The Newcastle upon Tyne Hospitals NHS Foundation Trust

Public Trust Board of Directors' Meeting

Thursday 23 May 2024, 15:30 – 17.00

Venue: Training Rooms 3 & 4, Education Centre, Freeman Hospital

Agenda

Item		Lead	Paper	Timing
1.	Apologies for absence and declarations of interest	Kath McCourt	Verbal	15:30 – 15:31
2.	Minutes of the Meeting held on 28 March 2024 and Matters Arising	Kath McCourt	Attached	15:31 - 15:32
3.	Chair's Report	Kath McCourt	Attached	15:32 – 15:37
4.	Chief Executive's Report; including: - CQC update	Jim Mackey	Presentation	15:37 – 15:52
Strategic items:				
5.	Patients: Patient Story	Annie Laverty	Attached	15:52 – 15:57
6.	Patients: Cardiac Surgery Update	Jim Mackey & Michael Wright	Presentation	15:57 – 16:15
7.	People: Fuller Enquiry Update	Lucia Pareja-Cebrian	Attached	16:15 – 16:20
8.	People: WRES & WDES [FOR APPROVAL]	Christine Brereton	Attached	16:20 – 16:25
9.	Performance: Revised Integrated Quality and Performance Report	Rob Harrison & Vicky McFarlane-Reid	Attached	16:25 – 16:30
10.	Partnerships: GNH Alliance	Jim Mackey	Attached	16:30 – 16:35
Items to receive *[NB for information – matters to be raised by exception only]*:				16:35 – 16:45
11.	Director reports: a. Joint Medical Directors Report; including: i) Consultant Appointments	Lucia Pareja Cebrian & Michael Wright	Attached	
	b. Executive Director of Nursing; including: i) Maternity Update	Ian Joy	Attached	
	c. Director of Quality & Effectiveness: i) Maternity CNST – Year 6 ii) Learning from Deaths Q4 report	Angela O'Brien	Attached	
	d. Healthcare Associated Infections (HCAI)	Julie Samuel	Attached	
Items to approve				

12.	i)	Annual Committee Reports 2023/24, including Terms of Reference Reviews and Schedules of Business 2024/25	Kelly Jupp	Attached	16:45 – 16:47
	ii)	Quality Account	Angela O'Brien	Attached	16:47 – 16:50

Any other business: 16:50 – 17:00

13.	Board Assurance Framework (BAF) 2024/25	Caroline Docking	Attached
14.	Update from Committee Chairs	Committee Chairs	Attached
15.	Meeting Action Log	Kath McCourt	Attached
16.	Any other business	All	Verbal

Date of next meeting:
Public Board of Directors – Wednesday 17 July 2024

Professor Kath McCourt, Interim Chair

Sir Jim Mackey, Chief Executive Officer

Mr Rob Harrison, Managing Director

Mr Ian Joy, Executive Director of Nursing

Dr Lucia Pareja-Cebrian and Dr Michael Wright, Joint Medical Director

Dr Vicky McFarlane-Reid, Director for Commercial Development & Innovation

Mrs Angela O'Brien, Director of Quality & Effectiveness

Ms Annie Laverty, Chief Experience Officer

Ms Julie Samuel, Director of Infection Prevention and Control

Mrs Caroline Docking, Director of Communications and Corporate Affairs

Mrs Kelly Jupp, Trust Secretary

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PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 28 MARCH 2024

Present:	Professor K McCourt *[Chair]*	Interim Chair
	Sir J Mackey	Chief Executive Officer [CEO]
	Mr R Harrison	Managing Director [MD]
	Dr M Wright	Joint Medical Director [JMD - MWr]
	Dr L Pareja-Cebrian	Joint Medical Director [JMD - LPC]
	Mrs J Bilcliff	Chief Finance Officer [CFO]
	Ms Maurya Cushlow	Executive Chief Nurse [ECN]
	Mr Ian Joy	Executive Director of Nursing [EDN]
	Dr V McFarlane Reid	Director for Commercial Development & Innovation [DCDI]
	Ms J Baker	Non-Executive Director [NED]
	Ms S Edusei	NED
	Mr J Jowett	NED
	Mr B MacLeod	NED
	Miss C Smith	NED
	Mr G Chapman	NED

In attendance:
Mrs C Docking, Director of Communications and Corporate Affairs [DCCA]
Mrs A O'Brien, Director of Quality and Effectiveness [DQE]
Mrs C Brereton, Chief People Officer [CPO]
Mr R C Smith, Director of Estates [DoE]
Mrs K Jupp, Trust Secretary [TS]
Dr J Samuel, Director of Infection Prevention Control [DIPC]
Mrs A Laverty Chief Experience Officer [CXO]

Observers:
Mrs P Yanez, Lead Governor
Dr A Dearges-Chantler, Public Governor
Professor P Home, Public Governor
Mrs C Watson, Public Governor

Secretary:	Miss J Richards	Corporate Governance Officer and PA to the Chairman and Trust Secretary

Note: The minutes of the meeting were written as per the order in which items were discussed.

24/05 **STANDING ITEMS:**

i) **Apologies for Absence and Declarations of Interest**

Apologies were received from Mr M Wilson, Chief Operating Officer [COO], Mrs S McMahon, Chief Information Officer [CIO], Mrs L Bromley, NED, and there were no new declarations of interest.

It was resolved: to (i) **receive** the apologies for absence and (ii) **note** no declarations of interest.

ii) Minutes of the previous meeting held on 25 January 2024 and matters arising

The minutes of the meeting held on 25 January 2024 were accepted as a true record of the business transacted subject to a correction to note that Mrs J Samuel should be addressed as Dr.

It was resolved: to **agree** the minutes as an accurate record subject to the correction being made as highlighted, and to **note** there were no matters arising other than noted above.

iii) Interim Chair's Report

The report outlined a summary of the Interim Chair's activities and key areas of recent focus since the previous Board of Directors meeting.

The Interim Chair noted she had been busy undertaking a number of activities since the previous meeting, this has included lots of work with the Governors, as well as the Members Event – End of Life which was a very successful event, to which the Interim Chair thanked all involved. Two "Spotlight on Services" sessions on The Stroke Unit and Long Term Ventilation have also been held.

The Interim Chair has undertaken a number of informal visits to wards during various shifts engaging with both staff, such as Security Staff and Patient Flow Coordinators, as well as patients.

The Interim Chair along with MD and the CEO attended an Emergency Care Conference organised by the Great North Healthcare Alliance which was a real opportunity for the alliance organisations to focus on this key area of health and develop collaborative ideas and plans.

At a regional level, the Interim Chair continued to engage with both Foundation Trust Chairs and the Integrated Care Board (ICB).

It was **resolved:** to **receive** the report.

iv) Chief Executive's Report

The CEO delivered a short presentation highlighting key areas of focus, including the work on rewriting the governance system, changes in postholders such as the Freedom to Speak

Up Guardian, positive engagement with staff, the local staff survey and the work undertaken on developing the 'Big Signals'.

The implementation of the Patient Safety Incident Response Framework (PSIRF) was going well with very good engagement. The number of clinical incidents reported was rising, which demonstrated improvements in reporting and staff feeling confident to raise incidents.

There had been a positive reduction in the number of long waiting patients, as well as a 9% decrease in the overarching waiting list size for Newcastle Hospitals.

The second round of Chief Executive roadshows with staff were scheduled for April and May providing further opportunity for staff engagement and to provide feedback on issues raised previously.

Mr J Jowett referred to recent feedback from staff members who had commented positively on the changes made by the CEO since his appointment.

It was **resolved:** to **receive** the report.

24/06 STRATEGIC ITEMS:

i) Patients: Patient Story

The CXO gave an overview of a patient's story which focussed on a 64-year-old gentleman diagnosed with advanced bowel cancer in 2017. The patient had emailed Trust Management in March 2024, having read the CQC report and was motivated to get in touch, because the shortfalls in care described in the report did not reflect his own experience and wanted to have his account of excellent care on record.

The CXO had visited the patient where they described the positive contributions of all members of the multidisciplinary team over 'hundreds of interactions' and the reasons why these encounters were so memorable. She highlighted how small things can have a positive lasting impact, particularly regarding care and compassion.

It was **resolved:** to **receive** the people story.

ii) Patients: Experience of Care Strategy [FOR APPROVAL]

The report provided an overview of the development of Experience of Care Strategy and outlined the plans for the launch of this strategy in April 2024. The EDN noted the following key points:

- A piece of work to deliver a public and patient experience strategy was commissioned in July 2023 with the organisation Stand, with funding received from the Trust Charity.

- There was a lot of engagement with a number of key stakeholders, carers, frontline staff, Senior Managers and Governors to develop a strategy that represented collective views.
- Five key objectives have been identified which are outlined in the strategy.
- Successful delivery is reliant on a really cohesive work plan which will be developed in the coming weeks.

Miss Smith questioned if there had been a previous strategy, and if there had what the key differences were with the previous strategy. The EDN noted that whilst the Trust had some key patient experience priorities/principles, an overarching strategy had not been developed. He added that the strategy signals an intent and approach to drive delivery and practice.

Mr MacLeod queried how the strategy would provide consistency across the Clinical Boards to which the EDN noted that workplans would be developed for each Clinical Board, with the CXO being the Executive lead.

The CXO added that a real time pilot for staff / patient experience would be commencing in May, with the support of the Trust Charity, and the variation across Clinical Boards will be monitored. The outcomes would also be widely publicised across the organisation providing full transparency.

Ms Edusei welcomed the strategy but questioned if feedback should be sought with stakeholders prior to the launch to which the EDN advised that the strategy had been developed with full engagement of the stakeholders and the future feedback to be gathered would focus more on its delivery.

In response to a query from the Interim Chair with regard to future updates, the EDN advised that the results from the real time pilot would be presented to the Quality Committee and Trust Board.

It was **resolved** to (i) **note** the process undertaken to develop; (ii) **approve** the Experience of Care Strategy and (iii) **endorse** the launch of the strategy in April 2024.

iii) People: Staff Survey results / People Programme

The CPO delivered a short presentation highlighting the following points:

- There was a 42% response rate and the staff survey results are reported against a number of core domains.
- The Trust scored below average in each of the 9 staff survey domains – and was worst in the country for the “we are a team” The Trust scored worst nationally in 8 questions aligned to leadership and line management. There were 10 areas of negative decline compared to 2022 and 2023.
- Staff engagement ‘Advocacy’ showed a steady decline over the last 3 years.
- The Trust sits above national average in two elements of advocacy and sits below the national average for recommending the Trust as a place to work.

The themes triangulated from the staff survey results, staff conversations and the CQC findings were being used to shape the People Strategy. Four main themes had been identified, being leadership and management, behaviours and civility, feeling valued and heard and Health and Wellbeing.

All of the information/data from the Focus Groups and other sources was taken to an event held on 22 January 2024 where it was shared with the staff steering groups and those who attended the Focus Groups. Those in attendance confirmed that the key messages resonated with them, and an activity was held to agree the main asks from staff to take this forward. The seven key actions developed initially were shared and agreed, which now form the People Programme Action Plan. This will be used to create an overall People Strategy based on the four pillars. The action plan will shape the priorities for delivery in Year 1.

Ms Edusei acknowledged how disappointing the results were however recognised this was also reflected in the CQC report.

Mr Chapman sought clarity as to whether the survey results could be disaggregated to first line manager level to which the CPO noted that more granular data was being triangulated to identify areas that needed some targeted support. At the moment the data could be disaggregated to a level of circa 10-12 individuals.

Mr MacLeod noted that whilst acknowledging the disappointing results, positive achievements should also be celebrated. This was echoed by the CPO citing the Celebrating Excellence Awards as an example.

Mr Jowett noted that Ms Edusei would be chairing the People Committee moving forward but he would remain a member of the Committee adding that the Schedule of Business for the Committee would be developed to reflect the areas of focus identified in the CQC report and the Staff Survey results.

It was **resolved:** to **receive** the report.

iv) <u>Performance: Performance Report</u>

The report provided assurance to the Board on the Trust's elective recovery progress as well as performance against NHS England (NHSE) priorities for 2023/24 and key operational indicators.

The DCDI highlighted the following metrics:

- Provisional data suggests activity delivery levels (volumes) in February were below both plan and the revised 103% target across all points of delivery except for Day Cases (105.3%). Cumulatively for 2023/24 to date total activity delivery stands at 102.7% of the re-based 2019/20 baseline.
- Newcastle Hospitals delivered performance below the revised 4-hour Accident & Emergency (A&E) arrival to admission/discharge target, with performance standing at 74.9% against the 76% target. This was the fifth successive month that the Trust

failed to hit the 76% target. February and March had been particularly challenging in relation to demand for the service.

- The Trust failed all three newly consolidated cancer standards in January 2024, with metrics having been simplified into three clear targets. The Trust was escalated into Tier 1 intervention and support measures by NHSE for cancer care in December due to below target performance delivery, having already been escalated into Tier 1 for elective care.
- More positively, the volume of patients waiting over 62 days for treatment fell to 212 at the end of the month, with a high level of confidence that this will further reduce to below the end of year target (200) by the end of March 2024.
- February saw the continued elimination of >104 week waits at Newcastle Hospitals, as well as a significant reduction in the number of patients waiting over 78 weeks for treatment (163 vs 308). The Trust had agreed a revised trajectory with NHSE to bring the number of patients waiting this length of time down to 167 by the end of March 2024,. Whilst the ambition had been to eliminate 78 week waits by the end of March 2024, it was anticipated that there would be 7 breaches.
- The number of patients waiting over 65 weeks for elective treatment also improved significantly over February, down from 1,362 to 1,096. The H2 planning reset established an end of financial year target of 995, which the organisation is on track to meet and exceed delivery against. From these results it is hopeful the Trust will be removed from Tier 1 for elective care.
- Organisational performance against the six week diagnostic standard improved in February, with 28.8% of patients now waiting over this length of time – although this remains some way short of the national ambition to improve to under 5% by the end of the financial year.

The MD added that in April there would be targeted focus within Emergency Care, following significant investment in the Clinical Board. A key focus would be on improving performance against waiting times, reducing crowding and improving outcomes for patients. Work in relation to the Outpatient Transformation Programme would also continue.

Mr Chapman questioned if there had been changes in the process for reducing the backlog in waiting patients to which the MD advised that there must be continued focus on the order of booking appointments to ensure that theatres can be fully utilised acknowledging the positive start. Some refinements had been made to processes and further work was needed.

Miss Smith welcomed the significant improvement in performance for elective care recognising that the challenge now was to ensure it remained sustainable.

It was resolved: to **note** the performance detailed within the month 11 performance report.

v) <u>Performance: Planning 2024/25</u>

The DCDI presented the report which outlined the contents of the interim submission as it relates to activity and workforce.

The operational planning guidance had been received on 27 March 2024 however planning activities have been ongoing in the absence of the national targets, but instead working to internal Newcastle Hospitals ambitions. She added that a draft submission was submitted on 15 March 2024 to the Integrated Care Board (ICB) for collation into the submission to the national team on the 21 March 2024. Final submission was expected to be on the 26 April 2024 to the regional team to meet the national deadline of 2 May 2024.

The DCDI noted that the A&E target of 83% would be particularly challenging, along with the overarching activity target of 107%. Work was underway to identify schemes and investments to deliver the required activity. Activity targets would be set for each Clinical Board.

It was resolved: to **receive** the report.

24/07 BUSINESS ITEMS:

i) Director reports:

a. Joint Medical Directors Report; including:

The JMD – MWr presented the first joint Medical Directors Board report following their appointment on 1 March 2024. The JMD – MWr formally thanked Mr Andy Welch for his leadership and commitment to the care of patients and wellbeing of staff in Newcastle Hospitals, throughout his tenure as the former Medical Director.

The JMD – MWr explained that a review of the existing Medical Director and Associate Medical Director (AMD) portfolios had been undertaken. He noted that both he and JMD - LPC will hold joint overall Medical Director responsibility and will each lead on specific areas of the portfolio which he outlined.

Development of the Trust Clinical Strategy would be undertaken by both of the Joint Medical Directors along with the MD, COO and EDN.

Along with the CEO, the Joint Medical Directors had attended the recent Local Negotiating Committee and Medical Staff Committee meetings.

Mr Chapman questioned if there was a link between the Quality Account and the Clinical Strategy to which JMD – MWr advised that the clinical strategy focuses on the clinical direction of the organisation whereas the Quality Account focuses on specific quality priorities and reflects on priorities over the last 12 months. The DQE added that the Quality Account is a regulatory document with very prescriptive requirements from the Department of Health and Social Care and NHS England.

The DQE referred to the backlog of Serous Incident reports (SI) noted in the JMD's report which stated that there were 65 outstanding of which 42 were overdue. There had been a

significant reduction with the current backlog of 38 outstanding reports of which 26 were overdue.

The JMD – LPC highlighted the following points from the report:

- The Quality Oversight Groups for all of the Clinical Boards were now fully operational. Further refinements would be made in relation to oversight and reporting arrangements.
- Implementation of PSIRF was progressing well with good and regular attendance at the Rapid Action Review meetings.
- There was good progress on the backlog of SI's and it was anticipated that this work would conclude in April 2024.
- An update on Martha's Rule was noted, with a series of workstreams established.
- Work was ongoing to improve the level of incident reporting.

The JMC – MWr noted that cancer performance remained an area of significant focus for all of the clinical teams, particularly around the 62 day performance. Concern remained for some tumour groups including skin and urology however a significant improvement in lung cancer performance was envisaged.

There was particular focus on the undertaking of harm reviews for those patients experiencing a delay for treatment. Gail Jones, Associate Medical Director and Trust Cancer lead was also leading on the corporate cancer governance framework within each Clinical Board across the organisation. A Cancer Strategy was being developed.

In terms of Clinical Research activity, Newcastle Hospitals remains in the top 4 trusts in the country for the number of studies that have recruited one or more participants this year (2023/24). For Commercial research, the Directorate continues to be focussed on growing commercial activity and income in line with national priorities.

The JMD – MWr noted a further period of industrial action by junior medical staff from 24 to 28 February inclusive. There was an excellent response from many staff once again to ensure that patients remained safe and received good care. Elective activity was reduced significantly to ensure that senior medical staff could be released to provide cover in other areas. The outcome of the ballot for further industrial action by consultants was still awaited.

It was **resolved:** to **receive** the report.

(i) Consultant Appointments

There had been 13 consultant appointments since the last report.

It was **resolved:** to **receive** the report.

(ii) Guardian of Safe Working Quarterly Report (Quarter 3 2023/24)

The report outlined the number and main causes of exception reports for the period 27 September to 26 December 2023.

It was **resolved**: to **receive** the report.

Mr Chapman highlighted previous discussions of cancer referrals in the Quality Committee and questioned the process for tertiary referrals in the region noting that patients may come to harm if not treated in a timely matter to which the JMD-MWr advised that by working collaboratively with organisations within the Alliance, this provided an opportunity to reduce delays in treatment.

Mr Chapman noted the correlation between research and outcomes, and formally thanked those involved in the partnership with Academic Health Science Centre (AHSC) and questioned if there was an opportunity for more research to which the JMD – MWr advised that this is one of his defined responsibilities, and he has a primary relationship with Newcastle University but was also keen to develop relationships with other universities.

Miss Smith referred to the consultant appointments and questioned the level of demand to which the JMD – LPC advised that demand depended upon the specialty. Attracting people to the North East was challenging however there was generally an average of 4 candidates per post.

The Interim Chair noted that previous reports had included biographies of the successful candidates and it would be helpful to include in future reports to demonstrate diversification of expertise and skills. She agreed to discuss further with the JMD-LPC [**ACTION01].**

b) <u>Executive Chief Nurse; including:</u>

The report provided the Board with a summary of key issues, achievements, and challenges within the Executive Chief Nurse (ECN) portfolio. The following points were noted:

- The preceptorship offer has been fully reviewed, with the support of the CPOs team, and now offers a formal 5 day programme. Whilst the vacancy position has improved the skill mix is still very junior.
- In February, the Trust was awarded the Nursing Preceptorship Quality Mark. The dedicated Preceptorship Lead has been funded for one year initially within the Trust and will focus on evaluation of the preceptor and the preceptee.
- Three Wards of Concern had been reported to the Quality Committee, with one having been de-escalated since the meeting.
- Registered nurse vacancy rate remains low at 2.59% and turnover has reduced although there is a higher vacancy factor in paediatric areas.
- International recruitment has been very successful over the last 3-4 years a decision has been taken to pause international recruitment for the next year to support people in practice and to address the skill mix issues. The sacrifices international recruits make to gain employment with the Organisation was acknowledged.

- The Quarter 3 summary update of Safeguarding and Mental Capacity Act activity highlighted the volume and complexity of cases presented to the team.
- An overview of the recently released National Maternity Survey Results was provided. Results showed maternity services at Newcastle Hospitals were rated much better than most trusts for 1 question, better than most trusts for 4 questions and somewhat better than most trusts for 1 question. This had been discussed in detail at the Quality Committee.

It was **resolved**: to **receive** the report.

(i) Maternity Update Report

The report provided Trust Board members with an overview and update of the main priorities and quality considerations for the Maternity Service. The following points were noted:

- The service has maintained its positive workforce position with a vacancy rate of 0% with focus on training and education. The report included an update following the Care Quality Commission (CQC) inspection of the Maternity Service in January 2023, whose findings were published in May 2023.

  The maternity service was graded 'requires improvement' against the domains of 'well-led' and 'safe' as part of the national maternity inspection programme.

  The Trust met with the Integrated Care Board (ICB) on 12 February 2024 as part of the ongoing monitoring and assurance of progress against the action plan agreed as part of the System Oversight Framework (SOF) in December 2023. The report also included an update against the SOF action plan.
- Findings of the unannounced CQC core inspection of the Maternity Service in July 2023 were published on 24 January 2024. An update on the findings and actions from the July inspection was detailed in the report to the Trust Board which includes a second action plan to be monitored as part of the continuing SOF. It was hoped that the meeting in May would focus on agreement of the exit criteria from the CQC oversight/reporting.

Mr Chapman extended an invite for a staff member to attend a future Quality Committee to share their experience of preceptorship and also to undertake a deeper dive in to how that preceptorship is executed **[ACTION02]**

The Interim Chair thanked the EDN for the comprehensive reports and highlighted the importance of retaining international nurses noting that some nurses had been with the Trust for over 20 years.

Ms Baker referred to a recent NED informal visit whereby she met with some of the Trust internationally recruited nurses who shared some positive ideas about embedding future international recruits into the community.

Mr MacLeod noted the pause in international recruitment and questioned what impact this could have down the pipeline in 2-3 years' time. He also questioned if the if the CQC rating had impacted on nursing recruitment and retention and if the retention rate was worse than in neighbouring trusts. The EDN advised that there was generally a lower level of turnover from international recruits. The decision to pause international recruitment for the next year was to support staff in practice and to address the skill mix issues. It was noted that in the longer term there could also be a targeted approach to apprenticeships.
In response to a question from Ms Edusei in relation to the experience of transgender patients, the EDN advised that there have been multiple cases of transgender patients requesting their name and gender marker on their hospital record be changed to the name and gender they identify as. These cases have highlighted multiple challenges for both patients and staff to ensure changes made are in line with the law, are safe and provides a good patient experience. A task and finish group has been established to progress this work to ensure that care and treatment is provided sensitively.

The CXO added that by capturing data further learning will be gained about protected characteristics.

The EDN noted that a new Director of Midwifery had been appointed with an expected start date of June 2024.

It was **resolved:** to **receive** the report.

c) Learning from Deaths Q3 Report

The report provided assurance to the Board that the processes for Learning from Deaths across the organisation are in line with best practice as defined in the National Quality Boards (NQB) National Guidance on Learning from Deaths (LFD) March 2017, and guidance on working with bereaved families and carers (July 2018).

It also summarised the processes in place to provide assurance to the Board that all deaths are reviewed including those with potentially modifiable factors. All deaths that require a more in-depth review (level 2) are recorded into the mortality review database to ensure lessons are learned and shared.

The DQE highlighted the following points:

- From October 2023 to December 2023 there were 545 deaths.
- From January 2023 to December 2023 there were a total of 2003 deaths.
- 720 patients were referred to the coroner and resulted in approximately 600 inquests.
- 49% of the deaths have been subject to a level 2 mortality review.
- Of the 545 deaths 1 death was deemed preventable and is subsequently being reviewed as a serious incident.
- The Crude mortality rate remains at less than 1% (this is the percentage of in-hospital mortality from all hospital admissions).
- The standardised Hospital-level Mortality Indicator is less than the national average at 0.91.

- The Medical Examiner has continued to scrutinise all non-coronial deaths and is expanding their scope into community (GPs and community practitioners – to review community-based deaths) and there are examples of learning from reviews of deaths that were subject to serious incident review.

It was **resolved**: to **receive** the report.

d) Healthcare Associated Infections (HCAI)

The DIPC discussed the bi-monthly report on Infection Prevention and Control (IPC) and summarised the position at the end of February 2024 highlighting the following:

- One MRSA bacteraemia was attributed to the Trust in January 2024 which takes the Trust total to four against a target of zero.
- This period identified HCAI themes relating to intra-vascular infections in patients on parenteral nutrition; cancer patients on chemotherapy and patients with lower Urinary Tract Infection (UTI).
- Reduction of avoidable urinary catheter insertion with a target of 5% reduction is a Newcastle Improvement initiative.
- Work on the Patient Safety Incident Response Framework (PSIRF) was aimed at trying to make this easier to understand for staff.
- There had been a sustained reduction in Clostridium difficile Infections (CDI), with a concerted effort from IPC and Estates.
- Bacteraemia's – intravascular devices were an area of concern and improvements were required in the management of them.
- Front of house audits on documentation were noted to be very good.
- MRSA bacteraemia – improvements were required on screening patients when they arrive.
- There are currently 3 cases of measles in the North East all of which are unvaccinated and highlighted an emerging risk.
- Antimicrobial Stewardship (AMS) teams continue to work collaboratively with IPC and provide quarterly updates to Clinical Boards through the oversight groups. Antibiotic guidelines with high risk and high cost drugs are also under review. Oversight for these processes requires strategic leadership from the AMS team which requires further investment in resources. An investment proposal for the team is currently being re-submitted.

The EDN noted that the Trust was 9th highest nationally delivering a successful vaccination programme for Covid and influenza.

Ms Edusei questioned if a targeted approach could be undertaken to promote measles vaccination in communities with low uptake to which the DIPC advised that this was the first cluster identified. .

Mr Chapman questioned how difficult it was to baseline AMS to measure improvement to which the DIPC noted that due to competing priorities, monthly audit compliance was currently 30% with the target being 80%. Mr Chapman advised that he would welcome a more in-depth discussion at a future Quality Committee **[ACTION03].**

It was **resolved:** to **receive** the report.

24/08 ITEMS TO APPROVE:

i) Gender Pay Gap Report

The CPO presented the report which showed the Trust's gender pay gap data for the 'snapshot' date of 31 March 2023 and included a supporting narrative and action plan.

The workforce is made up of 22% male and 78% female however there is a gender pay gap of 22.44%. The highest paid staff are in medical and dental and are male.

In recognising more females were employed within the administrative and clerical sector Miss Smith sought clarity as to the large gap to which the CPO advised that those on higher pays bands within this section of staff were male.

Miss Smith therefore suggested that for future recruitment, real gender focus is required to look at attracting females into higher paid roles. She recommended that the number of actions be reduced if possible.

It was **resolved:** to **approve** the report and its publication.

ii) Effective Governance System

The MD explained that during 2023/24, the Care Quality Commission (CQC) undertook several inspections of Trust services and imposed conditions on the Trust's registration. One of the conditions required the Trust to implement an effective governance system.

The MD summarised the recent work undertaken in conjunction with The Value Circle to implement an effective governance system.

Following detailed discussion, the Board agreed to approve the recommendations contained in the report, subject to the following:

- Clarification of the position of Vice Chair of Audit, Risk and Assurance Committee as well as Senior Independent Director.
- Amendment under 4.04 in the Terms of Reference for the Audit, Risk and Assurance Committee to read "not limited to."
- A review of effectiveness of the Audit, Risk and Assurance Committee to be undertaken after six months rather than twelve.

It was **resolved:** to **approve** the recommendations in the report (subject to the clarification and/or amendments noted above) being to approve:

1. The new Committee structure.
2. The Updated Performance and Accountability Framework.

3. The Terms of Reference and Schedules of Business for both the Digital and Data Committee, and the combined Audit, Risk and Assurance Committee.
4. The Board Development Programme for 2024/25.

24/09 ITEMS TO RECEIVE AND ANY OTHER BUSINESS:

i) Update from Committee Chairs

The report was received, with the following additional points to note:

People Committee
Mr Jowett noted that the schedule of business would be developed to reflect the areas of focus identified in the CQC report, actions required following the staff survey results as well as focusing on the staff and patient experience work undertaken by the CXO.

Quality Committee
Mr Chapman noted that as part of the new governance arrangements the Committee was now meeting monthly.

Mr Chapman welcomed the new governance process which included representatives from the ICB attending the Quality Committee.

Mr Chapman noted the increase in violence against staff particularly in the emergency department. It was agreed that a deep dive in to violence & aggression and its subsequent impact would be undertaken via the People Committee.

Digital & Data Committee
Mr Chapman noted the good attendance at the first meeting of this Committee. He highlighted 3 key component parts which are getting the basics right, strong partnership with our clinical colleagues around EPR, and data which allows us to develop a strategy for transformation.

Finance Committee
Miss Smith noted no specific matters requiring escalation to the Trust Board other than the amount of business cases approved at the Committee which required subsequent Trust Board approval.

Charity Committee
Ms Baker noted two updates. The first related to Nurses, Midwives & Allied Health Professionals (NMAHP) Research Programme which had secured a funding grant of £1M from the charity. A comprehensive update was provided on the work of the programme and all agreed this was a good example of Charity Funding being used to create 'added value'.

An Investment Project Update was received and today the Board have reviewed the Investment Policy for the first time. The Charity Risk Statement and Connected Charities Checklist was also discussed.

The Charity Committee Grants meeting held on 11 March 2024 approved 3 grants.

It was **resolved:** to **receive** the update.

ii) Integrated Board Report

The MD presented the report which provided assurance to the Board on the Trust's performance against key indicators relating to Quality, People and Finance.

The CFO noted that the report covered the month 11 position with showed a deficit against plan, with a forecast to break even for the year end.

It was **resolved:** to **receive** the report.

iii) Meeting Action Log

The action log was received, and the content noted. Progress against the 1 open action would be documented prior to the next meeting. The actions proposed for closure were agreed.

iv) Any other business

The Interim Chair thanked everyone for their attendance and formally thanked the ECN on behalf of the Board and the organisation for all of the work and commitment during her career and wished her well on her retirement.

The meeting closed at 15:55.

Date of next meeting:
Public Board of Directors – Thursday 23 May 2024

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024					
Title	Chair's Report					
Report of	Professor Kath McCourt, Interim Chair					
Prepared by	Professor Kath McCourt, Interim Chair Jayne Richards, Corporate Governance Officer and PA to the Chair and Trust Secretary					
Status of Report	Public		Private		Internal	
	☒		☐		☒	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☐		☒	

Summary	This report outlines a summary of the Chair's activity and key areas of recent focus since the previous Board of Directors meeting, including:
	• Board Activity
	• Spotlight on Services"
	  • Genetics
	  • End of Life Care
	• Governor and Member Activity
	• Regional engagement with Foundation Trust Chairs of the North Integrated Care Partnership (ICP)
	• Engagement with the NENC Foundation Trust Chair & CEO PwC Workshop					

Recommendation	The Trust Board is asked to note the contents of the report.					
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. Pioneers – Ensuring that we are at the forefront of health innovation and research.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☐	☐	☐
Link to the Board Assurance Framework [BAF]	No direct link however provides an update on key matters.					
Reports previously considered by	Previous reports presented at each meeting.					

CHAIR'S REPORT

EXECUTIVE SUMMARY

This report outlines a summary of the Chair's activity and key areas of focus since the previous Board of Directors meeting, including:

- Board Activity
- "Spotlight on Services"
    - Genetics
    - End of Life Care
- Governor and Member Activity
- Regional engagement with Foundation Trust Chairs of the North Integrated Care Partnership (ICP)
- Engagement with the NENC Foundation Trust Chair & CEO PwC Workshop

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

CHAIR'S REPORT

Work at the Trust continues at a pace, tackling issues raised by the CQC as well addressing performance and efficiency targets.

April and May have proved to be busy with a visit from Sir Steve Powis and the National clinical director for Stroke. They had a most useful discussion with Trust colleagues and visit to our Thrombectomy service at the RVI.

We held an Extraordinary Council of Governors on 29th April which I chaired. This was to discuss and update the Governors following a meeting Sir Jim and I had with the North East and North Cumbria Board Chair and the Regional Director of NHS England, to discuss the Trust Board composition and governance arrangements. This meeting was well attended by our Governors.

We interviewed for our new clinical NED and have appointed Philip Kane, and we will welcome him to the Board in due course.

The Great North Health Care Alliance held its first formal meeting of all Board members on 2nd May. This was a well-received event with a positive atmosphere, and we made some real progress.

St James Park was the venue for our Annual Medical Education conference in April. Dr Ifti Hak, Director of Medical Education, and his team did an amazing job, attracting a large number of colleagues with Chris Turner, (Civility saves lives), as keynote speaker, alongside well attended workshops. I also attended the medical staff meeting with Sir Jim to receive an update and progress of the work of the Local Negotiating Committee.

Within the Trust I have undertaken a series of clinical visits to the Great North Childrens Hospital, Freeman Mortuary, RVI Laboratories and the Patient Services Command Centre. These have all been most informative and display the huge amount of work that takes place across the organisation.

Spotlight session with the NED's continue and most recently we have heard from Genetics and End of life Care teams.

- **Genetics –** Michael Wright Consultant Geneticist/Joint Medical Director shared a presentation and discussed clinical genetics and what the national and regional opportunities are. Michael discussed the human genome project and the development of the Genomic Medicine Service for England.

- **End of Life Care –** Dr Alexa Clark, Dr Jen Vidrine, Elizabeth Zabrocki, Nurse Specialist, shared a presentation and discussions around supporting the delivery of high quality equitable palliative and end of life care across hospitals (RVI, FRH and NCCC) and Newcastle Community.

Governor and Member activity since our last meeting has included:

- The Quality of Patient Experience (QPE) Working Group which met on 7 May 2024, where a complaints update was given followed by a discussion regarding the visits process.

- The Business & Development (B&D) Working Group met recently where two presentations were given, one on the patient hub and patient engagement, the other was an update on capital expenditure given by Jackie Bilcliff, Chief Finance Officer.

- The People, Engagement and Membership (PEM) Working Group met on 9 April 2024 and discussed that membership has increased significantly since February as a result of including work by Charlie Comms, upcoming elections and improvements in the membership materials by the Corporate Governance Team. The members event had been successful. A guest speaker at the meeting was Jake Turnbull from the Integrated Care Board (ICB) who explained who the ICB are and what they do.

  The PEM Working Group met again on 14 May 2024 and discussed management training in detail, Celebrating Excellence and the People at our hearts awards. Updates were given from the outreach community groups and plans for future member events were discussed.

- The Council of Governors met on 18 April 2024 for a private workshop and covered the Governor Development Programme with representatives from the Value Circle discussing feedback from the Governor survey and the next phase. There was a Chief Executive update, discussions regarding the CQC report, the Trust's financial position and the Governor's plan for responding to the CQC report.

At a regional level, I attended FT Chairs Forum on 23rd April and also attended the NENC FT Chair & CEO PwC Workshop on 25th April.

RECOMMENDATION

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

Report of Professor Kath McCourt
Interim Chair
17 May 2024

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024					
Title	Patient and staff story					
Report of	Annie Laverty					
Prepared by	Annie Laverty					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☐		☒	
Summary	Our patient story highlights the frustrations of a woman with autism as she accounts for her experience of care during 3 recent outpatient appointments in Ophthalmology. On each occasion communication was very poor and, at times, disrespectful. She describes a lack of compassion, with staff failing to see the person behind the patient or understand what reasonable adjustments needed to be made to ensure her care needs were met in the most effective way. The waste associated with a poor experience and repeated cancellations is evident. This story is shared recognising that improving patient safety and experience in Ophthalmology has been identified as a key quality priority for the Trust this year. In contrast, our staff story is a positive one. It is shared by one of the administrators in the Cardiothoracic team. A moving example of someone who is highly motivated to provide a person-centred service across directorates and departments. A proud advocate for patients who goes out of her way to support the needs of a father and his terminally ill son.						
Recommendation	The Board are asked to receive both stories for information and note our commitment to learning and transparency by highlighting positive and negative experiences of care.					
Links to Strategic Objectives	Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☒	☐
Link to Board Assurance Framework [BAF]	Linked to key areas in the BAF relating to Effective Patient Safety and Workforce, these stories are associated with strategic aims of putting patients at the heart of everything we do and providing care of the highest standard focussing on safety and quality.					
Reports previously considered by	Patient and People stories are a recurrent feature of all Public Board meetings. The Ophthalmology experience was discussed at the Executive Team 15th May 2024.					

PATIENT STORY

Background: A little bit about myself: I am Neurodivergent and Diabetic (Type2) medication controlled. I work 30 hours a week over 5 days as a Volunteer Coordinator and Complex 121 Support Worker for Blue Sky Trust. It is a requirement of my work that I need to be able to drive. Until recently I have attended clinics on the 3rd floor of RVI which had been quite straightforward, in the sense that I turned up and checks were made on my eyes. My only issue with them was that I wasn't sure why I was there or why I had been referred into the RVI in the first place. The letters I received following visits I don't find very easy to decipher so I ended up asking my optician, so I have a general idea of what is going on.

Recently, my eyes worsened due to my diabetes not responding to the Metformin. My medication was adjusted and 50mg Sitagliptin were added to the Metformin and my blood sugar readings lowered. This year I was called in to Level 2 to see, as I understood it, a consultant to discuss what was happening with my eyes and potential solutions. Thus far I have had 3 appointments. I would now like to share my experiences with you, which, in my view, have been less than satisfactory.

Visit 1 - January 18th. I booked a morning off work to attend my appointment. I thought my plan to start work at 12.30pm should be possible given my appointment time of 10.15am. I turned up on time, paid for the maximum 2 hours parking that I was able to on Claremont Road (avoiding the roadworks on Victoria Road). I had travelled by car by myself as on no previous appointment at the RVI had eye drops been used. In addition, my son would need to book time off work if he was to accompany me, and I would need to book a full day off work as it usually takes 24 hours for the effect of the drops to wear off - meaning I cannot drive nor use a computer.

Following booking in I went for the early checks and the staff doing them weren't happy to find out I had driven myself there as they wanted to use eye drops. I appreciate it's difficult to know if you are going to use eye drops or not, but for someone like me, it's vitally important that I know in advance so that I can make the appropriate arrangements. That issue aside, I had my pre-checks at which point we were told that the clinic was running an hour late - that was at 10.15am. I thought that wouldn't be a problem as I would be seen by 11.15am. By 11.40, as my car parking time would be running out and I needed to get back to my car and then on to work, I asked how long it would be before I saw the Dr? A nurse asked the Dr and had explained that I needed to leave. I was told that there were 2 people in front of me and then I would be the next person to be seen. Two people were called through and then a third. At that point I left as my car parking was running out, I needed to get to work, and more importantly I felt had been misled. I explained to the desk why I was leaving and asked them to make me a new appointment.

Visit 2 - April 18th: I received the appointment letter and, mindful as to what had happened last time, booked a day off work just in case eye drops were to be used, and my son booked time off work so that he could take me to the RVI. I arrived ahead of my appointment time and the receptionist couldn't find my notes. She asked if my appointment had been made in the last day or two. It hadn't, and I had received a reminder text on Tuesday 16th April.

Checking my electronic record she then told me that my appointment had been cancelled and a letter had been written but not sent.

The Dr appeared and was clearly unhappy at the prospect of having to add me in to an already expanded clinic list as a further 6-8 people had already been added in. I wasn't happy either - yet again I'd wasted my annual leave by attending an Eye Clinic appointment that wasn't going to happen. To add insult to injury the second receptionist told me that receiving a reminder text was just one of those things that happened regardless of whether an appointment had been cancelled or not? Seriously? I would suggest a text letting patients know that their appointment has been cancelled plus NOT sending out a reminder text for a cancelled appointment. The current system cannot be seen as exemplary customer care, it is in fact misleading.

I was then asked to wait. A nurse took me into a room to explain that the Dr would see me, but I would have to wait until the end of clinic once she had seen the 36 people before me. This was quite overwhelming news for a Neurodivergent person. With respect, the clinic had cancelled my appointment, did not let me know and then did not honour the appointment made that I turned up for in good faith having had myself and my son book time off work and rearranged my work commitments for the week. They then expected me to feel grateful, instead of overwhelmed and trying hard not to go into an autistic melt down. The nurse couldn't tell me how long the wait would be, I would just have to sit and wait and see. She also told me that even giving an appointment time, delays happen, so they weren't responsible for waiting times and effectively an appointment time is just a guideline. I went home feeling overwhelmed and very upset.

19th & 20th April - Further letters. Following the above incident on 19th April I received a copy of the previously unsent letter now dated 18 April advising me of the cancellation of the appointment on 18th April with a rescheduled appointment for 9.30am on 26th April. I also received a second letter on 20th April which was an exact copy as the one received the previous day. I believe I mentioned I work and need to book time off?

22nd April – I rang to cancel the appointment for 26th April as my work diary was full for that day and I was offered a cancelled appointment for 23rd April at 2.15pm. I accepted the appointment, although I knew I would be driving as I would be heading to the RVI straight from work following a training session. However, as I thought I was going to be seeing a consultant to discuss my options going forwards I didn't think this would be a problem.

23rd April – I was 5 minutes late to my appointment as getting out of work and finding parking was a bit of an issue. The clinic was a bit triggering as it was very busy, but I worked on staying calm. I also decided that I would stay for as long as necessary this time as I really wanted to finally speak to the Consultant. Again, eye drops weren't used but the member of staff assessing me mentioned that I had cancelled two previous appointments. I advised that I had turned up for them both, and that they were the ones who cancelled 18th April. I had photographs done and then some more.

Finally, 2 hours or so after my appointment time I was taken through to a treatment room by a nurse and after an initial chat I was introduced to her colleague. It was only when I mentioned that I couldn't have had eye drops for the imaging of my eyes, due to driving, that I found out that I was there for an eye injection! I believe I mentioned that I am

Neurodivergent. I explained to the two staff members that my autism means I need to process things, which they acknowledged and then continued regardless.

I am pleased that I had driven there as it gave me a reason to defer treatment that I hadn't been given the opportunity to make an informed choice about. One of the nurses told me that I have Diabetic Macular Oedema – no preparation nor lead in. Neither nurse could answer my questions about how the eye injections would affect me for being able to work or drive. They said that most of the people attending their clinics tend not to be in work! That isn't helpful to me. I was also told that I would need to have 5 injections 1 per month for the next 5 months which would be reviewed.

As part of the session, I was given a consent form to sign, which I did, but shouldn't have as I was still in shock. So having been hijacked into having treatment I haven't discussed nor agreed to, I was hustled into making an appointment to have my first injection next Friday 3rd May at an injection clinic at 5.00pm. I should also add that I told the nurses about my raised blood sugar levels which would explain the November readings, I also explained about my modified medication and the subsequent lowering of my blood sugar – no one on any visit has asked.

24th April – impact. I am still very upset as to what has happened to me. I am still processing what I've been told and the actions that were planned without my consent. I hadn't signed a consent form prior to yesterday – I hadn't discussed treatment options, and I still haven't. No one should find out a diagnosis in the way I did with staff expecting to initiate treatment there and then.

Staff need to be more aware of working with people with autism and have training to improve their understanding of neurodiversity. I don't believe anyone, at any time, asked if I was ok? In my terms yesterday I felt hijacked and hustled into something that I hadn't had time to process.

I work with vulnerable people, and I would hate for someone else to have the type of experience that I have had so if any actions from this could be taken to enhance the patient experience, I would welcome that.

STAFF STORY

I remember my involvement with a gentleman: switchboard put him through to me by mistake. He was ringing from the USA. His son was terminally ill with cancer and was being cared for here, with no immediate family to support him in the UK. The father was desperate to get to see his son but was unable to travel because he had less than 6 months on his passport.

The father was ringing for information, the secretary in the cancer team was on annual leave, and he felt like he was being passed from pillar to post. He felt like no one was listening, I remember that first call was a long one. I was conscious of trying to save money so I took his email address and agreed that would be our format for future communication.

I contacted the son's cancer consultant and asked if I could see it through in his secretary's absence. I wondered if a letter could be written on the gentleman's behalf to explain the circumstances and the need to waive the airline restrictions and get him to the UK as soon as possible. The Consultant agreed to write the letter and I was able to collect it without delay.

I continued to communicate with the father via email. I was careful to ensure that patient confidentiality was never breached. Wasn't for me to agree or disagree with what was happening. It was important to protect the son, but also possible to support the father. The airline responded positively to the Consultant's letter and allowed him to travel to the UK on his current passport. He arrived in time for his son's treatment. I knew it meant everything to him.

What does a good day feel like?

I get up in the morning and if I can go home and believe that I've made a difference, even for just one person, then that's a good day for me. I take my role and responsibility seriously – I am an ambassador of the Trust in everything I do. The things I say, my actions and how I respond all reflect on the organisation that employs me. If a patient gets put through to someone who doesn't seem to care, then that gives the trust a bad name.

What does a bad day feel like?

Sometimes you have angry and verbally abusive patients on the phone, who shout "*Don't forget I'm paying your wages. All these rainbows in Covid, how much has that cost the NHS?"* I try to understand that they're angry for different reasons, not me.

I'm very proud to make people feel important, feel listened to and that we're willing to give them our time. These people aren't with us because of something trivial, some are coming in for open heart surgery. We've got to remember that, rather than appear too busy to listen to their concerns.

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024					
Title	Fuller Inquiry – Trust Response					
Report of	Rob Harrison, Managing Director					
Prepared by	Hannah Morrison, Personal Assistant, Caroline Docking, Director of Communications, Chris Shaw, Associate Director of Operations ILM					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	On 28 November 2023, Sir Jonathan Michael, Chair of the Independent Inquiry into the issues raised by the actions of David Fuller, (the Inquiry) published the Phase 1 Report. The inquiry was set up to establish what happened in the Maidstone and Tunbridge Wells NHS Trust to allow Fuller to commit multiple crimes and to understand how his offending remained undetected for so long. The report and action plan sets out the recommendations, our response, and our progress. It highlights the remaining single action to complete which is in relation to the appointment of a permanent full time Mortuary Manager.					
Recommendation	The Board are asked to receive this report and reflect on the specific assurances for Board Members in carrying out their duties.					
Links to Strategic Objectives	Patients – putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☐	☐	☐	☐
Link to Board Assurance Framework [BAF]	Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.					
Reports previously considered by	New report.					

FULLER INQUIRY – TRUST RESPONSE

EXECUTIVE SUMMARY

The report provides updates around the Trust's response to the independent inquiry into issues raised by the David Fuller Case. It covers:

- Introduction
- Trust Response and Assurance
- Human Tissue Authority Regulations

FULLER INQUIRY – TRUST RESPONSE

1. INTRODUCTION

On 28 November 2023, Sir Jonathan Michael, Chair of the Independent Inquiry into the issues raised by the actions of David Fuller, (the Inquiry) published the Phase 1 Report. The inquiry was set up to establish what happened in the Maidstone and Tunbridge Wells NHS Trust to allow Fuller to commit multiple crimes and to understand how his offending remained undetected for so long.

The Inquiry Report outlines the missed opportunities to question Fuller's working practices. He routinely worked beyond his contracted hours, undertaking tasks in the mortuary that were not necessary or which should not have been carried out by someone with his chronic back problems. This was never properly questioned. There was little regard given to who was accessing the mortuary. Fuller entered the mortuary 444 times in a single year and this went unnoticed and unchecked.

Failures of management, of governance, of regulation, failure to follow standard policies and procedures, together with a persistent lack of curiosity, all contributed to the creation of the environment in which he was able to offend, and to do so for 15 years without ever being suspected or caught. He is now serving a whole life sentence.

The full Phase 1 inquiry report (Independent inquiry into the issues raised by the David Fuller case: phase 1 report (publishing.service.gov.uk)) is available for Board Members. It should be noted that this is a distressing and disturbing report. The Inquiry makes 17 recommendations for action for the Maidstone and Tunbridge Wells Trust, which are all relevant to NHS organisations more widely.

2. TRUST RESPONSE AND ASSURANCE

Providing safe and dignified services for the deceased must always be of the utmost importance, and it is vital that appropriate checks and balances are in place to provide assurance that our services are safe and well governed.

Our Mortuary Service sits within the Clinical and Research Services Clinical Board, and a group has been established to oversee the recommendations, which is led through the Clinical Board. This includes representatives from other relevant areas of the hospital, particularly estates and security.

The action plan enclosed sets out the recommendations, our response, and our progress. It highlights the remaining single action to complete which is in relation to the appointment of a permanent full time Mortuary Manager.

Board members will note that there are specific recommendations for the Board of Directors in terms of assurance, these are:

Recommendation 13: We have illustrated throughout this Report how Maidstone and Tunbridge Wells NHS Trust relied on reassurance rather than assurance in monitoring its processes. The Board must review its governance structures and function in light of this.

Recommendation 14: Maidstone and Tunbridge Wells NHS Trust Board must have greater oversight of licensed activity in the mortuary. It must ensure that the Designated Individual is actively involved in reporting to the Board and is supported in this.

Recommendation 15: Maidstone and Tunbridge Wells NHS Trust should treat compliance with Human Tissue Authority standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the Designated Individual. The Act will be subject to review in Phase 2 of the Inquiry's work.

Recommendation 16: The Chief Nurse should be made explicitly responsible for assuring the Maidstone and Tunbridge Wells NHS Trust Board that mortuary management is delivered in such a way that it protects the security and dignity of the deceased.

Recommendation 17: Maidstone and Tunbridge Wells NHS Trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.

Board members are asked to reflect on their personal responsibilities in this area, and in addition the action plan confirms that:

- The Compliance and Assurance Group (CAG) will receive routine and exception reports from the 'Designated Individual;
- Routes for reporting to Board (via Audit, Risk and Assurance Committee and Quality Committee) have been strengthened.
- The Designated Individual will report annually to Quality Committee and will have open access as required to the Executive Chief Nurse who will be the lead director for security, privacy and dignity within the mortuary.

The North East and North Cumbria Integrated Care Board have asked the Trust to provide assurance that all actions in relation to the inquiry have been undertaken, and that appropriate governance routes have been followed. This assurance was given to them on Friday 10 May 2024, noting that the Board would receive this update.

3. OTHER ISSUES

The Trust has recently received an inspection of its license by the Human Tissue Authority (HTA) which did identify some shortfalls in security at both mortuary sites. At the Freeman Hospital, the inspection found that there was no procedure for issuing the mortuary key out-of-hours, and staff had no knowledge of the number of keys in circulation. At the Royal Victoria Infirmary, one entrance to mortuary was opened without verifying who was attempting to gain entry. These failings were seen as a critical shortfall and urgent action was taken to address these issues. All actions are complete, apart from alterations to the door mechanism at the RVI, which will be addressed on the 16 May and three additional CCTV cameras within the RVI Theatre which will be installed by the 15 June. Following submission of our Corrective and Preventative Action (CAPA) plan on the 9 May a response from the HTA is anticipated within 21 days to provide further details on re-assessment timeframes.

4. RECOMMENDATIONS

The Board are asked to receive this report and reflect on the specific assurances for Board Members in carrying out their duties.

Report of
Mr Rob Harrison, Managing Director
15 May 2024

Fuller Report Recommendation	Local Context Interpretation	Action Required	Action Assigned	RAG	Progress	Assurance
1. Maidstone and Tunbridge Wells NHS Trust must ensure that non-mortuary staff and contractors, including maintenance staff employed by the Trust's external facilities management provider, are always accompanied by another staff member when they visit the mortuary. For example, maintenance staff should undertake tasks in the mortuary in pairs.	During working hours non-mortuary staff and contractors are supervised by the APT staff working in that area.	Check Trust policy regarding contractors working out of hours to assure compliance.	CK/TI		Completed - 30/04/2024 Policy is compliant. Mortuary staff are always present in working hours and no individuals are left unsupervised.	Visitor Policy and security SOP provide evidence. Monthly CCTV and Swipe card audits will provide assurance process in place and compliant, with any deviations escalated accordingly.
	Out of hours contractors and porters work in pairs.	Operational Manager (CK) to confirm with security that all out of hours access to mortuary in undertaken in pairs, and permission sought for the contractors to access is approved via security and mortuary manager approval.	CK/TI		Completed - 30/04/2024 assurances observed from CCTV audits of porters coming in pairs. Security request permission for any out of hours access to Mortuary Manager and Laboratory Manager.	
		Mortuary SOP updated to confirm all access for non-mortuary staff is in line with recommendation.	CK		Mortuary security SOP to be updated to include the above processes are documented. Deadline 10/05/2024 10/05/2024 SOP in place, action complete.	
2. Maidstone and Tunbridge Wells NHS Trust must assure itself that all regulatory requirements and standards relating to the mortuary are met and that the practice of leaving deceased people out of mortuary fridges overnight, or while maintenance in undertaken, does not happen.	Deceased patients are only removed from the refrigerated storage before a post-mortem (PM)/viewing and are always placed back into refrigerated storage when investigations/viewings are completed.	No action required for operational practice as we do not leave deceased people out of the mortuary fridges overnight or whilst maintenance conducted.	TI		19/03/2024. Compliant, deceased are never left out of freezers overnight or for periods other than to conduct PM and support viewings. Contractors only access for works outside of theatre hours.	Revised access SOP will provide detail that maintenance is not conducted in chapel of rest or theatre whilst deceased patients are out of fridges. All visitors sign into visitors log and are supervised. Out of hours supported via swipe card and CCTV coverage and appropriate security access.
	Maintenance work and other access cannot be undertaken when the theatre in in use.	Clearly define that maintenance in not undertaken whilst deceased in theatre or chapel of rest, and is documented in the access SOP to evidence compliance.			19/03/2024 SOPs under review to ensure that the action is included in the access SOP. Deadline 10/05/2024 10/05/2024 SOP in place action complete.	
3.Maidstone and Tunbridge Wells NHS Trust must assure itself that it in compliant with its own current policy on criminal record checks and re-checks for staff. The Trust should ensure that staff who are employed by its facilities management provider or other contractors are subject to the same requirements.	All staff are subject to DBS checks before being employed within the department. It is the responsibility of the staff member to declare any further convictions to the Trust. Re-checks are not routinely performed.	Confirm with all internal departments and contractors that DBS checks are in place according to Trust Policy.	CK		DBS are undertaken as per Trust policy including external contractors.	DBS for all staff held by HR and can be provided. Can be requested from contractors. HR policy can be provided.

4. Maidstone and Tunbridge Wells NHS Trust must assure itself that its Mortuary Managers are suitably qualified and have relevant anatomical pathology technologist experience. The Mortuary Manager should have a clear line of accountability within the Trust's management structure and must be adequately managed and supported.	The current acting mortuary manager has the relevant APT qualifications and experience.	No further action	N/A		Holds correct qualification. No action required, compliant.	Mortuary Manager qualifications can be evidenced. Job description can be evidenced. Mortuary manager attendance at departmental meetings can be provided to assure engagement and accountability.
	Consider interim MM management and support	Determine how are Mortuary Manager's supported and define pathways for escalation, reporting etc. governed and escalated.	CK/SLN		Mortuary manager has clear line of accountability from department, directorate and clinical board. This is demonstrated in departmental organogram and evidenced at regular attendance meetings e.g. operational, performance and governance meetings.	
5. The role of Mortuary Manager at Maidstone and Tunbridge Wells NHS Trust should be protected as a full-time dedicated role, in recognition of the fact that this in a complex regulated service, based across two sites, that requires the appropriate level of management attention.	Current interim Mortuary Manager has other areas of responsibility. The department have mitigated by providing full time additional managerial support for the role, whilst at the same time advertising for the new dedicated position of Operational Mortuary Manager	Seek Trust approval for dedicated Mortuary Manager	SLN		30/04/2024 Resource required: dedicated Mortuary Manager. RCG approved, Job description requires adaptation. SLN undertaking. 08/05/24 JD approved Action complete	New Mortuary Manager JD and appointment to post can assure requirements will be met
		Update Mortuary Manager JD to reflect dedicated role	SLN		The job description for the new mortuary manager role is being reviewed to be a more managerial position. 08/05/2024 JD is approved, awaiting panel to approve and issue VAF for advertising post	
		Appointment of permanent full time Mortuary Manager	SLN		10/05/2024 Post being advertised, interviews being held 14/06/2024.	
6. Maidstone and Tunbridge Wells NHS Trust must review its policies to ensure that only those with appropriate and legitimate access can enter the mortuary.	Review local policies to ensure access to the mortuaries in restricted via swipe access and access logs are kept, reviewed and permit only individuals with a genuine reason to enter. Mortuary policies are reviewed to ensure that access to the mortuary is included in the policy, e.g. security policy, use of external contractors etc.	Review security access and visitor policy to reflect that access to mortuary in for legitimate use only and controlled.	CK/TI		30/04/2024 Mortuary manager has undertaken a comprehensive review of all policies and SOPs. Update to security and access SOPs. Target completion date 10/05/2024 10/05/2024 SOP in place action complete	Review of access can be evidenced and audited for assurance using CCTV, visitor log book and swipe card access.

7. Maidstone and Tunbridge Wells NHS Trust must audit implementation of any resulting new policy and must regularly monitor access to restricted areas, including the mortuary, by all staff and contractors.	The current access policy to the mortuary is under review. A new SOP is required to describe the audit process of CCTV and swipe card conducted.	Access policy to be reviewed	CK		Revised policy to be completed 10/05/2024 10/05/2024 SOP in place, action complete.	Review of access can be evidenced and list of those with access provided. Security access and visitor policies will describe process. CCTV and swipe card access will assure processes followed, any issues escalated.
		Access Audit SOP to be updated			30/04/2024 Security/Access SOP is being updated but not yet completed. Deadline 10/05/2024 10/05/2024 SOP in place, Action complete	
8. Maidstone and Tunbridge Wells NHS Trust should treat security as a corporate not a local departmental responsibility.	CCTV is managed by Trust security as a corporate function. Security provide monthly card swipe card access reports. The audit in conducted monthly as CCTV footage in line with current retention of images (1 month)	Trust security already support provision of CCTV and provide swipe card access reports. No further action required.	CK		Compliant	Can demonstrate Trust security provide access reports and CCTV available to show they take corporate responsibility for Mortuary security
9. Maidstone and Tunbridge Wells NHS Trust must install CCTV cameras in the mortuary, including the post-mortem room, to monitor the security of the deceased and safeguard their privacy and dignity.	CCTV has been installed in the mortuary for some time, covering the body store areas and the viewing rooms. This footage is accessible by the security team. Local CCTV has now been installed to cover the main corridors outside the mortuary, all access doors and the under croft. This footage can be accessed on screens installed in the mortuary.	Additional CCTV camera coverage is required to cover black spots including autopsy theatre and fridge doors.	CK/RS		30/04/2024 Completed. Enhanced CCTV cameras installed in both mortuaries and all on wisenet system which can be accessed, via protected logins, by mortuary staff.	CCTV locations of both mortuaries can be provided and security access SOP and audit to provide assurance
10. Maidstone and Tunbridge Wells NHS Trust must ensure that footage from the CCTV in reviewed on a regular basis by appropriately trained staff and examined in conjunction with swipe card data to identify trends that might be of concern.	Security currently provide swipe card access reports for mortuaries and CCTV footage availed to conduct the required audit as per recommendation.	No further action, audit in place			Compliant.	Audit will be documented and available to evidence.

11. Maidstone and Tunbridge Wells NHS Trust must proactively share Human Tissue Authority reports with organisations that rely on Human Tissue Authority licensing for assurance of the service provided by the mortuary.	HTA reports and certificates are available on request but are not proactively shared with organisation's that rely on the HTA licensing for assurance of service, e.g., Coroner, local councils.	HTA reports to be shared with organisations that rely on HTA licensed service provided to them.	PNC/SLN		HTA reports have been shared with all organisations that rely on Human tissue authority licensing for assurance.	E-mail evidence can be provided on request.
12. Kent County Council and East Sussex County Council should examine their contractual arrangements with Maidstone and Tunbridge Wells NHS Trust to ensure that they are effective in protecting the safety and dignity of the deceased.	Quarterly meetings take place with the councils involved in the regional coroner contract to review the KPI's detailed in the contract. This includes discussion of incident reporting including HTA reportable incidents and performance against agreed targets to ensure the safety and dignity of the deceased. Meeting minutes are retained and available.	No further action, active engagement in place.	PNC/SLN		19/03/2024 Quarterly meetings take place with the councils involved in the regional coroner contract to review the KPI's detailed in the contract. This includes incident reporting and performance against agreed targets. Minutes available for meetings held.	Council and coroner contract in place and regularly reviewed with meetings, minutes available and circulated to those with governance responsibility via QPulse, and discussed in mortuary performance meetings. Assurance on provision of providing dignity and respect to all required from council as only Trust process in place.
14. Maidstone and Tunbridge Wells NHS Trust Board must have greater oversight of licensed activity in the mortuary. It must ensure that the Designated Individual in actively involved in reporting to the Board and in supported in this.	The DI was previously Governance lead for Cellular Pathology when he was Head of department. In this role he would attend both the local governance meeting and the Directorate Governance meetings. However, he has stepped down from this role of HoD. The DI in no longer actively involved in reporting to the Board.	Need to consider the mechanisms by which the DI reports directly to the Trust Board.	PNC		Joint Medical Directors and Managing Director have confirmed routes for DI reporting. DI will routinely report to Compliance and Assurance Group, chaired by Medical Director. In addition, an annual report for Audit, Risk and Assurance Committee and Quality Committee, who will then in turn report to Trust Board. Any immediate issues or concerns will be escalated to Trust Medical Directors.	DI report will be available as evidence and Board meeting minutes available
15. Maidstone and Tunbridge Wells NHS Trust should treat compliance with Human Tissue Authority standards as a statutory responsibility for the Trust, notwithstanding the fact that the formal responsibility under the Human Tissue Act 2004 rests with the Designated Individual. The Act will be subject to review in Phase 2 of the Inquiry's work.	HTA compliance is considered a statutory responsibility of the Trust by accountability to Trust Board.	No further action.	PNC			

16. The Chief Nurse should be made explicitly responsible for assuring the Maidstone and Tunbridge Wells NHS Trust Board that mortuary management in delivered in such a way that it protects the security and dignity of the deceased.	Formal confirmation of The Executive Director of Nursing (Ian Joy) needs to be agreed and communicated as a Trust requirement to satisfy the recommendation.	Define and confirm the appropriate governance mechanisms to support the Executive Director of Nursing in discharging their responsibilities.	PNC/SLN		Appropriate governance route has been confirmed via executive. In the new governance route, the DI reports to the quality committee annually, with open access to as required on security or dignity issues to the Executive Director of Nursing (lead director for the Quality Committee).	Arrangements confirmed with Director of Nursing and added to cycle of business for the Quality Committee
17. Maidstone and Tunbridge Wells NHS Trust must treat the deceased with the same due regard to dignity and safeguarding as it does its other patients.	The mortuary staff treat the deceased with dignity and respect.	Need to ensure that the importance of this in stressed to all involved with the deceased, including nursing and portering staff.	CK/TI		Action complete. The requirement to treat deceased with same dignity and respect in practised. The Trust have mortuary and bereavement task group meetings on a monthly basis, with representation across key departments all involved in care of deceased.	SOPs, staff training and competency evidence in place. Audits support compliance and assurance.

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024					
Title	Workforce Race Equality Standard (WRES)					
Report of	Christine Brereton, Chief People Officer					
Prepared by	Karen Pearce, Head of Equality, Diversity and Inclusion (People)					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☒		☐		☒	
Summary	The purpose of this report is to provide the Trust's position in relation to Workforce Race Equality Standards (WRES) metrics for 2023/24 which requires publication by 31 May 2024 on the Data Collection Framework website and the Trust's website.					
Recommendation	Trust Board Trust Board is asked to: • Note the contents of this report. • Provide approval to publish by 31 May 2024 on the Data Collection Framework website and the Trust's website.					
Links to Strategic Objectives	People – Supported by our People Plan, we will ensure that each member of staff is able to liberate their potential.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☒	☒
Link to Board Assurance Framework [BAF]	Differences in staff experience could potentially breach legislation and lead to legal challenge resulting in significant financial and reputational consequences.					
Reports previously considered by	Trust Board 25 May 2023. People Committee 16 April 2024.					

WORKFORCE RACE EQUALITY STANDARD (WRES) 2023

Introduction

This report provides the Trust's position in relation to the WRES report for 2023/24 which requires publication by 31 May 2024.

The Workforce Race Equality Standard (WRES) is a set of nine specific measures which enables the Trust to compare the workplace and career experiences of black and minority ethnic (BME) and White staff. The Trust uses the data to develop and publish an action plan. Year on year comparison enables the Trust to demonstrate progress against the indicators of race equality. Five metrics are taken from the Electronic Staff Record (ESR) and the remainder are taken from the staff survey. All percentages relate to those who completed the staff survey.

1. **Name of organisation**
   The Newcastle upon Tyne Hospitals NHS Foundation Trust

2. **Date of report**
   Month: May Year: 2024

3. **Name and title of Board lead for the Workforce Race Equality Standard**
   Christine Brereton – Chief People Officer

4. **Name and contact details of lead manager compiling this report**
   Karen Pearce – Head of Equality, Diversity and Inclusion (People)

5. **Unique URL link on which this Report and associated Action Plan will be found**

   https://www.newcastle-hospitals.nhs.uk/about/trust/equality-diversity-and-inclusion/workforce-race-equality-standard/

6. **This report has been signed off by on behalf of the board on**
   Date: 23 May 2024
   Name: Christine Brereton, Chief People Officer

Background narrative

7. **Any issues of completeness of data**
   A comparatively small number of unknown/null data relating to ethnicity of current staff remain

8. **Any matters relating to reliability of comparisons with previous years**
   None

9. Total number of staff employed within this organisation at the date of the report (March 2023)
16,391 (excluding bank and agency staff)

10. Proportion of BME staff employed within this organisation at the date of the report?
16.25% (Full Time Equivalent (FTE))

11. The proportion of total staff who have self–reported their ethnicity?
98.65%

12. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity?

- Fully implemented Employee Self Service.
- Full roll out of the ESR employee portal complete.
- Employee Self-Service portal now includes a portlet to notify staff if they have not updated their equality and diversity details in the past 12 months and allows them to update their record directly from the portal.

13. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity?
No

14. What period does the organisation's workforce data refer to?
April 2023 - March 2024

Workforce Race Equality Indicators

15. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff

Non-Clinical Workforce 2023 and 2024 (headcount)

	Ethnicity 2023			Ethnicity 2024		
Band	% White of whole Non-Clinical Workforce	% BME of whole Non-Clinical Workforce	% Not Recorded of whole Non-Clinical Workforce	% White of whole Non-Clinical Workforce	% BME of whole Non-Clinical Workforce	% Not Recorded of whole Non-Clinical Workforce
Band 1	0.08%	0.00%	0.00%	0.08	0.00	0.00
Band 2	28.70%	3.17%	0.53%	26.80	3.97	0.52
Band 3	20.84%	1.33%	0.56%	20.97	1.75	0.34
Band 4	16.68%	0.88%	0.24%	15.87	1.12	0.26
Band 5	9.62%	0.53%	0.11%	9.86	0.76	0.13
Band 6	5.38%	0.40%	0.03%	5.20	0.60	0.05
Band 7	4.64%	0.40%	0.05%	4.97	0.39	0.05
Band 8A	2.21%	0.13%	0.03%	2.48	0.08	0.03
Band 8B	1.49%	0.03%	0.00%	1.65	0.05	0.00

Band 8C	0.93%	0.00%	0.00%	1.05	0.00	0.00
Band 8D	0.51%	0.03%	0.00%	0.29	0.03	0.00
Band 9	0.00%	0.00%	0.00%	0.21	0.00	0.00
VSM	0.45%	0.03%	0.00%	0.42	0.03	0.00
Totals	**91.53%**	**6.93%**	**1.55%**	**89.83%**	**8.78%**	1.39%

Clinical Workforce 2023 and 2024 (headcount)

	Ethnicity 2023			Ethnicity 2024		
Band	**% White of whole Clinical Workforce**	**% BME of whole Clinical Workforce**	**% Not Recorded of whole Clinical Workforce**	**% White of whole Clinical Workforce**	**% BME of whole Clinical Workforce**	**% Not Recorded of whole Clinical Workforce**
Band 1	0.02%	0.00%	0.00%	0.02	0.00	0.00
Band 2	13.75%	1.28%	0.20%	8.10	0.65	0.07
Band 3	5.37%	0.47%	0.07%	10.28	1.54	0.12
Band 4	3.96%	0.29%	0.06%	3.98	0.31	0.06
Band 5	19.90%	8.41%	0.52%	18.72	10.29	0.44
Band 6	16.50%	1.54%	0.30%	16.23	1.71	0.17
Band 7	11.32%	0.45%	0.18%	11.30	0.52	0.15
Band 8A	2.79%	0.14%	0.07%	2.79	0.13	0.06
Band 8B	0.87%	0.02%	0.02%	1.02	0.02	0.02
Band 8C	0.40%	0.00%	0.01%	0.42	0.00	0.00
Band 8D	0.07%	0.00%	0.00%	0.06	0.00	0.00
Band 9	0.01%	0.00%	0.00%	0.02	0.00	0.00
VSM	0.03%	0.00%	0.01%	0.05	0.00	0.00
Consultants	5.74%	1.85%	0.19%	5.64	1.91	0.22
Senior Medical Manager	0.22%	0.06%	0.00%	0.21	0.05	0.00
Non-Consultant Career Grade	1.49%	1.22%	0.07%	1.29	1.39	0.03
Trainee Grades	0.07%	0.04%	0.04%	0.02	0.00	0.00
Other	0.01%	0.00%	0.00%	0.00	0.00	0.00
Totals	**82.51%**	**15.76%**	**1.73%**	**80.14**	**18.52**	**1.34**

- 98.65% of staff have recorded their ethnicity.

16. Relative likelihood of staff being appointed from shortlisting across all posts.

Data for reporting year: 1.35
Data for previous year: 1.06

17. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Data for reporting year: 0.47
Data for previous year: 0.87

Trust data identifies BME members of staff are less likely to enter formal disciplinary processes.
Trust is now outside the non-adverse range of 0.8 - 1.25.

18. Relative likelihood of staff accessing non-mandatory training and CPD

Data for reporting year: 1.41
Data for previous year: 1.21

Trust data identifies BME members of staff are less likely to access non-mandatory training and Continuing Professional Development (CPD).

19. KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

Data for reporting year:	White 22.34%	BME 22.15%
Data for previous reporting year:	White 25.89%	BME 28.13%

20. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Data for reporting year:	White 23.01%	BME 32.62%
Data for previous year:	White 22.15%	BME 30.33%

21. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.

Data for reporting year:	White 57.01%	BME 45.45%
Data for previous year:	White 63.12%	BME 50.25%

22. Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Data for reporting year:	White 7.58%	BME 21.81%
Data for previous year:	White 6.03%	BME 20.3%

23. Percentage difference between the organisations' Board voting membership and its overall workforce.

Data for reporting year:	BME -12.1%
Data for previous year:	BME -8.9%

24. Are there any other factors or data which should be taken into consideration in assessing progress?
None

25. Organisations should produce a detailed WRES action plan, agreed by its board. It is good practice for this action plan to be published on the organisation's website, alongside their WRES data. Such a plan would elaborate on the actions summarised in this report, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at board level, such as EDS2. You are asked to provide a link to your WRES action plan in the space below.

https://www.newcastle-hospitals.nhs.uk/about/trust/equality-diversity-and-inclusion/workforce-race-equality-standard/

26. Organisational Priorities Going Forward

The Trust still has some significant challenges. Despite the initiatives put in place, the WRES data still identifies some areas that are concerning for the Trust specifically around compassionate leadership, cultural awareness, race discrimination and behaviours.

Culture/behaviours: Indicator 6 (percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months) and Indicator 8 (percentage of staff experiencing discrimination at work from a manager/team leader or other colleagues). The People Priorities work for 2024/25 are linked directly to the NHS People Promise aimed at improving staff experience and retention. It is evident from the WRES data that there needs to be some specific focus around cultural awareness, race discrimination and behaviours.

In addition, through further development of the data we will look to identify hotspot areas through the newly developed clinical boards and introduce intense Organisational Development (OD) support as necessary.

Key activities going forward include;

- **People Programme** Board - Our People Programme Board was formed to guide and ensure the success of the NHS People Plan and our people priorities, emphasising a cultural focus. It drives delivery, identifying priorities and planning transformative initiatives in line with the Trust's people agenda. Key priorities involve workforce planning, culture change, supporting future-ready Clinical Boards and reshaping the People Directorate to prioritise people.

- **People Plan – Year 1 Action plan** - Developed, aligned to our People Priorities and assured through the People Programme Board.

- **Civility Charter -** In partnership with our Staff Networks and Staff Side colleagues we have developed a civility charter with the intention of embedding it across the Trust and the employee life cycle.

- **Incivilities/Micro-aggressions training** - Continue to roll out (and develop and improve based on feedback) training for staff on civilities/micro-aggressions, supporting the roll out of our People Programme and raising awareness of poor behaviour.

- **Just and learning approach -** a review of HR processes, practises and approach are being prioritised to ensure an increase in autonomy and flexibility and a reduced focus on rules, violations, and consequences.
- **Staff and patient experience -** A focus on staff and patient experience, tailored to individual needs to improve staff outcomes and staff morale, attract and retain talent, nurturing a positive culture.

- **Staff Networks -** Through the Equality, Diversity and Inclusion (EDI) Steering Group we continue to work with staff networks on key projects to ensure all are mindful of lived experience. An important part of change is changing attitudes and increasing understanding around impact but it's also about improving the 'experiences' of minority groups within the Trust and the most effective way is to enable staff to influence the design and delivery of our People Priorities, providing an authentic voice and unique insights that challenge assumptions and motivate us to do things differently.

- **Values based recruitment (VBR) for senior roles -** VBR questions will be incorporated into competency-based interviews with a recommendation that two value-based questions are asked as part of interview which are underpinned by other supplementary questions for each value.

- **EDI Improvement Plan;** The NHS EDI Improvement Plan contains targeted measures to combat prejudice and discrimination, both direct and indirect, manifested through behaviours, policies, practices, and cultures against specific groups and individuals within the NHS workforce. The plan has an aim of improving the culture and equity and the experiences of our workforce. Additionally, 'belonging' is a key theme highlighting the need to address poor behaviours, reduce discrimination and ensure opportunities for progression are equitable. The plan supports the delivery of the Trust's People Strategy.

Trust Board is asked to:

- Note the contents of this report.
- Provide approval to publish by 31 May 2024 on the Data Collection Framework website and the Trust's website..

Report of Karen Pearce
Head of Equality, Diversity and Inclusion (People)
10 May 2024

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024					
Title	Workforce Disability Equality Standard (WDES)					
Report of	Christine Brereton, Chief People Officer					
Prepared by	Karen Pearce, Head of Equality, Diversity and Inclusion (People)					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☐	☒			
Summary	The purpose of this report is to provide the Trust's position in relation to Workforce Disability Equality Standards (WDES) metrics for 2023/24 which requires publication by 31 May 2024 on the Data Collection Framework website and the Trust's website.					
Recommendation	Trust Board Trust Board is asked to: • Note the contents of this report. • Provide approval to publish by 31 May 2024 on the Data Collection Framework website and the Trust's website.					
Links to Strategic Objectives	People – Supported by our People Plan, we will ensure that each member of staff is able to liberate their potential.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☒	☒
Link to Board Assurance Framework [BAF]	Differences in staff experience could potentially breach legislation and lead to legal challenge resulting in significant financial and reputational consequences.					
Reports previously considered by	Trust Board 25 May 2023. People Committee 16 April 2024.					

WORKFORCE DISABILITY EQUALITY STANDARD (WDES) 2023/2024

Introduction

This report provides the Trust's position in relation to the WDES report for 2023/24 which requires publication by 31 May 2024.

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures which enables the Trust to compare the workplace and career experiences of disabled and non-disabled staff. The Trust uses the data to develop and publish an action plan. Year on year comparison enables the Trust to demonstrate progress against the indicators of disability equality. Three metrics are taken form Electronic Staff Record (ESR), and the remainder are taken from the staff survey. All percentages relate to those who completed the staff survey.

1. **Name of organisation**
   The Newcastle upon Tyne Hospitals NHS Foundation Trust

2. **Date of report**
   Month: May Year: 2024

3. **Name and title of Board lead for the Workforce Disability Equality Standard**
   Christine Brereton – Chief People Officer

4. **Name and contact details of lead manager compiling this report.**
   Karen Pearce – Head of Equality, Diversity, and Inclusion (People)

5. **Unique URL link on which this Report and associated Action Plan will be found.**

   https://www.newcastle-hospitals.nhs.uk/about/trust/equality-diversity-and-inclusion/workforce-Disability-equality-standard/

6. **This report has been signed off by on behalf of the board on**
   Date: 23rd May 2024
   Name: Christine Brereton, Chief People Officer

Background narrative

7. **Any issues of completeness of data**
   12.73% of staff have not declared their disability status.

8. **Any matters relating to reliability of comparisons with previous years.**
   None

9. **Total number of staff employed within this organisation at the date of the report (March 2023)**
   16,391 (excluding bank and agency)

10. Proportion of Disabled staff employed within this organisation at the date of the report?
5.16%

11. The proportion of total staff who have self–reported their disability status?
87.25%

12. Have any steps been taken in the last reporting period to improve the level of self-reporting by Disability?
Fully implemented Employee Self Service.
Full roll out of the ESR employee portal complete.

13. Are any steps planned during the current reporting period to improve the level of self-reporting by Disability?
We will work with the enabled network and EDI steering group to establish how we might increase self-reporting to declare disability.

14. What period does the organisation's workforce data refer to?
April 2023 - March 2024

Workforce Disability Equality Indicators

15. Percentage of Disabled staff in each of the Agenda for Change (AfC) bands 1-9, VSM (including executive board members), medical/dental and other staff compared with the percentage of non-disabled staff in the overall workforce.

Non-Clinical Workforce 2023 and 2024 (headcount)

	% Disability 2023			% Disability 2024		
Band	Disabled	Non-Disabled	Not Recorded	Disabled	Non-Disabled	Not Recorded
Band 1	0.05	0.00	0.03	0.05	0.00	0.03
Band 2	1.78	22.94	7.51	2.07	22.75	6.48
Band 3	1.35	17.15	4.14	1.67	18.04	3.35
Band 4	0.74	11.79	5.20	0.94	12.26	4.05
Band 5	0.66	8.42	1.14	0.68	8.86	1.20
Band 6	0.37	4.86	0.56	0.47	4.99	0.39
Band 7	0.16	4.30	0.61	0.26	4.73	0.42
Band 8A	0.05	2.04	0.24	0.10	2.30	0.18
Band 8B	0.05	1.38	0.08	0.05	1.57	0.08
Band 8C	0.03	0.82	0.08	0.00	0.94	0.10
Band 8D	0.00	0.45	0.08	0.00	0.24	0.08
Band 9	0.00	0.00	0.00	0.03	0.21	0.00
VSM	0.00	0.32	0.13	0.00	0.42	0.00
Other	0.00	0.32	0.13	0.00	0.00	0.00
Total	5.26%	74.80%	19.94%	6.33%	77.35%	16.32%

Clinical Workforce 2023 and 2024 (headcount)

	% Disability 2023			% Disability 2024		
Band	**Disabled**	**Non-Disabled**	**Not Recorded**	**Disabled**	**Non-Disabled**	**Not Recorded**
Band 1	0.02	0.00	0.00	0.02	0.00	0.00
Band 2	0.87	11.31	2.13	0.77	6.78	1.29
Band 3	0.29	3.97	1.31	0.70	9.63	1.64
Band 4	0.17	3.31	0.56	0.23	3.56	0.56
Band 5	1.29	22.80	3.10	1.43	25.34	2.76
Band 6	0.68	14.64	1.96	0.94	15.62	1.60
Band 7	0.35	9.24	1.69	0.42	10.11	1.47
Band 8A	0.09	2.37	0.37	0.13	2.54	0.33
Band 8B	0.01	0.66	0.18	0.02	0.88	0.16
Band 8C	0.02	0.29	0.07	0.02	0.31	0.09
Band 8D	0.00	0.05	0.02	0.00	0.05	0.01
Band 9	0.00	0.00	0.01	0.00	0.01	0.01
VSM	0.00	0.02	0.02	0.00	0.03	0.02
other	0.00	0.01	0.00	0.00	0.00	0.00
Medical and Dental Consultants	0.06	5.54	5.54	0.09	6.17	1.54
Non-Consultant Career Grades	0.05	2.37	2.37	0.04	2.51	0.18
Trainee Grades	0.01	0.10	0.10	0.00	0.02	0.02
Totals	3.90	76.68	19.41	4.81	83.54	11.66

16. Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

Data for reporting year: 1.13
Data for previous year: 1.20

17. Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process.

Data for reporting year: 1.59
Data for previous year: 1.13

18. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from patients, service users or the public.

Data for reporting year:	Non-disabled 29.82%	Disabled: 19.41%
Data for previous reporting year:	Non-disabled 23.98%	Disabled: 32.57%

19. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from a line manager.

Data for reporting year:	Non-disabled 8.79%	Disabled 16.00%
Data for previous year:	Non-disabled 7.31%	Disabled 15.79%

20. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from other colleagues.

Data for reporting year:	Non-disabled 16.98%	Disabled 26.12%
Data for previous year:	Non-disabled 16.46%	Disabled 26.98%

21. Percentage of staff who reported harassment, bullying or abuse the latest time it happened.

Data for reporting year:	Non-disabled 45.11%	Disabled 46.21%
Data for previous year:	Non-disabled 47.14%	Disabled 44.78%

22. Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.

Data for reporting year:	Non-disabled 57.92%	Disabled 49.77
Data for previous year:	Non-disabled 63.53%	Disabled 56.48

23. Percentage of staff who have felt pressure from their manager to come to work despite not feeling well enough to perform duties.

Data for reporting year:	Non-disabled 24.00%	Disabled 33.52%
Data for previous year:	Non-disabled 21.78%	Disabled 32.4%

24. Percentage of staff satisfied with the extent to which their organisation values their work.

Data for reporting year:	Non-disabled 40.78%	Disabled 28.51%
Data for previous year:	Non-disabled 43.10%	Disabled 30.90%

25. Percentage of disabled staff who said their employer has made adequate adjustments to enable them to carry out their work.

Data for reporting year:	72.79%
Data for previous year	76.76%

Staff Engagement

Data for reporting year:	Non-disabled 6.35%	Disabled 6.75%
Data for previous year:	Non-disabled 6.92%	Disabled 6.49%

27. Percentage difference between the organisations' Board voting membership and its overall workforce.

Data for reporting year: Non-disabled 18% Disabled -5%

28. Are there any other factors or data which should be taken into consideration in assessing progress?

No

29. Organisations should produce a detailed WDES action plan, agreed by its board. It is good practice for this action plan to be published on the organisation's website, alongside their WDES data. Such a plan would elaborate on the actions summarised in this report, setting out the next steps with milestones for expected progress against the WDES indicators. It may also identify the links with other work streams agreed at board level, such as EDS2. You are asked to provide a link to your WDES action plan in the space below.

Workforce Disability Equality Standard - Newcastle Hospitals NHS Foundation Trust (newcastle-hospitals.nhs.uk)

Organisational Priorities Going Forward

The Trust still has some significant challenges. Despite the initiatives put in place, the WDES data still identifies some areas that are concerning for the Trust specifically around compassionate leadership, equity of opportunity, reasonable adjustments and Disabled staff feeling valued and heard.

Culture/behaviours: The People Priorities work for 2024/25 are linked directly to the NHS People Promise aimed at improving staff experience and retention. It is evident from the WDES data that there needs to be some specific focus around leading with compassion, taking a person-centred approach to reasonable adjustments and providing individual support.

In addition, through further development of the data we will look to identify hotspot areas through the newly developed Clinical Boards and introduce intense Organisational Development (OD) support as necessary.

Key activities going forward include.

- **People Programme** Board - Our People Programme Board was formed to guide and ensure the success of the NHS People Plan and our people priorities, emphasising a cultural focus. It drives delivery, identifying priorities and planning transformative initiatives in line with the

Trust's people agenda. Key priorities involve workforce planning, culture change, supporting future-ready Clinical Boards and reshaping the People Directorate to prioritise people.

- **People Plan – Year 1 Action plan** - Developed, aligned to our People Priorities and assured through the People Programme Board.

- **Civility Charter -** In partnership with our Staff Networks and Staff Side colleagues we have developed a civility charter with the intention of embedding it across the Trust and the employee life cycle.

- **Incivilities/Micro-aggressions training** - Continue to roll out (and develop and improve based on feedback) training for staff on civilities/micro-aggressions, supporting the roll out of our People Programme and raising awareness of poor behaviour.

- **Just and learning approach -** a review of HR processes, practises and approach are being prioritised to ensure an increase in autonomy and flexibility and a reduced focus on rules, violations, and consequences.

- **Staff and patient experience -** A focus on staff and patient experience, tailored to individual needs to improve staff outcomes and staff morale, attract and retain talent, nurturing a positive culture.

- **Staff Networks -** Through the Equality, Diversity and Inclusion (EDI) Steering Group, we continue to work with staff networks on key projects to ensure all are mindful of lived experience. An important part of change is changing attitudes and increasing understanding around impact but it's also about improving the 'experiences' of minority groups within the Trust and the most effective way is to enable staff to influence the design and delivery of our People Priorities, providing an authentic voice and unique insights that challenge assumptions and motivate us to do things differently.

- **Values based recruitment (VBR) for senior roles -** VBR questions will be incorporated into competency-based interviews with a recommendation that two value-based questions are asked as part of interview which are underpinned by other supplementary questions for each value.

- **EDI Improvement Plan -** The NHS EDI Improvement Plan contains targeted measures to combat prejudice and discrimination, both direct and indirect, manifested through behaviours, policies, practices, and cultures against specific groups and individuals within the NHS workforce. The plan has an aim of improving the culture and equity and the experiences of our workforce. Additionally, 'belonging' is a key theme highlighting the need to address poor behaviours, reduce discrimination and ensure opportunities for progression are equitable. The plan supports the delivery of the Trust's People Strategy.

- **Reasonable Adjustment Guidance -** for managers and staff to raise awareness and increase understanding.

Trust Board Trust Board is asked to:

- Note the contents of this report.
- Provide approval to publish by 31 May 2024 on the Data Collection Framework website and the Trust's website.

Report of Karen Pearce
Head of Equality, Diversity and Inclusion (People)
10 May 2024

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024				
Title	Integrated Quality and Performance Report				
Report of	Rob Harrison, Managing Director				
Prepared by	Joanne Field, Senior Information Manager Elliot Tame, Senior Business Development Manager (Performance) Keith Wheldon, People Systems and Data Manager Pauline McKinney, Quality & Assurance Lead				
Status of Report	Public	Private	Internal		
	☒	☐	☐		
Purpose of Report	For Decision	For Assurance	For Information		
	☐	☒	☐		
Summary	This paper is to provide assurance to the Board on the Trust's performance against key Indicators relating to Quality, HR and Finance. In addition it also provides assurance to the Board on the Trust's progress against NHS England (NHSE) performance priorities and key operational indicators.				
Recommendation	For assurance.				
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality. Performance – Being outstanding now and in the future.				
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	Details compliance against national access standards which are written into the NHS standard contract. Details compliance against key quality targets.					
Reports previously considered by	Regular report.					

The Newcastle upon Tyne Hospitals NHS Foundation Trust

INTEGRATED QUALITY AND PERFORMACE REPORT

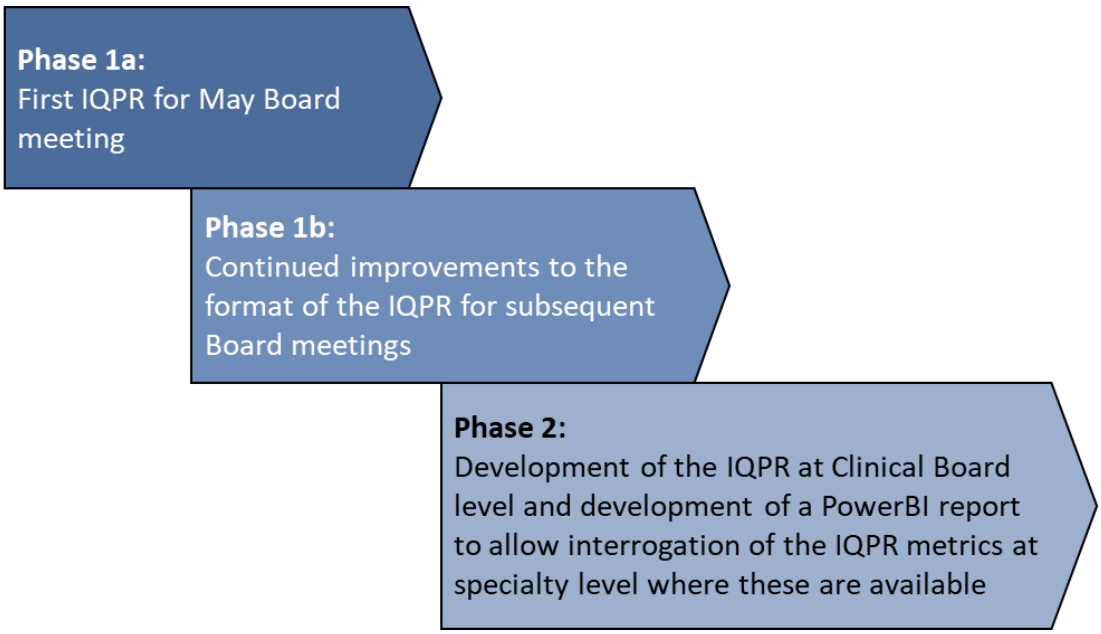
EXECUTIVE SUMMARY

The Board of Directors is asked to receive the report.

1. Development of the report

Prior to the May 2024 meeting the Trust Board has received two separate reports a) an Integrated Board Report covering key quality, Human Resources (HR) and finance metrics and b) a Trust Performance report covering the key access targets and other performance targets as set put in the NHSE planning guidance, or within the NHS standard contract. As part of the response to the CQC report the Trust continues to look at ways to strengthen the approach to more integrated governance structures and reporting, combining these two reports into a single Integrated Quality and Performance Board Report (IQPR) is part of this work.

Whilst this first integrated report is an important step, it will need to develop and iterate and become not only a report to provide the Board assurance, but also be used by the Clinical Boards within their governance arrangements. A summary of how the report will develop is shown below.



Planned improvements in Phase 1b include:

a) Expansion of the use of Statistical Process Control Charts and other aspects of the 'Making Data Count' guidance.
b) Better use of benchmarking data (at the Alliance, ICB and national levels).
c) Ensuring alignment with the outcome of the current consultation on the revised NHS Oversight and Assessment Framework. This will also provide an opportunity to potentially consolidate the number of metrics being reported. The implementation of the new framework is expected in July 2024.

d) Further development of metrics including: Health Inequalities reporting in accordance with NHSE statement on Health Inequalities and associated metrics; addition of a quality metric in relation to medicines reconciliation (percentage of patients having an emergency admission who have their medicines reconciled by pharmacy staff within 24 hours); and inclusion more timely patient and staff experience data, starting with the real time patient experience pilot work being rolled out to 13 wards with comparative data expected in September 2024.
e) Develop triangulation of the narrative across all four domains, picking up related issues to highlight.
f) Introduction of sub-section summary pages to more clearly highlight areas where improvement is required.

The phases of development of the report are being coordinated by a Task and Finish Group with representatives from each of the corporate team responsible for the different domains within the report and is being led by the Deputy Director, Business Development and Enterprise.

2. Summary points to note – contents of the report

Quality:

- Throughout the month of April 2024, the number of Trust onset Pseudomonas bacteraemia have increased since the previous publication in March 2024. MSSA, C. Difficile, E.Coli and Klebsiella have all decreased. MRSA bacteraemia remains the same with zero reporting.
- March 2024 showed a decrease in inpatient acquired pressure ulcers and falls since the previous publication in February 2024. The number of pressure ulcers causing serious harm has also decreased from six in February 2024 to three in March 2024.
- The number of moderate and above harmful incidents increased from March 2024 to April 2024 with the majority of incidents being reported by Therapy Services. One Never Event was reported in April 2024.
- The latest Mortality “SHMI” publication, shows the Trust to be at 0.92. This is within “expected limits” and one of the lowest within the region.
- The Trust received 48 formal complaints in April 24 with clinical treatment (General Medicine) n=9, being the most common category of complaint.
- Throughout the month of April 2024, the Maternity Unit reported an increase in emergency caesareans since the last publication in March 2024, whilst a decrease was reported for elective caesareans.

People:

- Total sickness absence reduced from 5.72% (May 2022 to April 2023) to 5.31% (May 2023 to April 2024).
- Top three reasons for sickness absence are ‘anxiety/stress/depression/other psychiatric illnesses’, ‘other musculoskeletal problems’ (11.30%) and ‘Gastrointestinal problems’.
- Staff in post increased by 3.80% compared to the previous year with the biggest increase in nursing & midwifery, allied health professionals.
- Retention of staff with over 1-year service increased from 85.99% to 87.67% (March to April 2024).
- Turnover has been reducing since May 2023 and stands at 10.41% (April 2024) compared to target of 8%.
- Top reason for leaving was ‘work-life balance’ 17.22%.

- Top destinations on leaving were: 'no employment' 38.9% (half were accounted for by retirement, health and temporary contract); and other 'NHS organisation' 31.0%.
- Mandatory training compliance is 92.84% compared to target of 95%.
- Lowest rate of compliance is medical and dental staff 86.53%.
- Mandatory training courses below 80% compliance: 'local induction' 76.23%; 'moving and handling level 2' 79.98%.
- Appraisal compliance is 85.3% compared to target of 95%.

Performance:

- March 2024 saw the continued elimination of >104 week waits at Newcastle Hospitals and significant reductions in >78 week waits - just 7 by the end of March.
- The number of patients waiting over 65 weeks for elective treatment also improved significantly over March, down from 1,096 to 622. The H2 planning reset established an end of financial year target of 995, one that the organisation has significantly exceeded delivery against.
- The Trust achieved the 28-day faster diagnosis standard for the first time in seven months, with performance of 83.2% against the 75% target. Whilst the organisation failed to meet the other two newly consolidated standards in March, significant improvements were made (31-day performance 88%, +5.5%, and 62-day performance 61.1%, +5.2%).
- The end of March position for patients waiting over 62 days without receiving a diagnosis or starting treatment for cancer was 186, this back to pre-pandemic levels and below the system allocated target of 200.
- The improvements in performance for elective and cancer waits has resulted in confirmation that the Trust has been de-escalated from the mandated NHSE tiered support process.
- Organisational performance against the six week diagnostic standard declined in March, with 33.1% of patients now waiting over this length of time.
- The Trust also delivered performance below the revised 4-hour Accident & Emergency (A&E) arrival to admission/discharge target for April, with performance standing at 73.2% against the 78% target.

Finance:

- As at month 1, the Trust is reporting delivery against the planned deficit of £2m.
- From an income perspective the in-month position is an overall favourable variance, partly due to over-performance on matched drugs and devices.
- For expenditure the variance on employee expenses mainly relates to the impact of the Consultant Pay Reform expenditure accrued for April. The overspend on drugs expenditure is partly matched with income and an increase on the 2023/24 levels that will be monitored.
- Agency costs are at 0.8% of the gross staff costs. This is below the national target set at 3.2%. Although overall positive, there continues to be medical agency usage across a number of specialties where it is proven difficult to recruit on a permanent/substantive basis, resulting in cost pressures at a speciality level.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Quality & Performance Board Report

Quality, People, Performance and Finance

May 2024

Healthcare at its best
with people at our heart

Executive Summary (i)

The Trust has experienced unusual pressure in April. Following closure of the winter ward and ceasing of the overnight transfer vehicle funded through Winter, there has been recurring Norovirus outbreaks across several wards on both acute sites, reducing bed availability and increasing the demand for specialist cleans, all directly impacting on patient flow and ambulance handovers. There has been where elective activity that has had to be cancelled in advance to help manage emergency demand but this has been minimal.

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- Staff in post increased by 3.80% compared to previous year with biggest increase in nursing & midwifery, allied health professionals
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- Turnover has been reducing since May 2023 and stands at 10.41% (April 2024) compared to target of 8%
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Executive Summary (ii)

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Contents: May 2024

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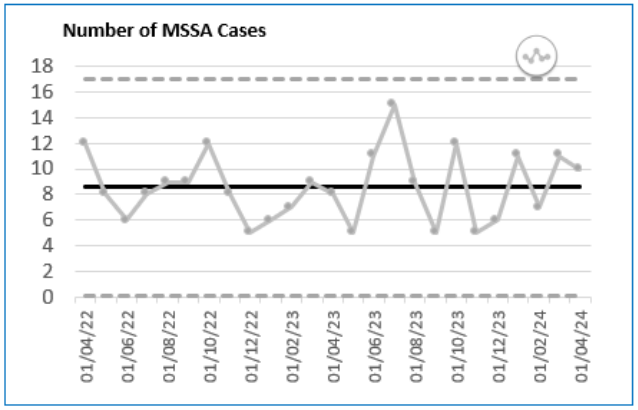
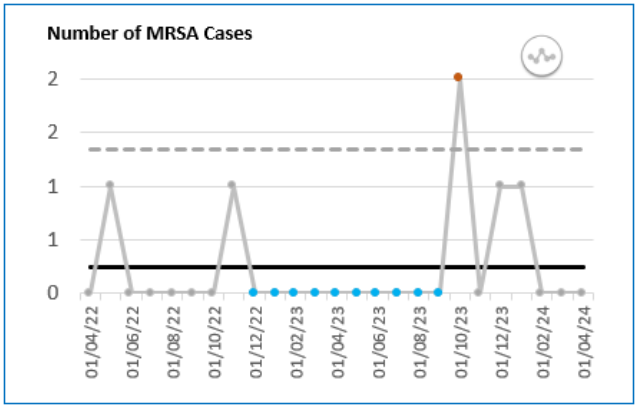
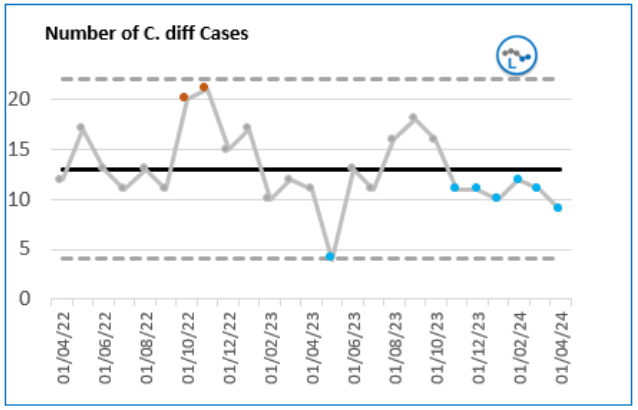
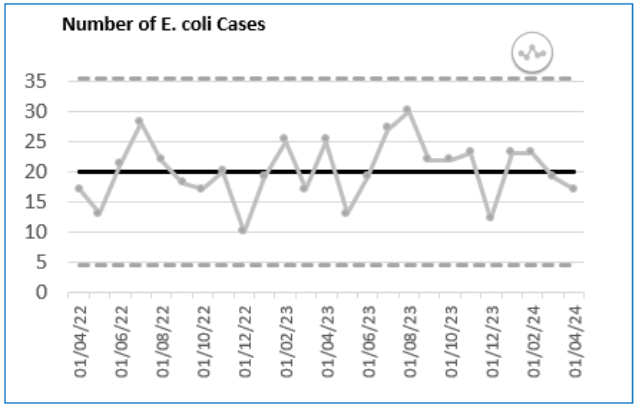
Quality

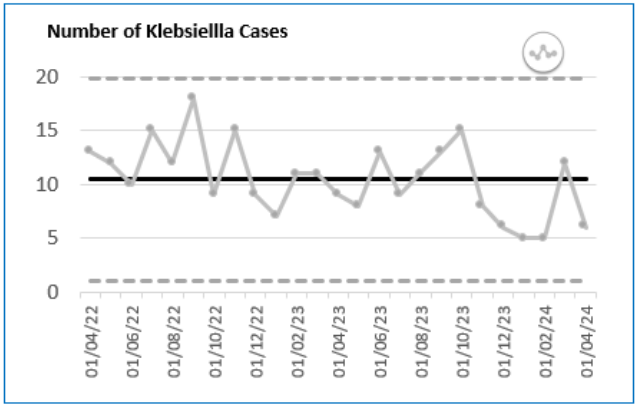
Quality: Healthcare Associated Infections

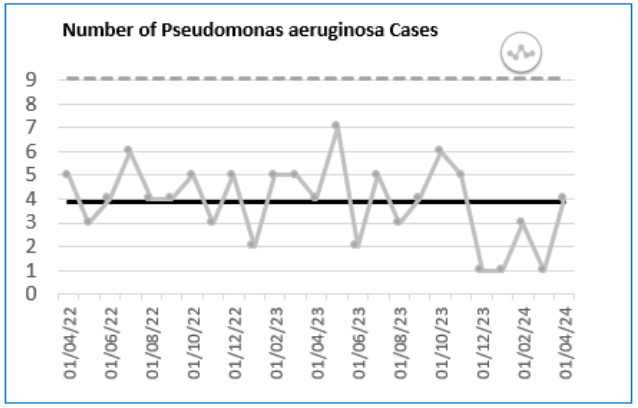












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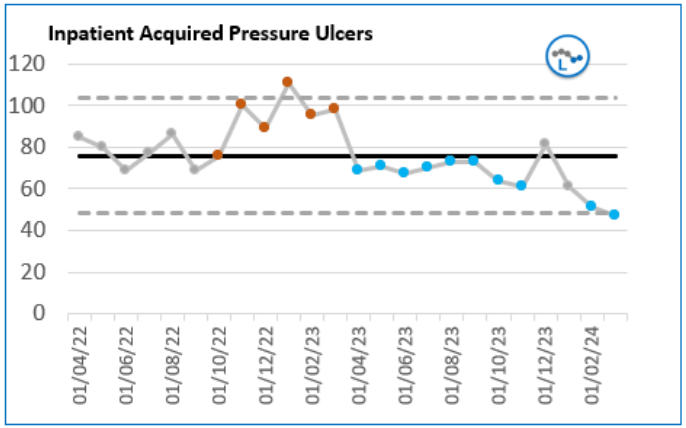
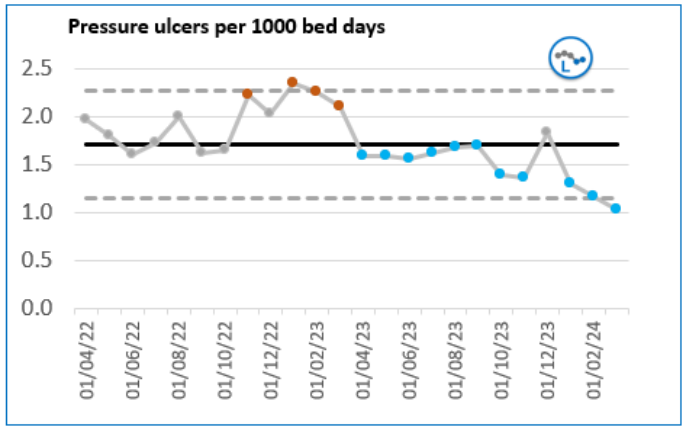
* National thresholds for 2024/25 are not yet available.

Quality: Harm Free Care – Pressure Damage

Current position:

- Since April 2023, there has been a sustained decrease in Trust acquired pressure ulcers, with the exception of December, whereby a rise occurred. This is consistent with winter months in previous years.
- Pressure ulcers per 1000 bed days in March was 1.02, this is the lowest rate since January 2020.
- The number of pressure ulcers causing serious harm also decreased from six in February 2024 to three in March.
- The Trust has not reported an inpatient acquired Category IV or above pressure ulcer since June 2022.





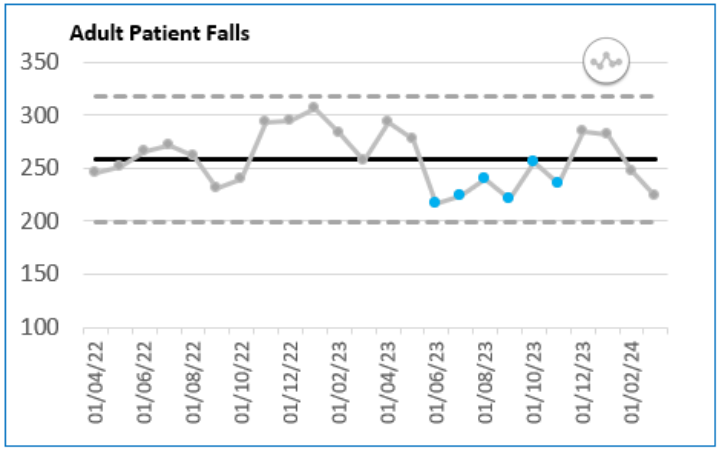
Current actions in place:

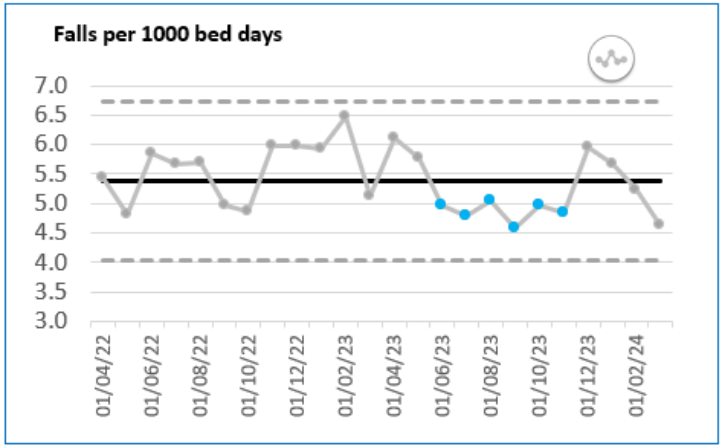
- Tissue Viability have implemented a structured programme of education for 2024 reflecting the themes identified through RCA. This includes both E-learning and face to face sessions.
- The Patient Safety Incident Response Framework (PSIRF) framework has been introduced in February for Pressure Ulcer's. The Tissue Viability team will identify Trust wide themes and quality improvement initiatives for implementation in line with the PSIRF framework . The first PSIRF pressure ulcer reviews identified some improvement and learning around documentation and staff training.
- Mattress Champion training has been reintroduced, there was excellent engagement from clinical teams, with 29 attendees in January . Further training is planned on a 3 monthly basis

Quality: Harm Free Care - Falls

Current position:

- Total falls reported in the Trust have fallen for the third consecutive month, in March there were 237. Of the total falls reported there were 218 in inpatient areas. A peak in falls did occur in January, however, this is consistent with previous years, with increased numbers of falls in the winter months.
- The National target for falls per 1000 bed days is 6.6. The Trust local target for falls per 1000 bed days is 6.0. In March 2024 the Trust reported 4.7 falls per 1000 bed days and an 18-month average of 5.4.

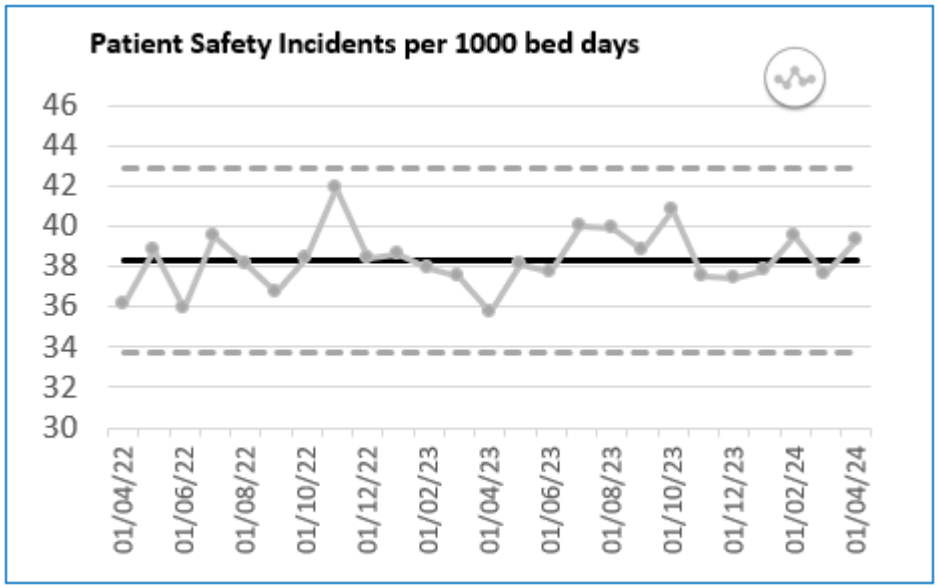




Current actions in place:

- The Falls Prevention Co-ordinator (FPC) continues to review ward level data on a monthly basis. Wards with the highest incidence of falls are reviewed to identify contributory factors and understand any learning or potential quality improvements.
- In February, the Patient Safety Incident Response Framework (PSIRF) was implemented for falls. The first PSIRF falls review took place in February, the clinical team were able to identify the need for some improvement work around Falls Risk Assessment, the correct assessment of Enhanced Care Observations and the use of flat lifting equipment post fall. An action plan has been developed with the ward. Themes and trends will be shared at the Clinical Boards Quality Oversight Group. Trust wide themes will be collated by the FBC, quality improvement initiatives will be commenced.

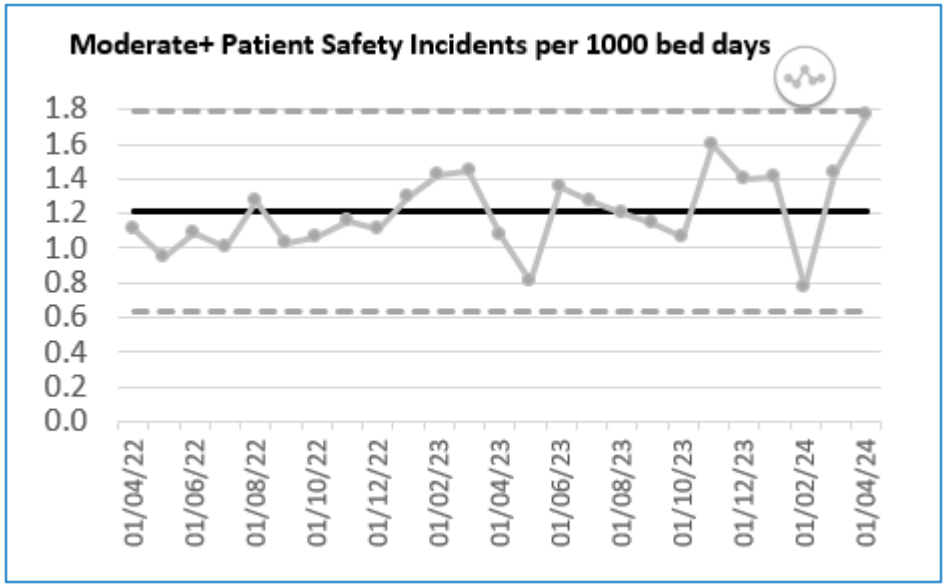
Quality: Incident Reporting



All patient incidents: The number of patient safety incidents per 1000 bed days reported in April 2024 has increased again from March.

Work remains ongoing around the Trust to improve incident reporting rates and support staff in this process. This includes

- Asking clinical boards to review their incident data and identify 3-5 areas that are potentially lower reporters in order to work with them to promote incident reporting.



Moderate and above harm incidents: The number of moderate and above harmful incidents increased again in April 2024. This may be due, be in part, to the increased number of Datixes (one in March and seven in April submitted by Therapy Services in relation to reduced service capacity In the Disablement Service Centre leading to patient harm.

Quality: PSIRF and Never Events

The number of Patient Safety Incident Investigations and After Action reviews along with the themes identified in April 2024 can be found below:

Patient Safety Incident Investigation April 2024 (March 2024: n=4)	
Theme	**Number of cases**
Never Event: Wrong lens surgery	1
Treatment delay	1
Failure to act on test results	1

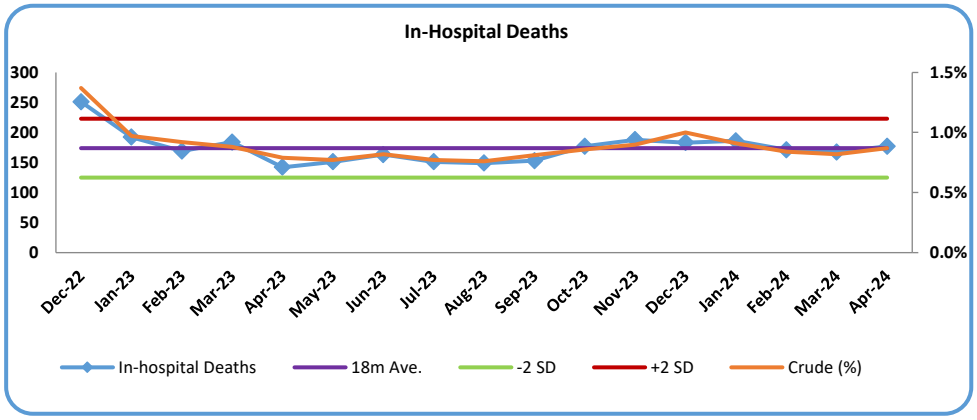
After Action Reviews April 2024 (March 2024: n=4)	
Theme	**Number of cases**
Treatment delay	3
Diagnosis delay	1
Failure to follow up patient	1
Medication incident	1

Never Events April 2024 (March 2024: n=0)	
Theme	**Number of cases**
Wrong lens surgery	1

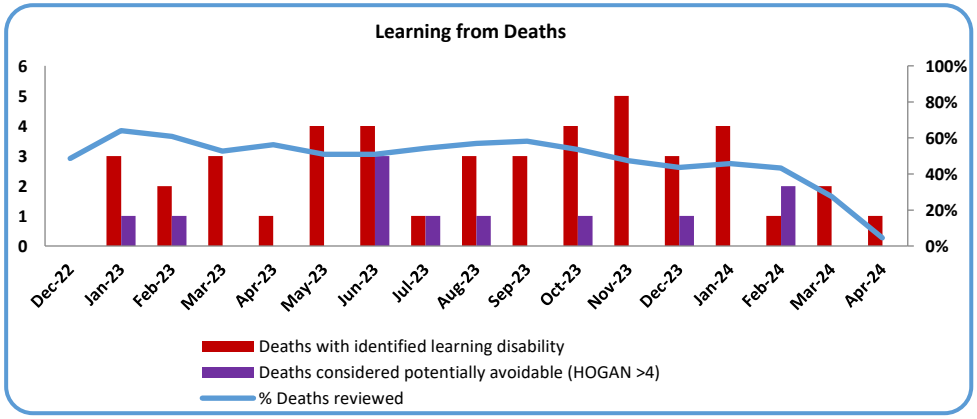
Duty of Candour has been initiated for all cases that meet the mandatory requirement. Please note under the new PSIRF guidance, the Trust may wish to investigate incidents to enhance learning and improve patient safety where the requirement to carry out Duty of Candour is not met.

Quality: Mortality Indicators 1/3

In-hospital Deaths: In total there were 177 inpatient deaths reported in April 2024, which is higher than the amount reported 12 months previously (n=142). Nationally the deaths were high in December 2022, with influenza reported to be the main cause of death. The crude rate in April 2024 is 0.87%.



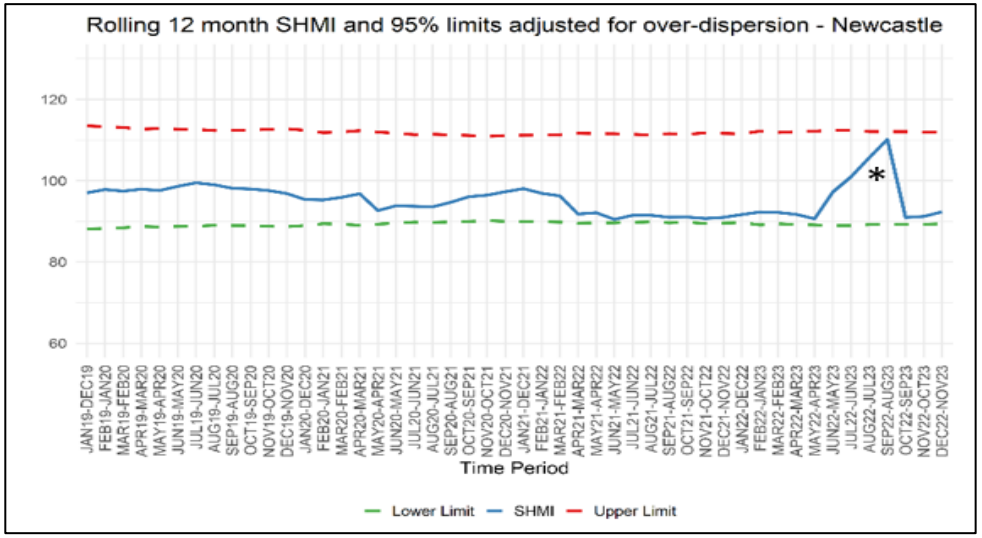
Learning from Deaths: Out of the 177 deaths reported in April 2024, eight patients have, to date, received a level 2 mortality review. However, these figures will continue to rise due to ongoing M&M meetings held over the forthcoming months. All figures will continue to be monitored and modified accordingly. One patient who died as an inpatient in April 2024, had an identified learning disability.



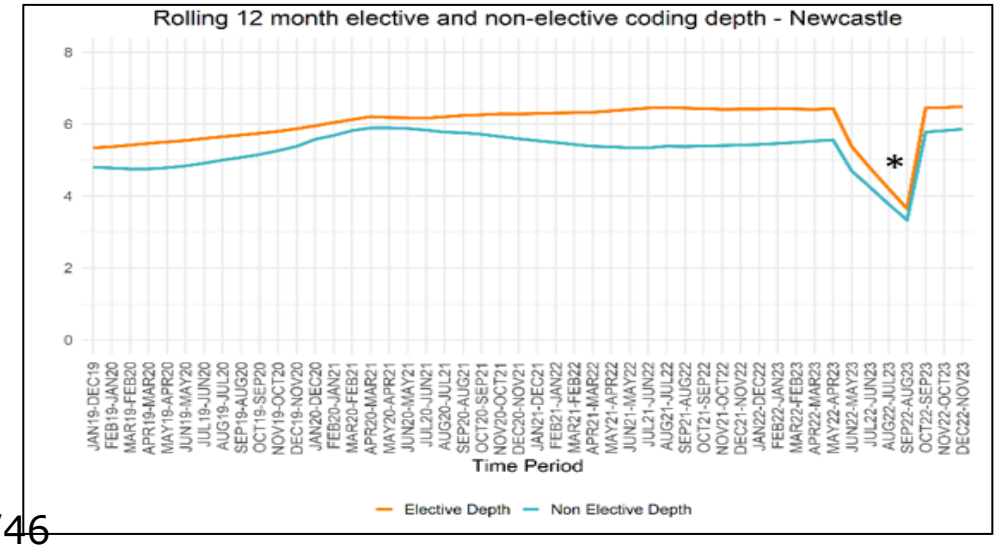
Quality: Mortality Indicators 2/3

SHMI Trend Analysis – rolling 12 months
January 2019 – December 2019 to December 2022 – November 2023

The following graphs published by NEQOS, replace the historic graphs showing HSMR data. HSMR data is no longer monitored nationally or published in local NEQOS reports. This is primarily due to the data source for HSMR data being Dr Foster Intelligence, who no longer monitor the mortality performance within NHS Hospitals.



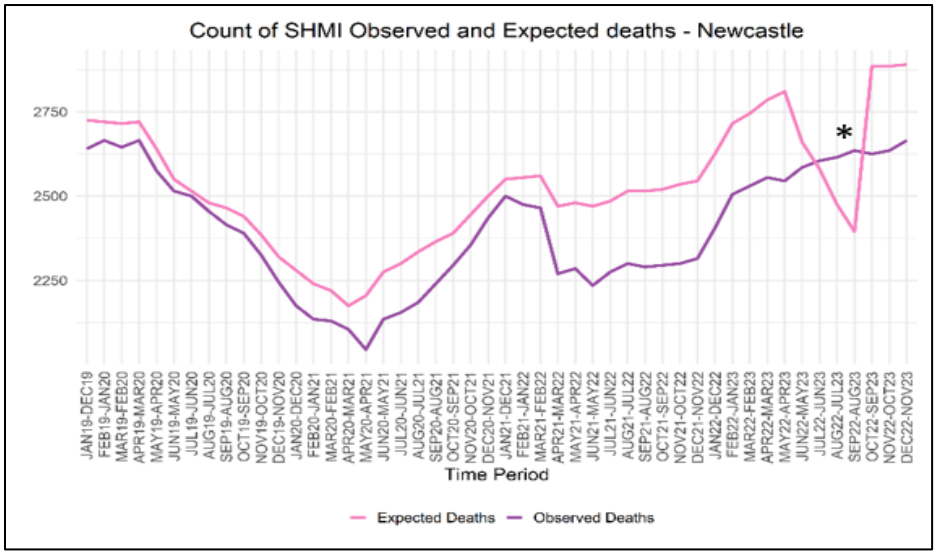
SHMI: Within the latest published quarterly SHMI data (December 2022 – November 2023) shows the Trust has scored 0.92. This is within the "as expected" category.



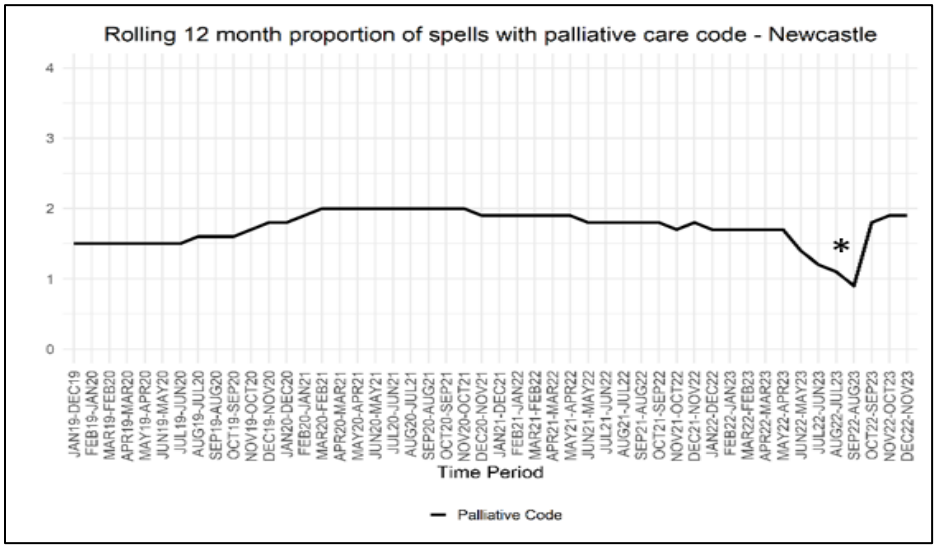
Coding depth (codes/spell): Coding depth has a substantial impact on mortality indicators. Within the latest published quarterly SHMI data (December 2022 – November 2023), the Trust has an elective coding depth of 6.5 and a non-elective coding depth slightly below of 5.9.

Data Source: NHS Digital
Monthly SHMI publication

Quality: Mortality Indicators 3/3



Observed/Expected deaths – Within the latest published quarterly SHMI data (December 2022– November 2023) the Trust has 2665 observed deaths and 2890 expected deaths.

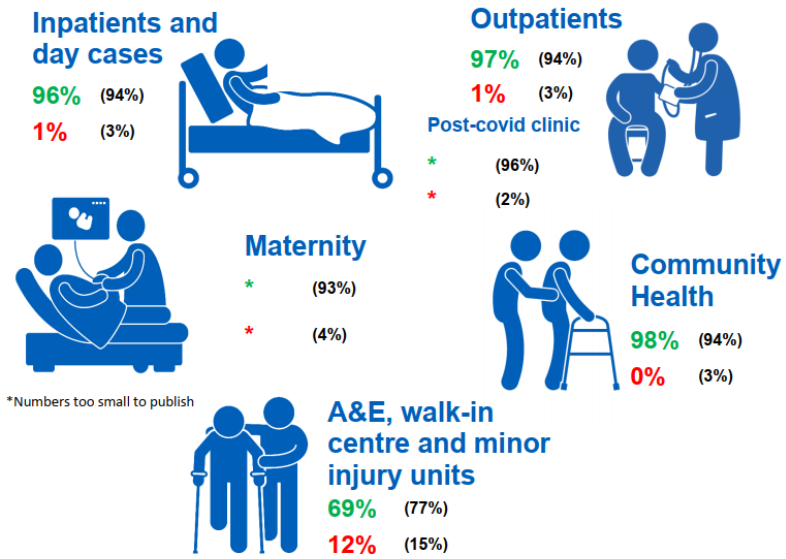


Spells with palliative care coding – Within the latest published quarterly SHMI data (December 2022 – November 2023) the Trust has a 1.9% palliative care coding rate.

***** Trust data is as reported by NHS Digital, there was an issue with the Trust's SUS data flow which affected the clinical coding. This issue has now been resolved

Data Source: NHS Digital
Monthly SHMI publication

Quality: FFT and Complaints



Friends and Family Test

There were 1,464 responses to the Friends and Family test from the Trust in February 2024 (published April 2024) compared to 1,344 in the previous month.

The infographic shows the proportion of patients who give a positive or negative rating of the care they received. The national average results are shown in brackets for comparison.

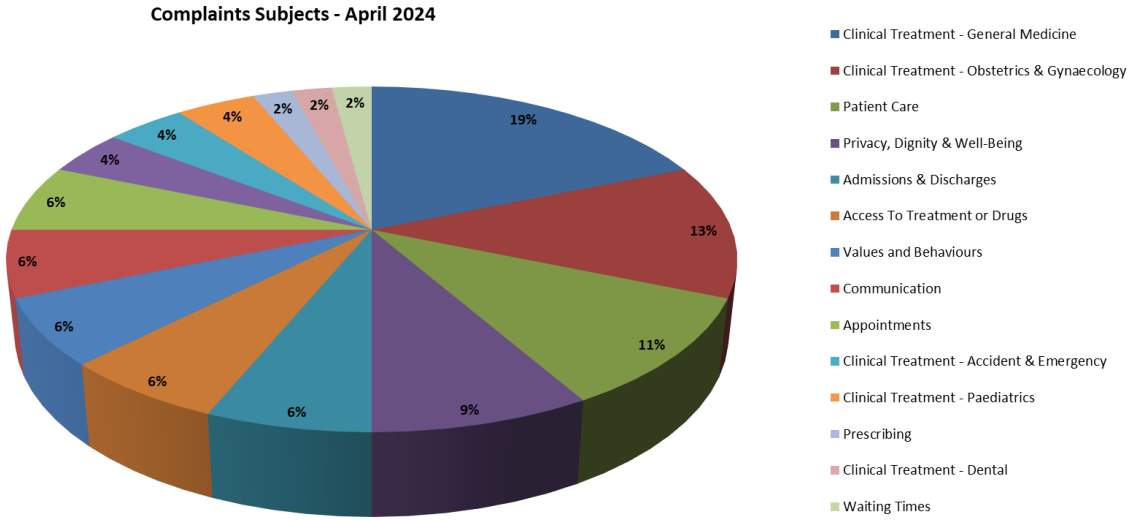
All data is available at: www.england.nhs.uk/fft/friends-and-family-test-data/

*numbers too small to publish

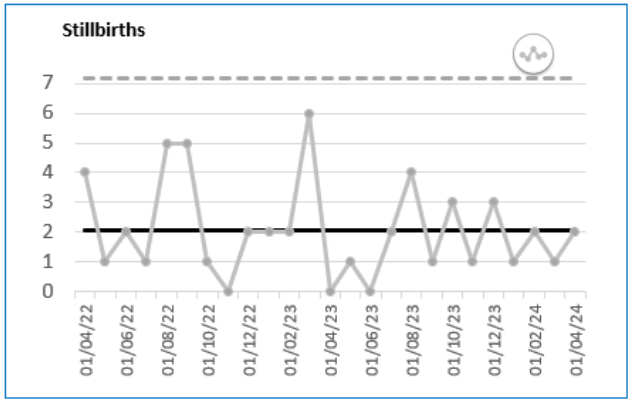
Formal Complaints

The Trust has opened 48 formal complaints In April 2024. This is the same as the Trust average for the last financial year 23/24.

The chart opposite summarises the complaints for April 24, with Clinical Treatment (General Medicine) (n=9) Clinical Treatment (Obs & Gynae) (n=6) and Patient Care (n=6) being the top three themes.

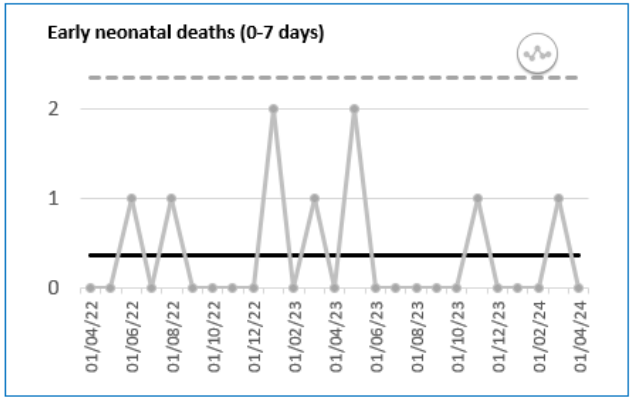


Quality: Maternity



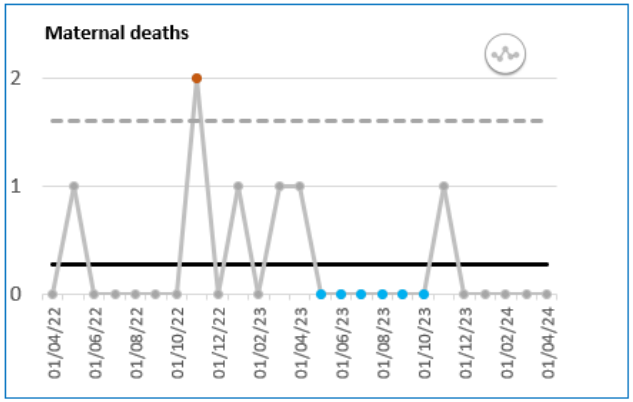
Stillbirths

As NuTH is a tertiary referral Fetal Medicine Unit, complex cases are often referred to the Trust from other units within the region, with women opting to deliver here rather than return to their local unit. This data therefore includes termination for fetal anomalies > 24 weeks gestation. All cases undergo an initial local review and then a more detailed multidisciplinary team review including external input. Findings and actions required, as a result of reviewing each case, are then shared with the family involved. There were two stillbirths in April 2024.



Early Neonatal Deaths

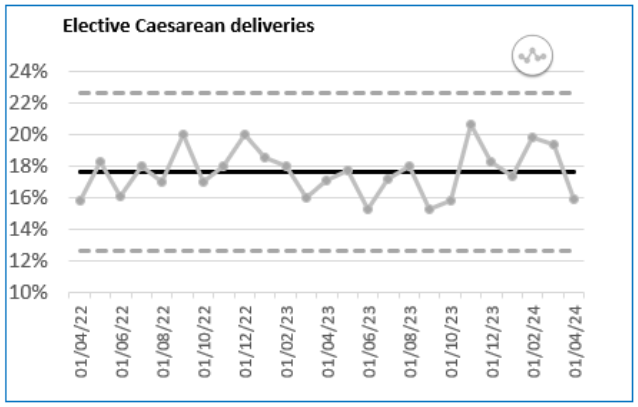
These figures are for term infants (born between 37 and 41 weeks) who delivered at the Trust but sadly died within the first week of life. These deaths are reported to the Child Death Review panel (as are all neonatal deaths regardless of gestation) who will have oversight of the investigation and review process. Neonatal deaths of term infants are also reported to Maternity and Newborn Safety Investigations (MNSI was HSIB) and the Coroner. A post-mortem examination may be requested to try and identify the cause of death. In April 2024 there were no term early neonatal deaths.



Maternal Deaths

Maternal deaths are reported to MBRRACE-UK and a national report is provided annually. Early maternal deaths are categorised as the death of a woman while pregnant or within 42 days of pregnancy (including termination of pregnancy). Late maternal deaths are reported from 42 days and within a year of pregnancy. Direct deaths are those resulting from obstetric complications of the pregnant state. Indirect deaths are those from pre-existing disease or disease that developed but has no direct link to obstetric cause and was aggravated by pregnancy.
Early maternal deaths are also reported to Maternity and Newborn Safety Investigations (MNSI previously known as HSIB), investigation is dependent on certain criteria. There have been no maternal deaths reported in 2024.

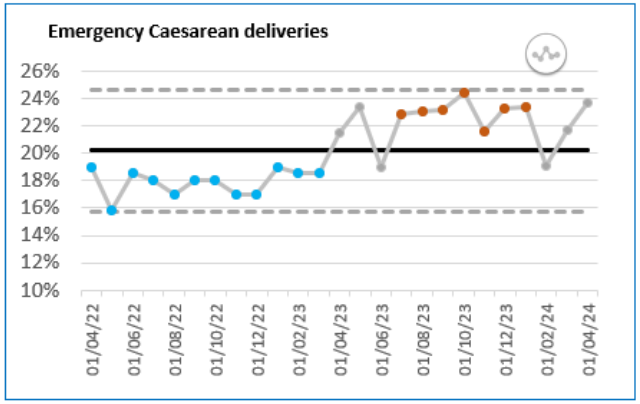
Quality: Maternity



Elective Caesarean section

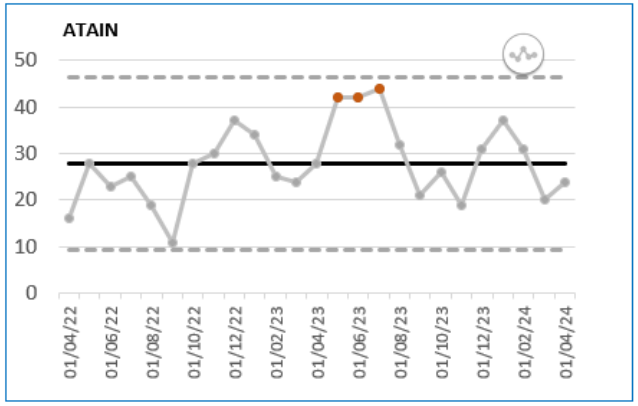
Maternity at the Trust is an outlier for elective Caesarean section compared to other UK Trusts. However, the rates are comparable to that of other tertiary centres in the UK.

The service also has at its heart a shared decision-making philosophy and offers informed, non-directive counselling for women over mode of delivery. There is an obstetrician/midwifery specialised clinic to facilitate this counselling and patient choice.



Emergency Caesarean section

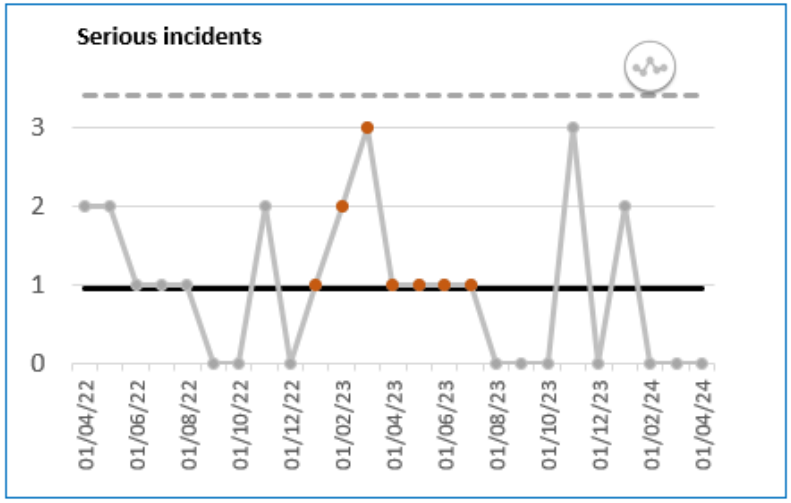
The emergency Caesarean section rate is comparable to other Trusts. Maternity is a consultant led service with dedicated consultant presence on Labour Ward 8am-10pm daily, consultant led multi-disciplinary ward rounds occur twice daily. The majority of obstetric consultants remain onsite overnight, from 10pm-8am and are involved with all decisions for emergency Caesarean section.



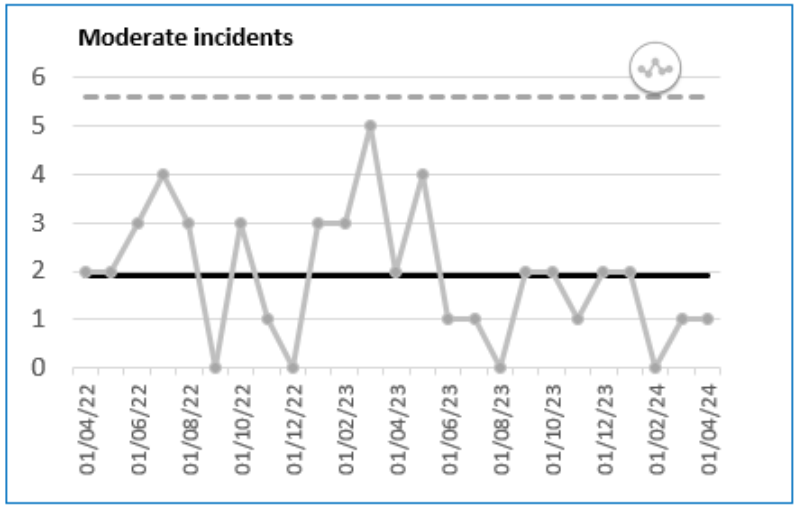
Avoiding Term Admission into Neonatal Units (ATAIN)

All unplanned admissions of term babies (37 – 41 weeks) into the neonatal unit are currently reviewed at a regular multi-disciplinary meeting and a quarterly report is produced and learning shared. Analysis for Quarter 4 (Jan-Mar) term admissions highlighted 8 avoidable admissions from a total of 89, with a rate of 8.9%, a rise from the previous quarter of 6.7%. The number of unplanned admissions has stayed the same as Quarter 3, however the birth rate has decreased hence the increased rate. There were 24 term admissions in April 2024. New maternity and neonatal services guidance recommends that Trusts now focus audit and quality improvement work toward transitional care admissions for babies born from 34 weeks to 36+6 weeks gestation. This is mandated through implementing the Saving Babies Lives Care Bundle version 3 (SBLCBv3) and a requirement of the Year 6 NHS Resolution Maternity Incentive Scheme.

Quality: Maternity 3/3



Serious Incidents
Working within the newly implemented Patient Safety Incident Response Framework (PSIRF), the Trust no longer uses the classification of 'Serious Incident'. These cases include outcomes involving potential or confirmed Hypoxic Ischaemic Encephalopathy (HIE), neonatal death, intrapartum stillbirth, antepartum intrauterine death and maternal death. There are national requirements for Trusts to refer cases involving HIE, Term Intrapartum Stillbirths, Neonatal deaths and Maternal deaths to Maternity and Newborn Safety Investigations (MNSI was previously known as HSIB) for external review. There have been no MNSI referrals in April 2024.



Moderate incidents
There was one moderate (and above) incident reported in Maternity this month involving the unexpected deterioration of a newborn baby. Working within the newly implemented Patient Safety Incident Response Framework (PSIRF), all moderate and above incidents will be reviewed by the maternity governance team and a multidisciplinary team rapid review undertaken. These cases will then be presented to a weekly Trust 'Response Action Review' meeting to agree grading, identify immediate learning/action and agree a proportionate response to each incident which may include local review, after action review of for more significant incidents a Patient Safety Incident Investigation (PSII). Thematic learning from incidents will also be gathered through this process.

People

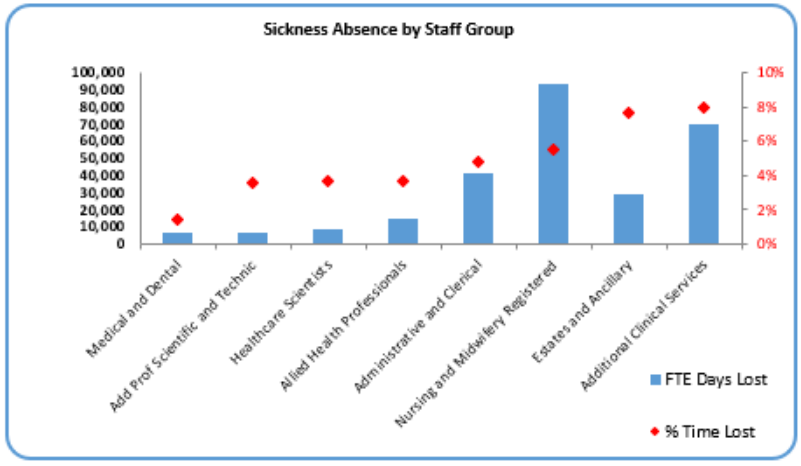
People: Sickness absence

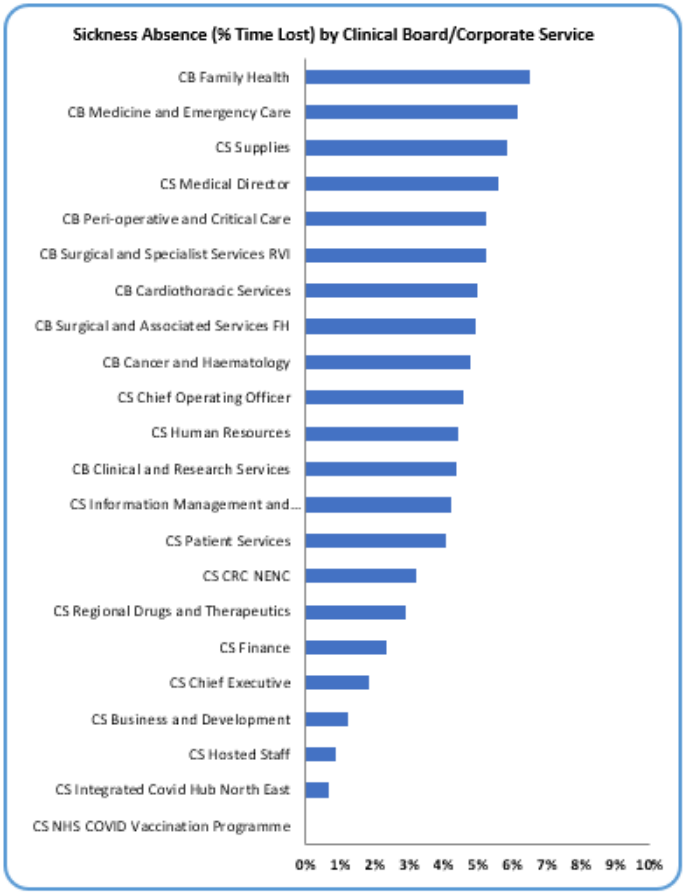
Sickness absence by Staff Group and Clinical Board

270,845 FTE working days were lost due to sickness, compared to 280,530 for the previous year - a reduction of 3.45%

Total sickness absence reduced from 5.72% (May 2022 to April 2023) to 5.31% (May 2023 to April 2024).

The top three reasons for sickness absence are S10 Anxiety/stress/depression/other psychiatric illnesses (28%), S12 Other musculoskeletal problems (11%), and S25 Gastrointestinal problems (10%).





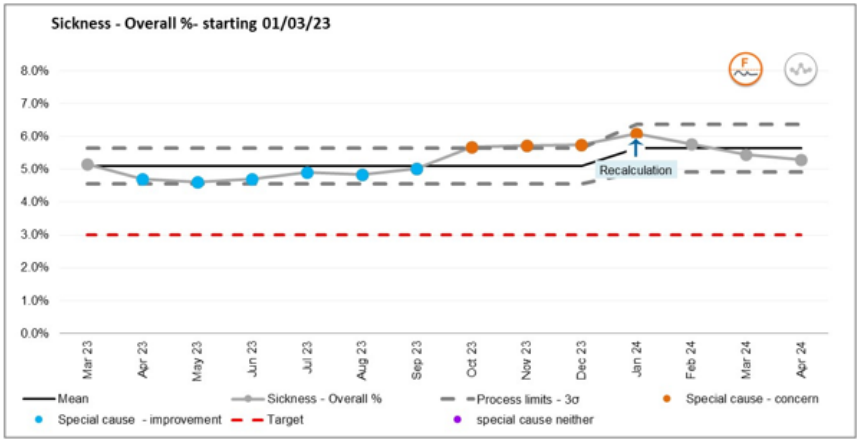
People: Sickness absence 2/3

Sickness absence April 2024 (target 3%)

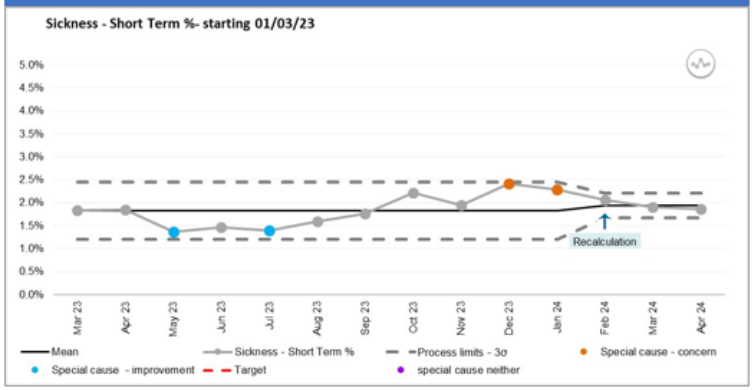
Metric	Assurance	Variation
Sickness – Overall %	Consistently fail target	Common Cause
Sickness – ST %		Common Cause
Sickness – LT %		Common Cause

For the month of April 2024, sickness absence is reporting 5.28%, this is demonstrating a consistent trend above the 3.00% target with long term sickness the main contributing factor.

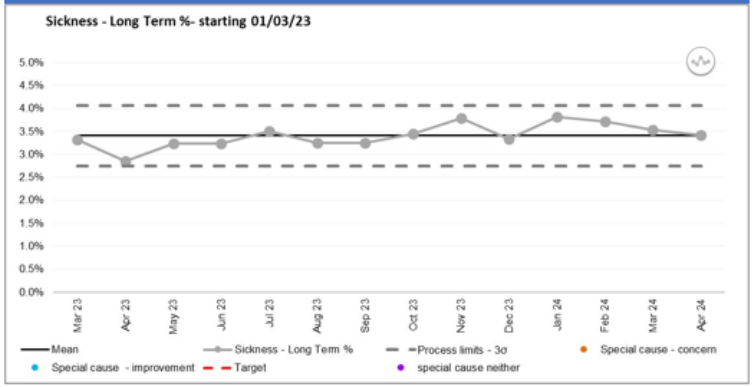
Sickness – Overall % 5.28%



Sickness – Short Term % 1.86%



Sickness – Long Term % 3.42%



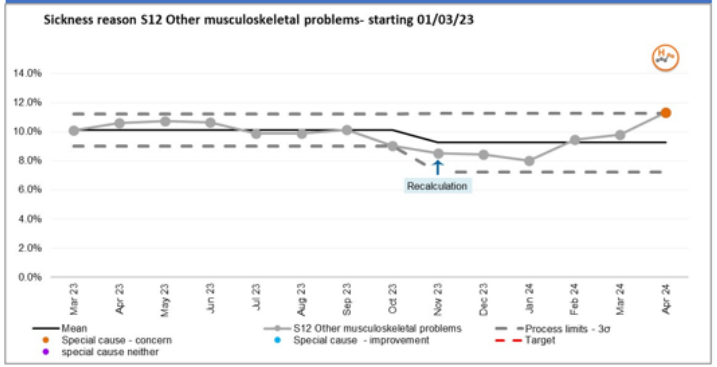
People: Sickness absence 3/3

Top three sickness reasons May 2023 to April 2024 (%FTE)

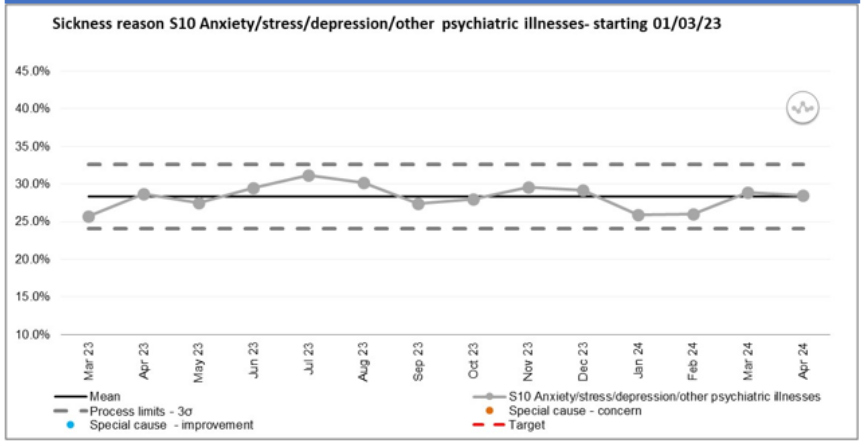
Metric	Variation
S10 Anxiety/stress/depression/other psychiatric illnesses	Common cause
S12 Other musculoskeletal problems	Common cause
S25 Gastrointestinal problems	Common cause

Overall sickness absence for Anxiety/stress/depression/other psychiatric illnesses is 28.46%, this has remained at 'Common Cause variation'. Other musculoskeletal problems has seen an increase to 11.30% in April 24 from 9.11% in March 24.

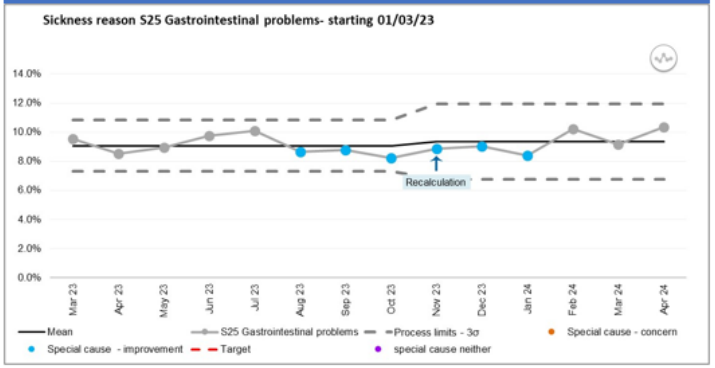
S12 Other musculoskeletal problems 11.30%



S10 Anxiety/stress/depression/other psychiatric illnesses 28.46%



S25 Gastrointestinal problems 10.36%



People: Equality and diversity

The tables identify by disability and ethnicity the recruitment outcome of applicants during the twelve months ending April 2024.

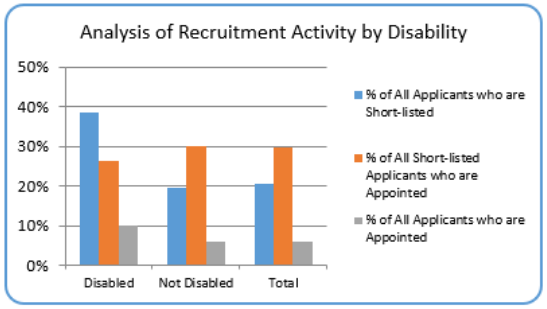
Disability %	April 2023	April 2024	
Yes	4.74%	5.00%	↑
No	80.96%	82.26%	↑
Not recorded	14.30%	12.74%	↓

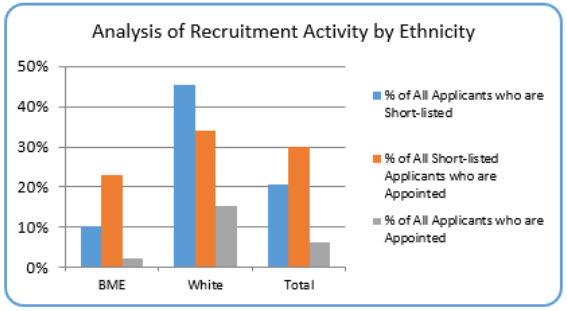
Ethnicity %	April 2023	April 2024	
BME	13.32%	16.18%	↑
White	85.31%	82.58%	↓
Not recorded	1.38%	1.24%	↓

The charts identify, by headcount, the percentage of staff in post in April 2023 and April 2024 by disability and ethnicity.

The percentage of staff employed disclosing a disability has increased (year on year) from 4.74% to 5% and the percentage of BAME staff has increased from 13.32% to 16.18%

Recruitment





People: Sustainable workforce planning 1/3

Staff in post and staff retention

Staff in Post

Staff Group	April 23	April 24	% Increase April 23 to April 24
Add Prof Scientific and Technic	531	547	2.98%
Additional Clinical Services	2385	2426	1.73%
Administrative and Clerical	2304	2393	3.89%
Allied Health Professionals	1035	1077	4.00%
Estates and Ancillary	1052	1053	0.14%
Healthcare Scientists	656	670	2.18%
Medical and Dental	1180	1194	1.21%
Nursing and Midwifery Registered	4536	4838	6.66%
Total	13,678	14,198	3.80%

Staff in post has increased by 3.8% since April 23. The staff groups with the largest increase are Nursing and Midwifery Registered and Allied Health Professionals.

Retention for staff over 1 year service is 87.67%, an increase from 85.99% in April 23

Staff Retention

Category	2022	2023	2024
Over 1 year service	86.73%	85.99%	87.67%
Less than 1 year service	13.27%	14.01%	12.33%

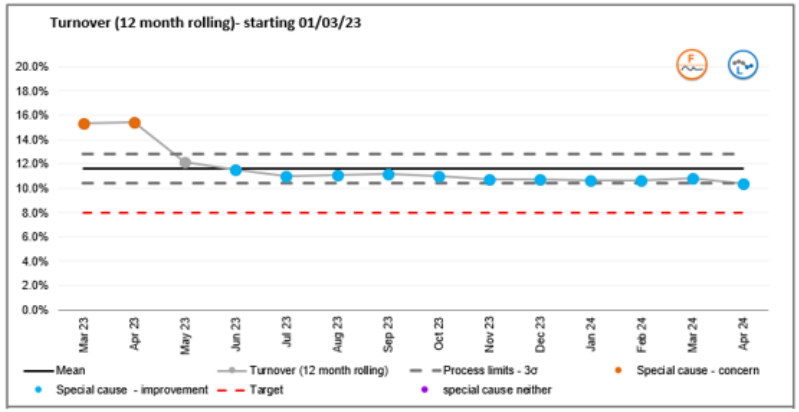
Staff Group (2024)	Over 1 year service	Less than 1 year service
Add Prof Scientific and Technic	90.30%	9.70%
Additional Clinical Services	84.72%	15.28%
Administrative and Clerical	86.44%	13.56%
Allied Health Professionals	88.57%	11.43%
Estates and Ancillary	88.18%	11.82%
Healthcare Scientists	92.71%	7.29%
Medical and Dental	85.80%	14.20%
Nursing and Midwifery Registered	88.94%	11.06%

People: Sustainable workforce planning 2/3

Workforce turnover (target 8%)

Turnover (rolling 12 months)	10.41%	
Clinical Board	**Turnover**	**Achieved**
317 CS Integrated Covid Hub North East	0.00%	✓
317 CS NHS COVID Vaccination Programme	0.00%	✓
317 CS Business and Development	3.03%	✓
317 CS CRC NENC	7.25%	✓
317 CB Peri-operative and Critical Care	8.02%	✓
317 CS Patient Services	9.07%	✗
317 CB Medicine and Emergency Care	9.23%	✗
317 CB Surgical and Specialist Services RVI	9.71%	✗
317 CB Surgical and Associated Services FH	9.71%	✗
317 CB Cancer and Haematology	10.07%	✗
317 CB Clinical and Research Services	10.39%	✗
317 CB Cardiothoracic Services	10.87%	✗
317 CS Supplies	11.04%	✗
317 CS Finance	11.45%	✗
317 CB Family Health	11.77%	✗
317 CS Chief Executive	12.21%	✗
317 CS Human Resources	12.26%	✗
317 CS Estates	12.42%	✗
317 CS Information Management and Technology	12.95%	✗
317 CS Regional Drugs and Therapeutics	13.70%	✗
317 CS Hosted Staff	14.08%	✗
317 CS Medical Director	17.07%	✗
317 CS Chief Operating Officer	31.58%	✗
Trust Total	10.41%	✗

Metric	Assurance	Variation
Turnover (rolling 12 months)	Consistently fail target	Common Cause Improving Variation



Staff turnover has decreased from 15.46% in April 2023 to 10.41% in April 2024, target is 8.0%.

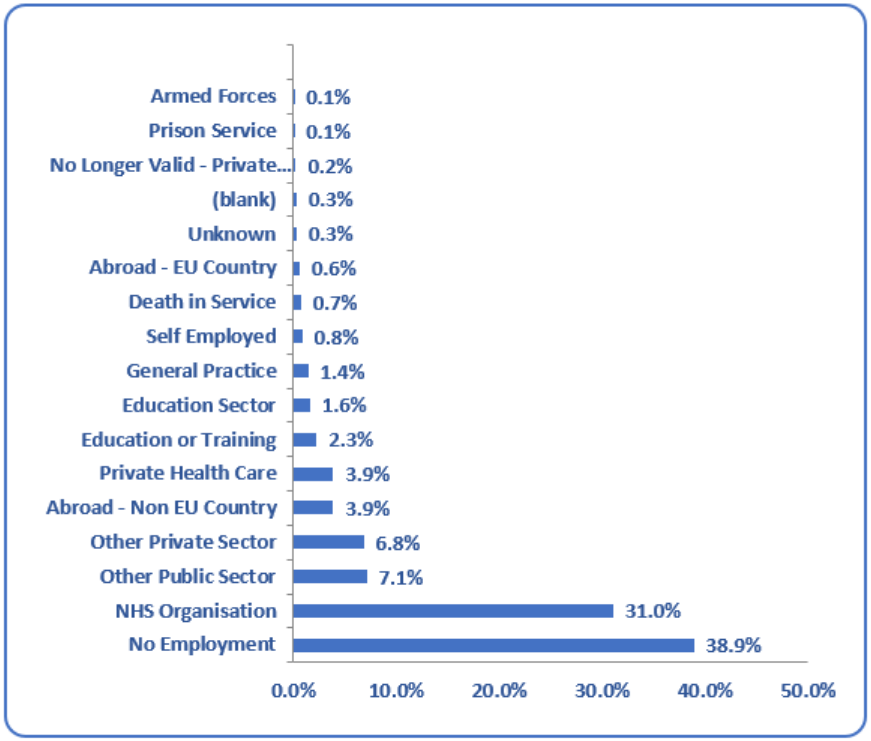
The total number of leavers in the period May 2023 to April 2024 was 1,672.

People: Sustainable workforce planning 3/3

Workforce turnover - reasons and destination

Top 5 Leaving Reasons

Destination on Leaving



31% of leavers across the Trust disclosed they were going to another NHS organisation.

People: Sustainable workforce planning 1/2

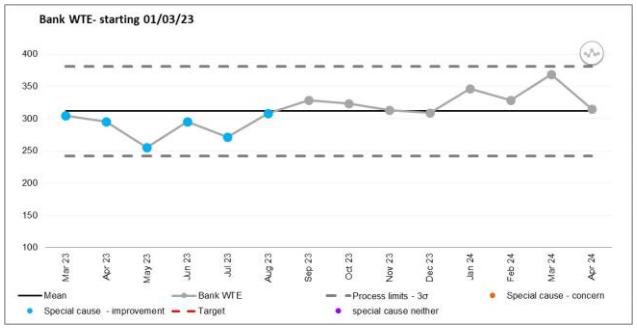
Bank/Agency

Bank (Whole Time Equivalent - wte)

Metric	Variation
Bank WTE	Common cause

Bank wte is demonstrating 'Special Cause Concerning' Variation. This is present when a random pattern of variation with all points within the control limits.

When a control chart shows common cause variation, a process measure is said to be in statistical control or stable.



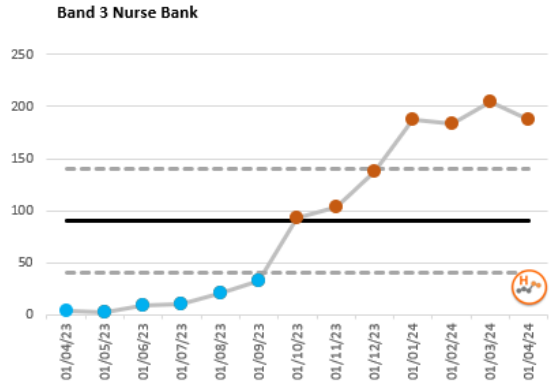
Outlier(s)

Staff Group	Variation
Band 3 Nurse Bank	Special Cause Concerning Variation

There is 'Special Cause Concerning' Variation for Band 3 Nurse Bank staff.

Special causes are a signal to act to make the process improvements necessary to bring the process measure back into control.

Note, increase is due to Band 2 Nurse bank staff being re-banded to Band 3 Nurse Bank since July 23.



Bank Staff Group	Variation
Admin & Clerical Bank	Common cause
AHP Bank	Common cause
Band 2 Nurse Bank	Special Cause Improving Variation
Band 3 Nurse Bank	Special Cause Concerning Variation
Band 4 Nurse Bank	Special Cause Improving Variation
Band 5 Nurse Bank	Common cause
Band 6 Nurse Bank	Common cause
Band 7 Nurse Bank	Common cause
Band 8 Nurse Bank	Special Cause Improving Variation
Healthcare Scientist	Common cause
Scientific, Therapeutic & Technical	Special Cause Improving Variation
Support Staff	Common cause

People: Sustainable workforce planning 2/2

Bank/Agency (continued)

Bank Utilisation (£)

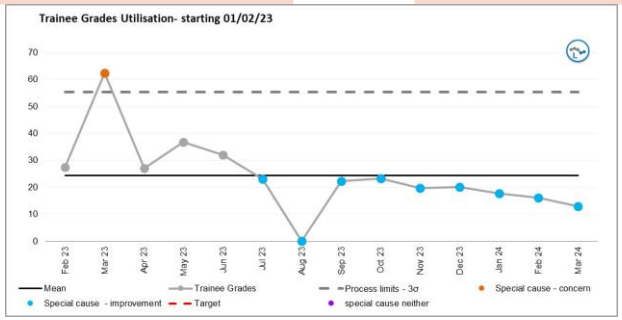
Staff Group	May 22 - Apr 23	May 23 - Apr 24	Difference
Admin & Clerical	£1,311,184	£330,033	-£981,150
Ancillary	£361,319	£1,147,304	£785,985
Estates			-
Nursing & Midwifery (Registered)	£6,784,623	£5,738,089	-£1,046,533
Nursing & Midwifery (Unregistered)	£8,065,001	£9,024,629	£959,628
Professional & Technical	£1,446,256	£946,736	-£499,520

Agency Utilisation (£)

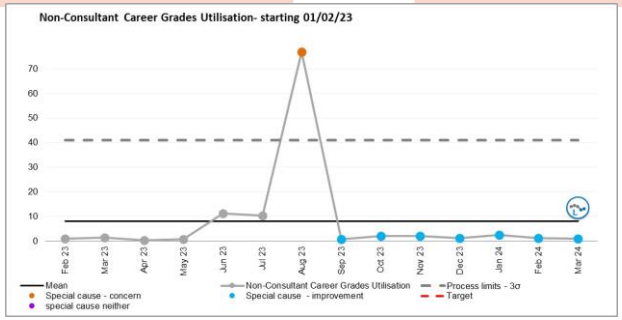
Staff Group	May 22 - Apr 23	May 23 - Apr 24	Difference
Admin & Clerical	£850,643	£719,690	-£130,953
Ancillary	£40,649	£15,801	-£24,848
Estates	£107,914	£55,806	-£52,107
Nursing & Midwifery (Registered)	£108,165	£78,549	-£29,616
Nursing & Midwifery (Unregistered)	£2,563,343	£2,789,146	£225,803
Professional & Technical	£855,301	£936,579	£81,277

Internal Medical & Dental Bank Utilisation

Metric	Variation
Trainee Grades	Special Cause Improving Variation



Metric	Variation
Non-Consultant Career Grade	Special Cause Improving Variation



People: Excellence in education and training 1/3

Mandatory training

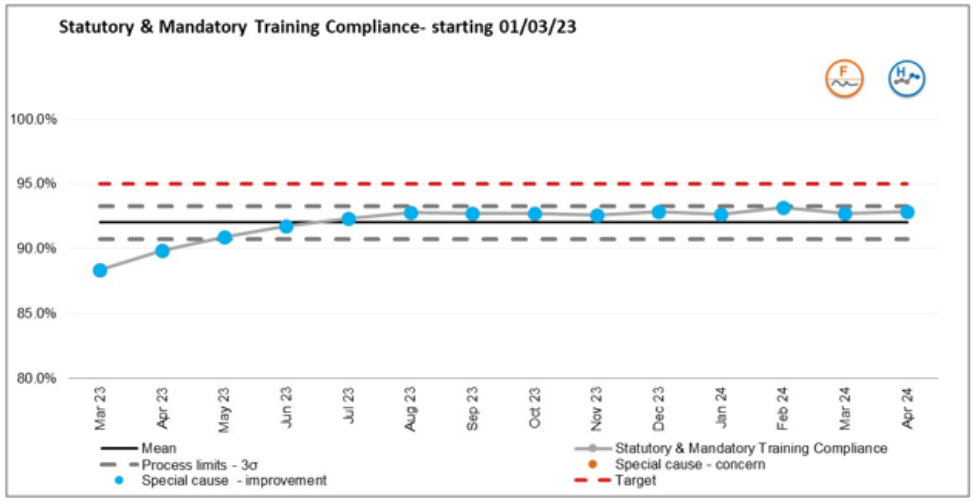
Mandatory Training Compliance (target 95%)				92.84%
Metric	**Assurance**		**Variation**	
Mandatory Training Compliance %	F	Consistently fail target	H	Special Cause Improving Variation

Mandatory training compliance is 92.84% at end April 2024, target is 95%.

Medical and Dental are the staff group with the lowest training compliance at 86.53%

Staff Group	Compliance	Achieved
Medical and Dental	86.53%	✗
Senior Staff (Band 8c and Above)	91.84%	✗
Nursing and Midwifery Registered	92.62%	✗
Allied Health Professionals	92.07%	✗
Additional Clinical Services	93.46%	✗
Estates and Ancillary	92.55%	✗
Add Prof Scientific and Technic	93.41%	✗
Healthcare Scientists	94.54%	✗
Administrative and Clerical	95.90%	✓

Mandatory Training Compliance (target 95%)



People: Excellence in education and training 2/3

Mandatory training (continued)

Mandatory Training Compliance (target 95%)		92.84% ✗
Mandatory Training	**Compliance**	**Achieved**
Local Induction	76.23%	✗
Moving and Handling Level 2	79.98%	✗
Paediatric Basic Life Support	81.18%	✗
Fire Safety	84.37%	✗
Adult Basic Life Support	85.86%	✗
Infection Prevention and Control (Level 2)	86.79%	✗
Moving and Handling Level 1	89.66%	✗
Information Governance	89.95%	✗
Infection Prevention and Control (Level 1)	93.99%	✗
Trust Induction	94.22%	✗
Prevent WRAP	95.93%	✓
Prevention of Patient Falls	96.36%	✓
Health and Safety	96.38%	✓
Prevent Awareness	96.43%	✓
Equality and Diversity	96.51%	✓
Safeguarding Adults (Level 1)	96.69%	✓
Safeguarding Children (Level 1)	96.91%	✓
Anti-Bribery and Corruption	97.34%	✓
Conflict Resolution	97.63%	✓

Lowest Two Mandatory Training Compliance %		
Staff Group	**Local Induction**	**Moving and Handling Level 2**
April 2024	**76.23%**	**79.98%**
Add Prof Scientific and Technic	72%	89%
Additional Clinical Services	77%	82%
Administrative and Clerical	81%	60%
Allied Health Professionals	89%	84%
Estates and Ancillary	83%	93%
Healthcare Scientists	80%	15%
Medical and Dental	28%	61%
Senior Staff (Band 8c and Above)	30%	8%
Nursing and Midwifery Registered	84%	79%

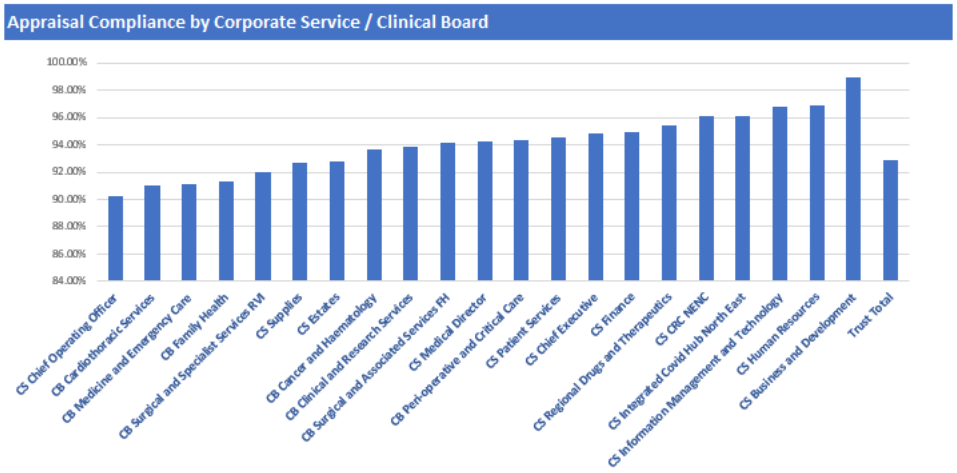
At end April 2024, mandatory training compliance was 92.84%

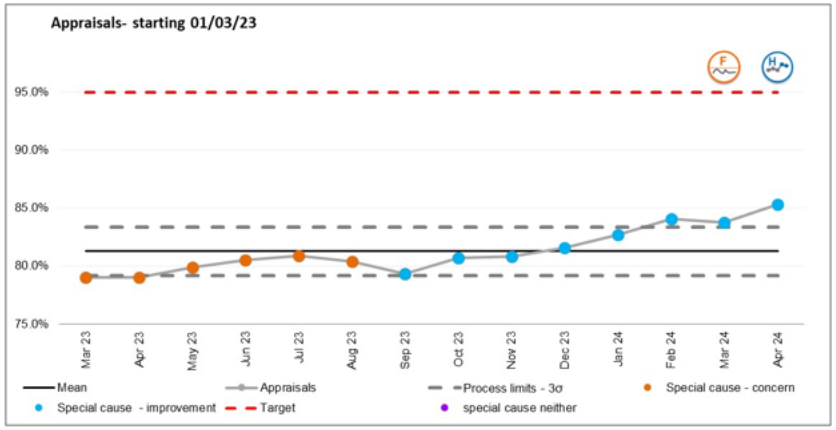
People: Excellence in education and training 3/3

Appraisal compliance

Appraisal Compliance (target 95%)		85.30%
Staff Group	**Compliance**	**Achieved**
Medical and Dental	79.71%	✗
Add Prof Scientific and Technic	82.85%	✗
Additional Clinical Services	83.47%	✗
Allied Health Professionals	84.45%	✗
Administrative and Clerical	84.46%	✗
Healthcare Scientists	84.47%	✗
Nursing and Midwifery Registered	87.31%	✗
Estates and Ancillary	89.71%	✗
Manager Band 8c and Above	91.80%	✗

Appraisal compliance stands at 85.30% at end April 2024, target is 95%.





Metric	Assurance	Variation
Appraisal Compliance	Consistently fail target	Common Cause Improving Variation

Appraisal compliance is demonstrating 'Special Cause Improving' Variation. This is present when a pattern of variation demonstrates a consistent improvement.

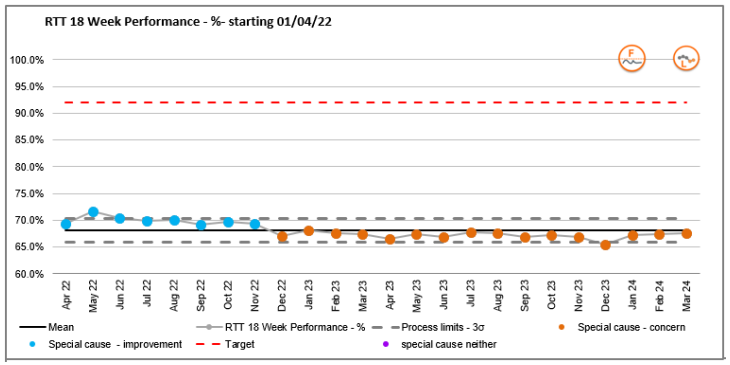
However, the reported values consistently fail to meet the target of 95%.

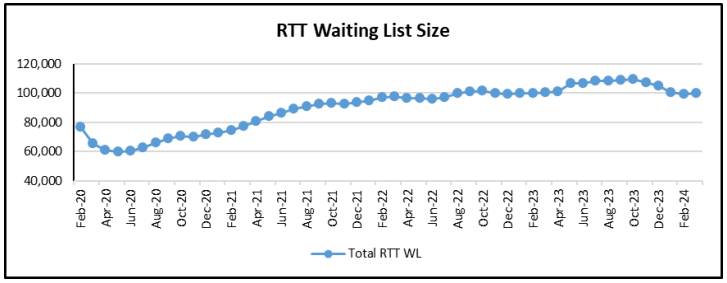
Performance

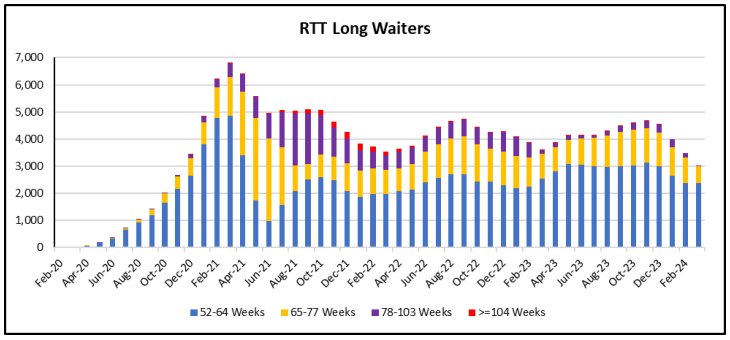
Performance: Elective Waits

Reporting Month: March 2024

RAG Rating







Current position:

- March saw the continued elimination of >104 week waits at Newcastle Hospitals.
- The total number of patients waiting >78 weeks dramatically reduced to just 7 compared to 163 in February, with the number of patients waiting over 65 weeks also falling significantly to 622. This is the lowest level for these two metrics since 2020.
- The total waiting list (WL) size remained largely stable compared to February - 99,884 overall. The total number of patients waiting >18 weeks stood at 32,413, with RTT 18 week performance standing at 67.5%.

Underlying Issues:

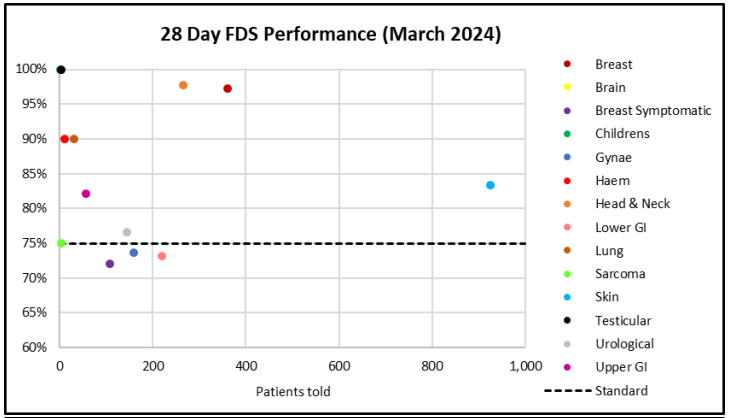
- The inability to deliver a full elective care programme throughout the pandemic, persistent staffing gaps, growth in demand for non-elective and cancer care, increased cancellations and higher DNA rates have all contributed to an increased backlog of patients waiting to receive treatment over recent years. Previous industrial action has also been a factor.
- Whilst considerable progress continues to be made in the reduction of long waiters, there are number of issues that continue to hamper progress. These include:
  - Consultant vacancies in Urology, T&O and Ophthalmology.
  - Short-term sickness in sub-specialties within Ophthalmology and Gynaecology.
  - Increased cancer demand generally, but particularly in Dermatology.
  - Increased urgent cases taking clinical priority, particularly in Plastic & Spinal Surgery.

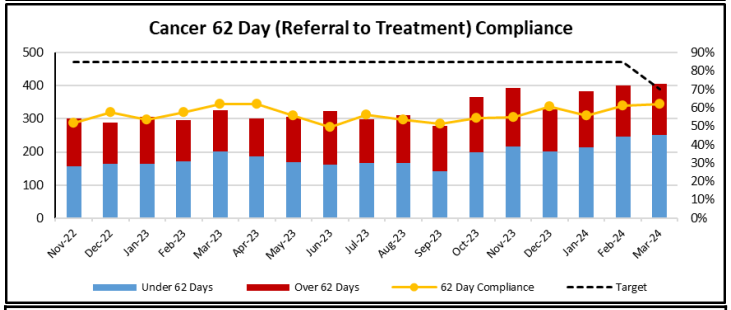
Actions undertaken:

- The implementation of the spinal business case outlined in previous reports, continues to see the improvement in the numbers of patients waiting for spinal surgery.
- The Trust also continues to work with both South Tees and Northumbria Healthcare FTs in the repatriation of referrals back to these providers where that it is clinically appropriate.
- A new consultant Foot and Ankle surgeon has started in February (previously flagged a key workforce gap).
- The recent improvements that have been seen have been driven by a combination of:
  - Improved engagement in the development and monitoring of trajectories.
  - Enhanced provision of progress reporting to the operational teams.
  - Better use of targeted additional sessions.
  - More rigorous validation and application of the Trust's access policy.
  - Improved pooling of patients across the consultant teams in some specialties.
  - Additional scrutiny around booking patients in order for surgery.

Performance: Cancer Care

Reporting Month: March 2024 | **RAG Rating**





62 DAY PERFORMANCE – MARCH 2024

Brain	100%	Head & Neck	75.4%	Skin	88.3%
Breast	82.9%	Lower GI	51.9%	Testicular	100%
Gynae	60.0%	Lung	41.5%	Upper GI	26.7%
Haem	83.3%	Sarcoma	52.4%	Urological	50.86%
Newcastle Hospitals Total					**61.9%**

Current position:

- The 75% 28 Day Faster Diagnosis Standard (FDS) was achieved for the second successive month (84.6%), increasing by 1.4% from February.
- 62 Day compliance was 61.9% in March. Lower GI, Lung, Upper GI and Urological tumour groups delivered the lowest performance levels – all below 52%.
- 31 Day performance improved by 1.1% to 89.1% in March.

Underlying Issues:

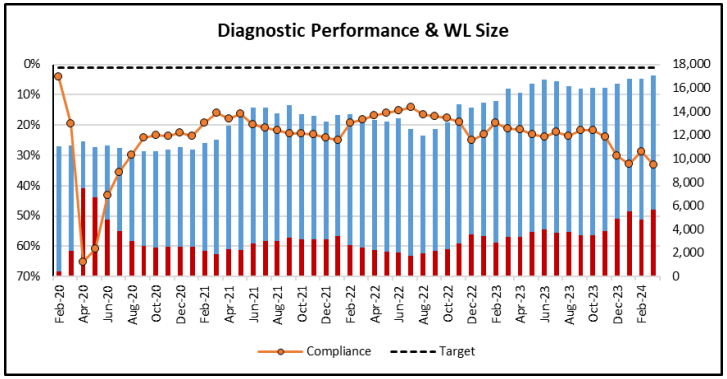
- Diagnostic delays including within Pathology, Radiology and Endoscopy mean that the majority of patients waiting 40-62 days are still awaiting diagnosis. CT capacity is particularly impacting Urology performance and there have been delays for cystoscopies.
- Circa 50% of tertiary cancer referrals are received from Trusts after the 38 day deadline, with Lung the most heavily affected tumour group.
- Various tumour groups have limited theatre capacity and staff shortages – there is a limited appetite from staff to undertake additional theatre work, whilst theatre refurbishments have also impacted Lung in particular.
- Workforce gaps are significantly impacting Gynae and Upper GI cancer performance, with Gynae capacity further impacted by annual leave.

Actions undertaken:

- Radiology: The service continue to push to shorten MRI request to report times to 10 days and CT request to report times to 7 days. Mobile units for MRIs and PET CT scans have been extended to provide additional temporary capacity.
- Urology: Staff are currently being trained to be able to provide specialist TURT processes. The service are also risk stratifying patients to ensure patients are seen in order of urgency.
- Head & Neck: Risk stratifying referrals into high & low-risk groups and managing high risk into <7day waits with the aim to shorten the diagnostic pathways for patients with cancer.
- Skin: Additional theatre sessions, supported by the Plastics team, took place in February/March. The waiting list team was been instructed to solely book cancer backlog patients onto these lists where clinically appropriate. In addition the team continue to validate all long waiters to ensure all are fit for treatment, with demonstrable improvements in performance in recent months.

Performance: Diagnostics

Reporting Month: March 2024 | **RAG Rating**



MARCH 2024		Total WL	Breaches	Compliance
Imaging	MRI	5,777	2,496	43.2%
	CT	1,817	251	13.8%
	Non-obs Ultrasound	3,669	106	2.9%
	Barium Enema	1	0	0.0%
	DEXA	428	6	1.4%
Physiological Measurement	Audiology	3,324	2,242	67.4%
	ECHO	735	319	43.4%
	Electrophysiology	37	22	59.5%
	Periph. Neurophysiology	367	70	19.1%
	Sleep Studies	58	29	50.0%
	Urodynamics	29	5	17.2%
Endoscopy	Colonoscopy	287	31	10.8%
	Flexi sigmoidoscopy	99	10	10.1%
	Cystoscopy	52	5	9.6%
	Gastroscopy	346	45	13.0%

Current position:

- Performance against the 5% standard declined compared to February, with 33.1% of patients waiting longer than six weeks for their test (-4.3%).
- The volume of activity delivered per working day increased by 2.3% from February.
- The total WL size grew by 268 patients from the previous month, with the total 6-week breaches increasing by 811 over the same period (5,637, +16.8%). The volume of patients waiting >13 weeks fell by 50 to 1,817.

Underlying Issues:

- Staffing deficits continue to constrain the volumes of activity several of our diagnostic services can undertake. ECHO have been short of physiologists due to maternity leave and Audiology have had long standing issues with staffing levels.
- Endoscopy have seen a shift in diagnostic requests towards tests that require longer slots per patient following a recent change in GP referral processes and direct to test availability.
- Throughout 23/24 MRI have experienced an increase in referrals across both inpatient and outpatient settings that has far exceeded expectations, resulting in deteriorating waiting time performance. The complexity/casemix of requested scans has also impacted waits, such as Cardiac & GA MRIs which are increasingly referred to NuTH by other DGHs, as has the need to prioritise suspected cancer cases at the expense of more routine referrals.

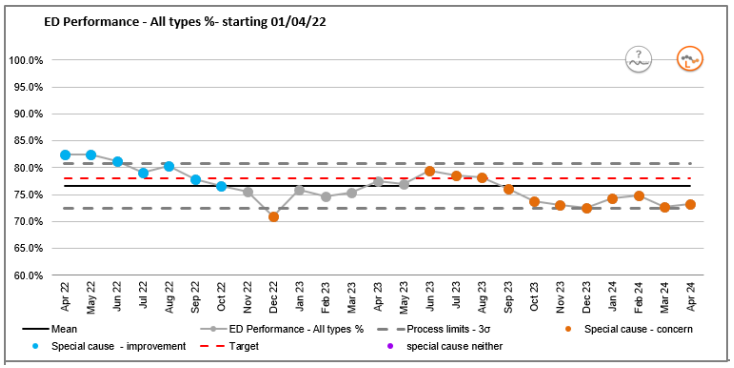
Actions undertaken:

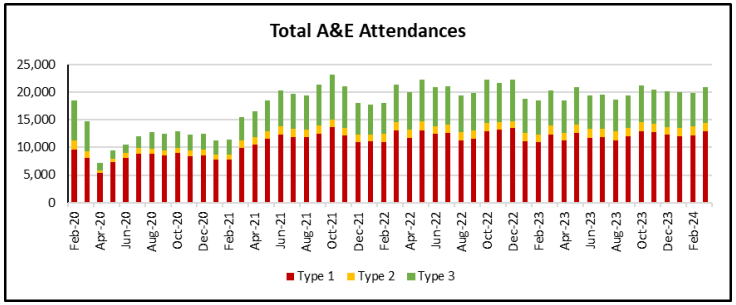
- A whole service review is being undertaken within Audiology to determine the actions required to establish a long-term sustainable service and reduce the number of inappropriate referrals received. The team are also working with Newcastle Improvement to test and measure a variety of pathway changes.
- ECHO continue to utilise insourcing providers to increase capacity. Clinic schedules are presently being amended to maximise efficiency.
- Endoscopy have stepped up their outsourcing provision to minimise waiting times as well as mitigate against the negative impacts of industrial action.
- Radiology continue to share use of the CT and MRI scanners at the CDC, as well as utilising two additional MRI vans at the Freeman. An internal capacity and demand exercise continues to definitively establish the level of additional resource required to reduce long waits on a sustainable basis.

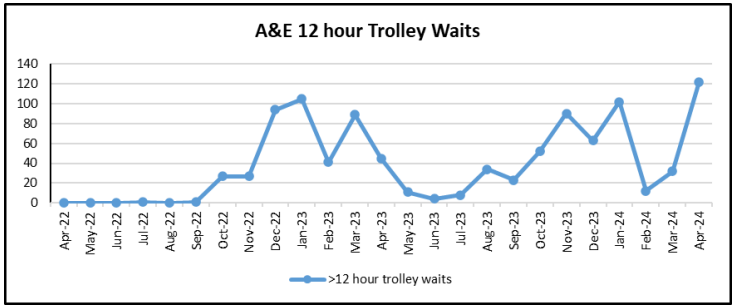
Performance: Emergency Care

Reporting Month: April 2024

RAG Rating







Current position:

- Type 1 and overall performance slightly improved from the previous month to 57.1% (+0.2%) and 73.2% (+0.4%) respectively.
- Handovers >60 minutes reduced from a high of 75 in March to 54 in April. There were 342 handovers >30 mins.
- Trolley waits >12 hours dramatically increased from March (122 vs 32).

Underlying Issues:

- Waits to be seen by a clinician continue to be one of the primary delays in a patient's ED attendance due to a capacity and demand imbalance between the current workforce and volume of attendances.
- Exit block due to lack of bed availability contributes to breaches and overcrowding.
- The current configuration of the ED estate contributes to issues with flow and was not designed for the current volume of attendances.
- High numbers of patients with mental health issues are seeking help in the department, with no improvement in waiting times for crisis/mental health beds. CNTW staffing issues continue to exacerbate this.

Actions undertaken:

- A workforce review has taken place and business case approved for additional medical staff to reduce waits to see a clinician - recruitment commencing from April 2024.
- A number of initiatives have been implemented to improve flow front of house. These include a consultant "See and Treat" shift, streaming patients to alternative services (e.g. SDEC and SAU), additional nursing resource to reduce time to assessment at peak times, and ambulatory cardiology pathways.
- A workstream has been established to review discharge lounge provision with a view to this being made permanent.
- Review of ED, AS and SDEC estates has taken place to review if any changes can be made in the short term to improve flow.
- An ICB commissioned Mental Health "Crisis Hub" is due to open in Spring 2024.

Performance: Access & Outcomes 1/2

Theme	Standard	Jan-24	Feb-24	Mar-24	Apr-24	Num.	Den.
Activity & Elective Care							
Total Activity (Elective Recovery)	**100%** of Plan (equivalent to **107%** of 19/20 value-weighted activity)	99.1%	100.1%	97.2%	**91.3%**	49,360	54,089
Day Case		93.1%	98.7%	98.4%	**98.7%**	10,954	11,103
Elective Overnight		66.9%	75.5%	83.5%	**98.3%**	1,762	1,792
Outpatient New		99.5%	98.7%	99.0%	**101.4%**	23,079	22,764
Outpatient Procedures		106.4%	105.9%	96.1%	**70.1%**	13,565	19,361
Outpatient Review		114.5%	107.6%	111.0%	**110.6%**	59,102	53,437
RTT 18 Week Wait	**92%**	67.3%	67.5%	**67.5%**	TBC	67,471	99,884
>78 Week Waiters	**Zero**	308	163	**7**	TBC	7	
>65 Week Waiters	**Zero** (by Sep-24)	1,362	1,096	**622**	TBC	622	
>52 Week Waiters	As per submitted trajectory	4,009	3,478	**3,017**	TBC	3,017	
RTT Waiting List Size	As per submitted trajectory	100,624	99,066	**99,884**	TBC	99,884	
Diagnostic Activity	**120%** of 19/20 activity	110.9%	111.3%	**118.3%**	TBC	20,319	17,828
Diagnostic 6 week wait	<=**5%** (local target of <=15%)	32.9%	28.8%	**33.1%**	TBC	5,637	17,026
Urgent Ops. Cancelled Twice	**Zero**	0	0	**0**	TBC	0	
Cancelled Ops. Rescheduled >28 Days	**Zero**	9	3	**8**	TBC	8	
OP Activity Ratio: New/Procedure	**46%**	41.3%	41.9%	**38.7%**	TBC	37,812	97,804
>12 Week Waiters Validated	**90%**	54.2%	56.6%	62.4%	**61.2%**	18,789	30,676
Outpatient Review Reduction	**25%** reduction vs 19/20 baseline	106.2%	106.4%	109.5%	**93.4%**	78,236	79,743
PIFU Take-up (%)	>=5% of all OP atts. (by Mar-25)	2.5%	2.6%	2.7%	**1.7%**	1,341	78,236

Performance: Access & Outcomes 2/2

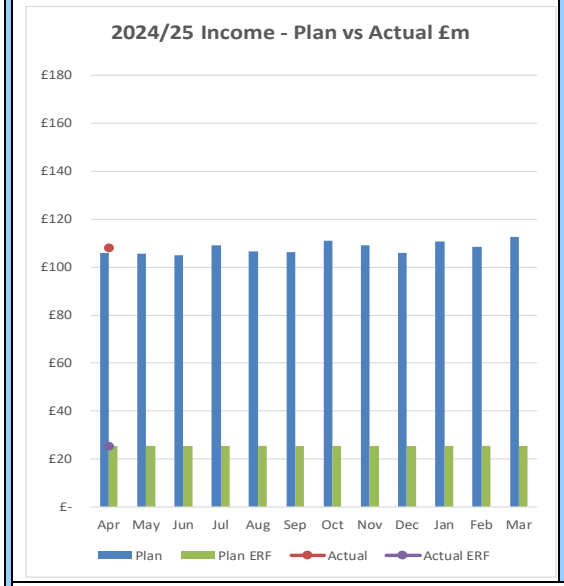
Theme	Standard		Jan-24	Feb-24	Mar-24	Apr-24		Num.	Den.
Cancer Care									
28 Day Faster Diagnosis	**77%** (by Mar-25)		72.0%	83.2%	**84.6%**	TBC		1,946	2,299
31 Days (DTT to Treatment)	**96%**		82.5%	88.0%	**89.1%**	TBC		1,185	1,330
62 Days (Referral to Treatment)	**70%** (by Mar-25)		55.9%	61.1%	**61.9%**	TBC		251	406
>62 Day Cancer Waiters			264	212	186	**167**		167	
Urgent & Emergency Care									
A&E Arrival to Admission/Discharge	**>=78%** under 4 hours (by Mar-25)		74.3%	74.9%	72.8%	**73.2%**		14,152	19,332
	<=2% over 12 hours		3.1%	1.8%	2.2%	**3.6%**		703	19,332
A&E Decision to Admit to Admission	**Zero** over 12 hours		102	12	32	**122**		122	
Adult General & Acute Bed Occupancy	**<=92%**		91.2%	90.2%	89.8%	**91.0%**		1,294	1,422
Ambulance Handovers <15 mins	**65%**		57.2%	58.6%	55.8%	**52.7%**		1,589	3,018
Ambulance Handovers <30 mins	**95%**		88.5%	89.3%	86.7%	**86.9%**		2,622	3,018
Ambulance Handovers >60 mins	**Zero**		36	26	75	**54**		54	
Urgent Community Response Standard	**>=70%** under 2 hours		79.9%	80.4%	82.0%	**82.0%**		337	411
Safe, High Quality Care									
Mixed Sex Acommodation Breach	**Zero**		114	89	**78**	TBC		78	
VTE Risk Assessment	**95%**		95.5%	95.9%	**95.1%**	TBC			
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour		66.0%	66.0%	**66.0%**	TBC			
Sepsis Screening Treat. (All)			64.0%	64.0%	**64.0%**	TBC			

Finance

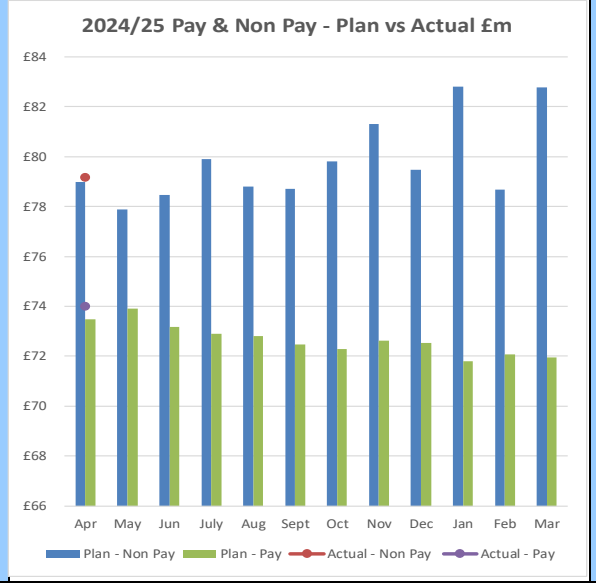
Finance: Overall Financial Position 1/3

Financial Overview as at 30th April 2024

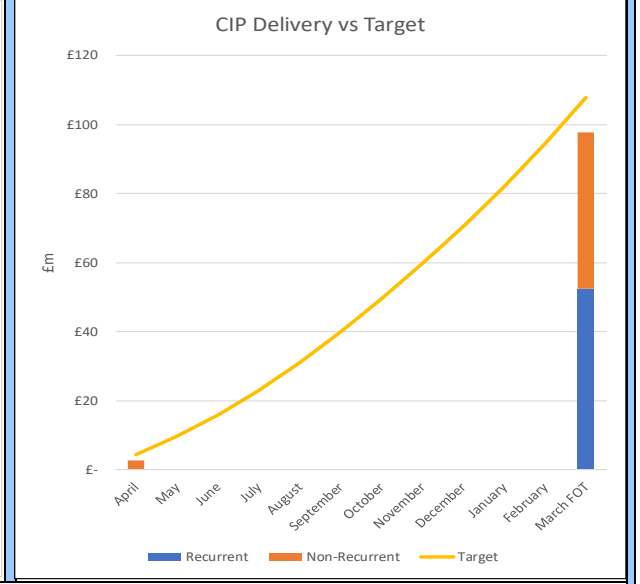
Income



Expenditure



Cost Improvement Analysis



Commentary

This page summarises the financial position of the Trust for the period ending 30th April 2024. The Trust has agreed a Financial Plan for 2024/25 with a break-even position. As at Month 1 the Trust is reporting delivery against the planned defiict of £2 million (after Contol Total). The financial information includes the costs of the Consultant Pay Reform agreement for 2023/24 accrued for the April estimated impact of arpound £760k, which is contributing to the overspend on pay, with a pressure on drugs, partly off-set with income. The delivery of the plan has a siginficant Cost Improvment Plan (CIP) and a number of non-recurrent factors.

Risk

- Delivery of required levels of activity compared with 2019/20 activity levels.
- Reliance on non-recurrent income and expenditure benefits
- Achievement of CIP targets
- Assumptions relating to inflation, subject to change and unfunded

Capital Expenditure

The Plan for April is £0.7 million and the year to date expenditure is £0.8 million creating a variance of £0.1 million to date.

Finance: Overall Financial Position 2/3

Income & Expenditure Statement	In Month (April 2024)			Year To Date (April)		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Operating income from patient services	(116,514)	(118,136)	(1,623)	(116,514)	(118,136)	(1,623)
Other operating income	(15,022)	(15,430)	(408)	(15,022)	(15,430)	(408)
Employee expenses	73,505	73,995	490	73,505	73,995	490
Operating expenses excl. employee expenses	53,597	55,989	2,392	53,597	55,989	2,392
OPERATING SURPLUS/(DEFICIT)	**4,434**	**3,583**	**(852)**	**4,434**	**3,583**	**(852)**
Finance income	(248)	(1,522)	(1,274)	(248)	(1,522)	(1,274)
Depreciation	3,379	3,086	(293)	3,379	3,086	(293)
Finance expense	21,917	20,007	(1,910)	21,917	20,007	(1,910)
PDC dividends payable/refundable	81	81	0	81	81	0
NET FINANCE COSTS	**25,129**	**21,652**	**(3,477)**	**25,129**	**21,652**	**(3,477)**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(20,695)**	**(18,070)**	**2,625**	**(20,695)**	**(18,070)**	**2,625**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR - CONTROL TOTAL	**(2,041)**	**(2,041)**	**(0)**	**(2,041)**	**(2,041)**	**(0)**

The reported performance for April 2024 is as follows:-

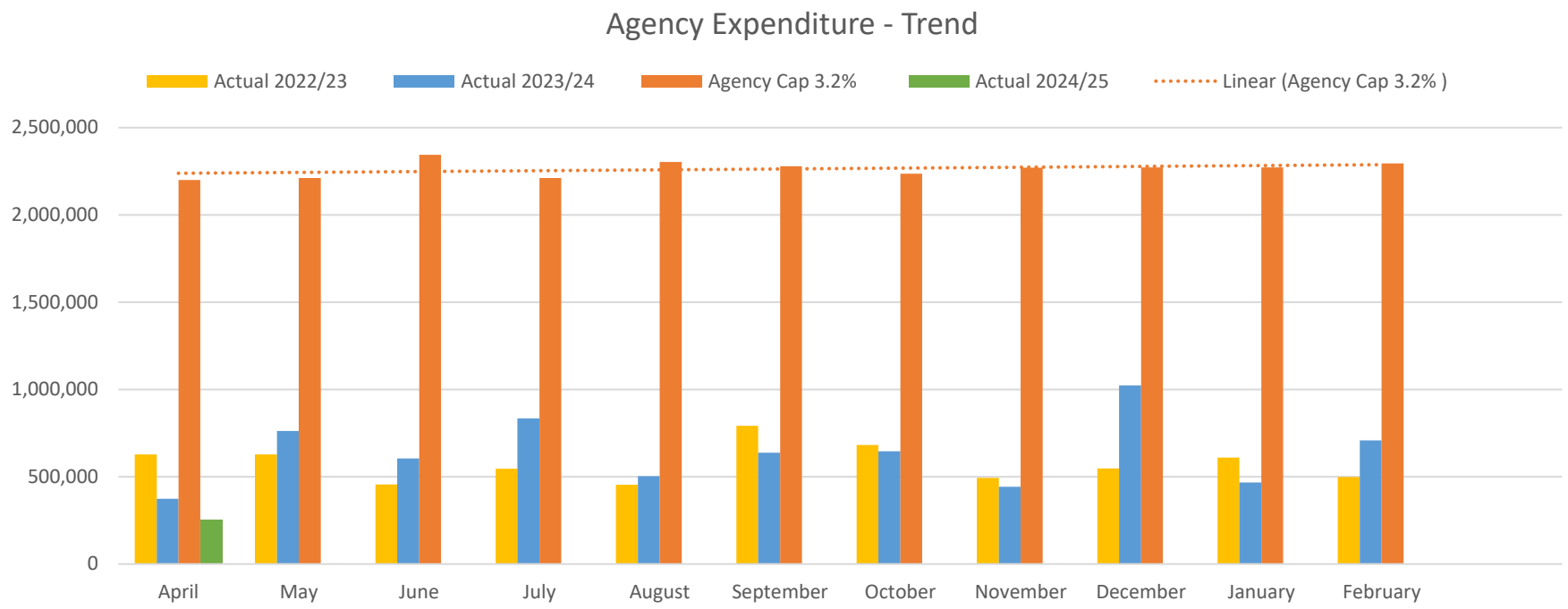
Income

- The in-month position is an overall favourable variance of £480k, partly due to over-performance on matched drugs and devices and miscellaneous income behind plan currently.

Expenditure

- The variance on employee expenses mainly relates to the impact of the Consultant Pay Reform expenditure accrued for April. There is an overspend on drugs expenditure partly matched with income and an increase on the 2023/24 levels that will be monitored.

Finance: Overall Financial Position 3/3



Agency

- The above chart provides the overall trend in relation to agency usage over the last couple of years. This is running at around 0.8% of the gross staff costs. This is below the national target set at 3.2%. Although the analysis is positive, there continues to be medical agency usage across a number of specialties where it is proven difficult to recruit on a permanent/substantive basis. This will continue to be managed and monitored on an ongoing basis to reduce the reliance on agency.

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024					
Title	Great North Healthcare Alliance – Update					
Report of	Sir James Mackey, Chief Executive					
Prepared by	Martin Wilson, Chief Operating Officer and other members of the Alliance Formation Team					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☐		☒	
Summary	This paper provides an update on the ongoing work to form and develop the planning for the Great North Healthcare Alliance, which brings together: o Gateshead Health NHS Foundation Trust; o North Cumbria Integrated Care NHS Foundation Trust; o Northumbria Healthcare NHS Foundation Trust; and o The Newcastle upon Tyne Hospitals NHS Foundation Trust. There are clear opportunities and benefits for patients from closer working, whilst recognising there are also benefits that come from each individual Trust's identities and integrity as a separate organisations. Our plan is to work towards formally establishing the Alliance early in this financial year.					
Recommendation	The Trust Board is asked to note the progress made.					
Links to Strategic Objectives	Patients, People, Performance, Partnerships, Pioneering					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☐	☒
Link to Board Assurance Framework [BAF]	Potential links to all areas of the Board Assurance Framework which is currently under review.					
Reports previously considered by	This is a new report for the Board of Directors and builds on updates provided at recent meetings.					

GREAT NORTH HEALTHCARE ALLIANCE UPDATE

EXECUTIVE SUMMARY

This paper provides an update on the ongoing work to form and develop the planning for the Great North Healthcare Alliance, which brings together:

- Gateshead Health NHS Foundation Trust;
- North Cumbria Integrated Care NHS Foundation Trust;
- Northumbria Healthcare NHS Foundation Trust; and
- The Newcastle upon Tyne Hospitals NHS Foundation Trust.

There are clear opportunities and benefits for patients from closer working, whilst recognising there are also benefits that come from each individual Foundation Trust's (FT) identities and integrity as a separate organisations.

Our plan is to work towards formally establishing the Alliance early in this financial year.

The Trust Board is asked to:

- Note the progress made.

GREAT NORTH HEALTHCARE ALLIANCE UPDATE

1. OVERVIEW

The Newcastle upon Tyne Hospitals NHS FT, Gateshead NHS FT, Northumbria Healthcare NHS FT and North Cumbria Integrated Care NHS FT have agreed to work more closely together to as a Great North Healthcare Alliance. The Trusts believe that there is huge potential to work together to deliver significant benefits to our patients and staff within our own organisations and in the wider region.

The overarching vision of the Alliance is to deliver:

i. Improved patient outcomes and reduced inequalities by optimising and simplifying existing pathways and clinical services, and by jointly tackling existing service resilience issues;
ii. The best staff experience, recruitment and retention, through workforce opportunities;
iii. Pioneering innovation, transformation, research and development, maximising our academic and commercial opportunities;
iv. Greater economic, environmental and social impact, reducing health inequalities alongside clearer partnership working with local and national stakeholders; and
v. An improved and sustainable financial position with value for public money that maximises resources for front-line care.
vi. Short-term priorities include working together to stabilise fragile clinical services to ensure that patients always have access to the best possible care. The Trusts will also explore opportunities for closer working on support services and estates/facilities management, collaborate on data collection and analysis, and share expertise in organisational development, technology, research, commercial activities and innovation.

Work to form and iterate closer working between the four Foundation Trusts is progressing positively. The partners have agreed guiding principles, including:

i. Working together where it makes sense, where there is clinical leadership and agreement , and the proposed activity is supported by data and/or patient voice;
ii. The independence and interdependence between partners is recognised – with all partners retaining the autonomy to move at the pace, phasing and degree that is appropriate to them and their communities;
iii. Resources can be shared where the opportunities arise and where it contributes to achieving the overall vision; and
iv. Honest and constructive challenge will be crucial to building trust.

The principal focus has been to prioritise alliance working on shared areas of interest, as well as beginning to establish the ways of working that will be central to the success of the Alliance and the work that it takes forward in future.

This is directed through monthly Alliance Steering Group meetings, made up of the Chairs and CEOs from the four organisations, as well as more regular meetings of the CEOs who in

turn work with their Boards, Governing Bodies and Executive Teams to input and shape the Alliance formation work. This input is central to building the momentum of alliance working, and ensuring that the views of a wide range of colleagues within the organisations is an integral part of shaping the strategy and work plan as it develops. The input from Governors and Non-Executive Directors in particular has been helpful.

2. AREAS OF FOCUS

The main areas of focus have been to prioritise alliance working in specific areas where the Steering Group are agreed that there is value to be obtained from early alliance working. Each is led by a trust Chief Executive and specifically include:

i. Patient and staff experience – sharing learnings to provide consistency of approach and expanding programmes.
ii. Urgent and emergency care – hosting a joint conference on 22 March 2024 to bring together Emergency Department leaders and wider teams to examine where improvements can be made, and where best practice sharing and strengthened mutual support can best help.
iii. Paediatric services – bringing together paediatric teams to identify opportunities to improve pathways of care between local and regional services and address capacity pressures.
iv. Urology – strengthening collaboration, communication and cooperation across the Alliance members to improve performance and resilience of the services as a whole. The underlying objective is to ensure equity of access to a safe, high quality services for all patients regardless of location.
v. Initial scoping discussions are also intended for obstetrics and gynaecology, cardiology and neurology.
vi. Corporate services – scoping where specific resilience issues exist in trusts, and what options exist to improve and optimise services.
vii. Subsidiaries – exploring where benefits can be achieved from closer working between subsidiaries.
viii. Alliance governance – exploring what options exist to formalise the Alliance Steering Group to ensure clear governance over the development and delivery of the Alliance work plan.

3. DEVELOPING THE WORK PROGRAMME IN COLLABORATION

Work has been also underway to bring together Board level colleagues in similar roles across the four trust Boards to identify what should be in the Alliance work plan.

Peer groups of relevant Executive Director leads from across the Alliance have been coming together to collectively review and prioritise potential collaboration opportunities in their areas and to develop shared pieces of work.

Where this was not already in place informally, Non-Executive Directors who chair Board Committees in the four trusts are also linking together at the request of trust Chairs. These discussions are intended to provide an opportunity for colleagues to build relationships

across our Non-Executive teams, to generate ideas on how closer collaboration through the Alliance may lead to opportunities relevant to their areas, and to identify any concerns or risks which may arise from the Alliance work.

All Board members were invited to attend a Great North Healthcare Alliance leadership event on 2 May 2024. This event intended to bring together colleagues from all four trust Boards as a positive, forward-looking session to strengthen team working and further establish the Alliance work plan.

4. RECOMMENDATION

The Board is recommended to note the progress made.

Report of Martin Wilson
Chief Operating Officer & Member of the Great North Healthcare Alliance Formation Team
14 May 2024

Note paper jointly prepared by Great North Healthcare Alliance Formation Team:
Martin Wilson, Newcastle; Nicola Bruce, Gateshead; Stephen Park, North Cumbria; and Andrew Edmunds, Northumbria

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024					
Title	Joint Medical Directors Report					
Report of	Lucia Pareja-Cebrian / Michael Wright					
Prepared by	Lucia Pareja-Cebrian / Michael Wright, Joint Medical Directors					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	The Report highlights issues the Joint Medical Directors wish the Board to be made aware of.					
Recommendation	The Board of Directors is asked to note the contents of the report.					
Links to Strategic Objectives	Putting patients at the heart of everything we do and providing care of the highest standard focusing on safety and quality.					
Impact (Please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☐	☐	☐
Link to Board Assurance Framework [BAF]	No direct link.					
Reports previously considered by	This is a regular report to Board. Previous similar reports have been submitted.					

JOINT MEDICAL DIRECTORS REPORT

EXECUTIVE SUMMARY

The following items are described in more detail within this report:

i) Quality & Patient Safety Update
ii) Cancer Update
iii) Research Update

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

JOINT MEDICAL DIRECTORS REPORT

1. QUALITY AND PATIENT SAFETY

2.1 Patient Safety Incident Response Framework (PSIRF)/ Serious Incident (SI) Backlog

Following PSIRF implementation on the 31 January 2024, two new groups were established to support the process. These groups are the weekly Response Action Review meeting and the monthly Patient Safety Incident Forum.

Key changes have been made to Datix (our incident reporting system) that has enabled PSIRF dashboards, reporting on completed rapid reviews, proportionate learning responses identified and completed learning responses.

Since the 31 January 2024 until the end of April 2024:

- 123 Rapid Reviews have been completed and discussed at the Response Action Review meeting.
- Rapid Reviews have been completed within the 5 working day target on 82 (67%) occasions.
- Proportionate learning responses have included 9 Patient Safety Incident Investigations (PSIIs), 14 After Action Reviews (AARs) and 1 PSIRF priority.

Emergent risks are presented, notably the existing capacity to support the process in addition to other governance work within the Clinical Boards and centrally within the temporary PSIRF team.

The PSIRF dashboards are now providing assurance on Rapid Response completions, proportionate learning responses identified and completion of the learning responses within agreed timescales. Over time, as learning responses are completed it will also provide an update on where learning has been shared. These outputs are monitored by the PSIRF team and discussed weekly. Organisation wide sharing occurs via Clinical Safety meetings and Patient Safety Group as well as Patient Safety Bulletins.

The process whereby the Clinical Governance leads run the Rapid Reviews in their own areas as soon as possible is more mature in some areas than others, dependant on available resource. There is an ongoing review across Clinical Board to evaluate where differences are. Whilst Quality and Safety leads prioritise PSIRF and incident reporting, the outputs from all Quality Oversight Groups will be reviewed in due course for assurance and monitoring.

2.2 Martha's Rule

Martha's Rule comprises a set of safety standards based on clear and easy mechanisms for patients and their families/representatives to raise concerns regarding an acute deterioration in a patient's condition that, in the view of the patient or family, have not been acted upon adequately by the home team.

The first phase of the introduction of Martha's Rule will be implemented in the NHS from April 2024. Once fully implemented, patients, families, carers and staff will have round-the clock access to a rapid review from a separate care team if they are worried about a person's condition.

Martha's rule came into being following the case of Martha Mills, a 13 year-old who died in 2021 after developing sepsis in hospital, where she had been admitted to with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to; in 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier. In response to this and other cases related to the management of deterioration, the Secretary of State for Health and Social Care and NHS England committed to implement 'Martha's Rule': "to ensure the vitally important concerns of the patient and those who know the patient best are listened to and acted upon."

Martha's rule requires that:

- All staff in NHS trusts must have 24/7 access to a rapid review from a Critical Care Outreach Team (CCORT), who they can contact should they have concerns about a patient.

- All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around.

- The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

Our ability to provide a responder service, meeting Martha's Rule components 1 and 2 within paediatrics, presents the greatest immediate challenge to Newcastle Hospitals principally as we do not have a paediatric CCORT within Great North Children's Hospital (GNCH) nor at Freeman Hospital Cardiothoracic Board.

Initial discussion and proposals for Martha's rule within GNCH have taken place, and alternative responders considered include:

- North East Children's Transport and Retrieval (NECTAR) acute practitioners.
- Paediatric Intensive Care Unit (PICU) specialty trainees.
- Senior Nurse coordinator for GNCH.

A paediatric sub-group is being set up presently to explore the feasibility of different options.

2.2.1 Adult

There are well established CCORT covering all in-patients on the RVI and FRH sites.

The challenges in implementing Martha's rule will include but not be limited to:

- Agreeing the mechanism by which a patient or family would raise their concern to the outreach team.
- Agreeing how outreach staff will be supported in managing a given situation.
- Considering the possible implications to work load over and above current duties of the outreach team.
- Education and information to all staff – this will need to be regular, ongoing and permanent.
- Considering how best to inform patients and families of the existence of this service – e.g. as part of admission information, posters and permanent displays and information in clinical areas. Describing the service to users is challenging and distinguishing it from other forms of complaint or concern will be important.
- Considering the optimal means of implementation based on improvement methodology e.g. initial implementation on one site or other sensible testing area.
- Considering how best to data collect and integrate with current safety insights at trust and board level.

2.2.2. Component 3

This element presents challenges – whilst communication with patients and families is of course routine in all areas, this differs from a structured daily mechanism by which direct communication occurs for every patient on every occasion discussion. It is hoped that this can be developed in coordination with parallel work on patient engagement and experience in the Trust.

3 CANCER UPDATE

3.1 Cancer Performance

	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
2ww (93%)	76.1	75.8	77.2	49.8	65.6	66.3	48.8	75.4	74.2	76.8	85.3	83.2
28D Faster Diagnosis Standard (FDS) (75%)		81.9	83.1	80	74.7	68.8	69.8	68.5	68.7	70..1	81.5	83
62D (85%)	61.1	53.9	47.2	55.2	56.5	53.7	52.6	53.1	55.7	56.7	55.6	66.6

The cancer performance remains a very significant challenge against targets as shown above although there has been progress particularly around 28D FDS standard. The current 62 day+ backlog is gradually falling; currently 181 patients. This compares to 450 patients in September 2023 and 307 in December 2023.

The backlog is the principle focus of the cancer teams and all teams are working to provide treatment dates to the patients; minimisation of backlog should improve overall pathway performance. The main specialities contributing, numerically, to the backlog are urology (55), upper Gastrointestinal (GI) including hepatobiliary (31), lower GI (31) and skin (20).

The current lung backlog over 62 days comprises 19 patients. This is of particular note as the majority of cancer harm reviews undertaken, where harm has been deemed to have occurred, affected patients with lung cancer (6 of 7 cases of harm). The need for repeat imaging prior to thoracic cancer surgery, if there has been a delay in getting to surgery, has been highlighted and there is a protocol enacted to minimise risk. There is also a 3 month trial of increased clinical review of the patient tracking list for lung cancer which has commenced.

Discussions are underway in respect of best pathways for patients from the Durham area who have lung cancer, including the increased referrals expected from the roll out of targeted lung health checks in County Durham. There is new capacity for lung cancer surgery at South Tees hence current work to redesign the surgical pathway.

3.1.1 Harm Reviews

104 day harm reviews remain challenging for a number of reasons; clinical time is limited and clinicians are rightly concentrating on trying to reduce the backlog and improve the pathways prospectively, many of our patients have pathways which cross organisations, the harm reviews are not yet fully embedded in the PSIRF pathways in each Board. Papers regarding the challenges in this area have been discussed at the Quality Committee in March and April 2024.

The current position on harm reviews is:

- Harm Reviews Undertaken June 2023 - end February 2024: 431
- Datix Required June 2023 - end February 2024: 7 (6 Lung and 1 Head and Neck)
- Outstanding Harm Reviews June 2023 - end February 2024: 56

There is a planned meeting facilitated by the Northern Cancer Alliance to discuss regional strategy in regard to harm reviews. There may be useful cross fertilisation of ideas as to how we complete the reviews. The meeting will also facilitate discussion as to how we undertake cross-organisational reviews and how we feedback to patients generally, but particularly in the case where several organisations / teams have been involved in the patient's treatment pathway.

3.1.2 Cancer Governance Framework

We continue to work to re-embed the principles of the cancer peer review programme. Each Multi-disciplinary team (MDT) has been asked to respond to audits planned, treated vs delivered treatment, alongside a review of MDT operational policy and their work plans for 2024/25. We hope to have responses from all teams by June 2024. In 2025 we aim to further develop this framework with submission of an annual review from each MDT highlighting areas of excellence and areas of difficulty. We would anticipate the reports would cover

capacity, demand, performance and training needs in addition to identifying specific areas for and barriers to improvement.

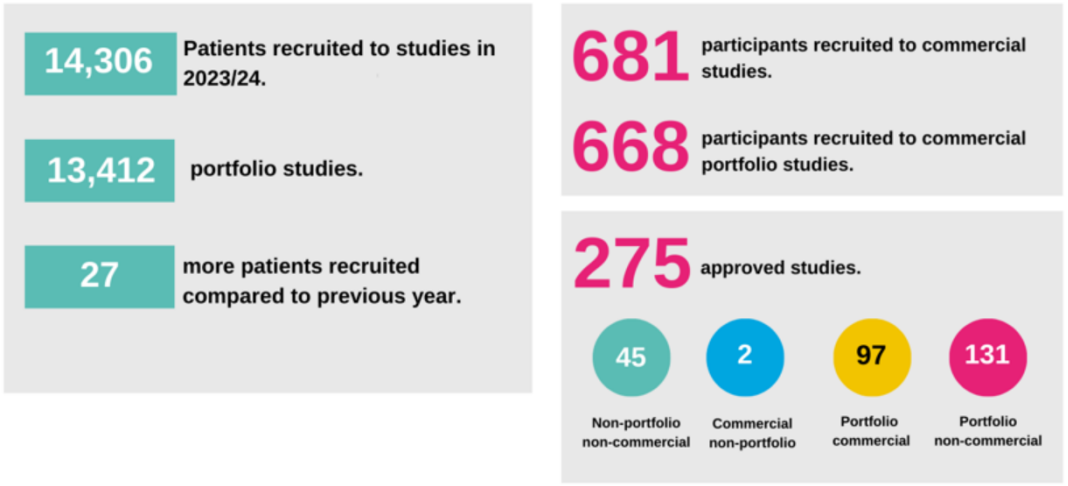
3.1.3 Cancer Strategy

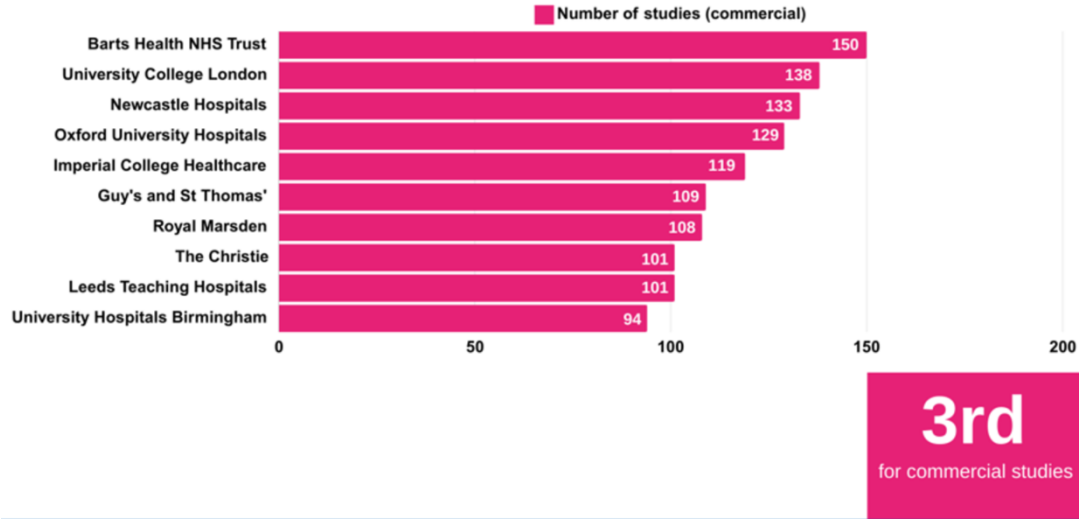
A first draft of the 5-year cancer strategy is out for consultation. It will be important to align this work with plans for a clinical strategy for the organisation.

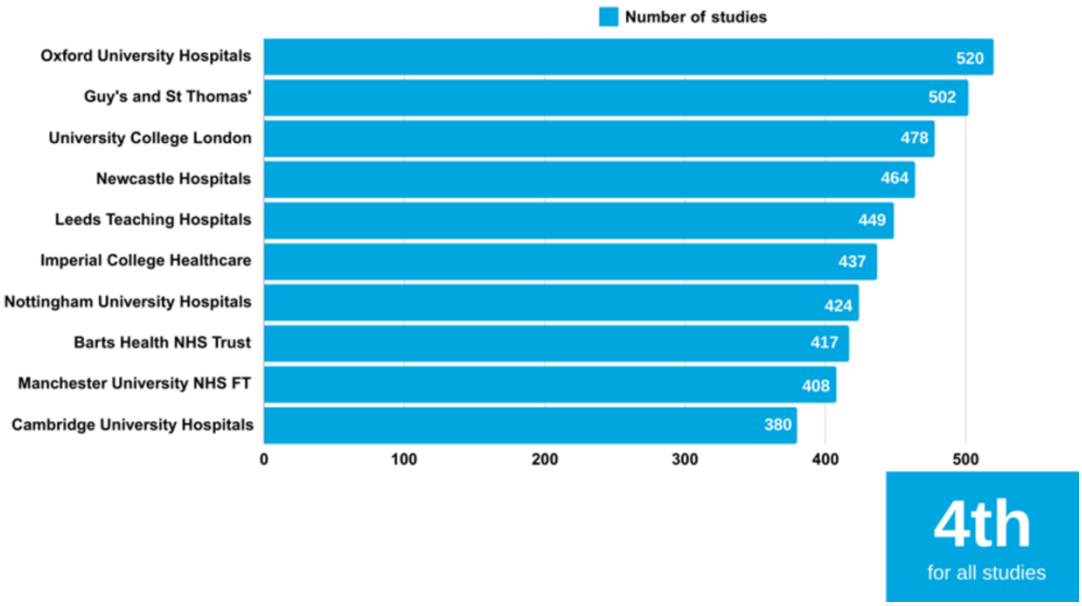
4 RESEARCH

4.1 Activity Including Commercial Research

Analysis of the year end research activity position (March 2024) is as follows:







Information supplied by Lesley McShane, Research Information Manager

4.2 Some notable highlights in the last quarter

- The Respiratory Research team recruited the first patient in the world to a study, led by Tony De-Soyza, which is testing a treatment for bronchiectasis, a long-term lung condition.
- We have received confirmation from the National Institute for Health and Care Research (NIHR) that the Clinical Research Facility (CRF) contract has been extended for 19 months until 31 March 2029 to the value of an additional £1,700,669.
- The Urology research team have secured a £2 million award from NIHR.
- Gareth Southgate, England Football team manager, visited the Sir Bobby Robson Cancer Trials Unit on 30 April 2024 emphasising the continued strong links between football and cancer research in Newcastle.
- STOP-D study launched. This study is investigating if an anti-depressant taken shortly after a traumatic brain injury can prevent later depression.
- The John Walton Muscular Dystrophy Research Centre (JWMDRC) recruited the first patient into the FORTIFY trial. This trial is evaluating the safety and efficacy of a treatment for patients with Limb Girdle Muscular Dystrophy.
- National media coverage of the Natasha Allergy Research Foundation included the story of 5-year-old Grace who has a milk allergy. She is participating in the study at Newcastle, led by Dr Louise Michaelis and Grace can now drink 120ml of milk per day – which means that she can enjoy a daily hot chocolate!

4.3 Other News

- We have advertised for both the NIHR Patient Recruitment Centre (PRC) and NIHR CRF Director positions – PRC Director interviews to be held May 2024 and CRF Director interviews June 2024.

- The Clinical and Research Services Board have approved the business case for electronic Investigator Site Files, utilising budget from within Clinical Research, and

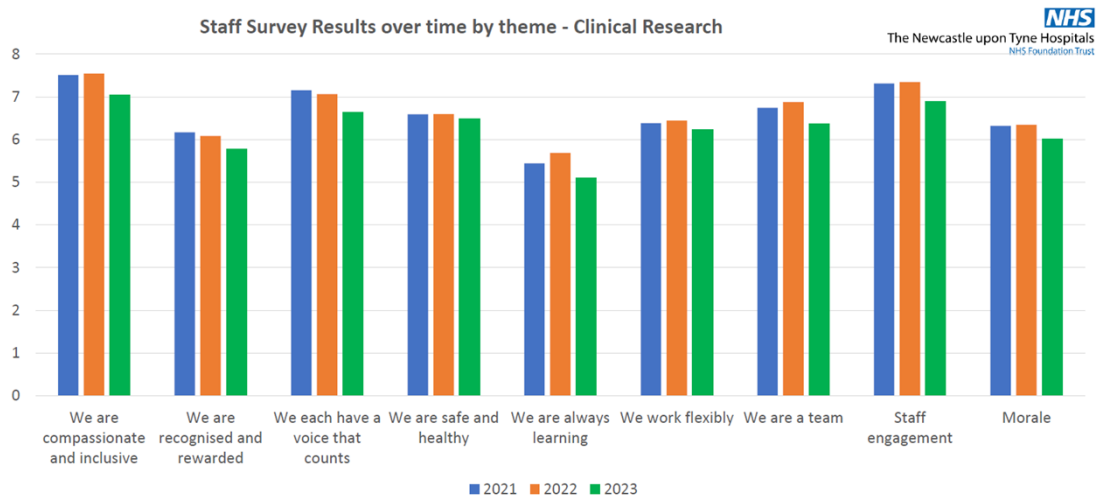
this will now proceed to Executives for final approval. If approved, we will be the first site in the UK to adopt this technology which, in addition to improving regulatory compliance, saving staff time and reducing paper and printing, would make us very attractive to commercial companies and allow us to increase the amount of commercial research studies. This would also align with the Trust's clinical research strategy and sustainability objectives.

- Promotion of the new Industry Brochure continues and this has been well received by commercial partners.

4.4 Research Challenges in the Last Quarter

- The relocation of the PRC from the CAV site to the RVI remains on hold, with timescales and next steps to be clarified. The space identified at the RVI is within existing research space in the NIHR CRF and requires only minor refurbishment.

- The Directorate received the National Staff Survey 2023 results and, whilst there were several areas where Clinical Research outperformed, there were also areas of concern. Disappointingly, results for the Directorate have decreased across all themes over the past 3 years:



Further analysis of specific questions identified some areas for further action including:

- Feeling part of a team and treating each other with respect.
- Tackling Discrimination.
- Making Appraisals meaningful.

Our What Matters to you facilitator group are leading on actions in this regard.

5 APPENDED DOCUMENTS

Appended to this report are the following documents to note:

i) Consultant Appointments

6 RECOMMENDATION

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

L Pareja-Cebrian/ M Wright
Joint Medical Directors
15 May 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024					
Title	Consultant Appointments					
Report of	Michael Wright, Medical Director and Lucia Pareja-Cebrian, Medical Director					
Prepared by	Claudia Sweeney, Senior HR Advisor					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☐		☒	
Summary	The content of this report outlines recent Consultant Appointments.					
Recommendation	The Board of Directors is asked to review the decisions of the Appointments Committee.					
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. People – We will ensure that each member of staff is able to liberate their potential.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☐	☐	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	Ensuring the Trust is sufficiently staffed to meet the demands of the organisation.					
Reports previously considered by	Consultant Appointments are submitted for information in the month following the Appointments Panel.					

CONSULTANT APPOINTMENTS

1. APPOINTMENTS COMMITTEE – CONSULTANT APPOINTMENTS

1.1 Appointments Committees were held between 21 March 2024 to 3 May 2024 and by unanimous resolution, the Committees were in favour of appointing the following:

Name	Job title	Start Date
Dr Akram Ali	Consultant Clinical Oncologist interest in Breast and Skin Cancers	01-May-24
Dr Eve Hamilton	Consultant Medical Microbiologist	01-May-24
Dr Celia Alcalde	Consultant Ophthalmologist - Glaucoma	11-Aug-24
Mr Justin Ong	Consultant Colorectal Surgeon	02-Sep-24
Mr Fady Hatem	Consultant Colorectal Surgeon	02-Sep-24
Mr Fergal Marlborough	Consultant Plastic Surgeon	16-Sep-24
Mr Chad Chang	Consultant Plastic Surgeon	01-Oct-24
Mr Aidan Rose	Consultant Plastic & Reconstructive Surgeon	ASAP
Dr Shuyang Xia	Consultant Radiologist - Musculoskeletal Imaging	ASAP
Dr Maha Zarroug	Consultant Clinical Oncologist with interest in Lung Cancers	ASAP
Mr Maziar Navidi	Consultant General Surgeon with Interest in Upper GI Surgery	ASAP
Mr Joshua Brown	Consultant General Surgeon with Interest in Upper GI Surgery	01-Apr-25

2. RECOMMENDATION

1.1– For the Board to receive the above report.

Report of Michael Wright and Lucia Pareja-Cebrian
Medical Directors
14 May 2024

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Agenda item A11(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024					
Title	Executive Director of Nursing (EDoN) Report					
Report of	Ian Joy, Executive Director of Nursing					
Prepared by	Lisa Guthrie, Deputy Director of Nursing Diane Cree, Personal Assistant					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☐		☒	
Summary	This paper has been prepared to inform the Board of Directors of key issues, challenges, and information regarding the Executive Director of Nursing areas of responsibility. The content of this report outlines: • Spotlight on Healthcare Support Worker Wisdom Group • Nursing and Midwifery Safer Staffing • Patient Experience Q4					
Recommendation	The Board of Directors is asked to note and discuss the content of this report.					
Links to Strategic Objectives	• Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. • We will be an effective partner, developing and delivering integrated care and playing our part in local, national, and international programmes. • Being outstanding, now and in the future.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☐	☒	☐
Link to Board Assurance Framework [BAF]	<u>Strategic Objective One</u> Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. <u>Strategic Risk Description</u> i. SO1.1 (Capacity and Demand) ii. SO1.4 (NHS core standards – patient safety and quality of care)					
Reports previously considered by	The EDoN update is a regular comprehensive report bringing together a range of issues to theTrust Board.					

EXECUTIVE DIRECTOR OF NURSING REPORT

EXECUTIVE SUMMARY

This paper is a regular update, providing the Board of Directors with a summary of key issues, achievements, and challenges within the Executive Director of Nursing (EDoN) portfolio.

Section 1: Spotlight on Healthcare Support Worker Wisdom Group.

Section one of the report contains this month's 'Spotlight' section which provides an overview of the Trust's Health Care Support Worker (HCSW) Wisdom Group.

The HCSW Wisdom Group was part of the NHS England endorsed programme **'Altogether Better'.** The aim of the programme was to deliver a more diverse HCSW workforce that is representative of the community we serve. It is recognised that the Northeast's Global majority population has doubled in the last 15 years, but our workforce does not reflect this. To address this and to showcase the variety of roles in the HCSW workforce a recruitment event within the community, with a new to care employment offer which would appeal to underrepresented groups was planned.

HCSW staff were invited to be part of the recruitment team for the event on the 23 May 2023 at the Beacon Centre in the West End of Newcastle. There was an overwhelming response with approximately 1000 applicants attending in one day. The HCSW staff were fundamental to the success of the day and a HCSW Wisdom Group was subsequently introduced to strengthen the HCSW voice.

The HCSW Wisdom Group is an informal forum in which the HCSW members have a safe space to share experiences, undertake task and finish projects and shape their own agendas. The group has advised on and led a range of workstreams which include celebrating the HCSW role, communication, training and development, staff forums and regional staff surveys. The HCSW Wisdom Group was instrumental in coordinating the responses and results of the regional HCSW survey which resulted in the Trust having the highest number of returns in the region.

The HCSW Wisdom Group have had a voice in shaping the training, recruitment and retention work for HCSWs in response to the survey results. This year HCSW Wisdom Group will be supported by NHSE funding for a HCSW Conference in November 2024 where they will lead the conference planning. Additionally, they will be key in the development of a Shared Decision Making Council for HCSW's so that their collective voice is heard in the Trust.

Sections 2 and 3: Nursing and Midwifery Safer Staffing

Sections two and three highlight areas of risk and details actions and mitigation to assure safer staffing in line with agreed escalation criteria for nursing (section two) and midwifery (section three).

The nurse staffing escalation remains at level two due to appropriate criteria being met. The necessary actions in response to this are in place and continue to be overseen by the Executive Director of Nursing.

The monitoring of nursing safer staffing metrics against clinical outcomes/nurse sensitive indicators as mandated in national guidance continues via the Nurse Staffing and Clinical Outcomes Operational Group.

The following key points from this group are noted below:

- Several wards have required support at medium or high level since the last report to Board. Action plans are in place for wards with additional clinical support, education and resources provided, overseen by the Executive Director of Nursing team and relevant Clinical Boards. Two wards have required high-level support and have robust action plans in place. An overview of this work has been reported into the Quality Committee.
- Wards requiring high-level support receive a mid-point review to ensure progress against the action plans and a process of peer review has been established before wards are stepped down to medium level support.
- In addition to the high-level monitoring, oversight and assurance provided by the Nurse Staffing and Clinical Outcomes group there continues to be a robust leadership and management framework led by the Head of Nursing and Matron team.
- The planned and actual staffing hours are reported as “fill rates” and entered onto the safer staffing dashboard, rag rated and reviewed monthly by the Nurse Staffing and Clinical Outcomes group. RN fill rates <85% are reported to the Executive Director of Nursing monthly. A review of the past 6-months fill rates demonstrates an upward trend on day and night shifts.
- In May 2024 the Trust will transition to automation of actual hours with the planned staffing hours continuing to be managed by the corporate senior nursing team. This will save nursing time at a ward and department level by removing the manual process.
- Average Care Hours Per Patient Day (CHPPD) has increased over the past 6 months, representative of the improved vacancy position. It should be noted that as the Trust moves to automated actual nursing hours, there is a risk that this may have an impact on the CHPPD trends. This will be closely monitored.
- Red flags generated within the SafeCare module by the nursing staff in conjunction with professional judgement have provided valuable triangulation of data alongside DATIX reports. All these alerts are responded to promptly by members of the corporate senior nursing team directly with the ward staff, Heads of Nursing and Matrons.
- Red flag incident reporting has shown a decreasing trend over the past six months.
- In the last quarter the number of DATIX submitted relating to staffing were:
    - January 3
    - February 3

- March 10
- Recruitment and Retention remain a priority workstream and the report provides an update on the current pipeline of Registered Nurses (RN) and Healthcare Support Workers (HCSWs). With the International Recruitment (IR) programme now concluded.

The following key points are contained within the report:

- The current RN vacancy rate is 0.58%, based on the financial ledger at Month 12, this is a further decrease from the 2.59% reported in March 2024.
- Whilst recruitment has improved there remains a number of departments which have operational challenges. This is particularly noted in Paediatrics where a number of commissioned beds remain closed. An active workforce plan is in place overseen jointly by the Family Health Clinical Board and corporate nursing team.
- Based on Month 12 data the RN turnover is 8.43% and this demonstrates a reduction from the previously reported 11.8% in the same period last year.
- The Trust has completed the ambitious two-year International Recruitment programme which commenced in June 2022, with a deployment 305 staff in 2022/23 and a further 236 staff in 2023/24. There have been 11 home grown talent candidates bringing the total number of staff deployed to 552 by the end of April 2024.
- The Trust will focus on retention of the internationally educated nurses to retain the diversity of skills and experience the staff have brought to the clinical workforce whilst maintaining and enhancing additional skills. A Career and Cultural event will be held on 11 July 2024 supported by the #Stay & Thrive programme funding.
- The Trust Health Care Support Worker (HCSW) vacancy rate reported on the Provider Workforce Report (PWR) is currently 6.5% with 54 (headcount) candidates in the recruitment pipeline. It should be noted that the PWR contains non-HCSW staff such as house keepers in the reported vacancy rate and so with those staff manually removed the HCSW vacancy rate is 2.9%.
- Four more of our HCSWs have received the prestigious NHSE Chief Nursing Officer Award making a total of ten for the Trust. Nationally only 50 awards have been given.

Section 3 provides an overview of the current midwifery staffing position. The following key points are noted:

The following key points are contained within the report:

- The Maternity Service has maintained a stable and positive workforce position with a Registered Midwife vacancy rate of 0%. Some workforce pressures continue due to the demands of supernumerary time for newly appointed staff.
- Recruitment continues towards a position of 20wte above the funded establishment to mitigate gaps for maternity leave and sickness absence, with a further 17 midwives appointed in the most recent round of recruitment.
- Turnover rates (as reported by NHSE Workforce Intelligence Portal) are currently 6.4%, compared to the national average of 9.3%. Four midwives have left the service during January and February, for reasons including work-life balance and retirement.

- From 1 March 2024 to 30 April 2024, there have been zero occasions against a possible 300 episodes recorded, where the midwife has been unable to provide continuous one-to-one care and support to a woman in established labour; and one occurrence where the delivery suite coordinator has not remained supernumerary and has been allocated as the named midwife for a woman.
- In March and April 2024, the number of red flags recorded on Delivery Suite was two and one respectively. This represents a significant decrease compared to monthly figures from 2023.
- The resource required to achieve the nationally mandated increase in training requirement for all Maternity staff as part of the Core Competency Framework v2 in 2023 has placed increased pressure on the service. In order to maintain the training schedule required to meet Maternity Incentive Scheme training compliance and to have the assurance of a safe maternity workforce and service, local escalation in response to acuity has led to the continued closure of Newcastle Birthing Centre in March and April 2024. A Quality Impact Assessment has been undertaken which indicates that this process supports the safety of women and babies.
- The homebirth service has been suspended since 17th July 2023 as part of local escalation initially in response to staffing deficits and subsequently due to non-compliance with intrapartum clinical updates over the past 12 months. Community midwives are currently undertaking a 3 month 'sprint' to ensure all are compliant with the necessary intrapartum clinical updates to reinstate the service in June 2024.

Section 4: Patient Experience Q4 Summary

Section 4 provides a summary of the Patient Experience Q4 Report. The report provides an in-depth appraisal of the following high level points:

- The Trust has opened 167 formal complaints in Quarter 4, an increase of 10% on the previous quarter. The Trust has received on average, 48 formal complaints per month for the financial year 2023-24, which is two complaints higher than the overall average for 2022-23, which was 46 complaints per month.
- 165 formal complaints were closed, which is an increase of 4% from the previous quarter. Of these, 31 complaints were upheld, 24 were partially upheld, 85 were not upheld and 25 were withdrawn. The most frequent category is communication with 16% of upheld complaints across five directorates: Surgical and Specialist Services (RVI), Surgical & Associated Services (FH), Medicine and Emergency Care, Perioperative and Critical Care and Family Health.
- 1202 issues have been raised with PALS over this period. This compares to 1090 issues raised in the previous quarter and is a 10% increase.
- The remaining surveys in 2024 for the National Patient Survey Programme include the Adult Inpatient Survey for which work is underway (January – April 2024), results are due to be reported in Autumn 2024.
- In January there were 1,344 responses to the Friends and Family Test and 40 items of feedback on the Reviews and Rating section of the NHS Choices website.
- There are a number of updates outlining Patient Involvement and Engagement with the following key points to note:
    - Service user feedback received via Maternity and Neonatal Voices

Partnership**.**

- The training offer developed in collaboration with Deaflink, CNTW and Northumbria Healthcare.
- The chaplaincy team support for both patients and staff.

5. RECOMMENDATION

The Board of Directors is asked to note and discuss the content of this report.

Report of Ian Joy
Executive Director of Nursing
23 May 2024

EXECUTIVE DIRECTOR OF NURSING

1. SPOTLIGHT – HEALTHCARE SUPPORT WORKER WISDOM GROUP.

As part of our commitment to the Health Care Assistant (HCA), Maternity Support Worker (MSW) and Allied Health Professional (AHP) support staff group we have sought to strengthen their voice in a Health Care Support Worker (HCSW) Wisdom Group. The HCSW Wisdom Group was part of the NHS England endorsed programme **'**Altogether Better.**'**

This leadership programme looks at ideas, practices and tools to support a more diverse workforce. It encourages us to explore bias in the recruitment process and in how people gain promotion. The aim of the programme is to deliver a more diverse HCSW workforce that is representative of the community we serve. It was recognised that the HCSW voice needed to be strengthened and so the HCSW Wisdom Group was continued after completion of the programme.

1.1 Background

The Northeast's Global majority population has doubled in the last 15 years, however, in Newcastle Hospitals our workforce does not reflect this. In HCSW recruitment the aspiration was recruit within our community, with a new to care employment offer which would appeal to underrepresented groups. HCSW staff were invited to be part of the recruitment team with the Trust accessing NHSE Widening Access funding to support the event.

The Widening Access Recruitment event took place on the 23 May 2023 at the Beacon Centre in the West End of Newcastle, where there was an overwhelming response with approximately 1000 applicants attending in one day. Importantly the recruiting team included ten HCSWs from different roles ensuring that they had a voice in the process and were fully recognised for the work they do. The HCSWs navigated candidates through the interview process, were part of the Trust presentation to showcase the HCSW opportunities and answered candidate questions. The HCSW staff were fundamental to the success of the day.

This experience and knowledge that was gained enabled the Trust to take part in the Altogether Better Programme, which is a leadership programme which encourages organisations to make small scale change in recruitment of HCSWs which could be scaled up. A HCSW Wisdom Group was recommended to support the improvements to HCSW recruitment with the first meeting taking place in August 2023. The ten HCSW staff who supported the recruitment event were invited to shape the group and have since become visible leaders in the Trust, regionally and nationally representing the HCSW staff group. The Trust now has three HCSW/MSWs members in the regional Shared Decision Making Council who are part of the HCSW Wisdom Group. All three have won Chief Nursing Officer Awards for the work they have done in the Trust. Additionally, members have been invited to join via the staff network groups, HCSW forums and newsletters.

1.2 HCSW Wisdom Group

The HCSW Wisdom Group is an informal forum in which the HCSW members have a safe space to share experiences, undertake task and finish projects and shape their own agendas.

The group has advised on the following:

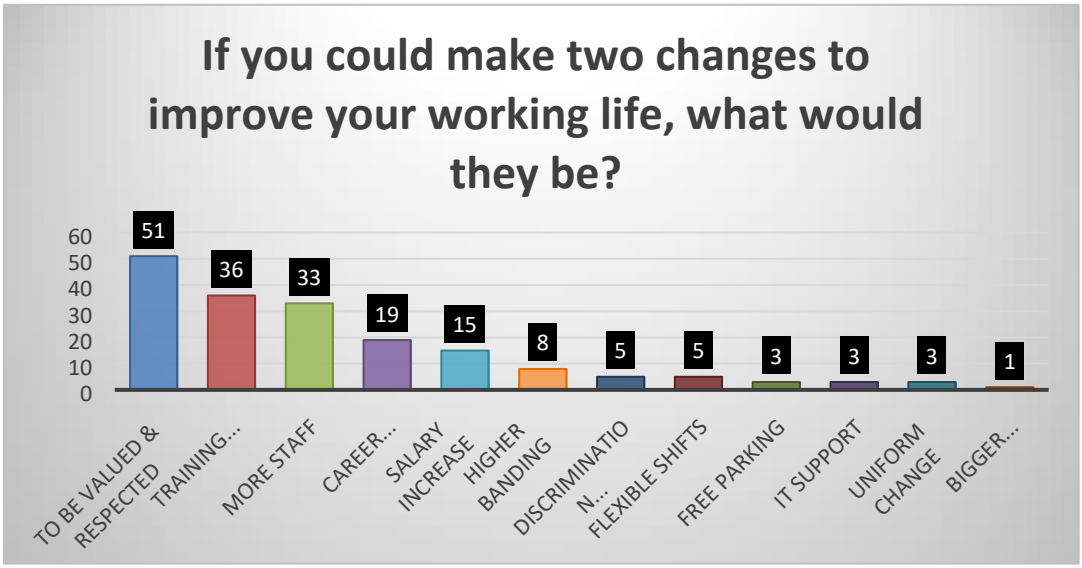
- What skills, qualities, experience do you need to be a great HCSW?
- Formulation of interview questions for HCSWs.
- HCSW Forums and wellbeing cafes.
- HCSW celebrations including HCSW/MSW/AHP support staffing celebration days and Chief Nursing Officer HCSW awards.
- HCSW surveys.
- Training in the Healthcare Academy.

1.3 HCSW Survey

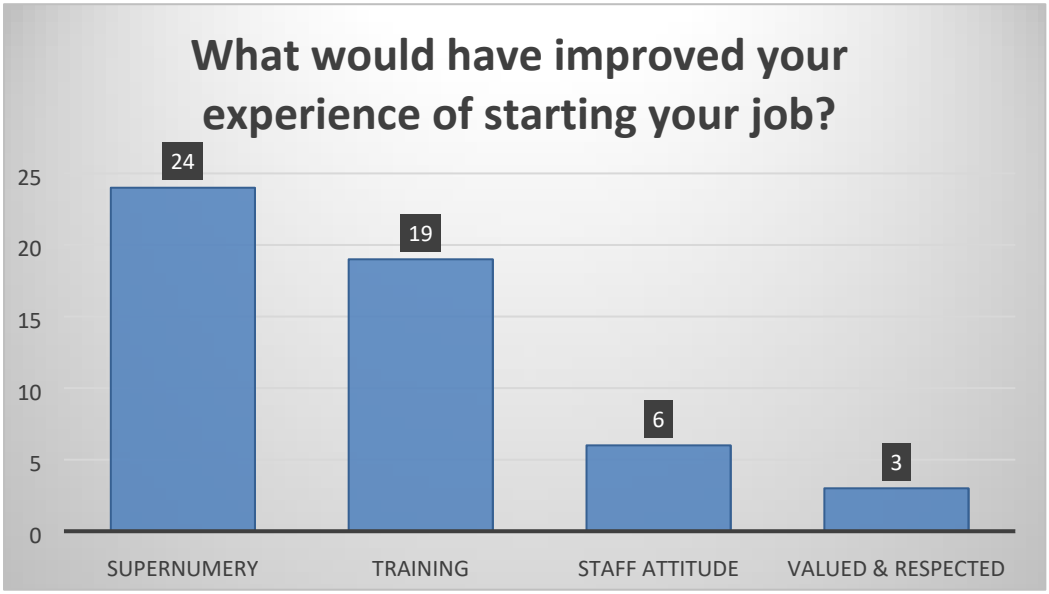
As part of the Altogether Better Programme, the Trust took part in a HCSW survey, along with the other eight participating organisations across Northeast and North Yorkshire. The survey aimed to learn new ways to ensure that the working lives and future career development of employees were optimised and to gain feedback on staff experience.

The Trust HCSW Wisdom Group was instrumental in encouraging and supporting our HCSWs to complete the survey and consequently the Trust had the highest number of returns in the region. The HCSWs then worked together to theme the results which are as follows:

If you could make two changes to improve your working life, what would they be?



What would have improved your experience of starting your job?



Using the survey results the HCSW Wisdom Group have had a voice in shaping the training delivered in the Healthcare Academy, planned celebration events to highlight the role of the HCSW, contributed to HCSW forums, newsletters and wellbeing cafes.

1.4 Next Steps

With the support of the HCSW Wisdom Group the Trust has secured funding from NHSE to strengthen the HCSW voice. The funding will support a HCSW Conference in November 2024, it will also allow HCSWs to be released from their clinical roles to lead the conference planning.

The HCSW Wisdom Group will be key in the development of a Shared Decision Making Council for the HCSW's so that their collective voice is heard. Again, NHSE funding will support the release of the HCSW staff to develop Shared Decision Making Council. The Wisdom Group will be integral in both of these projects.

The HCSW Wisdom Group has membership of the HCSW Steering Group which oversees recruitment and retention and feeds into the Nursing, Midwifery and AHP Recruitment and Retention Group and membership will be increased going forward, again to strengthen the HCSW voice.

Finally, the HCSW Wisdom Group will be part of a workstream established to explore supernumerary status for all of our new starters, including our HCSW's.

2. NURSING AND MIDWIFERY STAFFING UPDATE

2.1 Staffing Escalation

The Trust continues to work within the framework of the Nurse Staffing Guidelines to ensure a robust process for safe staffing escalation and governance. Although staffing pressures have reduced in the past 6 months, the nurse staffing escalation level remains at level two due to the following triggers being met:

- Nurse and midwifery sickness absence remains at around 5%.
- Associated Clinical Services, including support to nursing, sickness absence has remained above 8% over the past 6 months.

The requirement for enhanced care continues, in addition to acuity and dependency remaining high across all service areas. The Staff Bank Healthcare Assistant pool is reviewed daily, using safe care to identify areas of shortfall and reduce agency requirement in line with the NHS Long-term Workforce Plan.

The following actions remain in place:

- Daily staffing review by the corporate senior nursing team and reported into the Executive Director of Nursing and silver command.
- SafeCare (daily staffing deployment tool) utilised to deploy staff across directorates based on need.
- Daily review of staffing red flags and incident reports.

Level 2 escalation will remain in place until the de-escalation criteria has been met.

Workforce support remains in place from the corporate senior nursing team for the clinical areas where staffing levels continue to impact on the ability to maintain commissioned bed activity, with robust professional leadership from the Executive Director of Nursing Team.

2.2 Nurse Staffing and Clinical Outcomes

The monitoring of safer staffing metrics against clinical outcomes/nurse sensitive indicators as mandated in national guidance continues via the Nurse Staffing and Clinical Outcomes Operational Group. Wards are reviewed by the group at monthly meetings and are categorised as; requiring no support; low, medium, or high-level support. This is in line with the agreed criteria when supportive actions are implemented.

Below is a summary of the wards reviewed and the level of escalation required for the last three months:

Month	Total	Clinical Board	High level support	Medium level support	Low level support
Jan-24		Family Health Services	1	5	2
		Surgical and Specialist Services RVI		3	2
		Perioperative Services			1
		Cardiothoracic Services	1	1	1
		Medicine and Emergency Care Services			6

		Surgical and Associated Services FH			3
		Cancer and Clinical Haematology Services			1
Total	**29**		**2**	**9**	**16**
Feb-24		Family Health Services	1	5	2
		Surgical and Specialist Services RVI		1	3
		Perioperative Services			1
		Cardiothoracic Services	1	1	1
		Medicine and Emergency Care Services			4
		Surgical and Associated Services FH			3
		Cancer and Clinical Haematology Services	0	0	0
Total	**29**		**2**	**7**	**14**
Mar-24		Family Health Services	1	5	2
		Surgical and Specialist Services RVI		2	2
		Perioperative Services			2
		Cardiothoracic Services	1		4
		Medicine and Emergency Care Services		3	3
		Surgical and Associated Services FH		2	3
		Cancer and Clinical Haematology Services		1	
Total	**33**		**2**	**13**	**16**

Key points to note:

- A number of wards have required support at medium or high level since the last report to Board and have been highlighted and discussed in the Quality Committee. Action plans are in place for these areas in collaboration with the ward staff and additional clinical support, education and resources provided, overseen by the Executive Director of Nursing and Clinical Board Teams.
- All wards which require high level support or have required medium level support for more than 2 months, are presented in the Executive Director of Nursing meeting each month.
- An additional monthly nurse staffing and outcomes mid-point review meeting (for wards requiring high level support) has been introduced, to provide increased oversight of these wards and support with the action plans.
- Before wards are stepped down from high to medium level support, a comprehensive peer review takes place.
- In addition to the high-level monitoring, oversight and assurance provided by the group, there continues to be a robust leadership and management framework led by the Head of Nursing and Matron teams.

2.3 Planned and Actual Staffing *(October 23- March 24)*

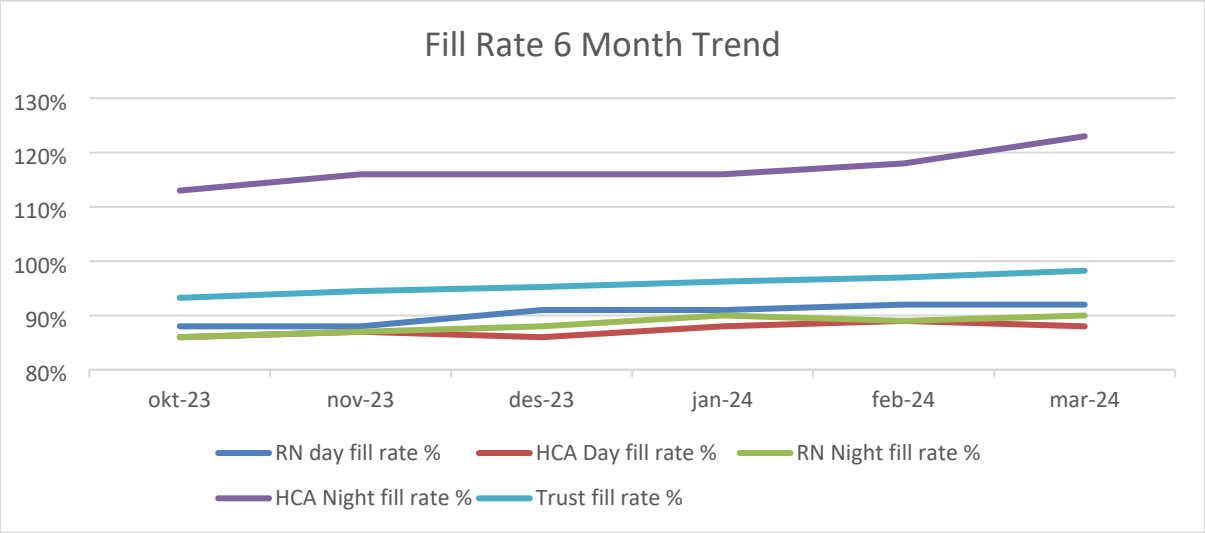
Planned staffing is the amount (in hours and minutes) of Registered Nurses (RN), Midwives and additional clinical support time that each in-patient ward is planned to have on duty each day and night. This is based on maximum utilisation of their funded establishment. Actual staffing is the amount of time (in hours and minutes) worked on duty each day and night shift. The planned staffing data is entered by the staffing team and adjusted for temporary bed closures or following any agreed nurse establishment change. The actual

hours are manually entered by each ward management team. These figures are posted on the public website in line with NICE (2014) guidance.

The planned and actual staffing hours are converted into "fill rates" which are entered onto the safer staffing dashboard, rag rated and reviewed monthly by the Nurse Staffing and Clinical Outcomes group. Any identified area of concern is discussed, alongside other staffing metrics, quality, and patient experience data to identify risk and determine any actions or further investigation required. RN fill rates <85% are reported to the Executive Director of Nursing each month.

Key points to note:

Month	RN day fill rate %	HCA Day fill rate %	RN Night fill rate %	HCA Night fill rate %	Trust fill rate %
Oct-23	88%	86%	86%	113%	93.25%
Nov-23	88%	87%	87%	116%	94.50%
Dec-23	91%	86%	88%	116%	95.25%
Jan-24	91%	88%	90%	116%	96.25%
Feb-24	92%	89%	89%	118%	97.00%
Mar-24	92%	88%	90%	123%	98.25%



- A review of the past 6-months fill rates demonstrates an upward trend on day and night shifts. The corporate senior nursing team are currently working closely with the staff bank and Heads of Nursing to ensure that nightshift HCA levels are aligned to patient acuity and dependency. It is anticipated that the fill rates will reduce in line with the increase in RN nightshift fill rate.
- An audit of actual hours nursing in April 2024, comparing an automated report from the Allocate system to the manually entered data appears to show that the data from Allocate is more accurate, as reduces error from transcription. The Trust will transition to automated actual hours from the 1st of May 2024. The planned staffing hours will continue to be managed by the corporate senior nursing team. It should be noted that the move to an automated process may demonstrate a difference in fill rates from previously reported figures.

2.4 Care Hours per Patient Day (CHPPD) *(October 23- March 24)*

Care hours per patient day (CHPPD) is the unit of measurement recommended in the Carter Report (2016) to record and report deployment of staff working on inpatient wards. This became the primary benchmarking metric from September 2019. It adds together Registered Nurses and support worker hours, divided by midnight census. All acute Trusts have been required to report their actual monthly CHPPD, to NHS Improvement (now NSHE) since May 2016.

Key points to note:

- There are some limitations to using CHPPD as a benchmark. NUTH has a high proportion of Critical Care beds which inflates the Trust overall average CHPPH score. In addition, NUTH has some highly specialised in-patient areas where there is no comparable benchmarking category, in these cases the wards are benchmarked to the closest comparable category.

Month	Oct-23	Nov-23	Dec-23	Jan-23	Feb-23	Mar-23
CHPPD	8.1	8.1	8.6	8.3	8.4	8.5

- The Trust average CHPPD has increased significantly over the past 6 months. It should also be noted that if the Trust moves to automated planned and actual nursing hours, this may have an impact on the CHPPD figures.
- The corporate senior nursing team continue to monitor CHPPD in SafeCare to enable the mitigation of risks form staffing shortfalls. Ward-specific CHPPD is also presented on the Safer Staffing Dashboard and reviewed at the Nurse Staffing and Outcomes Group every month.

2.5 Red Flags and Datix *(November 23-March 24)*

Red flag and Datix incident data are reviewed daily by the corporate senior nursing team and reported as part of the daily staffing briefing. Red flags also continue to be presented to the Nurse Staffing and Clinical Outcomes Group monthly to observe trends and highlight areas of concern. This data is available at a Ward, Clinical Board and Trust level. Staffing incident reports are considered in nurse staffing reviews during discussions about future establishment requirement.

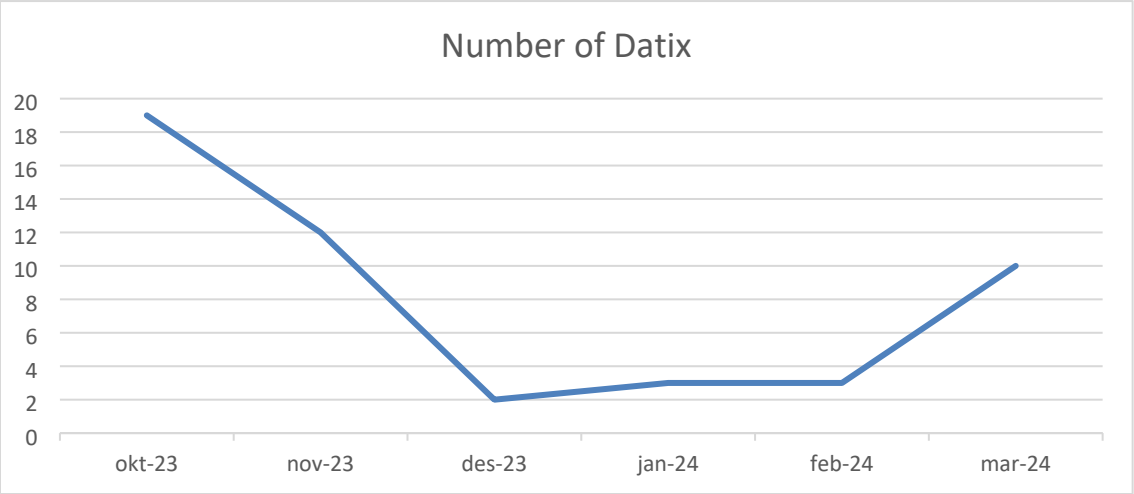
All staffing incidents reported on Datix are received by the Deputy Director of Nursing, Associate Director of Nursing, and the corporate senior nursing team. In hours, the incidents are reviewed in real time, and out of hours, as soon as practicable. Reporters and Matrons

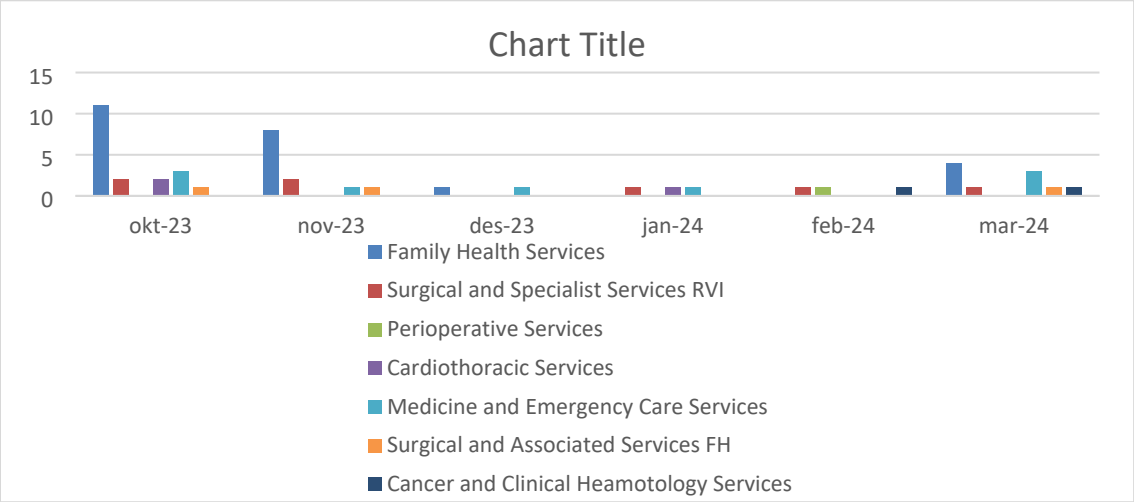
are contacted to acknowledge receipt and gain greater understanding of themes. When incidents are being responded to in real time mitigations and resolution is sought. Work continues to encourage staff to submit Datix reports for staffing shortfalls.

Red flags in the SafeCare application continue to be utilised effectively in conjunction with professional judgement. Red Flags are reviewed daily and acted upon/mitigated where possible in real time by the corporate senior nursing team and reported to the Executive Director of Nursing and Deputy Director of Nursing and into silver command as required.

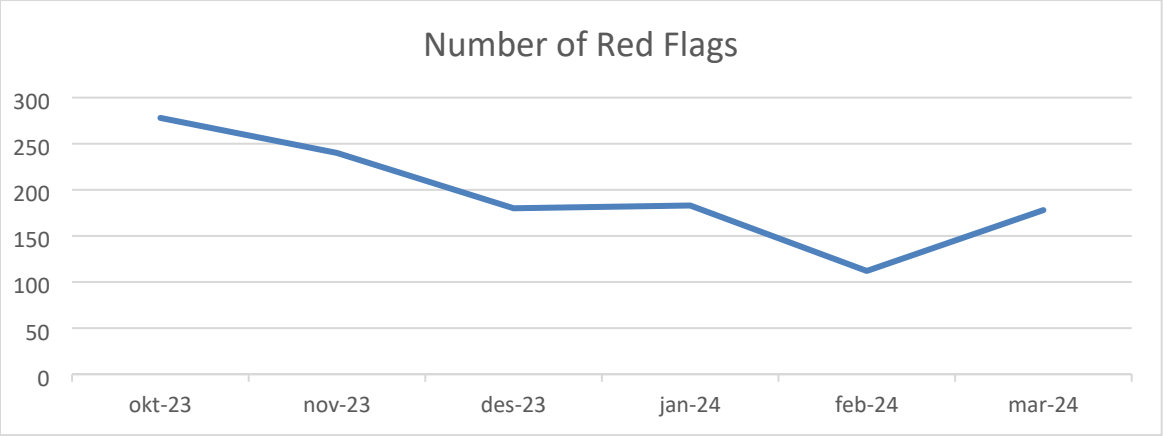
Key points from the last 6 months:

- Datix reports related to staffing incidents have reduced overall over the past six months. In October/November, most staffing incidents were reported in Family Health Services, reflecting the challenges in Children and Young Persons services. These challenges were partially mitigated by bed closures. These incidents have reduced significantly, which may be related to the impact of new registrants commencing employment in September and international recruitment.





- Red flag incident reporting has averaged at 195 per month, with a decreasing trend over the past six months. The most common red flag incident reported was “Shortfall in RN time”.



2.4 Recruitment and International Recruitment

2.4.1 RN Recruitment

The current RN vacancy rate is 0.58%, based on the financial ledger at Month 12 2024 this is a further decrease from the 2.59% reported in March 2024. This relates to current substantive staff in post and does not include those staff currently in the recruitment process.

Based on Month 12 2024 data the RN turnover is 8.43%, this demonstrates a reduction from the previously reported 11.8% in the same period last year.

Whilst recruitment has improved there remains a number of departments which have operational challenges. This is particularly noted in Children and Young Persons services where a number of commissioned beds remain closed. An active workforce plan is in place overseen jointly by the Family Health Clinical Board and corporate nursing team.

Quarterly Head of Nursing meetings are in place to optimize the vacancy data and ensure accuracy of appointable posts. As the vacancy rate has significantly reduced much of the recruitment has been bespoke to showcase specific clinical areas. This has complimented the successful generic recruitment led by the specialty teams with the corporate senior nursing team. This approach has evaluated well with the clinical teams and has led to positive outcomes in terms of successful appointments to those targeted areas with remaining vacancy.

The corporate senior nursing team and the practice education team have supported students to apply for posts within the Trust with supportive pre-engagement sessions which have evaluated well. The focused work continues with Childrens and Young Persons services and the Neonatal Intensive Care Unit.

2.4.2 International Recruitment

The Trust has successfully completed the ambitious two-year International Recruitment programme which commenced in June 2022, with a deployment 305 staff in 2022/23 and a further 236 staff in 2023/24. There has been a further 11 home grown talent candidates bringing the total number of staff deployed to 552 by the end of April 2024. This investment was partially funded by NHSE and has had a significant role in mitigating RN vacancy and turnover.

In line with the NHS Long-term Workforce Plan which recommends a reduction on the reliance of internationally educated staff in the next three to five years, the corporate senior nursing are leading a number of retention workstreams. Those workstreams will ensure the Trust retains the diversity of skills and experiences those staff have brought to the clinical workforce whilst maintaining and enhancing additional skills. The retention workstreams will enable the Trust to maintain the prestigious NHS Pastoral Care Quality Award which recognises the commitment to providing high-quality pastoral care to all the internationally educated nurses and midwives during their recruitment process and employment.

A successful bid for funding from the #Stay & Thrive programme will allow celebration of the overall success of International Recruitment programme with a Career and Cultural event on 11 July 2024. The event will promote the welcoming of staff, create strong foundations, build a sense of belonging, as well as maximizing personal and professional growth.

2.4.3 Healthcare Support Worker Recruitment

The Trust HCSW vacancy rate reported on the Provider Workforce Report (PWR) is currently 6.5% with 54 (headcount) candidates in the recruitment pipeline. This is a favourable position compared with the regional vacancy rate of 7.1% and a national vacancy rate of 9%. It should be noted that the PWR contains non-HCSW staff such as house keepers in the reported vacancy rate and so with those staff manually removed the HCSW vacancy rate is 2.9%. A solution is being sought with finance and human resources colleagues for this reporting issue which has been highlighted to NHSE.

A further four more of our HCSWs have received the prestigious NHSE Chief Nursing Officer Award making a total of ten for the Trust. An award ceremony took place to celebrate their achievement where work colleagues and family members were invited. Clare Taws, HCSW in Cardiothoracic Childrens Outpatients and NHSE Chief Nursing Officer Award winner has been chosen by the Royal Collage of Nursing to share her story as part of the Shining a Light Exhibition which covers the long history of nursing support workers and celebrates the contribution that they continue to make to today's workforce.

3 MIDWIFERY STAFFING POSITION

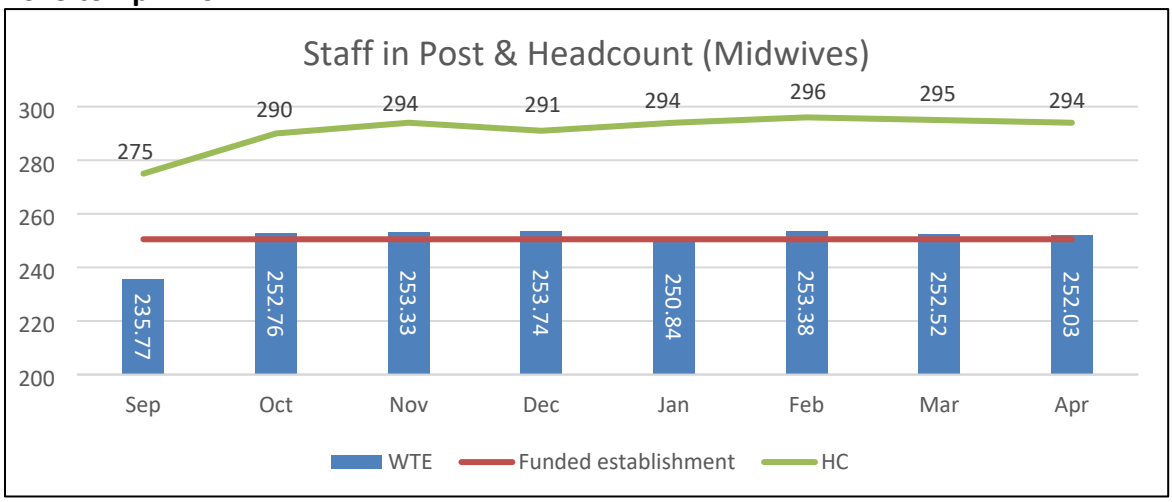
3.1 Current Staffing Position

The Maternity Service has maintained a stable workforce position over the last 6 months. Figure 1 illustrates the current midwifery staffing position, including frontline clinical staff

and those in specialist and management roles. This highlights the current 252.03wte midwives against the funded establishment of 250.50 wte. A rolling recruitment programme continues to further increase recruitment up to the Trust approved permanent 20wte over establishment; to allow for increased levels of maternity leave and to support the delivery of maternity specific core competency training in addition to Trust mandatory training. This has helped to ensure a consistent, sustainable position within the large midwifery workforce at Newcastle. A further 17 midwives have been recently recruited, 15 of whom will commence in post after qualification from September 2024 onwards.

All eight internationally educated Midwives have now commenced within the Trust, increasing numbers of staff in post, and providing valuable diversification of our workforce.

Figure 1: Midwives in Post (WTE and Headcount) against funded establishment September 2023 to April 2024



Average long-term and short-term sickness rates have improved since February 2024, decreasing from 8.05% in February to 5.5% in April. Targeted work has been undertaken within the service to understand and support the needs of the workforce in order to reduce sickness absence. This includes the introduction of wellbeing champions to provide support and develop initiatives across the Maternity Service, reinstatement of clinical psychologist support for staff within Women's Services for 2 days per week from April 2024 and a continuation of wellbeing sessions for new-to-post staff.

The service continues to feel the additional pressure created by the provision of support, preceptorship, and training for 27 newly qualified Midwives who joined the Trust since September 2023. This is expected to impact staffing until the 12-month preceptorship period is completed. However, newly qualified staff are integrating successfully into the service and are well-supported by their comprehensive preceptorship package, thereby prioritising and maximising retention.

Midwifery turnover rates, reported by NHSE Workforce Intelligence Portal, have fallen to 6.4%, compared to a national average of 9.3%. Four midwives have left the service during March and April, for reasons including work-life balance and retirement. A focus on recruitment and retention initiatives continues (in line with the Workforce Improvement Strategy) with Maternity Careers Conversation Drop-Ins, a relaunched appraisal guidance

and family tree, and a renewed focus on staff meetings and regular communication within the maternity team.

3.2.1 Red Flags: 1:1 Care in Labour and Supernumerary Status of the Labour Ward Coordinator

From 1 March 2024 to 30 April 2024, there have been zero occasions against a possible 300 episodes recorded, where the midwife has been unable to provide continuous one-to-one care and support to a woman in established labour and one occurrence where the delivery suite coordinator has not remained supernumerary and has resulted in the coordinator being the named midwife for a woman.

In March and April 2024, the number of red flags recorded on Delivery Suite were two and one respectively. This represents a significant decrease compared to monthly figures from 2023.

3.2.2 Risk and Mitigation

As noted above, the sustained pressure to support the preceptorship of a large cohort of newly qualified Midwives has resulted in continued staffing pressures for the service despite the increase in overall staff numbers. This continues to be compounded by the resource required to achieve the nationally mandated increase in training requirement for all Maternity staff as part of the Core Competency Framework v2 in 2023. In order to maintain the training schedule required to meet MIS training compliance and to have the assurance of a safe maternity workforce and service, local escalation in response to acuity has led to the continued closure of NBC during March and April 2024, in order to maintain safe staffing across the unit.

During periods of closure, women eligible and expressing a wish to use the Birth Centre are diverted to Delivery Suite where a low-risk midwifery service is being provided. A Quality Impact Assessment has been undertaken which indicates that this process supports the safety of women and babies.

Intermittent closure creates uncertainty for patients and families, and potentially impacts patient satisfaction as partners are unable to stay overnight on the postnatal ward in contrast to their expected experience on the Birth Centre.

The homebirth service has been suspended since 17th July 2023 as part of local escalation initially in response to staffing deficits and subsequently due to non-compliance with intrapartum clinical updates over the past 12 months. Community Midwives are currently undertaking a 3 month ‘sprint’ to ensure all are compliant with the necessary intrapartum clinical updates to reinstate the service in June 2024.

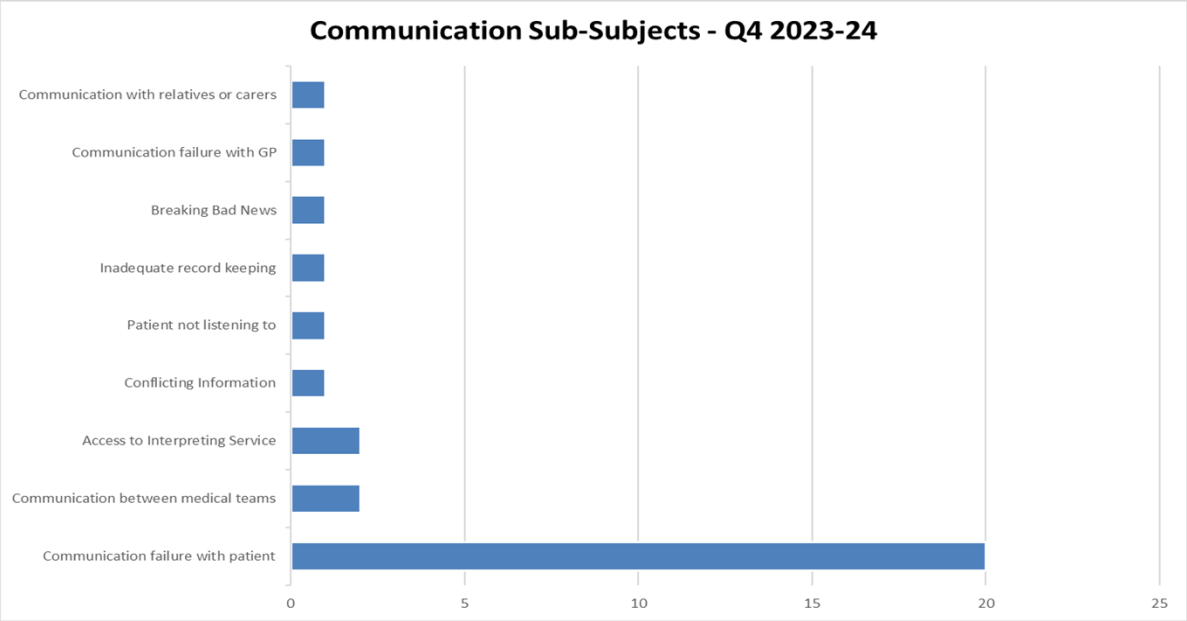
Daily monitoring of staffing levels in line with the North East North Cumbria daily SitRep continues in order to ensure escalation measures can be stepped down as soon as safe staffing across the unit is assured.

4. PATIENT EXPERIENCE QUARTER 4 REPORT

4.1 Complaints Activity

The Trust has opened 167 formal complaints in Quarter 4, an increase of 10% on the previous quarter. The Trust has received on average, 48 formal complaints per month for the financial year 2023-24, which is two complaints higher than the overall average for 2022-23, which was 46 complaints per month.

In Q4, Medicine & Emergency Care received the most formal complaints, with 40 (24%), which is a decrease of 3 complaints on the previous quarter.



In accordance with previous quarters, 30 complaints (18%) opened in this quarter with a primary concern of 'communication'. Within this category, 67% related to 'communication failure with patient' and 7% related to both 'communication between medical teams' and 'Access to Interpreting Services'. The remaining complaints are split between: 'Conflicting Information,' 'Patient not listening to,' 'Inadequate record Keeping,' 'Communication failure with GP,' 'Communication with relatives or carers' and 'breaking bad news.'

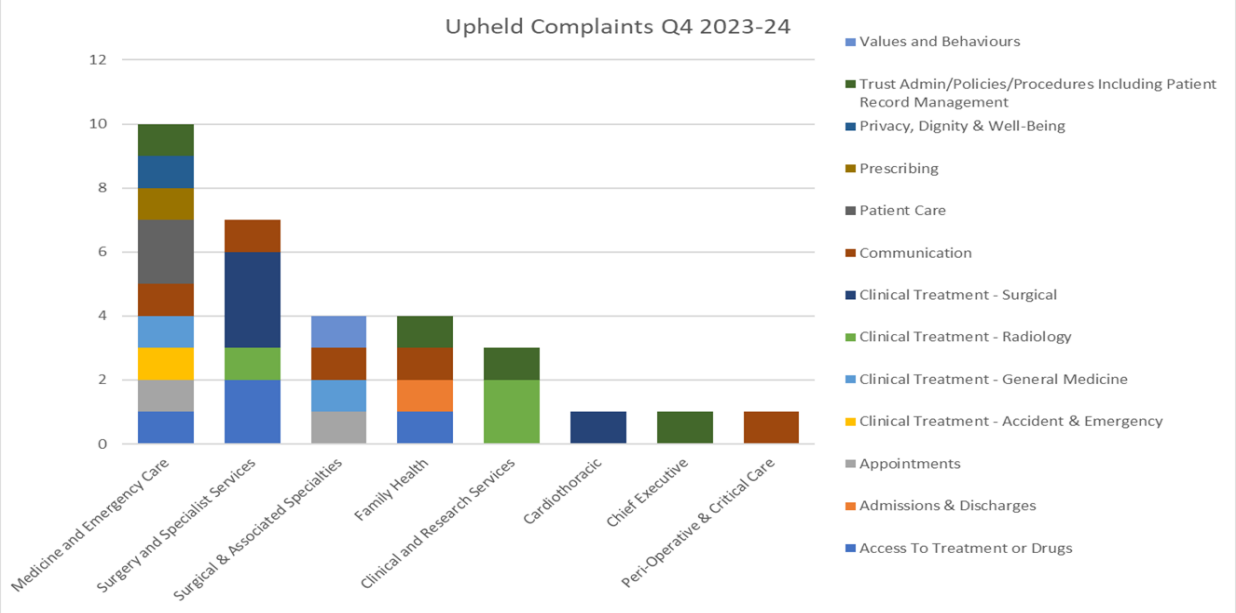
4.2 KO41 Mandatory Return

This quarter, 165 formal complaints were closed, which is an increase of 4% from the previous quarter. Of these, 31 complaints were upheld, 24 were partially upheld, 85 were not upheld and 25 were withdrawn.

The table below shows the breakdown of the 31 upheld complaints between clinical boards and categories. Medicine and Emergency Care have the most upheld complaints with 10, accounting for 32% of all upheld complaints for this period.

The most frequent category is communication with 16% of upheld complaints across five directorates: Surgical and Specialist Services (RVI), Surgical & Associated Services (FH), Medicine and Emergency Care, Perioperative and Critical Care and Family Health.

An annual complaints report is due to be presented to the Trust's complaint panel in June 2024.



4.3 PALS

1202 issues have been raised with PALS over this period. This compares to 1090 issues raised in the previous quarter and is a 10% increase. There were 1060 issues raised in the same quarter 2022-23 which represents a 12% increase. 38 enquiries were from carers.

4.4 PATIENT EXPERIENCE

4.4.1 National Patient Survey Programme

The remaining surveys in 2024 include the Adult Inpatient Survey for which fieldwork is well underway (January – April 2024), results are due to be reported in Autumn 2024.

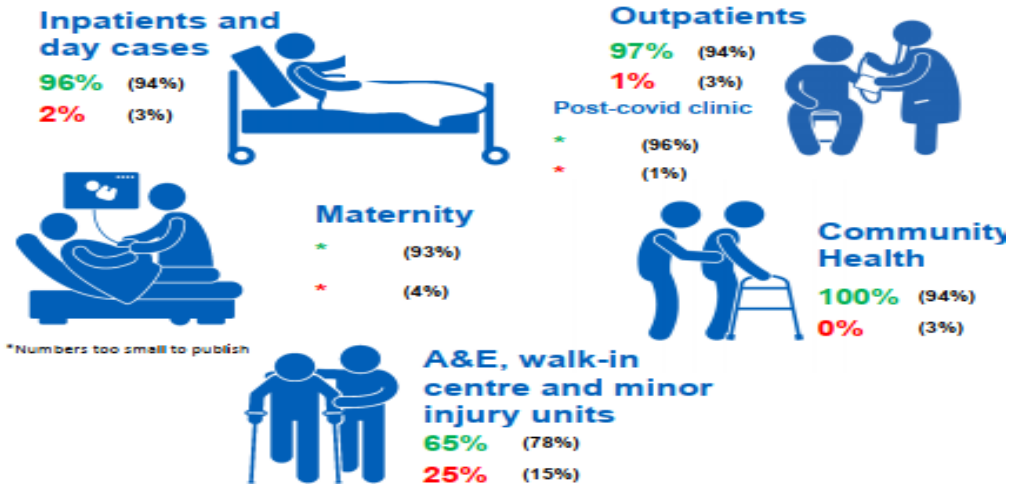
The national patient survey programme for 2024-25 includes:

- **2024 Children and young people:** fieldwork July – October 2024, publication March 2025
- **2024 Urgent and emergency care:** fieldwork April – July 2024, publication October 2024
- **2024 Maternity:** fieldwork April – June 2024, publication December 2024
- **2024 Adult inpatients:** fieldwork January – April 2025, publication August 2025
- **Cancer Patient Experience Survey:** fieldwork October-December 2024, publication Spring 2025

4.4.2 NHS Friends and Family (FFT)

The infographic to the right displays the overall positive and negative ratings for the services in January 2023 (published March 2024). In January there were 1,344 responses to the Friends and Family compared to just 664 in the previous month.

A number of areas are displaying the QR code link to the survey within departments to try to increase the number of responses.



4.4.3 NHS Choices

The Trust received 40 items of feedback on the Reviews and Rating section of the NHS website, with most comments being in relation to Medicine and ePOD, with 6 responses each. The Trust received the maximum score rating of five stars from 60% (n24) of comments received. All the published reviews are internally scrutinised, and a response provided. The response signposts users who have concerns to contact PALS or the Patient Experience team to further investigate and respond to any concerns.

4.5 PATIENT INVOLVEMENT AND ENGAGEMENT

4.5.1 Youth Forum

The forum continues to meet monthly, with group members representing over 17 services within the Trust. Group members recently presented their project Exam experiences of young people with long term conditions at the RCPCH Conference in Birmingham. The next steps of the project are to develop a customisable letter template which clinicians can use to communicate with schools.

4.5.2 Young Person's Advisory Group North East (YPAGne)

The group continue to meet monthly and currently has 52 members from across the region. Young Person's Advisory Group North East **(YPAGne)** members attended a pop-up hospital event in the February half term held at the Newcastle Cathedral delivering engagement activities to young children. Funding had recently been secured to pilot Outreach YPAGne

and explore delivering YPAG sessions to established youth groups in the region.

4.5.3 Maternity and Neonatal Voices Partnership (MNVP)

The final quarter of the reporting year began with embracing the expanded remit of the Maternity and Neonatal Voices Partnership (MNVP) to hear and understand the experiences of families with babies receiving care within the Neonatal Intensive Care Unit (NICU). The MNVP and Tiny Lives charity co- hosted a listening event for NICU parents following a visit to the unit, both of which provided valuable insights into the care and environment within the department and correspondingly, the lived experiences of both short- and long-term inpatient stay families.

The event also provided an important opportunity to strengthen MNVP links with Tiny Lives and NICU teams, united in their shared aim of responding to the needs, suggestions, and feedback of service users. Further NICU engagement will be interwoven throughout the MNVP work plan for the coming year to facilitate the forging of further connections and reaching more voices.

Reaching the four corners of Newcastle has been a long-standing priority of the MNVP and a community visit to a Breastfeeding Mams Newcastle group in Byker was a welcome opportunity to cement links with communities and our service users within the East End.

The rest of MNVP activity this quarter has centered around shared Trust activities including joining the inaugural Maternity Drug and Alcohol Service steering group, attending the bi-monthly Obstetric Governance Group, Equity and Equality Group, Maternity Feedback Forum, the induction of labour project steering group, and hosting the final MNVP quarterly meeting of the year.

4.5.5 Local Support for Patient Experience Projects

In addition to the support and co-ordination of the national measures of patient experience, the team provide support to staff within the Trust who undertake their own patient experience activities. This support has recently included, Evaluation of the Fitness After Stroke (FAST) Group, District Nurse led Ambulatory Care Clinics and in Mortuary Services

4.6 EQUALITY, DIVERSITY & INCLUSION

4.6.1 Deaf Awareness eLearning

Deaf and hard of hearing patients have provided feedback about their experience and care via complaints, PALS and local charities such as Deaflink and Becoming Visible. This feedback has given the Trust opportunities to identify where improvements need to be made. One significant piece of feedback from patients is that they would value staff being more deaf aware. This has also been feedback from staff about the knowledge and training they would like after they have faced challenges in understanding and overcoming communication barriers.

In partnership with Deaflink, CNTW and Northumbria Healthcare, the organisations mapped out what would support Deaf Awareness for staff and how training can be sustainably delivered to large organisations. Deaflink were commissioned to then develop and provide the Trust with an e-learning package which is led by Deaf people. The training uptake will be monitored and staff who have completed the training will be asked for their feedback.

4.6.3 CHAPLAINCY

The chaplaincy team continue to provide support for both patients and staff, making 2,365 contacts in the months Jan to March 2024. The team have been providing regular sessions through the Healthcare Academy, including training for new healthcare staff on Spirituality Matters. In Q4 the team conducted 321 chapel of rest, police identifications and coroners' cases in and out of hours. The chaplains, who are drawn from different faiths, beliefs and world views have been alongside 635 dying patients and their relatives; and conducted the appropriate rites, rituals, and funeral services. The team have had 398 new referrals, undertaken 1,012 follow ups, and have supported 56 individual members of staff.

5. RECOMMENDATION

The Board of Directors is asked to note and discuss the content of this report.

Report of Ian Joy
Executive Director of Nursing
16 May 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024		
Title	Maternity Update Report		
Report of	Ian Joy, Executive Director of Nursing		
Prepared by	Lucy Patterson, Head of Midwifery Jeanette Allan, Senior Risk Management Midwife		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	The purpose of this paper is to provide the Trust Board with an update against the national drivers and priorities for maternity services, including: • An update following the Care Quality Commission (CQC) inspection in January 2023, whose findings were published in May 2023. The maternity service was graded 'requires improvement' against the domains of 'well-led' and 'safe' as part of the national maternity inspection programme. The Trust continue to progress the System Oversight Framework (SOF) action plan; as agreed with the Integrated Care Board (ICB) in February 2024. Trust Board are provided with an update against the SOF action plan. • Findings of the unannounced CQC core inspection of the Maternity Service in July 2023 were published on 24 January 2024. The action plan arising from the July inspection was agreed to be monitored as part of the continuing SOF. Trust Board are provided with an update of this second action plan. • Trust Board are provided with an update of progress toward implementing the 'Three year delivery plan for Maternity and Neonatal Services'. The 'Three year plan' was published by NHS England (2023) in response to findings and recommendations from National maternity investigations including Ockenden. This is the first of a bi-annual update to Trust Board for 2024.		
Recommendation	Trust Board is asked to: i) Receive and discuss the report; ii) Note the ongoing oversight and assurance from the ICB through the System Oversight Framework (SOF) in response to the final report of the CQC inspection in January 2023; iii) Note the ongoing oversight and assurance from the ICB through the SOF for the second action plan arising from the formal findings of the CQC core inspection of Maternity in July 2023 published in January 2024; iv) Note the first biannual update of Trust progress in implementing the 'Three year plan'. v) Note the associated risks involved.		
Links to Strategic Objectives	Putting patients at the heart of everything we do. Providing care of the highest standards focussing on safety and quality.		

Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link. Risks are detailed within the main body of the report.					
Reports previously considered by	Previous reports have been presented to Trust Board on Ockenden, The Kirkup Report, and The Maternity Incentive Scheme (CNST).					

MATERNITY SERVICE UPDATE

EXECUTIVE SUMMARY

This paper provides Trust Board members with an overview and update of the main priorities and quality considerations for the Maternity Service.

Section 2 provides an update on the actions arising from the CQC maternity inspection undertaken in January 2023 as part of the national maternity inspection programme, the results were published on 12 May 2023. The maternity service was rated 'requires improvement' for the domains of 'safe' and 'well-led'.

As previously reported to Trust Board, the Maternity Service continues to be monitored through a formal System Oversight Framework (SOF) by the ICB. Progress against the SOF agreed action plan (Appendix 1 Tab 1) is reported, through the Family Health Clinical Board's governance framework and detailed within this paper.

A further unannounced CQC core services inspection of the Maternity Service was undertaken between 25-27 July 2023. Findings were published on 24 January 2024. As previously reported, actions from this core services inspection have been developed into a second action plan (Appendix 1 Tab 2) to be monitored as part of the formal SOF.

Section 3 Trust Board are provided with an update against the Trusts' monitoring of compliance against implementing the 'NHS Three Year Plan for Maternity and Neonatal Services'. This is the first bi-annual update for 2024. Details of the 'Three year plan' were presented to Trust Board in May 2023 following publication in March 2023, with initial Trust benchmark status presented in July 2023. The 'Three year plan' was developed in response to national reports (Ockenden and Kirkup) with the intention that Trusts focus on one clear plan comprising four high-level themes divided into twelve objectives, a detailed progress update is detailed in Appendix 2.

MATERNITY SERVICES UPDATE

1. INTRODUCTION

This paper provides Trust Board members with an overview and update of the main drivers and quality considerations for the Maternity Service. This paper provides an update on the SOF action plans in response to recent CQC inspections. The first bi-annual update for 2024 is presented to Trust Board on the Trust's progress toward implementing the 'Three year plan'.

2. CQC MATERNITY INSPECTION UPDATE

Trust Board members will recall that the Maternity services received a CQC inspection in January 2023. The national maternity inspection focused on the domains of 'safe' and 'well-led' and an overall rating of 'requires improvement' was published in May 2023.

As previously reported to Trust Board, the Maternity Service is subject to a formal SOF provided by the ICB due to the overall rating of 'requires improvement'. The Maternity CQC action plan (Appendix 1 Tab 1) has been developed in collaboration with the ICB to ensure robust monitoring and assurance is provided through agreed standards. The Maternity Action Plan was agreed by the ICB on 12 February 2024.

The Maternity Service was part of an additional CQC core inspection in July 2023. The final report was published on 24 January 2024. The two key domains from the previous inspection were revisited, resulting in a reduction from 'good' to 'requires improvement' for well led. The inspection maintained the 'requires improvement' rating for safe. The findings and recommendations were presented to the Director of Nursing and Midwifery for the ICB in a meeting with the Senior Maternity Leadership Team on 12 February 2024. Further actions have been developed into a second action plan (Appendix 1 Tab 2) to be monitored as part of the formal SOF. Given the short timeframe from report publication in January 2024 to SOF meeting in February 2024, exit criteria for each action plan will be agreed at the ICB quarterly review meeting in May 2024.

There were ten findings from the CQC core inspection relating to breach of statutory regulatory requirements that the Trust **must** action:

1. **The service must assess, monitor, and improve the quality and safety of the services and mitigate the risks relating to the health, safety and welfare of women, birthing people, and babies.**

The risk assessment recorded on the maternity electronic patient record (Badgernet) became a mandatory field for completion at each contact with a health professional in February 2024, in line with the Ockenden recommendations, to ensure personalised care is embedded within the service and women feel valued. Current compliance is noted to be 100% with ongoing assurance monitored via a monthly audit.

2. The service must ensure they are delivering fundamental standards of care that meets the needs of women, birthing people, and babies. This includes assessing the health and safety risks and doing all that is reasonably practicable to mitigate any such risks. This includes but is not limited to staffing, risk assessments and security.

3. The service must ensure that there are sufficient numbers of competent, skilled, and experienced midwifery and medical staff to meet minimum staffing levels and meet the care and treatment needs of women, birthing people, and babies. This includes but is not limited to ensure that the skill mix supports the acuity of patients.

A BirthRate+ Midwifery and Support Staff workforce review was commissioned by the Trust in October 2023 in line with the nationally recommended three-year review timeframe, the outcome of this is expected in May 2024 and will be reported to Trust Board in future papers. Maternity Services undertake a comprehensive daily staffing to acuity assessment in correlation with the North East and North Cumbria (NENC) Escalation Policy to ensure the service meets the needs of women, birthing people, and babies and mitigate risks associated with staffing via responsive local escalation as required. This is monitored at monthly Staffing vs Outcome meetings introduced to Maternity Services in January 2024 to align with monitoring processes in the wider Trust to ensure learning and quality improvements are made.

There are currently three Obstetric Consultant vacancies within the Maternity Service with a Business Case submitted to increase Obstetric Consultant capacity by a further three to enable a 52-week model of service delivery. Recent recruitment attempts have been unsuccessful in attracting Obstetricians to the Trust with support now sought from colleagues across the region to maintain tertiary service delivery.

As above (2.1) pregnancy risk assessment completion is now mandated at each contact with a health professional with a monthly audit programme implemented for monitoring and assurance.

The security of Maternity Services has been collaboratively reviewed with the Security Team and the Baby Abduction exercise frequency increased from annually to quarterly to ensure staff knowledge and vigilance. A robust exercise was undertaken in March 2024 with the perpetrators stopped and challenged by staff on three occasions while attempting to leave the postnatal ward. However, learning was identified around the risk of ‘tailgating’ into the department. Security surveillance audits were introduced in January 2024 and are undertaken twice per month to monitor adherence to the Baby Abduction Policy with findings reported immediately to the Leadership Team to act on as required, before sharing widely with the workforce as a whole. There has been a notable reduction in the observation of ‘tailgating’ with work ongoing to maintain vigilance. The need for estates work to strengthen the security of Delivery Suite and the postnatal wards has been escalated with the Estates Department with completion expected to be reported to Trust Board in July 2024.

4. The service must ensure there are sufficient quantities of cardiotocography (CTGs), central monitoring equipment and cleaning equipment to ensure the safety of women, birthing people, and babies.

The Trust completed a business case to secure 19 further CTG machines and replace seven older CTG machines to ensure appropriate resource is available to enable timely, safe care of women, birthing people and babies and mitigate human factors via the consistency of the CTG fleet. Delivery was received in April 2024 and work is ongoing with Digital and Estates colleagues to support the installation of central monitoring systems to the Antenatal Ward, Daycare and Maternity Assessment Unit. An update will be provided in future papers.

5. The service must ensure that mandatory and core competency training compliance meets the trust target.

Targeted work is ongoing within the Maternity Service to ensure that mandatory training compliance meets the Trust target, Core Competency Training v2 compliance and Maternity Incentive Scheme (MIS) training requirements within the agreed timeframe for Year 6 from 1st December 2023 - 30th November 2024. The NENC agreed requirement for Core Competency Training v2 continues as last year's requirement of 3 days: Multidisciplinary Obstetric Emergencies, Multidisciplinary Maternity Safety and Public Health in Practice and Fetal Wellbeing Training. The time apportioned to this includes the face-to-face mandatory Trust training and is significant for all staff groups, as an example for Midwives there is a requirement of 31.5 hours learning. The compliance for the rolling 12-month period to 25th April 2024 is 84% for Multidisciplinary Obstetric Emergencies, 72% for Multidisciplinary Maternity Safety and Public Health in Practice and for Fetal Wellbeing Training it is 70%. Maintenance of the current Maternity services provision will support trajectory to achieve all requirements within the timeframes listed above.

6. The service must ensure premises are safe. This includes but is not limited to ensuring storeroom doors are not left open or unlocked.

As this was highlighted widely across the Trust at the time of core service inspection, midwifery leaders responsively raised awareness across the workforce and senior leaders continue to monitor this in the maternity unit. Estates work is currently planned in the coming months to improve the security of the postnatal areas in line with Baby Abduction drill learning with an update provided in future papers.

7. The service must ensure it encourages the identification, reporting and investigation of incidents and risks in a timely fashion and shares learning to improve safety and quality of the service.

The Trust are in the process of developing a targeted and reactive approach to areas of under reporting. Working in collaboration with Quality and Safety (Q&S) Leads, Clinical Directors for Quality and Safety, Heads of Nursing/Midwifery and Matron's to provide proactive support to promote and encourage incident reporting and learning. Within Maternity Services, the Patient Safety Champion roles are held by the Non-Executive Director (NED) and Director of Quality and Effectiveness have been reviewed and a programme of engagement and increased awareness for the Patient Safety Champions was implemented in March and April 2024 to strengthen understanding of the role with the output shared via the NED report to People's Committee.

8. The service must ensure newly qualified midwifery staff receive the appropriate support, training, professional development, and supervision as is necessary to enable them to carry out their duties.

The Maternity Service offers a comprehensive preceptorship package comprised of bootcamp style training followed by bespoke supernumerary supported rotations. This ensures newly qualified midwifery staff receive individualised support, training, professional development, and supervision as appropriate to undertake their duties within each area of the service. Regular touchpoint meetings are offered and conducted with newly qualified midwives in the first year of employment by the Recruitment, Retention and Pastoral Care Midwife, Practice Development Midwife and individual Team Leads.

9. The service should ensure the guidance within their post-partum haemorrhage (PPH) policy is clear about defining and grading maternal blood loss in accordance with national guidance.

Following the CQC inspection, a guideline review was undertaken and found to be compliant with national guidance, with findings presented regionally for further assurance.

A PPH above 1500mls is currently classified as a 'Datix trigger' regionally to ensure the equity of investigation. A retrospective audit has been undertaken between January and March 2024 to understand the reporting and grading of PPH in relation to national guidance with consideration for the specialist services provided by the Trust. The grading of harm in all cases reported to Datix was reviewed with respect to whether an act or omission of care resulted in patient harm, with the grading for harm in all cases remaining low/no harm, however, it is important to acknowledge the outcome for the patient may be considered to have a more significant impact on their experience. The recent audit found under reporting of PPH within the Datix system when cross referenced with the EPR, this finding has been communicated with the wider workforce to highlight the need for consistent reporting and will be audited on a monthly basis moving forward. The reporting and investigation process for PPH will be further developed with the implementation of PSIRF within the Maternity Service influenced by wider regional patient safety workstreams to optimise thematic learning and proportionate response to maternity incidents.

10. The service should ensure that clinical sharps waste bins are dated and labelled in accordance with national guidance.

Maternity Services are included in the work ongoing within the wider Trust to ensure clinical sharps waste bins are labelled in accordance with national guidance. A monthly audit has been undertaken since February 2024 to monitor compliance, with communication shared locally within Maternity Services to raise awareness and ensure understanding of clinical expectations following a reduction in compliance in April 2024. A further monthly audit will be undertaken for the next three months to ensure compliance.

A meeting was held with the ICB on 12 February 2024 to review the Trust's position against the existing action plan and SOF in view of the additional findings and recommendations made by the CQC's core inspection report. It was acknowledged these should be reviewed in totality when agreeing exit criteria from the Framework and to ensure alignment with the work underway more widely across the Trust, it is expected this exercise will be undertaken in May 2024.

3. THREE YEAR PLAN

Trust Board members will recall, details of the 'Three year plan' were presented in May 2023 following publication in March 2023, with initial Trust benchmark status presented in July 2023. The 'Three year plan' was developed in response to national reports (Ockenden and Kirkup) with the intention that Trusts focus on one clear plan comprising four high-level themes divided into twelve objectives, a detailed update of compliance is provided in Appendix 2.

Four Key Themes and Twelve Objectives From the Three-Year Delivery Plan

As previously reported to Trust Board, the 'Three-year plan' determines that safer, more personalised, and more equitable care will be achieved through four, high level themes comprising twelve objectives:

THEME 1: LISTENING TO WOMEN AND FAMILIES WITH COMPASSION WHICH PROMOTES SAFE CARE

Objective 1: Provide care that is personalised.
This theme identifies actions for personalised care, reducing inequalities through improving equity, and working with service-users to improve care.

There has been regional work undertaken to identify the determinants of a Personalised Care and Support Plan (PCSP) with a specific task and finish group involving clinicians and Maternity and Neonatal Voices Partnership (MNVP) representatives from the region, outcomes are awaited. The ability to evidence personalised care planning in partnership with women and birthing people has been enhanced through mandatory data fields within the electronic patient record recording when plans have been made in partnership and agreement with women and birthing people and when care is planned out with guidance in respect of individual wishes.

Objective 2: Improve equity for mothers and babies.
Improving equity involves implementing midwifery continuity of carer (in line with safe staffing principles), particularly for women from minority ethnic communities and from the most deprived areas. Women and babies from these groups experience greater health inequalities and worse outcomes.

In April 2024 the Trust appointed to the post of 'Senior Midwife for Complex and Vulnerable families' to focus continuity of care and specialist support to women and babies at risk of greater inequalities and poorer outcomes.

Trust progress against this objective also includes ongoing implementation of the Local Maternity and Neonatal System (LMNS) -aligned Equality and Equity action plan.

Objective 3: Work with service users to improve care.
Collaborative working and co-production are key to improving care and providing services that are responsive and aligned to the needs of the local community.

The Trust have a strong commitment in working closely with the MNVP and are collaboratively creating a workplan for 2024/25. The MNVP are currently involved in the co-production of a quality improvement project for women and birthing people to improve the information, communication and care we provide for those recommended for and experiencing Induction of Labour (IOL).

THEME 2: GROWING, RETAINING, AND SUPPORTING OUR WORKFORCE

Objective 4: Grow our workforce.
High-quality care requires skilled teams with sufficient capacity and capability. NHSE recognise services require continued staffing growth to achieve the ambitions of the plan.

As outline above, the Trust have commissioned a BirthRate+ review of Midwifery and Support Staffing with the report expected in May 2024 to enable a full workforce and service review to be undertaken following the incoming Director of Midwifery's commencement in post in June 2024. The Trust have a rolling recruitment programme for Midwifery in order to support ongoing growth of the workforce and optimise the 20wte over recruit supported by the Trust and offer an attractive comprehensive preceptorship support package for new to post recruits.

Objective 5: Value and retain our workforce.
The Three-year plan seeks to ensure staff feel valued and fulfilled through sustainable careers, and to improve the experience of all staff to increase retention.

Maternity Services has been identified as one of the pilot areas within the 'Right Now, Right Time' patient and staff experience programme to commence in May 2024 as an opportunity to strengthen the identification of local retention issues affecting the maternity and neonatal workforce and address the key issues highlighted in the 2023 Staff Survey and 2024 SCORE Survey.

Objective 6: Invest in skills.
Training and developing staff makes them feel valued and enabled to deliver high-quality care.

The Maternity Service has completed a comprehensive annual training needs analysis in conjunction with the Core Competency Framework v2 and as outlined earlier in the paper, aims to ensure that core competency training compliance meets nationally agreed targets within the Maternity Incentive Scheme timeframe for Year 6 from 1st December 2023 - 30th November 2024.

THEME 3: DEVELOPING AND SUSTAINING A CULTURE OF SAFETY, LEARNING, AND SUPPORT
The ambition of the plan is for staff to be part of a positive safety culture, which will improve care experiences and outcomes for women and babies and will encourage staff to thrive.

Objective 7: Develop a positive safety culture.
Cultural change is enabled through leadership that is compassionate, diverse, and inclusive. The Trust have actively engaged in the NHSE mandated Perinatal Culture and Leadership Programme to develop the leadership and collective working of Perinatal Service Leads within the Trust.

The Non-Executive Director (NED) and Director of Quality and Effectiveness roles as Patient Safety Champions have been reviewed and a programme of engagement and increased awareness implemented in March and April 2024 to strengthen understanding of the role with the output shared via the NED report to the People Committee.

Objective 8: Learning and improving.
Promoting safer care requires continuous learning from when things go well and when they do not. As the Maternity Service implements PSIRF a framework will be developed to enhance communication surrounding the response to patient safety incidents and the subsequent shared learning to ensure that actions are agreed and implemented within an agreed timeframe.

The 'Right Now, Right Time' patient and staff experience programme will afford the opportunity to explore in more detail, 'what good looks like' and recognise good practice within the department nurturing a culture of identifying and celebrating success.

Objective 9: Support and oversight
The plan highlights that good oversight from trusts and ICBs is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise.

As highlighted above the Maternity Service is well supported by the LMNS and ICB through the Quarterly Perinatal Quality Surveillance Programme and CQC SOF.

THEME 4: MEETING AND IMPROVING STANDARDS AND STRUCTURES THAT UNDERPIN OUR NATIONAL AMBITION
Maternity and neonatal teams need to be supported by clear standards and structures and have access to quality data and digital tools that enable the flow of information.

Objective 10: Standards to ensure best practice.
Care should be offered in line with best practice using existing nationally defined guidance.

This objective aligns to NHS Resolution's Maternity Incentive Scheme (NHSR MIS) safety actions. The Trust has been working to progress implementation of the Saving Babies Lives Care Bundle version 3 (SBLCBv3) with monitoring and oversight from the LMNS.

Objective 11: Data to inform learning.
Accurate, up to date information is needed to identify concerns and to learn, act and improve from.

The Trust are improving the compliance of data submissions to the Maternity Services Data Set with specific focus on recording ethnic origin of women and birthing people at pregnancy booking. Reporting information to NHS Resolution, Maternity and Neonatal Safety Investigations (MNSI) and the National Perinatal Epidemiology Unit (NPEU) are embedded processes within the Trust.

Objective 12: Make better use of digital technology in maternity and neonatal services. Digital technology will make it easier for women to access the information they need, and for services to offer safe and personalised care.

The Trust have successfully implemented the electronic patient record 'BadgerNet' aligned to the region and are compliant with this objective.

4. CONCLUSION

Trust Board members are provided with an update against the CQC action plan relating to the January 2023 maternity inspection findings via the action plan developed and agreed as part of the ICB SOF. The Trust continue to monitor and progress the action plan and reports through the Family Health Clinical Board and externally on a quarterly basis to the ICB as part of the SOF.

The findings of the additional unannounced core inspection undertaken in July 2023 were published on 24 January 2024, where the two key domains from the previous inspection were revisited, resulting in a reduction from 'good' to 'requires improvement' for well led. The inspection maintained the 'requires improvement' rating for safe. The findings and recommendations were presented to the Director of Nursing and Midwifery for the ICB in a meeting with the Senior Maternity Leadership Team on 12 February 2024. Further actions have been developed into a second action plan to be monitored as part of the formal SOF with exit criteria expected to be agreed with the ICB in May 2024.

Trust Board are reminded the Trust benchmark status against the 'Three Year Plan' was presented in July 2023 and in subsequent papers reported to the Trust Board. The intention of the 'Three Year Plan' is to focus Trusts on one clear plan comprising four high-level themes divided into twelve objectives, an update of progress is provided and further detailed in Appendix 2 and will be revisited bi-annually. The Maternity Service plans to align workstreams together with the CQC action plan to form an overarching quality improvement plan for Maternity Services.

5. RECOMMENDATIONS

Trust Board is asked to:

i) Receive and discuss the report;
ii) Note the ongoing oversight and assurance from the ICB through the SOF in response to the final report of the CQC inspection in January 2023;
iii) Note the formal findings of the CQC core inspection of Maternity in July 2023 which were published on 24 January 2024 and the associated actions and ongoing oversight and assurance with ICB SOF;

iv) Note the Trust's progress toward implementation and monitoring against the 'Three year plan';

v) Note the associated risks involved.

Report of Ian Joy
Executive Director of Nursing
16 May 2024

Agenda item A11(b)(i)															
Unique Action ID	**Action**	**Action Owner**	**Must Do Desc**	**Regulation**	**Theme**	**Within report 2 - Maternity**	**Trust Wide or Board Specific**	**1 - Family Health**	**How will compliance be evidenced**	**Progress Updates**	**Completion Status**	**Timescale for Completion**	**Action RAG**	**Link to Additional Resources**
A-016	We will ensure staff complete daily checks of emergency equipment, and ensure equipment used by staff and women and birthing people is in date, checked regularly and safe for the intended purpose.	Lucy Patterson (Head of Midwifery)	The trust must ensure staff complete daily checks of emergency equipment. They must ensure equipment used by staff and women and birthing people is in date, checked regularly and safe for the intended purpose. Regulation 12(1)(2)(e)			Yes	Board Specific	Yes	A formal standardised process has been developed, implemented and embedded for the daily checking of emergency equipment which is monitored via the monthly Trustwide CAT tool. During the interim period compliance is monitored weekly within the department and reported to the Family Health Clinical Board on a monthly basis.	1) The Trust implemented immediate actions to meet with this requirement following CQC inspection in January 2023. Clinical Standards Checklists for each area/ward were standardised and embedded across every department in line with Trust wide templates since June 2023. 2) An additional interim local operational SOP was introduced in January 2024 for enhanced assurance of daily compliance over a 12 week period. Increased oversight is established with a supporting framework for compliance tolerance targets and responsive actions led by the responsible Midwifery Matron. Weekly oversight of Trust wide compliance tolerance targets and responsive actions are monitored via the Director/Head of Midwifery Meeting with data then feeding into the monthly Nursing and Midwifery Professional Meeting with the Director of Operations and Clinical Board Chair. 3) The 12 weekly enhanced assurance process ceased in April 2024 as Trust CAT Tool compliance was achieved and maintained across the department. Monitoring will continue via the Trust CAT with the enhanced process stepped up as required as per the SOP.	Live	Practice is now embedded and compliance maintained with step down to CAT Tool only for monthly monitoring from April 2024.	Compliant with mechanism for ongoing monitoring and reporting to ensure practice is embedded.	Clinical Standards Checklists Weekly Leaders Assurance Checklist Interim Local SOP for enhanced assurance Weekly DoM Meeting Minutes Enhanced Weekly Audit / CAT Tool Results
A-017	We will ensure staff appraisal rates meet the Trust target of 95% by March 2024 and compliance is maintained thereafter.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations)	The trust must ensure all staff receive such appraisal as is necessary to carry out their duties. Regulation 18 (1)(2)(a)	18 (1)(2)(a)	NOT ASSIGNED	Yes	Board Specific	Yes	Compliance for midwifery and support staff will be monitored weekly by the Midwifery Matrons at the Director of Midwifery Meeting against the Trust target of 95% compliance. There is monthly oversight by the Associate Director of Operations at the Directorate Management Meeting and compliance is formally reported to the Clinical Board at the monthly Nursing and Midwifery Professional Meeting with the Director of Operations and Clinical Board Chair. Medical staff appraisals are monitored by the Associate Director of Operations and Clinical Director on a monthly basis and features as a standing agenda item for the Consultant's monthly meeting.	1) The Trust immediately undertook targeted work to improve appraisal rates towards the Trust target of 95%. 2) The appraisal process for Midwifery and Support Staff was reviewed in Q3 2023 and the 'Maternity Family Tree' for Midwifery and Support Staff launched in February 2024 and has been updated in April 2024 alongside expectation and process guidance for both appraisers and appraisees. 3) The current appraisal rate as at 16th April 2024 is as follows: Medical Staff 70%, Midwives 90%, Support Staff 87%.	Live	Trust Target of 95% compliance met and sustained by 30th April 2024.	Partial Compliance with mechanism for ongoing monitoring with a trajectory for compliance to be achieved and sustained.	Midwifery and Support Staff Appraisal Process and 'Maternity Family Tree' DMT Meeting Minutes Monthly HR Dashboard Monthly Consultants Meeting Minutes
A-018	We will ensure the proper and safe management of medicines, ensuring out of date medicines are removed and medicines are stored securely.	Lucy Patterson (Head of Midwifery)	The trust must ensure the proper and safe management of medicines, ensuring out of date medicines are removed and medicines are stored securely. Regulation 12 (1)(2)(g)	12 (1)(2)(g)	NOT ASSIGNED	Yes	Board Specific	Yes	A strengthened process for medicine management has been developed, implemented and embedded across the Trust and is monitored via the monthly Trustwide CAT tool. During the interim period compliance is monitored weekly within the department and reported to the Family Health Clinical Board on a monthly basis.	1) The Trust implemented immediate actions to meet with this requirement following CQC inspection in January 2023. The storage of medication and IV Fluids was reviewed in each area in collaboration with the Estates Department and necessary action taken to ensure all are stored in locked cupboards behind a locked door in each area/ward. Fridge and Freezer temperature monitoring templates for each area/ward were standardised and embedded across every department in line with Trust wide templates since June 2023. 2) An additional interim local operational SOP has been introduced in January 2024 for enhanced assurance of daily compliance over a 12 week period. Increased oversight is established with a supporting framework for compliance tolerance targets and responsive actions led by the responsible Midwifery Matron. Weekly oversight of Trust wide compliance tolerance targets and responsive actions are monitored via the Director of Midwifery Meeting with data then feeding into the monthly Nursing and Midwifery Professional Meeting with the Director of Operations and Clinical Board Chair. 3) The 12 weekly enhanced assurance process ceased in April 2024 as Trust CAT Tool compliance was achieved and maintained across the department. Monitoring will continue via the Trust CAT with the enhanced process stepped up as required as per the SOP.	Live	Practice is now embedded and compliance maintained with step down to CAT Tool only for monthly monitoring in April 2024.	Compliant with mechanism for ongoing monitoring and reporting to ensure embedded practice.	Fridge and Freezer Monitoring Checklist Interim Local SOP for enhanced assurance Weekly DoM Meeting Minutes
A-019	We will ensure that mandatory training compliance including the appropriate level of safeguarding adults and children training meets the Trust target by March 2024 and is maintained thereafter.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations)	The Trust should ensure that all staff complete the required mandatory training including the appropriate level of safeguarding adults and children training. (Regulation 12)			Yes	Board Specific	Yes	Midwifery and Support Staff Trust wide mandatory training is monitored on a monthly basis at the Directorate Management Group in collaboration with HR Manager, and medical staff at the monthly Consultants Meeting.	1) As at 16.04.24 Trust wide mandatory training compliance is as follows: Midwives 86%, Support Staff 88% and Medical Staff 90%. Safeguarding Children Level 3 81%.	Live	Trust wide mandatory training target of 95% compliance met and sustained by 30th April 2024. Maternity specific training compliance will follow the requirements of MIS.	Partially Compliant	DMT Meeting Minutes Monthly HR Dashboard Monthly Consultants Meeting Minutes Quality Committee Paper Trust Board Paper
A-020	We will ensure all areas are clean and staff use control measures to prevent the spread of infection.	Lucy Patterson (Head of Midwifery) Tara Robinson (Hotel Services Manager)	The Trust should ensure all areas are clean and staff use control measures to prevent the spread of infection. (Regulation 12)			Yes	Board Specific	Yes	A strengthened process for the monitoring of clinical standards has been developed, implemented and embedded across the Trust. Compliance is measured monthly by the Midwifery Matrons using the CAT tool and is monitored via existing trust wide pathways.	1) The Trust implemented immediate actions to meet with this requirement following CQC inspection in January 2023. Clinical Standards Checklists for each area/ward were standardised and embedded across the department in line with Trust wide templates since June 2023. Clinical Standards are monitored and reported through the Trust-wide monthly Clinical Assurance Tool (CAT). 2) In February 2024 a departmental programme for Ward Manager peer review of clinical areas has been introduced bimonthly in addition to the quarterly peer review by an external Matron as part of the Trust peer review process. Peer assessment of inpatient areas was undertaken Trust wide in March 2024 with good representation from Maternity Services within the peer review teams. 3) To further strengthen the assurance process in maternity services, environment cleaning standards are triangulated on a monthly basis with Domestic Services Supervisor.	Live	Monthly monitoring ongoing to maintain compliance.	Compliant, with mechanism for ongoing monitoring and reporting to ensure embedded practice.	Clinical Standards Checklists Weekly Leaders Assurance Checklist Weekly DoM Meeting Minutes Monthly Maternity Cleaning Standards Meeting Minutes
A-021	We will ensure sufficient midwifery staff deployed to keep women, birthing people, and babies safe.	Lucy Patterson (Head of Midwifery) Lisa Jordan (Associate Director of Operations)	The Trust should ensure sufficient midwifery staff are deployed to keep women, birthing people and babies safe. (Regulation 18)			Yes	Board Specific	Yes	A monthly staffing vs outcome meeting was introduced in January 2024 in collaboration with the Trust Senior Nurse Staffing Team to review fill rates against clinical outcomes with Maternity Services recruitment position and Birthrate Plus Red Flags monitored and included in monthly ECN slide deck presented to Executive Directors.	1) A BirthRate+ staffing review was commissioned in October 2023, data collection is near completion with the recommendation expected in May 2024. Daily staffing to acuity assessments are undertake in correlation with NENY Escalation policy, shared regionally and monitored at the monthly Staffing vs Outcome oversight meeting with remedial actions plans as required. 2) Midwifery and support staffing skill mix were reviewed in March 2024 as part of the 6 month 'pause' on Band 6 rotations and baseline requirements agreed for each ward/area. 3) The Trust have introduced a quarterly rolling midwifery recruitment programme alongside the implementation of the Midwifery Workforce Improvement Strategy in October 2023, updated April 2024.	Live	BirthRate+ Staffing Review expected in May 2024	Compliant with a mechanism in place for monitoring and reporting.	NENC Daily SitRep and SOP Daily Monitoring and Mitigation Action Log Staffing vs Outcome Meeting Minutes Workforce Improvement Strategy ECN Slides Obstetric Staff Business Case
A-022	We will ensure estates and facilities in the delivery suite are suitable to meet the needs of women, birthing people and families and protect their privacy and dignity.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations) Rob Smith (Director of Estates)	The Trust should ensure estates and facilities in the delivery suite are suitable to meet the needs of women, birthing people and families and protect their privacy and dignity. (Regulation 15)			Yes	Board Specific	Yes	A multidisciplinary review of the Intrapartum environment was undertaken in Winter 2022 to identify areas requiring improvement that are restricted by the estate and are consequently listed on the departmental Risk Register. In 2024 there will be a focus on Intrapartum Services for the Service User 15 Steps Programme within Maternity Services.	1) Estates and environmental work across the service is a priority, however, the existing estate has limitations which requires significant change to bring resolution. Bespoke work is currently being explored to refurbish the bereavement facilities on Delivery Suite to improve the provision of privacy and dignity for families. Architect drawings have been completed outlining proposals for the bereavement suite which will be evaluated by staff and service users for comment. 2) A Delivery Suite focused 15 steps will be prioritised as part of the 2024-25 MNVP Workplan, this is currently being drafted with the 15 steps expected to be undertaken in May 2024. 3) The National Maternity and Neonatal Estates Survey was completed and returned in April 2024.	Live	The timescale for completion is expected to be 2024.	Partially Compliant	Architectural Drawings for the Halcyon Suite Risk Register Service User 15 steps output National Maternity and Neonatal Estates Audit Submission
A-023	We will ensure staff fully complete all aspects of modified obstetric early warning scores in order to assess the risks to women and birthing people.	Rhona Collis (Quality and Clinical Effectiveness Midwife)	The Trust should act to ensure staff fully complete all aspects of modified obstetric early warning scores in order to assess the risks to women and birthing people.			Yes	Board Specific	Yes	E-Obs and MEWS compliance are monitored monthly in line with existing Trust wide processes against the Trust target of 90%. There is monthly oversight by the Midwifery Leadership Team at the Staffing vs Outcome Meeting and compliance is formally reported to the Clinical Board at the monthly Nursing and Midwifery Professional Meeting with the Director of Operations and Clinical Board Chair where remedial action plans for each area will be agreed.	1) The Trust introduced an electronic Modified Early Warning Score (MEWS) system e-obs in July 2023. This has enabled a continuous process of review in relation to completion of MEWS, and greater quality assurance through audit. 2) The compliance rate for March 2024 was significantly below Trust compliance target but was noticed to have increased following staff education. Compliance will significantly improve with the introduction of the interface between eobs and Badgernet on 29th April 2024 as this will remove data duplication and therefore improved audit accuracy.	Live	Following implementation of the interface the Trust Target of 90% compliance will be met and sustained by 31st May 2024.	Partially Compliant	Monthly audit of eobs Monthly audit of MEWS documentation in Badgernet for Outpatient Areas Quality and Safety Clinical Board Minutes Staffing vs Outcome Action Log

Unique Action ID	Action	Action Owner	Must Do Desc	Regulation	Theme	Within report 2 - Maternity	Trust Wide or Board Specific	1 - Family Health	How will compliance be evidenced	Progress Updates	Completion Status	Timescale for Completion	Action RAG	Link to Additional Resources
A-024	We will continue to monitor the security of the unit in line with national guidance.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations)	The Trust should continue to monitor the security of the unit to be reviewed in line with national guidance.			Yes	Board Specific	Yes	A monthly audit programme commenced in January 2024 to monitor compliance with the Baby Abduction Policy with findings shared widely with the workforce. The frequency of Baby Abduction Drills has increased in 2024 with a drill undertaken quarterly and report shared with the Quality and Safety Group within the Clinical Board.	1) Estates improvements from the learning from 2022 annual Baby Abduction Drill undertaken and tested in the October 2023 Baby Abduction Drill. 2) The programme of Baby Abduction Drills has increased to quarterly frequency for 2024 with a successful drill undertaken in March 2024 and gaps in signage identified as a requirement to highlight the importance of tailgating. Further drills are scheduled as part of the drill programme this year and will include the Neonatal Intensive Care Unit and Delivery Suite. 3) In January 2024 twice monthly security audits were introduced to assess compliance with the Baby Abduction Policy. The learning from this audit has been shared with staff to highlight the importance of vigilance and tailgating. Audit data was reviewed in April 2024; while compliance with the Baby Abduction Policy has improved, the audit programme will remain in place until the next drill in order to gain assurance compliance continues to improve and is maintained. 4) A proposal for volunteer presence at Maternity Reception 10am-8pm is currently being explored as well as support from volunteers to commence a weekly 'Got In' programme where an individual will attempt to penetrate the department in order to maintain staff awareness and vigilance.	Live	Audit to remain in place for further 3 months until July 2024 in order to continue to monitor compliance.	Partially Compliant	2022 Baby Abduction Report and Action Plan 2023 Baby Abduction Report and Action Plan Security Audit and Infographics to share findings with the workforce
A-025	We will introduce a robust formal triage and escalation process within the maternity assessment unit.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations)	The Trust should continue work to introduce a robust formal triage and escalation process within the maternity assessment unit.			Yes	Board Specific	Yes	Monthly compliance reviewed at BSOTS Oversight Group and Staffing vs Outcome meeting. Triage Red Flags monitored and included in monthly ECN slide deck which is presented to Executive Directors.	1) The Trust implemented a bespoke electronic Maternity Triage system (BSOTS) in December 2023. A monthly audit programme has been implemented with monthly oversight for quality improvement.	Live	To continue to audit and monitor compliance for the duration of 2024.	Partially Compliant	BSOTS SOP BSOTS Dashboard BSOTS Monthly Oversight Group Action Log Staffing vs Outcome Action Log

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Unique Action ID	Action	Action Owner	INTERNAL - Additional Action Information	Must Do Desc	SRO	Trust Wide or Board Specific	1 - Family Health	How will compliance be evidenced		Progress Updates	Completion Status	Timescale for Completion	Link to Additional Resources
A-167	The risk assessment recorded on Badgernet will become a madatory field for completion at each contact with a health proffessional in line with the Ockenden IEA's with a monthly audit undertaken to monitor compliance for review at the monthly MDT Ockenden departmental meeting.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director)		The service must assess, monitor, and improve the quality and safety of the services and mitigate the risks relating to the health, safety and welfare of women, birthing people, and babies. Regulation 17(1)(2)(a)(b).	1	Board Specific	Board Specific	Monthly audit		1) The risk assessment field within the EPR became mandatory from 19.02.24; with a monthly audit undertaken thereafter. 2) Compliance for March 2024 was 100%.	Live	Ongoing with audit schedules to monitor compliance	Monthly audit
A-168	We will ensure we are meeting the needs of women, birthing people, and babies and mitigate risks associated with staffing, pregnancy risk assessments and security through monthly audit, monitoring of findings and remedial action plans as required.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations)		The service must ensure they are delivering fundamental standards of care that meets the needs of women, birthing people, and babies. This includes assessing the health and safety risks and doing all that is reasonably practicable to mitigate any such risks. This includes but is not limited to staffing, risk assessments and security. Regulation 12 (1)(2)(a)(b).		Board Specific	Board Specific	Birth Rate Plus Staffing Review; a daily staffing to acuity assesment in correlation with NENC Escalation Policy will be undertaken and shared regionally; with findings monitored at monthy Staffing vs Outcome oversight meeting Pregnancy risk assesment monthly audit Monthly security audit and quarterly baby abduction drills		1) A BirthRate+ staffing review was commissioned in October 2023, data collection is near completion with the recommendation expected in May 2024. Daily staffing to acuity assesments are undertake in correlation with NENY Escalation policy, shared regionally and monitored at the monthly Staffing vs Outcome oversight meeting with remedial actions plans as required. 2) The risk assessment field within the EPR became mandatory from 19.02.24; with a monthly audit undertaken thereafter. Compliance for March 2024 was 100%. 3) A monthly security audit programme commenced in January 2024 to monitor compliance with the Baby Abduction Policy with findings shared with the workforce. The frequency of Baby Abduction Drills increased in 2024 with a drill planned to be undertaken quarterly and report shared with the Quality Oversight Group within the Family Health Clinical Board.	Live	Current governance processes are robust but will be strengthened by these actions. BirthRate+ Staffing Review data collection to be completed in April 2024, with report expected May 2024.	BirthRate+ Staffing Review Daily NENY Sitrep Monthly Staffing vs Oversight Group Monitoring Template Pregnancy Risk Assessment Audit Twice Monthly Security Audit Quarterly Baby Abduction Drill reported to QOG within Family Health Clinical Board
A-169	Ensure there are sufficient numbers of competent, skilled and experienced midwifery and medical staff to meet minimum staffing levels and meet the care and treatment needs of women, birthing people, and babies.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations)		The service must ensure that there are sufficient numbers of competent, skilled, and experienced midwifery and medical staff to meet minimum staffing levels and meet the care and treatment needs of women, birthing people, and babies. This includes but is not limited to ensure that the skill mix supports the acuity of patients. Regulation 18 (1)(2)(a).		Board Specific	Board Specific	Birth Rate Plus Staffing Review; a daily staffing to acuity assesment in correlation with NENC Escalation Policy will be undertaken and shared regionally; with findings monitored at monthy Staffing vs Outcome oversight. Sufficent medical staff will be employed to support delivery of a 52 week model of service delivery.		1)A BirthRate+ staffing review was commissioned in October 2023, data collection is near completion with the recommendation expected in May 2024. Daily staffing to acuity assesments are undertake in correlation with NENY Escalation policy, shared regionally and monitored at the monthly Staffing vs Outcome oversight meeting with remedial actions plans as required. Midwifery and support staffing skill mix were reviewed in March 2024 as part of the 6 month 'pause' on Band 6 rotations and baseline requirements agreed for each ward/area. 2) In January 2024 a scoping exercise of medical staffing was undertaken to inform a business case for further recruitment. 3 roles are currently vacant with a further 3 opportunities available in the future. Due to an inability to appoint to the currently vacant role, support is being sought from the LMNS and Alliance.	Live	Current governance processes are robust but will be strengthened by these actions. BirthRate+ Staffing Review data collection to be completed in April 2024, with report expected May 2024.	BirthRate+ Staffing Review Daily NENY Sitrep Monthly Staffing vs Oversight Group Monitoring Template Midwifery and Support Staffing skill mix assessment Midwifery staff baseline for each area/ward Medical staffing business case Obstetric medical workforce planning document Safety Champion Meeting Minutes
A-170	Undertake a gap analysis of cardiotocography (CTGs), and cleaning equipment and prepare a business case to secure funding based on need to ensure the safety of women, birthing people, and babies.	Lucy Patterson (Head of Midwifery) Lisa Jordan (Associate Director of Operations)		The service must ensure there are sufficient quantities of cardiotocography (CTGs), central monitoring equipment and cleaning equipment to ensure the safety of women, birthing people, and babies. Regulation 12 (1)(2)(f).	2	Board Specific	Board Specific	A dedicated CTG machine will be available in each antenatal or high risk intrapartum bedspace within maternity services, at each station within Maternity Traige and Daycare, and 2 available on Newcastle Birthing Centre if required. Central monitoring equipment will be available within each antenatal and high risk intrapartum area and adequate cleaning equipment will be available when required.	CTG and central monitoring scoping exercise, gap analysis and Business Case; cleaning equipment scoping exercise	1) In January 2024 an exercise was completed to scope the number of CTG's and central monitoring equipment required to meet demand and procurement quotes were requested. 2) A Business Case was submitted to Capital Management Group and approved in February 2024. Equipment has now been delivered and work is ongoing with Digital and Estates colleague to facilitate the installation of central monitoring equiment in all Antenatal Areas.	Live	30th April 2024 for all equipment to be in use within the department	CTG business case Gap analysis
A-171	We will ensure that mandatory training compliance meets the Trust target by March 2024 and is maintained thereafter. The service will ensure that core competency training compliance meets nationally agreed targets within the MIS timeframe for Year 6, expected to be December 2023-24.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations)		The service must ensure that mandatory and core competency training compliance meets the trust target. Regulation 12 (1)(2)(c).	2	Board Specific	Board Specific	Midwifery and Support Staff Trustwide mandatory training is monitored on a monthly basis at the Directorate Management Group in collaboration with HR Manager, and medical staff at the monthly Consultants Meeting. Monthly monitoring of core competency training compliance against MIS target is undertaken at a monthly maternity training meeting and trajectory for achieving and sustaining agreed. This is reported bi-monthly to Quality Committee and Trust Board.	Trustwide manadatory training and core competency training compliance and trajectory for acheivement.	1) As at 16.04.24 Trustwide mandatory training compliance is as follows: Midwives 86%, Support Staff 88% and Medical Staff 90%. 2) As at 26.04.24 core competency training compliance is as follows: MDT Obstetric Emergencies Training Day 84%, Maternity Safety and Public Health in Practice Day 72% and Fetal Wellbeing Training 70%; the service is on target to acheive MIS compliance within nationally agreed timeframe for Year 6.	Live	Trust wide mandatory training target of 95% compliance to be met by 30th April 2024 and sustained thereafter. Maternity specific training compliance will meet the requirements of MIS.	DMT Meeting Minutes Monthly HR Dashboard Monthly Maternity Training Meeting Minutes Monthly Consultants Meeting Minutes Quality Committee Paper Trust Board Paper
A-172	EBME/Estates Engineering to implement ward based zonal inspection and develop compliance reporting mechanism for clinical boards including non-patient doors security checks in zonal inspections	Lucy Patterson (Head of Midwifery) Lisa Jordan (Associate Director of Operations)	To be compared against the Trust level action when populated	The service must ensure premises are safe. This includes but is not limited to ensuring storeroom doors are not left open or unlocked. Regulation 12 (1)(2)(d).	2					1) Further discussion with Estates colleagues to be undertaken to finalise actions and timeframes. 2) Adhoc audits are undertaken by the Head of Midwifery on a monthly basis as well as increased awareness rasied when all senior leaders are present in clinical areas. In April 2024, this was formally added to the Weekly Leaders Assurance Checklist.	Live	Compliant, with mechanism for ongoing monitoring and reporting to ensure embedded practice.	Weekly Leaders Assurance Checklist from April 2024 Monthly HoM Audit
A-173	Develop a targeted and reactive approach to areas of under reporting, and with Q & S Leads, CDs for Quality and Safety and Heads of Nursing/Matron's provide proactive support to promote and encourage incident reporting and learning.	Rhona Collis (Quality and Clinical Effectiveness Midwife)	To be compared against the Trust level action when populated	The service must ensure it encourages the identification, reporting and investigation of incidents and risks in a timely fashion and shares learning to improve safety and quality of the service. Regulation 17 (2)(b).						1) The NED and Board Level Safety Champions have had accompanied and unaccompanied presence within the Maternity and Neonatal Department and have a schedule of future dates that staff are aware of for future engagement opportunites. These are publicised in Newsletters and listed on the Patient Safety Board. 2) The Family Health Clinical Board had their first 27th March 24 with attendance from The Freedom to Speak Up Guardian outlining her role for the future. Further Clinical Board Events are planned for the future. 3) In addition to communications Trustwide to close the loop on learning and recognise areas of practice that have gone well in Maternity Services, the 'Risky Business Newsletter' is published quarterly across the workforce. This includes a section on the support available to staff.	Live		Safety Champion Information Risky Business
A-298	We will ensure newly qualified midwifery staff receive the appropriate support, training, professional development, and supervision as is necessary to carry out their duties. Note link to trust wide action	Lucy Patterson (Head of Midwifery)		The service must ensure newly qualified midwifery staff receive the appropriate support, training, professional development, and supervision as is necessary to enable them to carry out their duties. Regulation 18 (1) (2) (a)		Board Specific	Board Specific	The service has a robust preceptorship programme comprised of bootcamp style training followed by bespoke supervised supernumary supported rotations in each area of maternity services tailored as required on an individual basis to the needs of the midwife. Regular touch point meetings are offered and conducted when accepted with newly qualified midwives throughout the first year of employment by the Recruitment Retention and Pastoral Care Midwife, Practice Development Midwife and Team Leaders.	Preceptorship programme for supervision and support in place for each newly qualified Midwife with evaluation a 6 and 12 months post recruitment.	Over the past 12 months we have welcomed 38 midwives into Maternity Services and are supporting bespoke preceptorship programmes for them pending evaluation.	Live	Ongoing in line with rolling recruitment programme	Preceptorship Programme Preceptorship Experience Evaluation at 6 and 12 months
A-299	We will ensure the guidance within the PPH policy is clear about the definition and grading of maternal blood loss in accordance with national guidelines.	Paul Moran (Clinical Director)		The service should ensure the guidance within their PPH policy is clear about defining and grading maternal blood loss in accordance with national guidance.		Board Specific	Board Specific	A PPH audit was undertaken and Badgernet documentation reviewed.		1) A guideline review was undertaken in November 2023 and found to be compliant with national guidance. A PPH audit and Badgernet documentation review was undertaken in Q3 and highlighted double recording of PPH MBL on Badgernet . 2) In March 2024 a retrospective audit for January-March 2024 was undertaken to assess the consistent reporting and grading of PPH via Datix. Underreporting of PPH via datix was found when cross referenced with the EPR; this has been communicated with all staff and a monthly audit will continue to ensure improvement in appropriate reporting.	Live	Jun-24	Maternity Dashboard Audit data and workforce wide communication of findings
A-300	We will ensure clinical sharps waste bins are labelled in accordance with national guidance.	Lucy Patterson (Head of Midwifery)		The service should ensure that clinical sharps waste bins are dated and labelled in accordance with national guidance.		Board Specific	Board Specific	Monthly adhoc audits will be undertaken within each clinical area for 3 months to monitor compliance.		1) A monthly audit was undertaken by the Head of Midwifery in February and March 2024. 2) Compliance was noted to reduce in April 2024 and so a Breifing in a Minute was shared with all staff within Maternity Services, further monthly audit is scheduled for the 3 months following this communication to monitor compliance in each clinical area.	Live	Jun-24	Briefing in a Minute Audit data

Three Year Plan Guidance, themes, objectives and deliverables

Objective	Ref No:	Deliverable	Trusts	Trust Benchmark Status	ICB	NHS England
Theme 1: Listening to and working with women and families with compassion **Measures: Indicators from CQC Maternity Survey / Perinatal pelvic health services in place / UNICEF BFI accreditation / Number of women accessing perinatal mental health services / CQC inspection / CNST Maternity Incentive Scheme**						
Objective 1: Care that is personalised	1.1	Empower maternity and neonatal staff to deliver personalised care so they have the time, training, tools, and information, to deliver the ambition above.	✓	Partially compliant: Progressing		
	1.2	Monitor the delivery of personalised care by undertaking regular audits and seeking feedback from women and parents.	✓	Partially compliant: Progressing		
	1.3	Consider roll out midwifery continuity of carer in line with the principles NHS England set out in September 2022	✓	Paused		
	1.4	Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027.	✓	Partially compliant: Progressing		
	1.5	Commission for and monitor implementation of personalised care.			✓	
	1.6	Commission and implement by the end of March 2024, in line with national service specifications, Perinatal pelvic health services, to identify, prevent, and treat common pelvic floor problems in pregnant women and new mothers .			✓	
	1.7	Commission and implement by the end of March 2024, in line with national service specifications: Community perinatal mental health services including maternal mental health services, to improve the availability of mental health care.			✓	
	1.8	Work with service users and other partners to produce standardised information focused on priorities identified by service users: intrapartum interventions, mode of birth, induction of labour and pain relief.				✓
	1.9	Extend the national support offer to help services to achieve UNICEF BFI accreditation or an equivalent initiative.				✓

	1.10	Publish national postnatal care guidance, setting out the fundamental components of high-quality postnatal care, to support ICSs with their local improvement initiatives by the end of 2023. Information for GPs on the 6-8 week postnatal check will be published in spring 2023.				✓
	1.11	In April 2023, publish a national service specification for perinatal pelvic health services alongside associated implementation guidance.				✓
	1.12	Create a patient reported experience measure (PREM) by 2025 to help trusts and ICBs monitor and improve personalised care.				✓
	1.13	By March 2024, act on findings from the evaluation of independent senior advocate pilots, as set out in the first Ockenden report				
	1.14	Invest to ensure daily availability of bereavement services 7 days a week by the end of 2023/24. This will help trusts to provide high quality bereavement care including appropriate post-mortem consent and follow-up.				✓
Objective 2: Improve equity for mothers and babies	2.1	Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings	✓	Partially compliant: Progressing		
	2.2	Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds and improve care. This data should be used to make changes to services and pathways to address any inequity or inequalities identified.	✓	Partially compliant: Progressing		
	2.3	Publish and lead implementation of their LMNS equity and equality action plan alongside neonatal ODNs, including work across organisational boundaries.			✓	
	2.4	Commission MNVPs to reflect the ethnic diversity of the local population and reach out to seldom heard groups.			✓	
	2.5	Provide regional and national support for the implementation of LMNS equity and equality action plans.				✓
	2.6	Pilot and evaluate new service models built for reducing inequalities including enhanced midwifery continuity of carer and culturally sensitive genetics services for couples practising close relative marriage in high need areas.				✓
Objective 3: Work with service users to improve care	3.1	Involve services users in quality, governance and co-production when planning the design and delivery of maternity and neonatal services	✓	Compliant		
	3.2	Commission and fund MNVPs, to cover each trust within their footprint, reflecting the diversity of the local population in line with the ambition above.			✓	
	3.3	Remunerate and support MNVP leads, and ensure that an annual, fully funded workplan is agreed and signed off by the MNVP and the ICB. All MNVP members should have reasonable expenses reimbursed.			✓	

	3.4	Ensure service user representatives are members of the local maternity and neonatal system board.			✓	
	3.5	Co-produce national policy and quality improvement initiatives with national and regional service user representatives and MNVP leads.				✓
	3.6	Through operational delivery networks, support parent representation in governance of neonatal services.				✓
	3.7	Provide funding for clinical leadership and programme management of ICBs, which includes funding to support service user involvement				✓
Theme 2: Growing, retaining, and supporting our workforce **Measures: Staff surveys / education & medical training surveys / vacancy & turnover rates for staff groups / CQC inspection / CNST Maternity Incentive Scheme**						
Objective 4: Grow our workforce	4.1	Undertake regular local workforce planning, using nationally standardised tools where available, to establish the workforce required for each profession at every stage of care. Where trusts do not yet meet the staffing establishment levels set by Birthrate+ or equivalent tools, do so by 2027/28, and in future meet the expectations from nationally recognised tools for other professions.	✓	Partially compliant: Progressing		
	4.2	Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and midwives who wish to return to practice.	✓	Partially compliant: Progressing		
	4.3	Provide administrative support to free up pressured clinical time.	✓	Partially compliant: Progressing		
	4.4	Commission and fund safe staffing across their system			✓	
	4.5	Agree staffing levels with trusts for those professions where a nationally standardised tool has not yet been developed. National guidance should be considered when determining staffing levels (for example, Guidelines for the Provision of Anaesthesia Services for an Obstetric Population, Royal College of Anaesthetists, 2023; Implementing the Recommendations of the Neonatal Critical Care Transformation Review)			✓	
	4.6	Align commissioning of services to meet the ambitions outlined in this document with the available workforce capacity. It is envisaged that from 2024/25 ICBs will assume delegated responsibility for the commissioning of neonatal services.			✓	
	4.7	Work with trusts and higher education institutions to maximise student placement capacity, ensuring the effectiveness and quality of clinical placements.			✓	

	4.8	Assist trusts and regions with their workforce growth plans by providing direct support, including through operational delivery networks for neonatal staffing.				✓
	4.9	Boost midwifery workforce supply through undergraduate training, apprenticeships, postgraduate conversion, return to midwifery programmes, and international recruitment.				✓
	4.10	Increase medical training places across obstetrics and gynaecology and anaesthetics to expand the consultant workforce in maternity services.				✓
	4.11	Collaborate with the Royal College of Obstetricians and Gynaecologists (RCOG) to support their work developing an obstetric workforce planning tool, to be published in 2023/24. This initiative will help establish the staffing levels required to appropriately resource clinical leadership and intrapartum care.				✓
	4.12	Established midwifery posts have increased by over 2,000 WTE since March 2021, with obstetric consultant posts and maternity support worker posts each increasing by around 400 WTE since April 2021. For neonatal services, we have invested to establish over 550 new neonatal nurses, care-coordinators, and workforce and education leads, and have committed to funding 130 WTE new allied health professional and over 40 WTE new psychologist posts.				✓
Objective 5: Value and retain our workforce	5.1	Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan.	✓	Partially compliant: Progressing		
	5.2	Implement equity and equality plan actions to reduce workforce inequalities.	✓	Partially compliant: Progressing		
	5.3	Create an anti-racist workplace, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates resource	✓	Partially compliant: Progressing		
	5.4	Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey	✓	Partially compliant: Progressing		
	5.5	Offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time. Newly appointed Band 7 and 8 midwives should be supported by a mentor.	✓	Compliant		
	5.6	Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce.	✓	Partially compliant: Progressing		
	5.7	Share best practice for retention and staff support			✓	
	5.8	Highlight common or high-impact retention challenges to the national team to enable consideration of a national approach.			✓	

	5..9	Support retention with funding to continue a retention midwife in every maternity unit during 2023/24, with ICBs maintaining the focus on retention thereafter.				✓
	5.10	Continue to invest in neonatal operational delivery network (ODN) education and workforce leads to support the recruitment and retention of neonatal staff.				✓
	5.11	In 2023/24, provide funding to establish neonatal nurse quality and governance roles within trusts, to support cot-side clinical training and clinical governance.				
	5.12	In 2023/24, strengthen neonatal clinical leadership. Continue to address workforce inequalities through the Workforce Race Equality Standard. National clinical director for neonatal and national neonatal nurse lead.				✓
	5.13	Continue to address workforce inequalities through the Workforce Race Equality Standard.				✓
	5.14	Provide national guidance for implementation of the A-Equip model and for the professional midwifery advocate role to provide restorative clinical supervision in local services.				✓
	5.16	By April 2024, develop a framework and models for coaching, to improve the quality of midwifery student clinical placements.				✓
Objective 6: Invest in skills	6.1	Undertake an annual training needs analysis and make training available to all staff in line with the core competency framework.	✓	Partially compliant: Progressing		
	6.2	Ensure junior and SAS obstetricians and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively.	✓	Compliant		
	6.3	Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums.	✓	N/A		
	6.4	Refresh the curriculum for maternity support workers (MSWs) by June 2023.				✓
	6.5	Provide tools to support implementation of the MSW competency, education, and career development framework by September 2023.				✓
	6.6	Work with RCOG to develop leadership role descriptors for obstetricians by summer 2023 to support job planning, leadership, and development				✓
	6.7	Work with Royal Colleges and professional organisations to understand and address the challenges involved in recruiting and training the future neonatal medical workforce.				✓
	6.8	Through action set out above to grow the workforce, help to address pressures on backfill for training.				✓
	Theme 3: Developing and sustaining a culture of safety, learning, and support					

		Measures: Staff surveys / education & medical training surveys / appreciative inquiry / CQC inspection				
Objective 7: Develop a positive safety culture	7.1	Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. Including time to engage stakeholders, including MNVP leads.	✓	Partially compliant: Progressing		
	7.2	Support all their senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes (see below) by April 2024, identifying and sharing examples of best practice.	✓	Compliant		
	7.3	At board level, regularly review progress and support implementation of a focused plan to improve and sustain maternity and neonatal culture	✓	Partially compliant: Progressing		
	7.4	Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit.	✓	Partially compliant: Progressing		
	7.5	Ensure all staff have access to Freedom to Speak Up training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways.	✓	Partially compliant: Progressing		
	7.6	Monitor the impact of work to improve culture and provide additional support when needed.			✓	
	7.7	Provide opportunities for leaders to come together across organisational boundaries to learn from and support each other.			✓	
	7.8	By April 2024, offer the Perinatal Culture and Leadership Programme to all maternity and neonatal leadership quadrumvirates. This includes a diagnosis of local culture through a culture survey and provides practical support to nurture culture and leadership.				✓
Objective 8: Learn and improve	8.1	Understand 'what good looks like' to meet the needs of their local populations and learn from when things go well and when they do not.	✓	Partially compliant: Progressing		
	8.2	Respond effectively and openly to patient safety incidents using PSIRF.	✓	Partially compliant: Progressing		
	8.3	Ensure there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale.	✓	Partially compliant: Progressing		
	8.4	Consider culture, ethnicity and language when responding to incidents (NHS England, 2021).	✓	Compliant		
	8.5	Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well.	✓	Compliant		

	8.6	Share learning and good practice across all trusts in the ICS.			✓	
	8.7	Oversee implementation of the PSIRF safety improvement plan, monitoring the effectiveness of incident response systems in place.			✓	
	8.8	Support the transition to PSIRF through national learning events.				✓
	8.9	Through regional teams, share insights between organisations to improve patient safety incident response systems and improvement activity.				✓
Objective 9: Support and oversight	9.1	Maintain an ethos of open and honest reporting and sharing information on the safety, quality and experience of their services.	✓	Compliant		
	9.2	Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the perinatal quality surveillance model and informed by the national maternity dashboard.	✓	Compliant		
	9.3	Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions.	✓	Compliant		
	9.4	Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.	✓	Partially compliant: Progressing		
	9.5	At Board level listen to and act on Freedom to Speak Up data, concerns raised and suggested innovations in line with the FTSU Guide and improvement tool.	✓	Partially compliant: Progressing		
	9.6	Commission services that enable safe, equitable and personalised maternity care for the local population.			✓	
	9.7	Oversee quality in line with the PQSM and NQB guidance, with maternity and neonatal services included in ICB quality objectives.			✓	
	9.8	Lead local collaborative working, including the production of a local quality dashboard that brings together intelligence from trusts.			✓	
	9.9	National bodies, ICBs and trusts to address issues escalated to national level.				✓
	9.10	Provide nationally consistent support for trusts that need it through the Maternity Safety Support Programme (MSSP).				✓
	9.11	Work to align the MSSP with the NHS oversight framework and improve alignment with the recovery support programme and evaluate the programme by March 2024.				✓
	9.12	During 2023/24, test the extent to which the PQSM has been effectively implemented				✓
	9.13	By March 2024, provide targeted delivery of the Maternity and Neonatal Board Safety Champions Continuation Programme to support trust board assurance, oversight of maternity and neonatal services, and a positive safety culture.				✓

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care Measures: existing safety ambition themes – maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, preterm births / implementation of saving babies lives care bundle v3 / avoiding term admissions to NICU / CQC inspection / CNST Maternity incentive scheme						
Objective 10: Standards to ensure best practice	10.1	Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025.	✓	Partially compliant: Progressing		
	10.2	Regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services.	✓	Compliant		
	10.3	Complete the national maternity self-assessment tool if not already done, and use the findings to inform maternity and neonatal safety improvement plans.	✓	Partially compliant: Progressing		
	10.4	Prioritise areas for standardisation and co-produce ICS-wide clinical policies such as for implementation of the Saving Babies' Lives Care Bundle.			✓	
	10.5	Oversee and be assured of trusts' declarations to NHS Resolution for the Maternity Incentive Scheme.			✓	
	10.6	Monitor and support trusts to implement national standards.			✓	
	10.7	Commission care that has regard to NICE guidelines.			✓	
	10.8	Keep best practice up to date through version 3 of the Saving Babies Lives Care Bundle and the MEWS and NEWTT-2 tools, as well as developing tools to improve the detection and response to suspected intrapartum fetal deterioration.				✓
	10.9	By spring 2024, identify the common challenges trusts and ICSs face in meeting national standards, and take action where national solutions may help.				✓
	10.10	Support the integration of MEWS, NEWTT-2, and other clinical tools into existing digital maternity information systems by autumn 2024.				✓
	10.11	Provide support to capital projects to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.				✓
	10.12	Provide support to capital projects to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.				✓
Objective 11: Data to inform learning	11.1	Review available data to draw out themes and trends and identify and address areas of concern including consideration of the impact of inequalities.	✓	Partially compliant: Progressing		

	11.2	Ensure high-quality submissions to the Maternity Services Data Set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and National Perinatal Epidemiology Unit.	✓	Partially compliant: Progressing		
	11.3	Use data to compare their outcomes to similar systems and understand any variation and where improvements need to be made.			✓	
	11.4	At a regional level, understand any variation in outcomes and support local providers to address identified issues.				✓
	11.5	Convene a group to progress the recommendation from the Kirkup report for an early warning system to detect safety issues within maternity and neonatal services, reporting by autumn 2023.				✓
	11.6	Create a single notification portal by summer 2024 to make it easier to notify national organisations of specific incidents.				✓
	11.7	Publish a digital version of the national recommendations register by summer 2024, to support trusts to learn from and comply with national recommendations.				✓
Objective 12: Make better use of digital technology in maternity and neonatal services	12.1	Have and be implementing a digital maternity strategy and digital roadmap in line with the NHS England What Good Looks Like Framework.	✓	Compliant		
	12.2	Procure an EPR system – where that is not already being managed by the ICB – that complies with national specifications and standards, including the Digital Maternity Record Standard and the Maternity Services Data Set and can be updated to meet maternity and neonatal module specifications as they develop.	✓	Compliant		
	12.3	Aim to ensure that any neonatal module specifications include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set.	✓	Compliant		
	12.4	Have a digital strategy and, where possible, procure on a system-wide basis to improve standardisation and interoperability.			✓	
	12.5	Support women to set out their personalised care and support plan through digital means, monitoring uptake and feedback from users.			✓	
	12.6	Support regional digital maternity leadership networks.			✓	
	12.7	Set out the specification for a compliant EPR, including setting out the requirements for maternity by March 2024.				✓
	12.8	Publish a refreshed Digital Maternity Record Standard and Maternity Services Data Set standard by March 2024.				✓
	12.9	Grow the digital leaders' national community, providing resources, training and development opportunities to support local digital leadership.				✓
	12.01	Incorporate pregnancy-related data and features into the NHS App to enhance the facility for women to view their patient records via the NHS app.				✓

	12.11	Develop facets of a Digital Personal Child Health Record with citizen-facing tools to support neonatal and early years health by March 2025.				✓

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024					
Title	Maternity Incentive Scheme (MIS) Year 6 (CNST)					
Report of	Angela O'Brien, Director of Quality and Effectiveness					
Prepared by	Rhona Collis, Quality and Clinical Effectiveness Midwife/ Lucy Patterson, Head of Midwifery					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☒		☒		☐	
Summary	The NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity incentive scheme invites Trusts, in this Year 6 scheme, to provide evidence of their compliance using self-assessment against ten maternity safety actions. The scheme intends to reward those Trusts who have implemented all elements of the 10 Maternity Safety Actions. This is the first report regarding the 10 safety actions in the Year 6 scheme which were published on the 2 April 2024.					
Recommendation	The Trust Board are asked to note the contents of this report and approve the self- assessment to date to enable the Trust to provide assurance that the required progress with the standards outlined are being met.					
Links to Strategic Objectives	Putting patients first and providing care of the highest standard focusing on safety and quality. Enhancing our reputation as one of the country's top, first class teaching hospitals, promoting a culture of excellence in all that we do.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☐	☐	☐
Link to Board Assurance Framework [BAF]	SO1.4 [high-quality safe care] SO2.4 [statutory and mandatory training] Failure to comply with the ten safety action standards could impact negatively on maternity safety, result in financial loss to the Trust from the incentive scheme and from potential claims.					
Reports previously considered by	This is the first report for Year 6 of this Maternity Incentive Scheme.					

MATERNITY INCENTIVE SCHEME (MIS) YEAR 6 (CNST): MATERNITY SAFETY ACTION COMPLIANCE

EXECUTIVE SUMMARY

The NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme invites Trusts, in this Year 6 scheme, to provide evidence of their compliance using self-assessment against ten maternity safety actions. The scheme intends to financially reward those Trusts who have implemented all elements of the 10 Maternity Safety Actions. In addition, completion of all 10 Safety Actions upholds the reputation of the Trust in relation to the quality of care provision within the Maternity Service.

The Year 6 CNST safety actions were published on the 2 April 2024. There have been minor changes to the requirements from year 5 and these will be considered in this report.

The final submission date for year 6 is 3 March 2025. For Safety Actions 1, 8 and 10 the relevant time period continues from when the previous year finished – 1st December 2023 to 30 November 2024. For the remaining safety actions (2,3,4,5,6,7,9) the relevant time period starts from 2 April 2024 to 30 November 2024.

The Trust has undertaken a gap analysis on the Year 6 requirements and is confident that all ten safety actions can be met.

MATERNITY INCENTIVE SCHEME YEAR 6 (CNST): MATERNITY SAFETY ACTION COMPLIANCE

1. BACKGROUND TO CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) MATERNITY INCENTIVE SCHEME – YEAR 6

Maternity safety is an important issue for Trusts nationally as obstetric claims represent the scheme's biggest area of spend (£6,033.4 million in 2021/22). Of the clinical negligence claims notified to NHS Resolution in 2021/22, obstetric claims represented 12% of the volume and 62% of the value.

NHS Resolution is operating a sixth year of the CNST Maternity Incentive Scheme which continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

This scheme intends to reward those Trusts who have implemented all elements of the 10 maternity safety actions, enabling Trusts to recover the element of their contribution relating to the CNST incentive fund, and by receiving a share of any unallocated funds. Failure to achieve compliance against the safety actions will result in the Trust not achieving the 10% reduction in maternity premium which NHS Resolution has identified and the reputation of the Trust may be negatively affected in relation to the quality of care provision, within the Maternity Service.

To be eligible for the incentive payment for this scheme, the Board must be satisfied there is comprehensive and robust evidence to demonstrate achievement of all of the standards outlined in each of the 10 Safety Actions.

The Trust Board declared full compliance with all 10 maternity safety actions for Years 1 to 4 of this scheme. Confirmation of the Trust's achievement in fully complying with all 10 standards, was confirmed by NHS resolution and the Trust was rewarded, for Year 1, Year 2, Year 3, and Year 4, with £961k, £781k, £877k and £707k respectively in recognition of this achievement. In addition, the Trust also received £463k for year 4 – which was a share of the surplus funds in respect of Trusts that did not achieve ten out of ten actions. In year 4, 52% Trusts achieved full compliance with all ten safety actions.

In year 5 the Trust declared full compliance with 8 of the safety actions. The Trust had been informed of the challenges with achieving full compliance with the two safety actions – 6 and 8, throughout the year and it was disappointing to be in this position despite robust planning to achieve all ten safety actions. Both elements 6 and 8 had several training requirements which the Trust were unable to meet due to ongoing staffing challenges and clinical need taking priority. The Trust has been notified that they will be awarded up to £200k to assist them achieve the safety actions they did not meet in year 5.

2. SAFETY ACTION UPDATE

This paper provides a report on each safety action and the current position.

2.1 Safety Action 1: Are you using the National Perinatal Mortality Review. Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

a) **Notify all deaths:** *All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days.*

b) **Seek parents' views of care:** *For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.*

c) **Review the death and complete the review:** *For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.*

The Trust is fully compliant with these 3 standards. A database of all cases is maintained and there are robust systems in place to ensure these timescales are met as recommended by the PMRT Standard Operating Procedure.

d) **Report to the Trust Executive:** *Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.*

The quarterly PMRT report for Q3 is included in this report as per the requirements of this safety action and can be found in the Private Board papers.

2.2 Safety Action 2: Are you submitting data to the Maternity Service Data Set (MSDS) to the required standard?

This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.

a) Trust Boards to assure themselves that at least 10 out of 11 MSDS-only (see technical guidance) Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024. Final data for July 2024 will be published during October 2024.

The Trust achieved 11 out of 11 for the data submitted in February 2024.

b) *July 2024 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001).*

In February the Trust achieved 81% compliance with this requirement. In order to achieve full compliance the data needs to be manually amended. The Ethnicity field is submitted via eRecord, which may be 'unknown' at the time of data entry. The maternity electronic patient records (BadgerNet) will have the correct Ethnicity status recorded but this is not automatically updated in eRecord hence the need for manual correction. This issue is currently under review by the IT team. In the interim the data can be manually amended to achieve 90% compliance and the Trust will ensure this is undertaken prior to the July 2024 data upload.

2.3 Safety Action 3: Can you demonstrate that you have Transitional Care (TC) Services in place and undertaking quality improvement to minimize separation of parents and their babies?

a) *Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice*

or

Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards.

The Trust opened a stand-alone Transitional Care unit on the 22 April 2024. The pathway used previously for this safety action is being revised to reflect the new service in alignment with the BAPM Framework.

b) *Drawing on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and LMNS.*

This is a new requirement for safety action 3. A working group is being established to discuss the proposed QI project.

2.4 Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

a) Obstetric medical workforce

1). *NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:*

I. *Currently work in their unit on the tier 2 or 3 rota*

or

II. *have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)*

or

III. *hold a certificate of eligibility (CEL) to undertake short-term locums.*

Short term locums in Obstetrics and Gynaecology on tier 2 or 3 have been appointed to cover periods of sickness and industrial action within the past year. All locums have been from within our current cohort, or in 1 case during October from the previous year's cohort (an ST6 on Tier 3). All hold eligibility through the RCOG certificate. All Obstetric Consultant locum cover has been provided by the current Consultant cohort.

2). *Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings.* *rcog-guidance-on-the-engagement-of-long-term locums-in-mate.pdf*

The Trust does not currently have any staff employed as long term locums within Obstetrics. There are, however, significant vacancies at Consultant level which are out to advert. In the short term the frequency for Consultants on call residency has increased from 1 in 12 to 1 in 9 to address the shortfall for the acute service. We anticipate support from regional Consultant colleagues for elective daytime work until Consultant Obstetrician numbers can recover. In addition to the 25% shortfall, a business case was submitted to the Trust in April 2024 to increase the cohort by 3 further Consultant Obstetrician posts.

3) *Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following*
day. ***While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.***
rcog-guidance-on-compensatory-rest.pdf

The Trust provides 98 hour Consultant resident presence for the acute service. To do so with

current vacancy factor (25%) requires a rota of 1 in 9 24 hour on call residency shifts for Consultants; this is followed by a day of compensatory rest. The junior doctors work a 1 in 8 rota with fully compliant compensatory rest periods before and after their shifts.

4). *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 service roles-responsibilities-consultant-report.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.*

The Consultant attendance audit continues to show overall attendance of 100% with the occasional 1 clinical scenario where they were unable to attend but a tier 6/7 trainee was in attendance. Inconsistency of audit methodology across the region for this standard has been identified, this will be further explored at an LMNS meeting on the 3 May 2024 to clarify and agree methodology moving forward.

The next report will be presented to the Obstetric Governance Group on the 14 May 2024 which covers the period January to March 2024 with an update report also presented at the next Maternity Board Level Safety Champions meeting on the 12 June 2024.

b) Anaesthetic medical workforce

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation(ACSA) standard 1.7.2.1)

The Trust is confident that full compliance can be achieved with this element, as in previous years. An audit of one months rota will be reviewed in June 2024 and findings included in the July 2024 Trust Board report.

c) *Neonatal medical workforce*

The neonatal unit meets the relevant BAPM national standards of medical staffing.

or

the standards are not met, but there is an action plan with progress against any previously developed action plans.

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

A Workforce paper will be presented to the Maternity Board Level Safety Champions on the 12 June 2024 outlining the current position with the neonatal medical workforce.

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards.

Or

The standards are not met, but there is an action plan with progress against any previously developed action plans.

Any action plans should be shared with the LMNS and Neonatal ODN.

A neonatal nursing workforce review was undertaken in November 2023 which identified the Trust did not meet the BAPM neonatal nursing standards. An action plan was developed and shared with the LMNS and Neonatal Operational Delivery Network. A repeat Neonatal Nursing Workforce review is scheduled for May 2024. There has been progress with the action plan with ongoing monitoring of the outstanding issues.

2.5 Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.

The Trust completed the BirthRate+ workforce calculation in April 2024 with the report outlining recommendations expected in May 2024.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

Upon receipt of the revised staffing recommendation report a full workforce review will be undertaken by the incoming Director of Midwifery upon commencement in post in June 2024.

*c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator **at the start of every shift**) to ensure there is an oversight of all birth activity with the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.*

This requirement has been amended this year to re-iterate the supernumerary coordinator must be identified at the start of every shift. The Maternity Escalation Policy will be amended to reflect this change, however, given the tertiary status of the

unit, the supernumerary status of the coordinator for the entirety of the shift will remain Trust aspiration.

In the 11 month period from May 2023 to March 2024 there were 10 occasions whereby the co-ordinator was not supernumerary for part of the shift due to an escalation in activity for a short period of the shift.

d) *All women in active labour receive one-to-one midwifery care.*

In the 11 month period from May 2023 to March 2024 there were 11 occasions whereby 1:1 care was not provided.

For year 5 an action plan was signed off by the Trust Board outlining how c) and d) could be achieved.

For year 6 this time period starts from 2 April 2024. An update will be provided for the Trust Board in July 2024.

e) *Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.*

A midwifery staffing report has been included in the Executive Director of Nursing's Nursing and Midwifery Staffing report to Trust Board for the 30 May 2024. A further report will be provided in November 2024.

2.6 Safety Action 6: Can you demonstrate that you are on achieving compliance with all elements of the 'Saving Babies Lives' Care Bundle Version 3?

Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.

The Trust failed to meet full compliance with this safety action in year 5.

The meetings have been scheduled with the ICB. The first one was held on the 12 April 2024 and a further one is scheduled for 8 May 2024. The Trust achieved 76% compliance at the time of year 5 submission and has made progress since, working towards full compliance. One of the challenges remains achieving the compliance rates for the Stop Smoking targets. Additional resources have been provided to help the Trust achieve the targets and this will be monitored closely to ensure the compliance rates are achievable.

2.7 Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services within users.

1. *Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting:*

    a) Engagement and listening to families
    b) Strategic influence and decision-making.
    c) Infrastructure.

2. *Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.*

The Trust is confident in achieving full compliance with this safety action as the MVNP relationship with the Trust is well established and already meets each element of the safety action.

2.8 Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

90% of attendance in each relevant staff group at:

1. *Fetal monitoring training*
2. *Multi-professional maternity emergencies training*
3. *Neonatal Life Support Training*

See technical guidance for full details of relevant staff groups.

ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for MIS.

It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.

The Trust failed to meet full compliance with this safety action for year 5. Although there was a robust plan in place to deliver the training with a trajectory that would meet compliance, training sessions were cancelled due to staffing challenges.

For year 6 the training has been allocated with an achievable trajectory. The current position is (12 month period April 23 – April 24) :

(Table 1. Fetal Monitoring Training Day)

Staff Group	Percentage trained
Midwives including Midwifery Managers, Matrons, Community Midwives,	

Midwifery Led Unit Midwives and Bank Midwives	71%
Obstetric Consultants	67%
Obstetric trainees	63%
Total	**67%**

Table 2. Multi-professional maternity emergencies training

Staff Group	Percentage trained
Midwives including Midwifery Managers, Matrons, Community Midwives, Midwifery Led Unit Midwives and Bank Midwives	85%
HCA/MSW/NN	81%
Theatre Staff	100%
Obstetric Consultants	75%
Anaesthetists	92%
Obstetric Trainees	87%
Anaesthetic trainees	84%
Total	**86%**

Table 3. Neonatal Life Support training

Staff Group	**Percentage trained**
Neonatal Staff	86%
Midwives	85%
Total	**85%**

The Trust will continue to monitor the progress of compliance rates monthly so that the 90% target – for all staff groups – will be achieved by the 30 November 2024 timeframe.

2.9 <u>Safety Action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on Maternity and Neonatal Safety and Quality issues.</u>

a) All Trust requirements of the PQSM must be fully embedded.

b) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a

local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.

c) All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures.

The Trust is confident of achieving full compliance with this safety action. A new safety intelligence maternity dashboard is being developed and a further update will be provided for the July 2024 Trust Board report.

2.10 Safety Action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notifications (EN) Scheme from 8 December 2023 to 30 November 2024?

a) Reporting of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.

b) Reporting of all qualifying EN cases to NHS Resolution's Early Notification from 8 December 2023 until 30 November 2024.

c) For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that:

i. the family have received information on the role of MNSI and NHS Resolution's EN scheme; and

ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

The Trust has reported 2 qualifying cases to MNSI and NHS Resolution since 8 December 2023. All of the above requirements have been met.

3. CONCLUSION

It is acknowledged that to achieve full compliance with all ten safety actions remains a challenge but the Trust is confident these can be achieved in year 6 . Safety actions 6 and 8 will be monitored closely. Progress meetings continue every two weeks within the Maternity Department to enable direct oversight and support to be made by the Head of Midwifery and Clinical Director. Bi-monthly meetings with the Maternity Board level Safety Champions continue and issues of concern in relation to CNST compliance are discussed.

4. RECOMMENDATIONS

To (i) note the content of this report, (ii) comment accordingly and (iii) approve.

Report of Angela O'Brien
Director of Quality & Effectiveness
16 May 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024					
Title	Learning from Deaths - Quarter 4 (January 24- March 24)					
Report of	Angela O'Brien, Director of Quality and Effectiveness					
Prepared by	Jenny Simpson, Patient Safety Manager					
Status of Report	Public		Private		Internal	
	☒		☐		☒	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☒		☐	
Summary	This paper aims to provide assurance to the Board that the processes for Learning from Deaths across the organisation are in line with best practice as defined in the National Quality Boards (NQB) National Guidance on Learning from Deaths (LFD) March 2017, and guidance on working with bereaved families and carers (July 2018). This paper also summarises the processes that are in place to provide assurance to the Board that all deaths are reviewed including those with potentially modifiable factors. All deaths that require a more in-depth review (level 2) are recorded into the mortality review database to ensure lessons are learned and shared.					
Recommendation	The Board is asked to (i) receive the report and (ii) note the actions taken to further develop the mechanisms for sharing learning across the Trust.					
Links to Strategic Objectives	Putting patients first and providing care of the highest standard focusing on safety and quality • Put patients and carers first and plan services around them					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☐	☒	☐
Link to Board Assurance Framework [BAF]	Provision of assurance that patient outcomes are reviewed, and lessons learned to include deaths of people with learning disabilities.					
Reports previously considered by	This is a recurrent report and was previously presented to Quality Committee.					

LEARNING FROM DEATHS

Executive Summary

The objective of this report is to provide the Trust Board with assurance that there is a robust process in place to review unexpected deaths, as well as those deaths with potentially modifiable factors, and that mechanisms are in place to ensure lessons are learned and shared.

For the purpose of this paper 'modifiable factors' are defined as factors identified that may have contributed to the death and which by means of locally or nationally achievable interventions could be modified to reduce the risk of future deaths.

The Committee is asked to (i) receive the report and (ii) note the actions taken to further develop the mechanisms for sharing learning across the Trust.

LEARNING FROM DEATHS

1. BACKGROUND

Learning from deaths is essential and links to our Trust values. Reviewing the care provided to people can help improve services for all patients by identifying problems associated with poor care, and working to understand how and why these occurred so that meaningful action can be taken.

Although this view has always been a priority for Newcastle upon Tyne NHS Foundation Trust, the National Quality Board (NQB) published its first guidance in 2017 on Learning from Deaths. This guidance framework focused on how NHS Trusts and Foundation Trusts are to identify, report, investigate and learn from deaths in care.

In keeping with NQB guidance, this report details mortality quality metrics, which are used to reassure the Trust Board and Trust Board that the Trust is committed to monitoring inpatient deaths and learning from any unfortunate outcomes.

2. MORTALITY REVIEW DATABASE – DATA SUMMARY

Current Morbidity and Mortality (M&M) meetings provide a robust forum for multidisciplinary discussion of inpatient deaths. The mortality review database supports the sharing of lessons identified within M&M meetings across the Directorates and Clinical Boards.

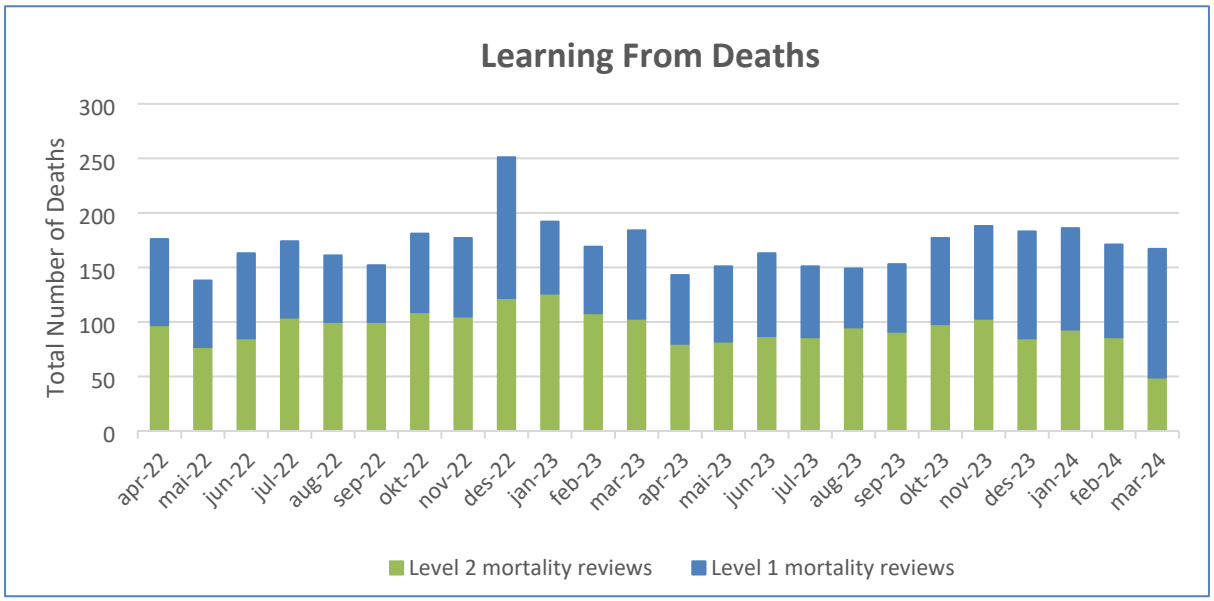
Mortality reviews are undertaken in two stages;
Level 1: The reviewer reviews the cause of death and discusses with the certifying doctor and Medical Examiner.

Level 2: In addition to the level 1 actions, the reviewer also considers documents and health records associated with the death and records findings into the Trust-wide mortality review database, in-line with Trust Mortality Policy.

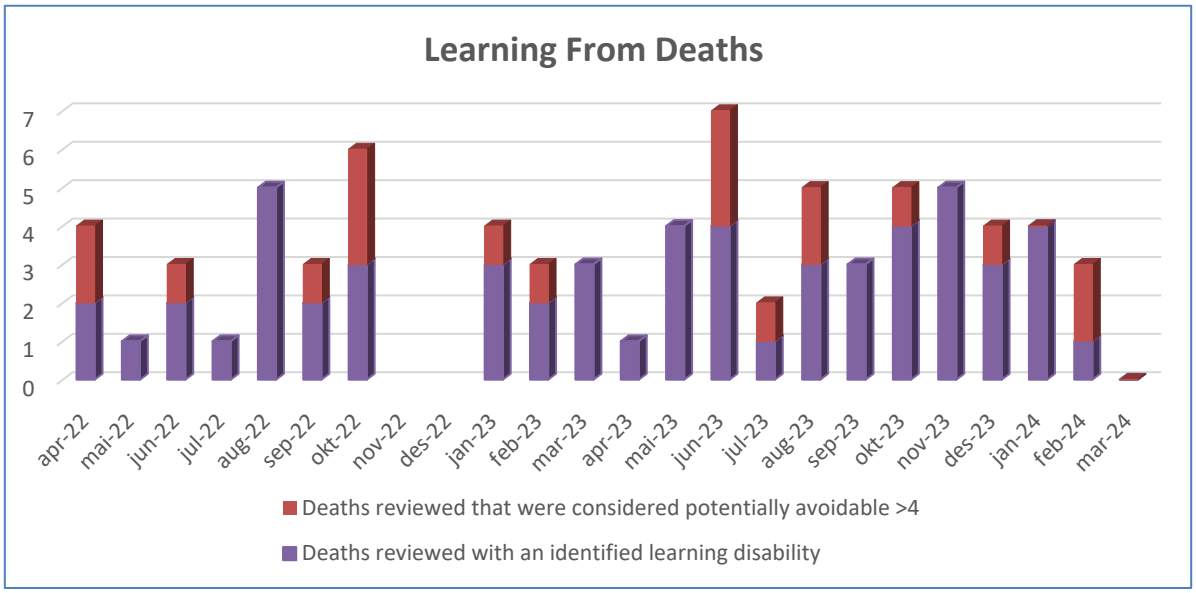
2.1 Inpatient Deaths

In the 12-month period (April 23 - March 24), 2,166 patients died within Newcastle Hospitals, during the same period 1,000 level 2 mortality reviews were undertaken on 821 patients. Mortality review figures for the period will continue to rise as subsequent reviews are completed.

Graph 1 shows a summary of deaths over a two year period (April 22 – March 24) and graph 2 details deaths reviewed in those with a Learning Disability and deaths that were potentially avoidable. There was a rise in inpatient deaths in December 2022. This was noted nationally as well as locally, with initial data showing influenza to be the cause of death.



Graph 1, level 1 and level 2 mortality review



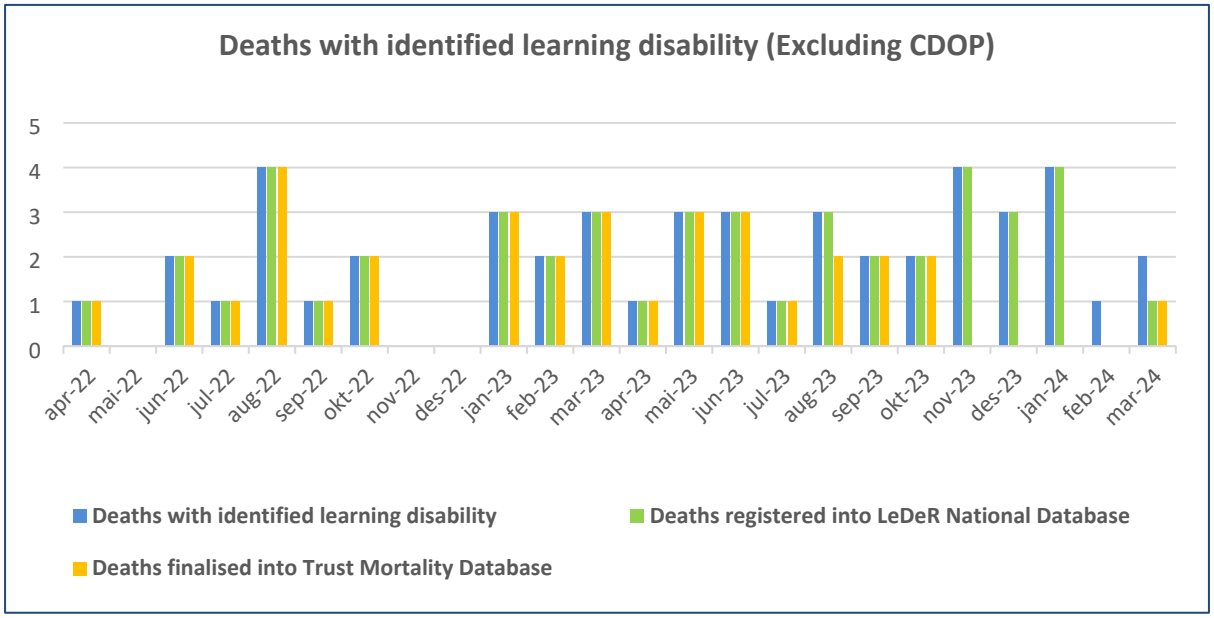
Graph 2, Learning Disability and potentially avoidable deaths

2.2 Patients identified with a Learning Disability

In the 12-month period (April 23 – December 24), 29 patients who died within Newcastle Hospitals were identified as having a learning disability. Within the Trust, whenever a patient with a learning disability dies, their death is reviewed by the clinical team along with the Learning Disability (LD) Team. There is a further in-depth case review at the Learning Disability Mortality Review Panel and the outcome of the case review is entered onto the Trust Mortality Review Database as well as into the LeDeR National Database. An update is provided from the Associate Director of Nursing at each quarterly Mortality Surveillance Group meeting and lessons learned are shared using various methods, which includes presenting at the Clinical Risk Group and via Patient Safety Bulletins.

It was agreed by the National LeDeR programme in June 2023, that any patients under 18years, are no longer required to be registered into the National LeDeR database, this is due to duplication within the Child Death Overview Panel (CDOP) investigation.

The graph below shows the data for the past 24 months (April 22 – March 24) and includes those patients who have been registered into the national LeDeR database and Trust mortality review database. The administration process for learning disability deaths to be reviewed and electronic databases updated results in a delay of finalised deaths in the Trusts mortality database, as highlighted November 2023 to March 2024.



Graph 3, deaths with identified Learning Disabilities.

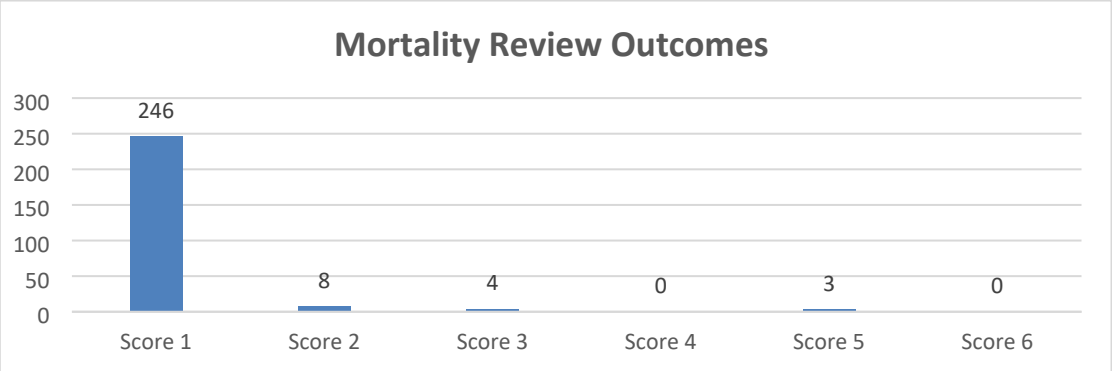
2.3 OUTCOME OF CASE REVIEWS – HOGAN SCORE

Throughout Q4, 524 patients died. During the same period 261 Level 2 case note reviews were completed. Level 2 reviews are undertaken by a multidisciplinary team, and findings recorded into the Trust-wide mortality review database. This number will continue to rise as more M&M meetings go ahead over the forthcoming months.

Case notes were reviewed estimating the life expectancy on admission and any identified problems in care contributing to death. The Hogan scale, ranging from 1 (definitely not preventable) to 6 (definitely preventable), was used to determine if deaths were potentially avoidable, taking into account a patient's overall condition at the time.

1	Definitely not preventable
2	Slight evidence for preventability
3	Possibly preventable, but not very likely, less than 50-50 but close call
4	Probably preventable more than 50-50 but close call
5	Strong evidence of preventability
6	Definitely preventable

A score of greater than 4 suggests 'strong evidence of preventability'. Where this occurs, the case is reviewed as part of the Trusts Patient Safety Incident Response Framework (PSRIF). Each case graded 4 or above is also presented on an individual basis at quarterly mortality surveillance group. The outcomes of the cases reviewed in Q4 are summarised in graph 4.



Graph 4, Mortiliaty review outcomes by Hogan Score.

3. KEY LEARNING POINTS

The National Quality Board (NQB) recommendations outline providers should have systems for deriving learning from reviews and investigations, and act on this learning. In addition, learning should be shared with other services where it is perceived this will benefit future patients.

Following a death, information gathered using case record reviews or investigations should be used to inform robust clinical governance processes. The findings should be considered with other information and data including complaints, clinical audit information, and patient safety incident reports and outcomes measures. This information resource can then inform the Trust's wider strategic plans and safety priorities.

Mortality reviews completed in Q4 with a Hogan score of 3 or more and the associated learning are summarised in table 1. Clinicians from each Directorate are also encouraged to share relevant learning from local mortality reviews with their own Clinical Board and any other Clinical Board throughout the Trust that may benefit from the learning identified.

Clinical Board	Speciality	Summary	Key Learning Points
Cardiothoracic	Cardiology	A CT abdomen with contrast was performed in a patient with hyperthyroidism.	Education regarding risk of contract in the setting of thyrotoxicosis.
Medicine and Emergency Care	Acute Medicine	Patient admitted to AS, high NEWS2 scores. Boarded to non-medical ward.	This case was reviewed as part of the PSIRF process and a Patient Safety Incident Investigation (PSII) is being undertaken.

Clinical Board	Speciality	Summary	Key Learning Points
Surgical & Associated Specialities	Urology	Emergency admission from outpatient renal clinic with high-pressure urinary retention	Steroid Alert within electronic prescriptions reviewed. Critical medication list reviewed and updated. Ward medication stock lists reviewed and updated. This death was investigated as a Serious Incident.

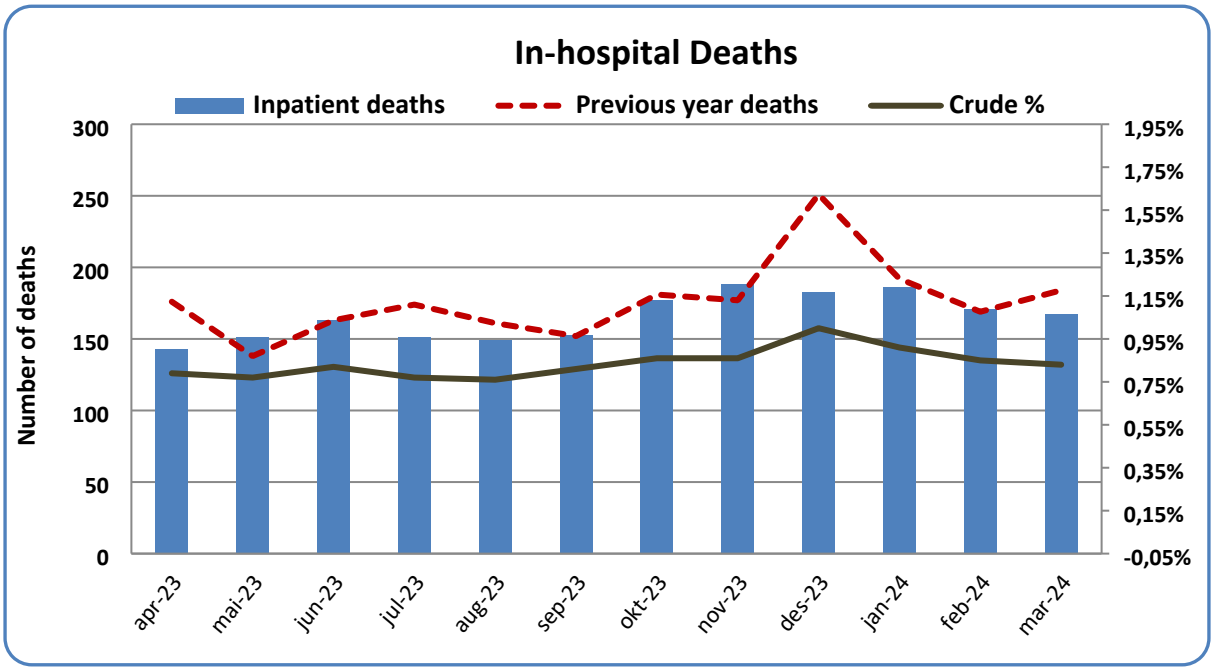
Table 1, Summary of learning from deaths with Hogan score ≥ 3

4. CRUDE MORTALITY

Crude mortality rate is the percentage of in-hospital mortality from all hospital admissions.

The crude mortality rate for Newcastle Hospitals is normally very low (averaging less than 1%), however differences in crude mortality rates between hospitals are not only caused by differences in hospital performances but also by differences in the case-mix of patients that are admitted. A hospital that admits on average a higher number of older patients and performs a larger proportion of higher risk procedures is likely to have a higher in-hospital crude mortality rate than a hospital with an average younger population.

Graph 5 shows the crude mortality rates for period April 23 - March 24, which clearly shows a decrease in deaths in relation to the same period the previous year.



Graph 5, crude mortality rates

5. SHMI AND HSMR MORTALITY RATES

Standardised Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) mortality rates are published quarterly by NHS Digital, however due to the time delay between data being uploaded by each individual Trust and primary care, the data is published approximately six months retrospectively.

SHMI and HSMR data is scrutinised on publication to determine any areas that may raise concern. All diagnostic groups within the data are individually monitored and all findings are presented to the Trust Mortality Surveillance Group on a quarterly basis. Any diagnostic group that flags as a concern is raised with the relevant Clinical Board to ensure an in-depth analysis is undertaken and findings recorded into the mortality review database. All learning from this analysis is shared with Clinical Boards and presented to the Mortality Surveillance Group.

The latest SHMI publication for October 22 – September 23 shows the Trust to be at 0.91, which is within the national "expected levels".

All mortality data including SHMI, HSMR and Variable Life Adjustment Displays (VLADS) are closely monitored.

6. NEQOS MORTALITY REPORT

The Northeast Quality Observatory Service (NEQOS) Mortality Report is published quarterly and presents analysis showing the SHMI mortality indices including a high level for Trusts identifying variation from the norm (outliers); trends through time; and using more granular analysis in order to describe contributing factors.

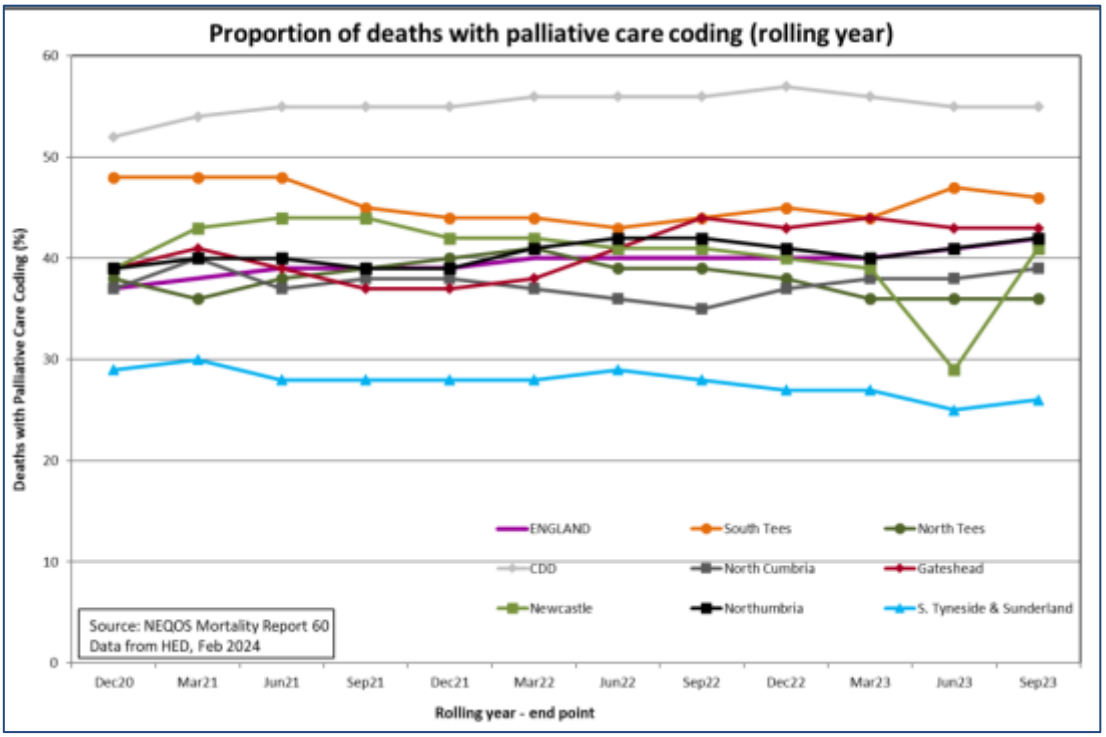
The latest NEQOS SHMI publication is up to September 2023. Overall, the table below shows the Trust to be below the national average, as well as being the lowest regionally.

Provider	October 2021 - September 2022			October 2022 - September 2023			SHMI Change	Observed Difference	Expected Difference
	Observed	Expected	SHMI	Observed	Expected	SHMI			
County Durham and Darlington NHS FT	2875	2645	109	3015	2455	123	14.1	4.9%	-7.2%
North Tees and Hartlepool NHS FT	1770	1800	98	1830	1915	96	-2.8	3.4%	6.4%
South Tees Hospitals NHS FT	2420	2275	106	2595	2340	111	4.5	7.2%	2.9%
Gateshead Health NHS FT	1250	1395	90	1310	1405	93	3.6	4.8%	0.7%
South Tyneside and Sunderland NHS FT	3005	2795	108	3125	2730	114	7.0	4.0%	-2.3%
The Newcastle Upon Tyne Hospitals NHS FT	2400	2575	93	2625	2885	91	-2.2	9.4%	12.0%
Northumbria Healthcare NHS FT	2625	2805	94	2850	3095	92	-1.5	8.6%	10.3%
North Cumbria Integrated Care NHS FT	1785	1670	107	1810	1775	102	-4.9	1.4%	6.3%

Table 2 SHMI Mortality Indices

7. PALLIATIVE CARE CODING

The graph below is published within the NEQOS quarterly report and is currently presented up to September 2023. The graph below shows deaths with a palliative care coding which includes those who have died within 30 days of discharge. Palliative care coding was historically low within Newcastle upon Tyne Hospitals in comparison to regional Trusts. The dramatic decline in palliative care coding in June 2023 is part of an upload issue between the Trust and NHS Digital. Patient comorbidities and palliative care status were sporadically uploaded into the new Trust dataset and therefore not being included, or risk adjusted by NHS Digital. This issue has now been resolved and we hope to see the data with a more positive outcome for June 2023 within the next published NEQOS report.



Graph 6, deaths with palliative care coding

8. OUTCOME OF INVESTIGATIONS LINKED TO PATIENT SAFETY INCIDENTS

During Q4 the Trust transitioned to new Patient Safety Incident Response Framework (PSIRF). For full details please see the PSIRF policy.

All unexpected patient deaths, or deaths with possible modifiable factors, are reviewed by the clinical boards and escalated via the Rapid Action Review Meeting for consideration as one of the four identified learning responses.

Patient Safety Incident Investigations (PSII) are carried out for all deaths which are thought to be more likely than not due to problems in care and where patients are detained under the MHA / MCA and linked to gaps in care.

Deaths reviewed as part of a PSII or alternative learning response are subject to a detailed review with key learning points identified and shared.

A summary of Rapid Action Review outcomes in Q4 resulting from safety incidents resulting in death (excluding IPC) are detailed in table 3.

ID	Incident date	Clinical Board	Outcome of Rapid Review
73196	06/02/2024	Medicine and Emergency Care	Patient Safety Incident Investigation
74066	13/02/2024	Cardiothoracic	Local Investigation
75508	27/02/2024	Cardiothoracic	Patient Safety Incident Investigation
75881	17/02/2024	Surgical & Associated Specialties	After Action Review
76581	21/12/2023	Medicine and Emergency Care	Local Investigation
77305	22/03/2024	Surgical & Associated Specialties	Local Investigation

Table 3, Rapid Action Review outcomes for incidents graded as fatal

In addition there was one Serious Incident resulting in Death.

A summary of key learning points from Patient Safety Incidents which are likely to have contributed to or resulted in a patient's death, and where the investigation has been submitted to the ICB during Q4 are detailed in table 4.

Reference	Clinical Board / Theme	Key Learning Points
2023/3753	Cardiothoracic Transcatheter Aortic Valve Implantation (TAVI)	The ECMO circuits used have been changed such that there is no longer a port on the venous limb, although not implicated in this case, reducing the chance of air entrainment.
2023/4050	Surgical & Associated Specialities Lost to Follow Up	Agreed protocol to be introduced to ensure MDT decisions on patient care are actioned and communicated to the appropriate departments, staff and patient.
2024/355	Cardiothoracic TAVI Complication	MDT notes to be reviewed and finalised before being uploaded to records. Letter of intent to be submitted to New Interventional Procedures Group.
2023/20210	Surgical & Associated Specialities Unexpected Death	Mobility assessment to be included for day case patients. Review of care pathways for patients undergoing lower limb blocks.
2023/20207	Surgical & Associated Specialities Unexpected Death	Review of ward medication stocks and explore whether all wards should stock hydrocortisone. Explore ways of maximising pharmacy resource to ensure high risk patients are reviewed across the Trust.

Table 4, Q4 Patient Safety Incidents and associated key learning.

9. MEDICAL EXAMINER

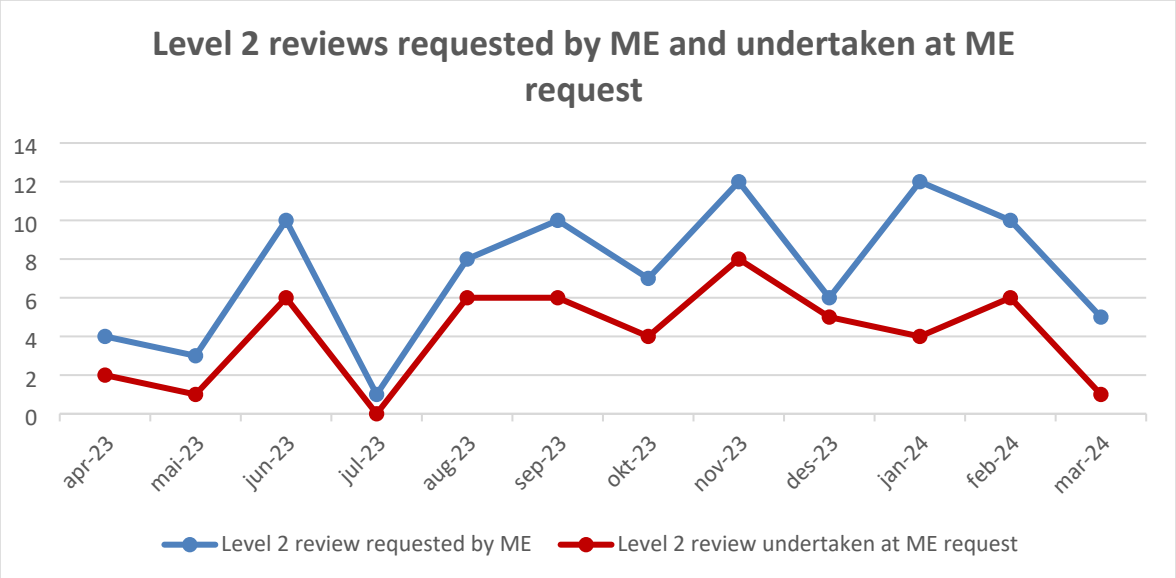
Since January 2023, Medical Examiners (ME) have started scrutinising all inpatient deaths other than those referred to the coroner's office.

The Medical Examiner process had planned to incorporate all community deaths by April 2024 in line with NHS England Guidance. This work has now been postponed until later on this year.

Medical Examiners are currently scrutinising some community deaths, however not all GPs and hospices are fully incorporated into the process. The Trust Medical Examiner office is continuing to offer training to all GPs and hospices in order for them to understand the scrutiny process.

Medical Examiners will inform Trust mortality leads if a level 2 review is to be undertaken in line with the Trust mortality policy. A large number of level two reviews are completed each month within the Trust, however only a small number of these come from the ME review process. Work is ongoing within the ME team to increase this number.

Numbers of level 2 reviews requested by the ME and the number of reviews completed is detailed in graph 7



Graph 7, ME requested level 2 Mortality reviews and numbers completed.

10. RECOMMENDATIONS

To (i) receive the report and (ii) note the actions taken to further develop the mechanism for sharing learning across the Trust.

Report of Angela O'Brien
Director of Quality & Effectiveness

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024					
Title	Healthcare Associated Infections (HCAI) Director of Infection Prevention and Control Report					
Report of	Mr Ian Joy, Executive Director of Nursing					
Prepared by	Dr Julie Samuel, Director of Infection Prevention & Control (DIPC), Consultant Microbiologist Mrs Lesley Wilson, IPC Matron Mrs Cheryl Teasdale Associate Director of Nursing					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☐			
Summary	This paper is the bi-monthly report on Infection Prevention & Control (IPC). It complements the regular Integrated Board Report and summarises the current position for the Trust to the end of April 2024. Trend data in Appendix 1 (HCAI Report and Scorecard March 2024 and April 2024) is appended, which details the performance against targets where applicable.					
Recommendation	The Board of Directors is asked to (i) receive the briefing, note and approve the content and (ii) comment accordingly.					
Links to Strategic Objectives	Achieving local excellence and global reach through compassionate and innovative healthcare, education and research. Patients - Putting patients at the heart of everything we do and providing care of the highest standards focussing on safety and quality. Partnerships - We will be an effective partner, developing and delivering integrated care and playing our part in local, regional, national and international programmes. Performance - Being outstanding, now and in the future					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☐	☐	☐	☐
Link to Board Assurance Framework (BAF)	<u>Strategic Objective: 1</u> Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality. Strategic Risk Description: i) SO1.4 [NHS core standards]. ii) SO1.10 [infections]					
Reports previously considered by	This is a bimonthly update to the Board on Healthcare Associated Infections (HCAI).					

HEALTHCARE ASSOCIATED INFECTIONS (HCAI) DIRECTOR OF INFECTION PREVENTION & CONTROL (DIPC) REPORT

EXECUTIVE SUMMARY

This paper provides bi-monthly overview to the Trust Board regarding Healthcare Associated Infections (HCAIs). The following key points are noted in the report:

- This period identified HCAI themes relating to intra-vascular infections, mainly MSSA bacteraemia, in different clinical areas. Details of reviews and collaborative initiatives are outlined in the report.

- Significant improvement in *Clostridioides difficile* Infection (CDI) rates with Newcastle Hospitals being one of the few Trusts in the Shelford Group to remain under trajectory for 2023/24.

RECOMMENDATIONS

The Board of Directors is asked to (i) receive the report and approve the content and (ii) comment accordingly.

HEALTHCARE ASSOCIATED INFECTIONS (HCAI) DIRECTOR OF INFECTION PREVENTION & CONTROL (DIPC) REPORT

1. KEY POINTS FOR MARCH/APRIL 2024

This paper provides a bi-monthly overview to the Trust Board regarding Healthcare Associated Infections (HCAI). This includes:

- Current performance against national HCAI reduction trajectories. This includes benchmarking with performance across Shelford Trusts.
- Overview of Trust actions and work streams to support HCAI monitoring and reduction strategies.
- Overview of the work undertaken to support antimicrobial stewardship.

1.1 *Clostridioides difficile* Infections (CDI)

At the end of March 2024, a total of 144 cases were attributed to the Trust (114 cases Hospital Onset Healthcare Associated (HOHA); 30 cases Community Onset Healthcare Associated (COHA)) – see Table 1. This placed the Trust under the national threshold (≤165) by 21 cases (4%) as shown in Table 2, and demonstrates a sustained improved position compared to the same period last year. National thresholds for 2024/25 are yet to be published. Continuous IPC education and weekly MDT reviews are the key strategies that have helped maintain our current position.

Table 1: Number of CDI attributed to Newcastle Hospitals from May 2022 to April 2024

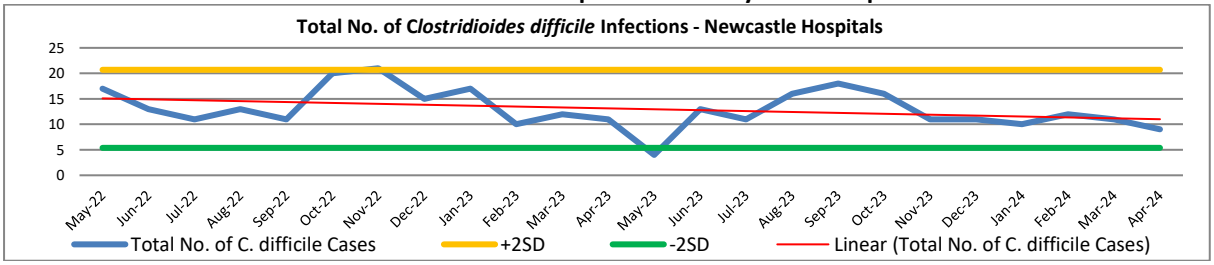
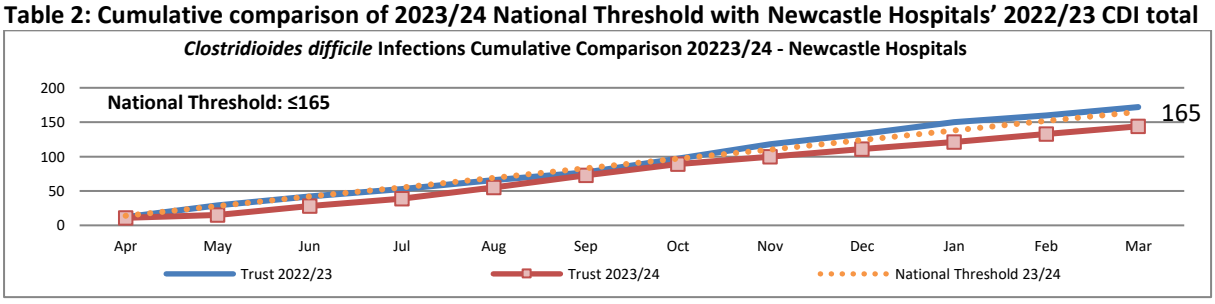


Table 2: Cumulative comparison of 2023/24 National Threshold with Newcastle Hospitals' 2022/23 CDI total



Tables 3 and 4 show the Trust's CDI infections compared with the Shelford Group for time periods between April 2022 and March 2024. Whilst there has been a reduction in CDI infections internally, the benchmark against the Shelford Group remains unchanged. Newcastle Hospitals was below the Shelford Group average and one of three hospitals within the Group (Sheffield Teaching Hospitals and University College London Hospitals being the other two) who were under their national threshold.

Table 3: CDI comparison data for Shelford group April 2023 – March 2024

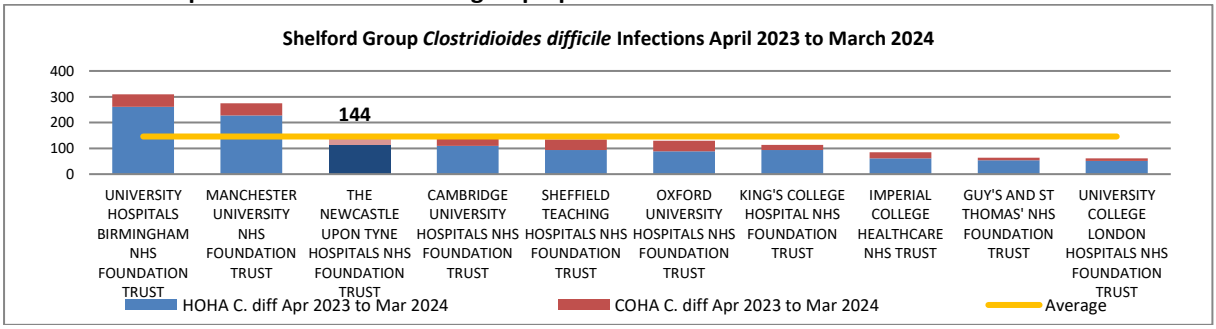
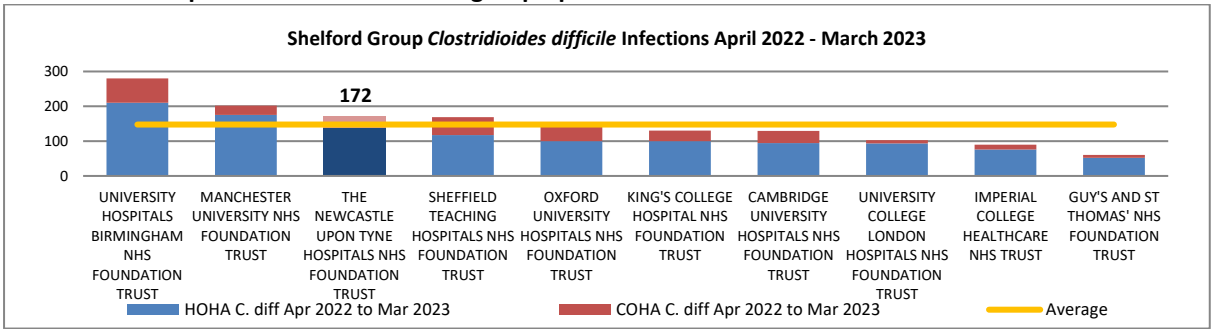


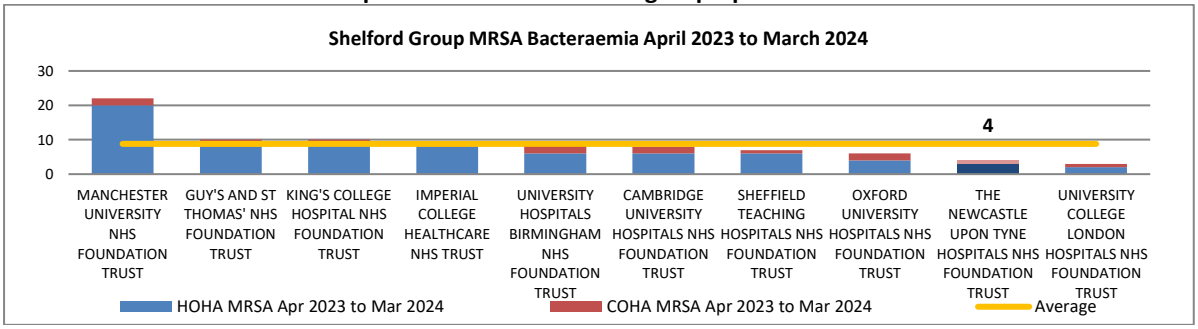
Table 4: CDI comparison data for Shelford group April 2022 – March 2023



1.2 MRSA / MSSA Blood stream infection (BSI)

At the end of March the Trust had a total of 4 MRSA bacteraemia cases. No new cases have been declared since the last update. This places the Trust's position as 9th with the Shelford Group (table 5) and below the Shelford average. This reflects the national increase in MRSA mainly in high risk groups.

Table 5: MRSA bacteraemia comparison data for Shelford group April 2023 – March 2024



At the end of March 2024, a total of 108 MSSA bacteraemia were attributed to the Trust (88 HOHA cases; 20 COHA cases). This places the Trust over our local trajectory by 18 cases (20%) (≤90 - no national threshold for MSSA), as outlined in table 6. Monthly trend graphs are included in the Integrated Board Report and performance against trajectories (table 7) and Shelford benchmarking (table 8) are included below for reference. At the end of April, a total of 10 cases were attributed to the Trust with the local trajectory for 2024/25 being ≤98 cases cumulatively.

Table 6: Total MSSA Bacteraemia at Newcastle Hospitals May 2022 - April 2024

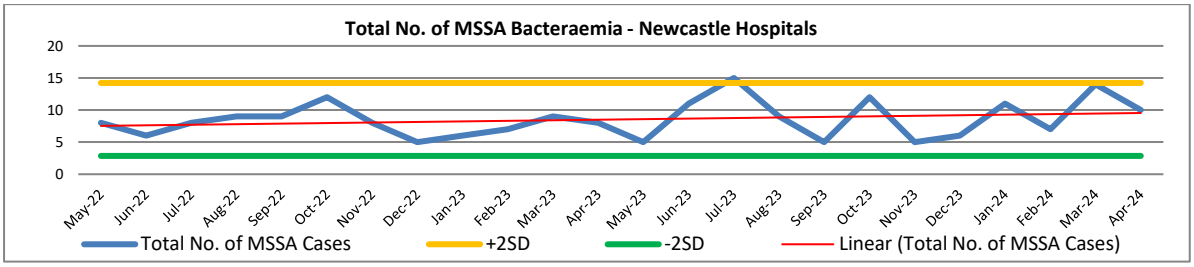


Table 7: MSSA cumulative comparison April 2022- end of March 2023 and April 2023 – March 2024

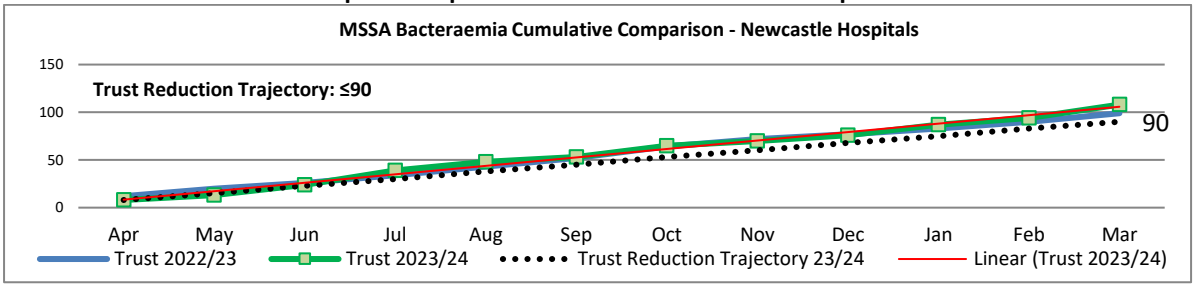
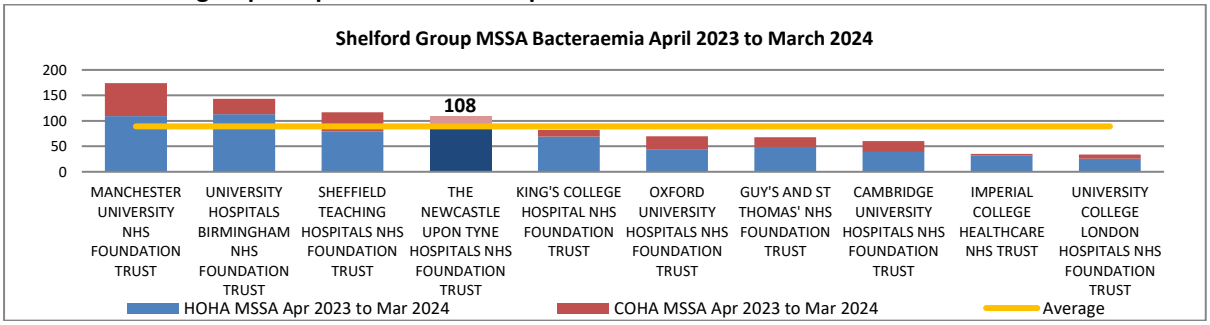


Table 8: Shelford group comparison for MSSA April 2023 – March 2024



8 out of 18 (44%) MSSA BSI during March and April were deemed avoidable following IPC investigations. The main themes identified were issues with management and documentation of IV devices which has remained a re-occurring theme therefore a collaborative proactive process has been developed to address these issues. The themes emerging from unavoidable cases are a combination of diabetic foot infections, pneumonia and complex cardiothoracic patients.

From June 2024, the Trust cannulation training sessions will now become a monthly planned training session rather than ad hoc for all registered nursing and medical staff as well as Healthcare Assistants (HCAs) within defined areas. In addition, the Vascular Access Team are developing a Difficult Venous Access (DVA) assessment tool to support clinicians across all departments to appropriately identify DVA patients. The aim is to promote early referral to preserve vessel health and reduce line associated complications. This work along with quality aftercare and maintenance will be supported with the relaunch of Aseptic Non-Touch Technique (ANTT). Clinical, IPC and IV specialists continue to work with clinical educators to review patient pathways and audit management of IV devices used in the clinical setting.

The implementation of a line care dashboard planned for Trust-wide rollout in May/June 2024 will provide continuous line surveillance. The Spring Clean collaborative 'Patient focused hygiene prevents infection' focussing on specific aspects of personal hygiene has been launched and will continue for the months of May and June.

1.3 Gram Negative Blood stream infection BSI GNBSI (*E. coli*, Klebsiella, Pseudomonas aeruginosa)

Table 9 compares GNBI rates against national thresholds and as illustrated, numbers exceed current national trajectory. Tables 10, 11 and 12 illustrate in graph format performance against trajectory. Table 13 illustrates the number of cases until end of April 2024 – as yet NHSE have not released national thresholds for 2024/25.

Table 9: The table(s) below outlines the Trust figures up to the end of March 2024

	E. coli	Klebsiella	Pseudomonas aeruginosa
Cumulative No. cases to end of March 2024	258 cases	114 cases	42 cases
National Threshold for March 2024	≤189 Over by 69 (37%)	≤130 Under by 16 (12%)	≤38 Over by 4 (11%)
For noting	No Shelford Trust achieved their national threshold	Newcastle Hospitals was one of only three Shelford Trust who were under their national threshold	No Shelford Trust achieved their national threshold. Newcastle Hospitals still saw a 18% reduction in numbers from 2022/23.

Table 10: Total *E. coli* bacteraemia April 2022- end of March 2023 and April 2023 – March 2024

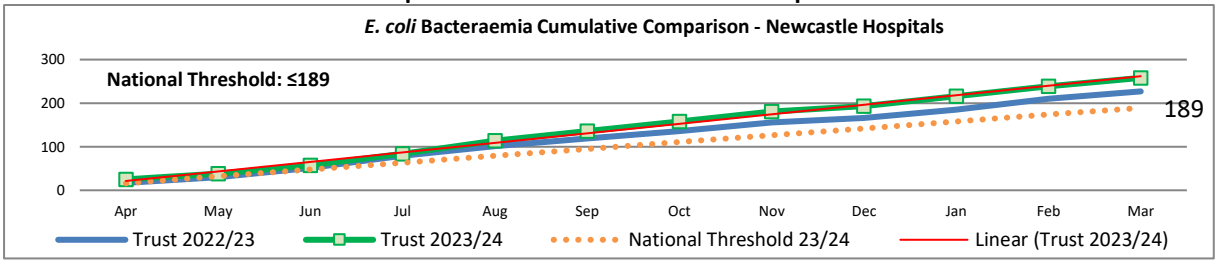


Table 11: Total Klebsiella bacteraemia April 2022- end of March 2023 and April 2023 – March 2024

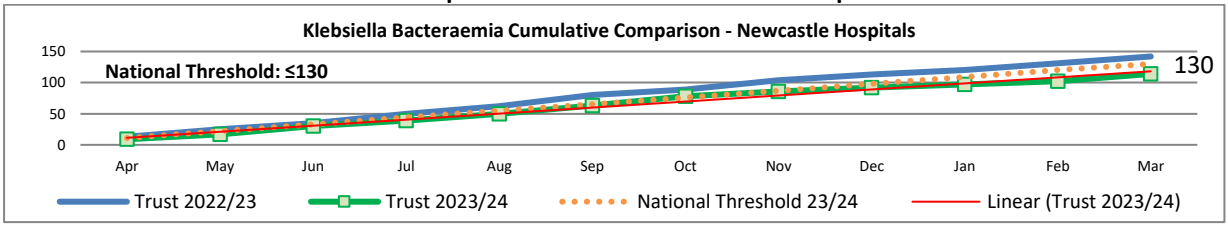


Table 12: Total Pseudomonas aeruginosa bacteraemia April 2022- end of March 2023 and April 2023 – March 2024

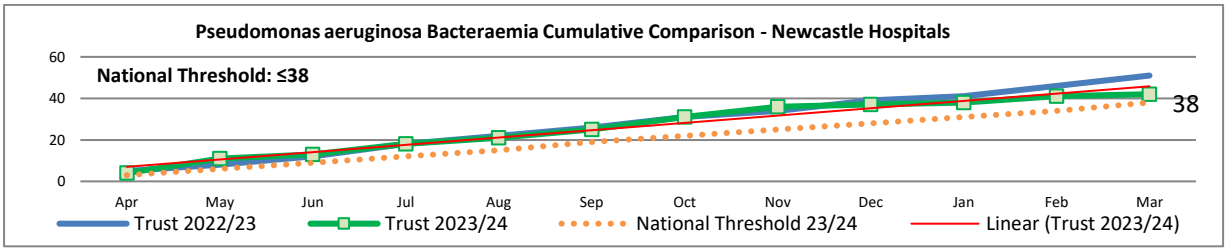


Table 13: The table(s) below outlines the Trust figures up to the end of April 2024

	E. coli	Klebsiella	Pseudomonas aeruginosa
Cumulative No. cases to end of April2024	**17 cases**	**6 cases**	**4 cases**
National Threshold for April 2024	**Not yet released by NHS England**		

11 *E. coli* bacteraemia cases in March and April were deemed unavoidable following IPC investigations with the main source for *E. coli* being lower urinary tract infections. IPC review

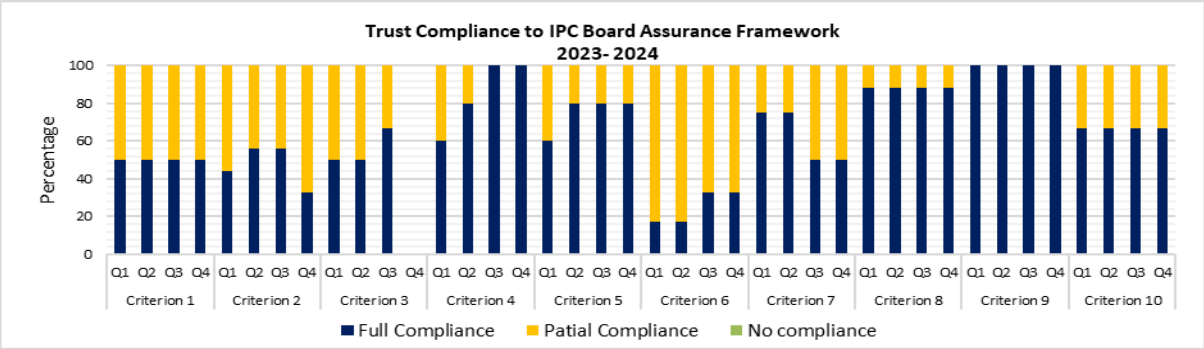
identified good practice with all cases being considered unavoidable, a positive reflection of the collaborative approach adopted in relation to CAUTI work. Gram Negative Blood stream infection (GNBSI) reviews have identified emerging themes associated with water as a source of Pseudomonas aeruginosa bacteraemia. This risk is being reviewed by the Trust Water Safety Group and risk assessments will be carried to understand the extent of the risk followed by review at Operational groups.

1.4 Board Assurance Framework (BAF)

The Quarter 4 BAF report demonstrates that the organisation continues to have oversight on the Trust's position of compliance in relation to IPC.

Table 14 shows the Trust compliance to the IPC BAF by quarter. The Trust is fully compliant in two of the criterion and partially compliant in all others. Criterion 3 is in draft and has not yet been finalised and therefore not been included below. There are no areas of non-compliance.

Table 14: Trust Compliance to IPC BAF



It is important to note that there is a significant amount of cross over in criterion meaning that a gap in assurance can impact on multiple areas of the BAF. Compliance to some criterion is affected as we are not fully compliant in monitoring systems such as the Clinical Assurance Tool (CAT) and IPC patient risk assessment. Collaborative work with key stakeholders is underway to improve the validation and completion of relevant tools with monitoring in place.

97% of IPC Trust policies are both in date and aligned to national guidelines. The Carbapenemase-Producing Enterobacteriaceae (CPE) and other Carbapenemase producing Organisms (CPO) Patient Management Policy is under review but remains out of date. National Guidance in relation to CPE requires organisations to implement screening of all patients who have been in hospital in the last 12 months for CPE on readmission. The Trust has increased testing to improve compliance and reduce risk but is not yet able to achieve full compliance due to current lab capacity which has an Impact on criterion 1, 5, 7, 8.

1.5 Incidence of Respiratory Viruses Including COVID-19

The number of reported COVID-19 cases have remained stable between March and April 2024 (47 cases respectively); however the number of cases in this period was an increase compared to February 2024 (23 cases). There was a sharp decline in the number of Flu A

cases being reported in the Trust during this period

1.6 Incidence of viral diarrhoeas illnesses including Norovirus

There were 12 outbreaks of Norovirus and an outbreak of Astrovirus declared in March and April 2024 which resulted in 516 lost bed days. This had a significant operational impact with neighbouring Trusts facing similar pressures. Discussions are underway to improve diagnostic pathways thereby reducing operational impact if appropriate testing strategies are in place.

1.7 Pertussis

Whooping cough, also known as pertussis, is an acute respiratory infection which can be spread by coughing and sneezing. The bacteria are present in the back of the throat and an infected person can pass the infection to other people for 21 days from the onset of their symptoms. Cases of whooping cough have been rising across England, increasing from 556 cases in January, 918 in February to 1,319 cases confirmed in March - bringing the total number of cases in 2024 to 2,793. Sadly, between January – March 2024, there have been five infant deaths. The whooping cough vaccine provides high levels of protection against severe disease. It is given as part of the routine childhood vaccination schedule in the UK and in pregnancy to protect newborn babies. Newcastle Hospitals saw a few paediatric admissions requiring intensive care support, patients were managed appropriately, and contacts given chemoprophylaxis with internal communication to increase vaccine uptake in high risk groups.

1.8 Antimicrobial Stewardship (AMS)

Newcastle Hospitals will participate in the 2024/25 national, non-mandated CQUIN for IVOS (IV to oral switch) which now includes paediatrics. The CQUIN involves the requirement to collect data on 100 patients per quarter, looking at timeliness and outcome of review. IVOS can help improve hospital flows, prevent harm from intravascular devices, reduce carbon footprint and save £110k per annum by switching one dose sooner in a 1000-bedded hospital plus save 30 hours (4 nursing shifts) of time preparing and administering IV antibiotics.

AMSG are working alongside Clinical Boards, to improve engagement in Take 5 audits with support from junior doctors to gain better insight into reasons for poor compliance. Local survey showed poor compliance due to auditors' lack of knowledge of AMS , lack of senior support and clinical pressures. It is clear that a comprehensive review is required, and an in-depth update and discussion is planned in the Trust Quality Committee in July.

1.9 Water Ventilation and Decontamination

Newcastle Hospitals have well established strategic groups for water, ventilation and decontamination with operational subgroups. Significant issues are escalated to Estates Risk management and IPC Committee with quarterly risk register reviews.

2.0. RECOMMENDATIONS

The Board of Directors is asked to (i) receive the report and approve the content and (ii) comment accordingly.

Report of

Ian Joy
Executive Director of Nursing

Dr Julie R Samuel
Director of Infection Prevention & Control (DIPC)

15 May 2024

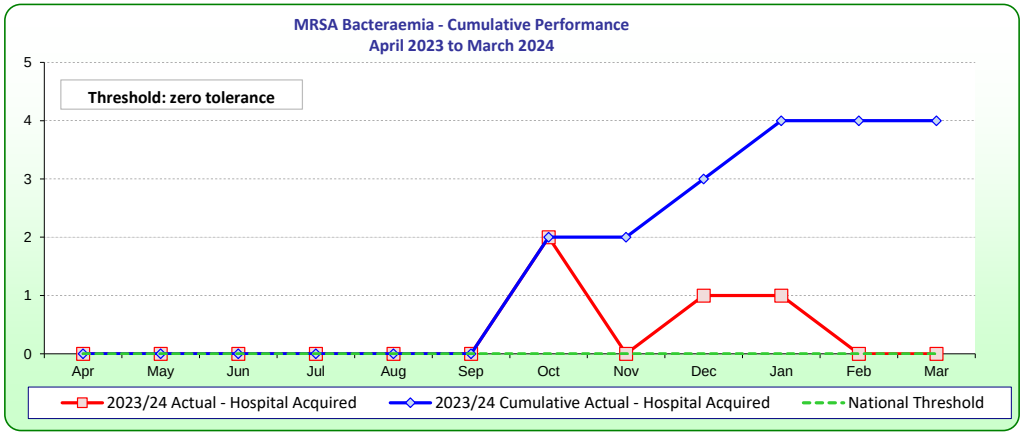
Agenda item A11(d)

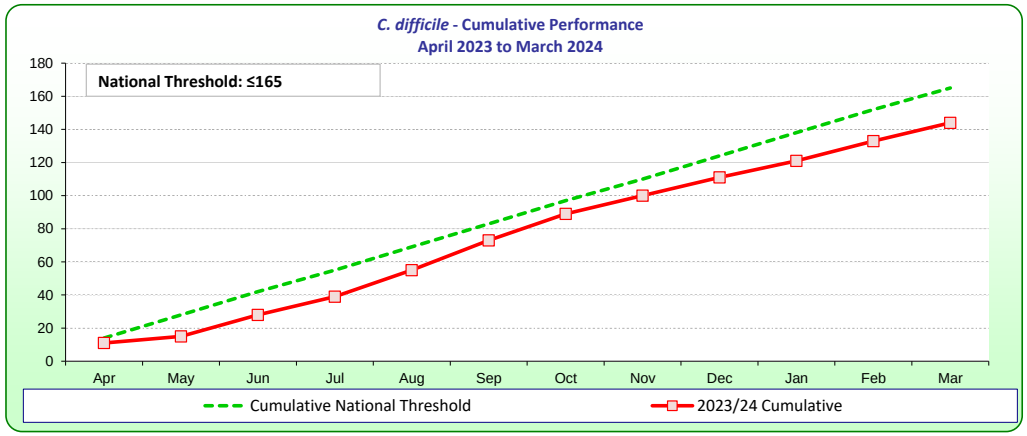
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

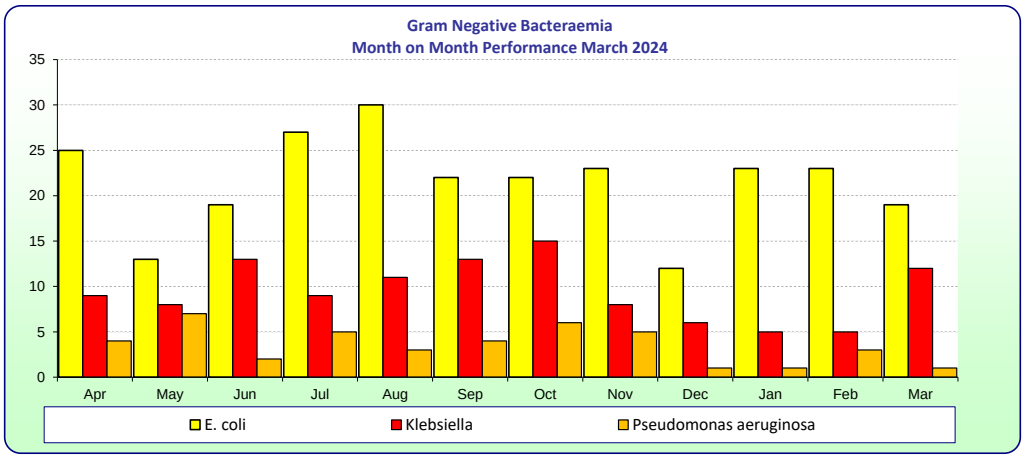
Healthcare-Associated Infections Report
March 2024

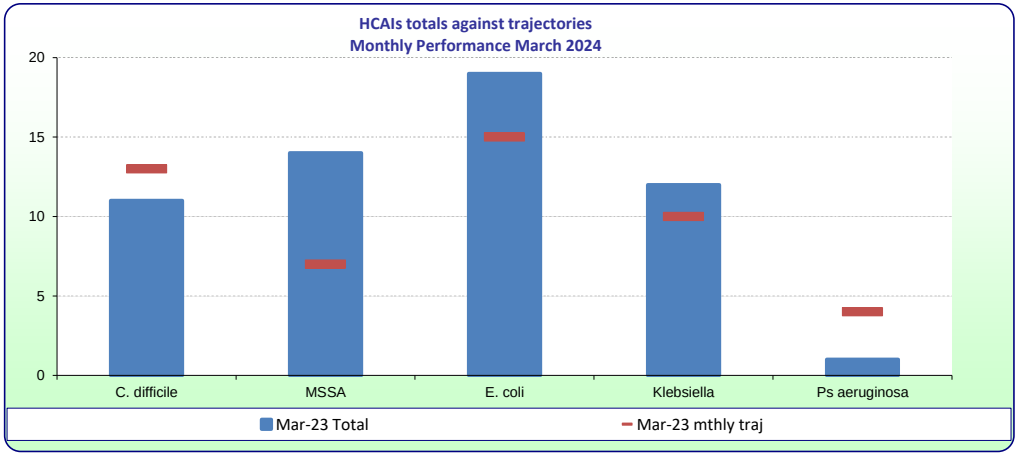
Healthcare-Associated Infection Report March 2024

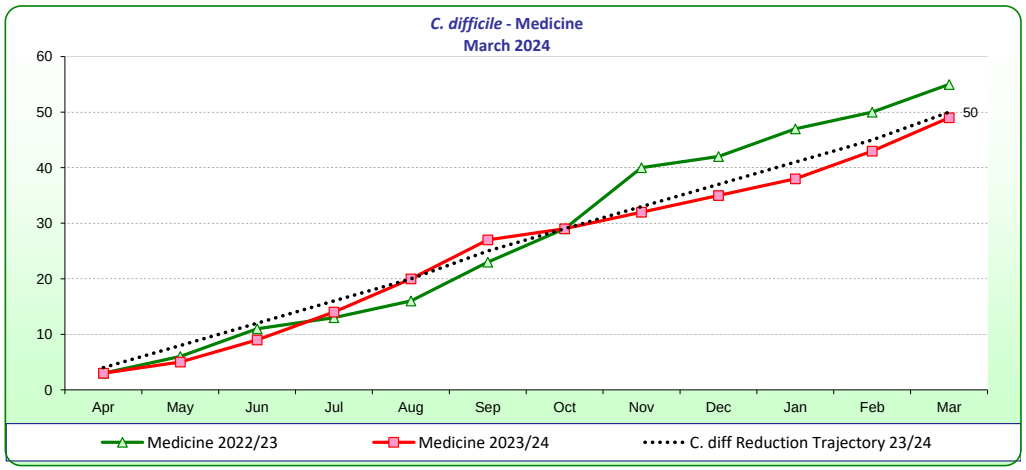
The Newcastle upon Tyne Hospitals NHS Foundation Trust

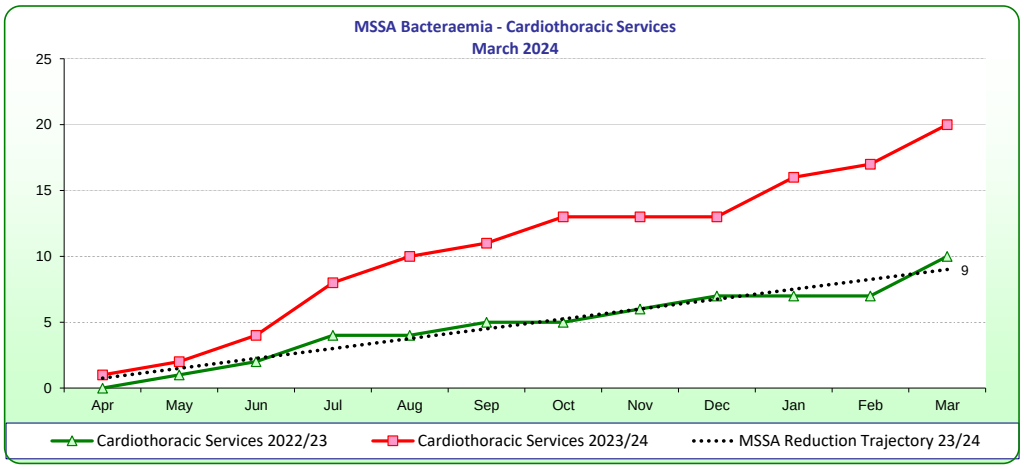












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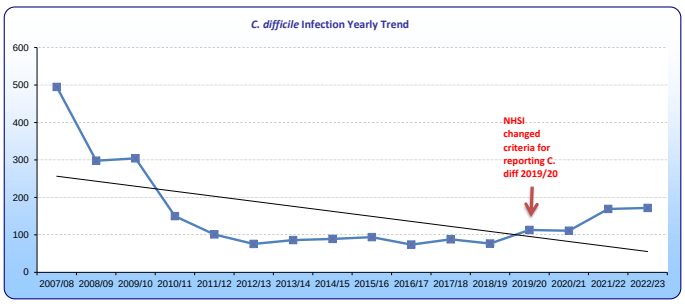

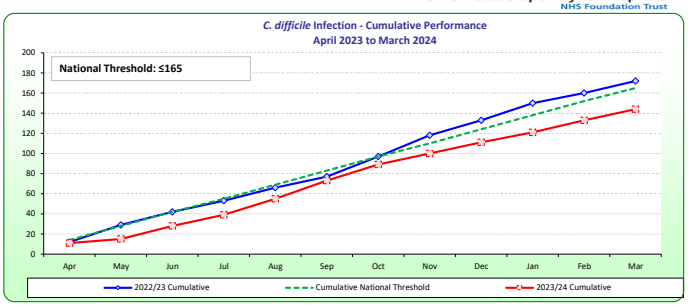

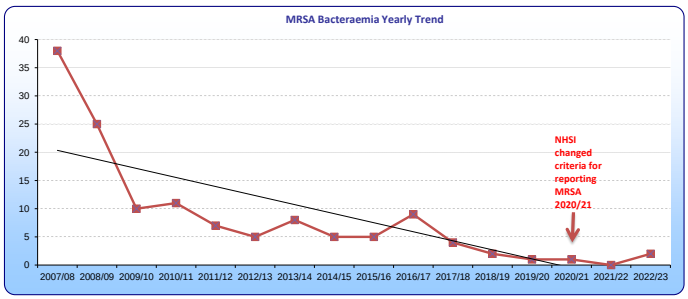

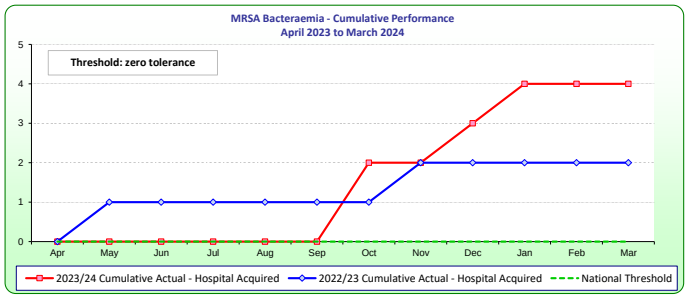

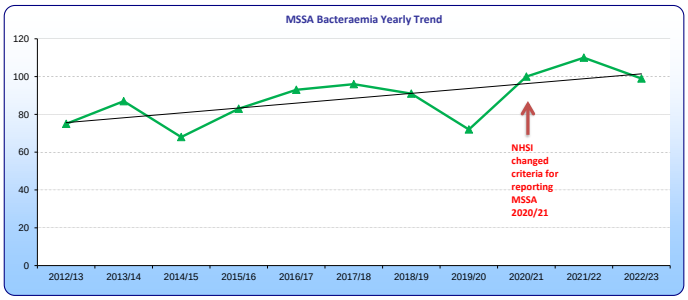

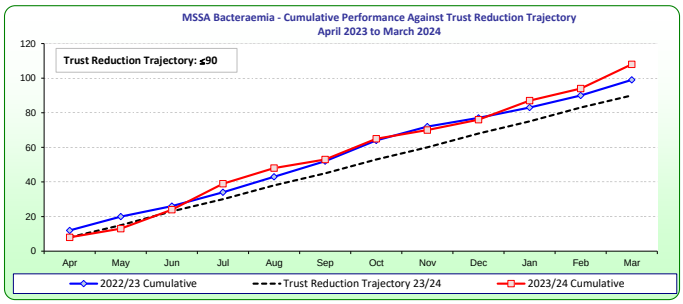

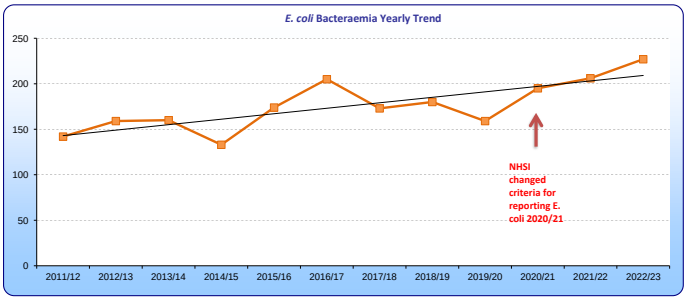

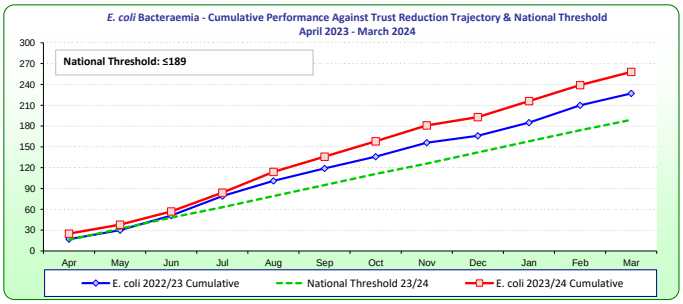

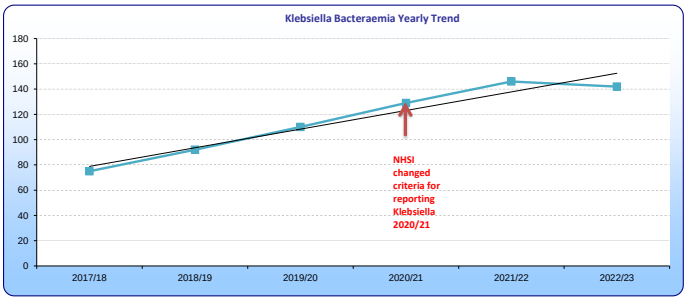

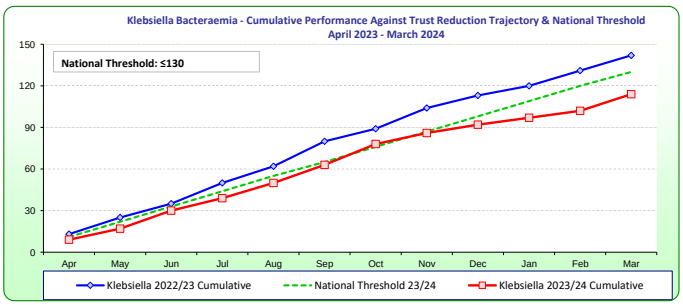

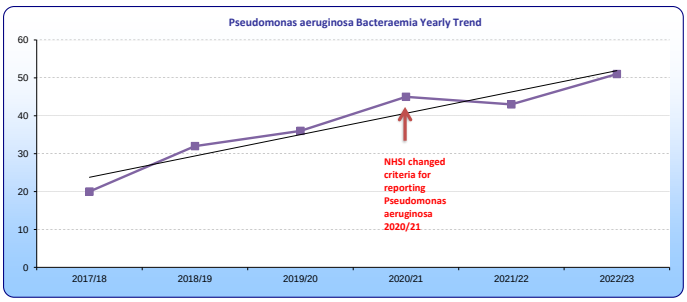

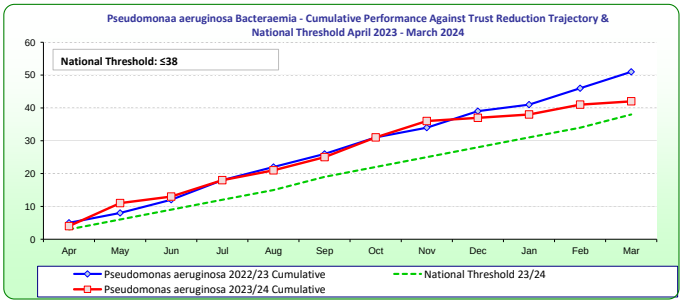

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Bacteraemia / Infections

IPC indicators (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA Bacteraemia - non-Trust	0	0	2	0	1	0	0	0	0	1	1	0	5
MRSA Bacteraemia - Trust-assigned (objective 0)	0	0	0	0	0	0	2	0	1	1	0	0	4
MSSA Bacteraemia - Healthcare Associated (local objective ≤90)	8	5	11	15	9	5	12	5	6	11	7	14	108
E. coli Bacteraemia - Healthcare Associated (National Threshold ≤189)	25	13	19	27	30	22	22	23	12	23	23	19	258
Klebsiella Bacteraemia - Healthcare Associated (National Threshold ≤130)	9	8	13	9	11	13	15	8	6	5	5	12	114
Pseudomonas aeruginosa Bacteraemia - Healthcare Associated National Threshold ≤38)	4	7	2	5	3	4	6	5	1	1	3	1	42
C. diff - Hospital Acquired (national threshold ≤165)	11	4	13	11	16	18	16	11	11	10	12	11	144
C. diff related death certificates	2	0	1	0	0	1	0	0	0	0	0	0	4
Part 1	2	0	1	0	0	1	0	0	0	0	0	0	4
Part 2	0	0	0	0	0	0	0	0	0	0	0	0	0

Periods of Increased Incidence (PIIs)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
C. diff - Hospital Acquired	0	2	2	1	3	4	2	4	1	1	3	2	25
Patients affected	1	2	6	1	6	12	7	8	5	1	5	6	60
COVID-19 - Hospital Acquired	1	1	1	0	5	0	2	0	0	4	0	2	16
Patients affected	2	3	2	0	11	0	6	0	0	8	0	6	38

Healthcare Associated COVID-19 cases (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Hospital onset Probable HC assoicated (8-14 days post admission)	23	8	6	1	30	25	28	13	17	18	5	18	192
Hospital onset Definite HC assoicated (≥15 days post admission)	39	20	7	0	32	37	46	20	20	26	12	20	279

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	2	1	0	0	0	1	0	0	1	1	1	1	8
Patients affected (total)	18	8	0	0	0	5	0	0	13	24	21	5	94
Staff affected (total)	4	7	0	0	0	3	0	0	2	2	7	3	28
Bed days losts (total)	126	3	0	0	0	0	0	0	59	24	88	14	314
Other Outbreaks	0	0	1	0	0	0	0	0	1	10	3	2	17
Patients affected (total)	0	0	18	0	0	0	0	0	3	33	8	6	68
Staff affected (total)	0	0	6	0	0	0	0	0	0	2	0	0	8
Bed days losts (total)	0	0	51	0	0	0	0	0	0	14	0	0	65
COVID Outbreaks	8	2	1	0	8	5	5	3	5	6	2	5	50
Patients affected (total)	38	18	4	0	63	37	43	23	23	40	6	26	321
Staff affected (total)	0	4	0	0	0	1	0	0	0	0	0	0	5

C.diff Transit and Testing Times Target <18hrs	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Trust Specimen Transit Time	13:47	13:55	11:53	12:09	12:41	11:36	11:53	11:54	13:07	12:18	12:34	12:16	12:30
Laboratory Turnaround Time	03:23	03:08	02:55	01:53	02:10	01:56	01:42	03:41	02:36	02:07	01:55	01:59	02:27
Total to Result Availability	17:10	17:03	14:48	14:02	14:51	13:32	13:35	15:35	15:43	14:25	14:29	14:15	14:57

Clinical Assurance Tool (CAT)

Clinical Assurance Indicators/Audits (%) - Trust as a whole	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Adult IP; Children's IP; Community HV/SN; Community Nursing; Critical Care; Day Procedure; Dental; Maternity; OP; Theatres) Trust Total	95%	94%	93%	95%	92%	88%	92%	91%	95%	95%	93%	94%	93%
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Trust Total	96%	96%	93%	94%	91%	89%	91%	89%	96%	95%	95%	94%	93%
Invasive Device Care Audit Trust Total	95%	96%	92%	93%	93%	92%	95%	95%	98%	97%	95%	95%	95%
Matron Checks (IP; OP/Community/Dental; Theatres) Trust Total	94%	96%	91%	97%	93%	92%	95%	94%	92%	96%	90%	96%	94%

Clinical Assurance Indicators/Audits (%) - Acute side only	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Adult IP; Children's IP; Critical Care; Day Procedure; Dental; Maternity; OP; Theatres) Acute only Total	95%	93%	93%	94%	91%	85%	92%	90%	94%	94%	91%	92%	92%
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Acute only Total	96%	95%	93%	94%	91%	89%	91%	89%	96%	96%	94%	93%	93%
Invasive Device Care Audit Acute only Total	96%	96%	92%	93%	93%	92%	96%	95%	98%	98%	94%	95%	95%
Matron Checks (IP; OP/Community/Dental; Theatres) Acute only Total	94%	96%	91%	97%	92%	92%	95%	94%	92%	96%	90%	96%	94%

Clinical Assurance Indicators/Audits (%) - Community side only	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Community HV/SN; Community Nursing; OP) Community only Total	97%	98%	96%	94%	97%	100%	95%	74%	99%	77%	96%	96%	93%
Standard IPC Precautions (incl HH, ANTT, PPE) Community only Total	91%	100%	95%	93%	92%	96%	91%	91%	100%	93%	100%	100%	95%
Invasive Device Care Audit Community only Total	78%	100%	100%	100%	100%	100%	78%	98%	100%	100%	100%	100%	96%
Matron Checks (OP/Community/Dental) Community only Total	98%	99%	99%	100%	98%	95%	100%	81%	90%	98%	96%	90%	95%

Education & Training

23/05/2023

Infection Control Mandatory Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Infection Control (Level 1)	95%	93%	94%	94%	95%	95%	95%	95%	96%	96%	95%	96%	95%

Aseptic Non Touch Technique Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
ANTT (M&D staff only)	65%	65%	65%	67%	NYA	NYA	NYA	NYA	NYA	NYA	NYA	NYA	66%

ANTT compliance levels

It should be noted that this compliance is only monitored in medical staff. Work is progressing to include the recording of ANTT assessment for all staff who undertake procedures requiring ANTT.

There may be several factors contributing to the low level of ANTT compliance in medical staff, these include staff pressure due to staffing levels, access to ANTT assessors and also the lack of an electronic form for medical staff to register their ANTT assessment. The latter was using a survey monkey link on the intranet however this is no longer available. Currently a copy of the completed assessment form has to be sent to Education and Workforce Development. Education and Workforce Development are in the process of developing a new electronic system for recording this assessment.

Aug/Sep 2023 re ANTT in the Learning Lab - TEL team have advised there have been some updates to the way ANTT is assigned. It has now been assigned as a 3 year renewal to anyone who also has Adult Resus Level 2 assigned to them. The Power BI dashboard has now been updated to include this 3 year renewal ANTT certification, which replaces the old one, but currently only 36 staff are compliant, making the compliance rate less than 1% therefore August's total is not recorded here

Agenda item A11(d)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Healthcare-Associated Infections Report
April 2024

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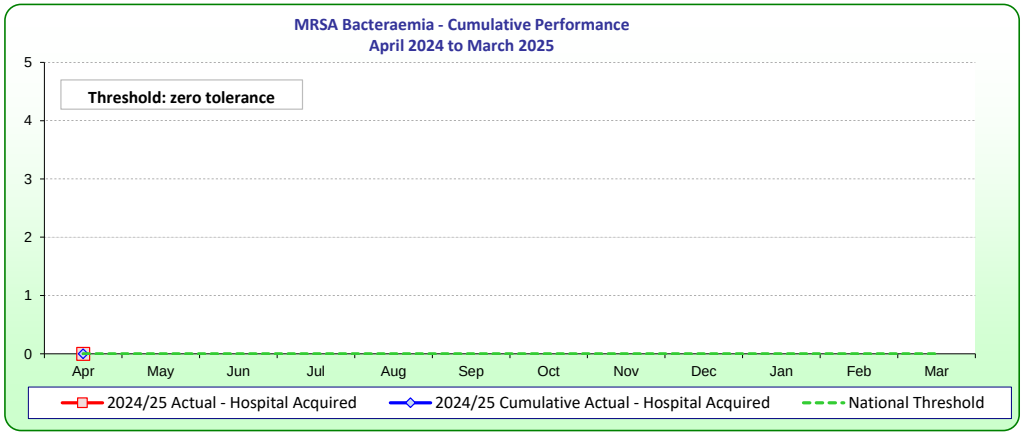

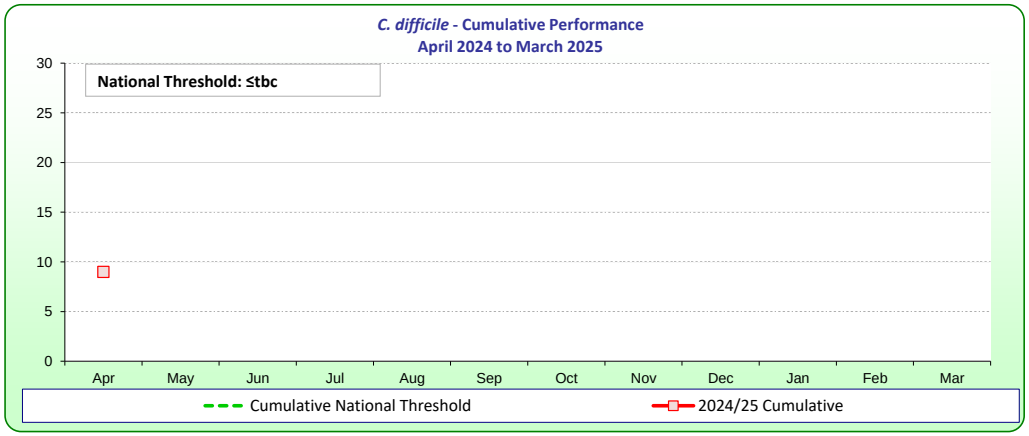

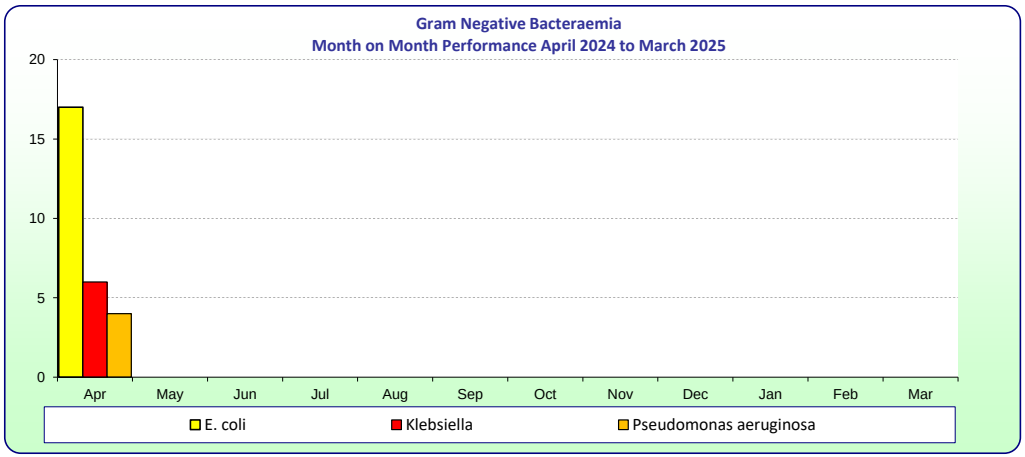

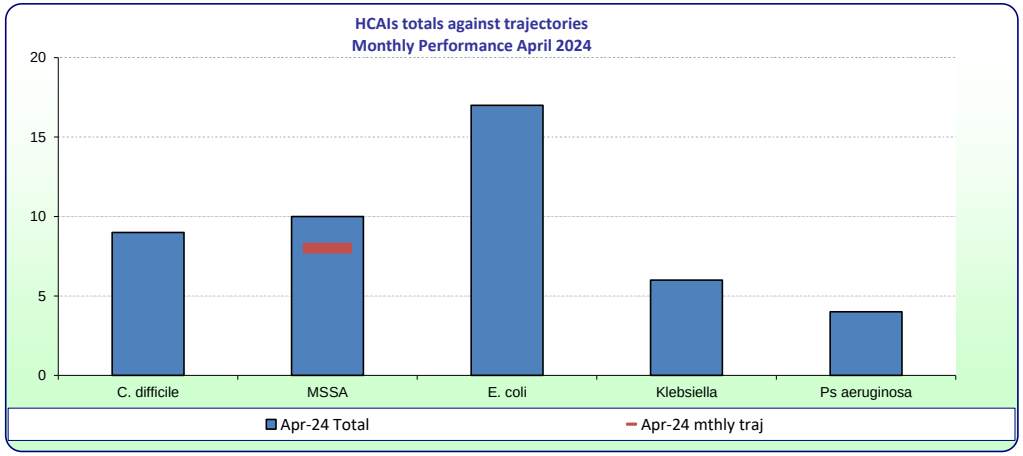

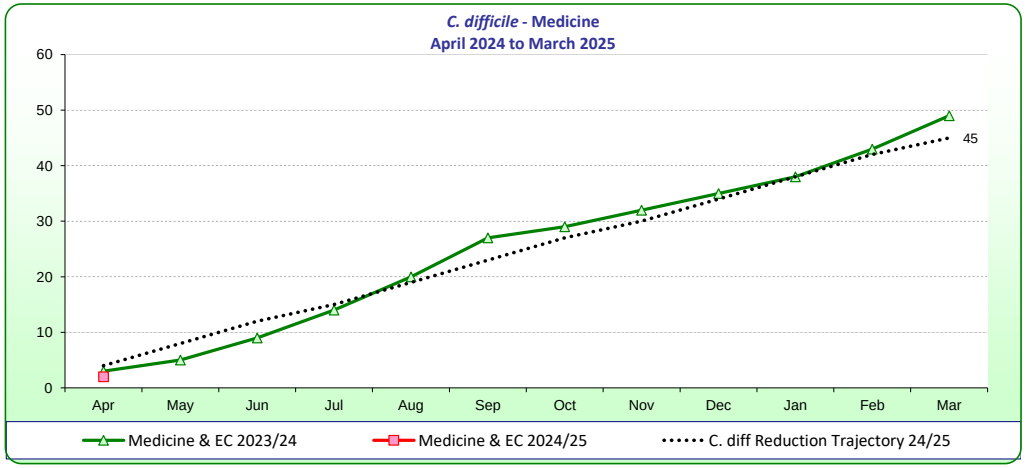

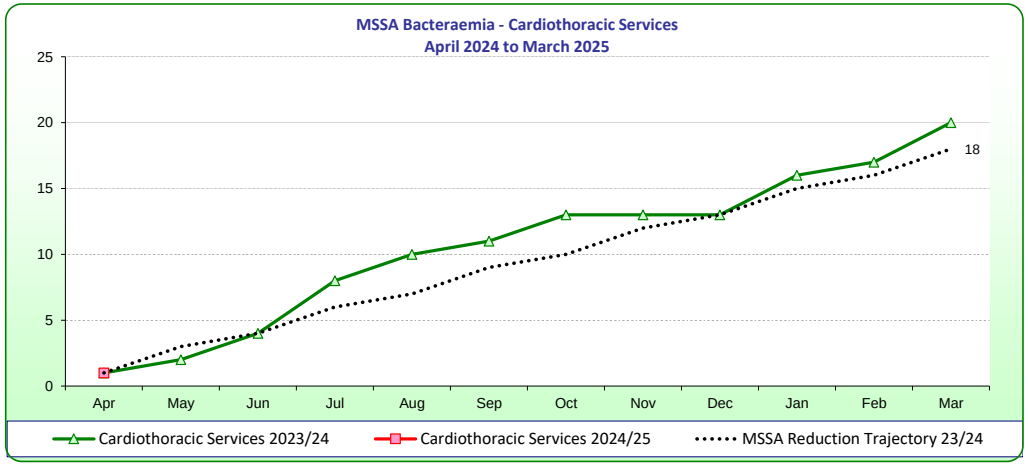

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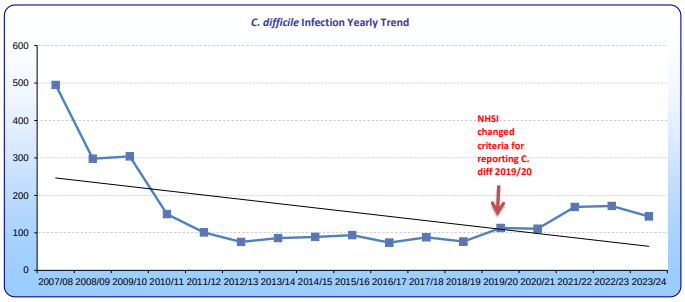

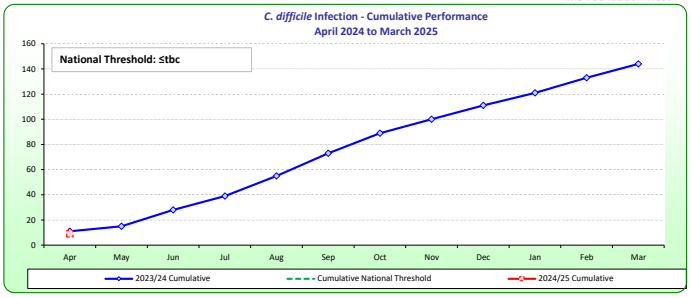

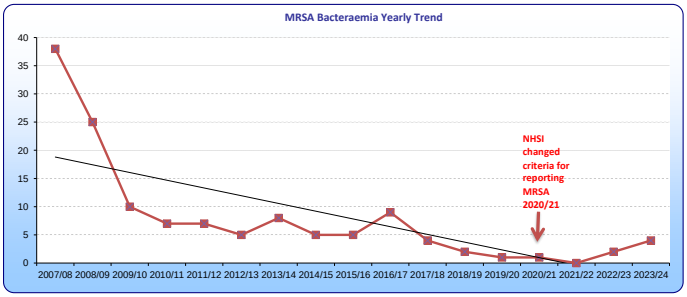

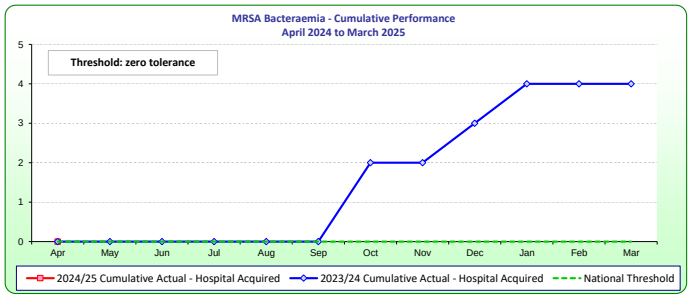

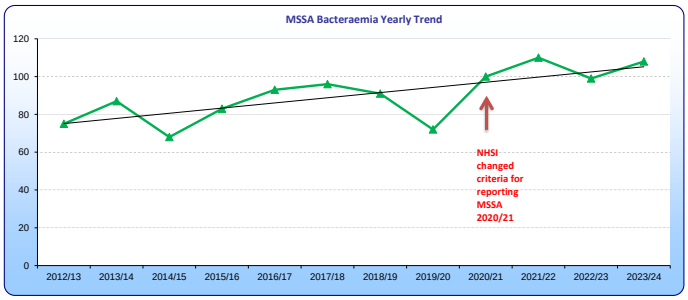

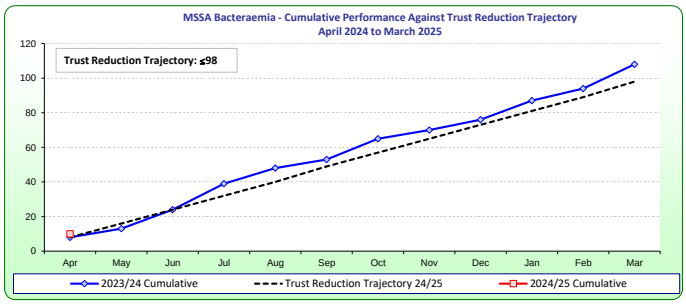

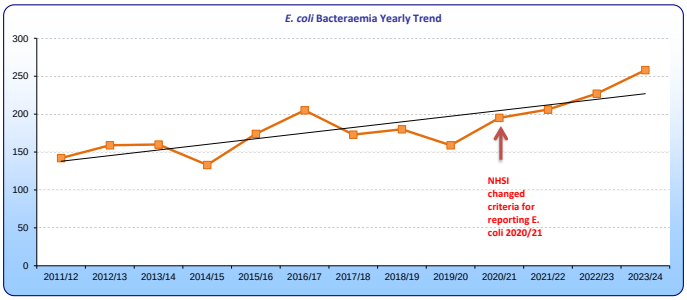

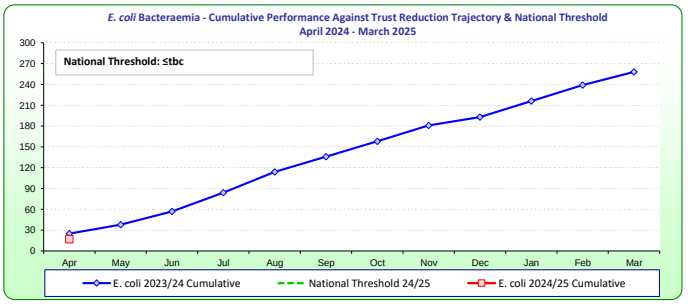

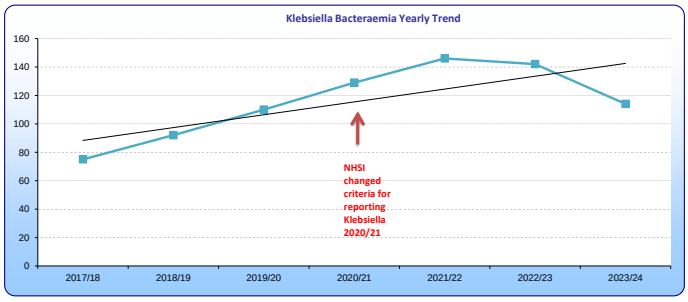

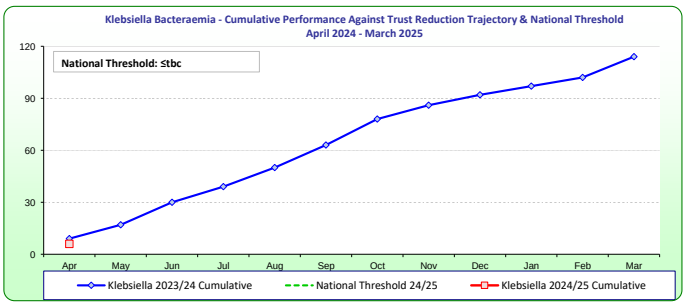

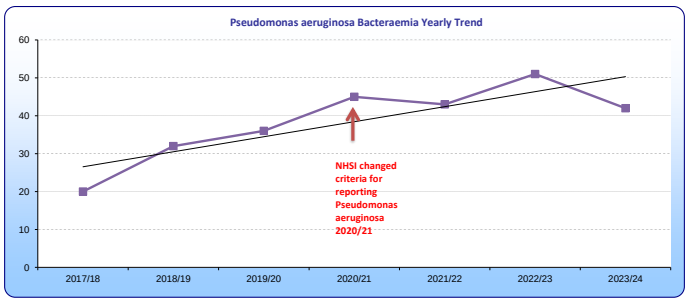

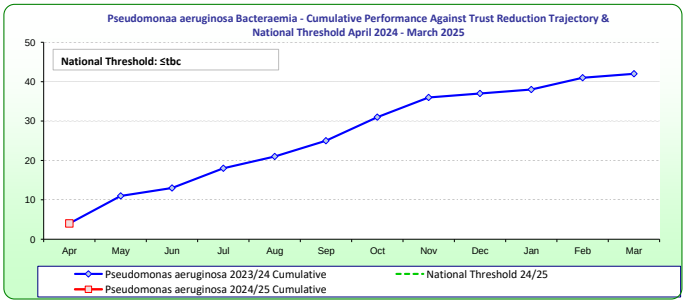

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Bacteraemia / Infections

IPC indicators (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA Bacteraemia - non-Trust	0												0
MRSA Bacteraemia - Trust-assigned (objective 0)	0												0
MSSA Bacteraemia - Healthcare Associated (local objective ≤98)	10												10
E. coli Bacteraemia - Healthcare Associated (National Threshold ≤NYK)	17												17
Klebsiella Bacteraemia - Healthcare Associated (National Threshold ≤NYK)	6												6
Pseudomonas aeruginosa Bacteraemia - Healthcare Associated National Threshold ≤NYK)	4												4
C. diff - Hospital Acquired (national threshold ≤NYK)	9												9
C. diff related death certificates	0												0
Part 1	0												0
Part 2	0												0

Periods of Increased Incidence (PIIs)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
C. diff - Hospital Acquired	1												1
Patients affected	4												4
COVID-19 - Hospital Acquired	0												0
Patients affected	0												0

Healthcare Associated COVID-19 cases (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Hospital onset Probable HC assoicated (8-14 days post admission)	13												13
Hospital onset Definite HC assoicated (≥15 days post admission)	18												18

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	11												11
Patients affected (total)	136												136
Staff affected (total)	49												49
Bed days losts (total)	425												425
Other Outbreaks	2												2
Patients affected (total)	24												24
Staff affected (total)	3												3
Bed days losts (total)	77												77
COVID Outbreaks	7												7
Patients affected (total)	37												37
Staff affected (total)	0												0

C.diff Transit and Testing Times Target <18hrs	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Trust Specimen Transit Time	12:38												12:38
Laboratory Turnaround Time	02:01												02:01
Total to Result Availability	14:39												14:39

Clinical Assurance Tool (CAT)

Clinical Assurance Indicators/Audits (%) - Trust as a whole	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Adult IP; Children's IP; Community HV/SN; Community Nursing; Critical Care; Day Procedure; Dental; Maternity; OP; Theatres) Trust Total	92%												92%
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Trust Total	94%												94%
Invasive Device Care Audit Trust Total	98%												98%
Matron Checks (IP; OP/Community/Dental; Theatres) Trust Total	97%												97%

Clinical Assurance Indicators/Audits (%) - Acute side only	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Adult IP; Children's IP; Critical Care; Day Procedure; Dental; Maternity; OP; Theatres) Acute only Total	92%												92%
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Acute only Total	93%												93%
Invasive Device Care Audit Acute only Total	97%												97%
Matron Checks (IP; OP/Community/Dental; Theatres) Acute only Total	97%												97%

Clinical Assurance Indicators/Audits (%) - Community side only	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Community HV/SN; Community Nursing; OP) Community only Total	93%												93%
Standard IPC Precautions (incl HH, ANTT, PPE) Community only Total	99%												99%
Invasive Device Care Audit Community only Total	100%												100%
Matron Checks (OP/Community/Dental) Community only Total	100%												100%

Education & Training

Infection Control Mandatory Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Infection Control (Level 1)	94%												94%

Aseptic Non Touch Technique Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
ANTT (M&D staff only)	NYA												

ANTT compliance levels

It should be noted that this compliance is only monitored in medical staff. Work is progressing to include the recording of ANTT assessment for all staff who undertake procedures requiring ANTT.

There may be several factors contributing to the low level of ANTT compliance in medical staff, these include staff pressure due to staffing levels, access to ANTT assessors and also the lack of an electronic form for medical staff to register their ANTT assessment. The latter was using a survey monkey link on the intranet however this is no longer available. Currently a copy of the completed assessment form has to be sent to Education and Workforce Development. Education and Workforce Development are in the process of developing a new electronic system for recording this assessment.

Aug/Sep 2023 re ANTT in the Learning Lab - TEL team have advised there have been some updates to the way ANTT is assigned. It has now been assigned as a 3 year renewal to anyone who also has Adult Resus Level 2 assigned to them. The Power BI dashboard has now been updated to include this 3 year renewal ANTT certification, which replaces the old one, but currently only 36 staff are compliant, making the compliance rate less than 1% therefore August's total is not recorded here

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024		
Title	Committee Annual Reports, including Terms of Reference Review and Schedule of Business for 2024/2025		
Report of	Kelly Jupp, Trust Secretary		
Prepared by	Kelly Jupp, Trust Secretary		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☒	☐
Summary	The purpose of this report is to provide assurance to the Trust Board that the Audit, Finance, People & Quality Committees have met their key responsibilities for 2023/24, in line with their Terms of Reference. The Committee Annual Reports outline overall achievements throughout the year and action points for continuing development during the coming year. The Annual Reports have been considered at the relevant Committee meetings. The Committee Terms of Reference (ToR) and Schedules of Business (SoB) have been discussed at each respective Committee meetings. Minor changes have been made to the ToRs and SoBs to reflect: - Updated responsibilities, governance arrangements and strategic priorities. - Changes to Director role titles. - Updates to guidance, references and Committee or document names. - Specific references to CQC updates. - Changes to the frequency of meetings. The new Digital and Data Committee, and updated Audit, Risk and Assurance Committee (ARAC), ToR and SoB were approved at the 28 March 2024 Trust Board meeting and are therefore not included in this report. At the 23 April 2024 ARAC Committee meeting it was agreed that the minutes of both the Charity Committee and the Compliance and Assurance Group be included in the ARAC meeting papers from May 2024. These will therefore be added to the SoB. At the 14 May 2024 Quality Committee meeting when the ToR and SoB were discussed the Executive Director of Nursing advised that further consideration would be given to the documents due to changes in the Committee Chair. He subsequently recommended that a minor amendment be made to the ToR to reference attendance by a representative from the Integrated Care Board and noted that further changes may be required in the future. The Charity Committee Annual Report, Terms of Reference and Schedule of Business will be submitted to the Trust Board in July 2024.		
Recommendation	The Trust Board is asked to: i) Approve the Committee Annual Reports, outlining 2023/24 work undertaken and note the key areas to revisit during 2024/25; and		

	ii) Approve the updated Terms of Reference and 2024/25 Schedules of Business.					
Links to Strategic Objectives	Performance – Being outstanding, now and in the future.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link.					
Reports previously considered by	Annual Review. Submission to the relevant Committee meetings has taken place in advance of the 23 May 2024 Board meeting.					

AUDIT COMMITTEE ANNUAL REPORT 2023-2024

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Audit Committee has met its key responsibilities for 2023-24, in line with its terms of reference and the requirements of the newly published Audit Committee Handbook 2024.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. AUDIT COMMITTEE RESPONSIBILITIES

The key purpose of the Audit Committee is to provide the Board with:

- an independent and objective review of financial and organisational controls, the system of integrated governance and risk management systems and practice across the whole of the organisation's activities (both clinical and non-clinical);
- assurance of value for money;
- compliance with relevant and applicable law;
- compliance with all applicable guidance, regulation, codes of conduct and good practice; and
- advice as to the position of the Trust as a "going concern."

It does this through receipt of assurances from auditors, management and other sources.

3. AUDIT COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board from the Non-Executive Directors of the Trust and consists of five members with a quorum being two members.

Four ordinary meetings and one extraordinary meeting were held between 1 April 2023 and 31 March 2024 and attendance was as follows:

	Attendance at ordinary meetings	Attendance at extraordinary meeting
Mr B MacLeod, Non-Executive Director	4 of 4	1 of 1
Mr J Jowett, Non-Executive Director	4 of 4	1 of 1
Mr G Chapman, Non-Executive Director	4 of 4	1 of 1
Professor K McCourt, Non-Executive Director*	1 of 1	0 of 0
Ms C Smith, Non-Executive Director#	2 of 2	1 of 1
Ms J Baker, Non-Executive Director^	1 of 1	0 of 0

* Professor K McCourt attended as an interim Committee member for the 25 April 2023 Committee meeting only.

Ms C Smith joined as a Committee member from June to October 2023.
^ Ms Baker joined as a Committee member from January 2024.

The Committee met the minimum number of five meetings per year and other attendees at the meetings have included:

- External and Internal Audit at all meetings;
- The Trust's Fraud Specialist Manager and the Counter Fraud Specialist;
- Management, represented by the Chief Executive Officer, the Chief Finance Officer, the Assistant Chief Executive/Director of Communications and Corporate Affairs, the Chief Information Officer, the Executive Director for Business, Development and Enterprise/Director for Commercial Development and Innovation, and the Chief Operating Officer.
- The Trust Secretary and Corporate Governance Manager / Deputy Trust Secretary who also provide Secretariat Support to the Committee;
- The Head of Corporate Risk & Assurance;
- The Clinical Effectiveness Manager, the Head of Quality Assurance and Clinical Effectiveness and the PSIRF Implementation Lead;
- The auditor of the Trust Charity; and
- Senior finance team and IT team members.

During 2023/24, the following training sessions were provided to Committee members (and offered to all Board members)

- 5 February 2024 – PwC facilitated a training session on the purpose of the Audit Committee, roles and responsibilities, governance and the definitions of risk, control and assurance.

In addition, a further briefing was scheduled in February 2024 on Information Governance (IG)/Cyber Security.

4. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee is required to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities that supports the achievement of the Trust's objectives, internal control and risk management.

The Audit Committee had a Schedule of Business for the year and uses a rolling programme and action log to track committee actions.

The Committee has reviewed:

- Its Terms of Reference and Schedule of Business.
- The Head of Internal Audit opinion (June 2024).
- The Board Assurance Framework (BAF); being the underlying assurance processes that indicate the achievement of corporate objectives and the effectiveness of management of principal risks.
- Risk management arrangements and the BAF Risk Management Annual Report.

- Amendments required to the Scheme of Delegation, Standings Orders and Standing Financial Instructions.
- The response to the External Auditors on:
    - ISA+240: Audit Committee responsibilities for preventing fraud in the Annual Accounts.
    - ISA+250: Audit Committee responsibilities for being satisfied that the Annual Accounts comply with laws and regulations.
    - ISA+501: Specific consideration of the potential for, and actual, litigation and claims affecting the financial statements.
    - ISA+570: Consideration for the Going Concern Assumption in an audit of financial statements.

  Committee members agreed the response for submission to the External Auditors for the year.

The BAF focuses on the key risks against achievement of the strategic objectives. The BAF is a 'live' document which is continuously reviewed and updated by the Corporate Risk & Assurance Department. Each ordinary meeting of the Committee is updated on the BAF and Register.

Each Committee of the Board has a responsibility to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the BAF specific to the Committee purpose and function. Quarterly each Committee of the Board receives a report detailing the:

- Executive Lead review undertaken during the previous 3 month period and any recommendations for risks held on the Board Assurance Framework aligned to that Committee;
- Assurances received and any areas requiring Committee consideration;
- Number of risks held on the BAF, movements in risks and the risks categorised by risk type;
- Risks added/removed to the Executive Oversight Register during the period; and
- Operational risk profile.

The Board Risk Appetite Statement was due to be presented to the Audit Committee in January 2024 however following publication of the Trust CQC inspection reports that month the production of the Statement was delayed to enable further work to be undertaken on the overarching Trust risk management arrangements. In January 2024 the Trust procured the services of thevaluecircle, to provide advice and support in ensuring an effective governance system was in place from Ward to Board.

Updates from members of the Finance, Quality and People Committees continue to appear as a standing agenda item on the Audit Committee agenda, with any matters raised for the Committee members' attention by exception.

The 2022/23 Risk Management audit report received a reasonable assurance rating from AuditOne, with one high-risk recommendation, reported to the June 2023 Audit Committee meeting. The 2022/23 BAF audit report received a good assurance rating. At the time of writing this report, the 2023/24 BAT internal audit report has been issued in draft with a good assurance rating.

The Committee is satisfied that the system of risk management in the organisation is adequate in identifying risks and allows the Board of Directors to understand the appropriate management of those risks. The Committee believes there are no areas of significant duplication or omission in the systems of governance (that have come to the Committee's attention) that have not been adequately resolved.

5. INTERNAL AUDIT

The Committee has ensured that there is an effective internal audit function established by management that meets mandatory Internal Audit Standards and provides appropriate independent assurance. The Trust receives its internal audit service from AuditOne.

This was achieved by:

- Reviewing and approving the Internal Audit Plan 2023/2024, including regular updates of performance against the Plan.
- Consideration of the major findings arising from internal audit work and management's responses.
- Receipt of the Internal Audit Annual Report and Head of Internal Audit Opinion.
- Monitoring progress with implementation of agreed audit recommendations.

The Committee received a report from the internal auditor at each of its Committee meetings which summarised the audit reports issued since the previous meeting.

The internal audit plan for 2023/24 was based on a risk assessment approach centred on discussions with senior staff and Directors and was linked to the organisation's assurance framework. Assurances from Internal Audit reports are, where possible, mapped to the BAF clearly in the BAF document itself.

Good progress continued to be made during the year in relation to the completion of historic internal audit recommendations.

A limited assurance report has been issued in relation to Outpatients (Appointment Booking Process) Follow Up during the year 2023/24.

A number of high priority recommendations were identified by Internal Audit and reported during 2023/24, these covered the following internal audits:

- Outpatients (Appointment Booking Process) and associated follow-up – the IT vacant slot report was available within Cerner but not configurable or exportable, and a capacity report is not available to identify available appointments or cancellations – Limited Assurance (reported June 2023 and January 2024)
- Outpatients (Appointment Booking Process) – Synertec – unable to fully reconcile the Trust records and Synertec invoices for outpatient letters – Limited Assurance (reported June 2023)
- Duty of Candour – six from a sample of 20 closed patient safety incidents had no evidence of duty of candour being enacted – Reasonable Assurance (reported June 2023)

- Mental Capacity Action – evidence of assessments of capacity are not recorded in a clear, consistent manner within e records, the MCA forms developed to record assessments should be fully utilised to demonstrate the assessments have been completed – Reasonable assurance (reported in draft in June 2023 and in final form in July 2023)
- Risk management – consider the underlying reasons behind the gaps / issues identified in Datix and consider whether improvements to the functionality of the risk management system are required in order to improve compliance – Reasonable assurance (reported July 2023)
- Temporary Staff (Non-Medical Staff) – two (out of ten) agency staff sampled, did not have their bookings made by the Staff Bank Team – Reasonable Assurance (reported in October 2023)
- Community Estate Management – 47% of the sites reviewed (18 out of 38) did not have Service Level Agreements in place to define individual roles and responsibilities, monitoring and reporting – Reasonable Assurance (reported October 2023)
- Management of Volunteers follow up – high rated recommendation reiterated around the fact that a signed Memorandum of Understanding was not in place with all third-party providers of volunteers to set out their key responsibilities including those in relation to compliance with NHS Employment Check Standards, confidentiality, induction, and statutory and mandatory training – Reasonable assurance (reported October 2023)
- Sustainability Agenda (advisory report) – four high rated recommendations were issued in relation to carbon footprint data, ISO Net Zero Gap Analysis, Red Flag Register (reported January 2024)
- PFI Performance Management – the Trust should implement a standard operating procedure or similar guidance document to detail the process to be followed for checking the accuracy of monthly performance reports received and verifying the completeness of any identified service breaches or quality failures – Reasonable assurance (reported January 2024)
- Business cases – all business cases should have evidence that they are full recommended and supported by the Directorate / Corporate Manager (and Directorate Finance Manager for those submitted via Salesforce). They should all then be authorised and approved in line with the Trust Scheme of Delegation – Reasonable assurance (reported January 2024)
- Procurement – waivers should not be considered for approval until all sections of the waiver form have been fully completed – Reasonable assurance (reported January 2024)

Regular updates on the progress in relation to high priority recommendations were received by Committee members during the year from management and internal audit.

Internal Audit performance against Plan was discussed at every Committee meeting during the year, along with updates on the workforce position within AuditOne. Workforce effort during the year was concentrated on completing the core audits required to deliver the internal audit plan.

6. EXTERNAL AUDIT

The Committee has reviewed the work and findings of external audit and considered the implications and management responses to their work.

This was achieved by:

- Discussing and agreeing with the external auditor the nature and scope of the audit as set out in the External Audit Annual Plan.
- Reviewing external audit reports, together with the appropriateness of management responses.
- Receiving the year-end Audit Opinion and ISA 260 report (Trust and Charity). For 2023/24, there was no requirement to undertake audit procedures on the Quality Report. During 2023/24, the Value for Money Conclusion certificate was signed separate to the Audit Opinion, at a later point during the financial year.
- Received the Annual Audit Letter.

The Council of Governors has the statutory responsibility for the appointment of the external auditors, and this process is led by a sub-group of public Governors supported by Trust officers and the Chair of the Audit Committee. During 2023/24, a robust procurement and evaluation process was undertaken regarding the external audit contract with Mazars LLP reappointed as the Trust's external auditors for an initial three year term commencing in the 2024/25 financial year – approval from the Trust's Council of Governors was granted in February 2024. This followed a satisfactory review of external audit performance undertaken.

The Mazars LLP external audit fees for 2023/2024:

- Statutory Accounts £90,000 (excluding VAT) which is lower than the statutory fee invoiced for 2022/23. The 2022/23 fee included an additional cost associated with auditing the Trusts lease accounting in accordance with the new International Financial Reporting Standard 16 (IFRS16) at that time.

The audit of the Charity Accounts is undertaken separately by Robson Laidler, with a 3-year contract in place.

For 2023/24, there was no mandated requirement to undertake external audit procedures on the Quality Report and therefore no fee was charged in relation to this.

To ensure that the independence of the external auditors is not compromised where work outside the scope of the Audit Code has been procured from the external auditors, the Trust has a policy which requires that no member of the team conducting the external audit may be a member of the team carrying out any additional work and their lines of accountability must be separate.

During 2022/23, the Trust's policy on Non-Audit Work was reviewed and updated. It was considered at the April 2023 Audit Committee meeting and the Council of Governors reviewed and approved the policy in June 2023. The policy requires review every three years.

No additional services/non-audit work was carried out by Mazars LLP during 2023/24.

7. MANAGEMENT

The Committee has challenged the assurance process when appropriate and has requested and received assurance reports/verbal updates from Trust management throughout the year.

8. FINANCIAL AREAS OF REVIEW

The Committee has ensured that the systems for financial reporting to the Board are subject to review.

The Committee has achieved this primarily through review and approval of the Annual Accounts, including those of the Newcastle upon Tyne Hospitals NHS Charity. The Committee also reviewed the External Audit Opinion and fed back relevant comments for consideration by the external auditors.

In the course of 2023/24, there were no significant issues that the Committee had to consider in relation to the financial statements. During the year, the Committee reviewed the following key areas of management judgement and significant risks:

- Accounting for PFI (Trust);
- Management over-ride of controls (Group and Trust);
- Valuation of property assets (Trust);
- Risk of fraud in revenue recognition (Group and Trust); and
- First time adoption IFRS 16.

Other areas discussed between External Audit and Management during the year, and reported to the Audit Committee, related to:

- Fire remedial work provision; and
- Value for money work.

These have been considered through the presentation of the external audit plan, associated progress updates and discussions during Committee meetings.

9. OTHER AREAS OF ACTION AND REVIEW

The Committee has:

- Reviewed details of all Losses and Compensation Payments.
- Received reports on approved single tender actions where applicable.
- Reviewed regular debtors and creditors reports.

- Received and approved the Counter Fraud annual plan, as well as regular updates in the form of the Fraud response log, associated progress reports, the Annual Report on Counter Fraud, and the Counter Fraud Functional Standard Return.
- Reviewed the minutes of associated Committees.
- Reviewed the content of the statutory Annual Report (including the Annual Governance Statement).
- Reviewed and endorsed changes to the Trust Scheme of Delegation, Standing Financial Instructions and Standing Orders.
- Received the Annual Accounts preparation timetable and subsequently the Annual Accounts and Going Concern Review.
- Received an annual report on special severance payments/settlement agreements.
- Approved the Trust's Annual Modern Slavery Act Statement.
- Received updates on Standards of Business Conduct, including declarations of interest, fit and proper persons and the annual review of the register of gifts and hospitality.
- Received a report on waivers and breaches of the Trust Standing Financial Instructions.
- Received an action log to follow up previous Committee meeting actions.
- Received an update on the Clinical Audit Process.
- Received regular updates on information governance, information management and technology (IM&T) and cyber security from the joint/single Senior Information Risk Owners (SIRO(s)).
- Received updates from the Chairs/members of the Quality, People and Finance Committees.
- Approved the Internal Audit Charter and Protocol (April 2023).
- Received an update on the PFI energy costs/VAT matter.
- Reviewed the performance of Internal Audit, External Audit and Counter Fraud.
- Received further updates on:
    - Progress made in relation to the follow up of internal audit recommendations;
    - The external audit tender; and
    - The HFMA checklist.

10. PROGRESS FOR 2024-2025

The self-assessment checklist from the HFMA Audit Committee Handbook (the 2024 version being the latest version) has been completed and is due to be discussed at the April 2024 Committee meeting.

The following area of focus has been identified for 2024/25:

1. Following on from the publication of the CQC inspection report it was evident that there was a need to increase the level of assurance received at Committee level in relation to the reporting, management and escalation of risks from Ward to Board. The Trust Board decided at their March 2024 meeting that the remit of the Audit Committee will be expanded further to incorporate 'risk' and 'assurance' elements, with the Committee renamed as the Audit, Risk and Assurance Committee (ARAC).

The Terms of Reference and Schedule of Business for the Committee have therefore been significantly updated to reflect the new ARAC, with the changes agreed at the Trust Board meeting in March 2024. These are appended for information.

The key area of focus for 2024/25 will be to fully embed the role of the new ARAC and ensure appropriate reporting and flow of risks and assurances into the Committee meeting.

In the 2023/24 Annual Report of the Committee the key area of focus was to consider the implementation of the new management structure and potential impacts on risk management, controls and governance processes, including associated updates to key documentation e.g. updating the Scheme of Delegation, Standing Orders and Standing Financial Instructions. The governance documents were updated during 2023/24 to reflect the changes in the new management structure and an Accountability Framework developed, and approved by the Trust Board.

Report of Kelly Jupp
Trust Secretary
8 April 2024

FINANCE COMMITTEE ANNUAL REPORT 2023-2024

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Finance Committee has met its key responsibilities for 2023/24, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. COMMITTEE RESPONSIBILITIES

The Finance Committee is a non-statutory Committee established by the Trust Board of Directors to provide assurance to the Board on the delivery of the financial aspects of the Trust's annual Operational Plan, including financial strategy and planning, transformation and sustainability, the financial performance of the Trust, and on commercial and procurement activity and strategic investments and the development of the Trust's digital and estates infrastructure.

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors, that:

- the strategic financial principles, priorities, risk and performance parameters are aligned and support the Trust's strategic objectives and its long-term sustainability;
- the Trust's degree of exposure to financial risk, and any potential to compromise the achievement of the strategic objectives is being effectively managed;
- reporting on the financial performance of the Trust is being triangulated against agreed plans, progress and performance measures, reporting on progress to the Trust Board;
- the Trust's resources and assets are being used and maintained effectively and efficiently;
- financial management and planning information is robust, credible and high quality, and that such information is reviewed and triangulated by the Committee;
- the Trust complies with current statutory and external reporting standards and requirements, including NHS and Treasury policies and procedures;
- the Trust's capital investment programme is fully developed, effectively managed and delivered, and that it is fit for purpose;
- mitigations and action plans as set out in the Board Assurance Framework specific to the Committee purpose and function are effective;
- procurement decision-making and documentation is robust; and
- Committee associated strategies are developed and delivered.

It does this through the receipt of assurances from management groups in the form of updates from Executive Team members and receipt of minutes from the Capital Management Group, the Supplies and Services Procurement Group, the Strategy, Planning and Capital Investment Group, the Community Diagnostic Centre Oversight Group and the Commercial Strategy Group. In addition, the Committee receives regular reports relating to

areas which impact the financial position of the Trust and considers reports on the management of risks relating to the Committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of six members (noting a minimum of six members is required as per the Terms of Reference), drawn from the Non-Executive Directors and members of the Executive Team.

The Committee's quorum is four members and include the Chair or Vice-Chair and at least one other Non-Executive Director.

Six ordinary meetings and two extraordinary meetings were held between 1 April 2023 and 31 March 2024. One of the extraordinary meetings was arranged to discuss the Draft Annual Accounts 2022/23 and a small number of items for approval prior to Trust Board consideration. The second of the extraordinary meetings was arranged to discuss the Financial Recovery Plan and a tender requiring approval prior to Trust Board consideration. The attendance during the year was as follows:

	Attendance at ordinary meetings	Attendance at extraordinary meetings
Ms C Smith, Non-Executive Director – joined the Committee in May 2023 as a member and became Chair of the Committee from 1 June 2023	5 of 6	1 of 2
Mr G Chapman, Non-Executive Director – was Interim Committee Chair until 31 May 2023, and then reverted back to being a Committee member (Vice Chair of the Committee)	5 of 6	1 of 2
Mr B MacLeod, Non-Executive Director – was a Committee member until 31 August 2023	2 of 2	1 of 1
Mrs L Bromley, Non-Executive Director –was an Interim Committee Member from 1 February 2023 until 31 May 2023, and then joined as a substantive Committee member from 1 September 2023	4 of 5	1 of 2
Professor K McCourt, Non-Executive Director – Interim Committee member from 1 April 2023 to 30 April 2023	0 of 0	1 of 1
Mrs J Bilcliff, Chief Finance Officer	6 of 6	2 of 2
Mr M Wilson, Chief Operating Officer	3 of 6	1 of 2
Mr G King, Chief Information Officer – Committee member until 31 May 2023	1 of 1	1 of 1
Mr R Smith, Estates Director	6 of 6	1 of 2
Dr V McFarlane-Reid, Director for Commercial Development and Innovation	6 of 6	2 of 2

Mrs S McMahon, Chief Information Officer – joined as a member of the Committee from January 2024	1 of 2	0 of 0
Mrs L Sewell, Interim Chief Information Officer – Committee member from June to December 2023	1 of 3	0 of 1

The Committee met for the minimum number of six meetings per year and other attendees at the meetings have included:

- The Chief Executive;
- The Deputy Director for Business, Development and Enterprise;
- The Deputy Chief Finance Officer;
- The Procurement and Supply Chain Director;
- The Deputy Director of Estates;
- The Deputy Chief Operating Officer;
- The Head of Corporate Risk and Assurance;
- Associate Director Commercial Enterprise;
- Assistant Director – Service & Business Development;
- Assistant Director Business Planning & Strategy Management;
- Senior Performance Managers;
- The Executive Director of Nursing;
- A Joint Medical Director;
- A Director of Operations;
- The Director of Communications and Corporate Affairs;
- The Assistant Director of Pharmacy;
- The Director of PMO; and
- The Trust Secretary, the Deputy Trust Secretary and the Governor and Membership Engagement Officer, who have provided secretariat support to the Committee.

In addition, the Chair of the Governor Business and Development Working Group observed one Committee meeting during the year.

4. REPORTING & AREAS OF REVIEW

During the year, the Committee:

- Received, and constructively challenged the content of the regular reports on the Trust financial position, including the closing position for the year and an update on the Annual Accounts for 2022/23.
- Discussed the Planning guidelines and the Key Line of Enquiry Review Report.
- Sought assurance over the financial management arrangements regarding:
  - The Productivity and Improvement Programme/Cost Improvement Programme;
  - Development of the Financial and Activity Plans; and
  - The Commercial Strategy.
- Requested 'deep dives' into a number of areas and risks e.g. Cancer Performance. The deep dive items were either included in the finance report or added as a separate agenda item.

- Received and discussed frequent updates on the Productivity and Efficiency Programme.
- Sought and received regular updates from the Procurement and Supply Chain Director regarding the Procurement Plan/Procurement activity.
- Considered the capital and revenue plans for future periods, seeking assurances over the validity of the assumptions and risks detailed within.
- Received updates on activity performance against plan, queried variances arising and discussed the impact on Elective Recovery Funding.
- Received updates on the 2023/24 Capital Programme (including investments and developments), critical infrastructure costs and considered the 2024/25 Capital Programme.
- Approved tenders, investments and business cases (BC) in accordance with the delegated authority of the Committee. This included for example ScubaTX, Health Call, Dermatology BC and Sophos Suite Replacement.
- Endorsed the Annual National Cost Collection Exercise.
- Received a close-out report on the Integrated Covid Hub North East, the Nightingale Hospital North East and the Day Treatment Centre.
- Challenged the process for the prioritisation/consideration of business cases, and received updates on business cases not approved.
- Received a briefing on the phase 2 funding for the Community Diagnostic Centre (CDC), as well as an update on progress with the construction of the Centre.
- Considered a proposal for the management of shareholdings and for resolving the HSN ventilation matter.
- Reviewed the content of the Financial Recovery Plan and ongoing development, as well as having considered the NHSE priorities and sought assurances over the associated risks.
- Reviewed and approved the Capital Management Group Terms of Reference.
- Received a briefing on IFRS 16.

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2023/24 and utilised a rolling programme and action log to track committee actions.

The Committee receives regular updates on risks recorded on the Board Assurance Framework which relate to the Committee's area of focus. Discussions have included those pertaining to the changes to the financial regimes/national funding.

During the year, the Committee has reviewed:

- Its Terms of Reference and Schedule of Business as part of the production of its Annual Report.
- The quarterly Board Assurance Framework (BAF) Assurance Reports.

6. MANAGEMENT

The Committee has challenged the assurance process when appropriate and has requested and received assurance reports/verbal updates from Trust management throughout the year.

7. FUTURE AREA OF COMMITTEE FOCUS

Good progress has continued during 2023/24 to embed 'deep dive' areas and strategic risks into Committee agendas.

Given the significant financial challenges anticipated in 2024/25, it is recommended that the Committee ensures sufficient time is allocated on each meeting agenda to reviewing delivery regarding the Financial Recovery Plan and Activity Performance. In order to assist with this the Committee meetings have been moved to monthly from bi-monthly for 2024/25.

The Terms of Reference (ToR) and Schedule of Business (SoB) for the Committee have been reviewed and minor changes proposed for consideration at the May 2024 Committee meeting. In summary the main changes are:

- To remove references to the Digital Strategy as this has been moved to the Digital and Data Committee ToR/SoB; and to the Estates/Capital Strategy as it was agreed previously that this be taken directly to Trust Board.
- The addition of anticipated Estates Capital Schemes and Contracts into the SoB.
- The change to monthly meetings of the Finance and Performance Committee (except in August).
- Amendments to reflect the change in name of the Committee to the Finance and Performance Committee from 1 April 2024; and to reflect changes in role/names of roles.
- A change to allow nominated deputies to be counted in the quorum.
- Removed references to the Commercial Strategy Group which has been stood down.
- Updated references to the Audit, Risk & Assurance Committee.

Both documents have been appended for approval.

Report of Kelly Jupp
Trust Secretary
29 April 2024

Terms of Reference – Finance & Performance Committee

1. Constitution of the Committee

The Finance & Performance (F&P) Committee is a non-statutory Committee established by the Trust Board of Directors to provide assurance to the Board on the delivery of the financial aspects of the Trust's annual Operational Plan, including financial strategy and planning, transformation and sustainability, the financial performance of the Trust, and on commercial and procurement activity, including strategic investments.

2. Purpose and function

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors:

2.01 that the strategic financial principles, priorities, risk and performance parameters are aligned and support the Trust's strategic objectives and its long-term sustainability;

2.02 that the Trust's degree of exposure to financial risk, and any potential to compromise the achievement of the strategic objectives is being effectively managed;

2.03 that reporting on the financial and activity performance of the Trust is being triangulated against agreed plans, progress and performance measures, reporting on progress to the Trust Board;

2.04 that the Trust's resources and assets are being used and maintained effectively and efficiently;

2.05 on the robustness, credibility and quality of financial management and planning information, which is reviewed and triangulated by the Committee;

2.06 on the Trust's compliance with current statutory and external reporting standards and requirements, including NHS and Treasury policies and procedures;

2.07 on the development, effective management, and delivery of the Trust's capital investment programme, and that this is fit for purpose;

2.08 to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the committee purpose and function; and

2.09 on the robustness of procurement decision-making and documentation.

2.10 The Committee will provide the Trust Board of Directors with advice and support on the development and delivery of the following strategies:

- Investment Strategy (regarding investments in services and business cases);
- Commercial Strategy; and
- Procurement Strategy.

3. Authority

The Committee is:

3.1 a non-statutory Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference;

3.2 authorised by the Board of Directors to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required; and

3.3 authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Lead of the Committee and / or the Trust Secretary).

3.4 The Committee shall be able, in exceptional circumstances, to establish sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility, if approved by the Trust Board. In accordance with the Trust's Standing Orders and Scheme of Delegation, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the Board of Directors.

3.5 The Terms of Reference, including the reporting procedures, of any sub-committees or task and finish group, must be approved by the Board of Directors and be reviewed on an annual basis.

4. Membership and quorum

Membership

4.01 Members of the Committee shall be appointed by the Trust Board of Directors and shall be made up of at least six members drawn from Non-Executive Directors (three members minimum) and members of the Executive Team (three members minimum).

4.02 One of the Non-Executive members will be appointed by the Trust Board of Directors as the Chair of the Committee.

4.03 A further Non-Executive member of the Committee will be appointed as Vice-Chair, likewise by the Trust Board of Directors.

4.04 The membership of the Committee shall include:

- a Non-Executive member;
- the Chief Finance Officer;
- the Managing Director;
- the Chief Information Officer;
- the Director of Estates; and

- the Director for Commercial Development and Innovation.

4.05 The Chief Executive, as the Trust's Accountable Officer, shall have the right to attend the Committee at any time. Otherwise, only members of the Committee have the right to attend Committee meetings. Other non-committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.06 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year.

4.07 The Chief Finance Officer shall act as Executive Lead for the Committee.

4.08 Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by either telephone or electronic means will count towards the quorum.

4.09 The Council of Governors may nominate up to two governors to attend one meeting of the Committee annually to observe proceedings. The observation of Board assurance committees by governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may, in exceptional circumstances, exclude governors from being present for specific items.

4.10 The Trust Secretary, or their designated deputy, shall act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, shall attend all meetings of the Committee.

4.11 All members of the Committee shall receive training and development support before joining the committee where required and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

4.12 An attendance record shall be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

4.13 The Chair of the Board of Directors will not be a member of the Committee but may be in attendance.

Quorum

4.14 The quorum necessary for the transaction of business shall be four members as defined in 4.01 and 4.04 above, including the Chair or Vice Chair and at least one Non-Executive Director.

4.15 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will count towards the quorum.

4.16 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers, and discretions delegated to the Committee.

5. Duties

5.1 Cycle of Business

The Committee will:

5.1.1 set an annual set of objectives and an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

5.2 Strategies and policies

The Committee will:

5.2.1 review the Trust's financial strategy, planning assumptions, and related delivery plans and transformation programmes, and provide informed advice to the Board of Directors on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact;

5.2.2 review guidance for the development and delivery of the financial aspects of annual operational, service, and financial planning, including assumptions on revenue, budgets, capital, working and associated targets, and parameters on efficient and effective use of resources;

5.2.3 review, and recommend to the Board of Directors, the Annual Financial Plan, including key financial performance indicators;

5.2.4 provide advice and support on significant financial and commercial policies prior to their recommendation for Board approval. This will include policies relating to costing, revenue, capital, working capital, treasury management, investments and benefits realisation;

5.2.5 seek assurance that financial policies and plans are aligned to the Trust's agreed approach to the development of place-based, systems and regional working, and align with the Trust's strategic approach to commissioners and stakeholders;

5.2.6 identify sources of economic, financial, and related intelligence and data, relevant to the Trust in the context of the "place" of Newcastle and the North East to inform the work of the Committee and the Board of Directors; and

5.2.7 identify learning and development needs arising from the work of the Committee for consideration by the People Committee.

5.3 Annual Financial Plan

The Committee will:

5.3.1 review the Trust's Annual Financial Plan for recommendation and approval by the Board;

5.3.2 review progress and performance against the approved plan and any significant supporting plans and targets, and analyse the robustness of any corrective action required;

5.3.3 assess reports regarding future cost pressures and key financial risk areas;

5.3.4 review the Trust's Statement of Financial Position, with a particular focus on debtors, creditors, and asset valuations; and

5.3.5 receive and review an overview of financial and service delivery agreements and key contractual arrangements entered into by the Trust.

5.4 Risk

The Committee will:

5.4.1 Receive the risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit, Risk and Assurance Committee with assurance on the effectiveness of the management of principal risks relating to the Committees purpose and function.

5.4.2 To receive the Executive Oversight Report for information.

5.5 Performance and progress reporting

The Committee will:

5.5.1 monitor the effectiveness of the Trust's financial and operational performance reporting systems, ensuring that the Board is assured of continued compliance through its annual reporting processes, reporting by exception where required to the Board;

5.5.2 agree a succinct set of key performance and progress measures relating to the full assurance purpose and function of the Committee, including:

- the Trust's strategic financial priorities;
- national performance and statutory targets;
- consolidated financial performance summaries and related budgets;
- statement of financial position;
- working capital performance;
- cash flow status;
- progress on capital investment programme;
- regulatory oversight ratings; and
- risk mitigation;

5.5.3 triangulate progress against these measures and seek assurance around any performance issues identified, including proposed corrective actions;

5.5.4 provide regular reports to the Board, including as part of the bi-monthly Integrated Board Report, on assurance around key areas of Trust performance, risk, and corrective actions, both retrospectively and prospectively;

5.5.5 agree a programme of benchmarking activities and reference points to inform the understanding and effectiveness of the Committee and its work;

5.5.6 be assured of the credibility of sources of evidence and data used for planning and progress reporting to the Committee, and to the Board, in relation to the Committee's purpose and function;

5.5.7 ensure the alignment and consistency of Board assurances, use of data and intelligence, by working closely with the Audit, Risk and Assurance Committee, Quality Committee and People Committee;

5.5.8 review the following formal reports to the Board as part of the Annual Cycle of Business:

- Annual Financial Plan;
- Finance Reports;
- Capital Investment Policy; and
- Annual Report and Accounts (Group, Trust and Charity); and

5.5.9 review and approve the Terms of Reference for, and receive the minutes of, the:
i) Supplies and Services Procurement Group;
ii) Capital Management Group;
iii) Strategy, Planning and Capital Investment Group; and
v) Any time-limited Strategic Oversight Groups created which are aligned to the Committee.

5.6 Capital, investments, acquisitions and disposals

The Committee will:

5.6.1 review the Trust's capital and investment policies against appropriate benchmarks prior to recommendation for Board approval;

5.6.2 agree a consistent and robust methodology for the assessment of proposed capital expenditure, acquisitions, joint ventures, equity stakes, major property transactions, mergers, and formal or informal alliances with other Institutions;

5.6.3 review business cases and proposals over the threshold specified within the Trust Scheme of Delegation, and provide advice to the Board accordingly;

5.6.4 assure the Trust Board, on a regular basis, of the effectiveness of, and compliance with, the capital and investment strategies and related policies, including the effective prioritisation of investment decisions, the robustness of processes and rigour of investment decision-making, and report on this as part of the Committee's Annual Report to the Board;

5.6.5 seek assurance that a process is in place to monitor the performance of investments, which incorporates a review of the benefits realised as part of infrastructure and service improvement investments made; and

5.6.6 exercise delegated responsibility on behalf of the Board in line with the Standing Financial Instructions for proposals for acquisition and disposal of assets in accordance with Trust policy.

5.7 Commercial strategy

The Committee will:

5.7.1 provide support and advice on the development and implementation of the commercial strategy for the Trust.

5.7.2 assure the Trust Board, on a regular basis, of the effectiveness of, and compliance with, the commercial strategy and related policies, including the effective prioritisation of commercial decisions, the robustness of processes and rigour of commercial decision-making, and report on this as part of the Committee's Annual Report to the Board.

5.8 Statutory compliance

The Committee will:

5.8.1 ensure, on behalf of the Board, that current statutory and regulatory compliance and reporting requirements are met, including compliance with treasury policies and procedures and the appropriate safeguards for security of the Trust's funds as an NHS Foundation Trust;

5.8.2 ensure the proper reporting of actions deemed "high-risk" by regulators, or actions with an equity component, which entail a potentially significant risk to reputation or to the stability of the business of the Trust, or which create material contingent liabilities;

5.8.3 ensure future legislative and regulatory and reporting requirements are identified and appropriate action taken; and

5.8.4 consider, and recommend for approval by the Audit, Risk & Assurance Committee, any proposed changes to Trust Standing Financial Instructions, Standing Orders and Scheme of Delegation.

6. Reporting and accountability

6.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Committee will provide an Annual Report to the Board to inform and / or accompany the Trust's Annual Report. This shall include an assessment of compliance with the Committee's Terms of Reference and a review of the work and effectiveness of the Committee.

6.3 The Chair of the Committee shall provide as a minimum, an annual update to the Council of Governors on the work of the Committee.

6.4 The terms of reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

7.1 The Committee will meet a minimum of ten times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

7.2 The Chair may at any time convene additional meetings, or Extraordinary meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than three working days before the date of the meeting.

7.5 Committee papers shall include an outline of their purpose and key points in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

7.7 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten working days of the meeting.

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: 29 April 2024
Date approved: [20 May 2024] [Finance & Performance Committee] and [TBA] [Board]
Approved by: Finance & Performance Committee and Board
Trust Board Review date: May 2025

Committee / Group:	**Finance & Performance Committee**
Chair:	**NED Committee Chair**
Annual Cycle Covered:	**2024/25**

	Lead	Authors / contacts of the report	Apr-24	May-24	Jun-24	Jul-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Notes
Standing Items														
Apologies for absence	Committee Chair		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Declaration of interests	Committee Chair		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Committee Chair	Kelly Jupp / Lauren Thompson		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Action log	Committee Chair	Kelly Jupp / Lauren Thompson		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Meeting debrief, matters requiring escalation and AOB	Committee Chair	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Regular Reports														
Finance report [Including KPIs, CIP, cquins, risks, capital summary, balance sheet updates]	Jackie Bilcliff	Claire Garrity / Jo Mason / Chris Haynes	✓	✓	✓		✓	✓	✓		✓	✓	✓	
Finance Committee Risk Report and New/emerging risks	Natalie Yeowart	Natalie Yeowart		✓			✓				✓		✓	Committee members will discuss any new and emerging risks at each meeting where relevant
Financial Recovery Plan/Updates	Jackie Bilcliff	Claire Garrity / Jo Mason / Chris Haynes		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Medium Term/Long Term Financial Recovery Schemes	Jackie Bilcliff	Claire Garrity / Jo Mason / Chris Haynes			✓									
Capital Plan and capital projects update (4 x a year)	Rob Smith / Jackie Bilcliff	Claire Garrity / Lynsey Allen		✓			✓			✓			✓	
Performance (against Operational Plans, contracts, B&D activity)	Vicky McFarlane-Reid / Rob Harrison	Kerry Leonard	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Procurement Plan/Update [4 x a year]	Dan Shelley	Dan Shelley			✓			✓			✓		✓	
Management Group Minutes:														
- Supplies & Service Procurement Group (SSPC) minutes [when available]	Committee Chair	Dan Shelley		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
- Capital Management Group (CMG) minutes [when available]	Committee Chair	Lynsey Allen		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
- Strategy, Planning and Capital Investment Group (SPCIG) minutes [when available]	Committee Chair	Lynsey Allen		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
- Any Strategic Oversight Group minutes as required	Committee Chair	Kelly Jupp		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Review of Commercial Schemes	Vicky McFarlane-Reid	Wayne Elliott				✓		✓			✓			Quarterly
Clinical Board / Corporate Service Updates	Rob Harrison	Hannah Morrison		✓ (ED)	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Annual Reports (AR) or updates														
Annual Report & Accounts Draft/Final	Jackie Bilcliff	Claire Garrity / Jo Mason / Chris Haynes		✓	✓									
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Kelly Jupp	Kelly Jupp / Lauren Thompson		✓									✓	
Revenue and budget setting	Jackie Bilcliff	Claire Garrity		✓									✓	
Capital expenditure deep dive, including PFI	Rob Smith / Jackie Bilcliff	Claire Garrity / Lynsey Allen / Russell Jones / Chris Haynes					✓				✓			
Month 12/year-end report	Jackie Bilcliff	Claire Garrity / Jo Mason	✓											
National Cost Collection	Jackie Bilcliff	Claire Garrity / Jo Mason					✓							
Plan /Plan updates (Finance and Activity)	Jackie Bilcliff Vicky McFarlane Reid	Claire Garrity / Kerry Leonard	✓								✓		✓	

Ad-hoc reports to be considered														
Waiting List Size Activity and Finance Considerations	Jackie Bilcliff Vicky McFarlane Reid	Claire Garrity / Kerry Leonard			✓									
Commercial strategy / Updates [twice a year]	Vicky McFarlane-Reid	Kerry Leonard		✓					✓					
Briefing on the new Procurement Act 2023	Dan Shelley	Dan Shelley					✓							
Policies and procedures e.g. Treasury management, Investment management as required in accordance with the SFIs/SoD	All	Kerry Leonard / Dan Shelley / Chris Haynes / Kelly Jupp												
Business cases / investment proposals [as and when required in accordance with the SoD/SFIs/SoD]	Vicky McFarlane-Reid / All	Kerry Leonard / Dan Shelley		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Schedule of Business Cases to be shared at the March 2025 Committee meeting for 2025/26
GIRFT/Model Hospital [to report by exception as required]	Rob Harrison	Hannah Morrison		✓										
Finance and Investment strategies	Jackie Bilcliff	Claire Garrity / Jo Mason / Chris Haynes					✓							
Business Cases not approved	Vicky McFarlane-Reid	Kerry Leonard		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

	Lead	Authors / contacts of the report	Apr-24	May-24	Jun-24	Jul-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Notes
ED Business Case Update	Vicky McFarlane-Reid	Kerry Leonard					✓							
Estates Capital Schemes														
FASS/OPM to Freeman	Rob Smith	Lynsey Allen					✓							
Diabetes / Endocrinology to Freeman	Rob Smith	Lynsey Allen					✓							
Freeman Ward 10, 10a, 11 (spans 2024/25 & 2025/26)	Rob Smith	Lynsey Allen					✓							
Freeman Theatre refurbishment (6)	Rob Smith	Lynsey Allen			✓									
Freeman Theatre refurbishment (TBA)	Rob Smith	Lynsey Allen												
RVI Theatre refurbishment phase 4 (3&4)	Rob Smith	Lynsey Allen			✓									
RVI Roche equipment upgrade	Rob Smith	Lynsey Allen												
Site wide public facing & clinical upgrades	Rob Smith	Lynsey Allen												
Contracts														Contracts schedule for 2025/26 to be shared at the March 2025 Committee meeting
Medicines Manufacturing Centre	Vicky McFarlane-Reid	Kerry Leonard	✓											
Taxi Services	Dan Shelley	Procurement team members			✓									
Orthotics Services	Dan Shelley	Procurement team members				✓								
Caresite Cannulation Packs	Dan Shelley	Procurement team members				✓								
Bespoke Membrane Oxygenator Kits	Dan Shelley	Procurement team members				✓								
Neuroradiology Consumables	Dan Shelley	Procurement team members				✓								
Radiology Consumables	Dan Shelley	Procurement team members				✓								
CISCO Licence Support	Dan Shelley	Procurement team members				✓								
Catering - Meals to Go and prepared meals	Dan Shelley	Procurement team members				✓								
NECTAR Specialist Critical Care Ambulance	Dan Shelley	Procurement team members					✓							
Internal & External Fixation (Trauma)	Dan Shelley	Procurement team members					✓							
Linen	Dan Shelley	Procurement team members					✓							
Radiology PACS	Dan Shelley	Procurement team members					✓							
Minimally Invasive Surgical Consumables, Surg. Stapling and Sutures	Dan Shelley	Procurement team members							✓					
Home Delivery, Enteral Feeds	Dan Shelley	Procurement team members							✓					
Document Management System	Dan Shelley	Procurement team members							✓					
Pharmacy Isolators	Dan Shelley	Procurement team members							✓					
Endoscopy Consumables	Dan Shelley	Procurement team members									✓			
Renal Dialysis	Dan Shelley	Procurement team members									✓			
Prosthetics Service	Dan Shelley	Procurement team members											✓	
Manual Wheelchairs	Dan Shelley	Procurement team members											✓	

✓	On agenda and discussed
	Item deferred

PEOPLE COMMITTEE ANNUAL REPORT 2023/24

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the People Committee has met its key responsibilities for 2023/24, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

The Terms of Reference and Schedule of Business for the Committee have been reviewed and minor changes recommended for agreement at the Committee meeting in April 2024.

2. COMMITTEE RESPONSIBILITIES

The People Committee is a non-statutory Committee established by the Board of Directors to monitor, review and report to the Board on the cultural and organisational development of the Trust, the strategic performance of people and workforce priorities, and the impact of the Trust as a significant employer, educator and partner in health, care and research.

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors, that:

- The strategic people and workforce priorities for the Trust as a significant employer and as a partner in training, education, and development of health and care capacity in the region and nationally are identified;
- The organisation has a clear understanding of strategic workforce needs (including well-being, recruitment, retention, development of people, and organisational capacity) and the quality and effectiveness of plans to deliver them;
- The commitments of the NHS Constitution, the NHS People Promise, and the stated values of the Trust and standards of behaviour, are being practiced throughout the organisation, based on evidence;
- The approach to all aspects of employment and culture in the Trust are informed by relevant and up-to-date research on innovation and practice;
- The effectiveness of mitigations and action plans as set out in the Board Assurance Framework are reviewed, assessed and assurances obtained specific to the committee purpose and function;
- Legislative and regulatory compliance is achieved as an employer, including anticipation of, and planning for, future requirements;
- Staff governance in the organisation is fully developed, including staff engagement processes;
- Strategic communications and engagement are developed, and reputation management is robust with internal and external stakeholders, local communities and partners;

- The impact on workforce of changing professional and organisational practices is considered, including those involved in increased system-based and partnership working (in collaboration with the other Committees of the Board as appropriate); and
- The Trust fulfils its leadership and influencing role on service quality standards and practice, as an organisation of national importance, as a significant service provider in the North East, and as a partner in training, education and development of health and care capacity in the region (in collaboration with the Quality Committee).

It does this through the receipt of assurances from management, the receipt of regular reports relating to areas which impact Trust staff, as detailed in section 4 below, and discussions and reports on the management of risks relating to the Committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of six members (as specified in the Terms of Reference), drawn from the Non-Executive Directors and members of the Executive Team.

The Committee's quorum is four members, with at least two Non-Executive Directors present.

Meetings are held bi-monthly. Six ordinary meetings were held between 1 April 2023 and 31 March 2024. The meeting scheduled on 19 December 2023 was postponed and instead a further Committee was arranged on 8 January 2024.

Attendance at the meetings was as follows:

	Attendance at ordinary meetings
Jonathan Jowett, Non-Executive Director (Committee Chair)	6 of 6
Kath McCourt, Non-Executive Director*	5 of 5
Steph Edusei, Non-Executive Director	5 of 6
Christine Brereton, Chief People Officer	6 of 6
Caroline Docking, Director of Communications and Corporate Affairs	4 of 6
Martin Wilson, Chief Operating Officer*	4 of 5
Liz Bromely**	2 of 2

*Stood down from the Committee as a member at the end of January 2024.
**Joined the Committee as a member in January 2024.

Other attendees at meetings have included:

- Managing Director;
- Chief Experience Officer;
- Chief Information Officer;
- Head of Human Resource Services;
- Head of Equality, Diversity & Inclusion – People;

- Head of Workforce Engagement & Information;
- Associate Director – Education, Training, and Workforce Development;
- Freedom to Speak Up Guardian;
- Guardian of Safe Working Hours;
- Associate Director – Sustainability & Environment;
- The Medical Director/Deputy Chief Executive Officer;
- Director of Medical Education;
- Head of Corporate Risk & Assurance;
- Deputy Head of Workforce;
- The Chair of the Finance Committee (as an observer);
- The Trust Secretary;
- The Corporate Governance Manager / Deputy Trust Secretary who provided Secretariat Support to the Committee; and
- Corporate Governance Officer and PA to the Chairman and Trust Secretary.

Mrs Judy Carrick, Public Governor and Chair of the People, Engagement and Membership (PEM) Working Group, observed two Committee meetings during the year.

4. REPORTING

i) Regular Reports

Over the course of the year, Committee members received regular reports/updates on:

- The Trust People Strategy/Plan/Priorities;
- People Committee Risk Report;
- Guardian of Safe Working Hours Quarterly Reports and Annual Report (prior to receipt at the Board of Directors);
- NHS Staff Survey results and staff engagement;
- Education, Training and Workforce Development Reports, covering e.g. Statutory and Mandatory Training, Appraisal Compliance, and Education and Training Update;
- People and Culture Dashboard;
- Legal Cases/Employee Relations Updates; and
- Freedom to speak up Guardian (FTSUG) reports (bi-annual);

ii) Annual Reports

The following Annual Reports were received by the Committee:

- Workplace Race Equality Standard (WRES) and Workplace Disability Equality Standard (WDES) Data and Action Plan (prior to approval at Trust Board);
- Gender Pay Report;
- Communication strategy;
- Apprenticeships Update;
- Sustainability Report;
- Equality and Diversity Update / EDS - including action plan;
- Trade Union Faculty Time Report; and
- Annual Report of the Committee, Committee Terms of Reference and Schedule of Business.

iii) Ad-Hoc Reports

In addition to those reports listed above, a number of reports were received by the Committee. These included:

- Emerging People risks;
- Medical and Dental Staff - People Update;
- Industrial action updates;
- Health and wellbeing update;
- Fit for the future update;
- Leadership Development, Talent and Succession planning;
- Speak in confidence system update;
- NHS EDI Improvement Plan;
- National Workforce Plan;
- Workforce Age Profile and Demographics update;
- Nursing, Midwifery and AHP update;
- Internal audit – Visas;
- Care Quality Commission (CQC) – People updates.

The Committee also received the minutes of both the Learning and Education Group and the Sustainable Healthcare Committee as a standing item.

The Schedule of Business for the year 2023/24 included an annual conversation with the Executive Chief Nurse (ECN) and Medical Director (MD) (separately). These were held in February 2024 and October 2023 respectively.

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2023/24 and utilised a rolling programme and action log to track committee actions.

As highlighted in Section 4(i), the Committee receives regular updates on risks recorded on the BAF which related to the Committee's area of focus. During 2023/24, the four risks included in the BAF and regularly discussed at the Committee were:

- SO2.2 - Trust sickness absence has not returned to pre- pandemic levels, there is a risk that we are unable to fill staffing gaps across our services which could create additional operational pressures across the Trust and impact on the quality of care we deliver.
- SO2.4 - There is a risk that the Trust fails to maintain compliance with Statutory and Mandatory training requirements, which could impact on quality and safety and impact the reputation of the Organisation.
- SO2.5 - Due to the increasing likelihood of industrial action including strike action between November 2022-May 2023, there is a risk of operational service disruption which could impact on patient safety and quality. In addition, both industrial relations and reputation could be adversely impacted.
- SO5.6 - There is a risk that we may fail to achieve the targets within the Climate Emergency Strategy, which could impact on the Trust's contribution to reducing local population ill health consequences and health inequalities as well as negatively

impacting the Trust reputation as a global leader in sustainable healthcare delivery. This is further exacerbated by energy centres outsourcing on performance, lack of national funding sources for the scale of investment required and CDEL restrictions.

The Committee received regular updates on mitigations in place.

In addition at the end of every meeting debriefs are held and matters for escalation to the Trust Board agreed (and captured within the meeting minutes).

6. PROGRESS FOR 2023/24 & REVIEW OF EFFECTIVENESS

In the Annual Report of the Committee for 2022/23, the following areas were identified as for action during 2023/24, with progress updates highlighted in italic font:

1. The Trust Secretary to work with the Chief People Officer to develop a more detailed review of Committee effectiveness to incorporate assurances gained.

   Consideration has been given to:
   - *Membership of the Committee – membership of the Committee is deemed appropriate and is clearly set out within the Terms of Reference. It is proposed that the Terms of Reference of the Committee are updated to include the Managing Director and the Chief Experience Officer as Committee members following their appointment in February 2024.*
   - *The scope of the Committee is clear and well defined in the Committee Terms of Reference.*
   - *Effectiveness of business conduct - During 2023/24 the Committee met bi-monthly with no issues identified which suggested that business was not conducted effectively e.g. meetings ran to time. For 2024/25 it is proposed that the Committee moves to monthly meetings for a period of time due to the significance of the issues identified within the CQC*
   - *Committee agendas – Committee agendas are clearly aligned to the duties articulated in the terms of reference and the agreed Schedule of Business. Emerging matters/risks are incorporated into the meeting agenda as they arise e.g. CQC People matters.*
   - *Constructive debate and challenge at the Committee – there is a good level of debate and challenge at Committee meetings which has been reflected in the meeting minutes.*
   - *Articulation of the key issues and assurances – papers are generally better at articulating the issues than the assurances. Work is underway with thevaluecircle as part of the CQC Notice of Decision to improve the reporting of assurances to the Committees and to the Trust Board.*
   - *Completeness of actions – an action log is maintained which highlights when actions are overdue. The action log is discussed at every meeting and progress recorded in the meeting minutes.*
   - *Meeting debriefs – the meeting agenda incorporates a meeting debrief at the end of each meeting which provides the opportunity to identify strengths, weaknesses and suggestions for improvements.*

2. To further develop the Schedule of Business and shape Committee meeting agendas around the strategic risks aligned to the Committee.

Updates on the strategic risks were presented to the Committee quarterly. In addition the Committee has undertaken deep-dives into the strategic risks pertinent to the remit of the Committee.

7. NEXT STEPS AND ACTIONS FOR 2024/25

The key action for 2024/25 is to ensure that the People-related recommendations within the CQC inspection reports are fully implemented, and assurance sought as to their implementation.

Report of Kelly Jupp
Trust Secretary

Lauren Thompson
Corporate Governance Manager / Deputy Trust Secretary
March 2024

Terms of Reference – People Committee

1. Constitution of the Committee

The People Committee is a non-statutory Committee established by the Board of Directors to monitor, review and report to the Board on the cultural and organisational development of the Trust. It also reviews the strategic performance of people and workforce priorities and considers the impact of the Trust as a significant employer, educator and partner in health, care and research.

2. Purpose and function

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors:

2.01 on the identification of strategic people, culture and workforce priorities for the Trust

2.02 to ensure that the Trust has effective plans in place to address these priorities such as but not limited to: health and well-being, recruitment, retention, training, learning and development, Culture, Equality, Diversity and Inclusion and staff experience

2.03 that the commitments of the NHS Constitution, the NHS People Promise, the NHS Workforce Plan, the Equality, Diversity and Inclusion (EDI) Improvement Plan and the stated values of the Trust and its Leadership Behaviours, are being practiced throughout the organisation, based on evidence;

2.04 that the approach to all aspects of employment and culture in the Trust are informed by relevant and up-to-date research on innovation and practice;

2.05 to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the Committee purpose and function;

2.06 on the Trust's legislative and regulatory compliance as an employer, including anticipation of, and planning for, future requirements;

2.07 on the development of robust governance processes relating to the management of staff in the organisation, including staff engagement processes, with the Committee acting as the oversight Committee;

2.08 on the development of strategic communications and engagement with internal and external stakeholders, local communities and partners, with the People Committee acting as the oversight Committee;

2.09 on the impact on workforce of changing professional and organisational practices, including those involved in increased system-based and partnership working (in collaboration with the other Committees of the Trust Board as appropriate); and

2.10 that high-quality training and education is delivered and innovative solutions are identified to develop health and care capacity that improves quality of care (in collaboration with the Quality Committee).

2.11 The Committee will agree progress reporting and information requirements relating to its remit on behalf of the Board of Directors, and will oversee the resulting performance.

3. Authority

The Committee is:

3.1 a non-statutory Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference;

3.2 authorised by the Board of Directors to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required; and

3.3 authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Lead of the Committee and / or Trust Secretary).

3.4 The Committee shall have the power to establish, in exceptional circumstances, sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility, if approved by the Trust Board. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the Trust Board of Directors.

3.5 The Terms of Reference, including the reporting procedures, of any sub-committees or task and finish groups, must be approved by the Trust Board of Directors and reviewed on an annual basis.

4. Membership and quorum

Membership

4.01 Members of the Committee shall be appointed by the Trust Board of Directors and shall be made up of at least six members drawn from Non-Executive Directors (three members minimum) and members of the Executive Team (three members minimum).

4.02 One of the Non-Executive members will be appointed by the Trust Board of Directors as the Chair of the Committee.

4.03 A further Non-Executive member of the committee shall be appointed as Vice-Chair, likewise by the Trust Board of Directors.

4.04 The membership shall be:

- the Chief People Officer;
- the Managing Director; and
- the Director of Communications and Corporate Affairs.

Other directors may be in attendance as appropriate.

4.05 The Chair of the Board of Directors shall not be a member of the Committee but may be in attendance.

4.06 Other than as specified above, only members of the Committee have the right to make decisions in relation to Committee business. Other non-Committee members may attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.07 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year.

4.08 The Chief People Officer shall act to fulfil the role of Executive lead for the Committee.

4.09 Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by either telephone or electronic means will count towards the quorum.

4.10 The Council of Governors may nominate up to two governors to attend one meeting of the Committee annually to observe proceedings. The observation of Board assurance committees by governors will be subject to conditions agreed by the Board of Directors. The Chair of the Committee may in exceptional circumstances exclude governors from being present for specific items.

4.11 The Trust Secretary, or their designated deputy, shall act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, shall attend all meetings of the Committee.

4.12 All members of the Committee shall receive training and development support as required to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

4.13 An attendance record shall be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

Quorum

4.14 The quorum necessary for the transaction of business shall be four members, as defined in 4.01 and 4.04 above, with at least two Non-Executive Directors present.

4.15 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will count towards the quorum.

4.16 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

5. Duties

5.1. Cycle of Business

The Committee will:

5.1.1 set an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

5.2 People Strategy and policies

The Committee will:

5.2.1 assess the strategic priorities and investments needed to support staff knowledge and skills to help them to be productive), to aid delivery of the local People Plan, and to advise the Board accordingly;

5.2.2 review the Trust's overall People Strategy and supporting strategies and related delivery plans including: Leadership Development, Talent Management, Health and Wellbeing, EDI and Education and Learning; providing informed advice to the Board of Directors on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact;

5.2.3 consider any people policies which have a significant impact on staff/employee relations e.g. health and wellbeing, prior to their adoption;

5.2.4 review strategic intelligence, research evidence on people and work, and distil their relevance to the Trust's strategic workforce priorities (including, where necessary, commissioning research to inform its work) relating to:

- the impact of changing working practices;
- developments and updates on pensions and pensions reform;
- the potential and impact of technology on working lives;
- models of employment practice drawn from multiple sectors;
- organisational and work design;
- incentives and rewards;
- developments and best practice in delivery of education, training and development;
- national, regional and local workforce and population trends; and
- other dynamics affecting the future development of the health and care workforce;

5.2.5 review the development and effective use of shared intelligence and data with partners to help shape future direction on partnership working with the Alliance.

5.3 Risk

The Committee will:

5.3.1 receive risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit, Risk and

Assurance Committee with assurance on the effectiveness of the management of principal risks relating to the Committee's purpose and function.

5.3.2 to receive the Executive Oversight Report for information.

5.4 Staff Experience and Engagement including organisational culture

The Committee will:

5.4.1 agree and oversee a credible process for assessing, measuring and reporting on the "culture of the organisation" on a consistent basis over time;

5.4.2 oversee the coherence and comprehensiveness of the ways in which the Trust engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications, to the Board of Directors;

5.4.3 act as the oversight Committee for the coherence and alignment of different codes of personal and professional behaviour and conduct, (considering, for example, Leadership Behaviours, the Standards of Business Conduct Policy, and The Nolan Principles), covering all permanent and temporary staff acting in the name of, or on the business of, the Trust;

5.4.4 take an oversight role on behalf of the Board of Directors in:

- securing positive progress on equality, diversity and inclusion (EDI), including shaping and setting direction, monitoring progress and promoting understanding inside and outside the Trust;
- evaluating the impact of work to promote the values of the organisation, the NHS Constitution and the NHS People Promise;
- promoting staff engagement and partnership working; and
- developing a consistent working environment where people feel safe and able to raise concerns, and where bullying and harassment are visibly and effectively addressed.

5.5 Organisational capacity – sustainability and strategic transformation

The Committee will:

5.5.1 ensure the systems, processes and plans used by the Trust have integrity and are fit for purpose in the following areas:

- strategic approach to growing the knowledge, skills and capacity of the people (human capital) in the Trust;
- analysis and use of sound workforce, employment and demographic intelligence;
- the planning of current and future workforce capacity;
- effective recruitment and retention;
- new models of care and roles;
- flexible working;
- identification of urgent capacity problems and their resolution;
- continuous development of personal and professional skills; and
- talent management.

5.5.2 review the productivity of permanent and temporary staff by exception, including the effectiveness and efficiency of their deployment, the best use of skills, and the flexibility and maturity of working practices in the Trust;

5.5.3 consider the coherence and pace of Trust plans to secure the benefits for the Trust and its staff from:

- transformational change and service redesign;
- new and innovative ways of working;
- use of tools and technology;
- environmental sustainability;
- opportunities for changing practices and skills across traditional professional boundaries;
- joint working with partners both in health and social care and other sectors; and
- the value of apprenticeships.

5.5.4 review plans for ensuring the development of leadership and management capacity, including the Trust's approach to succession planning.

5.6 Education and training

The Committee will:

5.6.1 review the Trust's current and future educational and training needs to ensure they support the strategic objectives of the organisation in the context of the wider health and care system;

5.6.2 review the Trust's strategic contribution to the development of the health and care workforce;

5.6.3 secure the necessary assurances about the Trust's compliance with the practice requirements of professional and regulatory bodies for all staff;

5.6.4 ensure the development of an annual education and training programme to meet the education and workforce development priorities described within the Trust's Strategy.

5.7 Communications

The Committee will:

5.7.1 provide advice and support on the development of the Trust's engagement and communications strategies and related programmes of work, and review the effectiveness of internal communications and engagement;

5.7.2 ensure engagement and consultation processes with staff, stakeholders and communities both reflect the ambition and values of the Trust and also meet statutory requirements;

5.7.3 agree and oversee a credible process for assessing, measuring and reporting on the effectiveness of the engagement of the organisation as an employer and workplace of choice;

5.7.4 review the appropriateness and effectiveness of stakeholder and partnership development in supporting strategic goals and programmes of work related to the purpose and function of the People Committee, and report to the Board of Directors accordingly.

5.8 Performance and progress reporting

The Committee will:

5.8.1 establish a succinct set of key performance and progress measures relating to the full purpose and function of the Committee, including:

- the Trust's strategic priorities on people;
- national performance targets;
- workforce culture;
- employee relations;
- staff experience
- ;
- Equality, Diversity and Inclusion
- EDI;
- staff health and well-being; and
- strategic communications.

5.8.2 review progress against these measures, and their impact, and seek assurance around any performance issues identified, including proposed corrective actions;

5.8.3 agree a programme of benchmarking activities to inform the understanding of the Committee and its work;

5.8.4 ensure the credibility of sources of evidence and data used for planning and progress reporting to the Committee, and to the Board of Directors in relation to the Committee's purpose and function;

5.8.5 ensure alignment of the Board assurances and consistent use of data and intelligence, by working closely with the Audit, Risk and Assurance Committee; the Quality Committee and the Finance and Performance Committee;

5.8.6 review and shape the people -related content of the bi-monthly Integrated Board Report;

5.8.7 review the following formal reports to the Board of Directors as part of the Annual Cycle of Business:

- Annual People Committee report;
- Equality and Diversity Reports and Action Plans – e.g. Gender Pay, EDI, WRES, WDES and Ethnic Pay etc.;
- NHS Staff Survey Results; and
- Trade Union Facility Time report.

5.8.8 review and approve the Terms of Reference for, and receive the minutes of, the:

- Learning and Education Group;
- Sustainable Healthcare Committee;

- People Programme Board;
- Health and Wellbeing Group; and
- Equality, Diversity and Inclusion Group.

5.9 Statutory compliance

The Committee will:

5.9.1 ensure, on behalf of the Board of Directors, that current statutory and regulatory compliance and reporting requirements are met:

- standards of professional conduct and practice (including consideration of Leadership Behaviours, the Standards of Business Conduct Policy, and The Nolan Principles);
- Freedom to Speak Up Guardian;
- Guardian of Safe Working Hours;
- Equality, Diversity and Inclusion; and
- consultation on service change.

5.9.2 ensure future legislative and regulatory requirements, which are to be placed on the Trust as an employer, are identified and appropriate action taken.

6. Reporting and accountability

6.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting, on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Committee shall report to the Trust Board annually on its work in support of the Annual Report. The Annual People Committee Report shall set out clearly how the Committee is discharging its responsibilities.

6.3 The Annual People Committee Report shall include an assessment of compliance with the Committee's Terms of Reference and a review of the effectiveness of the Committee.

6.4 The Chair of the Committee shall provide an update to the Council of Governors on the work of the Committee at least annually.

6.5 The Terms of Reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

7.1 The Committee shall meet a minimum of six times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

7.2 The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees to ensure it fulfils its duties and responsibilities in an open and transparent manner.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than three working days before the date of the meeting.

7.5 Committee papers shall include an outline of their purpose and key points, in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

7.7 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten working days of the meeting.

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: 8 April 2024
Date approved: [16 April 2024] [People Committee] and [TBA] [Trust Board]
Approved by: People Committee and Board
Trust Board review date: May 2025

Committee / Group:	**People Committee**
Chair:	**Steph Edusei**
Annual Cycle Covered:	**2024/25**

Meets monthly - no meeting in August

	Lead	Authors / contacts of the report	Apr-24	May-24	Jun-24	Jul-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Notes
Standing Items													
Apologies for absence and Declarations of interest	Steph Edusei		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Steph Edusei	Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Action log	Steph Edusei	Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Meeting debrief	Steph Edusei		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Matters requiring escalation and AOB	Steph Edusei	Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
New and emerging risks	Steph Edusei		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Regular Reports													
People and Culture Dashboard	Christine Brereton/Paul Turner	Deb Stuart	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Education and Training Update (including an annual update on Apprenticeships in April)	Christine Brereton/Gill Long	Deb Stuart	✓				✓				✓		Biannual report plus an annual apprenticeships update.
People Programme/People Priorities Delivery Update	Christine Brereton	Deb Stuart	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	To focus on a specific area at each meeting i.e. Health and Wellbeing, Recruitment and Retention, Staff Engagement and Experience.
Employee Relations	Paul Turner	Deb Stuart	✓					✓				✓	Biannual updates scheduled - further updates to be shared if required.
Workforce Planning	Christine Brereton	Deb Stuart		✓					✓				
People Committee Risk Report (BAF)	Caroline Docking / Natalie Yeowart	Natalie Yeowart	✓			✓				✓		✓	Quarterly report.
NHS Staff survey & Staff engagement plans/updates	Christine Brereton/Annie Lave	Donna Watson	✓	✓			✓			✓			3x a year updates.
Sustainability	James Dixon	James Dixon				✓(AR)						✓	JD to attend twice a year.
Guardian of Safe Working	Henrietta Dawson	Henrietta Dawson	✓		✓(AR)					✓		✓	HD to attend twice a year. Quarterly Reports
Freedom To Speak Up (FTSU) Guardian	Jill Taylor	Jill Taylor	✓					✓					JT to attend twice a year.
CQC Updates - People matters	Christine Brereton	Deb Stuart	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Communications strategy/strategic communications and external engagement update	Caroline Docking	Ellspeth Marshall				✓						✓	
Annual Reports (AR) or updates													
People Strategy and priorities	Christine Brereton	Paul Turner / Deb Stuart		✓									
Leadership Development, Talent and Succession Planning	Christine Brereton	Gill Long / Deb Stuart				✓							
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Kelly Jupp / Lauren Thompson /Christine Brereton	Kelly Jupp / Lauren Thompson	✓										To include effectiveness consideration
GMC training survey	Michael Wright / Ifti Haq	Ifti Haq										✓	
Gender Pay Report	Christine Brereton	Deb Stuart				✓							
WRES & WDES	Christine Brereton	Karen Pearce / Deb Stuart		✓									
Equality and Diversity Update/EDS - including action plans	Christine Brereton	Karen Pearce / Deb Stuart	✓			✓		✓			✓		Quarterly following Annual Review of PC in April
Workforce Profile & Demographics update	Christine Brereton/Paul Turner	Paul Turner / Deb Stuart								✓			
Legal Update	Paul Turner	Deb Stuart	✓										
Annual Conversation with Executive Directors	Michael Wright / Ian Joy							✓ (M&D)				✓ (NMAHP)	
Trade Union Faculty Time Report	Paul Turner	Paul Turner / Deb Stuart			✓								
Ad Hoc reports (tabled as required)													
Clinical Board updates	Rob Harrison / Paul Turner	Deb Stuart		✓		✓		✓		✓		✓	
Learning and Education Group, HWB, EDI and Sustainable Healthcare Committee minutes to be received during the year	Steph Edusei	Michelle Cruickshanks / Estates Admin Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Minutes to be included when available
Maternity Safety Champion observations	Liz Bromley	Liz Bromley	✓		✓		✓		✓		✓		Bi-montly as PC in April
Pensions Update	Christine Brereton	Paul Turner / Deb Stuart											
Industrial Action	Rob Harrison / Paul Turner	Paul Turner / Deb Stuart											

✓	On agenda and discussed
	Item deferred

QUALITY COMMITTEE ANNUAL REPORT 2023/24

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Quality Committee has met its key responsibilities for 2023/24, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during 2024/25.

2. COMMITTEE RESPONSIBILITIES

The Quality Committee is a non-statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience.

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors, that:

- The Trust has appropriate quality governance structures, systems, processes and controls in place and to meet Trust legal and regulatory requirements;
- Any shortcomings in the quality and safety of care are identified and addressed;
- The Trust's approach to, and delivery of, continuous quality improvement processes for all Trust services is effective;
- The Trust's research and development activities and its clinical practice are based on a robust mechanism of research governance which is subject to regular scrutiny and monitoring;
- The quality impact of changing professional and organisational practices is considered;
- The Trust fulfils its leadership and influencing role on service quality standards and practice; and
- Effective mechanisms are in place for the involvement of patients and the public, staff, partners and other stakeholders in improving quality assurance and patient safety.

It does this through the receipt of assurances from the management groups, the receipt of regular reports relating to areas which impact the quality of care provided to patients, such as Infection Prevention and Control (IPC), Safeguarding and Learning from Deaths (LfD), and discussions and reports on the management of risks relating to the committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of nine members (noting a minimum of 7 members is required as per the Terms of Reference), drawn from the Non-Executive Directors, members of the Executive Team and other senior staff members.

The Committee's quorum is four members and includes the Chair or Vice-Chair, and at least one other Non-Executive Director.

During 2023/24, the Committee met on a bimonthly schedule until December 2023, and a monthly schedule from January 2024 in recognition of the improvements needed/assurances required as part of the CQC inspection findings. Seven ordinary meetings were held between 1 April 2023 and 31 March 2024. In addition, during the year one deep-dive session was held for Committee members on agreed topic. Attendance at the ordinary meetings was as follows:

	Attendance at ordinary meetings
Graeme Chapman, Non-Executive Director (Committee Chair)	7 of 7
Kath McCourt, Non-Executive Director - Committee member until 30 November 2023	4 of 4
Steph Edusei, Non-Executive Director	3 of 7
Bill MacLeod, Non-Executive Director from November 2023	4 of 4
Andy Welch, Medical Director and Deputy CEO – Committee member until 31 January 2024	4 of 5
Michael Wright, Interim Medical Director from 1 February 2024, and then Joint Medical Director from 1 March 2024	2 of 2
Lucia Pareja-Cebrian - Joint Medical Director from 1 March 2024	1 of 1
Maurya Cushlow, Executive Chief Nurse	6 of 7
Martin Wilson, Chief Operating Officer – Committee member until 31 January 2024	3 of 5
Angela O'Brien, Director of Quality and Effectiveness	4 of 7
Gus Vincent, Assistant Medical Director, Patient Safety & Quality	7 of 7
Ian Joy, Deputy Chief Nurse until 29 February 2024 and then Executive Director of Nursing from 1 March 2024	7 of 7
Lisa Guthrie, Deputy Chief Nurse from 1 March 2024	0 of 1

Other attendees at the meetings have included:

- The Chief Executive;
- The Interim Chair;
- The Deputy Medical Director;
- The Managing Director;
- The Chief Experience Officer;
- The Associate Medical Director for Research;
- The Director of Infection Prevention and Control;
- The Clinical Effectiveness Manager;
- The Deputy Director of Quality & Safety;
- The Associate Director of Midwifery;
- The Head of Quality Assurance & Clinical Effectiveness;

- The Chief Information Officer;
- The Head of Midwifery;
- The Director of Operations – Family Health;
- The Chief People Officer;
- The Director of Commercial Development and Innovation;
- The Deputy Director of Business Development & Enterprise;
- The Director of Operations - Surgical and Specialist Services RVI;
- The Deputy Chief Operating Officer;
- The Head of Patient Safety;
- The Head of Corporate Risk and Assurance;
- A Consultant Vascular Surgeon/the Clinical Director for Quality and Safety (Chair of Patient Safety Group);
- A Consultant in Neonatal Paediatrics;
- A Consultant Obstetrician;
- A Consultant in Palliative Medicine;
- The Deputy Director of Estates;
- The Quality and Clinical Effectiveness Midwife;
- The Project Director, Newcastle Improvement;
- A Senior Business Development Manager;
- The PSIRF Implementation Lead; and
- The Corporate Governance Manager / Deputy Trust Secretary and PA to Chairman and Trust Secretary / Corporate Governance Administrator who provided Secretariat Support to the Committee.

4. MANAGEMENT GROUPS

To ensure that the Committee maintained adequate oversight of the management of quality related matters across the Trust, a series of Management Groups were established and continued to report into the Committee:

- Patient Safety;
- Patient Experience and Engagement;
- Clinical Outcomes and Effectiveness including updates from the Clinical Ethics Advisory Group; and
- Compliance and Assurance.

The Committee receive a report from a minimum of one group at each meeting, rotating across the course of the year. The reports detail the activities of the Management Groups and any risks/matters requiring escalation to the Committee. Additionally, the minutes of the Management Groups are received by the Committee at each meeting.

The Terms of Reference for each of the Management Groups, which clearly define the remit of each of the groups, were approved by the Committee on establishment, with any changes captured in the minutes of the groups shared with the Committee routinely.

In addition, a bi-annual Research and Development report is received by the Committee.

5. REPORTING

i. Regular Reports

During the year, the following reports were received by the Committee:

- The Integrated Quality and Performance Report;
- Management Group Chair Updates;
- Leadership Walkabouts/Spotlight on Services;
- Regulatory Updates e.g. Care Quality Commission Update Reports;
- Cardiac Oversight Group;
- Legal Cases Update; and
- Ockenden Report Progress Updates and Maternity Update Reports.

ii. Quarterly, Biannual and Annual Reports

The following Quarterly and Annual reports were received by the Committee during 2023/24:

- Safeguarding;
- Learning Disability;
- Quality Committee Risk Report relating to the Committee's area of focus;
- Mortality and Learning from Deaths;
- Research Update Bi-Annual Report;
- Health & Safety Annual Report;
- End of Life and Palliative Care Bi-Annual Report;
- PLACE assessment annual report and associated update report;
- Newcastle Improvement Update Report;
- Equality Delivery System – Patients Annual Report;
- Annual Specialised Services Declaration;
- National Patient Safety Strategy Bi-Annual Report;
- CNST Quarterly Report; and
- Quality Account Bi-Annual.

iii. Ad-Hoc Reports

In addition to those reports listed above, a number of ad-hoc reports have been received by the Committee. These included:

- New and emerging risks;
- Wards of concern;
- Intensive Support Team Report;
- Patient Safety Incident Response Framework Implementation Update;
- Falls and Pressure Ulcer Deep Dive documentation;
- Deep Dive – Quality Governance Oversight Framework;
- Performance Update;
- Outpatient appointments update;
- Protecting and Expanding Elective Capacity in Outpatients – Board Assurance;
- Internal Audit Report on Duty of Candour;
- Patient Access Policy;

- Patient and Public Engagement Strategy; and
- Minimising nitrous oxide exposure update.

6. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee developed a revised Schedule of Business during 2023/24 and utilised a rolling programme and action log to track committee actions.

As highlighted in Section 5(ii), the Committee received regular updates on risks recorded on the Board Assurance Framework (BAF) which related to the Committee's area of focus. There were four risks recorded on the BAF during 2023/24 relating to the Committee being:

- There is a risk that patients may present with or acquire infections including but not restricted to COVID-19, Influenza, MRSA, C Difficile, MSSA, GNBSI, Multi-resistant bacteria (e.g. CPE) or other harmful pathogens whilst in receipt of healthcare. This could result in harm to staff and patients, IPC outbreaks, shortage of staff and impact our ability to provide safe standards of patient care.
- Due to Operational pressures, Workforce sustainability and the trust financial position, there is a risk to the provision of high quality safe care which could result in patient harm.
- Failure to achieve required CQC standards could impact on the Trust's ability to remain "Outstanding".
- If we fail to maintain Trust estates and environments there is a risk to the safety of patients, staff and visitors which could impact on the quality of care and reputation of the Organisation. This is further exacerbated for 2023/24 due to CDEL restrictions and increase in critical infrastructure backlog.

The Committee received regular updates on the mitigating actions in relation to the four risks above and sought assurance that the risks were being managed effectively.

7. PROGRESS FOR 2023/24 & REVIEW OF EFFECTIVENESS

In the prior year Committee Annual Report, the following areas were identified to progress in 2023/24 – updates are shown in italic text below:

- Ensuring items for escalation from the management groups are appropriately raised with the Committee and/or ensuring assurance is sought that actions identified in the management groups are actioned accordingly, with action tracking in place.

  Update: Completed through the management group reports and the presentation of the reports by the Chairs of the Groups.

- Seeking assurance on the development of the new Trust Quality Strategy/PSIRF implementation.

  Update: Specific updates received to seek assurance over effective implementation of PSIRF. Further assurance required during 2024/25 regarding the development of the Quality Strategy.

- Seeking assurance regarding the process for evaluating the risk to Quality from deferred or declined business cases.

  Update: Feedback shared by the Quality Committee Chair with the Executive Lead for the business case process. Discussed regularly at the Finance Committee meetings.

- Ongoing focus on past and future CQC inspections and recommendations.

  Update: Regular updates provided during the course of the year.

8. NEXT STEPS AND ACTIONS FOR 2024/25

The key areas of focus/actions to undertake during 2024/25 are:

- Development of the Trust Quality Strategy and Quality Priorities.

The Terms of Reference and Schedule of Business for the Committee have been reviewed and minor changes proposed for agreement at the Committee in May 2024. In summary the main changes are:

- The change to monthly meetings of the Quality Committee (except in August).
- Amendments to reflect changes in role/names of roles.
- Changes to the membership of the Committee.
- A change to allow nominated deputies to be counted in the quorum.
- Updated references to the Audit, Risk & Assurance Committee and the Finance & Performance Committee.
- Added a reference to the informal visits.

Report of Kelly Jupp
Trust Secretary
29 April 2024

Terms of Reference – Quality Committee

1. Constitution of the Committee

The Quality Committee is a non-statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience.

2. Purpose and function

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors:

2.1 that the Trust has appropriate quality governance structures, systems, processes and controls in place to achieve consistently safe high-quality care and to meet the Trust's legal and regulatory obligations;

2.2 on the Trust's approach to, and delivery of, continuous quality improvement so that is a hallmark of the way the Trust and its people work, recognised by stakeholders, including partners and the public;

2.3 that any shortcomings in the quality and safety of care against agreed standards are being identified and addressed in a systematic and effective manner;

2.4 on the Trust's research and development activities and its clinical practice, acting as a guardian and advocate; and to seek assurance that the Trust has a robust mechanism of research governance which is subject to regular scrutiny and monitoring;

2.5 on the quality impact of changing professional and organisational practices, including those involved in increased system-based and partnership working (in collaboration with the People Committee);

2.6 that the Trust fulfils its leadership and influencing role on service quality, standards and practice, as an organisation of national importance, as a significant service provider and as a partner in training, education and development of health and care capacity in the region (in collaboration with the People Committee) and beyond;

2.7 around current and future statutory and mandatory quality and patient safety standards, such as Care Quality Commission (CQC) Fundamental Standards, and the actions needed to meet them;

2.8 on the effectiveness of mechanisms used for the involvement of patients and the public, staff, partners and other stakeholders in improving quality assurance and patient safety at the Trust, and report on their value and impact to the Board; and

2.9 to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the committee purpose and function.

3. Authority

The Committee is:

3.1. a non-statutory Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference;

3.2 authorised by the Board of Directors to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required; and

3.3 authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Lead of the Committee and / or the Trust Secretary).

3.4 The Committee shall have the power to establish sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility, if approved by the Trust Board. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the Trust Board of Directors.

3.5 The Terms of Reference, including the reporting procedures of any sub-committees or task and finish groups must be approved by the Trust Board of Directors and reviewed on an annual basis.

4. Membership

4.01 Members of the Committee shall be appointed by the Board of Directors and shall be made up of least seven members drawn from Non-Executive Directors (three members minimum) and members of the Executive team (four members).

4.02 One of the Non-Executive members will be appointed by the Trust Board of Directors as the Chair of the Committee.

4.03 A further Non-Executive member of the Committee shall be appointed as Vice-Chair, likewise by the Trust Board of Directors.

4.04 The membership shall include:

- the Joint Medical Directors;
- the Executive Director of Nursing;
- the Managing Director;
- the Director of Quality and Effectiveness;
- the Associate Medical Director, Patient Safety and Quality;
- the Chief Experience Officer;
- the Deputy Chief Nurse;
- Clinical Board Representation responsible for Quality and Safety; and

- Corporate Nursing, Medical and AHP leaders responsible for Quality and Safety

4.05 The Chair of the Board of Directors and the Chief Executive shall not be members of the Committee, but may be in attendance.

4.06 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed. This may include representatives from the North East & North Cumbria Integrated Care Board.

Additional (non-core) membership will be drawn from the senior clinical leadership teams within the Trust, including the Director of Midwifery and the Assistant Medical Director – Research and Development, to provide the depth and breadth of experience required to inform the committee to complete its business effectively.

4.07 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings.

4.08 The Director of Quality and Effectiveness shall act as the Executive Lead for the Committee.

4.09 Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by electronic means will count towards the quorum.

4.10 The Council of Governors may nominate up to two governors to attend one meeting of the Committee annually to observe proceedings. The observation of Board assurance committees by governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may exclude governors from being present for specific items.

4.11 The Trust Secretary, or their designated deputy, shall act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, shall attend all meetings of the Committee.

4.12 All members of the Committee shall receive training and development support before joining the Committee where required and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

4.13 An attendance record shall be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

Quorum

4.14 The quorum necessary for the transaction of business shall be four members, as defined in 4.01 and 4.04 above, including the Chair or Vice Chair, and at least one other Non-Executive Director.

4.15 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will count towards the quorum.

4.16 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

5. Duties

5.1 Cycle of Business

The Committee will:

5.1.1 set an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

5.2 Strategy

The Committee will:

5.2.1 advise and contribute to the strategic quality priorities and investments needed to support high-quality clinical outcomes and improve clinical effectiveness in the Trust, and advise the Board accordingly;

5.2.2 review the Trust's Quality Strategy, Quality Account and related delivery plans and programmes, and provide informed advice to the Board on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact;

5.2.3 take note of international intelligence and research evidence on clinical safety and practice and distil their relevance to the Trust's strategic quality priorities (including where necessary commissioning research to inform its work);

5.2.4 be assured around the monitoring of the Trust's suite of quality-assurance policies against benchmarks to ensure they are comprehensive, up-to-date and reflect best practice; and

5.2.5 scrutinise and triangulate advice on the development of significant clinical and quality policies prior to their adoption.

5.3 Risk

The Committee will:

5.3.1 receive risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit, Risk and Assurance Committee with assurance on the effectiveness of the management of principal risks relating to the Committees purpose and function.

5.3.2 to receive the Executive Oversight Report for information.

5.4 Outcomes and processes

The Committee will:

5.4.1 review the Quality Account to be assured it reflects the integration of clinical quality and patient safety improvement processes;

5.4.2 be assured of the integrity of the Trust's control systems, processes and procedures relating to critical areas, to include:

- high quality care (through the Trust's quality review processes);
- compliance with fundamental standards of quality and safety;
- patient safety and harm reduction;
- safeguarding – adults and children
- infection prevention and control;
- clinical audit;
- introduction of new clinical pathways and procedures;
- introduction of new clinical roles (in conjunction with the People Committee);
- dissemination and implementation of statutory guidance;
- escalation and resolution of quality concerns; and
- patient and carer involvement and engagement.

5.4.3 ensure the effective operation of processes relating to clinical practice and performance, including early detection of issues and problems, escalation, corrective action and learning.

5.5 Learning and communication

The Committee will:

5.5.1 be assured of the effectiveness of systems and processes used for continuous learning, innovation and quality improvement, establishing ways of gaining assurance that appropriate action is being taken;

5.5.2 be assured that the robustness of procedures ensure that adverse incidents and events are detected, openly investigated, with lessons learned being promptly applied and appropriately disseminated in the best interests of patients, of staff and of the Trust;

5.5.3 be assured that evidence-based practice, ideas, innovations and statutory and best practice guidance are identified, disseminated and applied within the Trust;

5.5.4 develop and oversee a programme of activities to engage Board members directly in quality assurance processes and to ensure that such processes include the establishment of a procedure to review, distil and implement the learning from these activities, including 'walk-abouts' and informal visits, reviews, focus groups and deep-dives; and

5.5.5 be assured of the effectiveness of communication, engagement and development activities designed to support patient safety and improve clinical governance.

5.6 Patient and public engagement

The Committee will:

5.6.1 be assured of the effectiveness of a credible process for assessing, measuring and reporting on the 'patient experience' in a consistent way over time, including the appropriateness and effectiveness of processes for patient engagement in support of the Trust's strategic goals and programmes of work.

5.7 Research

The Committee will:

5.7.1 triangulate through assurance the robustness of quality-assurance processes relating to all research undertaken in the name of the Trust and / or by its staff, in terms of compliance with standards and ethics, and clinical and patient safety improvement processes.

5.8 Progress and performance reporting

The Committee will:

5.8.1 review a range of evidence and data from multiple sources, including management and executive committees and groups, on which to arrive at informed opinions on:

- the standards of clinical, service quality and patient safety in the Trust;
- compliance with agreed standards of care and national targets and indicators; and
- organisational quality performance measured against specified standards and targets;

5.8.2 review a succinct set of key performance and progress measures relating to the full purpose and function of the Committee;

5.8.3 review progress against these measures on a regular basis and seek assurance around any performance issues identified, including proposed corrective actions and reporting any significant issues and trends to the Board of Directors;

5.8.4 review and shape the quality-related content of the Quality and Performance Reports to the Board of Directors;

5.8.5 agree the programme of benchmarking activities to inform the understanding of the Committee and its work;

5.8.6 be assured of the credibility of sources of evidence and data used for planning and progress reporting to the Committee and to the Board in relation to the Committee's purpose and function;

5.8.7 ensure alignment of the Board assurances and consistent use of data and intelligence, by working closely with the Audit, Risk and Assurance Committee, People Committee and the Finance & Performance Committee;

5.8.8 review the following formal reports prior to submission to the Board of Directors as part of the Annual Cycle of Business:

- an Annual Quality Report to inform and / or accompany the Trust's Annual Report;
- Infection Prevention and Control Annual Report;
- Safeguarding Annual Report; and
- the process for management review of specific service reports.

5.9 Statutory and regulatory compliance

The Committee will:

5.9.1 be assured of the arrangements for ensuring maintenance of the Trust's compliance standards specified by the Secretary of State, the CQC, NHS England, and statutory regulators of health care professionals.

6. Reporting and Accountability

6.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Committee will provide an Annual Report to the Board to inform and / or accompany the Trust's Annual Report. This shall include an assessment of compliance with the Committee's Terms of Reference and a review of the effectiveness of the committee.

6.3 The Chair of the Committee shall provide an annual update to the Council of Governors on the work of the Committee.

6.4 The Terms of Reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

7.1 The Committee shall meet a minimum of ten times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

7.2 The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less

than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than three working days before the date of the meeting.

7.5 Committee papers shall include an outline of their purpose and key points in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure these are recorded in the minutes accordingly.

7.7 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten days of the meeting.

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: 29 April 2024
Date approved: [14 May 2024] [Quality Committee] and [TBA] [Board]
Approved by: Quality Committee and Board
Trust Board Review date: May 2025

Committee / Group:	**Quality Committee**
Chair:	**Committee Chair**
Annual Cycle Covered:	**2024/25**

	Lead	Authors / contacts of the report	Apr-24	May-24	Jun-24	Jul-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Notes
Standing Items														
Apologies for absence	Committee Chair		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Declaration of interests	Committee Chair		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Committee Chair	Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Action log	Committee Chair	Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Meeting debrief and matters requiring escalation	Committee Chair	Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Regular Reports														
Minutes of management groups	Mike Clarke / Michael Wright / Gus Vincent / Ian Joy	As below	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Management Group Chair Reports – to focus on two areas per meeting														
• Patient Safety Group (PSG)	Mike Clarke	Steve Stoker	✓				✓(AR)		✓				✓	
• Patient Experience & Engagement Group (PEEG)	Ian Joy	Tracy Scott / Diane Cree		✓			✓				✓			
• Clinical Outcomes & Effectiveness Group (COEG)	Gus Vincent	Steve Stoker				✓(AR)	✓		✓				✓	
• Compliance & Assurance Group (CAG)	Michael Wright	David Edwards					✓		✓(AR)		✓			
Safeguarding	Ian Joy	Diane Cree			✓(Q4 AR)		✓(Q1)		✓(Q2)				✓(Q3)	
Mortality/Learning from Deaths	Angela O'Brien	Louise Hall / Pippa Breakspear-Dean		✓(Q4 AR)			✓(Q1)				✓(Q2)		✓(Q3)	
Learning Disability	Ian Joy	Diane Cree			✓(Q4)		✓(Q1)		✓(Q2)				✓(Q3)	
Ockenden Report Update, to include Maternity CNST Quarterly Report when available	Ian Joy / Angela O'Brien	Diane Cree / Pippa Breakspear-Dean	✓	✓ (including CNST year 6)		✓	✓			✓			✓	Updates to be coordinated with the Maternity SOG meetings.
Integrated Quality & Performance Report	Angela O'Brien / Vicky McFarlane-Reid	Pippa Breakspear-Dean / Kerry Leonard	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Leadership Walkabouts/Spotlight on Services Update/Informal visits	Angela O'Brien	Vic Smith/Gill Elsender/Jayne Richards	✓	✓	✓	✓(AR)	✓	✓	✓	✓	✓	✓	✓	
CQC Updates	Angela O'Brien / Ian Joy / Rob Harrison / Others	Pippa Breakspear-Dean/Hannah Morrison/Diane Cree		✓(Meds Man & NECTAR)	✓(ED)	✓(MH & LD)	✓(Maternity & NECTAR)	✓(Digital)	✓(All)	✓(Meds Man)	✓(MH & LD)	✓(ED)	✓(Maternity)	
Patient and Staff Experience	Annie Laverty	Annie Laverty	✓		✓		✓		✓		✓			Bi-Monthly
Quality Committee Risk Report	Natalie Yeowart	Natalie Yeowart	✓			✓		✓			✓			Quarterly
Legal Update	Angela O'Brien	Pippa Breakspear-Dean		✓			✓		✓		✓		✓	
Wards of concern	Ian Joy	Diane Cree	✓		✓		✓		✓		✓		✓	Bi-Monthly
Cardiac Oversight Group Report	Michael Wright	Caroline Docking / Ellspeth Marshall	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	
Annual/Biannual Reports														
PLACE Inspection Update Report	Rob Smith	Lynsey Allen			✓									
Health & Safety Annual Report	Craig Newby	Craig Newby					✓							
End of Life and Palliative Care	Ian Joy	Diane Cree		✓					✓					
Clinical Research	John Isaacs	John Isaacs					✓						✓	
Quality Account	Angela O'Brien	Louise Hall / Pippa Breakspear-Dean		✓					✓					
Newcastle Improvement	Iain Bestford	Iain Bestford				✓					✓			
Annual Specialised Services Declaration	Vicky McFarlane-Reid/Rob Harrison	Kerry Leonard/Hannah Morrison							✓					
EDS Annual Report	Ian Joy	Diane Cree							✓					
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Kelly Jupp / Lauren Thompson	Kelly Jupp / Lauren Thompson		✓										
Clinical Audit#														
Strategy														
PSIRF/PSIRF Updates	Angela O'Brien	Louise Hall / Pippa Breakspear-Dean	✓ (priorities - internal referrals)	✓	✓ (priorities - internal referrals)				✓					
Quality Strategy (QS)	Angela O'Brien	Louise Hall / Pippa Breakspear-Dean			✓(Including Quality Priority 1)		✓(Including Quality Priority 2)		✓(Including Quality Priority 3)		✓(Including Quality Priority 4)		✓(Including Quality Priority 5)	

Committee / Group:	**Quality Committee**
Chair:	**Committee Chair**
Annual Cycle Covered:	**2024/25**

	Lead	Authors / contacts of the report	Apr-24	May-24	Jun-24	Jul-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Notes
Clinical Strategy – AD HOC	Michael Wright/Lucia Pareja-Cebrian	Ruth Hall												
Alliance developments	Committee Chair/Others	Committee Chair/Others	✓											
Ad Hoc reports to be considered														
Health inequalities	Lucia Pareja-Cebrian	Balsam Ahmad				✓		✓			✓			Quarterly
Durham Thoracic	Michael Wright	Michael Wright			✓									
Cancer Patients Harm Reviews	Gail Jones	Gail Jones	✓			✓								
Outpatient Transformation Programme	Nichola Kenny	Nichola Kenny	✓					✓						
Policies/Internal audit reports [as and when required]	Exec Lead	Exec PA		✓(Enhanced care obs internal audit report)										May meeting - Angela O'Brien
Minimising nitrous oxide exposure update	Angela O'Brien	Louise Hall												
Clinical Boards update	Rob Harrison	Hannah Morrison					✓						✓	
Digital Update - including EPR and letters						✓								
Duty of Candour	Angela O'Brien	Jo Ledger		✓										
Mental Health Committee	Ian Joy	Diane Cree				✓								
QOG Monitoring & Evaluation Report	Angela O'Brien	Angela O'Brien			✓					✓				
Patient Safety - update on Marthas rule	Lucia Pareja-Cebrian	Gus Vincent		✓										

✓	On agenda and discussed
	Item deferred

The Annual Clinical Audit Report and regular updates feed into the COEG Chair updates/Annual Reports.

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024					
Title	Quality Account 2023/2024					
Report of	Mrs Angela O'Brien, Director of Quality & Effectiveness					
Prepared by	Anne Marie Troy-Smith, Quality Development Manager					
Status of Report	Public	Private	Internal			
	☒	☒	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☒	☒			
Summary	Each year the Trust is required to produce and publish a Quality Account. Contained within this is a review of the previous 12-month performance against the agreed Quality Priorities, as well as a narrative detailing the identified priorities for the coming year. The Trust Board is asked to review and approve the Quality Account for publication. Continuing the revised arrangements put in place two years ago, NHS foundation trusts are no longer required to include a quality report in their annual report. NHS Foundation Trusts were not required to commission assurance on their quality report for 2021/2022. From 2021/2022 onwards, this assurance exercise was deemed optional for all providers. At the Audit Committee meeting in January 2021, external auditors highlighted that the Governors, Audit Committee and Board needed to decide whether the Trust wanted to commission an external assurance exercise from 2021/2022 onwards, the decision was not to commission. The Quality Account will need to be published by June 28th 2024.					
Recommendation						
Links to Strategic Objectives						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☐	☐	☐	☐	☐	☐
Link to Board Assurance Framework [BAF]						
Reports previously considered by	Considered at the Quality Committee.					

QUALITY ACCOUNT 2023/2024

EXECUTIVE SUMMARY

The Trust Board is asked to:

- Review and approve the Quality Account for publication, noting priority detail to date with a change in focus for 2024/2025.
- Since the Trust was served a Warning Notice under Section 29A of the Health and Social Care Act 2008, the Trust has undertaken rapid improvements in the quality and safety of healthcare provided to patients with a mental health need, a learning disability and/or autism. The CQC provided a list of 'Must Dos' which have to be actioned by June 2024 and a CQC Compliance Group has been formed to ensure that full assurance can be provided to the CQC.
- Note a decrease in compliance with Key National Priorities with plans for improvement identified.

Review of Quality Performance 2023/2024

Patient Safety

Priority 1 - Reducing Healthcare Associated Infections – focusing on COVID-19, Methicillin-Sensitive *Staphylococcus aureus*/Gram Negative Blood Stream Infections /Clostridium difficile Infections. A new National Infection Prevention & Control BAF was adopted to monitor and report progress on all related standards in the Trust. There has been improved diagnosis and management of sepsis with a number of QI projects undertaken in Clinical Boards.

Priority 2 – Management of Abnormal Results. The Trust agreed a list of 1000+ lead clinicians with patient responsibility; implemented a robust process for new staff; made improvements to the electronic systems; reduced the number of blood samples being discarded and ensured that radiology requests are no longer cancelled when patient is discharged from hospital.

Priority 3 – Implementation of the National Patient Safety Strategy (NPSS) & Patient Safety Incident Response Framework (PSIRF). PSIRF Implementation Lead and NPSS Clinical Director were appointed who led the Trust in utilising the statutory PSIRF programme. The ICB now participate in the meetings where proportionate learning responses are identified and where learning responses are agreed. A charity funding application has been made for Patient Safety Partners who would support the Clinical Boards and Patient Safety Team.

Clinical Effectiveness

Priority 4a – Introduction of a formal triage process on the Maternity Assessment Unit, in order to improve the recognition of the deteriorating pregnant or recently pregnant woman. Badgernet electronic system implemented in January 2023. A new Band 7 role

was created to lead this implementation and training. A training package for core team of midwives and medical staff was implemented and the Brimingham Symptom Specific Obstetric Triage System implemented 18/12/2023.

Priority 4b - Modified Early Obstetric Warning Score (MEOWS). Admission documentation adapted to include additional questions concerning current and previous pregnancy (within 42 days) to identify patients meeting criteria. MEOWS created electronically. Electronic observations went live in May 2023 in all areas except Maternity Assessment Unit (which continues to be a high risk).

Priority 5 – Best Interests Decisions/Mental Capacity Assessment (MCA) and Deprivation of Liberty Safeguards (DoLS). Trust wide 'Care for me With Me' programme which includes training in relation to MCA and DoLS – current compliance 92%. Audit of referrals, electronic documentation and compliance have been undertaken. Increase in DoLS referrals shows greater awareness. Electronic MCA and Best Decisions forms have been updated.

Patient Experience

Priority 6 – Ensure reasonable adjustments are made for patients with suspected, or known, Learning Disability. Change in digital documentation for patients with Learning Disability with greater awareness of how to document correctly and reasonable adjustments required. Implementation of Learning Disability training (Diamond Standards eLearning). NUTH has been part of the regional pilot for Oliver McGowan training.

Priority 7 – Improve services in Emergency Department for children, young people, and adults with mental health issues. Clinical Manager appointed by CNTW to lead on Child and Young People Service liaison proposal (April 2023). 'We Can Talk' Programme Leads visited the Trust in April 2023 to promote training. 'We Can Talk in Private' QI project fully implemented in adult ED. Children and Young People QI project Welcome Pack fully implemented.

Priority 8 – Embed a consistent approach to transition young people from child to adult services. Project team has been funded for 23 months to embed principles of transition across the Trust, develop bespoke pathways for complex patients, ensure youth worker oversight for under 18s and recruit a Data Manager.

<u>Quality Priorities for Improvement 2024/2025</u>

Patient Safety:

Priority 1 – To improve patient safety by ensuring staff feel free to report safety concerns; incidents and near-misses, resulting in an overall increase in incident reporting rates.
Priority 2 – Achieve a reduction in the incidence of surgical 'never events' with a specific focus on Ophthalmology, sharing the learning to inform and improve practice across other surgical specialities.

Clinical Effectiveness:

Priority 3 – To ensure reasonable adjustments are made for patients with suspected or known Learning Disability &/or Autism. Appropriate and consistent use of Mental Capacity Assessment & Deprivation of Liberty Safeguards for patients with vulnerabilities.

Patient Experience:

Priority 4 - To ensure the Trust has a systematic way of improving from patient and staff feedback in all its forms.
Priority 4a - With new midwifery leadership, agree a staffing model for the birthing unit and associated staff development plan, to honour our commitment to consistent opening of the birthing centre.

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

QUALITY ACCOUNT 2023/2024

CONTENTS

Agenda Item 12(ii)

PART 1

CHIEF EXECUTIVE'S STATEMENT

Thank you for taking the time to read our 2023/2024 Quality Account which gives us an opportunity to reflect on the last year and to openly share our performance and outcomes with you.

2023/2024 has been a very difficult year for the Newcastle upon Tyne Hospitals NHS Foundation Trust due to serious concerns that we received from the Care Quality Commission following their inspections of our services.

The final report from the Care Quality Commission was received by the Trust in December 2023 which reflected their activity since June in a number of different services. The Trust also received restrictions on our licence to provide services which were imposed through a 'Notice of Decision' on December 18th 2023.

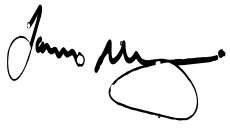
Since becoming Chief Executive on 1st January 2024, I have focussed on the two things that matter the most – how we can provide the best care for our patients, and how we can significantly improve the experience that our staff have at work. There is no denying how difficult and disappointing this has been for everyone working here, but I have seen a genuine strength of spirit and commitment to making swift and significant improvements.

The Trust is on a journey of improvement, and we have responded swiftly to rectify areas of concern raised by the Care Quality Commission, and will continue to do so, ensuring that patients remain truly at the centre of everything we do.

We are committed to encouraging a culture of openness and honesty, to listen, to learn and to innovate so that we can deliver the highest quality and safest care to patients, from skilled staff.

Providing high quality, patient focused care remains our highest priority. Our staff work tirelessly to ensure that patients receive the safest, most clinically effective care and a positive patient experience each and every time they use one of our services.

I would like to thank all our staff and volunteers for their incredibly hard work, dedication and compassionate care throughout the year.



Sir James Mackey
Chief Executive
23rd April 2024

To the best of my knowledge the information contained in this document is an accurate reflection of outcome and achievement.

WHAT IS A QUALITY ACCOUNT?

Quality Accounts are annual reports to the public from us about the quality of healthcare services that we provide. They are both retrospective and forward looking as they look back on the previous year's data, explaining our outcomes and, crucially, look forward to define our priorities for the next year to indicate how we plan to achieve these and quantify their outcomes.

PART 2

QUALITY PRIORITIES FOR IMPROVEMENT 2024/2025

Following discussion with the Board of Directors, the Council of Governors, patient representatives, staff and public, the following priorities for 2024/2025 have been agreed. A public consultation event was held in January 2024.

PATIENT SAFETY

Priority 1 – To improve patient safety by ensuring staff feel free to report safety concerns; incidents and near-misses, resulting in an overall increase in incident reporting rates.

Why have we chosen this?

Staff need to have clarity and confidence in the Trust incident reporting and learning mechanisms, knowing reported events will be escalated and acted on in an effective manner and supported by compassionate leadership as part of a 'Just Culture' that supports fairness, openness and learning, whilst encouraging staff to speak up without fear of blame. This priority aligns to the National Patient Safety Strategy and enhances the early implementation work of the Patient Safety Incident Response Framework. Using intelligence gathered from staff and the Trust's recent Care Quality Commission report, there is acknowledgement that we need to simplify the incident reporting system, to make it easier for staff to report when things wrong and to increase incident reporting rates. In addition, by ensuring that learning and feedback is captured and disseminated, the trust will strengthen the reporting culture of the organisation and improve safety performance.

What we aim to achieve?

The Trust aims to improve staff understanding and confidence in incident reporting mechanisms, thus improving the incident reporting rates and flow of learning throughout the organisation supporting the reduction of harm. We want staff to feel empowered and psychologically safe to report and escalate concerns in a timely way, demonstrating a positive and supportive culture of learning.

How will we achieve this?

- Review and simplify the Datix system, improving access options and rationalising coding.
- Further development of incident metrics available on the power BI platform and dashboards.
- Provide support to the Quality Oversight Groups to develop sharing mechanisms to devolve learning to front line staff.
- Provide supporting education and training packages that will encourage reporting, effective investigation, supportive leadership and psychological safety.
- Regular communications including weekly safety messages and monthly patient safety briefings.
- Establish twice yearly Patient Safety Incident Response Framework thematic reviews for Clinical Boards.
- Share learning from After Action Reviews and Patient Safety Incident Investigations.
- Review and refresh investigation training and Trust Induction information, including incident reporting & psychological safety themes.
- Key leaders trained in systems-based incident investigation and sharing learning.
- Engagement with staff via weekly Patient Safety Incident Response Framework drop-in sessions.

How will we measure success?

- Increased reporting rates.
- Outcomes from staff questionnaires/surveys.
- Evaluation & uptake of training packages.
- Attendance at patient safety briefings.
- Determination of incident learning mechanisms within Clinical Boards.
- Future Staff Survey information.
- General Medical Council trainee survey report.

Where will we report this to?

- Quality Oversight Groups.
- Quality and Performance Reviews.
- Patient Safety Group
- Quality Committee.

Priority 2 – Achieve a reduction in the incidence of surgical 'never events' with a specific focus on Ophthalmology, sharing the learning to inform and improve practice across other surgical specialities.

Why have we chosen this?

A Never Event is "*A serious largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers*."

Within Ophthalmology the investigation of Never Events is taken very seriously including the investigation of three Never Events in 2023/2024 under the following categories:

- Wrong site surgery x 1
- Wrong lens implant x 2.

The three Never Events above underwent a full investigation by the trust Clinical Governance and Risk Department with input from the speciality. Any immediate actions were implemented urgently whilst the incidents were fully investigated. Learning has been disseminated and discussed through the appropriate routes internally and with the Integrated Care Board. The Trust found important learning that has been shared with staff across the organisation, with our commissioners and the patient and/their family.

What we aim to achieve?

Reduction of Never Events in Ophthalmology to zero within 2024/2025.
Recognise the fallibility of practice, understand the tension between the concept of Never Events vs human factors and work to manage risks proactively.
Learning from this work will be shared organisation wide to accelerate learning potential.

How will we achieve this?

- Implement a Quality Improvement programme of work that seeks to implement the Local Safety Standards for Invasive Procedures.
  - Review and implement the Local Safety Standards for Invasive Procedures, with regular compliance audits carried out to monitor performance.
- Strengthen the team brief and debrief process, ensuring all team members are actively involved, and that normal practice is discussed with locum/agency staff and Peri -Operative staff.
- Ensuring there are methodical, systematic checks and confirmations prior to start of any procedure.

Macular injection pathway:

- Review efficiency of the macular injection pathway, from booking to point of administration of treatment, improving the process flow and removing unnecessary tasks.
- Whilst giving injections, implement interventions to stop distractions i.e. place “Do not disturb” signs on treatment doors.
- Agree/develop consistent treatment plans for use on Medisoft.
- Review and update Local Safety Standards for Invasive Procedure checklists.

Cataract Surgery:

- Local review of the “marking” procedure.
- Review and update the local policy on the lens check procedure and specialty specific World Health Organisation checklist, specifically:
  - Timeout so that theatre is quiet and no other tasks are taking place.
  - Lens checking by the surgeon against the cataract summary sheet/biometry summary sheet before floor staff handling the lens to the scrub nurse and signed by floor staff to confirm check.
  - If lens prescription is changed due to the required use of a sulcus lens then the lens check should still be undertaken against the original prescription and confirmation of the change should be noted on the summary sheet.
  - Any change of lens power due to use of a sulcus lens should be the same power or within 1.5 less than the originally chosen lens power.
  - Education for theatre teams into the World Health Organisation checklist including importance of entre team “time out” and importance of a team “knife check” pre-incision pause.

How will we measure success?

- Number of Never Events reported on the Datix Incident Reporting System.
- Number of Never Events presented at the weekly Rapid Review meeting.
- Number of staff trained across Ophthalmology & Peri-operative Theatres.
- Quarterly audit of 10 sets of relevant notes re compliance with Local Safety Standards for Invasive Procedures.
- Quarterly audit of current treatment plans recorded on Medisoft.
- Quarterly observational audit – to ensure standardisation and quality assurance of surgical safety checklist process in Newcastle Westgate Road Cataract Centre, Cataract theatres.

- Patient feedback on the service before and after changes which directly affect patients.

Where will we report this to?

- Ophthalmology surgical audit (Clinical Governance) meeting.
- Surgery & Specialist Services Quality Oversight meeting.
- Quality Committee.

CLINICAL EFFECTIVENESS

Priority 3 – To ensure reasonable adjustments are made for patients with suspected or known Learning Disability &/or Autism. Appropriate and consistent use of Mental Capacity Assessment & Deprivation of Liberty Safeguards for patients with vulnerabilities.

Why have we chosen this?

The Trust must ensure we are compliant with The Mental Capacity Act 2005, April 2007. The Act provides a statutory framework to empower and protect any person over the age of 16 in England and Wales who may not be able to make their own decisions. It sets out roles and responsibilities of carers, both professional and informal. The Mental Capacity Act and Safeguarding legislation have a significant overlap in order to ensure that the rights, as set out in the Human Rights Act 1998, and the safety of adults and young people at risk of harm are protected. The Mental Capacity Act aims to empower and also protect individuals. The Mental Capacity Act empowers by ensuring the fundamental right to make decisions is not inappropriately taken away from the individual. The Mental Capacity Act protects by ensuring where an individual lacks capacity in relation to a specific decision, actions taken by others are made in their best interests.

The Deprivation of Liberty Safeguards legislation was introduced in 2009, as an addendum to the Mental Capacity, 2005, providing a legal framework around depriving people of their liberty (England and Wales). The Deprivation of Liberty Safeguards provides legal protection for those in the main aged 18 and older, who are, or may become, deprived of their liberty.

The involvement of patients with a learning disability in reviewing services and planning improvements supports the Trust in ensuring their needs are heard. This contributes towards tackling the health inequalities faced by this patient group and empowers them to be partners in the care they receive.

What we aim to achieve?

Compliance with Mental Capacity Act, Best Interest Decision making, Deprivation of Liberty Safeguards and the Equality Act 2010.
Therefore, there needs to be assurance that clinical staff understand when and how to complete mental capacity assessments and best interest decisions. Staff also need to document assessments and decision making appropriately in patients electronic records.

Clinical Staff must understand Deprivation of Liberty Safeguards process and documentation, what this means for the patient and where to store and retrieve the appropriate information.

The collaborative work aims is to reduce health inequalities for patients with a learning disability by working in partnership with people with lived experience.

How will we achieve this?

- Training via E-learning packages in Mental Capacity Act and Diamond Standards for Learning Disability.
- Autism Awareness virtual sessions.
- Trust Forums – sessions delivered by Mental Capacity Act Lead, Learning Disability Liaison and Safeguarding teams.
- Visual information for patients i.e., Reasonable Adjustment Posters, 'How to use a Health and Care Hospital Passport'.
- Scope current position against the National Reasonable Adjustment Digital Flag Information and develop an action plan to achieve compliance and implementation.
- Sign posting of useful information through "Care for Me With Me" resource pages and Learning Lab.
- Collaborative Working with "Skills for People" to develop easy read information, using quality checks in three departments.

How will we measure success?

- Training compliance in line with trust standard (95%).
- Audit of the patient record in regard to the quality of Deprivation of Liberty Safeguards referrals.
- Patient Feedback via focus groups led by Skills for People.
- Production of ten easy read leaflets.

Where will we report this to?

- MCA Trust Steering Group.
- Safeguarding Committee.
- Patient Experience and Engagement Group.
- Quality Committee.

PATIENT EXPERIENCE

Priority 4 - To ensure the Trust has a systematic way of improving from patient and staff feedback in all its forms

Why have we chosen this?

Our people are central to improving the quality and delivery of safe and compassionate care. How they experience the culture of the organisation and how they feel about their workplace directly impacts on their ability to care for patients, their team, themselves, and their families.

In most NHS organisations, patient experience remains the weakest of the three arms of quality. It does not get the same attention as safety and clinical effectiveness and still tends to be seen as an add-on. This needs to change.

Although patient experience is currently captured through the Friends and Family test and national surveys, there has been remarkably little improvement in NHS patient experience data since surveys were introduced in 2002 – we aren't always measuring the right things, feedback is not representative or timely enough, and we don't get information to staff in ways that motivate them to act on results.

We have employed an approach to understanding and improving patient and staff experience across multiple hospital sites, which has been used successfully in other trusts. We set out to really understand quality in real time and with enough granularity to inform improvement.

What we aim to achieve?

Our ambition is to develop a patient and staff experience programme at Newcastle Hospitals that is the most comprehensive in the NHS. We will capture performance at a site, clinical board, speciality, and ward level. The introduction of individual consultant-level data to inform annual appraisals is relatively unique in the NHS, this will elevate our programme and help to ensure senior medical ownership.

This work also builds on the previous funding provided by the charity to develop the patient experience of care. Patients told us they wanted to be asked about their experience, they wanted their feedback to visible and they wanted to know how their feedback made a difference. This programme will therefore let us deliver the aims set out in the experience of care strategy.

How will we achieve this?

A new seconded role of Chief Experience Officer has been created within the Executive Team, designed to strengthen trust Board accountability, and provide visibility and momentum for a trust-wide patient and staff experience programme.

The Chief Experience Officer offers 15 years of experience in designing, developing, and sustaining a pioneering patient and staff experience programme – the first of its kind in the NHS. The programme has won multiple national awards and gained international recognition since first introduced in 2009.

Aims:

- Ensure the organisation has a systematic way of analysing patient and staff feedback in all its forms and dedicated analytics and intelligence support for its patient and staff experience data.
- Support the early implementation of an innovative and evidenced based staff engagement programme.
- Develop transparent and publicly accessible information about the feedback patients and staff have provided, with the organisation's response to this feedback.

- **Our 'real time' programme:** We will train a team of five patient coordinators to carry out hundreds of face-to-face interviews every month to enable a better understanding of the needs of inpatients whilst they are still with us; the results will be shared with staff within three to four hours of speaking to patients enabling a nimble response to any concerns. Charitable funds will support the inclusion of 25% of all wards in the first six months of implementing the programme.
- **Our 'right time' programme** will capture reflective feedback from patients once they are home. We deliberately survey two weeks after leaving hospital, because we know that this is the time, statistically, when people are likely to be at their most dissatisfied – our greatest improvement opportunity. Funds will enable us to appoint a Care Quality Commission approved contractor to provide externally validated patient experience data for inpatients, outpatients, maternity and emergency care users.

How will we measure success?

Patients have a positive experience where there is a culture of safety that puts the patient first and gives patient experience the highest priority with the implementation of real-time patient feedback. Information about real-time patient experience displayed on all wards and clinic areas gives added evidence of priority.

An open and transparent organisational culture has a positive impact on staff and patients. Where there are highly encouraged and evident innovation and quality improvement programmes, there was also a notable improvement in the patient experience. Where there is a culture of all staff groups showing pride in their work and feeling part of the organisation, this leads to a commitment to learn from mistakes.

Based on current activity levels we aim to get feedback from more than 250,000 people every year. The impact will be felt by many more.

- **Inpatients:** We would survey 5,000 individuals every month, to achieve at least 2,000 responses.
- **Emergency Care:** A sample of 20% of patients, 3,000 a month, providing reliable trackable results monthly at each Emergency Department.
- **Outpatients:** 20% or 18,000 responses a month to enable site, speciality, and Clinical Board results.
- **Maternity:** a census rather than sampling approach for every month apart from February which is for the National Survey.
- **Quarterly staff surveys and evidenced based improvement programme.**

Success will be evidenced by excellent engagement with patients, families, and communities – we will be able to demonstrate statistically significant gains in patient and staff experience within 12 months.

Where will we report this to?

- People Committee.
- Trust Management Group.
- Executives.
- Quality Committee.

Priority 4a - With new midwifery leadership, agree a staffing model for the birthing unit and associated staff development plan, to honour our commitment to consistent opening of the birthing centre

Why have we chosen this?

Although maternity service user experience is currently captured through the Friends and Family test, the Care Quality Commission National Maternity Survey, and feedback gathered by the Maternity and Neonatal Voice Partnership there has been remarkably little improvement in NHS patient experience data since surveys were introduced in 2002 – we are not always measuring the right things, feedback is not representative or timely enough, and we do not share the feedback with staff to 'close the loop' in ways that motivate them to act on results for service improvement.

It has been nationally acknowledged that it is a difficult time to work within Maternity Services and is a time of great change, therefore it is vital that we take steps to understand the experience of the individuals working within Maternity Services in each clinical area in order to support individual development and enhance their working lives.

Our maternity team are central to improving the quality and delivery of safe and compassionate maternity care. How they experience the culture of the organisation and how they feel about their workplace directly impacts on their ability to care for patients, their team, themselves, and their families.

The current reduction in intrapartum maternity service provision due to the long-term suspension of the midwifery-led Newcastle Birthing Centre has had a detrimental impact on the choice of environment afforded to maternity service users planning their birth and when attending in labour at Newcastle Hospitals; and has been a challenging new way of working for Midwives previously based in the Newcastle Birthing Centre.

The limitations of the Delivery Suite estate pose a significant challenge to the birthing environment for service users and is followed by postnatal care in a shared ward environment, restricting the opportunity for families to remain together in the precious first few hours and days following a baby's birth.

The remodelling of the Neonatal Transitional Care service from within postnatal to a stand-alone ward in April 2024 brings a new way of collaborative working for the maternity and neonatal team. It has provided the opportunity to pause the usual regular rotations of Midwives for a period of six months to bring stability to the implementation period which consequently offers the opportunity to understand individual staff experience within each clinical area of Maternity Services.

What we aim to achieve?

We aim to understand what matters to women and birthing people in Delivery Suite and the experience of postnatal inpatient area as well as the Maternity Team providing their care, to enable the collaborative design of a Maternity Service for the future; that meets the needs and expectations of service users and staff and supports the consistent delivery of safe maternity care in all environments.

How will we achieve this?

Early inclusion in the 'real time' service user and staff experience programme will enable the capture of service user feedback to be captured while service users are inpatients in Delivery Suite or the postnatal ward with information shared with the Maternity Team within three to four hours to provide the opportunity to immediately respond to the feedback and get things right for the families currently in our care.

Initial feedback will be further enhanced by reflective feedback that is captured via the 'right time' programme from service users when they are home. We will deliberately survey two weeks after leaving hospital, because we know that this is the time, statistically, when people are likely to be at their most dissatisfied – our greatest improvement opportunity.

Alongside this there will be a two-weekly staff experience capture of the Maternity Team providing intrapartum and postnatal care. With the combined information correlated to understand the challenges within each clinical area to responsively coproduce and develop quality improvement initiatives to improve service user and staff experience.

A new Director of Midwifery is due to join the trust in June 2024. Her leadership within this improvement programme will ensure agreement of a new staffing model for the birthing unit and associated staff development plan, to honour our commitment to consistent opening of the birthing centre.

How will we measure success?

Service Users have a positive maternity experience where there is a culture of safety that puts the Service User first and uses Service User experience feedback to coproduce services.

Information about real-time patient experience displayed in each area gives assurance that Service Users are at the heart of Maternity Services and shows the commitment to improve on the provision of Maternity Services and the environment in which care is provided.

An open and transparent organisational culture has a positive impact on staff and Service Users. Where there are highly encouraged and evident innovation and quality improvement programmes, there was also a notable improvement in the patient experience. Where there is a culture of all staff groups showing pride in their work and feeling part of the organisation, this leads to a commitment to learn from mistakes.

Success will be evidenced by excellent engagement with Service Users, families, and communities. We will demonstrate statistically significant gains in Maternity Service User and staff experience within 6-12 months and coproduce a consistent Maternity Service provision that meets the needs of all.

Where will we report this to?

- People Committee.
- Trust Management Group.
- Executives.
- Quality Committee.

COMMISSIONING FOR QUALITY AND INNOVATION INDICATORS

The Commissioning for Quality and Innovation payment framework is designed to support the cultural shift to put quality at the heart of the NHS. Local Commissioning for Quality and Innovation schemes contain goals for quality and innovation that have been agreed between the Trust and various Commissioning groups.

NHS England have paused the nationally mandated Commissioning for Quality and Innovation scheme in 2024/2025, however have continued to publish Commissioning for Quality and Innovation indicators as a non-mandatory list, comprising of the 2023/2024 Commissioning for Quality and Innovation schemes. During 2024/2025 the Organisation is committed to focusing its attention on the Patient Safety Incident Response Framework and digital patient safety improvements across the Trust.

STATEMENT OF ASSURANCE FROM THE BOARD

The Quality Account is an annual account that providers of NHS services must publish to inform the public of the quality of the services they provide, in addition to sharing useful information for current and future patients. It also supports us to focus on and to be completely open about service quality and assists us to develop and continuously improve. This report details the approach that we take to improving quality and safety at Newcastle Hospitals and an assessment on the quality of care our patients received in 2023/2024. There are some elements within the report that are mandatory. The following section provides explanation of our quality governance arrangements that provide assurance to the Board.

Quality governance arrangements

In December 2023 the Trust received restrictions on our license to provide services which were imposed through a 'Notice of Decision'. As a result, it is required to implement an effective governance system which assesses, monitors and drives improvement in the quality, safety and experience of the care it delivers to patients. In particular this included ensuring that:

a. Risks in services are appropriately recorded, assessed, escalated to the Trust's board where required, and regularly reviewed.
b. Progress against action plans is monitored to improve the quality and safety of services and appropriate action is taken without delay where progress is not achieved as expected.
c. An effective system to identify and report incidents including the severity of harm is in place. The system must ensure incidents are appropriately reported to internal and external systems within appropriate timescales. The system must ensure incidents are effectively reviewed, lessons and actions are identified and shared with staff.
d. There are effective quality assurance systems in place to support the delivery of safe and quality care.
e. Feedback from staff is used to drive improvements to the quality and safety of services, and once improvements are identified they are made without delay.
f. Staff are able to report service user safety concerns without fear of reprisal, retribution or detriment using internal routes and in line with policies and procedures.
g. Feedback from external bodies such as royal colleges and other bodies who provide best practice guidance is sought and acted upon.

In order to deliver the requirements above, a dedicated Care Quality Commission delivery group has been established, led by an interim Quality Support Director, with oversight from Trust Board.

In 2023/2024 Newcastle Hospitals underwent a significant organisational restructure, transitioning from 20 Directorates to eight Clinical Boards. In November 2023 this included the introduction of a new clinical board quality and safety governance framework, providing a structure for Clinical Board oversight of the key elements of quality (patient safety, clinical effectiveness and patient experience) and a mechanism

for providing assurance to the Quality Committee and Trust Board that the relevant structure and processes are working effectively.

Each Clinical Board has developed and established a monthly Quality Oversight Group, led by a Quality and Safety Lead, who is a senior medical leader within the Clinical Board. The Quality Oversight Group is attended by key stakeholders within the Clinical Board and supporting corporate services such as the Clinical Governance and Risk Department and Newcastle Improvement. The Clinical Boards have a standard agenda which facilitates a review of each element of quality, including highlighting any risks within the Clinical Board.

Each Clinical Board reports into a monthly Quality and Performance review, led by the Trust Managing Director and attended by Executives to monitor compliance, provide assurance and discuss any risks. These can be further escalated to the Trust Board as required.

Whilst the Clinical Board quality and safety framework becomes embedded, the Trust has continued with its established quality governance arrangements throughout 2023/2024 to ensure that key quality indicators and reports are regularly reviewed by clinical teams and by committees up to and including the Board of Directors.

The Board of Directors also continues to receive a regular Integrated Board Report that includes an overview of the Trust's position across the domains of quality, people, and finance sections.

The Quality Committee

The Quality Committee is a sub-committee of the Board of Directors which provides assurance regarding patient safety, clinical outcomes and effectiveness, compliance and assurance, patient experience and engagement and clinical research.

The Quality Committee is a subcommittee of the Board
The committee is chaired by a non-executive director and has met seven times this year.
Membership
• Non-Executive Directors (chair and vice chair) • Medical Director • Executive Chief Nurse • Chief Operating Officer • Director of Quality and Effectiveness • Associate Medical Director, Patient Safety and Quality • Deputy Chief Nurse.

The Quality Committee is responsible for providing assurance to the Board of Directors for the following;

Some examples of how the Quality Committee undertakes its role include;

- Following implementation of the National Patient Safety Strategy, the Quality Committee has monitored and received assurance on the development and delivery of the Patient Safety Incident Response Plan and Patient Safety Incident Response Framework.
- Following the Trust's Care Quality Commission inspections during June to September 2023, the Quality Committee has received regular updates from the Executive Chief Nurse in relation to the Trust's updated position and any action plan responses, including any 'must do' and 'should do' actions and key themes, seeking assurance on plans for improvement.
- To improve assurance to the Quality Committee and Board, a sub-group of the committee, the Maternity Strategic Oversight Group, was established in relation to maternity services.
- The Quality Committee has a process to undertake 'deep dives' in order to provide a detailed evaluation in some specific areas of the Trust. The deep dives aim to provide assurance and opportunities for the Non-Executive Directors to discuss key issues. In May 2023 a deep dive was undertaken to review pressure ulcer and falls quality data in relation to variations with reporting and comparative data. The deep dive looked at the link between the acuity of patients and associated hospital acquired infections.
  The Quality Committee supports leadership walkabouts that are undertaken by Executive, Non-Executive and members of the senior trust management team throughout the organisation. The walkabouts enhance links between senior leaders and front-line staff and raise awareness of front-line issues and support the visibility and accessibility of senior leaders within the organisation.
- The delivery of continuous quality improvement was the focus of a Quality Committee meeting in July 2023 when Newcastle Improvement presented an update. This update highlighted how the Quality Committee continues to support the development of improvement capability, improvement initiatives and sharing improvement stories.

PART 3

REVIEW OF QUALITY PERFORMANCE 2023/2024

The information presented in this Quality Account represents information which has been monitored over the last 12 months by the Trust Board, Council of Governors, Quality Committee, and the North East and North Cumbria Integrated Care Board.

Most of the account represents information from all eight Clinical Boards presented as total figures for the Trust. The indicators, to be presented and monitored, were selected following discussions with the Trust Board. They were agreed by the Executive Team and have been developed over the last 12 months following guidance from senior clinical staff. The quality priorities for improvement have been discussed and agreed by the Trust Board and representatives from the Council of Governors.

The Trust has consulted widely with members of the public and local committees to ensure that the indicators presented in this document are what the public expect to be reported.

Comments have been requested from the Newcastle Health Overview and Scrutiny Committee, North East and North Cumbria Integrated Care Board and Newcastle, North Tyneside and Northumberland Healthwatch organisations. Amendments will be made in line with this feedback.

PATIENT SAFETY

Priority 1 - Reducing Healthcare Associated Infections – focusing on COVID-19, Methicillin-Sensitive *Staphylococcus aureus*/Gram Negative Blood Stream Infections /Clostridium difficile Infections.

Why we chose this?

Gram Negative Blood Stream Infections constitute the most common cause of sepsis nationwide with associated high mortality. Proportionally, at the Newcastle Hospitals, the main source of infection is urinary tract infections, mostly catheter associated, line infections and hepatobiliary (liver, bile ducts and / gallbladder). There is an integrated approach to tackling these infections with multidisciplinary team engagement across the whole patient journey, focus on antibiotic stewardship, early identification of risks, surveillance and timely intervention from our reduction strategies. There is additional emphasis on Antimicrobial Resistance reduction, with high rates of resistance in most commonly used antibiotics i.e. Piperacillin-Tazobactam (Tazocin) for gram negative infections. The Gram Negative Blood Stream Infection Steering Group and Antimicrobial Steering Group continue to review reduction strategies on a quarterly basis.

Methicillin-Sensitive *Staphylococcus aureus* bacteraemia can cause significant harm. Within the Trust these are most commonly associated with lines, indwelling devices and soft tissue infections. Achieving excellent standards of care and improving practice is essential to reduce these infections and complications in line with harm free care.

In addition to COVID-19, there is a surge in respiratory infections, in particular Influenza and Respiratory Syncytical Virus. Each has the potential to require hospitalisation / intensive care admission and cause outbreaks across the Trust.

C. difficile infection is a potentially severe or life-threatening infection. It remains a national and local priority to continue to reduce trust rates of infection in line with the national and local objectives.

What we aimed to achieve?

- There is a national ambition to reduce Gram Negative Blood Stream Infections. We realigned ourselves with national reduction targets as these required greater than10% reductions for some pathogens.
- Targeted reduction in Broad spectrum antibiotic use (namely Tazocin).
- Internal 10% year-on-year reduction in Methicillin-Sensitive *Staphylococcus aureus* bacteraemia
- Prevent transmission of health care acquired infections, COVID-19 and other preventable respiratory infections in patients and staff.
- Sustained reduction in *C. difficile* infections in line with national trajectory.

What we achieved?

- We adopted the National Infection Prevention and Control Board Assurance Framework (2023) to monitor and report on progress on all related standards in the Trust.
- Improved diagnosis and management of sepsis, collaborative working with

Sepsis Clinical Director and specialist nurses. The National Contract data for sepsis identification, screening and treatment only includes a proportion of inpatients who undergo sepsis screening and who, if found to have suspected sepsis received Intravenous antibiotic treatment within one hour of diagnosis. Current sepsis compliance for inpatients increased from 66% to 81% in 2023/2024.

- Quality improvement projects undertaken in key Clinical Boards, running in parallel with trust-wide awareness campaigns, education projects, and audit of practice, with a specific focus on:
  - Antimicrobial stewardship and safe prescribing (Emergency Department). New Sepsis guidelines are in place to move selected patients away from broad spectrum antibiotic use.
  - Early recognition and management of suspected infective diarrhoea. Education and monitoring ongoing in surgical specialties resulting in improved recognition and management of *C. difficile* infection. This has been reflected in us achieving 144 cases in 2023/2024 which has met the national threshold aim of ≤165 cases.
  - The trust has also met the national threshold aim for Klebsiella bacteraemia. National threshold aim was less than 130 cases and we achieved a total of 114 cases.
  - Ward monitoring of device compliance for peripheral intravenous and urinary catheters. Improvement work continues with audit and targeted education. Electronic dashboard line surveillance to be implemented in May/June 2024.
  - Optimisation of the management of bladder health and catheter associated infection through quality improvement interventions and recommendations.
  - Insertion and ongoing care of invasive and prosthetic devices. Surveillance monitoring is in place for Joint and Spinal Surgery. Quarter 4 (October – December 2023) saw five (1.3%) Surgical Spine Infections recorded at the RVI which is a slight increase compared to the previous quarter where three infections (0.9%) were recorded. For hips Quarter 3 (July – September 2023), no infections were recorded.
  - Octenisan compliance. Project completed and actions to be implemented April 2024.
  - Evidence of improvement in line care management in Royal Victoria Infirmary Admission Suite.
- Clinical Board Quality Oversight Groups are provided with quarterly infection control updates and attended by senior team representatives.
- Ongoing work with partner organisations such as the Integrated Care Board to improve infection control practice for the wider health care economy.

How we measured success?

- Monitoring compliance with assurance frameworks.
- Continuous monitoring of healthcare associated infections and deaths within the Trust.
- Data sharing with Clinical Boards whilst focusing on best practice and learning from investigation of mandatory reportable organisms.
- Continue to report Methicillin-Sensitive *Staphylococcus aureus*/Gram Negative Blood Stream Infections /Clostridium difficile Infections monthly, internally and nationally.

Priority 2 – Management of Abnormal Results

Why have we chosen this?

The management of clinical investigations is a major patient safety issue in all healthcare systems. Nationally there is mounting evidence of serious harm caused by unintentional delays in clinical investigations being undertaken, acknowledged and endorsed, resulting in delays to clinical care, treatment and follow-up.

Problems related to the management of abnormal results are amongst the most common contributory factors leading to serious incidents and litigation related to delays in diagnosis/treatment and failures to act on results.

What we aimed to achieve?

- To be a world leader by improving patient safety through ensuring that appropriately ordered clinical investigations are undertaken, acknowledged and endorsed, resulting in timely clinical care, treatment and follow-up.
- Improving the management of abnormal results will require successful completion of Closed Loop Investigations.
- To ensure that all clinically appropriate investigation requests are fulfilled; results are returned to the correct consultant; and appropriate action is taken in response to critical results.
- More specifically, the aim is: When a test/investigation is ordered and undertaken, the result must be returned to the message centre inbox of the consultant with responsibility for patient care for endorsement and action by the team.

What we achieved?

The Trust has now:

- Agreed a list of over 1000 lead clinicians with patient responsibility (predominantly consultants, but also some senior allied health professionals).
- Implemented a robust process for new joiners to be added and leavers to be removed from the list of lead clinicians.
- Made improvements to our electronic systems so that they share information more effectively across laboratories, radiology and our patient record.
- Added a mandatory field to all electronic order entry forms used to digitally request investigations through eRecord (including radiology, laboratory medicine and echocardiography). This field asks for details of the “lead clinician to receive report”, and all results are channelled to the message centre of the specified clinician.
- Put in place measures to avoid blood samples being routinely discarded by the laboratory (blood sciences) where “collected” has not been ticked in “nurse task list” in eRecord.
- Ensured that radiology tests are no longer automatically cancelled when an inpatient is discharged from hospital.
- Made it easier to see the Results Review in eRecord to avoid test results being missed.
- Started to improve the configuration of the ‘message centre’ make it easier for staff to use. Results will be received in the message centres of recognised

clinicians with consultant-level responsibility for patient care. As a result, message centre is now a more reliable method for communication of results, thereby ensuring more timely clinical care, treatment and follow-up.

How we measured success?

We evaluated how often the lead clinician that asked for the investigation, received the results within the electronic patient record. The data was analysed within the following categories:

Magnetic Resonance Imaging Results: Our data shows that the correct clinician received the results as planned in 61.3 percent of cases. The Trust therefore estimates that 22,000 additional MRI reports will be sent to the correct clinician within the eRecord system.

Computerised Tomography Results: Our data shows that the correct clinician received the results as planned in 51 percent of cases. The Trust therefore estimates that, per year, over 48,500 additional Computerised Tomography reports will be sent to the correct clinician within the eRecord system.

Future work within the Trust aims to build on the results above the further improve and optimise the current systems.

Priority 3 – Implementation of the National Patient Safety Strategy & Patient Safety Incident Response Framework

Why have we chosen this?

The provision of healthcare unfortunately sometimes leads to avoidable harm. Despite decades of dedicated work, inadvertent harm continues across all providers, with the same types of patient safety incidents occurring time and again. The NHS Patient Safety Strategy outlines the national ambition for transformational change to continuously improve the safety of patients, by building on and improving patient safety culture and patient safety systems. Aligning to this national ambition is essential for the trust to provide meaningful patient safety improvement.

What we aimed to achieve?

- To transition to Phase 1 of the Trust Patient Safety Incident Response Framework implementation by autumn 2023, moving away from the Serious Incident Framework, and defining how we will respond to safety events differently.
- Staff will be skilled and equipped to respond to safety events, to provide opportunities for learning and improvement.
- Meaningful patient and staff involvement, to provide challenge and a positive impact across the wide patient safety agenda.

What we Achieved?

- A Patient Safety Incident Response Framework Implementation Lead and a Patient Safety Strategy Clinical Director were successfully appointed. They have

led the Patient Safety Incident Response Framework implementation, working with the new Clinical Boards to establish governance mechanisms for effective patient safety incident responses.

- The Trust's Patient Safety Incident Response Plan which outlines priorities for improvement, responses for different types of incidents, guides the identification of proportionate learning responses and outlines training requirements was developed with key stakeholders.
- The Trusts Patient Safety Incident Response Framework Policy which defines the scope and requirements, the types of response, timeframes for response and training requirement were developed and ratified.
- The Trust collaborated with the Integrated Care Board to agree oversight of the new systems for learning and improvement. Additionally, the Integrated Care Board now participate in trust meetings where proportionate learning responses are identified and meetings where learning responses are agreed.
- We have agreed roles, responsibilities and support available with the Clinical Boards Quality and Safety Leads, Heads of Nursing and Directors of Operations.
- Staff capacity and capability for systems-based investigation has been increased to support the proportionate learning responses identified by After Action Reviews and Patient Safety Incident Investigations.
- A charity funding application has been made to support patient safety partners who would support each of the Clinical Boards and the Patient Safety team.

How we measured success?

- The Trust's Patient Safety Incident Response Plan was approved by the Integrated Care Board in December 2023.
- The Trust's Patient Safety Incident Review Framework Policy was ratified in January 2024.
- The Trust has now moved away from the Serious Incident Framework and went live with the Patient Safety Incident Review Framework in January 2024.
- All three of the Trust Patient Safety Incident Review Framework priorities have an identified medical lead in addition to support from Newcastle Improvement, the Clinical Governance and Risk Department and a Non-Executive Director.
- A range of proportionate learning responses have been identified by the Patient Safety Incident Response Framework. A proportionate response is one which investigates the incident in the most appropriate level of detail to generate learning and recommendations. These responses fall into four main categories. Rapid Response Assessment, After Action Review, Patient safety Incident Investigation and Thematic Review.

CLINICAL EFFECTIVENESS

Priority 4a – Introduction of a formal triage process on the Maternity Assessment Unit, in order to improve the recognition of the deteriorating pregnant or recently pregnant woman.
Why we chose this?

The need for early recognition and management of deterioration of pregnant women was highlighted by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries and the Ockenden Report. Internally it was also identified that not having

triage at the point of presentation to the Maternity Assessment Unit was a contributory factor to Serious Incidents and Significant Learning Events within Maternity. It was therefore recognised that there was a need for formal triage on the assessment unit at the point of presentation to reduce the likelihood of avoidable harm to mothers and babies. A formal triage process would enable and facilitate rapid review and prioritisation of care, based on individual clinical need.

What was the aim?

Our aim was to improve early detection and escalation of women at risk of deterioration and to reduce the likelihood of avoidable harm to mothers and babies. A comprehensive Quality Improvement project was undertaken which facilitated significant changes and led to introducing a formal, objective triage using a bespoke platform within BadgerNet (electronic maternity system which was implemented in January 2023).

What has been achieved?

Work was ongoing to implement the Birmingham Symptom Specific Obstetric Triage System on the Maternity Assessment Unit. This is the bespoke maternity triage system within BadgerNet. We undertook the following:

- Implemented Badgernet in January 2023. This is an electronic end to end maternity package, which includes community and BadgerNotes, a woman's electronic hand-held record.
- Appointed a new Band 7 post to lead this implementation and training.
- Successfully applied for a Birmingham Symptom Specific Obstetric Triage System licence, enabling access to advice on implementation and training materials.
- Successfully moved elective workload away from the assessment unit. This has been achieved by the development of a new maternity day-care unit, within the antenatal ward. This has included a complete refurbishment of the clinical area and guidance has been developed for place of care/referral pathways. The women attending the assessment unit are now emergencies only, reducing the number of attendances which will support the implementation of electronic triage.
- Visited the maternity unit at a local Trust to see new processes working in practice.
- Implemented a training package for the core team of midwives and medical staff.
- Continued to use the paper version of the previous triage system in the interim and collected baseline audit data to monitor effectiveness. This showed 80% women were seen within 15 minutes in quieter periods, but this fell to 0-20% at busier times, particularly in the afternoons and evenings. This happened because there wasn't a formal electronic process to ensure formal triage took place.
- The Birmingham Symptom Specific Obstetric Triage System went live on December 18th 2023.

How we measured success?

- The Digital midwives have undertaken a weekly audit of women attending the assessment unit looking at:
  - The percentage of women formally triaged by a designated member of staff trained in triage, within fifteen minutes of arrival (target 95%). We have seen an increase in this to almost 90% since implementation.
  - The percentage of women receiving appropriate on-going care according to risk. This has increased to 80% for ongoing midwifery care but remains at approximately 50% for medical review within expected timeframe.

  A monthly dashboard is produced based on this data.
- The Triage Oversight and Implementation Group meets monthly to oversee compliance, assurance and effectiveness. The dashboard and process are reviewed, staff feedback is sought and areas for improvement identified. Experience from other users of this triage system in over 60 units are that it can take 6-12 months to achieve desired targets.
- The regional sharing and learning group meets monthly which is helpful for troubleshooting. The national team is also available on request to discuss issues/queries and we are currently meeting quarterly with them.

Priority 4b - Modified Early Obstetric Warning Score

Why we chose this?

In recent years there have sadly been several maternal deaths in England where the lack of Modified Early Obstetric Warning Score systems for pregnant women in hospital, but outside the maternity setting played a significant part. At present, pregnant and recently pregnant women outside the maternity unit are monitored using the traditional model of National Early Warning System monitoring for non-pregnant patients. The need for early recognition and management of deterioration of pregnant women has been highlighted by:

- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries
- The Ockenden Report
- The Maternity and Neonatal Safety Improvement Programme.
- Royal College of Physicians guidance, which states that all medical pregnant and recently pregnant women should be monitored using a MEOWS system.

What we aimed to achieve?

We aimed to achieve two things:

1. Creation of a means of identifying a pregnant and recently pregnant patients through our electronic patient record.
2. Introduce a maternal early warning observation chart linking to our electronic observations system.

What we achieved?

We have developed and brought into current practice a question in our admission documentation within our electronic patient record Electronic Patient Record to identify those patients who are pregnant or have been pregnant in the previous 42 days. This

allows us to identify all patients meeting this criteria, particularly for those in a non-maternity setting. We have created an electronic Modified Early Obstetric Warning Score chart. Electronic observations went live in May 2023 within maternity areas, apart from Maternity Assessment unit which remains a high-risk area. All the appropriate equipment is in place to enable staff to undertake the new assessment and we have also made changes to out electronic systems to make recording simpler.

How we measured success?

Success for the identification of pregnant or recently pregnant patients in the Electronic Patient Record is dependent on ability to record this information electronically. Deteriorating patients in adults are identified by reviewing the deterioration patient List, and more generally by observing compliance on the e-Observation compliance dashboard which gives trust wide data results.

Priority 5 – Best Interests Decisions/Mental Capacity Assessment and Deprivation of Liberty Safeguards.

Why we chose this?

Completion of mental capacity assessments and best interest decisions when appropriate will provide assurance that staff are providing high quality care that meets individual patient needs and assurance to the organisation. The completion of appropriate documentation will support this priority.

Staff must also be aware of the process of Deprivation of Liberty Safeguards, what this means for the patient and where to retrieve and store the appropriate information.

What we aimed to achieve?

- Ensure staff understand the need for mental capacity assessments and where and how to record these assessments.
- Ensure staff recognise when best interest discussions are needed and where and how to document these discussions.
- Ensure staff understand the process for requesting and completing Urgent Deprivation of Liberty Safeguards authorisations.

What we achieved?

- Trust-wide Care for me With Me programme.
- As part of the Trust's 'Care for Me, With Me' programme a significant amount of training has taken place across the Trust in relation to Mental Capacity Assessment and Deprivation of Liberty Safeguards Current compliance with MCA training is 92%.
- Compliance audits have demonstrated improvement across the Trust in the documentation of Mental Capacity Act assessment prior to Deprivation of Liberty Safeguards being put in place.
- Audit of referrals and electronic documentation for Quarter 3 audit showed 83% completed assessments of capacity for patients subject to Urgent Deprivation of Liberty Safeguards. 72% of assessments are seen as good or meeting minimal requirements. An appraisal of best interests (new audit measure introduced in Quarter 3) found that 32% were regarded as good assessments. There continues

to be some exemplary practice of thorough documentation of assessments and best interests' analysis, especially with regards to complex decisions.
- Increase in Deprivation of Liberty Safeguards referrals demonstrates greater awareness.
- Information shared to support staff in the process of completing mental capacity assessments and Best Interest decisions.
- Updated electronic mental capacity assessment and best interests' decision form.

How we measured success?
- Compliance with training.
- Audit of notes.

PATIENT EXPERIENCE

Priority 6 – Ensure reasonable adjustments are made for patients with suspected, or known, Learning Disability

Why we chose this?

We are committed to ensuring patients with a learning disability and or autism have access to services that will help improve their health and wellbeing and provide a positive and safe patient experience for them and their families.

Under the Equality Act 2010, the Trust must ensure services are accessible to children, young people, and adults with learning disabilities as well as everybody else. Reasonable adjustments can mean alterations to buildings by providing, wide doors and ramps, but may also mean changes to appointment times, duration, and location. Policies, procedures, and staff training should identify the requirement for reasonable adjustments to ensure that services work equally well for people with learning disabilities.

What we aimed to achieve?

- Ensure all staff are aware of where to document reasonable adjustments.
- Ensure staff are aware of the need to contact the Learning Disability Liaison Team if they have a patient with a confirmed learning disability who does not have an electronic alert flag and or a health and care passport.
- Ensure all clinical staff are compliant with the Diamond Standard training.

What we achieved?

- Change in digital documentation to ensure staff are prompted to identify if a patient has a confirmed learning disability, if they have a passport and alert flag on the system. There has been greater awareness of how to document reasonable adjustments and work undertaken in collaboration with patients in discussing their needs, as identified in their passports.
- Greater awareness of the role of the Learning Disability Liaison team.
- Implementation of learning disability training (Diamond Standards e-learning)
- Reintroduction of the role of the Learning Disability Champions.

- The Newcastle upon Tyne Hospitals NHS Foundation Trust has been part of the regional pilot with regard to the Oliver McGowan training.
- Reasonable adjustments posters placed across organisation.

How we measured success?

- Regular audits of patient records showing an increase of documenting diagnosis of a learning disability from 25% to 53%. Consideration of reasonable adjustments has increased from 43% to 46%.
- Review of training compliance which is now at 90%.

Priority 7 – Improve services in Emergency Department for children, young people, and adults with mental health issues.

Why have we chosen this?

According to 'Mental Health of children and young people in England 2022 – wave 3 follow up to the 2017 survey';

- In 2022 18% of children aged 7-16 years old and 22% of young people aged 17-24 years old had a probable mental disorder.
- In children aged 7-16 years old, rates rose from 1 in 9 (12.1%) in 2017 to 1 in 6 in 2020.
- 1 in 8 (12.6%) 11-16 year old social media users reported that they had been bullied online. This was more than 1 in 4 (29.4%) among those with a probable mental disorder.
- 11-16 year old social media users with a probable mental disorder were less likely to report feeling safe online (48.4%) than those unlikely to have a disorder (66.5%).

Throughout 2021/2022 there has been significant pressure on specialist mental health Tier 4 inpatient services across the Northeast and Yorkshire Region. There has been an increase in children and young people presenting and is especially high in those with eating disorders. This has resulted in some patients having delayed access to treatment in the right care environment.

The overarching purpose of the National Confidential Enquiry into Patient Outcome and Death Mental Healthcare in Young People and Young Adults report is to improve the quality of care provided to young people and young adults with mental health conditions.

As an organisation we will continue to review current service provision for children, young people, and young adults to assure that we identify gaps, areas of good practice and plan to improve the care we provide for these patients.

What we aimed to achieve?

- Improve the pathway and timeliness of access to appropriate services for all Children and Young People presenting acutely.
- Continue to promote the "We Can Talk" training across paediatric and adult areas.

- Improve the environment within the Emergency Department to ensure safety and well-being.

What we achieved?

- Clinical Manager appointed by Cumbria, Northumberland, Tyne and Wear to lead on the Children and Young People Service liaison proposal. This work commenced April 2023; business proposal submitted.
- The “We Can Talk” programme leads visited the Trust in April for a day to further promote the training.
- The ‘We Can Talk in Private’ Quality Improvement project is fully implemented in adult Emergency Department; the project aims to allow patients to indicate they wish to speak in private by holding a card up.
- Welcoming pack for the Children and Young People Quality Improvement project is fully implemented.

How we measured success?

- Development of more efficient pathways to access appropriate services such as Children and young people’s services for mental health difficulties.
- Positive impact of training, increased numbers of staff and disciplines trained totalling 253.

Priority 8 – Embed a consistent approach to transition young people from child to adult services.

Why have we chosen this?

Each year over 6,000 13–17-year-olds are admitted to our trust with over 11,000 attending outpatient services. The young people within the Great North Children’s Hospital are often cared for by multiple teams as rare conditions overlap into a variety of specialties. Co-ordination and preparation for transfer into adult care, including the pathways to adult care can often be inconsistent. Their care may also be transferred to a different area and can be stepped down to their local adult hospital or General Practitioner depending on their diagnosis.

There is increasing evidence that young people with chronic health conditions are at risk of being lost in the system. They can fail to engage when they move from child to adult services resulting in poor health outcomes. Transitional care is a process rather than an event and can facilitate the move between these services.

What we aimed to achieve?

- To facilitate and embed a coordinated approach for transition amongst specialist conditions and bespoke groups including mental health, safeguarding, learning disability/difficulty.
- To improve decision making to provide age and developmentally appropriate health care particularly outside paediatric services, for example in the adult Emergency Department.
- Provide a dedicated outreach support for young people managed outside

paediatric areas (youth worker role).

- To allow patient /family experience feedback.
- To promote a culture that the voice of the child/young person is recognised, valued, and acted upon across the organisation.
- In line with national guidelines the project will support, facilitate standards and principles for the management of young people in our care.

What we achieved?

- Funding has been agreed for a project team for 23 months to:
    - Embed the principles of transition across the organisation.
    - Develop bespoke pathways for more complex groups of patients.
    - Ensure youth worker oversight of any patient under 18 years old outside paediatric areas.
    - Recruit a data manager.

How we measured success?

As funding has now been agreed this work will progress throughout 2024/2025, led by a project team with the aim of facilitating and embedding a coordinated approach for transition amongst specialist conditions and bespoke groups including mental health, safeguarding, learning disability/difficulty and evaluating by collecting data on:

- Patient feedback on their experience, staff feedback surrounding improved knowledge.
- Measuring clinic attendance.
- Benchmark against the National Collaborative Framework.

National guidance requires Trusts to include the following updates in the annual Quality Account:

Update on Duty of Candour

Being open and transparent is an essential aspect of patient safety. Promoting a restorative, just and learning culture helps us to ensure we communicate in an open and timely way on when things go wrong.

An open and fair culture encourages staff to report incidents, to facilitate learning and continuous improvement to help prevent future incidents, improving the safety and quality of the care the Trust provides.

If a patient in our care experiences harm or is involved in an incident because of their healthcare treatment, we explain what happened and apologise to patients and/or their family as soon as possible after the event.

There is a statutory requirement to implement Regulation 20 of the Health and Social Act 2008: Duty of Candour. Within the organisation we have a multifaceted approach to providing assurance and monitoring of our adherence to the regulation in relation to patients who have experienced significant harm.

The Trust's Duty of Candour policy provides structure and guidance to our staff on the standard expected within the organisation. Our Duty of Candour compliance is assessed by the Care Quality Commission; however, we also monitor our own performance on an ongoing basis. This ensures verbal and written apologies have been provided to patients and their families and assures that those affected are provided with an open and honest account of events and fully understand what has happened.

Compliance with recording of Duty of Candour remains challenging. In 2023/2024 further work has been carried out to widen the Electronic Patient Record systems data that can be captured. A dashboard is also being launched to allow Clinical Boards to maintain oversight of their own compliance.

A key element of the Patient Safety Incident Response Framework is patient and family engagement in the investigation process. Over the next year work is planned to develop Duty of Candour to include patient/ families in the investigation process.

Duty of Candour requirements are regularly communicated across the organisation using several corporate communication channels, and it is a standard agenda item at the Patient Safety Group, where clinical Boards' compliance is monitored for assurance as part of a rolling programme. Staff learning and information sharing, in relation to Duty of Candour, also takes place at trust-wide forums such as Clinical Policy Group, Clinical Risk Group as well as other Clinical Board corporate governance committees.

Training is included in the Trust incident investigator training which is delivered to multidisciplinary staff once a month.

Statement on progress in implementing the priority clinical standards for seven-day hospital services

The Board Assurance Framework or seven-day hospital services submission was deferred due to the COVID-19 pandemic. The framework was then updated in 2022 to reduce internal data collection for Trust Boards, moving from data that was required to be uploaded twice yearly to a national portal, to Trust's producing a report signed off by the Executive Medical Director, at least once a year. The Trust is committed throughout 2024/2025 to undertaking an assessment of its performance as required by this guidance and producing the required reporting.

Gosport Independent Panel Report and ways in which staff can speak up

"In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS Foundation Trusts in England to report annually on staff who speak up (including whistleblowers). Ahead of such legislation, NHS trusts and NHS Foundation Trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust".

All staff permanent, temporary and bank workers are informed as part of their induction process, via the e-handbook 'First Day Kit' that there are several routes through which to report concerns about issues in the workplace. There is a recorded presentation at induction by The Freedom to Speak Up Guardian to introduce themselves to staff and to emphasise their role in this process.

We want staff who work for Newcastle Hospitals to be confident they have a voice and that they can raise concerns safely. This includes the ability to provide information anonymously.

Any of the reporting methods set out below can be used to log an issue, query, or question; this may relate to patient safety or quality, staff safety including concerns about inappropriate behaviour, leadership, governance matters or ideas for best practice and improvements.

These systems and processes enable the Trust to provide high quality patient care and a safe and productive working environment where staff can securely share comments or concerns.

Work in confidence – the anonymous dialogue system

The Trust continues to use the anonymous dialogue system 'Work in Confidence', a staff engagement platform which enables people to raise ideas or concerns directly with up to 20 senior leaders, including the Chief Executive, members of the Executive Team and the Freedom to Speak Up Guardian. The conversations are categorised into subject areas, including staff safety.

This secure web-based system is run by a third-party supplier. It enables staff to engage in a dialogue with senior leaders in the Trust, safe in the knowledge that they cannot be identified. Reports on themes raised are reported to the People Committee.

Freedom to Speak up Guardian

The Trust Freedom to Speak up Guardian acts as an independent, impartial point of contact to support, signpost and advise staff who may wish to raise serious issues or concerns. This person can be contacted, in confidence, by telephone, email or in person.

To support this work, a network of Freedom to Speak up Champions, spread across the organisation and sites, has been developed. A new Guardian has recently been appointed and the time dedicated to the role has increased.

Staff engagement to raise awareness about the roles and how to make contact have been undertaken through 'drop in' meetings, using posters campaigns and using a range of communications platforms.

In addition, the Freedom to Speak up Guardian is expected to report bi-annually to the People Committee, a subcommittee of the Board, to provide assurance and ensure learning from cases.

Speak up – We Are Listening Policy (Voicing Concerns about Suspected Wrongdoing in the Workplace)

This policy provides employees who raise such concerns, assurance from the Trust that they will be supported to do so and will not face any detriment because of raising their concerns.

The Trust is working hard to improve our culture of safety and learning to protect patients and staff. We recognises that the ability to engage in this process and feel safe and confident to raise concerns, is key to rectifying or resolving issues and underpins a shared commitment to continuous improvement.

Union and Staff Representatives

The Trust recognises a number of trade unions and works collaboratively in partnership with their representatives to improve the working environment for all. Staff are able to engage with these representatives to obtain advice and support if they wish to raise a concern.

Staff Networks

The staff networks have been established for several years. They provide support for Black and Minority Ethnic staff, LGBTQ+ staff, and people with a disability or long-standing health issue.

Each network has a Chair and Vice Chair and has its own independent email account and staff can make contact this way, and/or attend a staff network meeting. The Staff Networks can either signpost staff to the best route for raising concerns, can raise a general concern on behalf of its members or can offer peer support to its members.

Cultural Ambassadors

Cultural Ambassadors, trained to identify and challenge cultural bias, were introduced into the Trust during 2020. These colleagues are an additional resource to support Black and Minority Ethnic colleagues who may be subjected to formal employment relations proceedings.

A summary of the Guardian of Safe Working Hours Annual Report

This consolidated annual report covers the period April 2023 – March 2024. The aim of the report is to highlight the vacancies in junior doctor rotas and steps taken to resolve these.

Gaps are present on several different rotas; this is due to both gaps in the regional training rotations, challenges recruiting suitable locally employed doctors and less than full time doctors in full time posts. The main areas of recurrent or residual concern for vacancies are Accident and Emergency and Anaesthetics and Critical Care. The Trust takes a proactive approach to minimise the impact of these by active recruitment; utilisation of locums; and by rewriting work schedules to ensure that key areas are covered. In some areas trainee shifts are being covered by consultants when junior doctor locums are unavailable.

In addition to the specific actions above, the Trust takes a proactive role in management of gaps through the work of the Junior Doctor Recruitment and Education Group. Members of this group include the Director of Medical Education, Finance Team representative and Medical Staffing personnel. In addition to recruitment into locally employed doctor posts, the Trust runs several successful trust-based training fellowships, a teaching fellow programme, and has supported temporary and permanent expansion of the Foundation Training Programme.

Learning from deaths

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added new mandatory disclosure requirements relating to 'Learning from Deaths' to Quality Accounts from 2017/18 onwards. The information included below is provided as a result of those regulations.

1. During 2023/24, 1982 of The Newcastle upon Tyne Hospitals NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 457 in the first quarter; 453 in the second quarter; 548 in the third quarter; 524 in the fourth quarter.

2. During 2023/24, 887 case record reviews and 54 investigations have been carried out in relation to 1982 of the deaths included in point 1 above. In 15 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 260 in the first quarter; 265 in the second quarter; 260 in the third quarter; 156 in the fourth quarter.

3. 33, representing 1.72% of the patient deaths during the reporting period where the investigation is complete and has been judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter,

this consisted of: 17, representing 0.86% deaths for the first quarter, 10, representing 0.50% for the second quarter and five representing 0.25% for the third quarter. (To date, not all incidents have been fully investigated). Once all investigations have been completed, any death found to have been due to problems in care will be summarised in 2024/25 Quality Account. All deaths will continue to be reported via the Integrated Quality Report). These numbers have been estimated using the HOGAN evaluation score as well as root cause analysis and infection prevention control investigation toolkits.

Summaries from completed cases judged to be more likely than not to have had problems in care which have contributed to patient death:

Summary	Key Lessons learned from review	Action	Impact/Outcome
14 Healthcare Acquired Infections - Covid-19.	Compliance with Covid screening, Personal Protective Equipment and hand hygiene is essential to reducing infections.	Infection, prevention & control team to continue to investigate all Healthcare Associated Infection. All staff to continue to comply with all Covid screening.	Infection prevention measures are shown to be robust in comparison to national peer organisations. National data demonstrates low Healthcare Associated Infection rate within organisation.
Trust guidance not followed in relation to febrile convulsion.	Ongoing continued education of all new medical and nursing staff at the time of induction.	Training for staff during the first two weeks of rotation into the clinical area.	Improved awareness of protocols within relevant areas.
Patient died post operatively due to aspiration pneumonia.	Requirement for improved planning prior to commencement of Transapical Transcatheter Aortic Valve Implantation procedure.	Introduction of a technical Multi-Disciplinary Team prior to procedure and updated patient consent form.	Strengthened processes throughout the completion of the Transapical Transcatheter Aortic Valve Implantation programme.
Unexpected death post-transplant.	Lack of awareness of retroperitoneal bleeding post renal transplant.	Renal Transplant Protocol and Renal Transplant Enhanced Recovery After Surgery Protocol re-written to include a specific section on Post-operative bleeding.	Written guidance and support for staff updated and additional guidance material produced.
Unexpected death due to medical device fault.	All patients with implanted Ventricular Assist Devices should not disconnect both power sources at the same time.	Updates and changes to HAVD equipment now undertaken with patients during an inpatient stay.	No further HVAD devices have been implanted in patients since April 2021.

Summary	Key Lessons learned from review	Action	Impact/Outcome
Unexpected death due to surgical complication.	Requirement to introduce alternative equipment to prevent risk of air-embolism.	Anti-air embolism lines have been trialled and are in place on all adult units for use.	There is a reduced risk to patients of air embolisms through the introduction of new equipment.
Sepsis related death.	Patients and families require additional support with temperature monitoring. Triage Tool reference document needs to be accessible to all staff dealing with out of hour's helpline calls.	Ambulatory Care Unit Safety Checklist amended to ensure patient/ carers are observed and able to monitor temperatures with a tympanic thermometer. Improved availability across the department of the triage tool.	Improved compliance to completion of triage tool through the introduction of regular audits.
Hospital Acquired Infection.	Policies for the management of complex MSSA bacteraemia to be reviewed.	Updated guidance for antimicrobial prescriptions.	The Trust infection prevention measures are shown to be robust in comparison to National peer organisations. National data demonstrates low HCAI rate within organisation.
Patient died due to inpatient fall.	Trends and themes in patient falls are monitored and learning is targeted to areas of high risk.	Ongoing work trust wide to reduce the rate of falls with harm.	The Harm Free Care Team have a strategic action plan to support falls reduction across the Trust.
Patient died due to aspiration of food.	Review of the induction and training for volunteer mealtime assistants.	Updated induction and training delivered to volunteers.	Reduced patient risk from volunteers due to increased compliance with training and induction of volunteers.
Patient died due to post-operative wound infection.	Processes to be implemented to enable patients a point of contact for concerns over their wound on discharge.	Process of escalation and in / out of hour's contacts put in place for patients on discharge.	Improved lines of communications for patients with concerns about their wounds on discharge.
Surgical complication causing hypoxic brain injury.	Extremely rare complication that may have been attributable to equipment used.	Equipment of concern reviewed, and the decision made to discontinue its use.	Equipment of concern withdrawn from use within the Trust.

4. 174 case record reviews and 40 investigations were completed after April 2023 which related to deaths which took place before the start of the reporting period.

5. 14, representing 0.71% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

6. 21, representing 1.6% of the patient deaths during 2022/23 are judged to be more likely than not to have been due to problems in the care provided to the patient.

The Trust will monitor and discuss mortality findings at the quarterly Mortality Surveillance Group and the Patient Safety Incident Forum (formerly the Serious Incident Panel) which will be monitored and reported to the trust Board and Quality Committee.

INFORMATION ON PARTICIPATION IN NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

During 2023/2024, 65 national clinical audits and two national confidential enquiry reports / review outcome programmes covered NHS services that the Newcastle hospitals provides.

During that period, we participated in 58 (89%) of the national clinical audits and 100% of the national confidential enquiries / review outcome programmes which it was eligible to participate in.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2023/2024 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
Adult Respiratory Support	British Thoracic Society	To capture data on patients outside critical care that have required respiratory monitoring or intervention.	✓	Data Collection February 2023 – May 2023	No publication date yet identified
British Association of Urological Surgeons Nephrostomy	British Association of Urological Surgeons	To collect data on the management and outcomes of patients undergoing primary insertion of nephrostomy for an infected, obstructed, kidney in the emergency setting and identify variation in the nephrostomy pathway and its effect on the patient outcome.	✓	Data collection February 2023 – February 2024	Published report expected June 2024
Breast and Cosmetic Implant Registry	NHS Digital	Captures the details of all breast implant procedures	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
		completed by both the NHS and private providers.			
British Hernia Society Registry	British Hernia Society	The registry will, permit large-scale, cost-effective embedded research, guide product development, track outcomes across a lifetime and, therefore improve patient safety.	The Trust did not participate in the programme.		
Case Mix Programme	Intensive Care National Audit & Research Centre	This audit looks at patient outcomes from adult, general critical care units in England, Wales and Northern Ireland.	The Trust did not participate in the programme.		
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	The audit aims to assess the quality of healthcare and stimulate improvement in safety and effectiveness.	✓	Cohort 1st April 2021 to 31st March 2022	Report awaiting baseline assessment
Cleft Registry and Audit Network Database	Royal College of Surgeons of England	The CRANE Database collects information about all children born with cleft lip and/or cleft palate in England, Wales and Northern Ireland.	✓	Continuous data collection	Report awaiting baseline assessment
Elective Surgery (National	NHS Digital	This audit looks at patient reported outcome	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
Patient Reported Outcome Measures (PROMs) Programme)		measures in NHS funded patients eligible for hip or knee replacement.			
Emergency Medicine Quality Improvement Project : Care of Older People	Royal College of Emergency Medicine	The purpose of this audit is to assess and improve the quality of care given to older and frail patients and to ensure that recommended interventions that can make a meaningful difference to mortality, morbidity and quality of life are implemented where feasible.	✓	Data collection October 2022 – October 2024	No publication date yet identified
Emergency Medicine Quality Improvement Project : Mental Health (Self-Harm)	Royal College of Emergency Medicine	The purpose of this QIP is to improve patient safety and quality of care as well as workspace safety by collecting sufficient data to track change but with a rigorous focus on actions to improve.	✓	Data collection October 2022 – October 2024	No publication date yet identified
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Royal College of Paediatrics and Child Health	The audit aims to address the care of children and young people with suspected epilepsy who receive a first	✓	Continuous data collection	Published report expected July 2024

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
		paediatric assessment within acute, community and tertiary paediatric services.			
Falls and Fragility Fracture Audit Programme: Fracture Liaison Service Database	Royal College of Physicians	Fracture Liaison Services are the key secondary prevention service model to identify and prevent primary and secondary hip fractures. The audit has developed the Fracture Liaison Service Database to benchmark services and drive quality improvement.	The Trust did not participate in this audit.		
Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls	Royal College of Physicians	The audit provides the first comprehensive data sets on the quality of falls prevention practice in acute hospitals.	✓	Continuous data collection	Report awaiting baseline assessment
Falls and Fragility Fracture Audit Programme: National Hip Fracture Database	Royal College of Physicians	The audit measures quality of care for hip fracture patients and has developed into a clinical governance and quality improvement platform.	✓	Continuous data collection	Published expected September 2024
Improving Quality in Crohn's and Colitis	Inflammatory Bowel Disease	The audit aims to improve the quality and safety of care	The Trust did not participate in this audit.		

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
	Registry	for Inflammatory Bowel Disease patients throughout the UK.			
Learning from live and deaths of people with a learning disability and autistic people	NHS England	The audit aims to improve the health of people with a learning disability and reduce health inequalities.	The Trust did not participate in this audit		
Maternal, Newborn and Infant Clinical Outcome Review Programme	University of Oxford / MBRRACE UK	The aim of the audit is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, new-born and infant health services.	✓	Continuous data collection	Trust not fully compliant. Action plan developed.
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	The audit aims to assess the quality of healthcare and stimulate improvement in safety and effectiveness.	✓	1st April 2023 to 31st March 2024	Report awaiting baseline assessment.
Mental Health Clinical Outcome Review Programme	The University of Manchester / National Confidential Inquiry into Suicide and Safety in Mental Health	The audit aims to Decrease suicide rates, particularly in people under mental health care and in patient subgroups.	The Trust does not provide this service.		
National Adult Diabetes Audit: Diabetes Footcare	NHS Digital	Patients referred to specialist diabetes foot care services for an expert assessment on	✓	Continuous data collection	Publication date yet to be identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
		a new diabetic foot ulcer.			
National Adult Diabetes Audit: Inpatient Safety Audit	NHS Digital	The National Diabetes Inpatient Audit is an annual snapshot audit of diabetes inpatient care in England and Wales and is open to participation from hospitals with medical and surgical wards. The audit allows hospitals to benchmark hospital diabetes care and to prioritise improvements in service provision that will make a real difference to patients' experiences and outcomes.	✓	Continuous data collection	Publication date yet to be identified
National Adult Diabetes Audit: Pregnancy in Diabetes Audit	NHS Digital	The audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant.	✓	Continuous data collection	Publication date yest to be identified
National Adult Diabetes Audit: Core Audit	NHS Digital	National Diabetes Audit collects information on people with diabetes and whether they have received their annual care checks and achieved their treatment	✓	Continuous data collection	Publication date yet to be identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
		targets as set out by NICE guidelines.			
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Chronic Obstructive Pulmonary Disease Secondary Care	Royal College of Physicians	The aim of the audit is to drive improvements in the quality of care and services provided for Chronic Obstructive Pulmonary Disease patients.	✓	Continuous data collection	Report awaiting baseline assessment
National Asthma and Chronic Obstructive Pulmonary Disease Chronic Obstructive Pulmonary Disease Audit Programme: Pulmonary Rehabilitation	Royal College of Physicians	This audit looks at the care people with Chronic Obstructive Pulmonary Disease get in pulmonary rehabilitation services.	✓	Continuous data collection	Report awaiting baseline assessment
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Adult Asthma Secondary Care	Royal College of Physicians	The audit looks at the care of people admitted to hospital adult services with asthma attacks.	✓	Continuous data collection	Report awaiting baseline assessment
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme: Children and Young People's Secondary Care	Royal College of Physicians	The audit looks at the care children and young people with asthma receive when they are admitted to hospital because of an asthma attack.	The Trust did not participate in this audit.		
National Audit of Cardiac Rehabilitation	University of York	The audit aims to support cardiovascular	The Trust did not participate in this audit.		

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
		prevention and rehabilitation services to achieve the best possible outcomes for patients with cardiovascular disease, irrespective of where they live.			
National Audit of Cardiovascular Disease Prevention in Primary Care	NHS Benchmarking Network	Analysis and reporting of the suit is designed to support systematic quality improvement using the findings from annual audit reports and the associated Data & Improvement Tool, to reduce health inequalities and improve outcomes for individuals and populations.	The Trust does not provide this service		
National Audit of Care at the End of Life	NHS Benchmarking Network	The National Audit of Care at the End of Life is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute	✓	Data collection 01/01/2024 to 31/12/2024	No publication date identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
		hospitals, community hospitals and mental health inpatient providers in England, Wales and Northern Ireland.			
National Audit of Dementia	Royal College of Psychiatrists	The National Audit of Dementia looks at quality of care received by people with dementia in general hospitals.	✓	Data collection September 2023 – March 2024	Published report expected July 2024.
National Audit of Pulmonary Hypertension	NHS Digital	The audit measures the quality of care provided to people referred to pulmonary hypertension services.	✓	Continuous data collection	Report awaiting baseline assessment.
National Bariatric Surgery Registry	British Obesity & Metabolic Surgery Society		The Trust does not provide this service		
National Cancer Audit Collaborating Centre: National Audit of Metastatic Breast Cancer	Royal College of Surgeons of England	Aims to report on all patients diagnosed with metastatic breast cancer (MBC; also known as secondary, advanced or stage 4 breast cancer) in NHS hospitals in England and Wales.	✓	Continuous data collection	No publication date yet identified
National Cancer Audit Collaborating centre: National Audit of Primary	Royal College of Surgeons of England	The NAoPri will report on all patients newly diagnosed with primary breast	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
Brest Cancer		cancer (stages 0 to 3) in NHS hospitals in England and Wales.			
National Cardiac Arrest Audit	Intensive Care National Audit & Research Centre	Intensive Care National Audit and Research Centre / Resuscitation Council UK.	✓	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme: Adult Cardiac Surgery	National Institute for Cardio-vascular Outcomes Research	This audit looks at heart operations. Details of who undertakes the operations, the general health of the patients, the nature and outcome of the operation, particularly mortality rates in relation to preoperative risk and major complications.	✓	Continuous data collection	Published report expected April 2026
National Cardiac Audit Programme: Congenital Heart Disease	National Institute for Cardio-vascular Outcomes Research	The congenital heart disease website profiles every congenital heart disease centre in the UK, including the number and range of procedures they carry out and survival rates for the most common types of treatment.	✓	Continuous data collection	Published report expected April 2024
National Cardiac Audit Programme: Heart Failure	National Institute for Cardio-vascular Outcomes Research	The aim of this project is to improve the quality of care for patients with heart failure through continual audit and to support	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
		the implementation of the national service framework for coronary heart disease.			
National Cardiac Audit Programme: Cardiac Rhythm Management	National Institute for Cardio-vascular Outcomes Research	The audit aims to monitor the use of implantable devices and interventional procedures for management of cardiac rhythm disorders in UK hospitals.	✓	Continuous data collection	No publication yet identified
National Cardiac Audit Programme: Myocardial Ischaemia	National Institute for Cardio-vascular Outcomes Research	The Myocardial Ischaemia National Audit Project was established in 1999 in response to the National Service Framework for Coronary Heart Disease, to examine the quality of management of heart attacks (Myocardial Infarction) in hospitals in England and Wales.	✓	Continuous data collection	No publication yet identified
National Cardiac Audit Programme: Percutaneous Coronary Intervention	National Institute for Cardio-vascular Outcomes Research	The audit collects and analyses data on the nature and outcome of Percutaneous Coronary Intervention procedures, who performs	✓	Continuous data collection	No publication yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
		them and the general health of patients. The audit utilises the Central Cardiac Audit Database, which has developed secure data collection, analysis and monitoring tools and provides a common infrastructure for all the coronary heart disease audits.			
National Cardiac Audit Programme: Mitral Valve Leaflet Repairs	National Institute for Cardio-vascular Outcomes Research	The aim of the audit is to collect clinical and outcome data on structural heart intervention services carried out in the UK.	✓	Continuous data collection	publication yet identified
National Cardiac Audit Programme: UK Transcatheter Aortic Valve Implantation Registry	National Institute for Cardio-vascular Outcomes Research	The project aims to capture detailed information on how TAVI is used to treat patients with severe aortic stenosis and significant comorbidities; improving the care of patients and benchmarking TAVI units to learn best practice.	✓	Continuous data collection	Published report expected January 2025
National Child Mortality Database	University of Bristol	The National Child Mortality Database	✓	Continuous data collection	No publication date yet

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
		collates information nationally to ensure that deaths are learned from, that learning is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die.			identified.
National Clinical Audit of Psychosis	Royal College of Psychiatrists		The Trust does not provide this service		
National Comparative Audit of Blood Transfusion: 2023 Audit of Blood Transfusion against National Institute for Health and Care Excellence Quality Standard 138	NHS Blood and Transplant	The National Comparative Audit of Blood Transfusion is a programme of clinical audits which looks at the use and administration of blood and blood components in NHS and independent hospitals in England.	✓	Data 1st January 2023 to 31st March 2023	Report awaiting baseline assessment
National Comparative audit of Blood Transfusion: 2023 Bedside Transfusions	NHS Blood and Transplant	The National Comparative Audit of Blood Transfusion is a programme of clinical audits which looks at the use and administration of blood and blood components in NHS and independent hospitals in England.	✓	1st March 2024 to 31st April 2024	No publication date yet identified.

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
National Early Inflammatory Arthritis Audit	British Society for Rheum-atology	The audit aims to improve the quality of care for people living with inflammatory arthritis.	✓	Continuous data collection	Published report expected October 2024
National Emergency Laparotomy Audit	Royal College of Anaesthetists	National Emergency Laparotomy Audit aims to look at structure, process, and outcome measures for the quality of care received by patients undergoing emergency laparotomy.	✓	Continuous data collection	No publication date yet identified
National Gastro-Intestinal Cancer Audit Programme: Bowel Cancer Audit	Royal College of Surgeons of England	The National Bowel Cancer Audit collects data on items that have been identified and accepted as good measures of clinical care. It compares regional variation in outcomes between English cancer alliances and Wales as a nation. It also compares local variation between English NHS trusts or hospitals, and Welsh MDTs.	✓	Continuous data collection	No publication date yet identified
National Gastro-Intestinal Cancer Audit Programme: Oesophago-	Royal College of Surgeons of England	The audit aims to evaluate the quality of care received by patients with oesophago-	✓	Continuous data collection	Data has been paused nationally

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
Gastric Cancer Audit		gastric cancer in England and Wales.			
National Joint Registry	Healthcare Quality Improvement Partnership	The audit covers clinical audit during the previous calendar year and outcomes including survivorship, mortality, and length of stay.	✓	Continuous data collection	Published report expected September 2024
National Lung Cancer Audit	Royal College of Surgeons of England)	The audit was set up to monitor the introduction and effectiveness of cancer services.	✓	Continuous data collection	No publication date yet identified
National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynae-cologists	A large-scale audit of NHS maternity services across England, Scotland and Wales, collecting data on all registrable births delivered under NHS care.	✓	Continuous data collection	No publication date yet identified
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health	To assess whether babies requiring specialist neonatal care receive consistent high-quality care and identify areas for improvement in relation to service delivery and the outcomes of care.	✓	Continuous data collection	Published report expected October 2024

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
National Obesity Audit	NHS Digital	It will bring together comparable data from the different types of adult and children's weight management services across England in order to drive improvement for the benefit of those living with overweight and obesity.	✓	Continuous data collection	Report awaiting baseline assessment
National Ophthalmology Database Audit: Cataract Audit	Royal College of Ophthalmol-ogists	The Royal College of Ophthalmol-ogists runs the National Ophthalmology Database Cataract audit which measures the outcomes of Cataract surgery.	✓	Continuous data collection	Published report expected June 2025
National Paediatric Diabetes Audit	Royal College of Surgeons of England	The audit covers registrations, complications, care process and treatment targets.	✓	Continuous data collection	Published report expected April 2024 and January 2025
National Prostate Cancer Audit	Royal College of Surgeons of England	The National Prostate Cancer Audit is the first national clinical audit of the care that men receive following a diagnosis of prostate cancer.	✓	Continuous data collection	Published report expected August 2024
National Vascular Registry	Royal College of Surgeons of	The National Vascular Registry	✓	Continuous data collection	Trust not fully compliant. Action plan

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
	England	collects data on all patients undergoing major vascular surgery in NHS hospitals in the UK.			developed
Out-of-Hospital Cardiac Arrest Outcomes	University of Warwick		The Trust does not provide this service		
Paediatric Intensive Care Audit Network	University of Leeds / University of Leicester	Paediatric Intensive Care Audit Network aims to continually support the improvement of paediatric intensive care provision throughout the UK by providing detailed information on paediatric intensive care activity and outcomes.	✓	Continuous data collection	No publication date yet identified
Perinatal Mortality Review Tool	University of Oxford / Mothers and Babies :Reducing Risk through Audits and Confidential Enquiries UK Collaborative	The aim of this programme is introduce the Perinatal Mortality Review Tool to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland, and Wales.	✓	Continuous data collection	No publication date yet identified
Perioperative Quality Improvement Programme	Royal College of Anaesthetists	The Perioperative Quality Improvement Programme	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
		measures complications, mortality and patient reported outcomes from major non-cardiac surgery.			
Prescribing Observatory for Mental Health: Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	Royal College of Psychiatrists		The Trust does not provide this service		
Prescribing Observatory for Mental Health: Monitoring of patients prescribed lithium	Royal College of Psychiatrists		The Trust does not provide this service		
Sentinel Stroke National Audit Programme	King's College London	The audit collects data on all patients with a primary diagnosis of stroke, including any patients not on a stroke ward. Each incidence of new stroke is collected.	✓	Continuous data collection	Published report expected November 2024
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Serious Hazards of Transfusion	The scheme collects and analyses anonymised information on adverse events and reactions in blood transfusion from all	✓	Continuous data collection	Published report expected June 2024

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
		healthcare organisations that are involved in the transfusion of blood and blood components in the United Kingdom.			
Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine	This is a national benchmark audit of acute medical care. The aim is to describe the severity of illness of acute medical patients presenting to Acute Medicine, the speed of their assessment, their pathway and progress at seven days after admission and to provide a comparison for each participating unit with the national average.	✓	1st June 2023 to 30th June 2023	Trust is compliant with report
The Trauma Audit & Research Network	Trauma Audit & Research Network	The audit aims to highlight areas where improvements could be made in either the prevention of injury or the process of care for injured patients.	✓	Continuous data collection	Published report expected September 2024
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	This audit looks at the care of people with a	✓	Continuous data collection	Published report expected September

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2023/2024	Percentage Data completion	Outcome
		diagnosis of cystic fibrosis under the care of the NHS in the UK.			2024
UK Renal Registry Chronic Kidney Disease Audit	UK Kidney Association	The UK Renal Registry (UKRR) annual reports contain analyses about the care provided to patients with Chronic Kidney Disease (CKD) (including people pre-Kidney Replacement Therapy (KRT) and on KRT) at each of the UK's adult and paediatric kidney centres against the UK Kidney Association's guidelines.	✓	Continuous data collection	No publication date yet identified
UK Renal Registry National Acute Kidney Injury Audit	UK Kidney Association	The UKRR annual reports contain analyses about the care provided to patients with CKD (including people pre-KRT and on KRT) at each of the UK's adult and paediatric kidney centres against the UK Kidney Association's guidelines.	✓	Continuous data collection	No publication date yet identified

An additional twenty-four new audits have been added to the list for inclusion in 2024/2025 Quality Account. The audits include:

- British Association of Urological Surgeons Data and Audit Programme – Baus Penile Fracture Audit, BAUS I-DUNC (Impact of diagnostic ureteroscopy on radical nephroureterectomy and compliance with standard of care practice and environmental lessons Learnt and Applied to the Bladder Cancer Care pathway Audit
- Emergency Medicine Quality Improvement Project – Adolescent Mental Health and Time Critical Medications
- National Adult Diabetes Audit – Diabetes Prevention Programme, Transition (Adolescents and Young Adults) and Young Type 2 Audit and Gestational Diabetes Audit
- National Cancer Audit Collaborating Centre – National Kidney Cancer Audit, National Non-Hodgkin Lymphoma Audit, National Ovarian Cancer Audit, Pancreatic Cancer
- National Cardiac Audit Programme – Left Atrial Appendage Occlusion Registry, Patent Foramen Ovale Closure Registry, Transcatheter Mitral and Tricuspid Valve Registry
- National Major Trauma Registry
- National Ophthalmology Database – Age-Related Macular Degeneration Audit
- Prescribing Observatory for Mental Health – Rapid Tranquilisation in the context of the pharmacological management of acutely disturbed behaviour, The use of melatonin and The Use of Opioids in Mental Health Services
- Quality and Outcomes in Oral and Maxillofacial Surgery - Oncology and Reconstruction, Trauma, Orthognathic Surgery, Non-Melanoma Skin cancers, Oral and Dentoalveolar Surgery.

Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- The Trust has firmly embedded monitoring arrangements for national clinical audits with the identified lead clinician asked to complete an action plan and present this to the Clinical Audit and Guidelines Group.
- Each national clinical audit report is reviewed by an identified lead clinician who completes a baseline assessment indicating areas of good practice and recommendations related to the trust's performance in the respective audit.
- The Clinical Governance and Risk Department will provide the Clinical Boards with monthly profiles of outstanding baseline assessments and non-compliant report recommendations. The profiles will be reviewed at the monthly Clinical Board Quality Oversight Group meetings and any issues of significant non-compliance will be escalated to the Clinical Audit and Guidelines Group.
- In addition, each Clinical Board is required to present an Annual Clinical Audit Report to the Clinical Audit and Guidelines Group detailing all audit activity undertaken both national and local. Clinicians are required to report all audit activity using the Trust's Clinical Effectiveness Register.

- Compliance with National Confidential Enquiries is reported to the Clinical Outcomes and Effectiveness Group and exceptions subject to detailed scrutiny and monitored accordingly.
- Non-compliance with recommendations from National Clinical Audit and National Confidential Enquiries are considered in the Annual Business Planning process.

The reports of 414 local audits were reviewed by the provider in 2023/2024 and the Newcastle Hospitals intends to take the following action to improve the quality of health care provided:

- Each Clinical Board is required to present an Annual Clinical Audit Report to the Clinical Audit and Guidelines Group detailing all audit activity undertaken both national and local.
- Any areas of non-compliance with standards are risk assessed and escalated as appropriate to the Clinical Outcomes and Effectiveness Group.

INFORMATION ON PARTICIPATION IN CLINICAL RESEARCH

In the last year over 14,131 participants were recruited to clinical trials provided or hosted by Newcastle Hospitals, of which 13,315 enrolled onto the National Institute for Health and Care Research Clinical Research Network portfolio studies.

A wide range of clinical trials take place, ranging from complex and rare disease to common conditions that affect many of our patients. One such trial is the ADVANCE liver study, which aims to better understand how cirrhosis develops over time with a view to finding treatments for patients with the condition.

The Trust continues to be one of the top research trusts in the country for the number of individuals participating in research and for the number of studies open.

INFORMATION ON THE USE OF THE COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) FRAMEWORK

A proportion of the Trusts income in 2023/2024 was conditional upon achieving Quality Innovation and innovation goals agreed between Newcastle Hospitals and any person or body they entered a contract, agreement, or arrangement with for the provision of relevant health services, through Commissioning for Quality and Innovation payment framework. The monetary value totals from achievement of the specialised Commissioning for Quality and Innovation was £5.132m however achievement of the local Commissioning for Quality and Innovation (acute and community) was not explicit in the contract and was therefore estimated at 1.25% of total contract value.

Information on the use of the CQUIN framework

CQUIN Indicators - Acute Hospital – (CCG/Integrated Care Board)	CQUIN Indicators - Community – (CCG/Integrated Care Board)
CQUIN01: Flu vaccinations for frontline healthcare workers CQUIN04: Compliance with timed diagnostic pathways for cancer services CQUIN05: Identification and response to frailty in emergency departments CQUIN06: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service CQUIN07: Recording of and response to National Early Warning Score 2 score for unplanned critical care admissions	CQUIN01: Flu vaccinations for frontline healthcare workers. CQUIN13: Assessment, diagnosis, and treatment of lower leg wounds.

CQUIN Indicators - Specialised Commissioning
CQUIN01: Flu vaccinations for frontline healthcare workers CQUIN08: Achievement of revascularisation standards for lower limb ischaemia CQUIN09: Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres CQUIN10: Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway CQUIN11: Achieving high quality Shared Decision Making conversations in specific specialised pathways to support recovery

Further details of the agreed goals for 2023/2024 and for the following 12-month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin.

INFORMATION RELATING TO REGISTRATION WITH THE CARE QUALITY COMMISSION

Newcastle Hospitals is required to register with the Care Quality Commission and its current registration status is fully registered. Newcastle Hospitals currently has conditions imposed on its registration.

We are registered with the Care Quality Commission to deliver care from eight separate locations and for ten regulated activities.

During 2023/2024 the Care Quality Commission visited the Trust on a number of dates between June and September 2023. They looked at how the organisation was led and assessed some services at the Royal Victoria Infirmary and Freeman Hospital, which included urgent and emergency care, medicine, surgery, maternity, children and young people, as well as NECTAR, the regional patient transport service. They also spent some time in the cardiothoracic surgery department.

The inspectors found that overall Newcastle Hospitals' 'requires improvement'. They also highlighted areas for improvement with the way some services are run and that changes are required to ensure that learning always takes place when things don't go as planned.

The Care Quality Commission also highlighted some positive findings from their inspection, including staff who treated 'patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers'.

In response to the inspection findings the Trust has acted quickly to implement a rapid and focused programme of improvement to address the report recommendations which will continue until the issues raised have been addressed. This includes regular meetings with the CQC to demonstrate progress.

The Care Quality Commission did not inspect critical care, diagnostic and imaging, outpatients, end of life or community services during 2023/2024.

INFORMATION ON THE QUALITY OF DATA

The Newcastle upon Tyne Hospitals NHS Foundation Trust submitted records during 2023/2024 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Which included the patient's valid NHS number was:

- 99.7% for admitted patient care.
- 99.9% for outpatient care.
- 99.0% for accident and emergency care.

Which included the patients valid General Medical Practice Code was:

- 100% for admitted patient care.
- 100% for outpatient care.
- 100% for accident and emergency care.

Clinical Coding Information

Score for 2023/2024 for Information Quality and Records Management, assessed using the Data Security and Protection Toolkit.

Our annual Data Security and Protection Clinical Coding audit for diagnosis and treatment coding of inpatient activity demonstrated an excellent level of attainment and satisfies the requirements of the Data Security and Protection Toolkit Assessment.

200 episodes of care were audited, covering the following three specialties:

- Breast Surgery
- Colorectal Surgery
- Plastic Surgery

The level attained for Data Security Standard 1 Data Quality – Standards Exceeded.
The level attained for Data Security Standard 3 Training – Standard Exceeded.

Table shows the levels of attainment of coding of inpatient activity:

	Levels of Attainment		
	Standards Met	Standards Exceeded	Trust Level
Primary diagnosis	>=90%	>=95%	97.5%
Secondary diagnosis	>=80%	>=90%	96.2%
Primary procedure	>=90%	>=95%	96.3%
Secondary procedure	>=80%	>=90%	93.8%

Comments from the external Data Security and Protection audit:

Clinical coding accuracy overall was found to be at standards that exceeded level for all areas, the Trust should be commended on this excellent result. This is the most advanced level that can be achieved.

Compelling evidence suggests the local validation strategy has a positive impact on the data quality. The results are comparative to the previous year's outcomes. Effective management and support of motivated staff is a significant factor in this. The Team Leader's set a positive example through their actions, fostering constructive collaboration to achieve this accomplishment.

There is a well-established training unit that instils confidence for coders to develop to accredited levels, the Clinical Coders are up to date with their required training and demonstrate a sound grasp of national clinical coding rules and standards.

KEY NATIONAL PRIORITIES 2023/2024

The key national priorities are performance targets for the NHS, which are determined by the Department of Health and Social Care and form part of the Care Quality Commission Intelligent Monitoring Report. A wide range of measures are included and the Trust's performance against the key national priorities for 2023/24 are detailed in the table below.

Operating and Compliance Framework Target	Target	Annual Performance 2023/2024	Annual Performance 2022/2023
Incidence of Clostridium (*C .difficile:* variance from plan)	National Threshold ≤165	144 cases	172 cases
Incidence of Methicillin Resistant Staphylococcus Aureus Bacteraemia	Zero tolerance	4 cases	2 cases
28 Day Faster Diagnosis Standard - Wait from Urgent Referral to Patient Told they have Cancer (or Cancer is Definitively Excluded)	75%	75.1% (Apr-Jan)	75.2%
31 Day (Decision to Treat to Treatment) - Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	96%	85.9% (Apr-Jan)	87.7%
62 Day (Referral to Treatment) - Wait from an Urgent Suspected Cancer or Breast Symptomatic Referral, or Urgent Screening Referral, or Consultant Upgrade to a First Definitive Treatment for Cancer	85%	55.5%(Apr-Jan)	53.4%
Referral to Treatment - Admitted Compliance	90%	65.9%	61.3%
Referral to Treatment - Non-Admitted Compliance	95%	76.7%	77.6%
Referral to Treatment - Incomplete Compliance	92%	67.1%	69.2%
Maximum 6-week wait for diagnostic procedures	95%	71.2%	80.7%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	76%	75.65%	77.72% (target in 2022/2023 95%)
Cancelled operations – those not admitted within 28 days	Operations not arranged within 28 days of the day cancelled.	561	555
Maternity bookings within 12 weeks and 6 days	Not Defined	86%	86.5%

Details on Hospital-level Mortality Indicator please refer to page 71.

Rationale for any failed targets
Infection Prevention and Control:
Increase in the number of Methicillin-resistant *Staphylococcus aureus* bacteraemia cases – there are a number of reasons for this:

- A national increase in the number of hospital acquired Methicillin-resistant *Staphylococcus aureus* bacteraemia in 2023/24; this is being reviewed nationally.
- Themes from cases included intravenous drug use for immunocompromised patients; poor compliance with trust screening; community transmission of Methicillin-resistant *Staphylococcus aureus*; patient's non-compliance with skin washes; complex patients; difficult intravascular access.

Mitigations to address:

- Initiative on patient focused hygiene to prevent infection, includes washing patients, oral health, urinary catheter care and IV device management.
- Methicillin-resistant *Staphylococcus aureus* screening compliance audit undertaken and finalised result will be shared through various forums.
- Relaunch of Aseptic Non-Touch Technique, now part of mandatory training.

Cancer Wait times:
Please note that there has been a change in the national cancer standards this year, with the previous nine being consolidated into three overall standards. These are what we are now required to report against nationally and as such we have provided compliance levels for these new targets. The 2022/2023 position is taken from NHSE statistics as a retrospective production of what our compliance would have been against these standards had they been in place for 2022/2023.

Please also note that we only have 10 months of official performance data available to us for 2023/2024 against these standards (April-January). As such final year compliance levels are subject to change but will not be formally finalised until later in the year.

Underlying issues preventing the trust from achieving the 31 and 62 day cancer standards this year have included limited theatre capacity with additional provision not keeping pace with increases in demand, as well as some capacity throughout the year being lost due to estate updates and refurbishments. A significant shortfall in capacity for the provision of Radiofrequency ablation also exists with this treatment method becoming an increasingly popular option.

Theatre Capacity Mitigation:

- Implementation of 6:4:2 theatre scheduling (A model of theatre scheduling, named after the number of weeks in advance that plans should be finalised. E.g. at six weeks, surgical staff should have their annual leave approved. At four weeks, surgeons should have scheduled their theatre lists etc. The 6-4-2 model supports theatre teams to work more effectively together; to improve the quality of patient experience, the safety and outcomes of surgical services, the effective use of theatre time and overall staff experience).
- Continued role out of Care Coordination Solution to ensure theatre efficiency.
- Development of robust escalation plans by Clinical Board e.g. development of weekly theatre prioritisation meetings.
- Continued use of the independent sector for routine patients, freeing up capacity on site for cancer patients.
- Engagement in mutual aid processes.

- Various service improvement initiatives e.g. redesign of regional pathways to ensure the patients are seen in the most appropriate place e.g. Urology Alliance work.
- Maximisation of Day Treatment Centre utilisation.

Radiofrequency ablation Mitigation:

- Use of Community Diagnostic Centres to free up Computed Tomography capacity.
- Flagged the need for an additional Interventional Computed Tomography to the Executive team.
- There is a plan to do more procedures under General Anaesthetic as this will reduce the number of re-do procedures and improve patient experience.
- Re-prioritisation of capacity to dedicate more time to ablation procedures, they aim to use other resources as far as possible but anticipate some impact on routine scanning times to accommodate the ablation treatments.

Other contributing factors include the ongoing late receipt of a substantial number of tertiary referrals, as well as significant workforce gaps at times across numerous different tumour groups. Delays to the diagnostic element of the patient pathway have also contributed to lower levels of performance.

Late referrals mitigation:

- Working with the Northern Cancer Alliance through the pathway boards to monitor and reduce late referrals.
- Streamlining existing pathways to ensure that treatment can occur within 24 days of referral reducing the number of shared breaches we receive.
- Working towards implementation of the Best Practice Timed Pathways internally and across the region.

Workforce gaps mitigation:

- Looking at skill mix reviews e.g. the use of Advanced Clinical Practitioners and Physician Associates to implement the premenstrual bleed pathway in Gynaecology instead of consultants.
- The Trust has supported investment in teams where demand has outstripped capacity e.g. Dermatology business case approved in 2023 and once staff are fully trained this will increase capacity within the team.
- Reviewing induction and competency packages of staff (Multidisciplinary Team Co-ordinators, Care Co-ordinators, Navigators, Clinical Nurse Specialists) to ensure increase recruitment and retention rates.

Our skin cancer service has experienced unprecedented demand throughout 2023/2024, both in terms of peaks in the volume of referrals and the extent to which this has continued throughout the year – a summer peak is always anticipated, but above average demand continued much later into the year than usual. As the tumour group that already receives more referrals, and delivers more treatments, than any other across Newcastle Hospitals, any impact on performance within Skin will disproportionately affect the overall Trust position relative to other tumour groups.

Dermatology Mitigation:

- Implementation of tele dermatology – working with the Northern Cancer Alliance to complete a review of the tele dermatology pathway and implement best practice.

- Exploring the use of Artificial Intelligence in the pathway.
- Increased capacity through the Dermatology business case approved in 2023.
- Additional capacity through surgical lists with Plastics.
- Reducing inappropriate referrals through General Practitioner education.
- Work underway to reduce new to review ratio in line with peers.
- Implementation of Patient Initiated Follow-Up throughout the specialty increasing clinical buy in to create additional capacity.
- Maintaining cancer competency in those that don't routinely work in cancer by holding a monthly joint clinic – this will increase the number of staff that are able to cover capacity demand.

Referral to Treatment Targets:
Over the last year, the overall Referral to Treatment Targets performance has remained circa 67%. There has been an unrelenting focus on treating the longest waiters and a significant achievement for the Trust has been to treat all patients over 104 weeks wait by January 2024. This position has been maintained, whilst addressing 78 and 65 week waiters. Patients on the waiting list continue to be prioritised by clinical need and longest waits.

The overall size of Referral to Treatment Targets waiting list increased over the year to circa 108,000 and this position has now been reduced back down to 99066 patient waiting for first treatment in February 2024.

There remains a focus on achieving a sustainable solution to treat patients in a timely manner with pathway redesign and aligning demand and capacity as a result will improve performance. The performance details of long waiters are discussed and reported at Board level.

Additional pressures continue to affect the scheduling of patient care such as industrial action. Throughout this time, cancer and high clinical priority patients remained the priority to be treated.

CORE SET OF QUALITY INDICATORS

Data is compared nationally when available from the NHS Digital Indicator portal. Where national data is not available the Trust has reviewed our own internal data.

Measure	Data Source	Target	Value	2023/24		2022/2023				2021/2022			
1. The value and banding of the summary hospital-level mortality indicator for the Trust	NHS Digital Indicator Portal https://digital.nhs.uk/data-and-information/publications/statistical/shmi	Band 2 as expected		Oct22 – Sept 23 **NUTH Value:** 0.9095 **NUTH Band 2**	Jul22 - Jun 23 **NUTH Value:** 1.0095 **NUTH Band 2**	Apr22 - Mar 23 **NUTH Value:** 0.9170 **NUTH Band 2**	Jan21 - Dec 21 **NUTH Value:** 0.9167 **NUTH Band 2**	Oct21 – Sept 22 **NUTH Value:** 0.9105 **NUTH Band 2**	Jul21 - Jun 22 **NUTH Value:** 0.9148 **NUTH Band 2**	Apr21 - Mar 22 **NUTH Value:** 0.9180 **NUTH Band 2**	Jan21 - Dec 21 **NUTH Value:** 0.9804 **NUTH Band 2**	Oct20 – Sept 21 **NUTH Value:** 0.9606 **NUTH Band 2**	Jul20 - Jun 21 **NUTH Value:** 0.9369 **NUTH Band 2**
			National Average	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
			Highest National	1.2293	1.2129	1.2074	1.2186	1.2340	1.2112	1.1942	1.1897	1.1909	1.2017
			Lowest National	0.6770	0.7097	0.7191	0.7117	0.6454	0.7047	0.6964	0.7127	0.7132	0.7195
2. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust	NHS Digital Indicator Portal https://digital.nhs.uk/data-and-information/publications/statistical/shmi	N/A	Trust	41%	29%	39%	40%	41%	41%	42%	42%	44%	44%
			National Average	42%	41%	40%	40%	40%	40%	40%	39%	39%	39%
			Highest National	66%	66%	66%	65%	65%	65%	66%	64%	63%	64%
			Lowest National	15%	14%	14%	12%	12%	12%	11%	11%	12%	11%

Measure 1. The value and banding of the summary hospital-level mortality indicator for the Trust.

The Newcastle Hospitals considers that this data is as described for the following reasons:
The trust continues to perform well on mortality indicators. Mortality reports are regularly presented to the Trust Board. The Newcastle Hospitals has taken the following actions to improve this indicator, and so the quality of its services by closely monitoring mortality rates and conducting detailed investigations when rates increase. We continue to monitor and discuss mortality findings at the Quarterly Mortality Surveillance Group; representatives attend this group from multiple specialities and scrutinise Trust mortality data to ensure local learning and quality improvement. This group complements the departmental mortality and morbidity meetings within each speciality of all clinical boards.

Measure 2. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust.

The Newcastle Hospitals considers that this data is as described for the following reasons:
The use of palliative care codes in the trust has remained static and aligned to the national average percentage over recent years. The Newcastle Hospitals continues to monitor the quality of its services, by involving the Coding team and End of Life team in routine mortality reviews to ensure accuracy and consistency of palliative care coding. We continue to monitor and discuss patients with a palliative care coding at the quarterly Mortality Surveillance Group.

Measure	Value	2021/22	2020/21	2019/20	2018/19	2017/18	2016/17
5. The patient reported outcome measures scores (PROMS) for primary hip replacement surgery (adjusted average health gain – EQ5D)	Trust Score	**0.46**	**0.52**	**0.46**	**0.50**	**0.48**	**0.44**
	National average:	0.46	0.47	0.46	0.47	0.47	0.45
	Highest national:	0.53	0.57	0.54	0.56	0.54	0.54
	Lowest national:	0.37	0.39	0.35	0.35	0.39	0.31
6. The patient reported outcome measures scores (PROMS) for primary knee replacement surgery (adjusted average health gain – EQ5D)	Trust Score	*	**0.35**	**0.36**	**0.31**	**0.33**	**0.33**
	National average:	0.32	0.32	0.34	0.34	0.34	0.33
	Highest national:	0.42	0.40	0.42	0.41	0.42	0.40
	Lowest national:	0.25	0.18	0.22	0.28	0.25	0.25

Please note that finalised Patient Reported Outcome Measures scores data is only available for 2021/2022. The North East Quality Observatory Service have reviewed the provisional data for 2022/2023 but data quality issues mean that this cannot currently be used to give a comparison between us and the national average. The North East Quality Observatory Service are in contact with NHS Digital to try to get an update on when the next Patient Reported Outcome Measures scores publication will be.

Measure 3. The Patient Reported Outcome Measures scores for groin hernia surgery.

Collection of groin procedure scores ceased on 1 October 2017.

Measure 4. The Patient Reported Outcome Measures scores for varicose vein surgery.

Collection of varicose vein procedure scores ceased on 1 October 2017.

Measure 5. The Patient Reported Outcome Measures scores for hip replacement surgery.

The Newcastle Hospitals considers that this data is as described for the following reasons:
The Newcastle Hospitals Patient Reported Outcome Measures scores outcomes are good, and we are committed to increasing our participation rates going forward. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty multidisciplinary team.
Data for 2021/2022 has not yet been populated, but no other data is currently available. The North East Quality Observatory Service are in touch with the team at NHS England who work on the data but currently know the timetable for producing the final 2022/23 data – the provisional version of this has major issues with the data quality.

Measure 6. The Patient Reported Outcome Measures scores for knee replacement surgery.

The Newcastle Hospitals considers that this data is as described for the following reasons:

The Newcastle Hospitals Patient Reported Outcome Measures scores outcomes are good, and we are committed to increasing our participation rates going forward. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty multidisciplinary team.

Data for 2021/2022 has not yet been populated, but no other data is currently available. The North East Quality Observatory Service are in touch with the team at NHS England who work on this data but currently know the timetable for producing the final 2022/23 data – the provisional version of this has major issues with the data quality.

7a. Emergency readmissions to hospital within 28 days of discharge from hospital: Children of ages 0-15.

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
2012/2013	31,841	2,454	7.7
2013/2014	32,242	2,648	8.2
2014/2015	34,561	3,570	10.3
2015/2016	38,769	2,875	7.4
2016/2017	35,259	1,983	5.6
2017/2018	35,009	2,077	5.9
2018/2019	36,387	2,003	5.5
2019/2020	42,238	4,609	10.9
2020/2021	29,319	2,643	9.0
2021/2022	34,112	3,080	9.0
2022/2023	33,945	2,859	8.4
2023/2024	33,865	2,637	7.8

7b. Emergency readmissions to hospital within 28 days of being discharged aged 16+.

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
2012/2013	173,270	8,788	5.1
2013/2014	177,867	9,052	5.1
2014/2015	180,380	9,446	5.2
2015/2016	182,668	10,076	5.5
2016/2017	186,999	10,219	5.5
2017/2018	182,535	10,157	5.6
2018/2019	185,967	10,461	5.6
2019/2020	192,365	12,648	6.6
2020/2021	142,629	10,730	7.5
2021/2022	185,434	12,104	6.5
2022/2023	193,003	13,575	7.0
2023/2024	203,143	15,065	7.4

Measure 7. The percentage of patients aged— (i) 0 to 15; and (ii) 16 or over readmitted within 28 days of being discharged from hospital.

This indicator was last updated in December 2013 and future releases have been suspended pending a methodology review. Therefore, the trust has reviewed its own internal data and used its own methodology of reporting readmissions within 28 days (without Payment by Results exclusions). The Newcastle Hospitals considers that this data is as described for the following reasons: The trust has a robust reporting system in place and adopts a systematic approach to data quality improvement.

The Newcastle Hospitals intends to take the following actions to improve this indicator, and so the quality of its services, by continuing with the use of an electronic system.

Measure	Data Source	Value	2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
8. The Trust's responsiveness to the personal needs of its patients	NHS Information Centre Portal https://indicators.ic.nhs.uk/	Trust percentage	Ceased Publication August 2020	Ceased Publication August 2020	77.7%	72.6%	73.1%	74.9%
		National Average:			74.5%	67.1%	67.2%	68.6%
		Highest National:			85.4%	84.2%	85.0%	85.0%
		Lowest National:			67.3%	59.5%	58.9%	60.5%

Measure 8. The Trust's responsiveness to the personal needs of its patients.

This data used in the table above ceased to be published in August 2020.To assign a score to indicate the patient experience, the table below uses the Care Quality Commission benchmark data from the National Adult Inpatient Survey. The data shows that the Trust scores above the national average in this indicator. The results of the Inpatient 2023 survey are due to be published in August 2024.

Measure	Data Source	Value (out of 10)	2022 (Published Sept 2023)	2021 (Published August 2022)
8. Overall rating of experience	CQC Benchmark results for National Adult Inpatient Survey Adult inpatient survey 2022 - Care Quality Commission (cqc.org.uk)	Trust score	8.4	8.6
		National Average score:	8.1	8.1
		Highest National:	9.3	9.4
		Lowest National:	7.4	7.4

Measure	Data Source	Value	2023/24	2022/23	2021/22	2020/21	2019/20	2018/19
9. The percentage of staff employed by, or under contract to, the trust who would recommend the trust as a provider of care to their family or friends	http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/Results/	Trust percentage	77.4%	82.6%	85.4%	91.3%	90%	90%
		National Average	63.3%	61.9%	66.9%	74.3%	71%	70%
		Highest National	88.9%	86.4%	89.5%	91.7%	95%	95%
		Lowest National	44.3%	39.2%	43.6%	49.7%	36%	33%

Measure 9. The percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends changed to "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation" in 2021/2022 survey and has continued to be the same for the 2023/2024 survey. It has also changed from question ID 23d to 25d.

The Newcastle Hospitals considers that this data is as described for the following reasons:
The Trust continues to score well above the National average in relation to staff survey Q25d. By ensuring all colleagues have a voice and continuing to listen and act on all sources of staff feedback, The Newcastle Hospitals is committed to maintaining the highest quality of services for both patients/service users and its staff.

Measure 10. The percentage of patients that were admitted to hospital who were risk assessed for Venous thromboembolism

National data collection is yet to resume post COVID-19.

Measure	Data Source	Target	2023/2024	2022/2023	2021/2022	2020/2021
11. The number of cases of *Clostridioides difficile* infections reported within the Trust amongst patients aged two or over	PHE Data Capture System	Trust number of cases	144 HOHA* = 114 COHA* = 30	172 HOHA* = 138 COHA* = 34	169 HOHA* = 135 COHA* = 34	111 HOHA* = 85 COHA* = 26
		National Average number of cases	HOHA* = 54 COHA* = 20	HOHA* = 52 COHA* = 19	HOHA* = 44 COHA* = 18	HOHA* = 35 COHA* = 16
		Highest National number of cases	HOHA* = 227 COHA* = 82	HOHA* = 212 COHA* = 76	HOHA* = 189 COHA* = 76	HOHA* = 151 COHA* = 60
		Lowest National number of cases	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0

*HOHA = Hospital Onset – Healthcare Associated
*COHA = Community Onset – Healthcare Associated

Measure 11. The number of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over

The Newcastle Hospitals considers that this data is as described for the following reasons:
The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement. The Newcastle Hospitals has taken the following actions to improve this rate, and so the quality of its services by having a robust strategy;
Quarterly Health Care Associated Infection Report to share lessons learned and best practice from Clinical Board Oversight Groups.

Measure	Data Source	Target	2023/2024	2022/2023	2021/2022	2020/2021
12. The number and rate per 1000 admissions of patient safety incidents reported	NHS Information Centre Portal https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/	Trust no.	April 2023 – March 2024 20909	April 2022 – March 2023 20464	April 2021 – March 2022 18440	April 2020 – March 2021 17915
		Trust Rate	39.3	38.7	37.5	50.3
		National Average	Not available	50.0	57.5	58.4
		Highest National	Not available	224.6	205.5	118.7
		Lowest National	Not available	14.9	23.7	27.2

Measure 12. The number and rate of patient safety incidents reported

The Newcastle Hospitals considers that this data is as described for the following reasons:

Over the previous 12 months the trust has introduced two significant changes to patient safety incidents and their management.

In November 2023 Learning from Patient Safety Events was introduced. This changed the way incidents were graded with the introduction of psychological harm categories and moved the trust from reporting externally via the National Reporting and Learning System to real time updates via the Learning from Patient Safety Events database.

In January 2024 the Trust introduced the Patient Safety Incident Response Framework which resulted in new processes for review and escalation of incidents.

Incident data, themes and organisational learning is reported annually through the Trusts governance structures to Quality Committee and Trust Board.

In September 2023 NHS England paused the annual publishing of incident data while they consider future publications in line with the introduction of the Learning from Patient Safety Events service in replacement of National Reporting and Learning System.

Measure	Data Source	Target	2023/2024		2022/2023		2021/2022	
13. The number and percentage of patient safety incidents that resulted in severe harm or death	NHS Information Centre Portal https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/	Trust no.	April 2023 - March 2024 **Severe Harm** 115	April 2023 - March 2024 **Death** 50	April 2022 - March 2023 **Severe Harm** 88	April 2022 - March 2023 **Death** 53	April 2021 - March 2022 **Severe Harm** 85	April 2021- March 2022 **Death** 50
		Trust %	0.6%	0.2%	0.4%	0.2%	0.5%	0.3%
		National Average	Not available	Not available	Not available	Not available	Not available	Not available
		Highest National	Not available	Not available	Not available	Not available	Not available	Not available
		Lowest National	Not available	Not available	Not available	Not available	Not available	Not available

Measure 13. The number and percentage of patient safety incidents that resulted in severe harm or death

The Newcastle Hospitals considers that this data is as described for the following reasons:

The Trust takes incidents resulting in severe harm of death very seriously. Incident reporting rates have remained stable, but the trust has seen a small increase in incidents of severe harm.

The introduction of Patient Safety Incident Response Framework has introduced new ways in which the Trust investigates and learns from incidents with significant harm.

In September 2023 NHS England paused the annual publishing of incident data while they consider future publications in line with the introduction of the Learning from Patient Safety Events service in replacement to National Reporting and Learning System.

WORKFORCE FACTORS

The tables below provide data on the loss of workdays. The table directly below reports on the Trust and regional position rate (data taken from the NHS Information Centre) and the next table provides an update on the Trust number of staff sick days lost to industrial injury or illness caused by work.

This table shows the loss of workdays (rate).

	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023
The Newcastle Upon Tyne Hospitals	6.54	5.79	5.12	5.15	4.72	4.58	4.66	4.88	4.85	4.98	5.64	5.73
South Tyneside and Sunderland	7.47	6.64	5.73	5.26	4.99	5.24	5.58	5.68	5.64	5.68	5.85	5.68
County Durham and Darlington	6.90	6.07	5.31	5.09	5.04	4.85	4.83	5.20	5.00	5.49	5.59	5.80
Gateshead Health	6.66	6.10	5.24	5.51	4.96	5.02	5.11	5.37	5.76	6.04	6.11	6.02
North Tees and Hartlepool	7.06	5.93	5.79	5.65	5.10	4.98	5.10	5.60	5.46	5.52	5.77	5.80
Northumbria Healthcare	6.82	6.18	5.30	5.19	4.89	4.85	5.20	5.53	5.41	5.41	5.86	6.11
South Tees Hospitals	7.58	6.35	6.01	5.72	5.40	5.22	5.16	5.46	5.59	5.84	6.12	6.01
England	**6.30**	**5.34**	**5.01**	**4.95**	**4.52**	**4.47**	**4.52**	**4.77**	**4.89**	**4.99**	**5.33**	**5.30**

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year Total
2012/13 no. of days	154	138	174	209	675
2013/14 no. of days	489	331	785	147	1752
2014/15 no. of days	333	284	178	206	1001
2015/16 no. of days	360	194	365	219	1138
2016/17 no. of days	230	387	136	84	837
2017/18 no. of days	137	90	51	122	400
2018/19 no. of days	214	131	188	326	859
2019/20 no. of days	249	172	67	123	611
2020/21 no. of days	65	61	335	212	673
2021/22 no. of days	318	475	618	409	1820
2022/23 no. of days	319	119	139	321	898
2023/24 no.of days	368	454	263	168	1253

2023 NHS STAFF SURVEY RESULTS SUMMARY

The last few years have been exceptionally difficult for everyone working in the NHS, and it is important to hear what colleagues think about working in our Trust – to help improve working lives.

A full census survey was sent via email to all eligible employees of the Trust (via external post for those on maternity leave and employees under the Estates directorate), giving all members of our staff a voice with 6,457 staff participating in the survey, equalling a response rate of 42%. This is 3% lower than the sector average and was a 2% decrease on the 2022 response rate of 44%.

Providing the highest standard of care has always been our priority and we know how important this is to all our staff.

The NHS Staff Survey looks at staff experience in these areas, described as the 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.

Alongside the NHS People Promise are two main themes:

- Staff Engagement.
- Morale.

The Staff Engagement score is measured across three sub-themes:

- Advocacy: 6.99 out of 10, measured by Q23a, Q23c and Q23d (Staff recommendation of the trust as a place to work or receive treatment).
- Motivation: 6.76 out of 10, measured by Q2a, Q2b and Q2c (Staff motivation at work).
- Involvement: 6.86 out of 10, measured by Q3c, Q3h and Q3i (Staff ability to contribute towards improvement at work).

At Newcastle Hospitals this score was:
Overall: rating of staff engagement 6.76 (out of possible 10).
This score was 0.52 **below** top position and 0.42 **above** worst position in the sector (Combined Acute & Community Trusts). It sits **below** sector average by 0.15.
Including Staff engagement, the Trust scored slightly **lower** than average on all of the nine people promises / themes when compared with 126 other Combined Acute and Acute & Community Trusts in England. These are:

We are compassionate and inclusive
Newcastle Hospitals Score: 7.09 out of 10
Sector Score: 7.24 out of 10
Difference: -0.15

We are recognised and rewarded
Newcastle Hospitals Score: 5.60 out of 10
Sector Score: 5.94 out of 10
Difference: -0.34

We each have a voice that counts
Newcastle Hospitals Score: 6.49 out of 10
Sector Score: 6.70 out of 10
Difference: -0.21

We are safe and healthy
Newcastle Hospitals Score: 5.96 out of 10
Sector Score: 6.06 out of 10
Difference: -0.10

We are always learning
Newcastle Hospitals Score: 5.31 out of 10
Sector Score: 5.61 out of 10
Difference: -0.30

We work flexibly
Newcastle Hospitals Score: 5.72 out of 10
Sector Score: 6.20 out of 10
Difference: -0.48

We are a team
Newcastle Hospitals Score: 6.35 out of 10
Sector Score: 6.75 out of 10
Difference: -0.40

Morale
Newcastle Hospitals Score: 5.77 out of 10
Sector Score: 5.91 out of 10
Difference: -0.14

Additionally, the Trust scored favourably in several of the questions in the survey. Some to note include:

- **88.94%** feel trusted to do their job.
- **87.12%** feel their role makes a difference to patients.
- **86.98%** of employees have had an appraisal in the last 12 months which is a **1.73%** increase from last year's staff survey and **3.86%** higher than the sector average.
- **85.15%** know what their work responsibilities are.
- **78.48%** enjoy working with the colleagues in their teams.
- **77.48%** of staff feel care of patients is Newcastle Hospitals top priority.
- **77.41%** would be happy with the standard of care provided if a friend or family member needed treatment, meaning we are **14.09%** higher than the sector average.

The trust demonstrated improvement in 21 questions versus its 2022 results with the majority remaining below sector average.

Trust and Sector scoring both saw improvements under the “We are safe and healthy” and “We work flexibly” People Promise themes, with the trust performing above average in the following People Promise and Sub-score areas:

People Promise	Sub-score
Morale	Thinking about leaving
Morale	Work pressure
Staff Engagement	Motivation
We are safe and healthy	Burnout
We are safe and healthy	Health and safety climate
We work flexibly	Flexible working
We work flexibly	Support for work-life balance

Ensuring that the voices of our staff continue to be heard continues to be a priority, and our survey results provide more depth to understanding of the issues affecting staff and these findings, alongside other feedback drivers such as ‘What Matters to you’, will be fed into the development of our new People Plan Strategy. Feedback from the Staff Survey provides intelligence and informed steer on which areas our organisation can develop, but also which areas are showing growth and progression.

There is work ongoing to further understand and break down the 2023 results, including how they differ between staff groups and directorates, to help inform the Trust’s next steps in supporting staff through the People Plan Strategy.

INVOLVEMENT AND ENGAGEMENT 2023/2024

The Trust continues to be genuinely motivated and committed to improving the experience of patients, families, carers, and visitors and are constantly learning from lived experiences. We want to truly understand what matters to people who access our services and involve them in how we evaluate and improve the care we provide to them.

In our previous quality account, we explained the focus for 2023/2024 was to work in partnership with local communities and voluntary groups to help ensure that equal opportunities were promoted and encouraged. Over the past year we are proud to have been given the opportunity to work on projects driven by local communities which will have great outcomes for people accessing our services in the future.

We have worked in close partnership with Deaflink to implement the health navigator programme to help improve access and experience of care for patients who are deaf. Skills for People have facilitated focus groups with people who have a learning disability; they are currently developing some priority quality improvement work and will lead on this for us.

The patient experience team have also worked in partnership with patient contributors, recruited from the Cumbria, Northumberland, Tyne & Wear engagement bank who have been at the forefront of involving people with lived experience of mental health and ensuring their voices are central to the co-development of the mental health strategy which is due to be launched this year.

In addition, the equality diversity and human rights group continue to meet quarterly where charities and voluntary organisations, such as HAREF, Newcastle Vision Support, Newcastle Carers, Be Trans Support, Disability North, are key members; driving and leading on the mutually agreed priorities within the equality delivery system.

This year we also aspired to design a patient and engagement toolkit to help empower and support services to actively engage and work with patients. This toolkit is in the final draft stage and is hoped to be launched by summer 2024.

In 2023, with the support of Newcastle Hospitals Charity, we also began a journey to develop a clear, cohesive, and forward-thinking patient experience strategy which was developed through meaningful engagement and listening. A communications plan was drawn up to ensure the activities planned provided wide-ranging opportunities to participate and include as many people as possible. A period of involvement was conducted between June and August 2023, which led to the co-production of the Trust's Experience of Care Strategy. The strategy has 5 key objectives with a number of commitment statements related to each:

1. We take a patient-centred approach because patients should always be at the heart of everything, we do.
2. We develop a listening culture, actively asking people what matters to them, encouraging feedback at each stage of their journey. We will demonstrate how feedback has led to change.
3. We develop patient experience opportunities that are easy to understand and access, which reflect the diverse range of people who access our services.

4. We champion innovation in patient experience and actively seek to be the best we can.
5. We use experience feedback to instil pride amongst patients, stakeholders, and staff, celebrating contributions towards our overall success.

Most recently the trust has appointed a Director of Patient and Staff Experience within the Executive team, designed to strengthen board accountability, and provide visibility and momentum for a trust-wide patient and staff experience programme. A programme of work is currently being developed to help ensure the organisation has a systematic way of analysing patient feedback in all its forms and has dedicated analytics and intelligence support for patient experience data. We anticipate that our local communities will help us understand this data and work in co-production when any improvements or themes are identified.

In 2024/2025 the focus will be to:

- Launch and embed the patient and staff experience programme.
- Continue to work in partnership with local communities on projects and concerns which matter to them.
- Launch of the patient experience engagement toolkit to support services to involve and engage with patients when evaluating, redesigning or implanting new systems and processes.

ANNEX 1:

STATEMENT ON BEHALF OF THE NEWCASTLE HEALTH SCRUTINY COMMITTEE

STATEMENT ON BEHALF OF NORTHUMBERLAND COUNTY COUNCIL

STATEMENT ON BEHALF OF THE NEWCASTLE & GATESHEAD INTEGRATED CARE BOARD

STATEMENT ON BEHALF OF HEALTHWATCH NEWCASTLE AND HEALTHWATCH GATESHEAD

STATEMENT ON BEHALF OF NORTHUMBERLAND HEALTHWATCH AND NORTH TYNESIDE HEALTHWATCH

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024					
Title	Board Assurance Framework 2024-2025					
Report of	Caroline Docking, Director of Communications and Corporate Affairs					
Prepared by	Natalie Yeowart, Head of Corporate Risk and Assurance					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	The 2024/25 Board Assurance Framework (BAF) has been re-designed to ensure it can effectively capture all the relevant information relating to the Trust's Strategic risks to allow effective discussion and assurance to be received by each committee and Trust Board. The first iteration of the BAF is provided in this report.					
Recommendation	The Trust Board are asked to: • Note the refreshed Board Assurance template. • Review, consider and receive assurance on the content within the BAF; • Provide any comments;					
Links to Strategic Objectives	This relates to all Trust strategic objectives.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☒	☒
Link to Board Assurance Framework [BAF]	Full linkage to all Strategic BAF Risks.					
Reports previously considered by	This is a regular quarterly report to the Trust Board.					

BOARD ASSURANCE FRAMEWORK 2024/2025

The Newcastle upon Tyne Hospitals NHS Foundation Trust

The 2024/2025 BAF

The 2024/25 BAF has been re-designed to ensure it can effectively capture all the relevant information to allow effective discussion and assurance to be received by each committee and Trust Board. This approach informs the agenda and regular management information received by the relevant committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Trust Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, that forms the basis of the Trust's risk framework (with corresponding corporate and operational risks defined at a Trust-wide and service level if available).
- Risk ratings – initial, current and target levels.
- Clear identification of primary strategic threats and opportunities that are considered likely to increase or reduce the Principal Risk, within which they are expected to materialise.
- A statement of risk appetite for each risk to be defined by the Lead Committee on behalf of the Board (**Avoid** = Avoidance of risk; **Cautious**= ALARP (as little as reasonably possible)preference for ultra-safe delivery options; **Open** = willing to consider all potential delivery options where there is acceptable level of reward **Seek** = prepared to accept a higher level of risk in pursuit of higher business rewards despite greater inherent risk and **Seek** confident to set high levels of risk due to controls, forward scanning and robust responsive systems).
- Documented controls we already have in place to reduce the likelihood of the threat.
- Sources of assurance incorporate the three lines of defence: (1) **Management** (those responsible for the area reported on); (2) **Risk and compliance functions** (internal but independent of the area reported on); and (3) **Independent assurance** (Internal audit and other external assurance providers) to demonstrate the assurance and confidence of the control in place.
- Key actions identified for each threat; each assigned a timescale for completion. These will be individually rated by the lead committee noting the level of assurance they can take that the actions will be effective in treating the risk (see below for key)
- Clearly identified gaps in the primary control framework, with details of planned responses.

Committee assurance ratings:

Green (significant) = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity
- no gaps in assurance or control AND current exposure risk rating = target

OR - gaps in control and assurance are being addressed

Amber (moderate) = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy

Red (limited) = Negative assurance: the Committee is satisfied that there is sufficient reliable evidence that the current risk treatment strategy is not appropriate to the nature and/or scale of the threat or opportunity.

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.	**Strategic objective**	1. Quality of Care will be our main priority. We will improve our approach to safety, incident reporting, listening, and learning.

Lead Committee	Quality Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Nursing/Joint Medical Director	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Quality Safety
Date Added	01.05.2024	**Likelihood**	**4**	**3**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	01.05.2024	**Risk Score**	**20**	**15**	**5**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating**
Failure to successfully develop and nurture a positive safety culture: including the promotion of incident reporting and learning; creating a psychologically safe environment and listening to staff and patients. Capacity constraints that may impair the organisations ability to sustain improvements brought about by adopting PSIRF processes and principles (Linked to 2024/25 Quality Priority 1)	• The Patient Safety Incident Response Framework (PSIRF) went live in January 2024. • Central supportive infrastructure for implementation and embedding of PSIRF • The Quality Governance Framework underpinned by Quality Oversight Groups (QOG's) in each Clinical Board. • Rapid review meetings. • Policies and Procedures. • Patient Safety Incident Forum. • Incident reporting system • Patient Safety Briefings to ensure dissemination of learning from incidents.	• Rapid Review Meeting/Patient Safety Incident forum minutes and actions plans. • Monitoring of compliance with PSIRF timeframes for learning responses. Power BI dashboards shared at Clinical Board QOG's and Quality and Performance Reviews • Regular PSIRF implementation reports to Patient Safety Group • Patient Safety Briefing – key weekly messages. • Integrated Quality Report to Quality Committee. • Oversight through Clinical Board Quality Oversight Group, reported into performance reviews and the Executive Team • Quarterly pulse surveys including questions on safety culture • CQC Delivery Group and CQC Assurance Group oversight • Staff Survey	• Develop and embed a positive reporting and safety Culture – 01.06.2024. • Review and evaluation of reporting and safety culture – 01.10.2024 • Develop and embed New Clinical Board Leadership Model – 01.10.2024 • Delivery of CQC action plan – timescales dependant on action. • Report and ensure compliance against Duty of Candour – 01.07.2024.	

Cont./….

Failure to achieve best practice standards e.g. NICE/GIRFT/recommendations from National Clinical Audit Capacity constraints within Clinical Boards quality oversight infrastructure impacting on the ability to undertake baseline assessments against best practice standards.	• Clinical Effectiveness and Audit Group. • Clinical Outcomes and Effectiveness Group. • GIRFT oversight group • Clinical Effectiveness metrics • New Interventional Procedures Group	• Clinical Effectiveness and Audit Group minutes and Action plans. • Clinical Outcomes and Effectiveness Group (COEG)minutes and action plans • Reports to Quality Committee • Annual Clinical Audit Report to ARAC • GIRFT Oversight Group reports and minutes. • Minutes and reports of New Interventional Procedures including Robotic Surgical Group- reports to COEG. • Quality Oversight Group dashboards	• Review 6 month stocktake of progress with Clinical Board Quality Oversight Groups June 24 • Work with Clinical Board Quality & Safety Leads to ensure proportionate allocation of time between patient safety & clinical effectiveness elements of the Quality Oversight Framework June 24	
Gaps in assurance regarding compliance with policy and best practice relating to medication safety, storage and security. This could directly impact care quality and safety	• Medication Safety Task and Finish Group providing oversight of key improvement actions. • Monthly audit framework measuring compliance with policy to inform areas for improvement. • Internal peer review process. • Existing medication governance and oversight structures • Medicine Management Policies and procedures. • Commissioned and completed expert external review to inform improvement work streams. • CQC Delivery Group.	• Monthly audit data of ward and department compliance with core standards with dissemination of learning and action • Policy audits undertaken and reported through medicines management committee. • Datix data and trends relating to medicines management reported and reviewed • Peer review and external review reports and audit data. • CQC Delivery Group monitoring, reporting and minutes. • Compliance and Assurance Group reporting and minutes. • Quality Governance Structure via quality committee and Trust Board.	• Review of Medicines Reconciliation function across the Trust to identify urgent areas for improvement to attain to national best practice by June 2024 • Review existing governance systems in relation to Medicines Management to ensure robust oversight, monitoring, and escalation by July 2024 • 'Root and branches' review of medicines management improvement plan after external expert review undertaken in May 2024 by June 2024. This is to prioritise urgent actions and agree 12–18-month improvement plan	
Failure to improve the safety and quality of patient and staff experience in Maternity Services., (Linked to 2024/25 Quality Priority 4a)	• CQC, Ockenden and Maternity Three-Year action plan in place. These are reported into Quality Committee and Trust Board. • Robust Maternity Governance Team in place • Midwifery Staffing and Clinical Outcomes group • Board Maternity Safety Champions • Rapid review group • Family Health QOG • SOF quarterly meetings with ICB as part of Perinatal Mortality Surveillance monitoring • Monthly Maternity Staff meetings • Maternity Voices Partnership • LMNS (Local Maternity and Neonatal System) oversight	• Improvement action plan in place covering all core CQC must and should do. Signed off by ICB with monitoring and evidence reported. • Staff wellbeing/Recruitment and Retention Improvement plan in place. KPI monitored and reported in Family Health Board and to Executive Director of Nursing Team • Maternity Strategic Oversight Group • Reporting and oversight into Quality Committee and Trust Board • Maternity Services Quality Dashboard • Annual Maternity Survey results • CNST/MIS compliance • Pulse survey results. • Incident data • Rapid review group reporting and actions. • Family Health QOG minutes. • Maternity staff meeting minutes/notes.	• SOF exit criteria to be agreed - August 2024 • Director of Midwifery appointed - due to commence in post June 2024 • Real time patient/staff experience programme to include one post-natal Maternity ward. To commence in June 2024 • Re commencing of home birth service - June 2024 • Workforce review to include outputs of the 2024 Birthrate plus review and agree long term criteria for re-opening and sustainability of NBC – September 2024 • Review and refresh of Maternity Quality Metrics reported into Quality Committee - July 2024	

Failure to embed the learning from external service reviews including Cardiothoracic Services and Ophthalmology	• Cardiac Oversight Group • Cardiothoracic Improvement plan, including improvement actions from CQC and other external reviews • NUTH Quality Improvement Group • Quality and Performance Reviews • Compliance and Assurance Group	• Executive Oversight Cardiothoracic Compliance and Assurance Group reporting and minutes. • Reports to Trust Board and Quality Committee • Maintenance of central external review log • Central oversight of implementation of recommendations and monitoring of action plan completion via Quality and Performance Reviews • Compliance and Assurance Group Reports and Minutes.	• Completion of action plans for all reviews registered on the CB's external review log. July 24 • Monitoring of compliance with recently approved External Accreditations, Inspections and Reviews Policy • Implement Clinical Board Oversight arrangements to include management of action plans following external review.	
Failure to achieve and embed improvements in relation to PSIRF priorities: • Lost to follow up from internal referrals • Omissions and errors in thromboprophylaxis leading to VTE • Acting on abnormal results from radiology	• Endorsing documents on EPR QI project • Closed loop investigations QI project • VTE prophylaxis review • Patient Safety Group, Patient Safety Incident Forum • Clinical Board and corporate service engagement.	• Change management process - EPR. • Improvement Project report outs to PSG and PSIF • Quality Committee oversight of PSIRF priority topics • Monitoring of specific incident themes and trends via PSIRF processes • Patient Safety Group Report and Minutes.	• Timescales for completion tbc. • Ensure sufficient resource (digital, clinical, administrative) to ensure momentum and progress of all 3 projects are maintained. Review of progress to be undertaken quarterly.	

Risk ID	1.1
Comments:	

Threat (what might cause this to happen)	Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)	Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)	Actions and Timescales (Further actions required to manage risk)	Assurance rating
Failure to successfully develop and nurture a positive safety culture: including the promotion of incident reporting and learning; creating a psychologically safe environment and listening to staff and patients. Capacity constraints that may impair the organisations ability to sustain improvements brought about by adopting PSIRF processes and principles (Linked to 2024/25 Quality Priority 1)	• The Patient Safety Incident Response Framework (PSIRF) went live in January 2024. • Central supportive infrastructure for implementation and embedding of PSIRF • The Quality Governance Framework underpinned by Quality Oversight Groups (QOG's) in each Clinical Board. • Rapid review meetings. • Policies and Procedures. • Patient Safety Incident Forum. • Incident reporting system • Patient Safety Briefings to ensure dissemination of learning from incidents.	• Rapid Review Meeting/Patient Safety Incident forum minutes and actions plans. • Monitoring of compliance with PSIRF timeframes for learning responses. Power BI dashboards shared at Clinical Board QOG's and Quality and Performance Reviews • Regular PSIRF implementation reports to Patient Safety Group • Patient Safety Briefing – key weekly messages. • Integrated Quality Report to Quality Committee. • Oversight through Clinical Board Quality Oversight Group, reported into performance reviews and the Executive Team • Quarterly pulse surveys including questions on safety culture • CQC Delivery Group and CQC Assurance Group oversight • Staff Survey	• Develop and embed a positive reporting and safety Culture – 01.06.2024. • Review and evaluation of reporting and safety culture – 01.10.2024 • Develop and embed New Clinical Board Leadership Model – 01.10.2024 • Delivery of CQC action plan – timescales dependant on action. • Report and ensure compliance against Duty of Candour – 01.07.2024.	
Failure to safeguard and provide high quality personalised care for patients in mental health crisis, those who lack capacity or those with a learning disability and/or autism. (Linked to 2024/25 Quality Priority 3)	• Mental Capacity Oversight Group • Mental Health Committee • PLT meetings with core services • Restraint Review Group • MCA Quarterly audit framework • Health and Safety Committee • Patient Experience and Engagement Group • MCA training programmes/compliance • Learning Disability Steering Group • LeDeR review group • Environment review completed on two areas of concerns highlighted in Trust CQC report. • Learning Disabilities and MCA oversight by Safeguarding Committee/Quality Committee/Trust Board • Mental Health Awareness Training (specific packages for high-risk staff groups e.g Security staff) • Violence and Aggression Steering Group	• Quarterly MCA audit data demonstrating improved compliance with MCA • Increase in DOL's referrals represented of expected volume • Compliance with mandatory training and bite size training (Learning Disabilities, MCA and MH) • MHA provider review recommendations, action plan and evidence of completion • Ward and Department MHA files • Learning Disabilities and MCA reporting and minutes to Safeguarding Committee/Quality Committee and Trust Board. • Violence and Aggression Steering Group reports and minutes. • Compliance with Mental Health Awareness Training	• Agree and embed a quarterly audit framework for core mental health assessment metrics by July 2024 • Deliver level 2 MCA training programme and mandate for all relevant staff by July 2024 • Complete review of the environment in all core service to ensure they are safe and fit for purpose TBC • Real time Patient Experience programme. Pilot implementation June 2024 • Agree long term training framework for Learning Disabilities and Autism by August 2024 • Agree and implement quarterly and real time audit framework for Learning Disabilities by July 2024.	
Failure to achieve best practice standards e.g. NICE/GIRFT/recommendations from National Clinical Audit Capacity constraints within Clinical Boards quality oversight infrastructure impacting on the ability to undertake baseline assessments against best practice standards, implement best practice wherever possible and monitor implementation/impact.	• Clinical Effectiveness and Audit Group. • Clinical Outcomes and Effectiveness Group. • GIRFT oversight group • Clinical Effectiveness metrics • New Interventional Procedures Group	• Clinical Effectiveness and Audit Group minutes and Action plans. • Clinical Outcomes and Effectiveness Group (COEG)minutes and action plans • Reports to Quality Committee • Annual Clinical Audit Report to ARAC • GIRFT Oversight Group reports and minutes. • Minutes and reports of New Interventional Procedures including Robotic Surgical Group- reports to COEG. • Quality Oversight Group dashboards	• Review 6 month stocktake of progress with Clinical Board Quality Oversight Groups June 24 • Work with Clinical Board Quality & Safety Leads to ensure proportionate allocation of time between patient safety & clinical effectiveness elements of the Quality Oversight Framework June 24	

Gaps in assurance regarding compliance with policy and best practice relating to medication safety, storage and security. This could directly impact care quality and safety	• Medication Safety Task and Finish Group providing oversight of key improvement actions. • Monthly audit framework measuring compliance with policy to inform areas for improvement. • Internal peer review process. • Existing medication governance and oversight structures • Medicine Management Policies and procedures. • Commissioned and completed expert external review to inform improvement work streams. • CQC Delivery Group.	• Monthly audit data of ward and department compliance with core standards with dissemination of learning and action • Policy audits undertaken and reported through medicines management committee. • Datix data and trends relating to medicines management reported and reviewed. • Peer review and external review reports and audit data. • CQC Delivery Group monitoring, reporting and minutes. • Compliance and Assurance Group reporting and minutes. • Quality Governance Structure via quality committee and Trust Board.	• Review of Medicines Reconciliation function across the Trust to identify urgent areas for improvement by June 2024 • Review existing governance systems in relation to Medicines Management to ensure robust oversight, monitoring, and escalation by July 2024 • 'Root and branches' review of medicines management improvement plan subsequent to external expert review undertaken in May 2024 by June 2024. This is to prioritise urgent actions and agree 12–18-month improvement plan	
Failure to improve the safety and quality of patient and staff experience in Maternity Services., (Linked to 2024/25 Quality Priority 4a)	• CQC, Ockenden and Maternity Three-Year action plan in place. These are reported into Quality Committee and Trust Board. • Robust Maternity Governance Team in place • Midwifery Staffing and Clinical Outcomes group • Board Maternity Safety Champions. • Rapid review group • Family Health QOG • SOF quarterly meetings with ICB as part of Perinatal Mortality Surveillance monitoring • Monthly Maternity Staff meetings • Maternity Voices Partnership • LMNS (Local Maternity and Neonatal System) oversight	• Improvement action plan in place covering all core CQC must and should do. Signed off by ICB with monitoring and evidence reported. • Staff wellbeing/Recruitment and Retention Improvement plan in place. KPI monitored and reported in Family Health Board and to Executive Director of Nursing Team • Maternity Strategic Oversight Group • Reporting and oversight into Quality Committee and Trust Board • Maternity Services Quality Dashboard • Annual Maternity Survey results • CNST/MIS compliance • Pulse survey results. • Incident data • Rapid review group reporting and actions. • Family Health QOG minutes. • Maternity staff meeting minutes/notes.	• SOF exit criteria to be agreed - August 2024 • Director of Midwifery appointed - due to commence in post June 2024 • Real time patient/staff experience programme to include one post-natal Maternity ward. To commence in June 2024 • Re commencing of home birth service - June 2024 • Workforce review to include outputs of the 2024 Birthrate plus review and agree long term criteria for re-opening and sustainability of NBC – September 2024 • Review and refresh of Maternity Quality Metrics.	
Failure to embed the learning from external service reviews including Cardiothoracic Services and Ophthalmology	• Cardiac Oversight Group • Cardiothoracic Improvement plan, including improvement actions from CQC and other external reviews. • NUTH Quality Improvement Group • Quality and Performance Reviews • Compliance and Assurance Group	• Executive Oversight Cardiothoracic Compliance and Assurance Group reporting and minutes. • Reports to Trust Board and Quality Committee • Maintenance of central external review log • Central oversight of implementation of recommendations and monitoring of action plan completion via Quality and Performance Reviews • Compliance and Assurance Group Reports and Minutes.	• Completion of action plans for all reviews registered on the CB's external review log. July 24 • Monitoring of compliance with recently approved External Accreditations, Inspections and Reviews Policy • Implement Clinical Board Oversight arrangements to include management of action plans following external review.	

Failure to achieve and embed improvements in relation to PSIRF priorities: • Lost to follow up from internal referrals • Omissions and errors in thromboprophylaxis leading to VTE • Acting on abnormal results from radiology	• Endorsing documents on EPR QI project • Closed loop investigations QI project • VTE prophylaxis review • Patient Safety Group, Patient Safety Incident Forum • Clinical Board and corporate service engagement.	• Change management process - EPR. • Improvement Project report outs to PSG and PSIF • Quality Committee oversight of PSIRF priority topics • Monitoring of specific incident themes and trends via PSIRF processes • Patient Safety Group Report and Minutes.	• Timescales for completion tbc. • Ensure sufficient resource (digital, clinical, administrative) to ensure momentum and progress of all 3 projects are maintained. Review of progress to be undertaken quarterly.	

Risk ID	1.1
Comments:	

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to implement effective governance systems and processes across the Trust to assess, monitor and drive improvements in quality and safety.	**Strategic objective**	1. Quality of care will be our main priority. We will improve our approach to safety, incident reporting, listening, and learning.

Lead Committee	Audit, Risk and Assurance Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Managing Director	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	Compliance and Regulatory
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	01.05.2024	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating**
Failure to implement effective integrated governance focused on clinical quality, risk, finance, and performance. Ward to Board.	• Revised corporate governance structure and reporting arrangements in place. • Clinical Board Governance arrangements established including QOGs/MPRs/directorates. • Audit, Risk and Assurance Committee established. • CQC delivery group established. • External leadership and governance review.	• Terms of Reference – committees of Board. • Minutes of committee meetings. • Committee schedule of business. • Corporate Organograms. • Minutes of QOG/MPR and directorate governance meetings. • Effective governance system report to Trust Board. • CQC delivery group minutes and action plans. • Quality Performance Reviews	• Evaluate the implementation of revised integrated governance structure – 31.06.2024.	
Failure to embed escalation processes and ensure executive oversight.	• Performance and accountability framework. • Standardised reporting and governance. • Clinical Board development plan in place. • Quality performance review process. • Executive Leads for clinical boards. • Reporting hub dashboards.	• Performance and accountability framework document. • Clinical board reporting and minutes. • Performance review reports and minutes. • Clinical Board Chairs update to Executive Team.	• Review implementation of Clinical Board Governance Meetings to ensure consistency – 01.06.2024. • Review issue escalation through new governance route to Exec – 01.06.2024. • Review consistency of Monthly performance reviews – 01.06.2024	

Failure to implement effective systems to identify incidents including severity of harm.	• Incident Dashboards created. • Review and closure of legacy serious incidents. • Review and improvements to Datix System. • Patient Safety Briefing. • PSIRF implementation in Clinical Boards.	• Monthly dashboards to clinical boards. • All legacy SI's completed and closed. • Datix User Survey. • PSIRF update to Quality Committee.	• Analysis of data to identify areas of under reporting – 01.06.2024. • Review effectiveness of current rapid learning from serious incidents – 01.06.2024. • Review effectiveness of PSIRF implementation – 01.06.2024 • Review incident escalation process compliance – 01.06.2024 • Develop incident reporting communication plan – 01.06.2024 • Report and ensure compliance against Duty of Candour – 01.07.2024.	
Failure to implement effective corporate risk management including clear escalation and accountability.	• New risk management policy. • Refresh of risk management governance and reporting. • Quality and Safety leads appointed. • Risk Validation Group established. • Audit, Risk and Assurance Group established. • Risk management dashboard. • Executive Team lead assigned to CBs. • Refresh of risk management training. • Engagement with clinical boards. • Implementation of risk decision tool -risk vs issue. • Risk Management SOP.	• Risk Management Policy document and associated guidance. • Reporting, accountability, and escalation structure. • Terms of reference risk validation group • Historical risk trajectory. • Risk management dashboard. • Reporting to CQC Delivery Group weekly. • Risk management training TNA. • Clinical board risk presentation. • Embedded into clinical board governance arrangements – qog minutes and reporting. • Audit, Risk and Assurance ToR, minutes and Reports.	• Creation of risk management training video for induction. 31.06.2024. • Implementation/engagement sessions to embed new risk management policy – 31.07.2024. • Risk Refresher Training for all existing risk register users – 01.07.2024. • Review and approve a refreshed Board Assurance Framework – 01.06.2024	

Risk ID	1.2
Comments:	

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to manage our finances effectively to improve our underlying deficit and deliver long term financial sustainability.	**Strategic objective**	6. We will take our responsibilities as a public service seriously looking after patients and each other; managing our money, our performance, and our relationships with partners.

Lead Committee	Finance	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Finance	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Finance/VfM
Date Added	30.04.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	30.04.2024	**Risk Score**	**25**	**20**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating**
Failure to achieve levels of activity required to support ERF expectations in Financial Recovery Plan.	• Activity targets produced for each speciality. • Funding has been delegated at the start of the year for specific areas where identified this is necessary for impact. • DOPs and Clinical Board Chairs accountability for delivery of activity targets. • Monthly reporting reinstated within the Trust.	• Activity reporting via monthly performance reviews. • Monthly reporting of targets, activity and financial impact to Finance and Performance Committee and Trust Board. • National reporting back to Trust of validated activity levels (quarterly). • Internal and external audit of income levels • Finance Dashboard.	• Improvement to clinical coding – NEED DATE.	
Insufficient capability / bandwidth and reduction in financial grip and control.	• Standardised governance framework in place covering SFIs / RCGs / Contract waivers. • Financial governance framework in place, • DFM meetings with DOPs. • Monthly performance reviews. • Capital Management Group. • Procurement Cttee controls. • CIP plan. • Budget setting principles and budgets in place • Day to day budget management processes in place. • Finance business partners named for each CB. • Purchasing via procurement framework. • Enhancements to financial reporting. • DOPs reinforcing financial grip and control. through engagement with teams.	• Budgetary oversight at DOP level • Monthly revenue report at CB and corporate service level • Regular reporting of compliance through Internal Audit and monitoring of recommendations • HFMA audit of control reported through to ARAC • Reporting framework to ICB / cost control framework implemented. • NHSE/I monthly finance monitoring • Going concern and financial controls audit – LEVEL of Assurance Required.	• Revisit of control checklist provided by NHSE, rapid actions, workforce, financial control - JB 31/5/24 • Strategy to improve financial awareness throughout Trust - discussion with Head of Comms – JB 31/5/24 • Scheme of delegation at each level (1 to 6) requires input throughout the CB and Corporate Service. • Annual External Audit outcome – Mazars 01.06.2024.	

	• TMG engagement re Internal Reports and actions. • HFMA self-assessment report.			
Failure to deliver the required level of efficiency savings required in the Financial Recovery	• Agreed financial plan with ICB. • Financial Recovery Programme set with targets for trust wide schemes, CB and CS targets, commercial schemes and possible technical benefits all identified. • CIP programme risk assessed. • Deep dives with CFO/ DCFO/MD Month 1. • Commercial and Innovation board established. • Finance and Performance Cttee now moved to monthly. • Opportunities through Alliance conversations.	• Review of Financial Recovery Plans as part of annual financial planning process. • Monitoring delivery of plans by FRSG, fortnightly • Performance Review meetings co-ordinated by MD. • Revenue reporting and FRP reporting to Finance and Performance Cttee • Integrated Performance Report (IPR, refreshed) to Governors and Public Board of Directors • Annual external audit of Accounts and Value for Money report • Peer review and ICB focus as part of financial planning. • Work schedule for Finance and Performance Cttee refreshed to include DOPs attendance periodically.	• Following risk assessment deadline to set for 'course correction' if targets not being met - 31/5/24. • Repeat deep dives where necessary – JB 30/6/24.	
Lack of longer-term planning framework and certainty of funding / reliance on non-recurrent income sources	• Attendance and contribution at ICB level DOFs meetings. • Proactive engagement with Shelford colleagues / influencing of national decision making. • Reduction of costs where n/rec funding an issue achievement of recurrent cost savings. • Contracting team and regular meetings with commissioners alongside finance colleagues • Business case process.	• Reporting to FRSG (fortnightly). • Revenue reporting to Finance and Performance Committee.	• Production of longer-term financial plan - JB - draft 23.05.2024 • Rhythm of FRSG to be established, standard items etc – JB May 2024	
Further unplanned for emerging cost pressures such as inflation, pay awards	• Horizon scanning • Proactive engagement with suppliers • Supply and procurement committee. • Financial governance framework • ICB DOFs meeting. • Shelford networking / understanding the environment. • Use of frameworks. • Opportunities through Alliance working. • Engagement with MTPF workstreams (ICS).	• CB and CS finance reporting • Budget sign off • ICS updates through Finance report and CEO report to Committees and Board • Finance report to Board, Finance and Performance Committee • Procurement report to Finance and performance Cttee • Regional finance returns monthly.	• Going concern and financial controls audit as part of External and Internal audit programme.	
Insufficient capital funding required to invest in improvements to transform services and improve efficiency	• Capital Management Group. • Capital Infrastructure Group. • Annual capital plan including estates, medical equipment, IT and health and safety plus IFRS16. • ICS Infrastructure Board. • Cash forecast.	• PLACE AND ERIC returns • CMG report into Finance and Performance Cttee including • CDEL and IFRS 16 • Capital management audit by internal audit – Level of control needed. • ICS Infrastructure plan	• engagement with potential solutions to CDEL.	

Risk ID	6.1
Comments:	

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care.	**Strategic objective**	6. We will take our responsibilities as a public service seriously looking after patients and each other; managing our money, our performance, and our relationships with partners.

Lead Committee	Finance and Performance Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Managing Director	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	Compliance/Regulatory
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	01.05.2024	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating**
Failure to manage capacity and demand.	• PMO supported programme of demand and capacity planning across all surgical specialities. • Weekly Stand-up highlighting areas of focus. • Daily Site meetings and Site Handover. • Weekly speciality /tumour group PTL meetings for long waits and cancer. • Fortnightly performance meetings with operational leads for long waits and cancer. • Local A&E Delivery Board, supporting the management of non-elective patients across the system. • Weekly attendance at Provider Collaborative Mutual Support Co-ordination group facilitating patient transfers and collaboration amongst local providers. to level demand, make use of system capacity.	• Accountability Framework. • Activity and Income reports. • Integrated Quality and Performance Board Report. • Monthly Integrated Quality Performance Reviews.	• Further development of the Integrated Quality and Performance Board Report 31.05.2024. • Develop Clinical Board Level reports – 30.09.2024. • Review current information and performance reports to ensure they are fit for purpose - 30.06.2024. • Development of governance processes within the Clinical Board– 31.07.2024. • Theatre Demand and Capacity Exercise – 30.06.2024. • Outpatients D&C exercise – NEED DATE.	
Utilising available resource effectively – workforce, estate, and equipment.	• Activity plans developed with Clinical Boards as part of the annual planning process. • Capital planning process through Capital Management Group. • Allocation of growth funding from commissioners to under pressure services, where available.	• Integrated Quality and Performance Board Report. • Monthly Integrated Quality Performance Reviews. TMG Updates. • Clinical Board meeting minutes.	• Development of a medium-term radiology resource plan to mitigate the need for additional mobile MRI/CT scanners. • Revised annual planning process to incorporate approval of business cases for the coming financial year and utilisation – 01.09.2024. • Development of operational Establishing weekly activity and value performance reports. NEED DATE.	

Failure to transform and change service models at pace.	• Clinical Board Improvement Plans. • Winter Plan. • Bespoke programmes of support to critical / fragile services. • Clinical Board Structure in place from April 2023 • Director team buddy system to support Clinical Board leadership teams. • Alliance working groups. • GIRFT engagement and sharing of alternatives models, tools and support. • Outpatient Improvement Group. • Surgical Improvement Group.	• TMG Oversight. • Executive Team Oversight. • Quality Performance Reviews. • Monthly IPR to committees and Board. • Clinical Board meeting minutes. • Outpatient Improvement Group Minutes. • Surgical Improvement Group Minutes. • Diagnostic Improvement Group Minutes.	• Establishment or relaunch of the clinical lead Trust wide Improvement Groups in 30.06.2024. • Strengthen commissioner, primary care engagement and users on pathways/ service redesign – NEED DATE.	
Clinical service failure at neighbouring Trusts impacting on NUTH performance.	• Clinical Strategy work across the Alliance including a focus on vulnerable services. • Attendance at the Provider Collaborative Mutual Support Coordination Group and Alliance groups.	• Regular updates to TMG. • CEO attendance at Great North Care Alliance Steering Group and Minutes.	• Pain Management service transfer NEED DATE. • Working group to address service change for Laryngeal Botulinum Injection Service. NEED DATE.	

Risk ID	6.2

Comments:
Timescalesr required for some actions.

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to deliver digital systems, processes, and infrastructure to support the provision of safe effective patient care and our digital aspirations for the future.	**Strategic objective**	4. Our technology needs to improve so that it supports our work and patient care and does not hinder it.

Lead Committee	Digital and Data Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Chief Information Officer	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	Digital
Date Added	01.05.2024	**Likelihood**	**4**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	01.05.2024	**Risk Score**	**16**	**12**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating**
Lack of standardisation in clinical pathways, lack of capacity and capability resulting in failure to maximise our investment in E-record and digital systems.	• IT Town Hall, engagement sessions and Staff Roadshows. • Trust-wide adoption coaches appointed. • Digital Health Team Care optimisation project. • Digital request process in place.	• Presentations slides, staff roadshow sides and feedback from staff. • Supplier assessment based on site visit.	• Establish a Care Optimisation Group – 01.06.2024. • Implement Oracle/Cerner Remote Hosting project – 01.01.2025. • Upgrade current EPR version – 31.03.2025.	
Failure to protect and prevent against cyber-attack.	• Cyber Security Team Established. • Regular external penetration audit testing. • Compliance with Cyber Essentials accreditation. • Multi Factor Authentication in place. • Upgraded Firewall. • Patch testing compliance. • Reports to Digital and Data Committee.	• IT Security and Service Management Report to Digital and Data Committee. • Cyber Essentials Accreditation certificate. • Digital and Data Committee Minutes.	• Review of current Cyber Security Policies– 01.12.2024. • Completion and result of 2023/2024 DSPT audit and accreditation – 30.06.2024. • replace/update outdated systems and software, legacy hardware, and unsupported systems – TBC. • Implement process for the management of the inventory system - 01.12.2024. • Plan to remove all devices over 5 years old – 01.04.2025	
Lack of an approved financial plan for digital investment.	• Prioritising IT capital allocation with support from Finance Department. • Ongoing allocation of capital budget and a replacement plan based on oldest out first.	• IM&T Senior Leadership Meeting and minutes. • Review and reporting at Digital and Data Committee. • Minutes of Digital and Data Committee.	• Review and Development of IT CIP Plan – 30.05.2024. • Develop 3-year Digital financial Plan – 01.07.2024. • Develop Digital Strategy – 01.04.2025.	

Risk ID	4.1

Comments: Risk scores to be validated.

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to maintain the standard of the Trust Estate, Environment, and Infrastructure could result in a disruption to clinical activities and impact on the quality of care delivered.	**Strategic objective**	5. We want our buildings to be modern, environmentally sustainable, fit for purpose and great places to work and care for our patients.

Lead Committee	Finance and Performance	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Estates	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Compliance and Regulatory
Date Added	01.05.2024	**Likelihood**	**4**	**2**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	01.05.2024	**Risk Score**	**20**	**10**	**5**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating**
Funding or resources are not sufficient to deliver Estates priorities and ambitions. Failure to maintain or improve the standard of the Trust estate and environment as a result of under investment in the lifecycle upgrade of critical infrastructure assets.	• Regular planned preventive maintenance programme (PPM) in place in line with the requirements of SFG20 and Health Technical Memoranda (HTM) guidance. • Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of backlog maintenance programme. • Monthly HTM Compliance. • Monitoring/Reports. • Fire Safety Reports. • Health & Safety Reports. • Capital Programme. • Estates Strategy. • Trust HTM maintenance policies and procedures.	• Estates Operational Management Structures. • Estates Risk Management & Governance Group. • Estates Strategy and Capital. Investment Group. • Estates Fire Directors Group. • Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety). • Capital Management Group. • Compliance & Assurance Group. • Trust Internal Audit Programme (AuditOne). • Independent Authorising Engineer. annual HTM compliance Audit. • NHS Premises Assurance Model. • PLACE audits.	• Achievement of ISO 9001 accreditation expected 31 May 2024 • Delivering Dementia Friendly Environments (18–24-month programme) • Compliance with Self Harm Risk Assessment recommendations (18–24-month programme)	
Management of PFI Estate	• Monitoring of PFI annual and 5-year lifecycle plan (Lifecycle investment is included within the Project Agreement and Unitary Charge for the PFI Estate) • Monitoring of PFI annual condition surveys. • Regular zonal and ad hoc inspections of PFI areas	• GPFI Monthly Review Meetings • PFI Liaison Committee • Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety) • Trust Internal Audit Programme (AuditOne) • Independent Authorising Engineer annual HTM compliance Audit • PLACE audits	• Performance of the PFI Centre of Best Practice condition survey process in collaboration with PFI partners. Expected to commence during 2024	

Risk ID	5.1

Comments:

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to have sufficient capacity and capability in our workforce to deliver safe and effective care.	**Strategic objective**	2. We want this to be a great place to work where everyone feels supported appropriately by the organisation and compassionate leaders. We will always be civil and respectful to each other so that relationships within and across the teams will improve.

Lead Committee	People Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Chief People Officer	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	People
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	01.05.2024	**Risk Score**	**16**	**16**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating**
Ability to attract and retain competent staff resulting in critical workforce gaps in some clinical services.	• Establishment control to identify vacancies. • Vacancy control panel. • Retention data. • Training and development of staff. • Exit interviews. • Appraisals. • Bank and agency teams. • Clinical workforce plans. • Staff survey (national and local). • Flexible working.	• Performance review groups. • Retention data and exit interviews to people committee. • Staff survey results reported to people committee. • Vacancy levels monitored through finance committee. • Training data to people committee. • ICB /HRD oversight group.	• Vacancy control to be monitored through ESR – October 24 • People data integrated performance report and dashboards to be developed for people committee – from 31.07.2024	
Failure to develop workforce plans which identify current and future gaps (including new workforce models) to meet service demands.	• Establishment control. • Vacancy control panels. • Clinical board and corporate service establishment controls. • Rota plans. • Job plans for medical staff. • Bank and agency provision to cover rota gaps. • Safe staffing nursing models. • International recruitment. • Apprenticeship schemes in some areas of nursing. • Trainee intake and rotation. • Employment of local employed doctors.	• Performance review groups. • Retention data and exit interviews to people. committee. • Staff survey results reported to people committee • Vacancy levels monitored through finance. committee. • Training data to people committee. • ICB /HRD oversight group. • University placements. • NHS oversight of agency spend and control.	• Development of workforce plans within clinical boards to understand gaps and ways in which to address them including: Apprenticeships and funding streams International recruitment. University placement uptakes and developing new courses to meet service needs. Continued recruitment. Implementation of the workforce plan at regional level. - 31.10.2024	

Risk ID	2.1
Comments:	

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to develop, embed and maintain an organisational culture in line with our Trust values and the NHS people promise.	**Strategic objective**	3. We want this to be a great place to work where everyone feels supported appropriately by the organisation and compassionate leaders. We will always be civil and respectful to each other so that relationships within and across the teams will improve.

Lead Committee	People Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Patient and Staff Experience/Chief People Officer	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	01.05.2024	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating**
Staff do not feel valued and heard by their managers and leaders and the Trust.	• FTSUG in place with additional capacity from 1st May 24. • Implementation of a large-scale patient and staff experience programme as a cultural intervention • Transparent and timely sharing of all staff and patient feedback. • Opportunity for anonymous feedback via work in confidence. • 100 days review: feedback from 4500 staff with qualitative analysis of staff concerns – feedback to all staff via video within 2 weeks of the survey closure. • Civility and micro-aggression training.	• People Programme Board (operational group) - minutes and highlight reports. • Reports and minutes of Executive Team. • Minutes from TMG. • People Committee reports and minutes. • CQC oversight group. • QIP oversight group. • ICB regional group. • Clinical and Corporate Town Hall events • Focus Groups to hear staff views (with external facilitation. • Staff survey (national). • Quarterly surveys aligned to the People Plan. • Direct access to the CEO. • CEO roadshows. • CQC feedback. • JLNC and EPF.	• Implementation of the People Strategy 24/27 one of the key themes is “feeling valued and heard” - Board July 24. • Staff and patient experience data to be developed - June 24 • FTSU policy to be reviewed – September 24. • FTSU champions to be reviewed – September 24. • Widescale roll out of civilities training September 2025. • Embedding a staff and patient experience improvement programme (March 2026).	
Staff from minority groups feel bullied and discriminated against.	• Staff network groups and executive sponsors for the network groups. • Equality, Diversity and Inclusion Steering Group • Civilities and micro-aggression training. • Quarterly internal staff survey to monitor and measure staff experience broken down by groups. represented by protected characteristics.	• EDI dashboard information to clinical board and corporate areas. • Staff survey broken down by staff groups. • Minutes of EDI steering group. • Minutes of People Committee. • WRES/WDES action plans. • NHSI oversight. • WRES and WDES data.	• Timeout session with staff network groups representative to from next steps and inform. WRES/WDES action plans – May 24. • Action plan to improve WRES and WDES performance coproduced with staff networks – July 2024.	

Behaviours and incivilities impacting negatively on the quality and safety of patient care, staff morale, retention, and organisational productivity.	• All of the above and: • Dignity and Respect policy. • Facilitated conversations and mediation. • Grievance procedure to raise concerns.	• EDI, HR and OD teams recorded complaints. • People Programme Board (operational group) - minutes and highlight reports. • Reports and minutes of Executive Team. • Minutes from TMG. • People Committee reports and minutes. • CQC oversight group. • QIP oversight group. • Evaluation from training. • Feedback from focus groups.	All of the above plus: • Implementation of the People Strategy 24/27 one of the key themes is "behaviours and civility" - Board July 24 • Implementation of a civility charter setting out standards of expected behaviours - June 24	
Staff do not speak up about issues that cause them concern.	• New FTSUG in place from 1st May 2024 with increased capacity to 22.5 hours. • Datix system been reviewed to encourage. • Direct access to CEO including website with direct access to CEO, CPO, and Board chair. • Work in confidence system – concerns reported directly to the executive team.	• FTSU issues reported to People Programme board and workforce group. • FTSU reports on themes and issues reported to People committee. • Datix reports on themes issues to quality committee. • Work in confidence system reports on themes and issues reported to the People committee.	• FTSU guardian to visit all clinical and corporate areas and raise awareness with staff – from May 24. • Information sheets to be available for all staff to outline the various ways in which they can speak up safely – July 24. • Embed patient safety briefings encouraging more speak ups. • Analysis of staff survey feedback tracking psychological safety – trust wide report April 2025. • Anonymised, real time staff feedback piloted in summer 2024. • Visibility of senior leaders – Exec walkabouts.	

Risk ID	2.2
Comments:	

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to effectively develop and implement a new approach to leadership and organisational development to ensure that everyone feels supported appropriately by the organisation.	**Strategic objective**	4. We want this to be a great place to work where everyone feels supported appropriately by the organisation and compassionate leaders. We will always be civil and respectful to each other so that relationships within and across the teams will improve.

Lead Committee	People Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Chief People Officer	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	01.05.2024	**Risk Score**	**20**	**16**	**4**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating**
Capability and capacity of leaders and managers to support staff.	• Interim leadership development strategy in place. • Job descriptions outlining leadership expectations. • PLB – professional leadership behaviours currently linked to appraisals (to be removed from late 24). • Management structures in place within CB and corporate areas. • Clinical leadership model. • Data on people metrics: sickness, turnover, leadership, HWB. • Exit interviews. • Succession plans.	• HR and OD support. • Monthly operational performance reviews. • Appraisals People Programme Board. (operational group) - minutes and highlight reports. • Minutes from TMG • Leadership data from staff and patient survey. • People Committee reports and minutes. • CQC oversight group. • QIP oversight group. • Staff survey (national and local). • WRES and WDES data.	• Implementation of the People Strategy 24/27 one of the key themes is “Leadership and Management” - Board July 24. • Review of appraisal process for leaders and managers linked to the four themes of the People Strategy – September 24. • Leadership Development Training pilot to be run from June 24. • Introduction of Leadership. competency framework for Board members – from April 24. • Introduction of value/leadership competency into our recruitment processes – incrementally from June 24. • Review of People committee agenda to include more people data. • Value based recruitment.	

Failure to support staff with their health and wellbeing resulting in absence creating service pressures impacting their ability to deliver a high-quality service to patients.	• Health and wellbeing offer in place for staff. • Flexible working policy. • Flexible rotas. • Benefits programme for staff including salary sacrifice. • Attendance management policy. • Bank sand agency staff to cover shifts. • Access to occupational health. • Health workplace initiatives. • Seasonal food offers. • Mental first aiders in place (some areas). • Psychological support (some areas). • Health and Wellbeing co-ordinator. • HWB champions. • Charity supported HWB initiatives.	• HR and OD support. • HWB steering group – minutes. • Minutes from TMG. • People Committee reports and minutes. • CQC oversight group. • QIP oversight group.	• Implementation of the People Strategy 24/27 one of the key themes is “Health and Wellbeing” - Board July 24. • Gap analysis of HWB offer for staff to be undertaken – September 24. • Review of psychological support for staff – setting out options for the way forward – July 24.	
Current culture does not allow for flexible and responsive leadership to support staff and make them feel valued.	• Transformation of HR. • Changes to board and key leadership roles • HR, OD support and intervention • Targeted and focussed OD support in hotspot areas • Leadership and management training in place • Staff Networks / EDI steering groups • FTSU guardian in place	• HR and OD support • Monthly operational performance reviews • Appraisals • People Programme Board (operational group) - minutes and highlight reports. • Minutes from TMG • Leadership data from staff survey • People Committee reports and minutes • CQC oversight group • QIP oversight group • Staff survey (national and local) • TMG with focus on leadership	• Implementation of the People Strategy 24/27 one of the key themes is “Leadership and Management” - Board July 24. • Review of appraisal process for leaders and managers linked to the four themes of the People Strategy – September 24. • Leadership Development Training pilot to be run from June 24. • Introduction of Leadership competency framework for Board members – from April 24. • Introduction of value/leadership competency into our recruitment processes – incrementally from June 24. • Management skills training with focus on People over Process from June 24. • Review of key HR policies and processes aimed at supporting staff – September 24.	

Risk ID	2.1

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Inability to sufficiently influence priorities and actions of key partnerships (including the Great North Healthcare Alliance, the ICB, Provider Collaborative and Newcastle place arrangements) impacting on our ability to effectively deliver local and regional healthcare commitments.	**Strategic objective**	7. Our communities depend on us as the main regional centre, a key city partner and an employer. We acknowledge this responsibility and will make sure we deliver on our commitments.

Lead Committee	Trust Board	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Martin Wilson, Chief Operating Officer	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	Finance/VfM
Date Added	01.05.2024	**Likelihood**	**4**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	01.05.2024	**Risk Score**	**16**	**12**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating**
Lack of appropriate Board, Executive and senior clinician capacity to influence the key partnerships.	• Great North Healthcare Alliance Steering Group, with Chair and CEO as members • ICS Board • Provider collaborative leadership board • Newcastle place based ICB sub-committee • Collaborative Newcastle Joint Director Team • Great North Healthcare governing principles based around improved collaborative working whilst retaining organisational independence.	• CEO member of Great North Healthcare Alliance Steering Group and provider collaborative leadership board • Exec lead director as part of Alliance Formation Team • Executive Directors leading appropriate Alliance work streams with peers. • Director of Operations (family health) member of Newcastle Place ICB sub-committee • Great North Healthcare Alliance Steering Group Minutes • Great North Healthcare Alliance bi-monthly update to Trust Board • ICB/Provider Collaborative and PLACE Minutes • Legal support to ensure legislative compliance with establishment of Great North Healthcare Alliance	• Creation of Great North Healthcare Alliance Committees in Common – 01.09.2024 • Development of GNHA work plan including specific work streams with executive and clinical leadership and appropriate resourcing – 01.09.2024. • Agree arrangements for ICB Place based sub-committee following creation of ICB joint team for Newcastle and Gateshead – 01.09.2024. • Development of NUTH Clinical Strategy – 31.04.2025	

Risk ID	7.1
Comments:	

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2024					
Title	Update from Committee Chairs					
Report of	Non-Executive Director Committee Chairs					
Prepared by	Miss Jayne Richards, PA to Interim Chair and Trust Secretary / Corporate Governance Officer					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	The report includes updates on the work of the following Trust Committees that have taken place since the last meeting of the Trust Board in March 2024: ○ People Committee – 16 April 2024 and 15 May 2024 ○ Quality Committee – 23 April 2024 and 14 May 2024 ○ Digital & Data Committee – 18 April 2024 ○ Finance & Performance Committee – 22 April 2024 ○ Audit, Risk & Assurance Committee – 23 April 2024					
Recommendation	The Board of Directors is asked to (i) receive the update and (ii) note the contents.					
Links to Strategic Objectives	Links to all strategic objectives					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☒	☐
Link to Board Assurance Framework [BAF]	No direct link.					
Reports previously considered by	Regular report.					

UPDATE FROM COMMITTEE CHAIRS

EXECUTIVE SUMMARY

This report provides an update to the Board on the ongoing work of the Trust's Committees for those meetings that have taken place since the last meeting of the Board of Directors in March 2024.

UPDATE FROM COMMITTEE CHAIRS

1. PEOPLE COMMITTEE

A meeting of the People Committee took place on 16 April 2024 and 15 May 2024. During the meeting, the main areas of discussion included:

- CQC Action Plan (People matters).
- Freedom to Speak Up / speak in confidence triangulation report.
- A People Priorities Update.
- Education and Training – Apprenticeships update.

- The Head of Workforce Engagement & Information shared Performance and Delivery – People and Culture Dashboard.
- Items to consider included Employee Relations, Legal cases update, the People Committee Risk Quarterly Report (BAF), New and Emerging Risks, the Annual Report of the Committee and Maternity Safety Champion.
- Minutes of the Learning and Education Group for the 29 January 2024 meeting were received.

During the meeting on 15 May 2024, the main areas of discussion included:

- The CQC Action Plan (People matters).
- The People Programme / People Priorities Update.
- The Leadership and Management Development Offer.
- The Staff Survey 2023 and Internal Staff Survey.
- A Clinical Board Update.

- The Chief People Officer shared the People and Culture Data.
- Items to consider included WRES &WDES Reports, People Strategy, New and Emerging Risks.
- Minutes of the Learning and Education Group meeting were received, along with minutes from the EDI Steering Group, the Health & Wellbeing Group, and the Sustainable Healthcare Committee.

The next formal meeting of the People Committee will take place on Monday 24 June 2024.

2. QUALITY COMMITTEE

Meetings of the Quality Committee took place on 23 April 2024 and 14 May 2024.
During the meeting on 23 April 2024, the main area of discussion were:

- Cancer Patient Harms Review
- Outpatient Transformation Programme
- Wards of Concern
- Cardiac Oversight Group
- Patient Safety Incident Response Framework (PSIRF) Priorities Internal Referrals
- Maternity Update
- Patient & Staff Experience
- Board Reports:

        - Quality (IBR)
        - Performance
    - Quality Committee Risk Report (BAF)
    - Summary of feedback from NED Informal visits
    - Alliance

The main areas of focus during the meeting on 14 May 2024 included:

- End of Life and Palliative Care
- Cardiac Oversight Group Update
- CQC:
    - Medicines Management Reconciliation Governance
    - NECTAR
- Maternity Report
- CNST – Year 6
- PSIRF Update
- Marthas Rule
- Enhanced care observation internal audit report
- Duty of candour
- Patient Experience and Engagement Group (PEEG) Management Group Report
- Mortality / Learning from Deaths Q4 Report
- Quality Account
- Board Reports:
    - Quality (IBR)
    - Performance
- Annual Report of the Committee
- Legal Cases Update
- Paediatric Audiology Visit
- Receipt of Minutes from:
    - Compliance & Assurance Group.
    - Patient Experience & Engagement Group (PEEG).
    - Patient Safety Group.

The next meeting of the Quality Committee will take place on 18 June 2024.

3. DIGITAL & DATA COMMITTEE

The Digital & Data Committee took place on Thursday 18 April 2024. During the meeting, the main areas of discussion included:

- Chief Information Officer (CIO) Report including digital performance report and partnerships update
- SIRO Report including Data Security & Protection (DSPT), Information Governance and Cyber Security.
- Digital/Data incident review.
- External/Internal audit/review reports related to Digital & Data.
- Emerging risks.

- Strategic Digital & Data Priorities/Updates.
- Overview of Digital change projects.
- Digital financial plan/position/investments.

The next meeting of the Digital & Data Committee will take place on 4 June 2024.

4. FINANCE & PERFORMANCE COMMITTEE

A meeting of the Finance & Performance Committee took place on Monday 22 April 2024. During the meeting, the main areas of discussion included:

- Emergency Department Performance Recovery Plan.
- Month 12 Finance Report.
- Month 12 Performance Report.
- Planning Submission 2024/25.
- Finance & Activity.
- Tenders (PR) and Business Cases (BC) for approval included:
    - Medicines Manufacturing Centre (formerly known as the Aseptics Hub)
- New/emerging risks.

The next meeting of the Finance & Performance Committee will take place in 20 May 2024.

5. AUDIT, RISK AND ASSURANCE COMMITTEE

A meeting of the Audit, Risk and Assurance Committee took place on 23 April 2024. During the meeting, the main areas of discussion included:

- An overview of the refreshed risk management structure and risk escalation arrangements including risk profile by Clinical Board and Corporate Departments.
- Risk Management Policy, which was approved subject to some minor amendments.
- The Annual Board Assurance Framework and Risk Management Report including the end of year position including Development of the new BAF.
- Compliance and Assurance Group reporting.
- Escalations from other Board Committees to ARAC.
- Internal Audit
    - Progress Report
    - Annual Plan 2024/25
    - Draft Head of Internal Audit Opinion
- Counter Fraud
    - Activity Report including Fraud response log
    - Annual Plan and Annual Self Review Tool
- The External Audit Strategy Memorandum 2023/24.
- Trust Annual Financial Statements and TACs, including financial reporting/timetable matters, Accounting Policies, Estimates and Judgements

  - The Going Concern Statement.
  - Progress in drafting the Annual Governance Statement.
  - Annual Review of Special Severance Payments/Settlement Agreements
  - Committee Self-Assessment of effectiveness and Audit Committee Annual Report including Terms of Reference/Schedule of Business.
- Items to receive included a review of the schedule of approval single tender action and breaches and waivers exception report, Debtors and Creditors balances and the Schedule of losses and Compensation.
- Minutes of the Finance Committee, People Committee and Quality Committee were received.
- AuditOne Benchmarking report

The next meeting of the Audit, Risk and Assurance Committee will take place 25 June 2024.

Report of Jayne Richards
PA to Interim Chair and Trust Secretary / Corporate Governance Officer
17 May 2024

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BOARD MEETINGS - ACTIONS

Agenda item A15

Log No.	BOARD DATE	PRIVATE / PUBLIC	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
112	25 January 2024	PUBLIC	24/02 STRATEGIC ITEMS v) Performance: Performance Report	Miss Smith queried the cost of the dermatoscopes and if an increase in the number of those available would have a timely impact on reducing waiting times to which the COO noted that the maintenance and replacement of the dermatoscopes was the main barrier. The COO would liaise with the ICB to explore the cost of addressing the maintenance contracts issue [ACTION01]	MW/NK			22.03.24 - Update requested. 16.05.24 - AM chased MW/NK for update
114	28 March 2024	PUBLIC	24/07BUSINESS ITEMS: i) Director reports: a. Joint Medical Directors Report; including:	The Interim Chair noted that previous reports had included biographies of the successful candidates and it would be helpful to include in future reports to demonstrate diversification of expertise and skills. She agreed to discuss further with the JMD-LPC [ACTION01].	KM/LPC			17.05.24 - Report content to be discussed in advance of the next Board meeting.
115	28 March 2024	PUBLIC	b) Executive Chief Nurse; including:	Mr Chapman extended an invite for a staff member to attend a future Quality Committee to share their experience of preceptorship and also to undertake a deeper dive in to how that preceptorship is executed [ACTION02]	IJ			17.05.24 - Item to be discussed with the new Quality Committee Chair.
116	28 March 2024	PUBLIC	d) Healthcare Associated Infections (HCAI)	Mr Chapman questioned how difficult it was to baseline AMS to measure improvement to which the DIPC noted that due to competing priorities, monthly audit compliance was currently 30% with the target being 80%. Mr Chapman advised that he would welcome a more in-depth discussion at a future Quality Committee [ACTION03].	IJ			17.05.24 - Item to be discussed with the new Quality Committee Chair.

KEY

NEW ACTION	To be included to indicate when an action has been added to the log.
ON HOLD	Action on hold.
OVERDUE	When an action has reached or exceeded its agreed completion date. Owners will be asked to address the action at the next meeting.
IN PROGRESS	Action is progressing inline with its anticipated completion date. Information included to track progress.
COMPLETE	Action has been completed to the satisfaction of the Committee and will be kept on the 'in progress' log until the next meeting to demonstrate completion before being moved to the 'complete' log.