NHS
University Hospitals Tees

Group Board Meeting

Thursday, 8 May 2025 at 12:30

2nd Floor Murray Building, James Cook University Hospital

Caring Better Together

NHS
University Hospitals Tees

MEETING OF THE GROUP BOARD TO BE HELD IN PUBLIC
ON THURSDAY 8 MAY 2025 AT 12:30PM
IN THE BOARDROOM, 2ND FLOOR, MURRAY BUILDING
JAMES COOK UNIVERSITY HOSPITAL

AGENDA

	ITEM	PURPOSE	LEAD	FORMAT	TIME
CHAIR'S BUSINESS					
1.	Patient/Staff Story	Information	Group Chair	Verbal	12:30
2.	Welcome and Introductions	Information	Group Chair	Verbal	12:45
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 4 March 2025	Approval	Group Chair	ENC	12:50
6.	Matters Arising and Action Log	Information	Group Chair	ENC	12:55
7.	Group Chairman's Report	Information	Group Chair	ENC	13:00
8.	Group Chief Executive's Report	Information	Group Chief Executive	ENC	13:10
8b.	Group Management Team Chairs Log: 20 March & 17 April 2025	Information	Group Chief Executive	ENC	13:10
9.	University Hospital Tees (UHT) Group Strategy - UHT People Plan	Approval Information	Group Chief Strategy Officer Group Chief People Officer	ENC ENC	13:25
10.	Board Assurance Framework	Assurance	Director of Assurance	ENC	13:45
QUALITY AND SAFETY					

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

	ITEM	PURPOSE	LEAD	FORMAT	TIME
11.	Quality Committee Chairs Log: 28 April 2025	Assurance	Chair of Committee	ENC	13:55
12.	Care Quality Commission Compliance Update Report	Assurance	Group Chief Nurse	ENC	14:00
PEOPLE					
13.	People Committee Chairs Log: 26 March & 29 April 2025	Assurance	Chair of Committee	ENC	14:10
14.	NHS Staff Survey 2024	Assurance	Group Chief People Officer	ENC	14:15
15.	Freedom to Speak up End of Year Report 2024/25	Assurance	FTSU Guardians	ENC	14:25
FINANCE & PERFORMANCE					
16.	Resources Committee Chairs Log: 30 April 2025	Assurance	Chair of Committee	ENC	14:35
17.	Finance Report Month 12: 2024/25	Assurance	Group Chief Finance Officer	ENC	14:40
18.	Going Concern 2024/25	Approval	Group Chief Finance Officer	ENC	14:50
19.	Integrated Performance Report February 2025	Assurance	Group Managing Director	ENC	15:00
WELL LED					
20.	Maternity Reports: • Perinatal Quality Safety Quarter 4: 2024/25 Report • Perinatal Staffing Quarter 4: 2024/25 Report	Assurance	Director of Midwifery	ENC	15:15

SOUTH TEES HOSPITALS NHS TRUST UNITARY BOARD					
21.	Audit & Risk Committee Chairs Log: 28 March 2025 in Common	Assurance	Chair of Committee	ENC	15:30
22.	South Tees Charity Chairs Log and in Common Chairs Log: 12 March 2025	Assurance	Chair of Committee	ENC	
23.	Modern Slavery Statement 2025/26	Approval	Company Secretary	ENC	
24.	Use of Seal	Approval	Company Secretary	ENC	
NORTH TEES & HARTLEPOOL NHS TRUST UNITARY BOARD					
25.	Audit Committee Chairs Log: 28 March 2025 in common	Assurance	Chair of Committee	ENC	15:45
26.	North Tees Charity Chairs Log and in Common Chairs Log: 12 March 2025	Assurance	Chair of Committee	ENC	
27.	Modern Slavery Statement 2025/26	Approval	Company Secretary	ENC	
28.	Use of Seal	Approval	Company Secretary	ENC	
CLOSE					
	DATE OF NEXT MEETING The next meeting of the Group Board of Directors will take place on Thursday 3 July 2025 in the Board Room, Murray Building, James Cook University Hospital				

University Hospitals Tees

Register of members interests

Meeting date: 8 May 2025

Reporting to: Group Board

Agenda item No: 4

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 due to being jointly appointed directors of both Trusts. Under Group arrangements and by delegating jointly exercised functions, there are a number of reference points permitting this to occur;

- Overall NHS legal and policy framework for collaboration
- Specific statutory provisions for managing conflicts
- NHS best practice
- Authorisation of joint director roles

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

Robust processes are in place to provide all relevant information to support informed and robust decision making in the best interest of patients and the population the Group serves

Recommendations:

The Board 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 Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Alison Fellows	Non-Executive Director		Ongoing	Husband Partner at Firm – Ward Hadaway Solicitors
		December 2023	Ongoing	Governor of the Board and member of the Audit Committee Northumbria University
		December 2023	Ongoing	Independent Member of the Audit Committee Newcastle City Council
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Alison Wilson	Non-Executive Director	4 January 2022	Ongoing	Civil Partner – Counter Terrorism Policing North East
		September 2022	Ongoing	South Tees Healthcare Management Limited - Company number 10166808.
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Ann Baxter	Non-Executive Director		Ongoing	Independent Scrutineer of Safeguarding / Chair of Statutory Safeguarding Partnership – Darlington Borough Council
				School Governor at Thirsk High School and Sixth Form College
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Chris Hand	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 Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		April 2024	Ongoing	Representation on behalf of North Tees & Hartlepool NHS Trust on NTH Solutions LLP – Company Number OC419412
David Redpath	Non-Executive Director	1 January 2021	Ongoing	Director of DGR Consultancy - Company number 10340661
		September 2022	Ongoing	South Tees Healthcare Management Limited - Company number 10166808.
		September 2017	Ongoing	Vice President Senior Executive Partner – Gartner
		July 2022	Ongoing	Deputy Chairman – Seaton Delaval Football Club

Board Member	Position	Relevant Dates From	to	Declaration Details
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Elizabeth Barnes	Non-Executive Director		Ongoing	Non-Executive Director – Aspire Housing Trustee – University of Sunderland Trustee – Middlesex University Trustee – Peter Coates Foundation
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Emma Nunez	Group Chief Nurse	April 2025	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Fay Scullion	Non-Executive Director	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		October 2024	Ongoing	Chief Executive, Age UK North Yorkshire & Darlington
Jackie White	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 Foundation 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 Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
			Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Matt Neligan	Group Chief Strategy Officer	October 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Mark Dias		20 July 2015	Ongoing	Director of Be The Change HR Ltd – Company No. 9694576

Board Member	Position	Relevant Dates From	to	Declaration Details
		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 Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
		March 2025	Ongoing	Director of Nicholas Postgate Catholic Academy Trust
Michael Stewart	Group Chief Medical Officer			Wife is employed at South Tees NHS FT
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Miriam Davidson	Non-Executive Director		Ongoing	Local Government Association Associate, occasional work with English councils on Public Health Peer Reviews and facilitation of relevant workshops
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Neil Atkinson	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 Foundation 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	NHS South East London Chair of SEL SEEC
		March 2024	Ongoing	Member of the Council for Newcastle University. No remuneration.
		April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Rachael Metcalf	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 Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Rowena Dean	Chief Operating Officer North Tees & Hartlepool NHS Trust			No declared interest

Board Member	Position	Relevant Dates From	to	Declaration Details
Ruth Dalton	Group Director of Communications	April 2024	Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board
Samuel Peate	Chief Operating Officer South Tees Hospitals NHS Foundation Trust	1 April 2021	Ongoing	None
Stacey Hunter	Group Chief Executive	April 2024 July 2024	Ongoing Ongoing	Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board Partner, Dr Cornelle Parker, ad hoc project work within organisations of the NHS Co-Chair of NHS Confederation Productivity Group Member of NHS Confederation Acute Advisory Board Member of UHA Executive Advisory Committee (hosted by NHS Providers)
Steven Taylor	Group Director of Estates			Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board Son employed by NTH Solutions LLP – ICT Project Officer/Digital Performance Coordinator Wife employed by NTH Solutions LLP – Catering Assistant
Stuart Irvine	Director of Risk, Assurance and Compliance	2023	Ongoing	Chair – Hartlepool College of Further Education Trustee of Hospitals Trust of the Hartlepool Sons (x2) are employees at Hartlepool College of Further Education Director of North Tees & Hartlepool NHS Foundation Trust and Director of South Tees Hospitals NHS Foundation Trust Board

NHS
University Hospitals Tees

Minutes of a meeting of the University Hospitals Tees Group Board held in Public on Tuesday, 4 March 2025 at 1.00pm in the Health and Social Care Academy, 2nd floor, University Hospital Hartlepool

Present:
Derek Bell, Group Chair (Chair)
Ann Baxter, Group Vice Chair/Non-Executive Director & Maternity Champion
Ali Wilson, Group Vice Chair/Non-Executive Director
Liz Barnes, 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 & Maternity Champion
Ken Readshaw, Group Non-Executive Director
David Redpath, Group Non-Executive Director
Mark Dias, Group Non-Executive Director
Stacey Hunter, Group Chief Executive
Neil Atkinson, Group Managing Director
Chris Hand, Group Chief Finance Officer
Rachael Metcalf, Group Chief People Officer
Mike Stewart, Group Chief Medical Officer
Maurya Cushlow, Interim Group Chief Nurse & Maternity Champion (virtual)
Matt Neligan, Group Chief Strategy Officer

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

In Attendance:
Gareth Lightfoot, Local Democracy Reporter, Gazette
Mike Gill, Audit One
Sarah Hutt, Assistant Company Secretary (note taker)

GB/243 Welcome and Introductions

The Chair welcomed everyone to the meeting and announced that Chris Macklin, Group Non-Executive Director would be retiring on 30 April 2025, having completed 50 years in the NHS, which was a fantastic achievement. The Chair thanked Chris for his contribution on behalf of the Board.

Congratulations were given to Alison Fellows for her successful application to the aspiring chairs programme.

GB/244 Apologies for Absence

Apologies for absence were reported from Fay Scullion, Group Non-Executive Director and Rowena Dean, Chief Operating Officer, NTHFT.

GB/245 Quorum and Declaration of Interests

The meeting was confirmed as quorate.

No perceived conflicts of interest

A number of changes to the Declaration of Interest Register had been captured as part of the annual process and would be updated accordingly.

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 would be made to ensure appropriate action was taken.

GB/246 Minutes of the last meeting held on, 7 January 2025

The minutes of the last meeting held on, 7 January 2025 were accepted as a true and accurate record.

Resolved: that, the minutes of the meeting held on, Tuesday, 7 January 2025 be confirmed as a true and accurate record.

GB/247 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/248 Group Chair's Report

The Group Chair highlighted the key points of the Group Chair's Report, which was taken as read:

- Amanda Pritchard would stand down as Chief Executive of NHS England (NHSE) on 31 March 2025 and would be replaced by Sir James Mackey as Transition Chief Executive Officer.
- Ann Baxter, Vice Chair attended a regional event on behalf of the Chair regarding the new NHS operating model.
- It was 5 years since the COVID-19 pandemic began, marked nationally by a Day of Reflection on Sunday 9 March 2025. NTHFT had commissioned a memorial working with local schools and colleges. The installation would be unveiled on 7 April 2025 both at the University Hospitals of Hartlepool and North Tees.
- Her Majesty the Queen, President of Maggie's, the cancer charity visited Middlesbrough regarding Maggie's plans to take over the Trinity Holistic Centre at the James Cook University Hospital.
- Plans were progressing for the establishment of a new medical school at Teesside University, which would provide great opportunities for the local area. It was agreed to have a wider discussion at a future board development session.

Resolved: (i) that, the content of the report be noted; and
(ii) that, a discussion regarding the Teesside University Medical School take place at a future Board Development session.

GB/249 Group Chief Executive's Report

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

- University Hospital Tees Strategy continued to develop and was the topic of discussion of the Board Development session earlier in the day.

- Winter pressures had eased slightly during January. Thanks placed on record to all frontline staff.
- Planning guidance for 2025/26 was published on 30 January 2025 with initial local plans to be submitted by 21 February 2025 and final plans due by 21 March 2025. It would be a difficult year, with a priority for the NHS to live within its means. The Group was making good progress with its financial plans and had highlighted to the North East North Cumbria Integrated Care Board (NENC ICB) aspects, which would be challenging to achieve.
- A new 10-year Health Plan for the NHS was being developed, with a number of events planned in the coming months, which Trust representatives would attend.
- Directors and Board members continued to visit departments and connect with staff.
- A Group Management Team Meeting had been established to provide oversight of both trusts and to support delivery of the Trust's strategic objectives, providing assurance to the Group Board. The first meeting took place on 23 January 2025 and would continue to meet monthly.

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

GB/250 Board Assurance Framework

Stuart Irvine, Director of Risk, Assurance and Compliance presented the Board Assurance Framework (BAF) Update to the period 31 December 2024 and highlighted the key points.

For NTHFT:
- 37 strategic risks
- 11 strategic risks outside the approved risk appetite, with 6 red/high risks
- 91 planned mitigating actions
- 2 actions requiring extended timescales

For STHFT:
- 31 strategic risks
- 12 strategic risks outside the approved risk appetite, with 7 red/high risks
- 93 planned mitigating actions
- 4 actions requiring extended timescales

The process was established and strengthening work was ongoing in preparation for 2025/26. An internal audit was commencing in respect of the BAF and risk management processes at both trusts. The Committees would continue to focus on the red/high risk areas and seek assurance regarding the actions being taken.

Stacey Hunter, Group Chief Executive suggested that the operational plan for 2025/26 be reviewed alongside the BAF to understand any implications to the organisation's strategic risks. It was noted that the strategic objectives and risks would be carried forward into 2025/26 and amended as appropriate to meet the requirements of the organisation and provide assurance to the Board.

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

GB/251 Quality Assurance Committee Chairs Log

Miriam Davidson, Group Non-Executive Director presented the Group Quality Assurance Committee Chairs Log for the meetings held on 27 January and 24 February 2025.

Areas of escalation included the continued focus around infection prevention and control (IPC) due to the rates of infection across both trusts. The health and inequalities work streams continued to progress well locally and further opportunities to work jointly were being explored. The positive work of the organ donation teams was highlighted, with an increase in the number of received donations. The Care Quality Commission (CQC) 'must do' actions were on track with robust check and challenge

processes in place.

Stacey Hunter, Group Chief Executive, requested an update be provided in the private board meeting regarding Health Call, which was discussed as part of the System Working and External Threats BAF at Quality Committee. It was noted that the Committee could support NTHFT with a plan to achieve a higher CQC rating, in addition to overseeing completion of the operational actions.

Ada Burns sought to understand the work of the Health Inequalities Steering Group having attended an ICB session regarding inequalities, prompting discussion. It was agreed to invite the Public Health Consultants to a future Board Development session to share the current projects and progress to date, including the development of the new inequalities element of the IPR.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the Public Health Consultants be invited to attend a future Board Development session to provide an update regarding current projects and progress with the inequalities element of the IPR; and
(iii) that, the high level IPC plan be shared with the Board.

GB/252 Tees Valley Research Alliance (TVRA) Annual Report

Jane Greenaway, Associate Director, TVRA and Jeremy Henning, Consultant, TVRA presented the Tees Valley Research Alliance Annual Report 2024/25 and highlighted key points.

It had been a positive year overall for research, with a record level of recruitment into National Institute for Health Research (NIHR) portfolio research trials, with 11,903 participants. More collaborative work was taking place with external partners to bring research, training and development opportunities to staff and patients.

The TVRA had operated across the Group since 2019, combining the Research and Development teams across both trusts. The majority of staff supported recruitment of patients into trials in patient facing clinical roles supported by research funded staff in governance, sponsorship, pharmacy, pathology, management, finance and admin support roles. The development of an Academic Strategy for Research, Education and Innovation was being supported, which would enable direct line of sight between the functions and Board and ensure greater strategic alignment, transparency and accountability. The new Academic Board Committee would be established in April 2025 and the Strategy would be a key part of the Committee's work. Oversight of the Research and Innovation BAF was through the Quality Assurance Committee.

The function now supported two main activities research delivery and research development, to enable the internal development, operation and sponsorship of studies. Existing partnerships were being expanded to increase commercial trial opportunities across the group.

Future challenges included uncertainties in respect of funding for 2026/27 from the NIHR RRDN for Clinical Research Delivery Awards (RDAs), other routes to establish a sustainable platform were being explored. Opportunities to secure dedicated spaces across the Group footprint continued to be explored to capitalise on external opportunities for high recruiting commercial trials.

A brief discussion ensued with a number of questions posed and answered. It was noted that a Research Showcase event was scheduled to take place on 23 May 2025 to highlight current research activity and opportunities, as well as highlighting how academic partners were able to support with project ideas and career development in research. In addition, a Research Symposium was taking place on 22 April 2025 working in conjunction with partners, including Healthwatch.

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

GB/253 People Committee Chairs Log

Mark Dias, Group Non-Executive Director presented the Group People Committee Chairs Log for the meeting held on 29 January 2025, reporting that the February meeting had been postponed.

Key topics included an update from the Maternity Champions in respect of the NHSE Review into Maternity Services at STHFT, focusing on leadership and culture. Absence management work was ongoing and assurance was sought for the March meeting regarding planning and risk to support the Group reduction target of 1%. An update was provided regarding low medical job planning sign off rates, which was escalated to Group Board for the Chief Medical Officer to provide an update. A report was presented regarding nurse safe staffing, a report for NTHFT would be presented in March.

David Redpath, Group Non-Executive Director / Resources Committee Chair, sought reassurance regarding preventing timescales for actions being extended having already been agreed.

The positive progress of sharing information and actions between committees and escalation to Board mechanisms was noted. It was agreed that there should be a process in place that when actions were going to be delayed it would be flagged and discussed appropriately.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, the low medical job planning sign-off rates be escalated to Group Board for the Chief Medical Officer to provide an update; and
(iii) that, when a timescale for an action requires to be extended, it is flagged and discussed appropriately.

GB/254 Safer Staffing Report

Maurya Cushlow, Interim Group Chief Nurse presented the Safer Staffing Exception Report for the period December 2024 and highlighted the key points.

Assurance was provided that arrangements were in place to provide a workforce with the right skills in the right place to provide safe, sustainable and productive care. Daily Safe Care Staffing meetings were held to review staffing levels and where required staff were deployed to mitigate risk to the lowest level.

The percentage of shifts filled against the planned nursing staffing for December was 95.5% at STHFT and 99% at NTHFT, however, there remained a reliance on temporary staffing for both registered nurses (RNs) and healthcare assistants (HCSW). Across the Group, turnover and vacancy levels remained positive overall and an improving position was seen regarding the use of bank staff.

Stacey Hunter, Group Chief Executive sought to understand the stark differences in reported turnover data between the two trusts. It was noted that the data was being reviewed to ensure a more aligned approach using the same criteria, which would be included in the next report. Clarity was provided regarding skill mix and fill rate differences following a query by Liz Barnes, Group Non-Executive Director.

It was explained that both trusts were currently reviewing establishment in advance of 2025/26, following a query by Ali Wilson, Group Vice Chair. In addition, a wider review of changes to establishment since 2019 was being undertaken and reported to the Executive Team.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, a review of the criteria used to measure turnover across both trusts be undertaken to support a more aligned approach going forward; and
(iii) that, a Board Seminar be held in June linked to the Clinical Strategy around nursing establishment.

GB/255 Freedom to Speak up Report

Phillipa Imrie presented the Quarter 3: 2024/25 Freedom to Speak up (FTSU) Report and highlighted the key points.

Following the launch of FTSU training on ESR at STHFT, compliance was reporting at 55% for speak up, 50% for listen up and 6% for follow up. Due to lower uptake of the training on ESR at NTHFT, the FTSU Guardian delivered several team-based workshops covering the three modules.

Data showed that 38% of concerns raised by staff were in respect of relationships and behaviours, compared to 40% being reported to the National Guardian's Office for the same theme. Other main themes reported at STHFT were leadership and management, communication issues, systems and processes and bullying and harassment. Going forward the detail in the reports would be aligned for both Trusts to support group understanding and culture.

At NTHFT, the number of anonymous reporting in Quarter 3, was 14% compared to 0% in Quarter 2, at STHFT the number reduced to 28.6% in Quarter 3, from 56.4% in Quarter 2. Continued visibility of FTSU was planned for Quarter 4, through walkabouts, staff training, workshops and staff forums working towards the aim of shifting the culture and making speaking up 'business as usual'.

A single IT reporting system for the Group was being considered to help with the triangulation and like for like comparison of data going forward. There would be further developments for the Quarter 4 report to make the data more aligned. It was suggested that providing data over a 12-month period, as well as a quarter-by-quarter comparison would provide a useful trend analysis. (ACTION)

A discussion ensued regarding the range of themes being reported and staff groups reporting the concerns.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, future reports should include data over a 12 month period, in addition to quarterly information to provide a useful trend analysis; and
(iii) that, agreement be obtained from People Committee prior to the roll-out of the work in relation to detriment.

GB/256 Guardian of Safe Working Reports

Mike Stewart, Group Chief Medical Office presented the Guardian of Safe Working Reports for the period November 2024 to January 2025 and highlighted the key points.

Administration capacity within the rota team and clinical teams at STHFT continued to impact on the ability to meet deadlines regarding workforce schedules and the management of rotas, with work continuing to produce generic work schedules and the correct sized rotas, reporting 70% compliance in the period for issuing work schedules and 97% at NTHFT. Both trusts continued to report concerns relating to workload and staffing shortages, leading to Drs working beyond their contracted hours, which was being reviewed.

The Guardian of Safe Working fines account was now live at STHFT with six fines issued during the period at both trusts. The out of hours hot food provision was being utilised well at NTHFT.

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

GB/257 Resources Committee Chairs Log

David Redpath, Group Non-Executive Director and Chris Macklin, Group Non-Executive Director presented the Resources Committee Chairs Logs for the meetings held on 30 January and 27 February 2025.

Key topics remained the growth in WTE across the Group since 2019/20. A detailed report was

presented identifying the main reasons for the growth but it was noted this remained a real pressure. An update was provided regarding issues with the regional LIMS project, which had been escalated to Group Board and was being managed by the Group Chief Finance Officer and Group Chief Information Technology Officer. There was a focus on the planning guidance for 2025/26.

Acknowledgement was given to the work to date by teams to remain on track to deliver the 2024/25 plan whilst looking forward and working on the detail for the 2025/26 plan.

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

GB/258 Finance Reports Month 10, 2024/25

Chris Hand, Group Chief Finance Officer presented the Finance Reports for Month 10, 2024/25 and highlighted the key issues.

The Group was reporting a deficit of £7.6m, an adverse variance of £0.6m against year to date plan. The overall plan for 2024/25 was to deliver a deficit control total of £7.8m. Continued and sustained improvements in ERF delivery, achievement of recurrent CIP and reduction in expenditure run rates would be essential throughout the remainder of the financial year to ensure delivery of the control total.

The pressure to STHFT on the CDEL allocation for IFRS16 was being managed at an overall system level. An overall net increase of 438 WTE was reported, compared to the average in 2023/24 and was an increase of five WTE compared to the previous month. Income was ahead of plan for both trusts offset by an increase in overall expenditure. The group cash balance was £61.9m. The progress being made in respect of efficiencies was commended.

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

GB/259 Integrated Performance Report

Neil Atkinson, Group Managing Director Group presented the Integrated Performance Report (IPR) for the reporting period December 2024 and highlighted the key points, noting a detailed review had been undertaken through the Committees.

A six month review of the new style Group IPR would shortly commence to ensure it continued to be fit for purpose and a new appendix would be added in support of the health and inequalities work. The metrics would be updated following the 2025/26 planning round and would be mapped against the strategic aims instead of the Care Quality Commission (CQC) domains.

It was noted that a balanced, objective and supportive review of site performance based around the NHS Oversight Framework would commence shortly to provide assurance to the Board around the site leadership model. A brief discussion ensued regarding performance against individual metrics and it was reported that a focused piece of work regarding readmission rates was being undertaken across the Group.

Stacey Hunter, Group Chief Executive highlighted that group wide work was being undertaken in respect of performance against cancer waiting times, which was recognised as a strategic risk and suggested that the Quality Assurance Committee and/or Resources Committee have oversight of the Cancer Recovery Plan and actions being taken to provide assurance to the Board. In addition, introduce an automatic deep dive report to committee for any metrics that do not hit trajectory for 3 months or more.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, the Resources and/or Quality Assurance Committee have oversight of the Cancer Recovery Plan; and
(iii) that, an automatic deep dive report be generated for any metrics over trajectory by 3 months or more.

GB/260 Emergency Preparedness Resilience and Response (EPRR)

Sam Peate, Chief Operating Officer, STHFT and Neil Atkinson, Group Managing Director presented the Emergency Preparedness, Resilience and Response (EPRR) Reports for North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust.

It was reported that compliance was achieved for 50 out of the 62 EPRR core standards for 2024/25 for both trusts and it was proposed to declare a statement of partial compliance (81%) accordingly. This was an improved position on the previous year and work was ongoing in order to achieve substantial compliance going forward. A brief discussion ensued.

It was noted that both trusts were increasingly working together and opportunities for aligned processes and plans were being explored.

Resolved: (i) that, the content of the report be noted; and
(ii) that, the declaration of partial compliance against the 2024/25 EPRR core standards be noted for North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust.

GB/261 Annual Register of Interests

Jackie White, Head of Governance / Company Secretary presented the Annual Register of Interests for members of the Group Board. In line with the Constitution, trusts were required to maintain a register of interests of its Directors, which should be reviewed on an annual basis and referenced in the Trust's Annual Report, with a copy available for inspection on request.

A register of interests was also presented at each board and committee meeting and declaration of interest was a standing item at all key meetings and committees. Further notified changes and subsequent responses would be added to the register.

Resolved: that, the 2024-25 annual register of interests for board members be approved subject to the further notified changes being made.

South Tees Hospitals NHS Foundation Trust Unitary Board items only:

GB/262 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 19 February 2025.

Areas of escalation included Horizon scanning and soft intelligence in respect of risk management and Emergency Preparedness Resilience and Response (EPRR) approval.

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

GB/263 Annual Filings Update

Jackie White, Head of Governance / Company Secretary presented the Annual Filings Update, advising that the submission timetable for the annual filings had been published by NHS England (NHSE), noting the final submission date for the Trust's Annual Report and Accounts was 30 June 2025. Draft Group Accounting Manual (GAM) guidance had been issued by NHSE and the Department of Health and Social Care (DHSC) and a number of amendments to the Trust's accounting policies had made accordingly.

The Trust's external auditors, Mazars would undertake the audit of the 2024-25 Annual Report and Accounts. The Board were asked to delegate authority to the Audit and Risk Committee and the Quality and Assurance Committee for the ongoing monitoring and approval of the annual filings on behalf of the Board.

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

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

GB/264 Annual Filings Update

Jackie White, Head of Governance / Company Secretary presented the Annual Filings Update, advising that the submission timetable for the annual filings had been published by NHS England (NHSE), noting the final submission date for the Trust's Annual Report and Accounts was 30 June 2025. Draft Group Accounting Manual (GAM) guidance had been issued by NHSE and the Department of Health and Social Care (DHSC) and a number of amendments to the Trust's accounting policies had made accordingly.

The Trust's external auditors, Deloitte would undertake the audit of the 2024-25 Annual Report and Accounts. The Board were asked to delegate authority to the Audit and Risk Committee and the Quality and Assurance Committee for the ongoing monitoring and approval of the annual filings on behalf of the Board.

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

GB/265 Audit Committee Chairs Log

Alison Fellows, Group Non-Executive Director presented the Audit Committee Chairs Log for the meeting held on 5 February 2025.

Key topics included receiving a new assurance report setting out how the Trust gains assurance from a range of sources and has a proportionate framework of assurance in place. An overview of the audit recommendations from the Audit One 2023/24 and 2024/25 internal audits was provided including outstanding actions. Stacey Hunter, Group Chief Executive highlighted that any requests to extend the timescale to respond to outstanding audit actions should be presented to the Executive Team Meeting for approval.

It was agreed that an additional Group Non-Executive Director would be added to the Audit Committee membership to ensure quoracy at meetings.

David Redpath, Group Non-Executive Director and Group Resources Committee Chair highlighted there were outstanding actions in relation to under and over payments at STHFT. It was agreed to follow this up and agree a timescale.

Resolved:
(i) that, the content of the report be noted; and
(ii) that, an additional Non-Executive Director member be added to the Audit Committee to ensure quoracy at meetings; and
(iii) that, the outstanding audit actions in relation to under and over payments at STHFT be followed up and a timescale be agreed.

GB/266 Appointment of the Senior Independent Director

Jackie White, Head of Governance / Company Secretary presented a proposal to appoint Ada Burns, Group Non-Executive Director as the Senior Independent Director (SID) for North Tees and Hartlepool NHS Foundation Trust (NTHFT), in addition to her current role as SID for South Tees Hospitals NHS Foundation Trust (STHFT).

Chris Macklin, Group Non-Executive Director and current SID for NTHFT notified the Trust of his intention to retire and step down from both roles with effect from 30 April 2025. The SID is a statutory role appointed by the Board of Directors in consultation with the Council of Governors to provide a sounding board for the chair and to act as an intermediary when necessary, in addition to leading the annual chair appraisal process.

The proposed SID appointment would be discussed at the scheduled meeting in common of the Nominations Committee on 12 March 2025.

It was noted that Ada Burns would continue as SID of both trusts until 31 August 2025 when her current term of office was due to end. A process would be undertaken to appoint a Group SID with effect from 1 September 2025.

The Chair reported that Liz Barnes, Group Non-Executive Director would be standing down with effect from the end of June 2025.

Resolved: (i) that, the appointment of Ada Burns as Senior Independent Director for both South Tees Hospitals NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trust be approved, subject to consultation with the Council of Governors; and
(ii) that, it be noted Liz Barnes, Group Non-Executive Director would be standing down with effect from end of June 2025.

GB/267 Any Other Business

There was no other business reported.

GB/268 Date and Time of Next Meeting

Resolved: that, the next meeting be held on, Thursday, 8 May 2025 in the Boardroom, 2nd floor, Murray Building, James Cook University Hospital.

The meeting closed at 3.45pm.

Signed:  Date: 8 May 2025

Ann Baxter, Group Vice Chair

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	08 May 2025	Open	An update was provided. The NENC Innovation Board had not yet met, it was anticipated it would meet 3/4 times per year.
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	08 May 2025	Open	An update was provided, it would be taken through the Group People Committee in March 2025, as the February meeting had been stood down.
07 January 2025	GB/216	***Patient Experience and Involvement Report Quarter 2: 2024/25*** Deep dive into specific themes of complaints relating to 'communication' to be undertaken and reported to Quality Committee.	Emma Nunez	08 May 2025	Open	It was noted that 'communication' was a broad heading for complaints themes, so a deep dive would be undertaken and the analysis presented to the Group Quality Committee. It would be included in the next Patient Experience Report.
07 January 2025	GB/216	***Patient Experience and Involvement Report Quarter 2: 2024/25*** A trajectory to be introduced to monitor progress against the number of complaints outside of the statutory response timescale.	Emma Nunez	08 May 2025	Open	It was agreed to set a month on month trajectory to monitor improvement against the number of complaints outside the statutory 60 days complaint response time. It would be included in the next Patient Experience Report.
04 March 2025	GB/248	***Group Chair's Report*** *A discussion regarding the developing Teesside University Medical School to take place at a future Board Development session.*	Jackie White	05 June 2025	Completed	It was agreed to have a wider discussion at a future board development session regarding the development of the new Medical School at Teesside University. An update was provided at the April session.
04 March 2025	GB/251	***Quality Assurance Committee Chairs Log*** *The Public Health Consultants from both trusts to be invited to attend a future Board Development session to provide an update regarding current projects and progress with the inequalities element of the IPR.*	Jackie White	05 June 2025	Open	It was agreed it would be helpful to invite the Public Health Consultants to a future Board Development session to share with the Board current projects and progress to date, including the development of the new inequalities element of the IPR.
04 March 2025	GB/251	***Quality Assurance Committee Chairs Log*** *The high level IPC plan to be shared with Board*	Emma Nunez	08 May 2025	Open	It was agreed to share with the Board the high level plan in respect of IPC.
04 March 2025	GB/253	***Group People Committee Chairs Log*** *An escalation to Group Board for an update to be provided regarding low medical job planning sign off rates by the Chief Medical Officer.*	Mike Stewart	08 May 2025	Completed	An update was provided regarding low medical job planning sign off rates, which was escalated to Group Board for the Chief Medical Officer to provide an update.
04 March 2025	GB/253	***Group People Committee Chairs Log*** *A process to be set-up to ensure extended timescales for outstanding actions are flagged and discussed appropriately.*	Jackie White	08 May 2025	Open	It was agreed that when timescales for actions were required to be extended, they should be flagged and discussed appropriately.
04 March 2025	GB/254	***Safer Staffing Report*** *A review of the criteria used to measure turnover data across both trusts to be undertaken to support more aligned reporting going forward.*	Emma Nunez	08 May 2025	Open	There were stark differences in the reported turnover figures between the Trusts and a review was being undertaken to ensure the same criteria were being measure against.
04 March 2025	GB/254	***Safer Staffing Report*** *Undertake a Board Seminar in June 2025 linked to the Clinical Strategy around nursing establishment.*	Emma Nunez/ Jackie White	05 June 2025	Open	It was agreed to hold a Board Seminar to share with the Board the work being undertaken across both trusts in respect of nursing establishment.
04 March 2025	GB/255	***Freedom to Speak up Report*** *Ensure the roll out of the work around detriment as part of Freedom to Speak up has prior agreement with People Committee.*	Ian Bennett	08 May 2025	Open	Prior to the planned roll out of the detriment work agreement was to be obtained from People Committee.
04 March 2025	GB/255	***Freedom to Speak up Report*** *Future reports to include data over a 12 month period, in addition to quarterly information to enable a trend analysis.*	Ian Bennett	08 May 2025	Open	It was agreed that providing data over a 12 month period in future reports, in addition to quarterly information would provide a useful trend analysis.
04 March 2025	GB/259	***Integrated Performance Report*** *The Quality Assurance Committee and/or Resources Committee to have oversight of the Cancer Recovery Plan and actions being taken to provide assurance to the Board.*	Mike Stewart Emma Nunez	08 May 2025	Open	It was reported that performance against cancer waiting times was recognised as a strategic risk and suggested that the Quality Assurance Committee and/or Resources Committee have oversight of the Cancer Recovery Plan and actions being taken to provide assurance to Board.

04 March 2025	GB/259	***Integrated Performance Report*** *Introduce an automatic deep dive report to be presented to the Committees for any metrics that are not hitting trajectory for 3 months or more.*	Jackie White/ Neil Atkinson	08 May 2025	Open	To support oversight and scrutiny it was suggested to introduce an automatically generated deep dive report to be presented to Committee for any metrics not hitting trajectory for 3 months or more.
04 March 2025	GB/259	***Integrated Performance Report*** *Readmission rates to be discussed in Quality Committee*	Lindsay Garcia/Beth Swanson	08 May 2025	Open	It was agreed to review and discuss the group position regarding readmission rates in Quality Committee.
04 March 2025	GB/265	***Audit Committee Chair's Log*** *An additional Non-Executive Director member be added to the Audit Committee to ensure quoracy at meetings.*	Jackie White	08 May 2025	Open	It was agreed that an additional Group Non-Executive Director would be added to the Audit Committee membership to ensure quoracy at meetings.
04 March 2025	GB/265	***Audit Committee Chair's Log*** *The outstanding audit actions in relation to under and over payments at STHFT to be followed up and a timescale for completion to be agreed.*	Jackie White	08 May 2025	Open	It was agreed to follow up the outstanding actions in relation to under and over payments at STHFT and agree a timescale for completion.

University Hospitals Tees

Group Chair's Report

Meeting date: 8 May 2025

Reporting to: Group Board

Agenda item No 7

Report author: Jackie White, Company Secretary

Action required:
Information

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:

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 Board

Thursday, 8 May 2025

Group Chair's Update Report

1. Introduction

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

ICB Chairs and Trust Chair meeting

I attended an ICB and trust chairs meeting on Thursday, 13 March 2025. The discussion focussed on the key issues for the health service and the important role that Chairs and Non-Executive Directors can and will play in navigating them. This included the financial and operational planning process for 2025/26, as well as the 10 Year Health Plan.

Group governance report

The Chief Executives report refers to an audit undertaken by Audit One on behalf of both Trust Audit Committees who sought independent assurance on the implementation of the Group Governance framework. The report whilst in draft and an advisory report provides significant assurance on the implementation of the governance framework during the first year of operation.

Charities meeting in common

The teams of South Tees Hospitals Charity and North Tees & Hartlepool Charity have been working together to establish common processes for bidding for funding and grants by staff and joint working on fund raising events. The Trustees of the Charities are pleased with the progress to work together and align the charitable objectives for both charities in support of the Group.

New robotic and emergency maternity surgical theatre

I was pleased to be able to visit the new £4.3 million robotic and emergency maternity surgical theatre on the North Tees site. The state-of-the-art facility has been constructed on the hospital's first floor, spanning the space above the atrium near the main entrance and supported by permanent columns from the ground floor. This is one of the most ambitious estates projects in the history of hospital, the new theatre complex includes a cutting-edge robotic surgical and training space and a dedicated emergency maternity surgery theatre.

The new emergency maternity theatre is close to the delivery ward suite and is designed to provide the best clinical environment to support surgeons in providing what are often lifesaving procedures.

NHS Providers Chairs, CEO meeting – 1 April

The event on 1 April was well attended, and the focussed on updates on strategic policy and developments, sharing analysis on what these may mean for the provider sector. There was a good discussion on progressing the three shifts, the developing vision for integrating out of hospital care at neighbourhood level and early insights on the 10 Year Health Plan's development and finally on implementing the government's health mission
tunity to hear more about the government's health mission and the
nd 10-year health plan in progressing its ambitions. This also

included reflections on the introduction of regulation for NHS managers and ongoing reforms to tackle immediate operational and financial pressures. Colleagues from NHS England attended and there was a discussion on the impact of the abolition of NHS England and the merger of its functions with the Department of Health and Social Care.

Covid 19 memorial
I was very pleased to be able to attend with the Chief Executive the Covid 19 Memorial celebrations across our hospitals in North Tees and Hartlepool. Students from Stockton Sixth Form College were commissioned to paint duplicate pieces for installations at both Hospital sites, after successfully winning a competition.

The unveiling of both sets of paintings took place at both hospital sites on world health day, inviting Stockton Sixth Form College, local council, as well as key community stakeholders.

During the unveiling the trusts chaplaincy team held a small memorial service and offered blessings, with people encourage to share their own memories from the pandemic on special COVID-19 Memorial trees in each of the chapels.

Armed forces / veterans coffee
Under Group arrangements, both Trusts continue to work collaboratively to deliver on the Armed Forces Covenant commitment. Future reaccreditation processes will be a joint submission to demonstrate the greater benefit of operating under Group arrangements as University Hospital Tees.

The most recent Quarterly Armed Forces & Veterans Coffee Morning took place on 8th April 2025, which provided the opportunity to hear first-hand the experience of services being received by armed forces personnel and veterans in primary and secondary care. Quarterly coffee mornings are scheduled to take place at all 4 main sites during 2025/26 and we remain committed to working collaboratively with all our stakeholders. An update to the Group Board on the Armed Forces Covenant will take place later this year.

Governwell training for new governors
Last week we were pleased to invite NHS Providers to Teesside to provide core skills training for new governors along with subject specific updates in relation to finance and working with local community and constituents. This is the second session we have provided to our governors who have found the sessions very informative.

Changes to the Board
Chris Mackin, Non-Executive Director and Senior Independent Director left the Group on 30 April 2025 following a 50 year service across the NHS. Chris has been a key member of the Board of North Tees & Hartlepool NHS Trust and latterly in the Group steering the Board and Committees through some significant challenges. Enjoy your retirement Chris!

I would like to welcome Professor Chris Day who joins us from Newcastle University. Chris will support the Group with its ambition to have teaching hospital status and to chair our new Academic Board which will focus on education, research, development and innovation. Chris will join the Board in May.

Tees Valley research symposium
I was pleased to be asked to attend and do the closing speech for the Tees Valley Research Symposium, which Dr Mike Stewart opened. The event was well attended from lots of organisations involved in research and there was a great opportunity to work together to identify Teesside research challenges, strengths and opportunities for future collaborations regionally and nationally.

Group Board walkrounds and development sessions

The Group Board met on 3 April as part of their development programme. We received an update from Professor Stephen Cummings from Teesside University on the progress with establishing a medical school on Teesside. We also had the opportunity for a walk round and visited the new Digital Life building and Bios.

In the afternoon we had an update on the University Hospitals Tees Strategy which we will be considering in Board today and discussed the progress with delivery of the annual plan in regard to financial sustainability unwarranted variation.

2. Recommendation

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

Professor Derek Bell
Group Chair

University Hospitals Tees

Chief Executive Report

Meeting date: 8 May 2025

Reporting to: Group Board

Agenda item No 8

Report author: Abigail Smith, Executive Assistant to CEO

Action required: Information

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:

Key discussion points and matters to be escalated from the meeting

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

The Board are well sighted via the planning process on the level of risk to the delivery of our plan in 25/26, which will need continued drive and oversight.

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

Key focus throughout February and March was on responding to the planning guidance and what this means in terms of activity, workforce and financial plans. Final submission was agreed by the Board for the March deadline. Following this submission, I joined other NENC provider and the ICB CEOs in a session with the regional team. The regional team had opportunity to understanding the level of challenge in all providers' plans and explore our ongoing individual and collective efforts to mitigate the risks to delivery. This included the difficult decisions we have agreed to deliver as part of the requirement to live within our means. It was a productive meeting following which the regional team confirmed that NENC would not require further escalation or intervention at this stage.

I attended the national CEO forum on the 29th April, which focused on:

Current operating context
Financial position and progress
Emerging Operating Model
Update on the 10 year Health Plan

I will share further details with the Board when we meet in May.

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

The Board will want to join me in thanking our teams for their contributions to delivery of the financial plans for 24-25. Whilst we know there is more to do in this current year to secure greater recurrent savings it is important to acknowledge this achievement.

The commitment to delivery of a UHT wide strategy co-created with clinical boards, operational teams and broader partners for the Board's agreement early in Q1 25/26 has been executed. The Board will have the opportunity at our meeting in May to consider the final outputs of this work. This is a significant moment in our journey to use our collective group wide assets to achieve greater equity of access, experiences and outcomes for the communities we serve. As Board colleagues know from their involvement to date at its heart we want to take opportunity to ensure our hospital based services are horizontally integrated to reduce unwarranted variation in practices and ensure we are using our scale to help us with our ongoing efforts to be even more productive. This is balanced with ambition to build on our successes in delivering community health services with an explicit commitment to moving more activity into community settings and people's place of usual residence. This will help us ensure that as we transform how we deliver care over the coming years we make significant progress on the three shifts in the model of care as well as the focus on neighborhood health expected in the forthcoming 10-year health plan.

Recommendations:

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

Group Board

Thursday, 8 May 2025

Group Chief Executive's Report

1. Introduction

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

1.1 National priorities

As colleagues are aware this last 6-8 weeks has been a period of significant change across the NHS including a change of leadership at NHS England, announcement of the abolition of NHS England and the requirement for NHSE and ICBs to reduce their costs by 50 percent for Q3 25/26.

The immediate focus for Sir Jim Mackey was to make significant progress during the latter part of the 25/26 planning round with respect to financial position across the NHS. I am conscious all Board members have needed to commit significant time into our plans as part of this and I am grateful for that support. Of course, the hard work is in the delivery of our plans over the coming months and years.

Nationally there has been significant progress made by systems over this last period both in relation to the financial position and the performance standards.

The plans are acknowledged to be challenging and there is a recognition that alongside the national and ICB changes providers will have to take some difficult decisions to live within their financial plans.

This includes reductions in headcount, addressing unwarranted variation in clinical practice, increased productivity in core delivery of outpatients, theatres and length of stay alongside bespoke plans in individual services, which the Board have agreed.

There have been some changes to the elective recovery plan rules of engagement and a recent consultation, which we need to digest and understand what further opportunities this may present for reducing our waiting times for patients.

Work will continue on merging NHSE with the DHSC being led by Penny Dash and Alan Milburn to create a single aligned center and there is ongoing work on clarifying the roles and functions of ICBs (Model ICB) which are expected to be published imminently.

Given the scale and pace of change, it is clear that our collective leadership efforts need to be focused on securing delivery of our 25/26 plan during this transition period. This includes ensuring we have early and comprehensive oversight of our winter plans. I am keen that we

get the opportunity to do an initial Board review of these plans at the start of Q2.

1.2 Scotland's Ruling on Transgender

Colleagues may have seen the recent UK Supreme Court judgement that has ruled that the legal definition of a woman should be based on biological sex and not gender identity. The judgement also makes it clear that if a space or service is designated as women-only, a person who was born male but identifies as a woman does not have a right to use that space or service. We recognise that this ruling may have created additional anxiety for the transgender and non-binary community and are supporting our colleagues along with the help of our staff networks. We are now carefully considering this judgement, and balancing the needs to be legally compliant whilst also supporting and valuing our transgender colleagues and patient.

1.3 NENC CEO Leadership Group

There has been a clear shift from planning to delivery including a response to NHSE KLOEs, and de-risking the delivery plans. The system recovery board (of which I am a member) will expand its remit during the transition changes to include oversight of delivery of provider CIP plans.

1.4 NENC Provider Collaborative Leadership Board

The provider collaborative CEOs have agreed a plan to reduce the overhead and running costs of PLB by 40 percent. This has included re-prioritising the programmes of work for the next year aligned to the overall plans.

A Strategic Approach to Clinical Services (SACS) programme has been established to develop a 5-10 year approach to deliver clinical service sustainability across acute secondary and tertiary services. Following a recent engagement process with clinical leaders across NENC the team are working to triangulate data including performance, quality, finance and patient insight analysis, with a view to take to the SACS Board in April. The team are also looking at current services vulnerabilities with an aim to offset service destabilisation before it arises. One of the services that is being explored in respect of a more joined up collaborative approach is Neurology. Our Group Medical Director is a member of this board and will ensure we are kept appraised as this work progresses.

Workforce remains a key programme and plans are progressing to develop a regional bank to allow medical and nursing bank staff, being managed by a central location, to work across multiple locations. Enhancing governance and controls for the approval of bank staff and agency spend across the region, giving equity and sufficient level of oversight.

1.5 UHT

As Board colleagues will appreciate the context we are operating in and nature of the challenges we are responding too are causing concern for some of our staff. We are working hard to ensure we are being transparent about the difficult decisions we have made and are

continuing to consider, and are using all of our communication and engagement routes including our Cost of Caring campaign which includes giving staff the opportunities to share their ideas for waste reduction, changes in how we do things and any activities that they think are not adding value to patients and families.

The Rapid Quality Review meeting re Maternity services at South Tees took place on the 16 April 2025. It was chaired by Regional Chief Nurse and included colleagues from National Maternity Safety Support Programme, Regional Maternity Team North East North Cumbria ICB and Local Maternity and Neonatal System. The meeting reflected on the outputs of the cultural review, recognising the organisational change to date; with particular acknowledgement being paid to the action taken in relation to the report recommendations, and what support may be helpful as the change process for the group continues. It was agreed that South Tees will be on boarded to the Maternity Safety Support Programme and that Simon Meighan will be assigned as the Maternity Improvement Advisor to ensure continuity from the work in North Tees previously. It was agreed that the on boarding will be proportionate, recognising that although the Trust is NOF rating 3 for financial position, this is not the case for quality and therefore NHSE will need to review the entry criteria. Exit criteria for the programme will be agreed at the commencement of the process.

As Board members will recall the Audit Committees of North Tees & Hartlepool NHS Trust and South Tees Hospitals NHS Trust commissioned an internal audit of the Group Governance Framework to provide assurance to both Trust Boards of the effectiveness of group level governance arrangements following the formation of group working arrangements between the two Trusts. The report, which has been received in draft, highlights that the architecture and structure of governance is appropriate and that matters reserved and delegated have been appropriately complied with. In addition, it was pleasing to note that the governance structure was well received and understood by colleagues. Areas of focus for the Board and Committees over the next year as we progress with our Strategy, which will be considered by the Board today, include moving to delivery and oversight of the strategy and a focus on culture.

1.6 In other news!

Friarage Surgical Centre

The national GIRFT Team were at the Friarage on Sunday 6 April to complete an accreditation assessment of the surgical centre. Non-Executive Director Ali Wilson supported the process. Feedback was overwhelmingly positive highlighting the level of innovation and vision. Full accreditation was confirmed on Monday 28 April. (Please see appendix A – successful letter notification).

Covid Memorial

The Group Chair and Dr Jean Macleod, lead Medical Examiner and Chair of the Visual Arts Council for North Tees and Hartlepool NHS Foundation Trust, led a piece of work creating lasting Covid Memorials at both North Tees Hospital and Hartlepool Hospitals. I attended both Covid Memorial dedication opening events, which were well received. There are plans

to do the same at South Tees Hospitals NHS Foundation Trust.

Teesside University Medical School

The UHT Group has been in discussions with Teesside University (TU) and fully supports their ambition to establish a prestigious medical school. This initiative aims to attract and retain local talent, while addressing regional healthcare challenges. The North East, particularly Tees Valley, faces a shortage of GMC-recognised doctors, impacting clinical staff recruitment and retention. TU's history of training healthcare professionals and its collaboration with NHS Trusts and Integrated Care Boards supports the natural progression to a medical school.

The proposed TU Medical School will serve the Tees Valley's long-term healthcare needs, focusing on primary care and public health disparities, with themes of digital health and inter-professional learning. Located in Teesdale Business Park, Stockton, it will feature state-of-the-art facilities and aim to enrol new medical students annually, growing to include pharmacy, optometry, and speech and language therapy programs. Partnerships with regional NHS Trusts and academic institutions will ensure alignment with local healthcare needs and drive innovation.

2. RECOMMENDATIONS

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

NHS
University Hospitals Tees

Chair's Log – Group Management Team Meeting

Meeting date: 20 March 2025

Reporting to: Group Board

Agenda item No: 8.1

Report author: Abigail Smith, Executive Assistant to CEO

Action required: Assurance

Delegation status: 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 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:

All Board Assurance Framework domains

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 were no matters for escalation to the Board following the March meeting of the Group Management Team

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 annual planning submission has been a significant focus for all leadership teams over this period. Board have been kept updated on the progression via 2 weekly meetings that they delegated to the CFO, CEO, Chair of resources committee and one of the other NED members of the resources committee.

Whilst it has been an exceptionally challenging planning round particularly in relation to the financial requirement Group Management Team expressed increased confidence that the plans would be finalised and submitted for the March 21st deadline.

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

Site Leadership Team Reports

Chief Operating Officers from each Trust provided detailed site leadership reports. There were no matters for escalation to Board.

Cancer Recovery Plan STHFT

The position re 62 day cancer performance is an outlier which Board are aware. The teams have been asked for tumour site specific improvement plans with clear trajectories to support the delivery of the overall level if improvement we have committed to in the 25-26 plans (circa 10 percent at an aggregate level). Group Management had opportunity to review a report that provided data and analysis for each pathway including some forecasting of the increase in performance that is expected as the specific improvements are delivered. This will be reported via the IPR to the Board and we will continue to give this focus via the Group Management meeting. As colleagues will appreciate improving waiting times and experiences of people with a potential cancer diagnosis is a significant priority.

Digital Strategy

d the group on the working looking at the consolidation and ontracts with a view to reducing costs and aligning our infrastructure

at scale. There is a technical infrastructure review, looking to deliver a single technical infrastructure under UHT. This will also support opportunities to rationalise and consolidate digital estate across the trusts.

The business case for a UHT wide EPR is progressing with key delivery milestones agreed.

Estates Strategy

Work continues on cost savings looking at a wide range of projects, including;

- Car parking – standardisation across UHT
- Properties across UHT – lease opportunities
- Space Utilisation – standardised approach across UHT
- Sustainability/Energy and Waste – waste management across UHT, and Decarbonisation
- Capital – looking at priorities and a 3-5 capital programme
- CSSD – group working to support surgical sites
- PFI – additional monitoring
- Benchmarking and identifying areas of improvement

UHT People Plan

Proposed values - Collaborative, Support and Learn, these will be embedded throughout the plan. The four strategic aims are culture and belonging, looking after our people, collaborative way of working, and growth for the future.

Risk Management Strategy

Strategy is in the process of being finalised and is expected to be complete by July. Audit One are reviewing group arrangements therefore may get some recommendations from this that would be useful to reflect.

Strategic Outline Case

KPMG are now working with Director colleagues to support the production of the SOC which we want to have completed in the next 3-6 months. This will reflect the UHT clinical strategy and any emerging priorities from the national 10 year health plan. We should be in a position to share the first draft with the Board at the end of May 2025.

BAF & Operational Risk Report

Exception review of operational risks has been completed for both organisations. Internal audit review of BAF ongoing for both organisations. Planned drop in sessions arranged with BAF authors to look at future strategic risks.

Recommendations:

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

Caring Better Together

NHS
University Hospitals Tees

Chair's Log – Group Management Team Meeting

Meeting date: 17 April 2025

Reporting to: Group Board

Agenda item No: 8.2

Report author: Abigail Smith, Executive Assistant to CEO

Action required: Assurance

Delegation status: 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 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:

All Board Assurance Framework domains

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.

Nothing to escalate to the Board.

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 requirement to deliver job plans for 95% of all consultants by the end of March 2025 has not been met.

The CMO brought a report detailing the remedial plan to address this and ensure this standard is delivered by the end of quarter 1 25/26.

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

The group received a verbal update that the financial plan for both trusts for 24/25 was delivered. Given the challenges experienced throughout the year the group recognised and thanked colleagues for their contributions in securing this.

Whilst there is still further to go the group recognised the continued improvement in the delivery of ambulance handover times at James Cook.

The work needed to produce a strategic outline case for investment in a new build aligned to the UHT strategy is progressing to the timelines agreed.

Business Cases

The meeting considered 2 business cases focused on realising our ambition to shift more care closer to and into people's usual place of residence. They are priorities within the 25/26 plan, which Board will be familiar with.

One of the business cases is at options appraisal stage and the group considered 5 options, were able to exclude 2 and asked for further details to support the final decision in quarter 1.

The other business case is at a much earlier stage and the collaborative leading this work sought support from the group to strengthen the analysis, which will take circa 6-8 weeks. This was agreed.

Communications and Engagement

This report highlights the thematic focus of the communications team(s) for UHT. The team continue to monitor media (in house) and issue a media log with a rag rating on a weekly basis to board colleagues. The team also view thematic occurrences and work directly with teams to ensure a comprehensive understanding and narrative is as standard.

Consultant Job Planning

A collective approach has been adopted to continue to progress the Group's current job planning status towards the 95% target, with regular progress reports issued on a weekly/monthly basis. In FY 25/26, there will be an increased focus on the quality of job planning and how this is linked to demand and capacity data.

Strategic Outline Case for investment in a new build

A number of required activities have been completed and further key activities are planned to continue progress towards the draft SOC deadline date. The group were assured that the work is progressing to the timelines agreed to enable the Board to see a first draft at the end of quarter one.

Annual Declarations of Interest / Annual Register of Gifts and Hospitality

Final report submitted offering an overview of the annual requirements for all staff in a decision-making position to declare and declarations of interest and gifts or hospitality. There were no risk implications highlighted.

Recommendations:

[redacted]he report. No further action is required from the Board.

Caring Better Together

NHS
University Hospitals Tees

UHT Strategy

Meeting date: 8 May 2025

Reporting to: Group Board (public)

Agenda item No: 9

Report author: Matt Neligan/James Bromiley

Action required:
Approval

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:

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.

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.

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 development of the UHT strategy has been considered by the Group Board throughout the last year during Development sessions. This Strategy builds on that work and sets out our proposals for the future ambitions of University Hospital Tees (UHT).

Recommendations:

The Board is asked to:

- Approve the UHT Strategy (subject to any agreed changes and to formatting) for wider circulation and publication.
- Approve the strategic objectives within the strategy that will form the basis of the Board Assurance Framework (BAF) going forward.

Caring Better Together

Group Board of Directors
Thursday, 8 May 2025
UHT Strategy – final draft

1. PURPOSE OF REPORT

The report includes a final draft of the UHT Strategy and seeks approval from the Group Board for its publication and wider engagement.

2. BACKGROUND

The UHT Strategy has been developed since the inception of the Group. Board colleagues have collectively shaped its structure and content through board development session and specific discussions over the course of the last year, including regular discussions with a subgroup of Non-Executive Directors.

The Board has consistently said that it wanted the UHT Strategy to be bold and ambitious and to set out clearly the benefit in working together as a group beyond the aggregate scale implied in two individual statutory organisations. The Board has also been clear that we should be seeking to seize this opportunity not merely to adapt existing UHT services but to work with partners to re-invent the way in which healthcare is delivered across our population for the next generation.

The five UHT Clinical Boards, drawn from clinical and operational backgrounds and from across both Trusts, have been working on clinical proposals since May last year. Their work has contributed strongly to the strategy and sits at the core of our proposals for the future.

3. DETAILS

Structure and content

The structure of the Strategy has been agreed previously with the Board.

It starts by setting out our context and the specific features of our population and our current services. In particular it emphasises the impact of substantial health inequalities both within our area and relative to the wider UK population; and the opportunities we see to address those issues through working together as UHT.

Our vision and values underpin the way in which we will work together to achieve our strategic objectives. Each of these have been developed through extensive interaction at board level. The strategic objectives for UHT replace the previous separate objectives for South Tees Hospitals NHS FT and those for North Tees and Hartlepool NHS FT. These six new objectives address all of the areas of focus of the previous objectives for the two Trusts.

In order to deliver our strategic objectives we will need to work differently through three pillars of reform:

- **Patients and populations:** our work to reform our clinical services so that we develop new models of care across the UHT footprint that meet the needs of patients and address population health priorities;

- **People:** being an employer of choice for our existing people and potential new colleagues, developing our people through living our values and creating an outstanding experience across all teams in UHT. Ensuring that we are a learning health organisation with a culture of continuous improvement; and

- **Partnerships and places:** our close collaboration with all of our partners to develop and deliver our shared integrated care strategy and ambitions in local places. Working in communities to maximise our impact as an anchor institution.

Supporting these pillars will be our transformation of key enabling functions (in particular our work in quality, digital, estates and productivity) and the development of our revised operating model.

Our Clinical Strategy is at the core of our Strategy. The work of the Clinical Boards has led us towards the adoption of a model, which sits in three phases. In 2025/26 the focus will be on horizontal integration of some services; in 2026/30 the completion of horizontal integration across all services and some service consolidation; and then from 2030 onwards a major reconfiguration of services with a differentiated approach to the use of the two acute sites within a single UHT hospital system. This is tied in with our Strategic Outline Case for the redevelopment of the North Tees site.

Each year we will agree an action plan and will publish the metrics which will assess the impact of the changes we are making for our staff, patients and the wider population.

Next steps

We will finalise this version of the Strategy subject to feedback from the Board and will make it publicly available as the basis of the next phase of ongoing engagement with internal colleagues and with external partners.

While the publication of the Strategy is a major milestone, much more remains to determine the detail of how individual services will work within the broad direction that the Strategy outlines. We will need to engage widely both internally and externally on its content to ensure successful implementation. We will work intensively to engage with staff and partners so that we understand their views on the specifics of the proposals and how they should be implemented.

Any significant new feedback or developments (including the publication of the government Ten Year Health Plan) will be considered through the Board and reflected in a professionally designed version of the Strategy scheduled for autumn 2025.

4. RECOMMENDATIONS

The Board is asked to:

- Approve the UHT Strategy (subject to any agreed changes and to formatting) for wider circulation and publication.

- Approve the strategic objectives within the strategy that will form the basis of the Board Assurance Framework (BAF) going forward.

APPENDICES
(UHT Strategy final draft)

University Hospitals Tees: Group Strategy

Caring Better Together

Our population

Key points

- We serve 700,000 people who access our local acute and community services across Teesside, North Yorkshire and County Durham
- 1.85m people access our tertiary and specialised services within the wider regional footprint
- Our core local population live in seven different local authority areas
- Much of our population experiences poor health outcomes and deeply embedded health inequalities
- Wider social and economic conditions including post-industrial environment are key determinants of health outcomes

1. University Hospitals Tees serves a local population of around 700,000 people who live and work in the Tees Valley (Hartlepool, Stockton-on-Tees, Middlesbrough, Redcar and Cleveland, and Darlington) and in parts of North Yorkshire and County Durham.

2. For some of our more specialist services, for example in cancer, specialist rehabilitation and vascular surgery we serve a much wider population of around 1.85 million people, reaching from the Scottish Borders into Yorkshire.

3. There are high levels of health inequalities, both within our population and also between the local population and the England average. For example, in Stockton life expectancy is 15.2 years lower for men and 13.8 years lower for women in the most deprived areas than in the least deprived areas of the borough.

4. Our major concentrations of population are in the urban areas of the Tees Valley but our population also includes significant rural areas, for example in Hambleton and Richmondshire and in East Cleveland, and coastal communities such as Hartlepool and Peterlee. These factors are associated with differences in living conditions and health outcomes within those populations.

5. A significant proportion of our population experiences high levels of deprivation. All Tees Valley local authorities are more deprived than the national average with Middlesbrough and Hartlepool among the 10 most deprived local authorities in England.

6. There is a clear link between levels of deprivation and the likelihood of poor health and preventable mortality. The social and economic conditions across our communities drive significant demand for our services and require us to ensure that we are targeting our resources effectively and ensure that our services are accessible for our most deprived communities to make the biggest difference that we can to close this gap.

Insert graphics showing health inequality gaps

7. Over the next ten years we know that our population is likely to increase (although at a lower rate than for the rest of England), and will have an older average age, with the Tees Valley over 65 population increasing by about 2,000 per annum and the working age population shrinking. Our population is also becoming more diverse from the perspective of ethnic and cultural background. Both of these factors mean that the health issues people are likely to face will change. Alongside that, we are likely to see increased levels of deprivation and obesity in both children and adults.

8. While the Tees Valley has historically undergone economic shocks due to the closure of some of its heavy industry base, which has fed into some of the issues around deprivation, it is hugely ambitious. The wider Tees Valley economic region contributed £79 billion to the UK economy in 2020 and is projected to grow fast following recovery from the pandemic, providing 10% of GDP growth across the north of England by 2040 with only 4% of the population. Key areas of sectoral strength include the chemical and process industry, advanced manufacturing, and construction.

Our services

Key points

- University Hospitals Tees came together as a group in 2024, bringing North Tees and Hartlepool NHS FT and South Tees Hospitals NHS FT together
- We have 16,000 staff and a budget of £1.4bn
- We have four main hospital sites: James Cook University Hospital, University Hospital of North Tees, the Friarage Hospital Northallerton and University Hospital of Hartlepool
- Our community services are based out of 10+ sites across our communities and delivered across the district in patients' homes and community facilities
- As an anchor institution we are well-placed to have a significant positive impact for our wider communities

9. The University Hospitals Tees group is the largest employer in the Tees Valley with over 16,000 staff and a budget of £1.4bn per year.

10. We were formed in 2024 when North Tees and Hartlepool NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust came together to operate under a group model with shared governance and leadership arrangements across the two trusts.

11. We work with two Integrated Care Boards (ICB) as commissioners of our services – North East and North Cumbria ICB (for our population in Tees Valley and areas of County Durham), Humber, and North Yorkshire ICB (for our population in Hambleton and Richmondshire.

12. As a major public sector employer, we have a significant role as an anchor institution, working alongside partners and beyond our role as a healthcare provider to enable sustainable, prosperous, and healthy communities.

13. We are an integrated provider of acute and community healthcare. While there are obviously circumstances when people need to be in a hospital setting, it is also important that our population is able to access healthcare close to home where that is appropriate. This may be delivered in a range of community facilities or in patients' own homes.

14. Our services are based out of multiple community sites across the area and from four main hospital sites:

15. The **University Hospital of North Tees** in Stockton-on-Tees is a small local district general hospital with 563 beds. It provides a 24-hour emergency department, emergency and planned medical and surgical care, maternity services and a wide range of diagnostic services and outpatient clinics.

16. The **James Cook University Hospital** in Middlesbrough is a medium-sized specialist centre with 1,024 beds that provides a 24-hour emergency department, regional major trauma centre and a wide range of specialist services. It provides the full range of acute services across emergency and planned medical and surgical care and maternity services.

17. The **Friarage Hospital Northallerton** is a community hospital with 200 beds that has a 24-hour urgent treatment centre, inpatient services for medicine, orthopaedics, cancer and rehabilitation, with a wide range of outpatient and diagnostic services. It is an accredited surgical hub.

18. The **University Hospital of Hartlepool** is a community hospital with a 24-hour urgent treatment centre that provides a wide range of diagnostic services and outpatient clinics, and day case and low risk surgery.

19. We provide local **community healthcare** services in a number of community wards and venues across our footprint, including urgent treatment centres, diagnostic services, community and rehabilitation beds, outpatient services, district nursing, podiatry, physiotherapy, health visiting and school nursing. Our main community bases are Redcar Primary Care Hospital, East Cleveland Primary Care Hospital (in Brotton), the Friary Community Hospital (in Richmond), the Tees Valley Community Diagnostic Centre (in Stockton), Guisborough Primary Care Hospital, Peterlee Community Hospital and a number of other community locations.

20. We work with a wide variety of partners to deliver our services – GP practices right across the Tees Valley and Hambleton and Richmondshire working in Primary Care Networks; higher education providers including Teesside University, Hull and York Medical School, Newcastle University and Sunderland University; local NHS trusts in particular County Durham and Darlington NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust; Healthwatch organisations who help us to understand the needs, concerns and experiences of patients, and a wide variety of third sector partners working in local communities.

Insert diagram and map of our sites and services

Case for change: ambition and opportunity

Insert diagram of strategic drivers

16. The context in which we operate and the challenges and opportunities that face us in the future mean that we need to be clear on the future direction for the Group and to set ambition for how we are going to make a difference for our population over the next decade. Critical factors include:

17. **What matters most to our patients.** We have listened carefully to what patients, carers and the wider population have told us about what they want from their healthcare, both on an ongoing basis and through a bespoke study carried out by Healthwatch Tees Valley on behalf of all residents in our area including those parts of County Durham and North Yorkshire, which we serve. The key priorities that we have heard are for us to:

    - Ensure consistent, high-quality care across all hospitals
    - Modernise hospital spaces to improve patient comfort.
    - Reduce waiting times in emergency and surgery services.
    - Improve access for rural areas through better transport and local services; and
    - Strengthen communication so patients are fully informed about their care

18. **Changing demand.** Our population is growing and people are living longer with multiple long-term conditions. This means we are seeing increasing demand on healthcare services and a need to ensure that that we are better able to support individuals whose needs are increasingly complex.

19. **Opportunities as a group.** We came together as University Hospitals Tees in 2024 in order to maximise the benefits of working at scale. By bringing teams together across the two foundation trusts, we are able to improve resilience and sustainability of services, to develop a consistent service offer for patients across the Tees Valley, to deliver efficiencies and economies of scale in our ways of working and to maximise opportunities for our workforce. This represents a “once in a generation” opportunity for us to create a new offer to the communities in Teesside that gets the best out of our collective hospital and community healthcare resources and how we work with our partners at scale.

20. **National priorities for the NHS.** The Government's Ten Year Health Plan is due to be published later in 2025. The direction of travel for the NHS is clear:

- shifting care from hospitals to the community, focusing on providing care closer to people's homes and lives;
- preventing ill health, moving from a system which primarily treats sickness to one which focuses on preventing ill health and empowering the population to stay well; and
- moving from analogue to digital so that care is efficient and easy to access.

21. **System priorities in the North East and North Cumbria.** Partners across the North East and North Cumbria (NENC) integrated care system have agreed an integrated care strategy and joint forward plan and we are in the process of developing the clinical strategy for the system. The key elements feed into our own strategy, including the emphasis on working together across healthcare providers and other organisations to deliver better services which meet local needs, for example through integrated neighbourhood teams.

22. The NENC ten-year plan is called 'Better health and wellbeing for all.' It tackles major health problems, improves services, and reduces inequality. The four key goals are:

- Longer and healthier lives: reducing the gap between how long people live in the North East and North Cumbria compared to the rest of England.
- Fairer outcomes: addressing the fact that not everyone has the same opportunities to be healthy because of where they live, their income, education and employment.
- Better health and care services: not just high-quality services but also the same quality no-matter where you live and who you are.
- Giving our children the best start in life: enabling them to thrive, have great futures and improve lives for generations to come.

23. **System priorities in Humber and North Yorkshire.** Similarly, the integrated care strategy and joint forward plan for Humber and North Yorkshire set out partner priorities for this part of our population. The Humber and North Yorkshire Health and Care Partnership identifies a golden ambition of radically improving children and young people's wellbeing, health and care. The vision for Humber and North Yorkshire is to ensure that all people:

- Start Well: we want every child to have the best start in life and enable everyone to be safe, grow and learn.
- Live Well: we want to ensure the next generation are healthier than the last and have the opportunity to thrive.
- Age Well: we want to ensure live healthy and independent lives as long as possible by understanding what matters most to them.
- Die Well: we want to create an environment in which people can have positive conversations about death and dying.

24. **Emerging local partner priorities**. Each of our local authority partners works with the Tees Valley Combined Authority to develop a Strategic Economic Plan with economic ambitions to attract 25,000 new jobs into the region. We want to work with the local authorities in the Tees Valley and with County Durham and North Yorkshire in an integrated way to enable us to achieve our ambitions. In addition, we want to work with neighbouring NHS trusts including Tees Esk and Wear Valleys NHS Foundation Trust as our local mental health trust; and healthcare providers as well as the North East Ambulance Service and Yorkshire Ambulance Service to deliver shared priorities.

25. **Partnerships with academia and a new medical school.** We work with many academic partners. The ambition for Teesside University to develop a medical school forms a key focus of this partnership working. The aim of the new course will be to support the recruitment and retention of clinical talent within the region, and to develop the widening participation agenda.

26. **The financial context** is also important and the blunt fact is that while the Government has announced increased funding for our NHS the demands against that funding are increasing faster. In addition, there is a significant and ongoing underfunding into the NHS locally compared to the projected 'fair share' of funding that we should receive relative to other organisations nationally. A key part of our strategy is about living within our financial means by working smarter and benefiting from the economies of scale we can generate as a group; and delivering the best value for money that we can by slimming down back office services and focusing our funding on those services, which have the greatest impact for our population.

27. **Workforce pressures**. We know that recruitment and retention across the NHS is a challenge and this is true in our region. One of the key priorities of the NENC system strategy "Better health and wellbeing for all" is to reduce the vacancy rate across health and social care by 50% by 2030 by integrating our workforce and providing wider career opportunities, making our area the best place to work in health and care.

28. **The condition of our estate.** The buildings and facilities that we operate out of are in critical condition. Both of our main acute hospital sites are full to capacity and the North Tees Hospital site has significant backlog maintenance and has passed its intended design life.

29. **Digital and clinical technology.** The development of new technology to deliver care provides a step change in the way the Group cares for patients. Many patients are now keen to make use of the convenience of increased digital engagement through remote consultations and digital appointment management.

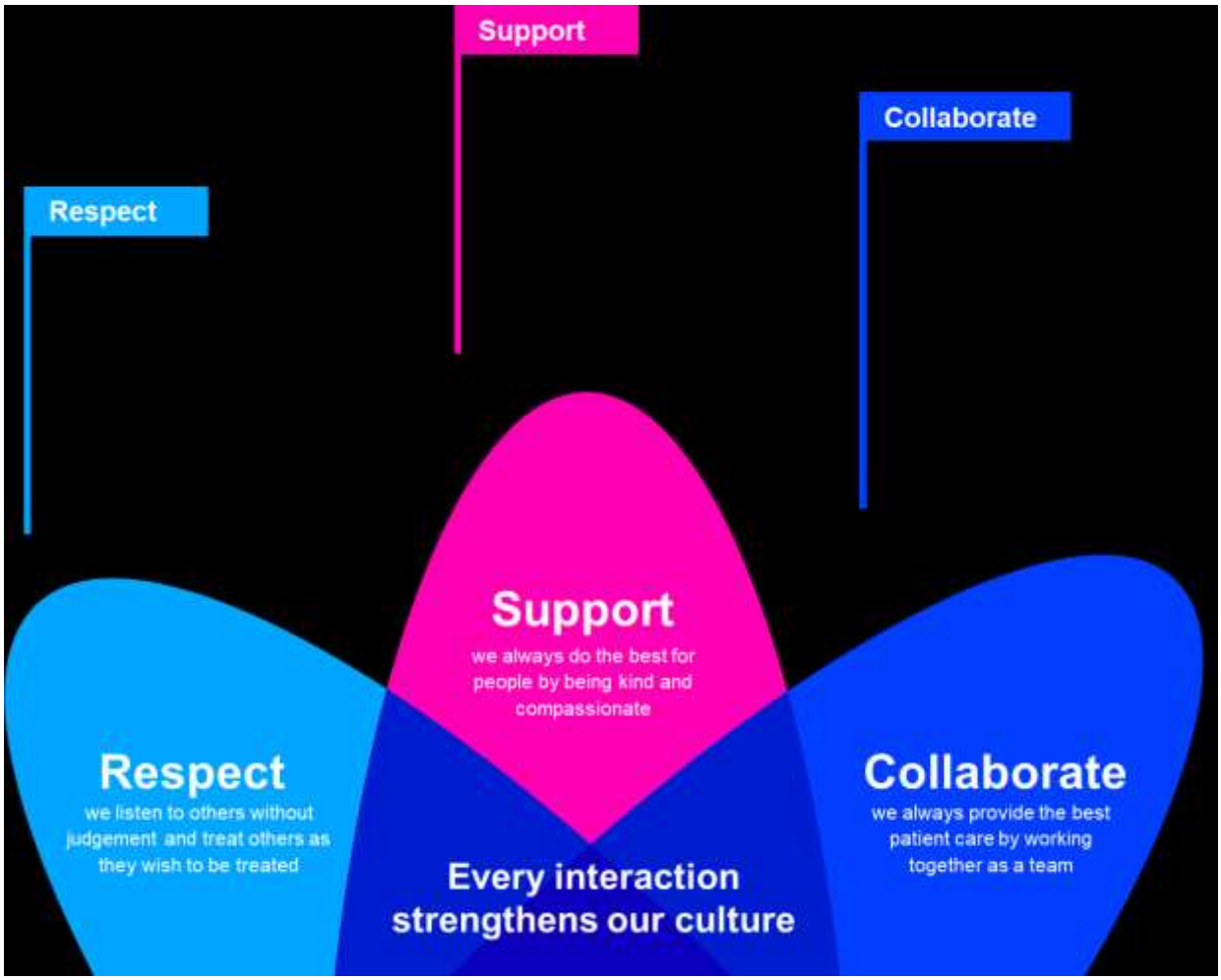
Vision and values

30. Our vision is that we are:

> "Caring better together to continuously improve the lives and wellbeing of the communities we serve"

31. Our values reflect a shared and collective ambition for how we want to work across our teams. They have been produced with input from over 6,000 of our colleagues.

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



Strategic objectives

33. Our strategic objectives set out how we will work towards achieving our vision. They are:

Putting patients first with consistent high-quality care that delivers best practice in effectiveness, safety and experience

Creating an outstanding experience for our people by leading well and being an employer of choice

Working with partners to tackle shared population health challenges and to reduce health inequalities for our population

Reforming models of care across our services and supporting the development of neighbourhood health systems

Developing excellence as a learning organisation through our work in research, education, improvement and innovation

Using our resources well and driving productivity in services to achieve financial sustainability

Our strategy: Caring Better Together

34. To make progress against these strategic objectives we need to transform how we work. The financial and demographic context means that our resources will not stretch far enough for us to try to do more of the same.

35. We are determined to seize the opportunity of working as a group to reform our services for the next generation so that we can provide great care for our patients and population on a sustainable basis.

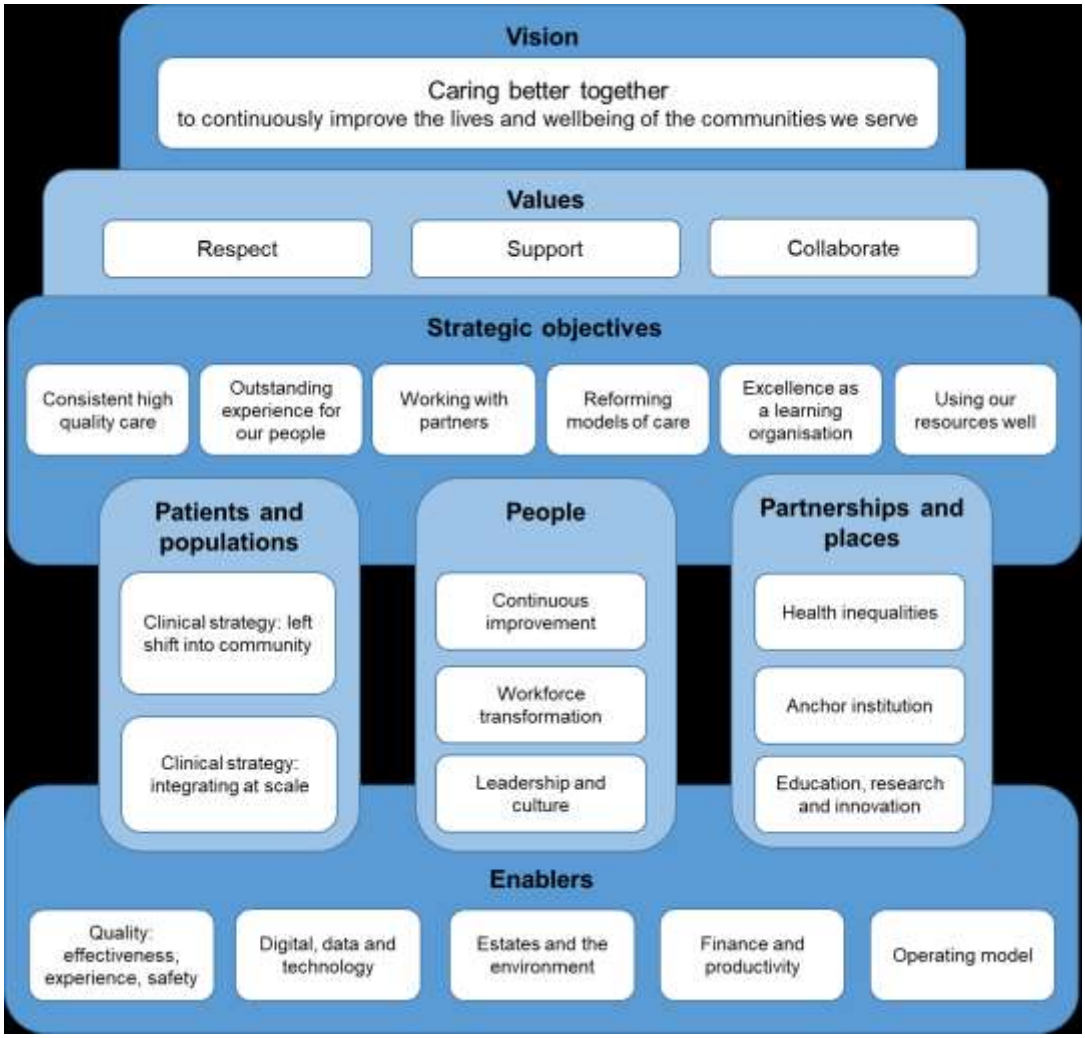
36. We will focus our teams to transform ways of working under three 'pillars' and a series of enabling strategies:

    - **Patients and populations:** implementing our clinical strategy that sets out how we will reform and transform clinical services to develop new models of care across the UHT footprint. Every service making use of operating at scale to meet the needs of patients and address population health priorities.

    - **People:** embedding a culture of continuous improvement and ensuring that we are a learning health organisation. Making University Hospitals Tees an employer of choice for our existing people and potential new colleagues. Developing our people through living our values and creating an outstanding experience across all teams in UHT.

    - **Partnerships and places:** building our close collaboration with all of our partners to deliver our shared integrated care strategy and developing ambitions in local places. Seeking to innovate in how we work across organisations in communities and maximising our impact as an anchor institution.

    - This transformation will be supported by a series of **enabling strategies** and plans in quality (effectiveness, experience and safety); digital, data and technology; estates and the environment; finance and productivity; and our operating model.


Vision
Caring better together
to continuously improve the lives and wellbeing of the communities we serve
Values
Respect
Support
Collaborate
Strategic objectives
Consistent high quality care
Outstanding experience for our people
Working with partners
Reforming models of care
Excellence as a learning organisation
Using our resources well
Patients and populations
Clinical strategy: left shift into community
Clinical strategy: integrating at scale
People
Continuous improvement
Workforce transformation
Leadership and culture
Partnerships and places
Health inequalities
Anchor institution
Education, research and innovation
Enablers
Quality: effectiveness, experience, safety
Digital, data and technology
Estates and the environment
Finance and productivity
Operating model

Patients and populations

Our **clinical strategy** sets out how we will reform and transform clinical services to develop new models of care across the UHT footprint that meet the needs of patients and address population health priorities.

We will join up services across maximise the benefits of **delivering clinical services at scale**, including by creating specialist units and making access fair so that everyone across our population can get high quality care quickly.

We will remove the need for people to come to hospitals unnecessarily by focusing on preventative care and providing **more healthcare in the community**. Our teams will work with partners to develop neighbourhood health systems in local communities that provide a joined-up offer across health and care. We will use population health management to target our resources effectively.

37. Our clinical strategy is the core of our overall strategy – it is the reason we have come together as a group to reform healthcare for the population we serve.

38. Our five clinical boards, comprising senior professionals from both trusts, have developed the clinical strategy who have worked to propose and design the optimal model of healthcare for the group. They have:

    - **reviewed data on performance across our group** and recommended how to achieve consistent high performance and then to go further to meet external best practice;
    - considered **a wide range of evidence of best clinical practice** for example from the Getting it Right First Time publications and the NHS Model Hospital and Model Health System; and
    - **carried out study visits** to other NHS providers to look at the best configuration of services within our group

39. This evidence on clinical best practice has been balanced with the financial, workforce, estates and wider considerations that shape the ambition in the clinical strategy.

40. Our clinical strategy is driven by the best clinical outcomes for our patients; and responds to the key shifts in the Government's Ten Year Health Plan:

    - **From treatment to prevention.** Preventative work in communities such as smoking cessation campaigns is key for the long-term health of our population and to ensure that we can focus work on those with the greatest need. Our joined-up approach to neighbourhood health enables us to work with partners to encourage good health among the population

- **From hospital to community.** We know that it is beneficial for many patients to be treated close to home – and that this is what many patients want. Therefore, we will work with partners such as local authorities and the third sector to do so, including an ambition to support 500 patients through “hospital at home” to decompress our acute hospital sites.
- **From analogue to digital.** Making better use of digital services is key to making our services easier to access for our patients and delivering value for money – including communicating online, the expansion of online medical consultations and the transformation of care delivery to harness technology.

Case Study: Hospital at Home

When 93-year-old Margaret fell during the night, her daughter found her on the floor in the morning. She called 999, and within 30 minutes a community team arrived, assessed Margaret for injuries, and helped her back into her chair.

Instead of going to hospital, Margaret was safely supported at home. Her medication was reviewed, she received a walking aid, and therapy visits helped her regain strength.

Thanks to joined-up care, Margaret avoided hospital admission and maintained her independence—unlike her sister, who spent a month in hospital after a similar fall and ended up in a care home. With a small increase in home care, Margaret remains where she wants to be: in her own home.

41. Our strategy aims to look ahead to meet demand as it will be over the next 10 years and beyond. Our future clinical model is in three broad phases:

Insert graphic of three phases

Phase 1 (by 2026): testing and learning from early integration

42. By 2026, we want to have made rapid progress in horizontal integration (by which we mean joining up our teams and processes as if they were working for a single organisation) and standardising processes across the Group.

43. Patients will see three main changes to the way in which we offer care:

44. First, to **expand services in the community** towards the ambition of 500 hospital at home beds so that patients can get their care near to their own homes where it is right to do so. This will include a range of specialties, including expanding existing provision of services for older people and some surgical and medical specialties including paediatrics. It will include our work in partnership with primary care, social care and the voluntary and community sector organisations to build and support neighbourhood health services and the development of our Care Coordination Centre.

45. Second, to offer **more planned care through our elective hubs** in Northallerton and Hartlepool. This will maximise the productivity of our surgical teams and will enable us to make better use of our valuable estate across the whole of the group's services. This will contribute to lower waiting lists and a reduction in cancellations for patients; and will free up space in our acute sites in Stockton and Middlesbrough. We expect that within five years an additional 20% of our elective surgery currently on acute sites will be delivered in our hubs.

46. Third, joining up teams to deliver **consistent care across the Group** by beginning the horizontal integration of key services. This means creating consistent pathways for patients with single waiting lists, delivered by single clinical teams to deliver equitable access and services that are more resilient across our population. Clinical teams and services will be operating as a single function across the group, regardless of location.

Case Study: patient accessing surgical hub

Lisa, a 56-year-old woman, was informed that her spinal elective procedure could be delivered in one of our surgical hubs. At the hub, her surgery was ring-fenced from emergency pressures, meaning it would not be cancelled or delayed by urgent cases. This gave Lisa confidence and peace of mind, allowing her to plan her recovery and rehabilitation without stress and uncertainty.

The surgical hub offered her a calm, focused environment with experienced staff and dedicated supportive services to allow the process to be straightforward and give Lisa reassurance that despite not being on an acute site she is in the right place for her care.

Phase 2 (by 2030): consistent, high quality services across the Group

47. By 2030, we will complete the process of joining up our teams and clinical services for patients and we will reconfigure our models of care as far as possible within our existing estate to improve clinical outcomes.

48. We want to ensure that all services across the Group are horizontally integrated as soon as is practicable. We will spread the learning from the early horizontal integration pilots and apply this across our full portfolio of services.

49. We will transform the way in which patients access health and care services, in particular through the continued development of our Care Coordination Centre. We will work with partners to ensure that patients get the right care, first time. We will explore how this might operate across partners including 111, 999, mental health support, access to hot clinics, access to community service and social care and potentially access to primary care.

Phase 3 (from 2030 onwards): reforming our services for the next generation

50. From 2030 onwards we will move towards having an “acute specialist hospital” on one of the two main sites and an “acute general hospital” on the other main site, while also making full use of our community-facing sites and reforming the model to continue to expand services in the community.

51. Our longer-term proposal is to seize the opportunity of working as a group to reform and reconfigure our services across the whole group so that they can better meet the likely demands of our patients and population in the medium to longer term.

52. That will mean moving towards a model where each of our main acute hospitals retains a range of services but is also able to focus in on providing some key specialisms on behalf of our whole population. The broad terminology for this is an “acute general hospital” and an “acute specialist hospital”.

53. In this model there will continue to be Emergency Departments on both the North Tees and James Cook sites. There would be some specialisation on each of those sites with, for example all cardiology services provided from one site on behalf of the whole population. In some cases that will mean that, patients will transfer from one hospital to another to get the appropriate care.

Case Study: patient accessing more specialist care that requires transfer to central “hub” service

Include case study content

54. This model provides a number of projected benefits for our patients, staff and population, including:

- improved patient flow to reduce waiting lists and improve outcomes – which is a key recommendation coming out of the work we have done with Healthwatch;
- allowing sub specialisation and sharing of ideas as easily as possible to drive outcomes – there is strong evidence that in some specialties especially surgery concentrating staff, particularly doctors and nurses, in one location makes it easier for patients get care from an expert, and for ideas to get shared
- easier standardisation of processes and pathways across the group to allow fair access for patients and better flow within the hospitals
- efficient use of expensive equipment and estate
- resilience of our workforce – having specialisms concentrated on single sites will enable better job planning and more efficient rotas for services
- improved recruitment and retention by supporting greater specialism within a profession on a site, helping us to recruit and retain key individuals within UHT

People

We will develop as a learning health organisation with a culture of continuous improvement. This will be a focus for all of our teams as a key enabler of the strategy, delivered through the rollout of a structured programme of to develop improvement capability and to link that to the execution of the strategy.

Through this work, we will empower our teams to embed their ideas and harness their energy for innovation and improvement into their day-to-day practice. This will be a core expectation for all our people – where they see the potential to improve and deliver our objectives more effectively, they can make this happen.

Our People Plan sets out how we will be an employer of choice for our existing people and potential new colleagues, developing our people through living our values and creating an outstanding experience across all teams in UHT.

55. We want to ensure that we develop a culture of impactful continuous improvement to drive innovation in our practice, drawing on expertise across the NHS and in industry. That will mean consolidating and increasing our capability and capacity around improvement skills and making sure that resource is very clearly focused so that it can make a real difference in how we work.

56. We will build on the work already underway across the group to ensure consistently high quality of care for example through the systematic use of Model Hospital, Getting Right First Time and high priority clinical audits. In addition, we will adopt an attitude of curiosity and look relentlessly across the sector and beyond to find good practice that we can adapt or adopt.

57. Through doing this we will reform and simplify our processes, making it easier and quicker for patients to access and move through our services; and for our patients to work with different cohorts of patients across our main sites and beyond.

58. We recognise that our workforce is key to our success as a group. We want to ensure that we are fit for future. In addition, we want to maximise the impact of our Group model with a focus on developing the culture and collective leadership across UHT.

59. Our People Plan sets this out in more detail. Our aim is to make University Hospitals Tees a great place to work. We want to be an employer of choice for our existing people and potential new colleagues.

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

- **Developing for the future:** with the aim of ensuring our workforce has the knowledge, skills, values and behaviours they need to deliver compassionate, high-quality care. Delivered through developing clear career pathways, building compassionate and inclusive leadership, and providing training opportunities for all.
- **Culture and inclusion:** fostering a culture of respect and inclusion, and ensuring our workforce is engaged and supported. Focusing on recognising, rewarding and celebrating achievements, respecting and celebrating individuality, and living our values.
- **Embedding wellbeing:** making the health and wellbeing of our people a priority because we know that a healthy and happy workforce provides better patient care. Doing this well through enhancing our health and wellbeing offer, understanding our community and developing an impactful onboarding and life cycle experience for our people.
- **Collaborative ways of working:** further developing capability and promoting innovation through working collaboratively with colleagues. Achieving this through developing an agile workforce,

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

Partnerships and places

We will build close collaboration with our local and regional partners to deliver our shared integrated care strategies in each of the systems in which we operate.

We will develop new ambitions with each of our groups of partners in local places. We will establish focused projects and strategies with each of our local authority partners to test and deliver joint working ambitions that target community priorities in each district.

We will seek to innovate in how we work across organisations in communities and will maximise our impact as an anchor institution, agreeing focus for action across Tees Valley and beyond to leverage our role as an employer, purchaser of goods and services and partner in local communities.

We will build academic and research partnerships with university and other educational partners, seeking in particular to maximise the opportunities arising from the planned development of the Teesside University Medical School.

62. We recognise that we are only part of a much wider health and care system and we are determined to work with our partners across the Tees Valley and beyond to deliver integrated services. That will of course include health partners but also VCS, academia and industry. We want that to be about much more than cooperating within an existing service model and become about re-imagining more radically how we can best serve our patients and population, for example as part of Neighbourhood Health Systems. Our joint working with partners will take place in a number of dimensions:

63. We will **tackle health inequalities** through working in new ways with local authorities and the Tees Valley Combined Authority to define and support the delivery of services at a community level. We want to use our joint resources together to put a joint collective focus on addressing the endemic health inequalities both within the region and relative to other areas. We will seek to ensure that community-based services are offered in a way that works for all groups in our population, with a focus on those who experience the poorest health outcomes.

64. We will develop the approach to **working at place with partners** and through Place Committees to make sure that UHT is having a maximal impact on joint working to make a difference to people's lives and health in local communities. This is a key mechanism to ensure we are joined up and able to make best use of our collective resources. We will work with partners across Integrated Care Boards and local authorities, mental health trust, ambulance trusts, primary

care, social care providers and the voluntary and community sector to join up our place based working and ensure we are having a strong collective impact.

65. With **partners in the voluntary and community sector** and through working with local Healthwatch and other organisations we will build our understanding of how well our services meet the needs of people living locally and how we might be able to develop mechanisms to improve access, experience and quality that is based around what works for those individuals and communities.

66. As the region's largest employer we are an **anchor institution** and will develop and agree a longer-term plan through the Tees Valley Anchor Network that looks across our estates, workforce and partnership activity to maximise our collective positive impact on communities.

67. Our joint working with public sector partners and at the scale of the UHT Group gives us a **stronger collective voice**. We will use this to make the case for increased funding to come into Tees Valley with our partners, in particular for capital redevelopments. This will enable us to maximise the power of the reforms we are making and how we can make a difference as a group.

68. Our **academic partnerships** are critical to how we can train and attract our future workforce and create new opportunities for innovation in service delivery. Our new Board Academic Committee will oversee delivery of integrated work across education, research and innovation. We will develop partnerships with the Universities of Newcastle, Sunderland, Teesside and Hull York Medical School to deliver new educational and research opportunities ensuring strong pathways to develop our future workforce locally

69. Work in **innovation** in the delivery of care also relies on strong partnerships into the commercial sector as we look to exploit new technology. We will develop commercial opportunities that arise from research and innovation programmes, seeking to optimise use of UHT facilities and increase commercial income.

70. Our work in **research** is central to how we improve patient care, develop evidence-based practice and adopt new technologies. We will continue to develop Academic Research Units, seeking to increase the number of Chief Investigators and successful research funding applications, growing trust-sponsored clinical trials of national and international significance.

Enabling work streams

71. Delivering our strategy will be everyone's responsibility. Supporting the pillars will be our key corporate strategies and our operating model, which focus our efforts on how best to enable our clinical priorities and ensure that we improve productivity and efficiency.

Quality

72. We will reform our clinical services so that we have a model of care which can provide consistently great care which meets patients' needs wherever they live

73. This means supporting effectiveness of care by removing unwarranted variation based on clinical evidence. In addition, ensuring that the views of patients, families and carers are consistently embedded in day-to-day care by listening to what people tell us matters to them. Our group strategic plan for quality will set that out in more detail.

Digital

74. We will deliver new digital solutions to make it simpler to communicate, to enable different models of care and to make our operations more efficient

75. This means implementing digitally enabled services providing exceptional safe, quality care for our patients, we will have a single view across the group of information for our staff, with collaboration at our core. Our digital strategy sets out the key elements of this.

Estates

76. We will modernise our estate to ensure it support high quality care, ease of access and environmental sustainability

77. This means delivering ambitious plans for improving the condition and utilisation of the estate; specifically developing plans for the University Hospital of North Tees (in view of the existing infrastructure challenges). Our Strategic Outline Case sets this out.

Productivity

78. We will develop more efficient and productive services through linking our improvement capacity to our cost improvement work.

79. This means developing a medium-term financial plan (in conjunction with the Integrated Care System), that maps out the route to financial sustainability for the Group and supports investment in clinical priorities. It also means using financial and efficiency benchmarks systematically to direct where cost can be removed while minimising clinical impact; and reviewing and aligning financial processes and system across the group to improve efficiency

Operating Model

80. We will ensure that our organisational structures support the delivery of our strategy.

81. We will establish group wide governance and accountability arrangements supporting clinical business units across the group to be able to make the changes outlined in this strategy.

82. This means that it is essential that we have an operating model and leadership structure, which joins together services across UHT to support our strategy. This will be consulted on and implemented in 2025.

Turning into action and achieving benefits

83. Every year we will agree a programme of work to implement our strategy. This will set out a series of changes that represent the progress we want to make in establishing new ways of working and successful implementation within our strategic pillars.

84. Each of our clinical business units and our cross-cutting work stream leads across the group will be responsible and accountable for owning their contribution to making the changes that this strategy outlines and making progress against the objectives.

85. We need to know whether those changes are having a measurable impact for our patients and population. So we need to manage and assess both:

    - **Inputs and processes:** how well we execute the ambition that this strategy outlines in making changes to service models, ways of working, behaviours and the way in which clinical care is organised and delivered; and
    - **Outputs and outcomes:** the extent to which those service changes are resulting in a greater and more sustainable ability to deliver services well in the future and to translate that into better care outcomes.

86. We will therefore track a basket of measures throughout the life of the strategy and will assess the extent to which our new service models and changed ways of working have been effective in achieving those outcomes and in improving against those measures.

87. We already report on a wide range of group-wide metrics on a monthly basis through our Integrated Performance Report and have selected a subset of those metrics to form our initial measures.

88. The measures below are not designed to be a comprehensive statement of our activity. They are focused on where we believe we can make a difference through working together as a group and we have chosen each of them to provide an objective basis on which to assess the real impact of our strategic changes on individuals.

89. Our Strategy Programme Board will therefore monitor both:

    - Progress in delivering the planned changes: the implementation of actions to deliver the new ways of working outlined in this strategy. This will include assurance over progress on the development of plans by clinical business units and work stream leads, and progress on the execution of those plans. This will primarily consider short to medium term (at least quarterly) progress on delivery.
    - The extent to which the changes in the plans are delivering the intended outcomes and benefits to patient care and the difference this is making

to health outcomes in our population. This will primarily consider long-term (at least yearly) progress on health and healthcare outcomes.

90. Key outcome metrics against our three strategic pillars are:

91. **Patients and populations:** our work to reform our clinical services so that we develop new models of care across the UHT footprint that meet the needs of patients and address population health priorities:

Short to medium term inputs and processes **Changes**	**Long term outputs and outcomes** **Measures**
Increase community services towards 500 hospital at home beds	• Patient experience rating • Community services 2 hour urgent response standard
Increase proportion of activity in the surgical hubs at Northallerton and Hartlepool	• Referral to treatment time • Elective waiting list time
Move towards horizontally integrated services and greater sub-specialisation on main sites	• Average length of stay • Reduction in hospital-acquired infection rates • Group level cancer 62 day standard

92. **People:** embedding a culture of continuous improvement and ensuring that we are a learning health organisation. Making University Hospitals Tees an employer of choice for our existing people and potential new colleagues. Developing our people through living our values and creating an outstanding experience across all teams in UHT.

Short to medium term inputs and processes **Changes**	**Long term outputs and outcomes** **Measures**
Embed continuous improvement approach throughout the group leading to operational improvement	• Theatre utilisation • Staff survey engagement measure
Implement UHT People Plan	• Staff turnover

93. **Partnerships and places:** building our close collaboration with all of our partners to deliver our shared integrated care strategy and developing ambitions in local places. Seeking to innovate in how we work across organisations in communities and maximising our impact as an anchor institution.

Short to medium term inputs and processes **Changes**	**Long term outputs and outcomes** **Measures**
Shared plans developed with partners to address health inequalities issues	• Elective recovery wait list by deprivation
Delivering anchor ambitions with partners	• Partnership measures including unemployment rates in target populations, staff health and wellbeing, workforce diversity

NHS
University Hospitals Tees

People Plan

Meeting date: 8 May 2025

Reporting to: Group Board of Directors

Agenda item No: 9.2

Report author: Rachael Metcalf, Group Chief People Officer

Action required:
Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: People Committee

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.

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.

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

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

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

The plan has four strategic enablers:

1, Developing for the Future

2, Culture and Inclusion

3, Embedding Wellbeing

4, Collaborative ways of working

The plan outlines key measures of success that will be monitored through the people committee.

Recommendations:

The Group Board of Directors are requested to acknowledge the work to date on the development of the 2025/2028 people plan and support the four strategic enablers. In addition, the Board of Directors are requested to accept the proposed measures as outlined monitor for assurance on an annual basis.

Caring Better Together

People Pl

2025 -2028

Caring Better Together

Foreword

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

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

Our strategic objectives are:

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

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

Welcome

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

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

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

Caring Better Together

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

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

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

The strategic enablers of our People Plan are:

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

Our values of respect, support and collaborate will thread through.

Rachael Metcalf
Group Chief People Officer

Our current workforce

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

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

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

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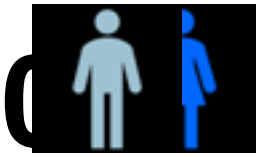
Total staff

16240



Male 2917 18%

Female 13323 82%

0 16240

18%

of our workforce are global majority

6%

of our workforce are disabled

40%

of our workforce live with areas of highest deprivation

Nationalities across our workforce

Workforce age range

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

Workforce disability

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

Disability reason

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

Workforce ethnicity

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

Workforce by continent

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

Top 5 nationalities

British	14397
Indian	553
Filipino	272
Nigerian	234
Pakistani	79

Our values

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

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

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

Respect

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

In practice:

Support

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

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

Collaborate

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

In practice:

Caring Better Together

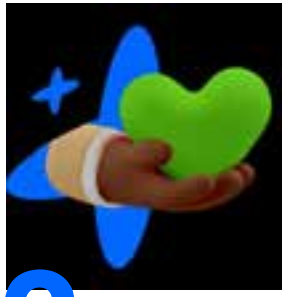
Purpose of Our People Plan

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

The strategic enablers of our people plan are:

1 Developing for the Future

2 Culture and inclusion



3 Embedding wellbeing

4 Collaborative ways of working

The NHS people promise

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

Our people plan on a page

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

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

Every interaction shapes our culture

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

Caring Better Together

Developing for the future

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

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

Develop clear career pathways

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

Compassionate and inclusive leadership

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

Training opportunities for all

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

Developing for the future

What Success Will Look Like

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

Measures

- Meeting our mandatory training compliance threshold continuously by March 2026.
- Meet appraisal compliance threshold by March 2026.
- Refreshed Leadership development offer in place and embedded by March 2026.
- Utilising 100% of the apprenticeship levy by October 2026 with an increase in breadth and number of apprenticeship opportunities.
- Development of strategic multi-year workforce plan, in conjunction with clinical, operational and finance colleagues by October 2026.
- Suite of clear career pathways guides in place by October 2026.
- Strategic workforce planning tool introduced and embedded by March 2027.
- 10% of the workforce to have talent management plans in place by March 2027.
- Improvement in staff survey results in the ‘we are always learning’ theme.
- Increase in numbers of individuals involved in ‘touch points’ with University Hospitals Tees before employment, such as work experience and engagement events with local schools/ colleges.

Your role…

All staff

Complete all your mandatory training
Have an annual appraisal conversation

Leaders and Managers

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

Caring Better Together

Culture and inclusion

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

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

Recognise, reward and celebrate

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

Respect and celebrate individuality

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

Living our values

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

Culture and inclusion

What Success Will Look Like

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

Measures

- Introduction of a race pay gap by March 2026.
- Develop and embed a group approach to rewarding and recognising our people by March 2026.
- Evidence through our staff survey that colleagues are confident to report inappropriate sexual behaviours in the workplace by March 2026.
- Provide Clinical Business Care Groups with a personalised WRES and WDES by October 2026.
- Achievement of ambitions in relation to increased representation and diversity in leadership positions by March 2027.
- Implementation of all six high impact actions under the NHS EDI improvement plan by March 2027.
- Embed our values within all our people interaction from recruitment to appraisal and developing the Tees Way. Increasing our staff survey score ‘we have a voice that counts from 6.67 to the upper quartile by March 2027.
- Improvement in Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) outcomes by 2027.
- An improvement in our staff survey result for reward and recognition from 5.89 to upper quartile by March 2028.
- Continue to develop our annual EDI conference, increasing attendance and reaching a wider audience year on year.

Your role…

All staff

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

Leaders and Managers

Develop local plans for equity and inclusion

Caring Better Together

Embedding wellbeing

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

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

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

Caring Better Together

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

Enhancing our health and wellbeing offer

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

Understand our community

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

On-boarding and life cycle experience

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

Embedding wellbeing

What Success Will Look Like

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

Measures

- Improved Mental health support provided for colleagues, with contact and pathway consultation to take place within 7 working days by March 2026.
- Develop digital feedback from candidates, new starters and recruiting managers by March 2026.
- 12-month check in with new colleagues to share their experiences and develop a learning log by March 2026.
- Introduce meaningful recruitment KPIs which set standards and measures performance by March 2026.
- Health and Wellbeing checks available at UHT welcome day and opportunity for personalised 1:1 health checks by October 2026.
- t of a wellbeing dashboard to improve education and health and wellbeing at Clinical Business Unit by October 2026.
- On site/remote workshops and the opportunity for 1-1 money management coaching available to all by March 2027.
- Implement a digital solution which allows greater engagement with new colleagues throughout the recruitment process by July 2027.
- Increased use of automation in people processes with a positive impact on user experience by July 2027.
- Introduce onboarding companions for new colleagues by October 2027.

Your role…

All staff

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

Leaders and Managers

Work closely with all colleagues to ensure wellbeing in the workplace

Caring Better Together

Collaborative ways of working with you

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

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

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

Agile workforce

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

Talent management and succession planning

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

Creating a respectful and responsive culture

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

Collaborative ways of working with you

What Success Will Look Like

- Each Directorate has a robust workforce plan, which includes a succession and talent management plan which meets the needs of the national planning workforce return.
- Improvement in colleagues recommending UHT as a place to work as evidenced in the national staff survey.
- Develop a blended learning people management programme for the group providing managers with the skills to lead a complex workforce.
- A reduction in the number of colleagues involved in a formal employee relations process.
- Our customers will be satisfied with our service.
- People policies and processes are consistent across University Hospital Tees.
- Improvement from the 2024 staff survey metrics relating to flexible working.

Measures

- Creation and delivery of flexible working action plan to understand our current uptake of flexible working by March 2026.
- Improved timescales for employee relations cases. Introduction of digital feedback mechanism by March 2026.
- Develop one single set of people policies for University Hospital Tees with the top 5 policies to be harmonised initially by March 2026.
- Creation and delivery of a harmonised University Hospitals Tees pathway for a restorative just and learning culture by March 2026.
- Embed the People Plan into our Clinical Business Units, with individual accountability by March 2026.
- Improvement in staff survey questions on flexible working from 6.07 to upper quartile by March 2027.
- Develop and communicate a growth in range and accessibility of formal and informal flexible working opportunities by October 2027.
- Robu… …themed from Just Culture, Freedom to Speaking Up, dignity at work concerns and staff surveys, used to inform organisational learning and other workstreams in our People Plan by October 2027.
- The remainder (after top 5) of policies to be harmonised by October 2027.
- Increased completion of the staff survey through promotion of results and continued implementation of action plans. Increase from current UHT response rate of 36% to 45% by March 2028.
- A decrease in formal grievance rates to 10% by 2028.
- Clinical and Corporate succession plans developed, which include the identification of successors for key roles and supported by individual development plans.
- Reduction of the number of colleagues reporting bullying, harassment or abuse at work.

Your role…

All staff

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

Leaders and Managers

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

Caring Better Together

University Hospitals Tees

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

Meeting date: 8 May 2025

Reporting to: Group Board

Agenda item No: 10

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.

Standardised and consistent Board Assurance Framework reporting arrangements are embedded at Committee and Board level and have been in place since November 2024. This includes the format, content and reporting arrangements. The reporting of the BAF aligns with the Integrated Performance Report to support triangulation of key performance metrics and the mitigation of strategic risks.

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

Headlines

NTHFT

- There are 37 strategic risks identified relating to North Tees & Hartlepool 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 90 planned mitigating actions within the BAF across the 8 domains.
- 3 actions are reported as completed and there are 7 timescale extension requests.
- Planned action timescale range is February 2025 – March 2026.

STHFT

- There are 31 strategic risks identified relating to South Tees Hospitals NHS Foundation Trust.
- 12 strategic risks are outside of approved risk appetite, of which there are 7 red/high strategic risks outside of approved risk appetite.
- There are 79 planned mitigating actions within the BAF across the 8 domains.
- 3 actions are reported as completed and there are 7 timescale extension requests.
- Planned action timescale range is February 2025 – April 2026.

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

Operational Risk Review

The exercise has been completed to review all risks within the InPhase System (NTHFT) and Datix system (STHFT) to determine risks that are non-compliant with the Risk Management Policy of each Trust. This has resulted in a number of risks being closed in the Datix system. The operational risks of each Trust are overseen by the respective Risk Management Groups that meet monthly.

The Risk Management Policies for each Trust have been reviewed to align processes as much as possible, along with a refresh of the Risk Management Strategy. The policy is in the final stages of review in readiness for approval.

Ongoing Actions

To ensure the BAF reporting is fit for purpose and provides effective assurance, improvement work remains ongoing and feedback will continually be sought from stakeholders. Further work is being undertaken with BAF Authors, which will be reflected in future reports:

- BAF authors to meet with Lead Directors to support the BAF refresh for 2025/26.
- Review of the BAF reports by domain to maximise alignment and consistency.
- Review assurances sources and the 3 lines of assurance.
- Strengthen cross referencing between the BAF and related IPR metrics.
- Strengthen cross referencing between BAF domains.
- Effectiveness of assurance for each strategic risk on a quarterly basis.
- Review the robustness of planned actions to achieve target risk scores and approved risk appetite.
- Link between operation and strategic risks.

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.

Assurance Statement

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

External Assurance

An internal audit has been completed for each Trust for 2024/25, relating to Board Assurance Framework and Risk Management. Feedback has been positive with some low priority findings for improvement. Assurances will be reported to respective Audit Committees.

Recommendations:

The Group Board is asked to;

- Receive the Board Assurance Framework Reports for NTHFT and STHFT (reporting to 28th February 2025).
- Note the 6 red/high strategic risks for NTHFT and 7 red/high strategic risks for STHFT and the planned mitigating actions.
- Acknowledge the assurance the report provides regarding the management and mitigation of strategic risks for each Trust.

North Tees & Hartlepool NHS Foundation Trust/South Tees Hospitals NHS Foundation Trust – Board Assurance Framework Report (reporting to 28th February 2025)

NTHFT – Key Headlines	STHFT – Key Headlines
• 37 identified strategic risks. • 6 red/high strategic risks that are outside of approved risk appetite. • No change from last report. • No current risk score changes. • One step from approved risk appetite. • 90 planned mitigating actions. • 3 actions reported as completed. • 7 timescale extension requests. • Planned action timescale range February 2025 – March 2026.	• 31 identified strategic risks. • 7 red/high strategic risks that are outside of approved risk appetite. • No change from last report. • No current risk score changes. • One step from approved risk appetite. • 79 planned mitigating actions. • 3 actions reported as completed. • 7 timescale extension requests. • Planned action timescale range February 2025 – April 2026.

1. Background

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

2. Purpose

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

3. Report Detail

Revised BAF Arrangements

Standardised and consistent Board Assurance Framework reporting were implemented and reported to the committees of the Group Board from November 2024. This includes the format, content and reporting arrangements. The reporting of the BAF aligns with the Integrated Performance Report to support triangulation of key performance metrics and the mitigation of strategic risks.

BAF Format

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

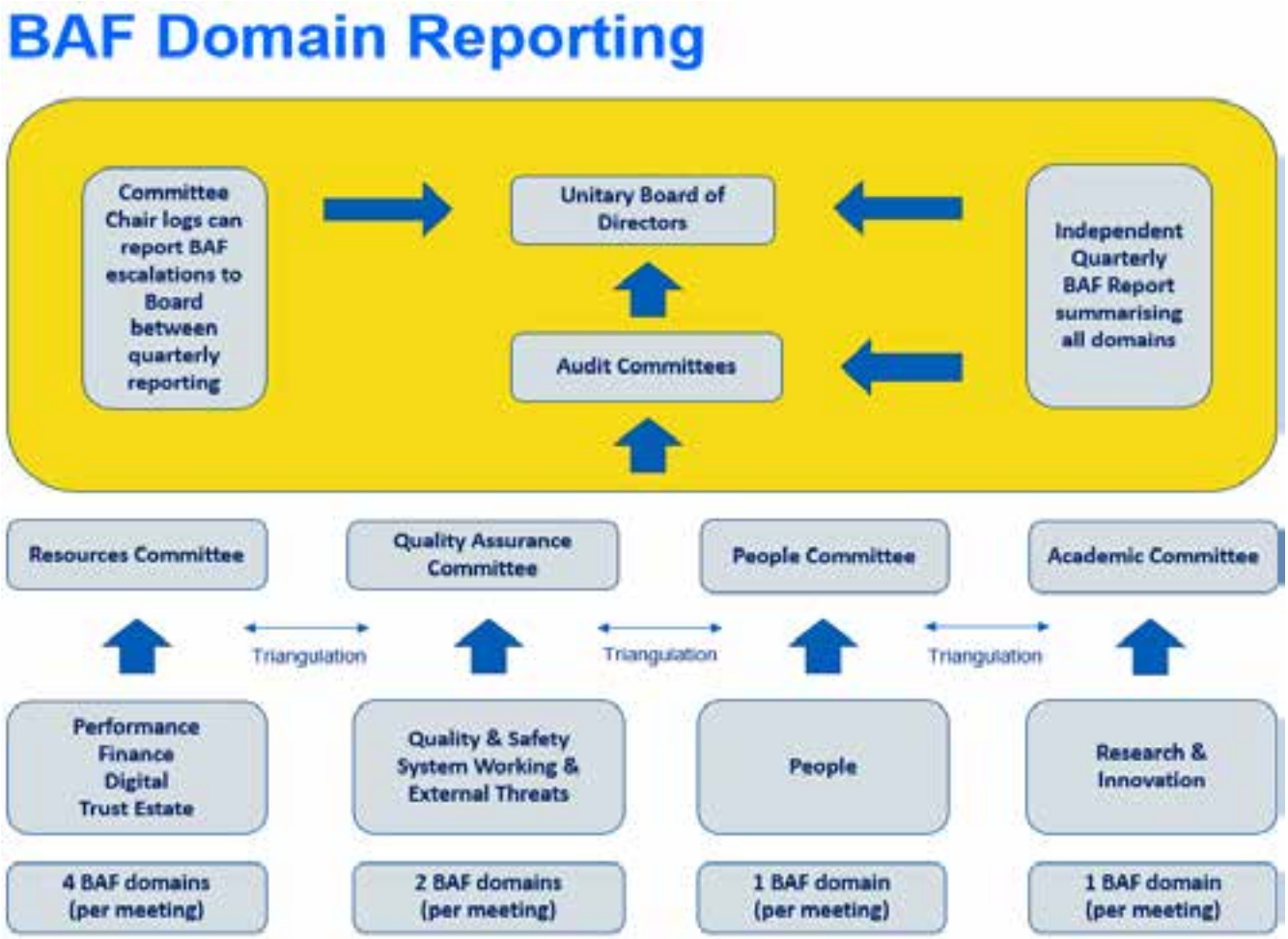
BAF Domains

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

BAF Domain	Responsible Director	BAF Author	Committee oversight
Quality & Safety	Group Chief Nurse	Group Deputy Director of Patient Safety/Deputy Chief Nurse	Quality Assurance Committee
Performance & Compliance	Group Managing Director/Chief Operating Officers	Deputy Director of Strategy & Planning/ Associate Director of Planning & Performance	Resources Committee
People	Group Chief People Officer	Deputy Director of People Services/ Head of Workforce Planning, Quality & Projects	People Committee
System Working & 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 is being undertaken by the Group Chief Strategy Officer.

For continued illustration purposes, the reporting arrangements for the BAF are set out below, with the addition of the Academic Committee, which held its first meeting in April 2025. 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.



BAF Domain Alignment to Strategic Objectives

The BAF domains for each Trust are linked to at least one strategic objective. 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 and to ensure there are no assurance gaps. The mapping of BAF domains to strategic objectives has been provided previously and is not included in this report.

Risk Appetite

Approved risk appetites are in place for each BAF domain for each Trust, that were approved by the committees of the Group Board and in the Group Board meeting in November 2024 and January 2025, respectively. The approved risk appetite position by domain is set out in the following table along with the current risk score range 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 Supporting Statements

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

Strategic Risk Score Analysis

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

Domain	Number of strategic risks		Number of strategic risks adversely outside of approved risk appetite		Number of steps away from approved risk appetite		Number of planned mitigating actions	
	NT	ST	NT	ST	NT	ST	NT	ST
Quality & Safety	5	5	**5**	**5**	1	1	13	14
Performance & Compliance	3	4	0	**2**	0	1	4	13
Digital	4	3	0	0	0	0	17	15
People	5	3	0	0	0	0	8	3
Finance	5	4	**1**	**1**	1	1	9	5
Trust Estate	5	5	**3**	**2**	1	1	9	12

Domain	Number of strategic risks		Number of strategic risks adversely outside of approved risk appetite		Number of steps away from approved risk appetite		Number of planned mitigating actions	
	NT	ST	NT	ST	NT	ST	NT	ST
System Working & External Threats	5	3	0	0	0	0	13	3
Research & Innovation	5	4	**2**	**2**	1	1	17	14
Total Number	**37**	**31**	**11**	**12**			**90**	**79**

NTHFT	STHFT
• The Trust has 37 identified strategic risks linked to Board Assurance Framework domains. • The Trust has 11 strategic risks that are outside of approved risk appetite. • All strategic risks are no more than one step from the approved risk appetite. • Planned actions are in place for each strategic risk. • Planned action timescale range is February 2025 – March 2026.	• The Trust has 31 identified strategic risks linked to Board Assurance Framework domains. • The Trust has 12 strategic risks that are outside of approved risk appetite. • All strategic risks are no more than one step from the approved risk appetite. • Planned actions are in place for each strategic risk. • Planned action timescale range is February 2025 – April 2026.

Excluded from the planned timescales are the actions linked to PFI exit strategy (2033) and eradicating RAAC 2030.

NTHFT Red/High Strategic Risks outside Approved Risk Appetite

The table below identifies that there are 6 strategic risks that are red/high and are outside of approved risk appetite. These risks will be presented to the Resources Committee and Quality Assurance Committee in April 2025 and will be continue to be monitored to ensure mitigating actions are robust and progressed as planned.

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
Delivery of recurrent savings	Finance	**4 x 4 = 16**	1	Resources Committee
Failure of Trust infrastructure (including buildings)	Trust Estate	**3 x 5 = 15**	2	Resources Committee

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
Insufficient capital funding to maintain Trust estate	Trust Estate	**4 x 5 = 20**	1	Resources Committee
Reduction of system capacity if the Trust is unable to provide services	Trust Estate	**3 x 5 = 15**	1	Resources Committee
Inconsistent funding for research to deliver R&I plans across group	Research & Innovation	**4 x 4 = 16**	4	Quality Assurance Committee
Risk that innovation is not embedded in the Trust and opportunities are missed to improve services and patient outcomes.	Research & Innovation	**4 x 4 = 16**	4	Quality Assurance Committee

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

STHFT Red/High Strategic Risks Outside Approved Risk Appetite

The Trust has 31 identified strategic risks linked to Board Assurance Framework domains. The table below identifies that there are 7 strategic risks that are red/high and are outside of approved risk appetite. These risks are presented to the Resources Committee and Quality Assurance Committee in April 2025 and will be continue to be monitored to ensure mitigating actions are robust and progressed as planned.

Strategic Risk Description	BAF Domain	Current Risk Score	Number of mitigating actions	Committee Oversight
Cost containment	Finance	**3 x 5 =15**	2	Resources Committee
Risk that the referral-to-treatment 18-week NHS Constitution standard is not met	Performance & Compliance	**3 x 5 = 15**	4	Resources Committee
Risk that the cancer referral to treatment 62-day NHS Constitution standard is not met	Performance & Compliance	**3 x 5 = 15**	5	Resources Committee

Insufficient capital funding to maintain Trust estate	Trust Estate	**4 x 5 = 20**	2	Resources Committee
Trust estate does not allow for the provision of optimal clinical services	Trust Estate	**3 x 5 = 15**	2	Resources Committee
Inconsistent funding for research to deliver R&I plans across group	Research & Innovation	**4 x 4 = 16**	3	Quality Assurance Committee
Risk that innovation is not embedded in the Trust and opportunities are missed to improve services and patient outcomes.	Research & Innovation	**4 x 4 = 16**	4	Quality Assurance Committee

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

Trust Operational Risks

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

Planned Review of Operational Risks

The exercise has been completed to review all risks within the InPhase System (NTHFT) and Datix system (STHFT) to determine risks that are non-compliant with the Risk Management Policy of each Trust. This has resulted in a number of risks being closed in the Datix system. The operational risks of each Trust are overseen by the respective Risk Management Groups that meet monthly.

The Risk Management Policies for each Trust have been reviewed to align processes as much as possible, along with a refresh of the Risk Management Strategy. The policy is in the final stages of review in readiness for approval.

4. Conclusion

- Standardised and consistent Board Assurance Framework reporting arrangements are in place for both Trusts (including the format, content and reporting arrangements).
- The reporting of the BAF aligns with the Integrated Performance Report to support triangulation of key performance metrics and the mitigation of strategic risks.
- Board Committees have full oversight of the BAF report, in additional to the oversight responsibility allocation for BAF domains. A copy of the full BAF report for each Trust is placed in the Reading Library of each Committee.
- Board Committees will escalate any concerns regarding the management and mitigation of strategic risks in BAF domains to the Board of Directors via the Chair's Logs.

- There are 37 strategic risks relating to NTHFT and there are 6 red/high strategic risks that are outside of approved risk appetite. Mitigating actions are in place to address all strategic risks.
- There are 31 strategic risks relating to STHFT and there are 7 red/high strategic risks that are outside of approved risk appetite. Mitigating actions are in place to address all strategic risks.
- This report continues to evolve, taking into account feedback from key stakeholders.
- This report is also presented to the Audit Committee/Audit & Risk Committee and Group Board.

Assurance Statement

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

Ongoing Actions

Work continues to further strengthen the Board Assurance Framework via the monthly drop-in clinics with BAF authors. There are a number of areas that continue to be progressed with BAF authors in the coming months:

- BAF authors to meet with Lead Directors to support the BAF refresh for 2025/26.
- Review of the BAF reports by domain to maximise alignment and consistency.
- Review assurances sources and the 3 lines of assurance.
- Strengthen cross referencing between the BAF and related IPR metrics.
- Strengthen cross referencing between BAF domains.
- Effectiveness of assurance for each strategic risk on a quarterly basis.
- Review the robustness of planned actions to achieve target risk scores and approved risk appetite.
- Link between operation and strategic risks.

5. Recommendation

The Group Board is asked to;

- Receive the Board Assurance Framework Reports for NTHFT and STHFT (reporting to 28th February 2025).
- Note the 6 red/high strategic risks for NTHFT and 7 red/high strategic risks for STHFT and the planned mitigating actions.
- Acknowledge the assurance the report provides regarding the management and mitigation of strategic risks for each Trust.

Supporting Appendices

- Appendix A – Risk Appetite Supporting Statements
- Appendix B – NTHFT Strategic Risk Overview
- Appendix C – NTHFT Risk Radar
- Appendix D – STHFT Strategic Risk Overview

- Appendix E – STHFT Risk Radar
- Appendix F – NTHFT Top 10 Operational risks
- Appendix G – STHFT Top 10 Operational Risks

Trust Risk Appetites & Supporting Statements (*)

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

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)	Investment into the implementation of new digital systems not meeting the needs of the Trust (Group) and its transformation agenda	Not addressing the health and well being needs of our people	Wider Health Economy Issues (ICP/ICS/ National)	Non-compliance with national standard in accordance with the Oversight Framework, and referral to treatment 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	Failure of Trust infrastructure (including buildings)	Lack of clarity of internal structures to support the delivery of the R&I agenda
Failure to provide care that is compassionate, kind and inclusive (Caring)	Failure to protect the information / data we hold as a result of non-compliance with legislation and/or non-compliance with Trust policy	Not having a culture of compassion, civility and respect	Contract Performance	Non-compliance with national standards in accordance with the Oversight Framework, and cancer recovery priorities	Lack of system wide approach to frailty management which may result in poor outcomes and unsustainable system pressure	Insufficient capital funding to maintain Trust estate	Inconsistent funding for research to deliver R&I plans across group
Failure to provide clinically effective treatment in line with best evidence (Effective)	Technical Infrastructure fails to maintain effective cyber defences, negatively impacting operational delivery, security and reputation (Cyber-attack)	Not growing our workforce for the future	Cost Containment	Non-compliance with national standards in accordance with the Oversight Framework, and Diagnostics recovery priorities	Lack of system wide approach to infrastructure with risk to delivering (integrated) optimal care	Trust estate does not allow for the provision of optimal clinical services	Infrastructure and resource prevents delivery of effective research
Failure to meet regulatory standards for quality and safety (Responsive)	Pressured resources within Digital teams which poses a risk to the delivery of the digital strategy and BAU activity (People & Process)	Not developing and embedding appropriate new ways of working	Delivery of recurrent savings		Lack of system wide approach to vulnerable services within the Integrated Care System with risk that some services are not sustainable in current form	Reduction of system capacity if the Trust is unable to provide services	Research not seen as core business in some clinical support services
Failure to deliver quality related strategies and improvements (Well-Led)		Not having appropriate levels of staff with the right skills to deliver safe services	Trust Subsidiaries		Lack of system wide approach to Engagement/Pathways with risk to delivering optimal care, experience and outcomes	Non-compliance with legal and regulatory standards of the Trust's estate	Risk that innovation is not embedded in the Trust and opportunities are missed to improve services and patient outcomes

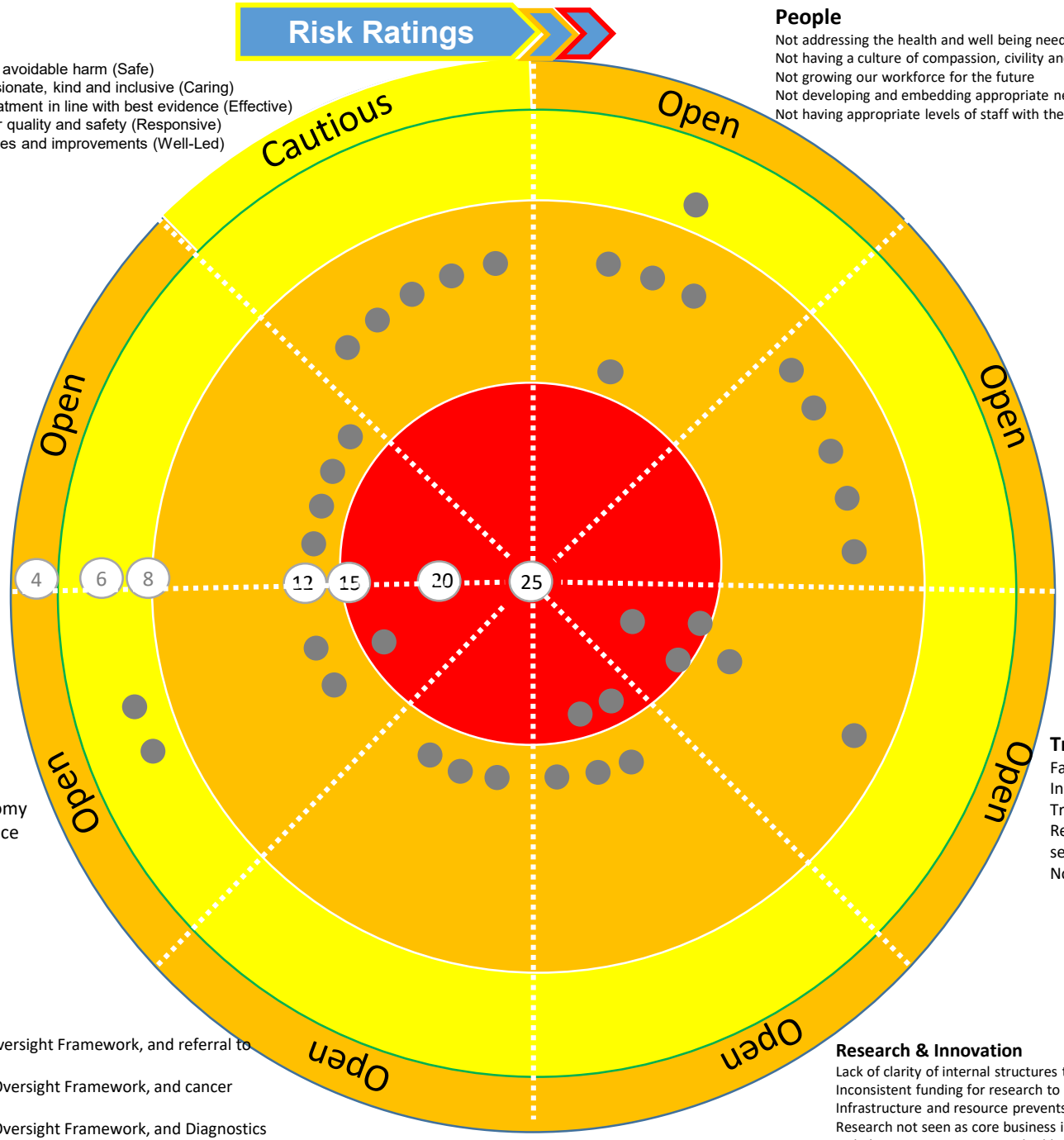
Strategic Risks

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

Appendix C

NHS North Tees and Hartlepool NHS Foundation Trust

28th February 2025 BAF Risk Radar



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

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)

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

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

- 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)

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

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

Finance

- Wider Health Economy Issues (ICP/ICS/ National)
- Contract Performance
- 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

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

Trust Estate

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

Research & Innovation

- Lack of 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

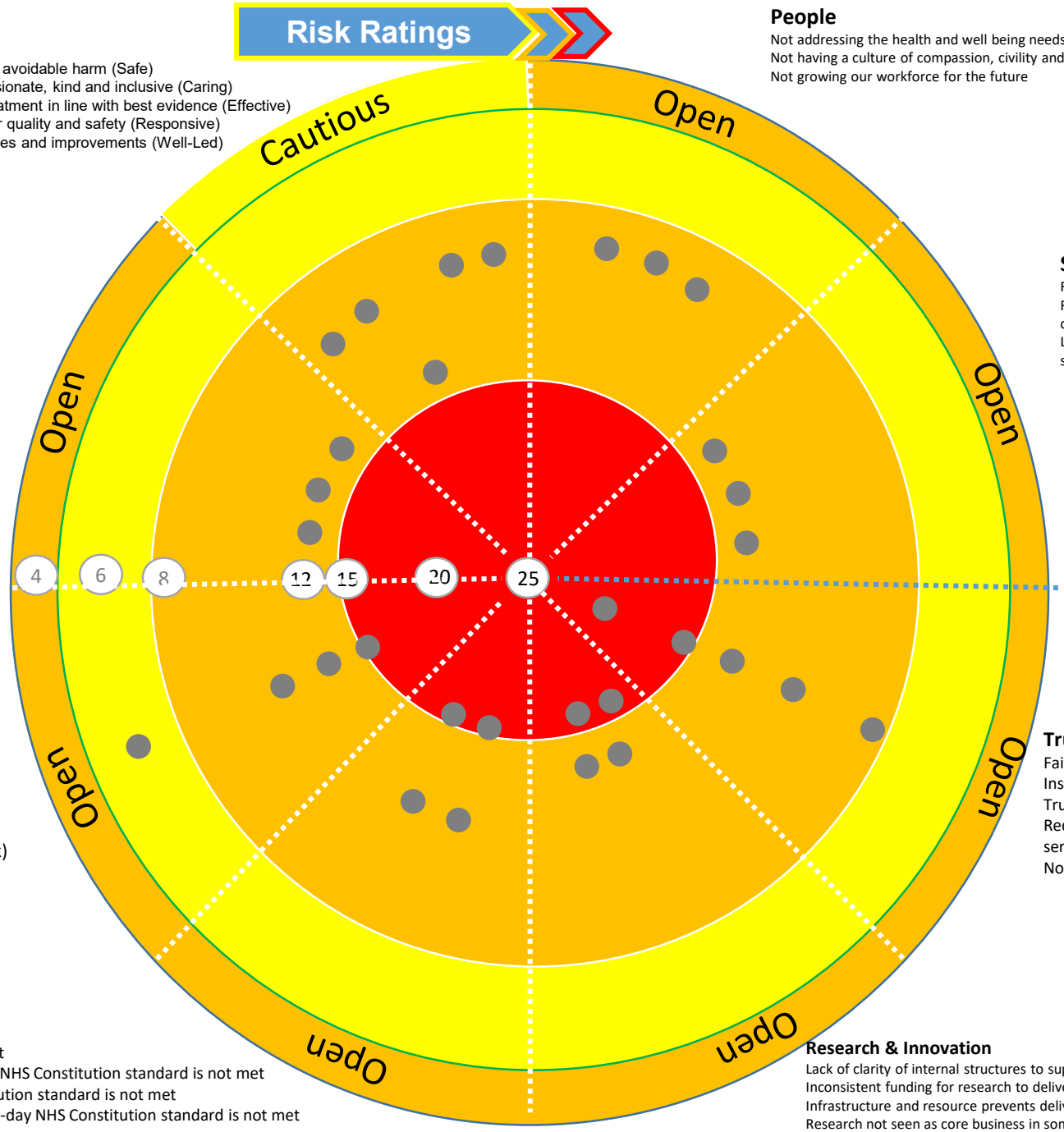
Strategic Risk Level			
Very Low 1-3	Low 4-6	Moderate 8-12	High 15- 25

Strategic Risks

Appendix E

South Tees Hospitals NHS Foundation Trust

28th February 2025
BAF Risk Radar



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

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

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

Finance
Wider Health Economy Issues (National ICS/ICP)
Contract Performance (operating on block)
Cost Containment
Delivery of recurrent savings

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

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

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

North Tees and Hartlepool NHS Foundation Trust

Top 10 Operational Risks (28 February 2025)

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
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 (28th February 2025)*

Datix Risk ID	Title of Risk	Department/Area	Risk Owner	Current Risk Score
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
797	RAAC - Panels - located in Women's and Children's area - James Cook - Area at risk of uncontrolled structural failure in areas where RAAC is present - Eradication required by 2035	Women and Children Services	Paul Swansbury Deputy Director of Estates, Capital, and Programmes	20
777	The Flouroscopy room at JCUH has been condemned reducing capacity, single remaining equipment has significant downtime due to age, This in impacting on Patient flow and treatment therefore patient may experience suboptimal outcome	Radiology	Callum Pearce Interventional Radiology and Fluoroscopy Modality Manager	15
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
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	Redacted	Information Technology	Michael Souter, Senior Information Manager	16
357	Risk that trust is not compliant with mandatory DCB 0129/0160 regarding risk management for Healthcare IT	Information Technology	Ian Willis	16
829	There is a risk of delays in cellular pathology results being available to support patient pathways, the patient outcome may be sub optimal.	Cellular Pathology	Sharron Pooley	20

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

NHS
University Hospitals Tees

Quality Assurance Committee

Connecting to: Group Board, Chair Fay Scullion, meeting held on 28 April 2025

Key topics discussed in the meeting:

The following reports and updates were considered at the April 2025 meeting. Most reports were from across the Group, presenting updates from both Trusts, and the considerable amount of work undertaken across all areas was noted.

- Annual Review of Terms of Reference and Cycle of Business
- Maternity Report (Q4 PMRT and Morbidity for March NTHSFT & STHFT – Maternity and Neonatal Quality and Safety Report NTHFT & STHFT – Maternity and Neonatal Services Staffing Report NTHFT & STHFT
- Maternity Newborn and Safety Investigation (MNSI)
- Board Assurance Framework
- Integrated Performance Report
- Patient Safety Report Q4, 2024/25
- Patient Safety Incident Investigation (PSII) Report – Ophthalmology STHFT
- Infection Prevention Control Report (Group monthly update)
- Learning from Deaths Report
- Q3 Patient Experience and Involvement Report
- Draft Quality Priorities and Account Report – NHTFT & STHFT
- Chairs Logs – NHHFT Safe and effective Care Strategy Group April 2025, STHFT Safe and Effective Care Strategy Group April 2025, Quality oversight Group April 2025

Caring Better Together

Board Assurance Framework

Quality & Safety

Infection prevention and control – infection rates have a continued focus across both Trusts and the challenges of maintaining good infection prevention control continue due to admission rates and movement.

North Tees has undertaken a deep dive into areas that are cause for concern, with a change in policy on cleaning / fogging to ensure that the Gold standard is met. There is a challenge with the Infection Prevention and Control Team due to staff turnover at North Tees, and a group solution is being explored. There is renewed focus with the MDT with Consultant input. There appear to be operational pressures and this is given as a reason for non-compliance, but it is being actioned by site leadership teams.

MRSA screening continues to have a more rigorous approach and the ICP Team are now visiting key areas to review new patients and ensure screening has taken place. This is in addition to the usual training and development and audit activity. Site Directors of Nursing are reviewing standards of professional practice and conduct and reinforcing what these are to teams to ensure that basic procedures and practices are adhered to. This is being linked to quality conversations with all staff on how they should work, and being linked to word/department/ team performance.

There has been a case of MRSA in a neonate, and Newcastle has had an outbreak in the neonatal suite. The resulting management of this, which will be shared, indicates that mitigating actions are needed and follow up conversations with Newcastle are being had.

The Committee is receiving monthly updates on progress.

Cancer targets remain a concern across both sites, in particular the 62-day target. Performance against all key targets is down in all areas, and work is being undertaken in each specific pathway to look at areas of improvement, with a focus on Urology where there are particular issues. The Committee escalated this concern to Resources Committee and suggest a joint deep dive into Cancer.

System Working and External Threats

Health Call now has a resolution with Northumbria, and we will continue having representation with key meetings taking place

Escalated items:

- The committee discussed the Human Tissue Authority outstanding issue regarding samples being stored, and are now awaiting the Corners feedback, which is positive.
- North Tees reported that the Triage System is now in place and by June should be functioning 24/7. There have been some staffing issues due to sickness / absence which has necessitated the suspension of the Intrapartum Service. The impact of this is very low in numbers, but all mothers have been informed and an alternative offer of the

use of the Rowan birthing suite at Hartlepool. LMNS launches year 7 and there has been informal feedback that all existing actions have been achieved.

- South Tees is conducting the engagement events, which are going well following the diagnostic report to ensure that staff are contributing to the plan.
- The stillbirth data is being interrogated at a regional level to understand any differences between the Trusts, and the LMS national MSDS dashboard. Further updates will be brought to QAC
- The Ophthalmology Never Event Review was discussed and the committee was assured that the action plan was comprehensive, with 6 6-monthly audit. There is work with the OD team to ensure that the changes are sustained within the team.
- The Draft Quality Priorities and accounts were discussed, and agreed that 8 out of the 9 the priorities would be carried forward for more work. The drafts are sufficient to be shared with stakeholders for comments and input.
- A joint committee deep dive on cancer 62 week waits.

Risks (Include ID if currently on risk register):

No new risks identified

University Hospitals Tees

Group CQC Compliance Update Report

Meeting date: *08 May 2025*

Reporting to: *Board of Directors*

Agenda item No: 12

Report author: *Diane Palmer, Deputy Director of Quality (Interim)*

Action required: Information

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.

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' actions on the Maternity Services Action Plan is progressing following allocation of additional NHS funding for the development of the maternity estate.

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.

South Tees:

- The remaining two 'Must do' actions and five 'Should do' actions on the South Tees Action Plan continue to be on track and are monitored through the CQC Compliance Group.
- A Safeguarding Joint Targeted Area Inspection (JTAI) was announced by Redcar & Cleveland Local Authority and commenced in late March 2025. The theme followed the recent JTAI completed for North Yorkshire; Domestic Abuse in under 7 year olds. On the 8 April CQC completed a site visit of ED, CYPED, UTC and Maternity where the CQC Inspector (and CQC observer) spent time with practitioners discussing cases and reviewed care in case notes. The full report is awaited.
- Following the Paediatric Audiology NHSE audit, the team have continued to meet with ICB colleagues and a virtual site visit is planned at the end of March 2025. There remains an expectation that services move towards completion of IQIPs accreditation by March 2026, and until that time, external monitoring will continue.

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

North Tees:

- 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.
- CQC enquiries continue to be responded to in a timely manner, with no concerns indicated by the CQC.

South Tees:

- ue to be responded to in a timely way with no undue concerns

Caring Better Together

Recommendations:

The Group are asked to:

- Receive assurance that plans are in place to address the outstanding ‘Must do’ and ‘Should do’ actions.
- Support that due to the progress with the maternity environment action it be moved from ‘alert’ to ‘advise’ in future reports.
- Note the participation in the recent JTAI inspection.

Caring Better Together

Group Board of Directors
Thursday, 8 May 2025
Group Care Quality Commission Compliance Update Report

1. PURPOSE OF REPORT

This report provides an update on progress with the Care Quality Commission (CQC) 'Must do' and 'Should do' actions in addition to highlighting any concerns relating to compliance with the CQC fundamental standards and single assessment framework.

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 assesses 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.

3. TRUST WIDE CQC REPORT AND ACTION PLAN UPDATE

North Tees:
The CQC published a report in September 2022, following inspection of 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'. All of the recommended actions following the inspection have been achieved. The Trust continues to monitor compliance with the CQC fundamental standards.

South Tees:
The CQC published a report in May 2023 following a routine inspection and in January 2024 following a review of the maternity service as part of the National Maternity Inspection Programme. The Trust currently has an overall rating of 'good'. Progress with the actions still to be completed since these inspections are summarised below;

Maternity service
*The service **must** address the environmental and equipment shortfalls that affect the safety, privacy and dignity of women, birthing people and babies.*
£1.2 million NHS funding has been secured for the maternity estate works. Plans are progressing and timelines will feature in future reports.

*The service **should** consider how they improve the model of care to ensure it is fit for purpose.*

el of Care Plan (developed with staff) is currently being discussed to
nd agree an implementation date.

Caring Better Together

Emergency department
*The service **must** ensure that all staff complete mandatory training and safeguarding training to meet the trusts standard of 90%.*
An improvement trajectory has been developed to ensure all staff are compliant with training by May 2025.

*The trust **should** ensure a more robust flagging system for risks associated with patients experiencing mental health crisis attending the department is in place.*
Actions recently include training, study days and implementation of an electronic risk assessment in Symphony. Audit indicates improvement, although there are still further improvements to be achieved.

Surgery
*The trust **must** ensure that pain relief is given to patients when they need it and there are no delays to prescribed pain relief being administered.*
An extensive piece of work has been completed around omitted doses with results indicating that in the last 12 months the number of missed doses is very low, providing assurance that patients are receiving their analgesia in a timely manner. Compliance with recording of pain assessments ranges from 73% to 100% and compliance with recording of pain assessments following analgesia ranges from 67% to 100%.

Friarage Hospital
*The trust **should** consider ways to improve provision of clinical supervision for nursing staff.*
Good and sustained improvements in appraisal compliance across the nursing workforce has been reported.

Critical Care
*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.*
Compliance is currently 32% of nursing staff have achieved the critical care award. A trajectory has been developed to set out staff compliance up to May 2026.

*Patients discharged from the critical care unit **should** have access to an intensive care follow up programme.*
A business case continues to be developed. Two Consultant PA's have been secured and a follow up clinic was established in November 2024.

*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.*
Plans have been prepared and agreed to provide a dedicated waiting area for Critical Care. Funding has been approved by the Charities Board. A business case is being prepared.

4. MONITORING AND ENGAGEMENT

CQC App
Further discussions are underway with the InPhase developers who have set out a ensure implementation of the App. Once the format, processes and een agreed then the App can be utilised for monitoring and assurance amental standards.

Safeguarding Joint Targeted Area Inspection (JTAI)
A Safeguarding JTAI within Redcar & Cleveland Local Authority commenced in late March 2025. The theme followed the recent JTAI completed for North Yorkshire; Domestic Abuse in under 7 years old. On the 8 April the CQC completed a site visit of ED, CYPED, UTC and Maternity where the CQC Inspector (and CQC observer) spent time with practitioners discussing cases concerning domestic abuse, particularly 0-7 years old. High level feedback from the CQC inspectors indicated that they had seen lots of great practice and that there was a strong culture of learning and teaching, they saw lots of professional curiosity in the Emergency Department. There was good multiagency working and teams were very positive about the role of the Independent Domestic Violence Advisor and how effective the role was. In Maternity they witnessed lots of good practice and saw very strong evidence of protecting the unborn child. The differing electronic systems used between agencies are preventing analysis of some data. They suggested we give further consideration to ethnicity/diversity and gender identification to ensure needs are being met.

Enquiries
Both trusts continue to receive enquiries from the CQC which often are as a result of concerns from relatives of patients who have been in our care. At times concerns are raised by patients themselves, members of staff or staff from external agencies. We always aim to respond to these enquiries in a timely manner and indicate any actions we have taken as a result of learning when improvements are necessary.

We meet regularly with our local CQC Inspector with the next 'Engagement' meeting scheduled for the 9th of May.

5. CONCLUSION/RECOMMENDATIONS

The Group are asked to:

- Receive assurance that plans are in place to address the outstanding 'Must do' and 'Should do' actions.

- Support that due to the progress with the maternity environment action it be moved from 'alert' to 'advise' in future reports.

- Note the participation in the recent JTAI inspection.

University Hospitals Tees

People Committee

26 March 2025
Connecting to: NHS UHT Group Board

Key topics discussed in the meeting:

- **Annual Review of Effectiveness**
  - Review concluded the committee has discharges its duties, including attendance, contend and level and of information.

- **Medical Job Planning**
  - Medical Job Planning rates are below the 95% target.
  - Long standing issues and various attempts to improve position.
  - L2P system standardisation into North Tees causing data concerns, i.e. medical staff have plan but not being signed off.
  - **[ESCALATION]** Board & Resources Committee.
    - **Board** – COO's & CMO intervention to ensure all (100%) medical staff job plans are recorded.
    - **Resource Committee** – Triangulation with digital programme rollout and change management

- **Education and Training Compliance**
  - Relatively high overall compliance with mandatory training
  - Concerns raised regarding low mandatory training compliance of medical staff and associated organisational risks
  - **[ACTION]** Rachael Metcalf & Gary Wright to update at April People Committee
  - **[ESCALATION]** Board & Resources Committee.
    - **Board** – COO's & CMO intervention to ensure all (100%) medical staff mandatory training is completed.

- **Autism Training Report**
  - Review of Oliver McGowan training on disability & autism
  - Further implementation work required before assurance is provided.
  - **[ACTION]** Rachel Metcalf to discuss with leadership team and return to People Committee

- **Annual Quality Report SAR/QIP**
  - Overview on education provided to clinical professions
  - Feedback on DDS compliance at James Cook [operational issue for Rachael Metcalf and Steve Taylor (estates)]

- **Core Skills Training Framework Frequency (CSTF) Alignment – UHT**
    - NHS Employers review the frequency of training against the national guidance
    - Proposal agreed on alignment

- **Nurse Safer Staffing Report**
    - Significant progress on reducing agency spend
    - Challenges remain and Ward 9 (ST) flagged to the CQC due to concerns around staff shortages and absence management
    - **[ESCALATION]** Board & QAC Committee.
        - **Board** – COO (S) and Chief Nurse intervention to ensure CQC concerns are mitigated.
        - **QAC** – Awareness of risk

- **Absence Management**
    - Target for 1% reduction per year
    - Assurance sought that long- and short-term absence were reducing. Systemic change to manage costs and both managers and individual were accountable

- **People Plan**
    - Reviewed

- **Staff Survey**
    - Survey return rate was 29% for STHFT and 45% for NTHFT
    - Committee raised question if conducting a full staff survey every year for everyone is the best approach, considering both cost and time implications.

- **Maternity Action Plan**
    - Verbal update on progress
    - Report noted and follow up with Steph Worn (Group Director of Midwifery) and Emma Nunez (Group Chief Nurse)

- **STRIVE Assurance Report**
    - Overview of education and learning resources
    - Ada Burns to support on income v expenditure analysis
    - Further assurance on a comprehensive plan for OD and leadership (in line with people plan)

- **Occupational Health & Wellbeing Report**
    - Improvement noted for South Tees referrals (9 weeks to 3 weeks)
    - Physiotherapy waiting time down to 7 days (Group wide)
    - UHT achieved 'maintaining excellence' Better Health at Work Accreditation.

- **Workforce Wellbeing and Health Inequalities Dashboard Overview**
    - Assurance UHT continues to enhance the understanding of workforce wellbeing needs
    - Recognises the high levels of deprivation in the region that are reflected in the workforce
    - [illegible] to align data across Group

- **Leadership and Improvement Report**
    - New strategy for leadership, management and improvement education will ensure that we meet the requirements of our 1300 managers and additionally our leaders for the new leadership and management framework.

- **Integrated Performance Report**
    - Sickness absence performance is inconsistent, and plan is not met. Cross cutting themes will be the primary focus of absence management (see above).
    - Turnover rates are acceptable
    - Appraisal rates are not acceptable, and committee raised concerns, especially where 24 months had lapsed between appraisals.
    - **[ESCALATION]** Board
        - **Board** – All board members are asked to champion compliance with appraisal in their directorate. Where are the gaps? Is there an underlying leadership issue in areas where appraisals are not considered a priority?

Actions:

- Education and Training Compliance
- Autism Training Report

Escalated items:

- Medical job planning
- Mandatory Training (Medical Staff)
- Nurse Safer Staffing (Ward 9 James Cook)
- Absence Management (Resource Committee)
- Staff Appraisal

Risks (Include ID if currently on risk register):

- None

NHS
University Hospitals Tees

People Committee

29 April 2025
Connecting to: NHS UHT Group Board

Key topics discussed in the meeting:

- **Group Report on the Governance arrangements for Physician Associates and Anaesthesia Associates**
    - Update on national governance changes
    - UHT paper was noted and further clarification on board responsibilities
    - **[ACTION]** Jackie White to review with CMO and update

- **Industrial & Employee Relations**
    - Committee noted the update on the car parking (South Tees) and disengagement by Staff Side (South Tees)
    - Committee discussed the pending risks associated with NHS performance, cost control and Group integration.
    - People Committee BAF should be updated to include industrial and employee relations
    - **[ACTION]** BAF to be updated for assurance on industrial and employee relations
    - **[ESCALATION]** Board
        - **Board** – Triangulation of an identified industrial and employee relations risk with delivery (against performance expectations) and leadership capability.

- **Supreme Court Judgement**
    - Women Scotland Ltd v The Scottish Ministers [2025] UKSC 16
    - Committee were updated on the judgement, interim guidance by the Equality & Human Rights Commission and challenge in the European Court of Human Rights
    - Committee were assured on the interim measures and support for individuals impacted by the judgement
    - **[ESCALATION]** Board
        - **Board** – Impacts on patients, staff and visitors.

- **Integrated Performance Report**
    - **Sickness absence** remains above plan at 6.2% (target 4%)
        - Systematic change on long term and short-term absence
        - Management and individual responsibility
    - **Staff turnover rates** lower than 10% plan. Recognising social economic changes. Medium term low turnover can have adverse consequences.

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- **Annual appraisal** data is below plan at 82.3% (target 85%)
  - Committee remains concerned with employees not having appraisal for 2 years (see March 2025 escalation)
  - **[ACTION]** Updated data in next People Committee
- **Mandatory Training** is moving in the wrong direction with 7 months of decreasing performance (South Tees)
  - Medical staff compliance remains a concern

  [ESCALATION] Board
  - **Board** – COO's & CMO intervention to ensure all (100%) medical staff mandatory training is completed.

- **Nurse Safer Staffing Report**
  - Committee notes the risks associated with a failure to have effective nursing workforce plans that anticipate and prevent shortages arising from sickness, maternity leave, planned retirements and any shortfalls in all recruitment and retention plans.
  - Turnover trend rates decreasing

- **Freedom To Speak Up**
  - The **ALERT** and ADVICE on the cover sheet were not completed
  - Committee noted the contents on the report and raised concerns on the high proportion of anonymous concerns rise (South Tees)
  - Group integration is nearly completed and committee needs less focus on the data (what has happened) and assurance on the 'so what'. How does FTSU support cultural change and improved performance?

- **People Plan**
  - Information on the revised UHT People Plan
  - Feedback provided by NED's and will be incorporated in to the final document
  - Excellent work by Rachel and her team (with executive directors) in a Group strategy for people.

- **Maternity Action Plan**
  - Verbal update on progress
  - People Committee Chair to meet with Rachel Metcalf, Steph Worn (Group Director of Midwifery) and Emma Nunez (Group Chief Nurse) and agree assurance metrics

- **Equality, Diversity, and Inclusion Update Report**
  - Committee updated on the implementation and progression of the six High Impact Actions (HIA) detailed in the NHS Equality, Diversity, and Inclusion Plan (2023)
  - Report noted

- **UHT Education and Training Compliance Report**
  - Training compliance is not consistently meeting the 90% threshold

- Specific concerns:
  - Medical staff mandatory training
  - Emergency and Urgent care services
  - Safeguarding and Resuscitation Training
  - Information Governance
- **[ESCALATION]** Board & Resource Committee.
  - **Board** – See above
  - **Resource Committee** – Awareness of risk associated with information (in light of recent national cyber security attacks)

- **Workforce Planning**
  - Report noted
  - Further work to attain assurance
  - **[ACTION]** Jane Herdman (Group Deputy Director of Workforce) and People Committee Chair to meet and agree expectations.

Actions:

- Governance arrangements for Physician Associates and Anaesthesia Associates
- BAF Updated for Industrial & Employee Relations
- Updated Annual Appraisal data
- Workforce Planning

Escalated items:

- Board Risk on Industrial & Employee Relations
- Mandatory Training (Medical Staff)
- Supreme Court Judgement

Risks (Include ID if currently on risk register):

- None

University Hospitals Tees

NHS Staff Survey 2024

Meeting date: *(insert the date of the meeting the report is going to)*

Reporting to: *Group Board*

Agenda item No: 14

Report author: *Rachael Metcalf*

Action required:
Information

Delegation status: Jointly delegated item to Group Board

Previously presented to: *People Committee*

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.

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 purpose of this paper is to advise the board of the staff survey results for 2024 for North and South Tees NHS Foundation Trusts.

Both quantitative and free text comment analysis is shared to give a complete picture of the survey results

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

Recommendations:

The Board is recommended to accept this paper as a summary of the staff survey results and be advised that the data has been disseminated, and each collaborative and care group is working with the data and three core goals per area to identify improvements.

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Group Board

Thursday, 8 May 2025

NHS Staff Survey 2024

1) PURPOSE OF REPORT

The Annual NHS Staff Survey is the collective voice of our workforce, offering invaluable insight into experiences, challenges and aspirations of those who dedicate themselves to patient care. The report provides a joint position for the Group Board regarding the NHS Staff Survey 2024.

2) RECOMMENDATIONS

The Board is recommended to accept this paper as a summary of the staff survey results and be advised that the data has been disseminated, and each collaborative and care group is working with the data and three core goals per area to identify improvements.

3) BACKGROUND

Each autumn staff within our Trusts are invited to take part in the NHS Staff Survey. Its strength is in capturing a national picture alongside local detail, enabling a range of organisations to understand what it is like for staff across different parts of the NHS and work to make improvements. The staff survey is undertaken as part of the National project and is carried out in order to improve staff experiences. It is aligned to the People Promise and offers a snapshot of how people experience and view their working lives.

4) DETAIL

The Staff Survey is aligned to the NHS People Promise plus two additional themes.

People Promise

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

Additional Themes

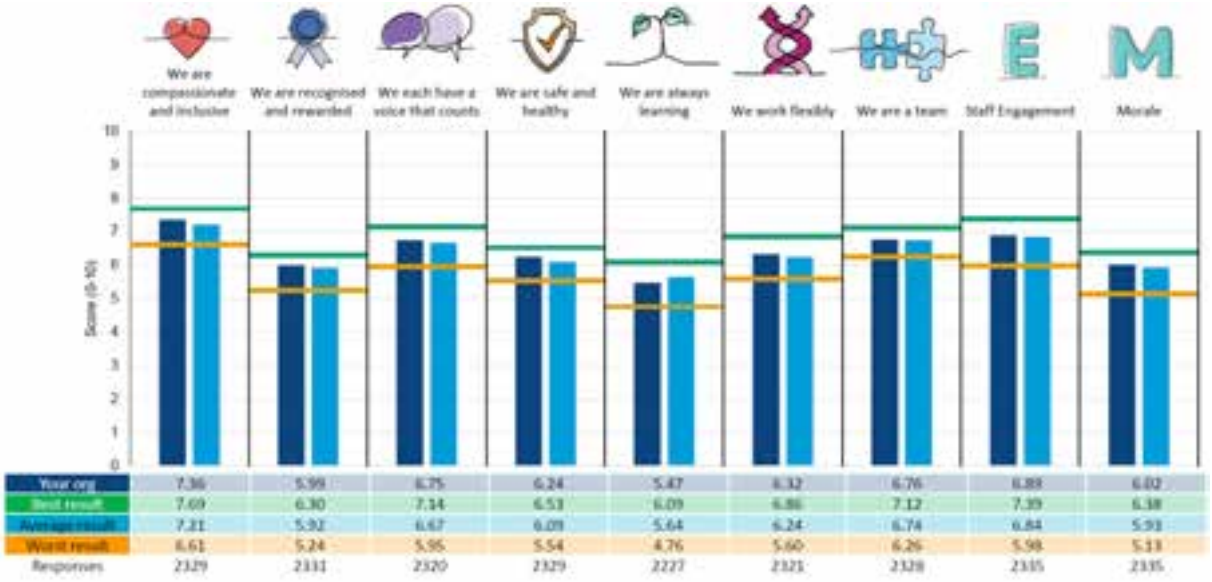
- Staff engagement
- Morale

The 2024 Survey saw a return of 29% (3,043 surveys completed) for South Tees and 45% (2,337 surveys completed) for North Tees. The 2023 Survey saw a return of 35% [illegible]pleted) for South Tees and 50% (2,444 surveys completed) for North

Tees. This is a reduction in 428 staff completing the survey in South Tees and 107 in North Tees.

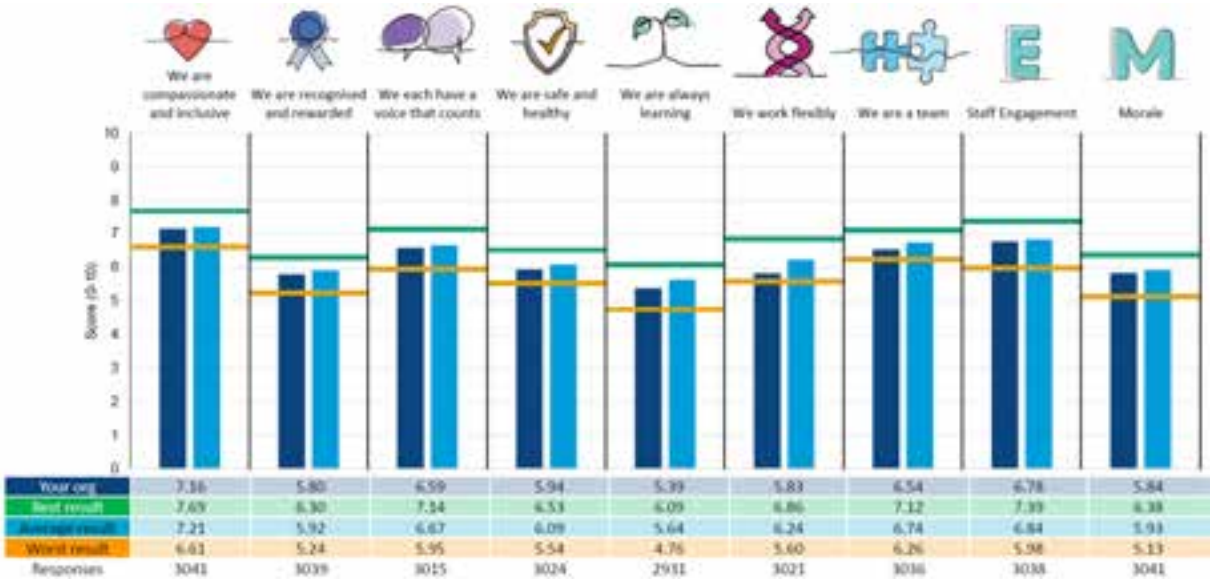
The following bar charts show the results of both Trusts, for the 7 areas of the NHS People Promise plus Staff Engagement and Morale.

North Tees and Hartlepool NHS Foundation Trust



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.36	5.99	6.75	6.24	5.47	6.32	6.76	6.89	6.02
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	2329	2331	2320	2329	2227	2321	2328	2335	2335

South Tees Hospitals NHS Foundation Trust



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.36	5.80	6.59	5.94	5.39	5.83	6.54	6.78	5.84
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	3041	3039	3015	3024	2931	3021	3036	3038	3041

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Overview of the People Promise 7 measures:

**Group average calculated locally*

1) **We are compassionate and inclusive**

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

Trust	2023 Result	2024 Result
South Tees	7.27	7.16
North Tees	7.44	7.36
Group*	7.36	7.26

Both Trust's 2024 results are lower this year at a combined group result of 7.26 but remain higher than the average across the benchmark comparator organisations which is 7.21. Within this theme, staff answering agree/strongly agree to the question "Does your trust respect individual differences" has decreased from 2023's result of 68.3% to 66.9% (ST) and from 73.5% to 72.3% (NT).

Throughout 2024/2025, both Trusts have:

- Continued to develop our staff networks, with executive support, encouraging membership and positive engagement including those from protected characteristics
- Launched an EDI calendar of events with additional engagement sessions ran throughout the course of the year
- Embedded civility in the workplace training
- Embedded the Cultural Ambassadors programme
- Development of People Hub to provide a safe, welcoming central location with practical information, support and guidance for all staff and volunteers

2) **We are recognised and rewarded**

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

Trust	2023 Result	2024 Result
South Tees	5.83	5.80
North Tees	6.11	5.99
Group*	5.97	5.90

Both Trusts have shown a decline in the results this year with a combined group result of 5.90. There has been a decrease of almost 4% (ST) and 1.5% (NT) of staff feeling "satisfied with their level of pay.'' With 67% of staff at North Tees and 63% of staff at South Tees reporting that they feel unsatisfied with their level of pay.

Throughout 2024/2025, both Trusts have:

- Engaged with staff to understand how they would like reward and recognition to
ure

- Love Admin event held for 2024 and plans for 2025
- Opportunity for staff to be recognised through Datix / Inphase / STARS
- Development of cultural boards to raise awareness of heritage and culture

3) **We each have a voice that counts**

This theme explores how colleagues feel about raising concerns and having a voice that counts.

Trust	2023 Result	2024 Result
South Tees	6.70	6.59
North Tees	6.84	6.75
Group*	6.77	6.67

Both Trusts 2024 results are lower this year at a combined group result of 6.67 and is now in line with the benchmarking comparator average. Within this theme, 89% (NT) and 89% (ST) staff agree/strongly agree that they are trusted to do their job.

Throughout 2024/2025, both Trusts have:

- Encouraged regular discussions between all staff to provide opportunity to share ideas, innovations and improvements across teams and services.
- Freedom to Speak up Guardians, policy and processes actively in place with Speak Up champions identified
- Hearing It sessions with Group Chief Executive
- Staff Facebook Groups and Staff Networks active
- Continued implementation of the Restorative Approach across the Groups

4) **We are safe and healthy**

This measure covers health and safety climate, burnout and negative experiences.

Trust	2023 Result	2024 Result
South Tees	6.02	5.94
North Tees	6.30	6.24
Group*	6.16	6.09

Both Trust's 2024 results are lower this year at a combined group result of 6.09 but is now in line with the benchmarking comparator average. Across the Group the results for the questions relating to burnout, fatigue and work-related stress remain worryingly low and have not seen an increase in 2024.

Throughout 2024/2025, both Trusts have:

- Embedded feedback from the National Staff Survey and the health needs assessment survey
- Menopause support in place, supported by policy
- Wellbeing 'walk abouts' in place

- Flu vaccines, health checks, mental health support and weight management programmes available
- Health and well-being initiatives and ambassadors
- Events such as Festival of Finance, Christmas savings scheme
- Development of a health inequalities dashboard for staff

5) **We are always learning**

This promise focuses on development opportunities and appraisals.

Trust	2023 Result	2024 Result
South Tees	5.45	5.39
North Tees	5.70	5.47
Group*	5.58	5.43

Across the Group we have seen a reduction from 5.58 to 5.43 within this theme. On a positive note, 71% of staff across both North Tees and South Tees agree/strongly agree that they "have the opportunity to improve their knowledge and skills".

Throughout 2024/2025, both Trusts have:

- Committed to ensuring staff have a meaningful appraisal annually
- Developed a proactive approach to responding to incidents and near misses across teams to promote Just Culture and PSIRF.
- Management and Leadership training in place (internal and external)
- Apprenticeships widely available
- Clinical skills training (simulation training)
- Further developed the Health and Social Care Academy at UHH

6) **We work flexibly**

This theme relates to home life balance and flexible working.

Trust	2023 Result	2024 Result
South Tees	5.90	5.83
North Tees	6.28	6.32
Group*	6.09	6.08

There has been improvement across the Group however the average result has declined and is lower than the benchmark comparator average at 6.24.

Throughout 2024/2025, both Trusts have:

- Increased awareness and education around flexible working and the policy
- Toolkits provided for staff and managers to access for visual aids
- Supported colleagues with reasonable adjustments
- Developed and implemented the generic health passport

7) **We are a team**

This theme looks at team and inter-team working and line management.

Trust	2023 Result	2024 Result
South Tees	6.65	6.54
North Tees	6.83	6.76
Group*	6.74	6.65

There has been a reduction in this theme across the Group. However, 81% (ST) and 82% (NTH) of "staff enjoy working with the colleagues within their team".

Throughout 2024/2025, both Trusts have:

- Encouraged team meetings and regular meetings with staff and leaders
- An active approach to team development including trained personality diagnostic facilitators and coaches.

Overview of the additional 2 measures:

**Group average calculated locally*

1) **Staff engagement**

This theme measures motivation, involvement and individual advocacy.

Trust	2023 Result	2024 Result
South Tees	6.90	6.78
North Tees	6.98	6.89
Group*	6.94	6.84

There has been a decrease across the Group in Staff Engagement. Both Trusts report on average only 52% of staff look forward to going to work.

2) **Morale**

Morale is dependent on the culture of the organisation and is influenced by multiple factors. This theme covers staff thoughts on leaving the Trust.

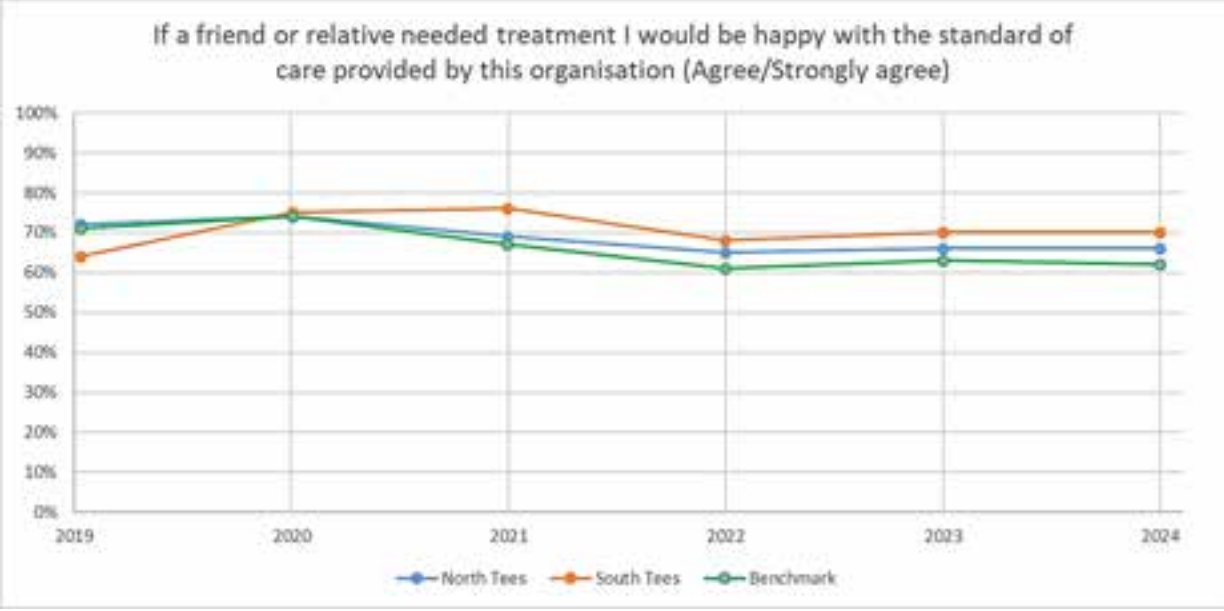
Trust	2023 Result	2024 Result
South Tees	5.93	5.84
North Tees	6.13	6.02
Group*	6.03	5.93

Morale has decreased across the Group. However, on average 84% of staff agree/strongly agree that they always know what their work responsibilities are.

Key Questions

1) **I would recommend my organisation as a place to work.**

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



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Free Text Comments Summary:

The analysis offers valuable insights into the lived experiences of frontline staff, highlighting both the strengths of the Trusts and the challenges faced within the working environment.

Key themes identified include:

- **Staff Values**: Employees emphasised the importance of respect, fairness, kindness, teamwork, and open communication. Concerns were raised about the perceived lack of clear, demonstrable values from leadership and the need for equitable treatment, particularly regarding pay, recognition, and opportunities.
- **Pride and Achievements**: Staff expressed pride in their resilience, teamwork, and professional development. Positive feedback centred on collaborative efforts, improved facilities, and patient care successes.
- **Positive Experiences**: Relationships with colleagues, supportive management, and appreciation from patients were frequently cited as highlights.

The word cloud below visually emphasises the most frequently mentioned terms, providing a quick, impactful overview of the survey's dominant topics.

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Workforce Race Equality Standards (WRES)

The results show the following:

- A higher percentage of staff from both Trusts say that they have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
- A lower percentage of staff from both Trusts say that they have experienced harassment, bullying or abuse from staff in the last 12 months.
- South Tees report a 6% increase (when compared to the 2023 staff survey results) of staff who say that they believe the organisations provides equal opportunities for career progression or promotion.

Workforce Disability Equality Standards (WDES)

The results show the following:

- A higher percentage of staff with a long-term condition/ illness at both Trusts say they have experienced harassment, bullying or abuse from managers in the last 12 months.
- A higher percentage of staff with a long-term condition/ illness at both Trusts say the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.
- North Tees report a 2.5% decrease (when compared to the 2023 staff survey results) of staff with a long-term condition/illness who say they have experienced harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months
- Both Trusts report a lower engagement score for staff with a long-term condition/ illness.

Synopsis

Despite the overall drop in results 'compassion and inclusivity' is proving to be a consistent strength across the Group followed by, 'staff engagement', 'having a voice' and 'we are a team'. These themes represent the cultural aspects of the Trusts working environment from which we can use the opportunity of the Group work to build and improve those themes influenced by mechanisms, processes, and policies.

Next Steps

The results of the 2024 staff survey demonstrate an overall drop in results across the Group however there are areas of positive improvement within both Trusts. Across the Group, both trusts will continue to delve deeper into the detail and work with Care Groups and Collaboratives to develop progressive plans which will allow improvements to be made.

5. CONCLUSION

The 2024 NHS Staff Survey saw a return of 29% 3,043 surveys completed for STHFT and 45% 2,337 surveys completed for NTHFT. The 2023 NHS Staff Survey saw a return of 35% 3,471 surveys completed for STHFT and 50% 2,444 surveys completed for NTHFT. This is a reduction in 428 staff completing the survey in STHFT and 107 in NTHFT

Our results have seen a decrease in all themes except '*We work flexibly'* in NTHFT which increased slightly by 0.04.

All care groups and collaboratives are now aware of their staff survey results and are working on action plans for the three areas most important for them with their staff groups. It is hoped that as each area works more closely with their staff survey results that improvements will be made.

University Hospitals Tees

Freedom to Speak Up End of Year Report 2024/25

Meeting date: 8 May 2025

Reporting to: Group Board

Agenda item No:15

Report author: Philippa Imrie, Samantha Sinclair, Jim Woods and Jules Huggan Freedom to Speak up Guardians.

Action required:
Information

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

Previously presented to:
Group People Committee on 29 April 2025

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

Key discussion points and matters to be escalated from the meeting

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

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

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

- 62.5% compliance in Freedom to Speak Up (FTSU) training at South Tees.
- North Tees has delivered speaking up workshops to 118 staff with positive feedback and will use the current NHS Staff Survey results to target areas that might benefit from a workshop. The FTSU Guardian (FTSUG) has received referrals for workshops following the outcomes of an MDT, initiated through the resolution policy and has also received referrals through the education team, and these are also going to be incorporated on the LLP leadership programme, this is in addition to promoting them through various promotional platforms.

Recommendations:

Members of the Board are asked to:

- Note the content of the paper

Group Board of Directors

Thursday 8 May 2025

Freedom to Speak up End of Year Report 2024/25

1. PURPOSE OF REPORT

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

The report provides an overview of the themes and issues raised between 1 April 2024 and 31 March 2025, training data, current actions linked to the group improvement plan and proactive work.

2. BACKGROUND

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

3. DETAILS

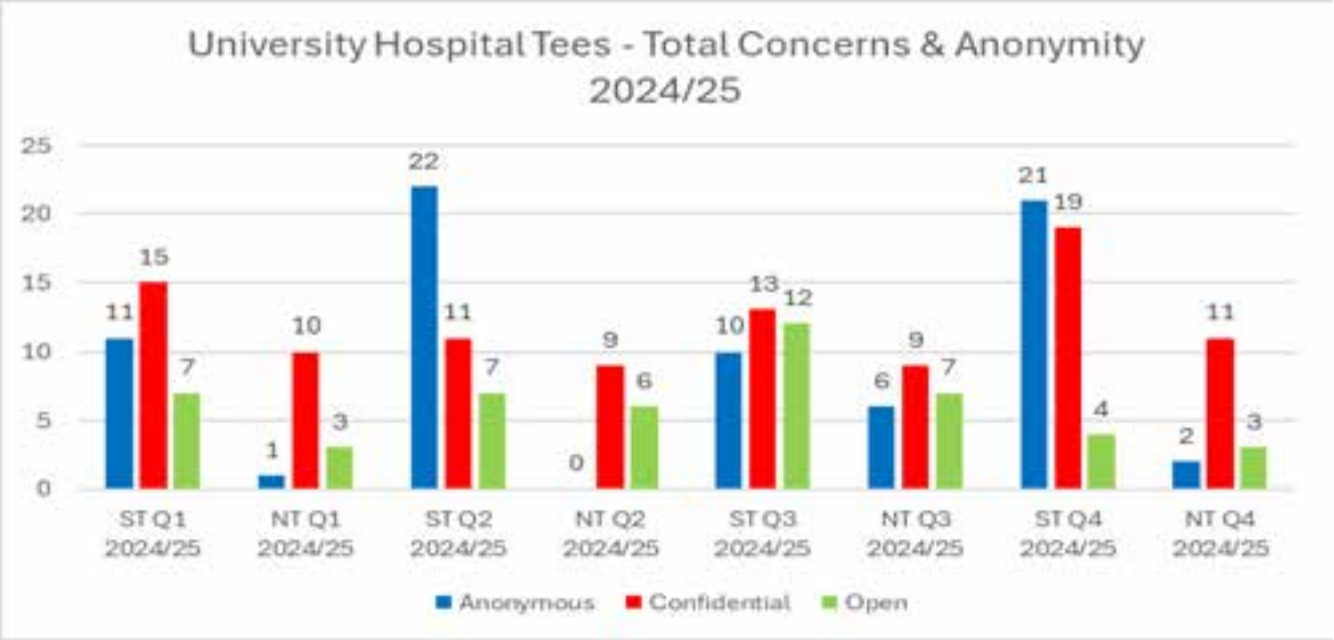
Assessment of concerns

Group:

During 2024/25 University Hospitals Tees received a total of 217 concerns. This is the first FTSU annual report in the group structure.

Graph 1 shows the number of concerns per quarter by Trust.

Graph 1



South Tees:

In Q4 the FTSUGs at South Tees received 44 concerns bringing the total number of concerns raised in 2024/25 year to 152, which is a 21.6%% increase compared to 125 concerns in 2023/24. The number of concerns raised anonymously increased from 40 (32%) in 2023/24 to 65 (42.67%) in 2024/25. Anonymous reporting at South Tees is higher than the national average (2023/24 9.5%). Work is ongoing with IT around some changes to the current FTSU system at South Tees to hopefully reduce anonymous cases going forward.

North Tees:

The number of concerns received at North Tees during Q4 was 13, bringing the total number of concerns raised in 2024/25 to 65, which is a 33% decrease compared to 97 concerns in 2023/24. The number of concerns raised anonymously at North Tees remains low at 6 (9.23%) in 2024/25.

Themes

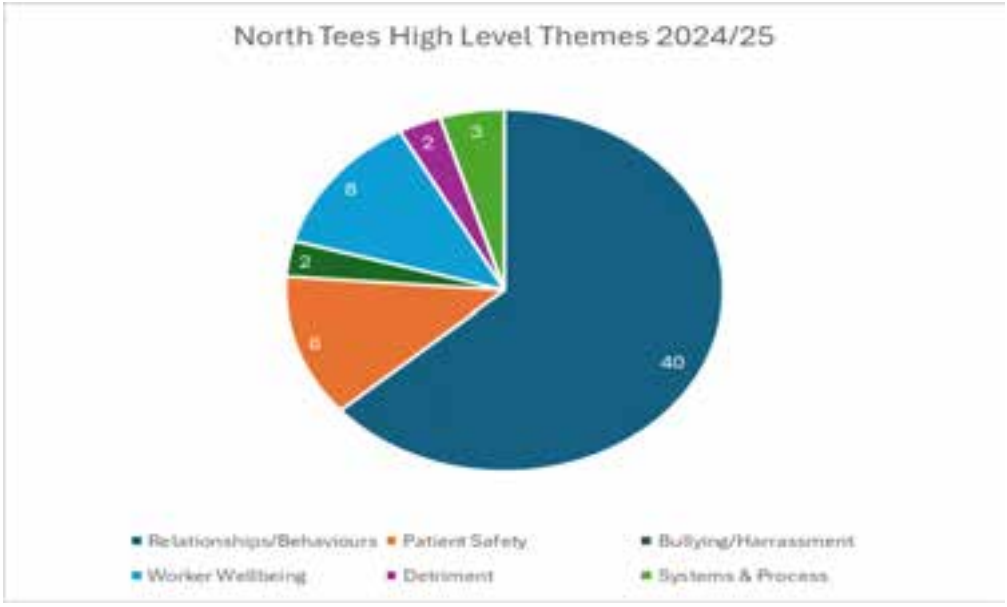
Charts 1 & 2 below shows the breakdown of higher-level themes identified in 2024/25 for both STEES and NTEES.

Chart 1

South Tees

Inappropriate Attitudes/Behaviours was the most reported theme during 2024/25 which is also the most reported theme nationally for 2023/24.

Chart 2



North Tees

The reporting of high-level themes in Q4 shows patient safety concern at 19%, still showing that there is low reporting of patient safety concerns, which aligns with the national data of the National Guardians' Office (NGO), which is 19.6%. Low reporting is believed to be due to the robust reporting structures elsewhere such as the Patient Safety Incident Response Framework (PSIRF) and InPhase, which encourages such concerns to be reported through

The FTSUGs, work in collaboration to seek assurance that patient safety concerns are being addressed effectively when other speaking up routes are being used.

The data shows that relationships and behaviours make 38% of what staff are speaking up about as their primary concern, which compares to the NGO that reports 40% for the same theme. More understanding of the culture work needs to be done to triangulate this data with civility in the workplace.

The reporting of high-level themes in Q3 showed that Inappropriate attitudes/behaviours featured in 25 of the 35 cases (71.42%). Nationally for 2023/24 this was 38.5%. It was also nationally the most reported theme in 2023/24.

National Guardian Office Annual Report Headlines 2022/23, presented to Parliament March 2025.

The total number of cases raised with the FTSUG was 32,167 the highest number of cases recorded and 27.6 % increase from 2022/23.

There were 18.7 % of cases raised about patient safety and quality, a marginal drop from 19.4 % 2022/23.

There was 19.8% of cases that reported bullying and harassment which was a 25% drop from the previous year.

There was two in every five cases 38.5% that included an element of inappropriate behaviours. This was the most reported theme in 2023/24.

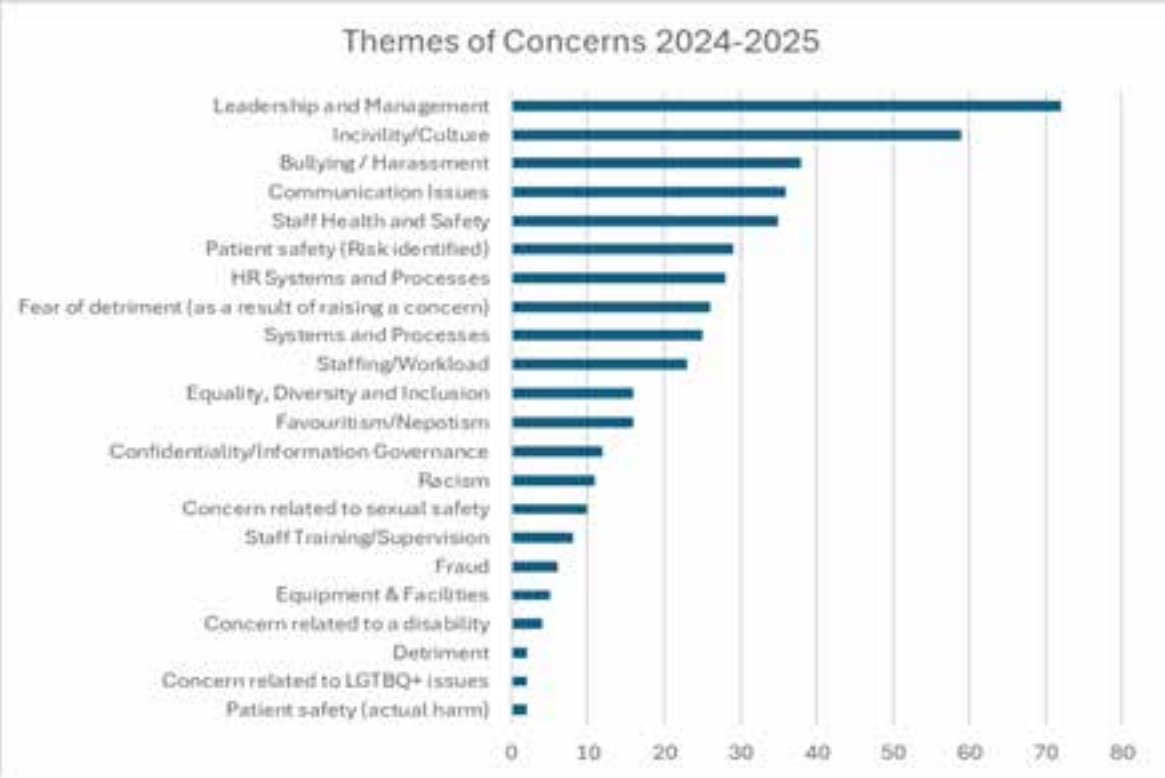
The percentage of cases, which were raised anonymously, was 9.5%, which is similar to the number of cases picked up in 2023/24, which were 9.4%.

Detriment for speaking up was indicated in 4.0% of cases, the same as the previous year.

Workers from a range of professions spoke up to the FTSUG, nurses and midwives accounted for the biggest portion of cases raised at 28.3%

Graph 2 provides a breakdown of the more detailed themes, across the year at South Tees. Leadership and management, Incivility/culture and Bullying/Harassment feature in the top three themes.

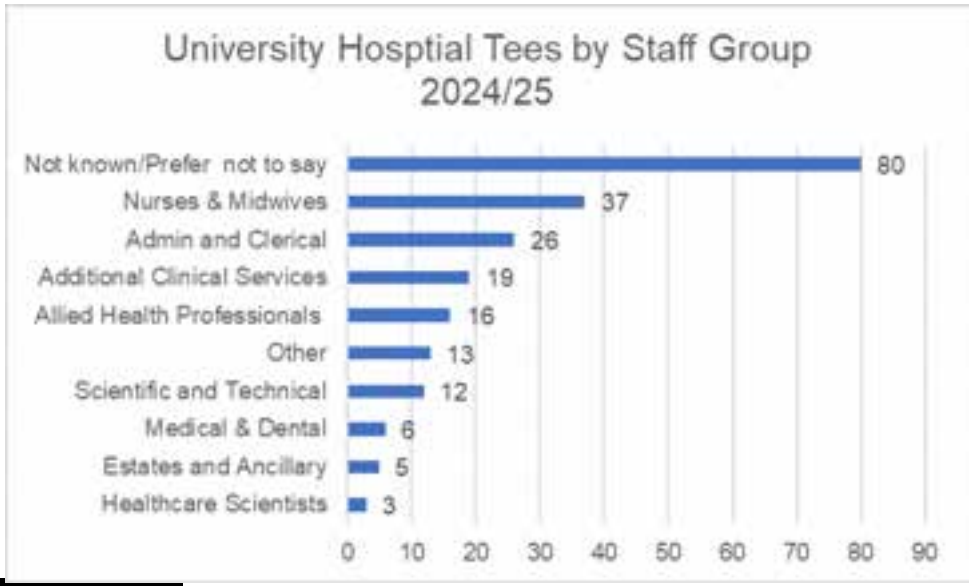
Graph 2



Staff Groups

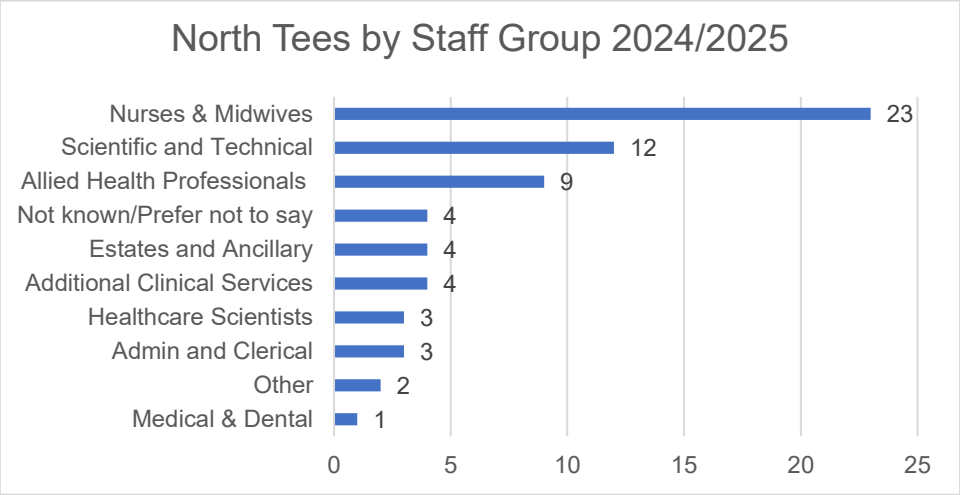
Graphs 3,4 & 5 below show the staff groups who have raised concerns at University Hospital Tees Group, North Tees and South Tees. These are the job titles used by the NGO. Not known/prefer not to say is the largest reported staff category as a group (76 of the 80 are at South Tees). Work is ongoing with IT to review the online reporting system at South Tees to encourage concern raisers to provide this detall when raising a concern.

Graph 3

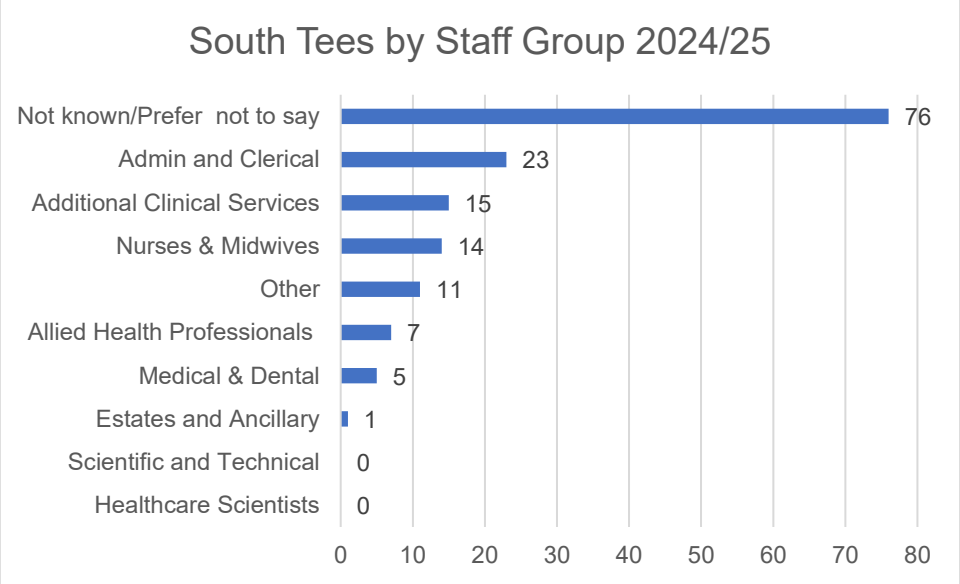


Caring Better Together

Graph 4



Graph 5



Equality, Diversity and Inclusion (EDI)

Currently North Tees does not capture EDI data as it is not a national requirement, or a previous requirement from the Trust Board of Directors and currently there is no IT system set up for workers to complete the EDI form online. The FTSUG will look to collect this data in quarter 1 of the next reporting year manually, and then electronically when the new group IT system is implemented.

Meanwhile the FTSUG is supporting the new People Hub, which is open every Tuesday at [illegible]un by the network leads and is a good opportunity for staff to drop in

and meet the leads and learn more about the available networks and wider support the Trust has to offer.

Table 1 shows the breakdown of concerns raised by sex, ethnicity, sexuality and disability at South Tees.

Table 1

EDI Information 2024/25					
Male	19	Female	76	Prefer not to say / Unknown	57
Ethnic Origin of Concern Raisers					
White					41
Asian					3
Mixed					0
Black					2
Other					5
Prefer not to say / Unknown					101
Sexuality of Concern Raiser					
Heterosexual / Straight					35
Gay Man / Woman					0
Bisexual					2
Prefer not to say / Unknown					115
Do you consider yourself to have a disability?					
Yes					74
No					48
Prefer not to say / Not stated					30

The FTSUGs are continuing work alongside the various EDI staff groups and meet regularly with the EDI lead to triangulate any issues and themes. Table 2 shows the concerns linked to protected characteristics at South Tees.

Table 2

Concerns linked to reported protected characteristics 2024/25 -			
No. of concern raisers who self-reported being from a BAME background	10	No. of concerns raised related to ethnicity or racism	5
No. of Concern Raisers who self-reported having a disability	74	No. of staff who raised concerns related directly to disability	3
No. of Concern Raisers who self-reported being from the LGBTQ+ community	2	No. of staff who raised concerns related directly to sexuality or gender identity	1

Feedback 2024/2025

The NGO reported in “A summary of speaking up to Freedom to speak up Guardians 2023/24” data that was published in July 2024 that of the feedback received 79.8% would speak up again, this was slightly lower than previous years (83.2% in 2022/23 and 85.1% in 2021/22). Within the report it states that the importance of ‘listening up’ was emphasised with the need for effective communication featuring strongly in learning comments.

Examples of the feedback received from concern raisers at South Tees during Q4 2025/25 is shown below, of the feedback received 100% of respondents confirmed they would use the FTSU service to speak up again if they needed to:

- *Thank you so much for having me and I felt relieved after speaking with you*
- *I feel like I have exorcised a demon just by speaking with you.*
- *I would like to take this opportunity to thank you very much, knowing that you are there to support any concerns we may have and the future I would have no hesitation in getting in touch with yourself.*
- *We have felt a difference since speaking up and have since had opportunities as a team to discuss our current issues with the right people and develop a plan of action moving forward.*

Examples of the feedback received from concern raisers at North Tees during Q4 2025/25 is shown below, of the feedback received 100% of respondents confirmed they would use the FTSU service to speak up again if they needed to:

- *Thank you, for your support and listening to me, when I needed someone to talk to*
- *Thank you so much for listening to me, I feel a lot better having spoken to you.*
- *Thank you for listening to me and helping me navigate my concerns, which has led to a positive conclusion. I really appreciated your support and expertise. The FTSUG role is so important to have in any organisation.*
- *Thank you for listening, it is good to have someone impartial to talk to for a fair perspective.”*
- *Speaking to you was incredibly reassuring, and I feel much more at peace, knowing there is support available. I truly appreciate your guidance and understanding.”*

Freedom to Speak Up Training

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

South Tees

The latest data results for South Tees demonstrates compliance of 65.62%, alongside this the guardians have developed bespoke workshop sessions that can be delivered to staff and are also in the process of developing guidance for managers dealing with concerns to support an effective process. Current NHS Staff Survey results are being used to target areas that may benefit from a workshop.

North Tees

North Tees has promoted and delivered speaking up workshops, following the poor uptake FTSUG has delivered to 118 staff with positive feedback and will use

the current NHS Staff Survey results to target areas that might benefit from a workshop. The FTSUG has received referrals for workshops following the outcomes of a MDT, initiated through the resolution policy and has also received referrals through the education team, and these are also going to be incorporated on the LLP leadership programme, this is in addition to promoting them through various promotional platforms.

Workshop Feedback includes:

- *I wanted to take a moment to sincerely thank you for delivering the listen up session today. I found it incredibly enlightening, eye opening and truly impactful. The insights were thought provoking."*
- *Initiatives like this play a crucial role in shaping the overall culture of the organisation, fostering openness and encouraging a safe and supportive environment for all."*
- *I just wanted to say thank you, I had low expectations of today's session, thinking it would be another tick in the box exercise. However, I have left feeling truly inspired and found the content very thought provoking."*
- *Wow that was so interesting and relevant and has given me so much to think about and why we need to get this right."*
- *I am going to reflect more on my own personal accountability, about helping get the culture right in the workplace. Considering more of a supportive approach, rather than a negative one."*

Awareness Raising

South Tees

The Guardian team continue to focus awareness across all groups of staff and satellite sites. Work continues with the Education and Practice Team to deliver sessions to Trust Inductions, International Nurse intakes, Junior Doctors, and Health Care Assistant training programmes. South Tees guardians also provide teaching sessions into Teesside University working with third year nursing students and Allied Health Professionals to raise awareness on the principles of Freedom to Speak up. Throughout the year, the guardians completed walkabouts and drop-in sessions across the South Tees Sites and also held promotional events.

Throughout the month of October 'Speak Up Month' was promoted with awareness sessions, promotional comms with organisational screen savers, a pod cast with Radio Stitch and a board development session attended by Jennie Fellows from the National Guardians Office. The Champion's Network has been reviewed with quarterly engagement sessions held for all champions offered the aim of these sessions is to offer support to champions, triangulate any themes and to share updates from the NGO and locally.

Following on from the latest staff survey results for 2024, the guardians are completing a detailed review of the results and have identified key areas of focus for walkabouts which are being carried out throughout April 2025, alongside this the South Tees Guardians are attending current cases meetings to support triangulation of data with patient safety, patient [redacted]effective care, safeguarding and legal services colleagues. More

recently a monthly meeting has been established with the STACQ team again to support the triangulation of data being gathered and to support focused work.

North Tees

The FTSUG has, through a fair recruiting process, recruited a further five Freedom to Speak Up Champions (FTSUC's), to expand their FTSUC network, which now stands at nineteen and with a further five people expressing an interest to become a FTSUC. The FTSUC's who have been recruited, completed an expression of interest form and line management sign off. An informal conversation was held in November, with a panel of the FTSUG and Head of People. The FTSUC's have all been trained by the FTSUG, and will attend the quarterly FTSUC network meeting, be buddied up with another FTSUC and will have a bi-annual informal 1-2-1 with the FTSUG and high-level data for triangulation, will be collected.

The FTSUG as part of 'Speak Up Month' was asked to be a guest speaker at a Teaching Hospital in the region to talk about supporting neurodiversity in the workplace, the FTSUG was accompanied by Head of People. Giving both a FTSUG and People perspective. This was well received, with positive feedback.

To tackle the barrier of detriment for workers speaking up. The Freedom to Speak Up Guardian (FTSUG) has developed a detriment presentation and a standing operational procedure on how to manage concerns about detriment. The FTSUG has also devised feedback forms asking if detriment has been suffered as a consequence of speaking up, which will be sent to workers three, six and twelve months after a case has closed. This work aims to educate staff and give them assurance that as an organisation, we do not tolerate detriment, with the hope to mitigate this as a barrier for staff speaking up. This work has been presented at People Group and will be presented at Group People Committee and Board before it is rolled out.

As part of the proactive work the FTSUG continues to promote the role via team meetings, floor walking, ward visits and has a high presence within the Trust, which can be demonstrated in the data. Those workers who have spoken up have been from different areas of the organisation and a variety of professional backgrounds including doctors, nursing, Allied Health Care Professionals, administration and student.

As we move to a culture of making speaking up "business as usual", we continue the proactive aspect of the FTSUG role, to encourage workers to report concerns openly, rather than confidentially, by helping them to feel empowered and psychologically safe.

To support this there are currently three training modules on ESR; Speak Up (core workers), Listen Up (middle managers) and Follow Up (senior leaders). The training is not mandatory at North Tees and Hartlepool NHS Foundation Trust and the undertaking of the training is low. The FTSUG as an alternative to completing the training modules, delivers workshops for [redacted]es, using each of the modules as a framework, whilst also using [redacted] podcast, Thirwell inquiry and the work of Chris Turner "Civility Saves

Lives" and Meghan Reitz "The power you hold that silences others" The FTSUG has delivered twelve workshops over quarter one and two.

Regular "Keep in Touch" meetings with the Executive Sponsor, Non-Executive Director for FTSU and Chairman have taken place. All other senior leaders have helped create a relational approach to speaking up as well progressing any concerns raised. Monthly meetings continue with the CEO. The FTSUGs also present monthly updates at People Group and quarterly at People Committee and Board of Directors.

To strengthen the organisational approach to the triangulation of data, the FTSUG has become a member of the trusts Culture Steering Group which aims to look at the soft intelligence where areas may be suffering difficulty and using the resources to provide an early holistic approach to resolve issues before they become more problematic. The FTSUG is also a member of the Patient Safety Steering Group.

To help build relationships with the network leads, the FTSUG attends all of the meet the network leads sessions and has been invited to be part of the People Hub, which has recently been established.

The FTSUG is the Deputy Chair of the Northeast, Yorkshire regional FTSUG network meetings with the aim of learning, sharing best practice, peer support and working collaboratively.

The FTSUG has been looking at how to support Neurodiversity in the workplace, the sexual safety charter, and attends the EDI steering group, the, Schwartz Round steering group and supports the Wellbeing Framework.

The FTSUG continues to deliver the FTSU presentation and promote the service in the following ways:

NTEES
All staff inductions
Preceptorship Training
Undergraduate Medical Students
Postgraduate Doctors
T-Level Students
Teesside University
Care Group 1-3
NTH Solutions
Quarterly Community Forum
Joint Forum
Schwartz Round Steering Group
Quarterly Community Forum
Quarterly Patient Safety Steering Group
Quarterly Senior Practitioner Manager Operational Meeting
Quarterly Matrons Meeting
up Senior Management

Quarterly Group People Committee
Quarterly Board
Monthly meetings with Care Group Directors
Ward/Directorate Meetings
Podcasts
Hearing it with Stacey session
People Hub

STEES
All staff inductions
Care Certificate
Preceptorship Training
Undergraduate Medical Students
Postgraduate Doctors
T-Level Students
Teesside University
Collaboratives
Quarterly Group People Committee
Quarterly Board
Monthly meetings with Care Group Directors
Ward/Directorate Meetings
Staff Networks
Podcasts
STAQC Monthly Meetings
Hearing it with Stacey Sessions

Group Implementation Plan

The FTSUG's across the Group, have developed an improvement plan. This is reviewed regularly, with updates provided (see below) on some elements of the plan. As elements of this are core business of the FTSUGs, some of the actions are ongoing, forming part of their everyday work.

Action	Lead Trust	Due Date	Progress	Status (open, ongoing, completed, to note)
FTSU Workshops	South Tees North Tees	Q4, 2024 In place	South Tees workshop content has been created is ready to present and is being actively promoted. NTees has delivered workshops to 118 workers and received positive feedback. The FTSUG has received referrals for workshops following the outcomes of MDT, initiated through the resolution policy and has also received referrals	Complete

			through the education team and incorporated into the LLP leadership programme.	
FTSU training to be made available to all staff across the group	Group	Q3, 2024	Both South and North Tees have the Speak Up, Listen Up and Follow Up training on ESR for staff. Data gathered for South Tees demonstrates 65.62% compliance	Complete
Champion training Development of Champion role, awareness and training Network	Group	Q1-4	Both North and South Tees continue to expand their FTSUC network, through a fair recruiting process, as per National Guidance. FTSUC are trained, can attend quarterly network meetings, have informal bi –annual 1-2-1 and are asked to support staff and signpost and collect high level themed data for triangulation.	Ongoing
Detriment Work	Group	Q4, 2025	To tackle the barrier of detriment for workers speaking up. The FTSUG at North Tees has developed a detriment presentation and a standing operational procedure on how to manage concerns about detriment. This is to be shared with the FTSUG at South Tees for joint work before being presented to group board for approval.	Ongoing
Peer Review	Group	Q2, 2024	As part of the group work the FTSUG's from North and South Tees, went to peer review Liverpool Heart and Chest Hospital, as they were at the top of the NHS staff survey results last year. There were some interesting conversations on creating an open and safe speaking up culture and tackling incivility in the workplace.	Complete
Staff survey to be used to develop focussed work in each area.	Group	Q1, 2025	The NGO devised the FTSU Index as an indicator to help build a picture of what speaking up culture feels like for workers. It is a metric for NHS Trusts, drawn from five questions in the Annual Staff Survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree that they would be	Ongoing

			treated fairly if involved in an error, near miss or an incident. Although the NGO does not do the index anymore, in Q4 2024 the FTSUG followed the same principles using six questions and will be doing the same in Q4 2025. The staff survey 2024 has now been published, the FTSUG's have completed a review of the data have broken this down into care groups and collaboratives and are in the process of completing walkabouts across sites focusing on those areas who have scored higher and lower than average.	
Data Peer Review	Group	Q1-4	As part of the Group reflection work the FTSUG's at North and South Tees have thematically peer reviewed two cases each. This work will continue on a monthly basis.	Ongoing
Triangulation of Data	STEES NTEES	Q1-4 Q1-4	STEES attend current cases, staff side, patient safety meetings, STACQ monthly meetings attended. NTEES attend the triangulation steering group, patient safety steering group.	Ongoing
EDI - Guardians to link with EDI Network Meetings	Group	Q1-4	All FTSUG's are members of relevant network meetings across the sites. N.Tees has established a weekly People Hub, run by the network leads. The FTSUG uses this as another platform to connect with staff and promote FTSU and work with the network leads.	Ongoing
Walkabouts	Group	Q1-4	To continue walkabouts in respective areas	Ongoing
Group Recording System	Group	TBC	FTSU System for recording concerns. Currently bespoke at STEES, North Tees currently has an Excel Spreadsheet. To align as a group in the recording of concerns, the InPhase system has been agreed and waiting for a date for implementation.	Ongoing

NHS Annual Staff Survey

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

Although the FTSU Index is not calculated anymore, for the purpose of this report it was thought, that it would be useful to use a similar concept to allow comparisons amongst Trusts and how that was broken down into Care Groups.

For the purpose of this paper, six questions and responses have been taken from the Annual Staff Survey 2022/23, 2023/24 and 2024/25 and benchmarked against the national average to check progress. Full details of each trust by care group/collaborative are in the attached appendices.

NHS Annual Staff Survey Results

Question	North Tees 2022/23	North Tees 2023/24	North Tees 2024/25	National Benchmark 2024/25
% of staff "agreeing" or "strongly agreeing" My organisation treats staff who are involved in an error, near miss or incident fairly	60.30 %	61.85 % (+1.55)	60.82% (-1.03)	59.47% (+1.35)
% of staff "agreeing" or "strongly agreeing" My organisation encourages us to report errors, near misses and incidents	87. 66 %	87.36 % (-0.36)	87.51% (+0.15)	85.95% (+1.56)
% of staff "agreeing" or "strongly agreeing" I would feel secure raising a concern about unsafe clinical practice	74.34 %	73.07 % (-1.27)	72.28% (-0.79)	70.44% (+1.84)
% of staff "agreeing" or "strongly agreeing" I am confident that my organisation would address my concerns	61.91%	61.51 % (-0.40)	60.52% (-0.99)	55.91% (+4.61)
% of staff "agreeing" or "strongly agreeing" I feel safe to speak up	65.03%	64.23% (-0.80)	63.24% (-0.99)	60.29% (+2.95)

concerns me in this organisation				
% of staff “agreeing” or “strongly agreeing” If I spoke up about something that concerned me, I am confident my organisation would address my concern	54.99%	54.93% (-0.06)	52.68% (-2.25)	48.23% (+4.45)

NHS Annual Staff Survey Results

Question	South Tees 2022/23	South Tees 2023/24	South Tees 2024/25	National Benchmark 2024/25
% of staff “agreeing” or “strongly agreeing” My organisation treats staff who are involved in an error, near miss or incident fairly	57.83%	57.86% (+0.03)	58.16% (+0.30)	59.47% (-1.31)
% of staff “agreeing” or “strongly agreeing” My organisation encourages us to report errors, near misses and incidents	87.70%	84.95% (-2.75)	85.01% (+0.06)	85.95% (-0.94)
% of staff “agreeing” or “strongly agreeing” I would feel secure raising a concern about unsafe clinical practice	74.34%	71.28% (-3.06)	70.25% (-1.03)	70.44% (-0.19)
% of staff “agreeing” or “strongly agreeing” I am confident that my organisation would address my concerns	58.43%	54.15% (-4.28)	53.35% (-0.80)	55.91% (-2.56)
% of staff “agreeing” or “strongly agreeing” I feel safe to speak up about anything that concerns me in this organisation	63.15%	62.88% (-0.27)	61.92% (-0.96)	60.29% (+1.63)
[illegible]	48.13%	48.71% (+0.58)	47.74% (-0.97)	48.23% (-0.49)

spoke up about something that concerned me, I am confident my organisation would address my concern				

Conclusion:

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

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

Appendices:

South Tees FTSU staff survey data by collab

North Tees FTSU staff survey data by care group (to follow)

South Tees Hospitals NHS Foundation Trust Standard Heatmap By HeatMap1 - Against Organisation Average

sitive question scores and people promises/themes/sub-scores for all categories compared to your Organisation average. It is a dynamic report that you can adjust to get the maximum insight from your data. By default the comparison is set at 3% / 0.3 (for people promises/themes/sub-scores) or more difference between the scores. To highlight all differences of 5% or more adjust cell E10 to 5 etc. Unfavourable differences of more than the specified amount are highlighted in red, favourable differences of more than the specified amount are highlighted in green. The positive question score is the

RAG Percentage Difference from Organisation Average:	0.3

				3,050	309,865	189	299	162	146	48	61	96	413	231	49	185	223	162	128	220	130	294
Data Type		Metric		Organisation	Comparator	Cardiovascular Care Services	Clinical Support Services	Corporate Affairs Directorate	Digestive Diseases, Urology & General Surgery Services	Digital Information	Estates & Facilities	Finance Directorate	Growing the Friarage & Community Services	Head & Neck, Orthopaedic & Reconstructive Services	Human Resources Directorate	James Cook Cancer Institute & Speciality Medicine Services	Medicine & Emergency Care Services	Neurosciences & Spinal Care Services	Nursing Directorate	Perioperative & Critical Care Services	Strive	Women & Children Services
Question score	Q19a	My organisation treats staff who are involved in an error, near miss or incident fairly (Agree/Strongly agree).		58.4%		63.7%	65.0%	50.0%	45.3%	57.1%	53.1%	52.4%	69.1%	52.9%	65.9%	55.0%	48.0%	56.1%	68.8%	58.6%	51.6%	58.6%
Question score	Q19b	My organisation encourages us to report errors, near misses or incidents (Agree/Strongly agree).		85.2%		88.6%	89.1%	73.2%	80.6%	76.7%	77.0%	74.4%	89.3%	83.6%	88.9%	87.2%	81.1%	87.7%	90.1%	84.7%	80.5%	90.2%
Question score	Q20a	I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).		70.4%		73.4%	76.3%	59.6%	66.4%	51.1%	54.1%	56.3%	75.9%	64.5%	65.3%	70.3%	67.6%	71.4%	76.6%	76.4%	67.7%	75.3%
Question score	Q20b	I am confident that my organisation would address my concern (Agree/Strongly agree).		53.2%		58.1%	52.8%	43.5%	47.2%	42.6%	36.7%	46.8%	59.8%	48.9%	59.2%	51.9%	42.5%	52.8%	70.3%	55.5%	54.6%	59.0%
Question score	Q25e	I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).		62.4%		67.0%	63.0%	49.4%	51.7%	54.2%	44.3%	62.5%	68.5%	61.7%	65.3%	66.8%	48.4%	63.4%	76.4%	65.9%	68.5%	63.1%
Question score	Q25f	If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).		47.8%		56.1%	46.3%	33.1%	45.1%	36.2%	35.0%	49.0%	52.7%	45.2%	59.2%	49.5%	35.6%	45.3%	62.2%	50.7%	53.8%	49.3%

North Tees and Hartlepool NHS Foundation Trust Standard Heatmap By Care Group - Against Organisation Average

This Heatmap report shows your positive question scores and people promises/themes/sub-scores for all categories compared to your Organisation average. It is a dynamic report that you can adjust to get the maximum insight from your data. By default the comparison is set at 3% / 0.3 (for people promises/themes/sub-scores) or more difference between the scores. To highlight all differences of 5% or more adjust cell E10 to 5 etc. Unfavourable differences of more than the specified amount are highlighted in red, favourable differences of more than the specified amount are highlighted in green. The positive question score is the percentage of respondents who gave a favourable response and is displayed to one decimal place, people promises/themes/sub-scores are displayed to two decimal places. Only questions that can be scored have been included. Where there are less than 10 responses to a question/metric the respective scores will be replaced with an asterisk (*).

KEY

(bright green)	Positive score of 100% / 10
(green)	Score > 3% / 0.3 better than Organisation average
(red)	Score > 3% / 0.3 worse than Organisation average
(amber)	Scores in between

RAG Percentage Difference from Organisation Average: **3**

Number of respondents: 2,337 | 375 | 389 | 982 | 591

Data Type	Metric		Questionnaire Section	People Promise		People Promise Sub-score		Theme		Theme Sub-score		Organisation	Collaborative Care Division	Corporate Division	Healthy Lives Division	Responsive Care Division
				Metric contributes towards:												
												2,337	375	389	982	591
Question score	Q19a	My organisation treats staff who are involved in an error, near miss or incident fairly (Agree/Strongly agree).	YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	61.6%	60.3%	61.2%	62.6%	60.8%
Question score	Q19b	My organisation encourages us to report errors, near misses or incidents (Agree/Strongly agree).	YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	88.1%	90.5%	83.5%	89.7%	86.7%
Question score	Q20a	I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	PP3	We each have a voice that counts	PP3_2	Raising concerns	N/A	N/A	N/A	N/A	73.2%	73.8%	65.5%	75.6%	73.9%
Question score	Q20b	I am confident that my organisation would address my concern (Agree/Strongly agree).	YOUR HEALTH, WELL-BEING AND SAFETY AT WORK	PP3	We each have a voice that counts	PP3_2	Raising concerns	N/A	N/A	N/A	N/A	61.0%	63.4%	57.8%	62.2%	59.7%
Question score	Q25e	I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	YOUR ORGANISATION	PP3	We each have a voice that counts	PP3_2	Raising concerns	N/A	N/A	N/A	N/A	63.8%	62.2%	65.1%	65.3%	61.6%
Question score	Q25f	If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	YOUR ORGANISATION	PP3	We each have a voice that counts	PP3_2	Raising concerns	N/A	N/A	N/A	N/A	53.3%	52.3%	55.6%	54.1%	51.3%

Resources Committee

30 April 2025, Chair David Redpath

Connecting to: Group Board

Key topics discussed in the meeting:

- **Finance Position**

  The Group plan for the 2024/25 financial year is now currently to deliver an overall deficit control total of £7.8m, with a break-even plan for NTH and a £7.8m deficit plan for STH. The changes in control total since Final Plan submission in June 2024 reflect the Group's share of:

  - Non-recurrent deficit support provided by NHSE 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 from Month 6.
  - Non-recurrent allocation of ICB planned surplus to address agreed contract pressures in providers in order to reduce the impact on cash flow and reduce borrowing costs for the overall system. The allocation to STH was £15.3m, confirmed in Month 10.

The financial position for Month 12 2024/25 is a deficit of £7.8m for the Group, which is a favourable variance of £0.08m against the year-to-date plan.

- **WTE**

  Month 12 shows a net overall increase of 603 WTE worked across the Group, compared to the average in 2023/24. Whilst WTE worked for Bank and Agency show a total reduction of 50wte from 2023/24, this is offset by increases in substantive staffing of 653wte.

- Compared to the previous month, Month 12 WTE worked is 80wte higher.
- Overall, WTEs worked across the Group in Month 12 are now 2,767wte (21%) higher than the average deployed during 2019/20.

- **Integrated performance report**
- We discussed February date with concern raised regarding
    - 65 week waits
    - Performance against cancer targets

- **Terms of Reference and Cycle of Business**

We reviewed the committee's Terms of reference and cycle of business

- Requested clarification on where Subsidiary reporting resides
- Updated required to include external requests from ICB / Centre
- Urgent action needed on Temporary Vice chair
- Updated required to reflect scope of procurement oversight.

For 2025/26, the committee will adopt a bimonthly full committee with an interim committee focusing on deep dives into areas / projects / subjects that need further scrutiny or assistance.

- **Procurement**
- We received an update from both trusts on procurement activity
    - First point to note is the marked improvement in the reporting since last period and it was good to see a joint report.
    - Some concern over procurement saving target at South Tees for 25/26 but actions in place to identify further opportunities
    - Work need to confirm both trusts are working on the same definition of procurement savings (cost avoidance v cost savings)

Actions:

- Vice Chair of Committee needs to be appointed
- Further work needed on whole time equivalent – actions to be agreed
    - Review of externally funded posts – is funded still in place for entire 25/26 and plan to remove costs if not
    - Review of business cases – are we seeing benefits – if not what is the plan to remove the additional roles

This is outstanding from last period

- Terms of reference updates

Escalated items:

- WTE
    - Trending in the wrong direction – this now needs Board discussion on grip and control at an operational level and action agreed and executed.

Risks (Include ID if currently on risk register):

- No new Risks identified

Month 12 2024-25 Finance Report

Meeting date: 8 May 2025

Reporting to: Group Board

Agenda item No: 17

Report author: Chris Hand, Group Chief Finance Officer

Action required:
Information

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

Previously presented to: *Group Resource committee*

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 Group plan for the 2024/25 financial year is now currently to deliver an overall deficit control total of £7.8m, with a break-even plan for NTH and a £7.8m deficit plan for STH.

The changes in control total since Final Plan submission in June 2024 reflect the Group's share of:

- Non-recurrent deficit support provided by NHSE 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 from Month 6.
- Non-recurrent allocation of ICB planned surplus to address agreed contract pressures in providers in order to reduce the impact on cash flow and reduce borrowing costs for the overall system. The allocation to STH was £15.3m, confirmed in Month 10.

The financial position for Month 12 2024/25 is a deficit of £7.8m for the Group, which is a favourable variance of £0.08m against the year-to-date 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.

Month 12 shows a net overall increase of 603 WTE worked across the Group, compared to the average in 2023/24. Whilst WTE worked for Bank and Agency show a total reduction of 50wte from 2023/24, this is offset by increases in Substantive staffing of 653wte.

Compared to the previous month, Month 12 WTE worked is 80wte higher.

Overall, WTEs worked across the Group in Month 12 are now 2,767wte (21%) higher than the average deployed during 2019/20.

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 received monthly assurance reports on the financial performance throughout the year, including monitoring of the assumptions made and the risks to delivery of the financial plan.

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.

Recommendations:

Members of the Board are asked to:

- Note the financial position for Month 12 2024/25.

Group Board
8th May 2025

Month 12 2024/25 Finance Report

1. PURPOSE OF REPORT

The purpose of this report is to update the Committee on the financial performance of the individual trusts and overall Group, at the end of Month 12 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 will be 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.

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.

NENC ICB agreed the further non-recurrent allocation of the ICB planned surplus to address agreed contract pressures in providers in order to reduce the impact on cash flow and reduce borrowing costs for the overall system. The allocation to STH was £15.3m and the Trust's financial control total for the year was centrally adjusted by NHSE in Month 10 to reflect this.

The Group plan for the 2024/25 financial year is now to deliver an overall deficit control total of £7.8m, with a break-even plan for NTH and a £7.8m 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 12 FINANCIAL POSITION

The table below shows the revenue position for the Group as at the end of Month 12 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	412,062	439,839	27,777	920,429	955,307	34,878	**1,332,491**	**1,395,146**	**62,655**
Other operating income	38,967	46,297	7,330	72,218	85,902	13,684	**111,185**	**132,199**	**21,014**
Employee expenses	(302,342)	(327,550)	(25,208)	(599,934)	(621,785)	(21,852)	**(902,276)**	**(949,335)**	**(47,060)**
Operating expenses excluding employee expenses	(144,418)	(152,644)	(8,226)	(364,882)	(419,282)	(54,400)	**(509,300)**	**(571,926)**	**(62,626)**
OPERATING SURPLUS/(DEFICIT)	**4,269**	**5,942**	**1,673**	**27,832**	**142**	**(27,690)**	**32,101**	**6,084**	**(26,017)**
FINANCE COSTS									
Finance income	2,500	2,948	448	1,400	3,065	1,665	**3,900**	**6,013**	**2,113**
Finance expense	(650)	(672)	(22)	(23,624)	(20,620)	3,004	**(24,274)**	**(21,292)**	**2,982**
PDC dividends payable/refundable	(2,276)	(2,400)	(124)	0	0	0	**(2,276)**	**(2,400)**	**(124)**
NET FINANCE COSTS	**(426)**	**(124)**	**302**	**(22,224)**	**(17,555)**	**4,669**	**(22,650)**	**(17,679)**	**4,971**
Other gains/(losses) including disposal of assets	0	59	59	0	64	64	**0**	**123**	**123**
Corporation tax expense	(59)	(51)	8	0	(13)	(13)	**(59)**	**(64)**	**(5)**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**3,784**	**5,826**	**2,042**	**5,608**	**(17,362)**	**(22,970)**	**9,392**	**(11,536)**	**(20,928)**
Add back all I&E impairments/(reversals)	6,633	5,644	(989)	7,625	33,203	25,578	**14,258**	**38,847**	**24,589**
Remove capital donations/grants I&E impact	(10,417)	(11,601)	(1,184)	(14,314)	(15,414)	(1,100)	**(24,731)**	**(27,015)**	**(2,284)**
Remove net impact of consumables donated from other DHSC boc	0	133	133	0	86	86	**0**	**219**	**219**
Adjust PFI revenue costs to UK GAAP basis	0	0	0	(6,723)	(8,311)	(1,588)	**(6,723)**	**(8,311)**	**(1,588)**
Adjusted financial performance for the purposes of system achievement	**0**	**2**	**2**	**(7,804)**	**(7,798)**	**6**	**(7,804)**	**(7,796)**	**8**

At the end of Month 12 2024/25 the Group is reporting a favourable variance of £0.08m (with a favourable variance of £2k relating to NTH and a favourable variance of £6k relating to STH).

The main drivers of the **NTH Month 12 position** are:

- Clinical Income is ahead of plan by £11.6m, which mostly relates to increased high-cost drugs and devices income, additional ERF income, non-recurrent ICB pressures funding, industrial action funding, and non-NHS income
- The plan assumed 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 is 124%, which is an additional £1.5m against plan.
- Other operating income (excluding donated asset income) is £6.1m 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.
- The net impact of industrial action was £0.1m
- Pay award pressure of £0.6m.
- Overspend against block funded high-cost drugs and devices of £1.8m
- Offsetting additional non-recurrent measures

The main drivers of the **STH Month 12 position** are:

- Clinical Income is ahead of plan by £34.9m, reflecting additional ERF income of £17.0m, passthrough high-cost drugs and devices income of £9.4m and additional contract variations.
- 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 124%, which is an additional £17.0m income against plan (and £24.7m above the national target).
- Overspends on Ward budgets of £2.0m year-to-date. The rate of overspend continued to reduce significantly over the course of the year, from a Q1 average overspend of £374k per month. The Month 12 overspend was £54k.
- Medical pay is overspent by £13.6m and is split between consultants £7.1m and resident doctors £6.5m. This is part-offset by the additional income received via contract variations (which has been adjusted in the operational budgets). Drivers of the underlying overspend include the impact of the unfunded pay award, delivery of ERF activity and under-delivery of CIP schemes (including progress against planned recruitment to reduce premium pay costs).
- Overspends on medical and surgical equipment and drugs (including high-cost drugs and devices expenditure) is £28.1m; this is partially offset by high-cost drugs and devices income of £9.4m and additional ERF income. Overspends relating to block-funded high-cost block drugs and devices is £10.2m.
- Overspend on Energy of £1.5m, relating to changed VAT recovery arrangements under the PFI contract.
- Interest receivable is ahead of plan by £1.7m, reflecting higher than plan cash balances.
- Offsetting additional non-recurrent measures

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 12:

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

	NTH			STH			GROUP		
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Nursing	4,061	1,852	-2,209	384	274	-110	4,445	2,126	-2,319
AHP and S&T	105	771	666	815	402	-413	920	1,173	253
Other Clinical	0	0	0	0	1	1	0	1	1
Consultants	2,052	1,726	-326	3,309	3,701	392	5,361	5,427	66
Career/staff grades	0	6	6	0	9	9	0	15	15
Trainee grades	0	34	34	0	0	0	0	34	34
Non Clinical	0	13	13	252	93	-159	252	106	-146
Total Agency	**6,218**	**4,402**	**-1,816**	**4,760**	**4,480**	**-280**	**10,978**	**8,882**	**-2,096**

At the end of Month 12, agency Expenditure is £2.1m below plan overall for the Group, with an underspend of £0.3m at STH and underspend of £1.8m at NTH.

2024/25 agency expenditure totalled £8.9m, which is a reduction of £4.3m (and 32.5%) on 2023/24 levels.

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 national and regional scrutiny, linked to the reductions in productivity noted across the NHS.

Worked	19/20 Average p.m.	23/24 Average p.m.	Q1 24/25 Average p.m.	Q2 24/25 Average p.m.	Q3 24/25 Average p.m.	Mth 10 24/25	Mth 11 24/25	Mth 12 24/25	Change from 19/20	Change from 23/24	Change from prior month
	NTH										
Agency	20.38	63.89	50.61	29.69	29.84	33.76	31.51	26.34	5.96	-37.55	-5.17
Bank	186.45	234.11	225.14	248.82	254.59	254.55	244.40	279.46	93.01	45.35	35.06
Substantive	4,659.47	5,130.23	5,273.22	5,301.06	5,365.49	5,332.11	5,376.51	5,383.39	723.92	253.16	6.88
Sub Total	**4,866.30**	**5,428.23**	**5,548.97**	**5,579.56**	**5,649.91**	**5,620.42**	**5,652.42**	**5,689.19**	**822.89**	**260.96**	**36.77**
	STH										
Agency	25.51	34.62	17.57	18.75	20.67	19.02	18.22	16.59	-8.92	-18.03	-1.63
Bank	198.01	393.05	375.16	356.22	317.86	341.40	326.44	353.26	155.25	-39.78	26.82
Substantive	7,836.68	9,235.07	9,427.08	9,402.81	9,540.04	9,548.44	9,616.41	9,634.51	1,797.83	399.44	18.10
Sub Total	**8,060.20**	**9,662.74**	**9,819.80**	**9,777.78**	**9,878.57**	**9,908.86**	**9,961.07**	**10,004.36**	**1,944.16**	**341.62**	**43.29**
	GROUP										
Agency	45.89	98.51	68.18	48.44	50.51	52.78	49.73	42.93	-2.96	-55.58	-6.80
Bank	384.46	627.16	600.29	605.03	572.45	595.95	570.84	632.72	248.26	5.57	61.88
Substantive	12,496.15	14,365.30	14,700.30	14,703.87	14,905.53	14,880.55	14,992.92	15,017.90	2,521.75	652.60	24.98
Grand Total	**12,926.50**	**15,090.97**	**15,368.77**	**15,357.34**	**15,528.48**	**15,529.28**	**15,613.49**	**15,693.55**	**2,767.05**	**602.58**	**80.06**

Month 12 shows a net overall increase of 603 WTE worked across the Group, compared to the average in 2023/24 (261wte (4.8%) at NTH and 342wte (3.5%) at STH). Whilst

WTE worked for Bank and Agency show a total reduction of 50wte from 2023/24 for the Group overall, this is offset by increases in Substantive staffing WTE worked of 653wte.

Overall, WTEs worked across the Group in Month 12 remain c21% (2,767wte) higher than the average deployed during 2019/20.

Efficiency

The plan assumes delivery of an overall efficiency target for the Group of £74.5m. 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.

The table below shows the year-to-date delivery against the Group's efficiency targets. Across the Group, overall year-to-date delivery is £75.4m (101% of target)

	NTH					STH					GROUP				
YTD Month 12	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	11,630	9,754	9,504	-250	97%	28,992	33,076	24,134	-8,942	73%	40,622	42,830	33,638	-9,192	79%
ERF Delivery	5,858	5,858	5,858	0	100%	7,400	7,400	8,209	809	111%	13,258	13,258	14,067	809	106%
Corporate	750	913	779	-135	85%	4,500	3,996	3,716	-280	93%	5,250	4,909	4,495	-415	92%
Central	7,615	9,519	10,815	1,296	114%	14,437	3,973	12,386	8,413	312%	22,052	13,492	23,201	9,709	172%
Total	**25,853**	**26,045**	**26,955**	**911**	**103%**	**55,329**	**48,445**	**48,445**	**0**	**100%**	**81,182**	**74,490**	**75,400**	**911**	**101%**

Capital

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

The Group's ICS Capital Departmental Expenditure Limit (CDEL) for 2024/25 amounted to £32.7m, including an additional £5m bonus allocation relating to UEC performance at NTH.

The capital programme also includes external support, in the form of Public Dividend Capital (PDC) of £23.8m (including 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 included 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 12 amounted to £121.5m, as detailed in the table below.

	NTH £000	STH £000	Group £000
Equipment	1,786	6,868	8,654
Digital	3,498	4,984	8,482
Estates	11,299	7,629	18,928
PFI	0	7,318	7,318
Salix	10,409	15,140	25,549
FHN Hub	0	18,495	18,495
JCUH UTC	0	768	768
CDC Hub	12,779	0	12,779
IFRS 16	3,097	17,391	20,488
Total Gross Capital	**42,868**	**78,593**	**121,461**

This is £20.9m higher than the opening 2024/25 plan, reflecting receipt of additional national PDC funding during the financial year, donated assets and a share of additional system CDEL underspends. Expenditure on PFI capital lifecycle by the PFI partner totalled £7.3m during 2024/25, compared to the £11.8m charge for lifecycle capital maintenance within the overall PFI unitary payment, resulting in a pre-payment of £4.5m at the end of the year.

The overspend against the CDEL allocation for IFRS16 (right of use) assets (largely relating to the impact of indexation increases on the rental payments for STH leased properties) was offset at overall system level by underspends across a number of providers and receipt of a fair shares allocation from national contingency funding for emerging IFRS16 pressures.

Liquidity

The cash balance at the end of Month 12 stood at £110.5m for the Group (with £57.6m relating to NTH and £52.9m 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	72,081	215,252
Total bills paid within target	70,357	211,858
Percentage of bills paid within target	**97.6%**	**98.4%**

STH	YTD Number	YTD Value £000
Total bills paid in the year	107,894	680,147
Total bills paid within target	104,666	653,193
Percentage of bills paid within target	**97.0%**	**96.0%**

GROUP	YTD Number	YTD Value £000
Total bills paid in the year	179,975	895,399
Total bills paid within target	175,023	865,051
Percentage of bills paid within target	**97.2%**	**96.6%**

Statement of Financial Position

The table below shows the balance sheet position for the two Trusts as at the end of Month 12:

	NTH £000	STH £000
Non-current assets		
Intangible assets	1,737	9,407
On-SoFP IFRIC 12 assets	0	143,167
Other property, plant and equipment (excludes leases)	148,485	166,867
Right of use assets - leased assets for lessee (excluding PFI/LIFT)	19,458	35,792
Receivables: due from NHS and DHSC group bodies	607	1,231
Receivables: due from non-NHS/DHSC Group bodies	1,267	2,836
Credit Loss Allowances		(2,760)
Total non-current assets	**171,554**	**356,540**
Current assets		
Inventories	7,024	15,772
Receivables: due from NHS and DHSC group bodies	6,573	27,882
Receivables: due from non-NHS/DHSC Group bodies	22,033	49,087
Credit Loss Allowances	(3,478)	(957)
Cash and cash equivalents: GBS/NLF	55,292	50,455
Cash and cash equivalents: commercial/in hand/other	2,298	2,454
Total current assets	**89,742**	**144,693**
Current liabilities		
Trade and other payables: capital	(990)	(24,029)
Trade and other payables: non-capital	(64,077)	(147,150)
Borrowings	(5,684)	(20,836)
Other financial liabilities	0	0
Provisions	(2,553)	(1,220)
Other liabilities: deferred income including contract liabilities	(6,833)	0
Total current liabilities	**(80,137)**	**(193,235)**
Total assets less current liabilities	**181,159**	**307,998**
Non-current liabilities		
Borrowings	(32,897)	(264,414)
Provisions	(1,662)	(1,378)
Total non-current liabilities	**(34,559)**	**(265,792)**
Total net assets employed	**146,600**	**42,206**
Financed by		
Public dividend capital	196,048	470,377
Revaluation reserve	12,937	32,808
Other reserves	0	26,476
Income and expenditure reserve	(62,385)	(487,455)
Total taxpayers' and others' equity	**146,600**	**42,206**

4. RECOMMENDATIONS

Members of the Board are asked to:

- Note the financial position for Month 12 2024/25.

NHS
University Hospitals Tees

Going Concern Status – Declaration for Annual Accounts 2024/25

Meeting date: 8 May 2025

Reporting to: Group Board

Agenda item No: 18

Report author: Helen Lane, Head of Financial Services

Action required:

Approval

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:

Effective

Board assurance / risk register this paper relates to:

Key discussion points and matters to be escalated from the meeting

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

Not applicable

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.

Accounting standard IAS1, Presentation of Financial Statements, requires that each year, as part of the accounts preparation process, management makes an assessment of the entity's ability to continue as a going concern.

The attached report outlines the Trust's position on Going Concern and it is recommended that the annual accounts for 2024/25 are prepared on a going concern basis as detailed within the report.

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

Recommendations:

Members of the Board of Directors are asked to approve the Trust's preparation of the Annual Accounts for 2024/25 on a going concern basis.

Caring Better Together

Group Board

Thursday, 8 May 2025

North Tees and Hartlepool NHS Foundation Trust

Going Concern Status – Declaration for Annual Accounts 2024/25

Report of the Group Chief Finance Officer

1. Introduction / Background

1.1 All public sector and commercial entities are expected to prepare their accounts on a '*going concern*' basis and this expectation needs to be tested each year.

1.2 For 2024/25, the Trust has operated under Integrated Care Board (ICB) capital and revenue allocations and following prolonged local and regional negotiations and delayed national guidance, the distribution of financial allocations were formally agreed at provider level. This is consistent with the arrangements for 2022/23 and follows previous years of operating under interim national financial arrangements, which formed the basis of preparing the Trust's accounts on a going concern basis.

1.3. The going concern declaration for review and recommendation by the Audit Committee and Resources Committee for consideration and recommendation for approval to the Board of Directors in relation to the preparation of the 2024/25 annual accounts is included below.

1.4 Accounting standard IAS1, Presentation of Financial Statements, requires that each year, as part of the accounts preparation process, management makes an assessment of the entity's ability to continue as a going concern.

1.5 The Treasury's Financial Reporting Manual (FReM) provides the following interpretation of the going concern requirements set out in International Accounting Standard (IAS)1:

The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents is normally sufficient evidence of going concern.

1.6 The FreM further outlines that:

DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.

As the continued provision of service approach (per paragraph 4.22 of the FReM) applies to DHSC group bodies, material uncertainties requiring disclosure, will only arise in very exceptional circumstances.

1.7 In addition, the Foundation Trust Annual Reporting Manual (FT ARM) states the following:

There is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the NHS trust to prepare its accounts on the going concern basis.

1.8 A typical going concern disclosure, based on guidance from the Accounting Standards Board, would read:

"***After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts, following the definition of going concern in the public sector, adopted by HM Treasury Financial Reporting Manual.*"**

1.9 This statement should be amended if the going concern basis is only adopted based on the interpretation in the FReM which focuses on the continued provision of services.

Where there is fundamental uncertainty over the going concern basis (for instance, continuing operational stability depends on finance or income that has not yet been approved), or where the going concern basis is not appropriate, the directors will need to disclose the relevant circumstances and should discuss the basis of accounting and the disclosures to be made with their auditors.

1.10 Disclosures on going concern will impact throughout the annual report in terms of the overview and performance analysis, the governance statement, the accounting officers' statement as well as the accounts themselves and it will therefore be important that the whole document tells a story.

2. Main content of report

Going concern basis for 2024/25 accounts

2.1 The management of the Trust has not, nor does it intend to apply to the Secretary of State for the dissolution of the foundation trust and therefore the accounts should be prepared on a going concern basis.

2.2 In terms of the provision of services into the future; under the Health & Care Act 2022, funding was allocated at Integrated Care System level and financial plans have been agreed across the system. Financial plans for 2024/25 were submitted on 21st March 2025, with further iterations expected.

Based on the confirmed financial arrangements for 2024/25 and reintroduction of the contracting and commissioning process, the Trust's accounts should be prepared on a going concern basis.

2.3 The cash position of the organisation is the most critical element in terms of going concern and in terms of being able to meet its current liabilities over the next twelve-month period. The Trust has sufficient cash available to cover its liabilities and should therefore remain a going concern.

2.4 The Trust has a comprehensive cash management process in place with weekly cash flow forecasting that is updated on a daily basis. The Trust has also reviewed the process for applying for Planned Term Support should the need arise over the course of the financial year. The Trust does not intend to utilise this support, nor anticipates the need to do so. The accounts should therefore be prepared on a going concern basis.

3. Conclusion/Summary

3.1 The Trust has previously operated under interim national financial arrangements, which formed the basis of preparing the Trust's accounts on a going concern basis. For 2024/25, under the Health & Care Act 2022, the Trust operated under Integrated Care Board (ICB) capital and revenue allocations, which formed the basis of preparing the Trust's accounts on a going concern basis. This has also been the approach for 2024/25.

This demonstrates a return to financial arrangements that were in place prior to the Covid-19 pandemic and has no bearing on the Trust's ability to operate on a going concern basis.

3.2 The Trust remains a Going Concern and the 2024/25 accounts will be prepared on that basis.

4. Recommendation

4.1 Based on the evidence outlined above and the submission of the Trust's financial plan for 2025/26, it is recommended that the annual accounts for 2024/25 are prepared on a going concern basis as follows:

(i) The body is clearly a going concern and it is appropriate for the accounts to be prepared on the going concern basis.

Chris Hand

Group Chief Finance Officer

Caring Better Together

NHS
University Hospitals Tees

Going Concern Status – Declaration for Annual Accounts 2024/25

Meeting date: 8 May 2025

Reporting to: Group Board

Agenda item No: 18.1

Report author: Brian Simpson (Head of Financial Governance and Control)

Action required:

Approval

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:

Effective

Board assurance / risk register this paper relates to:

Caring Better Together

Key discussion points and matters to be escalated from the meeting

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

Not applicable

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.

Accounting standard IAS1, Presentation of Financial Statements, requires that each year, as part of the accounts preparation process, management makes an assessment of the entity's ability to continue as a going concern.

The attached report outlines the Trust's position on Going Concern and it is recommended that the annual accounts for 2024/25 are prepared on a going concern basis as detailed within the report.

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

Recommendations:

Members of the Board of Directors are asked to approve the Trust's preparation of the Annual Accounts for 2024/25 on a going concern basis.

Group Board

Thursday, 8 May 2025

South Tees Hospitals NHS Foundation Trust

Going Concern Status – Declaration for Annual Accounts 2024/25

Report of the Group Chief Finance Officer

1. Introduction / Background

1.1 All public sector and commercial entities are expected to prepare their accounts on a 'going concern' basis and this expectation needs to be tested each year.

1.2 For 2024/25, the Trust has operated under Integrated Care Board (ICB) capital and revenue allocations and following prolonged local and regional negotiations and delayed national guidance, the distribution of financial allocations were formally agreed at provider level. This is consistent with the arrangements for 2023/24 and follows previous years of operating under interim national financial arrangements, which formed the basis of preparing the Trust's accounts on a going concern basis.

1.3. The going concern declaration for review and recommendation by the Audit Committee in relation to the preparation of the 2024/25 annual accounts is included below.

1.4 Accounting standard IAS1, Presentation of Financial Statements, requires that each year, as part of the accounts preparation process, management makes an assessment of the entity's ability to continue as a going concern.

1.5 The Treasury's Financial Reporting Manual (FReM) provides the following interpretation of the going concern requirements set out in International Accounting Standard (IAS)1:

The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents is normally sufficient evidence of going concern.

1.6 The FreM further outlines that:

DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.

As the continued provision of service approach (per paragraph 4.22 of the FReM) applies to DHSC group bodies, material uncertainties requiring disclosure, will only arise in very exceptional circumstances.

1.7 The Foundation Trust Annual Reporting Manual (FT ARM) states the following:

There is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the NHS foundation trust to prepare its accounts on the going concern basis.

1.8 A typical going concern disclosure, based on guidance from the Accounting Standards Board, would read:

"After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts, following the definition of going concern in the public sector, adopted by HM Treasury Financial Reporting Manual."

1.9 This statement should be amended if the going concern basis is only adopted based on the interpretation in the FReM which focuses on the continued provision of services.

Where there is fundamental uncertainty over the going concern basis (for instance, continuing operational stability depends on finance or income that has not yet been approved), or where the going concern basis is not appropriate, the directors will need to disclose the relevant circumstances and should discuss the basis of accounting and the disclosures to be made with their auditors.

1.10 Disclosures on going concern will impact throughout the annual report in terms of the overview and performance analysis, the governance statement, the accounting officers' statement as well as the accounts themselves and it will therefore be important that the whole document tells a story.

2. Main content of report

Going concern basis for 2024/25 accounts

2.1 The management of the Trust has not, nor does it intend to apply to the Secretary of State for the dissolution of the foundation trust and therefore the accounts should be prepared on a going concern basis.

2.2 In terms of the provision of services into the future; under the Health & Care Act 2022, funding was allocated at Integrated Care System level and financial plans have been agreed across the system. Financial plans for 2024/25 were submitted on 21st March 2025, with further iterations expected.

Based on the confirmed financial arrangements for 2024/25 and reintroduction of the contracting and commissioning process, the Trust's accounts should be prepared on a going concern basis.

2.3 The cash position of the organisation is the most critical element in terms of going concern in terms of being able to meet its current liabilities over the next twelve-

month period. The Trust is planning to maintain sufficient cash available to cover its liabilities and will therefore remain a going concern.

3. Conclusion/Summary

3.1 The Trust has previously operated under interim national financial arrangements, which formed the basis of preparing the Trust's accounts on a going concern basis. For 2024/25, under the Health & Care Act 2022, the Trust operated under Integrated Care Board (ICB) capital and revenue allocations, which formed the basis of preparing the Trust's accounts on a going concern basis. This has also been the approach for 2024/25.

This demonstrates a return to financial arrangements that were in place prior to the Covid-19 pandemic and has no bearing on the Trust's ability to operate on a going concern basis.

3.2 The Trust remains a Going Concern and the 2024/25 accounts will be prepared on that basis.

3.3 The position will be reported to the Audit and Risk Committee in May.

4. Recommendation

4.1 Based on the evidence outlined above and the submission of the Trust's financial plan for 2024/25, it is recommended that the annual accounts for 2024/25 are prepared on a going concern basis as follows:

(i) The body is clearly a going concern and it is appropriate for the accounts to be prepared on the going concern basis.

Chris Hand
Group Chief Finance Officer

University Hospitals Tees

Integrated Performance Report (IPR) – reporting month February 2025

Meeting date: 8 May 2025

Reporting to: Group Board of Directors

Agenda item No: 19

Report author:

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

Action required
Discussion

Information

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.

The current IPR for data reporting month of February 2025 is presented for information and discussion on the items stated in the following alert, advise and assure sections.

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, members of the Board are alerted to:

- MRSA is above trajectory with 5 cases reported YTD against a plan of zero, no new cases have been reported since December 2024.
- Still birth rate showing an increasing trend. Thematic review is in progress and will be reported in May 2025.
- Breast feeding rates remain below the regional average and benchmarked plan. Both sites are working towards breast feeding accreditation, with focused staff training included within the initiative.
- Re-admission rates continue to track above last year's national average. A clinical audit has been registered across both sites to identify compliance against guidance and potential protocol and pathway changes, with oversight and monitoring via Audit and Clinical Effectiveness Council.
- Performance against the 4-hour standard has not achieved plan since September 2024, however NTHFT consistently achieves the 78% 24/25 recovery target.
- Operations cancelled not rebooked within 28-days does not meet the plan, and despite numbers remaining low, reported ten patients in February outside of the 28-day time-frame which is higher than expected.
- NTHFT is working at both organisational and system level to reduce the longest waits for elective care, developing focused plans in line with *Reforming Elective Care for Patients* and 2025/26 Operational Guidance. The Trust has achieved zero 65 week waits since September 2024.
- Sickness absence performance is inconsistent, and plan is not met. Cross cutting themes will be the primary focus of absence management.
- Mandatory training is not consistently achieved, and performance is declining; improving [illegible]nce is a current focus.

For STHFT, members of the Board are alerted to:

- *E. coli* infections have been higher this year (2024/25) than the previous two years and remain 22% above trajectory year to date.
- Induction of labour rates showed a high outlying performance for December and January.
- Breastfeeding rates at first feed have deteriorated in the last two months and performance remains below the Trust's target.
- Readmission rates have fluctuated in two of the last three months despite being very close to national average.
- In ED, the rate of 12-hour breaches in December and January was high, as winter illnesses peaked in the local area creating additional demand and acuity of illness. February shows improved performance.
- Cancelled operations not rebooked within 28 days have been higher in 24/25 than previously, against a challenging zero tolerance standard.
- Overall referral to treatment standard has shown deterioration and is now comparable to the national average. The number of patients waiting more than 52 weeks remains consistently higher (worse) than plan. Services are prioritising the longest waiters and those most clinically urgent.
- Complaints are not concluded within target timescales.
- Sickness absence rates are above the Trust's internal plan and were above expected limits for December and January, coinciding with peaking prevalence of winter illnesses. Focus on long-term absence reduction will drive a 1% target reduction in absence across UHT.
- Annual appraisal trend has not changed significantly but compliance rate does not meet the new UHT plan of 85%.
- Mandatory training compliance continues to deteriorate in contrast to often meeting plan prior to September 2024.

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, members of the Board are advised:

- There is a continued focus on improving compliance with Hydrogen Peroxide fogging as *C. difficile* infections continue to track above trajectory. Zero *Pseudomonas* infections reported in February, however, infections are 15% higher YTD than tolerance. There is a group focus to reduce infections with policy and pathway review and increased education.
- Percentage of births with post-partum haemorrhage (PPH) greater than 1500ml rates does not consistently meet local plan. A research study on preventative interventions is underway across UHT.
- [redacted]r within 60 minutes is not consistently achieved; of the 1705 [redacted]ry two were outside of the 60 minutes standard.

- 12-Hour A&E standard is consistently achieved, however, performance is not assured as performance declined from November 2024 to January 2025.
- The Cancer Faster Diagnosis, 31- Day and 62- day standards are not consistently met. UHT-wide improvement work, across the tumour groups continues.
- Diagnostic 6-week standard was not met in February however there is a significant improvement trend.
- Referral to treatment incomplete pathways consistently breach the constitutional standard of 92%, however there is early indication of improvement and in February the Trust achieved higher than expected performance. Focused plans are being developed in line with *Reforming Elective Care for Patients* and 2025/26 Operational Guidance.
- Patient experience feedback standards are generally met but further work is required to address variation and embed changes in response to feedback.
- Complaints closed within time standard is not met. InPhase reporting is to be improved to enable better compliance monitoring.
- The financial position shows a small adverse variance year to date against month 11 plan. Financial controls are in place, with a focus on recurrent efficiency delivery, and oversight of financial risks through Resources Committee.

For STHFT, members of the Board are advised:

- Rates of incidents and falls with harm per 1,000 bed days remain stable. There were no new Patient Safety Incident Investigations.
- *C. difficile* infections were 17% higher (worse) than trajectory, *Pseudomonas* were 15% higher (worse) and there were no new MRSA infections in January but have been 2 cases YTD.
- Within maternity services, still births per 1,000 births is stable. All cases are reviewed. Post-partum haemorrhage rates are above local plan but are not a regional or national outlier. Rates of 3rd & 4th degree tears are often better than target. The proportion of patients giving positive feedback on their maternity care is often lower than the target.
- Standardised mortality is 'as expected'.
- A&E 4-hour standard remains slightly below planned trajectory in February. Ambulance handovers within 60 minutes had a significant single month improvement for February as the ED service implemented NHS England improvement trajectory work.
- Community 2-hour urgent response rate consistently exceeds plan but has performed lower recently as staff supported virtual wards.
- Compliance with cancer treatment waiting time standards is recognised as a strategic risk; the Trust has entered tiering support with NHSE for recovery of the 62-day standard position through delivery of action plans within specific tumour groups enabling earlier cancer diagnosis to reduce the overall time to treatment. Performance against the 31-day standard for February improved on a low January to within normal limits.
- Diagnostic 6-week wait is improving. Further gains are dependent on actions in specialist services that require longer timescales for delivery.
- Acknowledging patient feedback within 3 days has shown improvement and at 98.8%, is close to the 100% target.
- Staff turnover rates are much lower and have met target for the last 6 months.
- The financial position shows a small positive variance year to date against month 11 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, members of the Board are assured:

- Collective actions have supported a reduction in gram-negative infections; *E-Coli* and *Klebsiella* infections are lower than the Trust tolerance year to date.
- Standardised mortality is 'as expected' and consistently positively below the national standard.
- The Trust consistently achieves the 2-hour Community Response standard.
- There are assured, high levels of patient reported satisfaction with A&E services.
- Annual appraisal compliance consistently meets plan.
- Staff-turnover plan is consistently met.

For STHFT, members of the Board are assured:

- *Klebsiella* infections reported are 5% fewer (better) than trajectory year to date.
- The Trust consistently receives positive patient feedback, above the 94% target, in survey results for inpatient, outpatient and community services.

Recommendations:

Members of the Board are asked to:

- Receive the Integrated Performance Report for reporting period February 2025.
- 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.

University Hospitals Tees

Integrated Performance Report (IPR) – supplementary metrics Health Inequalities and Population Health.

Meeting date: 8th May 2025

Reporting to: Group Board of Directors

Agenda item No: 19.1

Report author:

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

Action required
Discussion

Information

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 Board of Directors should be informed of the Trusts' performance against key health inequalities and population health metrics, in addition to the performance ensures included in the IPR. This paper provides the metrics mandated in the document *NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006)* (November 2023).

These metrics are also reported in the Trusts' Annual Reports. The two papers attached, at Appendix 1 and Appendix 2, present the information for NTHFT ands STHFT.

The newly formed UHT Health Inequalities Strategy Group will lead and direct further work to identify the key metrics to support and evidence delivery of our UHT health inequalities and population health strategy (in prep.), in support of over over-arching group and clinical strategies, and will consolidate regular reporting across the group.

Further detail is also provided via regular reports from the Directors of Public Health, on behalf of the Trusts' Health Inequalities Groups, into Quality Assurance Committee.

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

The Board are alerted to areas of performance where standards are consistently below expectations, or where standards are variably met with deteriorating performance.

For NTHFT, members of the Board are alerted to:

- 34.82% of our patients with cancer (without a DTT profile) live in our core20 communities. 45.3% of all cancers are diagnosed at stage 1 or 2, however a higher proportion of patients diagnosed at late stages are from the core20communities. The tumour sites with the highest proportion of late diagnosis are Urology, Lung, Haematology and Upper GI.
- The main constraint to implementing our population health and inequalities programmes is the fact that all the funding streams are fixed term and therefore it is difficult to make longer term plans for sustainable improvements. This poses a risk for loss of experienced staff and destabilisation of services when there is uncertainty about continued funding. Budgets for the programmes are also overseen by different care groups with no overall programme budget oversight. Trust health inequality budget line will go a long way to ensure effective planning and implementation.

For STHFT, members of the Board are alerted to:

m births, with a correlation with ethnicity. There has been a significant roportion of births before 37 weeks gestation since last year, rising

from 7.6% to 8.8%. The increase in the most deprived quintile was the same or lower than that seen in all others apart from quintile 4 which fell. A child born in our most deprived population was 19% more likely to be pre-term than for the most affluent. Roles and interventions in place include public health specialist midwife, maternity tobacco dependency service, digital inclusion, targeted support for vulnerable people and better access to integration and information in different languages.

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, members of the Board are advised:

- About 1 in 4 patients are now waiting longer than 18weeks for elective treatment, an improvement from the 1 in 3 achieved at the time of the last annual report; 100% of our patients also receive treatment in less than 52weeks, an improvement as compared to the 1 in 100 that were waiting for 52 weeks at the time of the previous annual report.
- From April 2022 till date, approximately 15% of out-patient attendance has been by a virtual appointment with no significant differences by deprivation, gender or ethnicity.
- For all patients on the elective waiting list, there is no significant variation observed in waiting times by ethnicity.
- Last year's report showed that compared to patients who lived in other areas, our core20 patients had a higher proportion of preterm births in comparison with all births per deprivation quintile. We have since implemented interventions to strengthen our support to the core20 patients and are exploring alternative approaches to monitor impact on preterm births.

For STHFT, members of the Board are advised:

- People living in the most deprived areas (quintile 1) have seen the largest increase in elective activity and the lowest rise in average waiting times. Despite this they have seen the largest increase in the total referral to treatment (RTT) waiting list (PTL) and in the proportion of long waiters (patients who have breached their clinical waiting standard). In total someone from quintile 1 is 9% more likely to be a long waiter than someone from quintile 5. This is still a considerable improvement from the position before Covid when they were 28% more likely to be a long waiter.
- Whilst the data show no significant difference in long waiting times by ethnicity, smaller numbers and some gaps in data quality make it harder to provide definitive assurance.
- Children have seen the largest activity recovery of all the age groups. They still have a longer average wait than adults at 12 weeks. The elderly age group have seen the smallest increase in activity but still have the shortest average wait.
- Notwithstanding these high-level metrics, more detailed analysis demonstrates that there are differences between males and females, by age and ethnicity in rates of

appointments being missed ('did not attend' or 'was not brought') which impacts on timely care.

- Rates of emergency admissions for population in deprivation quintile 1 have reduced yet are 67% higher than for quintile 5. There has been a 9% increase in emergency admissions for patients over 60 years, compared to 2023/24. Deprivation, age and ethnicity profiles intersect to impact on A&E attendances and emergency admissions. New care pathways, with the integrated urgent treatment centre service and greater use of same day emergency care, preclude direct comparison year-to-year. Work streams are in place to provide interventions for high intensity users of UEC services, for young people involved in violence, and for people who present with alcohol and substance misuse.
- Cancer diagnosis at stage 1 or 2 has increased. People in quintile 1 saw a nearly 4% increase in early diagnosis, a continuation of the improvement seen in 2023/24. However, they are still 10% less likely to be diagnosed early than people in quintile 5.
- Admissions of children for tooth extraction due to tooth decay are delivered by other providers so not sufficient data to report.

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

Positive assurance is provided on performance where standards are consistently met.

Both Trusts have well-established health inequalities groups, embedded in a governance structure. The Health inequalities steering groups and working groups have vibrant and effective action plans delivered by engaged stakeholders and partnership working. These action plans sit within a strategic framework aligned to regional and national policy priorities.

Both Trusts have developed interactive dashboards to view our activity and performance metrics through a 'health inequalities lens', which are used to raised awareness and target the work of the HI groups. Research and evidence-based practice are prioritised. There is a good understanding of the HI and population health of the communities we serve.

For NTHFT, members of the Board are assured:

- From April 2022 till date, we have had only one patient admitted for a tooth extraction as a result of decay. An update from Community Dental Health indicates there were no further cases in 2024-25.
- The alcohol care, navigator and substance use team see patients who have an issue with alcohol and/or substance dependency, high risk of dependency or audit c score of 10 or above. The service has received a total of 5,259 referrals till date of which 3,662 assessments were undertaken and 953 admissions prevented. The average length of stay has been markedly reduce with to less that 24hours for over 50% of patients.
- The Trusts acute tobacco dependent treatment service (TDTS) has been fully established and provides support to eligible patients for all acute in-patient settings, maternity, staff and some out-patients. Currently, smoking status is checked for all admitted by the Trust. Referrals to the service has been increasing Majority of patients supported are from the core20 communities. The

ethnicity breakdown of referrals is very reflective of the Trust's catchment population profile.

- The Trust has developed our 'population health plan on a page' as an enabling plan for our corporate strategy with clear governance arrangements via the board assurance framework (BAF), from the multi-agency healthcare inequalities oversight group with reporting routes into the Trust Board, our 3 main place HWBBs and the NENC ICB healthier and fairer sub-committee. Our self-assessment against the national maturity matrix indicates that we are 'thriving' in all the four themes of development.
- The Trust is also providing training, leadership and capability of our entire workforce to support implementation and enable cultural shift across the organisation. Operational leadership for work programmes runs across all care groups, corporate services and NTH Solutions.
- The Trust will continue to develop regular health inequalities training for the board.

For STHFT, members of the Board are assured:

- Tobacco dependency treatment services are provided for adult inpatients and in maternity services. Treatment/support services were accepted by 1,200 inpatients, and 99 babies were born smoke-free.
- Work streams are in place for tackling DNA/WNB, health inequalities in access and experience in maternity services, Making Every Contact Count, health literacy, poverty-proofing, Waiting Well, armed Forces/Veterans awareness, amongst others.

Recommendations:

Members of the Board are asked to:

- Receive the Integrated Performance Report health inequalities and population health supplementary paper for reporting period 2024/25.
- Note that the agenda item on Health Inequalities in Quality Assurance Committee, as set out in the annual cycle of business, provides further detailed reporting, action plan updates and assurance.
- Note the 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.

APPENDIX 1

Health Inequalities & Population Health
North Tees and Hartlepool NHSFT
Annual Report 2024/25

Health Inequalities & Population Health
South Tees Hospitals NHSFT
Annual Report 2024/25

Caring
Better
Together

NHS
University Hospitals Tees

Integrated Performance Report (IPR)

Reporting month: February 2025

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 on infection prevention and control to support the sites in safely managing patient flow through the period of increased seasonal infections, in particular Norovirus due to an increased virulence and national prevalence.
- **EFFECTIVE:** Standardised mortality is 'as expected' for both Trusts. Readmission rates currently above 2023/24 national average for both Trusts. A clinical audit on readmissions has been registered across both sites to identify compliance against guidance and potential protocol, pathway changes with oversight and monitoring via Audit and Clinical Effectiveness Council.
- **RESPONSIVE:** NTHFT has strong performance in urgent and emergency care, with STHFT demonstrating improvement prior to December and the peak prevalence of winter illnesses in the local area. Both Trusts had upturns in performance in February for their core ED metrics as the winter demand surge subsided. Community services are integral, maximising use of urgent community response teams, '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 the further improvement required to tackle 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. In February, STHFT was placed in tier 2 of the NHS performance management regime for cancer waiting times. 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 address challenges.
- **CARING:** The IPR demonstrates that both trusts are generally performing well in patient feedback surveys. Our responsiveness to enquiries and complaints is being addressed with senior leadership support.
- **WELL LED:** The improvement of working lives, staff retention and attendance is a focus for the People Directorate. The national People Promise will be implemented as part of the Group People Plan. A detailed absence plan and focus on whole time equivalent reduction will support the Group's obligation to deliver the agreed financial position.

Regulation & Compliance

Regulated by CareQuality Commission

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.

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

South Tees Hospitals NHS Foundation Trust has an overall rating of Good. Since the 2023 CQC inspection 11 Must Do and 15 Should Do actions have been completed. The remaining 2 Must Do and 5 Should Do actions are in progress. Each action has a robust plan that is reviewed monthly by the CQC Compliance Group. Recent progress includes increased assurance around Resuscitation and Safeguarding training in ED and a trajectory developed which will ensure all staff are 100% compliant by May 2025.

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ May 2023	Good ↑ May 2023	Good → ← May 2023	Good → ← May 2023	Good ↑ May 2023	Good ↑ May 2023

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

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	Feb-25	Feb-25	Feb-25	Feb-25	Feb-25	Jan-25	Jan-25	Jan-25	Jan-25	Jan-25	Jan-25	Jan-25	Jan-25	Jan-25	Jan-25	Jan-25	Jan-25	Feb-25	Jan-25	Jan-25
Target	95%	Zero				92%	24/25 Plan	24/25 Plan	Zero	Zero	24/25 Plan					<=5%	85%	Mar 24 Plan		75%
North Tees & Hartlepool NHSFT	85.5%	1	0.0%	92	2	73.2%	169	0	0	0	20,104	106%	105%	102%	82%	8.4%	72.2%	101	232	75.3%
South Tees Hospitals NHSFT	75.4%	11	5.0%	375	150	59.5%	1,660	111	2	0	56,971	111%	105%	109%	93%	11.3%	63.1%	154	645	72.2%
NENC ICS Provider level *(including IS providers)*	76.6%	571	6.0%	2,405	848	69.0%	5,203	307	27	1	173,250	105%	104%	105%	101%	10.6%	71.3%	737	3,671	75.5%
North East & Yorkshire	73.2%		6.9%			64.2%										18.6%	67.9%			74.8%
National	73.4%		11.3%			58.9%										22.4%	67.3%			73.4%

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 continue to show good performance for NTHFT in February compared to national benchmarks. STHFT A&E standard had met the planned improvement trajectory all year until December and January when flu and respiratory illness peaked. Performance across the ED metrics showed improvement in February. 4-hour performance remains a strategic risk for STHFT with actions reviewed weekly by the operational team. Reducing ambulance handover delays and the longest department waits are a priority.

Elective care metrics show an RTT 18-week standard position at both Trusts that is above the national average, with NTHFT also benchmarking well in the region. NTHFT focus is 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 exceeding 23/24 levels of outpatient and elective activity.

Cancer 62-day standard is an area of key concern, logged as a strategic risk for both Trusts. Completed pathway performance is below comparator averages for STHFT, and backlogs remain above plan at both Trusts. NTHFT met the 28-day faster diagnosis standard in January 2025, a key enabling metric within cancer pathways. STHFT entered tiering support with NHS England for the 62-day standard in February 2025. Actions and progress are discussed fortnightly and focused on reducing delays in specific tumour pathways, whilst investment in cancer navigators helps to ensure individual cases are proactively pursued through the diagnostic and treatment steps.

North Tees & Hartlepool NHSFT summary

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

Alert

- MRSA is above trajectory with 5 cases reported YTD against a plan of zero, no new cases have been reported since December 2024.
- Still birth rate showing an increasing trend. Thematic review is in progress and will be reported in May 2025.
- Breast feeding rates remain below the regional average and benchmarked plan. Both sites are working towards breast feeding accreditation, with focused staff training included within the initiative.
- Re-admission rates continue to track above last year's national average. A clinical audit has been registered across both sites to identify compliance against guidance and potential protocol and pathway changes, with oversight and monitoring via Audit and Clinical Effectiveness Council.
- Performance against the 4-hour standard has not achieved plan since September 2024, however NTHFT consistently achieves the 78% 24/25 recovery target.
- Operations cancelled not rebooked within 28-days does not meet the plan, and despite numbers remaining low, reported ten patients in February outside of the 28-day time-frame which is higher than expected.
- NTHFT is working at both organisational and system level to reduce the longest waits for elective care, developing focused plans in line with *Reforming Elective Care for Patients* and 2025/26 Operational Guidance. The Trust has achieved zero 65 week waits since September 2024.
- Sickness absence performance is inconsistent, and plan is not met. Cross cutting themes will be the primary focus of absence management.
- Mandatory training is not consistently achieved, and performance is declining; improving medical staff compliance is a current focus.

Advise

- There is a continued focus on improving compliance with Hydrogen Peroxide fogging as *C. difficile* infections continue to track above trajectory. Zero *Pseudomonas* infections reported in February, however, infections are 15% higher YTD than tolerance. There is a group focus to reduce infections with policy and pathway review and increased education.
- Percentage of births with post-partum haemorrhage (PPH) greater than 1500ml rates does not consistently meet local plan. A research study on preventative interventions is underway across UHT.
- Ambulance handover within 60 minutes is not consistently achieved; of the 1705 handovers in February two were outside of the 60 minutes standard.
- 12-Hour A&E standard is consistently achieved, however, performance is not assured as performance declined from November 2024 to January 2025.
- The Cancer Faster Diagnosis, 31- Day and 62- day standards are not consistently met. UHT-wide improvement work, across the tumour groups continues.
- Diagnostic 6-week standard was not met in February however there is a significant improvement trend.
- Referral to treatment incomplete pathways consistently breach the constitutional standard of 92%, however there is early indication of improvement and in February the Trust achieved higher than expected performance. Focused plans are being developed in line with *Reforming Elective Care for Patients* and 2025/26 Operational Guidance.
- Patient experience feedback standards are generally met but further work is required to address variation and embed changes in response to feedback.
- Complaints closed within time standard is not met. InPhase reporting is to be improved to enable better compliance monitoring.
- The financial position shows a small adverse variance year to date against month 11 plan. Financial controls are in place, with a focus on recurrent efficiency delivery, and oversight of financial risks through Resources Committee.

Assure

- Collective actions have supported a reduction in gram-negative infections; *E-Coli* and *Klebsiella* infections are lower than the Trust tolerance year to date.
- Standardised mortality is 'as expected' and consistently positively below the national standard.
- The Trust consistently achieves the 2-hour Community Response standard.
- There are assured, high levels of patient reported satisfaction with A&E services.
- Annual appraisal compliance consistently meets plan.
- Staff-turnover plan is consistently met.

South Tees Hospitals NHSFT summary

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

Alert

- *E. coli* infections have been higher this year (2024/25) than the previous two years and remain 22% above trajectory year to date.
- Induction of labour rates showed a high outlying performance for December and January.
- Breastfeeding rates at first feed have deteriorated in the last two months and performance remains below the Trust's target.
- Readmission rates have fluctuated in two of the last three months despite being very close to national average.
- In ED, the rate of 12-hour breaches in December and January was high, as winter illnesses peaked in the local area creating additional demand and acuity of illness. February shows improved performance.
- Cancelled operations not rebooked within 28 days have been higher in 24/25 than previously, against a challenging zero tolerance standard.
- Overall referral to treatment standard has shown deterioration and is now comparable to the national average. The number of patients waiting more than 52 weeks remains consistently higher (worse) than plan. Services are prioritising the longest waiters and those most clinically urgent.
- Complaints are not concluded within target timescales.
- Sickness absence rates are above the Trust's internal plan and were above expected limits for December and January, coinciding with peaking prevalence of winter illnesses. Focus on long-term absence reduction will drive a 1% target reduction in absence across UHT.
- Annual appraisal trend has not changed significantly but compliance rate does not meet the new UHT plan of 85%.
- Mandatory training compliance continues to deteriorate in contrast to often meeting plan prior to September 2024.

Advise

- Rates of incidents and falls with harm per 1,000 bed days remain stable. There were no new Patient Safety Incident Investigations.
- *C. difficile* infections were 17% higher (worse) than trajectory, *Pseudomonas* were 15% higher (worse) and there were no new MRSA infections in January but have been 2 cases YTD.
- Within maternity services, still births per 1,000 births is stable. All cases are reviewed. Post partum haemorrhage rates are above local plan but are not a regional or national outlier. Rates of 3rd & 4th degree tears are often better than target. The proportion of patients giving positive feedback on their maternity care is often lower than the target.
- Standardised mortality is 'as expected'.
- A&E 4-hour standard remains slightly below planned trajectory in February. Ambulance handovers within 60 minutes had a significant single month improvement for February as the ED service implemented NHS England improvement trajectory work.
- Community 2-hour urgent response rate consistently exceeds plan but has performed lower recently as staff supported virtual wards.
- Compliance with cancer treatment waiting time standards is recognised as a strategic risk; the Trust has entered tiering support with NHSE for recovery of the 62-day standard position through delivery of action plans within specific tumour groups enabling earlier cancer diagnosis to reduce the overall time to treatment. Performance against the 31-day standard for February improved on a low January to within normal limits.
- Diagnostic 6-week wait is improving. Further gains are dependent on actions in specialist services that require longer timescales for delivery.
- Acknowledging patient feedback within 3 days has shown improvement and at 98.8%, is close to the 100% target.
- Staff turnover rates are much lower and have met target for the last 6 months.
- The financial position shows a small positive variance year to date against month 11 plan. Financial controls are in place, with a focus on recurrent efficiency delivery, and oversight of financial risks through Resources Committee.

Assure

- *Klebsiella* infections reported are 5% fewer (better) than trajectory year to date.
- The Trust consistently receives positive patient feedback, above the 94% target, in survey results for inpatient, outpatient and community services.

Caring Better Together

Index of metrics

SAFE:

Incidents per 1000 Bed Days
Patient Safety Incident Investigations
Never Events
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 Rate (Rolling 12 months, per 1000 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 in 28 Days
Cancer Faster Diagnosis Standard (%)
Cancer 31 Day Standard (%)
Cancer 62 Day Standard (%)
Diagnostic 6 Weeks Standard (%)
RTT Incomplete Pathways (%)
RTT 52 Week Waiters

CARING:

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

WELL LED:

Sickness Absence (%)
Staff Turnover (%)
Annual Appraisal (%)
Mandatory Training (%)
Cumulative YTD Financial Position (£Millions)

SAFE DOMAIN SUMMARY

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

The Patient Safety Incident Response Framework has been implemented across the Group since Jan 2024. Thematic review is used to identify trends and opportunities for learning; an example of this is the work being undertaken in relation to the provision of hot drinks and liquid foods for frail patients following an analysis of incidents leading to harm; the learning from this is being shared across the Group.

Healthcare acquired infections are closely monitored by the Infection Prevention Strategic Group/Committee. A full review identified three areas of focus, which are being addressed. Firstly, increasing compliance with hydrogen peroxide 'fogging' at North Tees Hospital through re-alignment of policy and key roles and responsibilities for cleaning around equipment. Secondly, antimicrobial stewardship that includes shared guidelines via EOLAS online resource, pharmacy ward rounds, education and training for resident doctors. Thirdly, a full reset of professional standards supported by the executive team in respect of dress code, bare below the elbows and professional etiquette. These actions alongside other specific work, will aim to realign trajectories as we enter the next financial year.

NTHFT

Metric	Month Target	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
Incidents Per 1000 Bed Days		79.05	91.1	94.34	96.91	109.35	94.32	96.33	98.92	94.86	89.01	98.76	93.1
Patient Safety Incident Investigations		0	0	0	3	2	3	1	3	2	0	1	0
Never Events	0	0	0	0	0	0	0	0	1	0	0	0	0
Never Event Rate (Per 1000 Bed Days)	0	0	0	0	0	0	0	0	0.07	0	0	0	0
Falls With Harm Rate (Per 1000 Bed Days)		0.27	0.14	0.14	0.15	0	0.22	0.28	0.07	0.27	0.14	0.19	0.37
C-Difficile	5	5	7	10	7	10	6	3	9	2	1	5	6
MRSA	0	0	0	0	0	0	1	1	1	1	1	0	0
E-Coli	8	8	5	4	6	10	7	13	13	5	3	6	6
Klebsiella	3	3	2	2	2	2	5	3	4	2	2	1	0
Pseudomonas	2	4	1	3	1	0	2	0	2	2	2	2	0

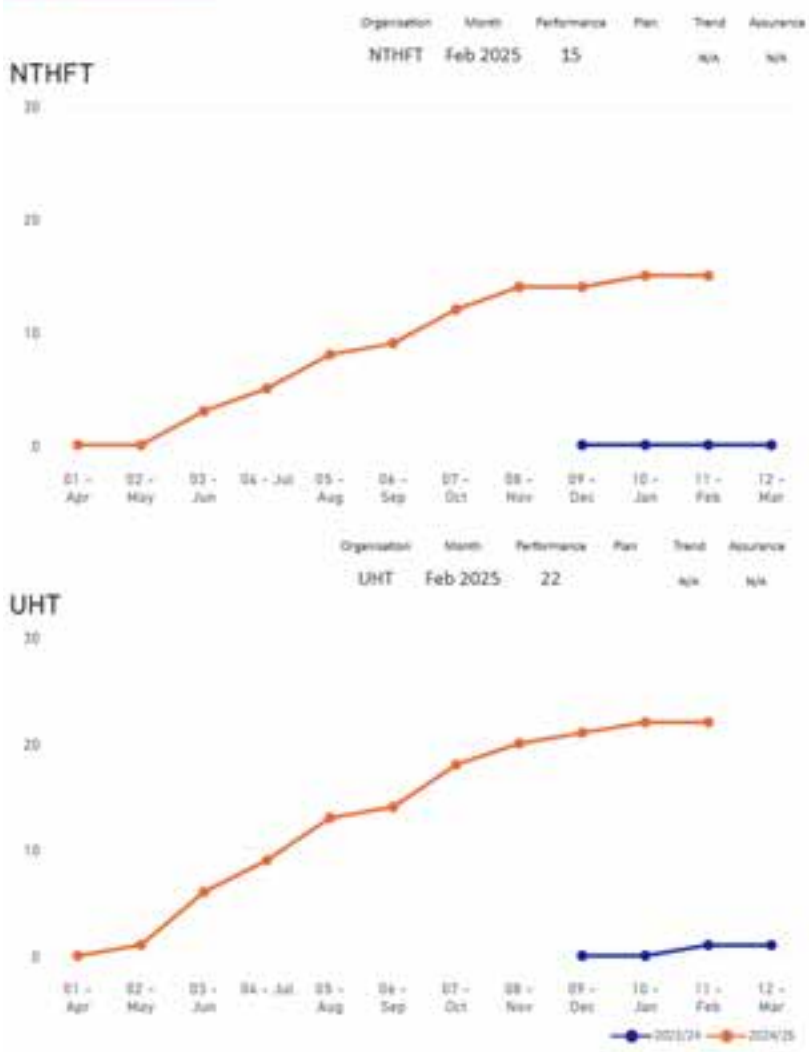
STHFT

Metric	Month Target	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
Incidents Per 1000 Bed Days		65.05	64.74	67.65	70.44	70.38	66.52	72.44	74.75	64.07	67.89	72.19	71.49
Patient Safety Incident Investigations		0	0	1	2	1	1	0	1	0	1	0	0
Never Events	0	0	0	0	1	0	1	0	2	1	1	0	0
Never Event Rate (Per 1000 Bed Days)	0	0	0	0	0.03	0	0.03	0	0.05	0.03	0.03	0	0
Falls With Harm Rate (Per 1000 Bed Days)		0.05	0.16	0.13	0.14	0.08	0.06	0.03	0.11	0.14	0.16	0.08	0.17
C-Difficile	10	9	9	8	12	15	13	9	11	17	11	13	15
MRSA	0	0	0	0	0	0	1	0	0	1	0	0	0
E-Coli	11	10	15	20	12	12	13	11	17	12	14	18	10
Klebsiella	5	5	6	1	5	9	4	6	8	1	3	5	4
Pseudomonas	1	0	2	3	0	3	2	1	3	1	0	1	1

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 trend
Assurance: n/a
Action taken: A review is being undertaken by patient safety teams to understand the differences in incident reporting numbers between sites. As NRLS data is no longer available for regional comparison, the ICB have agreed to support some regional benchmarking for additional context during Q1.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Patient Safety Incident Investigations (YTD)



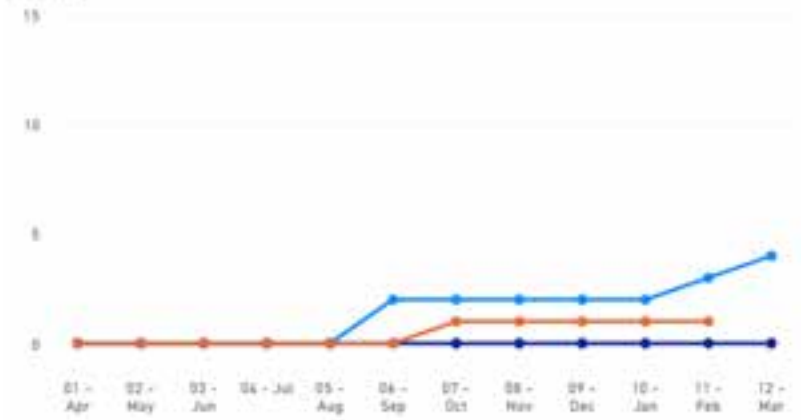
Metric: PSIIs initiated, cumulative annually from April.
Plan: n/a. An open reporting culture is encouraged.
Rationale: NHS Quality Accounts regulatory indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT 15 PSIIs YTD. STHFT: 7 PSIIs YTD.
Assurance: n/a
Action taken:. Incidents are reviewed at weekly site LRPs, to determine how they are investigated under PSIRF. There were no further PSIIs registered at either Trust in February 2025. An independent evaluation of PSIRF across the Group has commenced and will be concluded in May 2025.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

SAFE Never Events (YTD)

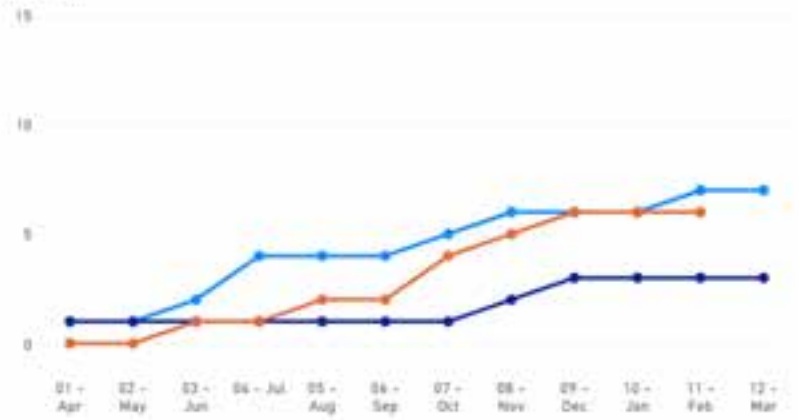
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 2025	1	0	n/a	n/a



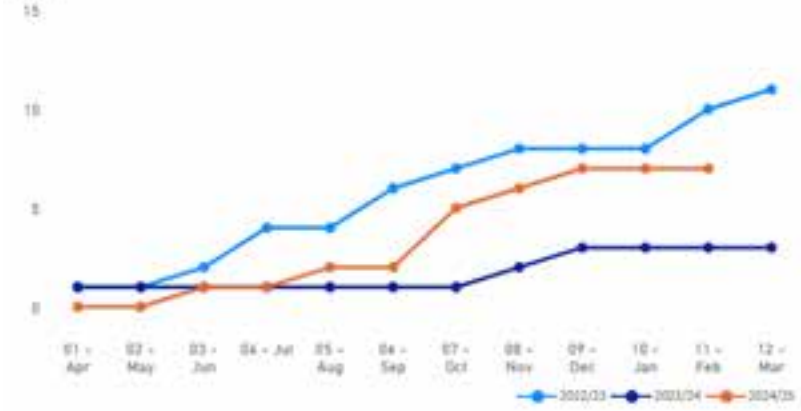
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 2025	6	0	n/a	n/a



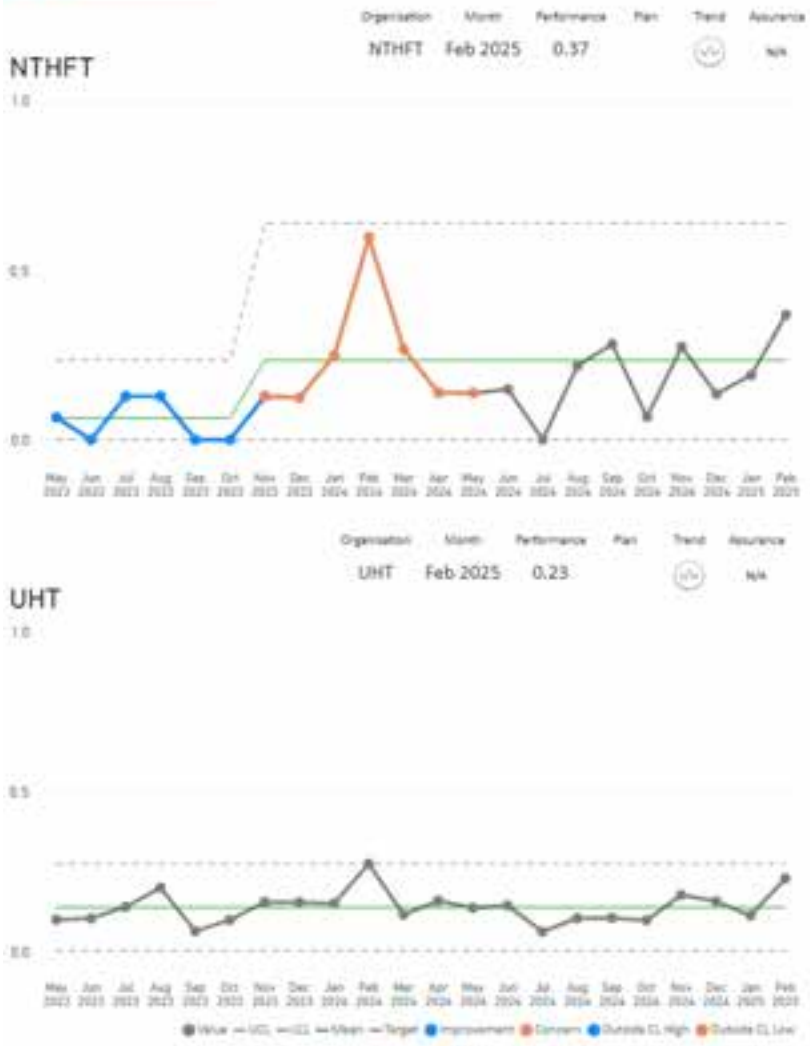
UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 2025	7		n/a	n/a



Metric: Never Events (a defined list of serious preventable errors), cumulative annually from April.
Plan: Zero.
Rationale: NHS Quality Accounts regulatory indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 1 Never Event YTD. STHFT: 6 Never Events YTD.
Assurance: Advise. No new events in February 2025.
Action taken: No new events – n/a.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Falls With Harm Rate (Per 1000 Bed Days)

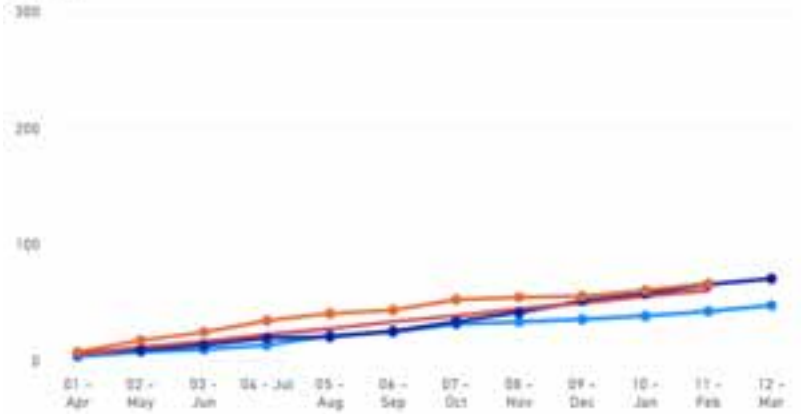


Metric: Falls resulting in harm graded moderate and above, as a rate per 1000 inpatient bed-days.
Plan: n/a
Rationale: NHS Quality Accounts regulatory indicator. National Audit of Inpatient Falls.
Data quality: Assured. Each incident is validated.
Trend: No trend.
Assurance: n/a
Action taken: Variance in clinical practice and staffing numbers in the ward areas where patients are at higher risk of falls is being explored.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE C-Difficile (YTD)

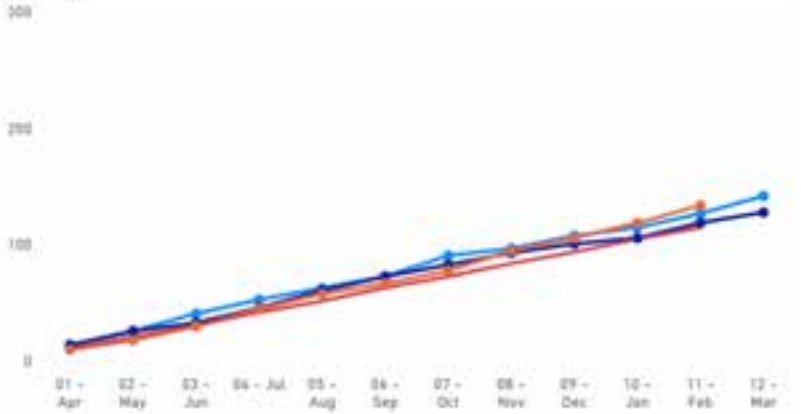
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 2025	66	60	N/A	N/A



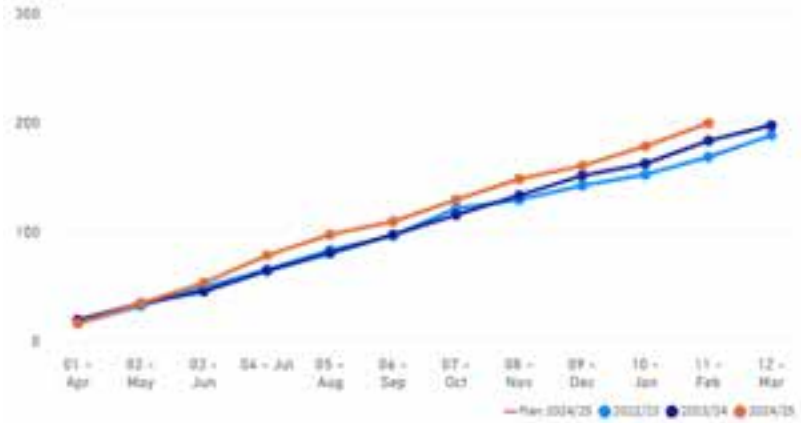
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 2025	133	114	N/A	N/A



UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 2025	199		N/A	N/A

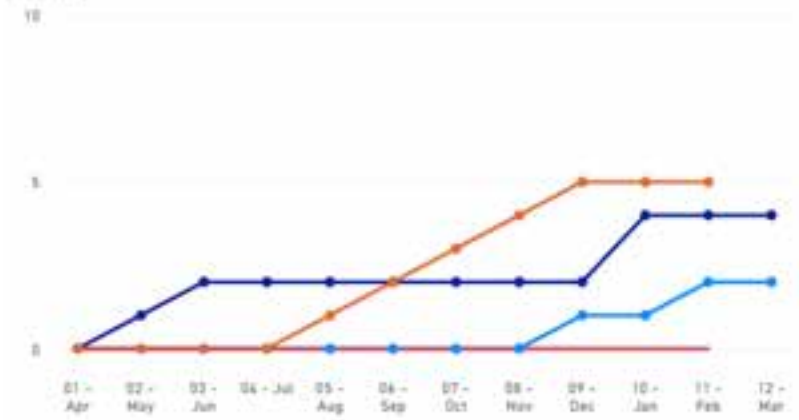


Metric: Healthcare associated cases of *Clostridioides difficile*, cumulative annually from April.
Plan: NHS standard contract trajectory: 5% reduction on 23/24 performance
Rationale: NHS Contract and Quality Accounts regulatory indicator.
Data quality: Assured. Each incident is validated.
Trend: NTHFT: 6 new cases in February, trajectory of 5; STHFT: 13 new cases in February, trajectory of 10.
Assurance: NTHFT: Advise, 10% above trajectory YTD. STHFT: Advise, 17% above trajectory YTD.
Action taken: Both Trusts have detailed action plans. Policy reviewed at North Tees to drive increased compliance with Hydrogen Peroxide Fogging.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE MRSA (YTD)

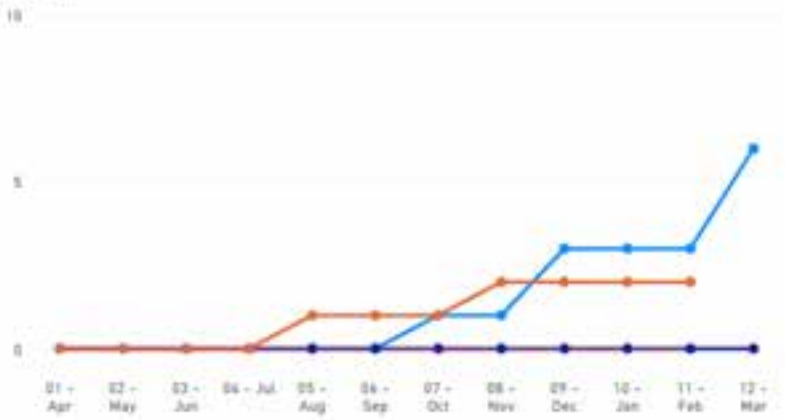
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 2025	5	0	n/a	n/a



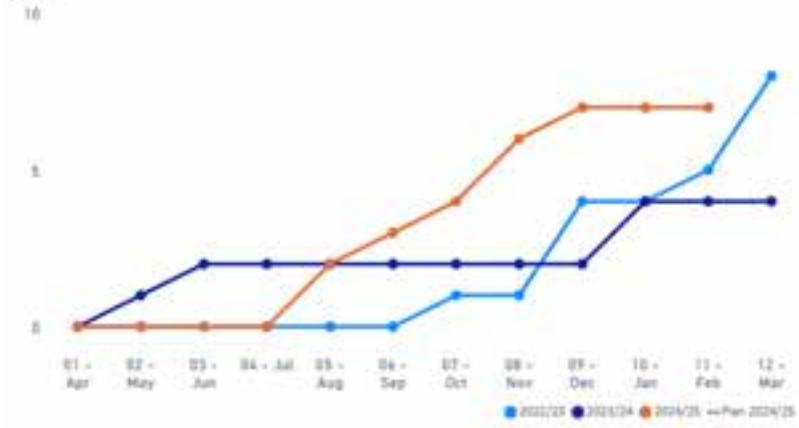
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 2025	2	0	n/a	n/a



UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 2025	7		n/a	n/a

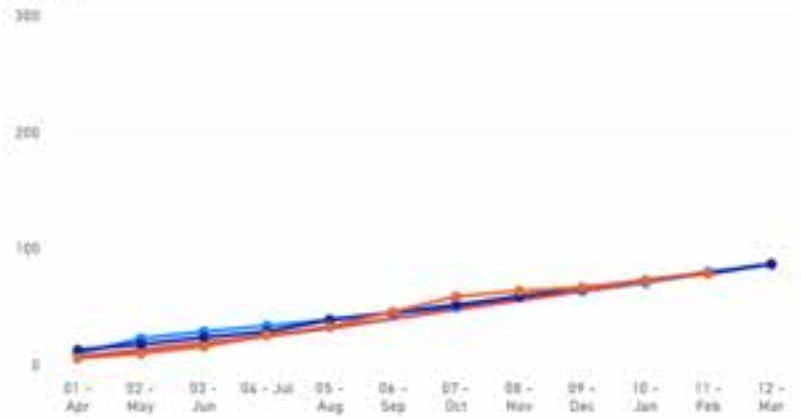


Metric: Healthcare associated cases of Methicillin resistant *Staphylococcus aureus*, cumulative annually from April.
Plan: Zero tolerance.
Rationale: NHS Contract indicator.
Data quality: Assured. Each incident is validated.
Trend: No new cases in February 2025.
Assurance: Alert. NTHFT: 5 cases YTD. STHFT: 2 cases YTD. Zero tolerance plan not achievable.
Action taken: A focus on MRSA screening on admission remains a priority alongside increased education and training. Blood culture pathway is a focus for 2025/26. Review of policies for MRSA screening on admission across UHT in order to standardise best practice.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE E-Coli (YTD)

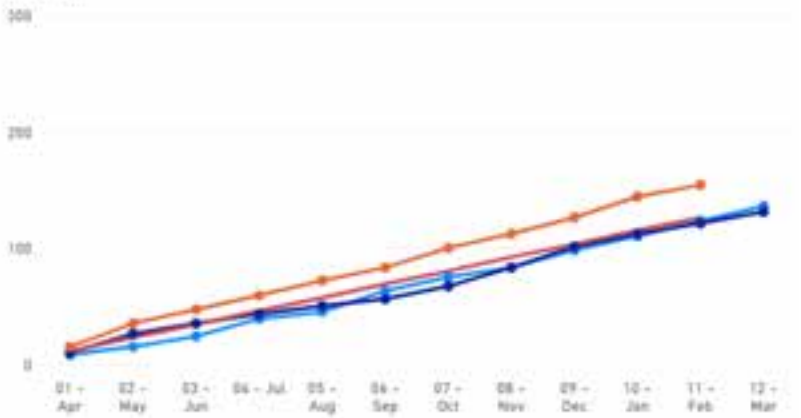
NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 2025	78	79	n/a	n/a



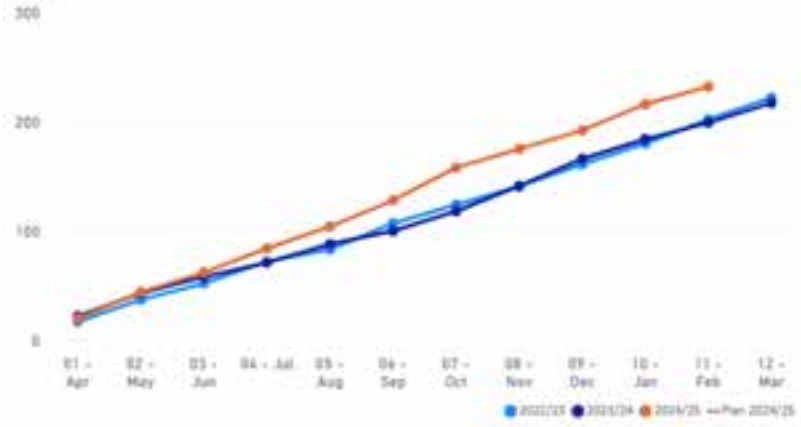
STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 2025	154	126	n/a	n/a



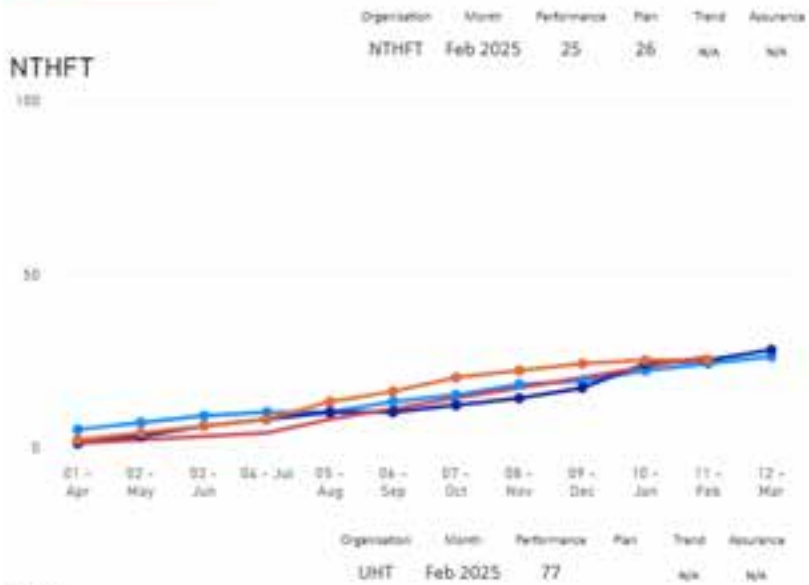
UHT

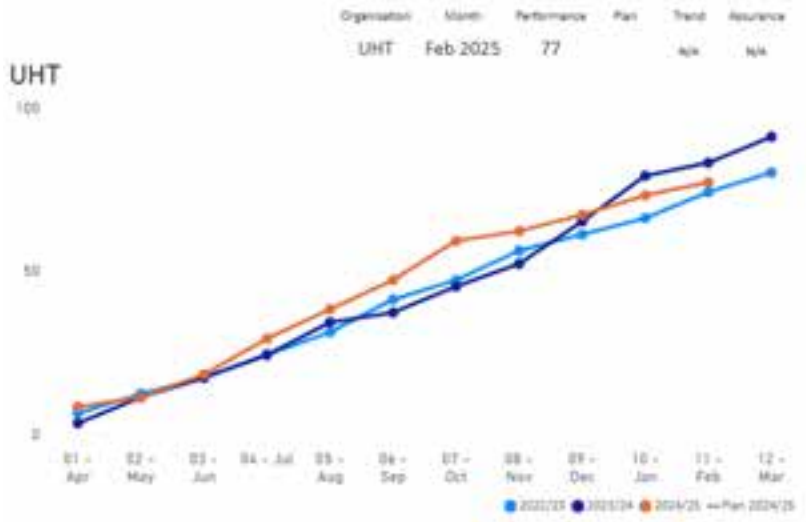
Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 2025	232		n/a	n/a



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: NTHFT: performance better than trajectory. STHFT: Number of cases tracking higher than trajectory.
Assurance: NTHFT: Assure, 1% better than trajectory YTD. STHFT: Alert, cases 22% worse than trajectory YTD.
Action taken: Participation in NHSE learning and action planning event, March 2025. Learning to be shared. Focus is on line-care and use of catheters across both sites.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Klebsiella (YTD)





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: NTHFT: Zero cases in February. STHFT: 4 cases in February. Cases YTD is in line with previous years.
Assurance: NTHFT: Assure, 4%, 1 case, better than trajectory YTD. STHFT: Assure, 5%, 3 cases, better than trajectory YTD.
Action taken: Regional review underway with input from NTHFT and STHFT, March 2025, and learning to be shared to deliver IPC plan for 2025/26.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Pseudomonas (YTD)

NTHFT

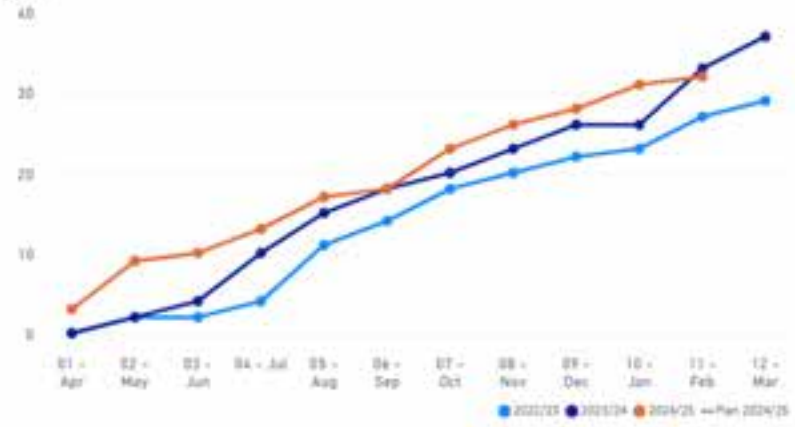
Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 2025	15	13	N/A	N/A

STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 2025	17	17	N/A	N/A

UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 2025	32		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: NTHFT: Zero cases in February. STHFT: 1 case in February. Cases YTD is in line with previous years.
Assurance: NTHFT: Advise, 15%, 2 cases, above trajectory YTD. STHFT: Advise, cases equal to trajectory YTD.
Action taken: Augmented care areas continue to receive increased monitoring and support for observation. Focus on water safety due to recent outbreaks.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE MATERNITY SUMMARY

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

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. Still birth rates are being reviewed in relation to published longer-term time series validated data. Breastfeeding rates are a focus, with actions in place and new roles being developed 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.

Regular in-depth reporting on maternity services takes place through Quality Assurance Committee and the Local Maternity and Neonatal System Board.

NTHFT

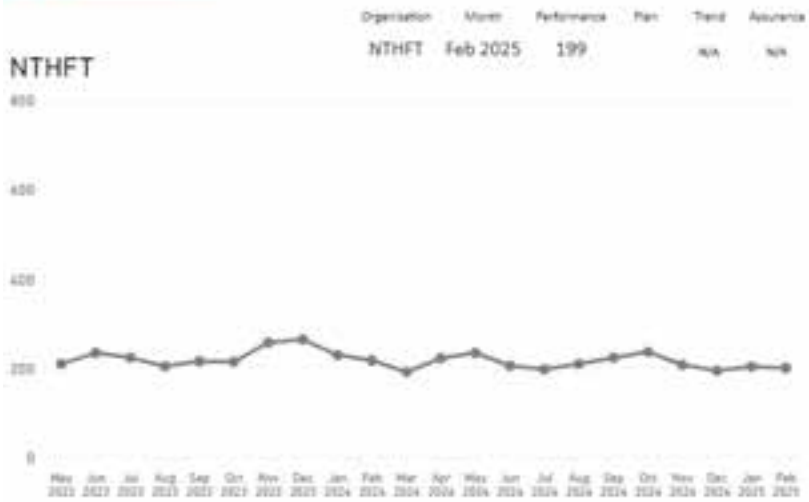
Metric	Month Target	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
No. of babies born		190	221	233	204	196	208	222	235	206	193	202	199
Still Birth Rate (Rolling 12 months per 1000 births)		1.5	1.5	1.9	2.3	1.5	1.9	1.5	2.2	2.7	2.4	2.8	3.2
Induction of Labour (%)		45%	43.6%	46.2%	44.8%	43.1%	44.9%	43.7%	44.5%	42.9%	45.9%	44%	42.9%
Breast Feeding at First Feed	75%	46.3%	50.2%	45.3%	54.7%	56.1%	50.2%	50%	48.5%	52.7%	53.9%	52.2%	51.5%
PPH >1500ml (%)	3.3%	1.05%	2.73%	1.28%	2.96%	3.05%	2.42%	2.7%	2.54%	3.41%	2.04%	4%	4.04%
Number of 3rd/4th degree tear (%)		1.6%	1.8%	0.4%	0.5%	0.5%	0%	2.3%	1.3%	1%	1.5%	0.5%	2%

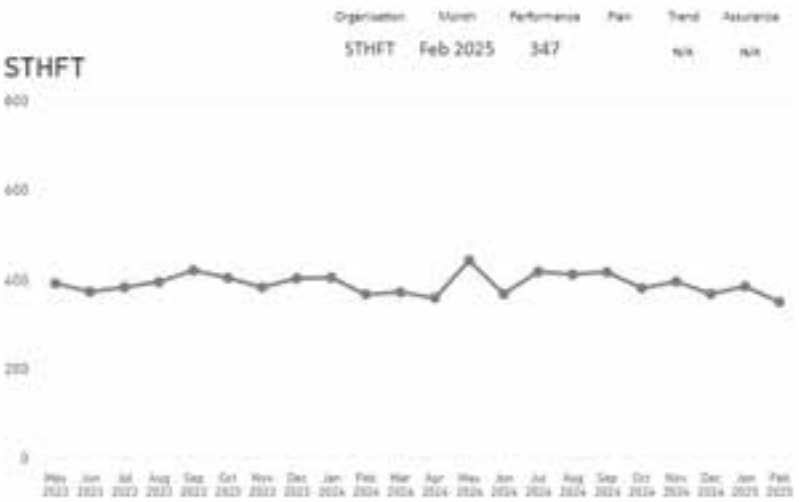
STHFT

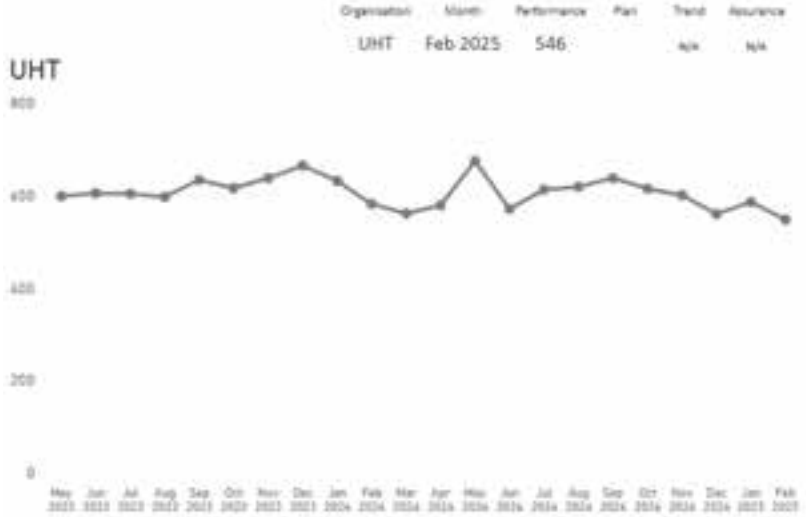
Metric	Month Target	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
No. of babies born		369	356	440	365	415	409	414	378	393	365	382	347
Still Birth Rate (Rolling 12 months per 1000 births)		4.1	4.1	4	4.1	3.6	4	3.8	4	4.2	4.3	3.6	3.9
Induction of Labour (%)		46.6%	48.3%	44.9%	46.3%	44.2%	46.4%	45.6%	45.7%	47%	53.2%	50.1%	47.1%
Breast Feeding at First Feed	74.5%	64.4%	68.6%	66.6%	67.1%	69.7%	69.5%	70.1%	67.2%	66.3%	67.8%	64.3%	63.4%
PPH >1500ml (%)	2%	4.41%	2.59%	3.23%	3.6%	4.2%	3.44%	3.19%	5.14%	3.62%	3.06%	2.68%	3.24%
Number of 3rd/4th degree tear (%)	3.5%	3%	3.3%	1.5%	2.9%	2.5%	2.8%	1.8%	2.3%	4%	2.8%	0.9%	2.6%

Caring Better Together

SAFE No. of babies born

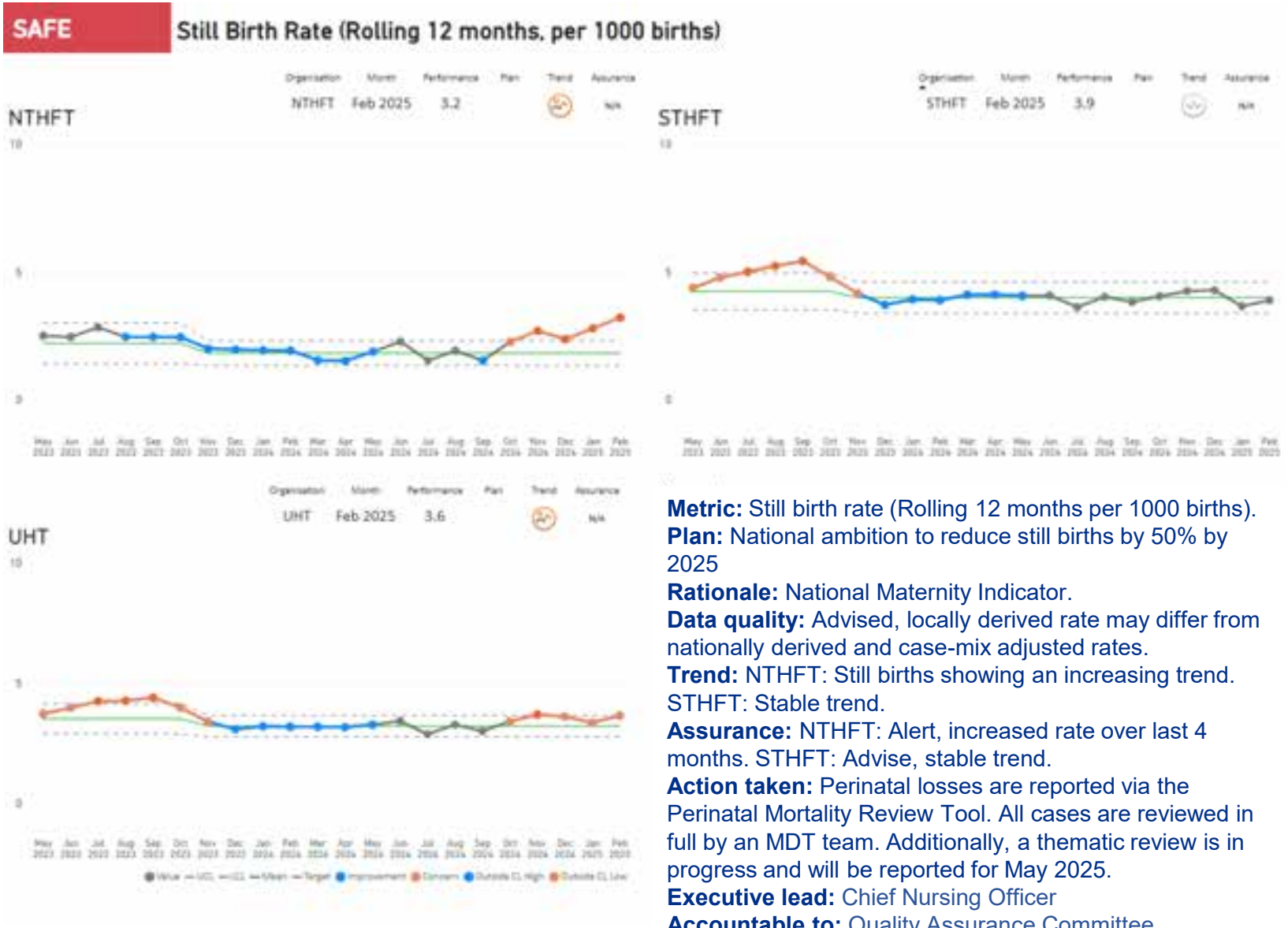






Metric: Count of babies born under care of each Trust.
Plan: n/a
Rationale: Context for maternity metrics.
Data quality: Assured, validated data.
Trend: Number of births at NTHFT and STHFT is stable over 2-year timeframe.
Assurance: n/a
Action taken: n/a
Executive lead: Chief Nursing Officer
Accountable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

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

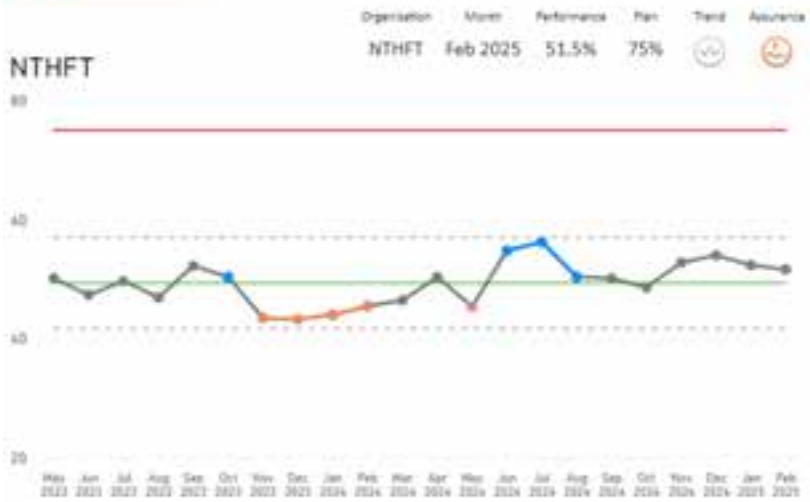


Metric: Still birth rate (Rolling 12 months per 1000 births).
Plan: National ambition to reduce still births by 50% by 2025
Rationale: National Maternity Indicator.
Data quality: Advised, locally derived rate may differ from nationally derived and case-mix adjusted rates.
Trend: NTHFT: Still births showing an increasing trend. STHFT: Stable trend.
Assurance: NTHFT: Alert, increased rate over last 4 months. STHFT: Advise, stable trend.
Action taken: Perinatal losses are reported via the Perinatal Mortality Review Tool. All cases are reviewed in full by an MDT team. Additionally, a thematic review is in progress and will be reported for May 2025.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Induction of Labour (%)

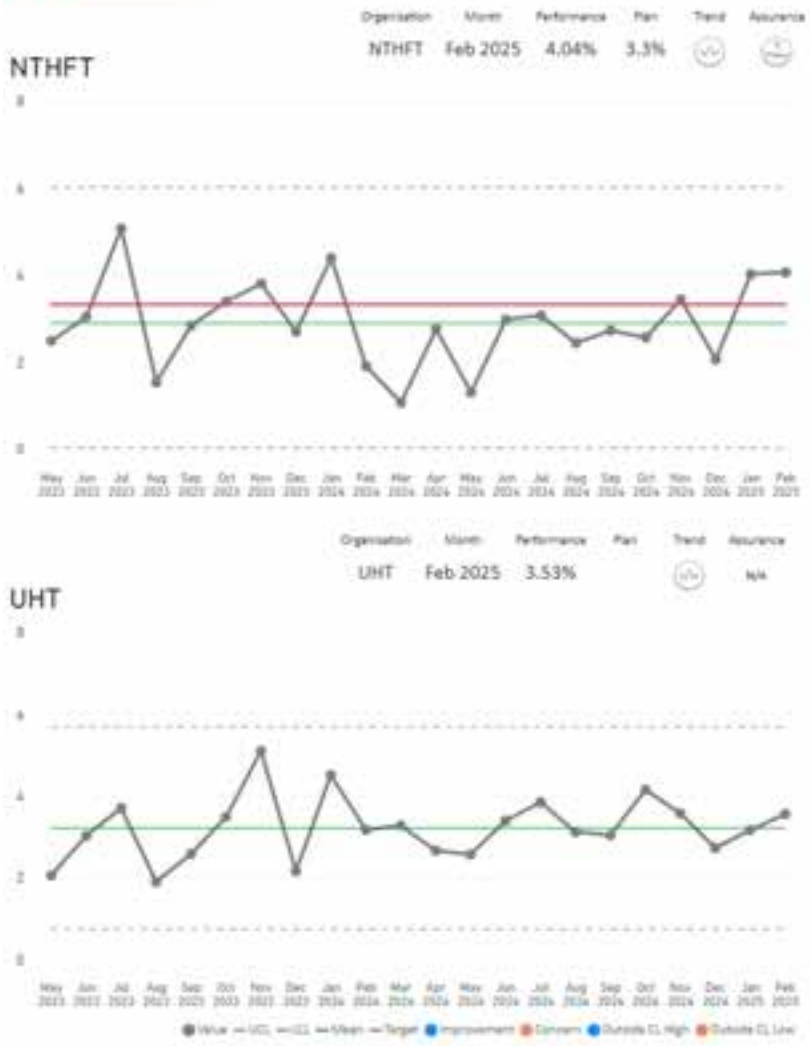
Metric: Percentage of births with induction of labour.
Plan: n/a. No national target.
Rationale: Saving Babies Lives care bundle local indicator.
Data quality: Assured, validated data.
Trend: NTHFT: no trend. STHFT: 2 of last 3 months have been higher than usual variation.
Assurance: NTHFT: n/a. STHFT: Alert over recent high rates in December 2024 and January 2025.
Action taken: Implementation of the Saving Babies Lives care bundle has led to enhanced foetal wellbeing surveillance and clinical pathways which can require appropriate higher rates of induction of labour.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

SAFE Breast Feeding at First Feed



Metric: Percentage of births where breast-feeding is initiated, reported at first feed.
Plan: Local plan 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: NTHFT: no trend. STHFT: last 2 months performance on the lower limit of expected variance.
Assurance: Alert. No statistical evidence of consistent improvement towards plan.
Action taken: Both sites are working towards breast-feeding initiative accreditation, which includes staff training, support to parents and infant feeding plans.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

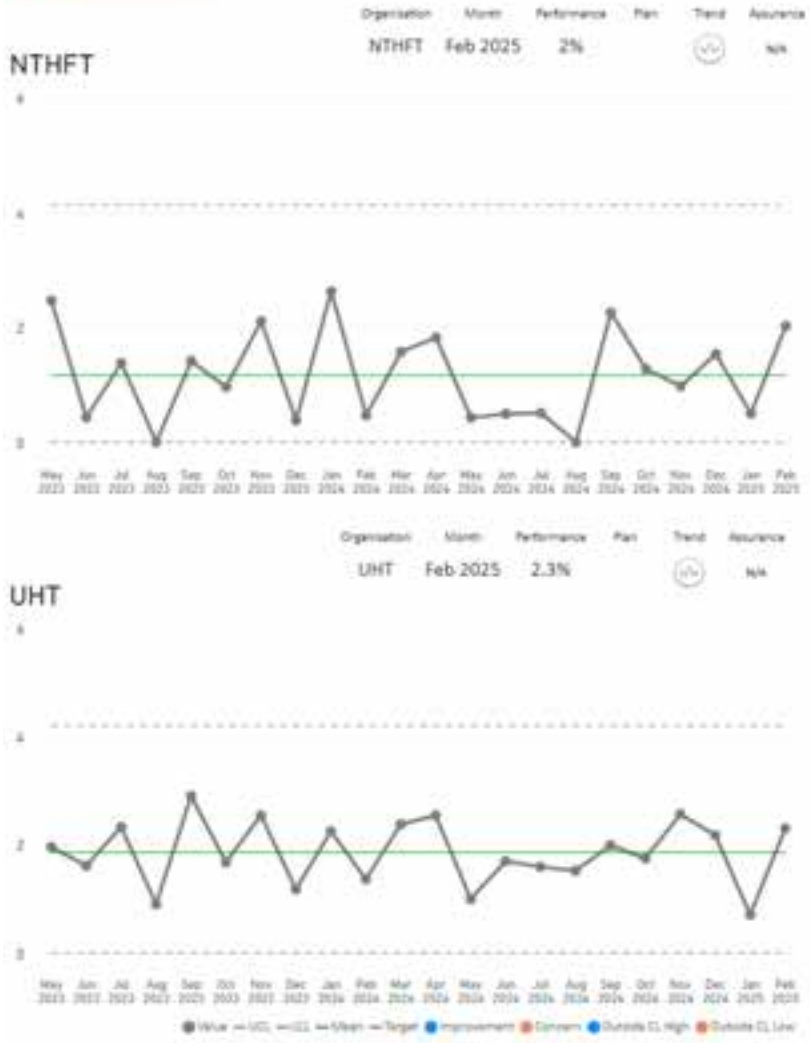
SAFE PPH >1500ml (%)



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: No trend.
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 trend.
Assurance: Advise: rates at STHFT meet plan most months but wide variation affects assurance. Similar rates at NTHFT.
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

Caring Better Together

EFFECTIVE DOMAIN SUMMARY

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

Summary Hospital-level Mortality Indicator (SHMI) is 'as expected' for both Trusts. Assurance is also provided by non-statistical approaches: Trust Medical Examiners review >98% of deaths and refer relevant cases to the Trust Mortality Surveillance team for further review/investigation/action where required. SHMI is influenced by the depth of co-morbidity coding: coding of co-morbidities is a theme in the STHFT coding action plan. Benchmarking identified this as an area for further improvement, and it appears that increased depth of codes recorded and flowing for analysis is impacting positively on SHMI. Learning across UHT contributes to this, as NTHFT benchmark well.

Both Trusts are focusing on understanding trends in readmission to identify the most clinically relevant improvement opportunities across medical and surgical care pathways, whilst enabling patients to be cared for out of hospital. The IPR reports a standardised metric to enable benchmarking.

NTHFT

Metric	Month Target	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Summary Hospital-Level Mortality Indicator	100	97.5	97.2	96.5	96.2	96.2	95.2	95.7	96.7		
Readmission Rate (%)	8.4%	11.1%	10.9%	10.9%	11.4%	10.8%	10.2%	10.4%	10.5%	11.1%	11%

STHFT

Metric	Month Target	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024
Summary Hospital-Level Mortality Indicator	100	107	106.6	107.1	106.1	106.8	104.7	104.6	103.9		
Readmission Rate (%)	8.4%	8.5%	8.5%	8.5%	8.5%	8.8%	8.7%	9.1%	9.1%	8%	8.6%

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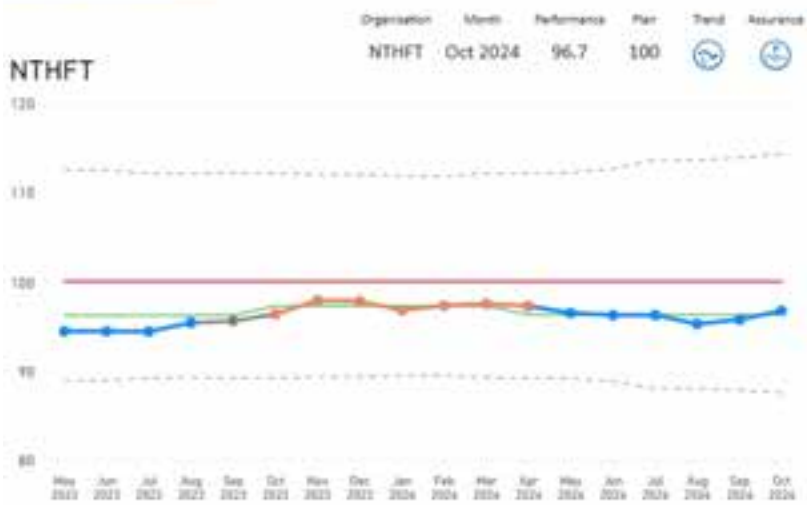
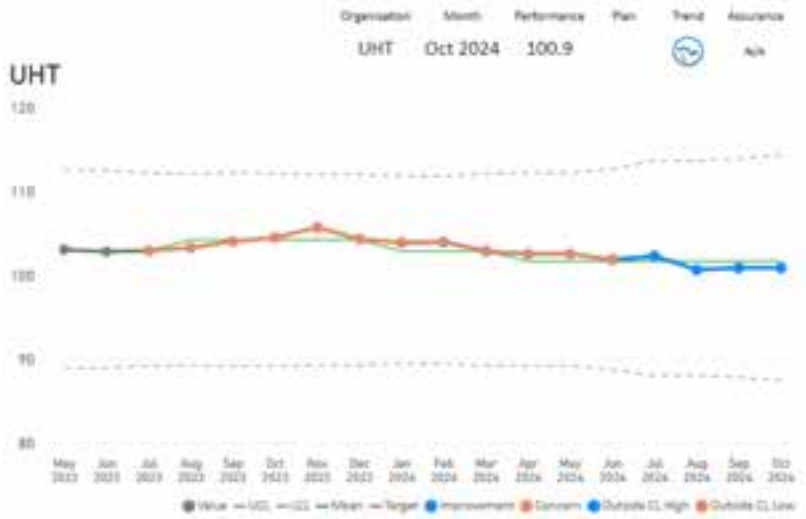
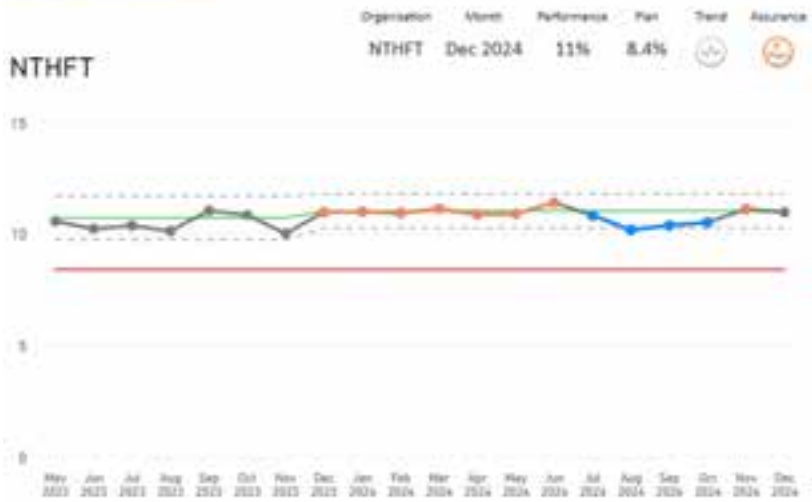
EFFECTIVE Summary Hospital-Level Mortality Indicator

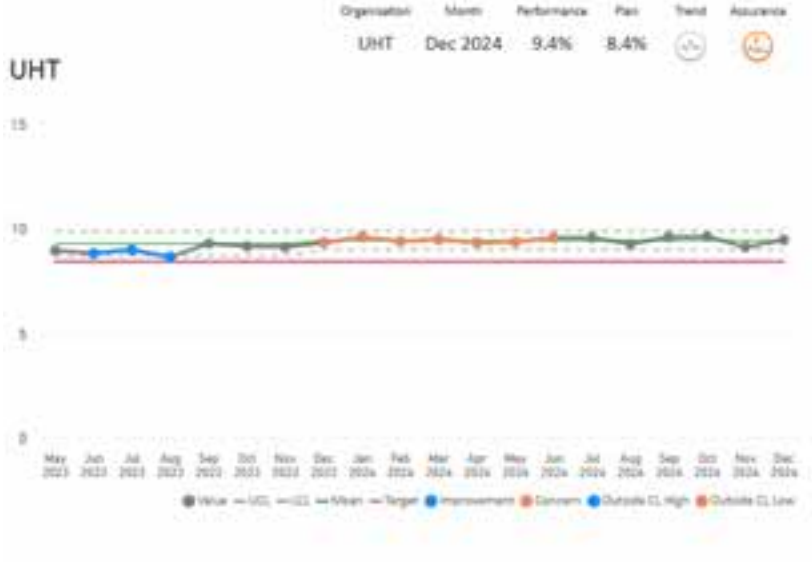




Metric: Summary hospital-level mortality indicator (SHMI). SHMI is calculated for rolling 12-months, published 4-months in arrears.
Plan: Standardised to 100.
Rationale: Quality Accounts regulatory indicator.
Data quality: Assured, validated data.
Trend: NTHFT: continued improving trend. STHFT: the improved SHMI is now sustained.
Assurance: NTHFT: Assure. Consistently below (better than) the national benchmark. STHFT: Advise. Above the national benchmark but within the expected variation nationally, with exception of one period impacted by data quality.
Action taken: Improved depth of coding at STHFT may lead to further improvement in SHMI.
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee

EFFECTIVE Readmission Rate (%)





Metric: Percentage of patients readmitted within 30 days.
Plan: 2023/24 national average.
Rationale: NHS Contract metric.
Data quality: Metric calculation adjustment to align with the published metric methodology. Reported two months in arrears to enable the data to be fully coded.
Trend: NTHFT: No Trend. STHFT increased from March 2024.
Assurance: NTHFT: Alert. Readmission rates consistently above national average. STHFT: Alert. Rates are close to national average but fluctuate.
Action taken: A clinical audit has been registered across both sites, to identify compliance against guidance and potential protocol, pathway changes with oversight and monitoring via Audit and Clinical Effectiveness Council.
Executive lead: Chief Medical Officer
Accountable to: Quality Assurance Committee

RESPONSIVE DOMAIN SUMMARY

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

Urgent and emergency care

In February, at both Trusts, performance showed single month improvements for each of the three ED metrics as the prevalence of winter illnesses in the local area decreased, i.e. ambulance handovers in 60 minutes, 4-hour standard and 12-hour breach rate. Most notably, ambulance handover performance has remained high for NTHFT as it did throughout winter and STHFT have begun service improvement work to reduce delays over 60 minutes which has driven a significant, single month improvement for February 2025.

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	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
Handovers - Within 60 Mins (%)	100%	98.6%	100%	98.1%	100%	100%	100%	99.8%	99.7%	99.3%	97.3%	98.8%	99.9%
4-Hour A&E Standard	88%	87.1%	88.7%	87.2%	89.9%	87.3%	89.4%	85.6%	83.8%	81.9%	80.9%	81.3%	85.5%
12-Hour A&E Breaches Rate	2%	0.1%	0.2%	0.2%	0%	0.2%	0.1%	0.4%	0.6%	1.1%	1.9%	2%	0.3%
Community UCR 2hr Response Rate (%)	70%	79%	84%	84%	82%	71%	75%	76%	78%	77%	73%	78%	
Cancelled Ops - Not Rebooked Within 28 days	0	4	2	1	3	2	2	2	3	3	4	5	10

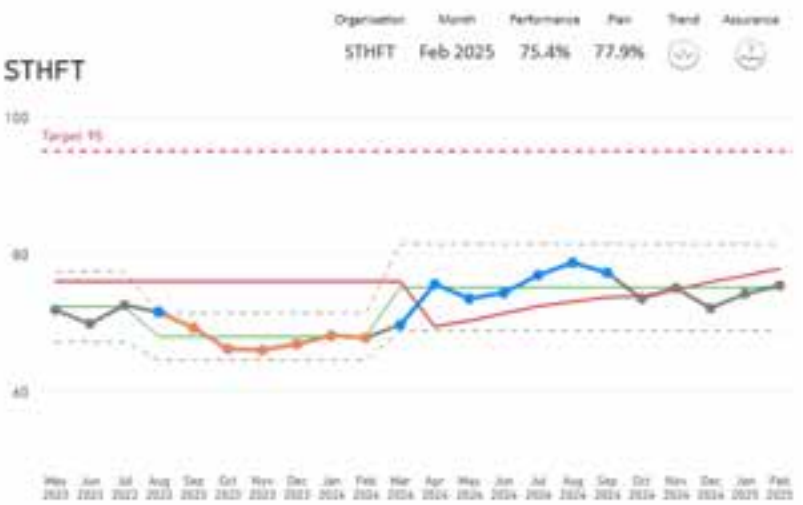
STHFT

Metric	Month Target	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
Handovers - Within 60 Mins (%)	100%	96.6%	93.7%	93.5%	96.3%	94.1%	97.1%	94.2%	84.1%	93.1%	79.5%	83.6%	95.6%
4-Hour A&E Standard	77.9%	69.7%	75.6%	73.5%	74.3%	76.9%	78.7%	77.3%	73.5%	75%	72.1%	74.2%	75.4%
12-Hour A&E Breaches Rate	2%	1.7%	2%	1.9%	1.7%	1%	0.7%	1%	3.6%	1.8%	4.1%	5%	2.1%
Community UCR 2hr Response Rate (%)	70%	88%	89%	87%	86%	87%	89%	83%	82%	83%	81%	81%	
Cancelled Ops - Not Rebooked Within 28 days	0	22	26	27	16	13	15	13	21	21	18	19	26

RESPONSIVE 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: no trend. STHFT: December and January performance outside expected variation due to peak of winter demand and acuity. Significant single month improvement in February 2025.
Assurance: NTHFT: Advise. STHFT: Advise.
Action taken: NTHFT have provided mutual aid when demand surges; focusing on timely release of crews, including the use of corridor care and handovers non-ED clinical areas. STHFT have adopted NHSE Improvement trajectory actions to eliminate delays over 60 mins, with daily meetings with NEAS and full use of 'Impact' nursing.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE 4-Hour A&E Standard

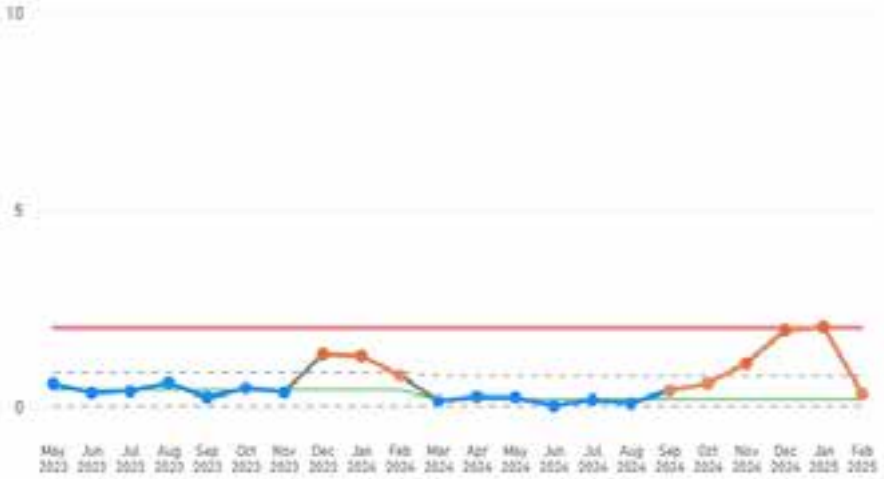


Metric: Percentage of patients admitted, transferred or discharged from A&E (all types) within 4 hours of arrival.
Plan: NHS Constitution standard 95%, operational plan per Trust to achieve 78% STHFT, 90% NTHFT by March 2025.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: lower performance from September 2024. STHFT: No recent trend.
Assurance: NTHFT: Alert, plan not met since August. STHFT: Advise, missed plan last three months.
Action taken: NTHFT: Partnership working to improve flow within and out of the Trust are key elements monitored via the 4-Hour Steering Group. Timestamp issues identified on patient records are being investigated with EPR supplier. STHFT: rapid process improvement methodology applied to triage times at start of patient journey, 'zoning' of medical teams for clearer departmental ownership and greater utilisation of SDEC.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE 12-Hour A&E Breaches Rate

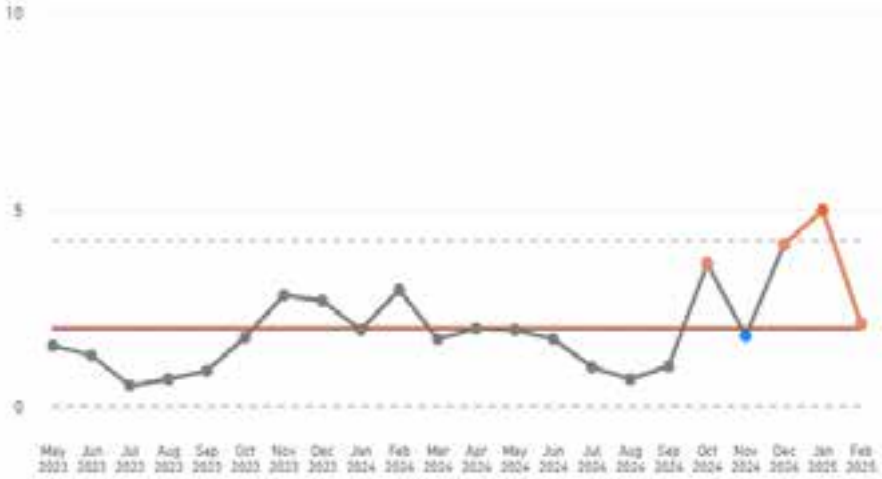
Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 2025	0.3%	2%		

NTHFT



Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 2025	2.1%	2%		

STHFT



Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 2025	1.2%			

UHT

Nar

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 spend more than 12 hours in A&E.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: Seasonal variation. For NTHFT and STHFT, improved performance in February 2025 but performance in 2 of last 3 months has been worse than would be anticipated.
Assurance: NTHFT: Advise: Standard achieved but impacted by seasonal variation. STHFT: Alert, standard not assured.
Action taken: NTHFT utilise all available escalation beds and temporary escalation spaces at times of surge, alongside Full Capacity Protocol reviewed at daily OPEL meetings to manage patient flow. STHFT: Participation in NHSE improvement programme with a trajectory that aims to eliminate 12-hour breaches by March 2025.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE Community UCR 2hr Response Rate (%)

Metric: Urgent community response within 2-hours
Plan: 70%
Rationale: NHS operational planning guidance
Data quality: Advisory, metric calculated from submitted raw community data sets.
Trend: NTHFT: no trend. STHFT: lower performance from September 2024 outside expected variation.
Assurance: NTHFT: Assure. STHFT: Advise, standard achieved for the last 2 years but recent 5 months are on or outside the limits of usual variation.
Action taken: Community rapid response services remain a key element of caring for patients in the most appropriate setting. Outlier points for STHFT due to some staffing resource being re-directed to support virtual ward services whilst maintaining the UCR standard.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE Cancelled Ops - Not Rebooked Within 28 days

Metric: Operations cancelled not rebooked within 28-days.
Plan: Zero.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: Special cause variation for February 2025. STHFT: No trend.
Assurance: NTHFT: Alert, number of operations not rebooked in 28 days higher than usual expected levels. STHFT: Alert, standard is consistently not met.
Action taken: Daily review of all cancellations is in place at NTHFT, and services remain focussed and committed to reappointing patients within the timeframe. At STHFT, two pilots have been undertaken to reduce avoidable cancellations with a view to wider roll out and services are working to improve compliance with 28-day rebooking.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE 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 with lower numbers in the last 4-5 months at STHFT. The national priority is to eliminate 65 week waits, NTHFT has achieved this since September 2024. 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 cancer faster diagnosis standard has been met by NTHFT for the last 7 months while STHFT performance was below standard for the last 5 months after previously achieving it for 11 months. Timely diagnosis is critical to improving cancer pathways. STHFT has entered tiered support from NHS England in February 2025 with a focus on improving 62-day standard performance and robust action plans are being implemented, beginning with the diagnostic process in the Urology prostate pathway where changes are being closely monitored. At NTHFT tumour specific pathway improvements continue to be driven by the clinically-led Cancer Delivery Group.

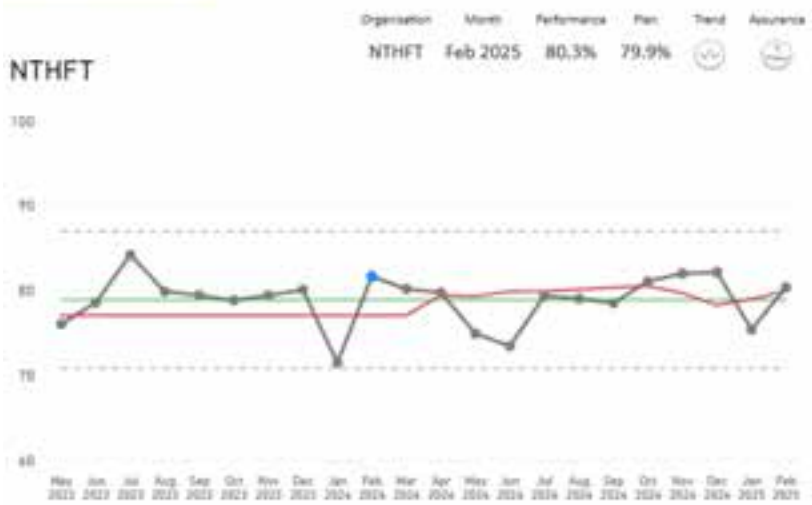
NTHFT

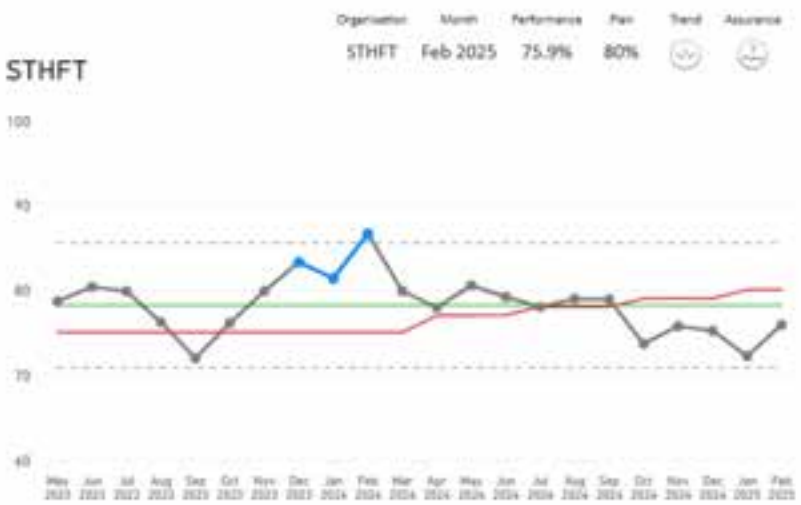
Metric	Month Target	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
Cancer Faster Diagnosis Standard (%)	79.9%	80.1%	79.7%	74.9%	73.4%	79.3%	79%	78.4%	81%	81.9%	82.1%	75.3%	80.3%
Cancer 31 Day Standard (%)	96%	94%	97.6%	97.8%	95.8%	96.3%	97.9%	91.8%	94.7%	96.2%	96.6%	96.6%	96.4%
Cancer 62 Day Standard (%)	72.4%	72%	62.7%	65.1%	59.7%	62.2%	72.7%	60.1%	70.8%	71.6%	76.2%	72.2%	63.4%
Diagnostic 6 Weeks Standard (%)	95%	84.7%	78.7%	74.5%	69%	72.9%	72.3%	77.7%	82.7%	86.5%	83.9%	91.6%	95.1%
RTT Incomplete Pathways (%)	92%	71.2%	71.8%	72.5%	72.2%	71.7%	71.4%	72.1%	72.4%	71.5%	72.5%	73.2%	74.4%
RTT 52 week waiters	100	218	175	163	159	183	180	173	179	221	176	169	171

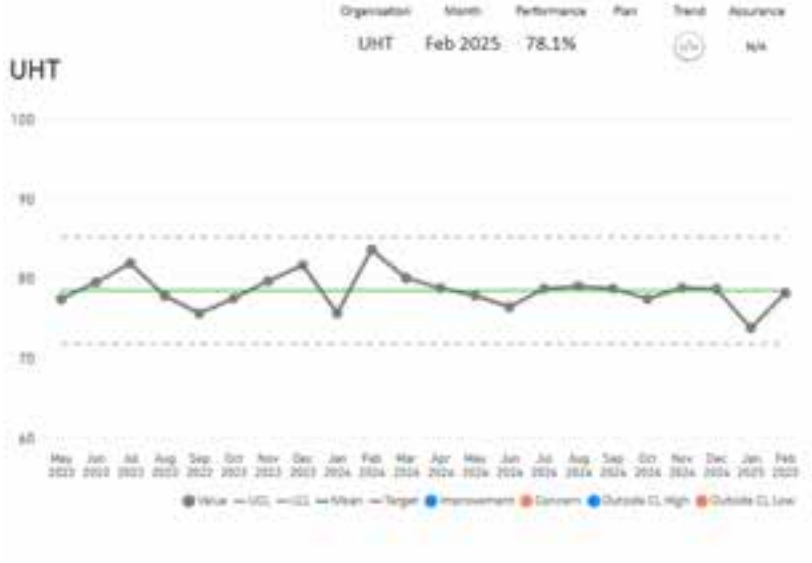
STHFT

Metric	Month Target	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
Cancer Faster Diagnosis Standard (%)	80%	79.9%	77.9%	80.5%	79.2%	78%	78.9%	78.9%	73.6%	75.7%	75.2%	72.2%	75.9%
Cancer 31 Day Standard (%)	96%	91.6%	86.4%	91.5%	92.4%	93.1%	92.3%	91.1%	90.5%	89.1%	88.3%	81.1%	86.8%
Cancer 62 Day Standard (%)	69.2%	59.1%	61%	58.7%	59.3%	63.7%	59.2%	61.9%	56.7%	58.5%	59.9%	63.1%	61%
Diagnostic 6 Weeks Standard (%)	95%	80.4%	81.7%	81.6%	80.9%	83.2%	82.2%	84.9%	85.9%	85.5%	85%	88.7%	88.7%
RTT Incomplete Pathways (%)	92%	61.5%	62.7%	61.6%	60.7%	60.3%	58.9%	59.1%	60.2%	60%	59.4%	59.5%	59.9%
RTT 52 week waiters	741	1483	1498	1863	2099	2106	2216	1848	1524	1591	1500	1661	1661

RESPONSIVE Cancer Faster Diagnosis Standard (%)

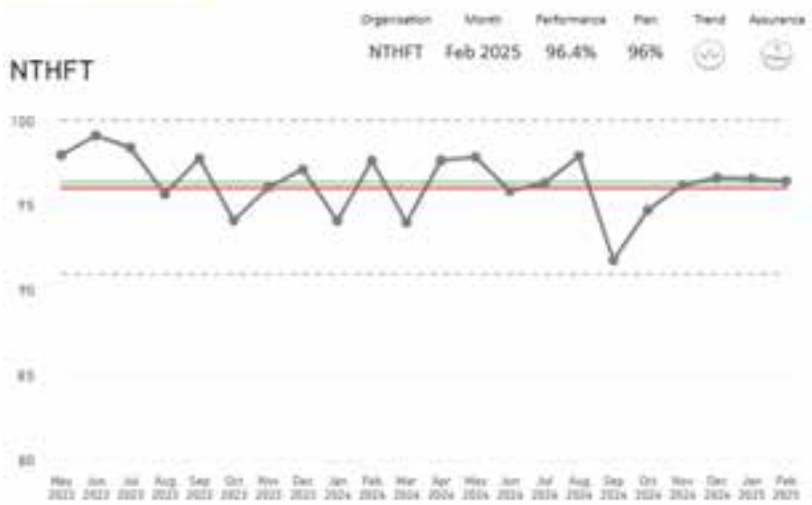


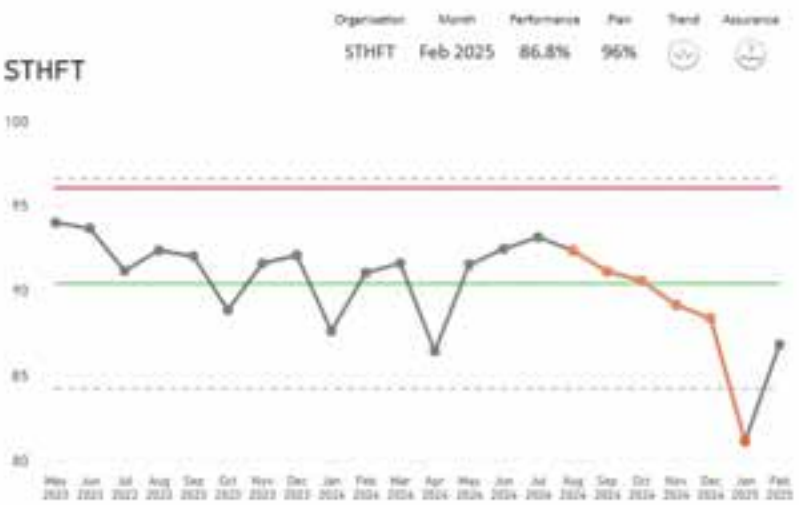




Metric: Percentage of patients on a cancer pathway who receive diagnosis or rule-out within 28 days from referral.
Plan: NHS Constitution standard 77%. Local operational planning trajectories: 80% by end March 2025.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend.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

RESPONSIVE Cancer 31 Day Standard (%)

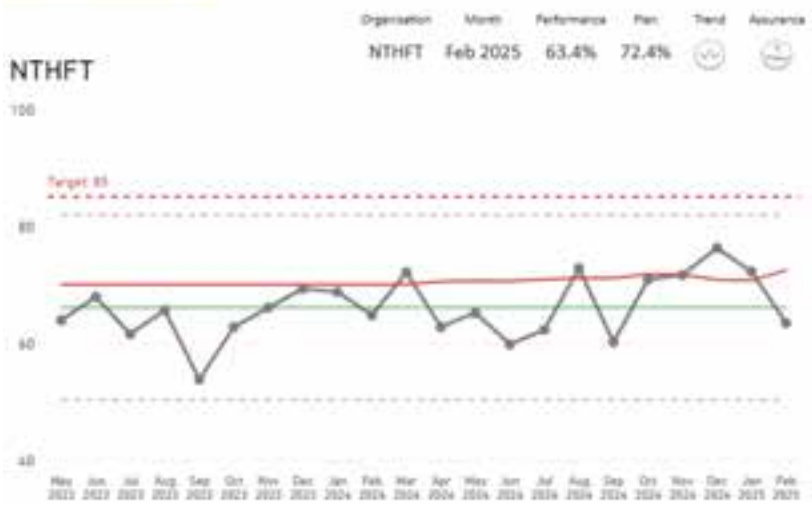


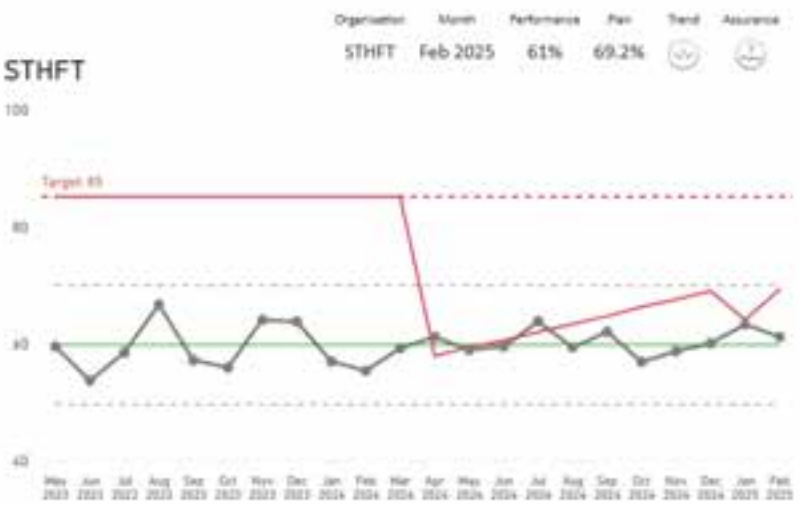


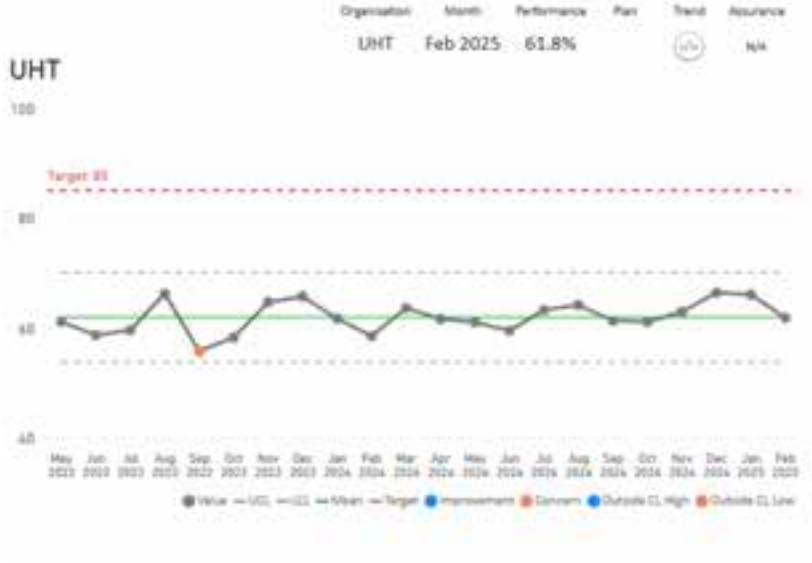
Metric: Percentage of patients on a cancer pathway who start treatment within 31 days of decision to treat.
Plan: NHS Constitution standard 96%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: NTHFT: Advise, standard is not consistently met; STHFT: Advise, performance recovered after a particularly low month in January 2025.
Action taken: NTHFT: Group improvement work across the tumour groups continues**.** STHFT focus is the patients waiting longest for treatment (overall pathway time) and pathway improvement work for suspected prostate cancer. For example, action plans for timeliness of radiotherapy subsequent treatments (driver of low performance in January) to be finalised in April 2025.
Executive lead: Managing Director
Accountable to: Resources Committee

Caring Better Together

RESPONSIVE Cancer 62 Day Standard (%)

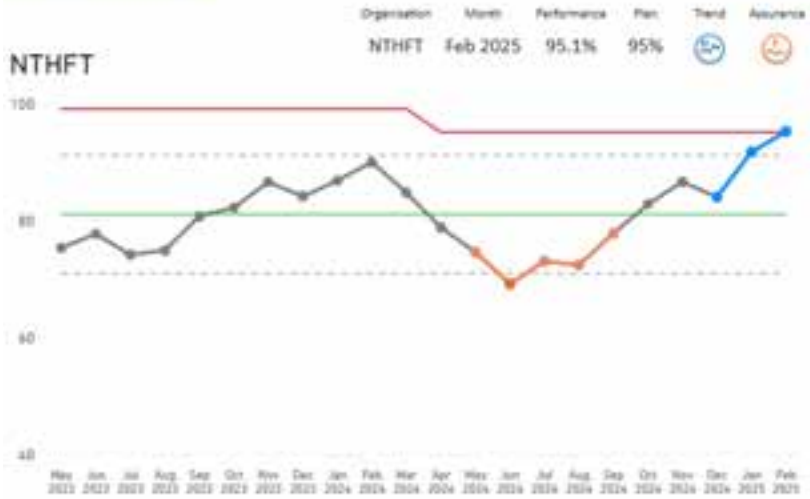






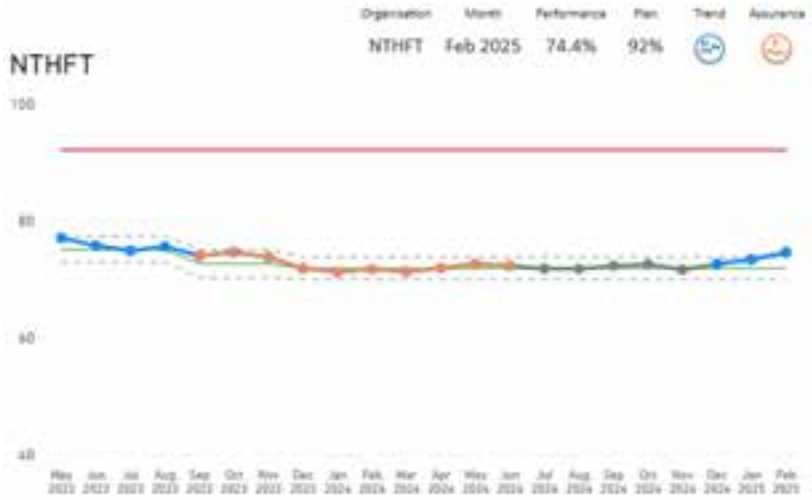
Metric: Percentage of patients on a cancer pathway who start treatment within 62 days of referral.
Plan: NHS Constitution standard 85%. Local operational planning trajectories: NTHFT 72.6% and STHFT 70.0% by end March 2025.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: Advise: plans not consistently met.
Action taken: Focus for both Trusts is the patients waiting longest for treatment, this brings patients beyond 62-days into the metric. Service improvement work across the Group is underway across tumour groups with recent changes in prostate diagnostic pathway being monitored for improvements which should begin to be evident from May 2025 with full effect from June 2025.
Executive lead: Managing Director
Accountable to: Resources Committee

RESPONSIVE Diagnostic 6 Weeks Standard (%)



Metric: Percentage of patients waiting for a diagnostic test less than 6 weeks from referral,13 modalities.
Plan: NHSE 24/25 operational standard 95%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: improved performance from December 2024. STHFT: improved since October 2023.
Assurance: NTHFT & STHFT: Advise. Both trusts demonstrating improvement with NTHFT now meeting the standard.
Action taken: Both Trusts gain additional capacity from April 2025 with the opening of the Stockton Community Diagnostic Centre, which will improve compliance. STHFT: improvement work is underway in specialist services but will show only incremental improvement over several months.
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: NTHFT: Improved performance since December 2024. STHFT: No trend.
Assurance: NTHFT: Advise Standard is consistently breached but performance above control in February has moved the Trust from Alert to advise. STHFT: Alert. Standard is consistently not met.
Action taken: Focus is on reducing the longest waiters beyond 52 and 65 weeks, in line with operational planning guidance and *Reforming elective care for patients*. Focused plans are being developed to achieve 5% improvement for 25/26, including further validation of lists.
Executive lead: Managing Director
Accountable to: Resources Committee

Caring Better Together

RESPONSIVE RTT 52 week waiters

Metric: Number of patients awaiting elective treatment who have waited more than 52 weeks from referral.
Plan: To reduce the number of 52-week waiters and eliminate 65-week waiters by September 2024.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: Alert. Number of patients waiting exceeds plans with no current improvement trend.
Action taken: Both Trusts are working at both organisational and system level to reduce the longest waits, developing focused plans in line with *Reforming elective care for patients* and 2025/26 operational guidance. STHFT are increasing capacity in key pressured specialties such as Neurology and Urology. These specialties have demand and sub-specialism capacity challenges, in common with other providers in the region.
Executive lead: Managing Director
Accountable to: Resources Committee

CARING DOMAIN SUMMARY

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

Performance in patient experience surveys is measured as the percentage of respondents rating their experience overall good or very good. In February NTHFT were above plan in three of the five surveys with statistical assurance of consistently positive responses from the A&E setting. Statistical assurance of consistently positive responses is provided for NTHST A&E services and STHFT inpatient, outpatient and community services. The focus is on increasing response rates to FFT to provide more assurance of positive experience of care.
Further work is being undertaken in Q1 25/26 to ensure consistency in timely responses to complaints, concerns and enquiries. Patient experience teams continue to support and escalate to the clinical and operational teams, requiring their focus on resolving these in a timely manner, prioritising those that have been longest in progress.

NTHFT

Metric	Month Target	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
A&E Experience (%)	79%	84.2%	86.9%	82.4%	83.3%	83.1%	86.9%	85.8%	85.7%	85%	85.2%	84.3%	85.9%
Inpatient Experience (%)	94%	90.6%	87%	89.8%	91.6%	90.7%	93.5%	95.8%	94.7%	94.8%	94.8%	91.2%	92.4%
Maternity Experience (%)	92%	80%	91.7%	93.3%	87.5%	90.5%	100%	83.3%	87.5%	100%	87.5%	96.3%	100%
Outpatient Experience (%)	94%	93.6%	95.3%	94.7%	95.8%	94.8%	95.3%	93.6%	93.8%	94.9%	94%	93.8%	94.4%
Community Experience (%)	95%	95.5%	95.5%	94.9%	97.5%	96.8%	96%	96.4%	98.3%	96.9%	97.1%	97.5%	94%
Collaborative Enquiries (Stage 0) Closed in Target (%)		28.9%	23.6%	16.7%	16.5%	18.3%	25%	25.3%	18.5%	33.7%	20.5%	19.3%	26.6%
Feedback Acknowledged in 3 Days (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Complaints Closed Within Target (%)	80%	65.5%	58.5%	61.2%	63%	60.4%	70.9%	54.4%	52.6%	72.1%	55.4%	60.9%	73.1%

STHFT

Metric	Month Target	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
A&E Experience (%)	79%	78.3%	75.1%	77.1%	77.2%	80.4%	83%	80.5%	75.5%	79.8%	76.7%	78.5%	78.3%
Inpatient Experience (%)	94%	96.5%	95.6%	97.3%	97.4%	97.3%	97.8%	97.6%	99.1%	96.8%	96.9%	98.9%	97.8%
Maternity Experience (%)	92%	91.8%	89%	85.2%	88.3%	92.7%	91%	94.6%	92.3%	91.7%	87.6%	89.6%	94.3%
Outpatient Experience (%)	94%	96.3%	96.8%	96.7%	96.1%	97.2%	97.2%	97.1%	96.5%	95.5%	96.7%	96.1%	95.8%
Community Experience (%)	95%	99.3%	98.4%	100%	98.9%	98.9%	99.4%	97.5%	97.5%	100%	100%	97.3%	100%
Collaborative Enquiries (Stage 0) Closed in Target (%)		94.8%	96.2%	74.2%	78.5%	91.5%	87%	91.4%	69.7%	88%	94.4%	100%	87.5%
Feedback Acknowledged in 3 Days (%)	100%	66%	46.8%	75.4%	54.3%	88.2%	97%	98.7%	100%	100%	100%	99.1%	98.8%
Complaints Closed Within Target (%)	80%	43.6%	27.3%	12.5%	26.9%	39.7%	30.7%	54.7%	34.4%	41.8%	38%	46.9%	61.8%

CARING A&E Experience (%)

NTHFT

Organisation	Month	Performance	Plan	Trend	Assurance
NTHFT	Feb 2025	85.9%	79%		

STHFT

Organisation	Month	Performance	Plan	Trend	Assurance
STHFT	Feb 2025	78.3%	79%		

UHT

Organisation	Month	Performance	Plan	Trend	Assurance
UHT	Feb 2025	79.9%			N/A

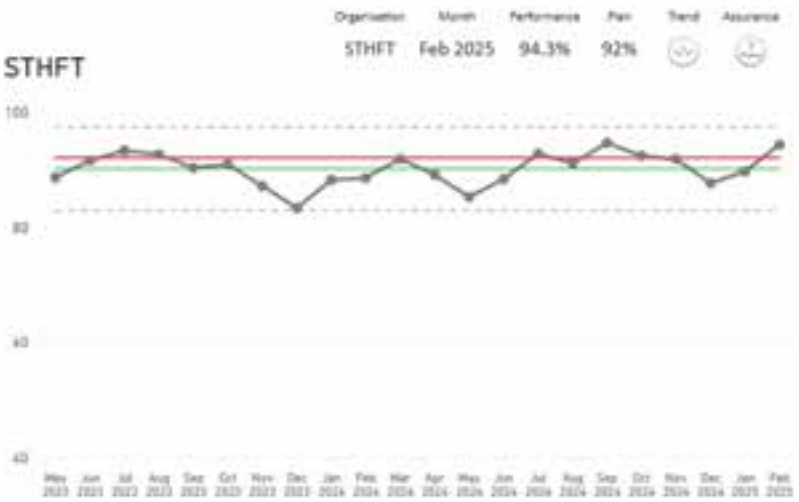
Metric: Percentage of respondents who attended A&E rating their experience good or very good in NHS Friends & Family test.
Plan: Local plan set on NHS Trusts average 23/24.
Rationale: NHS Contract metric.
Data quality: Assured (manual and digital systems).
Response rates: NTHFT 6.2%, STHFT 7.8%.
Trend: NTHFT: Recent stepped change in positive feedback. STHFT: No trend.
Assurance: NTHFT: Assure, consistently better than plan. STHFT: Advise, plan achieved in some months.
Action taken: Note that patient feedback appears to correlate inversely with A&E waiting times metrics, so focused improvement of A&E waiting times is expected to improve patient feedback.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

CARING Inpatient Experience (%)

Metric: Percentage of respondents rating their inpatient experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 23/24.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Response rates: NTHFT 13.5%, STHFT 17.1%.
Trend: No trend.
Assurance: NTHFT: Advise, plan is not consistently met. STHFT: Assure, plan has been met for two years.
Action taken: NTHFT Associate Directors of Nursing requested to raise awareness and actions through senior management teams and Directorate meetings.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

Caring Better Together

CARING Maternity Experience (%)



Metric: Percentage of respondents rating their maternity experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 23/24.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. Response rates and sample sizes can be low, NTHFT 7.4% (Birth only), STHFT 10.7% (Birth only).
Trend: No trend.
Assurance: Advise.
Action taken: To continue to promote engagement with Friends and Family Test.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

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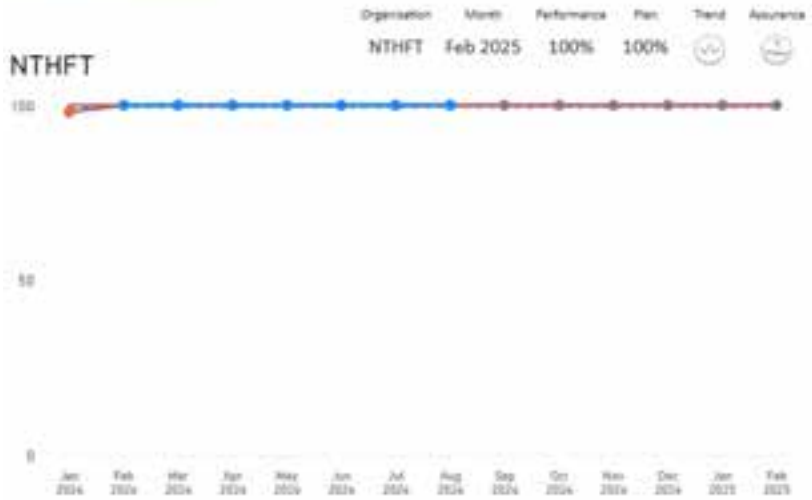
CARING Outpatient Experience (%)

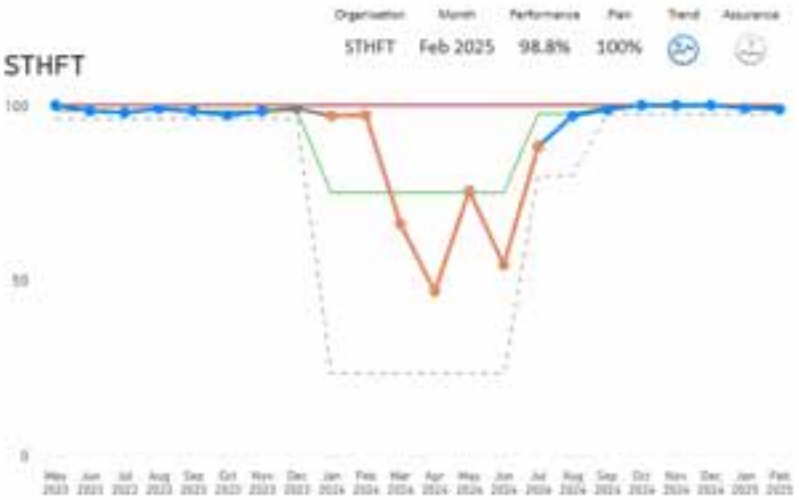
Metric: Percentage of respondents rating their outpatient experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 23/24.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. Response rates are 8.4% NTHFT, 15.0% STHFT.
Trend: No trend.
Assurance: NTHFT: Advise, performance is close to plan each month but does not always achieve. STHFT: Assure, performance consistently meets plan.
Action taken: Action plan to be developed to ensure targets are met consistently at NTHFT.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

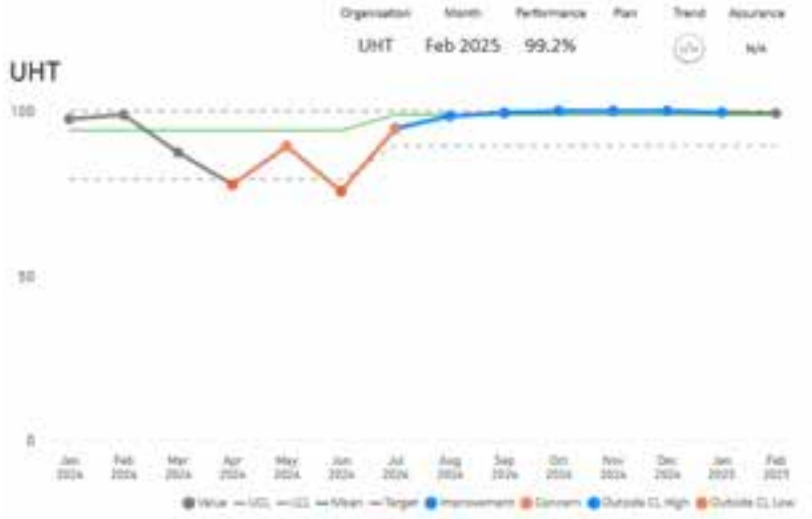
CARING Community Experience (%)

Metric: Percentage of respondents rating their community services experience good or very good in NHS Friends & Family test.
Plan: Local plan based on NHS Trusts average 23/24.
Rationale: NHS Contract metric.
Data quality: Assured, validated data. Response rates are 4% NTHFT, 10% STHFT.
Trend: No trend.
Assurance: NTHFT: Advise, plan not consistently met. STHFT: Assure.
Action taken: Further work is required to ensure plans are met consistently across both sites.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

CARING Feedback Acknowledged in 3 Days (%)







Metric: Percentage of complaints acknowledged in 3 days.
Plan: 100%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: No trend, sustained compliant performance. STHFT: improving trend since August 2024.
Assurance: NTHFT: Advise, target met since February 2024. STHFT: Advise, target not consistently met.
Action taken: STHFT: new process for acknowledging complaints implemented in July 2024 led to improved performance.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

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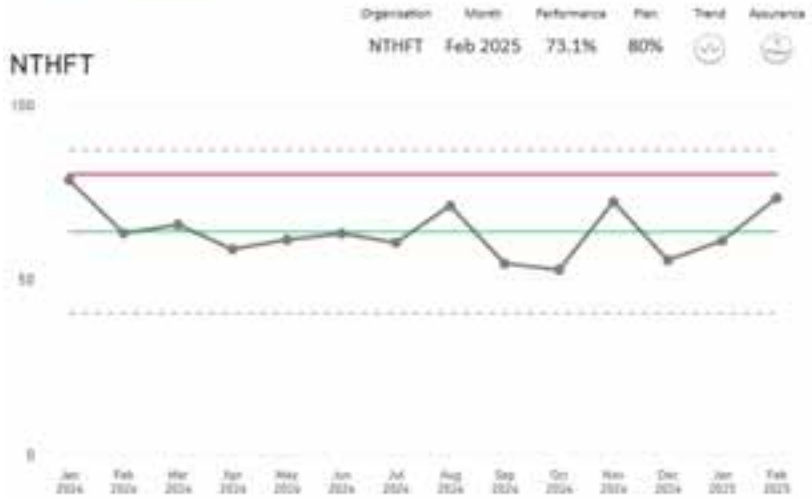
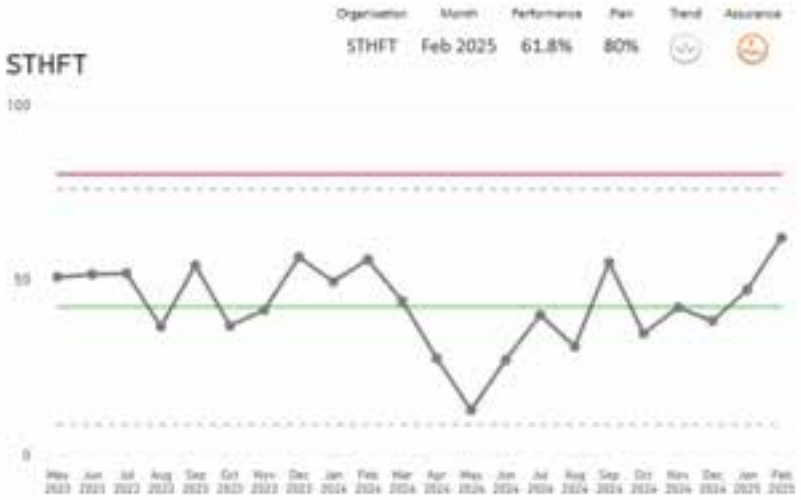
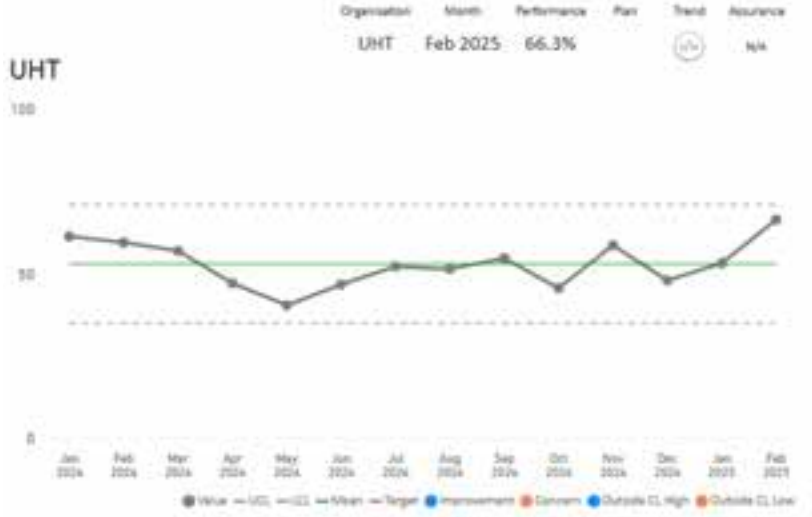
CARING Complaints Closed Within Target (%)







Metric: Percentage of complaints closed in agreed target time frame.
Plan: 80%.
Rationale: NHS Contract metric.
Data quality: Assured, validated data.
Trend: No trend. Wide variation at STHFT.
Assurance: NTHFT: Advise, plan not met but within range of variability. STHFT: Alert, current performance does not meet plan.
Action taken: NTHFT: 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 by Collaboratives.
Executive lead: Chief Nursing Officer
Accountable to: Quality Assurance Committee

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WELL LED DOMAIN SUMMARY

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

Accountable to: People Committee
Resources Committee

An absence reduction strategy has been developed, with actions to be implemented to support managers to reduce long term absence. A proposal to introduce a temporary absence team, to focus on 1% absence reduction, is being developed. Work is underway to ensure Training Needs Analysis is aligned to the National Core Skills Training Framework, to ensure the correct competency is consistently applied to the appropriate role. A new UHT occupational health (OH) system has been implemented. This will align OH referral processes across the Group. Focus remains on staff who have not had an appraisal for 2 years or more, this is making a difference with a 34% improvement across UHT.

The financial position shows a small adverse variance year to date against month 11 plan for NTHFT with a small positive variance against plan for STHFT. Financial controls are in place, with a focus on recurrent efficiency delivery, and Resources Committee oversight of financial risks.

NTHFT

Metric	Month Target	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
Sickness Absence (%)	4%	5.6%	5.8%	5.8%	5.7%	6%	5.8%	5.8%	6.1%	6.1%	7%	6.3%	6%
Staff Turnover (%)	10%	7.6%	7.1%	7.4%	7.2%	7.2%	7.3%	7.3%	7.3%	7.2%	6.9%	7.1%	7%
Annual Appraisal (%)	85%	87.2%	86.8%	86.4%	86.6%	86.9%	86.7%	87.2%	86.9%	86.9%	87%	87.2%	86.6%
Mandatory Training (%)	90%	90.1%	89.2%	88.6%	89.3%	89.4%	89.7%	89.5%	89.8%	89.4%	88.9%	88.9%	88.1%
Cumulative YTD Financial Position (£'millions)	-£0.436m		-£0.407m	-£0.817m	-£1.227m	-£1.266m	-£1.24m	-£0.861m	-£1.114m	-£1.289m	-£1.404m	-£0.994m	-£0.473m

STHFT

Metric	Month Target	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025
Sickness Absence (%)	4%	5.3%	5.3%	5.2%	5.3%	5.5%	5.4%	5.3%	6%	6%	6.8%	7%	6.2%
Staff Turnover (%)	10%	10.3%	10.1%	10.2%	10%	10%	10.2%	9.8%	9.3%	6.6%	6.5%	6.6%	6.5%
Annual Appraisal (%)	85%	79.1%	80%	79.6%	79%	80.3%	80.3%	80%	78.8%	78.7%	78.8%	78.8%	80.2%
Mandatory Training (%)	90%	90.3%	90.7%	90.7%	90.2%	90.3%	90%	89.7%	89.2%	87.8%	87.3%	86.8%	86.7%
Cumulative YTD Financial Position (£'millions)	-£7.502m	-£20.077m	-£5.595m	-£10.008m	-£13.615m	-£15.87m	-£19.33m	-£12.715m	-£14.342m	-£16.684m	-£18.873m	-£7.583m	-£7.489m

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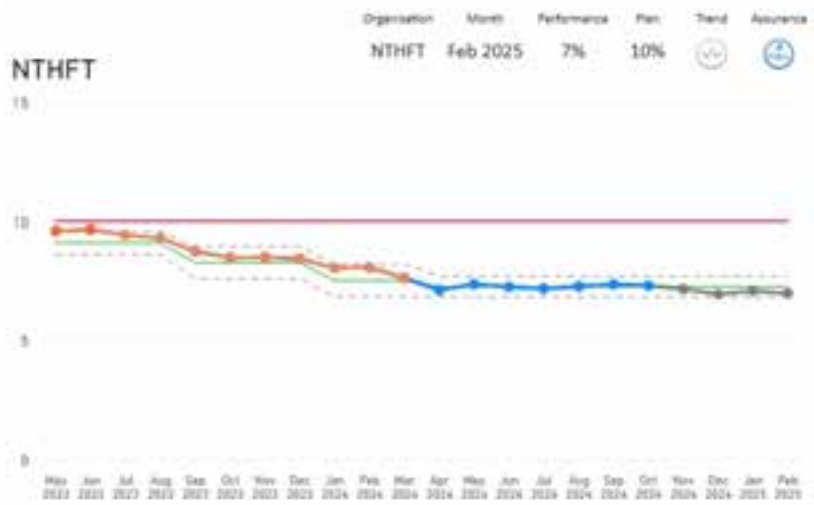
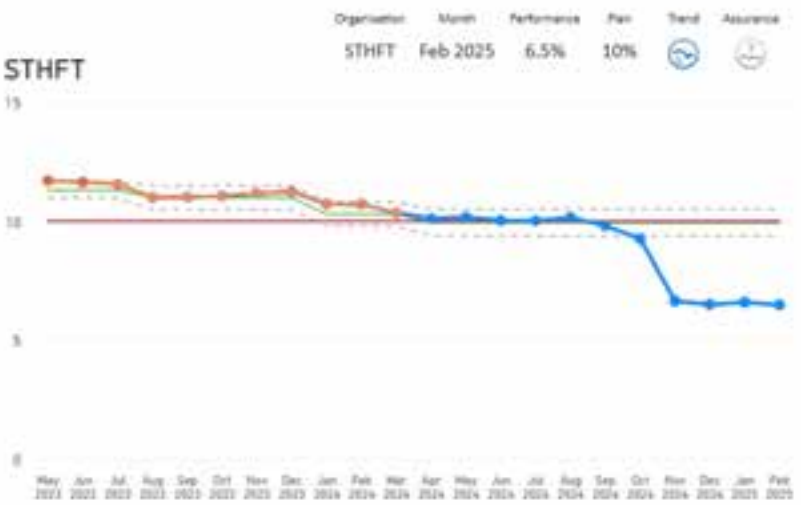
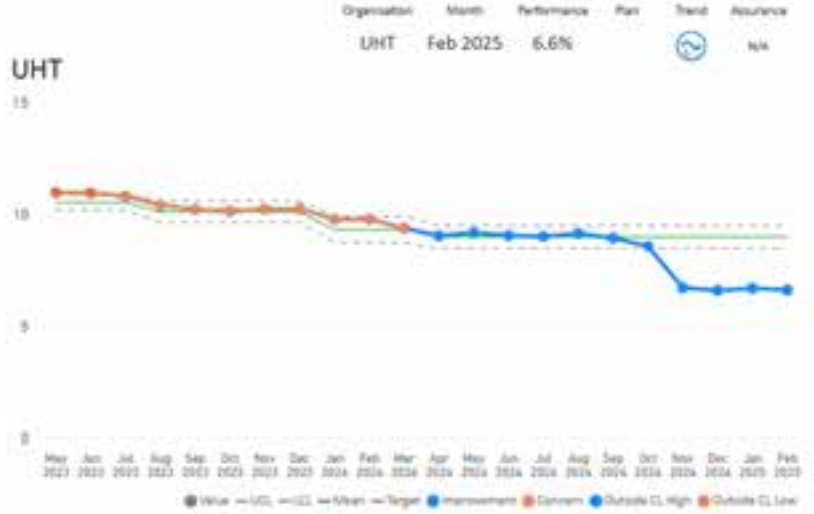
WELL LED Sickness Absence (%)

Metric: Percentage of staff working hours lost to sickness absence (all types) in each month.
Plan: Trust internal plans: 4%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: Increased absence rates since July 2024 for both Trusts.
Assurance: Alert: plans are not met.
Action taken: Commitment to reduce absence by 1%. Review of absence triggers and frequent absence cases. A proposal is being developed to allocate additional resources to focus on long term sickness.
Executive lead: Chief People Officer
Accountable to: People Committee

WELL LED Staff Turnover (%)



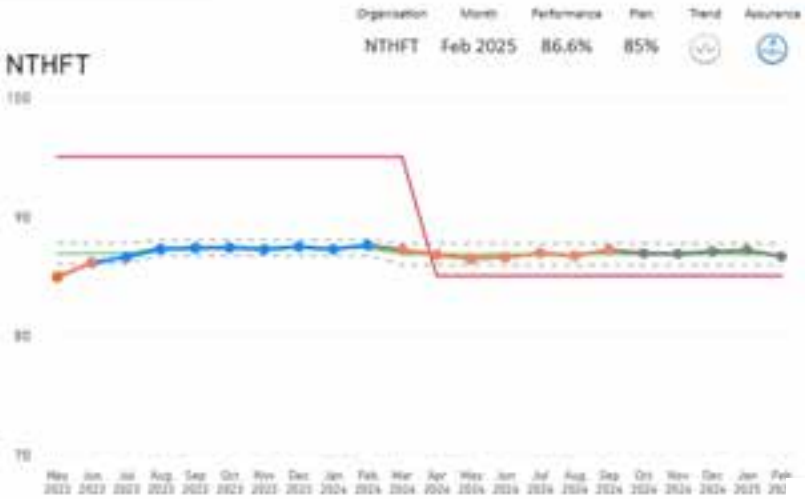




Metric: Percentage of staff changing or leaving job roles in the month (all staff groups, all changes).
Plan: Trust internal plans: 10%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data. Alignment of the metric criteria has improved STHFT reported performance from November 2024.
Trend: NTHFT: no current trend. STHFT: improvement trend of reducing turnover.
Assurance: NTHFT: Assure: plan is consistently met. STHFT: Advise: plan has been met in last 6 months. Continuation of similar performance will lead to assurance.
Action taken: Turnover to be included within the cycle of business at People Committee, a deep dive to be undertaken into retention and exit. The next step will then be to review and learn from leavers to improve processes across UHT.
Executive lead: Chief People Officer
Accountable to: People Committee

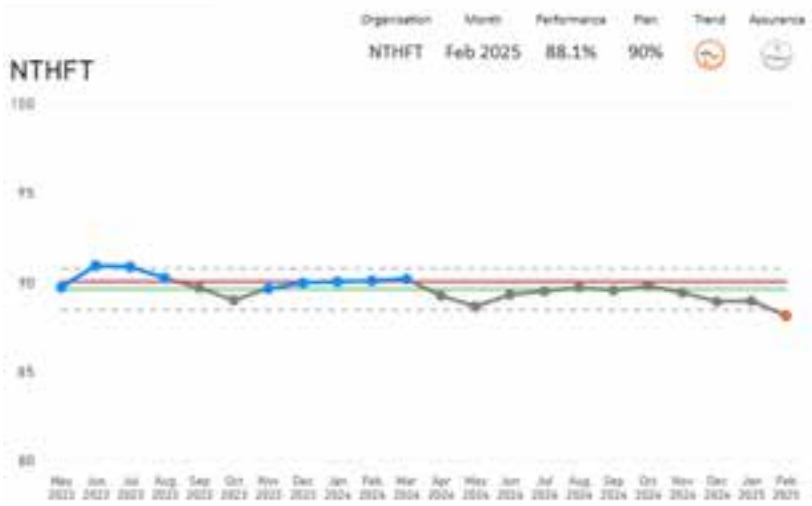
WELL LED

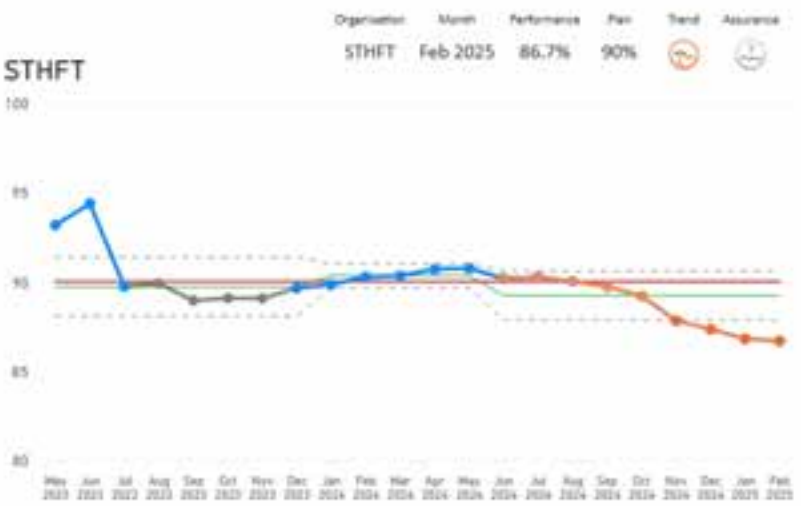
Annual Appraisal (%)

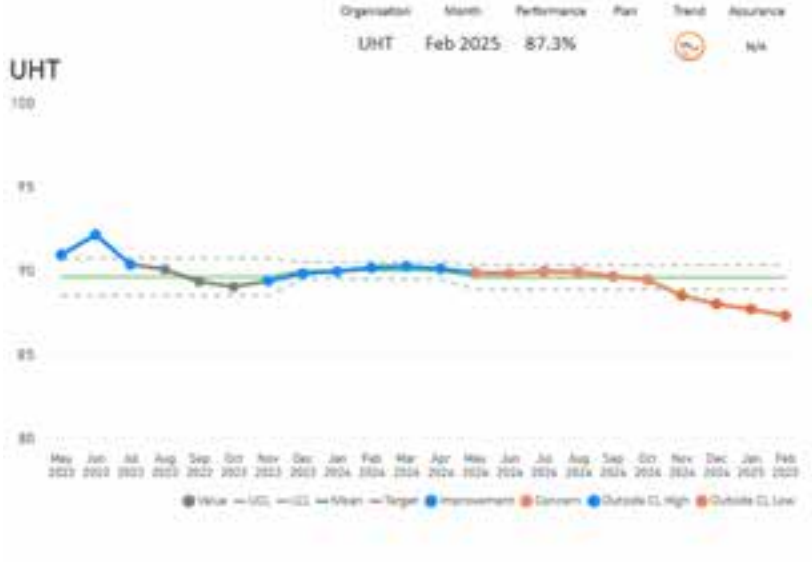


Metric: Percentage of staff with annual appraisal completed in last 12 months, at month end.
Plan: Trust internal plans: 85%, now aligned for 24/25.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: No trend.
Assurance: NTHFT: Assure: threshold met. STHFT: Alert: new plan not met.
Action taken: Following the drive for managers to complete appraisals, we have identified the need to review and revise the current process of providing appraisal documents to managers, and accountability for completion. Focus remails on staff who have not had an appraisal in 24 months or more.
Executive lead: Chief People Officer
Accountable to: People Committee

WELL LED Mandatory Training (%)







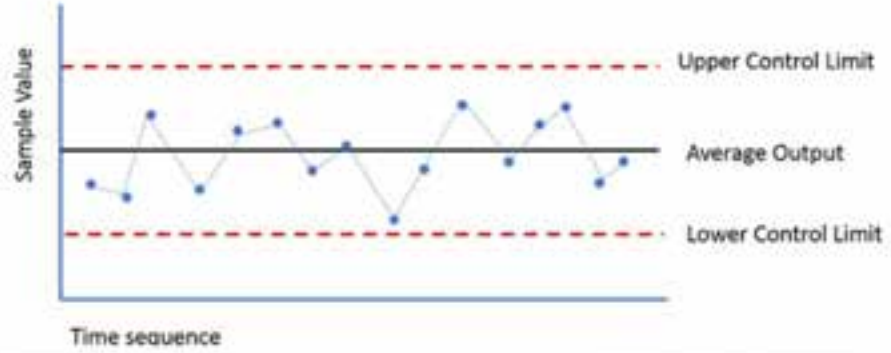
Metric: Percentage of mandatory training elements within date, across all staff groups at month end.
Plan: Trust internal plans: 90%.
Rationale: ICB Contract metric.
Data quality: Assured, validated data.
Trend: NTHFT: February performance lower than expected threshold. STHFT: Decreasing compliance. It has been evidenced that the rate of staff not attending for face-to-face training increases at times of winter pressure.
Assurance: NTHFT: Alert. February beyond expected variation. STHFT: Alert. 7 consecutive months of decreasing performance, more recently beyond expected variation.
Action taken: The focus of the next phase of the Mandatory Training Oversight Group is to ensure that the correct competencies are assigned to roles. Focus on medical staff compliance improvements. Exploring use of text messaging reminders to reduce DNA rates.
Executive lead: Chief People Officer
Accountable to: People Committee

WELL LED Cumulative YTD Financial Position (£'millions)

Metric: Cumulative year to date financial position.
Plan: Trust plans agreed with ICB. NTHFT submitted a breakeven plan for 2024/25. The STHFT control total for 2024/25 is a £7.8m 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 11 plan for both NTHFT and STHFT.
Action taken:. Financial controls in place, focus on recurrent efficiency delivery, and oversight of financial risks through Resources Committee.
Executive lead: Chief Finance Officer
Accountable to: Resources Committee

OVERVIEW SPC CHARTS

Statistical Process Control (SPC) charts with indicators of variation and assurance, are utilised where applicable, in line with the best practice standards of Making Data Count.



High level Key - Variation

High level Key - Assurance

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Thank you

University Hospitals Tees

NTHFT Perinatal Quality and Safety Report for Quarter 4 2024.25

Meeting date: *8th May 2025*

Reporting to: *Group Board of Directors*

Agenda item No: 20

Report author: *Hannah Matthews, Interim Head of Midwifery and Stephanie Worn; Group Director of Midwifery*

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

Delegation status: Jointly delegated item to Group Board

Previously presented to: *Perinatal Services Quality Assurance Council and Quality Assurance Committee*

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

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

Maternity and Newborn Safety Investigation – The Trust reported one event to MNSI which was accepted. Staff have been provided with support and directed to relevant agencies linked with the trust.

Stillbirth: the service reports a 12month rolling rate of 3.9% per 1,000births. In addition to the perinatal mortality review tool, thematic review is in development for due diligence.

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.

Service Transformation:

Maternity Triage: phase one towards a formal triage service aims to launch phase one at the end of May. Training will start in May for all staff, with communications planned to inform both the wider Trust and service users.

Key performance metric: Apgar scores under 7 at 5minutes of age: the service noted an increase of these scores in quarter 4 and this has been demonstrated via the NENC LMNS maternity dashboard. Learning from other Trusts has taken place, with a comprehensive audit tool developed by a NENC Trust being shared and an audit is in progress. The service intends to report on the new-born Apgar score under 7 at 5minutes of age in April.

Elective Caesarean Sections

Pressures was experienced in quarter 4 in relation to the demand of elective CS, this is both due to a rise in complexities during pregnancy and the availability of additional lists. This has been raised as a risk on the trust risk register and an initial meeting was undertaken by maternity and CG3 where initial discussions and actions were raised. A further meeting has been scheduled in April to look at progressing actions that were initiated; including change of start time, additional midwifery staffing and the possibility of an all-day elective list.

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

Recommendations:

The members are asked to receive and note the content of the report

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North Tees and Hartlepool NHS Foundation Trust

Meeting of the Group Board of Directors
8th May 2025
Maternity and Neonatal Services Safety and Quality Report for Quarter 4 2024/25

1. Introduction/Background

The purpose of the report is to inform and provide assurance to the Group Board of Directors that there is an effective system of clinical governance in place monitoring the safety of our perinatal services with clear direction for learning and improvement.

The data within this report is for Quarter 4 of 2024/25. This report contains the perinatal quality surveillance model dashboard and report for March 2025 (Appendix 1 and 2). Where any data provided sits outside this reporting timeframe, this will be specified within the report. This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020).

2. Perinatal mortality rate

In Quarter 4, the 12 month rolling annual stillbirth rate per 1000 births of 3.9% (exclusive of medical termination of pregnancy). The 12 month rolling neonatal death rate per 1000 births of 0.37, inclusive of early and late neonatal deaths. On average, the Trust has 200 births per month.

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

Mothers and Babies: Reducing Risk through Audits and Confidential Enquires-UK (MBRRACE-UK) collects data on perinatal death defined as babies born without signs of life from 22 weeks gestation to term and neonatal deaths at any gestation up to 28 days of age, excluding terminations of pregnancy. The definition for Stillbirths is from 24 weeks.

All eligible perinatal deaths have met the required standards of notification, parental input and multidisciplinary team (MDT) review. On a monthly basis the number of cases and key learning points are reported to the Quality Committee and quarterly to the Group Board of Directors.

2.2 Learning from PMRT reviews in Quarter 4 2024/25

A rapid response to learning is undertaken to identify and action any immediate learning until the full PMRT review has been completed within the expected timeframe. Learning points from review meetings were, to consider additional fetal surveillance investigations if indicated on clinical assessment.

tal Safety Investigations

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3.1 Background

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

3.1.1 Babies

Babies who meet the criteria for investigation include all term babies born following labour (at least 37 completed weeks of gestation), who have one of the following outcomes are:

- Intrapartum stillbirth.
- Early neonatal death.
- Severe brain injury diagnosed in the first seven days of life.

3.1.2 Mothers

Mothers who meet the criteria for investigation are direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy. MNSI do not investigate cases where suicide is the cause of death.

3.2 Reported and investigation progress update

MNSI were notified of one events that met the eligible criteria in quarter 4. Table 1 outlines the compliance requirements for MIS year 6. The case in March was reported to early notification however was not accepted due to the circumstances of the case.

Table 1 MNSI reporting compliance for quarter 4

MNSI and NHSR Early Notification scheme	Eligible cases	completed
Eligible cases reported to MNSI	1	1
Eligible cases reported to NHSR EN	0	NA
Family informed of MNSI, EN scheme and duty of candour	1	1
Trust Claims reporting wizard completed	0	NA

3.3 Safety recommendations and learning from completed investigations

The Trust had three completed MNSI investigations for quarter 4. Limited information is shared within this report to minimise patient identifiable details and a full report is provide to the Group Board of Directors In-Committee.

3.4 Coroner Reg 28 made directly to Trust

No requests made in this reporting period.

4. Maternity events

The service reports five moderate graded events inclusive of postpartum haemorrhage of >1.5l. All events that have been graded as moderate harm and above are discussed at the trust response-planning meeting, attended by the patient safety team and chaired by the patient safety operational lead.

Table 2. Grading of events

Event	January	February	March	Total
No Harm	53	46	57	**156**
Low Harm	32	27	26	**85**
Moderate Harm	1	1	3	**5**
PSII	0	0	0	**0**
Total	**86**	**74**	**86**	**246**

4.1 Maternity and /or neonatal services suspension/divert/closure

The maternity service reported no diverts for quarter 4. The Special Care Baby Unit (SCBU) did not report any closures in quarter 4.

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

In October 2022, the Maternity Services were placed on the Maternity Safety Support Programme (MSSP) following a review by the CQC, which rated Maternity Services as

Requires Improvement. The Trust are working with the Simon Mehigan - named Maternity Improvement Advisor. In May 2023 the exit criteria from the MSSP was agreed by Trust, ICB and NHSE, with an addition in November 2023. There are 7 elements are:

- Workforce
- Leadership
- Quality, risk and safety
- Digital
- Improvement plan
- CQC
- Communications

Following a review by the named Maternity Improvement Advisor the service is able to demonstrate attainment of the exit criteria. The process for exiting the MSSP is on hold during the development of the Group Model for University Hospitals Tees.

6. Three year delivery plan for maternity and neonatal services.
The service continues to work towards requirements set out in the Maternity and Neonatal three year service delivery plan with an objective of meeting. Current compliance is set out as below:

Theme	Compliance
Theme 1 – Listening to and working with women and families with compassion. 3 x Objectives/ 12 x trust responsibilities	57%
Theme 2 – Growing, retaining and supporting our workforce. 3 x objectives/ 12 x trust responsibilities	75%
Theme 3 – Developing and sustaining a culture of safety, learning, and support. 3x objectives/ 16x trust responsibilities	75%
Theme 4 – Standards and structures that underpin safer, more personalised and more equitable care. 3x objectives/ 9x trust responsibilities	75%

7. NHS Resolution Maternity Incentive Scheme (MIS)
The service is awaiting the outcome of compliance with the 10 safety actions set out by MIS year 6. The launch of year 7 is expected in April 2025.

8. Saving Babies Lives Care Bundle version 3
The Saving Babies' Lives Care Bundle is a group of actions that have been put together to reduce stillbirth. Each element has a specific action plan against it and together, these have now been shown to save babies' lives. The service declared compliance for all 70 interventions.

9. Avoiding Term Admissions into Neonatal Unit (ATAIN) Rates
This is a programme of work to reduce avoidable admissions to a neonatal unit for infants born at term (over 37 weeks gestation) paralleled by reducing separation of mother and baby. The National ambition is a rate below 6%. A total of 28 (4.6%) >37weeks gestation babies were admitted to SCBU in Quarter 4. The main reason for admissions to SCBU was respiratory distress with 18 (64%) babies admitted. The audit meeting has been extended to include the MDT. An improvement action plan of learning is shared at the maternity and neonatal safety champions meetings which includes the perinatal quadrumvirate. Monthly updates are reported at the perinatal services improvement group and quarterly to the LMNS. Respiratory distress is the planned focus for a perinatal Quality Improvement with the aim to reduce the amount of babies requiring admission for this reason. The service continues progress towards offering transitional care to late preterm babies against the action plan previously approved by the Board of Directors with an expectation this will be in place at by the end of Q1.

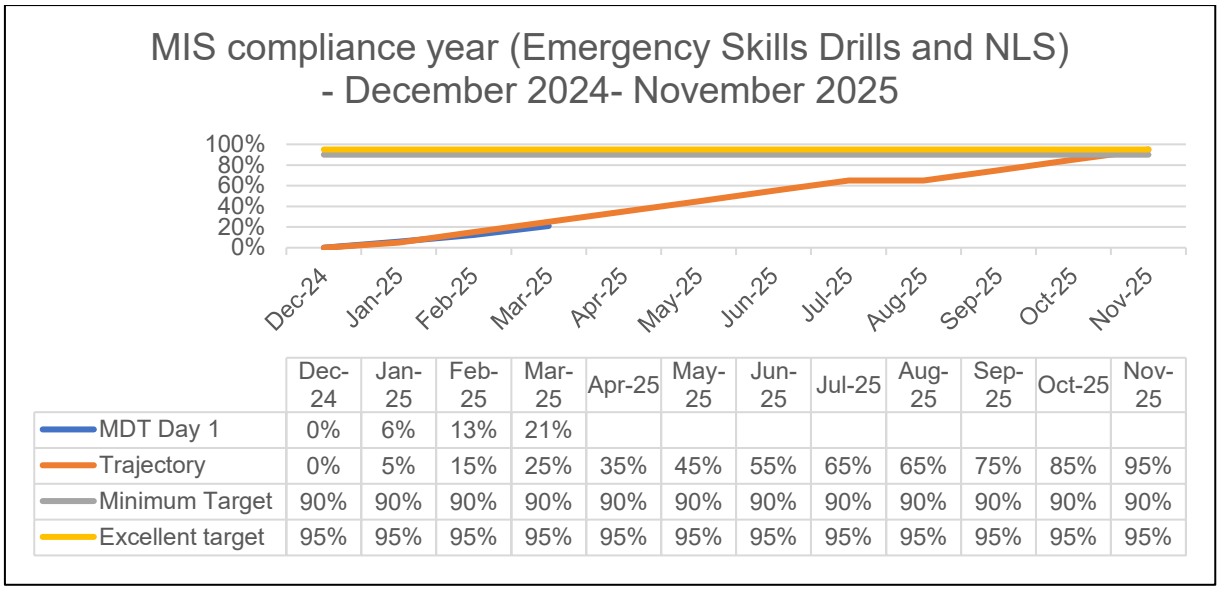
10. NENC Local Maternity and Neonatal System (LMNS) The service engages with the LMNS and shares quality and safety intelligence via the quarter returns presented at the LMNS Board, learning meetings and shared at the local Trust quarter meetings. The LMNS report into the ICB and regional oversight meetings. The Trust received the LMNS assurance report following a visit in November 2024, and the service continues to work towards meeting compliance of the actions set out in the LMNS assurance report.

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

11.1 Core Competency Framework v2 (CCFv2) year 2

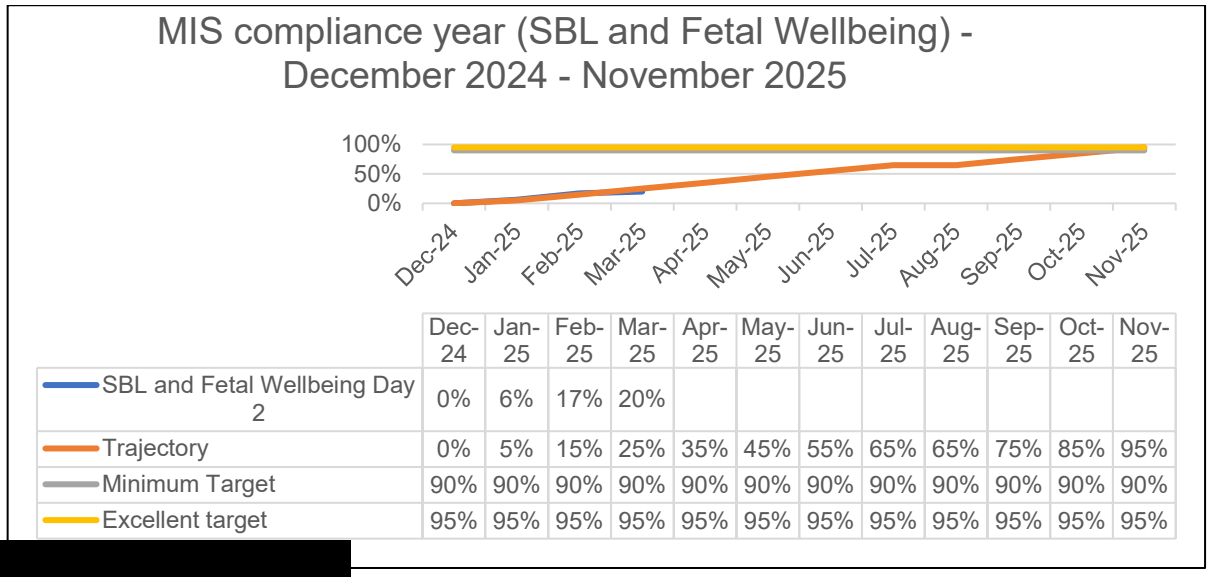
The Trust has worked in collaboration with the NENC Local Maternity and Neonatal System (LMNS) to develop a maternity training syllabus to meet the requirements of Core Competency Framework v2 (CCFv2), supporting standardisation of training, servicer user involvement and shared resources. The service declared compliance for MIS year 6. The service remains a core member of the NENC LMNS education faculty that is developing a 2025.26 syllabus. The obstetric and neonatal department Trust core 10 mandatory training is shown in Table 4. Compliance will continued to be monitored monthly and to support staff to access training.

Graph 3. MDT obstetric emergencies skills and newborn life support



	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
MDT Day 1	0%	6%	13%	21%								
Trajectory	0%	5%	15%	25%	35%	45%	55%	65%	65%	75%	85%	95%
Minimum Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Excellent target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Graph 4. Fetal monitoring training



	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
SBL and Fetal Wellbeing Day 2	0%	6%	17%	20%								
Trajectory	0%	5%	15%	25%	35%	45%	55%	65%	65%	75%	85%	95%
Minimum Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Excellent target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Caring Better Together

Table 4. Perinatal workforce Trust Mandatory Core training

Staff group	January	February	March
Midwifery and support staff	89.35%	90.03%	86.4%
Medical	77.88%	78.05%	78.4%
Neonatal Nursing and support staff	99.22%	99.21%	96.5%

12. Insights from service users

12.1 Complaints and compliments overview

The monthly numbers of both complaints and compliments are outlined in Table 5 and Table 6 formal complaints within quarter 4 related to:

- Care provided
- Lack of compassion
- Communication

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

Table 5. Complaints

Complaints	January	February	March	Total
Stage 1	2	4	3	**9**
Stage 2	3	0	1	**4**
Stage 3	1	0	0	**1**
Total	**6**	**4**	**4**	**14**

Table 6. Compliments

Compliments	January	February	March	Total
Care provided/compassion	58	48	44	**150**

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

The service continues to monitor friends and family test feedback, triangulating data with complaint themes. The latest results outlining positive feedback are identified in the Table 7.

Table 7. FFT

	January	February	March
Positive %	94.7%	100%	100%

12.3 Trust Claims Scorecard.
An overview update is provided in appendix 3

12.4 Service user insights from Maternity and Neonatal Voice Partnership (MNVP)
The MNVP meet with the senior leadership team on a monthly basis where feedback is shared from service users, local and regional forums. Other agenda items include work plans, and engagement opportunities. The MNVP regularly attend meetings within the governance structures, reflected in the Terms of Reference membership such as; Board safety champions, perinatal services improvement group, perinatal quality assurance council, PMRT and the MNVP quarterly meeting. Current projects include:

- Development of an action for the 2024 CQC maternity survey
- Progress position towards the 2024.25 work plan
- Progress position towards the 2023 CQC maternity survey

Due to personal reason of the current MNVP chair, the service will be advertising for a new chair early in Q1 2025 to take over this pivotal role. The service is currently engaging with the local population in view of an available MNVP chair position and plan to release the role to advert in April 2025. The service has informed the NENC LMNS of the recruitment plan.

12.5 Service user insights taken from a recent CQC peer review

The service has met the requirements of the action plan set out in the CQC maternity survey action plan, this surrounded mainly the introduction of the maternity EPR system in improving communications and information giving.

13. Community midwifery services

13.1 Continuity of Care

There is no longer a national target for Maternity Continuity of Carer (MCoC). Local midwifery and obstetric leaders should focus on retention and growth of the workforce, and develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths. NHS England expects the trust to continue to review our staffing in the context of the Ockenden final report. The Trust position is to maintain the one MCoC team and not to expand until the building blocks of a workforce are achieved. A project to explore an enhanced maternity model of care is underway; focus on those women from vulnerable groups who will benefit the most from this model. The local LMNS, regional and national colleagues are available to support the trust with this.

13.1 Progress to Date

Table 8 outlines the current percentage on a continuity pathway with the MCoC team (Rowan) i.e. the same team of midwives looking after women throughout their antenatal, intrapartum labour and postnatal care.

Table 8. Maternity Continuity of Carer (Rowan) Percentage

	% of women who are on a MCoC pathway at 29 weeks	% of women who are from the BAME community on a MCoC pathway at 29 weeks	% of women who live in the 10% most deprived on a MCoC pathway at 29 weeks	% of women who were cared for in labour by their continuity team	No births: UHH	No of births: Home
January	7.4%	3.1%	11.3%	6.2%	2	2
February	8.8%	3.3%	8.3%	14.3%	2	1
March	8.2%	10.9%	5.8%	5.9%	0	1

Due to a change in risk factors, the number of women that receive continuity of care through the intrapartum period is lower than the above figures. With support from the Trust's public health team, the service identified there was area for future development to explore enhanced continuity of care to progress the National maternity safety ambitions. A scoping project to understand population demographics will be developed to influence enhanced models of care.

Table 9 shows the current percentage of women who have antenatal care plans recorded by 29 weeks, with CoC pathway indicator and record of teams providing care. The data is submitted to the National maternity dashboard and quarter 4 demonstrates compliance.

Table 9. Antenatal MCoC antenatal pathways

Continuity of Care	January	February	March
i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed	96.7%	98.4%	96%
ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.	100%	100%	100%

14. Quality improvement and research

14.1 Research midwifery team

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

Study Name - Obstetrics	Status
COPE – Carboprost vs Syntocinon as first line treatment for PPH	Active Recruited 209
ROTATE – RCT of manual vs instrumental rotation of the fetal head in malposition at birth	Finished Recruiting 18 participants
iGBS3 – Cord blood for research into GBS protection	Finished Recruiting 2810 participants
iHOLDS – High or low dose syntocinon for IOL	Active Recruited 176
MiNESS – Mothers working to prevent early stillbirth	Active Recruited 11
TTTS Registry – Multiple Pregnancy Registry	Active Recruited 34
SNAP3 – Enhanced support NRT offered for preloading, lapse recovery and smoking reduction – impact on smoking in pregnancy	Active Recruited 52
INGR1D2 – Identification of infants with increased type 1 diabetes risk for enrolment into primary prevention trials	Active Recruited 2784
OBS PPH UK – Obstetric Bleeding Study	Active
SNAP2 – Smoking, Nicotine & Pregnancy 2	Active Recruited 2

14.2 Quality Improvement Lead

Postpartum Haemorrhage (PPH)

An initial spike in PPH rates was seen in January and February. A deep dive was undertaken and themes identified with the MDT across maternity and theatres along with the introduction of Carbetocin and pre made syntocinon infusions and March has shown an improvement with a current rate of 2.48%.

Mechanical Induction

Ongoing work to extract data for mechanical induction rates as first line management, including prostin spend, bed stay and patient experience. 90% of induction of labour is via mechanical induction of labour.

Smoking

The service has seen a significant improvement in referral rates in the acute since the new process and focusing now on the offer of nicotine replacement therapy (NRT) on admission. [redacted]ing through sign off on the new protocol and then will proceed to

support the aim of the offer of NRT to all smokers on admission. Hartlepool work is now completed which has shown sustainable improvement and the maternity assistants in Stockton to improve their compliance with the LMNS pathway. Current smoking rate are sitting on average around 9.79%.

NeoTRIPS

This projects aims to provide a premature infant with breastmilk. The service has seen a significant improvement (based on our average rates of 16% at the start of the project). The service achieved 100% in some months however, this has reduced over the last few months where engagement from maternity teams has been limited, this has been escalated and an action plan put in place.

Nexplanon Service

A working group has been initiated with the aim of first filling the first 10 places for training and looking at the service can start to be offered.

14.3 Retention, Recruitment and Pastoral Support Midwife

Within Q4 there the service has successfully appointed an additional Recruitment, Retention and pastoral support midwife to further develop the team. The service has seen a number of appointments during the quarter including

- The first legacy Midwife
- 5 x band 5's
- 4 x band 6's
- 1 x Vaccination Nurse
- Successfully organised the largest recruitment café for Newly Qualified Midwives resulting in 12 permanent positions with a further 6 on the waiting list.

There is a number of retention initiatives being undertaken including the perinatal staff council, with representation from all staff groups. Sleep boxes were provided to all maternity staff, including doctors, SCBU staff, administrate personnel and management to support wellbeing. Priorities for Q1 includes development in on boarding new staff members to ensure a smooth transition, ongoing support to newly qualified staff members to facilitate progression to band 6 and ensure internationally educated midwives are fully supported in their transition to Band 5 status.

14.4 Infant feeding and health in pregnancy specialist services

NTHFT population have some of lowest rates of Breast Feeding at a NENC and national level. A proposal is being developed to targeted support within the immediate postnatal period by support workers dedicated to infant feeding support. A new Infant feeding midwife has been appointed and the postnatal staffing model has been adapted to include an infant feeding midwifery support worker which is currently out to advert. Ongoing audit being undertaken ahead of Stage 2 BFI assessment with a monthly two-day infant feeding training between January – July. Plans for Q1 include preparation for stage

2 assessment and full staff audit including the reviewing of all curriculum and guidelines prior to submission. There is ongoing collaboration with neonatal services to prepare for the neonatal element.

14.5 Digital Specialist Midwife

Perinatal system analyst commenced in role 11th November 2024, the role has allowed the digital midwife role to expand significantly. The system Analyst is running daily, weekly and monthly reports from the BadgerNet system which acts as failsafe for documentation. The service is looking to increase the number of reports to include missing blood groups to support auditing for Anti-D.
The referrals in the BadgerNet system have multiplied since the original implementation of BadgerNet, some of which are very important for patient safety i.e. care plans for Community Midwives from Maternity Assessment Unit. Daily reports are produced to ensure all referrals sent from the previous day have been successfully sent.
Digital antenatal clinics have been set up within the system this quarter within the BadgerNet system which enables the Midwife to appoint the next review on BadgerNet. This appointment can be viewed in Badger Notes to enable women to keep a record of all upcoming appointments. The matrons have decided to remove all paper antenatal clinic diaries on 1st April 2025 to prevent confusion between paper and digital appointments. This system provides oversight for management to be able to review capacity in the community antenatal clinics. Additionally, this will hopefully reduce DNA's and also phone calls to the community office from women asking for confirmation of their next appointment.

Digital Inclusion
We now offer a service to women who are digitally excluded, meaning they are unable to access their Badger Notes due to insufficient mobile data or access to a mobile device. A referral has been created on the BadgerNet system to enable staff to refer to us for this service. Since its implementation, we have gifted the following: Data: 4 women Devices: 2 women We would like to promote this work by arranging a stall in the Trust alongside the charity who refurbishes the devices (FurbdIT) to try and increase donations to this charity for anyone who has an old mobile device.

14.6 Bereavement Specialist Midwife
Bereavement care champions have received training and will be able to support bereavement care on a 24/7 basis.

14.7 Practice Placement Facilitator Midwife (PPF)

The service continues to facilitate smooth placements for students aligning with their learning objectives and the PPF lead is heavily involved with the ongoing midwifery curriculum. There is ongoing work towards Safe Learning Environment Charter (SLEC) priorities and two nurses have commenced on the MSc Midwifery programme. The service is pleased to report that a number of student midwives that trained within the trust have secured band 5 positions within the trust.

14.8 Fetal Monitoring Midwife

SBL Audit

The audit methodology was changed between Q2 & Q3 to ensure compliance with the NENC tool, which includes:

- Ensuring hourly & peer review conducted on formalised assessment tool (fetal monitoring labour review tool FMLR)
- Risk assessment completed on formalised tool
- Peer review completed within 15min of original hourly review

A decrease in compliance was noted in Q4, and on discussion with the LMNS, this has been reflected across the system. An action has been developed to include:

- Buddy system
- Handover/ nightshift process

Fetal wellbeing Training

Q4 teaching days 100% compliance with end of day exam with continued positive feedback via slido results. Teaching to be altered against the training needs analysis and new exam prepared with NENC LMNS for April 2025. Weekly teaching has been recommenced in November and a rota created to ensure appropriate attendance. Monthly themes to be shared at obstetric teaching afternoon.

Equipment

Ongoing work with medical engineering department as an increased number of broken equipment related to CTG machines. An official complaint was raised with Huntleigh over poor standard of plastic within their equipment. A process has been mapped and implemented to track all equipment being sent for repairs to ensure oversight.

15. Culture and Leadership

15.1 Board level safety champion meetings

Safer maternity care called on maternity providers to designate and empower individuals to champion maternity safety in their organisation. The board-level maternity safety champion will act as a conduit between the board and the service level champions. The role of the maternity safety champions is to support delivering safer outcomes for pregnant women and babies. The meetings are held with the Executive Board Champion, Non-Executive Director Maternity Champion, the Obstetric, Midwifery and Neonatal Safety Champions, representative from Maternity and Neonatal Voice Partnership, Neonatal Matron, and Clinical Director, Interim Head of Midwifery, perinatal quadrumvirate and the Patient Safety, Risk and idwife. The meetings are bi-monthly, followed by a walkabout of the

clinical areas. National, Regional and system developments are discussed along with audits, dashboard metrics, service feedback, improvement plans for ATAIN and the optimisation Bundle. The perinatal quadrumvirate provide regular feedback and inform the members of progress and intelligence shared by peer 'perinatal quads'. There are no items for escalation for quarter 4.

The feedback from the perinatal walkabouts are:

- The overall impression was positive. Staff were able to articulate the staffing position and actions taken to improve service provision and flexible working. Current changes to senior leadership meant there are current opportunities available for staff to apply internally for development opportunities.

15.2 Advocating for education and quality improvement (A-equip) and professional midwifery advocacy themes

No update for quarter 4.

15.3 Perinatal Culture and Leadership Programme

Participation in the regional perinatal leadership development programme by members of our QUAD and culture coaches.

15.4 Opportunities and development

The team are developing an implementation plan for the culture coaches.

16. Risk register

There are eleven open risks, graded as:

- 5 x moderate
- 4 x low risk
- 1 x very low

oval (Moderate Risk)

In line with the Trust risk management process, risks raised by the service are developed by the service and are reviewed in the weekly Care Group SMT meeting. From here they go to the weekly Operational Delivery Group meeting for discussion and review by the team and then to Risk Management Group. Additionally, risks are raised at the Maternity Quality Assurance Council, through Quality Assurance Committee to Board.

17. Key issues, updates, significant risks and mitigations

Maternity Triage – Maternity Triage phase one is planned to go live at the end of May. A staff consultation paper is in progress die to a change in working hours as the service is to become 24hour / 7 days a week. Current processes have been developed to ensure women are triaged within a specified time frame, in relation to presenting complication of pregnancy. Training will start in May for all staff and we plan to ensure trust communication involvement in sharing this with the wider trust and our families.

Apgar scores under 7 at 5minutes of age: the service has noted an increase of these scores and this has been demonstrated via the NENC LMNS maternity dashboard. Learning from other Trusts has taken place, with a comprehensive audit tool developed by a NENC Trust being shared and an audit is in progress. The service intends to report on the new-born Apgar score under 7 at 5minutes of age in April, The team have undertaken a retrospective audit which will be presented during the month of April.

Stillbirth rate: The Service reports and investigates eligible cases through the PMRT process which identifies areas of learning. A deep dive into events from 2024 is in progress to further identify any themes for due diligence.

Elective caesarean section (C/S) - Pressures was experienced in quarter 4 in relation to the demand of elective CS, this is both due to a rise in complexities during pregnancy and the availability of additional lists. This has been raised as a risk on the trust risk register and an initial meeting was undertaken by maternity and CG3 where initial discussions and actions were raised. A further meeting has been scheduled in April to look at progressing actions that were initiated; including change of start time of lists, additional midwifery staffing and the possibility of an all-day list.

18. Assurance and Recommendations

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

Appendices

Appendix 1. Perinatal quality surveillance model dashboard.

Appendix 2. PQSM for March 2025

[redacted]ecard

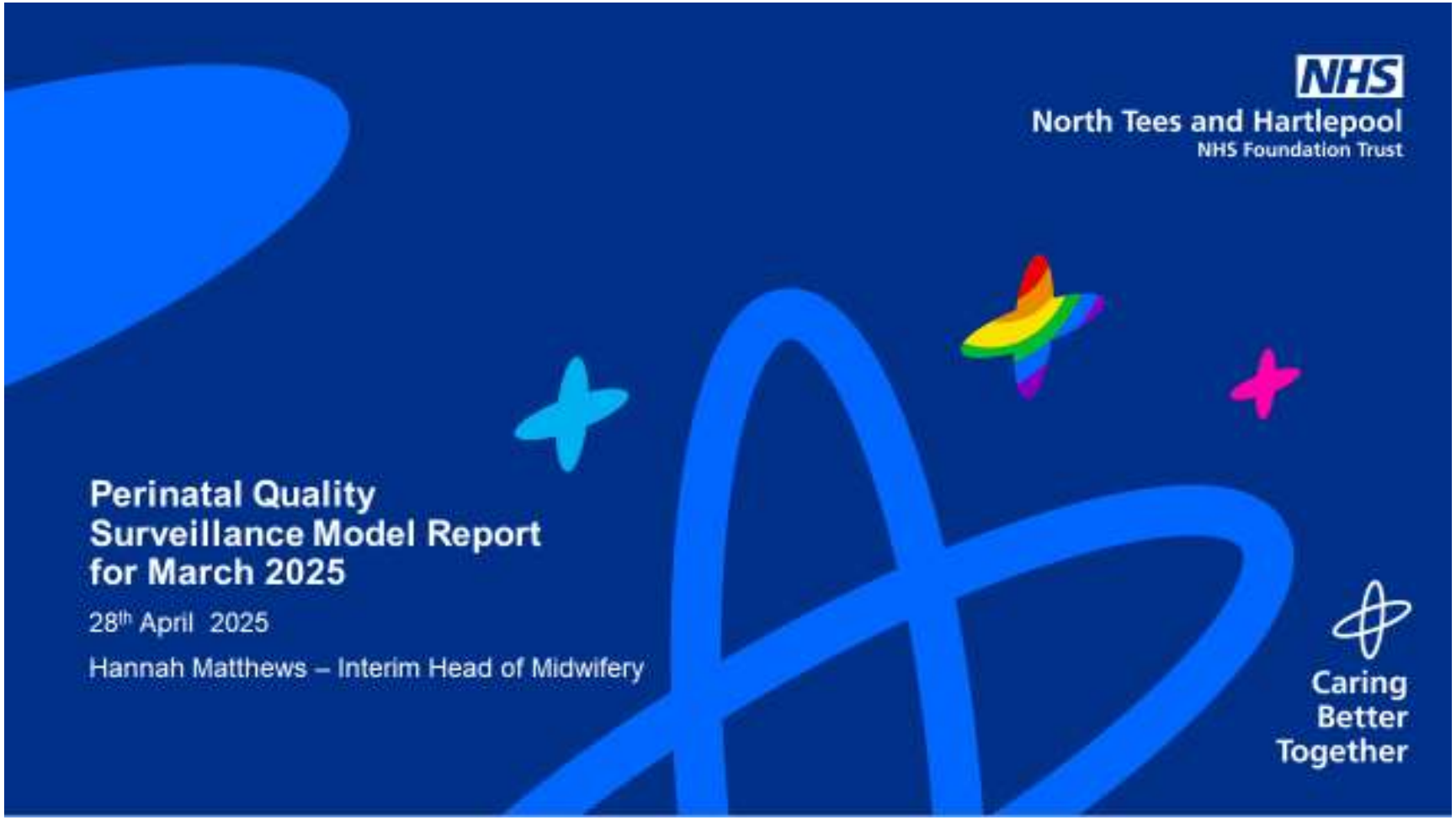
Appendix 1

University Hospitals Tees

CQC Maternity Ratings	Effective: RI	Caring: Good	Well-Led: RI	Responsive RI	Maternity safety support programme: YES

	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan 2025	Feb 2025	March 2025
1.Findings of review of all perinatal deaths using the real time data monitoring tool	NA	1 learning point	NA	2 learning points	NA	1 learning point	No learning points identified	No learning points identified	NA	NA	NA	2 learning points
2. Findings of review of all cases eligible for referral to MNSI	NA	NA	NA	Escalation process	NA	NA	NA	NA	NA	NA	NA	1 active review
Report on: 2a. The number of events logged graded as moderate or above and what actions are being taken	<5	<5	7	6	0	1	3	1	1	1	1	3
2b. Training compliance for all staff groups in maternity related to core competency framework **MDT skills** and **fetal wellbeing**	80% 90%	88% 94%	88% 92%	83% 94%	83% 94%	83% 83%	78% 76%%	98% 96%	98% 96%	New trajectory year 6% 6%	17% 13%	21% 20%
2c. Minimum safe staffing in maternity services to include **Obstetric cover** on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively (**midwife V birth ratio, 1:19**)	100% 1:20	100% 1:21.5	100% 1:22.4	100% 1:17.8	99.4% 1:18.9	100% 1:19.9	100% 1:21.4	100% 1:18.3	100% 1:17.4	100%	100% 1:17.9	100%
3.Service User Voice Feedback – positive %	95%	82%	90%	83.3%	100%	95%	80%	100%	85.7%	94.7%	100%	100%
4.Staff feedback from frontline champion and walk-abouts (bi-monthly)	Ward 22	No formal walkabout	DAU	Delivery suite	DAU and Delivery Suite	Women and Children's Clinical Board Triumvirate	Ward 22	Peterlee community	Hartlepool community	No formal walkabout	Delivery suite	
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
6.Coroner Reg 28 made directly to Trust	No	No	No	No	No	No	No	No	No	No	No	No
7.Progress in achievement of CNST 10	Yr 6 - In progress	Yr 6 in progress	Yr 6 in progress	Yr 6 in progress	Yr 6 in progress	Yr 6 in progress	Yr 6 in progress	Yr 6 in progress	9/10 compliance	Declared 9/10 compliance	Awaiting NHSr result	Awaiting NHSr result

To work	**Receive treatment**
2023 49.95%	53.66%
2022 45.42%	69.63%
2024 – 82%	


NHS
North Tees and Hartlepool
NHS Foundation Trust
Perinatal Quality Surveillance Model Report for March 2025
28th April 2025
Hannah Matthews – Interim Head of Midwifery
Caring Better Together

CQC Maternity Ratings 2022	Safe	Effective	Caring	Responsive	Well-Led	Overall
	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Key performance indicators Trust value / average NENC or National

Smoking at Booking	12.38% / 11.00%	
Venous Thromboembolism (VTE)	81.06% / 95.00%	
Right place of Birth	98.51% / 100%	
Number of Births	202	
Preterm Births (22+0 - 36+6 weeks)	14	
Induction of Labour	48.51% / 46.90%	
Obstetric Haemorrhage >1.5L	2.48%	
Obstetric Haemorrhage >1.5L (per 1000 births)	31.18	
3rd / 4th Degree Tear Rate	0.50%	
Still Birth Rate (per 1000 births)	3.94 / 2.9	
Neonatal Mortality (per 1000 births)	0.00 / 1.6	
Smoking at Delivery	10.89% / 11.00%	
Breastfeeding at first feed	53.50% / 74.40%	
ATAIN	5.00% / 6.00%	
APGAR <7 @ 5 Mins (per 1000 births)	41.23	

Narrative

Obstetric Haemorrhage
The service continues with the quality improvement project and is in discussions with a national research team offering a care bundle to reduce PPH. There has been a decrease in PPH in the month of March with 5 PPH's recorded and a percentage of 2.48%. The service will continue to monitor PPH rates in view of more recent interventions including introduction of administration of carbetocin at caesarean section.

Stillbirth
Two stillbirths recorded in the month of March that meet the criteria for PMRT reporting. One case is eligible for reporting to MNSI and this process has been completed, with the service awaiting further contact. An initial rapid response has taken place for both cases with initial rapid learning and actions disseminated to the clinical areas. The stillbirth rate currently shows a rate of 3.94% per 100 births which is above the MBRRACE comparator 2023 average of 2.8% - a deep dive review for 2024 in underway.

Breastfeeding
The infant feeding specialist midwife continues to train and educate staff, and promotion of the use of the infant feeding care plans. The service continues its drive to stage accreditation which is planned for June. The team has experienced some changes in which a band 7 infant feeding specialist has commenced at 0.64WTE and the service is currently advertising for an infant feeding MSW.

Smoking at time of delivery
Ongoing targeted work to reduce smoking at time of delivery, this has seen an increase in the rates during the month of February and March due to these women declining support for smoking cessation.

Apgar score <7 at 5minutes of age
The APGAR score provides an indication of the newborn's transition to extra-uterine life. There has been increase in APGAR scores <7 at 5 minutes, however, this has had no impact on the number of admissions to SCBU. To gain a further understanding, a retrospective audit was being undertaken and the results of this will be shared in April 2025.

There are national recommendations published by the RCOG for consultant attendance in certain clinical emergency scenarios in obstetrics. The Q4 audit has reported 100% compliance with the standards

Descriptor	Latest Value	Narrative
Findings from review of all perinatal deaths.	**March** — **Stillbirths** <5; **Neonatal deaths** 0	**PMRT - Learning & action from recent case reviews** Of the 2 stillbirth, the PMRT is in progress **Maternity and Neonatal Safety Investigation (MNSI)** 1 new case reported. The service received three completed MNSI reports for suspected or confirmed HIE and one PSII report. An over arching action plan has been developed and shared with members of the Quality Oversight Group **Coroners Inquests and Regulation 28. Prevention of Future Deaths Reports** Maternity Services have not had any cases which have been reviewed at a coroners inquest **Maternity Incentive Scheme year 6** Following submission of the declaration of compliance with nine safety actions to NHS resolution confirmation of compliance will be provided in April **Booking by 9+6weeks** The accepted standard is 50% with an achievement threshold of 66%. The service is undertaking a review to identify appropriate actions or geographical areas where further support is needed **Consultance attendance Audit** There are national recommendations published by the RCOG for consultant attendance in certain clinical emergency scenarios in obstetrics. The Q4 audit has reported 100% compliance with the standards
Findings of review of all cases eligible for referral to MNSI	**March** — **MNSI** 1; **PSII** 0	
MNSI/NHSR/CQC or other organisation with a concern or request for action. Maternity Safety Support Programme	**CQC must do's -** ongoing monitoring **MSSP -** continued work with Simon Mehigan (Maternity Improvement Advisor)	
The number of events logged graded as moderate or above	98 events (49 closed at time of reporting) x 3 Moderate harm / x 26 Low harm / x 71 No harm	
Progress with Maternity Incentive Scheme (MIS) Year 6	Confirmation from NHS resolution expected in April	

Descriptor	Latest Value	Narrative
Service User Feedback – Friends & Family Test (FFT)	100% positive feedback (6 responses Obstetrics/ 3 Neonates)	**3 year delivery Plan** Ongoing monitoring and work towards meeting compliance with 3 year delivery plan requirements. A break down of compliance is provided in the perinatal quality and safety report for Q4. **The Maternity and Neonatal Voices Partnership(MNVP)** The current MNVP lead has stepped out of the chair role 1st April 2025, the service is working with communications to promote this role and encourage interested candidates to contact the professional lead to discuss the role, the advert is due to go live in April 2025 following initial engagement. **Board Maternity Safety Champions** A further safety champion walkabout is due to be undertaken on delivery suite in the month of April. The overall impression from the previous walkabout was positive. Staff were able to articulate the staffing position and actions taken to improve service provision and flexible working. Further work is required with regards to ward boards and action plan has been sent to ward managers. **Complaints** The themes for complaints remain unchanged; communication and waiting times. Further work is planned to understand what are the sub sections for communication to enable a responsive action plan. **Compliments** Compliments reflect satisfaction with care provided across the service with the highest number being submitted for care provided and compassion. **Leadership and culture** The Perinatal quadrumvirate leadership continue to be support by the Board Safety Champions. Bi-Monthly meetings are scheduled to include the perinatal quad, maternity and neonatal safety champions, Board safety champions and the MNVP. The SCORE survey action plan is in development.
Feedback from frontline staff on champions walkabouts	No walkabout this month	
Complaints	Stage 0 – 1 closed within 24 hours Stage 1: 3 Stage 2: 1 Stage 3: 0 No complaints received for neonates	
Compliments	44 received for Maternity 8 received for Neonates	
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	To work: 2023 49.95% Receive treatment: 53.66%	
Proportion of speciality trainees in obstetrics and gynaecology responding with excellent or good on how they would rate the quality of clinical supervision out of hours (reported annually)	82% 2024 report	
Chair log from Perinatal Quality Assurance Council (PQAC)	Accessibility tool for patient experience via website	

Workforce

RM vacancy position

	Sum of Budget	Sum of Actual	Sum of Variance	Projected 3 month (May 2025)	Projected 6 month (August 2025)
B5/B6 RN's/RM's	106.67	102.12 Includes 2.96 on mat leave/2 HRM's currently in supernumerary period.	-4.55 Removing mat leave/ supernumerary/non clinical = -9.51	-4.67 1.96 mat leave - 6.63	-3.57 4.4 known mat leave – 7.97
B7 Clinical and Specialist Midwives	28.51	30.02 Includes 3 on mat leave	+0.51 Removing mat leave = -1.49	-1.63 Removing 2 mat leave = -3.63	-1.58 removing mat leave = -2.58
Grand Total	136.18	132.14	-4.04/ -11.0	-6.3 / -10.26	-5.15 / -10.55

Workforce safe staffing metrics	
Obstetric labour ward cover	100%
Labour ward coordinator (LWC) Supernumerary LWC supernumerary at start of shift	98.8% 100%
1-1 care in labour	97.7%
Midwife to Birth ratio (1:19.5)	1:18.2
Registered midwife fill rate	79.5%
BAPM compliance	89.66%

Escalation process:

- Daily staffing huddles
- Escalation of specialist roles and management to work clinically
- Elective workload prioritised to maximise available staffing
- Relocate staffing to ensure one to one care in active labour and dedicated supernumerary LWC roles are optimised
- Activate the on call midwives from the community to support labour ward
- Supporting LW in the appropriate use of BR+ acuity tool and escalation decision making
- Activate neonatal nurse staffing escalation

Midwifery red flags

Category		comments
LWC supernumerary	2	Oversight of triage
1-1 care in labour	4	
Delay in IOL	1	
Time critical	3	Delay in ARM
Missed or delayed care	2	Delay in ARM
Delay in triage	1	

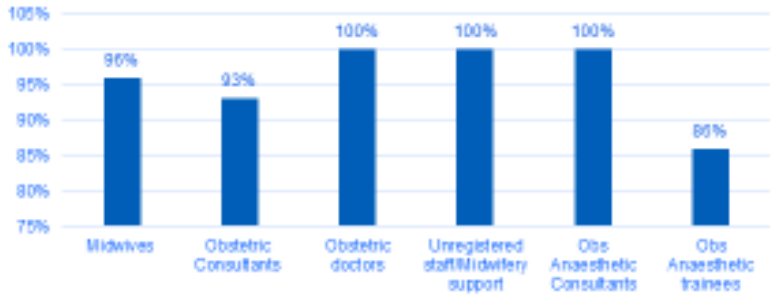
Training compliance

	MIS compliance year MDT skills		MIS compliance year Fetal wellbeing		MIS compliance Neonatal resuscitation		Trust Core 10
	In-month	In month Trajectory	In-month	In month Trajectory	In-month	In month Trajectory	In month
March	95%	100%	95%	100%	95%	100%	87.1%

12month rolling compliance overview

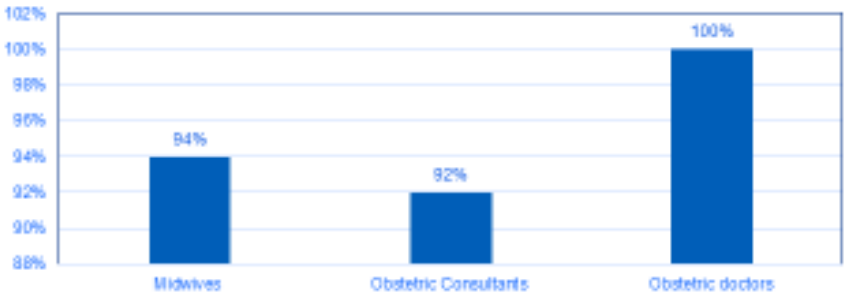
MDT Skills/NLS – staff groups

March 2024 – March 2025

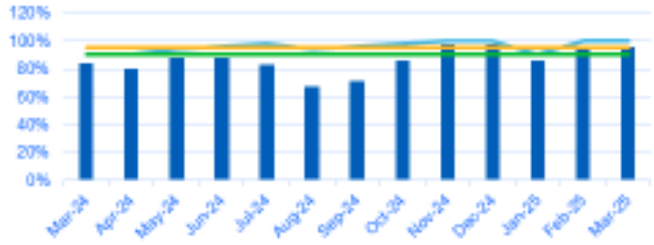


Fetal wellbeing – staff group

March 2024 – March 2025



March 2024 - March 2025
Day 1 MIS Compliance year



	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
MDT - Day 1	84%	80%	86%	88%	83%	67%	71%	86%	98%	98%	86%	97%	90%
Trajectory	90%	90%	94%	90%	98%	94%	90%	98%	100%	100%	90%	100%	100%
Minimum Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Excellent Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

March 2024 – March 2025

	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
SBL and fetal wellbeing - Day 2	92%	82%	94%	92%	94%	74%	80%	84%	96%	96%	96%	96%	95%
Trajectory	90%	90%	94%	90%	98%	94%	90%	98%	100%	100%	100%	100%	100%
Minimum Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Excellent Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Training compliance: all staff compliance

	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
MDT Day 1	0%	5%	13%	21%								
Trajectory	0%	5%	15%	25%	35%	45%	55%	65%	65%	75%	85%	95%
Minimum Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Excellent target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
SBL and Fetal Wellbeing Day 2	0%	5%	17%	20%								
Trajectory	0%	5%	15%	25%	35%	45%	55%	65%	65%	75%	85%	95%
Minimum Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Excellent target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Appendix 3 Claims scorecard update

University Hospitals Tees

North Tees and Hartlepool NHS Foundation Trust

Claims Scorecard (10 years of claims) Quarter 4 2025 (Jan Feb March)

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

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

Themes Q4 24-25

- Recording of Apgars and escalation for resuscitative support
- Escalation
- Communication

Complaints Q4 24-25

Communication – staff attitude
Care Provided
Access to services
Communication – felt staff did not take concerns seriously
Disjointed appointments

Learning Q4 24-25

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

Incidents Q4 24-25

PPH > 1.5litres
Timing of sections
Apgars <6 at 6 minutes
Term admissions
Escalation (Staffing Issues) impacting on service provision
Sample (Newborn blood spot)

Action Plan Q4 24-25 Not started | In progress | Completed

Working ongoing related to personalised care plans	By 30.9.25 (HM)	
Implementation of BSOTS	By 30.06.25 (GG)	
Review of stillbirth data	31.03.25 (LS)	
Apgar Audit / CTG	31.03.25 (AST)	
C Section Audit	30.04.25 (JL)	

University Hospitals Tees

STHFT Perinatal Quality and Safety Report Quarter 4 2024.25

Meeting date: *8 May 2025*

Reporting to: Group Board

Agenda item No: 20.1

Report author: *Tracey Gray Governance Lead Midwife and Steph Worn, Group Director of Midwifery*

Action required: Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: *Quality Assurance Committee*

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:

Safe

Board assurance / risk register this paper relates to:

Quality

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.

Operational support escalated following 10 datix reports submitted this quarter due to bed capacity and critical equipment storage related to loss of estate on ward 19. Discussions with the site leadership are in progress to resolve this issue.

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 service is holding engagement events for staff to address the recommendations from the NHSE diagnostic report.

The service training for neonatal staff is below trajectory die to sickness and absence however, an action plan will be developed to recover the training trajectory.

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

Recommendations:

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

Meeting of the Group Board of Directors
8th May 2025
Maternity and Neonatal Services Safety and Quality Report for Quarter 4 2024.25

1. Introduction/Background

The purpose of the report is to inform and provide assurance to the Quality Committee and University Hospitals Tees Board of Directors that there is an effective system of clinical governance in place monitoring the safety of our perinatal services with clear direction for learning and improvement.

The data within this report is for Quarter 4 of 2024/25. This report contains the perinatal quality surveillance model dashboard and monthly report for March 2025 (appendix 1 and 2). Where any data provided sits outside this reporting timeframe, this will be specified within the report. This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020).

2. Perinatal mortality rate

In Quarter 4 the rolling 12month stillbirth rate per 1000 births was 3.22 (exclusive of medical termination of pregnancy). The 12month rolling neonatal death rate per 1000 births was 1.64, inclusive of early and late neonatal deaths. On average, the Trust has 380 births per month.

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

Mothers and Babies: Reducing Risk through Audits and Confidential Enquires-UK (MBRRACE-UK) collects data on perinatal death defined as babies born without signs of life from 22 weeks gestation to term and neonatal deaths at any gestation up to 28 days of age, excluding terminations of pregnancy. The definition for Stillbirths is from 24 weeks.

All eligible perinatal deaths have met the required standards of notification, parental input and multidisciplinary team (MDT) review. On a monthly basis the number of cases and key learning points are reported to the Quality Committee and quarterly to the Group Board of Directors.

2.2 Learning from PMRT reviews in Quarter 4 2024/25

A rapid response to learning is undertaken to identify and action any immediate learning until the full PMRT review has been completed within the expected timeframe. During this quarter incidental learning points from investigations included the need for clarity related to frequency of blood gases obtained from neonates, a guideline is being developed to address this. There has been communication to all prescribers to prescribe 'once only' [illegible]algesia for preterm patients presenting with abdominal pain. This

was put in place to prompt a medical review for these patients. Clarity has also been provided related to steroid administration for preterm patients through the weekly share and learn.

3. Maternity and Neonatal Safety Investigations

3.1 Background

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

3.1.1 Babies

Babies who meet the criteria for investigation include all term babies born following labour (at least 37 completed weeks of gestation), who have one of the following outcomes are:

- Intrapartum stillbirth.
- Early neonatal death.
- Severe brain injury diagnosed in the first seven days of life.

3.1.2 Mothers

Mothers who meet the criteria for investigation are direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy. MNSI do not investigate cases where suicide is the cause of death.

3.2 Reported and investigation progress update

MNSI were notified of zero events that met the eligible criteria in quarter 4 with zero active investigations. Limited information is shared within this report to minimise patient identifiable details, and a full report is provided to the Group Board of Directors In-Committee. Table 1 outlines the compliance requirements for MIS year 6.

Table 1 MNSI reporting compliance for quarter 4

MNSI and NHSR Early Notification scheme	Eligible cases	completed
Eligible cases reported to MNSI	0	NA
Eligible cases reported to NHSR EN	0	NA
Family informed of MNSI, EN scheme and duty of candour	0	NA
Trust Claims reporting wizard completed	0	NA

3.3 Safety recommendations and learning from completed investigations

The Trust had two completed MNSI investigations for quarter 4. Two recommendations were received. The first was to develop a robust method of storage of CTGs to prevent loss or damage of those required for safety investigations. In response to this a new process has been implemented to store CTG's within the unit, previously they were stored in a set of handheld notes for patients to take home. This has also been escalated at trust level to provide further evidence for the implementation of centralised monitoring. The second recommendation was to ensure information stored on digital systems for home blood pressure monitoring could be shared throughout the region. It has been agreed that the system can be shared across the group but for those outside of this area traditional methods of monitoring are to be used until a regional pathway/system is agreed.

3.4 Coroner Reg 28 made directly to Trust

No requests made in this reporting period.

4. Maternity events

In addition to MNSI cases, the service reported four moderate graded events which included a missed infant screen, a postpartum haemorrhage above 2 litres and an accidental fall with injury to a baby. All events that have been graded as moderate harm and above are discussed at the trust safety huddle, attended by the patient safety team, chaired by the patient safety operational lead and a response plan is developed. The case related to the missed infant screen was also presented at the trust adverse events review group which is held twice monthly to provide assurance to the patient safety steering group and is chaired by the Medical Director.

Table 2. Grading of events

Event	January	February	March	Total
No Physical Harm	150	94	86	**330**
Low physical Harm	46	35	53	**134**
Moderate physical Harm	2	1	1	**4**
PSII	0	0	0	**0**
Total	**198**	**130**	**140**	**468**

4.1 Maternity and /or neonatal services suspension/divert/closure

The maternity service at James Cook University Hospital (JCUH) site did not report any

The service reported 17 closures of the birth centre at the Friarage hospital. Nine of these were due to acuity and escalation required for JCUH site and eight were due to staff sickness at the Friarage Hospital site.

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

In January 2025, Maternity Services received the NHSE diagnostic report following a diagnostic investigation which took place late in 2024. The report recognised areas of good practice and outlined a number of opportunities for improvement related to:

- Culture
- Workforce
- Leadership
- Training

A draft action plan has been developed to address the areas for improvement. The service is also holding staff engagement events to facilitate staff feedback and participation in development and implementation of the action plan. Further discussions are to be held for longer term support.

6. Three year delivery plan for maternity and neonatal services

No update for quarter 4.

7. NHS Resolution Maternity Incentive Scheme (MIS)

The trust has declared non-compliance with safety action one, specifically standard (ci) which relates to completion of the factual questions within two months of the death. All reviews were completed within six months and robust mitigation has been put in place to prevent future lapses. The PMRT database is now reviewed daily by patient safety staff to ensure completion of the factual questions. For those cases that require completion of the factual questions by an external trust, these are now being completed at local level. A PMRT CNST standards check is also completed monthly using the live national PMRT database. MIS year 7 is expected to be published in April 2025.

8. Saving Babies Live Care Bundle version 3

The Saving Babies' Lives Care Bundle is a group of actions that have been put together to reduce stillbirth. Each element has a specific action plan against it and together, these have now been shown to save babies' lives. The service declared compliance for all 70 interventions for MIS year 6 submission. On-going monitoring will continue.

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

This is a programme of work to reduce avoidable admissions to a neonatal unit for infants born at term (over 37 weeks gestation) paralleled by reducing separation of mother and baby. The National ambition is a rate below 6%.

A total of 40 (3.6%) >37weeks gestation babies were admitted to the neonatal unit in Quarter 4. The reasons for 62% of admissions were for respiratory distress. A review of all ATAIN cases are reviewed by the MDT for actions and shared learning via the perinatal learning response panel and learning meetings attended by the Obstetric and Neonatal Clinical Directors. Learning this month related to a delay in decision making for transfer to the neonatal unit in one case, this has been shared with neonatal staff.

10. NENC Local Maternity and Neonatal System (LMNS)

The service engages with the LMNS and shares quality and safety intelligence via the quarter returns presented at the LMNS Board, learning meetings and shared at the local Trust quarter meetings. The LMNS report into the ICB and regional oversight meetings. The Trust received the LMNS assurance report following a visit in September 2024. Overall the Trust received positive feedback and areas for further development which are already known to the service and reflected in the recommendations from the NHSE diagnostic report. An action plan incorporating areas for improvement is in development and will be finalised following staff engagement sessions.

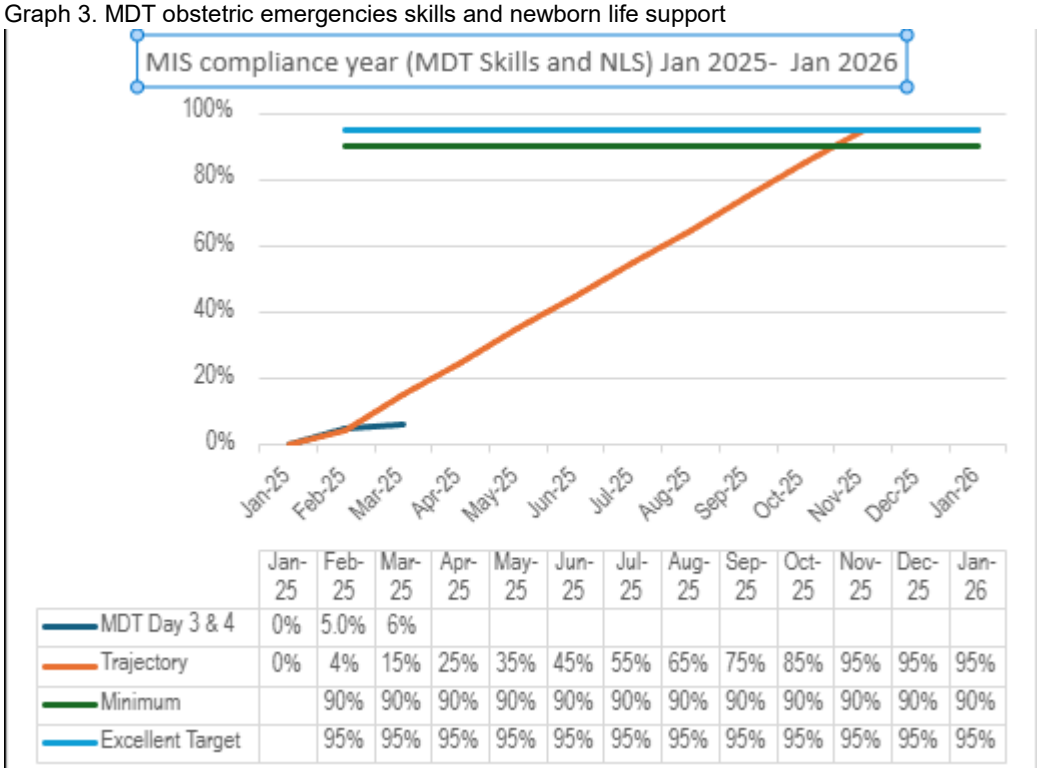
11. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

11.1 Core Competency Framework v2 (CCFv2) year 2

The Trust has worked in collaboration with the NENC Local Maternity and Neonatal System (LMNS) to develop a maternity training syllabus to meet the requirements of Core Competency Framework v2 (CCFv2), supporting standardisation of training, servicer user involvement and shared resources. The service declared compliance for MIS year 6. The service remains a core member of the NENC LMNS education faculty that is developing a 2025.26 syllabus. The service has not achieved the quarter trajectory of compliance for neonatal staff, this is due to educator sickness. An action plan is in development to address this to recover the trajectory.

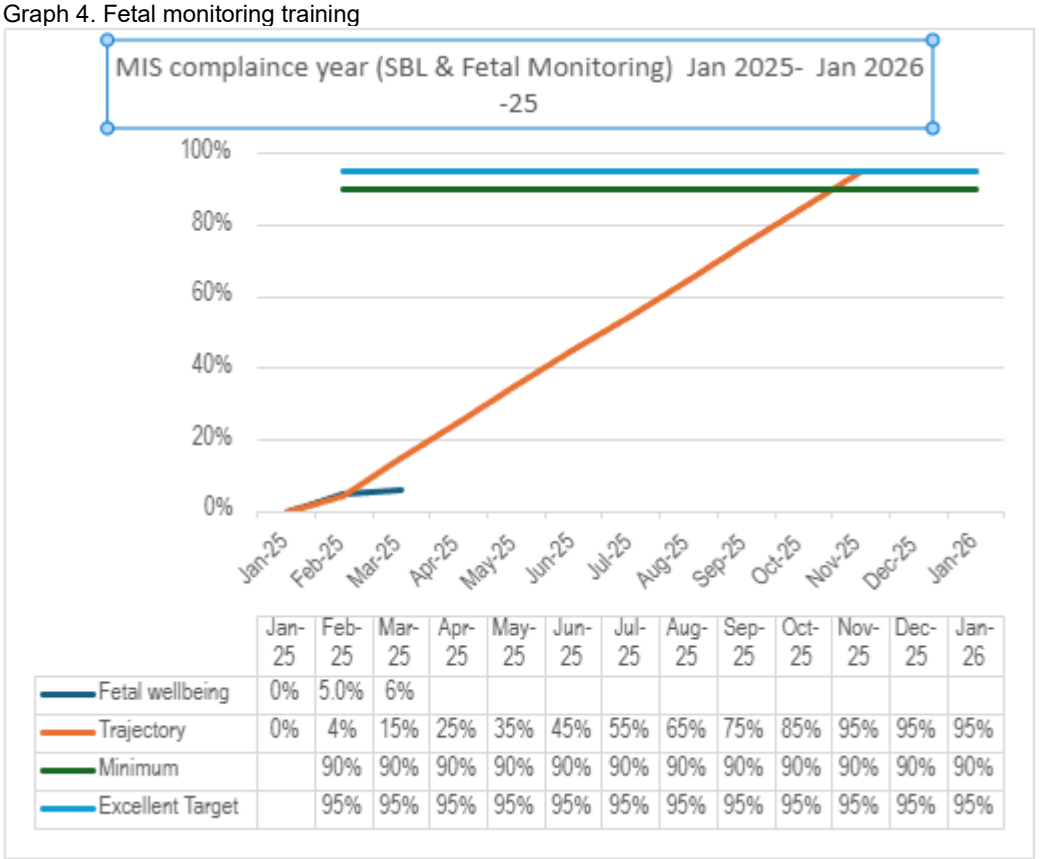
The obstetric and neonatal department Trust core 10 mandatory training is shown in Table 4. Compliance will continue to be monitored monthly and to support staff to access training.

Graph 3. MDT obstetric emergencies skills and newborn life support



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
MDT Day 3 & 4	0%	5.0%	6%										
Trajectory	0%	4%	15%	25%	35%	45%	55%	65%	75%	85%	95%	95%	95%
Minimum		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Excellent Target		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Graph 4. Fetal monitoring training



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Fetal wellbeing	0%	5.0%	6%										
Trajectory	0%	4%	15%	25%	35%	45%	55%	65%	75%	85%	95%	95%	95%
Minimum		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Excellent Target		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Caring Better Together

Table 4. Perinatal workforce Trust Mandatory Core training

Staff group	January	February	March
Obstetric directorate	83.46%	81.82%	79.48%
Neonatal directorate	86.18%	81.19%	79.04%

12. Insights from service users

12.1 Complaints and compliments overview

The monthly numbers of both complaints and compliments are outlined in Table 5 and Table 6 formal complaints within quarter 4 related to:

- Care provided
- Communication
- Staff attitudes

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

Table 5. Complaints

Complaints	January	February	March
Stage 1	**2**	**5**	**2**
Stage 2	**0**	**1**	**0**
Stage 3	**1**	**2**	**2**
Total	**3**	**8**	**4**

Table 6. Compliments

Compliments	January	February	March	Total
Care provided/compassion	79	32	24	**135**
Communication	19	12	9	**40**
Multiple	128	64	87	**279**
Staff to staff	0	0	0	**0**
Logged on datix	2	0	3	**5**
Total	**228**	**108**	**123**	

ghts from Friends and Family Test (FFT)

The service continues to monitor friends and family test feedback. The latest results are identified in the Table 7.

Table 7. FFT

	January	February	March
Maternity Positive %	88.1%	91%	93%

12.3 Trust Claims Scorecard.

Reviewed with no significant update for quarter 4 (appendix 3)

12.4 Service user insights from Maternity and Neonatal Voice Partnership (MNVP)

The MNVP meet with the senior leadership team on a monthly basis where feedback is shared from service users, local and regional forums. Other agenda items include work plans, and engagement opportunities. The MNVP regularly attend meetings within the governance structures, reflected in the Terms of Reference membership such as; Board safety champions, Clinical effectiveness and Education Group, PMRT. Current projects include:

- Engagement events to increase the voice of bereaved and neonatal parents
- Development of a shared data base for effective governance of documentation
- Work plan to look at social media and digital engagement

12.5 Service user insights taken from a recent CQC peer review

No update for quarter 4.

13. Community midwifery services

Community Midwifery services within Middlesbrough and Redcar and Cleveland are undergoing a service review which is focused on workforce, lean ways of working and estate. The FHN community team are undergoing a case for change for their staffing model. This is currently being reviewed by staff side.

13.1 Continuity of Care

There is no longer a national target for Maternity Continuity of Carer (MCoC). Local midwifery and obstetric leaders should focus on retention and growth of the workforce, and develop plans that will work locally taking account of local populations, current staffing, more specialised models of care required by some women and current ways of working supporting the whole maternity team to work to their strengths. NHS England expects the trust to continue to review our staffing in the context of the Ockenden final

The trust position is to focus on an enhanced model of care for women from vulnerable groups who will benefit most from this model. The indigo team was established in 2023 and consists of 3 WTE midwives and 8 enhanced Maternity Support workers who care for women who meet the vulnerability tool criteria for care.

Table 9 shows the current percentage of all women booked with the service who have antenatal care plans recorded by 29 weeks, with CoC pathway indicator and record of teams providing care. The data is submitted to the National maternity dashboard and quarter 4 demonstrates compliance.

Table 9. Antenatal MCoC antenatal pathways

Continuity of Care	January	February	March
i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed	94.7%	92.7%	91.2%
ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.	90.9%	91.7%	100%

14. Quality improvement and research

14.1 Maternity research team

No update for quarter 4.

14.2 Quality Improvement Lead

The service is undertaking two quality improvement projects:

- Booking by 9+6
- Neonatal hypoglycaemia

Both projects are at the data collection stage and are in development to drive improvements in compliance, staff knowledge and neonatal outcomes

14.3 Retention, Recruitment and Pastoral Support Midwife

No update for quarter 4.

14.4 Infant feeding specialist midwife.

Future focus to re-establish additional 2 day training for all staff.

14.5 Digital Specialist Midwife

The Great North Care Record (GNCR) Project is due to go live mid-April. Maternity data will be added to allow other GNCR users to view maternity information. This will not require any change to current clinical documentation, the data will be directly transferred from clinical documentation in Badgernet to the GNCR without any duplication. The service recruited a Digital Inclusion Officer and Digital Maternity Skills Educator to support both patients and staff with accessing and inputting standardised information into Badgernet. Eight additional training days have also been secured from system C. The team are working on a project to integrate Trac with Badgernet.

14.6 Bereavement Specialist Midwife

The service has recruited to a bereavement counsellor/support worker role on a twelve month fixed term contract. This is to provide counselling to patients and their families who have been cared for by the bereavement team on delivery suite within the last twelve months.
The bereavement team are working closely with the Maternity and Neonatal Independent Advocacy Service to ensure all bereaved parents have the opportunity to access advocacy support.

15. Culture and Leadership

15.1 Board level safety champion meetings

Safer maternity care called on maternity providers to designate and empower individuals to champion maternity safety in their organisation. The board-level maternity safety champion will act as a conduit between the board and the service level champions. The role of the maternity safety champions is to support delivering safer outcomes for pregnant women and babies. The monthly meetings are held with the Perinatal Quadrumvirate, Non-Executive Director, Trust Director of Nursing or Executive Director, representative from Maternity and Neonatal Voice Partnership MNVP and Head of Midwifery. National, Regional and system developments are discussed along with audits, dashboard metrics, service feedback, improvement plans for ATAIN and the optimisation Bundle. The perinatal quadrumvirate provide regular feedback and inform the members of progress and intelligence shared by peer 'perinatal quads'. Escalations from quarter four include:

- Loss of estate on ward 19 means that the neonatal resuscitaire situated on the corridor and does not have a piped supply of air/oxygen. There are potential implications for neonatal resuscitation ad thermoregulation associated with this and this has been added to the risk register. As an interim safety measure this has been moved to a side room until a long term solution is agreed.
- Loss of estate on ward 19 means there is a shortage of antenatal beds which means patients are cared for on the postnatal ward or delivery suite.
- Poor experience with trust translation services. The service is working with the translation service lead to address this by providing further staff training and implementing the use of vocera for telephone interpreting appointments

The feedback from the perinatal walkabouts are:

Generally positive with staff being responsive, engaging and open to discussions.

15.2 Advocating for education and quality improvement (A-equip) and professional midwifery advocacy themes

Work is ongoing to standardise and align the Professional Midwifery Advocacy (PMA) role to that of the Professional Nursing Advocate (PNA) within the trust.

15.3 Perinatal Culture and Leadership Programme

Participation in the regional perinatal leadership development programme by members of our QUAD and culture coaches.

Following our NHSE cultural diagnostic review, several engagement events are taking place with staff to formulate an action plan to address its recommendations.

15.4 Opportunities and development

- The quadrumvirate are engaged with and leading the recommendations of the diagnostic report.

16. Risk register

There are 11 open risks graded as:

- 9 moderate
- 2 low risk

In line with the Trust risk management process, risks raised by the service are developed by the service and are reviewed in the weekly risk review group. From here they go to the Senior Leadership Team Risk Management Group.

17. Key issues, updates, significant risks and mitigations

Stillbirth rate: the service has noted a discrepancy between local data and IPR which means reported data will have been incorrect. This has now been cleansed and rectified with IPR team liaising with the maternity services data analyst to ensure the correct rates are reported.

Antenatal Estate: on-going discusses regarding patient flow, environment and capacity.

Training: The service reports not achieving in quarter training trajectory for neonatal staff due sickness. An action plan is in development to address this.

RAC: RAC work continues throughout delivery suite. Plans are in development to facilitate theatre recovery and the adjoining corridor to prevent disruption to

18. Assurance and recommendations

The members are asked to receive and note the significant on-going work to meet National Maternity recommendations and workforce challenges.
The Committee asked to receive and note the content of the report.

Appendix 1

University Hospitals Tees

CQC Maternity Ratings	Good	Maternity safety support programme: No

2025	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
1.Findings of review of all perinatal deaths using the real time data monitoring tool	NA	1 learning point	NA									
2. Findings of review of all cases eligible for referral to MNSI	NA	NA	NA									
Report on: *2a. The number of events logged graded as moderate or above and what actions are being taken*	1	5	0									
2b. Training compliance for all staff groups in maternity related to core competency framework ***MDT skills*** *and* ***fetal wellbeing***	No data No data	91% 90%	94% 94%									
2c. Minimum safe staffing in maternity services to include ***Obstetric cover*** *on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively* ***(midwife V birth ratio, 1:19****)*	100%	100% 1:18	100% 1:20									
3.Service User Voice Feedback – positive %	88%	91%	93%									
4.Staff feedback from frontline champion and walk-abouts (bi-monthly)	No data	Friarage, Triage, CDS, ward 17	CDS, Triage, Ward 17, Ward 19 Nightshift									
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	NA	NA	NA									
6.Coroner Reg 28 made directly to Trust	No	No	No									
7.Progress in achievement of CNST 10	Yr 6 - In progress	Yr 6 in progress	Yr 6 completed. Declared 9/10 compliance									

To work ***2023*** *49.95%* ***2022*** *45.42%*

Receive treatment 2024 *– 82%*

Appendix 2


NHS
South Tees Hospitals
NHS Foundation Trust
Perinatal Quality Surveillance Model Report for March 2025
Group Quality Assurance Committee
8th March 2025
Caring Better Together

CQC Maternity Ratings 2024	Safe	Effective	Caring	Responsive	Well-Led	Overall
	Requires Improvement				Requires Improvement	Requires Improvement

Key performance indicators March: 25 Trust value / Ave. NENC or National

Smoking at Booking	9.21% / ≤10%	
Booking by 9+6	61.6% / 90%	
Right Place of Birth (Preterm births)	100% / >95%	
Number of Births	376	
Preterm births (22 - 36+6 weeks)	29	
Induction of labour	52.02% / 46.90%	
PPH >= 1.5L (rate per. 1000)	30	
3rd/4th degree tear rate	5.7% / ≤3.5%	
Stillbirth rate (per. 1000 births)	3.22 / 3.84	
Neonatal Mortality (per. 1000 births)	1.64 / 1.48	
Smoking at Delivery	4.8% / ≤5%	
Breast feeding initiated	68.20% / 74.40%	
ATAIN	4.1% / ≤5%	
Maternal re-admissions	2.9% / ≤2.4%	

Narrative

Smoking Cessation
In March smoking status at booking was 89.2%. CO monitoring recorded at 36 weeks is 88% which is just below target and an improvement on last month. Smoking status recorded at 36 weeks is 51.5%. There is a post being recruited to for a tobacco dependency advisor based in the hospital who will be tasked with improving compliance with this.

Booking by 9+6
There has been a further decline in booking by 9+6 which is currently 61.6% Data collection for the QI project to explore how further improvements can be made has commenced.

Obstetric Postpartum Haemorrhage (PPH)
Incidence of postpartum haemorrhages are within LMNS target of 2.7% this month. The incidence of large PPH above 2 litres has now dropped from 1.6% in January to 0.5% in March

Breastfeeding at first feed
There has been an increase in initial breastfeeding rates to 68% following a drop in January and February due to annual leave and sickness.

ATAIN
MDT ATAIN reviews completed this month were all appropriate admissions to the neonatal unit

Maternal readmissions
There has been a reduction in postnatal readmissions with 10 this month with no themes identified

Transfers and closures FHN
Triarage transfers from 2024 were reviewed in Februarys CEEG meeting. There were 31 transfers in total including postnatal mothers and babies. All were managed appropriately. In March there were three patient transfers to JCUH and three unit closures, two were due to acuity and staffing at JCUH one was due to triarage staff sickness.

Maternity Triage
88.4%% triage compliance in March which is above the current BSOTs standard of 80%

Descriptor	Latest Value	Narrative
Number of and findings from review of all perinatal deaths.	Stillbirths <5 Neonatal deaths <5 6 cases reviewed through PMRT this month – one of these was graded 'C'	PMRT – Learning & action from recent case reviews Actions developed are: • A need for services to support patients navigate digital platforms if English is not their first language • A need for further educational material to be developed in less common languages • The impact of loss of estate on ward 19 which led to a baby being resuscitated on a resuscitaire in the corridor Maternity and Neonatal Safety Investigation (MNSI) Recommendations and safety prompts from two completed MNSI cases shared at trust AERG Coroners Inquests and Regulation 28, Prevention of Future Deaths Reports – None CQC action plan 2 actions outstanding – FHN staffing model is currently being reviewed by staff side Options appraisal in development for placement of the birthing pool Maternity Incentive Scheme year 6 Compliant with 9 out of 10 year 6 MIS standards. Action plan to address safety Action 1 reviewed at monthly CEEG meeting
Findings of review of all cases eligible for referral to MNSI	March MNSI 0 PSII 0	
MNSI/NHSR/CQC or other organisation with a concern or request for action Maternity Safety Support Programme	CQC – 2 outstanding actions MNSI: - 0 outstanding cases.	
The number of events logged graded as moderate or above	151 events. 0 moderate harm incidents/ 33 x Low physical harm /86 x no harm	
The number of incidents related to out of hours supervision	Zero incidents reported this month	
Progress with Maternity Incentive Scheme (MIS) Year 6	Compliant with 9 out of 10 year 6 MIS safety actions	

Descriptor	Latest Value	Narrative
Service User Feedback- Friends and Family Test (FFT)	93 % positive feedback	**The Maternity and Neonatal Voices Partnership(MNVP)** No change from themes from February PQSM. MNVP meetings are now held bimonthly with alternate bimonthly community engagement sessions. **Board Maternity Safety Champions** Feedback included reflections on the different atmosphere on a night and the welcoming responsive attitudes of staff. Themes raised by staff persist around lack of antenatal beds due to sharing the estate on ward 19 and the impact on staff and patients attributed to this. Triage staff raised difficulties with the trust interpreter provider. Staff training has been arranged to address this and others expressed the difficulties experienced in 'listening events' arranged following the NHSE diagnostic report. **Complaints** Themes from complaints include not feeling heard, poor communication and staff attitudes. **Compliments** For caring, kind and supportive staff. Feeling well looked after and reassured and that nothing was too much trouble. **Leadership and culture** Engagement events are currently being held to address findings from the NHSE diagnostic report.
Feedback from frontline staff on champions walkabouts	Walkround completed during the nightshift and encompassed CDS, triage, ward 17 and ward 19.	
Complaints	Maternity: Stage 1 - 2; Stage 2 - 0; Stage 3 -2 Neonates: Stage 1 - 0; Stage 2 - 1; Stage 3 - 0	
Compliments	Maternity: 139 FFT; 3 submitted on datix Neonates: No data	
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	To work: 2023 60.5% Receive treatment: 70 %	
Proportion of speciality trainees in obstetrics and gynaecology responding with excellent or good on how they would rate the quality of clinical supervision out of hours (reported annually)	86% for out of hours supervision – this scores within the top 15 % in the country 2024 Report	

Workforce RM vacancy position

	Sum of Budget	Sum of Actual	Sum of Variance	Projected 3 month (June 2025)	Projected 6 month (Sept 2025)
B5/B6 RN's/RM's	180.37	174.08	(6.29)	0	0
B7 Clinical and Specialist Midwives	39.90	43.38	3.48	0	0
Grand Total	220.27	217.46	(2.81)	220.27	221

Workforce safe staffing metrics	
Obstetric labour ward cover	100%
Labour ward coordinator (LWC) Supernumerary	100%
LWC supernumerary at start of shift	100%
1-1 care in labour	100%
Midwife to Birth ratio	1:20.7
Registered midwife fill rate	90%
BAPM compliance	86%

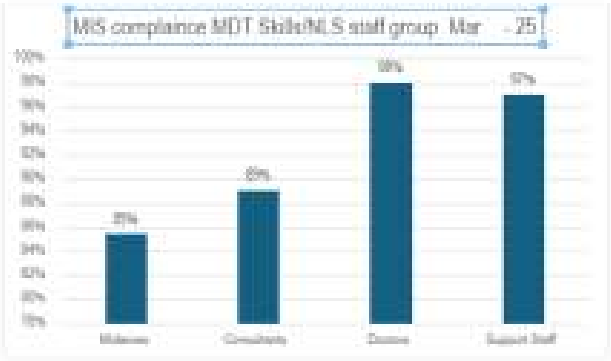
Midwifery red flags

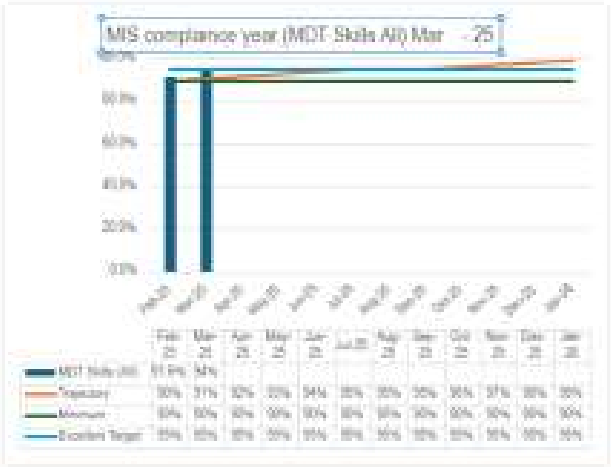
Category	number	comments
LWC supernumerary	0	
1-1 care in labour	0	
Delay in IOL	2	
Time critical	17	
Missed or delayed care	0	

Training compliance

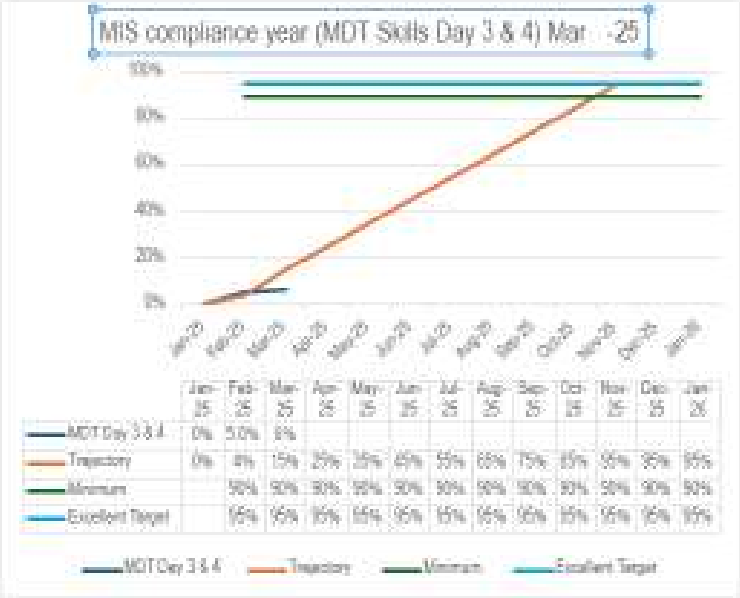
	MIS compliance year MDT skills		MIS compliance year Fetal wellbeing		MIS compliance Neonatal resuscitation		Trust Core 10
	In-month	Trajectory	In-month	Trajectory	In-month	Trajectory	In month
March	94%	>90%	94%	>90%	94%	>90%	81.32%

12month rolling compliance overview

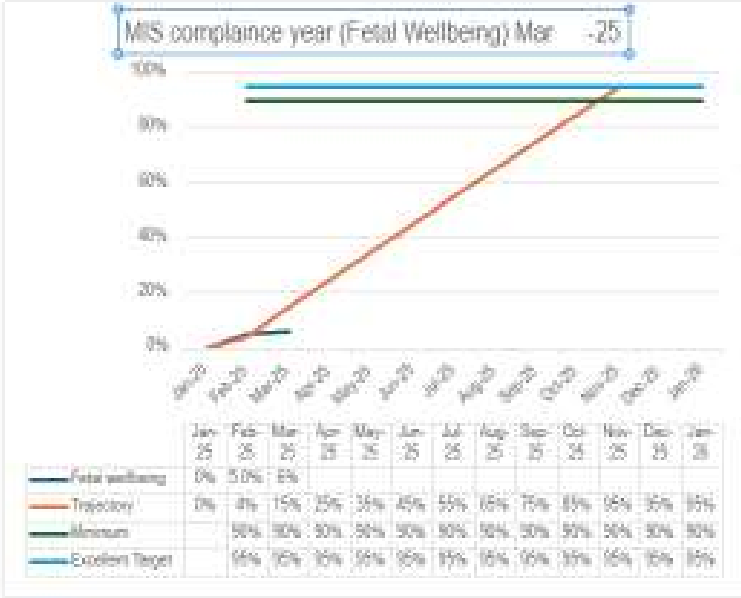




Training compliance: all staff compliance



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
MDT Day 3 & 4	0%	5.0%	6%										
Trajectory	0%	4%	15%	25%	35%	45%	55%	65%	75%	85%	95%	95%	95%
Minimum		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Excellent Target		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Fetal wellbeing	0%	5.0%	6%										
Trajectory	0%	4%	15%	25%	35%	45%	55%	65%	75%	85%	95%	95%	95%
Minimum		90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Excellent Target		95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Appendix 3

Maternity Triangulation Report Q4 2024 -25

Top Injuries by Volume:	Top Injuries by Value:
Additional/unnecessary operations (8) Unnecessary pain (7) Fatality (7) Stillborn (7) Loss of baby (6)	Brain damage (4) Psychological Damage (4)– New top 5 Cerebral palsy (2) Erbs palsy (4) Wrongful birth (1)
Top Causes by Volume:	**Top Causes by Value:**
Fail/delay treatment (22) Inappropriate treatment (3) Fail to monitor 2nd stage labour (4) Intra op problems (4) Forceps delivery (3)	Fail/delay treatment (22) Fail to warn/informed consent (3) Fail to inform test results (1) Failure to interpret US (1) Delay in performing operation (2)– new top 5

The scorecard summary covers all claims – there are only a small number which pay damages.

Complaints Themes/Actions for Closed Complaints Q4
Communication, not feeling heard, staff attitudes

Meridian FFT feedback:
Delays in care in antenatal clinic, Postnatal analgesia, patient choice

Top Incidents Q4 24-25:
Unexpected admission to NNU
Failure to follow local protocol
Readmission of Mother
Unexpected blood loss>1500mls
Readmission of Baby

Safety and Quality First

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

NHS
South Tees Hospitals
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Themes:
Informed consent, staffing, delays in care/appointments

Learning /Actions :
- Human Rights training offered to Consultants and Midwifery staffing
- Review of maternal readmissions has seen a drop from 4.4% to 2.9%, new action plan is being developed for 2024/5
- Ongoing work to improve translation services in maternity
- Action plan in development to address capacity in ANC

	Not started / In Progress / Completed
Work with Trust on improving Translation Services	Jun 25 (TG)
Informed Consent – work around what this means/ Human Rights training	Jun 25 (LS/RD/DM)
Develop Postnatal Readmission Action Plan for 2024/5 : covering microbial management, hypertension and Retained Products of Conception	Oct 25 (SM)
Review postnatal pain assessment and management	Mar 24 (LH/LG)
Capacity and demand modelling for ANC completed – To develop an action plan to address capacity	June 25 (AH/LS)
Reviewing staffing establishments with Trust SLT/ Develop business case for over recruitment	April 25 (LS/AR)

University Hospitals Tees

NTHFT Perinatal Staffing Report for Quarter 4 2024.25

Meeting date: *8th May 2025*

Reporting to: *Group Board of Directors*

Agenda item No: 20.2

Report author: *Hannah Matthews; Interim Head of Midwifery and Stephanie Worn, Group Director of Midwifery.*

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

Delegation status: Jointly delegated item to Group Board

Previously presented to: *Perinatal Services Quality Assurance Council and Quality Assurance Committee.*

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:

Safe

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.

Red Flags – there was an increase in red flags submitted within the BR plus tool in the months of February and March due extensive periods of high acuity within these months, often with multiple red flags inputted on one given shift. These are monitored by the ward matron and Senior Clinical Matron of delivery suite to obtain narrative behind the red flags.

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

Maternity vacancy rate – -4.55 (-9.52 including maternity leave, supernumerary period and non clinical). The service hosted a recruitment café for newly qualified midwives in March where 10 WTE were appointed to midwifery vacancies. These members of staff will not be in post until end of September or October and will require a supernumerary period therefore the service may not feel the impact of this until January 2026

Sickness rate: The service saw an increase in sickness and absence rate in January 2025 of 7.34% and a maternity leave rate of 6.01%. This has a direct impact on bank and agency spend during this period however an improvement was noted over the quarter with sickness and absence rate in March 4.79% and a maternity leave rate of 4.65%. Monthly people's clinic are between human resources and ward managers for oversight and support management plans

Obstetric and Neonatal medical Staffing: Following successful recruitment of 3 consultants; the service is fully established at an obstetrics and gynaecology consultant grade, however there remains challenges within the perinatal medical workforce. The service has a number of consultants with reasonable adjustments that result in some limitations and challenges to fulfil roles to the full extent. The service has historically experienced challenges in meeting BAPM compliance of neonatal medical staffing, there remains an open risk on the risk register that has proven to have appropriate controls in place to manage this risk.

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

Anaesthetics – The service provided a 24 hour service for anaesthetics in quarter 4.

Recommendations:

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

North Tees and Hartlepool NHS Foundation Trust

Meeting of the Group Board of Directors
2025

Maternity and Neonatal Services Staffing Report for Quarter 4 2024.25

Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

Previously midwifery staffing data has been included in the nurse staffing paper, however, to provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, a separate paper is now provided.

1. Minimum safe staffing maternity services

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

1.1 Midwifery Staffing

The Trust is compliant with the recommended funded midwifery establishment by Birth-rate Plus undertaken in January 2023. The recommended midwife to birth ratio is 1:19.5 with section 1.2 outlines actions and mitigations to minimise risks when the staffing levels ae below template.

The registered midwifery (RM) vacancy position at the end of March 2025 (inclusive of maternity leave) is -4.04 (removing maternity leave/supernumerary staff is -9.51). Table 1 shows the staffing position and Table 2 shows the monthly fill rates.

Table 1. Midwifery staffing position

RM vacancy position	Sum of Budget			Sum of Actual			Sum of Variance			Projected 3 month			Projected 6 month		
	January	February	March	January	February	March	January	February	March	April	May	June	July	August	September
B5/B6 RN's/RM's	106.67	106.67	106.67	101.48 Includes 4.34 on mat leave/2 supernumerary period and 1.02 non clinical reasonable adjustments = -6.42	104.6 Includes 3.8wte on mat leave/ 2 supernumerary and 1.2 non clinical reasonable adjustments = -6.82	102.12 Includes 2.96 on mat leave/ 2 currently in supernumerary = -4.96	-5.19 Removing mat leave/ supernumerary/ non clinical = -11.61	-2.07 Removing mat leave/ supernumerary/ non clinical = -8.89	-4.55 Removing mat leave/ supernumerary/ non clinical = -9.51	-2.57 4.76 mat leave - 7.33	-0.57 4.76 mat leave = -5.33	-4.67 1.96 mat leaves = -6.63	-0.67 2.76 known mat leave - 3.43	+0.63 2.76 known mat leave =- 2.13	-3.57 Forecasted 4.4 mat leave= -7.97
B7 Clinical and Specialist Midwives	26.31	26.31	26.31	31.32 Includes 3 on mat leave	30.75 Includes 3 mat leave	30.02 Includes 2 mat leave	+1.81 Removing mat leave = -1.19	+1.84 Removing mat leave = -1.6	+0.51 Removing mat leave = -1.49.	+0.15 Removing mat leave = -2.15	-0.81 Removing mat leave = -2.81	-1.63 Removing mat leave = -3.63	-1.41 removing mat leave = -4.41	-2.32 removing mat leave = - 3.32	-1.58 removing mat leave = - 2.58
Grand Total	132.98	132.98	132.98	132.80	135.35	132.14	-3.38 / -14.99	-0.23/ -10.05	-4.04/-11.0	-2.42 / -9.48	-1.38/-8.14	-6.3/-10.26	-2.08 / -7.84	-1.64/ -5.45	-5.15/ -10.55

Table 2. Unavailability for qualified staff across maternity services

	January	February	March
Sickness rate	7.34%	6.86%	4.79%
Maternity Leave rate	6.01%	4.66%	4.65%
RM fill rate %	81%	79%	79.5%
Midwife to birth ratio	1:18.2	1:17.9	1:18.3

1.2 Midwifery staffing safety measures.

Midwifery staffing rates are reviewed weekly and it has been identified that a decrease in compliance occurs out of hours or when the unit is in high acuity and escalation. On these occasions, the escalation policy has been followed with the Clinical Site manager (CSM) and manager on call contacted, staff being redeployed internally and the community midwives being brought in. These measures were taken for very short periods and the situation rectified at the earliest opportunity.

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

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

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

2. Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). The midwife in charge will then determine the action required (appendix 1). Red flags are collected through the Birth Rate Plus acuity tool, and reviewed by the perinatal quadrumvirate (Table 3). Twenty five red flags were documented in quarter 4 and appropriate clinical and management actions were taken to maintain safety. One red flags [illegible]ication) and currently there is no process to remove these. The re[illegible]he governance structures of the Maternity Quality Assurance Co[illegible]mmittee and Trust Board of Directors.

Table 3. Midwifery red flags

Red Flag category	January	February	March
Delayed or cancelled time critical activity	2	6. x1 duplicated	3
Delay between admission for induction and beginning of process.	1	0	1
Labour Ward Coordinator (LWC) not supernumerary.	1	1	2
One - one care in active labour		0	4
Delay in Triage	1	0	1
Missed or delayed care		0	2
Total			25

2.1 Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary LWC is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward. In quarter two, one red flag was raised for loss of LWC supernumerary status during the shift for a brief period to support a midwife with a comfort break. In addition, compliance is monitored for the allocated LWC having supernumerary status at the start of every shift, as per MIS year 6 (Table 4).

Table 4. LWC supernumerary status: start of shift

	Number of days per month	Number of shifts per month	Compliance
January	31	62	100%
February	28	56	100%
March	31	62	100%

2.2 One to One in Established Labour

Women in established labour are required to have one to one care (Table 5) and support from an assigned midwife. Care will not necessarily be given by the same midwife for the whole labour. If there is an occasion where one to one care cannot be achieved, then this will prompt the LWC to follow the course of actions above in section 10.2.

Table 5. One to one care compliance.

	January	February	March
One-one care in active labour	100%	100%	97.7%

Following a review, it was identified women transitioning from the induction of labour phase to augmentation would require one to one midwifery care, in these circumstances midwifery

support was escalated from other maternity clinical areas. The actions taken were appropriate to facilitate one to one midwifery care.

3. Obstetric staffing

The service is fully established at Consultant grade. The department has now successfully recruited three Consultants to cover the Consultant on call rota. There has been pressures within the consultant workforce since Q4 2023 for Consultant medical workforce available for on call emergency obstetric work due to occupational health requirements and acute sickness. One Consultant has also commenced maternity leave in Q4 and locum Consultant cover is being explored for the duration of maternity leave. The existing Consultant workforce are undertaking additional shifts to provide cover for acute sickness and safe staffing for obstetrics is being maintained. Weekly safe obstetrics and gynaecology staffing meetings coordinated by the operational manager, clinical director, rota administration team and the specialty training lead are taking place to ensure safe staffing and meeting the training needs of the doctors in training in the department. The department is undergoing a detailed perinatal workforce review and has plans for further consultant recruitment. The care group has supported an expansion plan for the medical leadership roles within the department. Consultant leads for Obstetrics and Gynaecology have been appointed and further roles are being advertised and appointments planned in Q1.There were no locum consultants working in the department in Q4.There are national recommendations published by the RCOG for consultant attendance in certain clinical emergency scenarios in obstetrics. The Q4 audit has reported 100% compliance with the standards (Appendix 2). There are twice daily multidisciplinary team handovers of care for obstetrics and twice daily consultant led multidisciplinary ward rounds taking place.

4. Neonatal Nurse Staffing

The staffing compliance rate was 91 % this quarter, a marked increase from Q3 compliance of 54%, this is largely due to the lower than average occupancy and acuity within this quarter. The national average for the quarter 4 was 78 % for SCBUs. The Trust use the National Neonatal workforce calculator tool and provide updates to the Neonatal Operational Delivery Network, this update is reported quarterly. There has been no requirement for additional shifts to manage increased acuity or occupancy in this quarter, and shifts only requested for sickness cover. The ward manager in SCBU started completing the Safer Nursing Care Tool 35 day audit in this quarter. There has been an agreement for over recruitment of establishment by 1 WTE following review of age profile in neonatal staffing to ensure skill levels are maintained who is now in place. Some vacancies created from staff moving to team lead and specialist roles have been filled. Due to the significant decrease in compliance in the last quarter and discussion at Perinatal Quality Assurance Council in December a separate paper for neonatal nurse staffing is being prepared to include findings from Safer Nursing Care Tool Audit undertaken this year. Neonatal nurse staffing is on the risk register and the action plan agreed at Trust Board is reviewed regularly, outlining progress against each of the actions with oversight from the LMNS and Neonatal Operational Delivery [illegible]arterly basis.

5. Neonatal Medical Staffing Compliance

The neonatal medical staffing continues to be compliant with BAPM guidance in all tiers with gaps supported with locum cover. This has previously been highlighted as a risk within the trust, with a risk currently on the register which is sufficiently managed through the use of controls stated within the risk. The Advanced Neonatal Nurse Practitioner (ANNP) Workforce is at full establishment from June 2024 with return from maternity leave and two trainees in the first year of study to future proof the establishment following review of age of workforce. This will facilitate ANNPs being able to spend time at James Cook hospital for skills maintenance and development which commenced at the end of quarter 4.

6. Anaesthetics

In quarter 4 the service provided a 24hour service. This can be evidenced via rotas

7. Recommendations

It is recommend for the Group Board of Directors to note for obstetric consultant attendance in complex emergency obstetrics.

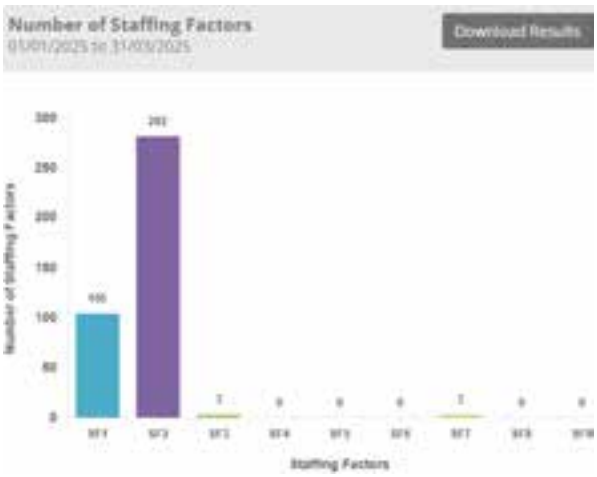
It is recommend for the Group Board of Directors to note the new risk register entry for neonatal nursing workforce.

8. Appendices

Appendix 1. Midwifery clinical actions to maintain safe staffing

Appendix 2. Consultant attendance for complex obstetric emergency care

Appendix 1 Staffing factors and Clinical Actions



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Appendix 2

NHS
University Hospitals Tees

Maternity Incentive Scheme Safety Action 4: Consultant Attendance Audit Report for Quarter 4 2024/25

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

NENC LMNS Audit Tool Audit of 5 cases (or all if <5) of each of the following triggers.	Q4 Cases	Consultant in attendance Compliant
Consultant MUST attend		
• MEWS >5	0	-
• Caesarean birth for major placenta praevia / abnormally invasive placenta	0	-
• Caesarean birth for women with a BMI >50	2	2
• Caesarean birth <28/40	0	-
• Premature twins (<30/40)	0	-
• 4th degree perineal tear repair	0	-
• Unexpected intrapartum stillbirth	1	1
• Eclampsia	2	2
• Maternal collapse eg septic shock, massive abruption	0	-
• PPH >2L where the haemorrhage is continuing & Massive Obstetric Haemorrhage protocol instigated	5	5
• Any laparotomy	0	-
Consultant must attend unless senior doctor signed as competent		
• Trial of instrumental birth	5	5
• Vaginal twin birth	0	-
• Caesarean birth at full dilatation	5	5
• Caesarean birth for women with a BMI >40	5	5
• Caesarean birth for transverse lie	0	-
• Caesarean birth at <32/40	1	1
• Vaginal breech birth	1	1
• 3rd degree perineal tear repair	5	5
Total	32	32
Overall Compliance		**100%**

University Hospitals Tees

STHFT Maternity and Neonatal Services Staffing Report for Quarter 4 2024.25

Meeting date: *8 May 2025*

Reporting to: *Group Board of Directors*

Agenda item No: 20.3

Report author: *Rosie Dawson, Consultant Midwife and Stephanie Worn, Group Director of Midwifery.*

Action required: Assurance

Delegation status: Jointly delegated item to Group Board

Previously presented to: *Quality Assurance Committee*

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:

Safe

Board assurance / risk register this paper relates to:

Quality

Key discussion points and matters to be escalated from the meeting

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

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

Red flags: on-going to review to identify any learning points to support patient flow.

Neonatal staff: the team are reviewing and developing plans to achieve BAPM compliance.

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

The maternity workforce is under review following successful recruitment.

Recommendations:

The members are asked to note the content of the report.

South Tees Hospitals NHS Foundation Trust

Meeting of the Group Board of Directors
8th May 2025

Maternity and Neonatal Services Staffing Report for Quarter 4 2024.25

Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

Previously midwifery staffing data has been included in the nurse staffing paper, however, to provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, a separate paper is now provided.

1.0 Minimum safe staffing maternity services

Minimum safe staffing maternity services

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

1.1 Midwifery Staffing

The Trust is compliant with the recommended funded midwifery establishment by Birth-rate Plus undertaken in January 2023. The recommended midwife to birth ratio is 1:22.6 with section 1.2 outlines actions and mitigations to minimise risks when the staffing levels ae below template. The registered midwifery (RM) vacancy position at the end of March 2025 (inclusive of maternity leave) is +4.17 .Table 1 shows the staffing position and Table 2 shows the monthly fill rates.

Table 1. Midwifery staffing position

NHS University Hospitals Tees

RM vacancy position	Sum of Budget			Sum of Actual			Sum of Variance			Projected 3 month			Projected 6 month		
	January	February	March	January	February	March	January	February	March	April	May	June	July	August	September
B5/B6 RN's/RM's	174.68	174.68	174.68	*173.21*	173.21	173.21	-1.47	-1.47	-1.47	176.21	176.21	176.21	175.21	175.21	174.21
B7 Clinical and Specialist Midwives	38.18 (inc.b6 specialist m/ws)	38.18 (inc.b6 specialist m/ws)	38.18 (inc.b6 specialist m/ws)	**43.82**	43.82	*43.82*	+5.64	+5.64	+5.64	**43.82**	**43.82**	**43.82**	**43.82**	**43.82**	**43.82**
Grand Total	212.86 +8 over allowance (220.86)	212.86 +8 over allowance (220.86)	212.86 +8 over allowance (220.86)	217.03	217.03	217.03	+4.17	+4.17	+4.17	+7.17	+7.17	+7.17	+6.17	+6.17	+5.17

Table 2. Unavailability for qualified staff across maternity services

	January	February	March
Sickness rate	6.45%	6.25%	5.94%
Maternity Leave rate	3.36%	3.15%	2.53%
RM fill rate %	88.7%	92.2%	90%
Midwife to birth ratio	1:21.1	1:19.3	1:20.7

1.2 Midwifery staffing safety measures.

Midwifery staffing rates are reviewed weekly and it has been identified that a decrease in compliance occurs out of hours or when the unit is in high acuity and escalation. On these occasions, the escalation policy has been followed with the Matron of the Day and manager on call contacted out of hours. Staff are redeployed internally and currently homebirth and midwifery led services are suspended at times of extreme pressure. We continue to work within the Tees group and LMNS trusts to provide and receive mutual aid where necessary to mitigate against red flags and elective work, utilising the sit rep tool and OPEL status to predict workload and pressures. These measures were taken for very short periods and the situation rectified at the earliest opportunity. Mitigations and escalation process to address staffing shortfalls have continued during this reporting period (appendix 1). The actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies. In addition, a significant number of bank hours have been used across the service to cover maternity leave and long and short-term sickness.

2. Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). The midwife in charge will then determine the action required. Red flags are collected through the Birth Rate Plus acuity tool and reviewed by the perinatal quadrumvirate (Table 3). 84 red flags were documented in quarter 4 and appropriate clinical and management actions were taken to maintain safety.

Table 3. Midwifery red flags

Red Flag category	January	February	March
Delayed or cancelled time critical activity	31	14	17
Delay between admission for induction and beginning of process.	15	4	2
Labour Ward Coordinator (LWC) not supernumerary.	0	0	0
One - one care in active labour	0	0	0
Delay in Triage	0	0	0
Missed or delayed care	0	1	0

2.1 Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary LWC is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward. In quarter two, one red flag was raised for loss of LWC supernumerary status during the shift for a brief period to support a midwife with a comfort break. In addition, compliance is monitored for the allocated LWC having supernumerary status at the start of every shift, as per MIS year 6 (Table 4).

Table 4. LWC supernumerary status: start of shift

	Number of days per month	Number of shifts per month	Compliance
January	31	62	100%
February	28	56	100%
March	30	60	100%

2.2 One to One in Established Labour

1:1 care is defined as “care provided for the woman throughout labour exclusively by a midwife solely dedicated to her care (not necessarily the same midwife for the whole of labour” (NICE 2015). During this reporting period there were no occasions when 1:1 care was recorded as not being provided (table 5).

Table 5. One to one care compliance.

	January	February	March
One-one care in active labour	100%	100%	100%

3. Obstetric staffing

The service meets full requirement established at consultant grade. There has been pressure within the consultant workforce since quarter 4 2024, available for on call and elective obstetric work due to occupational health requirements and acute sickness. This has involved 2 consultants. The department has now successfully recruited one Locum Consultant in one gap. The existing Consultant workforce are undertaking additional shifts to provide cover for one colleague. Weekly obstetrics and gynaecology staffing is coordinated with by the Rota Consultant lead, rota administration team and the College tutor to ensure safe staffing and meeting the training needs of the doctors in training in the department. There is an emergency rota cover contact doctor every day for resident doctor sickness and absence. This is reflected on the Medi rota. There are twice daily multidisciplinary team handovers of care for obstetrics and twice daily consultant led multidisciplinary ward rounds taking place. There is on-going monitoring of consultant attendance for obstetric emergencies to ensure appropriate consultant attendance for complex obstetric emergency care in line with the national recommendations of Royal College of Obstetrics and Gynaecology. The data is submitted regularly to the MIS lead, and we are 100% compliant from the last assessment.

4. Neonatal Nurse Staffing

Currently on the NICU, we have an agreement to go over budget by 5 WTE and we are fully recruited. In addition, we also have 2.5 WTE agreed to cover for maternity leave. We have seen an increase in clinical work over the last quarter due to alterations in pathways and more recently due to an outbreak of CPE in the quaternary unit. Therefore, despite the additional WTE staff, we have still, on occasion, utilised our paediatric colleagues for support as well as some NHSP shifts to fill this gap, enabling us to remain open to extremely preterm births and intensive care specific deliveries. Overall in Q4 we were 86% complaint with the BAPM nursing standards against a national standard of 79%.

5. Neonatal Medical Staffing Compliance

The neonatal tier 2 compliance rate was 84%. We have 6.7 WTE on tier 2 rota and the requirement is 8 as per BAPM. We have upskilled two tier 1 Nurse practitioners to start on tier 2. We were fully compliant with tier 1 rota and the consultant rota.

6. Anaesthetics

In quarter 4 the service provided a 24hour service. This can be evidenced via rotas

7. Recommendations

The members are asked to note the content of the report.

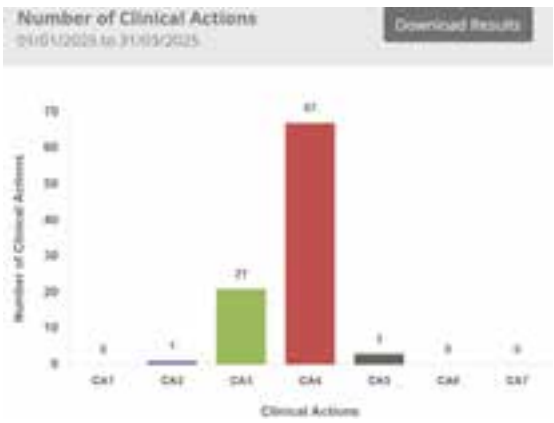
8. Appendices

Appendix 1. Clinical actions.

Appendix 1

Number of Staffing Factors
01/01/2025 to 31/03/2025 — Download Results

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	123	30%
SF2	Unable to fill vacant shifts	123	30%
SF3	MW on transfer duties	1	0%
SF4	MW redeployed to another area	16	4%
SF5	No MCA on duty	44	11%
SF6	No ward clerk on duty	108	26%
SF7	Skill mix issue (identify)	0	0%
TOTAL		415	



Number of Clinical Actions
01/01/2025 to 31/03/2025 — Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Decline in-utero transfer	0	0%
CA2	Delay in accepting transfers	1	1%
CA3	Delay in commencing IOL from admission (>2hrs)	21	23%
CA4	Delay in continuing IOL (>4hrs)	67	73%
CA5	Delay in transfer of cases to theatre (e.g. perineal repair, MROP)	3	3%
CA6	Delay in transfer of cases to theatre (e.g. perineal repair, MROP)	0	0%
CA7	Delay/cancel planned procedures, e.g. Ferriniject,cervical suture	0	0%
TOTAL		92	

Number of Management Actions
01/01/2025 to 31/03/2025 — Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	62	91%
MA2	Staff unable to take allocated breaks	2	3%
MA3	Staff stayed beyond rostered hours	0	0%
MA4	Specialist MW working clinically	0	0%
MA5	Manager/Matron working clinically	0	0%
MA6	Midwifery manager called in out of hours	2	3%
MA7	Close Marton Suite	2	3%
MA8	Low dependency women re-directed to FMC	0	0%
MA9	US dept. to undertake EPAU/MAU scans to free MW sonographers	0	0%

Audit & Risk Committee

Connecting to: Trust Board, Chair Ken Readshaw, 28 March 2025

Key topics discussed in the meeting:

External Audit

Draft audit strategy memorandum reviewed. Previous significant weakness in relation to VFM (NHSE licence conditions) to be reviewed.

Internal Audit

Two internal audits were received

Omnicell - controlled drugs on wards. Critical risk. Agreed actions have a very short timeline and so significant improved in the risk environment should already be in place.

Recruitment. High risk. Recommended to be considered by the people committee at their next meeting.

Escalated items:

- No issues escalated

Risks (Include ID if currently on risk register):

No new risks identified

NHS
University Hospitals Tees

Audit & Risk Committee STHT and Audit Committee NTHT meeting in common

Connecting to: Trust Boards, Chair Ken Readshaw, & Alison Fellows, 28 March 2025

Key topics discussed in the meeting:

Business of other committees – the Audit Committees of the Trusts are responsible for reviewing the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. This will include the Quality and Assurance Committee the Resource Committee and People Committee.

Presentations were given by the three Chairs of the Committees on their effectiveness over the last 10 months, work on managing strategic risk and key assurances received.

Escalated items:

The Audit Chair of NTHT and STHT Committees would escalate to the Trust Boards that they are satisfied that the Group Committees of the Board effectively discharge their responsibilities with assurance and managing risk.

Risks (Include ID if currently on risk register):

No new risks identified

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NHS
University Hospitals Tees

Charitable Funds Committee STHFT

Connecting to: Corporate Trustee via Unitary Board, Chair Derek Bell – 12 March 2025

Key topics discussed in the meeting:

Review of income and expenditure and current portfolio of investment report - Members noted that the income and expenditure position is showing a deficit and a negative contribution to reserves of £0.364m, which includes an unrealised loss on CCLA (investment provider) investments of £0.010m. CCLA investments from the time of deposit in 2020 are showing an unrealised gain of £0.799m as of 31 December 2024. Total dividend income received in year to date was £0.140m. The general fund opened the year with a balance of £1.391m. The current balance as of 31 December 2024 is £1.386m. The fund has current commitments of £0.655m, which would reduce the balance to £0.731m

Restricted / designated funds – 3 applications were discussed and all required further work and clarification before being reconsidered at Committee.

General fund applications - 2 applications were discussed and all required further work and clarification before being reconsidered at Committee.

Maggie's Centre update – work progressing the introduction of Maggie's onto the James Cook site was discussed.

Escalated items:

That a draw down from the investments would be undertaken

Risks (Include ID if currently on risk register):

No new risks identified

Caring Better Together

NHS
University Hospitals Tees

NTHFT Charitable Funds Committee and STHFT Charitable Funds Committee meeting in common

Connecting to: Corporate Trustee via Unitary Boards, Chair Derek Bell – 12 March 2025

Key topics discussed in the meeting:

Cycle of business – adopted across both Committees

Joint working initiatives – programme of opportunities to work together reviewed.

Charitable Funds open grant round 2025/26 – noted progress with further work to be undertaken to identify funding available and in what categories

Arts Council – TOR approved

Escalated items:

Ongoing joint working between the two charity teams

Risks (Include ID if currently on risk register):

No new risks identified

Caring Better Together

NHS
University Hospitals Tees

Modern Slavery and Human Trafficking Statement - STHFT

Meeting date: *8 May 2025*

Reporting to: *South Tees Trust Board*

Agenda item No: 23

Report author: *Jackie White, Head of Governance/Company Secretary*

Action required:
Approval

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:

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.

To present the Modern Slavery and Human Trafficking Statement for 2025/26 to the Board of Directors for approval, in line with requirements of section 54 (1) of the Modern Slavery Act 2015.

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps the Trust and its subsidiary company: South Tees Healthcare Management Limited have taken, and are continuing to take, to make sure that modern slavery or human trafficking is not taking place within the business, subsidiary companies or supply chain during the year ending 31 March 2026.

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

The Modern Slavery Act 2015 introduced changes in UK law, focused on increasing transparency in supply chains. Specifically, large businesses are now required to disclose the steps they have taken to ensure their business and supply chains are free from modern slavery, that is, slavery, servitude, forced and compulsory labour and human trafficking.

Commercial organisations that supply goods or services and have a minimum turnover of £36 million are required to produce a 'slavery and human trafficking statement' each financial year. This should set out the steps taken to ensure modern slavery is not taking place in the organisation's own business and its supply chains.

The Trust supports and has zero tolerance for slavery and human trafficking and is fully aware of its responsibilities towards service users, employees and local communities. There is an expectation that all the companies it does business with share and adhere to the same ethical values. The Trust has in place due diligence and internal policies and procedures that assess supplier risk in relation to the potential for modern slavery or human trafficking. It also operates a number of policies which support it in conducting business in an ethical manner, including recruitment and selection; equal opportunities and diversity; safeguarding; freedom to speak up; procurement; standards of business conduct; grievance and counter fraud, bribery and corruption.

The appended statement has been developed with input from a number of key stakeholders.

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

approval at Board level, following which it will be published in a organisation's website and that of its subsidiary companies.

Recommendations:

The Group Board of Directors are asked to approve the statement.

Caring Better Together

Slavery and Human Trafficking Statement 2025/26

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps that South Tees Hospitals NHS Foundation Trust and its subsidiary company: South Tees Healthcare Management Limited have taken, and are continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business, subsidiary companies or supply chain during the year ending 31 March 2026.

Due to the scope of our business, South Tees Hospitals NHS Foundation Trust recognises that it may be at risk of modern slavery, which encompasses slavery, servitude, human trafficking and forced labour. The Trust has a zero tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to putting effective systems and controls in place to safeguard against any form of modern slavery taking place within the business or our supply chain.

About the organisation

South Tees Hospitals NHS Foundation Trust provides more than 37 specialities to 1.5 million patients across Teesside, North Yorkshire and beyond. Care is delivered from two main acute hospital sites, James Cook University Hospital and the Friarage Hospital in Northallerton, in addition to a number of community facilities across the area including Redcar Primary Care Hospital, East Cleveland Primary Care Hospital and the Friary Community Hospital.

We provide a large number of specialist services – delivering world-class cancer, cardiothoracic, spinal, cochlear implant, neurosciences, gynaecology vascular and urology care for patients across our region.

Together with our three primary care hospital wards and local community NHS teams, we provide care closer to home for patients from Hawes to East Cleveland and everywhere in between.

With more than 10,000 staff, we are the largest employer in Teesside and North Yorkshire.

The Trust's Commitment

The Trust supports and is aware of its responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. We have internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking.

We have zero tolerance for slavery and human trafficking and are fully aware of our responsibilities towards our service users, employees and local communities. We expect all the companies we do business with to share the same ethical values.

We also have an impartial Freedom to Speak up Guardian who supports staff to raise any concerns.

Due Diligence

We are committed to ensuring that:

- There is no modern slavery or human trafficking in our supply chains or in any part of our business and this includes our subsidiary South Tees Healthcare Management Limited;
- Employment with the Trust and our suppliers is entirely voluntary;
- Our workplaces, and those of our subsidiaries and suppliers, are safe, healthy and free from discrimination or harassment based on age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex or sexual orientation, or any other characteristic that is protected by law;
- Corruption, in all its forms including extortion and bribery is prohibited;
- We have a number of policies which support us in conducting business in an ethical manner, including:
    - Recruitment and Selection Policy
    - Equal Opportunities and Diversity Policy
    - Adult Safeguarding Policy
    - Safeguarding Children Policy
    - Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy
    - Standards of Business Conduct Policy
    - Procurement Policy
    - Resolution Policy
    - Counter fraud, Bribery and Corruption Policy

All policies are reviewed to ensure they are working effectively every 3 years or earlier if relevant laws change or new evidence or guidance becomes available and they are available on the Trust's website www.southtees.nhs.uk.

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain, the Trust and its subsidiary companies operates and adheres to a robust recruitment process including compliance with the National NHS Employment Checks / Standards (this includes employees UK address, right to work in the UK and suitable references) and employ agency staff (where appropriate) from agencies on approved frameworks so that we are assured that pre-employment clearance has been obtained to safeguard against human trafficking or individuals being forced to work against their will. If there is not an available worker from a framework agency, this is escalated to senior managers and local pre-employment checks, including the right to work in the UK, are sought.

We adhere to the principles inherent within both our safeguarding children and adult's policies. These provide clear guidance so that our employees are clear on how to raise safeguarding concerns, and by ensuring representation via the safeguarding team, on the Modern Slavery Network and the Vulnerable, Exploited, Missing, Trafficked strategic and operational groups, we provide a level of compliance with all respective laws and regulations.
of fair pay rates, fair terms and conditions of employment and access
ent opportunities.

Our purchasing and procurement is governed by the new Procurement Act 2023, the NHS 'Supplier Code of Conduct' and standard NHS Terms & Conditions. The Procurement Act, which came into force in February 2025, strengthens the approach to tackle modern slavery in public procurement by introducing mandatory exclusion grounds and broader discretionary grounds for excluding suppliers. This means for suppliers found to be involved in modern slavery practices or connected to individuals convicted of such offences are more easily excluded from bidding on public contracts.

High value contracts are effectively managed and relationships built with suppliers through frameworks, which have been negotiated under the NHS Standard Terms and Conditions of Contract with anti-slavery and human trafficking policies and processes in place. All of our suppliers must comply with the provisions of the UK Modern Slavery Act (2015).

The Trust upholds professional codes of conduct and practice relating to procurement and supply, including through our Procurement Team's membership of the Chartered Institute of Procurement and Supply.

Training

Advice and training about modern slavery and human trafficking, including how to identify and respond to concerns and how to report suspected cases of modern slavery, is available to staff through our mandatory safeguarding children and adults training programmes, our safeguarding policies and procedures, and our safeguarding leads.

We also provide additional, targeted training for members of staff who are likely to identify modern slavery concerns in the course of their work. If required, bespoke training is provided to teams who identify a need for further information and support.

Our performance indicators

We will know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if: no reports are received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified.

The Trust reviews its Modern Slavery and Human Trafficking Statement on an annual basis and presents it at the Board of Directors meeting in Public. This demonstrates a public commitment, ensures visibility and encourages reporting standards.

Approval for this statement

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

Derek Bell
Group Chair

Stacey Hunter
Group Chief Executive

Caring Better Together

NHS
University Hospitals Tees

RETROSPECTIVE APPROVAL OF DOCUMENTS EXECUTED UNDER SEAL - STHFT

Meeting date: 8 May 2025

Reporting to: South Tees Trust Board

Agenda item No: 24

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

Action required:
Approval

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:

Key discussion points and matters to be escalated from the meeting

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

The NHS Act 2006, paragraph 29(1), Schedule 7 set out the requirement for foundation trust constitutions to make provision for the authentication of the fixing of the company's seal to execute documents as required and a report of all sealing to be made to the Board of Directors.

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

Seal No	Document	Signed and Sealed by
2024/006	UTC Supplemental Works V0772 Letter of Indemnity and Notice of Assignment Between 1. South Tees Hospitals NHS FT 2. Endeavour SCH PLC	Chris Hand, Group Chief Finance Officer Stacey Hunter, Group Chief Executive Sealed: 29 October 2024
2024/007	Engrossment Documents: Cath Lab Works Variation VO708 Between 1. South Tees Hospitals NHS FT 2. Endeavour SCH PLC	Derek Bell, Group Chair Stacey Hunter, Group Chief Executive Sealed: 12 November 2024
2024/008	EngrossmentDocuments: Radiotherapy CT Scanner Works Variation VO780 Between 1. South Tees Hospitals NHS FT 2. Endeavour SCH PLC	Derek Bell, Group Chair Stacey Hunter, Group Chief Executive Sealed: 12 November 2024
2024/009	Deed of Variation – Supplementary Agreement relating to 2018 Benchmarking Deed Between ospitals NHS FT	Derek Bell, Group Chair Stacey Hunter, Group Chief Executive Sealed: 9 December 2024

	2. Endeavour SCH PLC	
2025/001	Supplementary Agreement to a Concession Agreement dated 16 August 1999 in relation to Variations VO749, VO750, VO751 and VO752	Chris Hand, Group Chief Finance Officer Stacey Hunter, Group Chief Executive Sealed: 7 January 2025
2025/002	Sub Underlease relating to four second floor offices, Murray Building, JCUH, Marton Road, Middlesbrough TS4 3BW Between 1. South Tees Hospitals NHS FT 2. The Secretary of State for Defence	Chris Hand, Group Chief Finance Officer Stacey Hunter, Group Chief Executive Sealed: 7 January 2025
2025/003	Mould Room Works Variation VO749 Supplementary Agreement to Concession Agreement VO748 Between 1. South Tees Hospitals NHS FT 2. Endeavour SCH PLC	Chris Hand, Group Chief Finance Officer Stacey Hunter, Group Chief Executive Sealed: 4 February 2025
2025/004	Lease of Property known as Land at Brompton Road, Northallerton, DL6 1DS Between 1. South Tees Hospitals NHS FT 2. West Court Properties Limited	Chris Hand, Group Chief Finance Officer Derek Bell, Group Chair Sealed: 6 February 2025
2025/006	Sale Purchase Agreement – for the sale and purchase of certain shares of Healthcall Solutions Limited Between 1. Northumbria Healthcare NHS Foundation Trust 2. The Sellers 3. The Warrantors	Stacey Hunter, Group Chief Executive Derek Bell, Group Chair Sealed: 5 March 2025
2025/005	Shareholders' Agreement in relation to Healthcall Solutions Limited Between 1. Northumbria Healthcare [illegible] Foundation Trust	Signed by: Stacey Hunter, Group Chief Executive Derek Bell, Group Chair

	2. The Ordinary Shareholders 3. Healthcall Solutions Limited	Sealed: 5 March 2025

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

The documents were signed and executed under seal in line with the provisions set out in the Trust's Constitution.

Recommendations:

The Board are asked to grant retrospective approval for the sealing of this document.

NHS
University Hospitals Tees

Audit & Risk Committee STHT and Audit Committee NTHT meeting in common

Connecting to: Trust Boards, Chair Ken Readshaw, & Alison Fellows, 28 March 2025

Key topics discussed in the meeting:

Business of other committees – the Audit Committees of the Trusts are responsible for reviewing the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. This will include the Quality and Assurance Committee the Resource Committee and People Committee.

Presentations were given by the three Chairs of the Committees on their effectiveness over the last 10 months, work on managing strategic risk and key assurances received.

Escalated items:

The Audit Chair of NTHT and STHT Committees would escalate to the Trust Boards that they are satisfied that the Group Committees of the Board effectively discharge their responsibilities with assurance and managing risk.

Risks (Include ID if currently on risk register):

No new risks identified

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NHS
University Hospitals Tees

Charitable Funds Committee NTHFT

Connecting to: Corporate Trustee via Unitary Board, Chair Derek Bell – 12 March 2025

Key topics discussed in the meeting:

Review of income and expenditure and current portfolio of investment report - Members noted that income and expenditure position is showing £3,067,780, which includes a year to date unrealised gain of £57,115 in CCLA (portfolio investment provider)

Staff lottery update and bid update – noted that current fund was £42k; Members were noted that there were 72 bids received, 48 bids approved by the sub group of the Committee. There are 10 still processing and 19 bids have been through the process. 25 bids supported health and wellbeing projects, 12 supported equipment for health and wellbeing, 9 environmental upgrades and 2 staff education projects.

General fund bid update - 55 bids had been received. 37 bids progressed and 18 bids still outstanding from May last year.

Escalated items:

No issues to escalate

Risks (Include ID if currently on risk register):

No new risks identified

Caring Better Together

NHS
University Hospitals Tees

NTHFT Charitable Funds Committee and STHFT Charitable Funds Committee meeting in common

Connecting to: Corporate Trustee via Unitary Boards, Chair Derek Bell – 12 March 2025

Key topics discussed in the meeting:

Cycle of business – adopted across both Committees

Joint working initiatives – programme of opportunities to work together reviewed.

Charitable Funds open grant round 2025/26 – noted progress with further work to be undertaken to identify funding available and in what categories

Arts Council – TOR approved

Escalated items:

Ongoing joint working between the two charity teams

Risks (Include ID if currently on risk register):

No new risks identified

Caring Better Together

NHS
University Hospitals Tees

Modern Slavery and Human Trafficking Statement - NTHFT

Meeting date: *8 May 2025*

Reporting to: *North Tees Trust Board*

Agenda item No: 27

Report author: *Jackie White, Head of Governance/Company Secretary*

Action required:
Approval

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:

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.

To present the Modern Slavery and Human Trafficking Statement for 2025/26 to the Board of Directors for approval, in line with requirements of section 54 (1) of the Modern Slavery Act 2015.

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps the Trust and its subsidiary companies: North Tees and Hartlepool Solutions Limited Liability Partnership and Optimus Health Limited have taken, and are continuing to take, to make sure that modern slavery or human trafficking is not taking place within the business, subsidiary companies or supply chain during the year ending 31 March 2026.

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

The Modern Slavery Act 2015 introduced changes in UK law, focused on increasing transparency in supply chains. Specifically, large businesses are now required to disclose the steps they have taken to ensure their business and supply chains are free from modern slavery, that is, slavery, servitude, forced and compulsory labour and human trafficking.

Commercial organisations that supply goods or services and have a minimum turnover of £36 million are required to produce a 'slavery and human trafficking statement' each financial year. This should set out the steps taken to ensure modern slavery is not taking place in the organisation's own business and its supply chains.

The Trust supports and has zero tolerance for slavery and human trafficking and is fully aware of its responsibilities towards service users, employees and local communities. There is an expectation that all the companies it does business with share and adhere to the same ethical values. The Trust has in place due diligence and internal policies and procedures that assess supplier risk in relation to the potential for modern slavery or human trafficking. It also operates a number of policies which support it in conducting business in an ethical manner, including recruitment and selection; equal opportunities and diversity; safeguarding; freedom to speak up; procurement; standards of business conduct; grievance and counter fraud, bribery and corruption.

The appended statement has been developed with input from a number of key stakeholders.

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

approval at Board level, following which it will be published in a organisation's website and that of its subsidiary companies.

Caring Better Together

Recommendations:

The Group Board of Directors are asked to approve the statement.

Caring Better Together

Slavery and Human Trafficking Statement 2025/26

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps that North Tees and Hartlepool NHS Foundation Trust and its subsidiary companies: North Tees and Hartlepool Solutions Limited Liability Partnership (NTH Solutions LLP) and Optimus Health Limited have taken, and are continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business, subsidiary companies or supply chain during the year ending 31 March 2026.

Due to the scope of our business, North Tees and Hartlepool NHS Foundation Trust recognises that it may be at risk of modern slavery, which encompasses slavery, servitude, human trafficking and forced labour. The Trust has a zero tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to putting effective systems and controls in place to safeguard against any form of modern slavery taking place within the business or our supply chain.

About the organisation

North Tees and Hartlepool NHS Foundation Trust provides integrated hospital and community health services to a population of around 400,000 people in Stockton-on-Tees, Hartlepool and East Durham, including Sedgefield, Peterlee and Easington. Care is delivered from two main acute hospital sites, the University Hospital of Hartlepool and the University Hospital of North Tees in Stockton-on-Tees and a number of community facilities across the area including Peterlee Community Hospital and the One Life Centre, Hartlepool. The Trust provides bowel and breast screening services, as well as community dental services to a wider population in Teesside and Durham and employs approximately 5,500 medical, nursing, allied health professionals, clinical and non-clinical support staff with a total annual turnover of around £365 million.

The strategic objectives of the organisation are:

- Putting our population first
- Valuing People
- Transforming our services
- Health and Wellbeing

The Trust's Commitment

The Trust supports and is aware of its responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. We have internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking.

We have zero tolerance for slavery and human trafficking and are fully aware of our responsibilities towards our service users, employees and local communities. We expect all the companies we do business with to share the same ethical values.

We also have an impartial Freedom to Speak up Guardian who supports staff to raise any concerns.

Due Diligence

We are committed to ensuring that:

- There is no modern slavery or human trafficking in our supply chains or in any part of our business and this includes our subsidiaries NTH Solutions LLP and Optimus Health Limited;
- Employment with the Trust and our suppliers is entirely voluntary;
- Our workplaces, and those of our subsidiaries and suppliers, are safe, healthy and free from discrimination or harassment based on age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex or sexual orientation, or any other characteristic that is protected by law;
- Corruption, in all its forms including extortion and bribery is prohibited;
- We have a number of policies which support us in conducting business in an ethical manner, including:
    - Recruitment and Selection Policy
    - Equal Opportunities and Diversity Policy
    - Adult Safeguarding Policy
    - Safeguarding Children Policy
    - Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy
    - Standards of Business Conduct Policy
    - Procurement Policy
    - Resolution Policy
    - Counter fraud, Bribery and Corruption Policy

All policies are reviewed to ensure they are working effectively every 3 years or earlier if relevant laws change or new evidence or guidance becomes available and they are available on the Trust's website www.nth.nhs.uk.

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain, the Trust and its subsidiary companies operates and adheres to a robust recruitment process including compliance with the National NHS Employment Checks / Standards (this includes employees UK address, right to work in the UK and suitable references) and employ agency staff (where appropriate) from agencies on approved frameworks so that we are assured that pre-employment clearance has been obtained to safeguard against human trafficking or individuals being forced to work against their will. If there is not an available worker from a framework agency, this is escalated to senior managers and local pre-employment checks, including the right to work in the UK, are sought.

We adhere to the principles inherent within both our safeguarding children and adult's policies. These provide clear guidance so that our employees are clear on how to raise safeguarding concerns, and by ensuring representation via the safeguarding team, on the Modern Slavery Network and the Vulnerable, Exploited, Missing, Trafficked strategic and operational groups, we provide a level of compliance with all respective laws and regulations. [illegible]of fair pay rates, fair terms and conditions of employment and access [illegible]ent opportunities.

Our purchasing and procurement is governed by the new Procurement Act 2023, the NHS 'Supplier Code of Conduct' and standard NHS Terms & Conditions. The Procurement Act, which came into force in February 2025, strengthens the approach to tackle modern slavery in public procurement by introducing mandatory exclusion grounds and broader discretionary grounds for excluding suppliers. This means for suppliers found to be involved in modern slavery practices or connected to individuals convicted of such offences are more easily excluded from bidding on public contracts.

High value contracts are effectively managed and relationships built with suppliers through frameworks, which have been negotiated under the NHS Standard Terms and Conditions of Contract with anti-slavery and human trafficking policies and processes in place. All of our suppliers must comply with the provisions of the UK Modern Slavery Act (2015).

The Trust upholds professional codes of conduct and practice relating to procurement and supply, including through our Procurement Team's membership of the Chartered Institute of Procurement and Supply.

Training

Advice and training about modern slavery and human trafficking, including how to identify and respond to concerns and how to report suspected cases of modern slavery, is available to staff through our mandatory safeguarding children and adults training programmes, our safeguarding policies and procedures, and our safeguarding leads.

We also provide additional, targeted training for members of staff who are likely to identify modern slavery concerns in the course of their work. If required, bespoke training is provided to teams who identify a need for further information and support.

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The Trust reviews its Modern Slavery and Human Trafficking Statement on an annual basis and presents it at the Board of Directors meeting in Public. This demonstrates a public commitment, ensures visibility and encourages reporting standards.

Approval for this statement

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

Derek Bell
Group Chair

Stacey Hunter
Group Chief Executive

Caring Better Together

University Hospitals Tees

RETROSPECTIVE APPROVAL OF DOCUMENTS EXECUTED UNDER SEAL - NTHFT

Meeting date: 8 May 2025

Reporting to: North Tees Trust Board

Agenda item No: 28

Report author: Sarah Hutt, Assistant Company Secretary

Action required:
Approval

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:

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.

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

Sale Purchase Agreement – for the sale and purchase of certain shares of Healthcall Solutions Limited Between 1. Northumbria Healthcare NHS Foundation Trust 2. The Sellers 3. The Warrantors	Signed by: Stacey Hunter, Group Chief Executive Derek Bell, Group Chair Sealed: 5 March 2025
Shareholders' Agreement in relation to Healthcall Solutions Limited Between 1. Northumbria Healthcare NHS Foundation Trust 2. The Ordinary Shareholders 3. Healthcall Solutions Limited	Signed by: Stacey Hunter, Group Chief Executive Derek Bell, Group Chair Sealed: 5 March 2025

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

The documents were signed and executed under seal in line with the provisions set out in the Trust's Constitution.

Recommendations:

The Board are asked to grant retrospective approval for the sealing of this document.

Caring Better Together