Tees Conference and Celebration Awards recognising nursing, midwifery and allied health professional colleagues, as well as visiting some wards and departments providing the opportunity for staff to meet her.

The Chief Executive reported that there were already plans to work with the ICB regarding ways to modernise feedback from service users in addition to the current methods. Ali Wilson, Vice Chair welcomed the ten-point plan setting clear priorities to take forward, given the current plethora of maternity data required to be collected / submitted. The Chief Executive highlighted that as part of the two maternity reviews there was recognition that previously there had been too many recommendations and overlap across reviews. It was helpful to consolidate some of the recommendations and be clear about required improvements. The ten-point plan was focusing on the immediate 6-9 months, which would then inform the National Maternity and Neonatal Taskforce Action Plan, due to be published in

December. Ruth Dalton, Director of Communication reported that good progress had been made with the big Maternity and Neonates conversation with staff that the organisation had led-on, which would shortly be rolled out to the wider population to encourage further engagement. The Chief Executive reported that it was clear in the Amos Report that everybody using services should be listened to, but particularly women.

Mike Stewart, Chief Medical Officer concurred with the importance of having a set of focused priorities going forward, as the number of recommendations from previous reviews were unmanageable. It was however pleasing to note the position internally regarding the patient voice, work with the national team, the implementation of Martha's Voice in maternity and maternity triage, which had all been key areas of work.

The Chair confirmed that the recommendations would continue to be revisited to understand the ask on the organisation.

**Resolved:**
(i) that, the content of the report be noted; and
(ii) that, an update regarding the ten-point plan immediate actions in relation to Ockenden and Amos be provided for those due to be presented to Boards within 3 months; and
(iii) that, a session on Maternity and Perinatal Service be scheduled for Board Development.

**GB26/057 Chair's Log – UHT Management Team Meeting 21 May and 18 June 2026**

Stacey Hunter, Chief Executive presented the UHT Management Team Meeting Chairs Logs from meetings held on 21 May and 18 June 2026 taking the information as read.

Mike Stewart, Chief Medical Officer provided clarity regarding the Klebsiella outbreak in the Neonatal Unit at JCUH reported in the 21 May Chairs Log, following a query by Celia Weldon, Non-Executive Director, noting it was reflective of the overcrowded estate.

Ali Wilson, Vice Chair sought assurance regarding having sufficient capacity going into winter with planned bed reductions, as part of proposals to redesign elderly people's medicine ward capacity at JCUH with a targeted implementation date of September, increasing out of hospital capacity with the establishment of a rapid access Frailty Unit. The Chief Executive explained it was still a live conversation with clinical teams and working through a range of plans across various services noting winter plans would be brought to Board.

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

**GB26/058 Board Assurance Framework**

Stuart Irvine, Director of Assurance & Deputy Managing Director presented the Board Assurance Framework (BAF) to the period 30 April 2026 and highlighted the key points.

Existing BAF arrangements had been carried forward into 2026/27 for Quarter 1, whilst the comprehensive review of the BAF was completed. It was proposed the BAF would be reported quarterly instead of monthly using a single reporting structure and would be aligned to the UHT six strategic objectives (and each unitary Trust), with the revised BAF being reported from Quarter 2.

The proposed risk appetite for 2026/27 was presented to Board Committees for discussion in June 2026 in readiness to seek approval by the Board of Directors noting that the risk appetite remained unchanged from 2025/26 with a cautious appetite for quality & safety and open for the remaining domains, which was agreed.

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

There were no significant changes since last report:
NTHFT
• 30 strategic risks
• 10 strategic risks outside of approved risk appetite, with 7 red/high risks
• 65 planned mitigating actions
• 5 reported completed actions (R&I)
• No changes to current risk scores
• 12 action timescale extension requests (1 Digital, 4 Finance, 1 People, 6 R&I)
• Planned action timescale range: April 2026 – April 2035 including eradicating RAAC by 2035.

STHFT
• 31 strategic risks
• 8 strategic risks outside of approved risk appetite, with 5 red/high risks
• 66 planned mitigating actions
• 7 reported completed actions (R&I)
• No changes to current risk scores
• 14 action timescale extension requests (4 Finance, 7 R&I, 3 Trust Estate)
• Planned action timescale range: March 2026 – April 2035 including PFI exit strategy by 2033 and eradicating RAAC by 2035.

Ali Wilson, Non-Executive Director shared feedback from the Shadow Board's review of the BAF Report, with a number of questions posed including the issue regarding the delay in reporting, which the Director of Assurance & Deputy Managing Director responded to in turn. Assurance was provided that the refresh was changing the format and not the rigorous process of reviewing the strategic risks and would be aligned to the agreed UHT strategic objectives. There would be monthly escalating reporting into the UHT Management Team and continued reporting to Board including clear escalations if required.

It was noted that previously it had been agreed to report on a fully validated position both for the BAF and IPR through Committee and Board, creating a delay in the period being reported, prompting discussion regarding having more timely operational data available to be able to monitor performance and continuing to formally report on the BAF retrospectively. It was agreed for the Executive Team to review the approach.

Ken Readshaw, Non-Executive Director reported that both trusts achieved a good head of internal audit opinion, with both auditors confirming that the strength of the BAF and risk management processes were a factor in achieving that level of opinion. However, he sought clarity regarding whether the Clinical Service Units (CSUs) were using the Board risk appetite as part of their scheme design. Although information regarding the Board's setting of the risk appetite had been shared with the CSUs, it was agreed further work could be done.

**Resolved:**
(i) that, the content of the report be noted; and
(ii) that, the proposed risk appetite for 2026/27, carried over from 2025/26 be approved; and
(iii) that, the Executive Team revisit the approach regarding the reporting of data in terms of real-time and fully validated information.

**GB26/059 Quality Committee Chairs Logs 22 June 2026**

Fay Scullion, Non-Executive Director presented the Quality Committee Chairs Log for the meeting held on 22 June 2026 highlighting the key points and noting some items were already covered on the agenda.

- Fuller Compliance Report demonstrated two areas remained outstanding with the specialist survey for security not yet commissioned so Board were unable to gain assurance all areas were compliant, however, all actions were on track to be fully compliant by September and a review was planned in the Autumn. An issue had been reported regarding cooling units due to

hot weather, however, this was being managed.

- IPC metrics remain as Alert. UHT has been part of a wider ICB piece of work regarding infections, and continues to promote the fundamentals and back to basics of IPC to standardise practices across UHT. Handwashing audits were being monitored via the IPC dashboard and it was noted that premises and estate remain an issue.
- An update on the clinical audit was presented and the Committee discussed the significant lack of engagement and compliance with meaningful audits including a lack of movement from CSUs regarding a forward plan. It was noted that there would be escalation to the Quality Performance Review (QPR) meetings and follow up to deliver the clinical audit forward plan.
- Learning from death (LfD) reviews were significantly delayed at NTHFT due to the lack of resources within the mortality review team. There were plans to appoint a lead medical reviewer and subsequently a team of reviewers.
- Good progress continued to be made across UHT with health inequalities projects, noting that some projects were coming to an end and future funding was uncertain. Work was ongoing to make the projects business as usual. NHSE had revised their strategic priorities with a focus on 5 areas, which UHT were aligned to.
- The final draft Quality Account 2025/26 was presented for approval. The good work was commended and it was suggested that an easy read summary also be available to view on the website once published.
- The Organ Donation Report 2025/26 was presented for both trusts demonstrating consistently good performance in patients being referred to the donation services and the experience of families who had been part of the process, which was really positive. STHFT had received a letter commending their excellence in performance.

Miriam Davidson, Non-Executive Director / Maternity Champion reported that the Perinatal Quality Oversight Model Reports were presented for April and May 2026 including valuable clinical data and scores against a range of metrics including the MBRRACE comparator and Apgar score, as well as receiving updates on individual cases. The UHT Culture Improvement Plan 2026/27 was approved by the Committee.

Stacey Hunter, Chief Executive referenced a copy of a letter that had been shared for Board members' information regarding wider issues linked to the Ockenden Report in relation to post-death care and placed on record thanks to the Director of Assurance and Deputy Managing Director for his leadership to date in relation to required follow-up work for the Fuller Report, Phase 2 in order to provide assurance on behalf of the organisation's actions. The Chief Executive was confident based on the work already completed that the organisation would be able to meet the new set of requirements.

It was noted that a UHT lead for Learning for Deaths (LfD) had been appointed who would make further appointments with an expectation to be back on track in respect of the NTHFT LfD review position by Quarter 3: 2026/27.

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

**GB26/060 People Committee Chairs Logs 24 March and 28 April 2026**

Rachael Metcalf, Chief People Officer presented the People Committee Chairs Logs for the meetings held on 26 May and 23 June 2026 highlighting the key points.

Alert items

- The Committee remained concerned with limited assurance in relation to ongoing poor appraisal completion and mandatory training compliance across the organisation. Although improvement plans were in place, clarity of the approach to strengthen assurance was required to achieve as a minimum the agreed standards, noting. Check and challenge had been undertaken and the CSUs issued a trajectory.
- A query had been raised at a recent Council of Governors meeting regarding the application of the Violence and Aggression policy, there were two historic policies at each trust which were in line with NHS guidance, however, a single UHT policy was being developed and staff were being encouraged to use the policies.

Advise items

- Staff survey - Each CSU and Corporate function was undertaking a focused six-week improvement sprint to review both quantitative results and qualitative free text feedback, a gap analysis and update against the prioritised action plans would be provided to Committee and Board.
- The Committee noted the NHS England (NHSE) Improving Sexual Safety Letter detailing a strengthened focus on learning from serious sexual misconduct cases and building a culture that supports confidence to speak up and act. It was agreed that any discriminatory issues would be dealt as never events, which would be reviewed by the Committee. This was considered timely and aligned with the Committee's concerns regarding violence, aggression and discriminatory behaviour. It was noted that a monthly submission was made to the ICB regarding any cases.
- The Committee noted the national expectations arising from the Lord Mann Review including requirements for NHS Boards and staff to complete anti-racism training and strengthen leadership accountability for addressing racism and discrimination. It would be brought back to the next meeting.
- Committee noted improved controls in respect of sickness absence management and the implementation of a comprehensive action plan. It was noted that sickness absence had reduced structurally to 5.5%, with 14 attendance-related dismissals recorded in May 2026, indicating increased rigour and application of policy.

Assure items

- The Committee was assured through a detailed deep dive that early progress against the planned reduction of WTE in 2026/27 in line with the MTFP was on track. The voluntary redundancy (VR) scheme was being implemented with appropriate controls, ensuring releases were only approved where organisational resilience, patient safety and return on investment were evidenced.
- Committee were updated on the national Transforming People Services programme, which represented a significant reform that would require future organisational change.

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

**GB26/061 Academic Committee Chairs Log 11 June 2026**

Professor Chris Day, Non-Executive Director presented the Academic Committee Chairs Log for the meeting held on 11 June 2026 and highlighted the key points.

Advise

- An overview of the development of the Academic Research Units (ARUs) was provided, highlighting the need for clear criteria for establishing new units, alignment with organisational strategy and operating models, and an appropriate balance between research and education. It was agreed that the units should be inclusive of all professional groups, including Nursing, Midwifery and Allied Health Professionals, with leadership arrangements reflecting this diversity. A principles based framework setting out criteria and operating models for new academic units would be developed in advance of the next meeting. Slow progress was noted and it was confirmed that the newly appointed Associate Medical Director, Paul Baker would be taken the lead.
- An update was provided regarding the establishment of a new medical school in Teesside, in partnership with Newcastle University. Positive engagement with the GMC and ongoing legal negotiations were reported, with plans to utilise Newcastle's curriculum and secure contingency arrangements. Due to delays in the allocation of government-funded student places, the school may initially recruit a small cohort of self-funding students while awaiting formal approval to expand. The Committee emphasised the importance of attracting local students and exploring scholarships and financial support to support access to medical education. Approval has been given to recruit a full-time Programme Director to lead the school's development and accreditation process. It was noted that The GMC would be visiting

on 5 August 2026 with Mike Stewart, Chief Medical Officer and Gary Wright, Deputy Director of Education and Learning would represent the organisation at the visit.

Stacey Hunter, Chief Executive reiterated that an MoU had been signed in support of the Medical School with the aim to widen access to a medical school providing opportunities particularly for more deprived communities.

Ali Wilson, Vice Chair, sought to understand what mechanisms were in place to encourage staff interested in research. Mike Stewart, Chief Medical Officer explained that workshops were organised where those involved in research projects displayed their work and any staff interested were encouraged to attend, across all staff groups.

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

**GB26/062 UHT People Plan Update**

Rachael Metcalf, Chief People Officer presented the UHT People Plan Update, taking the information as read. It was the first annual update, following publication of the three-year People Plan in July 25, with 50% of the metrics achieved and 50% remaining in progress.

The areas that remained in progress included

- Mandatory training and appraisal compliance levels
- Sickness absence, although recent improvements noted
- CSU hierarchy for inclusion on ESR
- Level of pay inaccuracies at ST specifically Overpayments and Underpayments
- Lack of availability of management side job evaluation panellists which prevent Job Evaluation progression and length delays

Significant achievements included the delivery of a restorative just culture framework with 70 members of staff trained, extended health and wellbeing offer, strengthened partnerships with external organisations including the establishment of a name individual at Cleveland Police, and the development of policies addressing sexual safety and hate crime.

Ali Wilson, Vice Chair shared feedback from the Shadow Board's review of the Report, noting the progress made to date and a question posed regarding how assurance was gained that the required outcomes would be achieved and that the measures in the plan were effective, which the Chief People Officer responded to, through a reduction in metrics and a shift through staff survey responses. Some elements would form part of the longer cultural journey to embed values and framework. A wider discussion ensued regarding the aim to create an outstanding experience for our people within UHT.

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

**GB26/063 Nurse Safer Staffing Report**

Stacey Hunter, Chief Executive presented the Monthly Nurse Safer Staffing Report for the period April 2026 highlighting the key points and taking the report as read, noting it had been through Committee.

Items for Alert

- Turnover at STHFT increased for both registered and unregistered staff during April 2026, however, aligned to a recurrent seasonal pattern where a rise in turnover was typically seen in April as resignations submitted at the end of the previous financial year take effect.
- The largest variances between actual and required CHPPD were observed on Ward 9, Ward 25 Spinal Injuries and Ainderby.
- At NTHFT, the Band 5 Registered Nurse vacancy position across all in-patient and community services was 15.11WTE. Work continued monthly to move fixed term NQNs into permanent posts as soon are they become available via natural turnover.

- The highest number of In-Phase incidents relating to staff shortages and skill mix were reported in Critical Care and Ward 12.
- The financial ledger reports a vacancy position of 105.90 WTE for HCSWs.
- At NTHFT, the Band 3 HCSW vacancy position across the Trust for April 26 had reduced from 75.58WTE in March 26 to 63.87WTE in April 26 following a recruitment drive earlier this year. The next recruitment centre for both B3 and B2 CSW roles were currently being arranged.

Ali Wilson, Vice Chair shared feedback from the Shadow Board's review of the Report, with a number of questions posed and assurance sought on a number of aspects, prompting discussion.

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

**GB26/064 Resources and Performance Committee Chairs Logs 27 May and 25 June 2026**

Celia Weldon, Non-Executive Director presented the Chairs Log for the meetings held on 27 May and 25 June 2026 and highlighted the key points, noting some of the items had already been discussed earlier in the agenda.

The Committee reviewed 20 metrics, noting improvements in some areas with ongoing challenges around long waits, particularly in RTT and cancer pathways. Theatre refurbishment impacted patient throughput, although urgent and cancer patients had been prioritised.

For NTHFT Cancer Faster Diagnosis had been escalated to Alert from Advise, with a focus on improvement in Urology and Respiratory pathways and for STHFT Community 52ww had been escalated to Alert from Advise, with the longest waiters being brought forward and increased capacity in some areas.

Operational Challenges and Mitigations: Recovery space limitations at James Cook led to patient cancellations, with efforts underway to identify additional capacity. The recent flood in theatres at UHNT had led to cancelled appointments which had impacted around 400 patients, 4 of the 7 theatres were back up and running with work continuing on the remaining 3. The Committee noted high DNA rates and community wait times, with plans for a deep dive into outpatient transformation at the next meeting.

The UHT plan for the 2026/27 financial year was to deliver an overall break-even position, with a break-even plan for both NTHFT and for STHFT. At the end of Month 2 a year-to-date (YTD) position in line with plan was reported, which included additional non-recurrent measures totalling £2.1m year-to date. The Plan assumed workforce reductions across the financial year, with Month 2 reporting a net overall decrease of WTE Worked across the organisation, compared to the previous month and a deep dive had been undertaken to provide assurance regarding delivery of the required reductions.

Year-to-date Agency expenditure was £39k less than plan and £0.2m less (17%), adjusted for inflation, than at the same point in the previous year and year-to-date Bank expenditure was £0.1m higher than plan but £0.6m (12%) less, adjusted for inflation, than at the same point in the previous year. CIP delivery was £10.1m (95% of target), however, this position included a number of non-recurrent schemes, and delivery of recurrent savings was £0.7m behind plan at the end of Month 2. Against the overall CIP target of £81.7m, £11.9m was classified as 'opportunity' and £31.4m still assessed as 'high risk'.

The Committee requested a deep dive into the recent 6-facet survey of the UHNT buildings condition with detailed information provided including the back-log maintenance position, critical structure issue and importance of business continuity plans.

Updates were also provided regarding the targeted OPD improvement project, clinical coding, the national cost collection (NCI) index and the monthly BAF update.

The Committee discussed a letter from NHSE sent to all NHS trusts and ICBs requesting Boards assure themselves that cyber security risks were being managed effectively, with clear, sustained programmes for improvement. The Committee would continue to receive updates on progress being made and

would update the Board accordingly.

Ken Readshaw, Non-Executive Director sought to understand the level of assurance at this point in the year regarding the likelihood of achieving the challenging financial plan for 2026/27. Stacey Hunter, Chief Executive reminded members of the significant plan that was adjusted at the end of the planning round and agreed by the Board, however reported there was a growing confidence in respect of deliverability at this stage, with ongoing monitoring around the phased elements of the plan to increase assurance. The Financial Recovery Oversight Group (FROG) continued to monitor progress and had given a target of 5% savings to the CSUs and corporate areas to close the gap towards the end of the year as well as considering a number of top-down initiatives to see which were achievable. Work also remained ongoing to achieve the required reductions in WTE, noting that the current vacancy freeze was having an impact. The Chief Executive highlighted that the NHS as a whole was marginally off plan at the Month 2 position, with a number of trusts requiring a greater focus from the national team.

Ali Wilson, Vice Chair sought to understand the reasons for the drop in clinical coding performance at NTHFT. Worked remained ongoing to understand the position.

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

**GB26/065 Finance Report: Month 2: 2026/27**

Paul Mullins, Deputy Director of Finance presented the Finance Report for Month 2: 2026/27 and highlighted the key issues, taking the information as read.

The challenging plan for 2026/27 had been discussed earlier in the agenda, with UHT plan to deliver an overall break-even position for both NTHFT and for STHFT. At the end of Month 2 the Group was reporting a year-to-date (YTD) position in line with plan.

The reported position included additional non-recurrent measures totalling £2.1m year-to date across the Group and the forecast outturn position remained in line with plan as at Month 2. However, achievement of the financial control total would require delivery in line with key financial plan assumptions, including realising efficiency saving targets, and mitigation and management action to offset any financial impact from risks and issues that may arise.

Month 2 showed a net overall decrease of 162.89 WTE Worked across the Group, compared to the previous month and compared to the same period the previous year, WTEs were lower by 355.83wte.

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

Across the Group, overall year-to-date reported CIP delivery was £10.1m (95% of target). However, the position included a number of non-recurrent schemes, and delivery of recurrent savings was £0.7m behind plan in the reporting period. Against the overall CIP target of £81.7m, £11.9m was classified as 'opportunity' and £31.4m was still assessed as 'high risk'. De-risking of the CIP programme and maximising recurrent in-year delivery continued to be a key area of focus for the Financial Recovery Oversight Group (FROG) and CSU CIP meetings, with monthly updates provided to Resources and Performance Committee.

External assurance on the year-end financial position was received from the Group's external Auditors following submission of both trusts annual reports and accounts 2025/26, noting that this was the first year with Mazar's as the external auditors for NTHFT.

The cash balance at the end of Month 2 stood at £142.6m for the Group, which was positive.

A brief discussion ensued regarding achievement of the required reductions in WTE and progress to date.

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

**GB26/066 Integrated Performance Report**

Russell Nightingale, Chief Delivery Officer presented the Integrated Performance Report (IPR) for the reporting period to 30 April 2026 and highlighted the key points, noting improvements in some areas and ongoing challenges with long waits, particularly Referral to Treatment (RTT) and cancer pathways.

One new never event was reported following 7 consecutive months with zero reported, the case had been discussed at Quality Committee and there was a continuing focus to strengthen the approach to national safety standards.

Cancer faster diagnosis was outside expected variance, noting there had been a significant drop in performance since March. There was a continued focus on improvement in urology and respiratory pathways specifically and a further update would be provided in the Private Board meeting. Performance compliance for cancer waiting times and elective access standards remained strategic risks on the BAF, with improvement action plans in place.

High DNA rates and Community waiting times were being addressed, with the longest waiters being brought forward to improve the position. Capacity for paediatric therapy interventions at NTHFT, and specialist weight management at STHFT was being addressed with recovery plans in place and discussion with commissioners regarding service provision.

Other initiatives included a Corporate Outpatient Project focusing on partial booking, clinic template standardisation and increasing patient-initiated follow-up rates.

It was noted that performance against the Cancelled Operations – not rebooked within 28 days metric was anticipated to deteriorate following the flood at NTHFT and theatre recovery space issue at STHFT. The 6-4-2 theatre scheduling model was being implemented, which was a streamlined planning framework designed to reduce last-minute cancellations and maximise theatre efficiency.

The Chief Delivery Officer referenced the ongoing focus regarding complaints compliance with oversight by the Quality Committee and escalation via the Quality Performance Review meetings, prompting discussion. The Chair reported the issue had been raised at the recent Council of Governors meeting and it had been agreed to schedule a development session. Ali Wilson, Non-Executive Director sought assurance that the measures being undertaken to improve performance were sustainable. Stacey Hunter, Chief Executive acknowledged the conversation at Council of Governors and highlighted that the Chief Nursing Officer was restructuring across the Quality Team in regard to resources, to ensure that dedicated resource was aligned to the management of complaints and CSUs took ownership, addressing complaints with the same level of priority as patient care to drive out unwanted variation.

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

**GB26/067 Annual Review of Board Committee Terms of Reference**

Jackie White, Director of Corporate Affairs & Company Secretary presented the Annual Review of Board Committee Terms of Reference, highlighting key points and taking the information as read.

In line with good practice, the annual effectiveness review had been undertaken for all the Committees to review the duties and Terms of Reference, some minor changes were identified and agreed at the respective Committee. It was noted that the Resources Committee had been renamed the Resources and Performance Committee and the STHFT Audit and Risk Committee had been renamed the Audit Committee, both changes reflecting the revised remit.

Following discussion with Committee Chairs, it was agreed to include an additional duty into all the

Terms of Reference with the exception of the Audit Committees, in respect of escalation and information sharing between individual Committees and the Board.

Celia Weldon, Non-Executive Director suggested the inclusion of subcommittees that report into the committees to be included into the Terms of Reference. Matt Neligan, Deputy Chief Executive / Chief Strategy Officer highlighted that the Executive Directors associated to each Committee should be included, both suggestions were agreed.

The Terms of Reference were approved subject to the agreed changes.

**Resolved:**
(i) that, the content of the report be noted; and
(ii) that, the Terms of Reference be updated to include the sub-committees reporting to each Committee and the Executive Directors associated with each Committee; and
(iii) that, the Terms of Reference be approved subject to the agreed minor changes.

**South Tees Hospital NHS Trust Unitary Board**

**GB26/068 Modern Slavery Statement 2026/27**

Jackie White, Director of Corporate Affairs & Company Secretary presented the Modern Slavery Statement for 2026/27, which took into account supply chain requirements and included the subsidiary companies of the Trust, noting there were no required changes to the statement.

The signed statement was required to be displayed on the Trust website once approved.

The Board approved the Modern Slavery Statement 2026/27.

**Resolved:**
(i) that, the content of the report be noted; and
(ii) that, the approved Modern Slavery Statement 2026/27 be displayed on the Trust website.

**GB26/069 Use of Seal**

Jackie White, Director of Corporate Affairs & Company Secretary presented the Use of Seal Report for information, setting out the document required to be executed under seal recorded in the Seal Register.

For greater transparency and assurance, it was agreed for future reports to include where the decision for the individual transactions was made.

**Resolved:**
(i) that, the content of the report be noted; and
(ii) that, where the decision were made for individual transactions be noted in future reports.

**GB26/070 Audit Committee Chairs Log: 21 May and 19 June 2026**

Ken Readshaw, Non-Executive Director presented the Audit Committee Chairs Log for the meetings held on 21 May and 19 June 2026.

The Head of Internal Audit Opinion was a rating of Reasonable Assurance. The external audit completion report and auditors annual report were presented, with the audit opinion expected to be unqualified. The significant weakness around value for money remained due to the 2025/26 agreed deficit position, noting however, a break-even plan had been agreed for 2026/27, so the weakness was expected to lift.

The annual report and accounts 2025/26 had been submitted, which was a great achievement and thanks were placed on record to everyone involved in the process, which had been smooth.

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

**North Tees and Hartlepool NHS Trust Unitary Board**

**GB26/071 Modern Slavery Statement 2026/27**

Jackie White, Director of Corporate Affairs & Company Secretary presented the Modern Slavery Statement for 2026/27, which took into account supply chain requirements and included the subsidiary companies of the Trust, noting there were no required changes to the statement.

The signed statement was required to be displayed on the Trust website once approved.

The Board approved the Modern Slavery Statement 2026/27.

**Resolved:** (i) that, the content of the report be noted; and
(ii) that, the approved Modern Slavery Statement 2026/27 be displayed on the Trust website.

**GB26/072 Use of Seal**

Jackie White, Director of Corporate Affairs & Company Secretary presented the Use of Seal Report for information, setting out the document required to be executed under seal recorded in the Seal Register.

For greater transparency and assurance, it was agreed for future reports to include where the decision for the individual transactions was made.

**Resolved:** (i) that, the content of the report be noted; and
(ii) that, where the decision were made for individual transactions be noted in future reports.

**GB26/073 Audit Committee Chairs Logs: 21 May 2026 and EO Meetings 19 & 25 June 2026**

Ken Readshaw, Non-Executive Director presented the Audit Committee Chairs Log from the meeting held on 21 May 2026 and the two extra ordinary meetings held on 19 and 25 June 2026 to finalise the annual filings.

The Head of Internal Audit Opinion was a rating of Good Assurance, which was the same as the previous year, noting that the strength of the BAF and risk management processes were a factor in maintaining the good assurance opinion. The external audit completion report and auditors annual report were presented, with the audit opinion expecting to be unqualified and no significant weaknesses regarding value for money (vfm) due to a break-even plan.

The annual report and accounts 2025/26 had been submitted, which was a monumental achievement. Thanks were placed on record to everyone involved in the process. Stacey Hunter, Chief Executive echoed the sentiment, including the Chief Finance Officer and Director of Corporate Affairs.

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

**GB26/074 Any Other Business**

There was no other business reported.

**GB26/075 Date of Next Meeting**

The next meeting of the Board of Directors will take place on Thursday 3 September 2026 in the Health and Social Care Academy, University Hospital Hartlepool.

Meeting closed: 12.42pm

Signed:  Date: 3 September 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***<br>Consider aligning the IPR to the UHT strategic objectives rather than the CCQ domains for 2026/27 | Neil Atkinson<br>Stuart Irvine | 07 May 2026 | Close | Following discussion it was agreed to consider aligning both the BAF and IPR to the UHT strategic objectives as part of the refresh exercise in advance of 2026/27. it would be reviewed as part of the annual exercise and agreed that a proposal be brought to a future meeting. An update was provided at the meeting on 7 May, it was planned to bring an update to the June Board Devpt session. The Chief Executive referenced it would be a light touch piece of work at this stage. The Chair highlighted how the Board could receive more timely data to enable more real-time discussion and inform the improvement agenda. A proposal would be taken to UHT Management Team and then presented to Board with a discussion regarding timeliness of data. Agreement of the risk appetite would take place at the session on 4 June.<br>BAF and IPR being realigned to strategic objectives for 2026/27. | |
| 05 March 2026 | GB25/245 | ***People Committee Chairs Logs 27 January and 24 February 2026***<br>A development session be arranged to consider in more detail the instances where regulatory and process-driven reporting requirements were creating structural imbalances in how performance was presented and could result in one site or statutory body appearing to be comparatively underperforming. | Jackie White | 06 August 2026 | Open | In response to the Board being asked to think about Group decisions and the potential disparity in reporting for each trust as part of a broader risk due to the group structure maybe resulting in one site or statutory body appearing to be comparatively underperforming, it was agreed to discuss as part of a development session regarding options going forward for the organisation. | |
| 07 May 2026 | GB26/026 | ***Chair's Report***<br>A Well-Led Review for UHT would take place in Autumn 2026. | Jackie White | 01 October 2026 | Open | It was confirmed that a Well-Led Review for the organisation would be planned to take place in the Autumn of 2026 and a procurement process would be undertaken.<br>Update: postponed to early 2027. | |
| 07 May 2026 | GB26/027 | ***Chief Executive's Report***<br>Consideration to be given how best to capture the various strands of activity undertaken with schools and other external stakeholders as an anchor organisation. | Ruth Dalton | 03 September 2026 | Open | It was noted that there was wide engagement and strong links in place with local schools/colleges and external stakeholders as part of being an anchor organisation and it would be good to consider how best to capture the strands of activity being undertaken.<br>At the meeting on 2 July, Miriam highlighted demonstrating the organisation was an anchor institute would feed in well with the Delivery Plan of the Health and Equalities Strategy. Ruth agreed to follow up with Esther Mireku and colleagues. | |
| 07 May 2026 | GB26/028 | ***Chair's Log – UHT Management Team Meeting 19 March and 23 April 2026***<br>An update regarding single EPR system to be provided as part of Digital Update at Board Development session on 6 August 2026. | Ken Anderson | 01 October 2026 | Open | Connecting to discussion and action from Private Board regarding a Digital Update to be provided at a Board Development session to include Digital Strategy, digital initiatives/work streams and timescales.<br>In private meeting on 2 July further discussion regarding when to schedule update on EPR and wider digital initiatives linked to projects but also timelines of digital as part of the UHT Strategy. It was proposed to delay until Sep or October but to be confirmed.<br>POST MEETING NOTE: Agreed session to be at October Development session. | |

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| 07 May 2026 | GB26/031 | ***Perinatal Quality and Safety Report Quarter 4: 2025/26***<br>The sustainability and safety of the home birth service model to be reviewed in light of the national learning, considering whether to move to a single service or alternative staffing model for UHT. | Emma Nunez | 03 September 2026 | Open | Following discussion regarding home birth service provision and national focus, it was was agreed to review the sustainability and safety of the current home birth service model for consideration whether to move to a single service or alternative staffing model for UHT. To be taken through Quality Committee and escalated to Board. | Quality Committee |
| 07 May 2026 | GB26/031 | ***Perinatal Quality and Safety Report Quarter 4: 2025/26***<br>An update regarding the revised business case for elective caesareans with timelines and addressing the clinical concerns and theatre capacity issues be managed through the CSUs and presented to the UHT Management Team | Emma Nunez / Mike Stewart | 02 July 2026 | Open | Following discussion regarding the estates constraints and increase in demand for caesarean births were being actively reviewed as part of future service delivery, it was agreed to provide an updated regarding the revised business case with clarity around timelines and addressing the clinical concerns and theatre capacity issues to be managed through the CSUs and presented to the UHT Management Team with an update to Board via the Management Team Chairs Log.<br>An update not provided at 2 July meeting. | |
| 07 May 2026 | GB26/031 | ***Perinatal Quality and Safety Report Quarter 4: 2025/26***<br>A rapid risk assessment to be undertaken of the neonatal estate to identify any changes that can be made, pending further progression of the larger capital project. Update to be provided at the Board Development session on 4 June 2026 linked to the IPC session. | Emma Nunez / Steve Taylor | 04 June 2026 | Close | Following discussion regarding the estates constraints and not currently meeting national guidance for neonatal care, it was agreed to undertake a rapid risk assessment including cot numbers and spacing to identify any changes that can be made, pending further progression of the larger capital project. Update to be provided at the Board Development session on 4 June 2026 linked to the IPC session. Arrangements to be progressed through the CSUs and UHT Management Team.<br>It was noted at meeting on 2 July that interim minor works were being carried out to improve the estate in conjunction with the IPC team which would conclude at the end of July, separate from the larger maternity estates capital project. | |
| 07 May 2026 | GB26/035 | **NHS Staff Survey Overview 2025**<br>It was agreed to bring an update regarding the action plan to address the staff survey results encompassing all elements to ensure the concerns raised were addressed. | Rachael Metcalf | 02 July 2026 | Close | A lengthy discussion ensued regarding the poor results of the staff survey and the concerns raised. It was agreed that a more rigorous response and action plan encompassing all elements would be presented to People Committee in June and to Board in July.<br>Noted at meeting on 2 July, update due at People Committee in July. Part way through a 6 week sprint exercise with colleagues across the CSUs, working at pace to understand what sits behind the survey results. An update would be taken to Management Board and A Hearing it Session was planned once finished.<br>13/0826 - deep dive undertaken at People Committee and details will be esclated into Board | People Committee |
| 07 May 2026 | GB26/040 | ***Integrated Performance Report***<br>An update to be brought to the next meeting regarding a review of performance against 28 days and 62 days cancer targets. | Russ Nightingale | 02 July 2026 | Close | Following discussion regarding performance and the variation in compliance against 28 days and 62 days cancer targets, it was agreed to bring an update to the next meeting. Update provided at meeting on 2 July. | |
| 07 May 2026 | GB26/048 | ***Any Other Business***<br>A future Board Development session would be scheduled to discuss significant transactions and a review of contract strategies. | Matt Neligan | 01 October 2026 | Close | A Board Development session would be led by the Chief Strategy Officer regarding significant transactions and contract strategies in line with improvement plans linked to the Aubrey Report.<br>13/8/26 - Board session booked for October | |
| 02 July 2026 | GB26/055 | ***Chairs Report***<br>A new format and programme regarding patient experience and staff stories to be introduced to Board meetings after the summer. | Jackie White/Emma Nunez/Rachael Metcalf | 03 September 2026 | Close | Following query by Chair, it was confirmed that a review of the format for patient and staff stories was being undertaken in conjunction with the Chief Nursing Officer and Chief People Officer and it was anticipated to introduce the new programme after the summer.<br>13/8/26 - new format included on Board agenda for September | |

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| 02 July 2026 | GB26/056 | ***Chief Executive's Report***<br>An update regarding the Ten Point Plan immediate actions in relation to Ockenden and Amos that are due to be presented to Boards within 3 months | Emma Nunez | 03 September 2026 | Open | Following the publication of the final Ockenden Report and Baroness Amos Review, a ten point plan was issued setting out a set of urgent actions in response to the recommendations in both reports for trusts and the wider system to prioritise, with some actions requiring an update to be reported to Boards in 3 months-time. | |
| 02 July 2026 | GB26/056 | ***Chief Executive's Report***<br>A Board Development session on Maternity to be scheduled. | Stacey Hunter/Emma Nunez | 03 September 2026 | Close | As part of detailed discussion regarding the Ockenden and Amos Reports it was agreed to schedule a Board Development session on Maternity to further strenthen board governance. A session was scheduled for 3 December 2026 | |
| 02 July 2026 | GB26/058 | ***Board Assurance Framework***<br>Discussion to be revisited regarding presenting real-time data / reporting delays with fully validated information across the BAF and IPR. | Stacey Hunter/Stuart Irvine/Russ Nightingale | 03 September 2026 | Close | A discussion took place at 2 July meeting regarding the delay in reporting by providing full-validated data or providing more real-time information for the BAF and IPR. It was agreed for the Executive Team to review the approach<br>13/8/26 - Russ to provide up to date information at Resources Committee and Board supported by a validated IPR. | |
| 02 July 2026 | GB26/067 | ***Annual Review of Board Committee Terms of Reference***<br>Sub-groups of Committees and Executive Director names to be updated across Board Committee Terms of Reference | Jackie White | 03 September 2026 | Close | Was highlighted at 2 July meeting as part of Annual Review of Board Committee Terms of Reference, some sub-groups of committees and names of Executive Directors to be updated. ToR all checked and updated. | |
| 02 July 2026 | GB26/072 | ***Use of Seal***<br>In future reports to include where decision for the transaction was agreed. | Jackie White | 03 September 2026 | Close | For greater transparency and assurance, it was agreed in respect of the documents being sealed to include where the transaction was agreed in future reports. | |
| 02 July 2026 | | | | | | | |

University Hospitals Tees

# Chair's Report

**Meeting date:** 3 September 2026

**Reporting to:** Board of Directors

**Agenda item No: 1.7**

**Report author:** Jackie White, Company Secretary

**Executive director sponsor:** Derek Bell, Chairman

**Action required:** Information

**Delegation status:** Jointly delegated item to Group Board

**Previously presented to:** n/a

## UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

## CQC domain link:

Well-led

## Board assurance framework references this paper relates to:

Add in BAF reference.

## Key discussion points and matters to be escalated from the meeting

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

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

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

n/a

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

n/a

## Recommendations:

The Board of Directors are asked to note the report.

# 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

Over the reporting period, my activities have focused on five key themes: supporting the continued development of University Hospitals Tees, strengthening Board effectiveness and leadership, maintaining strong stakeholder relationships, promoting community and educational partnerships, and ensuring visible leadership across our hospital sites. Through participation in Board meetings, Board development sessions and engagement with the NHS England Board Development Programme, I have continued to contribute to the evolution of our governance arrangements and the delivery of our long-term strategic ambitions.

### 3.1 National and Regional updates

I attended with Stacey Hunter CEO a regional event on 7 July with Regional Director, Samantha Allen and Regional Chair, Bill McCarthy in York. The discussion focussed on our collective approach to values based, delivery focussed leadership, the big leaps we want to make together and future ways of working.

Ali Wilson, Vice Chair attended a National Meeting on the Amos and Ockenden Maternity reports and the 10-point plan.

Regionally, discussions continue in relation to greater collaboration including greater collaboration between CDDFT and Sunderland.

### 3.2 Governor update

UHT Annual Members' Meeting will take place on **5 October 2026** and will provide an opportunity for members, patients, staff and stakeholders to hear about UHT achievements, challenges and priorities for the future. The meeting will include updates on organisational performance, service developments and strategic plans, together with opportunities for members to ask questions and engage directly with UHT leaders. The event forms an important part of the UHT commitment to openness, accountability and member engagement.

As part of the Annual Members' Meeting on 5 October 2026, UHT external auditors will present their independent assessment of the Annual Report and Accounts, providing assurance to members and governors regarding the Trust's financial statements and responding to any questions arising from the audit to the Council of Governors at their meeting prior to the Annual Members meeting.

Members of the Council of Governors have continued to take a close interest in the Government's proposed NHS reforms and the Health Bill currently progressing through Parliament. The proposals include the removal of the statutory requirement for NHS Foundation Trusts to maintain a Council of Governors, alongside wider reforms to NHS governance arrangements. The Government has

indicated that new approaches to patient, staff and stakeholder engagement are expected to replace current arrangements, although the detail of these arrangements remains under development.

Governors expressed a strong interest in understanding the potential implications for local accountability, representation and engagement with members, patients, staff and partner organisations. Discussions by Governors supported by Healthwatch have highlighted the important contribution made by Governors and ensuring that the views of local communities continue to inform decision-making.

UHT will continue to monitor the progress of the legislation and any associated guidance. Until any legislative changes are enacted, the Council of Governors will continue to operate in accordance with its statutory responsibilities and the Trust Constitution. Further updates will be provided to both the Council of Governors and Board as the national position becomes clearer

Congratulations to Tony Collier, elected governor and newly appointed Lead Governor for North Tees & Hartlepool NHS Trust.

### 3.4 Board development / seminar

NHS England has launched a fully funded 12-month Board Development Programme for all NHS provider and ICB boards, designed to strengthen board effectiveness, governance and collective leadership. The programme comprises three face-to-face whole-board development sessions, supported learning opportunities and access to a comprehensive suite of leadership and governance resources. UHT has been included within the initial cohort and initial discussions are underway to shape a programme aligned to the Board's current priorities, organisational context and future ambitions. We will look to maximise this opportunity and dovetail it with our current.

We have a busy board development calendar for this year with in-depth sessions planned for Maternity Services, UHT strategy including digital and estates and we are currently in the process of planning a well-led review.

### 3.6 Non-Executive Directors

Following approval by the Council of Governors for South Tees Hospitals NHS Trust and North Tees & Hartlepool NHS Trust I am pleased to welcome Kate Nicholls OBE, David Gallagher and Diane French as new non-executive directors for UHT. Colleagues will be onboarded during the summer and join us for meetings and seminars during this time.

Appraisals for non-executive directors are concluded and a summary submitted to NHS England. A summary report will be received by the Nomination Committee on this year's appraisals and succession planning.

I am also pleased to report that my appraisal has been completed and the outputs fed into Council of Governors meeting in Common in July.

### 3.7 Social Mobility Foundation

On 14 July, I was invited to speak at a Social Mobility Foundation event, engaging with young people interested in future careers and leadership opportunities. The discussion highlighted the NHS's role as a major local employer, the importance of creating opportunities for people from all backgrounds, and the value of inclusive leadership in supporting social mobility and improving outcomes for our communities. The event provided an opportunity to promote the wide range of careers available within the NHS and to encourage the next generation of healthcare and public service leaders

### 3.8 Visibility

Throughout the period, I have maintained a visible presence across both North Tees and James Cook sites, meeting staff and gaining first-hand insight into the challenges and successes of our services. These engagements remain invaluable in ensuring that Board discussions and strategic decision-making remain connected to the experiences of our patients, staff and local communities.

Along with the full Board, I spent a morning with Community staff in Hambleton and Richmondshire as part of our Board visibility plan. I accompanied the Clinical Lead for District Nursing in Thirsk. The feedback from Board on their visits demonstrated a highly committed workforce delivering excellent care for increasingly complex patients within the community setting. Staff spoke positively about the quality of care provided and the value of services such as Hospital at Home. Key themes raised included workforce pressures, sickness absence, challenges with continuity of care and increasing demand. There were recurring concerns regarding digital connectivity, the implementation of the new rostering system and the need for improved information sharing between hospital, community and primary care services. Staff also highlighted opportunities to improve leadership visibility and address variation in service access and referral processes. Despite these challenges, morale remained positive and teams demonstrated a strong commitment to delivering high-quality, patient-centred care. Opportunities exist to further improve our community services for patients

### 3.9 Annual Members Meeting / Annual General Meeting

I am pleased to confirm that our Annual General Meeting and Annual Members meeting is taking place on 5 October 2026 from 12:45 for networking and refreshments and market place opportunities. We hope to see you again at the Digital Centre, Teesside University – thank you to our strategic Partner Teesside University.

### 3.10 Flu vaccination plans

Preparations are underway for the UHTs annual seasonal flu vaccination programme, which will commence in the autumn. The programme is an important part of protecting patients, staff and local communities during the winter period and helps reduce the impact of seasonal illness on both individuals and healthcare services. UHT will be encouraging all eligible staff and members of the public to take up the vaccine and will be working closely with teams across the organisation to maximise uptake. Information on vaccination clinics and arrangements for staff will be communicated over the coming weeks as part of UHTs wider winter preparedness planning

**Derek Bell**
**Chairman**

University Hospitals Tees

# Chief Executive Officer Report

**Meeting date:** 3 September 2026

**Reporting to:** Board of Directors

**Agenda item No:** 1.8

**Report authors:** Stacey Hunter CEO / Abigail Smith Executive Assistant to CEO

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

**Action required:** Information

**Delegation status:** Jointly delegated item to Group Board

**Previously presented to:** N/A

## UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

## CQC domain link:

Well-led

## Board assurance / risk register this paper relates to:

N/A

## Key discussion points and matters to be escalated from the meeting

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

The Board will want to note that our finances at month 4 reported in line with plan. The level of recurrent savings is increasing with ongoing work via the CSUs and the Financial Recovery Group.

Further to the floods that impacted theatres at North Tees in June and caused significant disruption with 2 theatres still not in use at the time of writing this report NTH are not delivering against the RTT plan in month 4. The national team have requested a recovery plan from us to ensure that this can be rectified over the coming weeks. The Chief Delivery Officer and his team are in the process of detailing the actions we need to take to recover the trajectory.

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

There is a new Interim Regional Director in place who in conjunction with the Regional Chair is reviewing the arrangements for CEOs and Chairs to come together. This will be focused on shared endeavours whereby operating as a region can bring significant additional benefits and learning from those providers who are making the most significant improvements and or who have sustained upper quartile performance in key standards.

As part of the new arrangements the region whose key priority is in recovering the financial position across the region have set out an additional framework called the Provider Assurance Model to increase grip and control in their oversight of providers and ICBs performance against their financial plans. This commenced for Month 4 and has to be reported externally by working day 7. The detail of this for UHT will be shared via the Financial Recovery Group and direct with the Resources and Performance Committee.

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

The report highlights a number of areas of clinical practice whereby our teams continue to excel and innovate.

It also reports on an excellent population health conference organised by our public health doctors which launched the UHT Reducing Health Inequalities strategy.

## Recommendations:

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

## Chief Executive's Report

### 1. Introduction

This report provides information to the Board of Directors on key national, regional and local issues and is linked to the strategic objectives of the Trust. It covers the period since our last Board meeting on 2 July 2026.

### 2. National Priorities

#### 2.1. UK Government Update

Following the appointment of Prime Minister Andy Burnham and the subsequent Cabinet reshuffle in July 2026, there has been a change in leadership at the Department of Health and Social Care, with Yvette Cooper appointed as Secretary of State for Health and Social Care. Early indications suggest a continued focus on NHS recovery, improving access to care, maternity services, workforce sustainability and the integration of health and social care services. The new administration has also signalled a stronger emphasis on social care reform, recognising the impact that delays in social care provision have on hospital flow, discharge performance and overall NHS capacity. At this stage, there are no significant immediate changes to NHS planning requirements; however, national policy priorities and funding expectations may evolve as the new government's health agenda develops. The Trust will continue to monitor emerging policy announcements and assess any implications for strategic planning, service transformation programmes and delivery of the NHS Long Term Plan objectives.

#### 2.2. Maternity and Neonatal Services National Review Programme

Following the publication of Baroness Amos' independent investigation into maternity and neonatal services in England and Donna Ockenden's review of services at Nottingham University Hospitals NHS Trust, NHS organisations have been issued with a 10-point urgent action plan aimed at strengthening maternity and neonatal services nationally.

As part of this programme, trusts are required to undertake a Board-approved assurance process, including completion of a baseline assessment by 25 September 2026 and a progress update by 31 December 2026. The Trust has completed its baseline assessment, which has been reviewed by the Quality Assurance Committee and is now presented to the Board for approval.

In parallel, NHS England is launching the "Amos into Action" programme to support the implementation of improvements and drive learning across maternity and neonatal services nationally. The programme places a strong emphasis on collaboration, engagement and continuous improvement, providing opportunities for staff and service users to contribute to the future development of services.

The Trust is already progressing work aligned to this approach across the Tees health

economy, engaging with staff, women and families to collaboratively shape service improvements and ensure that maternity and neonatal services remain safe, responsive and centred on the needs of patients and local communities.

### 2.3. Implementation of the NHS 10 Year Health Plan

The NHS 10 Year Health Plan continues to drive national policy and service redesign. The plan is built around three key shifts: moving care from hospital to community settings, accelerating digital transformation, and increasing the focus on prevention. These priorities are expected to influence future service models, capital investment, workforce planning and transformation programmes across all NHS organisations.

### 2.4. Greater Local Commissioning Responsibilities

National proposals continue to shift commissioning responsibilities closer to Integrated Care Boards, with further commissioning functions expected to transfer from NHS England to local systems. This is likely to strengthen the role of ICBs in determining service priorities and may create additional opportunities, as well as challenges, for provider collaboration and service reconfiguration across systems.

## 3. Regional Update

### 3.1. North East & North Cumbria NHS CEO Leaders update

The regional Chair Bill McCarthy and the CEO Samantha Allen held a Chairs and CEO event on the 17 August in York. It was a good opportunity to hear their views re the most effective ways to work together at a regional wide level. They shared and launched the new Provider Assurance Model which we have shared via our resources committee with the Board.

To support with learning across the region 3 providers gave brief, informative presentations on improvement priorities related to patient flow and non- elective care. They are keen to hear back from us re any other ideas of where collaboration as a region can help accelerate key priorities and standards. Early discussions focused on cancer, neighbourhood health and urgent care.

### 3.2. Partnership Working

We have continued to work closely with system partners to support the development and delivery of our clinical strategy. During July 2026, key messages outlining the case for change were presented to both the Tees Valley Joint Health Scrutiny Committee and the North Yorkshire Scrutiny Committee. These discussions form an important part of the engagement process underpinning UHT's Pre-Consultation Business Case (PCBC).

The scrutiny committees provided valuable feedback on a range of issues, including access to services, travel considerations for rural and disadvantaged communities, workforce engagement, and the importance of sustaining improvements in operational performance. There was broad support for the overall direction of travel and recognition of the need to transform clinical services to ensure long-term sustainability and improved patient outcomes. Members also acknowledged the strategic case for the redevelopment

of North Tees Hospital and emphasised the importance of continued stakeholder engagement as proposals progress.

Alongside this work, collaboration with local authority and health system partners continues to support the development of neighbourhood health models across each place within the Integrated Care System. New place-based partnership governance arrangements are being established to enable agreement of neighbourhood footprints, with work underway to develop neighbourhood health plans by March 2027.

There is strong alignment across partners around the development of integrated, community-centred models of care, with University Hospitals Tees playing an active role in shaping these arrangements. The Trust is also building on lessons learned from the Stockton Wave 1 programme to support the evolution of services, strengthen neighbourhood-based working, and improve the coordination of care for local populations.

### 3.3. UHT Improving Population Health and Reducing Healthcare Inequalities Conference

In July, University Hospitals Tees hosted a multi-agency conference to launch its Population Health and Reducing Healthcare Inequalities Strategy, supporting the Trust's six Strategic Objectives. The event brought together national, regional and local partners to explore the health challenges affecting local communities and to identify opportunities for collaborative action to reduce inequalities and improve outcomes.

The conference showcased a range of innovative and inclusive care models from across UHT, with workshops focusing on key areas including maternity services, children and young people, outpatient access, emergency care attendance, lung cancer screening, health literacy and poverty-proofing healthcare services. National experts commended the Trust's strong leadership, partnership working and commitment to tackling health inequalities. Particular recognition was given to UHT's Anchor Programme, Waiting Well initiative and Tobacco Dependency Service, which have been highlighted as examples of good practice for wider national sharing. The event reinforced UHT's ambition to work collaboratively with partners to address the wider determinants of health and improve outcomes for the most disadvantaged communities across Teesside.

## 4. Local update

### 4.1. Estates Update - Emergency Department Flooding

Recent heavy rain in the area caused some flooding within the Emergency Department at the University Hospital of North Tees; however, the issue was resolved quickly with minimal disruption to services.

It was noted that this was similar to a previous incident and resulted from a significant period of heavy rainfall, during which the ageing drainage infrastructure was unable to cope with the volume of water. The drains became overwhelmed, leading to localised flooding.

A review is being undertaken to identify common themes and contributory factors across all affected areas. The findings will be considered as part of the Trust's capital programme to determine what improvements may be required to strengthen infrastructure resilience

and reduce the risk of similar incidents occurring in the future.

The theatre floods as reported to the Board previously have caused significant disruption to patients and impacted the RTT performance for North Tees & Hartlepool NHS Foundation Trust. The national team have requested formal recovery plans from all trusts who are not delivering their RTT plans at month 4 which includes us due to the floods. The Chief Delivery Officer and his team are working through the mitigation and actions re return the performance to plan over the coming months.

### 4.2. Finance Update

Regional NHSE have implemented a revised financial oversight framework from Month 4.

Each NEY organisation has been stratified for financial risk, within the context of performance safety. This risk classification determines the reporting, oversight and support required for each organisation. The risk classifications are:

- On track – retained autonomy [Red]
- Financial recovery required and 'watch' approach by Region [Amber]
- Financial recovery required with active involvement by Region [Red]
- Mandated national support or non-compliant plan [Maroon]

Both UHT trusts have been assigned to the Amber 'watch' category.

This means that an additional 'Provider Assurance Model' must be submitted to Regional NHSE each month, by working day 7.

The PAM also works through a best/mid/worst case scenario in relation to the yearend forecast. The model takes into account current delivery against CIP and builds in a standardised set of risk adjustments. The details of this have been shared with the resources committee.

### 4.3. Violence and Aggression Towards Staff

Emergency Department teams across University Hospitals Tees have continued to raise awareness of the increasing incidence and impact of violence, aggression and abusive behaviour directed towards NHS staff. Protecting staff from harm remains a key priority, and the Trust continues to promote a zero-tolerance approach to violence and aggression in all healthcare settings.

As part of this work, colleagues have been highlighting the experiences of frontline staff and the importance of creating a safe working environment for those delivering patient care. This has included communications and engagement activity aimed at increasing public awareness of the challenges faced by Emergency Department teams and reinforcing the message that abusive or threatening behaviour towards staff is unacceptable.

The use of body-worn cameras within the Emergency Department at The James Cook University Hospital continues to support this approach. The cameras provide an additional safeguard for staff, act as a deterrent to aggressive behaviour and can assist in the investigation of incidents where violence or abuse has occurred. Early feedback from

clinical teams has been positive, with staff reporting increased confidence and reassurance when managing challenging situations.

The Trust remains committed to working with staff, partner organisations and local communities to reduce incidents of violence and aggression, support staff wellbeing, and ensure that all colleagues can work in an environment that is safe, secure and respectful.

### 4.4. Staff Survey Improvement Programme

Following publication of the 2025 NHS Staff Survey results, University Hospitals Tees has undertaken a targeted improvement programme using a sprint approach to better understand colleague feedback and identify priority areas for action. The first phase focused on engagement with CSU leadership teams to establish the three key themes requiring organisational attention. The second phase expanded this work through wider staff engagement activity, enabling colleagues across the organisation to provide further insight and help shape future improvements.

The phase two staff feedback exercise closed in August, with findings due to be shared across the organisation shortly. The outputs from this work will inform a comprehensive action plan and support the Trust's ongoing commitment to enhancing staff experience, strengthening organisational culture and ensuring UHT remains a positive place to work for all colleagues.

### 4.5. Staff Awards and Recognition

Early findings from the Staff Survey improvement programme and associated staff engagement activity highlighted reward and recognition as an area of focus for colleagues across University Hospitals Tees. In response, the Trust launched its inaugural University Hospitals Tees Caring Better Together Awards in August, providing a new opportunity to celebrate the exceptional contribution of staff, volunteers and teams across the organisation.

The awards ceremony will take place in October following the Annual General Meeting at the Digital Life Centre, Teesside University. Reflecting feedback received from staff, the awards categories have been designed to be non-role specific, ensuring an inclusive approach that enables colleagues from all professions and backgrounds to be recognised for their achievements. The launch has generated a highly positive response, with strong engagement and a significant number of nominations received, demonstrating the enthusiasm of staff to recognise and celebrate the contributions of their colleagues.

## 5. In other news!

### 5.1. Advancing Specialist Hepato-Pancreato-Biliary Services

The Gastroenterology team recently welcomed Professor Hassan Okasha, an internationally recognised expert in advanced endoscopy, to University Hospitals Tees to lead a specialist Endoscopic Ultrasound (EUS) workshop. The visit provided a valuable opportunity for clinicians to share expertise, observe advanced techniques and discuss emerging developments in the diagnosis and management of complex hepato-pancreato-biliary (HPB) conditions.

The workshop formed part of the UHT's ongoing commitment to clinical excellence, innovation and continuous professional development, supporting the delivery of high-quality specialist care for patients across the region. By facilitating access to internationally recognised expertise, the event further strengthened local capability in advanced diagnostic and therapeutic endoscopy and reinforced the Trust's ambition to develop and enhance HPB services in line with best practice.

This collaboration demonstrates the organisation's continued focus on investing in its workforce, promoting clinical learning and ensuring patients benefit from the latest advances in specialist gastrointestinal care.

### 5.2. Spotlight on our Bereavement Support Officers

Bereavement Support Officers play a vital role in supporting patients' families across University Hospitals Tees, providing practical guidance and compassionate support following the death of a loved one in hospital.

At the University Hospital of North Tees, Bereavement Support Officers work closely with families during what is often one of the most difficult and overwhelming periods of their lives. Through their professionalism, empathy and dedication, they provide reassurance, advice and practical assistance, helping relatives understand and navigate the processes that follow a bereavement.

In addition to serving as a key point of contact for bereaved families, the team play an essential role in ensuring the Trust meets its statutory responsibilities following a death. Their work includes supporting the completion of death certification processes, liaising with HM Coroner, funeral directors and registrars, and helping families understand the legal and administrative requirements involved.

Their contribution is invaluable in ensuring that families receive timely, sensitive and compassionate support at a particularly challenging time, while also facilitating the efficient management of important legal and regulatory processes.

### 5.3. Transforming Lives Through Innovative Heart Care

A significant milestone has been reached within the specialist cardiology services, with the successful completion of the 100th Mitral Transcatheter Edge-to-Edge Repair (TEER) procedure at The James Cook University Hospital.

Since introducing the pioneering procedure in 2019, the specialist structural heart team has provided a minimally invasive treatment option for patients living with mitral regurgitation, a condition caused by a leaking mitral valve that can lead to debilitating symptoms including breathlessness, fatigue and fluid retention. TEER offers an alternative for patients who may be unsuitable for traditional open-heart surgery, particularly older and higher-risk individuals.

The procedure enables patients to benefit from reduced recovery times, with many returning home the following day and experiencing rapid improvements in symptoms and

quality of life. The service has transformed treatment options for patients across the region, many of whom previously had limited or no viable interventions available.

This milestone further strengthens University Hospitals Tees' reputation as a provider of specialist cardiovascular services and demonstrates the ongoing commitment of our teams to improving outcomes and enhancing the quality of life for patients across the Tees Valley and wider region.

### 5.4. Commemorating Local Experiences of the COVID-19 Pandemic

Two memorial artworks, created by local students and inspired by the experiences of communities during the COVID-19 pandemic, have been unveiled at The James Cook University Hospital and Friarage Hospital. The installations form part of the ongoing work of the University Hospitals Tees Arts Council, which aims to enhance hospital environments and strengthen connections between healthcare services and the communities they serve.

The artworks provide a lasting tribute to those affected by the pandemic, recognising the experiences of patients, families, staff and local communities during an unprecedented period for the NHS. Developed in collaboration with local students, the projects have provided young people with an opportunity to reflect on the impact of the pandemic while contributing to meaningful and permanent pieces of artwork within Trust facilities.

The unveiling highlights the important role that arts and culture can play in supporting wellbeing, reflection and healing within healthcare environments. It also demonstrates the Trust's continued commitment to community engagement, ensuring that the voices and experiences of local people are represented within our hospitals. The memorials will serve as a lasting reminder of the resilience, dedication and compassion shown by staff, patients and communities throughout the pandemic.

### 5.5. Heart Failure Hospital at Home Service Supporting Patients to Live Well at Home

The Heart Failure Hospital at Home Team continues to demonstrate the benefits of innovative, patient-centred care through its cardiac remote monitoring service, helping patients manage complex heart conditions from the comfort of their own homes.

One such patient from Stockton has been supported by the team since suffering a heart attack four years ago. Since then, he has experienced a range of ongoing cardiac issues, including an irregular heart rhythm, breathlessness and fluid retention. Through regular monitoring and specialist support, the team has been able to help him manage his condition while reducing the need for frequent hospital visits.

Patients enrolled in the service are provided with a home monitoring kit and a dedicated digital app, enabling them to record key health information including blood pressure, heart rate, oxygen saturation levels and weight. These readings are reviewed remotely by specialist heart failure clinicians, allowing the team to closely monitor patients' conditions and identify any signs of deterioration at an early stage.

The service enables timely intervention, including medication adjustments and clinical advice, helping to prevent avoidable hospital admissions and improve patient outcomes. It

also supports greater independence and reassurance for patients and their families, ensuring they remain connected to specialist care while continuing to live safely at home.

The programme reflects the UHT's commitment to delivering care closer to home and aligns strongly with the national ambition to shift services from hospital settings into the community, improving patient experience while making the best use of healthcare resources.

## 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: 23 July 2026

**Meeting date:** 3 September 2026

**Reporting to:** Board of Directors

**Agenda item No:** 1.9

**Report author:** Stacey Hunter, CEO and 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:

Select:

Well-led

## Board assurance / risk register this paper relates to:

## Key discussion points and matters to be escalated from the meeting

**Financial Recovery and Workforce Controls**

- Noted continued progress against the Trust's financial recovery programme, including delivery of savings plans and the ongoing Vacancy Control Panel process.
- Discussions focused on balancing financial controls with operational requirements, with future aspirations to move towards an earned autonomy model as CSU financial positions improve.
- Received an update on the Voluntary Redundancy programme and the ongoing Administration Review

**Quality and Patient Safety**

- Received assurance that work relating to the Respiratory Dummy Clinic validation exercise has been completed, with identified concerns appropriately investigated and escalated through governance processes.
- Considered the Quality Performance Review and CSU escalation reports, including pressures within the Cardiothoracic elective programme due to Critical Care capacity constraints.

**Breast Services**

- Undertook detailed consideration of the developing Breast Services Business Case.
- Noted ongoing regional discussions and the need for further refinement of the financial modelling before the case progresses through formal approval processes.
- Reaffirmed the importance of securing a sustainable long-term service model for patients.

**Risk, Assurance and Governance**

- Received updates on the Board Assurance Framework (BAF), organisational risk management, internal audit findings and LLP contract performance.
- Noted ongoing work to strengthen assurance arrangements, improve oversight of Trust-level risks and address identified audit recommendations.
- Received an update regarding the recent flooding incident at UHNT, including work underway to assess impact and pursue insurance claims.

**Policy and Governance Compliance**

- Reviewed progress on policy management and governance arrangements, including efforts to improve consistency and reduce unnecessary policy development across the organisation.

**Overall Position**

The meeting reflected continued progress in strengthening organisational governance, financial recovery and service sustainability. Members acknowledged ongoing operational pressures but received assurance that appropriate actions and oversight arrangements are in place to address key risks, support service delivery and maintain a focus on quality and patient safety.

## Recommendations:

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

University Hospitals Tees

# Chair's Log of UHT Management Team Assurance Meeting: 20 August 2026

**Meeting date:** 3 September 2026

**Reporting to:** Board of Directors

**Agenda item No:** 1.9

**Report author:** Stacey Hunter, CEO and 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 ☒

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Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

## CQC domain link:

Select:

Well-led

## Board assurance / risk register this paper relates to:

## Key discussion points and matters to be escalated from the meeting

**Quality Performance and Operational Delivery**

The Management Team reviewed organisational performance across Clinical Service Units, noting ongoing challenges in delivering Cost Improvement Programmes, managing workforce pressures, patient flow and transformation programmes. There was a strong focus on maintaining delivery of agreed recovery plans and ensuring early escalation of emerging risks.

**Operational Escalations**

A recent flooding incident within the Emergency Department at North Tees was resolved with minimal disruption. Work is underway to assess wider infrastructure resilience issues linked to the ageing estate. The meeting noted that two of the theatres were stick not in use following the previous floods in June. This has impacted RTT performance with the national team now requesting a recovery plan from us for NTH RTT.

Progress was also reported on the development of a Trust-wide Bed Flow Standard Operating Procedure to strengthen operational decision-making and patient flow.

**Estates and Premises Assurance**

The Trust continues preparations for submission of the NHS England Premises Assurance Model (PAM) assessment. The process has highlighted infrastructure investment requirements, particularly within the North Tees estate, and will support wider discussions regarding future redevelopment and capital investment priorities.

**Partnership Working and System Integration**

Updates were received on partnership engagement through PLACE, scrutiny committees and wider health and care forums. Discussions focused on neighbourhood health models, integration of services closer to home and strengthening provider-led collaboration in response to changing NHS system arrangements.

**Business Case Development.**

**The group considered 3 business cases which are highlighted below:**

1) **Synopsis**

The meeting endorsed the recommendation to support the progression of a digital integration programme following assurance that governance, funding and implementation arrangements were in place.

## 2) Fertility Services

Following an early options appraisal paper in May 2026 further consideration was given to the future of Fertility Services, with members supporting a preferred option to address ongoing financial and accreditation challenges, subject to further stakeholder engagement. I will provide a more detailed update in our Board in committee meeting in September.

## 3) Richmondshire Services

Members supported proposals to reduce bed capacity at Richmondshire Friary Hospital as an interim measure while alternative intermediate care provision is developed. Assurance was sought regarding estate safety, risk mitigation and longer-term service redesign plans.

### Strategic Outline Case and Estate Redevelopment

The significant challenges associated with the ageing North Tees estate remain a strategic priority. Preparations are underway for a visit from NHS England's national estates leadership team to support the Trust's case for future capital investment and redevelopment.

### PFI Exit Strategy

Work continues to strengthen governance, contract management and financial oversight of the PFI programme. A comprehensive review of contractual arrangements, estate condition and future investment requirements is underway, alongside improvements in staff engagement and reporting processes.

### Health Inequalities

The Management Team considered the potential loss of funding for Personalised Care Lead roles and discussed opportunities to sustain key functions and benefits through existing organisational structures. There isn’t budget available to fund these roles.

### Risk, Compliance and Audit

The Trust reported its highest level of compliance performance this year. Attention was also drawn to concerns raised by Internal Audit regarding engagement with the audit process and completion of overdue actions, with targeted improvement work planned.

Updates were received on the Board Assurance Framework, water safety, ventilation improvements and governance arrangements.

### Policy Harmonisation

Progress continues on the development and harmonisation of University Hospitals Tees policies, with members approving the policies presented and supporting ongoing work to simplify and standardise the policy framework.

**Maternity Improvement Programme**

The Trust reviewed progress against the national maternity and neonatal improvement agenda following the Ockenden and Amos reviews, including consideration of estate implications and assurance arrangements to support compliance with recommendations.

**Pathology Leadership and Workforce Recognition**

Members welcomed the appointment of a new Head of Pathology and Pathology Director, recognising the positive opportunity this brings for the service.

The meeting also formally acknowledged and thanked Di Monkhouse for her significant contribution to the organisation ahead of her retirement.

**Overall Position**

The UHT Management Team received assurance that progress continues across a broad range of strategic, operational and transformation priorities, although delivery remains within a challenging financial and operational environment. Key discussions focused on financial recovery, performance and quality standards delivery, patient flow, estate sustainability, service transformation and governance, with members emphasising the importance of maintaining momentum against agreed organisational objectives.

There was a strong focus on the ageing estate and the need to secure future capital investment, particularly for the North Tees site, with significant work ongoing to strengthen the Trust's case for redevelopment. Members also considered several strategic business cases, supporting proposals that balance clinical sustainability, value for money and future service delivery requirements.

Partnership working across the wider health and care system remains positive, with continued progress in developing neighbourhood health models, reducing health inequalities and strengthening integration with local authority and system partners. The Trust continues to respond proactively to national policy developments and opportunities for service redesign aligned to the NHS long-term direction of travel.

Whilst assurance was received in a number of areas, including contract performance, compliance and policy harmonisation, concerns remain regarding audit engagement, delivery of some savings programmes and ongoing estate risks. Targeted actions are in place to address these challenges and strengthen organisational oversight.

Overall, the meeting provided assurance that the organisation continues to make progress against its strategic priorities, whilst appropriately managing emerging risks and taking forward significant programmes of transformation, estate modernisation and service redesign.

## Recommendations:

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

University Hospitals Tees

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

**Meeting date:** 3 September 2026

**Reporting to:** Board of Directors

**Agenda item No:** 1.10

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

**Executive director sponsor:** Neil Atkinson, Managing Director

**Action required:**
Assurance

**Delegation status:** Matter reserved to Unitary Board

**Previously presented to:** UHT Management Team

## UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

## CQC domain link:

Well-led

## Board assurance / risk register this paper relates to:

All sections of the Board Assurance Framework for each Trust.

## Key discussion points and matters to be escalated from the meeting

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

### Headlines

#### NTHFT

- There are 30 strategic risks identified relating to North Tees & Hartlepool NHS Foundation Trust.
- 10 strategic risks are outside of approved risk appetite, of which there are 7 red/high strategic risks outside of approved risk appetite.
- Mitigating actions are in place to address all strategic risks.
- There are 65 planned mitigating actions within the BAF across the 8 domains.
- No new planned actions.
- No reported completed actions.
- No changes to current risk scores.
- 4 requests for timescale extensions (3 Digital, 1 Q&S).
- Planned action timescale range – June 2026 – April 2035.

#### STHFT

- There are 31 strategic risks identified relating to South Tees Hospitals NHS Foundation Trust.
- 8 strategic risks are outside of approved risk appetite, of which there are 5 red/high strategic risks outside of approved risk appetite.
- Mitigating actions are in place to address all strategic risks.
- There are 68 planned mitigating actions within the BAF across the 8 domains.
- No new planned actions.
- No reported completed actions.
- No changes to current risk scores.
- No action timescale extension requests.
- Planned action timescale range – April 2026 – April 2035.

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

### BAF Reporting 2026/27

Existing BAF arrangements have been carried forward into 2026/27 for Quarter 1 and conclude as part of this report. The BAF review is ongoing and the BAF will be reported on a quarterly basis going forward, aligned to the 6 strategic objectives of University Hospitals Tees (and each unitary Trust). Quarter 2 BAF reporting will be presented to Board committees in October 2026.

**Risk Management Policy**

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

**Risk Appetite**

Board committees reviewed and proposed the risk appetite position for 2026/27 in June 2026 and this was approved by the Board of Directors on 2nd July 2026.

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

**Assurance Statement**

This report provides assurance that each Trust's Board Assurance Framework has been reviewed and provides a framework for the strategic risks of each Trust to be managed, mitigated and openly reported. Mitigating actions (with timescales) are in place for all strategic risks. Full details are reported to the assurance committees of the Group Board, allowing oversight and to allow for further actions to be identified for assurance purposes. Chair Escalation Reports are the mechanism to report assurance concerns to the Group Board.

**External Assurance**

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

## Recommendations:

The Board of Directors are asked to;

- Note the BAF carry forward arrangements into Quarter 1 of 2026/27 that conclude with this report.
- Receive the report and assurance that the Board Assurance Frameworks provide for each Trust.
- Note the content of this report to 30th June 2026.
- Note the 7 red/high strategic risks for NTHFT and 5 red/high strategic risks for STHFT and the planned mitigating actions.
- Note that the BAF will be reported quarterly going forward with Quarter 2 reporting into Board committees in October 2026.
- Advise on any further actions to be taken.

**[North Tees & Hartlepool NHS Foundation Trust/South Tees Hospitals NHS Foundation Trust – Board Assurance Framework Report (reporting to 30th June 2026)**

| NTHFT – Key Headlines | STHFT – Key Headlines |
|---|---|
| • 30 identified strategic risks.<br>• 7 red/high strategic risks are outside of approved risk appetite (no change).<br>• One step from approved risk appetite.<br>• 65 planned mitigating actions.<br>• No new planned actions.<br>• No reported completed actions.<br>• No changes to current risk scores.<br>• 4 action timescale extension requests (3 Digital, 1 Q&S).<br>• Planned action timescale range – June 2026 – April 2035. | • 31 identified strategic risks.<br>• 5 red/high strategic risks are outside of approved risk appetite (no change).<br>• One step from approved risk appetite.<br>• 68 planned mitigating actions.<br>• No new planned actions.<br>• No reported completed actions.<br>• No changes to current risk scores.<br>• No action timescale extension requests.<br>• Planned action timescale range – April 2026 – April 2035. |

## 1. Background

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

## 2. Purpose

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

## 3. Report Detail

### BAF Arrangements

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

### BAF Format

University Hospitals Tees has 6 approved strategic objectives for 2026/27 and the Board Assurance Framework makes direct reference to them and identifies the strategic risks that may prevent the delivery of each objective.

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

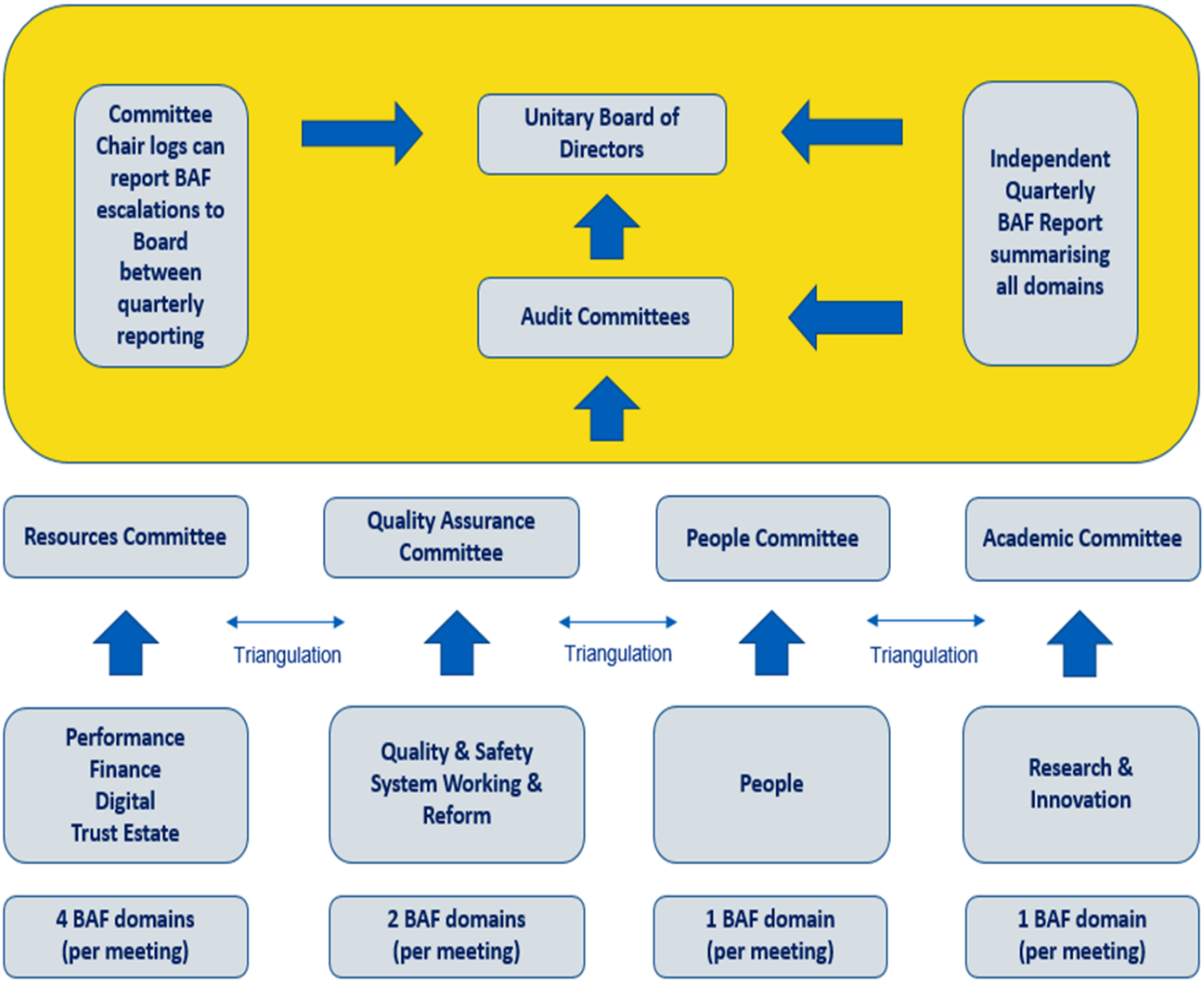
There are 8 BAF domains for each Trust. The BAF domains are informed by national best practice (Good Governance Institute) and benchmarking with regional and national NHS Foundation Trusts.

**BAF Domains**

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

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

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




**BAF Domain Alignment to Strategic Objectives**

It is important that all strategic objectives of each Trust are aligned to at least one BAF domain to support the delivery of strategic objectives. The BAF domain template require the BAF domain to be linked to at least one strategic objective. The mapping of BAF domains to strategic objectives confirms the strategic risks are linked to the BAF and are relevant for each organisation.

**Risk Appetite**

Board committees reviewed and proposed the risk appetite position for 2026/27 in June 2026 and this was approved by the Board of Directors on 2nd July 2026.

**Approved Risk Appetite (linked to strategic objectives) 2026/27**

| Strategic Objective | NTHFT Risk appetite level | STHFT Risk appetite level | Current Risk Score Range |
|---|---|---|---|
| Putting patients first with consistent high-quality care that delivers best practice in effectiveness, safety and experience | Cautious | Cautious | 4-6 |

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

**Risk Appetite Supporting Statements**

As part of the BAF refresh exercise for 2026/27, Lead Directors are reviewing the risk appetite supporting statements. This provides each Trust and the Boards with the ability consider future decision making against approved risk appetites by strategic objectives and supporting risk appetite statement. This maintains existing governance arrangements and ensures compliance with good governance requirements. Risk appetite is formally reviewed on an annual basis by the Board and an annual Board seminar on risk appetite is held. Attached at **Appendix A** is the approved risk appetite and supporting statements for 2025/26 which have been rolled forward into 2026/27 and will remain in place to the end of Quarter 1.

**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 |

| 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 |
| Performance & Compliance | 3 | 4 | **1** | 0 | 1 | 0 | 9 | 11 |
| Digital | 4 | 4 | 0 | 0 | 0 | 0 | 12 | 6 |
| People | 4 | 4 | 0 | 0 | 0 | 0 | 5 | 5 |
| Finance | 4 | 4 | **1** | **1** | 1 | 1 | 5 | 5 |
| Trust Estate | 5 | 5 | **3** | **2** | 1 | 1 | 8 | 14 |
| System Working & Reform | 2 | 2 | 0 | 0 | 0 | 0 | 11 | 11 |
| Research & Innovation | 5 | 5 | **2** | **2** | 1 | 1 | 7 | 8 |
| **Total Number** | **30** | **31** | **10** | **8** | | | **65** | **68** |

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

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

**NTHFT Red/High Strategic Risks outside Approved Risk Appetite**

The Trust has 30 identified strategic risks linked to Board Assurance Framework domains. The table below identifies that there are 7 strategic risks that are red/high and are outside of approved risk appetite, which is static from the previous reporting period. These risks are presented to the respective Board committees noted below and will be continue to be monitored to ensure mitigating actions are robust and progressed as planned.

| Strategic Risk Description | BAF Domain | Current Risk Score | Number of mitigating actions | Committee Oversight |
|---|---|---|---|---|
| Inability to deliver the required savings (recurrent/non-recurrent) within the annual financial plan. | Finance | **4 x 4 = 16** | 1 | Resource & Performance Committee |
| Non-compliance with national standards in accordance with NHS Oversight Framework 2025/26, and cancer recovery priorities as set out in the 2025/26 Operational Planning Guidance. | Performance & Compliance | **3 x 5 = 15** | 4 | Resource & Performance Committee |
| Failure of Trust infrastructure (including buildings). | Trust Estate | **3 x 5 = 15** | 1 | Resource & Performance Committee |
| Insufficient capital funding to maintain Trust estate. | Trust Estate | **5 x 4 = 20** | 2 | Resource & Performance Committee |
| Reduction of system capacity if the Trust is unable to provide services. | Trust Estate | **5 x 3 = 15** | 2 | Resource & Performance Committee |
| Innovation growth is limited by investment and resource constraints. | Research & Innovation | **5 x 3 = 15** | 1 | Academic Committee |
| Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture. | Research & Innovation | **5 x 4 = 20** | 1 | Academic Committee |

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

**STHFT Red/High Strategic Risks Outside Approved Risk Appetite**

The Trust has 31 identified strategic risks linked to Board Assurance Framework domains. The table below identifies that there are 5 strategic risks that are red/high and are outside of approved risk appetite. These risks are presented to the respective Board committees

noted below and will be continue to be monitored to ensure mitigating actions are robust and progressed as planned.

| Strategic Risk Description | BAF Domain | Current Risk Score | Number of mitigating actions | Committee Oversight |
|---|---|---|---|---|
| Inability to controls costs within allocated resources | Finance | **4 x 4 = 16** | 1 | Resource & Performance Committee |
| Insufficient capital funding to maintain Trust estate | Trust Estate | **4 x 5 = 20** | 2 | Resource & Performance Committee |
| Trust estate does not allow for the provision of optimal clinical services | Trust Estate | **3 x 5 = 15** | 1 | Resource & Performance Committee |
| Innovation growth is limited by investment and resource constraints | Research & Innovation | **5 x 3 = 15** | 1 | Academic Committee |
| Innovation is not clearly defined or embedded in the Group and opportunities are missed to improve services, patient outcomes and culture. | Research & Innovation | **5 x 4 = 20** | 2 | Academic Committee |

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

**Trust Operational Risks/UHT Risk Management Group**

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

**BAF Reporting 2026/27**

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

**Risk Management Policy**

A single University Hospitals Tees Risk Management Policy is now in place and was approved in June 2025. Following the formation of the CSUs from 1st November 2025, the policy will need to be updated to reflect new naming conventions and reporting processes.

The policy will also need to make reference to revised BAF reporting arrangements. This action has been delayed pending the refresh of the BAF for 2026/27.

**External Assurance**

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

**Risk Appetite**

Board committees reviewed and proposed the risk appetite position for 2026/27 in June 2026 and this was approved by the Board of Directors on 2nd July 2026.

## 4. Conclusion/Summary

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

- The requirement to maintain and report separate BAFs for each Trust as they remain separate legal entities.
- Mapping the BAF to the relevant Group strategic objectives.
- Approved risk appetites for each BAF domain and supporting statement for 2025/26 and approved risk appetite for 2026/27.
- The reporting of the BAF aligns with the Integrated Performance Report to support triangulation of key performance metrics and the mitigation of strategic risks.
- Board Committees have full oversight of the BAF report, in additional to the oversight responsibility allocation for BAF domains. A copy of the full BAF report for each Trust is placed in the Reading Library of each Committee and Board.
- Board Committees to escalate any concerns regarding the management and mitigation of strategic risks in BAF domains to the Board of Directors via the Chair's Escalation Reports.
- The medium/long term strategy/plan that each BAF domain is linking/referencing strategic risks e.g. UHT Strategy, Quality Priorities, People Plan etc.
- Ensuring strategic risks in each BAF domain are strategic in nature (they may run beyond a 12-month period).
- Ensure mitigating planned actions are strategic and will either maintain a current risk score or achieve a target risk score.
- Review of linked operational risks to ensure they are they up to date and linked to strategic risks. Work in this area remains ongoing.
- The learning from internal audit report findings.
- The reported position of 30 strategic risks relating to NTHFT and there are 7 red/high strategic risks that are outside of approved risk appetite. Mitigating actions are in place to address all strategic risks.
- The reported position of 31 strategic risks relating to STHFT and there are 5 red/high strategic risks that are outside of approved risk appetite. Mitigating actions are in place to address all strategic risks.
- Report of the BAF to respective Audit Committees.

**Assurance Statement**

This report provides assurance that each Trust's Board Assurance Framework has been reviewed and provides a framework for the strategic risks of each Trust to be managed, mitigated and openly reported.

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

## 5. Recommendation

The Board of Directors are asked to;

- Note the BAF carry forward arrangements into Quarter 1 of 2026/27 that conclude with this report.
- Receive the report and assurance that the Board Assurance Frameworks provide for each Trust.
- Note the content of this report to 30th June 2026.
- Note the 7 red/high strategic risks for NTHFT and 5 red/high strategic risks for STHFT and the planned mitigating actions.
- Note that the BAF will be reported quarterly going forward with Quarter 2 reporting into Board committees in October 2026.
- Advise on any further actions to be taken.

### Supporting Appendices

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

**Trust Risk Appetites & Supporting Statements (*)**

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

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

# NTHFT - Board Assurance Framework

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

| Quality & Safety | 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 |

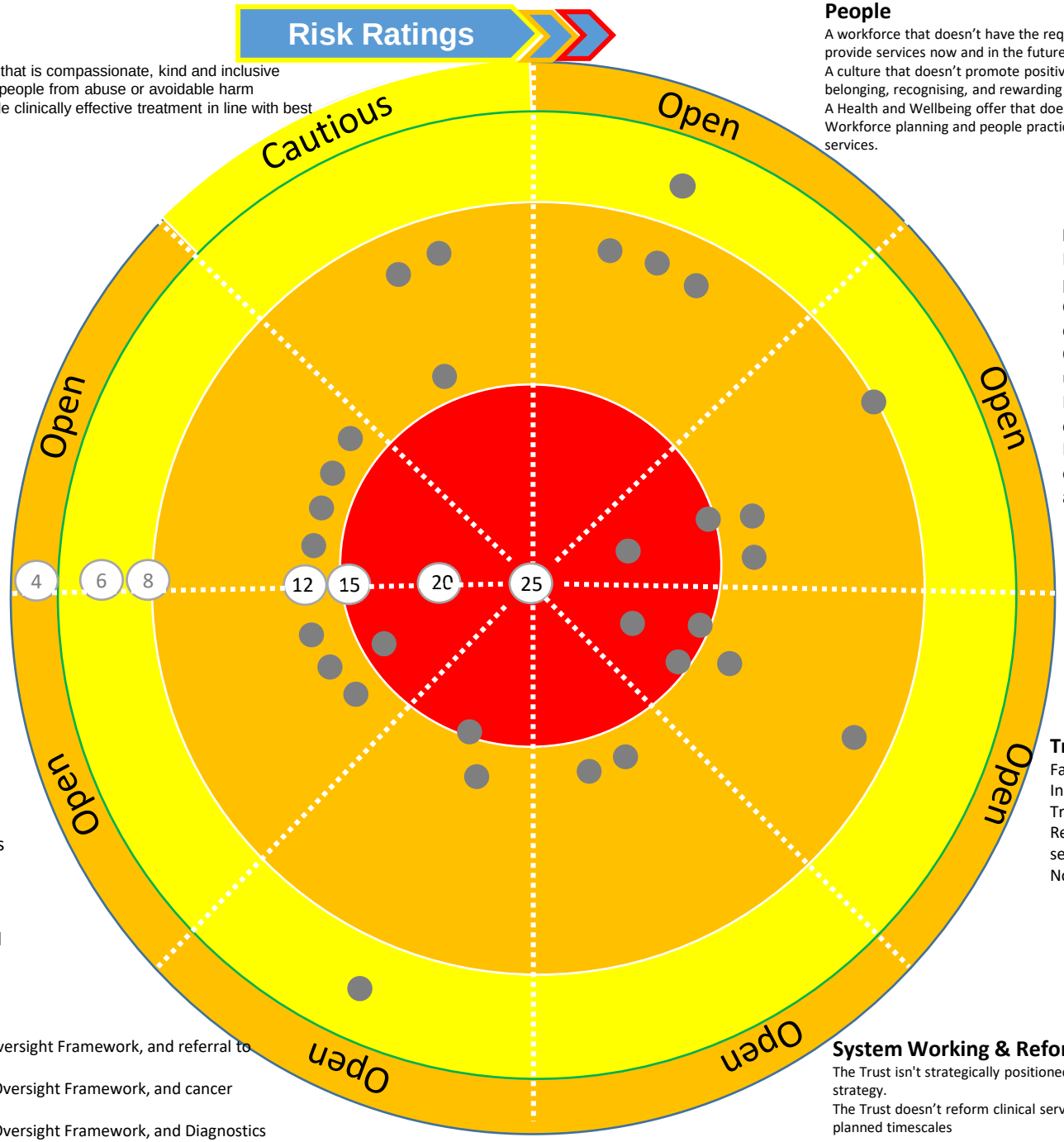
Strategic Risks

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

Appendix C

NHS
North Tees and Hartlepool
NHS Foundation Trust

# 30th June 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

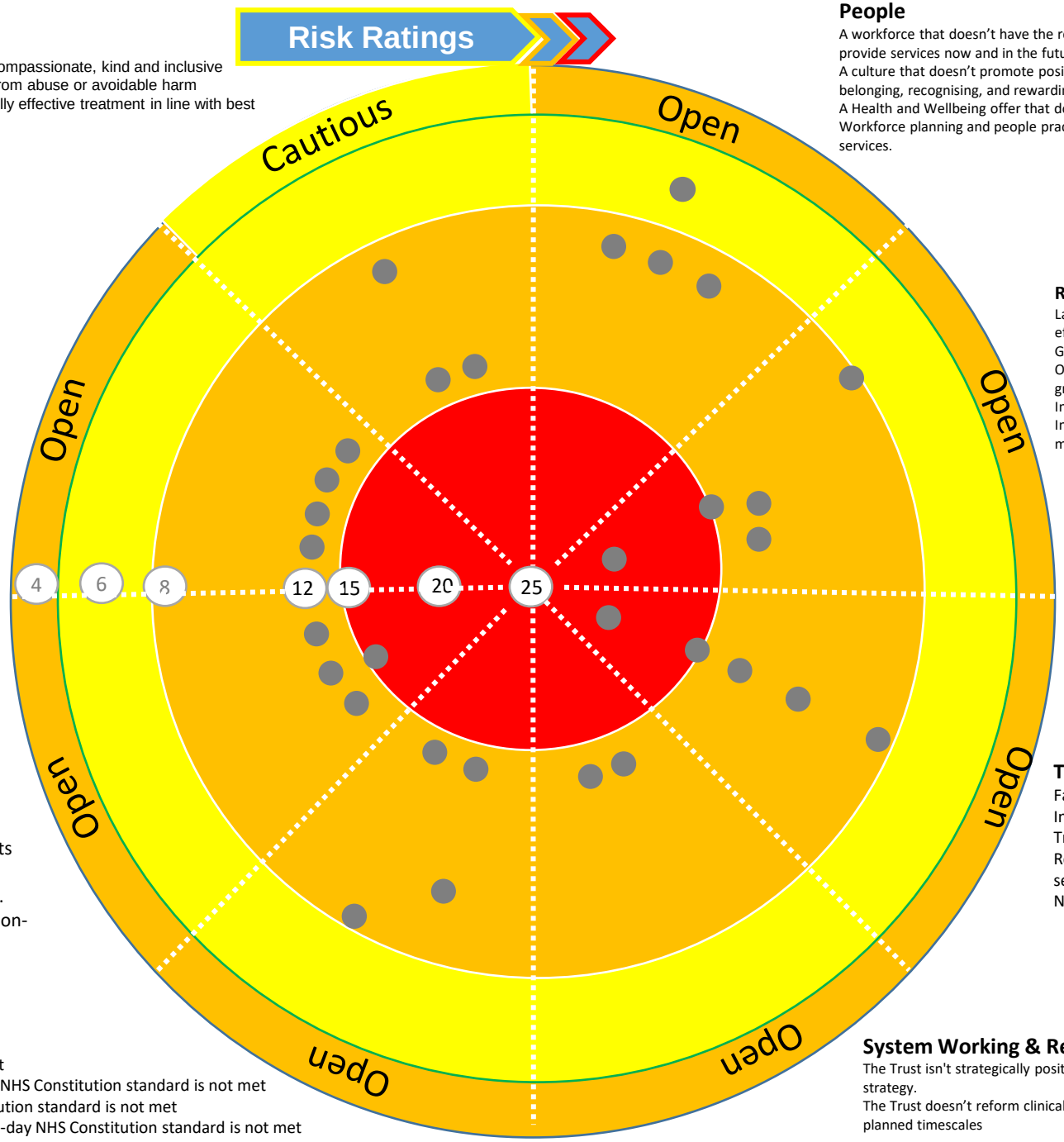
## Strategic Risks

| 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

# 30th June 2026 BAF Risk Radar




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

- High
- Moderate
- Low

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

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

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

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

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

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

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

**Top 10 Operational Risks (30 June 2026)***

North Tees and Hartlepool NHS Foundation Trust

**Appendix F**

| ID | Title of Risk | CSU/Corporate area | Risk Owner | Current Risk Score |
|---|---|---|---|---|
| 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 |
| 223 | Poor patient experience linked to unsuitable accommodation in the Wheelchair Service in Stockton | Community & Neighbourhood Health Services | Fiona Hardie | 12 |
| 275 | Due to vacancies in the Speech and Language Therapy Service, there is a delay in delivering assessments and intervention which may result in poorer patient outcomes and experience | Family Health Services | Lisa Piggott | 12 |
| 183 | Risk of suboptimal outcomes for patients due to being an outlier for the implementation of the National Wound Care Strategy Programme: Lower Limb  Lower Recommendations | Corporate Services | Andy Brown | 12 |
| 244 | Due to increased number of referrals received and vacant posts, there are longer waits for Under 5 Multi-agency autism team (MAAT) assessments resulting in possible reputational damage, possible suboptimal care and  unmet health needs | Family Health Services | Helen McCallan | 12 |
| 290 | Risk of suboptimal patient outcomes due to potential inability to provide Consultant emergency cover 24/7 | Family Health Services | Emma Cowan | 12 |
| 271 | workforce and skill mix deficit in critical care impacting on service delivery and patient safety | Theatres, Anaesthetics & Critical Care Services | Steph Gale | 12 |
| 88 | Potential for delayed care and management of paediatric testicular torsion due to lack of approved regional pathway | Digestive Health, Urology & General Surgery Services | Lauren Heaton | 12 |
| 30 | Fragility of Infection Prevention and Control Workforce can lead to a loss of service and affect patient outcomes | Corporate Services | Victoria Hancock | 12 |
| 224 | Due to staffing shortage, risk of deteriorating coding standards affecting recording of quality, performance and contract performance | Corporate Services | Sarah Hope | 12 |
| 267 | Due to insufficient FIT Testing provision, there is a number of staff non compliant with HSE FIT testing legislation impacting on staff and patient safety | Corporate Services | Graeme Kelly | 12 |
| 246 | Due increased demand there is a lack of available elective caesarean capacity to ensure timely access to theatres therefore increasing the likelihood of morbidity and mortality of the mother and fetus | Family Health Services | Gemma Gordon | 12 |

| | | | | |
|---|---|---|---|---|
| 217 | Due to insufficient staff to perform medicines reconciliation, the Trust does not meet NICE / CQC Standard of Medicine Reconciliation within 24 hours of admission. There is a risk of harm to patients if incorrect medication is administered | Clinical Support Services | Rebecca Alexander | 12 |
| 343 | Inability to deliver an end to end digital solution for the prompt identification and management of deteriorating patients leading to patient harm | Corporate Services | Ruksana Salim | 12 |
| 193 | Non-compliance with GDPR Article 15 - (Right of access) resulting in impact to the requestor (patient) though non receipt of requested records within the legal timescale (one calendar month) and to the Trust in the form of legislative sanctions being imposed. | Corporate Services | Diane Atkinson | 12 |
| 307 | Due to an increase in demand for specialist obstetric clinics there is a risk that women will not be seen within the recommended time scales by the appropriate clinician which may significantly affect the pregnancy outcome | Family Health Services | Donna Fincham | 12 |
| 324 | Due to levels of absence, vacancy and changes within budgeted skill mix in the NTHFT Dietetics service, urgent and non-urgent patients are waiting longer for assessment and follow-up appointments or contacts as inpatients leading to poor patient experience and suboptimal outcomes. | Community & Neighbourhood Health Services | Fiona Hardie | 12 |
| 327 | Risk of delay in emergency and routine maternity care due to current Triage estate and location | 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.**

**Top 10 Operational Risks (30 June 2026)***

South Tees Hospitals NHS Foundation Trust

**Appendix G**

| ID | Title of Risk | CSU/Corporate area | Risk Owner | Current Risk Score |
|---|---|---|---|---|
| 613 | RAAC - Panels - located in Women's and Children's area - James Cook - Area at risk of uncontrolled structural failure in areas where RAAC is present - Eradication required by 2035 | Corporate | Oliver Smith | 20 |
| 550 | Risk that patients come to harm due to poor image quality or critical failure of the Neuro angio unit equipment | Neuroscience Services | Richard Bore | 16 |
| 533 | Risk that patients may come to harm due to unavailability of critical care outreach practitioners to respond to a deteriorating patient | Theatres, Anaesthetics & Critical Care Services | Kerry Akther | 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 | Lindsey Hardy-Laws | 15 |
| 411 | Due to insufficient Therapeutic Radiographer Staffing Levels for Radiotherapy clinical demand, patients in the P2 category may wait longer resulting in breach of cancer targets and impact the outcomes of the patients waiting for curative cancer treatment | Clinical Support Services | Claire Huntley | 15 |
| 618 | Cyber breach or service outage by use of unsupported servers/clients/software which may result in business disruption or loss of service of critical operations impacting on patient care | Corporate Services | Ian Willis | 15 |
| 546 | Risk that the Trust does not meet General Provision of Intensive Care Services (GPICS) standards in neurosurgery HDU and spinal HDU | Neuroscience Services | Keir Rumins | 15 |
| 551 | Due to some replacement parts no longer being available for the Neuro 3T MRI equipment, the equipment may not be repairable in the event of failure resulting in reduced Imaging capacity affecting waiting time, timely interventions and extending lengt | Neuroscience Services | Richard Bore | 15 |
| 593 | Risk that services are affected due to insufficient resources available to fund capital replacement and new investment | Corporate Services | Christopher Dargue | 12 |
| 440 | Risk that no back up labelling system as Stand alone EMIS not updating | Clinical Support Services | Nicola Metcalfe | 12 |

| | | | | |
|---|---|---|---|---|
| 444 | Risk of vulnerable patients not being able to obtain medication by home delivery | Clinical Support Services | Nicola Metcalfe | 12 |
| 572 | Risk that Governance and assurance arrangements for cyber security may be ineffective, and could lead to non compliance with nat | Corporate Services | Ken Anderson | 12 |
| 571 | Risk that the Trusts ability to deliver normal service could be severely disrupted by a major cyber incident. | Corporate Services | Ken Anderson | 12 |
| 431 | Risk of delay to provision of chemotherapy treatment due to ageing aseptic facilities | Clinical Support Services | Nicola Metcalfe | 12 |
| 548 | Risk that existing Neurology patients come to harm as a result of limited capacity to deliver Botox service | Neuroscience Services | Joanne Evans | 12 |
| 545 | The trust is commissioned to deliver neurosurgical high dependency care, currently the service is not providing the required ICU consultant sessions in NHDU, the unit is non-compliant with the service specification. | Theatres, Anaesthetics & Critical Care Services | David McIntosh | 12 |
| 501 | Risk of Service User Morbidity as we do not use Patient Track to monitor MEOWS which would enable clearer identification of Deteriorating Patient. | Family Health Services | Leanne Boyd-Smith | 12 |
| 520 | Risk that the middle grade medical rota for Critical Care becomes unsustainable (1763) | Theatres, Anaesthetics & Critical Care Services | David McIntosh | 12 |
| 521 | Risk that a lack of Consultant Intensivists means that there is inadequate senior medical staff cover for 33 patients (2105) | Theatres, Anaesthetics & Critical Care Services | David McIntosh | 12 |
| 523 | Provision of critical care follow up is non compliant with the adult critical care service specification leading to a risk of patient physical and psychological harm and a proven risk of readmission to hospital because there is no dedicated critical care RaCi service | Theatres, Anaesthetics & Critical Care Services | David McIntosh | 12 |
| 615 | Due to an inability to decant patients from clinical areas there is a reduction in the ability to effectively manage the IPC risk to patients leading to an increase in patients acquiring HCAI's across the Trust. | Corporate Services | Julian Verity | 12 |
| 579 | Risk that the FHN Water Culvert may be damaged as part of Theatre Development Project groundworks | Corporate Services | Julian Verity | 12 |
| 601 | Governance and Assurance of Procedural Sedation Training - STNHSFT | Corporate Services | Maureen Tiernan | 12 |
| 527 | Due to a lack of storage in critical care there is a risk that equipment becomes damaged or inaccessible when required leading to sub optimal outcomes, including fire assessment breaches. Risk that there is a of lack of storage in Critical Care for e | Theatres, Anaesthetics & Critical Care Services | Tom Bingham | 12 |

| | | | | |
|---|---|---|---|---|
| 364 | Friary hospital stair case and Lift | Community & Neighbourhood Health Services | David Pratt | 12 |
| 417 | Head and Neck care pathway | Trauma & Orthopaedics, Reconstructive & Plastic Surgery, ENT & OMFS, Dermatology & Ophthalmology Services | Jamie Waters | 12 |
| 604 | PAGER BLEEP SYSTEM | Corporate Services | Ian Willis | 12 |
| 570 | Risk that there will be a loss of data due lack of business continuity and disaster recovery | Corporate Services | Ken Anderson | 12 |
| 499 | Risk that service delivery is compromised due to gaps in medical rota | Family Health Services | Leanne Boyd-Smith | 12 |
| 561 | Risk that patients come to harm and patient privacy and dignity is compromised due to lack of appropriate facilities in Neuroradiology for assessment and care for patients presenting with hyperacute strokes | Neuroscience Services | Joanne Evans | 12 |
| 554 | The Neurophysiology database containing all clinical reporting is held on an unsupported server which may result in patient reports being completely lost and unrecoverable in the event of system failure. | Neuroscience Services | Joanne Evans | 12 |
| 502 | Risk of  Increased Levels of Nitrous Oxide (Entonox) potentially causing staff morbidity | Family Health Services | Leanne Boyd-Smith | 12 |
| 577 | Risk that the Trust access control system will fail due to the phase out of the Granta portfolio at 31.12.21 | Corporate Services | Julian Verity | 12 |
| 530 | Risk that patients or staff come to harm from damaged and broken critical care pendants (2897) | Theatres, Anaesthetics & Critical Care Services | Tom Bingham | 12 |
| 382 | Risk that overdue refurbishment / lifecycle upgrade to CITU is leading to risk of increased infections to patients and a working environment not in line with recommended standards | Cardiovascular Services | Stuart Finn | 12 |
| 534 | There is a risk to the implementation of CHA CC due to the requirement to undertake significant estates work. | Theatres, Anaesthetics & Critical Care Services | David McIntosh | 12 |
| 457 | The Avanto fit MRI scanner is past its replacement date and is now experiencing errors resulting in downtime which has resulted in reduced capacity and cancellation of scans. | Clinical Support Services | Gail Griffiths | 12 |
| 401 | Ward 4 flooring | General & Emergency Medical Services | Lisa Trimble | 12 |
| 584 | Risk that cable fails due to age leading to a fire risk and impact to building. | Corporate Services | Julian Verity | 12 |
| 446 | Risk of Staff Injury due to working environment | Clinical Support Services | James Harris | 12 |

| | | | | |
|---|---|---|---|---|
| 506 | Risk of sub-optimal provision of care to Neonates leading to patient safety issues, such as; infection outbreaks and poor parent/patient experience due to the Neonatal estate | Family Health Services | Cathy Brammer | 12 |
| 535 | Risk that the temperature of the CCOT office is too hot to work in. | Theatres, Anaesthetics & Critical Care Services | Tom Bingham | 12 |
| 537 | Delayed discharges from critical care causes psychological harm to patients, who are exposed to witnessing distressing events within critical care. This increases length of hospital stay and increased healthcare costs. | Theatres, Anaesthetics & Critical Care Services | Tom Bingham | 12 |
| 452 | Risk that the unavailability of electronic requesting within the blood transfusion service affects patient safety | Clinical Support Services | Daniella Winterburn | 12 |
| 374 | Risk that lack of funding for community dysphagia (and therefore limited service availability in SALT) will impact on Patient Safety | Community & Neighbourhood Health Services | Carol Martin | 12 |
| 434 | Risk that POCT is not being appropriately governed across services | Clinical Support Services | Nicola Metcalfe | 12 |
| 360 | Due to the deployment of S1 and the IUTC contract we will experience a delay in timely NHS Situational Reporting (SitRep) and will lack Real-Time Reporting (RAIDR, Live Dashboards etc) for Type 3 Attendances, Urgent Treatment Centre activity. | General & Emergency Medical Services | Frances Bowden | 12 |
| 193 | Non-compliance with GDPR Article 15 - (Right of access) resulting in impact to the requestor (patient/staff) via non receipt of requested records within the legal timescale (one calendar month) and to the Trust in the form of legislative sanctions being imposed. | Corporate Services | Neil Dobinson | 12 |
| 543 | Failure to utilise available elective orthopaedic theatre sessions due to insufficient skilled staff. | Theatres, Anaesthetics & Critical Care Services | Louise Cawthorn | 12 |
| 700 | Due to process change there have been significant delays with patients reviews within respiratory at JCUH ,which may result in harm or disease progression to respiratory patients | General & Emergency Medical Services | Peter Robinson | 12 |

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

NHS
University Hospitals Tees

# Quality Assurance Committee

**27 July 2026**

**Connecting to: Trust Board**

**Chair of Committee: Fay Scullion**

## Key discussion points and matters to be escalated from the meeting

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

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

**The Patient Safety Report** demonstrated that PSIIs were taking longer than 6 months (182 days), with timeframes doubling at both North and South Tees. The extended time taken to complete and sign off is having an impact on the implications for learning, patient experience and in some cases impacting the HM Coroner process and time taken to inquests.

**The Infection Prevention and Control Report** showed reductions in some infection rates but noted that improvement has not met increasingly stringent trajectories, with multidisciplinary teams addressing outbreaks and learning from incidents

**Safer Staffing Bi-Annual Overview and Emerging Themes** alerted to the continued high and stable acuity of the inpatient population, with registered nurse staffing exceeds both funded and professional establishments due to planned over recruitment. Clinical support worker remain below funded and professional judgement levels, and there is pressure across both sites.



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**Safe Staffing Report** shows sickness absence amongst registered nurses at South Tees increased to 6.24% and unregistered staff absence reduced to 4.54%. At North Tees registered nurse sickness absence has increased to 6.71% and unregistered staff sickness absence has increased to 9.22%

**Clinical Effectiveness Report** demonstrated that the Clinical Annual Audit Plan 2025/26 and Forward Plam 2026/27 remain outstanding and that challenges exist within the CSUs in providing the unified plan. Several national clinical audits are at risk of reduced or non compliance within the 2026/27 Quality Accounts Programme, and there is an increasing volume of locally applicable NICE Guidance that is placing a challenge on clinical teams.

**Complaints Handling and Management** a sustained increase in complaints, partly due to PHSO recommendations, with current compliance at 40% against a 60% target for response rates, and improvements in acknowledging complaints within three working days

**Patient Experience and Involvement Annual Report** showed that the internal target of 80% for timeframe for response to complaints is not met During 2025/2026 there has been an increase in complaints by 31%, compliance of acknowledgement within 3 working days has not been consistently met, and the timeframe for responding has been more challenging. There were 2 final reports from the Parliamentary and Health Service Ombudsman, one not upheld and one partially upheld.

**Perinatal Safety and Quality Report Q1** showed an outbreak of Klebsiella infection at James Cook and mitigations put in place. In June 2026 the neonatal reports were published and NHSE responded with a 10 point plan. The service is undertaking a bench marking exercise.

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

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

**The Patient Safety Report** shows that there has been a decrease in reporting at South Tees since the implementation of the HealthCare Guardian across the group, which was anticipated. Since implementation there is a gradual increase in reporting raw data, which is monitored through the weekly safety panel.

Following NHSE Guidance there is no longer a requirement to take every Never Event as PSII, and this is being reviewed at Learning Response Panel with a decision made as to whether there is new learning.

**The Infection Prevention and Control Report** showed the Trust has experienced several outbreaks over the past year, some of which included Norovirus particularly at North Tees, with respiratory illness outbreaks across UHT, and an MRSA outbreak at NNU ant JCUH.

Work is underway to ensure that North Tees is compliant with isolation facilities for High Consequence Infectious Disease patients. There is a renewed focus in respect of antimicrobial stewardship across UHT with a clinical lead to drive this forward.

**Perinatal Safety and Quality Report Q1** Trust still birth rate remains above the MBRRACE comparator average and a thematic mortality review is completed, awaiting thematic outcomes. The Maternity Incentive year 8 is on track to meet the mid point check for training compliance

**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 Infection Prevention and Control Report** demonstrated that there are good governance systems that have been maintained throughout 2025/26 with the first alignment of processes across UHT. Policy alignment to be completed in first half of 2026/27

**Safer Staffing Bi-Annual Overview and Emerging Themes** there is assurance that there are robust systems in place to ensure safe staffing across UTH.

**Safe Staffing Report** showed that workforce deployment remains strong with the proportion of planned shifts being filled increasing marginally to 98.4%. Temporary staffing remained demand led with an emphasis on the utilisation of NHSP

**Patient Experience and Involvement Annual Report** demonstrated that the overall numbers of Friends and Family Tests has increased across UHT.

The National Cancer Experience Survey results for 2024 showed that NTHFT received an overall score of 8.8 and STHFT received an overall score of 9.

**Perinatal Safety and Quality Report Q1** A Maternity Outcomes Safety Signal )MOSS) simulation exercise was conducted and generated valuable insights and learning. Kate Brintworth (CMO for England) visited James Cook site and positive feedback was given.

## Recommendations:

The Trust Board undertake a development session to better understand the broader requirements of maternity and neonatal services in light of the pending report.



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NHS
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# Extra Ordinary Quality Assurance Committee

**14 August 2026**

**Connecting to: Trust Board**

**Chair of Committee: Fay Scullion**

## Key discussion points and matters to be escalated from the meeting

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

**Maternity and Neonatal Improvement Plan – Response to NHS England 10 Urgent Actions 2026**

Implementation of Martha's rule across maternity and neonatal services has not yet commenced, and currently carries a low assurance rating, and compliance with several urgent actions remains partial, including maternity triage requirements, health inequalities reporting, workforce resilience and post-death care assurance requirements.

**Maternity and Neonatal Improvement Plan – Response to NHS England Maternity Triage Specification**

The Trust's self-assessment against the specification has identified areas of partial compliance requiring Board support to achieve full alignment with the national standards. Facilities and estates represent the most significant risk, with NTHFT triage environment assessed as low assurance due to limitations in accessibility and visibility. Current day assessment unit capacity and weekday only provision continue to place pressure on triage services and can impact patient assessment and flow. The delivery of the triage specification requires investment in workforce as well as estates, which includes medical and support worker capacity, enhanced triage training and staffing to support service



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demand and rapid assessment. Failure to address workforce capacity may limit the Trust's ability to achieve full compliance.

The current data collection and reporting systems do not provide the triage metrics required by NHSE, limiting the Trust's ability to fully demonstrate compliance and to monitor performance, quality, and outcomes. There is a significant risk that the specification will not be fully implemented within the next 12 months expected timeframe without additional investment. Delivery is dependant on estates redevelopment and service improvement capacity.

**Maternity Workforce – Birthrate Plus Assessment 2026**

The assessment has shown an increase in case mix acuity and complexity by 11%. There is operational fragility due to redeployment of staff, and sustained temporary staffing. This may lead to a quality and safety risk, including timely clinical intervention and patient experience, workforce sustainability including sickness absence, fatigue and retention pressures.

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

**Maternity and Neonatal Improvement Plan – Response to NHS England 10 Urgent Actions 2026**

Improvement actions are underway across all ten NHS England maternity and neonatal urgent actions. There is some reassurance of work in development. Work is progressing to strengthen the patient voice, and a Patient Reported Experience Measures (PREMS) will be utilised when available. There is also a local “Big Maternity and Neonatal Conversation” initiative in progress which will help support the Amos into Action programme, which gives some reassurance. In addition, the partial development of the health inequalities dashboard will require a dedicated skill set and support to accelerate to full development.

The Maternity care bundle implementation plan is in development, with the interim gaps focusing on workforce and estate, and early development within primary care. This will require Board support and approval on completion.

**Maternity and Neonatal Improvement Plan – Response to NHS England Maternity Triage Specification**

A comprehensive review has been completed against all ten triage principles, and a detailed action plan has been developed. Estate development proposals, including the NTHFT triage development and STHFT triage reconfiguration associated with RAAC works are being progressed to improve compliance.

Workforce modelling and capacity reviews are being undertaken to determine the level of investment needed, alongside training requirements to support sustainable compliance and future demand.

A phased implementation approach has been developed, recognising that delivery timescales will be influenced by the availability of capital funding, workforce recruitment, training capacity and digital support.

**Maternity Workforce – Birthrate Plus Assessment 2026**

Review of the Birthrate Plus report identifies gaps in current establishments. Work is underway to quantify this prior to a final recommendation to Board.

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

Strong governance arrangements are in place with established Board oversight, with monthly perinatal quality and safety reporting. There are daily robust staffing oversight processes, with quality, safety, complaints, incidents and user feedback reviewed through governance and board reporting.

The Trust provides a 24 hour maternity triage service across both hospital sites, with established pathways supporting direct access, self-referral and MDT working across maternity and acute services. The Birmingham Symptom Specific Obstetric Triage System (BSOTS) is embedded providing consistent and evidenced based approach to clinical prioritisation and assessment. Current performance demonstrates compliance with clinical assessment priorities, and high assurance has been demonstrated for Access and Integration and Clear Information for Women.

**Mortuary Oversight and Assurance:** The Committee received an update on mortuary oversight, including compliance with NHS England requirements, assurance processes, and upcoming audits.

## Recommendations:

The Board are asked to note that the maternity team are progressing a business case for further investment to meet BR+ staffing ratios, this is due to come to the Board in autumn.

Note the alerts triggered by the work undertaken in response to the national maternity and neonatal 10 point plan.

The Board undertakes a development session to further understand the maternity and neonatal national standards and implication for UHT.

# Maternity and Neonatal Improvement Plan: Trust Response to NHS England 10 Urgent Actions 2026

**Meeting date:** *3 September 2026*

**Reporting to:** *Board of Directors*

**Agenda item No:** 2.2

**Report author:** *Steph Worn – Director of Midwifery, Adam Ruddock – Head of Operations*

**Executive director sponsor:** *Emma Nunez – Chief Nurse*

**Action required: Assurance**

**Delegation status: Jointly delegated item to Group Board**

**Previously presented to:** *(include here the meetings which the report has already been considered) CSU 1 Board 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:

Choose an item.

## 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.

Implementation of Martha's Rule across maternity and neonatal services has not yet commenced and currently carries a low assurance rating.

Compliance with several NHS England urgent actions remains partial, including maternity triage requirements, health inequalities reporting, workforce resilience, and post-death care assurance requirements.

Delivery of several NHS England urgent actions will require additional workforce, programme and analytical resource to ensure implementation within national timescales. Key areas include Midwifery Birth Rate Plus workforce recommendations, maternity triage improvements, development of the health inequalities dashboard, implementation of the Maternal Care Bundle and delivery of the Perinatal Equity and Anti-Discrimination Programme. Failure to secure sufficient capacity may impact the pace of compliance and delivery

National deadlines associated with NHS England's 10 Urgent Actions require ongoing executive oversight to mitigate risks of non-compliance.

**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.

Improvement actions are underway across all ten NHS England maternity and neonatal urgent actions, with moderate assurance reported in several key areas including workforce responsiveness, health inequalities, patient safety investigations, homebirth services, and staff engagement.

Work is progressing to strengthen patient voice mechanisms through improved Friends and Family Test uptake and the introduction of Patient Reported Experience Measures (PREMs) when available.

A local "Big Maternity and Neonatal Conversation" initiative is in progress and this will support the national Amos into Action programme and strengthen staff engagement and organisational culture.

Partial development of a health inequalities dashboard that will require dedicated resource to accelerate full development.

Maternal care bundle implementation plan is in development. The interim gaps focus on workforce and estate and early involvement with primary care, acknowledging this is beyond the Trusts control.  The implementation plan will require board support and approval on completion.

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

Strong governance arrangements are in place with established Board oversight, monthly perinatal quality and safety reporting, and dual accountability through the Chief Nurse and Chief Medical Officer structures.

Maternity and neonatal services maintain robust daily staffing oversight processes, with workforce, quality, safety, complaints, incidents and service-user feedback routinely reviewed through governance forums and Board reporting.

Homebirth services have already undergone review, with improvement plans submitted to both the Trust Board and regional NHS England team.

Clinical audit programmes, Saving Babies' Lives compliance activity, perinatal safety governance arrangements, and learning from patient feedback and incidents are embedded within existing quality improvement processes.

The Trust has demonstrated substantial progress against the majority of NHS England's urgent actions and has clear improvement plans in place to achieve full compliance and strengthen maternity and neonatal safety, quality and equity of care.

Good relationship and engagement with the maternity and neonatal voice partnerships (MNVP)

## Recommendations:

The Trust board is asked to;

1. Note progress against NHS England maternity and neonatal actions
2. Receive assurance regarding current governance and safety arrangements
3. Endorse the proposed improvement actions outlined within the report
4. Approve any resource or workforce requirements identified to date; Maternity workforce Birthrate+ recommendations and Trust wide accessibility tool for the website.
5. A progress report expected December 2026

# Maternity and Neonatal Improvement Plan: Trust Response to NHS England 10 Urgent Actions 2026

## 1. PURPOSE OF REPORT

To provide the Trust Board with assurance regarding progress against NHS England maternity and neonatal improvement actions, highlight areas of compliance and risk, and seek Board support for actions requiring executive oversight.

## 2. RECOMMENDATIONS

The board are asked to note progress against the national urgent actions for maternity and neonatal improvement.

## 3. BACKGROUND

Maternity and neonatal services remain a national priority following a series of independent reviews and investigations that have highlighted persistent concerns relating to safety, quality, culture, workforce pressures, inequalities in outcomes, and the experiences of women, babies and families. In July 2026, NHS England published its 10 Point Plan for Maternity and Neonatal Services, setting out a series of urgent actions for trusts and integrated care systems in response to the findings of the Baroness Amos Independent National Maternity and Neonatal Investigation and the recommendations of other major reviews, including those led by Donna Ockenden.

The 10-point plan represents a clear national expectation that all organisations providing maternity and neonatal care take immediate and measurable action to strengthen safety, improve governance and accountability, listen more effectively to women and families, address inequalities, and ensure services are appropriately staffed and responsive to risk. The programme forms part of a wider national commitment to restoring public confidence in maternity services and delivering sustainable improvements in outcomes and experience for women, babies and families.

This report provides the Trust Executive Board with an overview of the NHS England urgent actions, the Trust's current position against each requirement, and the arrangements being implemented to ensure compliance and delivery (appendix 1 and 2). It outlines progress to date, areas requiring further development, and the governance mechanisms through which assurance will be provided to the Board and external regulators. The report also demonstrates the organisation's commitment to continuous improvement, learning, and the delivery of safe, equitable and compassionate maternity care.

The Executive Board is asked to note the national requirements, review the Trust's response and improvement trajectory, and support the actions required to ensure full implementation of the NHS England 10 Point Plan and the associated ambitions of the National Maternity and Neonatal Taskforce

**Summary assurance level**

| Urgent Action | Assurance Level | RAG |
|---|---|---|
| **Listening to women and their families by rolling out Martha's Rule** | High / Moderate / **Low** | |
| **Listen to women and their families using real time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level** | **High** / Moderate / Low | |
| **Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care** | **High** / Moderate / Low | |
| **Amos into action' staff listening exercise** | High / **Moderate** / Low | |
| **Addressing inequalities in maternity and neonatal outcomes** | High / **Moderate** / Low | |
| **Ensuring 24/7 safety and responsiveness of maternity and neonatal services** | High / **Moderate** / Low | |
| **Trusts to review their homebirth services** | High / **Moderate** / Low | |
| **Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach** | High / **Moderate** / Low | |
| **Deliver safe and effective triage in maternity services (already committed by Government)** | High / **Moderate** / Low | |
| **Post death care (already committed by Government)** | High / Moderate / Low | |

## 4. DETAIL

Self-assessment against actions;

### 1. Listening to women and their families by rolling out Martha's Rule

Guidance: Commence roll out of Martha's Rule across all maternity and neonatal services in 2026/27.

**Current position**

- Across perinatal services Martha's rule has not yet been implemented.

**Action**

- Implementation will be led by the national Martha's Rule programme team.

## 2. Listen to women and their families using real time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level

Guidance: All trusts should implement a monthly cycle of collecting and analysing real-time patient outcomes and experience data at their public boards,(FFT) selected elements of PREM (when available) and insights from MNVP. Publishing data and patient commentary for full transparency, and ensuring a clear focus on the experiences of people from minority backgrounds.

Trusts should also reinvigorate clinical audits focusing on key and relevant recommendations identified in the Ockenden and Amos reviews in a focused and effective way, and act on the findings (aim to support this approach through national webinars).

**Current position**

- MNVP forums are hosted quarterly across UHT
- Response rate to FFT is low across both sites
- Monthly PQOM report includes service user insight
- MNVP work plans have a focus on underrepresented communities including service users from deprived and minority backgrounds
- Current compliance with existing perinatal audits such as Savings Babies Lives
- Audit plans in place and agreed

**Action**

- Align FFT systems across UHT to view data collectively and encourage improved uptake of completion.
- Await national implementation of PREM
- Revision of FFT questionnaire to include questions associated with socioeconomic factors. Analysis required to determine patient experience themes.
- To ensure attendance at national team webinars
- To ensure compliance with audits arising from Ockenden and Amos reports
- Review equity of access to birth reflections service across UHT

### 3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care

Guidance: All trusts must establish clear joint accountability at board level for maternity and neonatal services, with medical directors and chief nurses holding shared responsibility for oversight, performance and improvement. This must include consistent medical director engagement alongside the chief nurse, and parity between obstetric, midwifery, neonatal and operational leadership. Directors of midwifery and clinical directors leading maternity and neonatal services should attend boards when maternity or neonatal matters are discussed. This should also be implemented across all levels in the NHS including at system, regional, and NHS England boards to eliminate siloed working and strengthen system-wide leadership.

**Current position**

- Duel Board level accountability implemented within existing governance arrangements
- Director of Midwifery attends board where maternity reports are presented and discussed

**Action**

- Formal communication of addition of CMO as board level perinatal safety champion
- Perinatal Clinical Directors to attend board meetings regularly

### 4. 'Amos into action' staff listening exercise

Guidance: Following the listening conversation undertaken by Baroness Amos to understand the nature of the issues in maternity and neonatal services, NHS England will launch a full, open conversation with NHS staff and leaders to identify how the recommendations can be implemented across the system. It will explore and help address the role of culture, attitudes, approaches to practice and ways of working – bringing staff into the single largest national conversation about what trusts and individual clinicians need to do differently to implement both the letter and spirit of the Amos recommendations. This will be done in a way that aligns to rather than duplicates the work of the taskforce and will report findings into it. It will focus on how we implement Baroness Amos's findings from the listening exercise and the findings of the Ockenden review of Nottingham University Hospitals NHS Trust (NUH).

**Current position**

- Undertaking local exercise (big maternity and neonatal conversation)

**Action**

- Engage with national 'Amos into action' plan

## 5. Addressing inequalities in maternity and neonatal outcomes

Guidance: We can now confirm the timeline for national rollout of the Perinatal Equity and Anti-discrimination Programme, which will be available to all trusts by the end of 2026. The programme has been developed to support maternity and neonatal teams to tackle racism and discrimination, improve the experiences and outcomes of ethnic minority groups and those from deprived communities, and support staff to work in environments free from discrimination and racism. All boards must ensure that provision is in place to allow enough staff to be released to complete the Perinatal Equity and Anti-discrimination Programme, with full participation expected across multi-disciplinary teams. Boards must also regularly review and act on trends identified by their inequalities data dashboards: Maternity and Neonatal Equalities dashboard - NHS England Digital All NHS trusts providing maternity services are responsible for fully implementing the Maternal Care Bundle by March 2027. This includes providing regular reports to the trust board on implementation.

**Current position**

- To commence 2026 first cohort as senior perinatal team. Awaiting further guidance for implementation timeline for wider clinical team.
- Health inequalities dashboard in development

**Action**

- Board to agree commitment for staff attendance. Total commitment of 889 hours of clinical and leadership team attendance.
- Insights from health inequalities dashboard to be included in board reporting
- Board commitment to allocate resource to develop and enhance dashboard
- Maternal care bundle gap analysis and action plan in development for board approval

## 6. Ensuring 24/7 safety and responsiveness of maternity and neonatal services

Guidance: All boards must take accountability for ensuring safe and effective service arrangements, including reviewing staffing to ensure 24/7 availability and responsiveness across key workforce groups. Boards must also review internal resource deployment and consider whether roles not directly supporting frontline delivery can be redirected to strengthen service provision. Trusts must ensure that, where specialist posts exist (including in bereavement care and infant feeding), other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available. Commissioners also hold responsibility for ensuring that their maternity and neonatal service model aligns to local demographic needs. Boards and commissioners must address local gaps and eliminate siloed working to ensure services can consistently and safely respond to the needs of women, babies and families.

**Current position**

- Daily safe staffing meetings in place to identify risk and appropriate deployment

- Perinatal staffing reports produced monthly for board outlining vacancies, recruitment, and associated workforce red flags.
- Neonatal nursing workforce establishment currently calculated in line with 80% cot occupancy discussions on going with neonatal network regarding BAPM standards.

**Action**

- Formalise support offer for midwifery specialist roles across UHT and obstetric medical workforce
- Board support for the Midwifery BR+ workforce recommendations to be approved

**7. Trusts to review their homebirth services**

Guidance: Trusts should ensure Homebirth service review completed following national recommendations, reported to Board and regional team. That this review has been undertaken and reported to their board. Improvement plans are in place where necessary and that risks have been communicated to their regional NHS England team

**Current position**

- Service has been reviewed and improvement plans presented to trust board and regional team
- Workforce remodelling of community teams in progress

**Action**

- Expected home birth framework and standards to be published in 2026. Following this a further review will be undertaken.

**8. Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach**

Guidance: Trust boards should review how they are responding to patient safety incidents, Complaints and concerns within maternity and neonatal services, with openness, Humanity and candour. Taskforce to develop a blueprint for how organisations and leaders can respond with more humanity and compassion when things go wrong with a patient's care

**Current position**

- Complaints process in place with clear quality check by senior QUAD.
- Themes from events, complaints and feedback are reported monthly to board through perinatal governance
- Improvement plan in place based on learning from events and service insights.

**Actions**

- Trauma informed training

- Awaiting further guidance set by NHS England and the maternity and neonatal national task force

### 9. Deliver safe and effective triage in maternity services

Guidance: All trusts must commit to delivering safe and effective triage, starting by completing a board-level audit within 3 months, with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced. This will be supported by new NHS England guidance, which will be published this week. This includes having dedicated midwifery staffing to answer calls and provide face-to-face assessments, separate from other services such as the labour ward. Services should also have enough clinical, antenatal and bed capacity, with clear escalation routes in place at all times, including overnight and at weekends. Boards should have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes. Triage records should capture women's preferences, and services should use evidence-based standards, such as BSOTS, supported by rapid assessment training for triage midwives. This should enable trusts to identify risks, address delays and provide women with timely, consistent and high-quality triage care. The outcomes of this audit should be reported to regions and the Department of Health and Social Care / NHS England. Within 12 months, trusts must implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS. National maternity triage principles and a supporting measurement framework will be provided to trusts this week to reduce unwarranted variation, strengthen consistency in how concerns are assessed and escalated, and provide a clearer basis for local, regional and national improvement.

**Current position**

- Triage metrics are captured within some existing audits

**Action**

- National Maternity Triage Specification benchmarking implementation plan completed with board support required for additional resource
- Dedicated support to complete a maternity triage dashboard is required

***NB: The board are requested to note there is a standalone maternity triage paper following further NHS England specification**

### 10. Post death care

Guidance: All trusts must implement actions set out in the System letter following the Fuller and NUH reviews, including responding to the board assurance statement by 31 July and to the Human Tissue Authority requirement to review and assure completeness of incident records over the past 10 years. Every board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care

**Current position**

- Trust return required by board

**Action**

## 5. CONCLUSION

The Trust has demonstrated substantial progress against the majority of NHS England's 10 Urgent Actions, with many requirements already supported through established governance arrangements, robust safety oversight, quality improvement programmes, workforce monitoring processes and strong engagement with women, families and staff. Existing maternity and neonatal teams continue to support delivery of these actions alongside operational pressures and ongoing service improvement priorities.

The self-assessment confirms that there is a strong foundation for delivery; however, several areas require further development to achieve full compliance with national expectations and ensure that improvements are sustainable. These include implementation of Martha's Rule, development of the health inequalities dashboard, delivery of the Perinatal Equity and Anti-Discrimination Programme, implementation of the Maternal Care Bundle, maternity triage requirements and the Midwifery Birth Rate Plus workforce recommendations.

Whilst progress can continue through existing arrangements, achievement of some actions within the required timescales is likely to require additional investment in workforce capacity, analytical support and programme resource. Targeted investment would support accelerated delivery, strengthen assurance processes, improve responsiveness to emerging risks and help ensure compliance with national requirements whilst maintaining a continued focus on safety, quality and equity of care.

The Executive Board is therefore asked to note the findings of this review, acknowledge the significant contribution of existing teams in driving improvement, support the ongoing delivery of identified actions (appendix 2), and consider the resource implications associated with achieving full implementation of the NHS England 10 Urgent Actions. Regular progress updates will be provided to enable continued oversight and assurance of delivery against the national maternity and neonatal improvement programme.

## APPENDICES

Appendix 1 – NHSE benchmark tool summary

Appendix 2 – action plan

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Appendix 1. NHSE benchmark tool summary

| Baseline Assessment | | |
|---|---|---|
| Key Metrics | | |
| Total deliverables | | **26** |
| Compliance | 0. Not applicable | 0 |
| | 1. Non-compliant | 0 |
| | 2. Partially compliant | 0 |
| | 3. Compliant | 0 |
| Regional Match | Regional match - Yes | 0 |
| | Regional match - No | 0 |

| Summary by Action - Baseline | | Compliance | | | |
|---|---|---|---|---|---|
| Action | Total | Not applicable | Non-compliant | Partially compliant | Compliant |
| 1. Listening to women and families by rolling out Martha's Rule | **1** | 0 | 1 | 0 | 0 |
| 2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level | **3** | 0 | 0 | 1 | 2 |
| 3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care | **2** | 0 | 0 | 1 | 1 |
| 5. Addressing inequalities in maternity and neonatal outcomes | **3** | 0 | 2 | 1 | 0 |
| 6. Ensuring 24/7 safety and responsiveness of services | **7** | 0 | 0 | 3 | 4 |
| 7. Trust review of homebirth services | **2** | 1 | 0 | 0 | 1 |
| 8. Responding to incidents, complaints and concerns with humanity and candour | **3** | 0 | 0 | 1 | 2 |
| 9. Deliver safe and effective triage in maternity services | **3** | 0 | 1 | 2 | 0 |
| 10. Post death care | **2** | 0 | 0 | 0 | 2 |

Appendix 2. UHT Action plan

| Urgent Action | Action | Timescale | Responsible |
|---|---|---|---|
| 1. | • Implementation will be led by the national Martha's Rule programme team. | TBC | National Team/Trust |
| 2. | • Align FFT systems across UHT to view data collectively and encourage improved uptake of completion. | March 2027 | Trust/CSU1 QUAD |
| | • Await national implementation of PREM | TBC | PLT |
| | • Revision of FFT questionnaire to include questions associated with socioeconomic factors. Analysis required to determine patient experience themes. | September 2026 | PLT / PET |
| | • To ensure attendance at national team webinars | TBC | PLT |
| | • To ensure compliance with audits arising from Ockenden and Amos reports | On-going | Perinatal Guideline leads |
| | • Review equity of access to birth reflections service across UHT | November 2026 | DoM / HoM |
| 3. | • Formal communication of addition of CMO as board level perinatal safety champion | September 2026 | PLT |
| | • Perinatal Clinical Directors to attend board meetings regularly | On-going | CD for Obstetrics<br>CD for Neonates |
| 4. | • Engage with national maternity and neonatal taskforce action plan | TBC | National Team/Trust |
| 5. | • Board to agree commitment for staff attendance. Total commitment of 889 hours of clinical and leadership team attendance. | September 2026<br><br>November 2026 | Trust/CSU1 QUAD<br>PLT / BI team |

| | | | |
|---|---|---|---|
| | • Insights from health inequalities dashboard to be included in board reporting | | |
| | • Board commitment to allocate resource to develop and enhance dashboard | September 2026 | Trust/CSU1 QUAD |
| | • Maternal care bundle gap analysis and action plan in development for board approval | September 2026 | CD for Obs DoM . HoM |
| 6. | • Formalise support offer for midwifery specialist roles across UHT and obstetric medical workforce | October 2026 | DoM . HoM |
| | • Board support for the Midwifery BR+ workforce recommendations to be approved | September 2026 | Trust/CSU1 QUAD |
| 7. | • Expected home birth framework and standards to be published in 2026. Following this a further review will be undertaken. | TBC | National Team/Trust |
| 8. | • Board and CSU 1 support staff attendance for trauma informed training | December 2026 | Trust/CSU1 QUAD |
| | • Awaiting further guidance set by NHS England and the maternity and neonatal national task force | TBC | National Team/Trust |
| 9. | • National Maternity Triage Specification benchmarking implementation plan completed with board support required for additional resource | See separate paper | |
| 10. | • Trust return required by board | | |

# Maternity and Neonatal Improvement Plan: Trust Response to NHS England Maternity Triage Specification 2026

**Meeting date:** *3 September 2026*

**Reporting to:** *Board of Directors*

**Agenda item No:** 2.2.1

**Report author:** *Steph Worn – Director of Midwifery, Adam Ruddock – Head of Operations*

**Executive director sponsor:** *Emma Nunez – Chief Nurse*

**Action required:** *(select from the drop-down list for why the report is being received)* **Assurance**

**Delegation status:** **Jointly delegated item to Group Board**

**Previously presented to:** *CSU 1 Board meeting 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:

Choose an item.

## 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 Trust's self-assessment against the NHS England maternity triage specification has identified areas of partial compliance requiring Board support and oversight to achieve full alignment with national standards.

- Facilities and estates represent the most significant infrastructure risk, with the NTHFT triage environment assessed as low assurance due to limitations in accessibility, visibility of waiting areas and patient flow arrangements to delivery suite, requiring capital investment and Board approval
- Current day assessment unit capacity and weekday-only provision continue to place pressure on maternity triage services and may impact timely patient assessment and flow during periods of increasing demand.
- Delivery of the NHS England maternity triage specification will require investment in workforce as well as estate infrastructure. Reviews have identified a need for additional medical and maternity support worker capacity, enhanced triage training and competency development, and sufficient staffing resource to support service demand, rapid assessment standards and future seven-day service aspirations. Failure to address workforce capacity may limit the Trust's ability to achieve full compliance with the national specification.
- Current data collection and reporting systems do not yet provide all maternity triage metrics required by NHS England, limiting the Trust's ability to fully demonstrate compliance and monitor performance, equality and outcomes.
- There is a significant delivery risk that all ten principles of the NHS England Maternity Triage Specification will not be fully implemented within the expected 12-month timeframe without additional investment and organisational support. Delivery is dependent on estate redevelopment, workforce growth, training provision, digital and business intelligence support, and service capacity improvements, some of which require further business case development and Board approval

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

The Trust has completed a comprehensive review against all ten NHS England maternity triage principles and developed a detailed action plan with identified leads and delivery timescales
Priority improvement work includes enhancing service-user engagement and feedback mechanisms, improving accessibility of patient information, strengthening equality monitoring, improving interpreter access and developing maternity triage performance dashboards.

Estate development proposals, including the NTHFT triage redevelopment and STHFT triage reconfiguration associated with RAAC works, are being progressed to improve compliance with national standards.

Workforce modelling and capacity reviews are being undertaken to determine the level of investment required in medical, midwifery and maternity support worker staffing, alongside training requirements, to support sustainable compliance with the national standard and future service demand.

A phased implementation approach has been developed recognising that delivery timescales will be influenced by the availability of capital funding, workforce recruitment, training capacity and digital support. Regular progress updates and risk assessments will be reported through maternity governance structures and escalated to the Board where required

**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 Trust provides a 24-hour maternity triage service across both hospital sites, with established pathways supporting direct access, self-referral and multidisciplinary working across maternity and acute services.

The Birmingham Symptom-Specific Obstetric Triage System (BSOTS) is embedded across services, providing a consistent and evidence-based approach to clinical prioritisation and assessment.

Current performance demonstrates compliance with clinical assessment priorities, supported by established governance arrangements, patient safety reviews, maternity safety huddles and routine performance monitoring.

A phased implementation approach has been developed recognising that delivery timescales will be influenced by the availability of capital funding, workforce recruitment, training capacity and digital support. Regular progress updates and risk assessments will be reported through maternity governance structures and escalated to the Board where required

## Recommendations:

The Trust board is asked to.

Note the findings of the self-assessment against the NHS England Maternity Triage Specification (2026) and the current level of assurance against each of the ten national principles.

Recognise the significant delivery risk that full implementation of all ten principles within 12 months may not be achievable without additional investment in estates, workforce, training, digital infrastructure and service capacity.

Support development of business cases and investment proposals required to:

- Improve maternity triage estate compliance, particularly at NTHFT;
- Support the STHFT triage reconfiguration associated with RAAC redevelopment;
- Enhance workforce capacity and capability, including medical, midwifery and maternity support worker staffing;
- Develop maternity triage data and performance dashboards.

Approve the maternity triage improvement plan and associated actions, leads and delivery timescales.

Receive assurance that progress against the implementation plan, associated risks and compliance with the national specification will be monitored through established maternity governance arrangements and reported regularly to the Board

## Maternity Triage Improvement Plan: Trust Response to NHS England 10 principle actions 2026.

### 1. PURPOSE OF REPORT

To provide the Trust Board with assurance regarding progress against NHS England maternity triage specification; 10 principles for action (July 2026), highlight areas of compliance and risk, and seek Board support for actions requiring executive oversight.

## 2. RECOMMENDATIONS

The board are asked to note progress against the maternity triage 10 principles for improvement.

## 3. BACKGROUND

In response to national reviews and investigations that have identified recurring concerns regarding delays in assessment, inconsistent prioritisation, variable advice, workforce pressures and variation in maternity triage provision, NHS England published the National Maternity Triage Specification (July 2026). The specification defines maternity triage as the emergency front door for urgent and unscheduled maternity care and sets out ten national principles designed to support safe, timely, equitable and responsive services.

The specification requires all maternity providers to undertake a comprehensive review of their current service arrangements against the national standard, including assessment of access, pathways, staffing, facilities, governance, patient experience and performance metrics. Organisations must identify areas of compliance and non-compliance, develop a prioritised implementation plan and report progress through a public Trust Board meeting.

This benchmarking report presents the outcome of the Trust's assessment against the ten national maternity triage principles. It provides an overview of current performance, highlights areas of good practice and identifies opportunities for improvement to ensure alignment with national expectations and support the delivery of safe, effective and equitable maternity care. The findings will inform the Trust's implementation plan and ongoing Board assurance regarding compliance with the national specification (appendix 1, 2 and 3)

**Summary assurance level**

| Principle | Assurance Level | RAG |
|---|---|---|



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| | | |
|---|---|---|
| **Access and integration** | **High** / Moderate / Low | |
| **Recognition as urgent care** | High / **Moderate** / Low | |
| **Assessment and care of women** | High / **Moderate** / Low | |
| **Clear information for women** | **High** / Moderate / Low | |
| **Telephone maternity triage** | High / **Moderate** / Low | |
| **Service user voice and experience** | High / **Moderate** / Low | |
| **Facilities and estates** | High / Moderate / **Low** | NTH |
| | High / **Moderate** / Low | STH |
| **Staffing** | High / **Moderate** / Low | |
| **Equity and equality** | High / **Moderate** / Low | |
| **Data and measurement** | High / **Moderate** / Low | |

## 4. DETAIL

Self-assessment against the 10 principles for actions.

### 1. Access and integration

All women should be able to access maternity triage services 24/7. Maternity triage services should work closely with Emergency Departments, Primary Care, Early Pregnancy, Gynaecology and wider maternity services, so women can easily access the right care from early pregnancy to six weeks postnatal.

**Key measurement metrics**

- Rate of triage presentations per 1,000 births.
- Frequency of unplanned maternity triage service closures per month
- Ethnicity, deprivation and language (incl. English as a first language and need for interpretation services) data for each woman presenting.
- Proportion of women who attend without prior telephone triage.

**Current position**

- Both sites offer a 24/7 maternity triage, of which access has several options including self-referral, primary and community care referral. Information and contact details are shared with women at the booking appointment.
- Clinical care pathways identify most appropriate setting for women across acute settings and other directorates. Maternity triage work closely with antenatal clinic and day assessment units to ensure safe and appropriate care. Each site provides a postnatal maternal pathway up to 6wks
- Electronic patient records, email functions and GCNR offer access of information across the MDT. Each site offers an interpreter service though difficulties of access and support when out of hours or an acute presentation.
- Across UHT services, newborn concerns are assessed via 111, GP, or paediatric assessment unit
- STHFT offer an out of hours midwifery role to optimise patient flow and bed capacity across maternity services. NTHFT reply on support from the labour ward coordinator.

**Action**

- Enhance interpreter service access.

## 2. Recognition as urgent care

Maternity triage services must be recognised across the whole system as a safety-critical environment and the primary access point for urgent and emergency care and advice for pregnant women, and those up to six weeks postnatal, experiencing unexpected or urgent concerns or problems.

**Key measurement metrics**

- Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns.

**Current position**

- 24/7 access including those without a referral and /or walk-ins.
- A systematic triage process (BSOTs) embedded across UHT service that identifies initial assessment times and subsequent care grading times. Women are provided with the information. Standard operating procedure available across UHT to reflect BSOTs and appropriate clinical care pathways

**Action**

- Adopt a service user feedback survey across UHT service
- Board support to increase resources to provide a day unit assessment service 7 days a week, as both site provision is Monday to Friday, therefore impacting on triage

services. In addition, increase capacity of day assessment unit as both sites cannot meet demand.
- To add clear signposting throughout each site including digital maps

## 3. Assessment and care of women

The clinical model for maternity triage should align with existing RCOG Good Practice guidance and result in a clinical priority being assigned for every woman attending to ensure they receive timely, structured clinical assessment that takes into account their physical, mental and social wellbeing. The triage assessment and clinical prioritisation must be carried out by staff who are trained in the specific triage method.

The RCOG Good Practice Paper recommends the Birmingham Symptom-Specific Obstetric Triage System (BSOTS), which delivers these principles, and organisations should aim to adopt this approach. If services choose not to use BSOTS, they must ensure that any adaptation or alternative model is evidence-based, clinically evaluated or piloted, and demonstrates equivalent outcomes through audit. Any such variation must be formally agreed by the Trust Board.

Triage models and staff training must address unconscious bias and support equitable escalation. Services should recognise that Black and Asian women are more likely to present with higher risk factors, often later in their progression, and ensure triage systems and associated escalation pathways deliver timely, appropriate and equitable assessment and care based on clinical need.

### Key measurement metrics

- Proportion of women triaged in each category of urgency.
- Proportion of women for whom expected timeframes are met for initial assessment, waiting time to clinical review, and clinical review, based on their category of urgency.
- Proportion of women who experience a delay in assessment, review or onward care, with outcome recorded.
- Proportion of women who leave without further reviews or care following initial triage, despite an identified need for further review or care.

### Current position

- UHT service meets clinical assessment priorities.
- Staff training for BSOTs provided in-house as it cultural curiosity training.

### Action

- Board support to improve estate to enable visibility to the waiting room at both sites. See principle 7 for further information.

## 4. Clear information for women

All pregnant women must have clear, accessible information about maternity triage services throughout their pregnancy continuum and up to six weeks postnatal.

### Key measurement metrics

Reason for attendance, categorised by urgency and type of concern, including non-triage-specific concerns.

### Current position

- Information provided at booking and throughout pregnancy/postnatal period at appointments and Badgernet app.
- Interpreter service available

### Action

- Provision of alternative accessible information such as easy read and different languages that could be accessed via the website using an accessibility tool

## 5. Telephone maternity triage.

All maternity triage services should provide a dedicated telephone triage service alongside an open-door policy, as set out in Principles 2 and 4. Maternity telephone triage services need to provide a safe, responsive and consistent first point of contact for pregnant women or those who have been pregnant in the last six weeks experiencing unexpected / urgent concerns or problems.

### Key measurement metrics

- Rate of calls to telephone triage per 1,000 births.
- Proportion of women who call telephone triage but do not attend in person.
- Proportion of dropped or unanswered calls to telephone triage

### Current position

- Both sites have a 24/7 triage line, STHFT have a separate room and a midwife is allocated to telephone triage. NTHFT offer the same daily until 9pm, and then the line switched to the staff area within triage due to a low volume of calls.
- Diagnostic assessments are not undertaken via telephone assessment.
- All call documented via Badgernet app

### Action

- Telephone calls to be recorded.
- Work with ICT to ensure all key measures can be captured such as unanswered calls and rates

## 6. Service User Voice (SUV) and experience.

Triage services must actively seek and use feedback from women to improve care and ensure services meet the needs of local populations. As set out in NHS England's 10 Point Plan for maternity and neonatal services, all trusts should review patient outcome and experience data from their maternity and neonatal services at their public board meetings every month, using locally meaningful measures.

**Key measurement metrics**

- Qualitative and quantitative data on the experience of women using maternity triage services should be collected using existing local feedback methods, with transition to the national maternity and neonatal Patient Reported Experience Measure when it becomes available.
- Frequency and diversity of feedback collected.
- Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback, and the associated impact of these improvements.

**Current position**

- STHFT use a questionnaire to gain service user feedback, though offered in English only.
- Monthly data is shared across UHT service with staff. Staff feedback sough using the safety champion engagement sessions.
- Complaints process available and women advised raising any concerns with a member of staff/ward manager.

**Action**

- Align service user feedback with support from the MNVP.
- Enhance monthly data sharing to include feedback from routes such as compliments and complaints.
- Adopt the national Patient Reported Experience Measure (PREM) when available.

## 7. Facilities and estates

Maternity triage services should provide a safe, accessible and purpose-designed estate and environment that supports early recognition of deterioration, efficient clinical care and compassionate care for women.

**Key measurement metrics**

- Clinical area where the woman was admitted following triage (where relevant). For example, Antenatal Ward, Labour Ward, Intensive Treatment Unit etc.

**Current position**

- STHFT triage can be accessed timely to delivery suite on the same floor. NTHFT delivery suite is on a different level to triage.
- Waiting areas across UHT are suitably sized. STHFT have some line of visibility into the waiting area whereas at NTHFT there is no clear line of visibility.
- Reception area and a ward clerk are provided during standard hours across UHT services, but not between 5pm- 9am. Triage areas after 8pm do not have open access to enhance safety for women and staff.
- Accessibility standards?

**Action**

- Board support to enhance estate:
    - NTHFT for accessibility standards, clear line of visibility to the waiting areas and timely transfers to delivery suite. Plans have been developed with an estimated financial cost of £1m. Further support required as new footprint cannot accommodate two WCs, meaning access will be of the unit
    - STHFT current estate footprint to be demolished to enable RAAC replacement work. Interim arrangement to develop Ward 16 as triage and the plans will meet the requirements, as will the new triage plans.
- Dedicated BI/IT system support to develop triage dashboard to include onward admissions

## 8. Staffing

Maternity triage services must maintain safe and responsive staffing levels, with midwifery and medical skill mix adjusted according to demand and peak times. The priority is to ensure that every woman receives an initial triage assessment within 15 minutes of arrival, regardless of time of day or service pressures.

**Key measurement metrics**

- Proportion of women assessed (initial triage and medical clinical review) within expected timeframes based on the category of urgency.
- Frequency of staff being redeployed to other maternity care areas within the unit from maternity triage.

**Current position**

- Each service staffing model based on activity, and a review completed in readiness for a midwifery Birthrate+ reassessment.
- Availability of dedicated medical workforce and MSW is limited on a 24/7 basis
- In house training is limited to BSOTs triage process
- Across UHT services, unless in escalation, core triage midwives provide telephone triage. Each site an escalation process and Triage is the absolute last area to redeploy staff elsewhere across the unit.
- Daily maternity safety huddles include maternity triage.

- Day assessment units at the Midwifery led units' criteria have been reviewed against the Triage criteria to ensure appropriate care level directed to the right service: triage, day assessment unit, community etc

**Actions**

- Board to support additional resource to source external training for rapid assessment and competency and training time.
- Medical and MSW workforce modelling to be reviewed and reported

## 9. Equity and equality

A deliberate and targeted approach is required to identify and reduce inequalities in maternity triage access, experience and outcomes—particularly for women from ethnic minority backgrounds, socially deprived areas, and those with additional needs such as language support, disabilities, or low digital literacy.

**Key measurement principles:**

- Refer to Principle 1 where these metrics align to Principle 9 of Equity and Equality.

**Current position**

- UHT services provide cultural curiosity training annually.

**Action**

- Develop a local dashboard to capture service user feedback to identify areas for improvement.
- Develop a local dashboard to identify demographic information to improve outcomes

## 10. Data and measurement

Maternity triage services must adopt a structured, improvement-focused data collection and audit approach in line with the measurement strategy, supporting safe, effective and equitable care.

**Current position**

- Monthly reporting introduced for base data across the service – example provided in appendix 4
- Weekly patient safety and case reviews undertaken to include consideration of all aspects of care.

**Action**

- Board to support dedicated resource to develop and enhance existing maternity data and dashboard

## CONCLUSION

The Trust's self-assessment against the NHS England Maternity Triage Specification (July 2026) demonstrates that the foundations of a safe and responsive maternity triage service are in place across both sites, with 24/7 access, established clinical pathways, implementation of the Birmingham Symptom-Specific Obstetric Triage System (BSOTS), and effective multidisciplinary working arrangements. Women are able to access care through multiple referral routes, and existing governance, safety review processes and performance reporting provide a strong basis for ongoing quality improvement

The review has identified a number of areas where further development is required to achieve full alignment with the national principles and ensure consistency of provision across the Trust. Key priorities include improving maternity triage estate compliance, expanding day assessment capacity, strengthening workforce capability and capacity, improving access to interpretation and accessible information, enhancing service-user feedback mechanisms, and developing comprehensive data and performance dashboards. Estate limitations, particularly at NTHFT, alongside workforce and service capacity pressures, represent the most significant barriers to full compliance with the national specification (appendix 1, 2 and 3).

There is a risk that all ten principles of the NHS England Maternity Triage Specification will not be fully implemented within the expected 12-month timeframe without additional investment and organisational support. Delivery is dependent upon capital investment, workforce growth, training provision, digital infrastructure and business intelligence support, together with further service development to meet increasing demand.

The implementation plan within this report provides a programme of work to address identified gaps, with defined leads and timescales. Continued Board oversight and support will be essential to mitigate identified risks and enable delivery of the required improvements. Progress will continue to be monitored through established governance arrangements and reported to the Trust Board to provide ongoing assurance regarding compliance with the national specification and the safety, effectiveness and equity of maternity triage services across UHT.

## APPENDICES

Appendix 1. NHSE benchmark tool summary (North Tees)
Appendix 2. NHSE benchmark tool summary (South Tees)
Appendix 3. UHT Action plan
Appendix 4. Triage audit North and South Tees

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Appendix 1. NHSE benchmark tool summary (North Tees)

**North Tees** : Maternity Triage Specification
Benchmarking Audit Tool Dashboard

| Click below to link through to each principle | | Fully in place | Partially in place | Not in place | Not relevant | Data not complete | Estimated cost to progress compliance of specification standard |
|---|---|---|---|---|---|---|---|
| Principle 1: Access and integration | Clear, local 24/7 pathways so women know where to go and are supported between services. | 45% | 55% | 0% | 0% | 0% | £0.00 |
| Principle 2: Recognition as urgent care | Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such. | 40% | 50% | 10% | 0% | 0% | £0.00 |
| Principle 3: Assessment and care of women | Every woman receives timely assessment, prioritisation and a clear plan of care. | 40% | 40% | 0% | 20% | 0% | £0.00 |
| Principle 4: Clear information for women | Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried. | 67% | 33% | 0% | 0% | 0% | £0.00 |
| Principle 5: Telephone maternity triage | A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward. | 38% | 63% | 0% | 0% | 0% | £0.00 |
| Principle 6: Service user voice and experience | Women's feedback must shape service design, improvement and experience. | 20% | 0% | 60% | 20% | 0% | £30k |
| Principle 7: Facilities and estates | Triage needs safe, visible, fit-for-purpose space designed for urgent care. | 40% | 60% | 0% | 0% | 0% | £1m |
| Principle 8: Staffing | Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed. | 0% | 67% | 33% | 0% | 0% | £0.00 |
| Principle 9: Equity and equality | Services must use data and targeted action to identify and reduce inequalities. | 60% | 40% | 0% | 0% | 0% | £0.00 |
| Principle 10: Data and measurement | Data must drive oversight, learning from incidents and continuous improvement. | 14% | 86% | 0% | 0% | 0% | £0.00 |

Appendix 2. NHSE benchmark tool summary (South Tees)

**South Tees** : Maternity Triage Specification
Benchmarking Audit Tool Dashboard

| Click below to link through to each principle | | Fully in place | Partially in place | Not in place | Not relevant | Data not complete | Estimated cost to progress compliance of specification standard |
|---|---|---|---|---|---|---|---|
| Principle 1: Access and integration | Clear, local 24/7 pathways so women know where to go and are supported between services. | 45% | 55% | 0% | 0% | 0% | £0.00 |
| Principle 2: Recognition as urgent care | Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such. | 40% | 50% | 10% | 0% | 0% | £0.00 |
| Principle 3: Assessment and care of women | Every woman receives timely assessment, prioritisation and a clear plan of care. | 40% | 40% | 0% | 20% | 0% | £0.00 |
| Principle 4: Clear information for women | Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried. | 67% | 33% | 0% | 0% | 0% | £0.00 |
| Principle 5: Telephone maternity triage | A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward. | 38% | 63% | 0% | 0% | 0% | £0.00 |
| Principle 6: Service user voice and experience | Women's feedback must shape service design, improvement and experience. | 20% | 0% | 60% | 20% | 0% | £30k |
| Principle 7: Facilities and estates | Triage needs safe, visible, fit-for-purpose space designed for urgent care. | 80% | 20% | 0% | 0% | 0% | £0.00 |
| Principle 8: Staffing | Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed. | 0% | 67% | 33% | 0% | 0% | £0.00 |
| Principle 9: Equity and equality | Services must use data and targeted action to identify and reduce inequalities. | 60% | 40% | 0% | 0% | 0% | £0.00 |
| Principle 10: Data and measurement | Data must drive oversight, learning from incidents and continuous improvement. | 14% | 86% | 0% | 0% | 0% | £0.00 |

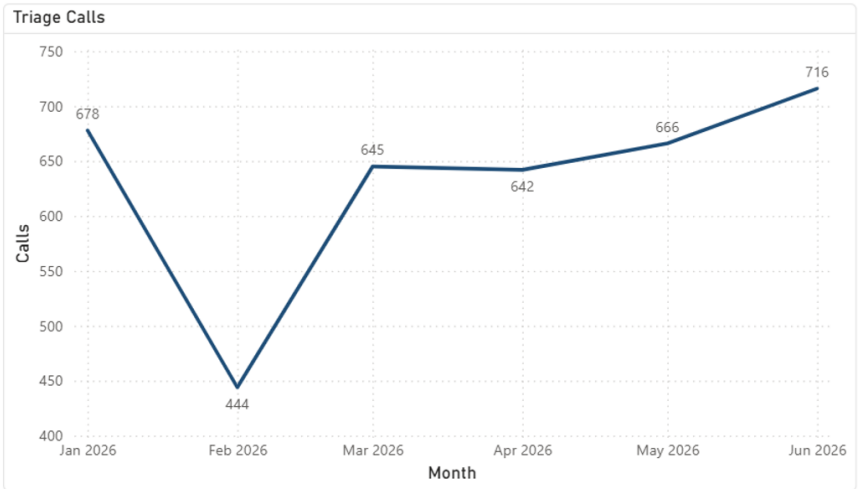
Appendix 1. Action plan

| Action | Action | Timescale | Lead |
|---|---|---|---|
| 1 | • Audit interpreter service availability when requested to inform if potential improvements | January 2027 | Triage Matron |
| 2. | • Create service user triage feedback survey and process | October 2026 | Triage Matron MNVP leads |
| | • Capacity and demand report for scheduled work to inform requirement for day assessment unit, 7 day a week service | October 2026 | Triage Matron General manager |
| | • Clear signage and digital map for maternity triage at both sites | September 2026 | Estate team |
| 3. | • See action 7 | | |
| 4. | • Trust to acquire accessibility tool | January 2027 | Trust Board |
| 5. | • Dedicated BI support to develop triage dashboard | September 2026 | PLT / BI |
| 6. | • Monthly reporting of existing feedback mechanisms | September 2026 | Triage Matron |
| | • Implement PREM when launched by NHSE | TBC | National/ Trust |
| 7. | • Seek Trust board approval for a new NTHFT Triage estate to meet requirements | January 2027 | Trust Board |

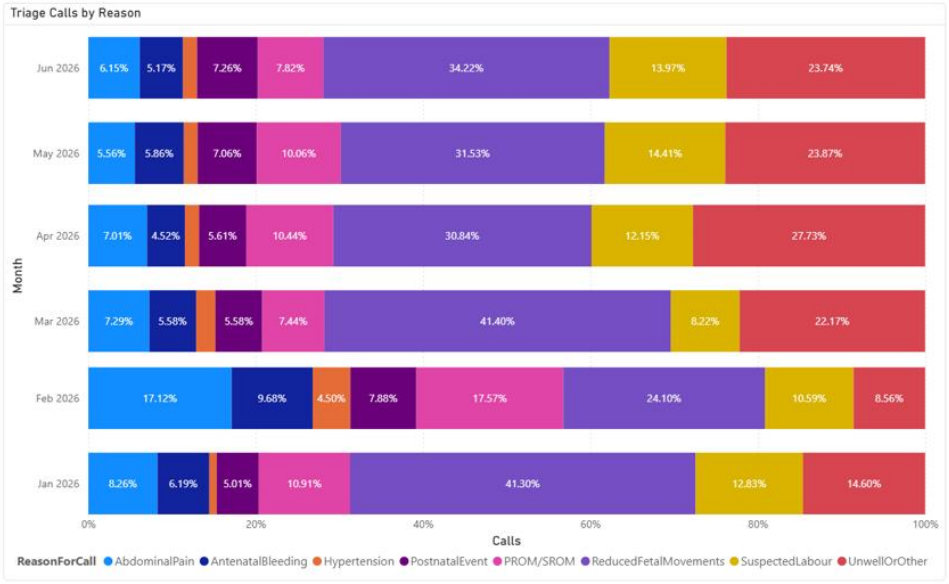
| | | | |
|---|---|---|---|
| 8. | • Acquire Triage training for competence for rapid assessment | November 2026 | Triage Matron |
| | • Workforce modelling report to Trust Board support increase in both medical and MSW roles, 24/7 | January 2027 | Triage matron<br>Obs CD<br>General manager |
| 9. | See principle 5 | September 2026 | Head of performance |
| 10. | • See principle 5 | September 2026 | PLT/Head of performance |

## Appendix 2. Triage audit January - June 2026

**Calls - North**



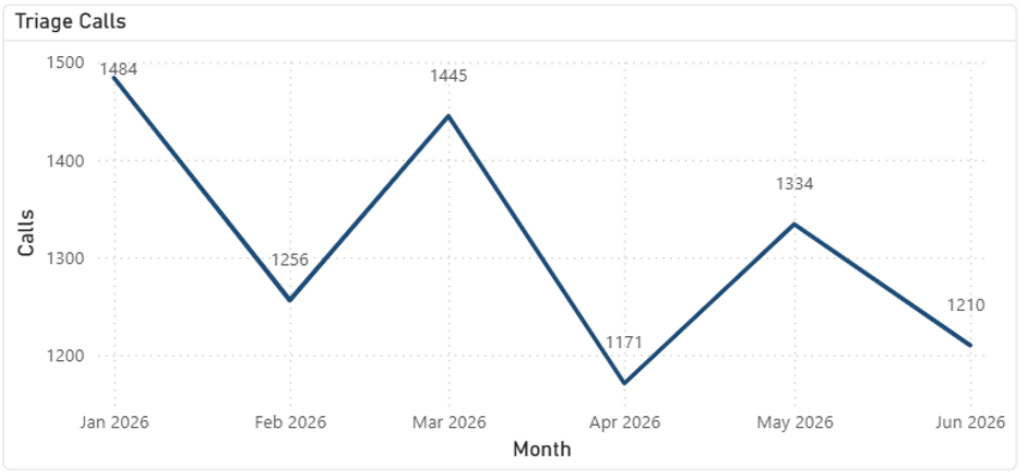

## Calls by Reason- North

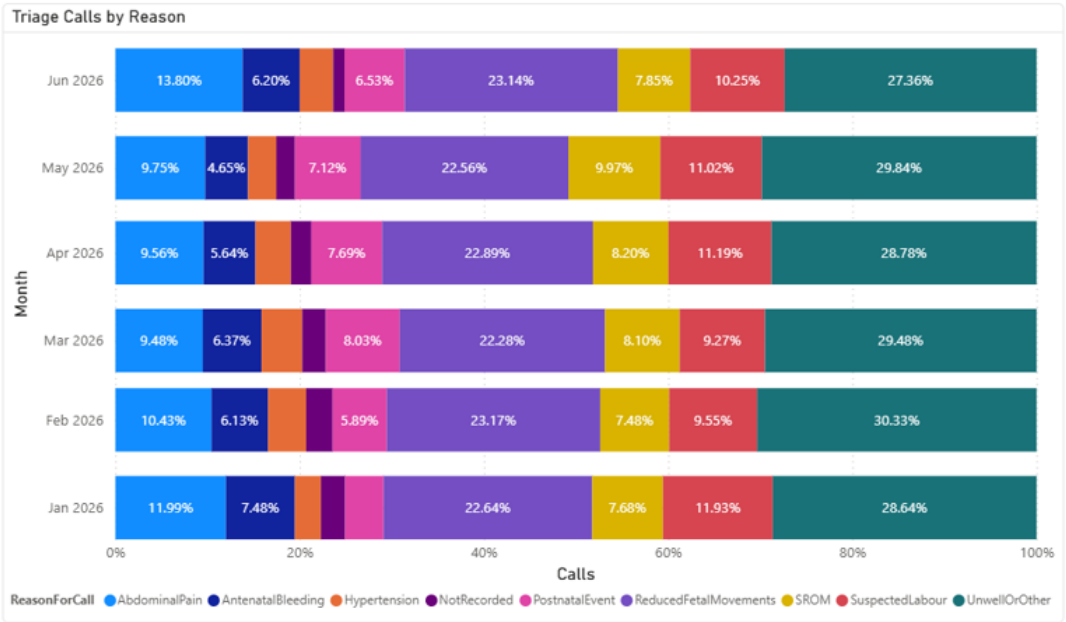



**Triage Calls by Reason**

| ReasonForCall | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 | **Total** |
|---|---|---|---|---|---|---|---|
| ReducedFetalMovements | 280 | 107 | 267 | 198 | 210 | 245 | **1307** |
| UnwellOrOther | 99 | 38 | 143 | 178 | 159 | 170 | **787** |
| SuspectedLabour | 87 | 47 | 53 | 78 | 96 | 100 | **461** |
| PROM/SROM | 74 | 78 | 48 | 67 | 67 | 56 | **390** |
| AbdominalPain | 56 | 76 | 47 | 45 | 37 | 44 | **305** |
| PostnatalEvent | 34 | 35 | 36 | 36 | 47 | 52 | **240** |
| AntenatalBleeding | 42 | 43 | 36 | 29 | 39 | 37 | **226** |
| Hypertension | 6 | 20 | 15 | 11 | 11 | 12 | **75** |
| **Total** | **678** | **444** | **645** | **642** | **666** | **716** | **3791** |

## Calls - South




| ReasonForCall | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 | Total |
|---|---|---|---|---|---|---|---|
| UnwellOrOther | 425 | 381 | 426 | 337 | 398 | 331 | **2298** |
| ReducedFetalMovements | 336 | 291 | 322 | 268 | 301 | 280 | **1798** |
| AbdominalPain | 178 | 131 | 137 | 112 | 130 | 167 | **855** |
| SuspectedLabour | 177 | 120 | 134 | 131 | 147 | 124 | **833** |
| SROM | 114 | 94 | 117 | 96 | 133 | 95 | **649** |
| PostnatalEvent | 62 | 74 | 116 | 90 | 95 | 79 | **516** |
| AntenatalBleeding | 111 | 77 | 92 | 66 | 62 | 75 | **483** |
| Hypertension | 42 | 52 | 64 | 45 | 41 | 44 | **288** |
| NotRecorded | 39 | 36 | 37 | 26 | 27 | 15 | **180** |
| **Total** | **1484** | **1256** | **1445** | **1171** | **1334** | **1210** | **7900** |

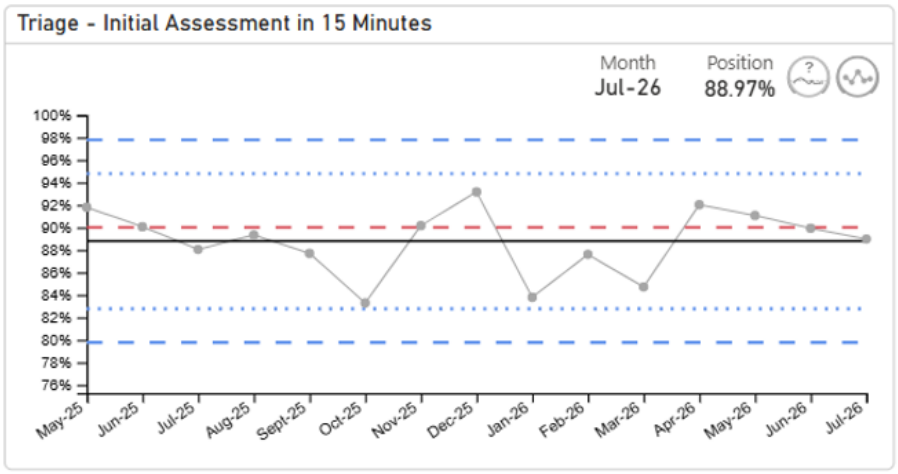


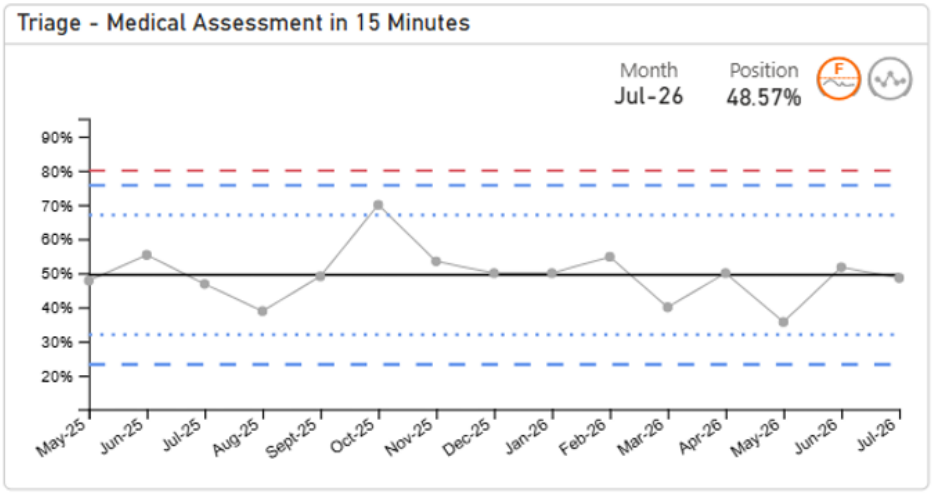
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**F2F Attendances - North**




## F2F Performance - North

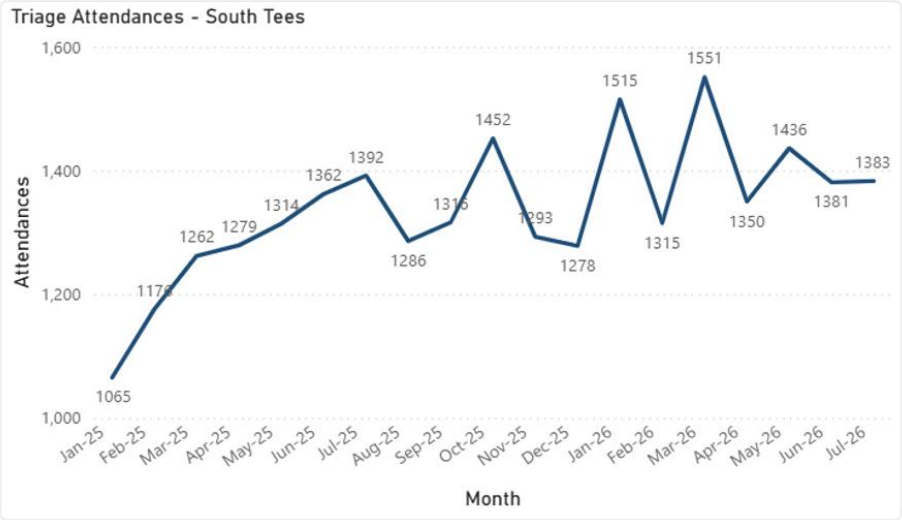


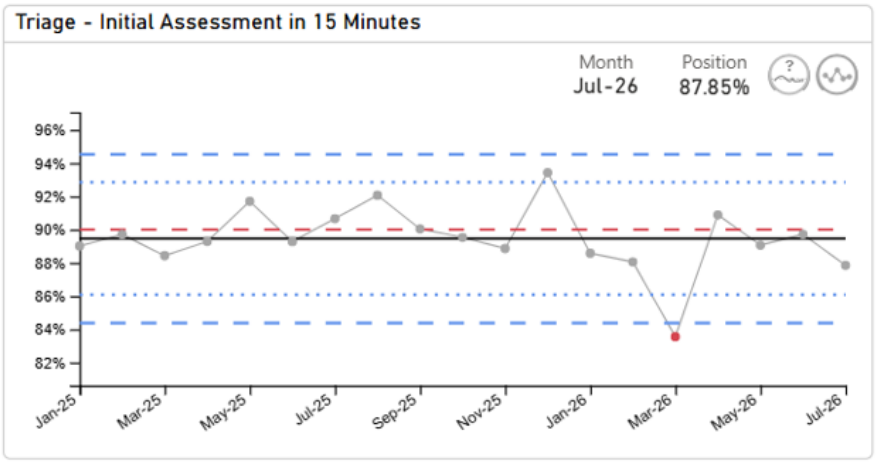


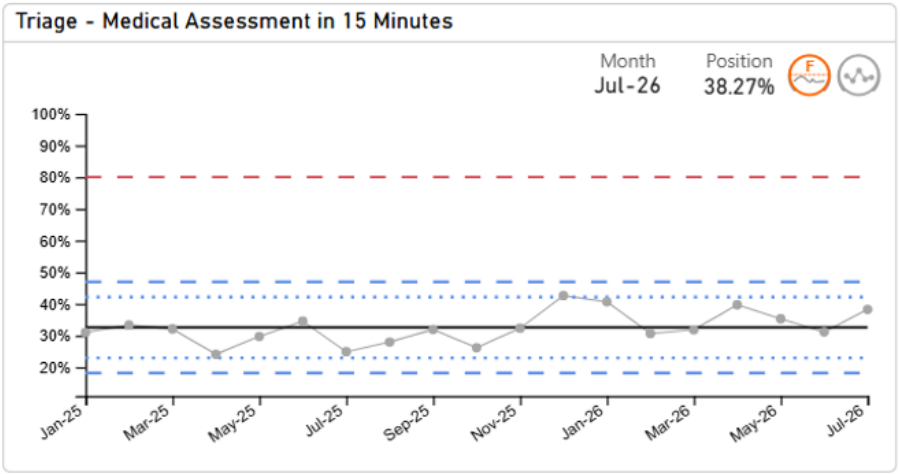

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## F2F Attendances - South




# F2F Performance - South

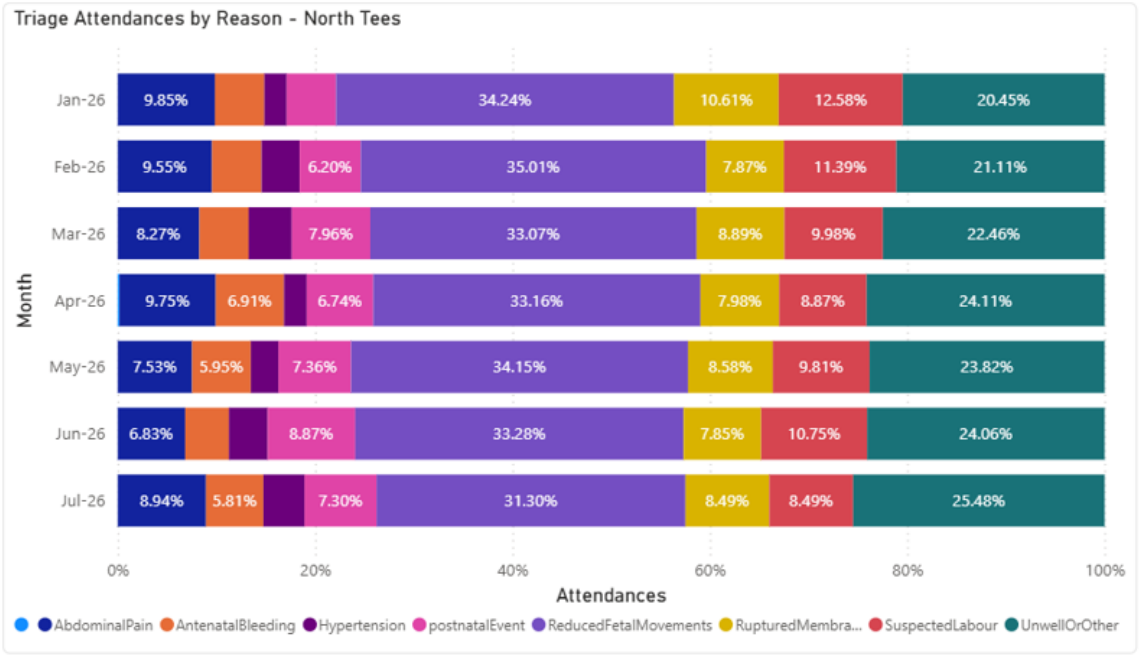





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# F2F Attendances by Reason - North



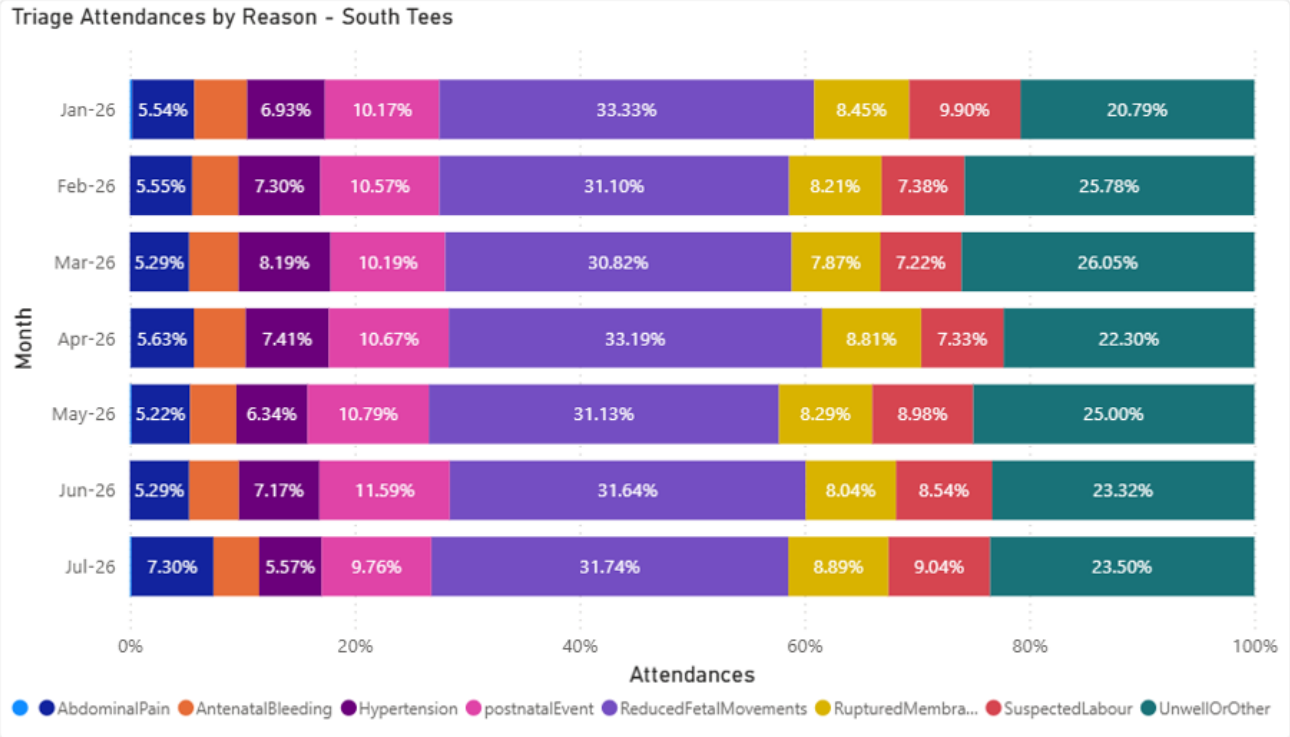

Triage Attendances by Reason - North Tees

| TriageReasonForAttending | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 | Jul-26 | Total |
|---|---|---|---|---|---|---|---|---|
| ReducedFetalMovements | 226 | 209 | 212 | 187 | 195 | 195 | 210 | **1434** |
| UnwellOrOther | 135 | 126 | 144 | 136 | 136 | 141 | 171 | **989** |
| SuspectedLabour | 83 | 68 | 64 | 50 | 56 | 63 | 57 | **441** |
| AbdominalPain | 65 | 57 | 53 | 55 | 43 | 40 | 60 | **373** |
| RupturedMembranes | 70 | 47 | 57 | 45 | 49 | 46 | 57 | **371** |
| postnatalEvent | 33 | 37 | 51 | 38 | 42 | 52 | 49 | **302** |
| AntenatalBleeding | 33 | 30 | 32 | 39 | 34 | 26 | 39 | **233** |
| Hypertension | 15 | 23 | 28 | 13 | 16 | 23 | 28 | **146** |
| | | | | 1 | | | | **1** |
| **Total** | **660** | **597** | **641** | **564** | **571** | **586** | **671** | **4290** |



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## F2F Attendances by Reason - South




Triage Attendances by Reason - South Tees

| TriageReasonForAttending | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 | Jul-26 | **Total** |
|---|---|---|---|---|---|---|---|---|
| ReducedFetalMovements | 505 | 409 | 478 | 448 | 447 | 437 | 439 | **3163** |
| UnwellOrOther | 315 | 339 | 404 | 301 | 359 | 322 | 325 | **2365** |
| postnatalEvent | 154 | 139 | 158 | 144 | 155 | 160 | 135 | **1045** |
| RupturedMembranes | 128 | 108 | 122 | 119 | 119 | 111 | 123 | **830** |
| SuspectedLabour | 150 | 97 | 112 | 99 | 129 | 118 | 125 | **830** |
| Hypertension | 105 | 96 | 127 | 100 | 91 | 99 | 77 | **695** |
| AbdominalPain | 84 | 73 | 82 | 76 | 75 | 73 | 101 | **564** |
| AntenatalBleeding | 71 | 54 | 68 | 62 | 59 | 61 | 56 | **431** |
| | 3 | | | 1 | 2 | | 2 | **8** |
| **Total** | **1515** | **1315** | **1551** | **1350** | **1436** | **1381** | **1383** | **9931** |



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# Perinatal Safety and Quality Report Quarter 1: 2026/27

**Meeting date:** *3 September 2026*

**Reporting to:** *Board of Directors*

**Agenda item No:** 2.3

**Report author:** *Stephanie Worn Director of Midwifery*

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

**Action required: Assurance**

**Delegation status: Jointly delegated item to Group Board**

**Previously presented to:** 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.

June 2026, maternity and neonatal services reports were published: Ockenden and Amos. NHSE responded with a 10 point plan. The service have provided a benchmark report as a separate paper.

**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.

External assurance is positive for South Tees making progress within the Maternity and Neonatal Improvement Support team framework. The programme is to be extended for 3months due to ambitious timeframes initially set.

In quarter, Trust reported crude 12 month rolling stillbirth rate above the MBRRACE comparator average. A thematic mortality review external review has been completed and is to be shared at Quality Committee in September 2026.

Maternity Incentive year 8; the services on track to meet the mid-point check for training compliance.

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

Kate Brintworth (Chief Midwifery Officer for England) visited James Cook site. Positive feedback was received.

## Recommendations:

Members are asked to note the content of the report
Members are asked to approve:

- UHT obstetric lead for preterm birth
- Perinatal culture improvement plan
- NTHFT and STHFT MNVP workplans

NHS
University Hospitals Tees

# Perinatal Safety and Quality report

## Quarter 1 2026.27

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# Executive summary

| Issues/Concerns | Actions/Mitigations |
|---|---|
| Trust stillbirth rate above the MBRRACE comparator average | Thematic mortality review completed and external stillbirth review scheduled with Maternity Improvement Advisor support |
| Workforce pressures across the midwifery service from acute sickness and absence | Daily staffing huddles for redeployment. Regular peoples clinics to be established to ensure support is timely and policy is followed |
| PPH >1.5l and Preterm rate at South Tees | An increase in rates was observed this month. A review is underway to establish whether there are any actionable findings or if the increase reflects normal variation. |
| Ultrasound System of imagery differs at each site | Discussions held to progress purchase of Viewpoint for North Tees, to align to South Tees. |
| **Quality Improvement initiatives/success** | **Impact** |
| Learning from PMRTs, MNSIs, incidents, complaints and claims incorporated into the UHT improvement plan | Support learning and improvements as a collaborative approach for UHT |
| Booking by 9+6wks of pregnancy | Trust has made improvements with some actions still in review. |
| MOSS simulation exercise completed | learning implemented to strengthen escalation, governance and safety response processes |
| **Escalations** | **Actions/Mitigations** |
| Ongoing focus needed on operational capacity and service resilience: planned caesarean sections | Business case with an options appraisal being reviewed at UHT management meetings |
| Ageing neonatal estate | There are challenges to facilitate modern and complex care needs of the babies. The current layout and condition of the neonatal unit makes the care provision challenging with limited space between the cots, increasing the risk of infection outbreaks, inability to provide privacy when sensitive discussions need to take place and lack of storage capacities. Some mitigations include visiting restrictions, enhanced use of all the rooms to avoid overcrowding etc.<br>. |

North Tees - PQSOM Summary Table

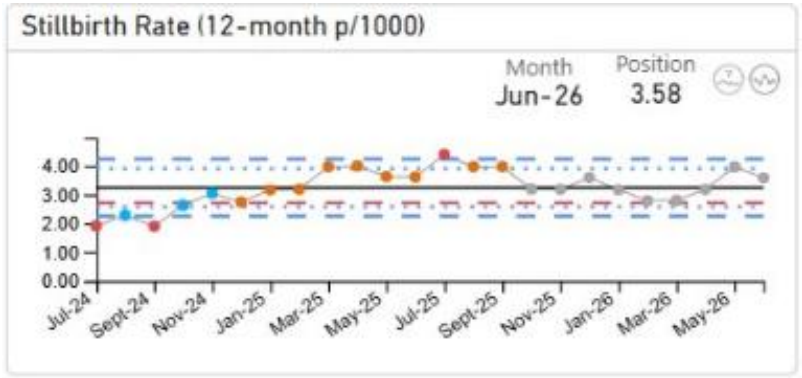
| Indicator | Latest Date | Value | Target | Variation | Assurance |
|---|---|---|---|---|---|
| Booking at 9+6 | Jun-26 | 66.02% | 80.00% | | F |
| Smoking at Booking | Jun-26 | 10.03% | 10.00% | | |
| Initial Assessment in 15 Min | Jun-26 | 80.95% | 90.00% | | |
| Medical Assessment in 15 Min | Jun-26 | 60.00% | 80.00% | | F |
| Right Place of Birth | Jun-26 | 93% | 95% | | |
| Registerable Births | Jun-26 | 201 | | | |
| Preterm Births (22-36+6) | Jun-26 | 7.46% | 7.00% | | |
| Induction of Labour | Jun-26 | 40.30% | | | |
| PPH >1.5L | Jun-26 | 15 | 31 | | |
| 3/4th Degree Tear | Jun-26 | 1.05% | 3.50% | | |
| Stillbirth Rate | Jun-26 | 3.58 | 2.71 | | |
| Neonatal Mortality Rate | Jun-26 | 0.40 | 0.83 | L | P |
| Smoking at Delivery | Jun-26 | 5.47% | 6.00% | | |
| Breastfeeding at First Feed | Jun-26 | 54.23% | 74.00% | | F |
| VTE (Post-delivery) | Jun-26 | 100% | 95% | H | P |
| ATAIN | Jun-26 | 1.08% | 6.00% | | |
| APGAR<7 at 5 | Jun-26 | 11 | 24 | | |
| HIE (Grade 2/3) Rate | Jun-26 | 0.80 | 0.91 | L | F |
| Baby re-admissions | Jun-26 | 1.49% | 6.00% | | |
| Maternal re-admissions | Jun-26 | 4.98% | 5.00% | | |

South Tees - PQSOM Summary Table

| Indicator | Latest Date | Value | Target | Variation | Assurance |
|---|---|---|---|---|---|
| Booking at 9+6 | Jun-26 | 68.68% | 80.00% | | F |
| Smoking at Booking | Jun-26 | 6.87% | 10.00% | | |
| Initial Assessment in 15 Min | Jun-26 | 89.73% | 90.00% | | |
| Medical Assessment in 15 Min | Jun-26 | 31.00% | 80.00% | | F |
| Right Place of Birth | Jun-26 | 100% | 95% | | P |
| Registerable Births | Jun-26 | 396 | | | |
| Preterm Births (22-36+6) | Jun-26 | 12.15% | 7.00% | | |
| Induction of Labour | Jun-26 | 46.84% | | | |
| PPH >1.5L | Jun-26 | 47 | 31 | H | |
| 3/4th Degree Tear | Jun-26 | 1.39% | 3.50% | | |
| Stillbirth Rate | Jun-26 | 3.47 | 3.22 | | |
| Neonatal Mortality Rate | Jun-26 | 1.52 | 1.46 | | |
| Smoking at Delivery | Jun-26 | 3.67% | 6.00% | L | |
| Breastfeeding at First Feed | Jun-26 | 67.50% | 74.00% | | F |
| VTE (Post-delivery) | Jun-26 | 100% | 95% | H | P |
| ATAIN | Jun-26 | 5.19% | 6.00% | | |
| APGAR<7 at 5 | Jun-26 | 23 | 24 | | |
| HIE (Grade 2/3) Rate | Jun-26 | 0.44 | 0.91 | H | P |
| Baby re-admissions | Jun-26 | 0.00% | 6.00% | | P |
| Maternal re-admissions | Jun-26 | 1.31% | 5.00% | | |

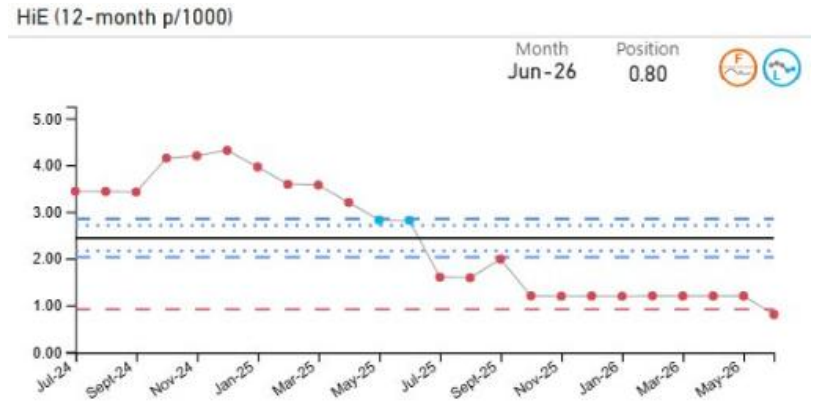
# Maternity performance overview

**NTHFT**

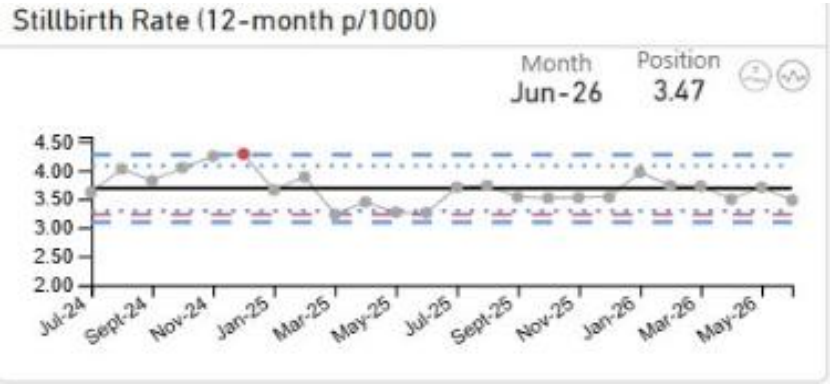


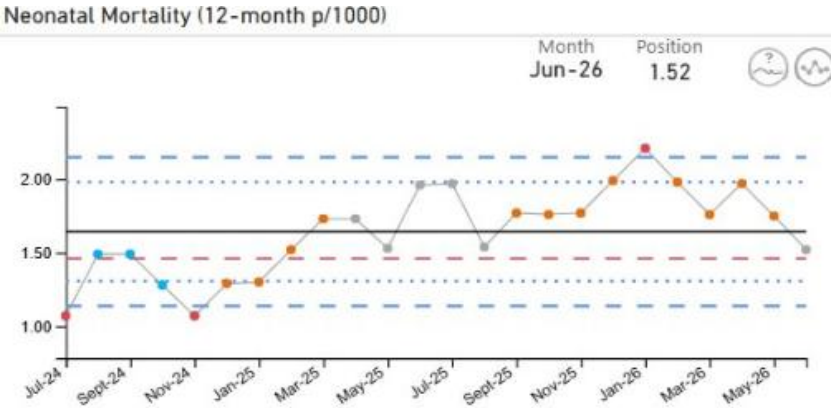


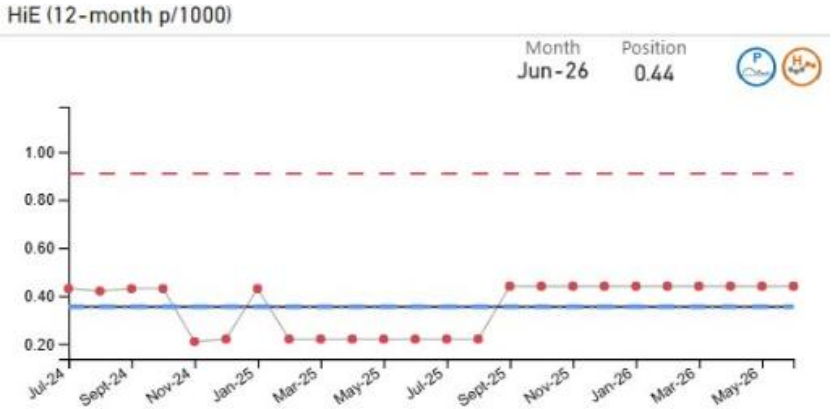





**STHFT**

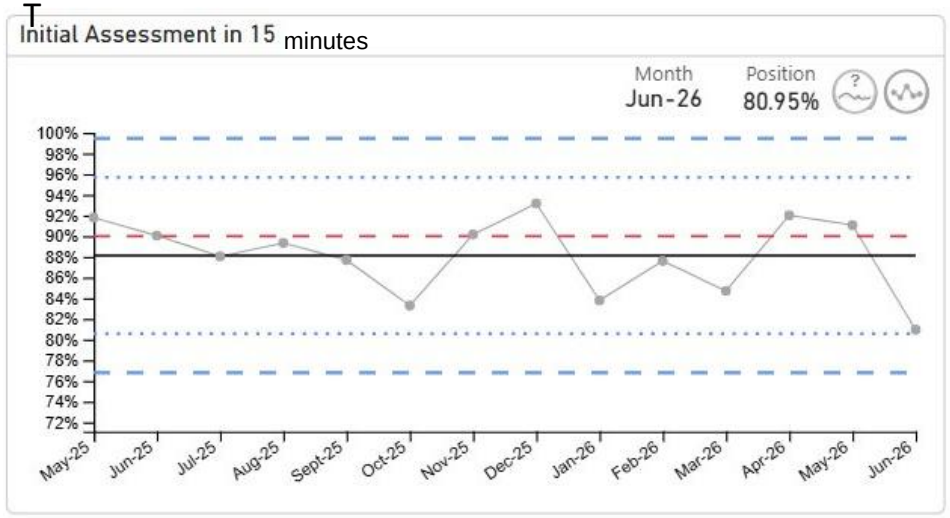


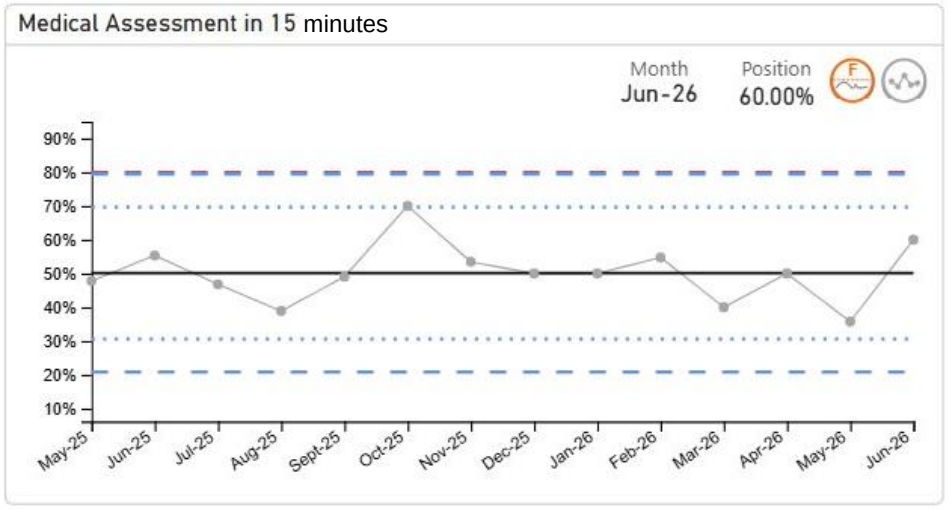



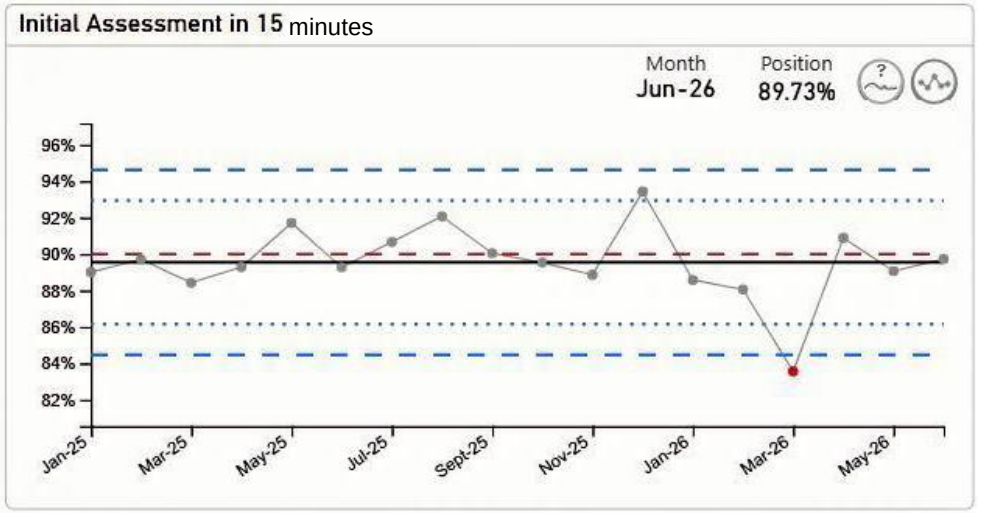
# Triage Data

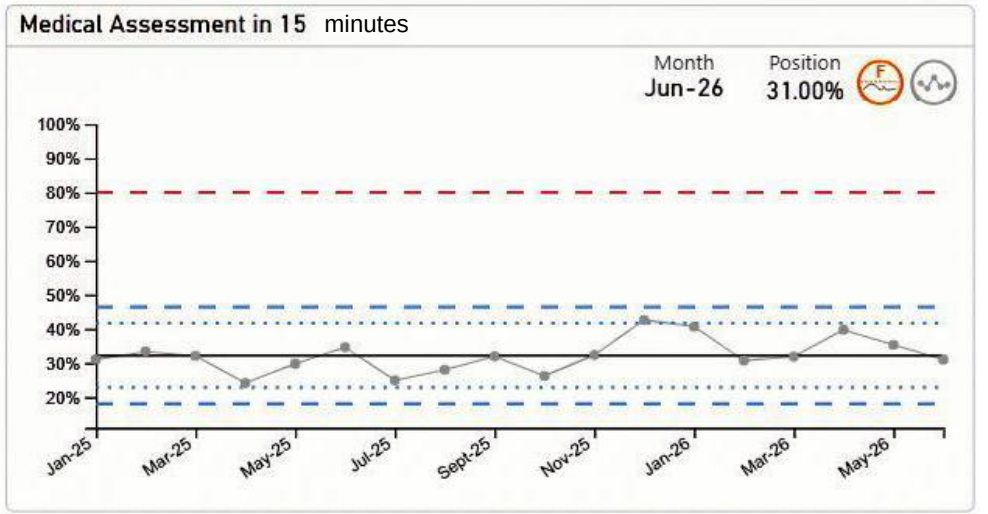
NTHFT




STHF




Caring Better Together

# Health equalities, Month of June 2026

| Metric | Unit | North Tees | | | South Tees | | |
|---|---|---|---|---|---|---|---|
| | | Numerator | Denominator | Position | Numerator | Denominator | Position |
| **Bookings by 9+6** | Percent | 204 | 309 | **66.02%** | 250 | 364 | **68.68%** |
| Bookings by 9+6 (BAME) | | 25 | 44 | 56.82% | 35 | 57 | 61.40% |
| **Preterm Births** | Percent | 15 | 201 | **7.46%** | 48 | 395 | **12.15%** |
| Preterm Births (BAME) | | 0 | 38 | 0.00% | 4 | 55 | 7.27% |
| **PPH > 1.5L** | Rate p/1000 | 3 | 201 | **15** | 18 | 381 | **47** |
| PPH > 1.5L (BAME) | | 1 | 38 | 26 | 2 | 54 | 37 |
| **Stillbirth Rate** | 12 Month Rate p/1000 | 9 | 2512 | **3.58** | 16 | 4611 | **3.47** |
| Stillbirth Rate (BAME) | | 1 | 378 | 2.65 | 1 | 635 | 1.57 |
| **Neonatal Mortality** | 12 Month Rate p/1000 | 1 | 2503 | **0.40** | 7 | 4593 | **1.52** |
| Neonatal Mortality (BAME) | | 0 | 377 | 0.00 | 2 | 633 | 3.16 |
| **HIE Rate** | 12 Month Rate p/1000 | 2 | 2503 | **0.80** | 2 | 4593 | **0.44** |
| HIE Rate (BAME) | | 0 | 377 | 0.00 | 0 | 633 | 0.00 |

# KPI review

- The Trust's crude 12-month rolling stillbirth rate remains above the MBRRACE comparator group average (2024). All cases have undergone review through the Perinatal Mortality Review Tool (PMRT) process with external clinical reviewer involvement. Cases were graded A–C to support assurance and due diligence. A thematic review has been completed for the cases within 2025, and an external review meeting is scheduled for July, supported by an Obstetric Maternity Improvement Advisor, to identify further opportunities for learning and improvement.
- Preterm rate at STH has increased in-month – the base level is 7.2% for women booked with and delivered with South tees. The additional 5% was intra-uterine transfers of care.
- PPH rate at STH – a review of cases in on progress
- Triage medical assessment within 15 minutes: Following the initial midwifery assessment, patients categorised as Amber cannot be reclassified prior to medical review. This issue has been raised at a national meeting with the developers of the BSOTS system; however, there are currently no plans to amend the process. Both sites are therefore piloting a revised recategorisation approach. In addition, neither site has a dedicated 24-hour obstetric team, which can contribute to delays in medical assessment, particularly during periods of high acuity and increased service demand.

# Regulation concerns

| CQC rating | | | | | | |
|---|---|---|---|---|---|---|
| **Site** | **Safe** | **Effective** | **Caring** | **Responsive** | **Well led** | **overall** |
| **NTHFT 2022** |  |  |  |  |  | RI |
| **STHFT 2024** |  |  |  |  |  | Good |

| Regulation enforcement/ regulation 28 | | | |
|---|---|---|---|
| **Site** | **Enforcement notice** | **Outcome** | **Progress** |
| **NTHFT** | 0 | N/A | N/A |
| **STHFT** | 0 | N/A | N/A |

# National data monitoring tools

| MOSS – end quarter 1 position | | | |
|---|---|---|---|
| **Site** | **No MOSS signals in last 3months** | **Trust Board exec within 8 days** | **Learning themes from critical safety review** |
| **NTHFT** | 0 | N/A | N/A |
| **STHFT** | 0 | N/A | N/A |

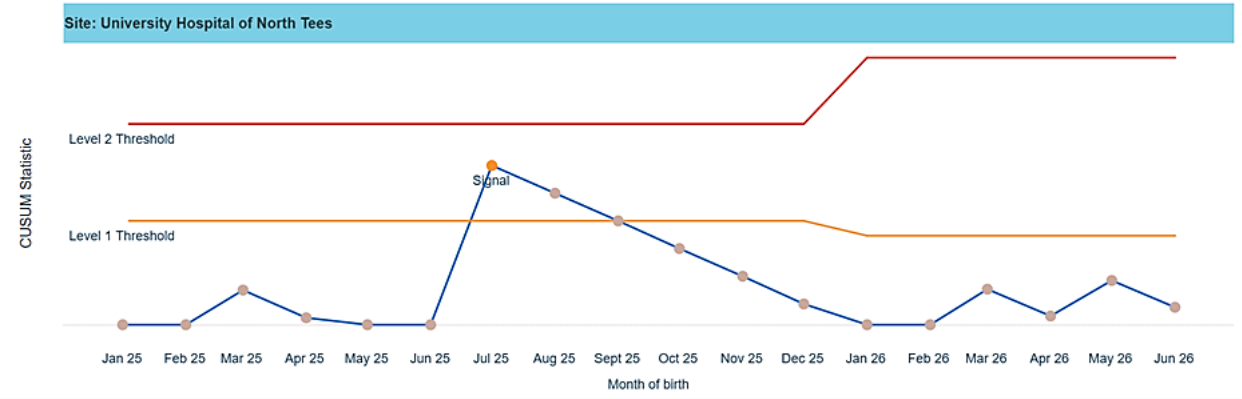



**Table of Events - Trust:** North Tees and Hartlepool NHS Foundation Trust

| Date of term birth | Events (term only) | Site name |
|---|---|---|
| **24 May 26** | 1 Term Stillbirth(s) | University Hospital of North Tees |
| **28 Mar 26** | 1 Term Stillbirth(s) | University Hospital of North Tees |
| **23 Jul 25** | 1 Term Neonatal Death(s) | University Hospital of North Tees |
| **19 Jul 25** | 1 Term Stillbirth(s) | University Hospital of North Tees |
| **06 Jul 25** | 1 Term Neonatal Death(s) | University Hospital of North Tees |
| **10 Mar 25** | 1 Term Stillbirth(s) | University Hospital of North Tees |

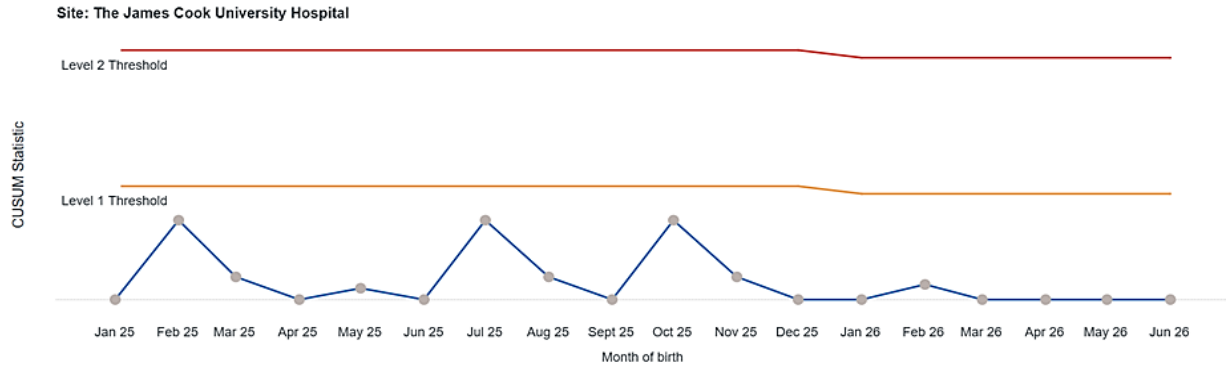



**Table of Events - Trust:** South Tees Hospitals NHS Foundation Trust

| Date of term birth | Events (term only) | Site name |
|---|---|---|
| **07 Feb 26** | 1 Term Stillbirth(s) | The James Cook University Hospital |
| **24 Oct 25** | 1 Term Stillbirth(s) | The James Cook University Hospital |
| **20 Oct 25** | 1 Term Stillbirth(s) | The James Cook University Hospital |
| **19 Jul 25** | 1 Term Neonatal Death(s) | The James Cook University Hospital |
| **11 Jul 25** | 1 Term Stillbirth(s) | The James Cook University Hospital |
| **13 May 25** | 1 Term Stillbirth(s) | The James Cook University Hospital |
| **18 Feb 25** | 1 Term Stillbirth(s) | The James Cook University Hospital |
| **17 Feb 25** | 1 Term Stillbirth(s) | The James Cook University Hospital |

# National data monitoring tools (cont)

| MOSS -DRILL for each site NTHFT and STHFT |
|---|
| 9 June 2026, A multidisciplinary clinical simulation exercise was undertaken in response to the MOSS alert to test team readiness, communication pathways, and adherence to escalation procedures. The scenario replicated a high-risk intrapartum event, allowing staff to rehearse critical decision-making, role clarity, and coordination under time pressure. The drill highlighted learning points (appendix 1) that are captured in the UHT improvement plan; learning from events and service insights (appendix 2) such as:<br>• a strengthened internal process on receipt of an alert<br>• Audit of caesarean birth decision to delivery times<br>The drill demonstrated strong commitment across the team and has provided valuable insight into both strengths and areas for improvement. By refining processes, clarifying responsibilities, strengthening improvement planning, and focusing on concise, consistent reporting, the organisation will be better positioned to respond effectively to real-time alerts in the future. The detailed document is within the reading room folder |

**Daily SitRep: quarter 1 overview**

| Site | No. Of mutual aid requests via local calls | No. of mutual aid requests via surge call | No. of closures or diverts in quarter | Reason | Learning themes |
|---|---|---|---|---|---|
| **NTHFT** | 0 | 0 | 0 | N/A | |
| **STHFT** | 0 | 2 | 1 closure for 2hrs | Capacity, staffing and clinical acuity | Proactive management of accumulating induction of labours. Early requests for mutual aid |

# Improvement plans

| Maternity & Neonatal Improvement Support Programme or Regional Oversight | | | |
|---|---|---|---|
| **Site** | **Level of support** | **Date commenced** | **Progress** |
| **NTHFT** | Regional oversight | January 2026 | Review requested as following new framework. Previous objectives were met and signed off by NHSE advisor |
| **STHFT** | MNIST | 30th January 2026 | Progressing with 5 focused areas. |

| **STHFT Maternity Neonatal Improvement Support plan** | **Progress towards 5 focussed areas for improvement** | | | | |
|---|---|---|---|---|---|
| **Commenced January 2026** | **Culture & leadership** 🟢 | **Workforce** 🟡 | **Governance & board effectiveness** 🟢 | **Obstetric leadership** 🟢 | **Clinical leadership** 🟢 |
| **Monthly escalation meetings:** | Progression has been made across the five focused area. Workforce is rated amber as internal process to remodel the workforce for birth availability has been slower than expected. Given the ambitious 6month timeframe and following advice from the MIA and discussions with the Trust, the programme will be extended for a further 3months. UHT perinatal governance arrangements have been established and will be monitored for effectiveness over the coming months. | | | | |

# Improvement plans

| Perinatal culture improvement for Trust Board approval (appendix 3) | | | |
|---|---|---|---|
| **Progress highlights** | **Escalations** | **Support required** | **Progress from previous escalations** |
| UHT commence perinatal equity and anti-discrimination programme (PEADP) in September 2026 | NA | Reviewing number of headcount and time to attend programme. Support to release staff may be required. Update will be provided on completion of the review | NA |
| Collaboration with organisation al development colleagues to widen the perinatal leadership team membership | NA | NA | NA |

# Executive summary Maternity incentive scheme year 8

| | Risk/Issue | Actions |
|---|---|---|
| **Alert** | Safety action B training compliance is dependent on staff attendance which can be influenced and impacted om by sickness and absence, maternity leave and clinical acuity | Dates planned including additional training dates and clinical escalation pathways. Added in an additional fortnight meeting to have current oversight. |
| **Advise** | Safety action E: saving babies lives on-going. Verification process now with the Trust and not the LMNS. | Regular updates provided. Exploring opportunity to work with CDDFT as a peer validation review |
| **Assure** | Governance process: MIS monthly meeting reporting to Perinatal Oversight Group and Quality Committee | Continue monthly review and reporting |

# Maternity Incentive Scheme Year 8

| Safety action | | North Tees | South Tees |
|---|---|---|---|
| A | Workforce and capacity | Q1 staffing report –September quarter reports to trust board<br>Planned caesarean section capacity and demand taken through UHT management<br>RCOG attendance audit is 96% , action plan developed<br>Midwifery BR+ 2026 assessment going through Trust governance process<br>Neonatal medical and nursing improvement plan developed for approval as current staffing does not meet BAPM standards | Q1 staffing report –September quarter reports to trust board<br>Planned caesarean section capacity and demand taken through UHT management<br>RCOG attendance audit is 100%<br>Midwifery BR+ 2026 assessment going through Trust governance process<br>BAPM nursing compliance under review |
| B | Training | Midpoint compliance: 27th July<br>Medical attendance below threshold – recovery plan in place | Midpoint compliance:27th July |
| C | Learning from reviews and investigations | Q1 safety and quality report revised to focus on learning | Q1 safety and quality report revised to focus on learning |
| D | Service user voice and equity | MNVP workplan developed for approval.<br>Interpreter service audit completed with action plan in supplementary pack | MNVP workplan developed for approval.<br>Interpreter service audit in progress |
| E | Care bundles | Maternal Care bundle published 2nd June. Review underway as UHT approach<br>Saving babies lives: Q4 showing compliant<br>Lead roles: one change for year 8 – UHT obstetric lead for preterm birth (appendix request approval) . All other roles remain unchanged from year 7. | Maternal Care bundle published 2nd June. Review underway as UHT approach<br>Saving babies lives: Q4 progress<br>Lead roles: one change for year 8 – UHT obstetric lead for preterm birth (request approval). All other roles remain unchanged from year 7 |
| F | Board oversight, governance, culture and leadership | Monthly attendance at Quality Committee to present PQOM and quarter reports<br>Quarterly attendance at Trust Board with quarter reports safety and quality and staffing | |

# SBL quarter 4 position

| NTHFT Quarter 4 2025.26 | | | |
|---|---|---|---|
| Element | Number of interventions implemented | compliant % | outcome |
| Element 1 Smoking in pregnancy | 23 | 100% | |
| Element 2 Fetal Growth Restriction | 19 | 100% | |
| Element 3 Reduced fetal movements | 5 | 100% | |
| Element 4 Fetal monitoring in labour | 13 | 100% | |
| Element 5 Preterm Birth | 23 | 100% | |
| Element 6 Diabetes | 4 | 100% | |
| All elements | | 100% | |

| STHFT Quarter 4 2025.26 | | | |
|---|---|---|---|
| Element | Number of interventions implemented | compliant % | outcome |
| Element 1 Smoking in pregnancy | 23 | 100% | |
| Element 2 Fetal Growth Restriction | 19 | 100% | |
| Element 3 Reduced fetal movements | 5 | 100% | |
| Element 4 Fetal monitoring in labour | 13 | 100% | |
| Element 5 Preterm Birth | 23 | 100% | |
| Element 6 Diabetes | 4 | 100% | |
| All elements | | 100% | |

Self-assessment position. External validation has been mutually agreed between UHT and CDDFT, this will commence by the end of July 2026. Previous arrangements had been with the LMNS, now removed for MIS year 8 following changes to the ICB role.

# MIS training midpoint compliance check

A new requirement for MIS year 8 safety action B, is to declare a mid-point compliance check of 90% for the 3 training elements that are Fetal wellbeing, MDT skills and newborn life support. There are 2 aspects:

- 90% compliance overall for all staff groups
- 90% compliance for each staff group

NTHFT has completed the July training programme and has met the required compliance standards for obstetric, maternity and anaesthetic staff. Compliance details for each professional group are provided in Appendix 5. Neonatal staff have scheduled Newborn Life Support (NLS) training sessions during July. At the time of reporting, the service remained on track to achieve the required compliance target, with updated compliance charts to be presented at the August PQOM.

South Tees has scheduled a training week in mid-July, following which updated training compliance figures will be reported. At the time of writing, the service was on track to meet the required compliance target, with the current position detailed in Appendix 5. Neonatal staff have also scheduled Newborn Life Support (NLS) training sessions during July. The service remains on target for compliance, with updated charts due to be presented at the August PQOM.

# Eligible reportable events and immediate learning

| Stillbirth -reportable | | | | | | |
|---|---|---|---|---|---|---|
| **Site** | **ID ref** | **Gestation** | **Ethnicity** | **SPEN completed** | **PMRT/MNSI/PSII** | **Learning themes from rapid review** |
| **NTHFT** | 10523 | 37+5 | White British | Yes | PMRT/MNSI | Lack of view point makes it difficult to read scan reports with transition from IG to WHO<br>Review if consultant is present when specialist midwife leading appointment |
| | 103924/2 | 34+6 | White British | Yes | PMRT/MSII | Transcription issue raised via scan system and badger, room for error, difficult to read as not using viewpoint system. |
| | 103926/2 | 37+6 | White British | yes | PMRT | No clear pathway for referral of patients to obstetric team whilst in the ED department |
| **STHFT** | 41435 | 24+2 | White British | yes | PMRT | None |
| | 44360 | 30+2 | White British | yes | PMRT | None |
| | 45772 | 24+4 | White British | yes | PMRT | System one alert in place to advise not to have home visits, however this was historical – safeguarding midwife to explore process the 0-19 team have in place for removal of alerts<br>Booking process to be reviewed to ensure women booking in advanced gestation are booked as soon as possible |
| | 47099 | 34 | White British | yes | PMRT | Not reviewed as yet |

# Learning from closed PMRT reports within previous quarter; Stillbirths

| Stillbirth – learning from closed PMRT reports within previous quarter | | | | | |
|---|---|---|---|---|---|
| **Site** | **ID ref** | **Grading Before/after birth** | **Learning identified** | **actions** | **progress** |
| **NTHFT** | 103114/1 | C/A | Patient  Leaflets need to be available in other languages (aspirin) | 1. LMNS contacted as previously undertaken work on this advised for trust level response<br>2. Digital midwives across UHT contacted to understand if this workstream can be achieve across badger platform | In progress |
| **STHFT** | MI-048374 123645 | B,A | Timely referral to clinic required for those with raised BP at booking | • Hypertension guideline amended<br>• Community teaching around the case ongoing | In progress |
| | 130661 | B,C | Unavailability of bereavement suite<br>Psychological impact of retained products | None | N/A |

* 2 grading points within PMRT: Grading of care of the mother and baby up to the point of birth of the baby and Grading of the care of mother following the death of her baby

# Eligible reportable events and immediate learning

| Neonatal death – reported in quarter | | | | | | |
|---|---|---|---|---|---|---|
| **Site** | **ID Ref** | **Age** | **Ethnicity** | **SPEN notification complete** | **PMRT/MNSI/PSII** | **Learning themes from rapid review** |
| **NTHFT** | N/A | NA | | NA | NA | None reported |
| **STHFT** | 40974 | 8 days | White British | yes | PMRT | None |
| | 42350 | 13 days | White British | yes | PMRT | None |
| | 44709 | 0 days | White British | yes | Review not supported (15+2 wks gestation) | None |
| | 45026 | 0 days | Asian other | yes | PMRT | Co-incidental learning (maternal); Correct VTE assessment and process for administration of medications in an emergency |
| | 49510 | 11 days | White British | yes | PMRT | Co-incidental learning (maternal); Discharge process from NICU flats for parents to be reviewed |

# Learning from closed PMRT reports within previous quarter; Neonatal deaths

| Neonatal death – learning from closed PMRT reports within previous quarter | | | | | |
|---|---|---|---|---|---|
| **Site** | **ID ref** | **Grading** Before/after birth | **Issue** | **actions** | **Progress** |
| **NTHFT** | N/A | NA | NA | None Reported | |
| **STHFT** | 129536 | C, A, A | Consideration needed to be taken around preterm labour rather than a provisional diagnosis of a UTI – a speculum examination needed to be completed | • Case learning shared with all teams through 'share and learn'<br>• Targeted teaching on triage<br>• Service working through speculum competencies<br>• Further education from pre-term birth team | In Progress |
| | 130066 | C,B,B | Timely medical reviews required<br>Guidance for cCTG interpretation followed but whole clinical picture to be considered regarding timing of delivery<br>Remote blood pressure system does not have information in different languages | • Reinforced to all staff the importance of asking for Consultant review if Registrars unable to review cases<br>• CCTGs to be shared in CTG learning meeting for reflection on case<br>• Review of remote BP monitoring system ongoing | In progress |
| | 129417 | C, B, D | Psychological impact of comments which were overheard and misinformation following the death of a baby<br>Lack of contemporaneous documentation | • IPads to be allocated to the team leaders so reviews and ongoing plans can be documented more easily<br>• Sharing of the case and patient experience to teams throughout maternity | In progress |

* 3 grading points in PMRT: Grading of the care of mother and baby up to the point of birth of the baby, grading of the care of the baby from birth up to the death of the baby and grading of care of the mother following the death of her baby

# Maternity & Newborn safety Investigation programme (MNSI)

| MNSI referrals in quarter 1 | | | | | |
|---|---|---|---|---|---|
| **Site** | **MNSI ref** | **Reason** | **Family informed** | **DoC** | **SPEN completed** |
| **NTHFT** | 1 | MI-58141 37+6 Intrapartum Stillbirth (Born before arrival) | Yes | Yes | Yes |
| **STHFT** | 1 | MI –060028 T+6 therapeutically cooled baby | Yes | Yes | Yes |

| Learning from closed MNSI reports within previous quarter | | | | | |
|---|---|---|---|---|---|
| **Site** | **No safety recom** | **No safety prompts** | **Themes** | **actions** | **On track** |
| **NTHFT** | NA | | | | |
| **STHFT** | NA | | | | |

# Maternity Patient Safety Incidents (PSI)

| PSII referrals | | | |
|---|---|---|---|
| **Site** | **PSII ref** | **Reason** | **Actions** |
| **NTHFT** | 0 | NA | |
| **STHFT** | 0 | N/A | |

# Events reported in quarter 1

| Events in quarter | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Site** | | **No Harm** | **Low harm** | **Moderate harm** | **Sever Harm** | **Themes** | **Learning actions** |
| **NTHFT** | **Maternity** | 211 | 91 | <5 | <5 | 1. 4th degree tear<br>2. Return to theatre bowel resection<br>3. HSV 1+2 positive SVD<br>4. Fractured skull | 1. Consent<br>2. Escalation<br>3. Clarity of information<br>4. Missed steroids |
| **STHFT** | **Maternity** | 171 | 161 | 8 | <5 | 1. Fetus/neonatal<br>2. Labour and delivery<br>3. Admission and readmission<br>4. Service availability<br>5. It systems and software | 1. Risk assessments<br>2. Postnatal feeding support<br>3. Record keeping<br>4. Medicines management |
| **NTHFT** | **Neonatal** | 35 | <5 | <5 | 0 | 1.Perinatal stroke – mod harm event<br>2. Term admissions | 1. Perinatal stroke not preventable from perinatal management.<br>2. Reflective learning from midwifery team re Escalation CTG |
| **STHFT** | **Neonatal** | 42 | 14 | 0 | 0 | 1.Medications | 1. Safe Medication prescribing and administration |

# NHS Resolution Scorecard

| North Tees | |
|---|---|
| Top injuries by volume | Top injuries by value |
| • Stillbirth (5)<br>• Atdnl/ Unnecessary operation (4)<br>• Brain Damage (3) | • Brain damage (3)<br>• Cerebral Palsy (1)<br>• Erb's Palsy (1) |
| **Top causes by volume** | **Top causes by value** |
| • Fail/ delay in treatment (7)<br>• Fail to make resp to abnormal FHR (4)<br>• Repeat attempt at forceps (2) | • Fail/ Delay in treatment (7)<br>• Fail/ Delay admitting to hospital<br>• Birth defects (1) |

| Themes identified | actions | Progress |
|---|---|---|
| Communication in scalation and staffing | Implementation of Each Baby Counts escalation toolkit | |
| Documentation via EPR | Embed correct practice for multiple swab counts on Badgernet – White boards implemented. | |
| Increase capacity for planned caesarean Sections | Business case completed. Awaiting approval. | |

# NHS Resolution Scorecard

## South Tees

| Top injuries by volume | Top injuries by value |
|---|---|
| •Atdnl / Unnecessary operations (8 )<br>•Stillborn (7)<br>•Fatality (7)<br>•Unnecessary pain (7)<br>•Loss of baby (6) | •Brain damage (4)<br>•Psychiatric/psychological dmge (4)<br>•Cerebral Palsy (2)<br>•Erbs's Palsy (4)<br>Wrongful birth (1) |
| **Top causes by volume** | **Top causes by value** |
| Fail/delay in treatment (22)<br>Intra-op problems (4)<br>Forceps delivery(4)<br>Fail to monitor 2nd stg labour (4)<br>Inappropriate treatment (3) | Fail to warn-informed consent (3)<br>Fail /Delay in treatment (22)<br>Delay in performing operation (2)<br>Fail to inform test results (1)<br>Fail to interpret USS (1) |

| Themes identified | actions | Progress |
|---|---|---|
| OASI care bundle relaunch | Staff education (RK) | |
| Apgar scoring | Ongoing audit and staff education (KK, JL, VN, KH) | |
| Risk assessments | Audit of compliance of VTE risk assessment to identify themes and develop actions (AT JL) | |
| Increase capacity for planned caesarean Sections | Business case completed. Awaiting approval. | |

ogether

# Risk register summary

| Site | Very low | Low | Medium | high |
|---|---|---|---|---|
| NTHFT: Maternity | | | 5 | |
| NTHFT: Neonatal | | 1 | | |
| STHFT: Maternity | | 2 | 7 | |
| STHFT: Neonatal | | 4 | 1 | |
| UHT: Maternity | | | 1 | |
| Total overdue | | 0 | 5 | |

Future developments of the risk register are to progress as a group approach unless it is site specific. The service has an entry for planned caesarean section capacity and demand, with demand exceeding capacity. A Business case has been developed and is going through local governance processes. Delays in care are monitored through midwifery red flags within the staffing paper and triangulated with events and complaints. The service provides a daily sitrep to the NEY regional maternity teams that includes delays of care. To avoid duplication, the service have asked for access to the collated information.

# Service User Voice

| MNVP | Commissioned | Concerns | Escalations |
|---|---|---|---|
| **NTHFT** | Yes | £10k Insufficient funding to meet national requirements incl governance meetings | Raised with NEY Service user lead |
| **STHFT** | Yes | £10k Insufficient funding to meet national requirements incl governance meetings | Raised with NEY Service user lead |

| North Tees & Hartlepool | | | | |
|---|---|---|---|---|
| **MNVP workplan 2026.27 -Yes** | **MNVP Quarter meetings** | **Insights and projects** | **FFT positive % & comments** | |
| Workplan developed for approval (appendix 6).<br>No escalations to report | Held in locality venues and booked for 26/27<br>Next meeting : 10th July 2026, Redhill family hub | Information videos for inpatient stays, service user feedback generated, awaiting for staff input. Service user voice round table – food on ward, initial feedback stage began. Bereavement/ baby loss space in the chapel. 4 x mothers circle events planned throughout the year and across region. | 100% | Positive across all teams: domestics, midwives, obstetricians and health care workers: kind and compassionate care |

| South Tees | | | | |
|---|---|---|---|---|
| **MNVP workplan 2026.27 – Y or N** | **MNVP Quarter meetings** | **Insights and projects** | **FFT positive % & comments** | |
| Workplan developed for approval (appendix 7).<br>No escalations to report | Dates .15th July<br>16th September | Focus this year on poverty and engaging with harder to reach communities- via baby banks.<br>Cross site working with NTHFT | 85.7% | Unable to extract qualitative data |

# 2025 CQC Maternity Survey

| North Tees & Hartlepool | | | |
|---|---|---|---|
| **Key areas of improvement /sustainability** | **Progress** | **Risks** | **Escalations** |
| Debrief service for women and families. | | N/A | No escalations – clinics now set up as per job plan. |
| Review of leaflets and information giving | | Requires input from significant number of stakeholders. | |
| Designated contact number for service users to contact separate departments: triage and community – triage line 24 hours. | | Delay in contacting community midwife | No escalations – awaiting go live of community line. |

| South Tees | | | |
|---|---|---|---|
| **Key areas of improvement /sustainability** | **Progress** | **Risks** | **Escalations** |
| No birth reflections service at Stees | | Risk of birth trauma | PN debrief via triage system where necessary with obs<br>Consultant MW to see birth choices where trauma is evident<br>Ongoing with BR plus to utilise Midwifery staffing |
| All areas of CQC survey positive<br>Some work continues in increasing trust in maternity services and working alongside Ntees | | Continued improvement | None |

# Complaints

| Directorate | stage | Number of Open complaints | Number of Overdue Complaints | Number awaiting PET closure | comments |
|---|---|---|---|---|---|
| **Obstetrics** | 1 | North – 1<br>South - 3 | 0 | | All on target |
| | 2 | North – 7<br>South - 3 | 1 | 2 | Awaiting action plan to be shared with family |
| | 3 | North – 4<br>South - 1 | 0 | 0 | All on target |
| **Neonates** | 1 | North – 1<br>South -0 | 0<br>0 | 1<br>0 | NT stage 1 closed in compliance timeframe beginning July awaiting PET closure |
| | 2 | North – 0<br>South- 0 | 0<br>0 | 0<br>0 | |
| | 3 | North – 0<br>South- 0 | 0<br>0 | 0<br>0 | |

| **Complaint themes – actions are within the UHT Learning from events and service insights Improvement plan (appendix 2)** |
|---|
| **CSU 1**<br>Communication<br>Patient Care<br>Appointments<br>Medication<br>Values and Behaviour of staff |

# Safety champion staff engagement

| North Tees & Hartlepool | | |
|---|---|---|
| Engagement Dates & location | Feedback | Actions |
| May 2026 – Ward 22 AN/ PN ward.<br>May 2026 – Ward 22 AN/ PN ward.<br>Hartlepool Community Midwifery<br>June 2026 | Concerns around UHT plans and what this will mean for staff. Concerns around sickness and absence and the effect this has on BAPM compliance. The environment ws calm, clean with lots of patient information displayed. Feedback from patients was extremely positive and they felt well supported by staff.<br>IT equipment a challenging. Challenges around escalation and can cause tension.<br>Good team working identified.<br>Progress with community clinics being visible on Badgernet.<br>Challenges includes internet connectivity within the areas. Impact of long-term sickness and covering clinics. Staff concerns around on call model and appropriate rest period.<br>Positivity expressed around relationships with health visitors and family hubs. | Feedback from MNVP around hunger on ward, poster devised.<br>Discuss with Hubs re internet and pressure this places on community midwives.<br><br>Continued communication around UHT model. |

| South Tees | | |
|---|---|---|
| Engagement Dates & location | Feedback | Actions |
| 20260503- FHN hospital<br>20260623 – Middlesbrough Community | Concerns expressed around staffing to keep the unit open and to deliver antenatal classes and the future model of care.<br>Staff expressed that sickness within the service and the absence of admin support was having an impact on the team and the ability to cover all clinics. From an IT and equipment perspective issues were raised related to inaccurate blood pressure monitors and the difficulties with women being able to access appointments on badgernet.<br>Positive interactions with student midwives were observed and a patient who attended the clinic spoke highly about the care she received mentioning that she felt listened to and had received continuity of care | Work ongoing on FHN model of care<br>To explore calibration of blood pressure monitors<br>To escalate badgernet concerns to the digital team to resolve |

# UHT Service user and staff engagement strategy




The service has launched The big maternity and neonates conversation:
These are engagement sessions to understand what is important to service users and staff either using or working within the service. Staff sessions held and service user sessions are in the planning stage. Updates are to be provided in the proceeding months

# Updates

| National/Regional/Local |
| --- |
| • System C: auto-populate function now disabled with a redesign expected by September 2026.<br>• Quarterly reviews for the PQOM are to be hosted by NEY maternity team<br>• Published national reports of maternity and neonatal services: Ockenden and Amos followed by NHSE 10 point plan. A separate paper is in development to present to Trust Board of Directors in September 2026<br>• Planned neonatal critical care review to amend neonatal unit care levels has been paused due to infection outbreak i within NENC.<br><br>**Local**<br>UHT hosted a celebrated event for nurse, midwives and allied health professionals with Kate Brintworth, Chief Midwifery Officer for England as guest speaker. Kate undertook a site visit at James Cook University Hospital, and provided positive feedback. |

# Recommendations

The Board of Directors/Trust Board/Quality Committee is asked to receive and discuss the content of the report

The Board of  Directors are asked to approve:

- UHT obstetric lead for preterm birth
- Perinatal culture improvement plan
- NTHFT and STHFT MNVP workplans

University Hospitals Tees

**MOSS Safety Checklist Drill 9th June 2026**

**Feedback and Key Learning Points**

## Introduction

Firstly, thank you to all colleagues for the considerable effort invested in preparing and generating the required information for this exercise. The level of engagement and collaboration was highly valued and contributed significantly to the success of the drill.

## 1. Pre-Population of the Checklist

Observations

- The current process for checklist completion is time-sensitive, resource-intensive, and highly dependent on advance planning.
- While pre-planning enabled coordination of reviewer availability, this approach is unlikely to be feasible during a real-time alert scenario, where immediate response will be required.
- The exercise highlighted the significant workload associated with coordinating, collating, and inputting information across multiple team members.
- Accessibility to documentation and shared resources was effectively supported through Microsoft Teams, which improved collaboration and visibility.
- The checklist itself is generic in design, rather than tailored to the specific nature of an alert. This limitation is outside of Trust control.

Learning Points

- Streamline processes to reduce reliance on pre-planning and improve readiness for real-time alerts.
- Explore opportunities to simplify data capture and reduce duplication of effort.
- Maintain and further develop centralised access platforms (e.g. Teams) to ensure rapid information sharing.

## 2. Completion of the Checklist

Observations

- The completed checklist included a high level of detail and extensive supporting evidence, demonstrating strong engagement and diligence.
- However, in some instances, excessive detail made it difficult to clearly answer the specific questions, and occasionally introduced conflicting interpretations.

- For example, reporting of BSOTS initial assessment within 15 minutes showed a discrepancy:
    - The checklist reported percentage compliance.
    - Supporting evidence suggested lower compliance, reflecting differences between initial triage assessment and subsequent medical review.
- The importance of a clear and concise summary section was evident, as this is likely to be the primary focus for reviewers.

Learning Points

- Focus on providing proportionate, relevant evidence that directly addresses each checklist question.
- Ensure consistency between summary data and supporting evidence to avoid ambiguity or misinterpretation.
- Clearly define and standardise terminology (e.g. triage vs medical review) to ensure consistent reporting.
- Strengthen the summary section as an executive overview, ensuring key messages, risks, and assurances are clearly articulated.

**3. Post-Exercise Reflections**

Observations

- Feedback from participants was overwhelmingly positive, with many noting that the exercise provided valuable insights and meaningful learning opportunities.
- The drill highlighted opportunities to standardise processes, systems, and governance arrangements, including audit approaches eg LSCS timing thresholds being met based on audit not inphase
- There is a need to clarify roles and responsibilities within the team, particularly for responding to such alerts.

Learning Points

- Use learning from this exercise to standardise and formalise processes, promoting consistency across future responses.
- Integrate findings into existing audit and assurance frameworks to strengthen oversight.
- Clearly define team roles and responsibilities, including identifying deputies to ensure resilience and continuity during live incidents.
- Develop a formal improvement plan based on the learning identified, with clear actions, owners and timescales.
- Ensure that existing improvement plans reviewed as part of this process are current, in-date, and actively monitored, with progress regularly evaluated.

- Continue to run structured exercises to maintain preparedness and embed learning.

**Conclusion**

This drill has demonstrated strong commitment across the team and has provided valuable insight into both strengths and areas for improvement. By refining processes, clarifying responsibilities, strengthening improvement planning, and focusing on concise, consistent reporting, the organisation will be better positioned to respond effectively to real-time alerts in the future.

| Theme | Issue | Actions | Lead | Expected date of completion | Current position | Evidence position | sustained improvement | RAG |
|---|---|---|---|---|---|---|---|---|
| **Communication and professionalism** | | | | | | | | |
| 1.Strengthening women-centred communication and informed choice | Options other than a mobile device to access leaflets | Accessible patient information via Trust website to include language options | Comms and Digital RM | Oct-26 | project to be planned | Launch of redeveloped maternity and neonatal internet page | updated website limited complaints for | |
| | | Collaborative with the MNVP for alternative options for patient information | MNVP and RM leads | Oct-26 | Link to safety champions actions. Wilcox surveyed what women would like to know and will produce short videos | To Hyperlink to benchmark tool | Feedback from MNVP | |
| | Potential to much within Badgernet | Review of digital leaflets available via Badgernet for relevancy and to include language options | Digital and Gov RMs | Oct-26 | project to be planned | leaflet tool tracker | Audit of regular review and ensure out dated leaflets are removed | |
| | Informed choice | promote a Decision making tool | MNVP RM leads | Oct-26 | linked to Ockenden action | To Hyperlink to benchmark tool | Feedback from MNVP, limited complaints | |
| Professional behaviours and attitudes | Respecting confidentiality of colleagues. NTH have had a couple of cases of colleagues pregnancy records being accessed without permission | Communication to all staff outlining expectations. | DoM HoMs | Aug-26 | Email shared with all staff outlining expectations. | email | No further incidences of staff sharing or accessing staff records. | |
| | Social media behaviours. STH aware a small number of individual share posts whilst on sick leave or personal options shared that me be inflammatory with individuals known to be registrants . | Communication to all staff outlining expectations. | DoM HoMs | Aug-26 | Email shared with all staff outlining expectations. | email | | |
| | MDT incivility are noticed when there are pressures due to acuity and or workload. This is the time when it is expected for teams to pull together. | Provide civility workshops | HoMs PDMs | Sep-26 | dates are being planned for Autumn 2026. Facilitated by the RCM | schedule of training and feedback | through events reviews and inphase, minimal issues for communication should be noted | |
| | | Implement RCOG escalation toolkit | HoMs PDMs Obs Lead | 01/09/2026 | NTH have adopted a QI project. This will be shared with STH and a working group to be established to monitor progress | Project plan | through events reviews and inphase, minimal issues for communication should be noted | |
| Escalation | Consistent approach to escalation processes. At STH following two surge calls, an AAR was undertaken and identified gaps in knowledge | Ensure MDT leadership team are aware of the process and guidance. Local sessions to be held | HoMs / CD | Sep-26 | NEY to launch escaltion process by August. Each site are remodelling community birth availability models which will require a change in internal escaltion processes. Local escalation process is under review once the above completed | escaltion SoP | subsequent AARs should not identify the same learning if change has been embedded | |
| | | ensure documents and checklists are readily available | Matrons HoMs | Jul-26 | in progress | checklist list easily accessible | AAR reviews demodntarte no issues with documentation | |
| | learning from a MOSS drill highlighted improvements in internal process and audit | establish a clear internal process on receipt of an alert or alarm | PLT | Jul-26 | in progress | flowchart | Positive team reflection of the process following a MOSS response | |
| | | Audit of caesarean section decision to delivery times . This will support delays in care theme | Obs audit lead | Aug-26 | in progress | audit | repeat audit | |
| **Clinical outcomes** | | | | | | | | |
| Risk assessment | lack of compliance with booking and at 28weeks for VTE assessment noted a STH | understand challenges why risk assessments are inconsistent | Commnity matron | Aug-26 | sample audit of reassessments | audit | repeat audit | |
| Apgar scoring | STH identified as an outlier for high than average Apgar score of <7 at 5minutes of age | Deep dive audit to identify any issues | HoM CDS maanger | Aug-26 | audit in progress | audit and recommendations | expected reduction in rate depending on audit findings | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Delays in care | Improve patient experience if delays occur | Planned caesarean sections, capacity and demand | ops team | Aug-26 | Business case completed. To go through local approval processes | Business case and minutes of approval | repeat capacity and demand on an annual basis | |
| | acuity tool compliance varied, therefore gaps evidence of workload and proactive planning | re-educate e staff on use of acuity tool | labour matrons | Sep-26 | ?reach out to BR plus for a refresher course with staff? | docments and dates of staff updates | increased complaince rate results | |
| | Proactive response to accumulating workload | use of daily sitrep to identifying increasing workload, discussed at safety huddles | snr maternity team | on-going | review safety huddle information and process of where this is escalated | safety huddle documents. | reducation in unit closues, surge cals if appropriate follwong AAR | |
| **Digital** | | | | | | | | |
| risk assessment | national issue for risk assessment function with badgernet | amend the digital process | Digital RMs | Aug-26 | local change in process completed | local process | system c redesign expected september to fully resolve | |
| | | inform all staff of issue and mitigations | Digital RMs | Aug-26 | communications with all staff | comms briefings | system c redesign expected september to fully resolve issue | |
| | | reassessment of the priority groups | Digital RMs | Aug-26 | re assessments completed | audit and recommendations | system c redesign expected september to fully resolve issue | |

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# UHT Culture Improvement Plan 2026.27

| Trusts must demonstrate that they have an agile perinatal culture improvement plan in place which triangulates data and engagement from multiple sources, uses recognised improvement methodology to evidence progress and impact, and is reviewed by the Trust Board at least six monthly. | | | | |
|---|---|---|---|---|
| **Action** | | **Lead** | **Completion date** | **BRAG** |
| **Staff wellbeing and psychological safety** | Establishment a staff council at STH | Head of Midwifery | September 2026 | |
| | Sustain staff council at NTHFT | Recruitment & Retention midwives | Review quarterly | |
| | Staff behaviour charter | PLT | June 2026 | |
| | Implement hot debriefs & training<br>• Develop SoP<br>• Consider training opportunities | Patient safety teams | March 2027 | |
| | Scope offers for supervision and reflection opportunities for all staff<br>• Clinical supervision<br>• PMAs & PNAs<br>• MSW Practice training lead<br>• Culture coaches | HoMs | March 2027 | |
| | TRIM practitioners | HoMs / Training leads | December 2026 | |
| **Equity and diversity** | Culture competency training for all staff | Training Leads | March 2027 | |
| | Service user involvement from diverse backgrounds<br>• Approved work plan | MNVP leads | September 2026 | |
| | Develop Equalities dashboard – staff and service user<br>• Liaise with Trust BI team | BI team | October 2026 | |
| **Learning culture** | Governance structure for shared learning opportunities<br>• Share structure | DoM/PLT | June 2026 | |

DRAFT

**Job Title: Preterm Birth Lead– Obstetrics: University Hospital Tees**

**Job Profile:**

We are inviting expressions of interest for the role of Preterm birth Lead– Obstetrics

**Remuneration/ Duration:**

Remuneration for the role will be 0.5 PA Additional Programmed Activity. This position is initially for a period of 12months and extendable pending further review.

**Line Management Reporting Relationships and role development:**

The Preterm Birth Lead operationally reports to the Clinical Director.

Training and leadership development opportunities will be provided and encouraged to establish in the role and further development in clinical management roles.

| **Key Responsibilities: (Key areas of focus)** | |
|---|---|
| 1 | **Leadership & Management**<br>• Lead and oversee the Preterm Birth Prevention Clinic and associated care pathways.<br>• Develop and implement evidence-based protocols for identification and management of women at risk of preterm birth.<br>• Provide expert clinical advice on complex preterm birth cases.<br>• Ensure compliance with national and local maternity safety standards.<br>• Support implementation of national maternity initiatives including the Saving Babies' Lives Care Bundle. |
| 2 | **Key meetings to attend:**<br>• 2 monthly Preterm birth local meetings<br>• LMNS Preterm birth meetings<br>• National PTB meetings/updates |
| 3 | **Service delivery and performance**:<br>• Monitor and audit preterm birth rates and outcomes.<br>• Lead quality improvement initiatives aimed at reducing neonatal morbidity and mortality.<br>• Work collaboratively with neonatology, midwifery, fetal medicine, and community teams. |
| 4 | **Governance and risk management**<br>• Lead audits and clinical reviews relating to preterm birth.<br>• Participate in serious incident investigations where preterm birth is implicated.<br>• Ensure accurate data submission to national databases such as the NHS futures. |
| 4 | **Collaborative Working**<br>• Provide training to obstetric, midwifery, and multidisciplinary teams on preterm birth prevention and management.<br>• Supervise trainees and contribute to continuing professional development programs. |

## Person Specification

**Essential**

- Consultant Obstetrician  participating in on call Obstetric rota.
- Demonstrated leadership capability and commitment to excellence in maternity care.
- Strong understanding of clinical governance, risk management, and quality improvement.
- Effective communication, teamworking, and conflict-resolution skills.

**Desirable**

- Previous leadership or management experience (e.g., lead clinician, governance roles).

**How to Apply**

Please submit a brief expression of interest (maximum one page) outlining your suitability for the role, your leadership experience, and your vision for the Maternity service.

Deadline: 20/4/26

Submit to: Shilpa.mahadasu@nhs.net

NHS
North Tees and Hartlepool
NHS Foundation Trust

July 2026 -

# Combined Monthly Mandatory Training day Statistics with trajectories

Statistics created: 31.07.2026

NHS
North Tees and Hartlepool
NHS Foundation Trust

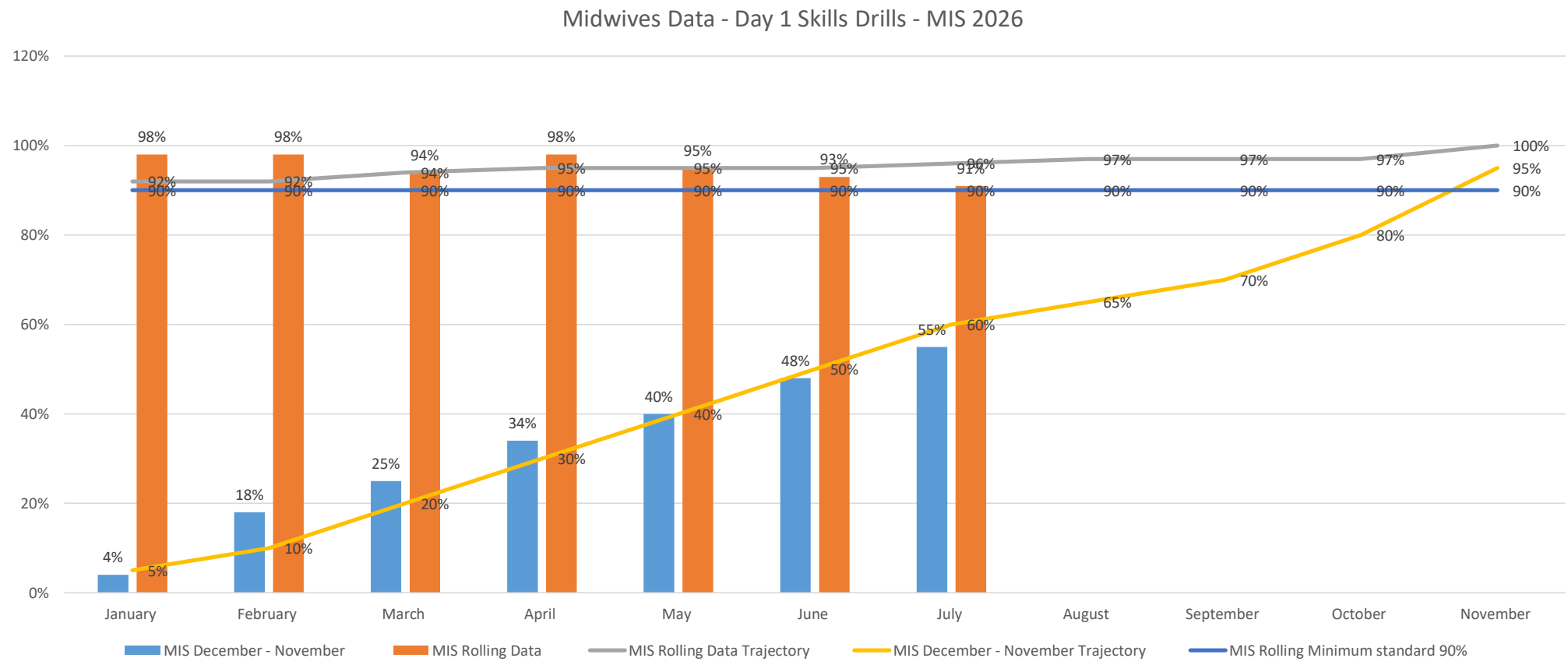
# Day 1 Skills Drills

MIS November – December statistics with trajectory

MIS Rolling Stats with Trajectory – Target >90% each month

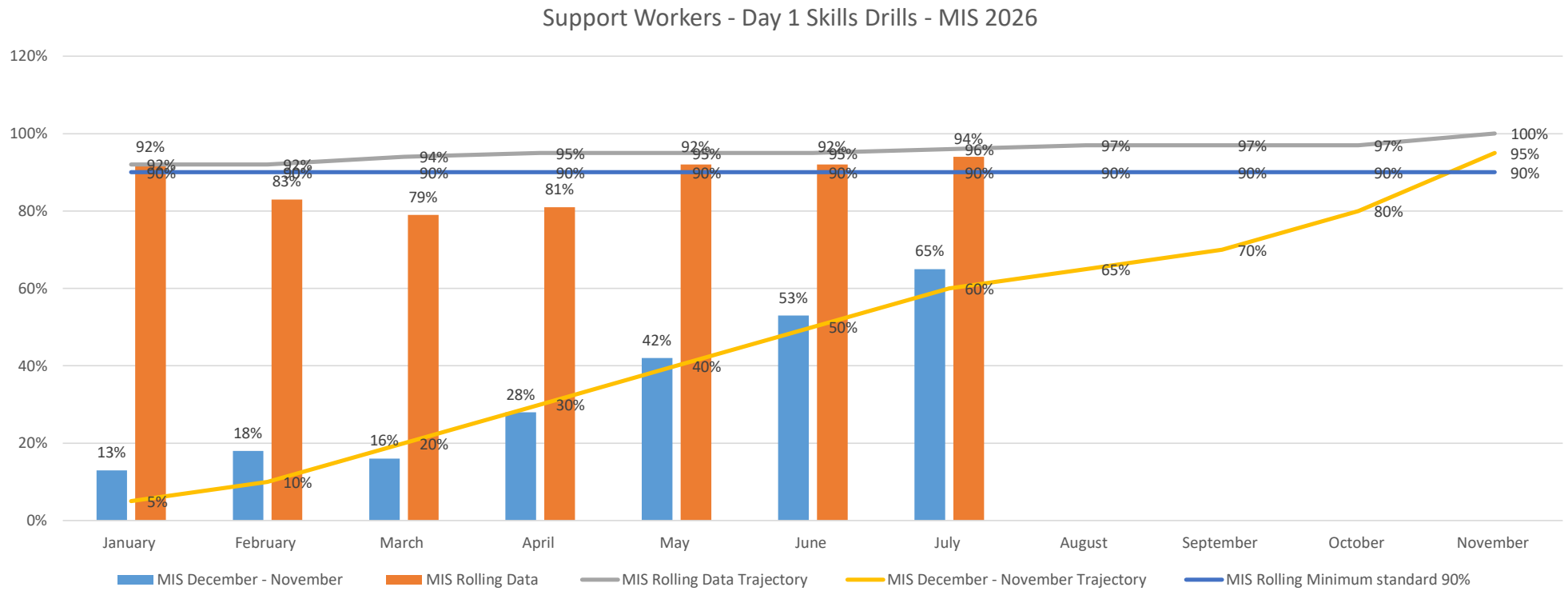
North Tees and Hartlepool
NHS Foundation Trust

# Midwives – Skills Drills



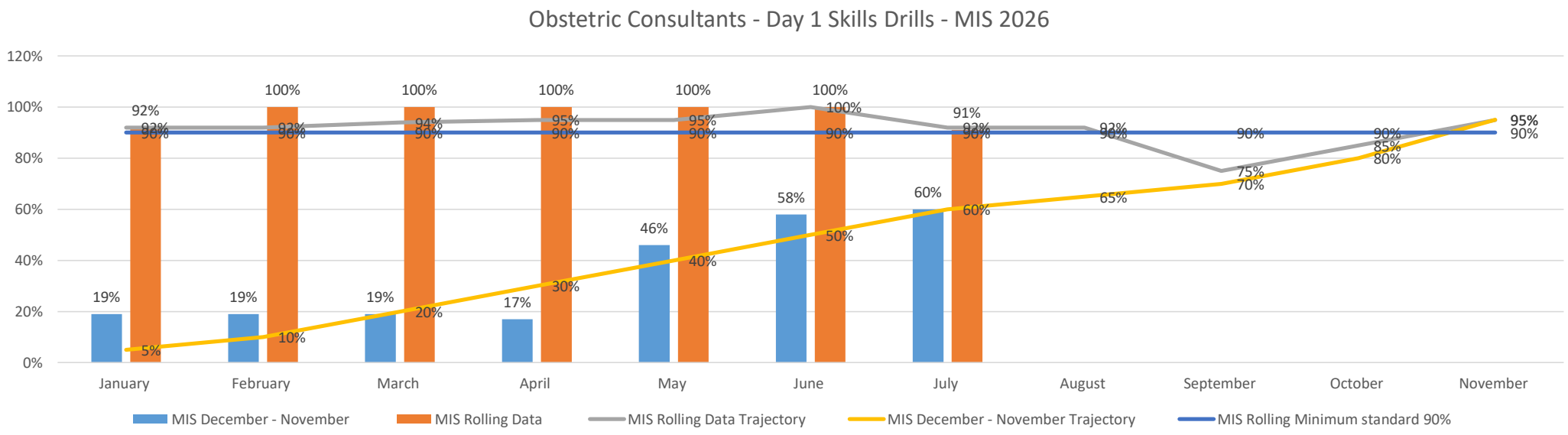
North Tees and Hartlepool
NHS Foundation Trust

# Support Workers – Skills Drills



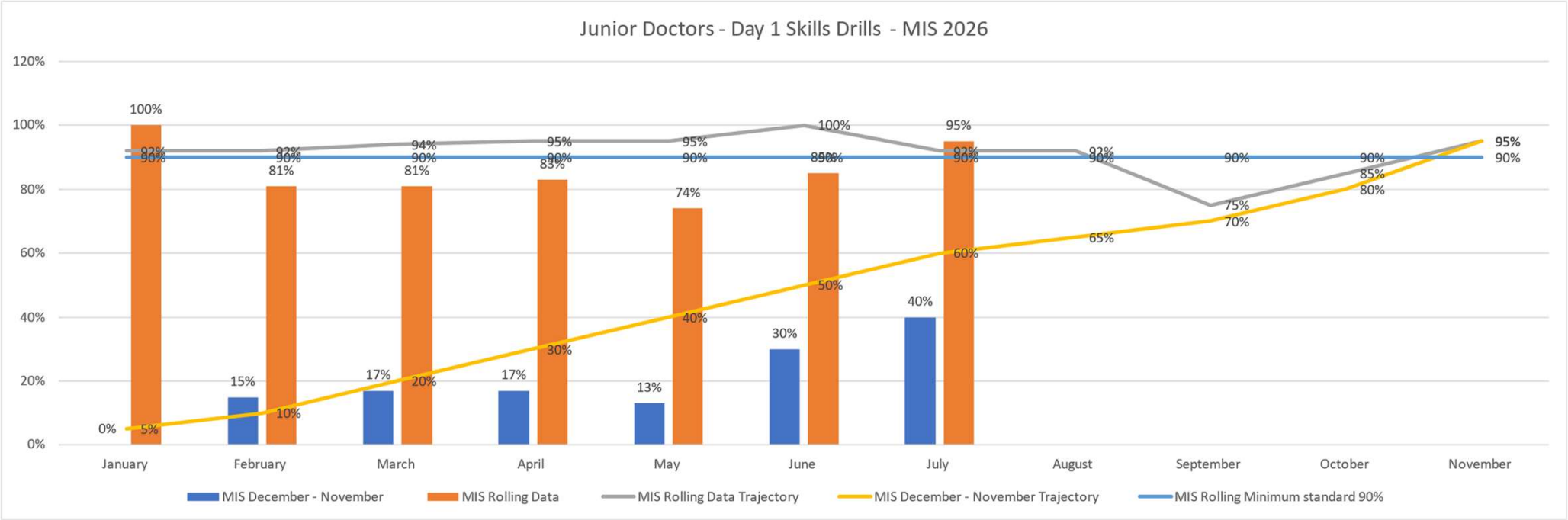
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# Obstetric Consultants – Skills Drills



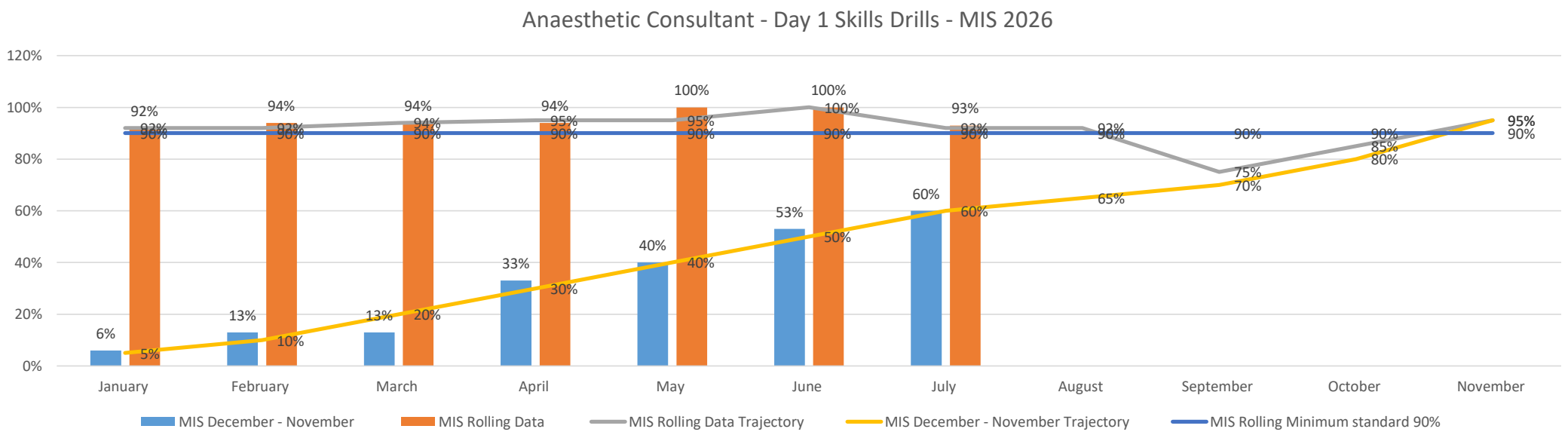
NHS
North Tees and Hartlepool
NHS Foundation Trust

# Junior Doctors – Skills Drills



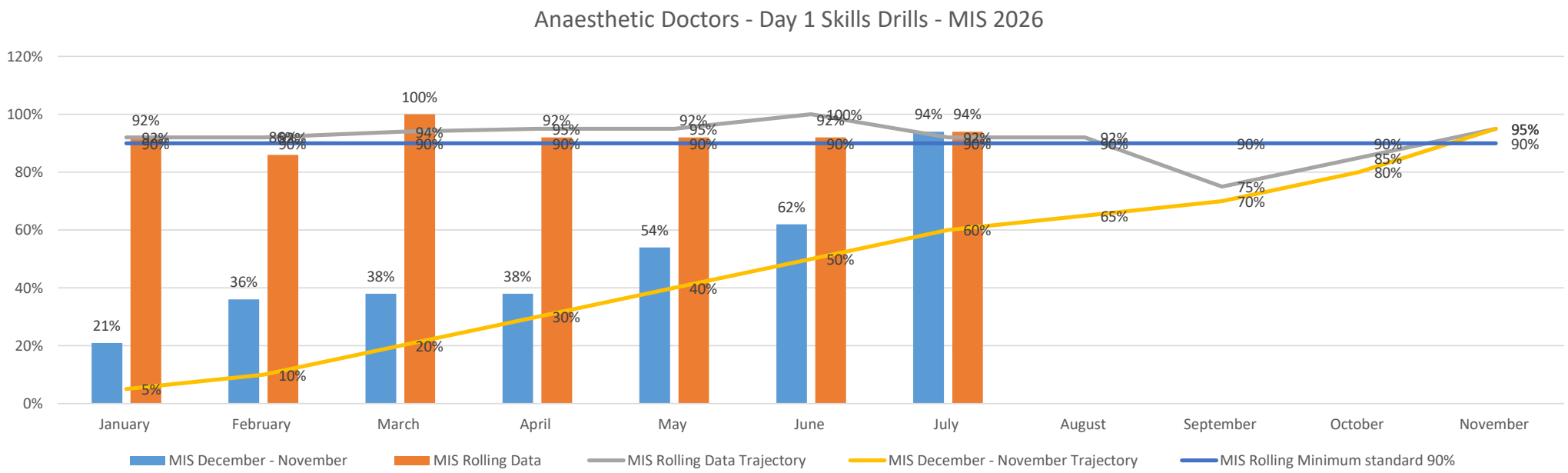
North Tees and Hartlepool
NHS Foundation Trust

# Anesthetic Consultant– Skills Drills



North Tees and Hartlepool
NHS Foundation Trust

# Anesthetic Doctors – Skills Drills



NHS
North Tees and Hartlepool
NHS Foundation Trust

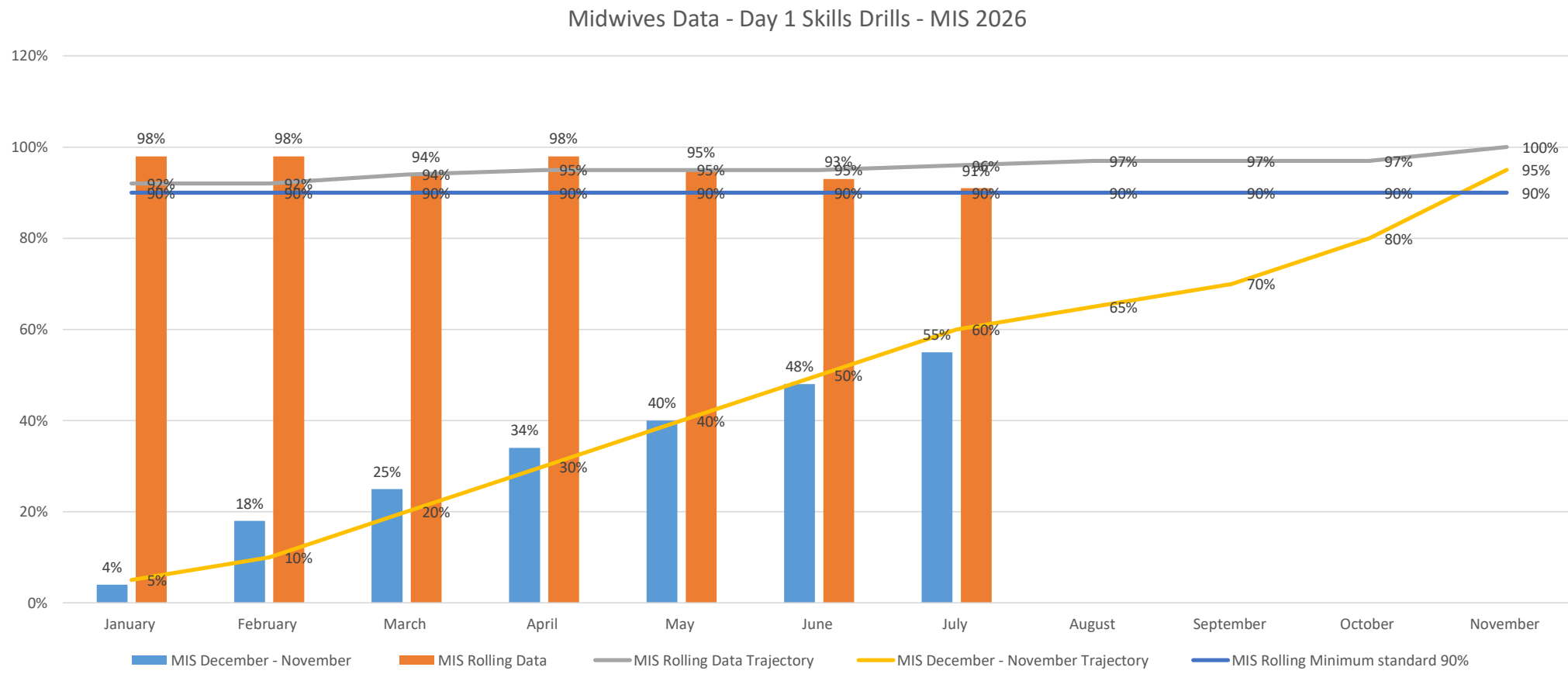
# NLS

MIS November – December statistics with trajectory

MIS Rolling Stats with Trajectory – Target >90% each month

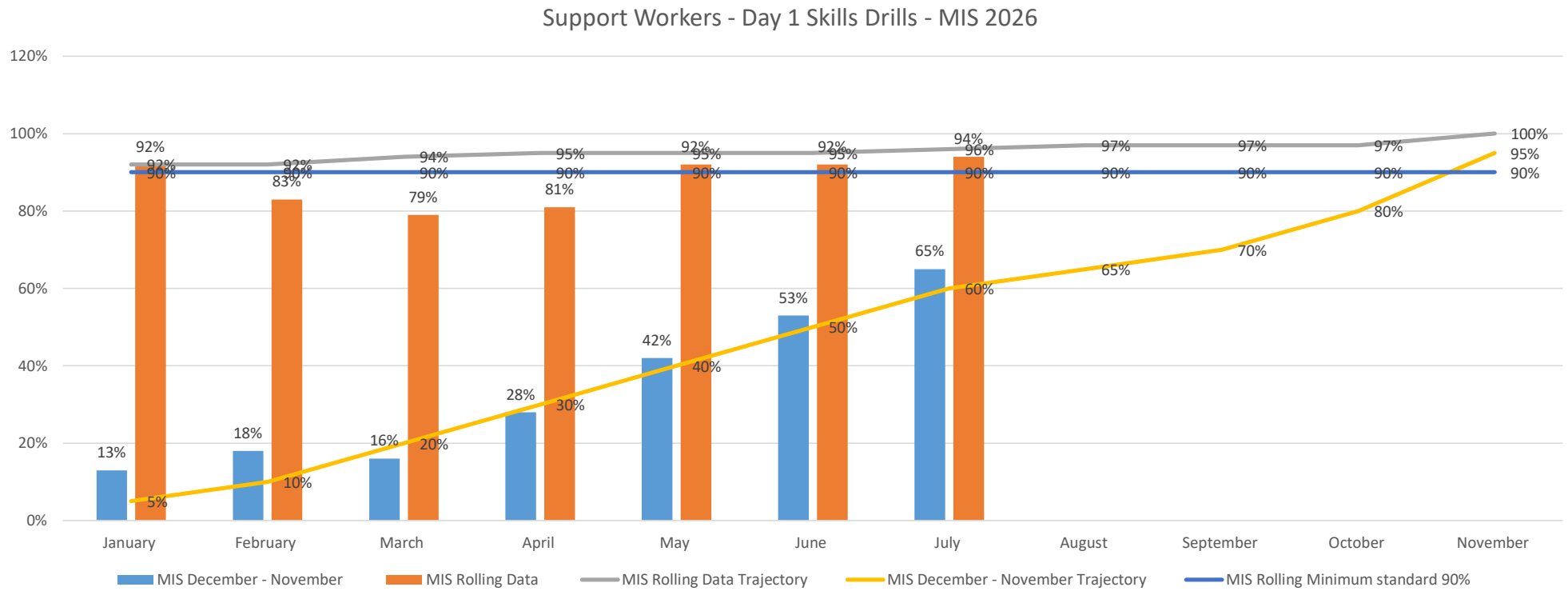
North Tees and Hartlepool
NHS Foundation Trust

# Midwives – NLS



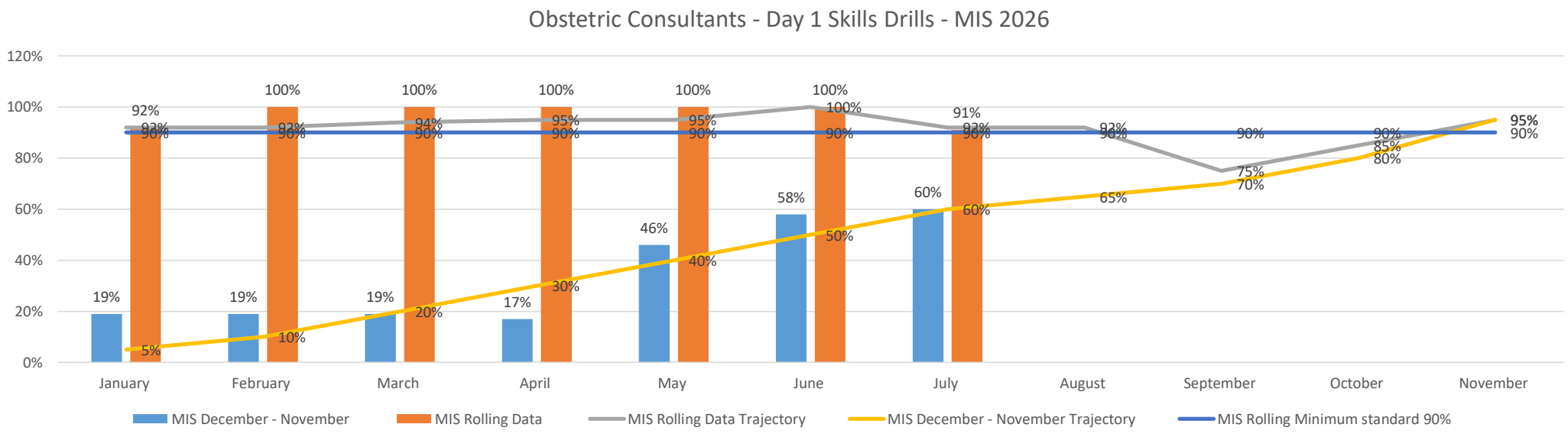
North Tees and Hartlepool
NHS Foundation Trust

# Support Workers – NLS



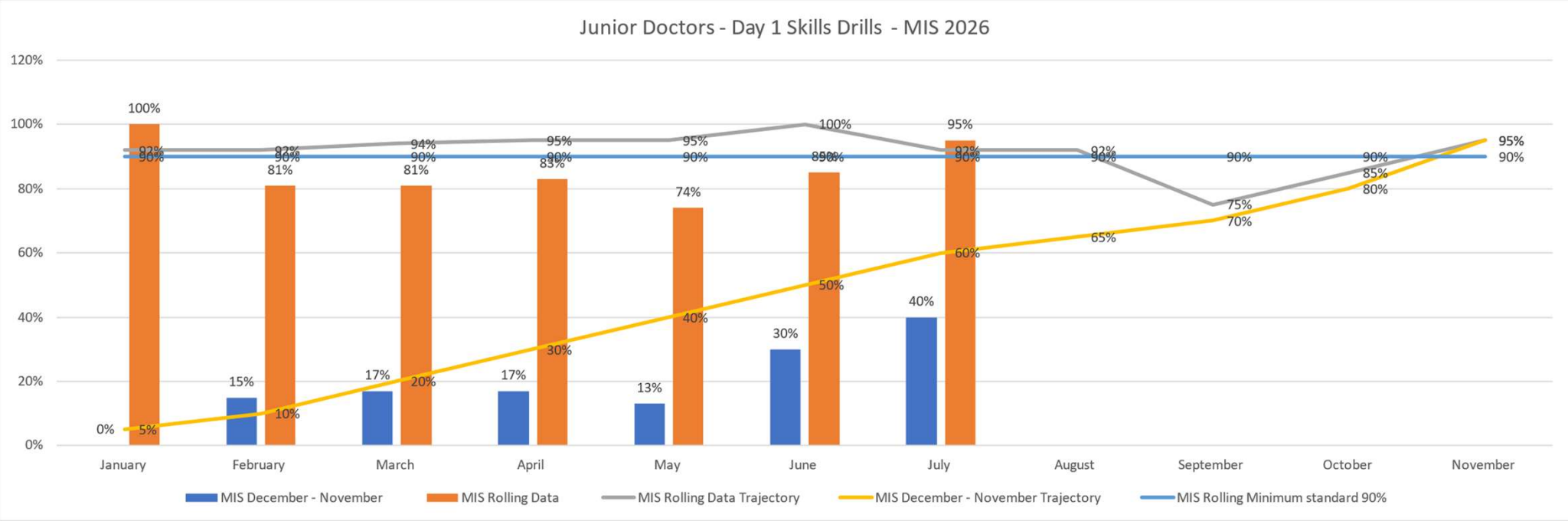
North Tees and Hartlepool
NHS Foundation Trust

# Obstetric Consultants – NLS



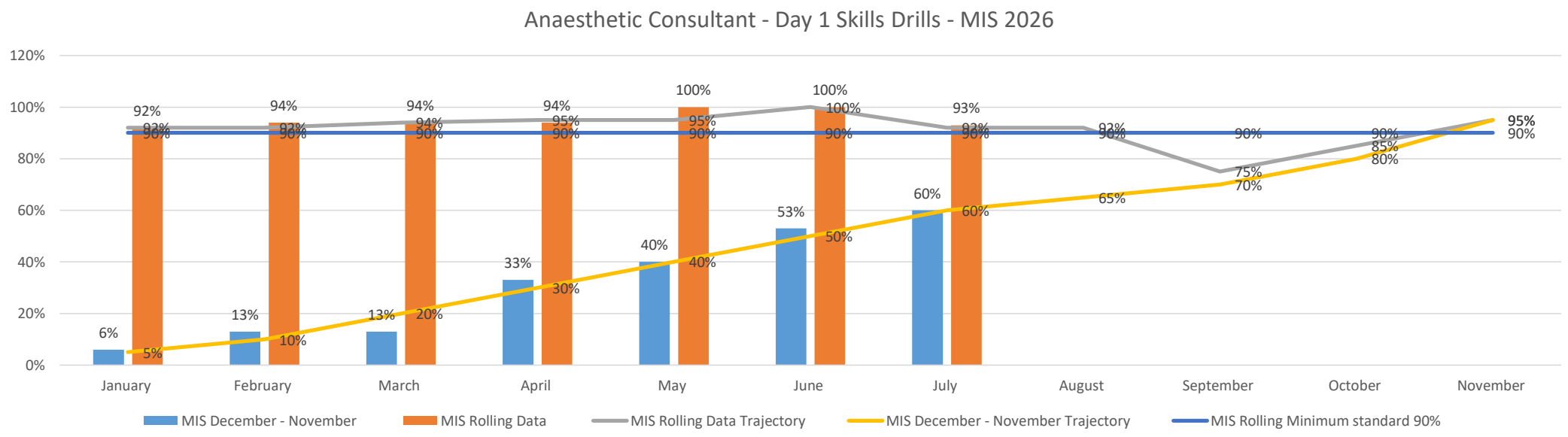
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NHS Foundation Trust

# Junior Doctors – NLS



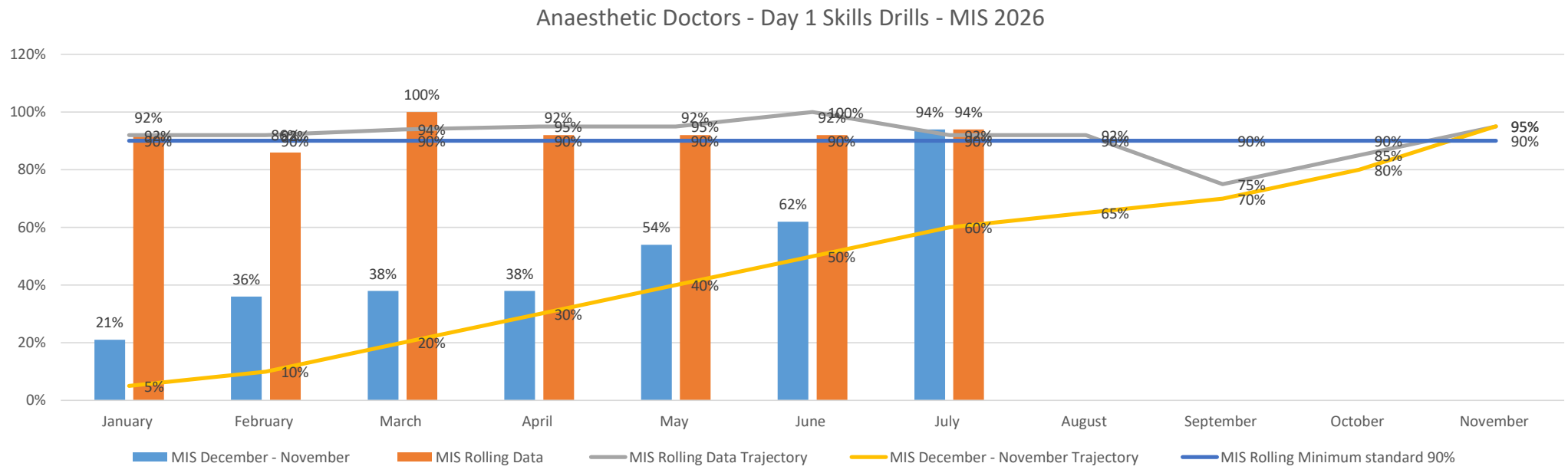
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NHS Foundation Trust

# Anesthetic Consultant– NLS



North Tees and Hartlepool
NHS Foundation Trust

# Anesthetic Doctors – NLS



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North Tees and Hartlepool
NHS Foundation Trust

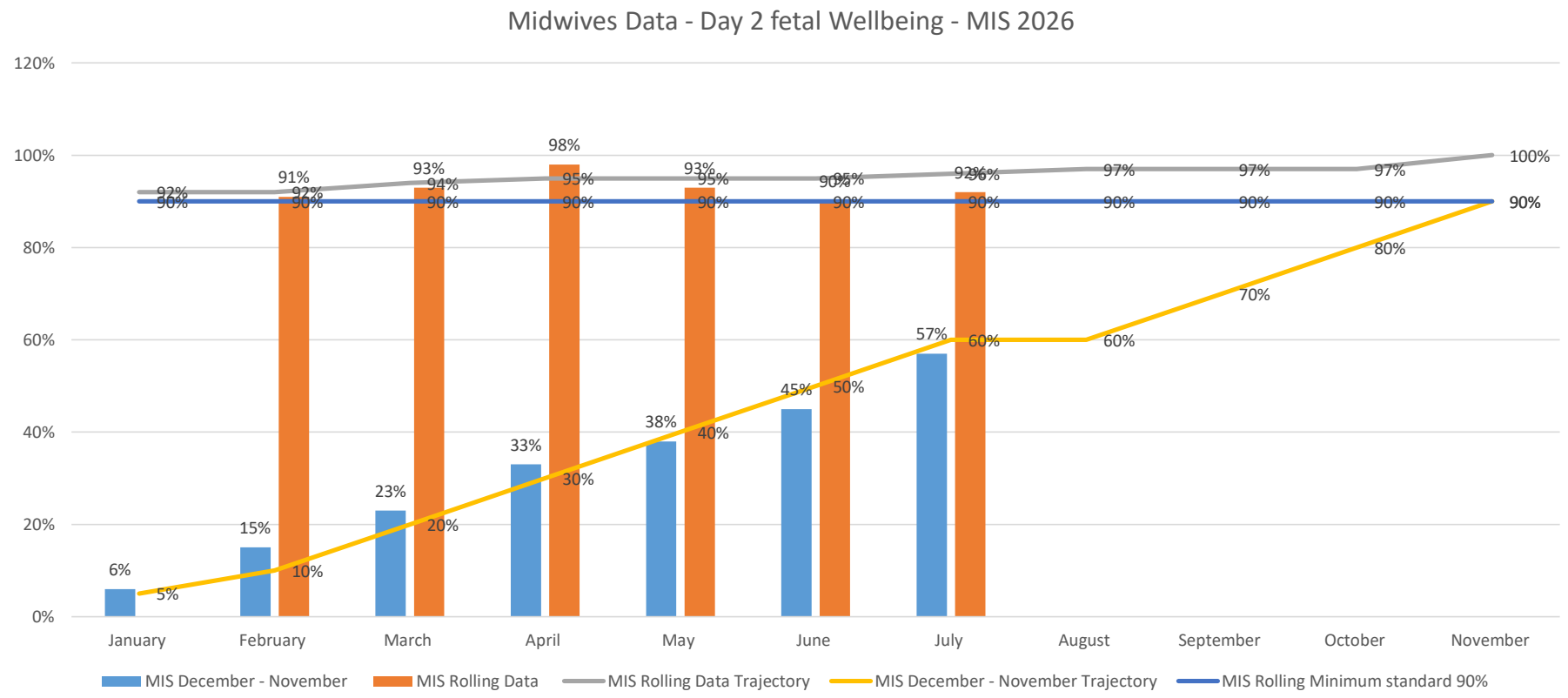
# Day 2 Fetal Wellbeing

MIS November – December statistics with trajectory

MIS Rolling Stats with Trajectory – Target >90% each month

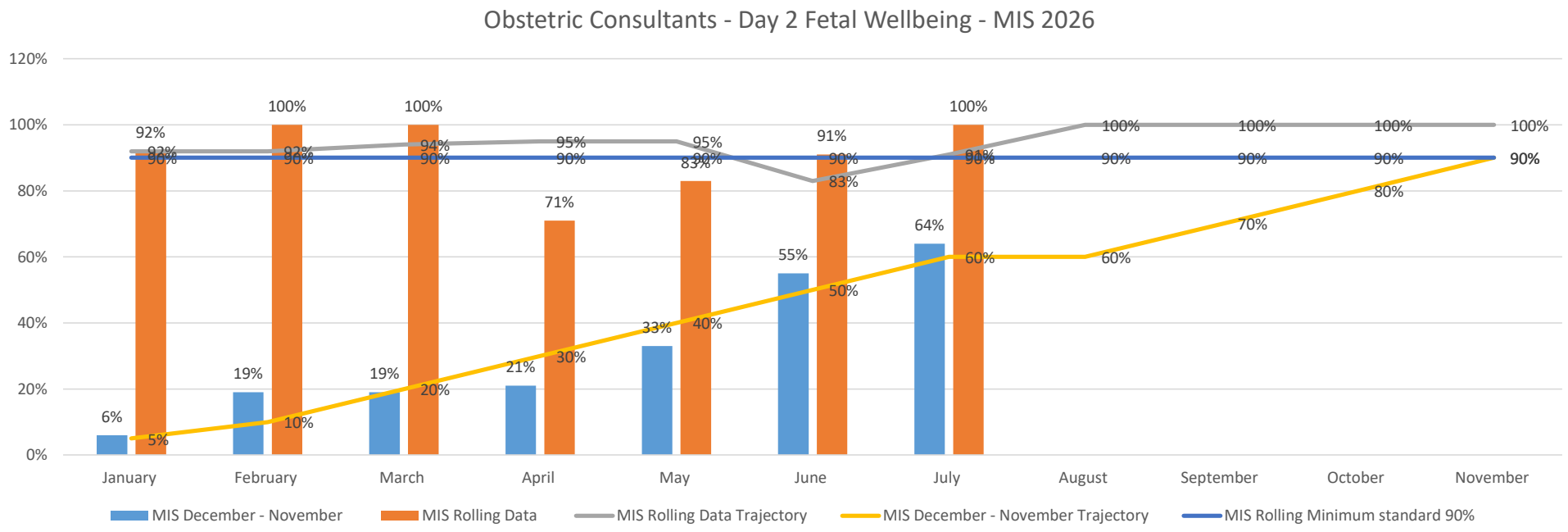
North Tees and Hartlepool
NHS Foundation Trust

# Midwives – Fetal Wellbeing



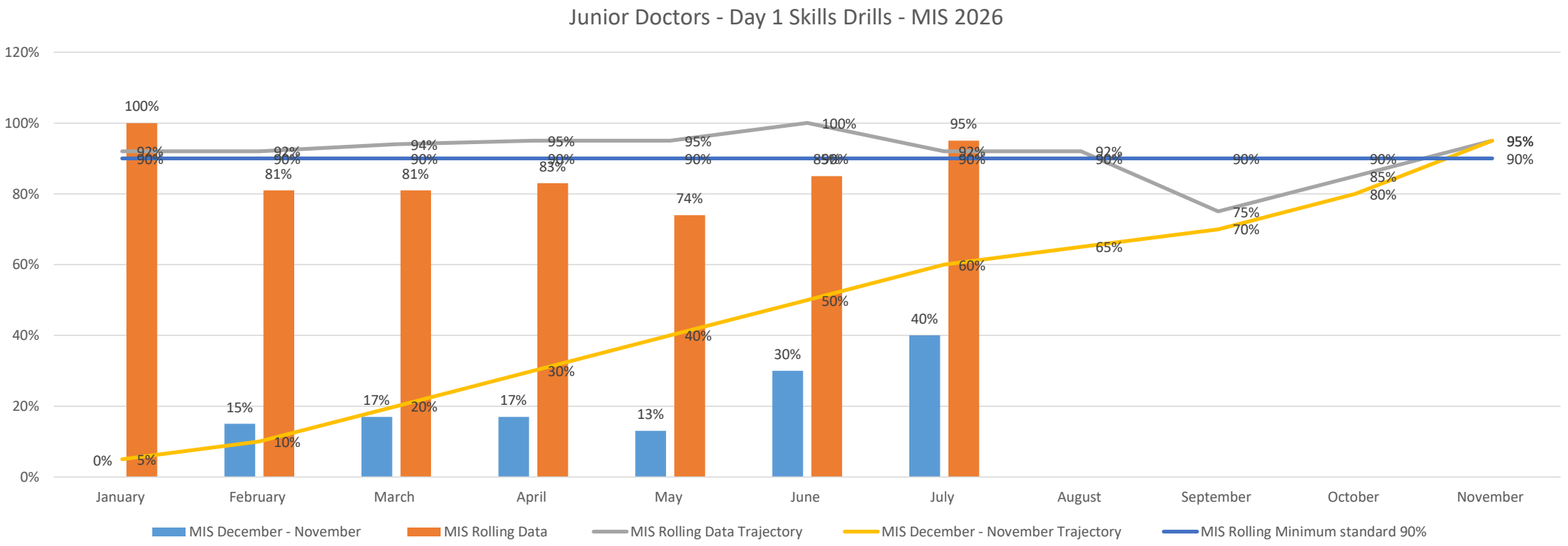
North Tees and Hartlepool
NHS Foundation Trust

# Obstetric Consultants – Fetal Wellbeing



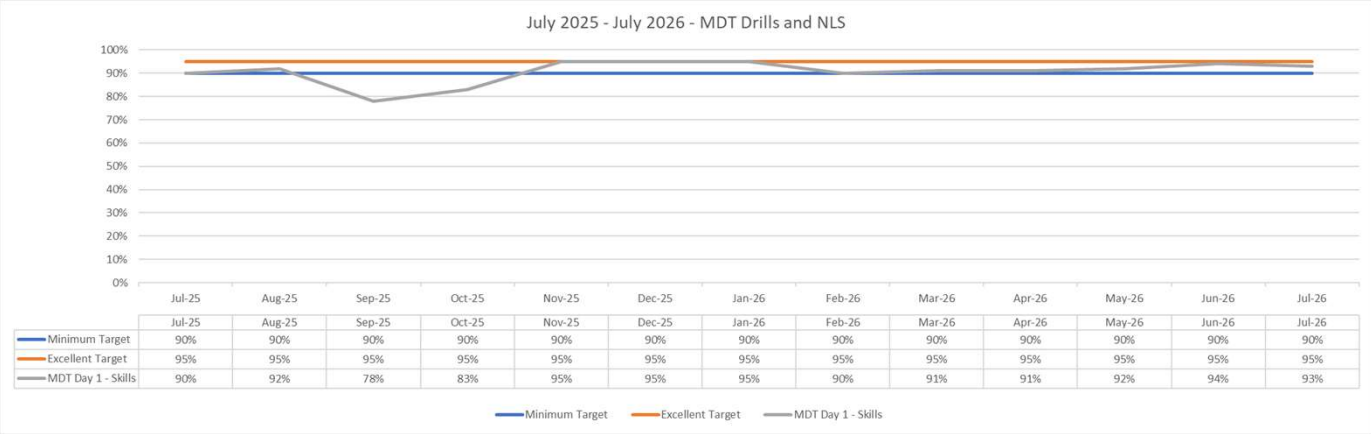
North Tees and Hartlepool
NHS Foundation Trust

# Junior Doctors – Fetal Wellbeing

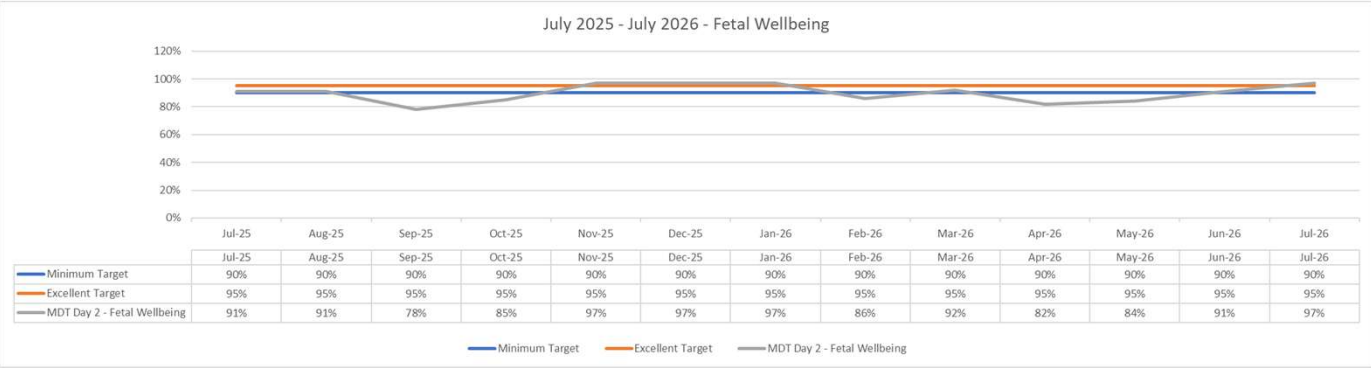


North Tees and Hartlepool
NHS Foundation Trust

# Obstetric, maternity and anesthetic staff (combined mid point complaince)



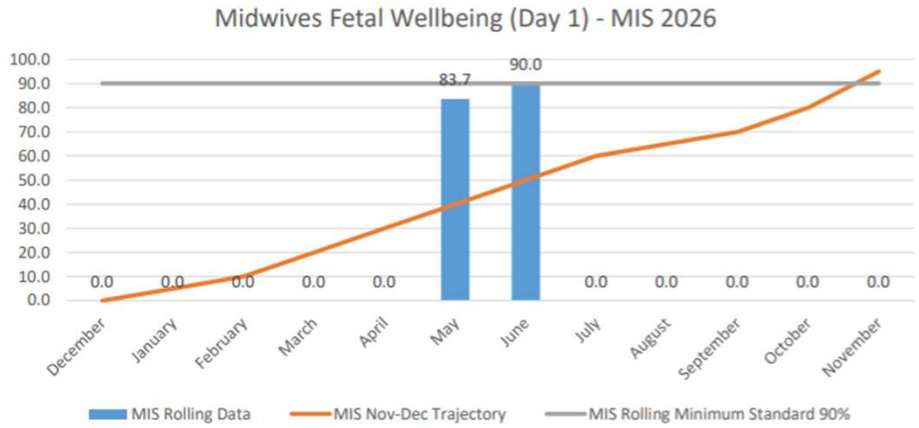

| | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 | Jul-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Minimum Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| Excellent Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| MDT Day 1 - Skills | 90% | 92% | 78% | 83% | 95% | 95% | 95% | 90% | 91% | 91% | 92% | 94% | 93% |

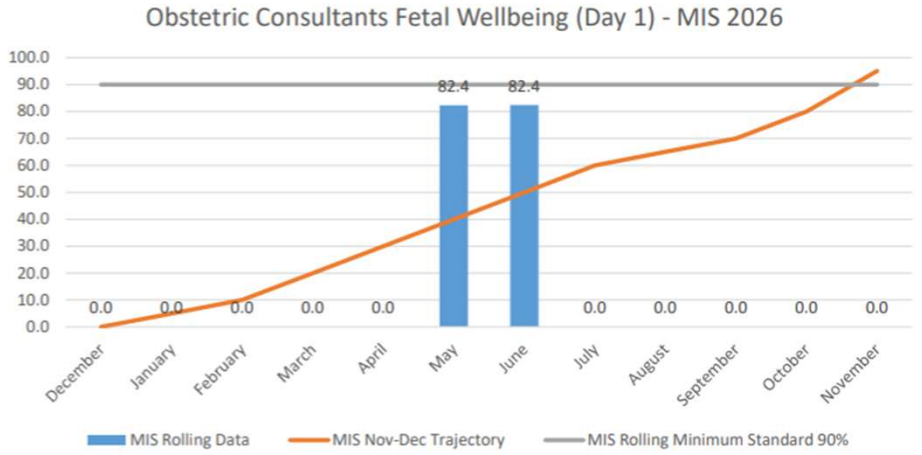


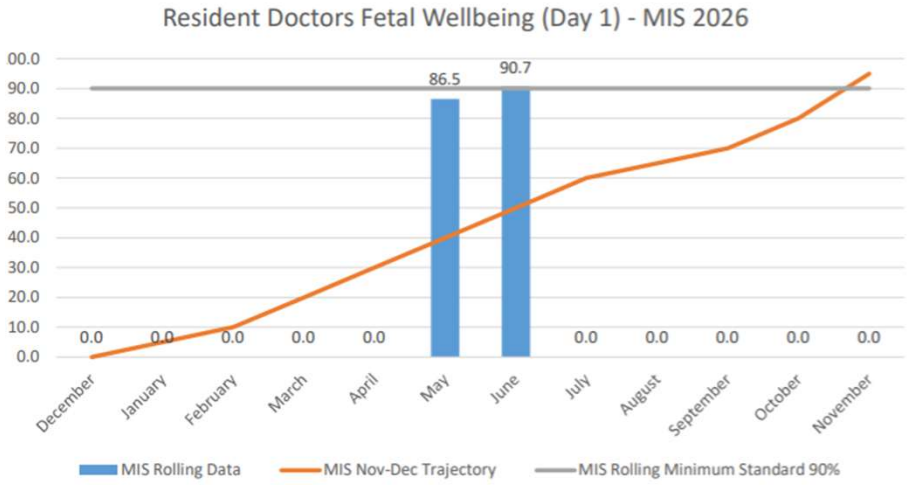

| | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 | Jul-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Minimum Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| Excellent Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| MDT Day 2 - Fetal Wellbeing | 91% | 91% | 78% | 85% | 97% | 97% | 97% | 86% | 92% | 82% | 84% | 91% | 97% |

Obstetric, maternity and anesthetic staff (combined MIS training year )

## South Tees – Fetal Wellbeing

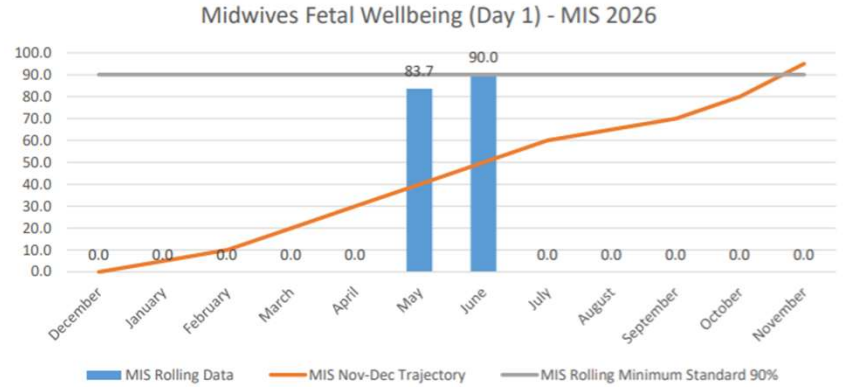


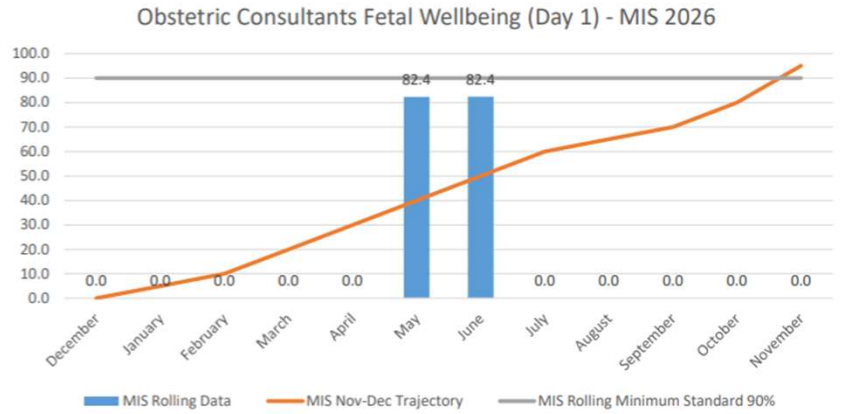



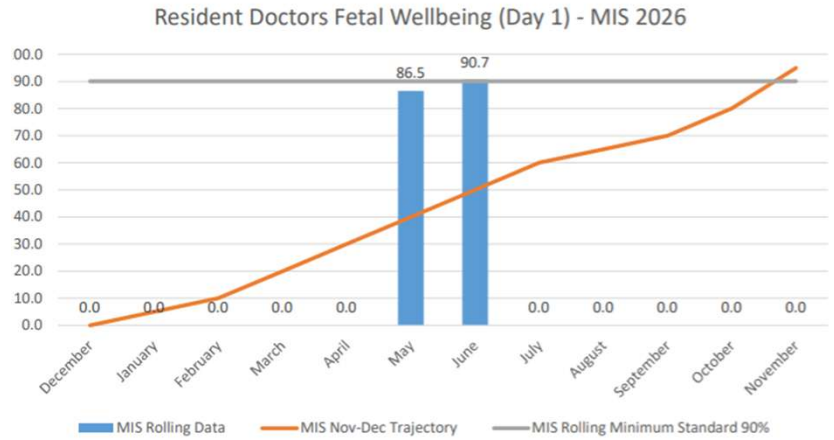



Obstetric, maternity and anesthetic staff (combined mid point)

## South Tees – Fetal Wellbeing



**NorthTees & Hartlepool MNVP Annual Workplan - Reviewed and updated**

| Link to Theme in Three-year Delivery Plan For Maternity And Neonatal Services, MIS CNST Safety Action 7 and mandatory training | Goal | Key Action Steps | Timeline | Expected Outcome | Data Source And Evaluation Methodology | Person/Area Responsible | Time Commitment/Number Of Days Per Year Jade Wilcock (and / or other Lead) | Time Commitment/Number Of Days Per Year Deputy or Co-Lead | Progress/Comments |
|---|---|---|---|---|---|---|---|---|---|
| Theme 1 Listening to and working with women and families with compassion | **Community Engagement & Visibility** . Increase MNVP engagement and visibility in the community including underrepresented, BAME, and deprived communities. Build trust and representation through compassionate engagement and a diverse volunteer team. | Identify areas and community groups experiencing health inequalities, with a focus on BAME communities, asylum seekers and families in deprived areas.<br><br>Continue expanding social media reach by simplifying content (short videos, signposting, less text-heavy posts) Continue to build the TikTok account to engage younger demographics.<br><br>Continue to increase visibility of MNVP within the community regular presence at family hubs, engagement events, family events, libraries, HAF<br><br>Establish a recognisable MNVP presence through community visits and outreach to build trust and encourage participation. Work with compassion to support women, babies, and families most at risk of health inequalities by actively engaging with hard-to-reach communities through family hubs, religious groups, food banks, the Stockton HAF programme, etc.<br><br>Contribute to existing community groups by offering teaching sessions (e.g. storytime, rhyme time, baby sensory, Makaton, glitter tattooing) to provide added value beyond feedback collection and establish MNVP as a trusted and familiar presence.<br><br>Build a diverse team of volunteers from different cultural, ethnic, and socioeconomic backgrounds — including those who speak community languages and live locally — to strengthen representation and engagement. | 31/3/2027 | Increased engagement and participation from underrepresented and seldom-heard groups.<br><br>Improved visibility and recognition of MNVP within diverse and deprived communities.<br><br>Stronger trust and relationships between MNVP and service users across the maternity and neonatal journey.Increased engagement and participation from families in hard-to-reach and vulnerable communities.<br><br>Strengthened trust between MNVP and service users through consistent presence and contribution.<br><br>Development of a volunteer base that reflects the diversity of the local population.<br><br>Recognition of MNVP as a visible and reliable support mechanism within communities. | Records of areas and groups visited, with logs of one-to-one discussions held.<br><br>Demographic information collected through accessible consent forms.<br><br>Feedback captured via QR code surveys, WhatsApp messages and digital questionnaires.<br><br>Analysis of engagement data and feedback trends to evaluate reach and effectiveness.Service user and volunteer demographic data captured through consented feedback forms.<br><br>Records of engagement activities delivered (teaching sessions, visits, group attendance).<br><br>Feedback collected during sessions and from volunteers in underrepresented areas.<br><br>Analysis of participation levels and qualitative feedback to measure trust and inclusivity. | 1. MNVP Lead<br>2. NVP Lead<br>3.Volunteer Team | 8 | | |
| Theme 1 Listening to and working with women and families with compassion | **Bereaved Family Feedback**. Ensure bereaved families are seen, heard and supported, safely and compasionately. | Ensure bereaved women and families, including those experiencing neonatal intensive care loss, are provided with safe and protected opportunities to share their experiences.<br><br>Liaise closely with the Bereavement Midwife, Neonatal Intensive Care Midwife, and local bereavement charities and support groups to strengthen collaboration and pathways of support. Work with the chaplaincy and families to create a baby loss remembrance space in the spirituality centre. Provide opportunities for reflection and feedback.<br><br>Undertake trauma-informed training to develop skills and sensitivity in supporting bereaved families. | 31-Mar-27 | Strong and trusted relationships established with local bereavement support networks, enabling joint identification of strengths and areas for improvement in bereavement care.<br><br>Increased engagement with bereaved families in a manner that prioritises dignity, safety, and compassion.<br><br>Enhanced capacity of the MNVP Lead and team to work sensitively and effectively with service users who have experienced loss. | Records of engagement sessions with bereaved families and partner organisations. Course attendance and successful completion.<br><br>Minutes from meetings with bereavement leads and support groups.<br><br>Feedback gathered through focus groups and qualitative analysis of themes to inform service improvement. | 1. MNVP Lead<br>2. Bereavement Specialist Midwife- Laura Smith<br>3. Chaplaincy | 4 | | |
| MIS Year 8 Safety Action D- Service User Voice | **Feedback & Action Planning**. Co-produce an action plan from CQC survey results and ensure all feedback is acted upon, monitored, and communicated back transparently. | Analyse the annual CQC Maternity Survey data, including free-text responses, to identify key themes, concerns, and positive feedback.<br><br>Collect and review feedback from all other sources, including questionnaires, 15 Steps Walkarounds, focus groups, and informal discussions.<br><br>Work collaboratively with service users, volunteers, and stakeholders to co-produce a clear, achievable action plan based on these findings.<br><br>Share progress and all significant feedback themes regularly with the Trust Safety Champions, LMNS Board, and Perinatal Improvement Group.<br><br>Monitor actions taken and ensure that outcomes are communicated back to families and the community, demonstrating that their voices have driven change. | Agree dates for Trust reporting. | A co-produced, evidence-based action plan that reflects service user priorities.<br><br>Transparent systems for escalating and addressing concerns raised by families.<br><br>Increased trust and confidence that feedback leads to visible improvements.<br><br>Ongoing monitoring and reporting of progress through formal governance channels. | Annual CQC Maternity Survey results and free-text thematic analysis.<br><br>Feedback data from questionnaires, 15 Steps, focus groups, and discussions.<br><br>Minutes from LMNS Board, Perinatal Improvement Group, and Safety Champion meetings.<br><br>Documented progress updates and communication with service users.<br><br>Tracking of actions completed and impact on service user experience. | 1. MNVP Lead<br>2. Trust Staff 3. Volunteer Team | 4 | | |

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|---|---|---|---|---|---|---|---|---|---|
| Neurodiversity | **Neurodiversity.** Develop a greater understanding of how maternity and neonatal services meet the needs of neurodiverse women, partners, siblings, and families, ensuring communication, environments, and support are accessible and inclusive. | Engage with neurodiverse women, partners, family members, and local support organisations to understand their experiences of maternity and neonatal services.<br>Gather feedback on communication methods, information sharing, sensory environments, appointments, inpatient stays, and visiting arrangements.<br>Explore how services currently identify and respond to neurodiverse needs across the maternity and neonatal pathway.<br>Review existing reasonable adjustments, support mechanisms, and information resources available to neurodiverse families.<br>Identify barriers experienced by neurodiverse individuals and opportunities to improve inclusivity, accessibility, and understanding.<br>Liaise with specialist services, community organisations, and staff to understand current good practice and areas for development. | 31/03/2027 | Improved understanding of the experiences and needs of neurodiverse women, partners, siblings, and families.<br>Identification of barriers relating to communication, sensory needs, access to information, and service delivery.<br>Increased awareness of opportunities to make maternity and neonatal services more inclusive and accessible.<br>Evidence-based recommendations to support future service improvements and reasonable adjustments.<br>Enhanced service user experience through more personalised and responsive care. | Feedback gathered through questionnaires, focus groups, one-to-one discussions, and community engagement activities.<br>Engagement with local neurodiversity support groups and organisations.<br>Review of current information resources, reasonable adjustment processes, and service pathways.<br>Thematic analysis of qualitative feedback to identify strengths, challenges, and areas for improvement.<br>Production of a summary report with recommendations for service development and ongoing monitoring. | | 4 | | |
| Perinatal Mental Health | **Perinatal Metntal Health**. Establish a baseline understanding of perinatal mental health needs to guide future improvements | (No mental health specialist Midwife)<br><br>Incorporate mental health discussions into community engagement sessions and volunteer activities, creating safe spaces for women and families to share their experiences. (As discussed above- ensuring asll conversations with women and famiies cover a range of themes)<br><br>Involvement in the Tees maternal mental health pathway to ensure the service user voice is at the heart of decisions regarding perinatal mental health. Understand the new offer, how to signpost and when/ where families can gain support. Provide more mental health break opportunites (such as the Padel for NICU dads) | 31/3/2027 | A clear understanding of current challenges faced by women and families regarding perinatal mental health support.<br><br>Insight into unmet needs and priorities directly from service users, forming a foundation for future service development.<br>MNVP lead involvement in Tees perinatal mental health pathway service development. | Thematic analysis of qualitative feedback gathered from women, families, and volunteers.<br><br>Minutes from Tees Perinatal mental health meeting input. | 1. MNVP Lead<br>2. NVP Lead | 4 | | |
| Ward Life | **Ward Life.** Develop a comprehensive understanding of the service user experience throughout their inpatient maternity and neonatal journey to identify opportunities for improving comfort, communication, accessibility, and support. | Gather feedback from women, birthing people, partners, and families regarding their experience of ward life across maternity and neonatal services.<br>Explore experiences relating to food and nourishment, including cultural, religious, dietary, and out-of-hours requirements.<br>Seek feedback on understanding of ward routines, expectations, available facilities, visiting arrangements, and how to access help and support when needed.<br>Identify aspects of the inpatient journey that service users found particularly helpful, confusing, challenging, or stressful.<br>Liaise with ward managers, ward staff, housekeepers, and service users to understand current processes and opportunities for improvement.<br>Review information currently provided to families before, during, and after admission to assess accessibility and effectiveness. | 31/3/2027 | Improved understanding of the lived experience of women, babies, partners, and families during their inpatient stay.<br>Identification of barriers, unmet needs, and opportunities to improve communication, accessibility, and comfort on maternity and neonatal wards.<br>Greater awareness of cultural, religious, and practical considerations affecting the service user experience.<br>Evidence-based recommendations to improve ward orientation, communication, and support for families.<br>Enhanced patient experience through improvements informed directly by service user feedback. | Feedback gathered through questionnaires, focus groups, community engagement activities, 15 Steps Walkarounds, and one-to-one discussions.<br>Thematic analysis of feedback to identify recurring themes and areas for improvement.<br>Production of a summary report with recommendations and actions for ongoing monitoring. | | 8 | | |
| **Incorporating Neonatal Voices** | **Neonatal Voices**. Continued collaboratin with the NVP lead to ensure integrated maternity and neonatal engagement. | Continue regular communication and collaborative working with the Neonatal Voices Lead<br>Share learning, insights, and feedback from maternity engagement to ensure a seamless approach across maternity and neonatal services.<br><br>Participate in joint discussions, meetings, and planning sessions to align priorities and avoid duplication of effort.<br><br>Explore opportunities for joint community engagement activities to present a unified presence and strengthen trust with families.<br>Work alongside NORNET to ensure wider themes are being addresses and actioned. | 31/03/2027 | Strengthened collaboration between maternity and neonatal voices, ensuring families experience a joined-up approach to engagement.<br><br>More comprehensive understanding of the full maternity-to-neonatal pathway from the perspective of service users.<br><br>Consistent messaging and shared priorities between MNVP and Neonatal Voices, leading to more impactful service improvements. | Records of joint meetings, planning sessions, and collaborative activities undertaken.<br><br>Shared feedback reports capturing themes across maternity and neonatal engagement.<br><br>Evidence of aligned action plans and co-produced recommendations for service improvement. | 1. MNVP Lead<br>2. NVP Lead | 8 | 12 | |
| **Infant feeding** | **Infant Feeding.** Ensure women, babies, and families receive timely, equitable, and effective specialist infant feeding support, with particular focus on neonatal and tongue-tie support. | Liaise with the Infant Feeding Midwife, NCT staff and Neonatal staff, to gain an understanding of current pathways, referral processes, and available support.<br>Gather feedback from women and families who have accessed neonatal infant feeding support and tongue-tie services to understand their experiences and identify what has worked well.<br>Engage with families who have experienced delays, barriers, or challenges in accessing support to identify areas for improvement.<br>Review current information, signposting, and communication provided to families regarding infant feeding support, neonatal feeding support, and tongue-tie assessment and treatment.<br>Collate and analyse findings to identify strengths, gaps, and opportunities for service development and improved access. | 31/3/2027 | Improved understanding of the experiences of families accessing specialist infant feeding support within neonatal services and the wider maternity pathway.<br>Identification of barriers to accessing tongue-tie assessment, treatment, and feeding support.<br>Enhanced understanding of whether current support pathways meet the needs of women, babies, and families.<br>Evidence-based recommendations to support future service improvement and equitable access to specialist infant feeding services. | Records of discussions and meetings with the Infant Feeding Midwife and Peer Supporters.<br><br>Existing service feedback and data sets reviewed and summarised.<br><br>Community feedback gathered via focus groups, QR-code surveys, and one-to-one conversations.<br><br>Thematic analysis of all feedback compiled into a baseline report with recommendations for next steps. | 1. MNVP Lead<br>2. Infant feeding Midwife | 4 | | |

| | |
|---|---|
| **MNVP Lead signature(s):**<br>**Date:** | |

**South Tees MNVP Annual Workplan - 2026/27**

| Action/Goal | Goal | Key Action Steps | Timeline | Expected Outcome | Data Source And Evaluation Methodology | Person/Area Responsible | Time Commitment/Number Of Days Per Year<br><br>Stefanie Robinson-Hoyle | Time Commitment/Number Of Days Per Year<br><br>Other SU Reps | Progress/Comments |
|---|---|---|---|---|---|---|---|---|---|
| Theme 1 Listening to and working with women and families with compassion<br>Amos report Action points 2 &4<br>2. Systematically listening to the voices of women, birthing people and families.<br>4. All Trusts must ensure women and families are listened to, acting appropriately upon any concerns within a timely manner. | All women and birthing people feel listened to and heard. That women feel their concerns are taken seriously and listened too. A prioritisation exercise has been co-produced by the MNVP and the Trust to hear the voices of women, babies and families who are most at risk of experience health inequalities.<br>That women, birthing peopel and their families feel the 'loop is closed' on any feedback, | Develop and implement a plan to prioritise those most at risk of health inequalities are heard.<br>Developing regular feedback events form exisitng groups.<br>Develop events with external partners, ie; first aid event, listening to bereaved parents sensitve event etc<br>Feeds in to Local Priority to engage with the Baby bank partnership<br>Action Point spredsheet developed to track progress of feedback.<br>Monthly MNVP meetings for sharing and attaining ffedback.<br>Large social media engagement to spread information, host surveys and share who the MNVP are.<br>Feedback discussed and followed up at MNVP Meetings | Monthly engagement events | Increase engagement with underrepresented groups, this will inlcude beraeved parents and neonatal families.<br>Themes will emerge from gathered feedback that will allow us to highlight and address issues as they arise.<br>An improved service with better outcomes for wmone and birthing people. | Minutes and records of meetings held and attended.<br><br>Spredsheet detailing feedback gathered and action taken. | 1. MNVP Group<br>2. Trust Staff | 12 | | MNVP sub Group priorities continue to work on hearing the voices of harder to reach groups. |
| Theme 1 Listening to and working with women and families with compassion - Bereaved Parents | All groups are heard, including bereaved families | Listen to the views of local women and families including bereaved parents and share feedback with the Trust to act upon views to review and design services<br>Bereavement midwife invited to MNVP meetings<br>Open lines of communication between MNVP, service user and Bereavement midwives.<br>Lunch and Craft group on Neonatal ward. | Ongoing | Increase engagement with a wide range of groups including bereaved families. | Engagement with service users including bereaved families | 1. MNVP Group<br>2. Trust Staff<br>3. External Organisations | | | Rolling yearly action. Continue to work closely with Bereavement midwives. Lead sits on PMRT meeting. |
| Training | Identify and support any training needed for MNVP leads and SU reps. Dissemtinate feeback from MNVP and SU into staff training. | Already attended this year -<br>Black Maternal and Neonatal Health Education with Keelie Grindley | Ongoing | - Understanding national governance structures, hospital/Trust governance structures, and how service user voices contribute and identify any gaps in learning<br>- Using voices effectively for change<br>- Knowing what good looks and reporting to staff and stakeholders<br>- Effective action planning | Course attendance (includes self study and in person training) | 1. MNVP Group<br>2. Trust Staff | | In corporate in MNVP meetings | Attend training as necessary<br>Continue to identify gaps<br>Attended Racism in Maternity Day. |
| Local Priority :<br>Continue with our social media engagements<br><br>Women have clear choices, supported by unbiased information and evidence-based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the Re:Birth report, and is co-produced. | Supply women and birthing people with information on their birthing journey in different digital formats.<br><br>To ensure that our social media presence is active and relevant. In turn this will ensure that we will have continued feedback, and a good number of survey feedback | Increase our presence on other social media channels.<br>Develop positive matenity stories and share good feedback stories to increase trust across service | | Further engagement with service users.<br>More feedback with service users<br>Continue with strong digital presence.<br>Develop linktree | Increase Social media followers /engagement<br>New Tick tok channel if funding for Social Media lead time allows<br>Qualitative feedback from service users regarding the helpfulness of the different digital tools. | 1. MNVP Group<br>2. Trust staff | | 12 - Social Media lead | |
| Local Priority : Big Maternity Conversations<br>Objective 1: 1.4 Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected | To ensure that service users are part of the Big Maternity Conversations. That their voice and opions are heard and valued<br><br>Work alongside collaborative trust for a vision for collaboration in university hospital tees | Plan and develop Quesitonnaires with North Tees MNVP<br>Attend and host conversation and engagement events, improve diversity of the feedback from wider communities. | | Greater understanding of the wants and needs of local women<br>Qualitative feedback from women and birthing people. | Questionnaire<br>Feedback and information gathering sessions<br>Plan that looks toward what the future of UTH maternoty services may look like. | 1. MNVP Group<br>2. Trust staff | 6 | | |
| Local Priority : Ensure the service users that they have the autonomy to create the space the labour rooms into the space they want to birth in.<br>Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected | To make service users feel comfortable and in control during labour. To ensure they are birthing in an environment they want. | Social Media Posts.<br>Working alongside staff and SU to promote personlaised birthing spaces.<br>Birth choice videos<br>Support and petition for the opening of the birhting pool | | Positive Feedback from service users<br>Service users feeling happier with their birthing environment.<br>Positive stories being shared<br>Help to broaden midwives understanding of different service users needs and desires in labour.<br>Women and birth people feel more in control and listened too.<br><br>Improve the theme of feeling listened to | Share narrative feeback via MNVP and use patient experience stories to create actions<br>Feedback data from questionnaires, 15 Steps, focus groups, and discussions.<br><br>Minutes from LMNS Board, Perinatal Improvement Group, and Safety Champion meetings.<br><br>Documented progress updates and communication with service users.<br><br>Tracking of actions completed and impact on service user experience. | 1. MNVP Group<br>2. Trust staff | 2 | Rolling annual action point | |
| Amos action points 3 & 6<br>3. Improving how the system responds and learns when something goes wrong.<br>6. Improving system governance and accountability structures and regulatory oversight. | Ensuring that families feel informed, supported and listened too.<br>Maternity and neonatal service user feedback is collated and acted upon within the maternity and neonatal service with evidence of reviews of themes and<br>subsequent actions monitored by local safety champions | An action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication<br>(due each January), including analysis of free text data<br>MNVP Lead ensure the voice of the service user is taken to govenrance level through sitting on PMRT, CEEG boards.<br>Present progress on a regular basis to the Trust safety champions via the MNVP and LMNS Board.<br>There is a collated database to review feedback themes from birth reflections, compliants, MNVP feedback and CQC survey in one place. | Agree dates for Tru | The views of women captured in the annual CQC Maternity<br>Minutes of govenrance meetings<br><br>Minutes from meetings | Annual CQC Maternity Survey<br>MNVP voice included in conversations | 1. MNVP Group<br>2. Trust staff | 12 | | |
| 5. Tackling racism, discrimination and inequality. *Social inequality and baby banks* | MNVP listens to and reflects the views of local communities to reducing inequalities for those women and babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas<br>There are mechanisms in place to hear the voices of women, babies and families who are most at risk of experiencing health inequalities | Work closely with the indigo team and Family hubs to ensure we are engaging and hearing from those living in the most deprived areas.<br>Our Ethnic Diversity Sub group will continue to work with VCSE and Religious organisations who are engaged wit h these women and birthing people.<br>Work with the Indigo team, specialist midwife for Public Health, Healthwatch, Ways to Wellness, NSPCC. To recruit engagement MNVP members.<br>Develop and implement a plan to prioritise those most at risk of health inequalities are heard.<br>Deveoping regular feedback events form exisitng groups.<br>Develop events with exteranl partners, ie; first aid event<br>Feeds in to Local Priority to engage with the Baby bank partnership | ongoing | Equitable care for all.<br><br>Increased awareness of the MNVP and the work we do in the local communities and local VCSE's who work with women and babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas | Minutes from meetings held and attended | 1. MNVP Group<br>2. Trust staff | | 6 - Ed sub group lead | |
| IEA 1: Strengthening women-centred communication and informed choice - Action Point 5.<br>5. Neonatal services should implement the principles set out in the BAPM Family Integrated Care Framework for Practice to ensure parents are recognised as partners in care, actively involved in decision-making and supported to participate in the care of their baby wherever clinically possible. | Women, birthing people and their families feel listened to and that they feel intergeral to the care their child is receiving. | Regular engagment sessions on the unit. Using lunch and crafts as an in to host monthly conversations with parents on the ward to gather real time feedback.<br>Continue to work closely with the team on the NICU, including Consultant Nurse, Physio, Speech Therapist, Clinical psychologist.<br>Continue to work with NOrthern Neo-natal network<br>MNVP lead also sits on regional Pre-term birth group. | Ongoing | Families are aware of FiCare.<br>Feedback reveals fmailies feel intergral to FiCare | Feedback from parents<br>Evidence of FiCare promoted and encourage displayed around the unit. | 1. MNVP Group<br>2. Trust staff | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 7. Regular, open conversations with parents, including use of translation where required, should be embedded into routine practice | All women feel informed of their choices. That language isnt a barrier to level of care | Working as UHT on deep dive into translation services.<br>Use and encourage us LMNS leaflets<br>MNVP Lead is also Co Chair of regional Equity and Equailty Group.<br>Regional Passport for asylum seekers and refugees.<br>Work closely with Indigo Team and comminity midwives.<br>Collaboration work with armed forces community. | | All women are able to receive information in a format that they understand.<br>There is an equity to the information the trust shares.<br>Feedback from service user groups reflects that they feel they receive information in a way that is accessible. | Evidence of a review of translation services.<br>Evidence of improved service. | | | | |
| IEA 1: Strengthening women-centred communication and informed choice<br><br>1. All women must be provided with clear, consistent, and accessible information throughout pregnancy to support informed decision-making.<br>6. Communication with parents must be a priority. Documentation should be consistent and clearly reflect meaningful parental involvement in daily decision-making. | Women and birthing people understand their choices | Promote Regional Personalised Care Bundle<br>MNVP leaflet review team<br>Leaflets are checked for easy read.<br>When relevent and/or.possible information shared on social media. | Ongoing | We receive feedback from women and birthing people that they feel informed about their choices.<br>. | Leaflets signed off MNVP meetings<br>Evidence of personalised care bundle shared on our social media | 1. MNVP Group<br>2. Trust staff<br>3. MNVP whats app leaflet review group | | | |
| Local Priority : To support and care for women and birthing people from underserved communities.<br>Amos Report Recommendation 2 and 4<br>2. Systematically listening to the voices of women, birthing people and families.<br>5. Tackling racism, discrimination and inequality<br>Ockaden Report - Nottingham<br>IEA 1: Strengthening women-centred communication and informed choice<br>Recommendation 2.4 Listening to women and families.<br>MISA Safety Action 4 | MNVP listens to and reflects the views of local communities to reducing inequalities.<br>There are mechanisms in place to hear the voices of women, babies and families who are most at risk of experiencing health inequalities | Continute and deepen our engagement work with the Baby bank partnership<br>Increaing our partnership work with organsiations who are part of the baby bank network to develop feedback pathways.<br>Develop our partnership with Thrive at Five, to host listneing and engagement and ask the midwife event at baby banks.<br>Develop and implement a plan to prioritise those most at risk of health inequalities are heard. | Ongoing | Greater understnading of women and birthing peoples needs and struggles.<br>Develop and understnading of best form of communication to this community i.e. facebook, tick tok, f2f etc. | Improved DNA<br>Annual CQC Maternity Survey and Free-text thematic analysis.<br>Feedback data from questionnaires, 15 Steps, focus groups, and discussions.<br><br>Minutes from LMNS Board, Perinatal Improvement Group, and Safety Champion meetings.<br><br>Documented progress updates and communication with service users.<br><br>Tracking of actions completed and impact on service user experience. | 1. MNVP Group<br>2. Trust staff | 6 | | This is the main focus of our workplan this year. Most of the other points will feed into this. |

**MNVP Lead signature(s): Stefanie Robinson-Hoyle** Stefanie Robinson-Hoyle
**Date:**

**Head of Midwifery signature: Lynne Staite**
**Date:**
**MNVP Professional Lead signature:RDawson** RDawson Rosie Dawson
**Date:** Consultant Midwife
**Date presented at NENC LMNS Board:**
**Date:**
**Date ratified at NENC LMNS Board:**
**Date:**

University Hospitals Tees

# Perinatal Staffing Report Quarter 1: 2026/27

**Meeting date:** *3 September 2026*

**Reporting to:** *Board of Directors*

**Agenda item No:** 2.4

**Report author:** *Stephanie worn, Director of Midwifery*

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

**Action required:** *(select from the drop-down list for why the report is being received)*
**Assurance**

**Delegation status: Jointly delegated item to Group Board**

**Previously presented to:** *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.

Neonatal nursing workforce compliance with BAPM standards remains below the expected level at both organisations, with North Tees reporting 65% compliance and South Tees 78%. NTHFT have developed an action plan and a review of data at STHFT is underway.

**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 recorded two occasions where continuous one-to-one care was temporarily not achieved for a short period of time, resulting in a reported maternity red flag event. Appropriate escalation and redeployment mitigations were enacted

Support progression through governance processes of the Birthrate Plus workforce review, which recommends a 26% uplift in maternity staffing establishments to reflect increasing complexity, acuity and demand not fully captured by birth numbers alone.

RCOG consultant attendance audit compliance was 96% compliance at North Tees, whist this exceeds the threshold of 80%, an with action plan has been developed as one criterion was 75%.

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

Labour Ward Coordinator supernumerary compliance was maintained at 100% across both organisations throughout Quarter 1.

Anaesthetic staffing achieved 100% compliance for immediate availability of anaesthetists and anaesthetic assistants 24/7 at both sites.

Neonatal medical staffing achieved 100% BAPM compliance at both organisations

RCOG consultant attendance audit compliance was 100% for STHFT

## Recommendations:

Members are asked to note the content of the report
Members are asked to approve:

- Appendix 1. NTHFT RCOG attendance action plan
- Appendix 2. NTHFT Neonatal workforce plan



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# Perinatal Staffing report: Quarter 1: 2026/27

Caring Better Together

# Executive summary

| Issues/Concerns | Actions/Mitigations |
|---|---|
| NTHFT have developed an action plan to achieve BAPM compliance. Medical is based on new guidance (MIS accept previous guidance due to significant changes. Nursing workforce includes the team leader to be supernumerary | Action plan developed (appendix 8) |
| STHFT BAPM compliance is under review | Action plan to be developed |
| | |
| **Workforce initiatives/plans** | **Impact** |
| BirthRate+ assessment report | Taken through governance process. Request for 26% uplift |
| | |
| **Escalations** | **Actions/Mitigations** |
| | |

# Birthrate+ workforce planning

The current midwifery establishment remains consistent with the Birthrate Plus recommendations. A workforce reassessment undertaken across NTHFT and STHFT in February 2026 demonstrated a stabilisation in birth numbers. While birth rates have remained stable, activity figures alone do not adequately capture the complexity of service demand, including higher acuity levels, increasing case mix complexity, triage attendances, and antenatal events requiring dedicated one-to-one care. The report is currently undergoing governance review and approval processes.

| Current BR+ approved recommendations | | |
|---|---|---|
| Site | Establishment | Midwife to Birth ratio |
| NTHFT | 142.75 | 1:19.5 |
| STHFT | 236.16 | 1:22.6 |

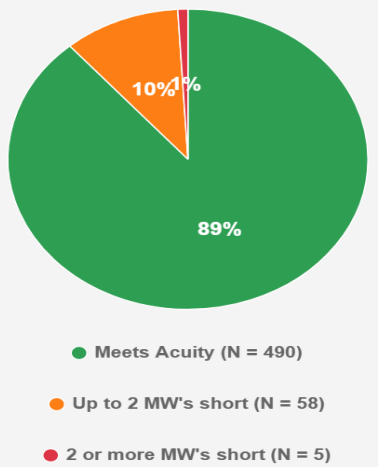
| Midwife to birth ratio | | | |
|---|---|---|---|
| Site | April | May | June |
| NTHFT | 1:18 | 1:18 | 1:17 |
| STHFT | 1:22 | 1:21 | 1:22 |

| % Specialist midwife/management | | | |
|---|---|---|---|
| Site | Apr | May | Jun |
| NTHFT | 10-12% | 10-12% | 10-12% |
| STHFT | 10-12% | 10-12% | 10-12% |

# Midwifery Red flags, quarter 1 2026.27

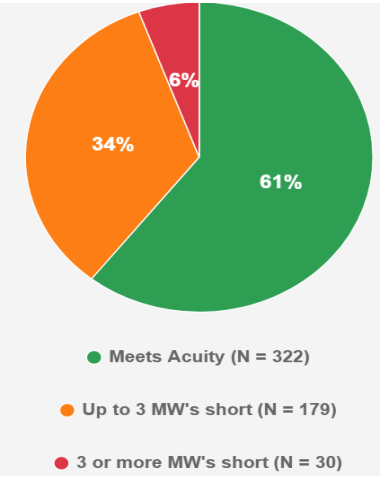
| 1-1 care in labour | | | | | | | |
|---|---|---|---|---|---|---|---|
| Site | No. Day / night shifts per month/ | | | Compliance % | | | Actions |
| | Apr | May | Jun | Apr | May | Jun | |
| NTHFT | 60 | 62 | 60 | 100% | 97% | 100% | Reviewed; appropriate staffing actions were undertaken - redeployment |
| STHFT | 60 | 62 | 60 | 100% | 100% | 100% | NA |

NTHFT acuity



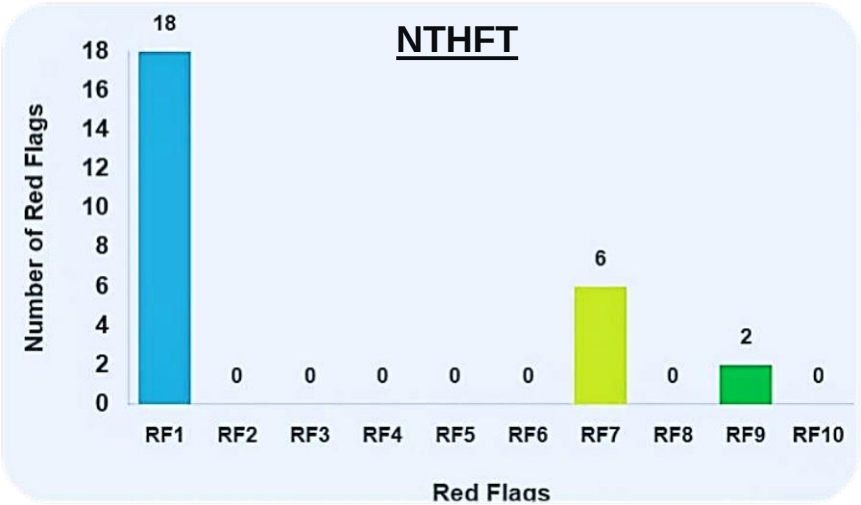

| Labour ward coordinator supernumerary | | | | | | | |
|---|---|---|---|---|---|---|---|
| Site | No. days per month | | | Compliance | | | Actions |
| | Apr | May | Jun | Apr | May | Jun | |
| NTHFT | 60 | 62 | 60 | 100% | 100% | 100% | NA |
| STHFT | 60 | 62 | 60 | 100% | 100% | 100% | NA |

STHFT acuity

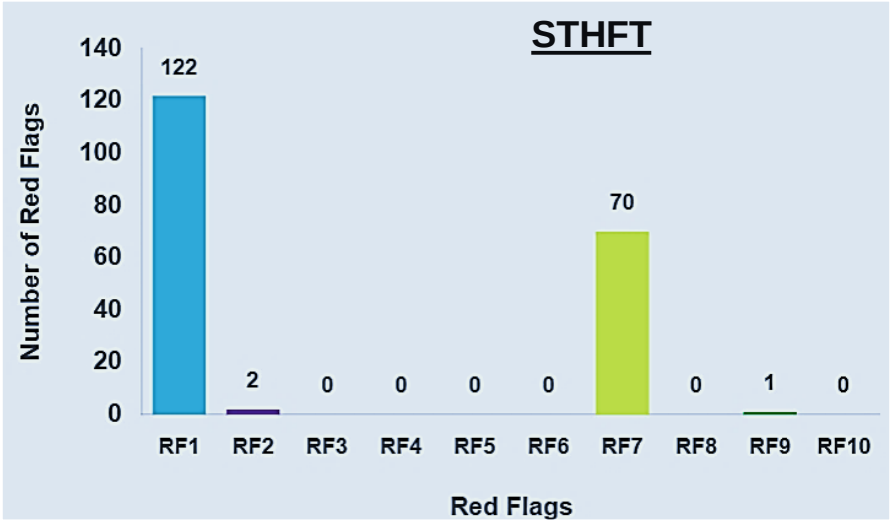



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# Midwifery Red flags, quarter 1 2026.27




**RF1** Delayed or cancelled time critical activity
**RF2** Missed or delayed care
**RF3** Missed medication
**RF4** Delay in providing pain relief
**RF5** Delay between presentation and triage
**RF6** Full clinical examination not carried out when presenting in labour
**RF7** Delay between admission for induction and beginning of process
**RF8** Delayed recognition of and action on abnormal vital signs
**RF9** Any occasion when 1 midwife is not able to provide continuous one-to-one care
**RF10** Labour Ward Coordinator not supernumerary – Providing 1:1 Care for a woman



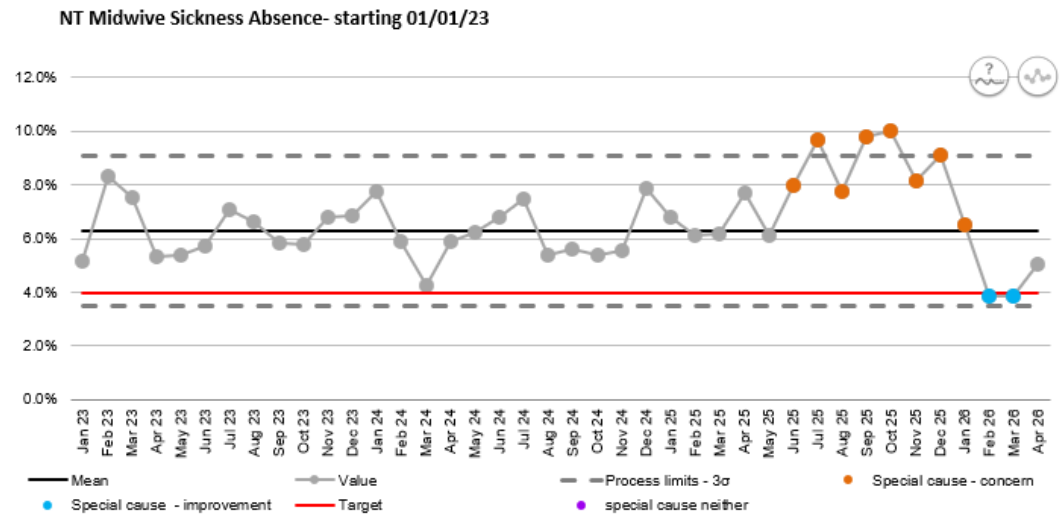

Each site conducts a daily multidisciplinary team (MDT) staffing huddle to review workforce requirements and implement appropriate measures to maintain safe staffing levels. These measures may include staff redeployment, escalation of support from non-clinical personnel, and, where necessary, requests for mutual aid from neighbouring maternity units. Appendix 1 outlines the clinical and managerial actions undertaken to ensure the continued provision of safe maternity services.
At NTHFT, there were two occasions during night shifts when one midwife was temporarily responsible for the care of two postnatal women while also supporting a woman with suspected established labour, until additional midwifery support could be redeployed.

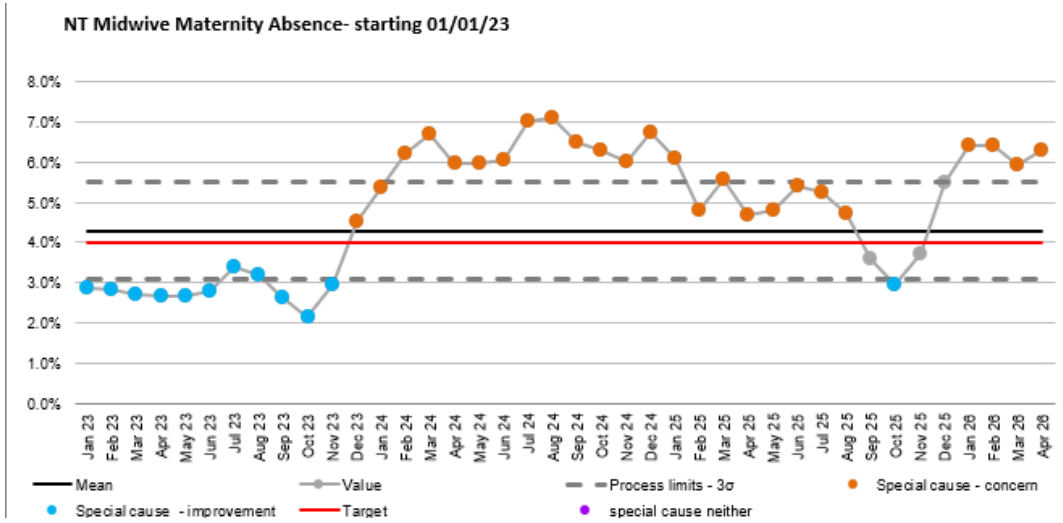
# Midwifery vacancy rates end of quarter 1

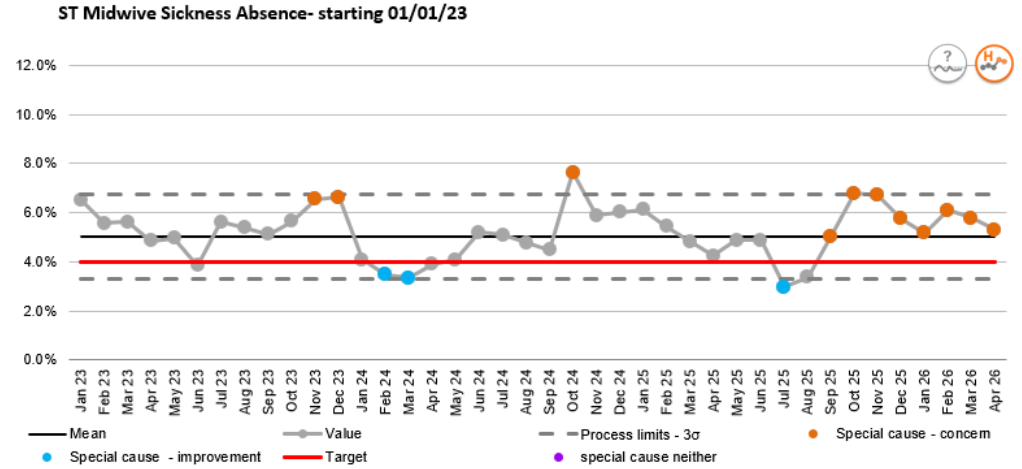
| Midwifery | | | |
|---|---|---|---|
| | **BR+ Budget** | **Actual** | **Projected 6mths** |
| **B5-6** | **NTH** 107.27 WTE (2 WTE Nursing) | 112.91 | 114.31 |
| | **STH** 174.68 WTE (10.40 WTE Nursing) | 168.68 | 174.68 |
| **B7 LWC** | **NTH** 6.56 WTE | 6.56 | 6.52 |
| | **STH** 11.00 WTE (inc 2.20 WTE OOH MW) | 14.12 | 14.12 |
| **B7 specialists** | **NTH** 12.66 WTE | 11.42 | 11.42 |
| | **STH** 14.48 WTE (9.64 WTE B7 & 4.84 WTE B6) - inc 2.20 WTE Midwife Sonographers EPAU | 18.00 (9.84 B7, 5.16 B6, 3 Sonographers) | 14.48 |
| **B7 –B8 managers** | **NTH** 10.20 WTE | 10.56 | 10.56 |
| | **STH** 15.00 WTE (6.00 WTE Management, 9.00 WTE Ward Managers) | 15.00 | 15.00 |

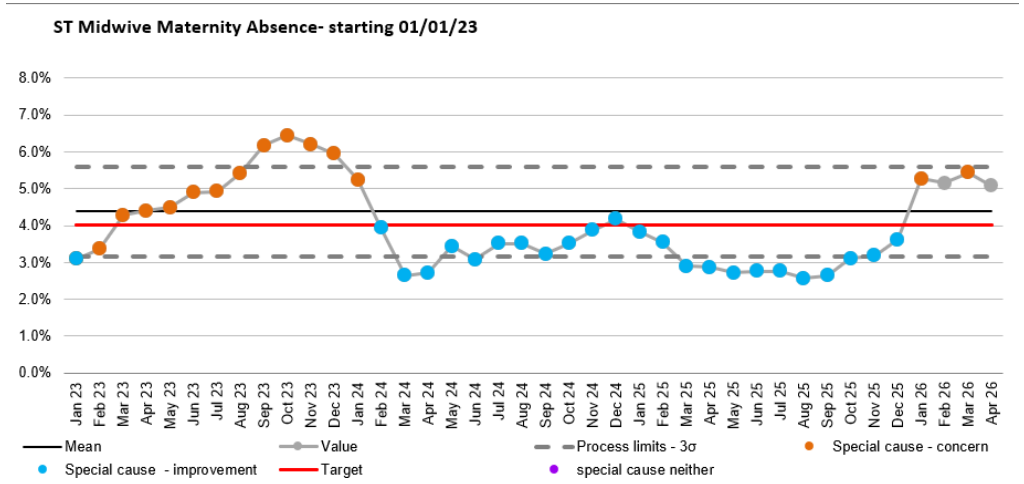
# Maternity services sickness absence and maternity leave rates

Data provided is the end of quarter 2025.26 – this is the most up to date, validated position



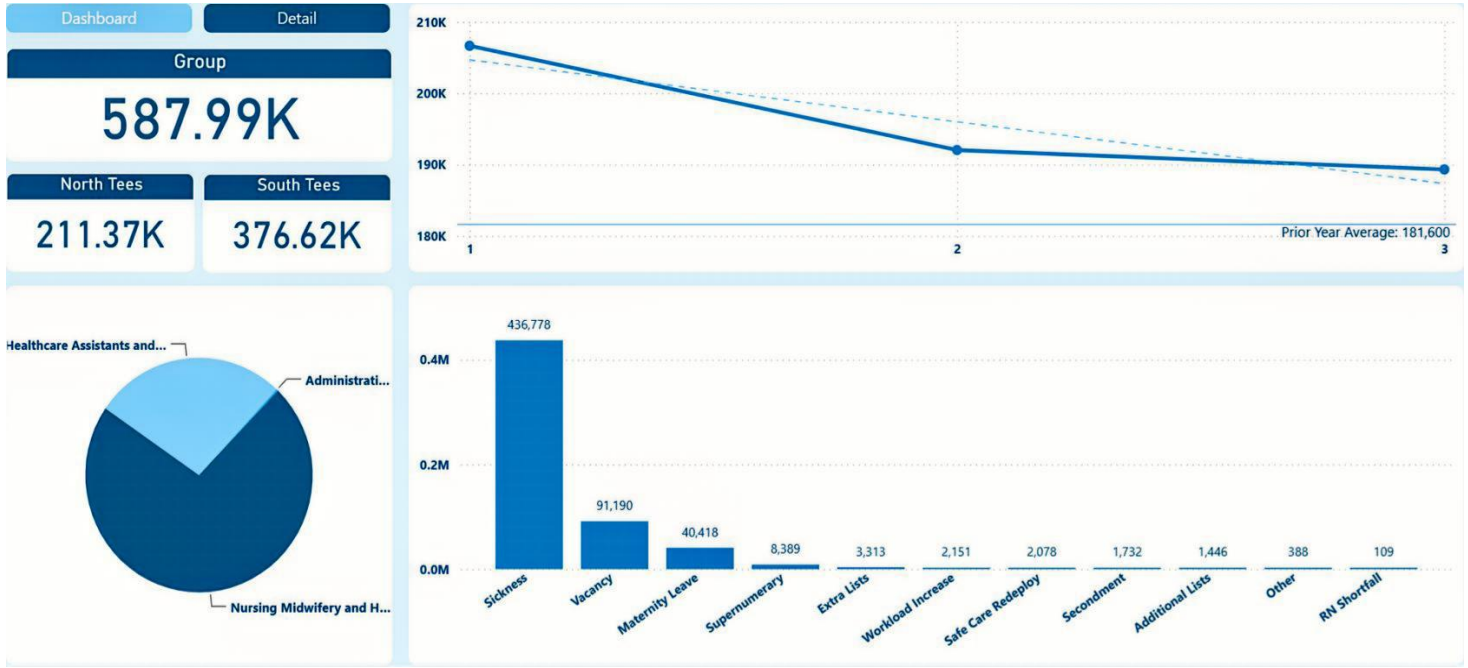




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# Maternity staffing NHSp - end of quarter 1 2026.27




| Reason | 1 | 2 | 3 | Total |
|---|---|---|---|---|
| Sickness | 24.29 | 23.90 | 25.19 | 73.38 |
| Vacancy | 4.64 | 5.34 | 5.79 | 15.77 |
| Maternity Leave | 3.23 | 1.63 | 1.66 | 6.52 |
| Supernumerary | 0.32 | 0.84 | 0.08 | 1.24 |
| Extra Lists | 0.40 | | 0.05 | 0.45 |
| Workload Increase | 0.43 | | | 0.43 |
| Safe Care Redeploy | 0.21 | 0.00 | 0.07 | 0.28 |
| Secondment | | | 0.28 | 0.28 |
| Additional Lists | 0.14 | | | 0.14 |
| Other | | | 0.08 | 0.08 |
| RN Shortfall | | 0.04 | | 0.04 |
| Total | 33.66 | 31.75 | 33.20 | 98.61 |

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# Obstetric staffing quarter 1 2026.27

| Vacancy | | Vacancy | Projected 6mths |
|---|---|---|---|
| **Obstetrics: consultants** | **NTH** | 3 | 2 appointments made starting in August and September<br>Business case for the remaining gap in progress |
| | **STH** | 1.5 | 0.5 job advertised and the other colleague intends to return from sabbatical leave in August |
| **Obstetrics: residents** | **NTH** | 3 SHO<br>3 registrars | 1 SHO<br>2 registrar gaps as the 2 allocated by the deanery have acquired consultant posts |
| | **STH** | 2 SHOs<br>1 registrar | 1 SHO gap<br>No Registrar gaps |

| RCOG consultant attendance audit | | | |
|---|---|---|---|
| **Compliance** | NTH | 96% | Action plan, as one criteria was under 80%. (appendix 2 and 3) |
| | STH | 100% | Re-audit Q2 for sustainability(appendix 4) |
| **RCOG compliance of short term locums** | | | **Actions** |
| **Compliance** | NTH | NA | No short term consultant Locums in North Tees<br>All 3 gaps covered internally<br>Day time on call gaps covered by Senor registrars acting up under supervision |
| | STH | 1 | One Short term locum approved and validated by Trust process |

Both services meet full requirement established at consultant grade.
South Tees :2 Gaps in the consultant rota - due to retirement and sabbatical leave .One post advertised and the other colleague plans to return in August.
North Tees: Currently there are 3 gaps in the Consultant rota – OH x2,1- vacancy : 2 appointments made starting in August and September .
Both sites Resident doctor gaps are due to a combination of vacancies ,maternity leave ,OH requirements and interdeanery transfers .
South Tees- resident cover internal by time shifting and internal locums who meet the RCOH locum standards (appendix 5)
North tees- internal and external resident doctor locums

# Anaesthetic staffing

| Immediate availability 24/7 | Site | Apr | May | Jun |
|---|---|---|---|---|
| Anaesthetist Compliance % | NTH | 100% | 100% | 100% |
| | STH | 100% | 100% | 100% |
| Anaesthetic assistant % | NTH | 100% | 100% | 100% |
| | STH | 100% | 100% | 100% |

Both sites provide 24/7 cover for obstetrics. Rotas are planned in advance with maternity given priority to ensure cover should there be any shortfalls across the other service lines (appendix 6). In addition, the Inphase system is checked monthly to ensure there have been no events whereby an anaesthetist and /or anaesthetic assistant was not available (appendix 6).

# Neonatal staffing

| | | Vacancy | Projected 6mths |
|---|---|---|---|
| **Neonatal nursing** | NTH | 1.6 WTE vacancy to budgeted establishment | 0 |
| | STH | 4 WTE vacancy to budgeted establishment | 0 |
| **QIS trained** | NTH | 86% | 80% |
| | STH | 58% | 58% |
| **Neonatal medical** | NTH | 0 | |
| | STH | 0 | |

| BAPM compliant Nursing workforce | | | Action |
|---|---|---|---|
| **Compliance** | NTH | 65% | Action plan developed and risk register entry to be reviewed. |
| | STH | 78% | Review of establishment against activity |
| **BAPM compliance Medical workforce** | | | **Action** |
| **Compliance** | NTH | 100% | NA |
| | STH | 100% | NA |

BAPM compliance for nursing workforce is being reviewed and discussions held with Neonatal Operational Delivery Network (ODN), to ensure a consistent descriptor and approach is undertaken. North Tees have developed an action plan for approval (appendix 8) and South Tees are reviewing the data

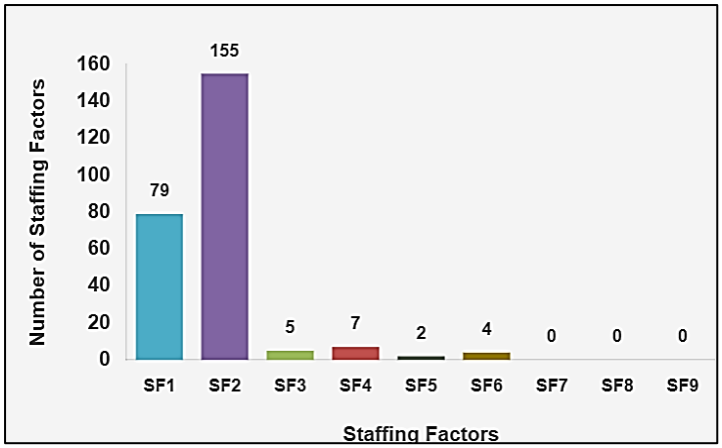
# Recommendations

The Board of Directors/Trust Board/Quality Committee is asked to receive and discuss the content of the report

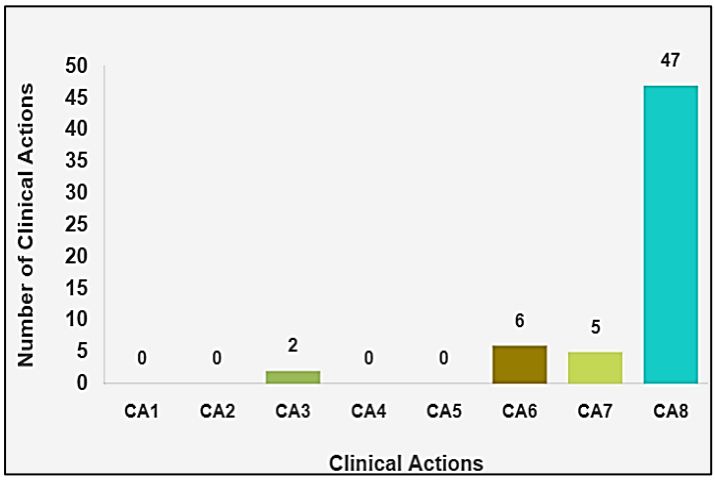
The Board of  Directors are asked to approve:

- NTHFT Consulantant attendance action plan
- NTHFT neonatal workforce action plan

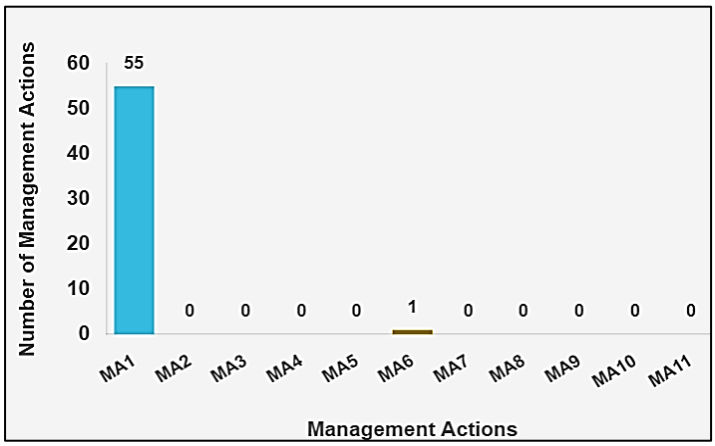
# NTHFT quarter 1 2026.27 Staffing factors and actions




SF1 Unexpected MW absence/sickness
SF2 Unable to fill vacant shifts
SF3 Staff redeployed to another area
SF4 MW on transfer duties
SF5 MW redeployed to another area
SF6 Support staff less than rostered numbers
SF7 More than 3 band 5 MWs on duty
SF8 No Band 7 Coordinator available
SF 9 Coordinator taking AN/PN care

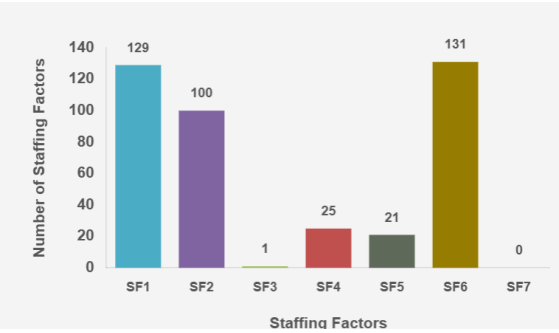



CA1 Decline in-utero
CA2 Delay in accepting transfers
CA3 Delay in commencing IOL (as per Trust guidelines)
CA4 Delay/cancel planned procedures e.g. ECV, Ferrinject, cervical suture
CA5 Delay in transfer of cases to theatre (perineal repair, MROP)
CA6 Delay Elective LSCS > 24hrs
CA7 Delay admissions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

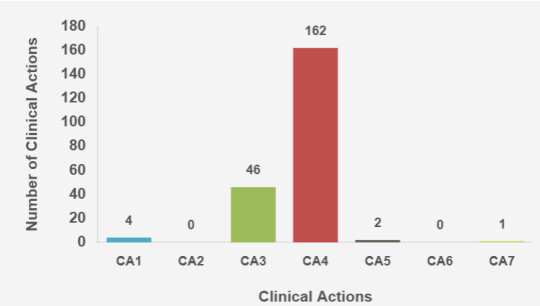



MA1 Redeploy staff internally
MA2 Redeploy staff from community
MA3 Redeploy staff from training
MA4 Staff unable to take allocated breaks
MA5 Staff stayed beyond rostered hours
MA6 Specialist MW working clinically
MA7 Manager/Matron working clinically
MA8 Staff sourced from bank/agency
MA9 Utilise on call MW
MA10 Maternity unit on Divert
MA11 Home Birth Service suspended

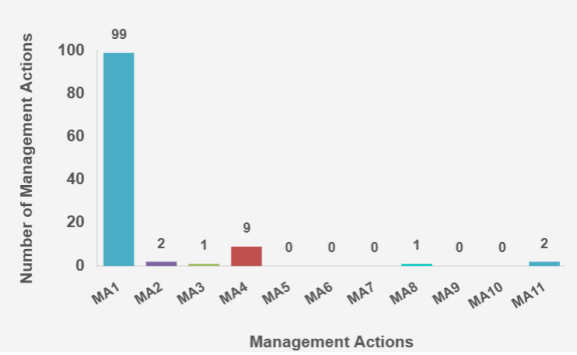
# STHFT quarter 1 2026.27 Staffing factors and actions




SF1 Unexpected MW absence/sickness
SF2 Unable to fill vacant shifts
SF3 MW on transfer duties
SF4 Staff redeployed to another area
SF5 No MCA o duty
SF6 No ward clerk on duty
SF7 Skill mix issue




CA1 Decline in-utero
CA2 Delay in accepting transfers
CA3 Delay admissions for IOL from 2hrs
CA4 Delay in continuing IOL (>4hr)
CA5 Delay in transfer of cases to theatre (perineal repair, MROP)
CA6 Delay Elective LSCS > 24hrs
CA7 Delay/cancel planned procedures e.g. ECV, Ferrinject, cervical suture




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

**Maternity Incentive Scheme Safety Action 4: Consultant Attendance Audit Report for Quarter 1 April-June 2026**

Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their serviceroles-responsibilities-consultantreport.pdf when a consultant is required to attend in person.
Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

| NENC LMNS Audit Tool<br>Audit of 5 cases (or all if <5) of each of the following triggers. | Q1 Cases | Consultant in attendance Compliant |
|---|---|---|
| **Consultant MUST attend** | | |
| • MEWS >5 | 0 | |
| • Caesarean birth for major placenta praevia / abnormally invasive placenta | 2/2 | 100% |
| • Caesarean birth for women with a BMI >50 (1: Performed by ST7) | 3/4 | 75% |
| • Caesarean birth <28/40 | 0 | |
| • Premature twins (<30/40) | 0 | |
| • 4th degree perineal tear repair | 1/1 | 100% |
| • Unexpected intrapartum stillbirth | 0 | |
| • Eclampsia | 0 | |
| • Maternal collapse eg septic shock, massive abruption | 0 | |
| • PPH >2L where the haemorrhage is continuing & Massive Obstetric Haemorrhage protocol instigated | 5/5 | 100% |
| • Any laparotomy | 0 | |
| **Consultant must attend unless senior doctor signed as competent** | | |
| • Trial of instrumental birth (22 trials in total, 6 with ST7, 1 ST5) | 14/15 | 93% |
| • Vaginal twin birth | 1/1 | 100% |
| • Caesarean birth at full dilatation (4 in total, 1 with ST7) | 3/3 | 100% |
| • Caesarean birth for women with a BMI >40 (22 in total, 9 with ST7) | 13/13 | 100% |
| • Caesarean birth for transverse lie | 5/5 | 100% |
| • Caesarean birth at <32/40 (4 in total, 2 with senior trainee) | 2/2 | 100% |
| • Vaginal breech birth (1 in total, managed by ST7 | 0 | |
| • 3rd degree perineal tear repair (1 in total, managed by ST7) | 0 | |
| Total | 51 | |
| **Overall Compliance** | **96 %** | |

Notes

ST7 has the appropriate assessments to be considered competent

2 cases in which a Consultant was required C Section for a woman with BMI >50 and trial in theatre undertaken by ST5

**Maternity Incentive Scheme Safety Action 4: Consultant Attendance Audit Report for Quarter 1 April-June 2026**

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| • Eclampsia | 0 | |
| • Maternal collapse eg septic shock, massive abruption | 0 | |
| • PPH >2L where the haemorrhage is continuing & Massive Obstetric Haemorrhage protocol instigated | 5/5 | 100% |
| • Any laparotomy | 0 | |
| **Consultant must attend unless senior doctor signed as competent** | | |
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| • 3rd degree perineal tear repair (1 in total, managed by ST7) | 0 | |
| Total | 51 | |
| **Overall Compliance** | **96 %** | |

D Fincham/S Mahadasu
July 2026

Notes
ST7 has the appropriate assessments to be considered competent
2 cases in which a Consultant was required : C Section for a woman with BMI >50 and trial in theatre undertaken by ST5

# Action plan

| | |
|---|---|
| Escalation policy discussed in consultant meeting in person (Teams) Emailed all Consultants participating in the on call Rota the mandatory requirement for the Roles and responsibilities standards to be 100 percent | To be achieved by September 30th |
| Ongoing audit for the next 3 months to assure compliance 100% | To be achieved by September 30th |

D Fincham/S Mahadasu
July 2026

**Maternity Incentive Scheme Safety Action 4: Consultant Attendance Audit Report for Quarter 1 2025/26**

Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their serviceroles-responsibilities-consultantreport.pdf when a consultant is required to attend in person.
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|---|---|---|
| **Consultant MUST attend** | | |
| • MEWS >5 | 5 | compliant |
| • Caesarean birth for major placenta praevia / abnormally invasive placenta | 3 | compliant |
| • Caesarean birth for women with a BMI >50 | 3 | compliant |
| • Caesarean birth <28/40 | 4 | compliant |
| • Premature twins (<30/40) | 2 | compliant |
| • 4th degree perineal tear repair | 0 | |
| • Unexpected intrapartum stillbirth | 0 | |
| • Eclampsia | 1 | compliant |
| • Maternal collapse eg septic shock, massive abruption | 0 | |
| • PPH >2L where the haemorrhage is continuing & Massive Obstetric Haemorrhage protocol instigated | 5 | compliant |
| • Any laparotomy | 1 | compliant |
| **Consultant must attend unless senior doctor signed as competent** | | |
| • Trial of instrumental birth | 5 | compliant |
| • Vaginal twin birth | 5 | compliant |
| • Caesarean birth at full dilatation | 5 | compliant |
| • Caesarean birth for women with a BMI >40 | 5 | compliant |
| • Caesarean birth for transverse lie | 4 | compliant |
| • Caesarean birth at <32/40 | 5 | compliant |
| • Vaginal breech birth | 6 | compliant |
| • 3rd degree perineal tear repair | 5 | compliant |
| Total | 64 | |
| **Overall Compliance** | **100 %** | |

# Monitoring of compliance/effectiveness

The RCOG/NHS recommends that units monitor compliance with this guidance.
The following is a simple tool which can be adapted for local use and retained as evidence of a robust process of assessment for all locum appointments. This could be completed by the lead consultant with support from a medical administrator

## Dr M.A: Consultant Obstetrics and Fetal Medicine

| Compliance | Completed Y/N | Date |
|---|---|---|
| Locum doctor CV reviewed by consultant lead prior to appointment | **Yes** | **1/4/25** |
| Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment | Yes | **1/4/25** |
| Departmental induction by consultant on commencement date | **yes** | **1/4/25** |
| Access to all IT systems and guidelines and training completed on commencement date | **yes** | **1/4/25** |
| Named consultant supervisor to support locum | Yes<br>Mr Sanjay Rao<br>Shilpa Mahadasu CD Obstetrics | **1/4/25** |
| Supernumerary clinical duties undertaken with appropriate direct supervision | **yes** | **1/4/25** |
| Review of suitability for post and OOH working based on MDT feedback | **yes** | **1/4/25** |
| Feedback to locum doctor and agency on performance | **NA Mohamed working as Trust registrar/RCOG MTI** | **1/4/25** |

| | | |
|---|---|---|
| | **trainee in South Tees from 2020<br>Not agency** | |

## Dr S.I: Consultant Obstetrics and Maternal Medicine

| **Compliance** | **Completed Y/N** | **Date** |
|---|---|---|
| Locum doctor CV reviewed by consultant lead prior to appointment | **Yes** | **1/1/26** |
| Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment | Yes | **1/1/26** |
| Departmental induction by consultant on commencement date | **yes** | **1/2/26** |
| Access to all IT systems and guidelines and training completed on commencement date | **yes** | **1/2/26** |
| Named consultant supervisor to support locum | Yes<br>Mr Sanjay Rao<br>Shilpa Mahadasu CD Obstetrics | **1/2/26** |
| Supernumerary clinical duties undertaken with appropriate direct supervision | **yes** | **1/2/26** |
| Review of suitability for post and OOH working based on MDT feedback | **yes** | **1/2/26** |
| Feedback to locum doctor and agency on performance | **NA Dr Imam working as Trust registrar/RCOG MTI trainee in South Tees from 2020** | **1/2/26** |

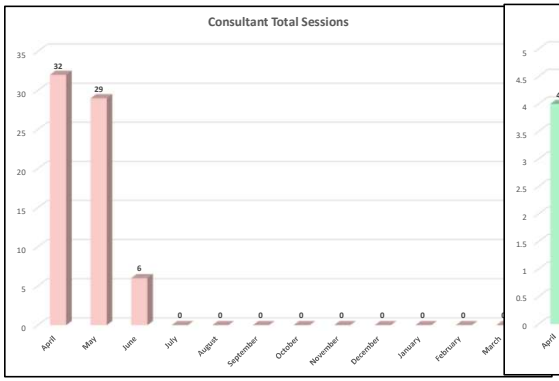
| | | |
|---|---|---|
| | **Not agency** | |

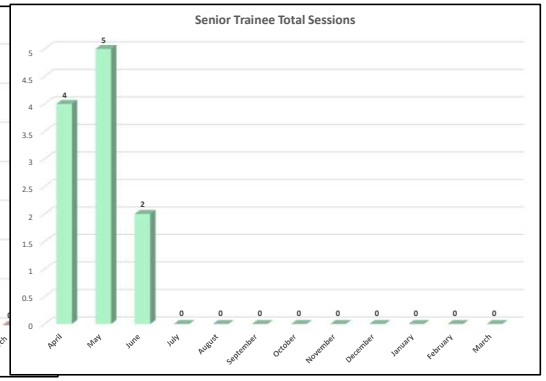
## Month by Month Total Sessions

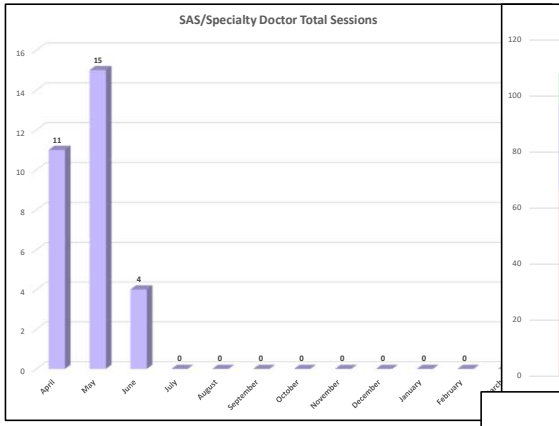
| | | L/Ward AM | L/Ward PM | C/Section AM | OTAL |
|---|---|---|---|---|---|
| Ap | Consultant | 12 | 14 | 6 | 32 |
| | SAS/Specialty | 6 | 4 | 1 | 11 |
| | Senior Trainee | 2 | 2 | 0 | 4 |
| | **Total Session** | **20** | **20** | **7** | **47** |
| Ma | Consultant | 11 | 11 | 7 | 29 |
| | SAS/Specialty | 7 | 7 | 1 | 15 |
| | Senior Trainee | 2 | 2 | 1 | 5 |
| | **Total Session** | **20** | **20** | **9** | **49** |
| Jun | Consultant | 2 | 2 | 2 | 6 |
| | SAS/Specialty | 3 | 1 | 0 | 4 |
| | Senior Trainee | 0 | 2 | 0 | 2 |
| | **Total Session** | **5** | **5** | **2** | **12** |
| Jul | Consultant | 0 | 0 | 0 | 0 |
| | SAS/Specialty | 0 | 0 | 0 | 0 |
| | Senior Trainee | 0 | 0 | 0 | 0 |
| | **Total Session** | **0** | **0** | **0** | **0** |
| Au | Consultant | 0 | 0 | 0 | 0 |
| | SAS/Specialty | 0 | 0 | 0 | 0 |
| | Senior Trainee | 0 | 0 | 0 | 0 |
| | **Total Session** | **0** | **0** | **0** | **0** |
| Se | Consultant | 0 | 0 | 0 | 0 |
| | SAS/Specialty | 0 | 0 | 0 | 0 |
| | Senior Trainee | 0 | 0 | 0 | 0 |
| | **Total Session** | **0** | **0** | **0** | **0** |
| Oc | Consultant | 0 | 0 | 0 | 0 |
| | SAS/Specialty | 0 | 0 | 0 | 0 |
| | Senior Trainee | 0 | 0 | 0 | 0 |
| | **Total Session** | **0** | **0** | **0** | **0** |
| No | Consultant | 0 | 0 | 0 | 0 |
| | SAS/Specialty | 0 | 0 | 0 | 0 |
| | Senior Trainee | 0 | 0 | 0 | 0 |
| | **Total Session** | **0** | **0** | **0** | **0** |
| De | Consultant | 0 | 0 | 0 | 0 |
| | SAS/Specialty | 0 | 0 | 0 | 0 |
| | Senior Trainee | 0 | 0 | 0 | 0 |
| | **Total Session** | **0** | **0** | **0** | **0** |
| Jan | Consultant | 0 | 0 | 0 | 0 |
| | SAS/Specialty | 0 | 0 | 0 | 0 |
| | Senior Trainee | 0 | 0 | 0 | 0 |
| | **Total Session** | **0** | **0** | **0** | **0** |
| Fe | Consultant | 0 | 0 | 0 | 0 |
| | SAS/Specialty | 0 | 0 | 0 | 0 |
| | Senior Trainee | 0 | 0 | 0 | 0 |
| | **Total Session** | **0** | **0** | **0** | **0** |
| March | Consultant | 0 | 0 | 0 | 0 |
| | SAS/Specialty | 0 | 0 | 0 | 0 |
| | Senior Trainee | 0 | 0 | 0 | 0 |
| | **Total Session** | **0** | **0** | **0** | **0** |

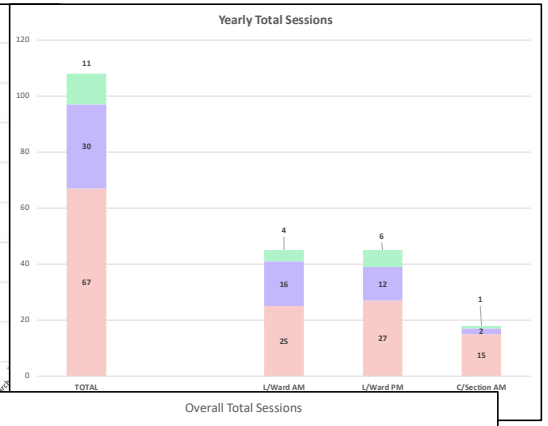
## Yearly Total Sessions

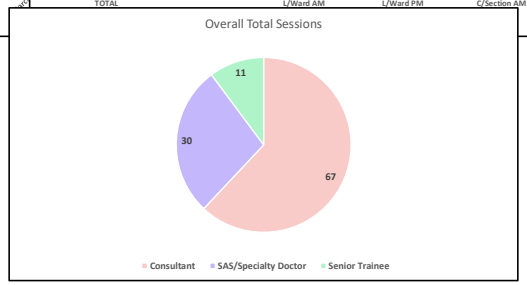
| | TOTAL | L/Ward AM | L/Ward PM | ction AM |
|---|---|---|---|---|
| **Consultant** | 67 | 25 | 27 | 15 |
| **SAS/Specialty Doctor** | 30 | 16 | 12 | 2 |
| **Senior Trainee** | 11 | 4 | 6 | 1 |
| **Total** | 108 | 45 | 63 | 18 |



University Hospitals Tees

**South Tees Hospitals**
**NHS Foundation Trust**
The James Cook University Hospital
Marton Road, Middlesbrough, TS4 3BW
Switchboard: 01642 850850

**North Tees and Hartlepool**
**NHS Foundation Trust**
University Hospital of North Tees
Hardwick Road, Hardwick
Stockton-on-Tees, TS19 8PE
Telephone: 01642 617617

Date: 10 July 2026

Anaesthetic immediate available

Dear Members

This letter is to confirm that in the period of quarter 1 2026.27, there were no events recorded within the events management system (Healthcare Guardian) of an anaesthetist and an anaesthetic assistant not being immediately available.

Yours sincerely

Stephanie Worn

Director of Midwifery

# Neonata+A1:K29I Workforce Action Plan 2026

**Author Janice Atkinson**

| |
|---|
| Not Started / Significantly off track - at risk |
| Not yet achieved but on track - minimal risk |
| On track / Completed but not sustained in practice |
| Completed and sustained in practice |

| Nurse Staffing | Action | Responsibility | Timescale | Rag Rating | Updates |
|---|---|---|---|---|---|
| 1.1 Unable to declare BAPM compliance as establishment does not meet requirement for 100% occupancy with a supernumary team lead . Compliance for SCU should meet 1:4 nurse patient ratio with additional supernumary team lead (11 cots) . Current budgeted establishment does not support this ratio. | Compliance is current risk (232) on register with controls to mitigate risk with escalation of staffing in times of increased acuity/occupancy. Risk updated quarterly and reviwed within trust overnance process | Clinical Matron Deputy HoN paeds | ongoing | | 10.7.26 Update risk with Q1 compliance and inability to utilise controls |
| | Review of commisoning and funding arrangements to ensure budgeted establishment meets activity | Neonatal General Manager | ongoing | | 10.7.26 EC to email contract leads both sites for clarity. |
| | Continue to monitor NHSP spend in SCBU and utilise staff from other departments to cover gaps. NHSP for increased acuity should be coded as such to inform of additional spend due to increased activity and acuity. This will be shared in the perinatal staffing report | Clinical Matron , Deputy HoN paeds | ongoing | | 10.7.26 monitored through workforce assurance, |
| | Use Safer Nursing Care Tool and Neonatal workforce calculator to inform of staffing position to include recommended uplift of 25% for neonatal staffing . Neonatal workforce tool will only calculate requirements to 80% occupancy. | Worforce lead, Clinical Matron Deputy HoN paeds | ongoing | | 10.7.26 Further SNCT data collection planned in March, neonatal tool completed each quarter |
| | Safety and quality events lnked to inadequate staffing to be recorded on health care guardian | Ward manager | ongoing | | 10.7.26 No events reported |
| | Complaince with BAPM nursing ratio's is monitored through PQOM monthly and included in quarterly staffing reports for board oversight as part of Maternity Incentive Scheme compliance | Clinical matron | ongoing | | |
| | Review current if current establishment within SCU meets 25% headroom recommendation of Neonatal Toolkit (2009) | Clinical Matron and Deputy HoN paeds | ongoing | | |
| 1.2 Ensure Skill mix is within 70% registered Nurse threshold to meet appropriate staffing requirements for SCU level care | Review and assure board that current establishment meets recommended skill mix for SCU level care. (80/20) | Clinical Matron and Deputy HoN paeds | ongoing | | 10.7.26 Skill mix meets requiremnets of SCBU |
| | Evaluate role of newly qualified Nursing associate and impact on compliance against BAPM standards | Worforce lead, Clinical Matron Deputy HoN paeds | 30.11.2026 | | 10.7.26 NA qulaified april 26 |
| 2. Medical Workforce | Actions | | | | |
| 2.1 Review updated BAPM workforce stadards for medical staff to ensure complince is maintained and to inform of medical cover requirement for SCU. | Use Data to inform if high or low activity SCU to assess medical staffing requirement. Complete self assessment tool to demonstrate requirements. | Neonatal Lead | 31/08/2026 | | 10.7.26 Review- high activity SCBU, nonatal lead completing self asessment |
| | Compliance monitored monthly through PQOM and quarterly through staffing paper for board oversight for MIS complaince | Clincal Matron/Neonatal Lead | ongoing | | |
| | Escalate any predicted gaps or concerns with meeting compliance via trust governance process | Neonatal Lead | ongoing | | |
| 3. Allied Health Professional workforce | Actions | | | | |
| 3.1 Review current provision against recommendations to assess if adequate requirement in all areas of AHP workforce | Review workforce against BAPM recommendations per cots in unit | Clinical Matron | 31.08.2026 | | 10.7.26 ODN work re AHP gaps to be reviewd |
| | Escalate gaps in workforce via meetings within trust governance process | Clinical matron | 31.10.2026 | | |
| 4. QIS Compliance | Actions | | | | |
| 4.1 A minimum of 70% of nurses/midwives within a neonatal unit hold the Qualification In Speciality (QIS) | Compliance monitored through PQOM and quarterly staffing paper | Clinical Matron | ongoing | | |
| | Ensure appropriate training plans in place to facilitate training provision whilst maintaining safety of unit staffing | Clinical Educator/ Ward manager | ongoing | | 10.7.26 Plan in place - 1 more staff member to complete |
| | Training trajectory to be collated and shared for current staff with training requirement . This will be reviewed in directoarte meetings and escalated as appropriate | Clinical educator | 31.07.2026 | | 10.7.26 requested |
| | Facilitate recommended supernumary time and placement in NICU for staff undertaking QIS whilst maintaining safe rota. | Clinical educator /Ward manager | ongoing | | |
| 5. Training | Actions | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 5.1 Paedaitric Consultants working in neontal care provide evidence of a minimum of 8 hours CPD specific to neonates each year | Monitored through training records | Neonatal Lead | Ongoing | | |
| 5.2 BAPM airway standard training for all neonatal staff using the skill matrix in BAPM Neonatal Airway Managemnet framework to identify level of skill required for each workgroup | Identify level of skill for each workgroup | Clinical Educator/Neonatal Lead | 31.07.2026 | | |
| | Include and record attendanvce at BAPM airway skill session in medical induction | Clinical Educator/Neonatal | ongoing | | |
| | Monitor and record attendance at Nursing update for NLS including BAPM airway skill. | Clinical Educator/ Ward | Ongoing | | |
| 5.3 Advanced Neonatal Nurse workforce require development and training in specific neonatal care to maintain skills in neonatal critical care to aide safe stabilisation of infants prior to transfer to tertiary unit | Maintainance of Newborn Life Support certifiction 4 yearly | Clinical Educator | Ongoing | | |
| | Shared training with ANNP colleagues at ST including specific ANNP day | Clinical matron | Ongoing | | |
| | All ANNP staff group at NT to spend time in NICU at ST to retain skill and knwoledge in neonatal critical care | Clinical Matron | Ongoing | | |
| | Facilitate attendance at Advanced Resuscitation in Newborn Infant course for each staff member on a rolling programme | Clinical educator | Ongoing | | |

University Hospitals Tees

# Safe Staffing Monthly Report (May 26 data)

**Meeting date:** 3 September 2026

**Reporting to:** Board of Directors Meeting

**Agenda item No:** 2.5

**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 May 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.

Sickness absence rates at South Tees presented a mixed picture, with registered staff absence increasing to 6.24% (+0.21%) whilst unregistered staff absence reduced slightly to 4.54% (-0.05%).

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

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

The financial ledger at South Tees reports a vacancy position of 92.77 WTE for HCSWs.

At North Tees and Hartlepool, total Registered Nurse sickness has increased from 6.10% in April 26 to 6.71% in May 2026, and total Unregistered Nurse sickness has also increased from 9.01% in April 2026 to 9.22% in May 2026.

At North Tees, the Band 3 HCSW vacancy position has reduced from 63.87WTE in April 2025 to 52.71WTE in May 2026.The next recruitment centres for both B3 and B2 CSW roles are planned for the 20 & 24 July 2026.

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

During May 2026, South Tees turnover rates among unregistered staff remained stable at 9.05%, whilst registered staff turnover improved, decreasing to 9.86% (-1.03%)

The temporary closure of The Friary and subsequent staff redeployment to support wards at the Friarage site has had an impact on Ainderby Ward, which has not consistently achieved its required CHPPD over recent months. Whilst the ward remained slightly below the required level in May 2026, performance showed marked improvement compared with previous months.

At North Tees and Hartlepool, the total RN turnover has increased slightly from 4.42% in April 206 to 4.50% in May 2026 but remains lower than the national average of 8%. The total turnover for CSWs has reduced slightly from 8.99% in April 2026 to 8.69% in May 2026.

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

Workforce deployment remained strong across South Tees in May 2026, with the average proportion of planned nursing shifts filled increasing marginally to 98.4%, despite increased sickness absence among unregistered staff and minimal change in registered staff sickness absence.

Staff sickness at University Hospital Tees continues to be proactively managed through Health Improvement Plans and twice daily SafeCare reviews, helping to mitigate the impact of absence and increased patient acuity on CHPPD compliance. Robust workforce oversight supports timely redeployment to maintain safe staffing levels. Staff sickness rates are routinely monitored and reviewed through the monthly Workforce Assurance Meetings to ensure sustained oversight and early identification of emerging trends.

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

HCSW vacancies continue to be managed through the centralised recruitment process. The next recruitment cohort is scheduled. The registered nurse workforce currently has –17.79 vacancies. There are robust plans within CSUs to convert fixed term contracts into substantive posts.

At North Tees, the NHSP fill rates for both Registered and Unregistered nurses have increased with Registered nurse fill increasing from 85.7% in April 26 to 92.6% in May 2026 and unregistered nurse fill increasing from 87.9% in April 26 t0 89.2% in May 2026.

## Recommendations:

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

## Nurse Monthly Safer Staffing Report: July 2026 (May 2026 data)

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

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

<u>Day Shifts:</u>

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

<u>Night Shifts:</u>

- Maternity Centre Friarage

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

- Ward 22 – Paediatric Surgery (Days and Nights)

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

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

- Low Midwifery Care staff during the day on Delivery Suite.
- Low Care Staff fill rate during the day on SDU, Ward 22, associated with sickness pressures and workforce vacancy levels.
- High Care Staff fill on wards 24, 25 and 36 during the day due to Enhanced Care requirements.
- Low Care Staff fill rate during the night on Elective care due to a reduction in planned activity and on Ward 22.
- High care staff fill rate during the night within wards 24/25, 26/27, 32/33, 36, 40/42 associated with a combination of enhanced care requirements, sickness and CSW vacancy position.

All safe staffing concerns were escalated to the daily safer staffing meetings, where appropriate redeployment was carried out based on patient acuity and dependency.

**Table 1a Trust Planned versus Actual fill – South Tees:**

| **Overall Ward Fill Rate** | | **May 2026** |
|---|---|---|
| | RN/RMs (%) Average fill rate – DAYS | 91.5% |
| | HCA (%) Average fill rate – DAYS | 96.1% |
| | NA (%) Average fill rate – DAYS | 100% |
| | SNA (%) Average fill rate – DAYS | 100% |
| | RN/RMs (%) Average fill rate – NIGHTS | 97.6% |
| | HCA (%) Average fill rate – NIGHTS | 102.0% |
| | NA (%) Average fill rate – NIGHTS | 100% |
| | SNA (%) Average fill rate – NIGHTS | 100% |
| | **Total % of Overall planned hours** | **98.4%** |

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

| **Overall, Ward Fill Rate** | | **May 2026** |
|---|---|---|
| | RN/RMs (%) Average fill rate – DAYS | 92% |
| | HCSW (%) Average fill rate – DAYS | 97% |
| | NA (%) Average fill rate – DAYS | 100% |
| | SNA (%) Average fill rate – DAYS | 100% |



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|---|---|---|
| | RN/RMs (%) Average fill rate – NIGHTS | 97% |
| | HCSW (%) Average fill rate – NIGHTS | 128% |
| | NA (%) Average fill rate – NIGHTS | 100% |
| | SNA (%) Average fill rate – NIGHTS | 100% |
| | **Total % of Overall planned hours** | **102%** |

- **Nurse Sensitive Indicators**

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

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

During May 2026, a total of nine staffing-related red flags were reported across South Tees through SafeCare Live:

| Clinical Area | Missed 'intentional rounding' | Shortfall HCA | Shortfall RN | **Total** |
|---|---|---|---|---|
| Critical Care | | | 2 | **2** |
| Ward 03 | 1 | | 1 | **2** |
| Ward 04 | | | 1 | **1** |
| Ward 14 | | 1 | | **1** |
| Ward 29 | | 1 | | **1** |
| Zetland | 2 | | | **2** |
| **Total** | **3** | **2** | **4** | **9** |

The total number of red flags reported during May 2026 remained low and were distributed across several clinical areas. All reported red flags were reviewed through established escalation processes and appropriate mitigation actions were implemented where required.

A total of 4 staffing related red flags were raised at North Tees and Hartlepool. One flag was raised by EAU due to a Shortfall in Registered Nurse time. All others were raised by wards 41 and 36 due to missed intentional rounding across both day and night shifts. Documented actions and resolutions are recorded within the SafeCare system and log, providing assurance that appropriate responses were implemented following escalation.

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

**InPhase Submissions**

During May 2026, South Tees recorded 32 InPhase submissions relating to staffing, representing an increase of two incidents compared to the previous month. The highest number of incidents were reported in Critical Care and Ward 12.

At North Tees, in May 2026, there were a total of 6 Healthcare Guardian reports, a reduction from 17 reports in April 2026, all relating to nurse staffing. Safe staffing was maintained through actions agreed within the daily safe staffing meetings during April 2026. It is noted that 2 of the 6 reports relate to the nurse staffing position on ward 32 where escalation to the Associate Director of Nursing within the CSU has been required.

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

**Vacancy & Turnover**

Registered Nurse vacancy and turnover levels across South Tees remain stable and continue to be monitored through monthly ESR workforce reporting. During May 2026, six fixed-term contracts were successfully converted to substantive appointments, comprising five staff from the September 2025 cohort and one staff member from the January 2026 cohort, supporting workforce stability and retention.

Key workforce pressures identified during May 2026 included:

- Short-notice sickness absence, impacting roster stability and staffing resilience.
- Fluctuations and increases in patient acuity, generating additional workforce demand that is not always reflected within planned staffing establishments.
- Skill mix challenges, particularly where the availability of experienced staff is limited.
- The ongoing requirement for real-time staffing reviews and redeployment by senior nursing teams to maintain safe staffing levels.
- Healthcare Support Worker (HCSW) vacancies pending appointment through the central recruitment process.

As reported within the South Tees financial ledger for May 2026, there was a net establishment variance of -17.79 WTE across registered nursing and midwifery roles and 92.77 WTE vacancies across Healthcare Support Worker posts. Recruitment activity remains ongoing to address these vacancies and support workforce sustainability.

At North Tees, the Band 5 Registered Nurse vacancy position across all in-patient and community services for May 2026 is +8.56WTE. Work continues monthly to move fixed term NQNs from the September 2025 and January 2026 cohorts into permanent posts as soon are they become available via natural turnover.

At North Tees, the Band 3 HCSW vacancy position has reduced from 63.87WTE in April 2025 to 52.71WTE in May 2026.The next recruitment centres for both B3 and B2 CSW roles are planned for the 20 & 24 July 2026.

**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 May 2026 can be reviewed in Appendix 2.

**Table 2 South Tees site:**

| | Required CHPPD (Average) | Actual CHPPD (Average) | Variance |
|---|---|---|---|
| March 26 | 9.23 | 8.99 | -0.24 |
| April 26 | 9.38 | 9.04 | -0.34 |
| May 26 | 9.55 | 9.66 | +0.11 |

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

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

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

- **Ward 9:** Workforce availability improved during May 2026, reflected in reduced sickness absence among both registered (3.7%) and unregistered staff (4.5%). However, sickness absence remained the main driver of temporary staffing demand, accounting for 70% of booking reasons. Maternity leave was the second largest contributor at 13%, followed by the requirement for additional staffing to support patients at risk of falls (9%).

- **Ward 25:** Demand for NHSP shifts in May 2026 was driven primarily by vacancies, which accounted for 42% of all requests. The ward continues to carry 1.61 WTE CSW vacancies pending recruitment through the next Central CSW cohort. Sickness absence accounted for a further 31% of bookings; although registered staff sickness reduced markedly to 2.1%, unregistered staff sickness increased slightly to 3.3%. In addition, sustained patient acuity contributed to staffing demand, with 14% of requests associated with care for patients at risk of falls.

- **Spinal Injuries Ward:** The nursing workforce experienced a significant increase in sickness absence during May 2026, particularly within the registered workforce, where the rate more than doubled from 6.2% to 12.6%. Unregistered staff sickness absence also increased although less markedly, rising by 1% to 12.3%. Consequently, sickness absence was the overwhelming driver of temporary staffing demand, accounting for 97% of all booking requests. A small proportion of requests related to the opening of escalation beds in the High Dependency Unit (2%) and vacancies within the establishment (1%).

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 |
|---|---|---|---|
| March 2026 | 9.03 | 9.12 | +0.19 |
| April 2026 | 9.14 | 8.99 | -0.15 |
| May 2026 | 9.14 | 8.97 | -0.17 |

In May 2026, the total variance is in a slightly positive position, this is due to areas including Critical Care, Elective Care and SCBU presenting an average positive variance of 11.73 CHPPD collectively.

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

- Acute Cardiology Unit
- Ward 24 – Respiratory and RSU
- Ward 25 – Respiratory and RSU
- Ward 26 - Gastroenterology
- Ward 27 – Gastroenterology
- Ward 36 – Endocrinology
- Ward 40 – Older Peoples Medicine



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- Ward 41 - Stroke

These areas were highlighted as requiring investment into the nursing workforce models as part of the bi-annual nurse establishment reviews carried out in 2025. The most recent Bi-annual establishment review carried out in March 2026 highlights the same themes whereby the wards current patient demand is exceeding established nursing capacity and so continues to require consideration for investment or workforce redesign as the CSUs review existing workforce models aligned to horizontal integration.

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**

Overall, demand for nursing and midwifery temporary staffing at South Tees continued to reduce during the reporting period, with demand decreasing by **16%** and bank filled hours by **17%** compared to May 2025. This sustained improvement reflects the impact of workforce optimisation initiatives, including strengthened workforce assurance processes, effective demand management, and improved staff deployment, which have reduced reliance on temporary staffing while maintaining safe service delivery.

Nursing agency usage remained minimal and confined to theatre services, while agency ODP utilisation continued its downward trajectory, reaching its lowest level since August 2025. This reflects the positive impact of the planned exit strategy and the ongoing development and competency progression of newly qualified nurses and operating department practitioners.

Bank expenditure reduced by £81,554 **(-7%)** year on year, while agency expenditure increased marginally for nursing (+£1,232) and ODPs (+£1,936), demonstrating continued progress towards a more sustainable staffing model with reduced reliance on temporary staffing solutions.

The overall bank and agency fill rate was 87.0% in May 2026, representing a month-on-month improvement of **1.4%** and remaining broadly in line with the position reported in May 2025 (87.3%). This indicates continued effectiveness in aligning staffing requirements with workforce availability.

Robust governance arrangements remain in place to provide oversight of temporary staffing usage and expenditure. Temporary staffing demand, fill rates and associated costs are reviewed monthly through Workforce Assurance meetings, enabling ongoing scrutiny of staffing trends, workforce risks and opportunities to further reduce agency and bank reliance. In addition, requests for additional duties are subject to daily review and challenge by senior nursing and workforce teams, with a stringent escalation and approval process in place to ensure that enhanced staffing is only authorised where there is a clear and evidenced requirement related to patient safety, acuity or service continuity. These arrangements support effective staffing resource management while maintaining safe and responsive care delivery.

At North Tees and Hartlepool;

**Bank spend** YTD is £475k lower than previous year

- Spend in M2 is £98k down on a like-for-like basis vs M1, excluding the M1 correction.
- Down in all areas, but enhanced care

**Overtime spend** YTD is £6k lower than previous year

- Reduction in May of £101k vs April (mostly Theatres linked to the additional Sprint work)

**Key Priorities**

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

- Strengthen vacancy oversight through the development of accurate and timely Healthcare Support Worker vacancy reporting at CSU level, providing improved workforce intelligence to support recruitment and workforce planning.
- Continue the development of a structured career pathway for Band 2 to Band 3 staff, supporting workforce retention, career progression and the development of the support workforce pipeline.
- Explore opportunities to maximise the contribution of T Level students to the future workforce through the development of sustainable onboarding pathways into substantive roles following successful completion of their studies.
- Ensure organisational readiness for the National Safer Staffing Audit scheduled for June 2026, including validation of workforce data and assurance of compliance with national requirements.
- Continue to reduce temporary staffing expenditure through enhanced roster effectiveness, optimisation of internal bank utilisation and the application of robust approval and governance processes.

- Develop and present a paper for Executive approval to support the September 2026 Newly Qualified Nurse recruitment cohort, ensuring a sustainable future nursing workforce pipeline.
- Further reduce reliance on agency staffing through targeted recruitment, effective workforce planning and maximising deployment of substantive and bank staff.
- Strengthen rostering effectiveness and optimise ward skill mix through the Workforce Assurance Framework, supporting safe staffing and efficient workforce utilisation.
- Improve staff wellbeing, attendance and retention through targeted interventions informed by workforce data, sickness absence trends and staff experience insights.

**Recommendations**

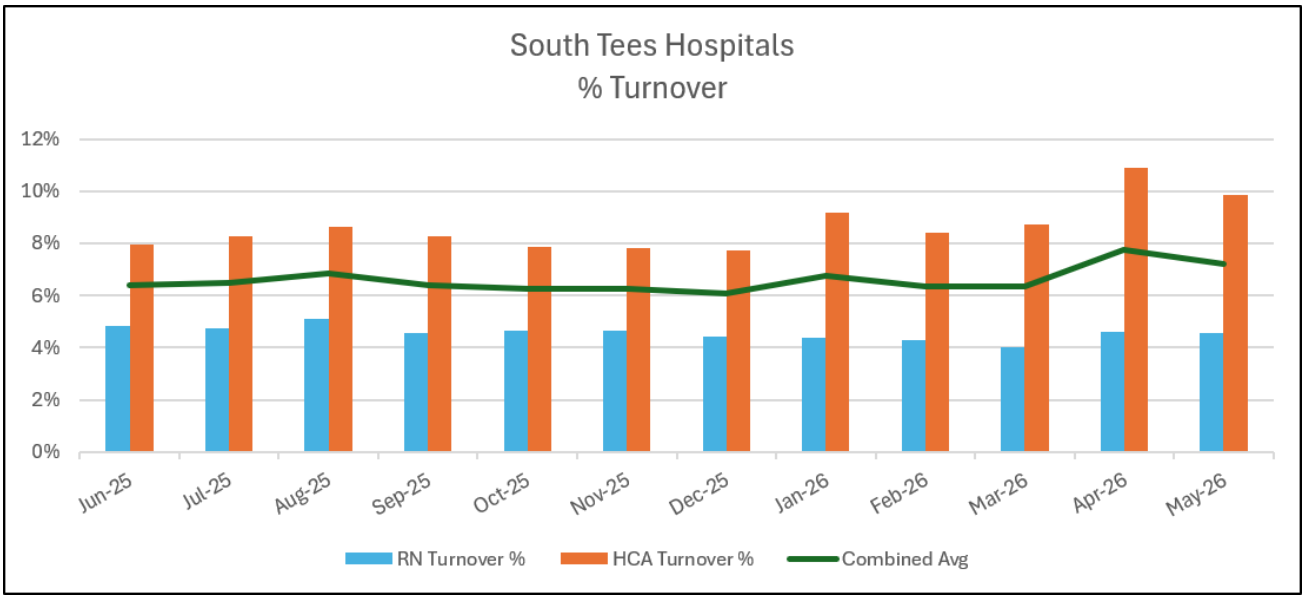
The Board is asked to note the progress made across University Hospital Tees in relation to developing and retaining the nursing workforce.

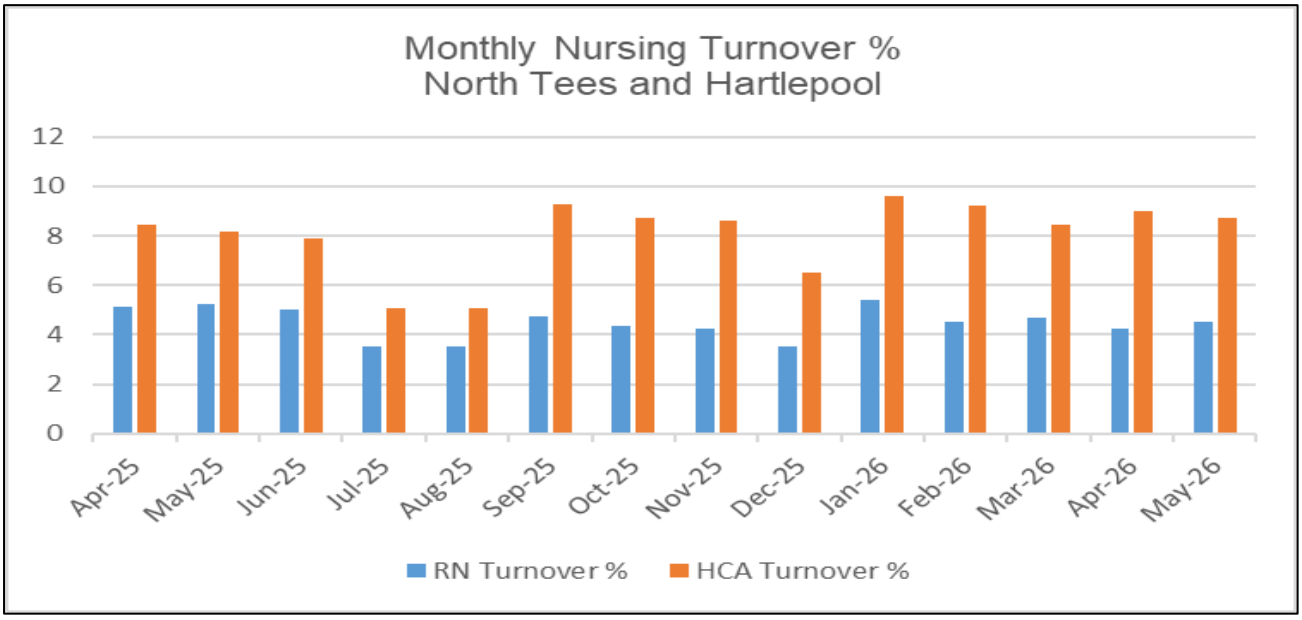
The Board are asked to note the assurance presented that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

The Board are asked to acknowledge the development of this report in the coming months to ensure that the two current reporting methods across both site teams continue to align. This will provide the continued assurance that arrangements are in place to staff services with the right skills in in the right place to provide safe, sustainable and productive staffing.

**Appendix 1**

**Nursing Turnover** May 2026






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**Appendix 2**

**South Tees Average CHPPD Breakdown by Ward (May 2026):**

| Ward | Average of Required CHPPD | Average of Actual CHPPD | Variance |
|---|---|---|---|
| Ainderby Ward | 8.28 | 6.37 | -1.91 |
| Cardio HDU | 10.89 | 13.13 | 2.24 |
| Cardio MB | 7.26 | 8.26 | 1.01 |
| CCU JCUH | 13.71 | 11.02 | -2.69 |
| CDU FHN | 8.13 | 8.63 | 0.50 |
| CICU | 22.52 | 22.02 | -0.50 |
| Critical Care | 19.71 | 26.92 | 7.21 |
| Friary Ward | CLOSED | | |
| Gara Ward | 7.24 | 16.86 | 9.62 |
| NNU | 15.02 | 15.09 | 0.07 |
| PCCU | 17.17 | 41.43 | 24.26 |
| Romanby Ward | 7.16 | 6.45 | -0.71 |
| Rutson Rehab Ward | 10.44 | 7.67 | -2.77 |
| Spinal Injuries Ward | 9.81 | 6.63 | -3.18 |
| Tocketts Ward | 8.13 | 6.30 | -1.83 |
| Ward 02 | 7.54 | 8.14 | 0.60 |
| Ward 03 | 7.41 | 5.22 | -2.18 |
| Ward 04 | 8.45 | 6.98 | -1.47 |
| Ward 05 | 6.42 | 5.53 | -0.89 |
| Ward 06 - Short Stay Elective | 5.84 | 6.17 | 0.33 |
| Ward 07 | 6.21 | 5.40 | -0.81 |
| Ward 08 | 5.31 | 4.88 | -0.43 |
| Ward 09 | 8.77 | 5.03 | -3.74 |
| Ward 10 | 6.25 | 5.36 | -0.89 |
| Ward 11 | 8.50 | 6.24 | -2.27 |
| Ward 12 | 8.83 | 6.30 | -2.52 |
| Ward 14 | 7.04 | 5.60 | -1.44 |



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| | | | |
|---|---|---|---|
| Ward 21 | 10.09 | 12.48 | 2.39 |
| Ward 22 | 14.64 | 13.05 | -1.59 |
| Ward 24 | 8.72 | 7.96 | -0.75 |
| Ward 24 HDU | 10.75 | 20.78 | 10.03 |
| Ward 25 | 10.84 | 7.56 | -3.28 |
| Ward 26 | 9.79 | 6.92 | -2.88 |
| Ward 27 | 9.54 | 12.51 | 2.97 |
| Ward 28 | 8.50 | 5.80 | -2.70 |
| Ward 29 | 6.23 | 5.31 | -0.92 |
| Ward 31 | 9.59 | 6.69 | -2.89 |
| Ward 32 | 6.58 | 5.60 | -0.99 |
| Ward 33 | 8.22 | 6.90 | -1.33 |
| Ward 34 | 8.92 | 6.66 | -2.26 |
| Ward 35 | 8.94 | 7.84 | -1.09 |
| Ward 36 | 6.54 | 5.57 | -0.97 |
| Ward 37 | 11.37 | 8.78 | -2.59 |
| Zetland Ward | 9.41 | 7.34 | -2.07 |
| **Grand Total** | **9.55** | **9.66** | **0.11** |

**North Tees Average CHPPD Breakdown by Ward (May 2026):**

| Row Labels | Average of Required CHPPD | Average of Actual CHPPD | Variance |
|---|---|---|---|
| Acute Cardiology Unit | 7.54 | 6.27 | -1.26 |
| Critical Care North Tees | 22.65 | 24.94 | 2.29 |
| Elective Care Unit | 5.19 | 13.06 | 7.87 |
| Emergency AMB | 8.01 | 8.53 | 0.52 |
| Neonatal Unit | 10.77 | 12.34 | 1.57 |
| Paediatrics | 10.04 | 10.64 | 0.61 |
| SDU | 8.86 | 11.67 | 2.81 |
| Ward 24 (Respiratory) | 10.46 | 7.55 | -2.91 |
| Ward 24 RSU | 13.66 | 10.65 | -3.01 |
| Ward 25 (Respiratory) | 8.88 | 6.73 | -2.16 |
| Ward 25 RSU | 11.65 | 9.79 | -1.86 |
| Ward 26 | 7.39 | 6.04 | -1.35 |
| Ward 27 (Gastroenterology) | 6.71 | 5.66 | -1.05 |
| Ward 28 (Surgery) | 6.30 | 5.56 | -0.74 |



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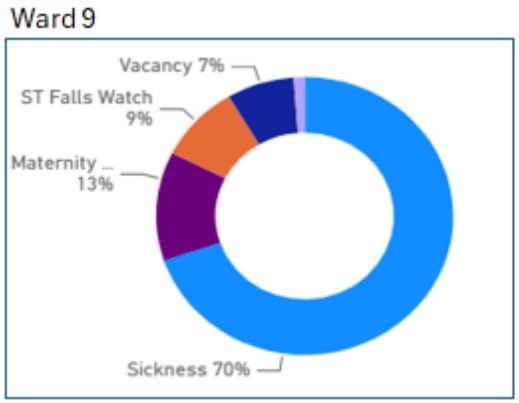
| | | | |
|---|---|---|---|
| Ward 31 (Surgical Observation Unit) | 8.22 | 8.71 | 0.49 |
| Ward 32 (Fragility Fracture) | 8.33 | 8.23 | -0.09 |
| Ward 33 (Orthopaedic & Spinal) | 6.17 | 6.56 | 0.39 |
| Ward 36 | 8.69 | 6.70 | -1.99 |
| Ward 38 | 6.54 | 5.97 | -0.58 |
| Ward 40 (Acute Elderly) | 8.16 | 6.89 | -1.27 |
| Ward 41 (Stroke Unit) | 7.97 | 6.89 | -1.08 |
| Ward 42 (Elderly Rehabilitation) | 8.79 | 8.00 | -0.78 |
| **Grand Total** | **9.14** | **8.97** | **-0.16** |

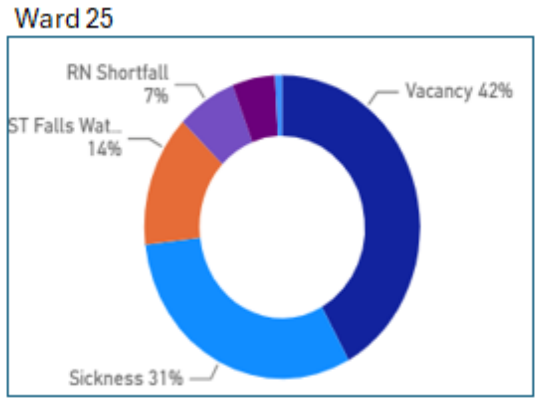


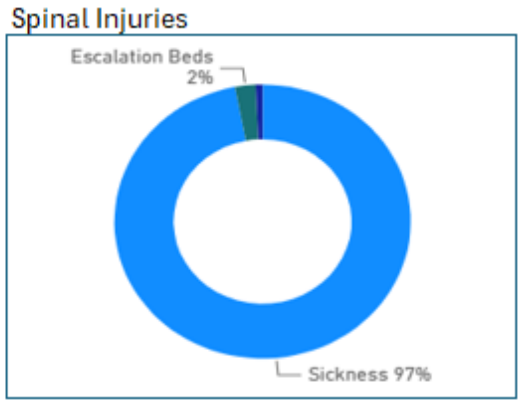
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**Appendix 3**

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



University Hospitals Tees

# Safer Staffing Bi-Annual Overview and Emerging Themes

**Meeting date:** 3 September 2026

**Reporting to:** Board of Directors

**Agenda item No:** 2.6

**Report author:** Debi McKeown, Nursing Workforce Lead ST, Emma Roberts Associate Director of Nursing and Professional Workforce NT

**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 partners ☒

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

This report presents the first combined nursing establishment review for University Hospitals Tees. It is important to note that horizontal integration has occurred at CSU level and that many services are reviewing their service models which will subsequently have a direct impact on the workforce model required. Therefore, this paper provides an overview of current requirements based on the traditional workforce models for both North and South Tees sites, that are likely to be subject to change in the future. It is the intention to repeat the exercise in the November 2026 when workforce models have been reviewed and considered for University Hospital Tees.

Recognising differing historical review cycles across the two Trusts, the review incorporates two approaches to the review period during the 2025/26 reporting year.

South Tees Hospitals NHS Foundation Trust has undertaken a bi-annual workforce assurance update in line with its current established reporting cycle. This review has utilised triangulated workforce, quality and safety data and professional judgement from March 2026 to provide assurance regarding workforce establishments and emerging workforce opportunities and risks.

North Tees and Hartlepool NHS Foundation Trust has undertaken a full annual Nurse establishment review in line with its establishment reporting cycle and to ensure compliance with NHS England Developing Workforce Safeguards (DWS 2018) requirements. The previous full establishment review was undertaken in October 2024 and therefore, a full review was required to provide updated Board assurance regarding current workforce establishments, workforce sustainability and future workforce requirements. This review was conducted using 6 months of triangulated workforce, quality, safety and patient experience data, alongside evidence-based tools and professional judgement reviews to assess current establishments and workforce requirements.

Whilst this report provides a single University Hospitals Tees review to provide workforce assurance, the findings, recommendations, workforce opportunities and residual risks are presented separately for each Trust. This reflects the different level of review undertaken at each site during 2025/26 and ensures the Board has clear visibility of the related workforce position at each site prior to the transition to a unified cycle of data collection and reporting.

A unified University Hospitals Tees annual Nurse establishment review will be undertaken during November 2026 and presented to Board in January 2027, establishing a single aligned Group reporting cycle for all future nursing workforce establishment reviews.

## 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 is alerted to the continued high and stable acuity of the Trust's inpatient population, as demonstrated by the March/April 2026 Safer Nursing Care Tool (SNCT) data. While actual Registered Nurse staffing currently exceeds both funded and professional judgement

establishments due to planned over recruitment, SNCT modelling continues to indicate a materially higher theoretical requirement. Clinical Support Worker establishments remain below both funded and professional judgement levels, with recruitment actions underway to address this shortfall.

Workforce pressures across both sites are concentrated within a number of clinical services where staffing requirements consistently exceed current funded establishments and where workforce sustainability is consistently reliant on operational mitigation and temporary staffing.

**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 is advised that the bi-annual establishment review has been undertaken in line with NHS Improvement and National Quality Board guidance, using triangulated SNCT, quality, workforce and professional judgement data.

Due to group alignment changes, South Tees continues to operate against agreed 2024/25 staffing establishments, with a second SNCT data collection scheduled for September 2026 to enable a full group establishment review in November 2026.

The findings of the full review at North Tees recommends a targeted investment approach in a number clinical services at North Tees if the bed base and services were to remain the same, focusing on the higher-risk areas identified through triangulation of SNCT data, workforce metrics and Nurse Sensitive Indicators (NSIs) and professional judgement. This approach provides the most proportionate balance between patient safety, service delivery and financial affordability. The preferred option presented within this report is option 2. Further consideration to this will be required given the service redesign that will occur across 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.

The Board is provided assurance that robust systems, governance and controls are in place to ensure safe nurse staffing across the Trust. Staffing establishments are informed by validated SNCT methodology, professional judgement, quality and nurse sensitive indicators and agreed uplift arrangements, that are subject to peer review and senior nurse oversight. Proactive recruitment of newly qualified nurses provides resilience and mitigates vacancy risk, while targeted actions are in place to strengthen Clinical Support Worker recruitment and maintain safe, high-quality patient care.

## Recommendations:

The Board of Directors is asked to note the contents of this report and to be assured that robust systems and processes are in place to ensure that registered nurse staffing levels are sufficient to support the delivery of safe, high-quality patient care across the Trust.

## Safer Staffing Bi-Annual Establishment Review

### 1. PURPOSE AND SCOPE OFTHE REVIEW

The requirement to undertake and publish bi-annual nurse staffing establishment reviews is outlined in Developing Workforce Safeguards (NHS England, 2018) and National Quality Board (NQB, 2016) guidance, ensuring Boards receive regular, triangulated assurance on staffing capacity, risk and quality.

Both South Tees and North Tees & Hartlepool NHS Foundation Trusts have completed reviews in line with this guidance, covering adult inpatient wards, acute assessment areas, and children and young people's services.

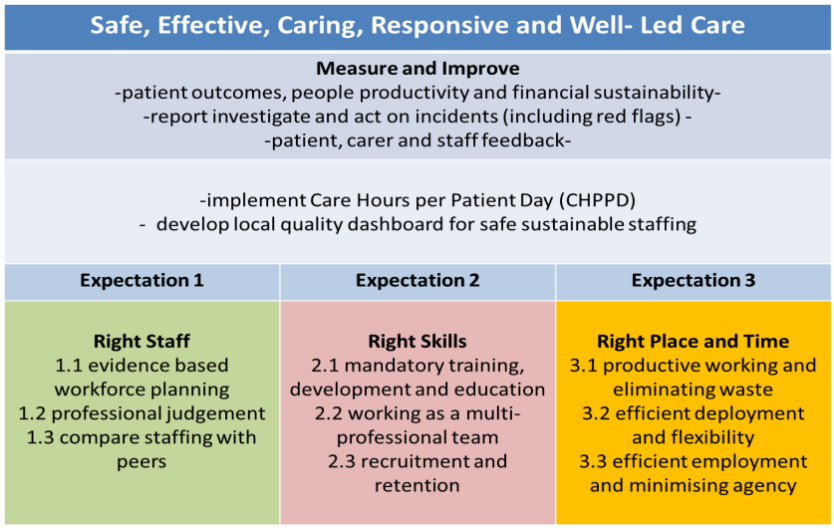
The Safer Nursing Care Tool (SNCT) is used as the primary evidence-based methodology, with outputs triangulated against quality indicators, financial data and workforce metrics, including sickness, turnover and temporary staffing, alongside structured professional judgement from senior nursing leaders.

The most recent data collection took place between March and May 2026, with a further collection planned for September 2026 to inform a groupwide review in November 2026.
In line with national direction UHT are supporting proactive recruitment, including hiring newly qualified nurses ahead of vacancies, to improve workforce resilience and maintain safe care.

These reviews provide the Board with a comprehensive assessment of workforce capacity, risks and future requirements, supporting informed decision making on workforce redesign, investment requirements and acceptable levels of tolerated risk. They align with national guidance including Developing Workforce Safeguards, NQB Safe Staffing Guidance, NICE Safe Staffing, and GPICS standards, forming a key part of the assurance framework for safe and sustainable staffing across the Group.

### 2. BACKGROUND

The National Quality Board (NQB) Guidance Framework (2016) supports the development of a workforce that is safe, sustainable, and productive. It provides a structured approach to workforce planning, ensuring that workforce decisions are aligned with patient needs and service delivery requirements. The framework's structure is outlined below;




South Tees Hospitals NHS Foundation Trust has utilised the **Safer Nursing Care Tool (SNCT)** since 2018, the previous review was completed in September 2025 and presented to board in January 2026. The previous review highlighted workforce risks linked to recruitment and retention challenges, acknowledging the potential impact on nurse workforce sustainability and service delivery. Actions included over-recruitment of newly qualified nurses to improve resilience, alongside enhancements to acuity measurement and the introduction of structured professional judgement to support more accurate, needs-led establishment setting.

At North Tees & Hartlepool NHS Trust, the previous Bi-annual nurse establishment review was conducted in October 2024 and was presented to the Executive Board in July 2025. At this time, further work was recommended to assess in more detail, the staffing levels, skill mix, workforce challenges, and to develop evidence-based recommendations for the coming year, as the Trust moved into the Group model of University Hospitals Tees. Since the previous review, data shows that patient dependency remains high, Enhanced Care demand continues to exceed capacity, RN vacancy levels have reduced, and temporary staffing reliance remains consistent across some services.

To ensure accuracy of data inputting and consistency, the CNO Safer Staffing fellow delivered training sessions to Clinical Matrons, Ward Managers, and Sisters. Training was provided both in-person and via Microsoft Teams. Attendees were required to pass an inter-relater reliability test prior to being given access to input patient scores into the daily data collection sheets. Clinical Matrons are responsible for peer-reviewing and the validation of the data to ensure it accurately reflects patient acuity and ward activity at the time of collection.

It is important to note that the SNCT assumes a **22% uplift** in staffing establishments to account for annual leave, sickness, training, and other absences. The Trust currently applies a **21% uplift** for Registered Nurses and a **19.7% uplift** for Care Support Workers at South Tees and 19.4% at North Tees for inpatient areas, resulting in a known 1%-2% differential.

This variance is not considered a risk, as SNCT outputs are always triangulated with professional judgement and other safe staffing metrics to inform establishment decisions. However, standardisation of uplift is required at University Hospital Tees and further consideration to those areas whereby additional training is mandated.

## 3. METHODOLOGY

Staffing levels are planned on a shift-by-shift basis across inpatient and assessment areas, using a standard ratio of 1:8 Registered Nurses to patients, with higher ratios applied in specialist areas to reflect acuity, for example, Acute Stroke, Respiratory Support, Acute Oncology and Stroke Rehabilitation. The need for mandated coordinators is recognised and included within Acute Assessment and Stroke Units.

SNCT data is collected for a minimum of 30 consecutive days, two to three times per year, with the most recent collection undertaken in March/April 2026. Patient acuity and dependency scores are used alongside validated multipliers to determine required nursing time. Findings are reviewed through a structured process involving senior nursing and workforce leads, with professional judgement applied to validate outputs. Where gaps are identified, comparison to funded establishments occurs, risk mitigation strategies developed and business cases developed if required.

The baseline data for this report is based on budgeted establishments for 2024/25 as they remained unchanged throughout 2025/26 recognising the imminent changes likely related to the horizontal integration of services. A further SNCT collection is planned for September 2026, with a group-wide review in November 2026.

A triangulated approach in line with DWS and NQB guidance has been applied, incorporating SNCT data, workforce metrics, patient safety, quality indicators and experience. A consistent methodology was applied across both sites, though triangulated data periods differed. Site specific findings are presented separately, with overarching themes and risks reported collectively. For North Tees, establishment recommendations were informed by the March 2026 SNCT collection and triangulated against 6 months of preceding workforce, quality, safety and patient experience data (September 2025 to February 2026). This approach supported the review of trends over time alongside current acuity and dependency requirements. For South Tees, establishment recommendations were informed by the March 2026 SNCT collection and triangulated with March 2026 data.

Services such as Emergency Departments, Community Services and Critical Care are excluded, with plans to align these into future reporting. A parallel review of GPICS v2 compliance has also been completed, with agreed phased investment planned on the North Tees site between 2025 and 2028.

## 4. RESULTS & FINDINGS

### 4.1 Staffing Establishment vs Requirement

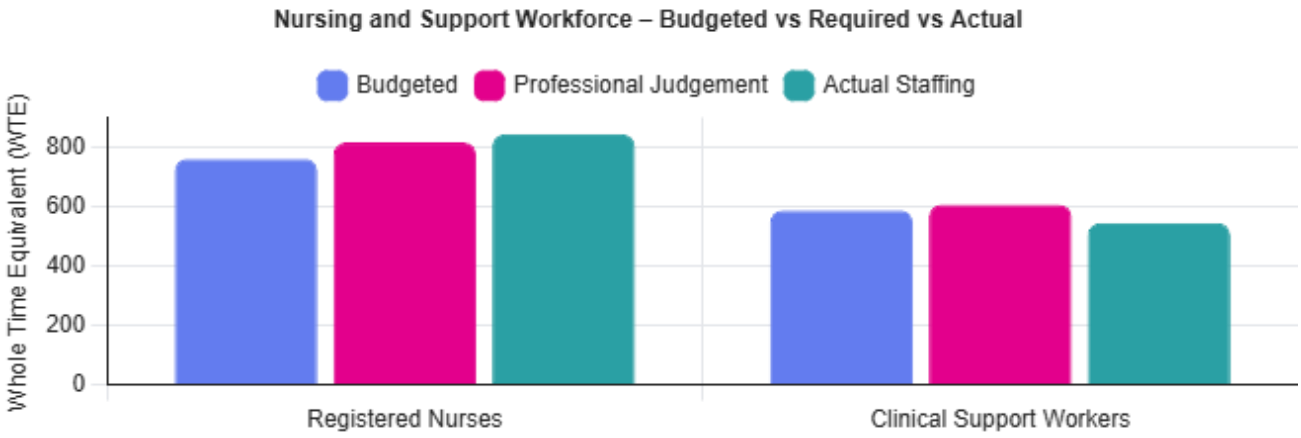
#### 4.1.1 Table 1 South Tees and North Tees Combined RN and CSW budget vs SNCT and Professional Judgment WTE

| UHT | RN | | | | | CSW | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Current Budget** | **Professional Judgement (PJ)** | **SNCT RN** | **Variance** | | **Current Budget** | **Professional Judgement (PJ)** | **SNCT CSW** | **Variance** | |
| | Budget RN WTE *includes WM | Required RN WTE *includes WM | Trust Headroom 21% (including 1c&1d) | Excess or deficit (-) SNCT against the **Current Budget** | RN Variance **Budget to PJ** | Budget CSW WTE | Required CSW WTE | Trust Headroom 19.7% (including 1c&1d) | Excess or deficit (-) SNCT against the **Current Budget** | RN Variance **Budget to PJ** |
| **CSU1.Family Health** | 95.77 | 99.15 | 87.08 | 8.69 | -3.38 | 36.22 | 29.68 | 32.76 | 3.46 | 6.54 |
| **CSU2.DHUGs** | 176.49 | 210.19 | 260.19 | -83.70 | -33.70 | 153.37 | 162.56 | 127.08 | 26.29 | -9.19 |
| **CSU3.TORPEDO** | 122.67 | 142.54 | 194.88 | -72.21 | -19.87 | 108.19 | 115.13 | 98.32 | 9.87 | -6.94 |
| **CSU5.Cardiovascular** | 118.89 | 129.44 | 152.21 | -33.32 | -10.55 | 66.00 | 66.45 | 60.05 | 5.95 | -0.45 |
| **CSU6.Cancer Institute** | 42.52 | 43.36 | 55.37 | -12.85 | -0.84 | 23.84 | 29.50 | 21.30 | 2.54 | -5.66 |
| **CSU8.GEMS** | 345.07 | 358.94 | 490.11 | -145.04 | -13.87 | 219.89 | 225.87 | 213.49 | 6.40 | -5.98 |
| **CSU9.Neuroscience** | 114.16 | 123.12 | 164.51 | -50.35 | -8.96 | 87.52 | 54.98 | 71.46 | 16.06 | 32.54 |
| **CSU10.CNHS** | 190.61 | 208.87 | 373.47 | -182.86 | -18.26 | 217.09 | 237.70 | 164.51 | 52.58 | -20.61 |
| **Totals** | **1206.18** | **1315.61** | **1777.82** | **-571.64** | **-109.43** | **912.12** | **921.87** | **788.97** | **123.15** | **-9.75** |

#### 4.1.2 South Tees NHS Foundation Trust Funded Establishment vs Recommended Establishment vs Actual Staffing – March 26

Here is a visual comparison of authorised funded establishments, professional judgement recommended establishments, and actual staffing levels (in WTE) for Registered Nurses and Clinical Support Workers at South Tees Hospitals NHS Foundation Trust:

**Graph 1: Budgeted WTE vs Professional Judgement WTE vs Actual Contacted Staff WTE (excluding temporary staffing)**




Key Insights:

- Registered Nurses:

- Budgeted: 760.66 WTE
- Professional Judgement: 815.74 WTE
- Actual Contracted Staffing: 843.23 WTE
- Budget vs Actual Staffing: Surplus 82.57 WTE
- Budget vs Professional Judgement: Deficit 55.08 WTE

- Clinical Support Workers:

- Budgeted: 587.00 WTE
- Professional Judgement: 606.37 WTE
- Actual Contracted Staffing: 544.30 WTE
- Budget vs Actual Staffing: Deficit of 42.70
- Budget vs Professional Judgement: Deficit of 19.37 WTE

The table demonstrates a variance between staffing position for Registered Nurses and Clinical Support Workers, reflecting recent changes in recruitment practice.

Registered Nurse staffing is currently above both the budgeted establishment and the professional judgement requirement. This over establishment is intentional and planned, following a recommendation from Duncan Barton in August 2025 to proactively recruit newly qualified nurses ahead of anticipated vacancies, rather than responding reactively once vacancies arise. Over recruitment of NQNs was supported via Senior Leadership Team and subsequently Management Group.

In line with this recommendation, the Trust has overrecruited across the last three cohorts of newly qualified nurses, employing these nurses on 12-month fixed term contracts. This approach provides resilience against natural turnover, supports safe staffing levels, and enables newly qualified nurses to transition into substantive permanent roles as vacancies arise through attrition. As a result, actual Registered Nurse staffing temporarily exceeds both

budgeted and professional judgement assessed requirements. However, a reduction in temporary staffing costs has been observed.

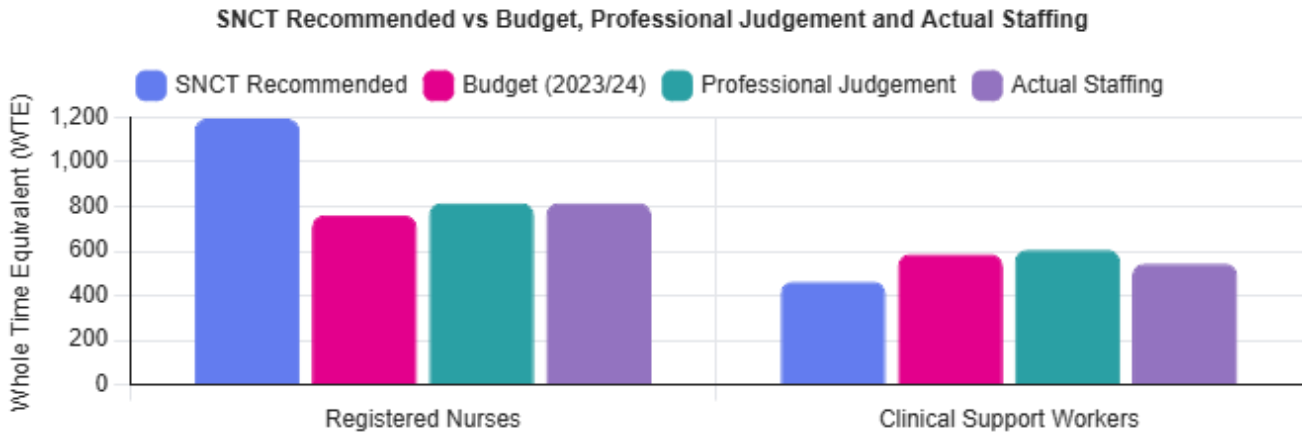
In contrast, Clinical Support Worker staffing remains below both budgeted and professional judgement levels. This reflects a different workforce challenge and approach. A centralised recruitment process for Clinical Support Workers has now been implemented, with the aim of improving recruitment consistency, oversight, and timeliness, and addressing the current shortfall.

Overall, the data illustrates a managed and strategic approach to workforce planning, with proactive investment in Registered Nurse staffing to maintain safety and stability, alongside targeted actions underway to strengthen Clinical Support Worker recruitment and establishment.

### 4.1.3 South Tees NHS Foundation Trust Safer Care Nursing Tool Results vs Funded Establishment – March 26

Here is a visual comparison of SNCT recommended establishments, authorised funded establishments, and actual staffing levels (in WTE) for Registered Nurses and Clinical Support Workers across South Tees Hospitals NHS Foundation Trust:

**Graph 2: SNCT Recommend WTE vs Budgeted WTE vs Professional Judgement WTE vs Actual Contracted Staff WTE (excluding temporary staffing)**




Key Insights:

- Registered Nurses (RNs):
    - SNCT Recommended: 1194.83 WTE
    - Budget (2023/24): 760.66 WTE
    - Actual Contracted Staffing: 843.23 WTE
    - Professional Judgement: 815.74 WTE
    - Budget vs SNCT: Deficit of 434.17 WTE
    - Actual Staffing vs SNCT: Deficit of 351.60 WTE
- Clinical Support Workers (CSWs):
    - SNCT Recommended: 463.68 WTE
    - Budget (2023/24): 587.00 WTE



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- Actual Contracted Staffing: 544.30 WTE
- Professional Judgement: 606.37 WTE
- Budget vs SNCT: Surplus 123.32 WTE
- Actual Staffing vs SNCT: Surplus of 80.62

The chart presents a comparison between SNCT recommended staffing levels, budgeted establishment, professional judgement, and actual staffing for Registered Nurses and Clinical Support Workers.

For Registered Nurses, the data highlights a significant gap between SNCT recommended staffing and the funded establishment, with actual staffing aligned to professional judgement but remaining materially below SNCT recommendations. This reflects the continued challenge of delivering the SNCT identified requirement within available funded resources.

For Clinical Support Workers (CSWs), the apparent variation between SNCT recommendations being below the agreed professional judgement, budgeted establishment and actual staffing reflects the way in which CSW roles are deployed in practice, which is not always fully captured by the SNCT methodology. In practice, CSWs within the Trust are often used flexibly across ward footprints, supporting a wider range of activity including direct care, enhanced observation, patient flow, workforce mitigation, and non ward specific duties.

It should be noted that the budget figures reflected are based on 2024/25 establishments. In line with any changes, updated budget data will be requested and will be incorporated into future reports, to ensure full alignment between workforce planning, funded establishments, and SNCT outputs.

**Table 2: South Tees Professional Judgement WTE templates compared to Agreed Funded Establishment WTE and AFE compared to SNCT recommended WTE broken down by CSU for Registered Nurses**

| South Tees CSU | RN | | | | | |
|---|---|---|---|---|---|---|
| | **Current Budget** | **Actual Staffing** | **Professional Judgement (PJ)** | **SNCT RN** | **Variance** | |
| | Budget RN WTE *includes WM | Mar 26 Contracted RN WTE *includes WM | Required RN WTE *includes WM | Trust Headroom 21% (including 1c&1d) | Excess or deficit (-) SNCT against the **Current Budget** | RN Variance **Budget to PJ** |
| **CSU1.Family Health** | 50.95 | 49.93 | 51.49 | 34.01 | 16.94 | -0.54 |
| **CSU2.DHUGs** | 64.89 | 88.49 | 85.82 | 121.51 | -56.62 | -20.93 |
| **CSU3.TORPEDO** | 82.27 | 93.42 | 91.02 | 142.98 | -60.71 | -8.75 |
| **CSU5.Cardiovascular** | 97.89 | 107.84 | 100.27 | 118.21 | -20.32 | -2.38 |
| **CSU6.Cancer Institute** | 42.52 | 46.72 | 43.36 | 55.37 | -12.85 | -0.84 |
| **CSU8.GEMS** | 179.07 | 193.28 | 189.71 | 287.67 | -108.60 | -10.64 |
| **CSU9.Neuroscience** | 92.36 | 102.00 | 94.85 | 135.49 | -43.13 | -2.49 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **CSU10.CNHS** | 150.71 | 161.55 | 159.22 | 299.60 | -148.89 | -8.51 |
| **Totals** | **760.66** | **843.23** | **815.74** | **1194.83** | **-434.17** | **-55.08** |

**Table 3: South Tees Professional Judgement WTE templates compared to Agreed Funded Establishment WTE and AFE compared to SNCT recommended WTE broken down by CSU for Clinical Support Workers**

| South Tees CSU | CSW | | | | | |
|---|---|---|---|---|---|---|
| | **Current Budget** | **Actual Staffing** | **Professional Judgement (PJ)** | **SNCT CSW** | **Variance** | |
| | Budget CSW WTE | Mar 26 Contracted RN WTE *includes WM | Required CSW WTE | Trust Headroom 19.7% (including 1c&1d) | Excess or deficit (-) SNCT against the **Current Budget** | RN Variance **Budget to PJ** |
| **CSU1.Family Health** | 22.90 | 17.72 | 16.09 | 17.10 | 5.80 | 6.81 |
| **CSU2.DHUGs** | 70.17 | 60.58 | 68.94 | 46.74 | 23.43 | 1.23 |
| **CSU3.TORPEDO** | 71.69 | 55.24 | 71.51 | 55.01 | 16.68 | 0.18 |
| **CSU5.Cardiovascular** | 52.00 | 46.59 | 53.63 | 45.48 | 6.52 | -1.63 |
| **CSU6.Cancer Institute** | 23.84 | 25.28 | 29.50 | 21.30 | 2.54 | -5.66 |
| **CSU8.GEMS** | 112.39 | 116.21 | 126.03 | 110.67 | 1.72 | -13.64 |
| **CSU9.Neuroscience** | 70.12 | 71.08 | 67.04 | 52.12 | 18.00 | 3.08 |
| **CSU10.CNHS** | 163.89 | 151.60 | 173.63 | 115.26 | 48.63 | -9.74 |
| **Totals** | **587.00** | **544.30** | **606.37** | **463.68** | **123.32** | **-19.37** |

A full ward break down by CSU can be found in **Appendix 1**.

### 4.1.4 North Tees Safer Nursing Care Tool Results vs Funded Establishments

The 2026 review demonstrates a continued variance between funded establishments, SNCT recommendations and professional judgement requirements across a number of clinical areas.

A significant gap has been identified between current funded nurse establishments and SNCT outputs. This finding has remained consistent across successive data collection periods over the previous 2-3 years at North Tees and Hartlepool NHSFT.

Whilst SNCT provides an important evidence-based benchmark, it does not fully account for several operational factors including ward layout, patient turnover, enhanced care demand, specialty-specific requirements, leadership capacity and workforce sustainability. For this reason, establishment recommendations have been informed by a structured professional judgement process involving Associate Directors of Nursing, Heads of Nursing, Clinical



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Matrons and Ward Managers, led by the Associate Director of Nursing & Professional Workforce.

The triangulated review indicates that some areas are currently able to maintain safe care through robust operational mitigations, daily staffing oversight, temporary staffing utilisation and proactive workforce management. However, current staffing arrangements are not considered sustainable in all areas and require either investment or service realignment to reduce ongoing workforce risk.

Professional judgement identifies a smaller, but clinically significant, establishment gap across several areas. These recommendations represent the minimum staffing requirement considered necessary to deliver safe and sustainable care whilst maintaining appropriate leadership, supervision and escalation capacity if the service model is to remain the same. **Table 4 and 5** summarises the Trust-wide establishment position by CSU and highlights the variance between the current budget establishment, SNCT recommendations and Professional judgement recommendations. A full ward breakdown of this information can be found in **appendix 2**.

**Table 4**

| CSU | Current budget RN | SNCT RN | PJ RN | Variance SNCT v Budget RN | Variance PJ v Budget RN |
|---|---|---|---|---|---|
| | | | | | |
| **CSU1 Family Health** | 44.82 | 53.07 | 47.66 | -8.52 | -2.84 |
| **CSU2 DHUGS** | 111.6 | 138.68 | 124.37 | -27.08 | -12.77 |
| **CSU3 TORPEDO** | 40.4 | 51.9 | 51.52 | -11.5 | -11.12 |
| **CSU5 CARDIO** | 21 | 34 | 29.17 | -13 | -8.17 |
| **CSU8 GEMs** | 166 | 202.44 | 169.23 | -36.44 | -3.23 |
| **CSU9 NEURO** | 21.8 | 29.02 | 28.27 | -7.22 | -6.47 |
| **CSU10 CNHS** | 39.9 | 73.87 | 49.65 | -33.97 | -9.75 |
| | **445.52** | **582.98** | **499.87** | **-137.73** | **-54.35** |

**Table 5**

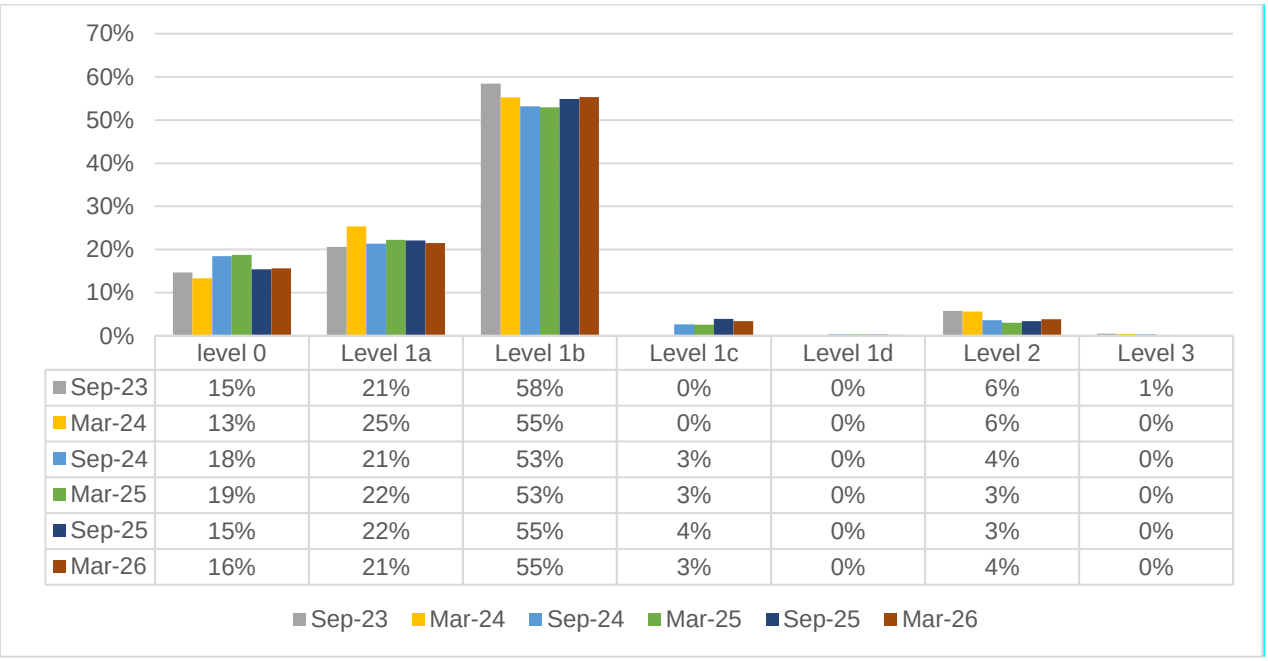
| CSU | Current CSW | SNCT CSW | PJ CSW | Variance SNCT v Budget CSW | Variance PJ v Budget CSW |
|---|---|---|---|---|---|
| | | | | | |
| **CSU1 Family Health** | 13.32 | 15.66 | 13.59 | -2.34 | -0.27 |
| **CSU2 DHUGS** | 83.2 | 80.34 | 93.62 | 2.86 | -10.42 |
| **CSU3 TORPEDO** | 36.5 | 43.31 | 43.62 | -6.81 | -7.12 |
| **CSU5 CARDIO** | 14 | 14.57 | 12.82 | -0.57 | 1.18 |
| **CSU8 GEMs** | 107.5 | 102.82 | 99.84 | 4.68 | 7.66 |
| **CSU9 NEURO** | 17.4 | 19.34 | 17.94 | -1.94 | -0.54 |
| **CSU10 CNHS** | 53.2 | 49.25 | 64.07 | 3.95 | -10.87 |
| | **325.12** | **325.29** | **345.5** | **-0.17** | **-20.38** |

### 4.2 Patient Acuity & Dependency

#### 4.2.1 South Tees NHS Foundation Trust Trends in Acuity and Dependency Levels

The figure below shows a summary of the overall patient acuity levels for the Trust as a percentage for all areas collected over 30 days in March/April 2026 compared to previous reports from September 2023.

**Graph 3:** Trust Acuity Levels by total %




| | level 0 | Level 1a | Level 1b | Level 1c | Level 1d | Level 2 | Level 3 |
|---|---|---|---|---|---|---|---|
| Sep-23 | 15% | 21% | 58% | 0% | 0% | 6% | 1% |
| Mar-24 | 13% | 25% | 55% | 0% | 0% | 6% | 0% |
| Sep-24 | 18% | 21% | 53% | 3% | 0% | 4% | 0% |
| Mar-25 | 19% | 22% | 53% | 3% | 0% | 3% | 0% |
| Sep-25 | 15% | 22% | 55% | 4% | 0% | 3% | 0% |
| Mar-26 | 16% | 21% | 55% | 3% | 0% | 4% | 0% |

Safer Nursing Care Tool (SNCT) data demonstrates a consistently high acuity inpatient population across all reporting periods. Most patients are classified as Level 1b, accounting for approximately 53–58% of the caseload, indicating sustained demand for enhanced nursing care and intervention.

Lower acuity patients (Levels 0 and 1a) collectively represent less than 40% of activity, reinforcing that the inpatient profile is predominantly complex rather than stable.

A small but persistent proportion of patients require enhanced supervision (Level 1c), while Level 2 (high dependency) patients remain consistently present at 3–6%.

Overall, the data indicates a stable but consistently high level of patient acuity, supporting the need for staffing establishments that are aligned to patient dependency and acuity rather than bed numbers alone, and providing assurance that SNCT assessments continue to reflect ongoing workforce pressure.

It is important to note for patients recorded as Level 1d with a requirement for 2:1 care. In certain cases, this is provided by one registered nurse or care support worker, with a member of the security team acting as the second staff member. As South Tees security services are provided by Serco, a separate external organisation, security staff cannot be counted within Trust staffing numbers. As a result, these patients cannot be fully captured as Level 1d within the SNCT, which may give the appearance of a lower Level 1d requirement.

The peer review has been scheduled to align with the next formal SNCT data collection period in September 2026. During the September 2026 collection, a peer review will be undertaken jointly by the Workforce Lead and the Therapeutic Care Lead, with specific focus on patients recorded as Level 1c and Level 1d, to provide assurance regarding the accuracy and consistency of SNCT assessments. In addition, SNCT data will be cross-validated against MIYA, TRACARE and ETOC systems to confirm alignment between recorded patient numbers during the collection period and electronic patient records. This work will strengthen data quality assurance and support confidence in the use of SNCT outputs for workforce planning and establishment setting.

### 4.2.2 North Tees Trust Trends in Acuity and Dependency Levels

The 2026 review demonstrates that North Tees & Hartlepool NHS Foundation Trust continues to care for a patient population with complex acuity and dependency needs across a number of inpatient services and is a significant driver of staffing demand.

Professional judgement reviews across these areas identified that patients' dependency needs were derived from factors including cognitive impairment, delirium, behavioural disturbance, enhanced care requirements and complex discharge planning. Whereas levels 1a and levels 2 (high acuity) were aligned to patients requiring non-invasive respiratory support, complex medication regimes, cardiac monitoring and acute stroke care.

Across adult inpatient wards, level 1b patients' higher dependency levels continue to represent the largest proportion of the inpatient population (44%). These patients require regular nursing intervention, frequent monitoring and ongoing clinical assessment. In addition, the 2026 SNCT cycle demonstrates a sustained increase in Level 1c patients, reflecting a consistent demand for enhanced care and supervision requirements.

The highest levels of dependency are consistently observed within:

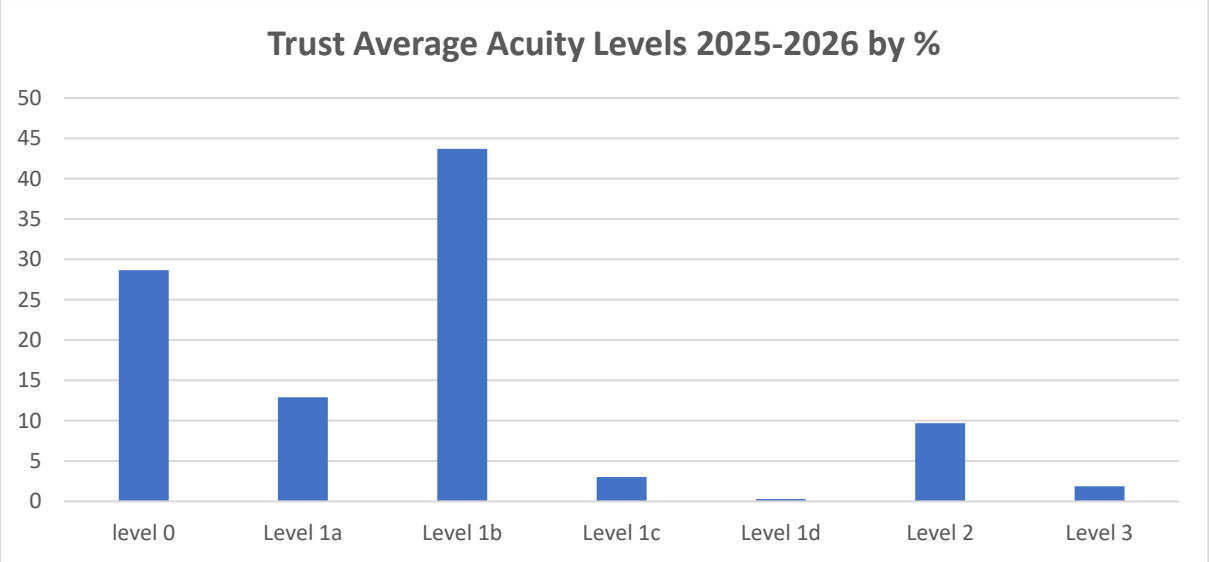
- Orthopaedic Frailty (Ward 32)
- Older Peoples Medicine (Wards 40 and 42)
- Respiratory Support Units (Wards 24 and 25)
- Acute Stroke Unit (Ward 41)
- Acute Cardiology Unit (Ward 29)
- Emergency Assessment Unit (EAU)

Data from the revised SNCT, which incorporates Level 1c and 1d dependency categories, indicates that patients requiring 1:1 care represent a consistent demand in certain areas rather than an occasional exception. CSU reviews identified multiple instances where the need for enhanced care exceeded the available substantive staffing capacity within both ward teams and the Enhanced Care Team. This shortfall is partly attributable to a high number of vacancies within the EC team, leading to increased reliance on temporary staffing and staff redeployment. This issue was particularly evident on Wards 40, 42, 24, 25 and 32, where heightened demand for enhanced care appears to be associated with increased rates of falls, pressure ulcers, and staffing-related incidents.

Importantly, triangulation of SNCT data and professional judgement reviews identified that the acuity and dependency levels of patients do not reduce during night shifts on all wards. This finding has significant implications for establishment setting and supports concerns regarding current night-time registered nurse to patient ratios being higher at night in some clinical areas.

The review concludes that the Trust is caring for a high-acuity and higher dependency patient population. **Graph 4** presents the total Trust average SNCT levels taken across two data collection periods (Oct25 and Mar26).

**Graph 4**




### 4.3 Trust Wide Workforce Review

For the Trust to deliver safe and effective care it is dependent not only upon the establishment funded within services, but also upon the availability, experience and sustainability of the workforce required to deliver that care. Whilst the Trust has continued to maintain safe staffing through proactive nursing management and workforce interventions, several indicators suggest that current staffing arrangements are becoming increasingly reliant upon mitigations rather than substantive workforce capacity.

#### 4.3.1 Vacancy Position

At South Tees, the Registered Nurse vacancy position for March 26 was 17.78 WTE vacancies. These posts are advertised internally to the pro-active over recruitment of the newly qualified nurses on fixed terms contracts, which has created additional resilience within the workforce.

The financial ledger reports a vacancy position of 97.68 WTE for HCSWs. Whilst vacancies persist within the Care Support Worker workforce, this is being actively addressed through a centralised recruitment initiative, which is enabling regular recruitment into vacant posts and supporting improved workforce stability.

At North Tees the trust has continued to benefit from successful recruitment, including the recruitment of Newly Qualified Nurses and continued recruitment of CSWs. As a result,

registered nurse vacancy levels remain low, approximately 15WTE Trust wide, and reliance upon agency RN has reduced significantly and completely in many in-patient areas.

However, the continued recruitment of CSWs to meet turnover and sickness absence demands remains challenging. The current Trust wide vacancy position for Band 3 CSW is approx. -50wte with this position forecasted to increase with monthly turnover, if a proactive approach to recruitment and retention is not taken. Regular central recruitment drives remain in place and a recent change to the job description, in line with the national job profile should support recruitment in the future.

### 4.3.2 Sickness absence

At South Tees, registered staff sickness decreased by 0.57% to 6.53% in March 26. This reduction often reflects seasonal recovery following the winter period, alongside improved workforce stability. Staff sickness at South Tees continues to be actively managed through Health Improvement Plans and twice daily Safe Care reviews, which mitigate the impact of sickness absence and increased patient acuity on CHPPD compliance. Workforce oversight enables timely redeployment to maintain safe staffing levels. Registered staff sickness rates will be routinely monitored and reviewed at monthly Workforce Assurance Meetings to ensure ongoing oversight and early identification of emerging trends.

Sickness absence at North Tees remains one of the most significant workforce pressures identified through the review. Data from September 2025 to February 2026 shows that, across most wards, sickness levels consistently exceed the 4% headroom assumption built into current staffing establishments. In March 2026 during the data collection period, sickness absence was 7.47%, highlighting the ongoing and increasing impact on workforce capacity and the importance of actively managing through workforce assurance meetings.

### 4.3.3 Turnover

At South Tees both registered and unregistered staff turnover remained stable in March 26, with a small month on month increase 0.01% across both staff groups, Nursing 4% and Care Support Workers 8.73%. Overall turnover remains lower than in March 2025, indicating continued year on year improvement in workforce retention.

At North Tees Trust-wide turnover remains broadly stable; however, variation exists across clinical services. Higher turnover, exceeding the national average of 8% can be seen across wards 36, 40 and 42. These areas have high levels of patient dependency. Professional judgement reviews highlighted concerns regarding the potential impact of sustained staffing pressures on retention and workforce wellbeing.

### 4.3.4 Day vs Night Staffing Fill Rates

In March 2026, overall staffing fill rates at South Tees remained high, with total planned hours achieved at 97.8%. Day shifts demonstrated slightly lower Registered Nurse fill rates (91.5%) compared to nights (94.9%), while Care Support Worker fill rates were strong across both, with nights exceeding planned levels (101.6%). Overall, staffing fill rates indicate a stable position, with slightly higher fill performance observed during night shifts.

In March 2026, overall staffing fill rates at North Tees and Hartlepool were 96% of planned hours. Day shifts showed lower fill rates, particularly for Registered Nurses (87%) and Care Support Workers (81%). Night shifts demonstrated a higher fill rate for Registered Nurse fill rates of 97% and Care Support Worker fill rates to 102% due to Enhanced Care requirements.

### 4.3.5 Temporary Staffing

At South Tees temporary staffing continues to be demand led, with redeployment prioritised over NHSP utilisation, contributing to a reduction in both demand and spend in the month of March 26. Demand for nursing bank staffing in March 2026 decreased by **7.9%** compared to March 2025. Overall fill rate was 85.4%. Bank filled hours also declined by **8.6%** over the same period. These reductions provide clear evidence that current workforce optimisation measures are sustainably improving staffing efficiency and reducing reliance on temporary staffing solutions. During this reporting period, overall expenditure decreased in line with a corresponding reduction in service demand. This improvement reflects the cumulative impact of workforce optimisation initiatives, including workforce assurance meetings, approval flowcharts and improved staffing deployment resultant in reducing the reliance on temporary staffing.

At North Tees temporary staffing continues to play an important role in maintaining safe staffing levels across the Trust. Registered nurse agency utilisation remains very low and non-existent in many areas, reflecting successful recruitment activity and proactive workforce management. However, reliance upon bank staffing remains significant within several services. The review identified high levels of bank RN utilisation across EAU and Respiratory with the main drivers being sickness and absence in EAU and a consistently high number of RSU patients (SNCT level 2 with high acuity) in Respiratory. Reliance upon bank CSWs was more evident across Older Peoples Medicine and Orthopaedic Frailty due to the high levels of more dependent patients and where enhanced care demand frequently exceeds substantive staffing capacity.

Whilst temporary staffing provides an essential safety mitigation at North Tees and Hartlepool, the review identified that continued reliance upon temporary staffing may impact on continuity of care, increased staffing costs and place additional pressure upon substantive staff. In the 6-month data review period there was an average monthly temporary staffing use across all in-patient areas of **63.31WTE RN and 96.02WTE CSW**.

### 4.3.6 Enhanced Care Demand at North Tees and Hartlepool

Enhanced care demand was one of the most significant themes across the 2026 review and represents a major contributor to nursing workforce pressure across several clinical services. Analysis of the data demonstrates that enhanced care demand is no longer an occasional pressure associated with periods of escalation but has become a routine requirement across multiple inpatient wards. The highest levels of enhanced care demand were seen in Older Peoples Medicine (Wards 40 and 42), Orthopaedic frailty (Ward 32), Diabetes (Ward 36), Gastroenterology (Ward 26).

Professional judgement reviews identified enhanced care capacity is not reflected within the current establishment models due to the team sitting external to the wards. In several areas, enhanced care requirements regularly exceeded the capacity available within ward establishments and the external enhanced care team, resulting in the need for temporary staffing, staff redeployment or adaptation of ward staffing models to maintain patient safety.

Consideration should also be given to establishing a more consistent approach to the allocation of enhanced care per patient load, ensuring demand is recognised, planned for, and equitably distributed across services.

There are currently two models in existence across UHT. It is the intention to transfer enhanced care to the corporate nursing team alongside therapeutic care and review the workforce model required.

## 5. QUALITY OUTCOMES (NURSE SENSITIVE INDICATORS)

**Nurse Sensitive Indicators (NSIs)** are recognised as key quality metrics that are directly influenced by nursing care. NSIs are used in conjunction with data from the Acuity and Dependency Tool to inform evidence-based workforce planning. This approach supports both the optimisation of existing services and the development of new care models.

NSIs provide valuable insight into the relationship between ward staffing levels and nurse sensitive outcomes, enabling the Trust to monitor and evaluate the impact of staffing decisions on patient care. By triangulating NSI data with acuity and dependency scores, the Trust ensures that workforce plans are responsive to patient needs and aligned with quality and safety standards.

At North Tees the analysis of quality and safety data across the required 6-month period for a full establishment review from September 2025 to February 2026, identified several recurring themes across clinical services, particularly within areas characterised by higher patient dependency, significant enhanced care demand and workforce fragility.

### 5.1 Falls

At South Tees the highest levels of falls are concentrated within key acute and high-turnover areas, notably the Clinical Decisions Unit and Ward 37 (7), alongside a number of wards highlighting 6 falls within the same data collection period, March 2026, including Older Persons Medicine (Ward 11), Vascular/Diabetic Foot (Ward 28), Short Stay (Ward 31), Renal

(Ward 4) and Gastroenterology (Ward 5). These areas reflect sustained workforce pressures associated with high patient acuity, rapid patient flow, and complex discharge needs, indicating where staffing demand is most consistently elevated across the Trust.

At North Tees, falls remain one of the most significant patient safety indicators across the Trust and were consistently higher within services caring for frail, elderly and highly dependent patient populations. The highest falls activity was observed within Wards 40, 42, 32 and 29. Triangulation of falls data, workforce metrics and professional judgement reviews identified a consistent association between increased falls activity and areas experiencing high enhanced care demand, patients with cognitive impairment and delirium and high temporary staffing use. Professional judgement reviews across wards 40, 42 and 32 identified concerns in the ability of the current staffing models to fully meet the supervision requirements of patients, requesting service redesign or an investment into the establishment to support changes to the current model of care to introduce 'bay watch'.

### 5.2 Pressure Ulcers

At South Tees, the highest prevalence of pressure ulcer incidents are concentrated within a small number of wards, notably Ward 11 and 12 (Older Persons Medicine), Ward 14 (Radiotherapy/Oncology) and Ward 8 (Urology/Upper GI). A notable proportion of these incidents are hospital-acquired, indicating that they developed during the patient's stay rather than being present on admission, and therefore may be indicative of opportunities for prevention. This pattern suggests that patients with higher dependency, complex care needs, and prolonged lengths of stay, particularly within older persons medicine and oncology, are contributing most significantly to pressure ulcer risk across the Trust.

At North Tees, analysis of pressure ulcer data demonstrated a similar pattern. The highest incidence of pressure damage was observed across Wards 40, 42, 32 and 29, with a notable proportion identified as hospital acquired, indicating the damage developed during the patient's stay. Professional judgement reviews highlighted that many patients within these services require frequent repositioning, complex interventions and ongoing clinical monitoring.

### 5.3 Patient Experience

At South Tees patient experience is most impacted upon within urgent care, unscheduled pathways, and high-volume outpatient services, where demand, waiting times, and patient flow pressures are greatest. While inpatient wards form a smaller part of the overall dataset, areas such as Older Persons Medicine and surgical wards are still evident within the data, suggesting that both patient complexity and service pressures continue to influence patient experience outcomes, acknowledging that other reasons may be attributable.
Overall, the findings highlight the link between operational pressure, particularly within emergency and outpatient services, and patient experience, reinforcing the importance of staffing, flow management, and communication in maintaining high-quality care.

At North Tees patient experience data was reviewed alongside quality indicators and workforce information. Whilst patient feedback remained positive across the organisation, recurring themes within complaints and patient experience reported included delays in

communication, delays in responding to patient requests and a perceived lack of staff availability. These themes were most frequently observed within EAU, Ward 30 and Ward 33 where there are higher levels of patient turnover.

### 5.4 Incidents/ Harm

At South Tees the highest concentration of medication incidents is observed in a small number of wards. It is important to note that these incidents are not attributable to a single error type, such as failures to administer medication (FO1), but instead reflect a broader range of medication-related issues, including prescribing, administration, and documentation errors. The areas with the highest number of incidents include Ward 36 (Trauma) Ward 7 (General Emergency Surgery) and Ward 1 (Acute Assessment Unit).
These areas are predominantly high-acuity, high-turnover, or unscheduled care environments, indicating where operational pressures and patient complexity are most likely contributing to increased incident occurrence across the Trust.

At North Tees medication incidents were most frequently observed across Ward 42, 32 and EAU, areas where nurses are caring for patients with complex medication regimes or have a high number of dependent patients who require additional support to take their medications. Professional judgement reviews identified concerns regarding increasing workload for registered nurses within these environments, particularly during periods of high occupancy and increased patient dependency.

At South Tees during March 26, there were 31 In-Phase submissions relating to staffing. This is a 62.2% decrease in comparison month on month reporting period (February and March, 2026). This change coincides with the mid-month transition from the Datix reporting system to the HealthCare Guardian. As a result, incidents may have been reported across two systems during the reporting period, with some activity no longer captured within Datix. The reduction therefore reflects the impact of a system migration rather than a confirmed reduction in incident occurrence. Reporting trends will be reviewed once InPhase data is established for a full reporting cycle to provide a more accurate comparison.

Staff are encouraged to report into HCG any staffing related issues which are reviewed and discussed as part of workforce assurance and governance meetings. The majority of HCG submissions, highlight a misalignment of staffing to level 3 enhanced observation equivalent patients in Ward 12. All staff shortages are raised and managed through the embedded Safe Care process throughout March 26.

Also, at North Tees review of staffing related incidents and local risk assessments identified recurring themes across a number of wards including insufficient staffing to meet enhanced care demand, delays in providing observations, increased reliance upon temporary staffing and a reduced manager supervisory capacity. The areas reporting staffing related concerns

were also areas identified through SNCT and professional judgement processes as requiring establishment review and potential CSU workforce remodelling or investment.

## 6. PROFESSIONAL JUDGEMENT (PJ)

For South Tees the data demonstrates that, across the majority of wards, there is a consistent deficit when comparing SNCT outputs to both current budgeted establishments and Professional Judgement (PJ). This indicates that SNCT is consistently identifying a higher theoretical staffing requirement than that is supported through professional judgement.

Professional judgement has therefore adjusted these requirements to reflect a more proportionate and clinically deliverable establishment position. While deficits remain across a number of wards this occurs particularly in high occupancy and high acuity areas such as Ward 31 (-21.32 WTE), Zetland (-23.21 WTE), Ward 12 (-18.75 WTE), Ward 03 (-17.99 WTE), and Tocketts (-18.10 WTE). PJ has reduced the scale of these gaps when compared to SNCT alone.

For Registered Nurses, the largest PJ variances against budget continue to be seen in wards such as Ward 07 (-6.22 WTE), Ward 06 (-5.90 WTE), Ward 09 (-4.84 WTE), Ward 28 (-4.38 WTE), and Ward 05 (-4.39 WTE), where professional judgement identifies a need for increased staffing above current budgeted establishments, though not to the level indicated by SNCT.

Professional judgement, when compared against the current budgeted establishment, identifies a need for adjustments to the whole-time equivalent (WTE) establishment for Care Support Workers across several areas. Increases in WTE are recommended for Ward 21 (+2.47 WTE), Ward 05 (+2.32 WTE), and SIU (+2.77 WTE), whereas reductions in WTE are indicated for Ward 09 (-6.25 WTE), Ward 33 (-4.19 WTE), and CDU (-3.49 WTE). These figures represent changes to the establishment WTE, not headcount, and reflect a review of skill mix requirements to support the optimal deployment of the workforce. The reduction in CSWs aligns to a required increase in RNs.

### SNCT and Professional Judgement

The differences between SNCT and professional judgement reflect the known position that SNCT often produces a higher theoretical establishment requirement, particularly in organisations caring for high acuity and higher dependency populations.
Professional judgement moderates these outputs by incorporating factors not fully captured within SNCT, including:

- Workforce availability and sustainability, ensuring recommendations are deliverable
- Skill mix and team composition, balancing the ratio of Registered Nurses and Care Support Workers
- Operational flow and ward function, particularly in high-turnover and short-stay areas
- Therapeutic Care / Enhanced care model
- Local mitigation strategies, such as escalation processes, redeployment and temporary staffing

As a result, while SNCT identifies a consistently higher staffing requirement across the Trust, professional judgement defines a realistic minimum safe budgeted establishment, ensuring staffing levels are aligned to patient need while remaining operationally sustainable.

At North Tees and Hartlepool, this analysis has been informed through triangulation of Safer Nursing Care Tool (SNCT) outputs, professional judgement reviews, nurse-sensitive indicators, workforce metrics, patient experience data. Collectively, this has enabled a comprehensive assessment of staffing need, workforce sustainability and patient safety risk across the organisation.

The review demonstrates that North Tees & Hartlepool NHS Foundation Trust continues to generally deliver safe patient care through robust governance arrangements, strong nursing leadership and effective daily staffing oversight. Established processes including twice-daily safe staffing reviews using rostering and Safe Care Live systems, clear escalation and safe staff redeployment processes, and senior nursing oversight, provide assurance that staffing risks are identified, monitored and managed in real time. The review also demonstrates that the Trust has maintained compliance with the key principles of Developing Workforce Safeguards (2018) and National Quality Board guidance using evidence-based workforce tools, professional judgement and systematic triangulation of staffing, quality and workforce information.

However, the triangulated findings consistently identify several services where current staffing models are under increasing pressure, with staffing requirements that continue to exceed the current funded establishments. The review concludes that the mitigations in place are increasingly being used to compensate for consistent workforce pressures.

In summary, the review identified that:

- Patient acuity and dependency remain high across multiple clinical services.
- Enhanced care demand has become a routine requirement, and demand frequently exceeds current budgeted capacity.
- Workforce sustainability remains challenged by sickness absence, maternity leave, turnover and reliance upon temporary staffing in some services.
- Several high-acuity areas continue to operate with registered nurse to patient ratios that require investment to maintain compliance with national expectations.
- Nurse-sensitive indicators demonstrate consistent patterns within the same services identified through SNCT and professional judgement reviews as presenting the greatest staffing pressures.

## 7. Main findings – Trends over time (Sep 25 to March 26)

### South Tees

For South Tees analysis of the September 2025 and March 2026 datasets demonstrates a consistent and sustained trend of high acuity driving staffing demand across the Trust, with several key themes emerging.

For Registered Nurses (RN), the overall position remains largely unchanged, with SNCT continuing to identify a significantly higher establishment requirement than both current budgeted establishments and Professional Judgement (PJ). The total variance between SNCT and budget has increased slightly from -425.23 WTE (Sept 2025) to -434.17 WTE (March 2026), indicating a worsening gap in theoretical staffing demand. Despite this, the variance between budgeted establishment and PJ has remained stable (-56.08 WTE to -55.08 WTE), demonstrating that professional judgement continues to provide a consistent and moderated view of the required establishment.

At a service level, this pattern is consistent across most CSUs:

- Medical & Emergency / GEMS and Community / CNHS continue to show the largest deficits, reflecting sustained pressure from high acuity, high activity ward environments
- DDUGs and TORPEDO (Head, Neck & Ortho equivalent) also maintain significant gaps, with minimal improvement over time
- Women & Children / Family Health remains an outlier, where SNCT suggests a lower requirement than budgeted establishment, reflecting differing acuity profiles and care models

For Care Support Workers (CSW), the overall position shows slight improvement but continues to reflect unmet demand. The SNCT deficit has reduced marginally from 126.68 WTE (Sept 2025) to 123.32 WTE (March 2026), suggesting minor progress in aligning support worker capacity to patient nursing dependency. However, the variance between budget and PJ remains relatively consistent (-20.37 WTE to -19.37 WTE), indicating that underlying workforce gaps persist within budgeted establishments.

At a service level:

- Community / CNHS and GEMS show the largest and increasing CSW gaps, aligning with rising patient dependency and enhanced care demand
- Some areas demonstrate improved alignment, including Cardiovascular and Neurosciences, where variances remain relatively stable
- Women & Children / Family Health continue to show a surplus or reduced requirement, reflecting lower dependency models

Across both staff groups, actual staffing levels have increased between periods, particularly for RNs (826.91 WTE to 843.23 WTE), reflecting the impact of proactive recruitment strategies. However, this has not been sufficient to close the gap identified, reinforcing that increases in workforce supply are being offset by rising patient acuity and complexity.

**North Tees and Hartlepool NHS Foundation Trust**

The review demonstrates that North Tees and Hartlepool NHS Foundation Trust continue to deliver safe nursing care through established workforce governance arrangements, effective senior nurse oversight and ongoing workforce mitigations. Triangulation of acuity and dependency data, workforce metrics, nurse-sensitive indicators and professional judgement confirm that current establishments remain broadly aligned to service need across many clinical services.

However, the review identified several services experiencing sustained workforce pressure associated with increasing patient acuity, dependency, enhanced care demand and workforce fragility. These pressures were most evident within Family Health, Digestive Health, Trauma and Orthopaedics, Cardiovascular, General Medicine, Neurosciences and Neighbouring Health, where multiple sources of evidence consistently identified increased workforce risk and reduced workforce resilience.

Within Family Health, the review identified a requirement for an additional 1.96 WTE Band 5 Registered Nurses within the Special Care Baby Unit to support compliance with British Association of Perinatal Medicine standards and maintain resilience within the neonatal workforce.

Within Digestive Health, Urology and General Surgery, professional judgement supports the addition of 5.62 WTE Band 5 Registered Nurses and 6.10 WTE Band 3 Clinical Support Workers into the Surgical Decisions Unit establishment to provide sufficient workforce capacity to safely deliver both inpatient and Same Day Emergency Care activity.

Within Trauma and Orthopaedics, increased patient dependency, enhanced care demand and complex discharge requirements support the addition of 7.60 WTE Band 5 Registered Nurses and 6.40 WTE Band 3 Clinical Support Workers into the Ward 32 establishment and 3.52 WTE Band 5 Registered Nurses and 0.72 WTE Band 3 Clinical Support Workers into the Ward 33 establishment. This will improve workforce resilience and reduce reliance on temporary staffing.

Within Cardiovascular Services, the review proposed the addition of 8.17 WTE Band 5 Registered Nurses into Ward 29 in the main to support a supernumerary telemetry coordinator role, strengthen specialist clinical oversight and improve the safety and consistency of telemetry monitoring.

Within General Medicine, the Respiratory Support Units demonstrated sustained high levels of patient acuity and Level 2 activity. Professional judgement recommends an addition of 2.97 WTE Band 5 Registered Nurses within Ward 24 and 3.97 WTE Band 5 Registered Nurses within Ward 25 to maintain the agreed nurse-to-patient ratios, strengthen workforce resilience and reduce reliance on temporary staffing.

Within Neurosciences, the review identified that the current establishment does not support a supernumerary Stroke Coordinator role. Professional judgement supports the addition of 6.47 WTE Band 5 Registered Nurses within Ward 41, to support compliance with national stroke standards and ensure coordination responsibilities are not routinely absorbed within direct patient care.

Within Neighbouring Health, Wards 40 and 42 continue to care for highly dependent frail patients with significant enhanced care and complex discharge requirements. Professional judgement proposes the addition of 4.63 WTE Band 5 Registered Nurses and 5.09 WTE Band 3 Clinical Support Workers within Ward 40, and 5.12 WTE Band 5 Registered Nurses and 5.73 WTE Band 3 Clinical Support Workers within Ward 42, to improve workforce

resilience, support timely discharge planning, strengthen delivery of enhanced care and reduce reliance on temporary staffing.

Whilst current staffing arrangements continue to maintain patient safety, the review identified reliance upon temporary staffing, enhanced care provision and operational workforce mitigations within several high-acuity services. These findings indicate that workforce sustainability risks remain within several clinical areas and will require ongoing monitoring through established workforce governance arrangements.

The findings of this review will continue to inform workforce planning, service development and future establishment reviews, with a comprehensive University Hospitals Tees Nurse Establishment Review scheduled for September/October 2026 and presentation to Board in January 2027.

**Overall Trend Summary**

- Sustained and increasing gap between SNCT and funded establishments
- Stable Professional Judgement position, providing a consistent, moderated benchmark
- Incremental improvements in actual staffing, though insufficient to close demand gap
- Ongoing pressure concentrated in acute, medical, and community services

These trends demonstrate that, while workforce supply has improved, demand continues to outpace capacity, reinforcing the need for continued focus on workforce growth, skill mix optimisation, and service redesign as part of the Group model.

## 8. RESIDUAL RISKS

The following risks remain, despite current mitigations and will continue to impact service resilience unless targeted investment is approved.

**Risk 1 – Increasing Patient Acuity and Dependency**

At both sites rising acuity and dependency continue to increase demand on nursing capacity.

**Risk 2 – Enhanced Care Demand**

At North Tees enhanced care activity frequently exceeds substantive workforce capacity, placing sustained pressure on staffing and maintains significant temporary staffing use and associated costs.

**Risk 3 – Workforce Sustainability**

Sickness, turnover, maternity leave and recruitment challenges continue to affect resilience and increase reliance on temporary staffing in relation to Care Support Workers.

**Risk 4 – Reliance on Temporary Staffing**

At both sites temporary staffing remains essential but impacts continuity, stability and financial sustainability.

**Risk 5 – Sustainability of Workforce Mitigations**

At both sites current mitigations (redeployment and escalation) are effective but not sustainable long-term substitutes for substantive capacity.

The findings of this review should also be considered alongside the NHS 10yr health plan and the continued shift towards care being delivered closer to home. Whilst future transformation may influence workforce requirements, current in-patient demand, patient acuity and dependency, and enhanced care needs continue to require planned nursing establishments to deliver safe and sustainable care.

## 10. GOVERNANCE AND ASSURANCE

### Professional Assurance Statement

Based on the evidence presented, it is the professional judgement of the senior nursing leadership team that:

- University Hospitals Tees is currently able to provide safe nursing care through governance arrangements, strong nursing leadership and effective workforce mitigations.
- Operational workforce oversight will be strengthened at UHT with Clinical Matron chair of safecare processes 12hrs daily inclusive of weekends.
- Overall, the findings confirm the need for further review of workforce models as services consolidate and align within CSUs prior to advising where further investment or redistribution of resource has the potential to be required.
- Without targeted intervention or workforce remodelling, the organisation is likely to experience increasing reliance on temporary staffing, reduced workforce resilience and challenges in meeting future patient demand, potentially impacting patient safety and experience.

This bi-annual nurse establishment review provides assurance that University Hospital Tees continues to apply a robust, triangulated approach to workforce planning, aligned with national guidance and best practice. The Safer Nursing Care Tool (SNCT), professional judgement, quality indicators and workforce metrics demonstrate a consistently high-acuity inpatient population, reinforcing the need for staffing establishments that reflect patient dependency rather than bed numbers alone.

The review highlights a managed and proactive approach to Registered Nurse workforce planning, with intentional over-recruitment of newly qualified nurses to mitigate vacancies and maintain safe staffing. In contrast, shortages within the Clinical Support Worker workforce have been identified, with targeted recruitment actions now in place. Differences between SNCT outputs, professional judgement and funded establishments are recognised and are being actively managed within the context of available resources and operational realities.

Overall, the Trust can be assured that effective systems, governance processes and professional oversight are in place to support safe, high-quality patient care. Further

assurance will be strengthened through the planned 2026 SNCT data collection commencing in September, peer review, and subsequent UHT establishment reviews.

The review concludes that, while current staffing arrangements remain safe, they are increasingly reliant on workforce mitigations to manage rising levels of patient acuity, dependency and enhanced care needs. Targeted workforce investment or workforce remodelling remains the most proportionate approach to maintaining safe and sustainable nursing care.

## 11. RECOMENDATIONS TO BOARD

The Board is asked to note that, whilst current staffing arrangements remain safe, they are dependent on workforce mitigations to manage rising levels of patient acuity, dependency and enhanced care requirements in highlighted areas.

That a further full workforce review will take place with data collection commencing in September 2026, followed by a UHT nursing establishment and service model review in November 2026. Together, this process will identify service redesign opportunities, validate workforce requirements, and inform a sustainable workforce strategy.

That workforce models will remain agile whilst horizontal integration aligns, services are consolidated wherever possible and workforce models reflect the requirements.

## Authors

**Debi McKeown**
**South Tees NHS Foundation Trust**
**Nursing Workforce Lead**

**Emma Roberts**
**North Tees NHS Foundation Trust**
**Associate Director of Nursing and Professional Workforce**

## APPENDICES

**Appendix 1** South Tees Nursing Workforce Establishment Reviews by Collaborative including SNCT Results compared to Agreed Funded Establishment and Professional Judgement

**Appendix 2** North Tees SNCT, Nursing Workforce, Safety and Quality and Professional Judgement data/narrative templates per CSU.

**Appendix 3** South Tees - Front Sheet SNCT Outcomes vs Actual Staffing with HON Comments

**Appendix 4** Front Sheet SNCT Outcomes vs Current Budget North Tees

**Appendix 5** North Tees and Hartlepool - Developing Workforce Safeguards gap analysis

**Appendix 6** The Triangulated Review Process

**Appendix 1**

NHS University Hospitals Tees

## South Tees Nursing Workforce Establishment Reviews by Collaborative

Using the data gathered in the SNCT audit for March/April 2026 and Professional Judgement template assessment, the overall summary indicates whether the Collaborative is optimally staffed against the SNCT criteria or not. Helping to identify the areas requiring further workforce planning and support.

**Contents**

1. CSU 5: Cardiovascular Services

2. CSU 2: Digestive Health, Urology and General Surgery Services

3. CSU 10: Community and Neighbourhood Health Services
   3.1 Friarage Hospital & H&R Community Services
   3.2 Tees Community
   3.3 James Cook Site – Older Persons Medicine

4. CSU 3: Trauma and Orthopaedics, Reconstructive and Plastic Surgery, ENT and OMFS, Dermatology and Ophthalmology Services

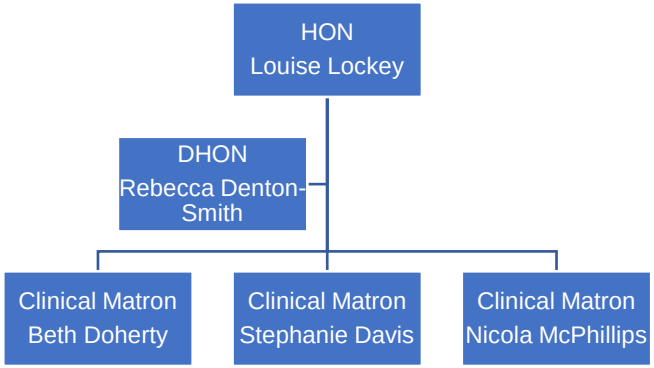
5. CSU 6: Cancer Institute

6. CSU 8: General and Emergency Medical Services

7. CSU 9: Neuroscience Services

8. CSU 1: Family Health Services

## 1. CSU 5: Cardiovascular Services




### 2.4 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Cardiovascular Care Services

**Table 3** below presents the average bed occupancy across the CSU during March 2026, which stood at 90.86%. The skill mix for this care setting comprised 60% Registered Nurses (RNs) and 40% Clinical Support Workers (CSWs).

**Workforce Budget vs. Professional Judgement**

- Registered Nurses (RNs):
  - Budgeted WTE: 97.89 WTE
  - Professional Judgement Requirement: 100.27 WTE
  - Deficit: 2.38 WTE
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 52.00 WTE
  - Professional Judgement Requirement: 53.63 WTE
  - Deficit: 1.63 WTE

**SNCT Tool Analysis**

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

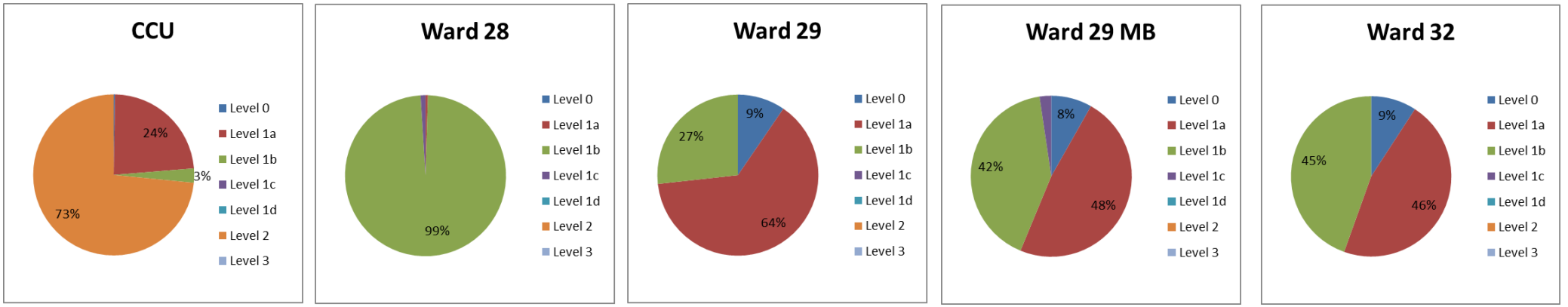
- RN Budget Deficit: 20.32 WTE
- CSW Budget Surplus: 6.52 WTE

**Table 3:** Cardiovascular Care Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

| | | | | RN | | | | | | CSW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Bed Management | | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT RN | Variance | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT CSW | Variance | |
| Ward | Bed Capacity | No of Patients Mar 26 | % Occupancy | Budget RN WTE *includes WM | Mar 26 Contracted RN WTE *includes WM | Required RN WTE *includes WM | Trust Headroom 21% | Excess or deficit (-) SNCT against the **Current Budget** | RN Variance **Budget to PJ** | Budget CSW WTE | Mar 26 Contracted RN WTE *includes WM | Required CSW WTE | Trust Headroom 19.7% (including 1c&1d) | Excess or deficit (-) SNCT against the **Current Budget** | CSW Variance Budget to PJ |
| **CCU** | 14 | 12.80 | 91.43% | 34.90 | 35.68 | 32.52 | 21.03 | 13.87 | 2.38 | 1.94 | 2.16 | 2.68 | 8.09 | -6.15 | -0.74 |
| **Ward 28** | 30 | 27.13 | 90.44% | 17.30 | 21.00 | 21.68 | 39.09 | -21.79 | -4.38 | 18.10 | 17.19 | 18.77 | 15.04 | 3.06 | -0.67 |
| **Ward 29** | 27 | 24.43 | 90.49% | 18.67 | 22.52 | 18.97 | 26.28 | -7.61 | -0.30 | 13.90 | 10.56 | 13.41 | 10.11 | 3.79 | 0.49 |
| **Ward 29 MB** | 9 | 8.53 | 94.81% | 10.93 | 8.84 | 10.84 | 9.88 | 1.05 | 0.09 | 5.16 | 5.20 | 5.36 | 3.80 | 1.36 | -0.20 |
| **Ward 32** | 21 | 18.87 | 89.84% | 16.09 | 19.80 | 16.26 | 21.93 | -5.84 | -0.17 | 12.90 | 11.48 | 13.41 | 8.44 | 4.46 | -0.51 |
| **Totals** | **101** | **91.77** | **90.86%** | **97.89** | **107.84** | **100.27** | **118.21** | **-20.32** | **-2.38** | **52.00** | **46.59** | **53.63** | **45.48** | **6.52** | **-1.63** |

## 1.2 Patient Acuity and Dependency Scores for Cardiovascular Services by Ward

**Figure 2:** Patient Acuity and Dependency scores during the audit period broken down by percentage




## 1.3 Cardiovascular activity and patient harms recorded during the audit period

**Table 4:** Activity and Patient Harms by Ward for March 2026

| Ward | Admissions | Discharges | Transfers in | Transfers Out | Ward Attenders | Deaths | Escorts on site | Escorts off Site | No of Patients requiring 1:1 care | No of Patients requiring Level 2 | New or Deteriorating PU 2's (inpatient) | New or deteriorating PU 3's (inpatient) | Medication Incidents | Falls | Complaints | Inpatient Survey |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **CCU** | 107 | 56 | 27 | 28 | 0 | 4 | 82 | 0 | 10 | 13 | | | | | | |
| **Ward 28** | 41 | 72 | 50 | 13 | 0 | 2 | 4 | 0 | 0 | 0 | 1 | | | 6 | 1 | |
| **Ward 29** | 71 | 117 | 80 | 36 | 0 | 1 | 21 | 0 | 0 | 1 | 1 | | 1 | 1 | 1 | |
| **Ward 29 MB** | 28 | 31 | 25 | 9 | 1 | 1 | 10 | 0 | 2 | 8 | | | | | | |
| **Ward 32** | 94 | 83 | 106 | 98 | 25 | 0 | 2 | 0 | 0 | 1 | | | 1 | | 1 | |

## 1.4 Head of Nursing Comments and Actions – Louise Lockey

**Ward 29 –** The SNCT recommendation of RN to HCSW for the ward reflects the requirement for the acuity on ward 29 ST. The challenge of sickness and vacancy impacts the shift-to-shift numbers currently. Ward 29 has 5 WTE over budget with NQN and NA, and is carrying 2 WTE HCAs vacancies. The HCSW is crucial to support the safe patient care at night when there is an increased

risk of falls. Explore role of floor coordinator for a 36 bedded ward, to support the flow throughout the department and coordinate the ACS transfers as currently coordinator for CCU and Cath lab flow only.

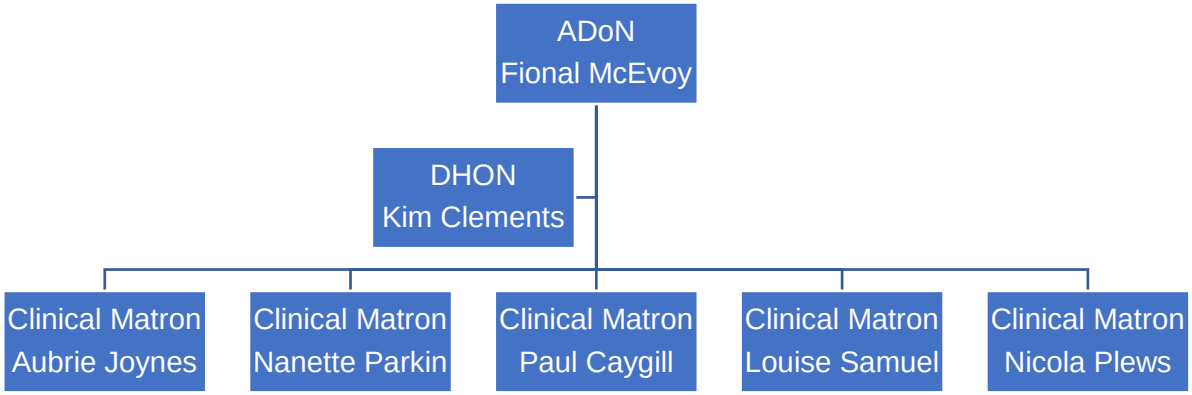
**Ward 29 Monitored Bay –** Staffing establishment is at the correct levels. We cannot reduce the number of RN's as suggested as we currently only have 2 Nurses for 9 patients and require a HCA around the clock for support and to ensure telemetry is monitored and alarms responded to.

**Ward 28 –** Based on the current footprint and high acuity of level 1 b patients the staffing establishment should remain the same on a day shift with a firm argument to revisit the stretch and extremis numbers for the ward, as these numbers are currently the same and teams running therefore on extremis predominantly. Revisit to Increase numbers to 4 RNs on a night as they currently struggle due to patient acuity and complex vascular, diabetic foot /ankle, amputee, mobility compromises, the risk of fall to patient ration is high due to this patient group. A further RN/ HCSW would provide increased ability to review patients and perform skin integrity checks and enable prompt reporting of deterioration. . The percentage of level 1B captures the number of patients with complex wounds that takes a considerable amount of time, and numbers of amputee patients who require the assistance of 2 or more nursing team members.

**Ward 32 –** SNCT supports the need for an additional RN on nights, due to patient acuity and post-operative acuity, medication requirements and rehabilitation of CT patients with ERACs program. The SNCT demonstrates a need for increased HCSW support for a night would support. The ward 32 staffing does not represent its teams roles as 0.8 WTE of a RN and 0.8 WTE of an HCSW of this workforce is required to deliver PAC weekly which depletes the ward staffing and increases the need for NHSP.

**CCU** – The SCNCT data is not suitable to represent a level 2 environment. It is a challenge to determine the exact need on CCU using the SNCT tool due to the level of patient acuity in this area. The audit tool is not fit for purpose for this level of acuity and the responsiveness required to leave the unit for emergency care provision outreaching (cath labs, cardiac arrest bleep).

## 2. CSU 2: Digestive Health, Urology and General Surgery Services




### 2.4 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Digestive Diseases, Urology and General Surgery

During March 2026, the average bed occupancy across this CSU was 89.28%. The skill mix for this care setting remained at 60% Registered Nurses (RNs) and 40% Care Support Workers (CSWs).

**Workforce Budget vs. Professional Judgement**

- Registered Nurses (RNs):
  - Budgeted WTE: 64.89 WTE
  - Professional Judgement Requirement: 85.82 WTE
  - Deficit: 20.93 WTE
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 70.17 WTE
  - Professional Judgement Requirement: 68.94 WTE
  - Surplus: 1.23 WTE

**SNCT Tool Analysis**

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

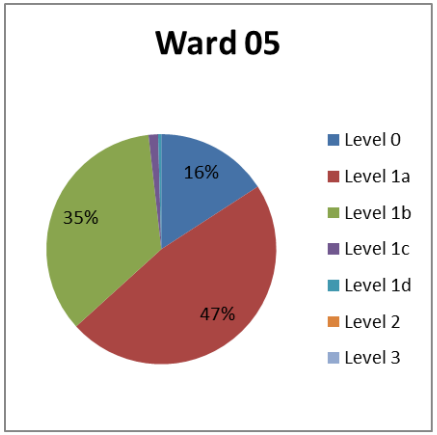
- RN Budget Deficit: 56.62 WTE
- CSW Budget Surplus: 23.43 WTE

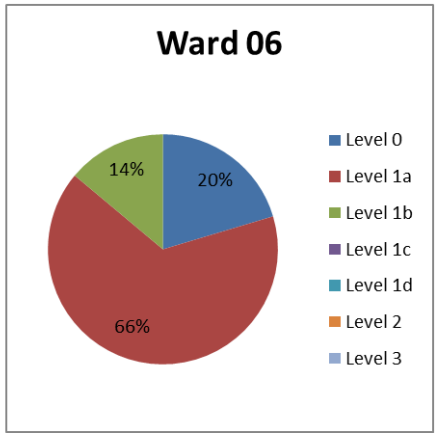
**Table 5:** DHUGS Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

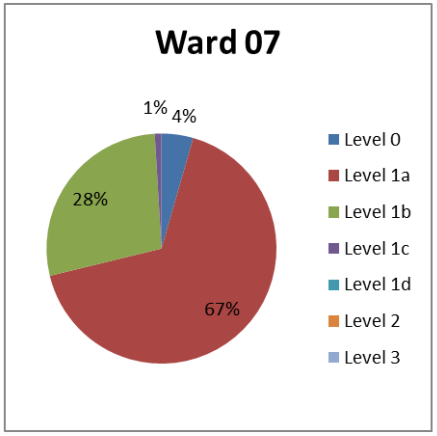
| | | | | RN | | | | | | CSW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Bed Management | | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT RN | Variance | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT CSW | Variance | |
| Ward | Bed Capacity | No of Patients Mar 26 | % Occupancy | Budget RN WTE *includes WM | Mar 26 Contracted RN WTE *includes WM | Required RN WTE *includes WM | Trust Headroom 21% | Excess or deficit (-) SNCT against the **Current Budget** | RN Variance **Budget to PJ** | Budget CSW WTE | Mar 26 Contracted RN WTE *includes WM | Required CSW WTE | Trust Headroom 19.7% | Excess or deficit (-) SNCT against the **Current Budget** | CSW Variance Budget to PJ |
| **Ward 05** | 31 | 29.87 | 96.34% | 16.39 | 21.97 | 20.78 | 32.97 | -16.58 | -4.39 | 20.31 | 16.05 | 17.99 | 12.68 | 7.63 | 2.32 |
| **Ward 06** | 29 | 23.23 | 80.11% | 15.78 | 18.92 | 21.68 | 25.50 | -9.72 | -5.90 | 14.74 | 13.93 | 13.41 | 9.81 | 4.93 | 1.33 |
| **Ward 07** | 31 | 28.47 | 91.83% | 15.46 | 23.68 | 21.68 | 31.28 | -15.82 | -6.22 | 17.06 | 16.80 | 18.77 | 12.03 | 5.03 | -1.71 |
| **Ward 08** | 30 | 26.47 | 88.22% | 17.26 | 23.92 | 21.68 | 31.76 | -14.50 | -4.42 | 18.06 | 13.80 | 18.77 | 12.22 | 5.84 | -0.71 |
| **Totals** | **121** | **108.03** | **89.28%** | **64.89** | **88.49** | **85.82** | **121.51** | **-56.62** | **-20.93** | **70.17** | **60.58** | **68.94** | **46.74** | **23.43** | **1.23** |

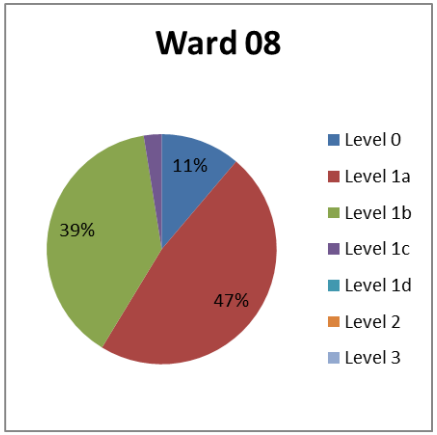
## 2.2 Patient Acuity and Dependency Scores for DDUGs by Ward

**Figure 3:** Patient Acuity and Dependency scores during the audit period broken down by percentage




2.3

## DHUGS activity and patient harms recorded during the audit period

**Table 6:** Activity and Patient Harms by Ward for March 2026

| Ward | Admissions | Discharges | Transfers in | Transfers Out | Ward Attenders | Deaths | Escorts on site | Escorts off Site | No of Patients requiring 1:1 care | No of Patients requiring Level 2 | New or Deteriorating PU 2's (inpatient) | New or deteriorating PU 3's (inpatient) | Medication Incidents | Falls | Complaints | Inpatient Survey |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward 05 | 58 | 112 | 104 | 57 | 2 | 10 | 109 | 4 | 1 | 3 | | | 1 | 6 | 1 | |
| Ward 06 | 42 | 247 | 344 | 242 | 0 | 0 | 60 | 3 | 1 | 0 | | | | 3 | 3 | |
| Ward 07 | 72 | 141 | 108 | 41 | 1 | 0 | 32 | 2 | 1 | 1 | 1 | | 7 | 1 | 4 | |
| Ward 08 | 116 | 154 | 156 | 84 | 0 | 1 | 46 | 4 | 16 | 0 | 4 | | 1 | 3 | 1 | |

## 2.4 Head of Nursing Comments and Actions – Fiona McEvoy

### Ward 5 - Gastroenterology

This is a 31 bedded ward with an occupancy level of 96.34% and with high acuity/dependency levels. The patients on this area often need a full MDT approach to their care involving the Consultants, Specialist nurses, Dieticians, Psychiatry and Clinical Psychologists. This is due to the complex nature of the patients for example the eating -disorder patients/alcohol and drug addiction. As reflective of the SNCT data it highlights an increase of Registered/Unregistered nurses to support not only this cohort of patients but the level of care required in terms of 1-1 supervision but also the patient group who are acutely unwell and can rapidly deteriorate. Therefore, it is important to consider the data above in support of requiring a higher level of registered nurse

input to reflect the overall acuity and dependency of the patients on Ward 5.
To note the CSU has been successful in securing non-recurrent funding from the ICB for 1 year for a dedicated detox bed on Ward 5 in support of improving their overall outcome and to proactively manage the disease profile. This will provide a standardised approach across UHT and provide our communities with an opportunity to improve their overall health and well- being aligned to the national profile of our catchment area in relation to health inequalities.

**Ward 6 - Short Stay Elective Unit**

This is a 29 bedded elective surgical ward and currently has an occupancy of 80.11%. As elective surgery has progressed and following GIRFT principles the move towards day case procedures has increased and therefore the requirement for overnight stays is reducing. The CSU is currently working through all the data to understand capacity and demand as in reality the figures are highlighting the increased demand for acute surgery which equates to over 50% of the bed base on Ward 6. However a full review of the bed stock is taking place within surgery to understand the requirement which will then feed into the wider discussions across the Group in terms of the overall bed modelling.

**Ward 7 – Acute Surgery**

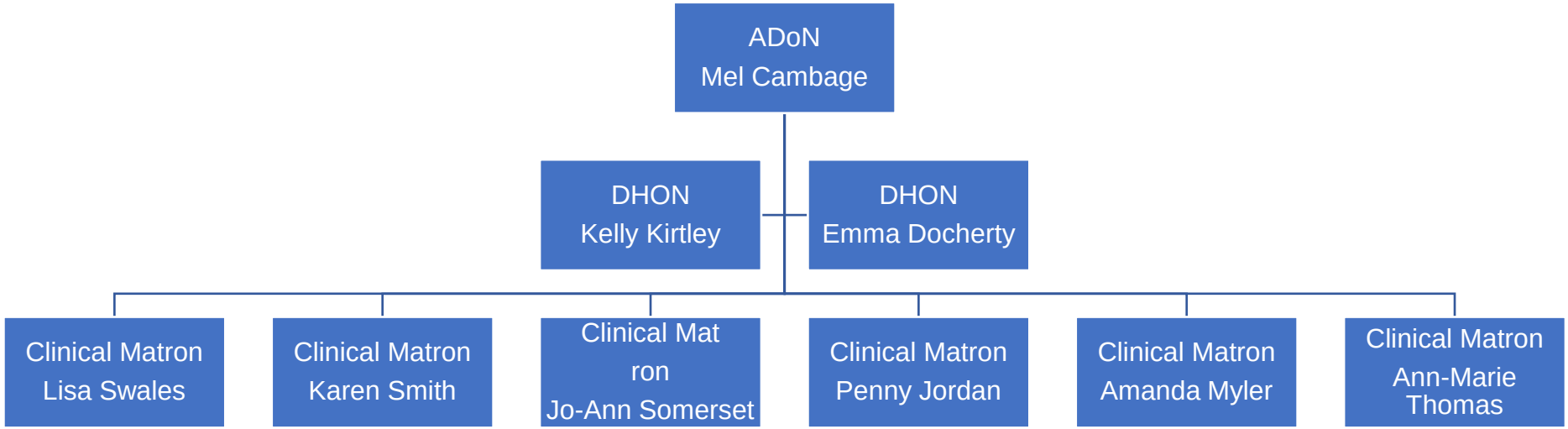
Ward 7 is a 31 bedded ward with an occupancy of 91.83% and admits complex acute and elective surgical patients, step down patients from both Critical care and PACU. This area also provides provision for complex nutritional needs, TPN, line care, chest drains and complex wound dressings. Ward 7 requires input regularly from Critical care outreach not only for the step-down patients but for patients who are acutely unwell which is reflective of their SNCT data both in September 2025 and March 2026. The SNCT data is highlighting an increased Registered nurse uplift to strengthen the skill mix in this area which is key to enable the safe care of patients within this area. To note surgical nurse staffing, in line with National Guidance Institute for Health and Care Excellence (NICE) guidance focuses on ensuring that patient needs are met through evidence -based planning rather than relying solely on fixed, mandatory ratios. However, safe surgical nurse to patient ratios commonly aims for 1:6 on an acute ward as the evidence indicates that each additional patient added to a nurse's workload increases 30-day mortality risk by 16%.The core NICE guidance (SG1) dictates that staffing should be based on acuity and dependency and NICE guidelines for level 1 surgical care (care for patients at risk of deterioration, often on a general surgical ward requiring increased support and are for escalation to Critical Care) are primarily covered under the Perioperative care in adults (NG180) and Acutely ill patients in hospital (CG50). As outlined in NICE guideline SG1: Safe staffing for nursing in adult inpatient wards in acute hospitals (NICE SG1) the ratio significantly reduces overnight despite little variation in patient activity or acuity. Therefore, to summarise there is a need to improve the skill mix based on the data, and the guidance. This will require the strengthening of the Registered nurse workforce both days and nights to enable a skill- mix uplift to 70% Registered nurse and 30% Care support worker.
There are some options we have already explored and are in the process of strengthening the skill mix by converting unregistered to registered without increased cost and headcount. Reducing the number of Nursing Associates in this area as they have limited

abilities in managing the complex patients and require guidance/support. A further option to consider is to close beds to 24 with no outliers and to ensure the area has clear identity due to the complex nature of the patients. This will support the ratios of staff required to manage the patients safely, reduce the number of complaints, CQC concerns and incidents and support the well-being of the staff. However, appreciate this will require further discussion and a collective approach across the Group and alignment to bed modelling. In summary, this area needs investment to meet safe staffing numbers and to improve their overall metrics. If there is no possibility of investment then an agreement to reduce the bed base in line with the guidance.

**Ward 8 – Acute Surgery (Urology and Gynaecology)**

Ward 8 is an acute 30 bedded ward with an occupancy of 88.2%. The ward is the acute Urology and Gynaecology but also accepts critical care steps downs, patients discharged from PACU and urology patients across the Tees Valley including patients from County Durham and Darlington. This area also accepts outliers which can impact on the elective programme, increased length of stay for patients being cared for out with Urology. Therefore, it is important we consider the bed modelling across the Group to ensure we are taking care of patients in the “right place”.
From June 2026 the area out of hours is commencing a proof of concept of accepting all acute Urology admissions after 5pm for a period of 3 months from both County Durham and Darlington and North Tees and Hartlepool. This is in support of our horizontal integration and regional direction. The workforce does not require any further investment; however, the template may require adjustment to reflect the changes.
In summary for CSU 2 the key area of concern is **Ward 7 staffing** and the need to strengthen the skill mix or consider the closure of beds in support of safe staffing.

## 3. CSU10: Community and Neighbourhood Health Services




### 3.1 Friarage Hospital & H&R Community Services

#### 3.1.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for FHN & H&R

During March 26, the average bed occupancy across this CSU was 88.53%. The standard skill mix for this care setting is 60% Registered Nurses (RNs) and 40% Clinical Support Workers (CSWs), with the exception of Romanby, which operates on a 50/50 split.

**Workforce Budget vs. Professional Judgement**

- Registered Nurses (RNs):
  - Budgeted WTE: 75.65 WTE
  - Professional Judgement Requirement: 77.92 WTE
  - Deficit: 2.27 WTE
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 71.97 WTE
  - Professional Judgement Requirement: 77.10 WTE

- Deficit: 5.13 WTE

**SNCT Tool Analysis**

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

- RN Budget Deficit: 66.68 WTE
- CSW Budget Surplus: 17.22 WTE

**Operational Considerations**

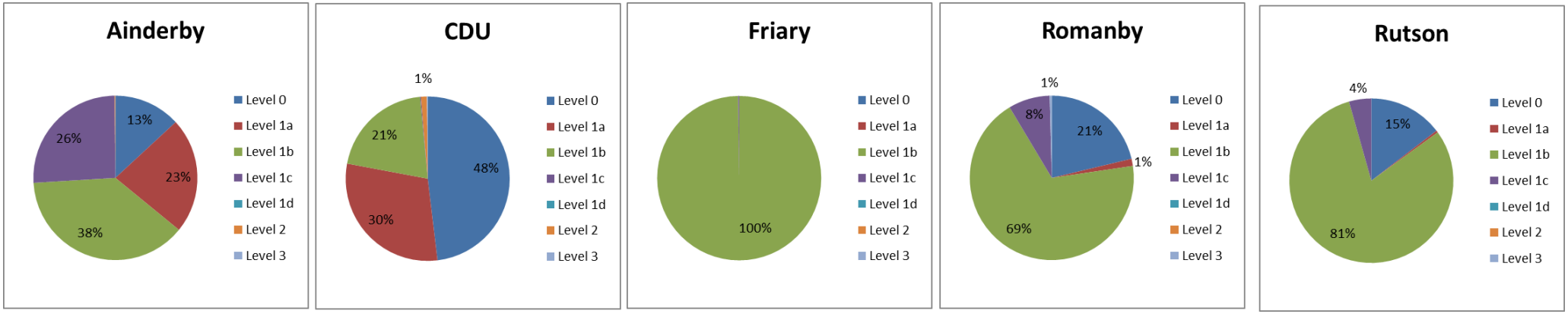
It is important to note that the Frailty and Health Needs (FHN) unit frequently absorbs the demand for enhanced patient observations, supported by therapeutic care staff and a reliance on NHS Professionals (NHSP) to fill short-notice staffing requests.

**Table 7:** FHN & H&R Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

| | | | | RN | | | | | | CSW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Bed Management | | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT RN | Variance | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT CSW | Variance | |
| Ward | Bed Capacity | No of Patients Mar 26 | % Occupancy | Budget RN WTE *includes WM | Mar 26 Contracted RN WTE *includes WM | Required RN WTE *includes WM | Trust Headroom 21% | Excess or deficit (-) SNCT against the Current Budget | RN Variance Budget to PJ | Budget CSW WTE | Mar 26 Contracted RN WTE *includes WM | Required CSW WTE | Trust Headroom 19.7% (including 1c&1d) | Excess or deficit (-) SNCT against the Current Budget | CSW Variance Budget to PJ |
| **Ainderby** | 27 | 20.80 | 77.04% | 14.87 | 15.33 | 15.58 | 37.44 | -22.57 | -0.71 | 16.10 | 15.80 | 17.99 | 14.40 | 1.70 | -1.89 |
| **CDU** | 22 | 20.10 | 91.36% | 19.39 | 18.98 | 20.78 | 26.45 | -7.06 | -1.39 | 9.36 | 8.30 | 12.85 | 10.17 | -0.81 | -3.49 |
| **Friary** | 18 | 17.03 | 94.63% | 12.97 | 11.87 | 12.99 | 23.77 | -10.80 | -0.02 | 14.84 | 12.75 | 15.42 | 9.14 | 5.70 | -0.58 |
| **Romanby** | 27 | 23.67 | 87.65% | 15.45 | 17.10 | 15.58 | 32.30 | -16.85 | -0.13 | 18.31 | 16.18 | 17.99 | 12.43 | 5.88 | 0.32 |
| **Rutson** | 17 | 16.67 | 98.04% | 12.97 | 13.93 | 12.99 | 22.37 | -9.40 | -0.02 | 13.36 | 11.79 | 12.85 | 8.61 | 4.75 | 0.51 |
| **Totals** | **111** | **98.27** | **88.53%** | **75.65** | **77.21** | **77.92** | **142.33** | **-66.68** | **-2.27** | **71.97** | **64.82** | **77.10** | **54.75** | **17.22** | **-5.13** |

### 3.1.2 Patient Acuity and Dependency Scores for FHN & H&R

**Figure 4**: Patient Acuity and Dependency scores during the audit period broken down by percentage




## 3.2 Tees Community

### 3.2.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Tees Community

During March 2026, the average bed occupancy across this CSU was 90.05%. The standard skill mix for this care setting is 60% Registered Nurses (RNs) and 40% Clinical Support Workers (CSWs).

**Workforce Budget vs. Professional Judgement**

- Registered Nurses (RNs):
  - Budgeted WTE: 38.93 WTE
  - Professional Judgement Requirement: 40.65 WTE
  - Deficit: 1.72 WTE
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 53.22 WTE
  - Professional Judgement Requirement: 56.31 WTE
  - Deficit: 3.09 WTE

**SNCT Tool Analysis**

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

- RN Budget Deficit: 43.03 WTE
- CSW Budget Surplus: 21.69 WTE

**Operational Considerations**

Both community hospitals within this collaborative are located in remote areas, with no adjacent wards available to support staffing shortfalls. Additionally:

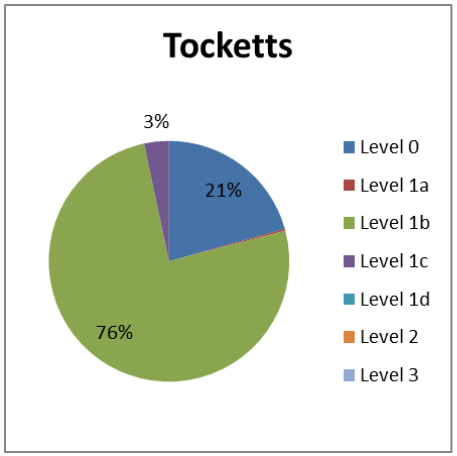
- Tocketts Ward has a layout that presents visibility challenges, necessitating increased CSW staffing to maintain patient safety.
- Zetland Ward consists entirely of single rooms, and its layout similarly requires additional CSW support to ensure safe patient care.

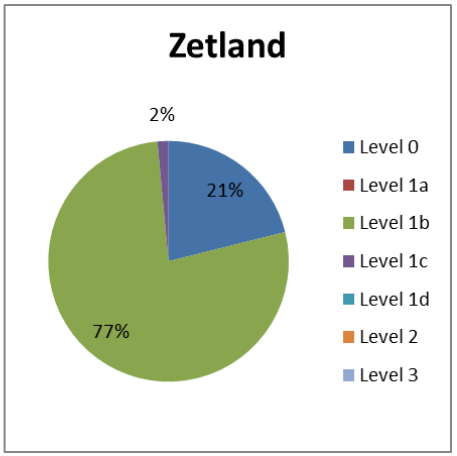
**Table 8:** Tees Community Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

| | | | | RN | | | | | | CSW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Bed Management | | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT RN | Variance | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT CSW | Variance | |
| Ward | Bed Capacity | No of Patients Mar 26 | % Occupancy | Budget RN WTE *includes WM | Mar 26 Contracted RN WTE *includes WM | Required RN WTE *includes WM | Trust Headroom 21% | Excess or deficit (-) SNCT against the Current Budget | RN Variance Budget to PJ | Budget CSW WTE | Mar 26 Contracted RN WTE *includes WM | Required CSW WTE | Trust Headroom 19.7% (including 1c&1d) | Excess or deficit (-) SNCT against the Current Budget | CSW Variance Budget to PJ |
| **Tocketts** | 30 | 28.07 | 93.56% | 16.67 | 19.45 | 18.97 | 37.07 | -20.40 | -2.30 | 23.22 | 22.79 | 24.13 | 14.26 | 8.96 | -0.91 |
| **Zetland** | 31 | 26.87 | 86.67% | 22.26 | 21.17 | 21.68 | 44.89 | -22.63 | 0.58 | 30.00 | 28.68 | 32.18 | 17.27 | 12.73 | -2.18 |
| **Totals** | **61** | **54.93** | **90.05%** | **38.93** | **40.62** | **40.65** | **81.96** | **-43.03** | **-1.72** | **53.22** | **51.47** | **56.31** | **31.53** | **21.69** | **-3.09** |

### 3.2.2 Patient Acuity and Dependency Scores for Tees Community

**Figure 5**: Patient Acuity and Dependency scores during the audit period broken down by percentage




## 3.3 Older Persons Medicine – James Cook Site

### 3.3.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Tees Community

During March 2026, the average bed occupancy across this CSU was 98.73%. The standard skill mix for this care setting is 60% Registered Nurses (RNs) and 40% Clinical Support Workers (CSWs).

**Workforce Budget vs. Professional Judgement**

- Registered Nurses (RNs):
  - Budgeted WTE: 36.13 WTE
  - Professional Judgement Requirement: 40.65 WTE
  - Deficit: 4.52 WTE
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 38.70 WTE
  - Professional Judgement Requirement: 40.22 WTE
  - Deficit: 1.52 WTE

**SNCT Tool Analysis**

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

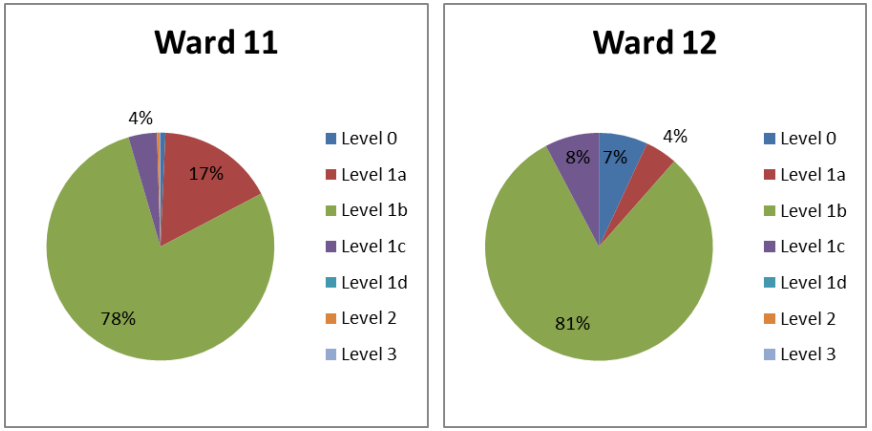
- RN Budget Deficit: 39.18 WTE
- CSW Budget Surplus: 9.73 WTE

**Table 9:** Older Persons Medicine Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

| | | | | RN | | | | | | CSW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Bed Management | | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT RN | Variance | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT CSW | Variance | |
| Ward | Bed Capacity | No of Patients Mar 26 | % Occupancy | Budget RN WTE *includes WM | Mar 26 Contracted RN WTE *includes WM | Required RN WTE *includes WM | Trust Headroom 21% | Excess or deficit (-) SNCT against the Current Budget | RN Variance Budget to PJ | Budget CSW WTE | Mar 26 Contracted RN WTE *includes WM | Required CSW WTE | Trust Headroom 19.7% (including 1c&1d) | Excess or deficit (-) SNCT against the Current Budget | CSW Variance Budget to PJ |
| **Ward 11** | 28 | 27.93 | 99.76% | 20.46 | 22.88 | 21.68 | 37.59 | -17.13 | -1.22 | 20.64 | 17.28 | 21.45 | 14.46 | 6.18 | -0.81 |
| **Ward 12** | 27 | 26.37 | 97.65% | 15.67 | 20.84 | 18.97 | 37.72 | -22.05 | -3.30 | 18.06 | 18.03 | 18.77 | 14.51 | 3.55 | -0.71 |
| **Totals** | **55** | **54.30** | **98.73%** | **36.13** | **43.72** | **40.65** | **75.31** | **-39.18** | **-4.52** | **38.70** | **35.31** | **40.22** | **28.97** | **9.73** | **-1.52** |

### 3.3.2 Patient Acuity and Dependency Scores for Older Persons Medicine

**Figure 6**: Patient Acuity and Dependency scores during the audit period broken down by percentage



## 3.4 Community and Neighbourhood Health Services activity and patient harms recorded during the audit period

**Table 10:** Activity and Patient Harms by the Wards for March 26.

| Ward | Admissions | Discharges | Transfers in | Transfers Out | Ward Attenders | Deaths | Escorts on site | Escorts off Site | No of Patients requiring 1:1 care | No of Patients requiring Level 2 | New or Deteriorating PU 2's (inpatient) | New or deteriorating PU 3's (inpatient) | Medication Incidents | Falls | Complaints | Inpatient Survey |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ainderby | 6 | 66 | 83 | 8 | 2 | 14 | 13 | 3 | 0 | 51 | 2 | | | 3 | 1 | |
| CDU | 221 | 147 | 45 | 119 | 1 | 11 | 177 | 2 | 7 | 19 | 1 | | 5 | 7 | | |
| Friary | 18 | 16 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 1 | 3 | | 3 | 6 | | |
| Romanby | 2 | 47 | 53 | 20 | 0 | 2 | 7 | 0 | 3 | 59 | 1 | | 1 | 3 | | |
| Rutson | 1 | 24 | 19 | 1 | 1 | 1 | 0 | 0 | 2 | 9 | | | | 2 | | |
| Tocketts | 36 | 30 | 31 | 0 | 9 | 3 | 0 | 12 | 20 | 10 | 3 | | 1 | 5 | 1 | |
| Ward 11 | 48 | 36 | 8 | 10 | 2 | 12 | 20 | 0 | 26 | 14 | 3 | | 2 | 6 | 1 | |
| Ward 12 | 14 | 47 | 37 | 4 | 0 | 7 | 33 | 0 | 36 | 15 | 3 | 1 | 1 | 5 | | |
| Zetland | 28 | 24 | 0 | 5 | 7 | 1 | 5 | 4 | 25 | 11 | 1 | | 2 | 4 | | |

## 3.5 Head of Nursing Comments and Actions – Mel Cambage

**Ainderby ward (FHN) –** This is a 27 bed ward with frail and complex medical patients and is managing effectively with a ratio of 4 RN +4 CSW. When not in winter pressures the ward is open to 22 beds and runs at a ratio of 4+4 through the day and 2+3 overnight. When the ward is at full capacity of 27 beds an additional RN overnight is required to deliver safe patient care and this ratio is 3+3 overnight. This ward currently supports surgical pathway day case procedures which are incorporated into the bed base. Future plans include a sit out area for patients who follow a surgical pathway for day care support which would not increase RN requirements.

**Clinical Decision Unit (FHN) –** This is a 22 bedded admission ward for medical patient admissions, including telemetry patients. There is not a requirement for an increase in RN or HCA establishment in this area.

**Victoria ward (The Friary Hospital Richmond) –** This ward is based in a remote area with no internal support structures, the current staffing ratios are effective at delivery of safe care.

**Romanby ward (FHN) –** This 27 bedded medical ward is providing safe care within the current establishment. Outside of winter pressures the ward is open to 22 beds and delivers safe patient care with the staffing at 4+4 throughout the day and 2+3 overnight. When the ward is open to full capacity of 27 beds, to deliver safe care overnight the ratio is increased to 3+3.

**Rutson Ward –** is a 17 bedded primary care rehabilitation ward with 10 stroke beds and 7 general rehab beds. This ward is ensuring safe care with the current establishment. This ward does not increase beds over the winter period and therefore to deliver safe patient care it works within the staffing of 3+3 throughout the day and 2+2 overnight. However, consideration to stroke guidance in relation to dependency of patients and increase in workforce recommended.

The Staffing establishment for FHN does not take into account that the Band 7's and some 6's have to carry the site management 627 bleep from 4pm to 8pm on weekdays and 8am to 8pm on weekends. This is currently under review within the FHN business continuity planning.

**Zetland Ward (Redcar Primary Care Hospital) –** This 31 bedded rehabilitation ward provides care in single side rooms. This is the reason that SNCT recommends a decrease in HCSWs, however the estate is very problematic and has a difficult footprint being a H shape, thus reducing visibility and due to the risk to patients in this side room layout there should not be a reduction to HCSW workforce. In addition, the ward has 16 stroke rehabilitation beds and 15 older persons medicine beds and due to the dependency of this group of patients. The requirement for HCSW is necessary and the ward is ensuring safe care with the current HCSW establishment albeit below the recommendations of the national stroke guidance published in 2023. However, this ward would benefit by an increase of RN workforce to ensure ability to maintain 5RN + 8HCSW throughout the day and 3RN + 4HCSW overnight.

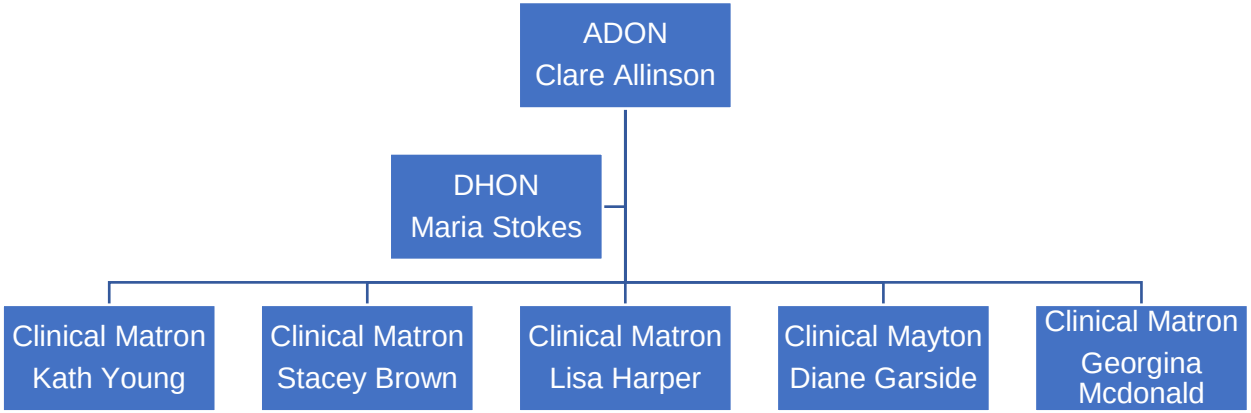
**Tocketts Ward (East Cleveland Hospital) –** This 30 bedded rehabilitation ward has 20 older persons medicine beds and 10 GP beds. The layout of the ward is problematic and due to the footprint reduces visibility and due to this risk to patients there should not be a reduction to HCSW workforce. The nurse-to-patient ratio when fully established provides safe care to the patients. The recommendations from SNCT do not match the patient need as a reduction in HCSW would not be appropriate due to the dependency of the patients on this older person's medicine ward. However, this ward would benefit from an increase of RN workforce to ensure ability to maintain 4RN + 5HCSW during the day and 3RN + 4HCSW overnight.

**Ward 11 Older Peoples Medicine –** This 28 bedded ward looks after older adults with physical dependency, multiple co-morbidities, clinical frailty, and high requirements for 1-1 observation for both behaviours and psychological symptoms of dementia, delirium and falls prevention. There is a high percentage for patients being scored as 1b, therefore indicative of a need to increase the RN workforce to ensure the ability to maintain 5RN + 4HCSW throughout the day and 3RN + 3HCSW overnight.

**Ward 12 –** This 27 bedded ward looks after older adults with physical dependency, multiple co-morbidities, clinical frailty, and high requirements for 1-1 observation for both behaviours and psychological symptoms of dementia, delirium and falls prevention. There

is a high percentage for patients being scored as 1b. In addition, this ward has a very similar patient group and SNCT results to reflect as per ward 11, however the establishment of RN's is less than ward 11. Therefore, indicative of a need to increase the RN workforce of 1 RN per day shift. This would enable ward 12 to function with 5RN + 4HCSW throughout the day and 3RN + 3HCSW overnight.

## 4. CSU 3: Trauma and Orthopaedics, Reconstructive and Plastic Surgery, ENT and OMFS, Dermatology and Ophthalmology Services




### 4.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for TORPEDO

During March 2026, the average bed occupancy across this CSU was 78.89%. The standard skill mix for this care setting is 60% Registered Nurses (RNs) and 40% Clinical Support Workers (CSWs), with the exception of Ward 25, which operates on a 50/50 split.

**Workforce Budget vs. Professional Judgement**

- Registered Nurses (RNs):
  - Budgeted WTE: 82.27 WTE
  - Professional Judgement Requirement: 91.02 WTE
  - Deficit: 8.75 WTE
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 71.69 WTE
  - Professional Judgement Requirement: 71.51 WTE
  - Surplus: 0.18 WTE

**SNCT Tool Analysis**

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

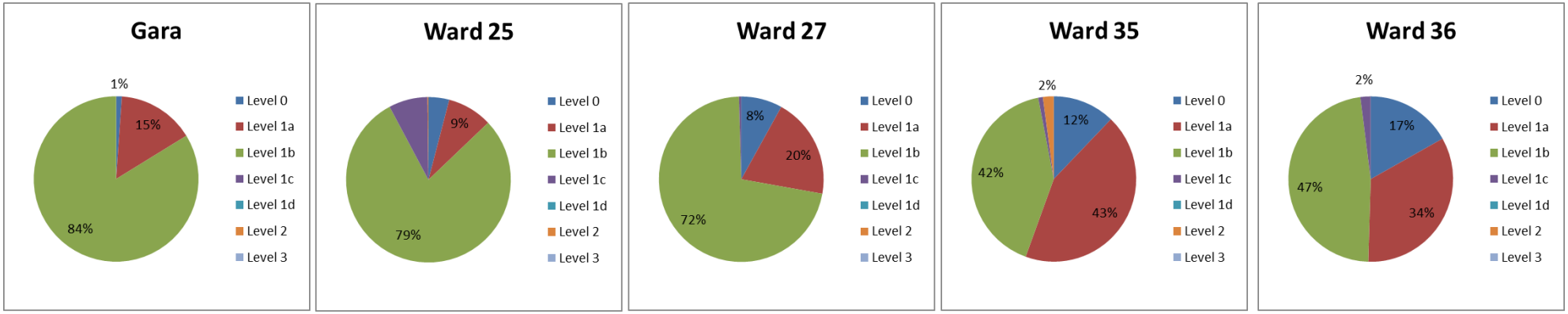
- RN Budget Deficit: 60.71 WTE
- CSW Budget Surplus: 16.68 WTE

**Table 11:** TORPEDO Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

| | | | | RN | | | | | | CSW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Bed Management | | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT RN | Variance | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT CSW | Variance | |
| Ward | Bed Capacity | No of Patients Mar 26 | % Occupancy | Budget RN WTE *includes WM | Mar 26 Contracted RN WTE *includes WM | Required RN WTE *includes WM | Trust Headroom 21% | Excess or deficit (-) SNCT against the **Current Budget** | RN Variance **Budget to PJ** | Budget CSW WTE | Mar 26 Contracted RN WTE *includes WM | Required CSW WTE | Trust Headroom 19.7% | Excess or deficit (-) SNCT against the **Current Budget** | CSW Variance Budget to PJ |
| **Gara** | 21 | 11.90 | 56.67% | 11.97 | 13.91 | 12.99 | 21.61 | -9.64 | -1.02 | 10.89 | 7.80 | 10.28 | 8.31 | 2.58 | 0.61 |
| **Ward 25** | 21 | 19.63 | 93.49% | 18.67 | 18.80 | 18.97 | 34.76 | -16.09 | -0.30 | 12.90 | 11.03 | 13.41 | 13.37 | -0.47 | -0.51 |
| **Ward 27** | 15 | 7.43 | 49.56% | 10.97 | 14.95 | 12.99 | 14.39 | -3.42 | -2.02 | 9.89 | 8.37 | 10.28 | 5.54 | 4.35 | -0.39 |
| **Ward 35** | 26 | 21.90 | 84.23% | 19.78 | 22.28 | 21.68 | 35.09 | -15.31 | -1.90 | 17.37 | 13.48 | 18.77 | 13.50 | 3.87 | -1.40 |
| **Ward 36** | 34 | 31.43 | 92.45% | 20.88 | 23.48 | 24.39 | 37.13 | -16.25 | -3.51 | 20.64 | 14.56 | 18.77 | 14.29 | 6.35 | 1.87 |
| **Totals** | **117** | **92.30** | **78.89%** | **82.27** | **93.42** | **91.02** | **142.98** | **-60.71** | **-8.75** | **71.69** | **55.24** | **71.51** | **55.01** | **16.68** | **0.18** |

## 4.2 Patient Acuity and Dependency Scores for TORPEDO

**Figure 7**: Patient Acuity and Dependency scores during the audit period broken down by percentage



### 4.3 TORPEDO activity and patient harms recorded during the audit period

**Table 12:** Activity and Patient Harms by Ward for March 26

| Ward | Admissions | Discharges | Transfers in | Transfers Out | Ward Attenders | Deaths | Escorts on site | Escorts off Site | No of Patients requiring 1:1 care | No of Patients requiring Level 2 | New or Deteriorating PU 2's (inpatient) | New or deteriorating PU 3's (inpatient) | Medication Incidents | Falls | Complaints | Inpatient Survey |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Gara | 147 | 139 | 2 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | | | | 1 | | |
| Ward 25 | 64 | 29 | 17 | 42 | 0 | 3 | 74 | 11 | 27 | 14 | 1 | | 4 | 2 | | |
| Ward 27 | 30 | 55 | 32 | 2 | 55 | 0 | 42 | 0 | 0 | 0 | | | | | | |
| Ward 35 | 134 | 139 | 74 | 57 | 0 | 2 | 5 | 0 | 15 | 1 | | | 1 | | 1 | |
| Ward 36 | 144 | 119 | 61 | 75 | 2 | 1 | 0 | 0 | 10 | 2 | 1 | | 13 | | | |

### 4.4 Head of Nursing Comments and Actions – Clare Allinson

**Gara (FHN)** – 21 bedded in patient elective ring-fenced orthopaedic ward, based at the Friarage site. Working collaboratively with the Surgical Hub, accommodating day case/day zero patients. Average number of patients over the month of March 2026 was 7.48 (BIU data). The ward worked at a general ratio of 3 RNs & 2 CSWs days and 2 RNs & 2 CSWs nights. No patient safety incidents reported during this period. Currently over established on RNs due to accommodating NQN and a RTP student. Under on HCAs due to maternity leave. There is a CSU 3 focused piece of work around elective hub work and increasing the activity coming through the ward, which would be supported by the current staffing model.

**Ward 25 (JC)** - 21 bedded in patient hip fracture unit, based at the James Cook site, working collaboratively with the care of the elderly team. Accommodating all hip fractures that come through the site predominantly a frail, multi co-morbid and elderly population that often pose a falls risk, which in turn requires 1:1 care via a falls watch. This is not staffed from the ward establishment and requires support from NHSP requests. For the month of March 2026 the ward spent £1362 on falls watches. Average number of patients over the month of March 2026 was 19.43 (BIU data). The ward worked at a general ratio of 4 RNs & 3 CSWs days and 3 RNs & 2 CSWs nights. No patient safety incidents reported during this period. Currently under established on RNs by 0.83 and under on CSWs by 1.61 all due to maternity leave. Professional judgement would suggest the need for additional CSWs both days and nights due to the dependency and frailty of the patient group.

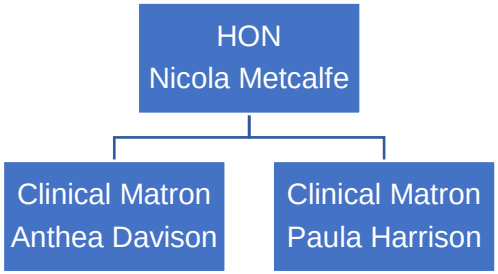
**Ward 27 (JC)** – 15 bedded in-patient green ringfenced elective orthopaedic ward based at the James Cook site. Average number of patients over the month of March 2026 was 6.97 (BIU data). The ward also accommodates up to two spinal patients at any one time

due to capacity in bed base. The ward worked at a general ratio of 3 RNs & 2 CSWs days and 2 RNs & 2 CSWs nights. No patient safety incidents reported during this period. Currently over established on RNs 2.82 WTE. Under on HCAs due to vacancy. There is a CSU 3 focused piece of work focusing on utilisation of bed base across all the sites, this in the future may suggest a reduction in workforce depending on bed base, location and capacity.

**Ward 35 (JC)** – 26 bedded in patient ward accommodating multiple specialties. It has been previously agreed that they require an additional 2.20 WTE at least twice a week to care for L2 post-op patients who require 1:1 specialist care. It has been previously agreed that OOH weekend work, the ward support patients requiring urgent plastics treatment. Agreement via the previous SLT forum, was that of an additional RN, this has never been aligned to budget. The ward is also supported by military personal, 2 WTE RNs and 1 WTE CSW, they are within the ward establishment. The military colleagues will withdraw from Ward 35 in June 2026, which leave a short fall in the additional RN ask as previously agreed. Professional judgement is to ensure recruitment into those gaps. Average number of patients over the month of March 2026 was 23 (BIU data). The ward worked at a general ratio of 5 RNs & 4 CSWs days and 3 RNs & 3 CSWs nights. No patient safety incidents reported during this period. There is ongoing work to develop an enhanced bay on Ward 35 where L2 post-op patients can be cohorted and therefore staffing aligned more efficiently and appropriately (SOP currently in development stage).

**Ward 36 MTC (JC)** - 34 bedded major trauma centre in patient ward, working collaboratively with ED, major trauma co-ordinators and surgical trauma teams. Physically demanding and often emotionally and psychologically complex patients requiring a specialist nursing skill set. The ward requires a major trauma trained nurse 24/7. The ward accommodates multiple specialties across both medical and surgical pathways. Average number of patients over the month of March 2026 was 26.1 (BIU data). The ward is also supported by military personal, 2 WTE RNs and 1 WTE CSW, they are within the ward establishment but can be re-deployed without notice. The ward worked at a general ratio of 5 RNs & 4 CSWs days and 4 RNs & 3 CSWs nights. No patient safety incidents reported during this period. Currently over established on RNs 1.92 mainly due to supporting NQN programme.

## 5. CSU 6: Cancer Institute




### 5.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Cancer Institute

During March 2026, the average bed occupancy across the CSU was 92.90%, indicating sustained demand for inpatient services. The current skill mix within this care setting comprises 60% Registered Nurses (RNs) and 40% Clinical Support Workers (CSWs).

**Workforce Budget vs. Professional Judgement**

Registered Nurses (RNs):
- Budgeted WTE: 42.52
- Professional Judgement Requirement: 43.36
- Deficit: 0.84 WTE

- Clinical Support Workers (CSWs):
  - Budgeted WTE: 23.84
  - Professional Judgement Requirement: 29.50
  - Deficit: 5.66 WTE

**SNCT Tool Analysis**

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:
- RN Budget Deficit: 12.85 WTE
- CSW Budget Surplus: 2.54 WTE

**Operational Considerations**

- Ward 14 and Ward 33 provide an out-of-hours support line aimed at admission avoidance. While beneficial, this service requires RN time, with calls ranging from 15 minutes to one hour, impacting direct patient care capacity.
- Patients undergoing chemotherapy or living with cancer require enhanced clinical oversight, including:

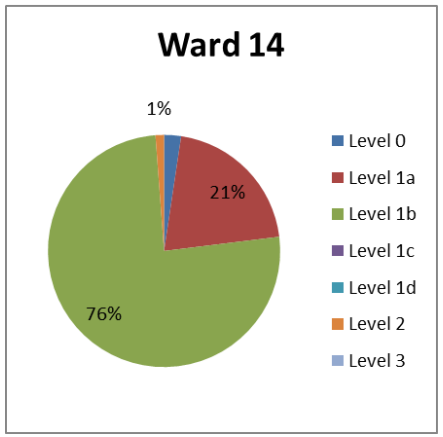
- Prolonged psychological support
- Intensive monitoring
- Complex discharge planning

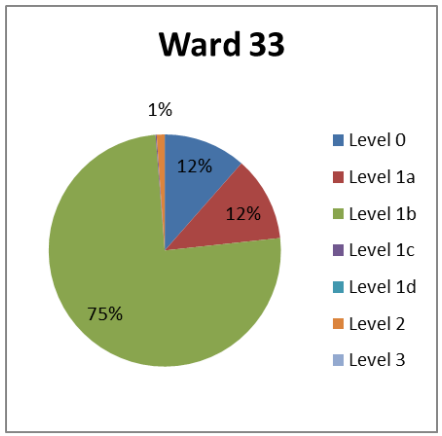
**Table 13:** JCCISM Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

| | | | | RN | | | | | | CSW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Bed Management | | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT RN | Variance | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT CSW | Variance | |
| Ward | Bed Capacity | No of Patients Mar 26 | % Occupancy | Budget RN WTE *includes WM | Mar 26 Contracted RN WTE *includes WM | Required RN WTE *includes WM | Trust Headroom 21% | Excess or deficit (-) SNCT against the **Current Budget** | RN Variance **Budget to PJ** | Budget CSW WTE | Mar 26 Contracted RN WTE *includes WM | Required CSW WTE | Trust Headroom 19.7% (including 1c&1d) | Excess or deficit (-) SNCT against the **Current Budget** | CSW Variance Budget to PJ |
| **Ward 14** | 23 | 21.83 | 94.93% | 22.26 | 23.20 | 21.68 | 28.14 | -5.88 | 0.58 | 11.94 | 12.32 | 13.41 | 10.83 | 1.11 | -1.47 |
| **Ward 33** | 23 | 20.90 | 90.87% | 20.26 | 23.52 | 21.68 | 27.23 | -6.97 | -1.42 | 11.90 | 12.96 | 16.09 | 10.48 | 1.42 | -4.19 |
| **Totals** | **46** | **42.73** | **92.90%** | **42.52** | **46.72** | **43.36** | **55.37** | **-12.85** | **-0.84** | **23.84** | **25.28** | **29.50** | **21.30** | **2.54** | **-5.66** |

## 5.2 Patient Acuity and Dependency Scores for Cancer Institute

**Figure 8**: Patient Acuity and Dependency scores during the audit period broken down by percentage




## 5.3 JCCISM activity and patient harms recorded during the audit period

**Table 14:** Activity and Patient Harms by Ward for March 2026

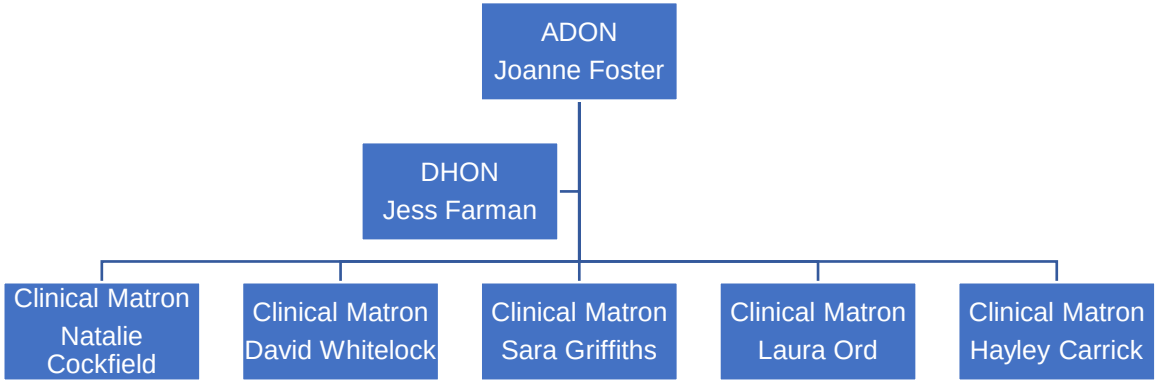
| Ward | Admissions | Discharges | Transfers in | Transfers Out | Ward Attenders | Deaths | Escorts on site | Escorts off Site | No of Patients requiring 1:1 care | No of Patients requiring Level 2 | New or Deteriorating PU 2's (inpatient) | New or deteriorating PU 3's (inpatient) | Medication Incidents | Falls | Complaints | Inpatient Survey |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Ward 14** | 77 | 89 | 13 | 9 | 14 | 4 | 58 | 2 | 8 | 0 | 2 | 4 | 2 | 3 | 1 | |
| **Ward 33** | 61 | 71 | 32 | 13 | 37 | 3 | 58 | 0 | 4 | 0 | 2 | | 3 | 2 | | |

## 5.4 Head of Nursing Comments and Actions – Nicola Metcalfe

**Ward 14 Oncology –** No change to establishment is required. Ward 14 offers a telephone support line at nights and weekends for patients requiring oncology advice as per UKONS guidance. It was expected additional HCA support recommendation given the complexities of EOLC patients and complexities of pain management and syringe drivers.

**Ward 33 Haematology –** Ward 33 offers a telephone support line at nights and weekends for patients requiring haematology advice as per UKONS guidance. The British Society for Haematology staffing guidance for patients who are neutropenic is a ratio of 1:4, the agreed ward staffing on ward 33 is 1:5 during the day and 1:8 during the night as not all patients on the ward are neutropenic, therefore a requirement to increase nurse staffing is recommended.

## 6. CSU 8: General and Emergency Medical Services




### 6.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for GEMS Admissions Units

During March 2026, the average bed occupancy across the CSU reached **97.85%**, reflecting a consistently high demand for inpatient care.

The current skill mix for this care setting is composed of **70% Registered Nurses (RNs)** and **30% Clinical Support Workers (CSWs)**, aligning with the complexity and acuity of patient need.

**Workforce Budget vs. Professional Judgement**

- Registered Nurses (RNs):
  - Budgeted WTE: 91.16
  - Professional Judgement Requirement: 94.85
  - Deficit: 3.69
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 64.50
  - Professional Judgement Requirement: 67.03
  - Deficit: 2.53

**SNCT Tool Analysis**

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

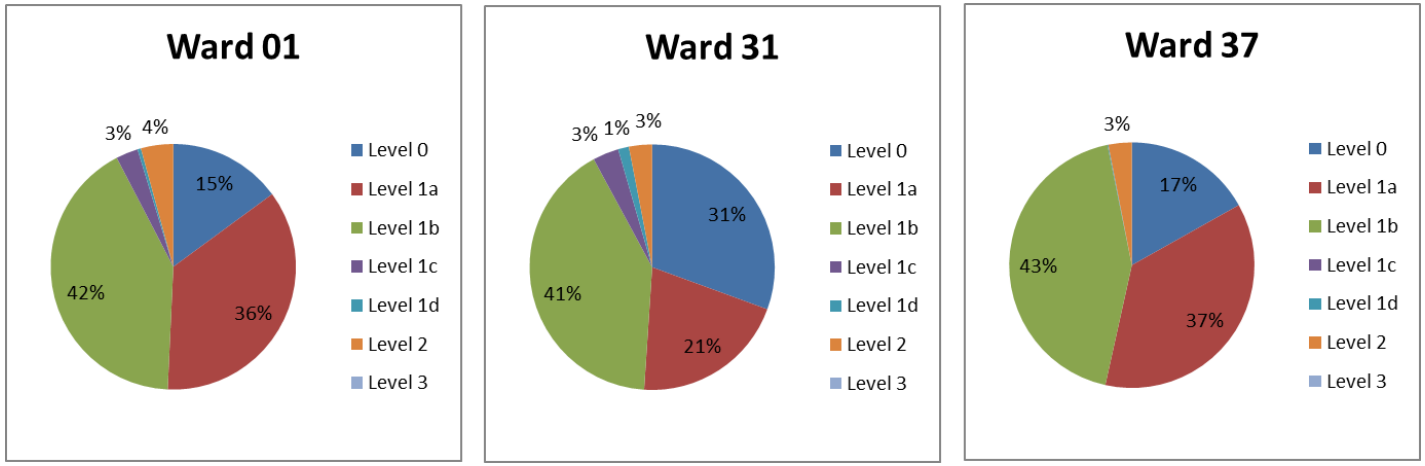
- RN Budget Deficit: 44.65
- CSW Budget Surplus: 12.25

**Table 15:** Admissions Units Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

| | | | | RN | | | | | | CSW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Bed Management | | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT RN | Variance | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT CSW | Variance | |
| Ward | Bed Capacity | No of Patients Mar 26 | % Occupancy | Budget RN WTE *includes WM | Mar 26 Contracted RN WTE *includes WM | Required RN WTE *includes WM | Trust Headroom 21% | Excess or deficit (-) SNCT against the Current Budget | RN Variance Budget to PJ | Budget CSW WTE | Mar 26 Contracted RN WTE *includes WM | Required CSW WTE | Trust Headroom 19.7% | Excess or deficit (-) SNCT against the Current Budget | CSW Variance Budget to PJ |
| **Ward 01** | 31 | 29.70 | 95.81% | 31.58 | 34.48 | 32.52 | 44.02 | -12.44 | -0.94 | 20.64 | 22.28 | 21.45 | 16.93 | 3.71 | -0.81 |
| **Ward 31** | 35 | 35.00 | 100.00% | 28.00 | 28.76 | 29.81 | 51.13 | -23.13 | -1.81 | 23.22 | 24.37 | 24.13 | 19.67 | 3.55 | -0.91 |
| **Ward 37** | 30 | 29.23 | 97.44% | 31.58 | 33.60 | 32.52 | 40.66 | -9.08 | -0.94 | 20.64 | 20.40 | 21.45 | 15.64 | 5.00 | -0.81 |
| **Totals** | **96** | **93.93** | **97.85%** | **91.16** | **96.84** | **94.85** | **135.81** | **-44.65** | **-3.69** | **64.50** | **67.05** | **67.03** | **52.25** | **12.25** | **-2.53** |

## 6.2 Patient Acuity and Dependency Scores for GEMS Admissions Units

**Figure 12**: Patient Acuity and Dependency scores during the audit period broken down by percentage




## 6.3 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for GEMS Acute Inpatient Wards

During March 2026 the bed occupancy across this CSU was an average of 95.75%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs.

**Workforce Budget vs. Professional Judgement**

- Registered Nurses (RNs):
  - Budgeted WTE: 87.91
  - Professional Judgement Requirement: 94.86
  - Deficit: 6.95
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 47.89
  - Professional Judgement Requirement: 59.00
  - Deficit: 11.11

**SNCT Tool Analysis**

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

- RN Budget Deficit: 63.95
- CSW Budget Deficit: 10.53

**Operational Considerations**

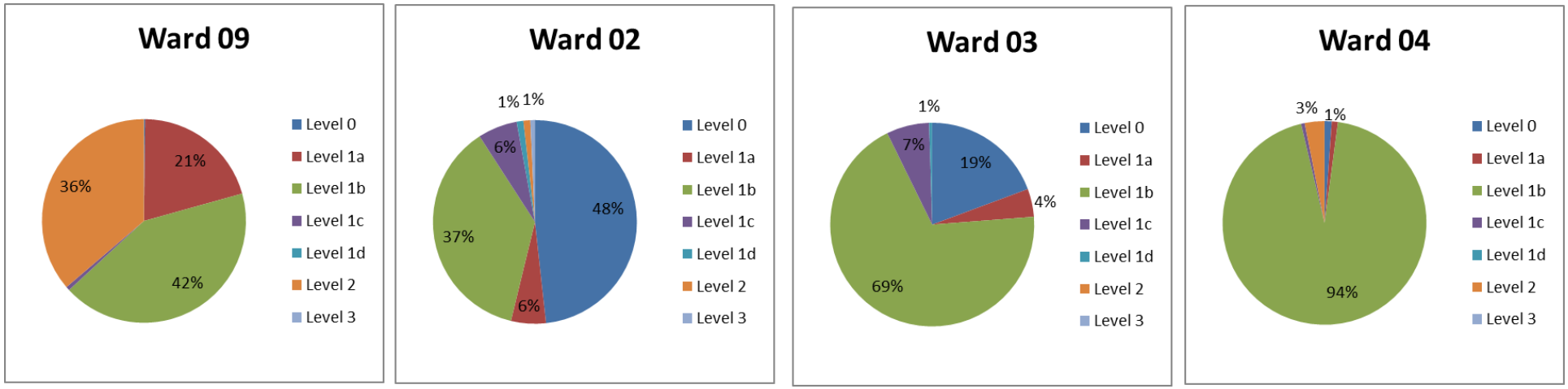
To note ward 9 has x 2 Respiratory Support Unit bays requiring 1:2 staffing for the first 24hrs of BIPAP and ward 3 multispecialty assessment ward.

**Table 16:** GEMS AIW Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

| | | | | RN | | | | | | CSW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Bed Management | | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT RN | Variance | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT CSW | Variance | |
| Ward | Bed Capacity | No of Patients Mar 26 | % Occupancy | Budget RN WTE *includes WM | Mar 26 Contracted RN WTE *includes WM | Required RN WTE *includes WM | Trust Headroom 21% | Excess or deficit (-) SNCT against the Current Budget | RN Variance Budget to PJ | Budget CSW WTE | Mar 26 Contracted RN WTE *includes WM | Required CSW WTE | Trust Headroom 19.7% | Excess or deficit (-) SNCT against the Current Budget | CSW Variance Budget to PJ |
| **Ward 02** | 30 | 27.77 | 92.56% | 16.92 | 23.13 | 18.97 | 34.72 | -17.80 | -2.05 | 13.36 | 11.53 | 13.41 | 13.36 | 0.00 | -0.05 |
| **Ward 03** | 28 | 27.07 | 96.67% | 18.23 | 18.51 | 18.97 | 36.96 | -18.73 | -0.74 | 12.75 | 11.23 | 13.41 | 14.22 | -1.47 | -0.66 |
| **Ward 04** | 24 | 23.50 | 97.92% | 22.36 | 22.36 | 21.68 | 32.40 | -10.04 | 0.68 | 11.94 | 12.00 | 16.09 | 12.46 | -0.52 | -4.15 |
| **Ward 09** | 34 | 32.73 | 96.27% | 30.40 | 32.44 | 35.24 | 47.78 | -17.38 | -4.84 | 9.84 | 14.40 | 16.09 | 18.38 | -8.54 | -6.25 |
| **Totals** | **116** | **111.07** | **95.75%** | **87.91** | **96.44** | **94.86** | **151.86** | **-63.95** | **-6.95** | **47.89** | **49.16** | **59.00** | **58.42** | **-10.53** | **-11.11** |

## 6.4 Patient Acuity and Dependency Scores for GEMS Acute Inpatient Wards

**Figure 13:** Patient Acuity and Dependency scores during the audit period broken down by percentage




## 6.5 GEMS activity and patient harms recorded during the audit period

**Table 17:** Activity and Patient Harms by Ward for March 2026

| Ward | Admissions | Discharges | Transfers in | Transfers Out | Ward Attenders | Deaths | Escorts on site | Escorts off Site | No of Patients requiring 1:1 care | No of Patients requiring Level 2 | New or Deteriorating PU 2's (inpatient) | New or deteriorating PU 3's (inpatient) | Medication Incidents | Falls | Complaints | Inpatient Survey |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Ward 01** | 640 | 171 | 242 | 450 | 18 | 11 | 343 | 1 | 18 | 12 | 1 | | 6 | | | |
| **Ward 02** | 71 | 51 | 35 | 18 | 0 | 6 | 54 | 3 | 9 | 15 | | | 1 | 2 | | |
| **Ward 03** | 17 | 94 | 99 | 21 | 0 | 11 | 44 | 0 | 16 | 41 | | | 2 | 4 | 1 | |
| **Ward 04** | 65 | 86 | 58 | 42 | 17 | 2 | 79 | 7 | 8 | 0 | 2 | | | 6 | | |
| **Ward 09** | 104 | 75 | 6 | 7 | 33 | 13 | 242 | 0 | 10 | 11 | 3 | 1 | 2 | 1 | 1 | |
| **Ward 31** | 343 | 349 | 2 | 6 | 25 | 4 | 318 | 7 | 23 | 11 | | | 2 | 6 | | |
| **Ward 37** | 613 | 269 | 103 | 319 | 100 | 7 | 946 | 228 | 16 | 6 | | | 4 | 7 | | |

### 6.6 Head of Nursing Comments and Actions – Jo Foster

**Ward 1 (located on Ward 2 for 10 months) Assessment Unit –** Takes direct admissions from the Emergency Department. There is a high activity level on Ward 1 with high numbers of admissions, discharges, and internal transfers / escorts recorded. In addition to the agreed bed base, the ward has patients waiting for admission via ambulance or with family in a dedicated area. The professional judgement recommends an additional 2 nurses to support the high level of acuity and dependency associated with this area of nursing. The ward has 24-hour supernumerary co-ordination due to the numbers of admissions and discharges. In addition, a designated nurse with ALS skills holds the cardiac arrest bleep 24 hours a day and must be able to leave immediately to attend emergency calls off the ward. Ward 1 will also provide care to patients requiring RSU level care (enhanced care of 1:4 ratio)

**Ward 37 Female Assessment Unit –** It takes direct admissions from the Emergency Department and via GP's. There is a high activity level on Ward 37 with high numbers of admissions, discharges, and internal transfers / escorts recorded. In addition to the agreed bed base the ward has patients waiting admission via ambulance or with family in a dedicated area. The professional judgement recommends an additional 2 nurses to support the high level of acuity and dependency associated with this area of nursing. The ward has 24-hour supernumerary co-ordination due to the numbers of admissions and discharges. In addition, a designated nurse with ALS skills holds the cardiac arrest bleep 24 hours a day and must be able to leave immediately to attend emergency calls off the ward. Ward 37 will also provide care to patients requiring RSU level care (enhanced care of 1:4 ratio)

**Ward 31 Short Stay –** Professional judgement and actual staffing are appropriate for Ward 31; no change is required.

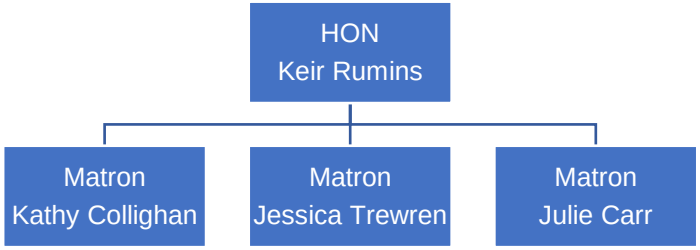
**Ward 3 Infectious Diseases –** No change is required, as the SNCT recommendation has included the CMD unit which no longer functions on Ward 3.

**Ward 9 Respiratory -** is a 34 bedded respiratory ward. The ward footprint includes 10 ring fenced beds that are used for patients requiring high levels of respiratory support split over 2 bays and 2 siderooms, offering dedicated male and female beds. The ward footprint is large, and this is challenging to manage as there is often a requirement to provide additional respiratory support in side rooms. All RSU beds require British Thoracic Society recommended level 2 nurse to patient ratios (1:2 – 1:4) and this is reflected in the wards funded establishment. In winter the ward's activity, acuity and dependency predictably increase. SNCT and professional judgement both indicate a requirement to increase RN and HCA numbers in this area. This is reflective of the patient need.

**Ward 2(Currently located on ward 10 for 2 years) –** SNCT recommendations exceeds the requirement of staffing required to provide safe care. The ward has an increase in patients with a higher level of acuity during the collection period. This is not a reflection of usual activity across a full year.

**Ward 4 Renal –** Whilst the nursing establishment currently provides safe care, the need to increase HCAs has been reflected in professional judgement and SNCT outcomes. Ward 4 offers a telephone support line at night and weekends for patients requiring Nephrology advice this includes renal transplantation open access. Ward 4 also delivers a vascular access service, which requires the assistance of a HCA with the procedure I would support the additional HCA for this as it has never been factored in the establishment, we also have a higher risk of falls due to the patient group and the value for a third HCA overnight would be safer care.

## 7. CSU 9: Neuroscience Services




### 7.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Neuroscience Services

During March 2026 the bed occupancy across this CSU was an average of 84.20%. The skill mix ratio for this care setting is 60% RNs to 40% HCAs except for ward 26 which was 50/50.

**Workforce Budget vs. Professional Judgement**

- Registered Nurses (RNs):
  - Budgeted WTE: 92.36
  - Professional Judgement Requirement: 94.85
  - Deficit: 2.49
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 70.12
  - Professional Judgement Requirement: 67.04
  - Surplus: 3.08

**SNCT Tool Analysis**

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

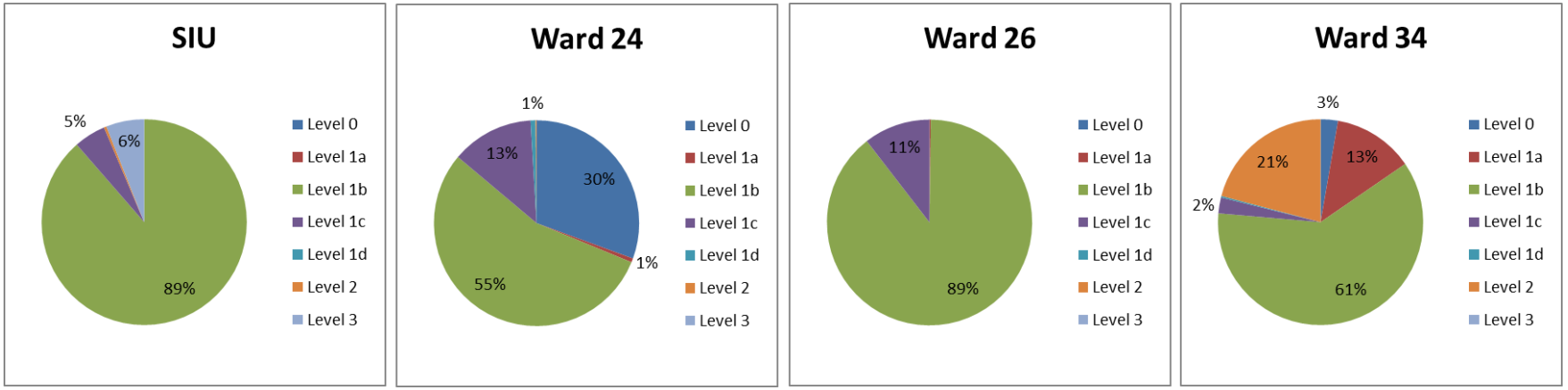
- RN Budget Deficit: 43.13
- CSW Budget Surplus: 18

**Table 18:** Neuroscience Services Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

| | | | | RN | | | | | | CSW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Bed Management | | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT RN | Variance | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT CSW | Variance | |
| Ward | Bed Capacity | No of Patients Mar 26 | % Occupancy | Budget RN WTE *includes WM | Mar 26 Contracted RN WTE *includes WM | Required RN WTE *includes WM | Trust Headroom 21% | Excess or deficit (-) SNCT against the **Current Budget** | RN Variance **Budget to PJ** | Budget CSW WTE | Mar 26 Contracted RN WTE *includes WM | Required CSW WTE | Trust Headroom 19.7% | Excess or deficit (-) SNCT against the **Current Budget** | CSW Variance Budget to PJ |
| **SIU** | 24 | 16.63 | 69.31% | 29.60 | 32.72 | 29.81 | 32.00 | -2.40 | -0.21 | 24.22 | 21.32 | 21.45 | 12.31 | 11.91 | 2.77 |
| **Ward 24** | 23 | 21.37 | 92.90% | 19.67 | 19.36 | 18.97 | 31.10 | -11.43 | 0.70 | 13.90 | 12.84 | 13.41 | 11.96 | 1.94 | 0.49 |
| **Ward 26** | 19 | 18.13 | 95.44% | 13.51 | 15.08 | 13.55 | 28.24 | -14.73 | -0.04 | 12.90 | 13.48 | 13.41 | 10.87 | 2.03 | -0.51 |
| **Ward 34** | 34 | 28.07 | 82.55% | 29.58 | 34.84 | 32.52 | 44.14 | -14.56 | -2.94 | 19.10 | 23.44 | 18.77 | 16.98 | 2.12 | 0.33 |
| **Totals** | **100** | **84.20** | **84.20%** | **92.36** | **102.00** | **94.85** | **135.49** | **-43.13** | **-2.49** | **70.12** | **71.08** | **67.04** | **52.12** | **18.00** | **3.08** |

## 7.2 Patient Acuity and Dependency Scores for Neuroscience Services

**Figure 14**: Patient Acuity and Dependency scores during the audit period broken down by percentage



## 7.3 Neuroscience Services activity and patient harms recorded during the audit period

**Table 19:** Activity and Patient Harms by Ward for March 2026

| Ward | Admissions | Discharges | Transfers in | Transfers Out | Ward Attenders | Deaths | Escorts on site | Escorts off Site | No of Patients requiring 1:1 care | No of Patients requiring Level 2 | New or Deteriorating PU 2's (inpatient) | New or deteriorating PU 3's (inpatient) | Medication Incidents | Falls | Complaints | Inpatient Survey |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SIU | 14 | 10 | 5 | 1 | 19 | 0 | 10 | 2 | 14 | 1 | | | | 2 | | |
| Ward 24 | 33 | 73 | 73 | 30 | 20 | 0 | 26 | 0 | 40 | 63 | 1 | | | 3 | 2 | |
| Ward 26 | 2 | 5 | 7 | 3 | 0 | 0 | 2 | 0 | 10 | 44 | | | 2 | | | |
| Ward 34 | 118 | 118 | 35 | 30 | 16 | 8 | 80 | 0 | 12 | 23 | 1 | | 2 | 3 | | |

## 7.4 Head of Nursing Comments and Actions – Keir Rumins

**Ward 24 –** There has been an ongoing requirement for an increase in HCAs with a consistent additional spend on NHSP for falls and acuity, we have asked for this to be added into the budget each year however has not been realised in the budget. It is not safe to reduce NHSP spend on this ward for HCSW however the number of RNS in budget is appropriate.

**Ward 26 –** The data suggests the ward would benefit from an increase in RN establishment which on reflection within CSU9 we feel an increase in CSW would be preferable aligned with the data and experiences for the ward. We have requested an increase year on year for CSW on this ward due to the number of patients requiring 1-1 level care due to the risk of falls and cognitive problems, again unable to reduce NHSP spend due to the requirement to maintain safety currently.

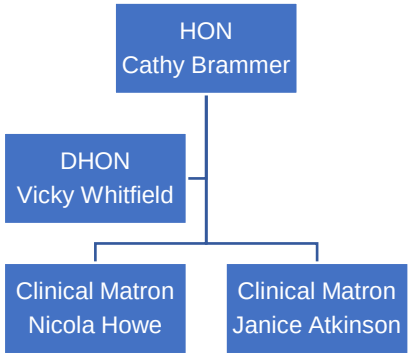
**Ward 34 -** Ward 34 is a 34 bedded NASU including a 6 bedded hyper acute stroke bay and 1 thrombolysis side ward. The remaining beds are a combination of Acute Strokes and Neurology patients and 2 telemetry beds Monday to Friday which are constantly monitored by a CSW with the beds used for sleep studies on a weekend. As a combined ward, there is a requirement to increase both RNs and HCAs to ensure that safe care is provided across the ward and monitored bay area. The monitored bay requires an increase in RN's to 3 day and nights which is not being achieved currently/budgeted, due to patient acuity and being a level 2 facility. In addition, the nurses spend a significant amount of time away from the ward with emergency admissions having diagnostics as part of the pathway for example. Although SNCT recommends a further uplift the investment requested here would be adequate. CSU 9 are currently working through a stroke pathway UHT redesign model which looks at both national, SNCT and both hyperacute and acute staffing ratios to work towards.

**Spinal injuries –** As a regional spinal injury unit, the unit should be commissioned for 1 RN and 1 HCA per 4 patients with a supernumerary coordinator for the ward during the day with 3 RNs overnight. The Spinal HDU should be 2 RNs days and night with an CSW. The recommendations from professional judgement and SNCT for SHDU. However, the reduction in the number of CSW wouldn't allow the spinal injuries unit to run safely and patient care and safety would not be maintained at the levels if reduced to

SNCT figures. The CSW figures are not capturing the level of support and care that is required for this type of injury day to day/night. National piece of SNCT work underway also to feedback.

Overall the focus of the areas looks at the increase in the numbers of both RN including level 1C and D and CSW should be represented in the CSW column which are justified through the data and professional judgement and recent CSU reviews.

## 8. CSU 1: Family Health Services – Paediatrics




### 8.1 Professional Judgement WTE vs Budget WTE vs Safer Nursing Care Tool WTE for Paediatrics

During March 26 the bed occupancy across the paediatric ward areas was an average of 63.10%. The skill mix ratio for this care setting is 70% RNs to 30% HCAs.

**Workforce Budget vs. Professional Judgement**

- Registered Nurses (RNs):
  - Budgeted WTE: 50.95
  - Professional Judgement Requirement: 51.49
  - Deficit: 0.54
- Clinical Support Workers (CSWs):
  - Budgeted WTE: 22.90
  - Professional Judgement Requirement: 16.09
  - Surplus: 6.81. However, these surplus hours are filled by play support staff who appear on the HCA budget line and have a very separate, non-clinical role.

**SNCT Tool Analysis**

Using the Safer Nursing Care Tool (SNCT), the following variances were identified:

- RN Budget Surplus: 16.94
- CSW Budget Surplus: 5.80

**Operational Considerations**

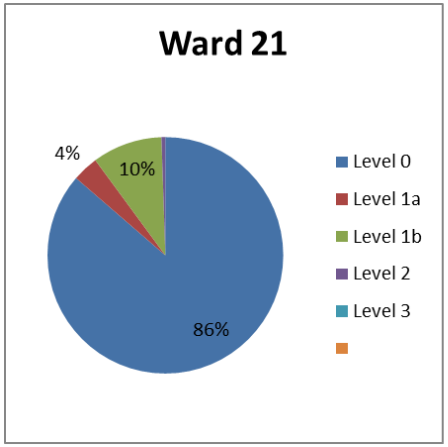
Paediatric surgery has a lot of short stay patient activity, as can be seen on ward 22 with children only staying overnight if necessary following surgery.

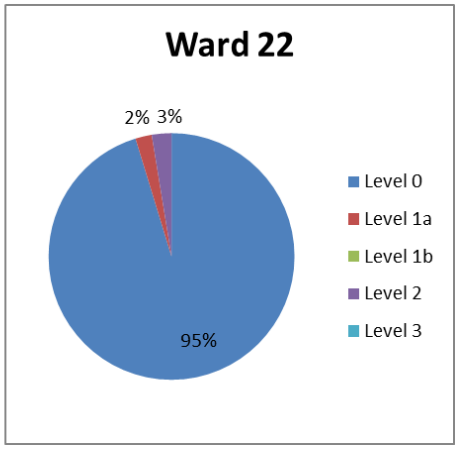
**Table 20:** Women & Children Bed Management, Professional Judgement WTE Templates compared to Agreed Funded Establishment WTE and Safer Nursing Care Tool Recommended WTE Comparison

| | | | | RN | | | | | | CSW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Bed Management | | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT RN | Variance | | Current Budget | Actual Staffing | Professional Judgement (PJ) | SNCT CSW | Variance | |
| Ward | Bed Capacity | No of Patients Mar 26 | % Occupancy | Budget RN WTE *includes WM | Mar 26 Contracted RN WTE *includes WM | Required RN WTE *includes WM | Trust Headroom 21% (including 1c&1d) | Excess or deficit (-) SNCT against the **Current Budget** | RN Variance **Budget to PJ** | Budget CSW WTE | Mar 26 Contracted RN WTE *includes WM | Required CSW WTE | Trust Headroom 19.7% (including 1c&1d) | Excess or deficit (-) SNCT against the **Current Budget** | CSW Variance Budget to PJ |
| **Ward 21** | 25 | 18.77 | 75.07% | 33.20 | 32.12 | 32.52 | 24.22 | 8.98 | 0.68 | 13.20 | 9.80 | 10.73 | 12.18 | 1.02 | 2.47 |
| **Ward 22** | 17 | 7.73 | 45.49% | 17.75 | 17.81 | 18.97 | 9.79 | 7.96 | -1.22 | 9.70 | 7.92 | 5.36 | 4.92 | 4.78 | 4.34 |
| **Totals** | **42** | **26.50** | **63.10%** | **50.95** | **49.93** | **51.49** | **34.01** | **16.94** | **-0.54** | **22.90** | **17.72** | **16.09** | **17.10** | **5.80** | **6.81** |

## 8.2 Patient Acuity and Dependency Scores for Paediatrics

**Figure 15**: Patient Acuity and Dependency scores during the audit period broken down by percentage



## 8.3 Paediatrics activity and patient harms recorded during the audit period

**Table 31:** Activity and Patient Harms by Ward for March 2026

| Ward | Admissions | Discharges | Transfers in | Transfers Out | Ward Attenders | Deaths | Escorts on site | Escorts off Site | No of Patients requiring 1:1 care | No of Patients requiring Level 2 | New or Deteriorating PU 2's (inpatient) | New or deteriorating PU 3's (inpatient) | Medication Incidents | Falls | Complaints | Inpatient Survey |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward 21 | 214 | 208 | 18 | 8 | 60 | 1 | 32 | 1 | 3 | 0 | | | | | 1 | |
| Ward 22 | 146 | 138 | 22 | 5 | 37 | 0 | 266 | 0 | 6 | 0 | | | 3 | 1 | | |

## 8.4 Head of Nursing Comments and Actions – Cathy Brammer

The data suggests a significant surplus of registered nursing staff across both wards based on bed occupancy at the time of the data collection HCA establishments would suggest being accurate when taking into consideration play staff. Bed occupancy and levels of acuity fluctuate greatly on a day-to-day basis across children and young people services. Bed occupancy on Ward 22 (children's surgery) is greatly impacted by the frequency and population of theatre lists for children and young people and this is continuing to increase but is not yet back to a level seen pre-covid. Ward 21, children's medicine sees continued higher levels of occupancy throughout October to April.

The Royal College of Nursing staffing guidance for CYP (RCN 2013) is available to benchmark staffing against and is used nationally when setting nursing establishments for CYP areas. It forms part of CQC inspection criteria when evaluating staffing establishments. This guidance stipulates a set of core standards to be applied in services providing health care for children and young people which includes a nurse-to-patient ratio of 1:3 for patients under 2 years and 1: 4 for over. NHSE&I have published a Children's safer nurse staffing framework for inpatient care in acute hospitals (NHSE&I, 2021). It also suggests a 70/ 30% ration of registered to unregistered staff rather than 66%/ 36% used above and a headroom of 25% as opposed to the Trusts 21%. This document identifies as a minimum; there should be a co-ordinating nurse on each shift who is supernumerary. Further guidance published by the Association of British Paediatric Nursing in September 2025 reinforces RCN guidance and suggests higher headroom of 27% (Standards for safe staffing in Children and Young Peoples wards and departments, ABPN, 2025)

There is a general perception that children always have carers present however this is not an accurate reflection of reality. Children in general are a vulnerable patient group who are unable to be left unsupervised due to their age and development. Parents and carers often also need a high level of support, education and reassurance. There has been a noticeable increase in the number of young people admitted requiring mental health/ social care support with increased pressure on inpatient mental health beds locally and nationally. These patients need an enhanced level of care and support.

Staffing within neonatal and all paediatric areas including PCCU and CYPED is reviewed on a daily basis and reallocated as needed, as due to the skill set, help cannot be sourced from any other areas of the Trust. Due to this, NHSP spend across paediatrics and neonates is minimal.

**Actions**

- Continue to review staffing on a 6 monthy basis in line with NHSI workforce Safeguards
- Promote robust data entry particularly in relation to day case/ ward attender patients
- Review staffing as part of group model and streamline any efficiencies

## Appendix 2

Ward 15

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (70/30) | Recommended CSW (WTE) (70/30) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 15 | Oct-25 | 20 | 20 | 9.54 | 1.43 | 7.06 | 0.00 | 0.00 | 1.97 | 0.00 | 36.08 | 70/30 | 43.34 | 30.34 | 13.00 | 0.29 | -7.26 |
| Ward 15 | Mar-26 | 20 | 20 | 6.40 | 5.40 | 6.60 | 0.00 | 0.00 | 1.60 | 0.00 | 36.08 | 70/30 | 44.50 | 31.15 | 13.35 | 3.63 | -8.42 |
| Average | - | 20.00 | 20.00 | 7.97 | 3.41 | 6.83 | 0.00 | 0.00 | 1.79 | 0.00 | 36.08 | - | 43.92 | 30.75 | 13.18 | 1.96 | -7.84 |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Suspected deep tissue injury (SDTI) | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 54.17 | 2.28 | 6.03 | 454 | 3.03 | 0 | 0.00 |
| Oct-25 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 72.95 | 5.15 | 6.03 | 535.75 | 3.57 | 62 | 0.41 |
| Nov-25 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 70.26 | 6.49 | 4.01 | 419.67 | 2.80 | 22.5 | 0.15 |
| Dec-25 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 70.99 | 11.92 | 5.84 | 196.5 | 1.31 | 36 | 0.24 |
| Jan-26 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 70.93 | 11.92 | 5.92 | 103.5 | 0.69 | 24 | 0.16 |
| Feb-26 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 70.14 | 11.92 | 5.92 | 40 | 0.27 | 12 | 0.08 |
| Total | 4 | 4 | 0 | 0 | 0 | 0 | 1 | 7 | 68.24 | 8.28 | 5.63 | Average | 1.94 | Average | 0.17 |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 36.08 | 25.26 | 10.82 | - | - | - |
| Total SNCT recommendation | 43.92 | 30.75 | 13.18 | -7.84 | -5.49 | -2.35 |
| Total PJ recommendation | 37.34 | 26.14 | 11.20 | -1.26 | -0.88 | -0.38 |

| Proposed RN | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| Ward Coordinator (supernumerary to meet PEWS scoring requirements) | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Assessment | 2 | 2 | 2 | 2 | 2 | 0 | 0 |
| Hartlepool | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| E/L | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| N | 4 | 4 | 4 | 4 | 4 | 4 | 4 |

| Proposed HCA | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| E/L | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| N | 2 | 2 | 2 | 2 | 2 | 2 | 2 |

plus 0.6 RN for ward manager time

**Summary**

The in-patient Paediatric ward holds a seasonal bed base and workforce model. There are 20 beds across most of the year but this increases to 26 from November through to the end of March each year to support with seasonal variations in occupancy and dependency. The role of the hospital play specialist (HPS) is well established within the Trust.

The current RN and HCA vacancy position forecast is positive and the unit is currently in an over recruited position of 2.8wte RN although at the time of this data collection they did have some vacancy posts. There is RN and HCA temporary staffing use but this tends to be their own staff via NHSP which does create a risk of staff burnout. There is zero RN agency use due to the skill set required for the area. Both RN and HCA sickness/absence levels are exceeding the 4% Trust target and headroom allocation and maternity leave is not covered with headroom and has not been backfilled.

To note that the template also provides a proportion of the staff to the assessment area (x2 RN Early shift Mon-Fri)

**Recommendations**

Est of 36.08 = Ward 15 plus Hpool (1RN one day per week) / Assessment (2RN 5 days per week)

An increase in establishment is required to meet national recommendations for safe staffing in paediatric units. This includes increasing the headroom to 27% as per RCN recommendations.

A supernumary team lead would aide the development and support of more juniour nurses and also support ability to review patients with increased PEWS scoring as per national recommendations, therefore a recommendation of 4 RN plus a supernumary team lead in addition to ward manager would support safe and quality care.

It is uncertain if the bed capacity will remain at 20 through out the year rather than previuos winter increase. The ability to flex beds and staffing to meet surge demand is essential to meet predicted seasonal variations and care being required childrens qualified RNs.

The current staffing establishment for ward 15 is also required to cover the Childrens and Young Peoples assessment unit where demand is now for 5 day week cover with 2 RN for ambulatory care, pre assessment of children for theatre and day surgery care. The establishment also covers an RN for hartlepool day surgey 1 x week, therefore establishment is not meeting the demand of the ward.

Housekeepers and play specialists have been removed from total establishment for purpose of SNCT calcs (do not provide direct patient care) but are essential to a quality paediatric service.

## Appendix 2

SCBU

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (90/10) | Recommended CSW (WTE) (90/10) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| SCBU | Oct-25 | 11 | 11 | 1.77 | 0.00 | 8.09 | 0.00 | 0.00 | 1.09 | 0.06 | 22.06 | 90/10 | 25.79 | 23.21 | 2.58 | 0 | -3.73 |
| SCBU | Mar-26 | 11 | 11 | 5.80 | 0.00 | 4.50 | 0.00 | 0.00 | 0.70 | 0.10 | 22.06 | 90/10 | 23.81 | 21.43 | 2.38 | 0 | -1.75 |
| **Average** | - | **11.00** | **11.00** | **3.79** | **0.00** | **6.29** | **0.00** | **0.00** | **0.90** | **0.08** | **22.06** | - | **24.80** | **22.32** | **2.48** | **0.00** | **-2.74** |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Suspected deep tissue injury (SDTI) | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 39.39 | 2.44 | 0.00 | 24 | 0.16 | 0 | 0.00 |
| Oct-25 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 58.65 | 4.48 | 0.00 | 60 | 0.40 | 0 | 0.00 |
| Nov-25 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 71.82 | 11.72 | 0.00 | 156 | 1.04 | 0 | 0.00 |
| Dec-25 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 55.13 | 13.00 | 0.00 | 48 | 0.32 | 3.5 | 0.02 |
| Jan-26 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 74.49 | 13.00 | 0.00 | 168 | 1.12 | 11.25 | 0.08 |
| Feb-26 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 43.18 | 13.00 | 0.00 | 132 | 0.88 | 0 | 0 |
| Total | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 68.24 | 9.61 | 0.00 | Average | 0.65 | Average | 0.02 |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 22.06 | 19.56 | 2.50 | - | - | - |
| Total SNCT recommendation | 24.80 | 22.32 | 2.48 | -2.74 | -2.76 | 0.02 |
| Total PJ recommendation | 23.91 | 21.52 | 2.39 | -1.85 | -1.96 | 0.11 |

| Proposed RN | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| Ward Coordinator (supernumerary to meet BAPM standards) | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| E/L | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| N | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Proposed HCA | M | T | W | T | F | S | S |
| E/L | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| N | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | | | | | | | |
| | | | | | | | |
| plus 0.6 RN for ward manager time | | | | | | | |

**Summary**

The special care baby unit is an 11 cot unit with a template of 3 RNs per shift . They provide level 1 Care- Special Care (BAPM Framework). Whilst at under 80% occupancy with level 1 patients the unit meets BAPM staffing framework requirements of 1 RN per 4 babies and supernumerary team lead.

When babies require a higher level of care such as level 2 (HDU) or level 3 (ITU prior to transfer) this decreases the compliance within the BAPM framework. There is an increasing level of patients requiring short term level 2 care and our occupancy has been at over 80% affecting the compliance.

Currently this non-compliance is mitigated by creating additional duties to allow an increase to 4 RN per shifts (excluding the supernumerary team lead) and is held as a risk(232) on the trsust risk register. There is a requirement to have an element of flex in the roster to allow staff to be utilised differently when babies' levels of care are escalated.

Neonatal nurses require adittional training to gain Qualification in Speciality (QIS) as a national standard . This training requires time allocated for academic work (105 hrs) and a number of supernumary hours (150) to meet criteria to pass. The number of QIS trained staff is monitored through regional and national dashboardsas an indicator of safety at the 70% staff trained.

**Recommendations**

National recommendations for headroom to ensure ability to relaese staff for QIS training is a minimum 25% but recent RCN guidance identifies 27% would be appropriate.

Consistent ability to have supernumary team lead on duty will enhance oversight and devlopment of nursing team and coordination of admissions/transfers and discharges in high risk infants and increase compliance with BAPM nursing ratio's.

Additional HCA establishment to cover 24/7 service to provide care and support to familes and newborns with lower care needs and prepare families for home.

An investment of 1.96WTE RN would support delivery of the proposed template.

## Appendix 2

**Ward 26**

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (60/40) | Recommended CSW (WTE) (60/40) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 26 | Oct-25 | 31 | 31 | 11.80 | 0.49 | 17.66 | 1.06 | 0.00 | 0.00 | 0.00 | 38.9 | 60/40 | 50.16 | 30.10 | 20.06 | 3.4 | -11.26 |
| Ward 26 | Mar-26 | 31 | 31 | 9.13 | 0.43 | 18.87 | 1.13 | 0.43 | 0.07 | 0.00 | 38.9 | 60/40 | 53.81 | 32.29 | 21.52 | 6.81 | -14.91 |
| **Average** | - | **31.00** | **31.00** | **10.47** | **0.46** | **18.26** | **1.09** | **0.22** | **0.04** | **0.00** | **38.90** | - | **51.99** | **31.19** | **20.79** | **5.11** | **-13.09** |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience<br>Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 7 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 98.49 | 6.00 | 0.00 | 234 | 1.56 | 1050.5 | 7.00 |
| Oct-25 | 6 | 2 | 1 | 3 | 0 | 0 | 0 | 1 | 99.06 | 6.90 | 0.00 | 235.5 | 1.57 | 1401 | 9.34 |
| Nov-25 | 7 | 1 | 0 | 3 | 0 | 0 | 0 | 0 | 98.39 | 8.52 | 0.00 | 326.5 | 2.18 | 1303.25 | 8.69 |
| Dec-25 | 9 | 2 | 0 | 0 | 0 | 0 | 2 | 2 | 99.81 | 2.49 | 0.00 | 195.25 | 1.30 | 1130 | 7.53 |
| Jan-26 | 6 | 7 | 0 | 2 | 0 | 0 | 0 | 0 | 99.38 | 2.49 | 0.00 | 287.75 | 1.92 | 985.5 | 6.57 |
| Feb-26 | 8 | 1 | 0 | 3 | 1 | 0 | 5 | 1 | 98.49 | 2.49 | 0.00 | 355.5 | 2.37 | 878.5 | 5.86 |
| **Total** | **43** | **13** | **2** | **11** | **2** | **0** | **7** | **4** | **98.94** | 4.82 | 0.00 | **Average** | **1.82** | **Average** | **7.50** |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 38.90 | 21.80 | 17.10 | - | - | - |
| Total SNCT recommendation | 51.99 | 31.19 | 20.79 | -13.09 | -9.39 | -3.69 |
| Total PJ recommendation | 39.54 | 23.49 | 16.05 | -0.64 | -1.69 | 1.05 |

| Proposed RN | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| Ward Coordinator | 1 | 1 | 1 | 1 | 1 | | |
| E/L | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| N | 4 | 4 | 4 | 4 | 4 | 4 | 4 |

| Proposed HCA | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| E/L | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| N | 3 | 3 | 3 | 3 | 3 | 3 | 3 |

plus 0.6 RN for ward manager time

**Summary**

Ward 26 is a 31 bedded ward including one oasis suite and specialises in gastroenterology including liver disorders, and drug and alcohol dependency. Due to the complexities of the patients within this area there is a heavy reliance on enhanced care and this is evident through the most recent SNCT data collection. Ward 26 captured approx. 5.11wte required for enhanced care needs of vulnerable patients requiring either 1:1 or 1:2 care.

**Recommendations**

There are no recommendations to increase the establishment on ward 26 currently, however there remains a slight variance between the current establishment and the planned template.

## Appendix 2

Ward 27

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (60/40) | Recommended CSW (WTE) (60/40) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 27 | Oct-25 | 30 | 30 | 12.97 | 0.42 | 14.66 | 1.97 | 0.00 | 0.00 | 0.00 | 37.4 | 60/40 | 49.36 | 29.62 | 19.74 | 0 | -11.96 |
| Ward 27 | Mar-26 | 30 | 30 | 12.10 | 1.00 | 15.40 | 1.50 | 0.00 | 0.00 | 0.00 | 37.4 | 60/40 | 48.67 | 29.20 | 19.47 | 0 | -11.27 |
| **Average** | - | **30.00** | **30.00** | **12.54** | **0.71** | **15.03** | **1.74** | **0.00** | **0.00** | **0.00** | **37.40** | - | **49.02** | **29.41** | **19.61** | **0.00** | **-11.62** |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience<br>Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 8 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 99.65 | 6.50 | 0.00 | 358.25 | 2.39 | 1024.33 | 6.83 |
| Oct-25 | 4 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 99.55 | 0.95 | 0.00 | 319.75 | 2.13 | 906.5 | 6.04 |
| Nov-25 | 2 | 1 | 0 | 2 | 0 | 0 | 0 | 1 | 99.11 | 1.73 | 0.00 | 289.5 | 1.93 | 912.25 | 6.08 |
| Dec-25 | 5 | 0 | 0 | 1 | 0 | 0 | 2 | 2 | 96.99 | 0.64 | 0.00 | 299.25 | 2.00 | 748 | 4.99 |
| Jan-26 | 12 | 0 | 0 | 1 | 0 | 1 | 1 | 1 | 99.89 | 0.64 | 0.00 | 237.75 | 1.59 | 656.33 | 4.38 |
| Feb-26 | 7 | 3 | 0 | 0 | 0 | 0 | 0 | 2 | 99.39 | 0.64 | 0.00 | 308.75 | 2.06 | 750 | 5 |
| **Total** | **38** | **7** | **0** | **5** | **0** | **1** | **3** | **7** | **99.10** | 1.85 | 0.00 | **Average** | **2.01** | **Average** | **5.55** |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 37.40 | 19.20 | 18.20 | - | - | - |
| Total SNCT recommendation | 49.02 | 29.41 | 19.61 | -11.62 | -10.21 | -1.41 |
| Total PJ recommendation | 42.22 | 23.49 | 18.72 | -4.82 | -4.29 | -0.52 |

| Proposed RN | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| Ward Coordinator | 1 | 1 | 1 | 1 | 1 | | |
| E/L | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| N | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| **Proposed HCA** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| E/L | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| N | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| | | | | | | | |
| | | | | | | | |
| plus 0.6 RN for ward manager time | | | | | | | |

**Summary**

Ward 27 is a 30 bedded ward and specialises in gastroenterology including drug and alcohol withdrawal and patients with acute problems associated with eating disorders. Previously the ward has invested into the HCA workforce establishment to meet the demands of the service due to the complexity of nursing patients with eating disorders, providing additional 24/7 cover to support the specialist 1:1 care that is consistently required for these patients. There is an average of one patient requiring this care at any given time on the ward and the current establishment now allows this without additional shifts being filled by NHSP.

**Recommendations**

There are no recommendations to increase the establishment on ward 27 currently, however there remains a slight variance between the current establishment and the planned template.

## Appendix 2

| Ward 28 | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (60/40) | Recommended CSW (WTE) (60/40) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 28 | Oct-25 | 31 | 31 | 15.45 | 1.00 | 13.71 | 0.83 | 0.00 | 0.00 | 0.00 | 39.4 | 60/40 | 45.98 | 27.59 | 18.39 | 2.67 | -6.58 |
| Ward 28 | Mar-26 | 31 | 31 | 17.33 | 0.57 | 12.23 | 0.87 | 0.00 | 0.00 | 0.00 | 39.4 | 60/40 | 44.65 | 26.79 | 17.86 | 2.79 | -5.25 |
| **Average** | - | **31.00** | **31.00** | **16.39** | **0.78** | **12.97** | **0.85** | **0.00** | **0.00** | **0.00** | **39.40** | - | **45.32** | **27.19** | **18.13** | **2.73** | **-5.92** |

| | Safety | | | | | | | Quality | Workforce | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience<br>Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) | |
| Sep-25 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 92.15 | 3.43 | 10.95 | 141.5 | 0.94 | 505.5 | 3.37 | |
| Oct-25 | 2 | 3 | 0 | 0 | 0 | 0 | 0 | 2 | 93.83 | 4.21 | 10.95 | 100.5 | 0.67 | 529 | 3.53 | |
| Nov-25 | 8 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 95.07 | 5.32 | 7.49 | 230.67 | 1.54 | 658 | 4.39 | |
| Dec-25 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 85.64 | 9.92 | 10.95 | 199.75 | 1.33 | 526.5 | 3.51 | |
| Jan-26 | 3 | 2 | 1 | 1 | 0 | 0 | 0 | 2 | 97.4 | 9.92 | 7.76 | 231 | 1.54 | 589.25 | 3.93 | |
| Feb-26 | 9 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 96.07 | 9.92 | 9.28 | 195.5 | 1.30 | 595.5 | 3.97 | |
| **Total** | **28** | **9** | **2** | **1** | **0** | **0** | **0** | **6** | **93.36** | **7.12** | **9.56** | **Average** | **1.22** | **Average** | **3.78** | |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 39.40 | 20.20 | 19.20 | - | - | - |
| Total SNCT recommendation | 45.32 | 27.19 | 18.13 | -5.92 | -6.99 | 1.07 |
| Total PJ recommendation | 42.18 | 20.78 | 21.4 | -2.78 | -0.58 | -2.20 |

| Summary | Recommendations |
|---|---|
| Ward 28 is a 31 bedded acute surgical ward plus one oasis suite. | There are no recommendations to increase the establishment on ward 28 currently, however there remains a slight variance between the current establishment and the planned template. |

| Proposed RN | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| Ward Coordinator | 1 | 1 | 1 | 1 | 1 | | |
| E/L | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| N | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| **Proposed HCA** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| E/L | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| N | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| | | | | | | | |
| | | | | | | | |
| plus 0.6 RN for ward manager time | | | | | | | |

## Appendix 2

| Ward 30 - SDU | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (70/30) | Recommended CSW (WTE) (70/30) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| SDU | Oct-25 | 22 | 22 | 11.37 | 6.60 | 3.63 | 0.29 | 0.06 | 0.06 | 0.00 | 42.8 | 63/37 | 37.54 | 26.28 | 11.26 | 1.21 | 5.26 |
| SDU | Mar-26 | 22 | 22 | 14.70 | 4.20 | 2.97 | 0.03 | 0.00 | 0.10 | 0.00 | 42.8 | 63/37 | 35.49 | 24.84 | 10.65 | 0.08 | 7.31 |
| Average | - | 22.00 | 22.00 | 13.04 | 5.40 | 3.30 | 0.16 | 0.03 | 0.08 | 0.00 | 42.80 | - | 36.52 | 25.56 | 10.95 | 0.65 | 6.29 |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 79.64 | 9.10 | 5.08 | 126.5 | 0.84 | 191 | 1.27 |
| Oct-25 | 1 | 3 | 0 | 1 | 0 | 0 | 0 | 5 | 86.88 | 9.87 | 5.08 | 241.5 | 1.61 | 387 | 2.58 |
| Nov-25 | 0 | 2 | 1 | 1 | 0 | 0 | 0 | 1 | 84.48 | 5.14 | 3.28 | 310.75 | 2.07 | 389 | 2.59 |
| Dec-25 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 2 | 69.23 | 7.88 | 4.98 | 195.5 | 1.30 | 352.17 | 2.35 |
| Jan-26 | 3 | 2 | 2 | 2 | 0 | 0 | 0 | 6 | 88.97 | 7.88 | 8.58 | 411 | 2.74 | 465.5 | 3.10 |
| Feb-26 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 3 | 84.47 | 7.88 | 5.88 | 644 | 4.29 | 443 | 2.95 |
| Total | 7 | 9 | 3 | 4 | 0 | 0 | 1 | 18 | 82.28 | 7.96 | 5.48 | Average | 2.14 | Average | 2.48 |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 42.80 | 27.50 | 15.30 | - | - | - |
| Total SNCT recommendation | 36.52 | 25.56 | 10.95 | 6.29 | 1.94 | 4.35 |
| Total PJ recommendation | 54.52 | 33.12 | 21.40 | -11.72 | -5.62 | -6.10 |

| Proposed RN | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| Ward Coordinator (E/L) | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| E/L | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Ward Coordinator (E/L) | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| N | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Ambu | 2 | 2 | 2 | 2 | 2 | 2 | 2 |

| Proposed HCA | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| E/L | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| N | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Ambu (E/L) | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Ambu (N) | 2 | 2 | 2 | 2 | 2 | 2 | 2 |

plus 0.6 RN for ward manager time

**Summary**

**Data for the assesment area is still being analysed and will follow.**

The Surgical Decisions unit (SDU) is a 22- bedded unit with triage and ambulatory facilities and operates 24/7. This facility is there to manage the safe and effective management of the emergency pathways for surgery, urology orthopaedics and gynaecology by a team of staff whom are expertly trained.

As part of the unit there is a Surgical Ambulatory area providing initial assessment to determine whether admission is required and this is co-located to the SDU (3 trollies). There are a further 2 triage rooms (1 of which is a dedicated Gynaecology examination suite). There are two dedicated waiting areas. Wait Area A is for 'ward attender' patients. Wait Area B is for 'Fit to Sit' patients streamed through the triage area, either awaiting assessment or review. This provides an early initial assessment for ambulatory emergency surgical, urological, orthopaedic and gynaecological patients. It also provides high quality, same day emergency care allowing patients to be rapidly assessed, investigated, diagnosed and treated.

The benefits of this area are to provide safe, effective and patient centred care, prevent unnecessary admissions and overnight stays, reduce length of stay, streamlined pathway for patients, reduce demand on ED, community services and outpatient clinics. Admission avoidance and improved patient experience and outcomes.

**Recommendations**

SNCT proposed an over establishment but the same nursing workforce establishment also staffs the ambulatory/ assessment area which require approx. 21.2wte of the total establishment. This is equivalent to the SDEC principles.

To safely deliver care for patients within SDEC and also the proposed ward template the area requires an investment of 5.6WTE RN and 6.1WTE CSW.

## Appendix 2

Ward 31

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (70/30) | Recommended CSW (WTE) (70/30) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 31 | Oct-25 | 20 | 20 | 4.54 | 5.03 | 1.97 | 1.29 | 0.00 | 7.17 | 0.00 | 36.5 | 60/40 | 38.10 | 26.67 | 11.43 | 4.14 | -1.60 |
| Ward 31 | Mar-26 | 20 | 20 | 5.04 | 5.63 | 2.23 | 0.07 | 0.00 | 7.00 | 0.00 | 36.5 | 60/40 | 34.28 | 24.00 | 10.28 | 0.22 | 2.22 |
| **Average** | - | **20.00** | **20.00** | **4.79** | **5.33** | **2.10** | **0.68** | **0.00** | **7.09** | **0.00** | **36.50** | - | **36.19** | **25.33** | **10.86** | **2.18** | **0.31** |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience<br>Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 95.36 | 7.24 | 0.00 | 567.5 | 3.78 | 569.08 | 3.79 |
| Oct-25 | 2 | 0 | 1 | 2 | 0 | 0 | 0 | 1 | 96.82 | 3.50 | 0.00 | 594.5 | 3.96 | 433 | 2.89 |
| Nov-25 | 1 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 95.56 | 7.49 | 0.00 | 854 | 5.69 | 653.75 | 4.36 |
| Dec-25 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 88.17 | 8.80 | 4.67 | 471 | 3.14 | 275 | 1.83 |
| Jan-26 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 98.63 | 8.80 | 4.57 | 758.75 | 5.06 | 218.5 | 1.46 |
| Feb-26 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 97.89 | 8.80 | 4.54 | 905 | 6.03 | 333.5 | 2.22 |
| **Total** | **7** | 3 | 3 | 3 | **0** | **0** | **0** | **4** | **95.41** | 7.44 | 2.30 | **Average** | **4.61** | **Average** | **2.76** |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 36.50 | 22.90 | 13.40 | - | - | - |
| Total SNCT recommendation | 36.19 | 25.33 | 10.86 | 0.31 | -2.43 | 2.54 |
| Total PJ recommendation | 39.53 | 23.49 | 16.05 | -3.03 | -0.59 | -2.65 |

| Proposed RN | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| Ward Coordinator | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| E/L | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| N | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| **Proposed HCA** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| E/L | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| N | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| | | | | | | | |
| | | | | | | | |
| plus 0.6 RN for ward manager time | | | | | | | |

**Summary**

Ward 31 is a 15-x level 1 beds and 5 x level 0 beds and admits complex acute and elective surgical patients, step down patients from Critical care. This area also provides provision for complex nutritional needs, TPN, line care, chest drains and complex wound dressings. Ward 31 requires input regularly from Critical care outreach not only for the step-down patients but for patients who are acutely unwell. The current establishment allows for 4 RNs per shift which provides an overall ratio of 1:5. There is strengthened leadership on each shift compromising of a Band 6 coordinator on shift 24/7.

Additional temporary staffing is used to manage not only gaps due to maternity leave and sickness but also surge capacity (4 extra beds) especially in the winter months. This is due to surge of medical outliers on Ward 28 and there is a need to revisit the bed modelling across the group.

**Recommendations**

There are no recommendations to increase the establishment on ward 31 currently, however there remains a slight variance between the current establishment and the planned template.

## Appendix 2

**Ward 32**

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (50/50) | Recommended CSW (WTE) (50/50) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 32 | Oct-25 | 30 | 30 | 6.49 | 0.17 | 22.20 | 1.11 | 0.00 | 0.00 | 0.00 | 41.61 | 48/52 | 53.26 | 26.63 | 26.63 | 0 | -11.65 |
| Ward 32 | Mar-26 | 30 | 30 | 10.33 | 1.34 | 16.47 | 1.97 | 0.00 | 0.00 | 0.00 | 41.61 | 48/52 | 51.31 | 25.66 | 25.66 | 6.01 | -9.70 |
| **Average** | - | **30.00** | **30.00** | **8.41** | **0.76** | **19.34** | **1.54** | **0.00** | **0.00** | **0.00** | **41.61** | - | **52.28** | **26.14** | **26.14** | **3.01** | **-10.67** |

| | Safety | | | | | | | Quality | Workforce | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 7 | 4 | 3 | 2 | 0 | 0 | 0 | 3 | 88.7 | 0.63 | 0.00 | 71.5 | 0.48 | 1373 | 9.15 |
| Oct-25 | 7 | 3 | 4 | 2 | 0 | 0 | 0 | 1 | 94.16 | 2.63 | 0.00 | 100.33 | 0.67 | 1799.74 | 12.00 |
| Nov-25 | 9 | 4 | 7 | 2 | 1 | 0 | 0 | 1 | 93.94 | 6.20 | 0.00 | 101.82 | 0.68 | 1208.82 | 8.06 |
| Dec-25 | 6 | 3 | 0 | 2 | 0 | 1 | 0 | 1 | 79 | 8.85 | 0.00 | 286 | 1.91 | 1009.33 | 6.73 |
| Jan-26 | 14 | 3 | 2 | 2 | 1 | 0 | 0 | 1 | 92.26 | 8.85 | 0.00 | 335.17 | 2.23 | 1552.5 | 10.35 |
| Feb-26 | 2 | 4 | 1 | 1 | 0 | 0 | 0 | 0 | 89.11 | 8.85 | 1.26 | 352 | 2.35 | 1292.75 | 8.62 |
| Total | **45** | **21** | **17** | **11** | 2 | **1** | **0** | **7** | **89.53** | 6.00 | 0.21 | **Average** | **1.39** | **Average** | **9.15** |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 41.61 | 20.20 | 21.40 | - | - | - |
| Total SNCT recommendation | 52.28 | 26.14 | 26.14 | -10.67 | -5.94 | -4.74 |
| Total PJ recommendation | 55.59 | 27.80 | 27.80 | -13.98 | -7.60 | -6.40 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Proposed RN** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| **Ward Coordinator** | 1 | 1 | 1 | 1 | 1 | 0 | 0 |
| **E/L** | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| **N** | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| | | | | | | | |
| | | | | | | | |
| **Proposed HCA** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| **E/L** | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| **N** | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| | | | | | | | 1@E/L Bay watch |
| | | | | | | | 2@N Bay watch |
| plus 0.6 RN for ward manager time | | | | | | | |

**Professional Judgement Summary**

Ward 32 is a 30 bedded ward specialises in patients with fragility fractures and emergency trauma and the ward taken direct fractured neck of femur patients. Due to the patient mix, there is a continuing reliance on enhanced care, recent SNCT data highlighted a potential requirement of 3.1wte for the provision of enhanced care.

The RN and HCA vacancy position is good with only 1wte RN vacancy and zero CSW vacancies. There is a forecasted gap of 3wte Associate Practitioners in the next 2-3 months with recent resignations.

Ward 32 sickness across both the RN and HCA workforce is exceeding the 4% Trust target and headroom allocation.

Ward 32 cares for highly dependent and unwell and vulnerable patients whose dependency needs particularly do generally do not reduce at night time so the proposed staffing models needs to reflect this.

The overall skill mix on the ward is 48% RN and 52% HCSW due to previous investment into the HCSW line to support with the basic needs and also enhanced care needs of the majority of patients who are frail and elderly. The CSU are keen to retain this 50/50 skill mix model to meet the needs of this patient group.

Nursing leadership within the CSU are keen to adopt a 'bay watch' process and to allocate 1 CSW during the day and 2CSW at night to specific areas where patients can be cohorted, accounting for their needs to be visible continuously to reduce the need for as much 1:1 enhanced care requests and to manage these patients needs in a different way.

**Recommendations**

The Professional judgement recommendation is to uplift the total establishment by 7.6WTE RN and 6.4WTE CSW to support the provision of the required template. This does slightly exceed the recommendations of the SNCT but professional judgement is accounting for an annual provision of care to this patient group and not just accounting for the 30 day data collection period.

The required template will allow for 60% Ward Manager supervisory time and will allow for RN Ward Coordination mon-Fri to support provide oversight and coordination of patients with complex healthcare and discharge plans.

Professional judgement requires a higher proportion of CSW both during the day and night to support with enhanced care needs of patients.

The proposed template will also support to provision of 4 teams of patients, reducing the nurse to patient ratio to a safe level to manage the complex needs of the patients.

## Appendix 2

**Ward 33**

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (60/40) | Recommended CSW (WTE) (60/40) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 33 | Oct-25 | 30 | 30 | 14.63 | 2.06 | 13.20 | 0.17 | 0.00 | 0.00 | 0.00 | 35.3 | 57/43 | 42.74 | 25.65 | 17.10 | 0.55 | -7.44 |
| Ward 33 | Mar-26 | 30 | 30 | 16.03 | 2.60 | 10.27 | 1.07 | 0.00 | 0.03 | 0.00 | 35.3 | 57/43 | 43.13 | 25.88 | 17.25 | 3.44 | -7.83 |
| Average | - | **30.00** | **30.00** | **15.33** | **2.33** | **11.74** | **0.62** | **0.00** | **0.02** | **0.00** | **35.30** | - | **42.94** | **25.76** | **17.17** | **2.00** | **-7.64** |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience<br>Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 4 | 2 | 0 | 0 | 0 | 0 | 0 | 2 | 88.7 | 7.32 | 0.00 | 219 | 1.46 | 685.5 | 4.57 |
| Oct-25 | 2 | 0 | 1 | 2 | 0 | 0 | 0 | 6 | 94.16 | 7.68 | 0.00 | 291 | 1.94 | 817.75 | 5.45 |
| Nov-25 | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 93.94 | 7.98 | 0.00 | 219.5 | 1.46 | 559 | 3.73 |
| Dec-25 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 79 | 9.28 | 0.00 | 318 | 2.12 | 625 | 4.17 |
| Jan-26 | 3 | 0 | 1 | 0 | 0 | 0 | 0 | 4 | 92.26 | 9.28 | 0.00 | 294.25 | 1.96 | 674.5 | 4.50 |
| Feb-26 | 7 | 1 | 2 | 0 | 1 | 0 | 0 | 3 | 89.11 | 9.28 | 0.00 | 253.5 | 1.69 | 714.08 | 4.76 |
| Total | 23 | 3 | 4 | 2 | 1 | 0 | 0 | 20 | 89.53 | 8.47 | 0.00 | Average | 1.77 | Average | 4.53 |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 35.30 | 20.20 | 15.10 | - | - | - |
| Total SNCT recommendation | 42.94 | 25.76 | 17.17 | -7.64 | -5.56 | -2.07 |
| Total PJ recommendation | 39.54 | 23.72 | 15.82 | -4.24 | -3.52 | -0.72 |

| Proposed RN | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| Ward Coordinator | 1 | 1 | 1 | 1 | 1 | 0 | 0 |
| E/L | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| N | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| | | | | | | | |
| **Proposed HCA** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| E/L | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| N | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| | | | | | | | |
| plus 0.6 RN for ward manager time | | | | | | | |

**Professional Judgement Summary**

Ward 33 is a 30 bedded unit and specialises in orthopaedic trauma and takes some direct patient admissions. The ward cares for acutely unwell and vulnerable patients whose acuity and dependency levels do not reduce at night time and the proposed staffing model needs to reflect this. Currently the Registered Nurse to patient ratio during the day is 1:7.5 but at night this is currently increases to 1:10 which exceeds the NICE safer staffing guidance.

RN and CSW vacancy position is low. RN and CSW sickness remains above the 4% headroom allocation, requireing NHSP usage, particularly in the CSW line, to backfill unfilled shifts.

The current skill mix split of 60/40 remains appropriate for this ward.

The current planned skill mix is RN60% / CSW 40% and the CSU confirm that this skill mix remains safe and appropriate for ward 33.

**Recommendations**

The Professional judgement recommendation is to uplift the total establishment by 2.57WTE RN and 1.70WTE CSW to support the provision of the required template.

The required template will allow for 60% Ward Manager supervisory time and will allow for RN Ward Coordination mon-Fri to support provide oversight and coordination of patients with complex healthcare and discharge plans.

The proposed template will also support to provision of 4 teams of patients, reducing the nurse to patient ratio to a safe level to manage needs of the patients but during the day and at night time.

# Appendix 2

Critical Care Unit

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (90/10) | Recommended CSW (WTE) (90/10) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Critical Care | Oct-25 | 16 | 16 | 4.91 | 0.00 | 0.00 | 0.00 | 1.20 | 6.57 | 4.31 | 78.45 | 90/10 | 57.30 | 51.57 | 5.73 | 1.2 | 21.15 |
| Critical Care | Mar-26 | 16 | 16 | 3.50 | 0.57 | 0.00 | 0.00 | 0.00 | 5.13 | 6.80 | 78.45 | 90/10 | 57.75 | 51.98 | 5.78 | 0 | 20.70 |
| **Average** | - | **16.00** | **16.00** | **4.21** | **0.29** | **0.00** | **0.00** | **0.60** | **5.85** | **5.56** | **78.45** | **90/10** | **57.53** | **51.77** | **5.75** | **0.60** | **20.92** |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience<br>Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 0 | 2 | 2 | 4 | 2 | 1 | 0 | 0 | 75.52 | 5.30 | 7.19 | 833.92 | 5.56 | 224.75 | 1.50 |
| Oct-25 | 0 | 1 | 1 | 4 | 1 | 2 | 0 | 1 | 75.45 | 7.82 | 7.19 | 826.5 | 5.51 | 152.41 | 1.02 |
| Nov-25 | 0 | 3 | 3 | 2 | 0 | 0 | 0 | 2 | 72.27 | 7.94 | 5.89 | 501.66 | 3.34 | 263.33 | 1.76 |
| Dec-25 | 0 | 1 | 3 | 2 | 0 | 0 | 0 | 0 | 72.95 | 4.27 | 8.78 | 243.5 | 1.62 | 240.5 | 1.60 |
| Jan-26 | 0 | 4 | 2 | 2 | 0 | 0 | 0 | 0 | 69.96 | 4.27 | 8.78 | 137.25 | 0.92 | 22.5 | 0.15 |
| Feb-26 | 1 | 1 | 1 | 2 | 0 | 0 | 0 | 1 | 65.18 | 4.27 | 8.78 | 72 | 0.48 | 52 | 0.35 |
| Total | **1** | **12** | **12** | **16** | 3 | 3 | **0** | **4** | **71.89** | 5.65 | 7.77 | Average | **2.91** | Average | **1.06** |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 78.45 | 72.65 | 5.80 | - | - | - |
| Total SNCT recommendation | 57.53 | 51.77 | 5.75 | 20.92 | 20.88 | 0.05 |
| Total PJ recommendation | 80.92 | 72.83 | 8.09 | -2.47 | -0.18 | -2.29 |

| Proposed RN | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| Ward Manager (100% supervisory) | 1 | 1 | 1 | 1 | 1 | 0 | 0 |
| Ward Coordinator | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| E/L | 12 | 12 | 12 | 12 | 12 | 12 | 12 |
| N | 12 | 12 | 12 | 12 | 12 | 12 | 12 |

| Proposed HCA | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| E/L | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| N | 2 | 2 | 2 | 2 | 2 | 2 | 2 |

Summary

The critical care unit is funded for 16 beds with the physical capacity for 17 patients and comprises of three areas: unit A (four beds), unit B (nine beds) and unit C (four beds). Within this footprint of units, B and C there are three double and three single side rooms. The nature and delivery of critical care services are evolving with great speed. This is seen both in the increased complexity of treatments being delivered and in the types of facilities to accommodate changes in service delivery

The RN and HCA vacancy position is positive and there has been zero RN agency use since Apr24. The RN sickness/absence however, does exceeds 4%, the departments 22% headroom allocation which is challenging and in addition there is a high level of RN maternity leave which require backfill by new nurses who have yet to complete the adult post graduate critical care award.

To achieve compliance with GPICs and have a ratio of one supernumerary coordinator to eight beds an additional co-ordinator per shift is required.

To achieve compliance with GPICs and have 1wte clinical educator per 75 members of staff an additional 1wte band 6 registered nurse is required. Critical care currently has 40% of the registered nursing workforce with a post registration academic programme in critical care nursing against a compliance standard of 50%.

As of 2026 with support from the board to ensure GPICs compliance, there has been an uplift to ensure 50% of the workforce are band 6 and above, whilst the team are working through this as staff are achieving their qualification there is recognised senior presence and skill within the department.

In terms of critical care nursing presence GPICs compliance is essential to ensure service delivery and provision of critical standards are equitable. We utilise the daily DOS within the region to support critical care service delivery and provision of critical care beds.

The SNCT tool does not lend well to critical care as there are clear standards of compliance to meet and maintain and the level 2's in critical care do have very different requirements to ward based level 2 patients.

Recommendations

There are no rececommended changes to the current establishment at this time due to the recent investment that has been approved and implemented via the Critical Care workforce review in 2026 following full GPICs review.

# Appendix 2

Ward 29 (ACU)

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (70/30) | Recommended CSW (WTE) (70/30) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 29 | Oct-25 | 30 | 30 | 4.37 | 14.37 | 8.43 | 0.09 | 0.00 | 2.74 | 0.00 | 35 | 59/41 | 45.67 | 31.97 | 13.70 | 0.29 | -10.67 |
| Ward 29 | Mar-26 | 30 | 30 | 4.57 | 8.10 | 14.10 | 1.13 | 0.00 | 2.10 | 0.00 | 35 | 59/41 | 51.46 | 36.02 | 15.44 | 3.63 | -16.46 |
| **Average** | - | **30.00** | **30.00** | **4.47** | **11.24** | **11.26** | **0.61** | **0.00** | **2.42** | **0.00** | **35** | - | **48.57** | **34.00** | **14.57** | **1.96** | **-13.57** |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Suspected deep tissue injury (SDTI) | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 10 | 2 | 0 | 3 | 0 | 0 | 0 | 0 | 99.20 | 0.86 | 7.01 | 420.75 | 2.81 | 306.5 | 2.04 |
| Oct-25 | 7 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 99.57 | 0.86 | 7.76 | 521.5 | 3.48 | 320.21 | 2.13 |
| Nov-25 | 9 | 2 | 3 | 3 | 0 | 0 | 1 | 1 | 99.22 | 0.86 | 7.96 | 540.5 | 3.60 | 483.5 | 3.22 |
| Dec-25 | 8 | 0 | 1 | 2 | 0 | 0 | 1 | 2 | 97.10 | 3.49 | 3.10 | 617 | 4.11 | 150 | 1.00 |
| Jan-26 | 13 | 1 | 1 | 1 | 0 | 1 | 0 | 1 | 99.57 | 1.87 | 4.79 | 611.25 | 4.08 | 521 | 3.47 |
| Feb-26 | 8 | 1 | 2 | 1 | 0 | 0 | 0 | 2 | 99.15 | 1.55 | 7.79 | 540 | 3.60 | 727.5 | 4.85 |
| **Total** | **55** | **6** | **8** | **12** | **0** | **1** | **2** | **6** | **98.97** | **1.58** | **6.40** | **Average** | **3.61** | **Average** | **2.79** |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 35 | 21.00 | 14.00 | - | - | - |
| Total SNCT recommendation | 48.57 | 34.00 | 14.57 | -13.57 | -13.00 | -0.57 |
| Total PJ recommendation | 41.99 | 29.17 | 12.82 | -6.99 | -8.17 | 1.18 |

| Proposed RN/AP/NA | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| Ward Coordinator E/L | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| E/L | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Supernum Telem E/L | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| N | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| Twilight (2-2) | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Supernum Telem N | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | | | | | | | |
| **Proposed HCA** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| E/L | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| N | 2 | 2 | 2 | 2 | 2 | 2 | 2 |

plus 0.6 RN for ward manager time

**Summary**

Acute Cardiology Unit (ACU) is a 30 bedded unit that specialises in providing general medicine and a proportion of acute level 1 cardiology (15 beds) that require a telemetry trained nurse each shift to manage the needs of the service and of the safe transfer of patient to South Tees University Hospital.

The current RN position slightly over established and the HCA vacancy position is zero.The Numbers which are for ACU are to include the AP and RN staffing group and the telemetry RN is a necessity, as historically the AP and or the telemetry RN are moved, leaving the ward and telemetry patients unsafe.

Planned staffing for ward 29 = 4 RN + Ward Manager + 1 supervisory Telemetry RN (6 RN or 5 RN and 1 AP) and 3 HCA days and Nights

The ward needs to move to having 4 teams of patients to reduce down the nurse to patient ratio and it is felt that the ward requires a 70% RN / 30%CSW planned skill mix to manage the acuity levels of the patients.

There is a requirement from the CSU to look at the appropriateness of patients coming onto the ward via site flow, some patients are general med yet patients on other wards requiring telemetry monitoring because they are on isoprenaline infusions and should really be on ward 29. There is a requirement to propose that some beds are ringfenced for pure cardiology patients to support this work.

Propose investment to support the safe and consistent monitoring of the telemetry systems (these monitor both patients on the unit and also patients on other wards within the hospital). When one RN is maintained as supernumerary to enable this service provision, the remaining workforce does not currently achieve the NICE safe staffing guidance.

**Recommendations**

The Professional judgement recommendation is to uplift the total establishment by 8.17WTE RN and reduce by1.8WTE CSW to support the provision of the required template.

The required template will allow for 60% Ward Manager supervisory time and will allow for x1 Telemetry RN 24/7 to remain 100% supernumerary to the main ward staffing levels, allowing them to safety monitor all patients requiring cardic monitoring including those patients that are external to ward 29.

The proposed template will support to provision of 4 teams of patients, reducing the nurse to patient ratio to a safe level to manage the acuity levels of the patients.

## Appendix 2

**Ward 24 & RSU**

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (70/30) | Recommended CSW (WTE) (70/30) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 24 | Oct-25 | 28 | 28 | 5.40 | 5.14 | 7.46 | 0.00 | 0.00 | 10.00 | 0.00 | 41.02 | Ward = 60/40 | 51.22 | 35.85 | 15.37 | 0 | -10.20 |
| Ward 24 | Mar-26 | 28 | 28 | 4.77 | 4.83 | 6.43 | 0.00 | 0.03 | 11.93 | 0.00 | 41.02 | RSU = 70/30 | 53.38 | 37.37 | 16.01 | 0.22 | -12.36 |
| Average | - | **28.00** | **28.00** | **5.09** | **4.99** | **6.94** | **0.00** | **0.02** | **10.97** | **0.00** | **41.02** | - | **52.30** | **36.61** | **15.69** | **0.11** | **-11.28** |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 97.98 | 5.66 | 8.90 | 996 | 6.64 | 845.92 | 5.64 |
| Oct-25 | 2 | 4 | 3 | 1 | 3 | 0 | 0 | 0 | 96.43 | 0.57 | 8.90 | 766 | 5.11 | 835 | 5.57 |
| Nov-25 | 2 | 3 | 1 | 1 | 0 | 0 | 0 | 0 | 97.74 | 0.12 | 5.90 | 904.5 | 6.03 | 988.5 | 6.59 |
| Dec-25 | 3 | 1 | 1 | 3 | 0 | 0 | 1 | 2 | 96.66 | 4.49 | 4.45 | 666.25 | 4.44 | 714.17 | 4.76 |
| Jan-26 | 7 | 2 | 0 | 2 | 0 | 0 | 0 | 2 | 97.12 | 4.49 | 4.53 | 761.5 | 5.08 | 558.5 | 3.72 |
| Feb-26 | 2 | 0 | 3 | 0 | 0 | 0 | 0 | 3 | 98.45 | 4.49 | 5.46 | 682 | 4.55 | 789.5 | 5.26 |
| Total | **19** | **11** | **8** | **7** | **3** | **0** | **1** | **8** | **97.40** | 3.30 | 6.36 | Average | **5.31** | Average | **5.26** |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | 3 | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 40.50 | 23.60 | 16.90 | 2 | - | - |
| Total SNCT recommendation | 52.30 | 36.61 | 15.69 | -11.80 | -13.01 | 1.21 |
| Total PJ recommendation | 41.95 | 26.57 | 15.38 | -1.45 | -2.97 | 1.52 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Proposed RN** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| **Ward Coordinator** | | | | | | | |
| **E/L** | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| **N** | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| | | | | | | | |
| **Proposed HCA** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| **E/L** | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| **N** | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| plus 0.6 RN for ward manager time | | | | | | | |

**Summary**

28 bedded respiratory ward comprising of 21 level 0 respiratory beds and 7 Respiratory Support Unit (RSU). The ward provides care for patients requiring non invasive ventilation (NIV) tracheostomy care, chest drain insertion and management, high flow oxygen and continuous positie airway pressure (CPAP), the ward also take direct admissions from ED and GPs.

RSU nurse to ratio is a ratio of 1:4 RN meaning in current establishment there is 2 nurses in RSU and 2 on the ward. This means there is not a nurse who is able to coordinate both units and have oversight of what patients are in either unit. Also when patients are first started on NIV the patient does require additional support meaning a nurse is required 1:1 with the patient for the first couple of hours. Due to the nature of the patients they also require regualr nurse escorts off the ward. The ward regularly increases the number of RSU patients they take meaning additional nursing staff is required and has to be sourced from within the trust or try to cover at short notice via NHSP.

The ward has a ratio of 1:7 patients which would remain in proposed staffing levels.

**Recommendations**

Increase RN staffing to 6 RN on a day shift- 1 coordinator who will not have an allocated team of patients but can support in RSU if needed and escort patients off the ward when required.

The required template will allow for 60% ward manager supervisory time and will allow for an RN coordinator 7 days a week to support oversight and coordination of patients with complex healthcare needs and discharge planning.

## Appendix 2

**Ward 25 & RSU**

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (70/30) | Recommended CSW (WTE) (70/30) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 25 | Oct-25 | 28 | 28 | 1.26 | 9.69 | 6.46 | 1.03 | 0.00 | 9.57 | 0.00 | 39.8 | Ward = 60/40 | 54.19 | 37.93 | 16.26 | 3.31 | -14.39 |
| Ward 25 | Mar-26 | 28 | 28 | 2.77 | 9.03 | 4.93 | 0.37 | 0.00 | 10.90 | 0.00 | 39.8 | RSU = 70/30 | 52.55 | 36.79 | 15.77 | 1.19 | -12.75 |
| **Average** | - | **28.00** | **28.00** | **2.01** | **9.36** | **5.70** | **0.70** | **0.00** | **10.24** | **0.00** | **39.80** | - | **53.37** | **37.36** | **16.01** | **2.25** | **-13.57** |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience<br>Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 2 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 96.43 | 1.27 | 4.19 | 988.5 | 6.59 | 876.5 | 5.84 |
| Oct-25 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 98.27 | 0.14 | 4.19 | 935.5 | 6.24 | 1050 | 7.00 |
| Nov-25 | 2 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 97.26 | 1.96 | 0.00 | 1162.5 | 7.75 | 998.25 | 7.00 |
| Dec-25 | 5 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 96.66 | 4.49 | 0.00 | 1034.25 | 6.90 | 1005.5 | 6.70 |
| Jan-26 | 2 | 2 | 2 | 3 | 0 | 1 | 0 | 1 | 99.08 | 4.49 | 0.00 | 1135 | 7.57 | 983.25 | 6.56 |
| Feb-26 | 0 | 5 | 0 | 0 | 0 | 0 | 0 | 2 | 98.3 | 4.49 | 0.00 | 801 | 5.34 | 818.25 | 5.455 |
| Total | 11 | 14 | 3 | 7 | 0 | 1 | 1 | 3 | 97.67 | 2.81 | 1.40 | Average | 6.73 | Average | 6.43 |

| Professional Judgement (WTE ) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 39.80 | 22.60 | 17.20 | - | - | - |
| Total SNCT recommendation | 53.37 | 37.36 | 16.01 | -13.57 | -14.76 | 1.19 |
| Total PJ recommendation | 41.95 | 26.57 | 15.38 | -2.15 | -3.97 | 1.82 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Proposed RN** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| **Ward Coordinator** | | | | | | | |
| **E/L** | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| **N** | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| | | | | | | | |
| **Proposed HCA** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| **E/L** | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| **N** | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| | | | | | | | |
| plus 0.6 RN for ward manager time | | | | | | | |

**Summary**

28 bedded respiratory ward comprising of 21 level 0 respiratory beds and 7 Respiratory Support Unit (RSU). The ward provides care for patients requiring non invasive ventilation (NIV) tracheostomy care, chest drain insertion and management, high flow oxygen and continuous positie airway pressure (CPAP), the ward also take direct admissions from ED and GPs.

RSU nurse to ratio is a ratio of 1:4 RN meaning in current establishment there is 2 nurses in RSU and 2 on the ward. This means there is not a nurse who is able to coordinate both units and have oversight of what patients are in either unit. Also when patients are first started on NIV the patient does require additional support meaning a nurse is required 1:1 with the patient for the first couple of hours. Due to the nature of the patients they also require regualr nurse escorts off the ward. The ward regularly increases the number of RSU patients they take meaning additional nursing staff is required and has to be sourced from within the trust or try to cover at short notice via NHSP.

The ward has a ratio of 1:7 patients which would remain in proposed staffing levels.

**Recommendations:**

Increase RN staffing to 6 RN on a day shift- 1 coordinator who will not have an allocated team of patients but can support in RSU if needed and escort patients off the ward when required.

The required template will allow for 60% ward manager supervisory time and will allow for an RN coordinator 7 days a week to support oversight and coordination of patients with complex healthcare needs and discharge planning.

## Appendix 2

**Ward 36**

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (60/40) | Recommended CSW (WTE) (60/40) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 36 | Oct-25 | 30 | 30 | 1.77 | 2.43 | 23.09 | 1.74 | 0.35 | 0.63 | 0.00 | 42.6 | 60/40 | 60.36 | 36.22 | 24.14 | 8.18 | -17.76 |
| Ward 36 | Mar-26 | 30 | 30 | 2.87 | 0.73 | 23.43 | 1.77 | 0.27 | 0.93 | 0.00 | 42.6 | 60/40 | 60.16 | 36.10 | 24.06 | 7.68 | -17.56 |
| **Average** | - | **30.00** | **30.00** | **2.32** | **1.58** | **23.26** | **1.75** | **0.31** | **0.78** | **0.00** | **42.60** | - | **60.26** | **36.16** | **24.10** | **7.93** | **-17.66** |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience<br>Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 6 | 1 | 0 | 1 | 1 | 0 | 0 | 3 | 99.56 | 8.02 | 12.21 | 598 | 3.99 | 1084.98 | 7.23 |
| Oct-25 | 7 | 3 | 0 | 1 | 0 | 0 | 0 | 2 | 99.57 | 5.34 | 12.21 | 750.5 | 5.00 | 1339.5 | 8.93 |
| Nov-25 | 7 | 2 | 0 | 0 | 0 | 1 | 0 | 2 | 99.44 | 1.30 | 8.22 | 644 | 4.29 | 801 | 5.34 |
| Dec-25 | 9 | 3 | 1 | 0 | 0 | 1 | 1 | 1 | 99.03 | 1.91 | 12.48 | 392.75 | 2.62 | 907.5 | 6.05 |
| Jan-26 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 99.78 | 1.91 | 8.31 | 472.5 | 3.15 | 659.5 | 4.40 |
| Feb-26 | 6 | 2 | 0 | 2 | 0 | 0 | 2 | 0 | 99.49 | 1.91 | 10.17 | 595.5 | 3.97 | 508 | 3.39 |
| Total | **41** | **11** | **1** | **4** | **1** | 2 | 3 | **13** | **99.48** | 3.40 | 10.60 | Average | **3.84** | Average | **5.89** |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 42.60 | 24.40 | 18.20 | - | - | - |
| Total SNCT recommendation | 60.26 | 36.16 | 24.10 | -17.66 | -11.76 | -5.90 |
| Total PJ recommendation | 39.36 | 23.98 | 15.38 | 3.24 | 0.42 | 2.82 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Proposed RN** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| **Ward Coordinator** | | | | | | | |
| **E/L** | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| **N** | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| | | | | | | | |
| **Proposed HCA** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| **E/L** | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| **N** | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| | | | | | | | |
| plus 0.6 RN for ward manager time | | | | | | | |

**Summary**

Ward 36 is a 30 bedded medical ward which specialises in diabetes and endocrinology, the ward also cares for patients who have stepped down from critical care who have suffered from intentional or nonintentional epsiodes of self harm

There are no current proposal for changes to the wards establishment.

**Recommendations:**

No recommendations to change establishment

## Appendix 2

**Ward 38**

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (50/50) | Recommended CSW (WTE) (50/50) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 38 | Oct-25 | 16 | 16 | 2.34 | 5.14 | 7.18 | 1.33 | 0.00 | 0.00 | 0.00 | 41.1 | Ward = 50/50 Excluding MDU and Butterwick | 27.96 | 13.98 | 13.98 | 4.27 | 13.14 |
| Ward 39 | Mar-26 | 16 | 16 | 5.50 | 3.43 | 6.60 | 0.47 | 0.00 | 0.00 | 0.00 | 41.1 | | 24.22 | 12.11 | 12.11 | 1.51 | 16.88 |
| Average | - | 16.00 | 16.00 | 3.92 | 4.29 | 6.89 | 0.90 | 0.00 | 0.00 | 0.00 | 41.10 | - | 26.09 | 13.05 | 13.05 | 2.89 | 15.01 |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 2 | 2 | 1 | 3 | 0 | 1 | 0 | 0 | 98.96 | 12.95 | 5.10 | 456.75 | 3.05 | 130 | 0.87 |
| Oct-25 | 4 | 3 | 0 | 1 | 0 | 0 | 0 | 0 | 98.99 | 11.37 | 5.10 | 484.25 | 3.23 | 370.25 | 2.47 |
| Nov-25 | 5 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 99.16 | 6.14 | 3.44 | 430 | 2.87 | 576 | 3.84 |
| Dec-25 | 6 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 94.77 | 4.25 | 6.46 | 429.5 | 2.86 | 797.25 | 5.32 |
| Jan-26 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 99.8 | 4.25 | 6.46 | 516.5 | 3.44 | 432 | 2.88 |
| Feb-26 | 5 | 1 | 0 | 1 | 0 | 1 | 0 | 1 | 98.67 | 4.25 | 6.10 | 457.75 | 3.05 | 351 | 2.34 |
| Total | 23 | 8 | 2 | 6 | 0 | 2 | 0 | 4 | 98.39 | 7.20 | 5.44 | Average | 3.08 | Average | 2.95 |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 41.10 | 25.70 | 15.40 | - | - | - |
| Total SNCT recommendation | 26.09 | 13.05 | 13.05 | 15.01 | 12.66 | 2.36 |
| Total PJ recommendation | 39.36 | 23.98 | 15.38 | 1.74 | 1.72 | 0.02 |

**Summary**

Ward 38 is a 16 bedded unit that specialises in acute general medicine and haematology/oncology. The management of the Medical Day Unit (MDU) also falls under the same workforce model and is open from 9-5pm monday to friday.

**Recommendations:**

No recommendations to change current establishments

| Proposed RN ward 38 | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| E/L | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| N | 2 | 2 | 2 | 2 | 2 | 2 | 2 |

| Proposed HCA ward 38 | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| E/L | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| N | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

| Proposed RN BW | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| E/L | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| N | 2 | 2 | 2 | 2 | 2 | 2 | 2 |

| Proposed HCA BW | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| E/L | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| N | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

# Appendix 2

**Ward 38**

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (50/50) | Recommended CSW (WTE) (50/50) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 38 | Oct-25 | 16 | 16 | 2.34 | 5.14 | 7.18 | 1.33 | 0.00 | 0.00 | 0.00 | 41.1 | Ward = 50/50 Excluding MDU and Butterwick | 27.96 | 13.98 | 13.98 | 4.27 | 13.14 |
| Ward 39 | Mar-26 | 16 | 16 | 5.50 | 3.43 | 6.60 | 0.47 | 0.00 | 0.00 | 0.00 | 41.1 | | 24.22 | 12.11 | 12.11 | 1.51 | 16.88 |
| **Average** | - | **16.00** | **16.00** | **3.92** | **4.29** | **6.89** | **0.90** | **0.00** | **0.00** | **0.00** | **41.10** | - | **26.09** | **13.05** | **13.05** | **2.89** | **15.01** |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined C SW temp staffing use (WTE) |
| Sep-25 | 2 | 2 | 1 | 3 | 0 | 1 | 0 | 0 | 98.96 | 12.95 | 5.10 | 456.75 | 3.05 | 130 | 0.87 |
| Oct-25 | 4 | 3 | 0 | 1 | 0 | 0 | 0 | 0 | 98.99 | 11.37 | 5.10 | 484.25 | 3.23 | 370.25 | 2.47 |
| Nov-25 | 5 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 99.16 | 6.14 | 3.44 | 430 | 2.87 | 576 | 3.84 |
| Dec-25 | 6 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 94.77 | 4.25 | 6.46 | 429.5 | 2.86 | 797.25 | 5.32 |
| Jan-26 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 99.8 | 4.25 | 6.46 | 516.5 | 3.44 | 432 | 2.88 |
| Feb-26 | 5 | 1 | 0 | 1 | 0 | 1 | 0 | 1 | 98.67 | 4.25 | 6.10 | 457.75 | 3.05 | 351 | 2.34 |
| **Total** | **23** | **8** | **2** | **6** | **0** | **2** | **0** | **4** | **98.39** | **7.20** | **5.44** | **Average** | **3.08** | **Average** | **2.95** |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 41.10 | 25.70 | 15.40 | - | - | - |
| Total SNCT recommendation | 26.09 | 13.05 | 13.05 | 15.01 | 12.66 | 2.36 |
| Total PJ recommendation | 39.36 | 23.98 | 15.38 | 1.74 | 1.72 | 0.02 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Proposed RN ward 38** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| **E/L** | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| **N** | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| | | | | | | | |
| **Proposed HCA ward 38** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| **E/L** | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| **N** | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | | | | | | | |
| **Proposed RN BW** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| **E/L** | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| **N** | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| | | | | | | | |
| **Proposed HCA BW** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| **E/L** | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| **N** | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

**Summary**

Ward 38 is a 16 bedded unit that specialises in acute general medicine and haematology/oncology. The management of the Medical Day Unit (MDU) also falls under the same workforce model and is open from 9-5pm monday to friday.

**Recommendations:**

No recommendations to change current establishments

## Appendix 2

EAU

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (70/30) | Recommended CSW (WTE) (70/30) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| EAU | Oct-25 | 60 | 60 | 17.29 | 17.57 | 20.66 | 1.71 | 0.00 | 2.77 | 0.00 | 109.5 | 60/40 | 114.90 | 80.43 | 34.47 | 4.68 | -5.40 |
| EAU | Mar-26 | 60 | 60 | 22.70 | 13.73 | 20.63 | 0.47 | 0.20 | 2.27 | 0 | 109.5 | 60/40 | 111.57 | 78.10 | 33.47 | 2.76 | -2.07 |
| Average | - | **60.00** | **60.00** | **19.99** | **15.65** | **20.64** | **1.09** | **0.10** | **2.52** | **0.00** | **109.50** | - | **113.24** | **79.26** | **33.97** | **3.72** | **-3.74** |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience<br>Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 11 | 9 | 1 | 0 | 0 | 0 | 0 | 6 | 97.43 | 6.32 | 3.74 | 1256.25 | 8.38 | 1370 | 9.13 |
| Oct-25 | 15 | 6 | 3 | 0 | 0 | 0 | 0 | 9 | 98.2 | 6.54 | 3.74 | 1501.5 | 10.01 | 1457.75 | 9.72 |
| Nov-25 | 13 | 7 | 0 | 2 | 2 | 0 | 0 | 7 | 95.88 | 3.24 | 2.44 | 974.67 | 6.50 | 1198.75 | 7.99 |
| Dec-25 | 8 | 11 | 0 | 3 | 1 | 0 | 0 | 6 | 89.73 | 3.59 | 3.69 | 1190.75 | 7.94 | 1165.33 | 7.77 |
| Jan-26 | 10 | 5 | 5 | 1 | 0 | 0 | 0 | 2 | 99.41 | 3.59 | 3.79 | 1317.83 | 8.79 | 1162.25 | 7.75 |
| Feb-26 | 13 | 4 | 2 | 1 | 1 | 0 | 0 | 6 | 95.89 | 3.59 | 3.69 | 1465.25 | 9.77 | 967.58 | 6.45 |
| Total | 70 | 42 | 11 | 7 | 4 | 0 | 0 | 36 | 96.09 | 4.48 | 3.52 | Average | 8.56 | Average | 8.14 |

| Professional Judgement (WTE ) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 109.50 | 69.70 | 39.80 | - | - | - |
| Total SNCT recommendation | 113.24 | 79.26 | 33.97 | -3.74 | -9.56 | 5.83 |
| Total PJ recommendation | 101.45 | 68.13 | 38.32 | 8.05 | 1.57 | 1.48 |

**Summary**

EAU is 60 bedded admitting ward and also has an additional assessment suite which is open 24 hours a day. Patient case mix includes those from paramedic, GP and ED acute medical admissions.

A workforce review has been completed of the assessment suite and EAU seperately and from this the establishemnt doesnt need increasing however the data showed busier periods in the assessment suite which has led to a shift pattern review.

**Recommendations:**

Not to change the establishment at present to but to change x1 night shift for HCA and RN into a twilight shift.

| EAU and Asssessment Suite | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| Proposed RN | M | T | W | T | F | S | S |
| Twilight (2pm-2am) | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| E/L | 13 | 13 | 13 | 13 | 13 | 13 | 13 |
| N | 12 | 12 | 12 | 12 | 12 | 12 | 12 |
| | | | | | | | |
| | | | | | | | |
| Proposed HCA | M | T | W | T | F | S | S |
| Twilight (2pm-2am) | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| E/L | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| N | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| | | | | | | | |
| plus 0.6 RN for ward manager time | | | | | | | |

# Appendix 2

**Ward 41**

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (60/40) | Recommended CSW (WTE) (60/40) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 41 | Oct-25 | 26 | 26 | 0.69 | 0.00 | 24.51 | 0.00 | 0.00 | 0.77 | 0.00 | 39.2 | 56/44 | 48.96 | 29.37 | 19.58 | 0 | -9.76 |
| Ward 41 | Mar-26 | 26 | 26 | 5.16 | 1.03 | 17.63 | 1.13 | 0.00 | 1.30 | 0.00 | 39.2 | 56/44 | 47.76 | 28.66 | 19.10 | 3.63 | -8.56 |
| **Average** | - | **26.00** | **26.00** | **2.93** | **0.52** | **21.07** | **0.57** | **0.00** | **1.04** | **0.00** | **39.20** | - | **48.36** | **29.02** | **19.34** | **1.82** | **-9.16** |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience<br>Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 7 | 0 | 1 | 0 | 1 | 0 | 1 | 2 | 98.03 | 12.28 | 0.00 | 517.5 | 3.45 | 366.75 | 2.45 |
| Oct-25 | 6 | 3 | 1 | 1 | 0 | 0 | 1 | 0 | 98.76 | 9.88 | 0.00 | 576 | 3.84 | 442.5 | 2.95 |
| Nov-25 | 4 | 0 | 2 | 1 | 0 | 0 | 0 | 2 | 97.2 | 8.99 | 0.00 | 774.5 | 5.16 | 422 | 2.81 |
| Dec-25 | 12 | 0 | 0 | 2 | 0 | 0 | 1 | 2 | 97.42 | 5.03 | 0.00 | 546.5 | 3.64 | 399 | 2.66 |
| Jan-26 | 10 | 2 | 0 | 1 | 2 | 0 | 1 | 0 | 98.89 | 5.03 | 0.00 | 548.83 | 3.66 | 615.25 | 4.10 |
| Feb-26 | 1 | 1 | 1 | 0 | 1 | 0 | 1 | 0 | 97.81 | 5.03 | 0.00 | 586.5 | 3.91 | 1001 | 6.67 |
| **Total** | **40** | **6** | **5** | **5** | **4** | **0** | **5** | **6** | **98.02** | **7.71** | **0.00** | **Average** | **3.94** | **Average** | **3.61** |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 39.20 | 21.80 | 17.40 | - | - | - |
| Total SNCT recommendation | 48.36 | 29.02 | 19.34 | -9.16 | -7.22 | -1.94 |
| Total PJ recommendation | 46.53 | 28.27 | 17.94 | -7.33 | -6.47 | -0.54 |

| Proposed RN | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| Ward Coordinator | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Stroke Coordinator (Supervisory) E/L | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| RN E/L | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Stroke Coordinator (Supervisory) N | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| RN N | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| | | | | | | | |
| **Proposed CSW** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| E/L | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| N | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| | | | | | | | |
| | | | | | | | |
| plus 0.6 RN for ward manager time | | | | | | | |

**Summary**

The Acute Stroke Unit is a 26 bedded admitting acute stroke unit and incorporates the thrombolysis service and TIA assessment and supports the safe and efficient transfer of patients for thrombectomy service. There is a stroke coordinator available 24/7 in addition to the ward-based workforce model.

RN and HCA vacancy positions are reducing.

The Nurse-to-patient ratio is 8.6 each day and night with a stroke coordinator in a supernumerary position and the current skill mix of 56% RN and 44% HCSW is not sufficient for an admitting acute stroke unit. Also, the current ratio for the stroke commissioned beds, not the additional x5 beds. Since working across site in stroke service I have yet to know a week when the additional beds (or at least some) haven't been occupied, for the 31 beds nurse to patient ratio is 1:10.3

To note, the stroke co-ordinator is often off the ward spending a bulk of the shift time seeing pre-alert patients arriving at CT with paramedics, conducting initial assessment, remaining with patients whilst having CT /MR and await for these to be reviewed by Consultant, if stroke confirmed, begin appropriate pathway ie administer thrombolysis treatment immediately and transfer to ward, transfer to ward whilst escalating for potential thrombectomy transfer to JCUH / RVI, not deemed a stroke transfer patient to EAU for ongoing medical assessment and handover to team. They take referrals from ED for patients that have either been brought in by ambulance and thought to have a differing presenting complaint by pre-hospital colleagues or patients whom have self-presented but on assessment identified potential stroke. They also attend in-patient areas for patients who have been admitted and are receiving treatment and have become unwell with stroke symptoms.

Guidance re: patients in hyperacute phase of stroke require close monitoring for first 72 hours, ward 41 does not have a monitored bay, these patients are admitted into wherever empty bed space and monitoring applied which can be seen at the nurse station. Dependent on type of stroke patients could have thrombolysis treatment or are at risk of increased intracranial pressure requiring close BP monitoring, sometimes on GTN infusions etc

**Recommendations**

Recommendation is to uplift the totsl establishment by 6.47WTE RN and 0.54WTE CSW to support the provision of the required template.

The required template will allow for 60% Ward Manager supervisory time and will allow for the Stroke Coordinator to remain 100% supernumerary to the main ward staffing levels, allowing them to safety carry out their role which includes leaving the deaprtment for period of time to manage acute admissions in ED, CT and EAU.

# Appendix 2

Ward 40

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (60/40) | Recommended CSW (WTE) (60/40) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 40 | Oct-25 | 30 | 30 | 4.49 | 1.77 | 20.74 | 3.00 | 0.00 | 0.00 | 0.00 | 42 | 39/61 | 58.48 | 35.09 | 23.39 | 0 | -16.48 |
| Ward 40 | Mar-26 | 30 | 30 | 9.97 | 3.87 | 14.30 | 1.87 | 0.00 | 0.00 | 0.00 | 42 | 39/61 | 49.63 | 29.78 | 19.85 | 6.01 | -7.63 |
| **Average** | - | **30.00** | **30.00** | **7.23** | **2.82** | **17.52** | **2.44** | **0.00** | **0.00** | **0.00** | **42.00** | - | **54.05** | **32.43** | **21.62** | **3.01** | **-12.05** |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience<br>Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 13 | 4 | 0 | 4 | 2 | 0 | 1 | 2 | 99.11 | 6.64 | 10.12 | 316.5 | 2.11 | 1677.25 | 11.18 |
| Oct-25 | 20 | 3 | 1 | 3 | 0 | 0 | 0 | 2 | 99.24 | 4.51 | 10.12 | 305.5 | 2.04 | 1772.75 | 11.82 |
| Nov-25 | 5 | 7 | 0 | 4 | 0 | 0 | 0 | 0 | 99.78 | 4.05 | 6.63 | 519.5 | 3.46 | 2098 | 13.99 |
| Dec-25 | 13 | 2 | 2 | 4 | 1 | 2 | 0 | 2 | 98.27 | 8.01 | 9.84 | 715.5 | 4.77 | 1662.75 | 11.09 |
| Jan-26 | 18 | 1 | 1 | 6 | 0 | 0 | 0 | 1 | 99.68 | 8.01 | 9.84 | 621.5 | 4.14 | 1004.17 | 6.69 |
| Feb-26 | 11 | 0 | 0 | 2 | 2 | 0 | 1 | 2 | 100.12 | 8.01 | 11.06 | 697.41 | 4.65 | 1091.5 | 7.28 |
| **Total** | **80** | **17** | **4** | **23** | **5** | **2** | **2** | **9** | **99.37** | 6.54 | 9.60 | **Average** | **3.53** | **Average** | **10.34** |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| Total current nurse establishment | 42.00 | 18.90 | 23.10 | - | - | - |
| Total SNCT recommendation | 54.05 | 32.43 | 21.62 | -12.05 | -13.53 | 1.48 |
| Total PJ recommendation | 51.72 | 23.53 | 28.19 | -9.72 | -4.63 | -5.09 |

| Proposed RN | M | T | W | T | F | S | S |
|---|---|---|---|---|---|---|---|
| Ward Coordinator | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| E/L | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| N | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| **Proposed HCA** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| E/L | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| N | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| | | | | | | | |
| | | | | | | | |
| plus 0.6 RN for ward manager time | | | | | | | |

**Summary**

Ward 40 is a 30 bedded ward that provides all essential nursing care to the high number of frail and elderly patients which includes providing full support with fluid and nutrition, safe mobility, pressure care assessment, prescribed care & enhanced care to those requiring 1:1 supervision.

SNCT proposes an average under establishment of 12.10wte
There is a requirement to move to a 60/40 sill mix (from 40/60)

High levels of falls which could correlate to an inability to provide enhanced care to patients when the service capacity is exceeded

High level of meds errors correlates with high dependency of patients and complex drug regimes. Increasing numbers of hospital acquired PU correlated with CSU concerns that can have up to 10 patients needing 2hrly repositioning

The Nurse-to-patient ratio is currently 1:10 both day and night with acutely unwell and vulnerable patients whose dependency levels generally do not reduce at night time. The proposed nursing model needs to reflect this and to also support moving to a 4 team structure to improve the over all nurse to patient ratios and maintain compliance with NICE and RCN safer staffing guidance.

By investing in the CSW workforce the ward would be in a position to absorb a part of the enhanced care demand within the nursing establishment, thus reducing the reliance on the enhanced care team or temporary staffing. This will also allow staff with the right skills to provide 1:1 or frequent visual monitoring to this specific patient group.

**Recommendations**

The Professional judgement recommendation is to uplift the total establishment by 5.86WTE RN and 3.91WTE CSW to support the provision of the required template.

The required template will allow for 60% Ward Manager supervisory time and will allow for RN Ward Coordination mon-sun to provide oversight and coordination of patients with complex healthcare and discharge plans.

The proposed template will also support to provision of 4 teams of patients, reducing the nurse to patient ratio to a safe level to manage needs of the patients but during the day and at night time.

# Appendix 2

**Ward 42**

| | | Capacity | | SNCT Outputs | | | | | | | Current Establishment | | SNCT Recommended Establishment | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Data Collection Date | Bed capacity | open beds | Average total Level 0 | Average total Level 1a | Average total Level 1b | Average total Level 1c | Average total Level 1d | Average total Level 2 | Average total Level 3 | Current budgeted total WTE nurse establishment | Current Planned skill mix (RN/CSW) | Total WTE nurses recommended by multiplyers | Recommended RN (WTE) (60/40) | Recommended CSW (WTE) (60/40) | Proportion of total WTE recommendation being 1c & 1d | Variance total recommended v total budget |
| Ward 42 | Oct-25 | 36 | 30 | 2.77 | 0.00 | 31.60 | 1.63 | 0.00 | 0.00 | 0.00 | 51.1 | 60/40 | 69.41 | 41.65 | 27.76 | 5.24 | -18.31 |
| Ward 42 | Mar-26 | 30 | 30 | 5.67 | 0.23 | 27.57 | 2.53 | 0.00 | 0.00 | 0.00 | 51.1 | 60/40 | 68.72 | 41.23 | 27.49 | 8.13 | -17.62 |
| **Average** | - | **36.00** | **36.00** | **4.22** | **0.12** | **29.59** | **2.08** | **0.00** | **0.00** | **0.00** | **51.10** | - | **69.07** | **41.44** | **27.63** | **6.69** | **-17.97** |

| | Safety | | | | | | | Quality | Workforce | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward/Dept | Falls including slips, trips and collapse | Medications | Trust acquired pressure ulcers Cat 1 | Trust acquired pressure ulcers Cat 2 | Trust acquired pressure ulcers Cat 3 or SDTI | Trust acquired pressure ulcer unstageable (min Cat 3) | Staffing related In-phase report | Patient Experience Total complaints | Average Occupancy % | Total Nursing Sickness / absense % | Total Nursing Turnover % | Combined RN Temp staffing (hours) | Combined RN Temp staffing (WTE) | CombinedCSW Temp staffing (hours) | Combined CSW temp staffing use (WTE) |
| Sep-25 | 12 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 99.59 | 8.76 | 6.05 | 472.58 | 3.15 | 2901.92 | 19.35 |
| Oct-25 | 9 | 3 | 1 | 1 | 0 | 0 | 1 | 3 | 99.73 | 8.84 | 6.05 | 616.5 | 4.11 | 1739.83 | 11.60 |
| Nov-25 | 6 | 0 | 1 | 2 | 0 | 0 | 0 | 1 | 99.72 | 7.35 | 7.76 | 704.58 | 4.70 | 1543.17 | 10.29 |
| Dec-25 | 13 | 0 | 0 | 1 | 1 | 1 | 2 | 1 | 98.12 | 9.94 | 12.18 | 697.5 | 4.65 | 1743 | 11.62 |
| Jan-26 | 10 | 1 | 2 | 0 | 1 | 0 | 0 | 1 | 99.82 | 9.94 | 11.46 | 730.75 | 4.87 | 2082 | 13.88 |
| Feb-26 | 11 | 5 | 0 | 2 | 0 | 0 | 0 | 3 | 99.7 | 9.94 | 10.22 | 599.75 | 4.00 | 2249.5 | 15.00 |
| **Total** | **61** | **10** | **5** | **6** | **2** | **1** | **3** | **10** | **99.45** | **9.13** | **8.95** | **Average** | **4.25** | **Average** | **13.62** |

| Professional Judgement (WTE) | | RN (WTE) | CSW (WTE) | Total variance to current nurse est. | Variance to current nurse est RN | Variance to current nurse est HCA |
|---|---|---|---|---|---|---|
| **Total current nurse establishment** | 51.10 | 21.00 | 30.10 | - | - | - |
| **Total SNCT recommendation** | 69.07 | 41.44 | 27.63 | -17.97 | -20.44 | 2.47 |
| **Total PJ recommendation** | 62.01 | 26.12 | 35.88 | -10.91 | -5.12 | -5.78 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Proposed RN** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| **Ward Coordinator** | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| **E/L** | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| **N** | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| | | | | | | | |
| | | | | | | | |
| **Proposed HCA** | **M** | **T** | **W** | **T** | **F** | **S** | **S** |
| **E/L** | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| **N** | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| | | | | | | | |
| | | | | | | | |
| plus 0.6 RN for ward manager time | | | | | | | |

**Summary**

Ward 42 is a 36 bedded ward that provides all essential nursing care to the high number of frail and elderly patients which includes the administration of fluid and nutrition, safe mobility, pressure care assessment, prescribed care & enhanced care to those requiring 1:1 supervision.

It was previously agreed that a skill mix of registered nurse to unregistered nurse of 40/60 was more appropriate to support this patient mix to allow more unregistered nurses in the overall workforce model to support safe and efficient care to meet the needs of the patients. However, this naturally increases the nurse-to-patient ratio in a large unit of 36 beds. The CSU would like to work to move this skill mix to 60/40 to improve ratios and the visibility of the RN to manage the complex needs of this patient group.

Enhanced care requirements are high on ward 42 which creates an increase in unregistered temporary staff usage. High levels of falls which could correlate to an inability to provide enhanced care to patients when the service capacity is exceeded. By investing in the CSW workforce the ward would be in a position to absorb the enhanced care demand within the nursing establishment. This will also allow staff with the right skills to provide 1:1 or frequent visual monitoring to patients..

SNCT proposes an under establishment of 17.92wte which supports a 60/40 sill mix (from 40/60).

The RN and HCA vacancy is minimal with zero RN vacancy and 0.6 CSW vacancy. RN and CSW sickness is high at 9% which is significantly higher than 4% planned headroom. High levels of falls which could correlate to an inability to provide enhanced care to patients when the service capacity is exceeded. High level of meds errors correlates with high dependency of patients and complex drug regimes.

The Nurse-to-patient ratio is currently 1:12 both day and night with patients whose dependency levels generally do not reduce at night. The proposed nursing model will support a 4 team structure to improve the over all nurse to patient ratios (1:9) and move towards improved compliance with NICE and RCN safer staffing guidance.

By investing in the CSW workforce the ward would be able to absorb a most of the enhanced care demand within the nursing establishment, thus reducing the reliance on the enhanced care team or temporary staffing. This will also allow staff with the right skills to provide 1:1 or frequent visual monitoring to this specific patient group.

**Recommendations**

The Professional judgement recommendation is to uplift the total establishment by 5.12WTE RN and 5.78WTE CSW to support the provision of the required template.

The required template will allow for 60% Ward Manager supervisory time and will allow for RN Ward Coordination mon-sun to provide oversight and coordination of patients with complex healthcare and discharge plans.

The proposed template will also support to provision of 4 teams of patients, reducing the nurse to patient ratio to a safe level to manage needs of the patients but during the day and at night time.

Investing in the CSW would be absorb most of the enhanced care demand within the nursing establishment, providing patients with 1:1 care by staff with the correct skill set to manage the needs of this patient group.

## Appendix 3

## Front Sheet - Actual staffing v SNCT outcomes

| Collab | Ward | SNCT Outcome RN | Actual RN | Variance ( - deficit) | SNCT Outcome HCA | Actual HCA | Variance ( - deficit) | HON Comments |
|---|---|---|---|---|---|---|---|---|
| CSU 5: Cardiovascular Services | **CCU** | 21.03 | 35.68 | **14.65** | 8.09 | 2.16 | **-5.93** | The SCNCT data is not suitable to represent a level 2 environment. It is a challenge to determine the exact need on CCU using the SNCT tool due to the level of patient acuity in this area. The audit tool is not fit for purpose for this level of acuity and the responsiveness required to leave the unit for emergency care provision outreaching (cath labs, cardiac arrest bleep). |
| | **Ward 28 Vas** | 39.09 | 21.00 | **-18.09** | 15.04 | 17.19 | 2.15 | Based on the current footprint and high acuity of level 1 b patients the staffing establishment should remain the same on a day shift with a firm argument to revisit the stretch and extremis numbers for the ward, as these numbers are currently the same and teams running therefore on extremis predominantly. Revisit to Increase numbers to 4 RNs on a night as they currently struggle due to patient acuity and complex vascular, diabetic foot /ankle, amputee, mobility compromises, the risk of fall to patient ration is high due to this patient group. A further RN/ HCSW would provide increased ability to review patients and perform skin integrity checks and enable prompt reporting of deterioration. . The percentage of level 1B captures the number of patients with complex wounds that takes a considerable amount of time, and numbers of amputee patients who require the assistance of 2 or more nursing team members. |
| | **Ward 29** | 26.28 | 22.52 | **-3.76** | 10.11 | 10.56 | 0.45 | The SNCT recommendation of RN to HCSW for the ward reflects the requirement for the acuity on ward 29 ST. The challenge of sickness and vacancy impacts the shift-to-shift numbers currently. Ward 29 has 5 WTE over budget with NQN and NA, and is carrying 2 WTE HCAs vacancies. The HCSW is crucial to support the safe patient care at night when there is an increased risk of falls. Explore role of floor coordinator for a 36 bedded ward, to support the flow throughout the department and coordinate the ACS transfers as currently coordinator for CCU and Cath lab flow only. |
| | **Cardio MB** | 9.88 | 8.84 | **-1.04** | 3.80 | 5.20 | 1.40 | Staffing establishment is at the correct levels. We cannot reduce the number of RN's as suggested as we currently only have 2 Nurses for 9 patients and require a HCA around the clock for support and to ensure telemetry is monitored and alarms responded to. |
| | **Ward 32** | 21.93 | 19.80 | **-2.13** | 8.44 | 11.48 | 3.04 | SNCT supports the need for an additional RN on nights, due to patient acuity and post-operative acuity, medication requirements and rehabilitation of CT patients with ERACs program. The SNCT demonstrates a need for increased HCSW support for a night would support. The ward 32 staffing does not represent its teams roles as 0.8 WTE of a RN and 0.8 WTE of an HCSW of this workforce is required to deliver PAC weekly which depletes the ward staffing and increases the need for NHSP. |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **CSU 2: Digestive Health, Urology and General Surgery Services** | **Ward 5** | 32.97 | 21.97 | **-11.00** | 12.68 | 16.05 | 3.37 | This is a 31 bedded ward with an occupancy level of 96.34% and with high acuity/dependency levels. The patients on this area often need a full MDT approach to their care involving the Consultants, Specialist nurses, Dieticians, Psychiatry and Clinical Psychologists. This is due to the complex nature of the patients for example the eating -disorder patients/alcohol and drug addiction. As reflective of the SNCT data it highlights an increase of Registered/Unregistered nurses to support not only this cohort of patients but the level of care required in terms of 1-1 supervision but also the patient group who are acutely unwell and can rapidly deteriorate. Therefore, it is important to consider the data above in support of requiring a higher level of registered nurse input to reflect the overall acuity and dependency of the patients on Ward 5. To note the CSU has been successful in securing non-recurrent funding from the ICB for 1 year for a dedicated detox bed on Ward 5 in support of improving their overall outcome and to proactively manage the disease profile. This will provide a standardised approach across UHT and provide our communities with an opportunity to improve their overall health andwell- being aligned to the national profile of our catchment area in relation to health inequalities. |
| | **Ward 6** | 25.50 | 18.92 | **-6.58** | 9.81 | 13.93 | 4.12 | This is a 29 bedded elective surgical ward and currently has an occupancy of 80.11%. As elective surgery has progressed and following GIRFT principles the move towards day case procedures has increased and therefore the requirement for overnight stays is reducing. The CSU is currently working through all the data to understand capacity and demand as in reality the figures are highlighting the increased demand for acute surgery which equates to over 50% of the bed base onWard 6. However a full review of the bed stock is taking place within surgery to understand the requirementwhich will then feed into the wider discussions across the Group in terms of the overall bed modelling. |

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| | **Ward 7** | 31.28 | 23.68 | **-7.60** | 12.03 | 16.80 | 4.77 | Ward 7 is a 31 bedded ward with an occupancy of 91.83% and admits complex acute and elective surgical patients, step down patients from both Critical care and PACU. This area also provides provision for complex nutritional needs, TPN, line care, chest drains and complex wound dressings. Ward 7 requires input regularly from Critical care outreach not only for the step-down<br>patients but for patients who are acutely unwell which is reflective of their SNCT data both in September 2025 and March 2026. The SNCT data is highlighting an increased Registered nurse uplift to strengthen the skill mix in this area which is key to enable the safe care of patients within this area. To note surgical nurse staffing, in line with National Guidance Institute for Health and Care Excellence (NICE) guidance focuses on ensuring that patient needs are met through evidence -based planning rather than relying solely on fixed, mandatory ratios. However, safe surgical nurse to patient ratios commonly aims for 1:6 on an acute ward as the evidence indicates that each additional patient added to a nurse's workload increases 30-day mortality risk by 16%.The core NICE guidance (SG1) dictates that staffing should be based on acuity and dependency and NICE guidelines for level 1 surgical care (care for patients at risk of deterioration, often on a general surgical ward requiring increased support and are for escalation to Critical Care) are primarily covered under the Perioperative care in adults (NG180) and Acutely ill patients in hospital (CG50). As outlined in NICE guideline SG1: Safe staffing for nursing in adult inpatient wards in acute hospitals (NICE SG1) the ratio significantly reduces overnight despite little variation in patient activity or acuity. Therefore, to summarise there is a need to improve the skill mix based on the data, and the guidance. This will require the strengthening of the Registered nurse workforce both days and nights to enable a skill- mix uplift to 70% Registered nurse and 30% Care support worker. There are some options we have already explored and are in the process of strengthening the skill mix by converting unregistered to registered without increased cost and headcount. Reducing the number of Nursing Associates in this area as they have limited abilities in managing the complex patients and require guidance/support. A further option to consider is to close beds to 24 with no outliers and to ensure the area has clear identity due to the complex nature of the patients. This will support the ratios of staff<br>required to manage the patients safely, reduce the number of complaints, CQC concerns and incidents and support the well-being of the staff. However, appreciate this will require further discussion and a collective approach across the Group and alignment to bed modelling. In summary, this area needs investment to meet safe staffing numbers and to improve their overall metrics. If there<br>is no possibility of investment then an agreement to reduce the bed base in line with the guidance. |

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| | **Ward 8** | 31.76 | 23.92 | **-7.84** | 12.22 | 13.80 | 1.58 | Ward 8 is an acute 30 bedded ward with an occupancy of 88.2%. The ward is the acute Urology and Gynaecology but also accepts critical care steps downs, patients discharged from PACU and urology patients across the Tees Valley including patients from County Durham and Darlington. This area also accepts outliers which can impact on the elective programme, increased length of<br>stay for patients being cared for out with Urology. Therefore, it is important we consider the bed modelling across the Group to ensure we are taking care of patients in the "right place".<br>From June 2026 the area out of hours is commencing a proof of concept of accepting all acute Urology admissions after 5pm for a period of 3 months from both County Durham and Darlington and North Tees and Hartlepool. This is in support of our horizontal integration and regional direction. The workforce does not require any further investment; however, the template may require adjustment to reflect the changes.<br>In summary for CSU 2 the key area of concern is Ward 7 staffing and the need to strengthen the skill mix or consider the closure of beds in support of safe staffing. |
| **CSU 10: Community and Neighbourhood Health Services** | **Ainderby** | 37.44 | 15.33 | **-22.11** | 14.40 | 15.80 | 1.40 | This is a 27 bed ward with frail and complex medical patients and is managing effectively with a ratio of 4 RN +4 CSW. When not in winter pressures the ward is open to 22 beds and runs at a ratio of 4+4 through the day and 2+3 overnight. When the ward is at full capacity of 27 beds an additional RN overnight is required to deliver safe patient care and this ratio is 3+3 overnight. This ward currently supports surgical pathway day case procedures which are incorporated into the bed base. Future plans include a sit out area for patients who follow a surgical pathway for day care support which would not increase RN requirements. |
| | **CDU** | 26.45 | 18.98 | **-7.47** | 10.17 | 8.30 | **-1.87** | This is a 22 bedded admission ward for medical patient admissions, including telemetry patients. There is not a requirement for an increase in RN or HCA establishment in this area. |
| | **Friary** | 23.77 | 11.87 | **-11.90** | 9.14 | 12.75 | 3.61 | This ward is based in a remote area with no internal support structures, the current staffing ratios are effective at delivery of safe care. |
| | **Romanby** | 32.30 | 17.10 | **-15.20** | 12.43 | 16.18 | 3.75 | This 27 bedded medical ward is providing safe care within the current establishment. Outside of winter pressures the ward is open to 22 beds and delivers safe patient care with the staffing at 4+4 throughout the day and 2+3 overnight. When the ward is open to full capacity of 27 beds, to deliver safe care overnight the ratio is increased to 3+3. |
| | **Rutson** | 22.37 | 13.93 | **-8.44** | 8.61 | 11.79 | 3.18 | is a 17 bedded primary care rehabilitation ward with 10 stroke beds and 7 general rehab beds. This ward is ensuring safe care with the current establishment. This ward does not increase beds over the winter period and therefore to deliver safe patient care it works within the staffing of 3+3 throughout the day and 2+2 overnight. However, consideration to stroke guidance in relation to dependency of patients and increase in workforce recommended. |

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| | **Tocketts** | 37.07 | 19.45 | **-17.62** | 14.26 | 22.79 | 8.53 | This 30 bedded rehabilitation ward has 20 older persons medicine beds and 10 GP beds. The layout of the ward is problematic and due to the footprint reduces visibility and due to this risk to patients there should not be a reduction to HCSW workforce. The nurse-to-patient ratio when fully established provides safe care to the patients. The recommendations from SNCT do not match the patient need as a reduction in HCSW would not be appropriate due to the dependency of the patients on this older person's medicine ward. However, this ward would benefit from an increase of RN workforce to ensure ability to maintain 4RN + 5HCSW during the day and 3RN + 4HCSW overnight. |
| | **Ward 11** | 37.59 | 22.88 | **-14.71** | 14.46 | 17.28 | 2.82 | This 28 bedded ward looks after older adults with physical dependency, multiple co-morbidities, clinical frailty, and high requirements for 1-1 observation for both behaviours and psychological symptoms of dementia, delirium and falls prevention. There is a high percentage for patients being scored as 1b, therefore indicative of a need to increase the RN workforce to ensure the ability to maintain 5RN + 4HCSW throughout the day and 3RN + 3HCSW overnight. |
| | **Ward 12** | 37.72 | 20.84 | **-16.88** | 14.51 | 18.03 | 3.52 | This 27 bedded ward looks after older adults with physical dependency, multiple co-morbidities, clinical frailty, and high requirements for 1-1 observation for both behaviours and psychological symptoms of dementia, delirium and falls prevention. There is a high percentage for patients being scored as 1b. In addition, this ward has a very similar patient group and SNCT results to reflect as per ward 11, however the establishment of RN's is less than ward 11. Therefore, indicative of a need to increase the RN workforce of 1 RN per day shift. This would enable ward 12 to function with 5RN + 4HCSW throughout the day and 3RN + 3HCSW overnight. |
| | **Zetland** | 44.89 | 21.17 | **-23.72** | 17.27 | 28.68 | 11.41 | This 31 bedded rehabilitation ward provides care in single side rooms. This is the reason that SNCT recommends a decrease in HCSWs, however the estate is very problematic and has a difficult footprint being a H shape, thus reducing visibility and due to the risk to patients in this side room layout there should not be a reduction to HCSW workforce. In addition, the ward has 16 stroke rehabilitation beds and 15 older persons medicine beds and due to the dependency of this group of patients. The requirement for HCSW is necessary and the ward is ensuring safe care with the current HCSW establishment albeit below the recommendations of the national stroke guidance published in 2023. However, this ward would benefit by an increase of RN workforce to ensure ability to maintain 5RN + 8HCSW throughout the day and 3RN + 4HCSW overnight. |
| **CSU 3: TORPEDO** | **Gara** | 21.61 | 13.91 | **-7.70** | 8.31 | 7.80 | -0.51 | 21 bedded in patient elective ring-fenced orthopaedic ward, based at the Friarage site. Working collaboratively with the Surgical Hub, accommodating day case/day zero patients. Average number of patients over the month of March 2026 was 7.48 (BIU data). The ward worked at a general ratio of 3 RNs & 2 CSWs days and 2 RNs & 2 CSWs nights. No patient safety incidents reported during this period. Currently over established on RNs due to accommodating NQN and a RTP student. Under on HCAs due to maternity leave. There is a CSU 3 focused piece of work around elective hub work and increasing the activity coming through the ward, which would be supported by the current staffing model. |

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| | **Ward 25** | 34.76 | 18.80 | **-15.96** | 13.37 | 11.03 | **-2.34** | 21 bedded in patient hip fracture unit, based at the James Cook site, working collaboratively with the care of the elderly team. Accommodating all hip fractures that come through the site predominantly a frail, multi co-morbid and elderly population that often pose a falls risk, which in turn requires 1:1 care via a falls watch. This is not staffed from the ward establishment and requires support from NHSP requests. For the month of March 2026 the ward spent £1362 on falls watches. Average number of patients over the month of March 2026 was 19.43 (BIU data). The ward worked at a general ratio of 4 RNs & 3 CSWs days and 3 RNs & 2 CSWs nights. No patient safety incidents reported during this period. Currently under established on RNs by 0.83 and under on CSWs by 1.61 all due to maternity leave. Professional judgement would suggest the need for additional CSWs both days and nights due to the dependency and frailty of the patient group. |
| | **Ward 27** | 14.39 | 14.95 | 0.56 | 5.54 | 8.37 | 2.83 | 15 bedded in-patient green ringfenced elective orthopaedic ward based at the James Cook site. Average number of patients over the month of March 2026 was 6.97 (BIU data). The ward also accommodates up to two spinal patients at any one time due to capacity in bed base. The ward worked at a general ratio of 3 RNs & 2 CSWs days and 2 RNs & 2 CSWs nights. No patient safety incidents reported during this period. Currently over established on RNs 2.82 WTE. Under on HCAs due to vacancy. There is a CSU 3 focused piece of work focusing on utilisation of bed base across all the sites, this in the future may suggest a reduction in workforce depending on bed base, location and capacity. |
| | **Ward 35** | 35.09 | 22.28 | **-12.81** | 13.50 | 13.48 | **-0.02** | 26 bedded in patient ward accommodating multiple specialties. It has been previously agreed that they require an additional 2.20 WTE at least twice a week to care for L2 post-op patients who require 1:1 specialist care. It has been previously agreed that OOH weekend work, the ward support patients requiring urgent plastics treatment. Agreement via the previous SLT forum, was that of an additional RN, this has never been aligned to budget. The ward is also supported by military personal, 2 WTE RNs and 1 WTE CSW, they are within the ward establishment. The military colleagues will withdraw from Ward 35 in June 2026, which leave a short fall in the additional RN ask as previously agreed. Professional judgement is to ensure recruitment into those gaps. Average number of patients over the month of March 2026 was 23 (BIU data). The ward worked at a general ratio of 5 RNs & 4 CSWs days and 3 RNs & 3 CSWs nights. No patient safety incidents reported during this period. There is ongoing work to develop an enhanced bay on Ward 35 where L2 post-op patients can be cohorted and therefore staffing aligned more efficiently and appropriately (SOP currently in development stage). |

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| | **Ward 36** | 37.13 | 23.48 | **-13.65** | 14.29 | 14.56 | 0.27 | 34 bedded major trauma centre in patient ward, working collaboratively with ED, major trauma co-ordinators and surgical trauma teams. Physically demanding and often emotionally and psychologically complex patients requiring a specialist nursing skill set. The ward requires a major trauma trained nurse 24/7. The ward accommodates multiple specialties across both medical and surgical pathways. Average number of patients over the month of March 2026 was 26.1 (BIU data). The ward is also supported by military personal, 2 WTE RNs and 1 WTE CSW, they are within the ward establishment but can be re-deployed without notice. The ward worked at a general ratio of 5 RNs & 4 CSWs days and 4 RNs & 3 CSWs nights. No patient safety incidents reported during this period. Currently over established on RNs 1.92 mainly due to supporting NQN programme. |
| **CSU 6: Cancer Institute** | **Ward 14** | 28.14 | 23.20 | **-4.94** | 10.83 | 12.32 | 1.49 | No change to establishment is required. Ward 14 offers a telephone support line at nights and weekends for patients requiring oncology advice as per UKONS guidance. It was expected additional HCA support recommendation given the complexities of EOLC patients and complexities of pain management and syringe drivers. |
| | **Ward 33** | 27.23 | 23.52 | **-3.71** | 10.48 | 12.96 | 2.48 | Ward 33 offers a telephone support line at nights and weekends for patients requiring haematology advice as per UKONS guidance. The British Society for Haematology staffing guidance for patients who are neutropenic is a ratio of 1:4, the agreed ward staffing on ward 33 is 1:5 during the day and 1:8 during the night as not all patients on the ward are neutropenic, therefore a requirement to increase nurse staffing is recommended. |
| **CSU 8: General and Emergency Medical Services** | **Ward 01 - Located on Ward 02 for 10 months** | 44.02 | 34.48 | **-9.54** | 16.93 | 22.28 | 5.35 | Takes direct admissions from the Emergency Department. There is a high activity level on Ward 1 with high numbers of admissions, discharges, and internal transfers / escorts recorded. In addition to the agreed bed base, the ward has patients waiting for admission via ambulance or with family in a dedicated area. The professional judgement recommends an additional 2 nurses to support the high level of acuity and dependency associated with this area of nursing. The ward has 24-hour supernumerary co-ordination due to the numbers of admissions and discharges. In addition, a designated nurse with ALS skills holds the cardiac arrest bleep 24 hours a day and must be able to leave immediately to attend emergency calls off the ward. Ward 1 will also provide care to patients requiring RSU level care (enhanced care of 1:4 ratio) |
| | **Ward 02 - Located on Ward 10 for 2 years** | 34.72 | 23.13 | **-11.59** | 13.36 | 11.53 | **-1.83** | SNCT recommendations exceeds the requirement of staffing required to provide safe care. The ward has an increase in patients with a higher level of acuity during the collection period. This is not a reflection of usual activity across a full year. |
| | **Ward 03** | 36.96 | 18.51 | **-18.45** | 14.22 | 11.23 | **-2.99** | No change is required, as the SNCT recommendation has included the CMD unit which no longer functions on Ward 3. |
| | **Ward 04** | 32.40 | 22.36 | **-10.04** | 12.46 | 12.00 | **-0.46** | Whilst the nursing establishment currently provides safe care, the need to increase HCAs has been reflected in professional judgement and SNCT outcomes. Ward 4 offers a telephone support line at night and weekends for patients requiring Nephrology advice this includes renal transplantation open access. Ward 4 also delivers a vascular access service, which requires the assistance of a HCA with the procedure I would support the additional HCA for this as it has never been factored in the establishment, we also have a higher risk of falls due to the patient group and the value for a third HCA overnight would be safer care. |

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| | **Ward 09** | 47.78 | 32.44 | **-15.34** | 18.38 | 14.40 | **-3.98** | is a 34 bedded respiratory ward. The ward footprint includes 10 ring fenced beds that are used for patients requiring high levels of respiratory support split over 2 bays and 2 siderooms, offering dedicated male and female beds. The ward footprint is large, and this is challenging to manage as there is often a requirement to provide additional respiratory support in side rooms. All RSU beds require British Thoracic Society recommended level 2 nurse to patient ratios (1:2 – 1:4) and this is reflected in the wards funded establishment. In winter the ward's activity, acuity and dependency predictably increase. SNCT and professional judgement both indicate a requirement to increase RN and HCA numbers in this area. This is reflective of the patient need. |
| | **Ward 31** | 51.13 | 28.76 | **-22.37** | 19.67 | 24.37 | 4.70 | Professional judgement and actual staffing are appropriate for Ward 31; no change is required. |
| | **Ward 37** | 40.66 | 33.60 | **-7.06** | 15.64 | 20.40 | 4.76 | It takes direct admissions from the Emergency Department and via GP's. There is a high activity level on Ward 37 with high numbers of admissions, discharges, and internal transfers / escorts recorded. In addition to the agreed bed base the ward has patients waiting admission via ambulance or with family in a dedicated area. The professional judgement recommends an additional 2 nurses to support the high level of acuity and dependency associated with this area of nursing. The ward has 24-hour supernumerary co-ordination due to the numbers of admissions and discharges. In addition, a designated nurse with ALS skills holds the cardiac arrest bleep 24 hours a day and must be able to leave immediately to attend emergency calls off the ward. Ward 37 will also provide care to patients requiring RSU level care (enhanced care of 1:4 ratio) |
| **CSU 9: Neuroscience Services** | **Spinal Injuries & HDU** | 32.00 | 32.72 | 0.72 | 12.31 | 21.32 | 9.01 | As a regional spinal injury unit, the unit should be commissioned for 1 RN and 1 HCA per 4 patients with a supernumerary coordinator for the ward during the day with 3 RNs overnight. The Spinal HDU should be 2 RNs days and night with an CSW. The recommendations from professional judgement and SNCT for SHDU. However, the reduction in the number of CSW wouldn't allow the spinal injuries unit to run safely and patient care and safety would not be maintained at the levels if reduced to SNCT figures. The CSW figures are not capturing the level of support and care that is required for this type of injury day to day/night. National piece of SNCT work underway also to feedback. |
| | **Ward 24** | 31.10 | 19.36 | **-11.74** | 11.96 | 12.84 | 0.88 | There has been an ongoing requirement for an increase in HCAs with a consistent additional spend on NHSP for falls and acuity, we have asked for this to be added into the budget each year however has not been realised in the budget. It is not safe to reduce NHSP spend on this ward for HCSW however the number of RNS in budget is appropriate. |
| | **Ward 26** | 28.24 | 15.08 | **-13.16** | 10.87 | 13.48 | 2.61 | The data suggests the ward would benefit from an increase in RN establishment which on reflection within CSU9 we feel an increase in CSW would be preferable aligned with the data and experiences for the ward. We have requested an increase year on year for CSW on this ward due to the number of patients requiring 1-1 level care due to the risk of falls and cognitive problems, again unable to reduce NHSP spend due to the requirement to maintain safety currently |

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| | **Ward 34** | 44.14 | 34.84 | **-9.30** | 16.98 | 23.44 | 6.46 | Ward 34 is a 34 bedded NASU including a 6 bedded hyper acute stroke bay and 1 thrombolysis side ward. The remaining beds are a combination of Acute Strokes and Neurology patients and 2 telemetry beds Monday to Friday which are constantly monitored by a CSW with the beds used for sleep studies on a weekend. As a combined ward, there is a requirement to increase both RNs and HCAs to ensure that safe care is provided across the ward and monitored bay area. The monitored bay requires an increase in RN's to 3 day and nights which is not being achieved currently/budgeted, due to patient acuity and being a level 2 facility. In addition, the nurses spend a significant amount of time away from the ward with emergency admissions having diagnostics as part of the pathway for example. Although SNCT recommends a further uplift the investment requested here would be adequate. CSU 9 are currently working through a stroke pathway UHT redesign model which looks at both national, SNCT and both hyperacute and acute staffing ratios to work towards. |
| **CSU 1: Family Health Services** | **Ward 21** | 24.22 | 32.12 | 7.90 | 12.18 | 9.80 | **-2.38** | Based on current bed occupancy data, there appears to be a surplus of registered nursing staff across both wards, while HCA staffing aligns when play staff are considered; however, this does not fully reflect the significant day-to-day fluctuations in occupancy and acuity across CYP services. Ward 22 activity is driven by variable theatre lists, which are increasing but remain below pre-COVID levels, while Ward 21 experiences sustained higher occupancy from October to April. National guidance (RCN 2013; NHSE&I 2021; ABPN 2025) highlights more stringent expectations for staffing ratios, skill mix, headroom, and the requirement for a supernumerary coordinator, exceeding current local assumptions. Children remain a highly vulnerable cohort requiring continuous supervision and increased parental support, with a notable rise in admissions involving mental health and social care needs requiring enhanced care. Staffing across paediatric and neonatal services is therefore actively managed and flexed daily due to specialist skill requirements, limiting reliance on NHSP, with ongoing actions focused on regular workforce review, improved data quality, and identifying efficiencies within the group model. |
| | **Ward 22** | 9.79 | 17.81 | 8.02 | 4.92 | 7.92 | 3.00 | |

## Appendix 4

| CSU | Ward | Current budget RN | SNCT RN | PJ RN | Variance SNCT v Budget RN | Variance PJ v Budget RN |
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| **CSU1 Family Health** | SCBU | 19.56 | 22.32 | 21.52 | -2.76 | -1.96 |
| | Ward 15 | 25.26 | 30.75 | 26.14 | -5.49 | -0.88 |
| | CYPED | 2nd cycle of data required in Sep26 | | | | |
| **CSU2 DHUGS** | Ward 26 | 21.8 | 31.19 | 23.49 | -9.39 | -1.69 |
| | Ward 27 | 19.2 | 29.41 | 23.49 | -10.21 | -4.29 |
| | Ward 28 | 20.2 | 27.19 | 20.78 | -6.99 | -0.58 |
| | Ward 30 | 27.5 | 25.56 | 33.12 | 1.94 | -5.62 |
| | Ward 31 | 22.9 | 25.33 | 23.49 | -2.43 | -0.59 |
| **CSU3 TORPEDO** | Ward 32 | 20.2 | 26.14 | 27.8 | -5.94 | -7.6 |
| | Ward 33 | 20.2 | 25.76 | 23.72 | -5.56 | -3.52 |
| **CSU4 TACCS** | Critical Care | N/A | | | | |
| **CSU5 CARDIO** | Ward 29 | 21 | 34 | 29.17 | -13 | -8.17 |
| **CSU8 GEMs** | Ward 24 | 23.6 | 36.61 | 26.57 | -13.01 | -2.97 |
| | Ward 25 | 22.6 | 37.36 | 26.57 | -14.76 | -3.97 |
| | Ward 36 | 24.4 | 36.16 | 23.98 | -11.76 | 0.42 |
| | Ward 38 | 25.7 | 13.05 | 23.98 | 12.65 | 1.72 |
| | EAU | 69.7 | 79.26 | 68.13 | -9.56 | 1.57 |
| | ED | 2nd cycle of data required in Sep26 | | | | |
| **CSU9 NEURO** | Ward 41 | 21.8 | 29.02 | 28.27 | -7.22 | -6.47 |
| **CSU10 CNHS** | Ward 40 | 18.9 | 32.43 | 23.53 | -13.53 | -4.63 |
| | Ward 42 | 21 | 41.44 | 26.12 | -20.44 | -5.12 |
| | | **445.52** | **582.98** | **499.87** | **-137.46** | **-54.35** |

| **CSU** | **Ward** | **Current CSW** | **SNCT CSW** | **PJ CSW** | **Variance SNCT v Budget CSW** | **Variance PJ v Budget CSW** |
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| **CSU1 Family Health** | SCBU | 2.5 | 2.48 | 2.39 | 0.02 | 0.11 |

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| | Ward 15 | 10.82 | 13.18 | 11.2 | -2.36 | -0.38 |
| | CYPED | 2nd cycle of data required in Sep26 | | | | |
| **CSU2 DHUGS** | Ward 26 | 17.1 | 20.79 | 16.05 | -3.69 | 1.05 |
| | Ward 27 | 18.2 | 19.61 | 18.72 | -1.41 | -0.52 |
| | Ward 28 | 19.2 | 18.13 | 21.4 | 1.07 | -2.2 |
| | Ward 30 | 15.3 | 10.95 | 21.4 | 4.35 | -6.1 |
| | Ward 31 | 13.4 | 10.86 | 16.05 | 2.54 | -2.65 |
| **CSU3 TORPEDO** | Ward 32 | 21.4 | 26.14 | 27.8 | -4.74 | -6.4 |
| | Ward 33 | 15.1 | 17.17 | 15.82 | -2.07 | -0.72 |
| **CSU4 TACCS** | Critical Care | N/A | | | | |
| **CSU5 CARDIO** | Ward 29 | 14 | 14.57 | 12.82 | -0.57 | 1.18 |
| **CSU8 GEMs** | Ward 24 | 16.9 | 15.69 | 15.38 | 1.21 | 1.52 |
| | Ward 25 | 17.2 | 16.01 | 15.38 | 1.19 | 1.82 |
| | Ward 36 | 18.2 | 24.1 | 15.38 | -5.9 | 2.82 |
| | Ward 38 | 15.4 | 13.05 | 15.38 | 2.35 | 0.02 |
| | EAU | 39.8 | 33.97 | 38.32 | 5.83 | 1.48 |
| | ED | 2nd cycle of data required in Sep26 | | | | |
| **CSU9 NEURO** | Ward 41 | 17.4 | 19.34 | 17.94 | -1.94 | -0.54 |
| **CSU10 CNHS** | Ward 40 | 23.1 | 21.62 | 28.19 | 1.48 | -5.09 |
| | Ward 42 | 30.1 | 27.63 | 35.88 | 2.47 | -5.78 |
| | | **325.12** | **325.29** | **345.5** | **-0.17** | **-20.38** |

**Appendix 5**

## North Tees and Hartlepool NHSFT

## Developing Workforce Safeguards Compliance Document

## May 2026

| Recommendation | Trust position | Identified Actions |
|---|---|---|
| **1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.** | **Compliant**<br><br>The Trust continues to apply the principles of ensuring the right staff, with the right skills, in the right place at the right time.<br><br>Nurse establishments are reviewed through a structured bi-annual review process incorporating evidence-based workforce tools, professional judgement, quality indicators and workforce sustainability measures.<br><br>SafeCare Live supports daily operational staffing decisions and workforce redeployment. Workforce governance arrangements include daily safe staffing reviews, escalation processes and Executive oversight. | Continue to align workforce governance arrangements with Developing Workforce Safeguards and National Quality Board guidance. |

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|---|---|---|
| **2. Trusts must ensure the three components of safe staffing are used in the safe staffing process:**<br><br>**Use of evidence-based tools**<br>**Incorporation of professional judgement**<br>**Use of patient quality outcomes** | **Compliant**<br><br>The 2026 Annual Nurse Establishment Review demonstrates application of all three required components:<br><br>• Evidence-based workforce tools (SNCT, Birth Rate Plus, BAPM, GPICs and specialty-specific methodologies)<br>• Professional judgement reviews undertaken at ward, service and CSU level<br>• Triangulation with quality, safety, workforce and patient experience outcomes<br><br>Recommendations arising from the review are based upon alignment across all three components. | Continue to strengthen triangulation through routine review of workforce sustainability and enhanced care demand indicators. |
| **3. NHSI will base the assessment on the annual governance statement, in which Trusts will be required to confirm their staffing governance processes are safe and sustainable.** | **Compliant**<br><br>The Trust maintains established staffing governance arrangements including twice-daily safe staffing reviews, workforce escalation processes, SafeCare Live oversight, e-Rostering controls and bi-annual workforce assurance reporting.<br><br>The 2026 Annual Nurse Establishment Review includes a formal Professional Assurance Statement confirming the review findings and residual risks. | None identified. |

| | | |
|---|---|---|
| **4. NHSI will review the annual governance statement through our usual regulatory arrangements and performance management processes, which compliment quality outcomes, operational and financial measures.** | **Compliant**<br><br>The Annual Nurse Establishment Review provides a comprehensive assessment of workforce capacity, patient acuity and dependency, workforce sustainability, quality indicators and financial implications.<br><br>Findings are triangulated using evidence-based tools, professional judgement and nurse-sensitive indicators to support informed Board decision-making. The review incorporates workforce, quality, operational and financial considerations, ensuring alignment with national workforce governance requirements. | Continue annual review and Board reporting processes in line with Developing Workforce Safeguards guidance. |
| **5. NHSI will seek assurance through the SOF monitoring performance.** | **Compliant**<br><br>The Trust maintains established workforce governance arrangements supported by routine Board reporting via the People Committee (Board subgroup), workforce performance monitoring and bi-annual establishment reviews.<br><br>Safe staffing, workforce sustainability and quality indicators are reviewed through governance structures and escalation processes to provide ongoing assurance regarding safe and effective staffing. | Continue routine monitoring of workforce indicators and maintain compliance with NHS England assurance requirements. |
| **6. As part of the safe staffing review, the Director of Nursing and Medical Director must confirm in a statement to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.** | **Compliant**<br><br>The 2026 Annual Nurse Establishment Review includes a formal Professional Assurance Statement summarising the findings of the review and confirming the overall | Continue annual assurance statement and Board review process. |

| | | |
|---|---|---|
| | assessment of staffing safety, effectiveness and sustainability.<br><br>Residual workforce risks and recommended mitigations are clearly identified to support informed Board decision-making and risk acceptance. | |
| **7. Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive leaders. The Board should discuss the workforce plan in a public meeting.** | Compliant<br><br>Workforce planning forms part of the Trust's annual planning cycle and is informed by workforce reviews, establishment assessments, service demand and workforce sustainability considerations.<br><br>Findings from the Annual Nurse Establishment Review directly inform workforce planning priorities, recruitment strategies and establishment setting.<br><br>Workforce plans are reviewed through Executive governance arrangements and reported through Board processes. | Continue integration of establishment review findings into workforce planning processes. |
| **8. Board must ensure their organisation has an agreed local quality dashboard that cross checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital Dashboard. Trusts should report on them to their Board every month.** | **Partial compliance**<br><br>The Annual Nurse Establishment Review triangulates workforce data with quality, safety, workforce and patient experience indicators. Review findings include assessment of falls, pressure ulcers, medication incidents, temporary staffing utilisation, sickness absence, turnover and patient feedback alongside establishment and dependency data. | Continue development of electronic workforce dashboards across the Group structure and benchmarking reports to support ongoing Board assurance. |

| | | |
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| | Benchmarking information and national workforce indicators are reviewed to support assurance regarding workforce effectiveness and efficiency. | |
| **9 An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the Board by ward or service area twice per year, in accordance with NQB guidance and NHSI resources. This must also be aligned with professional judgement and outcomes.** | **Non-compliant**<br><br>A full Annual Nurse Establishment Review was completed in Mar26 using evidence-based workforce tools, professional judgement reviews and outcome measures. The review included ward-level and CSU-level triangulation of acuity, dependency, quality indicators, workforce metrics and workforce sustainability information. This review is planned to be presented to Board in Jul26.<br><br>Recommendations regarding establishment changes were developed through structured professional judgement reviews and reported through Board governance processes.<br><br>**The previous establishment review was conducted in Oct24 and presented to Board in Jul25, delaying the provision of outcomes and recommendations to Board.** | Continue adherence to refreshed bi-annual workforce review cycle and annual establishment reassessment process. |
| **10. There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool** | **Compliant**<br><br>The Trust continues to utilise nationally recognised evidence-based workforce tools that have not been amended in any way. These include SNCT, Birth Rate Plus and BAPM and GPICs methodologies. Professional judgement reviews are used to supplement workforce tool outputs rather than replace them. | Continue application of approved evidence-based workforce methodologies.<br><br>Continue to await an evidence-based tool to support the establishment review of AHP models and services. |

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| | Any variance between tool outputs and recommended establishments is clearly documented and supported through triangulated evidence and professional review.<br><br>Workforce reviews based on data from approved evidence-based tools | |
| **11. As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.** | **Compliant**<br><br>The Trust maintains an established Quality Impact Assessment process to support service redesign, workforce change and skill-mix review. Workforce recommendations arising from establishment reviews are considered alongside quality, safety, workforce and operational implications through existing governance arrangements. | Continue application of QIA processes to workforce and service change proposals. |
| **12. Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.** | **Compliant**<br><br>New workforce roles, advanced practice developments and skill-mix changes are subject to formal governance and quality impact assessment processes. Workforce redesign proposals are reviewed to ensure patient safety, service quality and workforce sustainability considerations are fully assessed prior to implementation. | Continue governance oversight of workforce redesign initiatives. |
| **13. Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.** | **Compliant**<br><br>The Trust operates established daily safe staffing processes supported by SafeCare Live, twice-daily staffing reviews and formal escalation arrangements. | Continue routine review of staffing escalation processes and workforce risk management arrangements. |

| | | |
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| | Staffing risks are reviewed and managed in real time with escalation through operational, nursing and Executive structures where required.<br><br>Professional judgement is applied routinely to support safe staffing decisions and workforce deployment. | |
| **14. Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.** | **Compliant**<br><br>Workforce risks identified through establishment reviews, safe staffing processes and workforce governance arrangements are escalated through appropriate governance routes.<br><br>The Annual Nurse Establishment Review provides formal Board visibility of workforce risks, residual risks and recommended mitigations.<br><br>Escalation processes support consideration of workforce investment, service redesign and operational mitigations where required to maintain patient safety and care quality. | Continue Board oversight of workforce risks and review effectiveness of agreed mitigations through routine workforce assurance reporting. |

**Appendix 6**

The triangulated review incorporated:

**Safer Nursing Care Tool (SNCT)**
SNCT data collection was carried out in October 2025 and March 2026, two cycles of SNCT data collection were used in accordance with national guidance to assess patient acuity and dependency requirements.

**Professional Judgement Reviews**
Structured reviews were undertaken with each Clinical Service Unit involving Associate Directors of Nursing, Heads of Nursing, Matrons, Ward Managers. These reviews were led by the Associate Director of Nursing and Professional Workforce to review additional factors that are not fully captured through workforce planning tools, including ward layout, patient safety and quality data, staff sickness/absence and turnover, enhanced care demand and operational requirements.

**Workforce Metrics**
Workforce sustainability was assessed through review of:

- Vacancy levels
- Sickness absence
- Turnover
- Temporary staffing utilisation

**Quality and Safety Indicators**
The review incorporated:

- Falls
- Pressure ulcers
- Medication incidents
- Staffing-related incidents
- Patient experience data

University Hospitals Tees

# Infection Prevention & Control Annual Report 2025/2026

**Meeting date:** 3 September 2026

**Reporting to:** Board of Directors

**Agenda item No:** 2.7

**Report author:** Emma Nunez, Chief Nursing Officer/DIPC; Sharon Lance, Deputy DIPC

**Executive director sponsor:** Emma Nunez, Chief Nursing Officer/DIPC

**Action required:** Information

**Delegation status:** Jointly delegated item to Group Board

**Previously presented to:** 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:

Safe

## Board assurance / risk register this paper relates to

Patient Safety: Prevention Healthcare Associated Infections (HCAIs) remains a high scoring risk on UHT Board Assurance Framework.

## 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.

While UHT has maintained strong governance, compliance with the Hygiene Code, and delivered several improvement initiatives during 2025/26, the Trust's infection surveillance data shows a mixed picture, with some positive developments in prevention practices but continued challenges in meeting national reduction targets. Despite improvement in some areas from 2024/25 position, UHT exceeded infection targets across all monitored HCAIs.

Key themes identified across these infections include:

- Intravascular device-associated infections.
- Urinary tract infections and catheter-associated infections.
- High system pressures and bed occupancy.
- Continued use of broad-spectrum antibiotics.
- Delays in isolation and variable compliance with cleaning and IPC training standards.

**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.

Despite not achieving infection reduction targets, there is evidence that improvement measures are having a positive impact:

- Antimicrobial Stewardship (AMS) has significantly strengthened, with reductions in broad-spectrum (Watch and Reserve) antibiotic prescribing across both South Tees and North Tees.
- The Antimicrobial Working Group was re-established, providing stronger governance and oversight.
- Enhanced Aseptic Non-Touch Technique (ANTT) training has been implemented.
- Increased catheter audits, vascular access reviews, and hydration initiatives have been introduced to address common infection sources.
- The Trust has developed a more mature PSIRF learning approach, focusing on thematic learning rather than isolated investigations.
- Improved collaborative working across clinical divisions, pharmacy, estates, domestic services and IPC teams.
- Expansion of outbreak management processes, including successful management of CPE and MRSA outbreaks.
- Continued use of isolation facilities has helped minimise transmission risks during Norovirus, Influenza, RSV and COVID-19 pressures.

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

UHT has demonstrated significant improvement in infection prevention infrastructure, governance, antimicrobial stewardship, staff education, audit processes and outbreak management. Improvement actions are now better embedded, and there is evidence of stronger surveillance, learning, ownership and accountability across clinical services.

## Recommendations:

It is requested that the Board note the content of the annual report for 2025/26 in respect of the current IPC and HCAI position for University Hospital Tees and acknowledge the actions that are being taken across the group to address this.

UHT Board can take assurance regarding compliance with infection prevention and control standards, governance arrangements and quality improvement activity. Whilst healthcare-associated infection rates remain above target in several key categories, considerable progress has been made in antimicrobial stewardship, outbreak management, education, audit and organisational learning. Continued focus on device-related infections, catheter care, environmental cleanliness, training compliance and antimicrobial optimisation will continue during 2026/27 to translate these improvements into sustained reductions in infection rates.

NHS
University Hospitals Tees

# 2025 – 2026 Infection Prevention and Control Annual

Caring
Better
Together

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

This report gives a summary of infection prevention and control (IPC) activities which have been and continue to be implemented, to improve and sustain safety for our patients, visitors and staff across all our healthcare settings, during 2025-26. There has been collaborative working with partner organisations and close multi-disciplinary working with internal Trust hospital sites and departments to contribute to the delivery of the annual objectives and initiatives.

Occupancy and acuity of patients have increased within the Trust in 2025-26 which correlates with regional and national increases in infection rates being observed. The Trust continues to be committed to reducing infection rates and ensuring that our population receives the highest standard of care, we are taking a continuous improvement approach to IPC in understanding the biggest drivers for infections and ensuring that the fundamentals of care and best practice are consistently applied.

Looking forward to 2026/27, the IPC team and all STHFT staff will continue to work towards the prevention of all healthcare acquired infections with unification of infection control policies for University Hospital Tees (UHT).

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

*Emma Nunez*
*Director for Infection, Prevention and Control*

*Dr Richard Bellamy*
*Infection Control Doctor*

*Sharon Lance*
*Deputy Director for Infection, Prevention and Control*

*Victoria Charlton*
*Lead Nurse for Infection, Prevention and Control*

*Jo Carter*
*Lead Nurse for Infection, Prevention and Control*

## LIST OF ABBREVIATIONS

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

## SECTION 1: INTRODUCTION

The purpose of this report is to provide assurance to University Hospitals Tees (UHT) Board of Directors and the public for the reporting period 1 April 2025 - 31 March 2026 regarding the Infection Prevention and Control (IPC) activity. This includes compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (updated December 2022) (commonly known as The Hygiene Code) and regarding appropriate National Institute for Health and Care Excellence (NICE) guidance.

This annual report fulfils the Trust's statutory requirements under the hygiene code which sets out 10 compliance criteria against which a registered provider will be judged on how it complies with the registration requirements for cleanliness and infection prevention and control. This sets the basis of our annual plan which is monitored at the Trust's bimonthly Infection Prevention Strategic Group (IPSG) meeting. Infection prevention and control is the responsibility of everyone in our healthcare community and is only truly successful when everyone works together. The aim of the IPC team is to increase

organisational focus and collaborative working to ensure continued compliance and continuous improvement. The Trust is registered with the Care Quality Commission (CQC) and has declared full compliance with the ten compliance criteria as detailed in Table 1. The Deputy Director of IPC performs a regular gap analysis on this and it is included within the quarterly IPC report.

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

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

Infection Prevention and Control (IPC) is a scientific approach and practical solution designed to prevent harm caused by infection to patients and health care workers it is essential to ensure that the safety and quality of care for our patients can be provided. At UHT, IPC is a key priority. Our Trust is committed to delivering the highest IPC standards to prevent avoidable harm to patients, visitors and staff from healthcare associated infection (HCAI). It is a key priority to ensure that a robust infection prevention and control function operates and is embedded within all clinical areas of the organisation. Effective prevention and control of infection is embedded as part of everyday practice and applied consistently by everyone at all times. The infection prevention and control agenda faces many challenges, particularly over the last few years, including the ever-increasing threat from emerging diseases, antimicrobial resistant micro-organisms, and growing service development in addition to national targets and outcomes. The Board of Directors and ultimately the Chief Executive, as the accountable officer, carries responsibility for IPC throughout the Trust and it is a vital component of Quality and Safety. The day-to-day management is delegated to the Director of Infection Prevention and Control (DIPC) and her deputy, the Deputy Director of Infection Prevention and Control (DDIPC).

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

As with the previous year, the 2025/26 NHS Outcomes Framework included reducing the incidence of HCAIs, in particular, Gram-negative bloodstream infection (GNBSI), Methicillin Resistant Staphylococcus aureus (MRSA) Bacteraemia and Clostridioides difficile infection (CDI) as areas for improvement. This report will provide information on the activities and performance of Key Performance Indicators (KPI) for IPC during the period 1 April 2025 - 31 March 2026 by UHT. In addition, the report aims to reassure that

reducing the risk of infection through robust infection prevention and control practice is a key priority for UHT and supports the provision of high-quality services for patients and a safe working environment for staff.

The Infection Prevention and Control (IPC) Team provides a service covering all Trust settings and also supports local communities, care homes, hospices, Primary Care Hospitals and an independent hospital. We have a team of experienced IPC nurses supported by an IPC Doctor, audit and education, decontamination, clerical and surveillance staff. The team works in close collaboration with consultant microbiologists, biomedical scientists, the antimicrobial pharmacist and clinical teams. The DIPC, who is also the Chief Nurse, is supported in leading improvement in infection prevention across the Trust by the Deputy DIPC.

The DIPC provides an update to each Board of Directors via an Integrated Performance Report. A performance update is provided monthly to the Quality Committee, which is a subcommittee of the Board and is chaired by a Non-Executive Director. There is a quarterly Infection Prevention Steering Group (IPSG) and monthly IPC Operational Group which provides operational information to the IPSG. The IPC Operational Group undertakes targeted pieces of work as required by publication of new guidance, recommendations from incident investigations or audit findings.

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

### 2.1: Who are we?

University Hospitals Tees (UHT) was formed in 2024 when North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust came together to operate under a group model with shared governance and leadership arrangements across the two trusts.

UHT is the largest health and care employer in the Tees Valley and surrounding areas, with 16,000 staff and a budget of around £1.4billion. As a Trust, UHT provides health services to more than 1.5 million patients, carers and their families across the Tees Valley, North Yorkshire and beyond.

**The group has:**
Four main hospital sites:

- Friarage Hospital
- The James Cook University Hospital
- University Hospital of North Tees
- University Hospital of Hartlepool

Six main community sites:

- Redcar Primary Care Hospital
- Guisborough Primary Care Hospital
- Peterlee Community Hospital
- East Cleveland Primary Care Hospital (in Brotton)
- Tees Valley Community Diagnostic Centre (in Stockton)
- Friary Community Hospital (in Richmond)

Plus, lots of community locations supporting delivery of local healthcare services to help us provide the best possible care to the people in our areas.

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

The IPC team utilises both a reactive and proactive approach with the emphasis on being visible, so making their accessibility for guidance and advice a priority. This in turn has led to an improved IPC team image i.e. being a regular familiar friendly face rather than only visiting to audit or when there are outbreaks of infections or problems. This also includes when answering telephone calls or visitors with queries into the office.

Looking forward, it is critical that UHT maintain this level of commitment. As in previous years, we will continue to work closely with our partner organisations Integrated Care Board (ICB), and the Local Health Economy (LHE) as well as experts in other organisations, UK Health Security Agency (UK HSA) and NHS England.

**Our Duties and Arrangements**

**Infection Prevention and Control Service:**

• Director for Infection Prevention and Control (Chief Nurse)

• Deputy Director for Infection Prevention and Control

• Infection Control Doctor(s)

• Infection Prevention and Control Lead Nurses

• Decontamination Lead

• Infection Prevention and Control Senior IPC Nurses

• Infection Prevention and Control Nurses

• Quality and Governance Facilitator

• Audit and Surveillance Support

• Infection Prevention and Control Team Facilitator

• Infection Prevention and Control Team Administration Team

• Face Fit Testing Team

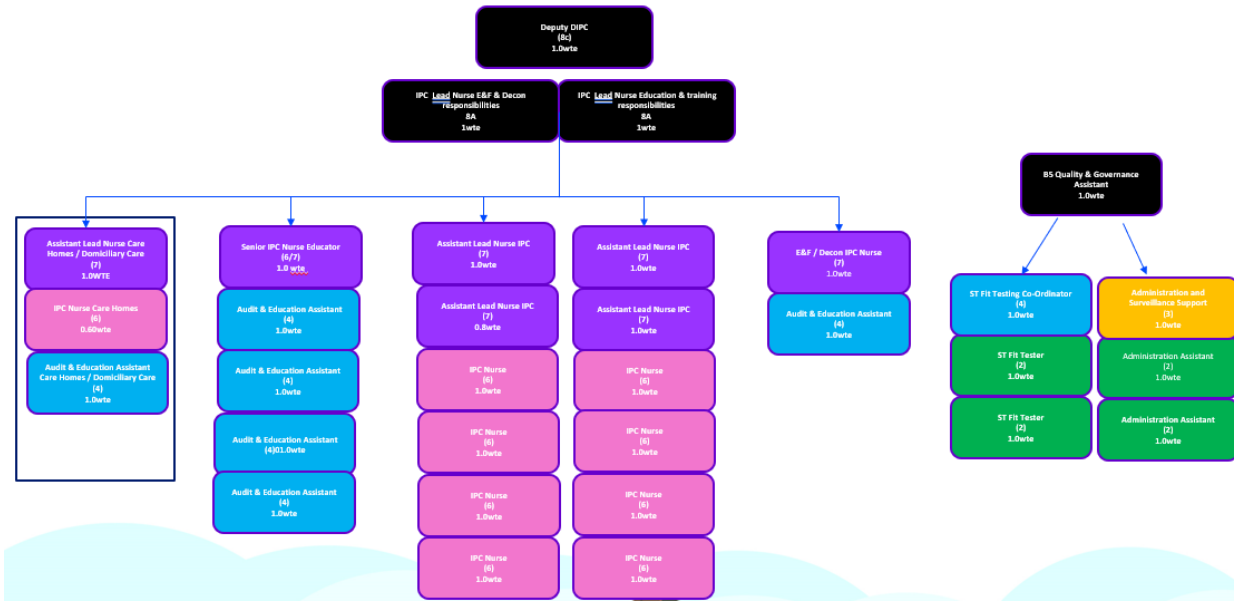



*FIGURE 1: The UHT IPC Team*

## 2.2 Director of Infection Prevention and Control – Emma Nunez (also Chief Nurse)

The Director of Infection Prevention and Control (DIPC) is a role required by all registered NHS care providers under current legislation (The Health and Social Care Act 2008, updated 2022), otherwise known as the Hygiene Code. The DIPC will have the executive authority and responsibilities for ensuring strategies are implemented to prevent avoidable Healthcare Associated Infections (HCAIs) at all levels within the organisation.

The DIPC will be the public face of IPC and will be responsible along with others for the Trust's annual report, providing details on the organisations IPC programme and publication of HCAI data for the organisation.

The DIPC will lead the commitment to quality and patient safety, good communication and ensure robust reporting channels and access to a group of staff with expert prevention and control knowledge, able to offer advice and support. The role and function of the IPC Service is to provide specialist knowledge, advice and education for staff, service users and visitors. All work undertaken by the service supports the Trust with the full implementation of and on-going compliance to the Hygiene Code.

At South Tees NHS Hospitals Foundations Trust, the Chief Nurse holds the role of DIPC.

### 2.3 The Infection Prevention and Control Team

The IPC Team is led day to day by the DDIPC for IPC and is supported by the Infection Prevention and Control Lead Nurses alongside the Infection Prevention Nurses and other members of the team.

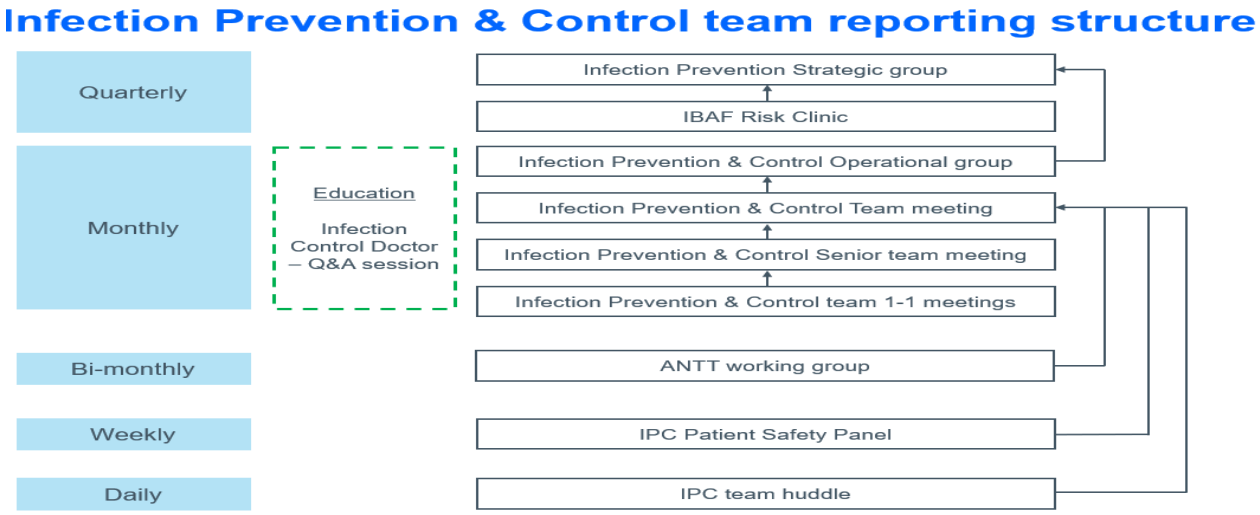
The IPC service is provided through a structured annual plan of work which includes expert advice, education, audit, policy development and review and service development.

The IPC Team cover across all areas of STHFT 7 days per week ensuring continuity of specialist advice and support is maintained. Out with of their regular working hours, the clinical areas have access to a Microbiologist on call. There is a plan for 2026-27 to extend the 7-day cover across the whole of UHT.

The IPC team develops and implements a robust annual plan of work to support in the reduction of HCAIs. This is achieved by working in collaboration with all UHT services and staff. The IPC team perform several activities that minimise the risk of infection to patients, staff and visitors including advice on all aspects of infection prevention and control; education and training; audit; formulating policies and procedures; interpreting and implementing national guidance at local level; alert organisms' surveillance and managing outbreaks of infection.

The IPC Team host an IPC Link Practitioner Programme, with sessions arranged monthly across sites on a variety of topics related to IPC and HCAIs.

### 2.4 Committee Structures and Reporting Processes



# Infection Prevention & Control team reporting structure

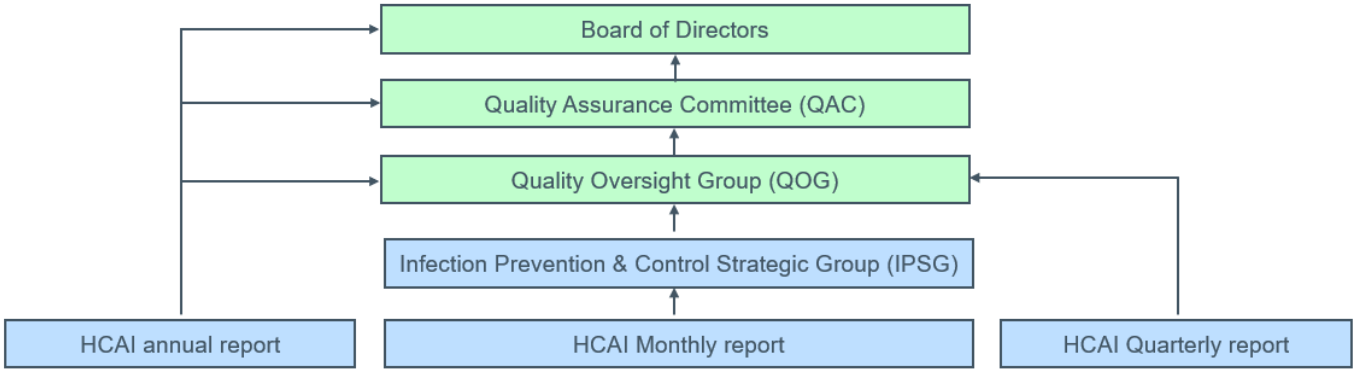



*FIGURE 2&3: The IPC reporting Governance Structure*

## SECTION 3: POSITION IN RELATION TO HEALTH CARE ASSOCIATED INFECTIONS

### 3.1 Surveillance and Performance of Healthcare Associated Infection

Surveillance is undertaken within UHT on several alert organisms and mandatory reporting to UK Health Security Agency (UKHSA), is undertaken via the HealthCare Associated Infection Data Capture System. Performance is monitored both internally and externally via reporting and meetings. The alert organisms reported include,

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

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

**HCAI -** Healthcare-associated infection. This term refers to infections that are related to the care delivered by healthcare providers. It does not necessarily imply that the patient is an inpatient. Also, it does not necessarily infer that the organism responsible was acquired from the healthcare provider. Many HCAIs are caused by the patient's own bacterial flora, which establish an infection because of a healthcare-related procedure (e.g. an operation).

**Hospital-acquired -** This term is often used for infection or colonisation which is first identified more than 48 hours after admission (or for simplicity after the second day). However, the definition is not perfect as patients who satisfy these criteria may have had unknown infection or colonisation prior to admission. National surveillance now uses the terms 'Trust-apportioned' (for MSSA) and 'Trust-assigned' (for MRSA) and healthcare-onset healthcare-associated plus community-onset healthcare-associated (for C. difficile) rather than hospital-acquired.

The 2025/26 *C. difficile* definitions are as follows:

- Hospital onset healthcare associated (HOHA): cases detected in the hospital ≥2 days after admission.
- Community onset healthcare associated (COHA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.
- Community onset indeterminate association (COIA): cases that occur in the community (or within <2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent 4 weeks.
- Community onset community associated (COCA): cases that occur in the community (or within <2 days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

*Table 2: National definitions*

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

Below demonstrates the thresholds and the actual cases recorded.

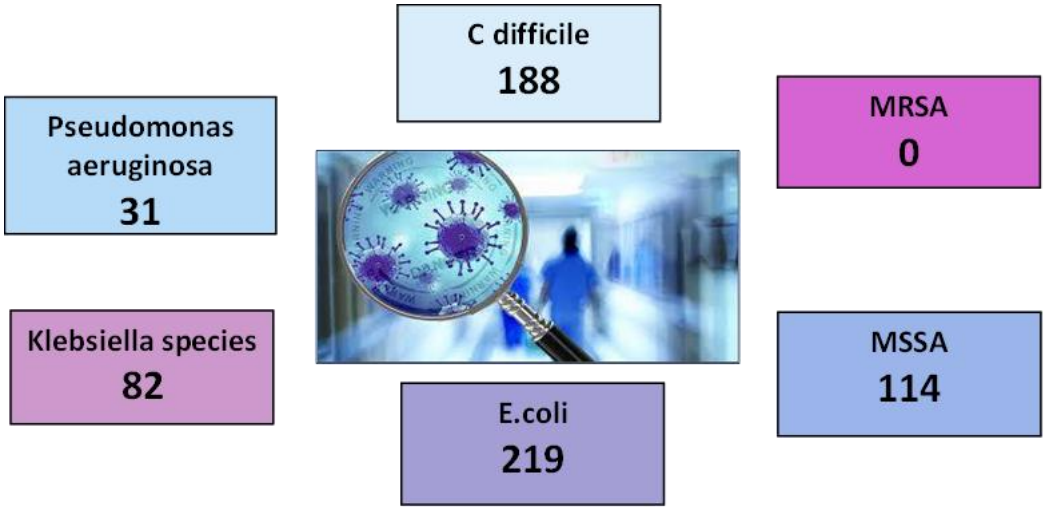



*Fig 4. Reduction objectives for infections in 2025-26*

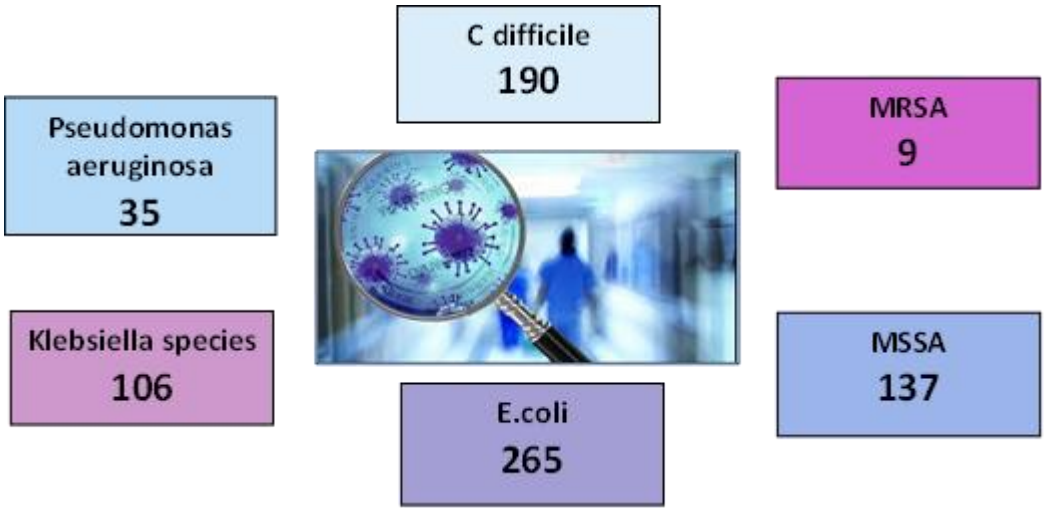


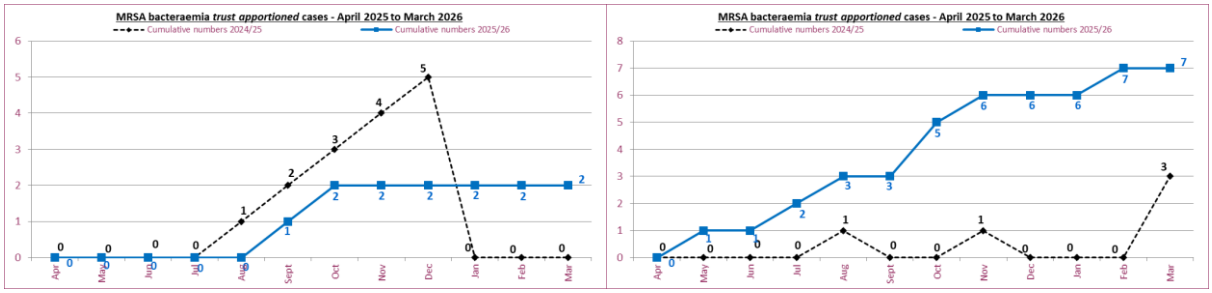
*Fig 5. End of year figures for 2025-26*

## 3.2 Meticillin Resistant *Staphylococcus aureus* Blood Stream Infections (MRSA)

*Staphylococcus aureus* is an organism harmlessly carried on the skin by around 1 in 30 of the healthy population and remains endemic in many UK hospitals. In serious cases it can cause blood stream infections. MRSA is a strain of this bacterium which has developed resistance to many antibiotics, making it more difficult to treat.

Many individuals carry MRSA on their skin, and this is called colonisation. It is important that we screen some groups of high-risk patients when they come into hospital so that we know if they are carrying MRSA. Screening involves simple skin and nasal swabs. If positive, we can provide treatment that helps to reduce the number of bacteria and therefore reduces the risk of developing infection. Guidance is in place regarding the screening of our patients for MRSA for both emergency and elective admissions at UHT and is also included in our IPC Policies, in line with national guidance.

In 2025-26 we reported **nine** healthcare associated MRSA blood stream infection **against a zero-tolerance threshold**. All MRSA cases are investigated individually.




*Graph 1. Trust apportioned MRSA cases 2025-26*

Infection associated with indwelling medical devices, particularly intravascular devices, is a major cause of morbidity and occasionally, mortality.

The Trust complies with national guidance to reduce the risk of blood stream infection and has systems in place for:

• The management and care of devices

• Antimicrobial prophylaxis
• Compliance with national guidance

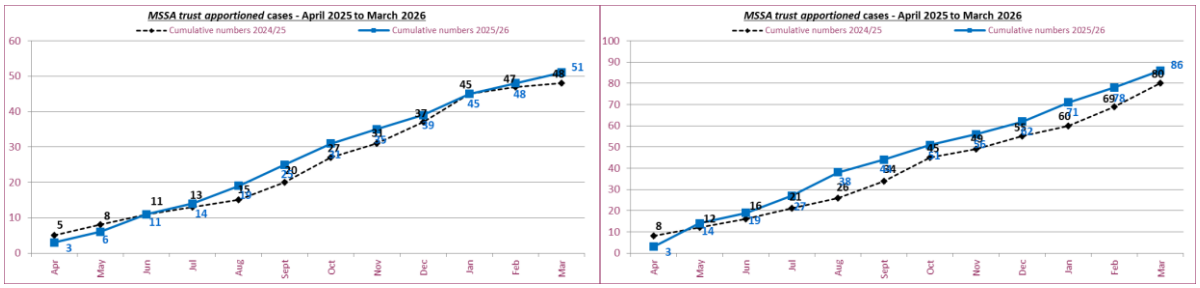
Since June 2006 every episode of MRSA bacteraemia has been investigated as a clinical incident to help identify lessons to be learnt and to guide improvements in practice. Following the Patient Safety Incident Response Framework (PSIRF) guidelines these have now changed to rapid learning reviews and actions from these are completed and monitored through the CSU forums which has helped the Trust to focus attention on avoidable causes of MRSA bacteraemia.

## 3.3 Meticillin Sensitive Staphylococcus aureus Blood Stream Infections (MSSA)

Methicillin-sensitive Staphylococcus aureus (MSSA) is a type of bacterium which lives harmlessly on the skin and in the nose of one in three people. People who carry MSSA on their skin or mucosa are said to be colonised.

MSSA colonisation usually causes no problems but can cause an infection when it penetrates the skin or mucosa. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g., grazes, surgical wounds.

MSSA can cause serious infections called septicaemia (blood poisoning) or a blood stream infection where it gets into the bloodstream.




*Graph 2. Trust apportioned MSSA cases 2025-26*

In 2025-26 we reported 137 healthcare associated cases of MSSA bacteraemia against the **internal objective of 114 cases.** The most common reported source has been intravascular devices. Cannula audits have been planned and specific training around intravascular devices as well as "scrub the hub" promotion has also been implemented as part of the collaboration across the organisation in respect of the vascular access council. Other common sources included (but not exhaustive), pneumonia (including empyema), skin and soft tissue infection (including leg ulcers/ pressure sores), urinary tract infection (including catheter-associated), surgical site infection, septic arthritis and endocarditis.

Enhanced training for Aseptic Non-Touch Technique (ANTT) continues to be implemented across the trust for all relevant staff groups to address avoidable causes related to invasive procedures.

## 3.4 Clostridioides difficile (Previously referred to as Clostridium difficile) infection (CDI)

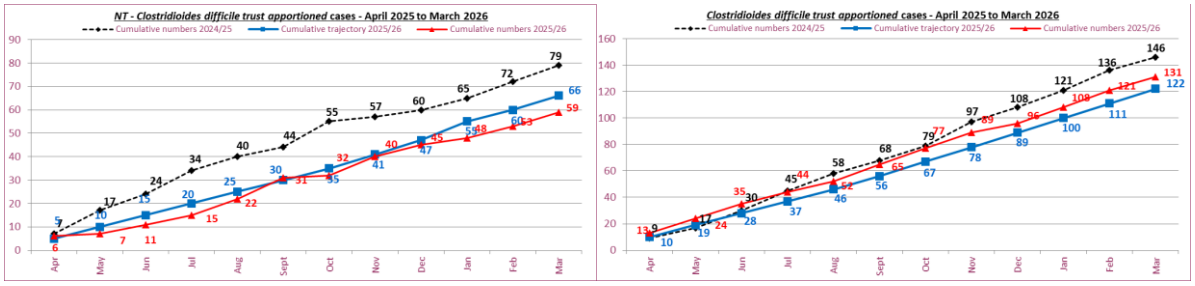
Clostridioides difficile (CDI) is a bacterium that is found in the gut of around 3% of healthy adults. It seldom causes a problem as it is kept under control by the normal bacteria of the intestine. However certain antibiotics can disturb the bacteria of the gut and the CDI can then multiply and produce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

During 2025-26 we reported **190** healthcare associated cases of CDI which was against the **threshold of 188 cases**. It should be noted that hospital admissions have remained pressured throughout the year, and that there remains an elevated use of broad-spectrum antibiotics, which increases the risk of CDI. Case reviews are completed on each healthcare associated case and are reviewed by a multi-disciplinary team including, IPC Team, clinical/ department staff, antibiotic pharmacist and microbiologist. Antibiotic usage is being monitored though the Trust antimicrobial stewardship working group (AWG).
The pressured position is echoed throughout the Integrated Care Board (ICB) and across the UK. CDI infection rates remain at the highest they have been for several years. Actions to reduce CDI infections have been discussed as an ICB and nationally, with national teams tasked to deep dive into cases to identify any potential causes of the increase in infections and ways to reduce the number of infections. There have been several improvements implemented such as,

- Change in Trust policy to improve rates of gold standard HPV cleaning.
- Increasing inpatient reviews by the IPC team
- Antimicrobial stewardship (AMS) group meeting regularly - reviewing antibiotic use and implementing teaching.
- Participating in regional initiatives to reduce CDI rates and introducing a CDI reduction action plan managed by the Clinical Service Units (CSU's).

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

Identifying a single root cause in cases of C. difficile is challenging and is often associated with one or more influencing factors; patient factors e.g. existing long-term conditions, and/or medical factors such as the requirement for antibiotics or laxatives and/or process concerns, e.g. delays in isolation.




*Graph 3. Trust apportioned CDI cases 2025-26*

**Lessons Learnt**

Following review of all of the rapid learning reviews completed some common themes have been identified. These include; antimicrobial stewardship and appropriateness of antimicrobial prescribing in line with Trust guidelines, Environmental Cleaning scores below an overall compliance of 95% and IPC Mandatory training compliance falling below the Trust objective of 90% compliance. All learning reviews have an action plan completed with objectives to achieve and a timeframe for completion. Many of the actions are addressed through CSU governance meetings and through CSU CDI action plans. Action plans and compliance are then monitored through the CSU governance route.

UHT closely monitors periods of increased incidents (PII) of patients with evidence of toxigenic CDI in any ward or area. The definition of a PII is 2 or more patients identified with evidence of toxigenic CDI within a period of 28 days and associated with stay in the same ward or area. Each case is then reviewed to establish if they can be linked by time and place and identify any common themes. Should this occur samples are obtained and submitted to UKHSA for ribotyping. This helps to identify wards or areas where patient to patient transmission is likely to have occurred, with enhanced focus on control measures and increased cleaning of the patient areas if necessary.

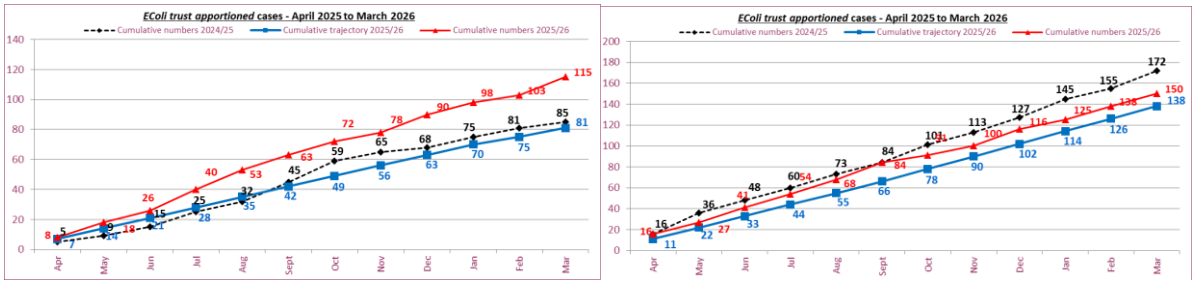
We define an outbreak of CDI as two or more linked cases (based on location, time and ribotyping if available). Following identification of this an outbreak control meeting will be called and all appropriate action agreed and implemented. Following the closure of an outbreak, a report is generated and learning shared across the organisation.

During 2025/26 the overview of the internal Deep dive continued which allows oversight and actions as a Trust but also ownership within CSUs with their own individual action plans. The Trust has also been involved with a regional approach to CDI with the local Integrated Care Board (ICB) in the form of a diagnostic visit from global IPC experts and also nationally with NHS England via the DDIPC.

## 3.5 Surveillance for other alert organisms

Reducing gram negative blood stream infections (GNBSI) is a national priority. The trust has provisionally been set a target for 2025/26 of no more than 219 cases of *E. coli*, 82 *Klebsiella* species and 31 *Pseudomonas aeruginosa* bacteraemia cases. During 2025/26 we have had 406. We are working with the Tees-wide collaborative which supports a number of initiatives within the community setting.

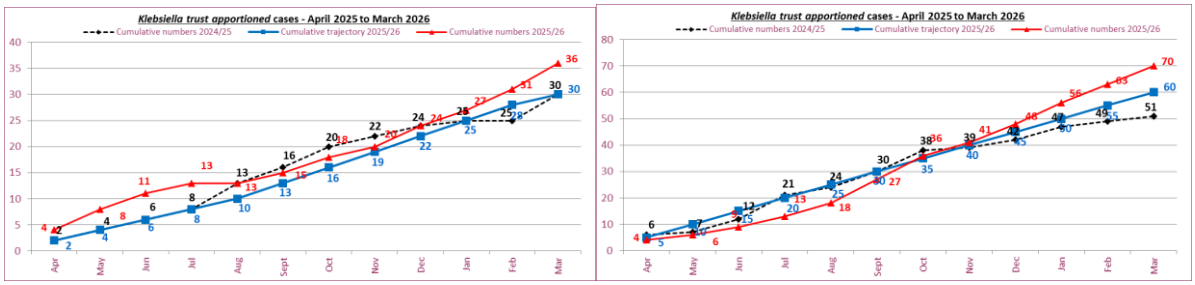
**E coli** is a very common bacterium found in the human gut which can cause serious infections such as blood poisoning. We reported **265** healthcare associated cases of E coli bacteraemia in 2025-26 against an objective of **219** cases The most common reported source was lower Urinary Tract Infection. The IPC team have completed increased catheter audits and training. There has been work undertaken as part of a relaunched CAUTI group at North Tees, as well as other initiatives to promote hydration and good catheter care, with the group also looking at alternative products to reduce catheter usage, which will develop across UHT in 2026-27 and includes clinical staff as part of the core membership.




*Graph 4. Trust apportioned E coli cases 2025-26*

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

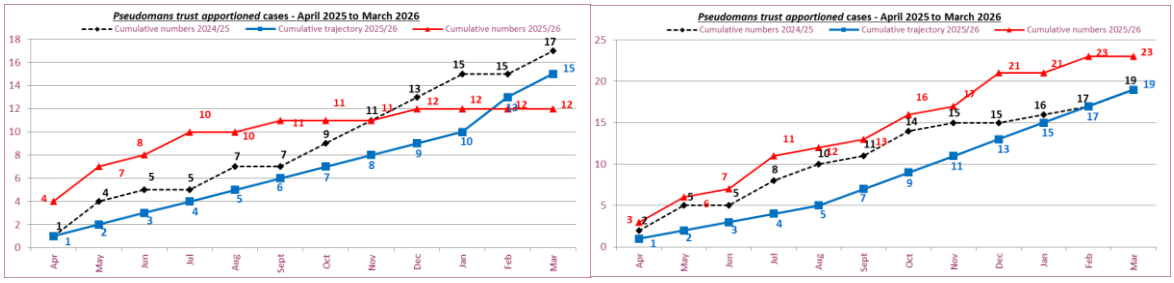
We reported **106** healthcare associated cases of Klebsiella bacteraemia in 2025-26 against **an objective of 82 cases**. Hepatobiliary and UTI remain the most common source of Klebsiella infection. The work being undertaken by the IPC team, link worker programme and CAUTI group will contribute to a reduction in these sources of infection. In addition to this, work has been undertaken in the surgical departments to address waiting list times for procedures such as cholecystectomy.




*Graph 5. Trust apportioned Klebsiella cases 2025-26*

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

In 2025-26 we reported **35** healthcare associated cases against an **objective of 31 cases.** Many of these cases are considered unavoidable infections. Whilst there has been a slight increase in healthcare associated cases, the community onset cases have also seen a significant increase on the previous year.




*Graph 6. Trust apportioned Klebsiella cases 2025-26*

**ESBL**-producing coliforms are highly antibiotic-resistant Gram-negative bacteria. The majority of isolates of these organisms are from the urinary tract, but they also cause wound infections, biliary and gastrointestinal tract infections, pneumonia and bacteraemia. The majority of infections are community-acquired. ESBL producing coliforms are not included in mandatory national surveillance.

### 3.6 Carbapenemase Producing Enterobacteriaceae (CPE)

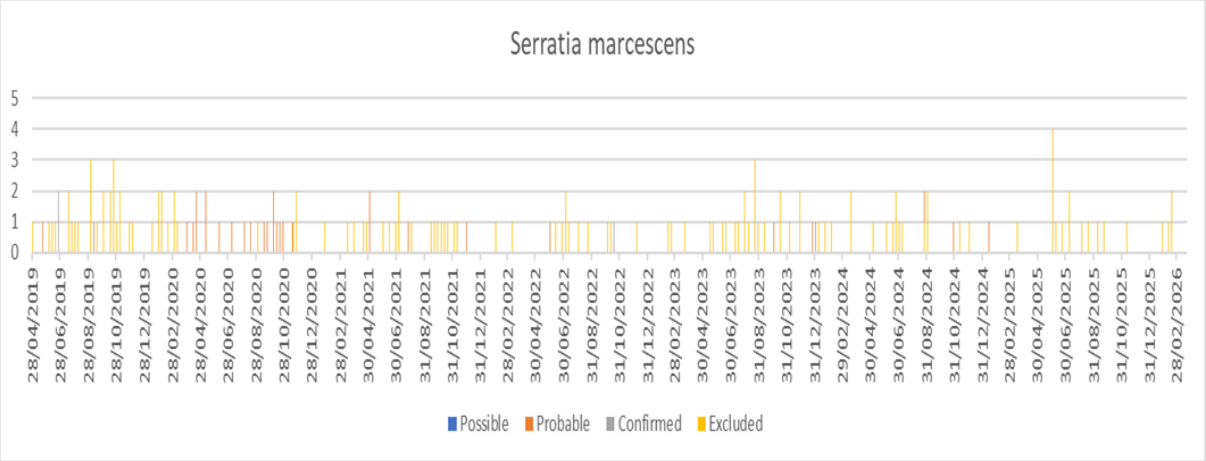
The Enterobacteriaceae are a large family of Gram-negative bacteria including species such as E. coli, Klebsiella species, Proteus species, and Enterobacter species. They live usually harmlessly in the guts of both humans and animals. They are opportunistic pathogens, capable of causing urinary tract infections, abdominal infections, and bloodstream infections (UK HSA 2013).

Some of these bacteria develop resistance to antibiotics through various mechanisms, one of them being the ability to produce an enzyme called Carbapenemase. The Carbapenemase enzyme makes these organisms resistant to multiple antibiotics and there are extremely limited treatment options. Antibiotic resistance is a major Public Health concern and stringent Infection Prevention and Control precautions need to be maintained to reduce the spread of these organisms. UKHSA published a toolkit in 2013 (updated 2022) to control the spread of CPE in healthcare and onwards in the community.

Across UHT we have adopted the national guidance in respect of screening to identify early any patients that may have or be at risk from CPE.

### 3.7 Outbreak of Serratia marcescens within the cardiothoracic surgical service

In July 2019 we found that our surveillance system for potential clusters of gram-negative bacteria had identified that 4 patients who had been treated in Cardiothoracic ICU and/or HDU had been colonised or infected with the same strain of *Serratia marcescens*. This outbreak was closed by the Infection Prevention Strategy Group in August 2021. There had been 5 confirmed cases, 27 probable cases and 46 excluded cases at the time the outbreak was closed. Investigations suggested a link to an environmental source. Ongoing surveillance graphs have been included in the infection control monthly report since that time (see below). The cases seemed to have fallen until July 2023, but there was then an increase. In response to this we reopened the outbreak meeting, and we investigated the potential causes. Numbers reduced again and the outbreak was closed in December 2024. We had 4 cases in the first week of June 2025 and the situation continues to be closely monitored.




*Graph 7: Timeline of Serratia marcescens cases*

### 3.8 Outbreaks

We reported several outbreaks of D&V during 2025-26 with areas experiencing significant numbers of Norovirus. Norovirus is defined as an abrupt explosive onset of profuse watery diarrhoea which may be accompanied by projectile or violent vomiting. Several cases may occur on the ward within hours. The virus is easily transmitted through contact with infected individuals from one person to another or environmental contamination. In hospital this environmental risk is considerable, and outbreaks are common.

Outbreak management has maintained patient safety through effective outbreak measures being implemented resulting in some bed closures. The infection control team has continued to assess risk and

aims to limit bed closures in line with patient safety, working closely with the clinical teams and clinical site managers.

North Tees has continued to use the 20 temporary isolation facility rooms called ‘Redi-rooms’; these continue to support IPC measures within clinical areas by improving the number of single room facilities. This has allowed the trust to maintain patient flow through critical periods of increased infection or outbreak, reducing the risk to others. Further work is planned around the management of these in 2026-27.

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

Once again, we experienced challenges in respect of respiratory illness over the 2025-26 winter period particularly COVID-19, RSV and Influenza.

An outbreak is classed as two or more cases which occur in the same clinical or non-clinical area within a timeframe, testing remains as symptomatic testing only in line with all respiratory pathogens

Each outbreak has an individual timeline where all information regarding these patients is collated and reviewed. Outbreak meetings are recorded and minutes taken, detailing all attendee discussions and findings. Outbreak meetings are arranged with both internal and external partners where necessary, and actions identified. Once outbreak areas have been identified within the trust, reviews are undertaken to find potential themes behind the outbreak occurring. Audits are undertaken by a member of the IPC team to identify compliance and where necessary action plans are devised to prevent any further occurrences.

Clinical practice audits including hand hygiene, matron peer review and environmental audits are completed and compliance scores for each ward are collated. Where improvements are required, advice is provided by the IPC team to the wards to facilitate an improvement in their overall compliance. By reviewing areas, risks and non-compliance can be identified to limit the potential of outbreaks occurring within the trust.

Carbapenemase-producing Enterobacteriaceae (CPE) are a group of bacteria that have developed resistance to carbapenem antibiotics, posing significant challenges in treating infections.

CPE refers to a subset of Enterobacteriaceae bacteria that produce enzymes known as carbapenemase. These enzymes enable the bacteria to break down carbapenem antibiotics, which are often used as a last resort for treating severe infections. Common examples of CPE include strains of Klebsiella pneumoniae and Escherichia coli.

Resistance: CPE are resistant to carbapenems and often to multiple other antibiotics, making infections difficult to treat. This resistance can lead to higher morbidity and mortality rates, especially in vulnerable populations such as hospitalized patients.

Infection Risk: While many individuals may carry CPE without symptoms (colonization), they can cause serious infections if they enter the bloodstream or other normally sterile areas of the body.

A CPE outbreak was identified on ward at North Tees during 2025-26. A total of 3 patients were affected and there was also CPE identified from some environmental swabbing. An outbreak meeting was held with all appropriate actions implemented, and negative environmental swabs have been received.

The Neonatal Unit at JCUH experience an outbreak of MRSA during 2025-26. A total of 6 babies were identified, 5 babies linked in time and place and a 6th baby with no clear links. Potential source of index baby’s mum due to wound. Weekly screening continued until outbreak closed with no further cases identified. Intense IPC programme in place and risk assessment underway in relation to the footprint of the unit.

The Trust continues to provide IPC support to adult care homes in Stockton and Hartlepool, Middlesbrough, Redcar and Cleveland and domiciliary care in Middlesbrough, Redcar and Cleveland through a dedicated care home team including IPC Nurses and an Audit and Education assistant. This is carried out through home visits, audits and specific training for care home staff to ensure they are aware of any changes in guidance and receive support in managing infected patients and outbreaks.

### 3.9 Other critical care surveillance

Isolation capacity for patients with infection continues to pose a challenge across all areas of UHT. Processes to mitigate risk of transmission of infection continue to be put in place including increased presence of the IPC team to support staff.

When isolation becomes challenging critical care staff work with IPC staff to ensure all risk reduction strategies are put in place. This includes appropriate use of aprons, gloves, gowns and other personal protective equipment, with the visual prompt of the PPE trolley displaying a 'STOP' sign alerting staff, who need to enter the bed space. Strict hand hygiene, equipment decontamination and any condition-specific devices (e.g. faecal collector) are put in place. For patients with infections in sputum, these measures may not be sufficient, so every effort is made to isolate across available footprint.

### 3.10 Audit Programme

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

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

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

Action plans are developed by the clinical areas, and these are managed and monitored within the collaboratives and escalated to IPSG and upwardly reported through the UHT Governance structure.

In addition to the above audits, the IPC audit programme also includes hand hygiene observation, sluice, equipment and commode audits. Results are shared with clinical areas and are presented and discussed at the IPC Operational Group meeting.

Patients, visitors, and staff are encouraged to challenge staff if they have any concerns about hand hygiene and in cases of repeated non-compliance, concerns are raised divisionally. This is across all staff groups including nurses, medical staff, AHP's and our PFI partners.

Raising awareness of hand hygiene and the 'Bare below the elbow' requirement are consistently monitored throughout the year.

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


"I'm bare below my elbows!"


Wash Your Hands
Hand Hygiene:
Hand Hygiene
Clean Hands with Soap and Water
20
PLEASE WASH YOUR HANDS
said ...We did
...we did
Welcome to
Ward 37
Ward Manager
Ward Rounds continue throughout the day
Medication Rounds Start (app
Meal Times Start (approx)
Visiting Times
Up to two visitors at a time

### 3.11 Training and Link Practitioner Programme

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

During the last year, there has also been close collaborative working between IPC and Estates, planning and design and domestic services teams, to ensure that knowledge of IPC is shared with all departments to positively impact on patient outcomes in relation to infections. There has been a bespoke training package developed with estates and has been delivered to NTH solutions (North Tees) estates teams and planning and design department, as well as contractors who regularly carry out work within the hospital. The feedback was very positive and there has been an observed improvement in practice in relation to infection control. This will be reviewed across all of UHT in 2026-27.

The IPC Team continues to provide the Infection Prevention and Control Link programme.

Link meetings run every month face to face or via MS TEAMS to provide education support and act as an IPC resource for the link staff to maintain their enthusiasm and commitment to IPC.

The aim of these meetings is to provide updates on any new guidance / policies, an opportunity to share learning outcomes and case studies, and to enhance effective communication across UHT. There is an ask to have at least one link worker in every department including inpatient and community areas. They are key in undertaking monthly audits of practice.

There has been an established dedicated Advancing Practice through IPC course at South Tees which is being reviewed and refreshed to incorporate all of UHT and this will be relaunched during 2026-27.

### 3.12 Care Quality Commission

The Care Quality Commission (CQC) are an independent regulator of health and social care in England. They ensure that health and social care services provide people with safe, effective, compassionate, high-quality care and encourage all care services to improve. Their assessment framework is made up of 5 key questions and, under each key question, a set of quality statements. The 5 key questions asked of all health and social care services are: are they 1. Safe; 2. Effective; 3. Caring; 4. Responsive to people's needs; 5. Well-led?

Quality statements are the commitments that providers, commissioners and system leaders should live up to. These are known as ‘we statements’, they show what is needed to deliver high-quality, person-centred care. When they refer to 'people' they mean people who use services, their families, friends and unpaid carers.

The IPC team are always heavily involved in the CQC inspection of the Trust and were extremely proud to be part of the organisations rating.

Positive findings from the most recent inspection included labelling of clinical equipment once cleaned and stored appropriately, isolation signage and policy, bare below the elbows policy and good hand hygiene practices. It was also clear that the IPC team are involved with the clinical teams to work towards both local and Trust quality programmes.

There were areas for improvement including some inconsistent use of Personal Protective Equipment (PPE) and monitoring of equipment cleaning which have been addressed and plans implemented to address.

## SECTION 4: ANTIMICROBIAL

There have been real challenges in respect on antimicrobial stewardship over the last few years with 2025-26 being no different, however there has been some progress noted which will be a platform for us

to build upon. Further detail can be sought through the Pharmacy reporting systems; however key areas are highlighted below.

**UK National Action Plan Targets**

**Target 4A:**
By 2029, reduce total antibiotic consumption in human healthcare by **5% compared to the 2019 baseline**.

- **South Tees** has achieved a **1.2% reduction** versus baseline and is currently the **only trust in the region performing below baseline**.
- **North Tees** remains **6.6% above baseline**; however, this represents a **3.6% reduction** compared with the previous 12-month period, indicating improving performance.

**Target 4B:**
By 2029, achieve **≥70%** of total antibiotic use from the **Access** category across human healthcare (higher percentages indicate better performance).

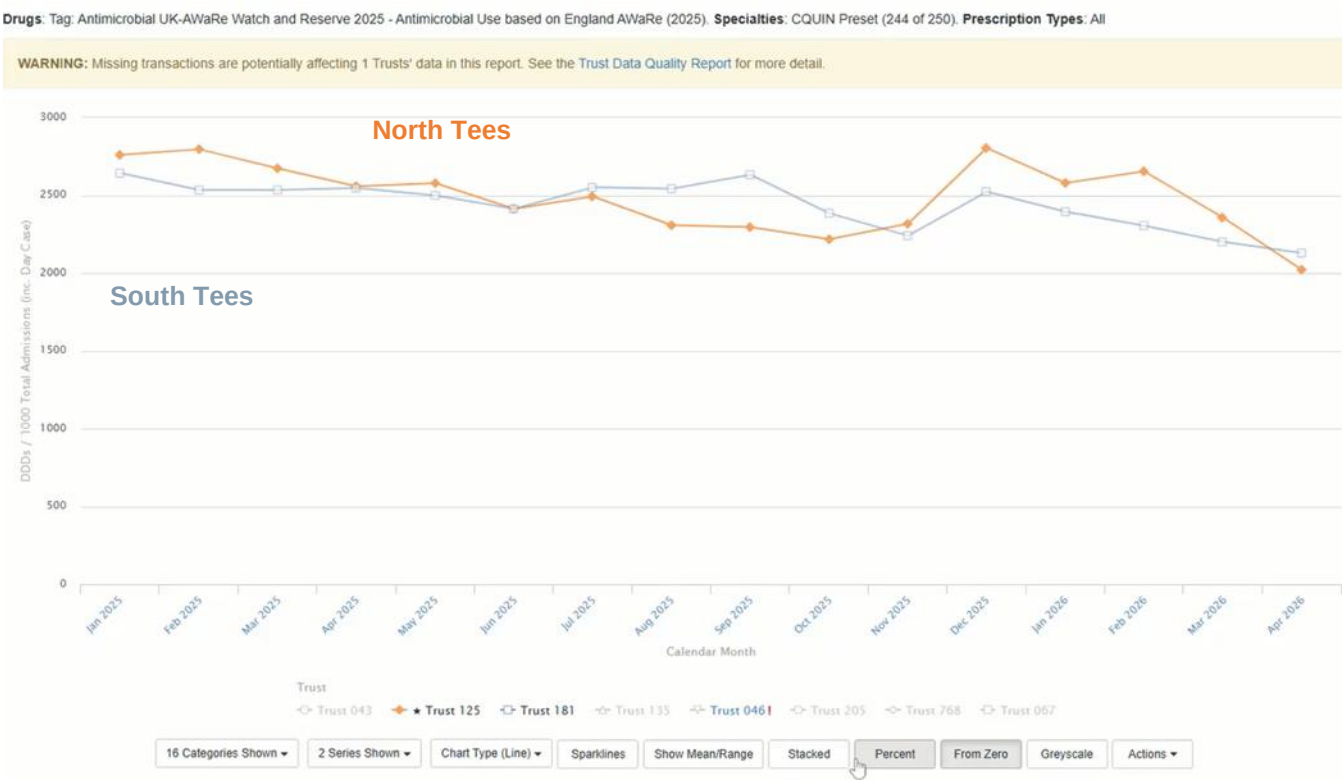
- **South Tees** is currently the lowest-performing trust in the region at **52%**, but this reflects a **significant improvement** from **46% in 2024–2025**, representing a **6% increase over 12 months**.
- **North Tees** is performing well, with **62% Access antibiotic use**, an increase from **57% in 2024–2025** (a **5% improvement**).

**Watch and Reserve (WaRe) Antibiotics**
A continued reduction in the use of broader-spectrum Watch and Reserve antibiotics remains a key stewardship priority.

- Both **South and North Tees demonstrate excellent performance** in this area.
- **South Tees** has reduced WaRe prescribing by **9% compared with the 2019 baseline**, representing a **19.5% reduction** from its position in 2024–2025 (+10.5% above baseline).
- **North Tees** has achieved a **3.6% reduction** versus baseline, equating to a **15.5% decrease** compared with 2024–2025.

The **Antimicrobial Working Group (AWG)** is preparing to convene its **third meeting** since being revitalised in **September 2025**. The reinstatement of the group has strengthened clinical governance of antimicrobial policies and guidelines, providing enhanced senior oversight and board-level assurance of effective AMS practice.

The AMS Pharmacy Team would like to thank all members of the AWG and colleagues across University Hospitals Tees for their continued support. These collective efforts are now being reflected positively in the prescribing data.




*Graph 8. Antimicrobial data*

## SECTION 5: CLEANING

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

The Sterile Services Department is responsible for reprocessing reusable invasive medical devices and flexible endoscopes. All processes are fully validated and compliant to national standards HTM 01-01, HTM 01-06, ISO 13485:2016 and UK MDR 2002 (as amended) Part 11 Regulation 14. The standards are validated by internal audit and independently by an external audit team. Disposable items are efficient and used whenever possible. No disposable items are ever re-processed.

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

The National Standards of Healthcare Cleanliness recently implemented were introduced by NHS England with the main drive being to ensure transparency in terms of the cleaning undertaken and scoring achieved to assure patients, public and staff that safe standards of cleanliness have been met. The standards have now adopted the widely recognised star rating for performance, with 5 stars being the highest. These star ratings are displayed at the entrance to each clinical ward & dept. and display units are currently being installed in which to display them in.
The Domestic team aim to achieve and maintain a minimum pass of 98% (5 Stars) for clinical cleaning compliance for all functional risk (FR) FR1 (very high risk) and FR2 (high risk) clinical areas in line with the standard.

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

The Domestic Department is also responsible for completing all Terminal Cleans (TC), following a patient being discharged with a known infection. These are responded to with a plan for high level disinfection following the TC usually Hydrogen Peroxide fogging. During 2026-27 there has been extensive work across North Tees in respect of this fogging in all appropriate cases with no deviation from the standard. There have been occasions when this has been challenging, however the requirement remains across all UHT areas.

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

There have been no concerns raised with the cleaning scores across UHT during 2026-27, any issues that raise are escalated immediately and actions addressed, including weekly cleaning huddles to address ongoing actions.

## SECTION 6: PROGRESS AGAINST 2025/2026 INFECTION PREVENTION AND CONTROL PROGRAMME

The 2025/26 IPC Annual Programme consisted of a number of elements and within each one there was a nominated lead with a distinctive action plan to follow. A summary of some of these are highlighted below.

### 6.1 CDI – action and monitor maintenance and reduction around CDI cases through implementation of CDI recovery plan

- Audit and surveillance of CDI identifying trends and themes.
- Audit and surveillance of clinical practice around CDI in collaboration with the clinical matron's council.
- Management of diarrhoea including refreshed paperwork and training.
- Education and training regarding CDI.
- Rapid learning reviews developed in line with PSIRF.
- Trust wide CDI 'Deep dive action plan', supported with collaborative owned plans and actions.
- Involvement with an ICB 'Deep dive diagnostic'.

### 6.2 MRSA / MSSA – reduce the incidence and increase staff awareness of MRSA/MSSA infection

- Audit and surveillance of MRSA/MSSA identifying trends and themes.
- Audit and surveillance of clinical practice around MRSA/MSSA in collaboration with the clinical matron's council.
- Refresh and strengthening of Aseptic Non-Touch Technique (ANTT) processes in the Trust.
- Learning from cases developed, reviewed, and shared.
- Education and training regarding MRSA/MSSA

## 6.3 GNBSI – surveillance of hospital acquired GNBSI

- Refresh and strengthening of Aseptic Non-Touch Technique (ANTT) processes in the Trust.
- Focussed work on oral hygiene in critical care and high-risk areas.
- Audit and surveillance of GNBSI's identifying trends and themes.
- Audit and surveillance of clinical practice around GNBSIs in collaboration with the clinical matrons' council.
- Focus on catheters and catheters associated UTIs linked to hydration.
- Education and training regarding GNBSI's.

## 6.4 CPE – action and monitor maintenance and reduction around CPE cases through implementation of CPE recovery plan

- Audit and surveillance of CPE identifying trends and themes.
- Audit and surveillance of clinical practice around CPE in collaboration with the clinical matrons' council.
- Education and training regarding CPE.
- Screening reviewed and developed in line with national guidance.
- Site team / bed management collaboration for isolation priority.

## 6.5 Respiratory Infections – maintain safety of our staff and patients and minimise risk of cross infection

- Outbreak management processes strengthened.
- Fit testing team established in the IPC team at South Tees and collaboration with NTH Solutions at North Tees.
- Surveillance of all respiratory infections and identify trends or concerns in respect of outbreaks etc.
- Support for ventilation and estates.
- Collaboration with Occupational Health regarding vaccinations

## 6.6 Antimicrobial Stewardship – to support with the Trusts antimicrobial strategy

- Support for AMS through collaboration with Pharmacy and through learning from HCAI cases.
- Attendance within Trust AMS working groups.
- Involvement in Regional and National initiatives around AMS.
- Development of additional AMS ward round and walk rounds.

## 6.7 Decontamination – to support the Trust with their overarching decontamination strategy from an IPC perspective

- Audit and surveillance of areas included in identifying trends and themes around decontamination services and initiatives.
- Oversee hand hygiene updates and work across organisation.
- Support with cleanliness initiatives such as use of UV light etc.
- Support for areas such as water safety, ventilation etc. in relation to decontamination.

## 6.8 Education and Teaching – to implement an effective and accessible IPC Education delivery plan

- Development of education and training across the organisation.
- Delivery of the 3-day IPC Advancing Care in Clinical Practice across the organisation and external as appropriate including North Tees.
- Review and continue IPC link practitioner's programme.

- Development of the IPC team in respect of ongoing service-specific training and education.

**6.9 Audit – development and maintenance of a robust audit delivery plan in line with Trust policies**

- Development and completion of a robust IPC audit programme.
- Surgical Site Infection an area of focus to carry into 2025/2026.
- Ensure registration of IPC audits as applicable via the Trust team.

**6.10 Strategic Team Planning - To create an experienced and resilient IPC team, with sufficient establishment to be able to provide full cover to all areas of the Trust, 7 days a week. To have efficient working practices to ensure IPCN time is maximised to spend on critical support and advice functions.**

- Review and refresh the IPC establishment including recruitment and retention initiatives.
- Development of a robust IPC team including planning for a UHT IPC team through consultation.
- Refresh the profile and roles and responsibilities of the IPC team.
- Ensure correct alignment of IPC governance and assurance structures.

**6.11 Community – provide a robust and resilient care home and social care domiciliary IPC service in collaboration with community services**

Focussed work on audit, surveillance and education in the care home and domiciliary sector in relation to the following,

- ANTT
- Catheters
- HCAIs
- Hydration
- Respiratory infections

**6.12 Achievements in 2025/2026**

There have been several achievements for the IPC team across the last year and some of these include,

- Investment for stability and resilience in the IPC team.
- Attendance at conferences to speak about IPC representing the Trust.
- Members of the team successfully completed the ‘Dare to Lead’ course.
- Members of the team completed the Human Performance Practitioner Course.
- Development of a robust audit and surveillance programme embedded in clinical areas.
- Close working with Non-Executive Director and Executive Director.

## SECTION 7: LOOKING FORWARD TO 2026/2027

The key aims in 2026/27 will be to build on the work that has been done in previous years to prevent HCAIs and improve the lives of the people who come into contact with UHT services. Patient safety is at the heart of IPC, and to ensure our work is sustainable, UHT promotes that every member of staff takes responsibility for IPC in order that that no person is harmed by a preventable infection. The work planned to prevent and control infections in 2026/27 and to achieve external thresholds and comply with the Code of Practice on the prevention and control of infections is reflected in the UHT Strategy to deliver care that is clinically effective; care that is safe; and care that provides as positive an experience for patients as possible.

## SECTION 8: CONCLUSION

The elimination of avoidable healthcare associated infections continues to be a priority for the Trust, patients and the wider public. In response, a robust annual programme of work has been implemented by the Trust over the last year which has been led by an experienced and highly motivated Infection Prevention and Control Team and supported by colleagues at all levels of the organisation. Although challenging, the successes over the last year have only been possible due to the commitment for infection prevention and control that is demonstrated at all levels within the Trust. High standards of infection prevention and control and antimicrobial stewardship will remain crucial to minimise the risk of infection and limit the emergence and spread of multi-drug-resistant organisms.

## SECTION 9: ACKNOWLEDGEMENTS AND FURTHER INFORMATION

Thank you for reading the IPC Annual Report for 2025/26. If you require any further information about IPC in UHT, please email the team at stees.infectioncontrol.team@nhs.net
nth-tr.infectioncontrol@nhs.net

This report was prepared by UHT's IPC team:

Emma Nunez - Chief Nurse & Director of Infection Prevention and Control
Richard Bellamy – Infection Control Doctor
Sharon Lance - Deputy Director of Infection Prevention and Control
Jo Carter – IPC Lead Nurse
Victoria Charlton – IPC Lead Nurse
Claire Phillips – IPC Governance and Quality Facilitator

In conjunction with:

Richard Cowan – Highly Specialist Pharmacist – Antimicrobials
Chioma Anyaegbu - Specialist Antimicrobial Pharmacist
Laura Mills - Head of Contract Management and Performance
Graeme Kelly - Director of Operations, Decontamination Lead
Julian Verity – Head of Estates
Richard Bertram – Assistant Director of Estates

# People Committee

**28 July 2026**

**Connecting to: University Hospitals Tees**

**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.

**Appraisal and Mandatory Training Compliance**

Appraisal compliance across UHT was 79.16% against 85% target. Only two CSUs met the standard and Corporate Services reported the lowest compliance at 66.13%. IPR recorded mandatory training compliance at 84% although there are particular challenges in resuscitation training. The Committee remains concerned about the current performance despite strengthened reporting and monthly oversight.

The Committee held a useful discussion on priorities in the context of limited organisational and line management capacity. The Board is requested to confirm the organisational compliance targets for appraisal and mandatory training and to reinforce clear accountability for delivery. Where performance remains below agreed standards, the Committee expects continued Board oversight, escalation and demonstrable management action to secure improvement.

**Discrimination Tribunal Learning**

The Committee received an update on current employee relations matters, including ongoing cases, suspensions, and an Employment Tribunal outcome relating to matters around 2018. The tribunal judgement highlighted areas where organisational arrangements and processes could be strengthened, including aspects of investigation, escalation, organisational learning, consistency in policy application, governance arrangements, and support for colleagues raising concerns, including those relating to race discrimination. The People Committee will

seek assurance on identification of change, implementation of agreed actions, and evidence of sustained organisational improvement. The Board will receive, via the People Committee Chairs Log, a summary of the key organisational learning and governance response arising from the Tribunal judgement.

**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.

**Regional Financial Oversight Framework & Voluntary Redundancy Scheme**

UHT under amber watch within revised NHSE regional financial oversight framework, requiring monthly review meetings and a new risk-adjusted forecast. The voluntary redundancy scheme closed and applications submitted to NHSE; an update will be provided to the Board in September.

**Absence Management Audit**

Audits across both trusts found recurring weaknesses in documentation, management compliance, trigger management, data quality, governance and occupational health support. Policy frameworks were in place and functioning, but further improvement is required before significant assurance can be given.

The Committee noted the comprehensive action plan and asked whether the Board should revisit the 4% absence planning assumption recognising historic performance and the need for realistic workforce and financial planning.

**Policy and Regulatory Developments**

Committee noted NHS trusts are required to adopt the **International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism**, '*Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities'.* Although BMA requested a pause connected with human rights and equality legislation, the organisation will continue unless NHS England issues different guidance.

Recent **EHRC guidance on transgender** services was discussed and would be considered jointly with the Resources & Performance Committee for policy and cost impact assessments.

**AHP Workforce Capacity and Succession**

Persistent vacancy pressures remain in Speech and Language Therapy, particularly paediatrics; adversely impacted by limited local university pipelines and competition from private practice. Committee members requested a clearer strategy for improving performance, culture, and succession planning across AHPs, with a more outcome-focused report to be presented at the October meeting.

**Payroll Overpayments [Limited Assurance]**

Overpayments remain a significant operational, financial and workforce challenge at STHFT. Approximately 70% were attributed to delayed, incomplete or missing management instructions. Although this represented a 15% improvement on the previous 12-month period, progress remained below the required standard. Sustained improvement requires continued executive focus. Progress will return to People Committee in three to six months.

**Workforce Equality Standards**

The WRES report showed increased representation of Global Majority staff but worsening reported experiences of bullying, harassment, abuse and discrimination in several measures, together with continued inequality in recruitment and perceptions of career opportunity. The WDES report showed a fall in disabled staff engagement scores at both trusts. Further scrutiny and assurance at People Committee in coming months.

**Staff Survey Sprint**

The six-week Staff Survey Sprint engaged CSUs and staff groups on morale and burnout, leadership and communication, the group model, culture and safe staffing. Findings and action plans will be summarised for Board assurance and integrated into wider organisational development work.

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

**Vaccination Programme**

Committee received assurance regarding the 2026/27 vaccination improvement plans, including targeted engagement with CSUs and enhanced clinician advocacy to support increased engagement and vaccine uptake

**Board Assurance Framework**

People BAF reported no strategic risks above the approved risk appetite and no red/high strategic risks for either trust. One planned action was agreed for closure: development of a single set of UHT People policies. Reporting will move to a quarterly cycle from Quarter 2 2026/27.

**Safer Staffing**

Committee agreed the Safer Staffing Report should be presented monthly to Quality Committee as the principal assurance forum and every other month to People Committee, with the assurance relevant to each committee clearly identified.

## Recommendations:

- The Board notes the Employment Tribunal findings and receives a formal summary of organisational learning, actions, accountabilities and governance, with a three-month follow-up through People Committee.
- The Board continues to require clear executive and CSU accountability for appraisal and mandatory training compliance, including evidence of sustained improvement against agreed standards.
- The Board considers whether the 4% sickness absence planning assumption remains appropriate for workforce and financial planning.

University Hospitals Tees

# WRES Report

**Meeting date:** 3 September 2026

**Reporting to:** Board of Directors

**Agenda item No:** 3.2

**Report author:** Nicola Hogarth, Culture and Inclusion Assurance Partner

**Executive director sponsor:** Rachael Metcalf, Chief People Officer

**Action required:** Information

**Delegation status Jointly delegated item to Group Board**

**Previously presented to:** People Committee on 28 July 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:

BAF strategic risk: A culture that doesn't promote positivity, respect, inclusion and a 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.

**North Tees and Hartlepool NHS Foundation Trust**
Key issues highlighted in this year's WRES was the increase of Global Majority staff personally experiencing bullying, harassment and abuse from staff, and also Global Majority staff experiencing discrimination from a manager/team leader.

**South Tees NHS Foundation Trust**
Key issues highlighted in this year's WRES was the increase of Global Majority staff personally experiencing bullying, harassment and abuse from patients, relatives or the public, and an increase of Global Majority staff experiencing Bullying, Harassment and Abuse from staff

**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 is advised that due to the reporting nature of the workforce race, equality standard, the report is written for both unitary bodies separately.

**North Tees and Hartlepool NHS Foundation Trust**

- Whilst there has been improvement from last year in this metric, there is a disproportionate underrepresentation of applicants from Global Majority ethnic backgrounds being appointed following shortlisting when compared to White applicants.
- The percentage of Global Majority staff believing the Trust provide equal opportunities for career progression or promotion has remained static 2026.
- Global Majority representation at Board level is reported at 0% (please note we can only report on those employees who are directly employed by North Tees and Hartlepool NHS Foundation Trust).

**South Tees NHS Foundation Trust**

- Whilst there has been improvement from last year in this metric, there is a disproportionate underrepresentation of applicants from Global Majority ethnic backgrounds being appointed following shortlisting when compared to White applicants.
- A decrease of Global Majority staff believing the Trust provide equal opportunities for career progression or promotion.

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

### North Tees and Hartlepool NHS Foundation Trust

- The number of Global Majority staff employed within the Trust has increased each year from 2022 and represents 16.50% of the workforce. In comparison to the Government's Office for National Statistics, Global Majority employees are well represented in the organisation when compared to the BAME population in the Northeast of England which is reported as 7%.
- A decrease in the percentage of Global Majority staff personally experiencing bullying, harassment and abuse from patients, relatives or the public.
- We continue to report that we do not have a disproportionate number of Global Majority employees entering a formal disciplinary process.
- There is a greater likelihood of Global Majority employees to access non-mandatory training opportunities.

### South Tees NHS Foundation Trust

- The number of Global Majority colleagues employed within the Trust has increased each year from 2022 and represents 14.89% of the workforce. In comparison to the Government's Office for National Statistics, Global Majority employees are very well represented in the organisation when compared to the BAME population in the Northeast of England which is reported as 7%.
- Equal experience for Global Majority and White employees to access non-mandatory training opportunities.
- We do not have a disproportionate number of Global Majority employees entering a formal disciplinary process
- Decrease in % of Global Majority staff experiencing discrimination from a manager/team leader.
- Global Majority representation at Board level has increased and is reported at 11.1% (please note we can only report on those employees who are directly employed by South Tees Hospitals NHS Foundation Trust).

## Recommendations:

This report presents a group update in relation to the Workforce Race Equality Standard (WRES) 2026 across University Hospitals Tees. The Board is asked to receive the content of the report and acknowledge the Workforce Race Equality Standard (WRES) results.

## University Hospitals Tees

## NHS Workforce Race Equality Standard (WRES) 2026

### 1. Introduction

As set out in the NHS Long Term Plan, respect, equality, and diversity are central to changing culture and are at the heart of the NHS workforce implementation plan.

The Workforce Race Equality Standard (WRES) was introduced as part of the NHS Standard Contract in 2015 and seeks to tackle one aspect of equality – the consistently less favourable treatment of those who identify themselves as Black, Asian or from a Minority Ethnic (BAME) background.

National research shows that those individuals who are from a Black, Asian or Minority Ethnic background (Global Majority) are:

- less likely to be appointed for jobs once shortlisted.
- less likely to be selected for training and development programmes.
- more likely to experience harassment, bullying or abuse.
- more likely to be disciplined and dismissed.

The purpose of this report is to present a group update in relation to the Workforce Race Equality Standard (WRES) 2026.

### 2. WRES Indicators

A summary of the results for North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust is shown in the tables below and includes comparison of the Trust's results covering a five-year period (2022 to 2026).

A copy of the WRES Reports 2026 for each Trust is contained at Appendix 1 and Appendix 2 for information purposes.

With reference to the Board Representation figure at South Tees; please note that the negative value reflects the difference between the proportion of BME staff represented on the Board and the proportion of BME staff within the overall workforce. The metric looks to measure representation against the workforce baseline, rather than calculate a standalone percentage for the Board itself.

| North Tees and Hartlepool - WRES Indicators 2026 | | | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|
| 1 | Percentage of BME staff | Overall | 11.4% | 12.8% | 14.33% | 16.06% | **16.50%** |
| | | VSM | 0.0% | 0.0% | 0.00% | 0.00% | **0.00%** |
| 2 | Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants | | 1.43 | 2.12 | 2.4 | 2.96 | **2.54** |
| 3 | Relative likelihood of BME staff entering the formal disciplinary process compared to white staff | | 0.88 | 0.78 | 0.99* | 0.64 | **0.67** |
| 4 | Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff | | 0.96 | 1.1 | 0.91 | 0.84 | **0.78** |
| | | | 2021 | 2022 | 2023 | 2024 | 2025 |
| 5 | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | BME | 34.9% | 30.7% | 28.3% | 33.9% | **32.7%** |
| | | White | 26.2% | 24.8% | 21.8% | 21.2% | **22.6%** |
| 6 | Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months | BME | 30.1% | 26.9% | 22.8% | 22.4% | **23.0%** |
| | | White | 18.7% | 18.6% | 16.1% | 16.9% | **17.7%** |
| 7 | Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion | BME | 48.2% | 48.1% | 50.6% | 47.6% | **47.6%** |
| | | White | 64.8% | 64.9% | 63.7% | 58.4% | **56.6%** |
| 8 | Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues | BME | 16.8% | 12.6% | 13.7% | 15.4% | **16.3%** |
| | | White | 5.2% | 4.7% | 5.2% | 4.7% | **4.7%** |
| | | | 2022 | 2023 | 2024 | 2025 | 2026 |
| 9 | BME Board membership | BME | 7.1% | 6.3% | 0.0% | 0.0% | **0.0%** |

*Remains positive as 1.00 would indicate equal experience of both White and BME Staff

| South Tees - WRES Indicators 2026 | | | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|
| 1 | Percentage of BME staff | Overall | 10.0% | 11.44% | 12.83% | 13.88% | **14.89%** |
| | | VSM | | | 14.30% | 0.00% | **0.00%** |
| 2 | Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants | | 1.6 | 1.52 | 1.86 | 2.62 | **2.14** |
| 3 | Relative likelihood of BME staff entering the formal disciplinary process compared to white staff | | 1.27 | 0.8 | 0.78 | 1.37 | **0.90** |
| 4 | Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff | | 0.98 | 1.08 | 0.99 | 1.00* | **0.88** |
| | | | 2021 | 2022 | 2023 | 2024 | 2025 |
| 5 | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | BME | 26.7% | 28.8% | 23.0% | 24.4% | **30.4%** |
| | | White | 23.9% | 24.8% | 22.0% | 21.9% | **22.0%** |
| 6 | Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months | BME | 28.6% | 32.9% | 30.1% | 28.3% | **32.3%** |
| | | White | 21.5% | 22.2% | 20.6% | 24.3% | **21.8%** |
| 7 | Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion | BME | 48.2% | 43.3% | 43.5% | 49.6% | **45.2%** |
| | | White | 58.2% | 58.4% | 58.7% | 57.8% | **53.1%** |
| 8 | Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues | BME | 19.9% | 20.4% | 20.0% | 19.7% | **18.3%** |
| | | White | 5.8% | 5.8% | 6.2% | 7.1% | **7.6%** |
| | | | 2022 | 2023 | 2024 | 2025 | 2025 |
| 9 | BME Board membership | BME | -9.6% | -10.0% | -13.0% | 0.0% | **11.1%** |

## 3. WRES Update - North Tees and Hartlepool

A review of the WRES data has highlighted the following points of interest:

- The number of Global Majority staff employed within the Trust has increased each year from 2022 and represents 16.50% of the workforce. In comparison to the Government's Office for National Statistics, Global Majority employees are well represented in the organisation when compared to the BAME population in the Northeast of England which is reported as 7%.

- Less likelihood of applicants with a Global Majority ethnicity being appointed from shortlisting.

- We continue to report that we do not have a disproportionate number of Global Majority employees entering a formal disciplinary process.

- There is a greater likelihood of Global Majority employees to access non-mandatory training opportunities.

- A decrease in % of Global Majority staff personally experiencing bullying, harassment and abuse from patients, relatives or the public.

- The % of Global Majority staff believing the Trust provide equal opportunities for career progression or promotion has remained static.

- Global Majority representation at Board level is reported at 0% (please note we can only report on those employees who are directly employed by North Tees and Hartlepool NHS Foundation Trust).

Key issues highlighted in this year's WRES was the increase of Global Majority staff personally experiencing bullying, harassment and abuse from staff, and also Global Majority staff experiencing discrimination from a manager/team leader.

## 4. WRES Update - South Tees

A review of the WRES data has highlighted the following points of interest:

- The number of Global Majority colleagues employed within the Trust has increased each year from 2022 and represents 14.89% of the workforce. In comparison to the Government's Office for National Statistics, Global Majority employees are very well represented in the organisation when compared to the BAME population in the North East of England which is reported as 7%.

- Less likelihood of applicants with a Global Majority ethnicity being appointed from shortlisting.

- We do not have a disproportionate number of Global Majority employees entering a formal disciplinary process.

- There is a greater likelihood of Global Majority employees to access non-mandatory training opportunities.

- A decrease of Global Majority staff believing the Trust provide equal opportunities for career progression or promotion.

- A decrease of Global Majority staff experiencing discrimination from a manager/team leader.

- An increase of Global Majority representation at Board level is reported at 11.1% (please note we can only report on those employees who are directly employed by South Tees Hospitals NHS Foundation Trust).

Key issues highlighted in this year's WRES was the increase of Global Majority staff personally experiencing bullying, harassment and abuse from patients, relatives or the public, and an increase of Global Majority staff experiencing Bullying, Harassment and Abuse from staff

## 5. WRES Group Update

A review of both Trusts data, has highlighted the following key points, as a Group:

**Indicator 1 – Representation.**

It is positive to report that both Trusts have seen an increase in employed Global Majority staff for 2026. When compared to the North East's ethnicity data (2021 census) which is reported at 7%, both Trusts report a higher representation within the overall workforce. Also, when compared against our local areas ethnicity data, including Stockton, Hartlepool, Redcar and Cleveland and Hambleton (with the exception of Middlesbrough) both Trusts have also reported a higher workforce representation in comparison to our local communities BAME population.

The ethnicity pay gap analysis further highlights disparities in workforce representation across pay quartiles. Global Majority staff are more strongly represented within the upper pay quartiles, while the lower pay quartile remains the least representative. This indicates that representation is not yet consistent across all levels of the workforce and reinforces the need for continued action to ensure equitable opportunities and outcomes for staff from all ethnic backgrounds.

**Indicator 2 – Likelihood of staff being appointed from shortlisting.**

Whilst both Trusts have reported an improvement against this indicator, a disparity remains, with applicants from Global Majority ethnic backgrounds continuing to be less likely to be appointed from shortlisting compared with White applicants.

To address this, a Group-wide review of recruitment practices will be undertaken, focusing on the end-to-end recruitment pathway, including attraction, advertising, shortlisting, and selection processes. Consideration has been given to strengthening the diversity of interview panels and ensuring recruitment practices promote equitable outcomes. This is reflected in the recently updated recruitment policy and framework.

Information contained within the advertisements for jobs across the Group has been reviewed and updated to make reference to encouraging applications where English is not someone's first language. '*We are committed to fostering an inclusive recruitment proves and welcome applications from suitably qualified candidates, including those whose first language is not English'*

Engagement with Staff Networks and EDI leads is recommended to review the findings and develop targeted actions, including increasing the use of inclusive interview panels and providing additional support for internal applicants from underrepresented group.

**Indicator 3 – Likelihood of staff entering formal disciplinary process**

Both Trusts have no evidence of a disproportionate number of Global Majority staff entering formal disciplinary processes. To further support equity and inclusion within employee relations processes, the Group has increased the number of trained Cultural Ambassadors available to provide support and insight during formal proceedings involving Global Majority staff.

The Trusts will continue to monitor performance against this indicator and undertake ongoing analysis of internal trends, benchmarking against regional comparators and reviewing outcomes against previous years' data to ensure sustained progress and identify any emerging disparities.

**Indicator 4 – Likelihood of staff accessing non-mandatory training**

Both Trusts continue to report a positive position against this indicator, demonstrating that Global Majority staff are more likely to access non-mandatory training opportunities compared with their White colleagues. This reflects continued progress in promoting equitable access to learning and development opportunities across the workforce.

As no disparity has been identified in relation to access to non-mandatory training, both Trusts will continue to monitor participation rates and undertake further analysis of workforce data. This will include ongoing review of ethnicity pay gaps and representation across pay bands to better understand career progression, development opportunities, and any emerging inequalities that may require targeted intervention.

**Indicator 5 – Percentage of staff experiencing harassment, bullying/abuse from patients, relatives/public**

South Tees have reported a negative increase of 6% (30.4% compared to 24.4% in 2024) in the percentage of staff stating they have experienced harassment, bullying/abuse from patients, relatives/public. North Tees and Hartlepool have reported a decrease of 1.2% (32.7% compared to 33.9% in 2024). Both Trusts report above the national average of 28.9%

Further analysis of this key finding has been undertaken to identify hotspots, and development of department specific action plans to address any areas of concern. We work closely with Cleveland Police and the Victim Care and Advice Service (VCAS) which is a further support mechanism for staff to access.

All staff are actively encouraged and supported to report any unacceptable behaviour, including abuse, harassment, discrimination or violence, from patients, relatives or members of the public. All reported incidents are recorded through the incident reporting system and are reviewed and addressed appropriately to ensure a safe and respectful working environment.

To strengthen this approach, the Group has appointed a Keeping Staff Safe Lead, who provides strategic oversight of this agenda and chairs monthly Keeping Staff Safe meetings. These meetings support the monitoring of incidents, identification of trends, sharing of learning, and development of actions to further enhance staff safety and wellbeing across the organisation.

We continue to work closely with Cleveland Police to address and prevent hate crime affecting our staff. This includes attending monthly multi-agency meetings to review reported hate crime incidents, identify emerging themes, and develop collaborative actions to improve staff safety and support.

A number of initiatives have been implemented to enhance the safety and wellbeing of staff, including improvements to environmental security measures such as increased lighting along pathways and walkways leading to local transport links. These measures form part of the

Group's ongoing commitment to providing a safe working environment and ensuring staff feel supported both on-site and when travelling to and from work

To help raise awareness of hate crime and promote a culture of safety, inclusion and respect for all staff, a dedicated Hate Crime Awareness Event is planned for November, in partnership with Cleveland Police and local authority colleagues. The event will provide staff with the opportunity to increase their understanding of hate crime, learn about available support mechanisms, and engage with external partners to raise awareness of reporting pathways and preventative initiatives. This collaborative approach aims to further strengthen staff confidence in reporting incidents and accessing appropriate support when required.

**Indicator 6 – Percentage of staff experiencing harassment, bullying/abuse from staff**

Across the Group we have seen negative increase in the percentage of Global Majority staff stating they have experienced harassment, bullying/abuse from staff and has been highlighted as priority area for the organisation.

We continue to raise awareness of the 'See me First Campaign'. The campaign aims to promote race equality, inclusion and anti-discriminatory practice by encouraging staff to make a visible pledge to support colleagues from Global Majority backgrounds and to challenge discrimination when it occurs. Pledges from colleagues across the Group range from helping to create an open, non-judgemental and inclusive workplace, calling out inequity and injustice and accountability for actions and stepping out of personal comfort zones.

In September, as part of national inclusion week, we will again highlight this campaign and as part of the EDI conference planned for November, we will be providing further education and training opportunities to increase workforce understanding of hate crime and to learn about available support mechanisms,

A seven-point plan has been developed in partnership with Cleveland Police to support staff who have been a victim of and reported discrimination/hate crime. Moving forward, work will focus on the effective implementation of these actions and the development of a robust zero-tolerance culture in relation to discrimination, bullying, harassment and racism.

As an organisation, we now look at a trauma informed approach to our leadership and restorative approach, and this will be included as part of review of the leadership programme in alignment of the NHS staff standards and Leadership and Management Framework (LAMF).

We will also continue to undertake awareness raising programmes for staff to promote understanding of examples and the effects of workplace bullying, including the actions that staff can take and where they may obtain further support as well as sign posting routes for reporting behaviours.

**Indicator 7 – Percentage of staff believing the Trust provides equal opportunities.**

The percentage of our Global Majority staff that believe we provide equal opportunities for career progression or promotion has decreased for South Tees, and the figures for North Tees and Hartlepool have remained static.

We will continue to monitor and review performance against this indicator. In addition, the recommendations outlined under Indicator 2, relating to the implementation of fairer and more inclusive recruitment processes, are expected to contribute positively to improvements in this area.

The Trusts will continue to engage with Staff Networks and leads to explore any perceived barriers to equitable access to opportunities and career progression. Insights gained through this engagement will inform the development of targeted actions to address any areas of concern and support the delivery of equitable outcomes for all staff.

Part of the new Leadership and Management Programme aims to attract, develop and retain the best talent. This will be included in the new framework which sets out clear expectations for career development, talent identification, performance and appraisal. A Talent Management Strategy is in place, and work continues to embed this across Group. The new appraisal documentation will support staff to have in-depth conversations to support personal and professional development. The objective of 10% of staff having a Talent Management Plan in place by March 2027 will be monitored from a protected characteristic perspective.

**Indicator 8 – Percentage of staff experiencing discrimination at work from their manager, team leader or other colleagues**

South Tees have seen a slight decrease (1.4%) to 18.3%, but this still remains above the national average which is reported at 14.7%. North Tees and Hartlepool have seen a negative increase of 0.9% (16.3%) when compared to the 2024 Staff Survey data.

It is essential that we continue to equip and empower managers with the skills, confidence and support required to challenge inappropriate behaviours effectively, conduct difficult conversations, and make fair and evidence-based decisions. This includes ensuring that the rationale for decisions is communicated clearly and transparently, particularly in circumstances where outcomes may be perceived as discriminatory.

As a Group we will also continue to monitor and analyse employee exit data to better understand the reasons why Global Majority staff leave the organisation. This will include reviewing whether experiences of discrimination, inequity or exclusion have influenced decisions to leave, enabling targeted actions to be developed where concerns or trends are identified.

**Indicator 9 –Board Membership**

It is encouraging to note the increase in Global Majority representation at Board level across the Group. However, Board-level representation within University Hospitals Tees remains below that of the overall Global Majority workforce, indicating an opportunity to further strengthen diversity within senior leadership.

The Group remains committed to ensuring that recruitment processes at all levels of the organisation are fair, transparent and inclusive, supporting equitable access to leadership opportunities for all candidates.

To further improve representation, it is recommended that a review of Board-level recruitment, development and succession arrangements is undertaken, including consideration of positive action initiatives aimed at encouraging applications from individuals from Global Majority backgrounds. The objective is to ensure that Board composition more closely reflects the diversity of our workforce, the populations we serve and the communities in which we operate. It is be noted that the Shadow Board currently has a 15% representation of global majority colleagues which is slightly higher that the Board representation.

In line with the NHS Equality, Diversity and Inclusion Improvement Plan and the new leadership framework, the Group will continue to prioritise succession planning and talent management initiatives to develop diverse leadership pipelines and support the progression of underrepresented groups into senior and Board-level positions

## 6. Conclusion and Next Steps

The Workforce Race Equality Standard (WRES) has now been collecting data on race inequality for eleven years, holding up a mirror to the service and revealing the disparities that exist for black and minority ethnic staff compared to their white colleagues.

Our actions to improve the WRES metrics are closely aligned with the Group People values, particularly *Respect*, and underpin our ongoing commitments as set out in the NHS People Plan.

We are pleased to report an improvement in some of the metrics for both Trusts for 2026 and note that this reflection of the continued EDI programme of work and the significant investment made in terms of data analysis, our restorative approach and focused interventions to improve staff experience across the range of protected characteristics. However, the disparity gap across a number of the indicators and the level of bullying, harassment and abuse by staff remains a significant concern.

We will continue to strengthen and embed existing good practice across the Organisation. This includes maintaining fair and transparent recruitment processes, delivering training in civility and unconscious bias, and proactively promoting leadership and development opportunities to ensure equitable access for all members of our workforce.

We continue to be fully committed to advancing racial equality. While a number of initiatives have been implemented that are expected to positively impact this agenda, we recognise that achieving meaningful and lasting change requires a significant and sustained cultural shift across the organisation. Although changes in workforce ethnicity profiles will take time to materialise, we are encouraged by the year-on-year increase in the representation of global majority staff.

It is equally important that we continue to support and develop our staff networks, ensuring that the voices of global majority colleagues are actively heard and play a central role in shaping improvements to the overall staff experience.

The Lord Mann Review (4th June 2026) recommends that Boards must assign explicit accountability to a designated Board member for monitoring and reviewing local race-related incidents (recommendation 4) and as we assign executive sponsorship to all the of the networks it is imperative that the Group also mandate that all our workforce undergo updated, comprehensive education on cultural competence, antisemitism, and Islamophobia as detailed in recommendation 29 of the Lord Mann Review.

The UHT Anti Racism Charter states our zero tolerance approach and our commitment to:

**Zero Tolerance of Racism**
Racism, racial harassment, bullying, and victimisation will not be tolerated—towards staff, patients, or the public.

**Active Anti-Racism**
We move beyond being “not racist” to taking deliberate action to challenge racism and racial inequality.

**Equity in Care and Workforce Experience**
We acknowledge that different groups experience healthcare and employment differently and commit to addressing unequal outcomes.

**Listening to Lived Experience**
We value the voices and experiences of Black, Asian and minoritised ethnic staff and patients and use this insight to drive change.

**Leadership Accountability**
Leaders at all levels are responsible for embedding anti-racism into everyday practice and decision-making.

This report provides a high-level overview based on current workforce metrics. The next phase will focus on engagement with staff to share these findings and collaboratively develop a targeted action plan, which will inform the WRES Annual Report to be submitted in October 2026.

## 7.0 Recommendation

This report presents a group update in relation to the Workforce Race Equality Standard (WRES) 2026 across University Hospitals Tees. The Board is asked to receive the content of the report and acknowledge the Workforce Race Equality Standard (WRES) results for both Trusts reported in Section 2 and the key points and recommendations outlined within Section 5. Both Trusts individual reports are included in the appendices for further information.

**Appendix 1** - North Tees & Hartlepool NHS Foundation Trust - NHS Workforce Race Equality Standard 2026

**Appendix 2** - South Tees Hospitals NHS Foundation Trust - NHS Workforce Race Equality Standard 2026

**Appendix 1**

## North Tees and Hartlepool NHS Foundation Trust

### WRES Indicators 2026

| North Tees and Hartlepool - WRES Indicators 2026 | | | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|
| 1 | Percentage of BME staff | Overall | 11.4% | 12.8% | 14.33% | 16.06% | **16.50%** |
| | | VSM | 0.0% | 0.0% | 0.00% | 0.00% | **0.00%** |
| 2 | Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants | | 1.43 | 2.12 | 2.4 | 2.96 | **2.54** |
| 3 | Relative likelihood of BME staff entering the formal disciplinary process compared to white staff | | 0.88 | 0.78 | 0.99* | 0.64 | **0.67** |
| 4 | Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff | | 0.96 | 1.1 | 0.91 | 0.84 | **0.78** |
| | | | **2021** | **2022** | **2023** | **2024** | **2025** |
| 5 | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | BME | 34.9% | 30.7% | 28.3% | 33.9% | **32.7%** |
| | | White | 26.2% | 24.8% | 21.8% | 21.2% | **22.6%** |
| 6 | Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months | BME | 30.1% | 26.9% | 22.8% | 22.4% | **23.0%** |
| | | White | 18.7% | 18.6% | 16.1% | 16.9% | **17.7%** |
| 7 | Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion | BME | 48.2% | 48.1% | 50.6% | 47.6% | **47.6%** |
| | | White | 64.8% | 64.9% | 63.7% | 58.4% | **56.6%** |
| 8 | Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues | BME | 16.8% | 12.6% | 13.7% | 15.4% | **16.3%** |
| | | White | 5.2% | 4.7% | 5.2% | 4.7% | **4.7%** |
| | | | **2022** | **2023** | **2024** | **2025** | **2026** |
| 9 | BME Board membership | BME | 7.1% | 6.3% | 0.0% | 0.0% | **0.0%** |

*Remains positive as 1.00 would indicate equal experience of both White and BME Staff

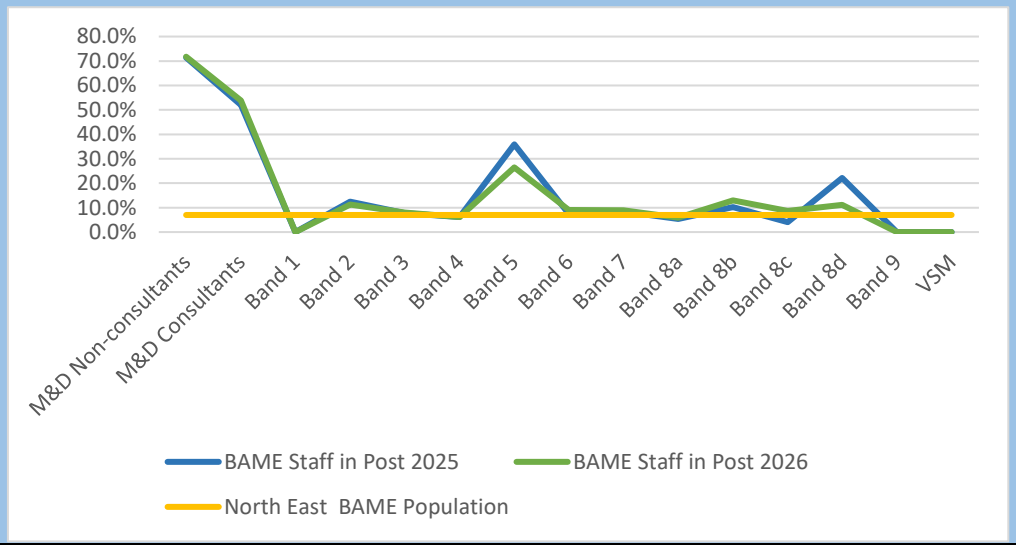
## Key Findings for 2026

The key findings in respect of the nine WRES indicators for 2026 are summarised below.

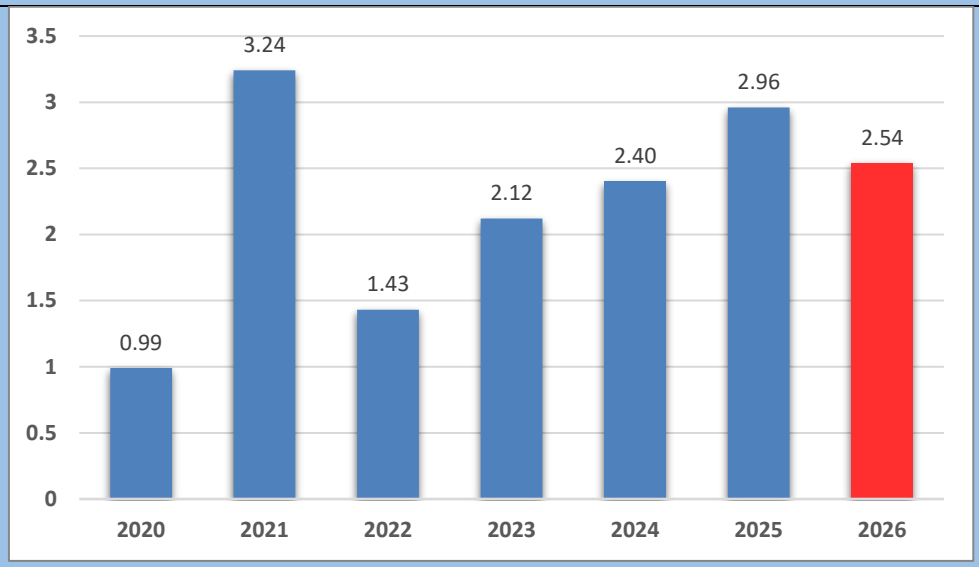
We are currently only able to undertake benchmarking for those areas which relate to the staff survey (indicators 5-8). Full benchmarking information is published by the national WRES team and this is expected for March 2027.

The data for the UK Census which took place in 2021 is now available for analysis and reporting and this provides us with a more accurate picture of the UK's ethnicity profile, which can also be broken down by Region and Local Authority Area.

- UK Population 81.7% White and 18.3% BAME
- North East Population 93% White and 7% BAME
- Stockton Population 92% White and 8% BAME
- Hartlepool Population 96.5% White and 3.5% BAME

| Indicators 1 and 9 – Representation across the organisation | |
|---|---|
|  | **Representative Workforce across all protected characteristics at all levels**.<br><br>This information is obtained from the Trust's ESR system as at 31 March 2026. There has been an increase in the number of global majority staff employed by the Trust for 2025 - an increase of 0.44% to 16.50%. When compared to the North East's ethnicity data (2021 census) the Trust has higher representation within the overall workforce, however this is not reflected across all grades.<br><br>Consistent with previous years, there is higher representation within the medical staffing group and at Band 2 and Band 5.<br><br>**Representation of BME at Board and senior management levels.**<br><br>For reporting purposes, we are only able to report on Board members who are directly employed by North Tees and Hartlepool Foundation Trust (NTH)<br><br>Representation at Board level is under represented at 0%, as compared to the Trust's overall global majority workforce of 16.50%. Bands 8a, 8b and 8c have all seen an increase in representation compared to the previous year. Band 8d has seen a decrease in representation and there continues to be no representation at VSM level |

## Indicator 2 – Likelihood of staff being appointed from shortlisting




**Equity of Experience.**

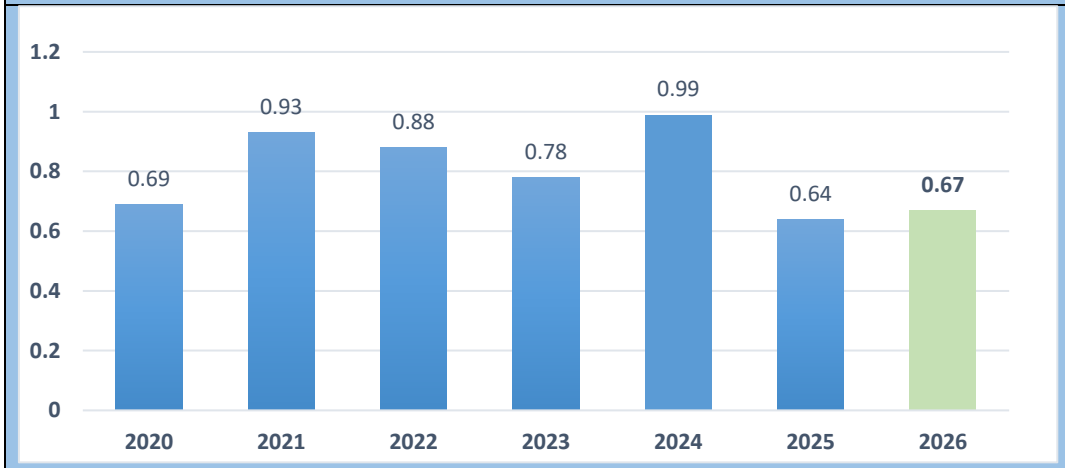
This information is obtained from the Trust's Trac Recruitment System for the period 1 April 2025 to 31 March 2026 and considers a ratio showing the likelihood of being appointed following shortlisting. A figure of 1 indicates equal experience between White and global majority applicants.

Global majority applicants are less likely to be appointed following shortlisting than White applicants, however there has been a positive decrease from the figure reported in 2025.

Work will continue to focus on inclusive interview panels and support for internal applicants.

(A figure above 1:00 indicates that White candidates are more likely than BME candidates to be appointed from shortlisting)

## Indicator 3 – Likelihood of staff entering formal disciplinary process




**Equality of Experience.**

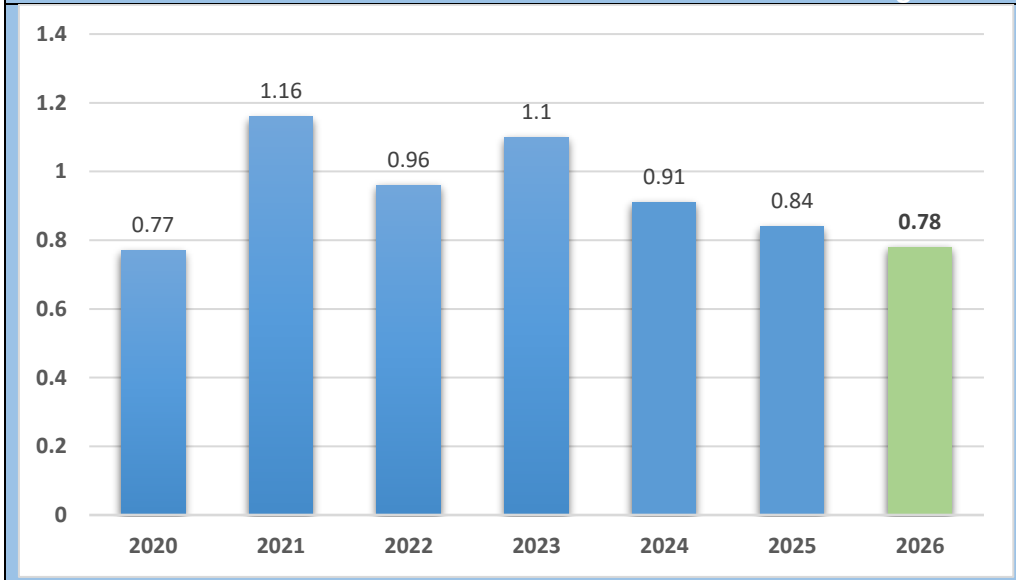
This information is obtained from the Trust's Workforce databases and considers a ratio showing the likelihood of entering formal disciplinary processes. A figure of 1 indicates equal experience between White and global majority staff.

The information for this metric is calculated over a 12-month period, with a total of 2 cases recorded, as compared to 15 cases involving staff from a White ethnicity.

The Trust has consistently reported that global majority colleagues are less likely to enter formal disciplinary processes and this figure is reported at 0.67 for 2026.

(A figure above 1:00 indicates that BME staff are more likely than White staff to enter the formal disciplinary process)

## Indicator 4 – Likelihood of staff accessing non-mandatory training and continuous personal development




**Belief in Equal Opportunities.**

This information is obtained from the Trust's ESR system for the period 1 April 2025 to 31 March 2026.

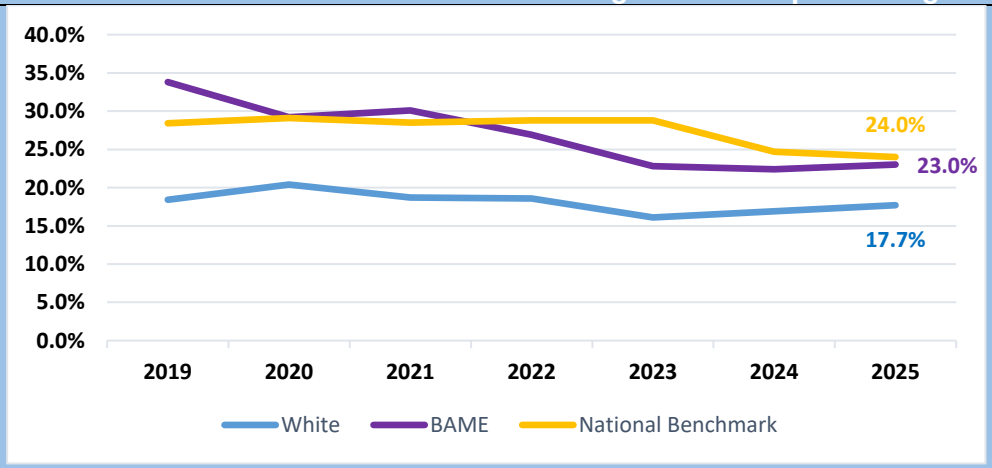
For this reporting cycle, global majority staff are more likely to access non-mandatory training and continuous personal development as compared to White Staff.

The ratio continues to remain below 1.0, and the overall differential remains low and does not indicate any real concern in this area.

The % of global majority staff accessing training has decreased from 81.5% in 2025, to 77.9% in 2026. The number of White staff accessing training has also decreased from to 68.6% in 2025, to 61.3% in 2026.

(A figure above 1:00 indicates that White staff are more likely than BME staff to access non-mandatory training and CPD)

## Indicator 5 – Percentage of staff experiencing harassment, bullying/abuse from patients, relatives/public




**Staff Survey Key Findings - B&H Public**

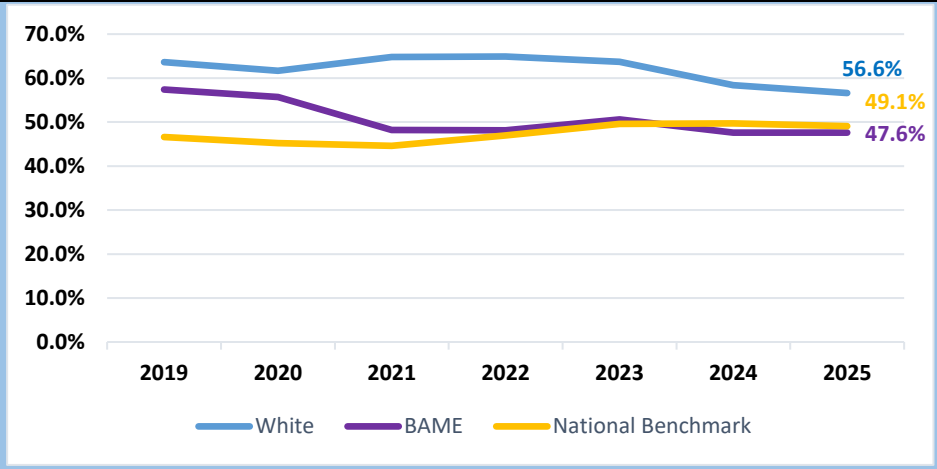
This information is derived from the 2025 staff survey.

Staff survey results show a positive decrease in the number of global majority staff experiencing harassment, bullying and abuse from patients, relatives/public (32.7% as compared to 33.9% for 2024).

Global majority staff continue to be more likely to experience harassment, bullying/abuse from patients than White staff and the gap is reported as 10.6%.

Staff are required to log all incidents of service user violence and harassment via Inphase. The Trust's Keeping People Safe group reviews this information to identify trends and this includes analysis of related themes including race.

## Indicator 6 – Percentage of staff experiencing harassment, bullying/abuse from staff




**Staff Survey Key Findings - B&H Staff**

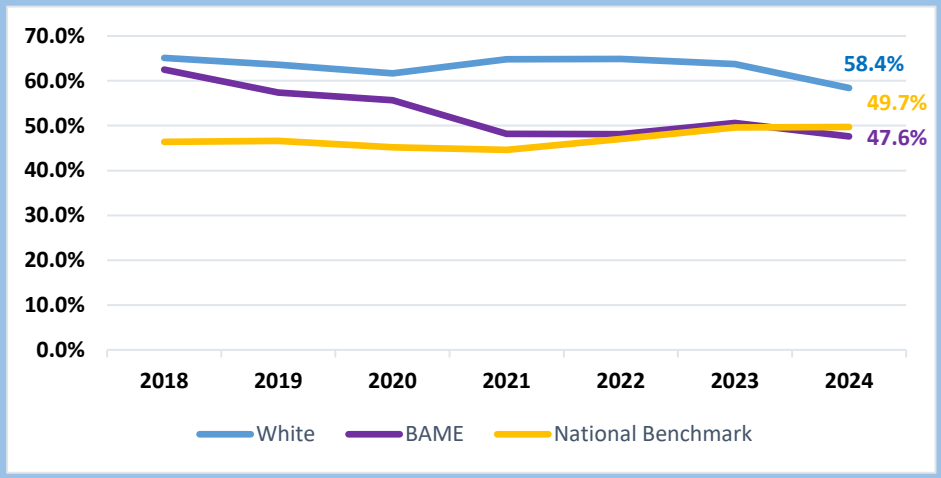
This information is derived from the 2025 staff survey.

Staff survey results show a slight increase in the number of global majority staff experiencing harassment, bullying and abuse from staff (23.0% compared to 22.4% for 2024).

Global majority staff continue to be more likely to experience harassment, bullying/abuse from colleagues than White staff and the gap is reported as 5.3%.

It is important that our staff feel supported to report concerns regarding bullying and harassment and all cases are logged and monitored by the Workforce Team.

## Indicator 7 – Percentage of staff believing the Trust provides equal opportunities for career progression or promotion



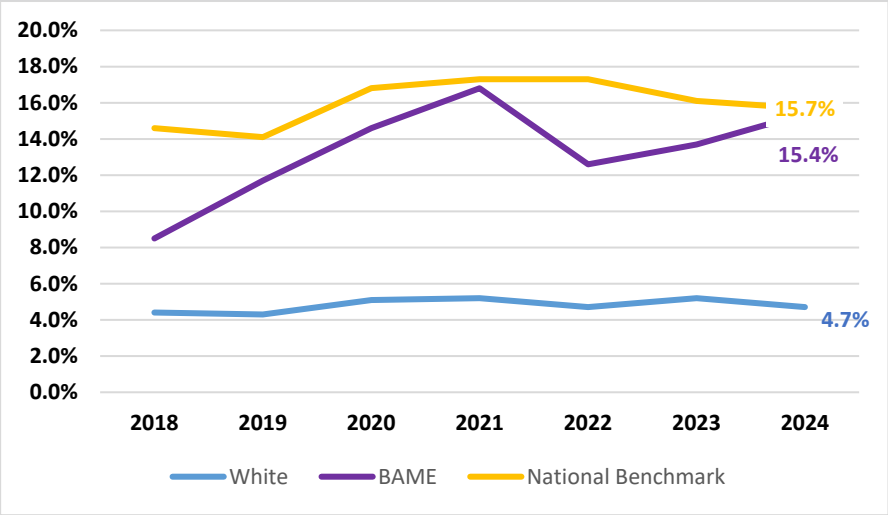

**Staff Survey Key Findings - Equal Opportunities**

This information is derived from the 2025 staff survey.

The results have remained static in terms of the % of global majority staff who believe the Trust provides equal opportunities for career progression/promotion (47.6% as compared to 47.6% in 2024).

As in previous years, White staff continue to report a higher belief in equal opportunities than global majority staff. The gap in experience has narrowed and is currently reported as 9.0% when compared to 10.8% in 2024.

## Indicator 8 – Percentage of staff experiencing discrimination at work from their manager, team leader or other colleagues




**Staff Survey Key Findings - Discrimination.**

This information is derived from the 2025 staff survey.

There has been an increase in the % of global majority staff who have reported experience of discrimination at work (16.3% as compared to 15.4% in 2024). There is a continued gap in experience, with global majority staff reporting a poorer experience when compared to White staff

It is important that our staff feel supported to report concerns regarding bullying and harassment and all cases are logged and monitored by the Workforce Team.

**Appendix 2**

## South Tees Hospitals NHS Foundation Trust

### WRES Indicators 2026

| South Tees - WRES Indicators 2026 | | | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|
| 1 | Percentage of BME staff | Overall | 10.0% | 11.44% | 12.83% | 13.88% | **14.89%** |
| | | VSM | | | 14.30% | 0.00% | **0.00%** |
| 2 | Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants | | 1.6 | 1.52 | 1.86 | 2.62 | **2.14** |
| 3 | Relative likelihood of BME staff entering the formal disciplinary process compared to white staff | | 1.27 | 0.8 | 0.78 | 1.37 | **0.90** |
| 4 | Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff | | 0.98 | 1.08 | 0.99 | 1.00* | **0.88** |
| | | | **2021** | **2022** | **2023** | **2024** | **2025** |
| 5 | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | BME | 26.7% | 28.8% | 23.0% | 24.4% | **30.4%** |
| | | White | 23.9% | 24.8% | 22.0% | 21.9% | **22.0%** |
| 6 | Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months | BME | 28.6% | 32.9% | 30.1% | 28.3% | **32.3%** |
| | | White | 21.5% | 22.2% | 20.6% | 24.3% | **21.8%** |
| 7 | Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion | BME | 48.2% | 43.3% | 43.5% | 49.6% | **45.2%** |
| | | White | 58.2% | 58.4% | 58.7% | 57.8% | **53.1%** |
| 8 | Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues | BME | 19.9% | 20.4% | 20.0% | 19.7% | **18.3%** |
| | | White | 5.8% | 5.8% | 6.2% | 7.1% | **7.6%** |
| | | | **2022** | **2023** | **2024** | **2025** | **2025** |
| 9 | BME Board membership | BME | -9.6% | -10.0% | -13.0% | 0.0% | **11.1%** |

## Findings for 2026

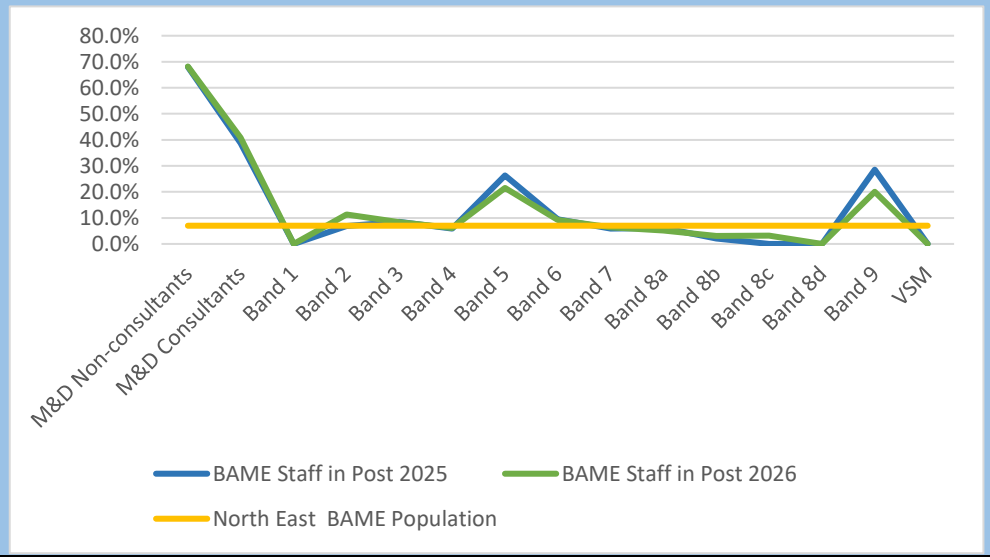
The key findings in respect of the nine WRES indicators for 2026 are summarised below.

We are currently only able to undertake benchmarking for those areas which relate to the staff survey (indicators 5-8). Full benchmarking information is published by the national WRES team and this is expected for March 2027.

The data for the UK Census which took place in 2021 is now available for analysis and reporting and this provides us with a more accurate picture of the UK's ethnicity profile, which can also be broken down by Region and Local Authority Area.

- UK Population 81.7% White and 18.3% BAME
- North East Population 93% White and 7% BAME
- Middlesbrough 82.4% White and 17.6% BAME
- Redcar and Cleveland 97.7% White and 2.3% BAME
- Hambleton 97.9% White and 2.1% BAME

**Indicators 1 and 9 – Representation across the organisation**




**Representative Workforce across all protected characteristics at all levels**.

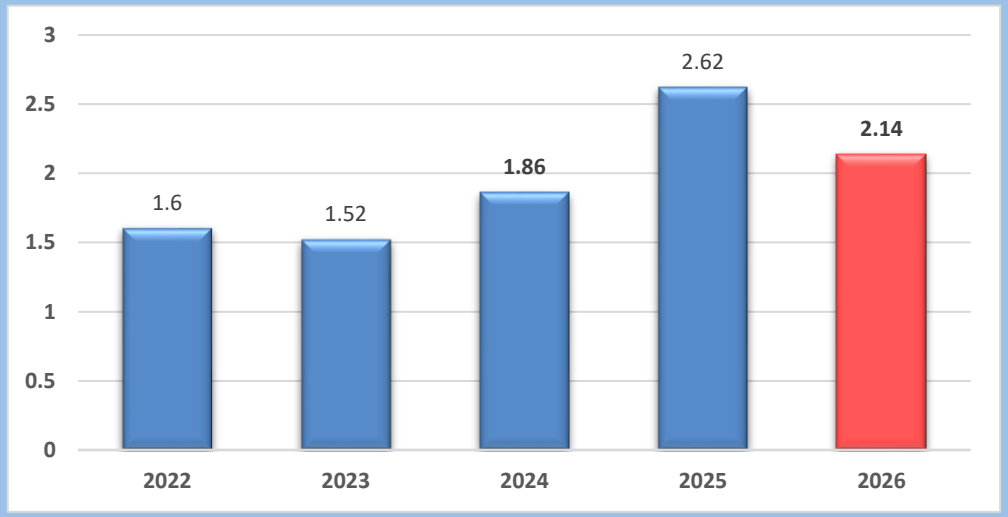
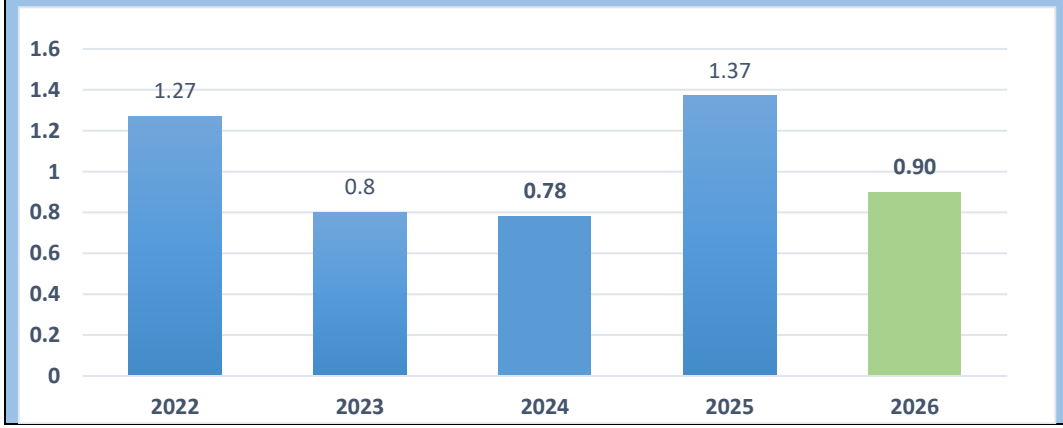
This information is obtained from the Trust's ESR system as at 31 March 2026. There has been an increase in the number of global majority staff employed by the Trust for 2026 - an increase of 1.01% to 14.89%. When compared to the North East's ethnicity data (2021 census) the Trust has higher representation within the overall workforce, however this is not reflected across all grades.

Consistent with previous years, there is higher representation within the medical staffing group and at Band 2 and Band 5.

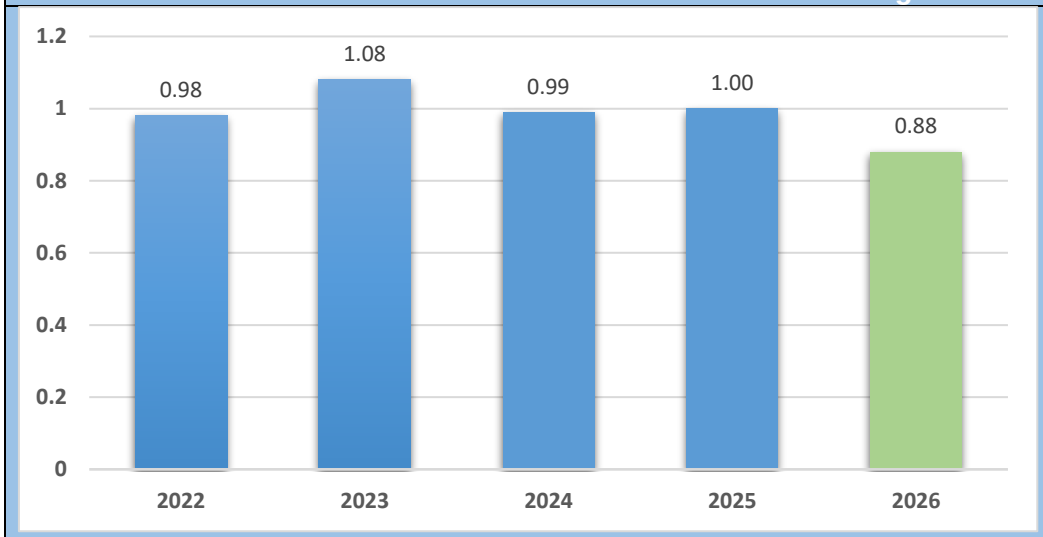
**Representation of BME at Board and senior management levels.**

For reporting purposes, we are only able to report on Board members who are directly employed by South Tees NHS Foundation Trust.

Representation at Board level is reported at 11.1%, which has been a positive increase from 2025. Board is still underrepresented as compared to the Trust's overall global majority workforce of 14.89%. Bands 8b and 8c have all seen an

| | |
|---|---|
| | increase in representation compared to the previous year. Band 8d has seen a decrease in representation and there continues to be no representation at VSM level |
| **Indicator 2 – Likelihood of staff being appointed from shortlisting** | |
|  | **Equity of Experience.**<br><br>This information is obtained from the Trust's Trac Recruitment System for the period 1 April 2025 to 31 March 2026 and considers a ratio showing the likelihood of being appointed following shortlisting. A figure of 1 indicates equal experience between White and global majority applicants.<br><br>Global majority applicants are less likely to be appointed following shortlisting than White applicants, however there has been a positive decrease from the figure reported in 2025.<br><br>Work will continue to focus on inclusive interview panels and support for internal applicants.<br><br>(A figure above 1:00 indicates that White candidates are more likely than BME candidates to be appointed from shortlisting) |
| **Indicator 3 – Likelihood of staff entering formal disciplinary process** | |
|  | **Equality of Experience.**<br><br>This information is obtained from the Trust's Workforce databases and considers a ratio showing the likelihood of entering formal disciplinary processes. A figure of 1 indicates equal experience between White and global majority staff.<br><br>The information for this metric is calculated over a 12-month period, with a total of 4 cases recorded, as compared to 25 cases involving staff from a White ethnicity.<br><br>The results show a positive decrease in that global majority colleagues are less likely to enter formal disciplinary processes and this figure is reported at 0.90 for 2026.<br><br>(A figure above 1:00 indicates that BME staff are more likely than White staff to enter the formal disciplinary process) |

## Indicator 4 – Likelihood of staff accessing non-mandatory training and continuous personal development




**Belief in Equal Opportunities.**

This information is obtained from the Trust's ESR system for the period 1 April 2025 to 31 March 2026.

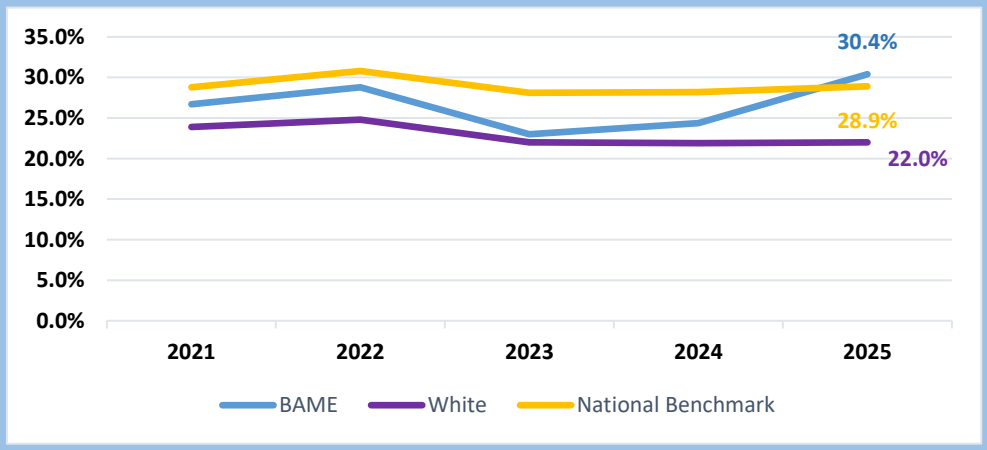
For this reporting cycle, global majority staff are more likely to access non-mandatory training and continuous personal development as compared to White Staff.

The ratio continues to remain below 1.0, and the overall differential remains low and does not indicate any real concern in this area.

The % of global majority staff accessing training is reported at 74.2% in 2026, and the number of White staff accessing training is reported at 65.9 % in 2026.

(A figure above 1:00 indicates that White staff are more likely than BME staff to access non-mandatory training and CPD)

## Indicator 5 – Percentage of staff experiencing harassment, bullying/abuse from patients, relatives/public




**Staff Survey Key Findings - B&H Public**

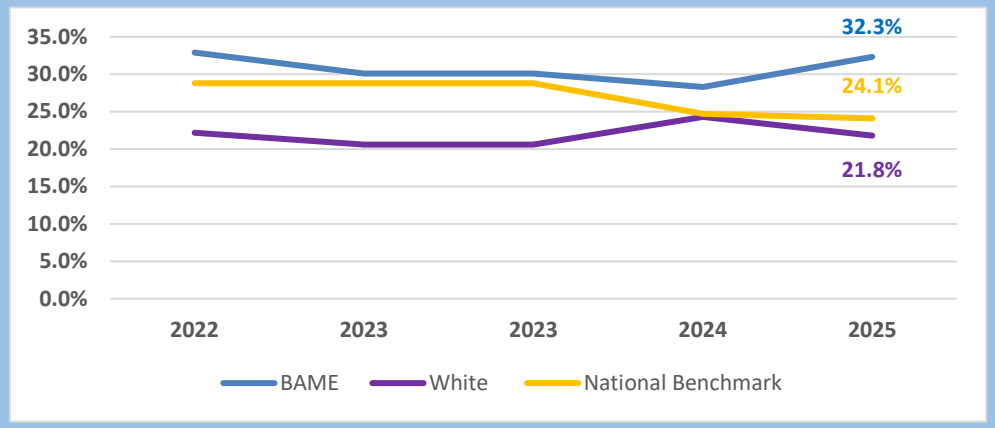
This information is derived from the 2025 staff survey.

Staff survey results show a negative increase in the number of global majority staff experiencing harassment, bullying and abuse from patients, relatives/public (30.4% as compared to 24.4% for 2024).

Global majority staff continue to be more likely to experience harassment, bullying/abuse from patients than White staff and the gap is reported as 8.4%.

Staff are required to log all incidents of service user violence and harassment via In phase.

## Indicator 6 – Percentage of staff experiencing harassment, bullying/abuse from staff




**Staff Survey Key Findings - B&H Staff**

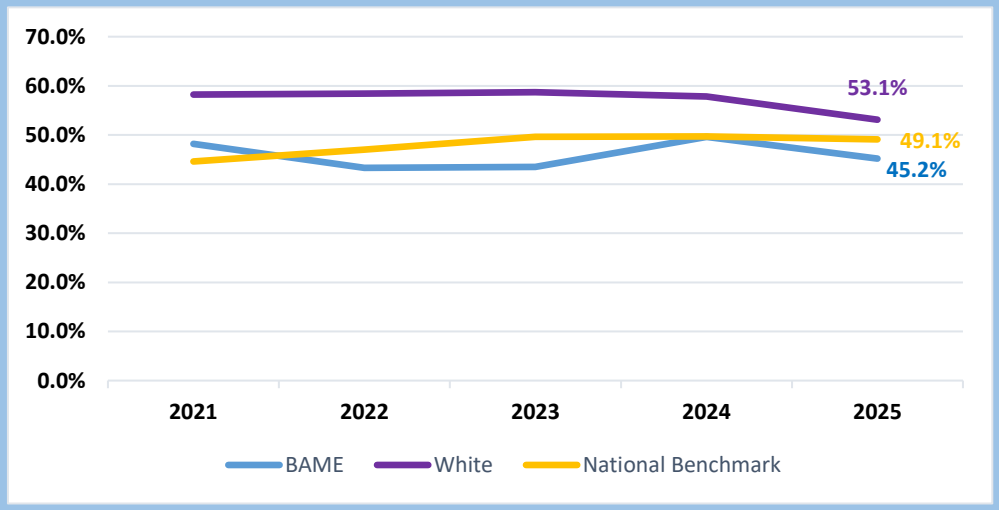
This information is derived from the 2025 staff survey.

Staff survey results show a negative increase in the number of global majority staff experiencing harassment, bullying and abuse from staff (32.3% compared to 28.3% for 2024).

Global majority staff continue to be more likely to experience harassment, bullying/abuse from colleagues than White staff and the gap is reported as 10.5%.

It is important that our staff feel supported to report concerns regarding bullying and harassment and all cases are logged and monitored by the Workforce Team.

## Indicator 7 – Percentage of staff believing the Trust provides equal opportunities for career progression or promotion



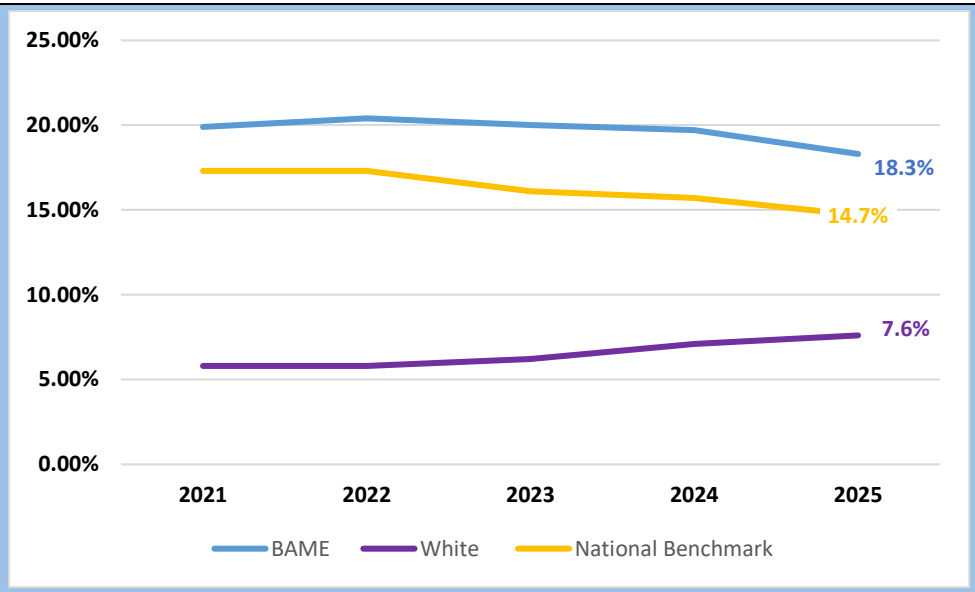

**Staff Survey Key Findings - Equal Opportunities**

This information is derived from the 2025 staff survey.

The results have decreased in terms of the % of global majority staff who believe the Trust provides equal opportunities for career progression/promotion (45.2% as compared to 49.6% in 2024).

As in previous years, White staff continue to report a higher belief in equal opportunities than global majority staff. The gap in experience has narrowed and is currently reported as 7.9% when compared to 8.2% in 2024

## Indicator 8 – Percentage of staff experiencing discrimination at work from their manager, team leader or other colleagues




**Staff Survey Key Findings - Discrimination.**

This information is derived from the 2025 staff survey.

There has been a positive decrease in the % of global majority staff who have reported experience of discrimination at work (18.3% as compared to 19.7% in 2024). There is a continued gap in experience, with global majority staff reporting a poorer experience when compared to White staff

It is important that our staff feel supported to report concerns regarding bullying and harassment and all cases are logged and monitored by the Workforce Team.

University Hospitals Tees

# WDES Joint Report

**Meeting date:** 3 September 2026

**Reporting to:** Board of Directors

**Agenda item No:** 3.3

**Report author:** Nicola Hogarth, Culture and Inclusion Assurance Partner

**Executive director sponsor:** Rachael Metcalf, Chief People Officer

**Action required:** Information

**Delegation status): Jointly delegated item to Group Board**

**Previously presented to:** People Committee on 28 July 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:

BAF strategic risk: A culture that doesn't promote positivity, respect, inclusion and a 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.

The Board is advised of summary relating to the Workforce Disability Standard for UHT.
The Board is advised that due to the reporting nature of the workforce disability, equality standard, the report is written for both unitary bodies separately.

**North Tees NHS Foundation Trust report:**

- Increase in capability cases involving staff with a disability or long-term health condition in the last 12 months.
- Negative increase in the number of disabled staff who:
    - Experience harassment, bullying/abuse from patients, relatives or the public;
    - Experience harassment, bullying/abuse from other colleagues.

- Negative decrease in the number of disabled staff who:
    - Believe the Trust provides Equal Opportunities for career progression;
    - Are likely to report harassment, bullying or abuse at work;
    - Feel valued.

- Figures have remained static for disabled staff saying reasonable adjustments have been put in place to enable them to carry out their work.

- The disabled staff engagement score is reported at 6.2 in the 2025 Staff Survey results. This has shown a decrease of 0.3 when compared to 6.5 in 2024.

**South Tees NHS Foundation Trust report:**

- Shortlisted disabled applicants are less likely to be appointed following shortlisting than non-disabled applicants
- Increase in capability cases involving staff with a disability or long-term health condition in the last 12 months.
- Negative increase in the number of disabled staff who:

    - Feel pressure to attend work when not feeling well enough to do so.

- Negative decrease in the number of disabled staff who:
    - Believe the Trust provides Equal Opportunities for career progression;
    - Are likely to report harassment, bullying or abuse at work;
    - Feel valued;
    - Have reasonable adjustments in place to enable them to carry out their work.

The disabled staff engagement score is reported at 6.1 in the 2024 Staff Survey results. This has shown a decrease of 0.3 when compared to 6.4 in 2024.

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

**North Tees and Hartlepool NHS Foundation Trust report:**

- There has been a further increase in the number of staff who have reported their disability status on ESR reflecting an increase from 6.3% to 6.7% in 2026.
- Disability at Board level has increased and is represented at 4%, which is a positive increase from previous years.
- Shortlisted disabled applicants are more likely to be appointed following shortlisting than non-disabled applicants.
- There has been a positive reduction in the number of disabled staff who:
    - Experience harassment, bullying/abuse from their manager;
    - Feel pressure to attend work when not feeling well enough to do so.

**South Tees NHS Foundation Trust report:**

- There has been a further increase in the number of staff who have reported their disability status on ESR reflecting an increase from 6.3% to 6.9% in 2026.
- There has been a positive decrease in the number of disabled staff who:
    - Experience harassment, bullying/abuse from patients, relatives or the public;
    - Experience harassment, bullying/abuse from their manager;
    - Experience harassment, bullying/abuse from other colleagues
- Disability at Board level is represented at 4%, which is a 1% decrease from previous years.

## Recommendations:

The Board is respectfully requested to accept the details within this paper relating to Workforce Disability Equality Standard (WDES) 2026 across University Hospitals Tees**.**

The Board is asked to receive the content of the report and acknowledge the Workforce Disability Equality Standard results for each Trust reported in Section 2 and the key points and recommendations outlined within Section 5.

Key areas of focus will be within the areas where negative increase/decrease has been seen.

**University Hospitals Tees**

**NHS Workforce Disability Equality Standard (WDES) 2026**

## 1. Introduction

As set out in the NHS Long Term Plan, respect, equality and diversity are central to changing culture and are at the heart of the NHS workforce implementation plan.

The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for people with a disability working, or seeking employment, in the NHS.

This report presents a group update in relation to the Workforce Disability Equality Standard (WDES) 2026.

## 2. WDES Indicators

A summary of the results for North Tees and Hartlepool NHS Foundation Trust and South Tees NHS Foundation Trust is shown in the tables below and includes comparison of the results covering a five-year period (2022 to 2026).

A copy of the WDES Reports 2026 for each Trust is contained at Appendix 1 and Appendix 2 for information purposes.

| North Tees and Hartlepool - WDES Indicators 2026 | | | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|
| 1 | Percentage of staff with a disability or long term health condition | Overall | 3.0% | 4.0% | 4.9% | 6.3% | 6.7% |
| | | Non-Clinical | 3.0% | 4.0% | 5.2% | 6.3% | 6.9% |
| | | Clinical | 3.0% | 3.0% | 4.8% | 6.5% | 6.6% |
| 2 | The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff | | 0.98 | 1.25 | 0.9 | 0.98* | 0.99* |
| 3 | The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff | | 0 | 0 | 0 | 0 | 1.75 |
| | | | 2021 | 2022 | 2023 | 2024 | 2025 |
| 4a | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | Staff with a disability or LTC | 28.6% | 30.7% | 28.1% | 26.0% | 28.0% |
| | | Staff without | 26.3% | 23.5% | 20.1% | 21.1% | 21.8% |
| 4b | Percentage of staff experiencing harassment, bullying or abuse from manager in the last 12 months | Staff with a disability or LTC | 14.2% | 12.5% | 10.5% | 12.2% | 10.4% |
| | | Staff without | 7.6% | 6.3% | 5.1% | 4.9% | 5.6% |
| 4c | Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months | Staff with a disability or LTC | 19.9% | 23.2% | 21.1% | 19.6% | 20.3% |
| | | Staff without | 13.3% | 12.7% | 11.9% | 12.0% | 12.8% |
| 4d | Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it | Staff with a disability or LTC | 46.2% | 53.2% | 50.3% | 50.8% | 47.1% |
| | | Staff without | 47.3% | 48.1% | 49.3% | 50.2% | 48.7% |
| 5 | Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion | Staff with a disability or LTC | 57.6% | 57.3% | 55.6% | 53.3% | 47.8% |
| | | Staff without | 65.5% | 65.3% | 64.8% | 58.7% | 57.9% |
| 6 | Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties | Staff with a disability or LTC | 27.8% | 26.9% | 26.7% | 26.8% | 26.0% |
| | | Staff without | 21.0% | 18.0% | 15.8% | 14.3% | 15.4% |
| 7 | Percentage of staff satisfied with the extent to which their organisation values their work | Staff with a disability or LTC | 37.4% | 34.6% | 36.3% | 35.5% | 32.0% |
| | | Staff without | 47.6% | 48.4% | 50.8% | 48.8% | 46.1% |
| 8 | Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work | Staff with a disability or LTC | 74.1% | 72.9% | 75.4% | 74.3% | 74.3% |
| 9 | Staff Engagement Score (0-10) | Staff with a disability or LTC | 6.6 | 6.6 | 6.6 | 6.5 | 6.2 |
| | | Staff without | 7.1 | 7.2 | 7.1 | 7.1 | 6.9 |
| | | Overall | 6.9 | 7 | 6.9 | 6.9 | 6.7 |
| | | | 2022 | 2023 | 2024 | 2025 | 2026 |
| 10 | Disabled/LTC Board Membership | | 7.1% | 0.0% | 3.0% | 0.0% | 4.0% |

*Remains postive as 1.00 would indicate equal experience of both Non-Disabled and Disabled staff



Caring Better Together

| South Tees - WDES Indicators 2026 | | | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|
| 1 | Percentage of staff with a disability or long term health condition | Overall | 3.5% | 4.6% | 4.9% | 6.3% | 6.9% |
| 2 | The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff | | 1.58 | 1.31 | 1.30 | 1.76 | 1.32 |
| 3 | The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff | | 0 | 0 | 0 | 8.4 | 15.5 |
| | | | 2021 | 2022 | 2023 | 2024 | 2025 |
| 4a | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | Staff with a disability or LTC | 27.1% | 28.9% | 26.3% | 28.2% | 27.5% |
| | | Staff without | 23.2% | 23.7% | 20.5% | 19.6% | 20.8% |
| 4b | Percentage of staff experiencing harassment, bullying or abuse from manager in the last 12 months | Staff with a disability or LTC | 14.4% | 13.9% | 10.4% | 13.9% | 13.5% |
| | | Staff without | 8.7% | 7.8% | 8.6% | 9.6% | 6.7% |
| 4c | Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months | Staff with a disability or LTC | 24.5% | 25.2% | 23.0% | 27.7% | 26.3% |
| | | Staff without | 15.2% | 17.1% | 16.0% | 16.9% | 16.8% |
| 4d | Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it | Staff with a disability or LTC | 50.4% | 49.4% | 49.2% | 52.6% | 48.2% |
| | | Staff without | 42.3% | 45.5% | 48.1% | 42.2% | 46.2% |
| 5 | Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion | Staff with a disability or LTC | 53.5% | 51.5% | 53.2% | 53.1% | 44.9% |
| | | Staff without | 58.4% | 59.0% | 58.6% | 58.4% | 55.3% |
| 6 | Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties | Staff with a disability or LTC | 29.9% | 26.8% | 25.0% | 27.7% | 28.5% |
| | | Staff without | 22.8% | 19.1% | 19.7% | 19.4% | 18.3% |
| 7 | Percentage of staff satisfied with the extent to which their organisation values their work | Staff with a disability or LTC | 32.7% | 34.2% | 33.4% | 34.1% | 27.5% |
| | | Staff without | 40.7% | 39.8% | 43.4% | 42.8% | 37.6% |
| 8 | Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work | Staff with a disability or LTC | 75.6% | 69.6% | 72.4% | 72.6% | 70.5% |
| 9 | Staff Engagement Score (0-10) | Staff with a disability or LTC | 6.6 | 6.5 | 6.9 | 6.4 | 6.1 |
| | | Staff without | 7 | 6.9 | 7 | 6.9 | 6.7 |
| | | Overall | 6.9 | 6.8 | 6.9 | 6.7 | 6.5 |
| | | | 2022 | 2023 | 2024 | 2025 | 2026 |
| 10 | Disabled/LTC Board Membership | | -3.3% | -4.3% | -3.0% | 5.0% | 4.0% |

## 3. WDES Update - North Tees and Hartlepool

A review of the WDES data for 2026 has highlighted the following points of interest:

- There has been a further increase in the number of staff who have reported their disability status on ESR reflecting an increase from 6.3% to 6.7% in 2026.

- For reporting purposes we are only able to report on Board members who are directly employed by North Tees and Hartlepool NHS Foundation Trust. Disability at Board level has increased and is represented at 4%, which is a positive increase from previous years.

- Shortlisted disabled applicants are more likely to be appointed following shortlisting than non-disabled applicants.

- There has been a positive reduction in the number of disabled staff who:

    - Experience harassment, bullying/abuse from their manager;
    - Feel pressure to attend work when not feeling well enough to do so.

The below will be key areas of focus:

- The Trust report an increase in capability cases involving staff with a disability or long-term health condition in the last 12 months.

- There has been a negative increase in the number of disabled staff who:
    - Experience harassment, bullying/abuse from patients, relatives or the public;
    - Experience harassment, bullying/abuse from other colleagues.

- There has been a negative decrease in the number of disabled staff who:
    - Believe the Trust provides Equal Opportunities for career progression;
    - Are likely to report harassment, bullying or abuse at work;
    - Feel valued;
    - Have reasonable adjustments in place to enable them to carry out their work.

- The disabled staff engagement score is reported at 6.2 in the 2025 Staff Survey results. This has shown a slight decrease of 0.3 when compared to 6.5 in 2024.

## 4. WDES Update - South Tees

A review of the WDES data for 2026 has highlighted the following points of interest:

- There has been a further increase in the number of staff who have reported their disability status on ESR reflecting an increase from 6.3% to 6.9% in 2026.

- There has been a positive decrease in the number of disabled staff who:

    - Experience harassment, bullying/abuse from patients, relatives or the public;
    - Experience harassment, bullying/abuse from their manager;
    - Experience harassment, bullying/abuse from other colleagues

- For reporting purposes, we are only able to report on Board members who are directly employed by South Tees Hospitals NHS Foundation Trust. Disability at Board level is represented at 4%, which is a 1% decrease from previous years.

The below will be key areas of focus:

- Although we have reported a decrease for 2026, shortlisted disabled applicants continue to be less likely to be appointed following shortlisting than non-disabled applicants

- The Trust report an increase in capability cases involving staff with a disability or long term health condition in the last 12 months.

- There has been a negative increase in the number of disabled staff who:
    - Feel pressure to attend work when not feeling well enough to do so.

- There has been a negative decrease in the number of disabled staff who:
    - Believe the Trust provides Equal Opportunities for career progression;
    - Are likely to report harassment, bullying or abuse at work.
    - Feel valued;
    - Have reasonable adjustments in place to enable them to carry out their work.

- The disabled staff engagement score is reported at 6.1 in the 2024 Staff Survey results. This has shown a decrease of 0.3 when compared to 6.4 in 2024.

## 5. WDES Group Update

## Key Findings for 2026

The key findings in respect of the ten WDES indicators for 2026 are summarised below.

We are currently only able to undertake benchmarking for those areas which relate to the staff survey (indicators 4-9). Full benchmarking information is published by the national WDES team and this is expected for March 2027. The data for the UK Census which took place in 2021 is now available for analysis and reporting and this provides us with a more accurate picture of the UK's disability profile, which can also be broken down by Region and Local Authority Area.

- UK Population 17.8% Disabled and 82.2% Non-Disabled
- North East Population 21.2% Disabled and 78.8% Non-Disabled
- Middlesbrough Population 21.9 % Disabled and 78.1% Non-Disabled
- Redcar and Cleveland Population 21.4% Disabled and 78.6% Non-Disabled
- Hambleton Population 15.4% Disabled and 84.6% Non-Disabled
- Stockton Population 20.2% Disabled and 79.8% Non-Disabled
- Hartlepool Population 22.9% Disabled and 77.1% Non-Disabled

**Indicator 1 – Representation.**

It is positive to report that across our organisation we have seen an increase in employed staff with disabilities or long-term health conditions (LTC), which is reported at 6.7% (0.4% increase) for North Tees and Hartlepool and 6.9% (0.6% increase) for South Tees in 2026.

However, this still remains an area of priority when compared to the North East's disability data (2021 census), which is reported at 21%, therefore significantly lower than the regional population. Also, when compared against the disabilities profile for the local areas, across the organisation report less workforce representation in comparison to our local communities' disabilities population. It is recommended that a collaborative review is undertaken in relation to local advertising and the reporting and recording of disabilities on the electronic staff record (ESR).

It is encouraging that disability declaration rates continue to increase across the Group. We will continue to promote the ESR self-service through internal communication activities and focus group workshops to promote the benefits of declaration and how this data can be used to facilitate the best support for staff.

We recognise from our Disability Pay Gap analysis that staff who have declared a disability are disproportionately represented within the lower pay quartiles, with lower levels of representation observed in the upper pay quartiles and higher-graded roles. This highlights disparities in representation across the workforce and we recommend that further work is required to understand and address potential barriers to career progression, development opportunities and equitable outcomes for disabled staff.

**Indicator 2 – Likelihood of staff being appointed from shortlisting.**

Analysis of South Tees recruitment data shows that applicants with a disability appear to be less likely to be appointed from shortlisting, with a reported ratio of 1.32 but positive to note there has been a decrease of 0.44 since 2025. North Tees and Hartlepool report a more likelihood of staff with a disability being appointed from shortlisting, with a reported ratio of 0.99.

We are ‘positive about people with a disability’ employer, which means any applicant who indicates that they have a disability as part of their application and meets the essential criteria of the post being recruited to, will be guaranteed an interview.

We will review actions and best practice in relation to this indicator including feedback from staff networks. South Tees were awarded Disability Confident Employer level 2 are in the process of applying for Disability Confident Leader Level 3 status. North Tees and Hartlepool were reaccredited Disability Confident Level 3 in 2026 in recognition of the work undertaken to ensure that people with a disability have opportunities to fulfil their potential and realise their aspirations.

A review of recruitment practices will be undertaken, focusing on the end-to-end recruitment pathway, including attraction, advertising, shortlisting, and selection processes. Consideration has been given to strengthening the diversity of interview panels and ensuring recruitment practices promote equitable outcomes. This is reflected in the recently updated recruitment policy and framework.

**Indicator 3 – Likelihood of staff entering formal capability process**

Across UHT we have seen an increase in capability cases involving staff with a disability or long-term health condition in the last 12 months, this is currently reported at 1.75 (North Tees and Hartlepool) and 15.5 (South Tees) for 2026.

For context, North Tees and Hartlepool have reported 1 case involving someone with a disability or long-term health condition and South Tees have reported 4 cases.

The Organisation continue to develop Restorative facilitators to promote and support a culture of transparency amongst the workforce. We will continue to review and compare against regional benchmarks as well as responses from previous years.

**Indicator 4a to 4c – Percentage of staff experiencing harassment, bullying/abuse from patients, relatives/public, managers and colleagues.**

South Tees have seen an overall positive reduction in the percentage of staff with a disability experiencing harassment, bullying/abuse across all three areas: patients, managers and colleagues as follows:

- Patients – 27.5% (compared to 28.2% for 2024)
- Managers – 13.5% (compared to 13.9% for 2024)
- Colleagues –26.3% (compared to 27.7% for 2024)

North Tees and Hartlepool have seen a negative increase in the percentage of staff with a disability experiencing harassment, bullying/abuse across all three areas: patients, colleagues as follows:

- Patients – 28.0% (compared to 26.0% for 2024)
- Colleagues –20.3% (compared to 19.6% for 2024)

The percentage of staff with a disability experiencing harassment, bullying/abuse from manager has positively decreased:

- Managers – 10.4% (compared to 12.2% for 2024)

Further analysis of this key finding will be undertaken to identify any areas of concern and trends at a departmental level. This will support the development and implementation of targeted action plans to address identified issues and drive improvement.

We will continue to seek feedback from staff who have been directly involved in bullying and harassment cases to better understand their experiences of the process and identify opportunities for improvement. Regular case reviews will be conducted to identify areas of good practice, ensure lessons learned are captured, and promote the sharing of learning across the organisation. In addition, we will continue to raise awareness of the impact of workplace bullying and harassment, ensuring staff understand the support available to them, the actions they can take, and the appropriate routes for reporting concerns.

We are committed to improving the experiences of staff with disabilities and long-term health conditions. This will include promoting access to support mechanisms, such as Freedom to Speak Up, and ensuring staff are aware of the resources available to them. We will also work closely with operational services to identify any areas where staff experiences indicate a need for more targeted interventions, enabling tailored support and action to be implemented where required.

**Indicator 4d - Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.**

We have seen an overall negative decrease in the percentage of staff saying they reported the last time they experienced harassment, bullying or abuse at work. South Tees' results have shown a decrease of 2.0% (48.2% compared to 52.6% for 2024). North Tees and Hartlepool have seen a decrease of 3.0% (47.8% compared to 50.8% for 2024).

We are currently developing a Health Inequalities Dashboard, which will incorporate a broad range of protected characteristics wherever possible. This will enable more targeted analysis and insight, supporting the identification and monitoring of staff complaints, experiences, and outcomes associated with protected characteristics such as ethnicity, disability, sexual orientation, and other equality groups. The dashboard will help inform evidence-based interventions and drive improvements in workforce equality, diversity, and inclusion.

**Indicator 5 – Percentage of staff believing the Trust provides equal opportunities.**

The results for North Tees and Hartlepool have decreased in terms of the percentage of both staff with/ without a disability who believe the organisation provides equal opportunities for career progression or promotion. The figures for staff with a disability are reported as 47.8% compared to 55.3% for 2024.

The results for South Tees show a decrease of colleagues with a disability who believe the organisation provides equal opportunities for career progression or promotion, and also colleagues without a disability which has also shown a slight decrease. Staff with a disability are reported as 44.9% compared to 53.1% for 2024.

We will undertake a review of this indicator with recommendations to explore perceived barriers to equal opportunities and career progression via the Staff Networks and Leads and undertake development of additional actions to address any areas of concern.

**Indicator 6 – Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.**

South Tees have shown an increase in the number of staff with a disability who have felt pressure from their manager to come to work whilst unwell. Staff with a disability are reported as 28.5% compared to 27.7% for 2024.

The results for North Tees and Hartlepool have shown a slight positive decrease in the number of staff with a disability who have felt pressure from their manager to come to work whilst unwell. Staff with a disability are reported as 60.0% compared to 60.8% for 2024.

Staff with a disability/LTC continue to be more likely to report pressure to attend work whilst unwell than staff without a disability.

We will review the processes and practices underpinning health and wellbeing conversations between managers and colleagues to ensure they are effective, supportive, and person-centred. The appraisal process has been reviewed and updated and includes health and wellbeing conversation.

In addition, we will launch a new digital training programme for managers, incorporating guidance on reasonable adjustments and increasing awareness of the impact that disabilities and long-term health conditions can have on an individual's experience and performance at work. Our generic passport is a resource available for staff and managers to facilitate a comprehensive and supportive conversation for all staff who may need further support or flexibility in the workplace.

We will also continue to evaluate and enhance management training and supporting resources to ensure managers have the knowledge, skills, and confidence to effectively support disabled staff. This will help foster a positive and inclusive workplace culture, ensuring that employees are supported appropriately and are not subjected to undue pressure to attend work when they are unwell.

The cultural development team has seen an increase in the request for reasonable adjustments information and has produced resources for staff and managers to support inclusion and wellbeing to meet individual need for all colleagues.

**Indicator 7 – Percentage of staff satisfied with the extent to which their organisation values their work.**

Across the organisation we have seen a negative decrease in the percentage of staff saying they are satisfied with the extent to which their organisation values their work. North Tees and Hartlepool report 32.0% of staff with a disability felt satisfied that the organisation valued their work, this has decreased by 3.5 since 2024.

South Tees have shown 27.5% of staff with a disability reported that they felt satisfied that the organisation valued their work, this has shown a negative decrease of 6.6% since 2025.

We recommend the introduction of a Disability Awareness Day for colleagues with disabilities and long-term health conditions. The event would focus on raising awareness, providing an opportunity to share good practice, and gathering feedback and suggestions from staff to inform further improvements and enhance inclusivity across the organisation.

**Indicator 8 – Percentage of staff with a long-lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work.**

South Tees have seen an overall negative decrease in the percentage of staff with a disability saying that adequate reasonable adjustment has been made to enable them to carry out their work. This is reported at 70.5% which has shown a 2.1% decreased since 2024.

North Tees and Hartlepool remains static in terms of the percentage of staff with a disability saying that adequate reasonable adjustment has been made to enable them to carry out their work. This is continued to be reported at 74.3% since 2024. It is positive to note that North Tees and Hartlepool figure of 74.3% is above the national average which is reported at 73.6%.

We will continue to support the effective implementation and embedding of Reasonable Adjustments in accordance with policy. In addition, we will launch a new digital Reasonable Adjustments training package for managers across the organisation, aimed at strengthening understanding and ensuring adjustments are applied consistently, appropriately, and meaningfully in practice.

As part of the revised Appraisal documentation, we signpost to the generic passport which is a resource available for staff and managers to facilitate a comprehensive and supportive conversation for all staff who may need further support or flexibility in the workplace.

**Indicator 9 – Staff Engagement Score**

The engagement score for staff with a disability has slightly decreased across the organisation.

South Tees disabled staff engagement score is reported at 6.1 in the 2025 Staff Survey results. This has shown a decrease of 0.3 when compared to 6.4 in 2024. North Tees and Hartlepool disabled staff engagement score is reported at 6.2 in the 2025 Staff Survey results. This has shown a slight decrease of 0.3 when compared to 6.5 in 2024.

Staff with a disability/LTC continue to be more likely to report lower levels of staff engagement than staff who do not have a disability. It is positive to note that the organisation is not reporting below the national benchmarking data, which indicates that the engagement score for staff with a disability is 6.1.

It is recommended that greater emphasis be placed on engaging with the workforce to gain a comprehensive understanding of both individual perspectives and the collective views of staff groups

**Indicator 10 – Board Membership**

Representation continues to be underrepresented across UHT, as compared to the overall disability workforce. (Please note for reporting purposes we are only able to report on Board members who are directly employed by each Trust).

UHT will continue to implement fair, transparent, and inclusive recruitment processes for positions at all levels of the organisation. It is recommended that a review of Board-level recruitment and succession arrangements is undertaken to identify opportunities to apply positive action principles and targeted attraction, engagement, and recruitment initiatives where appropriate. This will support the Trusts' ambition to achieve a Board of Directors that more closely reflects the diversity of the communities we serve.

## 6. Conclusion and next Steps

Our actions to improve the UHT Workforce Disability Equality Standard (WDES) metrics are aligned with the People Values, particularly the value of respect, and support our commitment to the ambitions set out within the NHS People Plan.

We are pleased to report some improvements across the WDES indicators for 2026. These positive outcomes reflect the impact of our Equality, Diversity and Inclusion (EDI) programme of work, alongside increased investment in workforce data analysis and targeted interventions designed to enhance staff experience and reduce inequalities across all protected characteristics.

UHT will continue to promote and embed the initiatives and good practice already in place, including the delivery of fair and transparent recruitment processes, civility and respect training, unconscious bias training, and the promotion of leadership and development opportunities available to staff across the organisation. We have successfully achieved Disability Confident Employer/Leader status.

UHT is committed to advancing disability equality and fostering an inclusive working environment where all staff are able to succeed. While a range of initiatives and practices have already been implemented to support this objective, we recognise that achieving sustainable improvement will require continued organisational focus and long-term cultural change.

Although changes to the workforce disability profile are likely to be gradual, it is encouraging to note a continued increase in the number of staff declaring a disability or long-term condition. This greater level of disclosure is an important indicator of growing confidence among staff and supports our ability to better understand and address workforce needs. We also acknowledge the importance of further developing the Disability and Long-Term Conditions Staff Network to ensure the voices and experiences of disabled staff are effectively represented and continue to inform organisational priorities and improvement activity.

It should be noted that this report provides a high-level overview of the overall WDES performance and workforce metrics. The next phase of the reporting process will focus on engagement with staff and key stakeholders to review the findings, gain further insight into the underlying themes, and collaboratively develop a targeted action plan. This action plan will form part of the WDES Annual Report to be published in October 2026 and will support our ongoing commitment to improving outcomes and experiences for disabled staff

## 7. Recommendation

This report presents a group update in relation to the Workforce Disability Equality Standard (WDES) 2026 across University Hospitals Tees. The Board is asked to receive the content of the report and acknowledge the Workforce Disability Equality Standard results for both Trusts reported in Section 2 and the key points and recommendations outlined within Section 5.

Individual reports are included in the appendices for further information.

**Appendix 1** - North Tees & Hartlepool NHS Foundation Trust - NHS Workforce Disability Equality Standard 2026.
**Appendix 2** - South Tees Hospitals NHS Foundation Trust - NHS Workforce Disability Equality Standard 2026.

**Appendix 1**

# North Tees and Hartlepool NHS Foundation Trust

| North Tees and Hartlepool - WDES Indicators 2026 | | | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|
| 1 | Percentage of staff with a disability or long term health condition | Overall | 3.0% | 4.0% | 4.9% | 6.3% | 6.7% |
| | | Non-Clinical | 3.0% | 4.0% | 5.2% | 6.3% | 6.9% |
| | | Clinical | 3.0% | 3.0% | 4.8% | 6.5% | 6.6% |
| 2 | The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff | | 0.98 | 1.25 | 0.9 | 0.98* | 0.99* |
| 3 | The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff | | 0 | 0 | 0 | 0 | 1.75 |
| | | | 2021 | 2022 | 2023 | 2024 | 2025 |
| 4a | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | Staff with a disability or LTC | 28.6% | 30.7% | 28.1% | 26.0% | 28.0% |
| | | Staff without | 26.3% | 23.5% | 20.1% | 21.1% | 21.8% |
| 4b | Percentage of staff experiencing harassment, bullying or abuse from manager in the last 12 months | Staff with a disability or LTC | 14.2% | 12.5% | 10.5% | 12.2% | 10.4% |
| | | Staff without | 7.6% | 6.3% | 5.1% | 4.9% | 5.6% |
| 4c | Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months | Staff with a disability or LTC | 19.9% | 23.2% | 21.1% | 19.6% | 20.3% |
| | | Staff without | 13.3% | 12.7% | 11.9% | 12.0% | 12.8% |
| 4d | Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it | Staff with a disability or LTC | 46.2% | 53.2% | 50.3% | 50.8% | 47.1% |
| | | Staff without | 47.3% | 48.1% | 49.3% | 50.2% | 48.7% |
| 5 | Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion | Staff with a disability or LTC | 57.6% | 57.3% | 55.6% | 53.3% | 47.8% |
| | | Staff without | 65.5% | 65.3% | 64.8% | 58.7% | 57.9% |
| 6 | Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties | Staff with a disability or LTC | 27.8% | 26.9% | 26.7% | 26.8% | 26.0% |
| | | Staff without | 21.0% | 18.0% | 15.8% | 14.3% | 15.4% |
| 7 | Percentage of staff satisfied with the extent to which their organisation values their work | Staff with a disability or LTC | 37.4% | 34.6% | 36.3% | 35.5% | 32.0% |
| | | Staff without | 47.6% | 48.4% | 50.8% | 48.8% | 46.1% |
| 8 | Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work | Staff with a disability or LTC | 74.1% | 72.9% | 75.4% | 74.3% | 74.3% |
| 9 | Staff Engagement Score (0-10) | Staff with a disability or LTC | 6.6 | 6.6 | 6.6 | 6.5 | 6.2 |
| | | Staff without | 7.1 | 7.2 | 7.1 | 7.1 | 6.9 |
| | | Overall | 6.9 | 7 | 6.9 | 6.9 | 6.7 |
| | | | 2022 | 2023 | 2024 | 2025 | 2026 |
| 10 | Disabled/LTC Board Membership | | 7.1% | 0.0% | 3.0% | 0.0% | 4.0% |

*Remains postive as 1.00 would indicate equal experience of both Non-Disabled and Disabled staff

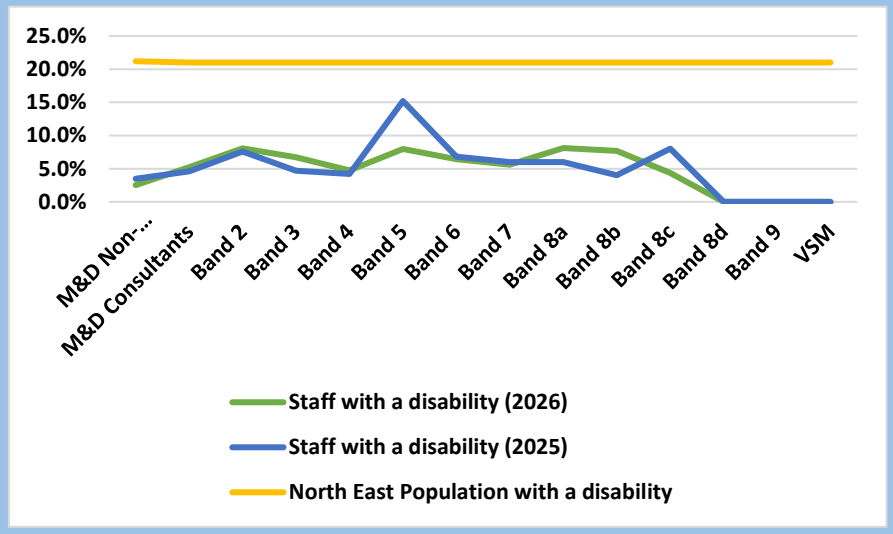
## Key Findings for 2026

The key findings in respect of the ten WDES indicators for 2026 are summarised below.

We are currently only able to undertake benchmarking for those areas which relate to the staff survey (indicators 4-9). Full benchmarking information is published by the national WDES team and this is expected for March 2027. The data for the UK Census which took place in 2021 is now available for analysis and reporting and this provides us with a more accurate picture of the UK's disability profile, which can also be broken down by Region and Local Authority Area.

- UK Population 17.8% Disabled and 82.2% Non-Disabled
- North East Population 21.2% Disabled and 78.8% Non-Disabled
- Stockton Population 20.2% Disabled and 79.8% Non-Disabled
- Hartlepool Population 22.9% Disabled and 77.1% Non-Disabled

### Indicators 1 and 10 – Percentage of staff with a disability or long term health condition




**Representative Workforce across all protected characteristics at all levels**.

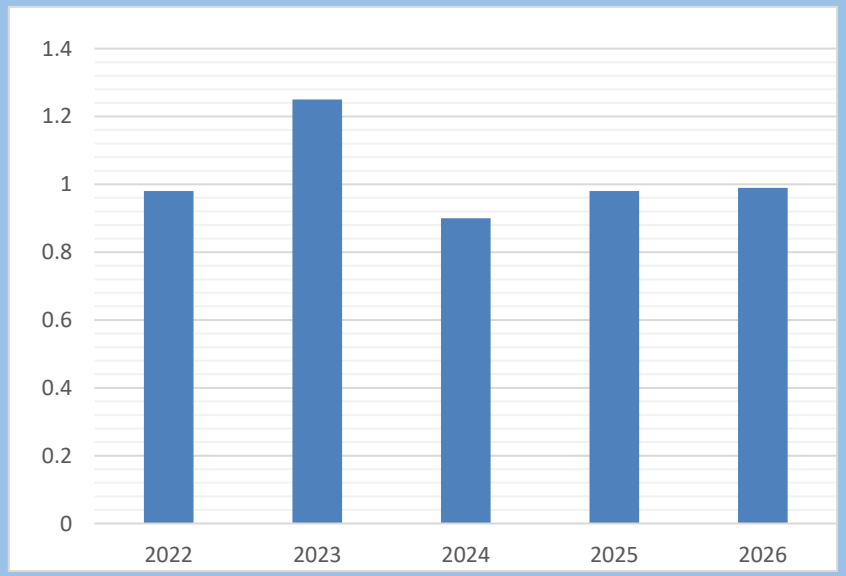
This information is obtained from the Trust's ESR system as at 31 March 2026. There has been a positive increase in the number of staff who have reported their disability status on ESR - an increase of 0.4% from 6.3% in 2025 to 6.7% in 2026. This is a result of continued staff campaigns, on how to use the online self-declaration service on ESR and also by raising awareness of this during relevant disability and staff network events and the importance of Trust workforce data. The North East's disability data (2021 census) is reported at 21.2% therefore representation within the Trust is significantly lower.

Representation is highest at Bands 2, 5 and band 8a for 2026. Although band 5 is one of the highest representations, we have seen a decrease of 7% since 2025. There are no disabled staff employed at Bands 8d, 9 and VSM.

**Representation of Disabled staff at Board and senior management levels.**

For reporting purposes, we are only able to report on Board members who are directly employed by North Tees and Hartlepool Foundation Trust (NTH)

| | |
|---|---|
| | There is a total of 10 employees reported on the Board for NTH, with Disability at Board level currently reported at 4%, which has shown a positive increase from 0% reported in 2025, however this still remains lower than the overall workforce figure of 6.7%. We have seen a positive increase at Bands 8a and 8b. |

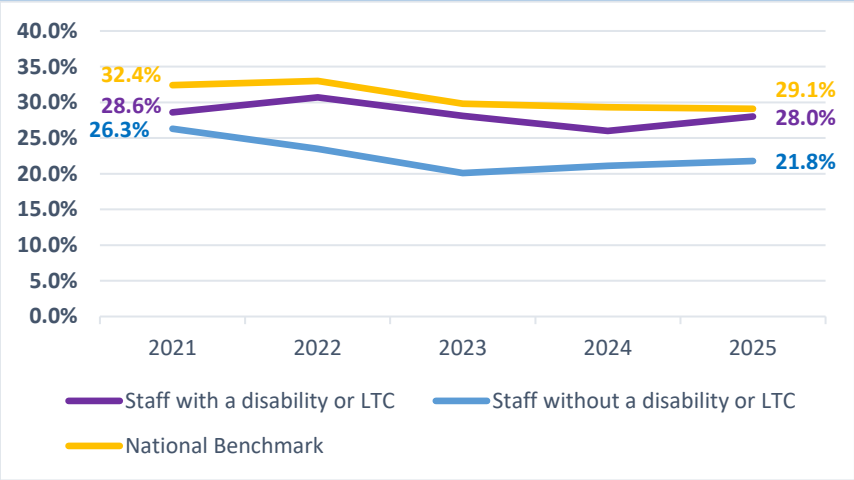
| Indicator 2 – The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff | |
|---|---|
|  | **Equity of Experience.**<br><br>This information is obtained from the Trust's Trac Recruitment System for the period 1 April 2024 to 31 March 2025 and considers a ratio showing the likelihood of being appointed following shortlisting. A figure of 1 indicates equal experience between disabled and non-disabled applicants.<br><br>The current figure for 2025 is reported as 0.99 which indicates shortlisted disabled applicants are more likely to be appointed following shortlisting than non-disabled applicants.<br><br>(A figure below 1:00 indicates that Disabled staff are more likely than non-Disabled staff to be appointed from shortlisting) |

## Indicator 3 – The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff

This information is obtained from the Trust's Workforce databases and considers a ratio showing the likelihood of entering formal capability processes. A figure of 1 indicates equal experience between disabled and non-disabled staff.

There have been 8 formal capability cases in total with 1 involving staff with a disability or long-term condition, therefore the relative likelihood of Disabled staff entering the formal capability process compared to non-Disabled staff is reported at 1.75. This has seen a increase from previous years where no cases were reported, therefore staff with a disability or long term condition are more likely to enter a formal capability process.

## Indicator 4a - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months




**Staff Survey Key Findings - B&H Public**

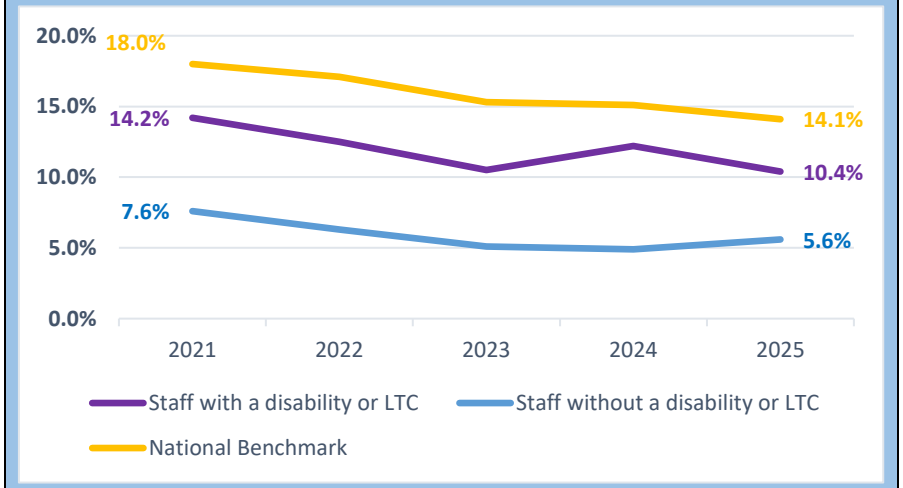
This information is derived from the 2025 Staff Survey.

Staff survey results show a negative increase in the number of disabled staff who have experienced harassment, bullying and abuse from patients, relatives/public (28% compared to 26% for 2024).

Staff with a disability/LTC continue to be more likely to experience harassment, bullying/abuse from patients than staff who do not have a disability and the gap is reported as 6.2%.

Staff are required to log all incidents of service user violence and harassment via InPhase. The Trust's Keeping People Safe group reviews this information on a regular basis to identify trends and this includes analysis of related themes where available.

## Indicator 4b – Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months



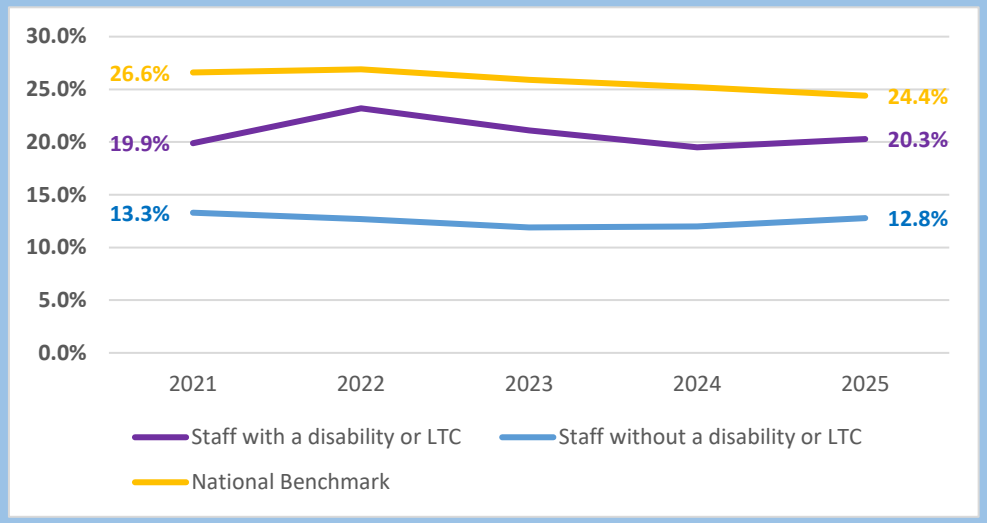

### Staff Survey Key Findings - B&H Manager

This information is derived from the 2025 Staff Survey.

Staff survey results show a positive decrease in the number of disabled staff experiencing harassment, bullying and abuse from a manager (10.4% compared to 12.2% for 2024).

Staff with a disability/LTC continue to be more likely to experience harassment, bullying/abuse from a manager than staff who do not have a disability, the gap has decreased for 2025 and this is currently reported as 4.8% compared to 7.3% in 2025.

## Indicator 4c – Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months



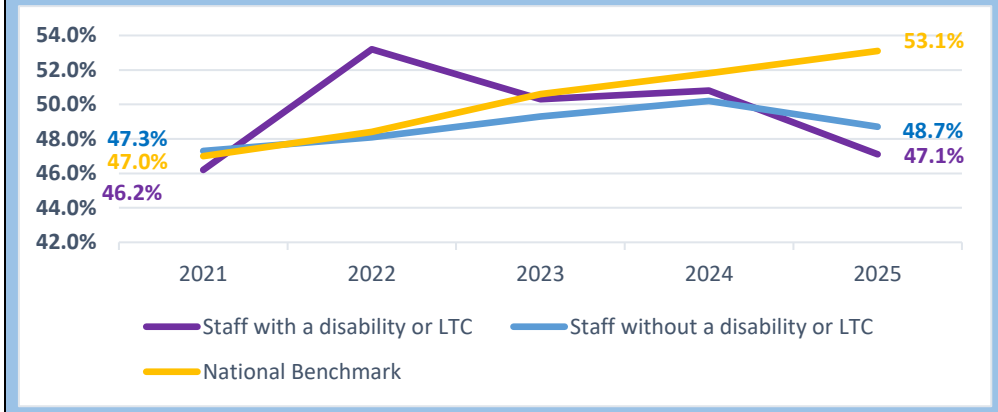

### Staff Survey Key Findings - B&H Colleagues

This information is derived from the 2025 Staff Survey.

Staff survey results show an increase in the number of disabled staff experiencing harassment, bullying and abuse from a colleague (20.3% compared to 19.6% in 2024).

Staff with a disability/LTC continue to be more likely to experience harassment, bullying/abuse from a colleague than staff who do not have a disability. The gap has slightly decreased for 2025 and this is reported as 7.5% (compared to 7.6% for 2024).

## Indicator 4d – Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it




### Staff Survey Key Findings - Reporting

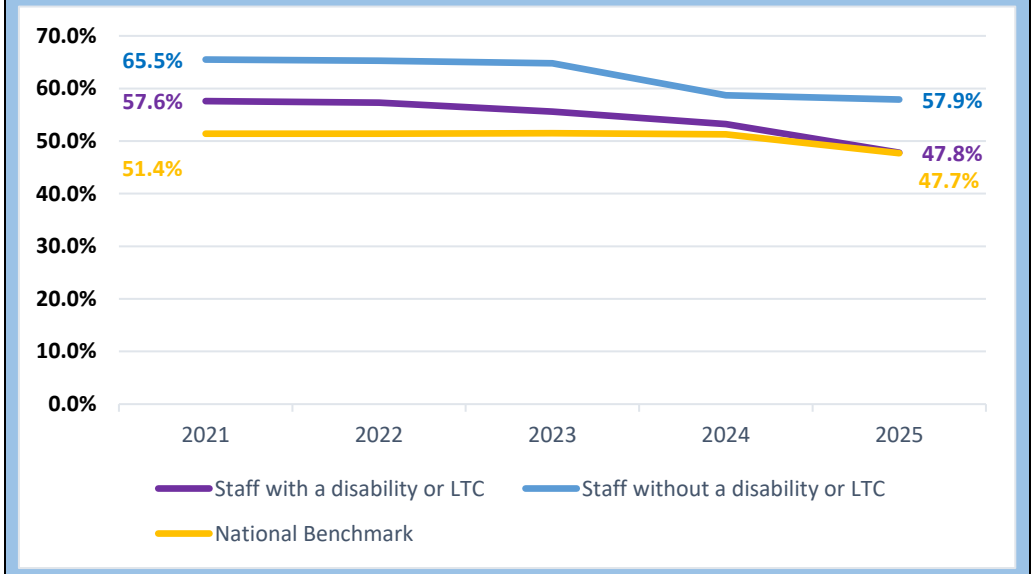
This information is derived from the 2025 Staff Survey.

Staff survey results show a decrease in the number of disabled staff who have reported harassment, bullying and abuse (47.1% compared to 50.8% for 2024).

Staff with a disability/LTC are less likely to report harassment, bullying/abuse than staff who do not have a disability, with a reported gap of 1.6%.

It is important that our staff feel supported to report concerns regarding bullying and harassment and all cases are logged and monitored by the Workforce Team.

## Indicator 5 – Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion



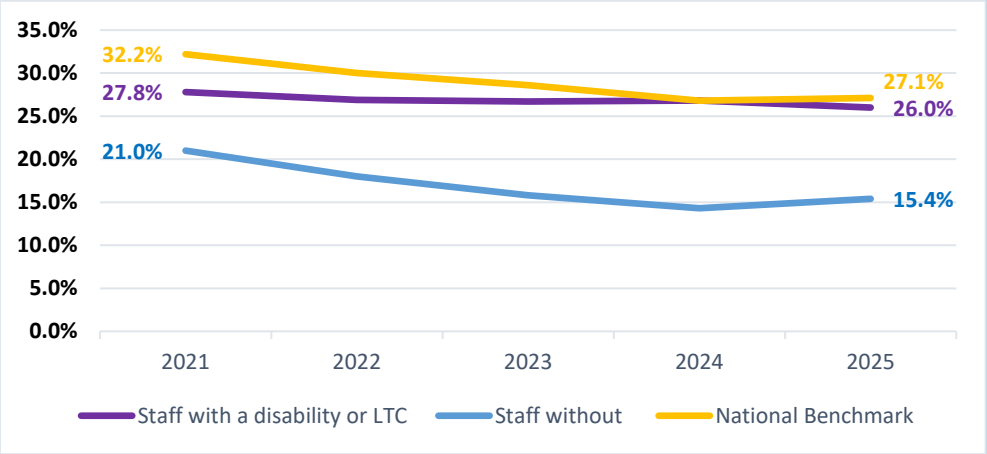

### Staff Survey Key Findings - Equal Opportunities

This information is derived from the 2025 Staff Survey.

The results have decreased in terms of the percentage of both disabled and non-disabled staff who believe the organisation provides equal opportunities for career progression or promotion. The disabled staff figures are reported as 47.8% compared to 53.2% for 2024 and non-disabled staff is reported 57.9% compared to 58.7% for 2024.

Staff with a disability/LTC continue to report lower levels of equal opportunities than staff who do not have a disability. The gap in experience is currently reported as 10.1%.

## Indicator 6 – Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties



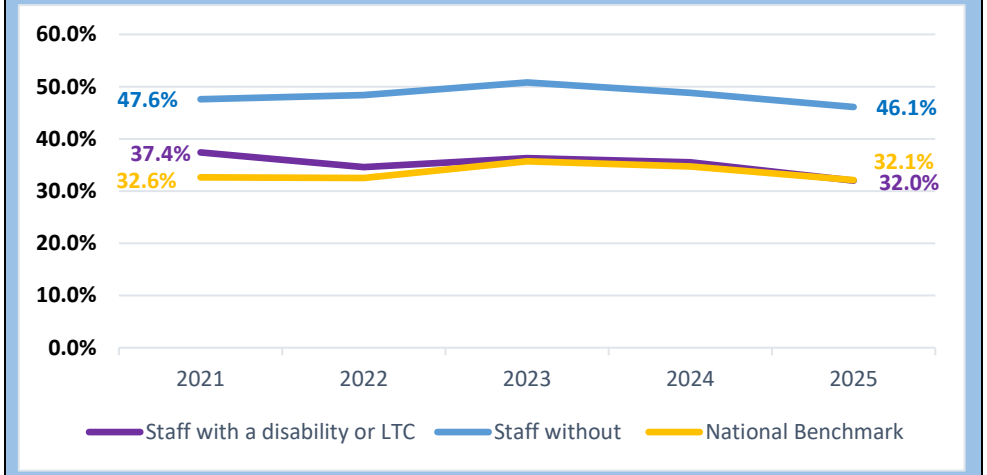

### Staff Survey Key Findings - Attendance at work whilst unwell

This information is derived from the 2025 Staff Survey.

The results show a slight positive decrease in the number of disabled staff who have felt pressure from their manager to come to work whilst unwell (26% compared to 26.8% for 2024).

Staff with a disability/LTC continue to be more likely to report pressure to attend work whilst unwell than staff who do not have a disability. The gap has decreased for 2025 and this is reported as 10.6%, compared to 14.5% for 2024.

## Indicator 7 – Percentage of staff satisfied with the extent to which their organisation values their work



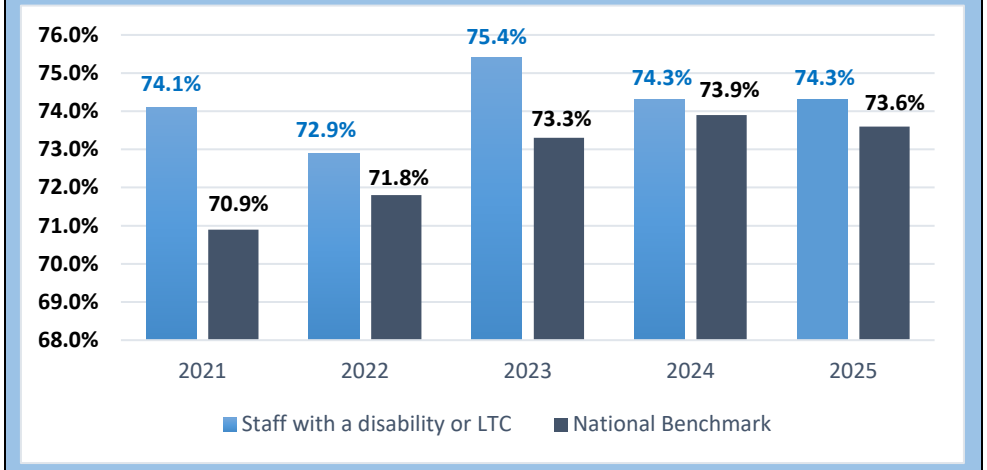

### Staff Survey Key Findings - Feeling Valued

This information is derived from the 2025 Staff Survey.

The number of disabled staff who feel satisfied that the organisation values their work has decreased for 2024 at 32.0%, compared to 35.5% for 2024.

Staff with a disability/LTC continue to be less likely to feel valued than staff who do not have a disability and the gap is reported at 14.1% which is a increase of 0.8% (13.3%) from 2024.

## Indicator 8 – Percentage of staff with a long-lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work



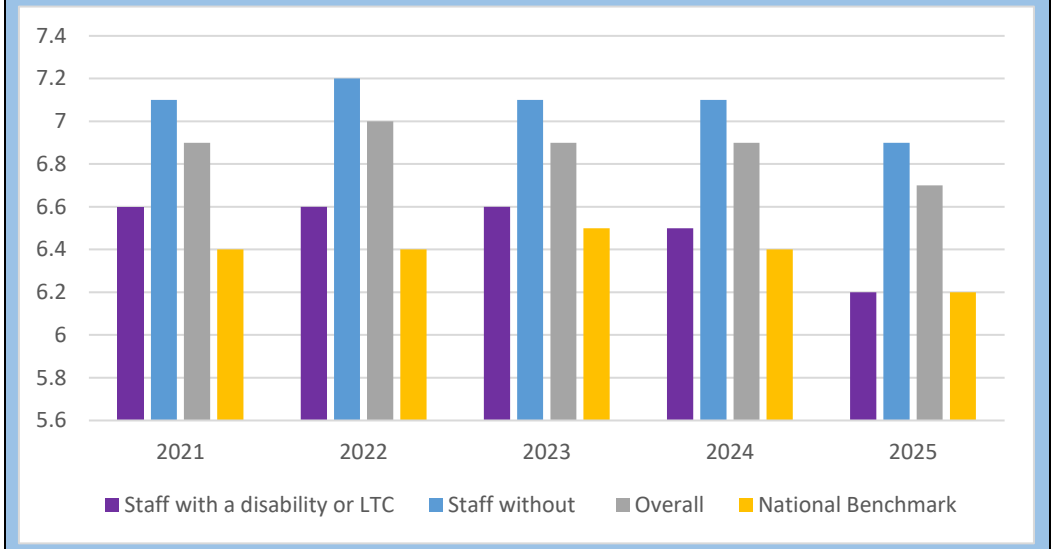

### Staff Survey Key Findings - Reasonable Adjustments

This information is derived from the 2025 Staff Survey. his information is derived from the 2025 Staff Survey.

Staff survey results have remained static in terms of the number of disabled staff who have reported that the Trust has made adequate reasonable adjustments to enable them to carry out their work, the figure still remains above the national average for this question.

Training continues to be delivered to managers on the application of the policy in practice.

## Indicator 9 – Staff engagement score (0-10)




### Staff Survey Key Findings - Engagement

Staff survey results show that the staff engagement score for disabled staff is 6.2 out of 10. This has shown a slight decrease of 0.3 when compared to 6.5 in 2024

Staff with a disability report lower report lower levels of staff engagement than staff who do not have a disability. Staff with a disability/LTC report on a comparable with national benchmarking data which indicates that the engagement score for disabled staff is 6.2.

**Appendix 2**

## South Tees Hospitals NHS Foundation Trust

| South Tees - WDES Indicators 2026 | | | 2022 | 2023 | 2024 | 2025 | 2026 |
|---|---|---|---|---|---|---|---|
| 1 | Percentage of staff with a disability or long term health condition | Overall | 3.5% | 4.6% | 4.9% | 6.3% | 6.9% |
| 2 | The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff | | 1.58 | 1.31 | 1.30 | 1.76 | 1.32 |
| 3 | The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff | | 0 | 0 | 0 | 8.4 | 15.5 |
| | | | 2021 | 2022 | 2023 | 2024 | 2025 |
| 4a | Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months | Staff with a disability or LTC | 27.1% | 28.9% | 26.3% | 28.2% | 27.5% |
| | | Staff without | 23.2% | 23.7% | 20.5% | 19.6% | 20.8% |
| 4b | Percentage of staff experiencing harassment, bullying or abuse from manager in the last 12 months | Staff with a disability or LTC | 14.4% | 13.9% | 10.4% | 13.9% | 13.5% |
| | | Staff without | 8.7% | 7.8% | 8.6% | 9.6% | 6.7% |
| 4c | Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months | Staff with a disability or LTC | 24.5% | 25.2% | 23.0% | 27.7% | 26.3% |
| | | Staff without | 15.2% | 17.1% | 16.0% | 16.9% | 16.8% |
| 4d | Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it | Staff with a disability or LTC | 50.4% | 49.4% | 49.2% | 52.6% | 48.2% |
| | | Staff without | 42.3% | 45.5% | 48.1% | 42.2% | 46.2% |
| 5 | Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion | Staff with a disability or LTC | 53.5% | 51.5% | 53.2% | 53.1% | 44.9% |
| | | Staff without | 58.4% | 59.0% | 58.6% | 58.4% | 55.3% |
| 6 | Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties | Staff with a disability or LTC | 29.9% | 26.8% | 25.0% | 27.7% | 28.5% |
| | | Staff without | 22.8% | 19.1% | 19.7% | 19.4% | 18.3% |
| 7 | Percentage of staff satisfied with the extent to which their organisation values their work | Staff with a disability or LTC | 32.7% | 34.2% | 33.4% | 34.1% | 27.5% |
| | | Staff without | 40.7% | 39.8% | 43.4% | 42.8% | 37.6% |
| 8 | Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work | Staff with a disability or LTC | 75.6% | 69.6% | 72.4% | 72.6% | 70.5% |
| 9 | Staff Engagement Score (0-10) | Staff with a disability or LTC | 6.6 | 6.5 | 6.9 | 6.4 | 6.1 |
| | | Staff without | 7 | 6.9 | 7 | 6.9 | 6.7 |
| | | Overall | 6.9 | 6.8 | 6.9 | 6.7 | 6.5 |
| | | | 2022 | 2023 | 2024 | 2025 | 2026 |
| 10 | Disabled/LTC Board Membership | | -3.3% | -4.3% | -3.0% | 5.0% | 4.0% |

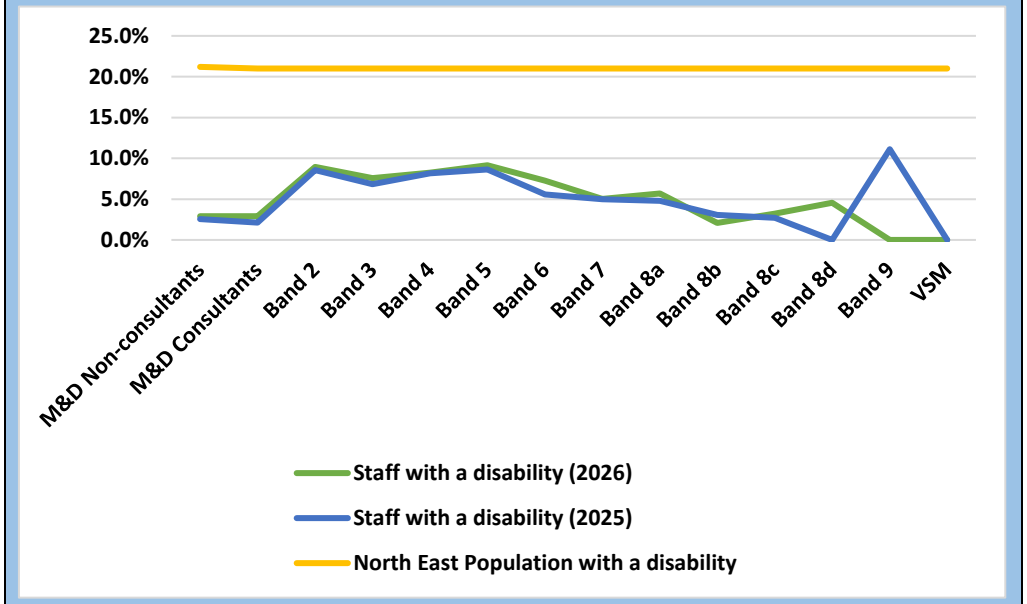
## Key Findings for 2026

The key findings in respect of the ten WDES indicators for 2026 are summarised below.

We are currently only able to undertake benchmarking for those areas which relate to the staff survey (indicators 4-9). Full benchmarking information is published by the national WDES team and this is expected for March 2027. The data for the UK Census which took place in 2021 is now available for analysis and reporting and this provides us with a more accurate picture of the UK's disability profile, which can also be broken down by Region and Local Authority Area.

- UK Population 17.8% Disabled and 82.2% Non-Disabled
- North East Population 21.2% Disabled and 78.8% Non-Disabled
- Middlesbrough Population 21.9 % Disabled and 78.1% Non-Disabled
- Redcar and Cleveland Population 21.4% Disabled and 78.6% Non-Disabled
- Hambleton Population 15.4% Disabled and 84.6% Non-Disabled

### Indicators 1 and 10 – Percentage of staff with a disability or long term health condition




**Representative Workforce across all protected characteristics at all levels.**

This information is obtained from the Trust's ESR system as at 31 March 2025. The number of staff who have reported their disability status on ESR has increased by 0.6% - this is reported at 6.9% in 2026. We continue to use staff campaigns, on how to use the online self-declaration service on ESR and also by raising awareness of this during relevant disability and staff network events and the importance of Trust workforce data. The North East's disability data (2021 census) is reported at 21.2% therefore representation within the Trust is significantly lower.

Representation is highest at Bands 2 and 5 and there are no disabled staff employed at Band 9 and VSM. Band 9 has reported a decrease of 11.1% and band 8d has seen a 4.5% increase when compared to 2025.

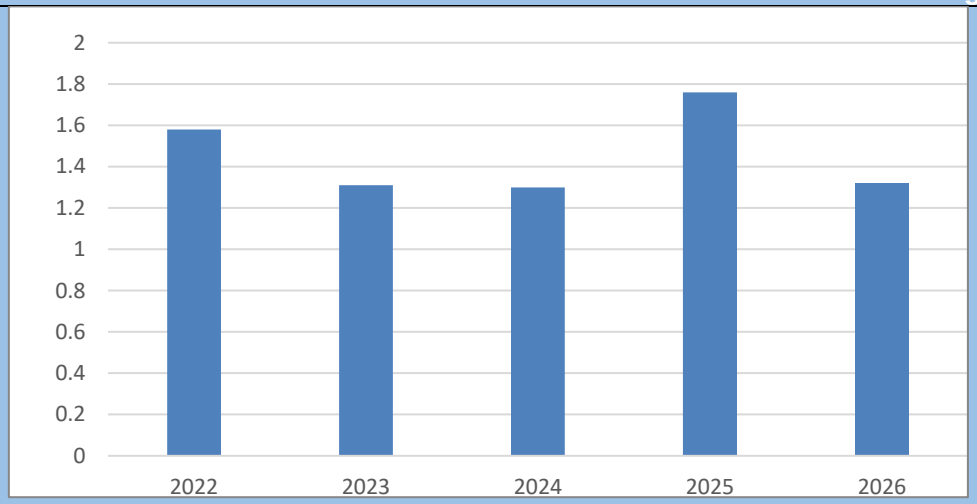
**Representation of Disabled staff at Board and senior management levels.**

For reporting purposes, we are only able to report on Board members who are directly employed by South Tees Hospitals NHS Foundation Trust.

There is a total of 9 employees reported on the Board for South Tees with Disability at Board level currently reported at 4.0%, this has seen a 1% decrease

| | |
|---|---|
| | (4.0% in 2026 compared to 5% in 2025). Representation is reported slightly below the overall workforce figure of 6.9% |

## Indicator 2 – The relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff




**Equity of Experience.**

This information is obtained from the Trust's Trac Recruitment System for the period 1 April 2025 to 31 March 2026 and considers a ratio showing the likelihood of being appointed following shortlisting. A figure of 1 indicates equal experience between disabled and non-disabled applicants.

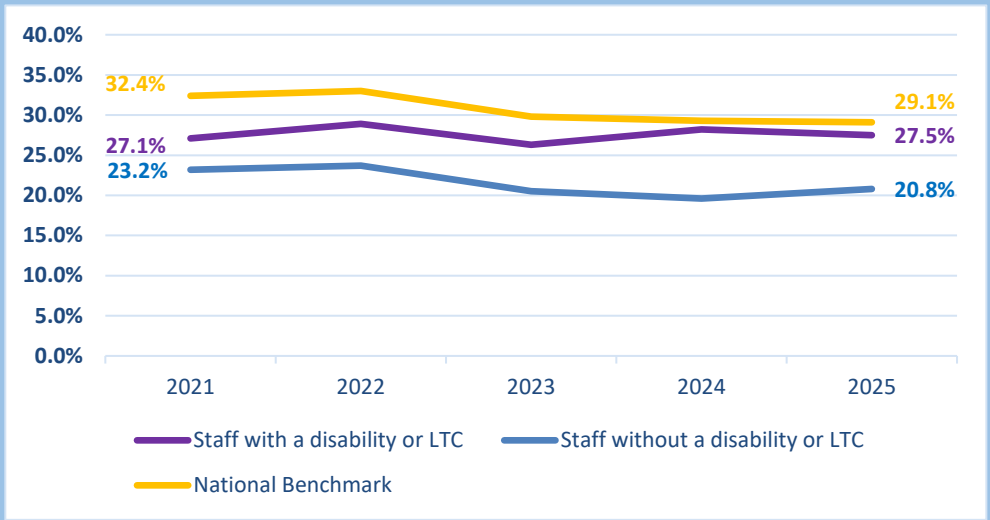
The current figure for 2026 is reported as 1.32 which has seen an improvement since 2025 when it was reported at 1.76, however the figure still indicates shortlisted disabled applicants are less likely to be appointed following shortlisting than non-disabled applicants.

## Indicator 3 – The relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff

This information is obtained from the Trust's Workforce databases and considers a ratio showing the likelihood of entering formal capability processes. A figure of 1 indicates equal experience between disabled and non-disabled staff.

There have been 8 formal capability cases in total with 4 involving staff with a disability or long-term condition, therefore the relative likelihood of Disabled staff entering the formal capability process compared to non-Disabled staff is reported at 15.5. This has seen an increase from previous years where this has been reported at 8.4.

## Indicator 4a - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months




### Staff Survey Key Findings - B&H Public

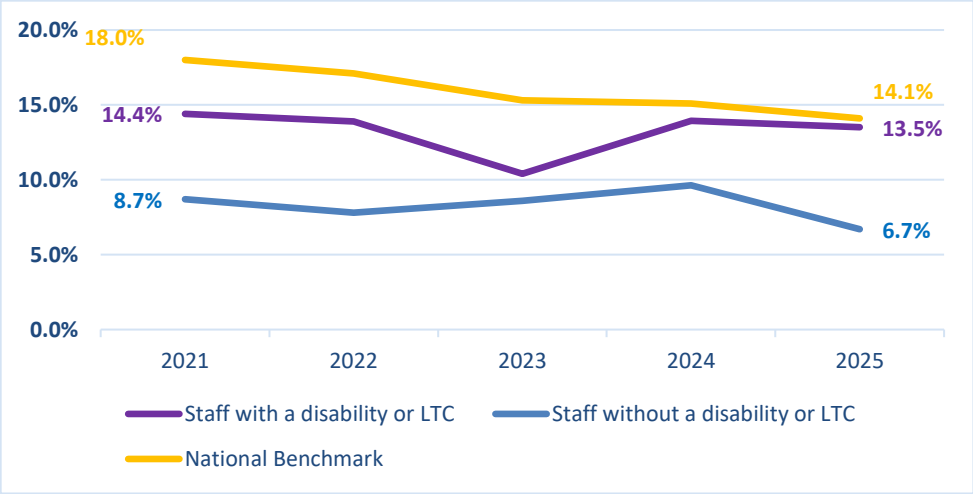
This information is derived from the 2025 Staff Survey.

Staff survey results show a positive decrease in the number of disabled staff who have experienced harassment, bullying and abuse from patients, relatives/public (27.5% compared to 28.2% for 2024). It's also positive to note we report below the national average of 29.1%.

Staff with a disability/LTC continue to be more likely to experience harassment, bullying/abuse from patients than staff who do not have a disability and the gap is reported as 6.7%.

Staff are required to log all incidents of service user violence and harassment via InPhase and the information is reviewed on a regular basis.

## Indicator 4b – Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months



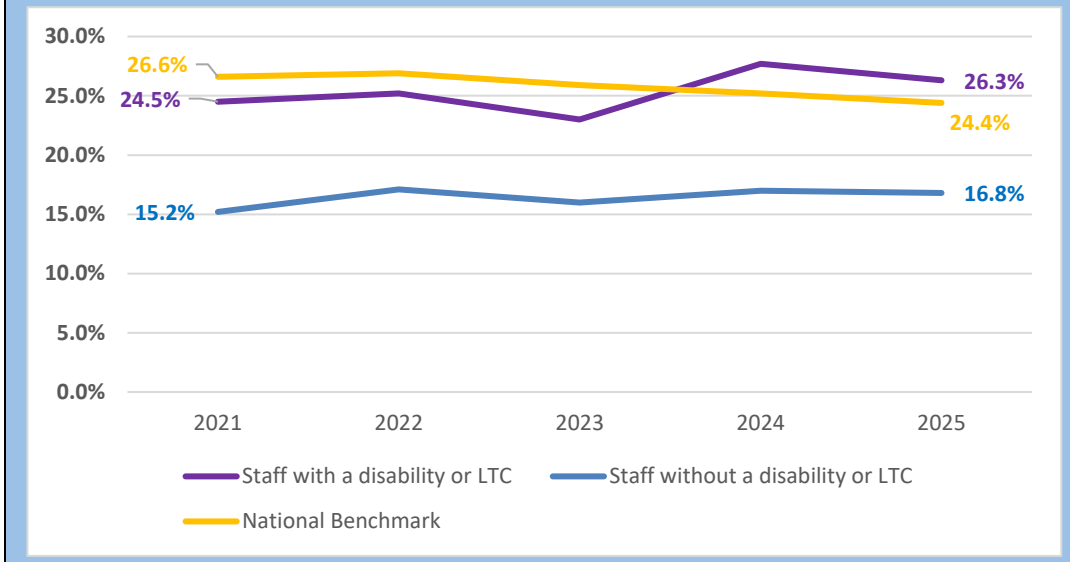

### Staff Survey Key Findings - B&H Manager

This information is derived from the 2025 Staff Survey.

Staff survey results show a slight positive decrease in the number of disabled staff experiencing harassment, bullying and abuse from a manager (13.5% compared to 13.9% for 2024).

Staff with a disability/LTC continue to be more likely to experience harassment, bullying/abuse from a manager than staff who do not have a disability, the gap has increased for 2025 and this is currently reported as 6.8%. Positive to note we continue to report below the national average of 14.1% for 2024.

## Indicator 4c – Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months



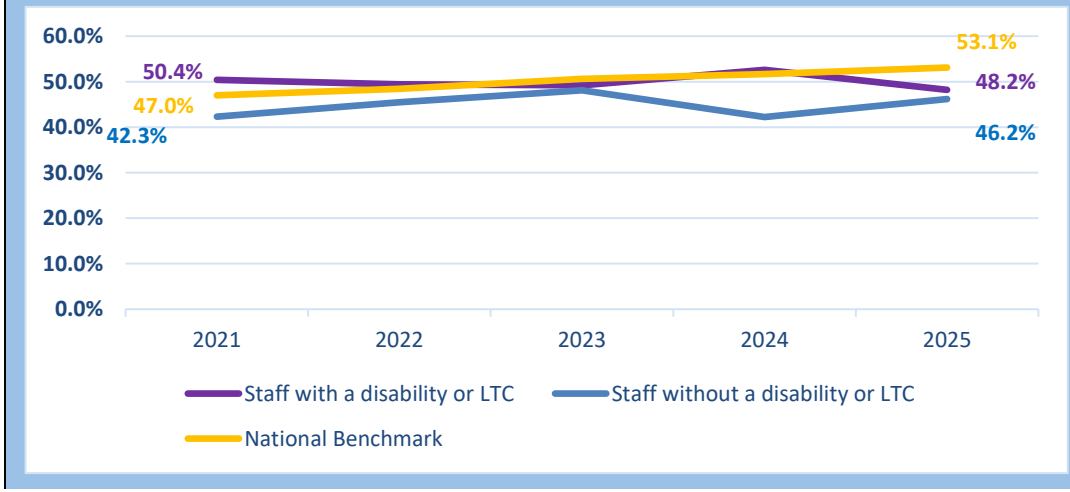

### Staff Survey Key Findings - B&H Colleagues

This information is derived from the 2025 Staff Survey.

Staff survey results show a positive decrease in the number of disabled staff experiencing harassment, bullying and abuse from a colleague (26.3% compared to 27.7% in 2024).

Staff with a disability/LTC continue to be more likely to experience harassment, bullying/abuse from a colleague than staff who do not have a disability. The gap has decreased for 2025 and this is reported as 9.5% (compared to 10.3% for 2024).

## Indicator 4d – Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it




### Staff Survey Key Findings – Reporting

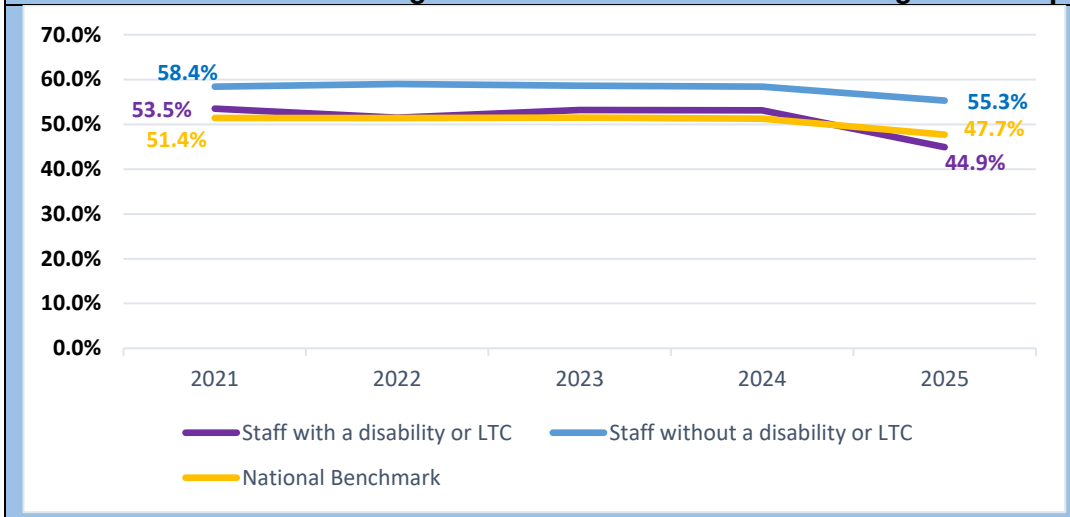
This information is derived from the 2025 Staff Survey.

Staff survey results show a negative decrease in the number of disabled staff who have reported harassment, bullying and abuse (48.2% compared to 52.6% for 2024).

Staff with a disability/LTC are now more likely to report harassment, bullying/abuse than staff who do not have a disability, with a reported gap of 2%.

It is important that our staff feel supported to report concerns regarding bullying and harassment and all cases are logged and monitored by the Workforce Team.

## Indicator 5 – Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion



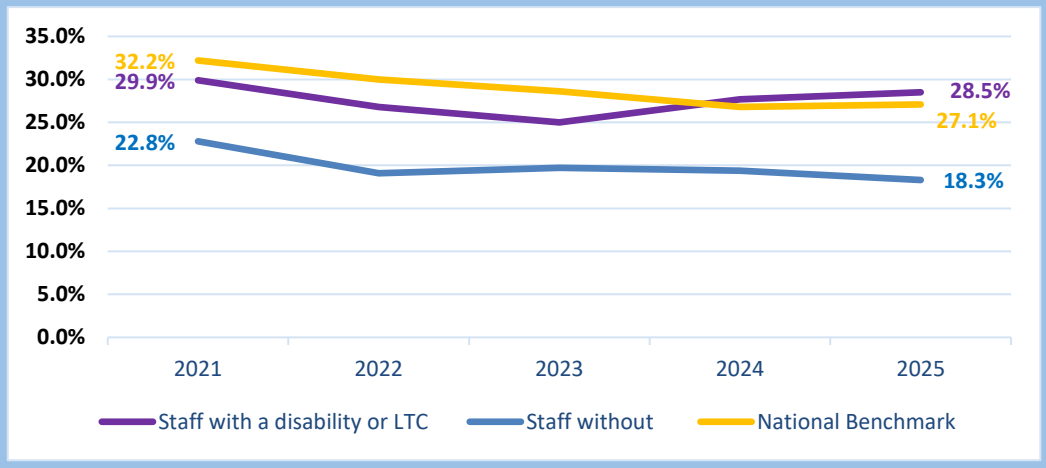

### Staff Survey Key Findings - Equal Opportunities

This information is derived from the 2025 Staff Survey.

The results have shown a negative decrease in terms of the number of disabled staff who believe the organisation provides equal opportunities for career progression or promotion (44.9% compared to 53.1% in 2024).

Staff with a disability/LTC continue to report lower levels of equal opportunities than staff who do not have a disability. The gap in experience is currently reported as 8.4%.

## Indicator 6 – Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties



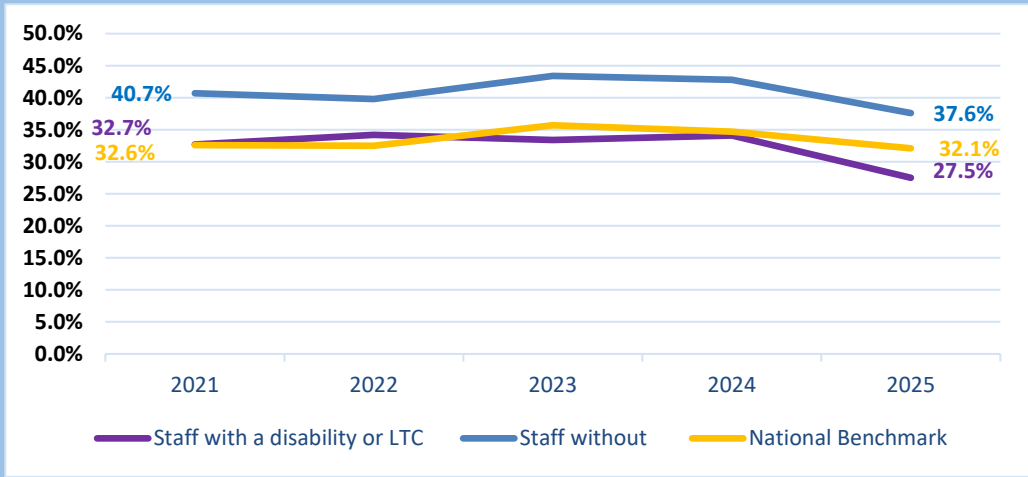

### Staff Survey Key Findings - Attendance at work whilst unwell

This information is derived from the 2025 Staff Survey.

The results show a negative increase in the number of disabled staff who have felt pressure from their manager to come to work whilst unwell (28.5% compared to 27.7% for 2024).

Staff with a disability/LTC continue to be more likely to report pressure to attend work whilst unwell than staff who do not have a disability. The gap has increased for 2025 and this is reported as 10.2%, compared to 8.3% for 2024.

## Indicator 7 – Percentage of staff satisfied with the extent to which their organisation values their work



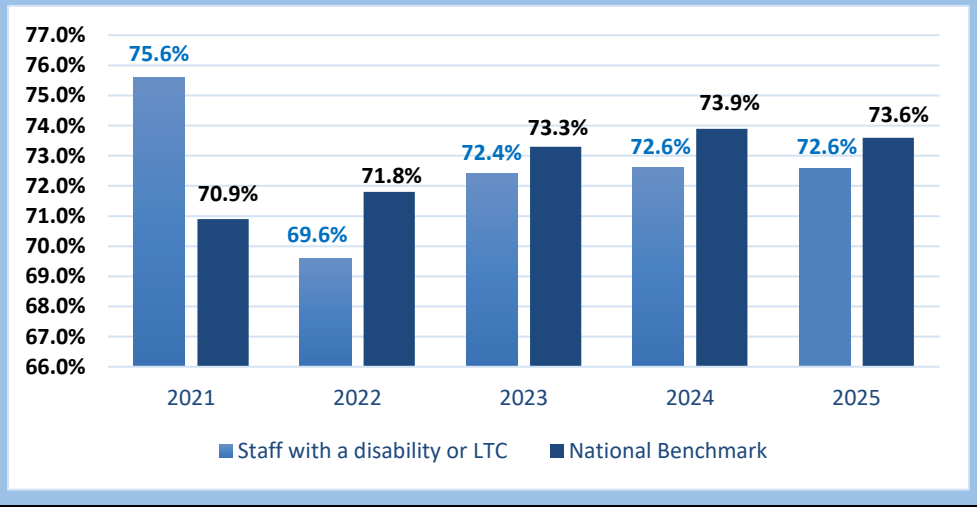

### Staff Survey Key Findings - Feeling Valued

This information is derived from the 2025 Staff Survey.

The number of disabled staff who feel satisfied that the organisation values their work has decreased for 2025 at 27.5%, compared to 34.1% for 2024.

Staff with a disability/LTC continue to be less likely to feel valued than staff who do not have a disability and the gap is reported at 9.9% which is an increase of 1.1% from 2024.

## Indicator 8 – Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work



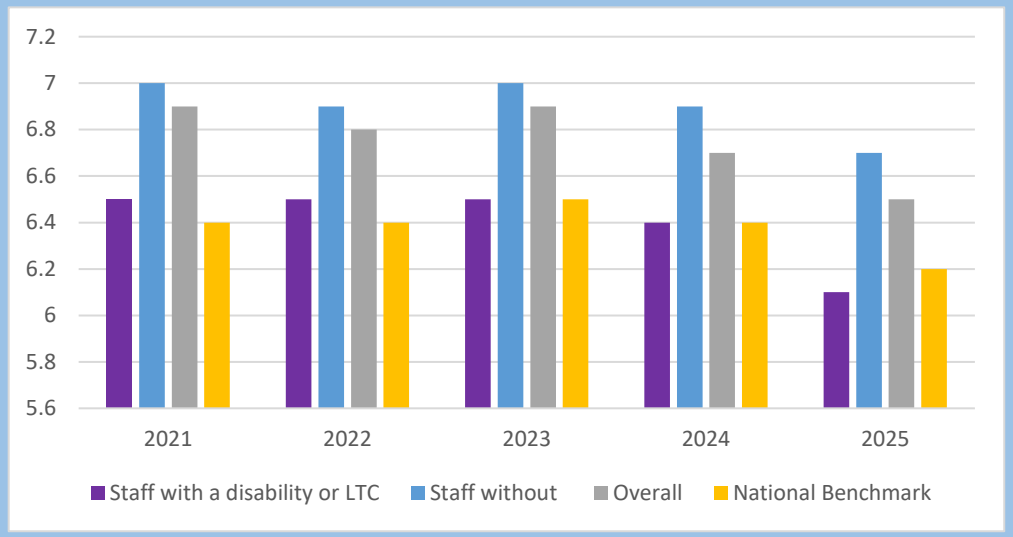

### Staff Survey Key Findings - Reasonable Adjustments

This information is derived from the 2025 Staff Survey.

Staff survey results have remained static in terms of the number of disabled staff who have reported that the Trust has made adequate reasonable adjustments to enable them to carry out their work (results have remained at 72.6% for 2025).

We have recently refreshed our training and we will continue to roll this to managers on the application of the policy in practice.

## Indicator 9 – Staff engagement score (0-10)




### Staff Survey Key Findings - Engagement

This information is derived from the 2025 Staff Survey.
Staff survey results show that the staff engagement score for disabled staff is 6.1. This has shown a decrease of 3% when compared to 6.4 in 2024.

Staff with a disability report lower levels of staff engagement than staff who do not have a disability. Staff with a disability/LTC continue to report lower than the national benchmarking data which indicates that the engagement score for disabled staff is 6.2, which is 0.1 higher than the Trust figure.

NHS
University Hospitals Tees

# Resource and Performance Committee

**29 July 2026**

**Connecting to: UHT Board**

**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 (Responsive domain)** *MAY 2026 data*

For NTHFT, one performance metric remained as Alert.

- Cancer Faster Diagnosis

In addition, three metrics have been regraded to Alert for May 2026.

- Community UCR 2 Hour Response (%) has been regraded from Advise to highlight a persistent decline in performance for 7 consecutive months when compared to the previous average. However, the national standard has been achieved since May 2025.
- Cancelled operations not rebooked in 28 days has been regraded from Advise following negative outliers in April and May 2026, near the limits of expected variance.
- A low outlier for performance in May 2026 means Cancer 62 Day Standard flags as Alert.

For STHFT, there was one metric newly regraded as Alert for May 2026.

- Cancelled operations not rebooked in 28 days has been regraded from Advise as performance has plateaued and the target remains outside the range of usual performance.



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

**Finance and CIP June 2026 data**

At the end of Month 3 the Group is reporting a year-to-date (YTD) position in line with plan. The reported position includes additional non-recurrent measures totalling £2.9m year-to date across the Group. The forecast outturn position remains in line with plan as at Month 3. Achievement of the financial control total will require delivery in line with key financial plan assumptions.

Regional NHSE are implementing a revised financial oversight framework from Month 4. Each NEY organisation has been stratified for financial risk, within the context of performance safety. This risk classification determines the reporting, oversight and support required for each organisation. The risk classifications are:

• On track – retained autonomy [Red]

• Financial recovery required and 'watch' approach by Region [Amber]

• Financial recovery required with active involvement by Region [Red]

• Mandated national support or non-compliant plan [Maroon]

Both UHT trusts have been formally notified that they have been assigned to the Amber 'watch' category. This means that an additional 'Provider Assurance Model' must be submitted to Regional NHSE each month.

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**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 (Responsive domain) May 2026 data**

The majority of IPR metrics remain graded Advise, for both Trusts.

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, in the RESPONSIVE domain, no metrics are rated as assured. For STHFT, Community 18-week compliance (%), in the RESPONSIVE domain, is assured above plan and national operational target for 26/27.

**Finance and CIP June 2026 data**

The Group plan assumes a net workforce reduction of 503wte across the financial year. Compared to the workforce plan (which uses Contracted WTE for substantive staff), the Month 3 position shows a small overall adverse variance of 8.75wte across the Group. Month 3 shows a net overall decrease of 78.88 WTE Worked across the Group, compared to the previous month. Compared to the same period last year (Month 3 2025/26) WTEs were lower by 386.68wte.

NHSE have set organisation caps for expenditure on Bank and Agency for 2026/27. Year-to-date Agency expenditure was £2k less than plan and £0.3m less (18%), adjusted for inflation, than that incurred at the same point in the previous year. Year-to-date Bank expenditure was £0.1m higher than plan but £0.9m (12%) less, adjusted for inflation, than that incurred at the same point in the previous year.

Across the Group, overall year-to-date reported CIP delivery is £16.3m (95% of target). However, this position includes a number of non-recurrent schemes, and delivery of recurrent savings is £0.6m behind plan at the end of Month 3.

**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 (Responsive domain) May 2026 data**

For NTHFT no metrics are rated as assured. For STHFT, Community 18-week compliance (%), is assured above plan and national operational target for 26/27.

**Finance and CIP June 2026 data**

The formal QPR meetings with each CSU (currently held monthly) includes a review of financial metrics and CIP delivery.

The Managing Director is leading a 'grip and control' review of local arrangements within each CSU, and observations of CSU Board meetings.

The Internal Audit plan for each trust includes reviews of Budgetary Control and Financial Reporting.

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

**Corporate Outpatients Project - Deep Dive**

The Chief Delivery Officer presented a deep dive into the Corporate Outpatients Project and highlighted the key issues. The three main areas of the Outpatient Project targets are

- Increasing patient-initiated follow-up (PIFU) rates to 6%
- improving first outpatient utilisation by 6%
- reducing Did Not Attend (DNA) rates to 6%,

The Committee heard that there is a focus on a few high-impact changes rather than many small initiatives. This work supports a single, consistent UHT Outpatient model which should in turn, improve access, productivity and patient experience across the organisations.

· Key changes included moving away from booking appointments a year in advance, implementing partial booking processes, standardising clinic templates and leveraging digital solutions while maintaining safety nets for patients with limited digital access.

The Committee discussed the need for clear Board-level decisions on prioritisation, documentation of governance choices and balancing focus on corporate projects with ongoing core business requirements such as appraisals.

In response to a query raised, it was explained that digital communications would be supplemented by paper letters for those not accessing digital platforms however, it was acknowledged that there was a need for further work to ensure vulnerable patients were not missed

NHS
University Hospitals Tees

# Resource and Performance Committee

**26 August 2026**

**Connecting to: UHT Board**

**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 (Responsive domain)** *JUNE 2026 data*

For NTHFT, two performance metrics remain as Alert.

- Cancer Faster Diagnosis
- Cancelled operations not rebooked in 28 days

In addition, one metrics has been regraded to Alert for June 2026.

- RTT 52 week waiters %

For STHFT, one metric remains as Alert for May 2026.

- Cancelled operations not rebooked in 28 days

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

**Finance and CIP July 2026 data**

At the end of Month 4 the Group is reporting a year-to-date (YTD) position in line with plan. The reported position includes additional non-recurrent measures totalling £3.9m year-to date across the Group. The forecast outturn position remains in line with plan as at Month 4.



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Achievement of the financial control total will require delivery in line with key financial plan assumptions.

Regional NHSE have implemented a revised financial oversight framework from Month 4. Each NEY organisation has been stratified for financial risk, within the context of performance safety. Both UHT trusts have been assigned to the amber 'watch' category.

This framework supplements the official monthly forecast submission, with additional analysis to describe the risk of delivery by determining a best, mid and worst-case scenario, using a consistent methodology across all organisations. The Month 4 submitted forecast submission shows a 'best-case' scenario in line with plan and a 'mid-case' forecast adverse variance of £11.9m.

**Digital Services update Q1 2026/27**

The increasing demands of the overall digital programme need to be carefully managed to ensure that the demand for digital resources matches capacity to deliver.

**Productivity update Q1 2026/2027**

Lower quartile performance is reported in five operational productivity measures and 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.

**Estates Update Q1 2026/2027**

Ageing estate and lifecycle issues continue to impact the UHT estate and this has impacted on PLACE (Patient Led Assessments of the Care Environment) dementia, privacy, dignity and accessibility scores at UHNT. These are tolerated risks and are monitored via the Estates Board Assurance Framework.

**Sustainability Update Q1 2026/2027**

To facilitate development of a Travel Plan, there will be a staff wide travel survey developed and issued which will assist in the direction the strategy takes.

South Tees - waste-management compliance remains an area of focus following previous audit findings at James Cook University Hospital although significant improvements have been achieved.

North Tees – there is some non-compliance in relation to clinical waste bags. There is engage with staff to educate and understand the issue and ensure compliance in this area going forward.

**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 (Responsive domain) June 2026 data**

The majority of IPR metrics remain graded Advise, for both Trusts.

For NTHFT, a further two metrics have been regraded to Advise in July 2026 in the RESPONSIVE domain:

- Community UCR 2 Hour Response (%) is regraded from Alert; following a period of declining performance, compliance has returned to above average for May 2026.
- Cancer 62 Day Standard returned to advise from Alert, as performance has returned within expected variance June 2026.

For STHFT, in the RESPONSIVE domain Community 18-Week Compliance is regraded from Assure after recent poorer performance, however compliance remains above plan.

**Finance M4 July 2026 data**

The Group's plan assumes a net workforce reduction of 503wte across the financial year. Compared to the workforce plan, the Month 4 position shows an adverse variance of 17.69wte across the Group. Month 4 shows a net overall increase of 99.01 WTE Worked across the Group, compared to the previous month.

NHSE have set organisation caps for expenditure on Bank and Agency for 2026/27. Year-to-date Agency expenditure was £30k less than plan and £0.7m less (18%), adjusted for inflation, than that incurred at the same point in the previous year. Year-to-date Bank expenditure was £0.3m higher than plan but £0.7m (7%) less, adjusted for inflation, than that incurred at the same point in the previous year.

Across the Group, overall year-to-date reported CIP delivery is £22.7m (96% of target). However, this position includes a number of non-recurrent schemes, and delivery of recurrent savings is £1.1m behind plan at the end of Month 4. Against the overall CIP target of £81.7m, £6.5m is classified as 'opportunity' and £23.3m still assessed as 'high risk'.

**Estates Update Q1 2026/2027**

ERIC provides the national benchmark for cost, efficiency and operational performance across the estate. The results were published in December 25 and show that UHT continues to perform well and provide a value for money estates and facilities service.

PLACE assessments focus exclusively on the environment in which care is delivered and do not cover clinical care provision or how well staff are doing their job. PLACE scores are not directly related to the efficiency and productivity of the organisation. However, decisions made by the organisation to improve their efficiency may affect the quality of that service and hence are reflected in the PLACE scores. The completion deadline was 8th December 2025.

Operations, Estates and Capital colleagues across UHT continue to work closely together to ensure future schemes pick up ongoing maintenance.

**Sustainability Update Q1 2026/2027**

South Tees - Positive progress has been made in medicines sustainability, travel and transport, food waste reduction, procurement, staff engagement and waste management. Ongoing monitoring is in place to support delivery of Green Plan objectives and Net Zero ambitions.

North Tees- The Waste Policy is currently being reviewed, along with South Tees, in order for alignment by mid-August 2026.

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

**Performance (Responsive domain) May 2026 data**

For STHFT, Community UCR 2 Hour Response (%) is regraded from Advise, as the lower limits of usual performance are consistently above target.

**Finance M4 July 2026 data**

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 Managing Director is leading a 'grip and control' review of local arrangements within each CSU, and observations of CSU Board meetings.

The Internal Audit plan for each trust includes reviews of Budgetary Control and Financial Reporting.

Regional NHSE have held 2 deep dives into the Group's workforce reduction plans and are ready to receive applications from the trust to access funding for voluntary redundancy costs and subsequent and ongoing workforce review processes will transition into routine business-as-usual governance arrangements.

**Productivity Update Q1 2026/2027**

Top quartile performance is seen in two headline productivity measures.

5 operational productivity metrics demonstrate top quartile performance:

- Utilisation of specialist advice and guidance (NTH and STH)
- Elective length of stay (NTH)
- Non-elective length of stay (NTH)
- % non-elective admissions with zero or one-day length of stay (NTH and STH)
- Theatre Utilisation (STH).

**Estates Update Q1 2026/2027**

The data collected annually through the ERIC, PLACE and PAM audits evaluate different dimensions of performance. They are each critical in understanding the condition and effectiveness of our Estates and Facilities service which in turn provides comprehensive Board assurance to this effect. The three are intrinsically linked. Together, ERIC, PLACE and PAM form a recognised ‘triangle of assurance’ for NHS estates and facilities services.

**Sustainability Update Q1 2026/2027**

South Tees successfully hosted its first Sustainability Day and has secured membership of the Modeshift Healthcare STARS programme. North Tees training programme on ESR is now online and being completed. Training figures will now become part of the Health, Safety and Security Council report.



Caring
Better
Together

# Finance Report Month 4: 2026-27

**Meeting date:** *3 September 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:** *Assurance*

**Delegation status:** *Jointly delegated item to Group Board*

**Previously presented to:** *Resources and Performance Committee*

## UHT strategic objectives supported:

Putting patients first ☐

Creating an outstanding experience for our people ☐

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☒

## CQC domain link:

Well-led

## Board assurance / risk register this paper relates to:

This report relates to the Board Assurance Framework Finance domain

## Key discussion points and matters to be escalated from the meeting

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

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

At the end of Month 4 the Group is reporting a year-to-date (YTD) position in line with plan.

The reported position includes additional non-recurrent measures totalling £3.9m year-to-date across the Group.

The forecast outturn position remains in line with plan as at Month 4. However, achievement of the financial control total will require delivery in line with key financial plan assumptions, including realising efficiency saving targets, and mitigation and management action to offset any financial impact from risks and issues that may arise.

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

Month 4 shows a net overall increase of 99.01 WTE Worked across the Group, compared to the previous month. Compared to the same period last year (Month 4 2025/26) WTEs were lower by 320.94wte.

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

Year-to-date Agency expenditure was £30k less than plan and £0.7m less (18%), adjusted for inflation, than that incurred at the same point in the previous year.

Year-to-date Bank expenditure was £0.3m higher than plan but £0.7m (7%) less, adjusted for inflation, than that incurred at the same point in the previous year.

Across the Group, overall year-to-date reported CIP delivery is £22.7m (96% of target). However, this position includes a number of non-recurrent schemes, and delivery of recurrent savings is £1.1m behind plan at the end of Month 4.

Against the overall CIP target of £81.7m, £6.5m is classified as 'opportunity' and £23.3m still assessed as 'high risk'. De-risking of the CIP programme and maximising recurrent in-year delivery continues to be a key area of focus for the Financial Recovery Oversight Group and CSU and Corporate CIP meetings.

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

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

The formal QPR meetings with each CSU (currently held monthly) includes a review of financial metrics and CIP delivery.

The Managing Director is leading a ‘grip and control’ review of local arrangements within each CSU, and observations of CSU Board meetings.

The Internal Audit plan for each trust includes reviews of Budgetary Control and Financial Reporting.

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

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

## Recommendations:

Members of the Board are asked to:

- Note the financial position for Month 4 2026/27.

# Board of Directors
# 3 September 2026

# Month 4 2026/27 Finance Report

## 1. PURPOSE OF REPORT

The purpose of this report is to update the Board on the financial performance of the individual trusts and overall Group, at the end of Month 4 of 2026/27.

## 2. BACKGROUND

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

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

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

## 3. MONTH 4 FINANCIAL POSITION

The table below shows the revenue position for the Group as at the end of Month 4 2026/27, shown by trust:

| STATEMENT OF COMPREHENSIVE INCOME | NTH | | | STH | | | GROUP | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan £000 | Actual £000 | Variance £000 | Plan £000 | Actual £000 | Variance £000 | Plan £000 | Actual £000 | Variance £000 |
| Operating income from patient care activities | 145,492 | 146,676 | 1,184 | 329,764 | 329,145 | (619) | **475,256** | **475,821** | **565** |
| Other operating income | 11,504 | 11,867 | 363 | 20,460 | 21,384 | 924 | **31,964** | **33,251** | **1,287** |
| Employee expenses | (108,325) | (109,957) | (1,632) | (211,777) | (212,159) | (382) | **(320,102)** | **(322,116)** | **(2,014)** |
| Operating expenses excluding employee expenses | (49,335) | (49,419) | (84) | (133,403) | (132,952) | 451 | **(182,738)** | **(182,371)** | **367** |
| **OPERATING SURPLUS/(DEFICIT)** | **(664)** | **(833)** | **(169)** | **5,044** | **5,418** | **374** | **4,380** | **4,585** | **205** |
| **FINANCE COSTS** | | | | | | | | | |
| Finance income | 856 | 799 | (57) | 2,040 | 1,385 | (655) | **2,896** | **2,184** | **(712)** |
| Finance expense | (292) | (222) | 70 | (7,012) | (7,018) | (6) | **(7,304)** | **(7,240)** | **64** |
| PDC dividends payable/refundable | (1,196) | (1,197) | (1) | (252) | 0 | 252 | **(1,448)** | **(1,197)** | **251** |
| **NET FINANCE COSTS** | **(632)** | **(620)** | **12** | **(5,224)** | **(5,633)** | **(409)** | **(5,856)** | **(6,253)** | **(397)** |
| Other gains/(losses) including disposal of assets | 0 | 5 | 5 | 0 | 20 | 20 | **0** | **25** | **25** |
| Corporation tax expense | (16) | (15) | 1 | (8) | 0 | 8 | **(24)** | **(15)** | **9** |
| **SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR** | **(1,312)** | **(1,463)** | **(151)** | **(188)** | **(195)** | **(7)** | **(1,500)** | **(1,658)** | **(158)** |
| Add back all I&E impairments/(reversals) | 0 | | 0 | 0 | 0 | 0 | **0** | **0** | **0** |
| Remove capital donations/grants I&E impact | 0 | 151 | 151 | 844 | 844 | 0 | **844** | **995** | **151** |
| Remove PFI revenue costs on an IFRS 16 basis | 0 | | 0 | 21,864 | 21,125 | (739) | **21,864** | **21,125** | **(739)** |
| Add back PFI revenue costs on a UK GAAP basis | 0 | | 0 | (25,648) | (24,897) | 751 | **(25,648)** | **(24,897)** | **751** |
| **Adjusted financial performance surplus/(deficit)** | **(1,312)** | **(1,312)** | **0** | **(3,128)** | **(3,123)** | **5** | **(4,440)** | **(4,435)** | **5** |
| Less Non-Recurrent Deficit Funding | 0 | | 0 | 0 | | 0 | **0** | **0** | **0** |
| **Adjusted financial peformance surplus (deficit) excluding Non-Recurrent Deficit Funding** | **(1,312)** | **(1,312)** | **0** | **(3,128)** | **(3,123)** | **5** | **(4,440)** | **(4,435)** | **5** |

At the end of Month 4 2026/27 the Group is reporting a year-to-date (YTD) position in line with plan, across both trusts.

The forecast outturn position remains in line with plan as at Month 4. However, achievement of the financial control total will require delivery in line with key financial plan assumptions, including realising efficiency saving targets, and mitigation and management action to offset any financial impact from risks and issues that may arise.

The main drivers of the **NTH Month 4 YTD position** are:

- Clinical Income is ahead of plan by £1.2m. This is mainly due to a non-recurrent benefit from reconciliation of prior-year variable depreciation income, CDC funding, and other ICB non-recurrent income.
- Other operating income is £0.4m ahead of plan, relating mainly to assumed voluntary redundancy funding, pathology income, and rental revenue.
- Interest receivable is slightly behind plan.
- Pay is £1.6m behind plan due to non-recurrent voluntary severance costs of £0.2m, cost of industrial action of £0.2m, arrears payments of £0.2m, flood recovery lists of £0.1m and CIP slippage.
- Non-Pay is £0.1m behind plan due to non-recurrent redundancy costs.
- CIP delivery is £0.3m behind plan overall.
- The position includes the impact of additional non-recurrent measures of £0.8m ahead of plan.

The main drivers of the **STH Month 4 YTD position** are:

- Clinical Income is behind plan by £0.6m. This mainly relates to the finalisation of 2025/26 income and 2026/27 mandates since plan submission, part offset by

additional variable high-cost drugs and devices income. The drugs and devices income can be offset by an overspend in Non pay.

- Other Operating Income is £0.9m ahead of plan, mainly relating to car parking and Education & Training.
- Pay is overspent by £0.4m which relates to substantive staff.
- Non-Pay is underspent by £0.5m, including non-recurrent benefits which offset clinical income.
- Interest receivable is behind plan by £0.7m and relates to the phasing of the plan. The variance to plan is expected to improve as the year progresses.
- CIP delivery is £0.7m behind the year-to-date plan.
- The position includes the impact of additional non-recurrent measures of £3.1m, ahead of the phased plan.

**Agency and Bank Expenditure**

Reductions in temporary staffing and premium pay costs are a national priority set by NHSE. The 2026/27 planning guidance included requirements to make further reductions to agency spend by at least 30% and to reduce bank spend by a further 10%.

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

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

The tables below show the position on agency and bank expenditure for the Group to the end of Month 4, 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 25/26 | Change | |
| | £000 | £000 | £000 | £000 | £000 | % |
| Nursing | 15 | 0 | (15) | 36 | (36) | -100% |
| AHP and Sci&Tech | 99 | 169 | 70 | 227 | (58) | -26% |
| Other Clinical | 0 | 0 | 0 | 0 | 0 | - |
| Consultants | 397 | 392 | (5) | 592 | (200) | -34% |
| Career/staff grades | 42 | 63 | 21 | 0 | 63 | - |
| Trainee grades | 11 | 26 | 15 | 23 | 3 | 14% |
| Non Clinical | 5 | 0 | (5) | 27 | (27) | -100% |
| **TOTAL** | **569** | **650** | **81** | **905** | **(255)** | **-28%** |

| BANK YTD | NTH | | | | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Adj 25/26 | Change | |
| | £000 | £000 | £000 | £000 | £000 | % |
| Nursing | 1,459 | 1,563 | 104 | 1,736 | (173) | -10% |
| AHP and Sci&Tech | 226 | 225 | (1) | 243 | (18) | -7% |
| Other Clinical | 1,400 | 1,554 | 154 | 1,975 | (421) | -21% |
| Consultants | 0 | 0 | 0 | 0 | 0 | - |
| Career/staff grades | 0 | 0 | 0 | 0 | 0 | - |
| Trainee grades | 0 | 0 | 0 | 0 | 0 | - |
| Non Clinical | 183 | 186 | 3 | 209 | (23) | -11% |
| **TOTAL** | **3,268** | **3,528** | **260** | **4,163** | **(635)** | **-15%** |

| AGENCY YTD | STH | | | | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Adj 25/26 | Change | |
| | £000 | £000 | £000 | £000 | £000 | % |
| Nursing | 105 | 69 | (36) | 38 | 31 | 81% |
| AHP and Sci&Tech | 157 | 212 | 55 | 222 | (10) | -5% |
| Other Clinical | 0 | 0 | 0 | 0 | 0 | - |
| Consultants | 1,028 | 797 | (231) | 1,301 | (504) | -39% |
| Career/staff grades | 0 | 0 | 0 | 0 | 0 | - |
| Trainee grades | 0 | 44 | 44 | 0 | 44 | - |
| Non Clinical | 27 | 84 | 57 | 71 | 13 | 18% |
| **TOTAL** | **1,317** | **1,206** | **(111)** | **1,632** | **(426)** | **-26%** |

| BANK YTD | STH | | | | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Adj 25/26 | Change | |
| | £000 | £000 | £000 | £000 | £000 | % |
| Nursing | 2,336 | 2,601 | 265 | 2,415 | 186 | 8% |
| AHP and Sci&Tech | 33 | 102 | 69 | 43 | 59 | 135% |
| Other Clinical | 2,288 | 1,995 | (293) | 2,140 | (145) | -7% |
| Consultants | 0 | 0 | 0 | 0 | 0 | - |
| Career/staff grades | 0 | 0 | 0 | 0 | 0 | - |
| Trainee grades | 360 | 310 | (50) | 483 | (173) | -36% |
| Non Clinical | 278 | 320 | 42 | 270 | 50 | 19% |
| **TOTAL** | **5,295** | **5,328** | **33** | **5,352** | **(24)** | **0%** |

| AGENCY YTD | UHT GROUP | | | | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Adj 25/26 | Change | |
| | £000 | £000 | £000 | £000 | £000 | % |
| Nursing | 120 | 69 | (51) | 74 | (5) | -7% |
| AHP and Sci&Tech | 256 | 381 | 125 | 449 | (68) | -15% |
| Other Clinical | 0 | 0 | 0 | 0 | 0 | - |
| Consultants | 1,425 | 1,189 | (236) | 1,892 | (703) | -37% |
| Career/staff grades | 42 | 63 | 21 | 0 | 63 | - |
| Trainee grades | 11 | 70 | 59 | 23 | 47 | 208% |
| Non Clinical | 32 | 84 | 52 | 98 | (14) | -14% |
| **TOTAL** | **1,886** | **1,856** | **(30)** | **2,537** | **(681)** | **-27%** |

| BANK YTD | UHT GROUP | | | | | |
|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Adj 25/26 | Change | |
| | £000 | £000 | £000 | £000 | £000 | % |
| Nursing | 3,795 | 4,164 | 369 | 4,152 | 12 | 0% |
| AHP and Sci&Tech | 259 | 327 | 68 | 286 | 41 | 14% |
| Other Clinical | 3,688 | 3,549 | (139) | 4,115 | (566) | -14% |
| Consultants | 0 | 0 | 0 | 0 | 0 | - |
| Career/staff grades | 0 | 0 | 0 | 0 | 0 | - |
| Trainee grades | 360 | 310 | (50) | 483 | (173) | -36% |
| Non Clinical | 461 | 506 | 45 | 478 | 28 | 6% |
| **TOTAL** | **8,563** | **8,856** | **293** | **9,515** | **(659)** | **-7%** |

Across the Group, **YTD agency** expenditure was £1.9m. This was £30k less than plan (which has been set in line with achieving the annual expenditure caps imposed by NHSE). Total agency expenditure was also £0.7m (27%) less than the agency expenditure incurred at the same point in the previous year (adjusted for inflation).

Across the Group, **YTD bank** expenditure was £8.9m. This was £0.3m higher than plan (which has been set in line with achieving the annual expenditure caps imposed by NHSE). Total bank expenditure was £0.7m (7%) 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.



Caring Better Together

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

The table below shows the WTE actual worked in Month 4 2026/27 (split between Substantive, Bank, and Agency staff) compared to each of:

- the average monthly WTE worked in 2019/20 (the pre-Covid baseline),
- the average monthly WTE worked in 2023/24, 2024/25 and the previous financial year 2025/26
- the WTE worked in the equivalent month of the previous financial year; and
- the previous month.

| WTE Worked | Mth 1 26/27 | Mth 2 26/27 | Mth 3 26/27 | Q1 Avg 26/27 | Mth 4 26/27 | Change from prior month | Change from M4 25/26 | Change from M12 25/26 | Change from 19/20 avg | Change from 23/24 avg | Change from 24/25 avg | Change from 25/26 avg |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NTH** | | | | | | | | | | | | |
| Agency | 23.59 | 23.07 | 16.75 | 21.14 | 21.66 | 4.91 | 6.81 | 8.29 | 1.28 | (42.23) | (13.51) | 7.02 |
| Bank | 209.29 | 187.00 | 181.65 | 192.65 | 229.35 | 47.70 | (18.69) | (30.04) | 42.90 | (4.76) | (17.65) | (15.17) |
| Substantive | 5,207.49 | 5,176.66 | 5,164.01 | 5,182.72 | 5,142.65 | (21.36) | (113.13) | (99.39) | 483.18 | 12.42 | (183.29) | (116.50) |
| **Sub Total** | **5,440.37** | **5,386.73** | **5,362.41** | **5,396.50** | **5,393.66** | **31.25** | **(125.01)** | **(121.14)** | **527.36** | **(34.57)** | **(214.45)** | **(124.65)** |
| **STH** | | | | | | | | | | | | |
| Agency | 26.49 | 12.86 | 15.44 | 18.26 | 17.62 | 2.18 | (3.55) | (2.96) | (7.89) | (17.00) | (1.11) | (4.42) |
| Bank | 279.06 | 234.23 | 226.81 | 246.70 | 287.80 | 60.99 | (24.82) | (27.90) | 89.79 | (105.25) | (59.60) | (0.04) |
| Substantive | 9,498.24 | 9,447.45 | 9,410.30 | 9,452.00 | 9,414.89 | 4.59 | (167.56) | (111.14) | 1,578.21 | 179.82 | (77.54) | (143.69) |
| **Sub Total** | **9,803.79** | **9,694.54** | **9,652.55** | **9,716.96** | **9,720.31** | **67.76** | **(195.93)** | **(142.00)** | **1,660.11** | **57.57** | **(138.25)** | **(148.16)** |
| **UHT GROUP** | | | | | | | | | | | | |
| Agency | 50.08 | 35.93 | 32.19 | 39.40 | 39.28 | 7.09 | 3.26 | 5.33 | (6.61) | (59.23) | (14.62) | 2.59 |
| Bank | 488.35 | 421.23 | 408.46 | 439.35 | 517.15 | 108.69 | (43.51) | (57.94) | 132.69 | (110.01) | (77.25) | (15.21) |
| Substantive | 14,705.73 | 14,624.11 | 14,574.31 | 14,634.72 | 14,557.54 | (16.77) | (280.69) | (210.53) | 2,061.39 | 192.24 | (260.83) | (260.19) |
| **Grand Total** | **15,244.16** | **15,081.27** | **15,014.96** | **15,113.46** | **15,113.97** | **99.01** | **(320.94)** | **(263.14)** | **2,187.47** | **23.00** | **(352.70)** | **(272.80)** |

Month 4 shows a net overall increase of 99.01wte worked across the Group, compared to the WTE worked reported in the previous month. The in-month change in WTE was a 31.25wte increase at NTH and a 67.76wte decrease at STH.

Compared to the same period last year (Month 4 2025/26) WTEs were lower by 320.94wte. WTEs worked in month were 272.80wte lower than the average of the previous financial year.

WTEs worked remains higher than the average deployed during 2019/20 (pre-Covid), by 2,187.47wte (16.9%). However, the increase over this time period includes workforce investment to remedy CQC safety and quality concerns and also to deliver additional commissioner funded services

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

| WTE Worked | Mth 1 26/27 | Mth 2 26/27 | Mth 3 26/27 | Q1 Avg 26/27 | Mth 4 26/27 | Change from prior month | Change from M4 25/26 | Change from M12 25/26 | Change from 19/20 avg | Change from 23/24 avg | Change from 24/25 avg | Change from 25/26 avg |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NTH** | | | | | | | | | | | | |
| Nursing & Midwifery | 1,706.37 | 1,680.93 | 1,671.37 | 1,686.22 | 1,683.33 | 11.96 | (14.71) | (53.06) | 302.21 | 75.82 | 1.03 | (25.25) |
| Medical & Dental | 576.96 | 594.22 | 595.88 | 589.02 | 595.37 | (0.51) | 2.58 | (0.84) | 60.23 | 39.90 | 9.42 | (2.14) |
| AHP, Sci., Ther.&Tech. | 570.38 | 570.05 | 571.46 | 570.63 | 571.06 | (0.40) | 3.94 | 9.13 | 30.74 | (17.22) | (32.93) | 6.63 |
| HCAs & Support Staff | 1,027.15 | 1,004.32 | 986.04 | 1,005.84 | 1,010.35 | 24.31 | (9.29) | (47.71) | 60.83 | (41.29) | (39.66) | (27.88) |
| Non Clinical | 1,559.51 | 1,537.21 | 1,537.66 | 1,544.79 | 1,533.55 | (4.11) | (107.53) | (28.66) | 73.35 | (91.79) | (152.32) | (76.01) |
| **Sub Total** | **5,440.37** | **5,386.73** | **5,362.41** | **5,396.50** | **5,393.66** | **31.25** | **(125.01)** | **(121.14)** | **527.36** | **(34.58)** | **(214.45)** | **(124.65)** |
| **STH** | | | | | | | | | | | | |
| Nursing & Midwifery | 3,171.20 | 3,125.17 | 3,107.16 | 3,134.51 | 3,155.28 | 48.12 | (15.06) | (37.47) | 649.22 | 197.15 | 59.78 | (2.80) |
| Medical & Dental | 1,413.38 | 1,385.28 | 1,402.16 | 1,400.27 | 1,393.78 | (8.38) | 1.74 | (31.86) | 151.02 | 74.84 | 17.50 | (6.39) |
| AHP, Sci., Ther.&Tech. | 1,609.51 | 1,604.17 | 1,595.32 | 1,603.00 | 1,594.22 | (1.10) | 8.14 | (12.79) | 369.02 | 109.46 | 23.64 | (6.73) |
| HCAs & Support Staff | 1,608.26 | 1,586.01 | 1,565.05 | 1,586.44 | 1,584.90 | 19.85 | (71.07) | (37.83) | 160.55 | (170.75) | (87.79) | (51.31) |
| Non Clinical | 2,001.44 | 1,993.91 | 1,982.86 | 1,992.74 | 1,992.13 | 9.27 | (119.68) | (22.05) | 330.30 | (153.14) | (151.37) | (80.93) |
| **Sub Total** | **9,803.79** | **9,694.54** | **9,652.55** | **9,716.96** | **9,720.31** | **67.76** | **(195.93)** | **(142.00)** | **1,660.11** | **57.57** | **(138.25)** | **(148.16)** |
| **UHT GROUP** | | | | | | | | | | | | |
| Nursing & Midwifery | 4,877.57 | 4,806.10 | 4,778.53 | 4,820.73 | 4,838.61 | 60.08 | (29.77) | (90.53) | 951.44 | 272.97 | 60.81 | (28.05) |
| Medical & Dental | 1,990.34 | 1,979.50 | 1,998.04 | 1,989.29 | 1,989.15 | (8.89) | 4.32 | (32.70) | 211.25 | 114.74 | 26.92 | (8.53) |
| AHP, Sci., Ther.&Tech. | 2,179.89 | 2,174.22 | 2,166.78 | 2,173.63 | 2,165.28 | (1.50) | 12.08 | (3.66) | 399.76 | 92.24 | (9.29) | (0.10) |
| HCAs & Support Staff | 2,635.41 | 2,590.33 | 2,551.09 | 2,592.28 | 2,595.25 | 44.16 | (80.36) | (85.54) | 221.38 | (212.04) | (127.46) | (79.18) |
| Non Clinical | 3,560.95 | 3,531.12 | 3,520.52 | 3,537.53 | 3,525.68 | 5.16 | (227.21) | (50.71) | 403.65 | (244.93) | (303.69) | (156.94) |
| **Sub Total** | **15,244.16** | **15,081.27** | **15,014.96** | **15,113.46** | **15,113.97** | **99.01** | **(320.94)** | **(263.14)** | **2,187.47** | **22.99** | **(352.71)** | **(272.81)** |

The Month 4 position includes a reduction of 320.94wte Non-Clinical staff compared to the same period last financial year, with an in-month increase of 5.16wte across the Group.

**Capital**

The Group's gross capital expenditure plan for the 2026/27 financial year totalled £68.5m at the start of the financial year.

The Group's ICS operational Capital Departmental Expenditure Limit (CDEL) for 2026/27 totals £34.3m. In addition, the Group has been awarded additional CDEL allocations of £14.0m for Return to Constitutional Standards and £3.2m from the Estates Safety fund. The plan also includes expected PFI lifecycle costs of £7.5m (the cost of which sits outside the ICS CDEL limit).

The capital programme also includes externally funded schemes for RAAC eradication (funded by Public Dividend Capital (PDC) of £11.8m, and de-carbonisation schemes, supported with Salix grant funding of £13.9m across the Group.

Since plan submission, STH has received an additional £2m of bonus CDEL resource in relation to urgent and emergency care performance in 2025/26.

The Group's capital expenditure to the end of Month 4 amounted to £8.7m, as detailed in the table below.

| | Group | | | |
|---|---|---|---|---|
| | YTD Plan £000 | YTD Actual £000 | YTD Variance £000 | FOT £000 |
| Equipment | 1,122 | 999 | (123) | 14,905 |
| Digital | 1,152 | 1,329 | 177 | 6,020 |
| Estates | 2,339 | 2,716 | 377 | 26,474 |
| PFI | 2,500 | 2,505 | 5 | 8,006 |
| Decarbonisation | 0 | 657 | 657 | 3,798 |
| RAAC | 3,368 | 200 | (3,168) | 11,810 |
| IFRS 16 | 1,129 | 331 | (798) | 3,539 |
| **Total Gross Capital** | **11,610** | **8,737** | **(2,873)** | **74,552** |

**Efficiency**

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

| | NTH | | | | STH | | | | GROUP | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2026/27 Total Plan Forecast | Plan £000 | Forecast £000 | % of FOT | Change £000 | Plan £000 | Forecast £000 | % of FOT | Change £000 | Plan £000 | Forecast £000 | % of FOT | Change £000 |
| Fully Developed | 1,975 | 20,035 | 80% | 18,060 | 7,624 | 48,206 | 85% | 40,582 | 9,599 | 68,241 | 84% | 58,642 |
| Plans in Progress | 13,804 | 1,076 | 4% | -12,728 | 33,934 | 5,861 | 10% | -28,073 | 47,738 | 6,937 | 8% | -40,801 |
| Opportunity | 9,221 | 3,889 | 16% | -5,332 | 15,142 | 2,633 | 5% | -12,509 | 24,363 | 6,522 | 8% | -17,841 |
| Unidentified | 0 | 0 | 0% | 0 | 0 | 0 | 0% | 0 | 0 | 0 | 0% | 0 |
| **Total** | **25,000** | **25,000** | **100%** | **0** | **56,700** | **56,700** | **100%** | **0** | **81,700** | **81,700** | **100%** | **0** |
| High Risk | 14,681 | 8,411 | 34% | -6,270 | 29,051 | 14,928 | 26% | -14,123 | 43,732 | 23,339 | 29% | -20,393 |
| Medium risk | 5,506 | 7,118 | 28% | 1,612 | 17,784 | 21,925 | 39% | 4,141 | 23,289 | 29,043 | 36% | 5,754 |
| Low Risk | 4,813 | 9,471 | 38% | 4,658 | 9,865 | 19,847 | 35% | 9,982 | 14,679 | 29,318 | 36% | 14,639 |
| **Total** | **25,000** | **25,000** | **100%** | **0** | **56,700** | **56,700** | **100%** | **0** | **81,700** | **81,700** | **100%** | **0** |
| Recurrent | 16,434 | 18,344 | 73% | 1,910 | 38,560 | 39,671 | 70% | 1,111 | 54,994 | 58,015 | 71% | 3,021 |
| Non-recurrent | 8,566 | 6,656 | 27% | -1,910 | 18,140 | 17,029 | 30% | -1,111 | 26,706 | 23,685 | 29% | -3,021 |
| **Total** | **25,000** | **25,000** | **100%** | **0** | **56,700** | **56,700** | **100%** | **0** | **81,700** | **81,700** | **100%** | **0** |

De-risking of the CIP programme and maximising recurrent in-year delivery continues to be a key area of focus for the Financial Recovery Oversight Group and CSU CIP meetings. There continues to be positive movement in development of schemes and de-risking of the programme since Final Plan submission in March, as schemes are progressed to completion of full PID and QEIA documentation.

At the end of the reporting period none of the CIP programme remains 'Unidentified', however £6.5m remains defined as 'Opportunity' (which is a reduction of £17.8m since plan submission). £23.3m of the programme is categorised as High Risk (which is a reduction of £20.4m since plan submission).

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

| | NTH | | | | STH | | | | GROUP | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| YTD Month 4 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 | 3,517 | 3,741 | 224 | 106% | 6,124 | 4,653 | -1,471 | 76% | 9,641 | 8,394 | -1,247 | 87% |
| Non Pay | 3,398 | 2,225 | -1,173 | 65% | 9,095 | 8,048 | -1,047 | 88% | 12,493 | 10,273 | -2,220 | 82% |
| Income | 297 | 928 | 631 | 312% | 1,312 | 3,119 | 1,807 | 238% | 1,609 | 4,047 | 2,438 | 252% |
| **Total** | **7,213** | **6,894** | **-319** | **96%** | **16,531** | **15,820** | **-711** | **96%** | **23,743** | **22,714** | **-1,029** | **96%** |
| Recurrent | 5,359 | 5,034 | -325 | 94% | 11,262 | 10,473 | -789 | 93% | 16,621 | 15,507 | -1,114 | 93% |
| Non-recurrent | 1,853 | 1,860 | 7 | 100% | 5,269 | 5,347 | 78 | 101% | 7,122 | 7,207 | 85 | 101% |
| **Total** | **7,213** | **6,894** | **-319** | **96%** | **16,531** | **15,820** | **-711** | **96%** | **23,743** | **22,714** | **-1,029** | **96%** |
| Recurrent % | 74% | 73% | -1% | - | 68% | 66% | -2% | - | 70% | 68% | -2% | - |

Across the Group, overall year-to-date delivery is £22.7m (96% of target). However, this position includes a number of non-recurrent schemes. Delivery of recurrent savings is £1.1m behind plan at the end of Month 4, constituting 68% of YTD delivery across the Group.

## Liquidity

The cash balance at the end of Month 4 stood at £112.4m for the Group. The month end revenue cash balance at NTH was £42.8m (equating to 34.8 operating expenditure days) and £43.5m at STH (equating to 15.7 operating expenditure days). The year-end balance sheet cash balance is forecast to be £60.0m at NTH and £35.0m at STH.

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

| 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 | 23,481 | 91,218 | 38,208 | 261,557 | 61,689 | 352,775 |
| Total bills paid within target | 22,947 | 90,133 | 36,941 | 235,261 | 59,888 | 325,394 |
| **Percentage of bills paid within target** | **97.7%** | **98.8%** | **96.7%** | **89.9%** | **97.1%** | **92.2%** |

## Statement of Financial Position

The table below shows the draft balance sheet position for the two Trusts as at the end of Month 4 2026/27:

| | NTH £000 | STH £000 |
|---|---|---|
| **Non-current assets** | | |
| Intangible assets | 3,091 | 5,727 |
| On-SoFP IFRIC 12 assets | 0 | 139,939 |
| Other property, plant and equipment (excludes leases) | 147,532 | 161,738 |
| Right of use assets - leased assets for lessee (excluding PFI/LIFT) | 15,155 | 32,950 |
| Receivables: due from NHS and DHSC group bodies | 512 | 1,123 |
| Receivables: due from non-NHS/DHSC Group bodies | 1,524 | 2,206 |
| Credit Loss Allowances | 0 | (685) |
| **Total non-current assets** | **167,814** | **342,998** |
| **Current assets** | | |
| Inventories | 7,219 | 15,394 |
| Receivables: due from NHS and DHSC group bodies | 5,092 | 21,486 |
| Receivables: due from non-NHS/DHSC Group bodies | 26,112 | 18,286 |
| Credit Loss Allowances | (4,532) | (4,057) |
| Other Assets | 0 | 16,802 |
| Cash and cash equivalents: GBS/NLF | 51,995 | 56,777 |
| Cash and cash equivalents: commercial/in hand/other | 4 | 3,621 |
| **Total current assets** | **85,890** | **128,309** |
| **Current liabilities** | | |
| Trade and other payables: capital | (2,627) | (10,587) |
| Trade and other payables: non-capital | (54,985) | (148,999) |
| Borrowings | (3,960) | (22,630) |
| Other financial liabilities | (680) | |
| Provisions | (1,954) | (1,357) |
| Other liabilities: deferred income including contract liabilities | (7,738) | |
| **Total current liabilities** | **(71,944)** | **(183,573)** |
| **Total assets less current liabilities** | **181,760** | **287,734** |
| **Non-current liabilities** | | |
| Borrowings | (27,735) | (244,734) |
| Provisions | (1,425) | (1,304) |
| **Total non-current liabilities** | **(29,160)** | **(246,038)** |
| **Total net assets employed** | **152,600** | **41,696** |
| **Financed by** | | |
| Public dividend capital | 215,014 | 507,293 |
| Revaluation reserve | 12,836 | 25,627 |
| Other reserves | 0 | 26,476 |
| Income and expenditure reserve | (75,250) | (517,700) |
| **Total taxpayers' and others' equity** | **152,600** | **41,696** |
| | | |
| **Debtor Days** | **26.0** | **15.0** |
| **Creditor Days** | **163.0** | **158.1** |

## 4. RECOMMENDATIONS

Members of the Board are asked to:

- Note the financial position for Month 4 2026/27

University Hospitals Tees

# Integrated Performance Report (reporting to end June 2026)

**Meeting date:** 3 September 2026

**Reporting to:** Board of Directors

**Agenda item No:** 4.3

**Report author:** Lucy Tulloch, Group Director Planning & Intelligence and Lynsey Atkins, Associate Director Planning, Performance & Improvement

**Executive director sponsor:** Russell Nightingale, Chief Delivery Officer

**Action required:** Assurance

**Delegation status:** Jointly delegated item to Group Board

**Previously presented to:** Resources Committee, Quality Assurance Committee, People Committee

## UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☐

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☒

## CQC domain link:

Well-led

## Board assurance / risk register this paper relates to:

Quality and Safety

People

Finance

Performance and Compliance

## Key discussion points and matters to be escalated from the meeting

The UHT Integrated Performance Report (IPR) provides, within one document, a consistent presentation of key metrics for each trust, and an aggregate UHT view. The narrative highlights performance trends and where applicable the actions in hand to address variance from plan. The alert, advise and assure framework is used to provide a clear line of sight on metric performance. Whilst underpinned by a larger number of measures and other evidence used to govern, manage and improve our services, these can be viewed as the sentinel metrics for the performance of the organisations. The IPR reports on the key standards by which Trusts' performance is monitored, reflecting the NHS Operating Framework 2025/26 published June 2025.

The IPR for reporting month of June 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 five performance metrics remain as Alert assurance.

- MSSA infections
- Readmission Rate
- Cancelled operations not rebooked in 28 days
- Cancer Faster Diagnosis
- Complaints Closed Within Target (%)
- Sickness Absence (%)

For STHFT, the following six performance metrics remain as Alert assurance:

- *Klebsiella* infections
- Breast feeding at first feed
- Cancelled Operations Not Rebooked In 28 Days
- Maternity Experience (%)
- Complaints Closed Within Target (%)
- Annual Appraisal (%)
- Sickness Absence (%)

**Complaints Closed Within Target** is retained as Alert across UHT reflecting the performance consistently below target; improvement actions are being expedited and monitored monthly at Quality Committee.

In addition for NTHFT, five metrics have been regraded to Alert for June 2026. In addition for STHFT, two metrics have been regraded to Alert for June 2026.

In the QUALITY domain, ***E.Coli Infections*** for NTHFT has been regraded from Assure as cases are 28% (5 cases) above trajectory year to date. ***Klebsiella Infections*** for NTHFT is regraded from advise as cases are 67% (2 cases above year-to-date trajectory. **Breast Feeding at First Feed** for NTHFT is regraded from Advise, as below target with no ongoing improvement trend

In the RESPONSIVE domain, **RTT 52 Week Waiters %** performance for NTHFT has declined for 7 consecutive months, regrading this metric from Advise to Alert.

In the WELL LED domain, **Annual Appraisal %** for NTHFT is regraded from Advise following a deteriorating performance trend.

In the CARING domain, **Outpatient Experience (%)** for STHFT is regraded from Advise due to recent poorer performance, the plan is no longer assured. **Feedback Acknowledged in 3 Days (%)** for STHFT is regraded from Advise following a low-performance outlier, outside of expected variance, for June 2026.

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

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

The majority of IPR metrics remain graded Advise, for both Trusts.

**Incidents per 1000 Bed Days** is regraded from Alert for both Trusts; a trend of reduced incident reporting has now stabilised.

In addition, for NTHFT, a further three metrics have been regraded to Advise in July 2026.

In the RESPONSIVE domain **Community UCR 2 Hour Response (%) is** regraded from Alert; following a period of declining performance, compliance has returned above the average May 2026. **The Cancer 62 Day Standard** returned to advise from Alert, as performance has returned within expected variance June 2026.

In the CARING domain, **Feedback Acknowledged in 3 days (%)** the plan remains assured with no variance for 23 months, however, due to an outlier in June 2026, performance has regraded from Assure. To note, the consistently compliant performance which is now expected each month means increased sensitivity to report any month-on-month variation in performance as an exception to the underlying process.

In addition, for STHFT, a further four metrics have been regraded to Advise in June 2026.

In the SAFE domain, **C. difficile Infections** regraded from assure, as 7%, 2 cases worse than trajectory YTD. **PPH >= 1500ml rate per 1,000 births** regraded from Alert, rate fluctuates within expected variation.

In the RESPONSIVE domain, the **Community 18-Week Compliance** is regraded from Assure after recent poorer performance.

In the WELL-LED domain, **Mandatory training (%)** regraded from alert as performance has returned within expected variation, and above previous average, following a sustained period of deterioration.

**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 six metrics:

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

Further to the six metrics, **Staff Turnover (%)** stabilised within target and is regraded from Advise.

For STHFT, assurance continues for three metrics:

- *E. coli* infections
- *Pseudomonas* infections
- Summary Hospital-Level Mortality Indicator

Further to the three metrics, **Staff Turnover %** is regraded from Advise stable and within target, plan continues to be assured. **Community UCR 2 Hour Response (%)** regraded from Advise, as the lower limits of usual performance are consistently above target. **Community Experience (%)** regraded from Advise, standard consistently met.

## Recommendations:

Members of the Board are asked to:

- Receive the Integrated Performance Report for the reporting period June 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:**

**June 2026**

Caring
Better
Together

# Index of metrics

**SAFE DOMAIN**
**Responsibility: Quality Assurance Committee**

Incidents per 1000 Bed Days
Patient Safety Incident Investigations
Never Events
Falls with Harm per 1000 Bed Days
*C. difficile* infections
MRSA infections
*E. coli* infections
MSSA infections
*Klebsiella* infections
*Pseudomonas* infections
Still Births Rate (Rolling 12 months, per 1000 Births)
Neonatal Mortality Rate (rolling 12 months, per 1,000 births)
Breast Feeding at First Feed (%)
PPH >= 1500ml Rate per 1,000 births
3rd/4th Degree Tear (%)

**EFFECTIVE DOMAIN**
**Responsibility: Quality Assurance Committee**

Summary Hospital-Level Mortality Indicator
Readmission Rate (%)
Discharge Delays Average (days)

**RESPONSIVE DOMAIN**
**Responsibility: Resources Committee**

NEAS Handovers – Over 45 mins (%)
4-Hour A&E Standard (%)
12-Hour ED Breaches Rate (%)
Community UCR 2 Hour Response (%)
Cancelled Operations Not Rebooked in 28 Days
Cancer Faster Diagnosis Standard (%)
Cancer 31 Day Standard (%)
Cancer 62 Day Standard (%)
Diagnostic 6 Weeks Standard (%)
RTT Incomplete Pathways (%)
RTT 52 Week Waiters (%)
Community 18 Week Wait Compliance (%)
Community over 52-week Waiters (%)

**CARING DOMAIN**
**Responsibility: Quality Assurance Committee**

A&E Experience (%)
Inpatient Experience (%)
Maternity Experience (%)
Outpatient Experience (%)
Community Experience (%)
Feedback Acknowledged in 3 Days (%)
Complaints Closed Within Target (%)

**WELL LED DOMAIN**
**Responsibility: People Committee, *Resources Committee (Finance only)**

Sickness Absence (%)
Staff Turnover (%)
Annual Appraisal (%)
Mandatory Training (%)
*Cumulative YTD Financial Position (£Millions)

# North Tees & Hartlepool assurance summary



## ALERT

### No change in assurance

- MSSA Infections
- Readmission Rate
- Cancelled operations not rebooked in 28 days
- Cancer Faster Diagnosis
- Complaints Closed Within Target (%)
  Sickness absence (%)

### New ALERT indicators

- ***E. coli* infections** regraded from Assure, 5 cases, 28% above trajectory YTD.
- ***Klebsiella* infections** regraded from Advise, 2 cases, 67% above trajectory YTD.
- **Breast feeding at first feed** as below target with no ongoing improvement trend.
- **RTT 52 Week Waiters (%)** regraded from Advise following a decline in performance for 7 consecutive months.
- **Annual Appraisal (%)** regraded from Advise following a deteriorating performance trend.

## ADVISE

### No change in assurance

- Patient Safety Incident Investigations
- Never Events
- Falls with Harm per 1000 Bed Days
- 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
- Ambulance Handover within 45 minutes
- 4 Hour A&E Standard
- 12-Hour ED Breaches Rate (%)
- Cancer 31 Day Standard
- Diagnostic 6 Week Standard
- RTT Incomplete Pathways (%)
- Community 18-week compliance
- Community 52-week waits%
- Inpatient Experience (%)
- Maternity Experience (%)
- Outpatient Experience (%)
- Community Experience (%)
- Mandatory Training (%)
- Cumulative YTD Financial Position (£Millions)

### New ADVISE indicators

- **Incidents per 1000 Bed Days** regraded from Alert, as trend of reduced incident reporting has stabilised.
- **Community UCR 2 Hour Response (%)** regraded from Alert, after a period of declining performance, compliance has returned above the average May 2026.
- **Cancer 62 Day Standard** regraded from Alert, performance returned within expected variation June 2026**.**
- **Feedback Acknowledged in 3 days (%)** regraded from Assure, outlier in June 2026.

## ASSURE

### No change in assurance

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

### New ASSURE indicators

- **Staff Turnover (%)** stabilised with target.

Caring Better Together

# South Tees Hospitals assurance summary



| No change in assurance | ALERT | New ALERT indicator |
|---|---|---|
| • *Klebsiella* infections<br>• Breast feeding at first feed<br>• Cancelled Operations Not Rebooked In 28 days | • Maternity Experience (%)<br>• Complaints Closed Within Target (%)<br>• Annual Appraisal (%)<br>• Sickness absence (%) | • **Outpatient Experience (%)** regraded from Advise, deteriorating performance for 7 consecutive months, plan no longer assured.<br>• **Feedback Acknowledged in 3 Days (%)** regraded from Advise; low outlier outside of expected variance June 2026 |

| No change in assurance | ADVISE | New ADVISE indicator |
|---|---|---|
| • Patient Safety Incident Investigations<br>• Never Events<br>• Falls with Harm per 1000 Bed Days<br>• MRSA infections<br>• MSSA infections<br>• Still birth rate (Rolling 12 months per 1000 Births)<br>• Neonatal Mortality Rate (rolling 12 months, per 1,000 births<br>• 3rd/4th Degree Tear (%)<br>• Readmission rate<br>• Discharge delay average days<br>• Ambulance handovers within 45 minutes<br>• 4-Hour A&E Standard (%)<br>• 12-Hour ED Breaches Rate (%) | • Diagnostic 6 Weeks Standard (%)<br>• Cancer Faster Diagnosis<br>• Cancer 31 Day Standard<br>• Cancer 62 Day Standard<br>• RTT Incomplete Pathways (%)<br>• RTT 52 Week Waiters (%)<br>• Community over 52-week Waiters (%)<br>• A&E Experience (%)<br>• Inpatient Experience (%)<br>• Cumulative YTD Financial Position (£Millions) | • **Incidents per 1000 Bed Days** regraded from Alert, reduced incident reporting has stabilised.<br>• ***C. difficile* Infections** regraded from Assure, 7%, 2 cases worse than trajectory YTD.<br>• **PPH >= 1500ml rate per 1,000 births** regraded from Alert, rate fluctuates within expected variation.<br>• **Community 18-week wait (%)** regraded from Assure after recent poorer performance.<br>• **Mandatory training (%**) regraded from Alert; performance returned within expected variation and above previous average following a sustained period of deterioration. |

| No change in assurance | ASSURE | New ASSURE indicator |
|---|---|---|
| • *E. coli* infections<br>• *Pseudomonas* infections<br>• Summary Hospital-Level Mortality Indicator | | • **Community UCR 2 Hour Response (%)** regraded from Advise, as performance stabilised above standard.<br>• **Community Experience (%)** regraded from Advise, standard consistently met.<br>• **Staff Turnover (%)** stable within target. |

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# SAFE DOMAIN SUMMARY

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

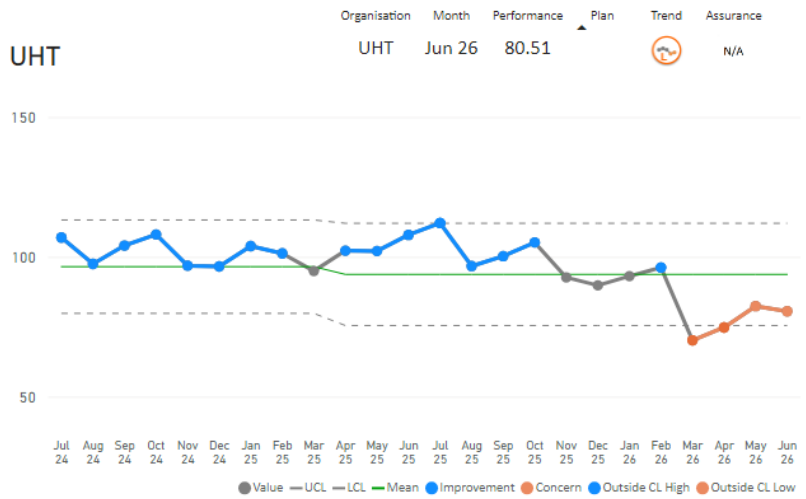
An external evaluation of implementation of PSIRF has been completed; the report identified positive progress and made recommendations to strengthen the Group's approach to patient safety, with improvement actions developed. These have informed the UHT PSIRF implementation plan which includes the development of a joint PSIRF plan and policy. The reporting of incidents is seen as a positive indicator of a safety culture; the move from Datix to Healthcare Guardian for STHFT, led to a reduction, incident reporting across both Trusts has now stabilised.

Healthcare-acquired infections (HCAI) plans align to NHS England target trajectories and continue to be challenging. HCAI are closely tracked by the Infection Prevention Strategic Group and an Improvement Plan developed and monitored, this is also again aligned to the UHT Quality Priorities for 2026/27. Opportunities for reducing HCAIs is centred on Antimicrobial Stewardship with the 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, with this demonstrated in the recent appointment of a clinical lead with responsibility for AMS. The IPC Board Assurance Framework encompasses all these measures.

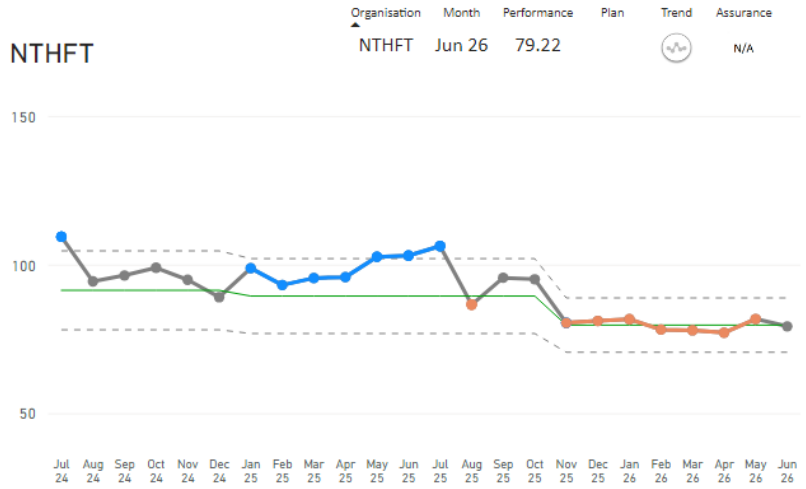
| North Tees & Hartlepool NHS FT | Plan | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Incidents Per 1000 Bed Days | | 106.22 | 86.51 | 95.56 | 95.05 | 80.38 | 81.04 | 81.61 | 78.12 | 77.88 | 77.09 | 81.69 | 79.22 |
| Patient Safety Incident Investigations | | 3 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| Never Events | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| Falls With Harm Rate (Per 1000 Bed Days) | | 0.14 | 0.21 | 0.07 | 0.21 | 0.07 | 0.21 | 0.19 | 0 | 0.42 | 0.3 | 0.15 | 0.38 |
| C-Difficile | 5 | 4 | 6 | 8 | 2 | 8 | 5 | 4 | 4 | 5 | 2 | 5 | 2 |
| MRSA | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| E-Coli | 6 | 12 | 12 | 10 | 9 | 6 | 12 | 7 | 6 | 12 | 4 | 8 | 11 |
| MSSA | 3 | 3 | 5 | 5 | 6 | 1 | 3 | 5 | 3 | 3 | 4 | 6 | 4 |
| Klebsiella | 1 | 2 | 0 | 2 | 3 | 2 | 4 | 3 | 5 | 5 | 1 | 1 | 3 |
| Pseudomonas | 0 | 2 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 0 |

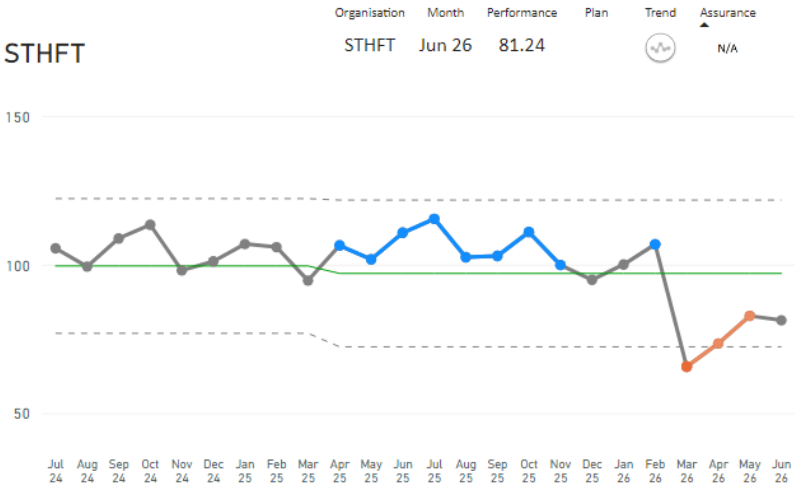
| South Tees Hospitals NHS FT | Plan | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Incidents Per 1000 Bed Days | | 115.38 | 102.47 | 102.88 | 110.94 | 99.83 | 94.85 | 100.01 | 106.79 | 65.66 | 73.44 | 82.72 | 81.24 |
| Patient Safety Incident Investigations | | 2 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 2 | 0 | 0 | 0 |
| Never Events | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 3 | 0 | 0 | 0 |
| Falls With Harm Rate (Per 1000 Bed Days) | | 0.21 | 0.08 | 0.25 | 0.08 | 0.21 | 0.12 | 0.19 | 0.09 | 0.28 | 0.16 | 0.16 | 0.26 |
| C-Difficile | 9 | 9 | 8 | 13 | 13 | 12 | 7 | 12 | 13 | 10 | 8 | 10 | 11 |
| MRSA | 0 | 1 | 1 | 0 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| E-Coli | 11 | 14 | 14 | 14 | 8 | 11 | 13 | 10 | 11 | 11 | 10 | 9 | 10 |
| MSSA | 7 | 8 | 11 | 6 | 7 | 5 | 6 | 9 | 7 | 8 | 8 | 8 | 4 |
| Klebsiella | 5 | 4 | 5 | 9 | 9 | 5 | 7 | 8 | 7 | 8 | 8 | 9 | 6 |
| Pseudomonas | 1 | 4 | 1 | 1 | 3 | 1 | 3 | 0 | 2 | 0 | 1 | 1 | 0 |

# 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:** Reduced number of incidents reported has stabilised at both trusts.
**Assurance:** NTHFT: Advise. STHFT: Advise.
**Action taken:** All CSUs have been asked to examine all areas of reporting and implement actions to further promote reporting. There are ongoing drop-in sessions, educational materials and communications to support staff accessing and using the new system.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

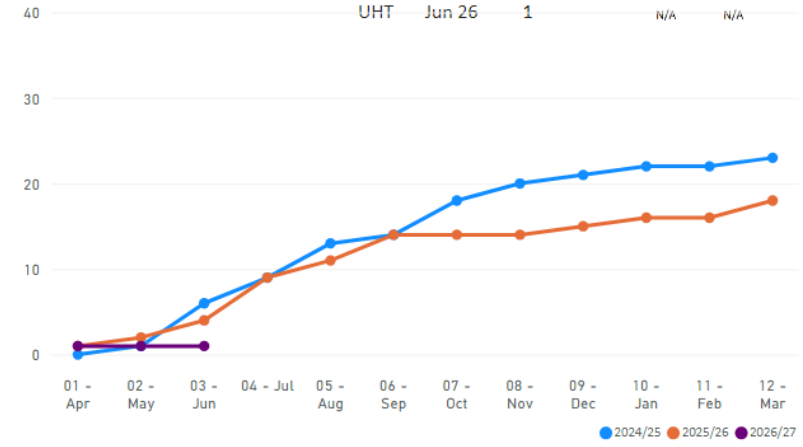


## SAFE Patient Safety Incident Investigations (YTD)

UHT

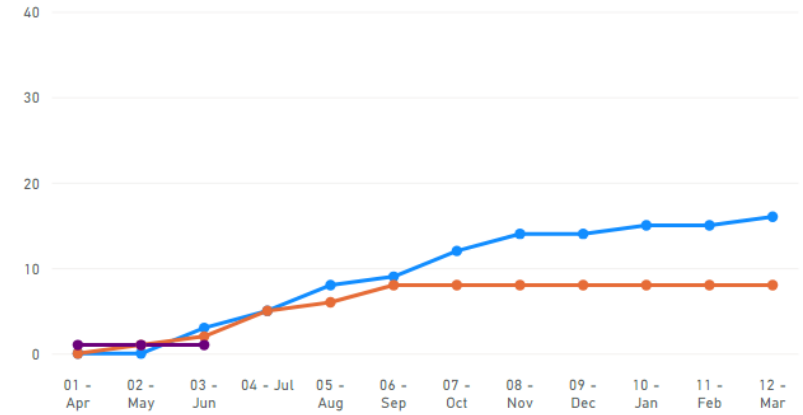
| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| UHT | Jun 26 | 1 | | N/A | N/A |




**Metric:** PSIIs initiated, cumulative annually from April.
**Plan:** n/a. An open reporting culture is encouraged.
**Rationale:** NHS Quality Accounts regulatory indicator.
**Data quality:** Assured. Each incident is validated.
**Trend:** NTHFT: Zero new PSII recorded in June, One PSII YTD. STHFT: Zero PSIIs in June 2026, Zero PSIIs YTD.
**Assurance:** n/a
**Action taken:** Incidents are reviewed at weekly group panels to determine how they are investigated under PSIRF. Recommendations and learning are monitored through Patient Safety Group and escalated to Quality Oversight Group, if requried.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

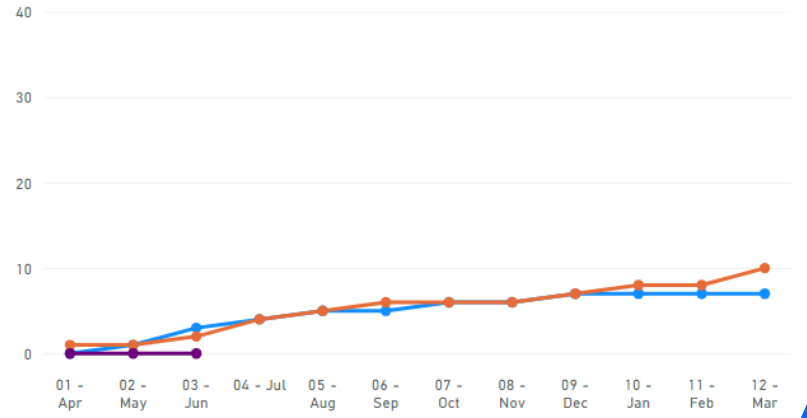
NTHFT

| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| NTHFT | Jun 26 | 1 | | N/A | N/A |

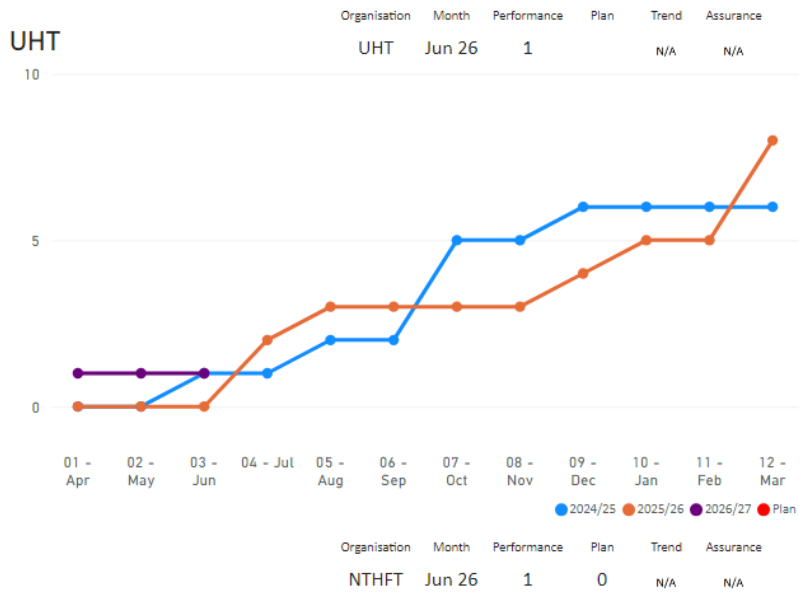


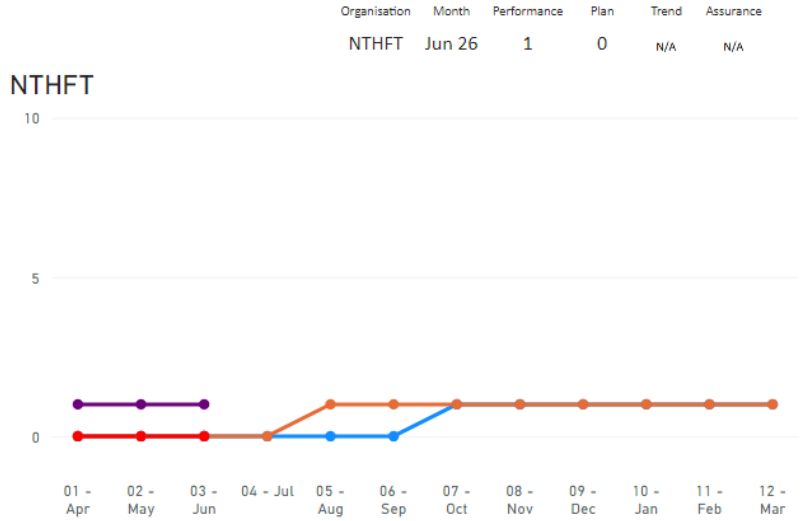

STHFT

| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| STHFT | Jun 26 | 0 | | N/A | N/A |

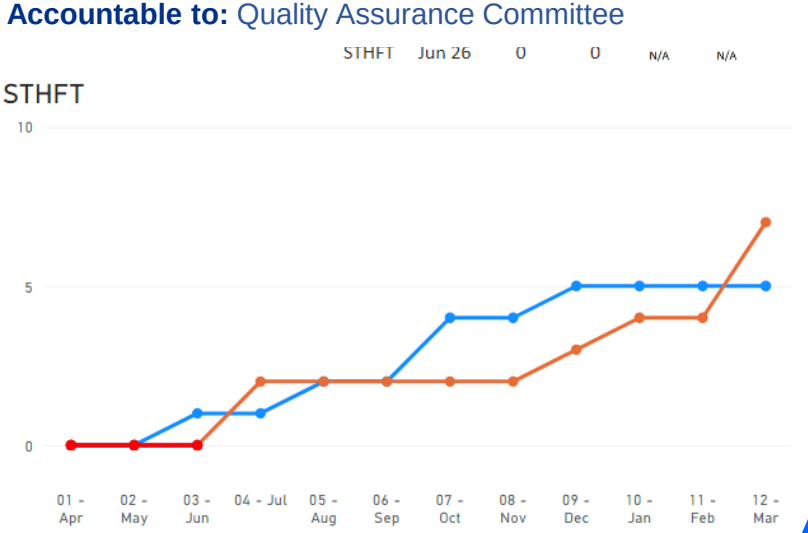


## SAFE Never Events (YTD)

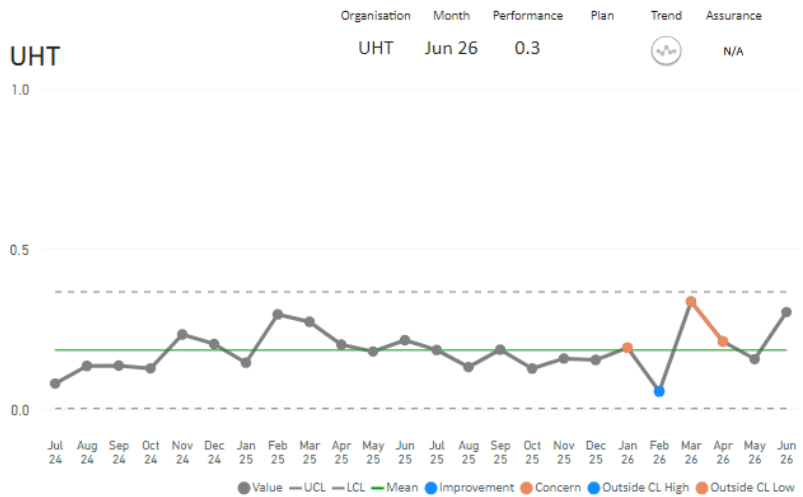


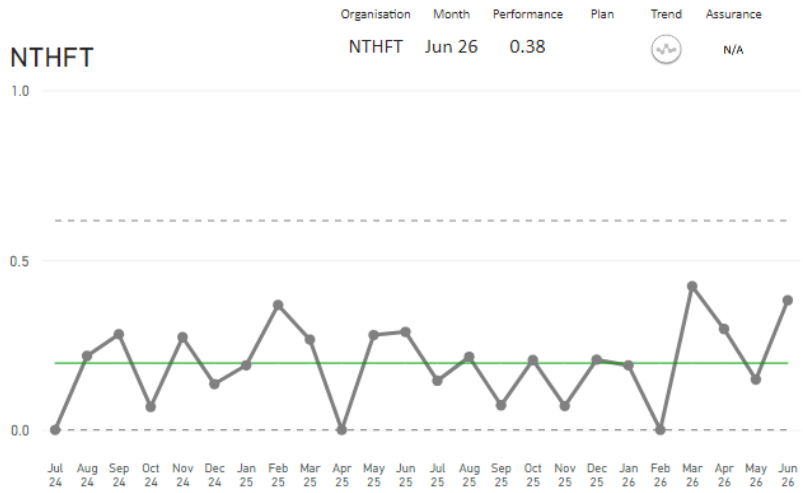

**Metric:** Never Events (a defined list of serious preventable errors), cumulative annually from April.
**Plan:** Zero.
**Rationale:** NHS Quality Accounts regulatory indicator.
**Data quality:** Assured. Each incident is validated.
**Trend:** NTHFT: Zero new never events reported in June 2026. STHFT: Zero new events recorded in June 2026.
**Assurance:** NTHFT: Advise, 1 YTD. STHFT: Advise, zero YTD.
**Action taken:** There is ongoing focus to strengthen UHT's approach to using national safety standards for invasive procedures. This is promoting collaborative approaches across the trusts in the development of joint LocSSIPs. The NHSE consultation is completed; further workshops will be held in 2026 to review the future of the Never Event framework. All are reported onto the national reporting system, with a proportionate investigation (not necessarily PSII).
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

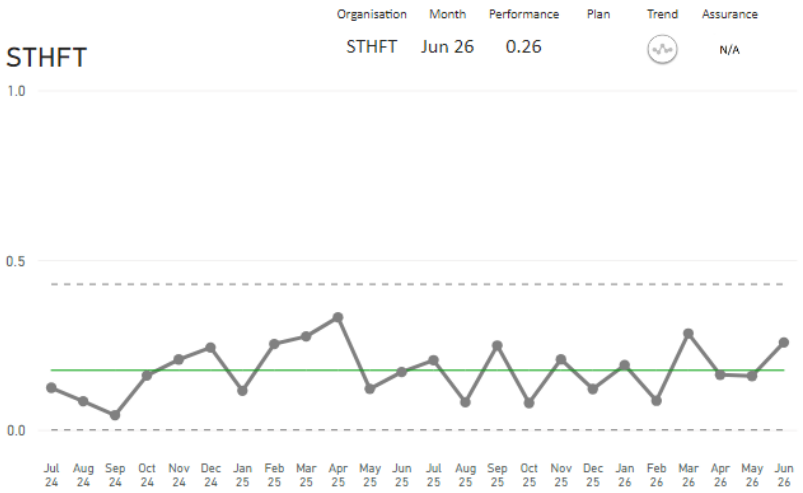


## SAFE Falls With Harm Rate (Per 1000 Bed Days)




**Metric:** Falls resulting in harm graded moderate and above, as a rate per 1000 inpatient bed-days.
**Plan:** n/a
**Rationale:** NHS Quality Accounts regulatory indicator. National Audit of Inpatient Falls.
**Data quality:** Assured. Each incident is validated.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** n/a
**Action taken:** The focus is on thematic learning from falls, targeted interventions and bringing together a single UHT approach to improve care for patients at risk of falls. The Falls improvement group has now moved to a UHT combined group.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

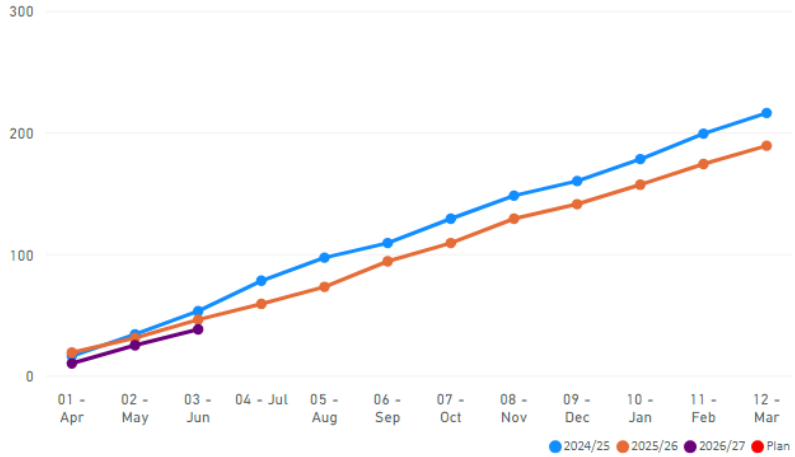


## SAFE C-Difficile (YTD)

UHT

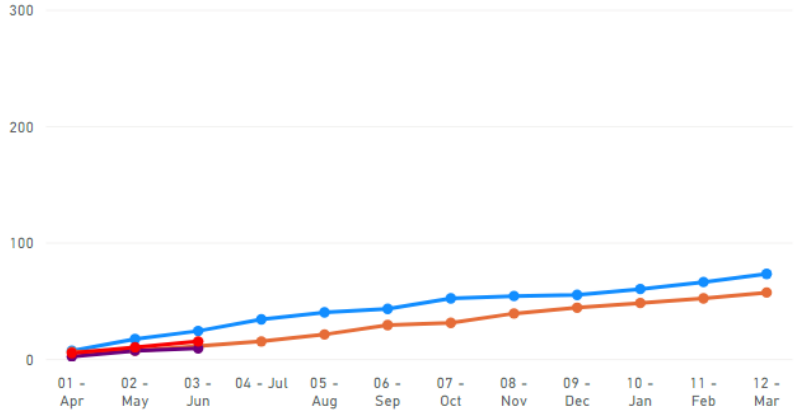
| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| UHT | Jun 26 | 38 | | N/A | N/A |




**Metric:** Healthcare associated cases of *Clostridioides difficile*, cumulative annually from April.
**Plan:** NHS standard contract trajectory: 10% decrease on 2025/26 financial year cases.
**Rationale:** NHS Contract indicator.
**Data quality:** Assured. Each incident is validated.
**Trend:** NTHFT: 2 new cases in June (trajectory of 5). STHFT: 11 new cases in June (trajectory of 9).
**Assurance:** NTHFT: Assure; 40%, 6 cases, better than trajectory YTD. STHFT: Advise; 7%, 2 cases, worse than trajectory YTD.
**Action taken:** Appropriate decant facility to be established. HPV fogging continues as gold standard. Audits to be aligned regarding commodes and sluice, waiting for implementation date.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

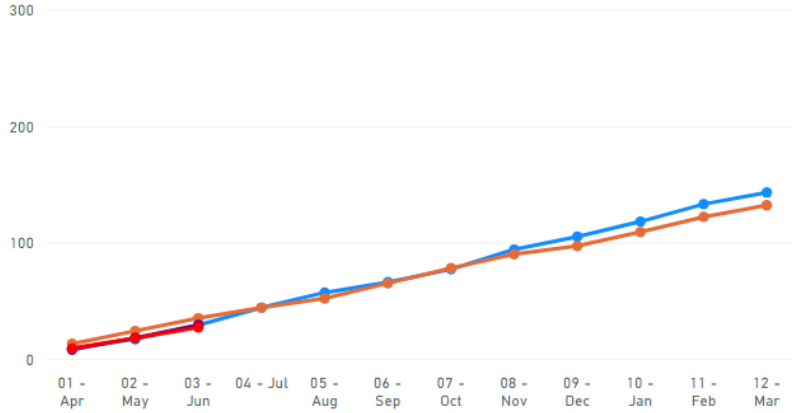
NTHFT

| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| NTHFT | Jun 26 | 9 | 15 | N/A | N/A |




STHFT

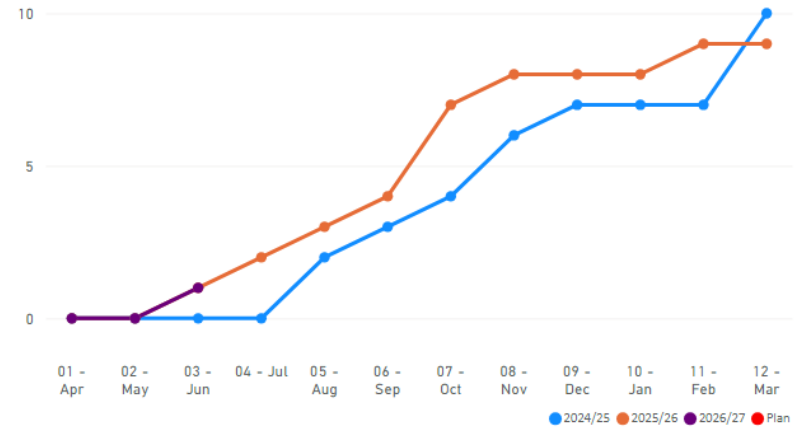
| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| STHFT | Jun 26 | 29 | 27 | N/A | N/A |



## SAFE MRSA (YTD)

UHT

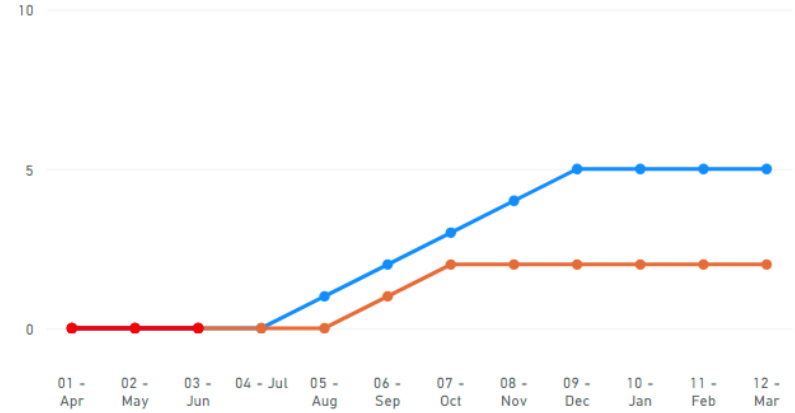
| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| UHT | Jun 26 | 1 | | N/A | N/A |




**Metric:** Healthcare associated cases of Methicillin resistant *Staphylococcus aureus*, cumulative annually from April.
**Plan:** Zero tolerance.
**Rationale:** NHS Contract indicator.
**Data quality:** Assured. Each incident is validated.
**Trend:** NTHFT No new cases in June 2026. STHFT: 1 new case in June 2026
**Assurance:** NTHFT: Assure, 0 cases YTD, STHFT: Advise, 1 case YTD.
**Action taken:** Alignment of policies to increase MRSA screening. Increased audit and education. Detailed learning is shared. Increased audit and surveillance in respect of line care.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

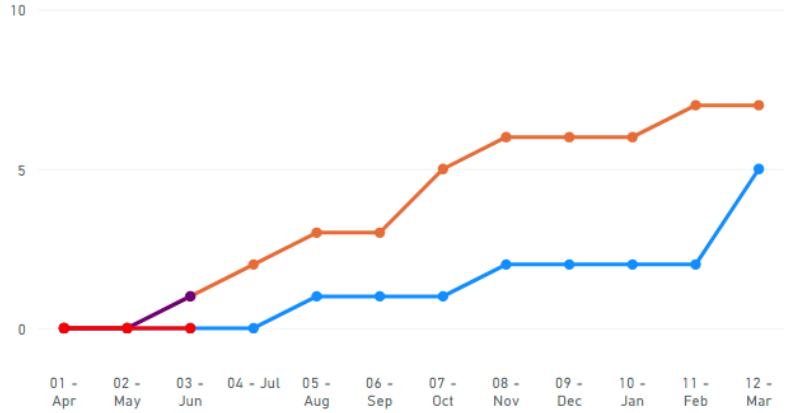
NTHFT

| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| NTHFT | Jun 26 | 0 | 0 | N/A | N/A |




STHFT

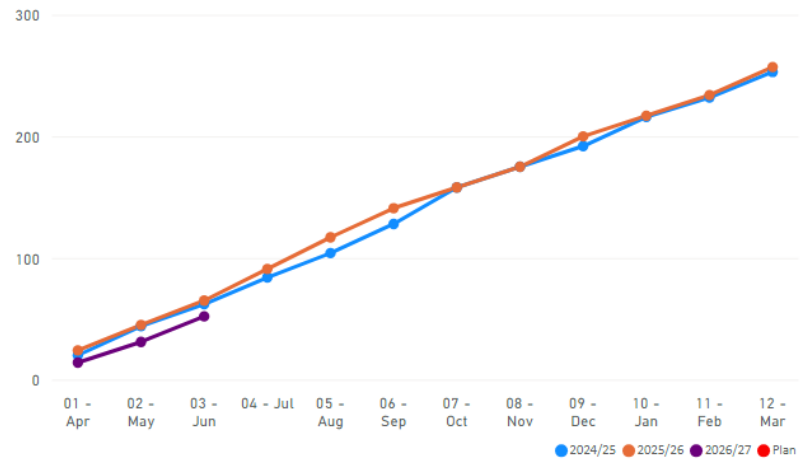
| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| STHFT | Jun 26 | 1 | 0 | N/A | N/A |



## SAFE E-Coli (YTD)

UHT

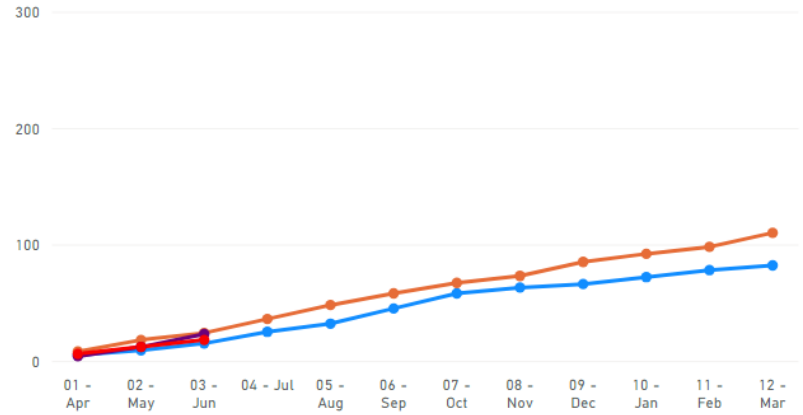
| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| UHT | Jun 26 | 52 | | N/A | N/A |




**Metric:** Healthcare associated cases of *Escherichia coli*, cumulative annually from April.
**Plan:** NHS standard contract trajectory: 10% decrease on 2025/26 financial year cases.
**Rationale:** NHS Contract indicator.
**Data quality:** Assured. Each incident is validated.
**Trend:** NTHFT: 11 cases June 2026 (trajectory of 6). STHFT: 11 cases in June 2026 (trajectory of 10).
**Assurance:** NTHFT: Alert, 5 cases, 28% above trajectory YTD. STHFT: Assure, 4 cases, 12% below trajectory YTD.
**Action taken:** Focus remains on catheter care with a particular community focus, supported regionally. Alignment of catheter associated UTI prevalence work across UHT including saving lives and Aseptic Non-Touch Technique (ANTT) audits.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

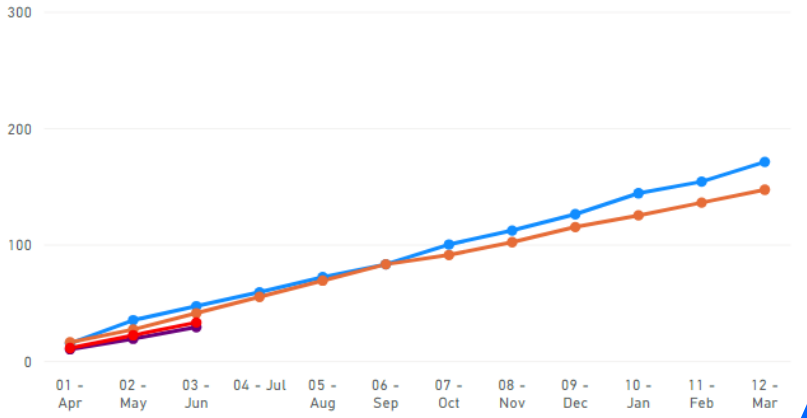
NTHFT

| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| NTHFT | Jun 26 | 23 | 18 | N/A | N/A |




STHFT

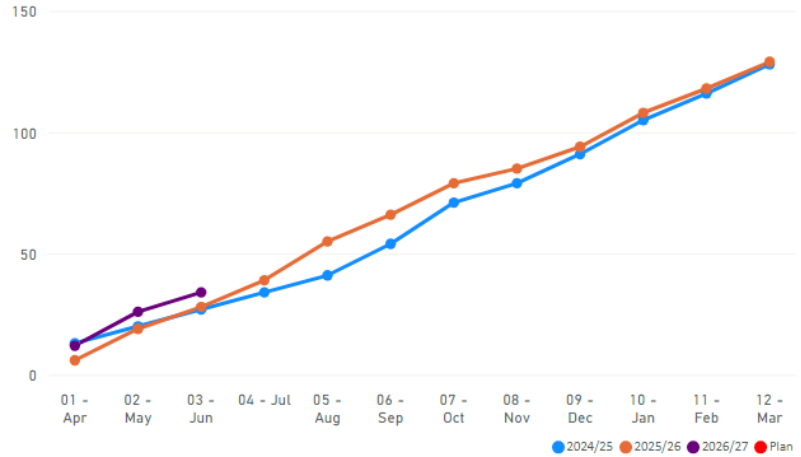
| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| STHFT | Jun 26 | 29 | 33 | N/A | N/A |



## SAFE MSSA (YTD)

UHT

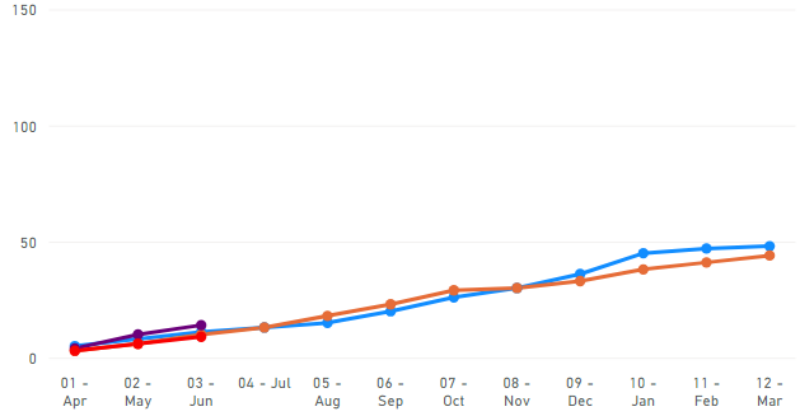
| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| UHT | Jun 26 | 34 | | N/A | N/A |




**Metric:** Healthcare associated cases of MSSA annually from April.
**Plan:** Local plan for 26/27 trajectory (no contractual plan).
**Rationale:** In line with other NHS Contract indicators.
**Data quality:** Assured. Each incident is validated.
**Trend:** NTHFT: 4 new cases in June 2026 (trajectory of 3).
STHFT: 3 new cases in June 2026 (trajectory of 7).
**Assurance:** NTHFT: Alert, 5 case, 55% worse than trajectory YTD. STHFT: Advise, 1 cases, 5% worse than trajectory YTD.
**Action taken:** UHT focus group continues with alignment of processes in respect of line care. Detailed audit and education aligned. Refreshed and revamped saving lives and ANTT audits across UHT.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

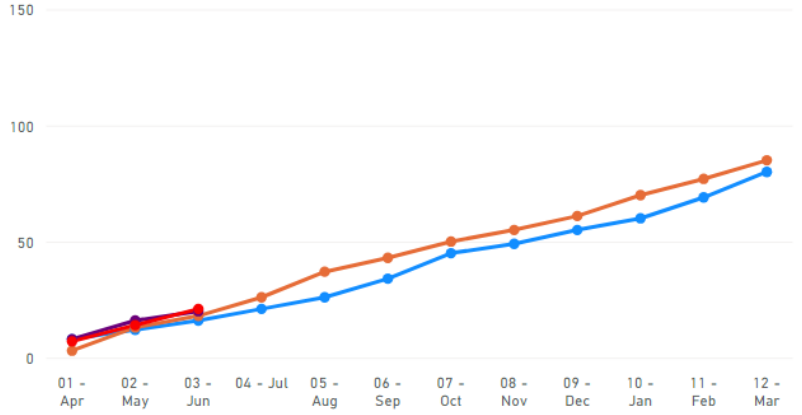
NTHFT

| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| NTHFT | Jun 26 | 14 | 9 | N/A | N/A |

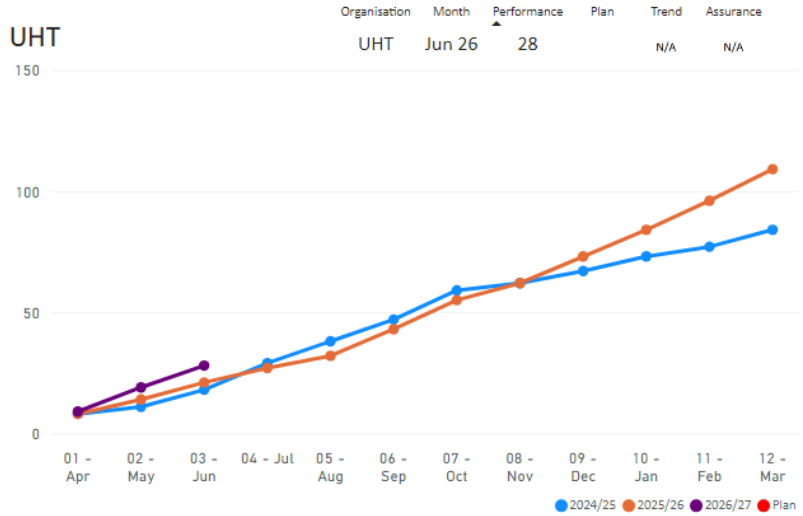



STHFT

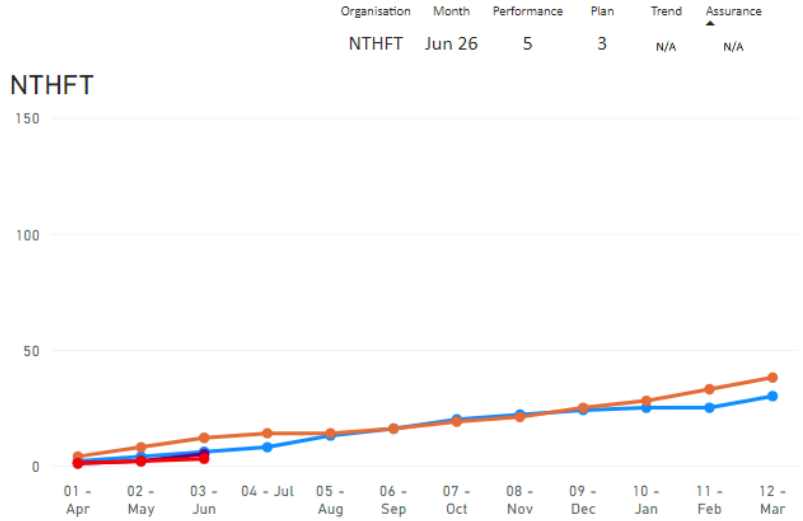
| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| STHFT | Jun 26 | 20 | 21 | N/A | N/A |

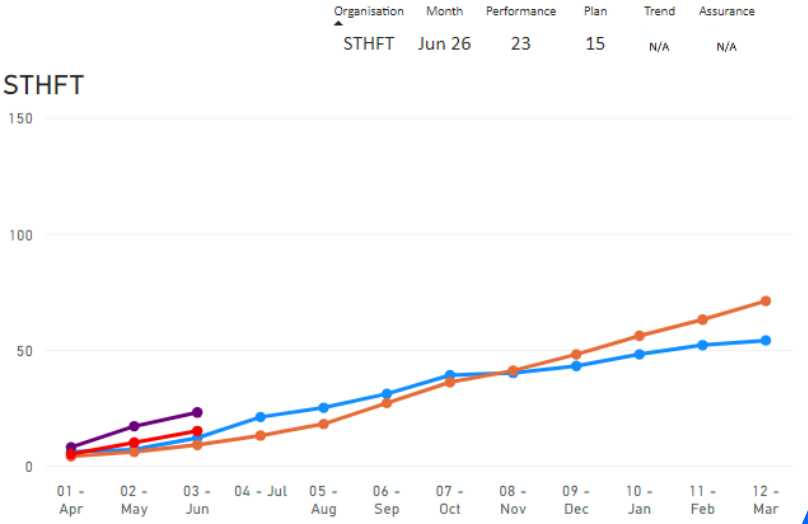


## SAFE Klebsiella (YTD)




**Metric:** Healthcare associated cases of *Klebsiella* infection, cumulative annually from April.
**Plan:** NHS standard contract trajectory: 10% decrease on 2025/26 financial year cases.
**Rationale:** NHS Contract indicator.
**Data quality:** Assured. Each incident is validated.
**Trend:** NTHFT: 3 new cases in June 2026 (trajectory of 1). STHFT: 6 new cases in June 2026 (trajectory of 5).
**Assurance:** NTHFT: Alert, 2 cases, 67% worse than trajectory YTD. STHFT: Alert, 7 cases, 53% worse than trajectory YTD.
**Action taken:** Urinary catheters indicated in cases, links to organisational focus on catheters including refreshed saving lives and ANTT audits. Increased communication on hand hygiene and line care across the wider community networks.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee



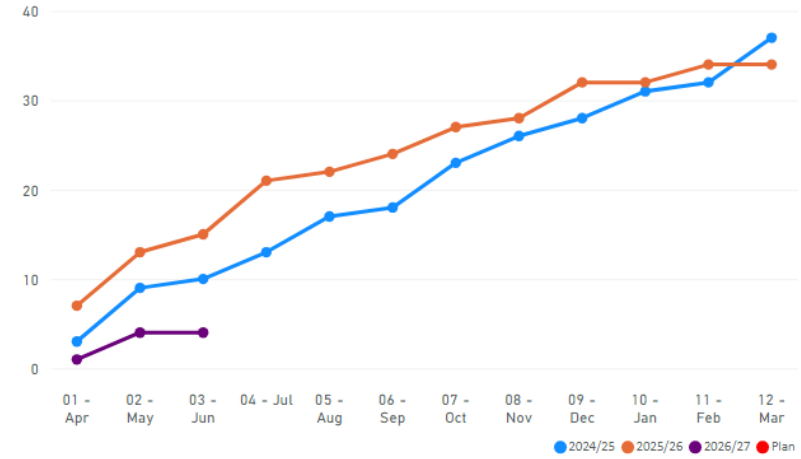

Caring Better Together

## SAFE Pseudomonas (YTD)

**Metric:** Healthcare associated cases of *Pseudomonas* infection, cumulative annually from April.
**Plan:** NHS standard contract trajectory: 10% decrease on 2025/26 financial year cases.
**Rationale:** NHS Contract indicator.
**Data quality:** Assured. Each incident is validated.
**Trend:** NTHFT: Zero new cases in June (trajectory of zero). STHFT: One new case in June (trajectory of zero).
**Assurance:** NTHFT: Advise, within tolerance YTD. STHFT: Assure, 1 case, 33%, better than trajectory YTD.
**Action taken**: Heightened awareness on water safety reporting and governance. Focussed drive on use of sinks and 'dangers in damp' campaign. Clear accountability in respect of water safety management across UHT.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

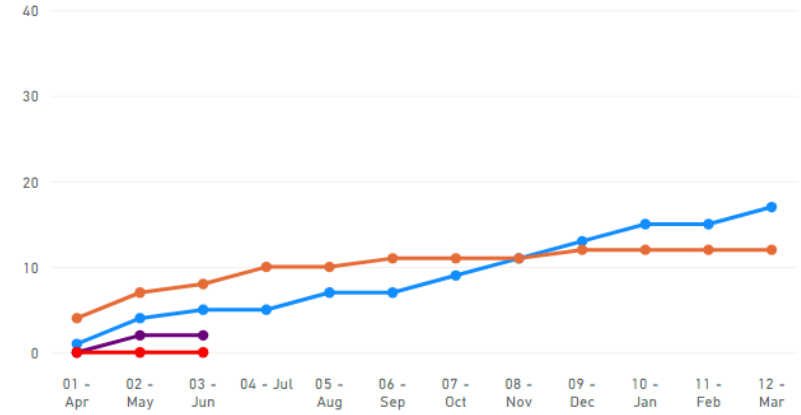
UHT

| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| UHT | Jun 26 | 4 | | N/A | N/A |



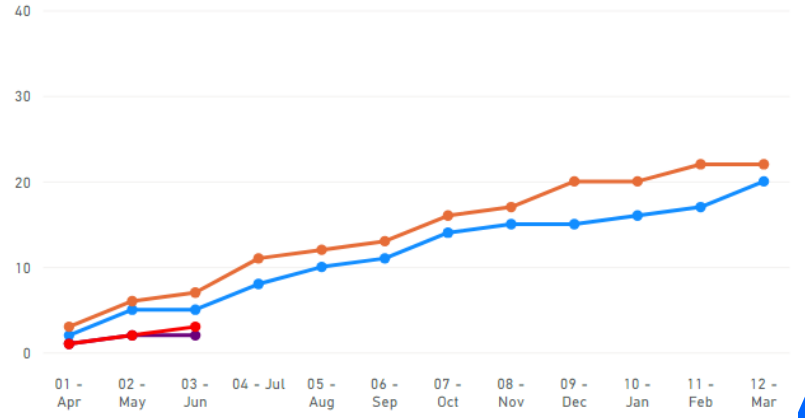

NTHFT

| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| NTHFT | Jun 26 | 2 | 0 | N/A | N/A |




STHFT

| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| STHFT | Jun 26 | 2 | 3 | N/A | N/A |



## SAFE MATERNITY SUMMARY

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

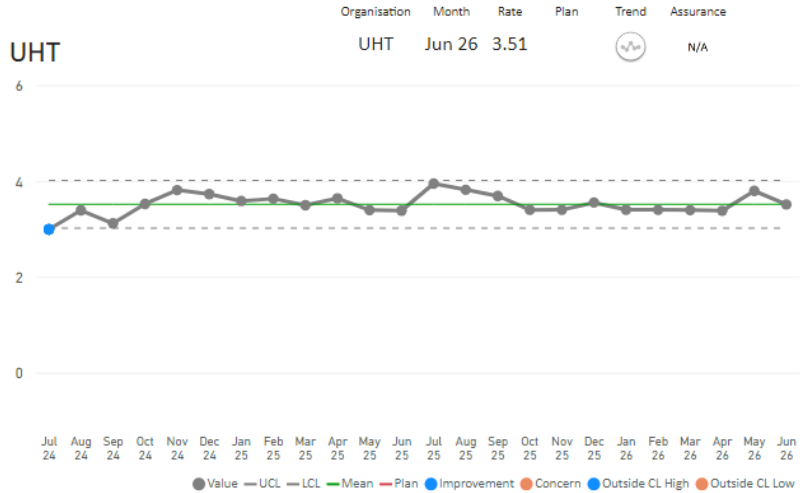
Maternity services metrics reflect the different case mix at our two trusts, with a greater proportion and the more complex of the high-risk pregnancies being cared for at the James Cook University Hospital.

Breastfeeding rates alerted to Board for both Trusts. 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.

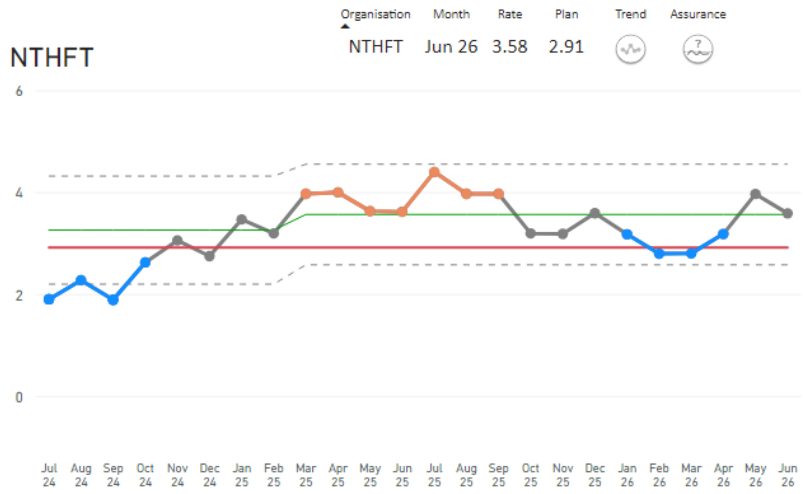
| North Tees & Hartlepool NHS FT | Plan | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Still Birth Rate (Rolling 12 months, per 1000 births) | 2.91 | 4.39 | 3.97 | 3.97 | 3.19 | 3.18 | 3.59 | 3.17 | 2.79 | 2.8 | 3.18 | 3.96 | 3.58 |
| Neonatal Mortality Rate (Rolling 12 months, per 1000 births) | 0.99 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 |
| Breast Feeding at First Feed | 72.3% | 49.5% | 46.3% | 47.5% | 47.3% | 52.4% | 42.8% | 55.1% | 46.2% | 53.3% | 48.6% | 55.1% | 54.2% |
| PPH >= 1500ml Rate per 1000 Births | 31 | 24 | 13 | 18 | 41 | 38 | 11 | 9 | 37 | 15 | 33 | 18 | 15 |
| 3rd/4th Degree Tear (%) | | 8.9% | 3.2% | 1% | 3% | 2.5% | 1.2% | 3.6% | 3% | 3.2% | 0.9% | 0.9% | 1.1% |

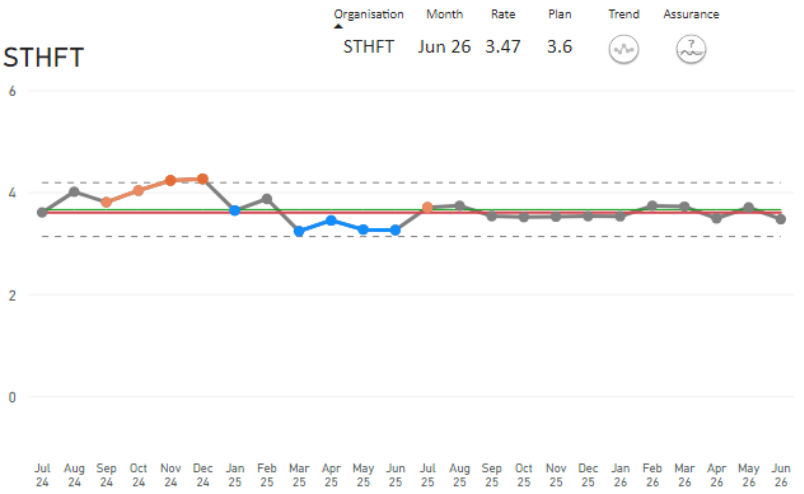
| South Tees Hospitals NHS FT | Plan | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Still Birth Rate (Rolling 12 months, per 1000 births) | 3.6 | 3.7 | 3.73 | 3.53 | 3.51 | 3.52 | 3.53 | 3.52 | 3.73 | 3.72 | 3.49 | 3.7 | 3.47 |
| Neonatal Mortality Rate (Rolling 12 months, per 1000 births) | 1.84 | 1.75 | 1.32 | 1.55 | 1.54 | 1.54 | 1.77 | 2.21 | 1.98 | 1.76 | 1.97 | 1.75 | 1.52 |
| Breast Feeding at First Feed | 77.1% | 62.3% | 63.5% | 69.5% | 65.7% | 65.7% | 68.1% | 65.5% | 69.4% | 68.3% | 68.8% | 68% | 67.5% |
| PPH >= 1500ml Rate per 1000 Births | 31 | 25 | 28 | 29 | 51 | 32 | 41 | 26 | 22 | 31 | 41 | 43 | 47 |
| 3rd/4th Degree Tear (%) | | 1.3% | 1.8% | 2.7% | 3.5% | 5.2% | 1.1% | 3.1% | 4.3% | 2.6% | 1.4% | 2.6% | 1.4% |

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

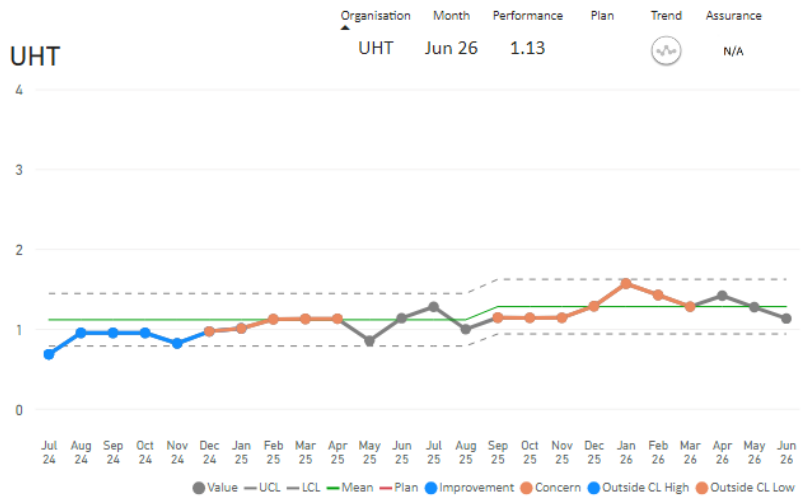



**Metric:** Still birth rate (rolling 12 months per 1000 births).
**Plan:** MBRRACE comparator group crude average 2024.
**Rationale:** National Maternity Indicator.
**Data quality:** Advised, locally derived rate may differ from nationally derived, and case-mix adjusted rates.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** NTHFT: Advise. STHFT: Advise. Rates at both trusts remain in line with their respective benchmarks.
**Action taken:** Perinatal losses are reported via the Perinatal Mortality Review Tool. All cases are reviewed in full by an MDT team. Thematic reviews to be completed for September 2026.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

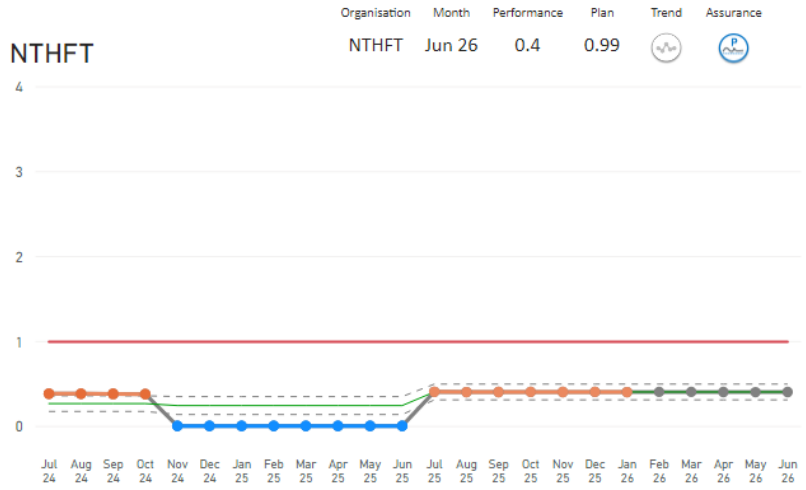


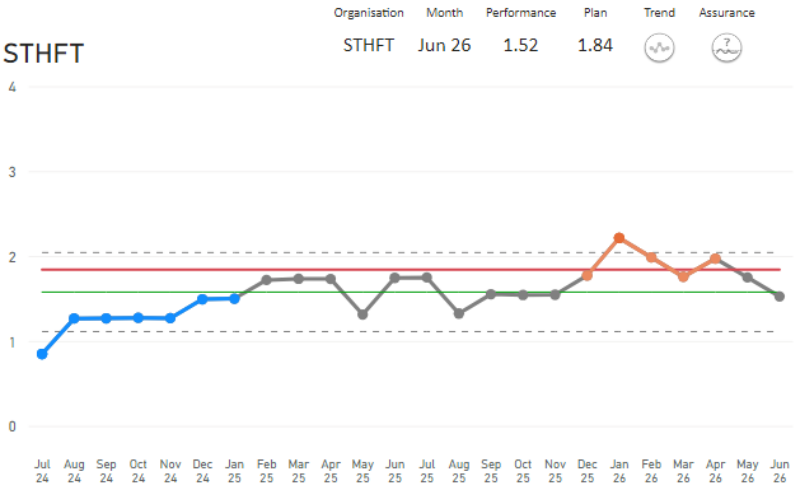



## SAFE Neonatal Mortality Rate (Rolling 12 months, per 1000 births)

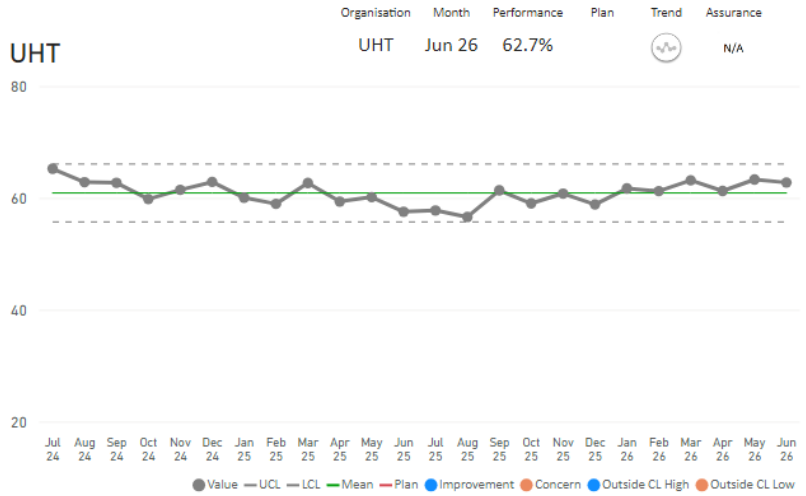



**Metric:** Neonatal mortality rate**,** rolling 12 months per 1,000 births.
**Plan:** MBRRACE audit comparator group average 2024.
**Rationale:** National Maternity Indicator.
**Data quality:** Assured, validated crude data, not case-mix adjusted.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** NTHFT: Assure, rate is consistently below benchmark. STHFT: Advise, monthly variation around expected benchmark.
**Action taken:** All perinatal deaths are reported via the Perinatal Mortality Review Tool. All cases are reviewed in full by an MDT team.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

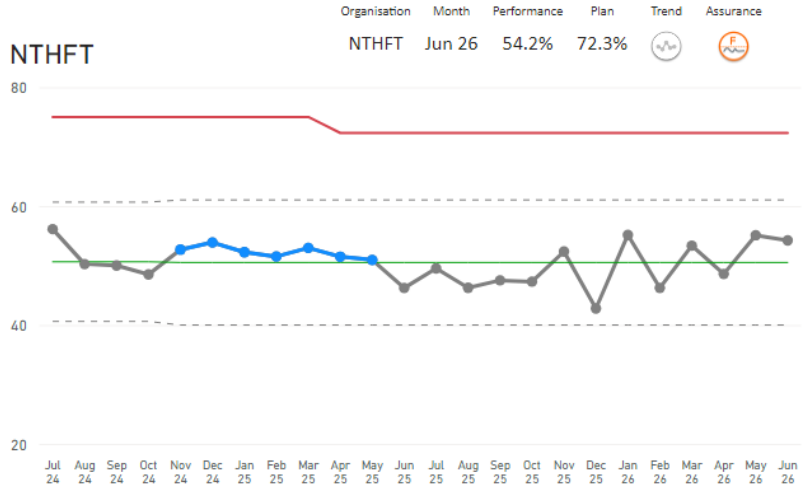


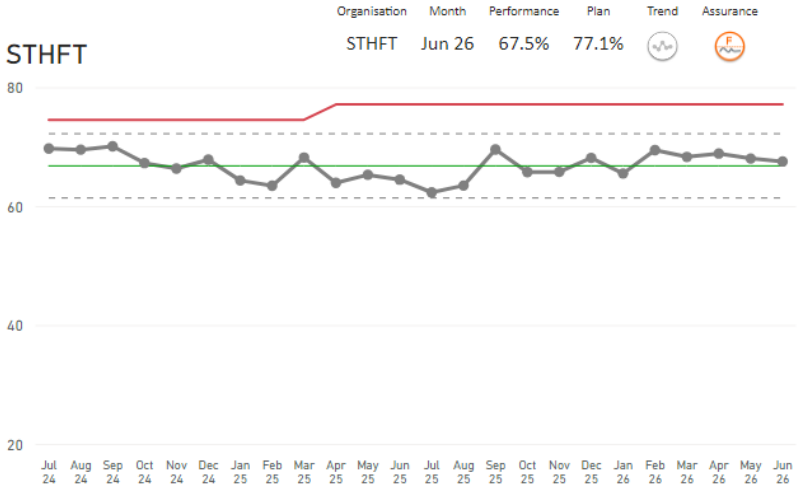



## SAFE Breast Feeding at First Feed

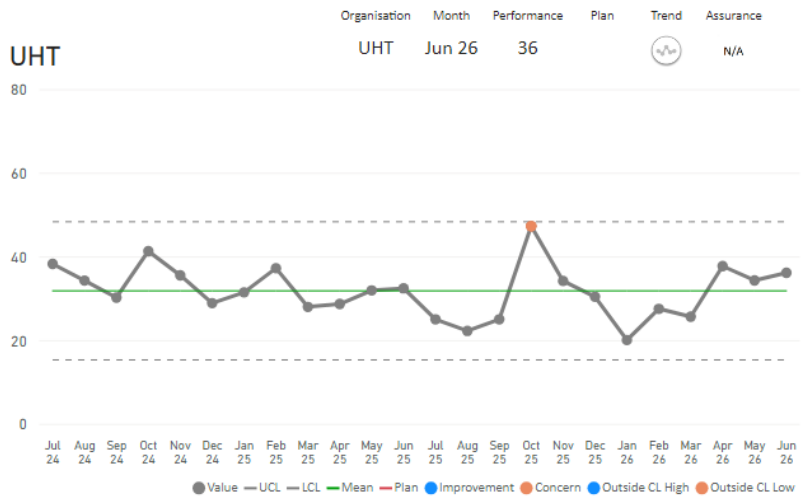



**Metric:** Percentage of births where breast-feeding is initiated, reported at first feed.
**Plan:** Local plan to achieve MBRRACE audit peer group mean (10% tolerance).
**Rationale:** National maternity dashboard Clinical Quality Improvement Metric (CQIM)
**Data quality:** Assured, validated data.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** NTHFT: Alert. STHFT: Alert.
**Action taken:** Ongoing collaboration to share learning and improvement insights.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

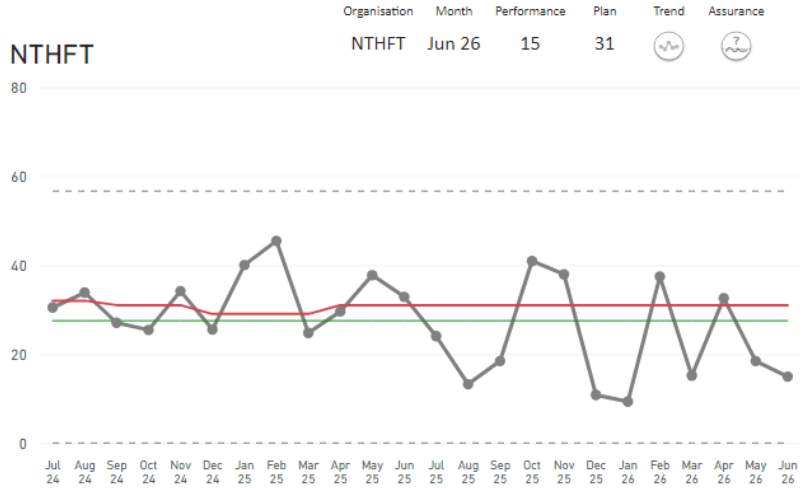


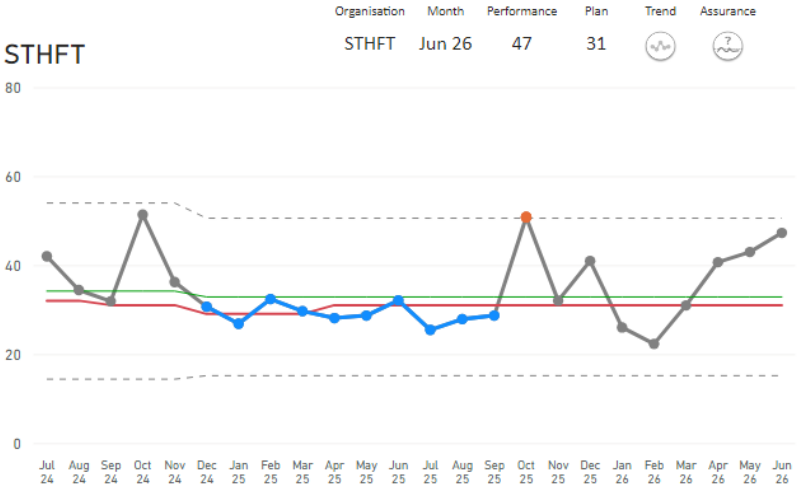



## SAFE PPH >= 1500ml Rate per 1000 Births

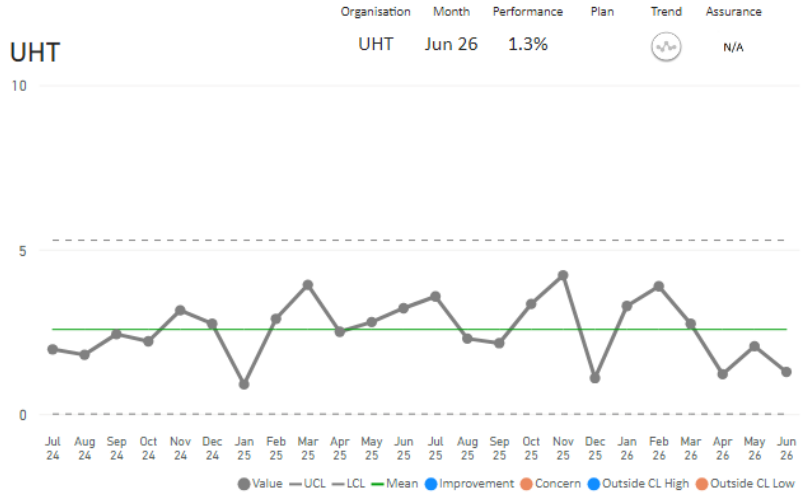



**Metric:** Post-partum haemorrhage (PPH) greater than or equal to 1500ml, rate per 1000 births.
**Plan:** North East and North Cumbria ICB regional average.
**Rationale:** National Maternity Indicator and Clinical Quality Improvement Metric.
**Data quality:** Assured, validated data.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** NTHFT: Advise. STHFT: Advise. Fluctuating performance around the benchmark at both trusts.
**Action taken:** NTHFT and STHFT participate in a research study on effectiveness of interventions to reduce PPH. JCUH team are undertaking an additional review of all PPH >1500ml to highlight any learning.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

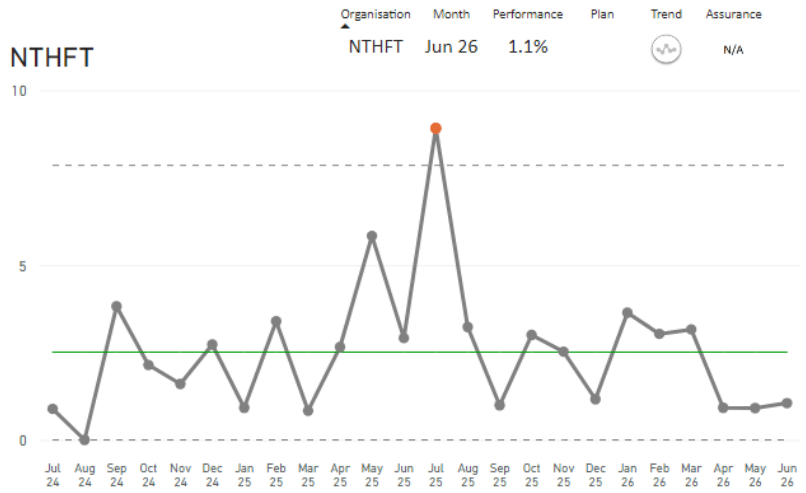


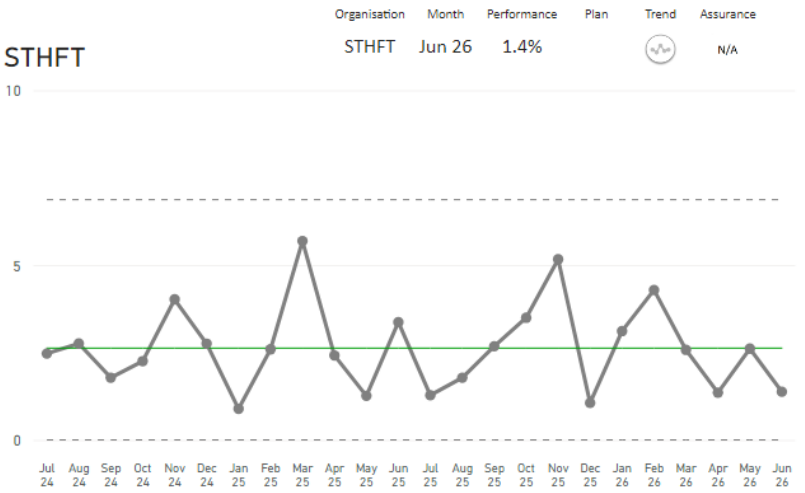



## SAFE 3rd/4th Degree Tear (%)




**Metric:** Percentage of births with 3rd/4th degree maternal tear.
**Plan:** n/a.
**Rationale:** National Maternity Indicator.
**Data quality:** Assured, validated data. NTHFT data descriptor aligned to national descriptor, July 2025.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** n/a
**Action taken:** All cases have a joint review to identify any learning points; no common themes have emerged.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee



## EFFECTIVE DOMAIN SUMMARY

**Executive lead:** **Dr Michael Stewart, Chief Medical Officer**
**Accountable to:** **Quality Assurance Committee**

Summary Hospital-level Mortality Indicator (SHMI) is 'as expected' for both trusts. Assurance is also provided by non-statistical approaches: Trust Medical Examiners review >98% of deaths and refer relevant cases to the Trust Mortality Surveillance team for further review/investigation/action where required.

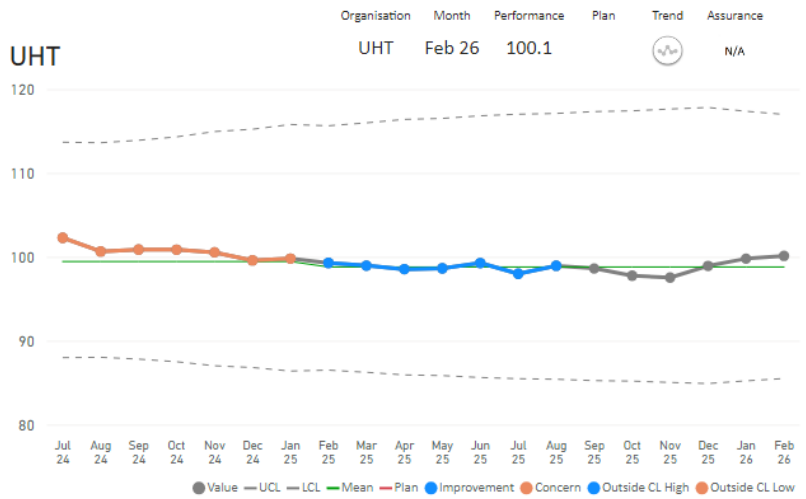
The IPR reports a standardised metric to enable benchmarking. Readmission rates have been built into standardised reporting via the monthly QPR slide sets, and are now tailored specifically for each CSU, to assist with local analysis and review.

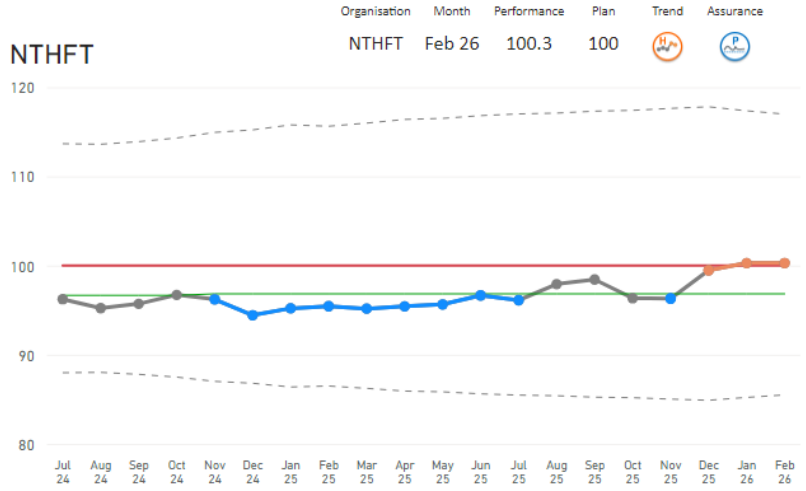
Discharge Delay Average (days) is reported to align to the National Oversight Framework. This metric highlights differences in access to social care provision across our footprint. There is a focus on utilisation of Home First in cases of delays. Both Trusts consistently perform better than the 24/25 national average.

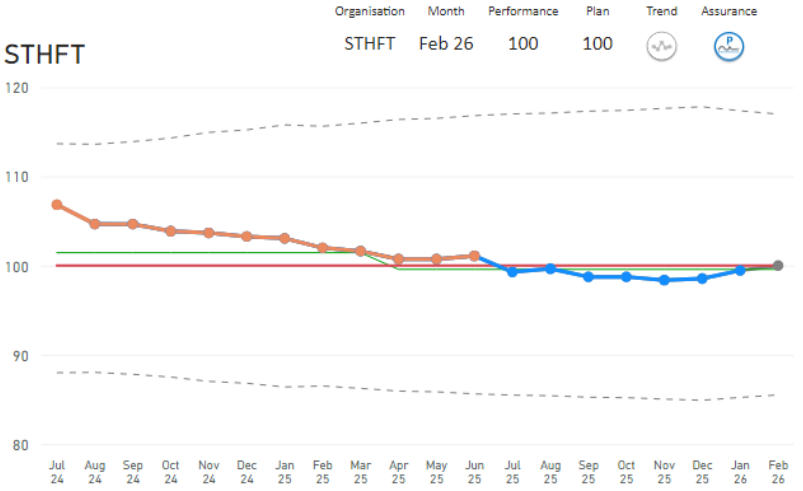
| North Tees & Hartlepool NHS FT | Plan | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary Hospital-Level Mortality Indicator | 100 | 96.1 | 97.9 | 98.4 | 96.3 | 96.3 | 99.5 | 100.3 | 100.3 | | | |
| Readmission Rate (%) | 8.4% | 10.5% | 10.1% | 10.2% | 11% | 10.4% | 9.9% | 10.9% | 10.8% | | | |
| Discharge Delay Average (days) | 0.825 | 0.681 | 0.67 | 0.574 | 0.553 | 0.632 | 0.709 | 0.619 | 0.647 | 0.622 | 0.65 | 0.647 |

| South Tees Hospitals NHS FT | Plan | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Summary Hospital-Level Mortality Indicator | 100 | 99.3 | 99.6 | 98.7 | 98.7 | 98.4 | 98.5 | 99.4 | 100 | | | |
| Readmission Rate (%) | 8.4% | 8.6% | 8.4% | 8.7% | 8.6% | 8.2% | 8.7% | 8.3% | 8.2% | | | |
| Discharge Delay Average (days) | 0.825 | 0.617 | 0.601 | 0.688 | 0.671 | 0.594 | 0.635 | 0.738 | 0.726 | 0.746 | 0.768 | 0.667 |

## EFFECTIVE Summary Hospital-Level Mortality Indicator

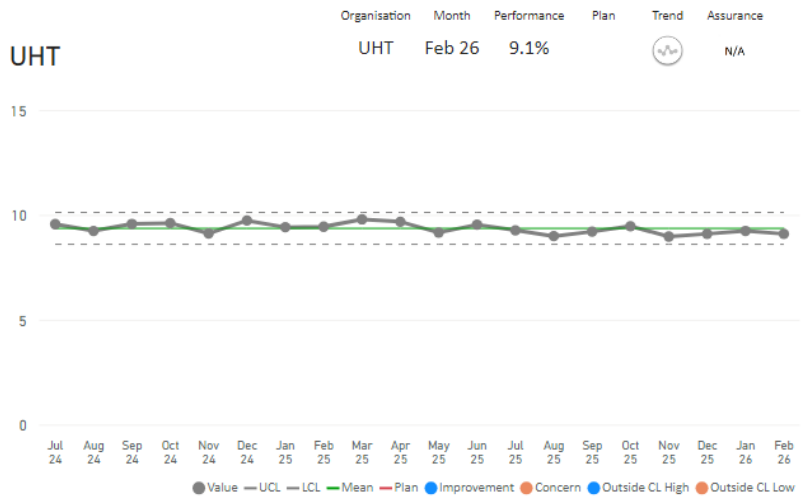


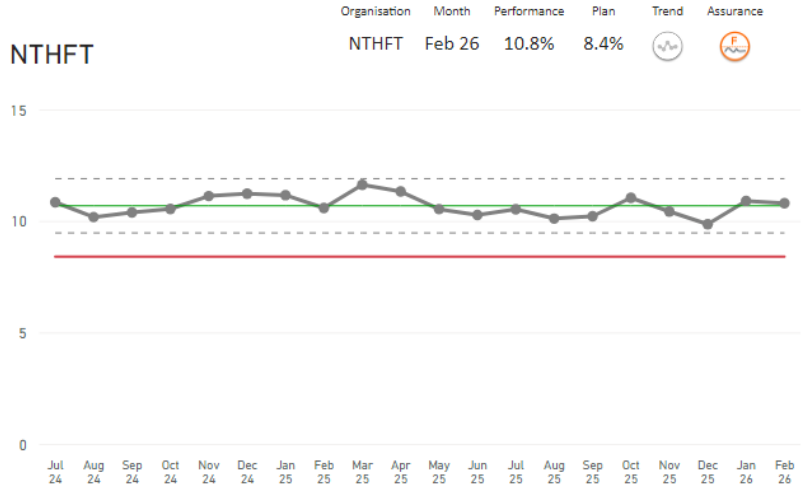



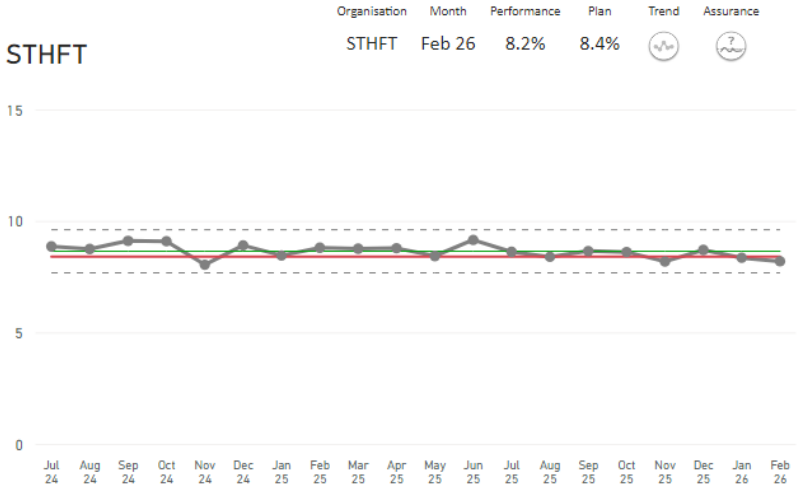

**Metric:** Summary hospital-level mortality indicator (SHMI), calculated for rolling 12-months, 4-months in arrears.
**Plan:** Standardised to 100.
**Rationale:** Quality Accounts regulatory indicator.
**Data quality:** Assured, validated data.
**Trend:** NTHFT: Higher than average SHIMI in 9 months to February 2026. STHFT: No current trend, following sustained improvement.
**Assurance:** NTHFT: Advise, assured in line with benchmark but three recent data points higher than usual variation. STHFT: Assure.
**Action taken:** UHT coding improvement group re-launched. Coding audit work is underway focusing on coding depth (co-morbidities) in diagnoses with higher mortality.
**Executive lead:** Chief Medical Officer
**Accountable to:** Quality Assurance Committee

## EFFECTIVE Readmission Rate (%)

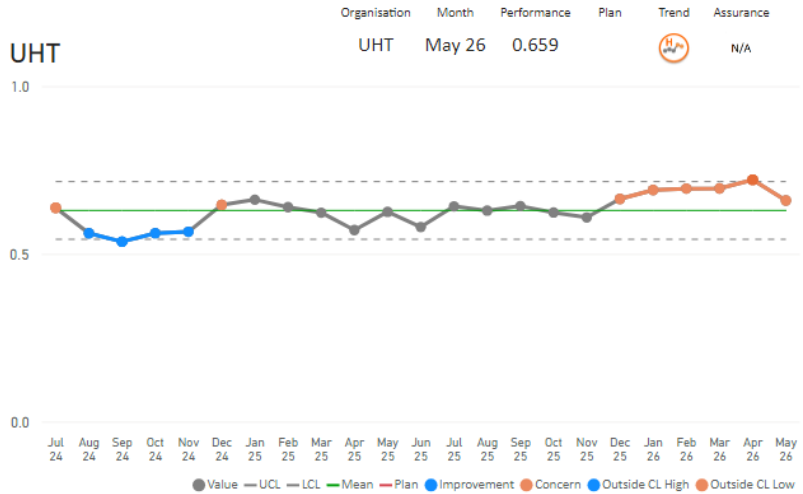


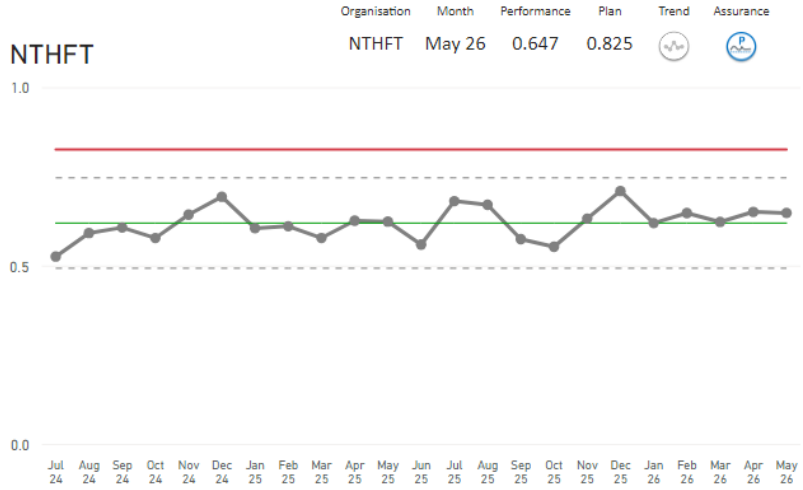

**Metric:** Average number of days between discharge ready date and discharge date, including zero-day length of stay.
**Plan:** No published standard, local plan to perform significantly better than national mean rate for 25/26.
**Rationale:** NHS Oversight Framework 25/26 core metric.
**Data quality**: Assured, validated data.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** NTHFT: Alert. STHFT: Advise.
**Action taken:** Readmissions analyses are now integral in the monthly Quality and Performance Review slide decks and are tailored specifically for each CSU.
**Executive lead:** Chief Medical Officer
**Accountable to:** Quality Assurance Committee

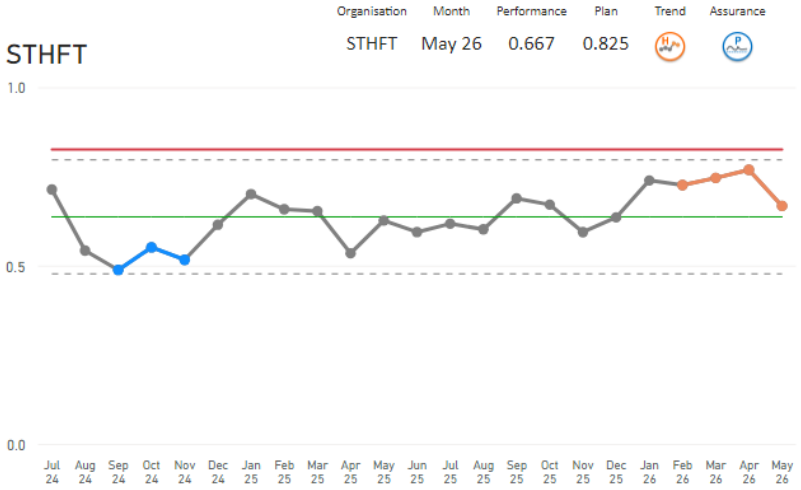


## EFFECTIVE Discharge Delay Average (days)




**Metric:** Percentage of patients readmitted within 30 days.
**Plan:** 2024/25 national average.
**Rationale:** NHS Contract metric.
**Data quality**: Aligned to published benchmark. Reported two months in arrears to enable the data to be fully coded.
**Trend:** NTHFT: No trend. STHFT: Declining performance
**Assurance:** NTHFT: Assure. STHFT: Advise, performance consistently better than benchmark but recent deterioration over the 4 months to May 2026.
**Action taken:** Renewed focus on ensuring plans and escalations are in place for patients with longer lengths of stay, including patients awaiting repatriation. Utilisation of Home First in cases of delays in access to social care which varies between the local authorities of each Trust.
**Executive lead:** Chief Medical Officer
**Accountable to:** Quality Assurance Committee

# RESPONSIVE DOMAIN SUMMARY

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

## Urgent and emergency care

Ambulance handover performance is tracking to plan at NTHFT in June, and handovers within 45 minutes are usually assured at >95% outside of peak winter demand. At STHFT, compliance remained within the expected performance variance although slightly below plan of 97.9%, at 96.9%.

Clinical teams at NTHFT delivered the A&E 4-hour standard performance above agreed NHSE plan, and performed better than plan for the 12-hour ED breach rate, in June 2026. STHFT did not meet plan for 4-hour standard but performed positively below the agreed June trajectory for 12-hour ED breach rate.

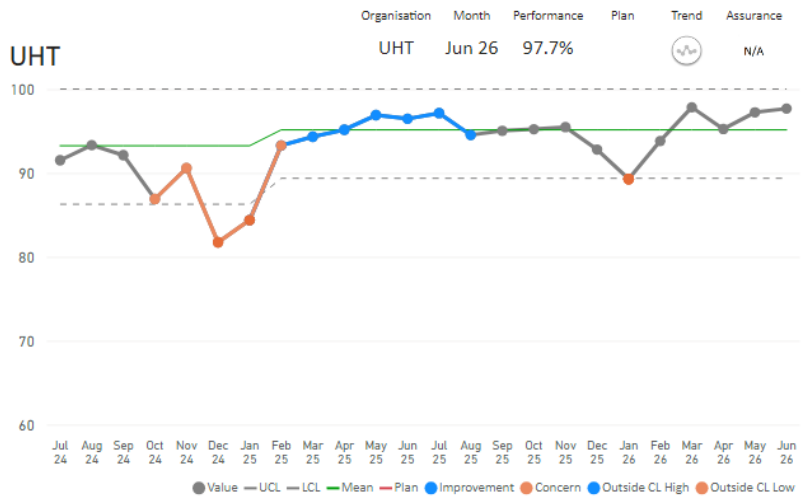
Above-standard performance in the community urgent 2-hour response reflects the continued focus on supporting urgent and emergency care pathways and caring for patients in the most appropriate setting. Work is ongoing with NEAS to reduce conveyance of care home residents, where an urgent community response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

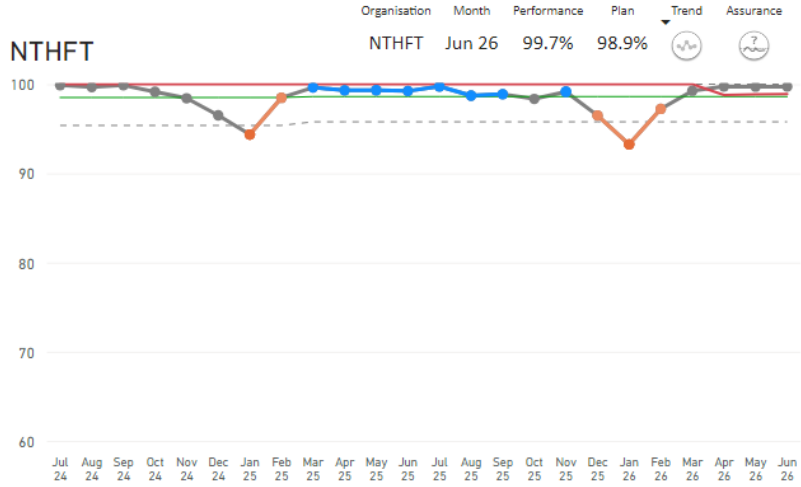
Elective operations cancelled on the day for non-medical reasons and not rebooked within 28 days remained static in Q1 for NTHFT, however there is an increase from the 5 or fewer per month throughout 25/26. At STHFT this metric has stabilised following increased cancellations January-March 2026. There is a continued focus on re-booking, actioned through the Surgical Improvement Group and the UHT Elective Access Group. Further improvement remains a priority.

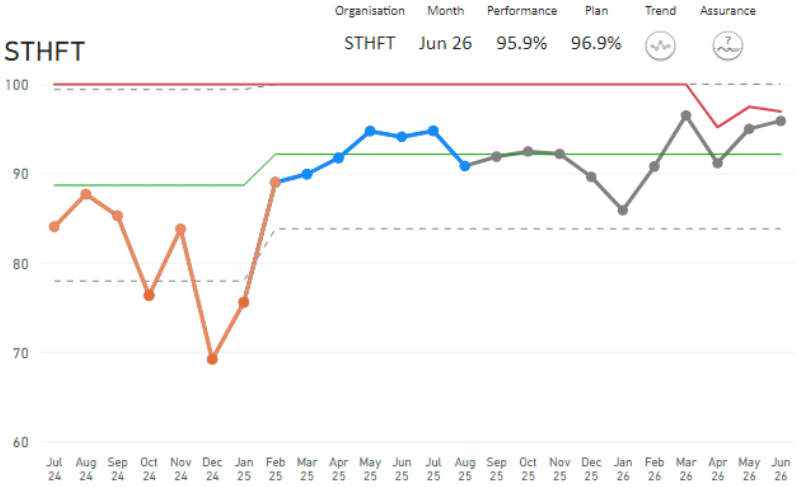
| North Tees & Hartlepool NHS FT | Plan | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NEAS Handovers - Within 45 Mins (%) | 98.9% | 99.7% | 98.7% | 98.9% | 98.4% | 99.2% | 96.5% | 93.3% | 97.2% | 99.3% | 99.7% | 99.7% | 99.7% |
| 4-Hour A&E Standard | 82.2% | 84.9% | 84.6% | 83.4% | 82% | 82% | 83.3% | 80.4% | 83% | 86.2% | 86.1% | 85.3% | 85.1% |
| 12-hour ED breaches rate | 2.2% | 1.5% | 1.4% | 4.5% | 6.4% | 5.5% | 6.9% | 9.5% | 5.7% | 0.7% | 1.1% | 1% | 1% |
| Community UCR 2hr Response Rate (%) | 70% | 76% | 80% | 76% | 73% | 75% | 74% | 75% | 72% | 74% | 75% | 77% | |
| Cancelled Ops - Not Rebooked Within 28 days | 0 | 1 | 0 | 3 | 4 | 2 | 2 | 4 | 3 | 3 | 8 | 8 | 8 |

| South Tees Hospitals NHS FT | Plan | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NEAS Handovers - Within 45 Mins (%) | 96.9% | 94.8% | 90.8% | 91.9% | 92.5% | 92.2% | 89.6% | 85.9% | 90.8% | 96.5% | 91.1% | 95% | 95.9% |
| 4-Hour A&E Standard | 80.1% | 78.5% | 78% | 76.7% | 77.3% | 77.7% | 78.5% | 75.6% | 77.6% | 80% | 78.7% | 80.5% | 78.4% |
| 12-hour ED breaches rate | 3.2% | 2.7% | 4.6% | 5.6% | 5.2% | 5.5% | 5.5% | 8.4% | 5.6% | 2.3% | 5.8% | 2.3% | 1.4% |
| Community UCR 2hr Response Rate (%) | 70% | 76% | 77% | 71% | 76% | 76% | 77% | 76% | 76% | 74% | 78% | 81% | |
| Cancelled Ops - Not Rebooked Within 28 days | 0 | 10 | 10 | 9 | 16 | 10 | 16 | 20 | 13 | 15 | 11 | 8 | 9 |

## RESPONSIVE NEAS Handovers - Within 45 Mins (%)

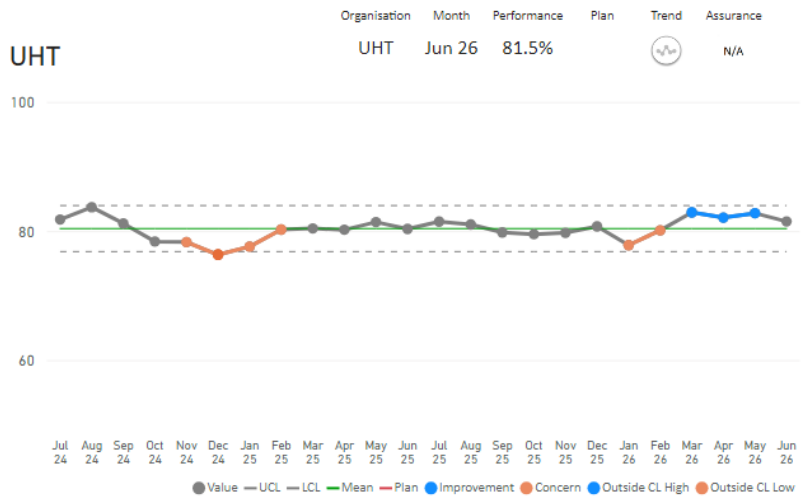


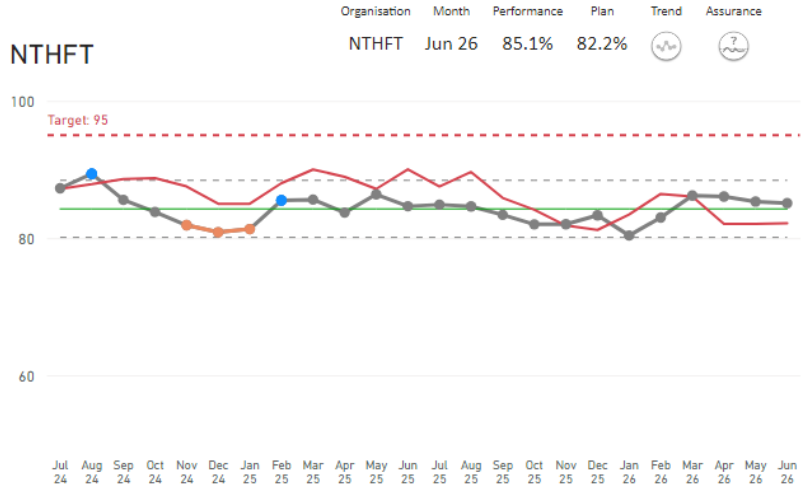



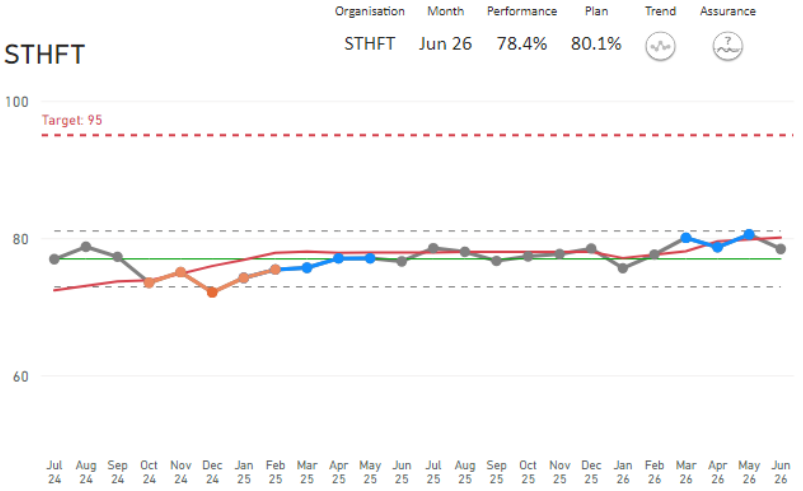

**Metric:** Percentage of NEAS ambulance handovers completed within 45 minutes of arrival at ED.
**Plan**: 100% within 45 minutes
**Rationale**: NHS Contract metric.
**Data quality**: NEAS data may differ from Trust data.
**Trend:** NTHFT: No trend (returned to previous levels of compliance). STHFT: No trend.
**Assurance:** NTHFT: Advise. Plan met but not statistically assured. STHFT: Advise. Plan within range but not met.
**Action taken:** Continued focus on timely registration of patients at JCUH. ED MDT huddle remains focussed on support required to maintain flow. Recent site visits with NEAS to review handover pathways.
**Executive lead:** Chief Delivery Officer
**Accountable to:** Resources Committee

## RESPONSIVE 4-Hour A&E Standard

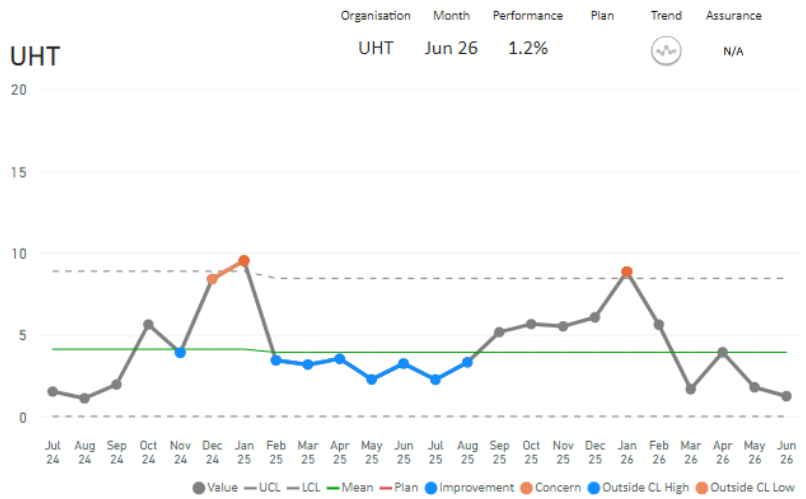



**Metric:** Percentage of patients admitted, transferred or discharged from A&E (all types) within 4 hours of arrival.
**Plan:** NHS Constitution standard 95%; recovery plan 82% by March 2027.
**Rationale:** NHS Contract metric.
**Data quality:** Assured, validated data.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** NTHFT: Advise. STHFT: Advise.
**Action taken:** The UHT Improving Better Together will focus on actions required to improve efficiency across the organisation to improve the 4- hour standard. SDEC 24/7 case for JCUH progressing with a start date of October, multi-speciality breach meetings, ED MDT daily huddle.
**Executive lead:** Chief Delivery Officer
**Accountable to:** Resources Committee

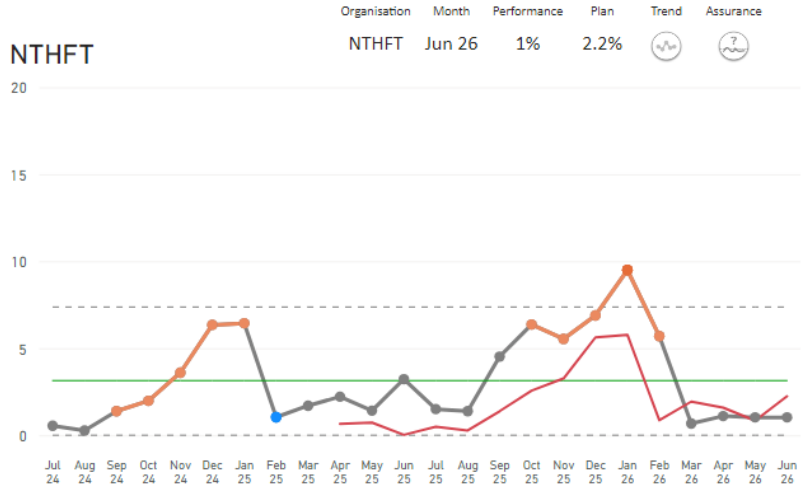


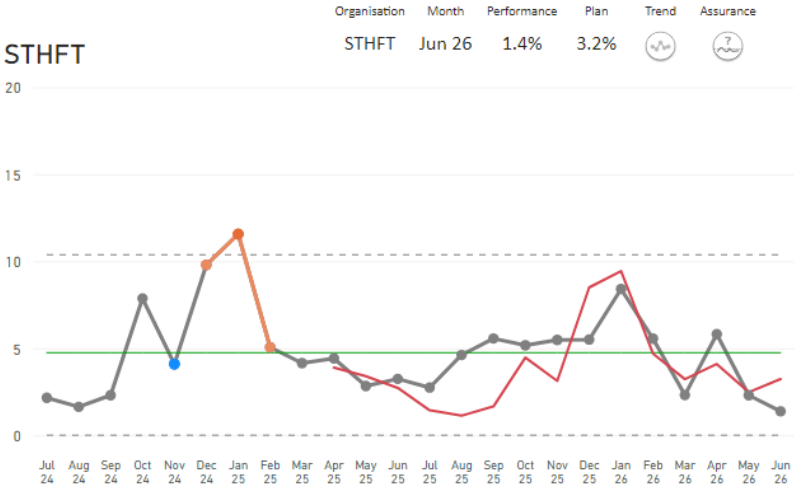



## RESPONSIVE 12-hour ED breaches rate




**Metric:** Percentage of patients admitted or discharged from Type 1 Emergency Department after 12 hours.
**Plan:** Seasonalised recovery plan, for year-on-year improvement.
**Rationale:** NHS Contract metric.
**Data quality:** Assured, validated data.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** NTHFT: Advise. STHFT: Advise. Both trusts show seasonal variation with performance around plan.
**Action taken:** GIRFT mental health UEC standards review commenced with TEWV NHSFT, 12-hour workstream established, thematic review scheduled at ED breach meeting.
**Executive lead:** Chief Delivery Officer
**Accountable to:** Resources Committee

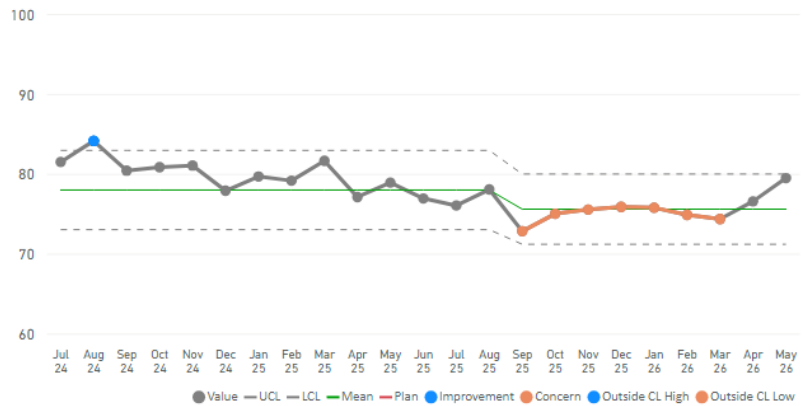


## RESPONSIVE Community UCR 2hr Response Rate (%)

UHT

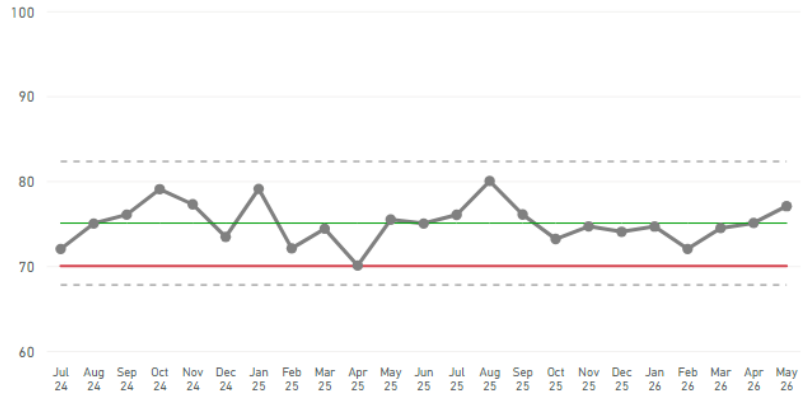
| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| UHT | May 26 | 79% | | | N/A |




**Metric:** Urgent community response within 2-hours
**Plan:** 70% national standard.
**Rationale:** NHS operational planning guidance
**Data quality:** Advisory, metric calculated from submitted raw community data sets, one month in arrears.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** NTHFT: Advise, after 7 consecutive months below previous average, performance has returned above the average May 2026 and remains above the standard . STHFT: Assure. Performance is now consistently above standard.
**Action taken:** Performance improving in relation to >2hr UCR. Work ongoing to further understand demand ahead of care coordination centre work planned for autumn.
**Executive lead:** Chief Delivery Officer
**Accountable to:** Resources Committee

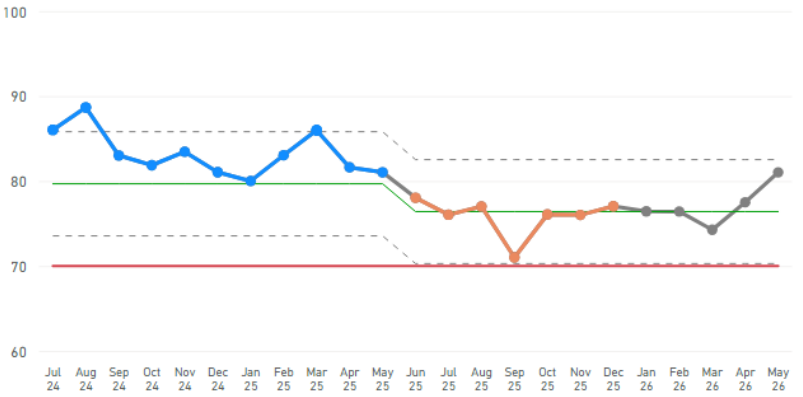
NTHFT

| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| NTHFT | May 26 | 77% | 70% | | |

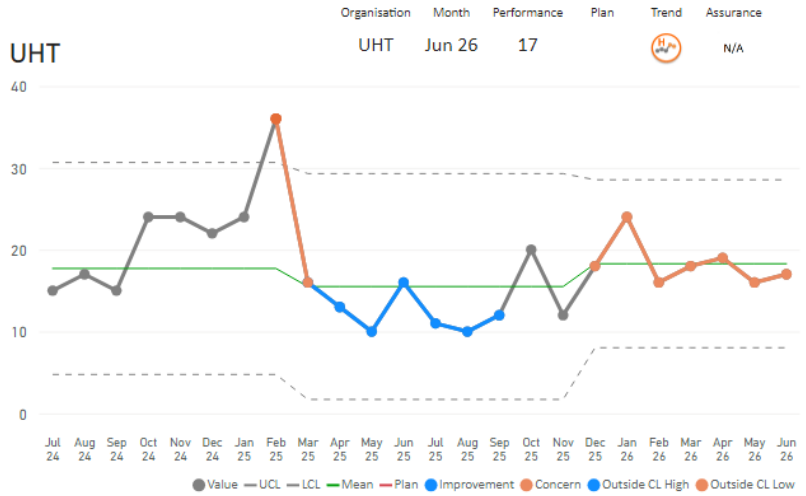



STHFT

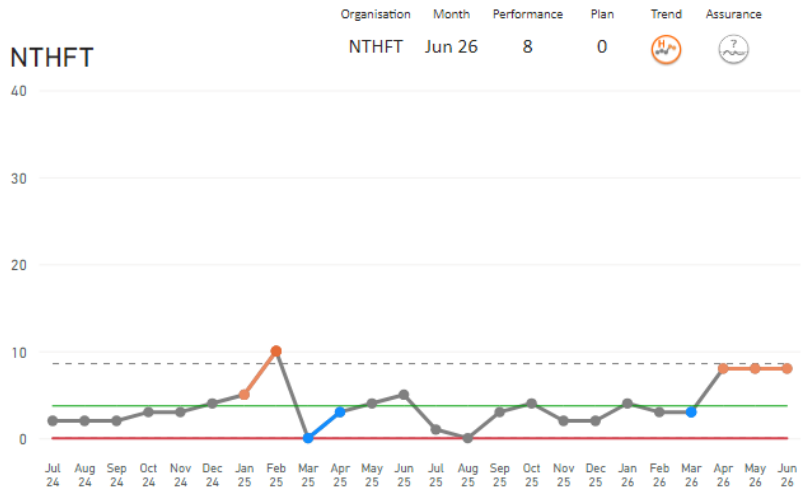
| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| STHFT | May 26 | 81% | 70% | | |

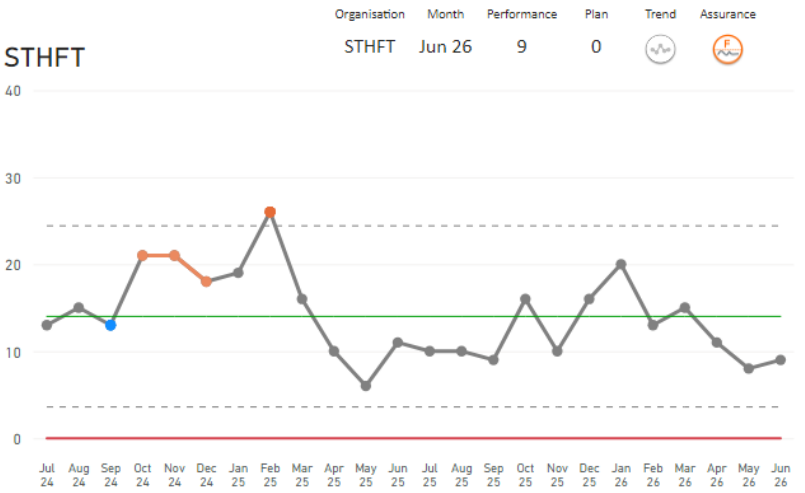


## RESPONSIVE Cancelled Ops - Not Rebooked Within 28 days




**Metric:** Operations cancelled not rebooked within 28-days.
**Plan:** Zero.
**Rationale:** NHS Contract metric.
**Data quality:** Assured, validated data.
**Trend:** NTHFT: high outliers April to June 2026. STHFT: No trend.
**Assurance:** NTHFT: Alert, target of zero is within range but poorer performance in last 3 months. STHFT: Alert, target of zero not in range of performance.
**Action taken:** Daily review of all cancellations. Services remain focussed and committed to reappointing patients within the timeframe. Renewed focus on rebooking is monitored via Surgical Improvement Group and Elective Access meetings.
**Executive lead:** Chief Delivery Officer
**Accountable to:** Resources Committee



## RESPONSIVE DOMAIN SUMMARY

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

**Elective, diagnostic and cancer care**

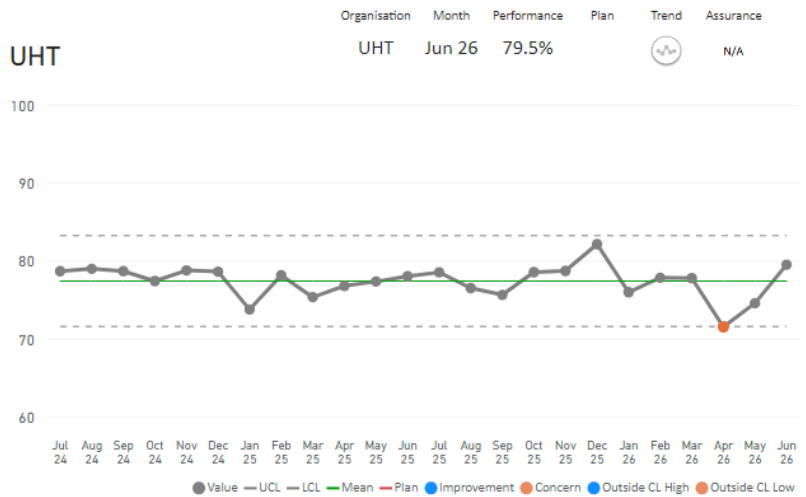
Achievement of key access targets continues to be challenging, logged as strategic risks. Cancer faster diagnosis standard is not assured for NTHFT or STHFT however, compliance was above plan for STHFT in June 2026. For the 31-day cancer standard, STHFT continue to focus on the patients waiting longest for subsequent treatments, for radiotherapy and managing constraints of capacity, with recruitment underway to increase radiotherapy capacity. NTHFT 31-day and 62-day performance compliance shows impact of a sustained increase in breast symptomatic referrals from the County Durham and Darlington catchment area since February 2025. Tumour specific pathway improvements are driven by the clinically-led Cancer Improvement Groups. Tiered support from NHS England continues, and a regional provider response group to increase breast clinic capacity is active.

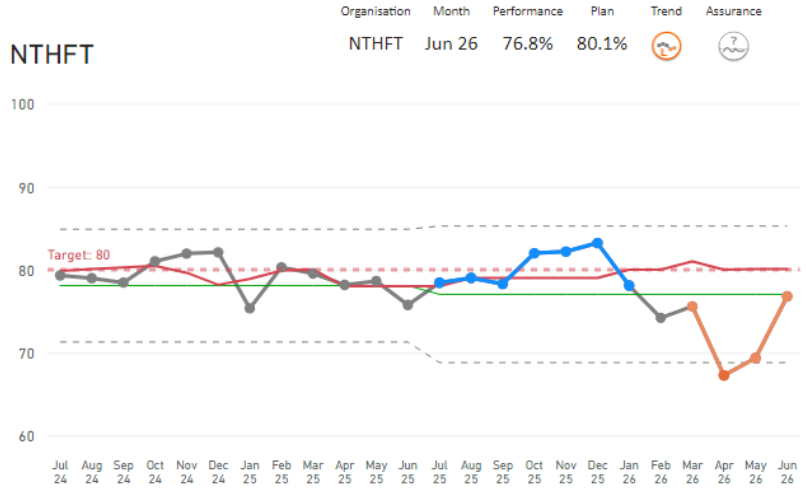
Elective recovery trajectories are supported by waiting list validation, clinic template review, and additional capacity in targeted specialties with the greatest patient access/demand challenges. Patients with the longest waits are prioritised with NTHFT . STHFT 52-week waits are reducing in line with the planned trajectory. STHFT entered tiered support arrangements with NHS England in November 2025 with the aim of eliminating 65 week waits. At June month end NTHFT had zero patients, and STHFT 13 patients, waiting over 65 weeks. Elective and Cancer access are priorities for our *Improving Better Together* programme.

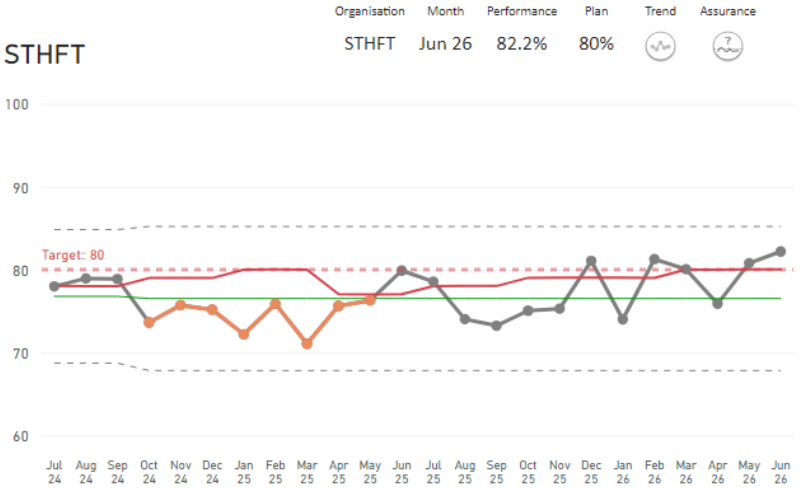
| North Tees & Hartlepool NHS FT | Plan | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer Faster Diagnosis Standard (%) | 80.1% | 78.4% | 79% | 78.3% | 82% | 82.2% | 83.2% | 78.1% | 74.2% | 75.6% | 67.3% | 69.3% | 76.8% |
| Cancer 31 Day Standard (%) | 93.9% | 92.5% | 88.8% | 92.4% | 94.2% | 93.3% | 97.2% | 92.7% | 96.6% | 97.8% | 94.7% | 95.5% | 88.8% |
| Cancer 62 Day Standard (%) | 56.5% | 52.3% | 51.7% | 56.7% | 61% | 63% | 62.1% | 54.8% | 52.9% | 66.6% | 58.3% | 46.6% | 59% |
| Diagnostic 6 Weeks Standard (%) | 95.4% | 96.6% | 94.5% | 96.1% | 94.9% | 95.5% | 95% | 95.5% | 98.3% | 97.3% | 95.8% | 95.9% | 97.8% |
| RTT Incomplete Pathways (%) | 73.3% | 74.2% | 72.7% | 73.3% | 73.8% | 72.8% | 71.3% | 70.7% | 70.1% | 70.6% | 72.4% | 72.3% | 71.5% |
| RTT 52 Week Waiters Rate | 1% | 0.9% | 0.8% | 0.7% | 0.9% | 0.8% | 1% | 1.1% | 1.1% | 1% | 0.9% | 0.9% | 1% |
| Community Over 52 Week Waiters Rate | 1.4% | 3% | 3.4% | 3.2% | 1.5% | 3.1% | 2.9% | 1.7% | 0.7% | 0.3% | 0.2% | 0.1% | 0.2% |
| Community 18 Week Compliance (%) | 77.9% | 80.4% | 80.7% | 78.3% | 77.9% | 72% | 75% | 75.1% | 75.3% | 76% | 78.7% | 87.8% | 87% |

| South Tees Hospitals NHS FT | Plan | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer Faster Diagnosis Standard (%) | 80% | 78.6% | 74% | 73.2% | 75.1% | 75.3% | 81.1% | 74% | 81.3% | 80.1% | 75.9% | 80.8% | 82.2% |
| Cancer 31 Day Standard (%) | 83.8% | 86.1% | 81.7% | 83.9% | 83.3% | 82.5% | 80.7% | 77.1% | 84.4% | 81.6% | 79.6% | 83% | 81.9% |
| Cancer 62 Day Standard (%) | 70.2% | 68.7% | 66.8% | 65.2% | 65.7% | 70.6% | 69.4% | 68.5% | 71.5% | 70.5% | 68.3% | 70.4% | 64.6% |
| Diagnostic 6 Weeks Standard (%) | 84.1% | 86.9% | 82.2% | 85.4% | 86.6% | 85.7% | 84.1% | 85.7% | 88% | 88.5% | 85% | 84.3% | 84.1% |
| RTT Incomplete Pathways (%) | 62.5% | 61.9% | 61.1% | 61.7% | 62.1% | 61.8% | 61.9% | 62.1% | 63.1% | 65.2% | 65.6% | 66.2% | 66.5% |
| RTT 52 Week Waiters Rate | 1.3% | 2.7% | 2.9% | 2.7% | 2.4% | 2.2% | 1.9% | 1.8% | 1.6% | 1.2% | 1.3% | 1.2% | 1.2% |
| Community Over 52 Week Waiters Rate | 2.3% | 2% | 1.9% | 1.9% | 1.8% | 2% | 2.2% | 2% | 1.1% | 2.1% | 2.3% | 2.3% | 2.3% |
| Community 18 Week Compliance (%) | 88.1% | 91.9% | 91.9% | 92.7% | 92.7% | 92.8% | 93.1% | 93.7% | 94.2% | 89.9% | 92.2% | 92% | 88.8% |

## RESPONSIVE Cancer Faster Diagnosis Standard (%)

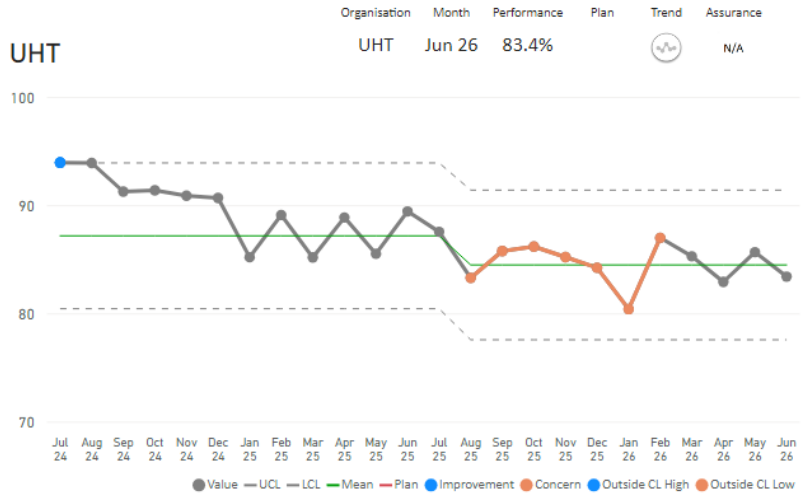


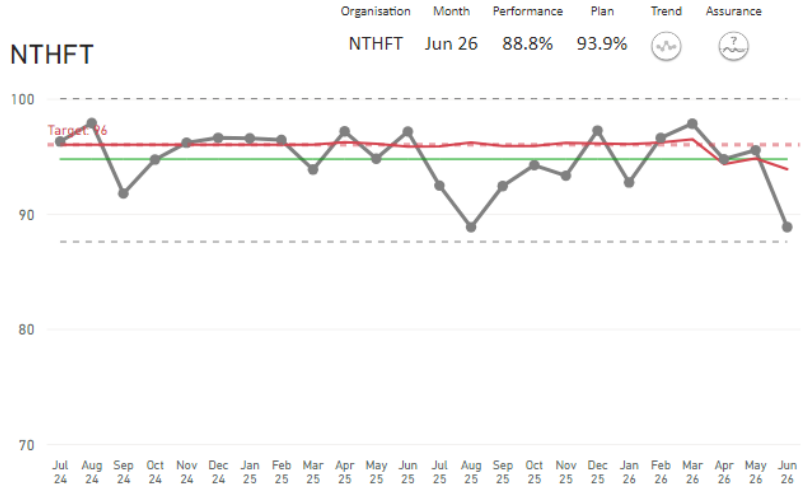



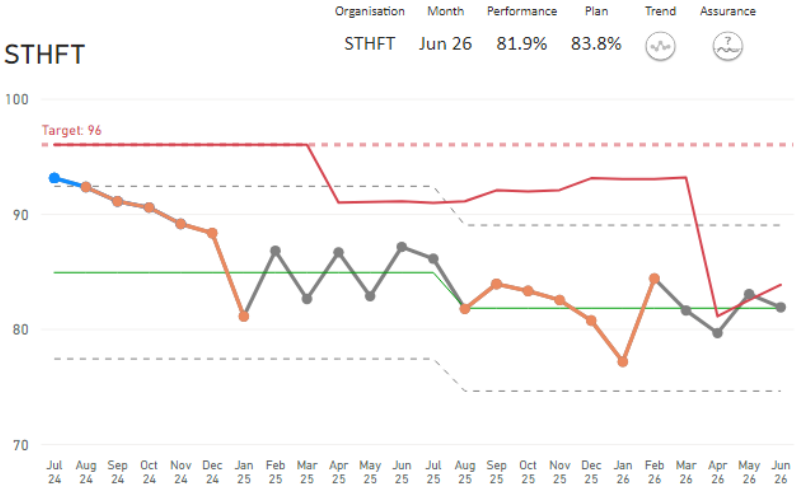

**Metric:** Percentage of patients on a cancer pathway who receive diagnosis or rule-out within 28 days from referral.
**Plan:** NHS Constitution standard 80%. Agreed operational planning trajectories: NTHFT 80%, STHFT 80% by March 2027.
**Rationale:** NHS Contract metric.
**Data quality:** Assured, validated data.
**Trend:** NTHFT: Deteriorated from March 2026. STHFT: No trend.
**Assurance:** NTHFT: Alert. STHFT: Advise.
**Action taken:** Focus on compliance in urology, respiratory and gastro-intestinal tumour groups. NTHFT FDS performance impacted by increase in breast pathway referrals. Regional meetings to address breast capacity, with mutual support and additional activity options being explored. UHNT respiratory team have introduced a weekly clinical huddle covering recording of FDS, expediting diagnostics, appointments and results letters to drive performance improvement in these areas.
**Executive lead:** Chief Delivery Officer
**Accountable to:** Resources Committee

**RESPONSIVE** **Cancer 31 Day Standard (%)**



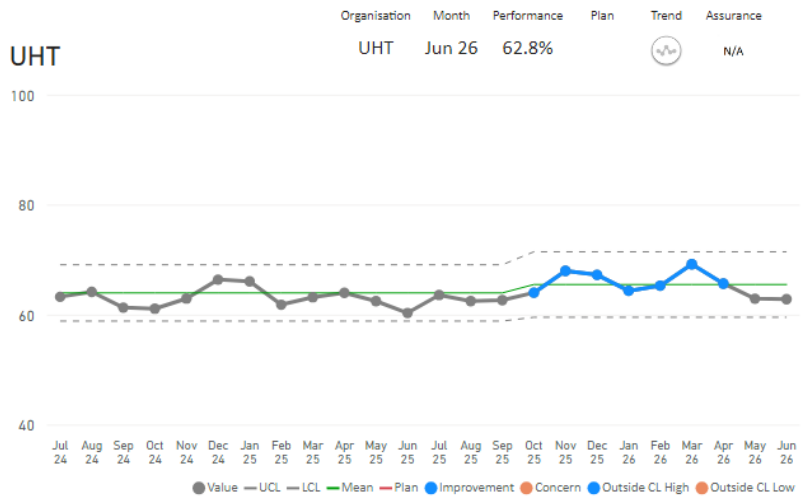

**Metric:** Percentage of patients on a cancer pathway who start treatment within 31 days of decision to treat.
**Plan:** NHS Constitution standard 96%. Agreed operational planning trajectories to 95.1% NTHFT, 92.1% STHFT by March 2027.
**Rationale:** NHS Contract metric.
**Data quality:** Assured, validated data.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** NTHFT: Advise. STHFT: Advise.
**Action taken:** Breast pathway demand is challenging to compliance. Regional meetings to address breast capacity, with mutual support and additional activity options being explored. STHFT focus is on the patients waiting longest for subsequent treatments for radiotherapy and managing constraints of capacity, with recruitment to increase capacity by quarter 3 26/27.
**Executive lead:** Chief Delivery Officer
**Accountable to:** Resources Committee

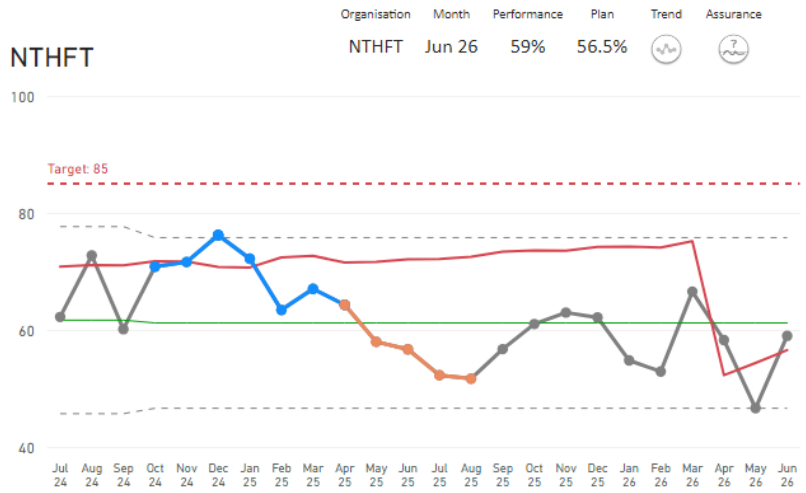


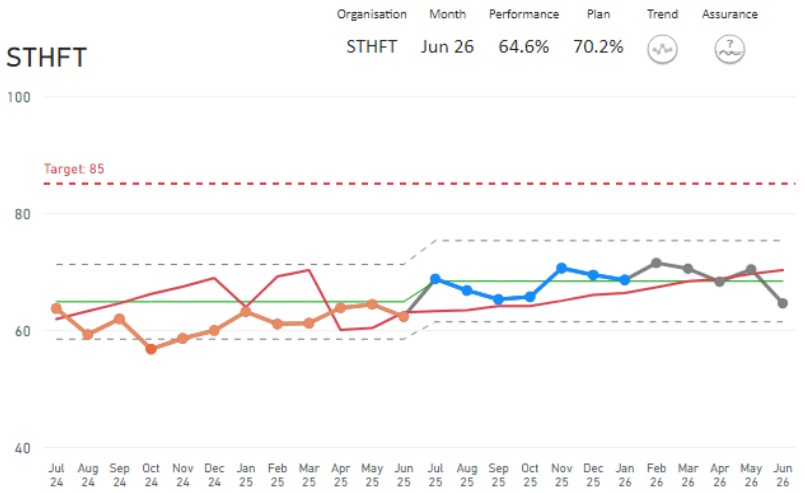




Caring Better Together

## RESPONSIVE Cancer 62 Day Standard (%)

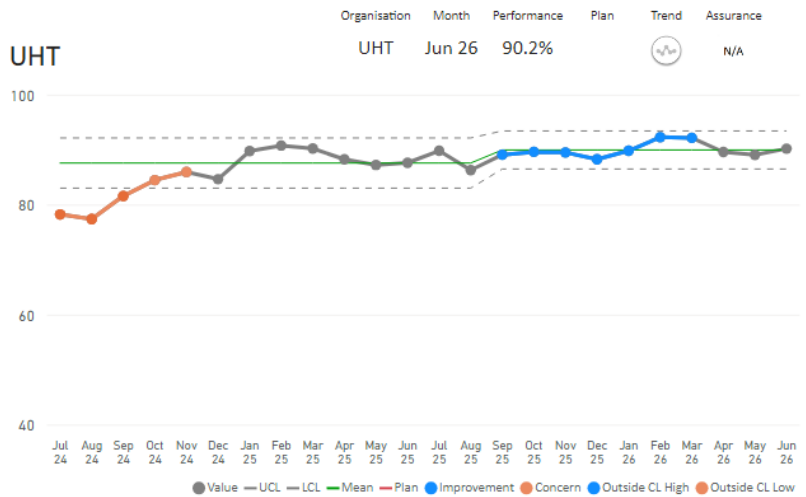


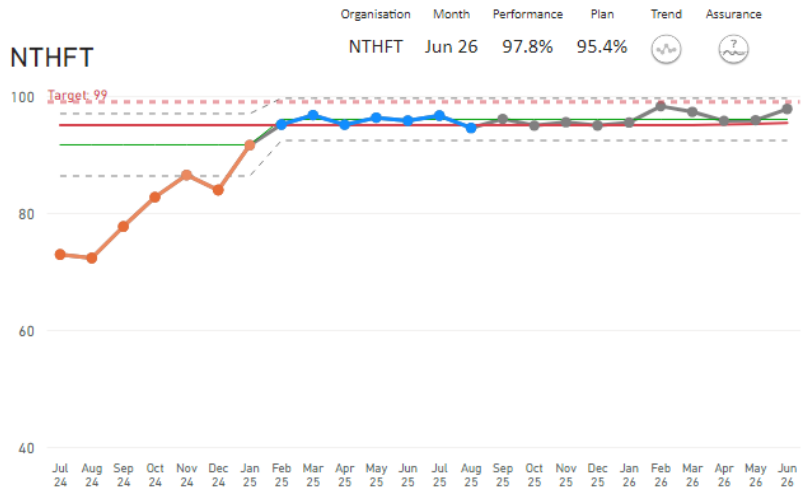



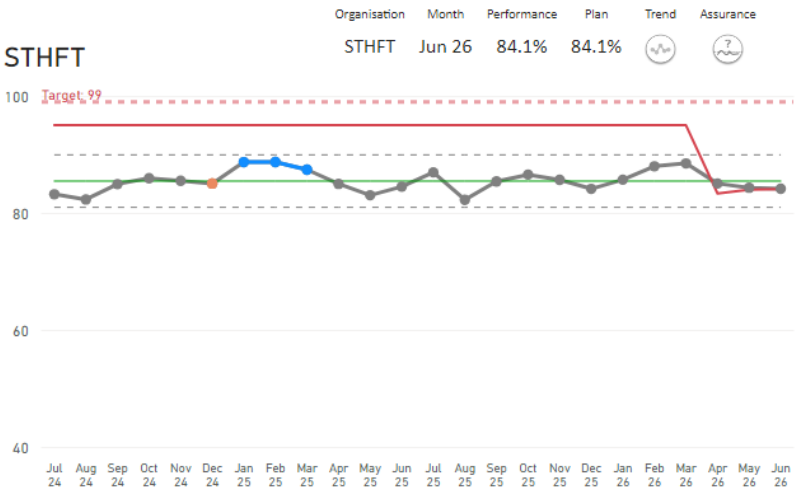

**Metric:** Percentage of patients on a cancer pathway who start treatment within 62 days of referral.
**Plan:** NHS Constitution standard 85%. Operational planning trajectories: NTHFT 76.1%, STHFT 76.1% by March 2027.
**Rationale:** NHS Contract metric.
**Data quality:** Assured, validated data.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** NTHFT: Advise. STHFT: Advise.
**Action taken:** Both Trusts are in NHSE tiered support for cancer 62-day performance. Regional meetings to address breast capacity are underway with mutual support and additional activity options being explored. Pathway changes implemented at STHFT have improved performance; UHT pathway improvement groups now established to deliver specific recovery trajectories.
**Executive lead:** Chief Delivery Officer
**Accountable to:** Resources Committee

## RESPONSIVE Diagnostic 6 Weeks Standard (%)

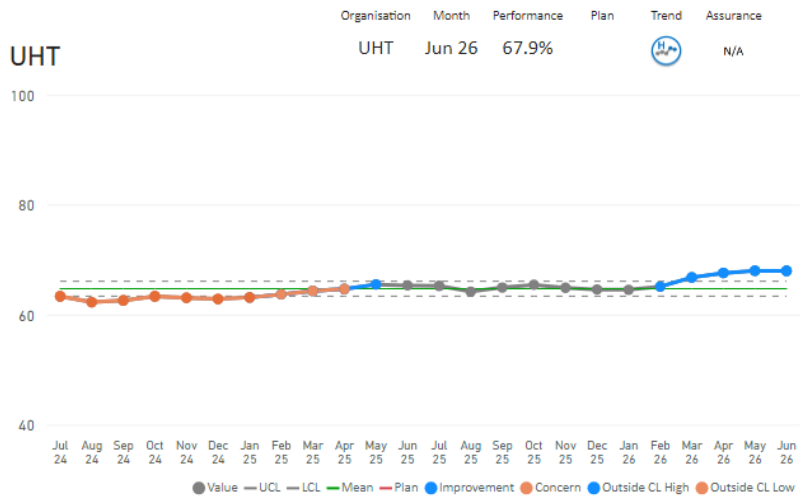


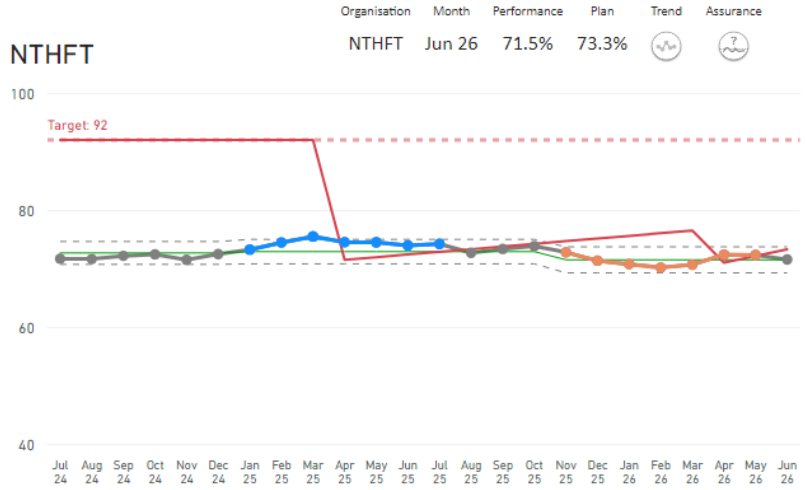

**Metric:** Percentage of patients waiting for a diagnostic test less than 6 weeks from referral,13 modalities.
**Plan:** NHS Constitution standard 99%; recovery plan NTHFT 3.5%, STHFT 10.3% by March 2027.
**Rationale:** NHS Contract metric.
**Data quality:** Assured, validated data.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** NTHFT: Advise. STHFT: Advise. Both trusts now meet plan but not statistically assured.
**Action taken:** Focus on optimising use of CDC capacity to support compliance with diagnostic, elective and cancer access targets.
**Executive lead:** Chief Delivery Officer
**Accountable to:** Resources Committee

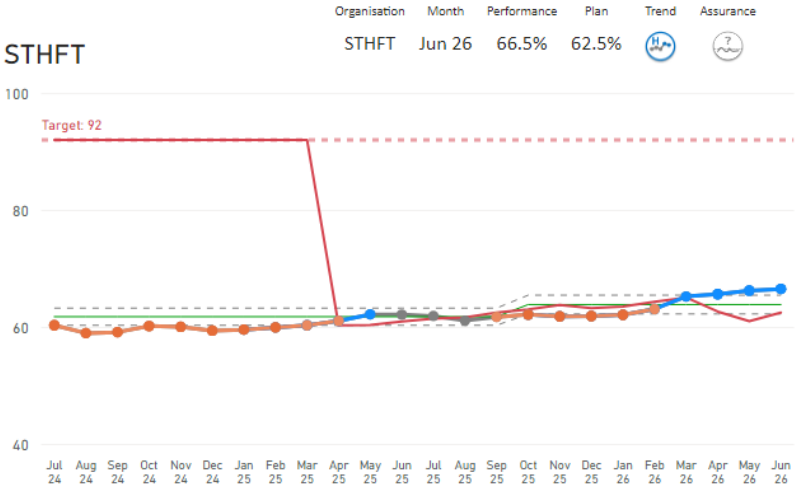


**RESPONSIVE** RTT Incomplete Pathways (%)

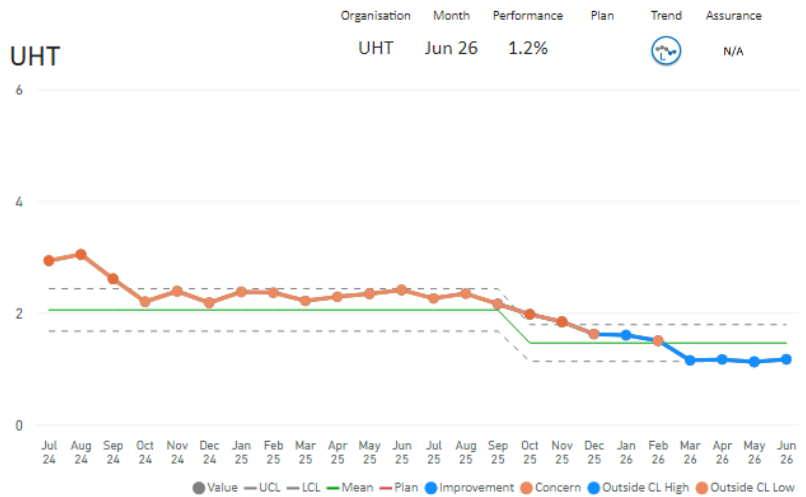


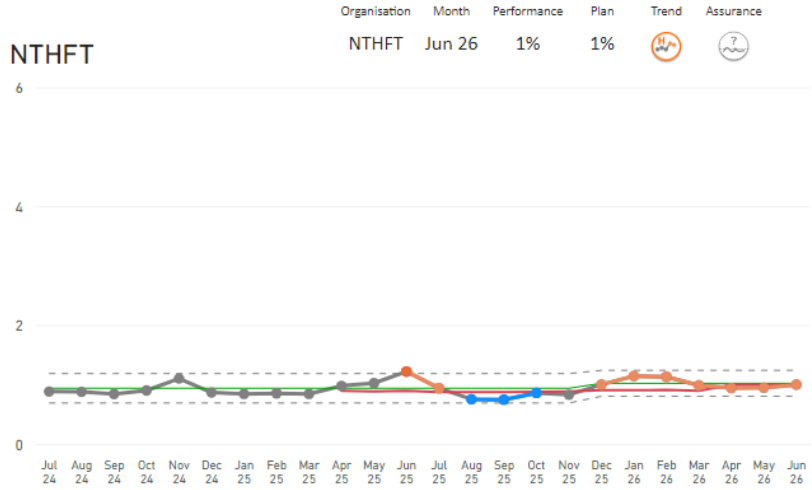



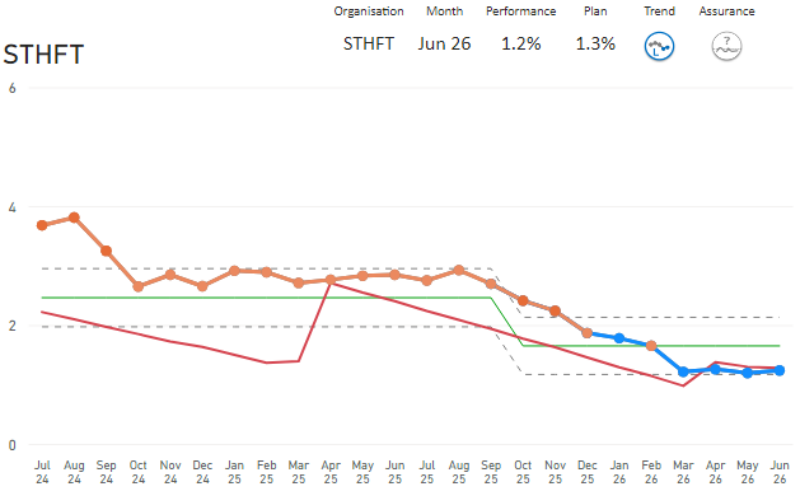

**Metric:** Percentage of patients awaiting elective treatment who have waited less than 18 weeks from referral.
**Plan:** NHS Constitution standard 92%; recovery plan NTHFT 83.5%, STHFT 72.0% by March 2027.
**Rationale:** NHS Contract metric.
**Data quality:** Assured, validated data.
**Trend:** NTHFT: No trend. STHFT: Improvement, performing above expected variation from March 2026.
**Assurance:** NTHFT: Advise. STHFT: Advise.
**Action taken:** The *Improving Better Together Programme* will provide a focused framework to improve RTT. Outpatient priorities: reducing follow up ratios through increasing PIFU, partial booking to reduce DNAs and optimising clinic templates, will increase outpatient capacity, with a wider strategy of proactive mutual support. Weekly elective access meetings are in place to problem-solve barriers to improvement, focus on the longest waiters.
**Executive lead:** Chief Delivery Officer
**Accountable to:** Resources Committee

## RESPONSIVE RTT 52 Week Waiters Rate

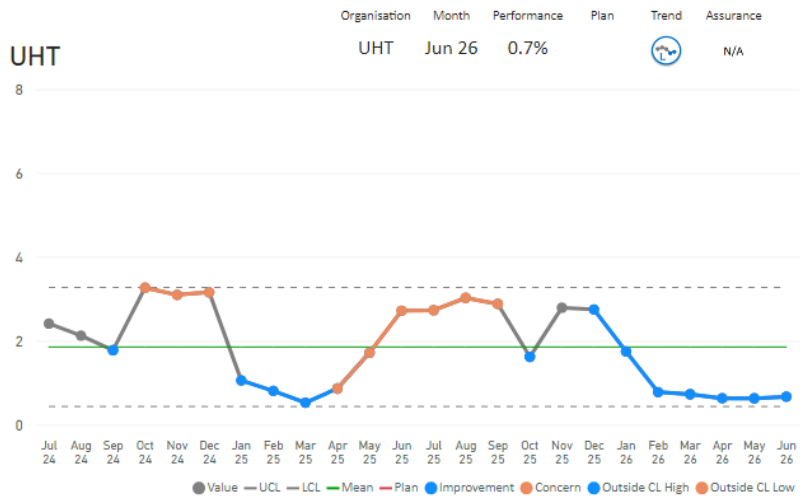


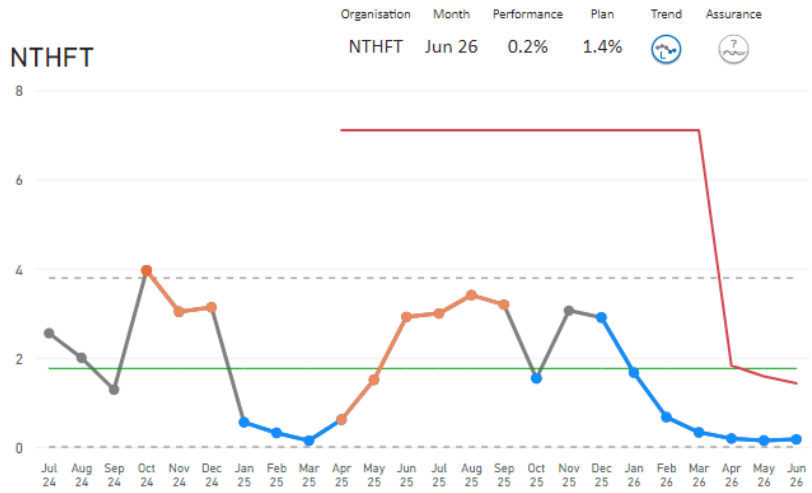

**Metric:** Rate of patients awaiting elective treatment who have waited more than 52 weeks from referral.
**Plan:** To maintain the number of 52-week waiters at less than 1% of the waiting list.
**Rationale:** NHS Contract metric.
**Data quality:** Assured, validated data.
**Trend:** NTHFT Declining performance for 7 consecutive months. STHFT: sustained improvement trend.
**Assurance:** NTHFT: Alert. STHFT: Advise.
**Action taken:** The UHT Elective Access Group scrutinise plans to eliminate 65 week waits and return to plan for 52 week waits. Services are utilising capacity more flexibly across UHT to improve patient access.
**Executive lead:** Chief Delivery Officer
**Accountable to:** Resources Committee

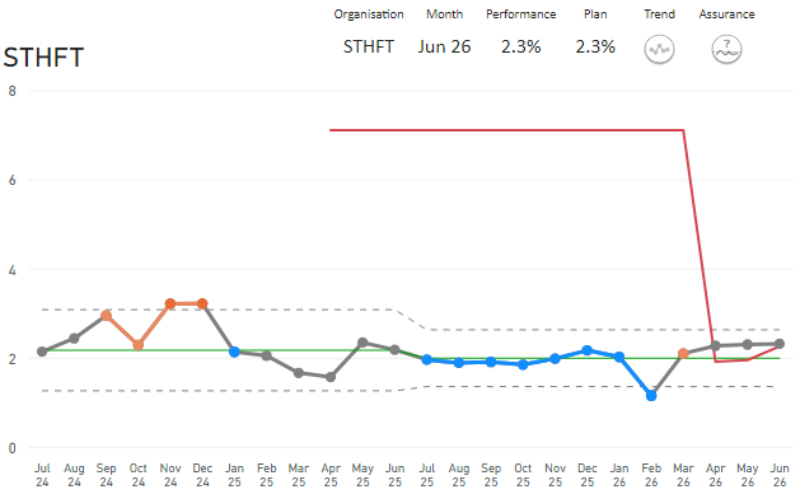


## RESPONSIVE Community Over 52 Week Waiters Rate

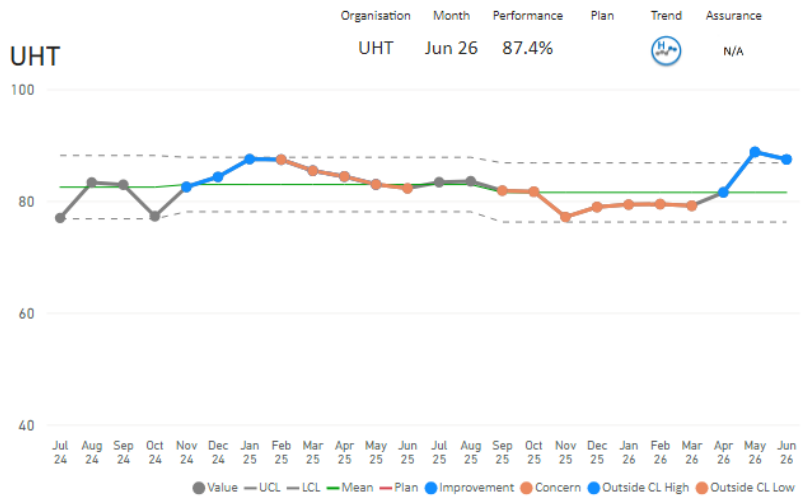


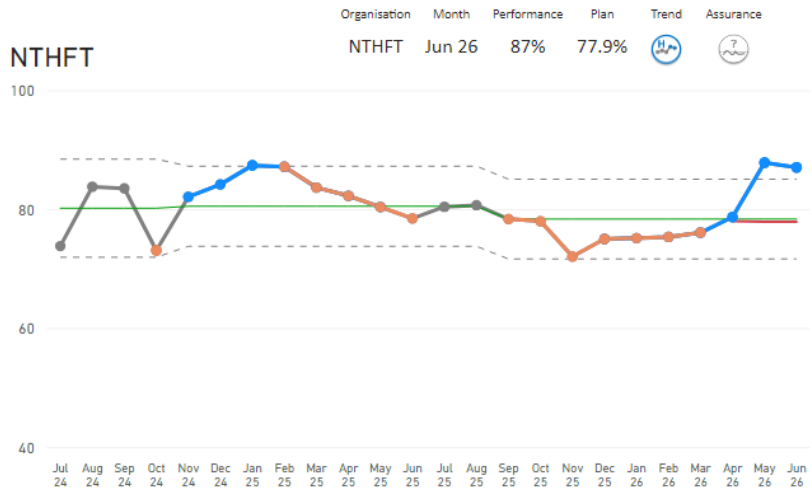



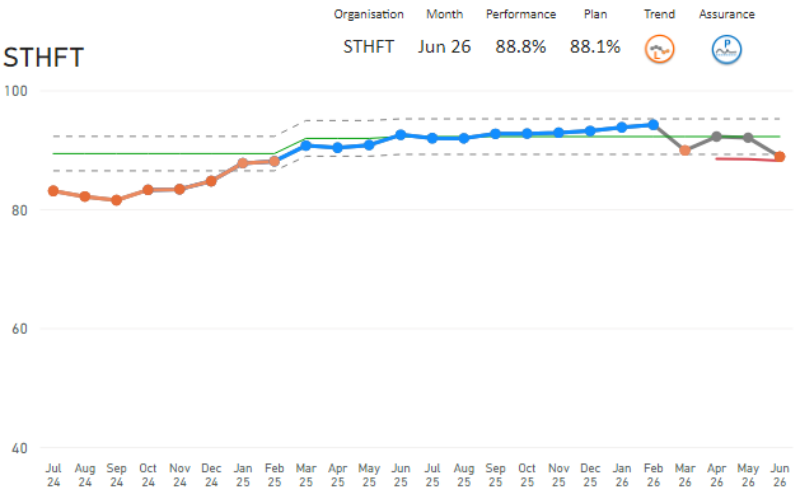

**Metric:** Rate of community patients awaiting treatment who have waited more than 52 weeks from referral.
**Plan:** Agreed operational planning trajectories per Trust.
**Rationale:** NHS Oversight Framework metric.
**Data quality:** Advisory, variation in reported position. further validation may be required.
**Trend:** NTHFT: Improvement trend for 7 consecutive months. STHFT: No trend.
**Assurance:** NTHFT: Advise. STHFT: Advise.
**Action taken:** Focused validation of reported position and bringing forward longest waiters. Capacity for paediatric therapy interventions is being addressed with recovery plans in place. Working with the ICB on the SWMS contract as demand exceeding capacity – cleansing/validation of the list on going
**Executive lead:** Chief Delivery Officer
**Accountable to:** Resources Committee

**RESPONSIVE** **Community 18 Week Compliance (%)**




**Metric:** Community 18 Week Compliance(%)
**Plan:** Agreed operational planning trajectories: NTHFT 81.8%, STHFT 88.3% by March 2027, Operational standard 2026/27 78%
**Rationale:** NHS operational planning guidance
**Data quality:** Advisory, variation in reported position. further validation may be required.
**Trend:** NTHFT: improvement trend with positive outlier May and June 2026. STHFT: Low outlier June 2026
**Assurance:** NTHFT: Advise, performance above plan is not yet assured. STHFT: Advise, performance above plan but lower than expected in June.
**Action taken:** Validation of reported position and bringing forward longest waiters. Recovery plans for paediatric therapies taking effect. Specialist weight management, is escalated to commissioners.
**Executive lead:** Chief Delivery Officer
**Accountable to:** Resources Committee



## CARING DOMAIN SUMMARY

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

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

Performance in patient experience surveys is measured as the percentage of respondents rating their experience overall as very good or good. For June 2026, NTHFT feedback was above plan in four out of the five surveys, not meeting plan for the inpatient score. STHFT were above plan in four of the five surveys. Maternity experience alerts a deteriorating trend at STHFT. The focus remains on increasing response rates to FFT surveys to provide more assurance that the information is reflective of the experience of our patients. STHFT are using Healthcare Guardian (HG) for all surveys. NTHFT will transition from an external service provider to HG in the near future.

Timely responses to complainants remains a key priority. Acknowledgement of receipt of the complaint within 3 working days fell below the 100% plan at NTHFT and decreased at STHFT. Given the level of compliance with no improvement trend, complaints closed within target is retained as Alert (NTHFT 59.3%, STHFT 46.5%). Due to poor performance targeted improvement interventions are being expedited, with a monthly action update to Quality Assurance Committee.

| North Tees & Hartlepool NHS FT | Plan | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A&E Experience (%) | 79% | 84.9% | 85.8% | 82.3% | 82.3% | 79.7% | 83% | 85.1% | 85.2% | 83.2% | 86% | 85.7% | 86.4% |
| Inpatient Experience (%) | 95% | 92.7% | 93.4% | 96.1% | 95.8% | 94.3% | 94.4% | 96.9% | 92.1% | 96.6% | 96.3% | 94.9% | 94% |
| Maternity Experience (%) | 92% | 94.3% | 96.2% | 95% | 93.8% | 94.8% | 95.3% | 97.8% | 96.8% | 93.6% | 91.5% | 98.4% | 97.8% |
| Outpatient Experience (%) | 94% | 94.2% | 94.4% | 94.1% | 94.9% | 94.7% | 95.7% | 94.9% | 94.7% | 94.8% | 95.1% | 94.5% | 94.8% |
| Community Experience (%) | 94% | 94.5% | 96% | 93.4% | 96.8% | 96.3% | 95.6% | 96.1% | 96.1% | 95.8% | 96.3% | 97.5% | 97.6% |
| Feedback Acknowledged in 3 Days (%) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 99.2% |
| Complaints Closed Within Target (%) | 80% | 62% | 73.6% | 76.8% | 73.5% | 80.5% | 69% | 70.4% | 69.2% | 58.1% | 70.3% | 56.5% | 59.3% |

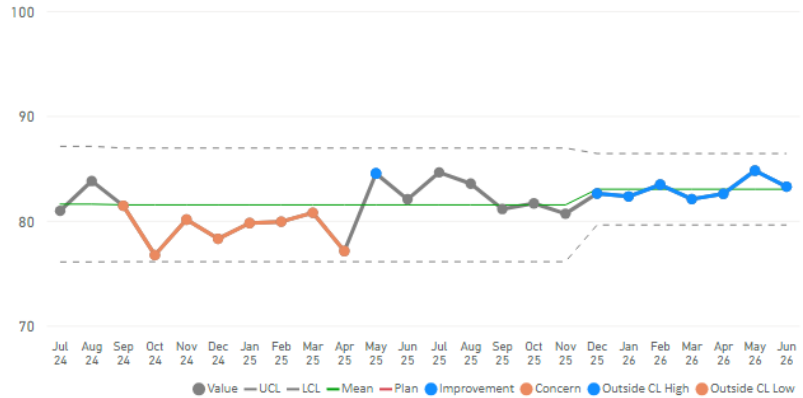
| South Tees Hospitals NHS FT | Plan | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A&E Experience (%) | 79% | 84.4% | 82.3% | 80.4% | 81.2% | 81.4% | 82.3% | 80.2% | 82.2% | 81.4% | 80.2% | 84.2% | 81.3% |
| Inpatient Experience (%) | 95% | 98.2% | 99.3% | 99.3% | 95.9% | 95.6% | 95.6% | 94.9% | 95% | 95.7% | 94.9% | 96.3% | 96% |
| Maternity Experience (%) | 92% | 89% | 91.2% | 91.3% | 96.6% | 91.5% | 89.9% | 87.8% | 86.1% | 83.2% | 87.8% | 85.7% | 90.3% |
| Outpatient Experience (%) | 94% | 95.8% | 95.7% | 96% | 95.3% | 96.6% | 93.8% | 94.5% | 94.6% | 94.5% | 94.5% | 94.9% | 94.2% |
| Community Experience (%) | 94% | 100% | 100% | 100% | 100% | 96.8% | 98.2% | 97.3% | 97.6% | 97.6% | 97.3% | 97.9% | 97.7% |
| Feedback Acknowledged in 3 Days (%) | 100% | 100% | 97.1% | 100% | 98.4% | 95.1% | 98.5% | 97.7% | 95% | 80.8% | 87.7% | 98.6% | 79.9% |
| Complaints Closed Within Target (%) | 80% | 53.3% | 54.9% | 48.3% | 52.4% | 32% | 48.1% | 59.1% | 41.8% | 32.6% | 45.3% | 25.7% | 46.5% |

## 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 25/26.
**Rationale:** NHS contract metric.
**Data quality:** Assured (manual and digital systems) but noting low response rates.
**Response rates:** NTHFT 6%, STHFT 9%.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** NTHFT: Assure, consistently exceeds plan. STHFT: Advise, plan met for 12 months but not statistically assured due to monthly variation.
**Action taken:** A&E waiting times continue to be the main theme noted in the survey comments. Actions to improve 4-hour standard performance.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

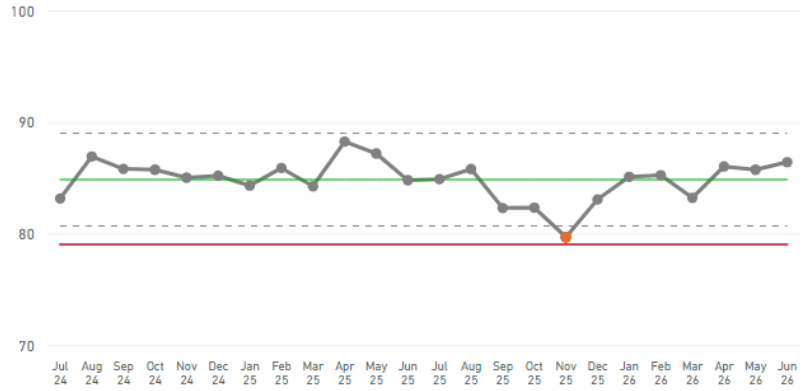
### UHT

| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| UHT | Jun 26 | 83.2% | | | N/A |



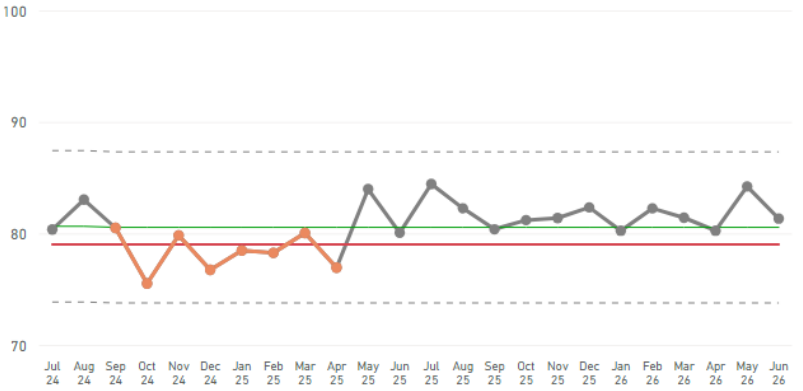

### NTHFT

| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| NTHFT | Jun 26 | 86.4% | 79% | | |

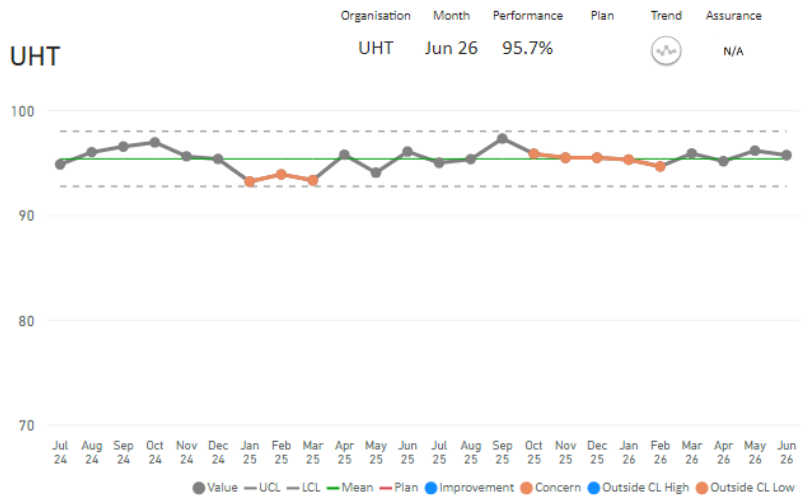


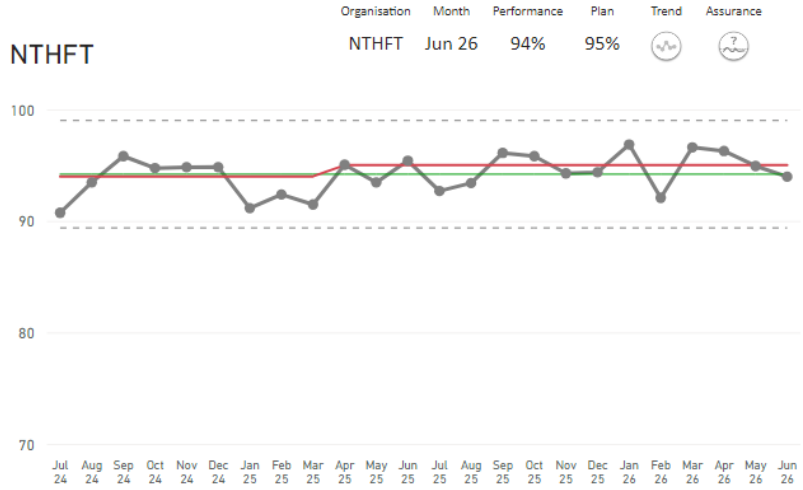

### STHFT

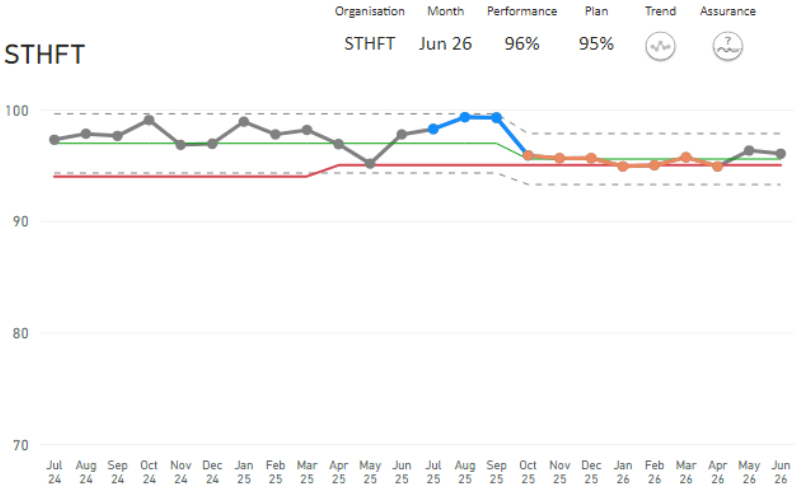
| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| STHFT | Jun 26 | 81.3% | 79% | | |



## CARING Inpatient Experience (%)

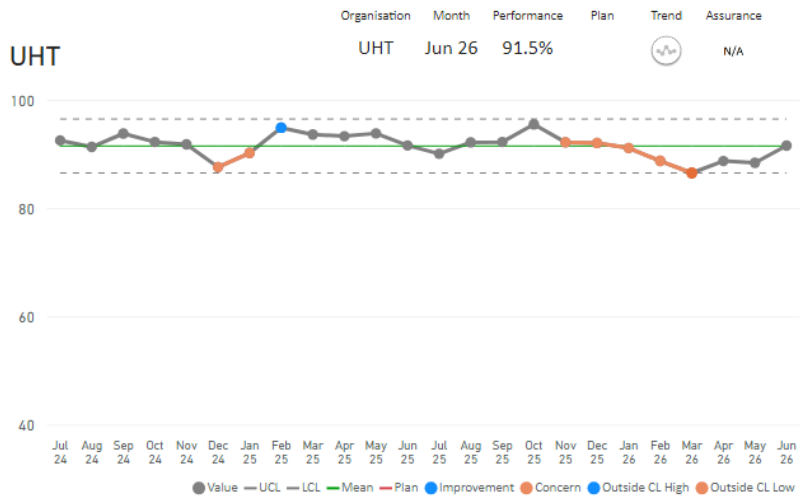


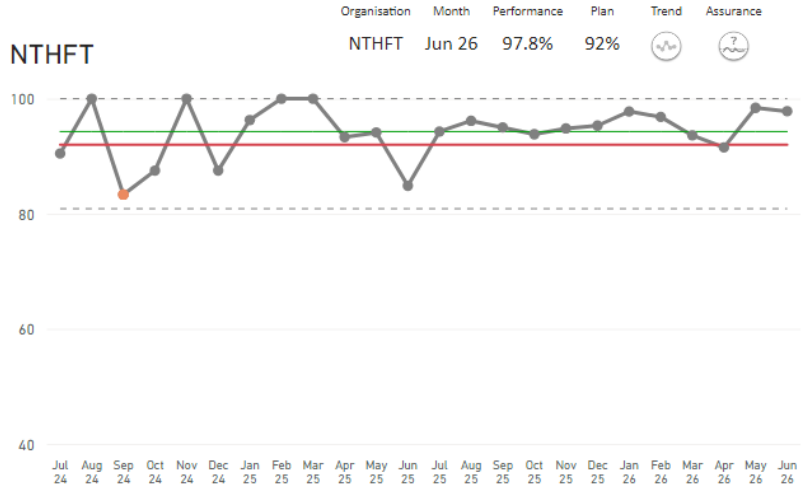



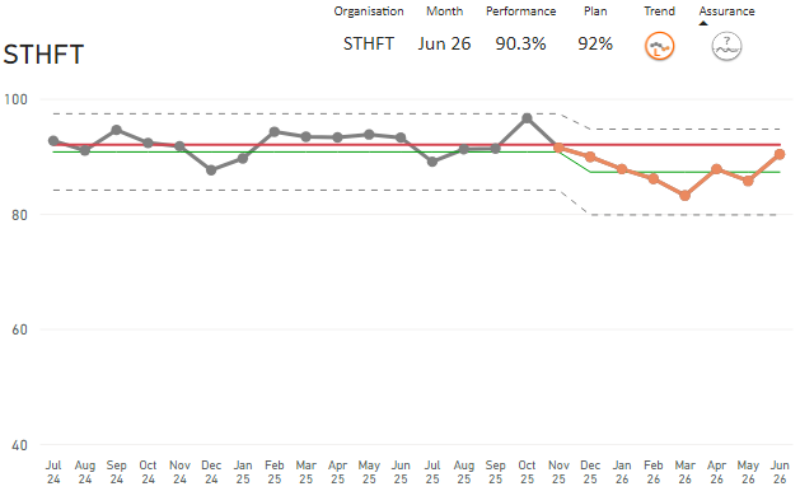

**Metric:** Percentage of respondents rating their inpatient experience good or very good in NHS Friends & Family test.
**Plan:** Local plan based on NHS Trusts average 25/26.
**Rationale:** NHS Contract metric.
**Data quality:** Assured, validated data, but noting lower response rates at NTHFT.
**Response rates:** NTHFT 12%, STHFT 23%.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** NTHFT: Advise, monthly variation in performance around plan. STHFT: Advise, performance stabilised, monthly variation around mean and close to plan.
**Action taken:** Continue to promote engagement with Friends and Family Test, particularly at NTHFT. STHFT has transitioned from Meridian to HCG, NTHFT plan to transition to HCG.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

## CARING Maternity Experience (%)

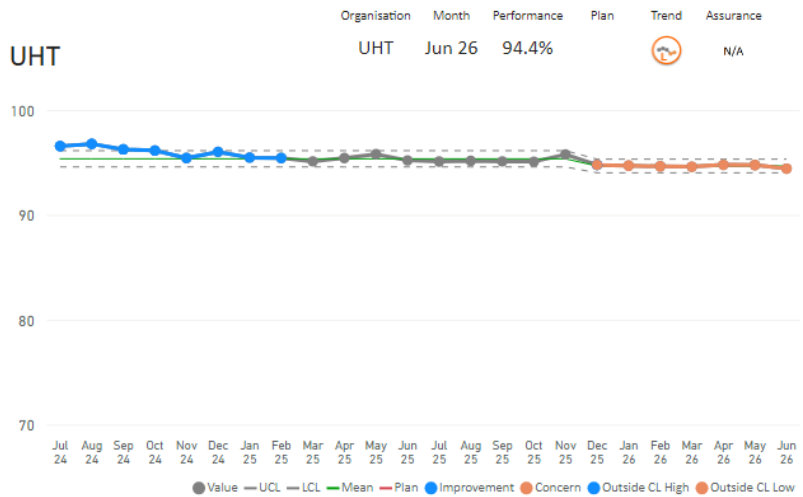


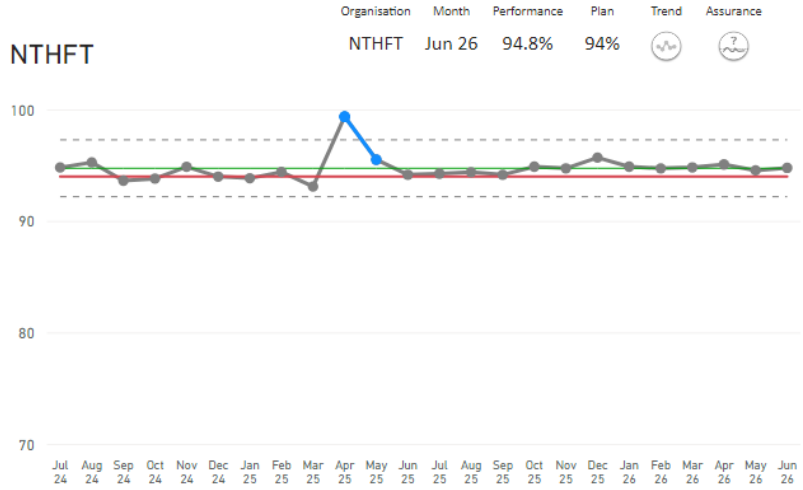

**Metric:** Percentage of respondents rating their maternity experience good or very good in NHS Friends & Family test.
**Plan:** Local plan based on NHS Trusts average 25/26.
**Rationale:** NHS Contract metric.
**Data quality:** Assured, validated data. Response rates and sample sizes can low, reported figure is Birth only.
**Response rates:** NTHFT 19%, STHFT 6%.
**Trend:** NTHFT: No trend. STHFT: Deteriorating trend.
**Assurance:** NTHFT: Advise. STHFT: Alert.
**Action taken:** Continue to promote engagement with Friends and Family Test, particularly at STHFT. STHFT has transitioned from Meridian to HG. NTHFT plan to transition to Healthcare Guardian.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

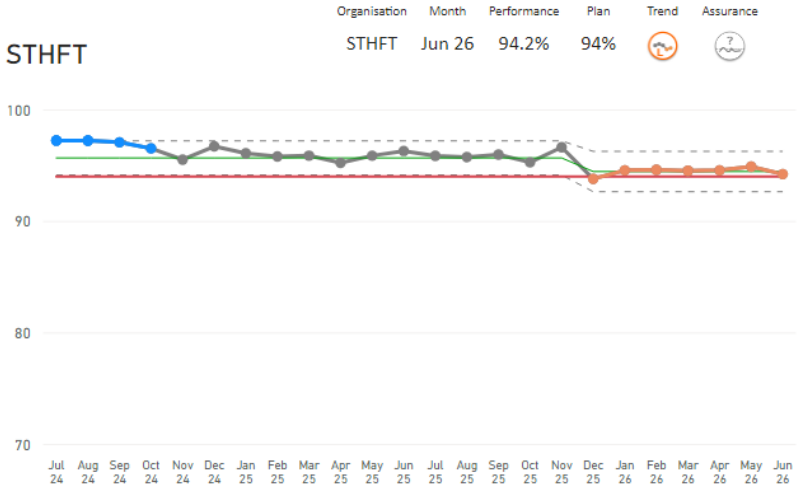


## CARING Outpatient Experience (%)

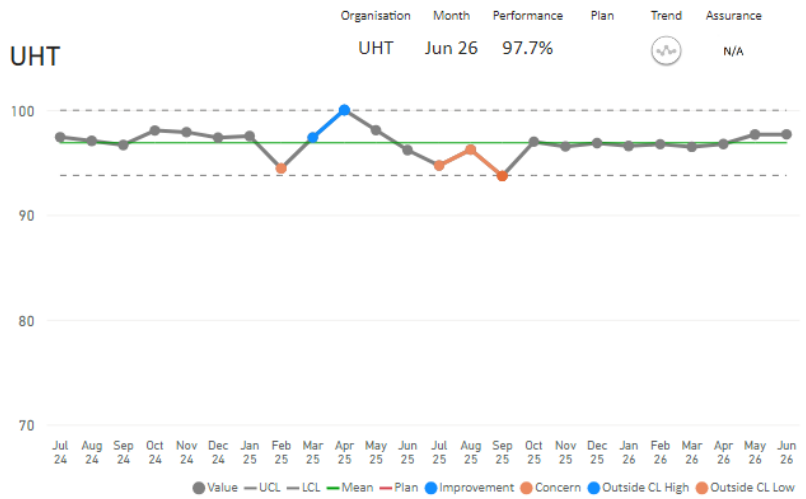


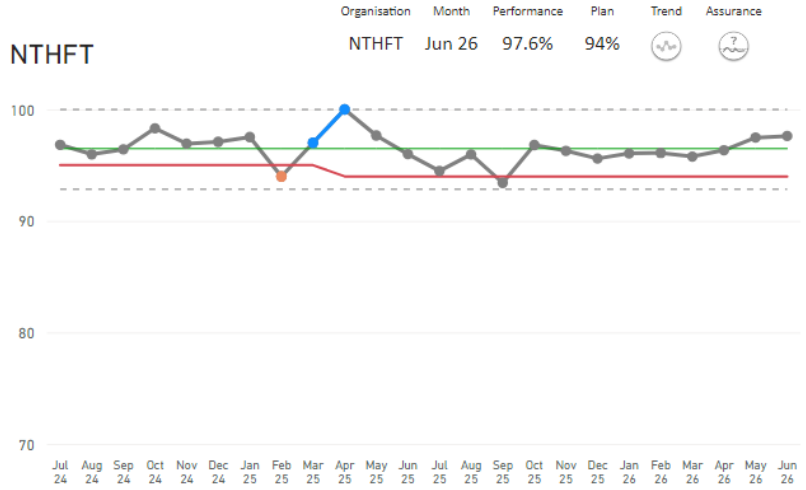



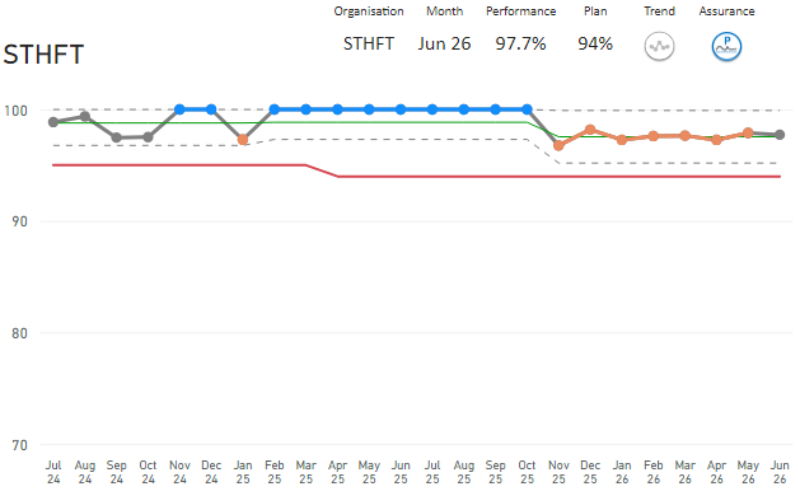




**Metric:** Percentage of respondents rating their outpatient experience good or very good in NHS Friends & Family test.
**Plan:** Local plan based on NHS Trusts average 25/26.
**Rationale:** NHS Contract metric.
**Data quality:** Assured, validated data.
**Response rates:** NTHFT 21%, STHFT 19%.
**Trend:** NTHFT: No trend. STHFT: Deteriorating performance for 7 consecutive months.
**Assurance:** NTHFT: Advise. Plan met since April 2025, not assured as variation is close to plan. STHFT: Alert. Plan no longer assured due to reduced performance.
**Action taken:** Continue to promote engagement with Friends and Family Test, particularly at STHFT. STHFT has transitioned from Meridian to HCG. NTHFT plan to transition to HCG.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

## CARING Community Experience (%)

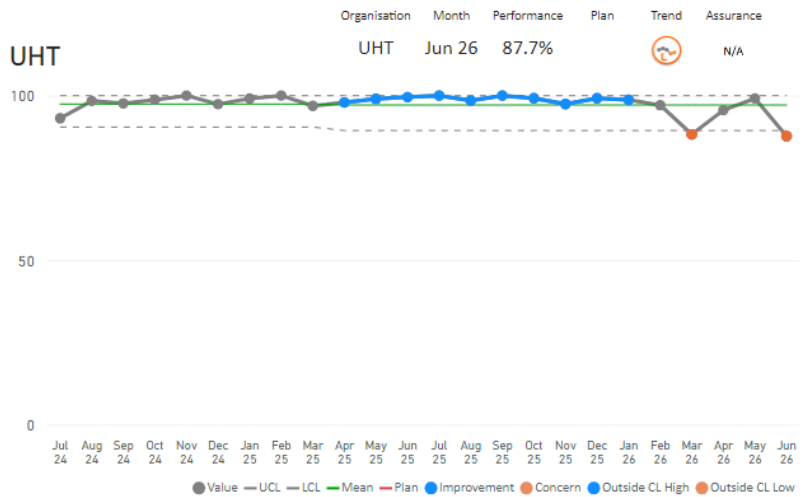


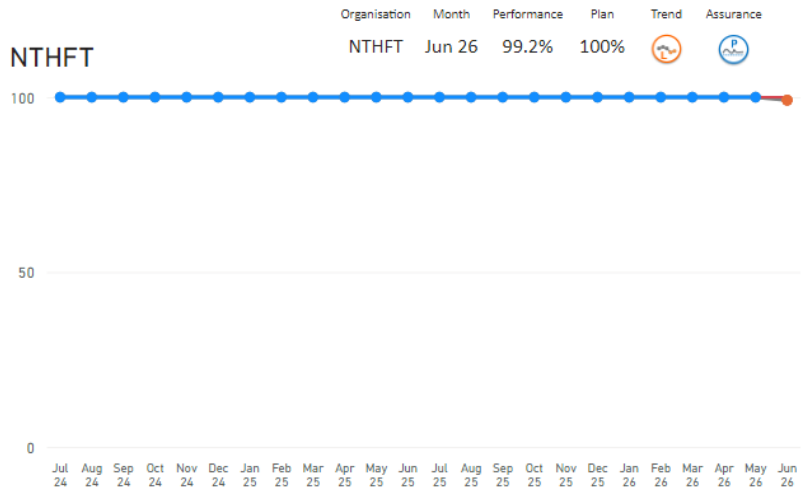



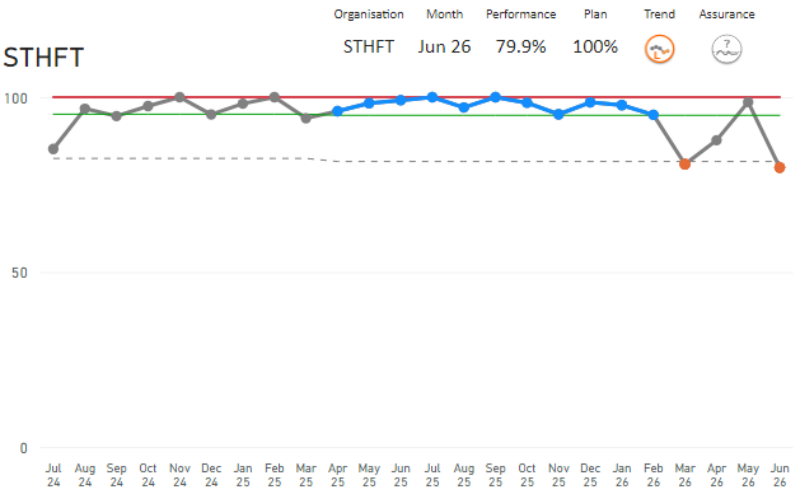

**Metric:** Percentage of respondents rating their community services experience good or very good in NHS Friends & Family test.
**Plan:** Local plan based on NHS Trusts average 25/26.
**Rationale:** NHS Contract metric.
**Data quality:** Assured, validated data, but noting low response rates.
**Response rates:** NTHFT 6%, STHFT 6%.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** NTHFT: Advise, above plan since October 2025 but not statistically assured. STHFT: Assure.
**Action taken:** Action planned at both NTHFT and STHFT to improve response rates in community services.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

## CARING Feedback Acknowledged in 3 Days (%)

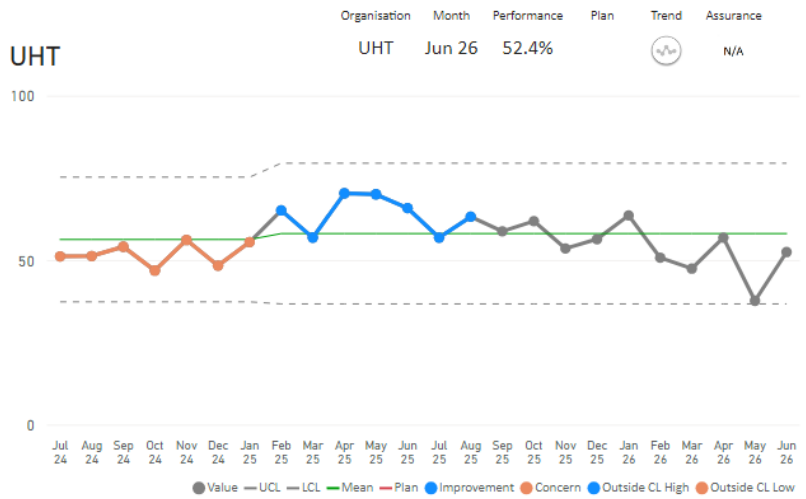



**Metric:** Percentage of complaints acknowledged in 3 days.
**Plan:** 100%.
**Rationale:** NHS Contract metric.
**Data quality:** Assured, validated data.
**Trend:** NTHFT: Outlier in June 2026, relative to usual full compliance. STHFT: Outlier in June 2026 outside of expected variance.
**Assurance:** NTHFT: Advise. STHFT: Alert.
**Action taken:** Work on aligning processes across UHT is underway to ensure the 3 working day target is consistently achieved. CSU 2 are pilot site for local closure of stage one complaints. More recent early feedback is showing positive results.
**Executive lead:** Chief Nursing Officer
**Accountable to:** Quality Assurance Committee

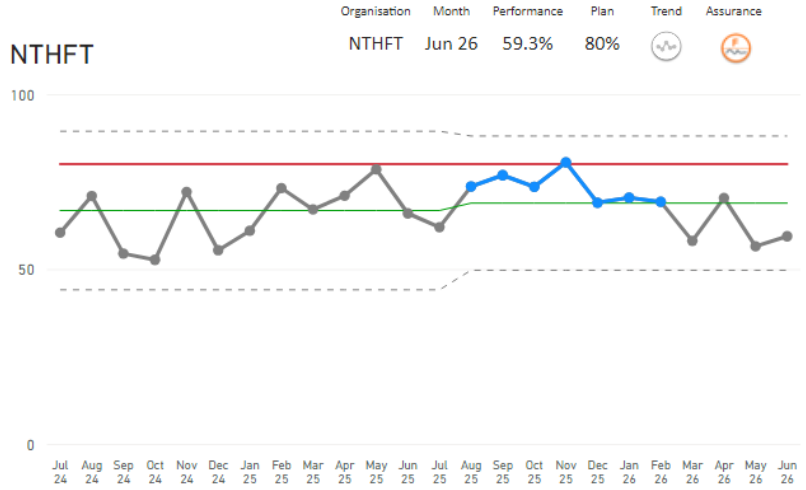


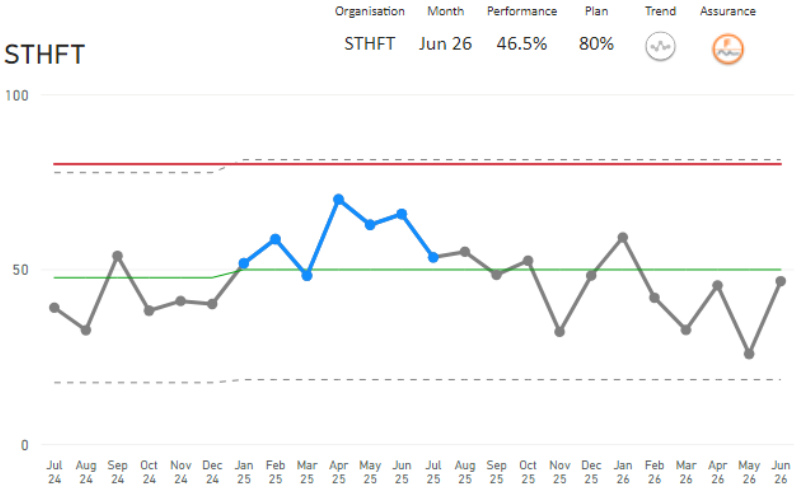



## CARING Complaints Closed Within Target (%)




**Metric:** Percentage of complaints closed in agreed timeframe.
**Plan:** 80%.
**Rationale:** NHS Contract metric.
**Data quality:** Assured, validated data. STHFT data definitions refreshed this month for consistency.
**Trend:** NTHFT: No trend. STHFT: No trend.
**Assurance:** NTHFT: Alert. STHFT: Alert. Whilst plan is within range of variation low compliance is alerted to Board.
**Action taken:** Improvement targets agreed with all CSUs and training offered on management of complaints.
**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**

Discussions with NHS England regarding the VR scheme are still underway with approximately 122 staff applying for VR. Appeal panels have been held and all appeals heard.

We are currently exploring the option of a digital absence management platform with the support from the Executive Team. Initial discussions with a potential have taken place and waiting further information on return on investment.

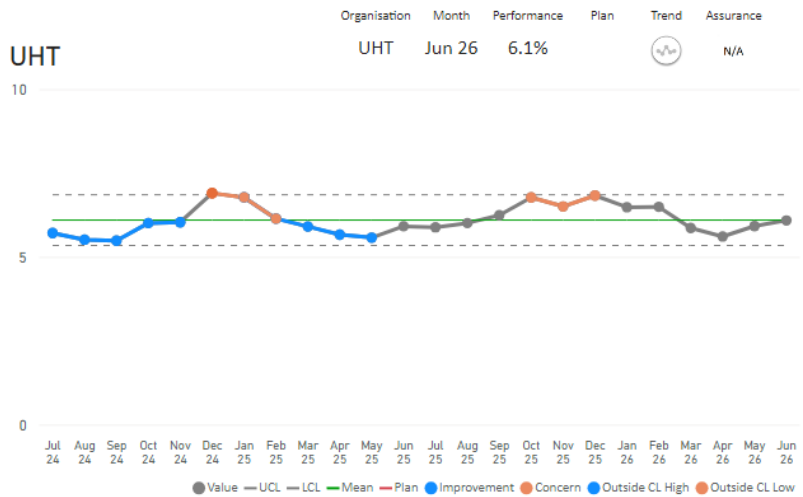
Revised, streamlined and standardised appraisal documentation has been agreed and implementation is progressing. BI dashboard is now live with appraisal data that allow managers target areas for improvement. Mandatory Learning Oversight Group monitors adherence to mandatory training targets. Work underway to improve compliance on all core topics whilst acknowledging national reform is likely to be published in coming months.

NTHFT position is reported to be on financial plan and is a deficit of £1.211m and STHFT position is reported to be on plan and is a deficit of £3.337m.

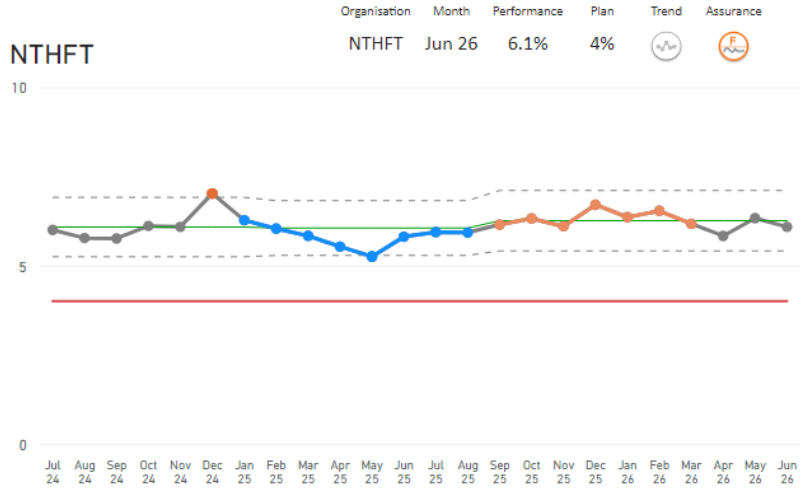
| North Tees & Hartlepool NHS FT | Plan | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sickness Absence (%) | 4% | 5.9% | 5.9% | 6.1% | 6.3% | 6.1% | 6.7% | 6.4% | 6.5% | 6.2% | 5.8% | 6.3% | 6.1% |
| Staff Turnover (%) | 10% | 7.4% | 7.6% | 7.5% | 7.6% | 7.7% | 7.6% | 7.7% | 7.7% | 7.6% | 7.5% | 7.8% | 8% |
| Annual Appraisal (%) | 85% | 88.6% | 87.9% | 88.1% | 87.9% | 87.5% | 86.5% | 85.4% | 85.6% | 85.3% | 85.7% | 85.2% | 86.5% |
| Mandatory Training (%) | 90% | 89.8% | 90.2% | 90% | 89.5% | 89.1% | 89.5% | 88.8% | 88.5% | 87.9% | 88.6% | 89.4% | 89.7% |
| Cumulative YTD Financial Position (£'millions) | -£1.211 | £0.416 | £0.833 | £0.85 | £0.693 | £0.389 | £0.601 | £0.176 | £0.542 | £3.28 | -£0.245 | -£0.687 | -£1.211 |

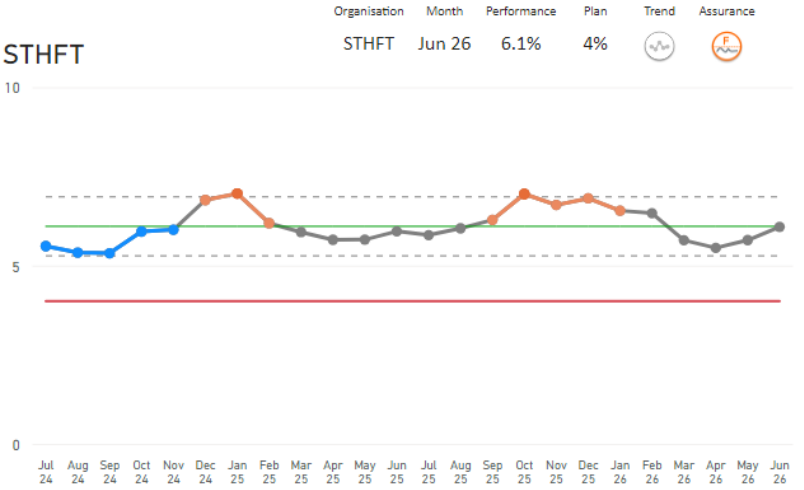
| South Tees NHS FT | Plan | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 | May 26 | Jun 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sickness Absence (%) | 4% | 5.9% | 6% | 6.3% | 7% | 6.7% | 6.9% | 6.5% | 6.5% | 5.7% | 5.5% | 5.7% | 6.1% |
| Staff Turnover (%) | 10% | 6.5% | 6.8% | 6.7% | 6% | 6.8% | 6.8% | 6.8% | 6.8% | 6.8% | 7% | 7.8% | 6% |
| Annual Appraisal (%) | 85% | 83.1% | 83.5% | 83.3% | 82.9% | 81.6% | 81.1% | 78.2% | 74.9% | 73.3% | 73.2% | 74% | 77.3% |
| Mandatory Training (%) | 90% | 86.2% | 85.9% | 84.7% | 84.8% | 84.7% | 84.6% | 83.7% | 83.7% | 82.6% | 82.3% | 81.7% | 84.5% |
| Cumulative YTD Financial Position (£'millions) | -£3.337 | -£4.503 | -£5.725 | -£6.232 | -£6.813 | -£7.596 | -£9.293 | -£10.066 | -£10.198 | -£4.138 | -£1.75 | -£3.186 | -£3.337 |

## WELL LED Sickness Absence (%)

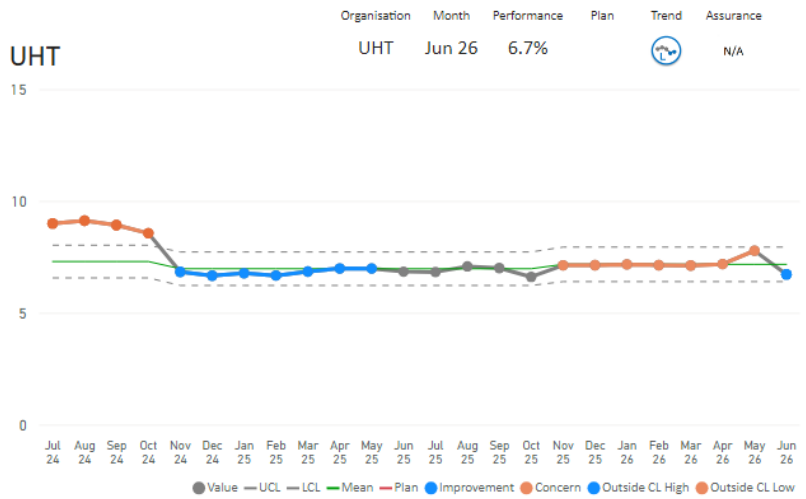


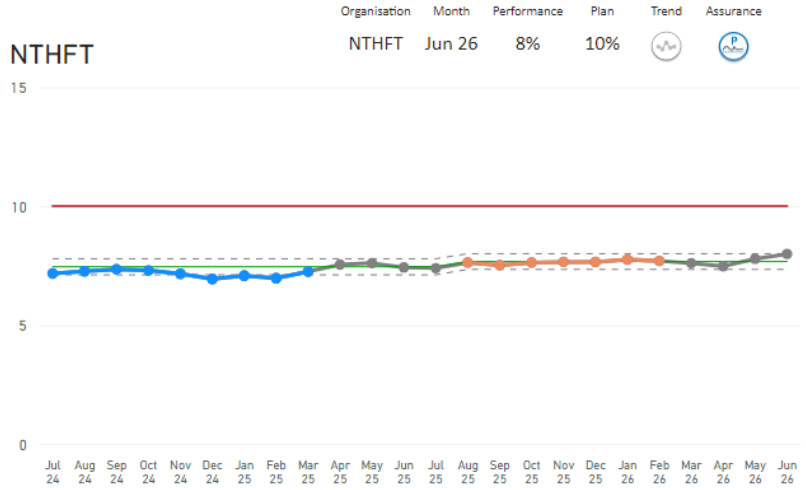

**Metric:** Percentage of staff working hours lost to sickness absence (all types) in each month.
**Plan:** Trust internal plans: 4%.
**Rationale:** ICB Contract metric.
**Data quality:** Assured, validated data.
**Trend:** NTHFT: No trend. STHFT: No trend
**Assurance:** NTHFT: Alert. STHFT: Alert.
**Action taken:** The UHT policy has been finalised for publication in August 2026. This will provide further robust case management processes. Roll out of the training programme to support the application of this policy commences in August.
**Executive Lead:** Chief People Officer
**Accountable to:** People Committee

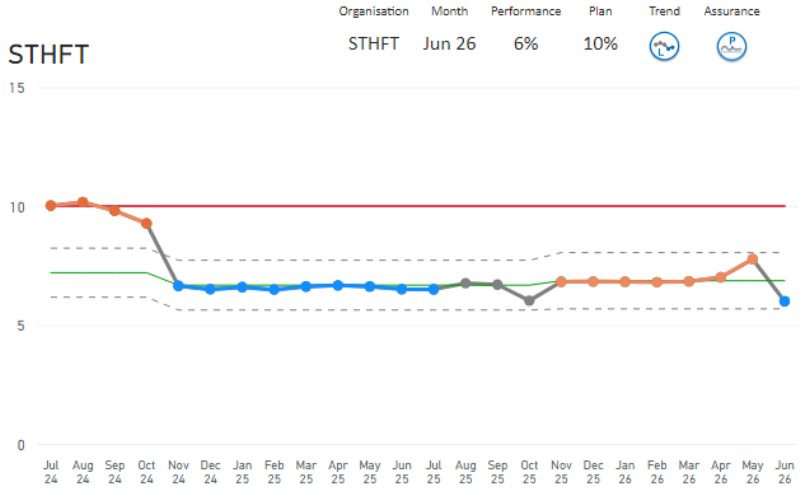


## WELL LED Staff Turnover (%)

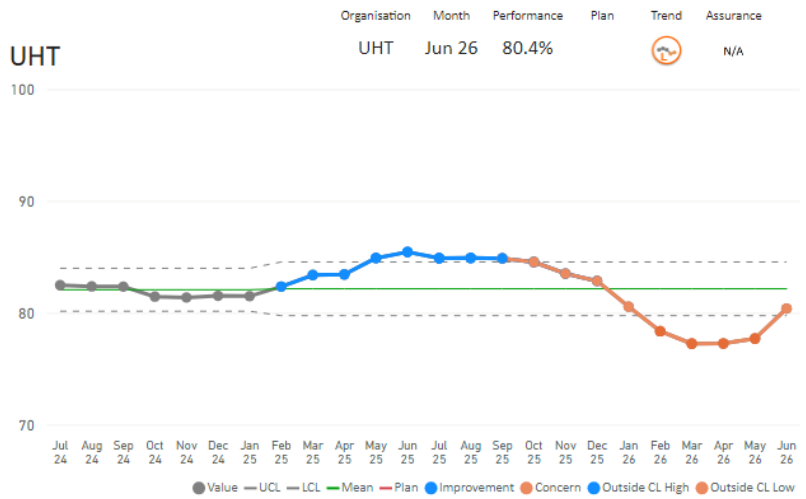


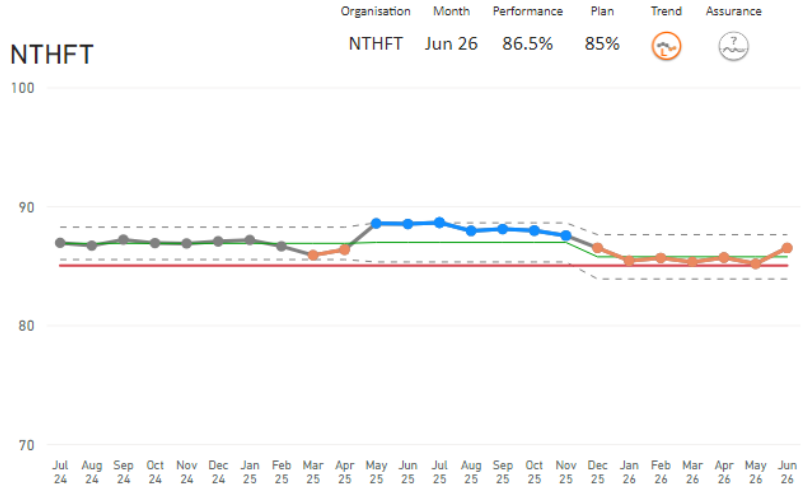



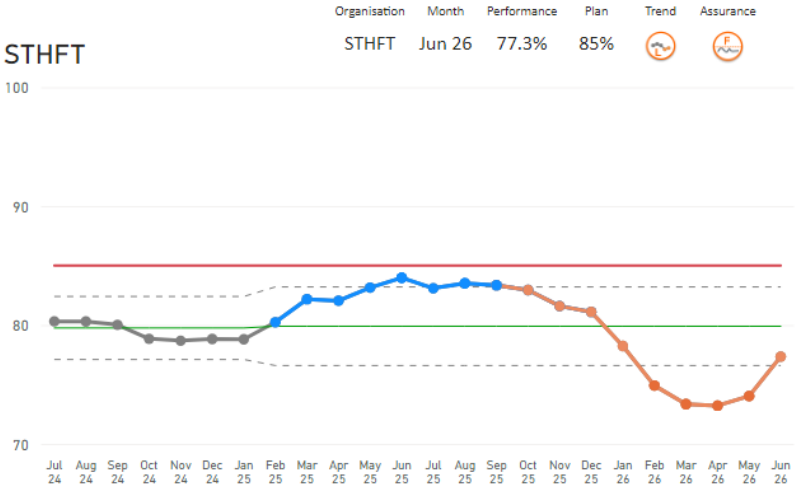

**Metric:** Percentage of staff changing or leaving job roles in the month (all staff groups, all changes).
**Plan:** Trust internal plans: 10%.
**Rationale:** ICB Contract metric.
**Data quality:** Assured, validated data. Alignment of the metric criteria has improved STHFT reported performance from November 2024.
**Trend:** NTHFT: No trend. STHFT: Positive outlier June 2026.
**Assurance:** NTHFT: Assure. STHFT: Assure.
**Action taken:** Analysis of data continues to identify any specific areas where turnover is an outlier and exploration into reasons taking place.
**Executive lead:** Chief People Officer
**Accountable to:** People Committee

## WELL LED Annual Appraisal (%)

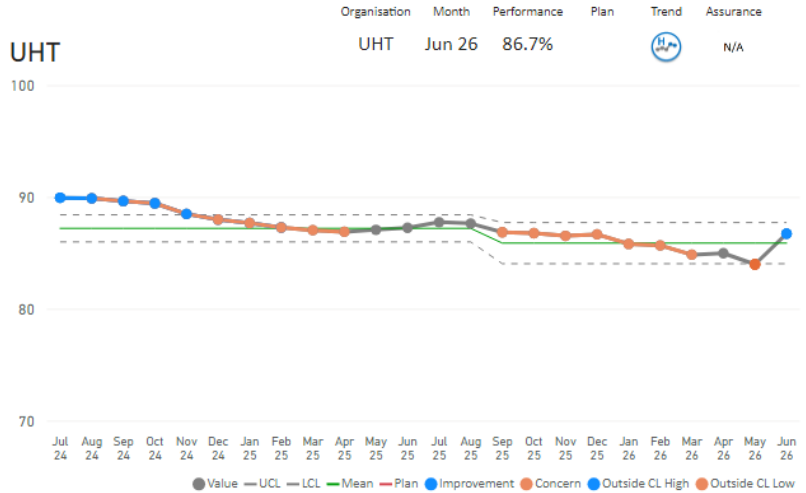



**Metric:** Percentage of staff with annual appraisal completed in last 12 months, at month end.
**Plan:** Trust internal plans: 85%.
**Rationale:** ICB Contract metric.
**Data quality:** Assured, validated data.
**Trend:** NTHFT: Deteriorating performance from previously higher compliance. STHFT: Deteriorating compliance.
**Assurance:** NTHFT: Alert. STHFT: Alert.
**Action taken:** Visual information for colleagues on revised appraisal has been developed and will be rolled out across the organisation. Appraisal deep dive paper was presented to People Committee in July 2026.
**Executive lead:** Chief People Officer
**Accountable to:** People Committee

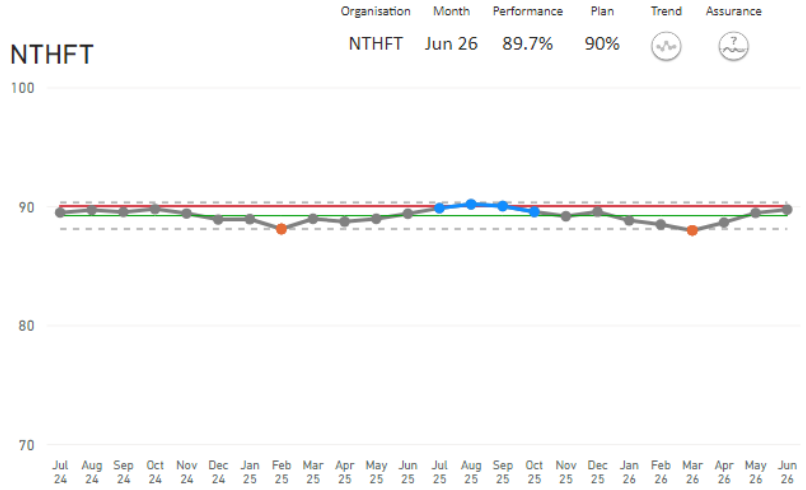


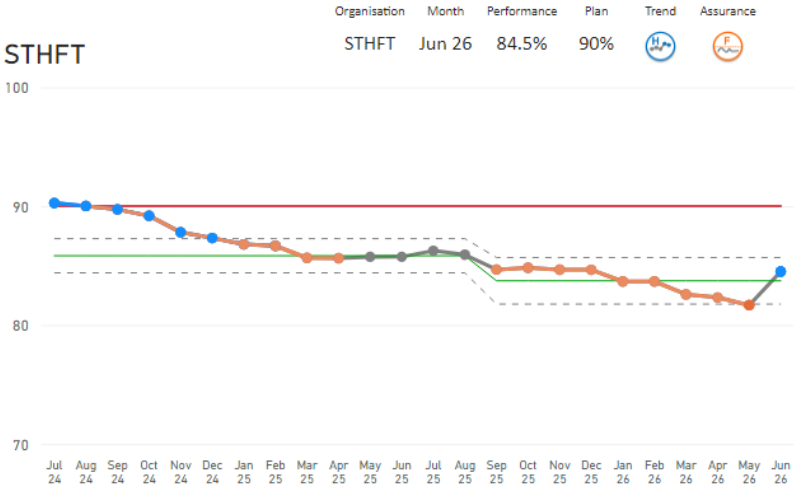



## WELL LED Mandatory Training (%)




**Metric:** Percentage of mandatory training elements within date, across all staff groups at month end.
**Plan:** Trust internal plans: 90%.
**Rationale:** ICB Contract metric.
**Data quality:** Assured, validated data.
**Trend:** NTHFT: No trend. STHFT: performance has returned within expected variance, and above previous average following a period of sustained deterioration.
**Assurance:** NTHFT: Advise, target is not met but is within range of variation. STHFT: Advise, recent improvement.
**Action taken:** BI dashboard developed to support managers to target areas for improvement. Mandatory training compliance forms part of QPR meetings with CSUs. Data will continue to be analysed to identify areas requiring supporting in meeting threshold.
**Executive lead:** Chief People Officer
**Accountable to:** People Committee

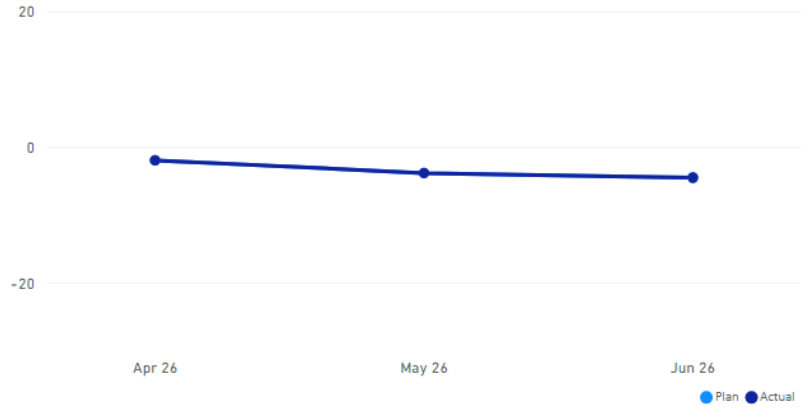


## WELL LED Cumulative YTD Financial Position (£'millions)

UHT

| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| UHT | Jun 26 | -£4.548 | -£4.548 | N/A | N/A |




NTHFT

| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| NTHFT | Jun 26 | -£1.211 | -£1.211 | N/A | N/A |




STHFT

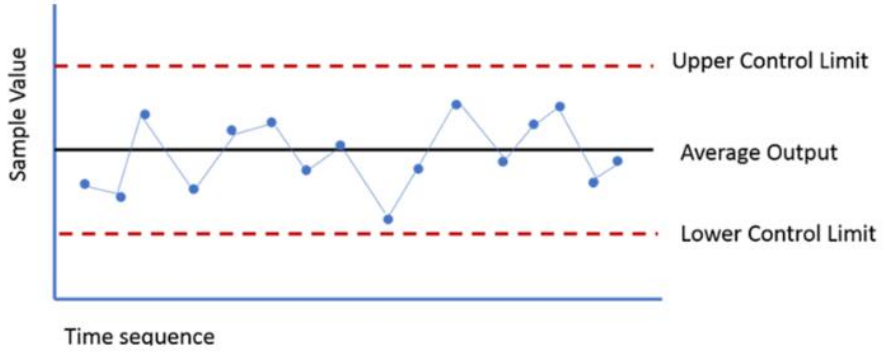
| Organisation | Month | Performance | Plan | Trend | Assurance |
|---|---|---|---|---|---|
| STHFT | Jun 26 | -£3.337 | -£3.337 | N/A | N/A |




**Metric:** Cumulative year to date financial position.
**Plan:** Trust plans agreed with NHSE. Both NTHFT and STHFT are required to deliver a break-even plan for 2026/27.
**Rationale:** ICB Contract metric.
**Data quality:** Assured, validated data.
**Trend:** Financial position tracks plans.
**Assurance:** Advise: At Month 3, NTHFT position is reported to be on plan and is a deficit of £1.211m and STHFT position is reported to be on plan and is a deficit of £3.337m. Both trusts are forecasting to be on plan at the 31st March 2027.
**Action taken:** Financial controls in place, focus on recurrent efficiency delivery, and oversight of financial risks through Resources Committee.
**Executive lead:** Chief Finance Officer
**Accountable to:** Resources Committee

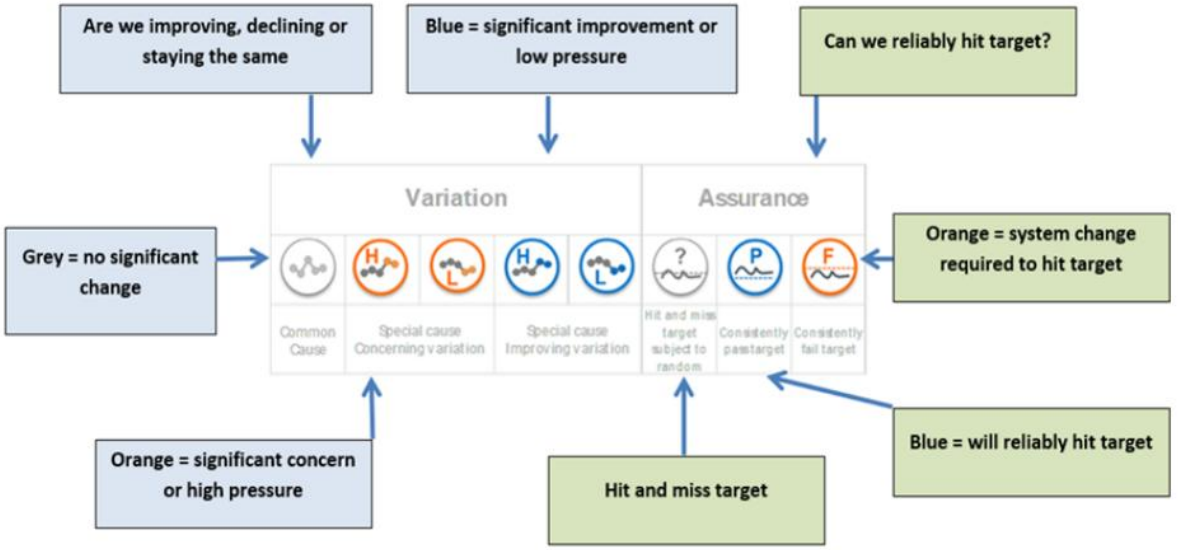
## OVERVIEW SPC CHARTS

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**



NHS
University Hospitals Tees

# Thank you

Caring
Better
Together

University Hospitals Tees

# Sustainability Plan Update

**Meeting date:** 3 September 2026

**Reporting to:** Board of Directors

**Agenda item No:** 4.4

**Report author:** Laura Hallett - Waste & Sustainability Manager (STFT) and Steve Bell - Environmental Services and Sustainability Manager (NTH Solutions)

**Executive director sponsor:** Steve Taylor - Director of Estates

**Action required:** Assurance

**Delegation status:** **Jointly delegated item to Group Board**

**Previously presented to:** UHT Management Assurance

## UHT strategic objectives supported:

Putting patients first ☒

Creating an outstanding experience for our people ☒

Working with partners ☒

Reforming models of care ☒

Developing excellence as a learning organisation ☒

Using our resources well ☒

## CQC domain link:

Well-led

## Board assurance / risk register this paper relates to:

Estates

## Key discussion points and matters to be escalated from the meeting

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

The cost of utilities (gas, electricity, water and oil) for FY25/26 for North Tees was £3.9M. The cost for South Tees was £10.6M.

UHT is upholding the NHS ambition to be the first Net Zero health system in the world by ensuring that the NHS 2040 & 2045 targets, set by Government, are being worked towards. We recognise that if we are to provide the best possible care to our patients and improve their quality of life, we need to significantly reduce our impact on the environment.

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

The Trust is progressing net zero clinical transformation through the development of Hospital at Home and wider out-of-hospital care models, enabling clinically appropriate patients to receive care in their own homes. This approach supports admission avoidance, earlier discharge and improved patient experience, while reducing reliance on the acute estate and associated carbon emissions.

The Hospital at Home service forms part of a broader system-wide approach across UHT, with similar models delivered through virtual wards and community-based services, supporting pathway redesign across acute and community care. These initiatives align with national priorities to deliver digitally enabled, preventative and lower-carbon care, embedding sustainability considerations into clinical transformation and service development.

A staff travel survey is planned for 2026, which will inform the development of a UHT wide travel strategy.

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

Monday 15th June 2026 was the first UHT dedicated Sustainability Day and showcased achievements and promoted best practice.

South Tees has made strong progress in reducing energy consumption and carbon emissions, supported by targeted investment in estate infrastructure, including the energy centre optimisation works at James Cook University Hospital (JCUH). Since completion in July, JCUH has recorded a 2% reduction in electricity consumption and a 5% reduction in gas usage.

The North Tees carbon impact of electricity and steam, combined with water, waste, oil and business miles show that the Trust carbon footprint for FY2025/26 currently sits at 10,302

$tCO_2e$. This is a decrease of 2.8% on the previous year. South Tees has achieved a 3% reduction in total carbon emissions, decreasing from 21,162 $tCO_2e$ to 20,473 $tCO_2e$.

The University Hospitals Tees Digital Programme Team was recognised nationally, winning 'Digital Transformation Organisation of the Year' at the Health Service Journal (HSJ) Digital Awards. This award acknowledges a clinically led transformation from paper-based records to a fully electronic system, delivering significant benefits including enhanced patient safety, improved clinical decision-making, increased time for direct patient care, and notable efficiency and cost improvements.

We have expanded the existing EV charging infrastructure at University Hospital of North Tees through the install of a 200KW EV charger to support the transition by NEAS (North East Ambulance Service) to a low emission fleet.

We have received external Salix funding of £46m (£16m UHH, £20m JCUH and £10m FHN) for investment in carbon reducing measures across UHT since 2024. UHH and FHN projects are both completing in FY26/27 and JCUH in FY27/28.

Great strides are being made in reducing our carbon footprint but the current initiatives and capital investment will not support us reaching the NHS net zero target. The final element of achieving net zero across UHT requires a culture change to embrace zero carbon solution across all the services we provide. Green champions play an essential role in delivering this message and changing our culture.

## Recommendations:

UHT Management Team are asked to accept this report, which outlines the progress being made in sustainability by detailing the initiatives and projects currently underway to support UHT's objectives and ambitions as set out in each Trusts Green Plan.

# South Tees – Sustainability Update

## 1. PURPOSE OF REPORT

This report provides an update on the current position regarding North Tees and Hartlepool NHS Foundation Trust green strategy and the initiatives currently being undertaken.

## 2. RECOMMENDATIONS

The recommendation is to accept this report, which demonstrates the progress being made in terms of sustainability by detailing the initiatives and projects currently being progressed to achieve Trust objectives and ambitions in terms of the revised Green Plan, and its update as per NHSE guidance.

## 3. BACKGROUND

The Trust is upholding the NHS ambition to be the first Net Zero health system in the world by ensuring that the NHS 2040 & 2045 targets, set by Government, are being worked towards. We recognise that if we are to provide the best possible care to our patients and improve their quality of life, we need to significantly reduce our impact on the environment.

## 4. DETAIL

### Green Plan Summary

In response to national NHS guidance, organisations were required to refresh their Green Plans in 2025. The Trust's Green Plan 2025–2028, approved in July 2025, outlines progress to date and sets out key priorities for the next three years. The plan is aligned with the Delivering a Net Zero NHS Strategy, alongside supporting national frameworks including the Estates Net Zero Delivery Plan, Net Zero Travel and Transport Strategy, and the Net Zero Supplier Roadmap, ensuring a coordinated approach to achieving net zero objectives.

### Green Plan Governance

Delivery of the Trust's Green Plan is supported through a clear governance and accountability structure, with executive leadership at Board level for net zero and sustainability to ensure strategic oversight and organisational commitment. Regular reporting is embedded within existing governance frameworks, with progress, risks and performance monitored through formal committee structures, including reporting to the Resources Committee, in line with corporate accountability arrangements.

Progress is further embedded within operational management through routine reporting into the Estates and Facilities Directorate Management Team, ensuring alignment with estates strategy and wider operational delivery. This structured approach reflects national guidance by ensuring clear lines of accountability, defined roles and responsibilities, and integration of sustainability into existing governance systems, supporting effective delivery of net zero objectives across the organisation.

Key areas of progress include:

- **Workforce and Leadership**
  Progress has been driven through strengthened collaboration with neighbouring NHS organisations and public sector partners, supporting delivery of the Trust's Green Plan and enabling the sharing of best practice. Sustainability is now embedded within Trust induction, ensuring all new starters understand key environmental priorities and their role in supporting them.

In addition, the Trust now hosts an annual Sustainability Day, showcasing progress against Green Plan objectives and setting future priorities, with contributions from both internal teams and external guest speakers to support knowledge sharing and continuous improvement.

- **Net Zero Clinical Transformation**
  The Trust is progressing net zero clinical transformation through the development of Hospital at Home and wider out-of-hospital care models, enabling clinically appropriate patients to receive care in their own homes. This approach supports admission avoidance, earlier discharge and improved patient experience, while reducing reliance on the acute estate and associated carbon emissions.

  At James Cook, the Hospital at Home service forms part of a broader system-wide approach across South Tees, with similar models delivered through virtual wards and community-based services, supporting pathway redesign across acute and community care. These initiatives align with national priorities to deliver digitally enabled, preventative and lower-carbon care, embedding sustainability considerations into clinical transformation and service development.

- **Digital transformation**
  The University Hospitals Tees Digital Programme Team was recognised nationally, winning 'Digital Transformation Organisation of the Year' at the Health Service Journal (HSJ) Digital Awards. This award acknowledges a clinically led transformation from paper-based records to a fully electronic system, delivering significant benefits including enhanced patient safety, improved clinical decision-making, increased time for direct patient care, and notable efficiency and cost improvements

- **Medicines**
  The Pharmacy team has delivered key sustainability progress, including the full removal of nitrous oxide, with the manifold and terminal outlets decommissioned at James Cook University Hospital in May 2026, achieving a major Green Plan target; work is now required to progress this at the Friarage site. There has also been significant advancement in IV-to-oral medication switching, reducing both carbon impact and resource use. Work to optimise respiratory care and inhaler use remains at an early stage, with further review and reporting required to strengthen this priority area. Efforts to reduce waste continue, with Trust-wide campaigns on medication waste planned for October 2026, alongside initial steps to cut single-use plastics, including the transition to paper pharmacy bags and exploration of wider procurement opportunities.

  Internally, the department is strengthening sustainability through improved staff awareness and promotion of active travel, supported by a staff survey and initiatives such as the Cycle to work scheme.

- **Travel and Transport**
  The Trust's successful inclusion in the Modeshift STARS Healthcare programme will support a more structured and evidence-based approach to improving travel and transport. Through access to the STARS platform, training, and accreditation framework, the Trust will be able to better understand staff and patient travel behaviours, identify opportunities to reduce single-occupancy car use, and implement targeted initiatives that promote active travel, public transport, and sustainable commuting. This will help reduce congestion, lower carbon emissions, and improve access to sites, while also supporting staff wellbeing and contributing to wider Green Plan objectives.

  The Park Active scheme, introduced last year, continues to deliver strong benefits for sustainable travel, with 70 staff enrolled in the combined gym membership and parking offer at the sports village, alongside utilisation of 30 residential parking spaces. The scheme has gained national recognition, with the British Parking Association highlighting it as the first model of its kind adopted

by an NHS Trust. The Trust's leadership in this area was further demonstrated through an invitation to present at the National Modeshift STARS Summit in London, showcasing progress in sustainable travel, staff engagement, and greener estates. This recognition reflects the Trust's growing reputation for innovation and alignment with national best practice in sustainability.

Work is ongoing to expand sustainable travel options across the Trust, including exploring funding opportunities to develop active walking routes at James Cook University Hospital in line with the Active Hospitals programme. Collaboration with Northern Rail continues to be positive, with 16 staff participating in a trial scheme, receiving one month of free rail travel in exchange for feedback on their commuting experience. This insight will help shape how rail services can better support staff, patients and visitors, encouraging a shift towards lower-carbon travel and improving site accessibility.

A staff travel survey is planned for 2026, which will inform the development of a Trust-wide travel strategy, to be delivered by December 2026.

- **Estates and Facilities**

  Salix-funded decarbonisation schemes are being delivered across both the Friarage Hospital and James Cook University Hospital, supporting the Trust's transition to low-carbon energy infrastructure. The programme includes the installation of air and water source heat pumps, conversion to low-temperature heating systems, and wider system optimisation, with additional measures at the Friarage such as solar photovoltaic panels, upgraded air handling systems and enhanced controls.

  These schemes are expected to deliver significant carbon reductions, with an estimated 20% (c.2,269 tonnes $CO_2$ per annum) at James Cook and 41% at the Friarage, alongside long-term energy efficiency improvements. Works have been carefully managed within live hospital environments, with ongoing monitoring and maintenance arrangements in place to ensure sustained performance.

  This investment represents a major step forward in reducing emissions from the Trust estate while maintaining resilient and effective heating systems to support patient care.

  We are reviewing existing EV charging infrastructure to support the transition to a low-emission fleet and position the Trust to take advantage of future funding opportunities, enabling further progress against Travel and Transport objectives and supporting staff access to greener travel options.

  Biodiversity progress has been advanced through a range of practical initiatives to enhance outdoor spaces and increase their use for wellbeing and recovery. This includes improving access to courtyard areas, introducing seating, planting and low-maintenance green infrastructure such as planters and potential living features, and supporting wildlife through initiatives like bird and bat boxes and NHS Forest tree planting. The Trust has also participated in No Mow May, supporting natural habitats and pollinators, and is working in partnership with Natural England and Teesside University to explore opportunities for green therapy placements.

  Partnerships with community organisations and social prescribing teams are helping to connect patients and staff with nature-based activities, while proposals such as walking routes and "walking waiting rooms" aim to further embed green space use into care and wellbeing. Ongoing work is also addressing safety, accessibility and infrastructure improvements to maximise the benefit of these environments across Trust sites.

  Significant progress has been made in improving community waste management across South Tees. All community sites now have dry mixed recycling in place, exceeding the original target and supporting improved segregation of waste streams. Clinical waste performance has been

maintained in line with national standards, with further opportunities identified to increase recycling rates beyond the current 26%.

In addition, food waste collection has been established at larger community sites, with plans in place to expand this provision more widely. These initiatives demonstrate continued progress in reducing waste, increasing recycling, and supporting the Trust's wider sustainability objectives.

- **Supply chain and procurement**
  The Trust continues to strengthen circular economy and waste reduction activity through the ongoing Ambu disposable endoscope recycling pilot within ENT Outpatients and the Emergency Department at The James Cook University Hospital. Since the pilot commenced in August 2025, two van collections have taken place, resulting in the recovery of 16 bins containing 407 single use endoscopes. This equates to 67 kg of materials diverted from hazardous waste, including 63 kg of recyclable plastics and 2 kg of recoverable metals, achieving an overall recycling rate of 97%. To date, the pilot has delivered an estimated carbon saving of 209 kg $CO_2e$ when compared with high temperature incineration. Early engagement from clinical teams has been highly positive, although further collections are required to understand the long-term impact.

  With the initial six-month pilot concluding at the end of April, an extension to June 2026 has been proposed to allow additional data collection, increase device capture, and strengthen the evaluation of environmental benefits. This work has involved collaboration across key stakeholders reflecting a strong cross departmental commitment to sustainable clinical practice.

- **Food and nutrition**
  Food waste reduction has been a key focus for the Trust following analysis in 2025 which identified significant waste across acute sites, with 68 tonnes recorded at James Cook University Hospital and 29 tonnes at the Friarage, highlighting clear operational, financial and environmental impacts. In response, a comprehensive menu optimisation and waste reduction programme was implemented across James Cook and Redcar Primary Care Hospital, supported by collaboration between catering, dietetics, Speech and Language Therapy, ward teams, PLACE representatives and Serco. Menu items with low patient uptake were removed, stock management improved and more appropriate choices introduced, balancing reduced waste with maintaining nutritional intake for recovery.

  Early outcomes are highly positive, with trolley waste reduced by 914 kg and plate waste by 1,587 kg in the first two months following implementation, equating to a combined reduction of 2,501 kg of food waste and approximately 1.2 tonnes $CO_2e$ avoided. Carbon considerations have also been embedded into menu planning, supporting wider sustainability goals without increasing costs. This work has improved both resource efficiency and patient experience, and has been recognised regionally, with the ICB adopting the initiative as a sustainability case study to inform wider system learning. The Trust also presented this collaborative approach at a regional event in 2026, receiving positive feedback and generating further opportunities for cross-system working.

  In parallel, an early-stage project focusing on nutritional supplement and enteral feed bottles is exploring opportunities for reuse, recycling and waste reduction, alongside potential cost savings. Initial engagement with regional partners has informed feasibility discussions, with further stakeholder involvement planned.

- **Adaptation**
  The Trust continues to strengthen its approach to climate adaptation and resilience, in line with national reporting requirements through the Estates Return Information Collection (ERIC). Key measures include monitoring and assessment of environmental risks across the estate, including:

- Overheating incidents triggering formal risk assessments in line with the Trust's Heatwave Plan, ensuring patient and staff safety during extreme temperatures
- Flood incidents requiring risk assessment and response measures, supporting ongoing estate resilience planning.

These metrics support a proactive approach to managing climate-related risks, ensuring that the Trust's estate remains safe, resilient and capable of delivering high-quality care under changing environmental conditions.

**Energy and Carbon Performance**

The Trust has made strong progress in reducing energy consumption and carbon emissions, supported by targeted investment in estate infrastructure, including the energy centre optimisation works at James Cook University Hospital (JCUH). Since completion in July, JCUH has recorded a 2% reduction in electricity consumption and a 5% reduction in gas usage, delivering significant financial savings of approximately £581k and £276k respectively. These improvements place the Trust on track to achieve its lowest annual electricity consumption since 2020/21, with an estimated £120k saving against forecasted costs year-to-date and over £500k savings compared to the previous year.

At the Friarage Hospital, energy consumption has increased in-year; however, this has not resulted in a significant cost increase, reflecting reduced unit energy prices.

Overall, the Trust has achieved a 3% reduction in total carbon emissions, decreasing from 21,162 $tCO_2e$ to 20,473 $tCO_2e$. This has been primarily driven by an 11% reduction in electricity emissions, reflecting both reduced consumption at JCUH and a lower national carbon factor, alongside a 2% reduction in gas emissions.

Carbon data for the past 2 years

| Emission Source | Emissions 24/25 | Emissions 25/26 | % Change | Comments |
|---|---|---|---|---|
| Gas | 12,360 | 12,149 | -2% | |
| Electricity | 8,299 | 7,348 | -11% | Reduction in consumption at JCUH and lower carbon factor |
| Waste | 310 | 552 | 78% | Increase in waste sent for incineration due to segregation non-compliances |
| Oil | 109 | 332 | 205% | Increase in oil usage during Energy Centre works |
| Water | 84 | 93 | 10% | Increase in carbon factor |
| Overall | 21,162 | 20,473 | -3% | |

Energy and Gas Consumption

| Energy | Consumption 24/25 | Consumption 25/26 | % Change | Comments |
|---|---|---|---|---|
| Electricity - JCUH | 25,546,943 | 24,955,126 | -2% | £581k reduction in costs |
| Gas -JCUH | 47,783,977 | 45,490,536 | -5% | £276k reduction in costs |
| Electricity - FHN | 4,605,359 | 4,986,305 | 8% | No major change in costs due to reduction in cost per unit |
| Gas -FHN | 10,465,963 | 11,548,534 | 10% | No major change in costs due to reduction in cost per unit |

**Taskforce on climate related financial disclosures (TCFD)**

NHS England continues to implement a phased approach to TCFD-aligned reporting, with full coverage across the four pillars Governance, Strategy, Risk Management, and Metrics and Targets



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required by 2025/26. South Tees Hospitals NHS Foundation Trust has developed its approach in line with this guidance, with disclosures set out below.

**Governance**

Oversight of climate-related matters is provided by a Board-level Net Zero Lead, with progress reported through the Resource Committee. Operational delivery is coordinated through the Waste and Sustainability Manager, supported by sub-groups aligned to Green Plan priorities, with assurance provided via the quarterly Sustainability Group and Estates and Facilities governance structures.

A Severe Weather Framework is in place, including a centralised adverse weather distribution group to ensure escalation of climate-related risks. Senior-led adverse weather group meetings are convened on a precautionary basis, informed by Met Office and UKHSA alerts (e.g. heat health alerts), to review response arrangements, assess forecast impacts and provide assurance that appropriate contingency measures are in place.

**Strategy**

The Trust's Green Plan 2025–2028, approved in July 2025, sets out a structured programme of work aligned to the Delivering a Net Zero NHS Strategy, Estates Net Zero Delivery Plan, Travel and Transport Strategy and Net Zero Supplier Roadmap.

The Trust is developing its approach to climate adaptation, with work underway to assess risks and resilience across the estate and services, informed by national frameworks. This will support the development of a formal Climate Adaptation Plan in line with NHS guidance.

**Risk Management**

Climate-related risks are identified, assessed and managed through established Trust risk management processes, including the Board Assurance Framework (BAF) and Emergency Preparedness, Resilience and Response (EPRR) arrangements.

Adverse weather is recognised as a key climate-related risk, defined as any meteorological event with the potential to cause disruption, infrastructure damage, or increased risks to health. To strengthen risk management, the Trust is implementing a coordinated approach through a Severe Weather Framework, supported by a centralised alert system.

All services are able to receive real-time weather and health alerts, including:

- National Severe Weather Warnings, providing risk-based forecasts of events such as heavy rain, snow, wind, fog and ice
- Weather Health Alerts, issued on behalf of the UK Health Security Agency, highlighting risks associated with prolonged temperature extremes
- Met Office Civil Contingencies updates, offering localised intelligence and forward planning insights

The timely receipt of these alerts provides improved situational awareness and supports early, risk-based decision-making across the organisation. Responsibility for responding to alerts sits with individual teams, ensuring that appropriate actions are taken, risks are mitigated, and concerns escalated where required.

This structured approach strengthens the Trust's ability to manage climate-related risks, particularly extreme weather events, and supports continuity of both corporate and clinical services.

**Metrics and Targets**

The Trust measures progress against its sustainability objectives through a combination of Green Plan indicators and national reporting requirements, including the Estates Return Information Collection (ERIC).

Key adaptation metrics include:

- Number of overheating incidents triggering risk assessments in line with the Trust's Heatwave Plan
- Number of flood incidents requiring formal risk assessment and response

## 5. CONCLUSION

In summary, the Trust has made strong and sustained progress in advancing its sustainability agenda, aligning fully with NHS England's statutory requirements through the refreshed 2025 Green Plan and demonstrating clear commitment to Net Zero ambitions. The work across the nine strategic areas continues to be actively monitored, with regular updates ensuring effective governance and timely delivery against objectives.

With continued staff engagement, and visible leadership including the dedicated Sustainability Day planned for June to showcase achievements and promote best practice the Trust is well-positioned to maintain momentum, enhance environmental performance, and embed sustainability as a core organisational priority.

**Laura Hallett**
**Waste & Sustainability Manager**

# North Tees – Sustainability Update

## 1. PURPOSE OF REPORT

This report provides an update on the current position regarding North Tees and Hartlepool NHS Foundation Trust green strategy and the initiatives currently being undertaken.

## 2. RECOMMENDATIONS

The recommendation is to accept this report, which demonstrates the progress being made in terms of sustainability by detailing the initiatives and projects currently being progressed to achieve Trust objectives and ambitions in terms of the revised Green Plan, and its update as per NHSE guidance.

## 3. BACKGROUND

The Trust is upholding the NHS ambition to be the first Net Zero health system in the world by ensuring that the NHS 2040 & 2045 targets, set by Government, are being worked towards.

Climate change presents an immediate and growing threat to health. The UK is already experiencing more frequent and severe floods and heatwaves, as well as worsening air pollution. Up to 38,000 deaths a year are associated with air pollution alone, disproportionately affecting the most deprived and further exacerbating health inequalities.

We recognise that if we are to provide the best possible care to our patients and improve their quality of life, we need to significantly reduce our impact on the environment.

## 4. UPDATES

### Green Plan Summary

In response to national NHS guidance, organisations were required to refresh their Green Plans in 2025. The Trust's Green Plan 2025–2028, approved in July 2025, outlines progress to date and sets out key priorities for the next three years. The plan is aligned with the Delivering a Net Zero NHS Strategy, alongside supporting national frameworks including the Estates Net Zero Delivery Plan, Net Zero Travel and Transport Strategy, and the Net Zero Supplier Roadmap, ensuring a coordinated approach to achieving net zero objectives.

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Progress is further embedded within operational management through routine reporting into the Estates and Facilities Directorate Management Team, ensuring alignment with estates strategy and wider operational delivery. This structured approach reflects national guidance by ensuring clear lines of accountability, defined roles and responsibilities, and integration of sustainability into existing governance systems, supporting effective delivery of net zero objectives across the organisation.

Key areas of progress include:

**Workforce and Leadership**

Progress has been driven through strengthened collaboration with neighbouring NHS organisations and public sector partners, supporting delivery of the Trust's Green Plan and enabling the sharing of best practice. Sustainability is now embedded within Trust induction, ensuring all new starters understand key environmental priorities and their role in supporting them. In addition, UHT now hosts an annual Sustainability Day, showcasing progress against Green Plan objectives and setting future priorities, with contributions from both internal teams and external guest speakers to support knowledge sharing and continuous improvement.

**Net Zero Clinical Transformation**

The Trust is progressing net zero clinical transformation through the development of Hospital at Home and wider out-of-hospital care models, enabling clinically appropriate patients to receive care in their own homes. This approach supports admission avoidance, earlier discharge and improved patient experience, while reducing reliance on the acute estate and associated carbon emissions.

The Hospital at Home service forms part of a broader system-wide approach across UHT, with similar models delivered through virtual wards and community-based services, supporting pathway redesign across acute and community care. These initiatives align with national priorities to deliver digitally enabled, preventative and lower-carbon care, embedding sustainability considerations into clinical transformation and service development.

**Digital transformation**

The UHT Digital Programme Team was recognised nationally, winning 'Digital Transformation Organisation of the Year' at the Health Service Journal (HSJ) Digital Awards. This award acknowledges a clinically led transformation from paper-based records to a fully electronic system, delivering significant benefits including enhanced patient safety, improved clinical decision-making, increased time for direct patient care, and notable efficiency and cost improvements.

**Medicines**

The Pharmacy team has delivered key sustainability progress. There has been significant advancement in IV-to-oral medication switching, reducing both carbon impact and resource use. Work to optimise respiratory care and inhaler use remains at an early stage, with further review and reporting required to strengthen this priority area. Efforts to reduce waste continue, with UHT-wide campaigns on medication waste planned for October 2026, alongside initial steps to cut single-use plastics, including the transition to paper pharmacy bags and exploration of wider procurement opportunities. Internally, the department is strengthening sustainability through improved staff awareness and promotion of active travel, supported by a staff survey and initiatives such as the Cycle to work scheme.

**Travel and Transport**

The successful inclusion in the Modeshift STARS Healthcare programme will support a more structured and evidence-based approach to improving travel and transport. Through access to the STARS platform, training, and accreditation framework, UHT will be able to better understand staff and patient travel behaviours, identify opportunities to reduce single-occupancy car use, and implement targeted initiatives that promote active travel, public transport, and sustainable commuting. This will help reduce congestion, lower carbon emissions, and improve access to sites, while also supporting staff wellbeing and contributing to wider Green Plan objectives.

A staff travel survey is planned for 2026, which will inform the development of a UHT wide travel strategy, to be delivered by December 2026.

We have expanded the existing EV charging infrastructure at University Hospital of North Tees through the install of a 200KW EV charger to support the transition by NEAS (North East Ambulance Service) to a low-emission fleet.

**Estates and Facilities**

The Salix-funded decarbonisation schemes has been delivered at University Hospital of Hartlepool, supporting the Trust's transition to low-carbon energy infrastructure. The programme includes the installation of ground source heat pump, de-steaming of heating systems, and wider system optimisation, with additional measures at UHH such as solar photovoltaic panels, upgraded air handling systems and enhanced controls.

The scheme is expected to deliver significant carbon reductions alongside long-term energy efficiency improvements. Works have been carefully managed within live hospital environments, with ongoing monitoring and maintenance arrangements in place to ensure sustained performance.

This investment represents a major step forward in reducing emissions from the Trust estate while maintaining resilient and effective heating systems to support patient care.

The Trust have a completed a decarbonisation plan which will put us in the best position to be able to take advantage of future funding opportunities, enabling further progress towards our net zero targets.

Partnerships with community organisations and social prescribing teams are helping to connect patients and staff with nature-based activities, while proposals such as walking routes and "walking waiting rooms" aim to further embed green space use into care and wellbeing. Ongoing work is also addressing safety, accessibility and infrastructure improvements to maximise the benefit of these environments across UHT sites.

Significant progress has been made in improving community waste management across the Trust. All community sites now have dry mixed recycling in place, exceeding the original target and supporting improved segregation of waste streams. Clinical waste performance has been maintained in line with national standards, with further opportunities identified to increase recycling rates beyond the current 32%. In addition, food waste collection has been established at larger community sites, with plans in place to expand this provision more widely. These initiatives demonstrate continued progress in reducing waste, increasing recycling, and supporting UHT's wider sustainability objectives.

**Food and nutrition**

Food waste reduction has been a key focus for the Trust following analysis in 2025 which identified significant waste across acute sites, with the Trust recording 9.14 tonnes of food waste, generated from production, highlighting clear operational, financial and environmental impacts. Menu items with low patient uptake were removed, stock management improved and more appropriate choices introduced, balancing reduced waste with maintaining nutritional intake for recovery.

**Adaptation**

The Trust continues to strengthen its approach to climate adaptation and resilience, in line with national reporting requirements through the Estates Return Information Collection (ERIC). Key measures include monitoring and assessment of environmental risks across the estate, including:

- Overheating incidents triggering formal risk assessments in line with the Trust's Heatwave Plan, ensuring patient and staff safety during extreme temperatures
- Flood incidents requiring risk assessment and response measures, supporting ongoing estate resilience planning
- These metrics support a proactive approach to managing climate-related risks, ensuring that the Trust's estate remains safe, resilient and capable of delivering high-quality care under changing environmental conditions.

**Energy and Carbon Performance**

The ongoing implementation of the Carbon Management Programme continues to make a significant impact on the carbon footprint. Against a trend of increasing activity, the Trust has made carbon reduction savings of more than 35% since 2010 in support of the government's 2050 targets. The Trust's Green Plan has developed a range of measures to reduce our carbon footprint, challenge behaviours, and define aspirations for North Tees and Hartlepool NHS Foundation Trust to work towards becoming net-zero by 2040.

The carbon impact of electricity and steam, combined with water, waste, oil and business miles show that the Trust carbon footprint for FY2025/26 currently sits at 10,302 TonnesCO2. This is a decrease of 2.8% on the previous year.

**Greenhouse Gas Emissions** - - - - -

| Area | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | 2023/24 | 2024/25 | 2025/26 | 2023/24 | 2024/25 | 2025/26 |
| **Finite Resources** | Electricity | 3695 Mwh | 3725 MWh | 3944 MWh | £1,038,416 | £1,197,209 | £1,219,617 |
| | | 757 tCO2 | 771 tCO2 | 690 tCO2 | | | |
| | Gas | 51,032 MWh | 51,699 MWh | 50,390 MWh | £2,152,298 | £1,894,838 | £2,094,915 |
| | | 9310 tCO2 | 9435 tCO2 | 9201 tCO2 | | | |
| | Oil | 33,832 kWh | 142,827 kWh | 91,751 kWh | £0 | £0 | £39,541 |
| | | 8.6 tCO2 | 36.2 tCO2 | 23.3 tCO2 | | | |
| **Waste** | Total Waste | 1330 t | 1360 t | 1532 t | £370,798 | £294,515 | £347,055 |
| Hazardous Waste | Clinical waste to alternative treatment of incineration | 251 t | 171 t | 155.4t | | | |
| | | 56.7 tCO2 | 1.1 tCO2 | tCO2 | | | |
| Non-hazardous Waste | Landfill | 0 t | 0 t | 0 t | | | |
| | | 0 tCO2 | 0 tCO2 | 0 tCO2 | | | |
| | Re-used / Recycled | 201 t | 172 t | 252.1 t | | | |
| | Incinerated with Energy Recovery | 926 t | 999.8 t | 1113.1 t | | | |
| | Electrical Waste (WEEE) | 14.1 t | 17.2 t | 11.4 t | | | |
| **Travel** | Commercial Vehicles Diesel | 0 | 0 | 0 | £0 | £0 | £0 |
| | | 0 tCO2 | 0 tCO2 | 0 tCO2 | | | |
| | Lease Vehicles Petrol | 199,028 miles | 175,359 miles | 131,750 miles | £79,611 | £70,143 | £59,287 |
| | | 40.2 tCO2 | 36.5 tCO2 | 34.4 tCO2 | | | |
| | Lease Vehicles Diesel | 9,296 miles | 3,811 miles | 191 miles | £3,720 | £1,525 | £86 |
| | | 2.3 tCO2 | 1.0 tCO2 | 0.1 tCO2 | | | |
| | Business Miles | 1,230,670 | 1,112,747 | 1,305,905 | £492,268 | £445,099 | £587,657 |
| | | 296.1 tCO2 | 268.2 tCO2 | 311.9 tCO2 | | | |
| **Water** | Water Consumption | 121,048 m3 | 120428 m3 | 126143 m3 | £406,944 | £443,212 | £560,659 |
| | | 45.7 tCO2 | 40.8 tCO2 | 45.7 tCO2 | | | |



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**Taskforce on climate related financial disclosures (TCFD)**

NHS England continues to implement a phased approach to TCFD-aligned reporting, with full coverage across the four pillars Governance, Strategy, Risk Management, and Metrics and Targets required by 2025/26. North Tees and Hartlepool NHS Foundation Trust has developed its approach in line with this guidance.

**Governance**

Oversight of climate-related matters is provided by a Board-level Net Zero Lead, with progress reported through the Resource Committee. Operational delivery is coordinated through the Waste and Sustainability Manager, supported by sub-groups aligned to Green Plan priorities, with assurance provided via the quarterly Sustainability Group and Estates and Facilities governance structures.

A Severe Weather Framework is in place, including a centralised adverse weather distribution group to ensure escalation of climate-related risks. Senior-led adverse weather group meetings are convened on a precautionary basis, informed by Met Office and UKHSA alerts (e.g. heat health alerts), to review response arrangements, assess forecast impacts and provide assurance that appropriate contingency measures are in place.

**Strategy**

The Trust's Green Plan 2025–2028, approved in July 2025, sets out a structured programme of work aligned to the Delivering a Net Zero NHS Strategy, Estates Net Zero Delivery Plan, Travel and Transport Strategy and Net Zero Supplier Roadmap.

The Trust is developing its approach to climate adaptation, with work underway to assess risks and resilience across the estate and services, informed by national frameworks. This will support the development of a formal Climate Adaptation Plan in line with NHS guidance.

**Risk Management**

Climate-related risks are identified, assessed and managed through established Trust risk management processes, including the Board Assurance Framework (BAF) and Emergency Preparedness, Resilience and Response (EPRR) arrangements.

Adverse weather is recognised as a key climate-related risk, defined as any meteorological event with the potential to cause disruption, infrastructure damage, or increased risks to health. To strengthen risk management, the Trust is implementing a coordinated approach through a Severe Weather Framework, supported by a centralised alert system.

All services are able to receive real-time weather and health alerts, including:

- National Severe Weather Warnings, providing risk-based forecasts of events such as heavy rain, snow, wind, fog and ice
- Weather Health Alerts, issued on behalf of the UK Health Security Agency, highlighting risks associated with prolonged temperature extremes
- Met Office Civil Contingencies updates, offering localised intelligence and forward planning insights

The timely receipt of these alerts provides improved situational awareness and supports early, risk-based decision-making across the organisation. Responsibility for responding to alerts sits with individual teams, ensuring that appropriate actions are taken, risks are mitigated, and concerns escalated where required.

This structured approach strengthens the Trust's ability to manage climate-related risks, particularly extreme weather events, and supports continuity of both corporate and clinical services.

**Metrics and Targets**

The Trust measures progress against its sustainability objectives through a combination of Green Plan indicators and national reporting requirements, including the Estates Return Information Collection (ERIC).

Key adaptation metrics include:

- Number of overheating incidents triggering risk assessments in line with the Trust's Heatwave Plan
- Number of flood incidents requiring formal risk assessment and response

## 5. CONCLUSION

The Trust continues to demonstrate good progress in managing its environmental and waste responsibilities, with strong assurance provided through completed Duty of Care audits and effective resolution of food waste issues. The actions now underway provide clear pathways for strengthening compliance and supporting the delivery of the Green Plan. Focused engagement, training, and collaboration will be key to sustaining progress and achieving our wider sustainability objectives.

**Steve Bell**
**Environmental Services & Sustainability Manager**

University Hospitals Tees

# Winter Plan Board Assurance Statements 2026/27

**Meeting date:** 3 September 2026

**Reporting to:** Board of Directors

**Agenda item No:** 4.5

**Report author:** Rob Armstrong, Chief Operating Officer

**Executive director sponsor:** Russell Nightingale, Chief Delivery Officer

**Action required:** Approval

**Delegation status:** Jointly delegated item to Group Board

**Previously presented to:** None

## 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:

Effective

## Board assurance / risk register this paper relates to:

## Key discussion points and matters to be escalated from the meeting

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

The Board is asked to note ongoing risks to patient flow and bed capacity ahead of winter. Specific areas of non-compliance include the absence of full assurance regarding discharge arrangements with system partners and the lack of agreed escalation arrangements with local authority partners to support timely transfers of care.

There remains a risk that reduced medical bed capacity associated with lifecycle commitments could adversely impact winter resilience, occupancy management and flow performance.

**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 UHT Winter Planning Meeting continues to monitor the delivery of winter planning actions and associated system dependencies. Risks discussed include reduced medical bed capacity, delays in establishing local authority escalation arrangements, and the impact of discharge delays on operational flow.

Mitigating actions include a Trust-wide focus on flow improvement initiatives, implementation of a "Perfect Week" programme to test discharge improvements, planned elective capacity adjustments to release beds, and continued development of 24/7 SDEC services.

A further area requiring development is oversight of high-intensity users within mental health services, which will be reviewed at a future meeting.

**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 Winter Planning Meeting demonstrated positive assurance that comprehensive winter planning arrangements are in place across prevention, infection prevention and control, leadership and operational grip.

Good practice highlighted includes targeted staff vaccination plans, vaccination programmes for long-stay inpatients, implementation of admission avoidance pathways through frailty services, the planned roll-out of 24/7 SDEC provision, robust IPC governance with DIPC involvement throughout planning, established OPEL escalation arrangements, tested on-call and business continuity processes, and readiness to activate surge and cohorting plans.

The Trust's overall BAS assessment of **Full Assurance** reflects strong preparedness with only a small number of outstanding actions requiring completion before winter.

## Recommendations:

Board to note the contents of the Winter Planning 2026/27 Board Assurance Statement and the assessment that the Trust currently has Substantial Assurance regarding its preparedness for winter. The Board should also note the identified risks relating to discharge capacity, patient flow, local authority escalation arrangements and reduced medical bed capacity.

Note the mitigations and actions outlined within the Winter Plan to address the outstanding areas requiring further assurance ahead of winter.

Delegate authority to the Resources and Performance Committee to review the outcomes of the regional winter preparedness exercise scheduled for 17 September 2026, receive assurance that any lessons learnt have been incorporated into the final Winter Plan, and approve the final Board Assurance Statement on behalf of the Board.

Authorize the Chair of the Resources and Performance Committee, in consultation with the Chief Executive and Chief Delivery Officer, to provide final sign-off of the Winter Planning 2026/27 Board Assurance Statement prior to the national submission deadline of 30 September 2026, recognising that the Board will not meet again until October 2026.

Receive assurance that the final approved submission, together with any amendments arising from the regional exercise, will be reported to the next available Board meeting for information and retrospective assurance.

# Winter Planning 26/27
# Board Assurance Statement (BAS)

**1. Purpose**
The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

**2. Guidance on completing the Board Assurance Statement (BAS)**

**Section A: Board Assurance Statement**
Please include the Trust / Provider name at the top of the tab.
This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

**Section B: 26/27 Winter Plan checklist**
This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

**3. Submission process and contacts**

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026.**

# Winter Planning 26/27
# Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.
**Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.**

| | |
|---|---|
| **Provider/Trust Name (drop down):** | |
| *If Other, write Provider/Trust Name:* | |
| **Contact details (email, phone number):** | |
| **Date:** | 01/07/2026 |

Please complete these sections

| Assurance statement | | | Confirm (Y/N) | Additional comments or qualifications (optional) | Blockers/Support requirements (optional) |
|---|---|---|---|---|---|
| **Governance and executive leadership** | | | | | |
| **1** | 1.1 | The Board has assured the Trust Winter Plan for 2026/27. | Yes | | |
| | 1.2 | The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board. | No | QEIA to be completed in September for final review and sign off | |
| | 1.3 | The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care. | Yes | | |
| | 1.4 | The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned. | No | Winter exerccies will take place on the 17th September. | |
| | 1.5 | The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery. | Yes | | |
| | 1.6 | The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period. | Yes | | |

# Winter Planning 26/27
# Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
**Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.**

| | | | Please complete these sections | | |
|---|---|---|---|---|---|
| **Section B: 26/27 Winter Plan checklist** | | | **Confirm (Y/N)** | **Additional comments or qualifications (optional)** | **Blockers/Support requirements (optional)** |
| **Prevention** | | | | | |
| **1** | 1.1 | The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates:<br>•the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November;<br>•that both walk-in and bookable appointments are available;<br>•that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and<br>•the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP. | **Yes** | Flu plan to be shared by Occupational Health. Will include station vaccinators plus roaming and local clinical team vaccinators. | HR to confrm ESR flag update. |
| | 1.2 | The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans. | **Yes** | As above - high risk areas prioritised by roaming vacinators. | |
| | 1.3 | The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home. | **Yes** | Neuro Clinical Matron leadng due to higher volume LLOS patient cohort. | |
| | 1.4 | The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure. | **Yes** | Full membershi and updates from leads including HR, IPC and operational colleagues. | |
| **Occupancy and discharge** | | | | | |
| **2** | 2.1 | The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements. | **No** | Current risk due to liefcycle commitment reducing medical bed capacity | Brief to CSC all CSUs requested to focus on flow out initiatives. |
| | 2.2 | The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include:<br>•coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand.<br>•executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays.<br>•targeted operational actions to reduce long discharge delays.<br>•Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow. | **Yes** | perfect week' planned (DOW) to test improvement opportunities | |
| | 2.3 | The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented. | **Yes** | Planned elective orthopeadic opertational delivery changes to release capacity | |
| | 2.4 | The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance. | **Yes** | 24/7 SDEC target operationalisation date Oct 26 JCUH | |
| | 2.5 | The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission. | **Yes** | FOH frailty established - Cae Hoe admission avoidance pathways in place | |
| **Capacity** | | | | | |
| **3** | 3.1 | The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand. | **Yes** | UTC GP additionality plan if resource/funds made available | |
| | 3.2 | The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements. | **Yes** | | |
| | 3.3 | The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services. | **Yes** | | |
| | 3.4 | The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27. | **Yes** | | |
| | 3.5 | The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients. | **Yes** | | |
| **Flow** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 4 | 4.1 | The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm. | Yes | Checklist ih use and monitoring in place | |
| | 4.2 | The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes. | Yes | | |
| | 4.3 | The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow. | No | LA escalation to be established | |
| | 4.4 | The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter. | Yes | | |
| **Infection Prevention and Control (IPC)** | | | | | |
| 5 | 5.1 | The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections. | Yes | | |
| | 5.2 | The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions. | Yes | DDIPC at all winter planning meetings | |
| | 5.3 | The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand. | Yes | | |
| | 5.4 | The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams. | Yes | Ongoing work with Ntees PFT | |
| **Leadership and operational grip** | | | | | |
| 6 | 6.1 | The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed. | Yes | | |
| | 6.2 | The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response. | Yes | | |
| | 6.3 | The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required. | Yes | | |
| | 6.4 | The Board is assured that business continuity plans have been reviewed and tested where appropriate. | Yes | | |
| | 6.5 | The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed. | Yes | Recent unknown risk in high temperatures of failed equipment requireent of additional coling (not winter) | |
| | 6.6 | The Board is assured that industrial action contingencies have been reviewed where relevant. | Yes | | |
| | 6.7 | The Board is assured that plans are in place to support staff welfare through periods of high demand. | Yes | | |
| **Specific actions for Mental Health Trusts** | | | | | |
| 7 | 7.1 | The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers. | Yes | | |
| | 7.2 | The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter. | No | High intensity users oversight to be brought to next meeting | |
| | 7.3 | The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand. | Yes | | |

# Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

| | |
|---|---|
| **Trust / Provider Name:** | |
| **Provider CEO name:** | |
| **Date reviewed:** | |
| **Provider Chair name:** | |
| **Date reviewed:** | |

*Please update following completion of the BAS template*

| **Please provide name and contact details of designated Senior Responsible Officer (Executive Level)** |
|---|
| |

| **Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.** |
|---|
| |

| **Please confirm date reviewed** |
|---|
| |

# BAS Self-Assessment Dashboard

## Trust

**Overall Assessment Rating: 5 - Full assurance**



| | | Rating |
|---|---|---|
| Section B | Prevention | **5 - Full assurance** |
| | Flow, occupancy and discharge | 4 - Substantial assurance |
| | Capacity and community | **5 - Full assurance** |
| | UEC Flow | 3 - Moderate assurance |
| | Infection Prevention and Control (IPC) | **5 - Full assurance** |
| | Leadership and operational grip | **5 - Full assurance** |
| | Specific actions for Mental Health Trusts | 3 - Moderate assurance |

# ST Audit Committee

**16 July 2026**

**Connecting to: Board of Directors Unitary**

**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.

An escalation around clinical audit completion rates was received from QAC. Significant numbers of mandatory clinical audits were not completed in 25/6. Previous internal audit work and follow up in this area was satisfactory therefore the assumption is that this deterioration in performance is linked to the restructuring of clinical teams and the additional work associated with this. It is important that this issue is resolved in 26/7 as lack of focus on clinical audit was an area raised in the Aubrey Report.

The audit committee is unable to give the Board assurance that the Clinical Audit System and associated controls are working as intended.

**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 assurance framework and proposed developments to the system were discussed

The register of Clinical and Non Clinical visits was reviewed

Losses and special payments were reviewed

*Internal audit*

Three internal audit reports were received

Sickness and absence management – High Risk

The Chief People Officer attended and explained the action plan to improve the systems in this area, in particular a focus on staff training to ensure sickness absence policies are complied with.

Data security and protection toolkit – High risk

Although high risk considerable progress has been made since last year and plans are in place to reduce risk further

Workforce safeguarding/nursing and midwifery – medium risk

The exec has put in place a new system to review high risk outstanding audit actions to ensure that these are visible and completed in a timely manner.

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

*External audit*

Year end work completed. No changes to previously advised position

## Recommendations:



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# Charitable Funds Committee in Common

**5 August 2026**

**Connecting to: Board of Directors**

**Chair of Committee: Derek Bell**

## 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.

### Historic charity governance documentation

The Committee received an update regarding gaps identified within historical charity deeds and governance documentation. Legal review is underway to determine whether sufficient records exist to support future engagement with the Charity Commission and the proposed charity consolidation programme. Depending on the outcome of the legal review, there may be implications for charity governance arrangements, charitable objects and future consolidation options. The Committee requested consideration of whether this matter should be escalated to the corporate risk register and/or Board Assurance Framework following receipt of legal advice

**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.

### Charity consolidation and governance alignment

Work continues to align governance arrangements, grant giving processes, policies and financial management arrangements across both charities. A comprehensive review of



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charitable fund management arrangements is being undertaken, with recommendations expected to be presented during Quarter 3

**North Tees and South Tees general funds position**

The Committee discussed the financial position and noted that funds are extremely limited with significant commitments against Maggie's and Horatio's Garden and loss of subsidiary income. Ongoing work is taking place to maximise the utilisation of charitable funds and reduce dormant balances.

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

**Strong joint working between charities**

The Committee received positive assurance regarding strengthened joint working between the North Tees and South Tees charity teams, including regular collaborative meetings, policy alignment, shared governance reviews and development of future grant giving arrangements.

**Open Grants Programme**

The Committee approved the 2027/28 Open Grants Programme, including a two-stage application process and funding allocations of £125,000 from each charity. This represents a significant opportunity to support innovation, patient experience and charitable impact across both organisations.

**Policy and governance review**

The Committee approved the annual review of charitable fund policies and procedures, including the revised Fundraising Policy, providing assurance that charity governance arrangements remain aligned with regulatory requirements and Fundraising Regulator guidance

## Recommendations:

The Board is asked to:

1. Note the matters escalated from the Charitable Funds Committee in Common.
2. Note the ongoing legal review relating to historic charity governance documentation and receive a further update once legal advice has been obtained.
3. Receive assurance that an agreed repayment plan is in place for the charitable funds intercompany balance and is expected to be completed within the current financial year.
4. Note the progress being made towards alignment of charitable governance, grant giving arrangements and future charity consolidation proposals

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# NT Audit Committee

**16 July 2026**

**Connecting to: Board of Directors Unitary**

**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.

An escalation around clinical audit completion rates was received from QAC. Significant numbers of mandatory clinical audits were not completed in 25/6. Previous internal audit work and follow up in this area was satisfactory therefore the assumption is that this deterioration in performance is linked to the restructuring of clinical teams and the additional work associated with this. It is important that this issue is resolved in 26/7 as lack of focus on clinical audit was an area raised in the Aubrey Report.

The audit committee is unable to give the Board assurance that the Clinical Audit System and associated controls are working as intended.

**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 assurance framework and proposed developments to the system were discussed

The register of Clinical and Non Clinical visits was reviewed

Losses and special payments were reviewed



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*Counter Fraud*

The 2025/6 Counter Fraud report was received. 10 areas were RAG rated green, 2 were amber. This is a similar position to other Audit One organisations

*Internal audit*

Eight internal audit reports were received

Patient letters process – Limited assurance

Managing Director attended and explained the urgent changes being made to address the significant weaknesses found

Attendance management – Reasonable assurance

The Chief People Officer attended and explained the action plan to improve the systems in this area, in particular a focus on staff training to ensure sickness absence policies are complied with.

Data security and protection toolkit – High risk

Although high risk considerable progress has been made since last year and plans are in place to reduce risk further

Workforce safeguards – safe staffing – Reasonable assurance

Implementing quality priorities – Reasonable assurance

IT asset management – Reasonable assurance

Risk management and board assurance framework – Good assurance

Accounts payable – Good assurance

The exec has put in place a new system to review high risk outstanding audit actions to ensure that these are visible and completed in a timely manner.

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

*External audit*

Year end work completed. No changes to previously advised position

## Recommendations:



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# Charitable Funds Committee in Common

**5 August 2026**

**Connecting to: Board of Directors**

**Chair of Committee: Derek Bell**

## 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.

### Historic charity governance documentation

The Committee received an update regarding gaps identified within historical charity deeds and governance documentation. Legal review is underway to determine whether sufficient records exist to support future engagement with the Charity Commission and the proposed charity consolidation programme. Depending on the outcome of the legal review, there may be implications for charity governance arrangements, charitable objects and future consolidation options. The Committee requested consideration of whether this matter should be escalated to the corporate risk register and/or Board Assurance Framework following receipt of legal advice

**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.

### Charity consolidation and governance alignment

Work continues to align governance arrangements, grant giving processes, policies and financial management arrangements across both charities. A comprehensive review of



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charitable fund management arrangements is being undertaken, with recommendations expected to be presented during Quarter 3

**North Tees and South Tees general funds position**

The Committee discussed the financial position and noted that funds are extremely limited with significant commitments against Maggie's and Horatio's Garden and loss of subsidiary income. Ongoing work is taking place to maximise the utilisation of charitable funds and reduce dormant balances.

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

**Strong joint working between charities**

The Committee received positive assurance regarding strengthened joint working between the North Tees and South Tees charity teams, including regular collaborative meetings, policy alignment, shared governance reviews and development of future grant giving arrangements.

**Open Grants Programme**

The Committee approved the 2027/28 Open Grants Programme, including a two-stage application process and funding allocations of £125,000 from each charity. This represents a significant opportunity to support innovation, patient experience and charitable impact across both organisations.

**Policy and governance review**

The Committee approved the annual review of charitable fund policies and procedures, including the revised Fundraising Policy, providing assurance that charity governance arrangements remain aligned with regulatory requirements and Fundraising Regulator guidance

## Recommendations:

The Board is asked to:

1. Note the matters escalated from the Charitable Funds Committee in Common.
2. Note the ongoing legal review relating to historic charity governance documentation and receive a further update once legal advice has been obtained.
3. Receive assurance that an agreed repayment plan is in place for the charitable funds intercompany balance and is expected to be completed within the current financial year.
4. Note the progress being made towards alignment of charitable governance, grant giving arrangements and future charity consolidation proposals

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# Appointment of Independent Chair of North Tees and Hartlepool Solutions LLP

**Meeting date:** 3 September 2026

**Reporting to:** Board of Directors

**Agenda item No:** 6.3

**Report author:** Jackie White, Director of Corporate Affairs & Company Secretary

**Executive director sponsor:** Derek Bell, Chairman

**Action required:** Approval

**Delegation status:** Matter reserved to Unitary Board

**Previously presented to:**

## UHT strategic objectives supported:

Putting patients first ☐

Creating an outstanding experience for our people ☐

Working with partners ☒

Reforming models of care ☐

Developing excellence as a learning organisation ☐

Using our resources well ☒

## CQC domain link:

Well-led

## Board assurance framework references this paper relates to:

Add in BAF reference.

## Key discussion points and matters to be escalated from the meeting

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

The current arrangements for the Chair of North Tees and Hartlepool Solutions LLP require review to ensure compliance with the LLP Agreement and to support future governance arrangements. Failure to implement a documented appointment process could lead to challenge regarding transparency, independence and value for money

**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.

External legal advice confirms that:

- Appointment of the Chair is a reserved matter for the LLP Members.
- The LLP Agreement does not require a competitive recruitment process.
- Members may determine the appointment criteria by Members' Resolution.
- As a matter of good governance, a competitive process is preferable where an independent Chair is to be appointed

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

Legal advice confirms the LLP Agreement permits the appointment of an independent Chair and provides flexibility for Members to determine the recruitment process and remuneration arrangements through a Members' Resolution

## Recommendations:

The Board is asked to:

1. Note the legal advice received regarding appointment of the Chair of North Tees and Hartlepool Solutions LLP.
2. Support the principle of appointing an independent Chair through a proportionate competitive recruitment process.
3. Approve a streamlined four-week competitive recruitment process to identify and appoint an Independent Chair of North Tees and Hartlepool Solutions LLP, with a preferred candidate being recommended to the Members by the end of September 2026
4. Approve the proposed timeline and process set out within this report.
5. Authorise the Trust's shareholder representative to support implementation of the process through the LLP Members.

## Appointment of Independent Chair of North Tees and Hartlepool Solutions LLP

### 1. PURPOSE OF REPORT

The purpose of this report is to seek approval for a proposed process and timetable for appointing an independent Chair of North Tees and Hartlepool Solutions LLP ("the LLP") following receipt of external legal advice regarding the requirements of the LLP Agreement and options available to Members.

### 2. RECOMMENDATIONS

The Board is asked to:

1. Note the legal advice received regarding appointment of the Chair of North Tees and Hartlepool Solutions LLP.
2. Support the principle of appointing an independent Chair through a proportionate competitive recruitment process.
3. Approve a streamlined four-week competitive recruitment process to identify and appoint an Independent Chair of North Tees and Hartlepool Solutions LLP, with a preferred candidate being recommended to the Members by the end of September 2026
4. Approve the proposed timeline and process set out within this report.
5. Authorise the Trust's shareholder representative to support implementation of the process through the LLP Members.

### 3. BACKGROUND

North Tees and Hartlepool Solutions LLP is jointly owned by:

North Tees and Hartlepool NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust

The LLP Agreement provides for the appointment of a Chair of the Management Board.

Recent legal advice was commissioned to clarify:

- the requirements of the LLP Agreement;
- whether a competitive recruitment process is required;
- the role of Members in making the appointment; and
- options for future governance arrangements.

The advice confirms that:

- the Chair is appointed by Members' Resolution;
- the Chair is a reserved matter for Members;
- there is no legal requirement to undertake a competitive process;
- Members may determine the criteria and process for appointment; and
- a competitive process would represent good governance given the LLP Agreement's reference to an "independent Chair"

### 4. GOVERNANCE CONSIDERATIONS

#### 4.1 Current LLP Agreement Position

The LLP Agreement provides that:



Caring Better Together

*"The Chair of the Management Board shall be nominated by the North Tees Trust from the North Tees Trust Representatives and appointed for a term of no longer than three years and otherwise in accordance with criteria and terms determined by Members' Resolution."*

The role is therefore governed through Member decisions rather than through the Management Board itself.

### 4.2 Future Governance Arrangements

The legal advice notes that Members should first determine:

- whether they wish to retain the role of Chair;
- the criteria that should apply to the role;
- expected responsibilities and time commitment; and
- appropriate remuneration arrangements.

The advice also notes that there is no legal requirement for the LLP to have a Chair and that the LLP Agreement could be amended should Members wish to alter current governance arrangements in the future.

At this stage it is proposed that the position of Chair be retained and that an independent Chair be appointed through a transparent process.

## 5. PROPOSED RECRUITMENT APPROACH

Whilst not legally required, a proportionate competitive recruitment process is recommended as a matter of good governance and to demonstrate the independence of the appointment. Given the relatively limited time commitment associated with the role and the need to ensure continuity of governance arrangements, it is proposed that a streamlined recruitment process be undertaken over a four-week period.

The role will be advertised through targeted governance and NHS networks, supported by direct approaches where appropriate. Following shortlisting by representatives of both Members, candidates will be interviewed by a joint panel with a recommendation made to the Members for formal appointment by Members' Resolution. This approach balances transparency, independence and value for money whilst enabling an appointment to be made within a timely timeframe.

## 6. PROPOSED TIMELINE

| Activity | Date |
|---|---|
| Members approve recruitment approach and role profile | 3 September 2026 |
| Recruitment pack finalised and advertisement launched | 4 September 2026 |
| Advertisement period (10 working days) | 4 to 18 September 2026 |
| Longlisting and shortlisting panel | 21 September 2026 |
| Candidate interviews | 24 September 2026 |
| Preferred candidate identified and due diligence completed | 25 to 28 September 2026 |
| Members' Resolution approving appointment | 30 September 2026 |
| Appointment announcement | 1 October 2026 |
| Independent Chair commences role | 1 October 2026 (or as agreed) |

## 7. FINANCIAL IMPLICATIONS

The legal advice notes that consideration is being given to remuneration of approximately £20,000 per annum.

Members will need to determine whether this remains appropriate in light of:

- expected duties;
- governance responsibilities;
- market comparisons; and
- value for money considerations.

Any remuneration approved by Members will reduce LLP distributable profits or resources available to support LLP services.

## 7. RISKS

| Risk | Mitigation |
|---|---|
| Challenge regarding independence of appointment | Transparent recruitment process |
| Lack of suitable candidates | Targeted recruitment campaign |
| Delay in appointment | Agreed recruitment timetable |
| Governance ambiguity | Members' Resolution establishing clear appointment arrangements |

## 8. CONCLUSION

External legal advice confirms that appointment of the LLP Chair is a reserved matter for Members and that no formal competitive recruitment process is legally required. However, given the LLP Agreement's reference to an independent Chair, a proportionate competitive recruitment process is recommended as good governance practice. The Board is therefore asked to support the proposed approach and timetable to enable Members to proceed with recruitment during 2026/27.

**APPENDICES**
Legal advice