Group Board

Tuesday 7 January 2025, 1pm, Board Room,
2nd Floor, Murray Building, James Cook
University Hospital

MEETING OF THE GROUP BOARD TO BE HELD IN PUBLIC ON TUESDAY 7 JANUARY 2025 AT 1PM IN THE BOARD ROOM, 2ND FLOOR, MURRAY BUILDING, JAMES COOK UNIVERSITY HOSPITAL

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT	TIME
CHAIR'S BUSINESS					
1.	Story	Information	Chairman	Presentation	1:00
2.	Welcome and Introductions	Information	Group Chair	Verbal	1:20
3.	Apologies for Absence	Information	Group Chair	Verbal	
4.	Quorum and Declarations of Interest	Information	Group Chair	ENC	
5.	Minutes of the last meeting of the held on, 5 November 2024	Approval	Group Chair	ENC	
6.	Matters Arising and Action Log	Information	Group Chair	ENC	1.25
7.	Group Chairman's Report	Information	Group Chair	ENC	1.35
8.	Group Chief Executive's Report	Information	Group Chief Executive	ENC	1.45
9.	Board Assurance Framework	Assurance	Director of Assurance	ENC	1.55
QUALITY AND SAFETY					
10.	Quality Committee Chairs Log	Assurance	Chair of Committee	ENC	2.05
11.	Learning from Deaths Report	Assurance	Group Chief Medical Officer	ENC	2.15
12.	Patient Experience Report	Assurance	Group Chief Nurse	ENC	2.25

	ITEM	PURPOSE	LEAD	FORMAT	TIME
13.	CQC Update Report	Assurance	Group Chief Nurse	ENC	2.35
PEOPLE					
14.	People Committee Chairs Log	Assurance	Chair of Committee	ENC	2.45
15.	Safer Staffing report	Assurance	Group Chief Nurse	ENC	2.55
FINANCE & PERFORMANCE					
16.	Resources Committee Chairs Log	Assurance	Chair of Committee	ENC	3.05
17.	Finance Reports Month 8	Assurance	Group Chief Finance Officer	ENC	3.15
18.	Integrated Performance Report	Assurance	Group Managing Director	ENC	3.25
19.	Audit and Risk Committee Chairs Log	Assurance	Chair of Committee	ENC	3.35
CLOSE					
	DATE OF NEXT MEETING The next meeting of the Group Board of Directors will take place on 4 March 2025				

University Hospitals Tees

Register of members interests

Meeting date: 7 January 2025

Reporting to: Group Board

Agenda item No: 3

Report author: Jackie White, Head of Governance & Co Secretary

Action required:
Information

Delegation status (Board only):
Jointly delegated item to Group Board

Previously presented to:
n/a

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☒

Health and wellbeing ☒

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A great place to work ☒

A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☒

Deliver care without boundaries in collaboration with our health and social care partners ☒

Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

All BAF risks

Key discussion points and matters to be escalated from the meeting

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

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

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

Careful consideration has been given to the risk that directors may have conflicts of interest by reason of 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 Boad are asked to note the register of interest.

Group Board of Directors Register of Interests

Board Member	Position	Relevant Dates From	to	Declaration Details
Ada Burns	Non-Executive Director	2022	Ongoing	Role – Governor and Chair of the Board of Governors, Teesside University
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Alison Fellows	Non-Executive Director		Ongoing	Non-Executive Director and committee chair – Gentoo Group (Housing Association) - Company number 04739226
			Ongoing	Husband Partner at Firm – Ward Hadaway Solicitors
		1.12.23	Ongoing	Governor of the Board and member of the Audit Committee Northumbria University
		6.12.23	Ongoing	Independent Member of the Audit Committee Newcastle City Council
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Alison Wilson	Non-Executive Director	4 January 2022	Ongoing	Civil Partner – Counter Terrorism Policing North East
		September 2022	Ongoing	South Tees Healthcare Management Limited - Company number 10166808.
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Ann Baxter	Non-Executive Director		Ongoing	Independent Scrutineer of Safeguarding / Chair of Statutory Safeguarding Partnership – Darlington Borough Council
				School Governor at Thirsk High School and Sixth Form College
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Chris Hand	Group Chief Finance Officer	2 July 2021	Ongoing	Director of South Tees Healthcare Management Limited - Company number 10166808
			Ongoing	Client Representative ELFS Shared Services Management Board
		June 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
		April 2024	Ongoing	Representation on behalf of North Tees & Hartlepool NHS Trust on NTH Solutions LLP – Company Number OC419412
Chris Macklin	Non-Executive Director	February 2023	Ongoing	Chair, Audit One
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board

David Redpath	Non-Executive Director	1 January 2021	Ongoing	Director of DGR Consultancy - Company number 10340661
		September 2022	Ongoing	South Tees Healthcare Management Limited - Company number 10166808.
		September 2017	Ongoing	Vice President Senior Executive Partner – Gartner
		July 2022	Ongoing	Deputy Chairman – Seaton Delaval Football Club
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Elizabeth Barnes	Non-Executive Director		Ongoing	Non-Executive Director – Aspire Housing
				Trustee – University of Sunderland
				Trustee – Middlesex University
				Trustee – Peter Coates Foundation
				Member – Queen Elizabeth Grammar School Multi-Academy Trust
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Fay Scullion	Non-Executive Director			School Governor at Jarrow Trust Secondary School
				Associate Tutor – Learning Curve Group
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
		October 2024	Ongoing	Chief Executive, Age UK North Yorkshire & Darlington
Hilary Lloyd	Group Chief Nurse	15 February 2021	Ongoing	Visiting Professor at Sunderland – no monetary gain
		May 2023	Ongoing	Chief Nurse for Clinical Research Network NENC
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Jackie White	Head of Governance & Company Secretary	March 2013	Ongoing	Registered with IMAS (NHS interim management & support)
		March 2023	Ongoing	Company Secretary of South Tees Healthcare Management Limited - Company number 10166808
			Ongoing	Daughter and Daughter in law employees of South Tees Hospitals NHS Trust
Ken Anderson	Group Chief Information Officer	May 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Kenneth Readshaw	Non-Executive Director	2016	Ongoing	Treasurer – Leyburn Community Leisure Club
		2018	Ongoing	Chair – Health Accommodation Trust
		2000	Ongoing	Chair – Horsehouse School Charity - Charity number: 513060

		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Matt Neligan	Group Chief Strategy Officer	October 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Mark Dias		20 July 2015	Ongoing	Director of Be The Change HR Ltd – Company No. 9694576
		21 June 2023	Ongoing	Chair – Workforce Committee, Seacole Group
		September 2023	Ongoing	Permanent Deacon in Training (Voluntary Position). Roman Catholic Diocese of Middlesbrough
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Michael Stewart	Group Chief Medical Officer	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Miriam Davidson	Non-Executive Director	December 2022	Ongoing	Care and Health Improvement Programme (SLI) Advisor Occasional work with Local Government Association (LGA)
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Neil Atkinson	Group Managing Director	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
		June 2024	Ongoing	Representation on behalf of North Tees & Hartlepool NHS Trust on NTH Solutions LLP – Company Number OC419412
Derek Bell	Group Chair	April 2020	Ongoing	Trustee Royal Medical Benevolent Fund – no remuneration
		April 2018	Ongoing	Chair and Trustee Tenovus Scotland (Edinburgh) – no remuneration
		April 2021	Ongoing	Centre for Quality in Governance
		July 2022	Ongoing	Sel clinical advisor for SDEC
		March 2024	Ongoing	Member of the Council for Newcastle University. No remuneration.
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Rachael Metcalf	Group Chief People Officer	December 2020	Ongoing	Role of School Governor at High Tunstall College of Science
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Rowena Dean	Chief Operating Officer North Tees & Hartlepool NHS Trust			
Ruth Dalton	Group Director of Communications		Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
Samuel Peate	Chief Operating Officer South Tees Hospitals NHS Foundation Trust	1 April 2021	Ongoing	No interests declared
Stacey Hunter	Group Chief Executive	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board
		July 2024	Ongoing	Partner, Dr Cornelle Parker, ad hoc project work with University Hospitals Tees and other parts of the NHS
Steven Taylor	Group Director of Estates			Director of North Tees & Hartlepool NHS Trust and Director of South Tees Hospitals NHS Trust Board

Stuart Irvine	Director of Risk, Assurance and Compliance	2023	Ongoing	Chair – Hartlepool College of Further Education Trustee of Hospitals Trust of the Hartlepool Son is employed by NTH Solutions LLP – Company Number OC419412

DRAFT Minutes of a meeting of the University Hospitals of Tees Group Board held in Public on Tuesday, 5 November 2024 at 1.00pm in Rooms 3 & 4, Strive, Friarage Hospital, Northallerton

Present:
Derek Bell, Group Chair (Chair)
Ann Baxter, Group Vice Chair/Non-Executive Director
Ali Wilson, Group Vice Chair/Non-Executive Director
Liz Barnes, Group Non-Executive Director
Fay Scullion, Group Non-Executive Director
Alison Fellows, Group Non-Executive Director
Ada Burns, Group Non-Executive Director/Senior Independent Director
Chris Macklin, Group Non-Executive Director/Senior Independent Director
Miriam Davidson, Group Non-Executive Director
Kenneth Readshaw, Group Non-Executive Director
Mark Dias, Group Non-Executive Director
Neil Atkinson, Group Managing Director
Chris Hand, Group Chief Finance Officer
Rachael Metcalf, Group Chief People Officer
Mike Stewart, Group Chief Medical Officer
Lindsay Garcia, Site Director of Nursing, STHFT on behalf of Hilary Lloyd, Group Chief Nurse

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

In Attendance:
Lucy Tulloch Deputy Director, Strategy and Planning (observing)
Emily Heney, Veteran's Community Nurse, Help for Heroes (item 1 only)
Kelly Glaister, Liaison Nurse, Help for Heroes (item 1 only)
Stephanie Worn, Assistant Director of Midwifery, North Tees & Hartlepool NHS Foundation Trust (Item 12 only)
Rosie Dawson, Consultant Midwife, South Tees Hospitals NHS Foundation Trust (Item 12 only)
Janet Crampton, Lead Governor, South Tees Hospitals NHS Foundation Trust
Sarah Hutt, Assistant Company Secretary (note taker)

GB/156 Veteran Story

The Chair welcomed Kelly Glaister, Liaison Nurse, Help for Heroes who was new in post working across the Group and Emily Heney, Veteran's Community Nurse, Help for Heroes who shared her experience as a veteran accessing health and welfare services following medical discharge from the army having served in the Queen Alexandria's Royal Army Nursing Corps.

Points of learning included the importance of providing support for veterans to navigate the healthcare system often through multiple specialities during the period of transition and adjustment from active service into civilian life and ensuring that the veteran status be flagged through all elements of the individual's care including appropriate discharge. Emily was commended for her sharing her journey and using her lived experience to help others in her new professional role.

DRAFT

GB/157 Welcome and Introductions

The Chair welcomed everyone to the meeting, reiterating the importance and value of holding meetings in venues across the Group.

Janet Crampton, Lead Governor, STHFT provided feedback regarding the Stockton Watersports Centre, the venue for the previous board meeting, highlighting the importance of good acoustics in order to adequately hear the business being discussed and as the meetings were held in public attendance by members of the public should be encouraged and acknowledged formally in the minutes.

GB/158 Apologies for Absence

Apologies for absence were reported from Stacey Hunter, Group Chief Executive, Hilary Lloyd, Group Chief Nurse and David Redpath, Group Non-Executive Director.

GB/159 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 and asked attendees if any new declarations needed to be noted. There was no perceived conflicts of interest from the agreed agenda. Should a conflict arise during the course of the meeting, affected individuals should raise the conflict and a decision will be made to ensure appropriate action is taken.

GB/160 Minutes of the last meeting held on, 3 September 2024

The minutes of the meeting were accepted as an accurate record subject to a minor correction regarding attendees at the meeting.

Resolved: that, the minutes of the meeting held on, Wednesday, 3 September 2024 be confirmed as an accurate record, subject to a minor correction regarding attendees at the meeting.

GB/161 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.

GB/162 Group Chair's Report

The Group Chair highlighted the key points of the Group Chair's Report:

CQC State of Care Report; Vaccinations; University Hospital Tees Group Strategy; Governor Elections; Governor walk rounds; Board Update; Annual Members Meeting (AMM)/Annual General Meeting (AGM) and Celebratory events.

Resolved: that, the content of the report be noted

GB/163 Group Chief Executive's Report

Mike Stewart, Group Chief Medical Officer highlighted the key points of the Group Chief Executive's Report:

System Oversight Framework; System Recovery Board; North East North Cumbria (NENC) Provider Collaborative Leadership Board; Board Development; Annual Members Meeting; Vaccination

DRAFT

Programme; Association of Groups Meeting, Manchester; STHFT Maternity Services Cultural Review ; Sexual Misconduct Policy; Further Faster 20 initiatives; NHS 10 Year Health Plan; PLACE; University Hospital Group Clinical Strategy; Matthew Taylor, Chief Executive, NHS Confederation visit and In other news.

It was noted there had been positive feedback following the first oversight meeting with the NENC Integrated Care Board (ICB) and NHS England since the Group had been established.

A formal update regarding the budget announcement on 30 October 2024 would be made at a future meeting once the exact detail had been published.

Ada Burns, Group Non-Executive Director/Senior Independent Director highlighted the nationally reported issue of reduced uptake to fill student nurse university places and sought assurance regarding local and system wide actions being taken, prompting discussion. The issue would be raised at the NENC Integrated Care System (ICS) Workforce Group, in addition to the continued development of an internal Strategic Workforce Plan for the Group.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the issue of reduced student nurse place uptake be raised at the NENC ICB Workforce Group to seek a system wide approach.

GB/164 Board Assurance Framework

Stuart Irvine, Director of Strategy, Assurance and Compliance presented the Interim Board Assurance Framework (BAF) Update to the period 31 August 2024. For NTHFT there were 35 strategic risks across seven BAF domains, with four red risks remaining outside of the risk appetite. For STHFT there were 22 identified threats linked to five principal risks and 19 planned actions to mitigate the threats.

The new BAF would report the position to 30 September 2024 at Committees in November. The reporting periods of the BAF and new Integrated Performance Report (IPR) were now aligned. A brief discussion ensued with check and challenge from Non-Executive members regarding the updated content. It was acknowledged that further refinement was required as the content of the reports and the information being presented continued to develop.

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

GB/165 Quality Assurance Committee Chairs Log

Fay Scullion, Group Non-Executive Director presented the Group Quality Assurance Committee Chairs Logs for the meetings held on 24 September 2024 and 28 October 2024.

Areas of escalation included increasing mandatory training compliance across maternity services, the management and monitoring of increasing health care acquired infection rates, performance against the 62-day cancer targets with deep dives taking place across specialties. It was noted that two never events in Ophthalmology had been reported since the last report, which were being reviewed. A brief discussion and challenge regarding focused actions to reduce infection rates ensued.

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

GB/166 Patient Experience and Involvement Annual Report 2023/24

Lindsay Garcia, Site Director of Nursing, STHFT presented the Patient Experience and Involvement Annual Report 2023/24 for both trusts and drew members' attention to the key points.

The number of complaints had increased, however, this was predicted following the implementation of the new NHS complaint standards. The timeframe to respond to complaints continued to be a challenge and was below the target for both trusts, which was being monitored through the Quality Assurance Committee. It was noted the Governors had raises similar concerns

DRAFT

Following discussion, it was proposed to look at how to triangulate the various sources of information regarding the views of staff and patients to help with direction setting as part of the overall Group Strategy development.

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

GB/167 Maternity & Neonatal Services Safety & Quality Report for Quarter 2:2024/25

Stephanie Worn, Assistant Director of Midwifery, NTHFT presented the Maternity & Neonatal Services Safety & Quality Report and Staffing Report Quarter 2: 2024/25 and highlighted the key points. Rosie Dawson, Consultant Midwife, STHFT presented the Perinatal Quality Surveillance Model Report August and September 2024.

For NTHFT, there were no items for escalation, however, a data validation exercise was required in respect of Appearance, Grimace, Activity and Respiration (APGAR) scores of under seven at 5 minutes of age. Two events had been reported to the Maternity and Neonatal Safety Investigation (MNSI) branch and the NHS Resolution Early Notification (EN) scheme, one event did not meet the threshold for a MNSI and would be managed as a Patient Safety Incident Investigation (PSII).

There was a risk of non-compliance for Maternity Incentive Scheme safety actions 6 and 8, with appropriate action plans in place. There was ongoing cultural work with support from the Health and Innovation Team to develop an action plan working with the five culture coaches. It was noted that the Board Maternity Safety Champions met regularly with the Perinatal Quadrumvirate Leadership Team to discuss and review the culture improvement plan, good progress was being made and would continue to be monitored.

The North East North Cumbria Integrated Care Board (NENC ICB) and Local Maternity and Neonatal System (LMNS) team had visited NTHFT the previous day, with positive feedback reported.

STHFT: A recovery plan was in place to achieve staff training compliance for the Maternity Incentive Scheme year 6. The maternity centre at the Friarage Hospital had closed on 53 occasions to support safe staffing for the James Cook Hospital site.

Resolved:
(i) that, the culture and leadership developments be noted; and
(ii) that, the NHS Resolution scorecard be noted; and
(iii) that, the Quality Improvement projects for ATAIN and SBL be noted; and
(iv) that, the progress made in relation to neonatal transitional care for late preterm newborn babies be approved.

GB/168 Maternity and Neonatal Services Staffing Report for Quarter 2:2024/25

Stephanie Worn, Assistant Director of Midwifery, NTHFT presented the Maternity and Neonatal Services Staffing Report for Quarter 2: 2024/25 and highlighted the key points.

Recruitment was ongoing across the workforce, there was an increase in sickness absence amongst the midwifery staff with no themes identified and would continue to be monitored through regular safe staffing huddles. Midwifery red flags were monitored weekly and currently on track for the compliance period for the Maternity Incentive Scheme year 6.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, the completed action plan for obstetric consultant attendance in complex emergency obstetrics be approved; and
(iii) that, the neonatal workforce action plan to achieve the BAPM recommendations be approved.

GB/168 People Committee Chairs Log

Mark Dias, Group Non-Executive Director presented the Group People Committee Chairs Log for the meeting held on 25 September 2024 and provided a verbal update for the meeting held on 30 October 2024.

Areas of note. Staff sickness absence remained a concern, which was being reviewed in detail plus gaps in mandatory training were being addressed. An updated position was requested regarding the Safer Staffing Reports to ensure consistency of the methodological approach across the Group. In addition, assurance was sought for evidence of financial governance to support the proposed increasing in staffing rates.

The risk in relation to the management and compliance of rotas for the Residents in Training Doctors was escalated to Group Board for discussion on 5 November 2024 to understand the actions being taken.

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

GB/169 Safe Staffing Report

Lindsay Garcia, Site Director of Nursing, STHFT presented the Safe Staffing Report for the period May to August 2024 and highlighted the key points.

Safe staffing levels were reviewed daily ensuring the correct skill mix, should a fill rate of less than 80% RNs occur, mitigating actions were taken including redeployment and the use of NHSP to fill the shift. Nurse sensitive factors were reviewed monthly with none during the reporting period. There had been 24 red flags reported at STHFT and two reported at NTHFT, mainly due to shortfall in RN time, which were addressed.

The vacancy position remained positive across the Group, following the agreed over recruitment and to provide assurance following scrutiny at the People Committee, it was confirmed that there was robust financial governance to support recruitment processes and the proposed increase in headcount, prompting challenge. It was clarified that there had been agreement for the planned recruitment creating an over established position for a temporary period only.

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

GB/170 Nurse Staffing, Capacity and Capability Annual Review 2024/25

Lindsay Garcia, Site Director of Nursing, STHFT presented the Nurse Staffing, Capacity and Capability Annual Review 2024/25 Report for STHFT and highlighted the key points.

It was a mandatory requirement to undertake a review of nurse staffing establishment incorporating requirements of the National Quality Board (NQB), NICE guidelines, the Safer Nursing Care Tool (SNCT), nurse sensitive outcome indicators and professional judgement. For STHFT, it was noted there was a suggested increase of 14 WTE RNs, with supporting rationale provided. Following presentation of the NTHFT report and discussion at People Committee, further scrutiny of the information would be undertaken and reported at a future meeting of People Committee.

In support of discussion relating to the national reduction in the uptake for student nurse places, it was noted there was a focus in the organisation on recruitment and retention, encouraging ‘home grown’ staff to stay with the organisation and using links with the universities to develop a plan.

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

GB/171 Freedom to Speak Up Report

Lindsay Garcia, Site Director of Nursing, STHFT presented the Freedom to Speak Up (FTSU) Report for Quarter 1 and 2: 2024/25 and highlighted the key points.

DRAFT

There was an increase in anonymous reporting of concerns at STHFT, which was being reviewed and learning shared from other organisations in order to make improvements. Non-Executive members shared the debate at People Committee and request for further alignment in future reports to support better analysis of data. A point of clarity was that FTSU training was available and encouraged for all staff to complete on ESR, but was not core mandatory training. A brief discussion ensued regarding tackling behaviours across the organisation positively and sharing with staff other ways to have their voice heard.

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

GB/172 Guardian of Safe Working

Mike Stewart, Group Chief Medical Officer presented the Guardian of Safe Working (GOSW) Reports for each trust for the period 1 August 2023 to 31 July 2024 and highlighted the key points. It was noted that the STHFT report was now aligned with the training year in line with the NTHFT report.

A lack of assurance had been noted at People Committee regarding the compliance and management of rotas for Residents in Training prompting escalation to Group Board. It was explained that a key priority for the year ahead was to ensure the right sizing of rotas across the Group, based upon clinical need, training requirements and staff wellbeing, which would rectify many of the issues cited in the GOSW reports. Accurately costed rotas would also aid financial management. Mark Dias, People Committee Chair was assured by the planned actions, which would be reflected in future reports to the People Committee.

In respect of the provision of hot food out of hours, this was being monitored in terms of uptake and standard, as currently at NTHFT, this was in the form of a vending machine.

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

GB/173 Equality, Diversity and Inclusion Annual Report 2023/24

Rachael Metcalf, Group Chief People Officer presented the Equality, Diversity and Inclusion (EDI) Annual Report 2023/24 for both trusts, reminding members it was a statutory duty for organisations under the Public Sector Equality Duty to produce and publish an EDI Annual Report. The key points were highlighted.

The priorities for 2025/26 were outlined, which would be across the Group including the development of a Staff Health Inequalities dashboard, in addition to completion of the EDI dashboard, and continuing to take active steps to reduce the gender pay gap. It was noted there were plans to introduce an ethnicity and LGBT+ pay gap to ensure a fair workplace for all.

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

GB/174 Resources Committee Chairs Log

Chris Macklin, Group Non-Executive Director presented the Resources Committee Chairs Log for the meetings held on 26 September and 31 October 2024. Areas of note included an amended Group control total to £23.1m deficit following STHFT receiving a share of the additional NHSE monies for deficit trusts. Focus remained to identify recurrent efficiencies at NTHFT to meet the Group CIP target. There was a need for ongoing grip and control of the increasing WTE across the Group. The business case for Salix PSDS was recommended for approval by Group Board.

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

GB/175 Finance Reports Month 6, 2024/25

Chris Hand, Group Chief Finance Officer presented the Finance Reports for Month 6, 2024/25 and highlighted the key issues.

DRAFT

At the end of Month 6: 2024/25, the Group was reporting a deficit of £13.6m, an adverse variance of £0.2m against year to date plan. STHFT had received a £17.3m share of deficit funding from NHSE, readjusting the Group control total for 2024/25 to £23.1m deficit. Continued improvements in ERF delivery, recurrent CIP scheme and reduction in run rates would be essential in H2 to ensure delivery of the control total. Pressure on CDEL allocation for IFRS16 for STHFT was forecast, however, mitigations were in place. A useful discussion ensued regarding identifying more recurrent schemes to support the CIP target and the continued oversight to reduce agency and locum spend, following check and challenge by Non-Executive members.

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

GB/176 Integrated Performance Report

Neil Atkinson, Group Managing Director Group presented the Integrated Performance Report (IPR) for the reporting period August 2024. The IPR redesigning process had concluded, with extensive stakeholder engagement to ensure the statutory and reporting requirements of each organisation were met as part of the Group going forward. Members provided positive feedback regarding the new report, acknowledging that it would remain an iterative document and continue to develop. It was agreed to share the development process of the new report with the Council of Governors.

Key issues were highlighted. The updated position regarding over 65 week waits was zero for NTHFT and 68 for STHFT, with plans in place to increase capacity to support STHFT achieve a zero position by the revised December 2024 target. There had been an increased number of stillbirths at STHFT, all cases had been individually reviewed. The Urgent and Emergency Care (UEC) metrics showed some improvement overall from a group position. The number of C.difficile infections at NTHFT were increasing with 40 reported against a trajectory of 18, the position and mitigating actions were being closely monitored through the Quality Assurance Committee.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the development process for the new IPR be shared with the Council of Governors.

GB/177 Audit and Risk Committee Chairs Log

Ken Readshaw, Group Non-Executive Director presented the STHFT Audit and Risk Committee Chairs Log for the meeting held on 18 September 2024.

Escalated items included the advisory audit regarding a fault with the patient letter system. The matter had been referred to the Resources Committee to take forward. Follow up regarding the fire safety audit concerns had been delegated to the Quality Assurance Committee for escalation to Group Board as required. There were a significant number of outstanding audit actions, which needed to be resolved and further discussion with Price Waterhouse Cooper (PWC).

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

GB/178 Retrospective Approval of Documents Executed Under Seal Report

Jackie White, Head of Governance/Company Secretary presented the Documents Executed under Seal Report for retrospective approval.

Resolved: that, retrospective approval be granted for the documents executed under seal.

GB/179 Audit and Risk Committee Terms of Reference

Jackie White, Head of Governance/Company Secretary presented updated Terms of Reference for the STHFT Audit and Risk Committee, following publication of the HFMA NHS audit committee handbook, the output from the committee effectiveness review and in common arrangements with the NTHFT

DRAFT

Audit Committee. It was highlighted that the items of exception to the NTHFT Terms of Reference were the inclusion of Clinical Audit and Freedom to Speak Up arrangements, which would transfer out to managed through the Committee structure for 2025/26.

Resolved: that, the updated Terms of Reference for the STHFT Audit and Risk Committee be approved.

GB/180 Audit Committee Chairs Log

Alison Fellows, Group Non-Executive Director presented the Chairs Log for the NTHFT Audit Committee held 24 October 2024.

A number of actions were agreed at the meeting, including adding a third Non-Executive Director to the Committee membership, escalation of the overdue internal audit actions to the Executive Team and a number of reports to be referred to other Committees.

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

GB/181 Audit Committee Terms of Reference

Jackie White, Head of Governance/Company Secretary presented updated Terms of Reference for the NTHFT Audit Committee, following publication of the HFMA NHS audit committee handbook, the output from the committee effectiveness review and in common arrangements with the STHFT Audit and Risk Committee. It was noted that the only difference was two items of business omitted from the NTHFT Terms of Reference, Clinical Audit and Freedom to Speak Up arrangements.

Resolved: that, the updated Terms of Reference for the NTHFT Audit Committee be approved.

GB/182 Any Other Business

There was no other business reported. It was agreed that key statutory documents would be included in the papers going forward and not in the reading room.

GB/183 Date and Time of Next Meeting

Resolved: that, the next meeting be held on, Tuesday, 7 January 2025.

The meeting closed at 4.05pm.

Signed: Date:

DRAFT

Group Board Public

Date	Ref.	Item Description	Owner	Deadline	Completed	Notes
05 June 2024	GB/069	***Research & Development Annual Report*** Stacey Hunter would provide an overview on the North East and North Cumbria Health Innovation Board at a future Board seminar	Stacey Hunter	01 January 2025		The NENC Innovation Board was scheduled for November and feedback would be included in the next CE Report in addition to an update regarding HealthCall.
03 September 2024	GB/126	***Finance Report, Month 4: 2024/25*** A review into the impact of research posts in STRIVE and wider review of the broader activities to be undertaken to provide assurance.	Rachael Metcalf	01 February 2025		Will be taken through the Group People Committee in early 2025.
03 September 2024	GB/131	***Group Patient Experience and Involvement Report*** Future reports to include the number of complaints as a ratio.	Hilary Lloyd	01 January 2025		Would be included in future reports.
05 November 2024	GB/163	***Group Chief Executive's Report*** The issue of reduced student nurse place uptake to be raised at the NENC ICB Workforce Group to seek a system wide approach.	Rachael Metcalf	01 Janaury 2025		As part of discussion regarding a local and system wide plan to tackle the drop in uptake for student nurse places.
05 November 2024	GB/176	***Integrated Performance Report*** An overview of the new IPR development to be shared with the Council of Governors	Neil Atkinson	01 February 2025		The item would be included as a future Governor development session.

Chairmans report

Meeting date: 7 January 2025

Reporting to: Group Board

Agenda item No 7

Report author: Jackie White, Company Secretary

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

Delegation status (Board only and completed by the Corporate Secretariat): Jointly delegated item to Group Board

Previously presented to: n/a

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☒

Health and wellbeing ☒

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A centre of excellence ☒

A great place to work ☒

Deliver care without boundaries ☒

Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

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

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

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

n/a

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

n/a

Recommendations:

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

Group Chairman's Update

1. Introduction

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

1.1 NHS Providers Conference and NHS Providers Chairs and CEO event 12 December 2024

I attended the Chairs and CEO event on 12 December with NHS Providers. We received a number of updates including hearing about the new political landscape including the work the new government is doing in developing its vision, the key legislation which is currently underway and the risks and pressures on government. Regarding health we heard that there will be an additional £22.6bn for DHSC review budget with a 4% average real terms growth rate, the highest since before 2010 but that this includes recurrent cost of pay settlements and in year pressures such as elective activity and £3.1bn more capital funding in 2025/26. There was a reminder regarding the 10 year plan and the three shifts including hospital to community; analogue to digital and sickness to prevention and a discussion regarding the reform plans including the new pay framework for VSMs and Insightful provider boards which the Group will be reviewing in a future board development session.

1.2 ICB and FT Chairs meeting

The NHS Provider Chairs continue to meet routinely and at our last meeting we heard about the work Newcastle, Northumbria, Gateshead and Cumbria Trusts are doing to form the Northern Care Alliance. I gave an update on the work of the Group as it progresses with development of the Strategy.

1.3 Stockton Health and Care Event

I was pleased to attend an event with Stockton Healthwatch on developing the future delivery plans for a health and care engagement strategy with a focus on improving access for communities and helping to address barriers in accessing services.

1.4 Medical School Teesside

I'm really pleased to share with you that Sunil Bhandari has been appointed by Teesside University to lead the development of a medical school for Teesside. Recently there has been a number of meetings to work up the business case including discussions on the curriculum, future delivery of student education, support from partners and regulatory organisations and the operating model.

1.5 Council of Governors meetings

The Council of Governors for North Tees & Hartlepool and South Tees Hospitals NHS Trusts met in November in common and held a development session which focussed on the development of the Tees Strategy for the University Hospitals Tees which involved lots of discussions and clarifications on its development and a session on the new Integrated Performance Report for the two Trusts and Group. The main meeting in common

welcomed two colleagues from Help the Heros who spoke regarding the services provided to veterans and the experience of one colleague in using health services at James Cook.

1.6 Charitable Funds Committees and in Common and Corporate Trustee

In November the Charitable Funds Committees of both Trust Charities held their quarterly meetings which focussed on the charitable donations and spending over the last 3 months. A meeting was also held in common to look at the opportunities both charities had in working together to support staff and patients. The Corporate Trustee of both Charities also meet in December and approved the financial statements and annual reports.

1.7 Group Board walkrounds in community and digital session

The Group Board of Directors held a board seminar in December with a focus on the new Group digital strategy. Members were reminded regarding the 10 year plan and 3 shifts including the move from analogue to digital. Ken Anderson, Group Chief Information Officer discussed the digital vision which had been draw together with stakeholders including staff and partners and the key themes of the digital strategy for delivery of the vision. Following the discovery phase which has now concluded work is now focussed on capturing the digital requirements of specialities and development of the network across the two Trusts with a view to launching the strategy in January.

In addition as part of the Board visibility plan, the Board undertook a walkround with community staff in Stockton and Hartlepool. Members of the Board spent 2 hours out with staff in patients homes, clinic areas and community sites understanding the work of our fabulous community colleagues and meeting staff and teams.

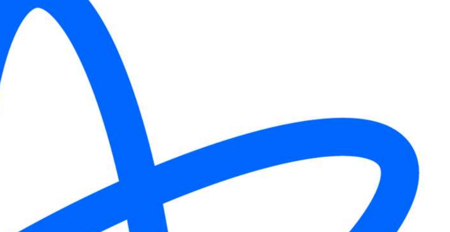
1.8 Covid Memorial Judging

As we recognise the significant challenges which impacted all of us during the pandemic we wanted to recognise that period for staff patients and public. We have agreed to establish a lasting Covid Memorial for North Tees & Hartlepool NHS Trust and have been working in partnership with local schools and colleagues take this forward. Following the successful bid against Charitable Funds in 2023 five schools in the Tees Valley participated in the Covid Memorial competition, with 36 images submitted and judged by the Covid Memorial Panel on 4 December 2024. It was unanimously agreed that the submission from Stockton Sixth Form College was the most thought provoking and the Trust have requested this installation be commissioned in readiness for National Covid-19 Day of Reflection on 9 March 2024. A further two pieces of art submitted by St Hilds Church of England School were judged second and third places and agreement has been reached with the students to display their artwork within the Trust.

2. Recommendation

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

Professor Derek Bell
Group Chair



Chief Executive report

Meeting date: 7 January 2025

Reporting to: Group Board

Agenda item No 8

Report author: Jackie White, Company Secretary

Action required: Information

Delegation status (Board only and completed by the Corporate Secretariat): Jointly delegated item to Group Board

Previously presented to: N/A

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☒

Health and wellbeing ☒

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A centre of excellence ☒

A great place to work ☒

Deliver care without boundaries ☒

Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

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

The report provides an overview of the health and wider related issues and the priorities for University Hospital Tees in response to these.

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 operational focus over this period has been on responding to the increased demands associated with winter infections and continuing to recover elective waiting times. The IPR provides the Board with the details. This includes our performance against our financial plan which Board members will know was the subject of a Board discussion at our development session.

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

Good progress is being made with the work to develop University Hospitals Tees strategy which will include digital, estates, medium term financial plan and our clinical strategy. Board members have had opportunity to understand the key drivers and we expect to bring to be in a position to agree the strategy in April 2025.

Recommendations:

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

Group Chief Executive's Report

1. Introduction

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

1.1 National priorities

The focus for DHSC and NHS England over this period has been final preparations and oversight of winter for front line services particularly ambulance services and our urgent care pathways. The secretary of state for health and care with NHSE CEO has had discussions with CEOs across the NHS which I was able to join. From a University Hospitals Tees perspective whilst our operational and clinical teams have faced significant increases in demand and acuity overall, they have continued to perform well.

Following the budget announcements in the autumn NHS England have been working with the Department of Health and Social Care to identify what this will mean in relation to resources and priorities for 25/26 across the NHS. At the time of writing this report we are waiting for the planning guidance which is expected in January 2025. There has been a CEO discussion with the national team identifying the high level details which allows us to commence our internal planning processes. We will update further at our Board meeting on the 7th January 2025.

1.2 NENC CEO Leadership Group

I was pleased to host at North Tees & Hartlepool NHS Trust the North East and North Cumbria Chief Executives leadership group who met to discuss a number of issues including receiving initial feedback on the work undertaken by PwC and Audit One financial grip and control audits and key themes from around the system. We discussed this and the likely performance priorities for 25/26 and agreed that our system work to ensure best use of resources and sustainable service delivery would be critical to build on our organisation plans for next year. It was noted by all that the need to deliver increased recurrent savings and live within our means across NENC will be a challenge. We have programmes of work across the ICB that should support each of the trusts with this

1.3 NENC FT Chair, CEO and Executive PWC meeting

The Chairman. I and other members of our Executive team attended a meeting with the NENC chairs, CEOs and Executives on 4 December to discuss in more detail feedback on the PWC audits and key themes from the work. The reports for North Tees & Hartlepool NHS Foundation Trust and South Tees Foundation Trust have been shared with all Board members and the recommendations for further improvements are being taken forward by the newly formed Financial Recovery Operational Group (FROG) and will be used as we plan for next year. An area of key focus will be on the need to reduce the whole time equivalent spend whilst ensuring the safe delivery of services. The Board will be kept informed throughout the planning process which we are aiming to have complete in March 2025.

Caring Better Together

1.4 System recovery board

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

As you will be aware, I lead on the procurement workstream for the Region and the work in this area has focussed on understanding the current opportunities both across the region and at a more local level. NENC Providers have engaged with other parts of the country to understand their procurement collaboration journeys so far.

It is recognised that collaboration in this area takes times to do well and needs a phased approach. There are, however, lots of opportunities to think about in terms of how we might be able to standardise our systems and processes to improve efficiencies.

Given the complexity of this work, we have agreed to work primarily at a local level and within 'nested' collaboratives over the next few years. These are:

- Great North Care Alliance
- University Hospitals Tees
- CDDFT and STSFT

In December the system recovery group reviewed the outputs of a deep dive into the Workforce and Elective work streams to identify further opportunities. The same will be done for the other two work streams in January. The CEOs will review all of the outputs and agree collective actions for example reduce sickness by 1% to include as part of each trust's plans in 25/26.

1.5 NENC Provider Collaborative Leadership Board

I attended the Provider Collaborative Leadership Board meetings in November and December. We discussed the operating model for 2025/26 which was a good opportunity to reflect on the work of the past four years since the Collaborative was introduced. The focus of both meetings continues to be in relation to the key programme deliveries such as elective care in particular trajectories to return the RTT standard over the next 3 years, ambulance handovers and winter plans and diagnostics with a focus on the CDC delivery

There is a renewed focus in the Provider Collaborative on the strategic approach to clinical services. There is an overview on three 'S's' – standardisation, stabilisation and sustainability and preparatory work around geographic distribution and disparities, co-dependency and associated elements. Mike Stewart is linking in on this work which will be important for our clinical strategy work.

1.6 Association of Groups Meeting

Matt Neligan, Group Chief Strategy and I recently attended the Association of Groups meeting in London. The focus of this meeting was around productivity and improvement with a number of members of the group showcasing case studies on productivity and improvement strategies. We also had the opportunity to hear from Amanda Pritchard and

Julian Kelly, Chief Finance Officer for NHS England on the national perspective of productivity improvement.
I have been asked by NHS Confederation and agreed to co-chair a national group focused on productivity which will commence next year. This should provide a good opportunity to share any learning that we may benefit from.

1.7 UHT strategy

Work to develop the UHT strategy is bringing together a number of Group-wide focus areas. These include the work of the five clinical boards to design future service models and the enabling strategies across the Group on digital, estates, and workforce. This is currently being progressed with a focus on three time horizons:

- long term transformation (5-10 years) to deliver our future ambition that is supported by new estates infrastructure, including a new hospital and further infrastructure for integrated services in the community at place. The Strategic Outline Case for the future estate requirements will be developed over Q4 and will draw on the headline future service models that the clinical boards have articulated.

- an intermediate five years of core service transformation. The clinical boards are developing options for the reconfiguration and development of services over the next five years within the existing estate footprint. The initial propositions from clinical boards are being tested and refined over Q4. They seek to ensure that our acute services are optimised across the Group, that we create a service offer that joins up care around patient and population need including through embedding community services as part of integrated neighbourhood teams. They will also look to leverage our role as an anchor institution in the local economy.

- immediate 12 month priorities. The clinical boards have selected six services to rapidly progress and test Group-wide “single service” models. These are in cardiology, stroke, reproductive medicine, urology (with a close interdependency and parallel work on general surgery), urgent care and integrated Single Point of Access for community services. Project teams are being identified to support the service transformation work over the next 12 months.

Over Q4 we will be engaging widely with staff, partners and patients to gather feedback on our emerging proposals and to ensure that the ambitions of all of these groups are reflected in the strategy before it comes to a future Board meeting.

1.8 **In other news!**

Board members will be aware that we have completed our recruitment for a new Group Chief Nurse and I am delighted that Emma Nunez who is currently the Chief Nurse & Deputy CEO at Harrogate District Foundation Trust has been appointed. We are working with Emma to agree a start date.

We have also secured Maurya Cushlow who will cover the role on an interim basis when Dr Hilary Lloyd finishes at the end of January.

I know the Board will want to join me in thanking Hilary for her contributions over this last 4 years and wish her well as she takes up her ICB role

A powerful suicide prevention campaign, helping healthcare specialists to speak up and champion a patient's care, has been launched at North Tees and Hartlepool NHS Foundation Trust. 'Chris's Voice', developed by the Irish family, was created after beloved brother and son, Chris Irish, sadly lost his life to suicide in 2021.

The campaign is aimed at empowering healthcare professionals to positively look at ways to better advocate and protect vulnerable patients. It looks to raise awareness of where opportunities may be missed and where improvements can be made to help prevent suicide.

Thanks to generous funding from Friends of the Friarage, Friarage Hospital is now the first in the UK to use Akara UV decontamination units in a ward environment. Following positive initial trial results, two decontamination robots from Akara Robotics can now frequently be seen in the hospital's clinical decisions unit, wards and operating theatres as part of the next stage of the clinical evaluation of the technology. Working in tandem with the strong team of domestic staff the robots serve as a powerful tool to enable environmental services staff to decontaminate rooms with a quicker turnaround time.

2. **RECOMMENDATIONS**

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

Caring
Better
Together

Board Assurance Framework Report (reporting to 31st October 2024) NTHFT/STHFT

Meeting date: 7 January 2025

Reporting to: Group Board

Agenda item No: 9

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

Action required:
Assurance

Delegation status (Board only):
Matter reserved to Unitary Board

Previously presented to:
N/A

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☒

Health and wellbeing ☒

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A great place to work ☒

A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☒

Deliver care without boundaries in collaboration with our health and social care partners ☒

Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

NTHFT BAF – All domains

STHFT BAF – All domains

Key discussion points and matters to be escalated from the meeting

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

A copy of the full BAF report for each Trust is contained in the Reading Library and will be published on the Trust's website after all Board meetings.

The Group Board requested an exercise be undertaken to review existing Board Assurance Framework arrangements (format, content and reporting), with a view to implementing consistent and standardised arrangements by November 2024.

This exercise has now been completed and effective from the Board Committee meetings that took place in November 2024, consistent and standardised BAF process and reporting arrangements are now in place.

This report provides the overall position for each Trust regarding the Board Assurance, Framework, exceptions and actions that are being taken.

Headlines

NTHFT

- For the 8 BAF domains, risk appetites and supporting statements have been proposed and are contained in the report.
- There are 37 strategic risks identified relating to North Tees & Hartlepool NHS Foundation Trust.
- 10 strategic risks are outside of approved risk appetite, of which there are 5 red/high strategic risks outside of approved risk appetite.
- There are 100 planned mitigating actions within the BAF across the 8 domains and there is at least one planned action for each strategic risk.

STHFT

- For the 8 BAF domains, risk appetites and supporting statements have been proposed and are contained in the report.
- There are 31 strategic risks identified relating to South Tees Hospitals NHS Foundation Trust.
- 11 strategic risks are outside of approved risk appetite, of which there are 6 red/high strategic risks outside of approved risk appetite.
- There are 91 planned mitigating actions within the BAF across the 8 domains and there is at least one planned action for each strategic risk.

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

This is the first report of the revised reporting arrangements and a number of actions will be completed in the following months with the BAF Authors:

- Review of the BAF reports by domain to maximise alignment and consistency.
- Review assurances sources and lines of assurance.
- Strengthen cross referencing between the BAF and related IPR metrics.
- Strengthen cross referencing between BAF domains for interdependencies.
- Propose the effectiveness of assurance for each strategic risk for Q3 reporting.
- Review the robustness of planned actions to achieve approved risk appetite/target risk scores.
- Strengthen the links between operational and strategic risks.

The actions will be reflected in future reporting of the BAF to ensure the Board receives robust and reliable assurance regarding the identification, management and mitigation of strategic risks for each Trust.

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

The revised BAF reporting builds upon and strengthens existing arrangements in place for each Trust and provides clear and consistent reporting and clear lines of escalation. The arrangements are also reflective of best practice (Good Governance Institute) and benchmarking with other NHS Foundation Trusts.

External Assurance

Planned internal audits will take place at each Trust in 2024/25, relating to Board Assurance Framework and Risk Management and assurances will be reported to respective Audit Committees.

Recommendations:

The Board of Directors are asked to;

- Receive the Board Assurance Framework Reports for NTHFT and STHFT (reporting to 31st October 2024).
- Approve the proposed strategic risks, risk scores, risk appetites and supporting risk appetite statements for each Trust.
- Acknowledge the assurance the report provides regarding the management and mitigation of strategic risks for each Trust.
- Note the 5 red/high strategic risks for NTHFT and 6 red/high strategic risks for STHFT and the planned mitigating actions.

North Tees & Hartlepool NHS Foundation Trust/South Tees Hospitals NHS Foundation Trust – Board Assurance Framework Report (reporting to 31st October 2024)

NTHFT – Key Headlines	STHFT – Key Headlines
• 37 identified strategic risks. • 5 strategic risks that are outside of approved risk appetite. • One step from approved risk appetite. • 100 planned mitigating actions.	• 31 identified strategic risks. • 6 strategic risks that are outside of approved risk appetite. • One step from approved risk appetite. • 91 planned mitigating actions.

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 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

Revised BAF Arrangements

The Group Board requested an exercise be undertaken to review existing Board Assurance Framework arrangements (format, content and reporting), with a view to implementing consistent and standardised arrangements by November 2024.

This exercise has now been completed and with effect from the Board Committee meetings taking place in November 2024, consistent and standardised BAF process and reporting arrangements are now in place.

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

BAF Format

The BAF for each Trust focuses on 8 (eight) domains, which are a reflection of the key areas of concerns of each Trust from a strategic risk perspective. The agreement of the BAF domains were informed by national best practice (Good Governance Institute) and benchmarking with regional and national NHS Foundation Trusts.

BAF Domains

The 8 BAF domains for each Trust are set out below, with the identified Lead Director, BAF author and the Board Committee that is responsible for oversight and escalation reporting to Board.

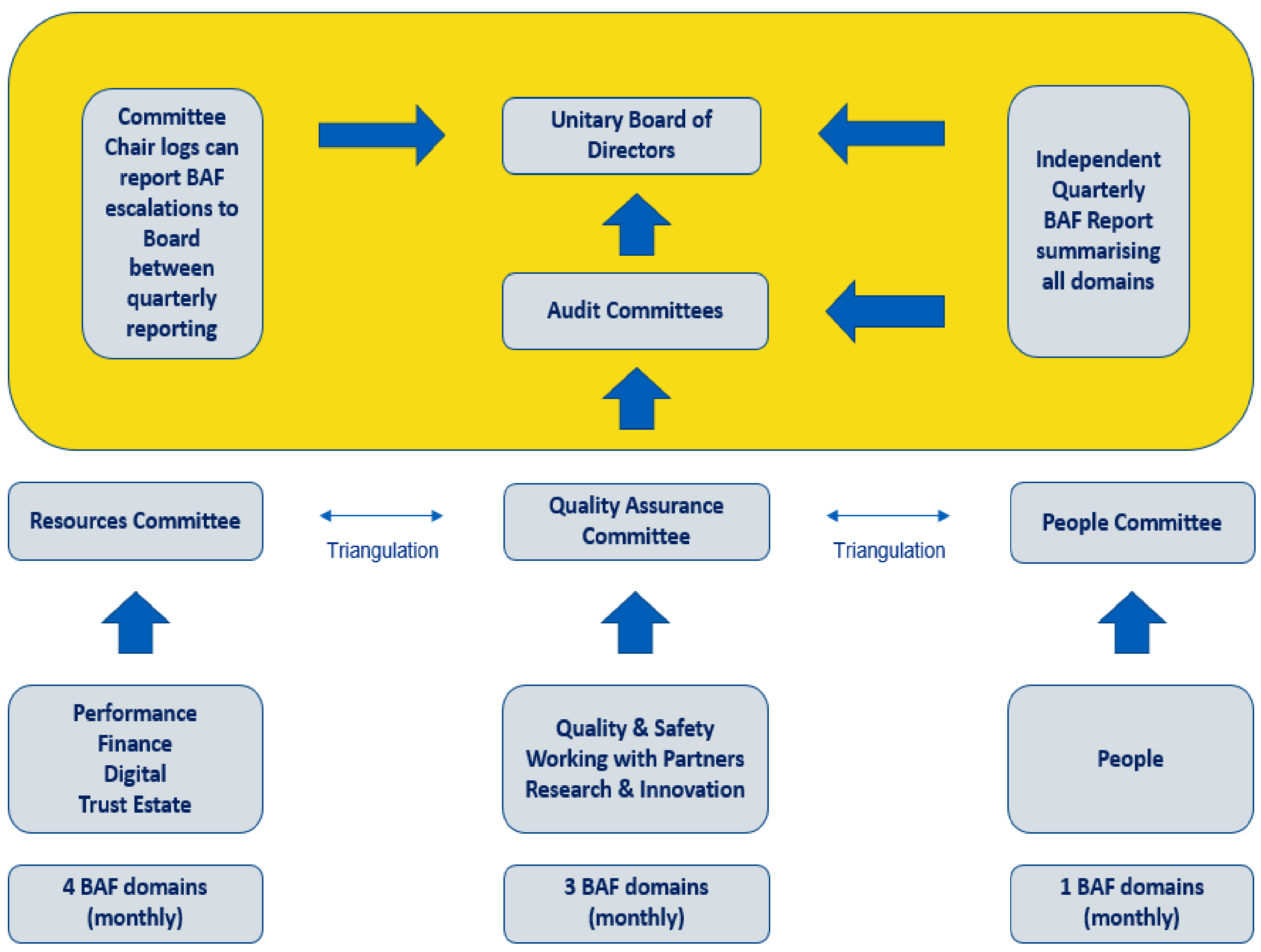
BAF Domain	Responsible Director	BAF Author	Committee oversight
Quality & Safety	Group Chief Nurse	Group Deputy Director of Patient Safety/Deputy Chief Nurse	Quality Assurance Committee
Performance & Compliance	Group Managing Director/Chief Operating Officers	Deputy Director of Strategy & Planning/ Associate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

(*) Review of this domain to be undertaken by the Group Chief Strategy Officer.

Question to Board: Do the 8 BAF domains reflect the key strategic risks facing each Trust? The BAF domains will be subject to an annual review for relevance and will be considered against available benchmarking information in readiness for 2025/26.

For illustration purposes, the reporting arrangements for the BAF are set out below. The benefit of this approach allow Board Committees to receive BAF reports at each meeting focus on their areas of expertise, reports are presented by subject matter experts who manage and mitigate the risks.

New Approach to BAF Domain Reporting



Key Point: Resources Committee has oversight of 4 BAF domains, Quality Assurance Committee has oversight of 3 BAF domains and People Committee has oversight of 1 BAF domain. To ensure each Board Committee has full oversight of all BAF domains for each Trust, a full BAF report is placed in the Committee Reading Library, detailing all 8 domains. Full reports will also be provided for Audit Committees and Group Board.

BAF Domain Alignment to Strategic Objectives

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

NTHFT Strategic Objectives/BAF Domain Links

BAF Domain	NTHFT Strategic Objectives			
	Putting Our Population First	Valuing People work	Transforming Our Services	Heath & Wellbeing
Quality & Safety	✓			
Performance & Compliance	✓			
Digital			✓	
Finance			✓	
People		✓		
Trust Estate	✓	✓	✓	✓
System Working & External Threats	✓			
Research & Innovation			✓	
Links to strategic objectives	**4**	**2**	**4**	**1**

STHFT Strategic Objectives/BAF Domain Links

BAF Domain	STHFT Strategic Objectives				
	Best for safe, clinically effective care and experience	A great place to work	A centre of excellence for core and specialist services…	Deliver care without boundaries in collaboration with our health and social care partners	Make best use of our resources
Quality & Safety	✓				
Performance & Compliance	✓				
Digital					✓
Finance					✓
People		✓			
Trust Estate					✓
System Working & External Threats				✓	
Research & Innovation			✓		
Links to strategic objectives	**2**	**1**	**1**	**1**	**3**

Risk Appetite

The proposed risk appetites for each BAF domain for each Trust have been presented to the Board Committees in November 2024 and they are set out below, along with score range for current risk scores for strategic risks.

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

Risk appetite statements for each BAF domain is provided in **Appendix A.**

Key Point: The proposed risk appetites and supporting risk appetite statements of each Trust are consistent. This provides each Trust and the Boards with the ability consider future decision making against approved risk appetites by domain and supporting risk appetite statement. This strengthens existing governance arrangements and ensures compliance with good governance requirements. Risk appetite will be reviewed annually.

Strategic Risk Score Analysis

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

Domain	Number of strategic risks		Number of strategic risks adversely outside of approved risk appetite		Number of steps away from approved risk appetite		Number of planned mitigating actions	
	NT	ST	NT	ST	NT	ST	NT	ST
Quality & Safety	5	5	**5**	**5**	1	1	17	18
Performance & Compliance	3	4	0	**2**	0	1	7	18
Digital	4	3	0	0	0	0	17	20
People	5	3	0	0	0	0	12	5

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
Finance	5	4	1	1	1	1	10	5
Trust Estate	5	5	3	2	1	1	7	8
System Working & External Threats	5	3	0	0	0	0	13	3
Research & Innovation	5	4	1	1	1	1	17	14
Total Number	**37**	**31**	**10**	**11**			**100**	**91**

NTHFT	STHFT
• The Trust has 37 identified strategic risks linked to Board Assurance Framework domains. • The Trust has 10 strategic risks that are outside of approved risk appetite. • All strategic risks are one step from the approved risk appetite. • Planned actions are in place for each strategic risk to achieve the target risk score.	• The Trust has 31 identified strategic risks linked to Board Assurance Framework domains. • The Trust has 11 strategic risks that are outside of approved risk appetite. • All strategic risks are one step from the approved risk appetite. • Planned actions are in place for each strategic risk to achieve the target risk score.

NTHFT Red/High Strategic Risks Outside Approved Risk Appetite

The table below identifies that there are 5 strategic risks that are red/high and are outside of approved risk appetite. These risks were presented to the Resources Committee and Quality Assurance Committee in November 2024 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
Delivery of recurrent savings	Finance	4 x 4 = 16	1
Failure of Trust infrastructure (including buildings)	Trust Estate	3 x 5 = 15	1

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions
Insufficient capital funding to maintain Trust estate	Trust Estate	4 x 5 = 20	1
Reduction of system capacity if the Trust is unable to provide services	Trust Estate	3 x 5 = 15	1
Inconsistent funding for research to deliver R&I plans across group	Research & Innovation	4 x 4 = 16	4

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 6 strategic risks that are red/high and are outside of approved risk appetite. These risks were presented to the Resources Committee and Quality Assurance Committee in November 2024 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
Cost containment	Finance	3 x 5 =15	2
Risk that the referral-to-treatment 18-week NHS Constitution standard is not met	Performance & Compliance	3 x 5 = 15	5
Risk that the cancer referral to treatment 62-day NHS Constitution standard is not met	Performance & Compliance	3 x 5 = 15	1
Insufficient capital funding to maintain Trust estate	Trust Estate	4 x 5 = 20	2
Trust estate does not allow for the provision of optimal clinical services	Trust Estate	3 x 5 = 15	2
Inconsistent funding for research to deliver R&I plans across group	Research & Innovation	4 x 4 = 16	3

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

Trust Operational Risks

Attached as appendices for information are the Top 10 operational risk for each Trust (**Appendix F** – NTHFT and **Appendix G** – STHFT).

4. Conclusion

- The exercise to review the Board Assurance Framework arrangements in place at each Trust has now concluded, resulting in standardised and consistent BAF reporting. This builds upon and strengthens existing governance arrangements.
- Whilst Board Committees have oversight responsibility for allocated BAF domains, a copy of the full BAF report for each Trust is placed in the Reading Library of each Committee to ensure full oversight is provided. Board Committees can escalate any concerns regarding the management and mitigation of strategic risks to the Board of Directors via Chair's Logs.
- This is the first version of the independent BAF report for each Trust and this will be presented to the Audit Committee and Group Board. It is important to consider whether this report provides a clear line of assurance for each Trust.
- There are 37 strategic risks relating to NTHFT 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.
- There are 31 strategic risks relating to STHFT and there are 6 red/high strategic risks that are outside of approved risk appetite. Mitigating actions are in place to address all strategic risks.

Assurance Statement: The revised BAF reporting arrangements build upon existing arrangement in place for each Trust and provides a clear and robust mechanism for each Trust to identify, report and receive constructive challenge on the effectiveness of the management of the strategic risks. There are a number of areas that will be progressed with BAF authors in the coming months:

- Review of the BAF reports by domain to maximise alignment and consistency.
- Review assurances sources and lines of assurance.
- Strengthen cross referencing between the BAF and related IPR metrics.
- Strengthen cross referencing between BAF domains.
- Propose the effectiveness of assurance for each strategic risk for Q3 reporting.
- Review the robustness of planned actions to achieve approved risk appetite.
- Link between operation and strategic risks.

5. Recommendation

The Board of Directors are asked to;

- Receive the Board Assurance Framework Reports for NTHFT and STHFT (reporting to 31st October 2024).
- Approve the proposed strategic risks, risk scores, risk appetites and supporting risk appetite statements for each Trust.
- Acknowledge the assurance the report provides regarding the management and mitigation of strategic risks for each Trust.
- Note the 5 red/high strategic risks for NTHFT and 6 red/high strategic risks for STHFT and the planned mitigating actions.

Supporting Appendices

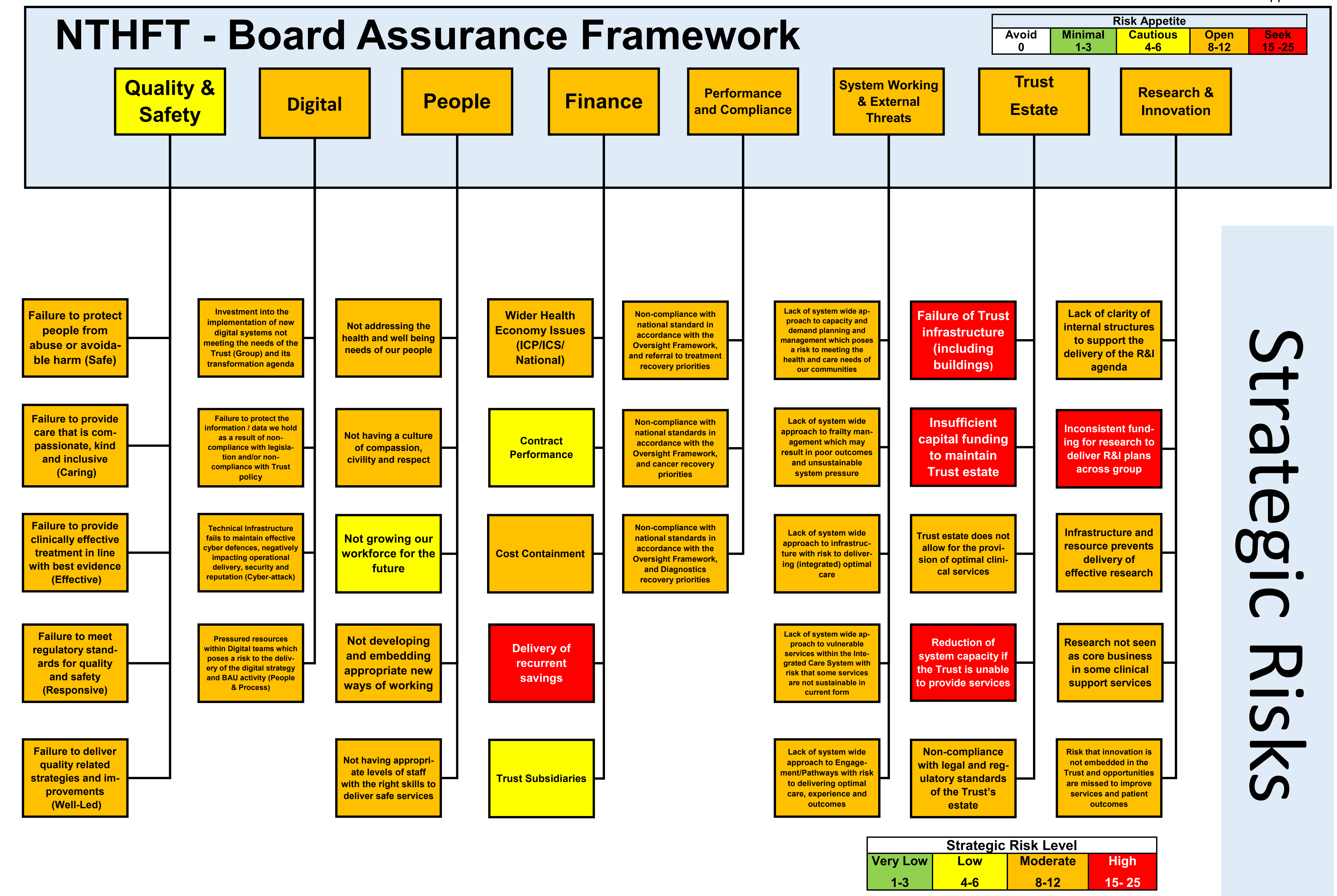
- Appendix A – Risk Appetite Supporting Statements
- Appendix B – NTHFT Strategic Risk Overview
- Appendix C – NTHFT Risk Radar
- Appendix D – STHFT Strategic Risk Overview
- Appendix E – STHFT Risk Radar
- Appendix F – NTHFT Top 10 Operational risks
- Appendix G – STHFT Top 10 Operational Risks

Appendix A

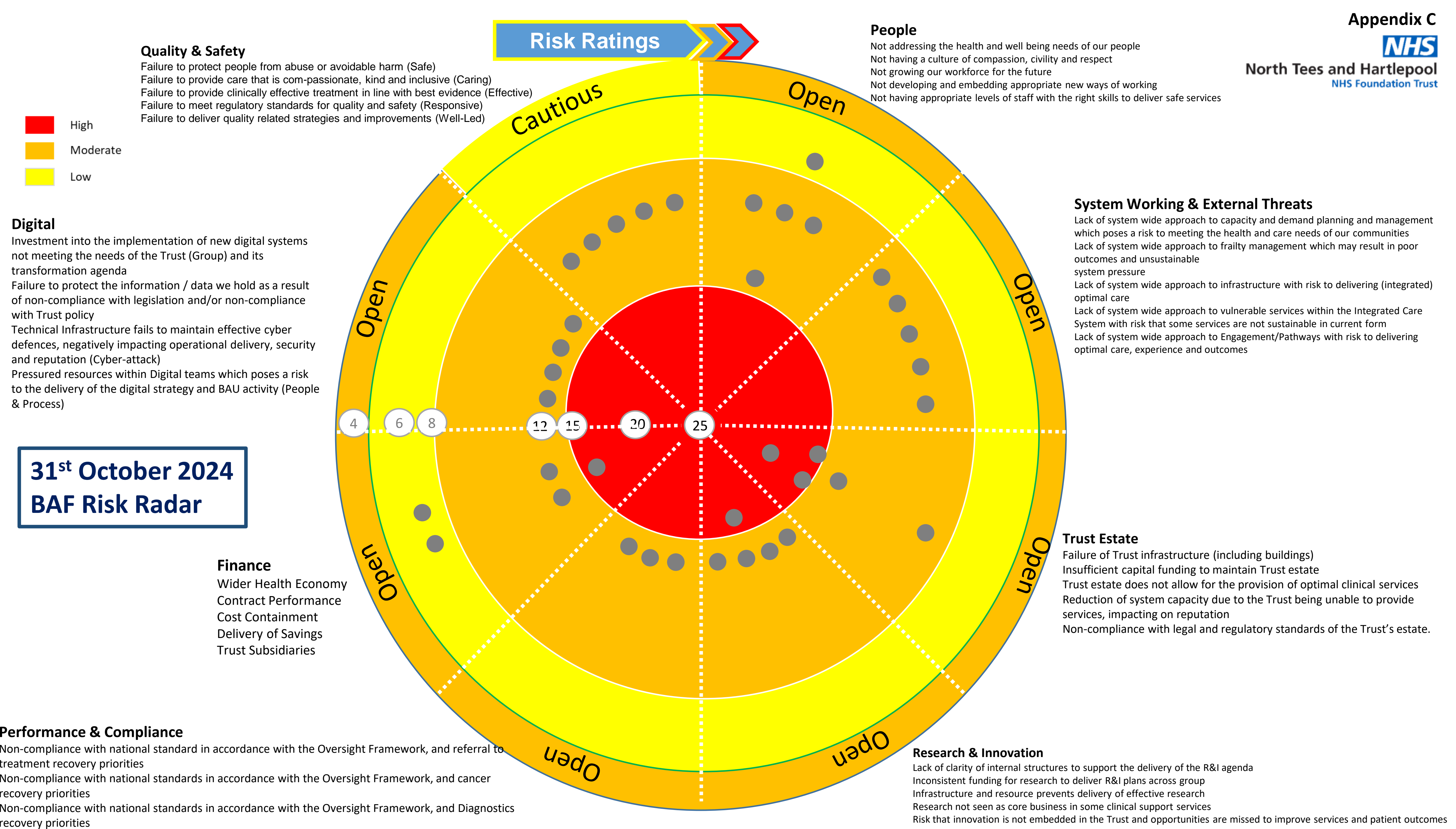
Trust Risk Appetites & Supporting Statements

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 & External Threats	**Open**	We have an **open** approach to **System Working & External Threats** to ensure future safe, effective and sustainable services are provided to our population, which may require changes in staffing models and an agile, resilient workforce. This will require collaborative working with our stakeholder and partners.
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.

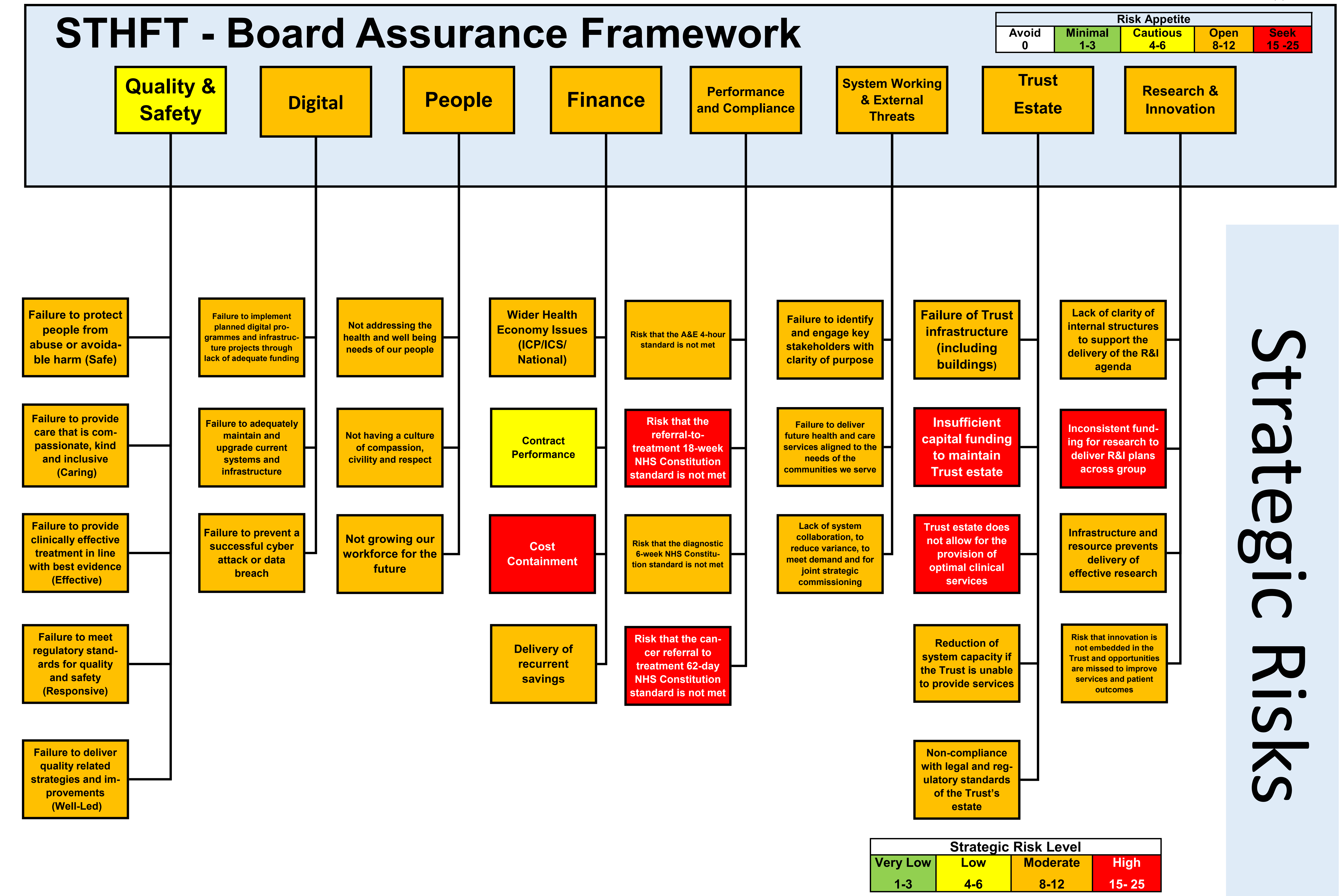
(*) The risk appetites and supporting risk appetite statements are the same for each Trust.



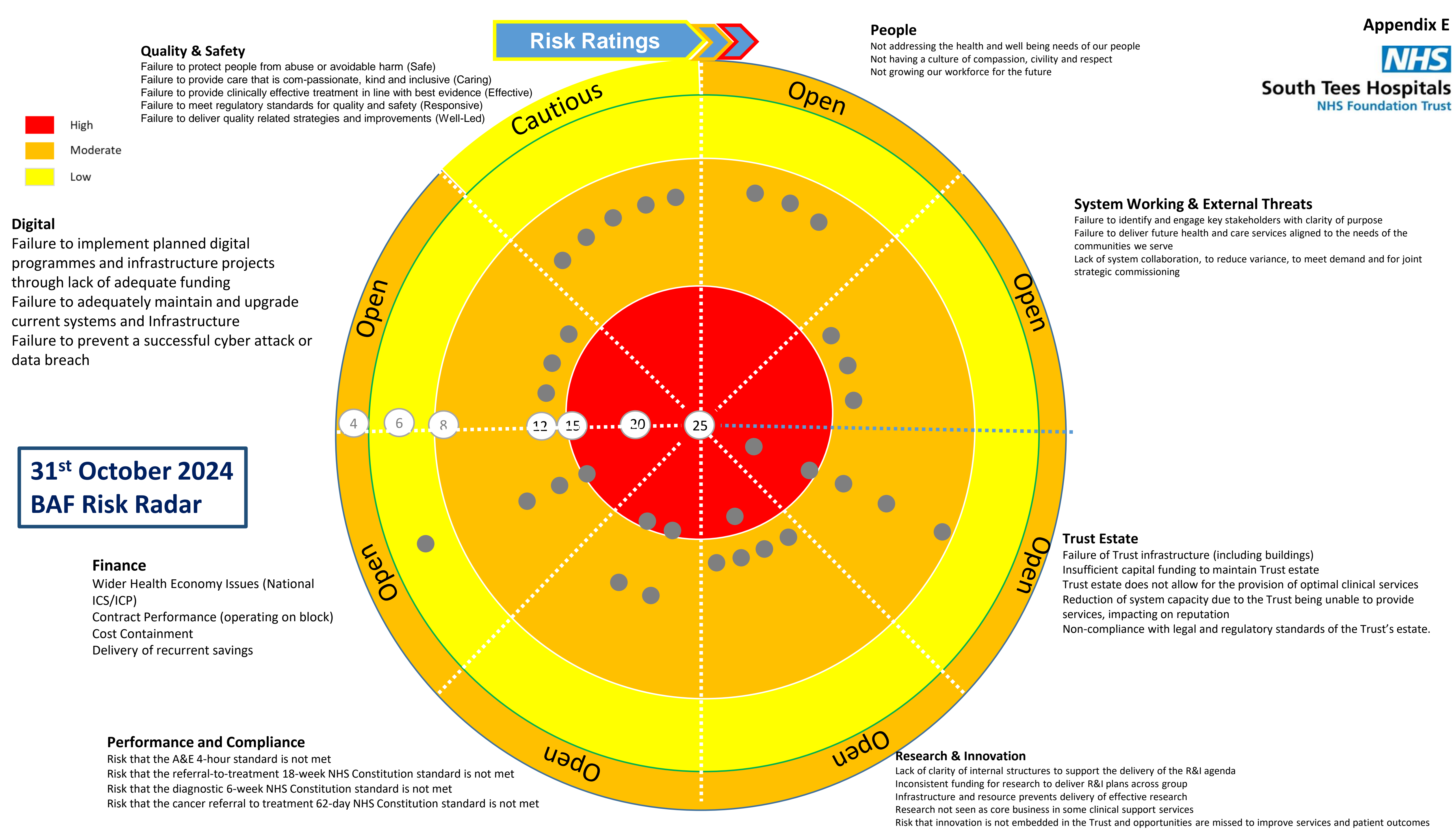
Appendix B
NTHFT - Board Assurance Framework
Risk Appetite
Avoid 0
Minimal 1-3
Cautious 4-6
Open 8-12
Seek 15 -25
Quality & Safety
Digital
People
Finance
Performance and Compliance
System Working & External Threats
Trust Estate
Research & Innovation
Failure to protect people from abuse or avoidable harm (Safe)
Failure to provide care that is compassionate, kind and inclusive (Caring)
Failure to provide clinically effective treatment in line with best evidence (Effective)
Failure to meet regulatory standards for quality and safety (Responsive)
Failure to deliver quality related strategies and improvements (Well-Led)
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)
Not addressing the health and well being needs of our people
Not having a culture of compassion, civility and respect
Not growing our workforce for the future
Not developing and embedding appropriate new ways of working
Not having appropriate levels of staff with the right skills to deliver safe services
Wider Health Economy Issues (ICP/ICS/ National)
Contract Performance
Cost Containment
Delivery of recurrent savings
Trust Subsidiaries
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
Lack of system wide approach to capacity and demand planning and management which poses a risk to meeting the health and care needs of our communities
Lack of system wide approach to frailty management which may result in poor outcomes and unsustainable system pressure
Lack of system wide approach to infrastructure with risk to delivering (integrated) optimal care
Lack of system wide approach to vulnerable services within the Integrated Care System with risk that some services are not sustainable in current form
Lack of system wide approach to Engagement/Pathways with risk to delivering optimal care, experience and outcomes
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
Lack of clarity of internal structures to support the delivery of the R&I agenda
Inconsistent funding for research to deliver R&I plans across group
Infrastructure and resource prevents delivery of effective research
Research not seen as core business in some clinical support services
Risk that innovation is not embedded in the Trust and opportunities are missed to improve services and patient outcomes
Strategic Risk Level
Very Low 1-3
Low 4-6
Moderate 8-12
High 15- 25
Strategic Risks



Appendix C
NHS
North Tees and Hartlepool
NHS Foundation Trust
Risk Ratings
High
Moderate
Low
Quality & Safety
Failure to protect people from abuse or avoidable harm (Safe)
Failure to provide care that is com-passionate, kind and inclusive (Caring)
Failure to provide clinically effective treatment in line with best evidence (Effective)
Failure to meet regulatory standards for quality and safety (Responsive)
Failure to deliver quality related strategies and improvements (Well-Led)
People
Not addressing the health and well being needs of our people
Not having a culture of compassion, civility and respect
Not growing our workforce for the future
Not developing and embedding appropriate new ways of working
Not having appropriate levels of staff with the right skills to deliver safe services
System Working & External Threats
Lack of system wide approach to capacity and demand planning and management which poses a risk to meeting the health and care needs of our communities
Lack of system wide approach to frailty management which may result in poor outcomes and unsustainable system pressure
Lack of system wide approach to infrastructure with risk to delivering (integrated) optimal care
Lack of system wide approach to vulnerable services within the Integrated Care System with risk that some services are not sustainable in current form
Lack of system wide approach to Engagement/Pathways with risk to delivering optimal care, experience and outcomes
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)
Cautious
Open
Open
Open
Open
Open
Open
Open
4
6
8
12
15
20
25
31st October 2024
BAF Risk Radar
Finance
Wider Health Economy
Contract Performance
Cost Containment
Delivery of Savings
Trust Subsidiaries
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
Research & Innovation
Lack of clarity of internal structures to support the delivery of the R&I agenda
Inconsistent funding for research to deliver R&I plans across group
Infrastructure and resource prevents delivery of effective research
Research not seen as core business in some clinical support services
Risk that innovation is not embedded in the Trust and opportunities are missed to improve services and patient outcomes



STHFT - 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 & External Threats
Trust Estate
Research & Innovation
Failure to protect people from abuse or avoidable harm (Safe)
Failure to provide care that is compassionate, kind and inclusive (Caring)
Failure to provide clinically effective treatment in line with best evidence (Effective)
Failure to meet regulatory standards for quality and safety (Responsive)
Failure to deliver quality related strategies and improvements (Well-Led)
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
Not addressing the health and well being needs of our people
Not having a culture of compassion, civility and respect
Not growing our workforce for the future
Wider Health Economy Issues (ICP/ICS/ National)
Contract Performance
Cost Containment
Delivery of recurrent savings
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
Failure to identify and engage key stakeholders with clarity of purpose
Failure to deliver future health and care services aligned to the needs of the communities we serve
Lack of system collaboration, to reduce variance, to meet demand and for joint strategic commissioning
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
Lack of clarity of internal structures to support the delivery of the R&I agenda
Inconsistent funding for research to deliver R&I plans across group
Infrastructure and resource prevents delivery of effective research
Risk that innovation is not embedded in the Trust and opportunities are missed to improve services and patient outcomes
Strategic Risks
Strategic Risk Level
Very Low 1-3
Low 4-6
Moderate 8-12
High 15- 25



Risk Ratings
Appendix E
NHS
South Tees Hospitals
NHS Foundation Trust
Quality & Safety
Failure to protect people from abuse or avoidable harm (Safe)
Failure to provide care that is com-passionate, kind and inclusive (Caring)
Failure to provide clinically effective treatment in line with best evidence (Effective)
Failure to meet regulatory standards for quality and safety (Responsive)
Failure to deliver quality related strategies and improvements (Well-Led)
High
Moderate
Low
People
Not addressing the health and well being needs of our people
Not having a culture of compassion, civility and respect
Not growing our workforce for the future
System Working & External Threats
Failure to identify and engage key stakeholders with clarity of purpose
Failure to deliver future health and care services aligned to the needs of the communities we serve
Lack of system collaboration, to reduce variance, to meet demand and for joint strategic commissioning
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
Cautious
Open
Open
Open
Open
Open
Open
Open
4
6
8
12
15
20
25
31st October 2024
BAF Risk Radar
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.
Finance
Wider Health Economy Issues (National ICS/ICP)
Contract Performance (operating on block)
Cost Containment
Delivery of recurrent savings
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
Research & Innovation
Lack of clarity of internal structures to support the delivery of the R&I agenda
Inconsistent funding for research to deliver R&I plans across group
Infrastructure and resource prevents delivery of effective research
Research not seen as core business in some clinical support services
Risk that innovation is not embedded in the Trust and opportunities are missed to improve services and patient outcomes

Appendix F

Top 10 Operational Risks (31st October 2024)

InPhase Risk ID	Title of Risk	Department/Area	Risk Owner	Current Risk Score
141	Significant sickness absence and vacancy within the Resus team impacting on the capacity to deliver required Resus training for Trust staff which could impact on patient safety and resus outcomes.	Trust wide (People Directorate)	Rachel DeSilva, Head Of Culture, Leadership And Development	12
21	Poor patient outcomes due to dis-jointed layout of the EAU Assessment Area estate. Potential impact of delays to assessment, diagnosis, and treatment commencement, as well as responding to and managing clinical incidents.	Responsive Care	Claire Ranson, Service Lead, Responsive Care	12
381	Learning from Deaths - National requirements.	Medical Directors Office	Julie Christie, Consultant in Palliative Medicine and Trust Lead for Mortality and Learning from Deaths	12
109	Reduced Capacity to support neurodevelopmental diagnostic pathways within the childrens SLT service within all localities.	Paediatrics, Healthy Lives	Lisa Piggott, Professional Lead Childrens Slt	12
69	Medical Job Planning Compliance.	Medical Directors Office	Caroline Metalf, Senior Rota lead	12
61	FIT testing provision.	Trustwide, Quality & Safety	Rebecca Denton Smith, Associate Director of Nursing	12
55	Risk of Patient Harm due to Aseptics reduced experience / capacity.	Pharmacy, Healthy Lives	Marco Pione, Lead Pharmacist For Aseptics And Sqcl Quality Assurance	12
36	Poor patient experience linked to unsuitable accommodation in the Wheelchair Service in Stockton.	Wheelchair Services, Healthy Lives	Fiona Hardie, Senior Clinical Professional	12
25	Delivery of Aseptics Services to the Trust are at risk due to current estate provision.	Pharmacy, Healthy Lives	Richard Scott, Associate Director of Pharmacy: Transformation & Business Lead	12
5970	Increase in levels of banding resulting from job evaluation requests.	Trust wide (People Directorate)	Michelle Taylor, Head Of Workforce Planning, Quality And Projects	12
88	Potential for delayed care and management of paediatric testicular torsion due to lack of approved regional pathway.	Surgery & Urology, Collaborative Care	Steve Heavysides, Care Group Operational Manager	12

Appendix G

Top 10 Operational Risks (31st October 2024)*

Datix Risk ID	Title of Risk	Department/Area	Risk Owner	Current Risk Score
40	Risk that priority radiology and pathology results are not acted upon despite failsafes.	Information Technology	Andrew Adair, Consultant in Emergency Medicine and Clinical Digital Lead	16
219	Risk that staff may suffer harm from violence or aggression due to not utilising lone worker devices.	Health and Safety	Catherine Maughan, Facilities Project / Staff Safety Lead	16
645	Pager Bleep System	Information Technology	Choi Cheng, IT Communications Manager	16
304	Risk that service provision is compromised in Cell Path due to failure of staining machines and now impact on digital scanners.	Cellular Pathology	Karl Hubbert, Pathology Director	16
382	Risk of harm to patients due to a lack of access to neuropsychology treatment for neurorehabilitation outpatients.	Neurohabilitation	Glynis Peat, Clinical Director	16
688	Unsupported SQL 2012 instance STAS461 leading to risks relating to cyber security and our ability to report essential information.	Information Technology	Michael Souter, Senior Information Manager	16
278	Risk that lack of isolation rooms in the Critical Care footprint can lead to cross infection (2121).	Critical Care - Intensive Care 2	Karen Banks, Clinical matron	15
356	Risk that the trust does not have accurate medical device training records causing insufficient competent users.	Trustwide, Quality & Safety Risk	Ian Bennett, Group Deputy Director of Quality	15
729	Risk that patients may come to harm due to unavailability of critical care outreach practitioners to respond to a deteriorating patient.	Perioperative and Critical Care Services	Kerry Akther, Associate Nurse Consultant	15
783	Head and neck Consultant recruitment.	Head and neck, Orthopaedic and reconstructive services	Richard Whitehouse, Senior General Manager	15

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

Quality Assurance Committee

Connecting to: Group Trust Board; Chair Fay Scullion, Meeting 25 November 2024

Key topics discussed in the meeting:

The following reports and updates were considered at the November meeting. All reports were from across the Group, presenting updates from both Trusts, and the considerable amount of work undertaken across all areas was noted.

- Safer Medication Report
- Patient Experience Report
- Patient Safety Report
- Maternity & Perinatal Quality Surveillance Model Reports
- Human Tissue Authority Report
- ICB Safety Alert
- Never Events and Risk Summits
- Learning From Deaths Report
- Mental Health Strategy
- Quality Priorities and Quality Account
- Integrated Performance Report
- Board Assurance Framework

It was noted that the ICB had previously issued a safety alert on 29 August regarding the needs of patients with Learning Disabilities receiving care in intensive care. The Group have undertaken training analysis, and an update paper will be brought to next QAC in January.

Actions:

There are important standing items from the IPR, and these were agreed to be continually monitored:

1. Infection prevention and control – infection rates, in particular C Diff had doubled, and the challenges of maintaining good infection prevention control continue. Strict cleaning programmes have been introduced across both sites, and there is a continued focus on developing a microbial stewardship plan and actions to keep infections down. Site Directors of Nursing are actively monitoring against the hand washing compliance monitoring programme.
2. Cancer targets remain a concern across both sites with regards to 62 day waits, and consistent action is being taken to continually address clinical needs, with extra clinical sessions where appropriate.
3. Complaints being closed within the timeframe remain an issue at both Trusts. Although considerable work has been undertaken to address this with systems and processes, this needs to have focused attention. A review of the policy is being undertaken which will enable a change in the way complaints are being handled. There is close monitoring by Directors of Nursing from both sites
4. The ICB Safety alert has required an audit, and although there are no safety issues a training programme is being implemented for staff caring for patients with Learning Disabilities receiving intensive care.

Escalated items:

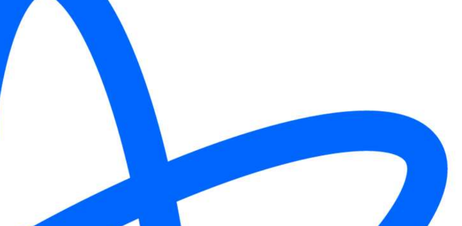
- The committee received the HTA report. An audit of the implementation of the actions has been undertaken, which shows a positive position in terms of security, and some actions have been closed on both sites. An issue remains on the South Tees site in terms of facilities, and this will be a budget priority for 2025/26.
- A risk summit was held in Ophthalmology, which showed areas of improvement required in parts of the process. There is an action plan in place with an investment to look at technical support and better coordination. A cultural survey is being undertaken.
- Maternity services in South Tees continue to be below trajectory for training, for both midwives and doctors, alternative dates have been arranged. Compliance towards the Trust core 10 mandatory training fluctuates in North Tees and alternative ways to achieve consistency in compliance.

Risks (Include ID if currently on risk register):

- Both Maternity services face a challenge in being compliant with training. South Tees has arranged additional dates for midwives and doctors, North Tees is focused on

Caring Better Together

compliance with core mandatory training and have plans in place to address the issue. South Tees is awaiting the final diagnostic report from the peer visit, and action plans are being developed.



Caring Better Together

Group Learning from Deaths Report to the end of Q2

Meeting date: 7 January 2025

Reporting to: Public Board of Directors

Agenda item No: 11

Report authors: Julie Christie, Katie Elmer – Lead Mortality Reviewers NT&H. Jo Raine, Data Analyst Mortality Surveillance & Becky Walls, Mortality Review Support Nurse – STH. Ian Bennett – Group Deputy Director of Quality.

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

Delegation status (Board only and completed by the Corporate Secretariat): Jointly delegated item to Group Board

Previously presented to: NT&H Quality Assurance Council, STH Patient Safety Steering Group, Group Quality Assurance Committee

NTHFT strategic objectives supported:

Putting patients first ☒
Transforming our services ☐
Valuing our people ☐
Health and wellbeing ☐

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☐
A great place to work ☐
Make best use of our resources ☒
A centre of excellence ☒
Deliver care without boundaries ☒

CQC domain link:

Effective

Board assurance / risk register this paper relates to:

All risk associated with this paper are on the risk register and aligned with the 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.

None

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

There is a small backlog of 16 LeDeR reviews at STH, with a plan in place to address this over the coming months.

STH have received a regulation 28 report from the coroner which is being reviewed before an action plan is submitted to the coroner.

Neither site is consistently achieving the planned number of mortality reviews and the approach to this is being reviewed as part of work to establish a consistent Group approach to reporting and Learning from Deaths.

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

SHIMI at both sites is as expected, with North Tees lower but South Tees higher than 100. There is marked variation in the depth of co-morbidity coding between Trusts which has a large impact on this metric and shared learning combined with the introduction of an EPR at South Tees should start to address this.

Over 98% of patients across the Group have a Medical Examiner review, which helps identify serious failings in care, warranting more in-depth review and, despite some variation in approach, robust mortality surveillance review is in place.

Both Sites have participated in the NACEL (National Audit of Care at the End of Life) with monitoring and improvement being overseen by the site patient experience groups.

Recommendations:

The Board of Directors are asked to:

- Note the content of this report and the information provided in relation to how we learn from deaths across the Group.
- Receive assurance that both sites latest SHIMI data is as expected.
- Note the further work which is required to align the learning from deaths approach across the Group.

GROUP LEARNING FROM DEATHS REPORT UP TO THE END OF Q2.

1. PURPOSE OF REPORT

This report is consistent with various reporting requirements required by NHS England[1] including the requirement to publish information on preventable deaths on a quarterly basis. The NHS Patient Safety Strategy (2019) emphasised the importance utilising the medical examiners (ME) review process as a source of insight into patient safety and the value of mortality reviews as part of the Learning from Deaths (LfD).

Therefore, the purpose of this report is to present qualitative and quantitative data regarding deaths within the Group, the care received by those patients, and resulting improvement work ongoing to improve the outcomes of patients in future.

The report covers Q4 (23/24) and Q1 and Q2 (24/25) for NT&H and September and October for STH. This will ensure that future reports are aligned and reporting the same period across the Group.

2. BACKGROUND

a. Mortality Indicators.

The Group reports and discusses various mortality statistics at site level. These include counts of deaths, unadjusted mortality rates, the Summary Hospital-level Mortality Indicator (SHMI), which is the NHS's official risk-adjusted hospital mortality statistic, various contextual indicators including quality of clinical coding and palliative care delivery plus a range of population level statistics including Excess Mortality as provided by the Office for National Statistics (ONS), Place of Death statistics and various other public health metrics. Detailed discussion occurs at Site level Mortality and Morbidity Groups; this report summarises the key metrics and learning and issues which require further escalation.

b. Learning from Deaths.

Both Sites have a *Responding to Deaths* policy, which sets out how they must respond and learn from deaths of patients who die under its management and care. The approach is summarised below

i. *A Medical Examiner (ME) review* occurs at the time of certification of death. The ME service began in May 2018 and became statutory in Sep 2024. It covers around 98% of all deaths in the Group. The process includes review of the case records, discussion with the attending team and a discussion with the bereaved family.
ii. A Trust Mortality Review is conducted if any potential concerns are identified during the ME Review. It is also conducted for all deaths of patients with learning disabilities, serious mental illness, within 30 days of a surgical procedure, where a

[1] https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

‘mortality alert’ from a range of sources has occurred, or where a patient safety event or complaint has been reported.

iii. Additionally, a Patient *Safety Incident Investigation* may occur before or after Trust Mortality Review. A *Nurse-led review* may also be completed if potential deficiencies in nursing care have been highlighted.

Further work continues to ensure consistency between the site LfD teams. This will see greater consistency in data, reporting and learning in future reports.

3. MORTALITY INDICATORS & LEARNING FROM DEATHS

NT&H. There were 338 deaths in Q4 23/24, 291 in and Q1 24-25 and 267 in Q2 24-25

STH. There were 159 deaths in September 2024 and 169 deaths in October. Rolling 12-month average of the unadjusted mortality rate is 1.11.

Standardised Hospital Mortality Index (SHMI) is the ratio of observed mortality rate/expected mortality rate (based on a statistical estimate of expected mortality). This includes all in-hospital deaths plus deaths within 30 days of discharge. It is published on a quarterly basis by NHS Digital and is an official government statistic.

Latest SHMI NT&H: is 96 (Jun 2023 - June 2024) – within expected range.
Latest SHMI STH: is 106 (Jun 2023 - June 2024) – within expected range.

SHMI is impacted on by co-morbidity coding and work to improve this at South Tees has seen a positive impact on elective episodes but not yet on non-elective. This is an area of continued focus.

Figure 1. NT&H:

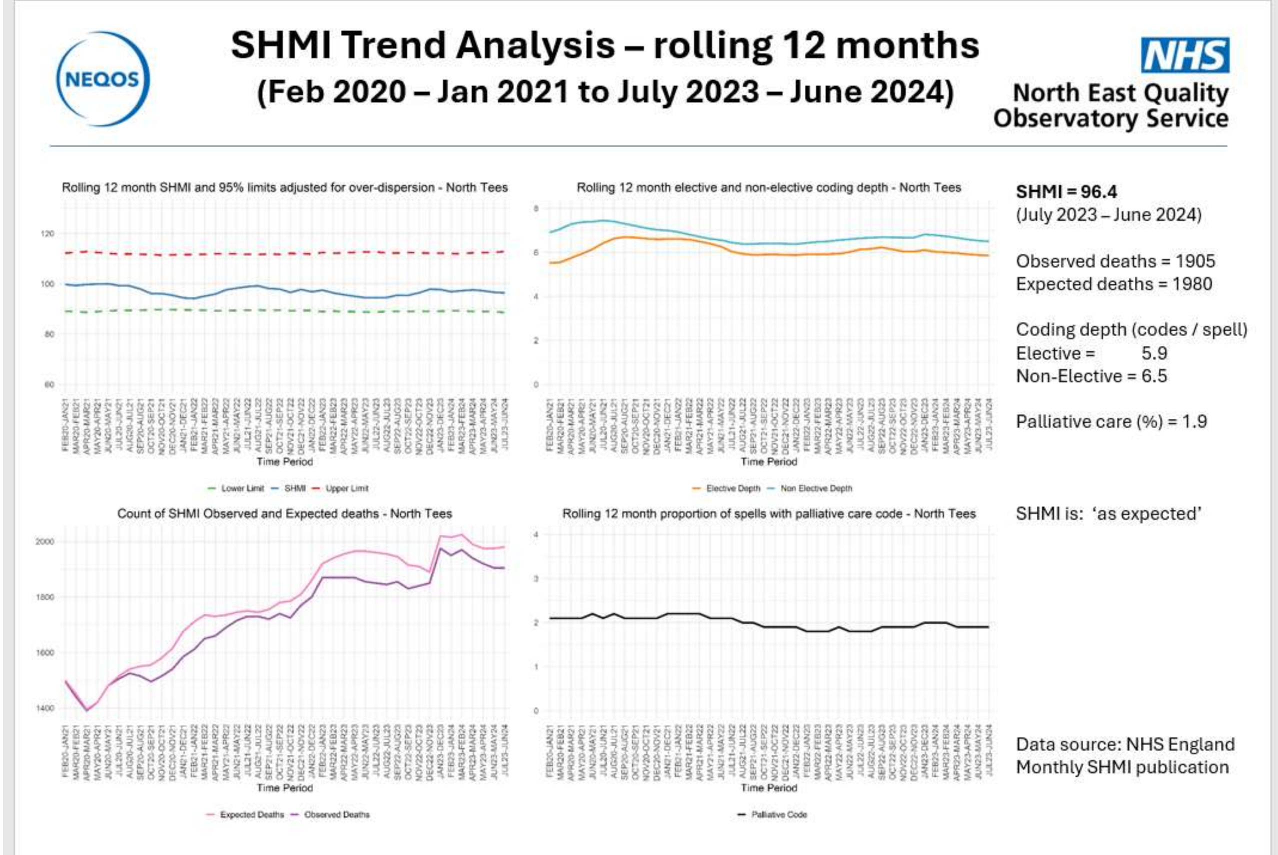
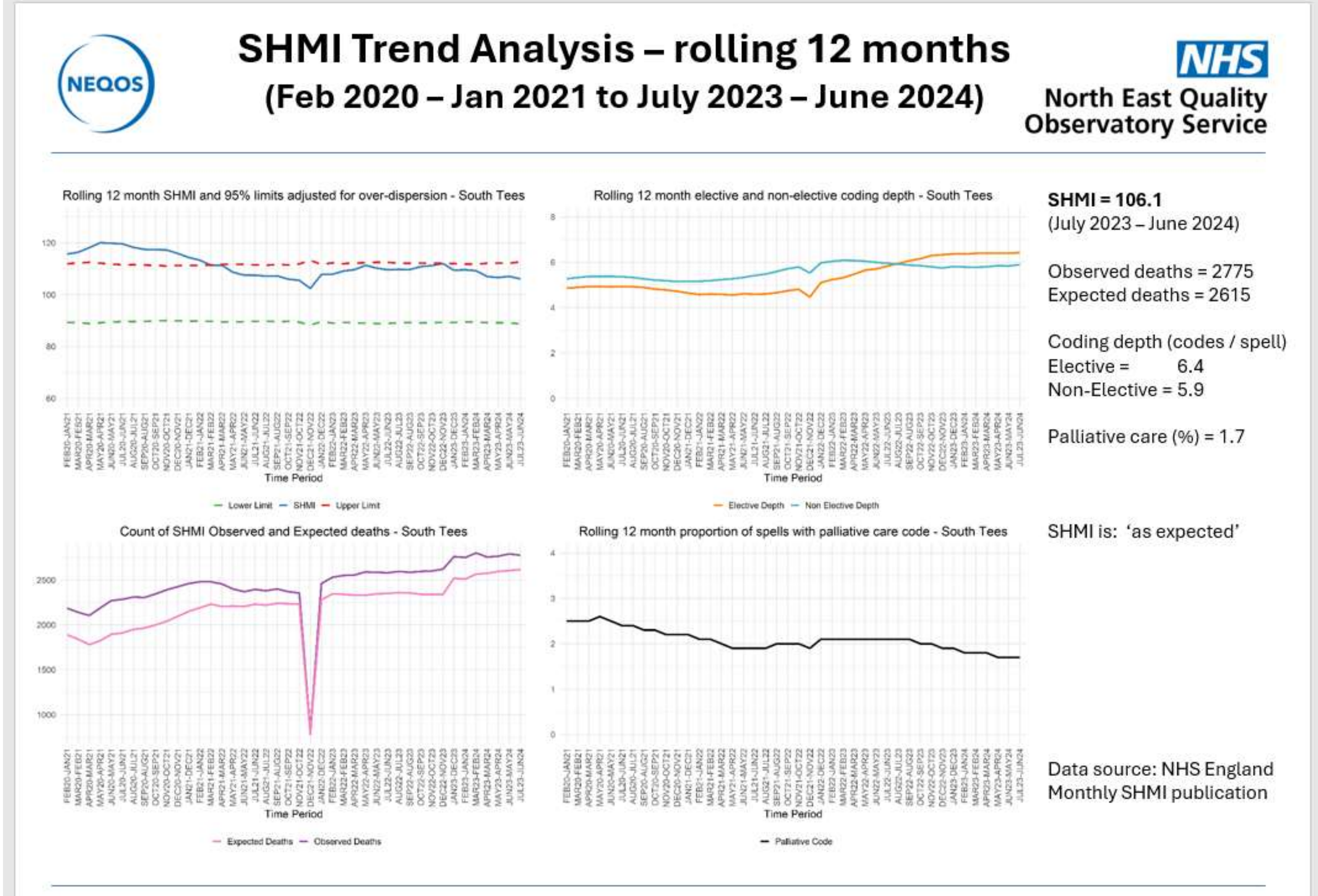


Figure 2. STH

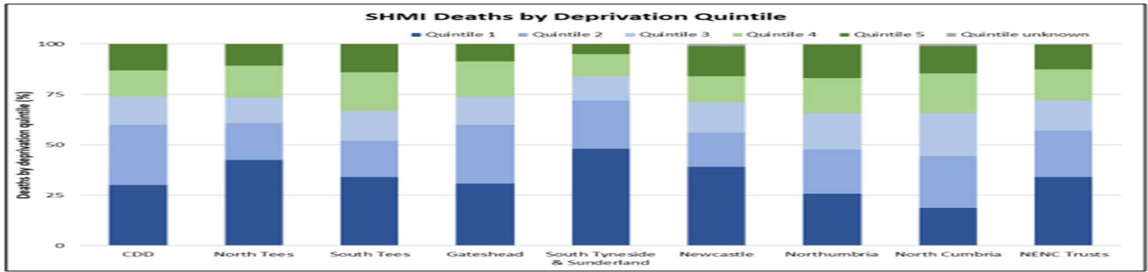


The apparent dip in SHMI deaths in the period Dec 21- Nov 22 is an artefact due to a data quality issue, reported previously.

It is worth noting that the removal of Same Day Emergency Care (SDEC) from the inpatient data (moving to the Emergency Care Dataset) from July 2024 will have a significant impact because SDEC amounts to around 10% of inpatient spells nationally. The short-term impact on SHMI of this change is difficult to predict, but likely to be greater at STH where there is a separate SDEC area. Both Trusts will remain focused on this issue.

Deprivation and Mortality. Figure 3 demonstrates that many of the people who die in our Group are amongst the most deprived in our society. This has implications around access to diagnosis and treatment, multi-morbidity, use of services and patient/family experience. (April 23-March 24, NEQOS). The variation between sites can be attributed to rural and affluent areas in North Yorkshire, which STH covers, with less deprivation but many older patients.

Figure 3.



Since the ME Service became statutory on 9 September 2024, and to maintain the independence of ME Service, this means that their data sits out with Trust systems and cannot be used for internal Trust governance process. A core part of their role is to

determine whether there are any concerns about patient care. If any concerns are highlighted, the ME will refer to the Trusts Patient Safety and Mortality Surveillance teams for further review, in order that opportunities for wider learning can be shared.

Aspects of good care and potential or actual problems in care is also shared with specific clinical team. It is not currently possible to collate this centrally and is an area of development which will be considered as LfD moves into a group model. More general themes are collated and areas of focus on both sites include:

End of Life Care.
Documentation in the medical records.
Coordination of care between specialities.
Transfer of patients from other hospitals.

As well as the ME referrals, the teams have a target of reviewing a proportion of all deaths for assurance purposes. This figure includes all cases where the ME has a concern (including concerns raised by family), all deaths in patients with Learning Disability, all deaths in people aged 18-40, deaths in people with a serious mental health condition, all deaths during an elective admission, and deaths where there was a Patient Safety incident or a DATIX raised where harm occurred to the patient. A certain number of randomly selected cases will also be reviewed for assurance, which enables the recognition and recording of good care. NT&H have had a policy of not reviewing deaths where there is a planned or probable coroner's inquest which has excluded some patients in these categories – this is being reviewed as part of Group standardisation. NT&H have set an internal target of reviewing at least 10% of all deaths, and STH 20%. These targets are not being met consistently at either site, with further work need to review this approach.

NT&H Medical Examiner and Mortality Surveillance Reviews (Table 1):

2024 Quarter 1 and 2	April	May	June	July	Aug	Sept	Total
Total deaths undergoing scrutiny	147	151	133	151	125	199	**906**
ME scrutiny recommending SJR	4	8	2	4	6	7	**31**
Coroner referrals (CR's)	31	38	23	26	11	16	**145**
Number of CR's taken for investigation	10	11	7	9	5	13	**55**

45 deaths were notified to the coroner's office of which 90 had Medical Certificate of Cause of Death (MCCD) issued without further concern or investigation. The coroner took on 55 deaths for further investigation, most for an unknown cause of death or harm pre-admission.

From September 24, if the number of in-patient deaths recommended for SJR from the ME service is less than 10% this is made up to that number with requests for SJR on random cases.

SJR sessions run monthly. There is a multidisciplinary panel of around 20 reviewers with a suggested attendance of 3-4 sessions a year.

- In Q1 20 SJRs were completed. The majority were requested as concerns noted or routine request as LD patient. Care was rated as good/excellent in 73 %, 18%

adequate, 1% poor. The majority showed good practice. Room for improvement in clinical/organisational care in 46%.

- In Q2 12 SJRs were completed.
- There were no deaths considered preventable in the scope of this report.

STH Medical Examiner and Mortality Surveillance Reviews

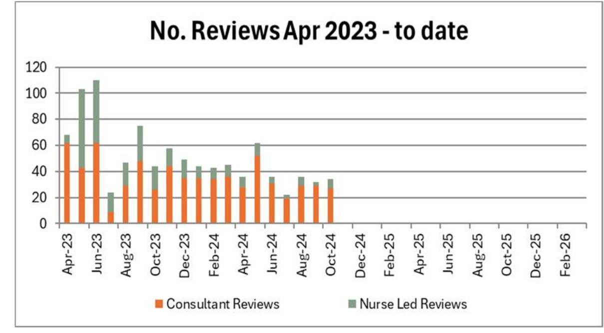
STH mortality surveillance review team currently consists of 4 consultant reviewers and one mortality review nurse. Most reviews are completed by an individual, with MDT panels including members of the patient safety team and the specialty for more complex cases.

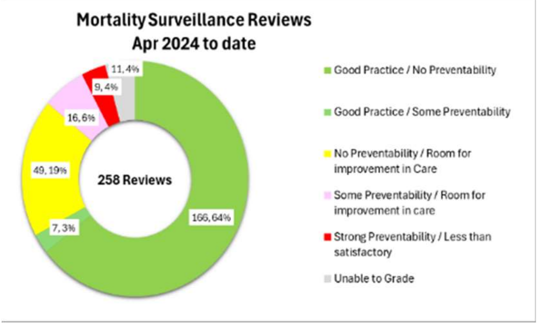
Mortality Surveillance Reviews and ME Referrals completed (Table 2).

Month of death	No. Deaths	No. Reviewed	% Reviewed (Target 20%)	ME Referrals	ME Complete	% Achieved
Jul-23	140	34	24.3%	14	14	100.0%
Aug-23	151	32	21.2%	24	24	100.0%
Sep-23	152	20	13.2%	15	15	100.0%
Oct-23	159	22	13.8%	18	18	100.0%
Nov-23	174	29	16.7%	25	25	100.0%
Dec-23	178	27	15.2%	23	23	100.0%
Jan-24	210	33	15.7%	15	15	100.0%
Feb-24	182	32	17.6%	20	20	100.0%
Mar-24	164	27	16.5%	13	13	100.0%
Apr-24	154	25	16.2%	15	15	100.0%
May-24	154	25	16.2%	20	20	100.0%
Jun-24	145	16	11.0%	12	10	83.3%
Jul-24	161	28	17.4%	22	20	90.9%
Aug-24	136	16	11.8%	16	12	75.0%
Sep-24	159	19	11.9%	17	12	70.6%
Oct-24	169	2	1.2%	15	2	13.3%

Figure 4 shows that 64% of the 258 case reviews this year at STH were judged to show good practice with no preventability. 19% showed room for improvement in care but with no preventability, 6% showed both preventability and room for improvement in care and 4% (9 reviews) showed strong preventability and/or less than satisfactory care.

Figure 4

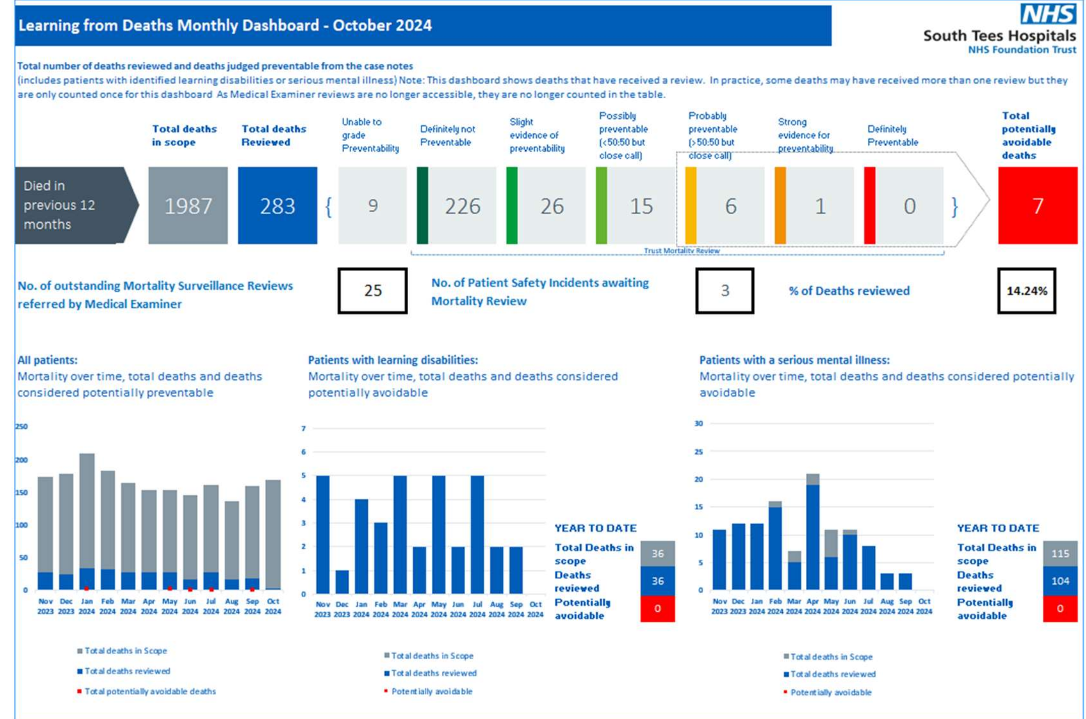




STH Learning from Deaths Dashboard (Figure 5)

Figure 5 summarises the rolling 12-month data on numbers of deaths and outcomes of mortality surveillance reviews. Key themes from the cases where important learning has been identified includes delay in recognition of a deteriorating patient, poor handover, delays linked to administrative errors (“lost to follow up”), and fragmented healthcare records. Positive lessons from care have highlighted good multidisciplinary care involving external agencies, rapid decision-making, and timely intervention.

Figure 5



4. Other Learning from Deaths Data

STH have concluded a regulation 28 report and action plan and have received a further regulation 28 report, with action plan now being finalised.

Both Sites have participated in the NACEL (National Audit of Care at the End of Life) with monitoring and improvement being overseen by the site patient experience groups.

There is a small backlog of 16 LeDeR reviews at STH, with a plan in place to address this over the coming months.

5. Next Steps & Developments

We continue to work towards a comprehensive approach to LfD, and to consider how to collaborate across both sites and the group structure, as we develop our model. We will review Morbidity and Mortality Meetings across the sites aiming to standardise across the group model by 25/26 year. We will explore opportunities to collaborate across settings (e.g. hospital and community) and between organisations.

6. Recommendations

The Board of Directors is asked to:

i) Note the content of this report and the information provided in relation to how we LfD across the Group.
ii) Receive assurance that both sites latest SHMI data is as expected.
iii) Note the further work which is required to align the learning from deaths approach across the Group, with investment likely to be required to increase the number and timeliness of mortality reviews being completed.

Group Patient Experience and Involvement Report Q2

Meeting date: 7 January 2025

Reporting to: Group Board of Directors

Agenda item No: 12

Report authors:

Jen Little, Patient Experience, Involvement and Bereavement Lead, STHFT, Jemma Zata, Patient Experience and Bereavement Manager, STHFT, Alison Connelly, Patient Experience Manager, Olivia Sawdon, Patient Experience Survey Facilitator, STHFT, Rebecca Phillips, Patient Experience Advisor, STHFT, Charlotte Pett, Patient Experience Survey Lead, UHNT, Erin Duckers, Deputy Patient Experience Manager, UHNT

Action required:
Assurance

Delegation status (Board only):
Jointly delegated item to Group Board

Previously presented to:
NT&H Quality Council, STH Safe & Effective Care Group, STHFT Patient Experience Steering Group, Group QAC

NTHFT strategic objectives supported:

Putting patients first ☒
Transforming our services ☒
Valuing our people ☒
Health and wellbeing ☐

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒
A great place to work ☐
A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☒
Deliver care without boundaries in collaboration with our health and social care partners ☒
Make best use of our resources ☒

CQC domain link:

Caring

Board assurance / risk register this paper relates to:

All risks associated with this paper are on the risk register and are aligned with the BAF.

Caring Better Together

Key discussion points and matters to be escalated from the meeting

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

- There are 13 complaints at South Tees which have been open for longer than the legislated 6 months. Actions is being taken to close these complaints, which includes weekly circulation of open complaints which is shared with collaboratives, promoting the importance of regular contact with the complainant and agreeing extensions where required. Regular monitoring and escalation of off target complaints is in place.

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

- Performance against the 80% target for complaint response timeframes improved in Q2 but remained under target throughout. Some STH collaboratives responded to 100% of complaints in timeframe.

- There is variation in the Friends and Family Test (FFT) scores across both sites for July and August 2024. With some areas being above and some being below national average.

- Both sites are in the early stages of aligning the complaint process to that followed by North Tees.

- The most common themes of complaints across both sites were care needs not met and communication with the patient.

- NTH has seen a continued decline in FFT returns since January 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.

- 188 collaborative enquiries were resolved in 24 hours in Q2, avoiding a complaint, which was a slight increase on Q1.

- STH acknowledged 96.3% and North Tees acknowledged 99% of all formal complaints within the three working days timeframe.

- The overall monthly total number of FFT returns for South Tees has gradually increased from 2,336 in April 2022 to 6,445 in September 2024.

Recommendations:

The Group is asked to;

- Receive the report and acknowledge the learning and progress which has been made.
- Note the areas which are off track and the actions which will be taken.

1. INTRODUCTION

This report sets out current information in relation to complaints received during Q2 by South Tees Hospitals NHS Foundation Trust and North Tees & Hartlepool NHS Foundation Trust. The report includes the actions/outcomes from Care Group and Collaborative investigations from complaints, and where cases have been investigated and founded by the Parliamentary and Health Service Ombudsman (PHSO).

Action taken as a result of the analysis of all patient feedback can impact by improving the experience and service provided to our patients. This can also potentially prevent further complaints regarding the same or similar issues.

2. KEY MESSAGES

In January 2024, both Trusts implemented new complaint processes in line with the PHSO Complaint Standards Framework. The Framework sets out a single set of Standards for NHS organisations to follow when handling complaints.

3. PROCESS

The complaints process in both Trusts promotes early contact and resolution of a verbal enquiry within 24 hours. If this is achieved, the organisation is not required to log this as a complaint. However, it is acknowledged that the majority of enquiries cannot be resolved within the 24 hour timeframe. Any enquiry unresolved are managed as a complaint, with the offer of a telephone response, meeting or a written response for North Tees & Hartlepool and a meeting or written response at South Tees.

North Tees Hospitals complaint stages:

Stage 1 – (Local/Early Resolution) for resolution by Care Group staff within 7 working days either face to face, via telephone or email and followed up in writing by the Patient Experience Team by way of a PDF providing a brief summary of issues, outcomes and actions digitally signed by the investigator (with delegated authority from the Group Chief Executive in line with the NHS Complaints Regulations 2009).

Stage 2 – Meeting with the complainant (face to face or virtual) to be arranged by Care Group with senior staff within the agreed timescale, meeting notes form the written response, signed by the Chair of the meeting, senior clinician or Patient Safety Team Lead (with delegated authority from the Group Chief Executive).

Stage 3 – Written response to be complied by the lead investigator in the Care Group, approved by the senior quality reviewer and the Care Group Director then approved and signed by the Group Chief Executive (or person with delegated authority).

South Tees Hospitals complaint stages:

The Collaborative staff contact the complainant to establish the facts of the complaint and agree a timeframe for response, dependant on the complexity. For a non-complex issue, a 10-working day response letter can be provided by the Collaborative staff detailing the issues discussed and a resolution. For complaints that require a deeper investigation, the Trust aims to provide a

response to complainants signed by the Chief Nurse or Chief Medical Officer, and the Group Chief Executive Officer.

Timescale Agreed length of time to respond to a complainant.

Both organisations aim to achieve the legislated six-month timeframe for completion of a complaint. Where this is not achievable this may be extended with the agreement of the complainant.

South Tees' timescales for written responses:

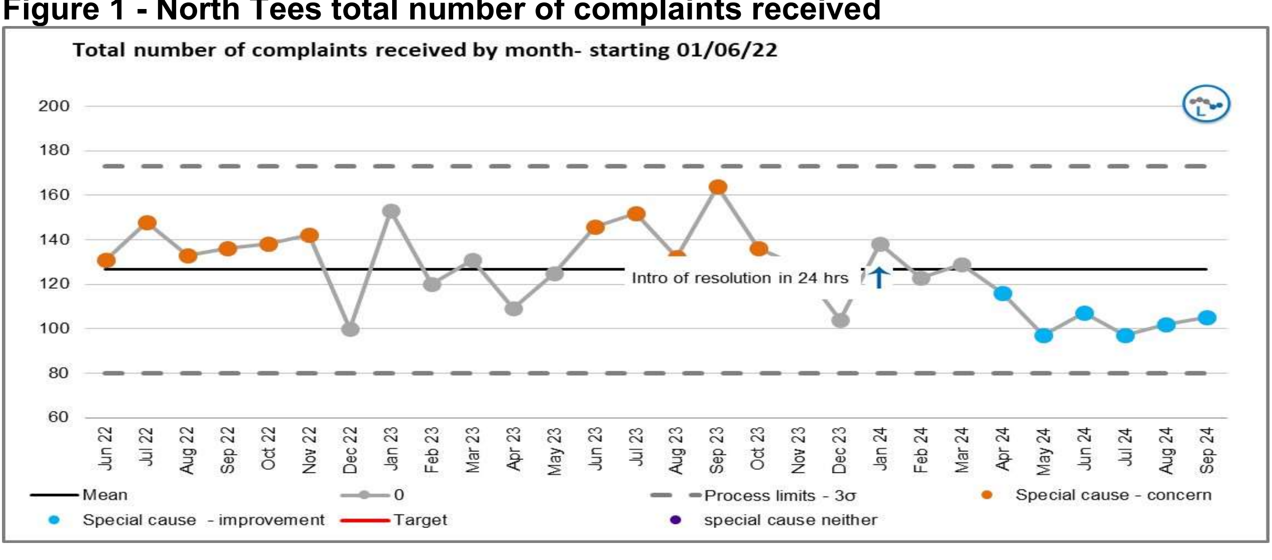
- Up to 10 working days (early resolution)
- Up to 25 working days (non-complex, a small number of issues)
- Up to 40 working days (complex, multi-issue, multi-collaborative complaints, including complaints that require external comments to be obtained).
- Up to 60 days working days if the complaint meets Serious Incident (SI) criteria.

North Tees' timescales:

- Up to 7 working days (local/early resolution)
  Stage 2 and Stage 3 complaints – the timeframe is specific to each complainant and agreed during triage with the complainant. It ranges between 20 and 60 working days if the complaint meets SI criteria.

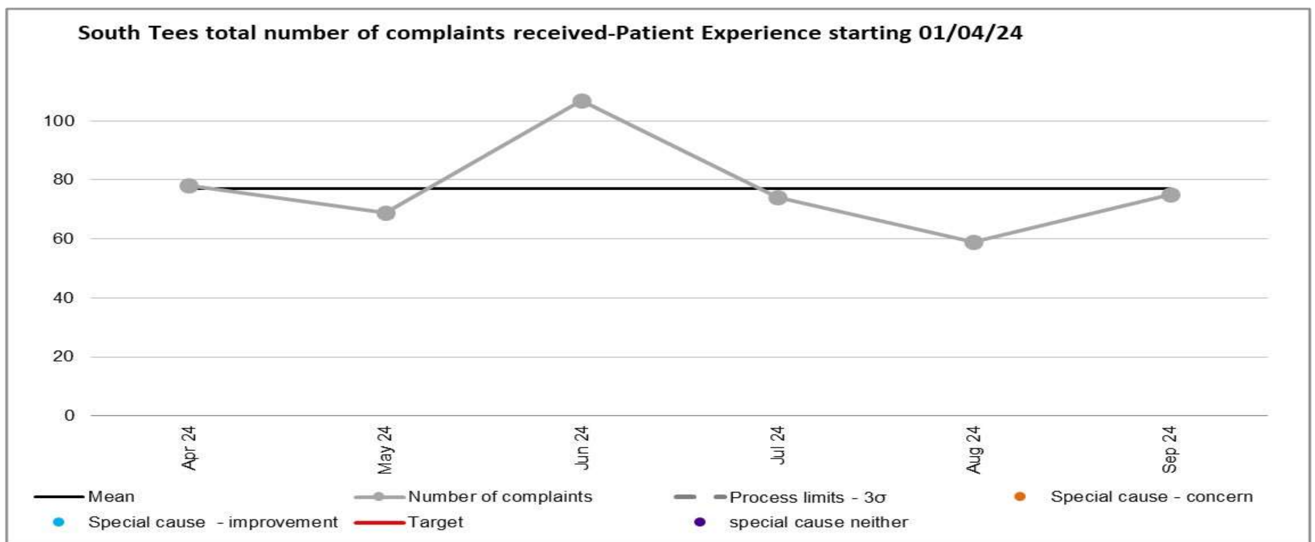
4. OVERALL COMPLAINT STATUS

Figure 1 - North Tees total number of complaints received



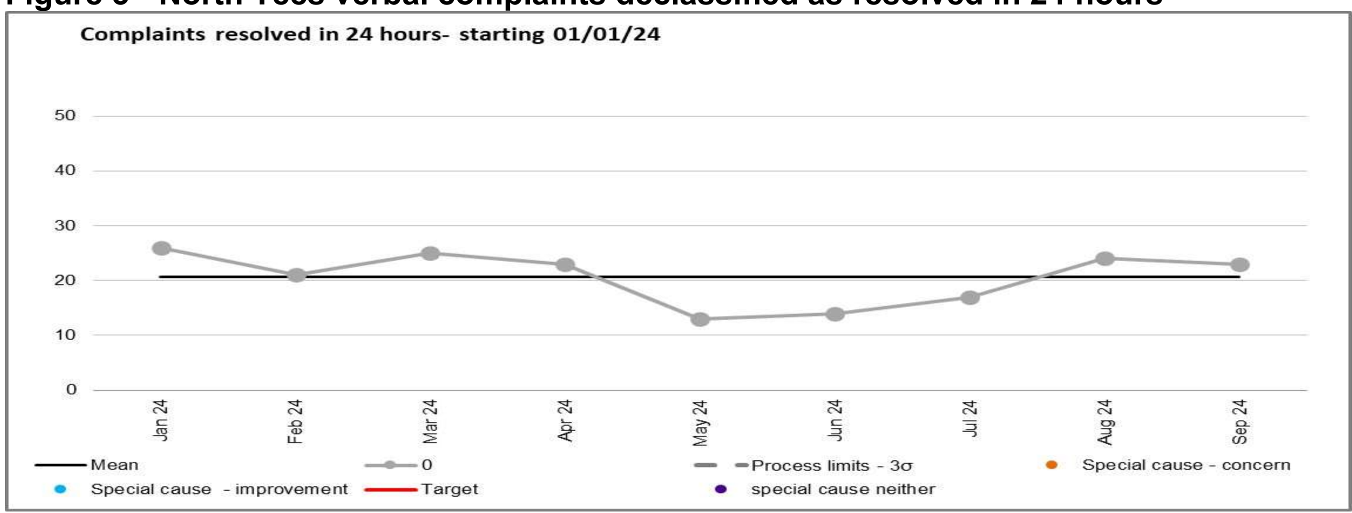
In Q2, a total of 304 complaints were received. This is a decrease from 320 compared with the total received in Q1. Of the 304, 285 were triaged as Stage 1, 2 or 3. The statistical variation noted on the SCP chart (figure 1) is a one-off event following changes within the complaint process in January 2024, which allows the de-classification of verbal complaints, resolved within 24 hours as a complaint – in line with Regulations 2009.

Figure 2 – South Tees total number of complaints received



In Q2, a total of 242 complaints were opened. This is a decrease compared with the total opened in Q1. Medicine & Emergency Care Services, and Neurosciences & Spinal Care Services received the most complaints in Q2.

Figure 3 - North Tees verbal complaints declassified as resolved in 24 hours



In Q2, 64 verbal complaints were declassified and changed to 'Stage 0 – Closed in 24 Hours' following resolution with the complainant by the next working day from when the complaint was received (figure 3). This is excluded from the total number of complaints opened data.

Table 2 - South Tees complaints declassified as resolved in 24 hours

South Tees	Q1 (2024-25)	Q2 (2024-25)
Total	182	188

In Q2, 188 collaborative enquiries were resolved within 24 hours, which was an increase on the 182 recorded in Q1 (table 2). This increase positively suggests that more collaborative enquiries were resolved within 24 hours, avoiding a complaint.

Table 3 - North Tees total number of complaints received by Care Group

North Tees - Care Groups	Q1 (2024-25)	Q2 (2024-25)
Healthy Lives	73	78
Responsive Care	141	116

Collaborative Care	102	109
Corporate Group	4	1

In Q2, Responsive Care Group received the most complaints with 116, a decrease of 25 on the previous quarter (table 3).

Table 4 - South Tees total number of complaints received by Collaborative

South Tees - Collaboratives	Q1 (2024-25)	Q2 (2024-25)
Cardiovascular Care Services	11	5
Clinical Support Services	8	7
Corporate Services	8	10
Digestive Diseases, Urology and General Surgery Services	45	30
Growing the Friarage and Community Services	19	12
Head and Neck, Orthopaedic and Reconstructive Services	55	43
James Cook Cancer Institute and Speciality Medicine	17	17
Medicine & Emergency Care Services	36	49
Neurosciences and Spinal Care services	33	49
Perioperative and Critical Care Services	2	7
Women and Children Services	17	13

In Q2, a total of 242 complaints were opened. This is a decrease from 251 compared with the total opened in Q1.

Table 5 - North Tees top 5 complaints by sub-subject

North Tees - Sub-subjects	Q1 (2024-25)	Q2 (2024-25)
Care needs for adequately met	46	49
Communication with patient	67	90
Appointment delay (inc length of wait)	43	36
Failure to provide adequate care (inc. overall level of care	47	57
Communication with relatives/carers	59	52

Please note: there usually are multiple sub-subjects within each complaint and all are included in the data above, rather than just the main sub-subject in each complaint.

The top theme in complaints for Q2 was communication with patient with 90 which is an increase of 23 compared with the previous quarter. Complaints relating to appointment delays continue to decrease.

Table 6 - South Tees top 5 complaints by sub-subject

South Tees - Sub-subjects	Q1 (2024-25)	Q2 (2024-25)
Care needs not adequately met	26	27
Communication with patient	22	23
Attitude of Medical Staff	6	20
Appointment delay (inc length of wait)	25	19

Appointment cancellations	6	15

Please note: there usually are multiple sub-subjects within each complaint and not all are included in the data above.

The top theme for complaints in Q2, is 'Care needs not adequately met', with 23, which is an increase of 1, compared to Q1. There was a decrease in complaints relating to 'Appointment delay (including length of wait)', however complaints relating to 'Appointment cancellations' increased.

Complaints are graded upon receipt, in line with NPSA Guidance 2008, and at the point of closure. Complaints graded 'high' or 'extreme' post investigation must be shared with the Integrated Care Board (ICB). The complaints graded as extreme or high are linked to a serious incident and investigated alongside the complaint. A Family Liaison Officer (FLO) is deployed to support the patient, carer and family during the investigation, ensuring their questions are responded to in the report. On completion of the investigation the report is shared with the ICB.

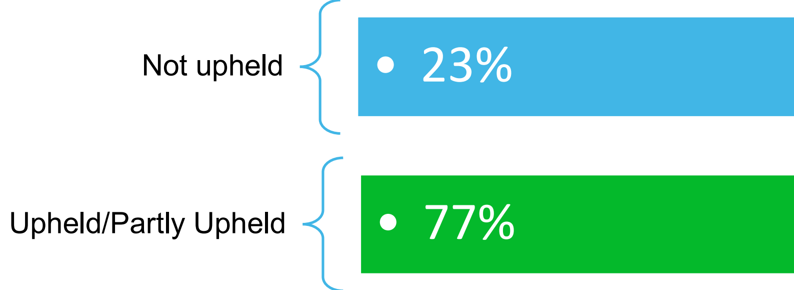
5. PERFORMANCE

Both sites remain below the 80% target for complaints closed within target during Q1 and Q2. This data is reported monthly in the IPR, including an update on actions being taken.

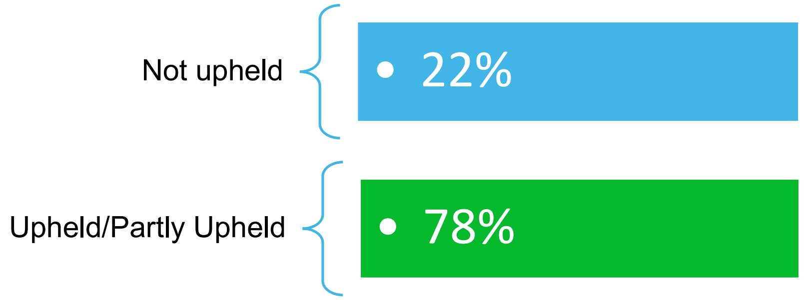
South Tees complaints open longer than 6 months
South Tees have 13 complaints that have been open for over 6 months and are reviewed on a weekly basis by the Senior Leadership Team (SLT). Actions taken to close the complaints include, a weekly circulation of open complaints, shared with collaboratives. Promoting the importance of regular contact with the complainant and agreeing extensions where required, regular monitoring and escalation of off target complaints by PET. The Trust is also in the early stages of aligning the complaint process to that followed by North Tees.

Outcome classification of all complaints closed in Q2
All complaints closed are given an outcome code to indicate if they have been upheld, partially upheld or not upheld.

North Tees:
Of the complaints closed in Q2:



South Tees:
Of the complaints closed in Q2:



Of the 323 closed complaints in Q2, 62 were not upheld, 123 were partially upheld and 100 were upheld. It is acknowledged that there are 38 closed complaints requiring the outcome code completing by the Collaboratives.

Table 7 - North Tees complaints acknowledged within 3 working days

North Tees	Q1 (2024-25)	Q2 (2024-25)
Ack in 3 Days	100%	99.34%

Table 8 - South Tees complaints acknowledged within 3 working days

South Tees	Q1 (2024-25)	Q2 (2024-25)
Ack in 3 Days	46.9%	96.3%

6. PARLIAMENTARY HEALTH SERVICE OMBUDSMAN (PHSO)

The role of the PHSO is to investigate complaints from members of the public who believe that they have suffered injustice by being treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.

North Tees:
One provisional report was received during Q2 for comment by the Trust, and currently awaiting the final report. There was 1 case closed by the Local PHSO in Q2 which was not upheld with no action required by the Trust.

South Tees:
During Q2 there were 2 decisions not to investigate and 1 new request for information received.

7. LEARNING FROM COMPLAINTS (EXAMPLES)

North Tees:

- To provide training around simple assessments for tongue tie to enable a referral to be completed.
- The importance of effective communication, privacy and dignity to be discussed in Doctors training teaching sessions.
- Practice Development Leads will anonymise the complaint to promote the provision of the family voice diary and its importance with all Community staff.
- Effective communication with relatives has been reinforced in ward huddles with both nursing and medical teams.
- To ensure all discharge prescriptions are checked by nursing staff, discussed with the patient and where necessary the patient’s family, to ensure accurate information is shared regarding ongoing medication.

- Training in Stoma Care to be provided to staff.
- Continue to train and develop Enhanced Care Workers with dementia skills and arrange further training by the Dementia Specialist Nurse.
- Ward staff to request on admission details of the care home/funding to assist with discharge planning.

South Tees:

- Effective communication to be included in ward newsletters.
- Review of information displayed in DEXA scan waiting area completed.
- Morning assurance rounds set up to ensure patient medication is taken and support provided where required.
- Continence products included in the discharge checklist and shared at learning forums for all staff.
- Introduction of nutritional support board to support patient nutrition and hydration and weekly mealtime assurance round by clinical matron started.
- Alert cards produced to prompt patients regarding follow up appointments, to be given at pre-assessment, and posters displayed in clinical areas reminding patients to ask about follow up appointments.
- Increased support to students completing admission to ensure accurate assessment of patient's needs, abilities and capacity.

8. FRIENDS AND FAMILY SURVEY

North Tees
The Trust overall positive experience is slightly higher for A&E at 85% compared to the national average of 81%. The Trust overall experience scores are also slightly higher than the national average for outpatients and community clinics, and for the maternity touchpoints for birth and postnatal inpatients. However, the scores are slightly lower for inpatient services as well as the maternity touchpoints for maternity antenatal and community postnatal.

South Tees
The A&E positive score for South Tees in July and August 2024 was above the national average at 84%. The overall Inpatient and Outpatient positive scores were above the national average at 97%. Similarly, the Community positive score was above the national average at 98%.

In July and August 2024 South Tees Antenatal services scored above the national average with a positive percentage of 93%, as did Postnatal Inpatient and Postnatal Community services with positive percentages of 100%. Birth services positive score was below the national average, with South Tees scoring 86%.

North Tees FFT total returns by month
The response rate has continued to fall slightly from 2,666 in July, 2,080 in August to 1,883 in September. However, this is dynamic data taken from the live Yellowfin dashboard, so we do expect September's total to rise.

South Tees FFT total returns by month
The overall monthly total number of FFT returns for South Tees has gradually increased from 2,336 in April 2022 to 6,445 in September 2024. There were 19,675 FFT returns in Q2.

Snapshot of FFT comments

North Tees:

"The service was absolutely excellent from the start, right the way through the process and on the day it was really lovely, there was lots of information given throughout. The whole process is slick and I felt fully confident in the team." – Podiatric Surgery, July 2024

"I wanted to say what a fantastic positive experience my son and I had, from Urgent Care to Outpatients. My son is autistic and we had a perfect, seamless service from start to finish. They let him ask questions and feel the bandages/cast materials before putting them on him. They made sure he was comfortable with everything before he left." – Urgent Care and Orthopaedic Outpatients/Plaster Room, August 2024

"Very helpful, giving the care my son needed. Can't fault anything. Took into consideration of my own needs as well as my son's needs. Answered questions and always reassured me when needed" – Ward 15, September 2024

South Tees:

"Exceptional service from every member of the team. Just wonderful. Cannot thank you enough. We are at a scary, palliative stage and the care has been kind, perfectly judged and very professional. A wonderful team, we are very lucky to have them thank you." – Richmondshire PCN Leyburn, August 2024

"Excellent team! All the members that I have had the good fortune to meet have been exemplary medical professionals and human beings. I feel most fortunate to have been accepted into their services and am absolutely delighted that such simple interventions have been successful, filling me with hope and determination to get this under control, finally."– Weight Management, July 2024

"My midwife has been incredibly supportive since my first appointment and listened to any concerns or questions I may have. Being able to utilise opportunities at the Friarage such as the active birth workshop and aqua natal classes has given me more contact with a midwife on a regular basis which I have found incredibly valuable." – Antenatal Clinic FHN, September 2024

9. RECOMMENDATIONS

The Group is asked to;

- Receive the report and acknowledge the learning and progress which has been made.
- Note the areas which are off track and the actions which will be taken.

Group CQC Compliance Update Report

Meeting date: 7 January 2025

Reporting to: Group Board of Directors

Agenda item No: 1

Report author: Rachel Scrimgour, Compliance Manager STHFT / Ruksana Salim Head of Quality, Clinical Safety and Interim CNIO NTHFT / Ian Bennett, Group Deputy Director of Quality STHFT

Action required: Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: N/A

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☐

Transforming our services ☐

Health and wellbeing ☐

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A centre of excellence ☒

A great place to work ☒

Deliver care without boundaries ☒

Make best use of our resources ☒

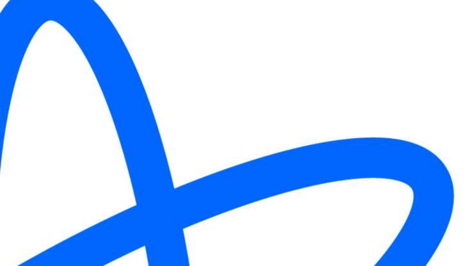
CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

This report is linked to the Quality Board Assurance Framework, NTHFT.

This paper is aligned to the Board Assurance Framework, with all risks recorded on the risk register, STHFT.



Caring Better Together

Key discussion points and matters to be escalated from the meeting

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

South Tees:

- The remaining one Must Do Requirement on the Maternity Services Action Plan will remain in progress. Some additional NHS funding has been secured and plans are being worked through for the development of the maternity estate.
- There is a lack of assurance around compliance with safeguarding and resuscitation training rates in ED. This has been escalated to the site leadership team, with bespoke training and ongoing improvement. This is a Must Do Requirement on the Trust wide CQC action plan.

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.

- Low numbers of CQC enquiries have been received by both Trusts. All enquiries have been reviewed and responded to in a timely way, closed by CQC and learning shared across the organisations.
- The remaining 2 Must do Requirements and 5 Should do Recommendations on the South Tees Trust wide action plan on are on track to be delivered.
- Development of a CQC App within InPhase is ongoing to explore how this can support the monitoring of compliance.
- The South Tees Radiotherapy Physics team has voluntary reported a group of incidents to CQC IR(ME)R team. Considered individually each incident is not clinically significant and does not meet the threshold for mandatory reporting however when presented as a group there is a common theme which warrants a voluntary report to CQC.

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

- Both sites now have access to the CQC Portal and have the ability to submit notifications online.

North Tees:

- The 'Must and Should Do' actions identified in the September 2022 inspection have all been addressed and completed, the team continue to monitor the evidence for sustainability and improvement via teams check and challenge sessions.
- A completed action plan has been shared with CQC IR(ME)R following their recent inspection of Nuclear Medicine at University Hospital Hartlepool. All actions were completed prior to the CQC deadline of 1 January 2025.

South Tees:

- Human Fertilisation & Embryology Authority (HFEA) completed an unannounced inspection of the Reproductive Medicine Department on 25 June 2024. The inspection identified 1 major area of non-compliance and 2 ‘other’ areas of non-compliance. All recommendations/actions have been completed and the HFEA panel agreed that the department was fit to have its treatment and storage licence continued until 2027.
- The Anaesthetic Department received a visit from Anaesthesia Clinical Services Accreditation and following review, the department has gained reaccreditation. A number of areas of good practice were noted.
- 11 Must Do Requirements and 15 Should Do Recommendations have been completed on the Trust wide action plan and there is a good level of assurance and evidence of sustained compliance.
- 6 Must Do Requirements and 11 Should do Recommendations have been completed on the Maternity Services action plan with good levels of evidence and assurance of completion.

Recommendations:

The Group Board are asked to:

- Receive assurance that plans are in place to address the outstanding Must Do Requirements and Should Do Recommendations for both Trust wide and Maternity Services actions
- Consider the maternity must do action relating to the estate that will not be delivered
- Receive assurance that CQC enquiries are being responded to appropriately and timely and learning shared
- Receive and note the organisational and national CQC updates

Care Quality Commission (CQC) Compliance Update Report

1. Purpose of the Report

This paper provides an update on the current CQC enquiries and themes. It also provides an update on CQC's new single assessment framework and national CQC news.

2. Background

The CQC monitors, inspects and regulates NHS trusts against regulated activities as set out in the Health and Social Care Act 2008 (the 'Act'). The CQC assess compliance with these requirements by monitoring the quality of care provided using feedback from staff, patients, and partners, changes to information held in CQC Insight, and by inspection.

Each Trust needs to address the findings of previous inspections, monitor compliance with regulations and quality of care, identify areas of weakness, and ensure improvements. The aim is to embed this in robust systems and processes that will provide ongoing assurance of compliance with CQC fundamental standards and readiness for future CQC inspections.

3. Trust Wide CQC Report and Action Plan update

North Tees:

The CQC published a report in September 2022, following inspecting two core services maternity and children and young people. The report identified that the ratings for the Trust were 'good' in two of the domains and 'requires improvement' in three domains as set out below. This meant that the trust's overall rating changed from 'good' to 'requires improvement'. The report outlined 13 'Must Dos' and 18 'Should Dos', which have now been addressed and closed.

Table 1

Overall rating for this Trust	Requires Improvement
Are services at this Trust safe?	Requires Improvement
Are services at this Trust effective?	Requires Improvement
Are services at this Trust caring?	Good
Are services at this Trust responsive?	Good
Are services at this Trust well-led?	Requires Improvement

CQC monthly meetings are embedded with good representation from Care Groups and Corporate Services. The check and challenge reviews continue with oversight for sustainability. To date the following services have had evidence approved:

Ongoing evidence reviews includes: Paediatrics (this includes evidence of sustainability of previous CQC inspection recommendations), Patient Safety, Risk Management, and Safe Staffing domains.

Nuclear Medicine - IR(ME)R inspection at Hartlepool Hospital took place on 28 August 2024. An improvement notice was issued to revise the Employer's Procedures and ensure that inclusive language was used when undertaking pregnancy checks of individuals of childbearing age. The procedures have been reviewed, updated and shared with the Radiation Safety Committee before being signed off by the Site Medical Director. There are now 14 separate procedures rather than one overarching document. All actions within the

action plan have now been completed and shared with CQC IR(ME)R. The team are awaiting confirmation from CQC that the inspection is now closed.

Next year's work plan for CQC Operational Group has agreed focussed work on the Freedom to Speak Up and Well Led, looking at governance and evidence of ward-to-board assurance, this includes reviewing evidence of sustainability from last CQC inspection.

South Tees - Trust Wide CQC Report and Action Plan
The Trust currently has an overall rating of Good, Table 2. Table 3 below demonstrates continued work on the action plan from May 2023 CQC report.

Table 2

Overall rating for this Trust	Good
Are services at this Trust safe?	Good
Are services at this Trust effective?	Good
Are services at this Trust caring?	Good
Are services at this Trust responsive?	Good
Are services at this Trust well-led?	Good

Table 3

Actions	Total	Completed	In Progress
Must Do requirements	13	11	2
Should do recommendations	20	15	5

The remaining actions remain areas of focus for the services and on track to be completed over the coming months. Review of ongoing compliance is through the monthly Site CQC Compliance Group. Improvements have been seen across a number of the outstanding actions, which currently remain amber until evidence of sustained improvement is provided.

Table 4 below details the must do actions which are in progress;

Table 4

Must do actions	Progress
The service must ensure that all staff complete mandatory training and safeguarding training to meet the trusts standard of 90% **(ED)**	Recent validated data shows that compliance remains lower than expected. Work continues to provide support and improve compliance levels. An action plan has been developed and this will be monitored through the CQC Compliance Group to ensure progress is made.
The trust must ensure that pain relief is given to patients when they need it and there are no delays to	Work continues across the surgical wards to ensure assessments and reassessments are completed. Audit data has been reviewed and triangulated against data provided by pharmacy in relation to omitted doses. Audit data is reassuring and sustained improvements have been

prescribed pain relief being administered. **(Surgery)**	seen across the wards. The action will remain ‘amber’ until further data provides ongoing sustained assurance.

Table 5 below details the ‘should do actions’ which are in progress:

Table 5

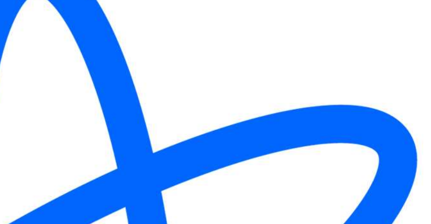
Should do actions	Progress
The trust should ensure a more robust flagging system for risks associated with patients experiencing mental health crisis attending the department is in place. **(ED)**	Electronic risk assessment now fully implemented within the department and audit data is being reviewed to demonstrate sustained compliance
The trust should consider ways to improve provision of clinical supervision for nursing staff at **Friarage Hospital.**	Improvements sustained in appraisal compliance across nursing workforce up until October 24. SDR compliance for FHN Medical Staff is at 91%, anticipated to be fully compliant next month.
The service should ensure that a minimum of 50% of registered nursing staff have a post registration award in **critical care** nursing in line with GPICS recommendations.	New educators recruited to support staff. Plan for trajectory to be prepared to evidence forward plan. An application has been made for a dedicated SIM room to support with education and training and competency compliance.
Patients discharged from the critical care unit should have access to an intensive care follow up programme**. (Critical Care)**	A follow-up clinic established for patients discharged from Critical Care and is led by the Site Medical Director. Business Case to be developed for RACI service and is progressing. The risk remains on risk register.
The service should review its waiting and overnight provision and facilities for families and visitors to the unit to ensure it is meeting current need. **(Critical Care)**	Preliminary plans have been prepared to reconfigure Cardio Rehabilitation and agreed by Fire Warden, Cardio and IPC. Plans now being worked up regarding timescales to move forward with development.

South Tees Maternity Inspection update

An action plan has been developed to address the 7 Must Do and 12 Should Do recommendations and was returned to CQC by the 15 February 2024. Table 6 below summarises the status of the actions identified:

Table 6

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



Caring Better Together

Work ongoing within Maternity to review and sign off the remaining outstanding actions over the coming months. The 1 remaining Must Do Action will remain amber in view of the ongoing estate work which currently does not a definitive timescale.

Table 7 below details the ‘must do action’ which is in progress:

Table 7

Must Do Action	Progress
The service must address the environmental and equipment shortfalls that affect the safety, privacy and dignity of women, birthing people and babies	£1.2million NHS funding has been secured for the maternity estate works. Plans are being worked through and progressed. Action will remain amber as currently no definitive plans or timescale.

Table 8 below details the ‘should do action’ which is in progress:

Table 8

Should Do Action	Progress
The service should consider how they improve the model of care to ensure it is fit for purpose.	Model of Care Plan has been shared with staff-side and HR. Further discussions are ongoing to move forward and implement new model of care.

South Tees 2024 Perinatal Quality Surveillance Annual Assurance peer review report has recently been received. The visit highlighted areas of excellence and opportunities for improvement with a number of recommendations made. An action plan is being developed to address the recommendations. In addition, we are awaiting the final report following the NHSE Maternity Diagnostic review that took place between 7-10 October 2024. Outcomes from both reports will be reviewed, and information triangulated alongside the current maternity CQC action plan.

4. CQC Enquiries and Themes

When the CQC receive information of concern, they share this with Trusts as a specific enquiry and ask for a response. There are a number of sources of CQC enquiries including from our own incident reporting (LFPSE) and RIDDOR, complaints from patients, families and carers, whistleblowing, inter-agency safeguarding concerns, Local Authority etc.

North Tees

The number of enquiries received in the last 4 months and themes are included below:

Table 9

Month	No. of enquiries	Themes
August	0	N/A
September	1	Treatment
October	0	N/A

November	2	Staff behaviours and complaint regarding timeliness of medication and transport

There are no open enquiries; all requested information has been provided to the CQC.

South Tees
The number of enquiries received in the last 4 months and themes are included below:

Table 9

Month	No. of enquiries	Themes
August	0	
September	3	Staff ability; Staffing levels; Care and treatment
October	2	Discharge, Nutrition & hydration concerns
November	3	Care and treatment, Delays in complaint response, Delay in treatment

5. CQC Organisation Update

Relationship Owner
From the beginning of November, the Trust has a new CQC Relationship Owner, Suzanne McLeod who will act as our CQC point of contact for both South Tees NHSFT and North Tees & Hartlepool NHSFT. A CQC Engagement Meeting is due to be arranged for early 2025 with the Group Chief Nurse, Group Deputy Director of Quality and Senior Site representatives.

CQC Portal
Colleagues across both sites continue to use the CQC Portal to submit notifications on line.

CQC InPhase App
Work is continuing around the development of the InPhase CQC App and colleagues from both sites recently met to look at how the app can be developed to support monitoring of compliance across both sites.

North Tees Update
The Trusts CQC Operational Group is actively progressing the collation of evidence to support the CQC framework and the quality statements underpinning this.

South Tees Update
CQC IR(ME)R
The South Tees Radiotherapy Physics team has voluntary reported a group of incidents to CQC IR(ME)R team. Considered individually each incident is not clinically significant and does not meet the threshold for mandatory reporting however when presented as a group there is a common theme which warrants a voluntary report to CQC.

A recent notification by another Trust highlighted the potential for the metal supporting structures of the linac treatment couches to inadvertently shield part of the radiation treatment

Caring Better Together

field. The team have undertaken a series of tests to determine the exact linac setup parameters that can give rise to this situation and have then reviewed the patient treatment records within our systems to retrospectively identify if any patient treatments had been affected. A review of the last 12 years of radiotherapy treatment (encompassing some 37,000 treatment courses) has identified 6 patients where the treatment field has overlapped with the metal support structures to a non-trivial extent (defined as > 1 cm). Individual assessment of each of these treatments has shown no significant changes to the delivered dose, i.e. no patient harm has resulted from these incidents

This situation is not unique to this Trust. It potentially affects all users of the equipment and the team are cooperating with several other centres to ensure respective investigations are suitably thorough. In addition to reporting this matter to the CQC a report will be made to the MHRA and have raised with the manufacturer (Elekta). The deadline for submission of our report is the 11/03/25

New regulated activity
On the 11th of December 2024, CQC have confirmed the approved of the Trust application to provide in house transport, with this now being included as regulated activity for South Tees. A phased approach to introduction of this new service has been commenced.

External Visits
Anaesthesia Clinical Services Accreditation (ACSA)
On 9, 10 and 11 January 2024, the Anaesthetic Department received a visit from Anaesthesia Clinical Services Accreditation. The Trust had previously been accredited by ACSA in 2017. Following the review the College's ACSA Committee recognised the anaesthetic department as an ACSA accredited department, and confirmed they had gained reaccreditation.

ACSA found the South Tees anaesthetic department to be a cohesive group with a clear commitment to patient safety and wellbeing. The department is a safe and forward thinking one that works collaboratively with other clinical teams throughout the perioperative pathway to improve outcomes for patients. The review team found many areas of good practice within the department, including:

- The good provision of Cardiac and thoracic WHO checklist/LocSSIPS.
- The standardised phrase for raising concern "Stop I am not happy" was noted as good practice
- The Paediatric Anaesthetic Preassessment Unit which has been developed to provide an excellent individualised and inclusive child centred service
- High quality rest and refreshment facilities for on-call and night shift staff

Human Fertilisation & Embryology Authority
The Human Fertilisation & Embryology Authority (HFEA) completed an unannounced inspection of our Reproductive Medicine Department on 25 June 2024 following a self-assessment in February 2024. A virtual inspection was also carried out on 2 July 2024. A report followed which identified one major area of con-compliance, and two 'other' areas of non-compliance. An action plan was developed to address each area of non-compliance and between July and October all areas of non-compliance have been addressed. A completed action plan has been shared with the HFEA who have recently confirmed that all areas of non-compliance are closed. The HFEA panel agreed that the department was fit to have its treatment and storage licence continued until 2027.

6. CQC National Update

Sir Julian Hartley commenced as Care Quality Commission's (CQC's) new Chief Executive on 2 December 2024.

Dr Penelope Dash started her **Review into the operational effectiveness of the Care Quality Commission: full report - GOV.UK** in May 2024. The review heard from over 300 people from across the health and care sectors (providers, user and patient groups, and national leaders) and within CQC, and analysed CQC's performance data. Dr Dash's final report has now been published and found significant failings in the internal workings of CQC.

The conclusions of the review are summarised around 10 topics;

1. Poor operational performance
2. Significant challenges with the provider portal and regulatory platform
3. Delays in producing reports and poor-quality reports
4. Loss of credibility within the health and care sectors due to the loss of sector expertise and wider restructuring, resulting in lost opportunities for improvement
5. Concerns around the single assessment framework (SAF) and its application
6. Lack of clarity regarding how ratings are calculated and concerning use of the outcome of previous inspections (that often took place several years ago) to calculate a current rating
7. There are opportunities to improve CQC's assessment of local authority Care Act duties
8. ICS assessments are in early stages of development with a number of concerns shared
9. CQC could do more to support improvements in quality across the health and care sector
10. There are opportunities to improve the sponsorship relationship between CQC and the Department of Health and Social Care (DHSC)

In order to restore confidence and credibility and support improvements in health and social care, 7 recommendations were made:

1. Rapidly improve operational performance, fix the provider portal and regulatory platform, improve use of performance data within CQC, and improve the quality and timeliness of reports.
2. Rebuild expertise within the organisation and relationships with providers in order to resurrect credibility.
3. Review the SAF and how it is implemented to ensure it is fit for purpose, with clear descriptors, and a far greater focus on effectiveness, outcomes, innovative models of care delivery and use of resources.
4. Clarify how ratings are calculated and make the results more transparent.
5. Continue to evolve and improve local authority assessments.
6. Formally pause ICS assessments.
7. Strengthen sponsorship arrangements to facilitate CQC's provision of accountable, efficient and effective services to the public.

A second review considering the wider landscape for quality of care, with an initial focus on safety, will be published in early 2025.

Changes to assessment approach
Feedback received by CQC highlighted that the new scoring model was too complex and hard to understand. From 2 December, CQC will stop scoring and reporting at evidence category level and instead will start reporting and scoring at quality statement level. They will still use the evidence categories to guide what they are looking at during assessments and to produce a judgement for individual quality statements.

Alongside this immediate change, CQC are also developing further improvements to how they work for early 2025. These include:

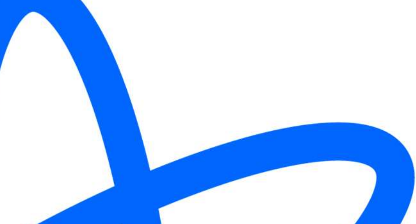
- Providing clearer descriptions of what CQC look for at different levels of quality under each of our 4 ratings
- Developing a new guidance handbook for providers
- Developing ways to produce an accurate rating while using a selected number of quality statements
- Stopping the use of existing ratings to produce new scores
- Developing how CQC use professional judgement when rating services

Further detail will be provided over the next 3 months and changes will only be made when CQC have completed that work. This will include consultation planned for 2025.

7. Recommendations

The Group Board are asked to:

- Receive assurance that plans are in place to address the outstanding Must Do Requirements and Should Do Recommendations for both Trustwide and Maternity Services actions
- Consider the maternity must do action relating to estate that will not be delivered
- Receive assurance that CQC enquiries are being responded to appropriately and timely and learning shared
- Receive and note the organisational and national CQC updates



People Committee

27 November 2024

Connecting to: Group Trust Board

Chair of Committee: Liz Barnes

Key topics discussed in the meeting:

The following reports and updates were considered at the November meeting. All reports were considered across the Group, presenting updates from both Trusts.

- NHS England work seeking to optimise, rationalise and redesign statutory and mandatory training to improve staff experience, deliver better outcomes and reduce the time burden
- Integrated Performance Report – specifically sickness absence rates, staff appraisal and staff turnover and retention
- NHS England internal review of workforce planning and controls
- Succession planning and talent management
- NHS Impact self assessment – focused on the evaluation of improvement culture and capability within organisations and across the system
- Implementation of an ‘app’ to support staff well-being within the Emergency Department at South Tees Hospitals.

Actions:

- The production of the Group Workforce Plan is central to the work of the Group, building on the emerging clinical strategy, ensuring a workforce that is fit for the future, meeting both the challenges of capacity and the appropriate skill mix, recognising new and emerging roles. This will be central to annual planning moving forward.
- There is currently no cohesive talent management framework or strategy across the Group or link to a strategic planning framework for the succession of staff to support

workforce planning. There are multiple effective initiatives in place to support staff development and talent management, but we recognise the need for a more effective Talent Management and Succession Planning strategy, drawing on the strengths across the Group.

- Staff turnover rates currently sit at a healthy level and below the 10% threshold, but we noted that most voluntary resignations occur in the first two years of service and are higher for the 21-30 age group. We will be undertaking further work to improve our ability to deepen our understanding through exit interviews and through conversations with staff considering leaving. In particular we wish to better understand if leavers leave the profession or move into other sectors and roles.

Escalated items:

- Statistics shared with respect to vaccination rates for flu, South Tees 30.9% and North Tees & Hartlepool 34% and COVID, South Tees 7.9% and North Tees and Hartlepool 8.9%. Action has been requested, noting that COVID is not nationally mandated
- At the previous meeting held on the 30th October the new rostering system for trainee doctors was discussed and it had been noted that there were ongoing challenges with the maintenance of rotas and training requirements. It was requested that this is monitored by the Group Board of Directors

Risks (Include ID if currently on risk register):

No new risks identified

Caring
Better
Together

Safer Staffing overview September – November 2024

Meeting date: 7 January 2024

Reporting to: Group Board

Agenda item No: 15

Report author: Debi McKeown, Nursing Workforce Lead; Emma Roberts, ADN and Professional Workforce Lead

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

Delegation status (Board only and completed by the Corporate Secretariat): Jointly delegated item to Group Board

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

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☐

Health and wellbeing ☐

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A centre of excellence ☐

A great place to work ☒

Deliver care without boundaries ☐

Make best use of our resources ☐

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

The requirement to publish nursing & midwifery staffing levels monthly is one of the ten expectations specified by the National Quality Board (2013 and 2016) and this is achieved through the monthly People Committee report.

This bi-monthly exception report will provide a group safer nurse staffing position across all inpatient areas.

The average percentage of shifts filled against the planned nurse and midwifery staffing across South Tees is 97.6% for throughout the months of September 24 – November 24

The average percentage of shifts filled against the planned nurse and midwifery staffing across North Tees is 100% throughout the months of September 24 - November 24.

At South Tees stretch staffing ratios in line with national guidance have been reviewed with Senior Nurse – Operational and implemented where necessary based on skill mix, acuity, and occupancy levels, all these actions agreed by senior nurses through safe care safer staffing meetings

The average Nursing Turnover for the months of September 24 – November 24 has decreased to 6.57% at South Tees.

The average Nursing Turnover for the month of November 2024 November 24 has decreased to 0.37% for Registered Nurses and 0.6% for HCSW.

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.

Threat - Ability to attract and retain good staff resulting in critical workforce gaps in some clinical services and impact on use of resources.

Failure to have effective nursing workforce plans that anticipate and prevent shortages arising from retirements, shortfalls in all recruitment and retention plans.

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

This report details nursing staffing levels for September, October and November 2024 for inpatient wards. The report provides assurance that arrangements are in place to staff services with the right skills in the right place to provide safe, sustainable and productive staffing. Daily Safe Care Safer Staffing meetings provide assurance that inpatient areas have been assessed from a staffing perspective.

This assessment is based on skill mix, acuity, and occupancy levels, and all actions agreed by Safe Care Chair and escalated to Senior Nurses as required.

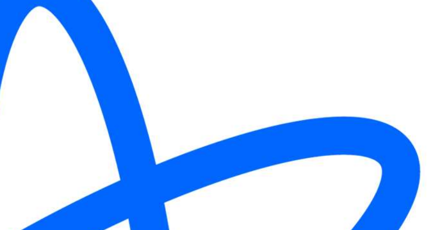
ASSURE: Assure Inform the board where positive assurance has been achieved, share any practice, innovation or action that the committee considers to be outstanding.

The average percentage of shifts filled against the planned nurse and midwifery staffing across South Tees is 97.6% for throughout the months of September 24 – November 24.

The average percentage of shifts filled against the planned nurse and midwifery staffing across North Tees is 100% throughout the months of September 24 - November 24.

Recommendations:

Members of the Trust Board are asked to: Note the content of this report and to be assured that significant work to ensure safe staffing across the nursing and midwifery workforce throughout September 2024 to November 2024 has taken place.



Caring
Better
Together

Resources Committee

November 2024

Connecting to: Group Board; November meeting; Chair David Redpath

Key topics discussed in the meeting:

- **Finance Position**
    - At the end of Month 7 2024/25 the Group is reporting an adverse variance of £0.4m (with an adverse variance of £352k relating to NTH and no variance relating to STH)
- **WTE**
    - We continue to monitor WTE across the group which is being closely scrutinised by Site teams using appropriate workforce controls. We discussed the workforce controls self assessment which the People Committee had received and we agreed to have a further discussion in a Board seminar in December.

CIP / Efficiency

- Across the Group, overall year-to-date delivery is £40.0m (102% of target), with forecast delivery by the end of the year currently at £72.5m (97%).
- Forecast delivery of group Cip is below target, with main concern being delivery of programmes at North Tees.

- **Digital Strategy**
    - This will be presented to the board as part of a development session in December 2024

- **Procurement update (North Tees)**
    - We received an update on North Tees procurement. The committee agreed that further work was required on providing assurance to the Committee and escalated this to the Board.
- We also received reports on
    - Estates
    - Capital
    - Sustainability

Actions:

- North Tees procurement Governance review

Escalated items:

- WTE controls and assurance to be discussed in a Board Seminar.
- Risk of delivery of financial plan (NT) and North Tees CIP is currently behind Target
- Change in financial control total for 2024/25

Risks (Include ID if currently on risk register):

- No new Risks identified

Caring
Better
Together

Month 8 2024-25 Finance Report

Meeting date: 7 January 2025

Reporting to: Group Board

Agenda item No: 17

Report author: Chris Hand, Group Chief Finance Officer

Action required:
Assurance

Delegation status (Board only):
Jointly delegated item to Group Board

Previously presented to:
N/A

NTHFT strategic objectives supported:

Putting patients first ☐

Valuing our people ☐

Transforming our services ☒

Health and wellbeing ☐

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☐

A great place to work ☐

A centre of excellence, for core and specialist services, research, digitally supported healthcare, education and innovation in the Northeast of England, North Yorkshire and beyond ☐

Deliver care without boundaries in collaboration with our health and social care partners ☐

Make best use of our resources ☒

CQC domain link:

Well-led

Board assurance / risk register this paper relates to:

This report relates to STH Board Assurance Framework risk 6 and section 3C (finance) of the NTH 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.

The financial position for Month 8 2024/25 is a deficit of £18.0m for the Group, which is an adverse variance of £1.0m against the year-to-date plan.

This report outlines the drivers of the variance, and actions being taken by the respective Site teams to ensure delivery of the financial control totals. Continued and sustained improvements in ERF delivery, achievement of recurrent CIP and reduction in expenditure run-rates will be essential throughout the second half of the financial year to ensure delivery of the financial control total.

A significant pressure on the CDEL allocation for IFRS16 (right of use) assets is forecast for STH. This pressure largely relates to the impact of indexation increases on the rental payments for leased properties, included significant 5-yearly rent review increases. Following discussion and agreement with the ICB and regional NHSE, this overspend was reported in the Month 6 PFR return (and is part off-set by forecast underspends at an overall system-level). Work is underway internally and across the system to identify options to mitigate the impact of the IFRS16 pressure. In addition, it is anticipated that the system will receive a fair shares allocation from national contingency funding for emerging IFRS16 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.

In September 2024, NHSE confirmed that non-recurrent deficit support will be made available to systems with an agreed deficit plan, to deliver break-even for the 2024/25 financial year.

NENC ICB received an additional allocation of £49.9m, which has been allocated to deficit trusts including an allocation of £17.3m for STH. Consequently, the Trust's financial control total for the year was centrally adjusted by NHSE in Month 6 to reflect this.

The Group plan for the 2024/25 financial year is now to deliver an overall deficit control total of £23.1m, with a break-even plan for NTH and a £23.1m deficit plan for STH.

The plans for the Group include a number of risks and assumptions, that are reported to Resources Committee and will need to be closely monitored over the course of the financial year.

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

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

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

The ICB commissioned a review of arrangements for financial control and CIP across all providers in the system, which provided assurance of the arrangements in place across the Group and any actions required to strengthen.

Recommendations:

Members of the Board are asked to:

- Note the financial position for Month 8 2024/25.

Group Board
7 January 2025

Month 8 2024/25 Finance Report

1. PURPOSE OF REPORT

The purpose of this report is to update the Board on the financial performance of the individual trusts and overall Group, at the end of Month 8 of 2024/25.

2. BACKGROUND

For 2024/25, the system-based approach to planning and delivery continues, with each provider trust fully mapped to a single Integrated Care System (ICS). Both North Tees and Hartlepool NHS Foundation Trust (NTH) and South Tees Hospitals NHS Foundation Trust (STH) and are aligned to the North Cumbria (NENC) Integrated Care System (ICS).

Following a planning assurance meeting between the ICS and NHSE executives on 22nd May, a system control total deficit of £49.9m was agreed for the ICS overall. An additional £20m funding was provided to the ICS in recognition of the impact of IFRS 16 on PFIs. Consequently, a further plan re-submission was required from all system partners on the 12th June 2024.

In September 2024, NHSE confirmed that non-recurrent deficit support will be made available to systems with an agreed deficit plan, to deliver break-even for the 2024/25 financial year. NENC ICB received an additional allocation of £49.9m, which has been allocated to deficit trusts including an allocation of £17.3m for STH. Consequently, the Trust’s financial control total for the year was centrally adjusted by NHSE in Month 6 to reflect this.

Therefore, the Group plan for the 2024/25 financial year is now to deliver an overall deficit control total of £23.1m, with a break-even plan for NTH and a £23.1m deficit plan 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 8 FINANCIAL POSITION

The table below shows the revenue position for the Group as at the end of Month 8 2024/25, shown by trust:

	NTH			STH			GROUP		
ATEMENT OF COMPREHENSIVE INCOME	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Operating income from patient care activities	274,710	278,414	3,704	583,640	595,693	12,053	**858,350**	**874,107**	**15,757**
Other operating income	25,976	25,506	(470)	42,624	39,946	(2,678)	**68,600**	**65,452**	**(3,148)**
Employee expenses	(202,507)	(207,145)	(4,638)	(378,836)	(386,057)	(7,221)	**(581,343)**	**(593,202)**	**(11,859)**
Operating expenses excluding employee expenses	(91,874)	(94,377)	(2,503)	(240,076)	(246,974)	(6,898)	**(331,950)**	**(341,351)**	**(9,401)**
OPERATING SURPLUS/(DEFICIT)	**6,305**	**2,398**	**(3,907)**	**7,352**	**2,608**	**(4,744)**	**13,657**	**5,006**	**(8,651)**
FINANCE COSTS									
Finance income	1,664	2,107	443	1,261	2,177	916	**2,925**	**4,284**	**1,359**
Finance expense	(425)	(463)	(38)	(15,728)	(15,531)	197	**(16,153)**	**(15,994)**	**159**
PDC dividends payable/refundable	(1,520)	(1,517)	3	0	0	0	**(1,520)**	**(1,517)**	**3**
NET FINANCE COSTS	**(281)**	**127**	**408**	**(14,467)**	**(13,354)**	**1,113**	**(14,748)**	**(13,227)**	**1,521**
Other gains/(losses) including disposal of assets	0	0	0	0	76	76	**0**	**76**	**76**
Corporation tax expense	(41)	(62)	(21)	0	0	0	**(41)**	**(62)**	**(21)**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**5,983**	**2,463**	**(3,520)**	**(7,115)**	**(10,670)**	**(3,555)**	**(1,132)**	**(8,207)**	**(7,075)**
Add back all I&E impairments/(reversals)	0	0	0	0	0	0	**0**	**0**	**0**
Remove capital donations/grants I&E impact	(6,944)	(3,752)	3,192	(4,557)	(1,758)	2,799	**(11,501)**	**(5,510)**	**5,991**
Adjust PFI revenue costs to UK GAAP basis	0	0	0	(4,384)	(4,256)	128	**(4,384)**	**(4,256)**	**128**
Adjusted financial performance for the purposes of system achievement	**(961)**	**(1,289)**	**(328)**	**(16,056)**	**(16,684)**	**(628)**	**(17,017)**	**(17,973)**	**(956)**

At the end of Month 8 2024/25 the Group is reporting an adverse variance of £1.0m (with an adverse variance of £328k relating to NTH and £628k relating to STH).

The main drivers of the NTH Month 8 position are:

- Clinical Income is ahead of plan by £3.7m, which mostly relates to increased high-cost drugs and devices income, non-recurrent ICB industrial action funding, and non-NHS income (including Butterwick and Macmillan).
- The plan assumes ERF delivery of 121% (against a national target of 112%), as part of delivering the Trust's overall efficiency and productivity target. The Trust's local estimate of year-to-date performance 122%, which is an additional £0.5m against plan.
- Other operating income (excluding donated asset income) is £2.7m ahead of plan, mainly relating to R&D, education and non-patient care income.
- Interest receivable is ahead of plan by £0.4m, reflecting current interest rates and cash balances.
- Net impact of strike cover of £0.1m
- Pay award pressure of £0.4m.
- Overspend against block funded high-cost drugs and devices of £1.1m
- Slippage on delivery of CIP savings £1.8m.
- Offsetting additional non-recurrent measures

The main drivers of the underlying STH Month 8 position are:

- The pay award has created a net £1.6m year-to-date pressure, however this is offset by additional ERF overperformance in-month of £0.9m
- Clinical Income is ahead of plan by £12.1m, reflecting additional ERF income of £6.3m, passthrough high-cost drugs and devices income of £3.2m and additional contract variations of £2.6m, including non-recurrent ICB industrial action funding of £0.9m.
- The plan assumed ERF delivery of 113% (against a national target of 108%), as part of delivering the Trust's overall efficiency and productivity target. The Trust's local estimate of year-to-date performance is 119%, which is an additional £6.3m income against plan (and £11.4m above the national target).
- Overspends on drugs including high-cost block drugs and other drugs is £6.5m, which is partially offset by clinical income.
- Overspends on medical and surgical equipment, including high-cost devices expenditure is £4.1m; this is partially offset by additional ERF income.
- Overspends on Ward budgets of £1.9m year-to-date, with an in-month overspend of £154k. This is a significant improvement on the Q1 average overspend of £374k, but shows a continued deterioration compared to the Month 6 position.
- Medical pay is overspent by £8.0m and is split between consultants £3.2m and resident doctors, £4.8m. Further analysis is being undertaken in month to understand the drivers, including the link to ERF overperformance, impact of the pay award and progress against planned recruitment to reduce premium costs.
- Overspend on PFI Energy costs of £1.1m.
- Interest receivable is ahead of plan by £0.9m, reflecting higher than plan cash balances.
- Offsetting additional non-recurrent measures

The NTH and STH Site teams are taking a number actions to address areas of overspend and maximise delivery against CIP and ERF targets, whilst mitigating the impact of non-elective activity pressures.

Agency Expenditure

Reduction in agency expenditure is a national priority set by NHSE, with clear Board accountability expected for agency spend and reporting of plans and actual agency spend. The 2024/25 planning guidance included requirements to reduce agency spend by at least 5% from the prior year, contain agency spend within 3.2% of total pay expenditure and remove all non-framework agency by July 2024.

The table below shows the position on agency expenditure for the Group to the end of Month 8:

	NTH			STH			GROUP		
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Nursing	2,662	1,517	-1,145	256	189	-67	2,918	1,706	-1,212
AHP and S&T	74	339	265	573	193	-380	647	532	-115
Other Clinical	0	0	0	0	1	1	0	1	1
Consultants	1,401	1,226	-175	2,261	2,002	-259	3,662	3,228	-434
Career/staff grades	0	6	6	0	0	0	0	6	6
Trainee grades	0	0	0	0	0	0	0	0	0
Non Clinical	0	34	34	158	0	-158	158	34	-124
Total Agency	**4,137**	**3,122**	**-1,015**	**3,248**	**2,385**	**-863**	**7,385**	**5,507**	**-1,878**

The agency plan for 2024/25 assumed a reduction of £2.2m (17%) compared to 2023/24.

At the end of Month 8, agency Expenditure is £1.9m below plan overall for the Group, with an underspend of £0.9m at STH and underspend of £1.0m at NTH.

Agency expenditure represents 0.9% of total pay expenditure (well within the 3.2% national cap). Both NTH and STH currently have no off-framework agency workers.

Workforce

Growth in workforce remains an area of significant internal focus and national and regional scrutiny, linked to the reductions in productivity noted across the wider NHS.

Compared to the previous month, Month 8 WTE worked is 85wte lower than the previous month (-27wte at NTH and -59wte at STH), mainly relating to a reduction in HCAs and Support Staff (-54wte).

'orked	19/20 Average p.m.	23/24 Average p.m.	Q1 24/25 Average p.m.	Q2 24/25 Average p.m.	Mth 7 24/25	Mth 8 24/25	Change from 19/20	Change from 23/24	Change from prior month
					NTH				
Agency	20.38	63.89	50.61	29.69	28.39	27.79	7.41	-36.10	-0.60
Bank	186.45	234.11	225.14	248.82	254.04	240.05	53.60	5.94	-13.99
Substantive	4,659.47	5,130.47	5,273.22	5,301.06	5,373.14	5,360.89	701.42	230.42	-12.25
Sub Total	**4,866.30**	**5,428.47**	**5,548.97**	**5,579.56**	**5,655.57**	**5,628.73**	**762.43**	**200.26**	**-26.84**
					STH				
Agency	25.51	34.62	17.57	18.75	22.23	18.92	-6.59	-15.70	-3.31
Bank	198.01	393.05	375.16	356.22	349.55	315.08	117.07	-77.96	-34.47
Substantive	7,836.68	9,235.07	9,427.08	9,402.81	9,546.15	9,525.37	1,688.69	290.30	-20.78
Sub Total	**8,060.20**	**9,662.74**	**9,819.80**	**9,777.78**	**9,917.93**	**9,859.37**	**1,799.17**	**196.63**	**-58.56**
					GROUP				
Agency	45.89	98.50	68.18	48.44	50.62	46.71	0.82	-51.79	-3.91
Bank	384.46	627.16	600.29	605.03	603.59	555.13	170.67	-72.03	-48.46
Substantive	12,496.15	14,365.55	14,700.30	14,703.87	14,919.29	14,886.26	2,390.11	520.71	-33.03
Grand Total	**12,926.50**	**15,091.21**	**15,368.77**	**15,357.34**	**15,573.50**	**15,488.10**	**2,561.60**	**396.89**	**-85.40**

Month 8 shows a net overall increase of 397 WTE worked across the Group, compared to the average in 2023/24 (200wte at NTH and 197wte at STH). Whilst WTE worked for both Bank and Agency show a total reduction of 124wte from 2023/24 for the Group overall, this is offset by increases in Substantive staffing of 521wte.

Overall, WTEs worked across the Group in Month 8 remain 2,561wte (20%) higher than the average deployed during 2019/20

Efficiency
The 2024/25 financial plan assumes delivery of an overall efficiency target for the Group of £74.5m. The tables below show the year-to-date delivery against the Group's efficiency targets:

	NTH					STH					GROUP				
YTD Month 8	YTD Plan £000	YTD Target £000	YTD Actual £000	YTD Variance £000	% Delivery	YTD Plan £000	YTD Target £000	YTD Actual £000	YTD Variance £000	% Delivery	YTD Plan £000	YTD Target £000	YTD Actual £000	YTD Variance £000	% Delivery
Care Groups / Collaboratives	6,981	5,527	5,187	-340	94%	18,126	19,524	13,517	-6,007	69%	25,107	25,051	18,704	-6,347	75%
ERF Delivery	3,901	3,319	3,901	582	118%	4,933	4,933	5,702	769	116%	8,834	8,252	9,603	1,351	116%
Corporate	514	518	426	-92	82%	3,000	2,668	2,076	-592	78%	3,514	3,186	2,502	-684	79%
Central	3,005	5,396	6,225	829	115%	9,382	3,630	9,460	5,830	261%	12,387	9,026	15,685	6,659	174%
Total	**14,401**	**14,760**	**15,739**	**979**	**107%**	**35,441**	**30,755**	**30,755**	**0**	**100%**	**49,842**	**45,515**	**46,494**	**979**	**102%**

Across the Group, overall year-to-date delivery is £46.5m (102% of target).

Work continues through the Site leadership teams to identify and deliver efficiency savings to meet the targets, with escalation meetings held with Care Groups and Collaboratives. A UHT Financial Recovery Oversight Group, chaired by the Managing Director, has been established to monitor Site delivery and to provide oversight of the overall efficiency programme at a Group level.

Capital
The Group's gross capital expenditure plan for the 2024/25 financial year totals £100.5m.

The Group's ICS Capital Departmental Expenditure Limit (CDEL) for 2024/25 amounts to £32.7m, including an additional £5m bonus allocation relating to UEC performance at NTH. The ICS is expected to receive an additional CDEL allocation for IFRS16 expenditure, with the Group's plan totalling £5.1m.

The capital programme also includes external support, in the form of Public Dividend Capital (PDC) of £23.8m, including support for the Friarage Theatre development (£15.8m) and the Stockton CDC Hub (£7.2m), and Salix grant funding (£25.6m) for de-

carbonisation schemes across the Group. The plan also includes expected PFI lifecycle costs of £12.7m (the cost of which sits outside the ICS CDEL limit).

The Group's capital expenditure to the end of Month 8 amounted to £45.7m, as detailed in the table below.

	NTH £000	STH £000	Group £000
Equipment	575	1,099	1,674
Digital	627	1,274	1,901
Estates	4,662	0	4,662
PFI	0	7,839	7,839
Salix	3,008	2,153	5,161
FHN Hub	0	12,007	12,007
JCUH UTC	0	397	397
CDC Hub	10,771	0	10,771
IFRS 16	1,265	0	1,265
Total Gross Capital	**20,908**	**24,769**	**45,677**

For core CDEL, the Group is currently forecasting delivery by the end of the year to the agreed plans and the respective trusts' share of the system CDEL allocation.

However, against the notional CDEL allocation IFRS16 (right of use) assets, there is currently a significant pressure identified for STH. This pressure largely relates to the impact of indexation increases on the rental payments for leased properties. Following discussion and agreement with the ICB and regional NHSE, the forecast was reported in the Month 6 PFR return (and is part off-set by forecast underspends at an overall system-level). Work is underway internally and across the system to identify options to mitigate the impact of the IFRS16 pressure during 2024/25. In addition, it is anticipated that the system will receive a fair shares allocation from national contingency funding for emerging IFRS16 pressures.

Liquidity

The cash balance at the end of Month 8 stood at £86.8m for the Group (with £52.0m relating to NTH and £34.8m relating to STH).

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

NTH	YTD Number	YTD Value £000
Total bills paid in the year	48,665	141,309
Total bills paid within target	47,368	138,705
Percentage of bills paid within target	**97.3%**	**98.2%**

STH	YTD Number	YTD Value £000
Total bills paid in the year	73,958	421,861
Total bills paid within target	71,843	407,042
Percentage of bills paid within target	**97.1%**	**96.5%**

GROUP	YTD Number	YTD Value £000
Total bills paid in the year	122,623	563,170
Total bills paid within target	119,211	545,747
Percentage of bills paid within target	**97.2%**	**96.9%**

Following Board approval on 7th of August, the Trust made a cash support application on the 16th August for £14.1m support. Following a number of delays, NHSE confirmed on the 16th September that the cash application had been approved, and payment of the cash support from DHSC was received on 23rd September.

On 17th September, NHSE confirmed the non-recurrent deficit support that will be made available to systems with an agreed deficit plan. NENC ICB has distributed its system deficit support allocation to providers in proportion to planned deficits, with the share attributable to STH being £17.4m. The year-to-date proportion of this cash was received on 15th October.

Following distribution of deficit support cash to systems to support break-even, national NHSE's expectations are that no further cash support applications are required by providers. However, given the residual STH deficit plan and working capital requirements, ongoing close monitoring and cashflow forecasting will be essential to minimise any additional cash support requirements.

Statement of Financial Position

The table below shows the balance sheet position for the two Trusts as at the end of Month 8:

	NTH £000	STH £000
Non-current assets		
Intangible assets	892	8,142
On-SoFP IFRIC 12 assets	0	146,469
Other property, plant and equipment (excludes leases)	145,805	155,456
Right of use assets - leased assets for lessee (excluding PFI/LIFT)	18,536	31,533
Receivables: due from NHS and DHSC group bodies	579	1,155
Receivables: due from non-NHS/DHSC Group bodies	1,187	637
Credit Loss Allowances	0	(2,045)
Total non-current assets	**166,999**	**341,347**
Current assets		
Inventories	7,038	17,151
Receivables: due from NHS and DHSC group bodies	2,772	27,292
Receivables: due from non-NHS/DHSC Group bodies	28,874	25,679
Credit Loss Allowances	(3,015)	(1,300)
Cash and cash equivalents: GBS/NLF	45,430	32,930
Cash and cash equivalents: commercial/in hand/other	6,577	1,835
Total current assets	**87,676**	**103,587**
Current liabilities		
Trade and other payables: capital	(2,444)	(13,580)
Trade and other payables: non-capital	(58,354)	(138,353)
Borrowings	(5,094)	(14,037)
Other financial liabilities	(379)	
Provisions	(911)	(1,505)
Other liabilities: deferred income including contract liabilities	(6,644)	
Total current liabilities	**(73,826)**	**(167,475)**
Total assets less current liabilities	**180,849**	**277,459**
Non-current liabilities		
Borrowings	(33,007)	(259,602)
Provisions	(2,087)	(1,370)
Total non-current liabilities	**(35,094)**	**(260,972)**
Total net assets employed	**145,755**	**16,487**
Financed by		
Public dividend capital	193,280	439,633
Revaluation reserve	18,226	32,946
Other reserves	0	26,475
Income and expenditure reserve	(65,751)	(482,567)
Total taxpayers' and others' equity	**145,755**	**16,487**

4. RECOMMENDATIONS

Members of the Board are asked to:

- Note the financial position for Month 8 2024/25.

Integrated Performance Report (IPR) – reporting month October 2024

Meeting date: 7 January 2025

Reporting to: Group Board

Agenda item No: 18

Report author:

Lucy Tulloch, Deputy Director Strategy & Planning and Lynsey Atkins, Associate Director Planning, Performance & Improvement

Action required
Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to:

NTHFT strategic objectives supported:

Putting patients first ☒

Valuing our people ☒

Transforming our services ☒

Health and wellbeing ☒

STHFT strategic objectives supported:

Best for safe, clinically effective care and experience ☒

A centre of excellence ☒

A great place to work ☒

Deliver care without boundaries ☒

Make best use of our resources ☒

CQC domain link:

Choose an item.

Board assurance / risk register this paper relates to:

Performance and Compliance

Key discussion points and matters to be escalated from the meeting

The new group format Integrated Performance Report (IPR) provides, within one document, a consistent presentation of key metrics for each trust, and an aggregate group 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.

Two new metrics have been added this month in the ‘Safe’ domain; Incidents per 1,000 bed days and Never Events per 1,000 bed days. In addition the Statistical Process Control calculations throughout the report now reflect the last rolling 24 months of data per metric, if available, to improve clarity of trends.

The current IPR for data reporting month of October 2024 is presented for information and discussion on the items stated in the following alert, advise and assure sections.

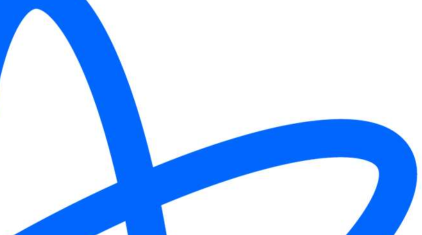
Following the completion of the exercise to align and standardise the Board Assurance Framework (BAF) arrangements within the Group, revised reporting processes are now in place. Attached to this report is the summary report to 30th October 2024. A copy of the full BAF report is included in the Resource Committee Reading Library.

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 Board and Committees are alerted to:

- *C. difficile* infections continue tracking ahead of plan reporting 52 cases YTD against a plan of 38. Collaborative working with NTH Solutions continues, in relation to a decant cleaning programme of equipment and pilot introduction of ward hygienists.
- Referral to treatment incomplete pathways consistently breach the standard of 92%. Patients waiting 52 weeks plus has increased since October 2023. The Trust focus continues around elective recovery, with targeted activity and regional mutual support. Reduction of the longest waiters beyond 65 weeks is the focus across specialities, in accordance with clinical priority and operational planning guidance; zero 65 week waits reported in October.
- Sickness absence performance is inconsistent, and plan is not met. A review of absence due to bereavement with potential of policy development is underway.
- Breastfeeding rates remain below the regional average and benchmarked plan, staffing models to support infant feeding are being explored.



- Diagnostic 6-week wait standard continues to report below the standard, however, with staffing capacity resolved performance is recovering. Revised diagnostic trajectories have been submitted.

For STHFT the Board and Committees are alerted to:

- 2 incidents meeting Never Event criteria were recorded in October 2024 at STHFT (Ophthalmology and Haematology)
- *E. coli* infections have been higher this year than the previous 2 years.
- Increased numbers of still births this year, reported via the Perinatal Mortality Review Tool and all cases are reviewed.
- Cancelled operations not rebooked within 28 days have been higher this year than previously.
- Overall referral to treatment standard is showing deterioration and is now comparable to the national average. The number of patients waiting more than 52 week had been increasing until the last 2 months. Focus is on prioritising the longest waiters as well those most clinically urgent.
- Sickness absence rates are consistently above the Trust's internal plan, ongoing focus on sickness management process leading to some improvement in rates of absence at department level.
- Annual Appraisal trend has not changed recently but the performance does not consistently meet the new UHT plan of 85%.

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

The Board and Committees are advised of areas of performance where there is ongoing focus to improve performance and/or assurance.

For NTHFT the Board and Committees are advised:

- Percentage of births with post-partum haemorrhage (PPH) greater than 1500ml rates is not consistently met within local plan.
- The 4-Hour standard, until recently, is consistently achieved, however, a number of challenges have impacted performance in October, including acuity, attendance volume and IPC outbreaks.
- Ambulance handover within 60 minutes is achieved the majority of days.
- Operations cancelled not rebooked within 28-days does not meet plan, however, numbers remain low. Task and finish groups continue to identify improvement solutions.
- Readmission rates continue to track above plan, audits continue to inform pathway improvements.
- The Cancer Faster Diagnosis, 31- Day and 62- day standards are not consistently met. Group improvement work across tumour groups is underway.
- Patient experience metrics are inconsistently met. Complaints are not consistently closed within the agreed time frame.

- The financial position shows a small adverse variance year to date against month 7 plan. Financial controls are in place and have recently been reviewed, with a focus on recurrent efficiency delivery, and oversight of financial risks through Resources Committee.

For STHFT the Board and Committees are advised:

- C-Difficile, Pseudomonas, Klebsiella infections are tracking slightly higher than plan.
- Within maternity services, breastfeeding rates have improved as a result of supportive interventions but remain below the regional average. Post partum hemorrhage rates are above local plan. Induction of labour rate shows an improving trend and the target for positive patient feedback was achieved for September and October but otherwise the trend remains inconsistent.
- Demonstrated improvement in urgent and emergency care metrics despite spikes in poorer performance in October, with the focus being on appropriate streaming to the JCUH urgent treatment center to see patients within 4 hours, and reducing ambulance handover delays in ED.
- Standardised mortality is 'as expected'.
- Positive patient feedback from users of A&E and inpatients is not always above the standard we have set, although inpatient feedback has met the target consistently since early 2023.
- Complaints are not concluded within target timescales often enough and acknowledging feedback can take longer than 3 days.
- Compliance with cancer treatment waiting time standards is recognised as a strategic risk; the position will be improved through delivery of action plans to improve access and processes within specific tumour groups enabling earlier diagnosis.
- Diagnostic 6-week wait is improving. Further gains are dependent on actions from specialist services that need longer timescales for delivery.
- Financial position in line agreed plan. Financial controls are in place, with a focus on recurrent efficiency delivery, and oversight of financial risks through Resources 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 IPR uses statistical process control to provide positive assurance on performance, where standards are consistently met.

For NTHFT the Board and Committees are assured:

- Standardised mortality is 'as expected' and consistently tracks positively below the national standard.
- The Trust consistently achieves the 2-hour Community Response, supporting management of flow into the emergency department.
- The Trust continues to perform positively below the 2% threshold for A&E 12-Hour waits in department.

- Staff turnover demonstrates improving performance, positively below plan which is consistently met.
- Annual appraisal is consistently achieved.

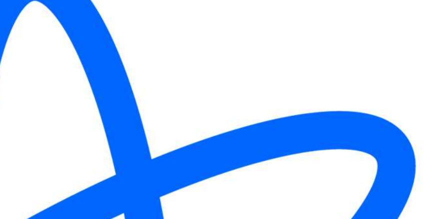
For STHFT the Board and Committees are assured:

- Rates of 3rd/4th degree tear in maternity care are consistently below plan.
- Community 2-hour urgent response rate consistently exceeds plan and is an important element of to manage emergency care.
- Consistently positive patient feedback surveys results for outpatient and community services

Recommendations:

Members of the Board of Directors and Committees are asked to:

- Receive the Integrated Performance Report for reporting period October 2024.
- Note that separate agenda items into the Committees, as set out in the annual cycles of business, will provide further detailed reporting and assurance.
- Note the performance standards on which assurance is provided; those advised for ongoing monitoring and improvement; and those alerted as exceptions or consistent under-performance against plan; and the improvement actions being taken.



Integrated Performance Report

Reporting month: October 2024

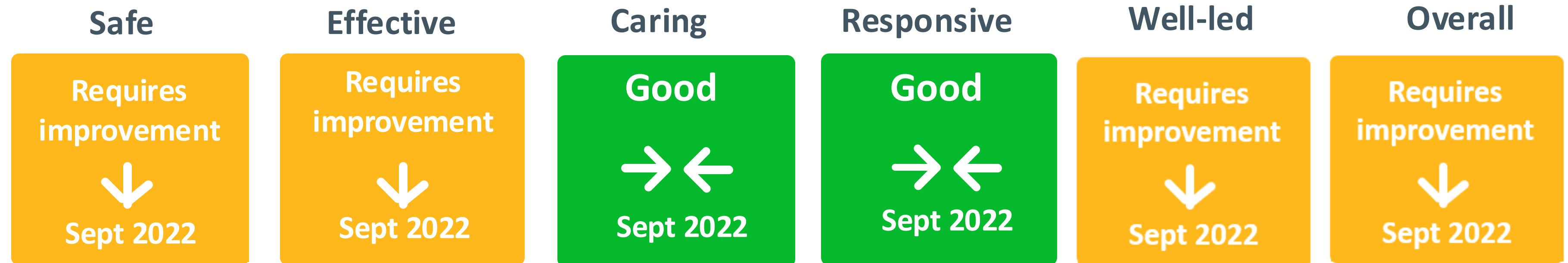
Caring
Better
Together

Overview

- The IPR reports on the key indicators and standards by which Trusts' performance is monitored. They are underpinned by a broader range of metrics and evidence for clinical governance and operational management.
- **SAFE:** Focus remains on embedding the patient safety incident response framework, with a group / site quality and safety senior leadership structure to strengthen and standardise how we learn and improve across the two Trusts.
- **EFFECTIVE:** Standardised mortality is 'as expected' for both Trusts.
- **RESPONSIVE:** NTHFT has strong performance in urgent and emergency care, with STHFT demonstrating improvement. However, managing increases in demand during the winter months will be challenging. Community services are integral to winter plans, maximising use of hospital at home and the frailty service to identify patients whose needs are best served in a community setting including their own home.
- Both Trusts are focusing on further improvement in tackling waiting times for elective care, diagnostics and within cancer pathways. Whilst focus has been on ensuring the very longest waiters receive their treatment, there is not consistent improvement/achievement across the core metrics. Productivity improvements such as driving up theatre utilisation to create more capacity for patients awaiting surgery, waiting list validation and cancer pathway action plans are tools being used to turn around the position.
- **CARING:** The IPR demonstrates that both Trusts are generally performing well against their plans on patient feedback surveys. Variance of response times within, and between the Trusts, is to be addressed in relation to our responsiveness to enquiries and complaints.
- **WELL LED:** Staff wellbeing is a Group and national priority. Despite a challenging financial climate, both Trusts plan to deliver their agreed financial position and are working towards the performance expectations within the envelope of available resources.

Regulation & Compliance

North Tees & Hartlepool Hospitals NHS Foundation Trust has an overall rating of Requires Improvement.
Since the 2022 inspection CQC recommendations have been addressed and action plan completed.



South Tees Hospitals NHS Foundation Trust has an overall rating of Good.
Since the 2023 CQC inspection 11 Must Do and 15 Should Do actions have been completed. The remaining 2 Must Do and 5 Should Do actions are in progress. Each has a robust plan that is reviewed monthly by the CQC Compliance Group. Recent progress includes assurance on the assessment of patient pain.

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

Caring Better Together

NHS Oversight Framework for UHT

NHS Oversight Framework Summary	Urgent & Emergency Care					Elective care											Cancer			
Provider	A&E 4 hour standard	12 hour delay from DTA	% A&E Type 1 Attendances >12hrs from arrival	Ambulance handovers 30-60 mins	Ambulance handovers 60+ mins	RTT - 18 week standard	52+ week waits	65+ week waits	78+ week waits	104+ week waits	RTT total Waiting List	OPFU - YTD growth 24/25 v 23/24	1st OP - YTD growth 24/25 v 23/24	Total elective - YTD growth 24/25 v 23/24	Diagnostic activity 24/25 v 23/24	Diagnostic 6 week waits	Cancer 62 day	Cancer 62 day backlog	Cancer treatments (first and subsequent)	Cancer 28 day FD
Data period	Oct-24	Oct-24	Oct-24	Oct-24	Oct-24	Sep-24	Sep-24	Sep-24	Sep-24	Sep-24	Sep-24	Sep-24	Sep-24	Sep-24	Sep-24	Sep-24	Sep-24	Oct-24	Sep-24	Sep-24
Target	95%	Zero				92%	24/25 Plan	24/25 Plan	Zero	Zero	24/25 Plan					<=1%	85%	Mar 24 Plan		75%
North Tees & Hartlepool NHSFT	83.8%	3	0.0%	127	5	72.1%	173	0	0	0	20,616	106%	103%	103%	102%	22.3%	60.1%	102	194	78.4%
South Tees Hospitals NHSFT	73.5%	33	7.9%	413	366	59.1%	1,847	68	4	0	56,848	111%	105%	110%	105%	15.1%	61.5%	117	561	79.1%
NENC ICS Provider level *(including IS providers)*	75.8%	821	7.5%	2,869	1,405	68.2%	6,627	375	38	0	377,865	106%	103%	107%	107%	17.4%	65.9%	792	3,263	77.4%
North East & Yorkshire	73.0%		8.7%			63.8%										18.5%	65.8%			76.7%
National	73.0%		11.1%			58.5%										22.7%	67.3%			74.8%

Notes:

•RTT Waiting List, Cancer 62 day backlog, Cancer treatments & MH metrics are RAG rated against 24/25 plans •Diagnostic activity against baseline only includes activity for the 7 tests included in the planning round

Urgent and emergency care metrics show a positive position for NTHFT heading into the start of higher winter demand and acuity. STHFT A&E standard is still demonstrating an improved position, close to the agreed recovery trajectory, but remains a strategic risk with actions reviewed monthly. Reducing ambulance delays and the longest department waits are a priority.

Elective care metrics show an RTT 18-week standard position at NTHFT that is above the regional and national average, with the focus now on ensuring patients wait no longer than 52 weeks. STHFT services are working to eliminate waits above 65 weeks. Given also the total waiting list size, achievement of this standard is a strategic risk for both Trusts. Both Trusts are delivering above 23/24 levels of outpatient and elective activity, STHFT are currently exceeding plan due to additional day case activity delivered and included in the reported position.

Cancer 62-day standard is an area of key concern, logged as a strategic risk. Whilst completed pathway performance is below comparator averages, backlogs also remain above plan. Both Trusts met the 28-day faster diagnosis standard in September 2024, a key enabling metric within the cancer pathway. Actions are focused on reducing delays in specific pathways, whilst investment in cancer navigators helps to ensure individual cases are proactively pursued through the diagnostic and treatment steps.

Caring Better Together

North Tees & Hartlepool NHSFT summary

NTHFT is in NHS Oversight Framework segment 2, the default segment for Trusts.

Alert

- *C. difficile* infections continue tracking ahead of plan reporting 52 cases YTD against a plan of 38. Collaborative working with NTH Solutions continues, in relation to a decant cleaning programme of equipment and pilot introduction of ward hygienists.
- Referral to treatment incomplete pathways consistently breach the standard of 92%. Patients waiting 52 weeks plus has increased since October 2023. The Trust focus continues around elective recovery, with targeted activity and regional mutual support. Reduction of the longest waiters beyond 65 weeks is the focus across specialities, in accordance with clinical priority and operational planning guidance; zero 65 week waits reported in October.
- Sickness absence performance is inconsistent, and plan is not met. A review of absence due to bereavement with potential of policy development is underway.
- Breastfeeding rates remain below the regional average and benchmarked plan, staffing models to support infant feeding are being explored.
- Diagnostic 6-week wait standard continues to report below the standard, however, with staffing capacity resolved performance is recovering. Revised diagnostic trajectories have been submitted.

Advise

- Percentage of births with post-partum haemorrhage (PPH) greater than 1500ml rates is not consistently met within local plan.
- The 4-Hour standard, until recently, is consistently achieved, however, a number of challenges have impacted performance in October, including acuity, attendance volume and IPC outbreaks.
- Ambulance handover within 60 minutes is achieved the majority of days.
- Operations cancelled not rebooked within 28-days does not meet plan, however, numbers remain low. Task and finish groups continue to identify improvement solutions.
- Readmission rates continue to track above plan, audits continue to inform pathway improvements.
- The Cancer Faster Diagnosis, 31- Day and 62- day standards are not consistently met. Group improvement work across tumour groups is underway.
- Patient experience metrics are inconsistently met. Complaints are not consistently closed within the agreed time frame.
- The financial position shows a small adverse variance year to date against month 7 plan. Financial controls are in place and have recently been reviewed, with a focus on recurrent efficiency delivery, and oversight of financial risks through Resources Committee.

Assure

- Standardised mortality is 'as expected' and consistently tracks positively below the national standard.
- The Trust consistently achieves the 2-hour Community Response, supporting management of flow into the emergency department.
- The Trust continues to perform positively below the 2% threshold for A&E 12-Hour waits in department.
- Staff turnover demonstrates improving performance, positively below plan which is consistently met.
- Annual appraisal is consistently achieved.

South Tees Hospitals NHSFT summary

STHFT is in NHS Oversight Framework segment 3, driven by the underlying financial deficit position of STHFT.

Alert .

- 2 incidents meeting Never Event criteria were recorded in October 2024 at STHFT (Ophthalmology and Haemotology)
- *E. coli* infections have been higher this year than the previous 2 years.
- Increased numbers of still births this year, reported via the Perinatal Mortality Review Tool and all cases are reviewed.
- Cancelled operations not rebooked within 28 days have been higher this year than previously.
- Overall referral to treatment standard is showing deterioration and is now comparable to the national average. The number of patients waiting more than 52 week had been increasing until the last 2 months. Focus is on prioritising the longest waiters as well those most clinically urgent.
- Sickness absence rates are consistently above the Trust's internal plan, ongoing focus on sickness management process leading to some improvement in rates of absence at department level.
- Annual Appraisal trend has not changed recently but the performance does not consistently meet the new UHT plan of 85%

Advise

- C-Difficile, Pseudomonas, Klebsiella infections are tracking slightly higher than plan.
- Within maternity services, breastfeeding rates have improved as a result of supportive interventions but remain below the regional average. Post partum haemorrhage rates are above local plan. Induction of labour rate shows an improving trend and the target for positive patient feedback was achieved for September and October but otherwise the trend remains inconsistent.
- Demonstrated improvement in urgent and emergency care metrics despite spikes in poorer performance in October, with the focus being on appropriate streaming to the JCUH urgent treatment centre to see patients within 4 hours, and reducing ambulance handover delays in ED.
- Standardised mortality is 'as expected'.
- Positive patient feedback from users of A&E and inpatients is not always above the standard we have set, although inpatient feedback has met the target consistently since early 2023.
- Complaints are not concluded within target timescales often enough and acknowledging feedback can take longer than 3 days.
- Compliance with cancer treatment waiting time standards is recognised as a strategic risk; the position will be improved through delivery of action plans to improve access and processes within specific tumour groups enabling earlier diagnosis.
- Diagnostic 6-week wait is improving. Further gains are dependent on actions from specialist services that need longer timescales for delivery.
- Financial position in line agreed plan. Financial controls are in place, with a focus on recurrent efficiency delivery, and oversight of financial risks through Resources Committee.

Assure

- Rates of 3rd/4th degree tear in maternity care are consistently below plan.
- Community 2-hour urgent response rate consistently exceeds plan and is an important element of to manage emergency care.
- Consistently positive patient feedback surveys results for outpatient and community services

Index of metrics

SAFE:
- Incidents per 1000 Bed Days
- Patient Safety Incident Investigations
- Never Events
- Never Events Per 1000 Bed Days
- Falls with Harm Rate % (Per 1000 Bed Days)
- C-Difficile infections
- MRSA infections
- E-Coli infections
- Klebsiella infections
- Pseudomonas infections

SAFE – MATERNITY:
- Babies Born
- Still Births
- Induction of Labour (%)
- Breast Feeding at First Feed (%)
- PPH > 1500ml (%)
- Number of 3rd/4th Degree Tear (%)

EFFECTIVE:
- Summary Hospital-Level Mortality Indicator
- Readmission Rate (%)

RESPONSIVE:
- Handovers – Within 60 mins (%)
- 4-Hour A&E Standard (%)
- 12-Hour A&E Breaches (%)
- Community UCR 2 Hour Response Rate (%)
- Cancelled Operations Not Rebooked Within 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

CARING:
- A&E Experience (%)
- Inpatient Experience (%)
- Maternity Experience (%)
- Outpatient Experience (%)
- Community Experience (%)
- Collaborative Enquiries Closed in Target (%)
- Feedback Acknowledged in 3 Days (%)
- Complaints Closed Within Target (%)

WELL LED:
- Sickness Absence (%)
- Staff Turnover (%)
- Annual Appraisal (%)
- Mandatory Training (%)
- Cumulative YTD Financial Position (£'Millions)

DOMAIN SUMMARY

Executive lead: Dr Hilary Lloyd, Chief Nursing Officer

Accountable to: Quality Assurance Committee

The Patient Safety Incident Response Framework is becoming embedded. PSIRF encompasses a range of system-based and proportionate approaches to learning from patient safety incidents. Compassionate engagement with all who are affected (patients, families, carers and staff members) is a cornerstone of PSIRF. Thematic review is used to identify trends and learning.

Healthcare acquired infections are closely monitored with an increase in *C. difficile* at NTHFT and *E.coli* at STHFT compared to the last two years. The need to maintain some capacity for decant and deep clean when required throughout the winter has been factored into winter resilience plans.

NTHFT

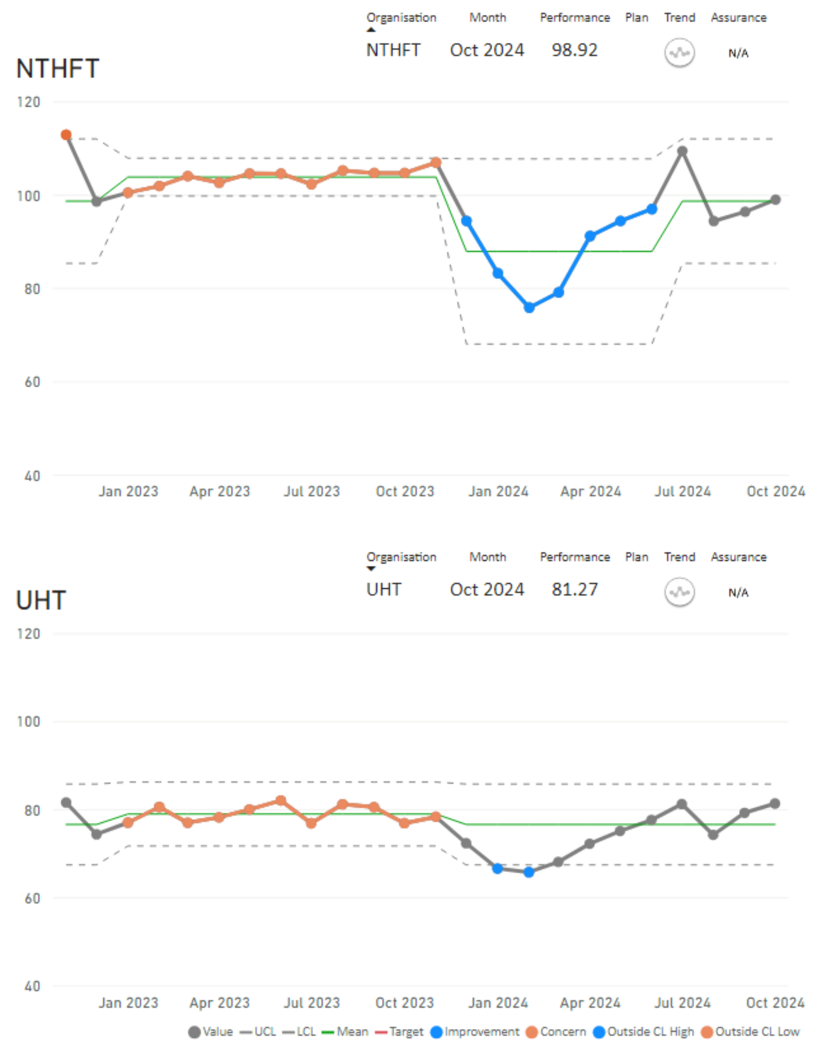
Metric	Month Target	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024
Incidents Per 1000 Bed Days		106.85	94.36	83.15	75.78	79.05	91.1	94.34	96.91	109.35	94.32	96.33	98.92
Patient Safety Incident Investigations			0	0	0	0	0	0	3	4	4	1	3
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	1
Never Event Rate (Per 1000 Bed Days)	0	0	0	0	0	0	0	0	0	0	0	0	0.07
Falls With Harm Rate (Per 1000 Bed Days)		0.13	0.12	0.25	0.6	0.27	0.14	0.14	0.15	0	0.22	0.28	0.07
C-Difficile	5	8	10	6	8	5	7	10	7	10	6	3	9
MRSA	0	0	0	2	0	0	0	0	0	0	1	1	1
E-Coli	8	7	7	7	6	8	5	4	6	10	7	13	13
Klebsiella	3	2	3	7	1	3	2	2	2	2	5	3	4
Pseudomonas	1	0	1	0	4	4	1	3	1	0	2	0	2

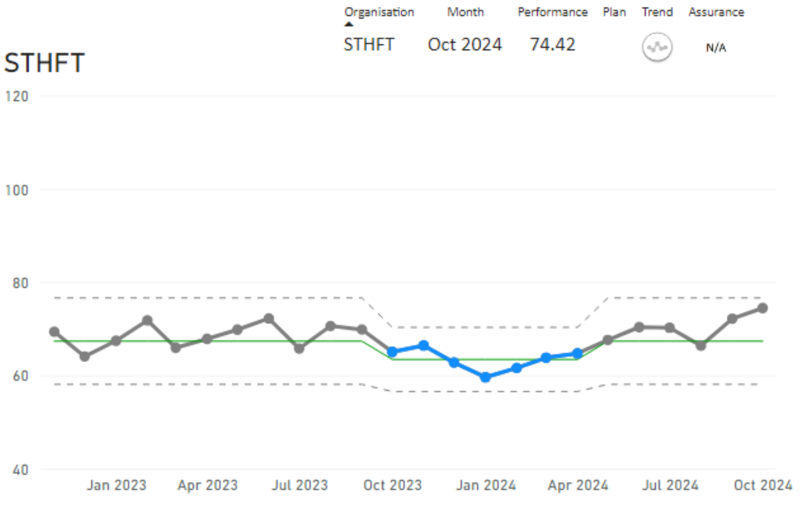
STHFT

Metric	Month Target	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024
Incidents Per 1000 Bed Days		66.39	62.72	59.57	61.58	63.76	64.68	67.58	70.32	70.2	66.33	72.15	74.42
Patient Safety Incident Investigations					1	0	0	1	2	1	1	0	1
Never Events	0	1	1	0	0	0	0	0	1	0	1	0	2
Never Event Rate (Per 1000 Bed Days)	0	0.03	0.03	0	0	0	0	0	0.03	0	0.03	0	0.05
Falls With Harm Rate (Per 1000 Bed Days)		0.16	0.16	0.1	0.13	0.05	0.16	0.13	0.14	0.08	0.06	0.03	0.11
C-Difficile	10	10	8	5	13	9	9	8	12	15	13	9	11
MRSA	0	0	0	0	0	0	0	0	0	0	1	0	0
E-Coli	11	16	18	11	9	10	15	20	12	12	13	11	17
Klebsiella	5	5	10	7	3	5	6	1	5	9	4	6	8
Pseudomonas	2	3	2	0	3	0	2	3	0	3	2	1	3

Caring Better Together

SAFE Incidents Per 1000 Bed Days

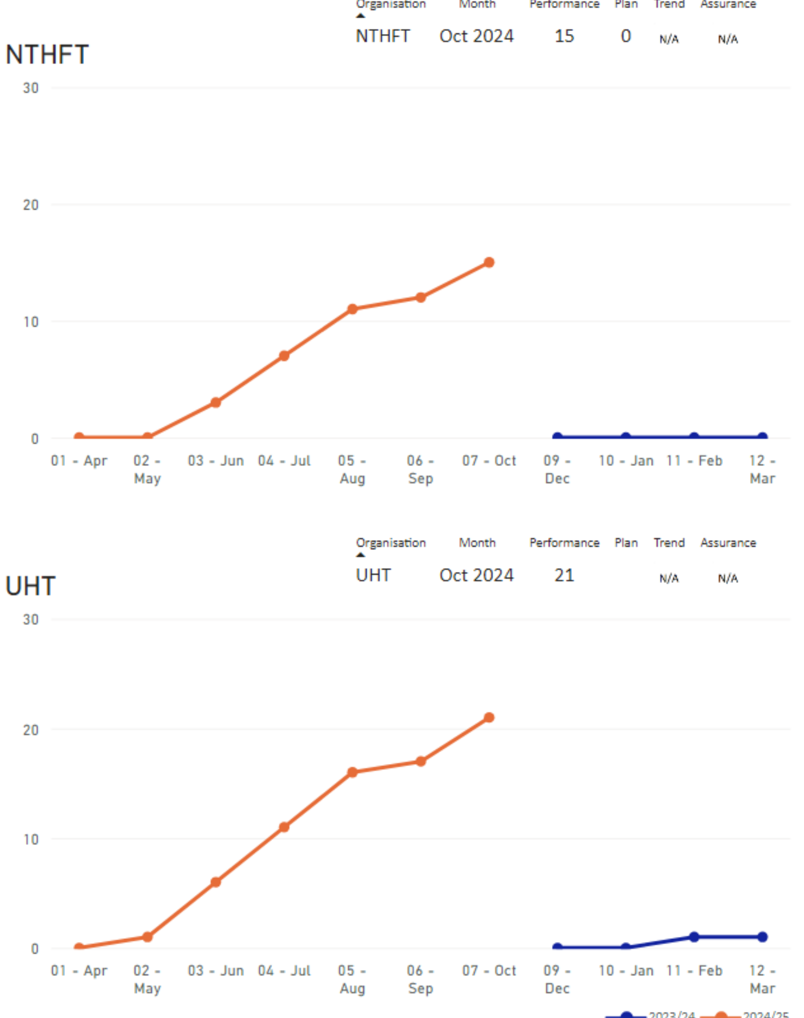




Metric: Incidents rate per 1000 bed days
Plan: n/a
Rationale: Enables benchmarking.
Data quality: Assured. Each incident is validated.
Trend: No significant trend in recent 4-5 months.
Assurance: n/a
Action taken: Further review will be undertaken by patient safety teams to understand the differences in incident reporting numbers. As NRLS data is no longer available for regional comparison, there has been discussion with the ICB to potentially undertake some regional benchmarking for additional context.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

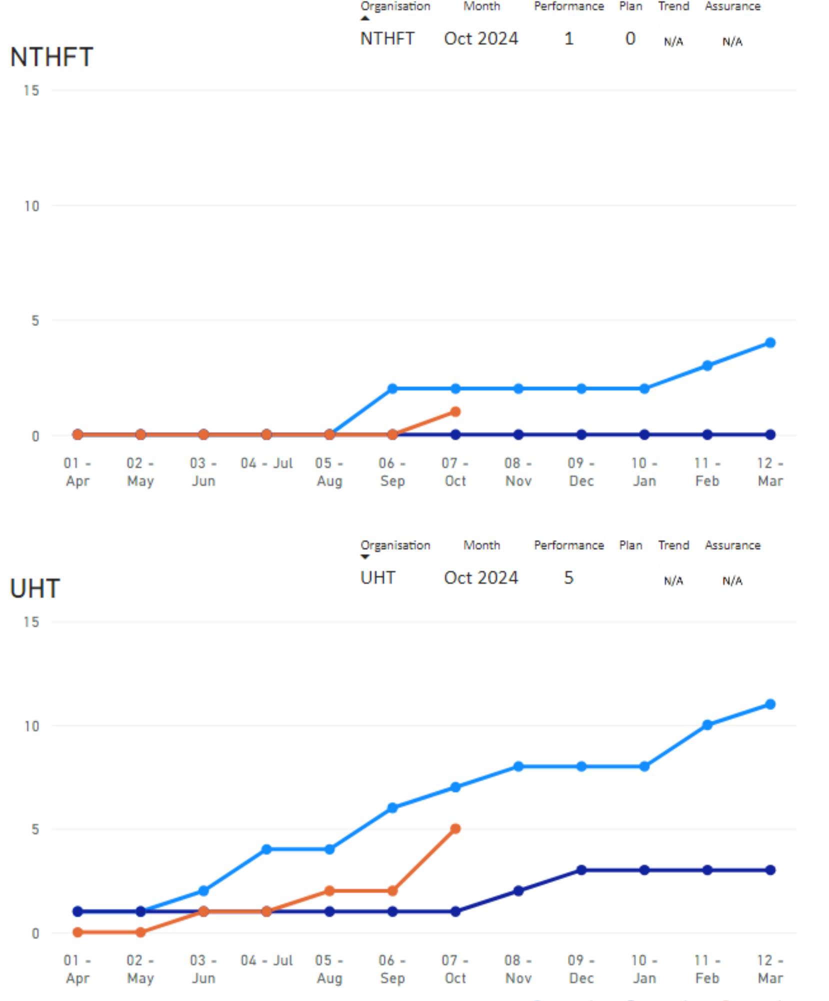
Patient Safety Incident Investigations (YTD)

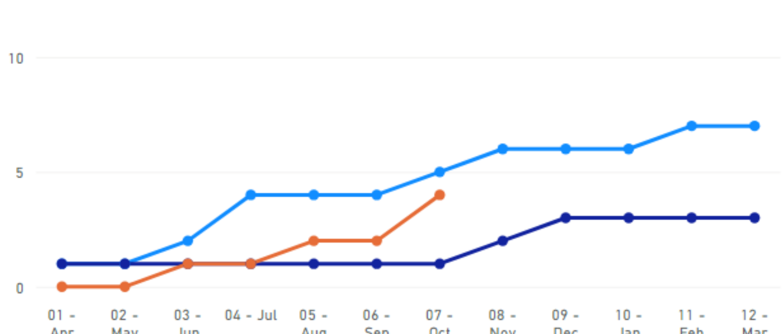


Metric: PSIIs initiated, cumulative annually from April.
Plan: n/a. An open reporting culture is encouraged.
Rationale: NHS Quality Accounts regulatory indicator.
Data quality: Assured. Each incident is validated.
Trend: 15 PSIIs YTD at NTHFT, 6 at STHFT.
Assurance: n/a
Action taken: PSIIs are reviewed at a weekly learning response panel, per Trust, to determine how they are investigated under the patient safety incident response framework. In October, 3 PSII were logged at NTHFT, 1 was logged at STHFT.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

Never Events (YTD)





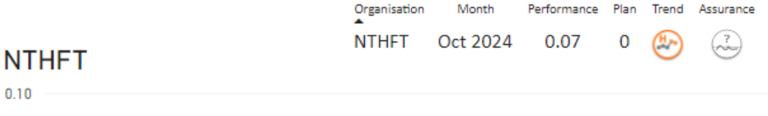
Metric: Never Events (a defined list of serious preventable errors), cumulative annually from April.
Plan: Zero.
Rationale: NHS Quality Accounts regulatory indicator.
Data quality: Assured. Each incident is validated.
Trend: One Never Event YTD at NTHFT, 4 at STHFT.
Assurance: Advise: 2 Never Events registered in October for STHFT and 1 Never Event registered at NTHFT. One of these has been added to a PSII already underway at STHFT.
Action taken: Never Events are reviewed at a multi-disciplinary panel. PSII methodology is used to review the incident from a systems perspective.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

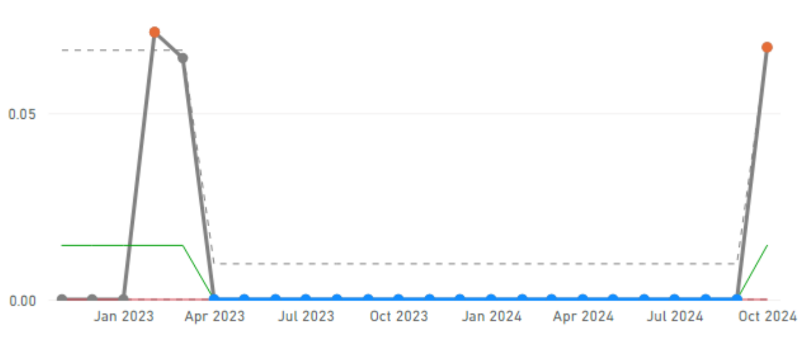
Caring Better Together

SAFE

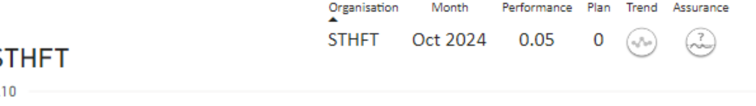
Never Event Rate (Per 1000 Bed Days)

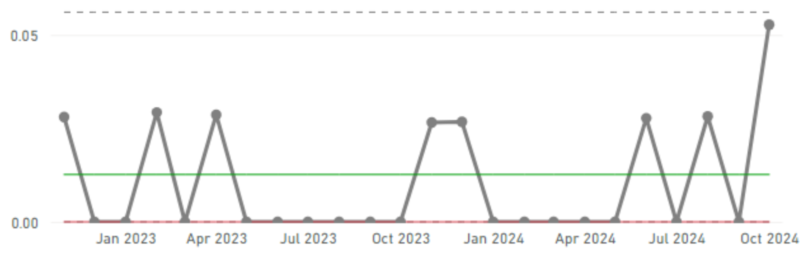
NTHFT



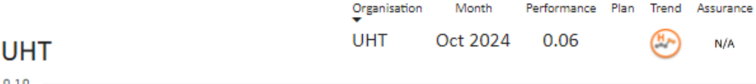


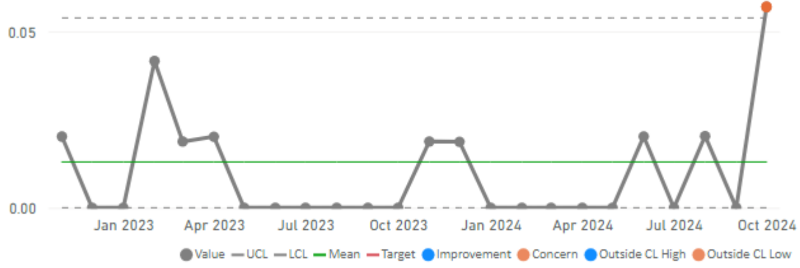
STHFT





UHT

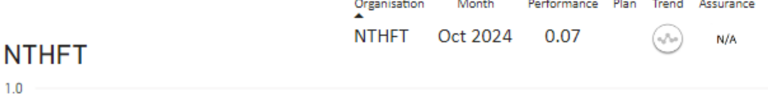




Metric: Never Events (a defined list of serious preventable errors), per 1000 bed days
Plan: Zero.
Rationale: Historically, Never Events occurring within a Trust have been viewed purely by crude numbers. However, evidence indicates that larger Trusts have higher number of Never Events, due to their level of activity.
Data quality: Assured. Each incident is validated.
Trend: NTHFT flags an increasing trend due one case having had zero Never Events for an extended period.
Assurance: n/a
Action taken: Discussed with ICB, to consider undertaking regional benchmarking exercise.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

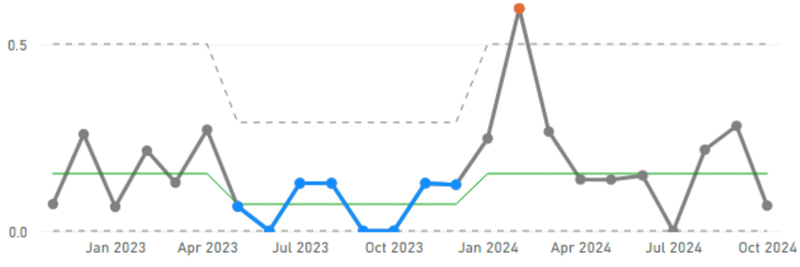
Caring Better Together

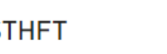
SAFE Falls With Harm Rate (Per 1000 Bed Days)



NTHFT

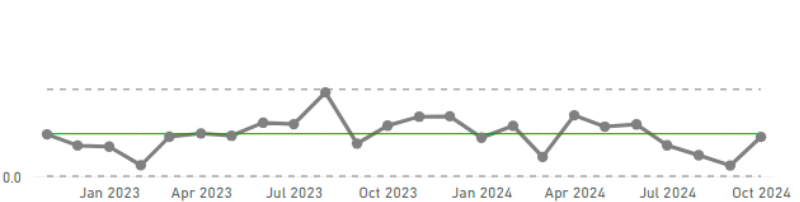
Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Oct 2024	0.07			N/A

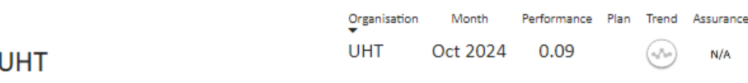




STHFT

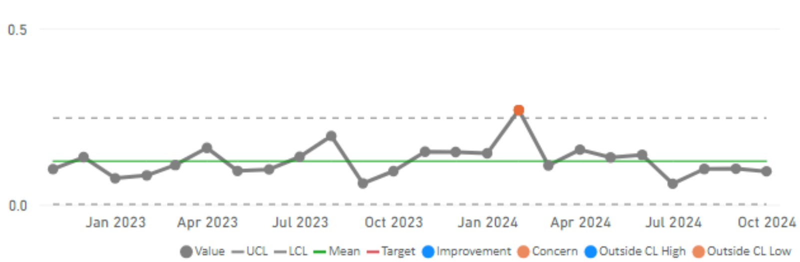
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Oct 2024	0.11			N/A





UHT

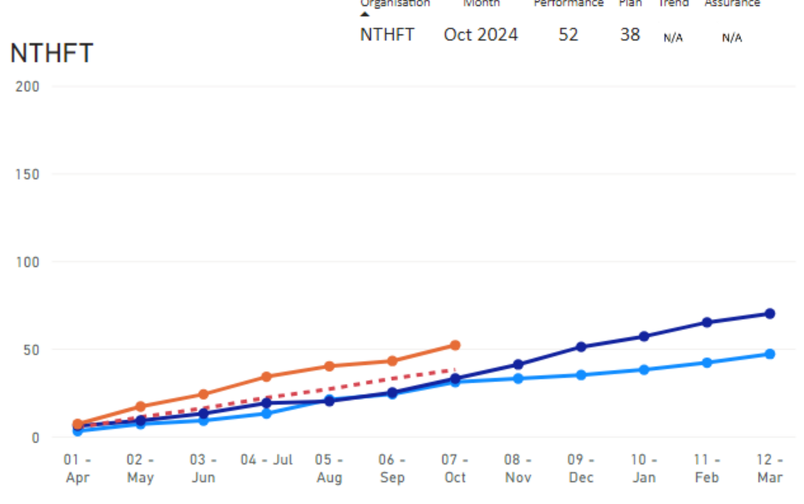
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Oct 2024	0.09			N/A

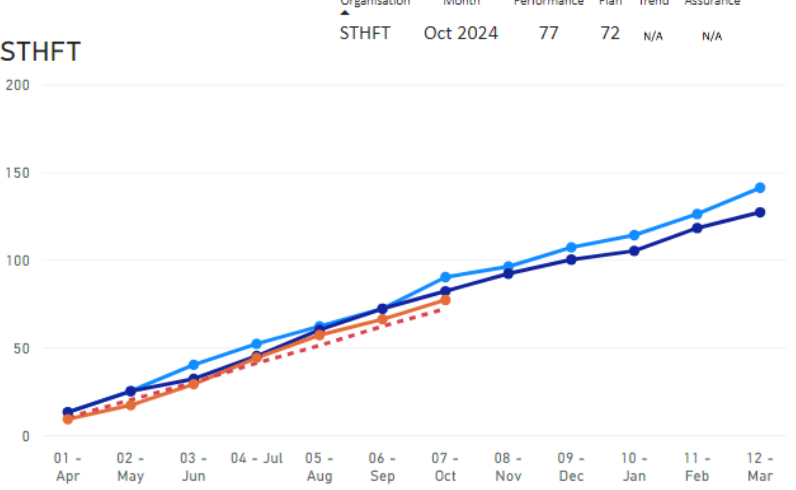


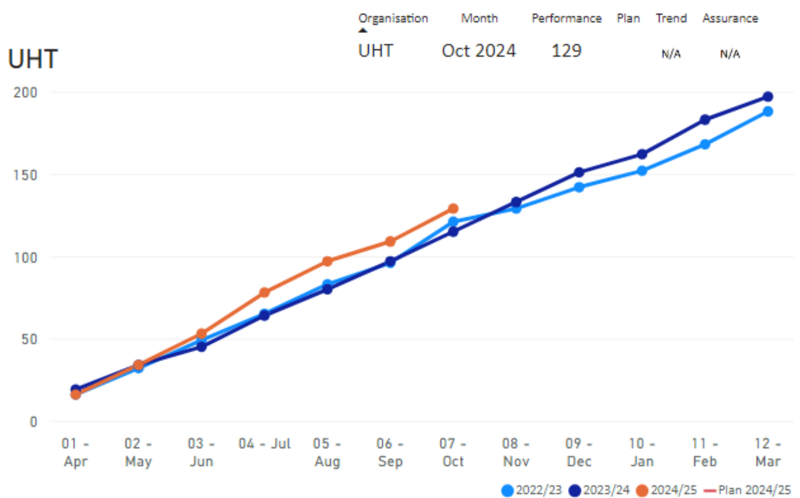
Metric: Falls resulting in harm graded moderate and above, as a rate per 1000 inpatient bed-days.
Plan: n/a
Rationale: NHS Quality Accounts regulatory indicator. National falls audit categorisation is expected to change January 2025, the metric will be reviewed to align with this.
Data quality: Assured. Each incident is validated.
Trend: No trend.
Assurance: n/a
Action taken: A Falls Educator Coordinator has been employed at NTHFT and will be supported by the Falls Educator Coordinator at STHFT. Joint working is planned with overall leadership by the Group Chief AHP.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

C-Difficile (YTD)





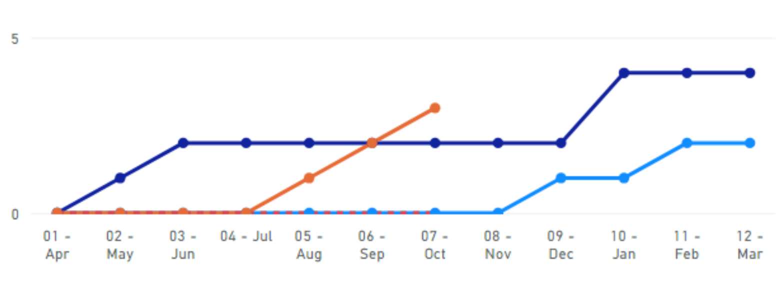


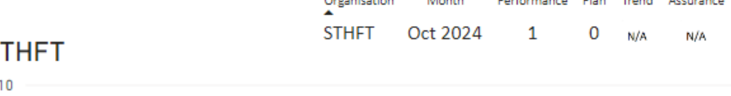
Metric: Healthcare associated cases of *Clostridioides difficile*, cumulative annually from April.
Plan: NHS standard contract trajectory: 5% reduction on 23/24 performance
Rationale: NHS Contract and Quality Accounts regulatory indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: Infections year-to-date tracking ahead of plan; STHFT in line with plan.
Assurance: NTHFT: Alert. STHFT: Advise.
Action taken: Priority hydrogen peroxide vapour fogging, in line with national guidance across both trusts. Cross-site collaborative working with NTH Solutions continues, in relation to a decant cleaning programme of equipment and pilot introduction of ward hygienists.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Oct 2024	3	0	N/A	N/A

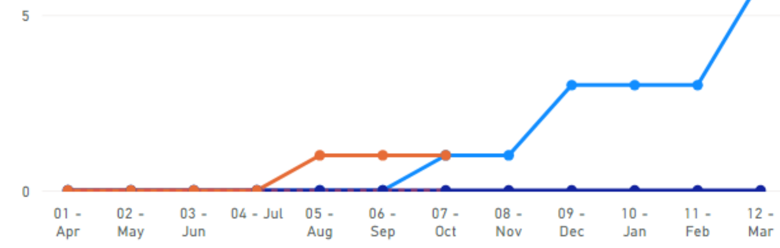
NTHFT

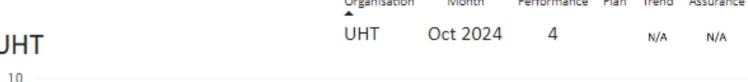




Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Oct 2024	1	0	N/A	N/A

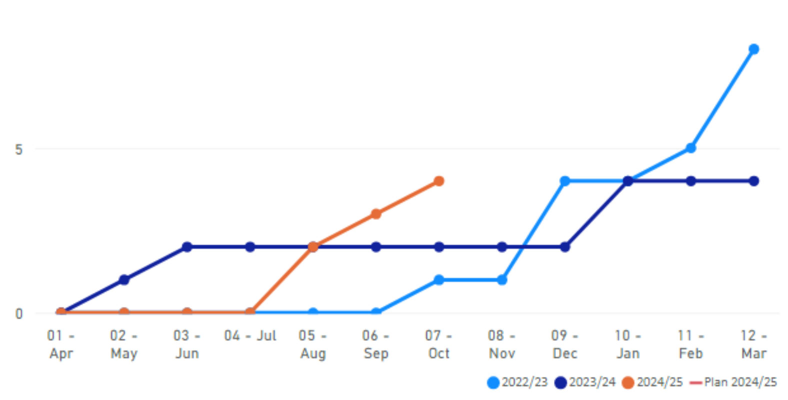
STHFT





Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Oct 2024	4		N/A	N/A

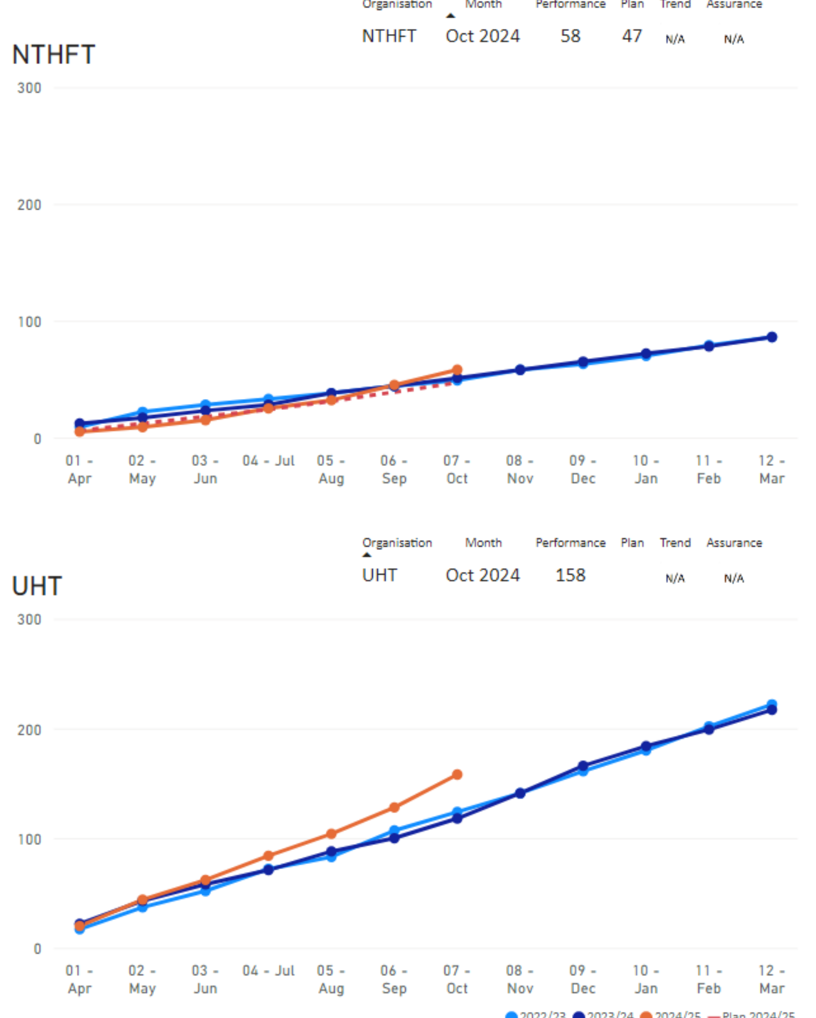
UHT

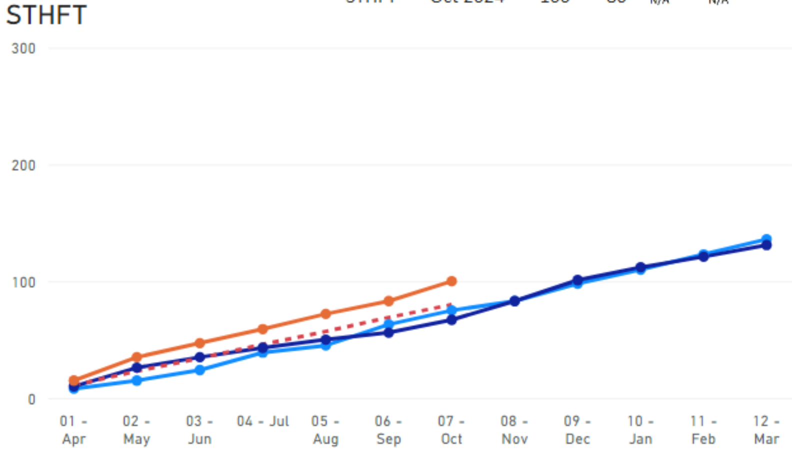


Metric: Healthcare associated cases of Methicillin resistant *Staphylococcus aureus*, cumulative annually from April.
Plan: Zero tolerance.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: Number of infections at NTHFT and STHFT in line with previous years against a challenging zero tolerance.
Assurance: Advise (plan not achievable).
Action taken: Antimicrobial Stewardship remains a priority for both Trusts in 2024/25. A focus on MRSA screening on admission remains a priority and audit in October demonstrated an improvement.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

E-Coli (YTD)

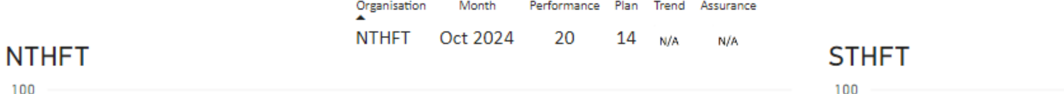




Metric: Healthcare associated cases of *Escherichia coli*, cumulative annually from April.
Plan: NHS standard contract trajectory: at least 1 case fewer than 23/24 outturn.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: Number of infections tracking higher than plan.
Assurance: Alert: cases >20% above plan YTD.
Action taken: A focus on reducing the number of Catheter Associated Urinary Tract Infections (CAUTI) supplier audit taking place at STHFT in line with NTHFT (re-audit in November).
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

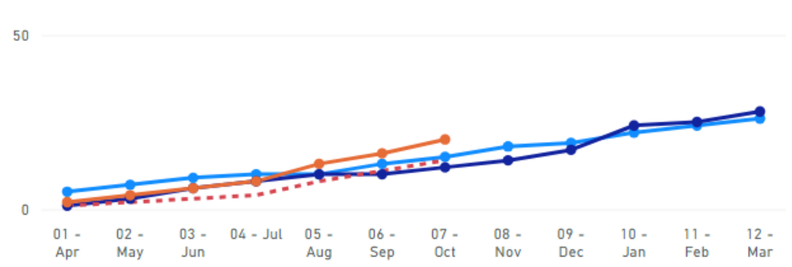
Caring Better Together

Klebsiella (YTD)



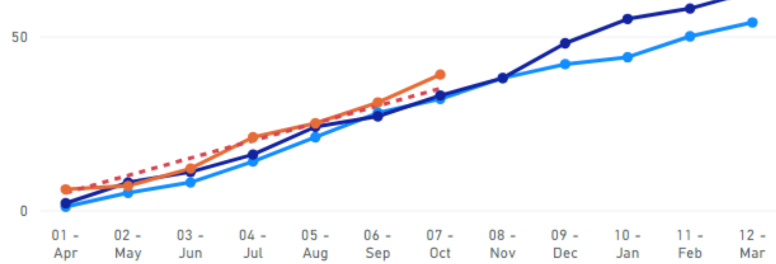
Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Oct 2024	20	14	N/A	N/A

NTHFT



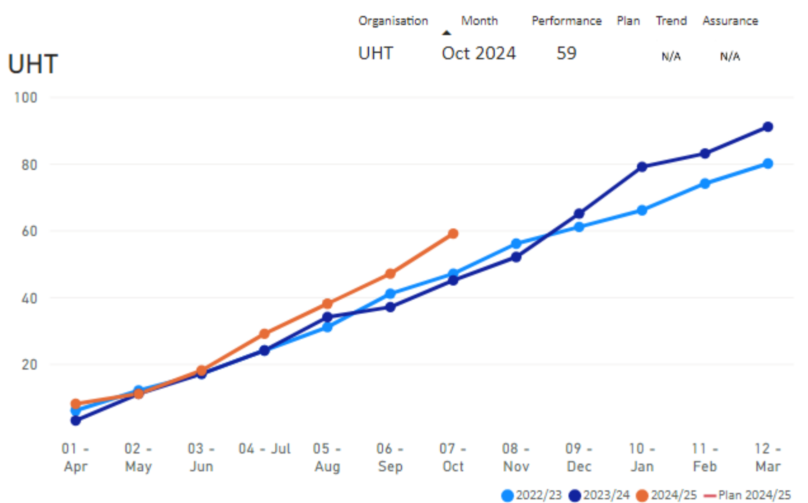
Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Oct 2024	39	35	N/A	N/A

STHFT



Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Oct 2024	59		N/A	N/A

UHT

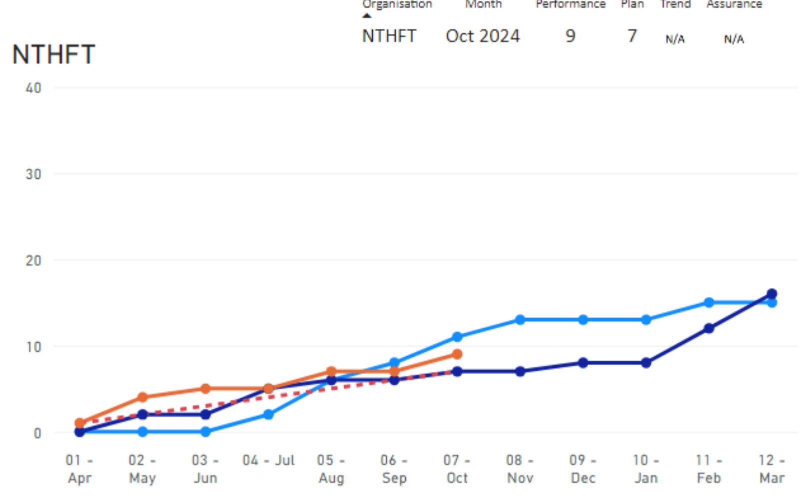


Metric: Healthcare associated cases of *Klebsiella* infection, cumulative annually from April.
Plan: NHS standard contract trajectory: at least 1 case fewer than 23/24 outturn.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: Number of infections at NTHFT and STHFT slightly raised on previous years, in context of national increase.
Assurance: NTHFT: Alert; STHFT: Advise.
Action taken: Regional review underway with input from NTHFT and STHFT.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

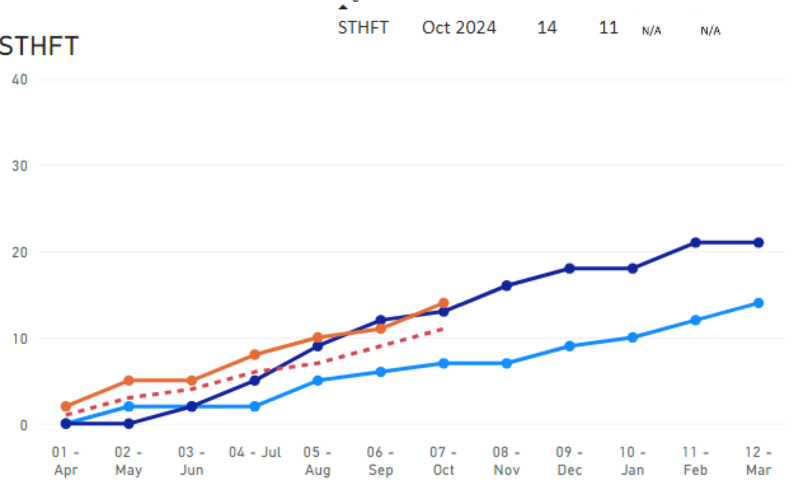
Caring Better Together

SAFE Pseudomonas (YTD)

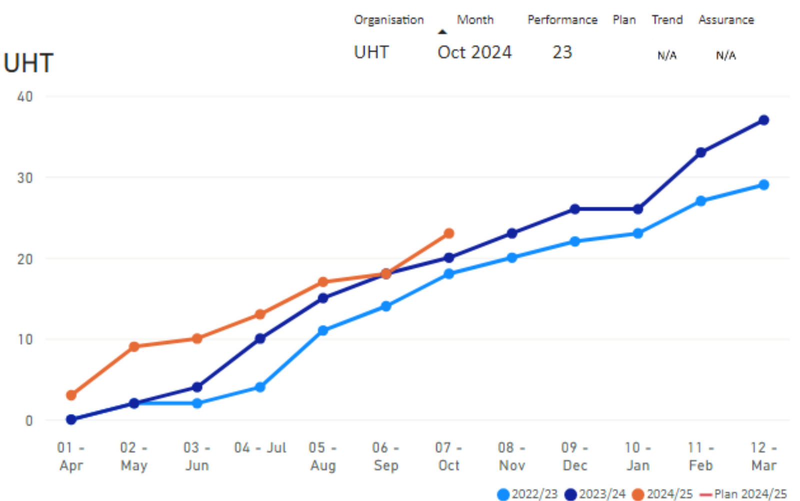
Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Oct 2024	9	7	N/A	N/A



Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Oct 2024	14	11	N/A	N/A



Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Oct 2024	23		N/A	N/A



Metric: Healthcare associated cases of *Pseudomonas* infection, cumulative annually from April.
Plan: NHS standard contract trajectory: at least 1 case fewer than 23/24 outturn.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: Number of infections at NTHFT below 23/24, STHFT in line with 24/25.
Assurance: Advise: Both Trusts not meeting plan.
Action taken: NTHFT removal of water coolers in augmented care in line with HTM. STHFT acquired Aseptic Non-Touch Technique e-learning to support.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

SAFE MATERNITY SUMMARY

Executive lead: Dr Hilary Lloyd, Chief Nursing Officer Accountable to: Quality Assurance Committee

Maternity services metrics for the IPR are being reviewed to ensure that the most relevant metrics to inform the Board of safe and effective care are included, as an overview of the regular in-depth reporting by maternity services through Quality Assurance Committee and the Local Maternity and Neonatal System Board.

Trends in maternity services metrics reflect the different case mix at the two Trusts, with a greater proportion and the more complex of the high-risk pregnancies, being cared for at the James Cook University Hospital, which impacts on metrics such as the number of still births, which have been higher at STHFT this year to date.This is being reviewed in relation to longer-term time series validated data. Breastfeeding rates are a focus, with actions in place at NTHFT to support and promote breastfeeding. Both Trusts participate in simulation exercises, care bundles and research studies to identify where clinical care can be further improved.

NTHFT

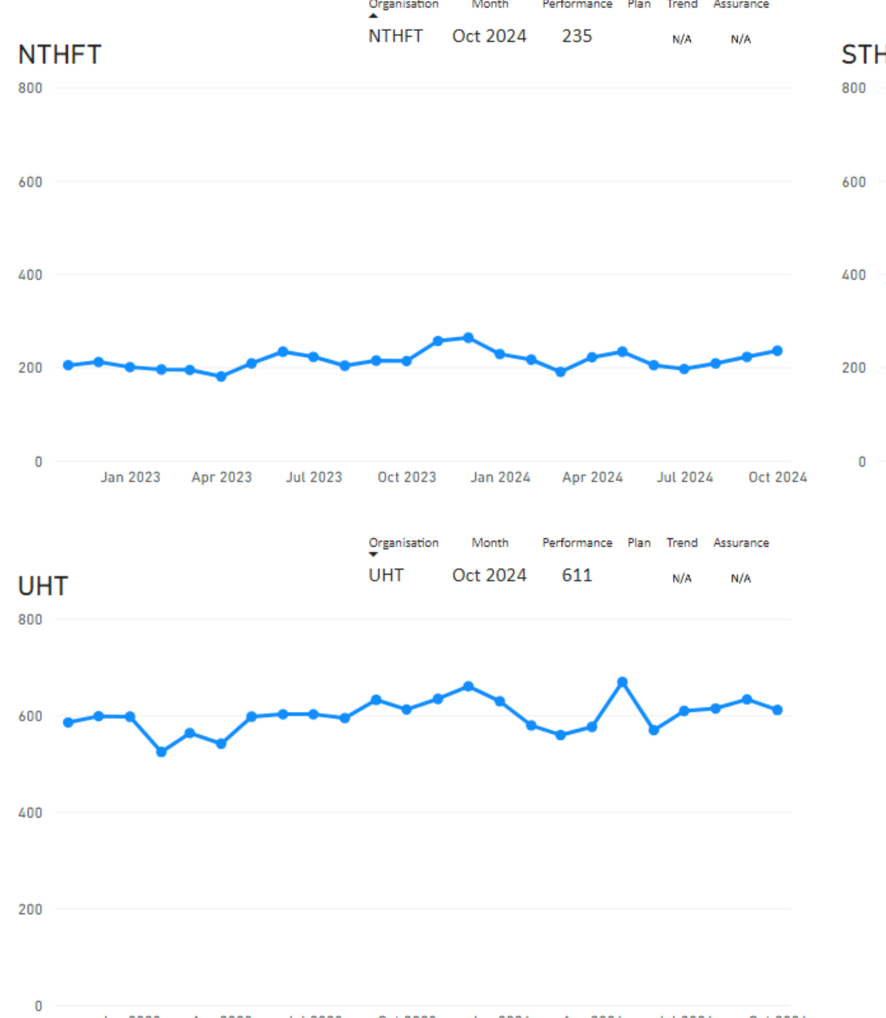
Metric	Month Target	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024
No. of babies born		256	263	228	216	190	221	233	204	196	208	222	235
Still Births	0	0	1	0	0	0	0	1	1	0	1	0	2
Induction of Labour (%)		38.5%	41.4%	41.7%	46.8%	45.3%	43.4%	46.4%	44.6%	43.4%	44.7%	44.7%	44.7%
Breast Feeding at First Feed	75%	40.6%	43%	43.9%	44.9%	46.3%	50.2%	45.1%	54.4%	56.1%	50%	50%	48.1%
PPH > 1500ml (%)	3.3%	3.77%	2.66%	4.39%	1.85%	1.05%	2.71%	1.29%	3.43%	3.06%	2.4%	2.76%	2.55%
Number of 3rd/4th degree tear (%)		2.1%	0.4%	2.6%	0.5%	1.6%	1.8%	0.4%	0.5%	0.5%	0%	2.3%	1.3%

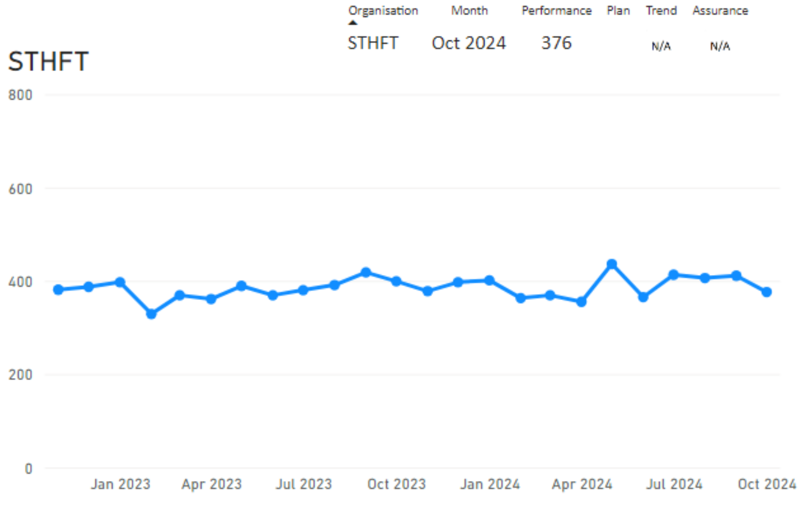
STHFT

Metric	Month Target	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024
No. of babies born		378	397	401	363	369	355	436	365	413	406	411	376
Still Births		0	0	3	1	5	1	3	3	0	4	1	2
Induction of Labour (%)		43.5%	37.4%	39.9%	40.2%	37.6%	40.1%	38%	37.6%	36.6%	35.8%	37.7%	37.7%
Breast Feeding at First Feed	74.5%	58.2%	61%	60.8%	61.2%	60.4%	65.6%	63.8%	63.8%	67.1%	65.8%	64.7%	63.3%
PPH > 1500ml (%)	2%	3.07%	1.96%	3.41%	3.75%	3.16%	3.02%	2.68%	3.17%	3.35%	2.39%	2.61%	4.16%
Number of 3rd/4th degree tear (%)	3.5%	1.8%	1.2%	1.2%	1.1%	1.6%	1.6%	0.9%	1.6%	1.2%	1.7%	0.9%	1.3%

Caring Better Together

No. of babies born

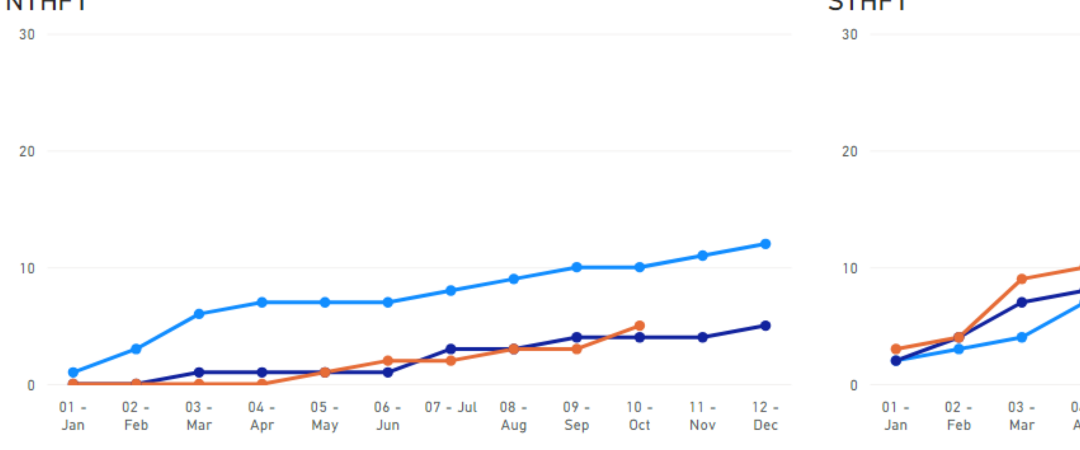


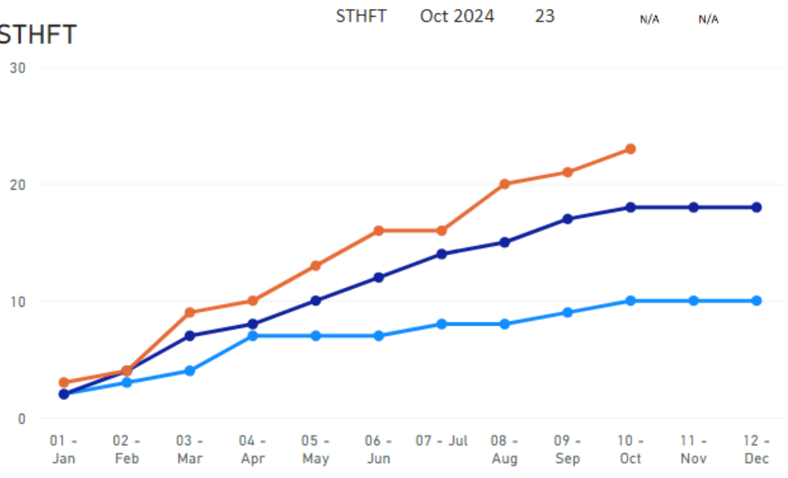


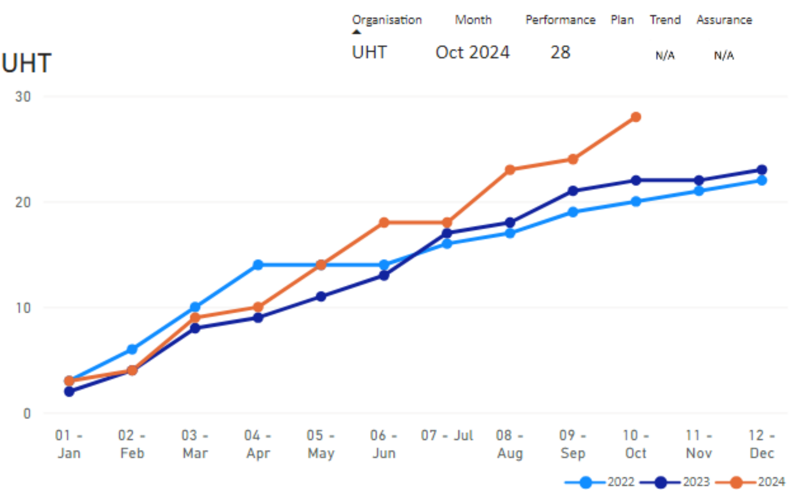
Metric: Count of babies born under care of each Trust.
Plan: n/a
Rationale: Context for maternity metrics.
Data quality: Assured, validated data.
Trend: Number of births at NTHFT and STHFT is stable over 2-year timeframe.
Assurance: n/a
Action taken: n/a
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

SAFE Still Births (YTD)



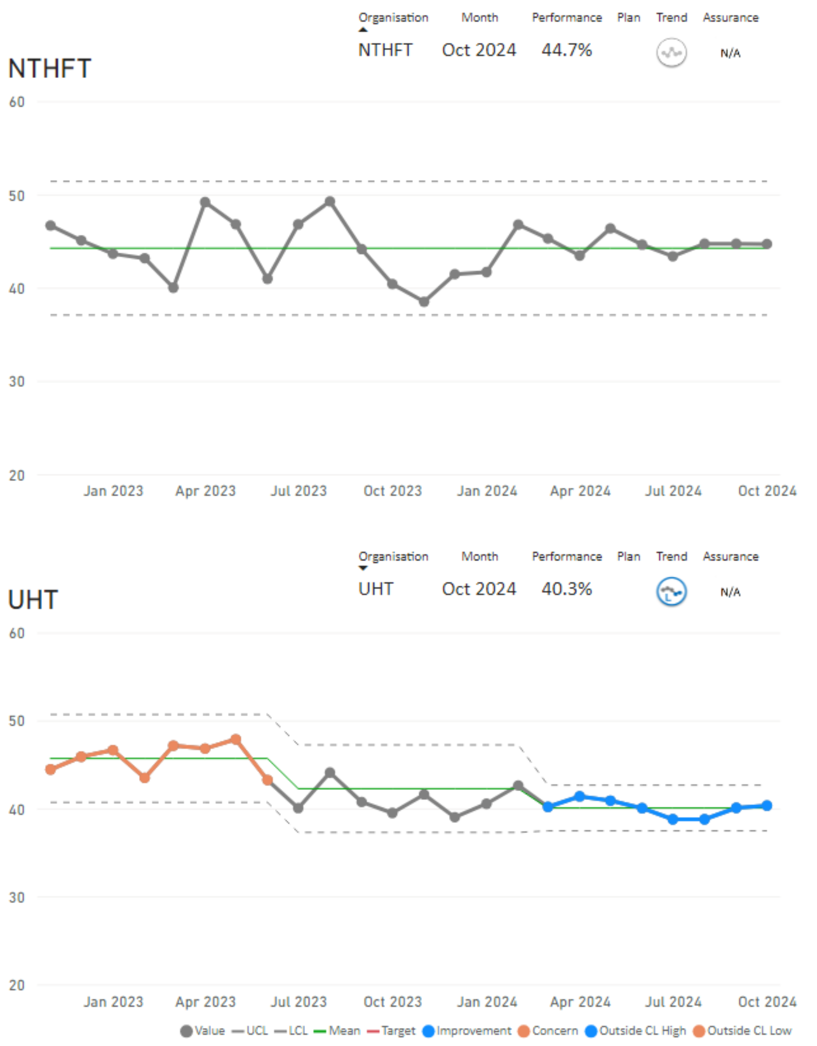


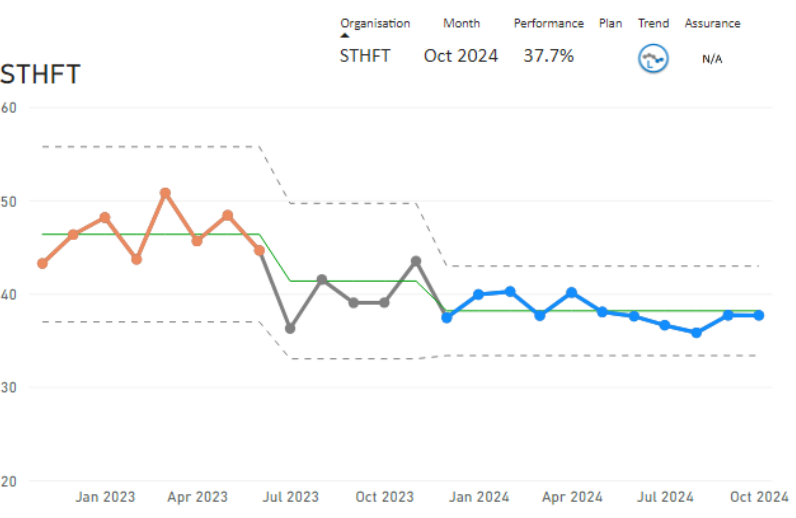


Metric: Count of still births under care of each Trust (deaths from 24 weeks gestation).
Plan: National ambition to reduce stillbirths by 50% by 2025
Rationale: National Maternity Indicator.
Data quality: Assured, validated data.
Trend: Number of still births at STHFT is higher than in previous two years.
Assurance: Alert: increased still births at STHFT this year.
Action taken: Recent rise in still births under review and monitored by clinical team. Perinatal losses are reported via the Perinatal Mortality Review Tool and all cases are reviewed in full by an MDT team.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

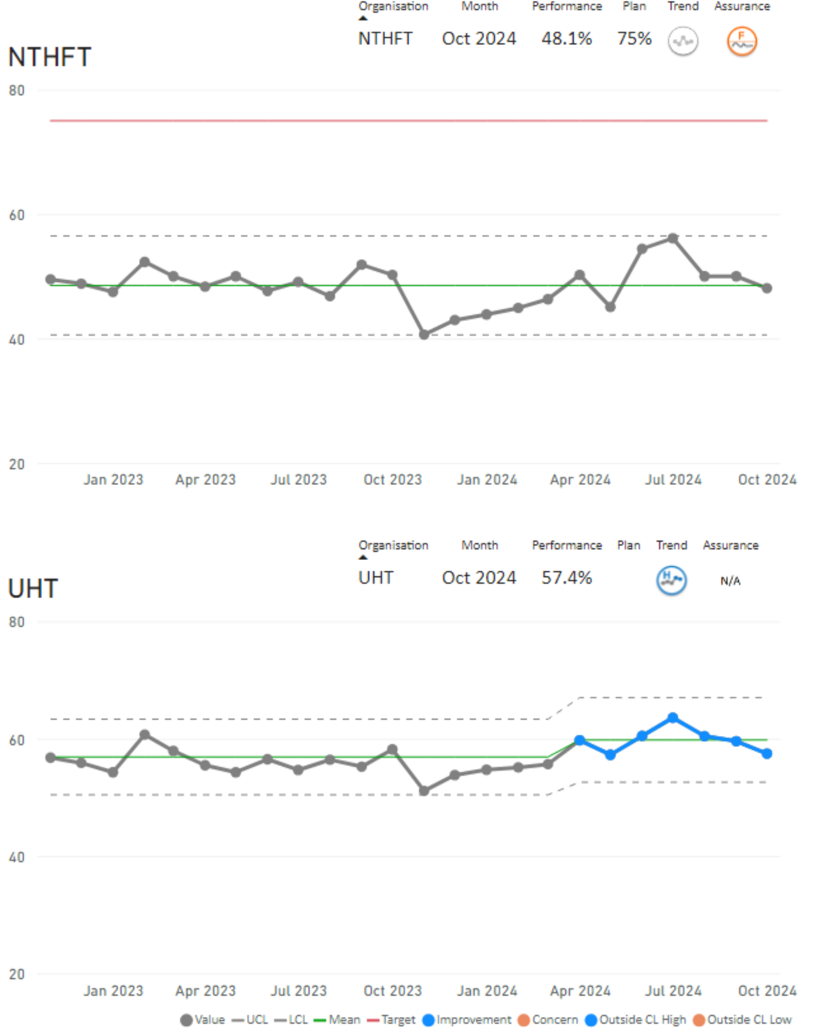
Induction of Labour (%)

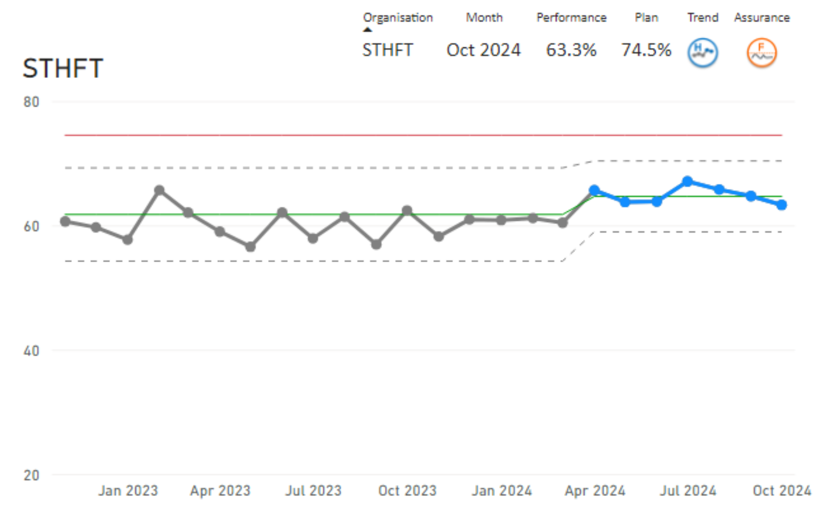




Metric: Percentage of births with induction of labour.
Plan: n/a
Rationale: Saving Babies Lives care bundle.
Data quality: Assured, validated data.
Trend: NTHFT remains at a consistent rate. Induction of labour rate at STHFT has significantly reduced since December 2023.
Assurance: n/a
Action taken: n/a
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Breast Feeding at First Feed

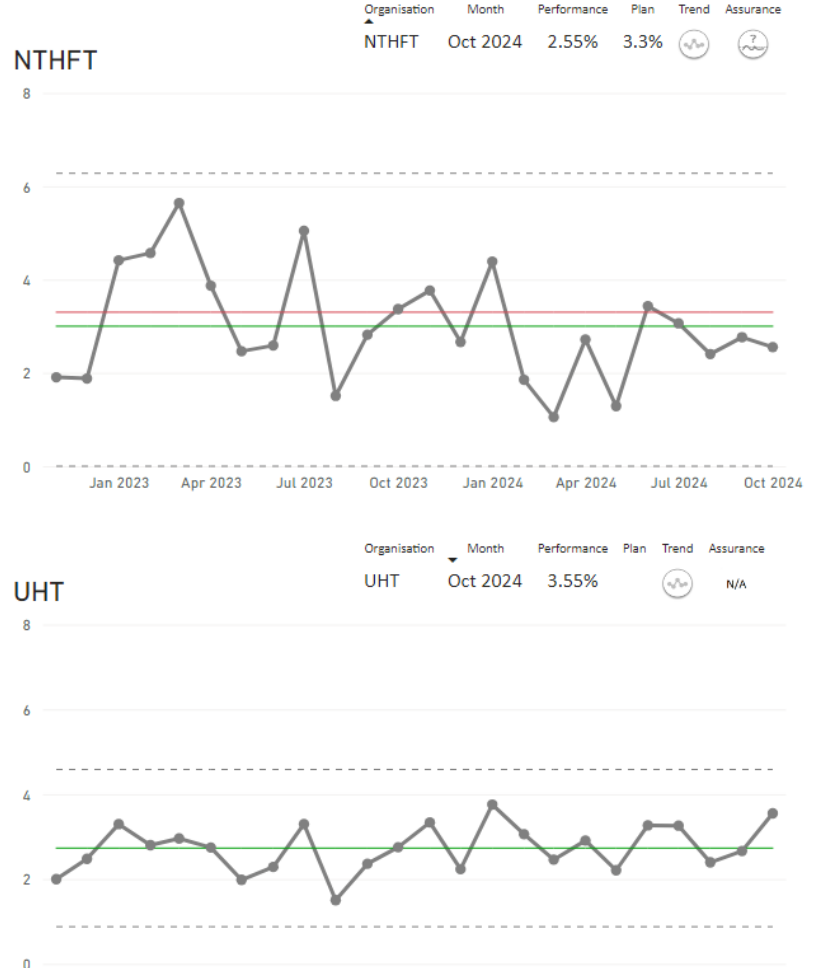


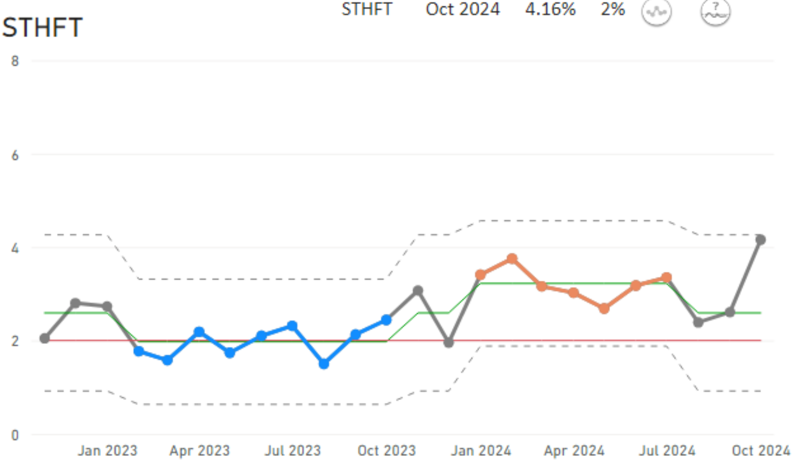


Metric: Percentage of births where breastfeeding is initiated, reported at first feed.
Plan: Local plan 75% (benchmarked to regional average
Rationale: UNICEF Baby Friendly breast-feeding initiative; national maternity dashboard Clinical Quality Improvement Metric (CQIM)
Data quality: Assured, validated data.
Trend: No recent change at NTHFT. Significant improvement in rates at STHFT since November 2023.
Assurance: NTHFT Alert: no improvement. STHFT Advise: recent improvement but consistently below plan.
Action taken: At NTHFT a different staffing model is being explored to support infant feeding and, as a result of a focused project, 80% of preterm newborns have received expressed breast milk within 6 hours.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

PPH > 1500ml (%)

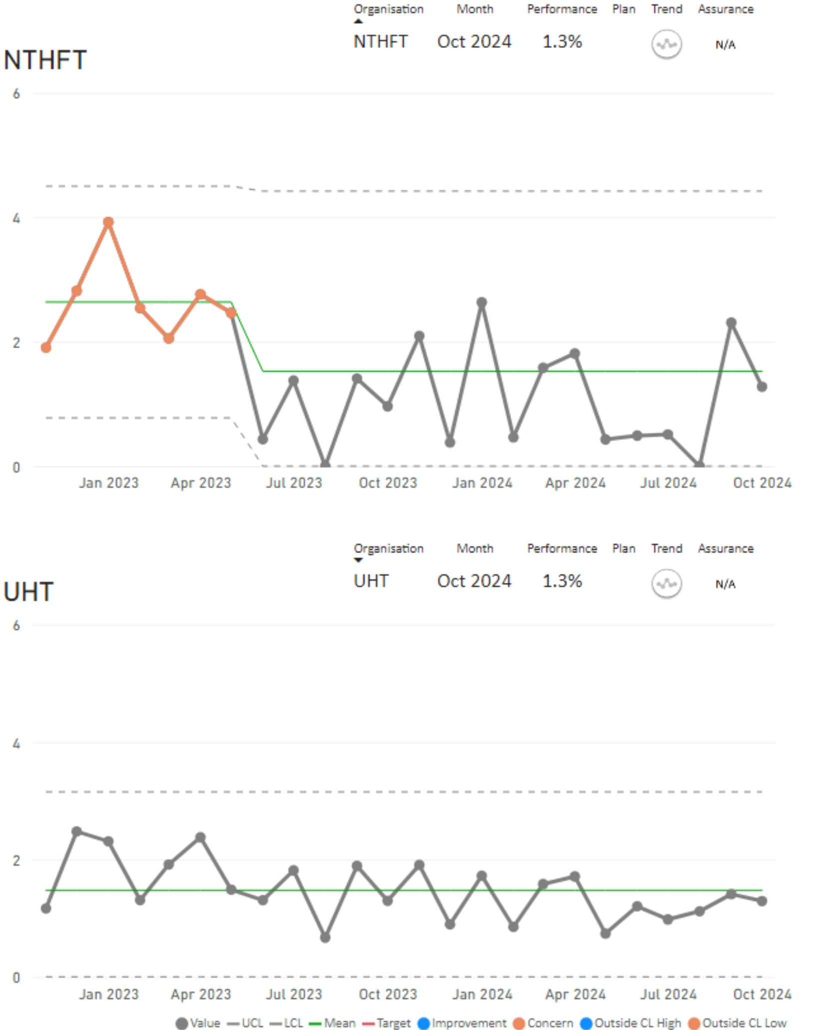


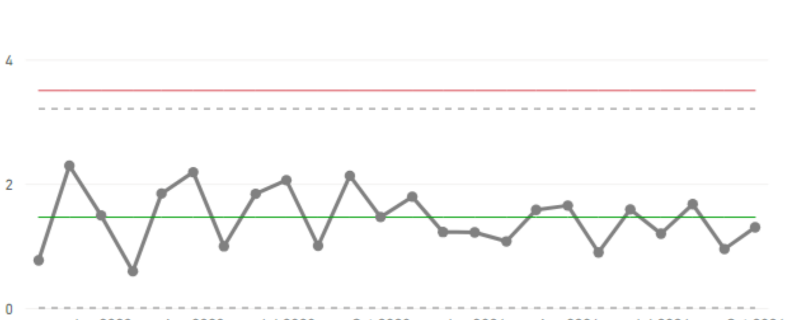


Metric: Percentage of births with post-partum haemorrhage (PPH) greater than 1500ml.
Plan: Local plans, previous national standard 3.3%.
Rationale: National Maternity Indicator and Clinical Quality Improvement Metric.
Data quality: Assured, validated data.
Trend: Decrease in rates at NTHFT with a positive performance over the last 4 months. PPH rates at STHFT have increased since September 2023. Obs Uk care bundle implementation and study underway.
Assurance: Advise: Rates do not consistently achieve local plans.
Action taken: Both NTHFT and STHFT are now part of a research study to look at interventions to reduce PPH.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

SAFE — Number of 3rd/4th degree tear (%)





Metric: Percentage of births with 3rd/4th degree maternal tear.
Plan: Local plans.
Rationale: National Maternity Indicator.
Data quality: Assured, validated data.
Trend: No change.
Assurance: Assure: rates at STHFT are consistently below plan, and similar rates at NTH.
Action taken: Royal College of Obstetricians & Gynaecologists care bundle (OASI) continues at both NTHFT and STHFT.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

EFFECTIVE DOMAIN SUMMARY

Executive lead: Dr Michael Stewart, Chief Medical Officer   Accountable to: Quality Assurance Committee

Summary Hospital-level Mortality Indicator (SHMI) is ‘as expected’ for both Trusts. Assurance continues to require non-statistical approaches. At STHFT, since the Medical Examiner Service became statutory on 9 September 2024, its information is no longer available to the Trust, but they continue to review >98% of deaths and refer relevant cases to the Trust Mortality Surveillance team for further review/investigation/action where required. SHMI is influenced by the depth of co-morbidity coding: coding of co-morbidities is a theme in the STHFT coding action plan, as benchmarking identifies this as an area for further improvement. Learning across the Group contributes to this as NTHFT benchmark well.

Readmission audits are regularly undertaken at NTHFT to identify any changes needed in clinical pathways to reduce avoidable readmissions.

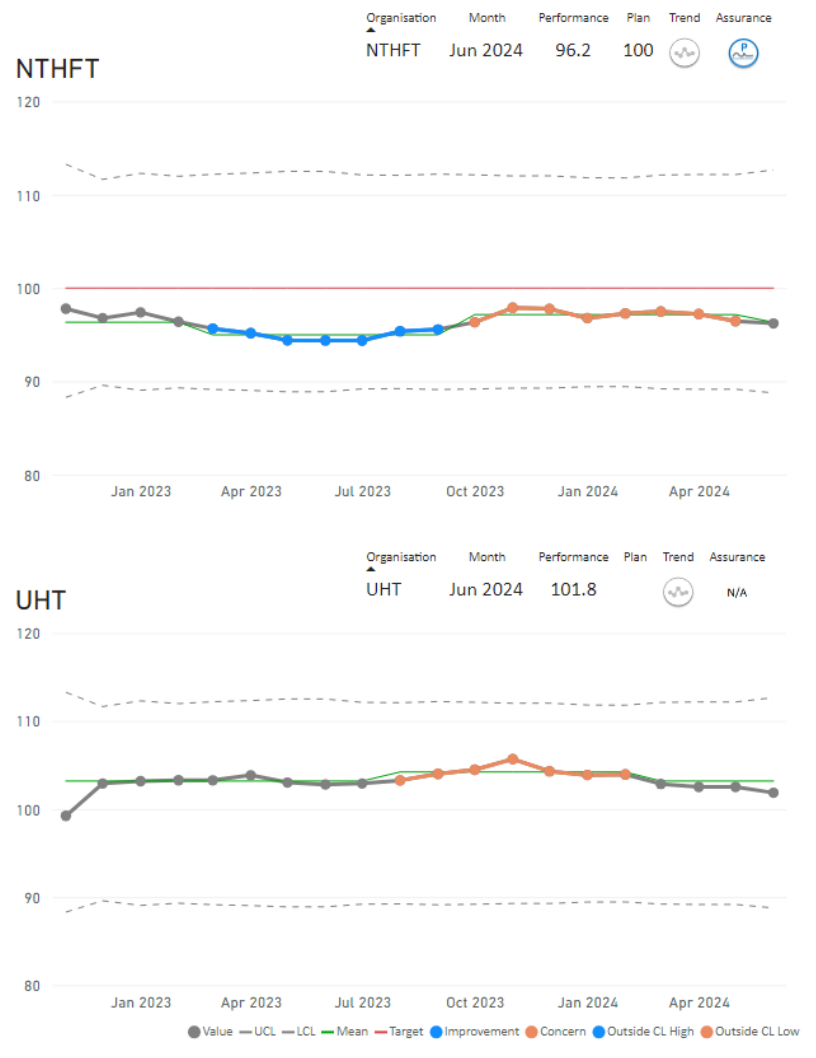
NTHFT

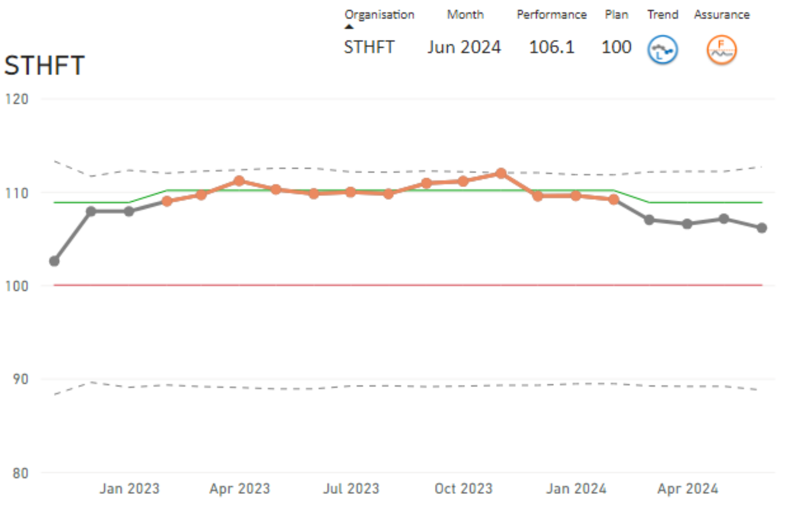
Metric	Month Target	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024
Summary Hospital-Level Mortality Indicator	100	97.9	97.8	96.8	97.3	97.5	97.2	96.5	96.2			
Readmission Rate (%)	7.7%	8.9%	9.4%	9.7%	9.4%	10.1%	9.4%	9.6%	10.1%	9%	9.1%	8.9%

STHFT

Metric	Month Target	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024
Summary Hospital-Level Mortality Indicator	100	112	109.5	109.6	109.2	107	106.6	107.1	106.1			
Readmission Rate (%)		6.4%	6.6%	6%	6.3%	6.7%	6.1%	6%	6.7%	6.7%	6.3%	6.4%

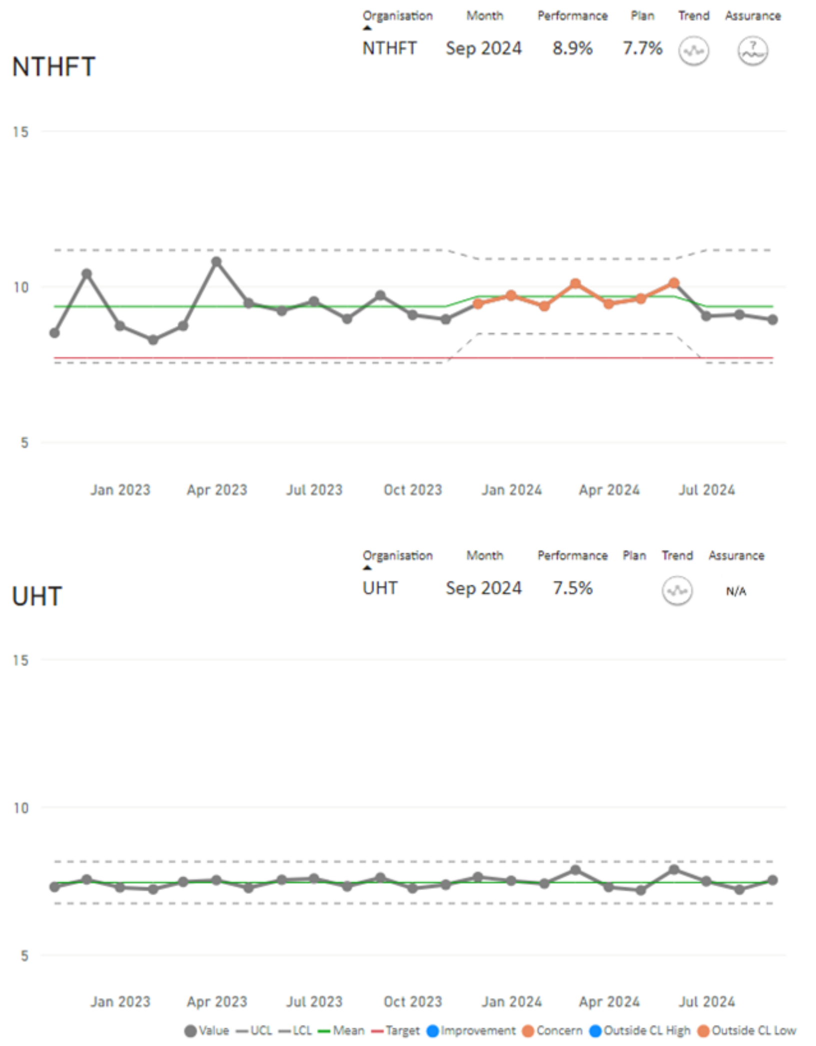
EFFECTIVE Summary Hospital-Level Mortality Indicator

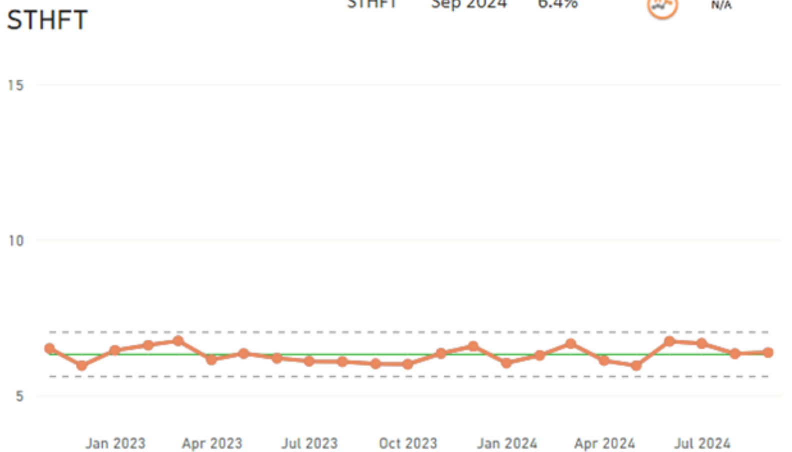




Metric: Summary hospital-level mortality indicator (SHMI). SHMI is calculated for rolling 12-months, published 4-months in arrears.
Plan: Standardised to 100.
Rationale: Quality Accounts regulatory indicator.
Data quality: Assured, validated data.
Trend: No change at NTHFT, continued improvement at STHFT, expected to continue to improve.
Assurance: NTHFT: Assure. Consistently below (better than) the national benchmark. STHFT: Advise. Above the national benchmark but within the expected variation, with exception of one period impacted by data quality.
Action taken: n/a
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee

Readmission Rate (%)





Metric: Percentage of patients readmitted within 30 days.
Plan: NTHFT internal plan.
Rationale: NHS Contract metric.
Data quality: Advise: further work to be done to align metric criteria to NHSE metrics. A month in arrears to enable the data to be fully coded.
Trend: Readmission rates at both Trusts are higher than previous levels.
Assurance: Advise. Rates at NTHFT are above plan.
Action taken: Monthly audits continue at NTHFT to determine avoidable/unavoidable readmissions with lessons learnt informing pathway improvements.
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee

Caring
Better
Together

RESPONSIVE DOMAIN SUMMARY

Executive lead: Neil Atkinson, Managing Director **Accountable to: Resources Committee**

Urgent and emergency care

For STHFT, improvement in emergency care metrics has been driven by the co-located Urgent Treatment Centre at James Cook Hospital A&E, closer working across the group and service improvement in collaboration with NEAS. However October was a very challenging month for performance. NTHFT supported neighbouring Trusts with diverts and mutual aid in periods of surge, which can be extremely challenging to facilitate due to significant increase in UEC attendances. During the month corridor care has been in place to support timely release of ambulance crews.

Above-standard performance in the community urgent 2-hour response reflects effective support to EDs by caring for patients in the most appropriate setting. Elective operations cancelled on the day not rebooked within 28 days requires improvement at STHFT with performance and actions now being monitored at the Surgical Improvement Group.

NTHFT

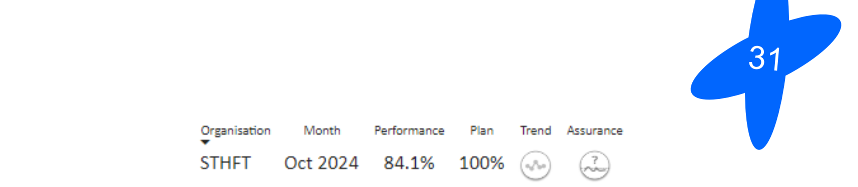
Metric	Month Target	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024
Handovers - Within 60 Mins (%)	100%	93.5%	90.1%	92.1%	96.5%	98.6%	100%	98.1%	100%	100%	100%	99.8%	99.7%
4-Hour A&E Standard	88.8%	84.4%	83%	84.2%	85.5%	87.1%	88.7%	87.2%	89.9%	87.3%	89.4%	85.6%	83.8%
12-Hour A&E Breaches Rate	2%	0.4%	1.3%	1.3%	0.8%	0.1%	0.2%	0.2%	0%	0.2%	0.1%	0.4%	0.6%
Community UCR 2hr Response Rate (%)	70%	76%	76%	77%	79%	79%	84%	84%	82%	71%	75%	76%	
Cancelled Ops - Not Rebooked Within 28 days	0	5	6	9	9	4	2	1	3	2	2	2	2

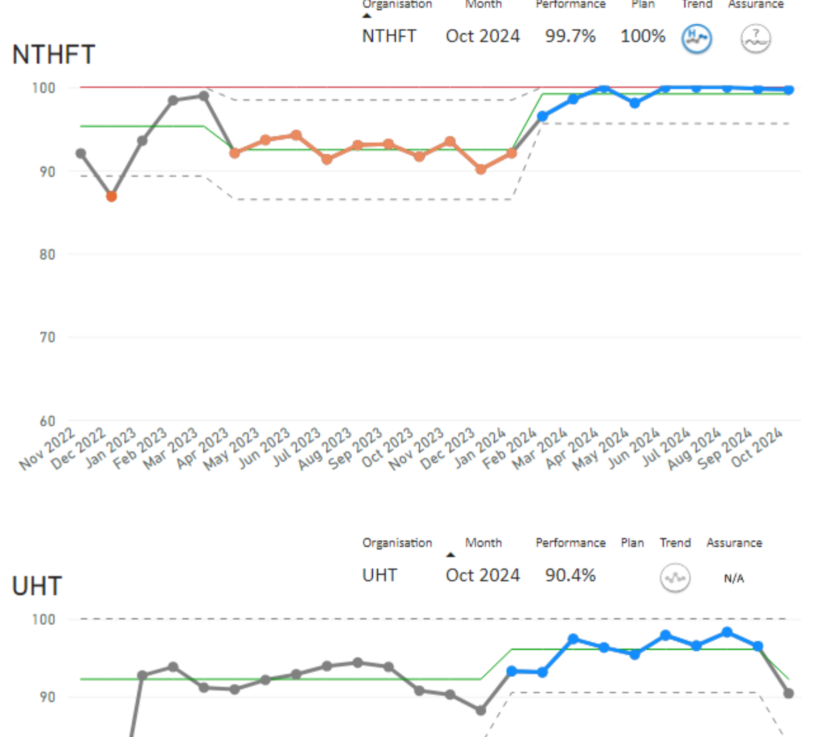
STHFT

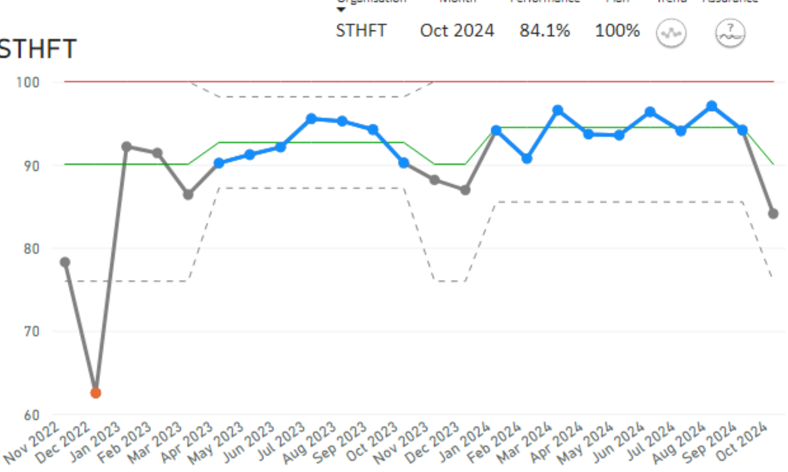
Metric	Month Target	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024
Handovers - Within 60 Mins (%)	100%	88.2%	86.9%	94.1%	90.7%	96.6%	93.7%	93.5%	96.3%	94.1%	97.1%	94.2%	84.1%
4-Hour A&E Standard	73.8%	66%	66.9%	68.1%	67.8%	69.7%	75.6%	73.5%	74.3%	76.9%	78.7%	77.3%	73.5%
12-Hour A&E Breaches Rate	2%	2.8%	2.7%	1.9%	3%	1.7%	2%	1.9%	1.7%	1%	0.7%	1%	3.6%
Community UCR 2hr Response Rate (%)	70%	87%	86%	88%	86%	88%	89%	87%	86%	87%	89%	83%	
Cancelled Ops - Not Rebooked Within 28 days	0	9	27	29	22	22	26	27	16	13	15	13	21

Caring Better Together

Handovers - Within 60 Mins (%)



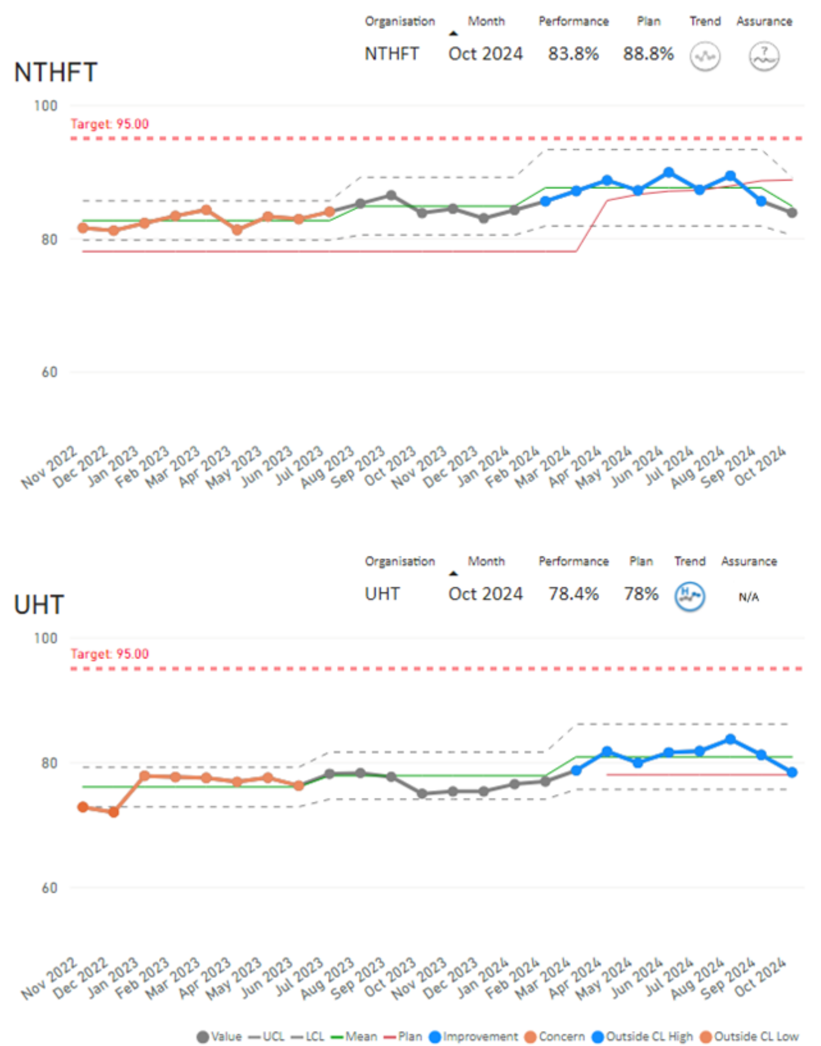


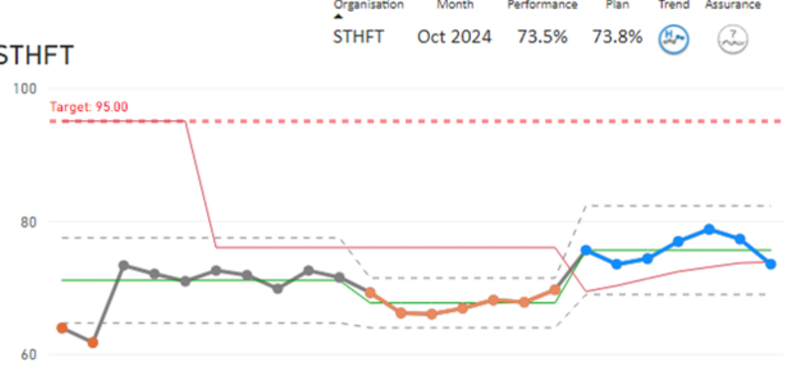


Metric: Percentage of ambulance handovers completed within 60 minutes of arrival at ED.
Plan: 100% within 60 minutes.
Rationale: NHS Contract metric.
Data quality: Advisory: validated data from Trust systems may differ from published data from ambulance services.
Trend: NTHFT: Improved performance since February 2024. STHFT: point dip in performance in October 2024, with increased attendances and higher acuity.
Assurance: NTHFT: Advise. Improved, standard not assured but met on most days. STHFT: Advise, standard not met.
Action taken: STHFT action plan, single handover process implemented with a view to incorporate additional best practice to reduce delays further. NTHFT have accepted additional demand to support STHFT and other Trusts when demand surges; and focusing on timely release of crews.
Executive lead: Managing Director
Accountable to: Resources Committee

Caring Better Together

RESPONSIVE 4-Hour A&E Standard



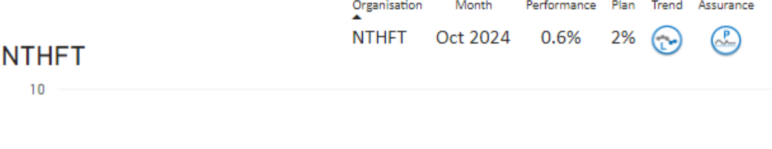


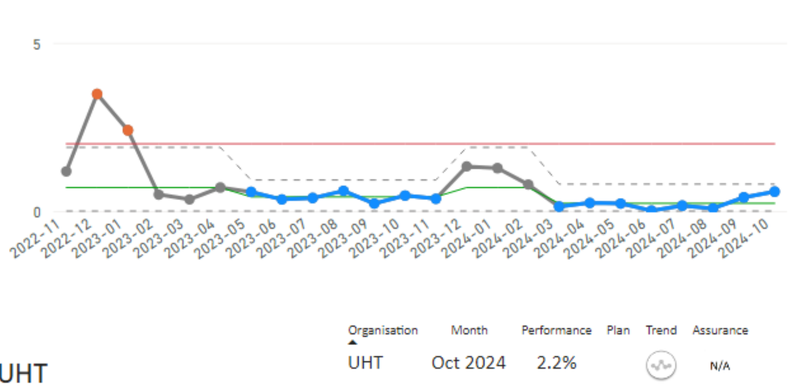
Metric: Percentage of patients admitted, transferred or discharged from A&E (all types) within 4 hours of arrival.
Plan: NHS Constitution standard 95%, operational plan per Trust to achieve 78% STHFT, 90% NTHFT.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: Improved performance at both Trusts since January (NTHFT) and March 2024 (STHFT).
Assurance: Advise: plans are now met in most months.
Action taken: Opening of the JCUH urgent treatment centre April 2024 created step change in performance at STHFT, now further focus on optimising streaming of patients between ED and Urgent Treatment Centre (UTC). NTHFT has been challenged by due to high volume of attendances, increased acuity, increased bed occupancy and discharge challenges due to infection control and community domiciliary care availability. However, the Trust continues to be a positive outlier both Regionally and Nationally.
Executive lead: Managing Director
Accountable to: Resources Committee

Caring Better Together

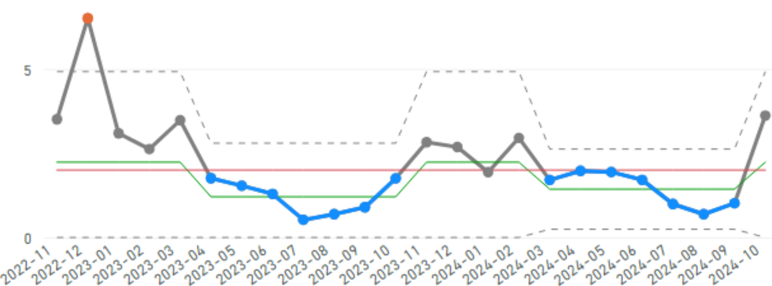
RESPONSIVE 12-Hour A&E Breaches Rate

NTHFT



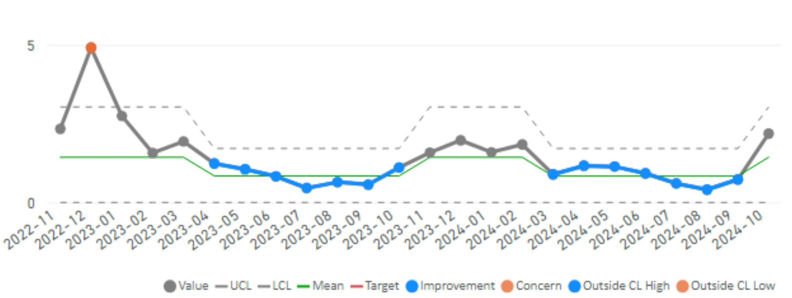


STHFT



UHT

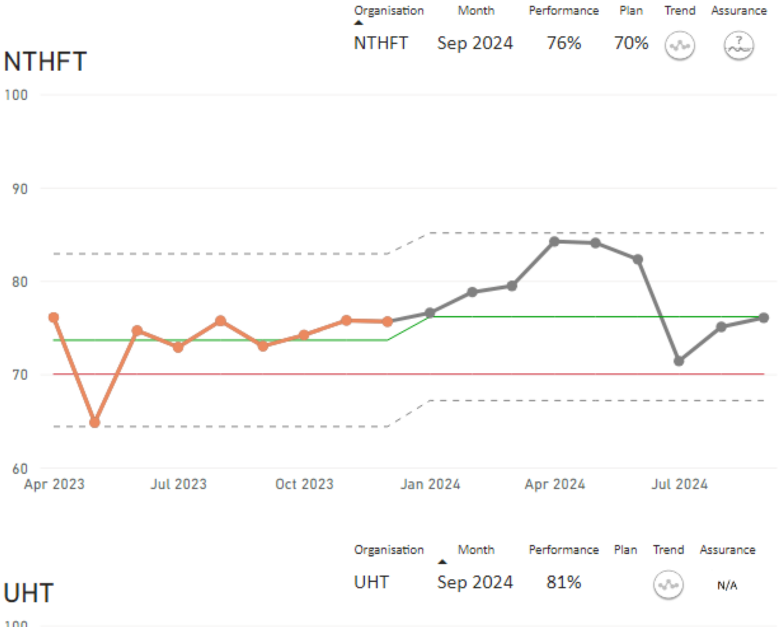
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Oct 2024	2.2%			N/A

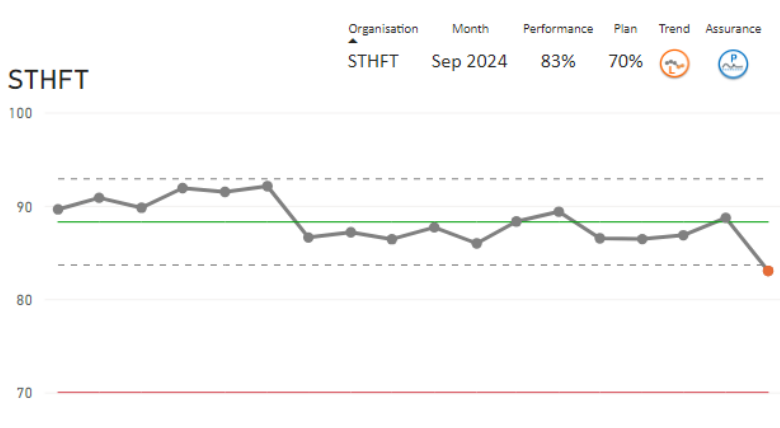


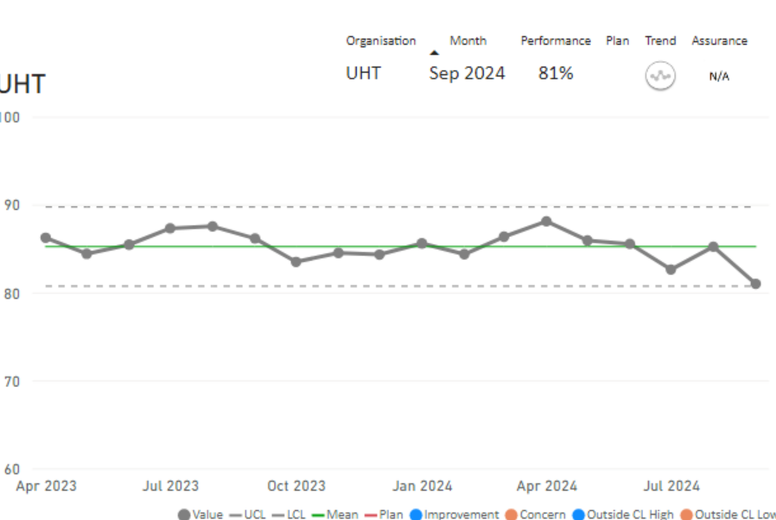
Metric: Percentage of patients admitted or discharged from A&E (all types) after 12 hours.
Plan: NHS Contract standard: No more than 2% of patients attending are in A&E more than 12 hours.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: Seasonal variation; improvement at NTHFT.
Assurance: NTHFT: Assure: Standard is achieved.
STHFT: Advise: poorer performance in October.
Action taken. STHFT focus is on optimal streaming of patients between ED and UTC, direct admissions to SDEC and making full use of UCR services which at times have been at full capacity. NTHFT nurse led pathway now operational. Teams have met to explore how this pathway can be expanded to further support flow.
Executive lead: Managing Director
Accountable to: Resources Committee

Caring Better Together

RESPONSIVE Community UCR 2hr Response Rate (%)



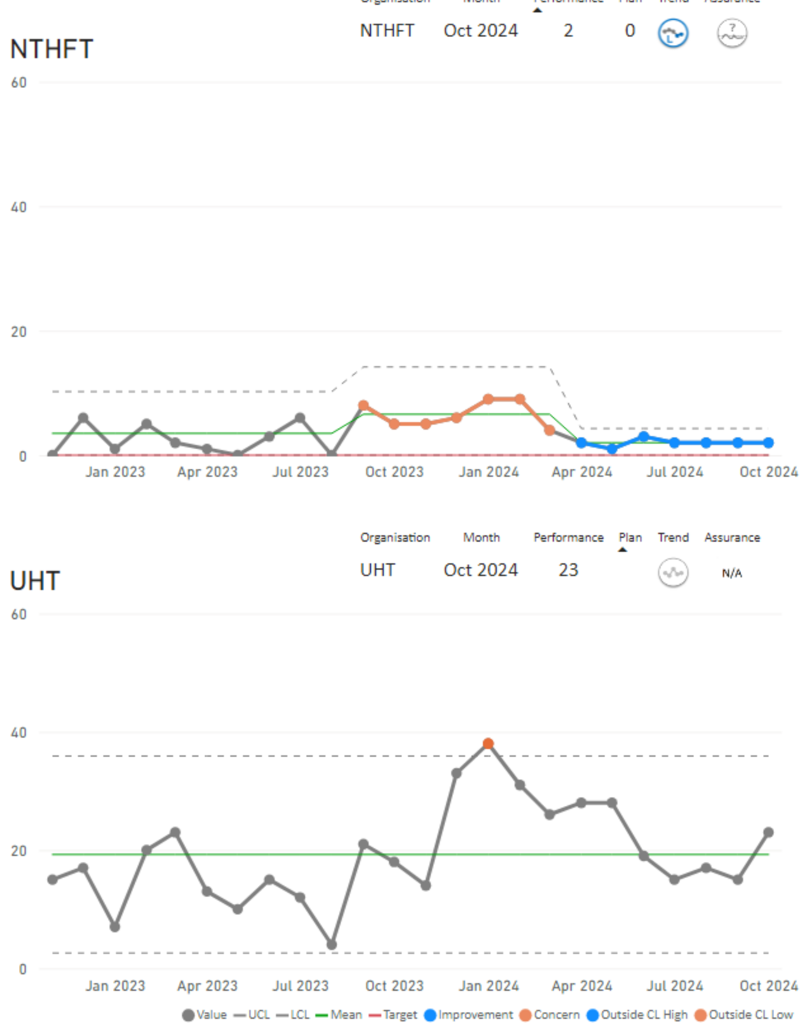


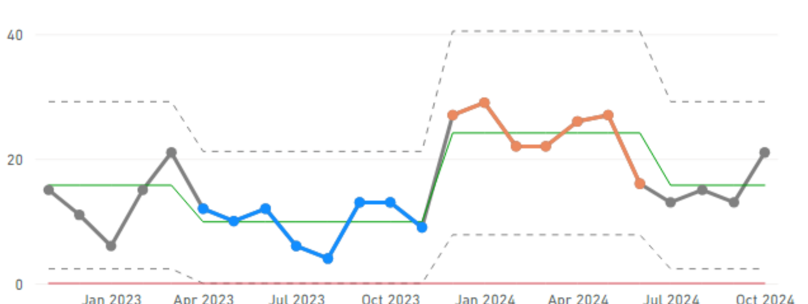


Metric: Urgent community response within 2-hours
Plan: 70%
Rationale: NHS operational planning guidance
Data quality: Advisory, metric calculated from submitted raw community data sets.
Trend: NTHFT: no trend but improved performance since January 2024. STHFT: Stable assured trend exceeding plan. Performance for October 2024 is outside expected variation.
Assurance: NTHFT: Advise. Achievement of plan is not statistically assured due to wide monthly variation but met for almost 2 years. STHFT: Assure. Plan is met.
Action taken: Community rapid response services remain a key element of winter plans. Outlier in STHFT performance for October likely caused by staffing factors.
Executive lead: Managing Director
Accountable to: Resources Committee

Caring Better Together

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: Increased numbers at STHFT, since December 2023. NTHFT rates continue to remain low.
Assurance: NTHFT: Advise. STHFT: Alert.
Action taken: Elective capacity planning through the winter months aims to minimise cancellations. Cancellations not re-booked are to be monitored by the Surgical Improvement Group at STHFT. Audit into avoidable cancellations to inform improvements. NTHFT Daily review of all cancellations is in place and the trust remains focussed and committed to reappointing patients within the timeframe.
Executive lead: Managing Director
Accountable to: Resources Committee

Caring Better Together

DOMAIN SUMMARY

Executive lead: Neil Atkinson, Managing Director | **Accountable to: Resources Committee**

Elective, diagnostic and cancer care

Both Trusts have elevated numbers of patients waiting beyond 52 weeks above their respective plans, more markedly at STHFT. There are potential green shoots of improvement for STHFT with reducing numbers for the last two months. The national priority is to eliminate 65 week waits, which NTHFT achieved at the end of September. Both Trusts are engaged in a range of actions including sharing capacity / mutual aid to improve equity of access and targeted additional clinical activity.

The faster diagnosis standard is met in most months for both Trusts and is critical to improving cancer pathways. Diagnostic improvement workshops with clinical teams developed shared tumour group action plans. Cancer treatment standards at STHFT require improvement, new investment in cancer navigators focuses on reducing delays and changes to the diagnostic phase of the Urology prostate pathway are to be implemented in December 2024.

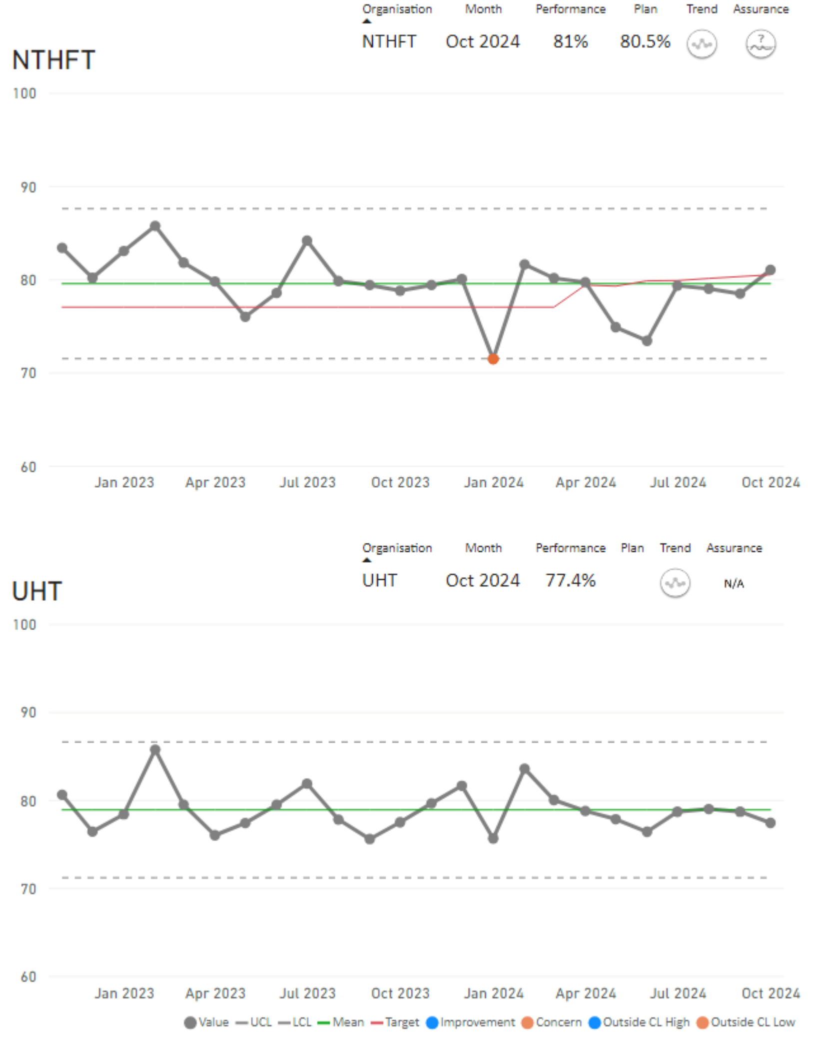
NTHFT

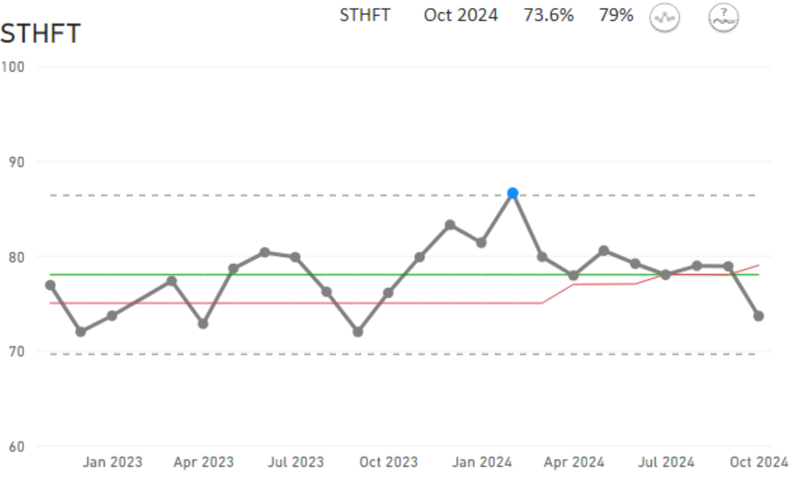
Metric	Month Target	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024
Cancer Faster Diagnosis Standard (%)	80.5%	79.4%	80%	71.4%	81.6%	80.1%	79.7%	74.9%	73.4%	79.3%	79%	78.4%	81%
Cancer 31 Day Standard (%)	96%	96%	97.1%	94.1%	97.6%	94%	97.6%	97.8%	95.8%	96.3%	97.9%	91.8%	94.7%
Cancer 62 Day Standard (%)	71.7%	66%	69.2%	68.7%	64.7%	72%	62.7%	65.1%	59.7%	62.2%	72.7%	60.1%	70.8%
Diagnostic 6 Weeks Standard (%)	95%	86.5%	84%	86.7%	89.9%	84.7%	78.7%	74.5%	69%	72.9%	72.3%	77.7%	82.7%
RTT Incomplete Pathways (%)	92%	73.6%	71.7%	71.1%	71.6%	71.2%	71.8%	72.5%	72.2%	71.7%	71.6%	72.1%	72.4%
RTT 52 week waiters	144	122	159	166	216	218	175	163	159	183	180	173	179

STHFT

Metric	Month Target	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024
Cancer Faster Diagnosis Standard (%)	79%	79.9%	83.3%	81.4%	86.6%	79.9%	77.9%	80.5%	79.2%	78%	78.9%	78.9%	73.6%
Cancer 31 Day Standard (%)	96%	91.6%	92%	87.6%	91%	91.6%	86.4%	91.5%	92.4%	93.1%	92.3%	91.1%	90.5%
Cancer 62 Day Standard (%)	66.1%	63.9%	63.6%	56.8%	55.2%	59.1%	61%	58.7%	59.3%	63.7%	59.2%	61.9%	56.7%
Diagnostic 6 Weeks Standard (%)	95%	79%	77.1%	83.1%	84.1%	80.4%	81.7%	81.6%	80.9%	83.2%	82.3%	84.9%	85.9%
RTT Incomplete Pathways (%)	92%	64%	63%	63.3%	63%	61.5%	62.7%	61.6%	60.7%	60.3%	58.9%	59.1%	60.2%
RTT 52 week waiters	1017	1551	1201	1270	1432	1483	1498	1863	2099	2106	2216	1848	1524

RESPONSIVE Cancer Faster Diagnosis Standard (%)

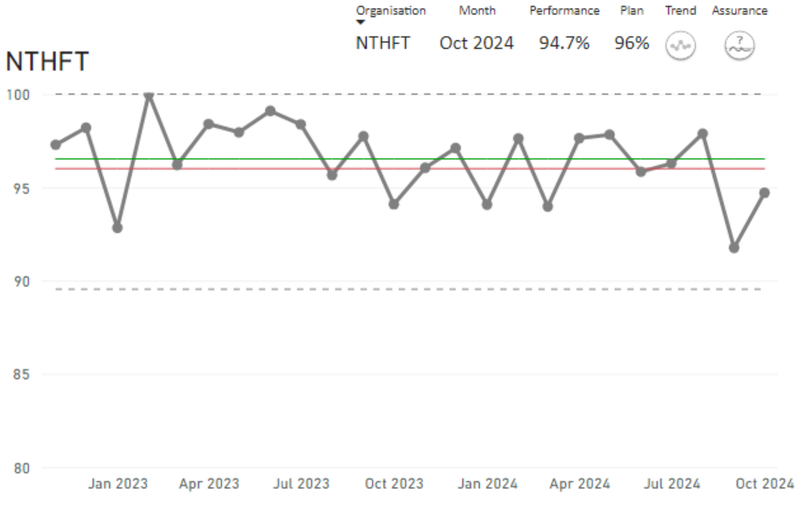


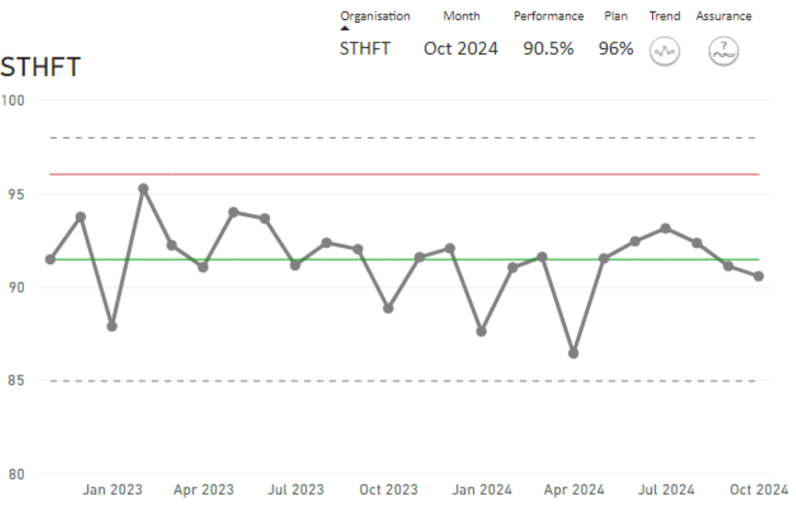


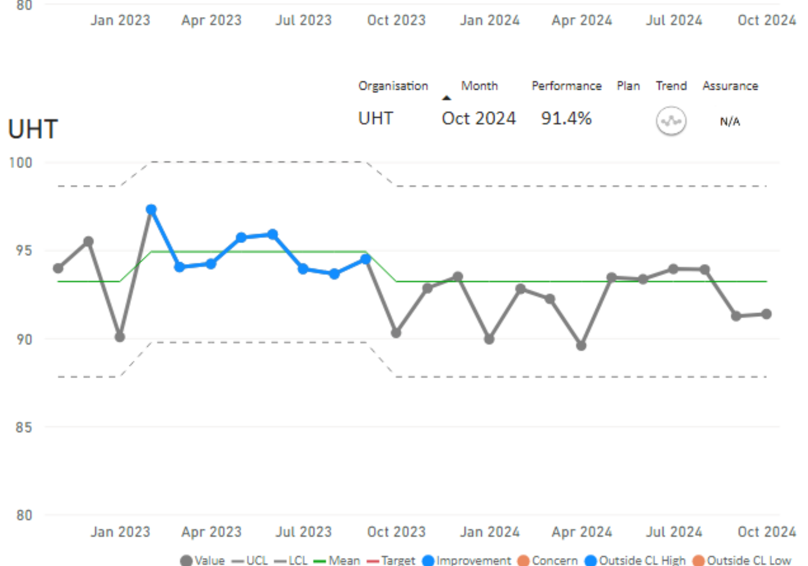
Metric: Percentage of patients on a cancer pathway who receive diagnosis or rule-out within 28 days from referral.
Plan: NHS Constitution standard 77%. Local operational planning trajectories: 80% by end March 2025.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: Advise. Plans are not met consistently.
Action taken: STHFT focus is on further improving compliance in urology and gastro-intestinal tumour groups.
Executive lead: Managing Director
Accountable to: Resources Committee

Caring Better Together

RESPONSIVE **Cancer 31 Day Standard (%)**



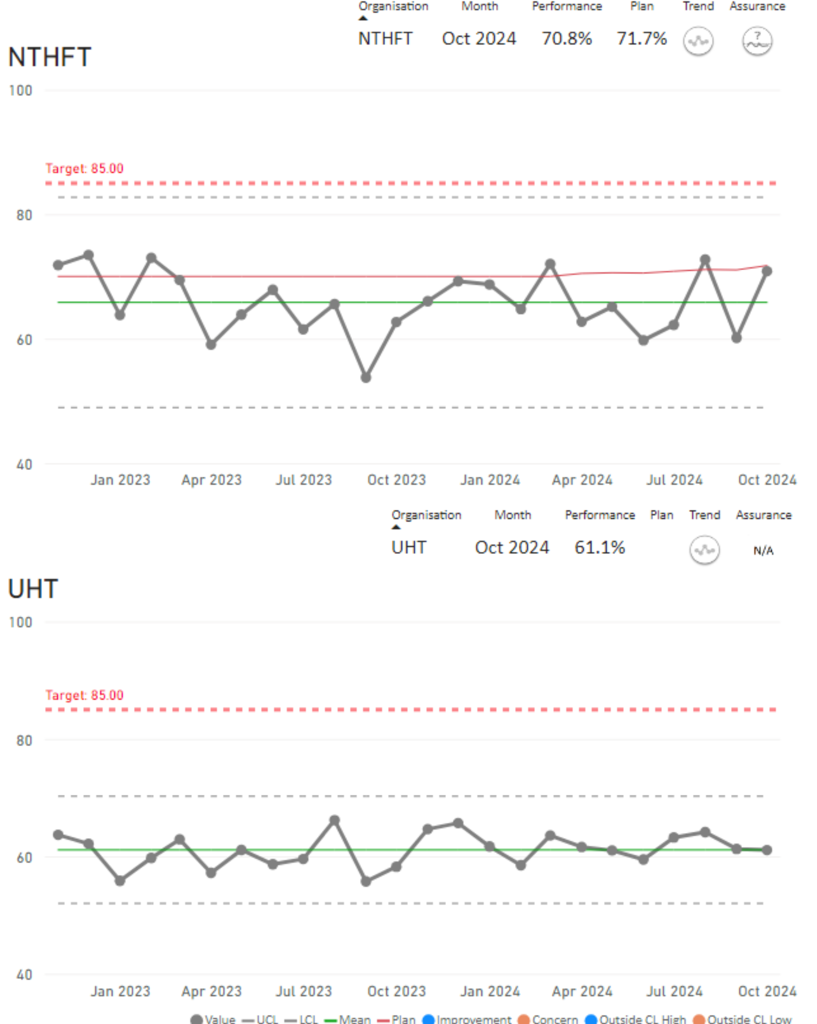


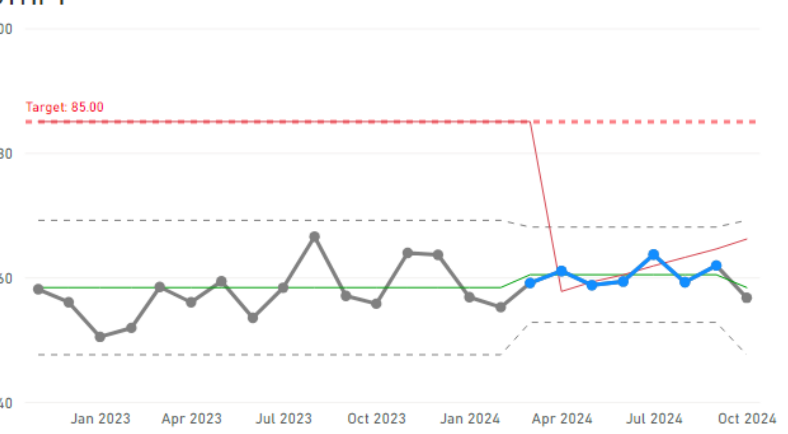


Metric: Percentage of patients on a cancer pathway who start treatment within 31 days of decision to treat.
Plan: NHS Constitution standard 96%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: NTHFT: Advise: standard is not consistently met; STHFT: Advise: standard is not met but within the range of variation.
Action taken: STHFT focus is the patients waiting longest for treatment (overall pathway time).
Executive lead: Managing Director
Accountable to: Resources Committee

Caring Better Together

RESPONSIVE **Cancer 62 Day Standard (%)**

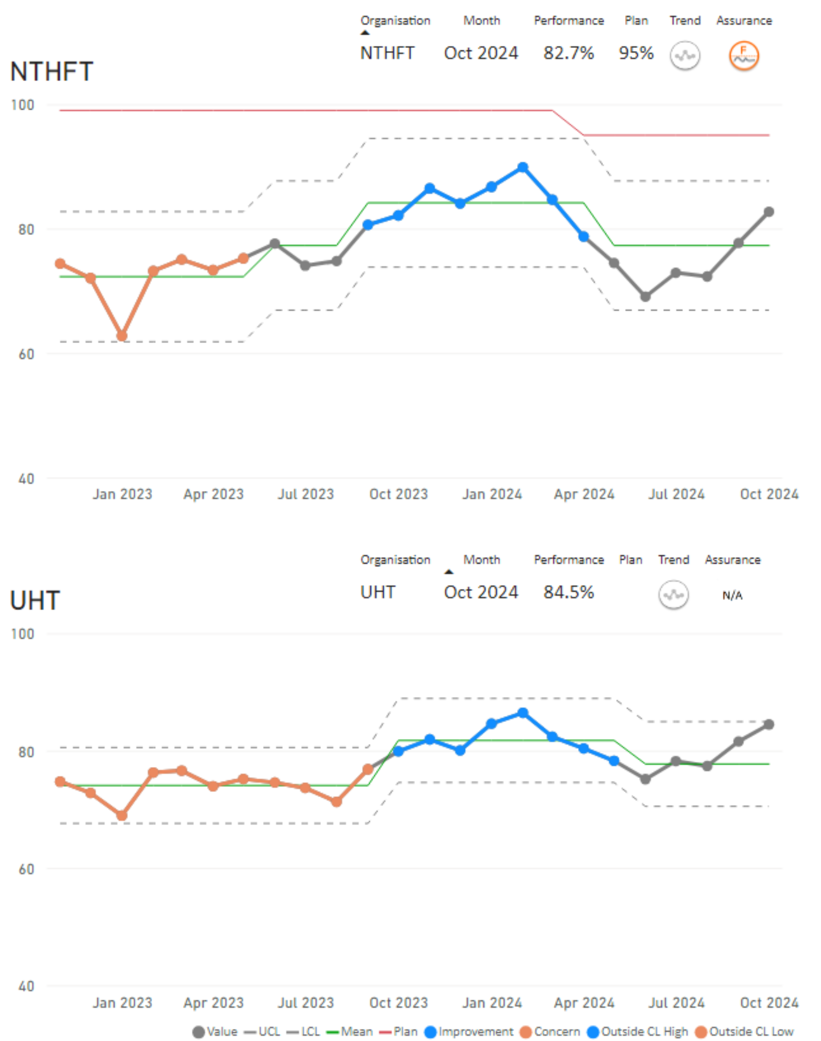


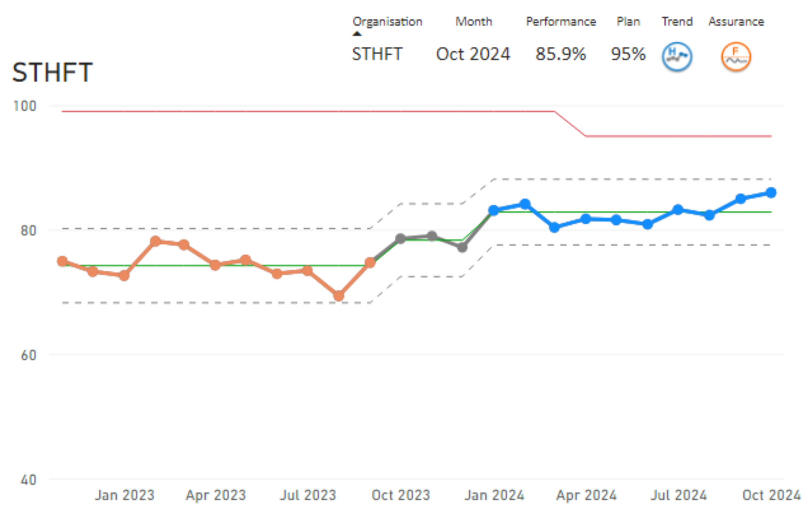


Metric: Percentage of patients on a cancer pathway who start treatment within 62 days of referral.
Plan: NHS Constitution standard 85%. Local operational planning trajectories: NTHFT 72.6% by end March 2025. STHFT 70% by end March 2025.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: NTHFT: Advise: plan is inconsistently met. STHFT Advise: plan is not met but within variation limits.
Action taken: Focus for both Trusts is the patients waiting longest for treatment, this brings patients beyond 62-days into the metric, reducing performance reported. Service improvement work across the Group is underway across tumour groups.
Executive lead: Managing Director
Accountable to: Resources Committee

Caring Better Together

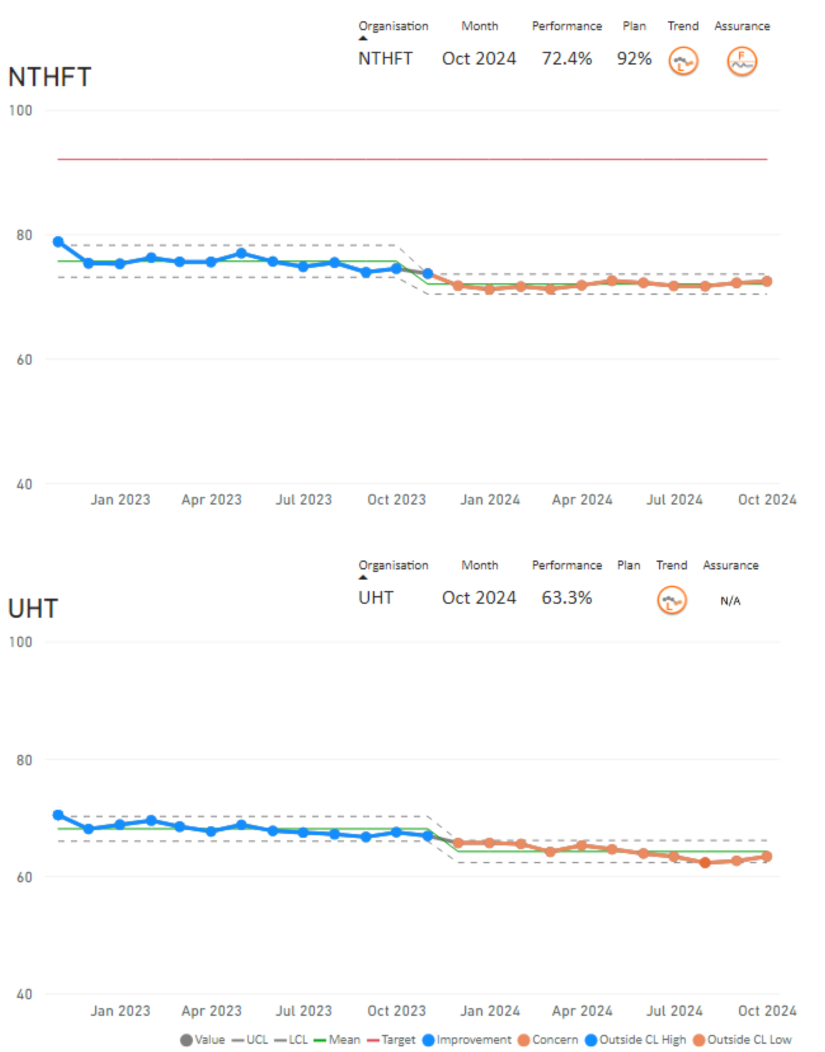
RESPONSIVE Diagnostic 6 Weeks Standard (%)

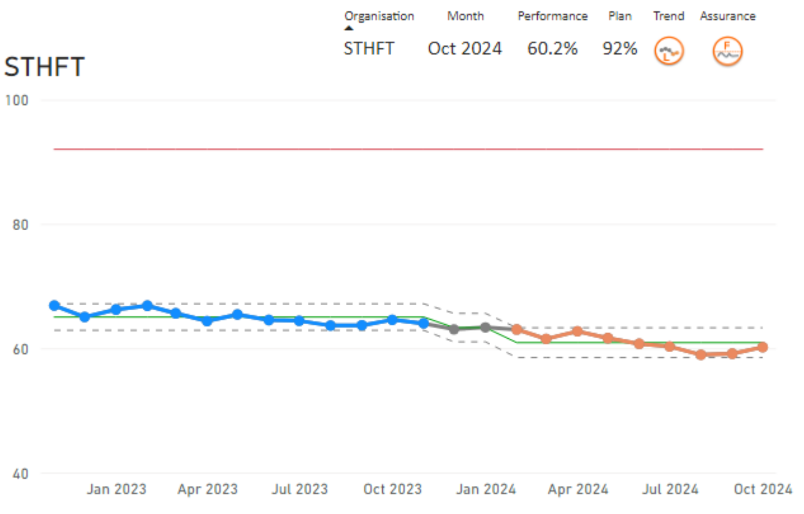




Metric: Percentage of patients waiting for a diagnostic test less than 6 weeks from referral,13 modalities.
Plan: NHSE 24/25 operational standard 95%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT performance is inconsistent. STHFT improved since October 2023.
Assurance: Standard not met. NTHFT: Alert. Standard consistently not met and no recent improvement STHFT: Advise. Standard not met but improvement evident.
Action taken: Both Trusts gain additional capacity from February 2025 with the opening of the Stockton Community Diagnostic Centre, which will improve compliance. STHFT: improvement work is underway in specialist services . Performance improving at NTHFT as staffing improves within the non-obstetric ultrasound service.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE RTT Incomplete Pathways (%)

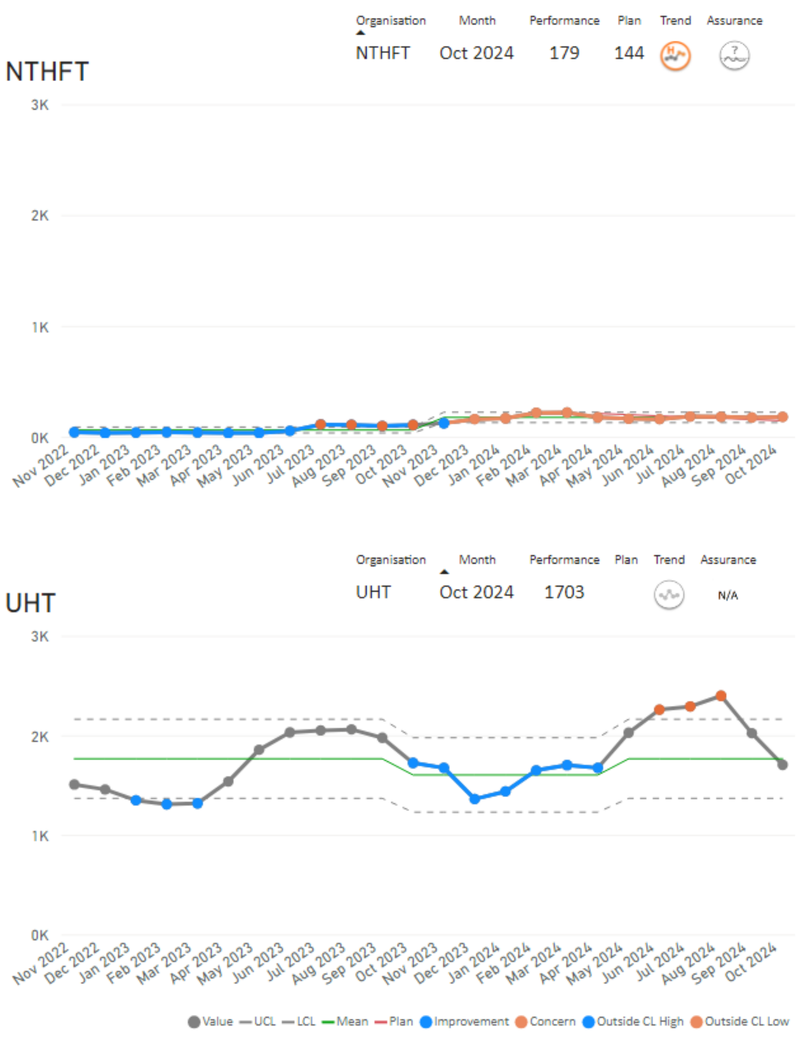


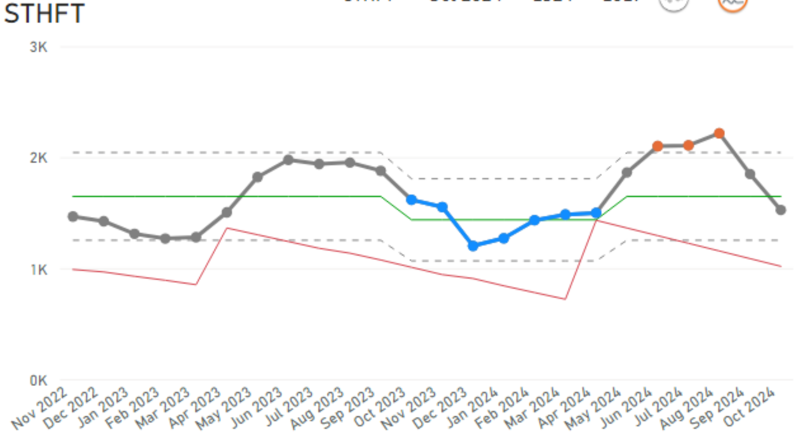


Metric: Percentage of patients awaiting elective treatment who have waited less than 18 weeks from referral.
Plan: NHS Constitution standard 92%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: Decreasing compliance at both Trusts since September 2023 (NTHFT) and June 2023 (STHFT).
Assurance: Alert. Standard is consistently breached.
Action taken: Focus is on reducing the longest waiters beyond 65 weeks, in line with operational planning guidance and those most clinically urgent (see following metrics).
Executive lead: Managing Director
Accountable to: Resources Committee

Caring Better Together

RTT 52 week waiters





Metric: Number of patients awaiting elective treatment who have waited more than 52 weeks from referral.
Plan: Local operational planning trajectories: NTHFT: zero patients by end March 2026, STHFT by end March 2026.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: Increasing numbers at both Trusts since October 2023 (NTHFT) and May 2023 (STHFT).
Assurance: NTHFT: Advise: reporting above plan. STHFT: Alert. Plan is consistently breached.
Action taken: Focus is on reducing the longest waiters beyond 65 weeks in line with operational planning guidance and treating those most clinically urgent.
Executive lead: Managing Director
Accountable to: Resources Committee

CARING DOMAIN SUMMARY

Executive lead: Dr Hilary Lloyd, Chief Nursing Officer Accountable to: Quality Assurance Committee

Targets for patient experience ratings (percentage respondents rating their experience overall good or very good) have now been aligned across the group, at the published national average. We aim to consistently achieve above average satisfaction. In October NTHFT is above plan in three of five surveys (not Maternity and Outpatient). STHFT is above plan in four out of five surveys (not A&E), with assurance of consistently positive responses in Community services. The focus is on increasing response rates to FFT to provide more assurance of positive experience of care. To note – the external provider for text returns for NTHFT FFT has experienced significant data issues resulting in missed opportunities to send text messages from mid October – issue resolved early December 2024. This is likely to have impacted response rates across all areas during October.

The complaints, concerns and enquiries process has been reviewed. Further work is being undertaken in Q3 24/25 to ensure consistency of responding. Clinical and operational teams are focused ensuring that patient enquiries, concerns and complaints are resolved in a timely manner, prioritising those that have been waiting the longest for closure.

NTHFT

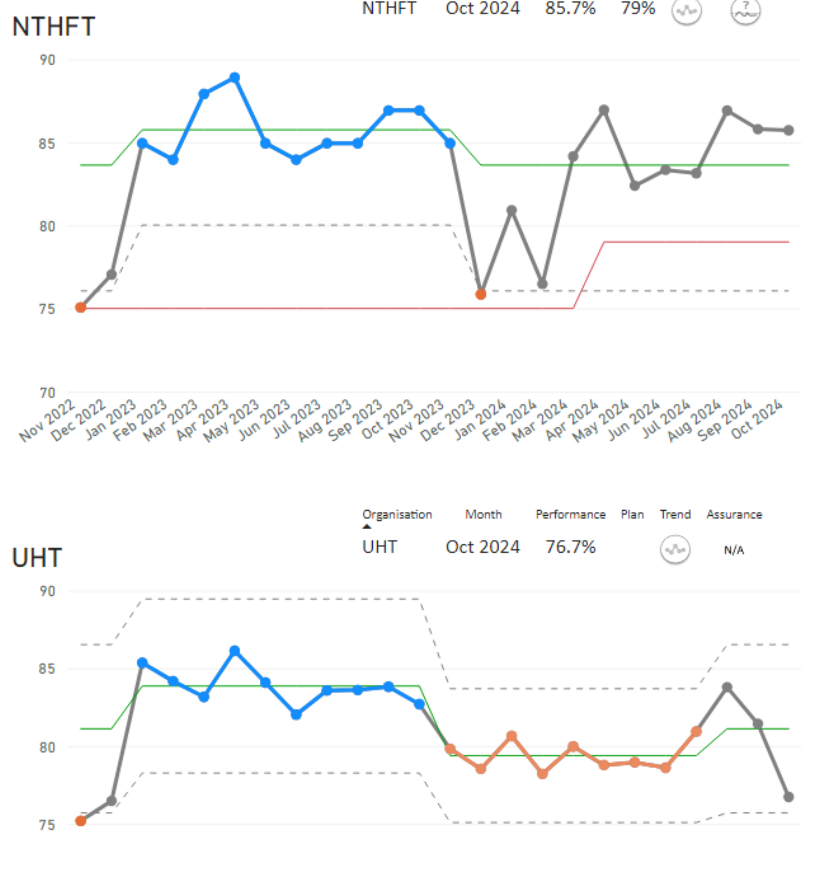
Metric	Month Target	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024
A&E Experience (%)	79%	84.9%	75.8%	80.9%	76.5%	84.2%	86.9%	82.4%	83.3%	83.1%	86.9%	85.8%	85.7%
Inpatient Experience (%)	94%	89.1%	92.8%	91%	88.8%	90.6%	87%	89.8%	91.6%	90.7%	93.5%	95.8%	94.7%
Maternity Experience (%)	92%	80%	57.1%	90.9%	100%	80%	91.7%	93.3%	87.5%	90.5%	100%	83.3%	87.5%
Outpatient Experience (%)	94%	95%	95.8%	95.1%	94.2%	93.6%	95.3%	94.7%	95.8%	94.8%	95.3%	93.6%	93.8%
Community Experience (%)	95%	96.9%	97.3%	96.1%	95%	95.5%	95.5%	94.9%	97.5%	96.8%	96%	96.4%	98.3%
Collaborative Enquiries (Stage 0) Closed in Target (%)				25.2%	22.1%	28.9%	23.6%	16.7%	16.5%	18.3%	25%	25.3%	18.5%
Feedback Acknowledged in 3 Days (%)	100%			98.1%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Complaints Closed Within Target (%)	80%			78.3%	63.1%	65.5%	58.5%	61.2%	63%	60.4%	70.9%	54.4%	52.6%

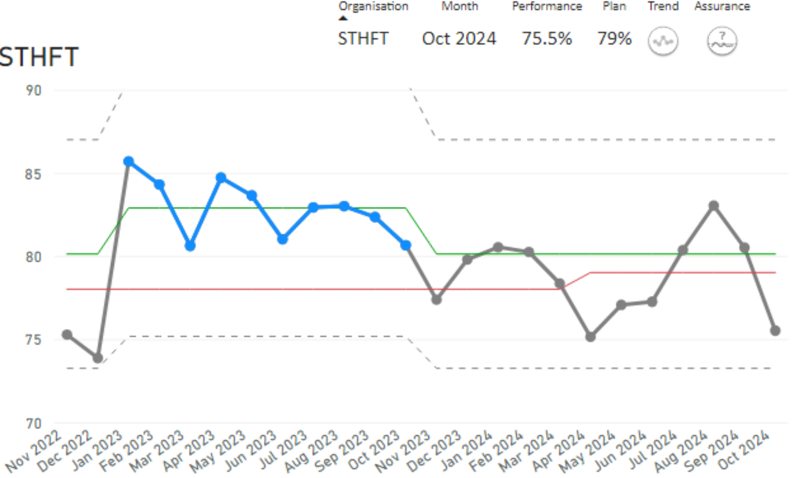
STHFT

Metric	Month Target	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024
A&E Experience (%)	79%	77.4%	79.8%	80.5%	80.2%	78.3%	75.1%	77.1%	77.2%	80.4%	83%	80.5%	75.5%
Inpatient Experience (%)	94%	97.5%	96.8%	95.3%	97.3%	96.5%	95.6%	97.3%	97.4%	97.3%	97.8%	97.6%	99.1%
Maternity Experience (%)	92%	87.1%	83.2%	88.1%	88.5%	91.8%	89%	85.2%	88.3%	92.7%	91%	94.6%	92.3%
Outpatient Experience (%)	94%	95.5%	97%	96.4%	96.2%	96.3%	96.8%	96.7%	96.1%	97.2%	97.2%	97.1%	96.5%
Community Experience (%)	95%	97.9%	98.4%	99.2%	99.3%	99.3%	98.4%	100%	98.9%	98.9%	99.4%	97.5%	97.5%
Collaborative Enquiries (Stage 0) Closed in Target (%)		16.7%	35%	88.6%	89.2%	93.4%	96.2%	74.6%	79.1%	91.5%	88.2%	91.5%	67.9%
Feedback Acknowledged in 3 Days (%)	100%	97.3%	95.7%	96.5%	96.8%	61.7%	47.4%	75.4%	53.9%	88.2%	97%	98.7%	100%
Complaints Closed Within Target (%)	80%	34.8%	45.8%	38.2%	55.6%	42.9%	26.8%	12.1%	26.5%	38%	29.4%	53.6%	28.4%

Caring Better Together

A&E Experience (%)

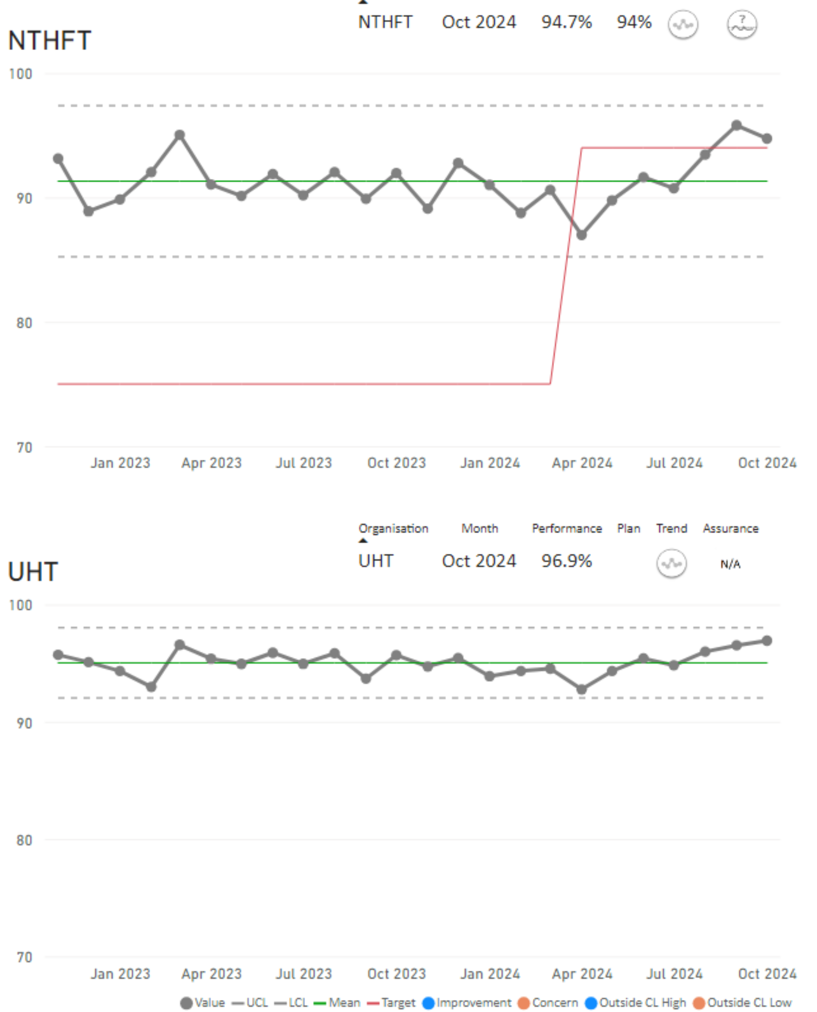


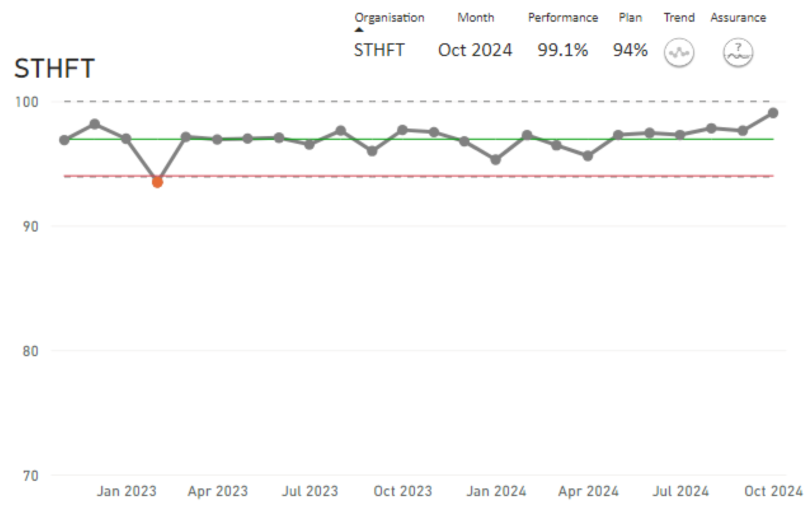


Metric: Percentage of patients who attended A&E rating their experience good or very good in NHS Friends & Family test.
Plan: Local plan set on NHS Trusts average 23/24.
Rationale: NHS Contract metric.
Data quality: Assured (manual and digital systems).
Response rates (October) NTHFT 1%, STHFT 8%.
Trend: NTHFT performance fluctuates. STHFT outside of expected variation.
Assurance: Advise: plan not consistently met.
Action taken: Note that patient feedback appears to correlate inversely with A&E waiting times metrics.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

Inpatient Experience (%)

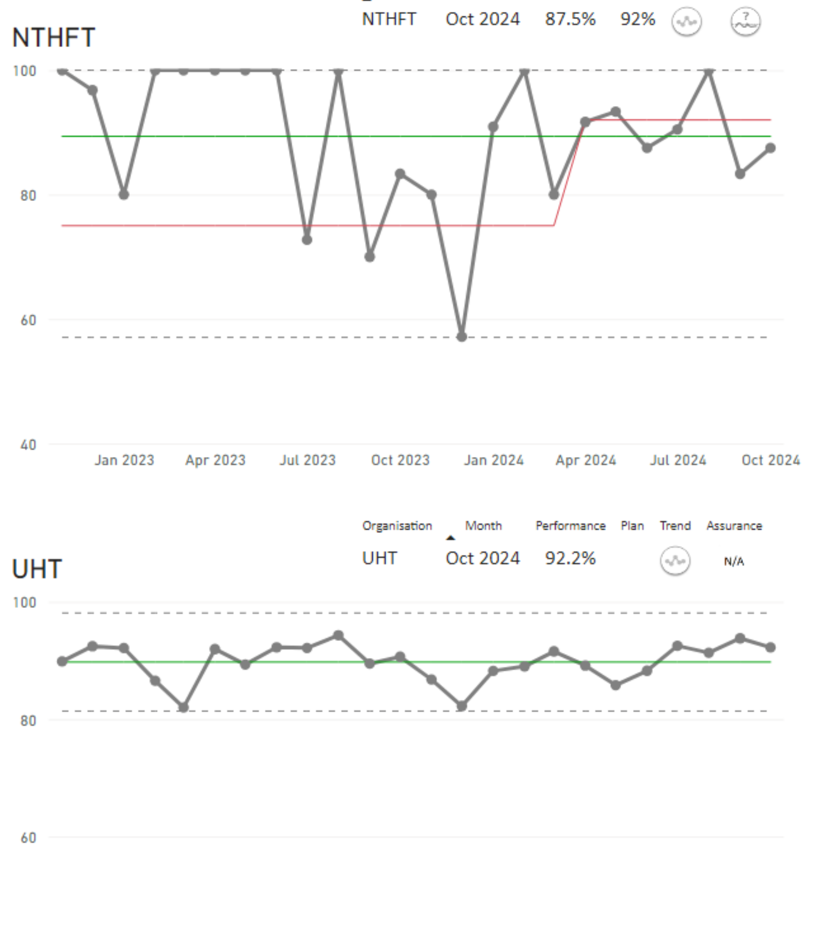


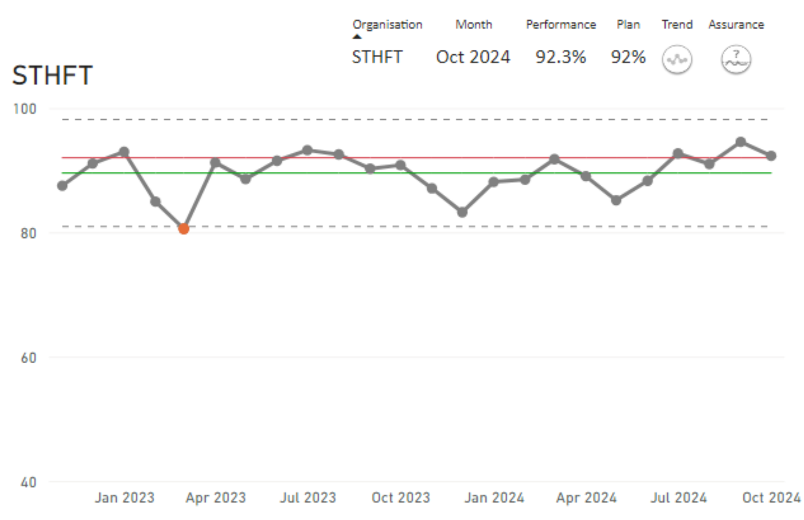


Metric: Percentage of inpatient respondents rating their experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 23/24.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. Response rates NTHFT 7%, STHFT 15%.
Trend: NTHFT an upward trend. STHFT an upward trend.
Assurance: Advise: plan has been met for over 18 months at STHFT, and in most recent 2 months at NTHFT, but performance can be inconsistent.
Action taken: n/a
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

Maternity Experience (%)

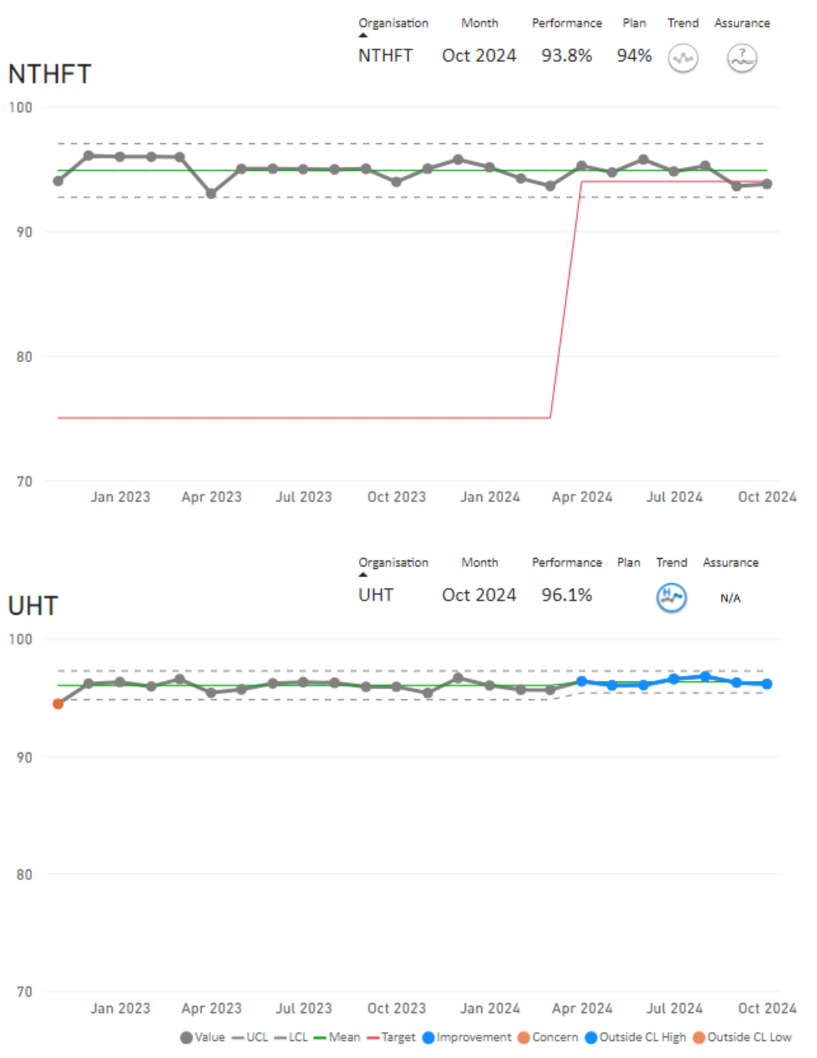


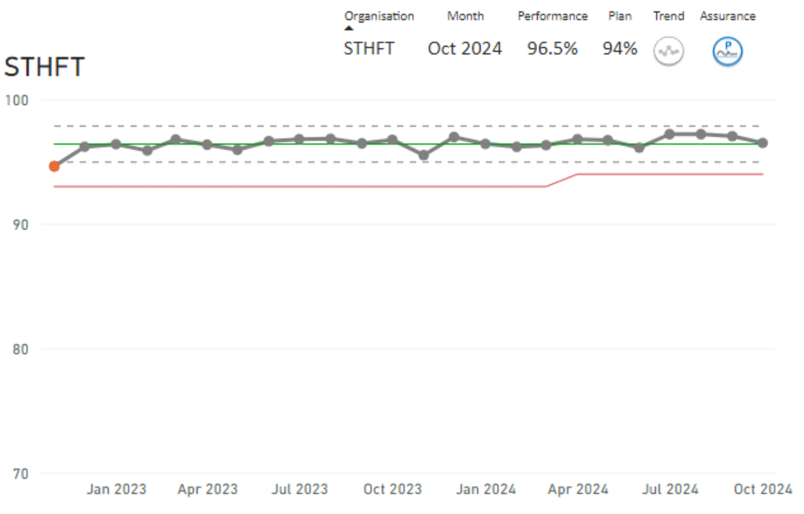


Metric: Percentage of maternity patient respondents rating their experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 23/24.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. Response rates and sample sizes can be low, NTHFT 3% (all Maternity), STHFT 37% (Birth only).
Trend: No trend.
Assurance: Advise: plan not consistently met.
Action taken: n/a
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

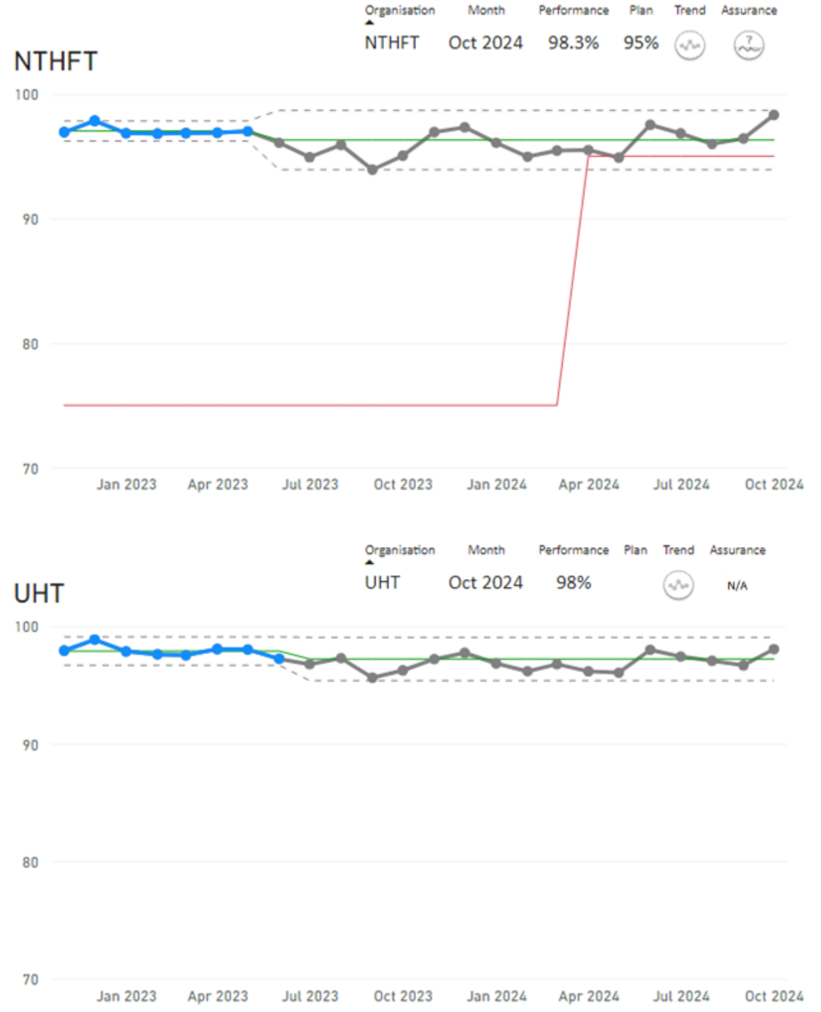
Outpatient Experience (%)

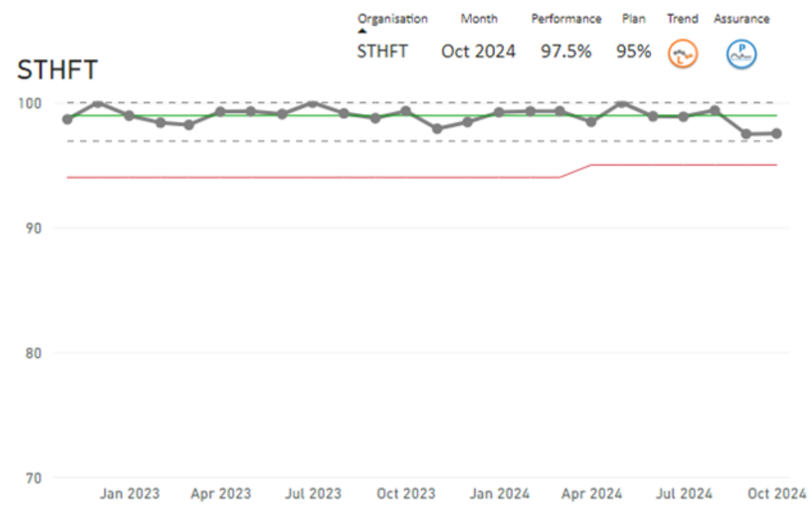




Metric: Percentage of outpatient respondents rating their experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 23/24.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. Response rates are 3% NTHFT, 16% STHFT.
Trend: No trend.
Assurance: Advise: achievement of plan is not assured.
Action taken: n/a
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

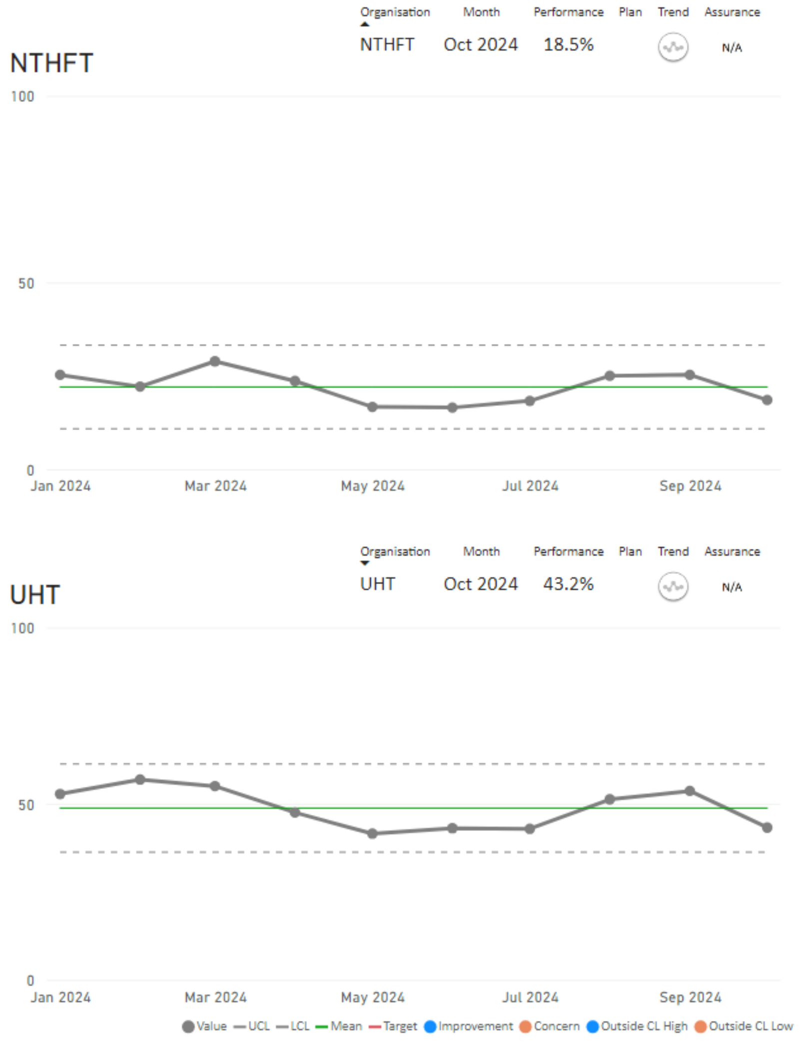


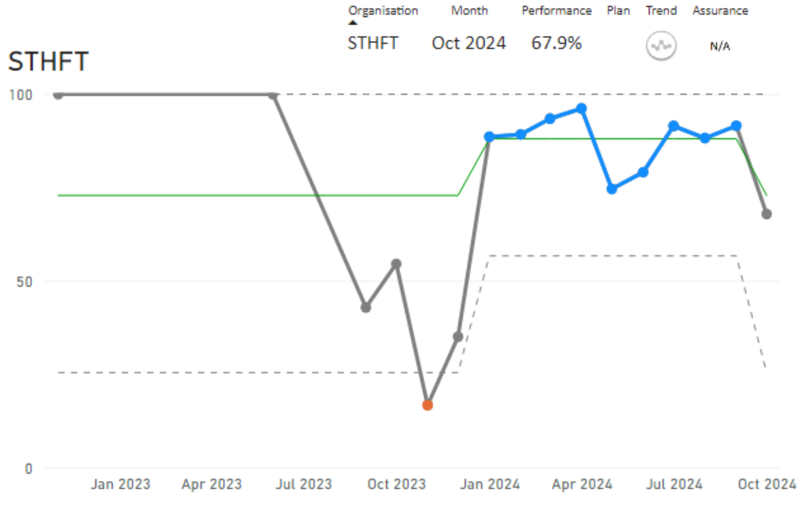


Metric: Percentage of community services patient respondents rating their experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 23/24.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. Response rates are 2% NTHFT, 12% STHFT
Trend: No trend.
Assurance: NTHFT: Advise: plan met for last 5 months. STHFT: Assure: plan is met.
Action taken: n/a.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

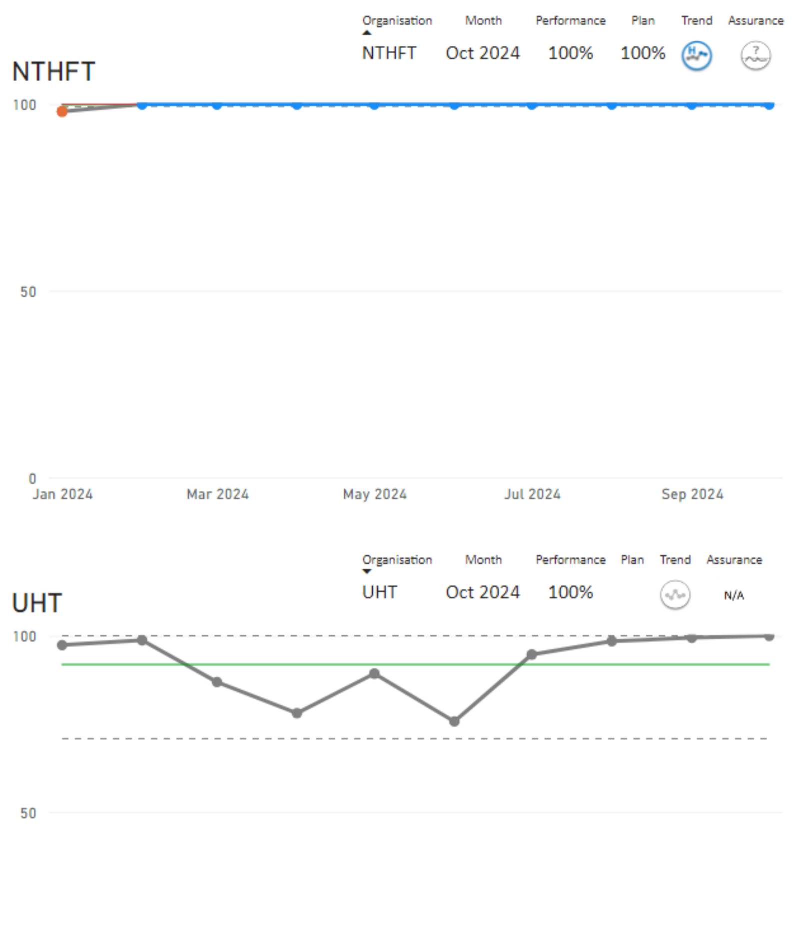
Caring Better Together

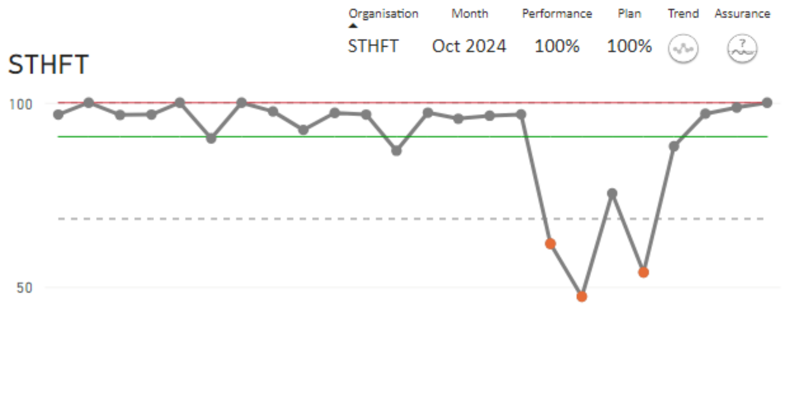
CARING Collaborative Enquiries (Stage 0) Closed in Target (%)





Metric: Percentage of complaints received that have been resolved in 24 hours and declassified.
Plan: n/a. National and local targets are not in place.
Rationale: Verbal complaints resolved within 24 hours are de-categorised as a complaint and not included in complaint reporting data.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: n/a
Action taken: n/a
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

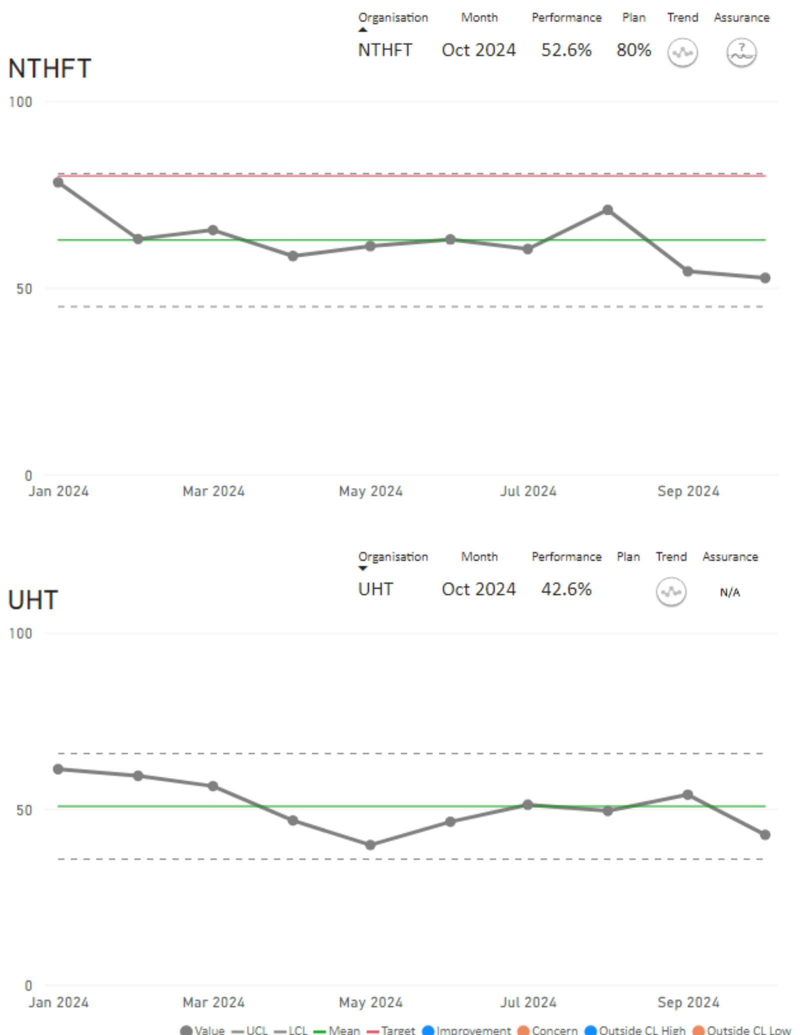


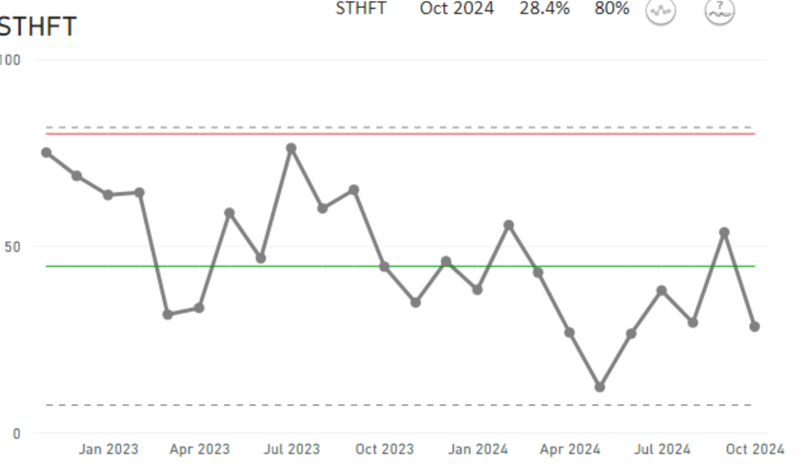


Metric: Percentage of complaints acknowledged in 3 days.
Plan: 100%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Achieved plan throughout 2024 except for January. STHFT: performance variable.
Assurance: NTHFT: Advise, target met since February 2024. STHFT: Advise, target met in October for first time since May 2023.
Action taken: STHFT: new process implemented for acknowledging complaints in July 2024 and team now fully esablished.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

CARING Complaints Closed Within Target (%)





Metric: Percentage of complaints closed in agreed target time frame.
Plan: 80%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: Advise. Plans not consistently met.
Action taken: NTHFT: Metric aligned with STHFT. Inphase reporting to be improved to allow increased performance monitoring within Care Groups. STHFT: off target complaint responses are reported weekly for senior focus and accountability for completing responses.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

WELL LED DOMAIN SUMMARY

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

Accountable to: People Committee
Resources Committee

Plans are progressing to ensure collaboration across UHT and the region to reduce sickness absence. Best practice will be shared with the aim of a 1% year on year reduction. We continue to promote the opportunity for staff to get protected from flu and covid: the flu campaign will run until end March 2025 and covid vaccination will be available until end January 2025. Staff turnover is reducing at STHFT and remains low at NTHFT. Innovative ideas for the continuous improvement of this KPI are being explored including tools and resources to retain our talented workforce, such as an internal transfer policy to support career mobility. Staff annual appraisal and mandatory training remain an areas of focus with over 78% of staff in date for their appraisal and over 89% of staff compliant in mandatory training.

The financial position shows a small adverse variance year to date against month 7 plan for NTHP. Financial controls are in place ,with a focus on recurrent efficiency delivery, and oversight of financial risks through Resources Committee.

NTHFT

Metric	Month Target	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024
Sickness Absence (%)	4%	6%	5.8%	5.4%	5.6%	5.8%	5.8%	5.7%	6%	5.8%	5.8%	6.1%
Staff Turnover (%)	10%	8.4%	8%	8.1%	7.6%	7.1%	7.4%	7.2%	7.2%	7.3%	7.3%	7.3%
Annual Appraisal (%)	85%	87.4%	87.2%	87.6%	87.2%	86.8%	86.4%	86.6%	86.9%	86.7%	87.2%	86.9%
Mandatory Training (%)	90%	89.9%	90%	90%	90.1%	89.2%	88.6%	89.3%	89.4%	89.7%	89.5%	89.8%
Cumulative YTD Financial Position (£'millions)	-£0.8m					-£0.4m	-£0.4m	-£1.2m	-£1.3m	-£1.2m	-£0.9m	-£1.1m

STHFT

Metric	Month Target	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024
Sickness Absence (%)	4%	6.3%	6.5%	5.9%	5.3%	5.3%	5.2%	5.3%	5.5%	5.4%	5.3%	6%
Staff Turnover (%)	10%	11.2%	10.7%	10.7%	10.3%	10.1%	10.2%	10%	10%	10.2%	9.8%	9.3%
Annual Appraisal (%)	85%	78.5%	78.6%	79.7%	79.1%	80%	79.6%	79%	80.3%	80.3%	80%	78.8%
Mandatory Training (%)	90%	89.6%	89.8%	90.3%	90.3%	90.7%	90.7%	90.2%	90.3%	90%	89.7%	89.2%
Cumulative YTD Financial Position (£'millions)	-£14.3m	-£23.5m	-£26.1m	-£18m	-£20.1m	-£5.6m	-£10m	-£13.6m	-£15.9m	-£19.3m	-£12.7m	-£14.3m

Caring Better Together

WELL LED Sickness Absence (%)

NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Oct 2024	6.1%	4%		

10
5
0
Jan 2023 Apr 2023 Jul 2023 Oct 2023 Jan 2024 Apr 2024 Jul 2024 Oct 2024

STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Oct 2024	6%	4%		

10
5
0
Jan 2023 Apr 2023 Jul 2023 Oct 2023 Jan 2024 Apr 2024 Jul 2024 Oct 2024

UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Oct 2024	6%			N/A

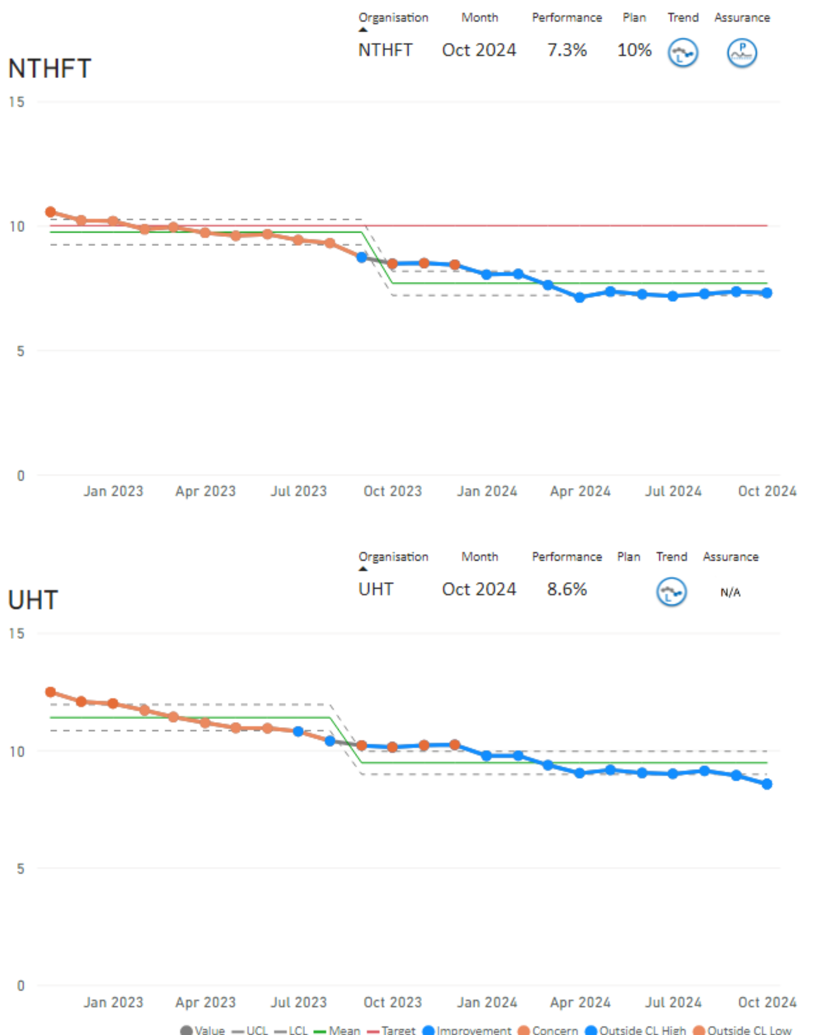
10
5
0
Jan 2023 Apr 2023 Jul 2023 Oct 2023 Jan 2024 Apr 2024 Jul 2024 Oct 2024

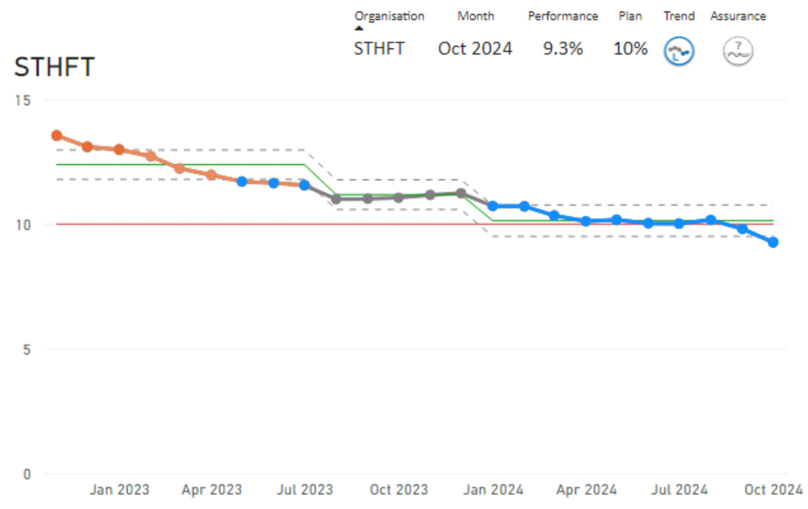
Value — UCL — LCL — Mean — Target Improvement Concern Outside CL High Outside CL Low

Metric: Percentage of staff working hours lost to sickness absence (all types) in each month.
Plan: Trust internal plans: NTHFT: 4%. STHFT: 4%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT and STHFT performance inconsistent.
Assurance: Alert: plans are not met.
Action taken: Review of staff absence due to bereavement leave with a potential to develop the current policy to take bereavement leave into consideration. Workshop to share best practice across Group.
Executive lead: Chief People Officer
Accountable to: People Committee

Caring Better Together

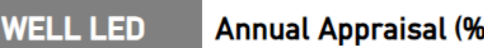
WELL LED Staff Turnover (%)



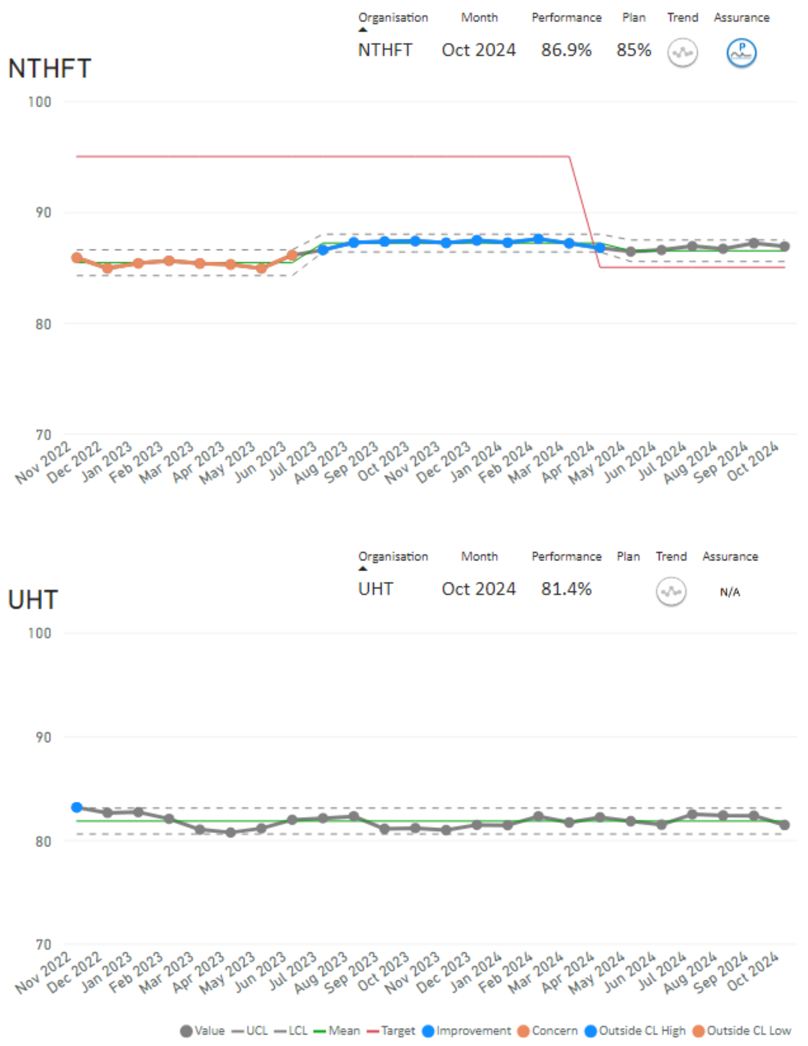


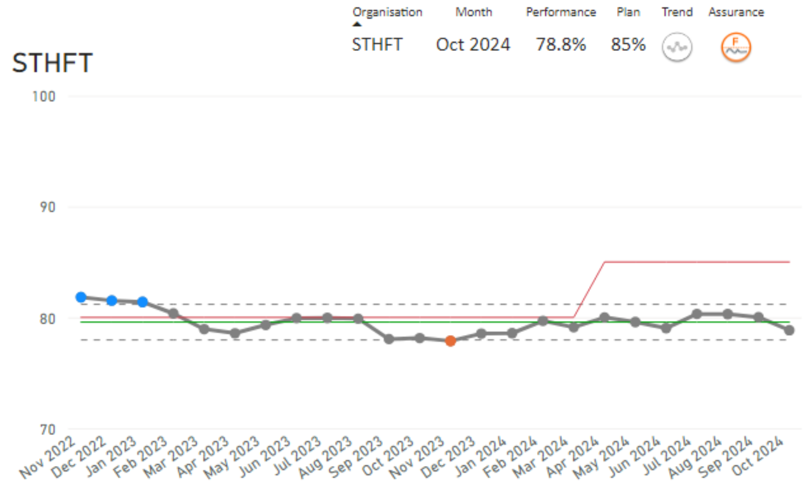
Metric: Percentage of staff changing or leaving job roles in the month (all staff groups, all changes).
Plan: Trust internal plans: NTHFT: 10%. STHFT: 10%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: Performance improving.
Assurance: NTHFT: Assure: plan is consistently met. STHFT: Advise: plan is now met but not consistently.
Action taken: Consider the feasibility of introducing robotic exit interview process to improve exit interview uptake. Ensure consistency in reporting across Group.
Executive lead: Chief People Officer
Accountable to: People Committee

Caring Better Together



Annual Appraisal (%)

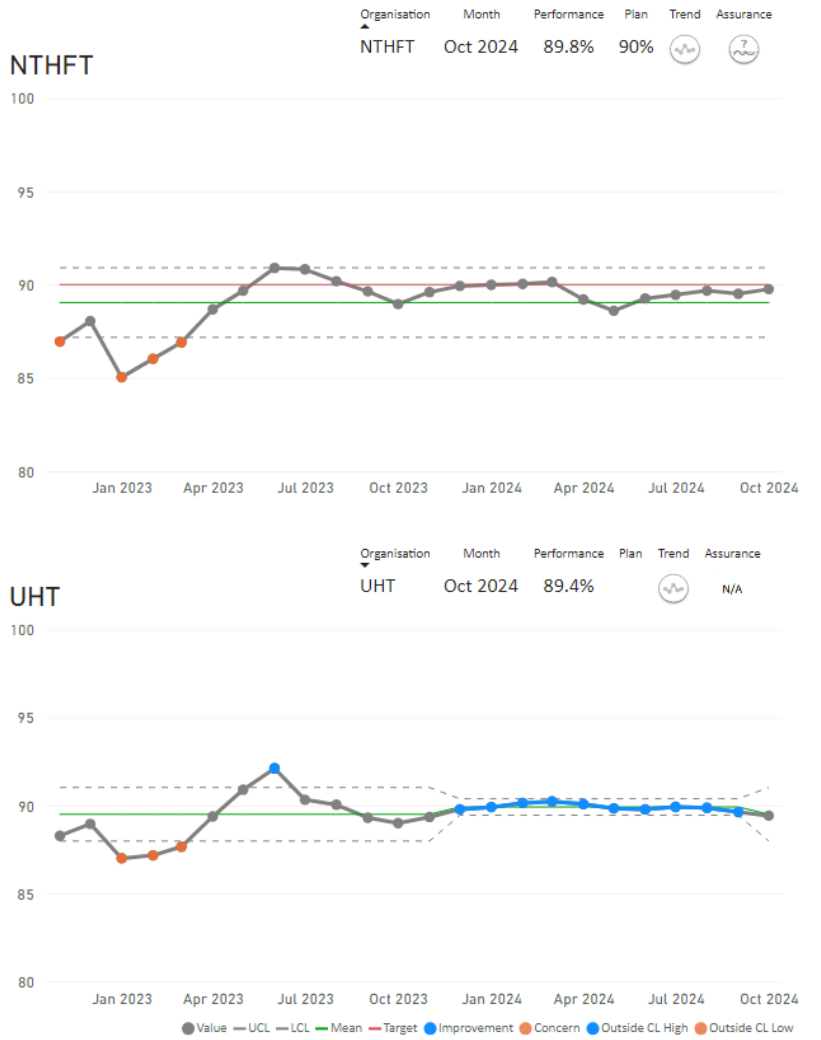


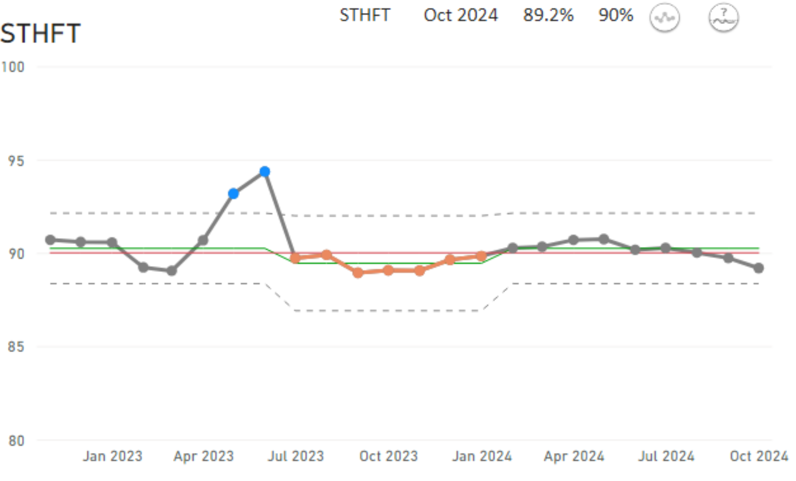


Metric: Percentage of staff with annual appraisal completed in last 12 months, at month end.
Plan: Trust internal plans: NTHFT: 85%. STHFT: 85%, now aligned for 24/25.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: NTHFT: Assure: new plan not met; STHFT: Alert: new plan not met.
Action taken: Focus on staff who have not had an appraisal for 24 months or longer.
Executive lead: Chief People Officer
Accountable to: People Committee

Caring Better Together

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: No trend.
Assurance: Advise. Plan is not consistently met.
Action taken: In line with national request, review of mandatory training against the core skills training framework to incorporate frequency, needs analysis, and impact. Establishment of a multi-professional steering group.
Executive lead: Chief People Officer
Accountable to: People Committee

Caring Better Together

Cumulative YTD Financial Position (£'millions)

NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Oct 2024	-£1.114m	-£0.762m	N/A	N/A

20
0
-20

Apr 2024 May 2024 Jun 2024 Jul 2024 Aug 2024 Sep 2024 Oct 2024

STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Oct 2024	-£14.342m	-£14.342m	N/A	N/A

20
0
-20

Apr 2024 May 2024 Jun 2024 Jul 2024 Aug 2024 Sep 2024 Oct 2024

UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Oct 2024	-£15.456m		N/A	N/A

20
0
-20

Apr 2024 May 2024 Jun 2024 Jul 2024 Aug 2024 Sep 2024 Oct 2024

Actual Plan

Metric: Cumulative year to date financial position.
Plan: Trust plans agreed with ICB. NTHFT submitted a breakeven plan for 2024-25. The STHFT control total for 2024-25 is a £23.1m deficit.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: Financial position tracks plans.
Assurance: Advise: small adverse variance year to date against month 7 plan for NTHFT.
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

Caring Better Together

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.

Sample Value

Upper Control Limit

Average Output

Lower Control Limit

Time sequence

High level Key - Variation

High level Key - Assurance

Are we improving, declining or staying the same

Blue = significant improvement or low pressure

Can we reliably hit target?

Variation

Assurance

Grey = no significant change

Orange = system change required to hit target

Common Cause

Special cause Concerning variation

Special cause Improving variation

Hit and miss target subject to random

Consistently pass target

Consistently fail target

Orange = significant concern or high pressure

Hit and miss target

Blue = will reliably hit target

Caring Better Together

Thank you

Audit & Risk Committee – South Tees

Connecting to: South Tees Trust Board; Meeting held 20 November 2024; Chair Ken Readshaw

Key topics discussed in the meeting:

External Audit - Accounts and audit reports for South Tees Hospitals Charity and the Subsidiary companies were received and reviewed. All are suitable for approval in the normal way. Consideration should be given to winding up the dormant companies. More finance support is needed for South Tees Healthcare management.

External audit tender process update received.

Internal Audit- Financial planning controls – an advisory audit as part of an ICB programme. No significant items to note although it is worth highlighting that the capacity of the organisation to respond to multiple in-depth audit processes is not sufficient and this stretches resource in a sub optimal way.

Fire Audit follow up – a review of the current position took place. Board to continue to monitor progress.

Outstanding Audit actions – A revised system for tracking and clearing audit actions is being implemented to give consistency across the group.

Risk management - Risk management progress against improvement plan reviewed. Risk management systems are being revised to give consistency across the group.

Revised group board delegation matrix assessment report received. This shows group and statutory decision making in a form that gives us assurance on appropriate decision making (ie not ultra vires) and conflicts of interest management.

Other matters - A meeting in common with North Tees audit committee is planned for March to gain assurance on the work of board sub committees.

Escalated items:

- South Tees Charity and subsidiary accounts for relevant approval

Risks (Include ID if currently on risk register):

- No new risks.