The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Public Trust Board of Directors' Meeting

Wednesday 17 July 2024, 12:15 – 13:15

Venue: Boardroom, Freeman Hospital

Agenda

Item		Lead	Paper	Timing
1.	Apologies for absence and declarations of interest	Kath McCourt	Verbal	12:15 – 12:16
2.	Minutes of the Meeting held on 23 May 2024 and Matters Arising	Kath McCourt	Attached	12:16 - 12:17
3.	Chair's Report	Kath McCourt	Attached	12:17 – 12:19
4.	Chief Executive's Report; including updates on: - CQC; and - Cardiac Surgery	Jim Mackey	Presentation	12:19 – 12:25
Strategic items:				
5.	Patients: Patient and Staff Stories	Annie Laverty	Attached	12:25 – 12:30
6.	Patients: Health Inequalities Update	Michael Wright and Martin Wilson	Verbal	12:30 – 12:35
7.	People: People Strategy (Plan) 2024 - 2027	Christine Brereton	Attached	12:35 – 12:40
8.	Performance: Integrated Board Report	Rob Harrison	Attached	12:40 – 12:45
9.	Partnerships: GNH Alliance	Martin Wilson	Attached	12:45 - 12:50
Items to receive *[NB for information – matters to be raised by exception only]*:				12:50 – 13:00
10.	Director reports: a. Joint Medical Directors Report; including: i) Consultant Appointments ii) Guardian of Safe Working Quarter 4 Report and Annual Report 2023/24	Michael Wright	Attached	
	b. Executive Director of Nursing; including: i) Midwifery Staffing update ii) Nurse Staffing Review Report	Ian Joy	Attached	
Items to approve				13:00 – 13:10
11.	i) Trade Union Facility Time Report	Christine Brereton	Attached	
	ii) Updated People Committee Schedule of Business	Christine Brereton	Attached	

	iii)	Fit and Proper Persons Statement	Christine Brereton & Kelly Jupp	Attached
	iv)	Annual Modern Slavery Statement	Kelly Jupp	Attached
12.	Board Assurance Framework (BAF) 2024/25		Caroline Docking	Attached

Any other business: 13:10 – 13:15

13.	Update from Committee Chairs	Committee Chairs	Attached
14.	Meeting Action Log	Kath McCourt	Attached
15.	Any other business	All	Verbal

Date of next meeting:
Public Board of Directors – Thursday 26 September 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 Michael Wright, Joint Medical Director

Mr Martin Wilson, Chief Operating Officer

Mrs Christine Brereton, Chief People Officer

Ms Annie Laverty, Chief Experience Officer

Mrs Caroline Docking, Director of Communications and Corporate Affairs

Mrs Kelly Jupp, Trust Secretary

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 23 MAY 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]
	Mrs L Pareja-Cebrian	Joint Medical Director [JMD - LPC]
	Mrs J Bilcliff	Chief Finance Officer [CFO]
	Mr Ian Joy	Executive Director of Nursing [EDN]
	Dr V McFarlane Reid	Director for Commercial Development & Innovation [DCDI]
	Ms S Edusei	NED
	Mr J Jowett	NED
	Mr B MacLeod	NED
	Mrs L Bromley	NED
	Mrs A Stabler	Interim NED
	Mr B McCardle	Interim NED

In attendance:
Mrs C Docking, Director of Communications and Corporate Affairs [DCCA]
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
Mr D Black, Public Governor
Ms K Booth, Consultant Cardiothoracic Surgeon, NUTH
Ms S Rutherford, Head of Nursing, NUTH
Ms L Dodd, Associate Director of Operations, NUTH
Ms A Kennedy, Director of Operations, NUTH
Ms S West, Clinical Board Chair, NUTH
Ms D Youssef, Director of Operations, NUTH
Mr D Crossland, Consultant Paediatric Cardiologist, NUTH
Mr N Chilvers, Hon RSC Clinical Fellow in Cardiothoracic Surgery, NUTH
Mr F Oezalp, Consultant Cardiothoracic Surgeon, NUTH
Ms S Gamio, Public
Mr R Purewal, Public
Ms A Redfearn, Public
Ms S Carr, Public
Mr I McPhearson, Public

Secretary: Mrs G Elsender — Corporate Governance Officer & PA to the Chair and Trust Secretary

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

24/10 STANDING ITEMS:

i) Apologies for Absence and Declarations of Interest

Apologies were received from Ms Jill Baker, NED, and Mrs A O'Brien, Director of Quality and Effectiveness [DQE].

Mrs Stabler declared an interest in being a substantive NED at Gateshead Health NHS Foundation Trust and as a Trustee at St Oswald's Hospice, and Mr McCardle declared an interest as being a substantive NED at Northumbria Healthcare NHS Foundation Trust.

It was resolved: to (i) **receive** the apologies for absence and (ii) **note** the new declarations of interest.

ii) Minutes of the previous meeting held on 28 March 2024 and matters arising

The minutes of the meeting held on 28 March 2024 were accepted as a true record of the business transacted.

It was resolved: to **agree** the minutes as an accurate record 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.

Following the inspection findings raised by the Care Quality Commission (CQC), the Interim Chair wished to acknowledge the pace of work, together with the effort and energy from staff to respond to the findings, and to improve performance and efficiency.

There had been some recent visits from senior colleagues including Professor Sir Stephen Powis, National Medical Director of NHS England (NHSE) and Professor of Renal Medicine at University College London, and the National Clinical Director for Stroke. Useful discussions were held with Trust colleagues and both visitors visited the Thrombectomy service at the Royal Victoria Infirmary (RVI).

The Great North Healthcare Alliance (GNHA) continues to move at pace and held its first launch event and formal meeting of all Board members on 2 May 2024. This was a well-received event with a positive atmosphere, and real progress made.

St James Park was the venue for the Annual Medical Education conference in April. Gratitude was expressed to Dr Ifti Haq, Director of Medical Education, and his team for scheduling the event and attracting a large number of colleagues with Chris Turner, (Civility saves lives), as keynote speaker, alongside well attended workshops.

The Interim Chair, together with the CEO attended the recent Senior Medical Staff Committee meeting, and was pleased to receive an update and progress of the work of the Local Negotiating Committee (LNC).

The Interim Chair had undertaken a series of informative visits to the Great North Childrens Hospital, Freeman Mortuary, RVI Laboratories and the Patient Services Command Centre. She noted that these display the significant and varied work that takes place across the organisation.

'Spotlight' sessions with the NED's continued, and most recently the NEDs heard from Genetics and End of life Care teams.

Governor Working Groups have also continued. The Council of Governors last met on 18 April 2024 for a private workshop which included a discussion on the Governor Development Programme with representatives from The Value Circle (tvc) discussing feedback from the Governor survey.

The Interim Chair explained there had been some changes to the governance arrangements, and changes within the Board composition, which reflected requirements of the CQC, Integrated Care Board (ICB) and NHSE. She welcomed the NED support from both Gateshead Health and Northumbria Healthcare NHS Foundation Trusts.

It was anticipated that the Annual Members Meeting (AMM) would take place on 17 July 2024 and Sir Paul Ennals would become Interim Shared Chair following the AMM. Discussions would take place at future Council of Governors meetings regarding the appointment of a substantive Chair, including consideration of a substantive Joint Chair model. Recruitment also continued for new NEDs.

The Interim Chair formally welcomed Mrs Anna Stabler and Mr Bernie McCardle, Interim NEDs. She highlighted the greater time commitment required of the NEDs and acknowledged the work of the non-executive colleagues who had recently left the Board, being Mr Graeme Chapman and Miss Christine Smith. The Interim Chair also thanked Ms Jill Baker and Ms Steph Edusei who would be stepping down as NEDs at the end of May 2024.

The Interim Chair referred to Infected Blood Inquiry, the report of which published on 20 May 2024 set out a catalogue of failures in relation to blood and blood products which led to great suffering and the loss of many lives. She noted that the Prime Minister had issued an apology on behalf of successive governments. Amanda Pritchard, Chief Executive of NHSE also issued a public apology on behalf of the NHS.

It was noted that the Trust had provided evidence to the inquiry and was referenced in the report. The Board acknowledged the role played by Newcastle Hospitals and extended their

deepest sympathises to everyone affected. The report will be considered in detail and the Trust will work with NHSE to respond to the recommendations of the inquiry. Arrangements have been made to support patients and families and the public who have contacted the Trust with concerns, the information of which was available on the website.

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

iv) Chief Executive's Report

In addition to the Interim Chairs description of a very busy period, the CEO highlighted the following points:

- There had been a strong focus on patients and staff engagement, having listened to patients and staff stories to build and learn from them.

  Significant engagement had taken place over the previous few months with staff through roadshows and specific staff group sessions, including whistleblowers who had been very open and honest. Following this engagement, several actions had been identified to take forward.
- There had been significant improvement in performance on elective care having reduced the overall Trust waiting list size by approximately 8%, and the Trust had been de-escalated from the national tiering process of oversight following improvements made.
- A good rhythm had been established in terms of the reporting of information and collation of evidence to address the CQC requirements, working towards having the licence restrictions lifted with an anticipated re-inspection taking place during Autumn.
- Whilst making the improvements noted above, focus was also on making improvements in the workplace in relation to safety and providing higher standards of care, as well as improving health and wellbeing of staff.
- Whilst there had been some negativity arising from the CQC inspection findings, it was important to acknowledge the great work being undertaken in the Trust which should be celebrated and shared publicly.

The CEO echoed the thanks of the Interim Chair to former NED colleagues and also thanked the Interim Chair for her support since she had commenced in role.

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

24/11 STRATEGIC ITEMS:

i) Patients: Patient Story

The CXO gave an overview of a patient's story which focussed on a woman with autism as she recounts her experience of care during three recent outpatient appointments in Ophthalmology. On each occasion communication was very poor and, at times, disrespectful. She described 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 was evident. The story was 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, the staff story was a positive one. It was shared by one of the administrators in the Cardiothoracic team. A moving example of someone who was highly motivated to provide a person-centred service across directorates and departments, a proud advocate for patients who went out of her way to support the needs of a father and his terminally ill son.

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

ii) Patients: Cardiac Surgery Update

The CEO explained that several external reviews had been undertaken within Cardiac Surgery over a long period of time. He highlighted that addressing the recommendations had been difficult, but was crucial in rebuilding and re-developing services to ensure resilience and future sustainability.

It was noted that there had been some consistent themes within the external reviews which needed to be addressed for the organisation to move forward. In the interests of transparency, the contents of the external review reports would be shared publicly on the Trust website. It was acknowledged that some issues had not been resolved timely, but a commitment was made to addressing the issues, drawing a line on the past and focussing on moving forward.

The CEO noted that the reports detailed some difficult messages which had also been referenced in the standalone CQC inspection report.

The JMD - MWr highlighted the following points:

- There had been concerns in several different aspects of care within Cardiothoracics, particularly in adult cardiac surgery dating back to 2017.
- Several different reports had been published following the external reviews undertaken, and these had all been reviewed in detail.
- The Trust invited the Royal College of Surgeons to undertake an external review following some issues raised regarding culture and behaviours. The report identified some concerns, particularly in relation to culture and training.
- The standalone CQC inspection report was published in January 2024, and this followed a publication at the end of last year of a peer review by NHSE of cardiac and transplant services. Most recently the Adams Report was published which was commissioned specifically to look at the way in which the organisation had responded to those concerns raised during the period 2018 to 2021.
- The reports drew out several different recommendations which fall broadly under four main themes of Quality & Safety of patient care, Culture and ways of working, Governance Structures and Training.

- Cardiac surgery is complex, and not without risk, but it's important to emphasise that, overall, the Trust's results and outcomes for adult cardiac surgery are in line with that of other organisations of a similar type.
- Where colleagues have highlighted specific concerns about quality and safety, these have been investigated, addressed and appropriate action has been taken.
- Culture in the department is important in terms of maintaining Quality & Safety in patient care and the reports have highlighted concerns as to how staff work and interact with each other in the department.
- The external review reports also identified that there was a need to strengthen clinical governance and put in place better systems and processes to provide assurance to patients and staff that the Trusts services are safe and of high quality. A key part of this is people feeling safe and confident to report clinical and broader concerns where they see them and having the confidence that when they do, their concerns will be addressed, and appropriate action taken.
- A major programme of cultural change is underway which includes:
    - Strengthening new leadership arrangements and behavioural expectations;
    - Improving multi-disciplinary team processes and decision making; and
    - Improving the consistency of approach to referring clinicians from other regional hospitals, ensuring patients are transferred promptly and that the number of patients treated is in line with a unit of this size.
- As previously reported, there has been concern in relation to the quality of training available to cardiac surgery trainees and the experiences the trainees have had. The decision was taken for trainees to be removed from the Department. It was noted that the presence of trainees is a fundamental element to their development and the sustainability of the services therefore a supportive environment needs to be present to allow trainees to function effectively.
- There are several recommendations and actions in the reports to be collectively taken to improve the position.
- Work has been on-going for a long period of time to try and improve the position by several leaders within the organisation and the focus was now to ensure that the actions being taken are appropriately supported to deliver the changes needed to allow the department to prosper.
- The focus for the organisation now is on accountability and improvement through the actions and improvements made. There is a need to ensure the actions being taken are appropriately supported and deliver the change needed to allow the department to prosper.
- While there are some tough messages in these reports, it's important we get this right and that people can see change happening. Our key priority is ensuring patients have confidence in our services and the care and treatment they receive.
- The Trust is working very closely with the ICB and NHSE to monitor and measure close all of the improvements, including those outlined above.

Mrs Stabler noted that an extract from the action plan was shared with the Quality Committee on 14 May 2024 and a more comprehensive plan would be shared with the Committee in June. She questioned how assurance was being triangulated to which the JMD - MWr advised that there were a series of recommendations in the different reports from which a very detailed action plan had been developed to ensure all recommendations were

captured. He noted that many actions had been completed and there was now a much more consolidated plan with areas of focus highlighted. In addition, there were several groups in place to monitor the plan, progress and the processes in place. This not only provides reassurance but assurance through the evidence generated e.g. minutes of meetings, audits of processes and outcomes.

Ms Edusei welcomed the transparency which should allow learning for others both across the organisation and externally. This was echoed by JMD - MWr, recognising that whilst issues should be dealt with, it was important to take the learning and share across the organisation.

Mr MacLeod referred the recent Audit, Risk & Assurance Committee (ARAC) meeting where a deep dive of the cardiothoracic risk register was undertaken to which he noted confidence in the awareness and management of risks. He questioned the effectiveness of risk management within other Clinical Boards to which JMD - MWr advised that some Clinical Boards reflected the previous directorate structure whilst others were different teams brought together. Cardiothoracic was largely reflective of the previous directorate signifying some maturity however they had also fully embraced the benefits of the Clinical Board structure and the introduction of Patient Safety Incident Response Framework (PSIRF), as well as the establishment of the Quality Oversight Group (QOG).

Whilst providing assurance of quality and safety of the services provided for patients, IJ noted the equal importance of supporting staff within the Cardiothoracic Clinical Board and sought assurance as to what support was in place to support them compassionately during the process. The JMD - MWr noted that the key priority was to deliver a safe service to patients, therefore monitoring key indicators has provide assurance regarding safety. He noted that in order to deliver a safe and high-quality service staff need to be looked after and a great deal of effort has been afforded to engaging with staff and communicating the work that is being undertaken. This included Town Hall meetings and regular discussions with staff groups.

The CPO advised that support was in place for patients should they have concerns following publication of the reports, and staff would be given guidance about how to direct patients appropriately.

The CEO recognised there was a great deal of information to digest, however one of the commitments was to deal with the issues. The second commitment was to re-build and develop the service to ensure it is fit for the future. He reiterated that transparency would be key as plans were developed.

It was **resolved** to (i) **note** the update.

iii) <u>People: Fuller Inquiry Update</u>

The JMD-MWr highlighted the following points from the Trust response to the Fuller inquiry:

- The Fuller Inquiry was a response to the actions of David Fuller a maintenance technician within Maidstone and Tunbridge Wells NHS Trust who was able to gain entry in to the mortuary on many occasions to commit terrible actions.
- Several recommendations were made Maidstone and Tunbridge Wells NHS Trust which also apply to other trusts. These covered areas such as access to mortuaries, the monitoring of such access, employment checks and qualifications.
- Mortuary Services sits within Clinical and Research Services Clinical Board who have undertaken significant work to ensure the Trust complies with the recommendations of the Fuller Inquiry.
- An Action plan has been developed with only one outstanding action remaining. This relates to the appointment of a Mortuary Manager with interviews scheduled for 14 June 2024.
- Gratitude was expressed to the DoE and Estates team members for their support with the estates work needed to access to the mortuaries.
- The recommendations will continue to be monitored to ensure compliance is maintained. This will be done via regular updates by the designated individual for mortuaries under the Human Tissue Authority (HTA) Licence will provide regular updates to the Compliance and Assurance Group, reporting though to ARAC and on an annual basis to Quality Committee.

Mrs Stabler questioned if the Trust response/action plan was included in the Internal Audit plan to monitor against policy. The JMD-MWr agreed to follow up outwith the meeting **[ACTION01].**

Mr MacLeod welcomed the recommendations in the report and sought assurance that staff were comfortable in speaking up and raising any issues to which JMD-MWr advised that staff working in the mortuaries were very dedicated to their role and were confident to raise any issues. The Interim Chair added that her visit to the mortuary on the Freeman site had been a positive experience with staff being totally dedicated, showing respect and compassion to deceased patients and their families at all times. She noted that the security and restricted access measures were in place. Mr Jowett echoed the comments of the Interim Chair noting that during his visit to the mortuary at the RVI, the empathy shown by the staff to families was exemplary.

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

iv) People: WRES & WDES [FOR APPROVAL]

The CPO presented the reports which provided the Trust's position in relation to the Workforce Disability Equality Standards (WDES) and the Workforce Race Equality Standards (WRES) metrics for 2023/24 which required publication by 31 May 2024 on the Data Collection Framework website and the Trust's website.

The reports measure the experiences of disabled and black and minority ethnic staff (BME) compared to non-disabled and white staff. Metrics are taken from the annual staff survey and the electronic staff record (ESR). Whilst there have been some improvements on the

workforce disability standards, there had been decline in standards for bullying and harassment for both disable and BME staff.

The CPO expressed her disappointment and noted that focused action was being taken to address this as outlined within the report. She added that the Equality Diversity and Inclusion Steering Group (EDI) will focus on race equality for this year.

Ms Edusei echoed the disappointment of the CPO; however, she commended the staff networks and the Chairs of the staff networks who have been very active and supported staff within the networks.

It was resolved: to **note** the contents of the reports and **approve** publication on the Data Collection Framework website and the Trust's website.

v) Performance: Revised Integrated Quality & Performance Report

The MD presented the new report which now included performance rather than having a separate performance report. The aim of the report being to provide assurance to the Board on the Trust's performance against key indicators relating to Quality, Performance, People and Finance; and on the Trust's progress against NHSE performance priorities and key operational indicators.

The following points were noted:

- Work has been undertaken to improve information flows across the organisation to enable more informed decision making.
- Gratitude was expressed to the work of the DCDIs team in revising the report.
- The new report uses a 'Making Data Count' approach which incorporates Statistical Process Control Charts (SPC) which will support the Board in assurance and decision making.
- The report aligns to the NHS Oversight and Assessment Framework and the content and metrics will continue to be refined moving forward.
- The new use of SPC charts will allow the identification of trends and changes to facilitate corrective actions.
- Significant work had been undertaken across the organisation which had resulted in a positive reduction in pressure ulcers and falls.
- There had been an improvement in appraisal rates and improvements in reducing long waits for elective care.
- Areas requiring further improvement were detailed within the report, specifically in the emergency department whereby performance was relatively static. A comprehensive improvement plan was in place which had been discussed in detail at the Finance and Performance Committee meeting held earlier this week. There has been some significant changes in terms of investment in additional medical staff who will commence in post during the Summer.
- There had been further progress in relation to cancer standards, focusing on those patients waiting longer than over 62 days.

Whilst acknowledging that a rise in the reporting of incidents was a positive move, Ms Edusei questioned how the number of incidents benchmarked against Trusts of a similar size. The JMD-LPC advised that it was difficult to benchmark but the ambition was to create a culture where reporting incidents was normal and welcomed, and there was a dashboard that showed areas of reporting / under-reporting. In addition, incident data was being triangulated with other sources. Ms Edusei asked if there were other ways of measuring the culture of reporting to which the CXO advised that there were key metrics in the staff survey regarding staff feeling safe to report and also that when staff report incidents there will be action taken and communicated.

The MD advised that he, along with some of the Executive Team members and staff from the performance team had met with the national team who provide training on 'Making Data Count'. He was seeking to arrange some training for the Board as well as the analytics team to refine the process for a standard reporting approach which can be aligned across all of the committees.

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

vi) <u>Alliance</u>

The COO presented the report which provided an update on the ongoing work to form and develop the planning for the GNHA. It was noted that Newcastle upon Tyne Hospitals NHS FT, Gateshead Health NHS FT, Northumbria Healthcare NHS FT and North Cumbria Integrated Care NHS FT have agreed to work more closely together as the GNHA.

Many clinical staff already work across organisations and it was acknowledged that there is significant potential to work together to deliver benefits to patients and staff within their own organisations and in the wider region. The organisations will continue to respect the independence and the interdependence of each other.

The GNHA held a Leadership Event on 2 May which was well attended by the Alliance stakeholders. Work continues on the work programme through the Alliance Steering Group with Chairs and CEOs, and an update for which will be brought to a future Board meeting.

[Mr MacLeod left the meeting at 16:45]

Mrs Stabler noted that patients often assume that the organisations already work together and recommended that thought should be given to involving the patients with the work of the Alliance to aid with accessibility of services. The Interim Chair added that a key aspect being considered was the patient pathways across the organisations. The COO added that the report detailed the areas where there had been key challenges across the system but there had also been conversations relating to opportunities to work on areas that were already working well collaboratively.

AL noted that one of the opportunities was to look at a consistent way of measuring patient experience across the four organisations.

It was resolved: to **note** the progress to date.

24/12 ITEMS TO RECEIVE

i) Director reports:

a. Joint Medical Directors Report; including:

The JMD-LPC highlighted the work that had been undertaken over the last quarter in relation to PSIRF following its implementation on 31 January 2024, and the identification of the PSIRF priorities.

The JMD-LPC provided an update in relation to Martha's rule which had been created to support patients and relatives to have a clear point of escalation for concerns. She noted that applications had been made to become pilot sites at both the Freeman Hospital and the RVI, which were approved by NHSE on 29 April 2024.

Whilst the Trust was keen to provide a responder service there were some challenges in that the organisation does not currently have a paediatric Critical Care Outreach Team (CCORT) however alternative models are being explored.

Cancer performance remains a significant challenge although there has been progress particularly around the 28-Day Faster Diagnosis Standard. The current 62 day+ backlog is gradually falling and currently stands at 181 patients. This compares to 450 patients in September 2023 and 307 in December 2023.

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

(i) Consultant Appointments

There had been 12 consultant appointments since the last report.

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

b) Executive Director of Nursing; including:

The report provided the Board with a summary of key issues, achievements, and challenges within the Executive Director of Nursing (EDN) portfolio.

The EDN referred to the 'Spotlight' section of the report which provided an overview of the Trust's Health Care Support Worker (HCSW) Wisdom Group. The HCSW Wisdom Group was part of the NHSE endorsed programme 'Altogether Better' and is an informal forum in which HCSW members have a safe space to share experiences, undertake task and finish projects and shape their own agendas. The EDN noted the HCSW Wisdom Group are also involved in shaping the training, recruitment and retention work for HCSWs.

The EDN noted that 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 EDN.

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 vacancy position was improving, with the lowest level of vacancies being observed for a number of months. This was as a result of a successful recruitment campaigns domestically and internationally. A focus was now being placed on training for the high numbers of newly recruited staff.

The EDN wished to formally recognise the international recruitment team and all of the staff across the organisation who have supported the international recruitment programme. There had been over 500 international nurses recruited over the last 2 years, which was testament to the teams involved.

Mrs Stabler referred to the nurse staffing report and questioned how many wards were occupied by less than 85% of registered nurses, and how many red flags were reported. The EDN advised that "fill rates" are entered onto the safer staffing dashboard, RAG rated and reviewed monthly by the Nurse Staffing and Clinical Outcomes Group. Those with fill rates <85% are reported to the EDN monthly. The EDN agreed to meet with Mrs Stabler outwith the meeting to provide further clarification on the escalation and reporting process **[ACTION02].**

Whilst it was encouraging to see an improvement in recruitment levels Ms Edusei noted that a greater number of newly qualified staff would also create an added pressure until they were fully trained and embedded. Further, she noted that a lesser number of international nurses progressed beyond Band 5 and questioned what measures were in place to show that a career in leadership was available. The CPO advised that there was a focussed piece of work underway via a task and finish group, triangulating with WRES data which will highlight where the barriers to progression are for that section of the workforce. The results of this piece of work will be shared with the People Committee.

The EDN added that by pausing the international recruitment for this year will allow for targeted support for both newly qualified staff and international recruitments in relation to career development.

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

(i) <u>Maternity Update Report</u>

The report provided Trust Board members with an overview and update of the main priorities and quality considerations for the Maternity Service. The EDN noted that following the CQC inspection in January 2023 and the unannounced CQC core inspection of the service in July 2023, the Maternity Service is now monitored through a formal System

Oversight Framework (SOF) supported by the Local Maternity and Neonatal System (LMNS) and the Integrated Care Board (ICB).

Action Plans have been submitted in response to the findings and are monitored through the quarterly perinatal group meetings. Exit criteria from the additional oversight is expected to be agreed at the next quarterly meeting in August. The EDN assured the Board that there were no major concerns to highlight, albeit some additional focus was needed with the bespoke maternity triage system (BSOTS) in maternity assessment which was fully implemented in January 2024. A static team will be in place to work through the quality improvement process.

A multidisciplinary approach to the action plan would be taken, with the plan to be presented to the ICB to monitor progress. Any areas for escalation, will be identified via the quarterly perinatal review meetings and will be monitored internally through the substantive governance processes in the department and the Clinical Board.

Mrs Bromley endorsed the comments of the EDN and also highly commended the induction process for midwives which was a rigorous, extensive and well-resourced training programme.

Mr MacLeod referred to the recent All-Party Parliamentary Group Report on Birth Trauma and queried if there was any learning for Trust to be taken to which the Chair highlighted this was a key area that the new Director of Midwifery would be focusing on. The EDN noted that the report had just been released and further national correspondence was awaited.

It was **resolved:** to **receive** the report and **note** the contents within.

c) Director of Quality & Effectiveness:

(i) Maternity CNST - Year 6

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 a 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.

The report detailed the minor changes to the requirements to those of year 5. It was noted that the Trust has undertaken a gap analysis on the Year 6 requirements and is confident that all ten safety actions can be met.

The EDN advised that the Trust had received notification from NHS Resolution with a request to re-review the year 4 submission to ensure it was accurate and aligned to the requirements in the technical guidance following the publication of the CQC inspection report. He informed the Board that an in-depth review had been undertaken internally, and that the submission had previously been reviewed by internal audit for added assurance. A response was currently being drafted.

The EDN referred to safety action 5 in the report "Can you demonstrate an effective system of midwifery workforce planning to the required standard?" and noted that the Trust had completed the BirthRate+ workforce calculation in April 2024 with the report outlining recommendations expected imminently. Upon receipt of the revised staffing recommendation report, a full workforce review will be undertaken and an in-depth report will be presented to Trust Board in July 2024 **[ACTION03].**

Mrs Stabler referred to discussions at the previous Quality Committee meeting in relation to payments from the CNST Scheme and asked the Board to note that any funding should be ring-fenced for re-investment within Maternity Services. This was acknowledged by the CFO and the Board.

It was **resolved:** to **note** the contents of the 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.

(ii) Learning form Deaths Q4 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).

The report 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 in the mortality review database to ensure lessons are learned and shared.

The JMD-LPC noted that 524 patients had died within the Quarter 4 (January 2024 to March 24) of which 3 were determined to be potentially avoidable.

The JMD-LPC highlighted that the Standardised Hospital-level Mortality Indicator (SHMI) for October 2022 – September 2023 showed the Trust to be at 0.91, which was within the national "expected levels" and positively the lowest in the region.

Following a question from the Chair in relation to sharing any learning, the JMD-LPC advised that all learning was shared via the Patient Safety Group as well as other Patient Safety Forums and the Patient Safety Bulletin. Work was also being undertaken on a framework for communications.

Mrs Stabler noted that the Medical Examiner process had planned to incorporate all community deaths by April 2024 in line with NHSE guidance, however this had been postponed and therefore questioned if there was a timescale for this work to be restarted. She also queried what support would be provided to those organisations not fully incorporated into the process to which the JMD-LPC advised that discussions were currently ongoing and would be able to provide an update for Mrs Stabler outwith the meeting **[ACTION04].**

It was **resolved**: to (i) **receive** and (ii) **note** the actions taken to further develop the mechanisms for sharing learning across the Trust.

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 April 2024, highlighting the following points:

- This period identified HCAI themes relating to intra-vascular infections, mainly MSSA bacteraemia, in different clinical areas. Details of reviews and collaborative initiatives were outlined in the report.
- There had been 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.
- There had been an increase in pseudomonas and more careful consideration of risk assessments was needed when considering the environment risk for infections and the transmission to patients.
- There was a targeted approach for education and surveillance in relation to device management.

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

24/13 ITEMS TO APPROVE:

(i) Annual Committee Reports 2023/24, including Terms of Reference Reviews and Schedules of Business 2024/25

The TS presented the report, the purpose of which was 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 outlined overall achievements throughout the year and action points for continuing development during the coming year.

The Annual Reports, the Committee Terms of Reference (ToR) and the Schedules of Business (SoB) have been discussed at each respective Committee meetings. Minor changes have been made to the ToRs and SoBs to reflect the recent changes in governance arrangements and guidance.

It was noted that the Charity Committee 2023/24 Annual Report, ToR and SoB would be presented for approval at the July Trust Board meeting.

It was resolved: 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.

(ii) Quality Account

The EDN noted that the Quality Account is published annually which looks back on the previous year and sets put the Quality Priorities for the year ahead with engagement from both internal and external stakeholders. It was noted that the Quality Account had been presented to both Newcastle and Northumberland Oversight & Scrutiny Committees and feedback was awaited which will be added once received. This would be circulated with Board members once available [**ACTION05**].

The Quality Account would be shared with other forums such as the Advising on the Patient Experience Group (APEX).

The EDN noted that Quality Priorities for year ahead are lower in number but much more aligned to the Trust's strategic aims and PSIRF, and links to feedback following the CQC report as well as from staff. Once agreed it is important for the Trust to be able to demonstrably evidence improvement and alignment to the priorities.

The EDN noted that compliance against the priorities will be regularly monitored via the Quality Committee.

Ms Edusei questioned if there had been patient engagement to which the EDN advised that engagement had been through internal Groups and would take place through APEX. One of the priorities was to ensure the Trust has a systematic way of improving from patient and staff feedback in all its forms, the work undertaken by the CXO will be critical to this. Me Edusei highlighted the importance of co-production.

The DCCA noted that verbal feedback received from the Overview and Scrutiny Committees was that the approach taken this year to simplify the document and presentations had been welcomed.

It was **resolved:** to **approve** the Quality Account for publication.

24/14 **ANY OTHER BUSINESS:**

(i) **Board Assurance Framework (BAF) 2024/25**

The DCCA presented the report noting that 2024/25 Board Assurance Framework (BAF) had 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 report had previously been included in the Private Board papers but going forwards would be included in the Public Board papers for transparency.

The development of the revised BAF had been supported by governance experts tvc who were also supporting the Trusts wider improvement programme.

It was **resolved:** to **receive** the first iteration of the Board Assurance Framework 2024/25.

(ii) Update from Committee Chairs

The report was received, with the following additional points noted:

People Committee
Ms Edusei highlighted that work that had been undertaken in relation to the People Plan, which needs to be owned across the whole of the organisation.

Quality Committee
Mrs Stabler noted that there were no escalations from either of the Quality Committees in March or April, however the Committee would be seeking more assurance from information presented at future meetings.

Finance Committee
Mrs Bromley reiterated the significant financial challenge for the coming year.

Audit Committee
Mr MacLeod advised that in response to the CQC inspection report findings, significant work has been undertaken to refresh the risk management structure and escalation procedures and a new Risk Management Policy developed and approved at the Committee meeting in April.

Digital & Data Committee
Mrs Bromley noted the in-depth discussions in relation to data ownership management and the security of data with positive work ongoing.

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

iii) Meeting Action Log

The action log was received, and the content noted. Action 112 was agreed as complete and the remaining outstanding actions would be followed up and resolved where possible by the next meeting.

iv) Any other business

The Interim Chair thanked everyone for their attendance and formally thanked former NEDs Miss Christine Smith and Mr Graeme Chapman, as well as Ms Steph Edusei and Ms Jill Baker who would be leaving at the end of May 2024.

The meeting closed at 15:55.

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

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	17 July 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"
	  • Accident & Emergency (A&E), in relation to how they are dealing with continuous large numbers of patients.
	  • An in-person visit to the Social Work Department at the Royal Victoria Infirmary (RVI).
	• Governor and Member Activity.
	• Regional engagement with Foundation Trust (FT) Chairs of the North Integrated Care Partnership (ICP).
	• Engagement with FT Chairs and the Integrated Care Board (ICB) Chair and FT Chairs Forum.
	• North Sub ICP Chairs – Local Authority (LA) leaders, primary care & Voluntary Care Sector (VCS) representatives monthly meeting.
	• Great North Healthcare Alliance.
	• Alliance Steering Group.		

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"
    - A&E, in relation to how they are dealing with continuous large numbers of patients.
    - An in-person visit to the Social Work Department at the RVI.
- Governor and Member Activity.
- Regional engagement with Foundation Trust Chairs of the North ICP.
- Engagement with FT Chairs and ICB Chair and FT Chairs Forum
- North Sub ICP Chairs – LA leaders, primary care & VCS representatives monthly meeting.
- Great North Healthcare Alliance.
- Alliance Steering Group.

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

CHAIR'S REPORT

It has been another busy time for the Trust tackling issues raised by the Care Quality Commission (CQC) as well addressing performance and efficiency targets.

May was a busy month for the Governors as we held the Governor Elections and successfully appointed 9 new Governors which included 2 new staff Governors and an appointed Governor from Newcastle City Council. For Governors who chose not to re-stand in this year's Elections, or who were unsuccessful in being re-elected, I want to express my gratitude for the time and commitment they all gave to Newcastle Hospitals.

New Governor Induction – we held our New Governor Induction on 14 June 2024 where I was delighted to meet eight of our new Governors. Thank you to all who attended to support the induction session.

We interviewed for two new Non-Executive Directors (NED), one with financial expertise and one with legal. We have appointed David Weatherburn as our new NED with legal expertise and will welcome David to the Board in due course. We will be interviewing again for a NED with finance expertise.

The Great North Healthcare Alliance held its monthly meeting on 1 July 2024 and the Alliance Steering Group met on 4 July 2024 which were well attended.

Within the Trust I have undertaken clinical visits with Sir Paul Ennals (Chair of Northumbria Healthcare NHS Foundation Trust) to the Emergency Department, Maternity and the Command Centre at the RVI. At the Freeman Hospital Sir Paul and I visited Cancer Services, the Cardio Unit, Paediatric HDU – Cardio, the Day Treatment Centre and the Admissions Suite. These visits displayed the huge amount of hard work and dedication from our staff right across the organisation.

Spotlight sessions with the NED's continue and most recently we have heard from A&E, in relation to how they are dealing with continuous large numbers of patients and also attended an in-person visit to the Social Work Department at the RVI.

- **A&E** - Dr Chris Gibbins Consultant/Clinical Board Chair and Claire Pinder Director of Operations for Medicine and Emergency Care along with their team shared a presentation and discussed how the team are dealing with the continuous large numbers of patients arriving in A&E for care.

- **Social Work Department** - Joanne Westthorp, Christine McGorie and Julie Anderson conducted a tour of the Social Work Department and answered questions regarding the work they do for the Trust with regard to helping patients.

Governor and Member activity since our last meeting has included:

- The Quality of Patient Experience (QPE) Working Group which met on 4 June 2024, and discussions took place regarding the Governor visits process and the visits

template to provide feedback. They met again on 2 July 2024 and discussed the Governor reset items.

- The Business & Development (B&D) Working Group met on 13 June 2024 and a presentation was given by Wayne Elliott to give an update on Commercial activity. The B&D Working Group then met on 11 July 2024 and had a presentation from Martin Wilson, Chief Operating Officer on Strategy.

- The People, Engagement and Membership (PEM) Working Group met on 11 June 2024, and discussions took place regarding the next members event taking place on 1 August 2024: FOOD FOR THOUGHT: Addressing Food Insecurity in a Healthcare Setting. It was noted that there has been a significant improvement in new public members but a slight fall in staff membership. The PEM Working Group met again on 9 July 2024 where Christine Brereton presented an update on the People Plan.

- The Council of Governors met on 20 June 2024. In addition to the standing agenda items we received a very informative presentation on Care Optimisation Digital Update.

- An Extraordinary Council of Governors meeting was held on 5 July 2024 to approve the appointment of a new NED as referenced earlier.

At a regional level, I attended the ICB Chair and FT Chairs Forum on 18 June 2024, the North Sub ICP Chairs – LA leaders, primary care & VCS representatives monthly meetings on 13 June 2024 and 11 July 2024.

RECOMMENDATION

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

Report of Professor Kath McCourt
Interim Chair
11 July 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	17 July 2024		
Title	Patient and Staff Stories		
Report of	Ms Annie Laverty, Director of Patient and Staff Experience		
Prepared by	Miss Hannah Morrison, Personal Assistant		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☐	☒
Summary	Our Patient and Staff stories this month highlight the experiences of two people with HIV. The trust has recently begun work to become 'HIV Confident' and these patient and staff stories bring to life the reasons we need to undertake this work across Newcastle Hospitals. Despite all the advances in clinical care, life for people living with HIV can be difficult because of stigma and discrimination. HIV stigma is often based on outdated ideas and made worse by discrimination in other areas like gender, sexuality or race. To get to zero new cases of HIV, zero preventable deaths, and 100 per cent of people living well, we must fight stigma and discrimination. 'HIV Confident' members make a commitment to ensure that people living with HIV can access their services and work for them without fear of discrimination by committing to: • **Increasing** employee knowledge about HIV • **Improving** employee attitudes towards people living with HIV • **Tackling** stigma and discrimination within their organisation • **Providing** people living with HIV a way to report any stigma or discrimination they experience.		
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 focusing 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.

PATIENT STORY

Patient Story – Becky, 46 year old woman living in Newcastle

I will be talking about the impact of stigma. As a person with over 16 years lived experience with HIV, I have since the early days of my diagnosis tackled self-stigma, something that had never been an issue for me previously. Despite this, and also being a person that is outspoken about living with HIV, I still find myself feeling low, isolated and vulnerable whenever I am treated differently because of my HIV.

Stigma from friends and family is hurtful but even worse was what I experienced in the healthcare system. I remember in 2015 having gone in for a procedure on my spine at a local hospital. After confirming to the nurse that I had have HIV having put it on my pre-op form, the next time she came to my bedside my folder was decorated with a 'high risk' sticker on the cover and on every page within. Another time, at the RVI in 2020 having my baby, I had a tear after delivery. Whilst the midwife was suturing me she said she had a needle prick and the atmosphere in the room changed. Although she completed suturing me, she then left to go to A&E and another person came in to tend to me and my baby. Two other hospital staff came in and asked lots of questions which I was told was the procedure after any 'hazard'. It still left me feeling vulnerable, worried and guilty as the whole atmosphere felt like I'd put the midwife at risk and she might die or something. I kept assuring them that she would be OK as I am undetectable.

I would also like to share some other stories about healthcare stigma from fellow Blue Sky Trust members.

"they've isolated me off into rooms on my own when I have been admitted and told me they are doing that because of the HIV. They told me it was Trust policy to isolate anyone with a blood borne virus and barrier nurse them"

"I'm always put at the bottom of dental and hospital lists"

"I was compelled into disclosing my status when I went for my covid booster as I was under 40. The vaccinator then went to talk to other staff and came back wearing full protective equipment and took me to a separate room for the vaccination"

And lastly "after 3 or 4 attempts to extract blood, the health care assistant sought the help of an experienced nurse. The nurse was about to take my blood when I mentioned my HIV status. She visibly reacted, then said she better put gloves on. I was shocked at her response and assured her I was undetectable. I felt ashamed and when I got back to my car, I cried"

When told about HIV Confident, Becky shared: I know that HIV stigma and discrimination may never be easily eradicated. However, it can massively be reduced. Many people living with HIV have overcome self stigma and having to be stigmatised by organisations, especially those that provide primary health care can be devastating. I believe that organisations who want to be involved in changing this narrative can start by educating themselves and their whole workforce, and be committed to ensuring that everyone that is living with HIV involved with them can live without the fear of stigma and discrimination.

STAFF STORY

I am a staff member at Newcastle Hospitals, working in a busy and demanding clinical role. I have been living with HIV over twenty years. At no point during my training or employment have I felt able to share my status with my team, my manager, or even occupational health.

I know I struggle to accept my own status and carry a lot of stigma myself, but I have also witnessed my colleagues and managers saying negative things about people living with HIV, often in staff only spaces, and treating them differently. The thought of letting my colleagues know that I too am living with HIV is terrifying. During the covid pandemic I was absolutely petrified that I would be more at risk from the impact of covid because of my HIV, but I still did not feel I could share the reason for my additional fears and kept this all to myself. I worked every day with that fear huge in my mind. I bottled up my feelings and just got on with it. I don't feel there is really anyone safe I can talk to about my HIV, outside of my clinical team.

When told about HIV Confident, the staff member shared: I totally agree that this seems like a good idea. I am in for anything that can improve the life of someone and make it even better. We all should feel free to discuss our health issues without any boundaries attached to it, and nobody should be made to feel uncomfortable talking about their health condition.

We also have at least one other staff member currently living with HIV and working for the trust who did not even feel they could share their story or opinions anonymously, so scared are they of being identified and experiencing negative consequences. This is also impacting this staff member's ability to seek appropriate healthcare for themselves as they remain frightened that their status will be shared with people they work with.

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	17 July 2024		
Title	People Strategy (Plan) 2024-2027		
Report of	Christine Brereton, Chief People Officer		
Prepared by	Christine Brereton, Chief People Officer Donna Watson, Head of HR Strategy and Transformation		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☐
Summary	This report presents to the Board the People Strategy (Plan)– which outlines the strategic direction for our people plans for 2024-2027. The plan has been developed following extensive engagement with staff during 2023 and 2024 and has identified four key themes: 1. Health and Wellbeing. 2. Valued and Heard. 3. Behaviours and Civilities. 4. Leadership and Management. A year 1 plan has also been developed to support delivery of the plan.		
Recommendations	The Trust Board is asked to: 1. Approve the People Plan 2024-27 and its four themes (Appendix 1). 2. Note the supporting Year 1 delivery actions for 2024/25 (outlined in the plan pages 15-19). 3. Note the plans for ongoing communication and monitoring to ensure delivery of the People Plan and year 1 deliverable objectives (sections 4 and 5 of the report).		
Links to Strategic Objectives	People		

Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☒	☐

Link to Board Assurance Framework [BAF]	Risk ID: 2.1, 2.2 and 2.3.
Reports previously considered by	Presentation to People Committee on 18th April 2023, 22nd June 2023, August 2023, 17th October 2023, 9th January 2024, 20th February 2024, 15th May 2024 and 9th July 2024.

PEOPLE STRATEGY (PLAN) 2024-2027

EXECUTIVE SUMMARY

This report presents to the Board the People Strategy (to be known as the Newcastle Hospitals People Plan) – which outlines the strategic direction for our people plans for 2024-2027.

The plan has been developed following extensive engagement with staff during 2023 and 2024 which included:

- Staff survey (national survey November 2023 and local survey April 2024).
- Focus groups with a wide range of staff (October 2023 – February 2024).
- CEO Roadshows (January and May 2024).
- Retention data.
- WRES and WDES data (2022 and 2023).
- What matters to you programme (2022 - 2024).
- Engagement with, and partnership working with Staff side and Staff Networks.
- Freedom to speak up themes.
- Care Quality Commission (CQC) findings.

It is especially important to note the partnership working with staff side colleagues and staff networks in the development and creation of the plan. They have played a key role in providing valuable input and feedback throughout.

All the data and information gathered has been analysed and as a result four key themes have consistently been identified as:

1. Health and Wellbeing.
2. Behaviours and Civility.
3. Valued and Heard.
4. Leadership and Management.

As a result, the People Plan will focus around these four themes, each with aspirations, commitments and year on year objectives as identified through our supporting year 1 delivery action plan. The year 1 action plan will outline exactly what we will deliver and focus on during 2024/25. Work on these actions is already underway and delivering.

The ongoing and final development of the People Plan has been monitored through the Executive Team and People Committee during 2024. The People Committee will continue to monitor and seek assurance of delivery of the plan, especially focussed on the impact on our people.

A supporting communications plan has been developed which will help promote the plan and communicate this to staff across the Trust. Full engagement with the Clinical Boards and Support Services will be vital to the successful implementation of the plan. This will ensure that the actions are fully embedded and have the desired impact on improving staff experience, morale and retention as evidenced through our local and national staff survey.

PEOPLE PLAN – YEAR 1 DELIVERY PROGRAMME

1. INTRODUCTION

The purpose of this report is to present to the Board the People Strategy 2024-2027 (to be known as the Newcastle Hospitals People Plan) – which outlines the strategic direction for our people plans for the next 3 years. This will be supported by year-on-year delivery plans to ensure that the aspirations of the plan are achieved and delivered, and more importantly have the desired impact for our people.

The plan has been developed based upon direct feedback and engagement with our staff obtained in a number of different ways, including but not limited to:

- Staff survey (national survey November 2023 and local survey April 2024).
- Focus groups with a wide range of staff (October 2023 – February 2024).
- CEO Roadshows (January and May 2024).
- Retention data.
- WRES and WDES data (2022 and 2023).
- What matters to you programme (2022 - 2024).
- Engagement with, and partnership working with Staff side and Staff Networks.
- Freedom to speak up themes.
- CQC findings (November 2023).

Of important note, the People Plan has been fully endorsed and developed with the involvement from our internal partners including the Staff Networks, Staff Side and Freedom to Speak Up Guardian.

2. AIMS AND OBJECTIVES OF THE PEOPLE PLAN

Following the engagement programme, we have analysed all the data and intelligence received and overwhelming identified four themes that will form the basis of our People Plan, these are:

1. Health and Wellbeing.
2. Behaviours and Civility.
3. Valued and Heard.
4. Leadership and Management.

The plan will seek to:

Health and Wellbeing

"We will strive to create an environment where our people feel safe and well, experiencing care and compassion from leaders and colleagues."

Behaviours and Civility

"We will embed a culture of inclusivity and felt fairness where our people take responsibility for their own behaviours to others and feel safe to respectfully challenge the behaviours of others were these don't align to our values."

Valued and Heard

"*We will create the conditions where our people feel safe and supported to speak up and speak out about things that matter to them. We will celebrate the equality and diversity of our people and embed inclusion in all that we do."*

Leadership and Management

"We will develop, support and enable leaders at all levels to act with compassion and confidence so our people experience kindness, respect and dignity at work."

The overall aim of our plan is to address the feedback from our staff, so we can improve morale, staff experience and retention which will be beneficial not only for our staff but for our patients.

3. YEAR 1 DELIVERY PLAN 2024/25

To fully support delivery of the People, Plan, year on year plans will be developed. The objectives for 2024/25 have been identified, again based upon feedback from staff and staff partners about the priority areas. The year 1 delivery plan outlines objectives against the four themes of the Plan: Health and Wellbeing, Valued and Heard, Behaviours and Civilities and Leadership and Management (pages 15-19 of our People Plan).

The delivery plan will be a regular feature at the Executive Team and People Committee to ensure delivery and provide assurance that progress is being made against the actions.

Work has already commenced to deliver the year 1 people plan, examples include development of a behaviours and civility charter, the pilot of a leadership development programme for our front-line leaders focussed on compassionate leadership and the development of a sexual misconduct policy. Next steps will be to communicate the Plan fully to staff.

4. COMMUNICATING AND ENGAGING THE PEOPLE PLAN

A communication and engagement plan is actively underway in partnership with the Communications Team to support the promotion of the People Plan and subsequent delivery of actions. Formal launch of the Plan is scheduled for the week commencing 22nd July 2024 which is interdependent to the Trust intranet launch that will be the platform hosting the People Plan.

Promotions will be through a phased approach and aligning to the delivery programme outcomes over a 12-month period. Promotional materials will further support key activities such as managers briefings, staff stalls and videos for example.

In addition, senior members of the People Directorate are engaging directly with Clinical Boards and Support Services to promote the People Plan and its objectives to staff through attendance at Town Hall events and other staff forums. Data will be analysed to identify hotspot areas so that the themes and associated activities can be aligned where they are needed most.

5. MEASURING IMPACT

Delivery of the specific objectives of the Plan will be monitored through detailed plans with overall oversight through the Executive Team and through assurance through the People Committee.

However, as well as delivering the actual objectives it will be important to measure the impact for our staff to establish whether:
1. We address the things that matter to them; and
2. They feel more positively about working in the Trust.

The specific measures for the plan are outlined on page 14 and this will be monitored using local data for staff and patient experience.

6. RECOMMENDATIONS

The Trust Board is asked to:

1. Approve the People Plan 24-27 and its four themes (Appendix 1).
2. Note the supporting Year 1 delivery actions for 2024/25 (outlined in the Plan on pages 15-19).
3. Note the plans for ongoing communication and monitoring to ensure delivery of the People Plan and year 1 deliverable objectives (sections 4 and 5 of the report).

Report of
Christine Brereton, Chief People Officer
Donna Watson, Head of HR Strategy and Transformation

Newcastle Hospitals People Plan

Contents:

Foreword by:

I am delighted to be able to present the Trust's People Strategy for 2024-27 (to be known as Newcastle Hospitals People Plan). The development of this plan has been about focussing on listening, engaging and acting on feedback directly from you, our staff, on the things that are important to you. I want to personally thank you for speaking up and engaging with us and providing feedback through the staff focus groups, staff survey or whatever other means.

We wanted to ensure that this plan reflected what you told us: that feeling valued and really heard is important, that you have been through a lot and life can sometimes be difficult, and you want us to support your health and wellbeing so that you can look after our patients. You want your managers and leaders to support you and be compassionate and kind, and that our behaviours to each other affect us every day.

We hope we have managed to reflect your voices in this plan which outlines the things that we will make a priority. We will measure the impact so that we can understand whether what we are doing is right, if not, we will seek to understand further from you, what we need to do. We know that we need to focus more on People over Process, and that will be our ultimate aim in the delivery of this plan.

Finally, the development of our plan has been collectively brought together with the help of our staff side colleagues and staff networks. My heartfelt thanks for their contributions, voices and challenges.

Mrs Christine Brereton - Chief People Officer

As the Chief Executive of Newcastle Hospitals, I have been overwhelmed by the stories and experiences that a large number of you have shared with me in my short time with the Trust. Please continue to speak up and speak out about things that matter to you through the various forums and methods available to you. I will continue to engage personally with you so that I can listen, hear and act.

We know that having a plan alone will not resolve the issues. We acknowledge that we have work to do to truly embed a culture that we can all be proud of. By focussing on the four key themes outlined in this strategy year on year, we hope that we can begin to improve and truly celebrate the fantastic place that we know and want Newcastle Hospitals to be.

Sir Jim Mackey - Chief Executive Officer

The Board knows that the quality of the people who work here is our greatest asset. The more our staff feel valued, supported and listened to, the better our patient outcomes will be. We are determined to do what it takes to make Newcastle Hospitals the very best place to work.

Sir Paul Ennals - Interim Shared Chair

Our Staff Partnerships and Networks

Our people plan will help to guide us on our journey to creating a culture of authenticity and belonging where everyone feels welcomed, celebrated, supported and valued as their true authentic selves. We challenge you, as individual staff members, to champion equality, diversity and inclusion and to oppose discrimination and demonstrate effective allyship.

The plan has been shaped and developed by a variety of voices and perspectives across the Trust. We believe every member of staff has a responsibility to behave in a way that supports our organisation to move forward. We have not always got this right in the past but we are willing to grow and change to make our organisation a fairer, more equitable place that will allow us all to thrive. We must all take responsibility for our part in the longstanding and perpetuated discrimination within our organisation.

We believe we've co-created a bold, ambitious plan that recognises the challenges of becoming an anti-discriminatory organisation, one which not only meets but exceeds our legal obligations, but also enhances our organisational values and vision.

Of course, words alone are never enough. So, we'll keep working with our staff and other stakeholders to deliver this strategy and to further develop our learning. As staff networks, we are committed to anti-racism and anti-discrimination in every context.

Staff Network Chairs

Odeth Richardson, Poonam Singh, Steven Hewitt, Darren Beal, Andrew McEvoy

Trade unions within the Trust have consistently advocated increased focus on staff and workforce issues. As a result, we regard the people plan as a significant step forward. Trade unions prioritise staff health, safety, and overall well-being and proactively work to address concerns related to violence, discrimination, bullying, harassment, workplace stress, and greater flexibility at work. Additionally, we are committed to fostering a more inclusive, compassionate, and equitable environment within the NHS.

Throughout the pandemic, staff demonstrated exceptional dedication by going above and beyond their regular duties to care for patients and each other. Working within the NHS continues to be challenging; however, some of our cultures and behaviours have fallen short and negatively impacted staff. This is not acceptable and cannot continue.

The people plan contains many commendable ambitions to create a fairer and more compassionate workplace, and its successful implementation requires commitment at both national and local levels. We all have a part to play but cannot achieve these ambitions in isolation. We must work together, with everyone's unique contributions and perspectives, to make this a reality.

The trade unions have been pleased to work in partnership in developing this local people plan and affirm their ongoing dedication to ensure equality, diversity, and inclusion remain pivotal in all decision-making processes that impact staff and that the voices of staff are included.

Linda Hobson, Chair of Staff Side

Our plan is looking forward and giving focus to the long-term aims of the trust. Welcoming true engagement of staff and speaking up is core to this. We must strive to deliver this plan together and as the Freedom to Speak Up Guardian (FTSUG) I am committed to support this.

This is not a short-term fix but a commitment for us all. I believe in the benefits of working in an organisation that promotes speaking up and listening up because it is vital for innovation, motivation and true engagement. It is essential for our trust not only to survive but to thrive for its staff and ultimately the patients we serve.

Jill Taylor, Freedom to Speak up Guardian, FTSUG

The National NHS People Agenda

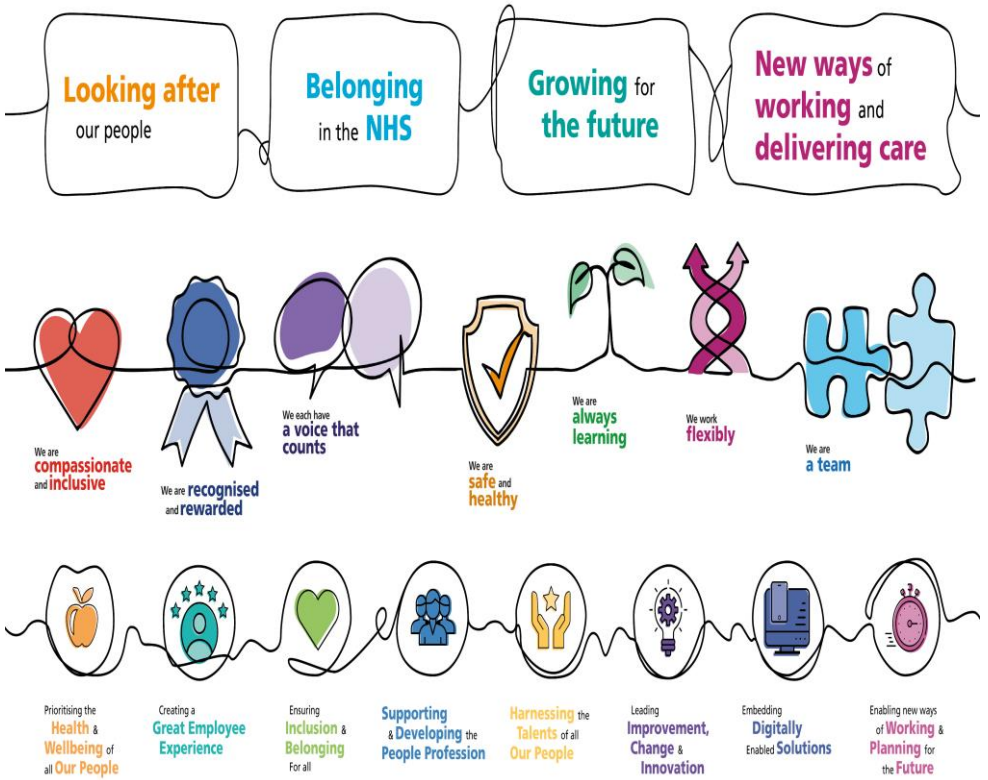
In 2020, The National NHS People Plan was published. This focuses on four key areas and is underpinned by the People Promise. Together, the People Plan and People Promise are grounded in inclusion, belonging, growing and embracing new and innovative ways of working.

In November 2021, The Future of HR and OD in the NHS was published. Following detailed consultation with stakeholders across HR services and acquiring expert advice, the reports set the blueprint for the delivery of people services in the NHS for the next 10 years.

What does this mean for our People Plan?

The national agenda acts as a key national enabler to our people plan's main framework.

We will continually review the benefits of national initiatives, toolkits and self-assessments and implement them where these are relevant and appropriate



Insights from our People

Our people's voice and insights is the very foundation of our people plan. Over 8000 staff shared their experiences with us. This was through a range of feedback routes such as CEO roadshows, focus groups, working in partnership with staff networks, staff side, our freedom to speak up guardian, the NHS Staff Survey and our internal staff survey.

THE ENGAGEMENT HAS TOLD US THAT OUR PEOPLE:

- Are passionate about our Trust and the care we give
- Still feel the impact covid had on their health and wellbeing
- Feel kindness and civility are key to high quality staff and patient care
- Want line managers to care for them, whilst they care for patients
- Are keen to enhance a sense of togetherness
- Are concerned about the pressure on our services and the impact this has
- Support equality, diversity and inclusion
- Want to see action from speaking up
- Want fair and equitable treatment
- Want people prioritised over process

Our People Plan Delivery Framework

We have listened to and engaged with over 8000 colleagues; analysed our data and extensively considered our intelligence from our staff networks and staff side colleagues. Consistently, this has identified four themes as the key areas of focus for our people plan 2024-2027.

1. **Health and Wellbeing**
2. **Behaviours and Civility**
3. **Valued and Heard**
4. **Leadership and Management**

To ensure that we address the issues that matter to our staff, we have set out aspirations and commitments for the next three years under the four key themes. This will ensure that we keep focussed on what we need to deliver. However, we recognise that our staff want to see some immediate action. Therefore, we will develop year on year delivery plans and continually measure progress against them through our identified governance structures.

1 Health and Wellbeing

Our aspirations…..

"We will strive to create an environment where our people feel safe and well, experiencing care and compassion from leaders and colleagues"

During the next three years we will:

- Review and develop the Health and Wellbeing offer to reflect the needs of our people.
- Effectively communicate the Health and Wellbeing offer.
- Make available resources to support our people with their wellbeing both in and out of work.
- Enable managers to be compassionate to support our people, especially when they feel vulnerable.
- Empower managers to facilitate and enable flexible working wherever possible, maximising wellbeing and improving overall staff experience.
- Strive to improve and adapt our physical and psychological environment to promote the wellbeing of our people.

2 Behaviours and Civility

Our aspirations…..

“We will embed a culture of inclusivity and felt fairness where our people take responsibility for their own behaviours to others, and feel safe to respectfully challenge the behaviours of others where these don’t align to our values”

During the next three years we will:

- Embed a Trust behaviour and civility charter to promote positive behaviour in line with our values.
- Hear and listen to staff at all levels and support underrepresented groups; and act on their feedback.
- Ensure our values and expected behaviours are embedded across people practices including recruitment, appraisal, supervision and training.
- Develop staff and patient experience feedback from ward to board, to develop a learning culture.
- Embed principles of civility; understanding their direct impact on patient safety.
- Take the appropriate action where behaviours fall short and impact negatively on our people.

3 Valued and Heard

Our aspirations…..

"We will create the conditions where our people feel safe and supported to speak up and speak out about things that matter to them. We will celebrate the equality and diversity of our people and embed inclusion in all that we do".

During the next three years we will:

- Create the conditions, through our Freedom to Speak up approach and overall leadership, where our people feel safe to speak up.
- Commit to action and feeding back when staff speak out.
- Develop a staff experience programme to guide our areas of improvement.
- Grow our partnership working with staff networks and staff side; to focus on things that matter to our people.
- Have a high-visibility programme of engagement and communication to support and listen to staff, through a variety of different methods.
- Prioritise people over process by reviewing people processes, procedures and policies to ensure that our people are at the heart of what we do.
- Further develop our staff reward and recognition programme to celebrate and recognise our staff.

4 Leadership and Management

Our aspirations…..

"We will develop, support and enable leaders at all levels to act with compassion and confidence so our people experience kindness, respect and dignity at work".

During the next three years we will:

- Create tools, resources and training to address core people management needs.
- Introduce value-based recruitment so leaders are appointed with the right attitude, skill, and willingness to learn and lead.
- Support managers to further develop their leadership skills aligned with a compassionate approach.
- Ensure the development of organisational development tools, capability and capacity is enhanced across all levels of the Trust.
- Embed development of leaders and line managers in culture, equality, diversity, inclusion, fairness and accountability.
- Empower our leaders at all levels through building and maintaining a community that promotes and supports compassionate distributed leadership.

Enabling Programmes

HR Transformation Programme

As part of the Trust's cultural improvement journey, we recognise the need to prioritise our people over process. Our journey in HR is to develop our ways of working in recognition of this.

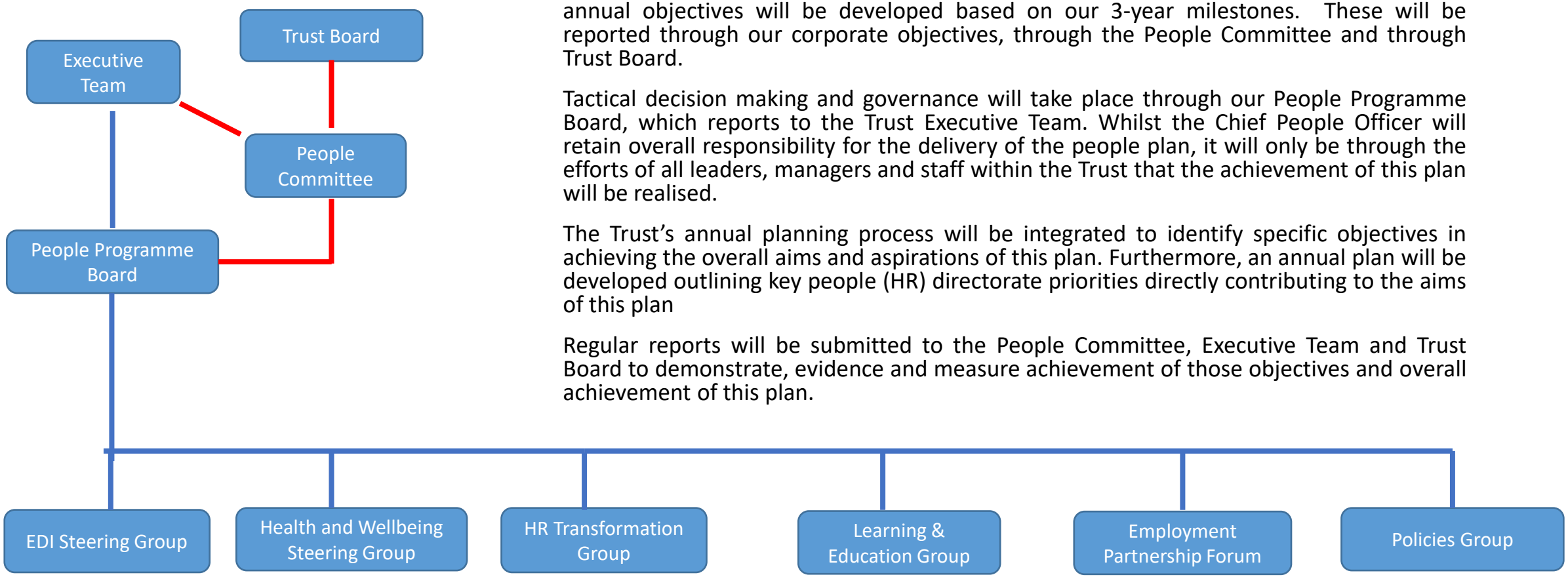
The People Directorate Transformation programme will include a range of workstreams designed to support a just and learning culture. This includes working in partnership with colleagues in reviewing our policies, procedures and processes as well as developing new ways of delivering people services.

Supporting our Trust services

Through our Clinical Boards and Corporate Services we will ensure that this people plan is embedded into local practices and processes, ensuring wherever possible we make the plan come alive so that staff can feel the positive impact.

We will also ensure that we identify the specific workforce needs and issues of our Clinical Boards and Corporate Services, such as staff shortages, training and development, staff morale and culture. We will put local **workforce plans** in place to address them at a local level.

Governance and Oversight



This plan is our home for all people activities at Newcastle Hospitals. Each year a set of annual objectives will be developed based on our 3-year milestones. These will be reported through our corporate objectives, through the People Committee and through Trust Board.

Tactical decision making and governance will take place through our People Programme Board, which reports to the Trust Executive Team. Whilst the Chief People Officer will retain overall responsibility for the delivery of the people plan, it will only be through the efforts of all leaders, managers and staff within the Trust that the achievement of this plan will be realised.

The Trust's annual planning process will be integrated to identify specific objectives in achieving the overall aims and aspirations of this plan. Furthermore, an annual plan will be developed outlining key people (HR) directorate priorities directly contributing to the aims of this plan

Regular reports will be submitted to the People Committee, Executive Team and Trust Board to demonstrate, evidence and measure achievement of those objectives and overall achievement of this plan.

Key: Assurance
Approval/Oversight

Measuring Impact

We want to ensure our people plan has the impact needed to support our staff's experience. We have developed an impact measurement framework aligned to the four themes of the people plan; quarterly trust staff surveys will monitor the impact of each theme:

- **Health and Wellbeing** - *January*
- **Behaviours and Civility** – *April*
- **Valued and Heard** - *Rotating throughout year*
- **Leadership and Management** – *June*
- **Annual National NHS Staff Survey** – *October*

Key impact measures are from the NHS Staff Survey and link to areas we view as important based on what our staff have told us. We will continue to assess the key indicators that we use to monitor progress

1. Health and Wellbeing

- My organisation takes positive action on health and wellbeing.
- I can approach my immediate manager to talk openly about flexible working.
- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.

2. Behaviours and Civility

- The people I work with are polite and treat each other with respect.
- I feel safe to speak up about anything that concerns me in this organisation.
- In the last 12 months, I have personally experienced harassment, bullying or abuse at work from other colleagues.

3. Valued and Heard

- The recognition I get for good work.
- If I spoke up about anything that concerns me I am confident my organisation would address my concern.
- I would recommend my organisation as a place to work.

4. Leadership and Management

- My immediate manager values my work.
- My immediate manager cares about my concerns
- If I spoke up about something that concerns me I am confident my organisation would address my concern.

Year 1
Delivery Programme

2024/2025

1 Health and Wellbeing

1.In partnership with our Staff Networks and Staff Side develop new tools to support staff as part of the attendance management process. This includes:

- Compassionate approach and communication tools including letters
- Reasonable adjustment guidelines
- Supportive return to work plans

2. Ensure that staff have access to current Health and Wellbeing offers
3. Undertake a gap analysis in our Health and Wellbeing offer and develop a Health and Wellbeing plan to support our overall approach
4. Review and assess our psychological support offer for staff
5. Work in partnership with our charity to provide support on Health and Wellbeing initiatives
6. Develop and improve processes and closer alignment between People Directorate and Occupational Health to ensure overall support for our people
7. Review our flexible working process with a view to support wherever we can
8. Review our support packages for staff who are involved in HR processes to ensure that they are cared for throughout regardless of the circumstances

2 Behaviours and Civility

1. In partnership with our Staff Networks and Staff Side colleagues, create and implement a behaviour & civility charter which sets out a framework for positive behaviour and interaction for ALL staff regardless of position or status
2. Integrate the charter into our people practices such as recruitment, induction, training and celebration
3. Roll out Civility/Micro-aggression Training; with specific targeted focus on hotspot areas
4. Develop our Equality Diversity and Inclusion (EDI) Improvement Plan (High Impact Actions)
5. Develop a cultural dashboard from ward to board to address areas of required focus / support
6. Specifically address areas identified within our staff survey of poor behaviours and staff experience
7. Implement new policies for Sexual Misconduct and Dignity and Respect with a focus on anti-racism.

3 Valued and Heard

1. Review our key HR policies– and implement a “Just and Learning Culture” - People not Process
2. Ensure that our staff know how to speak up safely within their own teams and department and promote the role of our new Freedom To Speak Up Guardian (FTSUG) and champion network
3. Develop a highly visible senior leadership engagement programme
4. Promote and encourage use of our “speak in confidence system” for anonymous feedback
5. Engage with staff throughout the year to seek feedback and act on the findings
6. Review our recruitment processes to ensure they are fair and inclusive
7. Continue to engage with our staff networks to ensure that minority voices are strong voices
8. Celebrate success through our reward and recognition process against the four key people themes
9. Review our approaches to receiving, listening to, and acting on staff feedback as they exit the organisation so we can learn lessons and improve staff experience

4 Leadership and Management

1. Roll out a supportive e-rostering coaching to support use of e-rostering system within wards based on Trust
2. Assessment of current leadership and management development offers completed to inform future development programme
3. Implement a new leadership and management training programme based on compassion and responsive leadership
4. Hold workshops with front line managers to support the implementation of HR policies and procedures which focus on People not Process
5. Implement value-based recruitment with a focus on leadership competency for leadership roles
6. Review of appraisal process for leaders which include reference to the four key themes of the People plan and equality and diversity

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	17 July 2024					
Title	Integrated Board Report					
Report of	Rob Harrison, Managing Director Angela O'Brien, Director of Quality & Effectiveness Vicky McFarlane-Reid, Director of Commercial Development & Innovation					
Prepared by	Elliot Tame, Senior Business Development Manager (Performance) 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 of Directors on the Trust's performance against key Indicators relating to Quality & Safety, Access, People, Finance and Health Inequalities.					
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]						
Reports previously considered by	This is a regular paper provided to Trust Board.					

INTEGRATED BOARD REPORT

EXECUTIVE SUMMARY

This report provides an integrated overview of the Trust's position across the domains of Quality & Safety, Access, People, Performance, Finance and Health Inequalities.

Quality:

- Throughout the month of May 2024, the number of Trust onset C. Difficile and E.Coli have increased since the previous publication in April 2024. Pseudomonas and MSSA bacteraemia have decreased since the previous publication and Klebsiella and MRSA bacteraemia remains the same with zero reporting.
- May 2024 shows a decrease in inpatient acquired pressure ulcers since the previous publication. The number of falls since previous publication has increased but the rate remains the same in terms of falls per 100 bed says.
- The number of moderate and above harmful incidents fell slightly from April 2024 to May 2024.
- The latest Mortality "SHMI" publication, shows the Trust to be at 0.9o. This is within "expected limits" and one of the lowest within the region.
- The Trust have reported one late indirect maternal death in May 2024, this has been reported to MBRRACE-UK but falls outside MNSI referral criteria. A local review has been undertaken and action identified.
- In May 2024, the levels of emergency caesareans returned back to average compared to the previous month, there was a corresponding increase in elective caesarean sections rates.

People:

- Data is for year-ending May 2024 unless otherwise stated.
- Total sickness absence reduced from 5.62% (June 2022 to May 2023) to 5.34% (June 2023 to May 2024).
- Top three reasons for sickness absence are 'anxiety/stress/depression/other psychiatric illnesses' (29%), 'Other musculoskeletal problems' (11%) and 'Gastrointestinal problems' (9%).
- Staff in post increased by 3.78% compared to previous year with biggest increase in nursing & midwifery, allied health professionals.
- Retention of staff with over 1-year service decreased from 87.88% (May 2023) to 85.89% (May 2024).
- Turnover has been reducing since May 2023 and stands at 10.31% (May 2024) compared to target of 8%.
- Top reason for leaving was 'work-life balance' 17.22%.
- Top destinations on leaving were: 'no employment' 38.8% (half were accounted for by retirement, health and temporary contract); and other 'NHS organisation' 30.2%.
- Mandatory training compliance is 92.01% compared to target of 95%.
- Lowest rate of compliance is medical and dental staff 85.68%.
- Mandatory training courses below 80% compliance: 'Paediatric Basic Life Support' 78.84%.

- Appraisal compliance is 85.99% compared to target of 95%.

Performance:

- The total number of patients waiting >78 weeks in May remained low but increased to 22, from 15 in April.
- The number of patients waiting over 65 weeks fell to 476 from the previous month, with the volume of patients waiting over a year for treatment dropping to 2,547.
- The 75% 28 Day Faster Diagnosis Standard (FDS) was achieved for the third successive month in April (77.0%), despite performance declining by 7.6% from March.
- However the organisation failed to meet the other two consolidated standards in April - 62 Day compliance was 58.9%, whilst 31 Day performance fell back by 4.3% to 84.8%.
- Organisational performance against the six week diagnostic standard declined again in May, with 34.1% of patients now waiting over six weeks for their diagnostic test.
- The Trust also delivered performance below the revised 4-hour A&E arrival to admission/discharge target for May, with performance standing at 72.0% against the 78% target.

Finance:

- As at month 2, the Trust is reporting delivery against the planned deficit of £2m.
- From an income perspective the in-month position is an overall favourable variance.
- For expenditure the variance on employee expenses mainly relates to the impact of the Consultant Pay Reform expenditure that was paid in May. The overspend on drugs expenditure is partly matched with income and an increase on the 2023/24 levels that will be monitored.
- Agency costs continue to run at around 0.8% of the gross staff costs. This is below the national target set at 3.2%. However 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.

Health Inequalities:

- This is the 2nd Integrated Quality & Performance Board Report containing a section on Health Inequalities.
- This update contains information on elective admissions and inpatient waits for elective treatment disaggregated by age, sex, ethnicity and deprivation.
- This section of the report will continue to expand and develop over time to give greater insight into Health Inequalities.

The Board of Directors is asked to receive the report.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Quality & Performance Board Report

Quality, People, Performance, Finance and Health Inequalities

July 2024

Healthcare at its best
with people at our heart

Executive Summary (i)

Please note due to the timing of Board Committees this month only a few areas have up to date data to include. The updates relate to diagnostics performance and the Health Inequalities section.

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Executive Summary (ii)

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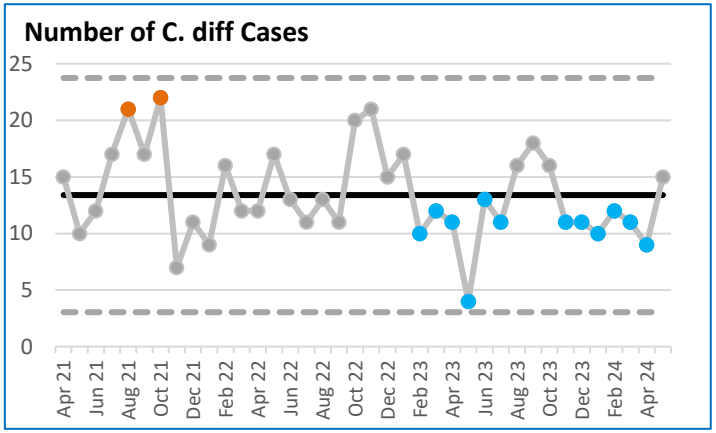
Contents: July 2024

Quality

Quality: Healthcare Associated Infections 1/4

***Clostridioides difficile* Infections (CDI)**

- All hospital acquired, hospital onset *Clostridioides difficile* infections are reviewed by a Microbiologist, Antimicrobial Pharmacist and an Infection Prevention and Control Nurse. Following implementation of PSIRF this investigation determines if any lapses in care (which might include, but not restricted to reviewing antimicrobial stewardship, safe patient placements, timely sample collection) have resulted in the acquisition of the organism. Where there have been no lapses of care identified, these cases are deemed unavoidable.



Background

- Currently no national threshold published.

Current position

- There was a rise in cases from nine in April to fifteen in May. This is comparable with previous trends and will be closely monitored.
- Out of the fifteen cases in May, five were deemed unavoidable and four were avoidable. Themes identified in the avoidable cases were timely sampling and delay in isolation of symptomatic patients. A review of antimicrobial stewardship for the remaining six cases is currently being undertaken and will be included in future reporting.

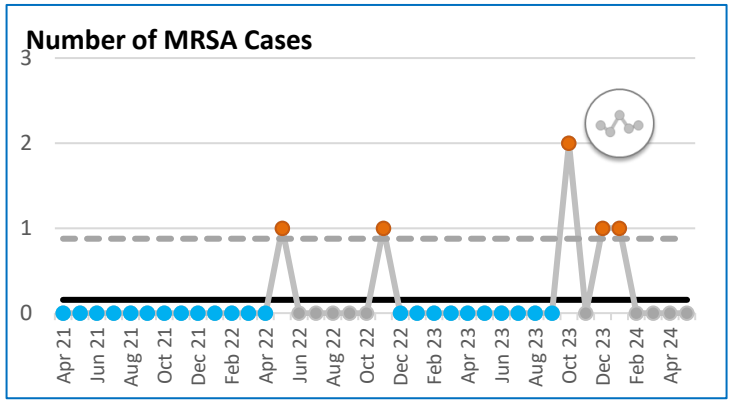
Quality: Healthcare Associated Infections 2/4

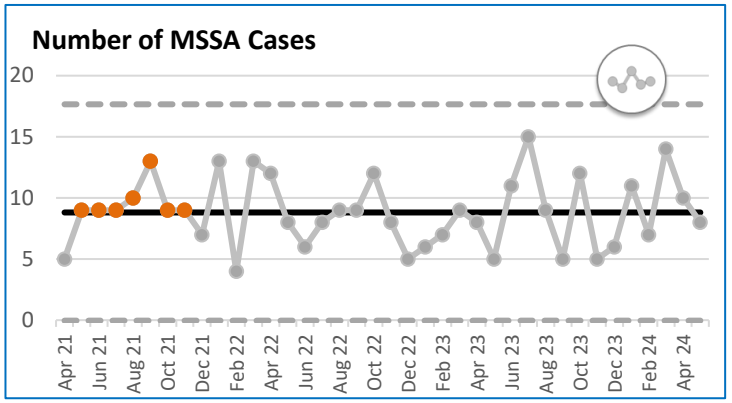
Blood Stream Infections (BSI)

- A Microbiologist undertakes a review of all blood stream infections and determines whether further investigation is required. Following implementation of PSIRF this investigation determines if any lapses in care (which might include, but not restricted to reviewing correct invasive device management, safe patient placements, timely sample collection) have resulted in the acquisition of the organism. Where there have been no lapses of care identified, these cases are deemed unavoidable.

Background

- The national threshold target is zero cases for MRSA, and it is likely that this will remain for this financial year There is no national threshold set for MSSA, however the Trust set a local target of a 10% year on year reduction.





Current Position

MRSA

- The chart indicates no reported cases since January 2024.

Current Position

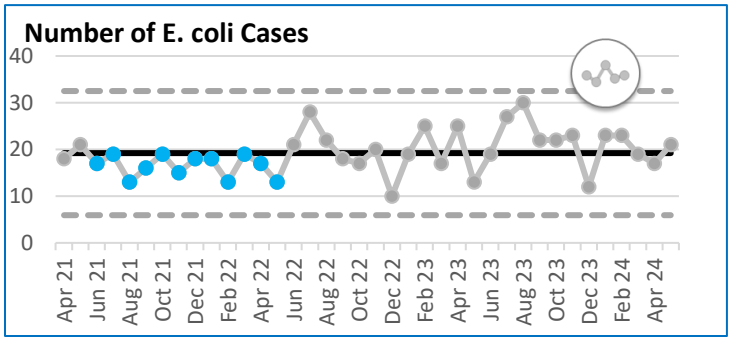
MSSA

- The chart indicates that there were eight MSSA cases in May 2024, on investigation six were deemed unavoidable.
- Investigations highlighted there were gaps in documentation associated with intravascular devices.

Quality: Healthcare Associated Infections 3/4

Gram Negative Blood Stream Infections (GNBSI)

- A Microbiologist undertakes a review of all blood stream infections and determines whether further investigation is required. Following implementation of PSIRF this investigation determines if any lapses in care (which might include, but not restricted to reviewing correct invasive device management, safe patient placements, timely sample collection) have resulted in the acquisition of the organism. Where there have been no lapses of care identified, these cases are deemed unavoidable.

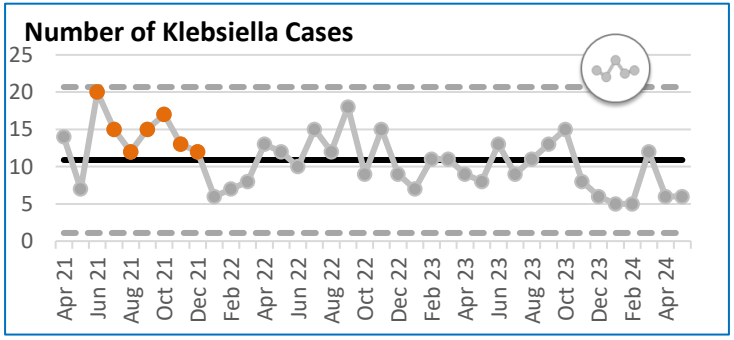


***E. coli* Bacteraemia**

- Currently no national threshold published.

Current position

- No concerning variations are noted.
- Upon investigation in May, from the twenty-one cases, nineteen were deemed unavoidable, with the remaining two associated with Catheter-Associated Urinary Tract Infection (CAUTI).

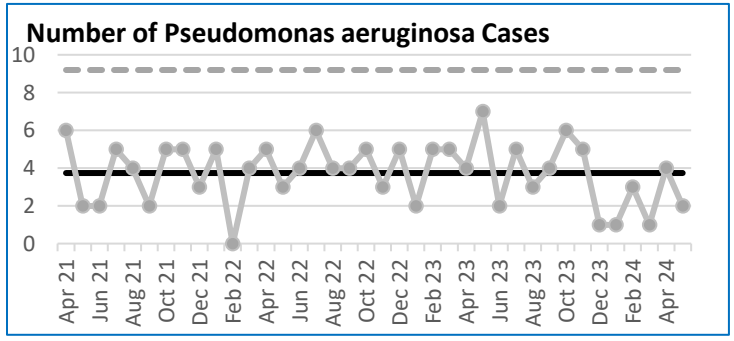


Klebsiella Bacteraemia

- Currently no national threshold published.

Current position

- The chart indicates no common cause and figures remain unchanged in May.
- Upon investigation all cases were deemed unavoidable.



Pseudomonas aeruginosa Bacteraemia

- Currently no national threshold published.

Current position

- The chart indicates a no common cause with two cases seen in May, both of which were deemed unavoidable.

Quality: Healthcare Associated Infections 4/4

Current Actions in place

- Harm Free Care Dashboards for 2024/25 have been circulated with this year's 10% reduction trajectories in line with the ward 'How We are Doing boards'. The Matrons in the clinical boards have created action logs to focus on areas for improvement and quality improvement initiatives.

- Changes to the method of capturing data with the implementation of PSRIF will facilitate improved reporting and allow thematic analysis, providing valuable IPC information to Clinical Boards.

- In periods of high incidence of infection, patient flow pathways are examined through collaboration between IPC, Facilities Teams, PSC Teams and clinical leaders to facilitate safe and timely patient placement and prompt specialised cleaning when required.

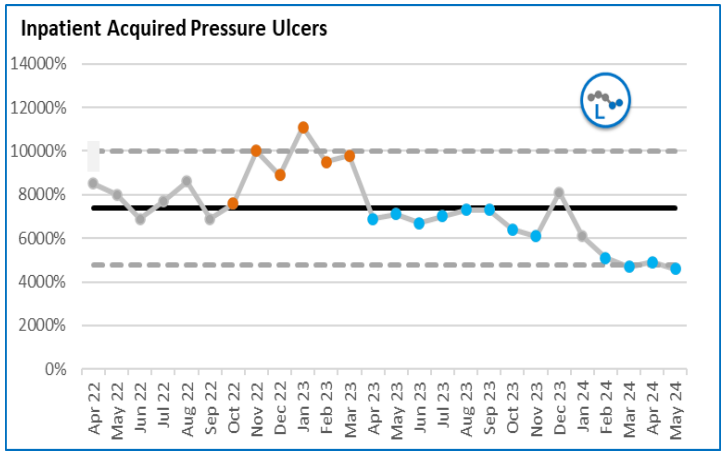
- On a weekly basis *Clostridioides difficile* and Blood Stream infections are reviewed by an MDT to establish if any lapse in care contributed to the acquisition of infection. This information is conveyed and shared with clinical teams for them to facilitate learning within clinical boards and to improve Antimicrobial Stewardship (AMS). Harm Free Care Dashboards are updated to enable monthly monitoring at ward / department level. This information is displayed on ward information boards with an annual reduction trajectory set at 10%.

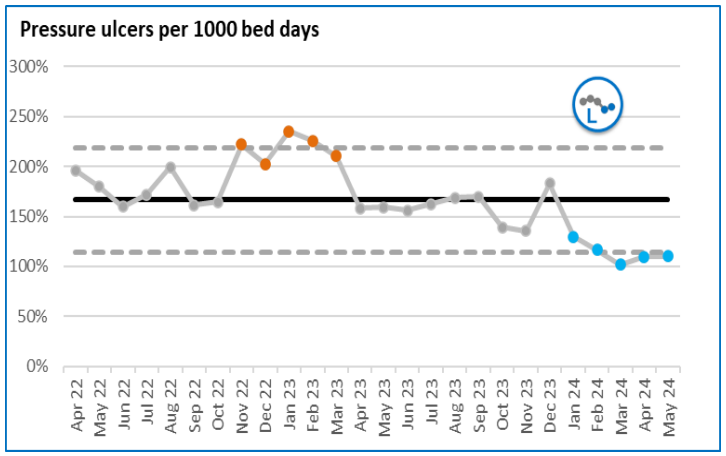
- Currently the digital dashboard to monitor invasive devices is in testing phase and set to go live in quarter 2. This new platform will support real time monitoring of lines, drains and tubes at ward and departmental level to increase compliance and support through proactive intervention. This work will be augmented through the relaunch of Aseptic Non-Touch Technique (ANTT) training.

- The educational programme is ongoing with the Harm Free Care Specialists, performing trolley dashes, in-depth educational support within clinical areas at ward / department level, with specific focus in areas of high incidents of HCAI. The impact of this is continually monitored through ward / department level data and shared within the Clinical Board Governance Framework.

- A Quality Improvement project has commenced in Older People's Medicine to decrease avoidable urinary catheters by 5% in collaboration with the clinical teams, IPC and the Bladder and Bowel Specialist Nursing Team. This will be monitored and shared quarterly within the Clinical Board Oversight Group (COG), Infection Prevention and Control Committee (IPCC) and Quality Committee.

Quality: Harm Free Care – Pressure Damage





Background

- The reporting of all skin damage is encouraged and expected.
- Year on year there has been a reduction strategy set at 20% for pressure ulcers at Category II and above.

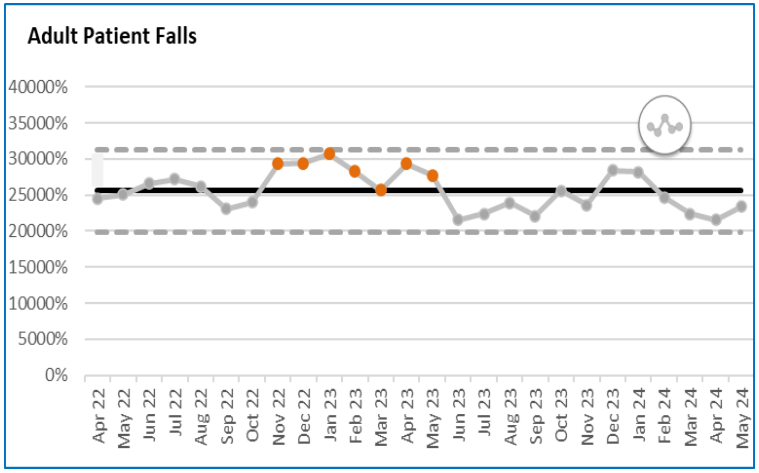
Current position:

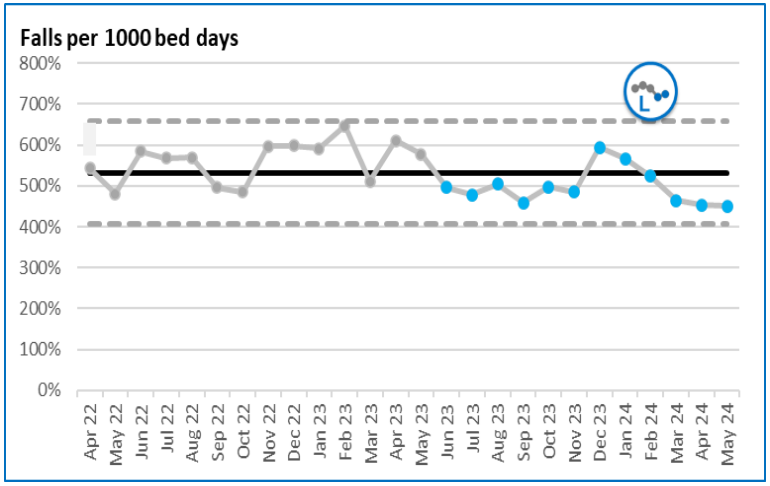
- The chart demonstrates a sustained reduction trend in in-patient acquired pressure ulcers, with the exception of December, whereby a rise occurred and is consistent with previous winter trends.
- There were two pressure ulcers causing serious harm in May 2024, both of which were category III. There has been no Category IV or above since June 2022.

Current actions in place

- Harm Free Care Dashboards are shared on a monthly basis, with Wards and Departments, with a reduction trajectory set at 20% for Cat II and above. The Tissue viability teams are delivering education to highlight the importance of reporting skin damage at the earliest stage, as the evidence shows this increases staff awareness, skin surveillance reduces levels of deterioration to higher category skin damage. Data is not yet available to demonstrate the impact of this, this will be monitored and reported on in the coming months.
- The Tissue Viability and Podiatry teams continue to deliver regular educational updates and have introduced a ward surveillance programme to monitor practice in clinical areas.
- The pressure ulcer risk tool Purpose T has been trialled across the Trust. Following evaluation and digital development there will be a planned Trust wide roll out in the coming year with specific timeframes still to be agreed.

Quality: Harm Free Care - Falls





Background

- The reporting of all falls, suspected and confirmed is encouraged and expected.
- A reduction trajectory of 20% has been set year on year.

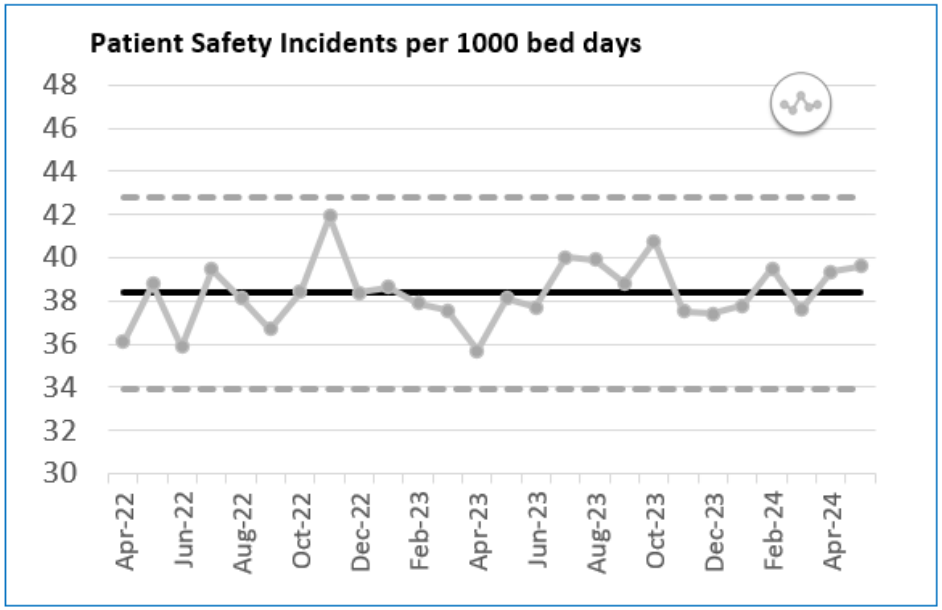
Current position

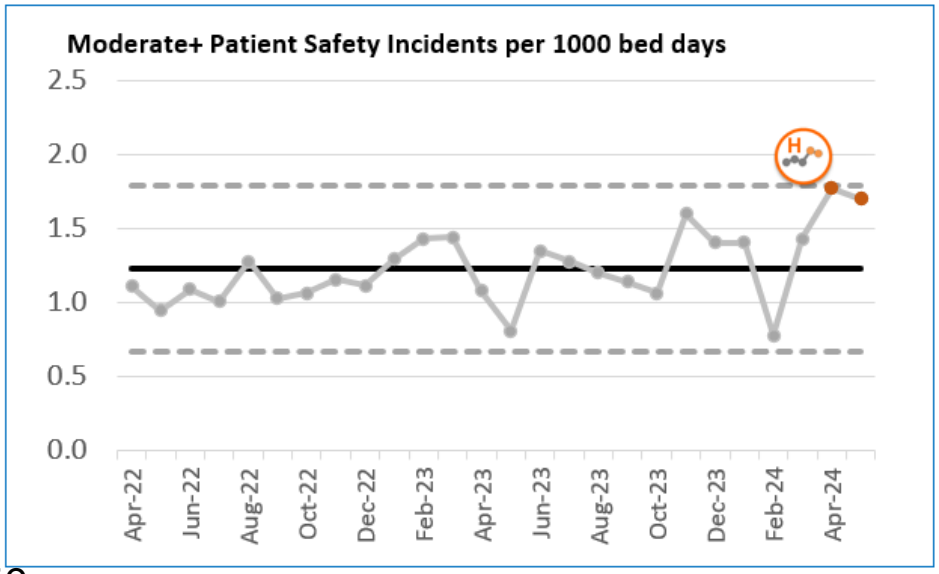
- In May there was a slight rise in falls to 234 from 216 in April, however falls with harm remain extremely low at 0.9% of total falls in May, with 2 incidents, 1 of which was moderate and a fractured neck of femur which is identified as a major harm.
- Falls per 1,000 bed days remain static at 4.5, significantly under the Trust target of 6.0.

Current actions in place:

- The Falls Prevention Coordinator post is currently vacant with the new post holder commencing the role at the end of July. The Senior Nurse for Clinical Standards & Quality Improvement and the Associate Director of Nursing for Clinical Standards continue to review ward level data on a monthly basis.
- Wards and Departments are provided with ward level data on a monthly basis, with a reduction trajectory set at 20%. This information is displayed on the ward information boards.
- The roll out of Trust wide training upon the Enhanced Care Observation (ECO) policy is planned for July/August, the Trust wide safety briefing will also feature ECO in the early July bulletin.

Quality: Incident Reporting





All patient incidents: There has been an increase in the number of patient safety incidents per 1,000 bed days reported in May 2024, but this remains within the common cause for variation.

Causes of variation:
Work remains ongoing around the Trust to raise awareness of the importance of reporting incidents on Datix.

Actions:
Continue to encourage reporting and, more importantly, encourage robust feedback to be shared within and between Clinical Boards
Low/no harm Clinical Board data being shared at the Patient Safety Incident Forum

Expected outcome:
It is anticipated that the Trust's incident reporting rates will continue to increase, and this is considered to be a positive trend

Moderate and above harm incidents: The number of moderate and above harmful incidents decreased slightly in May 2024, but remains close to the upper limit of common cause for variation. A high number of incidents is not necessarily a negative phenomenon.

Causes of high numbers of reported incidents:

- Increased awareness and oversight of moderate and above harm grading, including psychological harm, by the Clinical Boards due to the PSIRF rapid review process.
- Some harm noted to be due to limited or absent services, eg physiotherapy and psychology.

Actions:

- Continue to encourage reporting and share learning of moderate and above incidents.
- Risks relating to reduced service capacity escalated to Exec team following rapid action review meeting.

Expected outcomes:

- Incident reporting rates may increase.
- Support with service review and business case to enhance services where relevant.

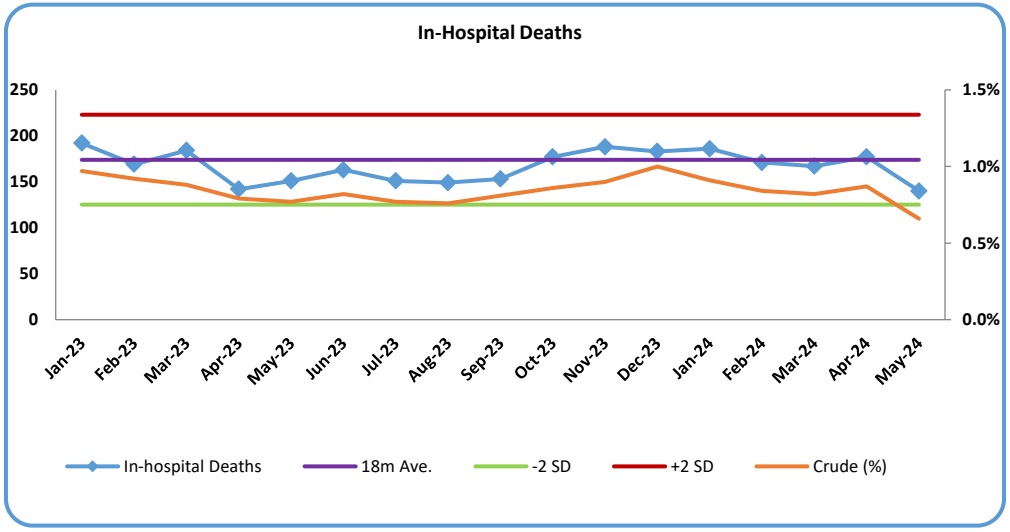
Quality: PSIRF and Never Events

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

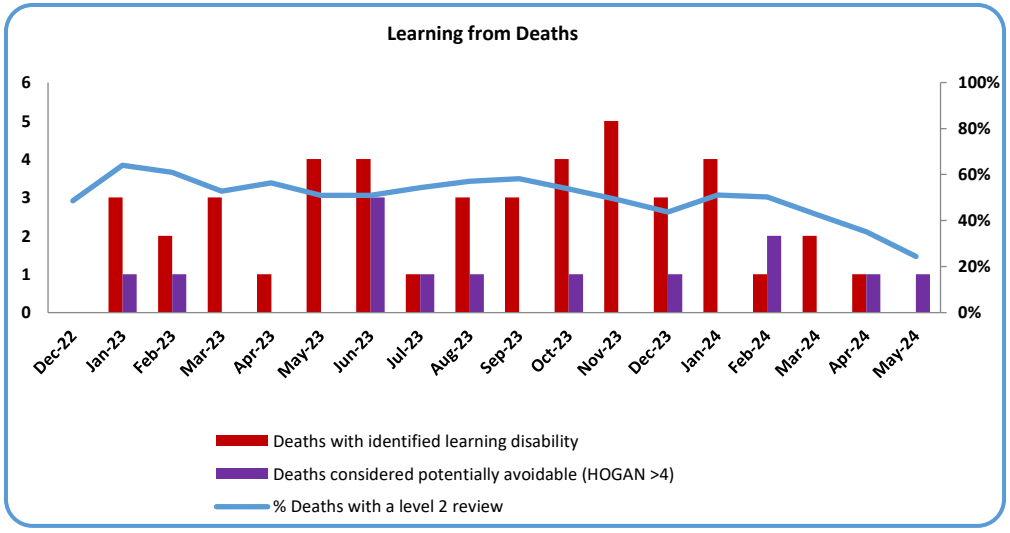
Patient Safety Incident Investigation May 2024 (April 2024: n=3)	
Theme	**Number of cases**
Screening incident	1
Delayed treatment	3
After Action Reviews May 2024 (April 2024: n=6)	
Theme	**Number of cases**
Treatment delay	1
Diagnosis delay	1
Never Events May 2024 (April 2024: n=1)	
Theme	**Number of cases**
There were no Never Events declared in May 2024	
PSIRF priorities May 2024 (April 2024: n=1)	
Theme	**Number of cases**
Internal referrals	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



In-hospital Deaths: In total there were 140 inpatient deaths reported in May 2024, which is lower than the amount reported 12 months previously (n=151). The crude rate in May 2024 is 0.66%. This is due to the high number of patient discharges in May 2024 and the relatively low number of inpatient deaths.

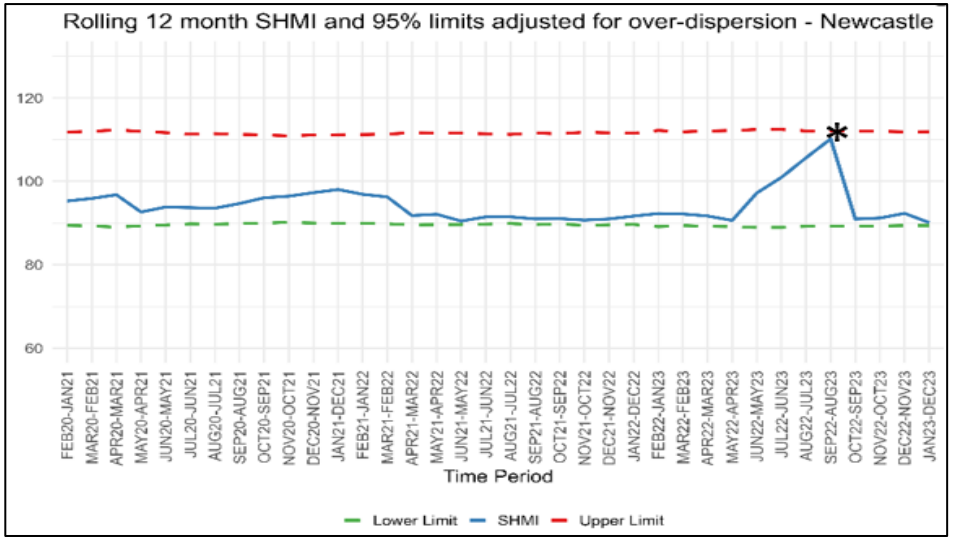


Learning from Deaths: Out of the 140 inpatient deaths reported in May 2024. 34 (24%)patients have, to date, received a level 2 mortality review. However, these figures will continue to rise due to ongoing M&M meetings held over the forthcoming months. All figures will continue to be monitored and modified accordingly.

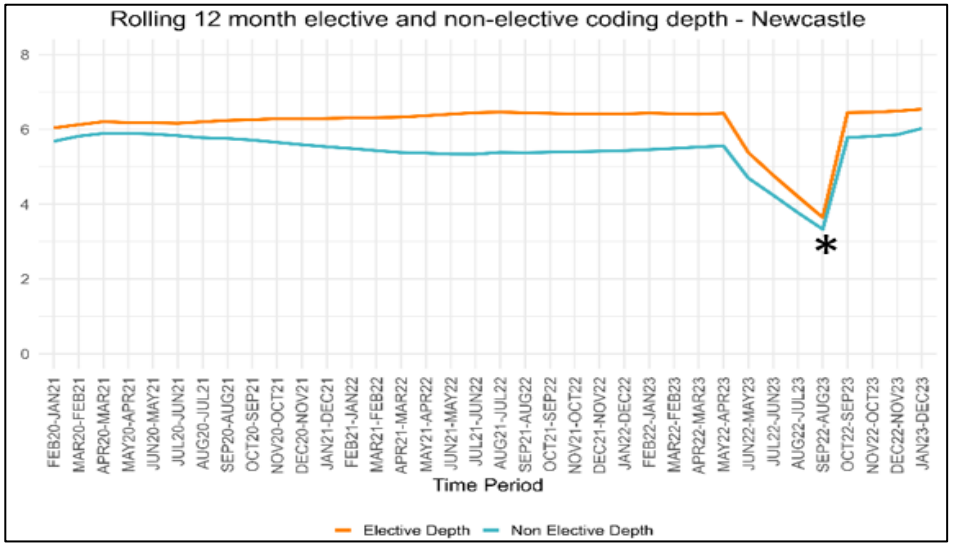
One patient who died as an inpatient in May 2024, had a HOGAN grading of ≥4. This case has had a Rapid Action Review undertaken by the Clinical Board, has been discussed at the Trust Rapid Action Review meeting and is undergoing an after-action review.

Quality: Mortality Indicators 2/3

SHMI Trend Analysis – rolling 12 months
February 2020 – January 2021 to January 2023 - December 2023



SHMI: Within the latest published quarterly SHMI data (January 2023 – December 2023) the Trust SHMI is at 0.90. This is within the "as expected" category.

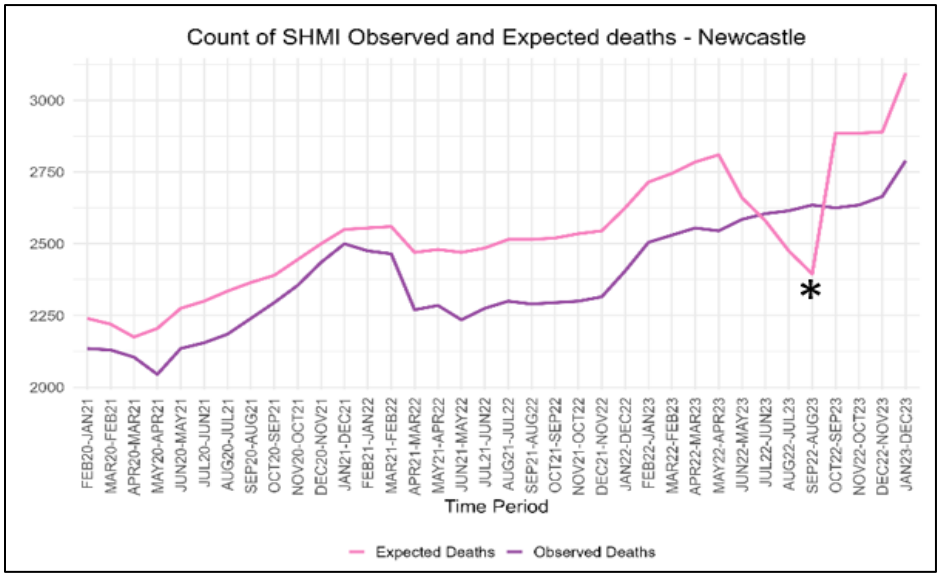


Coding depth (codes/spell): Coding depth has a substantial impact on mortality indicators. Within the latest published quarterly SHMI data (January 2023 – December 2023), the Trust has an elective coding depth of 6.5 and a non-elective coding depth slightly below 6.0.

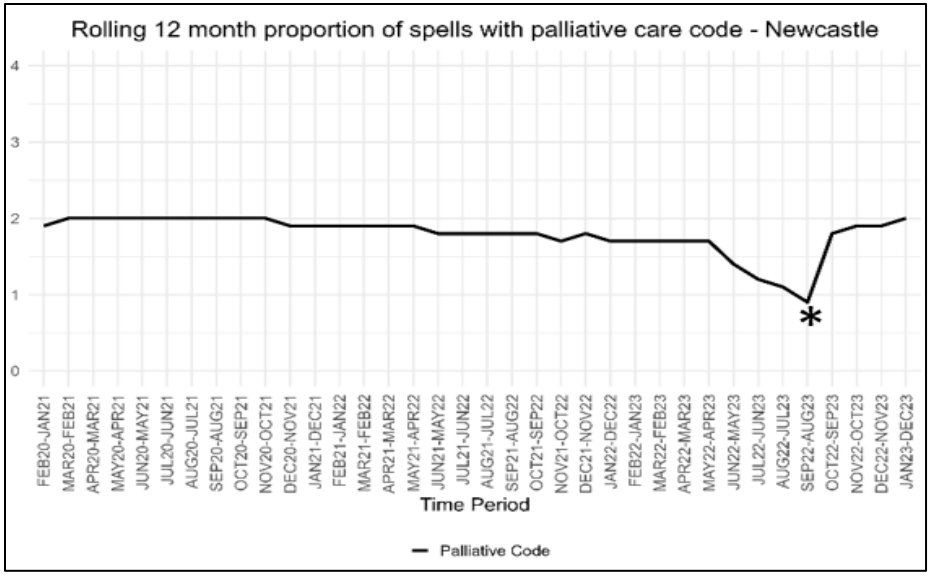
*Trust data is as reported by NHS Digital, there was an issue with the Trust's SUS data flow which affected the clinical coding.
This issue has now been resolved.

Data Source: NEQOS
Monthly SHMI publication

Quality: Mortality Indicators



Observed/Expected deaths – Within the latest published quarterly SHMI data (January 2023 – December 2023) the Trust has 2,790 observed deaths and 3095 expected deaths.

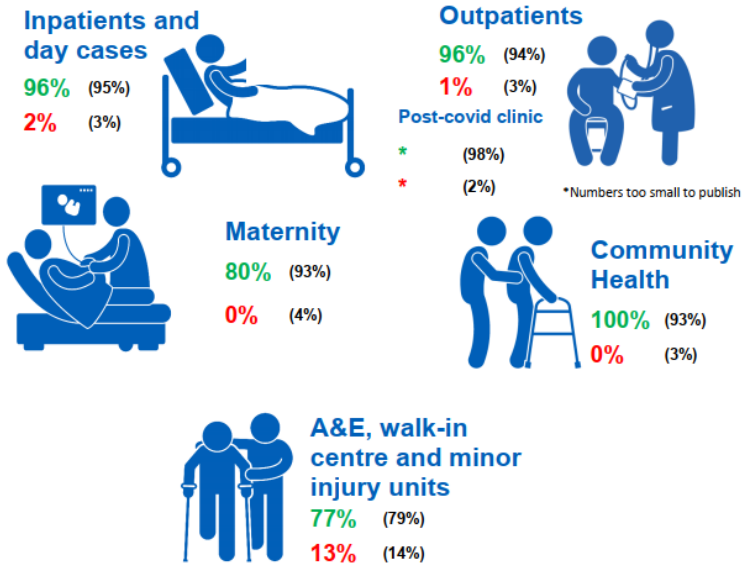


Spells with palliative care coding – Within the latest published quarterly SHMI data (January 2023 – December 2023) the Trust has a 2.0% palliative care coding rate.

* 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: NEQOS
Monthly SHMI publication

Quality: FFT and Complaints



*numbers too small to publish

Friends and Family Test

There were 1,324 responses to the Friends and Family test from the Trust in April 2024 (published April 2024) compared to 1,649 in the previous month.

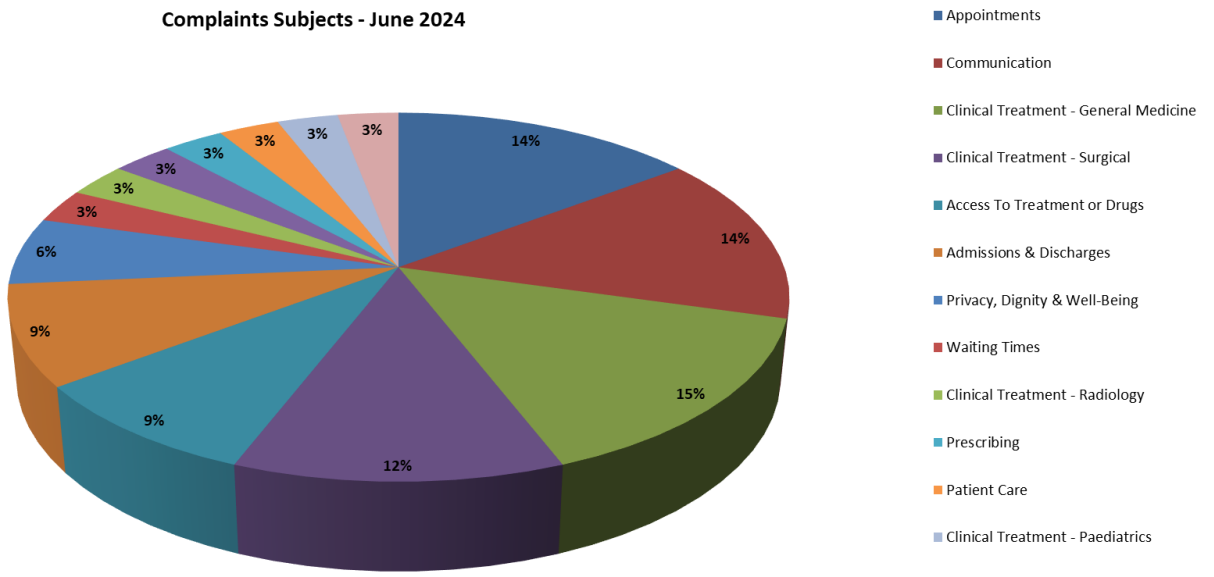
The infographic shows the proportion of patients who give a positive or negative rating of the care they received. The national average results are shown in brackets for comparison.

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

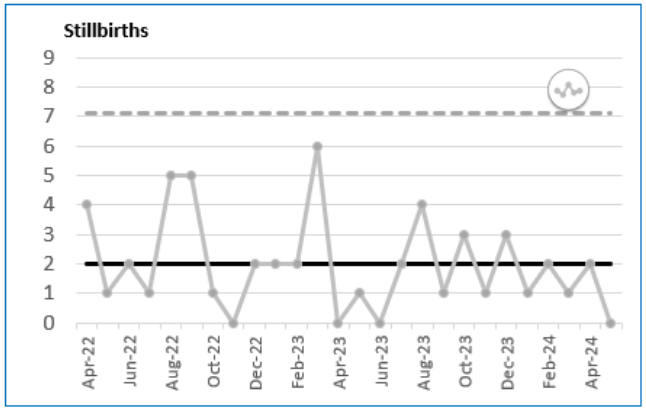
Formal Complaints

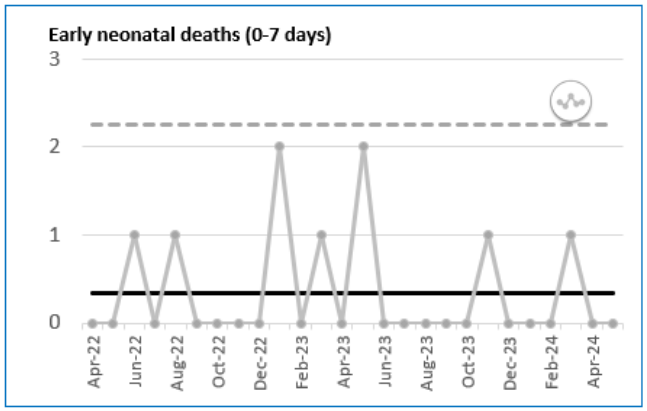
The Trust has opened 34 formal complaints In June 2024. The average number of complaints opened this financial year is 50, which is 2 complaints higher than the Trust average for the last financial year 23/24.

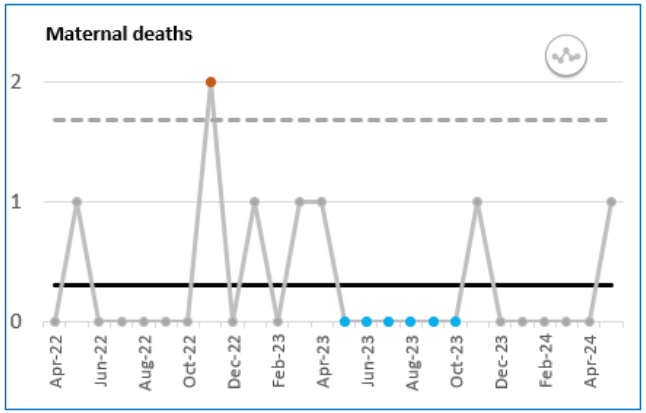
The chart opposite summarises the complaint themes for this month, with Communication (n=5) Clinical Treatment (General Medicine) (n=5) Appointments (n=5) being the top three themes.



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 was one stillbirth in June 2024, this case has been referred for Maternity and Neonatal Safety Investigation (MNSI) as met the criteria for review.

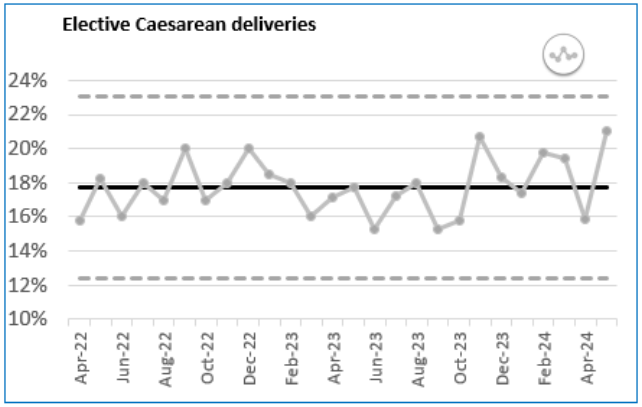
Early Neonatal Deaths

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 MNSI and the Coroner. A post-mortem examination may be requested to try and identify the cause of death. In June 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 MNSI, investigation is dependent on certain criteria. The Trust have reported one early maternal death in June 2024, this has been reported to MBRRACE-UK and MNSI. The maternity care for this patient was provided by a neighbouring Trust and therefore a joint review is being coordinated to identify immediate learning .

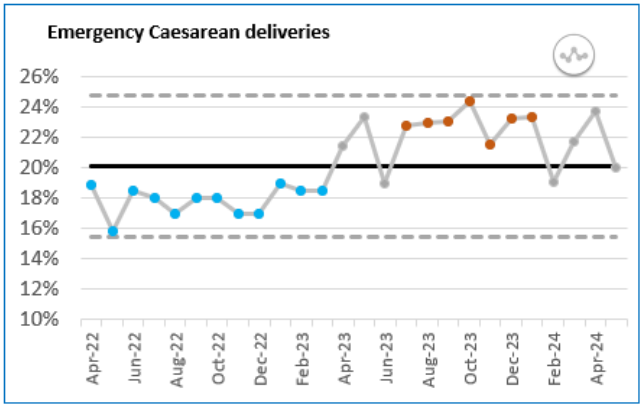
Quality: Maternity



Elective Caesarean section

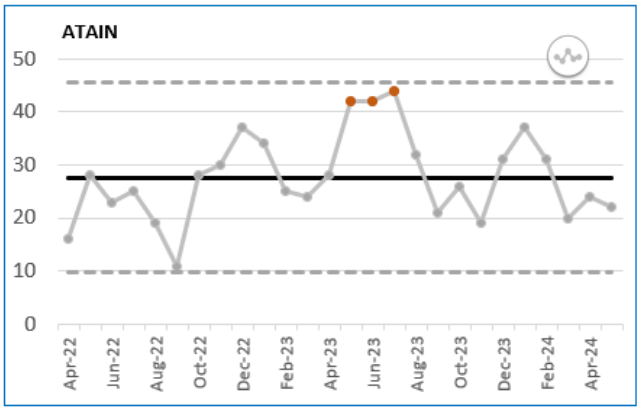
Maternity at the Trust is an outlier for elective Caesarean section compared to other UK Trusts. However, the rates are comparable to that of other tertiary centres in the UK.

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

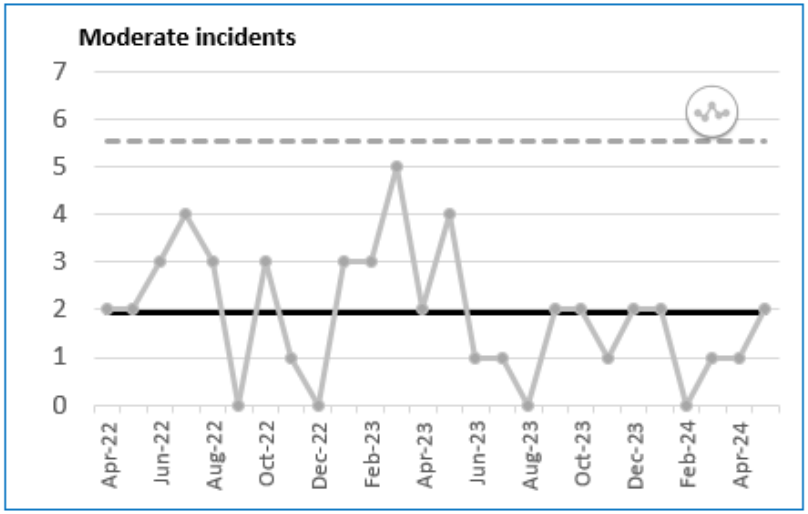
The emergency Caesarean section rate is comparable to other Trusts. Maternity is a consultant led service with dedicated consultant presence on Labour Ward 8am-10pm daily, consultant led multi-disciplinary ward rounds occur twice daily. The majority of obstetric consultants remain onsite overnight, from 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. There were 28 term admissions in June 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



Moderate and above incidents prompting PSIRF rapid review

There were four moderate (and above) incidents reported in Maternity this month. 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 or for more significant incidents a Patient Safety Incident Investigation (PSII). Thematic learning from incidents will also be gathered through this process. There are national requirements for Trusts to refer specific cases to Maternity and Newborn Safety Investigations (MNSI was previously known as HSIB) for external review. These include cases involving neonatal brain injury - Hypoxic Ischaemic Encephalopathy (HIE), Term Intrapartum Stillbirths, Early Neonatal deaths and Maternal deaths. Of the moderate and above incidents this month, there were two MNSI referrals. One case has been accepted for investigation by MNSI, while the other case did not meet their criteria for investigation and will be reviewed through other mandated processes. Two cases involved failure to meet national Antenatal Screening Programme standards and will be reviewed through a PSII.

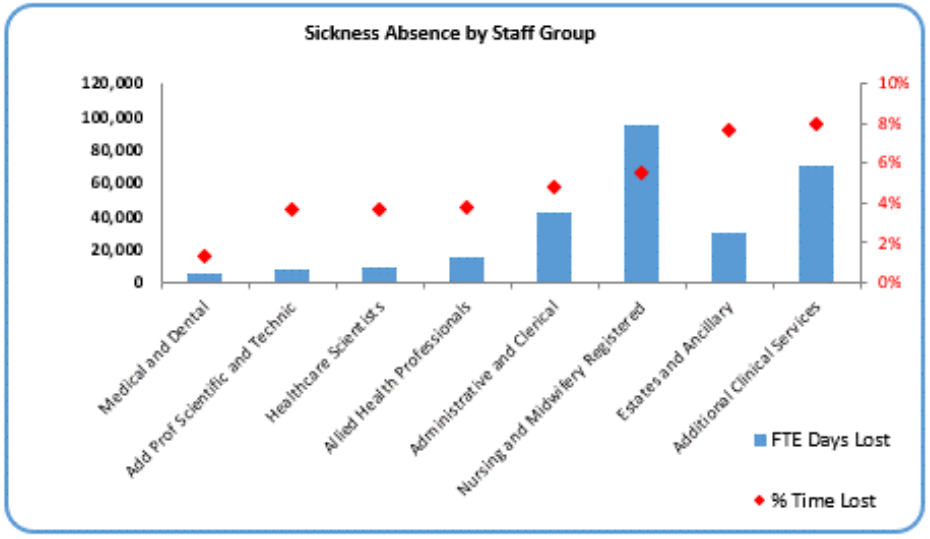
People

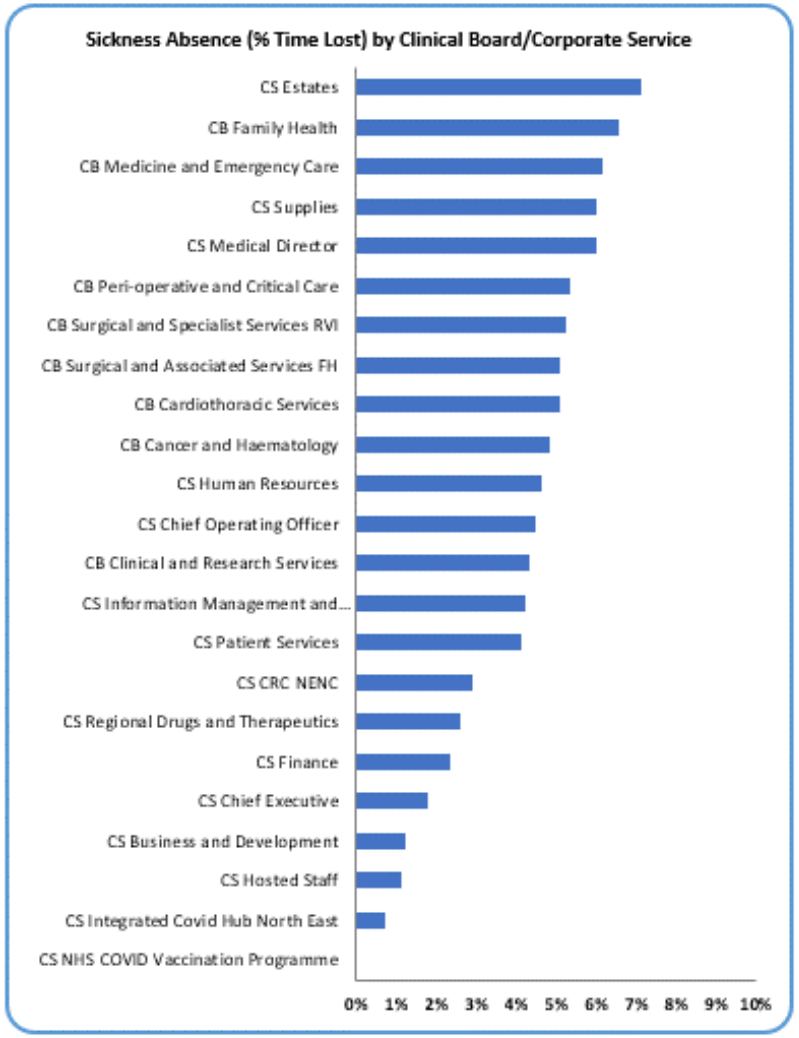
Sickness absence by Staff Group and Clinical Board

273,688 FTE working days were lost due to sickness, compared to 274,896 for the previous year - a reduction of 0.44%

Total sickness absence reduced from 5.62% (June 2022 to May 2023) to 5.34% (June 2023 to May 2024).

The top three reasons for sickness absence are S10 Anxiety/stress/depression/other psychiatric illnesses (29%), S12 Other musculoskeletal problems (11%), and S25 Gastrointestinal problems (9%).





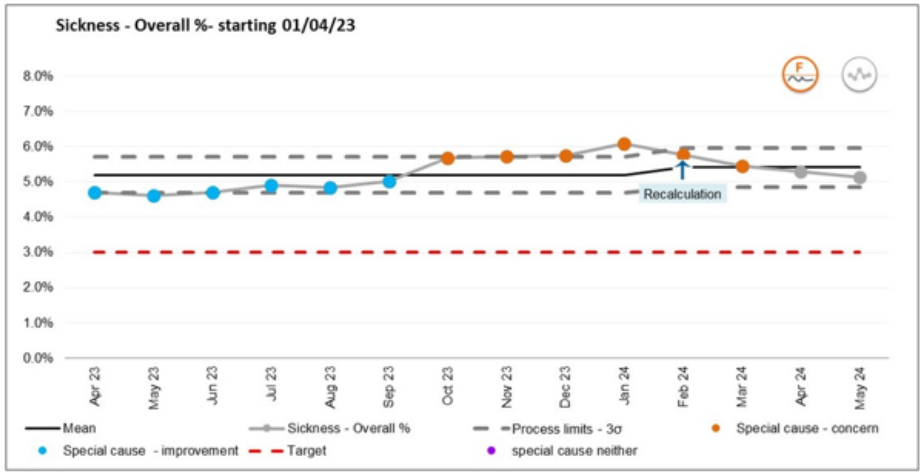
People: Sickness absence 2/4

Sickness absence May 2024 (target 3%)

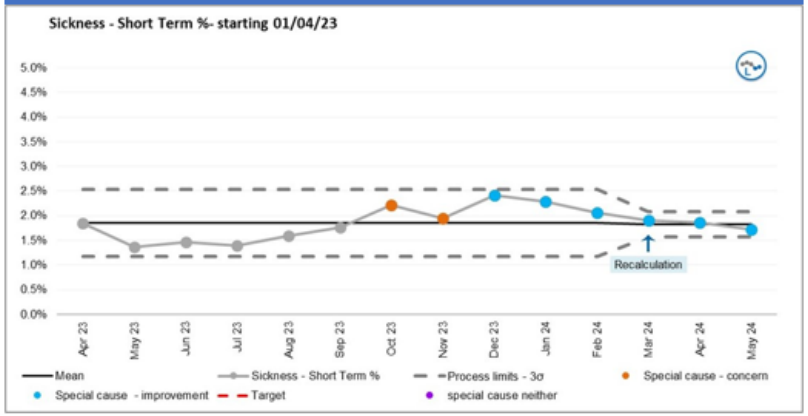
Metric	Assurance	Variation
Sickness – Overall %	Consistently fail target	Common Cause
Sickness – ST %		Common Cause
Sickness – LT %		Common Cause

For the month of May 2024, sickness absence is reporting 5.14%, this is demonstrating a consistent trend above the 3.00% target with long term sickness the main contributing factor.

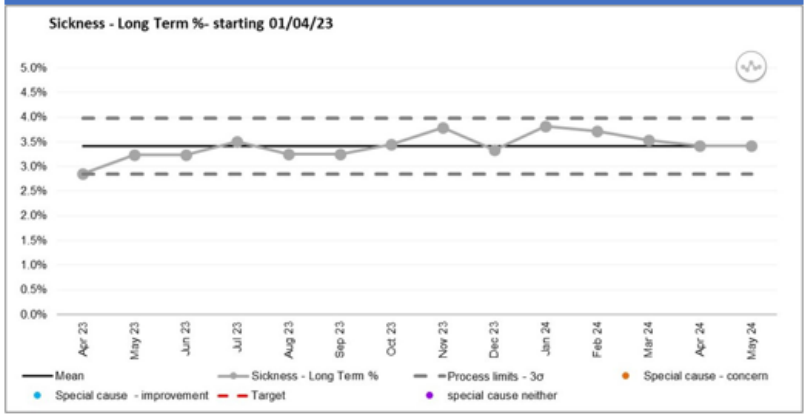
Sickness – Overall % 5.14%



Sickness – Short Term % 1.72%



Sickness – Long Term % 3.42%



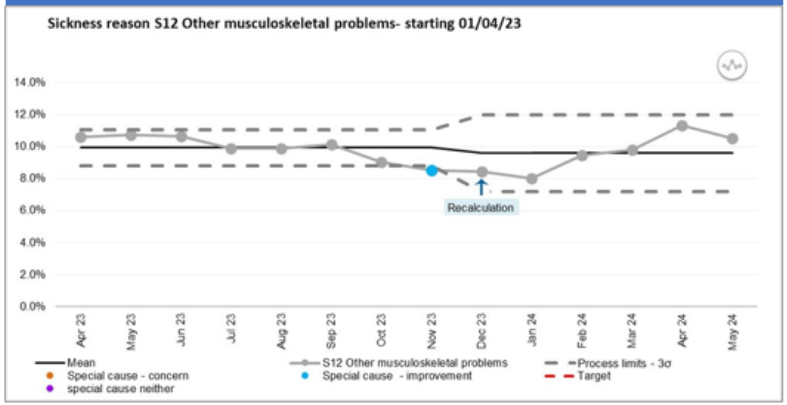
People: Sickness absence

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

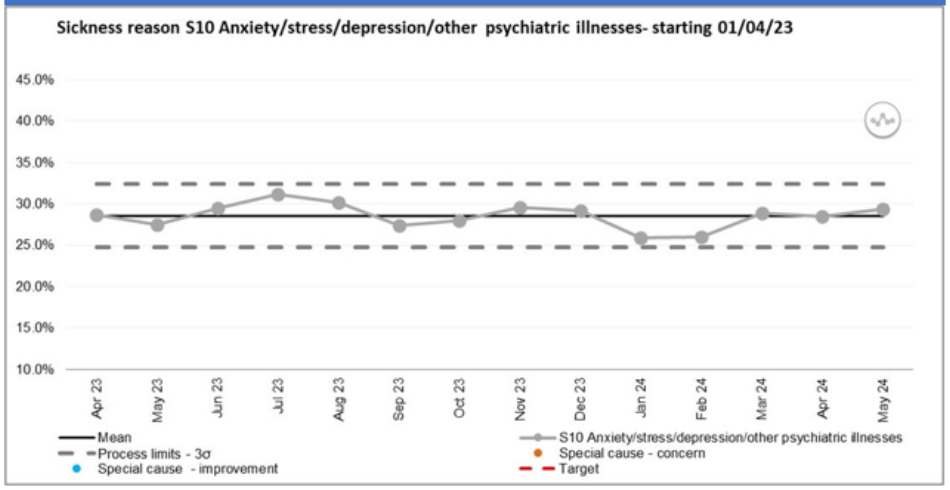
Metric	Variation
S10 Anxiety/stress/depression/other psychiatric illnesses	Common cause
S12 Other musculoskeletal problems	Common cause
S25 Gastrointestinal problems	Common cause

Overall sickness absence for Anxiety/stress/depression/other psychiatric illnesses is 29.34%, this has remained at 'Common Cause variation'.

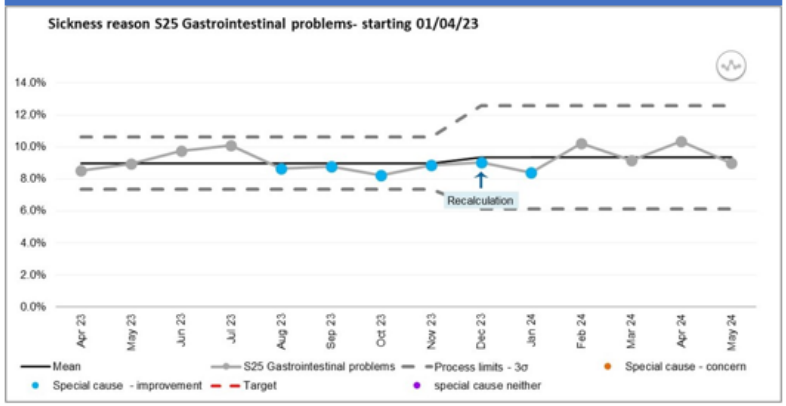
S12 Other musculoskeletal problems 10.53%



S10 Anxiety/stress/depression/other psychiatric illnesses 29.34%



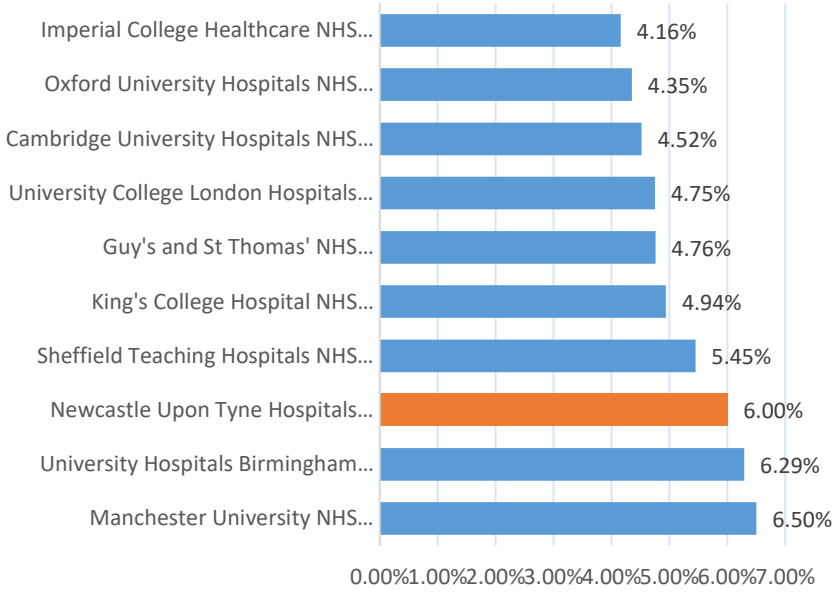
S25 Gastrointestinal problems 9.00%



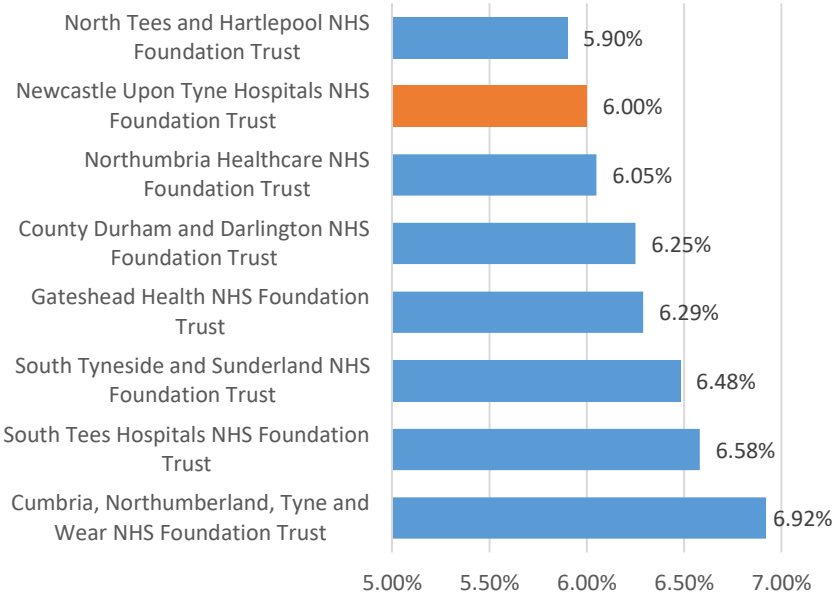
People: Sickness absence

Benchmarking – Shelford Group and North East Region January 2024

Shelford Group - January 2024



North East Region - January 2024



Shelford Group Sickness Average for January 2024 is 5.17%.

North-East Region Sickness Average for January 2024 is 6.31%.

People: Equality and diversity 1/2

Disability

The charts identify the percentage of staff in post in May 2023 and May 2024 by disability.

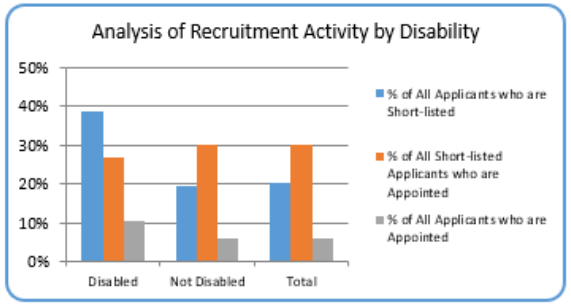
The percentage of staff employed disclosing a disability has increased from 4.93% to 5.19%

Disability - Yes %	May 2023	May 2024	
Add Prof Scientific and Technic	5.37%	5.40%	↑
Additional Clinical Services	6.31%	6.89%	↑
Administrative and Clerical	7.03%	7.33%	↑
Allied Health Professionals	5.94%	5.83%	↓
Estates and Ancillary	4.52%	5.49%	↑
Healthcare Scientists	2.81%	2.23%	↓
Medical and Dental	1.61%	1.36%	↓
Nursing and Midwifery Registered	4.09%	4.30%	↑
Trust Total	**4.93%**	**5.19%**	↑

	Disability - Yes %		
Clinical Board / Corporate Service	May 2023	May 2024	
CB Cancer and Haematology	2.92%	4.24%	↑
CB Cardiothoracic Services	4.57%	4.83%	↑
CB Clinical and Research Services	6.35%	6.42%	↑
CB Family Health	4.97%	5.30%	↑
CB Medicine and Emergency Care	3.77%	4.01%	↑
CB Peri-operative and Critical Care	4.62%	4.48%	↓
CB Surgical and Associated Services FH	4.02%	4.52%	↑
CB Surgical and Specialist Services RVI	3.81%	3.76%	↓
CS Business and Development	8.33%	8.57%	↑
CS Chief Executive	1.85%	4.84%	↑
CS Chief Operating Officer	0.00%	8.33%	↑
CS CRC NENC	9.23%	11.27%	↑
CS Estates	4.19%	5.00%	↑
CS Finance	8.04%	6.84%	↓
CS Human Resources	6.30%	6.87%	↑
CS Information Management and Technology	8.83%	8.41%	↓
CS Integrated Covid Hub North East	0.00%	0.00%	→
CS Medical Director	12.82%	12.20%	↓
CS Patient Services	5.26%	5.70%	↑
CS Regional Drugs and Therapeutics	7.89%	5.71%	↓
CS Supplies	10.53%	8.42%	↓

Recruitment

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



People: Equality and diversity 2/2

Ethnicity

The charts identify the percentage of staff in post in May 2023 and May 2024 by ethnicity.

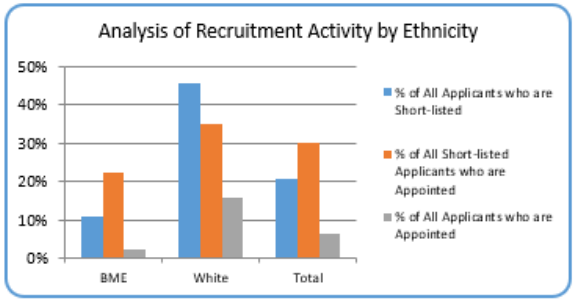
The percentage of BAME staff has increased from 13.63% to 16.34%

Ethnicity - BME%	May 2023	May 2024	
Add Prof Scientific and Technic	7.11%	7.87%	↑
Additional Clinical Services	8.72%	10.41%	↑
Administrative and Clerical	6.49%	8.33%	↑
Allied Health Professionals	7.19%	7.91%	↑
Estates and Ancillary	8.90%	10.91%	↑
Healthcare Scientists	9.12%	9.05%	↓
Medical and Dental	29.37%	31.57%	↑
Nursing and Midwifery Registered	20.11%	25.02%	↑
Trust Total	**13.63%**	**16.34%**	↑

	Ethnicity - BME%		
Clinical Board / Corporate Service	May 2023	May 2024	
CB Cancer and Haematology	11.02%	14.29%	↑
CB Cardiothoracic Services	22.93%	26.59%	↑
CB Clinical and Research Services	8.58%	9.58%	↑
CB Family Health	6.79%	9.97%	↑
CB Medicine and Emergency Care	19.08%	24.09%	↑
CB Peri-operative and Critical Care	24.93%	28.34%	↑
CB Surgical and Associated Services FH	22.99%	26.83%	↑
CB Surgical and Specialist Services RVI	15.67%	16.81%	↑
CS Business and Development	0.00%	2.86%	↑
CS Chief Executive	3.70%	1.61%	↓
CS Chief Operating Officer	0.00%	0.00%	→
CS CRC NENC	4.62%	8.45%	↑
CS Estates	8.96%	10.95%	↑
CS Finance	10.71%	11.11%	↑
CS Human Resources	7.14%	10.73%	↑
CS Information Management and Technology	11.66%	15.53%	↑
CS Integrated Covid Hub North East	12.50%	12.50%	→
CS Medical Director	0.00%	9.76%	↑
CS Patient Services	6.14%	7.89%	↑
CS Regional Drugs and Therapeutics	13.16%	17.14%	↑
CS Supplies	0.00%	1.05%	↑

Recruitment

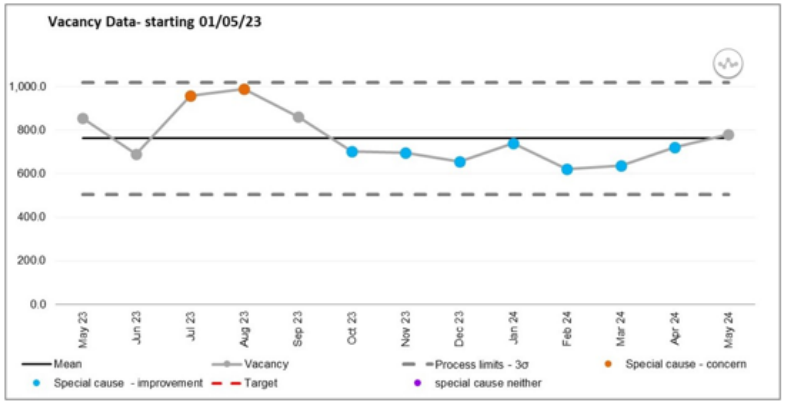
The tables identify by ethnicity the recruitment outcome of applicants during the twelve months ending May 2024.



People: Sustainable workforce planning 1/8

Vacancies

Metric	Variation
Vacancies	Special Cause Improving Variation



The Trust is currently at 782 WTE vacancies as of May 2024.

This has increased from 722 in April 2024, with the largest increase in vacancies being within 'Registered/ Qualified Scientific, Therapeutic and Technical staff' (65 to 116).

Vacacnies WTE	Change Jan 2020 - May 2024
In Month Overall Staff Vacancies WTE	
Registered Nursing, Midwifery and Health Visiting Staff	
Registered/ Qualified Scientific, Therapeutic and Technical staff	
Support to Clinical Staff	
Total NHS Infrastructure support	
Medical and Dental	

Vacancies	
Staff Group	**May 2024**
Registered Nursing, Midwifery and Health Visiting Staff	*117.14*
Adult nursing	*60.97*
Children's nursing	*32.28*
Registered midwives	*13.31*
Community nursing staff	*12.41*
Mental health nursing	*0*
Learning disability nursing	*0*
Post registration learners	*0*
Registered/ Qualified Scientific, Therapeutic and Technical staff	*115.66*
Allied Health Professionals	***6.87***
Art / Music / Dramatherapy	*0*
Dietetics	*-1.76*
Occupational therapy	*-3.42*
Operating department practitioners	*-6.34*
Orthoptics	*1.19*
Osteopathy	*0*
Paramedic	*0*
Physiotherapy	*-17.73*
Podiatry	*-0.92*
Prosthetics and Orthotics	*0*
Radiography (Diagnostic)	*32.05*
Radiography (Therapeutic)	*6.5*
Speech and Language Therapy	*-2.7*
Other Registered Scientific, Therapeutic and Technical Staff	***9.09***
Registered health care scientists	***99.7***
Support to Clinical Staff	*168.21*
Support to nursing and midwifery	*189.74*
Support to AHPs	*3.54*
Support to healthcare scientists and other ST&T	*-10.08*
Support to ambulance	*0*
Other clinical support	*-14.99*
Total NHS Infrastructure support	*299.91*
Managers & senior managers	*-9.78*
Admin and estates staff	*135.33*
Other infrastructure & support staff	*174.36*
Medical and Dental	*83.94*
Consultant	*27.26*
Non-Consultant career grades (excluding trainees)	*4.49*
Trainees	*52.19*
In Month Overall Staff Vacancies WTE	*781.86*

Posts in red and with (-) are over established.

People: Sustainable workforce planning

Staff in Post

Staff in Post (FTE)			
Staff Group	May 23	May 24	% Increase May 23 to May 24
Add Prof Scientific and Technic	529	535	1.07%
Additional Clinical Services	2387	2427	1.65%
Administrative and Clerical	2303	2405	4.43%
Allied Health Professionals	1044	1095	4.85%
Estates and Ancillary	1050	1064	1.34%
Healthcare Scientists	662	661	-0.13%
Medical and Dental	1185	1198	1.08%
Nursing and Midwifery Registered	4538	4833	6.49%
Total	13,699	14,217	3.78%

Staff in post has increased by 3.78% since May 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 87.88%, an increase from 85.89% in May 23

Staff Retention			
Category	2022	2023	2024
Over 1 year service	87.46%	85.89%	87.88%
Less than 1 year service	12.54%	14.11%	12.12%

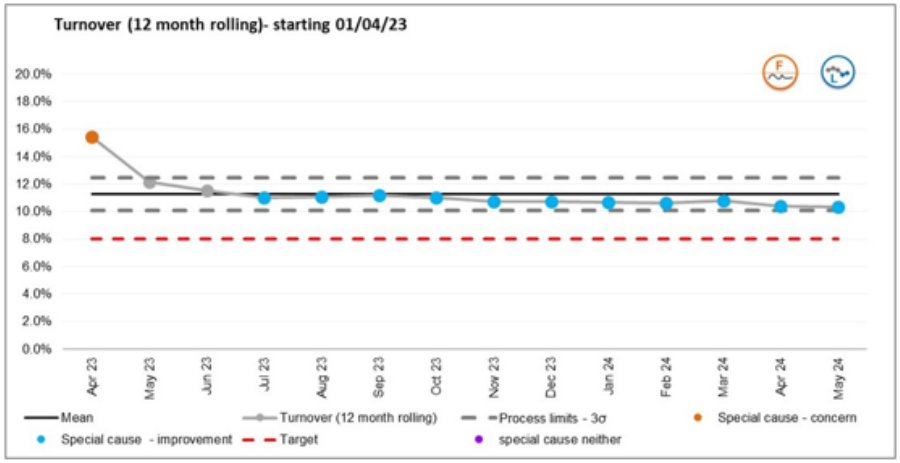
Staff Group (2024)	Over 1 year service	Less than 1 year service
Add Prof Scientific and Technic	90.74%	9.26%
Additional Clinical Services	85.07%	14.93%
Administrative and Clerical	86.96%	13.04%
Allied Health Professionals	89.31%	10.69%
Estates and Ancillary	87.59%	12.41%
Healthcare Scientists	92.62%	7.38%
Medical and Dental	85.85%	14.15%
Nursing and Midwifery Registered	89.07%	10.93%

People: Sustainable workforce planning 3/8

Workforce turnover May 2024 (target 8%)

Turnover (rolling 12 months)	10.31%	
Clinical Board	**Turnover**	**Achieved**
CS Integrated Covid Hub North East	0.00%	✓
CS NHS COVID Vaccination Programme	0.00%	✓
CS Business and Development	2.82%	✓
CB Peri-operative and Critical Care	7.71%	✓
CS CRC NENC	8.89%	✗
CB Medicine and Emergency Care	9.01%	✗
CS Patient Services	9.30%	✗
CB Surgical and Associated Services FH	9.47%	✗
CB Surgical and Specialist Services RVI	9.99%	✗
CB Clinical and Research Services	10.32%	✗
CS Finance	10.48%	✗
CS Supplies	10.53%	✗
CB Cardiothoracic Services	10.59%	✗
CB Cancer and Haematology	10.91%	✗
CB Family Health	11.25%	✗
CS Human Resources	12.31%	✗
CS Estates	12.52%	✗
CS Information Management and Technology	12.84%	✗
CS Regional Drugs and Therapeutics	13.70%	✗
CS Hosted Staff	14.29%	✗
CS Medical Director	15.00%	✗
CS Chief Executive	17.78%	✗
CS Chief Operating Officer	31.58%	✗
Trust Total	10.31%	✗

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



Staff turnover has decreased from 12.81% in May 2023 to 10.31% in May 2024, target is 8.0%.

The total number of leavers in the period June 2023 to May 2024 was 1,666.

Staff in post and staff retention

May 2024	Staff Retention			
Clinical Board	Over 1 year service	Less than 1 year service	Staff in Post (Headcount)	Turnover
CS Chief Operating Officer	67%	33%	12	32%
CS Hosted Staff	70%	30%	38	14%
CS Information Management and Technology	82%	18%	306	13%
CS Medical Director	85%	15%	42	15%
CS Chief Executive	86%	14%	60	18%
CB Cardiothoracic Services	87%	13%	1119	11%
CB Surgical and Specialist Services RVI	87%	13%	1542	10%
CB Medicine and Emergency Care	87%	13%	1893	9%
CS Estates	87%	13%	1374	13%
CS Finance	87%	13%	115	10%
CB Family Health	88%	12%	2416	11%
CB Clinical and Research Services	88%	12%	3509	10%
CS CRC NENC	89%	11%	73	9%
CB Cancer and Haematology	89%	11%	637	11%
CB Surgical and Associated Services FH	89%	11%	1036	9%
CS Human Resources	89%	11%	235	12%
CB Peri-operative and Critical Care	91%	9%	1480	8%
CS Business and Development	91%	9%	36	3%
CS Supplies	93%	7%	87	11%
CS Patient Services	93%	7%	235	9%
CS Regional Drugs and Therapeutics	97%	3%	35	14%
CS Integrated Covid Hub North East	100%	0%	8	0%
Trust	88%	12%	16288	10%

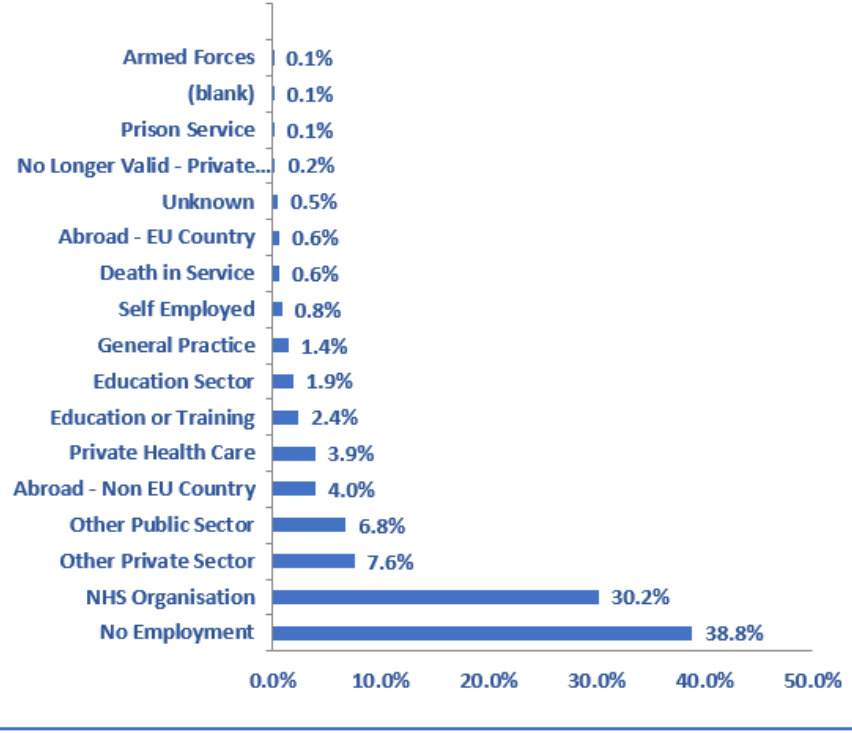
There are two areas with the highest percentage service for 1 year or less, these are CS Chief Operating Officer(33%) and CS Hosted Staff (32%).

To note, these areas do have a lower headcount so the percentages are affected greater by staff changes.

Workforce turnover - reasons and destination

Top 5 Leaving Reasons

Destination on Leaving



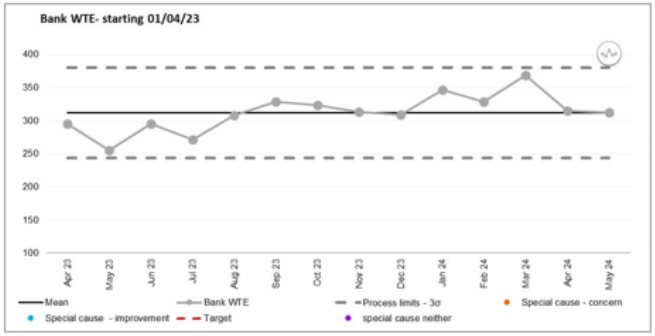
30% of leavers across the Trust disclosed they were going to another NHS organisation.

People: Sustainable workforce planning 6/8

Bank/Agency

Bank (Whole Time Equivalent - wte)

Metric	Variation
Bank WTE	Common cause

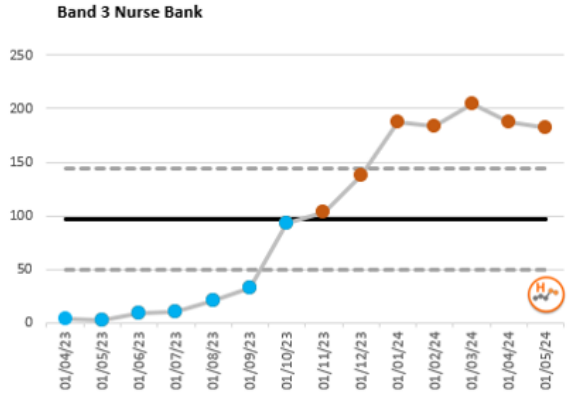


Bank wte is demonstrating 'Special Cause Concerning' Variation. This is present when a random pattern of variation with all points within the control limits.

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

Bank/Agency (continued)

Bank Utilisation (£)

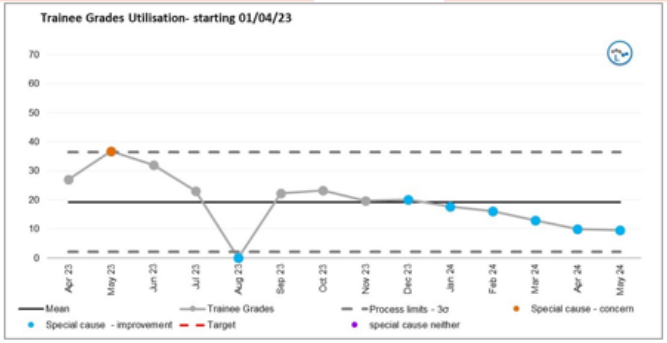
Staff Group	Jun 22 - May 23	Jun 23 - May 24	Difference
Admin & Clerical	£1,240,763	£314,450	-£926,313
Ancillary	£362,913	£1,180,339	£817,426
Estates			
Nursing & Midwifery (Registered)	£6,881,166	£5,628,935	-£1,252,231
Nursing & Midwifery (Unregistered)	£8,249,399	£9,087,270	£837,872
Professional & Technical	£1,349,047	£926,251	-£422,796

Agency Utilisation (£)

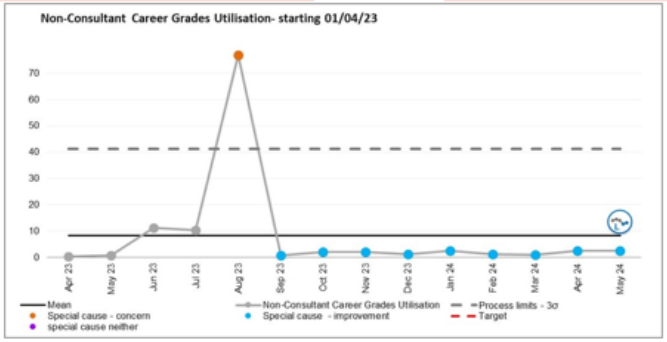
Staff Group	Jun 22 - May 23	Jun 23 - May 24	Difference
Admin & Clerical	£808,073	£639,258	-£168,816
Ancillary	£36,621	£10,614	-£26,006
Estates	£110,549	£57,548	-£53,001
Nursing & Midwifery (Registered)	£95,791	£92,425	-£3,366
Nursing & Midwifery (Unregistered)	£2,440,271	£2,668,875	£228,604
Professional & Technical	£814,779	£857,187	£42,408

Internal Medical & Dental Bank Utilisation

Metric	Variation
Trainee Grades	Special Cause Improving Variation



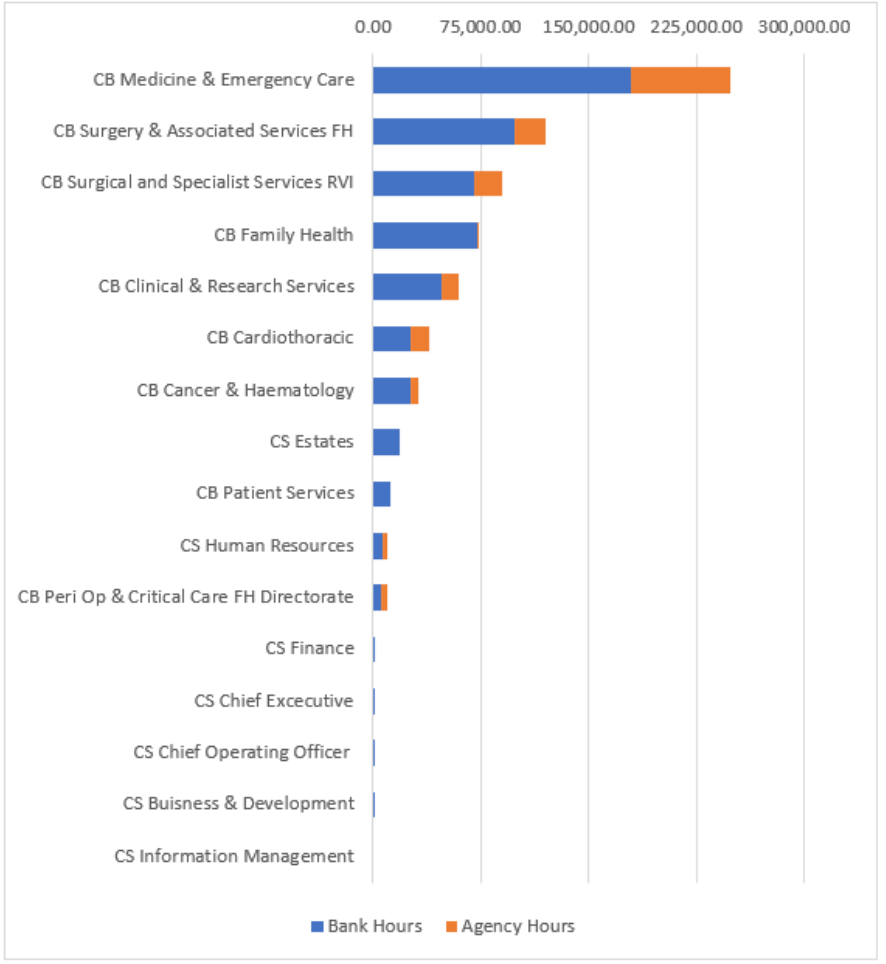
Metric	Variation
Non-Consultant Career Grade	Special Cause Improving Variation



Bank/Agency (continued)

Bank & Agency Utilisation by CB/CS (June 2023 to May 2024)

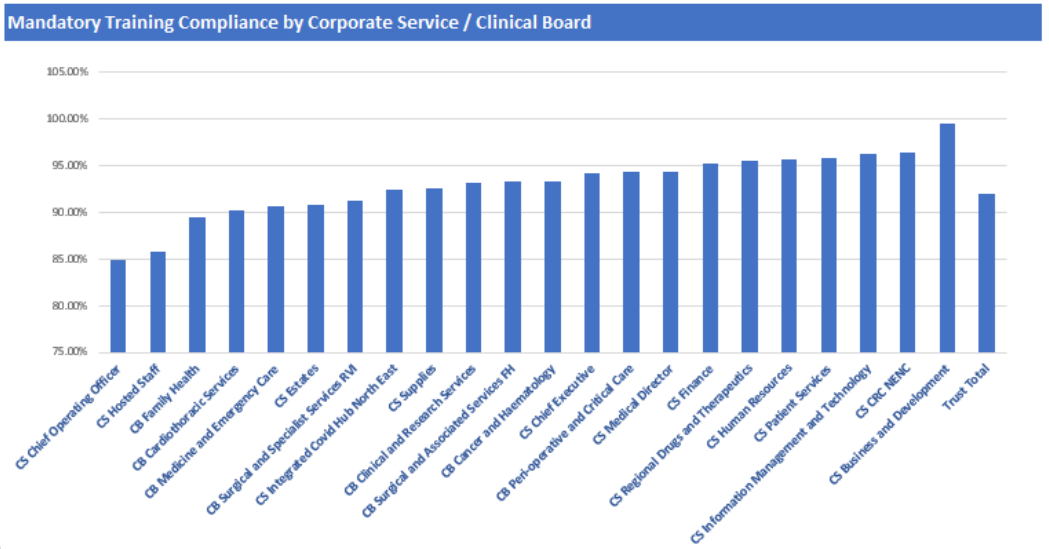
CB/CS	Bank	Agency	Total
CB Medicine & Emergency Care	179,900.75	68,647.32	248,548.07
CB Surgery & Associated Services FH	98,271.81	22,073.26	120,345.07
CB Surgical and Specialist Services RVI	70,349.74	19,084.61	89,434.35
CB Family Health	72,400.22	1,320.85	73,721.08
CB Clinical & Research Services	48,017.02	11,139.00	59,156.02
CB Cardiothoracic	25,765.67	13,710.50	39,476.17
CB Cancer & Haematology	26,282.38	4,744.69	31,026.98
CS Estates	18,864.46	0	18,864.46
CB Patient Services	12,049.28	0.00	12,049.28
CS Human Resources	7,135.92	2514	9,649.92
CB Peri Op & Critical Care	5,495.00	3940.47	9,436.43
CS Finance	1,606.19	0	1,606.19
CS Chief Excecutive	818.03	0	818.03
CS Chief Operating Officer	324.92	0	324.92
CS Buisness & Development	71.73	0	71.73
CS Information Management	0	0	0

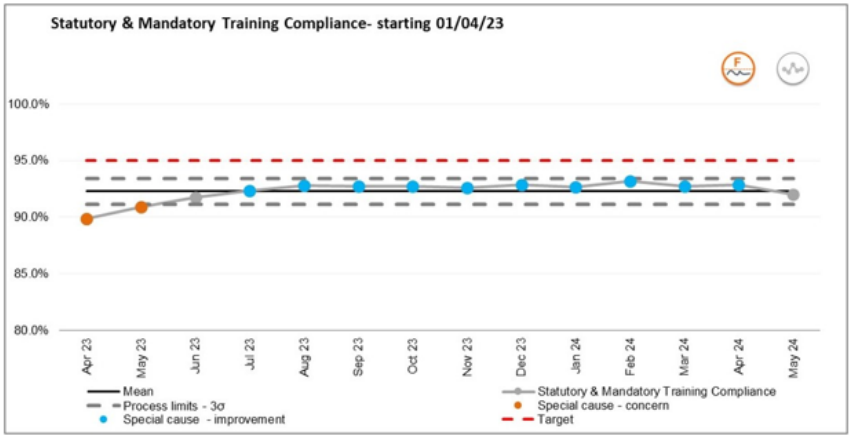


People: Excellence in education and training 1/3

Mandatory training May 2024 (target 95%)

Mandatory Training Compliance (target 95%)	92.01%	
Staff Group	**Compliance**	**Achieved**
Medical and Dental	85.68%	✗
Senior Staff (Band 8c and Above)	90.21%	✗
Estates and Ancillary	90.82%	✗
Allied Health Professionals	91.72%	✗
Nursing and Midwifery Registered	91.79%	✗
Healthcare Scientists	93.12%	✗
Additional Clinical Services	93.14%	✗
Add Prof Scientific and Technic	93.36%	✗
Administrative and Clerical	94.81%	✗





Metric	Assurance		Variation	
Mandatory Training Compliance %	F	Consistently fail target		Special Cause Improving Variation

Mandatory training compliance is 92.01% at end May 2024, target is 95%.

Medical and Dental are the staff group with the lowest training compliance at 85.68%

People: Excellence in education and training 2/3

Mandatory training (continued)

Mandatory Training Compliance (target 95%)		92.01% ✗
Mandatory Training	**Compliance**	**Achieved**
Paediatric Basic Life Support	78.84%	✗
Moving and Handling Level 2	81.84%	✗
Adult Basic Life Support	83.89%	✗
Fire Safety	84.28%	✗
Infection Prevention and Control (Level 2)	88.90%	✗
Information Governance	90.78%	✗
Moving and Handling Level 1	93.29%	✗
Infection Prevention and Control (Level 1)	94.91%	✗
Health and Safety	95.99%	✓
Prevent WRAP	96.22%	✓
Prevent Awareness	96.58%	✓
Equality and Diversity	96.65%	✓
Safeguarding Adults (Level 1)	96.83%	✓
Safeguarding Children (Level 1)	96.90%	✓
Conflict Resolution	97.80%	✓

Lowest Two Mandatory Training Compliance %		
Staff Group	**Paediatric Basic Life Support**	**Moving and Handling Level 2**
May 2024	**78.84%**	**81.84%**
Add Prof Scientific and Technic	82%	87%
Additional Clinical Services	78%	83%
Administrative and Clerical	80%	0%
Allied Health Professionals	79%	85%
Estates and Ancillary	0%	93%
Healthcare Scientists	77%	17%
Medical and Dental	78%	0%
Senior Staff (Band 8c and Above)	100%	0%
Nursing and Midwifery Registered	79%	81%

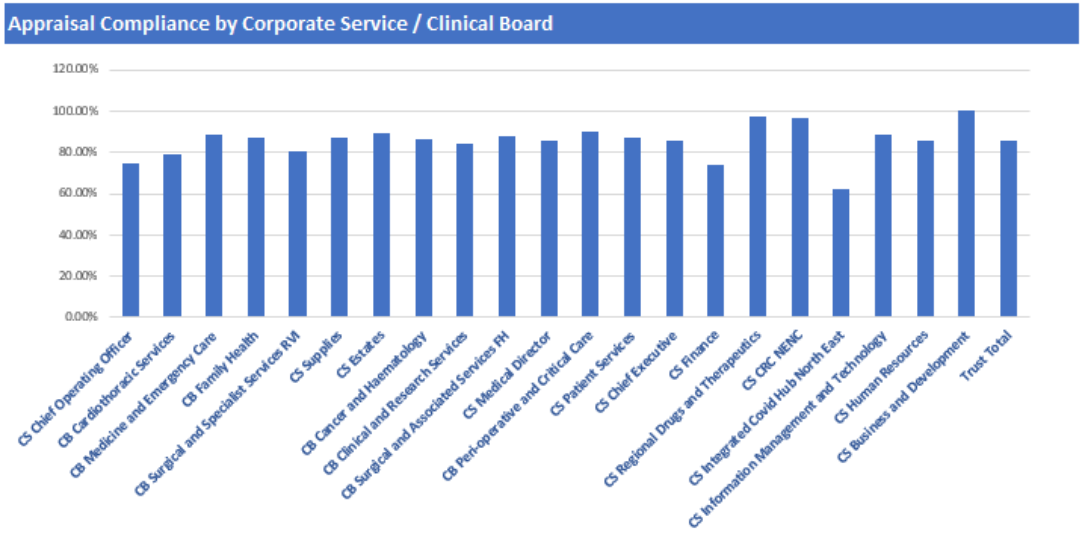
At end May 2024, mandatory training compliance was 92.01%

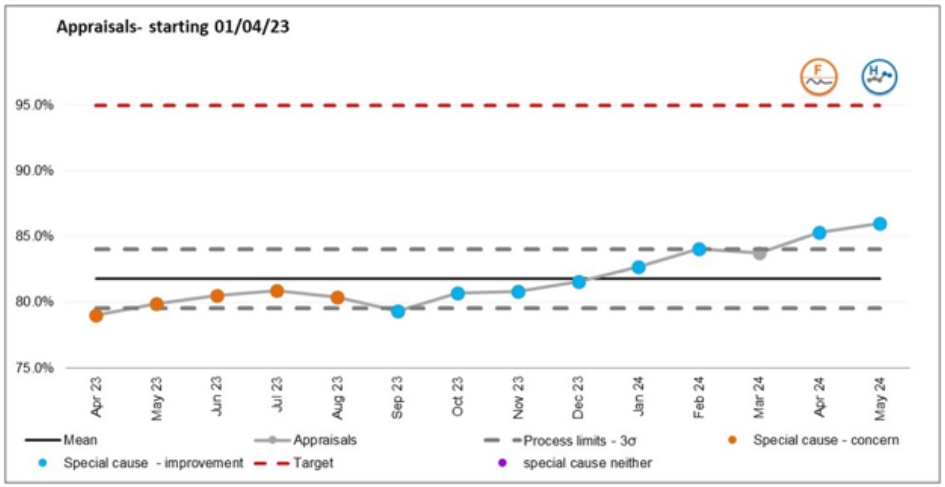
People: Excellence in education and training 3/3

Appraisal compliance May 2024 (target 95%)

Appraisal Compliance (target 95%)		85.99%
Staff Group	**Compliance**	**Achieved**
Medical and Dental	78.24%	
Allied Health Professionals	82.55%	
Administrative and Clerical	84.72%	
Healthcare Scientists	84.87%	
Add Prof Scientific and Technic	85.24%	
Additional Clinical Services	86.08%	
Nursing and Midwifery Registered	88.21%	
Estates and Ancillary	90.10%	
Manager Band 8c and Above	98.32%	

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: Access & Outcomes 1/2

Theme	Standard	Mar-24	Apr-24	May-24	Num.	Den.	24/25 YTD
Activity & Elective Care							
Day Case	**100%** of 24/25 Plan (equivalent to **107%** of 19/20 value-weighted activity)		100.3%	**100.2%**	11,041	11,018	**100.2%**
Elective Overnight			97.6%	**100.9%**	1,811	1,794	**99.3%**
Outpatient New			98.9%	**97.2%**	25,268	26,005	**98.0%**
Outpatient Procedures			99.8%	**93.4%**	18,495	19,801	**96.6%**
Outpatient Review	**N/A**		116.6%	**117.5%**	66,492	56,575	**117.1%**
Non-Elective			104.0%	**108.7%**	6,522	6,001	**106.4%**
Emergency			84.6%	**89.7%**	974	1,086	**87.2%**
RTT 18 Week Wait	**92%**	67.5%	68.4%	**69.1%**	69,209	100,186	**68.7%**
>78 Week Waiters	**Zero**	7	15	**22**	22		
>65 Week Waiters	**Zero** (by Sep-24)	622	541	**476**	476		
>52 Week Waiters	As per submitted trajectory	3,017	2,711	**2,547**	2,547		
RTT Waiting List Size	As per submitted trajectory	99,884	100,012	**100,186**	100,186		
Diagnostic Activity	**120%** of 19/20 activity	118.3%	111.8%	**113.5%**	22,167	19,591	**112.2%**
Diagnostic 6 week wait	<=**5%** (local target of <=15%)	33.1%	33.9%	**34.1%**	6,104	17,911	**34.0%**
Urgent Ops. Cancelled Twice	**Zero**	0	0	**0**	0		**0**
Cancelled Ops. Rescheduled >28 Days	**Zero**	8	13	**7**	7		**20**
OP Activity Ratio: New/Procedure	**46%**	40.7%	41.3%	**40.1%**	41,984	104,622	**41.2%**
>12 Week Waiters Validated	**90%**	62.4%	61.2%	**54.3%**	17,210	31,715	**57.7%**
Outpatient Review Reduction	**25%** reduction vs 19/20 baseline	132.1%	103.0%	**108.1%**	86,968	79,070	**105.5%**
PIFU Take-up (%)	>=**5%** of all OP atts. (by Mar-25)	2.0%	1.9%	**2.1%**	2,452	117,275	**2.0%**

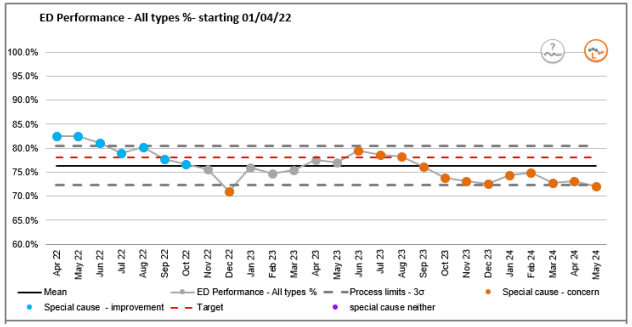
Performance: Access & Outcomes 2/2

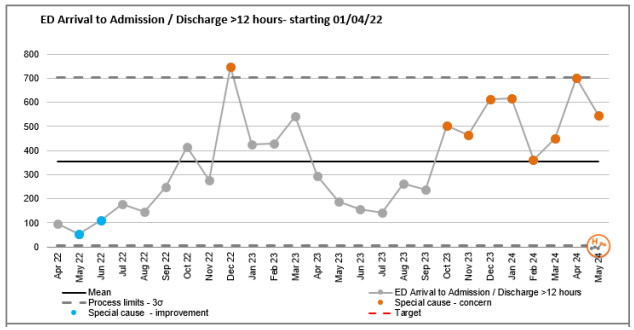
Theme	Standard	Mar-24	Apr-24	May-24	Num.	Den.	24/25 YTD
Cancer Care							
28 Day Faster Diagnosis	**77%** (by Mar-25)	84.6%	**77.0%**	TBC	1,873	2,299	**77.0%**
31 Days (DTT to Treatment)	**96%**	89.1%	**84.8%**	TBC	1,184	1,330	**84.8%**
62 Days (Referral to Treatment)	**70%** (by Mar-25)	61.9%	**58.9%**	TBC	242	406	**58.9%**
>62 Day Cancer Waiters		186	167	**178**	178		
Urgent & Emergency Care							
A&E Arrival to Admission/Discharge	**>=78%** under 4 hours (by Mar-25)	72.8%	73.2%	**72.0%**	14,802	20,559	**72.6%**
	<=2% over 12 hours	2.2%	3.6%	**2.7%**	547	20,559	**3.1%**
A&E Decision to Admit to Admission	**Zero** over 12 hours	32	122	**65**	65		**187**
Adult General & Acute Bed Occupancy	**<=92%**	89.8%	91.0%	**89.4%**	1,267	1,417	**90.2%**
Ambulance Handovers <15 mins	**65%**	55.8%	52.7%	**53.6%**	1,965	3,394	**53.2%**
Ambulance Handovers <30 mins	**95%**	86.7%	86.9%	**84.1%**	2,998	3,394	**85.4%**
Ambulance Handovers >60 mins	**Zero**	75	54	**89**	89		**143**
Urgent Community Response Standard	**>=70%** under 2 hours	82.0%	82.0%	**78.0%**	383	411	**79.8%**
Safe, High Quality Care							
Mixed Sex Acommodation Breach	**Zero**	78	112	**102**	102		**214**
VTE Risk Assessment	**95%**	**95.1%**	TBC	TBC			
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour	**66.0%**	TBC	TBC			
Sepsis Screening Treat. (All)		**64.0%**	TBC	TBC			

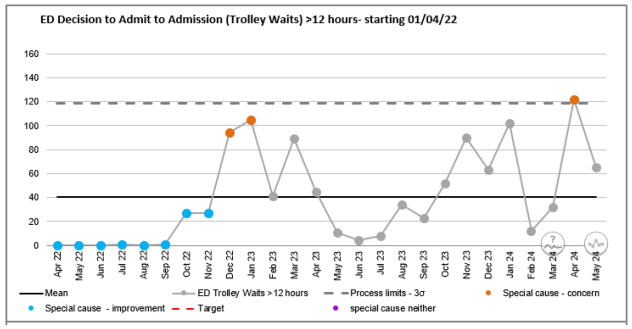
Performance: Emergency Care

Reporting Month: May 2024

RAG Rating







Standards:

- 78% of patients to be admitted/transferred/discharged from A&E in <4 hours (by Mar-25).
- No ambulance handovers to A&E exceeding 60 minutes.
- Less than 2% of patients to wait over 12 hours from A&E arrival to admission/discharge.

Current position:

- Type 1 and overall performance slightly worsened from the previous month to 56.4% (-0.7%) and 72.0% (-1.2%) respectively.
- Handovers >60 minutes increased to the highest level on record – 89 in May compared to 54 in April. There were 452 handovers >30 mins.
- Trolley waits >12 hours almost halved from the peak recorded in April (65 vs 122).

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.

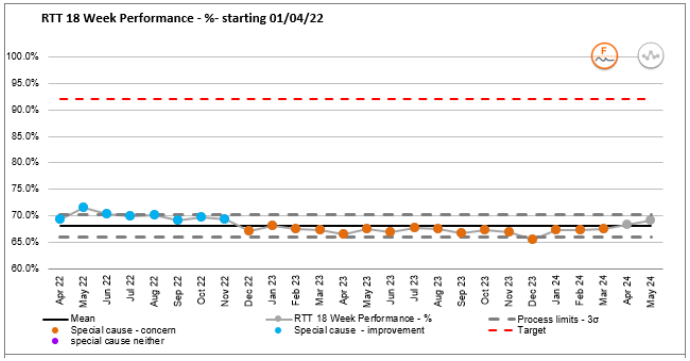
Actions undertaken:

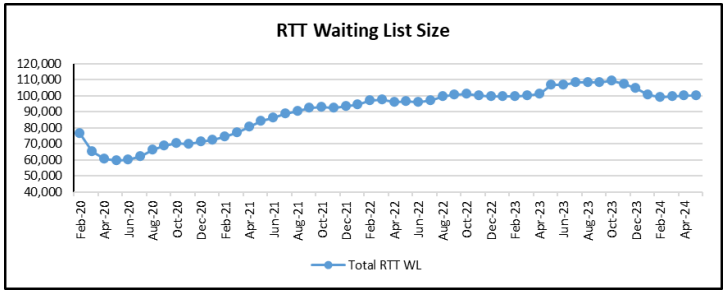
- A workforce review has taken place and business case approved for additional medical staff to reduce waits to see a clinician.
- A number of initiatives have been implemented to improve flow front of house. These include a consultant "See and Treat" shift, streaming patients to alternative services (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.

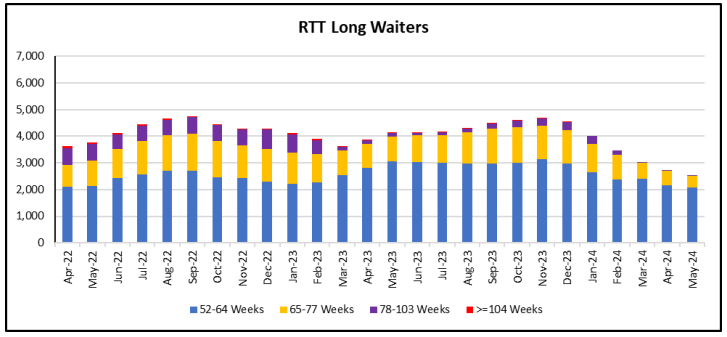
Performance: Elective Waits

Reporting Month: May 2024

RAG Rating







Standards:

- 92% of patients on incomplete RTT pathways to be waiting less than 18 weeks.
- Zero tolerance on incomplete RTT waits over 65 weeks (by Sep-24).

Current position:

- May saw the continued reduction of >65 & >52 week waits at Newcastle Hospitals.
- The total number of patients waiting >78 weeks remained low but increased to 22, from 15 in April. The number of patients waiting over 65 weeks fell to 476, with those waiting over a year for treatment dropping to 2,547.
- The total waiting list (WL) size remained largely stable compared to April – 100,186 overall. The total number of patients waiting >18 weeks stood at 30,977, with RTT 18 week performance recorded at 69.1% (+0.7%).

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. 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.
  - Increased cancer demand generally, but particularly in Dermatology.
  - Increased urgent cases taking clinical priority, particularly in Plastic & Spinal Surgery.

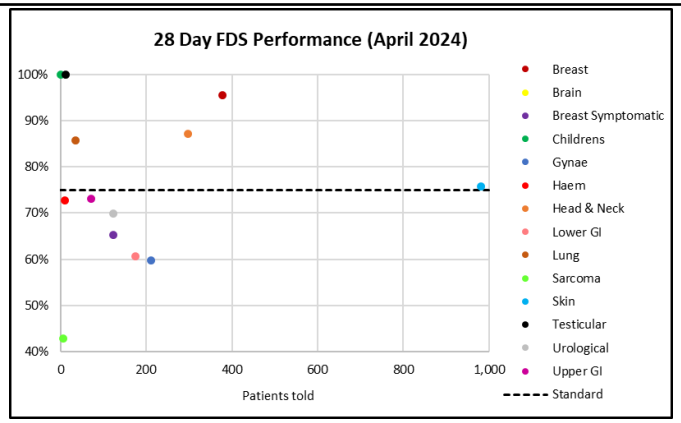
Actions undertaken:

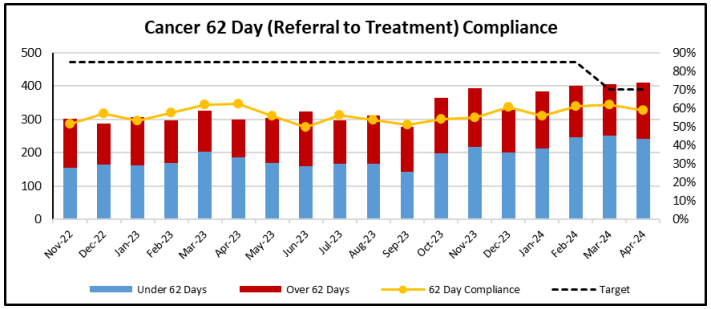
- The implementation of the spinal business case outlined in previous reports, continues to see the improvement in the numbers of patients waiting for spinal surgery.
- The Trust also continues to work with both South Tees and Northumbria Healthcare FTs in the repatriation of referrals back to these providers where that it is clinically appropriate.
- The improvements that have been seen over recent months have been driven by:
  - 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: April 2024

RAG Rating





62 DAY PERFORMANCE – APRIL 2024					
Brain	100%	Head & Neck	80.0%	Skin	80.5%
Breast	89.9%	Lower GI	25.3%	Testicular	100%
Gynae	45.0%	Lung	29.3%	Upper GI	37.9%
Haem	82.1%	Sarcoma	71.4%	Urological	46.0%
Newcastle Hospitals Total					**58.9%**

Standards:

- 77% of patients on a suspected cancer or breast symptomatic pathway to receive results/diagnosis within 28 days of referral (by Mar-25).
- 70% of patients to wait no more than 62 days from urgent/screening referral to first cancer treatment (by Mar-25).
- 96% to wait no more than 31 days from diagnosis to first cancer treatment.

Current position:

- The 75% 28 Day Faster Diagnosis Standard (FDS) was achieved for the third successive month (77.0%), despite dropping by 7.6% from March.
- 62 Day compliance was 58.9% in April. Lower GI, Lung, Upper GI, Gynae and Urological tumour groups delivered the lowest performance levels – all below 50%.
- 31 Day performance fell back by 4.3% to 84.8% in April.

Underlying Issues:

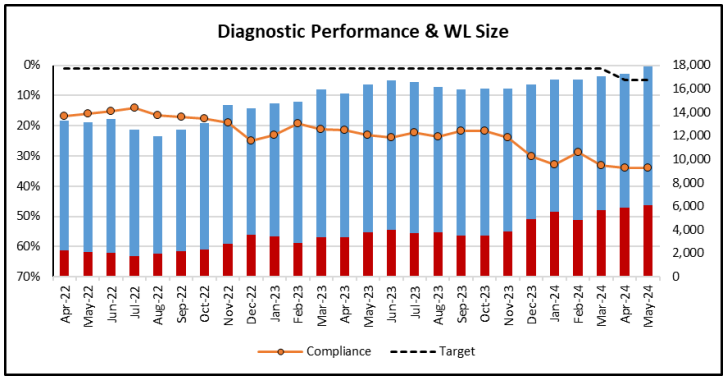
- Diagnostic delays including within Pathology, Radiology and Endoscopy mean that the majority of patients waiting 40-62 days are still awaiting diagnosis. CT capacity is particularly impacting Urology performance and there have been delays for cystoscopies.
- Various tumour groups have limited theatre capacity and staff shortages - staffing to undertake additional theatre work remains challenging, 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.
- Endoscopy: Two additional upper GI consultants have now been appointed, one starting in September, which will ensure additional capacity is secured in the medium to long-term.
- All tumour groups have now submitted performance trajectories with accompanying action plans which cumulatively match the Trust's trajectory and comply with the standards set by NHSE for providers to deliver by the end of the financial year. These will be monitored through the monthly Quality & Performance Reviews for each Clinical Board.

Performance: Diagnostics

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



MAY 2024		Total WL	Breaches	Compliance
Imaging	MRI	5,328	2,405	45.1%
	CT	1,964	210	10.7%
	Non-obs Ultrasound	3,862	83	2.1%
	Barium Enema	0	0	N/A
	DEXA	375	37	9.9%
Physiological Measurement	Audiology	3,859	2,891	74.9%
	ECHO	1,044	175	16.8%
	Electrophysiology	22	3	13.6%
	Periph. Neurophysiology	489	154	31.5%
	Sleep Studies	99	55	55.6%
	Urodynamics	23	7	30.4%
Endoscopy	Colonoscopy	290	25	8.6%
	Flexi sigmoidoscopy	128	10	7.8%
	Cystoscopy	49	0	0.0%
	Gastroscopy	379	49	12.9%

Standard: <=1% of patients on incomplete diagnostic pathways waiting six weeks or longer.

Current position:

- Performance against the 5% standard declined slightly compared to April, with 34.1% of patients waiting longer than six weeks for their test (-0.2%).
- The volume of activity delivered per working day increased by 6.7% from April.
- The total WL size grew by 627 patients from the previous month, with total 6-week breaches increasing by 231 over the same period (6,104, +3.9%). The volume of patients waiting >13 weeks grew by 538 to 2,158 (+24.9%).

Underlying Issues:

- Staffing deficits continue to constrain the volumes of activity several of our diagnostic services can undertake, particularly within Audiology.
- MRI continue to experience significant growth in referrals compared to historic trends across both inpatient and outpatient settings, as well as ongoing pressure to deliver prompt scans for patients on cancer pathways or that have experienced long elective waits – squeezing the ability to deliver routine diagnostics within six weeks. The complexity / casemix of requested scans has also impacted waits, such as Cardiac & GA MRIs which are increasingly referred to NuTH by other DGHs.
- 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.

Actions undertaken:

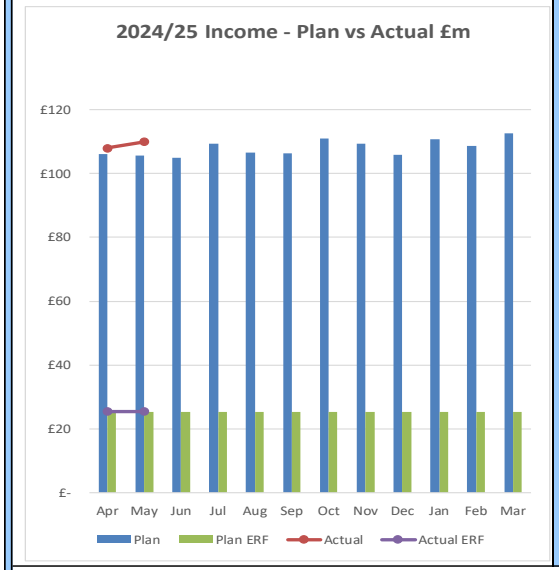
- A whole service review is being undertaken within Audiology, including ensuring that patients are being appropriately referred into the service. The waiting list has been split into age groups with additional resource being dedicated to improve the waiting times of paediatric patients in the first instance, whilst there are also plans being developed to introduce patient-initiated follow-up guidelines into the service, with regular reviews being discontinued after three years.
- ECHO continue to work with insourcing providers to deliver additional capacity, with performance improving by 15% last month. Clinic schedules are also being amended to maximise efficiency.
- Radiology continue to share use of the CT and MRI scanners at Blaydon CDC, as well as utilising two additional MRI vans at the Freeman. Significant gains have been made through a dedicated improvement programme within main radiology booking and scheduling.

Finance

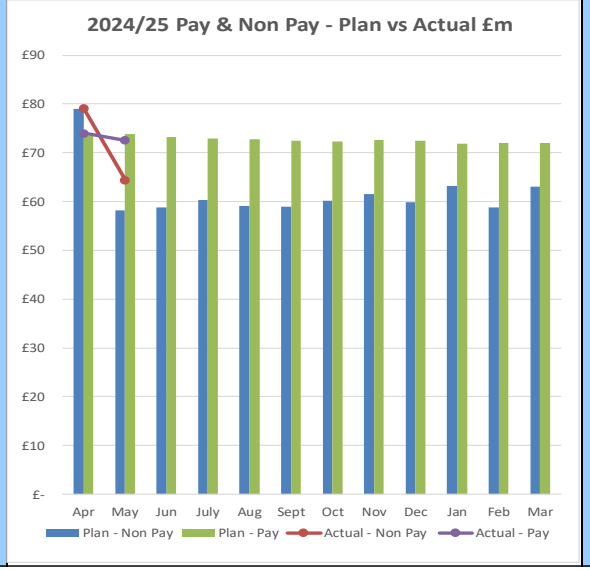
Finance: Overall Financial Position

Financial Overview as at 31st May 2024

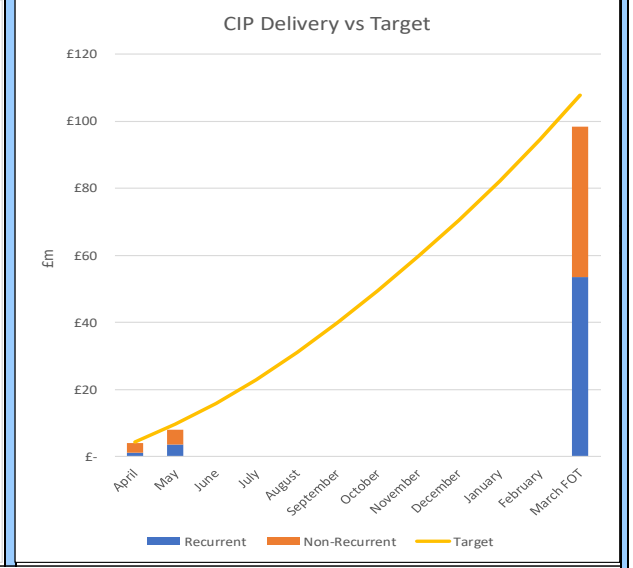
Income



Expenditure



Cost Improvement Analysis



This page summarises the financial position of the Trust for the period ending 31st May 2024. The Trust has agreed a Financial Plan for 2024/25 with a break-even position. As at Month 2 the Trust is reporting delivery against the planned deficit of £4 million (after Control Total). The financial information includes the costs of the Consultant Pay Reform agreement for 2023/24 paid in May, with a pressure on drugs, partly off-set with income.
The delivery of the plan has a significant Cost Improvement Plan (CIP) and a number of non-recurrent factors. in May. There is an overspend on drugs expenditure partly matched with income and an increase on the 2023/24 levels that will be monitored.

Capital Expenditure - The Plan for April is £1.4 million and the year to date expenditure is £1.6 million creating a variance of £0.2 million to date.

Risks

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

Finance: Overall Financial Position 2/3

Income & Expenditure Statement	In Month (May 2024)			Year To Date (May)		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Operating income from patient services	(115,948)	(118,569)	(2,622)	(232,461)	(236,706)	(4,245)
Other operating income	(14,695)	(16,904)	(2,209)	(29,718)	(32,334)	(2,617)
Employee expenses	73,919	72,603	(1,316)	147,424	146,598	(826)
Operating expenses excl. employee expenses	52,137	59,060	6,923	105,734	115,049	9,315
OPERATING SURPLUS/(DEFICIT)	**4,587**	**3,811**	**(776)**	**9,021**	**7,393**	**(1,628)**
Finance income	(248)	(1,390)	(1,142)	(496)	(2,912)	(2,416)
Depreciation	3,374	3,057	(317)	6,753	6,144	(609)
Finance expense	2,271	2,268	(3)	24,188	22,275	(1,913)
PDC dividends payable/refundable	81	81	0	162	162	0
NET FINANCE COSTS	**5,478**	**4,017**	**(1,461)**	**30,607**	**25,669**	**(4,938)**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(891)**	**(206)**	**685**	**(21,586)**	**(18,276)**	**3,310**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR - CONTROL TOTAL	**(2,022)**	**(2,022)**	**(0)**	**(4,064)**	**(4,063)**	**0**

The reported performance for May 2024 is as follows:-

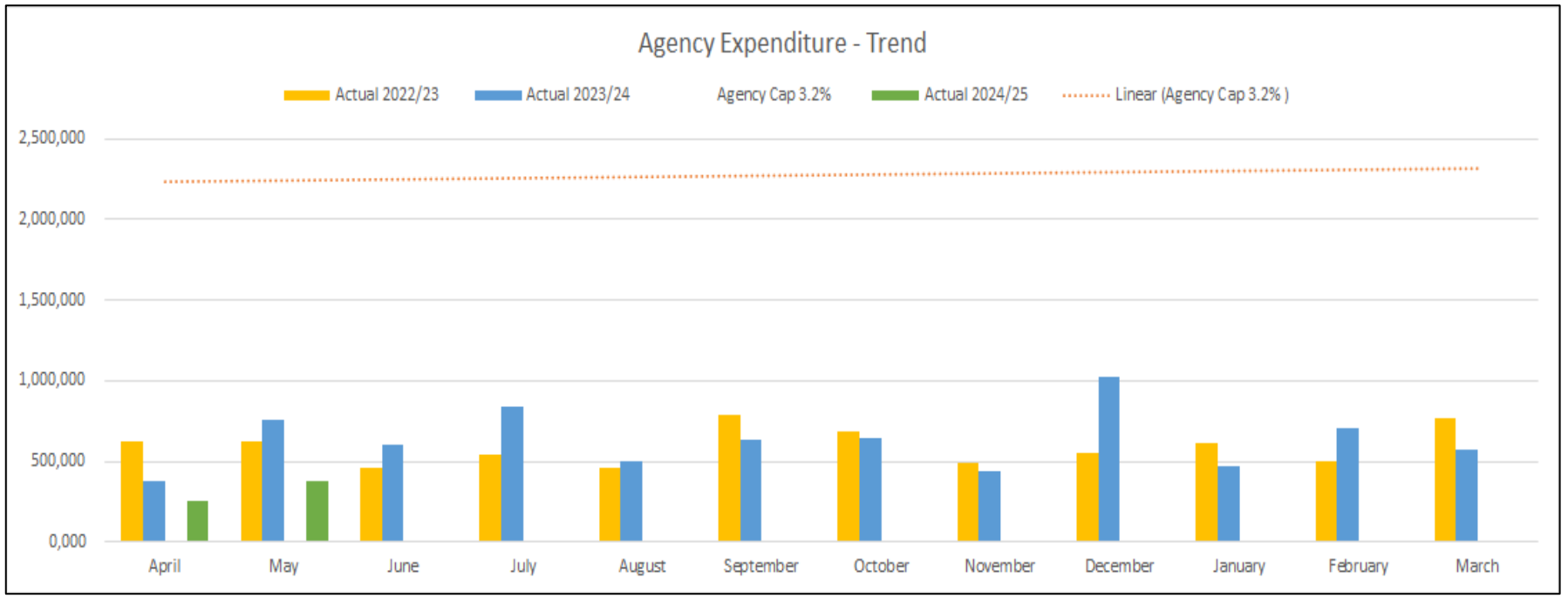
Income

- The in-month position is an overall favourable variance of £4,831k, partly due to over-performance on matched drugs and devices and miscellaneous income behind plan currently.

Expenditure

- The employee expenses includes the impact of the Consultant Pay Reform expenditure paid in May. There is an overspend on drugs expenditure partly matched with income and an increase on the 2023/24 levels that will be monitored.

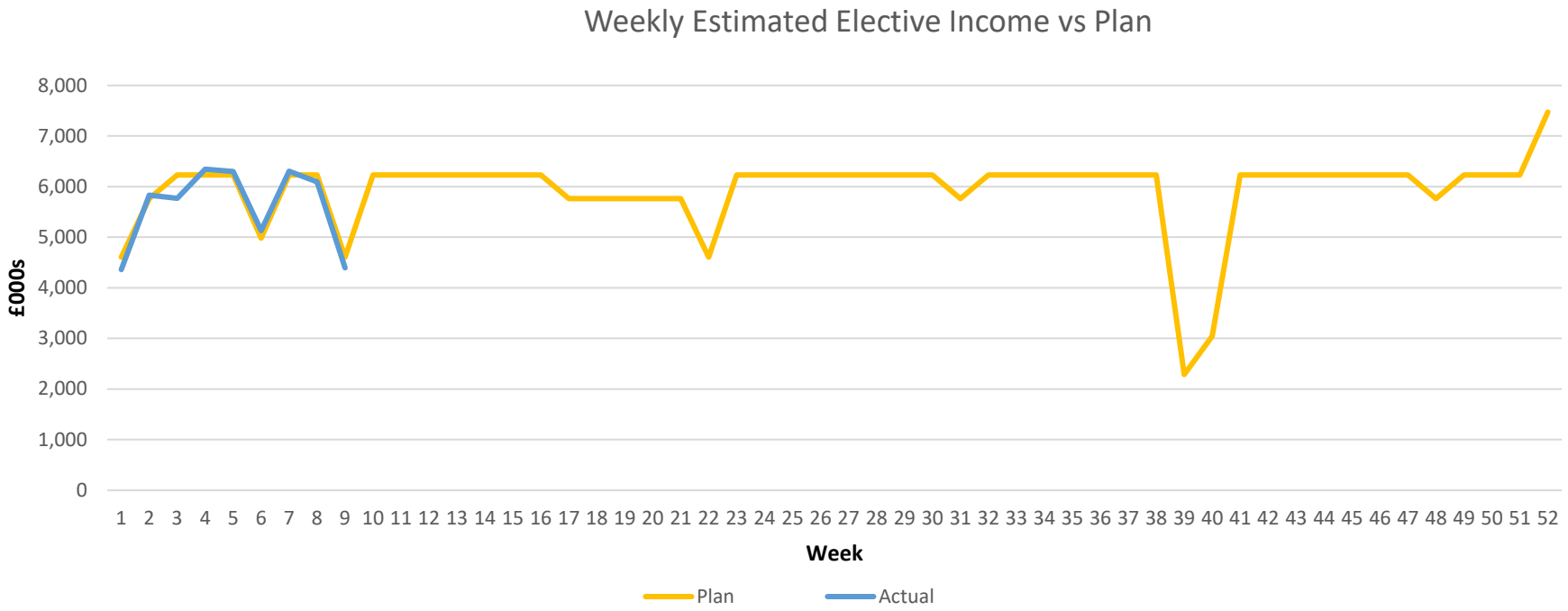
Finance: Overall Financial Position 3/3



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.

Finance: Overall Financial Position 4/4



Elective Recovery Performance

Background

- Elective income (Ordinary Elective, Day Case, Outpatient New and Outpatient Procedure Income) is paid on a tariff basis
- The clinical boards have committed to deliver a plan of £307m which is £4m higher than the nationally set target for elective activity. The graph above shows estimated performance against this plan.
- There is a time lag in recognising income relating to outpatient procedures - outpatient procedures attendances in review appointments default to outpatient reviews (which are outside of the ERF tariff payment) until they coded.

Current Position

- To week 9, total delivery is £586k away from the agreed plans, however this is expected to improve back to target as outpatient procedures are coded. There is a specific issue in Ophthalmology where coding is behind the usual 4 weeks for outpatient procedures.

Health Inequalities

Health Inequalities: Overview

- The Health Inequality performance report for July will focus on describing the Trust's elective admissions based on catchment population data by the Office of Health Improvement and Disparities (OHID) and the Trust inpatient lists.
- Given that the admission date is known in advance for elective admissions or not determined yet for inpatients waiting lists, exploring inequalities, particularly by deprivation and ethnicity can inform an inclusive approach to elective recovery. This can be done by working closely with community partners.
- Inequalities resulting from the wider determinants (structural, economic and social factors) mean that patients with the same clinical need may experience different impacts while on the waiting list (for example patients living in more deprived areas are more likely to experience multiple morbidities and hence develop complications while they wait. Also depending on the length of wait, that can also impact employment, especially for those in manual professions and zero-hour pay employment).
- Understanding the catchment population is important as it provides a baseline denominator that enables us to evaluate unmet need, service provision, inequity of access and hence utilise a more efficient and equitable planning and delivery of care.

Health Inequalities: Trust Catchment Population

Figure 1: Trust Catchment Population

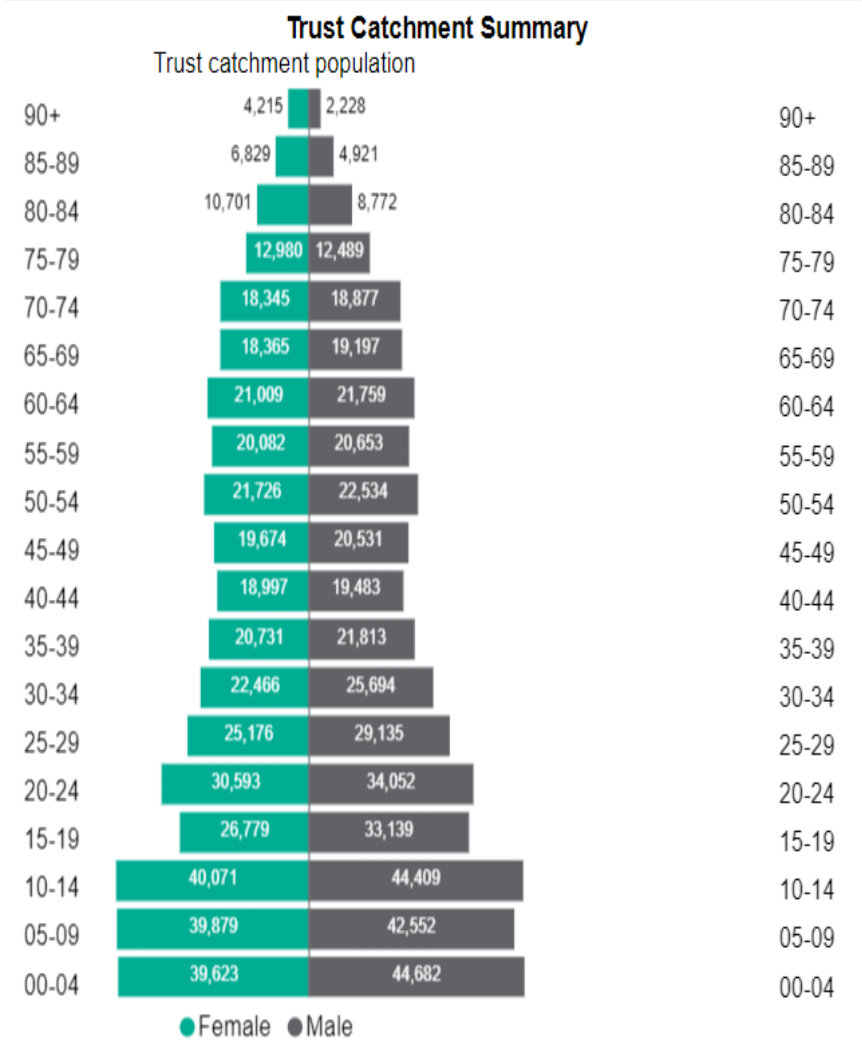
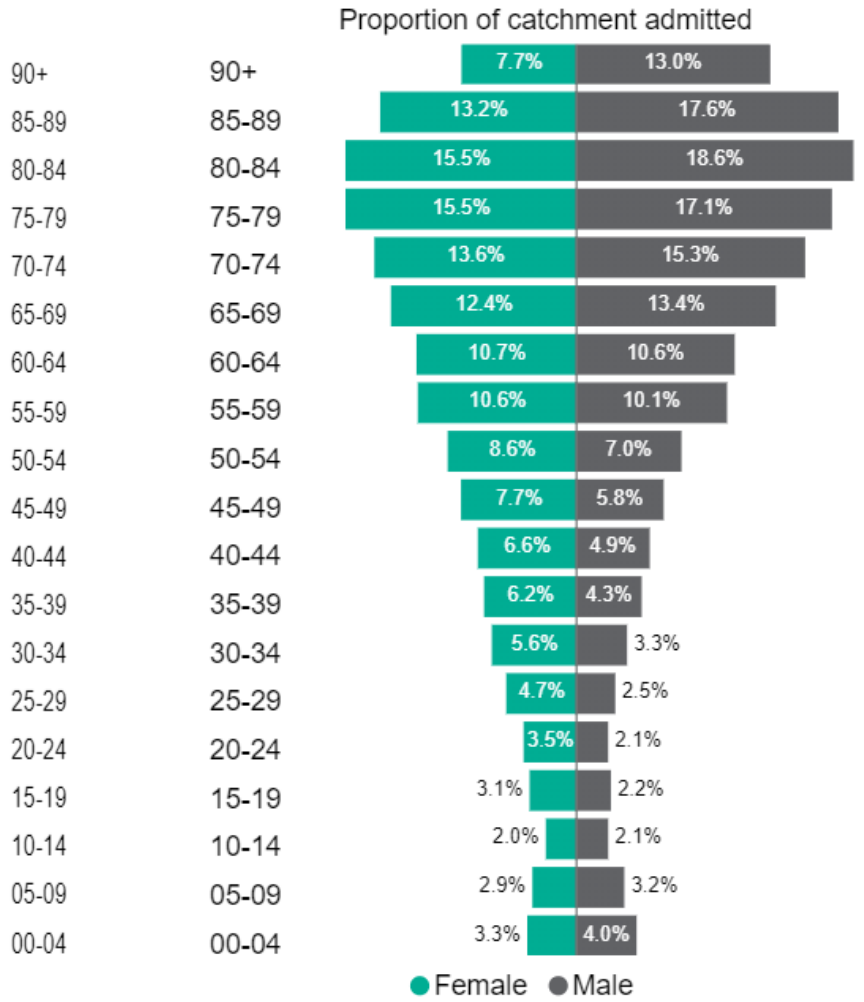
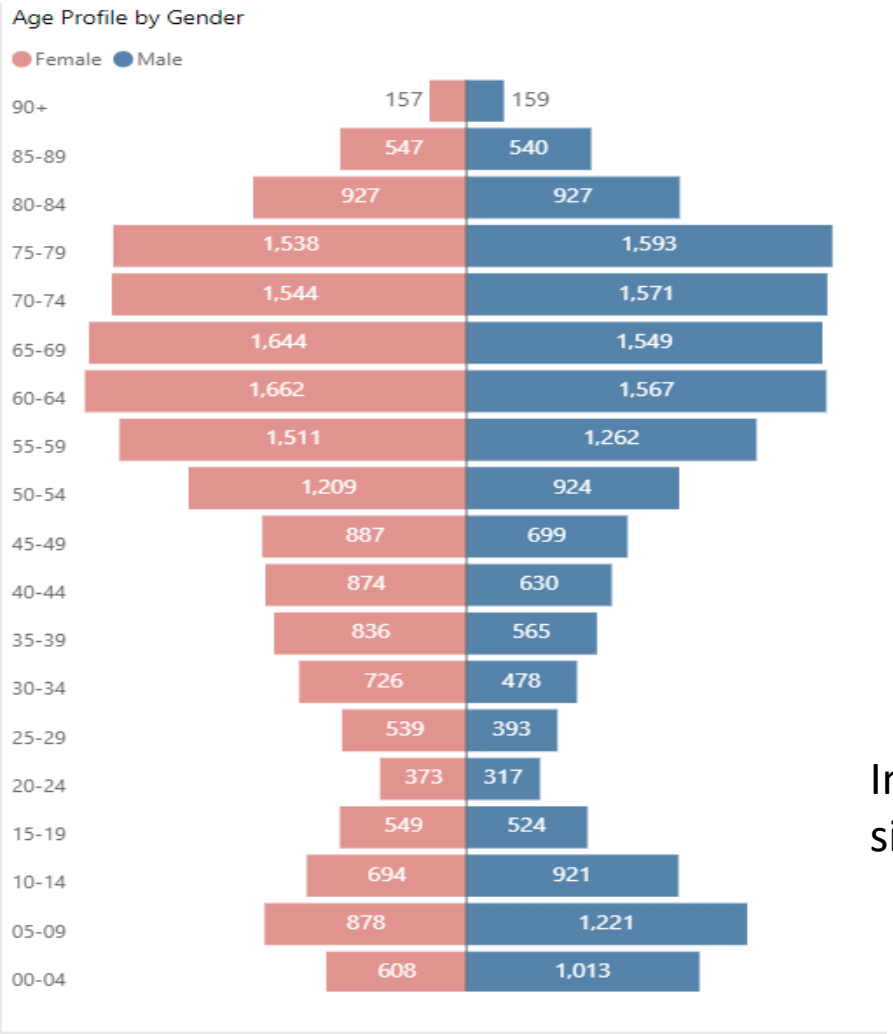


Figure 2: NHS Acute (hospital) trust catchment population (Elective admissions) (2020) [PHE dashboard 2020 -OHID (2022).]



Heath Inequalities: Age and Sex



Inpatient waiting list size=34,574

Figure 3: Inpatient Waiting List by age & Sex (2024)

Health Inequalities: Summary Points (Age and Sex)

- The NuTH catchment population has a younger age profile evidenced by the proportion of those in the under 19 age categories and actual size of the population in the 0-19 age catchment population.
- The older age population is overrepresented in elective admissions to the trust. That is evidenced in the relatively high proportion of catchment population admitted (e.g. in all age categories 55 years and older except for females over 90 years old) (Figure 2).
- Despite the small proportion of catchment population admitted in the younger age categories (up to 19 years) their absolute number is relatively large.
- Males are overrepresented in the under 5s and over 65s age categories in elective admissions (figure 2) and 14 years and under trust inpatient waiting list (figure 3).

Health Inequalities: Elective Admissions (Deprivation & Ethnicity)

Figure 4

Elective admissions (Trust Catchment Population) by Index of Multiple Deprivation (IMD) Quintile and Ethnicity -

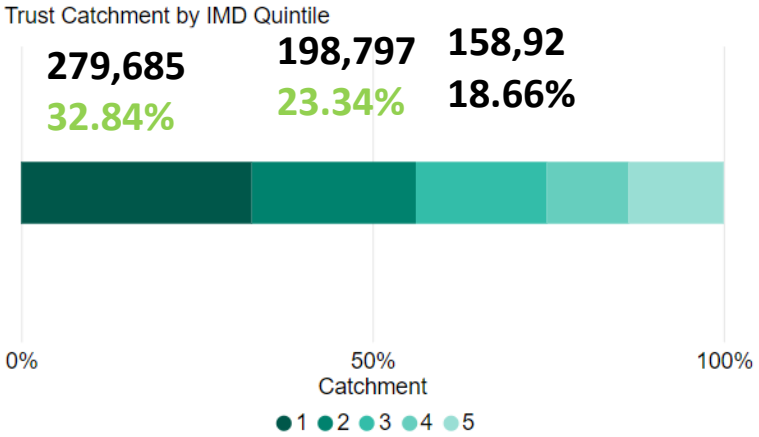
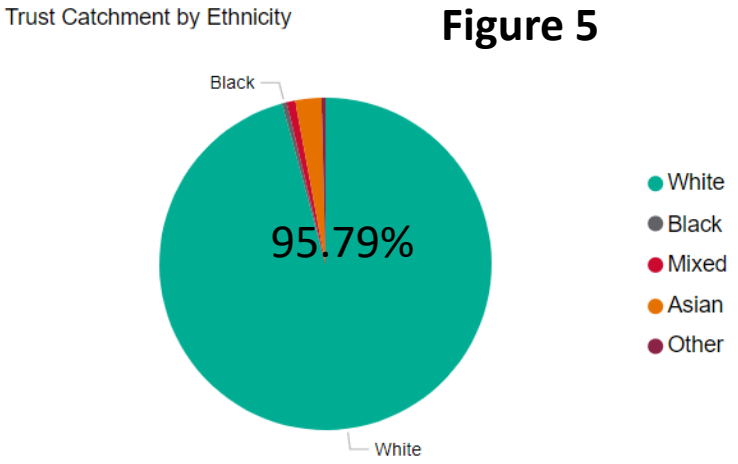


Figure 5



Source: OHID (2022). NHS Acute (hospital) trust catchment populations (2020) PHE dashboard 2020

Office for Health Improvement & Disparities

Health Inequalities: IPWL by Deprivation (IMD) and Ethnicity

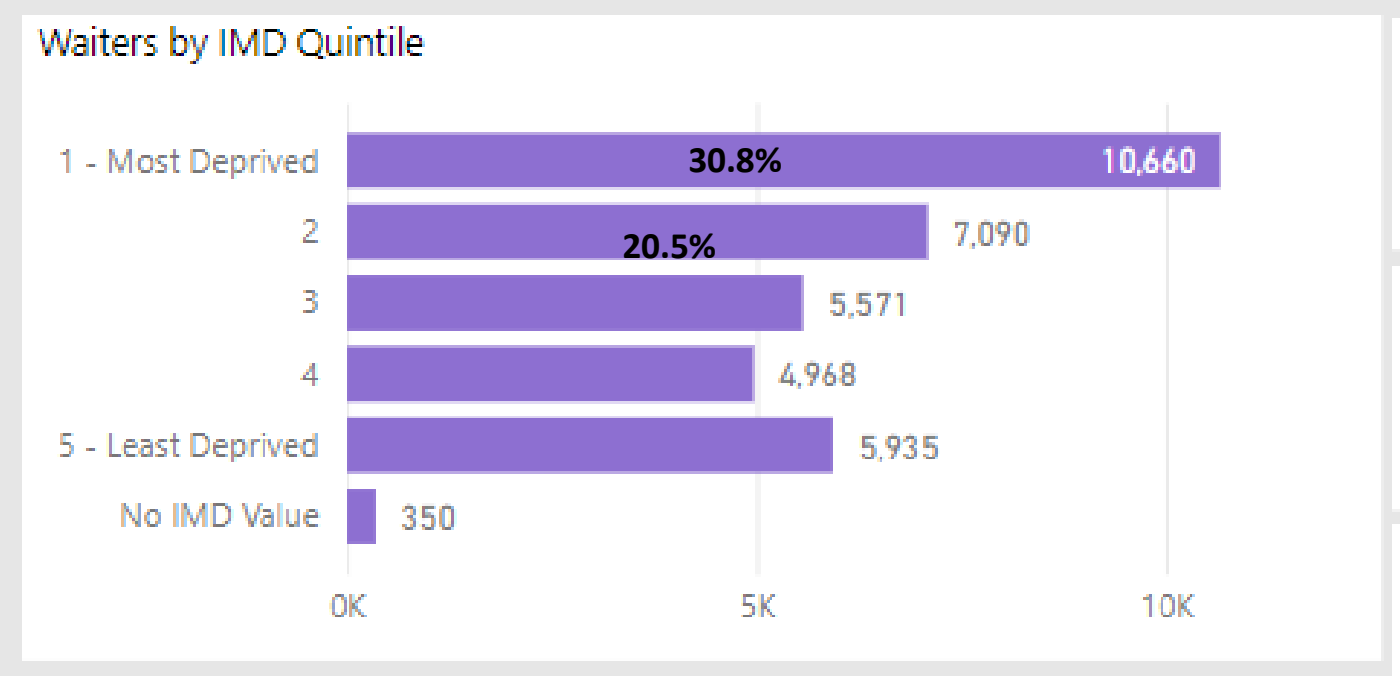


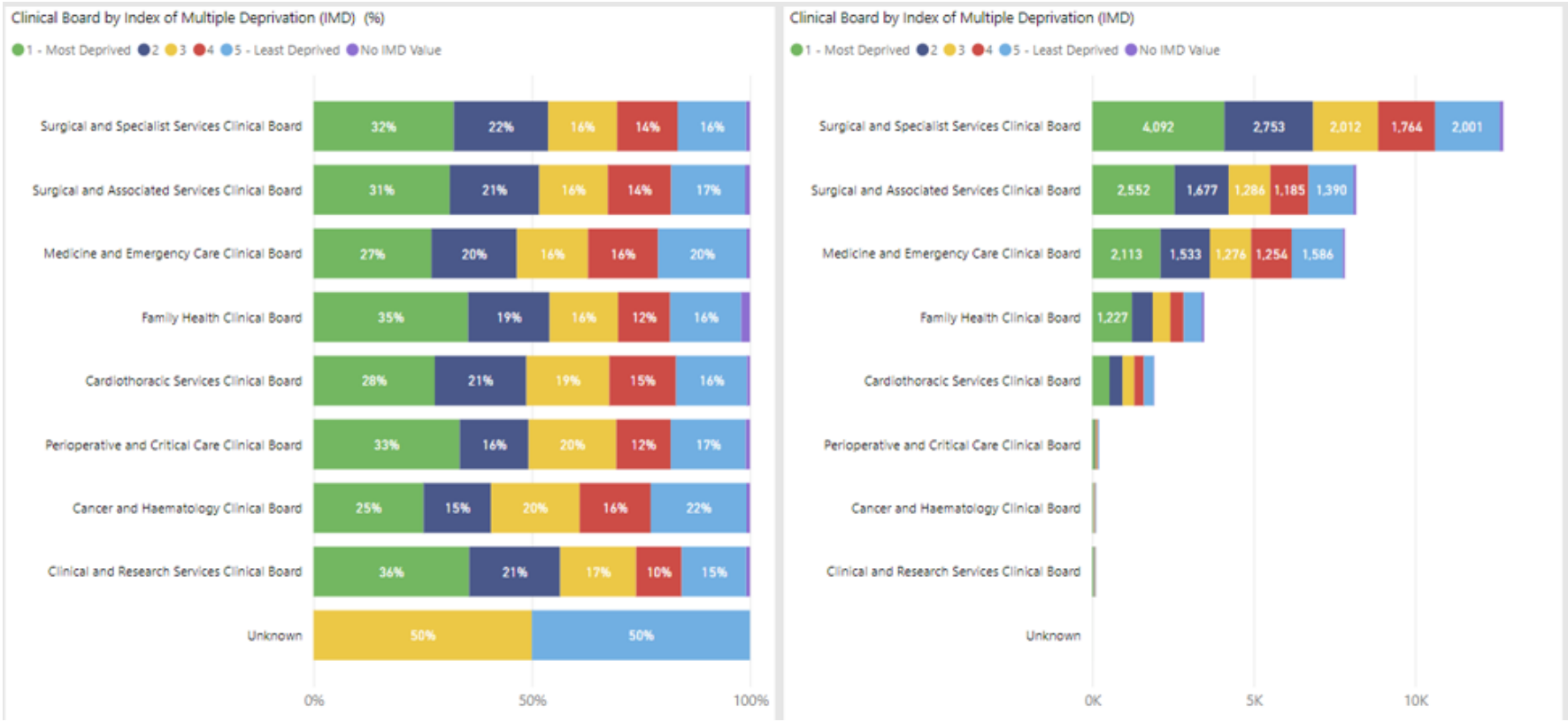
Figure 6: Inpatient Waiting List as at 29th June 2024

Inpatient waiting list size=34,574

Inpatient Waiting List (IPWL) - Power BI Report Server

Health Inequalities: IPWL by Deprivation & Clinical Board

Figure 7: IMD for Inpatient Waiting Lists by Clinical Board

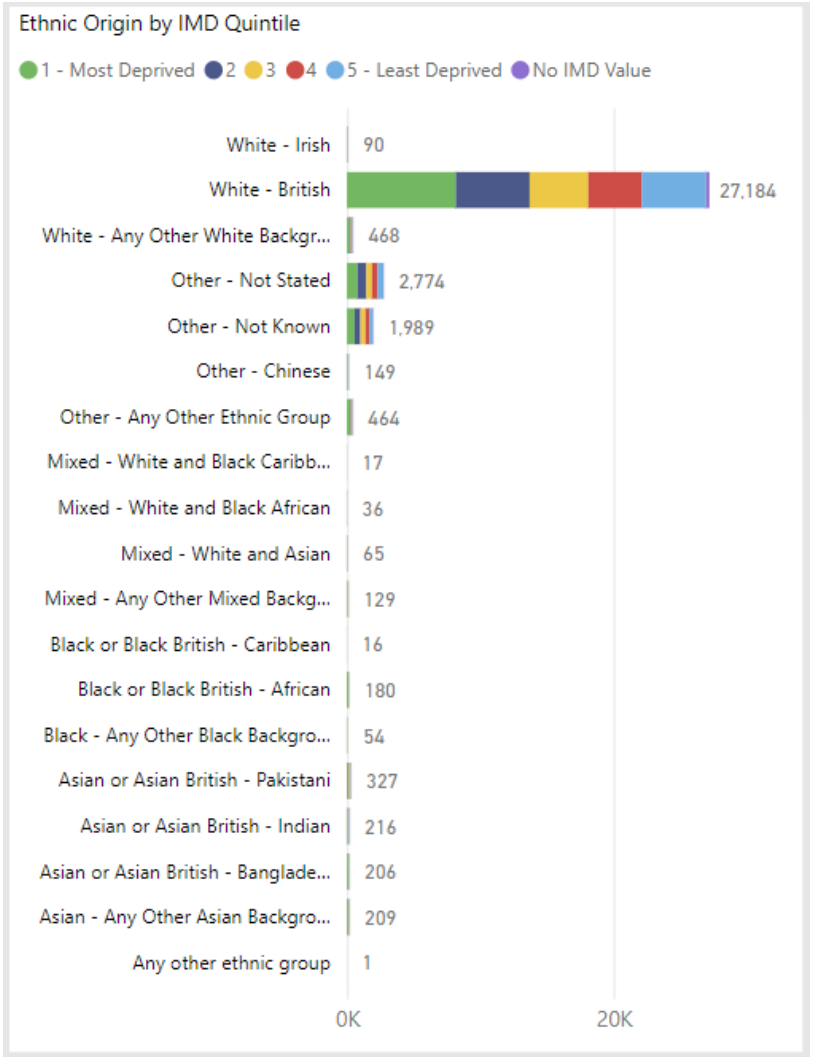


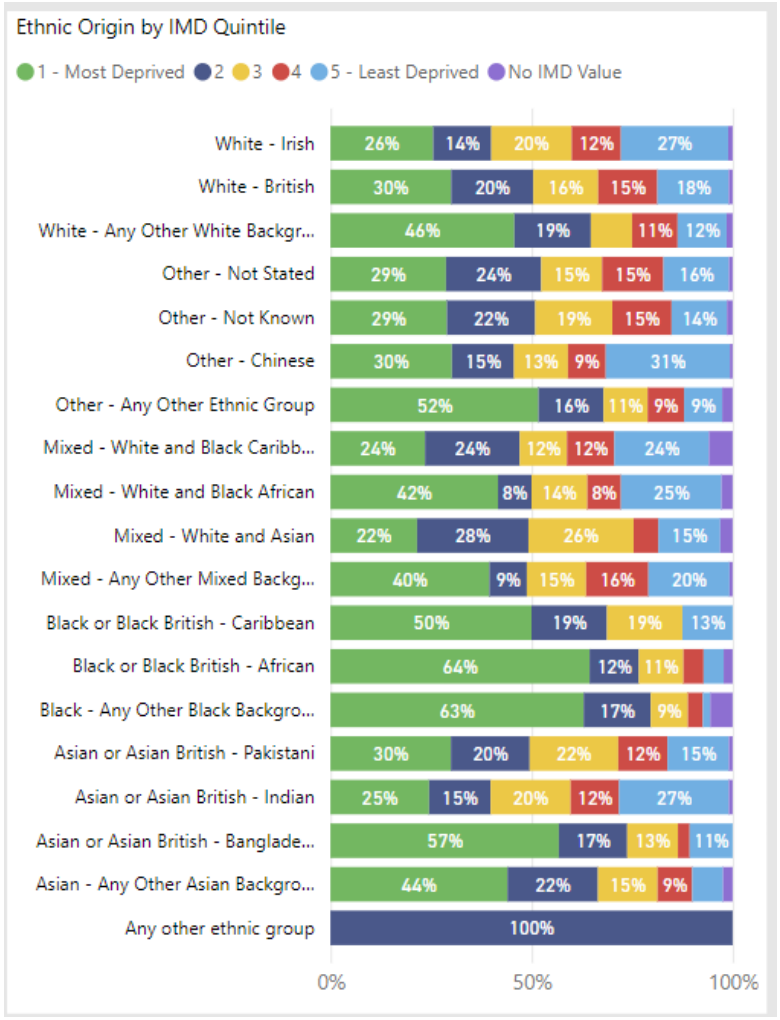
Health Inequalities: Summary Points (Socioeconomic Deprivation)

- The Indices of Multiple Deprivation (IMD) are overall relative measures of deprivation at a small geographical area constructed by combining 7 domains of deprivation according to respective weights (Income, employment, education, skills and training; health and disability; crime; barriers to housing and services and living environments).
- Over a third of the Trust catchment population (elective admissions) (32.84%) (figure 4) and 30.8% of the Trust inpatient waiting list resides in the 20% most deprived areas nationally in England (Figure 6.
- Generally, the level of deprivation in each of the Trust Clinical Boards is in line with that seen in the overall catchment population and the Trust Inpatient Wating Lists.
- A higher proportion (35%) of the inpatient waiting lists in the Family Health Clinical Board live in the most deprived areas nationally compared to other clinical boards and the overall Trust inpatient list (Figure 7). However, it is important to note the relatively large size of the inpatient waiting list residing in the most deprived areas nationally (Q1) in the Surgical and Specialist Services Clinical Board; Surgical & Associated Services Clinical Board and Medicine and Emergency Care Clinical Board.

Health Inequalities: IPWL (Socioeconomic Deprivation and Ethnicity)

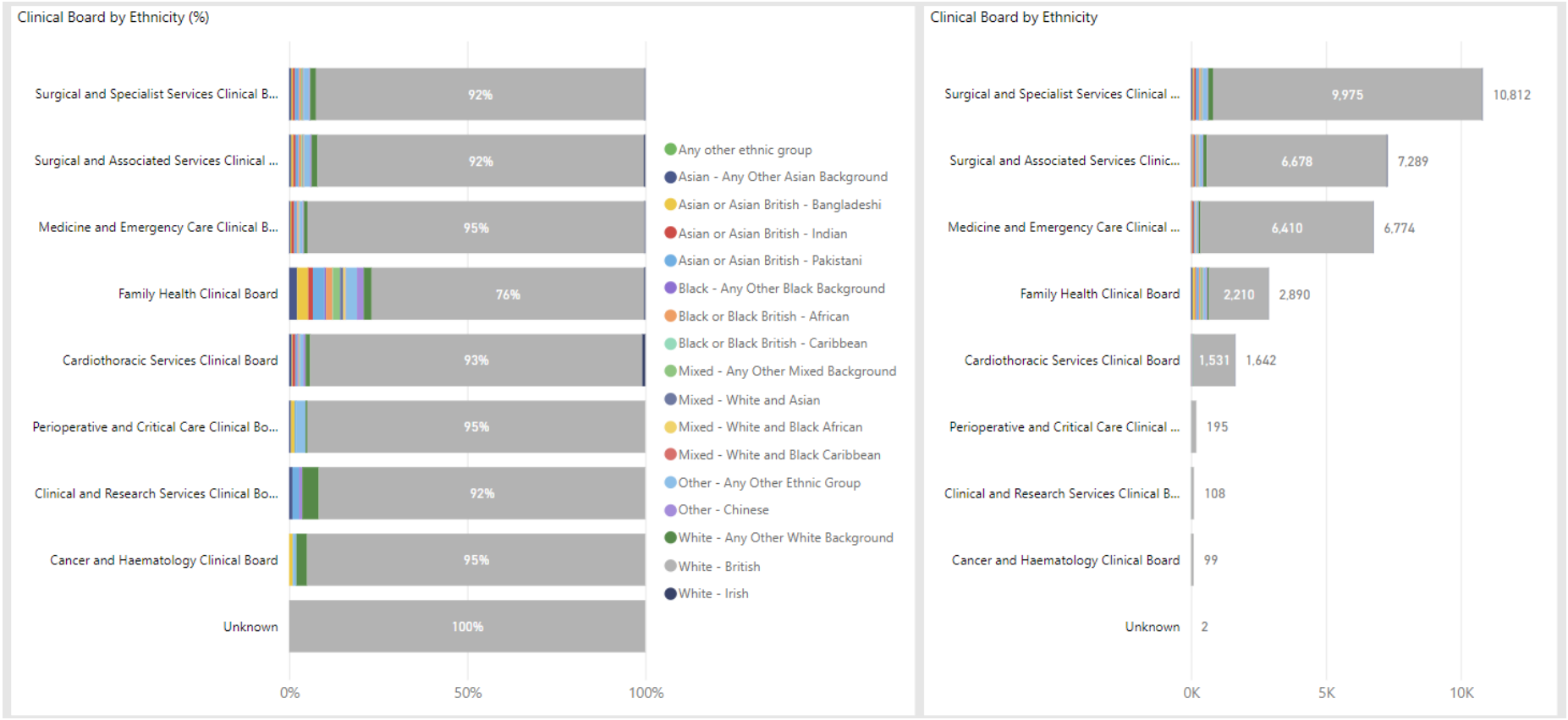
Figure 8: Ethnic Origin by IMD Quintiles





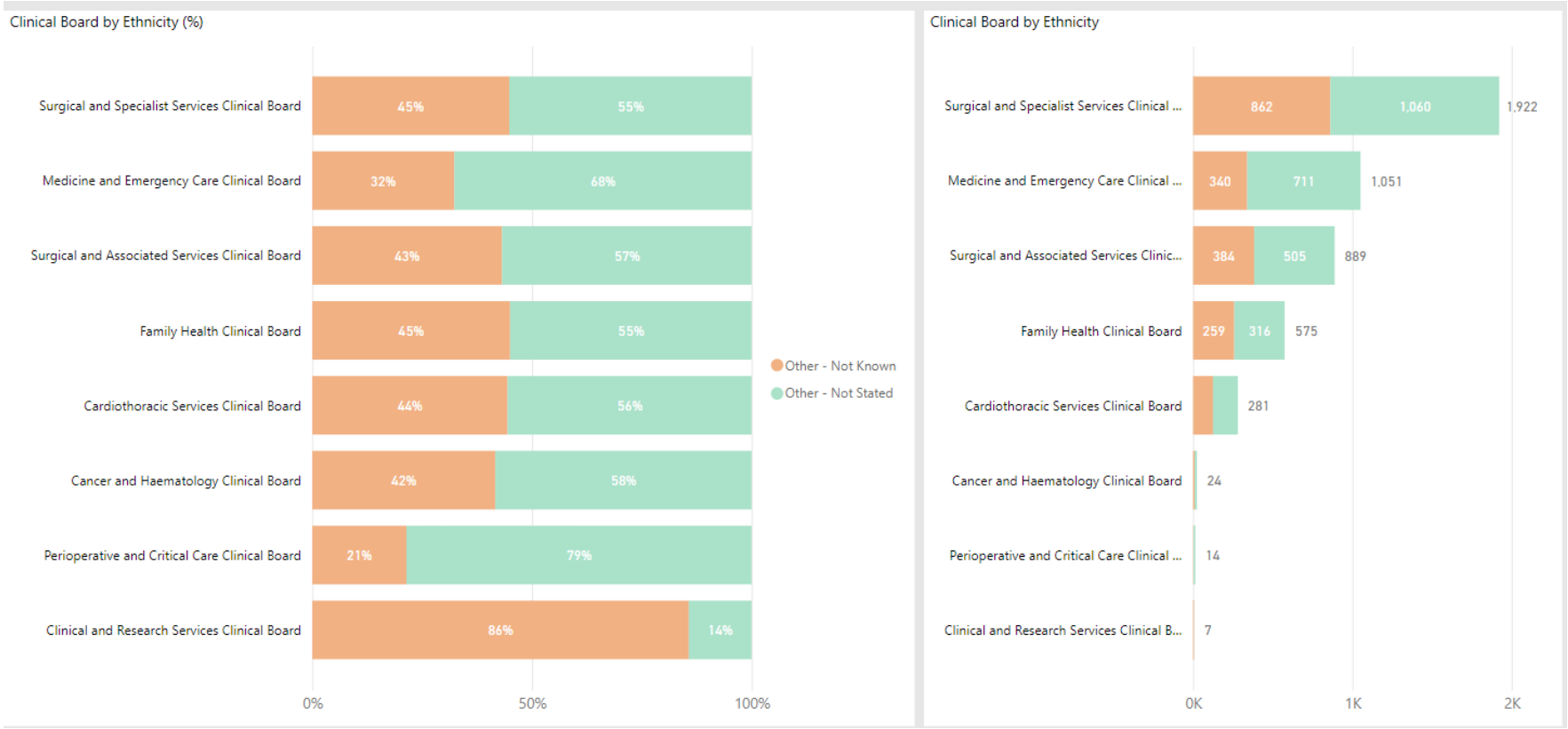
Health Inequalities: Ethnicity by Clinical Board

Figure 9: Ethnicity by Trust Clinical Board



Heath Inequalities: Ethnicity Coding (Data Quality)

Figure 10: Data quality-Ethnicity recording by Trust Clinical Board



Health Inequalities: Summary Points (Ethnicity)

- Ethnicity can be closely linked to health inequalities and socioeconomic deprivation. Therefore, it is important to pay attention to improving the quality of data by improving coding of ethnicity (both completeness and accuracy).
- A significant proportion of patients in the inpatient waiting list are White British (Over 78%). This group generally resembles the overall Trust catchment population in socioeconomic deprivation with 30% living in the 20% most deprived areas nationally.
- There is considerable socioeconomic deprivation observed among certain ethnic groupings in the trust inpatient waiting lists compared to the White British Population. For example, in the inpatient waiting list among Black or Black British (Caribbean) 50% live in the 20% most deprived areas nationally (Q1); in Black or Black British (African origin): 63% live in in the 20% most deprived areas nationally and in any other Black (63% live in Q1. Among Asian or Asian British in the IPWL those with a Bangladeshi origin are the most deprived with 57% of those on our inpatient waiting list living in the 20% most deprived areas nationally (IMD Quintile 1) (figure 8).
- Among the Trust Clinical Boards inpatient waiting lists that of the Family Health Clinical Board is the most ethnically diverse with 76% White British compared to over 90% White British in all other clinical Boards. This is in line with population data at place (Newcastle) as evidenced by ONS and the School Census Data (figure 9).
- Although the Trust has made significant progress in improving the quality of ethnicity data, there is more work to be done. A priority is in Surgical and Medicine Clinical Boards whereby there is a relatively large number of unknown & not stated ethnic categories (Figure 10).

Appendices

Appendix 1: Guidance on SPC

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

PUBLIC TRUST BOARD OF DIRECTORS

Date of meeting	17th July 2024					
Title	Great North Healthcare Alliance – Update					
Report of	Martin Wilson, Chief Operating Officer					
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 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 Trust's identities and integrity as a separate organisations.					
Recommendation	The Trust Board is asked to note the progress made.					
Links to Strategic Objectives	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.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☐	☒
Link to Board Assurance Framework [BAF]	Links to BAF risk 7.1 - Inability to sufficiently influence priorities of key partnerships (including the Great North Healthcare Alliance, the ICB, Provider Collaborative and Newcastle place arrangements) or to deliver on agreed commitments due to capacity or culture, impacting on our ability to effectively deliver local and regional healthcare commitments.					
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 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 Trust's identities and integrity as a separate organisations.

Specific areas of focus for Alliance working have been agreed, with leads from across the four organisations identified. These fall into the following categories:

- Clinical projects and pathways;
- Professional issues and opportunities; and
- Cultural and enabling work.

We have established the Alliance with a Collaboration Agreement signed by each of the four organisations. This agreement underpins meetings of Trust Board Committees in Common to steer and govern the Alliance work plan.

There is a desire to ensure that Boards receive the same information across the Alliance. The content of this update adds to a previous update from May, which was not heard at all Trust Boards due to the timing of the announcement of the July 2024 General Election.

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 Health 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; and
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 work is directed through monthly Alliance Steering Group meetings, made up of the Chairs and CEOs from the four organisations. Since the last update, all four Trust Boards agreed to establish Committees in Common across the Alliance. The first Committees in

Common meeting was held on 6th June 2024. Part of the agenda for the meeting included the signing of a Collaboration Agreement and Memorandum of Understanding, which underpin consistent Terms of Reference for each Trust Committee.

This is a positive step forward to demonstrate Alliance working and the collaborative nature of the relationship between our Trusts. Committees in Common are an established and externally recognised means to formalise and strengthen the governance of collaborative work. It has been established in such a way to not change the independence of Trust Boards and Governing Bodies, or the delegations, powers and authorities that Chief Executive Officers already have. Minutes of the Committees in Common will be shared with Trust Boards in the same manner as any other Board Committee.

This formal governance is supplemented by 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 AND WORK TO DATE

The main areas of focus have been to prioritise alliance working in specific areas where there is agreement that there is value to be obtained from alliance working. This emerging work plan falls into the following themes, with specific areas of work within each set out below:

- **Clinical projects and pathways** theme, including:
  - Paediatric services – bringing together paediatric teams to identify opportunities to improve pathways of care between local and regional services and address capacity pressures leading to longer-term pathway improvements.
  - Urgent and emergency care – examining where improvements can be made, and where best practice sharing and strengthened mutual support can best help. Aiming to improve and standardise the offer to patients, alongside improving performance overall.
  - 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.
  - Obstetrics and gynaecology – assessing and addressing challenges across the four services, with a particular focus on performance, resilience and workforce pressures.

- **Professional issues and opportunities** theme, including:
  - Patient and staff experience – sharing learnings to provide consistency of approach and expanding programmes.
  - Supporting clinical, in particular medical, recruitment and education and training.
  - Sharing approaches to implementing the Patient Safety Incident Response Framework (PSIRF), and identifying areas for congruent thinking.
  - Sharing our learning safety and quality expertise.

- **Cultural and enabling work** theme, including:
  - Corporate services – scoping where specific resilience issues exist in trusts, and what options exist to improve and optimise services.
  - Subsidiaries – exploring where benefits can be achieved from closer working between subsidiaries.
  - Working across Alliance Trusts – exploring what practical steps can be made to make it easier to work in and with other Alliance Trusts.

3. DEVELOPING THE WORK PLAN 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 2nd May. 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 asked to note the progress made.

Report of Martin Wilson
Chief Operating Officer
9 July 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	17 July 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) Industrial action response
ii) Quality & Patient Safety Update
iii) Job Planning and Study Leave Policy
iv) Cancer Update
v) Cardiothoracic Update
vi) Cancer Update
vii) Research Update
viii) Patient Safety and Quality of Care in Pressurised Services
ix) Infected Blood Inquiry Response

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

JOINT MEDICAL DIRECTORS REPORT

1. JUNIOR DOCTORS INDUSTRIAL ACTION

There was planned Junior Doctor Industrial Action between 07:00, 27 June until 07:00 2 July.

Contingency planning was ongoing. Whilst trying to minimise disruption as much as possible to patients, the priority had been to ensure safe emergency and inpatient care, as well as avoiding delays to cancer surgery and long waiters. It was however anticipated that disruption to patient care was inevitable.

2. QUALITY AND PATIENT SAFETY

2.1 Clinical Boards' Quality Oversight Groups (QOG)

The Clinical Boards' QOG continue to establish themselves as an essential structure supporting the Quality and Safety framework.

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

Under the PSIRF processes previously described to Trust Board, a Rapid Action Review should take place within five days of a notification of an incident that caused moderate harm or above. The Response Action Review Meetings (RARM) at which these are considered have run weekly since the 12 February 2024 and they determine the proportionate learning response to be actioned by the Clinical Board through their QOG. Whilst this is working well, the QOGs have prioritised the PSIRF element of their agenda; the next steps in further establishing these groups is to focus on other aspects of quality and safety such as guideline reviews or audits.

Low and no harm incidents do not come through RARM and are instead managed at Clinical Board QOG level, with data available on Power Bi. Following analysis, the Quality and Safety Leads subsequently provide an update on the themes and trends at the Patient Safety Incident Forum (PSIF).

The number of Patient Safety Incident Investigations (PSIIs) generated so far is higher than had been forecasted pre-implementation of PSIRF. This has been discussed at Patient Safety forums and will be monitored.

Monthly snapshot audits to ensure that local learning is taking place are being undertaken, choosing two incidents per months per Board at random. These will ensure:

- 90% of the investigations are closed within the timeframe dictated in the PSIRF policy.
- That the actions are specific, measurable, achievable, relevant and time-bound (SMART).
- That the actions are underway or have been completed.
- That the actions follow the hierarchy of controls and where possible seek to reduce the risk through substitution, isolation or engineering controls.

- That Duty of Candour has been enacted where appropriate.
- That learning has been shared in suitable forums.

A review of the After Action Reviews (AARs) and PSIIs was planned to be undertaken by the Clinical Governance and Risk Department (CGARD) team on 24 June to establish the percentage of the investigations closed in line with the timeframe set out in the PSIRF policy; whether the learning response was correct, actions are underway, the Duty of Candour has been enacted and that the learning has been shared.

Feedback will be given to the Clinical Boards and support offered where needed. Accountability is to the Patient Safety Group (PSG).

2.3 Trust Priorities

Work is ongoing on the PSIRF priorities for the Trust: Lost to follow up from internal referrals, action on abnormal results in radiology and laboratory medicine and errors and omissions in thromboprophylaxis with updates on these provided to the PSG.

The MDs together with the Director of Quality and Effectiveness and Executive Director of Nursing are undertaking a review and refresh of the Terms of Reference, agenda and membership of the PSG to ensure it continues to support improvements in patient safety following the implementation of the PSIRF framework.

2.4 Martha's Rule

The Trust received notice from NHS England (NHSE) that it will be a pilot site for early implementation of Martha's rule. A working group has now been established to oversee the operationalisation of this framework and regular updates on this work will be provided at relevant Patient Safety and Quality forum.

2.5 Incident Reporting

There has been a small but significant improvement on incident reporting across the Trust of 5.7%. Whilst the improvement has been more modest in relation to patient safety incidents of just over 2%, this is a positive and encouraging sign. Incident reporting has been a feature of Patient Safety Bulletins and has been discussed at all Quality and Performance Reviews.

3. JOB PLANNING AND STUDY LEAVE POLICY

The new updated Study leave policy for medical and dental staff was approved and ratified by the Clinical Policy Group (CPG) on 28 May after extensive consultation with the clinical teams and the Local Negotiating Committee (LNC). This has been welcomed positively by consultants and other senior medical and dental professionals and will contribute to supporting clinical teams to gain knowledge and expertise that will benefit our patients.

Discussions around the new job planning policy are ongoing. An implementation group has been formed chaired by Dr. Chris Dipper, Associate Medical Director (AMD) and pilot

implementation will begin in a number of areas in the coming month with spread across all clinical boards in subsequent months. It is anticipated that the first round of job planning under the new guidance will be completed by end of December 2024. The new guidance ensures that there is greater clarity about responsibilities and expectations of both the organisation and individual clinicians in delivery of job plans and ensures that adequate time is available in job plans to support training and education of trainees. The introduction of specific service level agreements between individuals and their Clinical Board will provide greater clarity and accountability in job plans.

4. CANCER UPDATE

4.1 Cancer Performance

	March 24	April 24	May 24
14-Day (14D)	83.2%	77.7%	82.5%
No. Pt Referred on 14D	2302	2336	2912
28-Day (28-D) Faster Diagnosis Standard (FDS) Cancer	76.9%	69.5%	79.5%
28D FDS Non-Cancer	84.1%	76.5%	79.5%
62-Day (62D)	65%	61.9%	64%

Total number of patients waiting >62 days has dropped from 191 to 170 at the start of June for which the clinical teams are to be congratulated. Further improvement is still required and work is ongoing to reduce this backlog.

The Dermatology team have seen a very significant rise in referrals in May which is to be expected as summer approaches. The team are currently managing this increase in demand and waiting times are being monitored.

The most challenged tumour groups in terms of 62 day performance are: lower GI, upper GI, lung and urology as previously reported.

Work continues in all these areas to try to improve performance:

- Lung: additional theatre lists and increased clinical involvement in Patient Tracking List (PTL) review.
- Endobronchial Ultrasound (EBUS): capacity remains a significant pressure point for this service.
- Upper and Lower GI: Ongoing roll out of combined pathway aiming for full implementation September 2024, rationalisation of Multidisciplinary Team, (MDT) referral to oncology, earlier involvement of oncology in the pathway where possible.

4.2 Specific Service Updates

4.2.1 Breast

A clinical service review in County Durham and Darlington Foundation Trust (CDDFT) has raised concerns about the range of treatment options that can be offered to patients at CDDFT. The full clinical report is not yet released but as an interim measure colleagues from Newcastle Hospitals (NUTH), CDDFT and North Tees are rotating into the CDDFT breast MDT and, where appropriate, patients are being offered consultation at sites outside CDDFT. This is particularly the case where oncoplastic surgery may be an option. The full report is awaited and a further update can come to Trust Board at that time. In the interim a relatively small number of patients (circa 3 per week) may need treatment at NUTH rather than CDDFT with the potential for a small impact on cancer wait and breaches depending on day of pathway transfer.

An NHSE safety alert has been raised concerning patients who have developed breast cancer after treatment with radiotherapy for Hodgkin lymphoma. There has been a failure of recall of some women to the national screening programme and the work aims to investigate and inform any women who missed out on screening and subsequently developed breast cancer. Phase 1 of this work has been published nationally. One patient at NUTH was highlighted. Case review revealed the patient has been screened appropriately post radiotherapy and breast cancer was picked up at screening. The patient thus was not impacted by a failure of recall and this will be fed back to NHSE. Phase 2 and 3 of the work is awaited.

4.2.2 Hepatobiliary Cancer

This service was visited by the pancreatic cancer Getting it Right First Time (GIRFT) team on 20 May 2024. The team noted that we are the third busiest service of 23 in England. We also have the patient cohort with the highest levels of deprivation nationally. Late presentation and patient frailty impact patient outcomes.

The GIRFT team have produced a draft report which has highlighted a significant number of areas for improvement. It is fair to say that most if not all of those areas were issues that we were aware of prior to the visit and work has been ongoing for at least 6 months with a NUTH HPB Improvement Group to address concerns. Speed of triage of referral, delay to MDT review and communication with regional colleagues were highlighted as areas of concern. The introduction of an electronic referral model is aimed to help; implementation is imminent. MDT capacity needs to increase and work is underway to identify any patients that do not need MDT review and to maximise efficient use of MDT time. Whilst access to theatre does not seem to be a fundamental problem, the current work suggests that an increase in Clinical Nurse Specialist (CNS) input into nurse-led clinics is necessary to facilitate the medical team undertaking triage clinics to speed up the pathway.

There is a current lack of capacity for endoscopic ultrasound (EUS) procedures in the region which does slow pathways. The Cancer Alliance are keen to work to build this service regionally and we will fully engage with that approach.

There is a current lack of capacity for liver and renal cancer ablation procedures which is resulting in unacceptable waits for patients. This is being addressed with radiology, peri-ops and surgery. The current bottleneck is anaesthetic capacity. If additional anaesthetic capacity cannot be found then prioritisation decisions will be needed in regard to elective, long wait and cancer work.

The GIRFT team would like to have a separate meeting with NUTH oncology colleagues who provide the regional pancreatic cancer service to better understand how that service works and the current constraints.

4.2.3 Gynaecology-Oncology

The NUTH team is fully engaged with the Managed Clinical Network (MCN). The service is under pressure due to sickness absence and recent loss of locum colleagues. A new level 2 unit led consultant should be in post by late September which will allow some changes in the team to facilitate greater engagement with tertiary work and with the regional MDT.

We are working to ensure access to the day treatment centre which will create capacity for a consultant colleague from Queen Elizabeth Hospital (QEH) to do some surgery at the RVI. One day per week is required for gynae work in the Day Treatment Centre (DTC). Local involvement with a colleague from QEH will have advantages in terms of surgical adjacencies and access to robotic techniques and will also be fundamental from a governance perspective in terms of improving team working and communication and reducing single points of failure.

5. CARDIOTHORACIC UPDATE

Work is ongoing with the Cardiothoracic Clinical Board leadership team to support the key workstreams within the service recovery plan around quality and safety, governance, culture and behaviours and training. Progress has been made in each of these areas as previously described to Trust Board.

In the last month there has been further work to restructure the clinical leadership team with the appointment of a CD for surgery. Additional appointments to heads of department and clinical governance roles within the clinical Board will now take place.

Ongoing concerns about the functioning of one of the MDTs (Revascularisation) have resulted in a change of leadership of this MDT. Audit of the performance of this MDT will continue as part of the regular cycle of audits now established.

Progress in education and training of clinical and educational supervisors continues as part of the structured programme being carried out in collaboration with HEE NE. This was reviewed at a recent annual quality review meeting. Further discussions are taking place about the point at which existing trainees can return to the department.

Mediation work is being undertaken with the thoracic surgery team to resolve working relationship difficulties within that team.

6. RESEARCH

6.1 Activity including Commercial Research (to end May 2024)

The Trust currently has approx. 700 clinical research studies open (201 in recruitment) with a further 400 in follow up. Recruitment to all clinical research studies for April & May 2024 is showing a dramatic decrease in comparison to previous years and this is due to the temporary suspension of a high recruiting study due to amendment. It should be noted that we continue to approve the same number of studies per month (25-30) and recruitment to commercial studies is in line with target, reflecting the Trust's commitment to increasing commercial research activity.

The Clinical Research Directorate will continue to review and monitor this performance via the monthly Operational Management Group.

Information supplied from LPMS by Lesley McShane, Research Information Manager

6.2 Some Notable Highlights In The Last Quarter

- Dr Edwin Wong, Consultant Nephrologist with the Clinical Research Facility (CRF) team recruited the first patient in the world to the OMS906-CSG-001 trial. The trial is testing a treatment for two rare kidney disorders that affects how the kidneys function.
- The iPREDICT trial, led by Dr Rachel Pearson and the Oncology Haematology Research (OHR) research team was covered in the Evening Chronicle. The trial uses an investigational imaging agent called CD8 ImmunoPET which illuminates CD8+ cells on a PET scan. It is hoped the agent could help to predict a patient's response to immunotherapy by highlighting these cancer-killing cells.
- Dr Ben Hood, Nurse Consultant has been shortlisted in the Nursing Times Awards 2024: A national teenager and young adults with cancer co-produced educational resource for demystifying clinical trials, genomic testing and biobanking has been shortlisted in the Clinical Research Nursing category.
- A new Public Partnership Steering Group for Clinical Research held its inaugural meeting in June 2024. This group will provide patients with a stronger voice in how our research is developed and delivered. It will be particularly focussed on raising the profile of research and communications.
- Dr Ashley Price, Infectious Diseases Consultant, has been appointed as the Patient Recruitment Centre (PRC) Director. His first task was to complete and submit a bid to National Institute for Health and Care Research (NIHR) for NUTH to be a Commercial Research Delivery Centre (CRDC) build in the success of the PRC. If successful the CRDC will operate a hub and spoke model with other organisations across the region.
- Clinical Research had 2 Informal visits in June 2024 from Bill MacLeod, Non-Executive Director (NED) and Rob Harrison, Managing Director (MD). We would be delighted to

show more members of the Trust Board our facilities and to provide the opportunity to meet with research participants.

- The Clinical Research Directorate supported the Trust submission for the UK Health Security Agency (UKHSA) clinical evaluations tender.
- The Clinical Research Directorate has been working with the Digital team on a major project to digitise the clinical research record, as this was not part of the original eRecord project in 2019. CAV Phase 1 of this project will be complete by the beginning of August 2024 enabling all new research trials to use eRecord.

6.3 Challenges in the Last Quarter

- Our bid for a Vaccination innovation award was unfortunately not successful and the Directorate will review on the bid process and learn from this.
- Media coverage was suspended due to Purdah and so we have had less opportunity to share good news stories.
- The Directorate restructure has been placed on hold at the request of Executives, pending agreements on the final overall Trust structure changes

6.4 Key Activities For Next Quarter

- Proposal for development of a standalone research facility to be submitted to the Finance & Performance Committee and Board, seeking support to commence fundraising.
- Relocation of the Patient Recruitment Centre (PRC) team from the Centre for Aging and Vitality (CAV) site once estates work completed.
- Clinical Research Facility (CRF) Director interviews to be held end July.
- Quarterly research performance reports to be piloted with Cancer Services Board and then rolled out to all board. These aim to raise the profile of research within the Clinical Board and increase understanding of current research activities in the board services.
- Continue to work with the Hospital Charity to develop a robust process for receiving, reviewing and agreeing charitable funds for research projects.
- The Trust Clinical Research Strategy will have been in place for 3 years and with the refresh of the Trust Strategy, this will be a good time to review and refresh the Clinical Research Strategy to further align with the Trust.
- Working with the Digital team, refine the scope for the next stage of the research digitisation project, including the implementation of the Patient Engagement Portal for research.

7. PATIENT SAFETY AND QUALITY OF CARE IN PRESSURISED SERVICES

Recent publicity including the Channel 4 Dispatches Documentary filmed in Royal Shrewsbury Hospital and aired on 24 June 2024 , has highlighted concerns about fundamental standards of care in Emergency Departments.

Following this all Trusts received a letter from national Medical Director, Chief Nursing Officer, Chief Operating Officer (COO) and Director of Urgent and Emergency Care on 26

June 2024 emphasising the importance of "maintaining focus and oversight on quality of care and experience in pressurised services".

Trusts Boards are required to work with system partners to:

- Provide alternatives to emergency department attendance and admission, especially for those frail older people who are better served with a community response in their usual place of residence.
- Maximise in-hospital flow with appropriate streaming, senior decision-making and board and ward rounds regularly throughout the day, and timely discharge, regardless of the pathway a patient is leaving hospital or a community bedded facility.

A number of specific actions are identified for Trust Boards. They should assure themselves that:

- Their organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter.
- Basic standards of care, based on the Care Quality Commission's (CQC's) fundamental standards, are in place in all care settings.
- Services across the whole system are supporting flow out of Emergency Department (ED) and out of hospital, including making full and appropriate use of the Better Care Fund.
- Executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance.
- There is consistent, visible, executive leadership across the Urgent and Emergency Care (UEC) pathway and appropriate escalation protocols in place every day of the week at both trust and system level.
- Regular non-executive director safety walkabouts take place where patients are asked about their experiences in real time and these are relayed back to the Board.

This issue was discussed with Clinical Board Leadership Teams at the Trust Management Group on 10 July 2024. Plans are already in place to reduce reliance on corridor care in ED and a renewed focus on delivery of fundamental standards of care is being emphasised. Escalation protocols are already in place and their application is being reviewed. The Executive Director of Nursing, Joint Medical Directors and Managing Director will oversee the development of a programme of work with Clinical Boards to ensure that all of the requirements laid out in the letter of 26 June 2024 are met. A report will be made to the next Trust Board.

8. INFECTED BLOOD INQUIRY RESPONSES

The Infected Blood Inquiry highlighted the harm done to patients and families as a result of the use of infected blood and blood products in the NHS during the 1970s and 1980s. Newcastle Hospitals contributed evidence to the inquiry and is committed to supporting individuals who were either infected by blood borne infections or were affected by the infection of a family member. We are currently working with NHSE to develop support services including psychological support for those involved and are also considering a bid to be the national co-ordinating centre for the delivery of these services. These negotiations are nearing completion and it is hoped that services for the

population of the North East will become available before the end of 2024. Further updates will be provided to the next Trust Board when negotiations are completed.

9. RECOMMENDATION

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

L Pareja-Cebrian/ M Wright
Joint Medical Directors
11 July 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	17 July 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 4 May 2024 to 11 July 2024 and by unanimous resolution, the Committees were in favour of appointing the following:

Name	Job title	Start Date
Dr Eve Foley	Consultant Anaesthetist	5 Aug 24
Dr Hannah Gamblin	Consultant Gynaecologist	ASAP
Dr Joseph Raper	Consultant Paediatric Neurologist	ASAP
Dr Rebecca Gilbert	Consultant General Paediatrician	1 Oct 24
Dr Hugh Whalley	Consultant General Paediatrician	1 Sep 24
Dr Alastair Coleman	Consultant Paediatric Cardiothoracic Anaesthetist	Aug 24
Dr Kerri Devine	Consultant Physician	3 Jun 24
Dr Philip Brown	Consultant Rheumatologist	11 Sep 24

2. RECOMMENDATION

1.1– For the Board to receive the above report.

Report of Michael Wright and Lucia Pareja-Cebrian
Medical Directors
17 July 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	17 July 2024					
Title	Guardian of Safe Working Quarterly Report (Q4 2023-24)					
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	The terms and conditions of service of the new junior doctor contract (2016) require the Guardian of Safe Working Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant. The content of this report outlines the number and main causes of exception reports for the period 27 December 2023 to 26 March 2024 for consideration by the Trust People Committee, prior to submission to the Trust Board.					
Recommendation	The Trust Board is asked to note the contents of this 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.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link to the BAF. In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.					
Reports previously considered by	Quarterly report of the Guardian of Safe Working Hours. Presented to the June meeting of the People Committee.					

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

This quarterly report covers the period 27 December 2023 to 26 March 2024.

There are now 985 postgraduate doctors in training on the New Junior Doctor Contract and a total of 1,061 postgraduate doctors in the Trust.

There were 110 exception reports in this period. This compares to 136 exception reports in the previous quarter.

The main areas of exception reports are general medicine and general surgery.

The main cause of exception reports is when the staffing levels available are insufficient for the workload.

2. INTRODUCTION / BACKGROUND

The 2016 New Junior Doctor Contract came into effect on 3 August 2016 and was reviewed in August 2019, with changes implemented in a staggered approach from August 2019 to October 2020. From August 2023 Locally Employed Doctors are also employed on a contract which mirrors the 2016 contract.

The TCS of the 2016 contract allows for exception reporting to raise reports on breaches of working hours and educational opportunities The Guardian of Safe Working Hours must provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant.

3. HIGH LEVEL DATA

		(Previous quarter data for comparison)
Number of Junior Doctors on New Contract	985	(950)
Total Number of Junior Doctors	1,061	(1,040)
Number of Exception reports	110	(136)
Number of Exception reports for Hours Breaches	97	(131)
Number of Exception reports for Educational Breaches	15	(7)
Fines	5	(14)
Admin Support for Role	Good	
Job Planned time for supervisors	Variable	

4. EXCEPTION REPORTS

4.1 Exception Report by Speciality (Top 5)

		(Previous quarter for comparison)
General Surgery	64	(48)
General Medicine	26	(51)
Ophthalmology	6	(2)
Paediatrics	5	(3)
Gastroenterology	4	(0)

4.2 Exception Report by Rota/Grade

General Surgery

FH (F1) including HPB, colorectal, vascular	63 (4 education)
RVI (F1)	1

General medicine

RVI (F1)	14
RVI (F2/CT2/IMT)	9
FH (CT/IMT/LED)	3

Ophthalmology

SHO	6 (all education)

Paediatrics

SHO	5

Gastroenterology

CT	4

4.3 Example Themes from Exception Reports

General Surgery FH

“Not enough staff. Seniors aware.”

The workload/workforce imbalance within general surgery F1 at the Freeman Hospital are well known to the Executive Team. This is a longstanding issue that needs to be addressed. Some exception reports were raised for missed teaching due to clinical pressures.

General Medicine RVI/FH

”Busy shift; multiple unwell patients in last hour; stayed late to document”

Exception reports submitted when there was excessive workload for the workforce available – either due to clinical complexity of patients or reduced staffing levels. Teaching also missed when clinical pressures prevent doctors from leaving the ward.

Ophthalmology

"Pulled from rostered paediatrics clinic to cover AM ward session today. Shift designated for GP trainee; but not currently available to work shift."

One doctor went off acutely on long term sickness leaving a shortfall in the rota. The educational impact of this has been reviewed, and the education team are involved.

Paediatrics

"No surgical SHO cover overnight and unable to handover to surgical registrar as in theatres so stayed to complete jobs / update list. Locum put out; not taken up."

4/5 exception reports mention staying late to cover a gap on the paediatric surgical SHO rota.

5. EXCEPTION REPORT OUTCOMES

5.1 Work Schedule Reviews

No work schedule reviews were completed on the back of exception reports.

5.2 Fines

5 fines have been issued:

- General Medicine (3 fines): Rule breached "Late finish; Exceeded the maximum 13-hour shift length" Total fine money £160.40.
- General Surgery (1 fine): Rule breached "Late finish; Unable to achieve breaks; Exceeded the maximum 13-hour shift length. Total fine money £182.42.
- Paediatric Surgery (1 fine): Rule breached "Unable to achieve breaks; Unable to achieve minimum overnight continuous rest of five hours between 22:00 and 07:00 during a non-resident on-call (NROC); Unable to achieve the minimum 8 hours total rest per 24-hour NROC shift" Total fine money £606.69.

6. ISSUES ARISING

6.1 Workforce and workload

The recurring theme as to when exception reports are raised is when there is a reduction of doctor numbers on the ward or high workloads.

6.2 Supervisor Engagement

Supervisor engagement is generally good. Weekly prompting by the medical staffing team has reduced supervisor response time. There are still issues in some departments of a lack of job planned time for supervisors. High numbers of exception reporting increases the burden on consultants who are already experiencing high clinical demand.

6.3 Administrative Support

Administrative support is currently good.

7. LOCUM SPEND

The purpose of reporting locum spend is as a source of information indicating where there is a workload/workforce imbalance.

LET Locum Spend

January to March (Q4 2023-2024)	£2,183,744
October to December (Q3 2023-24)	£1,383,095
July to September (Q2 2023-24)	£2,016,109

Comment from finance team:

"In terms of expenditure we rely on invoices from the LET and so there are differences between the actual incidence of spend and the Trust being invoiced for it. There was an increase of £801k between Q3 23/24 and Q4 23/24. Of this increase, £456k was Internal Medicine, £138k was in Surgical Services & £136k Childrens."

"For reference, when comparing Q4 23/24 to Q4 22/23, there is still a significant increase of £766k in expenditure between these periods."

Trust Locum Spend

January to March (Q4 2023-2-24)	£957,439
October to December (Q3 2023-24)	£872,776
July to September (Q2 2023-24)	£2,483,523

Comment from finance team:

"Based on information supplied by Medical Staffing this was made up predominately of increases of £91k Industrial Action Cover, £70k Increased Workload & a decrease of £94k on Establishment Vacancies.

With regards to Clinical Boards the increase of spend can be seen particularly in Surgical & Associated Specialities (£51k), Family Health (£28k) & Surgical & Specialist Services (£18k). ”

For reference, although there is an increase shown between the periods above, when comparing Q4 23/24 to Q4 22/23, there is a decrease of £47k. This is driven mainly by decreases of £298k on Covid – Additional Dependency, with increases of £105k for Industrial Action Cover, £66k for Increased Workload, £49k for Establishment Vacancies & £38k for On-Call Cover.

8. RISKS AND MITIGATION

The main risk remains medical workforce coverage across a number of rotas. As previously noted, this is exacerbated by changes in working patterns due to alterations of the TCS of the Junior Doctor Contract, and changes in training requirements. The continued pressures within general surgery at the Freeman Hospital must again be highlighted.

9. JUNIOR DOCTOR FORUM

Issues discussed included allocation of self-development time, out of hours medical cover at the Freeman Hospital, and doctors being asked to prescribe for non-prescribers.

10. RECOMMENDATIONS

I recommend that we continue to review the workforce workload balance to ensure safe and sustainable staffing, particularly within general surgery at the Freeman Hospital.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
17 April 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	17 July 2024					
Title	Guardian of Safe Working Hours Annual Report					
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	The terms and conditions of service of the new junior doctor contract (2016) require a consolidated annual report on rota gaps, and the plan for improvement to reduce these gaps to be included in the Trust's Quality Account. This report addresses the requirement for the year from April 2023 to March 2024 for consideration by the Trust People Committee, prior to submission to the Trust Board.					
Recommendation	The Trust Board is asked to note the content of this report which has been included in the Trust's Quality Account.					
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.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☐	☐	☐
Link to Board Assurance Framework [BAF]	No direct link. In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.					
Reports previously considered by	Annual Report of the Guardian of Safe Working Hours. This report was considered at the June meeting of the People Committee.					

GUARDIAN OF SAFE WORKING ANNUAL REPORT

1. EXECUTIVE SUMMARY

The purpose of this annual report is to highlight the vacancies in junior doctor rotas and steps taken to resolve these during the year from April 2023 to March 2024.

Rota gaps on actual working rotas are also influenced by sickness absence, individualised working requirements, and changes in working patterns due to changes in educational and rest requirements. These additional factors are not outlined in this report. However, the locum spend may give some indication of the gaps in service coverage.

Where vacancies exist, the gaps in service coverage are mainly addressed by rewriting work schedules, redeployment of doctors to areas of greatest clinical need and the use of locums. In some areas we are seeing trainee shifts being covered by consultants, or shifts being left uncovered, and other members of the team picking up the extra work.

The main areas of persistent or recurrent concern for vacancies are:

- Accident and Emergency.
- Anaesthetics and Critical Care

The Trust takes a proactive role in recruiting to vacancies where funding is identified. Delays from recruitment to the appointment of overseas candidates were experienced due to visa issues.

The current issues, obstacles, and actions taken to resolve the issues for these and other areas with high vacancies are outlined below.

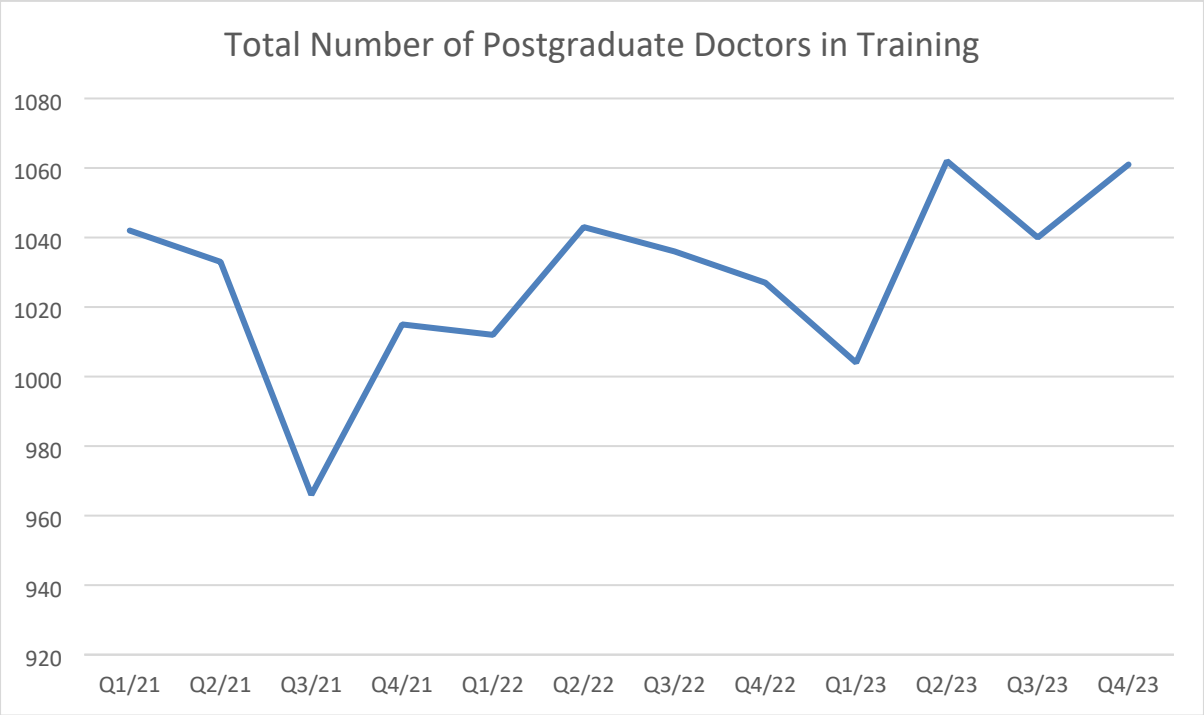
2. INTRODUCTION / BACKGROUND

The 2016 New Junior Doctor Contract came into effect on 3rd August 2016. The terms and conditions of service require a consolidated annual report on rota gaps, and the plan for improvement to reduce these gaps to be included in the Trust's Quality Account.

3. HIGH LEVEL DATA

Number of postgraduate doctors / dentists in training on 2016 TCS:	985
Number of postgraduate doctors on 2002 TCS:	76
Total number of postgraduate doctors / dentists:	1,061

3.1 Trend of Number of Postgraduate doctors by quarter:



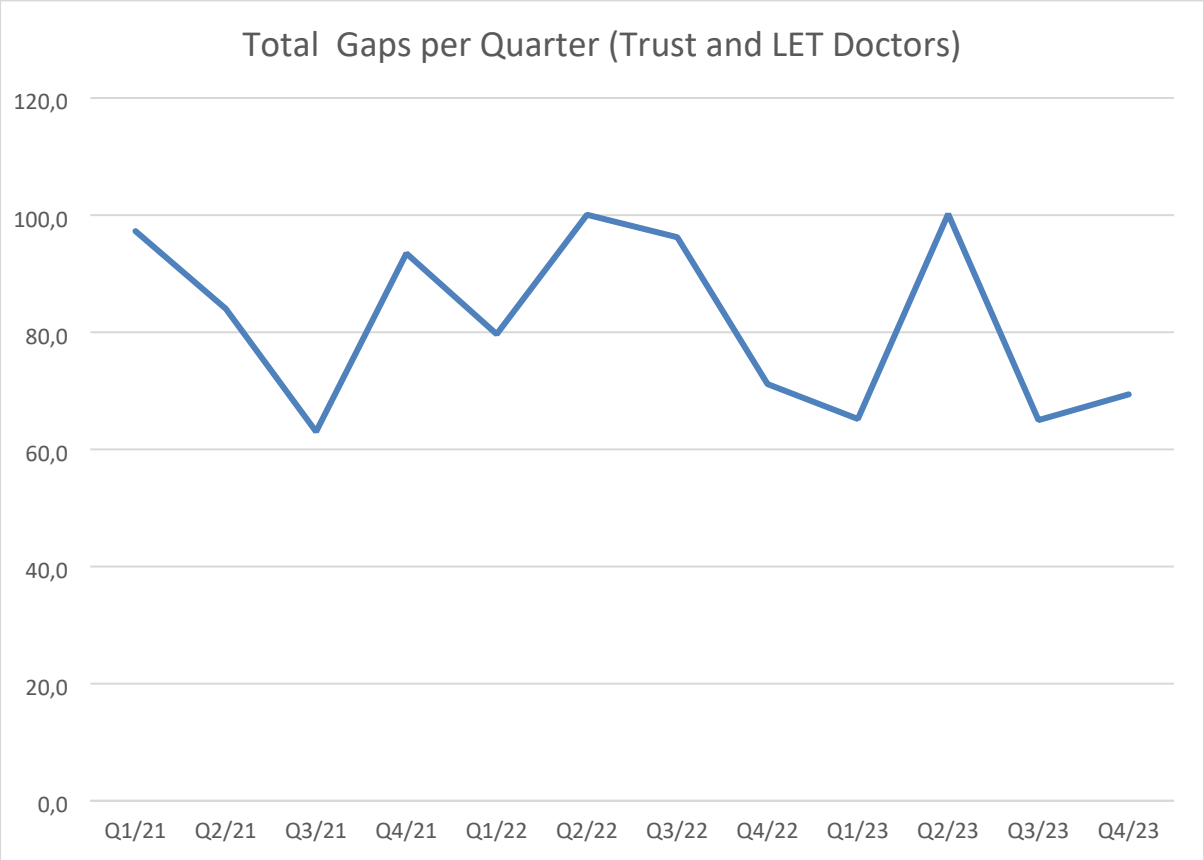
4. ANNUAL VACANCIES DATA SUMMARY BY SPECIALTY AND GRADE PER QUARTER

Site	Specialty/Sub Specialty	Grade	No. required on rota (at full complement)	Q4 (Jan/ Feb)	Q3	Q2	Q1
	Cancer Services						
FH	Oncology	ST3+	22 (September 2023)	5.5	5.5	2.3	1.3
FH	Palliative Medicine	F2/ST1+	13	0.8	0.8	1.7	0.2
FH	Haematology / Oncology	F2/ST1/ST2	14	1.6	0.9	2.0	1.0
FH	Haematology / Oncology	CMT	3	0.0	0.0	0.3	0.2
FH	Haematology	ST3+	9	1.4	0.8	2.0	0.9
	Cardiothoracic Services						
FH	Cardiology	F2/ST1-2	5	0.0	0.0	1.2	0.7
FH	Cardiology	ST3+	15	1.2	1.2	0.0	0.0
FH	Cardiology	CMT	3	0.0	0.0	1.0	1.0
FH	Cardiothoracic Anaesthesia	ST3+	9	1.5	2.0	3.7	0.7
FH	Cardiothoracic Surgery	F2/ST1-2	2	0.0	0.0	0.7	0.0
FH	Cardiothoracic Surgery	ST3+	11	2.0	1.3	3.0	1.0
FH	Cardiothoracic Transplant	ST3+	3	1.0	1.0	1.0	1.0
FH	Paediatric Intensive Care Unit (PICU)	ST3+	8	0.4	0.2	0.7	1.0
FH	Paediatric Cardiology 1st	F2/ST1/ST2	6	1.4	1.4	1.3	1.6
FH	Paediatric Cardiology 2nd	ST3+	9	1.2	1.0	0.2	0.3
FH	Respiratory Medicine	CMT/ST1-2	6	0.0	0.0	1.0	0.6
FH	Respiratory Medicine	ST3+	8 (rotate with RVI)	0.0	0.0	0.7	1.0

	Children's Services						
RVI	Paediatric Surgery 2nd	ST3+	9 (January 2024)	0.0	0.0	2.0	0.0
RVI	Paediatrics 1st - ST1/ST2 (now including Paediatric Surgery)	F2/ST1/ST2	25	1.7	2	2.4	2.0
RVI	General Paediatrics	ST3+	23 (August 2023)	2.7	2.2	2.0	2.4
RVI	Paediatric Oncology	ST3+	6	0.2	0.2	2.0	1.3
RVI	PICU	ST3+	10 (January 2024)	1.4	0.4	1.8	0.2
	Dental						
RVI	Maxillofacial Surgery	ST1/ST2	8	0.0	0.0	1.7	0.0
RVI	Dental Core Training	DCT	12	0.0	0.0	0.7	0.0
	EPOD						
FH	Ear, Nose and Throat (ENT)	F2 / CST / ST1-2	5	1.0	0.0	0.7	0.4
FH	ENT	ST3+	9	0.0	0.0	1.0	0.4
RVI	Plastic Surgery	F2/ST1/ST2	8	0.2	0.1	1.7	1.7
RVI	Plastic Surgery	ST3+	13	0.5	1.0	0.3	0.0
RVI	Ophthalmology	F2/ST1/ST2	6	0.1	0.2	1.7	0.0
RVI	Ophthalmology	ST3+	25 (December 2023)	1.12	1.0	1.0	3.0
RVI	Dermatology	F2	1	0.0	1.0	0.0	0.0
RVI	Dermatology	ST3+	7	0.9	0.4	0.9	0.0
RVI	Dermatology	CMT	2	0.0	0.0	1.0	0.0
RVI	Dermatology	GPSTR	1	0.3	0.2	0.4	0.0
	Integrated Lab Medicine						
RVI	Histopathology	ST3+	16	0.9	0.9	1.5	1.1
RVI	Histopathology	F2	1	0.0	0.0	0.0	0.0
RVI	Forensic Histopathology	ST3+	2	0.0	0.0	2.0	0.0
RVI	Histopathology	ST1/2	8	0.2	0.2	2.0	3.1
C4L	Genetics	ST3+	4	0.0	0.0	0.4	0.0
RVI	Medical Microbiology	ST1+	21	2.6	2.6	0.9	2.0
	Medicine						
FH	General Internal Medicine	F2/GPVTS/CMT/TF	12	0.4	0.2	1.3	2.0
RVI	Core Medical Training Back of House and Front of House Combined (August 2019)	CMT	11	0.0	0.0	1.0	1.2
RVI	Core Medical Training Acute Care Unit (August 2019)	CMT	2	0.5	1.0	1.3	0.0
RVI	Acute Care Common Stem on Assessment Suite Only	ACCS	2	1.0	1.0	0.1	0.0
RVI	General Internal Medicine	ST3+	25	1.4	1.2	2.9	1.3
RVI	Clinical Immunology	ST3+	3	1.0	1.0	0.0	0.0
FH	Gastroenterology	ST3+	6	0.2	0.2	0.0	0.0
FH	Care of the Elderly	ST3+	5	0.7	1.0	0.9	0.2
RVI	Accident & Emergency 1st	F2	7	0.0	0.0	0.0	0.2
RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	20	2.0	1.0	4.5	0.6
RVI	Accident & Emergency 2nd	ST3+	15 (16 from February 2024)	4.7	3.7	4.2	0.9
RVI	Accident & Emergency	F2 GP Placement	12	0.4	0.4	0.0	0.0
	Musculoskeletal						
FH	Rheumatology	ST3+	5	1.0	0.6	1.7	0.0
FH	Rheumatology	CMT1-2	3	0.0	0.0	1.3	1.0

FH	Orthopaedics	F2/ST1/ST2	4	0.0	0.7	1.0	1.0
RVI	Orthopaedics	F2/ST1/ST2	4	0.0	0.0	0.3	0.0
RVI/FRH	Orthopaedics	ST3+	19	1.2	1.2	0.9	2.9
	Neurosciences						
RVI	Neurosurgery	F2/ST1/ST2	5	0.1	0.2	0.7	1.0
RVI	Neurosurgery	ST3+	13	0.0	0.0	0.7	0.0
RVI	Neurology	ST3+	13	0.5	0.3	1.6	0.9
RVI	Neurology	F2/ST1/ST2	2	0.0	0.0	0.1	0.0
RVI	Neurology	IMT/CMT	3	0.0	0.0	0.0	1.0
RVI	Neurophysiology	All grades	3	0.0	0.0	0.2	0.0
	Peri-operative FH						
FH	Critical Care	F2 ST1-7	13 (August 2023)	2.0	0.0	2.5	0.5
FH	Anaesthetics General	ST1-7 CT1-2	27 (August 2023)	3.7	3.9	1.9	2.1
	Peri-operative RVI						
RVI	Critical Care	ST1+	16 (August 2023)	2.5	3.0	1.8	1.8
RVI	Anaesthetics	ST1-2 / ST3 +	40	2.7	3.2	3.4	2.5
	Radiology						
RVI / FH	Radiology On Call	ST2 / ST3+	33	1.0	1.3	1.4	0.0
RVI / FH	Neuroradiology	All grades	4	0.0	0.0	0.7	0.2
	Surgical Services						
FH	General Surgery	F2/ST1/ST2/ST3+	7	1.0	1.0	1.7	1.0
FH	Vascular	ST3+	10	0.5	0.3	1.3	1.0
FH	Hepatobiliary/ Transplant	ST3+	11	0.7	0.5	0.0	0.4
RVI	General Surgery	F2/ST1/ST2	7	0.5	0.3	0.7	0.0
RVI	General Surgery	ST3+	15 (August 2023)	1.3	1.7	2.6	2.6
FH	Institute of Transplantation Norther Surgical Training & Teaching Fellows	ST1-2 NSR TFs	4	0.0	0.0	0.7	0.0
	Urology & Renal						
FH	Renal Medicine	F2/ST1/ST2	5	0.0	0.0	0.3	0.3
FH	Renal Medicine	ST3+	6	0.4	0.4	0.6	0.4
FH	Urology	F2/ST1/ST2	7	0.0	0.0	0.1	0.0
FH	Urology	ST3+	11	0.0	0.0	0.0	0.2
	Women's Services						
RVI	Obstetrics & Gynaecology	F2/ST1/ST2	14	1.4	1.4	0.3	3.0
RVI	Obstetrics & Gynaecology	ST3+	22	2.6	2.6	1.3	3.0
RVI	Neonates	F2/ST1/ST2	7	1.4	1.4	1.4	1.0
RVI	Neonates	ST3+	13	0.8	1.8	1.4	0.8

4.1 Trends in rota gaps



5. ISSUES ARISING

The purpose of this report is to highlight any current issues or concerns, including the reasons for the gaps, obstacles in resolving this and actions taken to resolve the issues.

Key:
LED = Locally Employed Doctor
LET = Lead Employer Trust
MTI = Medical Training Initiative – a UK scheme allowing a fixed number of international graduates to work and train within NHS for a maximum of 24 months
LTFT = Less Than Full Time

Site	Specialty/Sub Specialty	Reason for Gap	Obstacles to Recruitment	Actions taken to overcome obstacles
	Cancer Services			
FH	Oncology	Extra training posts created	Lack of LET doctors to fill gaps	Accommodating workload within workforce

Site	Specialty/Sub Specialty	Reason for Gap	Obstacles to Recruitment	Actions taken to overcome obstacles
FH	Haematology/ Oncology	LET gap/ LTFT in full time slot		Accommodating workload within workforce
	Cardiothoracic Services			
FH	Cardiothoracic anaesthesia	LEDs not recruited	Challenges to MTI recruitment and visa issues.	Proactive recruitment into posts
FH	Cardiothoracic surgery/ transplant	Postgraduate trainees removed by LET	Overseas candidates – visa issues	Extension of contracts to existing LEDs
FH	Paediatric Cardiology	Training post removed by Health Education North East (HENE)		Extra recruitment of foundation doctors
	Children's Services			
RVI	Paediatrics	LTFT in full time slots		Temporary posts created to fill gaps
	Accident & Emergency			
RVI	Accident & Emergency	LET gaps, LTFT in full time slots	Unable to recruit into advertised posts	Further LED and Allied Health Professional posts created to add resilience to rotas
	Perioperative			
RVI	Critical Care	LEDs leaving and LET gaps	Unable to recruit into advertised posts	New LED posts created to add resilience to rotas
RVI	Anaesthetics	LTFT in full time slots and LET gaps, maternity leave		Use of internal locums
FH	Critical Care	LEDs leaving	Unable to recruit into advertised posts	Readvertisement of posts. Use of internal locums
FH	Anaesthetics	LTFT in full time slots and LET gaps. Loss of LED posts		New LED posts created
	Surgical Services			
RVI	General Surgery	LFTF in full time slots and LET gaps		Accommodating workload within current workforce
	Women's Services			
RVI	Obstetrics & Gynaecology	LTFT in full time slots		Accommodating workload within current workforce
	Neonates	LTFT in full time slots. LEDs leaving	Overseas candidates – delays in recruitment due to visa issues	Proactive approach to managing anticipated gaps

5.1 Actions taken to resolve these issues

The Trust takes a proactive role in the management of vacancies where funding is identified through the work of the Junior Doctor Recruitment and Education Group (JDREG). Members of this group include the Director of Medical Education, a Finance Team representative and Medical Staffing personnel.

In addition to recruitment to postgraduate doctor posts, the Trust runs several successful Trust based training fellowships and a teaching fellow programme to fill anticipated gaps in the rota. These are 12-month posts aimed to maintain doctors in post and avoid the problem of staff retention.

Other actions to resolve the issues are rewriting work schedules to reflect the number of available doctors, employing physician associates and advanced care practitioners to assist with junior doctor workload, redeployment of doctors to areas of clinical need, and the use of locums.

5.2 Locum Spend

The purpose of reporting locum spend is as a source of information indicating where there were gaps in service coverage requiring temporary workforce cover. All data shown here is supplied by the finance team.

Locum Spend 01.04.23 – 31.03.24

Lead Employer Trust:	£7,156,944
NUTH:	£6,139,785
Total:	£13,296,729

Locum Spend 01.04.22 – 31.03.23

Lead Employer Trust:	£4,800,000
NUTH:	£3,183,368
Total:	£7,983,368

The figures reported in last year's annual report were an under representation. There were several causes for this including missing data and errors in data assignation which are beyond the scope of this report. I am assured by the finance team that the figures supplied here are correct. There is a significant increase in spend. The main areas of locum spend were both surgical boards, medicine and emergency care and family health.

Further Comments from the finance team are included in an appendix.

6. SUMMARY

Vacancies are present on a number of rotas. This is due to both gaps in the regional training rotations, partial gaps created by less than full time doctors in a full-time training slot, and lack of recruitment of suitable locally employed doctors.

Overseas recruitment often results in a delay between recruitment and appointment due to delays in the medical training initiative process and delays in issuing visas.

The Trust takes a proactive approach to minimising the impact of vacancies by active recruitment, with a clear focus on staff retention to attract the best candidates. Other strategies include the use of advanced nurse practitioners and physician associates, rewriting work schedules to ensure that key areas are covered and with the use of locums.

Gaps on actual working rotas are also impacted by short term sickness and changes in working patterns. These gaps are not highlighted in this report.

Locum use is high in many areas, and many directorates reported consultants covering junior doctor shifts, and shifts going uncovered.

7. RECOMMENDATIONS

The Trust Board are asked to (i) note the content of this report which has been included in the Trust's Annual Quality Account; (ii) encourage pro-active recruitment of doctors to reduce vacancies and to continue to consider the impact of changes to working patterns on the workforce workload balance in order to provide a resilient workforce.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
16th April 2024

Locum Spend: Comment from Finance Team

LET Locum Spend

In terms of expenditure, we rely on the invoices from the LET and so there are differences between the actual incidence of spend and the Trust being invoiced for it. There was an increase of £2.39m between 22/23 and 23/24. Of this increase, £559k was Surgical & Associated Specialties , £541k Medicine & Emergency Care, £414 Surgical & Specialist Services & £357k Family Health.

The expenditure for 23/24 was £7.2m.

The expenditure for 22/23 was £4.8m.

Spend by quarter:

2024			
APRIL TO JUNE	JULY TO SEPTEMBER	OCTOBER TO DECEMBER	JANUARY TO MARCH
1,573,939	2,016,109	1,383,104	2,183,792

Trust Locum Spend

The expenditure for 23/24 was £6,139,785.

The expenditure for 22/23 was £3,181,368.

Spend on locums between these periods increased by £2.96m. Based on information supplied by Medical Staffing this was made up predominately of increases of £1.04m on Establishment Vacancies, £781k On-Call Cover, £771k Increased Workload, £365k Industrial Action Cover, £364k Major Incident and offset by a reduction of £430k in Covid 19 – Additional Dependency.

With reference to Clinical Boards, the increases can be seen particularly in Medicine & Emergency Care (£933k), Surgical & Specialist Services (£635k) and Surgical & Associated Specialties (£343k).

The increase in Trust Locum spend across the two years is significant, although this looks to have reduced in the second half of the year as below.

2024				2024 Total
April to June	July to September	October to December	January to March	
1,826,046	2,483,523	872,776	957,439	6,139,785

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	17 July 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 Ward Accreditation • Safeguarding and Mental Capacity Act Quarter 4 Summary • Learning Disability Quarter 4 Summary					
Recommendation	The Board of Directors is asked to note and discuss the content of this report.					
Links to Strategic Objectives	• Quality of Care will be our main priority. We will improve our approach to safety, incident reporting, listening, and learning.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☐	☒	☐
Link to Board Assurance Framework [BAF]	BAF risk ID 1.1 - 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	The EDoN update is a regular comprehensive report bringing together a range of issues to the Trust 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– Ward Accreditation

This section provides an overview of the development of a new Ward Accreditation Programme (**AC**crediting **E**xcellence ACE Awards).

Ward accreditation programmes have been implemented widely across NHS organisations, with the agreed consensus that they are a key enabler in creating shared governance, by empowering frontline nurses and midwives, to develop and improve practice and enhance patient and staff experience, recognising, accrediting and celebrating high standards.

Historically, the Trust had a ward accreditation programme which predominantly reflected achievement in the clinical assurance tool (CAT). Whilst limited, this sense of recognition was highly valued by staff across the Trust but has not been deployed for a number of years. The aspiration is to develop, launch and embed an accreditation framework aligned to national best practice. A draft accreditation framework has been developed and an overview of this is found in the report.

A pilot of the framework has been undertaken in June and July in three in-patient wards across the RVI and Freeman Hospital. This has included coaching, a self-assessment, desk top review and accreditation review. Based on this pilot, the framework and scoring matrix is being reviewed and altered and discussions ongoing regarding the accreditation levels and benchmarks. These wards will be accredited over the summer once amendments are made, with the first awards ceremony planned for September. The pilot wards have been immensely helpful in shaping this work and have been extremely positive about the accreditation process.

Due to the generosity of the Newcastle Hospitals Chairty, funding has been received for 18 months to recruit an accreditation lead, accreditation coaches and admin support. Job descriptions are being finished and recruitment will commence over the summer. Further work is also required to engage with key stakeholders from across the Trust to ensure wider support from key groups as this work progresses.

The aim is to launch the full programme in September 2024, with a roll out up to 4 Wards per month initially.

Section 2: Safeguarding and Mental Capacity Act Quarter 4

Section 2 of the report provides a Q4 summary update of Safeguarding and Mental Capacity Act (MCA) activity throughout the Trust and includes references to activity, education and training, audit and assurance and progress with CQC Improvement Plans.

Activity for Q4 evidences the following key high-level points:

- In Adult Safeguarding, Q4 data demonstrates a decrease in activity compared to Q3. 864 referrals/cause for concern were received against a total of 1106 in Q3. The increased activity and complexity, along with requirement to support other multi-agency work streams does remain a challenging for the team and has impacted on other improvement and audit work streams.
- In Childrens Safeguarding, activity reports suggested a decrease in activity in Children's Safeguarding activity in Q4 compared to that of Q3. This was not felt to be accurate. In December, a new paperless activity report was introduced, and this is not accurately capturing all activity. This is in the process of being reviewed.
- For Maternity the Q4 dashboard demonstrates an increase in activity for the last four quarters compared to the 2022/2023 figures. This is in line with the introduction of Badgernet as the maternity electronic patient record system. This is recognised to be due to the easier process for which midwives can notify the maternity safeguarding team of all cause for concern (CfC) cases, providing greater assurance that activity is accurate.
- In Q4 there were 237 reported MCA and Deprivation of Liberty Safeguards (DoLS) related enquiries, with six regarded as complex. 'Complex' can be where external legal advice has been required and/or be cases that have been put before the Court of Protection.
- Q4 numbers for urgent DoLS received and sent to Local Authorities is sustained at high levels, which has been an ongoing trend since May 2023. For each month in Q4, numbers have remained at an average of 190 applications. The total number of applications for 2023/24 is at 2061. In the previous year the number was 1,026, which was a 40% increase on 2021/22. This demonstrates that many wards continue to integrate DoLS into day-to-day activities.

The report includes an update in relation to compliance with Safeguarding and MCA training requirements which continues to be closely monitored.

- Level 1 and Level 2 training demonstrates good compliance with 97% and 96% respectively for adults and 97% and 96% for Childrens. Current Level 3 compliance remains lower than expected at 82% for adults and 84% for Childrens – this is a small improvement from 81% and 82% respectively when reported into Quality Committee. Work remains in progress to maximise compliance across all Clinical Boards and workforce groups.
- In relation to MCA training, in Q1 2023/24, the Trust embarked on mandating a best practice Level 1 MCA training programme for all clinical and patient facing staff. Compliance currently sits at 95% with updates provided to leaders across the Trust via the operational meetings to increase and maintain compliance.

A number of audit reports were discussed in the Safeguarding and Quality Committee and an overview of these can be found within the report.

There is a standalone CQC action plan for the application of the Mental Capacity Act. This is part of Section B of the Trust's improvement plan.

The action plan consists of five actions of which three have been completed. Of the remaining two, one is due for July 2024 relating to the roll out of Level 2 DOLs and MCA Training as outlined above. This is slightly behind plan, but all action progress remains closely monitored. The second action relates to embedding a process of audit relating to the application of the MCA. This action is continuous throughout 2024/25 and progress has been outlined in section 2.3 of the report.

Section 3 Learning Disability Q4

This section of the report provides a Q4 summary update regarding the work of the Learning Disability Liaison Team.

The following activity trends are noted for Q3:

- There continues to be an increase in both total number of referrals and complexity of referrals into the Liaison Team. In 2023/24 there was a total of 3505 referrals compared to 2806 in 2022/23, an increase of 699. There is also an increase in emergency department attendances with a rise of 217 in the last year.
- At the time of writing there were 113 patients requiring oversight of admission planning and 26 inpatients. This does not include capturing those who are autistic which is currently an unmet need.
- This increase in activity and complexity is impacting on the Liaison Team and the ability to deliver on all aspects of required work. Actions to address this and mitigations are contained within the report.

The report includes an overview of training and education and progress with the CQC Improvement Plan. The following key points are noted:

- In line with the Learning Disability CQC improvement plan, there has been focused work to ensure all relevant staff undertake the Diamond Standards Learning Disabilities training and that this is mandated for all clinical and patient facing staff. This been completed and current compliance is 93%.
- It is recognised that the Diamond Standards training does not sufficiently cover learning on autism. To mitigate this, Northeast Autism Society have provided three education sessions for all staff, with content covering general awareness of autism and meeting the needs of autistic people.
- In regard to national confirmation on mandatory learning disability and autism training, there remains no update following The Code of Practice (Health and Social Care Act 2008) consultation paper which closed September 2023. It is a working assumption that learning disability and autism training will be mandated, and the Oliver McGowan training will be the preferred option. The Trust continues to work closely with the Learning Disability Northeast and North Cumbria Network and an update will be provided once the regional pilot review and evaluation is completed.
- There is a standalone CQC action plan for Learning Disabilities. This is part of Section B of the Trust's improvement plan. An overview of progress and areas of risk are included in the report.
- The action plan is overseen by the Learning Disability Steering Group at bi-monthly meetings and reported into the CQC Delivery Group as requested.

RECOMMENDATION

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

Report of Ian Joy
Executive Director of Nursing
17 July 2024

EXECUTIVE DIRECTOR OF NURSING

1. SPOTLIGHT – WARD ACCREDITATION

Staff in Newcastle Hospitals are proud to work for the Trust and consistently deliver safe and high-quality care. This is evidenced through multiple measures, ascertained through audit and assurance frameworks as part of the Trust's business as usual function. Where we can further strengthen this work is by recognising, celebrating, and accrediting quality and the unique contribution of teams at a ward and department level, seizing the opportunity to build a sense a pride and recognition whilst supporting staff to continually strive for improvement.

1.1 The Background

Ward accreditation programmes have been implemented widely across NHS organisations, with the agreed consensus that they are a key enabler in creating shared governance, by empowering frontline nurses and midwives, to develop and improve practice and enhance patient and staff experience, recognising, accrediting and celebrating high standards. NHSI (2019) described Accreditation as bringing together key measures of nursing and clinical care into one overarching framework to enable a comprehensive overview of the quality of care at ward, unit or team level. When used effectively, it can drive continuous improvement in patient outcomes, and increase patient satisfaction and staff experience at ward and unit level. With a clear direction and a structured approach, it creates the collective sense of purpose necessary to help communication, encourage ownership and achieve a sense of pride in service delivery.

Historically, the Trust had a ward accreditation programme which predominantly reflected achievement in the clinical assurance tool (CAT). Whilst limited, this sense of recognition was highly valued by staff across the Trust but has not been deployed for a number of years. The aspiration is to develop, launch and embed an accreditation framework aligned to national best practice.

1.2 The Framework

A draft accreditation framework has been developed, aligned to local and national best practice. Initially the framework is designed to focus on in-patient areas, including adults, children and young people, with an aim to extend this to other departments and teams across the Trust with minor and appropriate modifications to the framework. The framework has been designed around the key pillars in the Trust Nursing, Midwifery and Allied Health Professional (NMAHP) strategy with a number of accreditation criteria under of the following pillars:

- **Improving Quality and Reducing Patient Harm -** Harm free care is evidence based, care is individualised, and the environment is maintained to ensure safety.
- **Patient Experience** - All patients receive timely, holistic individualised care. The

ward/department is a welcoming and pleasant place to be.

- **Staff Experience** - Staff are engaged, empowered, and have the knowledge and skills to do their work. Staff enjoy working on the ward and ward resources are used efficiently with sufficient staffing to meet patient needs. Patients receive the right care, at right time in the right place.
- **Engagement for Improvement -** The Ward leadership team creates conditions for continuous improvement, as well as the wider ward team demonstrating improvement capabilities and local ownership.
- **Research** - Increase research opportunities and impact, embedding evidenced based research in practice.
- **Digital -** Utilise digital technology to improve patient safety, clinical practice and overall patient experience, whilst enabling staff to embrace, shape and drive digital transformation.

With support from accreditation coaches, wards will prepare for the accreditation process. This will include a review of all the individual metrics included in the accreditation framework and undertake a self-assessment. In advance of the accreditation day, a desk top review will be undertaken by the accreditation team followed by an on-site review of the ward/department and a discussion with staff and patients. An outcome based on the scoring tool will be agreed, and the department will be accredited as either:

- Developing
- Silver
- Gold
- Platinum

(N.B the ratings are in review and subject to change)

This will be celebrated by an accreditation ceremony and a plaque for the individual ward or department. Feedback will be given to all wards with a copy of their accreditation scores to support continued improvement. The aim of this work is to improve the delivery of high-quality care, enhancing patient and staff experience and celebrating excellence across in excess of 200 clinical areas.

1.3 Progress and timescales

A pilot of the framework has been undertaken in June and July in three in-patient wards across the RVI and Freeman Hospital. This has included coaching, a self-assessment, desk top review and accreditation review. Based on this pilot, the framework and scoring matrix is being reviewed and altered with discussions ongoing regarding the accreditation levels and benchmarks. These wards will be accredited over the summer once amendments are made, with the first awards ceremony planned for September. The pilot wards have been immensely helpful in shaping this work and have been extremely positive about the accreditation process.

Due to the generosity of the Newcastle Hospitals Chairty, funding has been received for 18 months to recruit an accreditation lead, accreditation coaches and admin support. Job descriptions are being finished and recruitment will commence over the summer. Further work is also required to engage with stakeholders from across the Trust to ensure wider support from key groups as this work progresses.

The aim is to launch the full programme in September 2024, with a roll out up to four Wards per month initially.

Work is in progress to agree a communications and engagement strategy for the launch along with continued celebration and recognition.

2. SAFEGUARDING AND MENTAL CAPACITY ACT Q4

This summary provides a Q4 update of safeguarding activity throughout the Trust and includes references to developments in practice as well as an overview of national practice developments and the Trust's compliance with these recommendations. This detail was presented to the Safeguarding Committee (May) and Quality Committee (June). The following key points are noted.

2.1 Activity

Safeguarding activity for Q4 evidences the following key high-level points:

- In Adult Safeguarding, Q4 data demonstrates a decrease in activity compared to Q3. 864 referrals/cause for concern were received against a total of 1106 in Q3. The increased activity and complexity, along with requirement to support other multi-agency work streams does remain a challenging for the team and has impacted on other improvement and audit work streams.
- In Childrens Safeguarding, activity reports suggested a decrease in activity in Children's Safeguarding activity in Q4 compared to that of Q3. This was not felt to be accurate. In December, a new paperless activity report was introduced, and this is not accurately capturing all activity. This is in the process of being reviewed.
- For Maternity the Q4 dashboard demonstrates an increase in activity for the last four quarters compared to the 2022/2023 figures. This is in line with the introduction of Badgernet as the maternity electronic patient record system. This is recognised to be due to the easier process for which midwives can notify the maternity safeguarding team of all cause for concern (CfC) cases, providing greater assurance that activity is accurate.
- In Q4 there were 237 reported MCA and DoLS related enquiries, with six regarded as complex. 'Complex' can be where external legal advice has been required and/or be cases that have been put before the Court of Protection.
- Q4 numbers for urgent DoLS received and sent to Local Authorities is sustained at high levels, which has been an ongoing trend since May 2023. For each month in Q4, numbers have remained at an average of 190 applications. The total number of applications for 2023/24 is at 2061. In the previous year the number was 1026, which was a 40% increase on 2021/22. This demonstrates that many wards continue to integrate DoLS into day-to-day activities.

2.2 Education and Training

Safeguarding Adults and Children training compliance continues to be closely monitored. Level 1 and Level 2 training demonstrates good compliance with 97% and 96% respectively

for adults and 97% and 96% for Childrens. Current Level 3 compliance remains lower than expected at 82% for adults and 84% for Childrens – this is a small improvement from 81% and 82% respectively when reported into Quality Committee. Work remains in progress to maximise compliance across all Clinical Boards and workforce groups.

Key improvement actions in progress/completed:

1) Review of staff groups who should have Level 3 attached to their profile.
2) Continue to develop training sessions and learning opportunities that would support staff to reach intercollegiate guidance to have 12-16 hours of training at Level 3 and transition to this requirement rather than an annual completion of a training session.
3) Review current e-learning training.
4) Review current training and ensure these sessions are in line with intercollegiate requirements.

Due to the previous improved compliance the risk relating to impact of poor training compliance was closed. This is in the process of being reviewed and the risks register updated as required.

In relation to MCA training, in Q1 2023/24, the Trust embarked on mandating a best practice Level 1 MCA training programme for all clinical and patient facing staff. Compliance currently sits at 95% with updates provided to leaders across the Trust via the operational meetings to increase and maintain compliance.

In addition to this, Level 2 DoLS and separate MCA training is nearing completion and will be submitted to the Trust's Learning and Education Group for final approval.

2.3 Audit and Assurance

A number of audit reports were discussed in the Safeguarding and Quality Committee. The following key points are noted in relation to the Q4 MCA and DOLS Audit:

- 90% of the patients who required an MCA assessment had some form of documented evidence of a capacity assessment. This was 83% in Q3.
- 6 patients had no documented assessment of capacity or BI decision (Jan: 2, Feb: 2, Mar: 2). In these circumstances, some limited reference was found in DoLS forms and subsequent requests made by DoLS team in e-records for assessments of capacity to be completed by the ward. This was 10 in Q3.
- 88% of the 60 patients had MCA using the Trust MCA 'ad hoc' form. This figure was 83% in Q3.
- Of the 53 patients with a completed MCA form, 51 (85%) had a best interests decision completed. 2 patients (3.3%) had no evidence of BI decision. This was 78% and 22% respectively in Q3 for 50 patients.
- A deeper appraisal of MCA assessments completed in Q4 found 35 (66%) were regarded as good assessments, 16 (30%) met minimum standards and (4%) were substandard. This is compared to Q3 where 28 (46.6%) were regarded as good assessments, 21 (35%) met minimum standards and 11 (18.3%) were substandard.

An action plan is in place to share learning from this audit to inform improvements whilst acknowledging the positive progress made across the Trust.

2.4 CQC Action Plan

There is a standalone CQC action plan for the application of the Mental Capacity Act. This is part of Section B of the Trust's improvement plan.

The action plan consists of five actions of which three have been completed. Of the remaining two, one is due for July 2024 relating to the roll out of Level 2 DOLs and MCA Training as outlined above. This is slightly behind plan but all actions progress remains closely monitored. The second action relates to embedding a process of audit relating to the application of the MCA. This action is continuous throughout 2024/25 and progress has been outlined in section 2.3.

3. LEARNING DISABILITY Q4 REPORT

3.1 Activity

There continues to be an increase in both total number of referrals and complexity of referrals into the Liaison Team. In 2023/24 there was a total of 3505 referrals compared to 2806 in 2022/23, an increase of 699. There is also an increase in emergency department attendances with a rise of 217 in the last year.

At the time of writing there were 113 patients requiring oversight of admission planning and 26 inpatients. This does not include capturing those who are autistic which is currently and unmet need.

This increase in activity and complexity is impacting on the Liaison Team and the ability to deliver on all aspects of required work. The following actions have been taken to mitigate this:

- There is an additional Band 5 x3 days per week to supporting in-patient work.
- There is a Band 5 nurse working x1 day per week to support audit in line with the CQC Action Plan
- The Associate Director of Nursing is supporting referrals and advice for queries relating to those who are autistic.
- A review of Patient Services budget is being undertaken to identify funding to support a substantive increase to team and provide a develop a service to support those who are autistic.

This is logged on the risk register and is currently rated as a 12.

As there are many patients that have significant and complex needs who require multidisciplinary team support in admission planning, the team are working closely with the Clinical Boards to ensure representation at the Learning Disability Steering Group.

3.2 Mandatory training compliance and overview of educational developments

In line with the Learning Disability CQC action plan (action LD1), there has been focused work to ensure all relevant staff undertake the Diamond Standards Learning Disabilities training and that this is mandated for all clinical and patient facing staff. This been completed and current compliance is 93%. It has also been agreed that via the Trust Learning and Education Group that this will be mandated for all other staff. This is in progress.

It is recognised that the Diamond Standards training does not sufficiently cover learning on autism. To mitigate this, Northeast Autism Society have provided three education sessions for all staff, with content covering general awareness of autism and meeting the needs of autistic people. 164 people attended the first three sessions, and this has been positively reviewed. Funding is being explored to support an additional six sessions.

In regard to national confirmation on mandatory learning disability and autism training, there remains no update following The Code of Practice (Health and Social Care Act 2008) consultation paper which closed September 2023. It is a working assumption that learning disability and autism training will be mandated, and the Oliver McGowan training will be the preferred option. The Trust continues to work closely with the Learning Disability Northeast and North Cumbria Network and an update will be provided once the regional pilot review and evaluation is completed.

3.3 Progress with the CQC Action Plan

There is a standalone CQC action plan for Learning Disabilities. This is part of Section B of the Trust's improvement plan.

The following key points were discussed and noted at the Quality Committee:

- Two actions have been completed (LD1 and LD3) and evidence provided as outlined in the evidence action tracker.
- Action LD4 (*Implement an audit framework regarding the use of hospital passports and the documentation of reasonable adjustments for patients with a Learning Disability. Results will be shared and inform improvements is behind plan)* is behind plan (April 24 target date). A quarterly audit framework has been agreed and Q1 data capture has been completed. 57 records have been audited and the results are being analysed. The audit report is due to be presented to the Learning Disability Steering Group in July and learning disseminated through the relevant forums.
- Action LD5 *(Working with the Learning Disability Network to develop and introduce clear guidance for staff on the use and re-use of Health Care Hospital passports)* is due for completion this month and will be completed in time. An overview of evidence and progress is included in the action plan.
- Action LD8 *(Identify additional staffing resource to lead workstreams relating to autism, working as part of the wider Learning Disability Liaison Team. This team will be overseen by an Associate Director of Nursing)* is due for completion in June but is unlikely to be achieved. No funding from existing budget has yet been found. This

activity is currently being picked up by the Associate Director of Nursing and additional bank staff as previously documented.

The action plan is overseen by the Learning Disability Steering Group at bi-monthly meetings and reported into the CQC Delivery Group as requested.

4. RECOMMENDATION

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

Report of Ian Joy
Executive Director of Nursing
17 July 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	17 July 2024					
Title	Midwifery staffing report					
Report of	Ian Joy, Executive Director of Nursing					
Prepared by	Jenna Wall, Director of Midwifery					
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 Board with an overview of midwifery staffing and provide assurance that the Trust is compliant with national guidance in relation to safe staffing and the ongoing monitoring processes which support ensuring safe staffing levels are maintained, including Safety Action 5 of the Maternity Incentive Scheme (MIS).					
Recommendation	The Trust Board are requested to: i) Receive and review the midwifery staffing review update. ii) Review and note the current compliance with MIS requirements. iii) Acknowledge a furthermore detailed workforce review will be received in September 2024, and that an uplift in midwifery staffing maybe be required to fulfil the 2024 Birth Rate+ recommended staffing establishment.					
Links to Strategic Objectives	Quality of Care will be our main priority. We will improve our approach to safety, incident reporting, listening, and learning.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☐	☐	☐
Link to Board Assurance Framework [BAF]	BAF risk ID 1.1 - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients. Threat - Failure to improve the safety and quality of patient and staff experience in Maternity Services.					
Reports previously considered by	The EDoN update, incorporating midwifery staffing, and previous midwifery staffing reports are presented biannually to the Board.					

MIDWIFERY STAFFING REPORT

EXECUTIVE SUMMARY

The purpose of this report is to provide the Board with an overview of midwifery staffing and provide assurance that the Trust is compliant with national guidance in relation to safe staffing and the ongoing monitoring processes which support ensuring safe staffing levels are maintained, including Safety Action 5 of the Maternity Incentive Scheme (MIS).

RECOMMENDATIONS

The Trust Board are asked to:

i) Receive and review the midwifery staffing review update.
ii) Review and note the current compliance with MIS requirements.
iii) Acknowledge a furthermore detailed workforce review will be received in September 2024, and that an uplift in midwifery staffing maybe be required to fulfil the 2024 Birth Rate+ recommended staffing establishment.

Report of Ian Joy
Executive Director of Nursing
9 July 2024

MIDWIFERY STAFFING REPORT

1. INTRODUCTION

The purpose of this report is to provide the Board with an overview of midwifery staffing and provide assurance that the Trust is compliant with national guidance in relation to safe staffing and the ongoing monitoring processes which support ensuring safe staffing levels are maintained. NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) requires a bi-annual report that covers staffing and safety issues. The Developing Workforce Safeguards (2018) guidance clearly articulates the requirement to undertake an in-depth nursing and midwifery staffing review annually, with an update on actions highlighted to the Board on a six-monthly basis, this also fulfils the requirement for assurance as part of the Ockenden assessment and assurance tool regarding safe staffing levels. This report also forms part of the annual monitoring process for maternity services by NHS England and the Local Maternity and Neonatal System (LMNS).

2. SETTING THE MIDWIFERY ESTABLISHMENTS

Maternity services must be able to assess midwifery workforce needs using a validated tool. Birth Rate + is the only research-based methodology for midwifery workforce planning and is endorsed by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists. A Birth Rate+ assessment is required every 3 years with a workforce review on a bi-annual basis, the previous Trust Birth Rate+ assessment was completed in October 2020, the 2024 report is expected to be received by the Trust this month. A further staffing update will be provided in 3 months' time following the receipt of the report to outline the staffing model to ensure a sustainable service, and a timeline for providing intrapartum care in the Newcastle Birth Centre (NBC). The Trust currently has a Birth Rate+ compliant funded midwifery establishment, it is expected, based on the increased case mix acuity and additional national training requirements, that an uplift in midwifery staffing will be required to fulfil the 2024 Birth Rate+ recommended staffing establishment, and maintain compliance with MIS Safety Action 5.

3. CURRENT MIDWIFERY STAFFING AND IMPACT

The service has faced midwifery staffing challenges over the last 12 months as a result of sickness absence, vacancy and increased training requirements. In July 2023 the difficult decision was made to temporary suspend the Newcastle Birth Centre and home birth service to preserve safety across the acute and community services and consolidate midwifery staffing on the Delivery Suite. This decision was made following the completion of a quality impact assessment, with senior clinical review, and with Executive Director oversight, and although this decision has supported safety it has reduced choice of place of birth for women and has had a negative impact on the experience of women and the reputation of the Trust. This is reflected in a reduced number of births in recent months, as a result of service users opting to access services in neighbouring Trusts, often to ensure

their partners can be present until discharge, an option supported by the estate in the Newcastle Birthing Centre but precluded by the shared bays on the postnatal wards.

The Newcastle Birthing Centre (NBC) reopened temporarily on 6 November 2023, however further instability of midwifery staffing resulted in an intermittent service, and there was a further suspension by the end of November, which is ongoing. Following receipt of the Birth Rate+ report and the subsequent workforce review, a plan to sustainably reopen the services will be agreed, and shared in the next staffing paper in September.

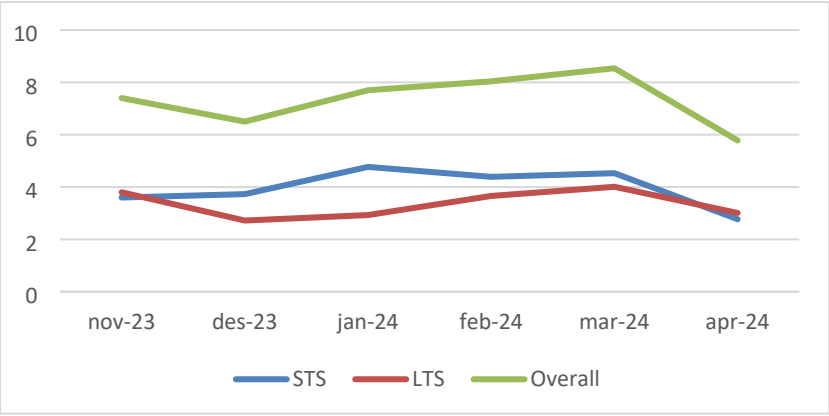
The consolidation of midwifery staffing on the Delivery Suite has supported safe care, and this is reflected in the detailed data generated by the Birth Rate+ daily acuity tool.

During the period 1 November to 30 April 2024 there were no occasions when one to one care in labour was not possible and no occasions were the co-ordinator was not supernumerary at the start of the shift. This is an improvement on the preceding 6 months whereby there were 4 occasions when one to one care was not provided, and 8 where the co-ordinator was not supernumerary. The staffing meeting the live acuity is also improving, with an increase from 53% in November 2023 to 73% in April 2024, this is in part due to reduced activity, but also reflective of the reduction in sickness absence rates.

Following the suspension of NBC there has been an overall reduction in red flags (6 November 2023 and 1 in April 2024), however, there continues to be challenge in ensuring delays to induction of labour are eliminated, although these too have also reduced. The Trust is currently embarking on a co-produced induction of labour project, alongside the Maternity and Neonatal Voice Lead, to understand women's experience of induction of labour, and how this can be optimised.

The midwifery sickness rate is being closely monitored and has broadly remained between 6-8% (Shelford comparator 4.9%) however, there has been a significant reduction in April 2024. Reassuringly, the absence rates attributed to mental health concerns have reduced from 30.1% in November 2023 to 25.1% in April 2024. This will continue to be monitored, and the impact of staff wellbeing interventions evaluated, alongside real time staff experience metrics.

Midwifery sickness rates % by month



Recruitment has been successful, with 24 midwives recruited in the most recent round, 18 of whom qualify in September 2024. Until such a time that the student midwives are in post,

and have completed their newly qualified supernumerary period, there will continue to be staffing pressures. However, the 12 month turnover rate until the end of March 2024 was 8.2%, compared with a national average of 8.9% and the service had a reduction in the number of leavers (11) of which 2 retired and 2 relocated. This, combined with a reduced sickness absence rate, indicates improved stability in the workforce.

The current establishment uplift of 20% adds additional staffing challenges as the training time allocated is not sufficient to deliver the nationally mandated core competency framework, comparable Trusts have a 25% uplift to facilitate adequate supernumerary training time to fulfil the core competency framework requirements of MIS Safety Action 6 and 8. The service is making good progress with the training requirements and is on target to achieve compliance with the MIS requirement.

4. CONCLUSION AND ACTIONS

From this midwifery staffing assurance report, the following conclusions have been drawn:

- The maternity service has achieved compliance with the requirements of Safety Action 5 of the Maternity Incentive Scheme
- 100% compliance with one to one labour in labour
- 100% compliance with co-ordinator being supernumerary at the beginning of each shift.
- The current funded establishment fulfils the 2020 Birth Rate+ recommendations.
- A further workforce review will be conducted following the receipt of the 2024 Birth Rate + report which will include a workforce model to ensure a sustainable service of the Newcastle Birth Centre.
- The senior midwifery team continue to provide scrutiny and oversight regarding the sickness absence rates, turnover and attrition, and the resultant staffing versus acuity ensuring appropriate redeployment to maintain safety.

5. RECOMMENDATIONS

The Trust Board are asked to:

i) Receive and review the midwifery staffing review update.
ii) Review and note the current compliance with MIS requirements.
iii) Acknowledge a further more detailed workforce review will be received in September 2024, and that an uplift in midwifery staffing maybe be required to fulfil the 2024 Birth Rate+ recommended staffing establishment.

Report of Ian Joy
Executive Director of Nursing
9 July 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	17 July 2024		
Title	Nursing Staffing Review Paper		
Report of	Ian Joy, Executive Director of Nursing		
Prepared by	Lisa Guthrie, Deputy Director of Nursing Peter Towns, Associate Director of Nursing Lindsey Cooper, Senior Nurse: Nurse & Midwifery Staffing		
Status of Report	Public	Private	Internal
	☐	☐	☒
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	This report comprises both the Nurse Staffing (2023/24 Quarters 3 and4) six-month review and the quarterly safe staffing assurance report. It fulfils the recommendations of the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) and adheres to the recommendations set out by the National Quality Board (NQB 2016): How to ensure the right people, with the right skills, are in the right place at the right time. It updates the Board in relation to the following: Nurse Staffing Review Update including: • Actions agreed in the Quarter 3 and 4 2023/24 Staffing Report • Setting evidenced based staffing establishments. • In-patient Skill Mix Three month Safe Staffing Assurance Report including: • Vacancy and turnover data • Red flags and Datix • Planned and actual staffing fill rates • Care Hours Per Patient Day (CHPPD) figures. • Recruitment and Retention • Check, Challenge and Coach – financial controls		
Recommendation	Trust Board is asked to: i) Receive and review the deep dive staffing review report. ii) Review and note the progress with the actions from the previous review. iii) Comment on the content of this approach which has been prepared in line with national guidance. iv) Acknowledge and comment on actions outlined within the document. v) Receive and review the quarterly staffing and outcomes review from April, May and June 2024.		
Links to Strategic Objectives	Quality of Care will be our main priority. We will improve our approach to safety, incident reporting, listening, and learning.		

Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☒	☒
Link to Board Assurance Framework [BAF]	BAF risk ID 1.1 - 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	The Board has previously received the annual nurse staffing review report, the six-month review report and quarterly safer staffing assurance reports.					

NURSE STAFFING REVIEW PAPER

EXECUTIVE SUMMARY

This report combines the nurse staffing six-month review report with the quarterly safe staffing assurance report. The purpose is to provide assurance that the Trust remains compliant with national guidance in relation to safer staffing. The Developing Workforce Safeguards (2018) guidance clearly communicates the requirement to undertake an in-depth nurse staffing review every six months and update be provided to the Trust Board on actions and progress.

Nurse staffing continues to be affected by the nationally recognised workforce pressures alongside a sustained increase in patient acuity and dependency. Although nurse vacancy levels have improved, staffing remains challenging due to the need to support new staff in clinical practice and ensure appropriate skills mix across wards and departments is safe.

The report covers the following key points:

- Progress on the actions outlined in the previous report (November 2023) are included in the report and have all been addressed.
- In line with national guidance, the SNCT data capture has been completed and the results triangulated with professional judgment. The staffing establishments in the majority of clinical areas remain broadly fit for purpose.
- There are a number of areas highlighted in this report which may necessitate additional resource. Temporary mitigations are in place, options are being explored to identify funding from within Clinical Boards and if this cannot be achieved, will be discussed with the Executive Team to agree an investment strategy. Based on risk, areas will be prioritised as required.
- Robust staffing oversight remains in place through the Nurse Staffing and Clinical Outcomes Group. Two wards have required high level support and have been discussed in the Quality Committee. Action plans remain in place and a peer review to agree de-escalation in both areas is being progressed.
- The vacancy and turnover rates have improved for registered nurses and healthcare support worker staff. This is evidenced through fill rates, reduction in red flags and CHPPD metrics. Whilst this is positive, the skill and experience of the workforce remains a concern and close monitoring is in place.
- There are opportunities to optimise roster management to maintain fair and transparent rotas for staff. To support this Check, Challenge and Coach meetings are in place to support effective roster management. A reduction in agency spend has been noted in Q1.

A number of actions are proposed within the report for discussion and endorsement.

RECOMMENDATIONS

The Trust Board is asked to:

i) Receive and review the deep dive staffing review report.
ii) Review and note the progress with the actions from the previous review.
iii) Comment on the content of this approach which has been prepared in line with national guidance.
iv) Acknowledge and comment on actions outlined within the document.
v) Receive and review the quarterly staffing and outcomes review from April, May and June 2024.

Report of Ian Joy
Executive Director of Nursing
11 July 2024

NURSE STAFFING REVIEW PAPER

1 INTRODUCTION/BACKGROUND

This report combines the nurse staffing six-month review report with the quarterly safe staffing assurance report. The purpose is to provide assurance that the Trust remains compliant with national guidance in relation to safer staffing. The Developing Workforce Safeguards (2018) guidance clearly communicates the requirement to undertake an in-depth nurse staffing review every six months and update be provided to the Trust Board on actions and progress.

Nurse staffing continues to be affected by the nationally recognised workforce pressures alongside a sustained increase in patient acuity and dependency. Although nurse vacancy levels have improved, staffing remains challenging due to the need to support new staff in clinical practice and ensure appropriate skills mix across wards and departments is safe.

2. 2023/24 NURSE STAFFING REVIEW UPDATE

2.1 Progress on actions from 2023/24 six-month review

A six-month staffing review was presented to the Trust Board in November 2023. Actions were proposed and an update on progress with these actions is provided below:

- **Complete the nurse staffing review meetings across the Trust and sign off 2023/24 staffing requirements. The final report with recommendations will be drafted for review by the Executive Team and highlighted to the Trust Board in a future report.**
  A progress update can be found in section three of this report. An overview of the staffing review process and areas of risk and mitigation was presented to the Executive Team on 3rd July 2024.
- **The data collected in the Emergency Department Safer Nursing Care Tool has demonstrated that the overall nursing establishment appears to be fit for purpose, this is triangulated with professional judgement. However, as attendances in ED remain at unprecedented levels further discussion is needed to ensure that their skill mix is optimised to meet the needs of the service and requires action.**
  An update is found in section three of this report.
- **Complete the analysis of the October 2023 Community Nursing Services Safer Staffing Tool to ascertain if the establishment is fit for purpose as recommendations for investment would not made following a single data collection.**
  An update can be found in section three of this report.

3 2023/24 NURSE STAFFING REVIEW (NSR) UPDATE

3.1 The review process

A comprehensive nurse staffing review which included Trust wide reallocation of budgets and establishments was undertaken in 2019/20. Subsequent reviews have monitored variance from previously agreed skill mix, budgets and establishments and included a review of any areas of risk based on changes to service provision or acuity and dependency profile.

A comprehensive staffing review of all in-patient areas was undertaken throughout November and December 2023, and a light touch staffing review in March 2024. An in-depth nurse staffing review of non-bed holding wards and departments is taking place between April and July 2024.

The review process has been overseen by the corporate senior nursing staffing team and has included a review of the results of the evidence-based staffing tools (Safer Nursing Care Tool – SNCT, Community Nursing Safer Staffing Tool – CNSST), nurse-sensitive indicators and professional judgement to inform recommendations for staffing establishments. The review conducted has been more comprehensive as many areas have been impacted by either service changes, local skill mix adjustments or changes in patient acuity and dependency. This has meant that this process whilst thorough, has been time consuming with some actions still in progress.

3.2 Adult In-Patient Wards and Assessment Suite

The SNCT tool assumes at least 22% uplift when setting establishments for annual leave, sickness and study leave. This Trust funds a 20% uplift for in-patient areas (14% annual leave, 3% sickness and 3% study leave). However, there is no formal allocation of maternity leave in the uplift calculation. To mitigate risk, over-recruitment agreements remain in place and maternity leave posts are offered substantively for Band 3 HCSW and Band 5 Registered Nurse (RN) posts, to maximise the available workforce.

This means that the SNCT calculation will always include a 2% differential. This is well known and is not viewed as a risk; in line with national guidance, SNCT metrics are always interpreted and triangulated with nurse-sensitive indicators, staffing metrics and professional judgement, to inform establishment setting. However, 3% sickness absence allowance is consistently exceeded which can impact either on the study time allowance or staffing levels.

Under the SNCT licence agreement and in line with guidance, all ward leaders, matrons, and heads of nursing undertaking SNCT data collection require to be trained and validated by assessment, to ensure data quality and inter-rater reliability. A new adult inpatient and adult assessment unit tool was released in October 2023, including categories for enhanced care observation and uplift for wards with a high proportion of cubicles. All staff involved in data collection and validation needed to be re-validated for use of the new tool. Daily training sessions were held throughout February, however due to operational pressures, only 38% of staff were signed off. The validated staff have been mapped against the data collection, and there is further education required for most wards before there can be

assurance of accurate and valid data. This is in progress but in the interim risk is mitigated in that staff have had training in the previous tool.

In accordance with national guidance, a minimum 30-day data SNCT capture was undertaken across eligible Adult and Assessment Suite in-patient areas in March 2024. As this is the first data collection of a new tool, at least two valid data collections will need to be analysed before SNCT can be used for decisions about staffing establishments.

Any areas below, identified with staffing risk, will add this to their risk register.

3.2.1 Outcome of the review process

Based on the review over the last six months, the following key points are noted:

- The complex gynaecology service delivered from Ward 40 RVI has been reviewed and demonstrated that the establishment is inconsistent with other Wards. Work is ongoing to review demand for all these services, alongside a review of processes and activity. Temporary staff are being utilised to mitigate any gaps in the interim.
- The review combined with information from the Nurse Staffing and Clinical Outcomes Group has indicated a staffing deficit in Trauma and Orthopaedic Wards 22 and 23 at the RVI. Temporary mitigations are in place through additional use of bank staff. The staffing team are supporting the Clinical Board to find solutions to resolve this risk recurrently, but it is likely recurrent funding will be required.
- Across Adult Critical Care the establishments are broadly fit for purpose with some minor skill mix adjustments and movement of unregistered resource across departments to ensure consistency and equity of staffing levels. This is being actioned within the Clinical Board.
- Ward 29 Freeman Hospital has seen a change in patient acuity and dependency since the COVID 19 pandemic. The ward cares for a small number of high acuity patients who receive non-invasive respiratory support. This has created an area of staffing risk, mostly associated with registered nurse staffing on nightshift. There has been an increase in the dependency of in-patients which creates an additional demand on unregistered staff during day shift. Temporary mitigations have been agreed through bank and over establishment with the requirement to invest recurrently being costed and efficiencies within the Clinical Board are being explored in the first instance.
- The review has identified that some medical wards are not fully established for the current level of enhanced care observation required. This is mitigated through the use of bank staff whilst a recurrent solution is costed and discussed.
- A review of Assessment Suite, RVI recommends additional unregistered staff, considering patient dependency, department footprint and falls risks. Temporary mitigations are in place whilst any potential increase in establishment is costed.
- Professional judgement and benchmark data recommend that the Urology Wards at FH require an additional registered nurse on nightshift. This can be partially mitigated by a reduction in unregistered staffing, and demand template work is under review to determine the impact of this skill mix adjustment.

- An increase in enhanced care observation and patients demonstrating responsive behaviours in two surgical wards at FH have created additional unregistered staffing demand which is currently mitigated by bank and agency use.
- Ward 44 at the RVI, which has cared for predominantly medical patients since 2020 is not established for that patient cohort. Recurrent changes are being addressed.
- All other in-patient adult ward establishments are broadly fit for purpose.

3.3 Children and Young People In-Patient Wards

The Trust uses SNCT (CYP) as the evidence-based establishment-staffing tool for CYP in-patient nursing establishments. In accordance with national guidance a minimum 30-day data SNCT capture was undertaken across eligible CYP in-patient areas in March 2024 using the existing tool, and a series of collaborative nurse staffing reviews were held in May 2024, the findings are summarised below:

- The renal/gastroenterology ward SNCT data supports professional judgement that there is a gap in staffing establishment to deliver all bed capacity. Care hours per patient day (CHPPD) are at lower levels than benchmarks. Long-term bed closures are in place and a long-term strategy for this area is being progressed within the Clinical Board.
- The paediatric surgical ward is managing bed capacity and acuity daily due to the high acuity and dependency of the patients for the staffing establishment. Care hours per patient day (CHPPD) are at lower levels than benchmarks. Additional investment would be required to ensure full bed capacity and accommodate current acuity and dependency trends.
- The Burns and Plastics ward currently does not meet some national burns standards. Increased leadership administration time and increase in play staff would be required to meet these standards.
- The Paediatric ICU currently falls short of national standards in terms of uplift (which is partially mitigated by over-recruit into maternity leave), play staff, critical care outreach services, and clinical educator posts. Temporary funding in year has been agreed to increase capacity and move towards achieving national standards with an incremental business plan being developed by the Clinical Board.

3.4 Adult and Paediatric Emergency Departments

The Trust uses SNCT (Emergency Department) as the evidence-based establishment-staffing tool for Emergency Departments nursing establishments. A data capture was undertaken in adult Emergency Department in March 2024 and paediatric Emergency Department in May 2024, using the existing tool. Date review is in progress. In the interim, the establishment remains broadly fit for purpose but at times of pressure and high attendances, additional staff are required to manage capacity. Temporary mitigations are in place locally through deployment of additional healthcare resource.

3.5 Community (CNSST)

The national acuity and dependency tool for community district nursing services was launched in 2022. An in-depth nurse staffing review took place in February 2024 following

two periods of data collection in 2023. Service activity has demonstrated a significant increase in patient referrals since 2020, particularly in relation to support of patients with diabetes, without reciprocal investment. There have also been several skill mix changes to support recruitment and retention. The CNSST data has given a consistent outcome at both data collections, which suggests an increase in nursing establishment is required, although professional judgement has advised that the establishment would be able to meet the needs of the service with an increase less than the data recommends. This is in the process of being costed. It is noted that the CNSST programme has now been paused nationally for three months for review and relaunch later in the year when beta testing has been completed.

3.6 Non-bed holding areas.

In-depth nurse staffing reviews are taking place between April and July 2024 for all outpatient, community, day-units, and theatre areas to review nursing establishments using a professional judgement framework. A preliminary overview of the findings is presented below:

- The emergency eye casualty department has a staffing pressure due to consistent late closures of the department. An extension to nursing hours is recommended to mitigate this but would require additional resource. Late closures are currently being managed within the department.
- Nurse staffing reviews have identified the need for demand template review across most theatre areas which is currently underway.
- Within Cardiothoracic Theatres there is an ongoing increase in Transcatheter Aortic Valve Implantation (TAVI) work, which has created a demand for Cardiac Catheter Laboratory services to be opened to capacity which are not fully funded for the nursing establishment. Cardiac theatres have also had longstanding recruitment and retention issues, which is currently mitigated with agency nursing. Collaborative working between the nurse leaders and staffing team is underway to determine a long-term solution.
- The adult dialysis unit (Ward 31 FH) has increased activity and a change in patient demographic which has increased nursing demand. Patient numbers are expected to continue to rise, in line with national predictions. A business case has been submitted to request additional staffing resource.
- Interventional radiology (IR) procedures are increasing nationally. Currently the IR nursing establishment does not meet IR nursing care guidelines relating to number of staff in theatres and on call, with high sickness, turnover and staffing incidents. Plans to extend nursing hours to match medical staff will reduce unplanned extended shifts but will create additional staffing demand. A staffing proposal is in the process of being costed.

4 Nursing Skill Mix

Skill mix reviews form part of the triangulation of data as recommended by the Developing Workforce Safeguards (2018) guidance. Skill mix reviews are conducted as part of the annual nurse staffing reviews or if a ward has altered from their primary function.

Key points to note:

- All skill mix changes requested to demand templates are subjected to a quality impact assessment and costed by the clinical board finance team. The updated demand template and subsequent costings are then shared with the Head of Nursing, Matron and Senior Sister/Charge Nurse prior to changes being made to the demand template or business case submission being made.
- During the current nurse review process, skill mix changes have been explored in many areas to embed the nursing associate role in areas where this is clinically appropriate.

5 THREE MONTH SAFE STAFFING ASSURANCE REPORT.

5.1 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 six 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 sickness absence has continued to be around 6-9% for the last six months.

The significant requirement for enhanced care continues, in addition to acuity and dependency remaining high across all service areas. The following actions remain in place:

- Daily staffing review by the corporate nursing team and reported into the Executive Director of Nursing
- SafeCare (daily staffing deployment tool) utilised to deploy staff across directorates based on need.
- Daily review of staffing red flags and incident reports.
- Staff Bank HCA pool reviewed daily, using safe care to identify areas of shortfall and reduce agency requirement.

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

Workforce support remains in place from the 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.

5.2 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. Safer Staffing Metrics are reviewed with nurse-sensitive indicators and patient experience on the Safer Staffing Dashboard alongside any concerns raised by

professional judgement or following any incidents. These metrics are rag-rated and following discussion are categorised as; requiring no support; low, medium, or high-level support. Actions are agreed in line with level of escalation: low/medium (focused interventions for areas of concern), High (full action plan). Mid-point meetings are held to scrutinise and support action plans. High and Medium (>2 months) level support are reported to Executive Director of Nursing every month. Wards are only de-escalated from high level support following a successful peer review.

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

Month	No. of wards reviewed	Clinical Board	High level support	Medium level support	Low level support
Apr-24		Family Health	GNCH 4	5	2
		Surgical and Specialist Services		3	1
		Perioperative Services		1	1
		Cardiothoracic Services	FH 29	0	4
		Medicine and Emergency Care		4	4
		Surgical and Associated Services		2	1
		Cancer and Clinical Haematology		1	0
Total	**31**		**2**	**16**	**13**
May-24		Family Health	GNCH 4	0	4
		Surgical and Specialist Services		3	1
		Perioperative Services		1	1
		Cardiothoracic Services	FH 29	0	3
		Medicine and Emergency Care		3	4
		Surgical and Associated Services		1	2
		Cancer and Clinical Haematology		1	0
Total	**26**		**2**	**9**	**15**
June-24		Family Health	GNCH 4	1	3
		Surgical and Specialist Services		2	2
		Perioperative Services		1	1
		Cardiothoracic Services	FH 29	0	3
		Medicine and Emergency Care		0	8
		Surgical and Associated Services		1	2
		Cancer and Clinical Haematology		1	
Total	**28**		**2**	**6**	**19**

Key points to note:

- There are two wards currently requiring high level support: Ward 4 GNCH & Ward 29 FH. These wards have been highlighted and discussed in the Quality Committee. Action plans are in place for these areas in collaboration with the Heads of Nursing and teams with additional support, education and resources provided, overseen by the Executive Director of Nursing. Both wards have achieved significant

improvement in their action plans. Peer review will be planned when consistent and sustained improvement has been demonstrated.

- 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.

5.3 Planned and Actual Staffing

Planned staffing is the amount (in hours and minutes) of RN, Midwives, and additional clinical support time that each in-patient ward is planned to have on duty each day. This is based on maximum utilisation of their planned establishment. Actual staffing is the amount of time (in hours and minutes) worked on duty each day, separated into 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 were manually calculated and entered by the ward leader teams (March & April) and generated by automated report via allocate health roster (May). This data is 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. RN fill rates <85% are reported to the Executive Director of Nursing every month.

Key points to note:

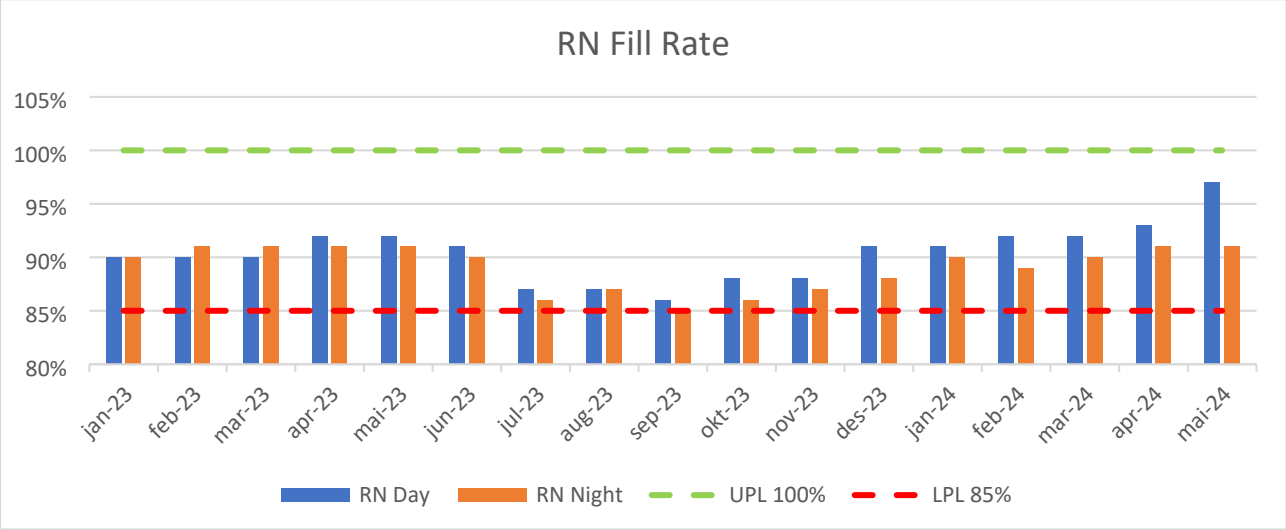
- Fill rate data is reported below as averages, this means that it does not fully represent outlier wards with particularly high or low fill rates. However, individual ward fill rate data is reviewed at the nurse staffing and outcomes group as described below.
- A review of RN fill rates shows an increased trend since October 2023, with the average RN dayshift average fill rate exceeding the nightshift every month. Both day and nightshift average RN fill rates have exceeded 85% since October 2023, with the highest fill-rate reported in May 2024 (97% dayshift, 91% nightshift). The increase in fill rates in May, could be attributed to the new automated method of data collection. Further monitoring is required to determine if this is the case.
- HCA fill rate data demonstrates a large discrepancy between dayshift and nightshift fill rates. With nightshift fill rates maintained at a level of 116-123% and dayshift fill rates between 86-94% over the past six months. The staffing team are working alongside Matrons to improve nightshift rostering to ensure consistency of fill rates across 24-hours.

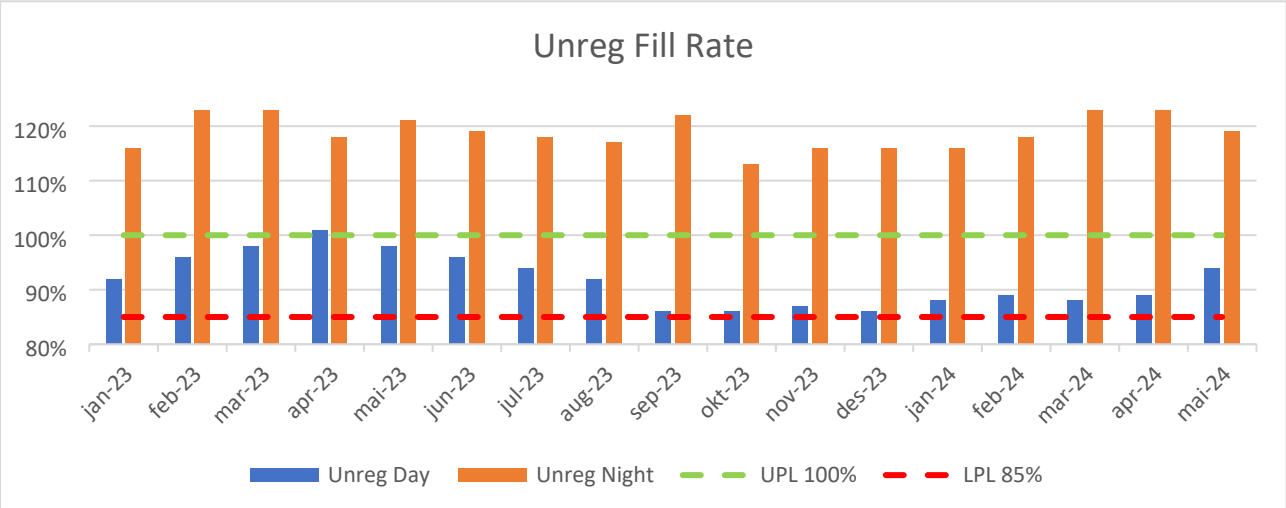
Wards Reporting <85% Fill Rate							
	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Family Health Services	3, 4, 10, 12 GNCH	3, 10, 12 GNCH	3, 10, 12 GNCH	3, 4, 10, 12 GNCH	3, 10, 11, 12 GNCH	3, 12 GNCH	3, 4, 12 GNCH
Surgical and Specialist Services RVI	19 FH, 37, 43, 47 RVI	19 FH. 15, 17, 37, 43, 47 RVI.	19 FH, 15, 17, 37, 47 RVI	37, 43 RVI	17, 37, 47 RVI	17, 43 RVI	17 RVI

Perioperative Services	37 FH, 38 RVI	37 FH. 18, 38 RVI	18, 38 RVI	18, 38 RVI	37, FH 38 RVI	38 RVI	18, 38 RVI
Cardiothoracic Services	PICU, 21, 23, 29 FH	PICU, 21, 23, 27 FH.	PICU FH	PICU FH	PICU, 27 FH	PICU, 21, 23 FH	PICU, 23, 27 FH
Medicine and Emergency Care Services	9, 13, 14, 18 FH. 19, 30, 31, 48, 52 RVI	9, 12 FH. 30, 31, 48 RVI.	9, 12, 18 FH. 19, 30, 31, 48 RVI	9, 12 FH. 30, 31, 48, 52 RVI	9, 12, 18 FH. 48 RVI	9 FH. 19, 48, 52 RVI	9 FH. 48 RVI
Surgical and Associated Services FH	2, 6, 7, 8 FH. 36, 46 RVI	7 FH. 46 RVI	7, 8 FH. 46 RVI	5, 7, 8 FH. 46 RVI	7, 8, 38 FH. 46 RVI	7, 8 FH	7, 8 FH
Cancer and Clinical Haematology Services	33 NCCC	33 NCCC	33 NCCC	33, 34 NCCC	NCCC 33	33 NCCC	33 NCCC

Trust-wide fill rates

Month	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
RN Day	88%	91%	91%	92%	92%	93%	97%
RN Night	87%	88%	90%	89%	90%	91%	91%
Unreg Day	87%	86%	88%	89%	88%	89%	94%
Unreg Night	116%	116%	116%	118%	123%	123%	119%





5.4 Care Hours per Patient Day (CHPPD)

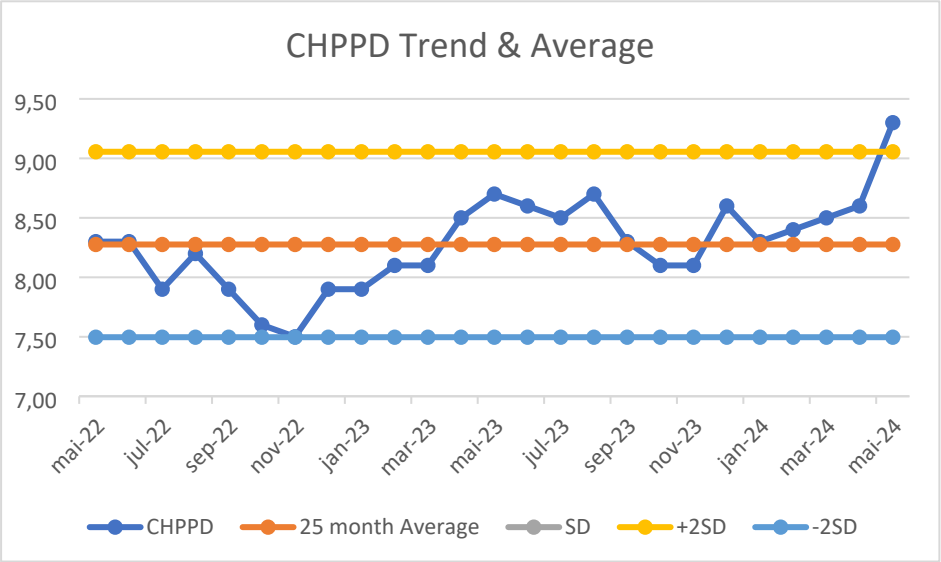
Care hours per patient day (CHPPD) is the unit of measurement recommended in the Carter Report (2016) to record and report deployment of staff working on inpatient wards. This became the primary benchmarking metric from September 2019. It adds together RN and support worker hours, divided by midnight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

There are some limitations to using CHPPD as a benchmark. Newcastle Hospitals has a high proportion of Critical Care beds which inflates the Trust overall average CHPPH score. In addition, the Trust 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.

The staffing team monitor Ward-specific CHPPD on the Safer Staffing Dashboard and is reviewed at the Nurse Staffing and Outcomes Group every month.

Key points to note:

- The Trust average CHPPD has been on an upward trajectory since October 2022.
- There has been a marked increase in CHPPD in May 2024. This is likely related to improved accuracy since automating the nursing hours data report. This will require further monitoring and an update will be provided in future reports.



5.6 Red Flags and Datix

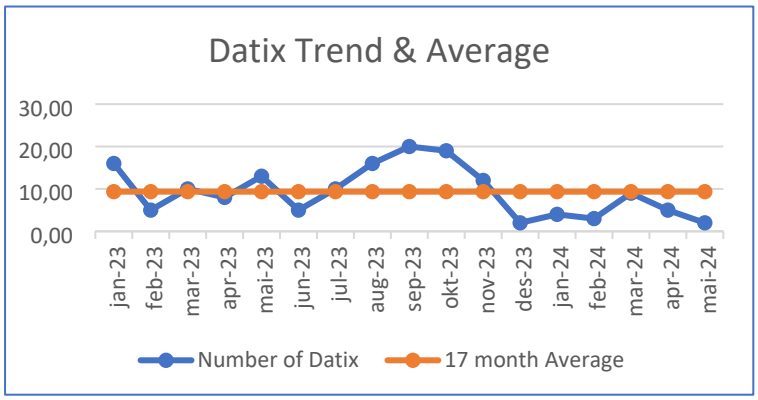
Red flag and Datix incident data are reviewed daily by the senior nursing team and reported as part of the daily staffing briefing. Red flags also continue to be presented to the nurse staffing and clinical outcomes group monthly to observe trends and highlight areas of concern.

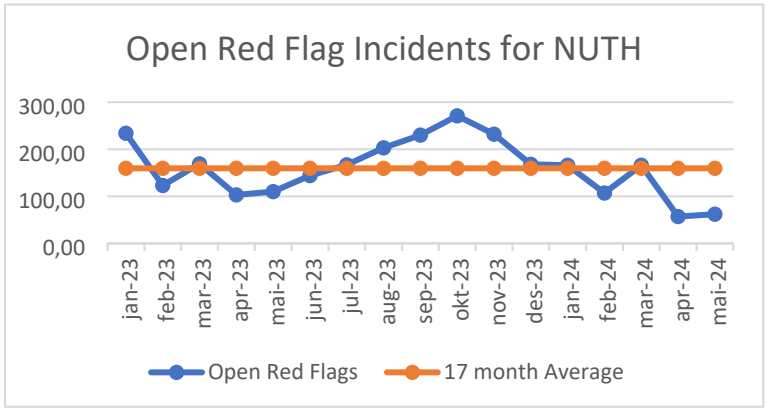
All staffing incidents reported on Datix are received by the Deputy Director of Nursing, Associate Director of Nursing, and the senior nursing workforce team. In hours, the incidents are reviewed in real time, and out of hours, as soon as practicable. Reporters and Matrons are contacted to acknowledge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

Key points to note:

- Datix reports related to staffing incidents have demonstrated significant and sustained reduction since December 2023, compared with the previous 4-month surge period.
- Over the past six-month period, Datix staffing incident reports were submitted most frequently from Medicine and Emergency Care Services, which is the Clinical Board with the most in-patient wards and has the largest proportion of enhanced care requirements. Family Health Board have reported the second highest number of staffing Datix reports in the past six-month period, due to staffing challenges within Childrens and Young People services, which has been partially mitigated by temporary bed closures.
- Open Red Flag incidents for the whole organisation average at 160. The past two months have seen a marked decrease in open red flag incidents.
- Over the past 3 months (March to May 2024) red flag incidents have predominantly been assigned as “shortfall in RN time” (137) and “missed intentional rounding” (47).
- 2 x “less than 2 RN on shift” red flags were raised during the past 3 months by NSSU RVI. This is a 10-bed unit which is connected to Ward 15 RVI with no physical barrier

and the unit is managed as one area. The risk was mitigated by increase in HCA and the NSSU/Ward 15 RN working together as a team.





6. RECRUITMENT AND RETENTION

6.1 Registers Nurse (RN) Recruitment

Key points to note:

- The current total RN turnover is 7.62% based on Month 2 financial ledger and represents a reduction from the previously reported 9.61% in the same period last year.
- The current Trust RN vacancy rate is 1.74%, based on financial ledger at Month 2, this demonstrates a decrease from the 4.66% position reported in the same period last year. This figure relates to current substantive staff in post and does not include those staff currently in the recruitment process, where there is a pipeline of 149 (head count) staff across adult and children's services.
- The favourable vacancy position has been achieved through a combination of centralised, bespoke and international recruitment. With the limited vacancy profile for qualifying RN and Operating Department Practitioner (ODP) in September 2024 the senior nursing workforce team have worked to support students to access their preferred vacancies. The Trust has facilitated a direct student advert and interviews which took place over April, May and June. All successful candidates at interview were offered a current vacancy and if their preferred area of working is unavailable, they are

placed on a provisional list and contacted as vacancies arise to ensure they receive an allocated post by the time they are ready to commence employment.

6.2 Healthcare Support Worker (HCSW) Recruitment

Key points to note:

- The Trust Healthcare Support Worker (HCSW) vacancy rate reported on the Provider Workforce Report (PWR) is currently 6.5% with 39.63 WTE 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 lower. A solution is being sought with finance and human resources colleagues to address this issue and this has also been highlighted to NHS England.
- Based on Month 2, the HCSW turnover rate is 9.88% compared to 11.72% in the same point in the previous year
- Funding has been secured from NHS England for a HCSW Conference and the implementation of a HCSW Shared Decision-Making Council. The HCSW Conference is planned for November. Both workstreams are being led by HCSW with the support of the senior nursing workforce team.

7. CHECK, CHALLENGE AND COACH – FINANCIAL CONTROLS

The Executive Director of Nursing receives a monthly financial report providing an overview of nursing spend per ward and department and run rate. This is analysed on a quarterly basis to identify areas which may require support. The expectations regarding local control and oversight have been clearly outlined to the Clinical Boards by the Executive Director of Nursing.

It is noted through the report that there are a number of areas where enhanced care requirements are greater than the funded establishment and temporary mitigation are in place through additional bank use to maintain safety. This has led to a cost pressure in a number of areas. There are a number of controls in place such as daily corporate oversight of redeployment and discussion/challenge through performance reviews. One new control has been the establishment of Check Challenge and Coach Meetings which are undertaken with nursing leaders in Clinical Boards on a bi-monthly basis.

The purpose of these meetings, in combination with e-roster dashboards, is to support inpatient areas in their use of e-rostering to provide safe, effective, and fair rosters. The dashboard for each in-patient Clinical Board outlines compliance with key performance indicators to identify potential risk and implement appropriate supportive action to mitigate. This process supports the organisation to provide consistent staffing levels, inform assurance and will assist in providing safe and high-quality care minimising risk to patients and staff members.

Data in Q1 has demonstrated a noted reduction in HCA agency use and spend without a reciprocal increase in bank or substantive spend. There has also been a reduction in the run rate across the nursing budget. This continues to be closely monitored.

8. CONCLUSIONS AND ACTIONS

From this deep dive staffing review, the following conclusions have been drawn:

- In line with national guidance, the SNCT data capture has been completed and the results triangulated with professional judgment. The staffing establishments in the majority of clinical areas remain broadly fit for purpose.
- There are a number of areas highlighted in this report which may necessitate additional resource. Temporary mitigations are in place, options are being explored to identify funding from within Clinical Boards and if this cannot be achieved, will be discussed with the Executive Team to agree an investment strategy. Based on risk, areas will be prioritised as required.
- Robust staffing oversight remains in place through the Nurse Staffing and Clinical Outcomes Group. Two wards have required high level support and have been discussed in the Quality Committee. Action plans remain in place and a peer review to agree de-escalation in both areas is being progressed.
- The vacancy and turnover rates have improved for registered nurses and healthcare support worker staff. This is evidenced through fill rates, reduction in red flags and CHPPD metrics. Whilst this is positive, the skill and experience of the workforce remains a concern and close monitoring is in place.
- There are opportunities to optimise roster management to maintain fair and transparent rotas for staff. To support this check, challenge and coach meetings are in place. A reduction in agency spend has been noted in Q1.

The following actions are proposed:

- Finalise revised demand templates and costings for all areas requiring additional resource. Efficiencies within Clinical Boards will be progressed in the first instance and any gaps escalated. All changes will be reviewed and signed off by the Executive Director of Nursing.
- Conclude the staffing review in non-bed holding areas.
- Complete inter-rater reliability training for SNCT across all clinical areas.
- Continue to provide scrutiny and oversight regarding the re-deployment of staff to respond to continued service pressures based on the level of staffing escalation.

9. RECOMMENDATIONS

The Trust Board is asked to:

i) Receive and review the deep dive staffing review report.
ii) Review and note the progress with the actions from the previous review.

iii) Comment on the content of this approach which has been prepared in line with national guidance.
iv) Acknowledge and comment on actions outlined within the document.
v) Receive and review the quarterly staffing and outcomes review from April, May and June 2024.

Report of Ian Joy
Executive Director of Nursing
11 July 2024

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	17 July 2024					
Title	Trade Union Facility Time Report					
Report of	Christine Brereton, Chief People Officer					
Prepared by	Paul Turner, Head of HR Services					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☐	☐			
Summary	There is a legal requirement for public sector organisations to report and publish on an annual basis information on facility time for staff who are trade union representatives. This year the information is required by 31 July 2024. The purpose of this paper is to share the required data with the Board for approval and provide assurance the Trust will meet its legal obligation to publish. This report went to People Committee on 21 June 2024 for information.					
Recommendation	The Board is asked to: a) note the Trade Union Facility Time reporting information for 2023-2024 b) endorse submission to the government portal, publication on the Trust website and publication in the Trust's Annual Report & Accounts for 2023-24					
Links to Strategic Objectives	People					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☐	☐	☒	☒	☐	☐
Impact detail	Failure to comply with legal obligation, financial impact					
Reports previously considered by	Annual report, Board 27 July 2023					

TRADE UNION FACILITY TIME REPORT

EXECUTIVE SUMMARY

This report is to comply with the annual requirement under the Trade Union (Facility Time Publication Requirements) Regulations 2017 for public sector employers to collect and publish a specific set of data on the use and spend of TU facility time by their staff.

The Regulations provide transparency on the use and spend of facility time in the public sector.

The reporting period is 1 April 2023 to 31 March 2024.

Publication of the data set on the government portal is required by 31 July 2024.

Publication is also required in the Trust's annual report and accounts 2023-24 and on its website.

This report went to People Committee on 21 June 2024 for information.

TRADE UNION FACILITY TIME REPORT

1. BACKGROUND

We recognise the many benefits of the Trust and Staff Side colleagues working together in partnership. Our Recognition Agreement is the cornerstone of our relationship and sets out the arrangements between the Trust and trade unions colleagues for representation, facility time, accommodation and joint consultation and collective bargaining.

This report is to comply with the annual requirement under the Trade Union (Facility Time Publication Requirements) Regulations 2017 for public sector employers to collect and publish a specific set of data on the use and spend of TU facility time by their staff. The Regulations provide transparency on the use and spend of facility time in the public sector.

The reporting period is 1 April 2023 to 31 March 2024.

Publication of the data set on the government portal is required by 31 July 2024.

Publication is also required on the Trust's website and in its annual report and accounts 2023-24.

This report went to People Committee on 21 June 2024.

2. FACILITY TIME

Facility time is when staff take time off from their normal role to carry out their *duties* and *activities* as a trade union representative.

A trade union *duty* is paid time off during working hours to carry out recognised trade union duties. The amount of time off must be reasonable. Duties include: taking part in collective bargaining (e.g. terms and conditions and redundancy), consultation and negotiation; participating in disciplinary and grievance cases; and attending training for a trade union role.

Trade union *activity* can be paid or unpaid. Requests for such time off is normally unpaid. Activities include discussing internal union matters and dealing with internal administration of the union, for example answering union correspondence and meetings other than as part of the negotiating or consultation process.

Requests for paid and unpaid time off to attend courses/conferences/meetings are decided centrally by the Head of HR Services and normally paid – they are subject to completion of an application by the trade union representative and signature from their manager.

3. DATA SET FOR REPORT

3.1 RELEVANT UNION OFFICIALS

Total number of staff who were relevant union officials during the relevant period:

Number of staff who were relevant union officials during the relevant period	Full-time equivalent
41	35.88

3.2 PERCENTAGE OF TIME SPENT ON FACILITY TIME

Total number of staff who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time:

Percentage of time	Number of employees
0%	27
1-50%	13
51%-99%	0
100%	1

3.3 PERCENTAGE OF PAY BILL SPEND ON FACILITY TIME

Percentage of Trust's total pay bill spent on paying staff who were relevant union officials for facility time during the relevant period:

First Column	Figures
Provide the total cost of facility time	£41,890.30
Provide the total pay bill	*£806,337,669
Provide the % of total pay bill spent on facility time	0.0052%

(*pending audit)

3.4 PAID TRADE UNION ACTIVITIES

Percentage of total paid facility time hours that were spent by staff who were relevant union officials on paid trade union activities?

Time spent on paid trade union activities as percentage of total paid facility time hours	5.17%

4. SUMMARY COMPARISON WITH LAST YEAR'S RETURN

	2022-2023	2023-2024
Number of TU officials	27 (19.32 FTE)	41 (35.88 FTE)
Cost of facility time	£27,019.69	£41,890.30
Percentage of total pay bill	0.0037%	0.0052%
Time spent on paid TU activity as percentage of total paid facility time hours	7.08%	5.17%

Following an exercise in 2023 to validate TU representative records held in ESR, the number of officially recognised local representatives increased which in turn increased the total cost of facility time. The amount of time spent on paid TU *activity* as a percentage of total paid facility time hours reduced due to the increase in the number of TU representatives and the proportionate amount of more time this generated under TU *duties* compared to TU activity.

5. RECOMMENDATION

The Board is asked to:

a) Note the content of this report
b) Approve publication of the data on the government portal by 31 July 2024
c) Approve publication of the data in the Trust's annual report and accounts 2023-24 and on its website

Paul Turner
Head of HR Services

Christine Brereton,
Chief People Officer

29 April 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	17 July 2024					
Title	Updated People Committee Schedule of Business					
Report of	Christine Brereton, Chief People Officer					
Prepared by	Kelly Jupp, Trust Secretary					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☐	☐			
Summary	Further to the approval of the People Committee Schedule of Business (SoB) at the Trust Board in May and discussion between the Chair of the Committee with the Chief People Officer, there have been some minor amendments to the SoB to reflect changes to the frequency of some agenda items as well as some additional items added (as highlighted in red font).					
Recommendation	The Trust Board is asked to approve the updated Schedules of Business for People Committee.					
Links to Strategic Objectives	Putting patients at the heart of everything we do. 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	Approved at People Committee on 24 June 2024					

Committee / Group:	**People Committee**
Chair:	**Bernie McCardle**
Annual Cycle Covered:	**2024/25**

Meets monthly - no formal 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	Bernie McCardle		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Bernie McCardle	Gill Elsender	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Action log	Bernie McCardle	Gill Elsender	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Meeting debrief	Bernie McCardle		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Matters requiring escalation and AOB	Bernie McCardle	Gill Elsender	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
New and emerging risks	Bernie McCardle		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Regular Reports													
People and Culture Dashboard	Christine Brereton/Paul Turner	Deb Stuart	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Delivery of the Education and Training Strategy and update on the provision of high-quality education and training	Christine Brereton/Gill Long	Deb Stuart	✓				✓				✓		Biannual report plus an annual apprenticeships update.
People Strategy/Plan 2024/27 - Year 1 deliverable plan updates	Christine Brereton	Deb Stuart	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	To focus on the themes of the People Plan at each meeting: Feeling Valued and Heard, Civilities and Behaviour, Leadership and Management and Health and Wellbeing
Employee Relations	Paul Turner	Deb Stuart	✓					✓				✓	Biannual updates scheduled - further updates to be shared if required.
Development of the Trust Workforce Plan	Christine Brereton/Rob Harrison	Deb Stuart								✓		✓	
People Committee Risk Report (BAF)	Christine Brereton	Natalie Yeowart	✓			✓				✓		✓	Quarterly report.
NHS Staff survey & Staff engagement plans/updates	Christine Brereton/Annie Laverty	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	Deb Stuart		✓									
Leadership Development, Talent and Succession Planning	Christine Brereton	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
Retention/Turnover	Christine Brereton	Paul Turner			✓								
GMC training survey	Michael Wright / Ifti Haq	Ifti Haq										✓	
Gender Pay Report	Christine Brereton	Deb Stuart										✓	
WRES & WDES	Christine Brereton	Karen Pearce		✓									
Equality and Diversity Update/EDS - including action plans	Christine Brereton	Karen Pearce / Deb Stuart			✓	✓			✓			✓	Agreed in May 2024 to do quarterly updates following discussion at the April meeting
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	✓	✓			✓		✓		✓		Added after approval of schedule in April Committee meeting
Pensions Update	Christine Brereton	Paul Turner / Deb Stuart											
Industrial Action	Rob Harrison / Paul Turner	Paul Turner / Deb Stuart											
Deep Dive in to Violence & Aggression to staff	Christine Brereton	Gill Long			✓								Added after approval of schedule in April Committee meeting - Action from Board
Deep Dive into Sickness Absence	Christine Brereton	Paul Turner				✓							
	✓	On agenda and discussed		V									
		Item deferred											

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	17 July 2024					
Title	Fit and Proper Persons Test (FPPT) Annual Report					
Report of	Christine Brereton, Chief People Officer					
Prepared by	Rachel Cockburn, People Resourcing Manager Kelly Jupp, Trust Secretary					
Status of Report	Public	Private	Internal			
	☐	☒	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☐			
Summary	The Trust requires all persons appointed to the role of Board Director or similar senior level role to meet the requirements of the Fit and Proper Person Test (FPPT) (Directors) Regulation 5. This report gives an update on the annual checks undertaken for 2023/24 and provides assurance that the requirements have been met.					
Recommendation	To note the assurance provided that the FPPT requirements have been met.					
Links to Strategic Objectives	People					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☐	☒	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	Culture					
Reports previously considered by	Annual report to provide assurance that the requirements of the FPPT Regulation have been met (previously included within the Standards of Business Conduct Report).					

FIT AND PROPER PERSONS TEST (FPPT) ANNUAL REPORT

EXECUTIVE SUMMARY

FPPTs apply to the appointment of Board of Director, Director and Very Senior Management level roles and compliance ensures that providers are able to continue to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which have been in place within the Trust since November 2014.

Following a review, new arrangements via a national framework came into place in August 2023. Compliance with the new requirements has been in place in the Trust for offers of appointment to relevant posts from 2nd August 2023 onwards.

The FPPT annual return process was undertaken in June 2024 for those that were in post and deemed 'in-scope' on 1st June 2024. This was undertaken for 29 people, which included members of the Board of Directors. The list of roles covered by the annual checks process is detailed in Appendix 1 and the list held in the People Directorate. This annual submission was made by the Chief People Officer to the Regional Director at NHS England by the deadline of 30th June. This report is to provide assurance that this requirement has now been completed.

FIT AND PROPER PERSONS TEST (FPPT) ANNUAL REPORT

1. INTRODUCTION

FPPTs apply to the appointment of Board of Director, Director and Very Senior Management level roles and compliance ensures that providers are able to continue to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which have been in place within the Trust since November 2014.

New FPPT requirements were published in August 2023 by NHS England in the form of a Fit and Proper Person Test (FPT) Framework. This followed recommendations made by Tom Kark KC in his 2019 review which was commissioned by the Minster of State for Health. The new requirements also take into account the requirements of the Care Quality Commission (CQC) in relation to Directors being fit and proper for their roles.

Checks for new appointments are undertaken by the People Directorate. For the changes to the annual check requirements, these became effective for the 2023/2024 return and were also undertaken by the People Directorate.

After appointment, those post holders deemed 'in-scope' are subject to on-going checks on an annual basis. All checks (for appointment since 2nd August 2023 and on-going employment/appointment for the 2023/2024 annual return) were signed-off by the Chair of the Trust (or by the Senior Independent Director in the case of the Chair), and an annual submission made to the Regional Director at NHS England.

Compliance with the new requirements has been in place in the Trust for offers of appointment to relevant posts from 2nd August 2023 onwards.

2. ANNUAL CHECKS

The following summarises the on appointment and annual checks that have been undertaken for the 2023/2024 return:

	On Appointment Checks	Annual Checks
Right to work in the UK	✓	×
Verification of identity	✓	×
References that cover a period for 6 years and also cover at least 2 roles including Training and Development.	✓	×
Qualifications	✓	×
Professional Registration	✓	×
Occupational Health	✓	✓* (undertaken if advised that health changed since previous assessment)

Disclosure and Barring Service (DBS) - in line with local policy, if not required annually checks undertaken every 3-years	⚑	⚑
FPPT Model Declaration	⚑	⚑
FPPT Self-Attestation Form Signed	⚑	⚑
County Court Judgements (CCJ) Check	⚑	⚑
Insolvency check	⚑	⚑
Disqualified Directors Register Check	⚑	⚑
Disqualified from being a Charity Trustee Check	⚑	⚑
Employment Tribunal Judgement Check	⚑	⚑
Social Media Check	⚑	⚑
Reference template to be completed for those leaving the Board	×	⚑
Sign-off by the Chair	⚑	⚑

The FPPT annual return process was undertaken in June 2024 for those that were in post and deemed 'in-scope' on 1st June 2024. This was undertaken for 29 people, which included members of the Board of Directors. The list of roles covered by the annual checks process is detailed in Appendix 1 and the list held in the People Directorate.

The results of the annual process are as detailed below:

Fit and Proper Person Test	**Outcome**	**Notes**
Professional Registration	No issues identified	-
Occupational Health	No assessments undertaken as no declaration on health changes	-
Disclosure and Barring Service (DBS)	No issues identified	1 of the DBS checks is in progress with the DBS, however the previous DBS confirmed that there were no issues identified and nothing declared on the self-attestation and model declaration forms. Enhanced DBS Checks were undertaken for all that are subject to FPPT.
FPPT Model Declaration	No issues identified	-
FPPT Self-Attestation Form	No issues identified	-

County Court Judgements (CCJ) Check	No issues identified	-
Insolvency Register Check	No issues identified	-
Disqualified Directors Register Check	No issues identified	-
Disqualified from being a Charity Trustee Check	No issues identified	-
Employment Tribunal Judgement Check	No issues identified	-
Social Media Check	No significant issues identified	Some content identified which highlighted that shared learning was required.
Adverse Media Check	No issues identified	Some content identified where the individual provided a comment/press statement in the normal course of their role. This was deemed to be within normal parameters.
Reference Template completed for those leaving the board.	Complete	The FPPT Reference Templates were completed for those that left the Board in 2023/2024.
Disciplinary Findings	No content identified	
Grievance Against The Board Member	No content identified	
Whistleblowing Against the Board Member	No content identified	
Behaviour Not In Accordance With Organisational Values and Behaviours or Related Local Policies	No content identified	
Settlement Agreements	No content identified	
Training and Development	In progress	At the submission date a small number of face to face training was scheduled and those who had training identified as outstanding had confirmed their intention to complete by no later than 31st July 2024.

Annual Appraisal	Complete	At the submission date there were two Non-Executive Director appraisals relating to 2023/2024 which were scheduled in early July 2024 which could not be undertaken in June due to annual leave/sickness absence.
Signed By Chair	Complete	

Following completion of the annual FPPT all those that are subject to FPPT have been tested and concluded as fit and proper and there were no issues arising that required further management action. The Annual FPPT Submission Reporting Template for 2023/2024 was submitted to the NHS England Regional Director on 28th June 2024 by the Chief People Officer.

For areas where content was identified regarding social media and adverse media, this was deemed to be within normal parameters. This was discussed with the Chief People Officer, the Trust Secretary and the Interim Chair. Some of the social media content was in relation to the resharing of others posts and the use of wording which can been interpreted in more than one way. This was content from several years ago. There will be some shared learning communicated as lessons learnt, see section 3 below.

For the Training and Development the statutory and mandatory training compliance was 89% at the submission date. There was a small number of individuals where face to face training was outstanding and sessions were booked as required, and for two others the individuals confirmed their intention to complete.

In June 2023 new DBS Checks were undertaken and it was deemed a requirement for the individuals in scope to sign up to the DBS Update Service which is renewed on annual basis by the individual. This will allow a DBS Update service check to be undertaken annually by the Trust and negates the requirement to conduct a new DBS check every 3 years.

3. LESSONS LEARNT

Following the first annual submission to NHS England and the implementation of the additional checks for the annual submission the following were identified as lessons learnt:

- **FPPT Plan**: the annual checks:
  - Due to the increase in requirements for the annual checks and the time taken to conclude the work, these will be started earlier in April and completed by 31st May;
  - Reported to the Trust Board in June; and
  - The return made to NHS England in June
- **Annual Appraisal** – dates will be realigned so they are completed in line with the FPPT reporting period of 1st April to 31st March.
- **Statutory and Mandatory Training Compliance** – a reminder will be circulated to those that are subject to FPPT to ensure that the required training is undertaken in

the Learning Lab. In addition a monthly review against compliance will be made and for any individuals with training modules that are expiring shortly, a reminder will be sent to encourage these to be undertaken prior to expiry.

- **Statutory and Mandatory Training Compliance Reports** – a quarterly report of compliance on statutory and mandatory training will be produced and reviewed.
- **Social Media** – An email will be circulated to those that are subject to FPPT about the need to be mindful in the use of social media, sharing, re-sharing, re-tweeting of posts and the content of photographs that those subject to FPPT are in.

The actions identified in this new approach will be completed by the Trust Secretary and Chief People Officer.

4. FPPT NEXT STEPS

It is acknowledged that the NHS Leadership Competency Framework needs to be embedded in appraisals for 2024/2025. The framework and the implementation of this is being undertaken during 2024/2025.

There will be statutory and compliance reports reviewed on a monthly basis as appropriate by the Chief People Officer and via the People Committee where appropriate.

Report of Rachel Cockburn
People Resourcing Manager
People Directorate
3 July 2024

Appendix 1: FPPT Applied To The Following Roles:

- Interim Chair
- Non-Executive Directors
- Chief Executive
- Managing Director
- Acting Executive Director of Nursing
- Chief Finance Officer
- Director of Commercial Development and Innovation
- Director of Communications and Corporate Affairs
- Chief Operating Officer
- Director of Patient and Staff Experience
- Director of Estates
- Chief People Officer
- Director of Quality and Effectiveness
- Chief Information Officer
- Director of Pharmacy
- Trust Secretary
- Interim Quality Support Director
- Medical Directors
- Procurement and Supply Chain Director
- Managing Director of Provider Collaborative
- Deputy Director of Business Development and Enterprise
- Interim Deputy Director of Nursing
- Deputy Chief Operating Officer
- Deputy Chief Finance Officer

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	17 July 2024					
Title	Annual Statement on behalf of The Newcastle upon Tyne Hospitals NHS Foundation Trust 2024/25 - Modern Slavery and Human Trafficking Act 2015					
Report of	Kelly Jupp, Trust Secretary Dan Shelley, Procurement and Supply Chain Director					
Prepared by	Kelly Jupp, Trust Secretary Dan Shelley, Procurement and Supply Chain Director					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☒	☐			
Summary	The content of this report outlines the Trust's commitment prevent modern slavery and human trafficking in its supply chain. It demonstrates that the Trust have reviewed and met it's requirements in line with Section 54 of the Modern Slavery Act 2015.					
Recommendation	The Board is asked to consider and approve this statement which demonstrates the Trust's continuing support of the requirements of the legislation, prior to final sign off by the Trust's Chief Executive.					
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	This is an Annual submission. The previous Declaration was approved by the Trust Audit Committee on 25 July 2023 and subsequently the Trust Board on 27 July 2023. This Declaration was considered at the Audit, Risk and Assurance Committee meeting on 16 July 2024.					

ANNUAL STATEMENT ON BEHALF OF THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST 2024/25

MODERN SLAVERY AND HUMAN TRAFFICKING ACT 2015

EXECUTIVE SUMMARY

The content of this report outlines the Trust's commitment prevent modern slavery and human trafficking in its supply chain. It demonstrates that the Trust have reviewed and met it's requirements in line with Section 54 of the Modern Slavery Act 2015.

The main changes from the previous statement include:

- A redrafted 'organisation' section to better match the updated CQC Statement of Purpose and remove the references to being rated 'Outstanding' by the CQC.
- Updating the financial year references.
- Included a new section named 'Our People' following previous discussions at the Audit Committee following the Fraud Specialist Manager briefing Committee members on a case involving two individuals who had breached the terms of their right to work visas. Contributions to this section were received from Paul Turner, Head of HR Services, and Lesley Sinclair, Named Nurse Adult Safeguarding.
- Updates to the 2024/25 priorities and the RAG rating in the procurement action plan (Appendix 1) with ongoing actions, to account for the upcoming legislative changes from the Procurement Act 2023.

The Audit, Risk and Assurance Committee is asked to consider and approve this statement which demonstrates the Trust's continuing support of the requirements of the legislation, prior to final sign off by the Trust Board and Trust's Chief Executive.

ANNUAL STATEMENT ON BEHALF OF THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST 2024/25

MODERN SLAVERY AND HUMAN TRAFFICKING ACT 2015

1. INTRODUCTION

The Newcastle upon Tyne Hospitals NHS Foundation Trust offers the following statement regarding its efforts to prevent modern slavery and human trafficking in its supply chain. It demonstrates that the Trust have reviewed and met it's requirements in line with Section 54 of the Modern Slavery Act 2015.

2. THE ORGANISATION

The Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH) is one of the largest teaching hospitals in England providing academically supported and clinically led acute, specialist and community services for adults and children to a large and diverse population across the North East and Cumbria as well as nationally and internationally. The Trust aspires to deliver outstanding services and a positive staff and patient experience.

The Trust has around 150 critical care beds, 1,600 other inpatient beds and 500 day case beds across 108 Wards and departments. There are 75 operating theatres and approximately 18,000 staff across several professions and staff groups. The Trust sees approximately 1.7 million patients per year. A range of procedures are provided including organ transplants, heart and lung operations, joint replacement surgery, consultant-led and midwife-led maternity services, with full supporting Neonatal Intensive Care, The Northern Neonatal Transport Service and Special Care Baby Unit facilities.

The Trust provides innovative, high quality healthcare, including community services. Services are provided locally, regionally, nationally and internationally.

The Trust has an annual turnover of over £1 billion.

The core values of the organisation are:

- **We care and are kind -** We care for our patients and their families, and we care for each other as colleagues.
- **We have high standards -** We work hard to make sure that we deliver the very best standards of care in the NHS. We are constantly seeking to improve.
- **We are inclusive -** Everyone is welcome here. We value and celebrate diversity, challenge discrimination and support equality. We actively listen to different voices.
- **We are innovative -** We value research, we seek to learn and to create and apply new knowledge.
- **We are proud -** We take huge pride in working here and we all contribute to its ongoing success.

3. PROCUREMENT AND SUPPLY CHAIN

The Trust considers the potential social impact and effect of its supply chain prior to the commencement of a procurement. It is committed to ensuring its suppliers adhere to the highest standards of ethics and undertakes due diligence when considering new suppliers as well as regularly reviewing existing suppliers.

The Trust continues to utilise the Standard Selection Questionnaire (SQ), which includes the requirement for supplier disclosure of any offence under the Mandatory Exclusion Grounds and also requires confirmation of compliance with reporting requirements under Section 54 of the Act 2015.

The Trust recognises that it has a responsibility to take a robust approach preventing and addressing any concerns to slavery and human trafficking.

The organisation is absolutely committed to preventing slavery and human trafficking in its corporate activities, and to ensuring that its supply chains are free from slavery and human trafficking.

The Procurement Act 2023 comes into force on 28th October 2024 and with it additional flexibility and obligations, the Trusts procurement approach and processes will be reviewed and updated in line with the new legislation.

The Trust holds the Chartered Institute of Procurement & Supply (CIPS) Corporate Ethics Accreditation.

4. OUR PEOPLE

We are committed to preventing slavery and human trafficking and have processes in place to ensure that our staff are not being exploited and have a safe and supportive working environment.

We carry out employment checks on our staff in line with NHS Employment Check Standards which are mandated by the Department for Health and Social Care for all appointments to the NHS, including temporary staff such as locum doctors, Bank workers and workers supplied by an agency or other third-party contractor. The Standards also apply to volunteers, trainees, students and those on work experience. Checks cover identity, right to work, employment history and references, criminal record, health and professional registration and qualification and are subject to periodic review to ensure they reflect changes in legal and regulatory requirements.

All our staff are required to complete training to increase their awareness of modern slavery, human trafficking and issues related to these so they are able to understand, identify and report on these risks. The training covers: equality, diversity and human rights; safeguarding adults and children; anti-bribery and corruption; and Prevent awareness.

The Trust remains the only NHS Acute to hold the CIPS Corporate Ethics accreditation which demonstrates NuTHs commitment to ethical procurement and compliance with the CIPS

code of ethics. All staff within the team who make sourcing decisions have attended and passed the annual training and assessment.

In addition, we have a number of policies and procedures in place, including:

a) Prevention of Illegal Working
b) Pre-employment checks and use of the Disclosure & Barring Service policy
c) Fraud, Bribery and Corruption Policy and Response Plan
d) Safeguarding Adults Policy and Guidelines
e) Safeguarding Adults – Guidance on handling allegations/complaints of abuse made against employees
f) Safeguarding Children – Guidance on handling allegations/complaints of abuse made against employees
g) Domestic Abuse – Employee Policy
h) Staff Bank and Agency Workers Policy (Non-Medical & Dental)
i) Agency and Internal Locum Engagement Procedure (Medical & Dental)
j) Recruitment and Selection Policy (Non-Medical & Dental)
k) Recruitment and Selection Policy (Senior Medical & Dental)
l) Recruitment and Selection Policy (Junior Doctors & LET Doctors)
m) Mandatory Training Policy
n) Speak-up we're listening policy
o) Relationships and Professional Boundaries Policy
p) Volunteer Policy
q) Policy Statement on Re-employment of Ex-Trust Employees
r) Professional Registration Policy (GMC/GDC)
s) Professional Registration Policy
t) Staff Engagement Policy
u) Policy statement on the Recruitment of Ex-Offenders

5. THE TRUST'S POLICY FRAMEWORK

In addition to the People-related policies referred to in section 4 above, the Trust has a number of other policies in place which support this agenda including the Contractors – Guidance in the use of Contractors.

The Trust's policy on the Use of Contractors clearly refers to the "Right to Work", stating that:

"Checks must be undertaken for all workers to confirm that a worker has the legal right to work in the UK, the contractor must see one of the documents or combinations of the documents specified in List A or List B (included in the policy) of the Employment Check Standard. The worker must only provide documents from List B if they cannot provide documents from List A.

The documents must show that the worker is entitled to do the type of work being offered.

If the worker shows one of the original documents, or combinations of documents contained in List B, it indicates that they only have limited leave to work in the UK. The contractor must evidence that checks have been repeated before the expiry date of the document/s, at which point the worker must produce evidence that they have applied for further right to work and/or leave to remain or cease working for the contractor. All documentation provided as evidence must be copied as per the detailed guidance, signed and dated by the individual making the copy ".

6. PRIORITIES FOR 2024/25

- Continuing to progress the actions within the Modern Slavery Action Plan (current plan is included at Appendix 1).
- Continue to work with NHS Supply Chain to gain assurances on their Supply Chains which supply the Trust.
- Continually review procurement processes to ensure the Trust is meeting its commitments to eradicating modern slavery in its supply chains.
- Continue to work with partners across the NENC ICS to deliver a coordinated approach.
- The Trust will work with the NHS England team to support the implementation of the recommendations of the NHSE Review of risk of modern slavery and human trafficking in the NHS supply chain. We will also work with Trusts across the ICS to develop a consistent approach which maximises resources.

7. APPROVAL FOR THIS STATEMENT

The Audit, Risk and Assurance Committee is asked to consider and approve this statement which demonstrates the Trust's continuing support of the requirements of the legislation, prior to final sign off by the Trust Board and signature by the Trust's Chief Executive.

Report of Kelly Jupp, Trust Secretary, and Dan Shelley Procurement and Supply Chain Director
06 July 2024

Appendix 1

Modern Slavery Action Plan – procurement & Supply Chain 2024/2025

Priority	Action	Owner(s)	RAG
Strategy	Update our priorities and actions, seeking to go beyond the Annual Statement requirements, taking into account the new obligations within the Procurement Act (28th October 2024)	Procurement & Supply Chain Director and Trust Secretary	A
Regional Coordination	Continue engagement with the ICS and Collaborative Newcastle partners to network and share best practice and develop a coordinated approach across the system.	Procurement & Supply Chain Director	G
Supplier mapping	Look to map our suppliers and categorise according to risk of modern slavery in the supply chain. Work closely with those suppliers deemed highest risk to ensure compliance.	Head of Procurement	A
Gain assurances around 2nd tier suppliers to the Trust	Receive verification and assurances from the NHS supply chain manufacturer visits.	Head of Procurement	A
Enhance the Contract Management and Audit process to include Modern Slavery assurances.	Develop and deliver a risk-based programme of due diligence in the Trust's own business and its supply chain (to include for example seeking assurances from suppliers regarding Modern Slavery, and reviewing existing contracts) taking into account the new obligations within the Procurement Act (28th October 2024)	Head of Procurement	A
Continually review our procurement processes to ensure that NUTH is meeting its commitment to eradicating Modern Slavery in its supply Chains.	Procurement SOP's to be updated to include defined responsibilities, taking into account the new obligations within the Procurement Act (28th October 2024)	Head of Procurement	A
CIPS Corporate Ethics Accreditation CIPS CORPORATE ETHICS	Ensure Training and development of team to maintain CIPS Ethics Accredited Status, (annual renewal is November)	Procurement & Supply Chain Director	G

*RAG based on progress since 2023/24

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	16 July 2024.					
Title	Board Assurance Framework Report.					
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	This report aims to support the Trust Board to seek assurance that strategic risks are being managed effectively; that risk have an appropriate action plan in place to mitigate them; and that risk scores are realistic and achievable. Please note there is one BAF risk ID 7.1 which is aligned to the Trust Board. The Trust Board are asked to discuss the recommended assurance rating and agree an assurance level for each threat. The Executive Lead will present the risk for discussion.					
Recommendation	The Trust Board are asked to: • Risk ID 7.1 review and discuss the recommended assurance rating and agree an assurance level for each threat. • Receive assurance from the Audit, Risk and Assurance Committee on the management of the Board Assurance Framework. • Provide any feedback or comments. • Approve Board Assurance Framework.					
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]	N/A					
Reports previously considered by	Executive Team and Committees of the Board.					

BOARD ASSURANCE FRAMEWORK COMMITTEE REPORT

Executive Summary

The 2024/25 Board Assurance Framework (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 will support and inform the committee agenda and regular management information received by the Committee, to enable them to make informed judgements as to the level of assurance that they can take, can then be agreed by the Audit, Risk and Assurance Committee, and reported to the Trust Board as well as identify any further actions required to mitigate risk.

Please note the BAF will be reviewed, discussed, and at the Audit, Risk and Assurance Committee on 16th July 2024. A verbal update will be provided to the Trust Board by the Chair of the Audit, Risk and Assurance Committee on assurance relating to the BAF.

1.0 INTRODUCTION

The 2024/25 Board Assurance Framework (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 will support and inform the committee agenda and regular management information received by the Committee, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be approved by the Audit, Risk and Assurance Committee and reported to the Trust Board as well as identify any further actions required to mitigate risk.

The key elements of new 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 that are considered likely to increase or reduce the Principal Risk.
- A statement of risk appetite for each risk to be defined by the Lead Committee on behalf of the Board – This field will be populated when the Trust risk Appetite Statement is agreed.
- Documented controls already have in place to reduce the likelihood of the threat.
- Sources of assurance incorporate the three lines of defence 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.
- Clearly identified gaps in the primary control framework, with details of planned responses.
- The committee should provide a level of assurance for each threat based on the committee review of the Board Assurance Framework Risk.
  Levels of assurance are documented below.

2.0 BOARD ASSURANCE FRAMEWORK REVIEW PROCESS

A full BAF review cycle has now been completed. The process followed to complete the BAF review process is documented in the table below.

	Stage 1: The BAF is reviewed by the Executive Lead for each BAF risk on a quarterly basis. Each threat must be comprehensively reviewed, updated with any new control/actions and any new strategic risks or threats proposed. The Executive Lead is to recommend a level of assurance for each threat to the Committee of the Board.
	Stage 2: The BAF document is reviewed collectively at Executive Team Meeting prior to review at Committees of the Board.
	Stage 3: Committees of the Board review all BAF risks for which they are responsible quarterly at each committee meeting. The Executive Lead will discuss the assurance recommendation with the Committee. The Committee will then agree the recommendations and agreed levels of assurance will be reported the BAF risk report to the Audit, Risk and Assurance Committee.
	The Audit, Risk and Assurance Committee receive a BAF risk report including the full board assurance framework and recommendations proposed by Committee Chairs. The Audit, Risk and Assurance Committee will review and approve the recommendations or provide feedback/questions or queries back to the Committees for further consideration.
	The BAF is submitted to Trust Board following approval at Audit, Risk and Assurance Committee.

3.0 COMMITTEE ASSURANCE

A full BAF committee review cycle has now been completed and each committee of the board has now discussed, reviewed, and agreed an assurance rating for each strategic threat.

The Committee assurance rating have been added to each BAF threat on the BAF document to demonstrate the level of assurance discussed, received, and agreed by the Committee.

Please note there is one BAF risk ID 1.2 which is aligned to the Audit, Risk and Assurance Committee. The Committee are asked to discuss the recommended assurance rating and agree an assurance level for each threat. The Executive Lead will present the risk for discussion.

The assurance rating and assurance statements are documented below.

Assurance Rating	Assurance Statement
Green	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 and no gaps in assurance or control or confidence that gaps in control are being addressed.
Amber	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	Negative assurance: the Committee is not 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.

3.1. Demonstrating Progress

It has been identified that whilst the assurance ratings give a level of assurance, they do not demonstrate progress against actions to mitigate the threat. It is proposed to introduce an indicator to demonstrate progress.

For continuity it is proposed that the CQC progress indicators are adopted. These are:

1. Fully on plan across all actions.
2. Actions defined- most progressing, where delays are occurring interventions are being taken.
3. Actions defined – work started but behind plan.
4. Actions defined -but largely behind plan.
5. Actions not yet fully defined.

Following agreement by the Audit, Risk and Assurance Committee progress indicators will be implemented in the next cycle of BAF reviews.

4.0 RISK THEMATICS

In order to ensure that the BAF accurately reflects the key threats to the Trust all risk rated 15+ have been mapped to each Committee of the Board. 15+ risks will continue to be mapped monthly. This will support the Executive Lead to review and ensure that the BAF accurately reflects the key threats to the Trust, provide assurance to the committee as well as demonstrate a link between operational risk registers and the BAF.

Following the first mapping exercise key themes identified included:

- Environment – maintenance/aging estate/building compliance.
- Ageing medical equipment.
- Capacity and demand.
- Staffing shortages.
- Service delivery.
- EPR – quality/functionality.
- Medical staffing.

All themes are linked in one or more of the current risks/threats held on BAF.

5.0 RECOMMENDATIONS:

The Trust Board are asked to:

- Receive assurance from the Audit, Risk and Assurance Committee on the management of the Board Assurance Framework.
- Provide any feedback or comments.

Report of:
Natalie Yeowart
Head of Corporate Risk and Assurance
11.07.2024

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 not 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	02.07.2024	**Likelihood**	**4**	**3**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	02.07.2024	**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. (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 evidenced by pulse survey and staff survey and monitoring of reporting–March 2025. • Develop and embed New Clinical Board Leadership Model evidenced through effective reporting QPRs –October 2024. • Delivery of CQC action plan – timescales dependant on action. • Development of Duty of Candour action plan to ensure compliance against Duty of Candour standards– January 2025.	Cont./….

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 September 2024 • Complete review of the environment in all core service to ensure they are safe and fit for purpose by January 2025 • 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.	• Clinical Effectiveness and Audit Group. • Clinical Outcomes and Effectiveness Group. • GIRFT oversight group. • Clinical Effectiveness metrics. • New Interventional Procedures Group. Review • Stocktake of progress with Clinical Board Quality Oversight Groups completed.	• 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.	• Design and implement a standardised quality reporting framework for clinical boards to report into QPRs. This will include GIRFT/NICE etc – September 2024. • Explore current infrastructure of quality oversight and local governance groups and make recommendations around enhanced support – October 2024	
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. • Completed review of Medicines Reconciliation function across the Trust to identify urgent areas for improvement to attain to national best practice.	• 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 existing governance systems in relation to Medicines Management to ensure robust oversight, monitoring, and escalation by August 2024. • 'Root and branches' review of medicines management. improvement plan after external expert review undertaken in May 2024 by August. This is to prioritise urgent actions and agree 12–18-month improvement plan. • Increase clinical nursing infrastructure to support application of medicine policy and practice. August 2024.	

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 • Director of Midwifery appointed and in post.	• 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. • Real time patient/staff experience programme to include one post-natal Maternity ward. Complete. • Workforce review to include outputs of the 2024 Birthrate plus review and agree long term criteria for re-opening and sustainability of NBC – August 2024. • Review and refresh of Maternity Quality Metrics reported into Quality Committee – September 2024. • Director of Midwifery in process of reviewing maternity and obstetrics to strengthen governance and oversight – October 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	• 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.	• CB review of action plans for all reviews registered on the CB's external review log – August 2024. • Explore current infrastructure of quality oversight and local governance groups and make recommendations around enhanced support – October 2024	
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 PSIRF. • Quality Committee oversight of PSIRF priority topics • Monitoring of specific incident themes and trends via PSIRF processes • Patient Safety Group Report and Minutes.	• Monitoring and oversight at Quality committee to ensure completion of key action – January 2025.	
Failure to deliver care optimisation improvements impacting on quality and safety.	• IT Town Hall, engagement sessions and Staff Roadshows. • Trust-wide adoption coaches appointed. • Digital Health Team Care optimisation project.	• Presentations slides, staff roadshow sides and feedback from staff. • Supplier assessment based on site visit.	• Establish a Care Optimisation Group – 01.08.2024. • Implement Oracle/Cerner Remote Hosting project – 01.01.2025. • Upgrade current EPR version – 31.03.2025.	

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	08.07.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	08.07.2024	**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. • External Tabletop Governance Review. • Risk Registers.	• 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 • External Tabletop Governance Report.	• Evaluate the implementation of revised integrated governance structure – 01.10.2024. • Develop action plan following external tabletop exercise and CGARD QOG review – 01.09.2024.	
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. • Quality Oversight Group Evaluation. • Risk Management Dashboard.	• Performance and accountability framework document. • Clinical board reporting and minutes. • Performance review reports and minutes. • Clinical Board Chairs update to Executive Team. • Quality Committee Quality Oversight Evaluation Report, June 2024. • QPRs report to Trust Board.	• Review issue escalation through new governance route to Exec – 01.08.2024. • Review consistency of Monthly performance reviews – 01.08.2024	

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. • Completed incident review of areas of under reporting. • Completed Review effectiveness of PSIRF implementation. • Completed review effectiveness of current rapid learning from serious incidents. • Review and implementation of incident escalation process.	• Monthly dashboards to clinical boards. • All legacy SI's completed and closed. • Datix User Survey. • PSIRF update to Quality Committee. • Data available to provide continued monitoring. • PSIRF implementation and assurance report June 2024, 90% of investigations closed within appropriate timeframe. • Incidents/Rapid review outcomes reported to Executive Team weekly. • Quality Committee Monthly Report. • Chairs report to Trust Board.	• Develop and implement incident reporting communication plan – 01.08.2024. • Report and ensure compliance against Duty of Candour – 01.01.2025.	
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 training video for induction. • Refreshed Board Assurance Framework.	• 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. • Clinical Risk reporting to Quality Committee. • Quality Performance Reviews.	• Implementation/engagement risk refresher sessions to embed new risk management policy – 30.08.2024. • Develop further strategies to support ward/departmental level risk identification and documentation 01.09.2024.	

Risk ID	1.2

Comments:
Completed actions moved to Controls, assurance/evidence aligned. Timescales updated for DOC and governance evaluation.

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	28.06.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	28.06.2024	**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	• 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. SMc to confirm timeline for improvement.	
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. • TMG engagement re Internal Reports and actions.	• 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. • Mazars external audit – satisfactory assurance, no issues re going concern. • Head of Internal Audit Opinion – reasonable assurance.	• Revisit of control checklist provided by NHSE, rapid actions, workforce, financial control - Ongoing 31.7.24 • Strategy to improve financial awareness throughout Trust - discussion with Head of Comms –Ongoing 31.7.24	Timescales revised.

	• HFMA self-assessment report. • Annual Internal and External Audit complete.			
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. • Risk assessments completed to set for 'course correction' if targets not being met.	• 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. • Escalation plans for course correction.	Repeat deep dives where necessary – Monthly deep dives agreed in cardiothoracic and medicine – this will be ongoing.	
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. • Financial Recovery Steering Group.	• Reporting to FRSG (fortnightly). • Revenue reporting to Finance and Performance Committee. • Financial Recovery Steering Group minutes and papers.	• Production of longer-term financial plan - JB - draft Ongoing will be presented to Execs before 31.07.2024.	Timescales revised.
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). • Annual Internal and External Audit complete.	• 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. • Mazars external audit – satisfactory assurance, no issues re going concern. • Head of Internal Audit Opinion – reasonable assurance.		
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 Committee • Capital management audit by internal audit – Level of control needed. • ICS Infrastructure plan	• engagement with potential solutions to CDEL. Ongoing, meeting held with PWC re PPP	

Risk ID	6.1

Comments:
Timescales revised. New actions required on emerging cost pressures threat.

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	08.07.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	08.07.2024	**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. Completed Theatre Demand and Capacity Exercise.	• Accountability Framework. • Activity and Income reports. • Integrated Quality and Performance Board Report. • Monthly Integrated Quality Performance Reviews. • Theatre Demand and Capacity data.	• Further development of the Integrated Quality and Performance Board Report next key update 30.09.2024. • Develop Clinical Board Level reports – 30.09.2024. • Review current information and performance reports to ensure they are fit for purpose - 30.09.2024. • Development of governance processes within the Clinical Board– 31.07.2024. • Finalise 62-day cancer performance improvement plans and trajectories – 31.07.2024. • Agree 65-week cohort reduction trajectories with specialities – 17.07.2024. • Develop Service Review methodology 01.08.2024. **Cont./….**	Timescales revised

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. • Revised annual planning process to incorporate approval of business cases for the coming financial year and utilisation. • Operational reports establishing weekly activity and value performance reports. • Diagnostic, Surgical and Outpatient Improvement Groups in place, with organisation wide scope to deliver improvements in effectiveness.	• Integrated Quality and Performance Board Report. • Monthly Integrated Quality Performance Reviews. TMG Updates. • Clinical Board meeting minutes. • Weekly Activity and ERF (income) reports	• Development of a medium-term radiology resource plan to mitigate the need for additional mobile MRI/CT scanners -30.08.2024.	
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. • Establishment or relaunch of the clinical lead Trust wide Improvement Groups. • Diagnostic Improvement Groups. • Surgical Improvement Group. • Urgent and Emergency Care 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. •	• Strengthen commissioner, primary care engagement and users on pathways/ service redesign – 01.09.2024. • Development of GP leadership roles for UEC and Community Care – 01.09.2024. •	
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.	• Development of Alliance plans for designated services – MD, CN and Ops leads identified – 01.09.2024	

Risk ID	6.2
Comments:	

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 – 01.08.2024. • 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 agreed digital strategy and aligned 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: Threat description amended from lack of an approved financial plan for digital investment to lack of agreed digital strategy and aligned financial plan for digital investment.

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:
Following discussion at Finance Committee in June this risk is to be re-reviewed. Consideration of scoring and expansion of threats.

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	02.07.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	02.07.2024	**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**
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	02.07.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	02.07.2024	**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. • Staff and patient experience data developed.	• 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” – September 2024. • 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 groups and areas in the Trust 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. • Executive Directors EDI objectives.	• 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.	• Action plan to improve WRES and WDES performance coproduced with staff networks – July 2024. • Review of Dignity and Respect Policy – with a focus on anti-racism – September 24	

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. • Timeout session with staff network groups representative to from next steps and inform. WRES/WDES action plans. • Implementation of a behaviour and civility charter setting out standards of expected behaviours	• 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 • Further embedding of the behavioural and civilities charter through people processes – October 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.	• Raise awareness of FTSU and Speaking up about regarding safety and quality concerns in all clinical and corporate areas – by October 2024. • 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	02.07.2024	**Likelihood**	**5**	**4**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	02.07.2024	**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. • Introduction of Leadership. competency framework for Board members.	• 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 September 2024. • Introduction of value/leadership competency into our recruitment processes – incrementally from June 24, fully implemented by March 2025. • Review of People committee agenda to include more people data.	

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 2024, fully implemented by March 2025. • Management skills training with focus on People over Process from August 2024. • Review of key HR policies and processes aimed at supporting staff – September 24.	

Risk ID	2.3

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Inability to sufficiently influence priorities of key partnerships (including the Great North Healthcare Alliance, the ICB, Provider Collaborative and Newcastle place arrangements) or to deliver on agreed commitments due to capacity or culture, 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	09.07.2024	**Likelihood**	**4**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	09.07.2024	**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 and/or culture of the organisation resistant to working in effective partnerships.	• Great North Healthcare Alliance Steering Group Committees in Common established. • ICS Board • Great North Healthcare Alliance Collaboration Agreement based around improving collaboration working whilst retaining organisational independence. • Provider collaborative leadership board • Newcastle place based ICB sub-committee • Collaborative Newcastle Joint Director Team •	• 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 Committees in Common 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 work plan to private board 26.09.2024. • 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:

Trust-Wide Risks Scored 15+ - Committee Mapping

Quality Committee			
Risk ID	**Clinical Board/Corporate Directorate**	**Risk Description**	**Current Risk Score**
3079	Estates and Facilities	There is a risk to patient safety and people should they be exposed to contaminated water outlets in PFI estate. This is caused by water outlets where proliferation of thermostatic mixing valves (TMV), flow-straighteners and flexible hoses do not conform to HTM standards. This could result in: harm to, or death of, patients, staff or public.	15
3141	Cardiothoracic	There is a risk to quality safety which is caused by non-compliance with current treatment timeframes for adults with acute cardiac conditions. Which could result in immediate or higher risk of future adverse complicated cardiovascular events which has resulted in death and continues to do so.	16
3527	Estates and Facilities	There is a risk to patient safety and people in the event of a fire due to non-compliant active fire protection meeting the L1 standard which causes inadequate coverage. This is caused by the presence of obsolete components due to insufficient investment and maintenance of active fire safety systems at the Freeman Site. This could result in harm to, or death of, patients, staff or public; compromised fire safety standards, unplanned interruption of services.	15
3525	Estates and Facilities	There is a risk to patient safety and people at Royal Victoria Infirmary retained estate should fire and smoke spread in the event of a fire due non-compliant passive fire protection with compartmentation breaches within fire walls, floors, and ceilings. This is caused by significant defects and asset management systems regarding Fire Door sets and Dampers. This could result in harm to, or death of, patients, staff or public; compromised fire safety standards, unplanned interruption of services.	15
3524	Estates and Facilities	There is a risk to patient safety and people at Freeman retained estate should fire and smoke spread in the event of a fire due non-compliant passive fire protection with compartmentation breaches within fire walls, floors, and ceilings. This is caused by significant defects and asset management systems regarding Fire Door sets and Dampers. This could result in harm to, or death of, patients, staff or public; compromised fire safety standards, unplanned interruption of services; potential for legal enforcement notices through non-compliance with Regulatory Reform (Fire Safety Order)	15
3535	Estates and Facilities	There is a risk to patient safety and people at NCCC (FH) should fire and smoke spread in the event of a fire due non-compliant passive fire protection with compartmentation breaches within fire walls, floors, and ceilings. This is caused by significant defects and asset management systems regarding Fire Door sets and Dampers. This could result in harm to, or death of, patients, staff or public; compromised fire safety standards, unplanned interruption of services; potential for legal enforcement notices through non-compliance with Regulatory Reform (Fire Safety Order)	15
3534	Estates and Facilities	There is a risk to patient safety and people at New Victoria Wing and COB (RVI) should fire and smoke spread in the event of a fire due non-compliant passive fire protection with compartmentation breaches within fire walls, floors, and ceilings. This is caused by significant defects and asset management systems regarding Fire Door sets and Dampers. This could result in: harm to, or death of, patients, staff or public; compromised fire safety standards, unplanned interruption of services; potential for legal enforcement notices through non-compliance with Regulatory Reform (Fire Safety Order)	15
3591	Estates and Facilities	There is a risk to patients and people due to the unexpected potential failure of critical ventilation infrastructure at the RVI. This is caused by underinvestment in the lifecycle replacement of ventilation infrastructure in certain areas of the Trust Estate. Limited central capital funding allocation has led to the aging and deteriorating condition of these assets which increases the likelihood of failure of the associated infrastructure. This could result in a direct impact on patient safety/satisfaction including increased risk of HCAI and unplanned disruption to clinical activity.	15
3634	Medicine and Emergency Care	There is a risk to quality safety for patients who present to ED with mental health issues, will experience deterioration in their MH and potentially to their physical safety, due to excessive periods of time in the ED awaiting mental health review. This is due to long waits for assessment by appropriate mental health services, lack of suitable mental health treatment options and shortage of mental health beds commissioned by CNTW. This results in a poor patient experience, negative impact on patient health and delays to treatment for patients in crisis.	16
3718	Clinical and Research Services	There is a risk to quality safety, which is caused by aging facilities and failing infrastructure in the BMT Unit within the William Leech Building (university owned) adjacent to the RVI. This could result in a significant critical incident, delay lifesaving BMT treatment to patients and impact on the Trust's ability to be a centre of excellence.	20
3811	Clinical and Research Services	There is a risk to Service/Business interruption/Environmental impact in Blood Sciences at RVI caused by an inadequate cooling/heating system which could result in loss of service.	20
3886	Clinical and Research Services	There is a risk to Service/Business interruption/Environmental impact caused by terminal failure of the MPA pre-analytical element of the Roche lines which could result in significant delays to patient test result turnaround times in Blood Sciences RVI.	20
3937	Clinical and Research Services	There is a risk to quality safety that investigation results could be issued electronically without being endorsed and acknowledged in the electronic health record (EHR). This is caused by lack of assurance that investigation results, issued electronically, are appropriately endorsed, and acknowledged in the electronic health record (EHR). Significant problems currently affect every phase of the ordering and resulting process. This could result in results not being endorsed or acknowledged, which could lead to investigation results being reported to the incorrect Lead Consultant in e-record message centre. Without addressing the problems affecting each phase, patients under our care will remain at significant risk.	16
4000	Patient Services	There is a risk to quality safety caused by a lack of robust arrangements and clinical capacity to support antimicrobial stewardship which could result in the emergence of antimicrobial resistance adversely impacting on patient stay, patient safety and quality of care.	16
4141	Information Technology	There is a risk of non-compliance with MHRA guidelines, which is caused by the quality control of scanned Health Records as MFD's. This could result in records without quality assurance or validation checks.	16
4155	Medicine and Emergency Care	There is risk to service delivery as well as pt and staff safety due to the environment on CAV site. The directorate has a number of services on CAV site including diabetes and older peoples medicine service. Pts with mobility issues are struggling to navigate the site which is getting further into dis-repair. There are regular estates issues with specific buildings e.g Belsay that regularly impact on service delivery and result in patient cancellations. This could result in delays to patient care, and issues with staff and patient safety.	16
4163	Estates and Facilities	There is a risk to patient safety and people in the event of a fire should fire dampers fail due to the PPM program to inspect and test fire dampers (as per the HTM 03-01, BS:9999 and BESA TR19/VH001) not being achieved. This is caused by resource constraints, access availability to all areas and asset management systems and financial constraints. This could result in: harm to, or death of, patients, staff or public; compromised fire safety standards, unplanned interruption of services; potential for legal enforcement notices through non-compliance with Regulatory Reform (Fire Safety Order)	15
4208	Family Health	There is a risk to patient safety, caused by inadequate pharmacy resource within GNCH which could result in patient herm, medication errors and lack of access to new medications. As well as additional impact on GNCH staffing and flow.	16

4225	Surgery and Specialist Services	There is a risk to quality safety for giving vulnerable patients a timely MRI under GA. This is caused by MRI scanner capacity and anaesthetics capacity to staff GA lists, and no other hospitals now providing this service. This could result in delayed diagnosis of serious conditions, poor patient experience, complaints, and accusations of inequitable access to health (as LD patients usually have MRIs under GA)	16
4221	Surgery and Specialist Services	There is a risk to patient quality and safety, caused by a mismatch of demand and capacity within the glaucoma subspecialty. This could result in patients not receiving timely treatment with resulting visual loss.	25
4224	Surgery and Specialist Services	There is a risk of patient quality and safety. This risk is caused by a demand and capacity mismatch across all ophthalmology specialties. This could result in patients not receiving timely treatment with resulting visual loss	16
4234	Patient Services	There is a risk to patient safety caused by the contamination of hand wash sinks in the clinical areas, which could result in increased infections and health and safety incidents.	16
4237	Clinical and Research Services	There is a risk to quality safety, which is caused by the aging blood culture analysers being out of service, and the inability to source parts for the analysers which means they cannot be fixed. There is a risk to service delivery if we are unable to source another analyser. This would impact on the delivery of the sepsis 6 pathway which could result in patient harm.	20
4262	Cardiothoracic	There is a risk to quality and safety regarding the KOKO lung function equipment that is used for assessing lung function in a range of patients, both out and in-patients. The tests are used to assess disease progression, effect of medication and for preoperative assessment. This is caused by the equipment failing on multiple occasions. It could result in patients needing to be rescheduled and could also mean that important information regarding lung function is not available for medical staff to discuss with the patient, potentially causing a delay to their treatment.	15
4312	Clinical and Research Services	There is a risk to Service/Business interruption/Environmental impact caused by acute staffing shortage which could periodically result in an inability to provide the Haematology/Transfusion service to the Trust.	20
4310	Medicine and Emergency Care	There is a risk to quality safety caused by overcrowding in ED which could result in acutely unwell patients not being appropriately identified or experience treatment delays.	20
4342	Family Health	There is a risk to patient safety which is caused by insufficient obstetric consultants which could result in inability to deliver timely and effective tertiary services as required by the region.	15
4344	Medicine and Emergency Care	There is a risk of patient harm due to inability to provide timely haemodialysis to patients. This is caused by an increase in demand and imbalance between capacity and demand.	16
4353	Clinical and Research Services	There is a risk to Quality Safety for paediatric gastroenterology patients which is caused by limited Psychology capacity and subsequent delays to be seen which could result in harm and poor outcomes to patients.	15
4378	Surgery and Specialist Services	There is a risk to patient quality and safety. This is caused by patients' appointment being cancelled during covid and this information being held on XL spreadsheets. This could result in patients not receiving timely treatment and resulting in visual loss.	25
4389	Family Health	There is a risk to Quality Safety caused by delays in IAS medical procuring new ambulances for the NECTAR service which could result in ambulances breaking down, impacting on patient safety and delivery of care when in transit and inability to provide service.	15
4407	Peri-operative and Critical Care	There is a risk to patient safety caused by insufficient staffing within the home ventilation service which means that we can no longer meet the demand of the increasing number of patients that require this service. This could result in delays to patient assessments and treatment plans which could ultimately result in patient deterioration or premature death.	16
4422	Clinical and Research Services	There is a risk to quality safety for amputee patients, which is caused by increased volume and complexity of the amputee caseload, and no matched increase in Therapy / Rehab capacity, which could result in harm and poor outcomes to patients.	16
4429	Surgery and Specialist Services	There is a risk to Quality Safety for patients suffering major Trauma. This is caused by a failure to meet standards and ongoing underinvestment in the service and increasing patient numbers. Which could result in poor outcomes for patients.	16
4433	Patient Services	There is a risk to patient safety caused by non-compliance with HTM02-01 in relation nursing staff use of oxygen and related equipment. Which could result in patient harm.	15
4448	Surgery and Specialist Services	This risk replaces risk 3881 There is a risk to Quality safety. This is caused by the lack of a robust electronic appointment system for review patients. This could result in patients cannot access timely review appointments or treatment with resulting poor clinical outcomes/ visual loss.	25
4450	Surgery and Specialist Services	There is a risk to quality safety. This is caused by lack of long-term plan for cataract theatre provision and reliance of a temporary rented theatre at CAV. This could result inability to provide cataract surgery services, and resultant patient harm. (+financial loss)	15
4451	Surgery and Specialist Services	There is a risk to quality safety. This is cause by limited physical space- in clinic and theatre to see patients and offer appointments/treatment. This could result in patients not accessing timely treatment with resulting visual loss.	16
4452	Surgical and Associated Specialties	There is a risk to Quality safety caused by failure to achieve CQUIN standards which could result in major amputations, extended lengths of stay as well as a financial implication to the Trust	16
4460	Patient Services	There is a risk to Quality safety if we are unable to assess, respond and document effectively due to ineffective core clinical documentation and processes (digital and paper) to support individualised care planning which could result in patient harm, reduced quality of care, patient experience and the reputation damage to the Trust.	15
4466	Clinical and Research Services	There is a risk to patient safety which is caused by inadequate pharmacy support for medicines reconciliation on admission, inpatient medicine review / monitoring and safe transfer of care. This results in avoidable medicines related harm and reduced quality of care.	15
4473	Surgical and Associated Specialties	There is a risk to patient safety caused by ineffective discharge processes which could result in patients leaving hospital without a discharge summary, clinical consequences as well as follow up Appointments could be missed, GPs are not informed of important diagnosis. Safe continuity medication management on discharge for medi-box patients, medication changes.	15
4486	Family Health	There is a risk to patient safety which is caused by the NECTAR Service being unable provide consistent clinical cover out of hours due to sharing of consultants between NECTAR and PICU. This could result in patients waiting longer for retrieval and patient safety risks.	16
4496	Cardiothoracic	There is a risk to quality safety which is caused by the current Trust Telemetry system being reliant on Wi-Fi to operate. This could result in monitoring systems being compromised significantly impacting on patient safety, as the telemetry systems would stop working and stop recording patient observations.	15
4501	Medical Director	There is a risk to Quality Safety caused by falls from height risks across the organisation, which could result in death or serious injury. The Trust has a number of areas which may be used by patients or the public to self-harm by way of intentional falls from height. Specific areas include the New Victoria Wing (NVW) Atrium, NCCC Atrium, Claremont MSCP, balconies in Leazes Wing Wards (x6). There is also the potential in NVW for items to be rested on the balustrade ledges which may fall and injure those below. This is a specific issue outside Ward 8 where patients queue outside of this day case ward. Such events will have a significant impact on the organisation and those staff who are involved in responding.	15

4503	Cardiothoracic	There is a risk to quality and patient safety which is caused by non-compliance with clinical management plans agreeing treatment plans within MDT meetings. This could result in patient harm and safety incidents. In addition, this could result in wasted resources in the event of a change of a patient's treatment plan, and effect clinical outcomes.	15
4509	Cardiothoracic	There is a risk to quality and patient safety which is caused by there not being enough cardiac physiologists in post to maintain the region's critical PCI on call service. This is a service that is needed 24/7 with high significant patient demands. This has resulted in significant patient care. Catheter lists are now frequently being cancelled or cut short due to this lack of physiology cover.	15
4510	Medicine and Emergency Care	There is a risk to quality and patient safety which is caused by the Dornier Medilas Fibertom 8100 laser unit continually malfunctioning due to the device now not internally logging errors. This could result in patients with endotracheal and endobronchial tumours / obstructions not being able to be treated by the surgical laser within the department and which could then require them to be diverted to other centres for airway debulking and haemostasis procedures to avoid harm. There is also a concern that patients could lose their airway if not treated urgently as a result or their cancer could grow with likely poorer patient outcomes.	15
4514	Cardiothoracic	There is a risk to quality effectiveness (delivery of patient care) which is caused by insufficient equipment provision from CSSD due to inadequate staffing and inefficiencies in CSSD which could result in the inability to process and distribute equipment to clinics, compromise patient care and treatment plans.	15
4518	Surgery and Specialist Services	There is a risk to patient safety, treatment delivery and patient experience caused by obsolete dental chairs and insufficient air exchange, lack of refurb / investment in >30 years adding to further deterioration of the dental estate. This could result in patient cancellations impacting performance, waiting times, reputational damage, and also impact under-grad and post-grad numbers and associated income (approx. £8m per annum).	16
4516	Surgery and Specialist Services	There is a risk to quality effectiveness (delivery of patient care) in Dental Services which is caused by single consultant delivered services, staff withdrawal from WLI activity and academic staff limitations on NHS activity. Several services are reliant on sole Consultants who create a single point of failure and two of these are University employed. This could result in the failure of service to meet waiting time standards and deliver plan.	15
4517	Surgery and Specialist Services	There is a risk to patient safety which is caused by the R4 EPR system functionality, Patient records are missing and/or the system operates an unmanageably slow rate, disrupting clinics and delaying patient care. This could result in sub-optimal care, litigation, reputational damage and additional scrutiny from regulatory bodies (CQC aware of recent incidents).	16
4519	Surgery and Specialist Services	There is a risk to patient safety, quality of surgical outcomes and Trust reputation. This is caused by an imbalance between demand and capacity for spinal work, by GPs having direct access to the service, and by the demands of the emergency service competing for the same resources. This could result in patients having delayed treatment (and potentially suboptimal outcomes/complaints/legal claims), failure of Trust targets and loss of elective income.	15
4522	Surgery and Specialist Services	There is a risk to patient safety and outcomes. This is caused by increasing demand not matched by capacity within the neuroradiology MRI department. This could result in delays to patient care (causing harm or suboptimal outcomes), targets being breached, patients staying in hospital longer than needed waiting for scans, staff burnout and additional cost to the Trust funding private sector scanners.	15
4524	Surgery and Specialist Services	There is a risk to patient safety, which is caused by the unavailability of the home birth, and Newcastle birthing centre service. This could result in women choosing to birth unattended, compromising both theirs and their baby's safety.	15
4526	Family Health	There is a risk to patient safety which is caused by the inability to record maternal observations via E-obs which could result in a delay in identifying the deteriorating patient.	15
4528	Family Health	There is a risk to quality safety which is caused by the lack of general medical cover within FRH medical wards out-of-hours which is subsequently covered by 2nd on-call for anaesthetics. This could result in 2nd on call anaesthetics being unable to provide ITU opinions, to deliver anaesthesia, and support anaesthetic and ITU trainees and may result in suboptimal management of the patient and or patient harm.	16
4538	Peri-operative and Critical Care	There is a risk to patient safety, caused by GP Practices not adhering to prescribing and referral pathways relating foot infections including osteomyelitis in community. This could result in patient harm, worsening infections, and increased attendance via ED.	16
4547	Clinical and Research Services	There is a risk to patient safety and people should they be exposed to contaminated water outlets in PFI estate. This is caused by water outlets where proliferation of thermostatic mixing valves (TMV), flow-straighteners and flexible hoses do not conform to HTM standards. This could result in harm to, or death of, patients, staff or public.	15
2596	Clinical and Research Services	There is a risk to quality effectiveness which is caused by the LIMS system having been built by a single member of staff, who is the only person with access codes, the knowledge to update and fix the database. This could result in genetic laboratory and clinical services becoming disrupted with the potential to result in outright system failure if there are no staff available with the training and competence to maintain clinical and laboratory LIMS.	16
3850	Surgical and Associated Specialties	There is a risk to patient safety due to increased risk to line infections. This is caused by not having a designated IF unit, and patients being cared for in sub-optimal across multiple wards due to lack of IF expertise on general wards. This results in long stays for patients and poor service provision across the region.	15
3945	Clinical and Research Services	There is a risk to quality effectiveness caused by a full-service review, it has been highlighted that ILM do not have the appropriate number of PA to effectively provide medic/consultant cover to the ILM directorate, this could impact on the safe and timely delivery of ILM services, patient safety and the health and wellbeing existing staff.	16
3988	Clinical and Research Services	There is a risk to quality effectiveness for children & young patients with developmental language disorder, which is caused by limited Speech & Language Therapy capacity and subsequent delays to be seen. This could result in harm and poor outcomes to patients.	16
4007	Clinical and Research Services	There is a risk to patients' safety due to ageing Incumbent rapid gassing isolators and the frequency of system failures which could result in equipment failures and impact service delivery.	20
4056	Clinical and Research Services	There is a risk to quality effectiveness to children & young patients following critical illness, injury, post-surgical, and neuro-developmental patients, which is caused by extremely limited Therapy / Rehab / AHP & Psychology capacity. This could result in harm and poor outcomes to patients.	15
4057	Clinical and Research Services	There is a risk to quality effectiveness within the community following discharge from hospital, which is caused by extremely limited Therapy / Rehab / AHP & Psychology capacity in a number of community services which could result in harm and poor outcomes to patients.	15
4058	Clinical and Research Services	There is a risk to quality effectiveness to patients, following critical illness, injury, or post-surgical patients which is caused by extremely limited Therapy / Rehab / AHP & Psychology capacity, which could result in harm and poor outcomes to patients.	15
4481	Clinical and Research Services	There is a risk to quality safety and compliance and regulatory from a potential CPE outbreak in NUTH. CPE is a type of multi-drug resistant bacteria which can to spread between patients and into the hospital environment, it is very difficult to treat with antibiotics. This is caused by the inability to implement CPE screening as per national guidelines due to insufficient laboratory resources. Which could result in untreatable infections and possible deaths.	15
4222	Surgery and Specialist Services	There is a risk to patients' quality and safety. This risk is caused by non-compliance with NICE guideline 2 week to treatment target. This could result in patients not receiving timely treatment with resulting visual loss	20

Finance Committee			
Risk ID	**Clinical Board/Corporate Directorate**	**Risk Description**	**Current Risk Score**
4392	Information Technology	There is a financial risk to the Trust, which is caused by a 5-year contract ending, meaning the Trust will be wholly responsible for future liabilities for licensing/funding, covered under this agreement after 31 March 2028. This could result in additional annual costs of £4.3M.	20

Audit, Risk and Assurance Committee			
Risk ID	**Clinical Board/Corporate Directorate**	**Risk Description**	**Current Risk Score**
3774	Clinical and Research Services	There is a risk to compliance from a critical finding of the MHRA, which is caused by the lack of electronic health record and supporting processes for Clinical Research. This could result in suspension of all Clinical Research activity, patient safety issues due to other clinical services not being aware of research activity, and reduction in research income.	15
4261	Family Health	There is a risk to compliance and regulatory, which is caused by the introduction of accreditation standard (ISO 15189) for Sexual Assault Referral Centres (SARCs). There is Risk of failing to achieve compliance by October 2025 (extended from 2023 due to COVID), which could result in non-compliance with accreditation and commissioning standards, leading to decommissioning of service. Evidence not permissible in court if collected from a non-accredited service.	16
4428	Clinical and Research Services	There is a risk to compliance and regulatory and safeguarding the dignity of the deceased which is caused by insufficient fridge and freezer storage capacity for deceased patients, especially bariatric patients, which could result in the loss of our HTA Post-mortem licence and UKAS accreditation.	16

People Committee			
Risk ID	**Clinical Board/Corporate Directorate**	**Risk Description**	**Current Risk Score**
4480	Medicine and Emergency Care	There is a risk of physical and psychological harm to staff in ED due to violence and aggression from patients and visitors. This is caused by long waits, overcrowding, and flow issues. This could result in incivility to all staff as a result of changing expectations and increased frustration with the performance of NHS services.	15
4499	Cardiothoracic	There is a risk to People and quality safety caused by a negative culture with the service. This is caused by staff behaviours and poor communication amongst teams, and with patients. This could result in patient care due to concerns of people not being able to speak up for fear of retribution or other negative impact on individuals. This negative impact may result in staff being concerns to work in this environment and affect recruitment and retention.	20
4137	Estates and Facilities	There is a risk to our people should the targets within the Climate Emergency Strategy not being achieved. This is caused by staffing resource shortages, and access to capital funding and further exacerbated by Trust's decisions on methods of estate expansion, energy centres outsourcing on performance, lack of national funding sources for the scale of investment required and CDEL restrictions. This could result in impacting on the Trust's contribution to the local population with subsequent ill health consequences and health inequalities as well as driving further global warming and the associated risks of passing climate tipping points and setting off irreversible runaway global warming. In addition, this would negatively impact the Trust reputation as a global leader in sustainable healthcare delivery.	20

Digital and Data Committee			
Risk ID	**Clinical Board/Corporate Directorate**	**Risk Description**	**Current Risk Score**
3909	Clinical and Research Services	There is a risk to compliance and regulatory guidelines, which is caused by the retention of the clinical 7 Genetics laboratory and clinical database residing on an Access 97 database, which breaches Cyber Essentials Guidelines. The inability to maintain and protect this database adequately could ultimately result in inappropriate access or database corruption which could ultimately lead to the complete failure of the system and hence an inability to support both Laboratory and Clinical Genetics service.	20
4417	Information Management and Technology	There is a risk to DSPT/CE compliance and Trust regulatory fulfilment, which is caused by Windows 2012 servers not decommissioned or on extended support by EoL date. This could result in the Trust being at significant risk of a cyber security incident.	16

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	17 July 2024					
Title	Update from Committee Chairs					
Report of	Non-Executive Director Committee Chairs					
Prepared by	Mrs G Elsender, 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 Public in May 2024: ○ People Committee – 24 June 2024 and 9 July 2024 ○ Quality Committee – 18 June 2024 and 9 July 2024 ○ Digital & Data Committee – 4 June 2024 ○ Finance & Performance Committee – 24 June 2024 and 15 July ○ Audit, Risk & Assurance Committee – 25 June 2024 and 16 July					
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 May 2024.

UPDATE FROM COMMITTEE CHAIRS

1. PEOPLE COMMITTEE

A meeting of the People Committee took place on 24 June 2024 and 9 July 2024. During the meeting on 24th June, the main areas of discussion included:

- Care Quality Commission (CQC) Action Plan (People matters).
- People Plan 2024/27 – Year 1 deliverable actions update.
- Civility Charter.
- Retention Data (annual review).
- Deep Dive on Violence and Aggression.
- The Head of Workforce Engagement & Information shared Performance and Delivery – People and Culture Dashboard.
- Items to consider included the Trade Union Facilities Annual Report; as well as the Guardian of Safe Working Quarter 4 Report and Annual Report.
- Minutes of the following meetings were received:
    - People Programme Board 8 April 2024.
    - Equality, Diversity and Inclusion (EDI) Steering Group 16 May 2024.
    - Health & Wellbeing Steering Group 8 May 2024.
    - Sustainable Healthcare Committee 16 May 2024.

During the meeting on 9 July 2024, the main areas of discussion included:

- CQC Action Plan (People matters).
- People Plan 2024/27 – Year 1 deliverable actions update.
- Update on Leadership Development Offer.
- Clinical Board update – People Focus.
- Deep Dive on Sickness Absence.
- Risk Report – Board Assurance Framework (BAF).
- EDI Improvement Plan – Update on progress.
- The Head of Workforce Engagement & Information shared Performance and Delivery – People and Culture Dashboard.
- Minutes of the following meetings were received:
    - Learning and Education Group – 20 May 2024.
    - People Programme Board – 14 May 2024.
    - EDI Steering Group 4 July 2024.
    - Health & Wellbeing Group – 19 June 2024.

The next formal meeting of the People Committee will take place on Tuesday 17th September 2024.

2. QUALITY COMMITTEE

Meetings of the Quality Committee took place on 18 June 2024 and 9 July 2024.

During the meeting on 18 June 2024, the main area of discussion were:

- Cardiac Oversight Group Update.

- CQC Update - Emergency Department.
- Wards requiring additional support.
- Patient Safety Incident Response Framework (PSIRF) Priorities - Internal Referrals.
- Quality Account including Quality 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.*
- Patient & Staff Experience Update.
- Safeguarding and Mental Capacity Act Quarter 4 Report.
- Approval of the Mental Health Strategy.
- Learning Disabilities Quarter 4 Report.
- Feedback from Leadership Walkabouts / Board Visits.
- Board Reports:
    - Integrated Quality & Performance Report.
    - Quality Oversight Group Monitoring & Evaluation Report.
- Minutes of the following meetings were received:
    - Patient Safety Group – 19 April 2024.
    - Clinical Outcomes & Effectiveness Group (COEG) 9 February 2024.

The main areas of focus during the meeting on 9 July included:

- Cardiac Oversight Group Update.
- CQC Medicines Management Update including Deep-dive on Medicines Reconciliation.
- Maternity Update including Midwifery Staffing update.
- Nurse Staffing Deep Dive Report.
- Duty of Candour Deep Dive.
- Venous thromboembolism (VTE) Update.
- Feedback from the Pancreatic Cancer Get It Right First Time (GIRFT) Review.
- Update on unverified letters and compliance with discharge summaries.
- Clinical Board Quality & Safety Escalation Report.
- Performance Reports:
    - Integrated Quality & Performance Report.
    - Serious Incident Close Out Assurance Report.
    - Infection Prevention and Control (IPC) BAF Report.
    - BAF and Quality Committee Risk Report.
- Feedback from Leadership Walkabouts / Board Visits.
- Minutes of the Patient Safety Group 11 June 2024 were received.

The next formal meeting of the Quality Committee will take place on Tuesday 17th September 2024.

3. DIGITAL & DATA COMMITTEE

The Digital & Data Committee took place on Tuesday 4 June 2024. During the meeting, the main areas of discussion included:

- Chief Information Officer (CIO) Report, including digital performance report and partnerships update.

- Digital Maturity Assessment.
- BAF/risk report & emerging risks.
- Update on Electronic Patient Record - Adoption Coaches.
- Options for the Path 5 Laboratory Information Management System (LIMS).
- Accessible Information Standard (Improving Patient Experience).
- Digital & Data Priorities/Updates.
- Digital financial plan/position/investments - update on Cost Improvement Programme (CIP).

The next meeting of the Digital & Data Committee will take place on Friday 16 August 2024.

4. FINANCE & PERFORMANCE COMMITTEE

Meetings of the meeting of the Finance & Performance Committee took place on 24 June 2024 and 15 July 2024. During the meeting on 24 June, the main areas of discussion included:

- Annual Accounts (deferred to the Audit, Risk and Assurance Committee).
- Month 2 Finance Report.
- BAF/Risk report and emerging risks.
- Financial Recovery Plan, including:
    - Clinical Board Financial Position Update: Cardiothoracic.
    - Escalation measures.
- Month 2 Performance (included within the Integrated Quality & Performance Report).
- Procurement Update, including:
    - Plan 2024/25.
    - Provider Selection Regime.
- Tenders (PR) and Business Cases (BC): Terumo Oxygenators (PR) (Approved)
- Estates Capital Schemes:
    - Freeman Theatre refurbishment (6).
    - RVI Theatre refurbishment phase 4 (3&4).
    - Nuclear Medicine Solid-State Scanner Replacement.
- 2023/24 National Cost Collection Pre-Submission.
- Minutes from the following groups were received:
    - Capital Management Group – 9 April 2024 and 13 May 2024.
    - Supplies & Services Procurement Group – 3 May 2024.
    - Strategy, Planning & Capital Investment Group - 16 May 2024.

During the meeting held on the 15 July main areas of discussion included:

- Month 3 Finance Report.
- Clinical Board Financial Position Update: Medicine and Emergency Care.
- Month 3 Performance (included within the Integrated Quality & Performance Report).
- Day Treatment Centre Quarterly Update.
- Review of Commercial Schemes.
- Tenders (PR) and Business Cases (BC): A Research Facility BC.

- Month 3 – Financial Recovery Plan Report.
- Minutes of the following meetings were received:
    - Capital Management Group – 11 June 2024.
    - Supplies & Services Procurement Group – 7 June 2024.

The next formal meeting of the Finance & Performance Committee will take place on 23 September 2024.

5. AUDIT, RISK AND ASSURANCE COMMITTEE

Meetings of the Audit, Risk and Assurance Committee took place on 25 June 2024 and 16 July 2024. During the meeting of 25 June, the main areas of discussion included:

- Escalations from other Board Committees to ARAC.
- Risk Register Report.
- Clinical Board risk deep dive [Family Health].
- Internal Audit (IA) Annual Report, including Internal Audit Opinion 2023/24.
- IA Progress Report 2024/25.
- Audit Completion Report and Auditor's Annual Report (VFM).
- Annual Governance Statement [FINAL].
- Annual Report, including final Annual Register of Directors' interest.
- Annual Accounts 2023/24 [FINAL], including:
    - Accounting issues raised as part of the Financial Statements audit
    - Accounting Policies, Estimates and Judgements

  The Annual Report and Accounts were recommended for approval by the Trust Board.
- Minutes from the following Committees were received:
    - Finance & Performance Committee 20 May 2024.
    - People Committee 15 May 2024.
    - Quality Committee 14 May 2024.
    - Digital & Data Committee 18 March 2024, 18 April 2024 and 4 June 2024.
    - Charity Committee 31 May 2024.

During the meeting of 16 July 2024 the main areas of discussion included:

- Escalations from other Board Committees to ARAC.
- Board Assurance Framework (BAF).
- Risk Register Report.
- Compliance & Assurance Group Update.
- Review of Clinical Audit Process.
- Counter Fraud Annual Report.
- Internal Audit Progress report and Protocol.
- Modern Slavery Act Statement [FOR APPROVAL].
- Non-Audit Services Policy [FOR APPROVAL].
- Fit and Proper Persons Annual Update.
- Standards of Business Conduct.

The next formal meeting of the Audit, Risk and Assurance Committee will take place 24 September 2024.

Report of Gillian Elsender
PA to Interim Chair and Trust Secretary / Corporate Governance Officer
11 July 2024

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PUBLIC BOARD MEETINGS - ACTIONS

Agenda item A14

Log No.	BOARD DATE	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
114	28 March 2024	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. 11.07.24 - Update awaited.
115	28 March 2024	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. 11.07.24 - Update awaited.
116	28 March 2024	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. 11.07.24 - Update awaited.
117	23 May 2024	24/11STRATEGIC ITEMS: iii) People: Fuller Inquiry Update	Mrs Stabler questioned if the Trust response/action plan was included in the Internal Audit plan to monitor against policy. The JMD-MWr agreed to follow up outwith the meeting [ACTION01].	MWr			11.07.24 - Update awaited.
118	23 May 2024	24/12ITEMS TO RECEIVE b) Executive Director of Nursing; including:	Mrs Stabler referred to the nurse staffing report and questioned how many wards were occupied by less than 85% of registered nurses, and how may red flags were report. The EDN advised that “fill rates” are entered onto the safer staffing dashboard, RAG rated and reviewed monthly by the Nurse Staffing and Clinical Outcomes Group. Those with fill rates <85% are reported to the EDN monthly. The EDN agreed to meet with Mrs Stabler outwith the meeting to provide further clarification on the escalation and reporting process [ACTION02].	IJ			11.07.24 - Update awaited.
119	23 May 2024	24/12ITEMS TO RECEIVE c) Director of Quality & Effectiveness: (i) Maternity CNST - Year 6	The EDN referred to safety action 5 in the report “Can you demonstrate an effective system of midwifery workforce planning to the required standard?” and noted that the Trust had completed the BirthRate+ workforce calculation in April 2024 with the report outlining recommendations expected imminently. Upon receipt of the revised staffing recommendation report, a full workforce review will be undertaken and an in-depth report will be presented to Trust Board in July 2024 [ACTION03].	IJ			11.07.24 - Maternity Staffing report included in the Public Board meeting papers for the 17 July meeting. Propose close action.

Log No.	BOARD DATE	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
120	23 May 2024	24/12ITEMS TO RECEIVE (ii)Learning form Deaths Q4 Report	Mrs Stabler noted that the Medical Examiner process had planned to incorporate all community deaths by April 2024 in line with NHSE guidance, however this had been postponed and therefore questioned if there was a timescale for this work to be restarted. She also queried what support would be provided to those organisations not fully incorporated into the process to which the JMD-LPC advised that discussions were currently ongoing and would be able to provide an update for Mrs Stabler outwith the meeting [ACTION04].	LPC			11.07.24 - Update awaited.
121	23 May 2024	24/13ITEMS TO APPROVE: (ii)Quality Account	The EDN noted that the Quality Account is published annually which looks back on the previous year and sets put the Quality Priorities for the year ahead with engagement from both internal and external stakeholders. It was noted that the Quality Account had been presented to both Newcastle and Northumberland Oversight & Scrutiny Committees and feedback was awaited which will be added once received. This would be circulated with Board members once available [ACTION05].	IJ			11.07.24 - Feedback included in the 27 June 2024 Private Board meeting papers. The responses have been included in the final Quality Account which can be found at: **https://www.newcastle-hospitals.nhs.uk/about/trust/corporate-information/quality-accounts/** Propose close action.

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.