The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Public Trust Board of Directors' Meeting

Friday 27 September 2024, 13.00 – 14.30

Venue: Boardroom, Freeman Hospital

Agenda

Item		Lead	Paper	Timing
1.	Apologies for absence and declarations of interest	Paul Ennals	Verbal	13:00 – 13:01
2.	Minutes of the Meeting held on 23 July 2024 and Matters Arising	Paul Ennals	Attached	13:01 – 13:02
3.	Chair's Report	Paul Ennals	Attached	13:02 – 13:08
4.	Chief Executive's Report	Jim Mackey	Presentation	13:08 – 13:15
Strategic items:				
5.	Patients: Patient and Staff Stories	Annie Laverty	Attached	13:15 – 13:20
6.	Patients: CQC update	Rob Harrison	Attached	13:20 – 13:30
7.	Performance: Integrated Board Report	Rob Harrison & Patrick Garner	Attached	13:30 – 13:40
Items to receive *[NB for information – matters to be raised by exception only]*:				13:40 – 14:10
8.	Director reports:			
	a. Joint Medical Directors Report; including: i) Consultant Appointments ii) Guardian of Safe Working	Michael Wright & Lucia Pareja-Cebrian	Attached	
	b. Executive Director of Nursing	Ian Joy	Attached	
	c. Maternity:			
	i) Perinatal Quality Surveillance Report (formerly named the Maternity Update report)	Ian Joy & Jenna Wall	Attached	
	ii) Maternity Incentive Scheme (CNST) Report (FOR APPROVAL)	Angela O'Brien	Attached	
	iii) Maternity Safety Champion Report	Liz Bromley	Attached	
9.	Board Visibility Programme	Angela O'Brien	Attached	
10.	Committee Chair Meeting Logs	Committee Chairs	Attached	

Items to approve:				14:10 – 14:25
11.	Shine (Sustainable Healthcare in Newcastle) Update – Annual Shine Report 2023/24 and Carbon Reduction Plan	Vicky McFarlane-Reid & James Dixon	Attached	
12.	Board Assurance Framework (BAF) 2024/25	Rob Harrison	Attached	
13.	People Committee Schedule of Business (SoB)	Christine Brereton	Attached	
Any other business:				14:25 – 14:30
14.	Meeting Action Log	Paul Ennals	Attached	
15.	Any other business	All	Verbal	

Date of next meeting:
Public Board of Directors – Thursday 29 November 2024

Sir Paul Ennals, Interim Shared Chair

Sir Jim Mackey, Chief Executive Officer

Mrs Liz Bromley, Non-Executive Director and Maternity Safety Champion

Mr Rob Harrison, Managing Director

Mr Ian Joy, Executive Director of Nursing

Dr Michael Wright, Joint Medical Director

Mrs Lucia Pareja-Cebrian, Joint Medical Director

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

Mrs Christine Brereton, Chief People Officer

Mrs Angela O'Brien, Director of Quality & Effectiveness

Ms Annie Laverty, Chief Experience Officer

Mr Patrick Garner, Director of Performance and Governance

Mrs Jenna Wall, Director of Midwifery

Mr James Dixon, Associate Director - Sustainability

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PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 17 JULY 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 - W]
	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]
	Mr M Wilson	Chief Operating Officer [COO]
	Mr B MacLeod	Non-Executive Director (NED)
	Mr P Kane	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 A O'Brien, Director of Quality & Effectiveness [DQE]
Mrs K Jupp, Trust Secretary [TS]
Dr J Samuel, Director of Infection Prevention Control [DIPC]
Mrs A Laverty, Chief Experience Officer [CXO]
Mrs J Wall, Director of Midwifery [DoM]

Observers:
Sir P Ennals, Chair Northumbria Healthcare NHS Foundation Trust (NHFT) and incoming Interim Shared Chair
Ms S Sutton, CQC Inspection Manager
Miss C Bodey, PA to Director of Communications and Corporate Affairs and Chief Experience Officer
Mr R Purwal, Member of the Public
Mr K Windebank, Public Governor for Northumberland, Tyne and Wear

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.

24/15 STANDING ITEMS:

i) Apologies for Absence and Declarations of Interest

The Chair welcomed Mr Kane and Ms Sutton to the meeting.

Apologies were received from Mr J Jowett, (NED), and Mrs L Pareja-Cebrian [JMD-PC].

The following declarations of interest were made:

- Sir Paul Ennals as the Chair at NHFT.
- Mrs Stabler as a substantive NED at Gateshead Health NHS Foundation Trust (GHFT) and as a Trustee at St Oswald's Hospice.
- Mr McCardle as a substantive NED at NHFT.

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

ii) Minutes of the previous meeting held on 23 May 2024 and matters arising

The minutes of the meeting held on 23 May 2024 were accepted as a true record of the business transacted noting that an amendment was required to add in Professor Home, Public Governor, who also observed the meeting.

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

iii) Interim Chair's Report

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

The Interim Chair noted it had been another busy time for the Trust and highlighted the following points:

- Work continued on addressing the issues raised by the Care Quality Commission (CQC) as well improving on performance and efficiency targets.
- Governor elections were held in May where nine new Governors were successfully appointed which included two new staff Governors and an appointed Governor from Newcastle City Council. This was followed by the new Governor induction in June where they also had the opportunity to meet with Sir P Ennals as the incoming Interim Shared Chair.
- Following a robust interview process for a Non-Executive Director, Mr David Weatherburn has been appointed as NED with legal expertise. Mr Weatherburn would join the Trust Board in August following completion of the required Fit and Proper Persons checks.
- The Interim Chair had undertaken clinical visits with Sir Paul Ennals to the Emergency Department (ED), Maternity and the Command Centre at the Royal Victoria Infirmary (RVI). At the Freeman Hospital visits were made to Cancer Services, the Cardio Unit,

the Paediatric High Dependency Unit (HDU) - Cardio, the Day Treatment Centre and the Admissions Suite.

- Spotlight sessions with the NED's continued and most recently they heard from Dr Chris Gibbins, Consultant/Clinical Board Chair, and Claire Pinder, Director of Operations for Medicine and Emergency Care, who detailed the challenges whilst dealing with the continuous large numbers of patients in the ED. An in-person visit to the Social Work Department at the RVI was also undertaken.

Governor and Member activity had continued and the Interim Chair thanked the Council of Governors for the valuable work they undertake as part of their role.

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:

- The huge amount of work continued across the organisation as the Trust addressed the issues identified by the CQC.
- As a consequence of the sustained work and improvements to the governance arrangements in relation to Board, Committees and Clinical Boards, an application to remove the licence conditions had been submitted to the CQC. A decision was expected in August 2024, which it was hoped would allow the Trust to move on and continue with the next phase of preparing for re-inspection.
- Further work was needed to create a healthy and happy organisation for staff. Work continued to improve the organisations culture and to increase engagement with staff. The CEO was pleased to note the new appointment of a Clinical Director for Surgery and Anaesthesia in Adult Cardiac Surgery.
- There had been significant progress in relation to performance for elective recovery, reducing waiting times; specifically long waits. The CEO commended all involved on making significant progress over recent months.
- The agenda for today's meeting highlighted a strong focus on people which was a priority of the Trust.

On behalf of the Board, the Interim Chair acknowledged the significant amount of work that had been undertaken within the Clinical Boards resulting in the improvement in performance and asked that the gratitude of the Trust Board be shared.

Mrs Bromley offered her commendation for the amount of work being undertaken. She noted the new laws/policies proposed by the new Labour Government, the focus of some included mental health as well as physical health and changes to employment law. Mrs Bromley questioned if there would be sufficient time to plan ahead and future proof whilst considering the impact of the new policies to which the CEO advised that understanding the new policy direction, pace and prioritisation would be a focus in the Autumn in collaboration with the medium term planning exercise.

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

24/16 STRATEGIC ITEMS:

i) Patients: Patient Story

The CXO gave an overview of the patient's stories which focussed on experiences of two people with Human Immunodeficiency Virus (HIV).

It was noted that as part of a pilot exercise the Trust had recently begun work to become a 'HIV Confident' organisation and the patient and staff stories brought to life the reasons needed to undertake this work across Newcastle Hospitals. The principles behind the work were to challenge the stigma associated with HIV, increasing awareness and improved understanding as well as providing from a staff or patient experience perspective the opportunity to report examples of stigma and discrimination. In addition the work formed part of the overall Patient and Staff Experience programme.

The Interim Chair noted that she and some of the NEDs had attended a Governor session on HIV stigma which was very beneficial to all present.

The DCCA noted the emotion in the report which had made an impact and welcomed the approach in tackling stigma.

The CEO sought clarity on what learning and actions the Trust would be taking to which the CXO advised that a programme would be launched in August as part of a pilot to achieve the HIV Confident charter mark. This would begin with a survey to help understand staff knowledge and understanding around HIV across all areas of the Trust. The results of the survey would help identify gaps in knowledge which would inform what further learning was needed. HIV awareness training was also being built into the induction programme as well as bespoke training sessions planned throughout the year.

Mr McCardle noted the stories to be very thought provoking and thanked those who had shared their stories for discussion today. He suggested that a module with real-life patient stories relating to stigma could be an area for inclusion in future statutory and mandatory training for staff to which the CXO agreed that any learning with regard to discrimination was beneficial.

Mr Kane queried if there was a broader issue of understanding infection prevention control and if policies and processes in place were leading stigma to which the CXO highlighted a lack of understanding regarding transmission was evident.

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

ii) Health Inequalities Update

The COO reminded colleagues of the health inequalities challenges that is faced in the northeast and highlighted the following points:

- There was now support from the CEO and Chair of the Quality Committee to establish a Health Inequalities & Prevention Group that will report through the Quality Committee.
- In the North East a significant challenge was the high level of deprivation faced by the population resulting in those most in need of health care were often the latest to receive it resulting in the worst outcomes.
- It was noted that people within Newcastle will die 2 years younger than the national average and over half with a lesser healthy life expectancy. There was also a 12-year difference in healthy life expectancy across the wards of the city.
- Newcastle is very much a changing city becoming more diverse which not only contributes to the richness of the society but also the diversity within the Trust.
- Looking ahead to the next 20 years, it was expected that there will be a 30% increase in people who live in Newcastle over the age of 70, therefore consideration must be given to preventative measures to reduce the level of demand for healthcare treatments.
- The next Health Inequalities Prevention Collaboration Day which is supported by Newcastle Hospitals Charity will be held on the 26 November 2024. Staff from the Trust together with partners from the voluntary sector will come together and share knowledge and awareness as well as the work being undertaken in this area.

The CPO welcomed the establishment of the Group noting that it was a real opportunity to align the Equality Diversity & Inclusion (EDI) agenda with health inequalities to ensure no duplication.

Mr MacLeod noted the improvement in metrics in relation to Referral To Treatment (RTT) waiting times and questioned if there was a disproportion in terms of demographics and the experiences in RTT waiting times. The COO advised that the metrics of experience within communities was somewhat unknown however people who were in need of elective care were most likely to come from deprived communities but their levels of accessing elective care was lower than those accessing care from more affluent communities. Individuals in deprived communities are often much higher users of emergency care services, having not accessed care early.

The CEO noted that the during the preparation of the original plan for elective recovery following Covid, there seemed to be a large proportion of patients not accessing the system who ordinarily would have been in a care pathway had the pandemic not have occurred. There was concern that these patients would present in ED and therefore there should be a targeted approach to addressing the gap in those accessing healthcare from underrepresented communities.

Sir Paul welcomed the establishment of the Group and noted that a lot of the issues regarding health inequalities were issues were deep rooted and will take time to address. He noted however that there may be some quick wins as Did Not Attends (DNAs) were proportionally higher from low socioeconomic groups and therefore some targeted intervention to determine the reasons for not attending appointments may provide economic benefits. The COO highlighted that this was being explored by some of the Clinical Leads, particularly in relation to radiology.

The Interim Chair suggested that this was an area of work that Governors may be able to assist with in terms of engaging with communities.

Mrs Stabler noted the importance of working with volunteers and local charities to further understand health inequalities and the barriers for people accessing services as well as learning from partner organisations.

The Interim Chair noted that Newcastle Hospitals Charity had helped significantly with a project to assist unaccompanied children of refugee and asylum seekers in the city who required health assessments and/or vaccinations.

The MD echoed the opportunity to learn from the best elsewhere and in doing so creating a model of care that is future proofed through working with local government partners to better understand public health data and to make the right interventions at the right time as an organisation.

The Interim Chair highlighted the poverty which was prevalent in some schools, especially in the early years and the children affected during the pandemic in relation to e.g. poor eating habits and language skills.

Mrs Stabler referenced her visit to the social work team where she heard stories of families experiencing poverty. Referring to the previous patient and staff stories relating to stigma, the CXO noted that there was also stigma about poverty with many afraid to ask for help.

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

iii) <u>People: People Strategy (Plan) 2024 - 2027</u>

The CPO presented the People Strategy (Plan) for approval. The plan focussed on four key themes of Health and Wellbeing, Behaviour and Civility, Valued and Heard, and Leadership and Management, all of which had been identified by Trust staff through a number of engagement events, staff data and in the CQC findings.

The CPO noted the importance of having a plan for delivery, therefore a year 1 action plan had been developed against the four main themes where the delivery of the actions will be measured against, using data through staff surveys, the national staff survey and the link between patient and staff experience to determine the actions were working and having a positive impact on staff.

A communications plan had also been developed in support of the launch of the strategy, once approved. Work was already underway regarding the year one actions, including the development of a Behaviour and Civilities Charter and the Sexual Misconduct Policy.

Mrs Stabler fully supported the strategy but also noted the importance of finding innovative ways to feedback messages to staff who don't routinely access emails to which the CPO advised that details were included in the communications plan and included face to face

sessions with the CEO as well as using the Trust Facebook page. There was also a one-page information sheet of key messages that the CPO agreed to share with the Board **[ACTION01].** A session had been held with the Council of Governors last week to brief them on the People Plan.

Whilst recognising the benefits of the communications plan during the launch, the EDN questioned what would be involved later in the year to which the CPO advised that in the lead up to the national staff survey there will be updates for staff in the form of "you said - we did" to show staff the benefits of speaking up. This would also link into the rolling 12-month programme of communications to staff.

The DCCA added that the communications plan had been developed through staff engagement and it was important to keep staff engaged but in way that they can feel the impact which can be amplified. It was noted that the plan would be iterative during the first phase.

Mr McCardle commended the CPO and her team on an excellent piece of work, the progressive iterations of which had been shared with the People Committee. He noted that the added value had been the consultative process during the development stage. Sir Paul concurred adding that it was a strategy that applied to everyone's behaviour and actions.

Mrs Bromley referred to the 4 strategic themes in the plan and being mindful of continuing engagement with staff, having a visual reminder in the form of posters would have a real impact and bring the plan to life. The CPO noted that posters, pens and water bottles were also being produced.

The CXO added that there would be a quarterly evaluation undertaken, with each of the four themes tracked, measured and reported with an associated colour so staff can begin to tie in the staff experience measurement programme and integrate with the themes in the strategy.

The CPO thanked the staff networks and staff side representative for their partnership approach in the development of the strategy and particularly to Donna Watson, Head of HR Strategy and Transformation. Thanks were extended by the Board of Directors.

It was **resolved:** to **approve** the strategy.

iv) Performance: Revised Integrated Quality & Performance Report

The MD presented the revised report, noting that developments were ongoing including further metrics relating to maternity services. He added that a section in relation to health inequalities had been added to this iteration which started to draw out basic metrics which would be helpful to understand how the Trust was performing in terms of waiting list management for the population.

The following highlights were noted:

- In the Quality section of the report, it was noted that there had been a sustained improvement in falls and pressure ulcers.
- In the People section of the report, whilst sickness absence was higher than the target there had been a reduction to that of the previous month which was positive.
- There was an increase in nursing and midwifery staff and a good level of competition for roles. It was noted that staff turnover and vacancy levels had also reduced.
- There was continued improvement in performance related to elective activity.
- There was now a particular focus on improving emergency care performance which should show improvements from September, as well as working towards the development of an Urgent Treatment Centre.
- Diagnostic activity remained an areas of concern, including audiology and cardiac physiology, therefore it was important to focus on workforce in those areas working with alliance partners to establish apprenticeship programmes.
- Specific work was currently being undertaken in audiology and neuroradiology to make improvements.

[R Purwal left the meeting]

The CFO highlighted another improvement financially in that when there is a reduced vacancy factor there is also a cost benefit by the reduction in usage of temporary / agency staff.

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

v) <u>Alliance</u>

The COO presented the report which provided an update on the ongoing work of the Great North Healthcare Alliance (GNHA) between Newcastle upon Tyne Hospitals NHS FT, GHFT, NHFT and North Cumbria Integrated Care NHS FT. It was noted that the same report would also be presented to the Boards of all four of the Alliance partners.

The COO highlighted section 2 of the report which detailed the three priority areas of work for the Alliance which included clinical projects and pathways, professional issues and opportunities and cultural and enabling work. As the Alliance develops the focus would be on those areas that had the biggest impact.

The CEO advised the Board that Sir Brendan Foster had agreed for the Alliance to use the 'Great North' naming being mindful that the brand was all about excellence and having a strong and local presence, which needed to be considered.

Mrs Stabler welcomed the areas that the Alliance would be focusing on and noted the strength of collaborative working to achieve positive outcomes.

The Interim Chair thanked the formation team for the work that had been undertaken to date.

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

24/17 ITEMS TO RECEIVE

i) Director reports:

a. Joint Medical Directors Report; including:

The JMD-W highlighted the themes from the report, being:

- Work continued with regard to the implementation and embedding of the Patient Safety Incident Response Framework (PSIRF) which was important for the Trust in relation to the overall quality and safety structures within the Clinical Boards.
- There were ongoing challenges in relation to cancer performance and specifically with 62-day performance. Whilst there was progress, further work was required and there had been a significant increase in referrals within dermatology during the Summer season.
- A Job Planning review was currently being undertaken for all senior medical and dental staff.
- With regard to patient safety and quality of care in pressurised services including corridor care, particularly in the ED, conversations have already begun with senior colleagues and escalation protocols are already in place with their application being reviewed. The EDN, JMDs and MD 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.

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

(i) Consultant Appointments

There had been 8 consultant appointments since the last report.

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

(ii) Guardian of Safe Working Quarter 4 Report and Annual Report

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

b) Executive Director of Nursing; including:

The EDN highlighted the following points:

- There continued to be an increase in both total number of referrals and complexity of referrals into the Liaison Team for Learning Disabilities.
- This increase in activity and complexity has impacted on the Liaison Team and the ability to deliver on all aspects of required work with mitigations put in place to support the team. This was discussed extensively at the previous Quality Committee meeting.
- There had been a continued improvement in the results from the Mental Capacity Act audits in terms of capacity assessment and best interests decision

documentation completed as well as overall quality of work through the Safeguarding Committee.

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

[R Purwal re-joined the meeting]

(ii) Nurse Staffing Review Report

The EDN presented the report which combined the nurse staffing six-month review report with the quarterly safe staffing assurance report. Following the review, it was noted that there some risks/shortfalls had been identified in terms of funded establishment therefore the report outlined the temporary mitigations in place whilst considering a medium-term plan which has recently been communicated to the Clinical Boards.

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

(i) Midwifery Staffing Update

The report provided the Trust Board with an overview of midwifery staffing and provided 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).

The DoM highlighted the following points:

- Pressures in relation to midwifery staffing had resulted in the closure of the birthing centre approximately 12 months ago.
- The Trust does have an appropriately funded birthrate+ compliance staffing establishment however the inadequate uplift of 20% to cover staff training, sickness absence and maternity leave the service in a pressurised position.
- The closure of the birthing centre has had an impact on service user choice around place of birth.
- The consolidation of staff on the delivery suite has supported safety and there has been an improvement in some of the metrics relating to safety and patient experience particularly 1:1 care in labour.
- The Birthrate+ report was received into the Trust last week and there will be a review of the staffing configuration to ensure there is a sustainable plan to open the birthing centre while supporting safety of other elements in the service which were currently challenging. An update on the Birthrate+ report would be shared at the September Trust Board meeting.
- Further recruitment would be needed to maintain a sustainable workforce.

In response to a question from the Interim Chair, the DoM confirmed that there was a 20% uplift however a further 22.5 hours were needed to deliver the core competency framework and training requirements which is not built in to the current establishment and creates added staffing pressures.

The DoM commented on the exceptionally busy period over the previous weekend and noted that whilst the staffing establishment was adequate for the initial period, an episode of short-term sickness can expose the fragility of the service.

The DoM noted that the general feeling amongst the workforce was improving in terms of wellbeing and there had been a reduction in the number of absences relating to stress and anxiety.

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

24/18 ITEMS TO APPROVE:

(i) Trade Union Facility Time Report

The paper provided details of trade union activity for the reporting period 1 April 2023 to 31 March 2024.

It was resolved: to (i) **note** the Trade Union Facility Time reporting information for 2023-2024 and (ii) **endorse** submission to the government portal, publication on the Trust website and publication in the Trust's Annual Report & Accounts for 2023-24.

(ii) Updated People Committee Schedule of Business

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 had been some minor amendments to the SoB to reflect changes to the frequency of some agenda items as well as some additional items added.

It was **resolved:** to **approve** the updated People Committee Schedule of Business.

(iii) Fit and Proper Persons Statement

The CPO advised that 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.

The report provided an update on the annual checks undertaken for 2023/24 and provided assurance that the requirements had been met.

It was **resolved:** to **note** the assurance provided that the FPPT requirements had been met.

(iv) Annual Modern Slavery Statement

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

It was noted that this had previously been discussed in detail at the Audit, Risk & Assurance Committee (ARAC) held on 16th July 2024.

It was **resolved:** to **approve** the statement.

(v) Board Assurance Framework (BAF) 2024/25

The DCCA noted 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 the Trust Board.

The report presented today was a more substantive report which had been presented at the first cycle of Committee meetings with the risks aligned to each of the respective Committees examined and challenged in detail. Feedback had suggested this was a helpful and robust process.

The DCCA noted that one of the challenges would be keeping the document completely up to date being mindful of the timings of the Committee cycle. It would continue to be an iterative document thought the year.

It was noted that all risks on the Trust risk register had been aligned to the Committees via themes for scrutiny and oversight. In addition, the ARAC would be undertaking deep dives in the risks across all of the Clinical Boards which will be cross referenced to what is documented in the BAF.

Mrs Stabler noted that it had been particularly helpful aligning the risks to Committees which had actually highlighted an additional risk for Quality Committee. Mrs Stabler wished to thank the Head of Risk and Assurance for their help in aligning the risks.

Mr MacLeod noted his attendance at the Committee meetings for the month where the risks and the BAF had been discussed in great detail and should continue to be used as a live document.

The CEO noted that it initially it was difficult to see alignment and how Committees and Clinical Boards were connected, but there was now a visible thread and connectivity which had been undertaken in short period of time.

It was **resolved:** to **approve** the Board Assurance Framework.

24/19 ANY OTHER BUSINESS:

(i) Update from Committee Chairs

The report was received, with no additional points to note.

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

iii) Meeting Action Log

The action log was received, and the content noted. The actions proposed for closure were agreed. A number of updates had been received since the publication of the papers which the TS agreed to email to the Board members and update the website [**ACTION02**].

iv) Any other business

The Interim Chair advised that she would be handing over the Chairmanship of the Trust to Sir Paul Ennals after the Review of the Year meeting. She thanked everyone involved in the organisation which had provided her with some precious memories.

The CEO commended the Interim Chair on her commitment and leadership since her appointment in December 2023 during a particularly challenging time.

The meeting closed at 13:17.

Date of next meeting:
Public Board of Directors – Friday 27 September 2024

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Agenda item A3

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 September 2024					
Title	Chair's Report					
Report of	Sir Paul Ennals, Interim Shared Chair					
Prepared by	Sir Paul Ennals, Interim Shared Chair Lauren Thompson, Corporate Governance Manager / Deputy Trust Secretary Kelly Jupp, 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. • Governor and Member Activity. • NHS Providers Chairs and Chief Executives Network. • North Integrated Care Partnership (ICP) Chairs, Local Authority (LA) Leaders, Primary Care & Voluntary and Community Sector representatives monthly meeting. • Alliance Steering Group. • The Net Zero North East England Board.					
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

I would first like to thank every staff member from the Trust for making me feel so welcome since I joined Newcastle Hospitals on 17 July 2024 as Interim Shared Chair. My first eight weeks have been focussed on getting to know the organisation, as well as understanding the key issues that we are facing at this current time. Such issues have included:

- Understanding the overall performance of the Trust, in relation to Quality, People, Finances, and Health Inequalities – identifying in particular the stand-out areas of strength and weakness, and the most significant risks and opportunities.
- Understanding the latest position within Cardiac Surgery following the CQC report and other external reviews conducted.
- Seeking assurance over areas where performance has deteriorated e.g. pharmacy services waiting times and delivery of recurrent Cost Improvement Programme schemes.
- The overarching Care Quality Commission (CQC) inspection findings and the associated Delivery Plan. We were notified in August that the conditions applied to our CQC licence have been lifted which is a fantastic achievement by all involved.
- Changes in the Trust Board composition which will require further recruitment of Non-Executive Directors, and a review of our Board Development Programme.
- Beginning to sketch out our ambitions for the years ahead, in the light of the new Government agenda and the opportunities that working within the Alliance offer us.

We interviewed for a Non-Executive Director (NED) with clinical expertise on 12 August and subsequently appointed Anna Stabler as a new substantive NED. Anna commenced with us an Interim NED in May 2024 and we are delighted to welcome her on a permanent basis to our Board, where she Chairs the Quality Committee with skill and drive.

I have been fortunate enough to have had introductory meetings with many staff members, as well as with members of the Board of Directors and Clinical Board leaders. I have also attended a number of Committee meetings, and the Trust Management Group (TMG), in order to better understand emerging issues, risks, assurances and any gaps in assurance.

My visits include to the Dental Hospital and the Centre for Life. In the future we will include the report on the Leadership Walkabouts and NED informal visits undertaken within the Public Board meeting papers for information.

Working collectively as a Council of Governors we are trialling some new ways of working, including meeting more frequently, but for shorter periods, introducing 'drop in' sessions to allow more informal time to discuss queries or feedback, creation of a 'Reading Room' and providing the opportunity for more Governors to observe Board Committees more frequently.

Governor and Member activity since our last Public Board meeting has included:

- Meetings of the Governor Working Groups - Quality of Patient Experience (QPE), Business & Development (B&D), and People, Engagement and Membership.

- Behaviours and Civilities Training, facilitated by our Chief People Officer, Christine and this meeting was well attended.
- A formal Council of Governors meeting.
- A briefing session on recent developments with the Great North Healthcare Alliance.
- The first of the monthly "Drop In" Sessions where I meet governors informally for an hour to discuss current issues.

At a national level, I attended the NHS Providers Chairs and Chief Executives Network on 17 September 2024 where we discussed strategic policy developments, developing the NHS ten-year health plan and hearing from Trusts that have leveraged their role as anchor institutions to boost local employment opportunities and work collaboratively with system partners. I hope that our own work within the Trust on developing our next Five year plan can feed into the national discussions of an NHS Ten Year Plan.

At a regional level, I attended the North Integrated Care Partnership (ICP) Chairs, Local Authority (LA) Leaders, Primary Care & Voluntary and Community Sector representatives monthly meeting on 12 September 2024 which provides the opportunity for leaders of the various sectors to share informal views on key developments. On this occasion we discussed in particular the current industrial action within primary care, and considered how best to mitigate against any negative impacts on patients. To that end I have also been meeting with leaders within Newcastle of the Primary Care community – the Chair and CEO of the Newcastle Federation, and the Integrated Care Board (ICB) lead on primary care for Newcastle.

The Alliance Steering Group held its monthly meeting in early September where we spent time developing our aspirations for the work of the Alliance, and strengthening the ever-expanding work plan. The mood is positive amongst Alliance members, though we are all conscious of moving at a measured pace that retains the commitment of all partners and key stakeholders.

I represent the local NHS community on the Net Zero North East England Board, chaired jointly by the regional Mayor Kim McGuiness and the Chief Executive Officer (CEO) of Northumbria Water Heidi Mottram. The NHS – and our Trust in particular – has an important role to play in ensuring the region plays its full part in moving as fast as feasible to a position where our carbon emissions reach Net Zero.

RECOMMENDATION

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

Report of Sir Paul Ennals
Interim Shared Chair
18 September 2024

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Agenda item A5

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 September 2024					
Title	Patient and Staff Story					
Report of	Mrs Annie Laverty, Director of Patient and Staff Experience					
Prepared by	Mrs Annie Laverty, Rachel McConnell, and Catherine Forster					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☐		☒	
Summary	This month's patient and staff story describes important steps taken to humanise healthcare for families of babies with Congenital Heart Disease (CHD). The Cuddle Project has thrived under the impressive leadership of Rachel McConnell (Physiotherapist) and Catherine Forster (Occupational Therapist) who were determined to introduce an evidence-based approach of 'Developmental Care' to the Children's Heart Unit at the Freeman Hospital. Developmental care is an umbrella term used to change the way we look after premature babies or medically complex babies in hospital. This approach is established practice for babies nursed in neonatal units, but not babies cared for in general Paediatric Intensive Care Units (PICUs) or children's wards. Over the last two years 93 babies have received skin-skin care (SSC), and 140 staff members have received introductory training to develop family friendly care. The implications from a public health perspective are considerable.					
Recommendation	The Board are asked to receive this story for information and note our commitment to safe, compassionate, and person-centred 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.					

Cardiac Unit Delivering Developmental learning Experiences
CUDDLE

STAFF STORY: THE CUDDLE PROJECT

I have worked as a Paediatric Physiotherapist at the Trust for 28 years. And the last 13 years on the Children's Heart Unit at the Freeman Hospital.

Despite considerable experience working in acute paediatrics, I was initially shocked by the cardiac surgical journey that many patients and families experienced, particularly the young infant with complex heart disease.

Whilst there was, undoubtedly, amazing cutting-edge work being undertaken in the medical and surgical fields resulting in significant reduction in mortality, little consideration was given to the impact that multiple surgeries, and long and complex hospital stays may have on a baby's future developmental outcomes and quality of life.

I saw first-hand the brutality of multiple invasive interventions, the pain and stress, and could only wonder what impact this might have on a child's development, not to mention the stress and trauma this had on parents and carers.

Changing the way we work requires investment in the right personnel, moving away from a purely medical model to have a workforce equipped to be able to care patients holistically.

The Cuddle project was initiated in August 2022 by myself Rachel McConnell (Physio) and my colleague Catherine Forster (Occupational Therapist (OT)), to introduce developmental care to a Cardiac Unit and establish Skin-to-Skin Care (SSC) for babies in hospital with congenital heart disease.

The 3 core elements of developmental care are:

- Protect the infant's brain.
- Individualised care.
- Promote the parent-baby bond.

At the start of the project a staff questionnaire highlighted that no staff on the Cardiac Unit had received any training in developmental care or skin-to-skin care. All respondents stated that they felt education and training in this area would enhance their practice.

In my 13 years working in this area, I had no knowledge of any babies receiving skin-to-skin care – I think it is important to note that this is not unique to the Freeman Unit and international studies have found the same.

The reasons for this are complex and there are many challenges. The Cardiac Unit can care for children from approx. 32 weeks gestation to 17 years old. It is not a neonatal unit, so awareness about the unique developmental requirements of a medially complex baby, are not taught or routinely considered. The environment and culture are historically much more medicalised and neurodevelopmental considerations and the importance of parent-baby bonding given little, if any, consideration within this field worldwide.

What did we do?

- Develop an education package - theory and practical guidance.

- Support skin-to skin care and develop our own professional guidelines to support staff.
- Initiate a weekly Cuddle Round.
- Adapted the ward nursery environment – from a stark clinical setting to a nurturing environment. This involved working with the OT Sensational Thinking Project (which was NHS England funded). Collaboration with many amazing teams from OT to medical physics and the Estates department. There was also collaboration with the Northumbria Innovation Hub.

Since the initiation of the SSC project in August 2022 approx. 93 babies have received SSC. 140 staff members have received introductory training to develop care and SSC. This doesn't include the many staff who we have worked at the bedside providing practical support and training, individualised for the baby they are caring for.

The most recent aspect of the Cuddle project is the implementation of the Cuddle rounds. These takes place every Monday and are an opportunity for parents to talk about their baby, highlighting their own baby's developmental strengths and challenges and enabling them to put together a weekly plan with us to ensure all staff understand how to support their baby when they are not there. Truly delivering family led, individualised care.

"***I found the cuddle cards helpful when I was looking after Caitlin last night. When she became unsettled the cuddle card told me that she hates a dirty nappy, so I changed it straight away but did it in the way she prefers, lying on her side and not lifting her legs like I would usually do. Cupping her head really settled her too. I felt good that I was able to comfort her in a way that worked for her and by the end of the shift I felt like I knew her quite well''*** - Staff Nurse

''I enjoy the Cuddle Round as it is a chance to talk about Bonnie, not her medical issues, but just Bonnie'' - Sanna - Bonnie's mum.

''I didn't realise how much I do know about her,'' - Fiona, Caitlin's mum.

''I did skin to skin care on the first day whilst Jane, Evelyn's mum, was still in hospital. I felt guilty at first as I knew that Jane was desperate to be there, but we talked about it and agreed that we had to do what was best for Evelyn. It was amazing and emotional, and my wife was able to do it the next day'' - John, Evelyn's Dad.

''When she was born, she was taken to the Freeman, and I couldn't be there for another 3 days as I had a traumatic birth and needed surgery. I had skin-to-skin care 3 days later and this was the first time I felt she was mine. To feel her warmth and smell her was amazing.'' - Natalie, Freya's mum

''I think everyone should do this training, including the Doctors'' - Deputy Matron

PATIENT STORY

Rowe was born at the Royal Victoria Infirmary (RVI). He had been diagnosed antenatally with complex CHD. After birth he was separated from his mum (Brooke) and brought to the Freeman at 2 hours old. Brooke remained at the RVI for another 1 ½ days - Dad (Morgan) arrived at the Freeman PICU. The cuddle project supported Morgan in skin-to-skin care with Rowe and suggested he bring some colostrum from Brooke for Rowe.

When Brooke arrived, she too was supported in skin-to-skin care. She didn't want to breast feed but did want to express her milk to give to Rowe. Support was given to help this through providing a reclining chair, which we had purchased using charitable funds, information, and support about protecting milk supply, skin to skin care, and support to increase confidence about holding Rowe, despite being attached to wires etc. having heart surgery etc. Skin to skin care helped to develop Brooke's confidence, and she decided when she held Rowe at her breast to progress to breast feeding.

The role of the Cuddle project adapted as Rowe's clinical status changed. Rowe was in hospital for 3 ½ months.

Picture of Morgan, Brook, and Rowe.

Rowe is Nasogastric (NG) fed in this picture and Morgan is feeding Rowe breast milk while Rowe and Brooke have skin- to- skin care. (September 2023)

''I was worried in case he didn't know who I was when I got to the hospital. I knew there were lots of nurses working around him and I worried, what if he thinks someone else is his mam, and he doesn't recognise who I am when I come. But with doing the skin-to-skin you could tell straight away he knew I was his mam'' - Brook (Rowe's Mam)

Conclusion and next steps: Changing our way of working and our culture is challenging. We are incredibly grateful for the Trust's investment in us as employees. We have received support and funding to advance our clinical, leadership, coaching, teaching, and quality improvement skills, which has enabled us to initiate and progress with this project.

An exciting opportunity has arisen to enhance and scale the Cuddle Project and incorporate the UNICEF Baby Friendly Standards by being the first hospital in the UK to gain accreditation. We are in the process of writing a proposal to realise this ambition. If we can secure funding and the support of the Trust, we already have the training, expertise, and experience plus the full support of Consultant Paediatrician, Dr Vicky Thomas, to drive this forward.

Rachel McConnell, Clinical Specialist Cardiac Neonatal Physiotherapist and Catherine Forster, Advanced Paediatric Occupational Therapist.

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Agenda item A6

The Newcastle upon Tyne Hospitals NHS Foundation Trust

PUBLIC TRUST BOARD

Date of meeting	27th September 2024					
Title	CQC Update					
Report of	Rob Harrison, Managing Director Ian Joy, Executive Director of Nursing					
Prepared by	Ellspeth Marshall, Project Manager Stephen Lowis, Senior Manager PMO					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☐			
Summary	This report outlines an update in relation to: - The removal of the conditions imposed on the Trust license relating to the Notice of Decision - The next phase of improvement planning will focus on testing impact, implementation and embeddedness - Clinical boards to report against their local quality and safety priorities - Testing of impact and assurance through Rapid Quality and Safety Reviews and mock inspection					
Recommendation	The Board of Directors is asked to note the following: - The removal of conditions imposed on the Trust following the Notice of Decision - The transition for the improvement plan to focus on embeddedness and optimisation - The change for Clinical Boards to report against local quality and safety priorities and close the original improvement plans - The activity carried out to test impact and assurance at ward / department level.					
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]	1.2 - Failure to implement effective governance systems and processes across the Trust to assess, monitor and drive improvements in quality and safety.					
Reports previously considered by	Monthly report to Trust Board.					

CARE QUALITY COMMISSION (CQC) UPDATE

1. INTRODUCTION - NOTICE OF DECISION

CQC wrote to the Trust to impose conditions in October 2023 and served a Notice of Decision (NoD) on 18th December 2023. This action was taken in response to the number of failings found during inspection and failure to assure CQC that the risks to safety had been addressed in a timely way.

An application was submitted to remove the conditions from the Trust license in August. The Trust formally received notice on 3rd September 2024 that all conditions would be removed following the implementation of a new governance system.

2. CORPORATE IMPROVEMENT PLAN

The focus of the Corporate Improvement Plan has been to assist the organisation in rapidly stepping up an Effective Governance System and to address any recommendations from the CQC report. Actions were primarily about initial implementation and singular activity, rather than ongoing optimisation and impact monitoring. This action plan will be closed by the end of September and the next phase of improvement planning will focus on testing impact, implementation and embeddedness at ward and department level across the organisation.

3. FOCUS AREAS

A number of key areas remain a focus for the trust which include:

- Medicines management
- Promoting and improving incident reporting
- Mental Capacity Act / DoLs
- Deteriorating patients

As part of the continuing work with clinical boards, these key areas will be included in their quality and safety priorities alongside the priorities identified through local intelligence. This application of local quality and safety priorities prevents any duplication as they are already reported through established governance mechanisms such as Quality Oversight Group and Quality and Performance Review meetings.

4. IMPACT AND ASSURANCE

Rapid Quality and Safety Reviews (RQSR)

Throughout September, a series of rapid quality and safety reviews have taken place across the wards to understand the impact of the Clinical Board's Ward to Board Improvement Plans at ward/ department level.

The objectives of the RQSR were:

- To provide real time feedback to clinical leader of good practice and any gaps / risks to improve safety and quality.

- Prepare clinical areas for any future inspection.
- Inform on the future development of the Clinical Assurance Tool (CAT) and Ward Accreditation Programme.

Inpatient and Day Case areas were reviewed on 3rd and 4th September 2024 including:

- 22 Inpatient areas at Freeman Hospital
- 26 Inpatient areas at RVI
- 3 Day case areas at the RVI
- ED RVI

There were 7 clinical areas identified as requiring immediate feedback which included escalation to Matron and the Executive Nursing Team. Themes included staff support, estates issues, medicines management and cleanliness.

Following the reviews a feedback session was held, and the following initial themes were identified:

- Staff very welcoming and approachable.
- General improvement of Medicines Management since last Peer Review in May 2024 although further work required.
- Further work still required to ensure information sharing re incidents is reaching all staff consistently at ward level.
- COSHH /Fire Files: areas need to ensure accessible when senior staff not on duty.
- Safety Checks on 'Hub' not accessible when senior staff not on duty – actions in progress to rectify this.

Next Steps include:

- Action planning with Clinical Boards in response to results.
- Profiling of areas of good practice to enhance learning.
- Peer support strategy to improve safety and quality standards.

RQPRs are planned for theatre areas (25th Sept) and critical care areas (1st Oct) with the plan to repeat the process in November.

Independent Review by thevaluecircle (TVC)

As part of the next phase of support aimed at strengthening the organisation, TVC will undertake a developmental independent review. The aim is to prepare teams for a re-inspection and ensure staff are well-positioned to demonstrate improvements and areas of good practice. The process will also identify areas for improvement with live feedback and support.

The approach to this independent review will include:

- Documentation and data review
- On-site service line inspections
- Well-led interviews and feedback sessions with triumvirate leadership teams
- Reporting and recommendations
- Feedback sessions

5. NEXT STEPS

The Compliance Team will continue to work on:

- The next phase of improvement planning to test impact and embeddedness of change.
- Testing impact across the organisation including through Rapid Quality and Safety Reviews and the review led by thevaluecircle.
- Linking progress from clinical board quality priorities to ward visit checks to ensure full ward to board assurance.

Further consideration is required around how the improvement initiatives will integrate into business-as-usual framework moving forwards.

6. RECOMMENDATIONS

The Board of Directors is asked to note the following:

- The removal of conditions imposed on the Trust following the Notice of Decision
- The transition for the improvement plan to focus on embeddedness and optimisation
- The change for Clinical Boards to report against local quality and safety priorities and close the original improvement plans
- The activity carried out to test impact and assurance at ward / department level.

Report of:
Rob Harrison, Managing Director
Ian Joy, Executive Director of Nursing
18th September 2024

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Agenda item A7

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 September 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)				
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	The Board of Directors is asked to receive the report.				
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 the Trust Board.					

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

Quality, Performance, People, Finance, Health Inequalities

September 2024

Healthcare at its best
with people at our heart

Contents

Executive Summary (1/2)

Quality

- Throughout the month of July 2024, the number of Trust onset *Clostridioides difficile*, Klebsiella and *E. coli* have increased since the previous publication in June 2024. MSSA and Pseudomonas aeruginosa have decreased since the previous publication and MRSA bacteraemia remains the same with zero reporting.
- No notable special cause variation has been registered across any of the Healthcare Associated Infection (HCAI) metrics.
- July 2024 continues to show special cause variation of an improving nature for both the numbers of falls and the number of inpatient acquired pressure ulcers, although there has been an increase in the numbers of the latter compared to the previous month.
- The number of patient safety incidents (per thousand beds) has increased compared to the previous month whilst the number of severe/fatal patient safety incidents (per thousand beds) has decreased. No notable special cause variation has been recorded.
- The number of After-Action Reviews and Patient Safety Incident Investigations since the previous publication has increased.
- The number of inpatient deaths in August 2024 have increased since last publication. The Summary Hospital-level Mortality Indicator (SHMI) is showing the Trust to be 0.91 - one of the lowest in the region.
- The Trust has opened 46 formal complaints in July 2024.
- There were five stillbirths in August 2024 - these cases will be reviewed through the Perinatal Mortality Review Tool (PMRT) process. No cases met the referral criteria for Maternity and Neonatal Safety Investigation (MNSI) review.
- The emergency Caesarean section rate is comparable to other Trusts. No special cause variation in noted in caesarean rates.
- In 2023 the Trust was highlighted as an outlier for Post Partum Haemorrhage (PPH), specifically for Caesarean section. Recommendations made following a review provided additional assurance to the Trust that the management of women undergoing a PPH was appropriate. Minor changes were implemented, and cases have reduced below the mean in recent months.

Performance

- Type 1 and overall Accident & Emergency (A&E) performance improved from the previous month to 61.1% (+3%) and 75.5% (+1.6%) respectively. However, generally there is special cause variation of a concerning nature in relation to A&E performance. Waits to be seen by a clinician continue to be one of the primary delays in a patient's Emergency Department (ED) attendance due to a capacity and demand imbalance between the current workforce and volume of attendances.
- Trolley waits >12 hours reduced by more than half in July. (14 vs 37). The current configuration of the ED estate contributes to issues with flow and was not designed for the current volume of attendances.
- The total waiting list (WL) size increased slightly to 102,763 overall, with Referral to Treatment (RTT) 18-week performance recorded at 68.7% (-0.2%).
- July saw slower progress in the reduction of >65 week waits at Newcastle Hospitals, however special cause variation of an improving nature continues to be seen. The total number of patients waiting >78 weeks increased marginally to 18, with the number of patients waiting >65 weeks falling to 222 (-14).
- The 77% 28 Day Faster Diagnosis Standard (FDS) for cancer was achieved for the fifth successive month (79.2%), despite performance dropping by 1.6%.
- However, the Trust failed to meet the other two consolidated standards in June. This is despite 62 Day compliance reaching its highest level in recent years at 65.3% and improving special cause variation is shown. 31 Day performance also improved, but only to 90.6% in June which is still short of the national target.
- Performance against the 5% diagnostics standard remained almost static with 35.9% of patients waiting longer than six weeks for their test (-0.1%). Special cause variation of a concerning nature has been identified. MRI continue to experience high patient demand, as well as facing ongoing pressure to deliver prompt scans for patients on cancer or elective long wait pathways.

Executive Summary (2/2)

People

- Total sickness absence increased from 5.35% to 5.42%, target 4.50%.
- Top 3 reasons for sickness: anxiety/stress/depression/other psychiatric (30%); cold/cough/flu (13%); other musculoskeletal problems (10%).
- Short-term sickness 1.96%, long term sickness 3.25%.
- Total turnover reducing since May 2023 to 10.11%; target 10%. Special cause variation of an improving nature has been identified.
- Top reason for leaving work-life balance 18.3%.
- Top destinations on leaving: no employment 38.2% (half were accounted for by retirement, health and temporary contract); other NHS organisation 30.4% (includes retire-return).
- Mandatory training compliance 92.56%, target 90%. Lowest compliance in medical and dental staff 76.69%.
- Paediatric Basic Life Support only mandatory training below 80% compliance.
- Appraisal compliance 85.80%, target 90%. Improving special cause variation.
- Disabled staff increased to 5.36%. Improving special cause variation.
- BAME staff increased to 16.79%. Improving special cause variation.

Finance

- As at Month 4 the Trust is reporting an overspend of £1.4 million against the planned deficit of £5.2 million (after Control Total). This variance relates to the additional cost of the Junior Doctors Strike.
- From an income perspective the in-month position is an overall favourable variance.
- Pay costs are £0.9m under plan at month 4 and include the costs associated with industrial action. Total operating expenditure is £20.1m above plan due to increased costs relating to drugs and clinical supplies (including circa £4.7m that is matched with income) and unachieved CIP (£5.3m behind on expenditure).
- Agency costs continue to run at around 0.5% 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, with a further increase in July (Month 4) compared to previous months.

Health Inequalities

- This is the third Integrated Board Report containing a section on Health Inequalities. This update contains information on elective admissions disaggregated by age, sex, ethnicity and deprivation.

Quality

Quality Overview

Metric	Period	Actual	Target	Variation	Assurance
HCAI - MSSA	Jul-24	10	8		
HCAI – C. Diff	Jul-24	18	11		
Harm Free Care – IP Acquired Pressure Ulcers	Jul-24	58	69	L	
Harm Free Care – Adult Patient Falls	Jul-24	214	203	L	
Stillbirths	Aug-24	5			
Blood Loss >1500ml	Aug-24	21			
ATAIN	Aug-24	23			

Health Care Acquired Infections

- The monthly National target for MSSA is 8 cases. In July 2024, 10 were recorded, this is slightly above the mean and monthly target, but no special cause variation is noted.
- The monthly National target for C. Diff is 11 cases. July saw an increase in cases compared to the previous month (18 v 12), which sits above both the mean and monthly standard but does mirror peaks seen previously in summer months. No special cause variation is noted.

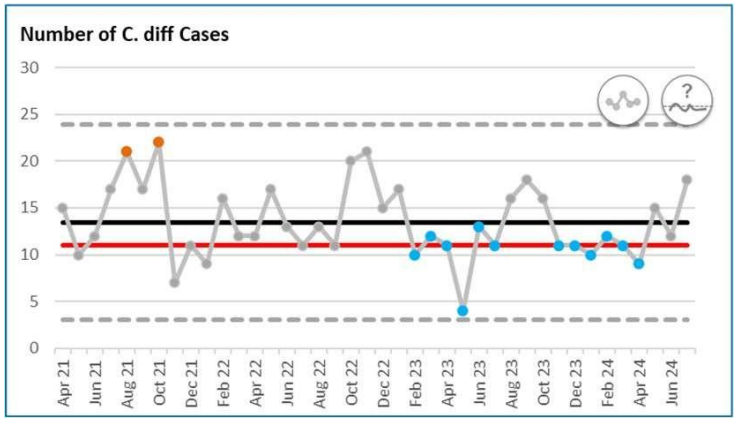
Harm Free Care

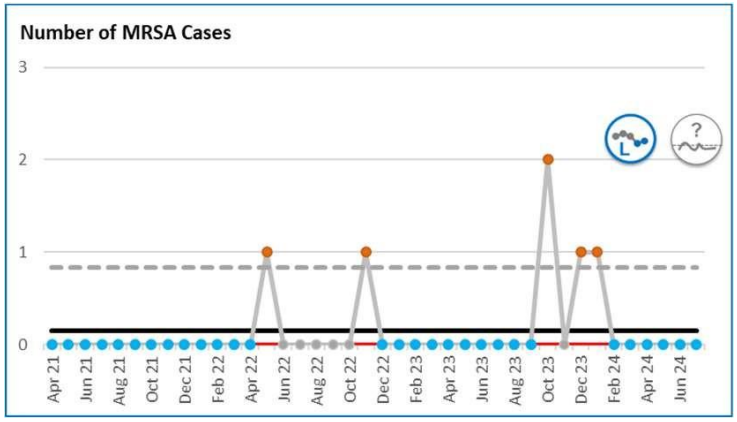
- The monthly target for Inpatient Acquired PUs is 69. The Trust has reported 58 in July 24, which is below target. Special cause variation of an improving nature is identified.
- The monthly target for adult inpatient falls is 203. The Trust reported 214 in July 24, above target but with no special cause variation is noted.

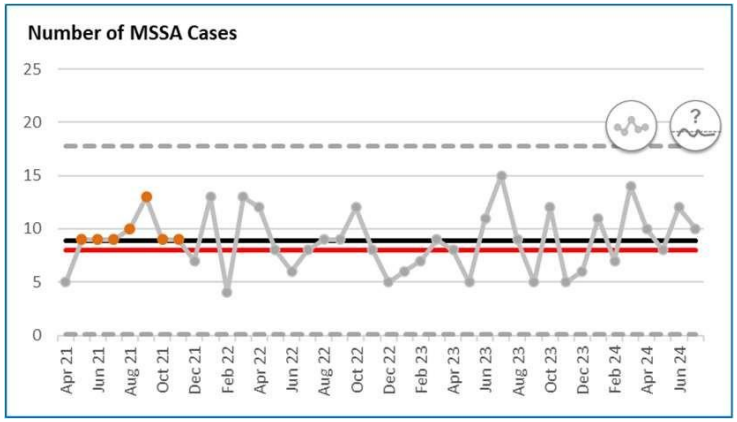
Perinatal Quality Surveillance

- There were five stillbirths in August 2024 - these cases will be reviewed through the Perinatal Mortality Review Tool (PMRT) process. No cases met the referral criteria for Maternity and Neonatal Safety Investigation (MNSI) review.
- In 2023 the Trust was highlighted as an outlier for Post Partum Haemorrhage, specifically for Caesarean section. Recommendations made following a review provided additional assurance to the Trust. Minor changes were implemented, and cases have reduced below the mean in recent months.
- There were 25 term admissions in July 2024. The Trust previously reviewed cases where admission time on NICU was >4hours - from July the Trust is reviewing all admissions including those babies who required minimal intervention leading to a period of separation from the mother.

Healthcare Associated Infections (1/2)







Background

- All Hospital Onset, Hospital Acquired (HOHA) Clostridioides difficile infections (CDIs) and blood stream infections (BSIs) are reviewed and investigated by a Microbiologist, an Infection Prevention and Control (IPC) Nurse and Antimicrobial Pharmacist. If lapses in care are identified the clinical area formulates an action plan to address concerns raised and prevent further incidents.
- Where there have been no lapses of care identified, these cases are deemed unavoidable.

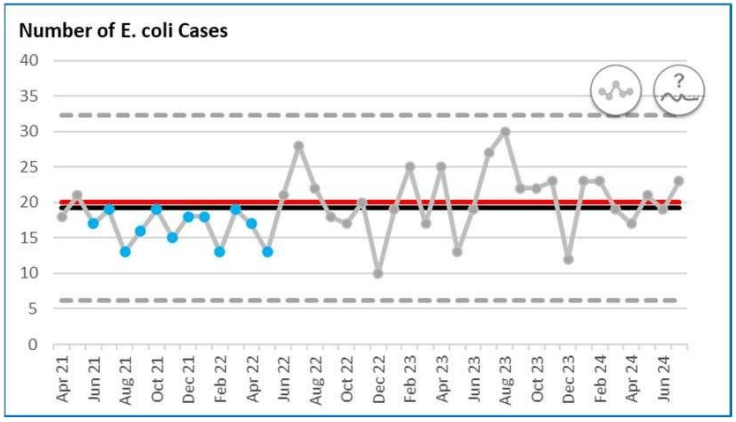
Standards

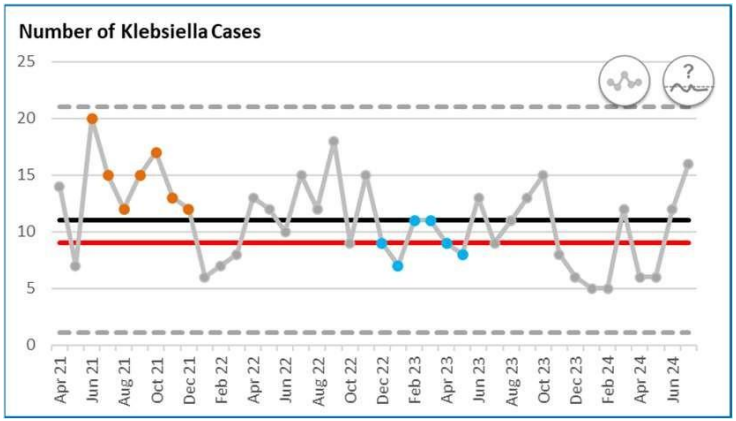
- **Zero MRSA** cases.
- **No more than 98 MSSA** cases across the financial year (local target - 10% reduction from 2023/24).
- **No more than 136 CDIs, 247 E. coli** cases, **108 Klebsiella** cases or **39 Pseudomonas aeruginosa** cases across the financial year.

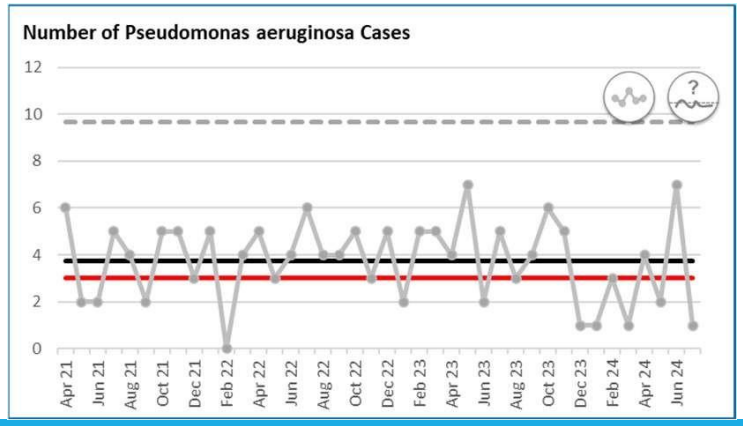
Current Position

- July saw an increase in CDI cases compared to the previous month (18 v 12), which sits above both the mean and monthly standard but does mirror peaks seen previously in summer months. Of the 18 cases, there were 13 HOHA and five Community Onset Healthcare Associated (COHA) CDIs. Of the 13 HOHA cases six were deemed unavoidable and three avoidable (due to inappropriate antibiotics/delayed sampling), with the remaining four cases still under investigation. No special cause variation is noted.
- There have been no reported cases of MRSA since January 2024.
- The number of MSSA cases remain slightly above the mean and monthly standard, with 10 recorded in July. Of these there were nine HOHA cases and one COHA case. Investigations into the HOHA cases determined that seven were deemed unavoidable and one deemed avoidable due to gaps identified in device management. One case is still under investigation. No special cause variation is noted.
- In July there were 23 E. coli bacteraemia cases recorded, slightly above the mean and monthly standard. Of these 8 were COHA cases and 15 HOHA, of which 12 were deemed unavoidable as no lapses in care were identified. The remaining three cases are pending investigation. No special cause variation is noted.

Healthcare Associated Infections (2/2)







Current Position (continued)

- The number of recorded Klebsiella bacteraemia cases increased to 16 in July - 13 HOHA cases and 3 COHA cases. Upon investigation of the HOHA cases, eight were deemed unavoidable whilst the remaining five are pending investigation. No special cause variation is noted.
- Only one Pseudomonas aeruginosa case was registered in July which was deemed unavoidable upon investigation. No special cause variation is noted.

Action taken

- Clinical Board Matrons have created action logs to focus on quality improvement initiatives in relation to healthcare associated infection (HCAI). These are monitored through their Quality Oversight Groups (QOGs) which are attended by the Director of Infection Prevention Control (IPC) and IPC Matron. Clinical Boards are provided with quarterly IPC reports.
- In periods of high incidence of infection, IPC colleagues, Facilities, Patient Services Coordinators (PSC) and clinical leaders continue to work together to facilitate safe and timely patient placement and prompt specialised cleaning as required.
- IPC / Facilities / Estates Teams continue to collaborate to ensure water safe environments are provided and maintained.
- Digital dashboards to monitor invasive devices are now live. This platform supports the real time monitoring of lines, drains and tubes at ward and departmental level to increase compliance and support through proactive intervention.
- Harm Free Care Specialists continue to collaborate with clinical teams through the provision of educational bundles 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.
- Certificates have been shared with clinical wards and departments to recognise and acknowledge their achievements where they have attained a reduction of HCAIs in 2023/24.
- One ongoing Quality Improvement project within Older People's Medicine aims to decrease avoidable urinary catheters by 5% with clinical teams, IPC and the Bladder and Bowel Specialist Nursing Team working collaboratively. Progress will be monitored and shared quarterly within the QOG, IPC Committee and Quality Committee.

Harm Free Care: Urinary Catheter Reduction

Fig. 1

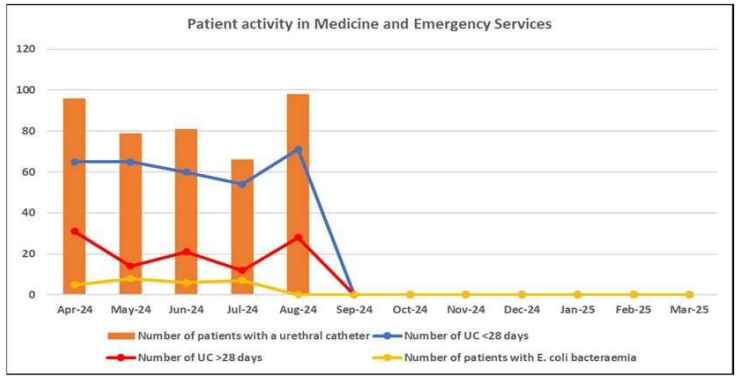
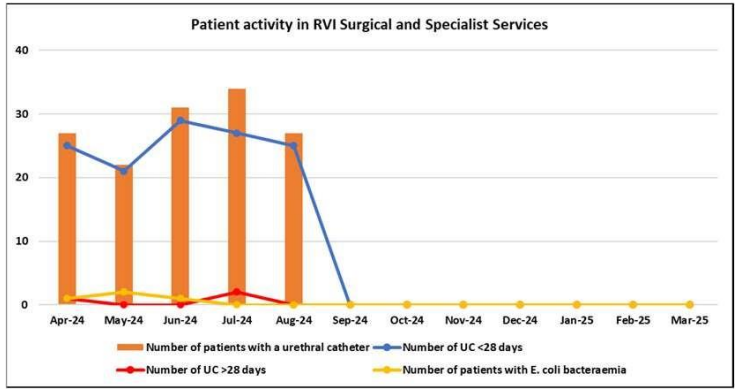


Fig. 2



Background

- A monthly catheter surveillance across all adult inpatient and community areas is currently undertaken to support the reduction of urinary gram-negative bloodstream infections, specifically catheter associated and urinary tract infection (CAUTI), by implementing best practice clinical standards of care.

Standard

- Currently there is no national surveillance tool and therefore no national threshold is published.

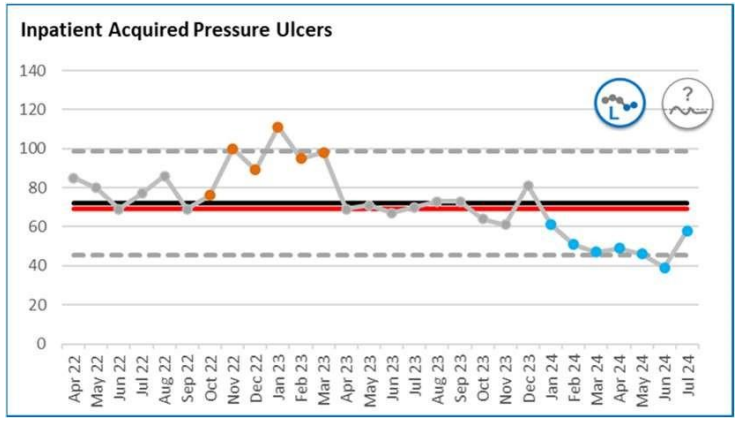
Current position

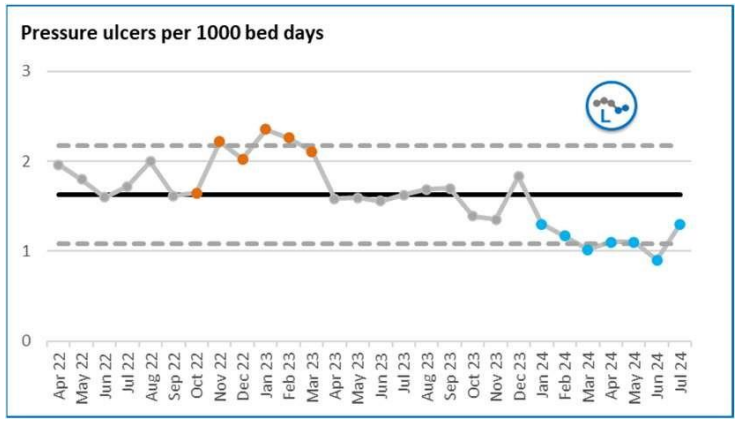
- The graphs demonstrate the levels of E. coli bacteraemia infections attributed to urinary catheters within both Medicine & Emergency services and Surgical & Specialist Services.
- Figure 1 displays the number of patients with a urinary catheter for the year to date in Medicine & Emergency Care. In July out of 451 patients, 66 (15%) had a urinary catheter. For only 12 (18%) of these patients was the catheter in situ >28 days.
- Figure 2 displays the number of patients with a urinary catheter for the year to date in Surgical & Specialist Services. In July out of 208 patients, 34 (16%) had a urinary catheter. Only two (6%) of these patients had a catheter in situ >28 days.
- Specialty teams have delivered a continually low running trend of urinary catheters in situ for greater than 28 days.

Action taken

- Optimising the management of urinary tract infection (UTI) and CAUTI through several quality improvement clinical interventions and recommendations.
- Peer reviews are undertaken to identify avoidable catheter use.
- Staff are showing an increased recognition of the risks of urinary catheters and the assessment for the clinical need.
- Ongoing surveillance also offers the opportunity to have conversations within the multidisciplinary team about urinary catheterisation and early removal.
- Further recognition of the reason for the catheter, documentation of the insertion event and twice daily checks are now required.

Harm Free Care: Pressure Damage





Standard

- A reduction target has been set at **20% year on year for pressure ulcers** at Category II and above.

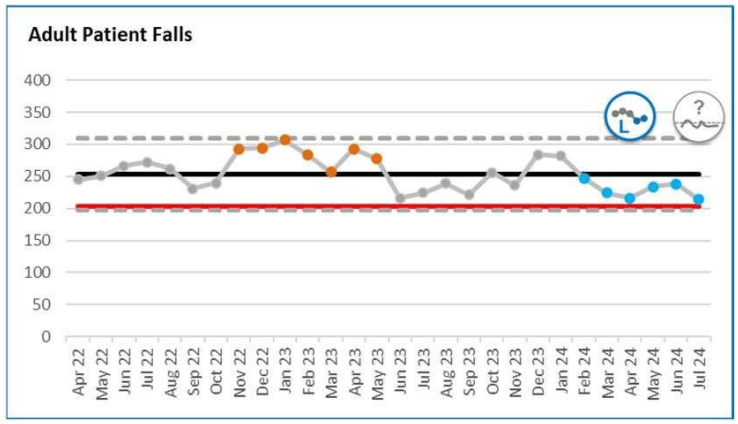
Current position:

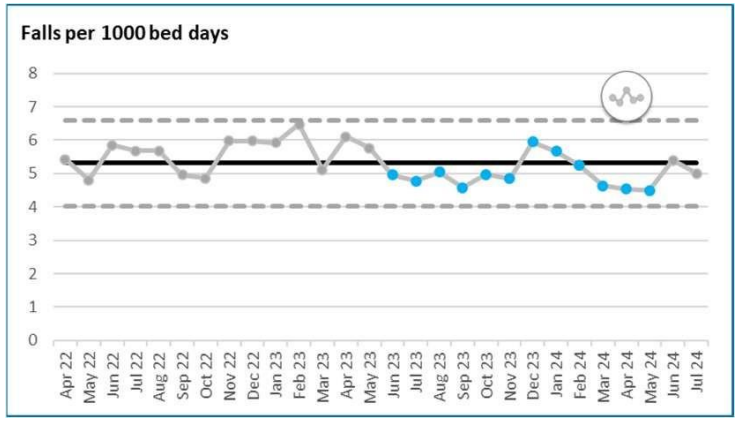
- Despite a small rise in July there has been an overall decline in inpatient acquired pressure ulcers since December 2023, with special cause variation of an improving nature identified.
- There were six pressure ulcers identified as causing serious harm in July 2024, five of which were category III.
- Additionally, in July a category IV pressure ulcer was reported for the first time since June 2022. Investigations have been undertaken and learning points identified:
    - Further support for nursing staff to undertake pressure ulcer prevention and categorisation training
    - Ensuring skin inspection and/or photographs are carried out on admission
    - Improve documentation around pressure area care
    - Ensure timely and appropriate skin and risk assessments take place.

Action taken

- Harm Free Care spreadsheets are shared on a monthly basis with wards and departments. Wards who achieved their 20% reduction trajectories for 23/24 have been rewarded with a certificate.
- The aSSKINg framework (Assess risk, Skin assessment and skin care, Surface, Keep moving, Incontinence, Nutrition and Give information) is a care bundle which outlines best practice in pressure ulcer prevention and the many available associated interventions aimed at reducing the risk of this often preventable patient harm. This has been added to Tissue Viability Education.
- Newcastle Hospitals Charity have supported the purchase of pens highlighting aSSKINg to help remind staff to take a holistic approach to pressure ulcer prevention.

Harm Free Care: Falls





Standard

- A reduction target has been set at **20% year on year for adult patient falls**.

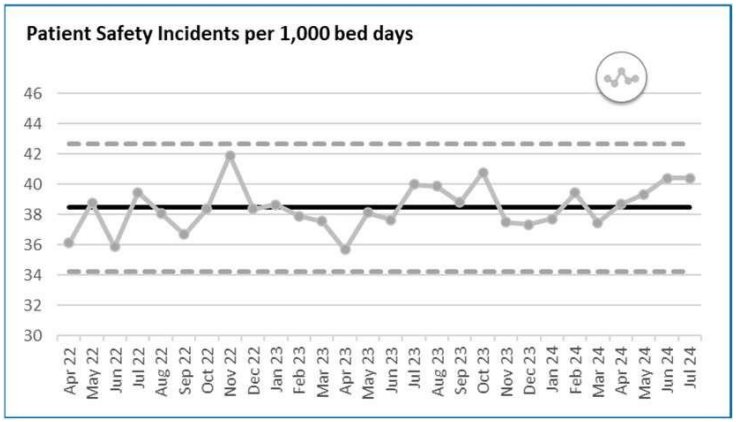
Current position:

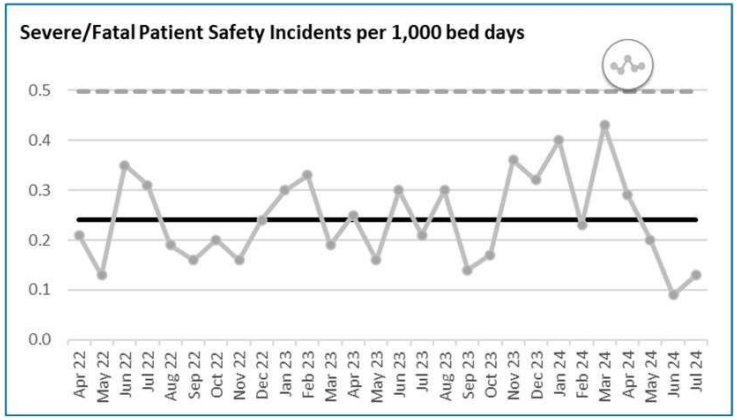
- The charts indicate improving special cause.
- In July there was a reduction in falls compared to the previous month (238 v 214), with falls with harm recorded as 5.1% of all falls. 11 incidents were registered of which eight were categorised as moderate harm. A further two were femoral fractures which have been identified as causing major harm, whilst one incident is awaiting review to enable classification.
- Overall, special cause variation of an improving nature is identified for the number of adult falls.
- Falls per 1,000 bed days have also reduced to 5.0, remaining significantly under the Trust target of 6.0.

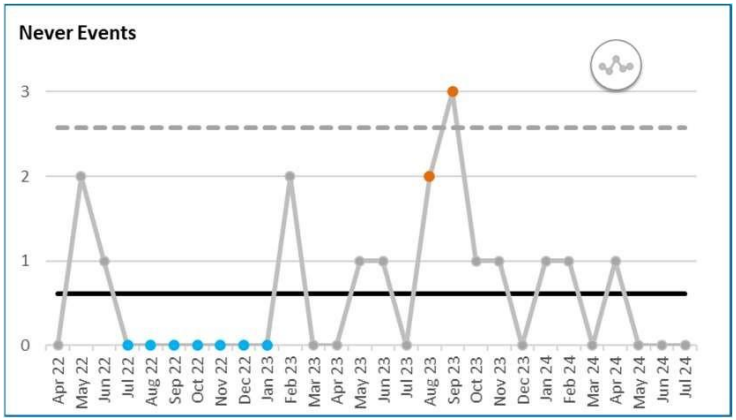
Action taken

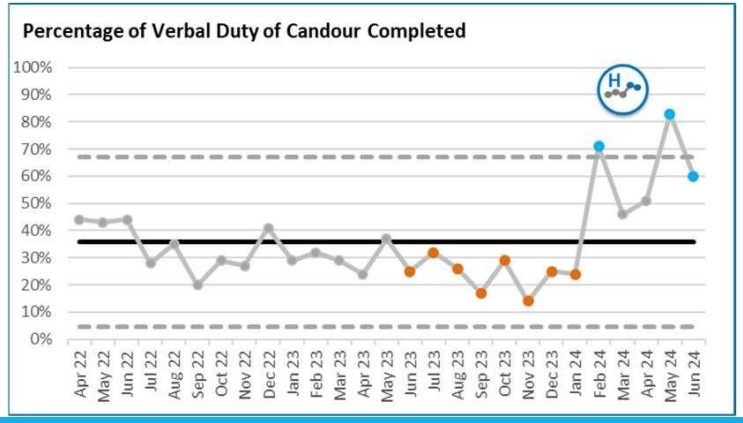
- A new Falls Prevention Coordinator commenced in post at the end of July and has identified working with wards and departments to reduce the incidence of falls as a priority.
- A project is being planned to ascertain if a link can be established between caffeine and falls in older people.
- Education undertaken at junior doctor induction sessions has led to some collaborative working to look at visual assessments for patients admitted to hospital.
- Certificates of achievement have been awarded to wards and departments who accomplished the 23/24 reduction in falls trajectory of 20%.
- Enhanced Care Observation (ECO) training has now been updated to reflect staff feedback and is being rolled out across the Trust. A Trust wide ECO audit will take place in September 2024.

Incident Reporting









Standards

- Continued trend of **increased incident reporting** across the Trust.
- **Zero tolerance to never events**.

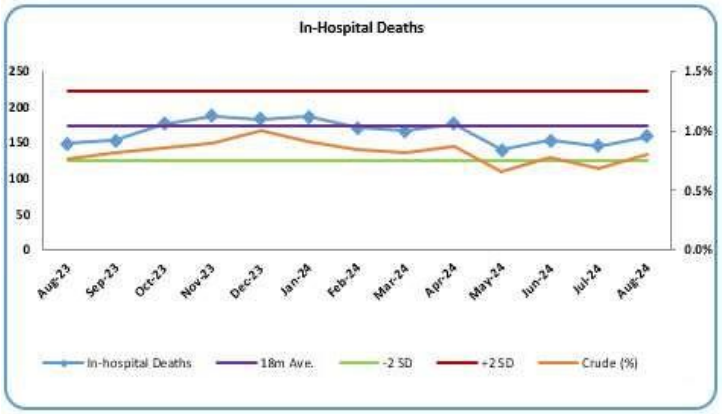
Current Position

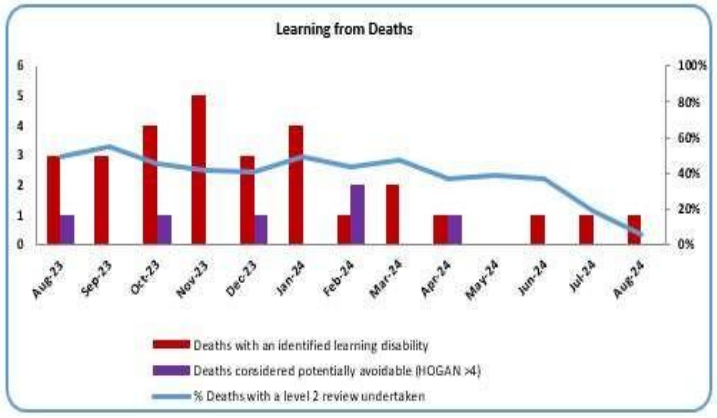
- The total number of patient safety incidents per 1,000 bed days reported in July 2024 remains relatively static, although this is the fourth consecutive month where the number reported has been above the mean.
- The number of severe/fatal safety incidents per 1,000 bed days remains well below the mean.
- No never events were declared in July 2024.
- 7 After Action Reviews (AAR) were declared in July, bringing the total number of AARs since launching PSIRF (31st January 2024) up to 23. Three Patient Safety Incident Investigations (PSII) were declared in July, bring the total to 22.
- Special cause variation of an improving nature noted for completion of verbal duty of candour.

Action taken

- Incident reporting remains a mandatory element of Trust induction.
- Clinical Boards have access to incident reporting rates and have identified areas of low reporting, implementing targeted plans to address this.
- Further changes have been made to the Datix form in response to staff feedback.

Mortality Indicators (1/2)

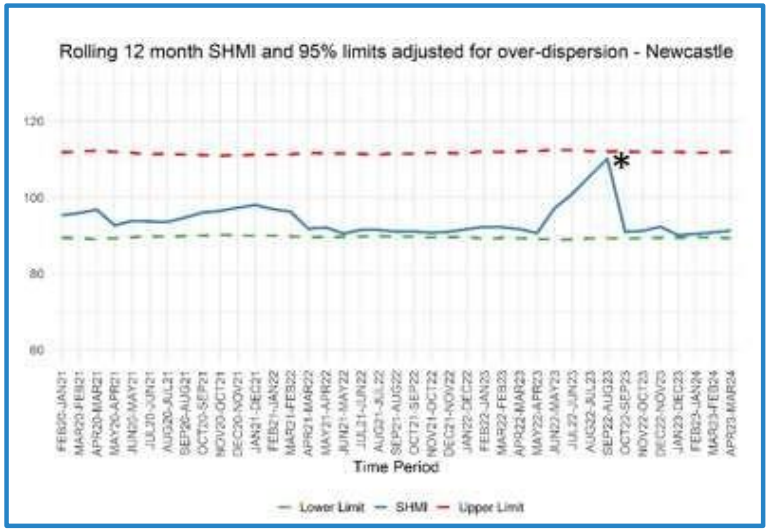




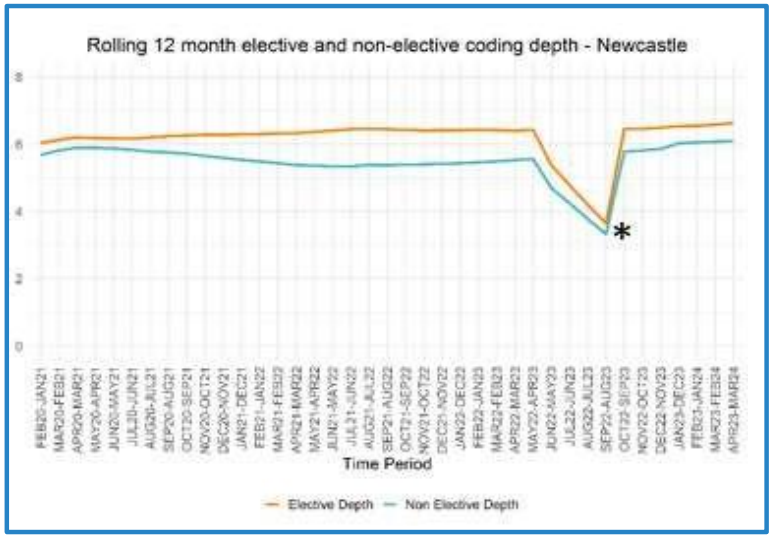
Current Position

- There were 159 inpatient deaths in total reported in August 2024, which is higher than the amount reported 12 months previously (n=149).
- The crude rate in August 2024 is 0.80%.
- Out of the 159 inpatient deaths reported, nine (6%) patients have received a level 2 mortality review to date – this rate will rise significantly over the coming month as M&M meetings continue to take place.
- There were no patients with a HOGAN grading >4 or an identified learning disability.

Mortality Indicators (2/2)



All data rolling 12 month periods. Data as reported by NHS England.



SHMI

Within the latest published SHMI data (April 2023 – March 2024) the Trust SHMI is at 0.91. This is within the "as expected" category.

Observed & Expected deaths

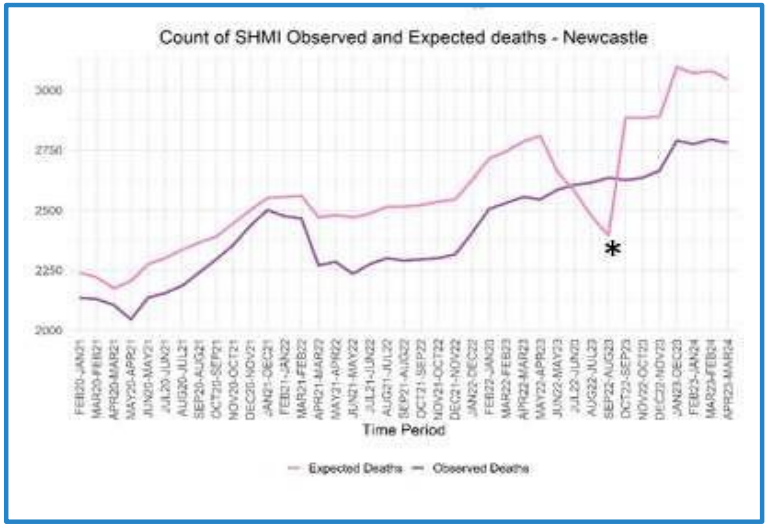
Between April 2023 – March 2024 the Trust has 2,780 observed deaths and 3,045 expected deaths. This is within the "as expected" category.

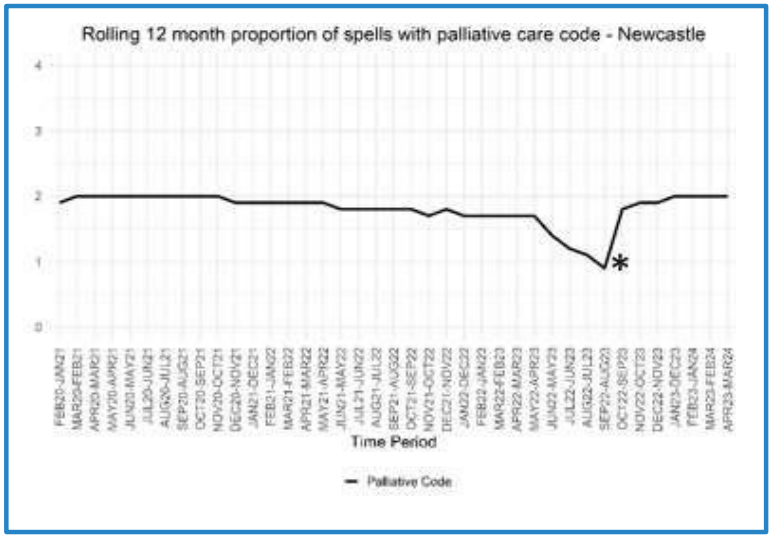
Coding Depth

Coding depth has a substantial impact on mortality indicators. Within the latest published SHMI data the Trust has an elective coding depth of 6.6 and a non-elective coding depth of 6.1. This is showing no concerns and within expected category.

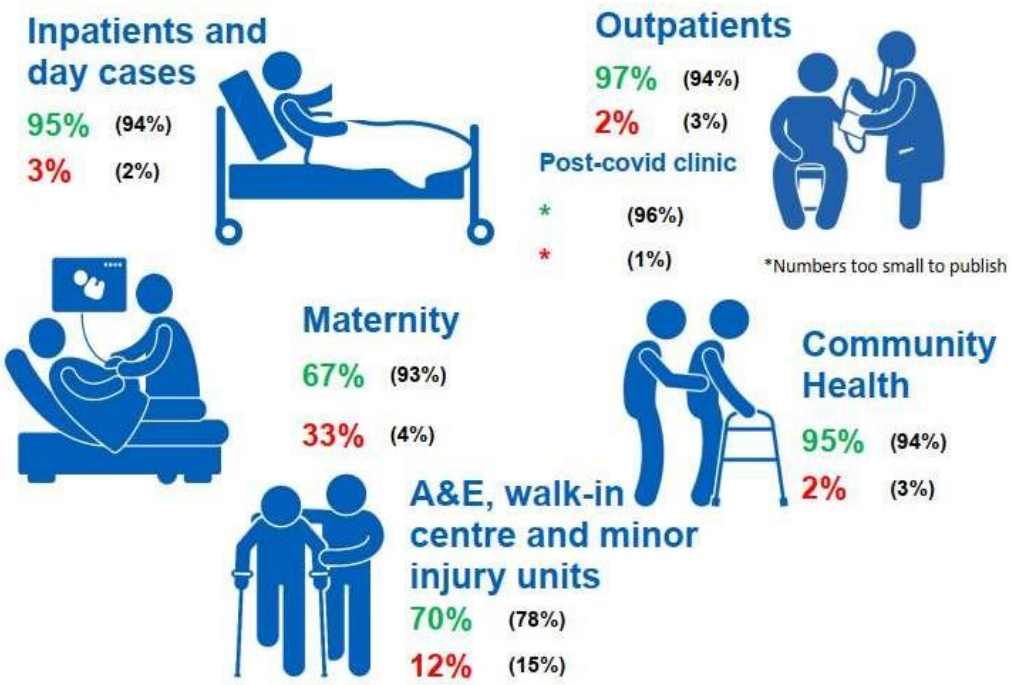
Spells with palliative code

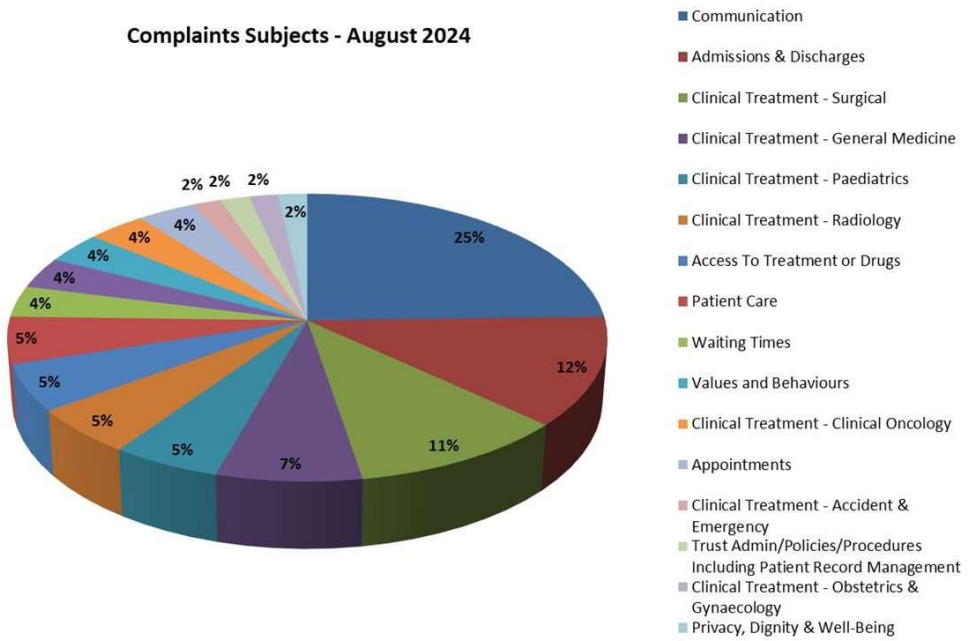
Between April 2023 – March 2024 the Trust has a 2.0% palliative care coding rate. Although this is low for a Trust of this size, taking into consideration this Trust does not have dedicated palliative care wards this is within expected limits.





Friends & Family Test / Complaints



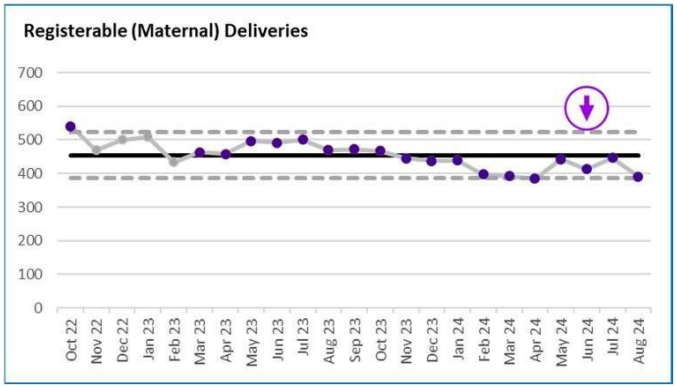


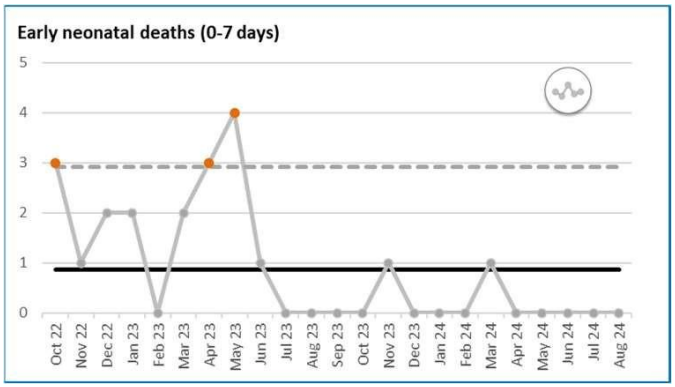
Current Position

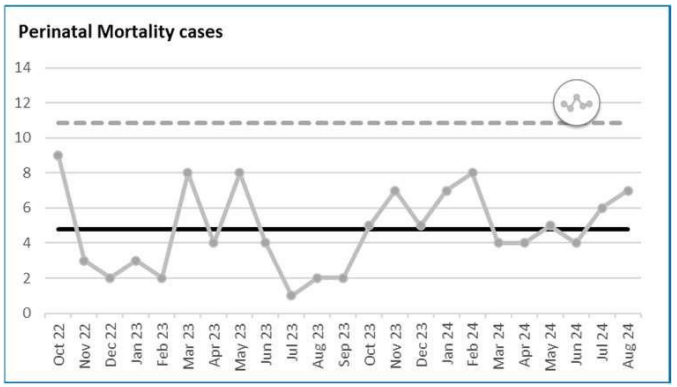
- There were 1,469 responses to the Friends and Family test from the Trust in May 2024 (published July 2024) compared to 1,324 in the previous month.
- The infographic shows the proportion of patients who give a positive or negative rating of the care they received. The national average results are shown in brackets for comparison.

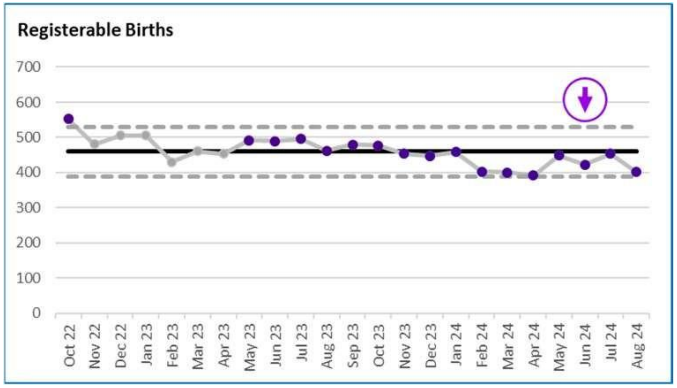
- The Trust has opened 57 formal complaints In August 2024. The average number of complaints opened this financial year is 51, which is three complaints higher than the Trust average for the previous financial year.
- The chart above summarises the complaint themes for this month, with Communication (n=14), Admissions & discharges (n=7) and Clinical Treatment - Surgical (n=6) being the top three themes.

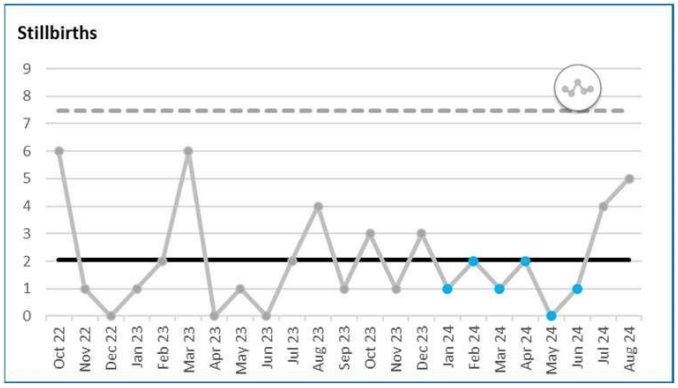
Perinatal Quality Surveillance: Births











Deliveries/Births

- There were 605,479 live births in England and Wales in 2022, a 3.1% decrease from 624,828 in 2021 and the lowest number since 2002; the number remains in line with the recent trend of decreasing live births seen before the coronavirus (COVID-19) pandemic. The impact of the reduced birth rate has been augmented by women choosing to deliver in other local units since the Newcastle Birthing Centre has been closed and the Homebirth service suspended, resulting in a reduced market share.

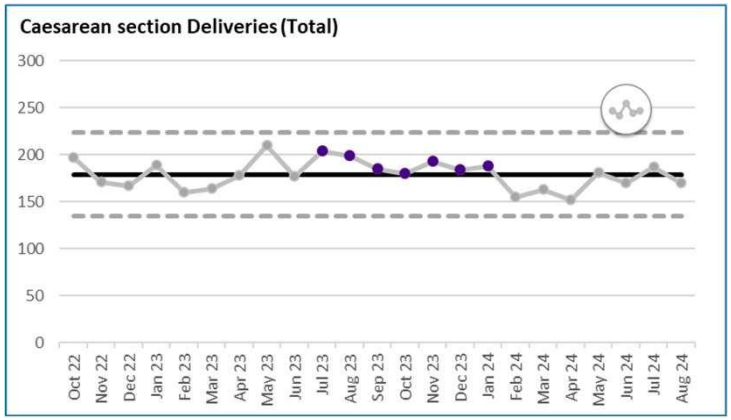
Stillbirths

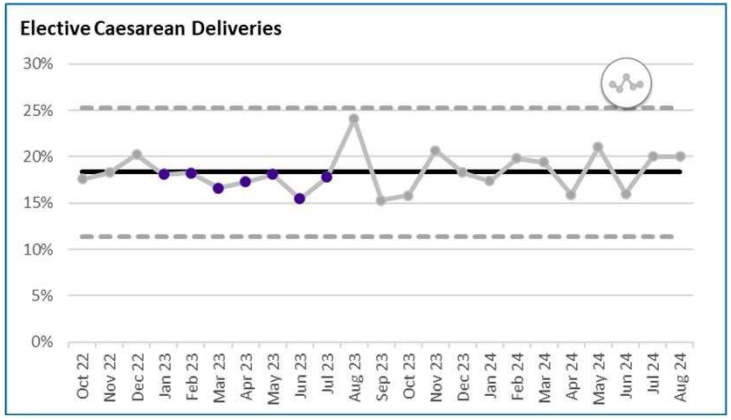
- Newcastle is a tertiary referral Fetal Medicine Unit, complex cases within the region are often referred here. This data includes termination for fetal anomalies > 24 weeks gestation. There were five stillbirths in August 2024, these cases will be reviewed through the Perinatal Mortality Review Tool (PMRT) process. No cases met the referral criteria for Maternity and Neonatal Safety Investigation (MNSI) review.

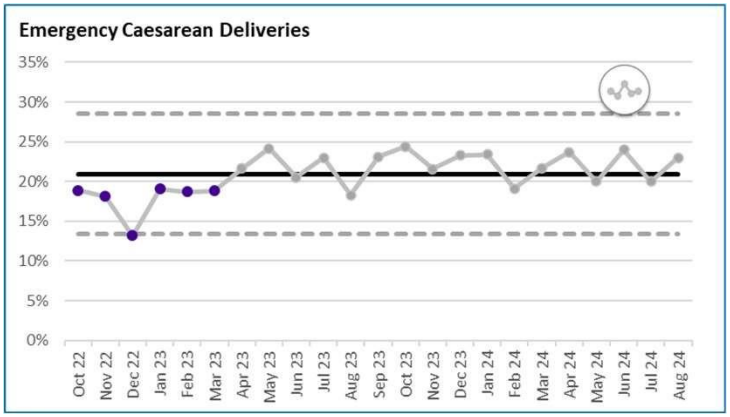
Early Neonatal Deaths

- 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. In August 2024 there were no term early neonatal deaths.

Perinatal Quality Surveillance: Deliveries







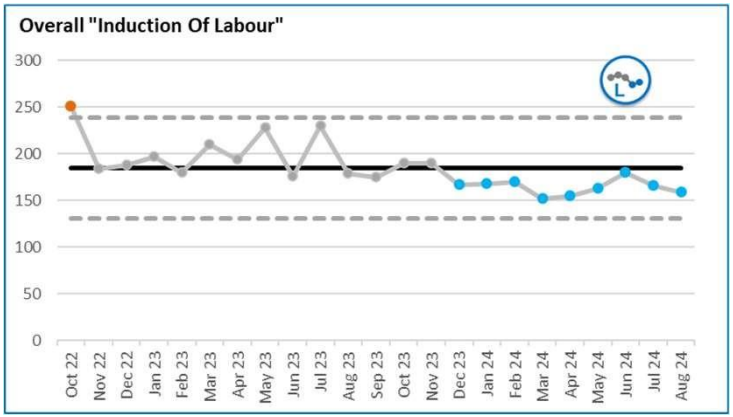
Elective Caesarean section

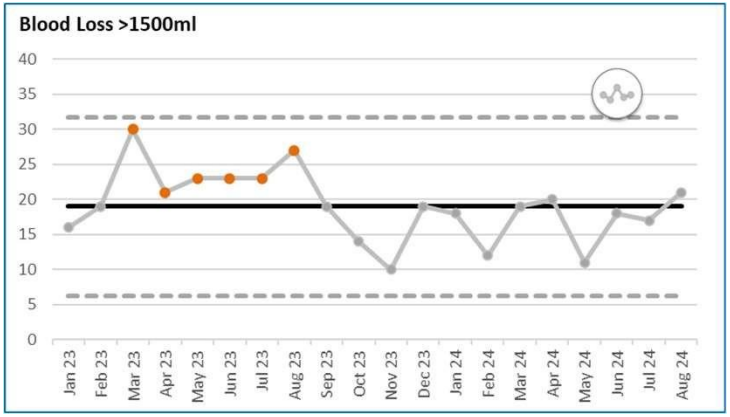
- There is no defined national metric for caesarean section rates although the World Health Organisation previously recommended that countries did not exceed 10-15%. This has now been abandoned as Trusts across England, Scotland and Wales have seen rates rise to about 30-35%.
- The rise is partially due to an increasing proportion being undertaken due to maternal request in accordance with the NICE guidance.
- The Trust has 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.

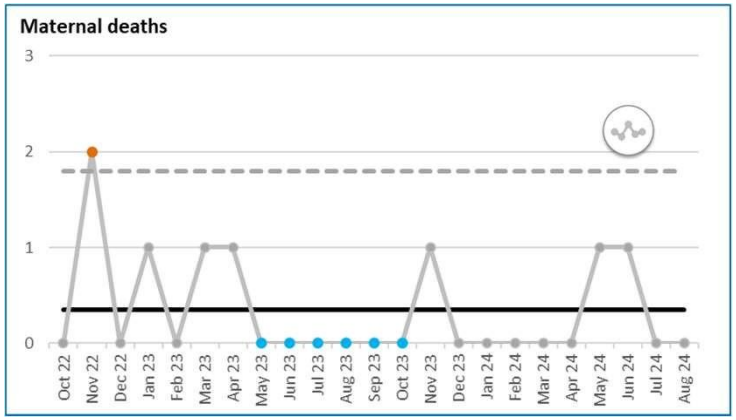
Emergency Caesarean section

- 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.

Perinatal Quality Surveillance: Labour







Induction of Labour

- The number of women being induced during pregnancy has increased due to changes in national guidelines. The evidence of the safety and effectiveness of Induction of Labour in improving outcomes has grown. Evidence suggests that inducing women in additional risk groups would improve outcomes and has driven a further increase in the induction rate, for example women with hypertension, diabetes in pregnancy and advanced maternal age.

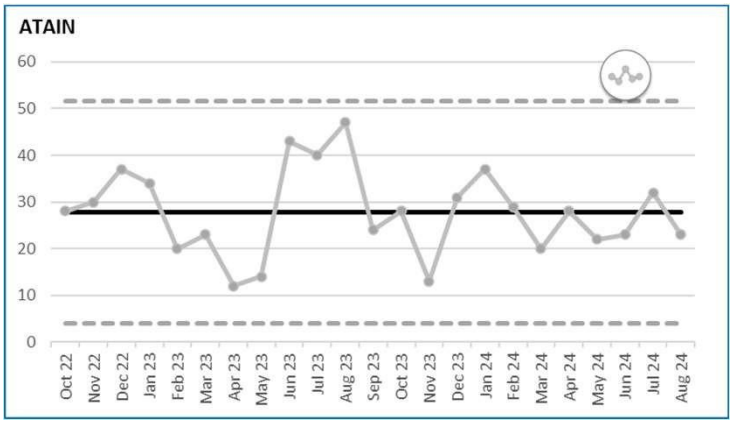
Blood Loss >1500ml

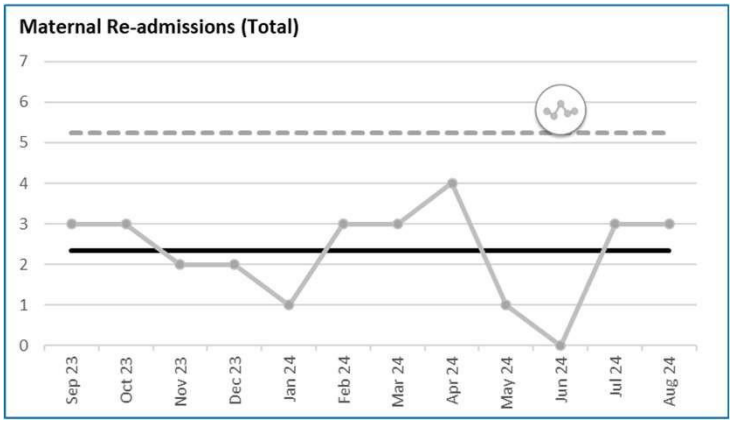
- In 2023 the Trust was highlighted as an outlier for Post Partum Haemorrhage, specifically for Caesarean section. A detailed review of cases over a 6-month period was undertaken. Recommendations made following the review provided additional assurance to the Trust that the management of women undergoing a PPH was appropriate. Minor changes were implemented. Of note the Trust delivers NENC high risk groups in view of the Maternal Medicine Centre and Fetal Medicine Unit based in Newcastle.

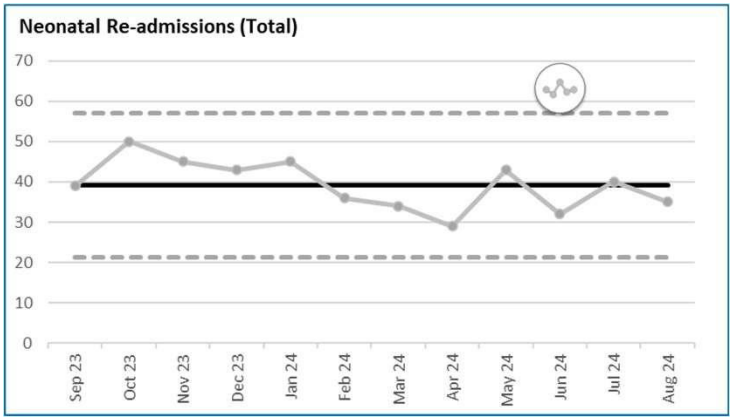
Maternal Deaths

- Maternal deaths are reported to MBRRACE-UK and an annual national report is provided. Early maternal deaths are 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 to 365 days of pregnancy. Direct deaths result 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. There have been no maternal deaths reported in August 2024.

Perinatal Quality Surveillance: Admissions







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 25 term admissions in July 2024. The Trust previously reviewed cases where admission time on NICU was >4hours, from July the Trust is now reviewing all admissions including those babies who required minimal intervention leading to a period of separation from the mother. 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.

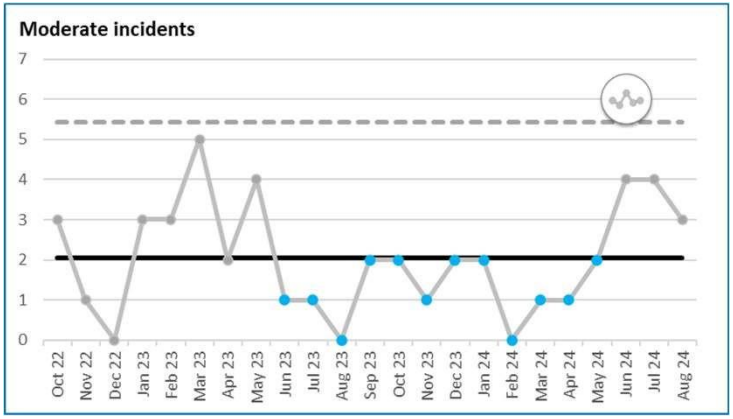
Maternal Readmissions

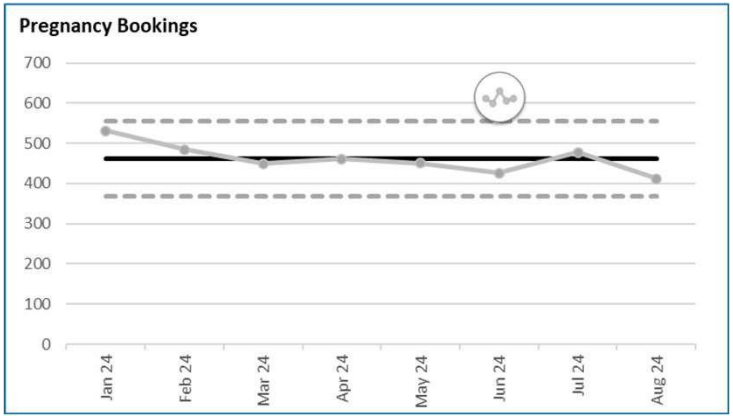
- This is a new metric, work in ongoing to benchmark performance with national parameters. From NMPA Report (2022) the maternal postnatal readmission rate for England was 3.3%, with rates being higher following c/s compared with vaginal birth (4.3% vs 2.9%).

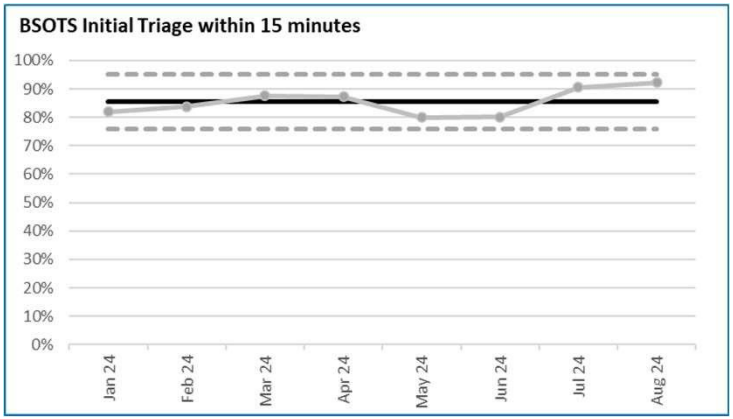
Neonatal Readmissions

- This is a new metric, work in ongoing to benchmark performance with national parameters. CQIM for ‘Babies readmitted to hospital who were under 30 days old’ and data is available for this indicator from March 2024- June 2024. The national rate for this period ranges from 5.3-5.5%,

Perinatal Quality Surveillance: Incidents, Bookings & Triage







Incidents

- There were three 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 was one MNSI referral. This case is awaiting triage from MNSI to determine whether it will be accepted for independent investigation.

Pregnancy Bookings

- The number of women choosing to book for care and delivery at the Trust has fallen steadily since January 2024. The Trust is aware that this decision has been influenced by the closure of the Newcastle Birthing Centre for low-risk women.

Birmingham Symptom Specific Obstetric Triage System (BSOTS)

- The Trust implemented the BSOTS triage system in January 2024. This is a new metric added to the Integrated Board report. Early audit data highlighted that the Trust was failing to meet the required triage target of women being triaged within 15 minutes of arrival to the Maternity Assessment Unit. There remains ongoing targeted work to improve on this with close monitoring of compliance.

Perinatal Quality Surveillance: Antenatal & NIPE Screening

Antenatal Screening

Quarter 4 2023/24	Infectious Diseases	FA2 20 week anomaly scan	FA3 T21,T18, T13 Screening	ST2 Timeliness of Antenatal Screening	ST3 Completion of FOQ	ST4a	ST4b	NB2 Avoidable NBBS repeats
Acceptable	>95%	>95%	Not set	>50%	>95%	TBC	TBC	<2%
Achievable	>99%	>99%	Not set	>75%	>99%	TBC	TBC	<1%
Q2	99.9%	98.5%		64.4%	97.9%	66.7%	33.3%	3.5%
Q3	100%	99.6%		63.6%	94%	-	50%	3.0%
Q4	99.6%	99.6%		65.6%	96.7%	66.7%	100%	2.5%

- 10 SIAF's noted in last 12 months caused by failure in the sonography booking process (2 to be reported)
- Support from Commissioner and Regional QA with Action Plan currently in place, not for QA inspection in 2024
- Recruitment in progress, all appointments expected to be in post September 2024

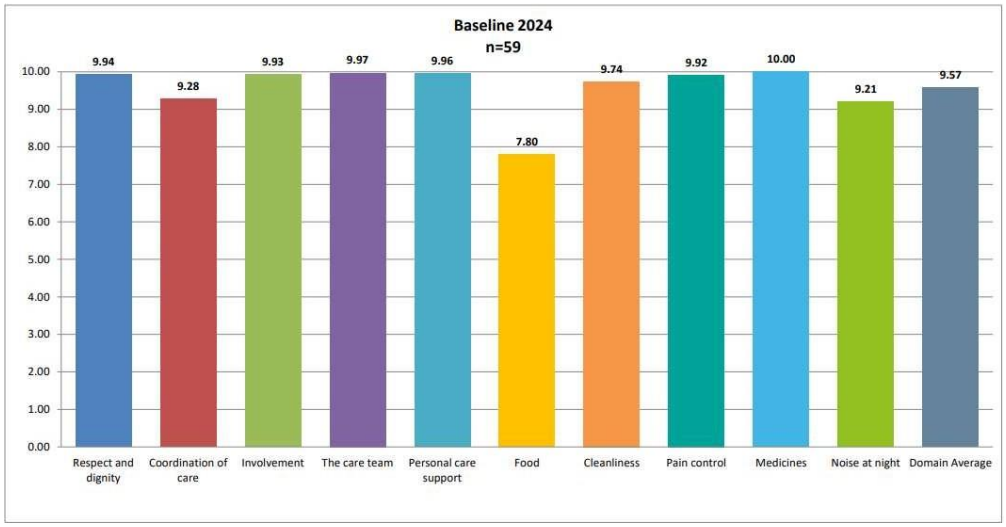
NIPE Screening

Quarter 4 2023/24	S01 – Percentage screen compliant <72 hours of age	S02 – Percentage eye abnormality suspected seen <14 days of examination	S03 – Percentage hip ultrasound scan (USS) attended between 4 and 6 weeks	S04 – Percentage of hip referral outcome decision made (<6 weeks corrected age)	S05 – Percentage suspected bi-lateral undescended testes seen <24 hours
Acceptable	95%	95%	90%	TBC	100%
Achievable	97.5%	100%	95%	TBC	-
Q2	92.9%	n/a	49.1%	56.5%	n/a
Q3	94.1%	n/a	67.3%	74.5%	100%
Q4	95.6%	n/a	74.5%	76.4%	100%

Perinatal Quality Surveillance: Patient Experience

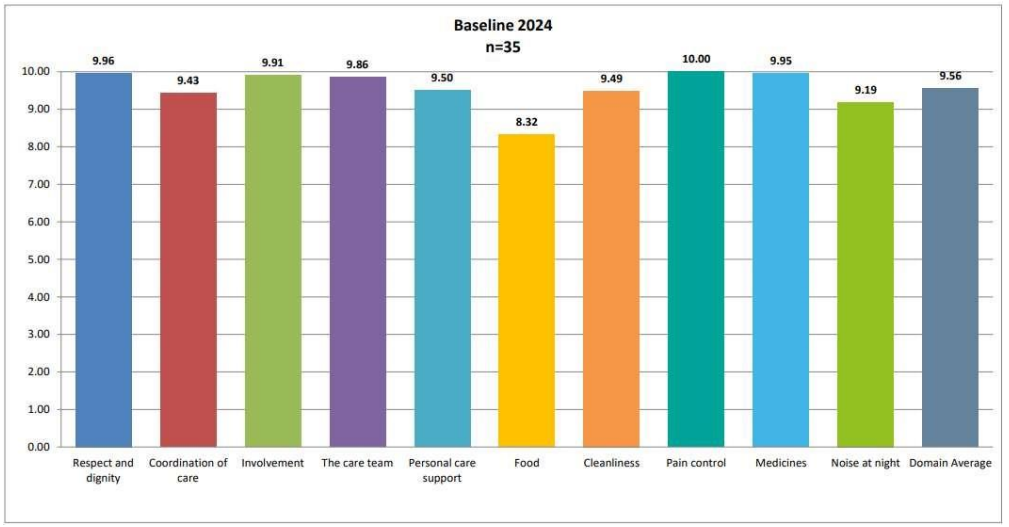
Ward 33, RVI June 2024 - August 2024

Patient Experience
Surveys and Reports



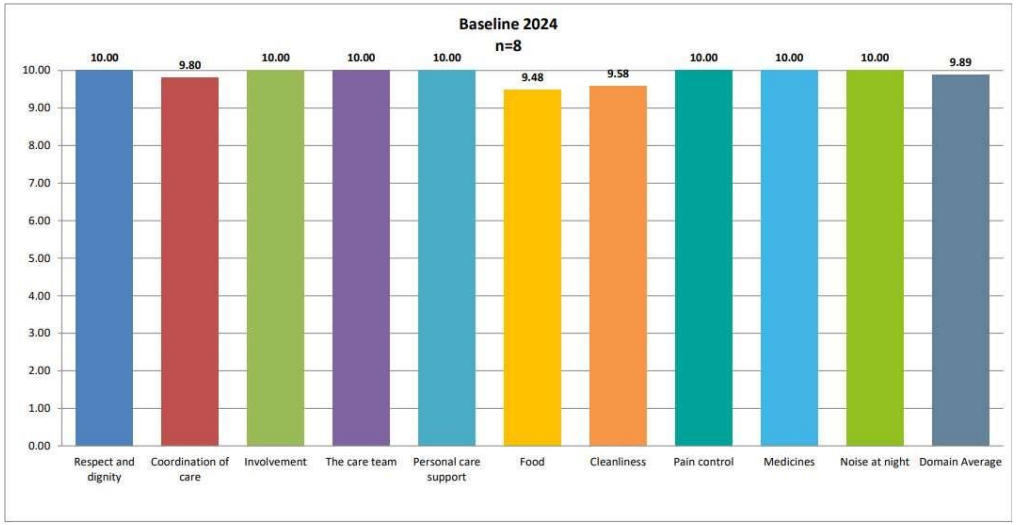
Ward 34, RVI June 2024 - August 2024

Patient Experience
Surveys and Reports



Delivery Suite, RVI June 2024 - August 2024

Patient Experience
Surveys and Reports



Ward Experience Surveys

- Positive feedback, quality improvement regarding meal provision on Ward 33 on going.

Patient Comments

'Everything has been fantastic throughout my stay. We had a little scare on the delivery suite when they lost the heartbeat. The anaesthetist could sense that we were panicking and helped put me at ease by explaining everything that was going on and what they were doing.'

'It has been a really nice experience. Every member of staff has been really helpful and efficient, they come really quickly if I press the buzzer.'

Performance

Performance Overview

Metric	Period	Actual	Target	Variation	Assurance
A&E Arrival to Admission / Discharge	Jul-24	75.5%	78%	L	?
A&E Trolley Waits	Jul-24	14	0		?
RTT 18 Weeks	Jul-24	68.7%	92%		F
>65 Week Waiters	Jul-24	222	0	L	F
Cancer 28 Day FDS	Jun-24	79.2%	77%		?
Cancer 62 Day	Jun-24	65.3%	70%	H	F
Diagnostic 6 Weeks	Jul-24	35.9%	5%	H	F

Emergency Care

- Type 1 and overall performance improved from the previous month to 61.1% (+3%) and 75.5% (+1.6%) respectively. 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.
- Trolley waits >12 hours reduced by more than half in July. (14 vs 37). The current configuration of the ED estate contributes to issues with flow and was not designed for the current volume of attendances.

Elective Waits

- The total waiting list (WL) size increased slightly to 102,763 overall, with RTT 18-week performance recorded at 68.7% (-0.2%).
- July saw slower progress in the reduction of >65 & >52 week waits at Newcastle Hospitals. The total number of patients waiting >78 weeks increased marginally to 18, with the number of patients waiting >65 weeks falling to 222 (-14).

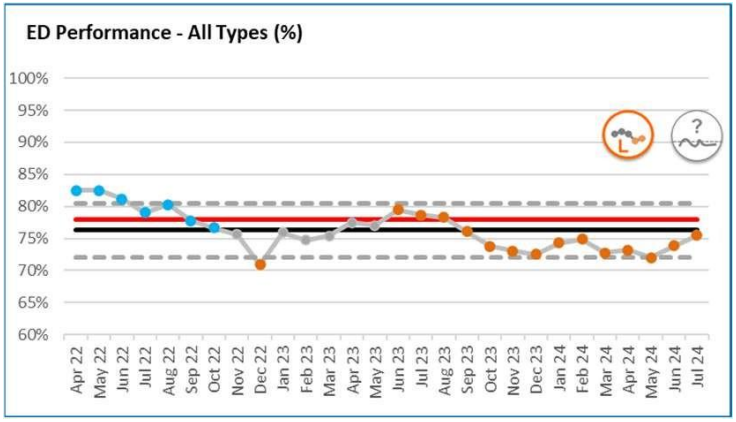
Cancer Care

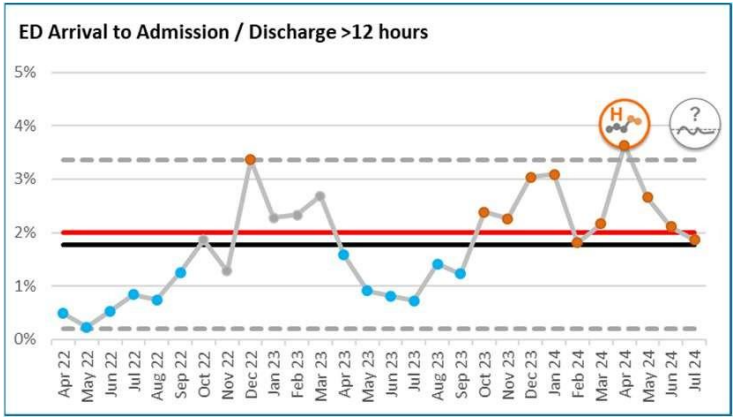
- The 77% 28 Day Faster Diagnosis Standard (FDS) was achieved for the fifth successive month (79.2%), despite performance dropping by 1.6%
- 62 Day compliance was 65.3% in June. Although this is below target, this is the highest compliance the Trust has achieved in recent years.

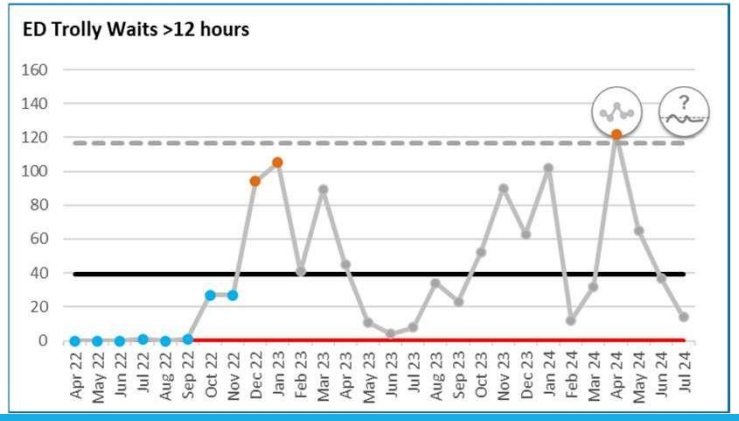
Diagnostics

- Performance against the 5% standard remained almost static with 35.9% of patients waiting longer than six weeks for their test (-0.1%). MRI continue to experience significantly high volumes of referrals compared to historic trends, as well as facing ongoing pressure to deliver prompt scans for patients on cancer pathways or that have experienced long elective waits. The increased complexity of scans required has also impacted performance.

Emergency Care







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.

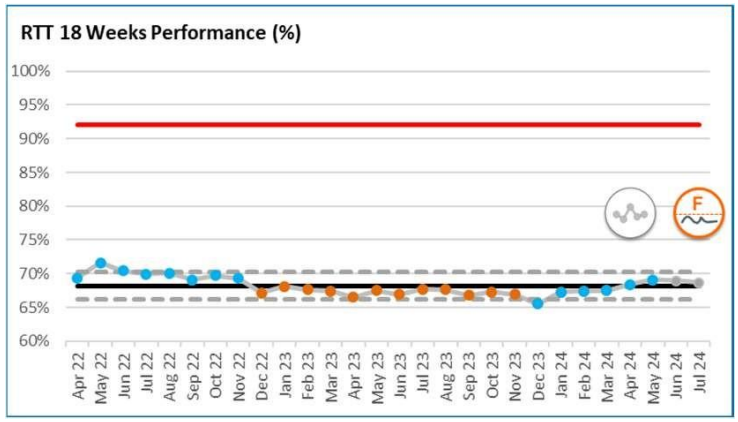
Current position:

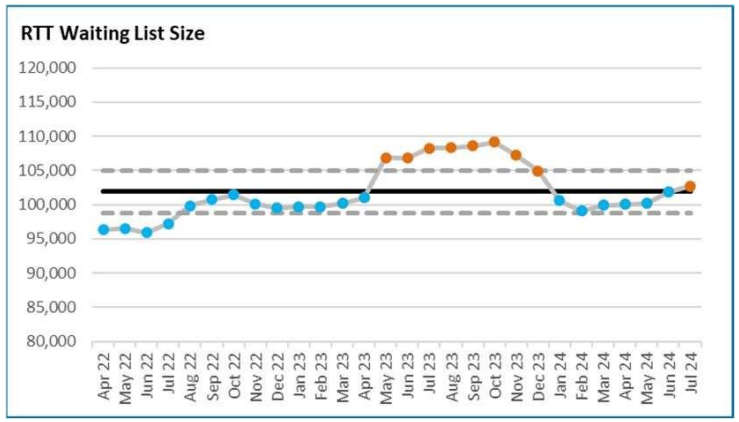
- Type 1 and overall performance improved from the previous month to 61.1% (+3%) and 75.5% (+1.6%) respectively. Waits to be seen by a clinician continue to be one of the primary delays in a patient's ED attendance due to a capacity and demand imbalance between the current workforce and volume of attendances. Exit blocks due to lack of bed availability further contribute to breaches and overcrowding.
- Furthermore, 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.
- Trolley waits >12 hours reduced by more than half in July. (14 vs 37). The current configuration of the ED estate contributes to issues with flow and was not designed for the current volume of attendances. Estate issues in the Assessment Suite are also causing challenges from a patient experience perspective.
- Handovers >60 minutes decreased with 47 in July compared to 73 in June. There were 392 handovers >30 mins.

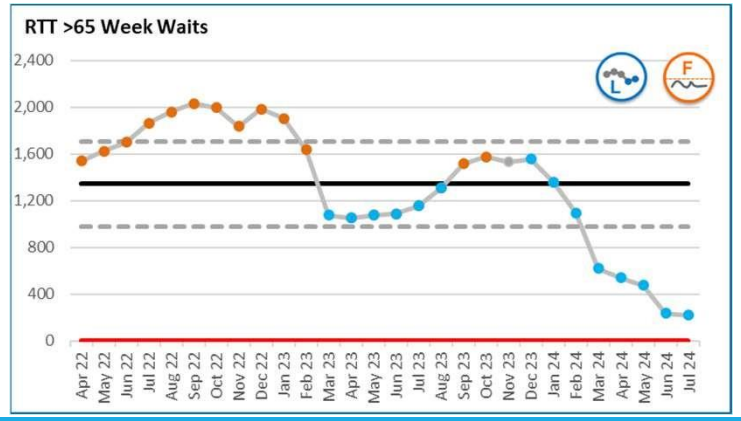
Action taken

- A workforce review has taken place and business case approved for additional medical staff to reduce waits to see a clinician.
- Several initiatives have been implemented to improve flow at front of house. These include a consultant "See and Treat" shift and a 'Golden Patient' initiative-that aims to safely discharge as many patients as possible before noon. A continuous flow model will also be trialled on medicine wards during the Perfect Week.
- 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 also taken place to review if any changes can be made in the short term to improve flow.
- Targeted work to increase ED waiting room checks - performance reached 96% in July.

Elective Waits







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).

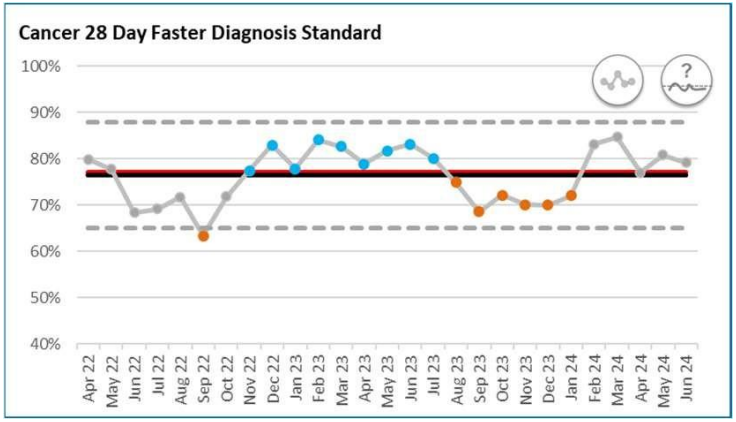
Current position:

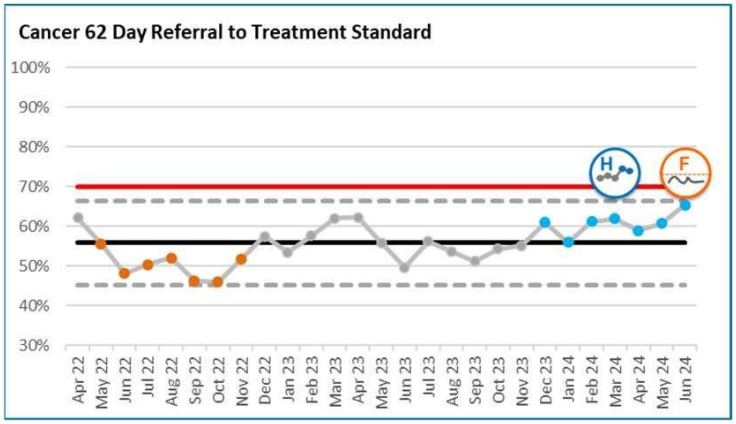
- July saw slower progress in the reduction of >65 & >52 week waits at Newcastle Hospitals. The total number of patients waiting >78 weeks increased marginally to 18 (compared to 15 in June) including 9 patients waiting for corneal graft surgery - for which there is a national tissue shortage. The total number of patients waiting >65 weeks fell to 222 (-14).
- Whilst considerable progress in the reduction of long waiters has been made in recent months – there are challenges that could impact the ambition of reaching zero patients waiting over 65 weeks by the end of September, including:
    - Limited capacity for MOHs surgery in Dermatology.
    - Consultant sickness in the specialist MESH service in Gynaecology.
    - The identification of non-RTT patients appropriate for conversion to an RTT pathway and resulting prioritisation of treatment for these patients.
- The total waiting list (WL) size increased slightly to 102,763 overall. The total number of patients waiting >18 weeks stood at 32,213, with RTT 18-week performance recorded at 68.7% (-0.2%).
- The inability to deliver a full elective care programme throughout the pandemic, persistent staffing gaps, and growth in demand for urgent care, as well as industrial action, have all contributed to an increased backlog of patients waiting to receive treatment.

Action taken

- 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.
    - More rigorous validation and application of the Trust's access policy.
    - Improved pooling of patients across the consultant teams in some specialties.

Cancer Care





62 Day Performance by Tumour Group – June 2024					
Brain	100%	Head & Neck	79.4%	Skin	87.9%
Breast	97.8%	Lower GI	28.8%	Testicular	N/A
Gynae	73.7%	Lung	48.3%	Upper GI	40.4%
Haem	93.2%	Sarcoma	85.7%	Urological	50.0%
Newcastle Hospitals Total					**65.3%**

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.

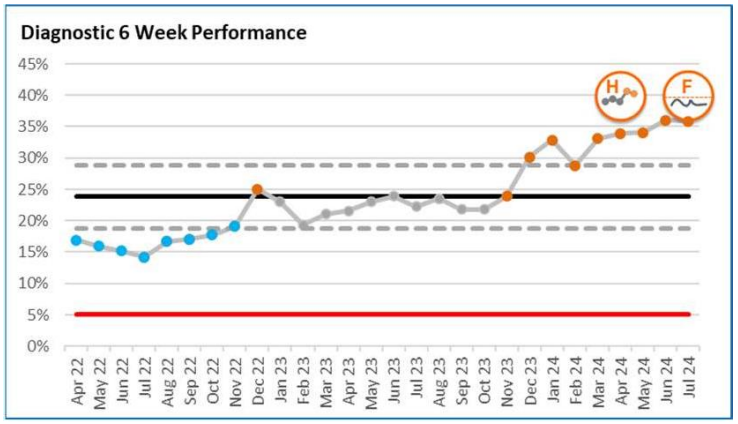
Current position:

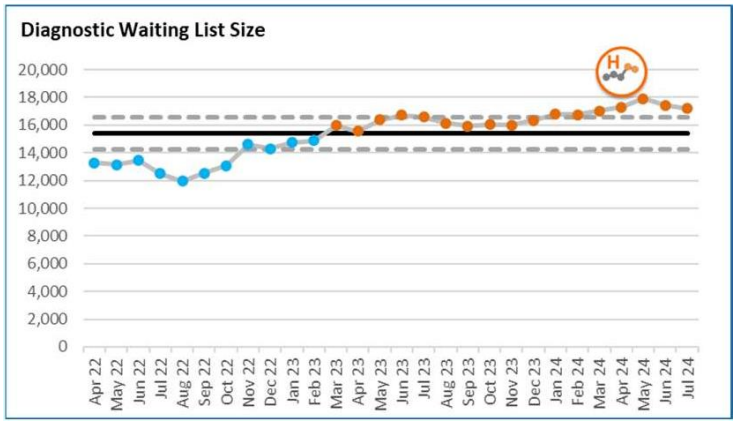
- The 77% 28 Day Faster Diagnosis Standard (FDS) was achieved for the fifth successive month (79.2%), despite performance dropping by 1.6% from May.
- 62 Day compliance was 65.3% in June. Although this is below target, this is the highest compliance the Trust has achieved in recent years. This was helped by improved 62 day performance in Breast, Haematology and Skin. However, Lower GI, Upper GI, Lung and Urological tumour groups all performed below 50%
- 31 Day performance improved to 90.6% in May but still fell short of the national target.
- Diagnostic delays remain within Pathology, Radiology and Endoscopy. Radiology are unable to meet the MRI request to report time of 10 days and CT request to report time of 7 days. MRI capacity is particularly impacting Urology and there have been delays for cystoscopies.
- Various tumour groups have limited theatre capacity due to staffing shortages and ongoing theatre refurbishments
- Workforce gaps are significantly impacting Gynae and Upper GI cancer performance

Action taken

- Mobile units for MRIs and PET CT scans have been extended to provide extra temporary capacity
- Head and Neck: The service are risk stratifying patients to ensure patients are seen in order of urgency.
- Gynae: New consultants starting at the beginning of September to ease staffing shortages
- Upper GI: 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.
- The refreshed monthly Quality & Performance Reviews for each Clinical Board are being used to monitor tumour group performance improvement trajectories and accompanying action plans, to deliver standards by the end of the financial year.

Diagnostics





6 Week Diagnostic Performance by Modality – July 2024			
MRI	42.2%	CT	11.9%
Non-obs US	3.9%	DEXA	14%
Audiology	77.8%	ECHO	12.3%
Electrophysiology	0%	Neurophysiology	50.6%
Sleep Studies	55.7%	Urodynamics	2.9%
Colonoscopy	20.7%	Flexi-Sig	36.3%
Cystoscopy	1.7%	Gastroscopy	30.8%
Newcastle Hospitals Total			**35.9%**

Standards

- <=5% of patients on incomplete diagnostic pathways waiting six weeks or longer.

Current position:

- Performance against the 5% standard remained almost static with 35.9% of patients waiting longer than six weeks for their test (-0.1%).
- MRI continue to experience significantly high volumes of referrals compared to historic trends across both inpatient and outpatient settings, as well as facing 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 increased complexity of scans required has also impacted performance.
- The volume of activity delivered per working day increased by 4.1%.
- The total WL size fell by 269 patients from the previous month, with the number of breaches falling by 112 patients. The volume of patients waiting >13 weeks grew by 66 to 3,010.
- Staffing deficits continue to constrain the volumes of activity several of our diagnostic services can undertake, particularly within Audiology.

Action taken

- A whole service review is being undertaken within Audiology, including ensuring that patients are being referred appropriately 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 initially, 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 maintained their performance in July despite reducing the use of insourcing to one company. Successful recruitment to posts at the CDC could allow for a further reduction of insourcing.
- Radiology continue to share use of the CT and MRI scanners at Blaydon CDC, as well as utilising three additional mobile units. Significant gains have been made through a dedicated improvement programme within main radiology booking and scheduling. The service is also implementing Dr Doctor to offer improved communication with patients.

Contractual & Planning Standards (1/2)

Theme	Standard	Apr-24	May-24	Jun-24	Jul-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%	100.5%	**96.3%**	**96.5%**	11,573	11,991	**98.4%**
Elective Overnight		97.6%	100.3%	**103.3%**	**95.2%**	1,841	1,933	**99.0%**
Outpatient New		98.2%	96.7%	**93.2%**	**92.7%**	25,933	27,978	**95.2%**
Outpatient Procedures		106.3%	103.7%	**108.3%**	**102.6%**	22,073	21,515	**105.1%**
Outpatient Review	**N/A**	115.2%	115.5%	**111.1%**	**109.3%**	66,521	60,869	**112.7%**
Non-Elective		104.0%	108.5%	**102.9%**	**105.2%**	6,314	6,001	**105.2%**
Emergency		80.7%	136.2%	**80.3%**	**75.2%**	817	1,086	**93.3%**
RTT 18 Week Wait	**92%**	68.4%	69.1%	**68.9%**	**68.7%**	70,550	102,763	**68.8%**
>78 Week Waiters	**Zero**	15	22	**15**	**18**	18		
>65 Week Waiters	**Zero** (by Sep-24)	541	476	**236**	**222**	222		
>52 Week Waiters	As per submitted trajectory	2,711	2,547	**2,357**	**2,499**	2,499		
RTT Waiting List Size	As per submitted trajectory	100,012	100,186	**101,810**	**102,763**	102,763		
Diagnostic Activity	**120%** of 19/20 activity	111.8%	113.5%	**111.7%**	**114.6%**	22,853	20,049	**112.5%**
Diagnostic 6 week wait	<=**5%** (local target of <=15%)	33.9%	34.1%	**36.0%**	**35.9%**	6,177	17,206	**35.0%**
Day case rates (BADS procedures)	**85%**	84.7%	84.4%	**TBC**	**TBC**			
Capped Theatre Utilisation	**85%**	77.1%	76.9%	**76.8%**	**74.1%**			
Urgent Ops. Cancelled Twice	**Zero**	0	0	**0**	**0**	0		**0**
Cancelled Ops. Rescheduled >28 Days	**Zero**	13	7	**9**	**3**	3		**32**
OP Activity Ratio: New/Procedure	**46%**	42.5%	**41.9%**	42.7%	**42.4%**	46,210	108,923	**42.0%**
>12 Week Waiters Validated	**90%**	61.2%	54.3%	**63.6%**	**70.2%**	22,674	32,306	**62.4%**
Outpatient Review Reduction	**25%** reduction vs 19/20 baseline	103.1%	108.7%	**107.8%**	**109.1%**	90,688	79,935	**107.2%**
PIFU Take-up (%)	>=**5%** of all OP atts. (by Mar-25)	1.9%	2.1%	**2.1%**	**2.2%**	2,671	122,810	**2.1%**

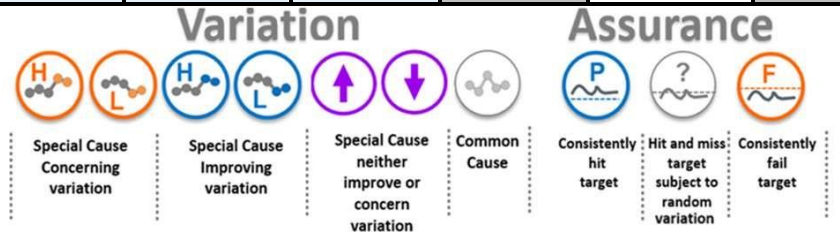
Contractual & Planning Standards (2/2)

Theme	Standard	Apr-24	May-24	Jun-24	Jul-24	Num.	Den.	24/25 YTD
Cancer Care								
28 Day Faster Diagnosis	**77%** (by Mar-25)	77.0%	80.8%	**79.2%**	TBC	2,090	2,640	**79.1%**
31 Days (DTT to Treatment)	**96%**	84.8%	90.5%	**90.6%**	TBC	1,098	1,212	**88.6%**
62 Days (Referral to Treatment)	**70%** (by Mar-25)	58.9%	60.6%	**65.3%**	TBC	238	364	**61.5%**
>62 Day Cancer Waiters		167	178	190	**170**	170		
Urgent & Emergency Care								
A&E Arrival to Admission/Discharge	**>=78%** under 4 hours (by Mar-25)	73.2%	72.0%	73.9%	**75.5%**	14,772	19,563	**73.6%**
	<=2% over 12 hours	3.6%	2.7%	2.1%	**1.9%**	364	19,563	**2.6%**
A&E Decision to Admit to Admission	**Zero** over 12 hours	122	65	37	**14**	14		**238**
Adult General & Acute Bed Occupancy	**<=92%**	91.0%	86.0%	80.2%	**87.3%**	1,253	1,435	**86.1%**
Ambulance Handovers <15 mins	**65%**	52.7%	53.6%	54.6%	**56.3%**	1,851	3,280	**54.3%**
Ambulance Handovers <30 mins	**95%**	86.9%	84.1%	84.2%	**86.6%**	2,884	3,280	**85.4%**
Ambulance Handovers >60 mins	**Zero**	54	89	73	**47**	47		**263**
Urgent Community Response Standard	**>=70%** under 2 hours	82.0%	78.0%	80.1%	**75.7%**	268	354	**79.0%**
Safe, High Quality Care								
Mixed Sex Acommodation Breach	**Zero**	112	102	**99**	**83**	83		**396**
VTE Risk Assessment	**95%**	**87.9%**			TBC			
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour	**57.0%**			TBC			
Sepsis Screening Treat. (All)		**61.0%**			TBC			

People

People Overview

Metric	Period	Actual	Target	Variation	Assurance
Sickness	Jul-24	5.42%	4.5%		F
Short-term	Jul-24	1.96%			
Long term	Jul-24	3.25%			
Turnover	Jul-24	10.11%	10%	L	F
Mandatory training	Jul-24	92.56%	90%		P
Appraisal	Jul-24	85.80%	90%	H	F
Disabled staff	Jul-24	5.36%		H	
Ethnicity (BAME staff)	Jul-24	16.79%		H	



(Data is for period **1 August 2023 to 31 July 2024** unless otherwise stated)

Sickness

- Total sickness absence increased from 5.35% to 5.42%, target 4.50%.
- Top 3 reasons for sickness: anxiety/stress/depression/other psychiatric (30%); cold/cough/flu (13%); other musculoskeletal problems (10%).
- Short-term sickness 1.96%.
- Long term sickness 3.25%.

Retention & Turnover

- Total turnover reducing since May 2023 to 10.11%; target 10%.
- Top reason for leaving work-life balance 18.3%.
- Top destinations on leaving: no employment 38.2% (half were accounted for by retirement, health and temporary contract); other NHS organisation 30.4% (includes retire-return).

Mandatory training and appraisal

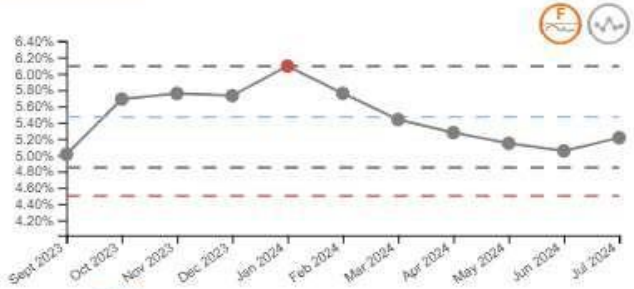
- Mandatory training compliance 92.56%, target 90%.
- Lowest compliance in medical and dental staff 76.69%.
- Paediatric Basic Life Support only mandatory training below 80% compliance.
- Appraisal compliance 85.80%, target 90%.

Equality & Diversity

- Disabled staff increased to 5.36%.
- BAME staff increased to 16.79%.

Sickness Absence

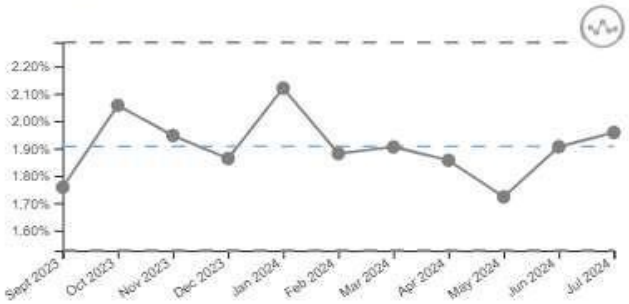
Trust Sickness %	12-Month Rolling	Value	Target
	Jul 24	5.47%	4.50%



Assurance: Consistently Fail Target

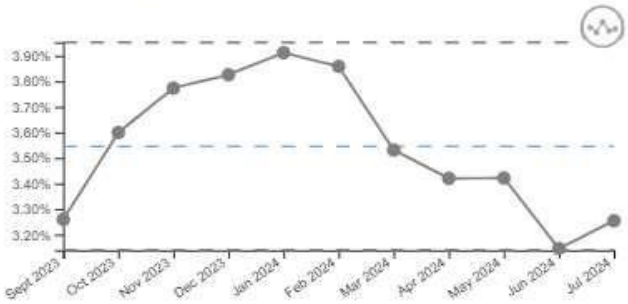
Variation: Common Cause Variation

Metric	Value
Short Term Sickness %	1.96%



Variation: Common Cause Variation

Metric	Value
Long Term Sickness %	3.25%



Variation: Special Cause Improving Variation

Current Position:

- 12-month average to July is 5.42%.
- July total sickness: 5.22%; short-term 1.96%; long-term 3.25%.
- Top three reasons for sickness:
  - Anxiety/stress/depression/other psychiatric (30.24%)
  - Cold, Cough, Flu – Influenza (13.12%)
  - Other musculoskeletal problems (9.73%)

Underlying Issues

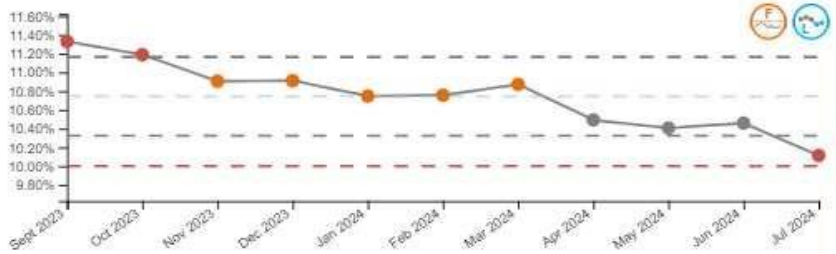
- Overall increase in absence due to **Anxiety/stress/ depression/other psychiatric** and **Cold, Cough, Flu – Influenza**.
- Estates has highest sickness rate 7.22%, causes mainly **Anxiety/stress/depression/other psychiatric** and **Other musculoskeletal problems** - both show increasing trend.

Actions Undertaken:

- Target: benchmarked with Trusts in NENC and Shelford and changed from 3% to 4.5% in July.
- Audit: report on absence management in June rated compliance with HAWB policy as 'Reasonable', action plan in place to address recommendations.
- HAWB offer: access refreshed and improved from June.
- Gap analysis: in process to enhance HAWB offer.
- Helping Hands: extended until end of March 2025.
- Menopause: guidance being developed.
- Policy: under review.
- Warning letters: reviewed and changed.
- Psychological Support Officer: business case in development.

Turnover

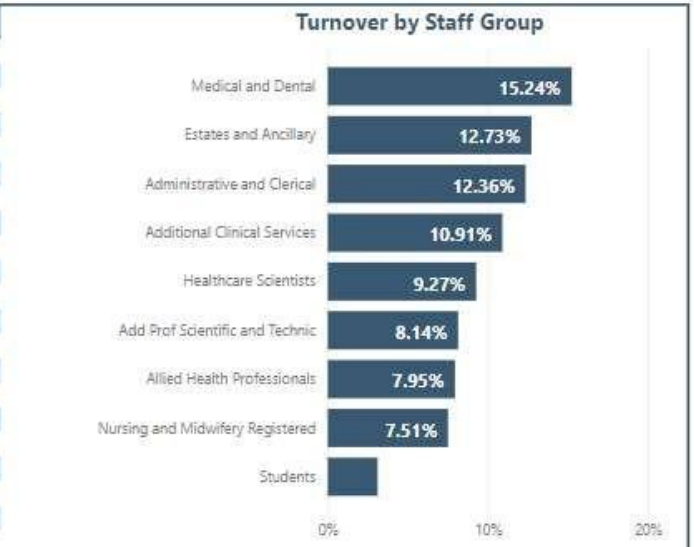
Trust Turnover %	12-Month Rolling	Value	Target
	Jul 24	10.11%	10.00%



Assurance: Consistently Fail Target

Variation: Common Cause Improving Variation

Org L4	Turnover %
CS Chief Operating Officer	39.67%
CS Chief Executive	15.77%
CS Information Management and Technology	13.40%
CS Estates	13.13%
CS Human Resources	11.83%
CS Regional Drugs and Therapeutics	11.46%
CB Family Health	10.89%
CB Cancer and Haematology	10.65%
CS Finance	10.55%
CS Medical Director	10.34%
CB Cardiothoracic Services	10.24%
CB Surgical and Specialist Services RVI	10.06%
CB Clinical and Research Services	9.97%
CS Supplies	9.51%
CB Surgical and Associated Services FH	9.28%
CS Patient Services	9.03%
CB Medicine and Emergency Care	8.55%
CS Hosted Staff	8.39%
CB Peri-operative and Critical Care	7.90%
CS CRN NENC	6.99%
CS Business Development	0.00%



Current Position:

- 12-month average to July is 5.42%.
- Chart shows performance is not meeting the target but continuing to improve.
- July 2024 shows a reduction of 0.34% from June which is illustrated by a positive outlier flag (red dot).
- Turnover in M&D (15.24%) includes Trust employed Junior Doctors on a fixed-term contract.

Underlying Issues

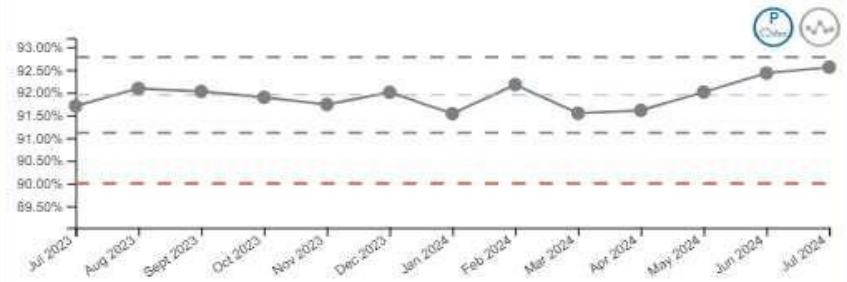
- 1,637 leavers in 12-months to July 2024: **Nursing/ Midwifery** (396) and **Admin and Clerical** (326) accounted for 44% of all leavers.
- Top destinations on leaving: **No Employment** (626, 38.24%); **Other NHS organisation** (498, 30.42%).
- Top reasons for leaving: **Work life Balance** (299, 18.27%), **Relocation** (208, 12.71%); **Retirement Age** (202, 12.34%)

Actions Undertaken:

- Target: benchmarked with Trusts in NENC and Shelford and changed from 8% to 10% in July.
- Audit: advisory report received in June, action plan in place to address recommendations. Turnover data now part of performance management framework with Clinical Boards.
- Flexible working: offer in place and encouraged.
- Exit process: under review.
- 'Stay conversations': being explored.

Mandatory Training

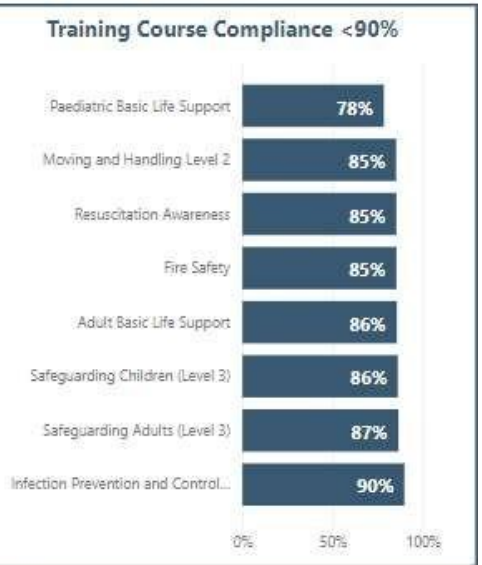
Mandatory Training Compliance	Month	Value	Target
	Jul 24	92.56%	90.00%



Assurance: Consistently Hit Target

Variation: Common Cause Variation

CB/CS	Compliance	Yes	No	Grand Total
CS Hosted Staff	76.87%	309	93	402
CB Family Health	90.83%	24,550	2,480	27,030
CB Cardiothoracic Services	91.06%	11,464	1,126	12,590
CS Estates	91.14%	14,004	1,361	15,365
CS Supplies	91.43%	971	91	1,062
CB Medicine and Emergency Care	91.96%	19,251	1,684	20,935
CS Finance	92.15%	1,221	104	1,325
CB Surgical and Specialist Services RVI	92.17%	15,305	1,300	16,605
CB Cancer and Haematology	93.20%	6,678	487	7,165
CS CRN NENC	93.42%	724	51	775
CB Clinical and Research Services	93.56%	36,193	2,490	38,683
CS Chief Operating Officer	93.75%	90	6	96
CB Peri-operative and Critical Care	93.79%	15,786	1,045	16,831
CB Surgical and Associated Services FH	93.89%	11,103	722	11,825
CS Patient Services	94.80%	2,426	133	2,559
CS Chief Executive	94.90%	633	34	667
CS Medical Director	95.39%	455	22	477
CS Information Management and Technology	96.28%	3,314	128	3,442
CS Business Development	96.34%	421	16	437
CS Regional Drugs and Therapeutics	96.62%	400	14	414
CS Human Resources	97.38%	2,529	68	2,597



Current Position:

- Chart shows improvement in this metric with target consistently hit.

Underlying Issues

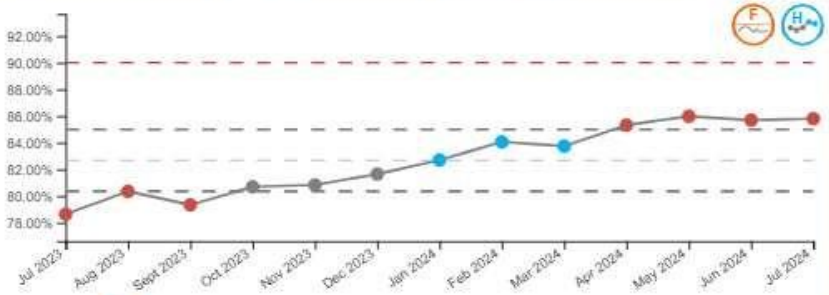
- Medical and Dental staff currently have the lowest compliance rate 84.68% with low compliance in **Resuscitation Awareness** (68.17%), **Fire Safety** (74.96%); **Paediatric Life support** (76.40%).
- Total **Paediatric Life Support** compliance is a concern at 78% for July 2024.

Actions Undertaken:

- Target: benchmarked with Trusts in NENC and Shelford and changed from 95% to 90% in July.
- Automated system of email reminders and escalation route via managers in place in areas of low compliance.
- Compliance now linked for Medical & Dental to Local Clinical Excellence Awards.
- Subject areas below target are subject to a focussed improvement project.
- Additional staffing capacity identified for Resus.
- Fire Safety is under national review.

Appraisal Compliance

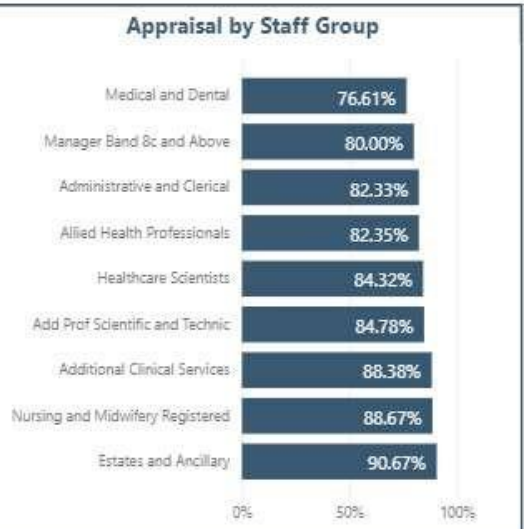
Appraisal Compliance	Month	Value	Target
	Jul 24	85.80%	90.00%



Assurance: Consistently Fail Target

Variation: Common Cause Improving Variation

CB/CS	Compliance	Yes	No	Grand Total
CS Chief Operating Officer	33.33%	2	4	6
CS Finance	67.37%	64	31	95
CS Supplies	74.16%	66	23	89
CS Business Development	80.56%	29	7	36
CB Cardiothoracic Services	81.70%	732	164	896
CB Surgical and Specialist Services RVI	82.40%	1,011	216	1,227
CB Clinical and Research Services	83.12%	2,383	484	2,867
CS Patient Services	83.50%	167	33	200
CB Cancer and Haematology	83.78%	439	85	524
CS Information Management and Technology	84.27%	209	39	248
CS Chief Executive	85.00%	51	9	60
CS Human Resources	85.35%	169	29	198
CS Medical Director	86.11%	31	5	36
CB Surgical and Associated Services FH	87.17%	768	113	881
CB Family Health	88.65%	1,711	219	1,930
CB Medicine and Emergency Care	89.02%	1,354	167	1,521
CS Estates	89.25%	1,005	121	1,126
CB Peri-operative and Critical Care	89.49%	1,116	131	1,247
CS Regional Drugs and Therapeutics	91.43%	32	3	35
CS CRN NENC	96.83%	61	2	63



Current Position:

- Chart shows performance is not meeting the target but continuing to improve.
- April-July 2024 shows consistent performance illustrated by a positive outlier flags (red dots).

Underlying Issues

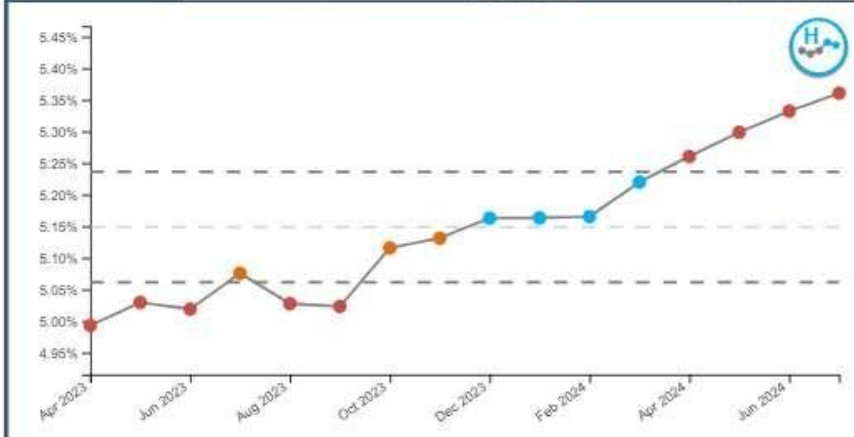
- Overall, there are 1,905 appraisals overdue
- Top two staff group outliers:
  - Nursing and Midwifery (498)
  - Admin and Clerical (386)
- Top Clinical Board outlier is Clinical and Research Services with 484 overdue: **AHPs** 138 – **Therapy Services** (87), **Radiology** (49), **Clinical Research** (2).

Actions Undertaken:

- Target: benchmarked with Trusts in NENC and Shelford and changed from 95% to 90% in July.
- Audit: report in August rated compliance with policy as ‘Reasonable’, action plan in place to address recommendations.
- Policy: new approach and documentation in pilot in 3 areas (Family Health, Pharmacy, HR) as part of a programme for improvement.

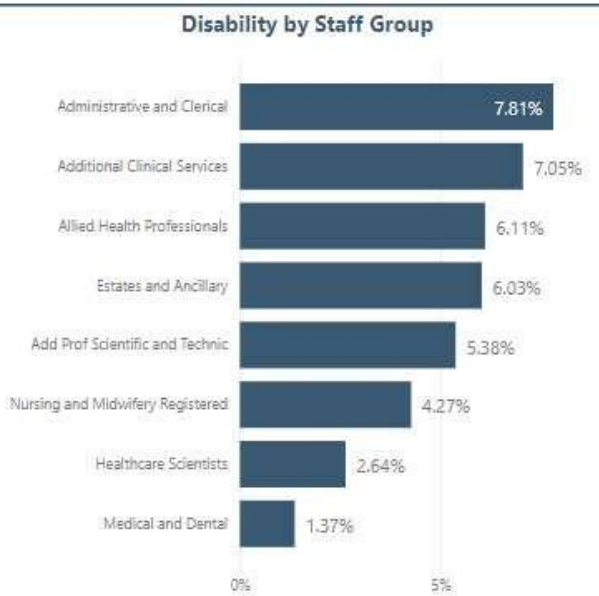
Equality, diversity and Inclusion (EDI) - Disability

EDI - Disability	Month	Value	Trust Headcount
	Jul 24	5.36%	16,192

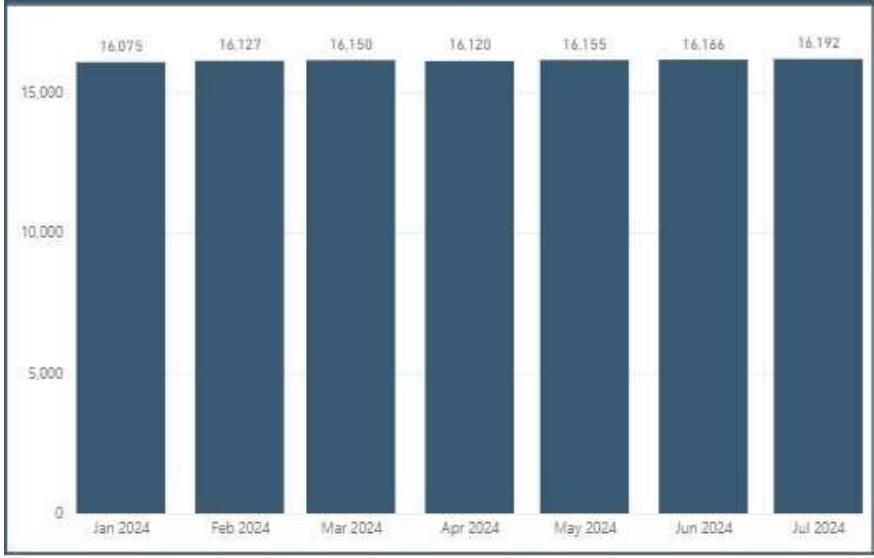


Variation: Common Cause Improving Variation

CB/CS	Disability %
CS Chief Operating Officer	25.00%
CS Medical Director	11.90%
CS CRN NENC	11.27%
CS Supplies	9.38%
CS Information Management and Technology	9.35%
CS Business Development	8.33%
CS Chief Executive	7.58%
CS Human Resources	7.05%
CS Finance	6.78%
CB Clinical and Research Services	6.53%
CS Regional Drugs and Therapeutics	5.71%
CS Patient Services	5.65%
CB Family Health	5.52%
CS Estates	5.42%
CB Cardiothoracic Services	4.75%
CB Cancer and Haematology	4.55%
CB Surgical and Associated Services FH	4.52%
CB Peri-operative and Critical Care	4.46%
CB Medicine and Emergency Care	4.19%
CB Surgical and Specialist Services RVI	3.88%



Trust Headcount Trend



Age Band

	Age Band	Disability %
1	<=20 Years	11.48%
2	21-25	10.42%
3	26-30	6.51%
4	31-35	5.71%
5	36-40	3.94%
6	41-45	4.58%
7	46-50	3.90%
8	51-55	4.48%
9	56-60	5.45%
10	61-65	4.63%
11	66-70	2.80%
12	>=71 Years	3.45%

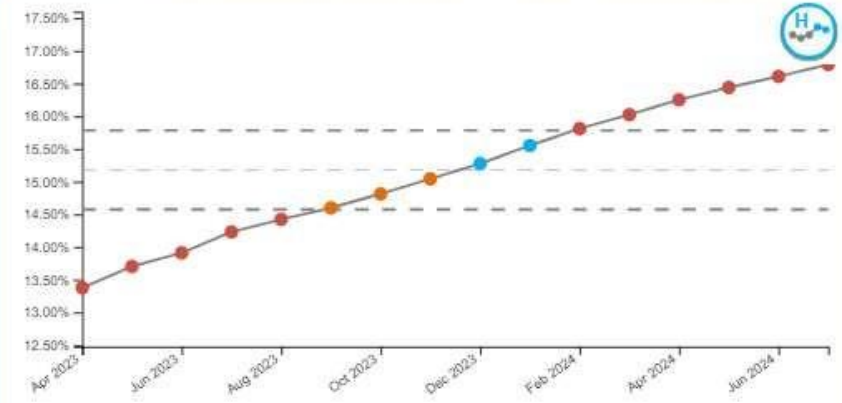
Current Position:

Charts show the percentage of staff in post each month by those disclosing a disability.

Percentage of staff employed disclosing a disability continues to demonstrate a month-on-month increase with the latest reporting period increasing to 5.36%.

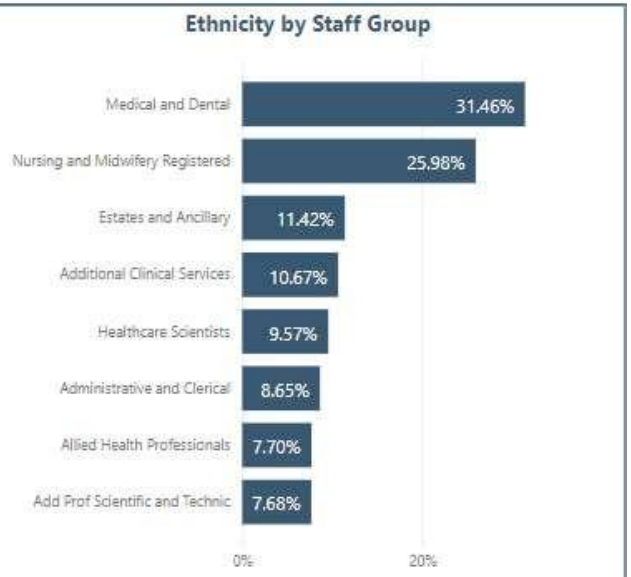
Equality, diversity and Inclusion (EDI) - Ethnicity

EDI - Ethnicity	Month	Value	Trust Headcount
	Jul 24	16.79%	16,192

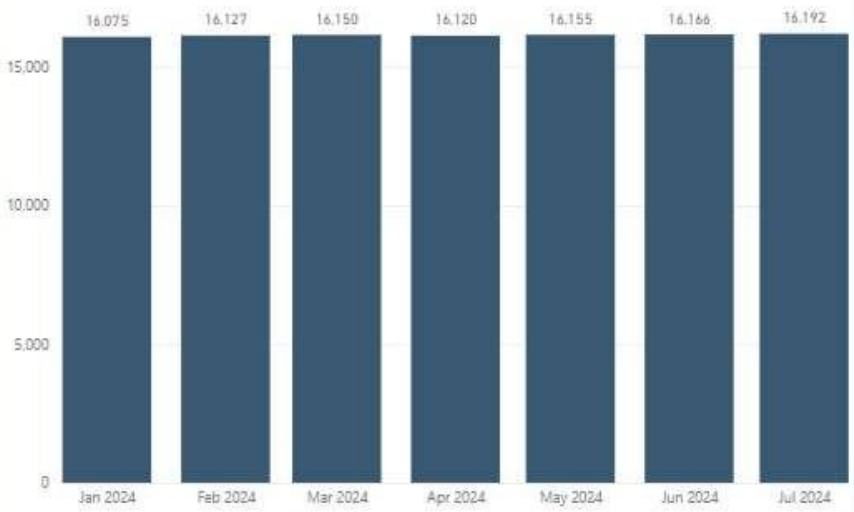


Variation: Common Cause Improving Variation

CB/CS	BME %
CB Peri-operative and Critical Care	28.65%
CB Surgical and Associated Services FH	27.56%
CB Cardiothoracic Services	27.15%
CB Medicine and Emergency Care	24.51%
CB Surgical and Specialist Services RVI	17.46%
CS Regional Drugs and Therapeutics	17.14%
CS Information Management and Technology	16.13%
CB Cancer and Haematology	14.76%
CS Integrated Covid Hub North East	14.29%
CS Estates	11.49%
CS Human Resources	11.45%
CS Finance	11.02%
CB Family Health	10.39%
CB Clinical and Research Services	10.03%
CS CRN NENC	8.45%
CS Medical Director	7.14%
CS Patient Services	6.96%
CS Business Development	2.78%
CS Chief Executive	1.52%
CS Supplies	1.04%



Trust Headcount Trend



Age Band

	Age Band	BME %
1	<=20 Years	11.48%
2	21-25	21.69%
3	26-30	22.10%
4	31-35	23.78%
5	36-40	19.53%
6	41-45	13.69%
7	46-50	20.20%
8	51-55	15.13%
9	56-60	7.07%
10	61-65	4.46%
11	66-70	5.14%
12	>=71 Years	1.72%

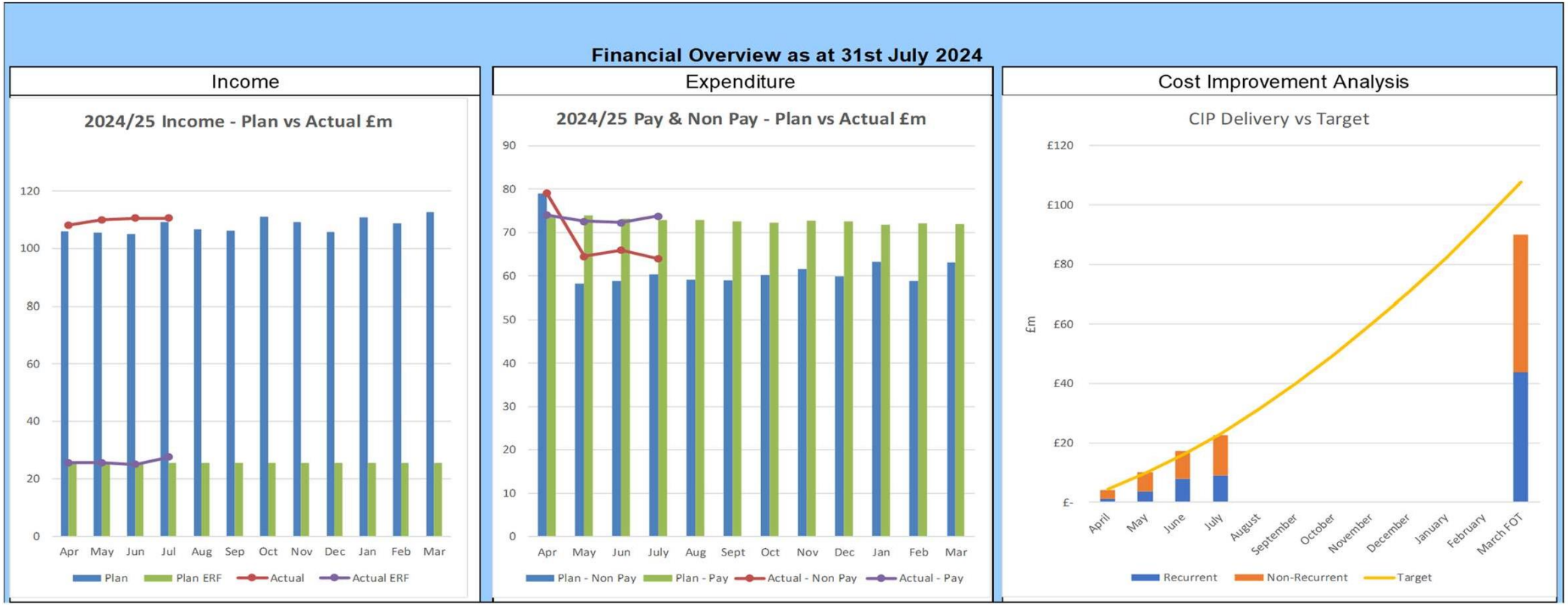
Current Position:

Charts show the percentage of staff in post each month by ethnicity (BAME).

Percentage of BAME staff continues to demonstrate a month-on-month increase with the latest position reflecting BAME staff at 16.79% of the workforce.

Finance

Overall Finance Position (1/4)



This page summarises the financial position of the Trust for the period ending 31st July 2024. The Trust has agreed a Financial Plan for 2024/25 with a break-even position. As at Month 4 the Trust is reporting an overspend of £1.4 million against the planned deficit of £5.2 million (after Control Total). This variance relates to the additional cost of the Junior Doctors Strike. 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 includes a number of non-recurrent factors.

Capital Expenditure - The Plan for July is £5.6 million and the year to date expenditure is £6.4 million creating a variance of £0.8 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

Overall Finance Position (2/4)

	In Month (July 2024)			Year To Date (July)		
	Plan	Actual	Variance	Plan	Actual	Variance
Income & Expenditure Statement	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
NHS Commissioner Income	117,099	119,191	2,092	457,331	464,201	6,869
Other Patient Care - & Non NHS	2,271	2,785	514	10,013	12,461	2,448
Non Patient Care - Other Income	15,266	15,958	693	60,085	65,723	5,638
TOTAL OPERATING INCOME (WITHIN EBITDA)	**134,635**	**137,935**	**3,299**	**527,430**	**542,385**	**14,955**
Employee expenses	72,920	73,775	855	293,525	292,632	(893)
Drugs	22,947	24,691	1,744	91,672	100,311	8,639
Supplies & Services Clinical	13,472	14,740	1,268	54,446	57,768	3,322
Operating expenses excl. employee expenses	16,664	19,533	2,869	66,872	75,990	9,118
TOTAL OPERATING EXPENSES (WITHIN EBITDA)	**126,003**	**132,740**	**6,737**	**506,515**	**526,701**	**20,186**
NET FINANCE COSTS	**5,457**	**4,422**	**(1,035)**	**41,445**	**33,654**	**(7,791)**
OPERATING SURPLUS/(DEFICIT)	**3,175**	**773**	**(2,402)**	**(20,530)**	**(17,970)**	**2,560**
Control Total & IFRS16 PFI Adjustments	**2,387**	**604**	**(1,783)**	**(15,319)**	**(11,360)**	**3,959**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR - CONTROL TOTAL	**788**	**169**	**(619)**	**(5,211)**	**(6,610)**	**(1,398)**

The reported performance for July 2024 is as follows:-

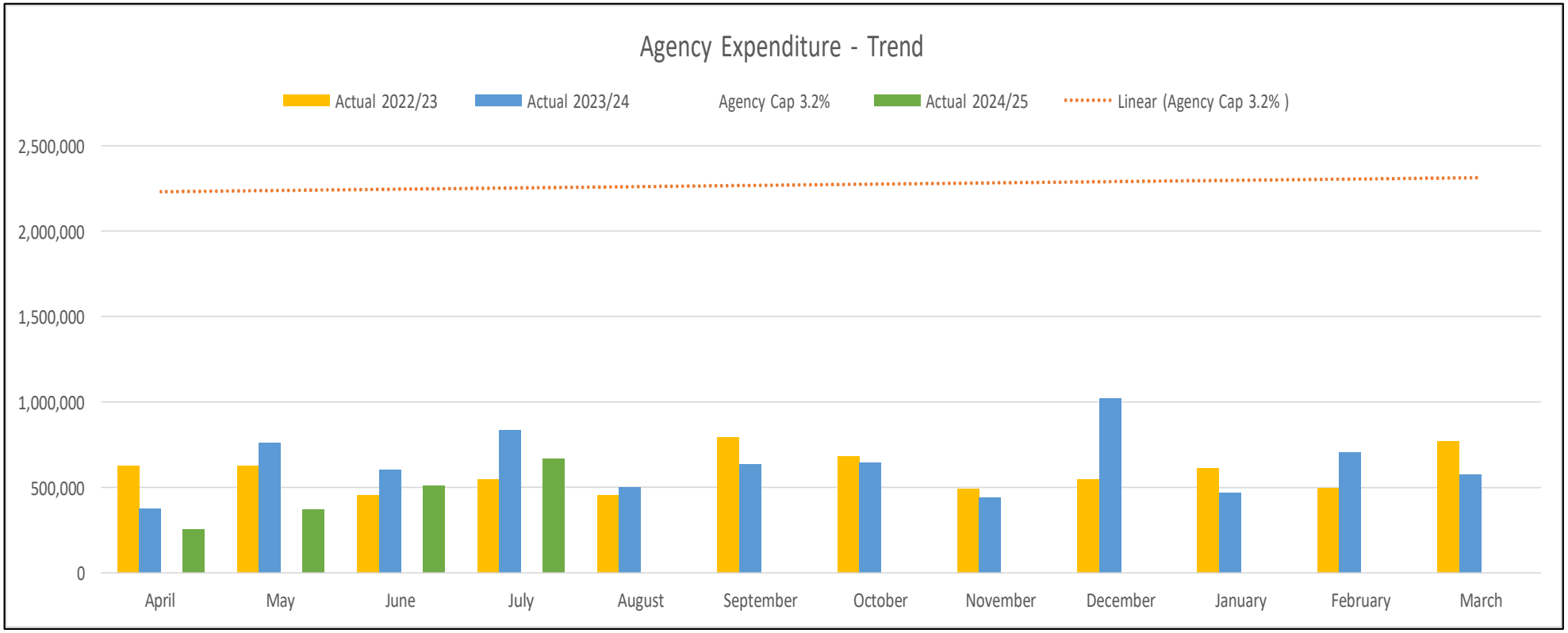
Income

- The in-month position is an overall favourable variance of £3,299k partly due to over-performance on matched drugs and devices and an over achievement on Non-recurrent income CIP. ERF income is on plan despite the impact of industrial action.

Expenditure

- Pay costs are £0.9m under plan at month 4 and include the costs associated with industrial action. Total operating expenditure is £20.1m above plan due to increased costs relating to drugs and clinical supplies (including circa £4.7m that is matched with income) and unachieved CIP (£5.3m behind on expenditure).

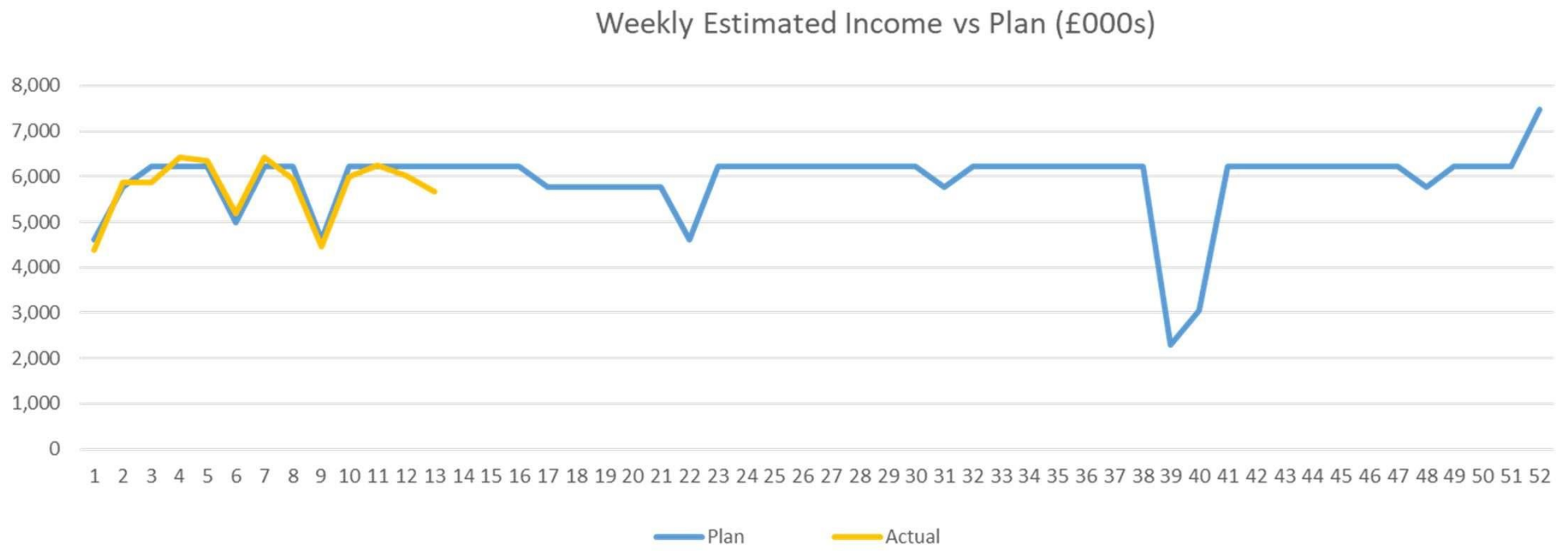
Overall Finance Position (3/4)



Agency

- This shows the overall trend in agency usage over the last two years. This is running at around 0.5% of the gross staff costs. This is below the national target set at 3.2%. Although this is positive compared with the national target, 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, with a further increase in July (Month 4) compared to previous months.

Overall Finance 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 13, total delivery is £1,151k away from the agreed plan (on the basis of the weekly model), 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.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Health Inequalities

Healthcare at its best
with people at our heart

Health Inequalities Overview: Emergency Admissions

- The NHSE Statement on Information on Health Inequalities (duty under section 13SA of the NHS Act 2006) requires trusts to report and publish in their annual report key metrics such as emergency admissions for under 18s disaggregated by age, sex, ethnicity and deprivation.
- Across England, the increase seen is driven by a sharp rise in emergency admissions for those aged 85 years or older and those with complex needs and multiple morbidities, the latter disproportionately overrepresented in patients living in areas of socioeconomic deprivation (Core 20).
- There is evidence that nearly half of emergency admissions result from socioeconomic inequalities (i.e. preventable emergency admissions would be nearly halved if everyone has the same rate of A&E admissions as patients living in the least deprived areas).
- One of the key aims of the NHS Long Term Plan is to encourage different emergency pathways and models of care outside hospital to reduce avoidable emergency attendance and admissions and length of hospital stay while improving patient outcome.
- A better understanding of the trust's baseline data for emergency hospital admissions - mainly patient flows and the demographic profile and comparing them to those for elective admissions and the catchment population - enables a data driven equitable approach to reducing emergency hospital demand.
- The data sources used for this section include when mentioned OHID data on Trust catchment population – and in all other cases refers to extracts from the inpatient CDS. For Trust data comparison is made between 2019/20 (before the COVID Pandemic) and 2023/24.

Table 1 – Admissions by type – Local Authority to Newcastle Hospitals

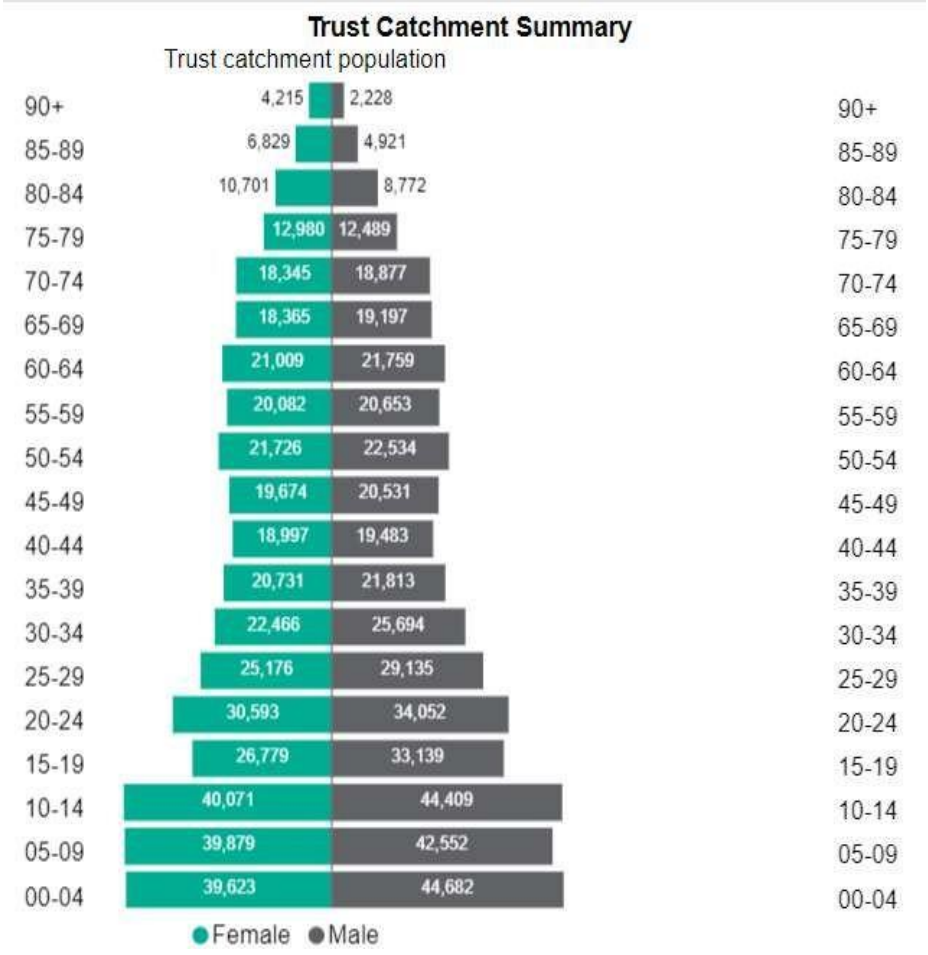
Local Authority	All		Elective		Emergency	
	2019/20	2023/24	2019/20	2023/24	2019/20	2023/24
Newcastle	38.8%	37.7%	30.5%	29.3%	56.1%	54.4%
Northumberland	14.2%	14.9%	16.8%	16.1%	10.1%	13.5%
North Tyneside	13.2%	12.1%	13.9%	12.5%	11.2%	11.4%
Gateshead	9.4%	9.3%	10.0%	9.5%	7.3%	8.0%
South Tyneside	3.6%	3.2%	4.2%	3.7%	1.9%	1.7%
Other	20.8%	22.8%	24.6%	28.9%	13.4%	11.0%
All Areas	100%	100%	100%	100%	100%	100%

Table 2 – Newcastle Hospitals Admissions by type

	2019/20		2023/24	
	Number	% of All	Number	% of All
Elective	143944	61.7%	146174	62.3%
Emergency	71898	30.8%	72632	30.9%
Other admissions	17608	7.5%	15887	6.8%
All admissions	233450	100%	234693	100%

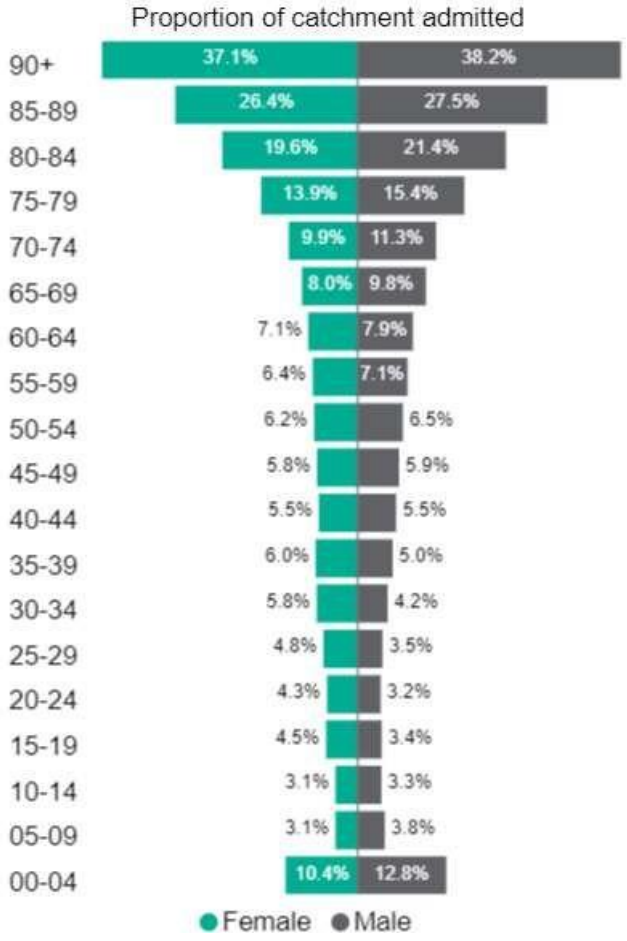
Trust Catchment Population – Age/Sex Profile

Figure 1



In **2020** the **The Newcastle Upon Tyne Hospitals NHS Foundation Trust** annualised number of patients admitted for **Emergency** was **37,120** from a catchment population of **558,501** with **6.6%** of the catchment admitted

Figure 2



Emergency Admissions 2019/20 – Age/Sex Profile

Figure 3

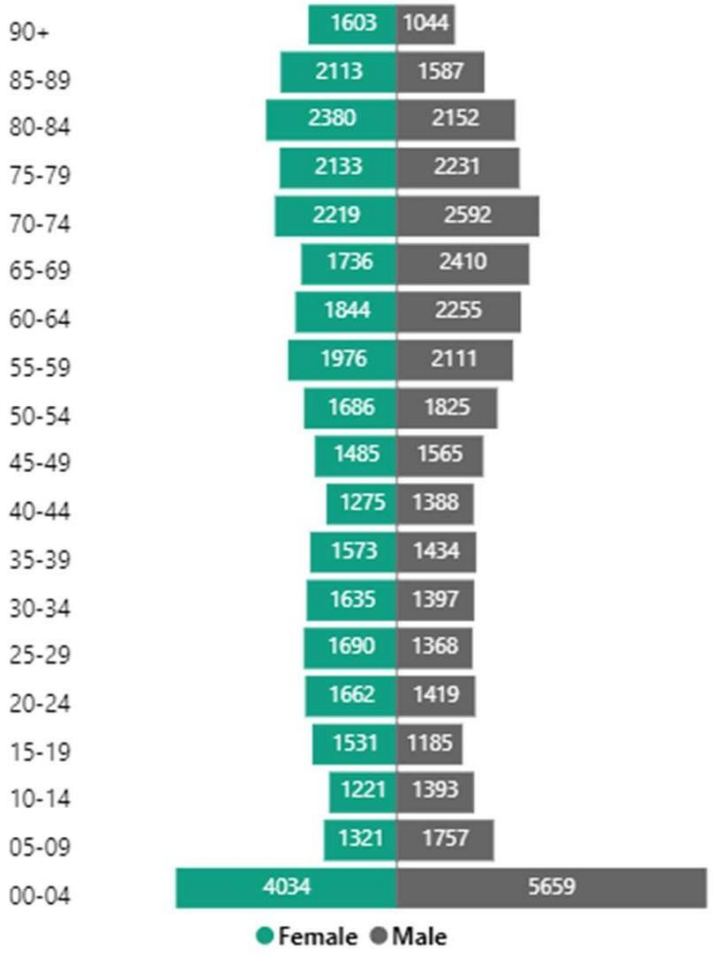
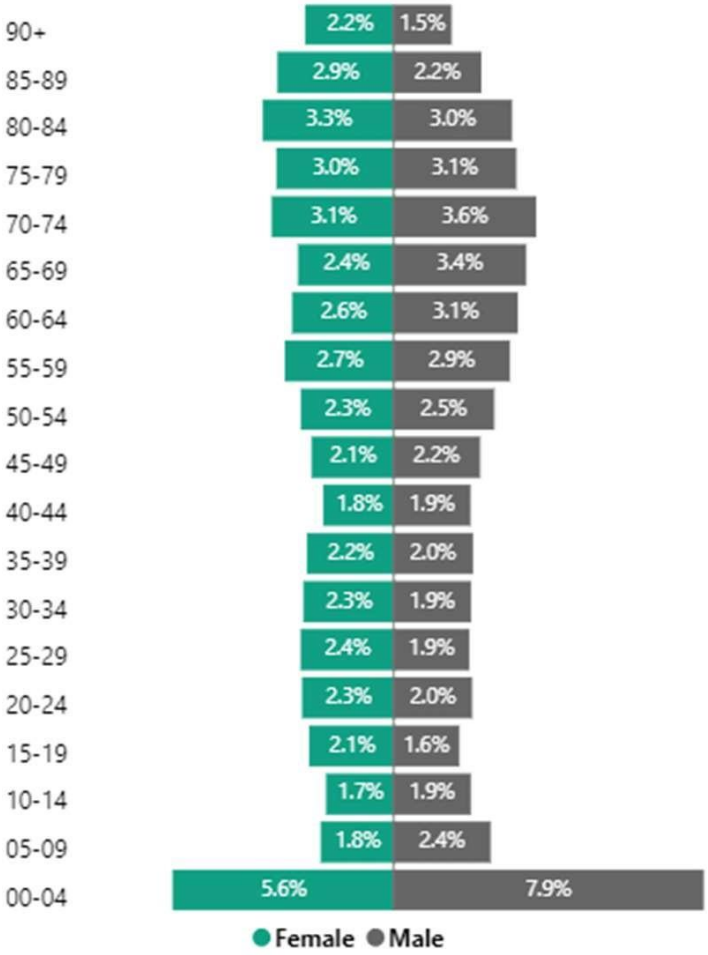


Figure 4



Total emergency admissions is the denominator used to calculate percentages

Emergency Admissions 2023/24 – Age/Sex Profile

Figure 5

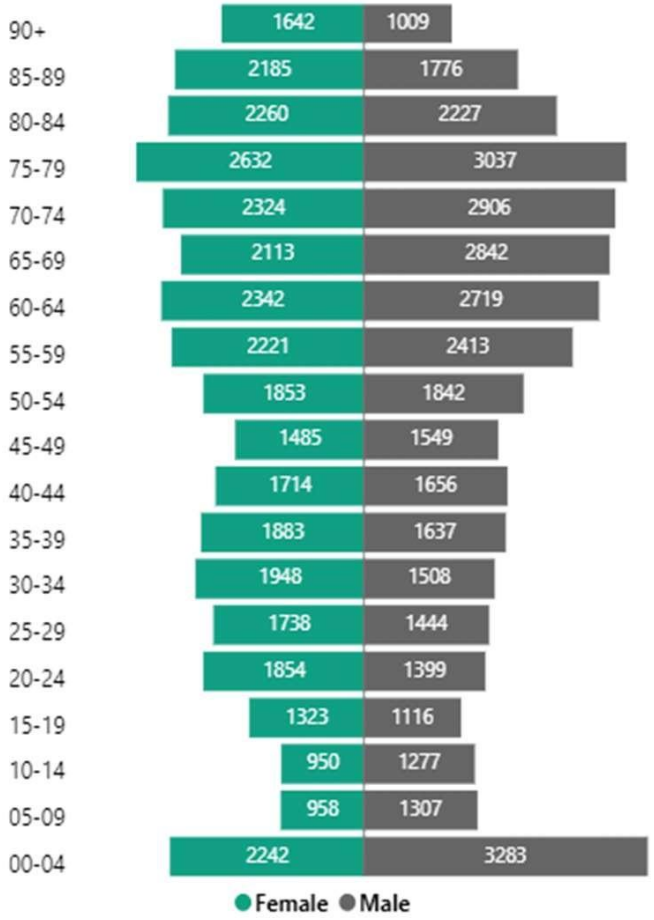
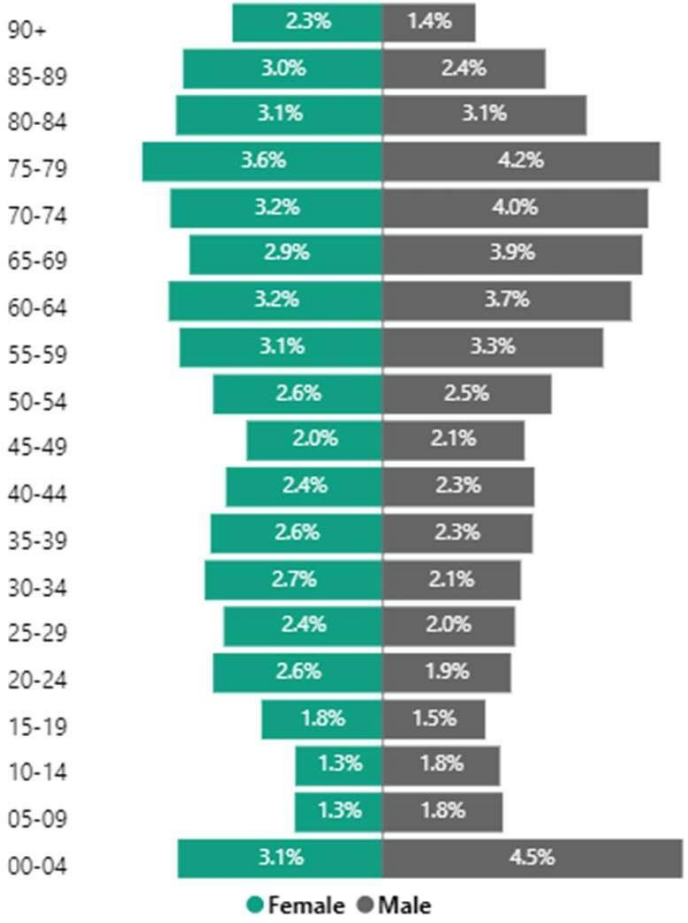


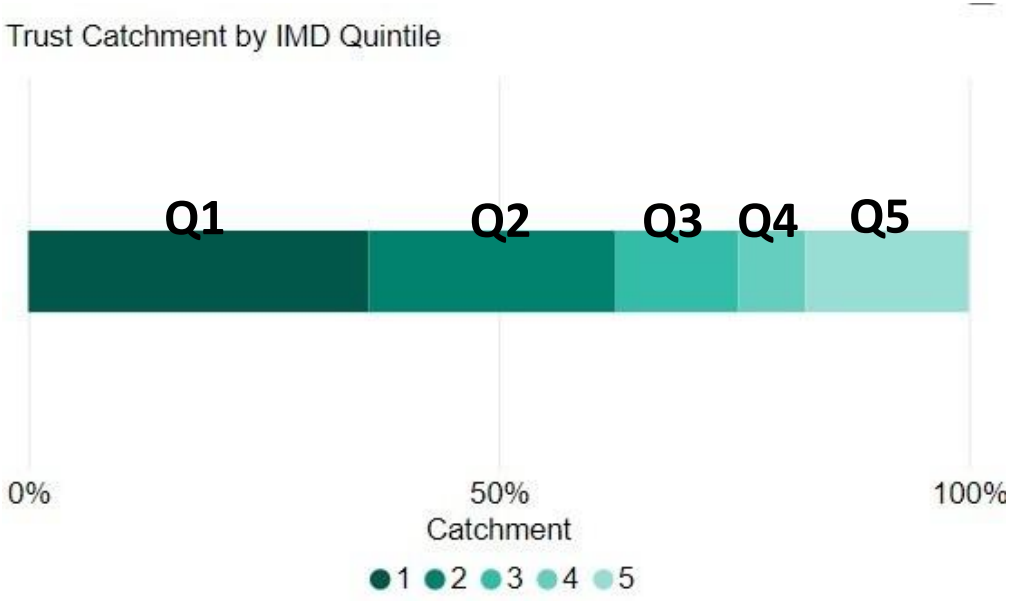
Figure 6



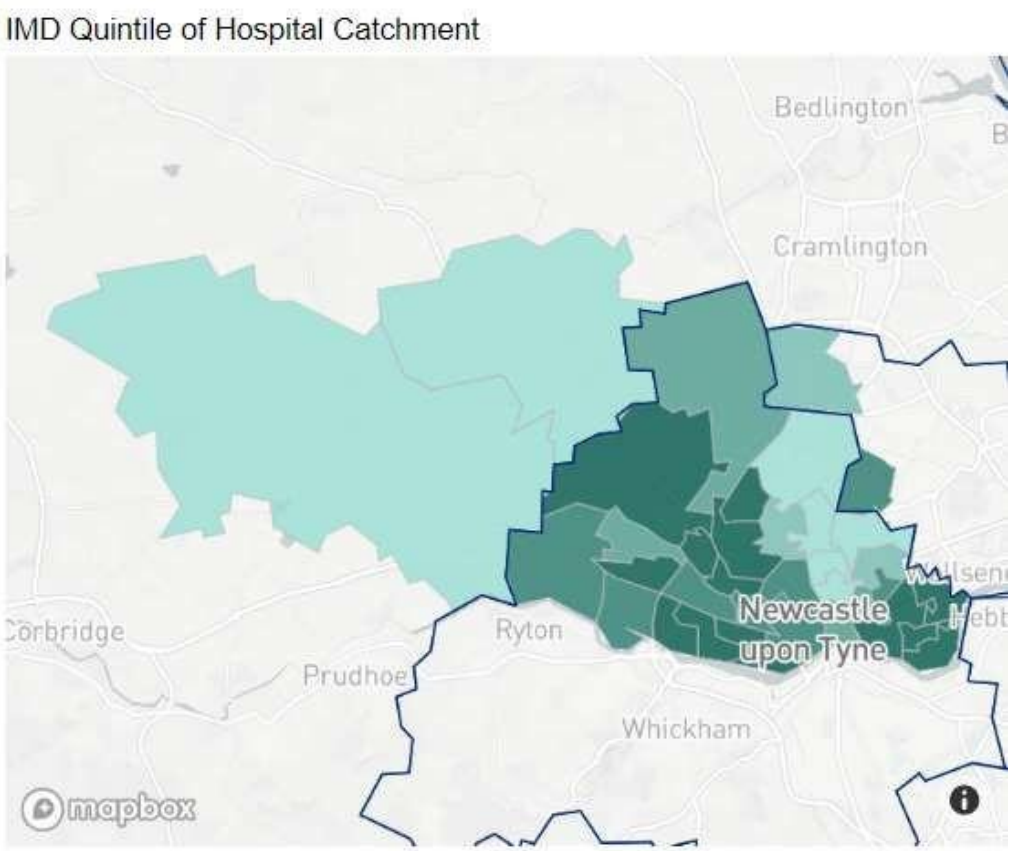
Total emergency admissions is the denominator used to calculate percentages

Emergency Admissions 2020 – IMD

Figure 7



IMD Quintile 1 (most deprived) catchment 110,140 (36.22%)
IMD Quintile 2 catchment 79,741 (26,23%)
IMD Quintile 3 catchment 39,597 (13.2%)
IMD Quintile 4 catchment 21,648 (7.12%)
IMD Quintile 5 catchment 52,927 (17.41%)



Includes only MSOAs where the majority of patients are admitted to the Trust

Emergency Admissions 2019/20 – IMD Quintile/Age Group

Figure 8

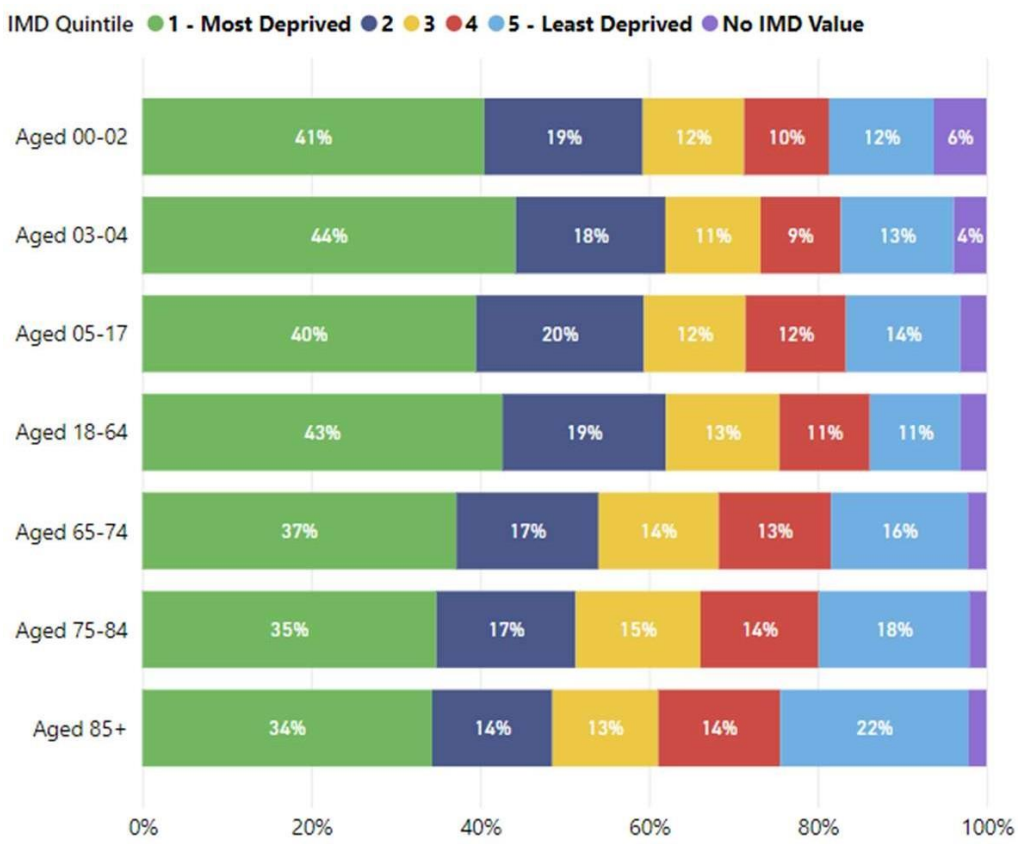
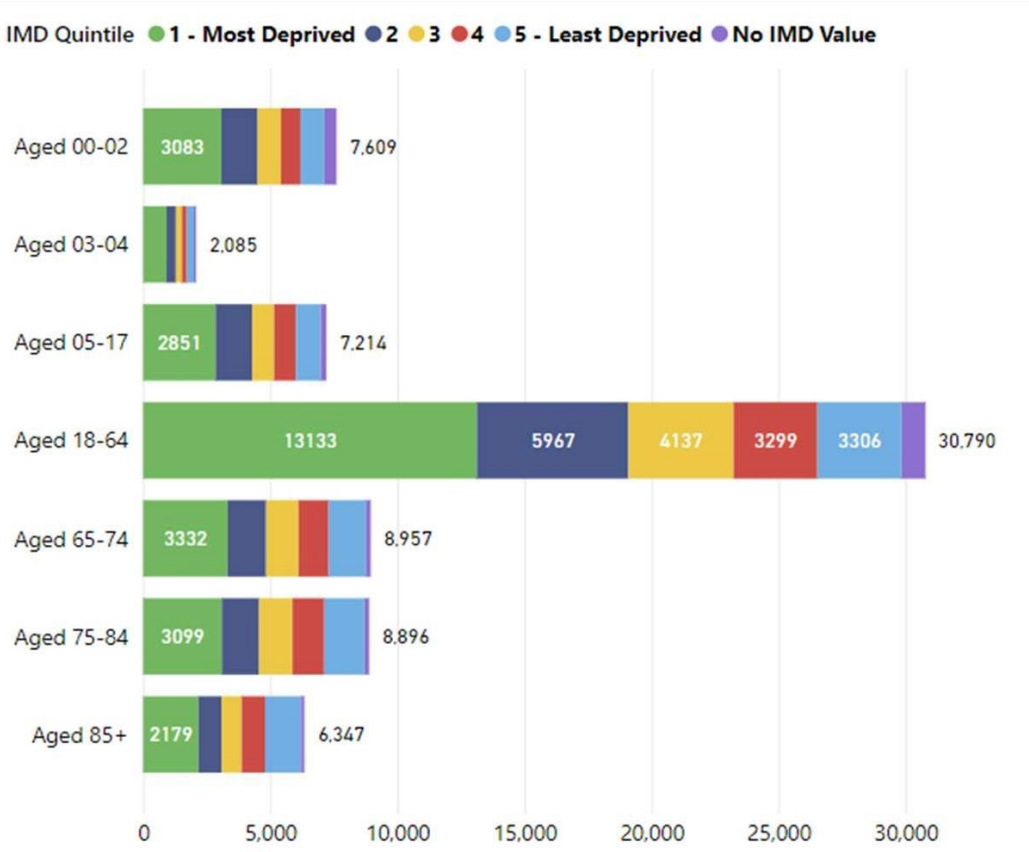


Figure 9



Emergency Admissions 2023/24 – IMD Quintile/Age Group

Figure 10

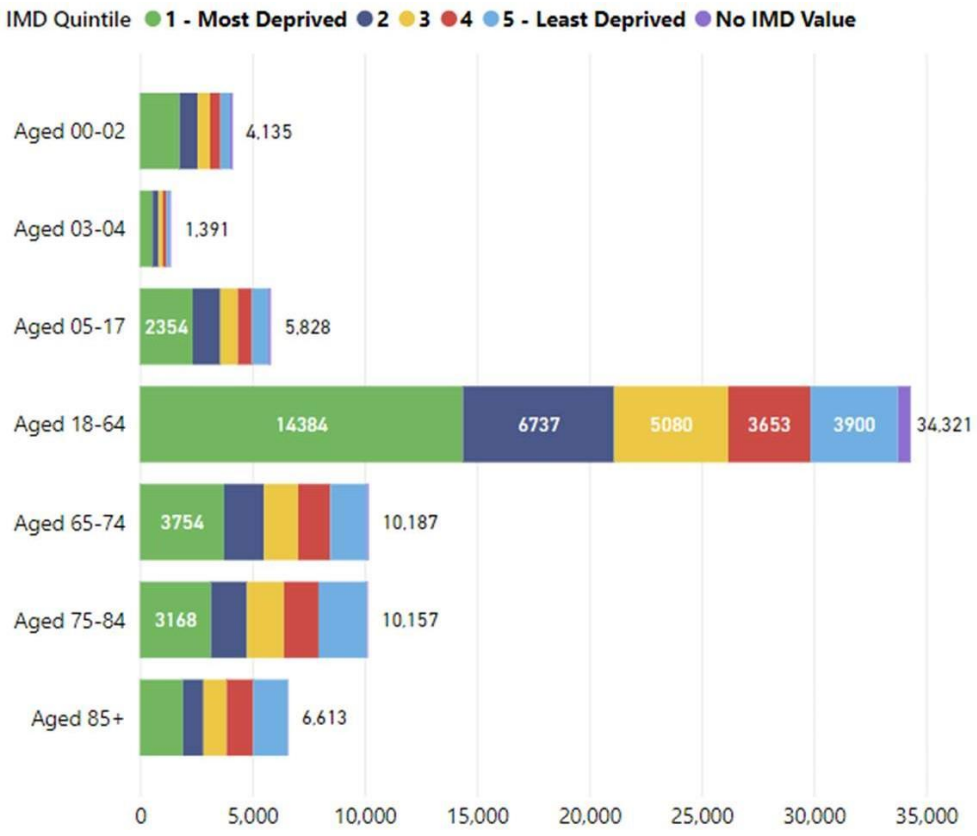
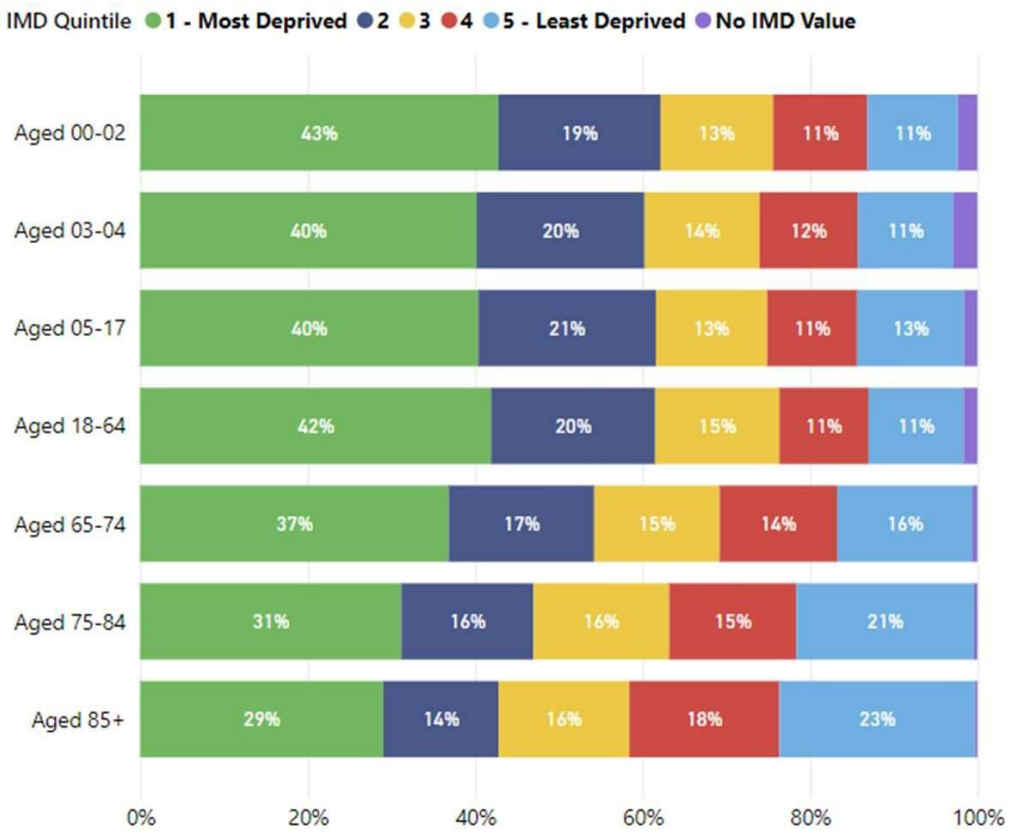
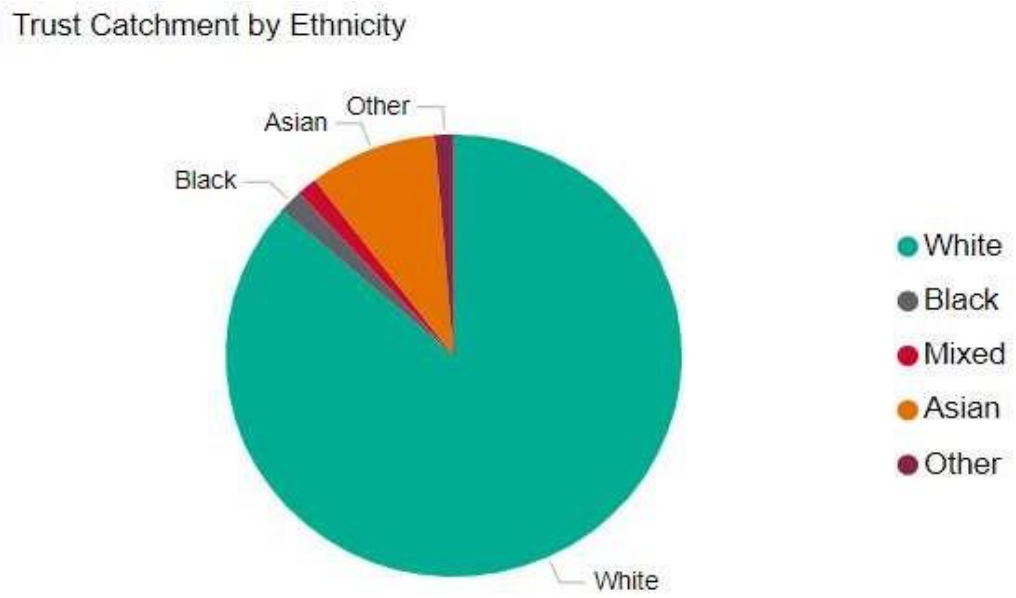


Figure 11



Trust Catchment by Ethnicity

Figure 12



White: 262,829 (86.44%)
Asian: 27,519 (9.05%)
Black: 5,184 (1.7%)
Mixed: 4,448 (1.46%)

Emergency Admissions 2019/20 – Ethnic & Age Group

Figure 13

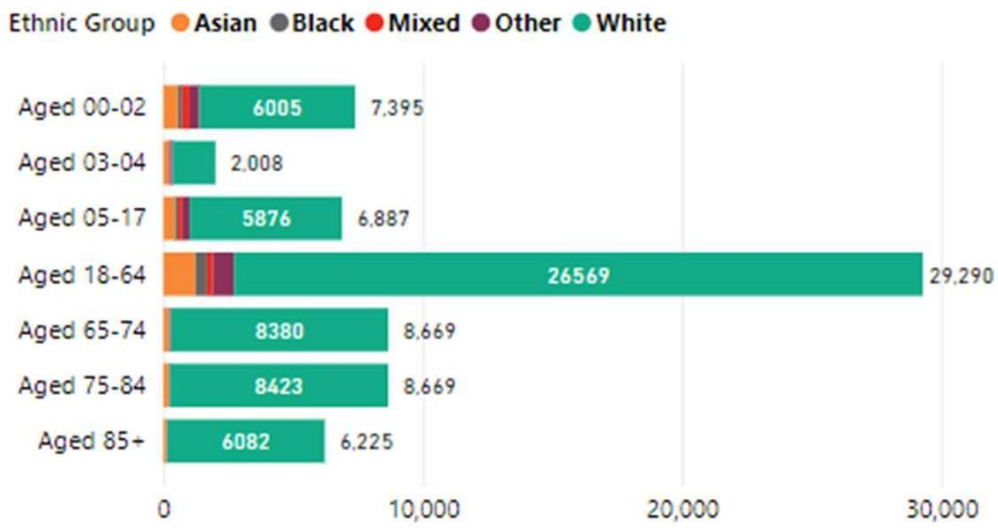


Figure 14

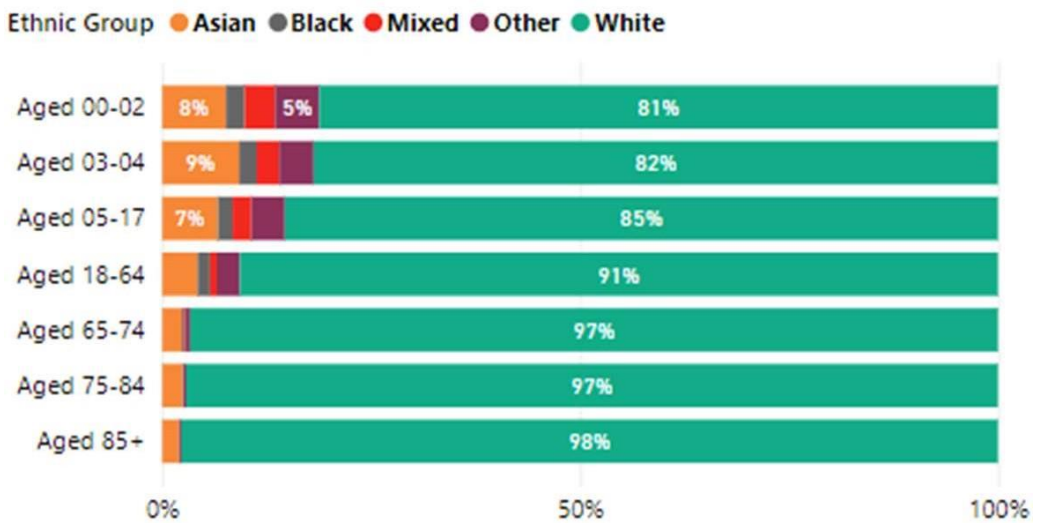


Figure 15

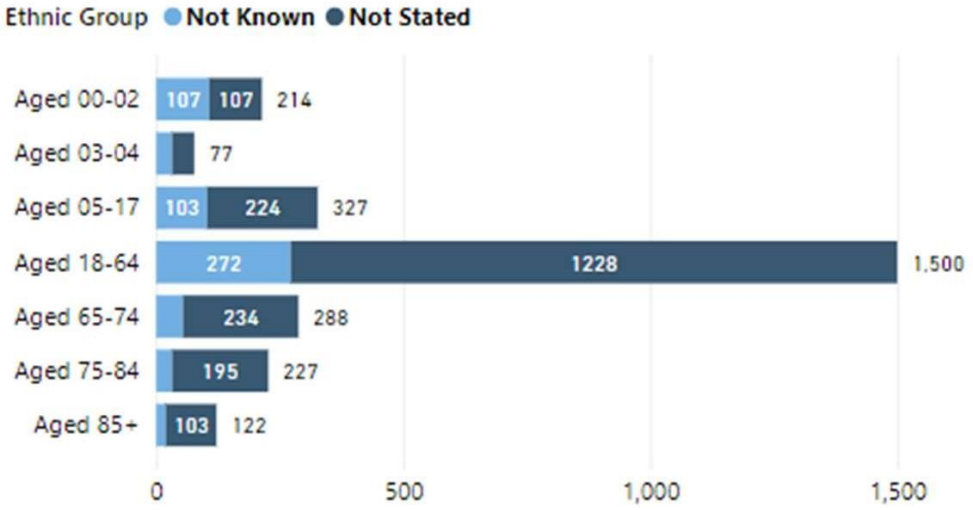
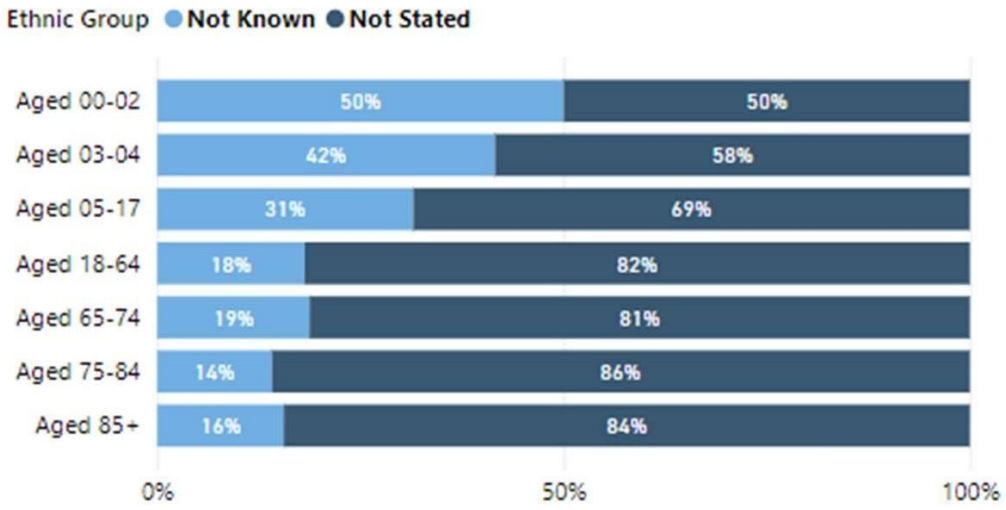


Figure 16



Emergency Admissions 2023/24 – Ethnic & Age Group

Figure 17

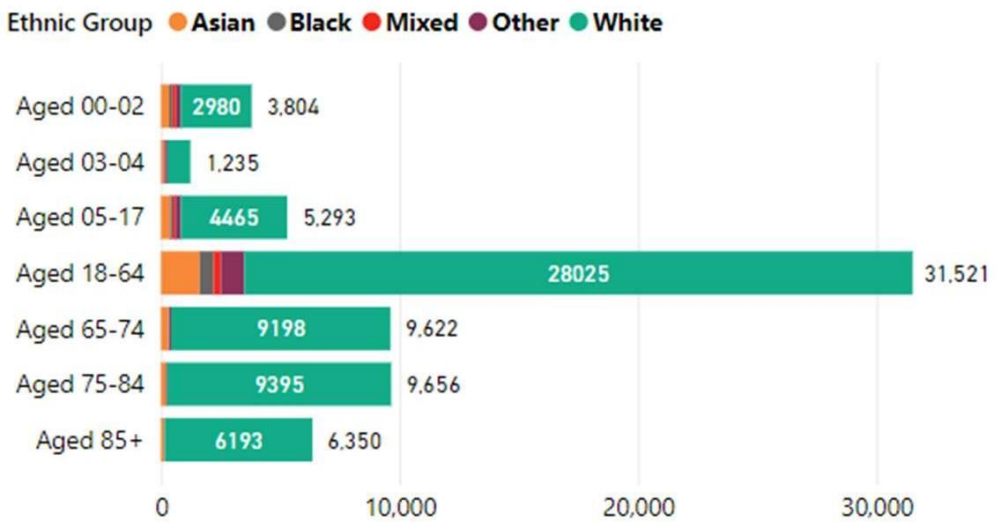


Figure 18

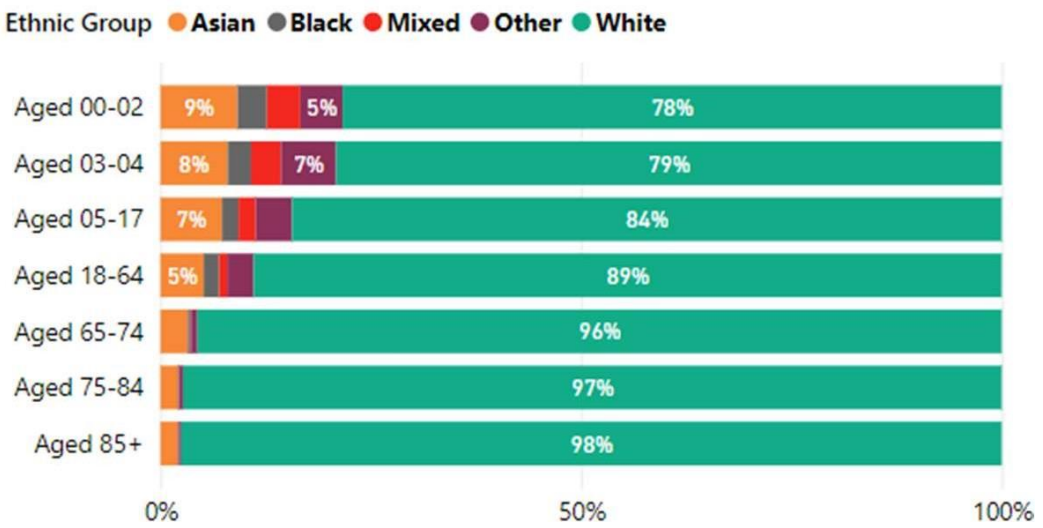


Figure 19

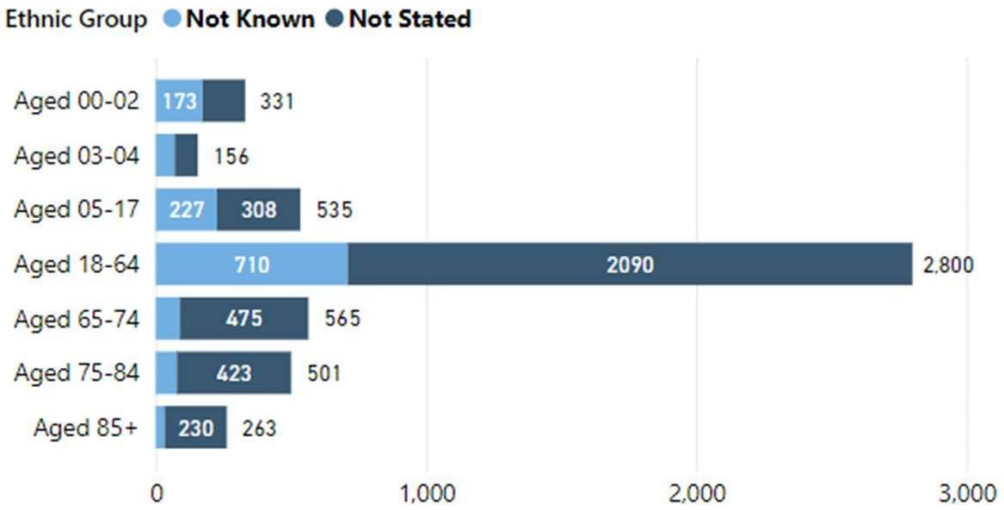
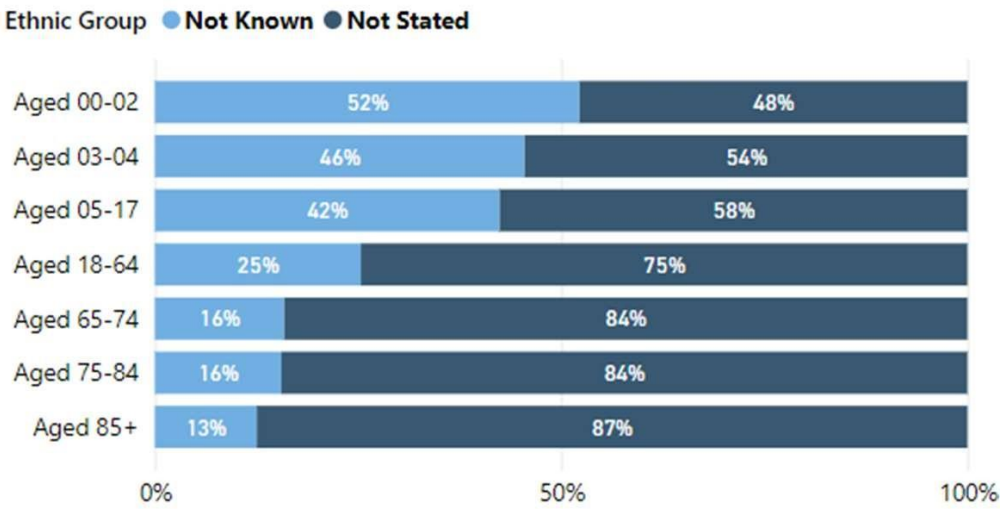


Figure 20



Emergency Admissions – Ethnic Group & IMD Quintile

Figure 21 (2019/20)

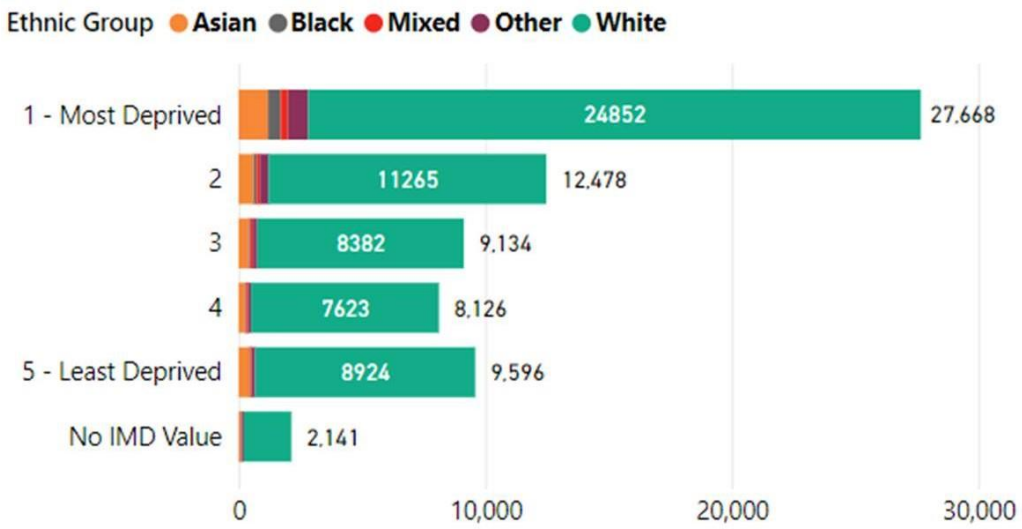


Figure 22 (2023/24)

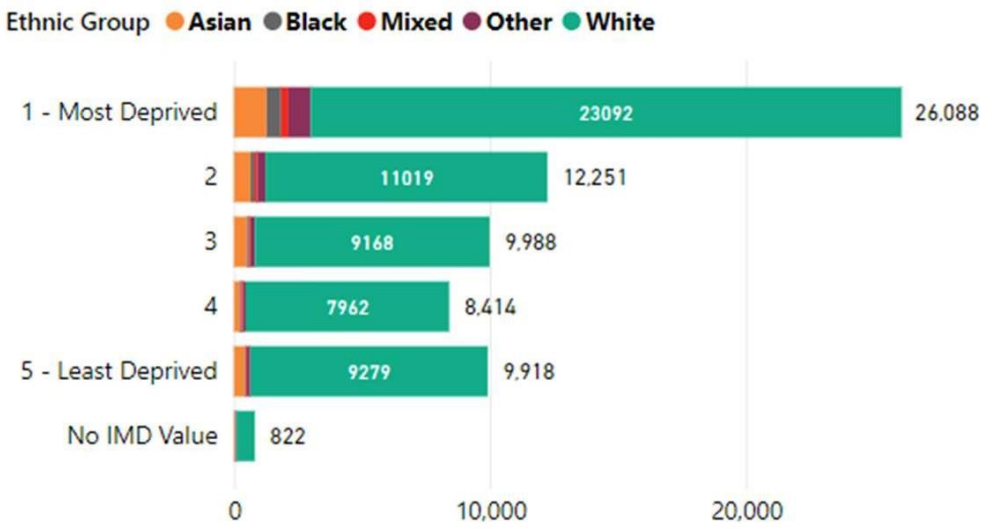


Figure 23

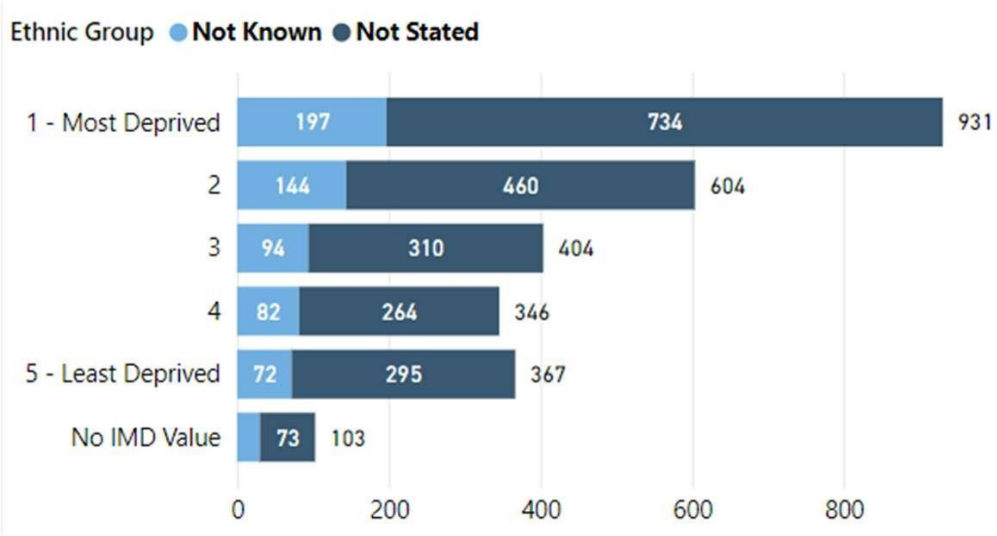
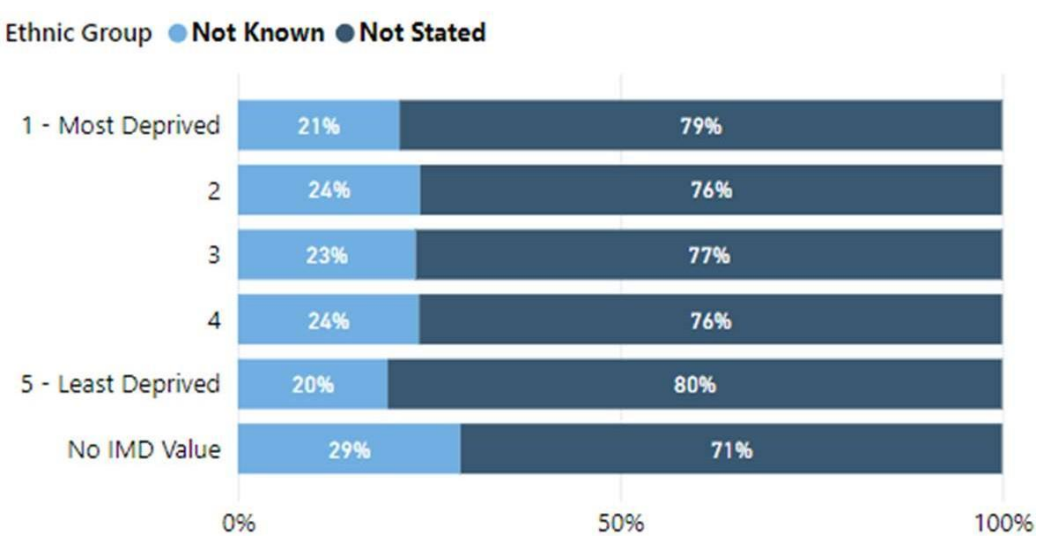


Figure 24



Health Inequalities Summary (1/3)

- The proportion of emergency admissions from Newcastle local authority has remained relatively unchanged between 2019/2020 and 2023/2024 (Table1).
- Emergency admissions constitute a third of all admissions at Newcastle Hospitals. This has remained relatively unchanged between 2019/2020 and 2023/2024 (Table 2).
- According to OHID data 6.6% of the catchment population of 558,551 was admitted as emergency admission to Newcastle Hospitals in 2020. This was driven mainly by the age groups 80+ and also by the under 5s (actual numbers).
- The NuTH catchment population has a younger age profile evidenced by the proportion of those in the 19 and under age categories and the actual size of the population in the 0-19 age catchment population. The trust age and sex pyramid for emergency admissions does not mirror that of the catchment population.
- The older age population, especially 80+ in both sexes is overrepresented in emergency admissions at the trust. That is evidenced in the high proportion of catchment population admitted from the older age categories. However, the total number of admissions from the 80+ is small compared to the under 19s is small (Figures 1 &2). It will be relevant to look in the future at length of stay and resource use for emergency admissions for this age group and impact of alternative models of care such as the Virtual Ward for Frailty.
- There is evidence (not from trust data) that patients with five or more conditions have longer hospital stays. Such cohorts are overrepresented in older age and patients living in socioeconomic deprivation.
- Despite the small proportion of catchment population admitted in the younger age categories (up to 19 years) their absolute number is large, especially for under 5s. For this report we have not looked at data to estimate the proportion of potentially preventable emergency admissions in this age group.
- There is a higher proportion of the catchment population of males than females admitted in most age categories, notably under 5s and 65 and over (Figure 2).
- Our trust emergency admission data by age and sex shows a slight increase in emergency admissions particularly for age groups between 55 and 79 years across both sexes in 2023/2024 compared to 2019/2020.

Health Inequalities Summary (2/3)

- 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 two thirds of the Trust catchment population (emergency admissions) resides in quintiles 1 and 2 or 40% of the most socioeconomically deprived areas nationally in England.

- The emergency admission population of patients at Newcastle Hospitals is relatively more socioeconomically disadvantaged compared to the elective admissions and to the overall population of Newcastle with 2 out of 5 (over 40%) patients in emergency admissions living in the most deprived 20% of areas nationally.

- What is notable is the overrepresentation of the core 20 population (i.e. those living in the most seriocomically deprived 20% of areas in England) in emergency admissions for the under 18 year old categories (i.e. 40% or over). This was the case before the COVID Pandemic 2019/2020 and more recently 2023/2024. There has been a increase in the proportion of 0-2 year olds living in the 20% most deprived areas nationally. This is in line with population trends and the reported increase in the number of children and families living in poverty, especially in the North East of England.

- Patients in the age categories 75-84 and 85+ seem to be relatively less socioeconomically deprived than those in other age categories with 31% and 27 % respectively living in the most deprived quintile of areas nationally in 2023/2024, a decrease from 35% and 34% respectively before the pandemic 2019/2020. However, the majority of emergency admissions regardless of the age group but more notable in the under 18s are socioeconomically disadvantaged.

- Please note the reason behind the significant decrease observed in the numbers of emergency admissions in the under 18s in 2023/2024 compared to 2019/2020. That is because of a change in the way Same Day Emergency Care (STEC) were coded for Paediatrics in 2020/2021.

Health Inequalities Summary (3/3)

- 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).

- In 2023/2024 emergency admission data show an increase in the proportion of ethnic minorities among all emergency admission age groups. However, the increase is more notable in under 18s, especially 0-2. Among the aged 0-2 category with a known and recorded ethnicity 22% were from an ethnic minority in 2023/2024 compared to 19% before the pandemic 2019/2020.

- In emergency admissions for the trust there is a clear socioeconomic gradient for both White British and ethnic minority populations with larger numbers in the more socioeconomically deprived Quintiles. The gradient is slightly more notable among those from ethnic minorities, particularly in the more recent data 2023/2024.

- We have shown categories for ethnic group ‘not known’ and ‘not stated’ by age group and IMD Quintiles to identify if there any observed patterns. There is relatively more ‘not stated’ in patients aged 18-64 and those living in the more deprived areas (Q1 and Q2).

- Although the Trust has made significant progress in improving the quality of ethnicity data, there is more work to be done. Compared to other trusts in the ICS the trust has done well in capturing ethnicity for patients admitted to hospital. However, there is still around 6% of inpatients who have an ethnicity of Not known or Not Stated.

- While many demographic data items that impact on health inequalities are almost 100% complete (age, gender, postcode) ethnicity is not as well populated. A patient’s ethnicity is not an NHS spine data item so organisations need to collect this information directly when they provide care. The national code Z (Not stated) should be used where the patient has been given the opportunity to state their ethnic category but chose not to. The default code of 99 (Not Known) is classed as invalid. The use of the default code 99 is a data quality issue because for this data item it potentially shows that no effort has been made to gather the ethnic category of the patient from the patient.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

A Guide to SPC

Healthcare at its best
with people at our heart

SPC Icons & How to Interpret (1/4)

	Variation/Performance Icons		
Icon	**Technical Description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

SPC Icons & How to Interpret (2/4)

	Assurance Icons		
Icon	**Technical Description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

SPC Icons & How to Interpret (3/4)

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: (blank)
H	**Excellent** **Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** **Celebrate and Understand** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** **Celebrate but Take Action** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** **Celebrate** • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent** **Celebrate and Learn** • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** **Celebrate and Understand** • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** **Celebrate but Take Action** • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** **Celebrate** • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
(blank)	**Good** **Celebrate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** **Investigate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** **Investigate and Take Action** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average** **Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H	**Concerning** **Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** **Investigate** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.

SPC Icons & How to Interpret (4/4)

Variation/Performance	Assurance			
				
	**Concerning** **Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** **Investigate** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
				**Unsure** **Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event above the upper process limits; a continued upward trend or shift above the mean. • There is no target set for this metric.
				**Unsure** **Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event below the lower process limits; a continued downward trend or shift below the mean. • There is no target set for this metric.
				**Unknown** **Watch and Learn** • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	27 September 2024		
Title	Joint Medical Directors (JMD) 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. The following items are described in more detail within this report: i) Quality and Patient Safety ii) Job Planning iii) Cancer Update iv) Cardiothoracic Update v) Research Update vi) Patient Safety and Quality of Care in Pressurised Services vii) Perfect Week viii) Appraisal and Revalidation Annual Report and Compliance statement. The Guardian of Safe Working Quarterly Report (Quarter 1 2024-25) is a separate report.		
Recommendation	The Board are asked to: i) Note the progress made with the implementation of Patient Safety Incident Response Framework (PSIRF). ii) Note ongoing concerns about performance against cancer targets and the actions being taken to improve this. iii) Note the work done to deliver the 'Perfect Week' and outcomes achieved. iv) Note the contents of the Appraisal and Revalidation annual report and confirm compliance with the Responsible Officer Regulations.		
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

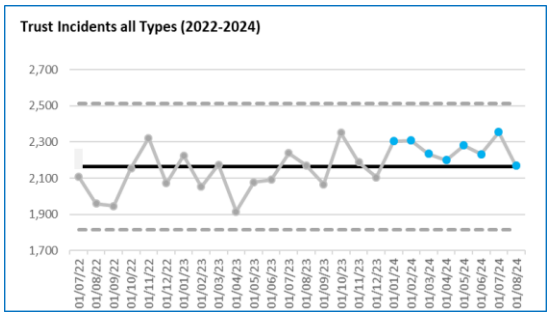
1. QUALITY AND PATIENT SAFETY (Q&PS)

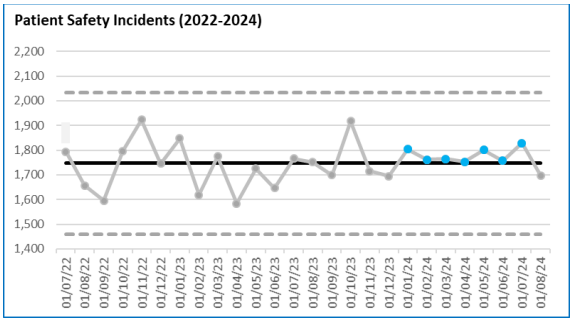
1.1 Patient Safety Incident Response Framework (PSIRF)/ Serious Incident (SI) Backlog

PSIRF implementation continues to mature in all Clinical Boards. The Patient Safety Group has reviewed its terms of reference and function to allow oversight of Quality Oversight Group (QOG) and PSIRF priorities. Following the completion of all legacy SI investigations and submission of the final reports to the Integrated Care Board (ICB) in April 2024, work commenced to address all SI investigations with outstanding action plans requiring completion. Since May 2024, a focused piece of work to ensure timeliness of action plan closure, and to ensure that any audits for assurance have been completed as planned has been ongoing, overseen by the Patient Safety Team. At the July 2024 meeting of the Quality Committee, progress to date was reviewed and a plan was agreed detailing that all outstanding SI actions would be closed by 31 December 2024, with monthly progress reports to be provided to the Patient Safety Group and quarterly reports to be provided to Quality Committee. Clinical Boards have been informed of the agreed deadline by the Patient Safety Coordinator. Current forecast indicates that closure of all action plans will be achieved by 31 December 2024.

1.2 Incident reporting

Incident reporting across the Trust has shown an increasing trend for all types of events including Patient Safety Incidents (PSIs) over the previous 2 quarters. The August 2024 data shows a reduction by number, when also comparing bed days rates, there is a slight variance. May (39.79), June (41.09), July (40.98) and August (40.40). Changes in rates will be monitored closely during September and October. (Charts 1 and 2).



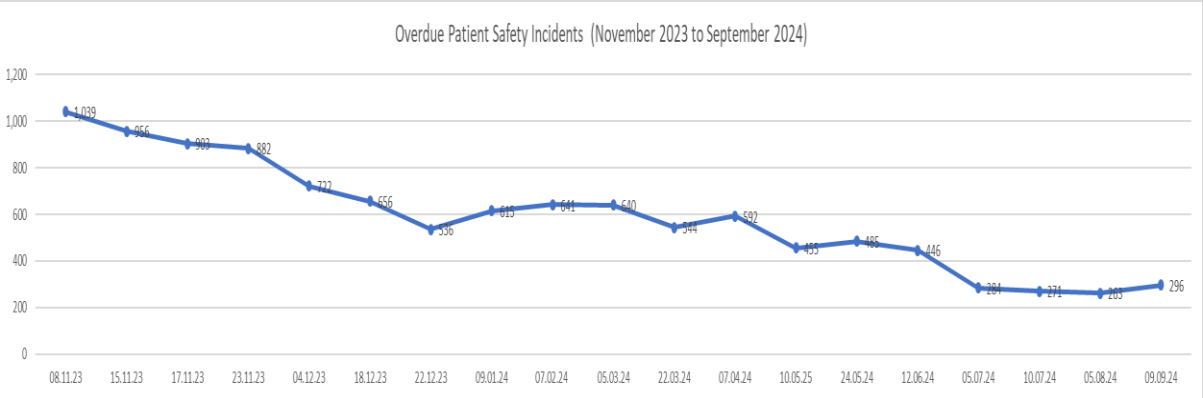


The mean monthly total for all types of incident reported over the period August 2022 to July 2024 is 2,086. More recent data shows the monthly mean line has increased to 2,245 for the period March 2024 to September 2024 indicating an improving reporting picture.

All Clinical Boards will continue to promote incident reporting and shared learning following effective investigations through the QOG's and its subgroups.

Incidents should be reported within 24 hours and become overdue if not finally approved within 60 days. Clinical Boards and other Trust services have reduced the level of overdue patient safety incidents from 1,039 in November 2023 to a low of 263 in July 2024, although there has been a slight increase to 296 (data from 9th September 2024) (Chart 3).

The number of overdue non patient safety related incidents has seen a similar reduction. All types of overdue incidents are 422 as of the 10 September 2024, of which 296 are patient safety incidents. Information on themes from these will be reported on in due course.



1.3 Clinical Board and Trust Priorities

Clinical Boards have been asked to identify around 6 quality and safety priorities.

Two priorities have been mandated:

- Medicines Management
- Mental Capacity Act (MCA) and Deprivation of Liberty standards (DoLs)

Additional priorities are to be identified by Clinical Boards. These will be reported at forthcoming Trust Board meetings.

Governance arrangements for delivery of Clinical Board Q&S priorities will be through existing QOGs, the integrated Quality and Performance Review (iQPR) meetings and monthly reports to Care Quality Commission (CQC) Delivery Group.

1.4 Martha's Rule

Work is ongoing to prepare for the rollout of this programme Trust-wide. There is some funding available from NHS England (NHSE), some of which will support the creation of three band 8A secondment posts of six months duration which will be recruited to by December.

There is progress also within Paediatrics with Board engagement meetings planned. Of note, there have been two recent appointments of consultant paediatricians with interests in critical care outreach and High Dependency Unit (HDU) which will be contributing to work on this area. Alternative solutions are being developed for the absence of paediatric

outreach, however, the Great North Children's Hospital (GNCH) is not unique in this nationally.

The group are still awaiting national materials or branding which will be essential before the programme can be rolled out.

2. REVISED JOB PLANNING PROCESS IMPLEMENTATION

There have been a series of roadshows with consultants and to other groups including the Local Negotiating Committee (LNC) and the Clinical Policy Group (CPG) to discuss the new job planning policy. We have previously reported the detail of this revised policy to Board and so will not re-iterate it here. Its implementation will lead to better understanding of the existing capacity within the senior medical and dental staff body, whilst also enabling appropriate Supporting Professional Activities (SPA) time for additional work, crucially educational supervision of resident (junior) and Locally Employed Doctors (LEDs). This is a key step in trying to address the deterioration of the position of the Trust in the General Medical Council (GMC) Trainee survey, now 8/10 in the region. It will also help address the deterioration in the position for trainer experience, where Newcastle Hospitals currently rates 229/231 nationally for time for training. This is not an acceptable position and one which we are keen to improved in the coming year.

The capacity element of the job plan will be set by defining Anticipated Delivered Activities (ADA) within existing Direct Clinical Care(DCC), previously referred to in discussion as Service Level Agreement (SLA). This will provide a much more granular oversight of work being undertaken by clinicians and enable more focussed solutions to some of the problems we face, particularly around waiting times. It will also allow more intelligent capacity planning for the future.

Pilot areas for the initial rollout will be Peri ops, Hepato-Pancreato-Biliary (HBP) surgery, Oncology and Paediatric Intensive Care Unit (ICU), and these are expected to go live in October.

There are ongoing discussions with finance colleagues about the cost pressures associated with the new guidance.

3. CANCER UPDATE

3.1 Cancer Performance

Month	1/24	2/24	3/24	4/24	5/24	6/24	7/24	8/24
28-day Faster Diagnosis Standard (FDS) %	72.0	83.2	84.9	77.0	80.8	79.2	73.0	68.4
Number of Patients	2,330	2,340	2,557	2,620	3,005	2,831	2,842	2,727

62-day %	56.1	60.9	61.6	58.9	60.6	65.3	60.0	64.8
62-day by Tumour								
Breast	76.6	86.4	82.9	89.9	93.8	97.8	89.7	
Lung	38.8	46.3	41.4	29.3	46.0	48.3	34.8	
Head and Neck	82.8	73.5	75.4	80.0	66.7	79.4	80.0	
Lower Gastrointestinal	41.2	46.3	52.6	25.3	46.4	28.8	49.3	
Upper Gastrointestinal	47.4	32.7	26.0	37.9	29.3	40.4	36.7	
Urology	32.2	28.6	50.8	46.0	36.1	50.0	46.9	
Skin	67.6	83.3	88.2	80.5	87.9	87.9	83.5	

Cancer performance is still markedly below the standard required and that we would want to see. The performance figures documented run alongside an increase in the number of patients waiting over 62 days to be treated. The total number of patients currently waiting >62 days is 239. The table shows breakdown by tumour group.

Suspected Cancer Type (2-week-wait)	Total waiting list	Number below 62	Total Number over 62	Number 63-104	Number >104
Skin	945	896	49	41	8
Urological	190	141	49	28	21
Upper GI	197	150	47	29	18
Lung	87	49	38	22	16
Lower GI	202	172	30	25	5
Gynaecological	172	159	13	12	1
Head and Neck	181	171	10	8	2
Breast	101	99	2	2	0
Haematological	14	13	1	0	1
Brain/Central Nervous System	2	2	0	0	0
Children's	0	0	0	0	0
Other	0	0	0	0	0
Sarcoma	18	18	0	0	0
All suspected cancers	**2,109**	**1,870**	**239**	**167**	**72**

Whilst the skin team have seen a very high number of referrals in early summer thus contributing to a backlog of treatment in the skin service, the most consistently challenged tumour groups in terms of 62 Day performance are: lower GI, upper GI, lung and urology Work continues in all these areas to try to improve performance:

Lung: Clinical involvement in Patient Tracking List (PTL) was a success but we need to find resource to make that a permanent feature. Endobronchial ultrasound-guided

transbronchial needle aspiration (EBUS) capacity remains too low for the service; there is a business case in development that we hope to submit by the end of September 2024. A bid to the Cancer Alliance for funding to start a navigational bronchoscopy service was successful (September 2024) and the team are currently working through a project plan with Alliance funding for 1 year but a business case will be required from year 2 and work is underway on that. There is overlap between EBUS costs and navigational bronchoscopy costs.

Upper and Lower GI: Combined pathway referral system instigated September 2024 so we are not yet able to assess the effectiveness of this change but it is designed to speed diagnosis thus allowing treatment plans to be made as early as possible.

HPB: Trial of a triage clinic with radiology support was successful. Work now underway to change job plans to make this permanent. Multi-disciplinary team (MDT) capacity has been increased with plans to lift cap in numbers discussed as soon as possible.

Urology: Unfortunately, 28 day FDS statistics are likely to be negatively impacted by the need to wait for biopsy results before completing this stage of the pathway rather than making decisions based on Magnetic Resonance Imaging (MRI) results. This change is necessary to comply with national standards.

3.2 Specific Service Updates

3.2.1 Breast

Locally a Quality Assurance (QA) visit to the screening service has raised concern that Clinical Nurse Specialist (CNS) colleagues are not present when patients return for review after a positive screening test. Patients are supported by an experienced band 4 nursing associate but not by a CNS colleague. The clinical team do not feel there is high clinical risk but their approach is outside national standards. A review is underway to inform an options appraisal.

Our team have been asked to work with Gateshead and North Tees screening services teams to provide support to the CDDFT breast MDT and this work is underway. This does include a small number of women coming to Newcastle Hospitals for surgery who would previously have been treated at CDDFT.

3.2.2 Head and Neck Services

The team do remain concerned about the impact of Carlisle work on capacity at Newcastle Hospitals both in terms of theatre capacity and staffing resource, including Allied Health Professionals (AHP) input in particular. We will keep this under review as the service is not fully established / stabilised yet.

3.2.3 Hepatobiliary Cancer

There is considerable work going on with this team to improve capacity and performance. There is a detailed action plan in response to Getting it Right First Time (GIRFT) which can be

shared if desired. Launch of an electronic referral tool to the region, increasing MDT capacity, delivering a triage clinic and improving PTL are areas of work in progress.

One area where there is clear lack of capacity is that of ablation work. This lack of capacity affects patients with both liver and renal tumours. There are significantly increasing indications for ablation and we need to increase available capacity. There will be a business case completed by the end September in respect of a short term plan but the requirement for interventional radiology to treat cancer is clearly going to rise over the next 3 years. In our opinion we should be aiming to create an operating theatre environment with a computerised tomography (CT) scanner in situ in order to allow this work to be delivered. This will require both revenue and capital spend and a cross-board business case is underway involving the surgical boards, cardiothoracics, peri ops and radiology.

3.2.4 Governance

All tumour groups are required to produce an operational policy and a work plan for their MDTs by 16 October 2024. The cancer services team aim to review these and begin a rolling programme of internal peer review discussions shortly thereafter. Between April and June 2025 we require each MDT to produce an annual report in addition to the operational policy and an updated work plan.

Work to embed harm reviews continues, alongside we are trying to improve the data capture and reporting.

4. CARDIOTHORACIC UPDATE

Delivery against the cardiothoracic action plan and the culture specific action plans continues. Of the 65 actions identified all except 2 are either complete or progress is being made at the expected rate. The 2 actions which require additional focus are on waiting list management and lung cancer waiting times as discussed above.

A new MDT chair has been appointed for the revascularisation MDT which has had a positive effect. Further work is required to ensure that behaviours seen in the MDT support effective decision making. A steering group to deliver these improvements chaired by the Clinical Board Chair has been established.

Work continues with the cardiac surgical team to resolve the complex issues highlighted in previous reports. Progress is being made however there is significant work still to be done.

Mediation work has begun with the thoracic surgical team to resolve the issues highlighted previously. The outcomes of initial meetings are awaited.

The initial report from Zeal of the themes emerging from the culture survey carried out with staff across the Clinical Board has been received and is currently being reviewed.

Ian Forrest, Deputy Director of Medical Education, continues to lead the work with the Clinical Board Education Lead, required to ensure that adult cardiac surgical trainees can return to the department. Clarification on any outstanding actions required by Heath

Education England North East (HEE NE) has been sought and is awaited. Undergraduate medical students will return to the department for the 2024/25 academic year.

Hannah Powell has taken up post as Director of Operations (DOP) for the Cardiothoracic Board. All of those in and involved with the Clinical Board would like to thank Dawn Youssef for her contributions to the work of the team during her tenure as DOP and wish her luck in her new role as DOP in Cancer and Haematology.

5. RESEARCH

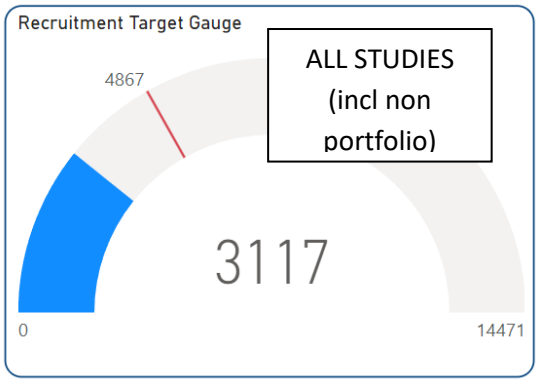
5.1 Activity including Commercial Research (to end July 2024)

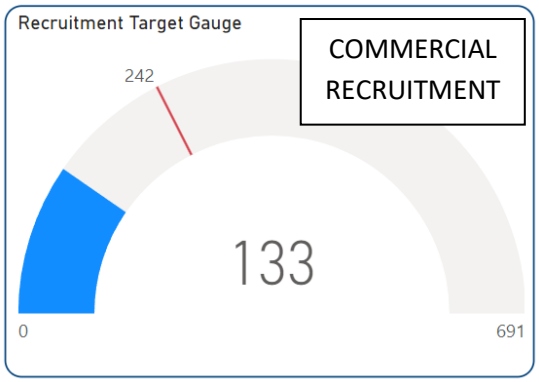
The Trust has 263 studies open and recruiting of which 237 are Portfolio studies for the current financial year as of 31 July 2024. This puts Newcastle 7th Nationally behind Guys (306), Oxford (288), University College London (UCL) (283), Manchester University (258), Leeds (251) and Barts (240) for this metric.

The 237 portfolio studies represent 190 Non-Commercial and 47 Commercial studies. From a commercial perspective, this equates to the Trust holding 6th position for open commercial Portfolio studies that have recruited this financial year.

In terms of complexity the breakdown for Non-Commercial Studies is 12 Large Scale, 130 Interventional and 95 Observational studies.

Data source: Portfolio ODP Data cut: 31/07/2024





For the current financial year between 1 April 2024 and 31 July 2024, 2,878 participants have been recruited into portfolio studies. This is a decrease on the same period in the previous financial year (4,478). The 2,878 recruits represent 2,759 Non-Commercial and 119 Commercial. This currently ranks Newcastle 21st for NHS Trusts in England (Newcastle were ranked 10th for the same period the previous financial year).

Data source: Portfolio ODP Data cut: 31/07/2024

The Trust received 371 commercial study opportunities either directly (192) or via the Clinical Research Network (179) for 2024/25 to date. A high proportion are declined mainly due to capacity. The Trust continues to maintain commercial research partnerships with

Industry - 11 formal, 3 informal and 2 in early discussions allowing increased visibility and first refusal on future pipeline.

5.2 Some Notable Highlights In The Last Quarter

- Dr Simon Hill, Consultant Clinical Toxicologist and Consultant Physician has been appointed as the Clinical Research Facility (CRF) Director (This includes the Paediatric CRF, Dental CRF and Clinical Ageing Research Unit (CARU): https://newcastle.crf.nihr.ac.uk/) The CRF is a cutting-edge experimental medical research and early phase clinical trials unit. Funding for the CRF has recently been extended and is now confirmed to 31 March 2029.
- The Clinical Research Directorate has transferred from Clinical Board 8 to the Corporate Setting under the Medical Directors and Director for Commercial Development and Innovation. A new Governance Structure to support the embedding of research into Clinical Boards is being finalised, including the proposal for a new Board Committee: Research, Commercial and Innovation Group.
- The Dental Clinical Research Facility was the highest UK recruiter to oral and dental research studies in 2023/24.
- Recruitment to the INGR1D2 study has more than doubled, with over 400 participants recruited in July (previously 150 patients a month) https://www.gppad.org/en/ingr1d2/
- Results of the SENIOR-RITA trial (https://www.bhf.org.uk/research-projects/the-older-patients-randomised-interventional-trial-in-acute-nonst-elevation-myocardial-infarctionthe-seniorrita-trial) have been published in the New England Journal of Medicine (NEJM) indicating that in older adults with a common type of heart attack, an invasive strategy did not provide additional benefit over a conservative strategy. https://www.nejm.org/doi/full/10.1056/NEJMoa2407791.
- A further publication in the NEJM discovered a new cause for inflammatory bowel disease (IBD) in neonates. https://www.nejm.org/doi/full/10.1056/NEJMoa2312302.
- Results published in the Lancet show that technology using Artificial Intelligence (AI) to spot the early signs of bowel cancer is effective. Newcastle was one of 11 sites involved in the COLO-DETECT study.
- Professor Chris Harding, Consultant Urological Surgeon has secured a £2million grant for the VESPER trial which will attempt to find the most effective treatment for drug-resistant bladder infections. https://www.dailymail.co.uk/health/article-13706321/2-million-NHS-trial-aim-effective-treatment-debilitating-drug-resistant-bladder-infections.html
- Our stroke team is the highest recruiter in Europe to the FASTEST study. The objective of the study is to establish whether a recombinant blood clotting factor (Factor VIII), administered within 120 minutes from stroke onset in a particular subgroup of patients, will improve outcomes and decrease ongoing bleeding. https://www.nihstrokenet.org/trials/fastest/home.

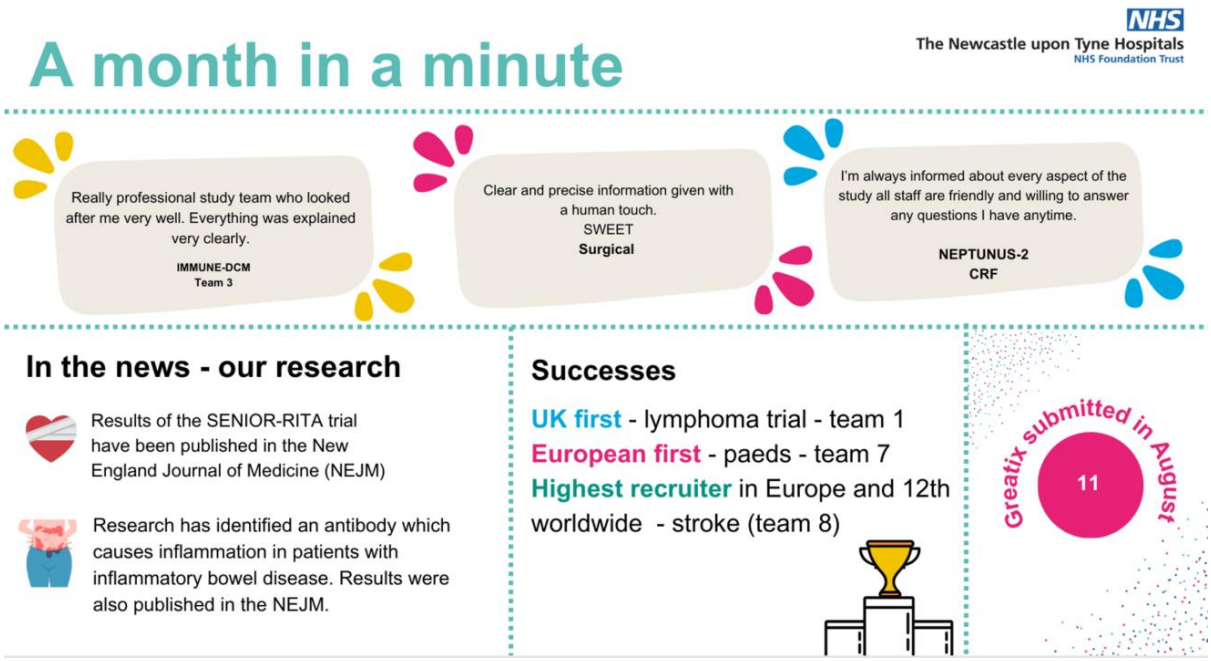
5.3 Challenges in the Last Quarter

- As noted above, recruitment rates to clinical trials are significantly lower than previous years. The Directorate is currently undertaking a deep dive with all teams to identify potential causes, particularly capacity or capability issues.
- At the end of Quarter 2 we have only received 226 Participant in Research Experience Survey (PRES) responses against a target of 668 (full year target is 1,336 responses). Our new research participant engagement team has agreed an action plan to address this drop, including exploring the use of text messages to improve levels of engagement. Of the responses received, we have maintained a high level of satisfaction from participants with the research experience.
- Of concern, is the 12 month rolling sickness rate of 6.31% within the Directorate against a Trust average of 5.47%. Anxiety, stress and depression accounts for 39.83% of the absence and there is ongoing work with all clinical research teams to support effective management of sickness absence and ensure appropriate support for staff is in place.

5.4 Key Activities For Next Quarter

- Business Case for Directorate Restructure to support alignment with Clinical Boards to be submitted for Executive Team approval. Implementation hoped to be completed by end of calendar year.
- The Directorate will continue to work with Clinical Boards on governance and research reporting into key Clinical Board meetings, identifying key link individuals.
- The Financial Contribution of overheads/indirect costs is currently under review.
- We hope to hear the results of our bid to run a Commercial Research Delivery Centre from NIHR end September/early October.
- With the imminent change of the Local Clinical Research Network (LCRN) to the Regional Research Delivery Network (RRDN) we will need to assess any impact of this change and, in particular, the potential removal of Research Delivery Awards in April 2025.
- We will be submitting a bid to join the UK Dementia trials network to advance dementia research. This will involve collaborative working with Cumbria, Northumberland, Tyne and Wear (CNTW) NHS Foundation Trust and be delivered at the CRF facility at the Royal Victoria Infirmary (RVI) and at the CARU on the Campus for Ageing and Vitality (CAV) site.
- We will advertise and recruit to the vacant Co-Director position in the CRF.

5.5 Directorate 'Month in a Minute' – September 2024



6. PATIENT SAFETY AND QUALITY OF CARE IN PRESSURISED SERVICES

Urgent and Emergency Care (UEC): The Executive Director of Nursing (EDON), JMDs and Managing Director (MD) oversee the progress on a programme on the action plan developed with the Clinical Boards to ensure that all of the requirements are met.

Area of assurance required	Overview of systems and processes in place
Organisations and systems are implementing the actions set out in the UEC Recovery Plan year 2 letter	The Trust has recently undertaken an assessment against the UEC 2 year recovery plan. This is overseen by the Urgent and Emergency Care Improvement Group and a planned detailed review is scheduled for September.
Basic standards of care, based on the CQC's fundamental standards, are in place in all care	Existing assurance mechanisms are in place through: • Clinical Assurance Toolkit • Quality and Safety Peer Reviews • Complaints and Patient Advice and Liaison Service (PALS) data • Incident reporting • Executive Walkabouts • Treatment room kept available at all times to ensure privacy for personal care for any patients not currently in a designated bay/room • Intentional rounding in place for high risk patient groups

	The clinical teams have recently designed a privacy and dignity charter for staff and patients. This is in draft format and is being reviewed by the Communications Team to support rollout and engagement.
Executive teams and Boards have visibility of the Seven Day Hospital Services audit results, as set out in the relevant Board Assurance Framework guidance	Seven Day Service provision was previously formally monitored through a standing group prior to COVID. An IT tool to monitor this was produced however subsequent system developments rendered this inoperable. An audit tool will be developed to be monitored through the Urgent and Emergency Care Group.
There is consistent, visible, executive leadership across the UEC pathway and appropriate escalation protocols in place every day of the week at both trust and system level	There is visible presence from the Clinical Board Leadership Team and Executive Team. Situation reports are sent out multiple times per day which alerts managers and the Executive Team to issues regarding flow, capacity and performance. Twice daily handover meetings in place with senior management/on-call team.
Services across the whole system are supporting flow out of ED and out of hospital, including making full and appropriate use of the Better Care Fund	The Better Care Fund has been utilised to support out of hospital care and patient flow. This has included initiative such as discharge flow navigators, discharge hub improvements and intermediate care staffing.
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	Regular Non-Executive Director walkabouts take place which involves speaking to patients in real time. Any urgent issues are fed back to the clinical team and a report collated and shared at Quality Committee/Trust Board.

7. PERFECT WEEK

A "Perfect Week" exercise was delivered between the 9th and 13th of September . The purpose was to reset and build momentum for change and to use the learning obtained during the week to develop sustainable models of care across the Trust.

The key priority areas ahead of the week were:

i. Reduce time for patients to get to the next step in their journey and the time it takes to transfer to an in-patient bed
ii. Improve patient and carer experience
iii. Reduce patient harm
iv. Engage staff and improve the working environment

During the week, there were many change ideas trialled and we saw the best performance in Emergency Department for many months. Analysis of the information collected during

the week is under way. Discussions at Clinical Board level are ongoing to build on the opportunities for improvement and lessons learned. A major challenge of this type of exercise is ensuring that the ideas generated during the week are converted into sustainable change.

Organising the week was a very significant logistical challenge and credit is due to Jo McCallum (Senior Project Manager – Transformation), Melanie Cunningham (Associate Director of Operations) and colleagues who organised much of the exercise and provided support throughout the week for the large number of clinical, operational and administrative staff involved in delivering the activities of the programme.

8. APPRAISAL AND REVALIDATION ANNUAL REPORT AND COMPLIANCE STATEMENT.

The Appraisal and Revalidation Annual report and Compliance statement are attached as Appendix 1.

The purpose of this document is to describe the Trusts approach to and delivery of Appraisal and Revalidation for Medical staff. We include senior dental staff in our commentary but not in the figures which are submitted.

The report highlights some of the progress that has been made in Appraisal for the reporting period of 1st April 2023 to 31st March 2024 and work which is ongoing in 2024/25. It includes description of our approach to concerns which are raised about conduct and capability of medical staff. Specifically we describe the introduction of the Concerns Oversight Group (COG) chaired by the Medical Directors with input from senior Human Resources (HR) representatives and Quality and Safety representatives. This group will report to People Committee.

We also describe current compliance with appraisal amongst senior medical staff and locally employed doctors (resident medical staff employed directly by the Trust). Overall compliance with appraisal for all of this group was 77% however compliance for senior medical staff was 82% and 92% when allowance is made for absence due to sickness, maternity leave and other long term absences. As part of the implementation of the new job planning process as described in section 3 compliance with appraisal will form part of the ADA agreement.

The data requested in sections 2D, E and F have not previously been requested and so are unverified. This was acknowledged by NHSE during the Higher Level Responsible Officer Quality Visit described above. Actions will be taken to record these data prospectively to allow reporting for future years.

9. INFECTED BLOOD INQUIRY- PSYCHOLOGICAL SUPPORT SERVICES

There are ongoing negotiations with NHSE on the provision of psychological support services for the infected, and those affected by, infected blood products. Agreement has effectively been reached on the provision of services for Newcastle Hospitals patients and their families.

Complex negotiations continue over the provision of co-ordination for the national service.

A productive meeting was held with NHSE on 18 July 2024 and it is hoped that a final proposal will be available for consideration by the Executive Team by the end of September 2024. The clinical and psychology teams are very keen to be involved in the provision of this service.

10. RECOMMENDATIONS

The Board is asked to note the contents of this report and:

i. Note the progress made with the implementation of PSIRF.
ii. Note ongoing concerns about performance against cancer targets and the actions being taken to improve this.
iii. Note the work done to deliver the 'Perfect Week' and outcomes achieved.
iv. Note the contents of the Appraisal and Revalidation annual report and confirm compliance with the Responsible Officer Regulations.

L Pareja-Cebrian/ M Wright
Joint Medical Directors
19th September 2024

Agenda item A8(a)

Appendix 1

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General
The board/executive management team can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	The previous Responsible Officer stood down as Medical Director in January 2024. The Deputy Medical Director and Associate Responsible Officer was appointed as Interim Medical Director in February and Joint Medical Director from 1st March. He has now been appointed as Responsible Officer. The RO has previously been trained in his role as ARO and will continue regular training through available RO training courses.
Comments:	There is no plan currently to recruit a new ARO.
Action for next year:	To ensure that the RO remains appropriately trained.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	An additional 0.25 WTE Band 4 postholder has joined the Revalidation Team to support with administrative responsibilities. A total of 76 appraisers are currently trained and delivering appraisals. A small cohort of additional appraisers were trained in November 2023 and appointed in April 2024. Some of our most experienced appraisers remain on the staff bank solely to support appraisal post-retirement.
Comments:	The current number of appraisers is lower than we would like to have. We aim to have a total of 85 appraisers active at any time.
Action for next year:	A further appraiser recruitment exercise. Promote bank appraisal work for retired appraisers.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	We maintain an accurate record of all licensed practitioners using he SARD appraisal and Revalidation system. New starters are added to this system at the time of commencement and leavers are withdrawn from the system as part of the leaving process. This list of people with prescribed connection is cross referenced with the General Medical Council (GMC) list for the Trust via the SARD system.
Comments:	
Action for next year:	To maintain the list of practitioners with prescribed connection and cross reference to GMC records.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	The Medical and Dental Appraisal for Revalidation policy was reviewed in 2023 and is due to be next reviewed in 2026. A further review will be undertaken in the current year in response to new job planning guidance.
Comments:	
Action for next year:	Review of Appraisal for Revalidation Policy

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	No peer review was undertaken this year however a review was undertaken with the Regional Medical Director's team and an action plan is being developed in response to this. A peer review will be undertaken in the current year with an equivalent sized and type of organisation.
Comments:	
Action for next year:	Peer review process to be undertaken.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are

supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	A number of different workstreams are underway in response to concerns we have had about this area: • The Medical Education Team are carrying out data gathering exercise regarding Locally Employed Doctor (LED) experience and link to appraisal and Revalidation. The results of this are expected by December 2024. • A review of appraisal and Revalidation processes for Bank Medical and Dental staff is underway. A report and action plan is expected by December 2024. • Initial communication from revalidation to new starter/ bank worker has been reviewed specifically for LED and bank doctors to increase awareness and engagement with appraisal and Revalidation.
Comments:	
Action for next year	Complete reviews currently underway of LED and Bank staff experiences of appraisal and Revalidation.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	Annual appraisal is a contractual requirement of all senior medical and dental staff and all LED staff. Appraisal is carried out by trained appraisers and the appraisals are reviewed by the Responsible Officer as part of the Revalidation process. Declaration of the whole of a clinicians scope of practice including any work carried out for other organisations is required and is reviewed as part of the Revalidation process
Comments:	
Action for next year:	To review process for assuring compliance with whole scope of practice declaration

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	Clinical Board Chairs are provided with monthly updates of those doctors who are due to have an appraisal in the reporting period but have not had and appraisal. A review of the process by which these exception reports are followed up and actioned in Clinical Boards is underway.
Comments:	The Revalidation Team previously carried out follow up of all medical and dental staff who had not had appraisal but this is more appropriately carried out at clinical board level. The process for assurance of this needs further review.
Action for next year:	To review and improve follow up of appraisal exception reports by Clinical Boards.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	The medical and dental appraisal for Revalidation policy was reviewed and ratified by Clinical Policy group in 2023.
Comments:	
Action for next year:	A further review of the policy will be carried out this year in light of changes to job planning guidance.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	A further cohort of appraisers was trained in November 2023 and appointed in April 2024. The Trust currently have 76 appraisers for medical and dental staff appraisers.
Comments:	It is estimated that 85 appraisers are required to provide a sustainable appraiser workforce.
Action for next year:	A further cohort of 9 appraisers will be trained and recruited in 2025.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	Regular appraiser update sessions are held on a quarterly basis led by the Trust Medical and Dental Appraisal Lead, the Revalidation Team and the Responsible Officer. Feedback from appraisees is obtained after each appraisal and fed back to appraisers.
Comments:	

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action for next year:	A peer review process for appraisers will be established as part of the external peer review process.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	An annual report on appraisal and Revalidation is provided to Trust Board. Appraisees provide feedback on appraisal process and appraiser performance on an annual basis. Appraisers are expected to discuss this feedback and their own appraisal. Appraisals are reviewed by the RO as part of the Revalidation recommendation process.
Comments:	Implementation of a structured quality assurance tool is currently under consideration. Previous quality assurance has been undertaken by an experienced appraiser trainer.
Action for next year:	To implement and appraisal quality assurance tool.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	All recommendations for Revalidation are made by the RO. Supporting information for recommendation is collated by the Revalidation team and reviewed by the RO. All recommendations were made on time during the reporting period. Where a positive recommendation for Revalidation cannot be made this is discussed at a weekly review meeting and the member of staff is informed by the Revalidation team and required actions agreed.
Comments:	
Action for next year:	To continue with the current process of evidence review and recommendation.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	See above for description of process for informing staff of decisions re Revalidation recommendation.
Comments:	
Action for next year:	

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	A full review of the governance structures in the organisation including clinical governance arrangements has been carried out in response to the CQC reports on their inspection of the Trust in 2023. This review has emphasised the importance of Clinical Boards as the mechanism through which the Trust operates on a daily basis. The establishment of Clinical Board level Quality Oversight Groups (QOGs) has made a significant improvement to the clinical governance of the organisation.
Comments:	
Action for next year:	To continue to embed new clinical governance structures in Clinical Boards and across the Trust.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	A concerns oversight group (COG) has been established led by the joint medical directors, the Trust medical Quality and Safety lead and senior members of the Medical Staffing team. This group meets on a weekly basis to manage response to concerns about conduct and capability of medical and dental staff. Clinical Board Chairs are invited to present low level problems to COG to ensure that early interventions are put in place. Regular review meetings take place between the RO and the GMC Employer Liaison Adviser to discuss concerns which may reach threshold for the referral to the GMC or doctors about whom the GMC are aware of concerns.
Comments:	
Action for next year:	To review the outcomes of COG intervention and report these on a regular basis to People Committee.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	This is currently under review as the information systems employed by the Trust to provide individual performance data have been changed. A review is being undertaken with the Clinical Governance and Risk Department to consider how best to provide this information. Discussions are ongoing with the Staff and Patient Experience Director to identify mechanisms of providing more rapid and effective patient feedback for medical and dental staff.
Comments:	
Action for next year:	To complete review of information systems and provision of patient experience data by January 2025.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	See above for description of development of Concerns Oversight Group. A review is currently underway of the Trust conduct and capability processes for medical and dental staff. These have until now been delivered through separate policies. These will be replaced by implementation of national MHPS policy. A revised responding to concerns guidance document is in preparation following the implementation of the Concerns Oversight Group.
Comments:	
Action for next year:	To implement MHPS and provide revised responding to concerns guidance.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	The Concerns Oversight Group will provide quarterly reports to People Committee. Analysis of the number and type of concerns will be provided as part of this reporting process. An annual report from COG will be provided to Trust Board as part of the Appraisal and Revalidation annual reporting process (this document).
Comments:	
Action for next year:	To develop reporting of the Concerns Oversight Group to People Committee with the first report being provided by December 2024.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	Information is provided to appropriate responsible officers and relevant others as part of the concerns oversight process where a doctor works in other organisations and is requested from other organisations by the Revalidation Team.
Comments:	
Action for next year:	To audit the transfer of data between organisations as part of the Concerns Oversight Group reporting process.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	All policies developed within the Trust are assessed at review and implementation to ensure that these processes are fair and free from bias.
Comments:	

Action for next year:	An audit of concerns raised through COG will be carried out to provide assurance on fairness and freedom from bias as per of the COG reporting process.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	A review of learning from external visits and inspections has been carried out as part of the response to inspection reports from CQC. Further work is ongoing to ensure that all learning from these visits and action plans developed from them are delivered.
Comments:	
Action for next year:	All external visits and appropriate learning/action plans is now reported to the Compliance and Assurance Group and then to Audit, Risk and Assurance Committee and where relevant Quality Committee.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	A review of leadership structures and leadership development within the Trust in line with the recommendations of the Messenger Review is currently underway supported by the Value Circle. This review will result in bespoke leadership development programmes for different professional groupings with emphasis on the Clinical Board Leadership Teams.
Comments:	
Action for next year:	To implement the leadership development recommendations of the Value Circle.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	All doctors including locum and short-term doctors have appropriate pre-employment checks carried out by the Medical and Dental Staffing Team who have particular expertise in the management of Medical and Dental Staff.
Comments:	
Action for next year:	To audit compliance of pre-employment checks as part of the reporting to People Committee process.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	A full review of organisational culture has been carried out following the reports of CQC inspections in 2023. This has resulted in a number of specific pieces of work to improve organisational culture which are encapsulated in the Trust People Plan.
Comments:	
Action for next year:	The four key themes for the people plan for the coming year are: Health and Wellbeing Behaviours and civility Valued and Heard Leadership and management These themes will support the development of a culture in which clinical excellence is encouraged and staff are supported in delivering high quality care across the organisation.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	See above re development and implementation of the People plan. All of these aims are enshrined within the people plan as described above.
Comments:	
Action for next year:	To continue the implementation of the People Plan.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	See above re: People plan
Comments:	
Action for next year:	

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	A formal complaints process exists in all of the Trust's professional standards processes with the opportunity for individual doctors to complain about or appeal against the outcomes of these processes.
Comments:	
Action for next year:	To ensure that all complaints and appeals are reported as part of the COG reporting to People Committee process.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	This is monitored as part of the COG process
Comments:	

Action for next year:	To include monitoring of these characteristics in reporting of COG activities to People Committee and audit against national standards on a quarterly basis.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	The RO attends RO Network events and a review meeting with the Higher Level RO and team has been carried out. An action plan is being developed in response to the report from this visit.
Comments:	
Action for next year:	To implement the action plan following HLRO visit and engage in further visits.

Section 2 – metrics

Year covered by this report and statement: 1April 2023 - 31March 2024 .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	1,290

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	996
Total number of appraisals approved missed	294
Total number of unapproved missed	94

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	248
Total number of late recommendations	0
Total number of positive recommendations	203
Total number of deferrals made	43

Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	43

2D – Governance

Total number of trained case investigators	10
Total number of trained case managers	10
Total number of new concerns registered	This data is not available for the reporting period but will be available for the next reporting period
Total number of concerns processes completed	
Longest duration of concerns process of those open on 31 March	
Median duration of concerns processes closed	
Total number of doctors excluded/suspended	
Total number of doctors referred to GMC	

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	This data is awaited
Number of new employment checks completed before commencement of employment	

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	2
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report

Since the last Board report there has been a major review of governance structures within the Trust following the reports of CQC investigations carried out in 2023. This has led to the establishment of the Quality Oversight Groups in Clinical Boards as part of the implementation of PSIRF structures. Further support for Clinical Board Quality and Safety structures will be provided by the recruitment of quality and safety leads in each of the Boards

The establishment of the Concerns Oversight Group (COG) as a forum for discussion and management of all concerns about conduct and capability issues relating to medical and dental staff has allowed major improvements in the oversight of these processes. This group will report to the People Committee and through this to Board on a regular basis providing assurance to the Board of the effectiveness of these processes. Centralising these processes in COG will allow audits described above to take place to contribute to these assurance processes.

A new Responsible Officer has been appointed.

A review of conduct and capability processes will result in the implementation of MHPS to replace existing policies.

The development and implementation of the People plan supports the development of a culture within the organisation which encourages delivery of clinical excellence and the supports staff wellbeing.

A workstream to deliver leadership development support for clinical leaders at Clinical Board and Directorate level is underway with advice from The Value Circle.

Actions still outstanding

Additional work is required to ensure that peer review of appraisal and Revalidation processes takes place and that greater quality assurance of the medical and dental appraisal process is in place. Further work is required to ensure that appraisal and Revalidation processes for locally employed doctors (LEDs) and doctors working solely or largely on the staff bank are appropriate and quality assured.

Additional work is required to increase compliance of medical and dental staff, both senior and LED with appraisal. This will be achieved by greater focus on review of monthly exception reports supplied to Clinical Board chairs, as part of the iQPR process and inclusion of completion of appraisal in the SLA (AQA) agreement with individual staff members as part of the new job planning process.

Current issues

There are ongoing issues with conduct and capability concerns about a small cohort of medical staff in several specialty areas. These are being dealt with through specific interventions led by Clinical Board leadership teams with executive support. Ongoing intensive action is likely to be required in a small number of areas over the coming year.

Actions for next year (replicate list of ‘Actions for next year’ identified in Section 1):

A further appraiser recruitment exercise.
Promote bank appraisal work for retired appraisers.
Peer review of appraisal and Revalidation processes
Implementation of People plan.
To develop appropriate reporting processes for Concerns Oversight Group (COG) to People Committee.
To carry out audits of COG activity to provide assurance of fairness and lack of discrimination.
To improve compliance with appraisal in medical and dental staff.
To review appraisal and Revalidation processes for LED and bank medical and dental staff.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
The organisation has undergone a period of major restructure and reorganisation in response to the findings of CQC inspections in 2023 highlighted in their reports. This has included additional focus on processes in place to manage professional standards amongst medical staff. The establishment of COG will make a major contribution towards this. The development and implementation of the People will plan will further support improvement in the culture, health and wellbeing of all staff groups. Further work will be carried out this year to improve compliance with appraisal amongst medical and dental staff and to ensure the governance structures in place in these areas are effective and assurance is provided on their effectiveness.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	The Newcastle upon Tyne Hospitals NHS Trust

Name:	
Role:	
Signed:	
Date:	

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Agenda item A8(a)(i)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 September 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 12 July 2024 to 13 September 2024 and by unanimous resolution, the Committees were in favour of appointing the following:

Name	Job Title	Start Date
Dr Louise Coats	Consultant in Adult Congenital Cardiology	01-Aug-24
Dr Barbara De Pinho Cardoso	Consultant Paediatric Cardiologist	02-Sep-24
Dr Christiana Stavrou	Consultant Dermatologist	03-Sep-24
Dr James Slack	Consultant General Paediatrician with HDU & Critical Care	18-Sep-24

2. RECOMMENDATION

1.1– For the Board to receive the above report.

Report of Michael Wright and Lucia Pareja-Cebrian
Medical Directors
18 September 2024

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Agenda item A8(a)(ii)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	27 September 2024					
Title	Guardian of Safe Working Quarterly Report (Q1 2024-25)					
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 March - 26 June 2024 for consideration by 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. September People Committee.					

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

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

There are now 1,025 postgraduate doctors in training on the New Junior Doctor Contract and a total of 1,084 postgraduate doctors in the Trust.

There were 109 exception reports in this period. This compares to 110 exception reports in the previous quarter.

The main area of exception reports is general medicine.

The main cause of exception reports for hours and rest is when there is a high clinical workload or low staffing levels. There have also been a large number of exception reports for doctors being unable to take their mandated self-development time.

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	1,025	(985)
Total Number of Junior Doctors	1,084	(1,061)
Number of Exception reports	109	(110)
Number of Exception reports for Hours Breaches	66	(97)
Number of Exception reports for Educational Breaches	43	(15)
Fines	7	(5)
Admin Support for Role	Good	
Job Planned time for supervisors	Variable	

4. EXCEPTION REPORTS

4.1 Exception Report by Speciality (Top 3)

		(Previous quarter for comparison)
General Surgery	8	(64)
General Medicine	79	(26)
Ophthalmology	4	(6)

4.2 Exception Report by Rota/Grade

General medicine

Hours and Rest	39
RVI (F1/F2/LED)	33
FH (F1/F2/LED)	6
Education	40
RVI (F1/SHO)	17
FH (F1/SHO)	23

General Surgery

FH (F1) including HPB, colorectal, vascular	4
RVI (F1/StR)	3

Ophthalmology

SHO	4 (3 education)

4.3 Example Themes from Exception Reports (ERs)

General Medicine RVI/FH

Education: “Unable to take 3 hours SDT time due to staffing levels.”
There was a change in policy of mandatory self-development time so that doctors were allocated this as a few hours in the clinical day compared to previously when it was allocated as full days. This was done to try to reduce the locum spend, but has led to doctors being unable to take this as they are unable to leave the ward due to clinical pressures. This has been highlighted to the department and discussions are ongoing to find a solution.

General Surgery

“Stayed an hour late on an on call shift due to demand.”

The ERs from general surgery are when there is either excessive workload or staff shortages. These have greatly reduced compared to previous reports.

5. EXCEPTION REPORT OUTCOMES

5.1 Work Schedule Reviews

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

5.2 Fines

7 fines have been issued:

- General Surgery (1 fine): Rule breached "Late finish; Unable to achieve breaks; Exceeded the maximum 13-hour shift length. " Total fine money £87.08.
- 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 £260.01.
- Paediatrics (2 fines): Rule breached "Exceeded the maximum 13-hour shift length." Total fine money £100.78.
- Renal Medicine (1 fine): Rule breached "Late finish; Unable to achieve breaks; Exceeded the maximum 13-hour shift length." Total fine money £75.58.
- Medical Microbiology (1 fine): Rule breached "Late finish; Unable to achieve breaks; Exceeded the maximum 13-hour shift length." Total fine money £113.35.
- Haematology/Oncology (1 fine): Rule breached "Late finish; Unable to achieve breaks; Exceeded the maximum 13-hour shift length." Total fine money £119.25.

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 Education

Self-development time (SDT) is mandatory in the foundation school curriculum. This takes time away from clinical duties, and discussions are ongoing as to how to ensure clinical demand is met as well as providing the educational requirements of doctors in training.

6.2 Supervisor Engagement

Supervisor engagement is generally good. Weekly prompting by the medical staffing team has reduced supervisor response time.

6.3 Administrative Support

Administrative support is currently good.

7. ROTA GAPS

Specialties and rotas with vacancies are outlined below.

Directorate	Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Jun-24	May-24	Apr-24
		Cancer Services					
Cancer Services	FH	Oncology	ST3+	22	4.2	4.2	6
Cancer Services	FH	Palliative Medicine	F2/ST1+	13	0.8	0.8	0.8
Cancer Services	FH	Haematology / Oncology	F2/ST1/ST2	12	1	1	1
Cancer Services	FH	Haematology	ST3+	9	1.4	2.4	2.4
		Cardiothoracic Services					
Cardiothoracic Services	FH	Cardiology	ST3+	15	0.2	0.2	0.2
Cardiothoracic Services	FH	Cardiothoracic Anaesthesia	ST3+	10	3	3	2
Cardiothoracic Services	FH	Cardiothoracic Surgery	ST3+	11	3	3	2
Cardiothoracic Services	FH	Cardiothoracic Transplant	ST3+	3	1	1	1
Cardiothoracic Services	FH	PICU	ST3+	8	1	1	1
Cardiothoracic Services	FH	Paediatric Cardiology 1st	F2/ST1/ST2	7	1.2	1.2	1.2
Cardiothoracic Services	FH	Paediatric Cardiology 2nd	ST3+	9	1	1	1
		Children's Services					
Children's Services	RVI	Paediatrics 1st - ST1/ST2 (now inc Paeds Surgery)	F2/ST1/ST2	25	1.4	1.4	1
Children's Services	RVI	General Paediatrics	ST3+	23	0	0	2.2
Children's Services	RVI	Paediatric Oncology	ST3+	6	1	1	1
Children's Services	RVI	Paediatric ICU (PICU)	ST3+	10	2	2	2
		EPOD					
EPOD	FH	ENT	F2 / CST / ST1-2	5	1	1	0
EPOD	RVI	Plastic Surgery	F2/ST1/ST2	8	0.2	0.2	0.2
EPOD	RVI	Ophthalmology	ST3+	25	1.2	1.2	1.2
EPOD	RVI	Dermatology	ST3+	7	0.4	0.4	0.4
		Integrated Lab Medicine					

Integrated Lab Medicine	RVI	Histopathology	ST3+	16	0.9	0.9	0.9
Integrated Lab Medicine	RVI	Histopathology	ST1/2	8	0.2	0.2	0.2
Integrated Lab Medicine	RVI	Medical Microbiology	ST1+	21	1.6	1.6	1.6
		Medicine					
Medicine	FH	General Internal Medicine	F2/GPVTS/CMT/TF	12	0.6	0.6	0.6
Medicine	RVI	CMT Acute	CMT	2	1	1	1
Medicine	RVI	ACCS on Assessment Suite Only	ACCS	2	0.2	0.2	0.2
Medicine	RVI	General Internal Medicine	ST3+	25	1.9	1.9	1.9
Medicine	RVI	Clinical Immunology	ST3+	3	1	1	1
Medicine	RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	20	1	1	1
Medicine	RVI	Accident & Emergency 2nd	ST3+	15	2.4	2.4	2.4
Medicine	RVI	Accident & Emergency	F2 GP Placement	12	0.2	0.2	0.2
		Musculoskeletal					
Musculoskeletal	FH	Rheumatology	ST3+	5	1	1	1
Musculoskeletal	RVI/FRH	Orthopaedics	ST3+	19	1	1	1
		Neurosciences					
Neurosciences	RVI	Neurosurgery	F2/ST1/ST2	5	0.2	0.2	0.2
Neurosciences	RVI	Neurology	ST3+	13	0.4	0.4	0.4
Neurosciences	RVI	Neurology	IMT/CMT	3	0.2	0.2	0.2
		Peri-operative FH					
Peri-operative & Critical Care	FH	Critical Care	F2 ST1-7	13	1	1	1
Peri-operative & Critical Care	FH	Anaesthetics General	ST1-7 CT1-2	27	3.8	3.8	3.8
		Peri-operative RVI					
Peri-operative & Critical Care	RVI	Critical Care	ST1+	16	2.6	2.6	2.6
Peri-operative & Critical Care	RVI	Anaesthetics	ST1-2 / ST3 +	40	3.6	3.6	3.6
		Radiology					
Radiology	RVI / FH	Radiology On Call	ST2 / ST3+	33	1	1	1
		Surgical Services					
Surgical Services	FH	General Surgery	F2/ST1/ST2/ST3+	7	1	1	1
Surgical Services	FH	Hpb / Transplant	ST3+	11	1.2	1.2	1.2
Surgical Services	RVI	General Surgery	ST3+	15	0.8	0.8	0.8
		Urology & Renal					
Urology	FH	Renal Medicine	ST3+	6	1.6	1.6	1.6
		Womens' Services					
Womens' Services	RVI	Obstetrics & Gynaecology	F2/ST1/ST2	14	1.4	1.4	1.4
Womens' Services	RVI	Obstetrics & Gynaecology	ST3+	22	2	2	2
Womens' Services	RVI	Neonates	F2/ST1/ST2	7	1	1	1
Womens' Services	RVI	Neonates	ST3+	13	1.2	1.2	1.2

8. 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

March to June (Q1 2024-2025)	£1,435,902
January to March (Q4 2023-2024)	£2,183,744

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 a decrease of £748k between Q4 23/24 and Q1 24/25. Of this decrease, -£384k was Medicine & Emergency Care, -£159k was Surgical & Associated Specialities, -£75k Perioperative & Critical Care, -£50k Surgical & Specialist Services and -£49k Cardiothoracic."

Trust Locum Spend

March to June (Q1 2024-2025)	£945,686
January to March (Q4 2023-2024)	£957,439

Comment from finance team:

"Based on information supplied by Medical Staffing this was made up predominately by decreases in Industrial Action Cover (-£73k), & Establishment Vacancies (-£30k), offset by increases in On Call Cover (£37k), Covid 19 Additional Dependency (£27k), Increased Workload (£21k) and Sickness (£10k).
With regards to Clinical Boards the decrease of spend can be seen particularly in Medicine & Emergency Care (£-£74k) & Surgical & Specialist Services (-£31k). This is partially offset by increase in Cardiothoracic (£57k).

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 meaning that doctors are required to have a mandated number of hours self-development time.

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, and ensure educational requirements are upheld.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours

July 2024

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Agenda item A8(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 September 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: <u>Section 1 - Spotlight on Nursing, Midwifery Research</u> In line with the Nursing, Midwifery and Allied Health Professionals (NMAHP) Strategy the NMAHP Research team focus on increasing awareness of the team and opportunities. The report outlines the work undertaken by the NMAHP Research Team including: • The development of a dedicated NMAHP Digital Research Intelligence Dashboard (now named IRIS) which continues to evolve. Since publishing a peer-reviewed article in January 2024, the team have received a significant amount of external interest. • Research Development Institute (RDI) Fellowships funded through a Newcastle Hospitals Trust Charity £3.2m grant, are available at every stage of an individual's research career, from Internship through to Post-Doc Chief Nurse Fellowships. The table included in section one details the fellowship programme and status for 2024. • The NMAHP Research team have supported 12 external applications to National Institute for Health and Care Research (NIHR) fellowship related funding streams. Of those, nine were successfully awarded, and one is still awaiting outcome. <u>Section 2 and 3 - Nursing and Midwifery Staffing Update</u> Sections two and three highlight areas of risk and detail actions and mitigation to assure safer staffing in line with agreed escalation criteria for nursing (section two) and midwifery (section three). Key points to note in section 2 • The nurse staffing escalation remains at level two due to appropriate criteria being met. The necessary actions in response to this are in place and continue to be overseen by the Executive Director of Nursing. • The monitoring of nursing safer staffing metrics against clinical outcomes/nurse sensitive indicators as mandated in national guidance continues via the Nurse Staffing and Clinical Outcomes Operational Group.		

- Several wards have required support at medium or high level since the last report to Board. Action plans are in place for wards with additional peer support, education and resources provided, overseen by the Executive Director of Nursing team and relevant Clinical Boards. Two wards have required high-level support and have robust action plans in place. One ward has been de-escalated following a successful peer review. An overview of this work has been reported into the Quality Committee.
- Registered Nursing (RN) fill rates <85% are reported to the Executive Director of Nursing monthly. The detail of those areas reporting <85% are contained in this report. RN dayshift fill rate has remained over 95%, and nightshift over 90% for the past three months with Healthcare Assistant (HCA) dayshift also improving over the past three months to between 94-96%.
- Datix and red flag reporting trends are closely monitored. There has been a reduction in both with a reciprocal increase in fill rates. Datix reporting continues to be encouraged.
- The current total RN turnover is 6.44%, Based on Month 4 2024 data, this demonstrates a reduction from the previously reported 8.72% in the same period last year.
- The current RN vacancy rate is 2.30%, based on the financial ledger at Month 4. This is a slight increase from the 2.07% reported in Month 3, however it is still below the figure of 4.99% reported in the same period last year.
- The Trust Healthcare Support Worker (HCSW) vacancy rate is currently 8.5%. This is a favourable position compared with the national vacancy rate of 9.3%.

From a maternity perspective the following key points are noted:

- The maternity service has maintained compliance with the requirements of Safety Action 5 of the Maternity Incentive Scheme with 100% compliance with one to one in labour and 100% compliance with the coordinator being supernumerary at the beginning of each shift.
- The current funded establishment fulfils the 2020 Birth Rate+ recommendations.
- The staffing meeting the live acuity is variable, with 53% in November 2023, 73% in April and 51% in July 2024. This is in part due to unpredictable intrapartum activity, but also as a result of the Delivery Suite planned establishment not having grown following the suspension of the intrapartum service in the Newcastle Birthing Centre (NBC) and the consolidation of all activity on the Delivery Suite.

<u>Section 4 Safeguarding and Mental Capacity Act (MCA)/Deprivation of Liberty Standards (DoLS) Quarter 1 (Q1)</u>

Section 4 provides a Q1 update of safeguarding activity throughout the Trust and includes references to developments in local and national practice and the Trust's compliance with these recommendations. This detail was presented to the Safeguarding Committee 23 July 2024 and Quality Committee 17 September 2024.

Key points to note:

- Q1 safeguarding activity data relating to adult, children and maternity safeguarding whilst variable, has notably increased in adults.
- Due to vacancy and staff sickness, along with case complexity and volume, staffing and capacity has been challenging. Case work has been a priority and there has therefore been an impact on the ability of the team to undertake assurance and audit work. Work is underway to recruit to all vacancies and additional support is in place to mitigate risk. This has been identified on the risk register and continues to be closely monitored by the Safeguarding Operational Group.
- In Q1 there were 533 reported MCA and DoLS related enquiries, with some being regarded as complex and duly escalated within the Trust. Complex cases may require

	external legal advice or be put before the Court of Protection. Q1 numbers for urgent DoLS applications received and sent to Local Authorities remained high, which is a trend seen since May 2023. For each month in Q1, numbers have remained at an average of 174 applications. • Level 1 and Level 2 Adult Safeguarding training demonstrates good compliance with 96% for both elements. Safeguarding Adult Level 3 compliance has increased to 88% and work continues to review all staff groups to ensure those with Level 3 attached to their profile is accurate. • Level 1 and Level 2 Safeguarding Children's training compliance rates are 96% and 97% respectively. Level 3 Safeguarding Children was at 88% which is below the required 90%. Support has been provided to the team from the Learning and Development Unit to improve training compliance rates across the Trust and work has commenced on a training needs analysis. • Level 1 MCA is mandatory training for all patient facing staff. Compliance currently sits at 95%. Level 2 DoLS and MCA e-learning module has been developed and reviewed at the Learning and Education Group. A further impact assessment has been requested and provided for review on 23 October 2024. This action forms part of the Care Quality Commission (CQC) action plan for the application of the Mental Capacity Act. • Several audit reports were discussed in the Safeguarding and Quality Committee and an overview of these can be found within the report. <u>Section 5: Learning Disability Q1</u> Section 5 of the report provides a Q1 summary update of the activity and work regarding the Learning Disability liaison team. The following key points are noted: • Q1 demonstrates increasing activity with 930 patient referrals, an increase of 386 patients compared to Q4 and an increase of 451 patients compared to Q1 2023/24. • In Q1 there have been several complex cases requiring joint work with legal services, the MCA/DoLS lead. • There remains no national guidance regarding mandatory learning disability and autism training but there is an assumption that the Oliver McGowan training will be the preferred option. The current compliance with existing regional Diamond Standard e-learning is 94%. • It is recognised that the Diamond Standards training does not sufficiently cover learning on autism. To mitigate this, the Northeast Autism Society have provided Autism Awareness education sessions in Q1 which have been positively evaluated and further sessions have been commissioned. • Work is in progress to identify additional staffing resource to lead work streams relating to autism, working as part of the wider Learning Disability Liaison Team. Substantive funding is being sought. <u>Section 6: Influenza/Vaccination update</u> Section 6 of the report contains an overview of the planned Covid and Flu winter vaccination programme. The vaccination steering group has bene meeting weekly to oversee this programme and there are no risks to escalate at this time.
Recommendation	The Board of Directors is asked to note and discuss the content of this report.

Agenda item A8(b)

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

1. SPOTLIGHT – INCREASING NMAHP RESEARCH OPPORTUNITIES AND IMPACT

In line with the NMAHP Strategy to increase research opportunities and impact, whilst strengthening our academic links, the NMAHP Research team focus on increasing awareness of the team and opportunities, has resulted in discussions with at least 1,014 nurses, midwifes, allied health professionals and students across 80 wards/departments/teams within the Trust. Consequently, there has been an increase in individuals expressing interest in applying for Researcher Development Institute fellowships. The future work plan will incorporate a significant face to face awareness raising element based on this work.

The dedicated NMAHP Digital Research Intelligence Dashboard (now named IRIS) work continues to evolve. Since publishing a peer-reviewed article in January 2024, the team have received a significant amount of external interest. Work is ongoing to build a version that is viable beyond the Trust, and the commercial team has been approached for support to cost and explore demand. National discussions are also underway to explore the most appropriate funding route to enable the IRIS to be tested and rolled out at sites across the UK or to use it as a catalyst to generate a system wide solution that would meet a range of needs in this strategic agenda.

Research Development Institute (RDI) Fellowships funded through a Newcastle Hospitals Trust Charity £3.2m grant, are available at every stage of an individual's research career, from Internship through to Post-Doc Chief Nurse Fellowships.

The table below also details the fellowship programme and status for 2024.

Fellowship	Status	Comments
Doctoral Fellowships	Closed - awarded	X3 applications, X1 award
Master's in Research	Closed - awarded	X3 applications, X2 award
Chief Nurse Fellowships	Closed - in review	X3 applications - interviews Sep
Research Internship	Due to open Sep	Biomedical Research Centre (BRC), RDI & Obstetric Sonography available
RCBF	Open year-round	X5 applications to date X4 successful, X1 pending

In 2024 the 4Ps Researcher Development Programme was refreshed bringing in a number of innovations. Cohorts are now delivered alternately in-person and online, to provide more choice for delegates. Bookings are now administered by Newcastle Clinical Skills Academy, utilising their skills and freeing-up NMAHP Team resource. Course places are now sold as a full package rather than session-by-session, for more stable income. The refresh has been a great success, with 90 delegates attending the programme so far in 2024, raising valuable income for the Trust. Delegates came from ten different Trusts across the region and beyond and comprise at least nine different health and care professions.

Additionally, following the Trust's successful bid to the NIHR INSIGHT scheme, a shorter and more accessible version of 4Ps, called 4Ps Lite has been launched. This programme was piloted in Spring 2024 with a cohort of 13 newly qualified Trust Pharmacists. The INSIGHT version was then launched in July. Eight healthcare students attended, from a range of professions and different Higher Education Institutions (HEIs) across the region.

Since the 1 August 2023, the NMAHP Research team have also supported 12 external applications to NIHR fellowship related funding streams. Of those, nine were successfully awarded, and one is still awaiting outcome. The Team have also been responsive to the current development of the Trust Accreditation Programme to develop a research pillar as part of the programme.

Trust data indicates that 19% of our Nursing and Midwifery workforce are from a global majority background. However, a review of data from the NMAHP research dashboard undertaken in October 2023, identified that only 7% of staff seeking research opportunities were from a global majority background. A proposal document is underway to develop a Chief Nurse Fellowship (CNF), specifically targeting internationally recruited Nurses at Newcastle Hospitals. The Fellowship would be supported and supervised by the Trust Lead for NMAHP Research and will provide an enhanced understanding of the organisational, professional and personal opportunities and challenges involved in building a career that successfully integrates clinical practice and research from the perspective of internationally recruited nursing staff within the Trust.

This spotlight has provided an oversight of the many current work streams that are being developed across the NMAHP Research agenda. Despite challenges the team continue to deliver on several key programmes and processes that ensure that the NMAHP Research Team are seen as strong and credible partners nationally.

2. NURSING AND MIDWIFERY STAFFING UPDATE

2.1 Nurse Staffing Escalation

The Trust's Nursing Safe Staffing Guidelines provide a robust framework to ensure safe nurse staffing governance and articulates a clear process for safe staffing escalation. The Trust staffing escalation is currently operating at level two due to the following triggers:

- Sustained sickness absence greater than 5% for the registered nursing and midwifery workforce.

It has been recognised that sickness absence has remained above 5% for several years and is reflected nationally. The nurse staffing guidelines are currently under revision and the absence profile will be considered when reviewing the escalation triggers.

The following actions remain in place and are overseen by the Executive Director of Nursing:

- Senior nursing team provide a twice daily staffing review which is reported into the Trust operational and tactical control teams.
- SafeCare (daily deployment tool) is utilised to deploy staff within and across Clinical Boards.
- Daily review of staffing red flags and incident (Datix) reports.
- Staff bank HCA pool is reviewed daily, using Safecare to identify areas of shortfall and reduce agency requirement.

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

2.2 Nurse Staffing and Clinical Outcomes

In line with Developing Workforce Safeguards (2018), the Nurse Staffing and Clinical Outcomes Operational Group (NS&O) continue to meet monthly to monitor safer staffing metrics which are triangulated with clinical outcomes and professional judgement. 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 with Heads of Nursing to examine and support action plans. High and Medium (>2 months) level support are reported to the Executive Director of Nursing each month and where wards have required high level support this is de-escalated following a successful peer review.

Below is an overview of the wards reviewed and level of support required for the last quarter:

Month	Total	Clinical Board	High level support	Medium level support	Low level support
May-24		Family Health Services	1	0	4
		Surgical and Specialist Services RVI	0	3	1
		Perioperative Services	0	1	1
		Cardiothoracic Services	1	0	3
		Medicine and Emergency Care Services	0	3	4
		Surgical and Associated Services Freeman Hospital (FH)	0	1	2
		Cancer and Clinical Haematology Services	0	1	0
Total	**26**		**2**	**9**	**15**
June-24		Family Health Services	1	1	3
		Surgical and Specialist Services RVI	0	2	2
		Perioperative Services	0	1	1
		Cardiothoracic Services	1	0	3
		Medicine and Emergency Care Services	0	0	8
		Surgical and Associated Services FH	0	1	2
		Cancer and Clinical Haematology Services	0	1	0
Total	**27**		**2**	**6**	**19**
July-24		Family Health Services	1	1	3
		Surgical and Specialist Services RVI	0	2	2
		Perioperative Services	0	1	1
		Cardiothoracic Services	1	0	3
		Medicine and Emergency Care Services	0	1	4
		Surgical and Associated Services FH	0	1	1
		Cancer and Clinical Haematology Services	0	1	0
Total	**23**		**2**	**7**	**14**

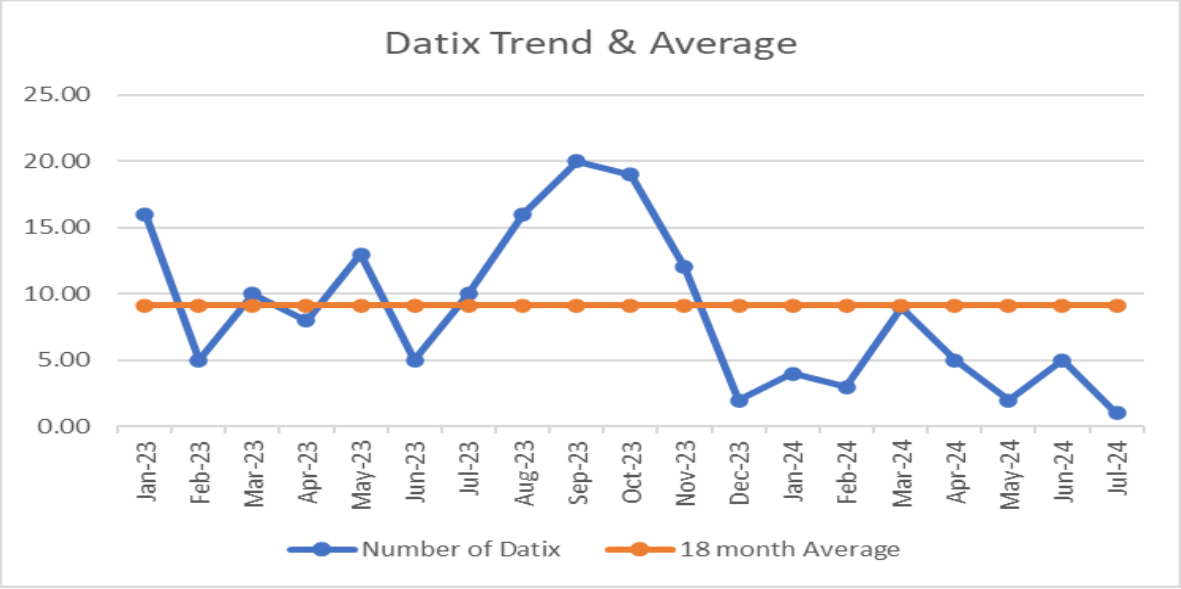
The key points from this Group are noted below:

- Two wards (Ward 4 Great North Children's Hospital (GNCH) and Ward 29 FH) have required high-level support over the last three months and have demonstrated significant and consistent improvement in areas of concern identified by their action plans.
- Ward 29 FH had a successful peer review on 31 July 2024 and has been de-escalated. The results of a staff survey are awaited to support future improvements.
- The paediatric peer review form for Ward 4 is being refined and a peer review will be organised once this form has been agreed.
- While still under high-level support, the wards have action plans in place led by the Heads of Nursing. The action plans are examined monthly at the NS&O mid-point review meeting, the outcome of which is fed back to the NS&O Group. The wards of concern needing high-level support are discussed and presented at the Trust's Quality Committee for scrutiny and oversight.
- In addition to the high-level monitoring, oversight and assurance provided by the Group, there continues to be a robust leadership and management framework led by the Head of Nursing and Matron teams.

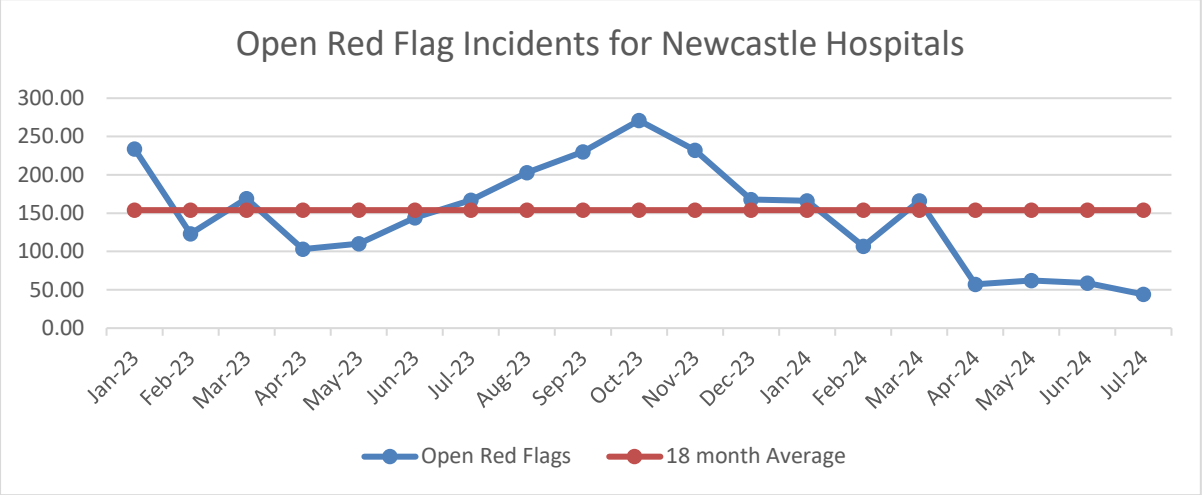
2.3 Datix and Red Flag data

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

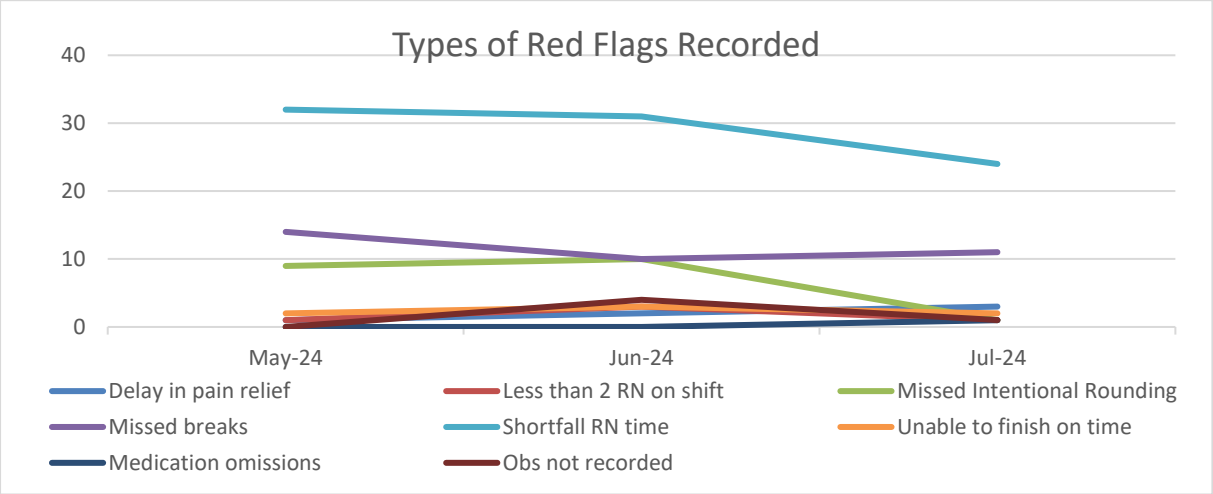
All staffing incidents reported on Datix are received by the Interim Deputy Director of Nursing, the Associate Director of Nursing, and the corporate senior nursing team. In hours, the incidents are reviewed in real time, and out of hours, as soon as practicable. Reporters and Matrons are contacted to acknowledge receipt and to gain greater understanding of themes. When incidents are being responded to in real time mitigations are put in place and resolution is sought. Work continues to encourage staff to report staffing shortfalls.



There has been a significant reduction in staffing Datix reported since December 2023, with the number of reports remaining at, or below the 18-month average (9).



There has been a significant reduction in red flag incidents reported since March 2024, with the number of reports remaining below the 18-month average (154).



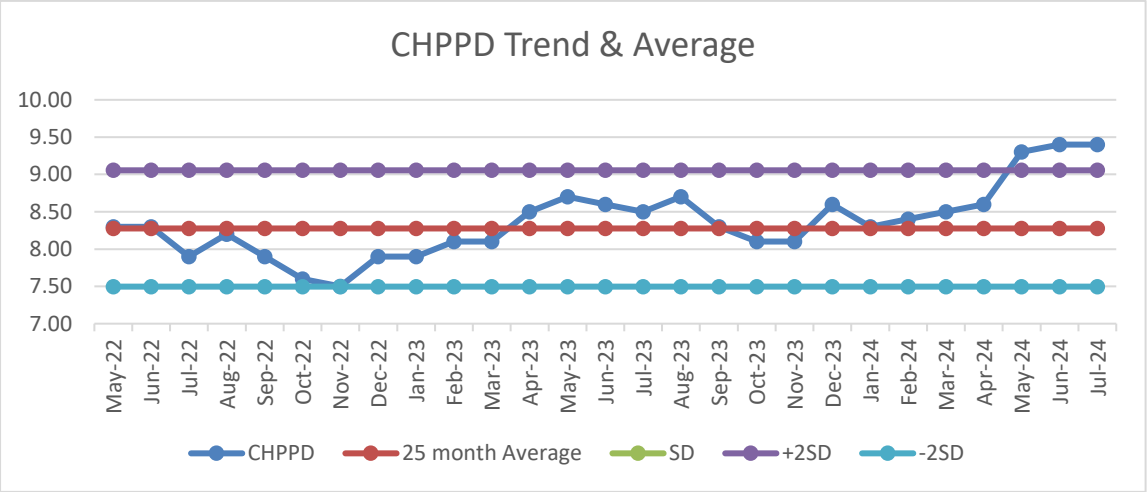
The most reported reg flag type was “Shortfall in RN time”, with “Missed Breaks” and “Missed Intentional Rounding” being regularly reported.

2.4 Care Hours Per Patient Day (CHPPD) data

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. It adds together Registered Nurses and Support Worker hours, divided by midnight census. All acute Trusts have been required to report their actual monthly CHPPD, to NHS Improvement 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, Newcastle Hospitals 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 corporate staffing team monitor Ward-specific CHPPD on the Safer Staffing Dashboard which is reviewed at the Nurse Staffing and Outcomes Group each month.

The Trust CHPPD trend data is detailed in the graph below:

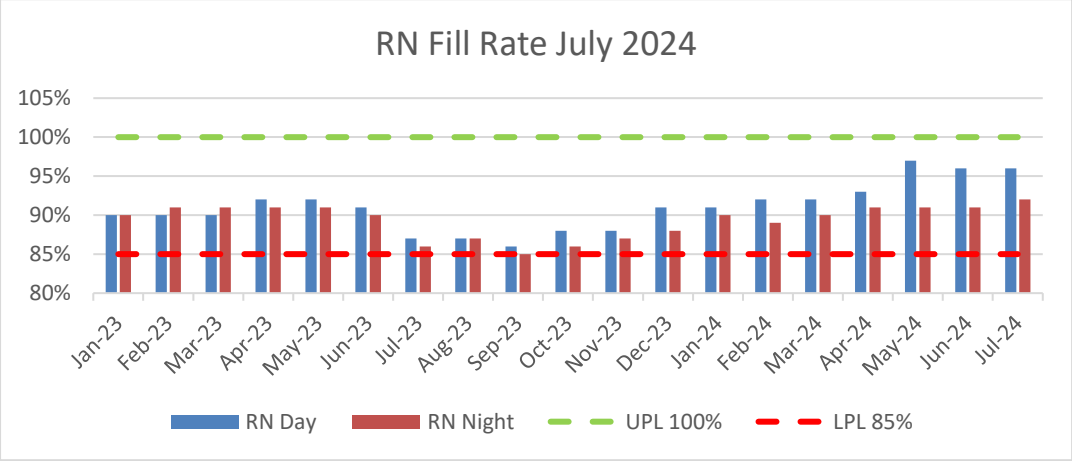


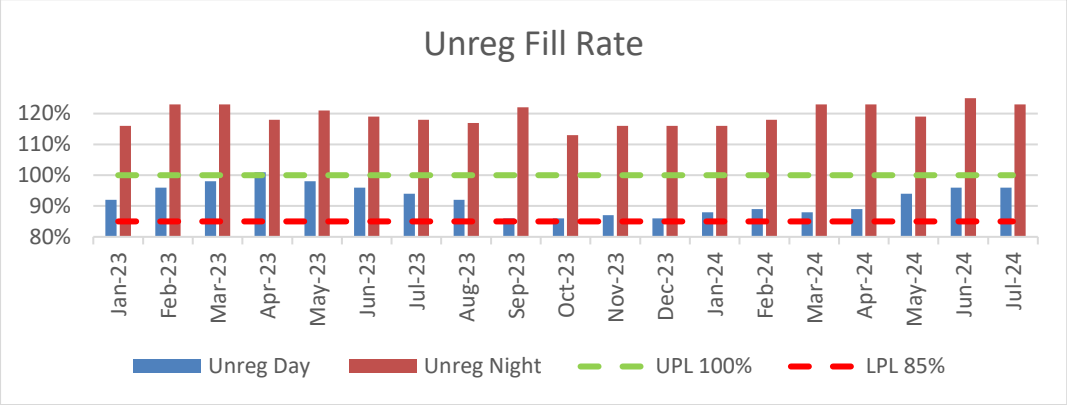
It should be noted that the increase in CHPPD will reflect the reduced vacancy rate but is also at a time when the Trust moved to automated fill rate calculations. This automated system supports accuracy and may reflect an under reporting historically.

2.5 Planned versus actual hours (fill rates)

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 corporate senior nursing team and adjusted for temporary bed closures or following any agreed nurse establishment change. The actual hours are generated by automated report via allocate health roster. This data is posted on the public website in line with National Institute for Health and Care Excellence (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 each month.





Wards Reporting <85% Fill Rate				
May-24	**No. Day**	**Wards**	**No. Night**	**Wards**
Family Health	1	12 GNCH	3	3, 4, 12 GNCH
Surgical & Specialist RVI	0		1	Neurosciences Short Stay Unit (NSSU) RVI
Peri Op & Critical Care	1	38 RVI	2	18, 38 RVI
Cardiothoracic	3	PICU, 23, 27 FH	2	Paediatric Intensive Care Unit (PICU), 23 FH
Medicine & Emergency	0		2	9 FH, 48 RVI
Surgical & Associated FH	0		2	7, 8 FH
Cancer & Haematology	0		1	33 Northern Cancer for Centre Care (NCCC)
Total	**5**		**13**	
Jun-24	**No. Day**	**Wards**	**No. Night**	**Wards**
Family Health	1	12 GNCH	2	3, 12 GNCH
Surgical & Specialist RVI	0		0	
Peri Op & Critical Care	0		1	38 RVI
Cardiothoracic	2	PICU, 27 FH	2	PICU, 21 FH
Medicine & Emergency	1	52 RVI	3	9 FH, 30, 48 RVI
Surgical & Associated FH	0		3	7, 8 FH, 46 RVI
Cancer & Haematology	0		1	33 NCCC
Total	**4**		**12**	
Jul-24	**No. Day**	**Wards**	**No. Night**	**Wards**
Family Health	1	12 GNCH	2	3, 12 RVI
Surgical & Specialist RVI	1	19 FH	0	
Peri Op & Critical Care	1	37 FH	0	
Cardiothoracic	2	PICU, 23 FH	2	PICU, 23 FH
Medicine & Emergency	1	52 RVI	1	9 FH
Surgical & Associated FH	0		3	7, 8 FH, 46 RVI
Cancer & Haematology	0		1	33 NCCC
Total	**6**		**9**	

The above chart details the wards and departments that reported <85% RN fill rate May-July 2024. The critical care shortfall was mitigated by limiting bed capacity to meet the acuity and dependency of the patients. Some shortfall was due to increased leave allowance to account for reduced service activity during summer holidays. There is some

ongoing support for wards with their vacancy, recruitment and rostering issues through the nurse staffing review process, nurse staffing and outcomes group and check, challenge and coach process.

Key points from the last 3 months:

- RN dayshift fill rate has remained over 95%, and nightshift over 90% for the past three months.
- HCA dayshift has improved over the past three months, between 94-96%.
- HCA nightshift fill rate has been 119-126%, which is partially due to backfill for RN shortage and enhanced care shifts being easier to fill on nightshift.
- In addition, some wards have been identified to have a staffing shortfall on nightshift through the nurse staffing review process, and are staffing to agreed levels, over their current establishment to maintain safety and quality of care.

2.6 Rostering Assurance (Check, Challenge & Coach)

The "Check Challenge and Coach" process aims to maximise rostering potential and improve fill rates. A coaching approach is taken supported by Quality Improvement methodology with a focus on achieving goals, identifying skills, tools and training to drive improvement. Monitoring is through bi-monthly meetings and e-roster dashboards for each Clinical Board. Key performance indicators are reviewed to identify potential risk and implement appropriate supportive action to mitigate.

Key Points to note

- The annual leave compliance continues to be variable. It has been noted that the system does not have user-friendly visibility for advance percentages of annual leave and a request has been submitted to Allocate requesting an upgrade in functionality. Annual leave percentages can also be skewed by new starters with existing leave approvals, and changes in vacancy levels.
- Unused hours have consistently decreased since check, challenge and coach was initiated, except for a spike over Christmas/New Year 2023.
- Advance rostering has significantly improved since the introduction of this programme.

2.7 Registered Nurse (RN) Recruitment

Key Points to note:

- The current total RN turnover is 6.44%, based on Month 4 2024 data, this demonstrates a reduction from the previously reported 8.72% in the same period last year.
- The current RN vacancy rate is 2.30%, based on the financial ledger at Month 4 2024 this is a slight increase from the 2.07% reported in Month 3, however it is still below the figure of 4.99% reported in the same period last year. This relates to current substantive staff in post and does not include those staff currently in the recruitment process.
- The Nursing Midwifery and Allied Health Professional (NMAHP) Recruitment and Retention Group continue to closely monitor Band 5 vacancy and turnover rates. The vacancy position has improved over the last two years and is a reflection of the innovative recruitment and retention strategies that the Trust has implemented. These strategies

have been recognized and showcased on NHS England (NHSE) and NHS Employer learning platforms.

- The NMAHP Recruitment and Retention Group has undertaken focused on recruitment of students registering in September 2024. In collaboration with human resources colleagues students have been supported through the recruitment process with 130 students having been successfully appointed since May 2024. There are currently 14 RN on a reserve list as their preferred area does not have a vacancy.

2.8 Healthcare Support Worker (HCSW) Recruitment

Key points to note:

- The Trust HCSW vacancy rate is currently 8.5%. This is a favourable position compared with the national vacancy rate of 9.3%. It should be noted that the Trust workforce report contains non-HCSW staff such as housekeepers reported in the 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 for this reporting issue which has been highlighted to NHSE.
- Based on Month 4 2024 data, the HCSW turnover rate was 10.37% compared to 12.79% the previous year highlighting a reduction which reflects the retention work undertaken.
- In May 2024, apprentice HCSW recruitment was held with successful appointment of 15 apprentices. At the time of interview some successful candidates were placed on a waiting list. All these candidates have now been appointed into suitable apprenticeship posts and will commence in the Healthcare Academy in September.

3. MIDWIFERY STAFFING UPDATE

Real time data generated by the Birth Rate + acuity tool is used to measure the effectiveness and safety of midwifery staffing across the maternity services, in conjunction with fill rates against the planned establishment.

During the period 1 May 2024 to 31 July 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, there was however an isolated occasion whereby the co-ordinator was not supernumerary during the shift for a short period. The remains an improving picture, the service has been able to consistently provide one to one care in labour over the last six months.

The staffing meeting the live acuity is variable, with 53% in November 2023, 73% in April and 51% in July 2024. This is in part due to unpredictable intrapartum activity, but also as a result of the Delivery Suite planned establishment not having grown following the suspension of the intrapartum service in the Newcastle Birthing Centre and the consolidation of all activity on the Delivery Suite. This is being considered as part of the workforce review and future intrapartum team model. 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.

Following the suspension of NBC there has been an overall reduction in red flags, 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, incorporating the results and feedback from the Maternity CQC survey, and how this can be optimised within the current estate configuration.

The service awaits the additional midwifery resource following recruitment of student midwives, who are expected to join the service in October and November. A carefully phased rotation to the intrapartum team will support maximising the midwifery establishment available to support the rosters whilst safeguarding the supernumerary preceptorship of the new entrant midwives. This will be effective from December, suggesting the integrated intrapartum team model would support the provision of care in NBC prior to Christmas.

The maternity service has maintained compliance with the requirements of Safety Action 5 of the Maternity Incentive Scheme with 100% compliance with one to one care in labour and 100% compliance with co-ordinator being supernumerary at the beginning of each shift.
The current funded establishment fulfils the 2020 Birth Rate+ recommendations.

4. SAFEGUARDING AND MENTAL CAPACITY ACT QUARTER 1 (Q1)

This summary provides a Q1 update of safeguarding activity throughout the Trust. This detail was presented to the Safeguarding Committee (July) and Quality Committee (September).

4.1 Activity

Safeguarding activity for Q1 evidences the following key high-level points:

- Q1 Safeguarding data demonstrates a decrease in activity compared to Q4, with 701 referrals/cause for concern being received against a total of 864 in Q4. However, the complexity, along with the requirement to support other multi-agency work does remain challenging for the team and continues to impact on improvement and audit work streams. Self-neglect continuing to present as the most significant concern. This is a consistent trend and reflects national and local Safeguarding Adult Reviews.
- Q1 Children's Safeguarding activity remains consistent, mirroring similar numbers to the same month in 2023.
- Q1 Maternity Safeguarding activity remains higher than previous years and is attributed to the implementation of BadgerNet, which has improved midwives ability to notify in maternity services.
- In Q1 there were 533 reported MCA and DoLS related enquiries, with some being regarded as complex and duly escalated within the Trust. Complex cases may require external legal advice or be put before the Court of Protection. These cases often necessitate a significant time commitment and resource from clinical teams along with Learning Disabilities Liaison and Safeguarding Adults/Children teams and have required coordination between agencies in order to satisfy legislative compliance.
- In Q1 numbers for urgent DoLS applications received and sent to Local Authorities remained high, which is a trend seen since May 2023. For each month in Q1, numbers have remained at an average of 174 applications. Additionally, the team gathers the numbers of DoLS

applications received from wards where there has been a decision not to forward the application to the Local Authority. For Q1 this number was 82 and indicates the need to ensure expert checks and scrutiny of DoLS forms prior to submission to Local Authorities. There is a clear process for this in the Trust and feedback is given to wards when such applications are received.

- Due to vacancy and staff sickness, along with case complexity, staffing and capacity has been challenging. Case work has been a priority and there has therefore been an impact on the ability of the team to undertake assurance and audit work. Work is underway to recruit to all vacancies whilst a wider review is undertaken of team capacity as a whole. This has been identified on the risk register and continues to be closely monitored by the Safeguarding Operational Group.

4.2 Education and Training

Safeguarding Adults training compliance continues to be closely monitored. Level 1 and Level 2 training demonstrates good compliance with 96% for both elements in Q1. Safeguarding Adult Level 3 compliance has increased to 88% and work continues to review all staff groups to ensure those with Level 3 attached to their profile is accurate.

Level 1 and Level 2 Safeguarding Children's training compliance rates are 96% and 97% respectively. In Q1 Level 3 Safeguarding Children was at 88% which is below the required 90%. Support has been provided to the team from the Learning and Development Unit to improve training compliance rates across the Trust and work has commenced on a training needs analysis.

In Maternity services, staff continue to undertake Level 3 Safeguarding Children training with an additional annual hour of maternity specific safeguarding training within the Public Health Day. This training supports midwives to meet the intercollegiate requirement of 16 hours of Level 3 Safeguarding Children training over a three-year period.

In Q1, the Trust embarked on a significant mandatory and best practice MCA training programme. This has been achieved through a Level 1 MCA mandatory training for all clinical and patient facing staff. Compliance currently sits at 95%. In addition to this, Level 2 DoLS and MCA e-learning module has been developed and reviewed at the Learning and Education Group. A further impact assessment has been requested and provided for review on 23 October 2024. This action forms part of the CQC action plan for the application of the Mental Capacity Act.

4.3 Audit and Assurance

The Safeguarding Internal Audit report was received in July 2024. The audit examined Trust procedures and processes relating to Regulation 13 of the CQC Guidance which is to safeguard service users, prevent improper treatment and that systems are in place to investigate any allegation or evidence of such abuse. Progress against the action plan will be monitored by the Safeguarding Committee.

MCA Q1 routine audit has been gathered and shared at the MCA Steering Group meeting. This action forms part of the CQC action plan for the application of the Mental Capacity Act. There is evidence that staff continue to complete assessments of capacity to a high frequency for patients who are subject to DoLS, which sits at 90% and is similar to previous quarters. There has

been a marked improvement (20%) in best interests assessments regarded as good quality, with a significant reduction in assessments regarded as substandard.

5. LEARNING DISABILITY QUARTER 1 (Q1) SUMMARY REPORT

5.1 Activity

Q1 data demonstrates an increase in activity compared to Q4 with 930 patient referrals to the team. This is an increase of 386 patients compared to Q4 and an increase of 451 patients compared to Q1 23-24. In Q1 there have been several cases which have involved complex planning and joint work with legal services, the MCA/DoLS lead and Northeast and Cumbria Transport and Retrieval (NECTAR) service. Some of these complex patients required a supported admission with an anaesthetic which is delivered either in the Emergency Department or other clinical location which has been risk assessed.

It is noted that a proportion of the activity undertaken by the learning disability team is not recorded, i.e. telephone triage, requests for advice and support for autistic people. The capture of the activity along with other aspects of the administrative workload is being assessed through an administrative review which has been supported by an expert senior colleague external to the team.

5.2 Mandatory Training Compliance and Overview of Educational Developments

There remains no national guidance regarding mandatory learning disability and autism training but there is an assumption that the Oliver McGowan training will be the preferred option. Therefore, the work to ensure all relevant staff undertake the Diamond Standards Learning Disabilities training continues. The current compliance with Diamond Standard e-learning is 94%. There has been agreement through the Learning and Education Group that this training is to be mandated for all Trust staff. As the Maternity Diamond Standards were pending release the update within the learning lab was held to make all the changes for the training at one time.

It is recognised that the Diamond Standards training does not sufficiently cover learning on autism. To mitigate this, the Northeast Autism Society have provided Autism Awareness education sessions in Q1 for 134 staff of varying disciplines. Funding is also being sought for additional sessions to raise awareness on managing distressed behaviours to support managers and autistic people in the workplace.

The Learning Disability team continue to work closely with the Learning Disability Northeast and North Cumbria Network, a current focus being on improving the autism content of the Diamond Standards training.

5.3 Progress with the CQC Action Plan

The Learning Disability Action Plan is overseen by the Learning Disability Steering Group at bi-monthly meetings.

Key points to note:

- The work to ensure relevant staff undertake the Diamond Standards Learning Disabilities training has been completed. Added to that the newly released e-learning Maternity Diamond Standard training has been incorporated for all relevant staff.
- The review of the Trust training provision for Learning Disabilities and Autism to ensure the Trust has an agreed plan in place for future training provision, which is aligned to national best practice has commenced but is behind plan, pending a regional decision. The training sessions already delivered will be evaluated and a decision on further training will be considered. The Trust continues to work closely with the Learning Disability Regional Network in reviewing national expectation with mandatory training.
- The plan to identify additional staffing resource to lead work streams relating to autism, working as part of the wider Learning Disability Liaison Team. Substantive funding is being sought and in the meantime a job description has been identified and a costing for the post has been obtained with the recruitment phase to be commenced.

5.4 Audit

In Q1, 56 electronic patient records (adults and children) have been audited to determine if the patient had a confirmed learning disability, if there is a flag on the system, if the patient had a hospital passport, if reasonable adjustments are required and if they are documented.

Of the 56 E-Records examined, 42 (75%) had the correct form on admission. Of the 42 who used the correct form there was a high proportion of forms where the questions relating to Learning Disability were not answered. Of the forms where the question was answered in relation to reasonable adjustments, between 58 – 75% of individuals were identified as not requiring reasonable adjustments. When asked if reasonable adjustments were identified as required, between 8.3 – 31.8% answered the question regarding whether they were documented.

The second phase of the Q1 audit was to assess staff understanding and to identify what barriers they perceived in completing Learning Disability information. 25 wards were audited across the Trust (adults and children). Initial data demonstrates good understanding of how to check flags and evidence of positive use of the safety brief. However, there were inconsistencies with where the Hospital Passport is kept and where reasonable adjustments should be documented. There was a generally poor understanding of Diamond Standard Training. From the audit, barriers to learning and understanding were identified and an action plan was confirmed which includes pilot work in a priority speciality, a digital request, training at induction and the launch of 'The use of Hospital Passports' posters.

Q2 audit activity will replicate Q1 with a focus in adult and paediatric emergency departments.

6. INFLUENZA/VACCINATION UPDATE

The Joint Committee on Vaccination and Immunisation (JCVI) recommendations for 2024 did not include the offer of the Covid vaccination for frontline health and social care workers based on clinical need but note organisations may wish to offer the Covid vaccine to benefit their workforce. The Department of Health have now recommended that both Covid and Flu vaccinations be administered together to frontline staff.

In the 2023/2024 program, the uptake for vaccine was 67% for Flu and 54% for Covid. These figures were slightly lower than the previous year but comparable to national uptake. However, the Trust reported the highest national uptake for Flu and Covid vaccinations in an organisation employing more than 10,000 staff.

At the time of writing, vaccine supply is still in the process of being finalised though it is expected that there will be a delivery of the Flu vaccine in mid-September. There is no confirmed date for Covid vaccine delivery. The proposed Trust plan would be to commence Flu vaccination in early October, with the Covid vaccination pending availability of training material and the national protocol finalisation. The approach to vaccine deployment will be a mixed model of fixed clinics on both sites, 'pop up' clinics and peer vaccinators working in clinical areas.

The vaccination steering group has commenced with weekly meetings to plan and co-ordinate the programme. The lessons learnt from the success of last year's programme will be taken forward to ensure safe and effective delivery. The administration of both vaccines will be monitored daily with weekly updates by Clinical Board or service, with regular reporting to the Executive Team and Trust Board.

7. RECOMMENDATION

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

Report of Ian Joy
Executive Director of Nursing
27 September 2024

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Agenda item A8(c)(i)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 September 2024		
Title	Perinatal Quality Surveillance 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	This paper provides the Trust Board members with an overview of the Maternity Service compliance with the Perinatal Quality Surveillance Model (PQSM), and updates on the main quality and safety considerations of the service. **Section 2** outlines the requirements of the perinatal quality surveillance model, and the six actions to strengthen and optimise Board oversight for perinatal safety. **Section 3** provides an update of the Trusts position with the required actions and safety intelligence to fulfil the requirements. This includes safe midwifery staffing and the revised intrapartum staffing model to support the sustainability of the Newcastle Birthing Centre, highlighting that additional investment is required and a business case will follow. The Trust Board is asked to support the proposal to incorporate the PQSM measures into the Integrated Board Report. **Section 4** provides an overview of progress with the Care Quality Commission (CQC) maternity action plan, and seeks approval of the proposed exit criteria for enhanced surveillance. **Section 5** provides an update on progress with the Ockenden Immediate and Essential Actions, and the requirement for additional audit assurance. **Section 6** outlines the current risk, namely the antenatal triage performance and antenatal and newborn screening failsafe processes, and the mitigations in place. This paper provides the Trust Board members with an overview of the Maternity Service compliance with the Perinatal Quality Surveillance Model, and updates on the main quality and safety considerations of the service.		
Recommendation	Trust Board is asked to: i. Receive and discuss the report;		

<table>
<tr><td></td><td colspan="6">ii. Note compliance with the PQSM and the receipt of the minimum data measures.
iii. Support the proposal for incorporating the PQSM measures into the Integrated Board Report, with monthly minimum data measures in the interim.
iv. Note the revised intrapartum staffing model to support the sustainability of the Newcastle Birthing Centre.
v. Approve, along with Integrated Care Board (ICB) Director of Nursing, the Oversight Framework enhanced surveillance exit criteria.
vi. Note the progress with the CQC action plan.
vii. Note the Ockenden position, and requirement for additional audit assurance.
viii. Note the current risks and mitigations in place</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Putting patients at the heart of everything we do. Providing care of the highest standards focussing on safety and quality.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☒</td><td>☐</td><td>☐</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">Principal Risk - 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.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Previous reports have been presented to the Trust Board, Maternity Update, Midwifery staffing paper, Maternity Incentive Scheme (CNST).</td></tr>
</table>

PERINATAL QUALITY SURVEILLANCE REPORT

1. INTRODUCTION

This paper provides the Trust Board members with an overview of the Maternity Service compliance with the Perinatal Quality Surveillance Model, and updates on the main quality and safety considerations of the service.

2. BACKGROUND TO THE PERINATAL QUALITY SURVEILLANCE MODEL (PQSM)

Following the publication of the First report of the Independent Review into the maternity services of the Shrewsbury and Telford Hospital NHS Trust (Ockenden, 2020) NHS England (NHSE) set out the key principles for a revised perinatal clinical quality surveillance model, the actions were set out with immediate effect and are based on principles for improving oversight for perinatal clinical quality to ensure a positive experience for women and their families. The quality surveillance model seeks to provide for consistent and methodical oversight of all services, specifically including maternity services.

The six requirements to strengthen and optimise Board oversight for perinatal safety include:

- To appoint a Non-Executive Director (NED) to work alongside the Board-level perinatal safety champion to provide objective, external challenge and enquiry.
- That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board, or sub-committee.
- That all Maternity and Newborn Safety Investigations (MNSI) and maternity Patient Safety Incident Investigations (PSII) reports are shared with Trust Boards and the local maternity neonatal system (LMNS).
- To use a locally agreed dashboard to include, as a minimum, the measures set out in the NHSE document, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.
- Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the LMNS lead and regional chief midwife, formalise how Trust-level intelligence will be shared to ensure early action and support for areas of concern or need.
- To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.

3. TRUST POSITION WITH PQSM

This paper provides a report on each element of the PQSM and the current position, and required safety intelligence to fulfil the requirements.

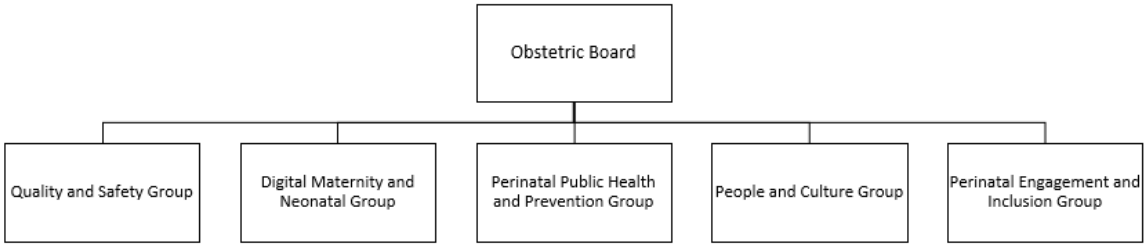
3.1 To appoint a Non-Executive Director to work alongside the Board-level perinatal safety champion to provide objective, external challenge and enquiry.

The Trust has appointed a Non-Executive Board Level Safety Champion, alongside the Board Level Safety Champion.

Regular safety champion meetings are embedded, however, the national guidance mandates the attendance of the Non-Executive Director Safety Champion alongside the Clinical Quadrumvirate and Executive Safety Champion at all meetings. Due to unavoidable circumstances the NED Safety Champion attendance has not been achieved at all meetings. A refresh of the current meeting format, terms of reference and agenda is underway to ensure this fulfils the national guidance moving forwards and will be ratified at the meeting in October 2024. The Trust Board Chair, a Non-Executive Director, has completed a walk around in the absence of the NED Safety Champion to ensure compliance with this element.

3.2 A monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board, sub-committee

Maternity updates are received by the Trust Board, outlining key quality and safety metrics. In addition to this the Maternity Services have revised their governance structure to align to the national drivers of the Three Year Plan for Maternity and Neonates, establishing a Perinatal Public Health and Prevention Group, a People and Culture Group, Maternity and Neonatal Digital Group, Perinatal Engagement and Inclusion and a Quality and Safety Group, all reporting into the Obstetric Board.



Perinatal quality and safety issues are then escalated to the Directorate Quality and Safety Group, Clinical Board Quality Oversight Group (QOG) and Family Health Clinical Board, and to Trust Board.

3.3 All maternity MNSI and PSII reports are shared with trust boards and the LMNS

The Trust continues to share the PQSM quarterly report with the LMNS, enclosing MNSI and PSII reports, alongside sharing early learning with the Maternity Patient Safety Learning Network (MPSLN). The Trust also shares themes and learning from After Action Reviews and other Patient Safety Incident Response Framework (PSIRF) review tools with the LMNS as part of the PQSM quarterly report. All MNSI and PSII reports for 2023/24 have been shared with the Trust Board, however, this needs to be strengthened to ensure this is explicit, and not just the themes and outline of the learning is shared.

3.4 Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the LMNS and Chief Midwife, formalise how trust-level intelligence will be shared to ensure early action and support.

The Trust continues to share the PQSM quarterly report with the LMNS, risks and issues are then escalated to the Regional Perinatal Quality Assurance Oversight Group, chaired by the Regional Chief Midwife and Obstetrician. This fulfils the requirements of the PQSM and Safety Action 9 of CNST MIS.

3.5 To review existing guidance, refreshed 'how to' guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.

A refresh of the current meeting format, terms of reference, standard operating procedure and agenda is underway to ensure this fulfils the national guidance moving forwards, and will be ratified at the meeting in October 2024.

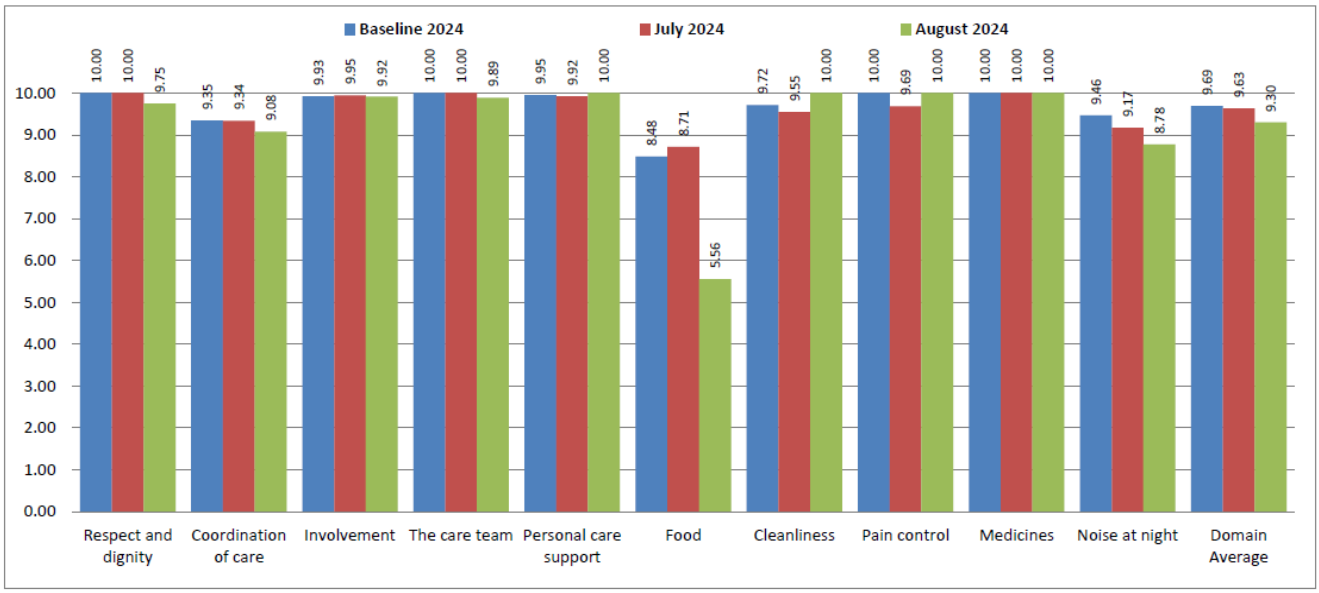
3.6 Use a locally agreed dashboard to include, as a minimum, the measures set out in the NHS England document, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.

A new safety intelligence maternity dashboard is being developed, but requires the support of the analytics team to bring to fruition, in future these metrics will be incorporated into the Integrated Board Report. In the interim the minimum data measures have been included in this report to fulfil this requirement.

4. MINIMUM DATA MEASURES

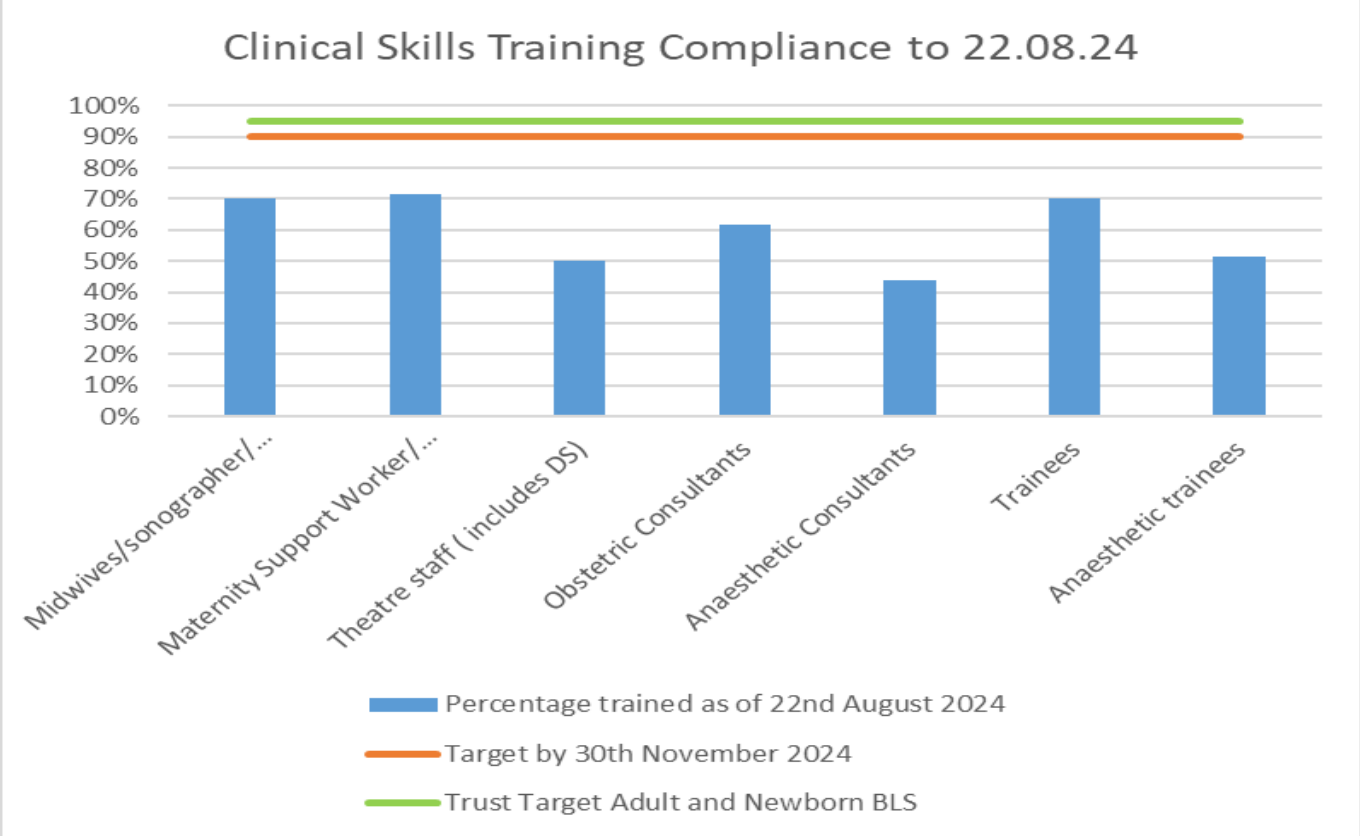
4.1 Service User Voice Feedback

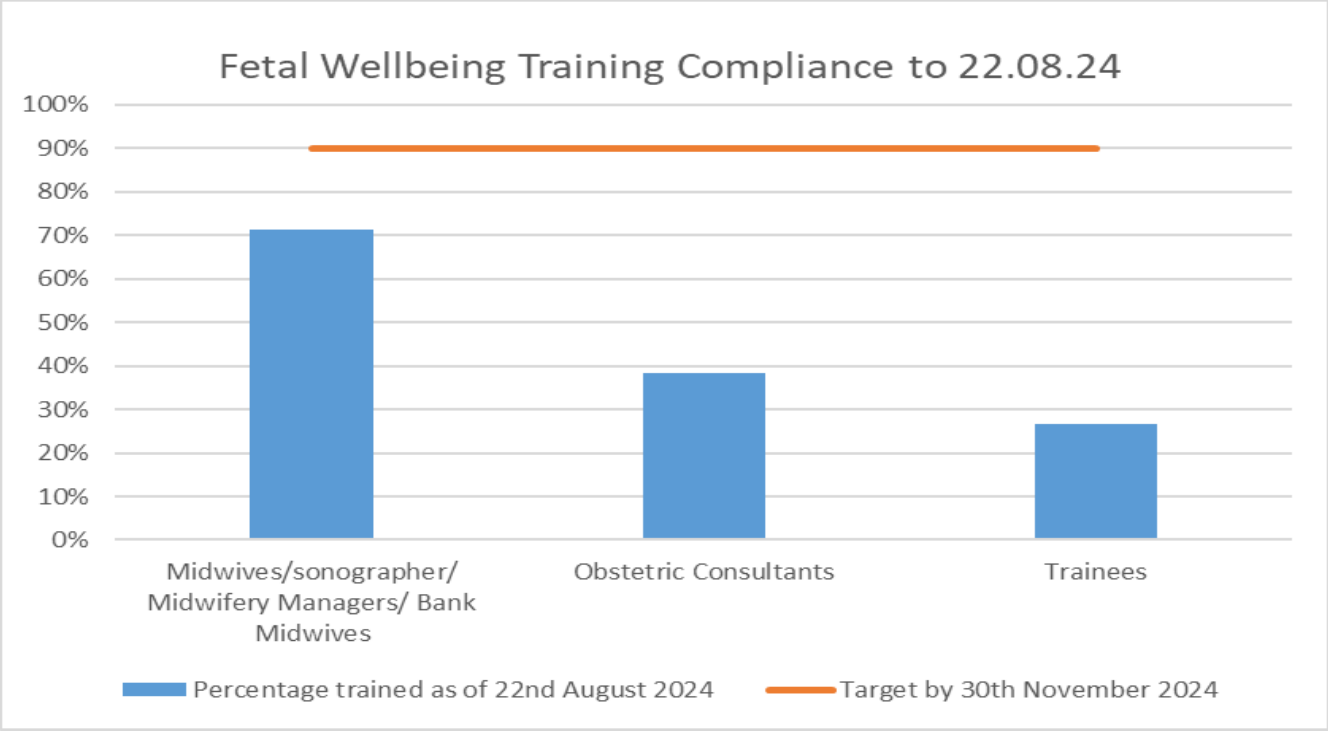
Real time patient experience programme has been introduced in the postnatal ward and delivery suite to capture feedback from service users regarding their care and experience. This is generating rich qualitative and quantitative feedback which is being considered to inform further quality improvements, currently there is a focus on nutrition and the introduction of a new menu. The real time patient experience data will be reviewed by the Perinatal Inclusion and Engagement Group, with service user voice representation.



93% of the patients surveyed would recommend their overall experience on the ward.

4.2 Training compliance





There are 10 more training days scheduled until the end of the relevant time period. The Consultant attendance has improved from the last Board report and the remaining 8 have dates scheduled to attend before the 30 November 2024. The Trust is confident this target will be achieved by November 2024.

4.3 Minimum safe staffing

The Trust Board are familiar with the midwifery staffing challenges the service has faced 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 Birthing Centre to preserve safety across the acute and community services and consolidate midwifery staffing on the Delivery Suite. The Newcastle Birthing Centre 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 ongoing workforce review, an intrapartum staffing model to sustainably reopen the services is proposed.

Despite the reduction in activity during the period of the BirthRate+ report, there has been an increase in the acuity of women with more women in the higher categories, factors impacting upon the case mix include co-morbidities such as diabetes, mental health, high BMI and increased induction of labour rates in line with national guidance such as the Saving Babies Lives Care Bundle.

77.9% of the births within the Trust are in the highest acuity categories, reflective of the tertiary service with Fetal Medicine provision, the regional Maternal Medicine Centre, Level 3 Neonatal Intensive Care Unit and the Placental Accreta Spectrum Service.

The number of women eligible for low risk midwifery care in the Newcastle Birthing Centre (NBC) has reduced in recent years, due to the reasons cited above. The service estimates (based on booking and pregnancy risk factors) that approximately 40-50 women will birth their baby on the NBC each month. To sustain the service, increase the market share, and maintain activity on the NBC, a sustainable staffing model for intrapartum services is required.

The forecasted activity does not require a separate team model, and the proposal is an integrated intrapartum team who provide care across the services regardless of location. During the period 1 November to 30 August 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, indicating that it is feasible to integrate the team, and for the staffing to be responsive to activity, rather than 'staffing the building.'

The integrated intrapartum model requires;

- The midwifery staff working in the NBC are experienced Band 6 midwives, with appropriate intrapartum skills and experience.
- All triage activity will be conducted on the Maternity Assessment Unit with only women attending in labour being admitted directly to NBC.
- A low risk postnatal care model with planned 6-12 hour postnatal stay for women birthing in NBC, longer postnatal stay requires admission to Ward 33.

Current planned midwifery staffing numbers for Delivery Suite

Delivery Suite	Days	Nights	Fill rates
Monday - Friday	14	12	100%
Saturday & Sunday	12	12	125%

Current planned midwifery staffing numbers for NBC

NBC	Days	Nights	Fill rates
Monday - Friday	3	3	0%
Saturday & Sunday	3	3	0%

Phase one of the intrapartum staffing model

Integrated Intrapartum team	Days	Nights
Monday - Friday	16	14
Saturday & Sunday	14	14

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. A carefully phased rotation to the intrapartum team will support maximising the midwifery establishment available to support the rosters whilst safeguarding the supernumerary preceptorship of the new entrant midwives.

There will be a three-phase approach to improve the midwifery staffing across the service, as there is a requirement for additional investment, with a variance of -8.31WTE against the BirthRate+ funded establishment recommendation, to support additional staffing in the Maternity Assessment Unit and postnatal ward. A business case will follow outlining the investment required.

Current funded clinical, specialist and management WTE	BirthRate+ WTE	Variance WTE
280.06	288.37	-8.31

4.4 CQC/MNSI/CQC concern or request for action made directly to the Trust

Nil

4.5 Findings of the review of all perinatal deaths using PMRT

Please refer to Q4 2023/24 and Q1 2024/25 PMRT report submitted with Maternity Incentive Scheme (MIS) Year 6 (CNST) paper.

4.6 Regulation 28 made directly to the Trust

Nil

4.7 Progress in achievement of CNST MIS 10 safety actions.

Please refer to the with Maternity Incentive Scheme (MIS) Year 6 (CNST) paper.

4.8 Staff feedback from frontline champions and walkabouts

Please refer to the Non-Executive Director report from the walkabout on 22 August 2024 and the Maternity Safey Champion report to Trust Board.

5. PROGRESS WITH THE CQC ACTION PLAN AND EXIT CRITERIA

In July 2022, the CQC began a new maternity inspection programme, with the aim to provide an overview of the quality and safety of maternity care across England. An assessment framework, focusing on safe and well led, was developed for this programme.

The national Maternity Safety Support Programme (MSSP) was launched in September 2017. During Phase 1 of the MSSP trusts were brought on to the programme following an inadequate by the Care Quality Commission (CQC). The MSSP targeted maternity units that required additional support to improve outcomes, the MSSP's overall aim is to help trusts realise sustainable improvements in the five CQC domains of safety, effectiveness, responsiveness, caring and well-led. Phase 2 was introduced in November 2020 with an amendment to the eligibility criteria that broadened the triggers for a maternity unit's entry onto the programme. Maternity services are formally entered onto the programme if they are rated requires improvement or inadequate in the well led and/or the safe domains by the CQC.

The MSSP is currently at capacity and Trusts are considered for entry on a case-by-case basis. In the interim the ICB is supporting Trusts whose maternity services drop their ratings

from a previously Outstanding or Good rating to Requires Improvement/Inadequate in the Safe or Well Led domains.

The Trust are currently receiving ICB and LMNS support, and oversight of progress, with the action plan. The Maternity Services Quadrumvirate meet with the LMNS and ICB team on a quarterly basis to review progress with the agreed action plan as part of the Perinatal Quality Oversight Model meeting. The Trust have made good progress with the required improvement actions and have co-produced exit criteria from the enhanced oversight, with the Deputy Director of Nursing (Quality) in July 2024, which require approval by the Trust and ICB.

Proposed exit criteria:

- Achieve compliance with the North East and North Cumbria (NENC) triage performance metrics.
- Achieve midwifery fill rate across the service of >80% over 6 month period with clear recruitment and retention plan in place.
- Achieve compliance with Safety Action 5 for Year 6 CNST MIS.
- Achieve compliance with Trust appraisal rate target for 2024/25.
- Achieve compliance with Trust and CNST MIS training targets across all multidisciplinary teams for 2024/25.
- Embed baby abduction drills and required changes to policy, with evidence of successful drills over a 6 month period.

The Quadrumvirate are in agreement with the proposed exit criteria, and will continue to review progress with the action plan as part of the enhanced oversight meetings with the ICB and LMNS, with a plan to consider reviewing and exit criteria compliance in March 2025.

6. PROGRESS WITH THE OCKENDEN IMMEDIATE AND ESSENTIAL ACTIONS

The Maternity Risk and Governance Team have conducted a review of current audit processes to ensure adequate assurance of ongoing compliance and that the service improvements have been embedded, unfortunately due to capacity constraints, the audit requirements to demonstrate compliance have not been completed. A gap analysis has been conducted to review the Trust position against the minimum national standards, and an action plan has been devised to ensure this is completed by the end of October 2024. The updated governance structure and audit plan will ensure processes are embedded with ongoing monitoring thereafter. The completed action plan will be presented to the Trust Board in November 2024.

7. PROGRESS WITH THE THREE PLAN FOR MATERNITY AND NEONATAL CARE

The biannual update was provided to the Trust Board in May 2024. Following the appointment of the Director of Midwifery the senior leadership team are currently reviewing the Trust position, and the metrics to track performance, in accordance with the national guidance. A further update will be presented, as planned, in November 2024.

8. RISKS TO BE NOTED

8.1 Antenatal and newborn screening services

Three of the four screening pathways are currently subject to a patient safety incident investigation due to failures in the failsafe processes in the maternity and laboratory services. Early learning indicates this is secondary to insufficient failsafe officer and midwifery resource, digital immaturity, and a lack of analytics and reporting capacity. There are also concerns regarding the accuracy of data, and as a result the KPI have been rejected by NHSE for a second year. The PSII report will inform the system level changes required to support safety. In the interim there are mitigations in place to support the failsafe processes, including admin audits, senior oversight, and additional recruitment and staffing resource. An Incident Oversight Group has been established with ICB and NHSE representation.

There has been no harm identified, duty of candour has been enacted as appropriate, and service users have been engaged in the patient safety incident investigation. The learning from the final report will be shared with the ICB, NHS England and LMNS.

8.2 Antenatal triage performance

Antenatal triage performance remains an area of focus, due to the previous poor performance and patient safety concerns. A comprehensive action plan is in place to support improvements, with robust data collection to track progress. During August the senior midwifery leadership team provided enhanced support for the team, and conducted a two week period of extended cover until 0200 to understand the patient flow and capacity concerns. This was a valuable exercise and provided insight into the educational needs of the midwifery and medical staff in regard to the Birmingham Symptom Specific Obstetric Triage (BSOT) System model, the capacity and staffing challenges and the impact of the estate configuration. The learning is incorporated into the action plan and performance has already improved significantly in regard to the initial triage within 15 minutes of attendance and the midwifery review thereafter. The medical review timescales remain a challenge due to the constraints of the medical workforce and lack of Advanced Clinical Practice (ACP) roles. A skill mixed workforce model is being considered as part of the workforce review.

Work is underway to optimise midwifery review and discharge with the development of competency assessments to support performance. The LMNS is currently devising NENC antenatal triage performance metrics, and compliance with these will be tracked once they are published.

Month	Number of Triage Phonecalls	Number of Attendances	Initial Assessment within 15 mins	Green (4 hours)	Yellow (1 hour)	Orange (15 mins)	Red (immediate transfer)	Ongoing Midwifery care commenced within allocated time (GREEN)	Ongoing Midwifery care commenced within allocated time (YELLOW)	Ongoing Midwifery care commenced within allocated time (ORANGE)	Ongoing Medical care care met within 2 hours (GREEN)	Ongoing Medical Care meet within 1 hour (YELLOW)	Ongoing Medical Care met within 15 mins (ORANGE)	Immediate review by Medical Team (RED)
				Level of Urgency										
Jan-24	974	1069	876 (82%)	253	463	341	9	188 (74.3%)	358 (77.3%)	251 (73.6%)	46.70%	45.10%	34.20%	100%
Feb-24	827	986	825 (83.7%)	228	460	277	20	147 (63.9%)	351 (76.1%)	185 (66.8%)	33.30%	47.70%	35.90%	100%
Mar-24	867	1053	922 (87.6%)	194	539	301	15	138 (70.8%)	427 (79.4%)	214 (71.1)	36.20%	29.40%	33.90%	60%
Apr-24	759	1026	896 (87.3%)	158	522	334	9	110 (69.6%)	411 (78.9%)	236 (70.9%)	46.20%	38.60%	34.20%	33%
May-24	941	1067	854 (80%)	182	557	320	7	136 (74.7%)	455 (81.8%)	255 (79.7%)	50%	36%	36.90%	100%
Jun-24	1172	1149	921 (80.2%)	193	659	287	8	163 (84.5%)	593 (90%)	236 (82.2%)	56.50%	42%	29.90%	100%
Jul-24	1288	1196	1082 (90.5%)	196	678	306	15	193 (98.5%)	666 (98.2%)	281 (91.8%)	61.20%	55.60%	39.80%	

In July 2024, triage assessment within 15 minutes was 90.5% and ongoing care was above 92%, during the first two weeks in August, with senior presence on the unit, the team achieved 98% compliance consistently. Medical review performance within 15 minutes was 39%, within 1 hour was 50% and 2 hours was 60%. Medical recruitment is underway.

To mitigate risk, any patients requiring urgent review are transferred to Delivery Suite for one-to-one care. For patients awaiting review on the Maternity Assessment Unit, the midwife will remain in attendance and there are clear processes for escalation in the event of deterioration.

9. CONCLUSION

The Trust Board members are provided with an update on the Maternity Service compliance with the Perinatal Quality Surveillance Model, and the main quality and safety considerations of the service.

The Trust is embedding the six requirements to strengthen and optimise board oversight of perinatal safety, this will be supported by the development of the integrated board report metrics and the visibility of the performance metrics, as included in this report, in relation to risks such as the antenatal triage performance. The minimum data measures will be shared with the Trust Board on a monthly basis in the interim.

The revised intrapartum staffing model will support the stability and provision of midwifery led care in the Newcastle Birthing Centre from December 2024, further investment in the midwifery staffing establishment is required to ensure compliance with safety action 5 and improved midwifery staffing within the antenatal and postnatal services. A business care will follow outlining the investment required.

The Maternity Service is making good progress with the CQC action plan, and seeks support from the ICB and Trust Board to approve the proposed enhanced surveillance exit criteria, with subsequent review in March 2025 with a view to returning to routine LMNS perinatal quality surveillance.

The Maternity Service is conducting comprehensive reviews of the progress against the national drivers for improvement, both the Ockenden report and the Three Year Plan for Maternity and Neonatal Care.

There are robust improvement plans for the areas of risk for the service, performance is being tracked and progress monitored to ensure the mitigations in place are supporting patient safety.

10. RECOMMENDATIONS

Trust Board is asked to:

i. Receive and discuss the report;

ii. Note compliance with the PQSM and the receipt of the minimum data measures.
iii. Support the proposal for incorporating the PQSM measures into the Integrated Board Report, with monthly minimum data measures in the interim.
iv. Note the revised intrapartum staffing model to support the sustainability of the Newcastle Birthing Centre.
v. Approve, along with ICB Director of Nursing, the SOF enhanced surveillance exit criteria.
vi. Note the progress with the CQC action plan.
vii. Note the Ockenden position, and requirement for additional audit assurance.
viii. Note the current risk and mitigations in place.

Report of Ian Joy
Executive Director of Nursing
19 September 2024

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Agenda Item A8(c)(ii)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 September 2024		
Title	Maternity Incentive Scheme (MIS) Year 6 (CNST)		
Report of	Angela O'Brien, Director of Quality and Effectiveness		
Prepared by	Rhona Collis, Quality and Clinical Effectiveness Midwife/ Jenna Wall, Director of Midwifery		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☒	☐
Summary	The NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) invites Trusts, in this Year 6 scheme, to provide evidence of their compliance using self-assessment against ten maternity safety actions. The scheme intends to reward those Trusts who have implemented all elements of the 10 Maternity Safety Actions. In addition, completion of all 10 Safety Actions upholds the reputation of the Trust in relation to the quality of care provision within the Maternity Service. The Year 6, CNST safety actions were published on the 2 April 2024. The final submission date is 3 March 2025. For Safety Actions 1, 8 and 10 the relevant time period continues from when the previous year finished – 1st December 2023 to 30 November 2024. For the remaining safety actions (2,3,4,5,6,7,9) the relevant time period starts from 2 April 2024 to 30 November 2024. The Trust is monitoring progress against the requirements. Good progress is being made with Safety Action 1, 2, 3, 4, 7, 8 and 10. <u>Risk of non-compliance</u> Safety Action 1 PMRT The Neonatal Safety Champion has raised concerns that the volume and complexity of neonatal mortality cases, alongside the requirement to ensure robust and comprehensive reviews, often involving several other Trusts and clinical specialties, is proving very challenging to the ensure the cases are completed within the stipulated time restraints of the guidance. This issue was raised at the recent Safety Champion meeting on 14th August 2024, with an action to escalate concerns to the Local Maternity and Neonatal System (LMNS) and Operational Delivery Network (ODN). The Trust is currently compliant, but this is becoming an increasingly difficult position to maintain. Safety Action 5 Midwifery Workforce The three yearly Birth Rate+ midwifery workforce report was received by the service in June 2024, a full workforce review is currently being conducted by the Director of Midwifery. The Birth Rate+ report recommends a clinical midwifery staffing establishment of 257.47 WTE. There is a shortfall of 8.31WTE between the current funded establishment and the recommendations of the report. Investment in the midwifery establishment to maintain compliance with this required standard, and business case will follow with the workforce review report. Safety Action 6 Saving Babies Lives Care Bundle		

<table>
<tr><td></td><td colspan="6">The Trust was unable to meet the requirements for this safety action in Year 5 as a result of failing to meet the minimum compliance targets with Element 1 (Smoking in Pregnancy) and Element 4 (Fetal Monitoring). An oversight group has been established, focused on reviewing the pathways and staff education, to drive compliance, this has included ‘Saving Lives Summer’ with weekly focus on the elements of the care bundle and targeted education and engagement events. This has resulted in some positive progress, however, the current performance does not meet the minimum national standards.

Safety Action 9
Regular safety champion meetings are embedded, however, the national guidance mandates the attendance of the Non-Executive Director Safety Champion alongside the Clinical Quadrumvirate and Executive Safety Champion at all meetings. Due to unavoidable circumstances the NED Safety Champion attendance has not been achieved at all meetings. A review of the current meeting format, terms of reference and agenda is underway to ensure this fulfils the national guidance moving forwards, and will be ratified at the meeting in October 2024. A review of the current meeting format, terms of reference and agenda is underway to ensure this fulfils the national guidance moving forwards. The Quality Committee Chair, a Non-Executive Director, has completed a walk around in the absence of the NED Safety Champion to ensure compliance with this element. A new safety intelligence maternity dashboard is being developed, but requires the support of the analytics team to bring to fruition.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Trust Board are asked to note the contents of this report and approve the self- assessment to date to enable the Trust to provide assurance that the required progress with the standards outlined are being met, and where there are risks of non-compliance note the actions.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Putting patients first and providing care of the highest standard focusing on safety and quality. Enhancing our reputation as one of the country’s top, first class teaching hospitals, promoting a culture of excellence in all that we do.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">SO1.4 [high-quality safe care]
SO2.4 [statutory and mandatory training]

Failure to comply with the ten safety action standards could impact negatively on maternity safety, result in financial loss to the Trust from the incentive scheme and from potential claims.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">This is the third report regarding the 10 safety actions in the Year 6 scheme which were published on the 2 April 2024.</td></tr>
</table>

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

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

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

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

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

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

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

In Year 5 the Trust declared full compliance with 8 of the safety actions. The Trust had been informed of the challenges with achieving full compliance with the two safety actions – 6 and 8, throughout the year and it was disappointing to be in this position despite robust planning to achieve all ten safety actions. Safety Actions 6 and 8 had several training requirements which the Trust were unable to meet due to ongoing staffing challenges and clinical need taking priority. The Trust was awarded £200k to assist in achieving the safety

actions not met in Year 5.

2. SAFETY ACTION UPDATE

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

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

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

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

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

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

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

The quarterly PMRT reports for Q4 23/24 and Q1 24/25 are included in this report as per the requirements of this safety action and can be found in the Private Board papers. The format of the Q1 report has changed since earlier reports.

The Neonatal Safety Champion has raised concerns that the volume and complexity of neonatal mortality cases, alongside the requirement to ensure robust and comprehensive reviews, often involving several other Trusts and clinical specialties, is proving very challenging to the ensure the cases are completed within the stipulated time restraints of the guidance. This issue was raised at the recent Safety Champion meeting on 14th August 2024, with an action to escalate concerns to the Local Maternity and Neonatal System (LMNS) and Operational Delivery Network (ODN). The Trust is currently compliant, but this is becoming an increasingly difficult position to maintain. An external expert is required to attend each review, and must possess the correct clinical expertise and experience to review the Level 3 tertiary cases, this

reduces the number of clinicians available to support the reviews, and also provides additional challenge for the Newcastle neonatal consultant team to provide reciprocal support to South Tees team.

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

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

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

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

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

The Trust achieved 97.4% compliance in June 2024. The Trust is confident that the data submit for July 2024 should meet the requirements.

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

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

or

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

The Trust opened a stand-alone Transitional Care unit on the 22 April 2024. The pathway used previously for this safety action is in draft format awaiting ratification through the relevant governance framework. It has been revised to reflect the new service in alignment with the BAPM Framework.

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

A working group has been established to agree the Quality Improvement (QI) project. The project has been registered with the Trust (project no. 16685). Progress on the project will be presented to the Safety Champions on the 9th October and the LMNS on the 15th October and a further update on the 16th January 2025.

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

a) Obstetric medical workforce

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

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

<u>or</u>

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

<u>or</u>

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

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

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

The Trust has had one long term locum within Obstetrics within the past 4 months. This post will shortly end with another post being advertised. There remain significant vacancies at Consultant level. A business case has been agreed for 3 further Consultants, in addition to

the 3 vacancies that already are unfilled. In the short term the frequency for Consultants on call residency has increased from 1 in 12 to 1 in 8.5 to address the shortfall for the acute service. 3 of these posts will be advertised in December with interviews scheduled for January 2025. The remaining posts will be advertised later in the year.

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

The Trust provides 98 hour Consultant resident presence for the acute service. To do so with current vacancy factor (25%) requires a rota of 1 in 8.5 24 hour on call residency shifts for Consultants; this is followed by a day of compensatory rest. The junior doctors work a 1 in 8 rota with fully compliant compensatory rest periods before and after their shifts. The compensatory rest period is included in the software package Medirota, which is used to roster all the shifts.

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

The Consultant attendance audit continues to show overall attendance of 100% with the occasional 1 clinical scenario where they were unable to attend but a Tier 6/7 trainee was in attendance.

A summary report was presented to the Maternity Board Level Safety Champions meeting on the 12 June 2024. A further report of Q1 incidents will be presented to the Maternity Board Level Safety Champions on the 9th October 2024.

b) Anaesthetic medical workforce

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

The Trust is confident that full compliance can be achieved with this element, as in previous years. An audit of one month's rota (August 2024) will be reviewed and findings included in the November 2024 Trust Board report.

c) *Neonatal medical workforce*

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

or

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

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

A workforce paper was presented to the Maternity Board Level Safety Champions on the 12 June 2024 outlining the current position with the neonatal medical workforce. The Consultant workforce is compliant with the BAPM national standards. Funding has been approved to increase trainees and mitigate whole-time-equivalent (WTE) shortfalls in the speciality training rota gaps. Trainee rota compliance can vary with every 6 months rotation. A further workforce paper will be presented to the Maternity Board Level Safety Champions in October 2024.

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards.

Or

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

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

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

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

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

The Trust completed the BirthRate+ workforce calculation in April 2024 and the report was shared with the Trust in July 2024.

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

The three yearly Birth Rate+ midwifery workforce report was received by the service in June 2024, a full workforce review is currently being conducted by the Director of Midwifery. The Birth Rate+ report recommends a clinical midwifery staffing establishment of 257.47 WTE. There is a shortfall of 8.31WTE between the current funded establishment and the recommendations of the report. Investment in the midwifery establishment is required to maintain compliance with this required standard, and a business case will follow with the workforce review report.

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

This requirement has been amended this year to re-iterate the supernumerary coordinator must be identified at the start of every shift. The Maternity Escalation Policy is under review and will be amended to reflect this change, however, given the tertiary status of the unit, the supernumerary status of the coordinator for the entirety of the shift will remain Trust aspiration.

In the 12 month period from August 2023 to July 2024 there were 10 occasions whereby the co-ordinator was not supernumerary for <u>part</u> of the shift due to an escalation in activity for a short period of the shift, however the rota confirms they were supernumerary at the start of the shift, fulfilling this requirement.

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

In the 12 month period from August 2023 to July 2024 there were 0 occasions whereby 1:1 care was not provided.

For Year 5 an action plan was signed off by the Trust Board outlining how c) and d) could be achieved. An action plan will be produced for the November Quality Committee and Trust Board meetings.

e) *Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.*

A midwifery staffing report is included in the Executive Director of Nursing's Nursing and Midwifery Staffing report to Trust Board. This was submitted in July 2024 and a further report will be provided in November 2024.

2.6 Safety Action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the 'Saving Babies Lives' Care Bundle Version 3?

Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.

The Trust was unable to meet the requirements for this safety action in Year 5 as a result of failing to meet the minimum compliance targets with Element 1 (Smoking in Pregnancy) and Element 4 (Fetal Monitoring). An oversight group has been established, focused on reviewing the pathways and staff education, to drive compliance, this has included 'Saving Lives Summer' with weekly focus on the elements of the care bundle and targeted education and engagement events. This has resulted in some positive progress, however, the current performance does not meet the minimum national standards and the Trust remains concerned that full compliance with this safety action is not achievable in the time frame required. The Trust has meetings scheduled for quarterly quality improvement discussions with the ICB. The first meeting took place on the 14 August 2024 and the progress thus far was noted, no further actions were recommended by the LMNS or ICB.

2.7 Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services within users.

1. *Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting:*

   a) Engagement and listening to families
   b) Strategic influence and decision-making.
   c) Infrastructure.

2. *Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.*

The Trust is confident in achieving full compliance with this safety action as the MVNP relationship with the Trust is well established and already meets each element of the safety action.

2.8 Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

90% of attendance in each relevant staff group at:

1. *Fetal monitoring training*
2. *Multi-professional maternity emergencies training*
3. *Neonatal Life Support Training*

See technical guidance for full details of relevant staff groups.

ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for MIS.

It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.

The Trust failed to meet full compliance with this safety action for Year 5. Although there was a robust plan in place to deliver the training with a trajectory that would meet compliance, training sessions were cancelled due to staffing challenges.

For Year 6 the training has been allocated with an achievable trajectory. The current position is (12 month period Aug 23 – July 24) :

(Table 1. Fetal Monitoring Training Day)

Staff Group	Percentage trained
Midwives including Midwifery Managers, Matrons, Community Midwives, Midwifery Led Unit Midwives and Bank Midwives	83%
Obstetric Consultants	31%
Obstetric trainees	86%

There are 10 more training days scheduled until the end of the relevant time period. The Consultant attendance has improved from the last Board report and the remaining 8 have dates scheduled to attend before the 30th November 2024.

Table 2. Multi-professional maternity emergencies training

Staff Group	Percentage trained
Midwives including Midwifery Managers, Matrons, Community Midwives, Midwifery Led Unit Midwives and Bank Midwives	90%
HCA/MSW/NN	90%
Theatre Staff	89%
Obstetric Consultants	92%

Anaesthetists	80%
Obstetric Trainees	100%
Anaesthetic trainees	94%

There are 16 training days scheduled until the end of the relevant time period. If all staff attend their allocated training day the compliance will be above 100%.

Table 3. Neonatal Life Support training

Staff Group	Percentage trained
Neonatal Staff	86%
Midwives	90%

The Trust will continue to monitor the progress of compliance rates monthly so that the 90% target – for all staff groups – will be achieved by the 30 November 2024 timeframe.

2.9 Safety Action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on Maternity and Neonatal Safety and Quality issues.

a) All Trust requirements of the PQSM must be fully embedded.

b) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.

c) All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures.

Regular safety champion meetings are embedded, however, the national guidance mandates the attendance of the Non-Executive Director Safety Champion alongside the Clinical Quadrumvirate and Executive Safety Champion at all meetings. Due to unavoidable circumstances the NED Safety Champion attendance has not been achieved at all meetings. A review of the current meeting format, terms of reference and agenda is underway to ensure this fulfils the national guidance moving forwards, and will be ratified at the meeting in October 2024. The Quality Committee Chair, a Non-Executive Director, has completed a walk around in the absence of the NED Safety Champion to ensure compliance with this

element. A new safety intelligence maternity dashboard is being developed, but requires the support of the analytics team to bring to fruition.

2.10 Safety Action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notifications (EN) Scheme from 8 December 2023 to 30 November 2024?

a) Reporting of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.

b) Reporting of all qualifying EN cases to NHS Resolution's Early Notification from 8 December 2023 until 30 November 2024.

c) For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that:

i. the family have received information on the role of MNSI and NHS Resolution's EN scheme; and

ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

The Trust has reported 2 qualifying cases to MNSI and NHS Resolution since 8 December 2023. All of the above requirements have been met.

3. CONCLUSION

It is acknowledged that to achieve full compliance with all ten safety actions remains a challenge. Safety actions 1, 5, 6 and 9 in particular will be monitored closely. Progress meetings continue every two weeks within the Maternity Department to enable direct oversight and support from the Director of Midwifery and Head of Obstetrics. The bi-monthly meetings with the Maternity Board level Safety Champions continue and issues of concern in relation to CNST compliance are discussed.

4. RECOMMENDATIONS

To (i) note the content of this report, (ii) comment accordingly and (iii) approve.

Report of Angela O'Brien
Director of Quality & Effectiveness
4 September 2024

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Agenda item A8(c)(iii)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	27 September 2024					
Title	Maternity Safety Champion Report					
Report of	Liz Bromley, Non-Executive Director and Trust Maternity Safety Champion					
Prepared by	Liz Bromley, Non-Executive Director and Trust Maternity Safety Champion					
Status of Report	Public		Private		Internal	
	☒		☐		☒	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☒		☒	
Summary	This report summarises feedback from the Maternity Safety Champion since the last report in June 2024. The red font included in the main report represents further context or additional information from the Director of Midwifery.					
Recommendation	The Trust Board is asked to receive the report and consider/discuss the content.					
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. Risks are detailed within the main body of the report.					
Reports previously considered by	Last report presented at the Private Board meeting on 27 June 2024.					

MATERNITY SAFETY CHAMPION REPORT FOR JULY- AUGUST 2024

During July I was able to spend a day in the department visiting a number of units including ante and postnatal, specialist midwives and screeners, and the Maternity Assessment Unit (MAU) and delivery teams.

Overall the service was very busy. The MAU continues to provide a robust service to pregnant mothers who are in need of urgent assessment. The Birmingham Symptom-specific Obstetric Triage (BSOT) system is working well but both patient and staff experience could be improved if a registrar or advanced clinical practitioner (ACP) were assigned on a permanent basis to the MAU. A business case (BC) has been submitted to the business case team and this BC should be reviewed and its outcome shared.

The business case is currently being updated as part of a broader staffing review. In the interim additional midwifery staffing has been allocated, alongside senior midwifery leadership to support patient flow and inform the future staffing model as part of the staffing review.

Colleagues consistently described the intensity of work and the challenge of delivering a highly satisfying patient experience. Examples were provided on very complex and challenging social and safeguarding cases, which understandably cause anxiety for the staff involved. A patient specific example was provided and the he consequences of this single patient's presence, in addition to being a major safeguarding incident, are:

1. Approximately 80% of management time presently being used up on this case.
2. Staff are anxious and workload is high protecting other patients and caring for this patient.
3. Midwives reluctant to use the metro to get home as patient and partner are known to frequent the station - incurring taxi costs.
4. Security on high alert in case father arrives at the hospital.

There are 10 beds in ante natal which is very short on anticipated usage levels. There are only two midwives on the ward, limiting professional time with patients. This means that currently there is a high proportion of antenatal patients being transferred to the postnatal ward which is inappropriate in a number of ways:

1. Postnatal (ward 33) is now also at capacity with ante natal outliers.
2. Capacity of postnatal midwives is being stretched impacting on the care of postnatal patients.
3. Women who have not yet given birth, who are presenting with at risk pregnancies are neighbours with new mums and crying new babies.
4. Postnatal midwives are not as familiar with antenatal pathways of care..
5. Careful risk assessments have to be made in terms of which patients are transferred from antenatal, which is another demand on time.

It was generally agreed among current staff that an additional grade 6 midwife working on ante natal would allow for an extra bed to be opened up, and would alleviate the workload. However this would not address the broader issue of space which will need to be consider in a review of the overall accommodation of the department / condition of the estate within the Royal Victoria Infirmary (RVI).

The service has seen a significant increase in very complex safeguarding cases, the management of the recent complex case has included bi-weekly safeguarding Multi-Disciplinary Team (MDT) meetings, chaired by the Director of Midwifery, with attendance from safeguarding, social care,

mental health, security and obstetric and midwifery colleagues to ensure staff and patient safety is assured.

The service is currently reviewing bed occupancy across the services, to inform future antenatal bed capacity, to be incorporated into the service staffing review.

I met the diabetes specialist midwives team and saw how they worked - intense with high workload but allowed to work flexibly, including a proportion of home-working to avoid a colleague with mobility issues having to take sick leave. There is much potential for education of pregnant women in order to reduce the risk of gestational diabetes evolving into type 2 diabetes, or being passed on to the baby but this would require more capacity within the team, and more physical space for the team. 20% of pregnant women suffer with gestational diabetes.

The service is currently reviewing the activity and job plans of all specialist teams to ensure appropriately staffed, there will be a focus on public health and prevention to ensure the wider public health issues, such as obesity, to tackle the number of women diagnosed with gestational diabetes.

There is a 1.4 full-time equivalent (FTE) in the specialist team which deals with blood screening for ante natal and new born babies. They are challenged by disjointed line management structures, external targets to meet, and the lack of a failsafe officer who would act as auditor and spot checker of blood sampling. This would help reduce the risk of babies being missed for blood testing. There is a related training issue to be considered, and the appropriate location of the Newborn and Infant Physical Examination (NIPE) service, and whether the governance of this service should be with the antenatal screening team, or part of the neonatal service. Management are sympathetic to the staffing need, and are supportive of the grade 7 midwife also acting as a Staff Governor. Staff had recently attended the cultural change programme run by Andy Pike, Head of Culture, and had found it both useful and positive as a way forward.

The service is currently recruiting a failsafe officer, and has introduced an oversight group to support the Antenatal and Newborn Screening programme service development, which includes the failsafe processes and digital systems.

I was accompanied by Catherine Collins, Senior Midwife, on this walk round and heard about her fixed term contract on workforce development. She has been working on workforce issues – retention, recruitment and pastoral support, including development of a two year (shortened) programme for qualified nurses to become midwives, run with Sheffield Hallam University with work placements at Newcastle Hospitals and a guaranteed job at the end of a successful programme. There have been three successful learners this year and an anticipated five more to be recruited next year. Catherine's focus is now turning to the development of Maternity Support Workers (MSWs), with Healthcare Assistants being upskilled to MSWs. The failure of the national framework to map directly to Agenda for Change is creating a challenge for Human Resources (HR) job description composition.

I have been delighted to separately visit the Infant Feeding part of the department. Led by Angela Gibbs (Gr 7), Infant Feeding Specialist Midwife, this is a key area of work in promoting public health by educating mothers about the health and wellbeing benefits of breast feeding (not to mention cost saving) and the facts between the marketing approaches of the formula making companies. I heard incredibly worrying stories of mothers feeding babies water between feeds to keep them satisfied (because of the cost of formula) without understanding the health risks that this posed for newborns

and tiny babies. Angela is also qualified to deal with infant tongue-tie which can have an impact on ability to feed, and the feeding experience for both mother and baby.

The breast feeding team is a unique, specialist team in the region and Newcastle Hospitals should be very proud of the work that they do and the impact that they have on patient experience and young baby health. They should not be seen as luxury, but should be seen as an excellent example of preventative, educational investment in patients and communities served by the Trust. They work to and are compliant with World Health Organization (WHO) standards. They have a real understanding of the benefits of breast feeding which they can explain in simple terms – such as the benefits for the mothers in reducing cancer risks, and for the babies in terms of reducing the chances of childhood leukaemia.

The clinic that is run by the Gr 6 Midwife colleague, Jasmine Draper-Dixon, manages baby weight loss and helps create feeding plans to maximise milk supply and good health and growth in very young babies. After early intervention by the clinic, patients are supported by community staff, demonstrating how collaboration across boundaries contributes to better public health. The clinic / team also use video consultations for the harder to reach / engage patients – one of the better long lasting consequences of Covid 19.

The team is awaiting a visit for UNICEF reaccreditation in mid-August. Colleagues have demonstrated their commitment to their work by cancelling annual leave to be sure that they are ready for the inspection. They are running internal audits on a regular basis to ensure that they are prepared for 20 breast feeding mothers and 20 formula feeding mothers to give a snapshot of the service at the point of inspection. Realistically the team expects that they will be given a list of recommendations to work on over a period of time, after which they will be reaccredited as Gold. This seems to be the current model of inspection.

The following requests by the team should be considered by the Board and the Executive Team:
1. More breast feeding rooms for staff who are new mothers, giving them adequate and respectful facilities to express milk or feed their babies in the workplace.
2. E-learning training to be included in the statutory and mandatory categories of training for all staff to raise awareness of informed feeding choices for newborns, and understanding of the link to better public health.
3. Recognition of the work that Victoria Thomas, Paediatric Consultant in the Great North Children's Hospital (GNCH) has done in writing standards for the Children's Hospital, improving work between the breast feeding clinic and the GNCH, and to support the case for them to be a pilot site for good practice.

I finally have had the pleasure of meeting Jenna Wall, the new Director of Midwifery. Jenna has been working on a progressive governance structure within the department, to report to the Obstetrics Board. The new structure will add strength and purpose to the Maternity Champion role and I am very confident that we will get to a more shaped and effective way of working going forward. We have agreed a number of dates for Champion visits up to Christmas as well as the formal meetings that will now be held in accordance with the new deliberative and monitoring structures.

My reflections:

The Maternity Department continues to deliver the best service it can with limited resources and a poor estate. Colleagues manage challenging issues with professionalism and continued dedication to patients. New leadership driving cultural and systemic changes, including recognition of good work as well as raised expectations, will be responded to positively. Estates planning will become more

important as the Newcastle Hospitals settles post CQC and regains ambition to be a market leader in a competitive landscape delivering the full range of maternity services in the North East. An expanded education offer to service users could have a massively positive impact on the health of young children and could act as a preventative measure for longer term health issues.

People should engage with an open mind with the breast feeding service and learn about the work that they do and the information that they can share with new parents.

During August I was plagued with my eye health and so I am deeply grateful to Anna Stabler, fellow Non-Executive Director, who conducted the RVI walk round and has written an informative report which is attached below and is self-explanatory.

My next walk round is scheduled for early September and as I am now fighting fit again I shall be very pleased and relieved to undertake it.

Liz Bromley
Maternity Safety Champion
9 September 2024

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Clinical Board Visit by Non-Executive Director Feedback Summary

Clinical Board/Department Visited: Maternity

Visit Date: 22/08/2024

Attendees: Anna Stabler on behalf of Liz Bromley Maternity Safety Champion

Clinical Board/Department Report

Areas visited: Maternity Assessment Unit, delivery suite, Wards 32/33, transitional care, Antenatal Clinic, Fetal Medicine Unit (FMU).

Environment: All areas were clean and tidy; however, corridors were cluttered with equipment due to the lack of storage space available. Equipment was labelled where appropriate as clean.

The patient buzzer system is an issue on Wards 32/33 [separate call bell systems] however a quote has been obtained to look at rectification work.

The environmental temperature was noted to be an issue (too hot) by staff however they advised that as the cooling system was linked to the Neonatal Intensive Care Unit (NICU) they did not think it could be resolved.

Patient Experience: Transitional care staff noted that patient meals were delivered to the Post natal ward, and they had to collect and carry hot meals to this area. Staff also told me that not all staff were trained on the temperature probe that had to be used to ensure meals were adequately heated.

Safety: All staff who I met were asked if they were any safety issues that they wished to escalate. All were consistent in acknowledging there was nothing to raise, they were happy that further midwives (approximately 30) would starting during September/October.

Staff on the MAU reported that BSOTs was going well, and that Matrons had worked some nights to support and embed work. It was confirmed by one of the matrons that this had been extremely useful and they plan to undertake add hoc night shifts for visibility and support good communication and embedding of new practices.

Staff on FMU told me the service is still stretched from a medical staffing perspective, however a consultant from South Tees Hospitals NHS Foundation Trust is to support 1 day per week.

Were there any issues you needed to address during your visit? No
If yes, what was the issue and how did you resolve it?

Is any further action needed? No
If yes, please advise:

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Agenda item A9

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 September 2024		
Title	Board Visibility Programme (Leadership Walkabouts and Non-Executive Director (NED) Informal Visits)		
Report of	Angela O'Brien, Director of Quality and Effectiveness		
Prepared by	Fiona Gladstone, Clinical Effectiveness Advisor		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	The content of this report outlines the updated process and focus of Leadership Walkabouts, as part of the Board Visibility Programme. The report also provides a summary of key themes identified during the Leadership Walkabouts and the NED informal visits undertaken during July and August 2024. Both positive feedback, and areas for improvement were identified. The Trust Board, Executive and NED teams have, for many years, undertaken 'Leadership Walkabouts' throughout the organisation to enhance links between senior leaders and front-line staff. The walkabouts and visits raise awareness of front-line issues and support the visibility and accessibility of senior leaders within the organisation. In April 2024, following publication of the Trust's most recent CQC report, a 'refresh and refocus' approach was agreed to build on the previous programme, providing opportunities for open communication and a fair and transparent culture, enabling staff to talk freely about the challenges they are facing, but also their achievements and what they are proud of. By creating this environment of psychological safety, the Trust aims to provide the highest quality care and experience for staff and patients. This report provides an overview of four leadership walkabouts that were undertaken by Senior Leaders and Executives, and the ten informal visits undertaken by NEDs. Unfortunately, six walkabouts were cancelled at short notice due to an unexpected change in availability. All leadership walkabout teams reported that staff were welcoming, and friendly and enjoyed their job. Overall, staff felt able to raise concerns and felt valued, supported and listened to. There were good examples of learning and training opportunities. Areas of improvement which were identified include a review of staff break facilities, safety equipment, security, staff car parking and travel to the Campus for Ageing and Vitality (CAV) and further education for all staff on the Patient Safety Incident Response Framework (PSIRF).		
Recommendation	The Trust Board is asked to note the contents of this report in relation to both positive feedback from Trust staff, and concerns/suggestions raised for improvements.		

Links to Strategic Objectives	Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☒	☒
Link to Board Assurance Framework [BAF]	Issues identified may impact negatively on patient safety and staff wellbeing.					
Reports previously considered by	A more detailed version of this report was presented to the Quality Committee in September 2024. In the future it has been agreed that the reports will come directly to the Trust Board (included in the Public Board meeting papers).					

BOARD VISIBILITY PROGRAMME: LEADERSHIP WALKABOUTS AND NED INFORMAL VISITS

1. INTRODUCTION

The Trust Board, Executive and NED teams have, for many years, undertaken 'Leadership Walkabouts' throughout the organisation to enhance links between senior leaders and front-line staff. The walkabouts raise awareness of front-line issues and support the visibility and accessibility of senior leaders within the organisation.

It remains the objective of Leadership Walkabouts to provide a structure to help identify areas of care delivery requiring improvement, and the support and expertise to address the more difficult issues that may be impacting on quality and safety of patients and staff.

During 2023, NEDs commenced an informal visits programme to supplement the Leadership Walkabout Programme. The informal visits are unaccompanied visits to areas/services across the Trust, with the areas selected generally identified by the individual NED. In addition, Executive Team members also undertake informal visits.

In April 2024, following publication of the Trust's most recent CQC report, a 'refresh and refocus' approach was agreed to build on the previous programme, providing opportunities for open communication and a fair and transparent culture, enabling staff to talk freely about the challenges they are facing, but also their achievements and what they are proud of. By creating this environment of psychological safety, the Trust aims to provide the highest quality care and experience for staff and patients.

This report provides an overview of the new processes implemented as part of the Leadership Walkabout Board Visibility Programme. In addition, a summary of the leadership walkabouts and NED informal visits undertaken during July and August 2024 is provided. During this time six scheduled Leadership Walkabouts were cancelled due to an unexpected change in availability.

2. PROCESS

The new leadership walkabout programme involves two 'streams' which run in parallel each month:

Stream 1 [Leadership Walkabouts]: Two senior leaders (Executive Team, Directors of Operations, Board Chairs, Associate Directors of Nursing, other senior managers within the Trust (8C and above) and senior managers from the Clinical Governance and Risk Department (CGARD)) participate in a one-hour joint visit to a pre-defined clinical or corporate area. Within this the Director of Operations and Board Chair are allocated a visit within their own Clinical Board with the aim of increasing visibility of the Board Leadership Team to staff working in that area.

Stream 2 [NED informal visits]: NEDs undertake informal visits to a specific area within a Clinical Board that they are aligned to. In addition, the Chair undertakes regular informal visits to various areas/services across the organisation and the feedback from those visits is included within this report.

Management of the Leadership Walkabout schedule is co-ordinated by the CGARD (stream one) and the Corporate Governance Team (stream two).

The leadership walkabouts are announced, with the ward or area being notified of the walkabout, the team visiting and the time of their visit. The aim is to provide this information approximately one week prior to the visit.

A short guide is provided to the walkabout team which offers a summary of the purpose of the visit and includes prompts to facilitate informal productive conversations.

For example:

- What does a great day here look like?
- What stops you having great days?
- What could be done to make things even better?

Following the visit, the walkabout team and NEDs are asked to provide a free-text summary Walkabout Report which highlights what they felt were the most important themes from the staff they spoke to. The Walkabout Report template allows the inclusion of brief details of any issues addressed during visits and if any further action is required, see Appendix 1 for more details. The data is then collated by the CGARD and presented in this report.

3. REVIEW

As part of the new programme the aim is for a minimum of eight Leadership Walkabouts to take place each month. The table below summarises the walkabouts undertaken, 14 walkabouts were conducted during July and August 2024 (four within stream one and ten by Non-Executive Directors, as part of stream two). Six walkabouts in July and August were also cancelled at short notice due to unexpected changes in availability. These walkabouts have been rescheduled.

LW Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
Stream One	Ward 41	RVI	Clinical Board Chair (CBC) and Patient Safety Manager	Midwives and Maternity Support Worker
	Ward 38	RVI	Director of Operations (DOps) and Deputy	Ward Clerk, Healthcare Assistant and Band 6 Sister

LW Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
			Director of Quality and Safety	
	Ward 48	RVI	CBC and Deputy Chief Operating Officer	Not Specified
	Ward 18	RVI	CBC and Patient Safety Manager	Consultants, Band 5,6 and 7 nurses, Clinical Educator, Ward Clerk, Domestic, Physiotherapist, Speech and Language Therapist, Advanced Critical Care Practitioner (ACCP)
Stream Two	Ward 35 and Day Unit, Ward 34 and Young Persons Unit, Outpatients/Radiotherapy	FH	NED and DOps	Matron, Ward Manager and Healthcare Assistant (HCA)
	Pharmacy	RVI	NED	Director and Deputy Director
	Children's Social Work	RVI	NEDs	Social Workers
	Night Visit to Security, Emergency Admissions Unit (EAU), Reception and Wards 32, 32, 36, 34, 33, 37, 23, 24, 24a, 21, 2, 20 and 18	FH	NEDs	Security staff, Nursing staff
	Night Visit to Accident and Emergency (A&E), EAU, Maternity, Security, Reception, Ward 38 and 22	RVI	NEDs	Not specified
	NECTAR	CAV	NEDs	Senior Nurse Ambulance lead
	Electronics and Medical Engineering	FH	NED	Technicians Senior Managers
	Night Visit to Wards1a, 1b, 3, 4, Paediatric Intensive Care Unit (PICU), 9, 22 and A&E	RVI	NED	Nursing staff
	Maternity Assessment Unit, Delivery Suite, Ward 32, 33, Transitional Care, Antenatal Clinical (ANC) and Fetal Medicine	RVI	NED	Matron, Midwives

LW Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
	Ophthalmology: CAV Cataract Centre, Eye A&E, Ward 20 and 21	RVI and CAV	NED	Nursing and Medical staff

There were a number of issues raised requiring action/escalation:

- Staff wellbeing – review of break room facilities.
- Safety equipment – portable resuscitaire and transfer trolley are required.
- Environmental – following a break-in last week, it was noted there was a security vulnerability and a risk to loan working staff. A white works form was completed, support to accelerate this.
- Environmental – The car park next to the service has been altered to patient only around 4 weeks ago, following a complaint from a patient who could not park to access breast screening. This was completed, without staff consultation and has again identified a security vulnerability.
- Procurement - The Charity Committee have agreed to fund a simulation doll for training. This has been ongoing for three years due to the lengthy process regarding quotes / price increases.
- Training and Education - Further education of all staff on PSIRF.
- Transport - Review number 47 bus and communicate to CAV staff.

4. RECOMMENDATION

To receive the report and note the content.

Report of Angela O'Brien, Director of Quality and Effectiveness
Prepared by Fiona Gladstone, Clinical Effectiveness Advisor
September 2024

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Appendix 1

LEADERSHIP WALKABOUTS AND NED INFORMAL VISITS – REPORT TEMPLATE

Leadership Team Names: **Date:** **Ward/Department visited:** **Job Title of staff spoken to:**
Walkabout Report Please provide your free-text commentary highlighting what you felt was most important to the staff you spoke to. If you need more space, please use the reverse of the page or additional sheets.
Were there any issues you needed to address during your visit? ◯ Yes ◯ No If yes, what was the issue and how did you resolve it? Is any further action needed? ◯ Yes ◯ No If yes, please advise:

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Agenda item A10

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 September 2024					
Title	Committee Chair Meeting Logs					
Report of	Bill MacLeod, Chair of the Finance and Performance Committee, and Chair of the Audit, Risk and Assurance Committee until 31 August 2024 Anna Stabler, Chair of the Quality Committee Liz Bromley, Chair of the Digital and Data Committee Bernie McCardle, Chair of the People Committee Phil Kane, Chair of the Charity Committee David Weatherburn, Chair of the Audit, Risk and Assurance Committee from 1 September 2024					
Prepared by	Lauren Thompson, Corporate Governance Manager / Deputy Trust Secretary					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	The following Committee Chairs Logs are included since the last Trust Board meeting in July 2024: • Finance and Performance Committee (Check In) – 19 August 2024 • Quality Committee (Check In) – 13 August 2024 • Digital and Data Committee – 16 August 2024 • People Committee (Check In) – 19 August 2024 • Charity Committee (Funding Only) – 20 August 2024 • Audit, Risk and Assurance Committee (Check In) – 22 August 2024					
Recommendation	The Trust Board is asked to note the contents of the Committee Chair Logs.					
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	Present at each relevant Committee. This is a new report to Trust Board (previously the Update from Committee Chairs Report).					

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Finance and Performance (F&P) Committee Check In - Chair's Log

Meeting: F&P Check In	**Date of Meeting**: 19 August 2024
Connecting to: ARAC Board	**Date of Meeting**: 24 September 2024 27 September 2024

Key topics discussed in the meeting

• An Executive update in relation to performance was shared by Rob Harrison, Managing Director.
• Month 4 Finance Report – the current financial performance was discussed. There is no reported variance against plan except for £1,398k relating the costs of the recent Industrial Action and the associated loss of income.
• The Five Year Financial Model was discussed which included three scenarios which demonstrate the impact on the Trusts bottom line and cash position. The next steps are to refine the future year assumptions in line with activity, waiting list and capacity, with an update to be shared at the next Committee meeting.
  ○ Model 1 – Achievement of the 2024/25 plan in full, including all recurrent Cost Improvement Programme (CIP).
  ○ Model 2 – Achievement of the 2024/25 forecast outturn as reported at the end of July, which includes circa £15m in non-recurrent measures over and above those included in plan that compensate for CIP under-performance and for additional forecast cost pressures not currently assumed in the position. This also includes assumptions around achievement of Clinical Board and Corporate CIP targets.
  ○ Model 3 – Forecast outturn at July 2024 plus additional £8m recurrent benefit from two specific areas.
• An update was provided on the Integrated Quality Performance Report which included a discussion in relation to the anticipated impact on performance of the opening of the Community Diagnostic Centre (CDC) in Quarter 3.
• The approved Board Assurance Framework was received.
• A proposal for the establishment of a subsidiary was considered. The Committee approved the proposal and for the business case to be discussed at the September Board of Directors meeting.
• The following Procurement Reports were reviewed and approved by the Committee:
  ○ Supply of Bespoke Cannulation Packs
  ○ Cisco Licence Renewal for the Wi-Fi Network
  ○ Maintenance of Carestream X-ray from Medray

Actions agreed in the meeting	Responsibility / timescale
1. Item 3.1 – BM suggested receiving further information with regards to the processes in understanding the drug, alternative drugs and people spend **[ACTION01]**.	1. JMa / JB 2. RH / VMR

2. Item 4 – AS requested that modelling on the impact of the CDC on performance be shared with the Committee **[ACTION02]**. 3. Item 7a – AS queried staff training in relation to Infection Prevention Control whilst trialling the reusable tourniquet to which IJ confirmed that this will be picked up as part of the process. An update was requested at a future Quality Committee meeting **[ACTION03]**.	3. IJ / AS
Escalation of issues for action by connecting group	Responsibility / timescale
• No matters for escalation were identified.	Not applicable.
Risks (Include ID if currently on risk register)	Responsibility / timescale
• No new risks were identified.	Not applicable.

Agenda item A10

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Quality Committee
Chair's Log

Meeting: Quality Committee	**Date of Meeting**: 13/08/2024
Connecting to: Trust Board	**Date of Meeting**: 22/08//2024

Key topics discussed in the meeting	
• Screening quality assurance visit report for North Cumbria Breast Screening Service where a series of recommendations were made however none of immediate/significant concern. • Delays in physiotherapy following amputation were discussed and issues in relation to therapy services more widely. • An update in relation to Medicines Management was provided noting that a number of urgent actions have been taken in response to previous findings the recent CQC visit has highlighted, there is clearly more to be done to ensure these are embedded consistently, and at pace. • An update on the Referral to Treatment (RTT) Pathway was presented. The work has led to the identification of 12 long wait patients who require their first treatment. Validation is ongoing and patients who have had significantly long waits are actively being progressed through their pathway. Some patients require an updated MRI and clinic appointment before they are confirmed for treatment and to undergo a harm assessment. • The Committee received a paper in relation to the current position of Anti-microbial Stewardship (AMS) risks, priorities and strategy. • Integrated Quality Performance Report was received. • Board Assurance Framework was received.	
Actions agreed in the meeting	**Responsibility / timescale**
• Improvement plan following the Risk Based Audit in to Safeguarding.	LG / IJ - September 2024.
• Screening quality assurance visit report for North Cumbria Breast Screening Service. Action plan will be monitored by the Committee with first iteration being presented in October 2024.	LPC - October 2024
• Delays in physiotherapy following amputation. AS requested that a review of the service be presented to the Committee in four months' time.	ED - December 2025

• Deep Dive into therapy services requested for October	ED - October 2024
• Meeting to discuss Specialist Commissioning and how it can link into the Committee.	AS, RS, IJ and LPC
• Medicines Management Action Plan to show what actions are on/off track and what are the mitigations to be presented in next iteration in September	NW - September 2024
• BAF - Risks aligned to Quality Committee - AS requested that any additions and/or changes to the risks / assurance ratings can be clearly articulated.	NY - September 2024
Escalation of issues for action by connecting group	**Responsibility / timescale**
• Delays in physiotherapy following amputation and a Deep Dive into Therapy Services had been requested for the October Committee meeting and a risk identified linked to Specialist Commissioning. • The committee requested the Executive Team to look at the medicines oversight group and consider if an independent chair be put in place as per the cardiac oversight group.	AS to raise at Board - August 2024 and ED to present Deep Dive in October. LPC / IJ
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• The committee also acknowledged the risk remaining in relation to medicines management pending the future CQC visit.	N/a

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Digital and Data Committee
Chair's Log

Meeting: Digital and Data Committee	**Date of Meeting**: 16 August 2024
Connecting to: Board Meeting	**Date of Meeting**: 27 Sept. 2024
Key topics discussed in the meeting	

Celebrating Success

The Great North Care Record Team, based at Newcastle won the Outstanding Team Award voted on by UK digital peers at the Digital Health Summer School held in Durham on 18/19 July. The nominations came from the digital health community in the UK and this was a significant achievement for the team.

In June, Stephanie Edawards and Kay Shovlin passed the National Clinical Coding Qualification gaining Accreditation. These are fantastic results, with our Trust now having one of the highest numbers of Accredited coders, with two thirds of our staff gaining this qualification.

Developing our Workforce

Chris Bill, Chief Nursing Information Officer attended the CHIME sixth Digital Health Leadership Academy for Nurses and Midwives.

Keighley Shilling and Victoria Mulholand from the Digital Health Team have enrolled in the Master's in Leadership and Management programme and are currently apprentices at Teesside University.

The Trust has taken out an organisational membership with the British Computer Society, The Chartered Institute for IT will provide support for our staff to improve their credentials, and this is a cost-effective way to provide educational opportunities. The membership is based on 100 staff taking advantage of the various credentialling processes.

The Trust has one employee awarded a bursary for the Shuri network. The Shuri Network is the first NHS and care network for women from ethnic minorities in digital health and data. They are committed to promoting difference and diversity in digital health, challenging the system to take action and supporting our members to succeed in their careers with the support of allies including the Digital Health network.

Visit to Riyadh

SM recently attended a visit in partnership with Northumbria, to Riyadh, Saudi Arabia where they met with the Habib Medical Group and their subsidiary Cloud Solutions. They also met with senior management of the Healthcare Holding Co. - the government group set up to manage

healthcare. The team visited the largest virtual hospital in the world which is very digitally advanced. We are continuing to engage with cloud solutions to see if there is an opportunity to use some of their solutions. Currently our interest is in the patient engagement application and potential across the Alliance. A demonstration has been booked for August to view their system in more details.

Cyber Attack CrowdStrike Cyber Attack

GT updated the Committee around the global system outages that were reported on 19 July which were linked to a CrowdStrike issue affecting 8.5 million systems worldwide. A software update released by CrowdStrike during a regular patch window caused IT systems to crash. Despite recalling the update, affected systems were already offline, preventing the recall from being effective.

The biggest impact was to EMIS causing an impact to the GNCR users for EMIS reader and EMIS Web users. Hearflow and Clinisys (ICE) confirmed their internal systems were impacted but with no impact reported to Trust systems.

The Trust does not consume any CrowdStrike products directly and therefore there was no impact to any Trust owned systems or assets. Several third-party suppliers were affected, impacting some externally hosted systems.

Synnovis Cyber Attack

GS gave an update on the recent Cyber Attack at Guy's and St Thomas' NHS Foundation Trust. ILM met with the Trusts Cyber Security Team to discuss the implications and whether any action was required from Labs. As there was no direct link between Synnovis and the Trust and it was unlikely that an attack could spread to our systems, the Trust decided to disable the interface between iLab/APEX and Labgnostic. This action prevented any incoming orders from other labs reaching LIMS, as-such business continuity plans within ILM were enacted.

On 5 June inbound connections were reactivated to minimise workflow disruptions and potential data loss to all other Trusts. GT confirmed there is shared intelligence with NHS England with a set procedure in place for Trusts to follow. Internally we are behind strong firewalls with vulnerability scanning. GT also confirmed had CrowdStrike hit the Trust, systems would have been able to be rebooted almost immediately.

VTE

Kate Musgrove (Consultant Haematologist/Co Lead) presented to the Committee the follow up findings report from the 2-year project that had taken place around VTE. Prior to March 2024 nurse specialists spent hours manually reviewing radiology reports to identify new VTE diagnoses. FuF-VTE is the use of an artificial intelligence (AI) system to "read" all relevant radiology reports in real-time.

Eobs

Matt Shaw (Clinical Director for Patient Safety) and Melissa Burnside (Lead Deterioration/Sepsis Specialist Nurse) gave a presentation on the element of patient safety. MS/MB gave an outline on eObs which is an electronic structure for the taking of patient observations and the integration of these into the patient record. Observations are now used in the generation of a National Early Warning Score (NEWS2) which is an aid for the recognition of deteriorating health in that patient. A response structure has been created to allow for assessment and intervention in the treatment patients.

The aim of using the eObs, deterioration and sepsis response system is to improve patient safety by increasing the early detection of deterioration and sepsis and to facilitate an appropriate

clinical response. This structure allows us improved clinical governance and quality assurance while also allowing for digital innovation in patient care.

Actions agreed in the meeting	Responsibility / timescale
CQC Update – It was noted that it the actions had been well received at the recovery meetings. MWr mentioned there was recognition from CQC that progress had been made and most importantly the Trust has a plan for them to see.	
It was agreed that Training and Adoption is recognised to be the first focus for the Trust. CB confirmed they were at the planning stage at present and are also in the process of producing the business case. CB to update the committee on progress. **[Action29]**	CB – Timescale: Update at next Committee meeting (17/10/24).
Digital/Data Incident Review - Windows XP system for Newborn hearing inhouse system found within the Audiology department used by two consultants who are due to leave the Trust. Business continuity plan required. GT confirmed they are unable to determine if they are Trust or third-party devices. GT has added onto risk register. MW to pick up with Nichola Kenny **[Action30]**	MWi – Timescale: Update at next Committee meeting (17/10/24).
Accessible Information Standards (Improving Patient Experience) - SM confirmed Digital IT are working with Nichola Kenny to ensure the Trust can deliver reports/email documentation to patients as requested. This is not just for accessible information standards use but for all patients who wish to receive their documents by email. Benefits are, not only for patients who wish to receive their documents electronically but also a cost reduction to the Trust. This is in the final stages of testing. SM to update at next Committee meeting **[Action31]**	SM – Timescales: Update at next Committee meeting (17/10/24)
VTE Presentation - VMR to have further discussion with CP/LS to discuss how this can be published and how we can work collaboratively with Solventum **[Action32].** The Committee agreed this is a good piece of work that should promoted within the Trust.	VMR to meet with CP/LS/KM to explore further – Timescales: Update at next Committee meeting (17/10/24)
eObservations and deterioration presentation - The Committee agreed this was a good piece of work and further discussion around taking this forward is required. VMR to meet with MS/MB/LS to discuss how to take this further. **[Action33]**	VMR to meet with MS/MB/LS to explore further– Timescales: Update at next Committee meeting (17/10/24)
Finance - SM met with JB on 12 August to discuss the capital plan and digital budget. SM still has concerns as to investment in digital and SM plans to relook at the overall budget plan in September. SM and the Senior Managers within Digital IT are reviewing the 5-year plan	SM – Timescales: Update at next Committee meeting (17/10/24)

on what our investment needs to be and then this will be presented to take forward at a later meeting. **[Action34]**	
Escalation of issues for action by connecting group	Responsibility / timescale
N/A	
Risks (Include ID if currently on risk register)	Responsibility / timescale
N/A	

Agenda item A10

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

People Committee - Chair's Log

Meeting: People	**Date of Meeting**: 19 August 2024
Connecting to: ARAC and Board	**Date of Meeting**: 22 August 2024

Key topics discussed in the meeting	
• An update was received on the People Plan and Year 1 deliverables. • Progress on the Leadership Development Offer was noted. • The Committee was informed that a report outlining the Trust's current arrangements for speaking up was being presented to the Executive Team on 21 August 2024 which set out plans and next steps to enhance and embed speaking up further in line with the CQC inspection findings and action plan and the recently published People Plan 2024-2027 • Discussion on recent civil unrest and the potential impact on recruitment of international employees. • A review of the targets on the people metrics, using benchmark information for comparable sized and neighbouring trusts had been undertaken and a proposal to change the targets had been agreed by the Executive Team and was endorsed by the Committee. • The Integrated Performance Report was presented where it was noted that Medical and Dental were significantly under the Trust targets for Statutory and Mandatory Training and Appraisal compliance. It was acknowledged significant progress had been made to increase compliance and that this will continue. However, the Chair asked that this was considered in more detail at the September meeting to give the Committee assurance that direction of travel is being maintained and compliance will be achieved • The Board Assurance Framework was received • No new or emerging risks were identified.	
Actions agreed in the meeting	**Responsibility / timescale**
1. To provide a breakdown of staff turnover of those leaving the organisation for other Trusts in the Alliance.	PT - September Meeting
2. To discuss Statutory and Mandatory Training and Appraisal compliance in more detail to ensure that improvements are being sustained.	Committee discussion in September.

Escalation of issues for action by connecting group	Responsibility / timescale
There were no matters requiring escalation.	N/a
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
No new or emerging risks were identified.	N/a

Agenda item A10

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Charity Committee - Chair's Log

Meeting: Charity Committee – Funding only	**Date of Meeting**: 20 August 2024
Connecting to: Board	**Date of Meeting**: 27 September 2024

Key topics discussed in the meeting

• Updates on previous funding applications were discussed.
• Funding proposals were discussed in relation to:
  ○ Family Health - £227,513.22 – Sophie's Legacy Project – Approved.
  ○ Family Health - £95,407 – Great North Children's Hospital (GNCH) Youth Worker – Approved.
  ○ Clinical & Research Services - £79,286 - AML Optical Genome Mapping Project – Approved.
  ○ Family Health - £50,000 - Child Brain Injury Trust North East ABI Co-ordinator – Rejected.
  ○ Medicine & Emergency Care - £48,275 - supporting transition to living with a chronic disease – enhanced service provision extension 2024 – Approved.
  ○ Family Health, £32,156 - Neonatal Videolaryngoscope – Approved.
  ○ Surgical and Associated Specialties - £27,168 - Laryngeal Endoscopy for inpatients and patients with exercise induced laryngeal obstruction – Approved.
• The summary of funding agreed since the last meeting was reviewed (bids up to £20k).

Actions agreed in the meeting	Responsibility / timescale
N/A	

Escalation of issues for action by connecting group	Responsibility / timescale
N/A	

Risks (Include ID if currently on risk register)	Responsibility / timescale
N/A	

Agenda item A10

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Audit, Risk and Assurance Committee (ARAC) Check In - Chair's Log

Meeting: ARAC	**Date of Meeting**: 22 August 2024
Connecting to: Board	**Date of Meeting**: 27 September 2024

Key topics discussed in the meeting	
• The updated Compliance and Assurance Group Terms of Reference (ToR) were approved subject to one action. The new reporting arrangements are included within the ToR. • The External Visits Compliance Report was discussed in detail noting that there is a clear process in place with regards to oversight of the visits. Further work is taking place to clarify that action has been taken in relation to previous visit reports. • A detailed presentation was received in relation to Clinical and Research Services Clinical Board. It was highlighted that there are several longstanding risks on the risk register however these are being mitigated where possible and regularly reviewed. The main themes raised were in relation to workforce and equipment. • A detailed presentation was received in relation to Medicines Management. It was highlighted that the risks on the risk register are regularly considered and the recommendations from the CQC report have been taken forward through the relevant groups. • The Trust Board approved, Board Assurance Framework was received for information.	
Actions agreed in the meeting	**Responsibility / timescale**
1. Compliance and Assurance Group Terms of Reference - CD referred to the risk bullet points and asked if they could be cross referenced with the Risk Management Policy to ensure they are accurate. NY agreed to meet with David Edwards to discuss **[ACTION01].** 2. Clinical and Research Services Risk Deep-Dive - It was agreed that a paper will be presented to ARAC to receive assurance that there is a plan in place with regards to tolerating longstanding risks **[ACTION02].** 3. Any other business, payroll overpayments - Committee members agreed the overpayments information be added to the 'write off' report bi-annually **[ACTION03].**	1. NY / DE – September 2024 2. RH / NY – October / November 2024 3. CH – next report.
Escalation of issues for action by connecting group	**Responsibility / timescale**

1. Escalate to Trust Board that there are 44 risks over two years old within the Clinical and Research Services Clinical Board but that there are development plans in place. The main themes raised were in relation to workforce and equipment.	1. BMc – August Trust Board
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
1. The following risks were discussed in detail on the Clinical and Research Services Clinical Board risk register: • Risk ID 3718 • Risk ID 3811 • Risk ID 4312 2. The following risks were discussed in detail on the Pharmacy risk register: • Risk ID 3718 • Risk ID 3880 • Risk ID 4568	N/A

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Agenda item A11

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 September 2024		
Title	Shine (Sustainable Healthcare in Newcastle) Update		
Report of	Vicky McFarlane Reid, Director for Commercial Development & Innovation (Executive Director Lead for Sustainability)		
Prepared by	James Dixon, Associate Director - Sustainability		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☒
Summary	Climate breakdown is the greatest threat to health in the 21st century. Newcastle Hospitals declared a 'Climate Emergency' in June 2019 to highlight this threat and stimulate urgent action. The Trust adopted a leadership position in becoming the first healthcare organisation in the world to do so, joining our Newcastle civic partners in collaborative action, committing to fast-tracking decarbonisation of our services a decade ahead of government targets. This paper updates the Trust Board on work to deliver on the commitments contained in the Board approved Climate Emergency Strategy 2020-2025 (which clearly sets out our vision, long-term goals and action plan, published in October 2020) (bit.ly/CEStrategy_NUTH). This report presents an overview of current Sustainability governance arrangements and presents a full annual update on performance and achievements, across all Shine priority areas, for the financial year 2023/24 (in the form of our standalone Annual Shine Report). Having been approved by People Committee, this report seeks Board approval to publish our Annual Shine Report 2023/24. As Newcastle Hospitals tenders for public contracts of significant value, UK Public Procurement Policy Note 06/21 requires a Board approved Carbon Reduction Plan (CRP). This report also presents a final draft CRP for discussion/approval to publish. This annual update to Trust Board also highlights significant risks to achieving the Trust sustainability targets at this point in our Climate Emergency Strategy 2020-2025 (lack of dedicated capacity, lack of dedicated funding and significant increases in Trust energy costs from April 2024 onwards).		
Recommendation	The Trust Board is recommended to receive this update report for information and approve the following documents for publication: • Annual Shine Report 2023/24 • Newcastle Hospitals' Carbon Reduction Plan (new for 2024)		

Links to Strategic Objectives	**Pioneering** – first healthcare organisation in the world to declare a Climate Emergency, ambitious aim for net zero by 2030 for our footprint and 2040 for our footprint plus **Performance** – continuing as leaders in healthcare environmental sustainability **People** – sustainable healthcare is a priority for our staff (99% rate it as important in our most recent survey)					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☐	☒	☒	☒	☐	☒
Link to Board Assurance Framework [BAF]	None (*Previous Board Assurance Framework Risk ID - SO5.6: Climate Emergency (Rated 20)*)					
Reports previously considered by	Annual update to Trust Board (following review at People Committee)					

SHINE (SUSTAINABLE HEALTHCARE IN NEWCASTLE) UPDATE

1. BACKGROUND

In 2019 Newcastle Hospitals became the first healthcare organisation in the world to publicly declare a climate emergency, committing to fast-tracking decarbonisation of our services a decade ahead of government targets. The 'Delivering a Net Zero NHS' report was published in October 2020, making the NHS the first healthcare system in the world to commit to net zero carbon. Our own Climate Emergency Strategy was subsequently published on 22nd October 2020 (bit.ly/CEStrategy_NUTH) clearly setting out our vision, long-term goals and action plan for 2020-25.

2. GOVERNANCE AND REPORTING

The Sustainable Healthcare Committee meets quarterly to monitor progress towards commitments in the strategy, with subsequent updates to People Committee, our Board Committee, six-monthly (previously quarterly). A comprehensive performance report, known as the Shine Report, is published annually and is signposted from the Trust Annual Report (which contains the NHS Standard Contract mandated summary of performance). The Trust internet site includes a Shine page with links to our strategy, each Shine Report and other resources: https://www.newcastle-hospitals.nhs.uk/about/sustainable-healthcare/

2.1 Sustainable Healthcare Committee (SHC)

The SHC is chaired by Dr Vicky McFarlane Reid, Director for Commercial Development & Innovation and Executive Lead for Sustainability. The Committee aim is to drive forward action on climate emergency projects to achieve the Trust's Climate Emergency Strategy aims and to provide a forum for the discussion, review and over-arching management of sustainability across the Trust, on behalf of Trust Board. Summary updates from each sub-group are presented to SHC and incorporated into performance reports.

2.2 Executive Oversight Group (EOG) for Climate Emergency

The EOG was established in 2020, meeting monthly and also chaired by Dr Vicky McFarlane Reid. It aimed to provide Executive oversight on the strategic direction and actions to deliver on the Trust's climate emergency priorities, to facilitate swift decision making to empower workstream leads into taking actions. Projects that directly benefited from this approach included: the ban on diesel for all fleet, hire and lease vehicles; the Shine Rewards app; government funding for heat decarbonisation plans and agreement to limit personal salary sacrifice vehicles to Ultra-low & Zero Emission Vehicles only. Wider Executive Team member attendance at EOG reduced in recent years due to a shift in other organisational priorities which affected the focus on this agenda as an organisation. The last meeting took place in January 2024 before it was stood down as part of a wider organisational governance refresh, following the recent CQC inspection.

3. FULL ANNUAL UPDATE ON PROGRESS (SHINE REPORT 2023-24)

A comprehensive update on progress towards the targets and actions in our Climate Emergency Strategy is produced in our Annual Sustainable Healthcare in Newcastle (Shine) Reports. The

attached final draft Shine Report 23/24 (Appendix 1) was presented to the People Committee on 17th September 2024 and approved onward submission to Trust Board (to seek final approval for publication).

The theme of this year's report is 'Empowering Action' and aims to showcase the amazing work of our staff, reducing environmental impact across the organisation, despite the challenging context we find ourselves in.

4. CARBON REDUCTION PLAN (CRP)

As part of the NHS' commitment to Net Zero, NHS England have committed to only do business with suppliers who share the same ambition for decarbonisation. UK Procurement Policy Note (PPN) 06/21 requires any company bidding on a public contract valued at £5million or more must produce a CRP, outlining their strategy to achieve net zero carbon emissions by 2050 and effectively make it a requirement under the Social Value Act for large public procurements.

Newcastle Hospitals tenders for public contracts of significant value and, as such, has a requirement for a Board approved CRP in a template stipulated in PPN 06/21. The Sustainability Team is aware of at least one major contract above the £5m threshold that is due in March 2025 (NICE) which will include this as a requirement. As we have developed and mandated our own 5-Step Net Zero Supplier framework for our own suppliers, which requires a CRP at step 5, it is important that we can lead by example and have our own Board approved CRP.

The attached CRP (Appendix 2) has been prepared by the Sustainability Team, working in conjunction with the Procurement Team, and follows the standard template required of PPN 06/21. The CRP is a headline summary of information that exists within existing Trust documentation (our Climate Emergency Strategy, action plan and annual Shine Reports etc). It requires sign-off by the Board of Directors and was presented to People Committee on 17th September 2024 and approved for formal submission to Trust Board for approval.

5. RISKS

There was a Board Assurance Framework risk entry for Climate Emergency (Ref SO5.6: Rated 20) which highlighted that the Trust is not on track to achieve the Net Zero by 2030 target (for emissions we control) and is currently overshooting our organisational carbon budget. This risk is dominated by the challenges in decarbonising our hospital heat and power and the lack of national funding to support this. In mitigation of this risk the Executive Team authorised the recruitment of additional Net Zero Engineering capacity within Estates (though recruitment to these roles has been a challenge). This risk has now been migrated to the Estates Risk Register.

Additional challenges/risks that hinder progress towards achieving the goals and targets within the Trust Climate Emergency Strategy include:

- **Lack of Dedicated Capacity** – both within the Sustainability team and protected time/capacity for staff working in key stakeholder departments i.e. Procurement, Pharmacy and in each Clinical Board. Whilst charitable funding has provided much-welcomed temporary capacity in

the form of Clinical Sustainability Fellows, further capacity is needed to deliver the transformational change required to achieve our strategic goals.

- **Lack of Dedicated Finance** – there is no operational budget for the Sustainability team or for Climate Emergency Strategy programme delivery. Successes and achievements to date have been delivered through non-recurrent pay underspend, limited regional Greener NHS funding or successful bids to Newcastle Hospital charities – this is not sustainable and will not lead to the transformational change required to achieve our strategic goals. In addition to this, there is very limited capital funding allocated to Net Zero/estates decarbonisation projects in the Trust Capital Plan. This stands in contrast to peer organisations like Newcastle University (£15m/year) Northumbria Healthcare NHS Foundation Trust (£3.2m/year) and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (£1.5m/year). We continue to apply for central government grant funding, but success has been limited to our Regent Point project (with repeated failed bids for our hospital sites).

- **Significant Increases in Energy Costs** – from 1st April 2024 the Trust has been exposed to a significant increase in the revenue costs of energy for our sites. Our long-term energy procurement strategy managed to minimise organisational exposure to energy market volatility over recent years, but these contracts ended in March. A cost pressure of approximately £20m is anticipated for 2024/25 (taking our energy costs from £16m in 2023/24 to nearer £36m). Investing in energy demand reduction projects now will reduce the impact of this cost pressure whilst also reducing carbon emissions.

6. RECOMMENDATIONS

The Trust Board of Directors is recommended to:

i) receive this report for information, noting the progress to date and the highlighted risks,
ii) approve the final draft of the Trust's Annual Shine Report 2023-24 for publication,
iii) approve the final draft of the Trust's Carbon Reduction Plan (requirement of PPN 06/21) for publication.

James Dixon
Associate Director - Sustainability
18 September 2024

On behalf of
Dr Vicky McFarlane Reid
Director for Commercial Development & Innovation and Executive Lead for Sustainability

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Shine

Sustainable Healthcare in Newcastle

Empowering Action

Sustainable Healthcare in Newcastle (Shine)

Annual Report 2023-24

Contents

1. Foreword

It is a pleasure to share our annual Shine Report. On 1 July 2022 the NHS became the first health system to embed 'net zero' into legislation through the Health and Care Act 2022[1]. The 'Delivering a Net Zero NHS' Report is statutory guidance[2] and our Annual Report sets out our progress towards this national objective, and our own target to reach net zero for our NHS carbon footprint 10 years ahead of the national ambition.

I want to be honest about the challenge the climate emergency presents to us. Providing great patient care within the means of our planet and supporting our patients whilst acknowledging the impact we have for future generations, is the biggest challenge we all face. We can only make progress if we work together.

To achieve this ambitious aim, leaders are required to understand these issues, empower and encourage their teams, and embed the principles of environmentally sustainable care into all of our services. In this report, we seek to empower staff and highlight the excellent work done to date, whilst acknowledging the challenging context we find ourselves in. All of our progress is thanks to our dedicated staff, and I extend my sincere gratitude to everyone working to ensure our patients receive the best care in an environmentally sustainable way.

I am grateful to the Green Champion network for their ongoing enthusiasm and commitment to support us in providing sustainable and future proofed services that acknowledge the importance of prevention. I am pleased to say that I have recently become a Green Champion myself and look forward to playing a personal role in this work.

I acknowledge the huge challenge we face, and that decarbonising our estate remains a priority so that we can reach our goal of Net Zero for the emissions we control by 2030. We are currently not on course to achieve this target as we are still reliant on fossil fuels to heat and power our hospitals. We know that changing this will require additional external funding and we report on our Public Sector Decarbonisation Scheme (PSDS) funding received for Regent Point in this report.

In respect of our NHS Carbon Footprint Plus (the emissions we can influence) we continue to work with our suppliers so that we can continue to work towards a net zero carbon supply chain by 2040.

We are not alone in seeking to make positive change. There is a great deal of work being developed nationally, within the Greener NHS programme, and with our partners across the North East and in the city and you can read more about these exciting partnerships in the report. We are also acutely focussed on cleaning up the air that we breathe around our hospitals – a way to create improvements for staff and patients, minimise health inequalities and reduce our carbon footprint.

I want to be honest about the challenge the climate emergency presents to us. Providing great patient care within the means of our planet and supporting our patients whilst acknowledging the impact we have for future generations, is the biggest challenge we all face. We can only make progress if we work together.

I hope you enjoy reading this report and that you continue to share our commitment to continue to work towards zero carbon care, clean air and zero waste.

Keep going.

Sir Jim Mackey
Chief Executive, Newcastle Hospitals

I am pleased to say that I have recently become a Green Champion myself and look forward to playing a personal role in this work.

Staff at our Day Treatment Centre, Freeman – read about their theatre sustainability work on page 27

[1] Health and Care Act 2022 (legislation.gov.uk)
[2] Greener NHS » Delivering a 'Net Zero' National Health Service (england.nhs.uk)

2. Introduction

In 2019 the Trust declared a climate emergency, acknowledging the urgency of the situation, and committing to taking the action necessary to reduce our impact on global heating. This resulted in the creation of our Climate Emergency Strategy, creating a vision for change to educate, engage and empower our staff, patients and stakeholders.

In last year's report, as Executive Lead for Climate Emergency, and Chair of the Executive Oversight Group (EOG) for Climate Emergency, I communicated our vision for how we think the Trust could reach Net Zero by 2030 and provided updates about the work being done on our "red flags". The challenges remain and so this year we want to empower our staff to take more action and create quick wins, by providing examples of where staff have made sustainable improvements to our services. We have also highlighted in this report where we have been able to make it stick, for example in reducing our emissions from anaesthetic gases, which are potent greenhouse gases. We acknowledge more needs to be done to build on the change we have seen so far and ensure that we continue to move forwards.

Our Green Champion network have communicated to our new Chief Executive, Sir Jim Mackey, their ambitions for the Trust and Jim has offered his support. We acknowledge that sustainability is part of Well-Led for the CQC and so leadership is key. We recognise the challenges we have had in embedding this strategy in the Trust. Given the prominence of our 2030 Net Zero ambition, we were selected by our internal audit team to review our published carbon performance data and progress against this target. The Sustainability Team were enthusiastic about this opportunity and found the exercise to be incredibly useful with key areas for improvement identified, including improvements to processes for reporting sustainability performance to the Trust Board, which we have embraced.

Breathing clean air should be a given, so we are continuing to work on improving the air quality both inside and outside the hospital

Our vision is that sustainability is embedded from ward to board and staff feel empowered to act. The Shine 10-step framework for embedding sustainability in departments or directorates is being followed by a number of teams, including the Integrated Laboratory Medicine Directorate, Procurement, Newcastle Nutrition and Clinical Research . These early adopters will help us refine the framework to roll it out more widely across the Trust. We are working on embedding sustainability in the ward accreditation framework, in clinical board governance structures and in the business case process.

We all want to see a reduction in the things that we waste. In addition to the directorate working groups on the Shine 10-step framework, the Theatres Sustainability Working Group is piloting projects with the potential to be rolled out across the trust, which reduce our reliance on single use items and increases reuse (moving up the waste hierarchy). Work is also ongoing with our Wasted Medicines Project, featured in last years' Shine Report 2022-23, to ensure the best practice from the wards involved is shared and replicated.

Our Procurement Team – read about their work to embed sustainable procurement on page 28

Our Green Champion network have communicated to our new Chief Executive, Sir Jim Mackey, their ambitions for the Trust and Jim has offered his support. We acknowledge that sustainability is part of Well-Led for the CQC and so leadership is key. We recognise the challenges we have had in embedding this strategy in the Trust

Breathing clean air should be a given, so we are continuing to work on improving the air quality both inside and outside the hospital, with collaboration between the Travel and Transport Team, the Sustainability Team, the Non-Smoking Team and the Public Health Team. The staff Hopper service is now an electric bus service[4], with zero tail pipe emissions. We are working on monitoring our air quality and Babatunde Okeowo our research PhD student has developed a prioritised action plan to clean up the air in and around our hospitals.

We are able to report a small decrease in our NHS Carbon Footprint, for the emissions within our control, but this is not sufficient to bring us within our carbon budget, and as we progress closer to 2030 the challenges are increasing to meet our Net Zero targets. This is in part because we are reliant on difficult to access external funding in order to de-carbonise our estate. We received PSDS funding for decarbonising Regent Point to install LED lighting, solar photovoltaic (PV) panels and heat pumps. We were not, however, successful in obtaining subsequent funding for our main hospitals (the biggest source of our controllable emissions), but we will be ready at each step of the way to ensure we make those applications for available funds, so that we can implement the capital projects required to decarbonise our estate.

In terms of the emissions we can influence, known as our NHS Carbon Footprint Plus, our supply chain and procurement of goods and services make up a significant proportion of those emissions. We have launched our 5-step Net Zero Carbon Supplier framework to help suppliers to decarbonise in line with our targets. This was launched at an event on 12 July 2023 and has been embedded in all future tenders. This is an example of the great joint work done by the Procurement Team and the Sustainability Team.

This report will show how we are progressing to make change to embed sustainability at Newcastle Hospitals. As ever we seek to empower staff to take action, to sustain the change and make it stick.

Victoria McFarlane Reid
Executive Director Lead
for Sustainability

[4] 97.8% of total mileage is electric.

Empowering Action

Declaring a climate emergency in 2019

A vision to be a global leader in sustainable healthcare

Published our Climate Emergency Strategy in 2020

Corporate Induction

Training & resources

Shine10-step framework for embedding sustainability

Reduction in emissions from anaesthetic gases

Shine rewards app

Reduction in clinical waste volumes

Step 1
Create urgency

Step 2
Form a powerful coalition

Step 3
Create a vision for change

Step 4
Communicate the vision

Step 5
Empower action

Step 6
Create quick wins

Step 7
Build on the change

Step 8
Make it stick

Shine GREEN CHAMPION

Network of 500+ Green Champions

Letter from Green Champions to Sir Jim

Climate Emergency Action Fund

Celebrating Excellence Awards

Decarbonisation of Regent Point

Clean Air Hospital Framework

Electric Hopper

5-step Net zero carbon supplier framework

(Inspired by Kotter's 8 Steps for Leading Change: Leading Change by John P Kotter)

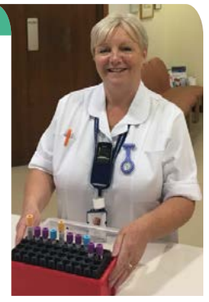
Empowering Action

1	Newcastle Hospitals was the first healthcare organisation in the world to declare a climate emergency in 2019.
2	There is a network of over 500 Green Champions across the Trust working in different departments and directorates forming a powerful coalition of staff members committed to sustainable healthcare.
3	Newcastle Hospitals Climate Emergency Strategy 2020-25 created Our Vision: to be a global leader in sustainable healthcare delivery through collaboration and innovation, helping our patients and communities to thrive within the means of our planet.
4	We continually work to ensure the vision is communicated to all of our staff, and this has been supported with the introduction of sustainability training for all staff when they join Newcastle Hospitals at corporate induction.
5	Shine 10-step framework for embedding sustainability empowers staff to take action in their departments and directorates. Our 500 + Green Champions have written a letter to our new CEO to ensure sustainability remains a priority and Sir Jim has confirmed his support.
6	We have allocated £150,000 of Climate Emergency Action Funding to support staff led sustainability projects.
7	Teams are working on embedding sustainability across the Trust, including via the Clean Air Hospital Framework and our 5-step Net Zero Carbon Supplier Framework.
8	We have made it stick, despite the challenges, in reducing our emissions from anaesthetic gases, running the hopper as an electric bus service, reducing our clinical waste, offering a rewards platform to staff, training all staff at induction and decarbonising Regent Point.

Climate Emergency Action Fund

£150,000 allocated to staff-led sustainability projects over the last three years (£50,000 per year)

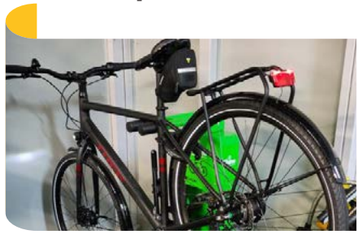
22 Number of projects supported



1 million
single use plastic bags eliminated each year by using reusable transport boxes

Bike repair stations

installed in staff cycle compounds at our hospital sites



Green the Grey

Enhancing biodiversity in and around our hospitals

Reusable theatre hats

Funding trials to reduce the carbon in our care pathways and saving money

3. Performance

Please see our Shine Annual Report 2022-23 for a detailed breakdown of our three long-term goals and our vision to reach Net Zero.

We are mirroring the Greener NHS definitions of 'carbon footprint' and 'carbon footprint plus' which were published in their Delivering a Net Zero NHS Strategy. The sources of carbon included under those definitions are shown in the diagram. In addition, we have also continued to calculate and present our carbon performance in line with the global best practice framework of the Greenhouse Gas Protocol.

Category	Sub-category	Total tCO_2e			% change from previous year	% change from baseline year
		2019-20	2022-23	2023-24		
Newcastle Hospitals carbon footprint	**Scope 1**					
	Building energy – fossil fuels	54,858	52,742	51,170	-3	-7
	Refrigerant gases	477	246	246	0	-48
	Anaesthetic gases	4,336	2,381	1,704	-28	-61
	Trust fleet	112	113	110	-2	-2
	Scope 2					
	Building energy - purchased electricity	4,933	4,943	5,187	5	5
	Scope 3					
	Water	441	204	207	1	-53
	Waste	558	518	496	-4	-11
	Inhalers	1,399	1,341	1,319	-2	-6
	Business Travel	1,278	1,015	1,020	0	-20
Newcastle Hospitals Carbon Footprint Total		**68,393**	**63,502**	**61,459**	**-3**	**-10**
Medicines, medical equipment and other supply chain	Medicines and chemicals	67,952	73,272	132,625	81	95
	Other supply chain	39,094	42,158	51,184	21	31
	Medical equipment	42,415	40,577	106,048	161	150
	Patient Transport Service	1,870	1,968	1,770	-10	-5
	Procurement total	**151,332**	**157,975**	**291,628**	**85**	**93**
Personal travel	Staff commute	14,863	11,601	11,994	3	-19
	Patient and visitor travel	22,257	22,056	22,240	1	0
Newcastle Hospitals Carbon Footprint Plus Total		**256,844**	**255,135**	**387,321**	**52**	**51**
Patient numbers		1,788,469	1,819,965	1,836,116	1	3
Carbon intensity (tCO_2e per patient contact)		**0.144**	**0.140**	**0.211**	50	47

Table 1: Breakdown of Total Newcastle Hospitals Carbon Footprint

3.1 Carbon Footprint

This year we are encouraged to report a small decrease in our Newcastle Hospitals carbon footprint. There has been a 3% reduction in the carbon footprint as compared to last year, and 10% as compared to the baseline year (2019/20).

This is mainly due to reductions in energy consumption, and changes to anaesthetic gas use, including banning the use of desflurane in almost all cases, the introduction of technology to capture and destroy Entonox and decommissioning piped nitrous oxide at the Freeman Hospital.

We are continually trying to improve our calculation process so in some areas, the calculation methods have altered or the data source is improved. Our baseline year has changed as emission factors have changed and we have accessed more data and improved our methodology. We have put a new line in for PTS, which was previously included within patient and visitor travel. Please see the end note for more detail.

NEWCASTLE HOSPITALS CARBON FOOTPRINT

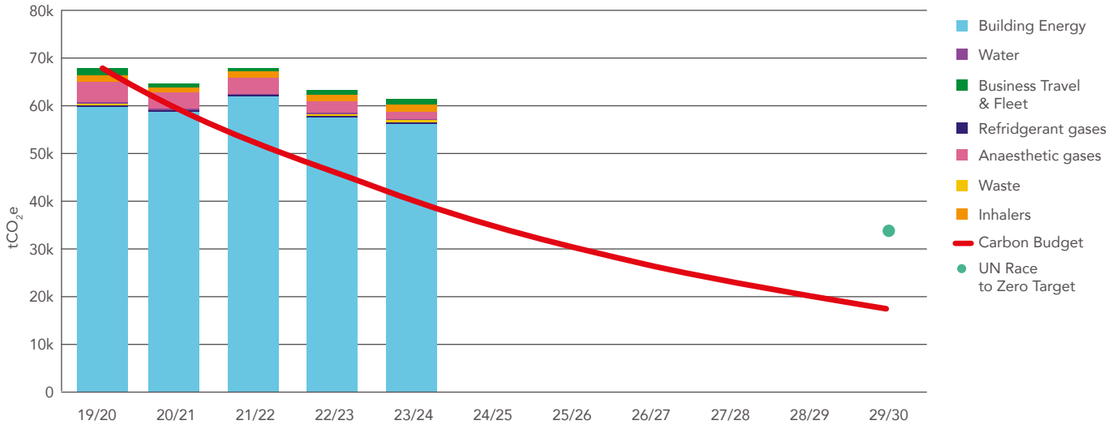


Figure 1: Newcastle Hospitals Carbon Footprint

This graph shows our progress in reducing our carbon footprint against our carbon budget (the red line). Like a financial budget we will have to account for overspend in later years.

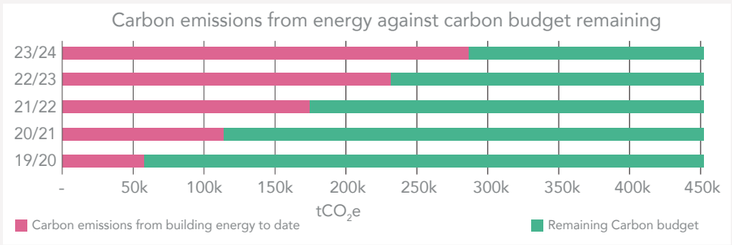
HOW MUCH OF OUR CARBON BUDGET HAVE WE USED?

The Tyndall Centre for Climate Change Research uses the principles of science and equity that are aligned with the commitments in the United Nations Paris Agreement to set budgets at national and sub-national levels, providing local authorities with recommendations that translate the 'well below 2°C and pursuing 1.5°C' global temperature target.

We took that method and applied it at our organisational level for Newcastle Hospitals to calculate our own carbon budget – giving us the absolute total amount of carbon dioxide we can emit – 450,000 tCO_2e.

As has been reported previously, we have not achieved a sufficient reduction for the last four years. This means the level of action required to stay within the carbon budget is now even greater, otherwise we are at risk of exceeding our total budget.

We have already emitted 286,983 tCO_2e out of our total carbon budget for building energy. If we continue at the current rate we will exceed the budget in under 3 years.



NEWCASTLE HOSPITALS CARBON FOOTPRINT PLUS

In relation to our carbon footprint plus we have reported a significant increase in emissions as we have continued to improve the calculation methodology, in line with the Greenhouse Gas Protocol Hybrid Approach. In previous years we estimated our emissions based on how much money we spent, with a small amount of data coming from our suppliers directly. This year thanks to our engagement work with suppliers through the 5-step Net Zero Carbon Supplier Framework we have received a much higher proportion of direct data from suppliers. The proportion of emissions from supplier data is highlighted, and we will continue to work to increase this, and in turn work with our suppliers to reduce their emissions.

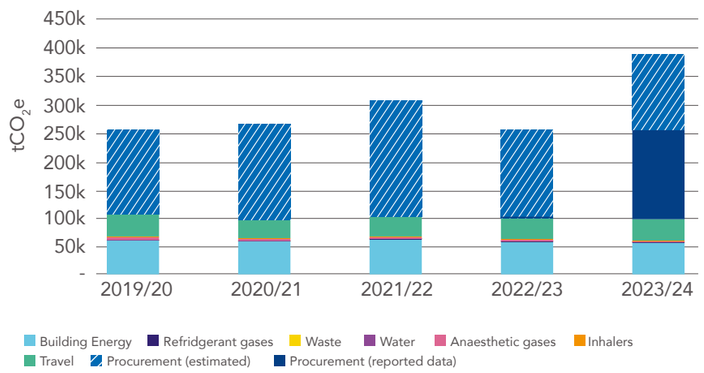
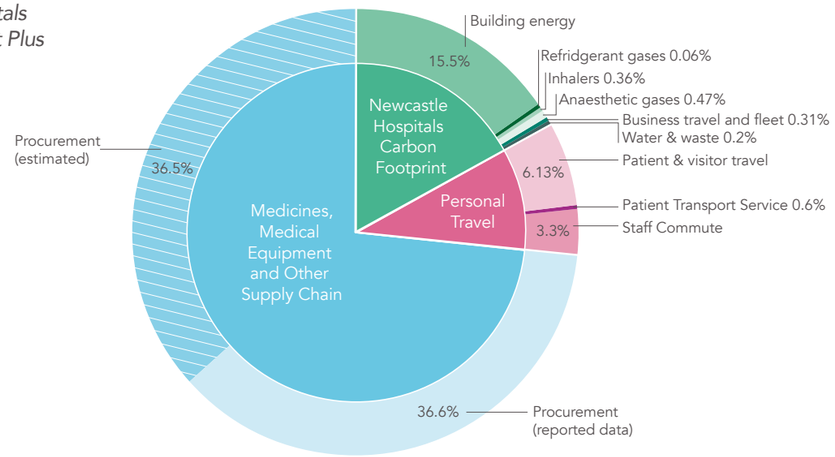
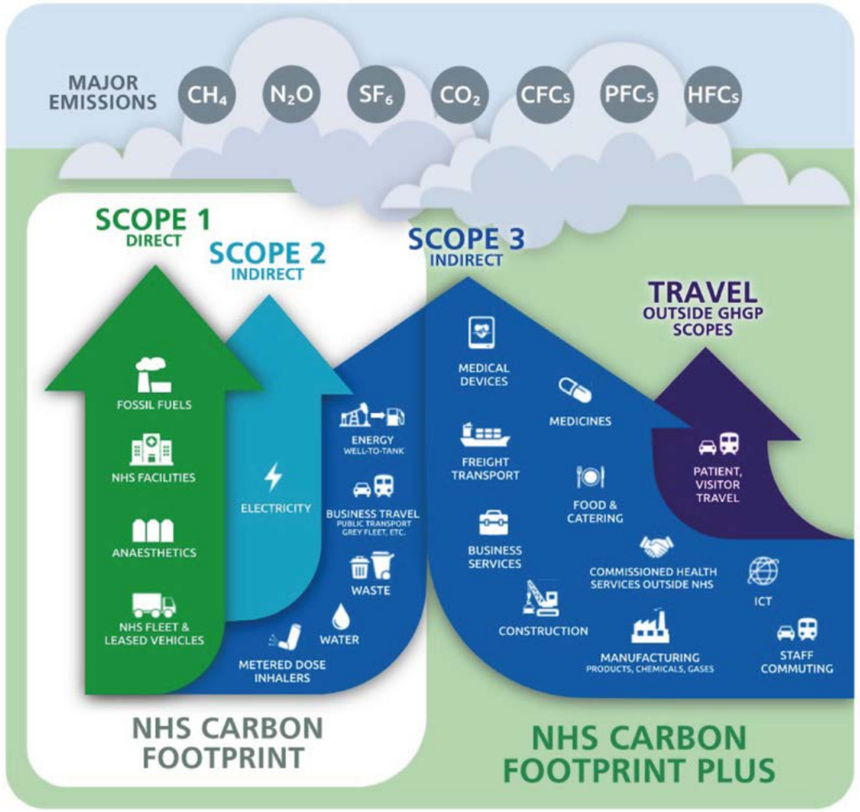


Figure 2: Newcastle Hospitals Carbon Footprint Plus

We aim by next year to be in a position to state the baseline impact of our footprint plus by using a greater proportion of reported data than estimated data. Please see the procurement section for more information.

Figure 3: Newcastle Hospitals Carbon Footprint Plus Pie Chart





3.2 Staff Sustainability Survey

STAFF SUSTAINABILITY SURVEY

Every year we ask our staff a number of questions in our annual staff sustainability survey. Of the 447 members of staff that completed the survey 98% said that it is important for the Trust to work in a more sustainable way.

How important do you think it is for the Trust to work in a more sustainable way?

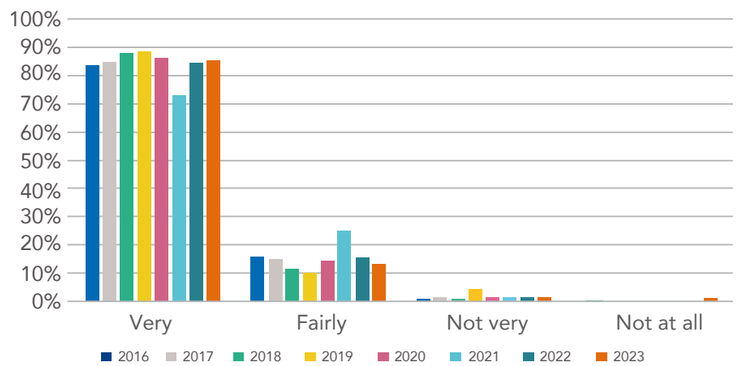


Figure 4: Staff survey – how important do you think it is for the Trust to work in a more sustainable way?

This year we had our highest rate of awareness for the sustainability work undertaken by the Trust. 85% of staff were aware, which is an increase from 78% the year before.

Are you aware of the sustainability work of the Trust?

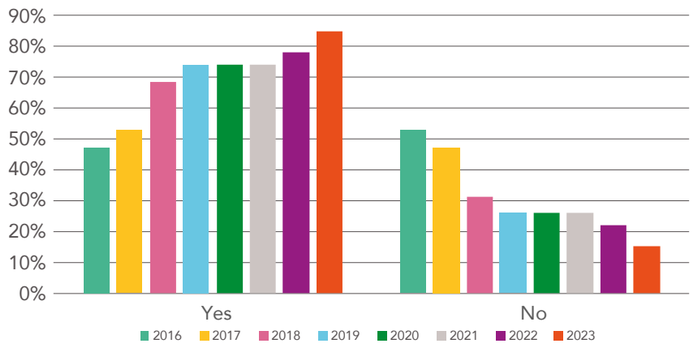


Figure 5: Staff survey – are you aware of the sustainability work of the Trust?

98% said that it is important for the Trust to work in a more sustainable way.

This year we also asked:

In the current Trust Strategy, there are five overall priorities - 5 'P's - for the organisation to focus on Patients, People, Partnerships, Pioneers, and Performance. As the strategy is due to be refreshed and reviewed, do you think it is important for Planet to be included as an additional priority for the Trust?

Should there be a 6th "P" for Planet in the Trust Strategy?

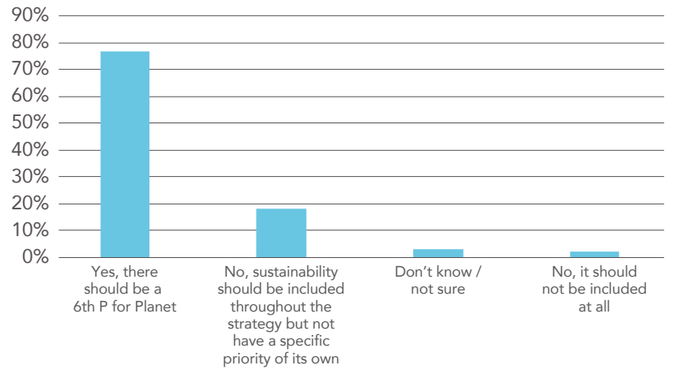


Figure 6: Staff survey – should there be a 6th "P" for Planet in the Trust Strategy?

We had lower response rates this year to our staff survey, with 447 members of staff completing the survey. We acknowledge the pressure that staff are under working in the NHS and the difficulty there is in communicating about the survey to staff, and then staff having the time to complete it! We will work to engage more staff in the survey process going forward. Trends can nonetheless be seen that sustainability is increasing as a priority for staff, but acting in a more sustainable way is becoming increasingly difficult. Our Green Champion network included the 6th P for planet as an ask to Sir Jim Mackey who confirmed his agreement to sustainability being part of business as usual and to consider the 6th P for Planet as part of the upcoming Trust Strategy review in 24/25.

How easy does the Trust make it for you to act in a more sustainable way when doing your job?

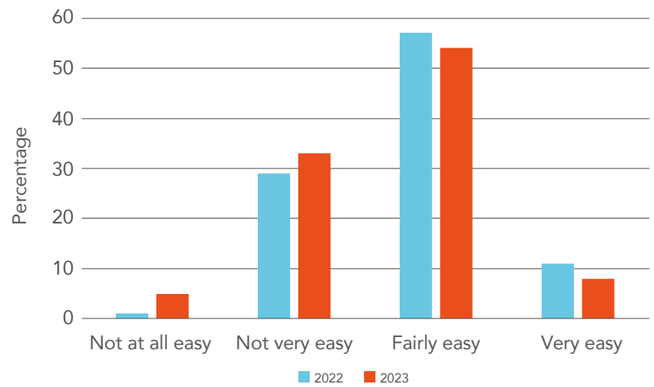


Figure 7: How easy does the Trust make it for you to act in a more sustainable way when doing your job?

3.3 Red Flag Register

As a result of the findings in our 'Red Flag' Shine Report (2021-22) a red flag register was compiled, which identified several key themes we believe must be addressed in order for us to progress towards Net Zero and most importantly remain within our carbon budget.

It is acknowledged the space that we are working in is extremely challenging, with limited resources. The CQC findings will have had an impact on staff across the Trust. The reason that we are driving this change is ultimately for the benefit of our patients, staff and local community so we remain focused on the red flags as the key to unlocking transformational change. Our ability to deliver services and care for our patients will be under threat if we do not take this action.

1. DEDICATED RESOURCE TO DRIVE URGENT CHANGE

Challenges and achievements

Appointments made to our Net Zero Estates and Energy Teams but vacant posts remain. There is a skills gap and so recruitment has proved a challenge.

We were unsuccessful in our bids for Low Carbon Skills Fund (LCSF) (Phase 4) and PSDS (Phase 3c) funding this year. This means we have progressed another year without securing the only source of funding available to decarbonise our hospital estate.

Focus for 2024-25

Prioritise a detailed estates decarbonisation pathway and applying for funding to deliver these schemes (with a particular focus on applications for LCSF 5 and PSDS 4 funding this financial year).

Suppliers at our annual Sustainable Suppliers event

2. SUSTAINABILITY CONSIDERATIONS IN ALL DECISION MAKING

Challenges and achievements

The Trust was rated "requires improvement" by the CQC. Nevertheless, Sir Jim Mackey has listened to our Green Champions request for action and has confirmed his agreement to make sustainability business as usual. We are challenged by a lack of specific resource for this.

The Procurement Team have done great work in working with suppliers to embed sustainability. This is now a requirement in all tenders.

Focus for 2024-25

Embed sustainability from ward to board through implementing the Shine 10-step framework in all clinical boards.

Embed sustainability into the Ward Accreditation Scheme and the business case template.

Solar panels being installed on Regent Point

3. SIGNIFICANTLY INCREASE INVESTMENT IN ESTATE DECARBONISATION

Achievements and challenges

Decarbonising Regent Point with the installation of LED lighting, solar panels and heat pumps. This was a £1m+ scheme, with 50% funding from a PSDS 3b government grant.

There is no internal funding available for estate decarbonisation. We are reliant on external funding which is a competitive process.

Focus for 2024-25

Work with Capital Team colleagues to ensure the limited capital allocation for critical estates backlog and refurbishment work supports our decarbonisation goals.

Our ability to deliver services and care for our patients will be under threat if we do not take this action

4. LEADERSHIP TO SIGNAL THAT ACTION ON THE CLIMATE EMERGENCY IS A TRUST PRIORITY

Achievements and challenges

James Dixon, Associate Director for Sustainability, delivered an educational workshop supported by IEMA (Institute for Environmental Management and Assessment) resources to the Trust Board on the climate emergency, the strategy, performance and what more needed to be done.

Focus for 2024-25

Ensure that sustainability is prominent in the Trust strategy refresh.

5. ACTION TO ELIMINATE WASTE AND WASTEFULNESS OF RESOURCES – MOVING TOWARDS ZERO WASTE

Achievements and challenges

Waste consigned at the disposal level of the waste hierarchy represents 1.8% of total waste.

Focus for 2024-25

Support for staff-led MDT waste reduction projects via working groups.

4. Key Action Areas

This section explores the progress made in each of our Shine action areas which feed into our three Climate Emergency Strategy goals, and the plans for next year and beyond.

We have mapped action across these areas within our existing eight Shine themes.

Energy
Minimise energy use and replace fossil fuels with zero carbon energy sources

Water
Minimise water use

Waste
Dispose of less, reuse and recycle more

Buildings & Land
Provide healthy, sustainable and biodiverse spaces

Journeys
Embed active, clean, low carbon travel

Procurement
Work with our supply chain to decarbonise

Care
Develop low carbon care pathways adapted to our changing climate

People
Inspire, inform and empower our people to deliver sustainable healthcare

4.1 Energy & Water

AIM: ENERGY

Reduce carbon emissions from energy use, in line with science informed budgets, to be on track for net zero by 2030:

- Use less energy.
- Replace fossil fuels with low and zero carbon energy sources.
- Investigate options to offset, or inset, our residual carbon emissions.

AIM: WATER

Minimise water use in our buildings:

- Eliminate wasted water.
- Increase water efficiency.

Despite the challenges, Newcastle Hospitals, working closely with PFI partners managed to reduce overall emissions from both electricity and gas.

PERFORMANCE

The Trust have faced significant challenges as a result of instability within the energy sector, increasing demand for electricity, limited funding for net zero projects and vacancies in our Energy Team and Net Zero Estates Team.

Despite the challenges, Newcastle Hospitals, working closely with PFI partners managed to reduce overall emissions from both electricity and gas.

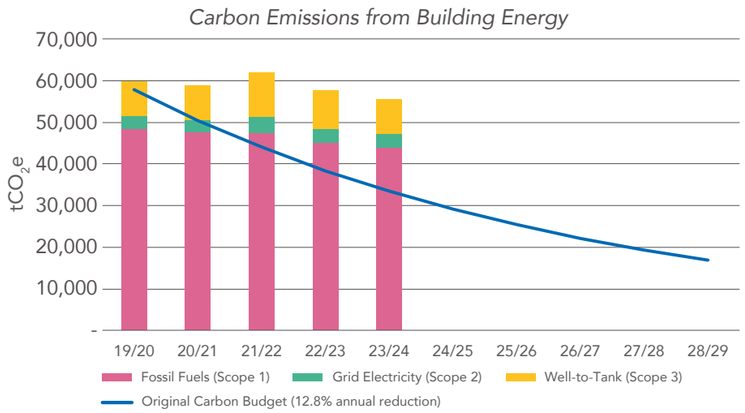
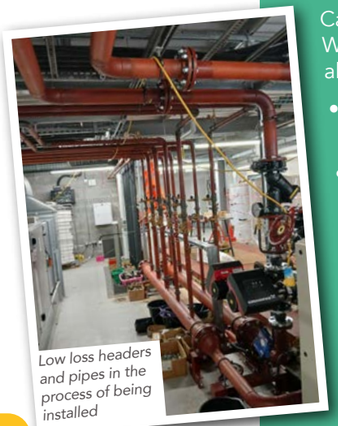


Figure 8: Carbon Emissions from Building Energy

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

Carbon emissions from building energy for 2023/24 are 2.5% lower than in 2022/23. While these are our lowest emissions to date, they still fall short of our science-aligned carbon budget target.

- Decarbonisation work at Regent Point began as part of the PSDS funded programme of works
- Completion of hydronic modelling of the Freeman building as part of a Heat Network Efficiency Scheme (HNES) funded project
- Completion of alpha phase of the Energy Catapult inform project, to create a tool for modelling energy use
- Continued roll out of LED lighting at RVI and Freeman, including 30% of lighting in the Clinical Resources Building
- Application for LCSF Phase 5 funding to complete a geothermal desktop survey
- Successful on boarding of a Net Zero engineer and Assistant Energy Manager.



Low loss headers and pipes in the process of being installed

PLANS FOR THE NEXT YEAR

- Recruitment to remaining vacancies
- Continue to improve energy and water metering
- Continued roll out of LED lighting and installation of solar panels
- Development of heat decarbonisation plans for community properties
- Estates rationalisation: withdrawal from the Campus for Ageing and Vitality (CAV) site
- PSDS phase 4 application
- Further exploration into sourcing heat from geothermal energy and city heat networks

Electrical cable for PV being installed on the roof of Regent Point

LED lights being installed

CASE STUDY: REGENT POINT

PV panels being installed onto the frame, on the roof of Regent Point

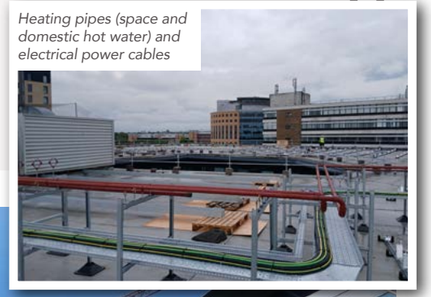
Work has begun to decarbonise Regent Point. £1m+ was allocated to the project, with 50% match funding provided by SALIX via the PSDS Phase 3b.

The project is expected to finish in the autumn.

The works involve:

- LED lights in place of less efficient fluorescent tube panels
- Heat pumps for the entire energy demand of the building – space heating and domestic hot water
- Solar panels to generate ultra-low carbon electricity
- Building management system (BMS) upgrades to allow better control of heating.

The project is anticipated to save 120 tonnes of carbon dioxide per year and is the first building in our estate to fully transition away from fossil fuels.



Heating pipes (space and domestic hot water) and electrical power cables

A heavy duty crane was required to lift the solar panels, structural steel and heat pumps onto the roof of the building

4.2 Journeys & Clean Air

AIM

Embed active, clean and low carbon travel to improve air quality and reduce carbon emissions from journeys:

- Reduce air pollution and carbon emissions from our owned and commissioned transport operations
- Use our influence to help fast-track the decarbonisation of transport in our supply chain
- Increase the proportion of people accessing our sites by active and sustainable travel methods
- Provide more care closer to, or at, home

PERFORMANCE

We have seen an increase in the emissions from our Trust Fleet, as additional data has been identified and incorporated into our calculation, and slight increases in emissions from business travel.

Travel within Newcastle Hospitals Carbon Footprint

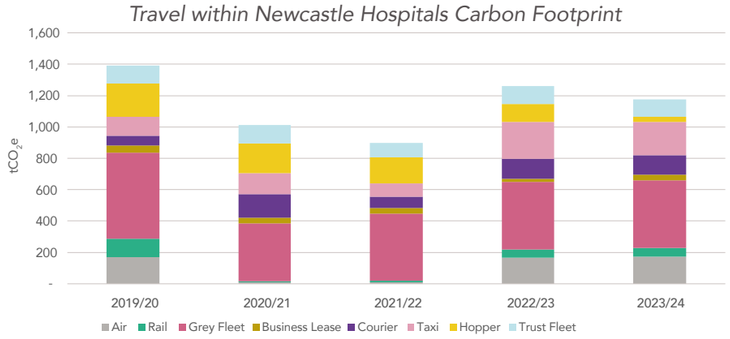


Figure 9: Carbon footprint from travel within the Newcastle Hospitals Carbon Footprint

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR, JOURNEYS

- Tesla pool cars have been loaned for community nurses, with two electric vehicles based at Newburn and two based at Regent Point
- A trial for transporting patients via an EV minivan for dialysis has commenced. There will therefore be fewer journeys as multiple patients can be transported, and they will travel with no tail pipe emissions
- The road works on Queen Victoria Road will improve the safety of the route into the hospital for cyclists and pedestrians and bring a bus stop to just outside the hospital
- Solar panels have been installed on the roof of the new multi-storey car park on our RVI site (providing zero carbon electricity for its LED lighting and electric vehicle charging points)

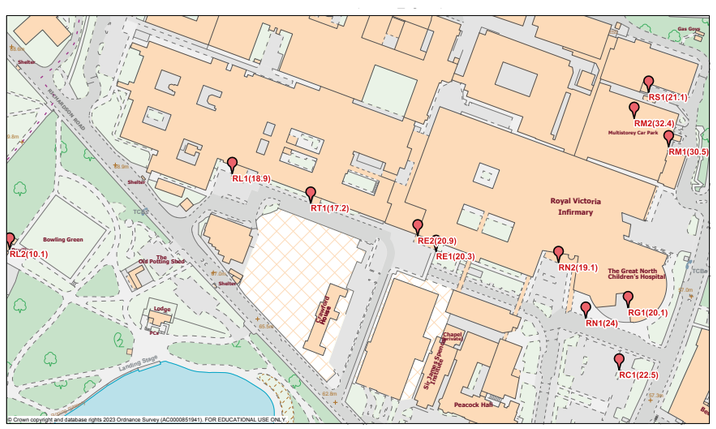


Figure 10: NO_2 Air Quality Monitor locations and readings (September 2023) at Royal Victoria Infirmary (RVI)

Babatunde Okeowo presenting his PhD research on Newcastle Hospitals Clean Air Hospital Framework

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR, CLEAN AIR

- We have 48 indoor and outdoor air quality monitoring devices across both the Freeman and RVI Hospital Estates, including an Urban Observatory Environmental Monitoring Unit, integrated into the wider city Air Quality Monitoring data
- Our PhD Research Student has completed extensive analysis of monitoring data and produced maps of air quality levels across the estate
- Held our first Clean Air Day to raise awareness of the impact of poor air quality and actions that can be taken to reduce exposure
- Our self-assessed score against the Clean Air Hospital Framework (CAHF) has increased from a baseline of 17% to 38%, representing progress from starting out to getting there within the framework
- Developed a prioritised action plan detailing projects and interventions to tackle indoor and ambient air quality at our hospitals
- Non-smoking multi-team collaboration work to reduce smoking on-site

We would like to use our influence to help fast-track the decarbonisation of transport in our supply chain

PLANS FOR THE NEXT YEAR

- Continue to work to move our Trust fleet to electric vehicles
- Improve infrastructure for active travel
- Achieve a score of 50% on the Clean Air Hospital Framework as we progress towards our published target of excellent status by 2025 (over 70%)

CASE STUDY: HOPPER BUS

The staff 'Hopper' bus service, which transports staff between our RVI and Freeman hospital sites, has operated via an all-electric bus since December 2022. The move from a vehicle powered by fossil fuels to an electric vehicle means we have saved 144 tonnes of CO_2e and improved the quality of the air for our patients, staff and our local communities.

4.3 Waste

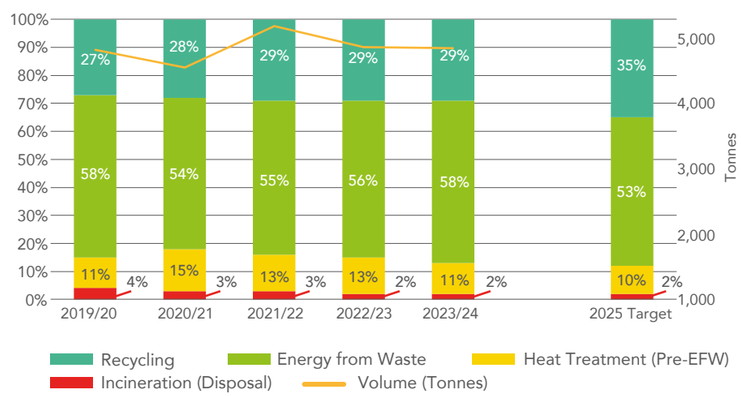
AIM

Generate less waste; reuse and recycle more, and ensure unavoidable waste is disposed of in the most sustainable way:

- Reduce the amount of waste we create by working and purchasing in more resource-efficient ways
- Increase the number of items we reuse with a focus on reducing single-use plastics
- Repair or reuse more items that can be repaired or reused
- Increase the amount of waste that we reuse or recycle to 35% of consigned waste by volume

PERFORMANCE

Annual Waste Performance



Total annual waste disposed of by waste outcome

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

- Waste volumes are very slightly lower than last year, however still marginally higher than our 2019-20 baseline year
- Work is ongoing to reduce waste volumes, including via a number of working groups in Pharmacy, Theatres and Integrated Laboratory Medicine
- The majority of Trust waste is sent for energy recovery and 29% of waste is currently recycled. No Trust waste has been sent to landfill since 2011
- We are ahead of national targets to reduce the clinical waste that we send for incineration
- Using large reusable sharps boxes (MR64s), for capturing single-use metal instruments in theatres and key departments, has enabled greater recycling of a waste stream that was previously incinerated. Last year over 4 tonnes of metal instruments were recycled
- Waste segregation training is now featured as part of the corporate induction for all staff, as part of the sustainability section
- A New2you clothes swap event was held at the RVI and the Freeman. Helping to facilitate the reuse of clothing and textiles

▲ *RVI Ward 23 and Pharmacy Teams nominated for a Celebrating Excellence award for their work on reducing wasted medicines*

PLANS FOR THE NEXT YEAR

- Continue to embed waste management into corporate induction and improve local induction guidance, including specialised training for key departments
- Develop metrics for measuring and reporting waste prevention and re-use
- Increase opportunities for recycling and implement the non-infectious waste stream in our Emergency Department and in community sites where appropriate
- Continue to work with established working groups and clinical departments to identify opportunities for waste reduction and removal of single use items
- Expand food waste recycling at our main hospitals

▲ *New2you clothes swap event*

CASE STUDY: THEATRE SUSTAINABILITY WORKING GROUP

A Theatres Sustainability Working Group has been set up which is a cross directorate working group to embed sustainable projects into theatres across the Trust. They have been working on pilot projects with support from funding from the **Climate Emergency Action Fund**, focusing on avoiding single use items and reducing energy consumption. Projects include reusable laryngoscopes, reusable cloth theatre hats, reusable drapes and gowns and shutting down ventilation and other theatre equipment when not in use.

Small amounts of funding from the Climate Emergency Action Fund has allowed this committed group of staff to pilot these projects with an aim to overcome hurdles to implementation and showing carbon and cost savings and rolling them out across the Trust.

Staff in the Day Treatment Centre (DTC) at Freeman Hospital have been trialling various reusable options, including laryngoscopes, theatre hats and containers for transporting theatre instruments. The hats have received a warm welcome within the DTC. Staff are engaged in their use and report increased familiarity with members of the MDT, which is impacting positively on working relationships within theatres.

"The DTC should be massively commended for their approach to sustainability. They really are a great example of how effective a healthcare team can be in initiating change." Dr Louise Sanderson, Consultant Anaesthetist

DTC staff with their reusable cloth theatre hats

4.4 Procurement

AIM

Embed sustainability and support for climate emergency action into all purchasing decisions, working towards a net zero carbon supply chain:

- Consume less
- Embed carbon reduction into our procurement processes
- Establish positive relationships with key suppliers
- Engage in research and innovation in order to reduce impact across whole value chain
- Improve confidence in our supply chain carbon data
- Invest more in our local supply chain
- Increase the amount of sustainable, local, healthy food available to staff, patients and visitors

To improve our confidence in the accuracy of our supply chain carbon data, and track progress towards our 2040 Net Zero target, we have developed a 5-step Net Zero Carbon Supplier Framework to enable us to collect data from our suppliers

PERFORMANCE

Carbon emissions associated with our purchased goods and services are included in our Carbon Footprint Plus results on page 14. To improve our confidence in the accuracy of our supply chain carbon data, and track progress towards our 2040 Net Zero target, we have developed a 5-step Net Zero Carbon Supplier Framework to enable us to collect data from our suppliers. The framework supports organisations of all sizes to report and reduce carbon emissions. 840 suppliers engaged with the 5-step framework this year and 87% confirmed their support for our Net Zero 2040 target. 40% of our reported data now comes directly from suppliers improving our data quality and ability to influence suppliers to reduce their carbon emissions.

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

- Following a 3-year voluntary engagement phase, which saw approximately 25% of our supplier base take part, we have mandated our 5-step Net Zero Carbon Supplier Framework for all suppliers to the Trust
- We continue to build a bank of case studies and resources to support suppliers with their journey to Net Zero and we host these on our Sustainable Supplier Webpage: https://www.newcastle-hospitals.nhs.uk/about/sustainable-healthcare/sustainable-suppliers/
- Over 100 local supply chain companies attended the Annual Sustainable Supplier Event held at St James Park Newcastle. Recordings of event presentations were added to the Sustainable Suppliers webpage so accessible to our global supplier community
- Joined the Net Zero North East Public Sector Sustainable Procurement Workshop series to Collaborate and share learning with other organisations
- Initiated conversations with one supplier to investigate the feasibility of an off-site furniture reuse scheme
- Social Value included in every tender process (10% weighting)

▲ *Procurement Team nominated for a Celebrating Excellence award for their work with suppliers supporting our net zero goal*

820 suppliers engaged with the 5-step framework this year and 87% confirmed their support for our Net Zero 2040 target

PLANS FOR THE NEXT YEAR

- Increase levels of reporting via our 5-step Net Zero Carbon Supplier framework, in order to Improve confidence in our reported supply chain carbon emissions and progress towards Net Zero
- Launch a Low Carbon Supplier Hub on LinkedIn to promote knowledge share and collaboration within the supplier community
- Complete feasibility study for an off-site furniture reuse scheme
- Upskilling all procurement staff B4 and above in Carbon Literacy
- Develop and implement a Sustainable Procurement Decision Making Tool
- Continue to collaborate and share learning with other organisations, in order to standardise approaches to sustainable procurement

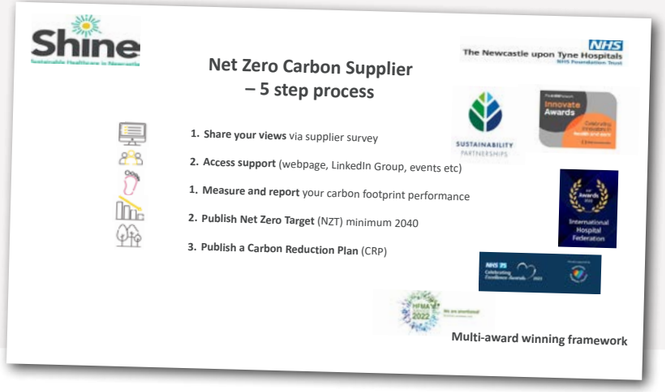
CASE STUDY: ANNUAL SUSTAINABLE SUPPLIER EVENT

We held our third annual Net Zero Carbon Supplier event on 12 July 2023, at Newcastle United Football Club.

Sponsored by the Academic Health Science Network for the North East and North Cumbria (AHSN NENC), and attended by over 100 local businesses (online recordings were also available to the wider supplier community), the event explored the role of suppliers in supporting Newcastle Hospitals Net Zero aspirations as well as wider goals for the City, Region and the National NHS.

The event outlined the new contractual requirements for all suppliers to follow our 5-step Net Zero Carbon Supplier Framework to promote innovation, collaboration, and knowledge share. There were also meet the buyer sessions to provide the opportunity for suppliers to discuss low carbon products and services.

Suppliers at our annual Sustainable Suppliers event



4.5 Models of Care

AIM

Develop low carbon care pathways adapted to our changing climate:

- Engage in research and innovation in order to lower carbon across our care pathways
- Lead on the systematic reduction of anaesthetic gas environmental impact across all care pathways
- Collaborate to reduce the carbon footprint of respiratory care through a detailed review of inhaler prescription and use
- Empower our clinicians to improve the sustainability of their models of care

Piped nitrous oxide has been decommissioned at Freeman Hospital and we are working with clinical teams at RVI to reduce nitrous oxide waste where it is still clinically required

PERFORMANCE

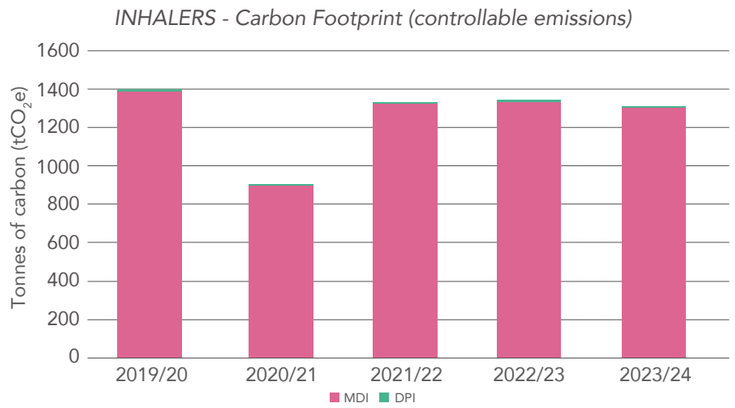


Figure 11: Carbon Footprint from inhaler prescribing at Newcastle Hospitals

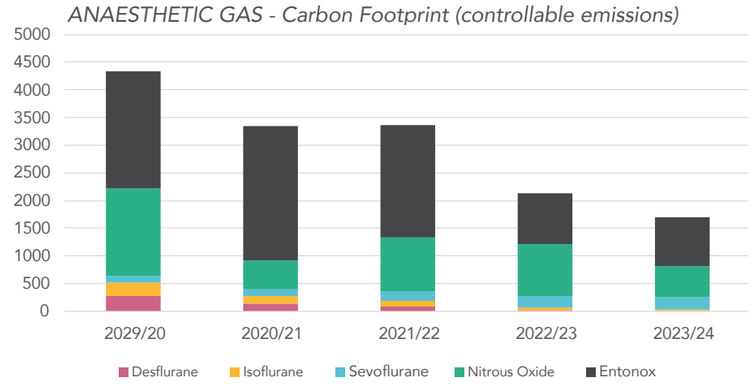


Figure 12: Carbon emissions from anaesthetic gas use at Newcastle Hospitals

Katy Whitehouse nominated for a Celebrating Excellence Award for her work in reducing emissions from anaesthetic gases

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

- Desflurane, which has a global warming potential 2,500 times greater than carbon dioxide, has been decommissioned. This volatile anaesthetic was last used in the Trust in June 2022, ahead of NHS England's commitment to decommission it nationally by early 2024[5]
- Nitrous oxide cracking technology is now well established in Maternity Services at RVI, which has led to a significant reduction in carbon emissions associated with our use of pain-relieving gas & air (Entonox)
- Piped nitrous oxide has been decommissioned at Freeman Hospital and we are working with clinical teams at RVI to reduce nitrous oxide waste where it is still clinically required
- Funded by the Newcastle Hospitals Charity, and co-managed by the Centre for Sustainable Healthcare, we have two part-time Clinical Sustainability Fellows, Emma Vittery with a Paediatric background and Fatima Tahir working part time in Oncology. Fatima has concluded work on a project showing that switching from oral morphine solution to pills significantly reduces the carbon footprint of this medication. Emma has worked on embedding sustainability into Trust governance, calculating carbon and cost savings (including medication formulation switches, and paper to electronic reporting), smoke-free air and engaging young patients in nature
- The Sustainability Team have supported the Emergency Preparedness Resilience and Response Team, to review the existing Severe Weather Plan and the Business Continuity Plans to ensure climate risks have been identified and planned for. The outcomes fed into the board approved Climate Adaptation Plan, which will be governed by the newly established Climate Adaptation Operational Group. With a commitment to continually review and refresh these documents, we have led a region wide series of workshops to collaborate on an updated master Climate Risk Register

PLANS FOR THE NEXT YEAR

- Work on the Born Green Generation project to embed sustainability into maternity care and protect the next generation from the harmful effects of plastics and chemicals
- Continue our work on mitigating the impact of our nitrous oxide and Entonox gas emissions by reducing wastage, for example by reducing piped nitrous oxide at the RVI (building on the successful decommissioning work at Freeman)
- Re-invigorate our work on reducing the impact of inhalers both by educating patients on effective use and whether a change can be made from Metered-Dose Inhaler to a lower carbon Dry Powder Inhaler
- Work with clinical teams to support them in identifying how they can embed sustainability into care pathways
- Hold an event for suppliers to showcase climate adaptation solutions, to be facilitated by HINENC (Health Innovation North East and North Cumbria)

[5] Association of Anaesthetists and Royal College of Anaesthetists Joint statement on NHSE's plan to decommission desflurane by early 2024

CASE STUDY: BORN GREEN

We are proud to confirm the launch of the Born Green Generation at Newcastle Hospitals; a movement to protect babies from the harmful effects of plastics and chemicals.

Over the next 3 years, the Trust is embarking on a unique project with **Health Care Without Harm Europe** and European healthcare institutions and universities. We will work together to show that toxic-free healthcare is possible and to make it a global norm.

The experiences and environments that shape babies' first 1,000 days, from conception to their second birthday, play a crucial role in influencing their future health. In this vulnerable stage, babies are routinely exposed to harmful chemicals and plastic products during their hospital care from items that could have safer alternatives like disinfectants, plastic gloves and disposable gowns. Exposure can lead to severe and lasting health issues, from chronic diseases, diabetes and even cancer, as babies' defence systems are not yet developed.

Research Midwife Aly (Alison) Kimber and Obstetrics and Gynaecology Registrar Dr Amy Manning who lead on the project

4.6 Buildings and Land

AIM

Provide healthy, sustainable and biodiverse spaces for patients, staff and visitors:

- Include opportunities for sustainability innovations in all new builds and refurbishments based on recognised standards
- Build climate adaptation and resilience into our management of existing estate as well as all new builds and refurbishments
- Expand our green space and enhance the biodiversity of our land

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

- Launched our 30-year Biodiversity Management Plan
- Improved the existing hedgerows at the Freeman hospital with more indigenous planting and enhanced wooded areas with woodland bulb planting, bat and bird boxes
- Completed our 3rd annual biodiversity metric audit to enable us to track the impact of the Biodiversity Management Plan
- Using funding from our Climate Emergency Action Fund, and Newcastle Charities, completed two Green the Grey projects in areas of courtyard identified by green champions as ideal locations to create green space for the benefit of patients, staff and visitors
- A sensory garden has been co-designed with hospital staff and contributions from child patients, by way of a design competition, for the courtyard in the RVI outpatients department
- Staff continue to contribute to the Green Gym established by Dr Suren Kanagasundaram who co-leads it with his Green Nephrology colleague Toni Poole, for example by planting hedgerow on the Town Moor

"Since we launched the Newcastle Hospitals Green Gym in May 2018, we have held nearly 50 conservation events for staff, family and friends ranging from beach cleans and tree and hedgerow planting, to habitat creation, wildlife walks and the restoration of a Victorian walled garden. We were runners up on the 2019 Celebrating Excellence awards and played our part in an Environment Agency award for a wetland development in Northumberland. However, the most satisfying part of Green Gym for me has been the way that participants have not only done their bit for nature but have felt empowered to speak up about the environment in their workplaces and schools."

DR SUREN KANAGASUNDARAM
Founder and co-lead of the Green Gym

PLANS FOR THE NEXT YEAR

- Create a pond on site to boost our biodiversity metric and provide a wonderful resource to boost health and wellbeing of patients, visitors and staff at Freeman Hospital
- Create a map showing walking routes around our Estate and promote use of greenspace by patients, staff and visitors
- Access funding to complete Ismail's garden, a redesign of the children's playground area at the RVI by a young patient
- Access funding to complete the sensory garden in the RVI outpatients department

CASE STUDY: THERAPY SERVICES COURTYARD

Approximately 100 clinical and admin staff from Physiotherapy, Occupational Therapy, Dietetics, Podiatry and Speech and Language Therapy are based at the Freeman. Staff accessed funding from the Climate Emergency Action Fund project to 'green the grey'. The installation of planters, a couple of which have trellises, has greatly enhanced the environment, and bedding plants, herbs and climbers have been included following input from staff around what they would like to see. It has created a much more attractive space for staff to spend breaks in, when weather allows, after working on the wards, but importantly also to view from the inside of the building in the rest room/ kitchen which we hope enhances wellbeing and has generated a lot of conversation and further ideas! An additional impact will be in maintaining the plants and flowers, staff can be part of the 'green gym' initiative, consequently reducing maintenance costs for the Trust.

Therapy Services Courtyard

Using funding from our Climate Emergency Action Fund, and Newcastle Charities, completed two Green the Grey projects in areas of courtyard identified by green champions as ideal locations to create green space for the benefit of patients, staff and visitors

4.7 People

AIM

Inspire, inform and empower our people to deliver sustainable healthcare:

- Embed Shine and climate emergency action into the culture of our organisation, demonstrated in staff behaviours
- Upskill our workforce and ensure capacity to address the climate emergency
- Empower our people to make the most sustainable choice
- Extend our reach to influence action amongst our wider stakeholders, including patients

PERFORMANCE

- 38 Green Champions Plus
- 540 Green Champions
- 22 Sustainability Ambassadors
- 59 tonnes of CO_2 avoided through Shine Reward App actions
- 22 Climate Emergency Action Fund projects funded
- 1,440 @sustainableNUTH Twitter followers
- 98% of staff think sustainability is important

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

- Our Shine 10 step framework is being followed by a number of departments and directorates, including Clinical Research, Dietetics, ILM and procurement
- Integrated Laboratory Medicine launched their sustainability work at events across Great Big Green Week in June 2023. They have been awarded a bronze award for the laboratory Efficient Assessment Framework (LEAF), which are standards set by University College London, and are working towards a silver award. They have been nominated for their sustainability work in the Institute of Biomedical Sciences awards. More information about their progress can be found here
- There is a sustainability slot on Corporate Induction for new starters to learn about the Climate Emergency Strategy, and key information about our waste policies
- Procurement were awarded the Shine Award, at the Trust Celebrating Excellence Awards 2023, for their work on embedding sustainability into tenders and their sustainable work with suppliers

Integrated Laboratory Medicine Sustainability Team nominated for a Celebrating Excellence Award for their work on embedding sustainable practices

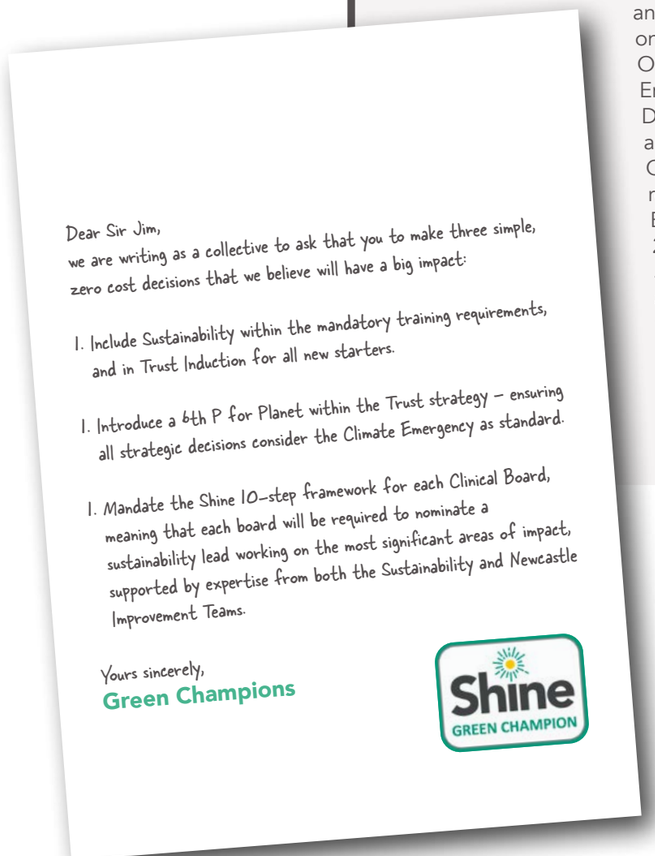
Procurement Team: winners of the Sustainable Healthcare in Newcastle (Shine) Celebrating Excellence Award 2023

PLANS FOR THE NEXT YEAR

- Work with clinical boards to embed sustainability using our Shine 10 step framework
- Embed sustainability training further by including it in statutory and mandatory training
- Ensure we continue to empower and engage our Green Champion network by raising their profile through regular Trust wide and external communications.

CASE STUDY: GREEN CHAMPION NETWORK ENGAGEMENT

At an in-person Green Champions network meeting in December it was agreed to issue a collective call for action to the Executive Oversight Group (EOG) for Climate Emergency. A draft letter was prepared and shared with the wider network. At short notice, it gained over 100 endorsements from Green Champions ahead of being tabled at the January EOG. The letter, and its proposal for three zero-cost high-impact actions, was supported at the meeting with an action to take it to Trust Management Group to gain formal approval. In the meantime, our new CEO Sir Jim Mackey was listening to staff concerns and working with his new Executive Team on the work to prioritise across the Trust. One of these priorities was the Climate Emergency and our next steps. James Dixon, Associate Director – Sustainability, and Dr Suren Kanagasundaram, Consultant Nephrologist and clinical representative at EOG, attended the Executive Team meeting on 6th March 2024 to discuss this. At the meeting, James shared the Green Champion letter and outlined each of the three 'asks', which received support from Sir Jim. He reiterated his support for making climate emergency action business as usual for the Trust and that he wanted to help deliver visible actions on the ground.



Dear Sir Jim,
we are writing as a collective to ask that you to make three simple, zero cost decisions that we believe will have a big impact:

1. Include Sustainability within the mandatory training requirements, and in Trust Induction for all new starters.

1. Introduce a 6th P for Planet within the Trust strategy – ensuring all strategic decisions consider the Climate Emergency as standard.

1. Mandate the Shine 10-step framework for each Clinical Board, meaning that each board will be required to nominate a sustainability lead working on the most significant areas of impact, supported by expertise from both the Sustainability and Newcastle Improvement Teams.

Yours sincerely,
Green Champions

Shine GREEN CHAMPION

5. Technical Appendix

In our Climate Emergency Strategy 2020-2025 we included a commitment to measure our performance across each of our eight Shine themes and report this publicly. We appreciate that this level of detail would make our Annual Shine Report very lengthy and hard to read, so we have included some headline performance data within this report. Our full key performance indicators are available on request along with our SECR compliant carbon footprint, by emailing nuth.environment@nhs.net

5.1 Overall Performance

In our Climate Emergency Strategy we set out three long term goals, and the actions we planned to take by 2025 for the eight Shine themes.

This is an overall summary of how we are progressing towards those goals, and the published actions. More detailed progress reports are included for each area in the next section of the report.

KEY

Red
Not on track and at serious risk of not being achieved

Amber
Not on track but still achievable by target date

Green
On track to be achieved by target date

GOAL	RAG RATING	DESCRIPTION
Zero Carbon Care		By 2030 the emissions we control will be net zero – our 'Newcastle Hospitals Carbon Footprint'
Clean Air		By 2030 our operational transport activities generate no harmful air pollution
Zero Waste		By 2030 we will reuse and repair everything that can be reused and repaired

SHINE THEME	RAG RATING	What do we want to achieve by 2025 (Climate Emergency Strategy commitment)
Energy & Water		Reduce carbon emissions from energy use, in line with science-informed carbon budgets, to be on track for net zero by 2030: • Use less energy • Replace fossil fuels with low and zero carbon energy sources • Investigate options to offset, or inset, our residual carbon emissions Minimise water use in our buildings: • Eliminate wasted water • Increase water efficiency
Journeys & Clean Air		Embed active, clean and low carbon travel to improve air quality and reduce carbon emissions from journeys: • Reduce air pollution and carbon emissions from our owned and commissioned transport operations • Use our influence to help fast-track the decarbonisation of transport in our supply chain • Increase the proportion of people accessing our sites by active and sustainable travel methods • Provide more care closer to, or at, home
Waste		Generate less waste; reuse and recycle more, and ensure unavoidable waste is disposed of in the most sustainable way: • Reduce the amount of waste we create by working and purchasing in more resource-efficient ways • Increase the number of items we reuse with a focus on reducing single-use plastics • Repair or reuse more items that can be repaired or reused • Increase the amount of waste that we reuse or recycle to 35% of consigned waste by volume
Procurement		Embed sustainability and support for climate emergency action in to all purchasing decisions, working towards a net zero carbon supply chain: • Consume less • Embed carbon reduction into our procurement processes • Establish positive relationships with key suppliers • Engage in research and innovation in order to reduce impact across whole value chain • Improve confidence in our supply chain carbon data • Invest more in our local supply chain • Increase the amount of sustainable, local, healthy food available to staff, patients and visitors

SHINE THEME	RAG RATING	Actions published in our Climate Emergency Strategy to be achieved by 2025
Models of Care		Low carbon care pathways adapted to our changing climate: • Engage in research and innovation in order to lower carbon across our care pathways • Lead on the systematic reduction of anaesthetic gas environmental impact across all care pathways • Collaborate to reduce the carbon footprint of respiratory care through a detailed review of inhaler prescription and use • Empower our clinicians to improve the sustainability of their models of care • Resilient care services that are adaptive to our changing climate
Buildings & Land		Provide healthy, sustainable and biodiverse spaces for patients, staff and visitors: • Include opportunities for sustainability innovations in all new builds and refurbishments based on recognised standards • Build climate adaptation and resilience into our management of existing estate as well as all new builds and refurbishments • Expand our green space and enhance the biodiversity of our land
People		Inspire, inform and empower our people to deliver sustainable healthcare: • Embed Shine and climate emergency action into the culture of our organisation, demonstrated in staff behaviours • Upskill our workforce and ensure capacity to address the climate emergency • Empower our people to make the most sustainable choice • Extend our reach to influence action amongst our wider stakeholders, including patients

6. Contact Details

This Annual Report has been produced by the Sustainability Team at Newcastle Hospitals but reflects work taking place across the Trust. All information contained within it is, to the best of our knowledge, accurate at the time of publishing.

Let us know your thoughts on this report, and how it could be improved

If you wish to contact the Sustainability Team please email **nuth.environment@nhs.net**

Or write to us at: Sustainability Team (Estates Department)
Royal Victoria Infirmary
Queen Victoria Road
Newcastle upon Tyne
Tyne and Wear
NE1 4LP

You can follow us on X: **@SustainableNUTH**

: **Sustainable healthcare at Newcastle Hospitals: About | LinkedIn**

Website: **Sustainable healthcare - Newcastle Hospitals NHS Foundation Trust (newcastle-hospitals.nhs.uk)**

7. Glossary

BREEAM – Building Research Establishment Environmental Assessment Method used to assess, rate and certify the sustainability of buildings.

Carbon dioxide equivalent (CO_2e) – A carbon dioxide equivalent or CO 2 e, is a metric measure used to compare the emissions from various greenhouse gases on the basis of their global-warming potential (GWP), by converting amounts of other gases to the equivalent amount of carbon dioxide with the same global warming potential.

CHP – Combined Heat and Power, the production of electricity or power from a single source of energy, in this case gas.

Climate emergency – A climate emergency declaration is action taken to acknowledge that humanity is in a climate emergency, and urgent action is required to reduce or halt climate change and avoid potentially irreversible damage resulting from it.

DPI – Dry Powder Inhalers deliver medication to the lungs as you inhale through the device.

Greenhouse gas protocol – global standardised framework to measure and manage greenhouse gas emissions.

Hybrid method – used to calculate emissions from purchased goods and services. Method uses a combination of supplier-specific activity data (where available) and secondary data to fill the gaps. This method involves collecting allocated scope 1 and scope 2 emission data directly from suppliers; and using secondary data to calculate upstream emissions wherever supplier-specific data is not available.

ICS – a statutory committee jointly convened by Local Authorities and the NHS, comprised of a broad alliance of organisations and other representatives as equal partners concerned with improving the health, public health and social care services provided to their population.

NHS E&I Net Zero Supplier Roadmap & Evergreen Framework – NHS England and NHS Improvement (NHS E&I) work together as a single organisation. In September 2021 a supplier roadmap was approved to help suppliers align with the NHS net zero ambition. The Evergreen sustainable supplier assessment is the mechanism for suppliers to engage with the NHS on the requirements of the roadmap. https://www.england.nhs.uk/greenernhs/get-involved/suppliers/

PPN 06/20 – Procurement Policy Note 06/20 (PPN06/20) applies to procurements covered by the Public Contracts Regulations 2015 and requires a minimum of a 10% weighting for social value questions.

PPN 06/21 – Public Procurement Notice 06/21 (PPN06/21) requires all companies and organisations who apply for central government contracts (above £5m framework value) to publish a Carbon Reduction Plan and demonstrate their alignment with the government's 2050 Net Zero goals.

PSDS – The Public Sector Decarbonisation Scheme (PSDS) provides grants for public sector bodies to fund heat decarbonisation and energy efficiency measures.

Shelford Group – is a collaboration between ten of the largest teaching and research NHS hospital trusts in England.

Spend-based method – used to estimate emissions from purchased goods and services by collecting data on the economic value of goods and services purchased and multiplying it by relevant secondary (e.g. industry average) emission factors.

Waste hierarchy – The waste hierarchy ranks waste management options according to what is best for the environment.

8. End Notes

Notes about methodology:

- *Newcastle Hospitals NHS Foundation Trust has adopted an operational control approach to establishing the boundary. The methodology adopted in line with the Greenhouse Gas Protocol and the BEIS Environmental Reporting Guidelines. The calculations were completed on the SmartCarbon™ Calculator using the latest UK Government emissions factors.*
- *CO_2e is the universal unit of measurement to indicate the global warming potential (GWP) of Greenhouse Gases (GHGs), expressed in terms of the GWP of one unit of carbon dioxide. There are seven main GHGs that contribute to climate change, as covered by the Kyoto Protocol: carbon dioxide (CO_2), methane (CH_4), nitrous oxide (N_2O), hydrofluorocarbons (HFCs), perfluorocarbons (PFCs), sulphur hexafluoride (SF6) and nitrogen trifluoride (NF_3). Different activities emit different gases. Using CO_2e allows all greenhouse gases to be measured on a like-for-like basis.*
- *For National grid electricity consumption, Newcastle Hospitals NHS Foundation Trust has included factors for the transmission and distribution of electricity (T&D) losses, which occur between the power station and site(s). The emissions from T&D has been accounted for in Scope 3. As with other Scope 3 impacts, reporting T&D is voluntary but is recommended standard practice by UK Government.*
- *Well-to-tank (WTT) fuels conversion factors have been included to account for the upstream Scope 3 emissions associated with extraction, refining and transportation of the raw fuel sources to an organisation's site (or asset), prior to combustion. As with other Scope 3 impacts, reporting WTT is voluntary but is recommended standard practice by UK Government.*
- *Procurement carbon emissions are calculated using a hybrid method – deducting known scope 1 & 2 reported carbon data from suppliers from the carbon footprint calculated using a spend based method - £ spent in eclass spend categories multiplied by average carbon factors for those categories.*
- *A full SECR compliant report is available on request* https://sciencebasedtargets.org/resources/files/Net-Zero-Standard.pdf


No-one is too
small to make
a difference

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Carbon Reduction Plan

Supplier name: **Newcastle upon Tyne Hospitals NHS Foundation Trust**

Publication date: **TBC 2024 (insert final date once Board approved)**

Commitment to achieving Net Zero

Newcastle Hospitals is proud to be the first healthcare organisation in the world to declare a climate emergency and acknowledge the associated risk to patient health.

In 2020, we published a 5-year Climate Emergency Strategy[i] which included the following vision and goals:

Our Vision

To be a global leader in sustainable healthcare delivery through collaboration and innovation, helping our patients and communities to thrive within the means of our planet.

Our Goals

To achieve our vision we have set three long-term goals:

1. Zero Carbon Care

• By 2030 the emissions we control will be net zero – our 'Newcastle Hospitals Carbon Footprint'

• By 2040 the emissions we can influence will be net zero – our 'Newcastle Hospitals Carbon Footprint Plus'

2. Clean Air

• By 2030 our operational transport activities generate no harmful air pollution

• By 2040 our healthcare facilities are accessed by only zero emission travel

3. Zero Waste

• By 2030 we will reuse and repair everything that can be reused and repaired

• By 2040 we will produce no waste. We will manage resources within the circular economy, with items surplus to requirements becoming a resource in another part of the system

These carbon targets are ahead of the NHS targets as set out in the Health and Care Act 2022 and Delivering a Net Zero National Health Service report.

In 2021, we were the first healthcare organisation to become a signatory to the UNFCC Race to Zero[ii].

Baseline Emissions Footprint

Baseline emissions are a record of the greenhouse gases that have been produced in the past and were produced prior to the introduction of any strategies to reduce emissions. Baseline emissions are the reference point against which emissions reduction can be measured.

Baseline Year: April 2019 – March 2020

Additional Details relating to the Baseline Emissions calculations.

We have adopted an operational control approach to setting the Carbon Footprint boundary and use the SmartCarbon Calculator[iii] to measure and report our carbon performance annually. The platform uses the UK Government Carbon Emission factors[iv] and supplementary healthcare specific factors, as well as a comprehensive supply chain hybrid approach. This methodology is in line with the NHS Net Zero Plan[v], The GHG Protocol Corporate Accounting and Reporting Standard[vi], The Greenhouse Gas Protocol Corporate Value Chain (Scope 3) Accounting and Reporting Standard[vii] and technical guidance[viii], as well as complying with the Streamlined Energy and Reporting Regulations (SECR)[ix].

Scope 1 and 2 emissions below include associated scope 3 emissions (WTT, T+D etc)

Please see our Annual Reports[x] and SECR compliant reports for more details.

Baseline year emissions: April 2019 – March 2020

EMISSIONS	**TOTAL (tCO_2e)**
Scope 1	59,784
Scope 2	4,933
Scope 3 **(Included Sources)**	191,674 (including water, waste, inhalers, business travel, patient transport service, staff commute, patient and visitor travel, purchased goods and services)
NHS Carbon Footprint (see Fig. 1 below)	67,939
Total Emissions NHS Carbon Footprint Plus (see Fig. 1)	256,391

Agenda item A11 - Appendix 2

Current Emissions Reporting

Reporting Year: April 2023 – March 2024	
EMISSIONS	**TOTAL (tCO_2e)**
Scope 1	53,230
Scope 2	5,187
Scope 3 **(Included Sources)**	328,904 (including water, waste, inhalers, business travel, patient transport service, staff commute, patient and visitor travel and purchased goods and services)
NHS Carbon Footprint (see Figure 1)	61,459
Total Emissions NHS Carbon Footprint Plus (see Figure 1)	387,321

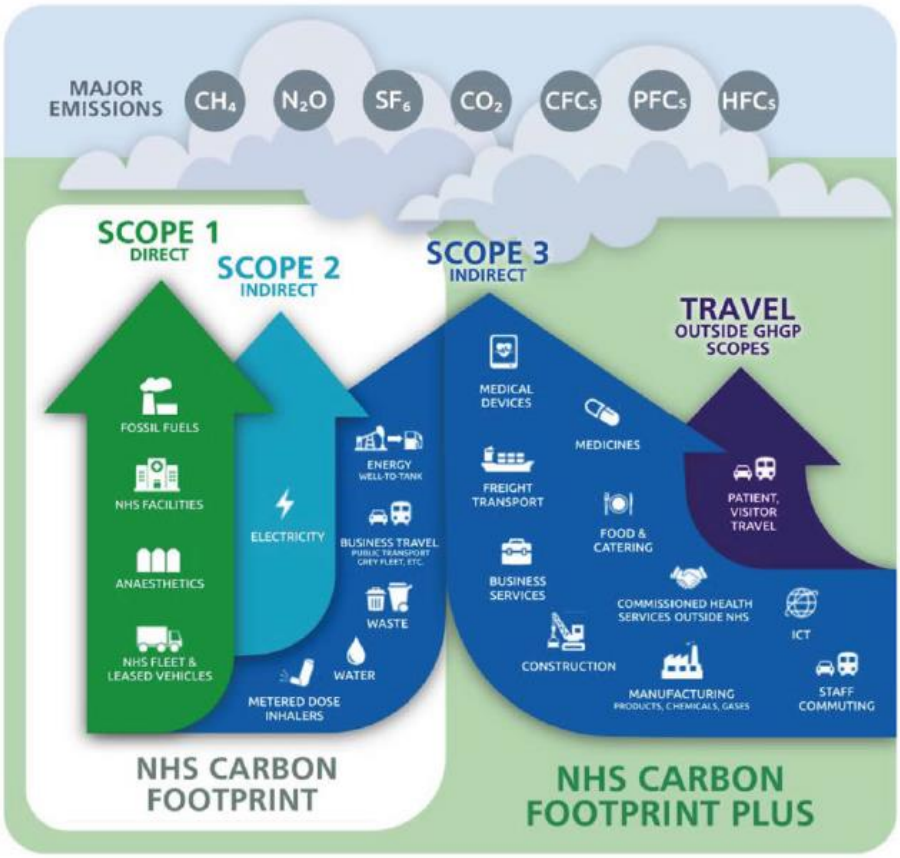
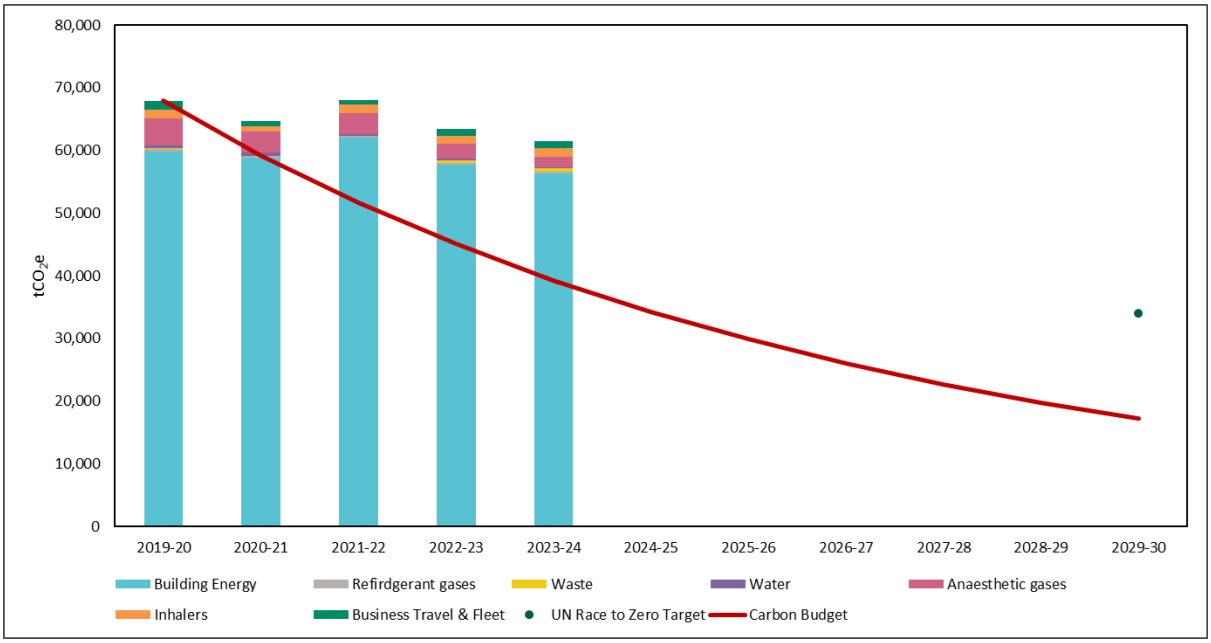


Figure 1. Greenhouse Gas Protocol scopes in the context of the NHS[xi]

Emissions Reduction Targets

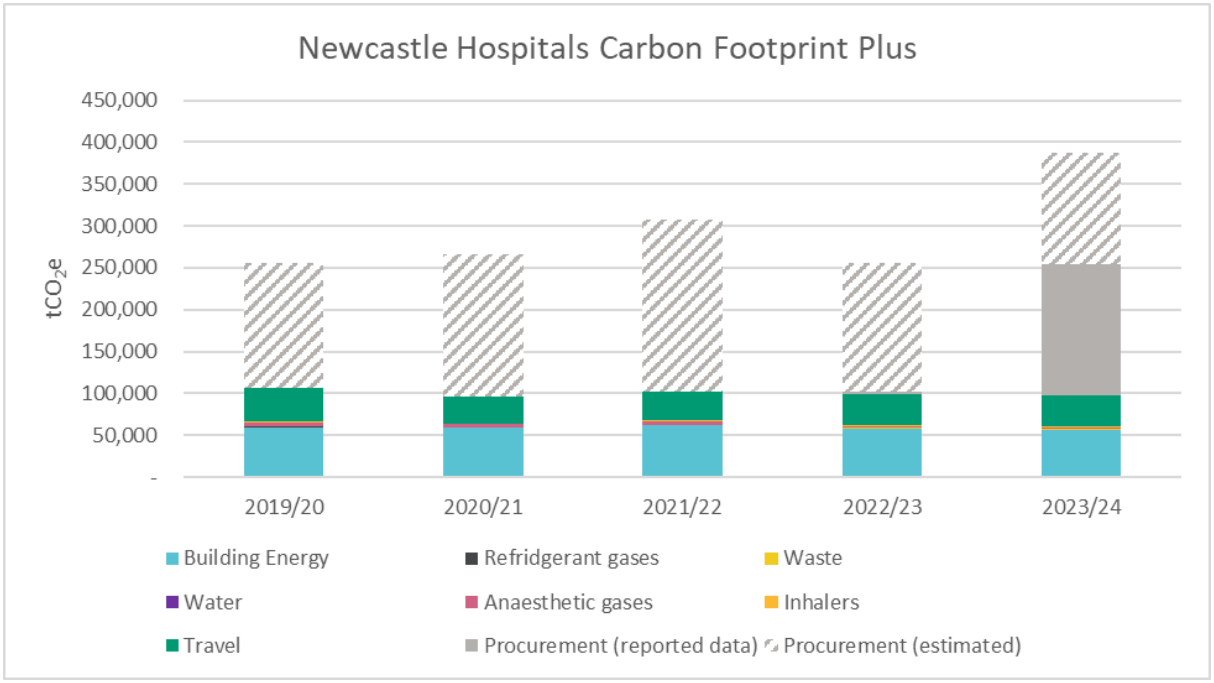
We project that carbon emissions from our NHS Carbon Footprint will decrease over the next five years to 6,793.9 tCO_2e by 2030. This is a reduction of 90%. This is dependent on us decommissioning our on-site fossil fuel combined heat and power energy centres and obtaining the external funding needed to replace these with renewable heat and power.

Progress against our NHS Carbon Footprint 2030 target can be seen in the graph below:



We have also set a reduction target for our NHS Carbon Footprint Plus of 90% by 2040. This will be quantified in tCO_2e when we have calculated an accurate baseline.

Our carbon emissions including our scope 3 NHS Carbon Footprint Plus can be seen in the graph below. We will need to recalculate our baseline in light of more accurate direct data received from suppliers for the first time this year (see note[xii]):



Please see our annual Shine Reports for further detail[xiii].

Carbon Reduction Projects

Completed Carbon Reduction Initiatives

The following environmental management measures and projects have been completed or implemented since the 2019 baseline for the emissions we control. The carbon emission reduction achieved by these schemes overall equates to 6,934 tCO_2e, a 10% reduction against the 2019 baseline and the measures will be in effect when performing the contract.

ORGANISATIONAL CULTURE

- We were the first healthcare organisation in the world to declare a climate emergency as a health emergency and commit to fast-tracking the decarbonisation of our services.
- We were the first healthcare organisation to use the Tyndall Centre for Climate Change Research methodology to calculate our own carbon budget – giving us the absolute total amount of carbon dioxide we can emit (450,000 tCO_2e) - to limit our organisational contribution to global heating to the 'well below 2°C and pursuing 1.5°C' global temperature target in the United Nations Paris Agreement. To achieve this we need to reduce our energy carbon emissions by an average of 18% per year from our 2019/20 baseline. We report our progress against this carbon budget, publicly, in our annual Shine Reports.
- We hold silver accreditation with Investors in the Environment for our approach to organisational environmental management.
- Our Sustainable Healthcare in Newcastle (Shine) programme covers eight priority action areas and our Sustainability Team works closely with our network of over 500 staff Green Champions to reduce our environmental impact in these areas.

BUILDING ENERGY

- We install energy efficient LED lighting as standard on refurbishments and continue to transition our estate from fluorescent to LED.
- We have installed solar panels on the roof of the multi-storey car park at Leazes Wing RVI.
- We received funding via PSDS Phase 3b to decarbonise Regent Point. The project is nearing completion and includes LED lights, heat pumps for the entire energy demand of the building, solar panels and BMS upgrades. The project is anticipated to save 120 tCO_2e per year (0.1%) against our total 2019 baseline. We were unsuccessful in receiving PSDS funding in phase 3c but are working in preparation for a phase 4 application this autumn.

LOWER CARBON CARE

- We limited and then ceased use of desflurane, an environmentally damaging volatile anaesthetic gas, and decommissioned the nitrous oxide manifold at our Freema Hospital. We were the first healthcare organisation in the UK to implement nitrous 'cracking' technology, which is used as standard in our Maternity Services at RVI. This equates to a carbon emission reduction of 2,632 tCO_2e (3%) against our 2019 baseline.

TRANSPORT & CLEAN AIR

- We have a Sustainable Travel Plan and promote and incentivise the travel hierarchy to staff, including discounted public transport, cycle to work scheme and cycle storage infrastructure.

- We have commissioned zero-tailpipe-emission all-electric buses from local operator Go North East to run our staff hopper service. This equates to a carbon emission reduction of 178.02 tCO_2e (0.2%) against our 2019 baseline.
- We utilise the Clean Air Hospital Framework (CAHF) as a tool to reduce local and global air pollution. Current self-assessed score against this framework is 38%. We jointly fund a Clean Air PhD student, with Northumbria University, to progress our CAHF score.

WASTE
- We send zero waste to landfill (and have done since 2011)
- We use reusable sharps containers (and have done since 2004)
- Our waste training and auditing efforts have resulted in sector leading segregation rates, with less than 2% of our waste sent for disposal – the rest sent for energy recovery or recycling.

BIODIVERSITY
- We have a staff-led Green Gym that undertakes voluntary conservation work including local beach cleans and tree planting.
- We are implementing our 30-year Biodiversity Management Plan to improve our biodiversity metric across our estate, knowing that access to nature and green space can improve patient recovery rates and staff health & wellbeing.

SUPPLY CHAIN
- We have established a dedicated Sustainable Supplier webpage[xiv], LinkedIn Group and email inbox to promote collaboration and knowledge share in the supplier community. We have over 850 supply chain companies actively engaged in our 5-step Net Zero Supplier Framework, collectively working towards our shared Net Zero target of 2040 for our scope 3 emissions (see note[1]).

In the future we hope to implement further measures such as:

BUILDING ENERGY
- Improvements to energy and water metering, to provide enhanced monitoring & targeting
- Further roll out of LED lighting, to achieve 100% coverage, and installation of solar panels on all viable roof space
- Evolving our Heat Decarbonisation Plans to include our community properties
- Continue to apply for government grant funding (PSDS) to deliver our estates net zero strategy
- Exploration of options to source renewable heat from geothermal energy and/or city heat networks

LOWER CARBON CARE
- Decommissioning nitrous oxide manifold at our RVI site (switching to a lean nitrous oxide supply where there is still a clinical need)
- Further lowering the carbon in our maternity services care pathway by collaborating with European hospitals in our three-year ‘Born Green Generation’ project.

TRANSPORT & CLEAN AIR
- Refresh and reissue our Sustainable Travel Plan
- Full electrification of our Trust owned and leased fleet
- Improve infrastructure for active travel access to our sites, including staff e-bike provision

- Achieve a score of 50% on the Clean Air Hospital Framework as we progress towards our published target of excellent status by 2025 (over 70%)

WASTE

- Explore innovative opportunities to reduce waste volumes and increase reuse i.e. reusable theatre hats, trialling reusable equipment to replace single use and expanding our food waste recycling

BIODVERSITY

- Progress our 30-year Biodiversity Management Plan to improve our biodiversity metric across our estate

SUPPLY CHAIN

- Increase confidence and accuracy in emissions associated with Scope 3 category 1, Purchased Goods and Services, by increasing the proportion of suppliers engaged in our 5-step framework and from 'estimated' to 'reported' data in our hybrid calculation.

Declaration and Sign Off

This Carbon Reduction Plan has been completed in accordance with PPN 06/21 and associated guidance and reporting standard for Carbon Reduction Plans.

Emissions have been reported and recorded in accordance with the published reporting standard for Carbon Reduction Plans and the GHG Reporting Protocol corporate standard[xv] and uses the appropriate Government emission conversion factors for greenhouse gas company reporting[xvi].

Scope 1 and Scope 2 emissions have been reported in accordance with SECR requirements, and the required subset of Scope 3 emissions. The full carbon footprint has been reported in accordance with the published reporting standard for Carbon Reduction Plans and the Corporate Value Chain (Scope 3) Standard[xvii].

This Carbon Reduction Plan has been reviewed and signed off by the board of directors.

Signed on behalf of the Supplier:

……

Date: ……

Footnotes

[i] https://www.newcastle-hospitals.nhs.uk/wp-content/uploads/2024/06/Climate-strategy-2020-2025.pdf
[ii] https://racetozero.unfccc.int/system/race-to-zero/

[iii] https://www.smartcarboncalculator.com/
[iv] https://www.gov.uk/government/collections/government-conversion-factors-for-company-reporting
[v] https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/
[vi] https://ghgprotocol.org/corporate-standard
[vii] https://ghgprotocol.org/standards/scope-3-standard
[viii] https://ghgprotocol.org/scope-3-calculation-guidance-2
[ix] https://www.gov.uk/government/publications/environmental-reporting-guidelines-including-mandatory-greenhouse-gas-emissions-reporting-guidance
[x] https://www.newcastle-hospitals.nhs.uk/about/sustainable-healthcare/shine-annual-reports/
[xi] https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/
[xii] In our baseline year we estimated emissions associated with our purchased goods and services (scope 3 Category 1/NHS Footprint Plus) using a spend based method. In 2023-24 we calculated these emissions using the Greenhouse Protocol hybrid method (40% of our emissions were reported directly from suppliers; 60% were estimated using a spend based method). This has resulted in a significant increase in our scope 3 emissions and so we will need to recalculate our Scope 3, or NHS Carbon footprint plus, baseline.
[xiii] https://www.newcastle-hospitals.nhs.uk/about/sustainable-healthcare/shine-annual-reports/
[xiv] https://www.newcastle-hospitals.nhs.uk/about/sustainable-healthcare/sustainable-suppliers/
[xv] https://ghgprotocol.org/corporate-standard
[xvi] https://www.gov.uk/government/collections/government-conversion-factors-for-company-reporting
[xvii] https://ghgprotocol.org/standards/scope-3-standard

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Agenda item A12

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 September 2024.					
Title	Board Assurance Framework Report.					
Report of	Rob Harrison, Managing Director. Patrick Garner, Director of Performance and Governance.					
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 with assurance that strategic risks are being managed effectively; that risks have an appropriate action plan in place; and that risk scores are realistic and achievable.					
Recommendation	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. • Approve the 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	Risk Validation Group, 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.

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 BAF RISK REVIEW

All BAF risks have been reviewed by each Executive Lead in September 2024. Below aims to give an overview of the Executive review and updates for each Committee.

Quality Committee

Quality Committee BAF risk has been reviewed by the Executive Director of Nursing, Joint Medical Director and the Director of Quality and Effectiveness. Following the risk review the key points to note are as follows:

- The current risk score remains at a score of 15 (5x3) The risk impact and likelihood scoring matrix can be found in appendix 2.0 to support the committee to understand how the risk has been scored.
- Several actions and timescales have been redefined since the last review providing more accurate action descriptions and achievable timescales.
- New actions have been added in relation to medicines management, embedding learning from external reviews, improvement in relation to PSIRF priorities and care optimisation.
- Controls have been added to the medicines management threat relating to the medicines management action plan and establishment of a medicines management oversight group.
- Assurance ratings remain between amber and red.
- Progress indicators detail that all actions are defined and are most progressing, where delays are occurring interventions are being taken.

People Committee

People Committee risks have been reviewed by the Chief People Office. Following the risk review the key points to note are as follows:

- The current risk score has remained the same for all 3 risks aligned to the People Committee. The risk impact and likelihood scoring matrix can be found in appendix 2.0 to support the committee to understand how the risk has been scored.
- Several actions and timescales have been redefined since the last review providing more accurate action descriptions and achievable timescales.
- New actions have been added in relation to strengthening people data in clinical Boards, recruitment of FTSU champions, implementation of FTSU 8-point plan, FTSU maturity self-assessment, pilot of appraisal process, promotion of the behaviours and civilities charter, 'you said, we did' campaign, development of anti-racism policy, review of dignity and respect policy and roll out of management skills sessions.
- Controls have been added relating to bespoke civilities and behaviours training, speak up policy and 8-point plan, new format for people committee, enhanced people committee data and sexual misconduct policy.
- Assurance ratings remain between amber and red.
- Progress indicators detail that all actions are defined and are most progressing, where delays are occurring interventions are being taken.

Finance Committee

Finance risks have been reviewed by the Managing Director, Director of Performance and Governance and Chief Finance Officer. Following the risk review the key points to note are as follows:

- The current risk score remains at a score of 20 (5x4) The risk impact and likelihood scoring matrix can be found in appendix 2.0 to support the committee to understand how the risk has been scored.

- Several actions and timescales have been redefined since the last review providing more accurate action descriptions and achievable timescales.
- The assurance rating for threat 4, lack of longer-term planning framework and certainty of funding/reliance on non-recurrent income has been reduced from Red to Amber.
- New actions have been added in relation to engagement with ICB regarding block contract drugs funding and a review of annual capital plan.
- No controls or sources of assurance have been added.
- Assurance ratings remain between amber and red.
- Progress indicators have been added for all risks.

Digital and Data Committee

The Digital and Data Committee BAF risk has been reviewed by the Chief Information Officer. Please note: this risk will not be reviewed by the Digital and Data Committee until the Committee meeting in October.

Following the risk review the key points to note are as follows:

- The current risk score has remained the same at 12 (4x3). The risk impact and likelihood scoring matrix can be found in appendix 2.0 to support the committee to understand how the risk has been scored.
- Several actions and timescales have been redefined since the last review providing more accurate action descriptions and achievable timescales.
- A new action has been added in relation to defining measurability and tracking specific investments for digital.
- One control has been added relating to the establishment of the care optimisation group.
- Assurance ratings remain the same, 2 red, 1 green.
- Progress indicators detail that 1 action is fully on plan across all actions and 2 actions are defined and are most progressing, where delays are occurring interventions are being taken.

Audit, Risk and Assurance Committee

The Audit, Risk and Assurance Committee BAF risk has been reviewed by the Managing Director and the Director of Performance and Governance.

Following the risk review the key points to note are as follows:

- The current risk score remains at a score of 16 (4x4). The risk impact and likelihood scoring matrix can be found in appendix 2.0 to support the committee to understand how the risk has been scored.
- One action timescale has been extended by 1 month, this relates to developing further strategies to support wards and department identification and documentation of risk.

- One new action has been added in relation to the development of action plan following the Clinical Board QoG review.
- Controls and assurances have been added to all four threats.
- Assurance ratings remain amber.
- Progress indicators detail that all actions are defined and progressing.

5.0 RECOMMENDATIONS:

The Trust Board asked to:

- Receive assurance from the Audit, Risk and Assurance Committee on the management of the Board Assurance Framework.
- Provide any feedback or comments.
- Approve the Board Assurance Framework document.

Report of:
Natalie Yeowart
Head of Corporate Risk and Assurance
17.09.2024

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 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 appropriate to the nature and/or scale of the threat or opportunity.

Progress Indicators:

One progress indicator should be added in the assurance rating/progress indicator box for each threat to demonstrate progress.

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.**

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	05.05.2024	**Likelihood**	**4**	**3**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	05.05.2024	**Risk Score**	**20**	**15**	**5**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating and Progress Indicator**
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. • Clinical Risk Group.	• 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. • Clinical Risk Group reports and sharing of learning, national patient safety alerts etc.	• 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.	**2- Actions defined – most progressing, where delays are occurring interventions are being taken.** 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. • Core quarterly mental health assessment metrics agreed. • Core quarterly learning disability assessment metrics agreed.	• 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. • Quarterly mental health assessment audit framework. • Quarterly learning disability assessment audit framework.	• Embed new core mental health quarterly audit framework. Q1 completed and learning shared. Q2 data to be reviewed in September 24. • Launch level 2 MCA training programme and mandate for all relevant staff by the end of 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 when ICB position has been agreed – expected Oct 24. • Embed quarterly real time learning disabilities audit framework. Q1 now complete, real-time process to commence Sept 24.	
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. • Recurrent stocktake of progress with clinical board QoGs.	• 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. • Initial stocktake of QOG activity completed in May 2024-shared with CB's.	• Design and implement a standardised quarterly quality reporting mechanism/dashboard including communications and guidance for clinical boards to report into QPRs. This will include compliance with all metrics e.g. GIRFT/NICE etc – October 24. • Explore current infrastructure of quality oversight and local governance groups and make recommendations around enhanced support – October 24 • Review of QoG activity to be completed and presented to Quality Committee in October 24. • Baseline review of Trust non-compliance with standards/guidelines, propose organisational approach to Quality Committee – October 24.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
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.	• 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.	• Trust wide peer review of clinical standards including medication safety to be completed in Sept 24 • Spot Check audit framework to be implemented to support existing assurance mechanisms – Sept 24	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

	• 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. • Revised medicines management action plan. • Established Medicines Management Oversight Group to ensure delivery of improvements • Increased nursing infrastructure to support medicines safety.	• 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.	Actions as outlined in MMOG Action Plan.	
Failure to improve the safety and quality of patient and staff experience in Maternity Services., (Linked to 2024/25 Quality Priority 4a)	• CQC, Ockenden and Maternity Three-Year action plan in place. These are reported into Quality Committee and Trust Board. • Robust Maternity Governance Team in place • Midwifery Staffing and Clinical Outcomes group • Board Maternity Safety Champions • Rapid review group • Family Health QOG • SOF quarterly meetings with ICB as part of Perinatal Mortality Surveillance monitoring • Monthly Maternity Staff meetings • Maternity Voices Partnership • LMNS (Local Maternity and Neonatal System) oversight • Director of Midwifery appointed and in post. Real time patient/staff experience programme. • Workforce review including outputs of 2024 birthrate plus.	• 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 Executive Director of Nursing. • 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 meeting minutes and QOG minutes. • Staff experience programme includes one post-natal maternity ward. • Workforce review outputs and report.	• Review and refresh of Maternity Quality Metrics reported into Quality Committee – on track for completion in September 2024. • Director of Midwifery in process of reviewing maternity and obstetrics governance to strengthen oversight – October 2024.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
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 – September 24. • Explore current infrastructure of quality oversight and local governance groups and make recommendations around enhanced support – October 24 • Design and implement a standardised quarterly quality and safety reporting mechanism for clinical boards to report into QPRs. – October 24.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

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, Clinical Board and corporate service engagement.	• Change management process - EPR. • Improvement Project report to PSG quarterly and sharing of updates via Clinical Risk Group and Clinical Policy Group. • Policy improvements and changes resulting from PSIRF priority work shared via CPG. • 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 25.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
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. • Digital leaders' group. • Care optimisation group.	• Presentations slides, staff roadshow sides and feedback from staff. • Supplier assessment based on site visit. • Power BI report of all discharge summaries in all areas in real time. • E-record reminders to clinicians of encounters that require discharge summary.	• Six revised core care plans due for roll out October 24 with evaluation at 6 months • End of shift evaluation revision due for roll out October 24 with evaluation at 6 months • Patient correspondence/letters audit to validate Clinical Board processes to maintain oversight of timeliness of completion of correspondence. End Sept 24. • Secondary review of all systems functionality in relation to patient correspondence/letters. End Oct 24. • Endorsing of laboratory results SOP to be agreed – Sept 24. • Internal referral standardisation PSIRF priority project – TBC following care optimisation meeting in Sept 24.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

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	05.09.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	05.09.2024	**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 and Progress Indicator**
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/QPRs/directorates. • Audit, Risk and Assurance Committee established. • CQC delivery group established. • Risk Registers. • Risk Validation Group • Recovery Oversight Group • Cardiac Oversight Group • Clinical Assurance Group	• Terms of Reference – committees of Board. • Minutes of committee meetings. • Committee schedule of business. • Corporate Organograms. • Minutes of QOG/QPR and directorate governance meetings. • Effective governance system report to Trust Board. • CQC delivery group minutes and action plans. • Quality Performance Reviews and summary to Board and relevant committees. • External Tabletop Governance Report. • External leadership and governance review. • Feedback at IQIG	• Evaluate the implementation of revised integrated governance structure – October 24. • Develop action plan following external tabletop exercise – September 24. • Action plan following CGARD QOG review – October 24.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
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. • The value circle report on QPR process • The value circle report on effective governance	• Review issue escalation through new governance route to Exec – September 2024.	**1-Fully on plan across all actions.**

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 SIs 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. • CQC Delivery Group • Harm free care dashboards • Incident Communications Plan developed.	• Implement incident reporting communication plan – TBC. • Report and ensure compliance against Duty of Candour – January 25.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Failure to implement effective 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. Implementation/engagement risk refresher sessions provided to risk system users.	• Risk Management Policy document and associated guidance. • Reporting, accountability, and escalation structure. • Terms of reference and minutes for the 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 and summary report to Board	• Implement further strategies to support ward/departmental level risk identification and documentation – October 2024.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

Risk ID	1.2
Comments:	

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to manage our finances effectively to improve our underlying deficit and deliver long term financial sustainability.	**Strategic objective**	6. We will take our responsibilities as a public service seriously looking after patients and each other; managing our money, our performance, and our relationships with partners.

Lead Committee	Finance	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Finance	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Finance/VfM
Date Added	09.09.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	09.09.2024	**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 and Progress Indicator**
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 –. SMc to confirm timeline for improvement.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Insufficient capability / bandwidth and reduction in financial grip and control.	• Standardised governance framework in place. • 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 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. • HFMA self-assessment report.	• 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.	• ICB Grip and Control investigation and intervention. Timescale of rapid action to be completed by end of October 24. • Strategy to improve financial awareness throughout Trust - discussion with Head of Comms – Ongoing.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

	• 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 – Sept.24 and ongoing.	**4-Action defined but largely behind plan.**
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. • Revenue reporting to Finance and Performance Committee. • Financial Recovery Steering Group minutes and papers.	• Production of longer-term financial plan, initial draft completed and presented to finance committee in August 24. To be further refined in subsequent months, informed by outturn position and national guidance/assumptions – ongoing.	**1-Fully on plan across all actions.**
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.	• Proactive engagement with ICB on increasing pressure relating to block drugs – initial meetings arranged.	**5-Action not yet fully defined.**
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.	• 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. • Review of annual capital plan required to ensure emerging pressures impacting CDEL are	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.** **Cont/…**

	• Cash forecast.		balanced through slippage - October 24.	

Risk ID	6.1
Comments:	

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care.	**Strategic objective**	6. We will take our responsibilities as a public service seriously looking after patients and each other; managing our money, our performance, and our relationships with partners.

Lead Committee	Finance and Performance Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Managing Director	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	Compliance/Regulatory
Date Added	05.09.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	05.09.2024	**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 and Progress Indicator**
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. • Theatre reprofiling exercise.	• Accountability Framework. • Activity and Income reports. • Integrated Quality and Performance Board Report. • Monthly Integrated Quality Performance Reviews. • Theatre Demand and Capacity data. • CEO permutations to TMG including national performance comparisons • Theatre capacity and demand data for reprofiling.	• Further development of the Integrated Quality and Performance Board Report next key update September 24. • Develop Clinical Board Level reports – December 24. • Review current information and performance reports to ensure they are fit for purpose – September 24. • 62-day cancer performance improvement plans and trajectories now complete – being monitored to provide evidence if delivery. • Agree 65-week cohort reduction trajectories with specialities completed – being monitored to provide evidence if delivery. • Conclude validation of the non-RTT cohort of long waits by November 24. • To improve waiting list booking process through a standardised SOP, training and implementation by September 24. • Outpatient capacity and demand analysis to be completed by the end of Q4 24/25. • Implement new Emergency Department workforce rota by September 24. • Develop Service Review methodology to be developed and reviews to start in April 25. **Cont/…**	**2 – Action defined-most progressing, where delays are occurring interventions are being taken.**

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 – September 24. • Develop a new workforce model for Cardiac Physiology –October 2024 • Maximise utilisation of CDC – December 24. • Improve theatre utilisation to greater than 85% by the end of March 2025. • Develop sustainable workforce plans across histopathology specialisms by March 25.	**2 – Action defined- most progressing, where delays are occurring interventions are being taken.**
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. • Monthly meetings in place with primary care.	• TMG Oversight. • Executive Team Oversight. • Quality Performance Reviews. • Monthly IPR to committees and Board. • Clinical Board meeting minutes. • Outpatient Improvement Group actions. • Surgical Improvement Group actions. • Diagnostic Improvement Group actions. • UEC Improvement Group actions. • Cancer Board actions. • Improvement and project management resource reprioritised to spot priority actions/service changes.	• Development of GP leadership roles for UEC and Community Care – October 24. • Review and revise winter plan – September 24. • Develop and implement co-located UTC – December 25. • Develop and implement extended SDEC capacity – March 25. • Establish effective Frailty model by March 25.	**2 - Action defined- most progressing, where delays are occurring interventions are being taken.**
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 – September 24	**1-Fully on plan across all actions.**

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	10.09.2024	**Likelihood**	**4**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	10.09.2024	**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 and Progress Indicator**
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. • Care Optimisation Group.	• Presentations slides, staff roadshow sides and feedback from staff. • Supplier assessment based on site visit.	• Implement Oracle/Cerner Remote Hosting project – January 25. • Upgrade current EPR version – June 25.	**2 - Action defined- most progressing, where delays are occurring interventions are being taken.**
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. • DSPT 2024/25 •	• IT Security and Service Management Report to Digital and Data Committee. • Cyber Essentials Accreditation certificate. • Digital and Data Committee Minutes. • DSPT 2024/25 – substantial assurance.	• Review of current Cyber Security Policies– December 24. • replace/update outdated systems and software, legacy hardware, and unsupported systems – TBC. • Implement process for the management of the inventory system – December 24. • Plan to remove all devices over 5 years old – April 25	**1-Fully on plan across all actions.**
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. • IT CIP Plan.	• IM&T Senior Leadership Meeting and minutes. • Review and reporting at Digital and Data Committee. • Minutes of Digital and Data Committee.	• Develop 3-year Digital financial Plan – October 24. • Develop Digital Strategy – April 25. • Define measurability and track specific investments for Digital – December 24.	**2 - Action defined- most progressing, where delays are occurring interventions are being taken.**

Risk ID	4.1
Comments:	

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	05.09.2024	**Likelihood**	**4**	**4**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	05.09.2024	**Risk Score**	**20**	**20**	**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 and Progress Indicator**
Insufficient capital funding to effectively manage the lifecycle replacement or upgrade of the Trust Estate, Environment and Critical Infrastructure assets (Backlog Maintenance).	Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of backlog maintenance programme. Annual capital investment plan including estates and medical devices. Estates Strategy. ICS Infrastructure plan.	Estates Risk Management & Governance Group minutes and action logs. ERIC/Model Health System. Estates Investment, Planning, Strategy and Capital Investment Group. CIR plan 2024/5 Capital programme. Capital Management Group oversight. CMG report - Finance and Performance Committee. ICS Infrastructure Board.	• Complete annual condition survey (20%) to determine condition of infrastructure in accordance with NHS Backlog Methodology - November 24. • Align results of condition survey on Estates CAFM system -January 25. • Develop a risk-based asset report for Clinical Boards to inform risk-based prioritisation of backlog maintenance programme -January 25. • Develop a detailed 5-year Backlog Maintenance plan to feed into the Estates Strategy -March 25. • Engagement with ICS Infrastructure Board and NHS National Estates & Facilities -ongoing.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Compliance with fire safety regulations & standards - Failure to deliver fire safety systems remediation programmes.	• Risk based fire remediation programme. • Condition monitoring of fire safety assets undertaken annually to enable ongoing re-prioritisation of fire safety remediation programme. • Monthly fire safety remediation programme monitoring reports. • Fire Safety Reports. • Incident reporting system. • Estates Strategy. •	• Trust Fire Safety Group minutes and action logs. • Oversight by Estates Fire Directors Group. • Estates Risk Management & Governance Group minutes and action logs. • Quarterly report to Compliance & Assurance Group. • Reports to Capital Management Group. • Fire Safety report to Trust Board. •	• Investment plan in Fire Safety upgrades -Q1 24. • Complete phase 2 passive fire remediation works to high-risk clinical areas -Q3 24. • Tender/award contract for phase 3 of passive fire remediation works -September 24. • Complete 24/25 upgrade programme of active fire system March 25.	**1-Fully on plan across all actions.**

			• Tender/award contract for 2025/26 upgrade of active fire systems -March 25.	
Failure of ageing critical estates M&E engineering infrastructure (Ventilation, Water, Electrical (HV & LV systems), Decontamination and Medical Gas Pipeline Systems).	• 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. • Health & Safety Reports. • Incident reporting system. • Capital Programme. • Estates Strategy. • Trust Policies and Procedures.	• Estates Operational Management Structures. • Estates Investment, Planning, Strategy and Capital Investment Group. • CIR plan 2024/5 Capital programme. • Oversight via Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety). • Estates Risk Management & Governance Group minutes and action logs. • Quarterly report to Compliance & Assurance Group. • Capital Management Group oversight. • IPCC oversight. • Independent Authorising Engineer annual HTM compliance Audit. • Trust Internal Audit Programme (AuditOne).	• Complete annual condition survey (20%) to determine condition of infrastructure in accordance with NHS Backlog Methodology -November 24. • Align results of condition survey on Estates CAFM system -January 25. • Develop a risk-based asset report for Clinical Boards to inform risk-based prioritisation of backlog maintenance programme - January 25. • Develop a detailed 5-year Backlog Maintenance plan to feed into the Estates Strategy -March 2025.	**1-Fully on plan across all actions.**
Insufficient capital funding to effectively manage the lifecycle replacement or upgrade of critical medical devices (Imaging assets, Theatre Equipment etc.).	• Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of capital replacement programme. • Annual capital plan includes medical devices.	• Medical Director medical device replacement oversight/prioritisation group. • Estates Investment, Planning, Strategy and Capital Investment Group. • Medical Device replacement plan 2024/5 Capital programme. • Capital Management Group oversight. • CMG report - Finance and Performance Committee. • Medical Device Steering Group.	• Develop a risk-based medical device asset report to inform Clinical Boards of lifecycle replacement priorities -Jan 2025. • Develop a detailed 3-year medical device asset replacement plan to feed into the Capital/Financial planning -September 2024.	**1-Fully on plan across all actions.**
Failure of ageing critical medical devices assets (Imaging assets, Theatre Equipment etc.).	• Regular planned preventive maintenance programme (PPM) in place in line with the requirements of MHRA guidance. • Monthly Compliance Monitoring Reports. • Incident reporting system. • Capital Programme. • Trust Policies and Procedures.	• EME Operational Management Structures. • Annual report to Medical Device Steering Group. • Estates Risk Management & Governance Group minutes and action logs.	• Analysis of CAFM medical device data to identify failure trends - March 2025. • Develop a risk-based medical device asset management and compliance report for Clinical Boards -Jan 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Failure to maintain the Quality and Safety of the care environment to meet CQC regulatory standards and deliver Trust priorities and ambitions including environments that are Dementia Friendly and free from Self Harm risks.	• Regular planned preventive maintenance programme (PPM) in place in line with the requirements of SFG20 and Health Technical Memoranda (HTM) guidance. • Health & Safety Audit Reports. • Incident reporting system. • Capital Programme. • Estates Strategy. • Trust Policies and Procedures	• Estates and Facilities Operational Management Structures. • Estates Risk Management & Governance Group minutes and action logs. • Quarterly report to Compliance & Assurance Group. • PLACE Assessments. • NHS Premises Assurance Model (PAM). • IPCC oversight. • CQC Delivery Group. • CQC Standards Assurance Group. • Trust Internal Audit Programme (AuditOne).	• Delivery of Estates & Facilities CQC action plan -timescales TBC. • PLACE Action Plan -March 25. • Review and implement agreed improvements relating to dementia Friendly standards (18–24-month programme). • Compliance with Self Harm Risk Assessment recommendations 18–24-month programme. • Review and implement agreed improvements relating to Real	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

			Time Patient Satisfaction Surveys -ongoing.	
Ability to attract and retain sufficient competent staff resources to deliver Trust priorities and ambitions.	• Monitoring of level of vacancies. • Appraisals. • Training and development of staff. • Exit interviews. • Agency/contract staff. • Staff survey (national and local). • Flexible working.	• Staff survey results reported to Estates & Facilities Senior Management Team. • Vacancy levels monitored by Estates & Facilities Senior Management Team.	• Implement Estates People Plan - July 24. • Introduction of Workforce Development Group -August 24. • Implement Staff survey-based E&F action plan -October 24. • Comparative benchmark salary review of at-risk groups August 24.	**1-Fully on plan across all actions.**
Lack of decant facility compromises the delivery of planned Estates objectives	• Estates Strategy. • Liaison meetings with Patient Services to minimise impact on clinical activity. • Project Management meetings.	• Senior Operational meetings. • Capital Management Group oversight. • Project Board oversight	• Co-ordinate with Patient Services to minimise impact on patient activity-timing project specific.	**5-Action not yet defined.**
Failure to maintain and invest in the PFI estate to keep it in a suitable and quality condition and at a safe level of compliance.	• 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.	• PFI Monthly Review Meetings. • PFI Liaison Committee. • Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety). • Compliance & Assurance Group. • Trust Internal Audit Programme (AuditOne) • Independent Authorising Engineer annual HTM compliance Audit. • PLACE audits. • Monitor helpdesk reporting	• Continue zonal inspection processes to identify and remedy any slippage in condition. • Performance of the PFI Centre of Best Practice condition survey process -Dec 2025 – on track.	**3-Action defined-work started but behind plan.**
Failure to effectively manage PFI partners resulting in disruption to clinical service delivery.	• Maintain meeting structures to ensure flow of dialogue. • Communications and correspondence to review matters and highlight and action concerns. • Adherence with contract management requirements outlined within the PFI Project Agreement. • Legal support if required to resolve any disagreements.	• PFI Liaison Committee. • Service Providers meeting. • Performance reports. • Performance report review meetings.	• Regular reviews of performance - takes place monthly. • Adherence to outlined performance parameters.	**3-Action defined-work started but behind plan.**
Failure to manage project delivery within PFI estate will impact the ability to transform services and improve efficiency.	• Follow variation procedure outlined with PFI Project Agreement. • Track works requests and escalate slippage. • Review progress within meeting structures. • Implement alternative routes if required.	• Review at monthly Variation meetings. • PFI Liaison Committee.	• Track and manage works requests through variation procedure and meeting structure -takes place monthly. • Implement alternative delivery models if required -further options by Dec 2024 – under pressure to achieve.	**4-Actions defined -but largely behind plan.**
Reduced fire compliance during PFI Programme of fire remedial works.	• Obligations to perform and conclude fire remedial works set out in PFI Project Agreement and Settlement Agreement. • Maintain meetings structures to manage progress with the works.	• Independent certification for each zone when completed. • Ongoing compliance requirements contained within PFI Project Agreement. • PFI Fire Steering Group.	• Regular reviews of requirements and progress with the remedial works -takes place monthly.	**4-Actions defined -but largely behind plan.**

Non-compliance of elements of the Ventilation and Air Conditioning Systems	• Obligations to perform remedial works set out in PFI Project Agreement. • Legal support if required to resolve any disagreements.	• Compliance requirements contained within PFI Project Agreement. • Performance reports. • Performance report review meetings. • PFI Liaison Committee.	• Seek remedial scope and programme from PFI partners - Dec 24 – on track. • Manage terms of the PFI Project Agreement to conclude remedial works-remedial works through to Dec 26. • Negotiate settlement agreement with PFI partners committed to delivering remedial works to programme -Dec 24.	**3-Action defined-work started but behind plan.**
Non-compliance of elements of the Electrical Systems.	• Obligations to perform remedial works set out in PFI Project Agreement. • Legal support if required to resolve any disagreements.	• Compliance requirements contained within PFI Project Agreement. • Performance reports. • Performance report review meetings. • PFI Liaison Committee. •	• Seek remedial scope and programme from PFI partners - Dec 24. Manage terms of the PFI Project Agreement to conclude remedial works-remedial works through to Dec 26 – on track. Commence condition survey of electrical installations to fully define issues and required remedial actions -December 24.	**3-Action defined-work started but behind plan.**

Risk ID	5.1
Comments:	

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to have sufficient capacity and capability in our workforce to deliver safe and effective care.	**Strategic objective**	2. We want this to be a great place to work where everyone feels supported appropriately by the organisation and compassionate leaders. We will always be civil and respectful to each other so that relationships within and across the teams will improve.

Lead Committee	People Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Chief People Officer	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	People
Date Added	09.09.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	09.09.2024	**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 and Progress Indicator**
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. • People data metrics developed and reported to People Committee.	• Vacancy control to be monitored through ESR – October 24 • People dashboards to be developed for corporate areas – further work to strengthen into clinical boards and corporate areas - November 24.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
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 • Continued recruitment. • Implementation of workforce plan– ongoing monitoring at clinical board level to manage vacancy and staffing levels.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

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	09.09.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	09.09.2024	**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 and Progress Indicator**
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. • FTSU policy and 8 point plan.	• 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 24. • FTSU champions to be recruited to during September and October 24. • Promotion of behaviours and civilities charter across the Trust including bespoke training from September 24. • 3rd CEO Roadshows to commence in September 24 to include “you said we did” campaign to feedback progress to staff. • Embedding a staff and patient experience improvement programme March 2026.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

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. • Bespoke training for areas as requested on the new published Civilities and Behaviours charter. • 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 – October 2024. • Review of Dignity and Respect Policy – with a focus on anti-racism – November 24. • Anti racism policy to be produced – November 24.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
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. • Guidelines for staff support- produced during the riots.	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 • Promotion campaign during September/October 24 – completed by December.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
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. • A Speaking up policy which sets out key objectives for the period October 24 – March 25	• FTSU issues reported to People Programme board and workforce group. • FTSU reports on themes and issues reported to People committee. • Datix reports on themes issues to quality committee. • Work in confidence system reports on themes and issues reported to the People committee. • FTSU action plan presented at TMG on 4 September 2024. • Visibility of senior leaders – visits and walkabout schedule.	• 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 – October 24. • Implement speaking up 8 point plan programme from October 24 – March 25. • Self-assessment on FTSU maternity to be undertaken - October 24, report to Trust Board in November 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.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

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	09.09.2024	**Likelihood**	**5**	**4**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	09.09.2024	**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 and Progress indicator**
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. • Review of People committee agendas and reporting to include more people data.	• 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” . • Review of appraisal process for leaders and managers linked to the four themes of the People Strategy – pilot to run from June 24 until December 24 to inform new process from April 25. • Leadership Development Training pilot to be run from December 2024. • Management skills on HR processes – sessions running July 24- November 24. • Introduction of value/leadership competency into our recruitment processes – incrementally from June 24, fully implemented by March 2025. • Development of People Committee Internal Audit Report to track progress with recommendations and assurance – November/December 24.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

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. • Gap analysis of HWB offer for staff to be undertaken – paper to be submitted to Executive Team and People Committee - September 24. • Review of psychological support for staff – setting out options for the way forward – Paper to be submitted to Executive Team and People Committee – September 24.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
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. • Sexual misconduct policy.	• 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”. • Review of appraisal process for leaders and managers linked to the four themes of the People Strategy – pilot to run from June 24 to December 24 to inform new process from April 25. • Leadership Development Training pilot to be run from June 24 – December 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 – November 24. • Review of key HR policies and processes aimed at supporting staff – September 24. • Review of dignity and respect policy – November 24. • Anti-racism polict to be produced – November 24.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

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	21.08.2024	**Likelihood**	**4**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	21.08.2024	**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 and Progress Indicator**
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	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

Risk ID	7.1
Comments:	

Trust-Wide Risks Scored 15+ - Committee Mapping

Risk Tracker Key	
	New risk added since last BAF review.
	Current risk score reduced but still rated 15+
	Current risk score reduced below 15.
	Risk Tolerated - mitigated as low as reasonably possible.
	Current 15+ risk score increased.
	Risk fully mitigated and closed from operational risk register.

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)	10 (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.	8 (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.	12 (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.	12 (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.	12 (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.	12 (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
4514	Cardiothoracic	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.	5(15)
4518	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
4516	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
4517	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
4519	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
4522	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
4524	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
4526	Family Health	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.	5 (15)
4528	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
4538	Peri-operative and Critical Care	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
4547	Clinical and Research Services	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
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.	20 (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.	12 (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.	16(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
4525	Surgery and Specialist Services	There is a risk to the Trust's ability to provide mechanical thrombectomy to patients having strokes outside of 9-5 hours. This is caused by several factors, but in particular a lack of Interventional Neuroradiologists (INRs) (as the Trust needs a 6th before the hours of the service can be extended), and a lack of commitment from NHSE to fund more staff. This could result in people in the north east having limited access to life saving stroke interventions that are available in other regions during certain times of day, and in the Trust's ability to meet the expectations of NHSE (causing reputational damage).	16
4335	Clinical and Research Services	There is a risk to Quality Safety for patients with Diabetes developing Diabetic foot ulceration due to lack of podiatry appointments. Which is caused by more patients with complex foot disease and the Trust is unable to meet the demand. Patients are at risk of admission to hospital and possible need for surgery and amputation, which could be avoided by more podiatry availability.	20
4550	Cancer and Haematology	There is a risk to quality safety, which is caused by the lack of ventilation in the Henderson space which is used as chemotherapy day unit. Which could result in delays to patients starting treatment, interruptions to current treatment plans, and patients being treated in a suboptimal environment.	15
4551	Family Health	There is a risk to patient safety due to the lack of designated HDU/level 2 capacity and a paediatric critical care outreach team, this may result in patients not receiving the right level of care and intervention at the right time. In addition to this, there is a risk to overall GNCH bed capacity as managing level 2 patients on inpatient wards requires a higher level of nursing and this can often result in bed closures.	20
4559	Surgical and Associated Specialties	There is a risk to patient safety, which is caused by insufficient medical specialist input available for vascular in-patients to address complex issues of frailty, multi-morbidity and acute medical issues that arise on daily basis to achieve key national recommendations comprehensive medical assessment vascular patients before and after vascular intervention (POVS 2021). This could result in unsafe complex medical decision making and management, missed diagnoses, delays in appropriate acute medical management in vascular in-patients, delays in surgery, impact on vascular patient outcome / survival, prolonged hospital admissions, and delayed discharges.	15
4560	Surgical and Associated Specialties	There is a risk to patient outcomes caused by ineffective/inefficient pathway for pancreatic and cancer referrals. This could result in delays in treatment and adverse outcomes for patients across the HPB network with cancer	16
4563	Family Health	There is a risk to patient safety and potential reputational damage caused by failure to follow agreed screening pathways/processes for screening, failure to meet screening KPIs and failure to accurately report on our screening data externally. This could result in missed opportunities for screening, missed diagnosis, late diagnosis and potential harm. This is an ongoing risk as we do not currently have a high level of assurance that it will not happen again/is not continuing to happen.	16
4565	Medical Director	There is a risk to quality and safety which is caused by the breakdown in provision of shared care pathways across the region. This could result in patients not receiving safe and effective continuing care, result in increased attendances to hospital and could lead to patient harm.	16
4568	Clinical and Research Services	There is a risk to quality and safety caused by out of date and unwanted medications not being stored securely and being accessible to the public. Which could result in patient harm and non-compliance with medications management standards.	16
4569	Clinical and Research Services	There is a risk to quality and safety caused by gaps in fridge temperature recordings and sub optimal temperature monitoring equipment. Which could result in potential patient harm if spoiled medications are administered to patients. This could also result in a financial impact in relation to medication wastage.	15

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.	20 (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
4528	Family Health	There is a risk to to patient safety, patient experience, staffing and reputational damage. This risk is caused by a wide-ranging digital immaturity within the women's health directorate which could result in; • ineffective use of clinical staff time. • inability to accurately report on our services externally • inability to communicate with GPs and patients in a timely and effective manner e.g. through discharge summaries • inability to identify deteriorating patients in a timely manner through lack of e-obs in MAU • inability to manage proactively plan and manage services using up to date accurate information e.g. via fit for purpose dashboards.	15

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Agenda item A13

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 September 2024					
Title	Updated People Committee Schedule of Business					
Report of	Christine Brereton, Chief People Officer					
Prepared by	Lauren Thompson, Corporate Governance Manager / Deputy 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 July a discussion has taking place with the Chair of the Committee and the Chief People Officer. Some minor amendments to the SoB have been made to the frequency of some agenda items, some additional items added, and March 2025 has now been included (as highlighted in red font).					
Recommendation	The Trust Board is asked to approve the updated Schedule of Business for the 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 17 September 2024.					

Agenda item A13

Committee / Group:	**People Committee**
Chair:	**Bernie McCardle**
Executive Lead:	**Christine Brereton**
Year:	**2024/25**

	Lead	Authors / contacts of the report	Apr-24	May-24	Jun-24	Jul-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	March-25 (Added this column)	Notes
Standing Items														
Apologies for absence and Declarations of interest	Bernie McCardle		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Bernie McCardle	Lauren Thompson / Gillian Elsender	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Action log	Bernie McCardle	Lauren Thompson / Gillian Elsender	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Meeting debrief	Bernie McCardle		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Matters requiring escalation and AOB	Bernie McCardle	Lauren Thompson / Gillian Elsender	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
New and emerging risks	Bernie McCardle		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
People and Culture Dashboard - Headlines (moved from Regular Reports)	Paul Turner	Deb Stuart	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	The IBR with People Data will be shared in full at each meeting for background information.
CQC Updates - People matters (moved from Regular Reports)	Christine Brereton	Donna Watson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
People Plan - Year 1 Delivery Plan - Overview (moved from Regular Reports)	Christine Brereton	Donna Watson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
People Plan - Deep dive on themes (moved from Regular Reports and made a separate item)	Christine Brereton	Donna Watson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Each meeting will focus on x2 themes of the people plan: Health and Wellbeing, Valued and Heard, Behaviours and Civilities and Leadership and Management
BAF Report (moved from Regular Reports)	Christine Brereton	Natalie Yeowart	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Committee to approve the BAF same month as Board then the Board approved version the following month to close governance cycle.
Regular Reports														
Clinical Board updates (Moved from Ad hoc)	Rob Harrison / Paul Turner	Deb Stuart		✓		✓		✓		✓		✓		
Employee Relations	Paul Turner	Deb Stuart	✓					✓						Biannual updates scheduled - further updates to be shared if required.
Governance: Audit Updates (New item)	Christine Brereton	Paul Turner	✓				✓				✓			3x per year
Equality, Diversity and Inclusion Update (Moved from AR)	Christine Brereton	Karen Pearce	✓			✓			✓			✓		4x per year
NHS Staff survey & Staff engagement plans/updates	Christine Brereton	Donna Watson		✓			✓			✓			✓	4x per year
Sustainability (Shine Report)	James Dixon	James Dixon				✓					✓			JD to attend twice a year.
Guardian of Safe Working	Henrietta Dawson	Henrietta Dawson	✓			✓		✓			✓			HD to attend twice a year. Quarterly Reports
Freedom To Speak Up (FTSU) Guardian	Jill Taylor	Jill Taylor	✓				✓							JT to attend twice a year.
Communications strategy/strategic communications and external engagement update	Caroline Docking	Cerys Bodey						✓				✓		2x per year
Deep Dive Reports (New category added - some were in Ad Hoc)														
Violence & Aggression to staff	Ian Joy	Tim White			✓									Added after approval of schedule in April Committee meeting - Action from Board
Sickness Absence	Christine Brereton	Paul Turner				✓			✓					
Retention and Turnover	Christine Brereton	Paul Turner			✓									
Recruitment and Selection	Christine Brereton	Paul Turner									✓			
Ad hoc as identified by Chair / committee (if required)	Christine Brereton		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Annual Reports (AR) or updates														
People Strategy and Year priorities	Christine Brereton	Deb Stuart		✓										
Development of the Trust Workforce Plan (New item)	Christine Brereton/Rob Harrison	Deb Stuart										✓		
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Kelly Jupp / Lauren Thompson /Christine Brereton	Kelly Jupp / Lauren Thompson	✓											To include effectiveness consideration
GMC training survey	Michael Wright / Ifti Haq	Ifti Haq						✓						
Gender Pay Report	Christine Brereton	Karen Pearce										✓		
WRES & WDES	Christine Brereton	Karen Pearce		✓										
Workforce Profile & Demographics update	Christine Brereton	Paul Turner								✓				
Legal Update	Christine Brereton	Deb Stuart	✓											
Annual Conversation with Executive Directors	Michael Wright / Ian Joy	Ruth Hall / Diane Cree						✓ (M&D)				✓ (NMAHP)		
Trade Union Faculty Time Report	Christine Brereton	Paul Turner			✓									
Ad Hoc reports (tabled as required)														
Learning and Education Group, HWB, EDI and Sustainable Healthcare Committee minutes to be received during the year	Christine Brereton	Michelle Cruickshanks / Estates Admin				✓	✓	✓	✓	✓	✓	✓	✓	
Maternity Safety Champion observations	Liz Bromley	Liz Bromley	✓	✓			✓		✓		✓		✓	Added after approval of schedule in April Committee meeting

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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. 19.09.24 - Update awaited from LPC.
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. 14.07.24 - The preceptorship team have been asked to identify a volunteer to share their experience once the cohort has finished in the Autumn. Discussion required as to whether this is shared with Quality Committee or People Committee. IJ will progress with AS and BM. Propose to close action. [Update circulated via email to Board members on 19/07/24]
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. 14.07.24 - An update on AMS was discussed as part of the IPC Board Assurance Framework agenda item in Quality Committee in July with a deep dive scheduled in August Quality Committee. Propose to close action. [Update circulated via email to Board members on 19/07/24]
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. 12.07.24 - MWr advised that this has been/will be considered as part of the review of external assessments and visits as standalone items rather than as part of the audit plan. Propose close action. [Update circulated via email to Board members on 19/07/24]
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. 14.07.24 - Relevant detail included in the July Safe Staffing Report and will be included in all subsequent reports. Propose to close action. [Update circulated via email to Board members on 19/07/24]

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. 17.07.24 - Lead Medical Examiner (ME) update shared below: - All parties that will need to participate have been repeatedly contacted, visited, encouraged. - All processes that will be needed are either already in place and have been tested or cannot be finalised until the formal guidance is officially released (expected in the next 2 weeks). - Following receipt of the new guidance the Lead ME will be meeting face to face with the Coroner, Registrars for deaths, Faith leaders if required, Mortuary staff and any other individuals as required. - A simple guide to the new process will be issued once the guidance has been finalised. - The GP roll-out has not been postponed, with all channels open. The majority of GPs have referred at least one patient to ensure the communication channels operate effectively. - Adequate staffing to deal with the incorporation of Community deaths. - For hospital deaths limited changes are expected until the new Medical Certificate of Case of Death (MCCD) digital format comes in and Cremation forms are removed (an administrative change, with no issues anticipated). A key consideration with be out of hours cover for the urgent release of deceased individuals, a plan is in place in relation to this. Propose to close action. [Update circulated via email to Board members on 19/07/24]
122	17 July 2024	24/16STRATEGIC ITEMS: iii) People: People Strategy (Plan) 2024 - 2027	Mrs Stabler fully supported the strategy but also noted the importance of finding innovative ways to feedback messages to staff who don't routinely access emails to which the CPO advised that details were included in the communications plan and included face to face sessions with the CEO as well as using the Trust Facebook page. There was also a one-page information sheet of key messages that the CPO agreed to share with the Board [ACTION01].	CB			19.09.24 - Awaiting update from CB.
123	17 July 2024	24/19ANY OTHER BUSINESS: iii) Meeting Action Log	The action log was received, and the content noted. The actions proposed for closure were agreed. A number of updates had been received since the publication of the papers which the TS agreed to email to the Board members and update the website [ACTION02].	KJ			19/07/24 - Updated action log circulated to Board members with changes highlighted in red font. 20/09/24 - Updated action log added to the Trust website. Propose to close.

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.