Public Trust Board of Directors' Meeting

Friday 29 November 2024, 10.15 – 11.45

Venue: Culture Centre Boardroom, RVI

Agenda

Item		Lead	Paper	Timing
1.	Apologies for absence and declarations of interest	Paul Ennals	Verbal	10:15 – 10:16
2.	Minutes of the Meeting held on 27 September 2024 and Matters Arising	Paul Ennals	Attached	10:16 – 10:17
3.	Chair's Report	Paul Ennals	Attached	10:17 – 10:23
4.	Chief Executive's Report	Jim Mackey	Dashboard	10:23 – 10:30
Strategic items:				
5.	Relative and Staff Member Story	Annie Laverty	Attached	10:30 – 10:35
6.	Board Visibility Programme	Kelly Jupp	Attached & Board Reading Room	10:35 – 10:40
7.	CQC update	Rob Harrison	Attached & Board Reading Room	10:40 – 10:50
8.	Integrated Board Report	Rob Harrison & Patrick Garner	Attached	10:50 – 10:55
9.	Trust Strategy	Patrick Garner & Martin Wilson	Attached	10:55 – 11:05
10.	Change NHS consultation response	Caroline Docking & Martin Wilson	Attached	11:05 – 11:15
Items to receive *[NB for information – matters to be raised by exception only]*:				11:15 – 11:30
11.	Director reports:			
	a. Joint Medical Directors Report; including: i) Guardian of Safe Working	Michael Wright & Lucia Pareja-Cebrian	Attached	
	b. Executive Director of Nursing Report; including: i) Nurse Staffing Six Monthly Deep Dive Report	Ian Joy	Attached & Board Reading Room	
	c. Maternity: i) Perinatal Quality Surveillance Report	Ian Joy & Jenna Wall	Attached	

	ii) Maternity Incentive Scheme progress report		Attached & Board Reading Room	
	iii) Maternity Safety Champion Report	Liz Bromley	Attached	
	d. Director of Quality & Effectiveness; including:	Lucia Pareja-Cebrian		
	i) Health and Safety Annual Report		Attached	
	ii) Learning from Deaths Report		Attached	
12.	Committee Chair Meeting Logs	Committee Chairs	Attached	
Items to approve:				11:30 – 11:40
13.	Board Assurance Framework (BAF) 2024/25	Rob Harrison	Attached	
Any other business:				11:40 – 11:45
14.	Meeting Action Log	Paul Ennals	Attached	
15.	Any other business	All	Verbal	

Date of next meeting:
Public Board of Directors – Friday 31 January 2025

Sir Paul Ennals, Interim Shared Chair

Sir Jim Mackey, Chief Executive Officer

Mr Rob Harrison, Managing Director

Mr Ian Joy, Executive Director of Nursing

Dr Michael Wright, Joint Medical Director

Mrs Lucia Pareja-Cebrian, Joint Medical Director

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

Mr Martin Wilson, Chief Operating Officer

Ms Annie Laverty, Chief Experience Officer

Mrs Caroline Docking, Director of Communications and Corporate Affairs

Mr Patrick Garner, Director of Performance and Governance

Mrs Kelly Jupp, Trust Secretary

Mrs Jenna Wall, Director of Midwifery

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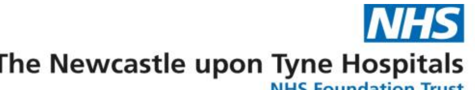

PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 27 SEPTEMBER 2024

Present:	Sir Paul Ennals *[Chair]*	Interim Shared 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
	Mr D Weatherburn	NED
	Mrs A Stabler	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]
Mrs A Laverty, Director of Patient and Staff Experience [DPSE]
Mrs J Wall, Director of Midwifery [DoM]
Ms L Hall, Deputy Director of Quality and Safety [DDQS]
Mr James Dixon, Associate Director – Sustainability [ADS]

Observers:
Mr R Purwal, Healthcare Director C2-ai
Dr A Dearges-Chantler, Public Governor for Newcastle
Mr S Volpe, Newcastle Chronicle
Mr T Nolan, NED at the Integrated Care Board (ICB) for Buckinghamshire, Oxfordshire & Berkshire West

Secretary: Mrs L Thompson Corporate Governance Manager / Deputy Trust Secretary

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

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24/20 STANDING ITEMS:

i) Apologies for Absence and Declarations of Interest

Apologies were received from Dr L Pareja-Cebrian, Joint Medical Director (JMD-PC).

The following declarations of interest were made:
- Sir Paul Ennals as the Chair at Northumbria Healthcare NHS Foundation Trust (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.
- Mrs Jenna Wall as Midwifery Clinical Lead for the North East North Cumbria Local Maternity and Neonatal System (LMNS).

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

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

The minutes of the meeting held on 23 July 2024 were accepted as a true record of the business transacted.

It was resolved: to **agree** the minutes as an accurate record and to **note** there were no matters arising.

iii) Chair's Report

The Chair advised that the report outlined activity and meetings attended since the last Trust Board meeting in July 2024. In addition the report had been expanded based on feedback from Governors to include further detail as to the key issues that the Chair had been discussing.

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

iv) Chief Executive's Report

The CEO highlighted the following key points:
- There is a great deal of work taking place within the organisation in relation to improving the Trust performance position.
- The Patient and Staff story on today's agenda which describes the important steps taken to humanise healthcare for families of babies with Congenital Heart Disease (CHD).
- The removal of the Care Quality Commission (CQC) licence conditions which is a huge step forward for the organisation.
- A focus on the future to address the CQC regulatory concerns and ensure services are fit for purpose in the long term.
- Due to a technological issue the performance infographic had not been included in the presentation but would be included for the next meeting.

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

24/21 <u>STRATEGIC ITEMS:</u>

i) <u>Patients: Patient Story</u>

The DPSE gave an overview of the patient story which focussed on care for the families of babies with Congenital Heart Disease (CHD). The Cuddle Project has thrived under the leadership of Rachel McConnell (Physiotherapist) and Catherine Forster (Occupational Therapist) who introduced an evidence-based approach of 'Developmental Care' to the Children's Heart Unit at the Freeman Hospital.

The JMD-W explained that this story highlights some of the innovations and positive work ongoing in this service area.

The Chair highlighted the affect that missing human contact may have on babies.

The MD advised that he had visited the Children's Heart Unit and observed firsthand the timely interactions and efforts by staff, including Play Specialists, and the educational support provided.

The EDN noted the positive use of leadership and quality improvement skills.

It was hoped that UNICEF accreditation could be achieved in the future.

The Chair referenced the positive impact the project had made on medical outcomes and thanked the team for their work.

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

ii) <u>Patients: CQC update</u>

The Chair explained that a detailed discussion took place at the Private Board of Directors meeting held earlier today.

The MD highlighted the following key points:
- An application was submitted to remove the conditions from the Trust licence in July. The Trust formally received notice on 3 September 2024 that all conditions had been removed following the implementation of an effective governance system. It was noted that the next phase of work was important in embedding the changes made to ensure safe, effective and high-quality care.
- A number of internal reviews as well as an independent external review is taking place with the support of thevaluecircule (tvc) to prepare teams for a re-inspection. The process will also identify areas for improvement with live feedback and support.

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The Chair queried departmental level assurance to which the EDN explained that the next step is to test impact at ward and department level and that rapid Quality and Safety reviews are now taking place across service areas. He highlighted the importance of learning from best practice which has been completed following the first review in Theatres and moving on to Outpatients. A review of the outcomes from the reviews will take place in October, and this will be presented to the Quality Committee in November.

The Chair noted the positive removal of the licence conditions, the progress on the Clinical Board quality priorities and the Quality and Safety reviews to ensure full ward to board assurance.

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

iii) <u>Performance: Integrated Board Report</u>

The MD highlighted the following key points on behalf of the Executive Directors:

- Work is ongoing to ensure that the highlights from each key area within the report are clear, succinct and easy to understand.
- In relation to elective performance, progress has been made with regards to reducing long waiters.
- Some cancer standards are now being met however there is still further work to do.
- The aim during the winter period is to reduce infection control markers, focus on health and wellbeing of staff, reduce sickness levels and increase resilience throughout the winter period.

Mrs Stabler highlighted that Infection, Prevention and Control (IPC) is discussed in detail at the Quality Committee especially in relation to Clostridium difficile (c.diff) and looking at environmental standards as well as clinical practice. The Chair queried if the Trust is an outlier to which Mrs Stabler confirmed that locally it is an outlier. Antibiotic compliance is also a regular discussion topic at the Quality Committee and has recently included a deep dive.

The Chair noted the progress with regards to MSSA and noted that it is sometimes difficult to differentiate between what is an internal case and a case which initiated in the community.

Mrs Stabler explained that a great deal of work has taken place with regards to c.diff however there is still work to be done to understand the decline in performance, and that funding was put into pharmacy to support this work. The EDN advised that avoidable and unavoidable cases were subject to detailed review.

Mr McCardle reported the positive shift to Statistical Process Control (SPC) charts and dashboard reporting. He highlighted that the People Committee are looking at more targeted areas as to where there are trends and patterns.

Mr MacLeod referred to the Health Inequalities section of the report and queried if there is anything to highlight to Trust Board. The MD confirmed that the reporting is in its early

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stages of development. The COO advised that Health Inequalities is transitioning to JMD-PC as Executive Lead and that the Quality Committee received a detailed update at the September meeting. Work is taking place with the local Council and communities to reduce health inequalities.

Mr Kane suggested for future reports to be more succinct, with clear mitigations for deteriorating areas of performance. He also recommended that the sufficient triangulation between reports is undertaken, citing for example the Medical and Dental appraisal information shows a more negative position in the Integrated Board Report but more positive in the Joint Medical Directors Report.

The Chair summarised that there is good news and areas of concern in the report that the Trust Board are aware of however there has been real progress with regards to electives. Further work will take place in relation to IPC and deep dives with regards to people trends.

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

24/22 ITEMS TO RECEIVE

i) Director reports:

a. Joint Medical Directors Report; including:

The JMD-W highlighted the following points:

- Ongoing work with regards to the implementation of the Patient Safety Incident Response Framework (PSIRF) and Serious Incidents (SI) backlog.
- Concerns remain in relation to the 62-day cancer performance in several tumour groups however there is work taking place to improve the position.
- Delivery against the Cardiothoracic action plan continues.
- Positive work is ongoing in the Research and Innovation team. The Clinical and Research Services Clinical Board is being amended to move Research services to sit within a Corporate service.
- With regards to patient safety and quality of care in pressurised services, the EDN, JMDs and MD oversee the progress on the action plan which includes challenges within Urgent and Emergency Care and ensuring to maintain core quality of care.
- In relation to the Perfect Week exercise, there are ongoing discussions at the appropriate meeting forums, including the Trust Management Group (TMG) regarding the amount of learning.

  The Chair requested a brief explanation with regards to the outcomes of the Perfect Week. The JMD-W explained that Urgent and Emergency Care performance improved during the Perfect Week but then declined the following week. Some staff were redeployed on a voluntary basis to support flow throughout the hospital and out of the Emergency Department. The JMD-W highlighted that improvements need to be made with regards to communication. Jo McCallum, Senior Project Manager for Transformation was currently analysing the data from the Perfect Week.

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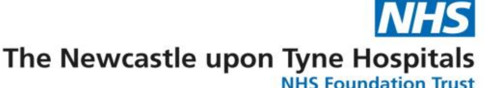

The MD highlighted the importance of incorporating positive changes into daily practice, the discharge lounge and the escalation process. Some will be included in the Winter Plan as part of the escalation process going through that period. The MD advised that a review would be commenced to look at how clinical teams are supported by admin staff.

A similar process would be adopted to take the key principles and apply to cancer pathways to develop the 'Perfect Pathway'.

The DPSE explained that patients that were inpatients, outpatients and users during the Perfect Week have been asked to feedback their experience compared to a normal week from the previous month.

The DCDI advised that a discussion took place at the most recent Clinical Policy Group (CPG) in relation to taking key principles and applying them to communication, with consistency of application noted to be important.

- Completion of the Appraisal and Revalidation Annual Report and Compliance Statement, was a regulatory requirement. The Concerns Oversight Group (COG) has been created which is chaired by the JMDs with input from senior Human Resources (HR) representatives and Quality and Safety representatives to discuss any matters regarding conduct and capability. This group will report into the People Committee. Overall compliance for appraisals 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 absence. The Trust is working with the Medical Education team to streamline the absence process with regards to the Lead Employer Trust (LET) as this remains a challenge.

  It was noted that NHS England have requested specific data that they have not previously asked for. The data had been difficult to extract but had now been extracted and would be included.

  The JMD-W highlighted that there are ongoing issues ensuring appropriate engagement especially in relation to appraisals and this will be included in the new job planning process.

The TS agreed to facilitate the signing of the agreed Appraisal and Revalidation Annual Report and Compliance Statement by the CEO **[ACTION01].**

Mr Nolan queried what is preventing the Trust from doing 52 Perfect Weeks. The JMD-W explained that many staff were redirected from their routine jobs and observers have helped collate the data which was sustainable for a period of time leading up to and during the Perfect Week. The question has been asked at the CPG as to the prioritisation of roles and responsibilities in relation to the lessons learned from the Perfect Week.

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Mr McCardle referred to incident reporting and noted that it is encouraging to see the increasing number and that this highlights the value of being heard under the People Plan which is a key element of speaking up.

It was **resolved:** to **receive** the report and **approve** the Appraisal and Revalidation Annual Report and Compliance Statement.

i) Consultant Appointments

The JMD-W referred to action 114 on the action log which related to including biographies of the successful candidates in the Consultant Appointments report. A discussion ensued and the Board of Directors agreed to close this action and remove the report from the Public Board of Directors agenda going forward as the Board of Directors are not required to ratify the appointments.

It was **resolved:** to **(i) receive** the report and **(ii) endorse** the Consultants Appointments made.

ii) Guardian of Safe Working

The JMD-W explained that the Guardian of Safe Working (GoSW) report is included to monitor the Trust's compliance with the requirements of the Junior Doctors contracts. The data is in line with what has been reported to Trust Board previously.

Mr McCardle noted that he is keen to continue to see GoSW updates as part of the JMD report on a quarterly basis. The Chair said that it would be useful to receive a summary of trends in the report to show how the data differs to the previous quarter and the TS agreed to feedback to the GOSW **[ACTION02].**

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

b. Executive Director of Nursing

The EDN highlighted the following points:

- In relation to the Spotlight on Nursing, Midwifery Research, Research Development Institute (RDI) Fellowships have been funded through the Newcastle Hospitals Trust Charity. Research has been embedded within areas around the organisation such as Paediatrics, Dietetics, Clinical Outcomes, and also regionally and nationally.
- With regards to Nursing and Midwifery Staffing, nurse staffing is currently at escalation level 2 and mitigations are in place. Two wards have required high level support which has been overseen through the Quality Committee and following a peer review, one ward has been de-escalated. There is a peer review scheduled with the aim of de-escalating the second ward in the coming weeks.
- Datix and red flag reporting trends are closely monitored. There has been a reduction in both with a reciprocal increase in fill rates.
- The Safeguarding and Mental Capacity Act (MCA)/Deprivation of Liberty Standards (DoLS) and Learning Disability quarter one reports have been discussed in detail at the

Quality Committee meeting. It was noted that the teams are dealing with increasingly complex issues and there has been an increase in referrals.

- An overview is included in the report relating to statutory and mandatory training for Safeguarding Adults and Children and the Mental Health Act.
- The winter vaccination programme will commence next week and a Steering Group is being established to maximise updates and communications.

The CPO explained that work is underway in relation to safe staffing levels and how staff are feeling. The EDN highlighted the work that has taken place over the last year with regards to International Nursing recruitment. He explained that there has been an increase in the numbers of new staff which wards feel is a positive step however there is a great deal of focus on looking at skill mix.

[The JMD-W left the meeting at 13:45].

Mrs Bromley referred to the 15 apprentices in health and social care and queried if the organisation can make the apprenticeship model work better and for this to be included in the workforce planning. The EDN explained that work is taking place nationally with regards to finding a sustainable model to support apprenticeships particularly in relation to higher level apprenticeships. It was agreed that the EDN and CPO would share more detail regarding the work underway to maximise apprenticeships and some of the challenges faced in sustainable delivery with Mrs Bromley, and the Chair, the EDN, the CPO and Mrs Bromley meet to discuss how to increase the use of apprenticeships across the Trust. **[ACTION03].**

The Chair sought clarification with regards to the increasing adult safeguarding numbers. The EDN advised that more patients are accessing services due to self neglect and domestic abuse, across a wider demographic. Mrs Stabler noted that she had attended a successful visit by the regional Learning Disability Network.

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

[The DCCA left the meeting at 13:50].

c. <u>Maternity</u>

i) <u>Perinatal Quality Surveillance (PQSM) Report (formerly named the Maternity Update report)</u>

The DoM advised that the Board of Directors is asked to support the proposal to incorporate the PQSM measures into the Integrated Board Report. The report provides assurance in relation to the safety of the service and the national drivers of the Three-Year Plan and summaries the Trust’s compliance.

The DoM highlighted the risks in relation to antenatal and newborn screening services and antenatal triage performance.

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

Mrs Stabler confirmed that this has been discussed in detail at the Quality Committee meeting.

It was **resolved**: to **(i) receive** the report and **(ii) approve** the proposal for incorporating the PQSM measures into the Integrated Board Report, with monthly minimum data measures in the interim and **(iii) approve** along with ICB Director of Nursing, the Oversight Framework enhanced surveillance exit criteria.

ii) **Maternity Incentive Scheme (CNST) Report (FOR APPROVAL)**

It was **resolved**: to **receive** the report and **approve** the self- assessment to date to enable the Trust to provide assurance that the required progress with the standards outlined are being met, and where there are risks of non-compliance note the actions.

iii) **Maternity Safety Champion Report**

Mrs Bromley highlighted the following key points:

- Anonymous feedback was received from patients which included being well looked after, feeling safe and feeling cared for.
- There has been a positive change in leadership, and this includes progress regarding staff and patient engagement.
- Concerns were raised in relation to the Maternity Services estate.
- Support is being provided to the Maternity Admissions Unit (MAU) due to the vacant consultant posts.
- Examples were provided on very complex and challenging social and safeguarding cases, which understandably causes anxiety for the staff involved.
- Overall, the department is very busy with a great deal of challenges however the staff are doing extremely well.

Mrs Bromley advised that the People Committee has oversight from a people perspective.

The DoM advised that a Consultant Obstetrician has been appointed this morning which is good news for the hard-working team. The DQE explained that she has visited the department recently and noted the optimism and positive impact of the new DoM. The DoM highlighted the positive progress made and that staff are looking forward to the future however noted the ongoing challenges.

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

d. **Board Visibility Programme**

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The DQE advised that the Board Visibility Programme has been reviewed and revised since the CQC inspection. She noted that the programme is going well however there are some areas of improvement. The DQE suggested including a theme with each of the walkabouts for example complaints or staffing issues. The DPSE suggested having further detail within the Trust Board 'Reading Room' within Admin Control. The CEO said that it would be useful to expand on actions and issues raised. The Chair noted the importance of the Trust Board having a sense of the issues.

It was agreed that the TS would feedback the request to include key themes in the main Public Board report to the report author and to ensure that the detailed Appendix is included in the Reading Room going forwards **[ACTION04].**

Mrs Stabler explained that she undertook a visit to Ward 34 at the Northern Cancer Care Centre (NCCC) and met a Health Care Assistant (HCA) called Millie Clough who demonstrated thorough knowledge and understanding of the Ward itself and in escalating patients where required. Mrs Stabler confirmed that she submitted a Greatix following this visit. The Chair suggested to contact the areas visited to thank them for their input into the visits after the visits have taken place.

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

e. Committee Chair Meeting Logs

In relation to the Finance and Performance Committee, Mr MacLeod noted the continued financial and capital programme pressures and the work taking place to achieve the year end outturn.

In relation to the Audit, Risk and Assurance Committee, Mr Weatherburn explained that a discussion took place in relation to ensuring the Committee Chair Meeting Logs contain specific narrative relating to the Board Assurance Framework (BAF).

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

24/23 ITEMS TO APPROVE:

i) Shine (Sustainable Healthcare in Newcastle) Update – Annual Shine Report 2023/24 and Carbon Reduction Plan

The Chair highlighted that he is the NED sustainability champion.

The ADS highlighted the following key points:

- An extract of the Shine Report is included within the Trust Annual Report.
- The excellent work taking place is included within the report.
- In relation to the Carbon Reduction Plan, if the Trust does not receive capital funding, it will be difficult to achieve but there are plans in place with some funding available.

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- Funding was received to decarbonise Regent Point, use all-electric buses from the local operator Go North East for the staff hopper service and reduce emissions from anaesthetic gases which are potent greenhouse gases.
- The eight Shine themes were discussed in detail.
- The Born Green Generation at Newcastle Hospitals has been launched which is a movement to protect babies from harmful effects of plastic and chemicals.
- Over the next three years, the Trust is embarking on a unique project with Health Care Without Harm Europe and European healthcare institutions and universities.
- The carbon reduction has been embedded into the Trust's procurement processes.
- The challenges within the report relate to capacity, the lack of funding and the increase in annual energy costs.

The report was presented at the September People Committee and requires Trust Board approval.

The Chair highlighted that this work should be embedded in the medium-term plan/Big Build project. The CEO noted the constraints in the current environment and build but that the organisation could make this a real exemplar. The DoE advised that the work will be included as part of the Big Build project. The Chair noted that when planning a hospital programme for next 30 years, sustainability should be a core principle.

Mrs Bromley sought clarification with regards to the Green Champions. The ADS advised that Green Champions are nominated and that there are several staff who obtain sign off from managers to have more dedicated time. The organisations also have 22 sustainability ambassadors however there is no funding in job planning. The aim is for the Clinical Boards to have sustainability leads.

Mr Weatherburn noted that the Corporate Induction session was well received, and the sustainability champions presented well.

Mr McCardle noted the positive recognition and clear risks within the report. He highlighted that there were no mitigations to the risks identified in the report and that there is a need to think about dedicated resources and budgets.

The Chair requested that the Executive Team discuss the risks highlighted in the Shine Report presentation and feedback to Board members thereafter **[ACTION05].** The DCDI explained that discussions are ongoing with regards to where sustainability updates sit as it is currently with the People Committee.

The ADS highlighted the importance of champions having a voice at the Clinical Boards. The DCDI explained that it is a request from TMG to identify a champion and embed within the Clinical Board structure. The CPO said that there is an opportunity to utilise skills from each ambassador role as there are different ones within the Trust.

The Trust Board approved the publication of the SHINE Annual Report and the Carbon Reduction Plan.

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It was **resolved**: to **(i) receive** the report and **(ii) approve** the publication of the SHINE Annual Report and **(iii) approve** the Carbon Reduction Plan.

ii) Board Assurance Framework (BAF) 2024/25

The MD explained that the BAF has been revised as part of governance system changes made earlier in the year. He highlighted that each Committee is responsible for reviewing their associated risks. The recommendation for Trust Board is to review and approve the BAF.

Mr Weatherburn advised that the Audit, Risk and Assurance Committee recommended the BAF for Trust Board approval.

It was **resolved**: to **(i) receive** the report and **(ii) approve** the Board Assurance Framework.

iii) People Committee Schedule of Business (SoB)

The proposed changes to the SoB were received.

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

24/24 ANY OTHER BUSINESS:

i) Meeting Action Log

The action log was received, and the content noted. The actions proposed for closure were agreed. Regarding action 122 [sharing key messages], the CPO advised that key messages were now being shared from the Staff Facebook page, increased staff communications and triangulated with other feedback mechanisms. The staff survey will launch on 7 October and the impact of the People Plan will be discussed regularly at the People Committee. All agreed that the action be closed as complete.

ii) Any other business

On behalf of the Board of Directors, the JMD-W thanked the DQE for all her hard work and dedication to the organisation and individuals over the years. He highlighted the DQE's extensive knowledge of the organisation and her helpful advice and wisdom. The JMD-W wished the DQE a happy retirement.

The CEO thanked the DQE for her commitment and support.

The Chair summarised the meeting and noted that feedback is welcome.

The meeting closed at 14:21.

Date of next meeting:

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Public Board of Directors – Friday 29 November 2024

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Agenda item A3

TRUST BOARD

Date of meeting	29 November 2024		
Title	Chair's Report		
Report of	Sir Paul Ennals, Interim Shared Chair		
Prepared by	Sir Paul Ennals, Interim Shared Chair Gillian Elsender, Corporate Governance Officer and PA to Chair and 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: • Spotlight on Services • Governor Activity • Trust Board • Alliance • Relationships with Primary Care • NHS Providers • Sustainability and Health Inequalities • Engagement with Regional Partners • Shared Chair Opportunities		
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

1. INTRODUCTION

I am now into my fourth month with the Trust, during which time I have continued to visit various departments – clinical and back office - and meet with many staff members, as well as attending Town Hall events, and the full range of Board Committees, all of which has allowed me to understand emerging issues, risks, assurances and get a real feel for the organisation. I was pleased also to meet with staff side – the collection of representatives from the various unions that operate within our Trust, and was given a warm welcome.

I was delighted to attend our Celebrating Excellence Awards on 27 September where I had the privilege of presenting the awards to our staff who have displayed amazing examples of care, compassion and expertise to support our patients and colleagues.

2. SPOTLIGHT ON SERVICES

Since the last Trust Board meeting, we have continued with two Spotlight on Services events for Non-Executive Directors (NEDs), both of which were in person sessions to Maternity Services and to Rehabilitation Services. Feedback from our NEDs who attended the maternity visit highlighted that from the outset it was evident that we have great teams delivering expert care to mothers and babies.

Our second visit was to Rehabilitation Services at the Royal Victoria Infirmary (RVI) where the NEDs and I visited a range of out-patient clinics, rehabilitation gyms and therapy treatment rooms, meeting several inspiring and passioned staff. Further details of our Leadership Walkabouts and NED informal visits are included in the Board Visibility Programme within the Public Board meeting papers for information.

3. GOVERNOR ACTIVITY

I continue to work collectively with our Council of Governors both formally and informally and during this period attended both the People, Engagement and Membership (PEM) Working Group (WG) and the Business & Development (B&D) WG. At the PEM WG we discussed how Governors could engage with their constituencies and the wider community to understand how we can better serve our patients and at the B&D WG we received an update on the Digital Innovation being undertaken within the Trust to help improve the patient experience.

In addition to the above, other Governor and Member activity since our last Public Board meeting has included:

- The Quality of Patient Experience (QPE) WG.
- A formal Council of Governors meeting.
- A briefing session on recent developments with the Great North Healthcare Alliance (the Alliance).

- Monthly Governor “Drop In” Sessions. Early days for this new venture, but I am encouraged by the willingness of governors to discuss ideas in a more relaxed way, and to enable me to test ideas and emerging thoughts amongst trusted friends.

4. TRUST BOARD

As we continue on our journey of improvement we have been focussed as a Board on setting the priorities for the Board’s Development, reflecting on the outcomes of our recent mock inspection and the rapid development and improvement during 2024. Focus has also been on developing our Medium-term Plan, incorporating ambitious targets for performance recovery whilst always keeping quality and safety at the forefront.

5. ALLIANCE

The development of the Alliance continues, having been formed because the member Trusts believe that there is huge potential to work together to deliver significant benefits to patients and staff within each organisation and in the wider region. We report elsewhere on the progress developing the Alliance – here let me mention that I meet monthly with all the Chairs and Chief Executive Officers (CEOs), and additionally just with the Alliance Chairs. I also meet regularly with the two CEOs of Newcastle Hospitals and of Northumbria Healthcare NHS Foundation Trust (‘Northumbria FT’), to monitor and review progress on developing our strands of joint working. The Northumbria FT CEO meets also with Newcastle’s Deputy CEO to drive a Joint Board, who are now showing real progress in aligning clinical pathways in respiratory, cardiology, urology, audiology and other clinical areas.

6. RELATIONSHIPS WITH PRIMARY CARE

I have been focussing on exploring the relationship between our Trust and the primary care community within Newcastle. To that end I have met the key Integrated Care Board (ICB) lead for our patch on primary care, David Jones; with the Newcastle Federation of GPs Chair and CEO, and recently I spoke to 150 primary colleagues at a “GP time out” bringing together colleagues from the 29 GP practices across the city. The express interest of our CEO has also been evident wherever I go. Especially at a time when primary care has introduced collective action, our discussions as to how we can build a new and stronger relationship are somewhat cautious, but the early soundings are positive, and as we develop our new strategy, I am confident we can explore some new shared ambitions as to how primary care can work better with secondary and tertiary care as one NHS.

7. NHS PROVIDERS

I have attended an NHS Provider Conference in London, focussing in particular on models of collaboration (groups, mergers, collaborates etc), partly in order to meet other chairs who

span more than one trust. The conference also focussed on the potential for trusts to serve as anchor institutions, throwing up in particular the potential for wider partnerships with universities and with other public sector bodies. The relationships formed through these occasions gives me, and therefore the Trust, access to a wider range of expertise and views than we could otherwise hope to meet internally.

8. SUSTAINABILITY AND HEALTH INEQUALITIES

I have attended two meetings of the Net Zero North East England Board, on behalf of the ICB. As well as seeing the progress of this cross-sector coalition that has been founded, it is now an opportunity for the trusts to explore creative opportunities for collaborating with the major businesses within the region, and with the combined authority. The Board is now co-chaired by the Mayor Kim McGuiness and the CEO of Northumbrian Water Heidi Mottram. North East Combined Authority (NECA) has additional opportunities to bring inward investment to the region, which provides some opportunities for us to make greater progress in achieving our net zero goals, and sharing our own progress across a wider footprint.

I now also serve on an Advisory Committee for NECA on the Environment, Rural Issues and Health Inequalities, chaired by the leader of Northumberland Council. Whilst this group is still in its infancy, it provides us with the chance to align our own activities around health inequalities with NECA. As NECA's remit is negotiated with Government to extend its reach, our partnership with them provides extra opportunities for accessing additional funding and support from Central Government, in parts of the Whitehall jungle where our current contacts do not reach quite so effectively.

9. ENGAGEMENT WITH REGIONAL PARTNERS

During this period, I have met three times with the ICB Chair and CEO (and other senior ICB officers), along with the other ICB Foundation Trust (FT) Chairs. We have discussed national developments and their impact on our region; common approaches to leadership; the financial situation within the ICB, and other issues. These regular meetings – with regular pre-meetings just for chairs – has enabled the chairs to develop a friendship network which facilitates joint working across the patch.

I am a member of the North East Child Poverty Commission, and in this guise have met with the Mayor Kim McGuiness to discuss how FTs can contribute to the drive to tackle child poverty in our region. Our status as a Real Living Wage employer means we have a good story to tell, but there is more we can do, as an anchor institution within the city, to impact much more widely on child poverty with all the impact it has on child health, learning from colleagues outside the Trust.

10. SHARED CHAIR OPPORTUNITIES

Given this report focusses also on my interactions outside the Trust, it is appropriate to reference my role chairing Northumbria FT. My engagement there with the trust at every level, with its primary care partners, with the universities in the city and with many of Northumbria's other partners enables me to promote the work of Newcastle Hospitals, share ideas, gain insights and encourage new partnerships, which are only partly captured in our regular reports on Alliance activities.

11. RECOMMENDATION

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

Report of Sir Paul Ennals
Interim Shared Chair
20 November 2024

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Agenda item A5

TRUST BOARD

<table>
<tr><td>Date of meeting</td><td colspan="3">29 November 2024</td></tr>
<tr><td>Title</td><td colspan="3">Relative’s Story</td></tr>
<tr><td>Report of</td><td colspan="3">Mrs Annie Laverty, Chief Experience Officer</td></tr>
<tr><td>Prepared by</td><td colspan="3">Mrs Annie Laverty, Chief Experience Officer
Ms Catherine Carr, Head of Nursing – Medicine and Emergency Care</td></tr>
<tr><td rowspan="2">Status of Report</td><td>Public</td><td>Private</td><td>Internal</td></tr>
<tr><td>☒</td><td>☐</td><td>☐</td></tr>
<tr><td rowspan="2">Purpose of Report</td><td>For Decision</td><td>For Assurance</td><td>For Information</td></tr>
<tr><td>☐</td><td>☐</td><td>☒</td></tr>
<tr><td>Summary</td><td colspan="3">Our story this month describes a relative’s experience of emergency care. The relative is also a staff member of the Trust.

The story highlights a department under extreme pressure with many areas for improvements including, support for and communication with patients and relatives from reception and nursing staff, pain management, infection control and patient safety.

To provide some context, on this occasion, there was a significant incident underway which involved many members of the public in the department and a very significant police presence. This was in addition to having a large volume of patients in the department. It was a particularly challenging day for all staff on duty.

The department has used this story, and others, as a focus for improvement. The team has also developed a patient charter, to support both patients and staff’s understanding of what standards are expected within the department. Some of these expectations are around what care we would not expect to happen on a corridor, even in the most difficult of circumstances.

It is important to say that the team want to avoid corridor care as much as possible, but due to high levels of attendances and patient flow challenges this has been necessary. When patients are on the corridor they are placed in a designated space with a number on the wall and a call bell.

Actions taken by the Emergency care leadership team:
▪ Feedback to the teams around this individual patient feedback to aid reflection around compassion and communication, with the subsequent development of a team privacy and dignity charter.
▪ Utilising feedback received from The Value Circle and their reflections on corridor care and other aspects of care delivery.
▪ A workshop for the senior team planned for the 12 December 2024 to work through improvement plans on what further can be done to support the quality of care within the Emergency Department (ED), this will cover corridor care & waiting room in addition to other workstreams such as Triage.</td></tr>
</table>

<table>
<tr><td></td><td colspan="6">Work to improve flow through a daily rhythm of touchpoints throughout the day to support escalation and provide support to various teams. A second flow facilitator has been appointed to support this.
Our Doctor in charge and Nurse in charge have come together to support better and faster communication on patient management plans.
Guideline in place to aid improvements into specialities to support a more engaged process of reviewing patients who require this support.
The nursing team improving the way patients around the department to aid privacy and dignity where practically possible and to meet care needs as efficiently as possible.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Board are asked to receive this story for information and to note our commitment to transparency and learning from all experiences of care.</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 standard focusing 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">Linked to key areas in the BAF relating to Effective Patient Safety and Workforce, these stories are associated with the strategic aims of putting patients at the heart of everything we do and providing care of the highest standard focussing on safety and quality.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Patient and People stories are a recurrent feature of all Public Board meetings.</td></tr>
</table>

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

A relative's reflections on care in the Emergency Department in May 2024

Patient A attended the Emergency Department (ED) initially on the Friday with chemical burns to both legs. They had a 4-hour procedure to treat their injuries and were sent home with painkillers.

The patient returned to the ED the next day due to pain. He was taken in by friends, and his relative. It was extremely busy as there had also been a significant incident that day and there was a huge police presence.

Patient A's relative witnessed an altercation between a member of the public and a receptionist. The member of the public was with a gentleman and was asking for help. They were concerned about the time this gentleman had already spent in the ED given his presenting symptoms. She witnessed the receptionist responding in a way which lacked compassion and seemed aggressive and confrontational, alluding to the fact that there were more important things happening in the department at the time. The member of the public said they would be going to the press and the staff member again responded in a defensive and dismissive way.

The relative was genuinely concerned by what she had witnessed as she felt this could have been addressed with more compassion to de-escalate the situation.

The relative was also concerned that Patient A was in a great deal of pain. She approached the staff nurse in the ED who was at the reception desk and requested some analgesia. The relative felt that this request was dismissed, and she was asked to wait. The relative persisted and the nurse said they would get some pain killers which was provided.

The relative was struggling to move the chair that patient A was in and was asked to move out of the way. She wanted to explain to the receptionist (a different receptionist) why she was struggling to get out of the way, but the receptionist would not engage in a conversation and responded in a way which seemed aggressive. Patient A was booked in and returned to the main waiting area. A wait of 10 hours was registered on the board.

The patient's pain increased so the relative returned to the reception desk to request a stronger pain killer. The patient was then moved into the first corridor. The relative struggled to find a member of staff to help with providing pain killers and this took a considerable time. A nurse arrived with drugs for two patients. She identified another patient and gave them tablets. The relative did not think that the nurse had undertaken an appropriate check for these drugs. The nurse then walked up and down looking for patient A. The nurse recognised the relative of patient A and handed over the medication with the relative to give to the patient.

Whilst waiting, a patient ('Patient B') was brought into the corridor accompanied by relatives. Patient B appeared to be experiencing seizure like activity. Initially a member of staff was present. Patient B continued to experience symptoms whilst sitting in a chair and her family requested some help and staff arrived and stood with patient B. When the symptoms settled the staff member left. A staff nurse stopped as patient B was having another episode of symptoms. Again, when it settled, the staff nurse left.

Patient A was transferred into a treatment room and waited for the plastic surgeon. A nurse removed and redressed the patients legs. However, the dressing fell off as patient A was moved back into the corridor to wait again.

Patient A was seen by a resident doctor. He asked about the dressings and suggested that the dressings put on were inappropriate. The doctor took patient A back into the treatment room and re-dressed the wounds, however there was not an appropriate surface to put the dressing pack on.

Patient A was in a lot of pain, so the doctor gave the relative a prescription for pain relief. Patient A wanted to go home as he was too distressed to stay. The doctor suggested that admission could have been considered on the Friday night attendance.

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Agenda item A6

TRUST BOARD

Date of meeting	29 November 2024					
Title	Board Visibility Programme					
Report of	Louise Hall, Deputy Director of Quality and Safety					
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 process and focus of the Leadership Walkabouts and Non-Executive Director (NED) informal visits, which are collectively known as the Board Visibility Programme. The Executive and Non-Executive Directors 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. 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 leadership walkabouts and informal visits that were undertaken in September and October by Senior Leaders, Executives and NEDs. Eighteen walkabouts were conducted. It also provides a summary of key themes identified during the walkabouts/visits undertaken, as well as both positive feedback and areas for improvement. Overall, staff felt able to raise any concerns and report incidents and were proud of their work and the patient care they provide. Areas of improvement which were identified include staffing resource, space and capacity issues, outstanding Estates work and frustrations with lack of, or not fit for purpose equipment.					
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	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability

(please mark as appropriate)	☐	☐	☐	☒	☐	☒
Link to Board Assurance Framework [BAF]	Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.					
Reports previously considered by	The previous Leadership Walkabouts and NED Informal Visits Report was presented to the Quality Committee and Trust Board in September 2024.					

BOARD VISIBILITY PROGRAMME

1. INTRODUCTION

The objective of the Board Visibility Programme is 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 pre-existing 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.

This report provides an overview of the findings from the 18 walkabouts and visits undertaken during September and October. During this time nine scheduled Leadership Walkabouts were cancelled due to an unexpected change in availability at short notice.

2. PROCESS

The leadership walkabout programme involves two 'streams' which run in parallel each month:

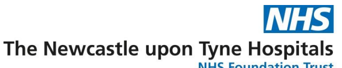
Stream 1 [Leadership Walkabouts]: Two senior leaders (Executive Team, Directors of Operations, Board Chairs, Associate Directors of Nursing, other senior managers within the Trust (8C and above) and senior managers from the Clinical Governance and Risk Department (CGARD)) participate in a one-hour joint visit to a pre-defined clinical or corporate area. Within this the Director of Operations and Clinical 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, or to an area that they are interested in visiting. 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/NED visits 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 are asked to provide a free-text summary report which highlights what they felt were the most important themes from the staff they spoke to. The template allows the inclusion of brief details of any issues addressed during visits and if any further action is required. The data is then collated by the CGARD (combined with the NED visits information) and presented in this report.

3. SUMMARY OF FINDINGS

As part of the programme the aim is for a minimum of eight Leadership Walkabouts to take place each month. The table below summarises the 18 walkabouts undertaken at the Royal Victoria Infirmary (RVI) and Freeman Hospital (FH), eight within stream one and ten by the NEDs, as part of stream two. Further detail is provided in the Summary of Findings Report in the Board of Directors Reading Room.

Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
Stream One	Ward 15	RVI	Associate Director of Operations (DOps)	Ward Sister, Staff Nurse, Domestic Staff
	Pre-assessment Unit	RVI	Director of Communications and Corporate Affairs and DOps	Matron, Sister, Technical and Nursing Staff, Receptionist
	Catering	RVI	Associate DOps and Head of Facilities	Catering Manager and Quality Monitoring Manager
	Catering	FH	Associate Director of Nursing and Patient Safety Incident Response Framework (PSIRF) Implementation Lead	Catering Assistant, Cook, Deputy Catering Manager
	Ward 46	RVI	NED, Deputy Director of Quality and Safety, Associate DOps	Junior Sister
	Neuroradiology	RVI	Chief Operating Officer and Head of Nursing	Head of Department, Radiographers, Consultant
	Pharmacy	RVI	Chief Information Officer and Deputy Director of Pharmacy	Head of Operations

Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
	Ward 1b	RVI	DOps and Deputy Director of Estates	Sister, Staff Nurses, Domestic staff
Stream Two	Northern Medical Physics and Clinical Engineering	FH	NED	Associate DOps and Business Manager
	Outpatients	FH	NED	General Manager, Assistant Operational Manager and Matron
	Ward 34 and Coronary Care	FH	NED	Nursing staff, HCA
	Ward 44/47	RVI	NED	Ward Sister, Nursing staff
	Mortuary	RVI	NED	Not specified
	Cardiothoracic	FH	NED	Patients, Matron Medical staff, nursing staff and physiologists
	Paediatric Intensive Care Unit and Ward 23	FH	NED	Head of Nursing, Consultants, Senior Sister
	Therapy Services	RVI	NED	Associate DOps and various members of the team
	Palliative Care	RVI	NED	Clinical Director, Senior Nurse and Nurse Specialist
	Rheumatology	RVI	NED	Operational Service Manager, Sister, Ward Clerk

There were several issues raised requiring immediate action or escalation:

- A floor tile was cracked, and a door was broken in Catering, RVI. This had been reported several times.
- Enquire about an issue regarding suitable mops on Ward 15.
- Follow up the status of a business case for relocation of the GAIT laboratory.
- Consideration about capacity for staff Christmas lunches.
- Bathroom on Ward 46 awaiting work to be carried out for over a year to be escalated to Estates.
- Follow up on reporting radiographer training and roles within the Clinical Board.
- Digital Health and Delivery Teams to follow up issues identified on the Pharmacy visit related to automated alerts for Pharmacy when discharges are entered on Cerner, implementing the new DEPART process in Cerner that identifies medication changes

for discharge, closed loop medication process linked with Pharmacy stock control and the deployment of dispensing robots on all wards.
- In Physiotherapy there are 15 permanent and 22 temporary posts. This requires new applications every three months (220 last time) and interviews. Each temporary post must be processed individually by Finance.
- Discussed access (improved signage etc.) and requested this is considered when the Urgent Treatment Centre (UTC) is being built.
- Consider deep dive into specific services for a future Quality Committee meeting e.g. Physiotherapy.
- Review the 42-week funding model in community podiatry, for further discussion with the Integrated Care Board (ICB).

Emerging Key Themes:
- All wards visited were clean and tidy with a calm feel.
- Overall, staff are proud to work in Newcastle Hospitals and work together to deliver an outstanding level of service.
- All staff were aware of Freedom to Speak Up and would feel comfortable doing so.
- There were mixed responses to the Perfect Week. In some areas it had worked well, and staff felt positive. In other areas they found it more stressful and felt it did not give a true reflection of usual activity.
- There were frustrations with lack of available and fit for purpose equipment.
- Some nursing staff were unaware of PSIRF.
- Technology issues were raised in several areas.
- Staffing challenges are ongoing.
- Space and capacity remain an issue in all areas.

4. RECOMMENDATION

To receive the report and note the content.

Report of Louise Hall, Deputy Director of Quality and Effectiveness
Prepared by Fiona Gladstone, Clinical Effectiveness Advisor

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PUBLIC TRUST BOARD

<table>
<tr><td>Date of meeting</td><td colspan="6">29 November 2024</td></tr>
<tr><td>Title</td><td colspan="6">CQC Update</td></tr>
<tr><td>Report of</td><td colspan="6">Rob Harrison, Managing Director
Ian Joy, Executive Director of Nursing</td></tr>
<tr><td>Prepared by</td><td colspan="6">Ellspeth Marshall, Project Manager</td></tr>
<tr><td rowspan="2">Status of Report</td><td colspan="2">Public</td><td colspan="2">Private</td><td colspan="2">Internal</td></tr>
<tr><td colspan="2">☒</td><td colspan="2">☐</td><td colspan="2">☐</td></tr>
<tr><td rowspan="2">Purpose of Report</td><td colspan="2">For Decision</td><td colspan="2">For Assurance</td><td colspan="2">For Information</td></tr>
<tr><td colspan="2">☐</td><td colspan="2">☒</td><td colspan="2">☐</td></tr>
<tr><td>Summary</td><td colspan="6">This report provides a summary of key highlights including:
- Improvement planning moved into Phase 2 with a focus on testing impact at all levels across the organisation.
- The second cycle of the Rapid Quality and Safety Peer Reviews has commenced with a focus on areas not included in the first cycle to ensure the majority of the organisation is covered.
- The independent review carried out by ‘thevaluecircle’ (TVC) focused on the Emergency Department and Surgery. The Trust is awaiting the final report whilst initial feedback of key themes is being shared with teams and improvement workstreams being established.
- The next step is to integrate the current working arrangements into a business-as-usual framework which is being mapped at present.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Board of Directors is asked to note:
1. The highlighted areas of progress.
2. The organisation is testing the impact of the improvement workstreams at all levels through various mechanisms and acting upon the findings appropriately.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Performance – Being outstanding now and in the future.</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">1.2 – Failure to implement effective governance systems and processes across the Trust to assess, monitor and drive improvements in quality and safety.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Regular report. The detailed report that was shared with the Quality Committee has been included within the Board Reading Room on AdminControl.</td></tr>
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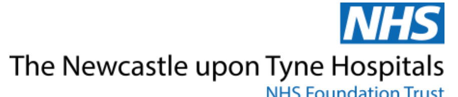
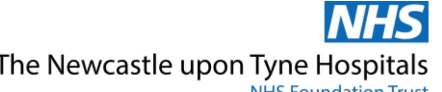
Agenda item A7



Public Trust Board
29 November 2024

CQC Update



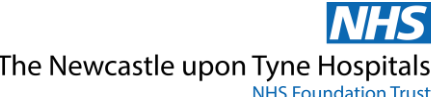
Key Highlights

- Improvement planning moved to Phase 2 with a focus on testing impact across the organisation.

- AuditOne, the Trust Internal Auditors, are carrying out further reviews in relation to service specific action plans and clinical board governance.

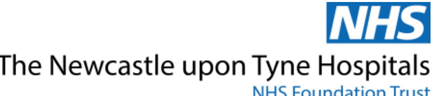
- The second cycle of Rapid Quality and Safety Peer Reviews commenced on 12 November, supported by external partners.

- Clinical Boards:
  - Movement to quality and safety priority plans reported through existing governance mechanisms.
  - Clinical Board Leadership Development Programme moving into the next phase.



Rapid Quality and Safety Peer Reviews

- 20 ward areas covered on 12 November.
- Focus placed on areas that were not included in the first cycle and giving real time feedback on the day.
- Additional visits planned to community sites.
- Further work to do on staff being able to verbalise changes in relation to lessons learnt.



Independent review by The Value Circle

Approach:

- Document and data review.
- On-site service line inspections (Emergency Department and Surgery).
- Well led interviews with the Clinical Board triumvirates (Clinical Board Chair, Director of Operations and Head of Nursing).

Next steps

- Sharing initial themes with teams.
- Feedback sessions and action planning to commence.
- Awaiting final report.

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Agenda item A8

TRUST BOARD

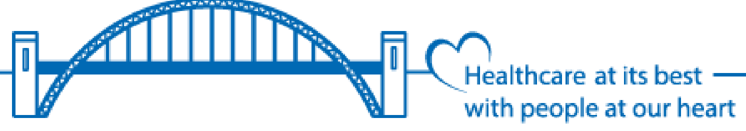
Date of meeting	29 November 2024					
Title	Integrated Board Report					
Report of	Rob Harrison, Managing Director Patrick Garner, Director of Performance & Governance Louise Hall, Deputy Director of Quality & Effectiveness					
Prepared by	Elliot Tame, Senior Business Development Manager (Performance)					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☐			
Summary	This report is to provide assurance to the Board of Directors on the Trust's performance against key Indicators relating to Quality & Safety, Access, People, Finance and Health Inequalities.					
Recommendation	For assurance.					
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality. Performance – Being outstanding now and in the future.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]						
Reports previously considered by	This is a regular report provided to the Trust Board.					

Agenda item A8

Integrated Board Report

Quality, Performance, People, Finance, Health Inequalities

November 2024



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  - Duty of Candour 12
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Executive Summary

Quality

- 26 Clostridioides difficile infections (CDIs) were recorded in September 2024, with this metric flagging concerning variation of a deteriorating nature (though within process limits). Cases deemed avoidable were attributed to poor stool documentation, delay in sampling/isolation/treatment and antimicrobial stewardship. Other Trusts both regionally and nationally have reported seeing an increase in CDIs.
- A further reduction in adult falls was recorded in September, with this metric highlighting special cause variation of an improving nature. Falls per 1,000 bed days have also reduced to 3.9, remaining significantly under the Trust target of 6.0.

Performance

- Performance against the 62 Day cancer standard in August was 61.2%, continuing the trend of improving special cause variation, although there remains a consistent failure to hit the target. Consultants have been recruited into both Upper Gastrointestinal (GI) and Gynae services where capacity has been in deficit to demand.
- Performance improved slightly against the 5% diagnostic standard in September, with 36.7% of patients waiting longer than six weeks for their test, however there is special cause variation of a concerning nature identified from the data and the target is consistently failed. A whole service review is ongoing within Audiology whereby the waiting list has been split into age groups with additional resource initially being dedicated to improve the waiting times of paediatric patients.

Executive Summary

People

- Total sickness absence remained at 5.42% in September against a target of 4.50%. Whilst common cause variation is identified within the data the Trust continues to consistently fail to meet target. The Executive Team have approved proposals for funding to address gaps in the wellbeing offer to staff.
- The 12-month rolling average turnover for the Trust is now highlighting special cause variation of an improving nature, and has fallen below the target of 10%, having been routinely missed throughout the last 12 months. Offers of flexible working are in place and encouraged, whilst a pilot to encourage exit interviews (and facilitate stay conversations) was recently completed in Surgery & Associated Services and is to be evaluated to consider potential wider roll-out.

Finance

- As at Month 6 the Trust is reporting an overspend of £0.3 million against the planned deficit of £6.4 million (after the 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.
- There is reliance on non-recurrent measures to bridge the recurrent Cost Improvement Programme (CIP) gap of £13.5 million.

Health Inequalities

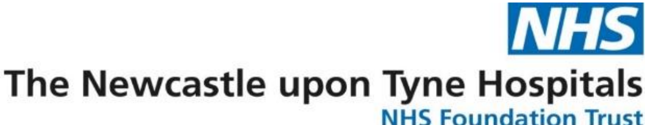
- The November 2024 Health Inequalities update contains information on tobacco dependency in patients on acute inpatient pathways. Less than 20% of inpatient smokers referred to the Tobacco Dependency Treatment Service (TDTS) opt in for a treatment plan and onward referral to the Community Stop Smoking Service. Understanding the barriers to uptake of the offer and interventions to improve are being undertaken as part of the review of the TDTS.

SPC Assurance Matrix

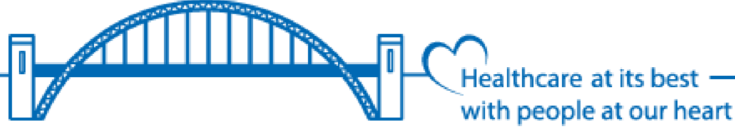
ASSURANCE

VARIATION

Variation	P (Pass)	? (Hit and miss)	F (Fail)	No Target	↑ / ↓
H / L (Improvement)		• Adult Patient Falls	• Cancer 62 Day Referral to Treatment Standard • Trust Turnover • Appraisal Compliance	• Falls per 1,000 bed days • Long-term Sickness Absence • EDI - Disability • EDI - Ethnicity	↑
Common cause	• Mandatory Training	• Inpatient Acquired Pressure Ulcers • Number of MSSA Cases • Number of E. coli Cases • Number of Pseudomonas aeruginosa Cases • Never Events • ATAIN • Proportion of level 1 mortality reviews undertaken • ED Performance - All Types (%) • ED Arrival to Admission / Discharge >12 hours • ED Trolly Waits >12 hours • Cancer 28 Day Faster Diagnosis Standard	• Percentage of Verbal Duty of Candour Completed • RTT 18 Weeks Performance (%) • RTT >65 Week Waits • Trust Sickness Absence	• Pressure ulcers per 1,000 bed days • Patient Safety Incidents per 1,000 bed days • Severe/Fatal Patient Safety Incidents per 1,000 bed days • Percentage of Written Duty of Candour Completed • Number of Verbal Duty of Candour Not Complete within 10 Days • Stillbirths • Early neonatal deaths (0-7 days) • Perinatal Mortality cases • Caesarean section Deliveries (Total) • Elective Caesarean Deliveries • Emergency Caesarean Deliveries • Overall "Induction Of Labour" • Blood Loss >1500ml (per 1,000 deliveries) • Maternal deaths	• Maternal Re-admissions (Total) • Neonatal Re-admissions (Total) • Moderate incidents • BSOTS Initial Triage within 15 minutes • Total number of inpatient deaths • Proportion of inpatient admissions where death occurred • RTT Waiting List Size • Short-term Sickness Absence ↓
H / L (Concern)		• Number of MRSA Cases • Number of C. diff Cases • Number of Klebsiella Cases	• Diagnostic 6 Week Performance	• Number of level 2 mortality reviews undertaken • Diagnostic Waiting List Size	• Registerable (Maternal) Deliveries • Registerable Births • Pregnancy Bookings

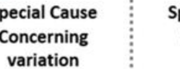


Quality



Quality Overview

Metric	Period	Actual	Target	Variation	Assurance
HCAI - MSSA	Sep-24	12	9		
HCAI – C. Diff	Sep-24	22	12		
Harm Free Care – Inpatient (IP) Acquired Pressure Ulcers	Sep-24	59	69		
Harm Free Care – Adult Patient Falls	Sep-24	176	203		
Stillbirths	Oct-24	1			
Blood Loss >1500ml	Oct-24	24			
ATAIN	Oct-24	43			



Health Care Acquired Infections (HCAI)

- The number of MSSA cases is now above the mean and monthly standard, with 12 recorded in September.
- September saw a slight decrease in CDI cases compared to the previous month (22 v 26) – but there remains special cause variation of a concerning nature.

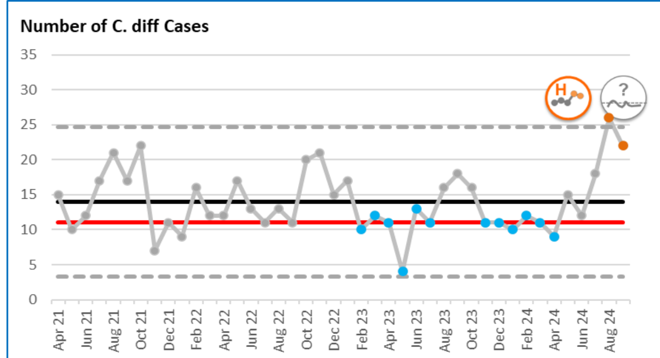
Harm Free Care

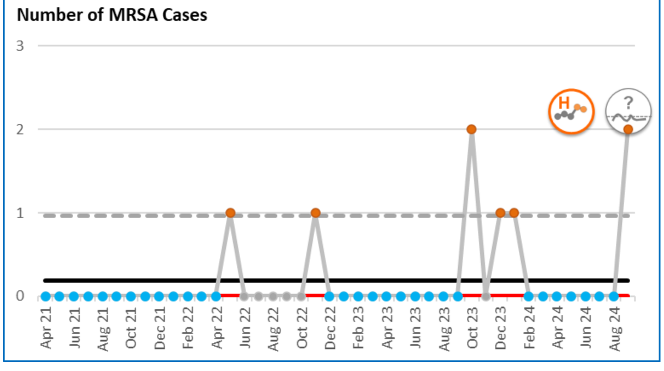
- There was a slight increase in September in the number of acute pressure ulcers reported from 49 to 59. However, the improving trend since December 2023 has been maintained.
- In September there was a further reduction in falls compared to the previous month (176 v 201).

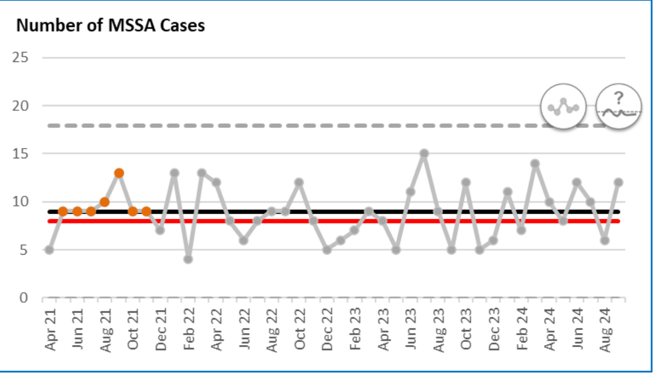
Perinatal Quality Surveillance

- In October 2024 there were two early neonatal deaths. These infants were born extremely prematurely before 24 weeks of pregnancy. These figures were previously reported for term infants only. There was one stillbirth in October 2024 following a therapeutic termination for fetal anomaly.
- In 2023 the Trust was highlighted as an outlier for postpartum haemorrhage >1500ml per 1,000 births, this is no longer the case and the Trust has a Postpartum Haemorrhage (PPH) rate less than England and the North East and North Cumbria (NENC) average, and the lowest rate for 5 months.
- There were 43 term admissions in October 2024. The Trust previously reviewed cases where admission time on Neonatal Intensive Care Unit (NICU) was >4hours. The Trust is now reviewing all admissions including those babies who required minimal intervention leading to any period of separation from the mother and has commenced a deep dive into the admissions of the infants of diabetic mothers.

Healthcare Associated Infections (1/2)







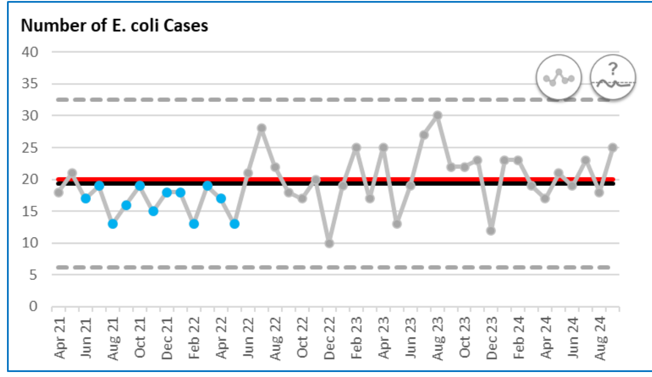
Standards

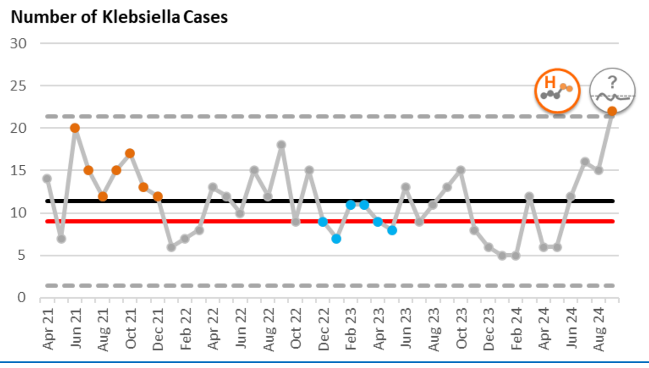
- **Zero MRSA** cases.
- **No more than 98 MSSA** cases across the financial year (local target - 10% reduction from 2023/24).
- **No more than 136 CDIs, 247 E. coli** cases, **108 Klebsiella** cases or **39 Pseudomonas aeruginosa** cases across the financial year.

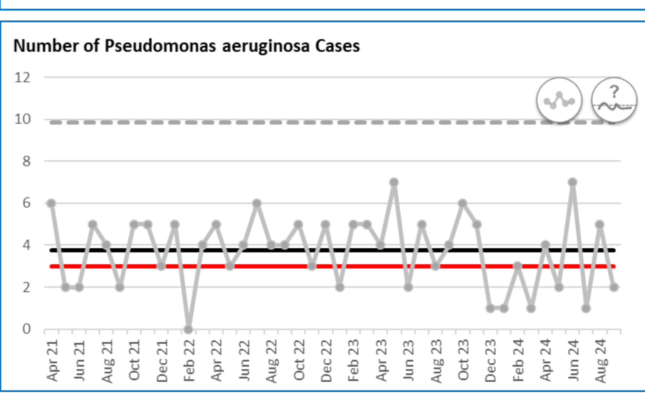
Current Position

- September 2024 saw a slight decrease in CDI cases compared to the previous month (22 v 26). These cases are predominantly spread across three large Clinical Boards with complex cohorts of patients. From the 17 hospital-onset healthcare associated (HOHA) cases investigated (community-onset healthcare associated (COHA) cases are not routinely reviewed), 6 were deemed unavoidable, 4 avoidable and the remaining 7 cases are awaiting final multi-disciplinary team (MDT) review.
- Cases deemed avoidable were attributed to poor stool documentation, delay in sampling/ isolation/treatment and antimicrobial stewardship. This increase can be seen as multifactorial, attributed to the complexity of the patients requiring multiple broad-spectrum antibiotics, however Trusts both in the Northeast and nationally have reported seeing an increase in CDIs.
- September saw 2 MRSA bacteraemia cases (1 HOHA and 1 COHA) one of which was deemed avoidable (HOHA) and the other unavoidable - as the patient was not screened for MRSA in line with policy missing the opportunity to start eradication therapy, which would have reduced the burden of infection on the skin, reducing the risk of a bacteraemia occurring.
- The number of MSSA cases is now above the mean and monthly standard, with 12 recorded in September. Of these there were 10 HOHAs and 2 COHA. Investigations into the HOHA cases determined that 7 were deemed unavoidable and the remaining 3 are under investigation.
- In September there was an increase seen in *E. coli* bacteraemia cases (25 v 18), taking the total above the mean and monthly standard. Factors that lead to *E. coli* bacteraemia include hepatobiliary complexities, GI or intraabdominal collections or lower urinary tract. Of these five were COHA cases and 20 HOHA, of which 16 were deemed unavoidable as no lapses in care were identified, with the remaining 4 under investigation.
- The number of recorded Klebsiella bacteraemia cases increased to 22 in September (22 v 15) - 14 HOHA cases and 8 COHA case. Upon investigation of the HOHA cases, 10 were deemed unavoidable, with the remaining 4 under investigation.
- Two Pseudomonas aeruginosa cases were registered in September - one COHA and one HOHA . The HOHA case was deemed unavoidable upon investigation. No special cause variation is noted.

Healthcare Associated Infections (2/2)



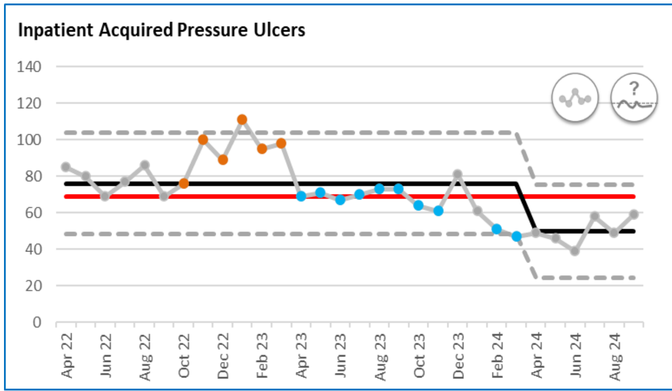


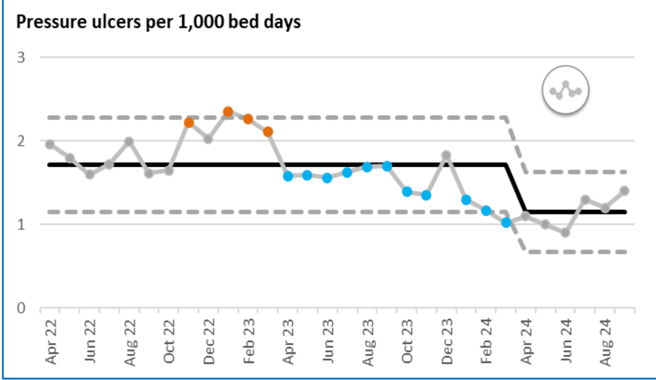


Action taken

- In order to tackle this rise in *Clostridioides difficile* infections (CDIs, a task and finish group has been established. Membership includes representation from the three clinical boards with the highest incidence. Outcomes from which include:
  - Formulation of clinical board specific action plans, addressing themes from their CDI cases. These action plans will be monitored within clinical boards with oversight from the Infection Prevention and Control Committee (IPCC).
  - A Trust wide action plan is being developed to address themes from cases of CDI, this includes the introduction of CDI/diarrhoea management eLearning package, which will be available from the end of December. In addition, the recent introduction of the end of shift nursing digital assessment document, will aid improvement in documentation.
  - The IPC team are raising awareness regarding isolation, and encouraging clinical teams to report incidents whereby isolation cannot be achieved due to a lack of isolation facilities due to high occupancy levels. These incidents continue to be reviewed in the IPC operational group, with escalation to board when required.
  - The Patient Safety Incident Response Framework (PSIRF) process of investigating a case of CDI, has been reviewed, to provide closer collaboration with the clinical teams, and IPC.
- A structured robust process for antimicrobial review in CDI cases with Antimicrobial Pharmacist continues. The in-depth review supports real time feedback to clinical teams and implementation of rapid improvement actions to facilitate safe and high standards of care.
- The IPC Team continues to monitor, investigate and report all HCAIs. Findings are shared Trust wide via Clinical Board, Quality and Safety meetings, Quality Oversight Groups (QOGs), Matrons and Clinical Leaders forums.
- Action logs to focus on quality improvement initiatives in relation to healthcare associated infection are monitored by Clinical Board Matrons and reported through their QOGs (attended by the Director of Infection Prevention Control (DIPC) and IPC Matron).
- IPC Operational Group continues to review any IPC incidents reported in datix such as lack of availability of isolation facilities due to high patient occupancy levels.
- Collaboration continues between IPC / Facilities / Estates Teams to ensure safe water provision.
- Work continues with Clinical Boards to improve compliance with invasive devices' digital dashboards.
- Antimicrobial Stewardship (AMS) and medicine management continue to work together to develop and implement AMS strategies. Stakeholders Strategic meeting continues as a subgroup of the Patient Safety Group which reports into Medicines Management Optimisation Group.
- The DIPC continues to chair AMS strategic and operational group.

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.

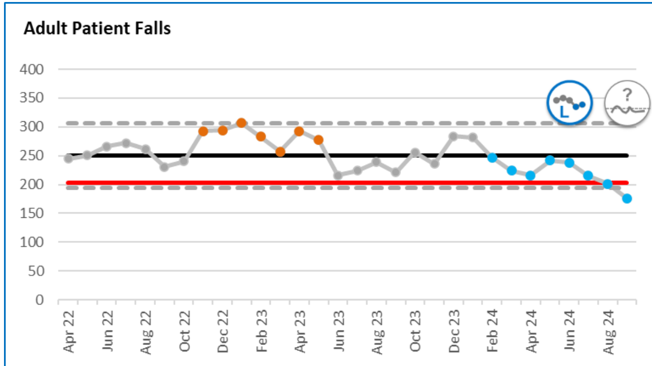
Current position

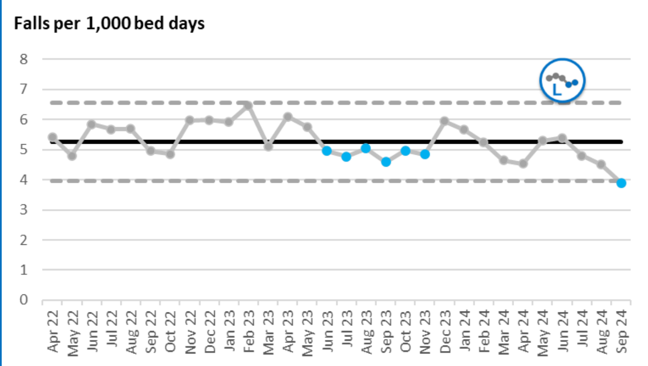
- There was a slight increase in September in the number of acute pressure ulcers reported from 49 to 59. The chart has been adapted to reflect a sustained reduction, therefore highlighting no special cause variation.
- There were four hospital acquired, or hospital deteriorated pressure ulcers identified as causing serious harm in September 2024, all of which were category III. Themes from these investigations include the identification of patient risk factors, the lack of use of the Trust pressure ulcer prevention framework, awareness within clinical teams of correct pressure ulcer categorisation, and lastly staff knowledge of pressure ulcer prevention measures with medical devices such as Non-Invasive Ventilation. The Tissue Viability team are providing education to address.

Action taken

- Preparation is under way for 'Stop the Pressure Ulcer' week which is 18-22 November 2024. The aim is to involve as many wards and departments as possible, to raise awareness and promote education around pressure ulcer prevention. Focused work will be done with those areas who report the highest number of pressure ulcers, as well as the tissue viability team sharing educational resources across the Trust.
- A new part time Podiatrist post will join the Harm Free Care team, working collaboratively on Quality Improvement (QI) initiatives.
- Following a concern with the integrity of mattresses within critical care areas, this resulted in the undertaking of a Trust wide audit to ascertain the position. An action plan was initiated to ensure future monitoring and assurance, this included as follows:
  - IPC are reviewing and renewing decontamination guidelines
  - Mattress passports
  - Monthly Mattress audits
  - All Mattresses to have an asset ID added by Electronic Medical Engineers (EME)
  - Covers labelled and transported as a pair for cleaning
- The areas who have participated in the Purpose T roll out have been audited, to review compliance. The results of this are currently being compiled.

Harm Free Care: Falls





Standard

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

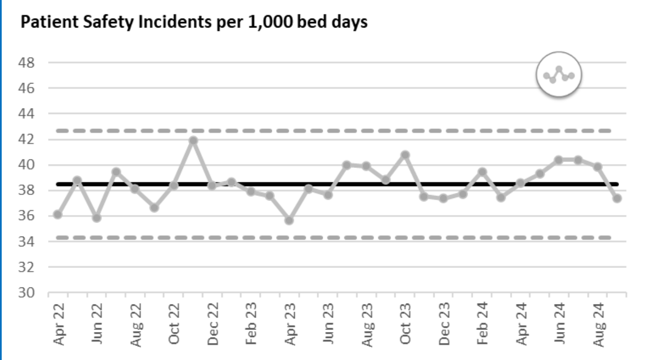
Current position:

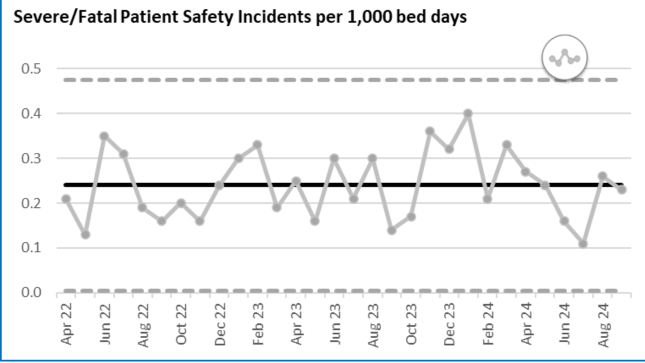
- In September there was a further reduction in falls compared to the previous month (176 v 201), with falls with moderate or above harm recorded as 6.8% (12) of all falls (10 of which were categorised as moderate harm). Of the 2 categorised as major, both were head injuries.
- Falls per 1,000 bed days has also reduced to 3.9, remaining significantly under the Trust target of 6.0.

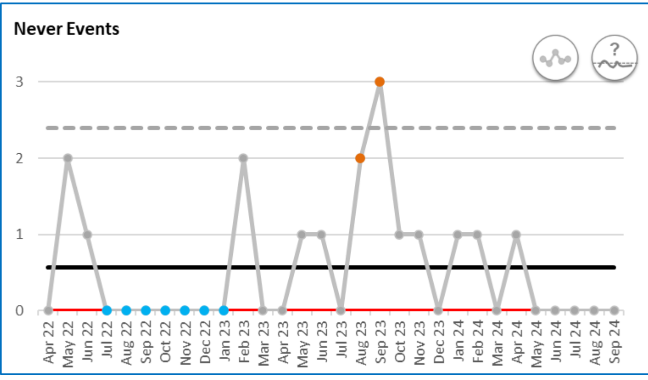
Action taken

- The Falls Prevention Coordinator (FPC) is actively identifying inpatients who have suffered multiple falls whilst in hospital. The FPC is liaising with the clinical areas where the patient resides, discussing with clinical staff, and providing advice on patient specific falls reduction strategies. Additionally, this information is documented in the patient's notes, to ensure staff have access to recommendations to enhance further falls reduction.
- Compliance with mandatory Falls Prevention training remains high at 97.5%.
- A Trust wide Enhanced Care Observation (ECO) audit took place in September 2024, the audit shows improved compliance with the Trusts ECO policy, accuracy in assessment and documentation, with an increase in staff knowledge in assessing ECO levels. Work is still required to continue this improvement, with the roll out of Trust wide ECO bitesize training by the clinical educators. Trust wide ECO audits are planned as an ongoing schedule of twice per year to ensure monitoring and assurance.
- Three wards have been identified to commence a project to identify if reducing caffeine has an impact in reducing falls. This project will start in January 2025.

Incident Reporting







Standards

- Continued trend of **increased incident reporting** across the Trust.
- Aim to achieve a target of **zero Never Events**.

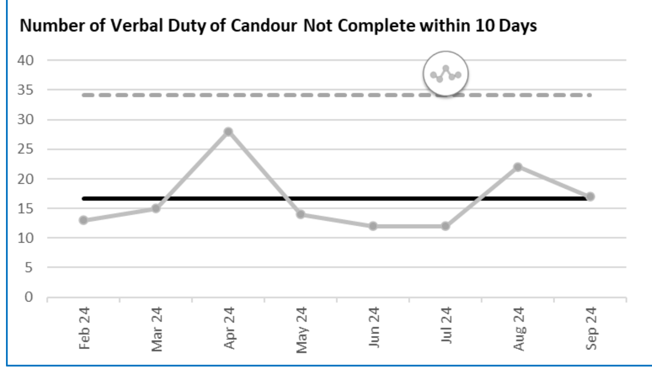
Current Position

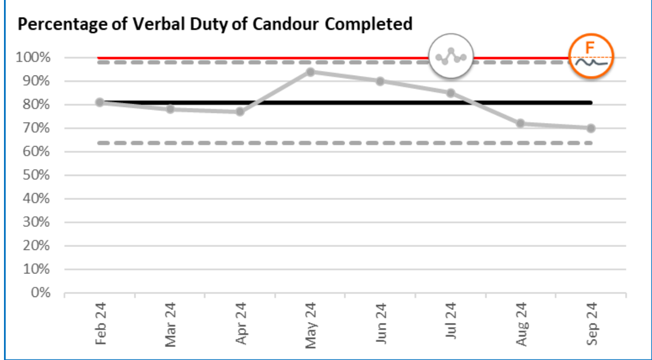
- The total number of patient safety incidents per 1,000 bed days reported in September 2024 has decreased for the second consecutive month – no special cause variation noted. A similar data trend was seen between August and September 2023.
- The number of severe/fatal safety incidents per 1,000 bed days has decreased.
- No never events were declared in September 2024.
- 1 After Action Review was declared in September 2024.
- 1 Patient Safety Incident Investigations (PSII) was declared in September 2024.

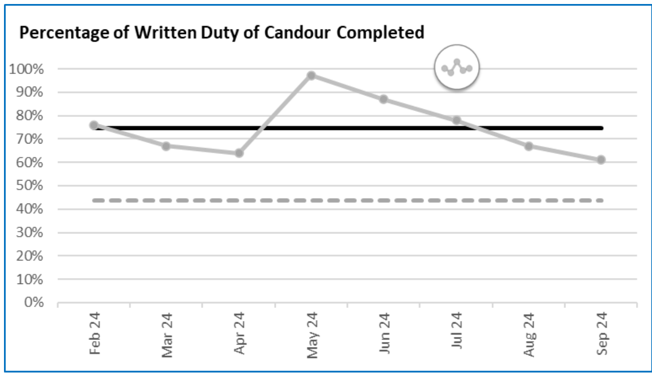
Action taken

- 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.
- Raising awareness of incidents and dissemination the learning continues to take place through the Patient Safety Message of the week, the Patient Safety Bulletin and the Patient Safety Briefings.
- The position on Never Events continues to be monitored Trust wide, with a specific improvement focus in Ophthalmology which is reported on as part of the Quality Account.

Duty Of Candour







Standards

- Statutory Duty of Candour (notification of the relevant person of suspected or actual notifiable safety incidents) to be undertaken for all notifiable safety incidents.
- To encourage openness and a timely apology, the trust's policy outlines verbal and written duty of candour should be completed within 10 days of the reported incident.

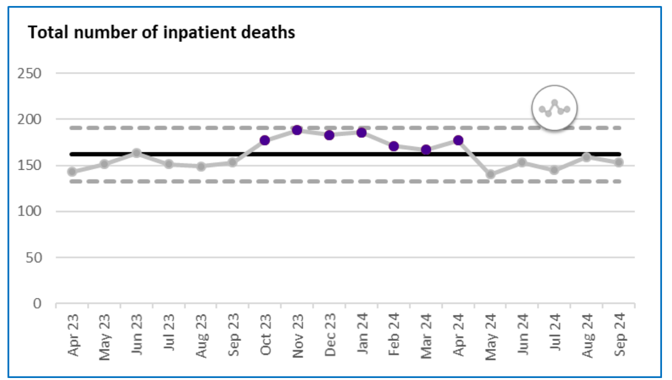
Current Position

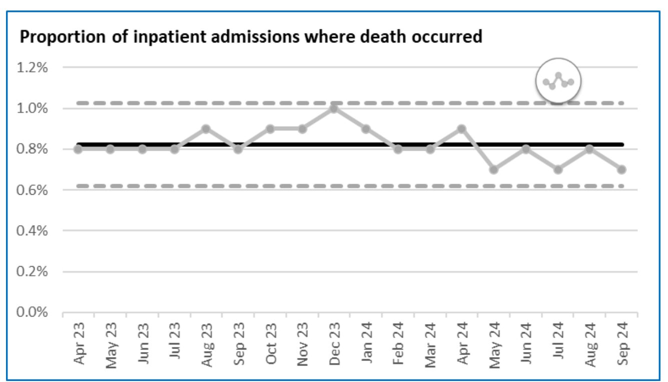
- Verbal duty of candour compliance taken as of 4 November 2024, shows there has been a slight reduction in completion following a high in May 2024. Written duty of candour compliance shows a similar trend.
- Compliance will continue to improve as incidents are reviewed, and an apologies provided to patients and their families.

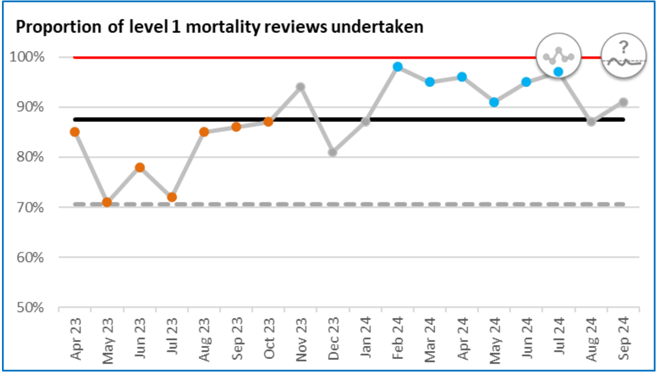
Action taken

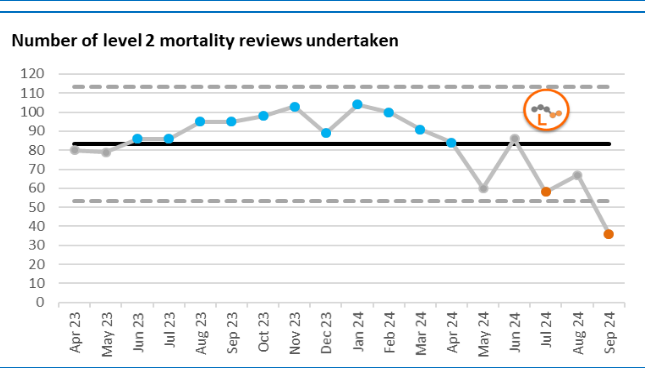
- Learning Lab module on duty of candour being developed in conjunction with Technology Enhanced Learning team.
- Wider sharing of duty of candour compliance data at Trust-wide meetings.
- Improvements made to simplify recording of duty candour completion within Datix and the opportunity to simplify recording in e-record with Digital Health Team being explored.

Mortality Indicators (1/2)









Standards

- Due to the recent changes nationally to the Medial Examiner (ME) process, from September 2024 it is now a statutory requirement **all deaths** are reviewed by either the Coroner or ME (level 1 mortality review criteria).

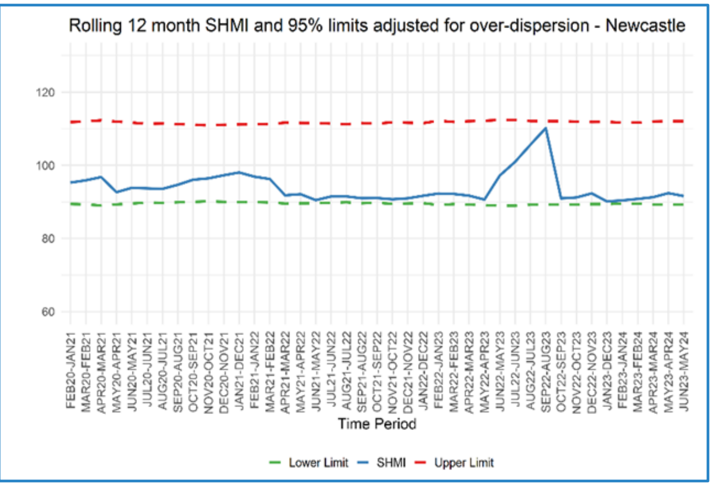
Current Position

- There were 153 inpatient deaths in total reported in September 2024, which is the same amount as reported 12 months previously.
- The crude rate in September 2024 is 0.70%.
- Out of the 153 inpatient deaths reported, 139 (91%) patients have received a level 1 mortality review and there are 36 level 2 mortality reviews entered into the Trust mortality review database.
- In September 2024, there were no patient deaths with a high HOGAN grading.
- In September 2024, there was 1 death with an identified learning disability.

Action taken

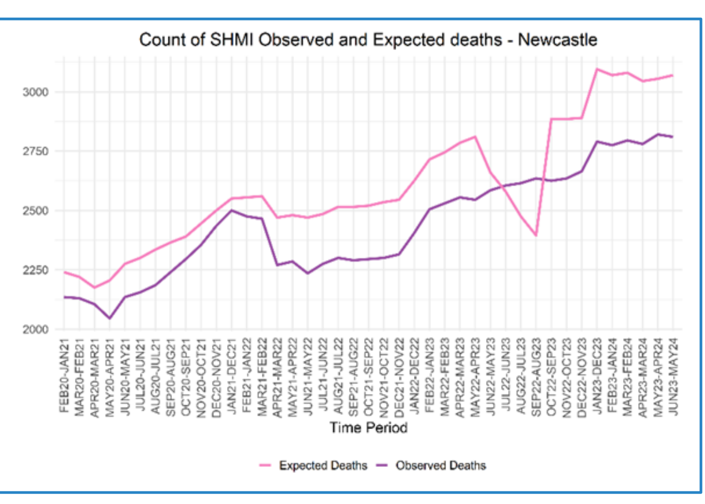
- All inpatient deaths are continually monitored.
- The number of level 2 mortality reviews will rise significantly over the coming months as Mortality & Morbidity (M&M) meetings continue to take place.

Mortality Indicators (2/2)



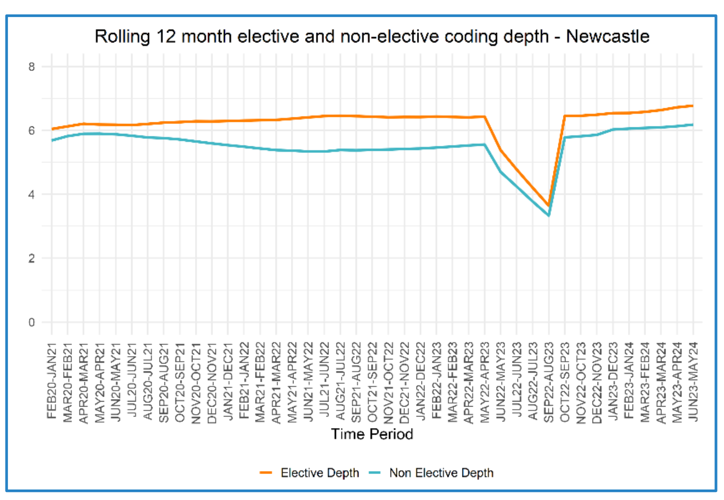
Summary Hospital-level Mortality Indicator (SHMI)
Within the latest published SHMI data (June 2023 – May 2024) the Trust SHMI is at 0.92. This is within the "as expected" category.

Observed & Expected deaths
Between June 2023 – May 2024 the Trust has 2,810 observed deaths and 3,070 expected deaths.



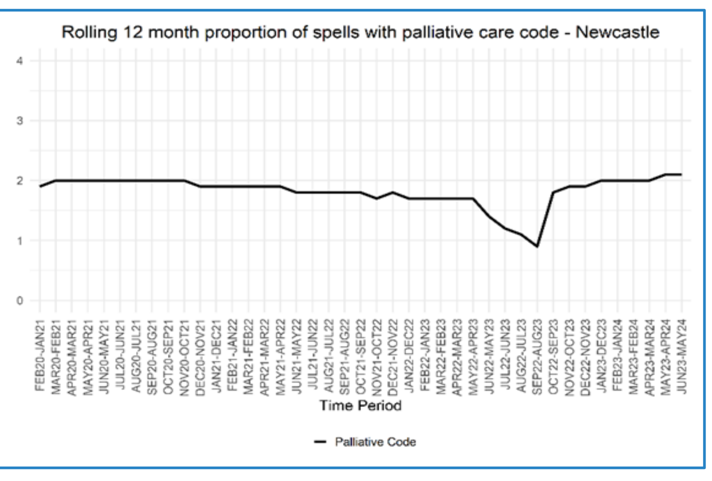
All data rolling 12 month periods. Data as reported by NHS England (NHSE).

* An issue with the Trust's Secondary Users Services data flow affected clinical coding completeness (now resolved).

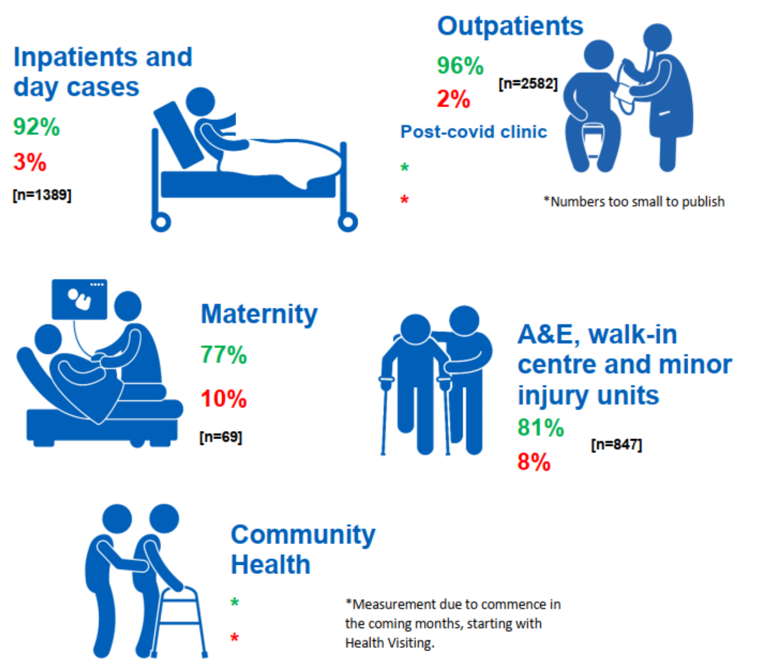


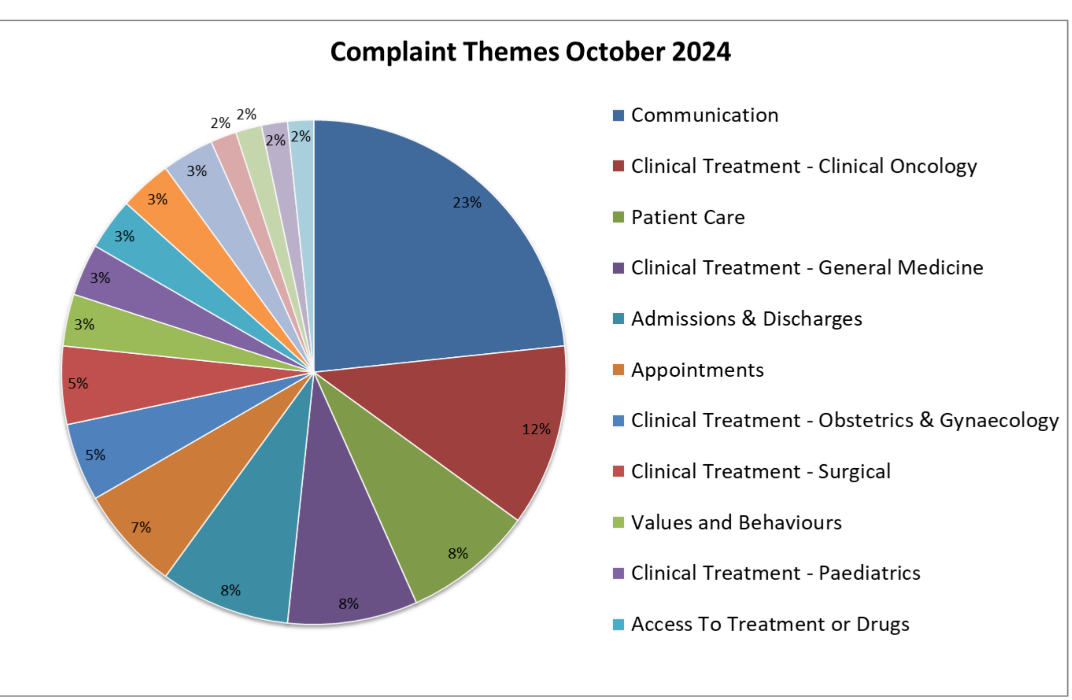
Coding Depth
Coding depth has a substantial impact on mortality indicators. Within the latest published SHMI data the Trust has an elective coding depth of 6.8 and a non-elective coding depth of 6.2.

Spells with palliative code
Between June 2023 – May 2024 the Trust has a 2.1% palliative care coding rate.



Friends & Family Test / Complaints





Current Position

- There were 4,887 responses to the Friends and Family test from the Trust in September 2024 under the pilot collection system.
- The infographic shows the proportion of patients who give a positive or negative rating of the care they received. The response rates are shown in black.

- The Trust has opened 60 formal complaints In October 2024. The average number of complaints opened this financial year is 54, which is six complaints higher than the Trust average for the previous financial year.

Patient Experience Surveys

'Perfect Week' (9-16th September) Responses

- Newcastle Hospitals carries out monthly surveys of all inpatients attending the Trust and patients attending the Emergency Departments/Outpatients. The surveys have been designed to include all of the key questions from the questionnaire used in the Care Quality Commission (CQC) national patient survey programme and the NHS England Friends and Family Test.
- The survey methodology is predominantly online – surveys are sent out by SMS to patients within a month of their attendance. Patients are offered the opportunity to opt out of the survey or request a paper copy of the questionnaire by post.
- This report includes all responses from patients attending or discharged during the 'Perfect Week' (9-16th September).

Inpatient Results

- The inpatient results for the perfect week are very good. On average the Trust is in the top 20% of all Trusts in England. It is in the top 20% of questions for 33 questions, middle 60% for eight and bottom 20% for one. The average score is 80%, 1% below the baseline. The threshold for the top 20% is 76%.
- 90% of patients rate the Trust as very good or good (The FFT Question), and overall scores by the two main sites are very similar: Freeman Hospital 80% (133 respondents), The Royal Victoria Infirmary 79% (127). Overall results continue to be excellent in all areas, including waiting, noise a night, communication with staff, cleanliness, pain management, discharge planning, overall ratings and respect and dignity. Results could be improved in asking patients for their views on the quality of care.

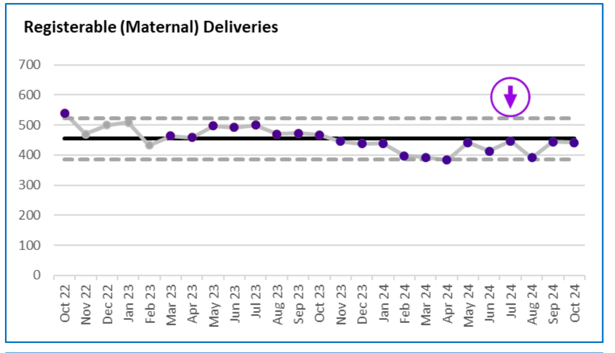
Outpatient Results

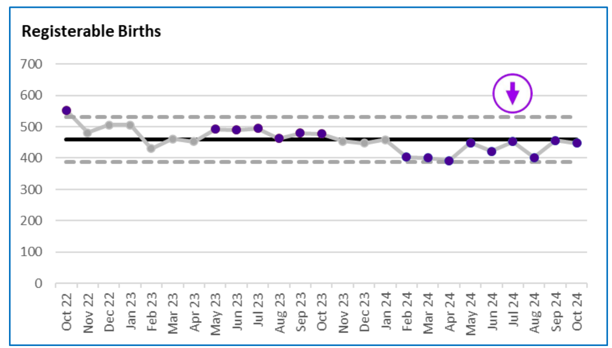
- The outpatient results for the perfect week are very good. On average the Trust is in the top 20% of all Trusts in England. It is the top 20% of questions for 29 questions, middle 60% for one and bottom 20% for one. The average score is 90%, 1% above the baseline. The threshold for the top 20% is 84%.
- 96% of patients rate the Trust as very good or good (The FFT Question), and overall scores by the two main sites are very similar: Freeman Hospital 90% (857 respondents), The Royal Victoria Infirmary 89% (1,074). Overall results continue to be excellent in all areas, including all aspects of communication between doctors and patients (and information about discharge), cleanliness, involvement in decisions, discharge planning, letters copied to patients, overall ratings and respect and dignity. The one area for improvement is in information to patients about the length of the waiting time and the reason for the wait.

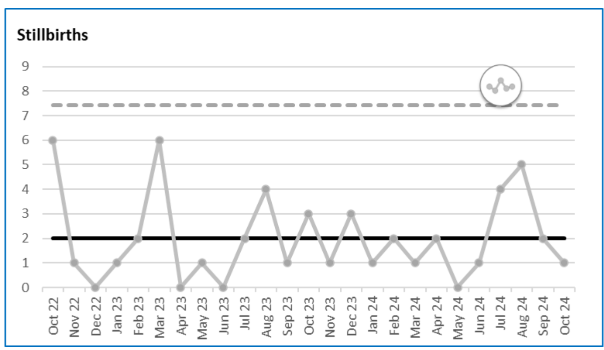
Emergency Department (ED) Results

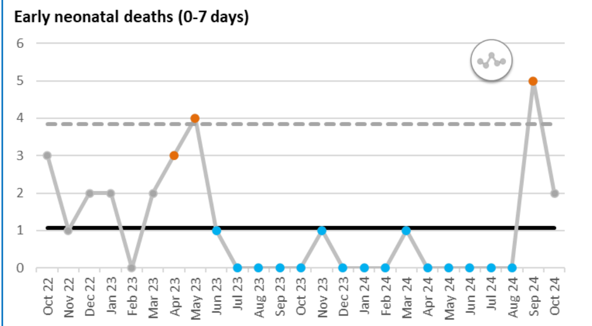
- Emergency Department results for the perfect week are very good. Results are marginally up from the baseline measure, although there are no statistically significant changes. The Trust is in the top 20% of Trusts. It is in the top 20% on 14 questions, middle 60% on 10 questions and bottom 20% on 3 questions.
- The average score is 79%, up from 76% at the baseline. Overall results are good in the following areas: information about waiting, communication with doctors and nurses, leaving the hospital, overall ratings. Results could be improved in pain management, amount of information given, patients feeling bothered or threatened by other patients.

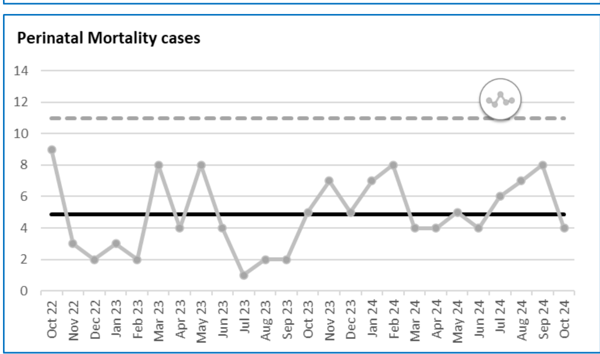
Perinatal Quality Surveillance: Births











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 impact of the reduced birth rate has been augmented by a reduction in market following the suspension of the Newcastle Birth Centre (NBC) services. This has had a significant impact on activity in other units and on patient safety. Mutual aid has been provided by Newcastle to neighbouring Trusts on a weekly basis. The NBC will provide services from December.

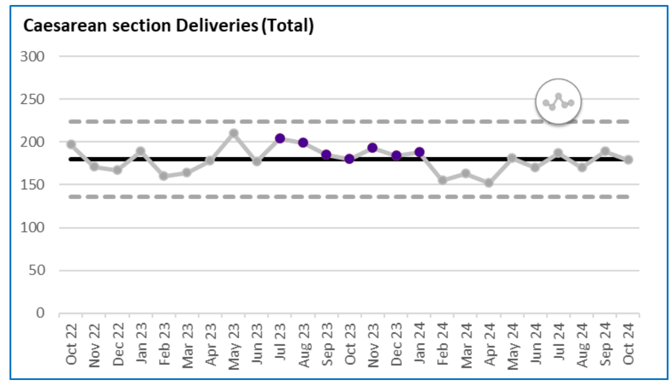
Stillbirths

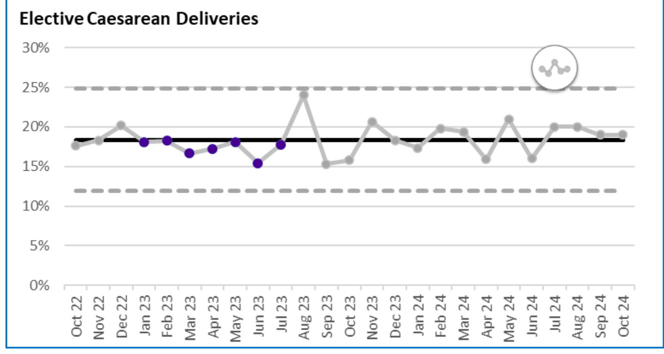
- Newcastle is a tertiary referral Fetal Medicine Unit, providing care to the most complex cases from across NENC. This data includes termination for fetal anomalies >24 weeks gestation. There was one stillbirth in October 2024, this was following therapeutic termination. This case does not meet the criteria for review through the Perinatal Mortality Review Tool process or the Maternity and Newborn Safety Investigation (MNSI) process. (Average per 1000 births: England 3.2, NENC 3.6).

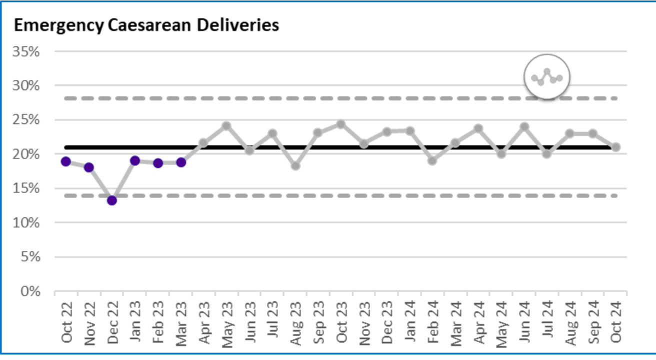
Early Neonatal Deaths

- These figures were previously reported for term infants only. The Trust are now reporting for liveborn infants from 20 weeks of pregnancy/weighing >400g (if unknown gestation) who received care by the Trust and sadly died within the first week of life, which accounts for the noted increase from September. The Trust has the highest level of neonatal intensive care provision supporting extremely premature babies. These deaths are reported to the Child Death Review panel who will have oversight of the investigation and review process. In October 2024 there were two early neonatal deaths of extremely premature babies (born under 24 weeks of pregnancy).

Perinatal Quality Surveillance: Deliveries







Caesarean section deliveries

- There is no defined national metric for caesarean section rates.
- National reports, including Ockenden and Reading the Signals (East Kent) have highlighted lower caesarean section rates do not reflect patient safety or the importance of offering individualised and personalised care where women's voices are heard.
- In England 42.9% of births are caesarean section, in the NENC this is 39.2%. The Trust is comparable with a caesarean section rate of 40.5% in October.

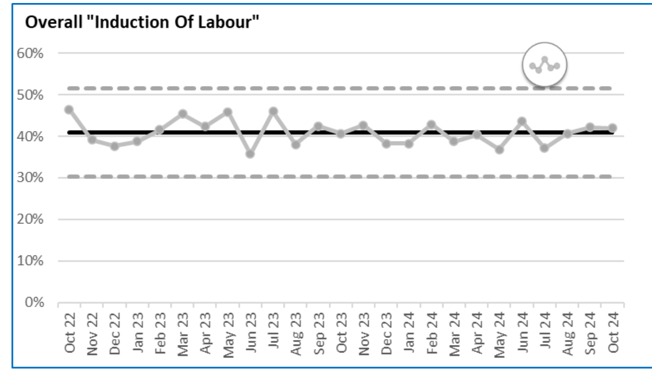
Elective Caesarean section

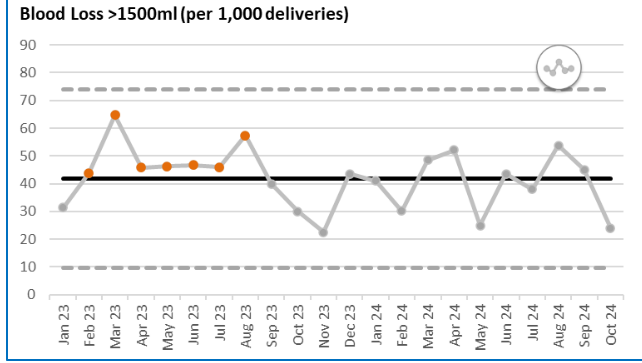
- The average England elective caesarean rate is 18.2%.
- The Trust elective caesarean rate was 19% in October.
- The rise in elective caesarean rates is partially due to an increasing proportion being undertaken due to maternal request in accordance with the NICE guidance.
- The Trust has a shared decision-making 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.

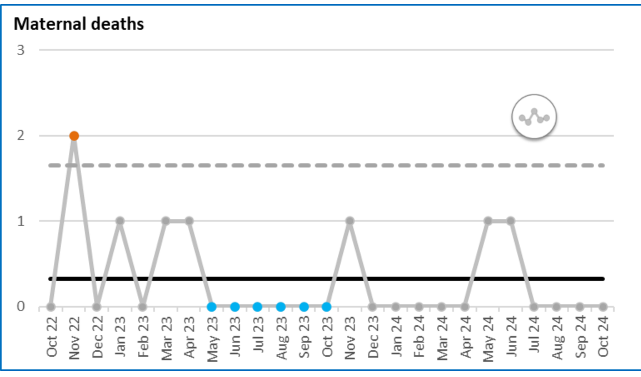
Emergency Caesarean section

- NHS Digital data for January 2024 47% of deliveries were spontaneous vaginal births, 10% had instrumental assistance, 19% were elective caesarean sections and 24% were emergency caesarean sections, the Trust is comparable with this national data.
- The Trust emergency caesarean rate in October was 21%.
- 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. 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. England average for induction of labour Q1 2024-25 29.7% and NENC 33.8%. The Trust induction of labour rate was 42% in October 2024.

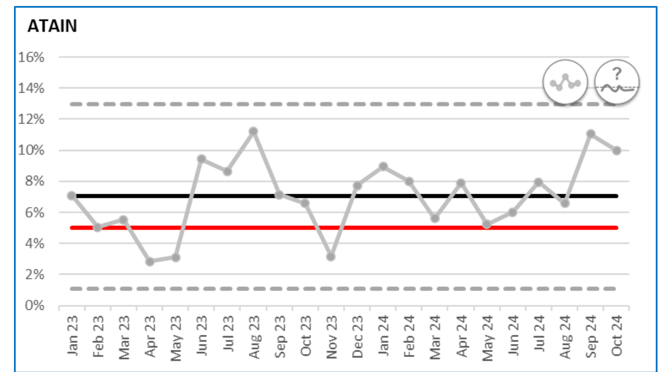
Blood Loss >1500ml

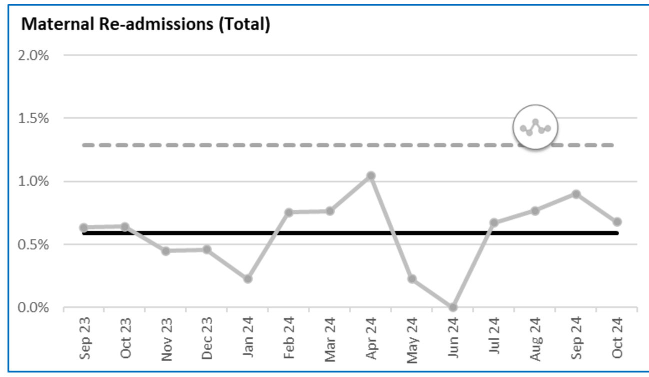
- In 2023 the Trust was highlighted as an outlier for postpartum haemorrhage (PPH) >1500ml per 1000 births. The average PPH rate for England is 30 per 1000 and NENC average is 27 per 1000. The Trust rate was 24 per 1000 in October, lower than previous 5 months.

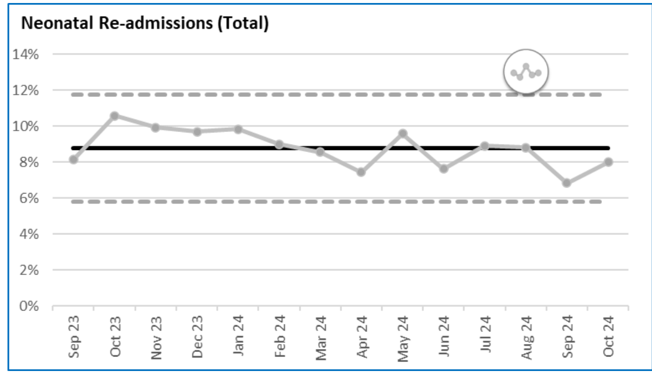
Maternal Deaths

- 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 October 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 reviewed at a regular multi-disciplinary meeting and quality improvement themes identified. The Trust previously reviewed cases where admission time on NICU was >4hours. The Trust is now reviewing all admissions including those babies who a short period of separation from the mother, 12 of the 43 babies fell within this group. National benchmark for term admissions is 5%. The Trust are currently benchmarking term admission rates with other Tertiary units to understand our performance against similar units for this metric, and has commenced a deep dive to review the admission of infants of diabetic mothers.

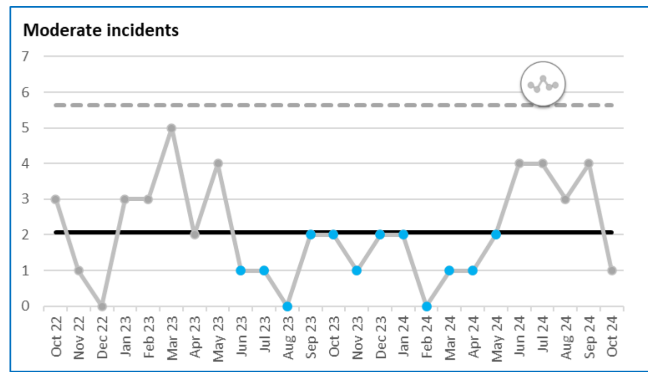
Maternal Readmissions

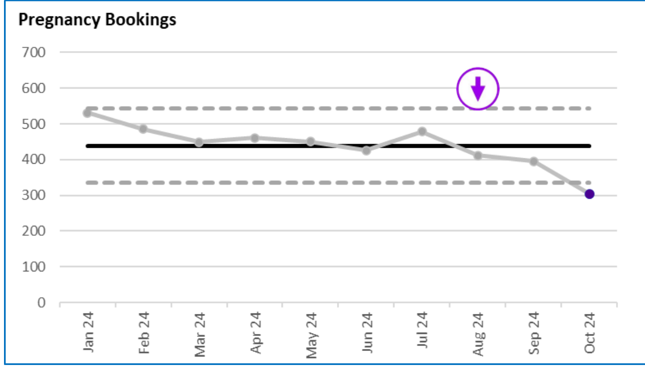
- This is a new metric, work is ongoing to benchmark performance with national parameters. From National Maternity & Perinatal Audit (NMPA) Report (2022) the maternal postnatal readmission rate for England was 3.3%, with rates being higher following c/s compared with vaginal birth (4.3% vs 2.9%). Maternal readmission rate for October was 1%.

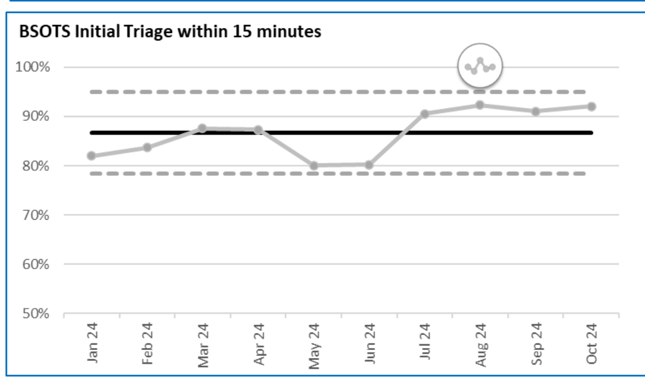
Neonatal Readmissions

- This is a new metric, work is ongoing to benchmark performance with national parameters. Clinical Quality Improvement Metrics (CQIM) for ‘Babies readmitted to hospital who were under 30 days old’ data is available for this indicator from March 2024- June 2024. The national rate for this period ranges from 5.3- 5.5%. Neonatal readmission rate for October was 8%.

Perinatal Quality Surveillance: Incidents, Bookings & Triage







Incidents

- There was one moderate (and above) incident reported in maternity this month, this met the referral criteria for Maternity and Newborn Safety Investigations (MNSI).
- There are national requirements for Trusts to refer specific cases to MNSI for external review. These include cases involving neonatal brain injury - Hypoxic Ischaemic Encephalopathy (HIE), Term Intrapartum Stillbirths, Early Neonatal deaths and Maternal deaths.

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, this metric will be monitored closely following the re-opening of the service in December.

Birmingham Symptom Specific Obstetric Triage System (BSOTS)

- The Trust implemented the BSOTS triage system in January 2024. Performance has been improving with initial triage times, further metrics are being developed regarding ongoing care and medical review, which remains challenged. Comprehensive action plan for improvement in place.
- NENC are implementing a regional dashboard for BSOTS compliance for future reporting and oversight.

Perinatal Quality Surveillance: Antenatal & NIPE Screening

Antenatal Screening

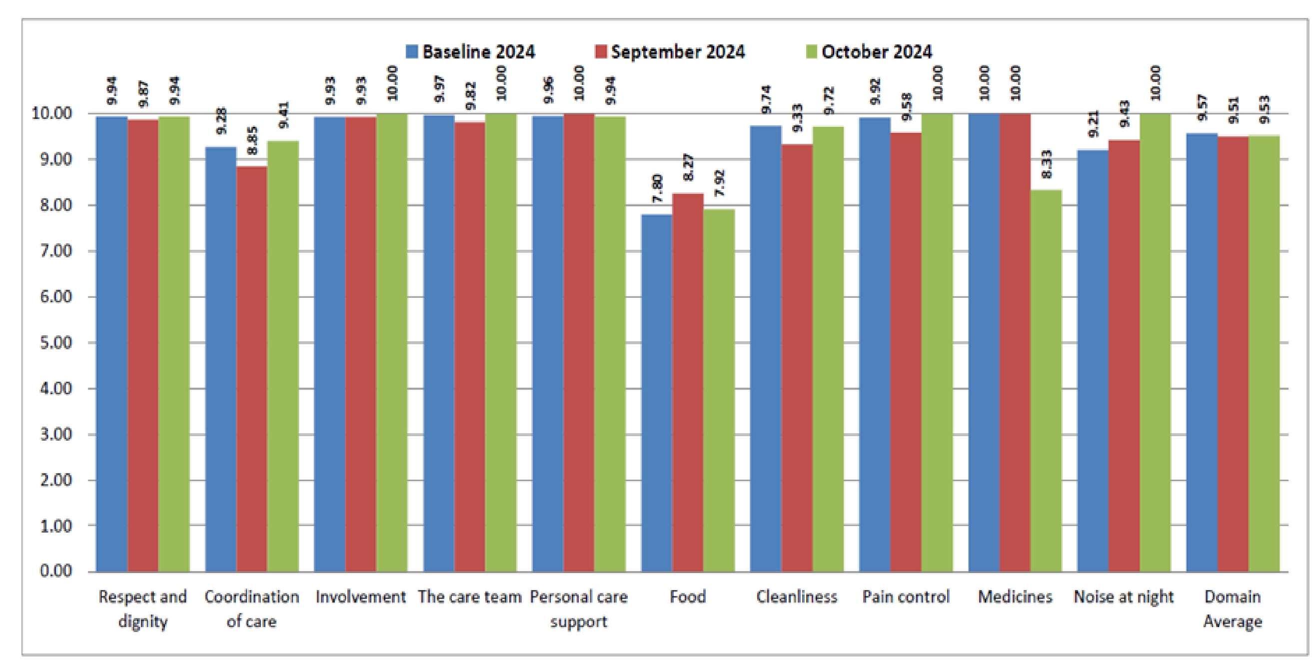
	Infectious Diseases	FA2 20 week anomaly scan	FA3 T21,T18, T13 Screening	ST2 Timeliness of Antenatal Screening	ST3 Completion of Family Origin Questionnaire (FOQ)	ST4a	ST4b	NB2 Avoidable Newborn blood spot screening (NBBS) repeats
Acceptable	>95%	>95%	Not set	>50%	>95%	TBC	TBC	<2%
Achievable	>99%	>99%	Not set	>75%	>99%	TBC	TBC	<1%
Q3	99.6%	98.6%	100%	65.5%	96.7%	66.7%	100%	2.5%
Q4	100%	99.5%	99.9%	65.1%	91.8%	0%	50%	3.8%
Q1	99.6%	99.7%	100%	61.2%	95.5%	100%	100%	4.0%

- 3 PSII Underway.
- Comprehensive action plan in place. Incident oversight group with NHSE & ICB colleagues meeting fortnightly.

Newborn and Infant Physical Examination (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 no babies	49.1%	56.5%	0% (n=3)
Q3	94.1%	n/a no babies	67.3%	74.5%	100%
Q4	95.6%	n/a no babies	74.5%	76.4%	100%
Q1	95.2%	n/a no babies	76.4%	79.8%	100% (75% reported due to error)

Perinatal Quality Surveillance: Patient Experience



Ward Experience Surveys

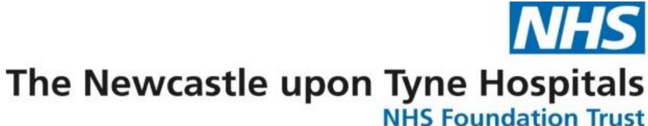
Work ongoing regarding patient experience across the maternity services. Current QI focus on postnatal ward experience from both a service user and staff perspective. Perinatal Inclusion and Engagement Group established to review and share patient experience data and inform improvements alongside Maternity Neonatal Voice Partnership.

100% of the patients surveyed would recommend their overall experience on the ward during October.

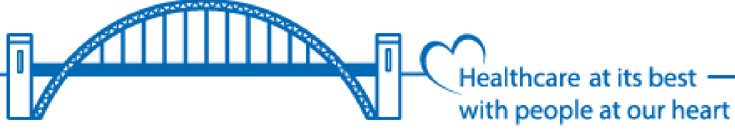
Patient Comments

''It has been a really pleasant experience. The staff are really supportive. My mum did find it hard to find the ward as she came in at the other side of the hospital - maybe a map for visitors would be helpful.''

''It is excellent here. The staff are so accommodating and approachable.''



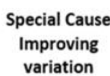
Performance



Performance Overview

Metric	Period	Actual	Target	Variation	Assurance
A&E Arrival to Admission / Discharge	Sep-24	75.0%	78%		?
A&E Trolley Waits	Sep-24	6	0		?
RTT 18 Weeks	Sep-24	67.3%	92%		F
>65 Week Waiters	Sep-24	199	0		F
Cancer 28 Day FDS	Sep-24	69.2%	77%		?
Cancer 62 Day	Sep-24	61.2%	70%	H	F
Diagnostic 6 Weeks	Sep-24	36.7%	5%	H	F

Variation



Special Cause Concerning variation

Special Cause Improving variation

Special Cause neither improve or concern variation

Common Cause

Assurance

Consistently hit target

Hit and miss target subject to random variation

Consistently fail target

Emergency Care

- Type 1 and overall performance in September fell from August to 60.7% (-1.8%) and 75.0% (-1.5%) respectively. Monthly fluctuations in performance are in line with common cause variation.
- In September the target for less than 2% of patients to wait over 12 hours from Accident and Emergency (A&E) arrival to admission/discharge was achieved (1.2%). However, the target lies between the SPC process limits, meaning there is not yet assurance this target will be hit consistently.

Elective Waits

- September saw considerable decreases in the number of >65 & >52 week waits at Newcastle Hospitals, though these changes remain in line with common cause variation. The total number of patients waiting >78 weeks reduced to 21, with the number of patients waiting >65 weeks fell to 199.
- The total waiting list (WL) size decreased slightly, in part due to additional administrative validation of patient pathways, but remained within the parameters of normal variation, albeit after a period of deterioration.

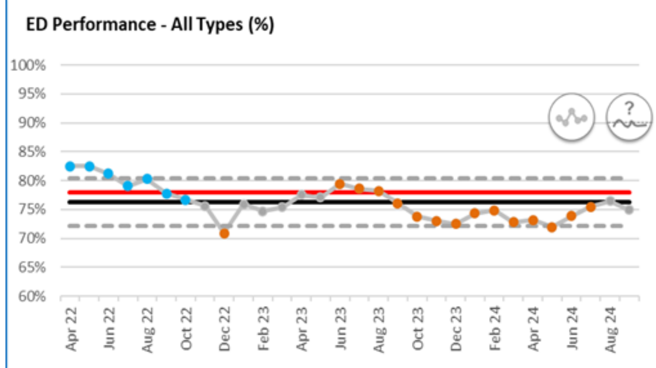
Cancer Care

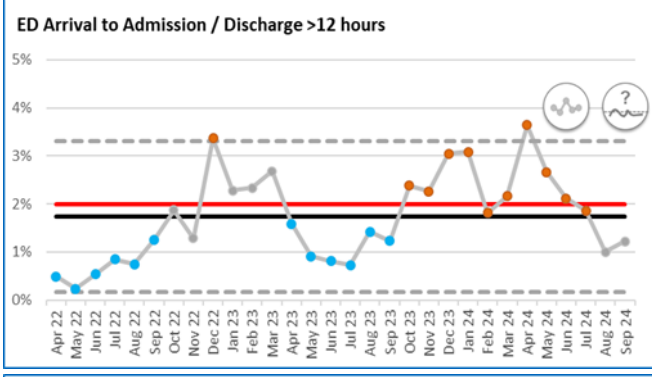
- In August the 77% 28 Day Faster Diagnosis Standard (FDS) was failed for the second successive month as performance dropped to 69.2%. This is within the level of natural variation to be expected given recent historical trends, as the target has only been sporadically achieved.
- 62 Day compliance in August was 61.2%, a continuing trend of improving special cause variation despite a consistent failure to hit the target.

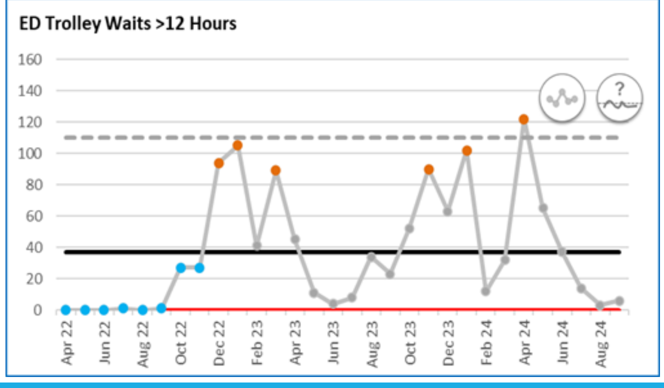
Diagnostics

- Performance against the 5% standard improved slightly in September, with 36.7% of patients waiting longer than six weeks for their test compared to 38.3% in August. However, there is special cause variation of a concerning nature in the data and the target is consistently failed.

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.

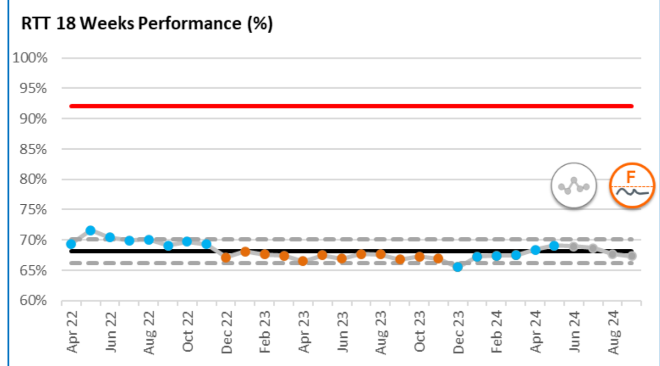
Current position

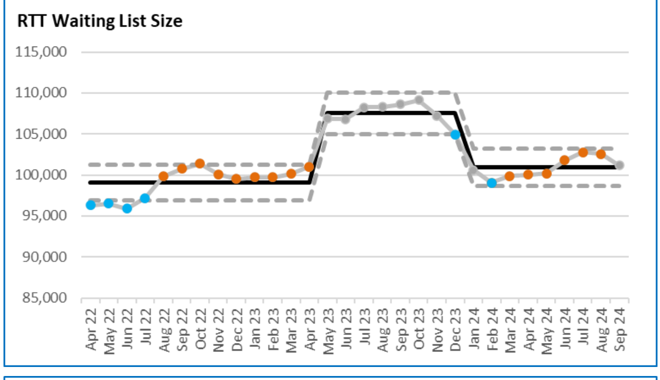
- Type 1 and overall performance in September fell from August to 60.7% (-1.8%) and 75.0% (-1.5%) respectively. Monthly fluctuations in performance are in line with common cause variation.
- In September the target for less than 2% of patients to wait over 12 hours from A&E arrival to admission/discharge was achieved - performance was 1.2%. However, the target lies between the SPC process limits, meaning there is not yet assurance this target will be hit consistently.
- There were 6 Trolley waits >12 hours, well below the monthly average (50) in the last 12 months
- Handovers >60 minutes almost doubled with 71 in September compared to 36 in August. There were 424 handovers >30 mins, which was a 35% increase from the previous month.
- The current configuration of the Emergency Department (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.

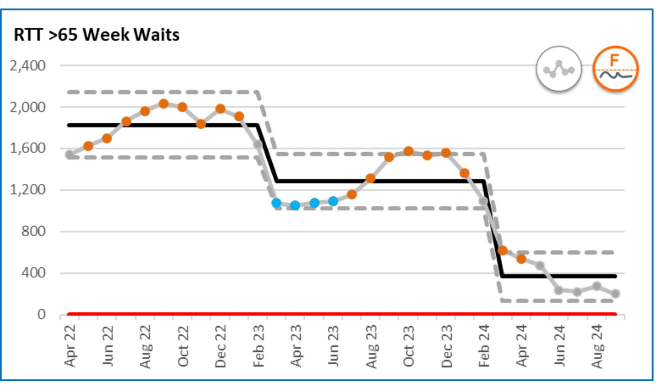
Action taken

- The Emergency Department action plan is being refreshed based on learning gained from the Trust's recent Perfect Week initiative which focused on improving patient flow and discharge. The plan is that any service improvements identified will be embedded into business as usual.
- Staffing - Changes have been made to the level of medical staffing and matron coverage within ED. Additionally, the ED has recruited to a patient flow coordinator role and the number of shifts covered by GPs within Paediatrics ED is improving.
- A workforce review has taken place and business case approved for additional medical staff to reduce waits to see a clinician, with full impact expected during the third quarter.
- The North East Ambulance Service NHS Foundation Trust (NEAS) will be completing a review of ED and will be sharing this with the department.
- The development of a co-located Urgent Treatment Centre (UTC) and the re-design of Same Day Emergency Care (SDEC) are both progressing to help address estates issues.

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).

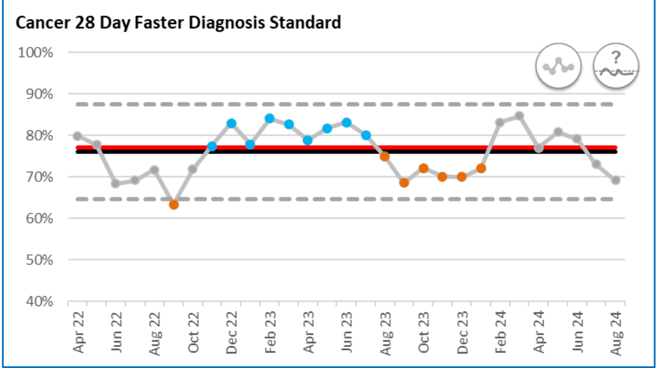
Current position:

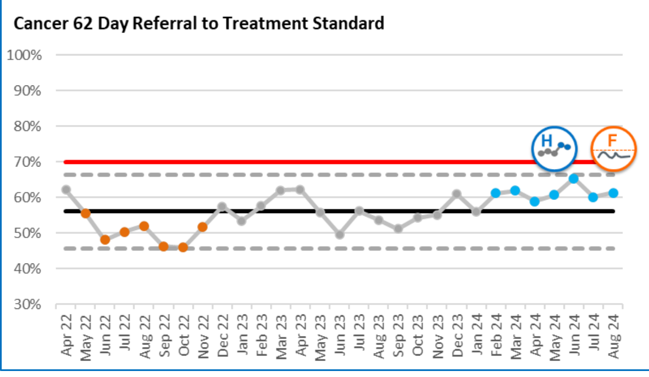
- September saw considerable decreases in the number of >65 & >52 week waits at Newcastle Hospitals, though these changes remain in line with common cause variation. The total number of patients waiting >78 weeks fell to 21 (compared to 32 in August) including 11 patients waiting for corneal graft surgery - for which there is a national tissue shortage. The total number of patients waiting >65 weeks reduced to 199 (-74).
- Whilst significant progress has been made over the financial year to reduce the number of long waiters, there have been challenges that have impacted the Trusts ability to meet the ambition of reaching zero patients waiting >65 weeks by the end of September 2024, including:
    - Limited capacity for Mohs Micrographic surgery in Dermatology.
    - Demand outstripping capacity within Trauma & Orthopaedics (T&O)/Spinal Surgery
    - 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 decreased slightly, in part due to additional administrative validation of patient pathways, but remained within the parameters of normal variation, albeit after a period of deterioration. The total number of patients waiting >18 weeks stood at 33,056, with Referral to Treatment (RTT) 18-week performance recorded at 67.3% (-0.4%).

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 Foundation Trusts (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 – August 2024					
Brain	100%	Head & Neck	66.7%	Skin	88.2%
Breast	91.8%	Lower GI	48.1%	Testicular	100%
Gynae	77.8%	Lung	33.5%	Upper GI	39.8%
Haem	81.8%	Sarcoma	76.9%	Urological	44.6%
Newcastle Hospitals Total					**61.2%**

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.

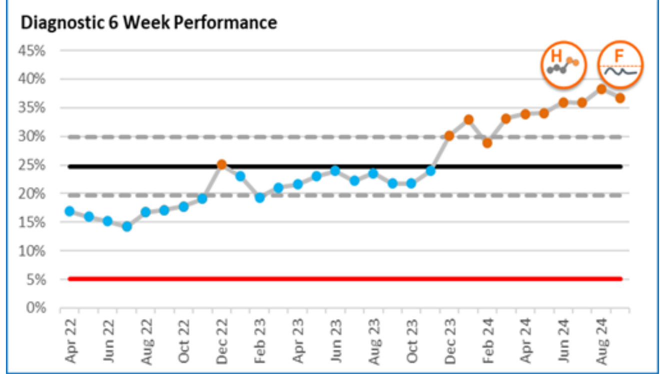
Current position:

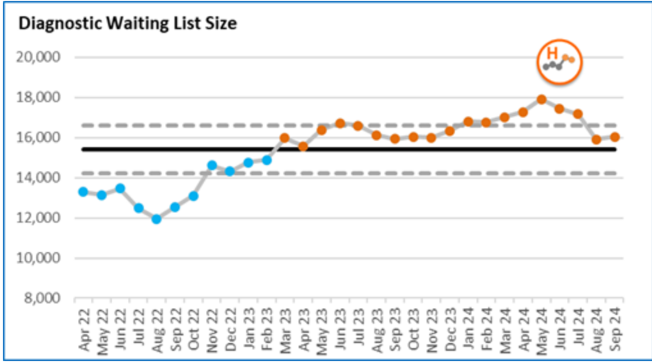
- In August the 77% 28 Day FDS was failed for the second successive month as performance dropped to 69.2%. This is within the level of natural variation to be expected given recent historical trends, as the target has only been sporadically achieved.
- 62 Day compliance for August was 61.2%, continuing the trend of improving special cause variation despite an overall consistent failure to hit the target.
- 31 Day performance continues to be short of the national target – 89.6% in August.
- 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 required to support the timely diagnosis of suspected cancers. MRI capacity shortfalls are 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 they are seen in priority order. Gynae: New consultants joined the service in September to increase capacity.
- Upper GI: Two additional Upper GI consultants have now been appointed, which will ensure additional capacity is secured in the medium to long-term.
- Lung: A number of improvement projects have commenced. There is also particular focus on the endobronchial ultrasound (EBUS) diagnostic element of the pathway.
- The refreshed monthly Quality & Performance Reviews for each Clinical Board are being used to monitor tumour group performance improvement trajectories and accompanying action plans.

Diagnostics





6 Week Diagnostic Performance by Modality – September 2024			
MRI	38.6%	CT	9.1%
Non-obs US	1.2%	DEXA	31.1%
Audiology	78.2%	ECHO	45.5%
Electrophysiology	0.0%	Neurophysiology	28.7%
Sleep Studies	71.9%	Urodynamics	7.5%
Colonoscopy	17.9%	Flexi-Sig	25.5%
Cystoscopy	0.0%	Gastroscopy	19.8%
Newcastle Hospitals Total			**36.7%**

Standards

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

Current position:

- Performance against the 5% standard improved slightly in September, with 36.7% of patients waiting longer than six weeks for their test compared to 38.3% in August. However, there is special cause variation of a concerning nature in the data and the target is consistently failed.
- The volume of activity delivered per working day has remained static for 3 successive months.
- The total WL size grew slightly by 122 patients from August's figure and there continues to be special cause variation of a concerning nature due to the growing WL.
- However, the number of 6 week breaches on the WL fell by 212 patients. There were 3,098 patients waiting >13 weeks, which was very similar to in August.
- Echocardiogram (ECHO) performance has declined considerably in the past 2 months, worsening from 12.3% in July to 45.5% in September. This follows a reduction in insourcing.
- Staffing deficits continue to constrain the volumes of activity several of our diagnostic services can undertake, particularly within Audiology.

Action taken

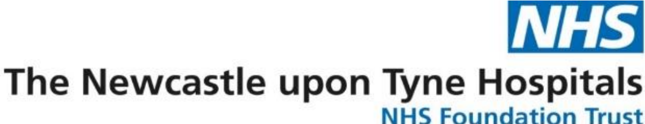
- The Community Diagnostic Centre (CDC) at the Metrocentre opened during October and this will increase capacity in numerous tests. Dependency on mobile CT units will be immediately reduced. Recruitment to posts at the CDC is ongoing to reduce reliance on insourcing in ECHO.
- Radiology have had approval to continue utilising additional mobile MRI units.
- Utilisation and efficiency gains have been made through a dedicated improvement programme in main radiology booking and scheduling, which has improved both booking systems and processes. Additionally, the booking teams are holding daily huddles and the service is also implementing Dr Doctor to offer improved communication with patients.
- A data analyst has been appointed to specifically focus on improving diagnostics performance reporting and data quality, which should increase awareness and prominence across the Trust
- 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.

Contractual & Planning Standards (1/2)

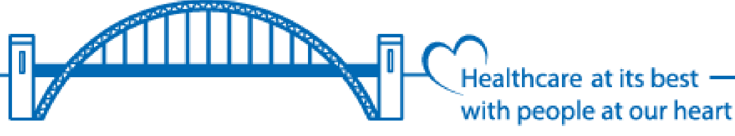
Theme	Standard	Jun-24	Jul-24	Aug-24	Sep-24	Num.	Den.	24/25 YTD
Activity & Elective Care								
Day Case	**100%** of 24/25 Plan (equivalent to 107% of 19/20 value-weighted activity)	96.3%	96.5%	**102.4%**	**96.8%**	10,742	11,102	**98.8%**
Elective Overnight		103.3%	95.1%	**103.0%**	**91.3%**	1,670	1,829	**98.3%**
Outpatient New		93.2%	95.3%	**95.2%**	**92.7%**	24,633	26,561	**95.2%**
Outpatient Procedures		108.3%	104.4%	**105.7%**	**100.4%**	20,076	19,992	**104.8%**
Outpatient Review	**N/A**	111.1%	110.3%	**112.7%**	**112.0%**	64,737	57,786	**112.8%**
Non-Elective		87.7%	91.0%	**82.8%**	**90.0%**	946	1,051	**87.6%**
Emergency		102.9%	105.2%	**97.1%**	**106.0%**	6,153	5,807	**103.9%**
RTT 18 Week Wait	**92%**	68.9%	68.7%	**67.7%**	**67.3%**	68,106	101,162	**68.4%**
>78 Week Waiters	**Zero**	15	18	**32**	**21**	21		
>65 Week Waiters	**Zero** (by Sep-24)	236	222	**273**	**199**	199		
>52 Week Waiters	As per submitted trajectory	2,357	2,499	**2,560**	**2,420**	2,420		
RTT Waiting List Size	As per submitted trajectory	101,810	102,763	102,589	**101,162**	101,162		
Diagnostic Activity	**120%** of 19/20 activity	111.7%	114.7%	112.5%	**112.7%**	20,797	18,552	**133.9%**
Diagnostic 6 week wait	<=**5%** (local target of <=15%)	36.0%	35.9%	38.3%	**36.7%**	5,882	16,035	**35.8%**
Day case rates (BADS procedures)	**85%**	**86.4%**	TBC	TBC	TBC			
Capped Theatre Utilisation	**85%**	76.8%	74.1%	**78.1%**	TBC			
Urgent Ops. Cancelled Twice	**Zero**	0	0	0	**0**	0		**0**
Cancelled Ops. Rescheduled >28 Days	**Zero**	9	10	16	**8**	8		**64**
OP Activity Ratio: New/Procedure	**46%**	42.7%	42.4%	37.8%	**41.8%**	43,174	103,254	**42.0%**
>12 Week Waiters Validated	**90%**	63.6%	70.2%	79.5%	**75.6%**	24,204	32,028	**67.6%**
Outpatient Review Reduction	**25%** reduction vs 19/20 baseline	107.9%	109.6%	108.9%	**109.6%**	85,401	78,008	**135.8%**
PIFU Take-up (%)	>=**5%** of all OP atts. (by Mar-25)	2.1%	2.2%	2.2%	**2.2%**	2,549	115,191	**2.1%**

Contractual & Planning Standards (2/2)

Theme	Standard	Jun-24	Jul-24	Aug-24	Sep-24	Num.	Den.	24/25 YTD
Cancer Care								
28 Day Faster Diagnosis	**77%** (by Mar-25)	79.2%	73.0%	**69.2%**	TBC	1,940	2,803	**77.5%**
31 Days (DTT to Treatment)	**96%**	90.6%	88.9%	**89.6%**	TBC	1,162	1,297	**88.7%**
62 Days (Referral to Treatment)	**70%** (by Mar-25)	65.3%	60.0%	**61.2%**	TBC	240	392	**61.1%**
>62 Day Cancer Waiters		190	172	211	**223**	223		
Urgent & Emergency Care								
A&E Arrival to Admission/Discharge	**>=78%** under 4 hours (by Mar-25)	73.9%	75.5%	76.5%	**75.0%**	14,658	19,552	**74.3%**
	<=2% over 12 hours	2.1%	1.9%	1.3%	**1.2%**	239	19,552	**2.2%**
A&E Decision to Admit to Admission	**Zero** over 12 hours	37	14	3	**6**	6		**247**
Adult General & Acute Bed Occupancy	**<=92%**	80.2%	87.3%	83.7%	**94.5%**	1,363	1,442	**87.2%**
Ambulance Handovers <15 mins	**65%**	54.6%	56.3%	59.9%	**53.0%**	1,704	3,133	**55.0%**
Ambulance Handovers <30 mins	**95%**	84.2%	86.6%	88.8%	**84.2%**	2,737	3,133	**85.8%**
Ambulance Handovers >60 mins	**Zero**	73	47	36	**71**	71		**370**
Urgent Community Response Standard	**>=70%** under 2 hours	80.1%	75.7%	77.3%	**86.5%**	313	362	**79.9%**
Safe, High Quality Care								
Mixed Sex Acommodation Breach	**Zero**	99	83	78	**70**	70		**544**
VTE Risk Assessment	**95%**	**87.9%**	TBC	TBC	TBC			
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour	**57.0%**	TBC	TBC	TBC			
Sepsis Screening Treat. (All)		**61.0%**	TBC	TBC	TBC			



People



People Overview

Metric	12-Month Rolling	Actual	Target	Variation	Assurance
Sickness	Sep-24	5.42%	4.5%		
Short-term	Sep-24	1.86%			
Long term	Sep-24	3.17%			
Turnover	Sep-24	9.59%	10%		
Mandatory training	Sep-24	92.38%	90%		
Appraisal	Sep-24	83.31%	90%		
Disabled staff	Sep-24	5.45%			
Ethnicity (BAME staff)	Sep-24	17.03%			

Variation

Special Cause Concerning variation | Special Cause Improving variation | Special Cause neither improve or concern variation | Common Cause

Assurance

Consistently hit target | Hit and miss target subject to random variation | Consistently fail target

Sickness

- Total sickness absence remained at 5.42%; target 4.50%.
- Slight increase in total sickness in September compared to August.
- Top reasons for sickness: anxiety/stress/depression 31%; cold/cough/flu 10%; gastrointestinal 9%,
- Short-term sickness increased in September to 1.86%.
- Long term sickness decreased in September to 3.17%.

Retention & Turnover

- Total turnover reducing since May 2023 to 9.59%; target 10%.
- Top reason for leaving: work-life balance 18.35%.
- Top destinations: no employment 39%; other NHS organisation 32.90% (includes retire-return).

Mandatory training

- Performance declined August to September to 92.38%; target 90%.
- Lowest performance in Medical and Dental 83.92%.
- Paediatric basic life support only mandatory training below 80%.

Appraisal

- Performance declining since July to 83.31%; target 90%.

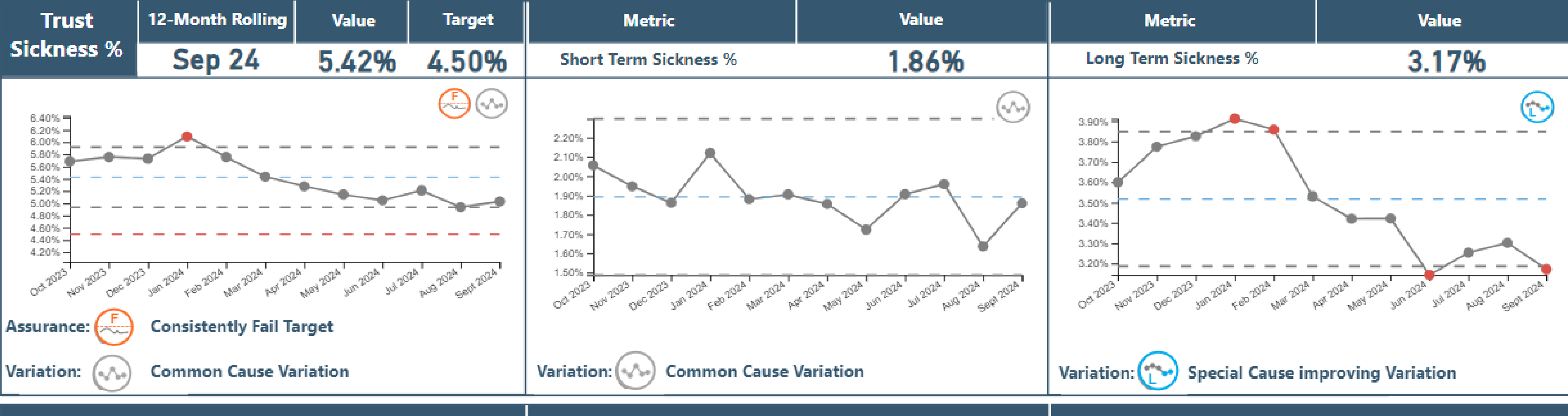
Bank & Agency

- Bank expenditure £16,767,519.
- Agency expenditure £4,026,185.

Equality & Diversity

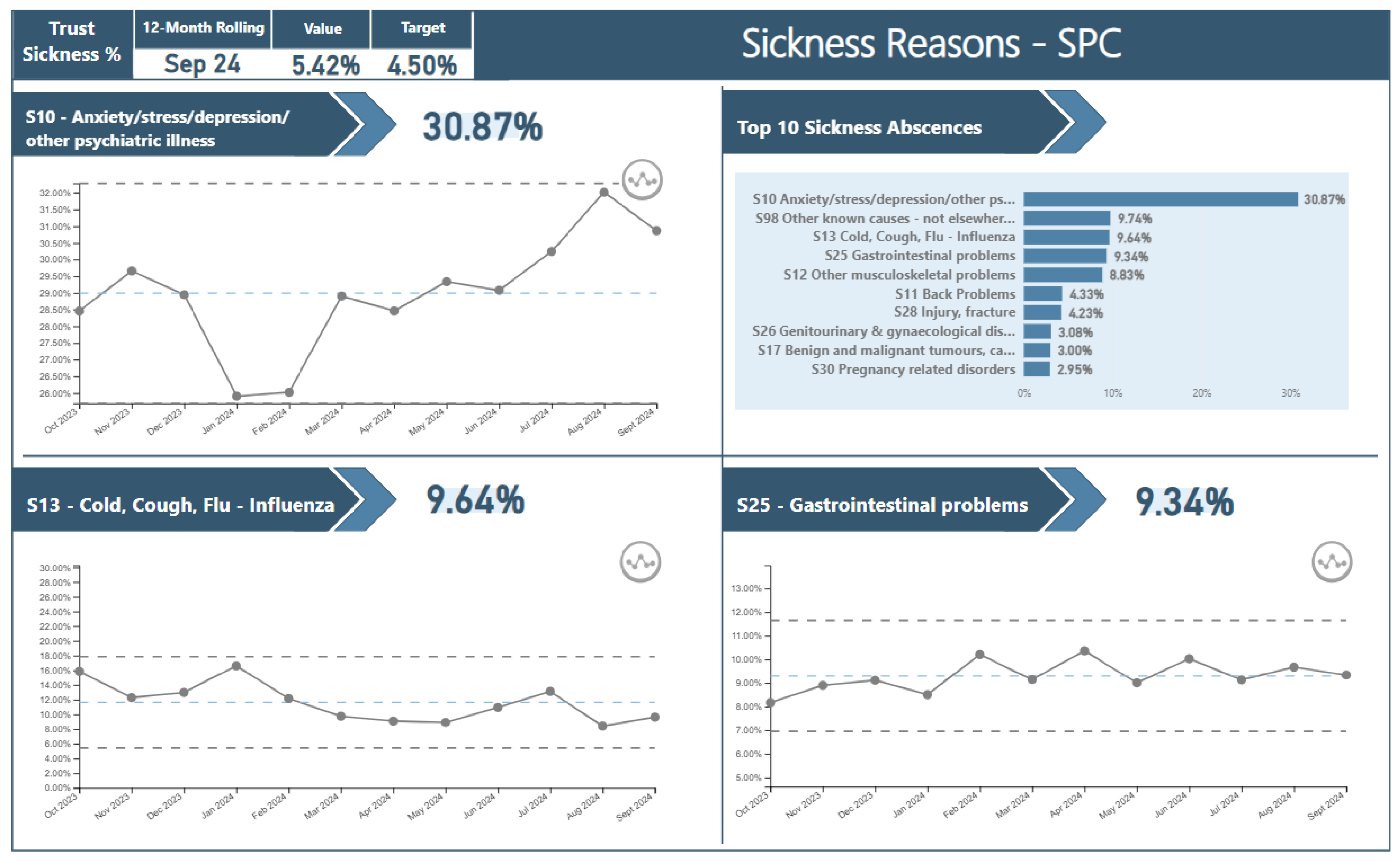
- Disabled staff increased to 5.45%.
- Black, Asian and Minority Ethnic (BAME) staff increased to 17.03%.

Sickness Absence



Current Position:	Underlying Issues	Actions Undertaken:
• 12-month average to September 5.42%. • September total sickness: 5.03%; short-term 1.86%; long-term 3.17%. • Top reasons for sickness: ○ Anxiety/stress/depression 31% ○ cold/cough/flu 10% ○ Gastrointestinal 9%	• Main reason for staff sickness is anxiety/ stress/depression which accounts for 31% of all sickness absence and has an upward underlying trend since May 2023. • Total full time equivalent days lost 280,131. • Total cost of sick pay £29.6m. • CS Estates has highest sickness 7.58%; short-term sick 1.96%; long term sick 5.61%. • Variation in sickness rates across Clinical Boards: ○ lowest is Clinical and Research Services 4.34%; short-term sick 1.61%; long term sick 2.73% ○ highest is Family Health 6.56%; short-term sick 1.99%; long term sick 4.57	• Health and Wellbeing Offer (HAWB) offer – Exec Team approved proposals for funding to address gaps in wellbeing offer including: mental health and psychological support; rapid access; leadership/ management training. Proposals to be taken forward. • Vaccine programme (flu and Covid) in process. • Better Health at Work Award (Maintaining Excellence) – assessment visit 17 December; health needs assessment planned in January. • Application of policy training being delivered across the Trust by Head of Culture and Head of Workforce Advisory Services. • Monitoring – daily information available to managers via People Dashboard; monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards (CB)/Corporate Services (CS).

Sickness Absence – Absence reasons



Sickness Absence – FTE working days lost & Formal Action

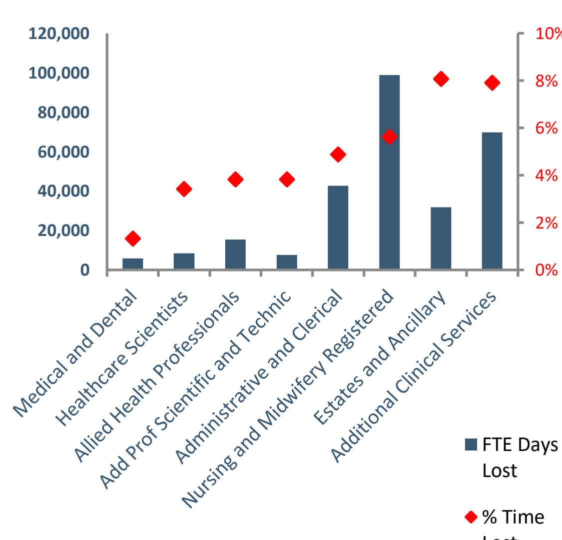
Sickness - FTE working days lost

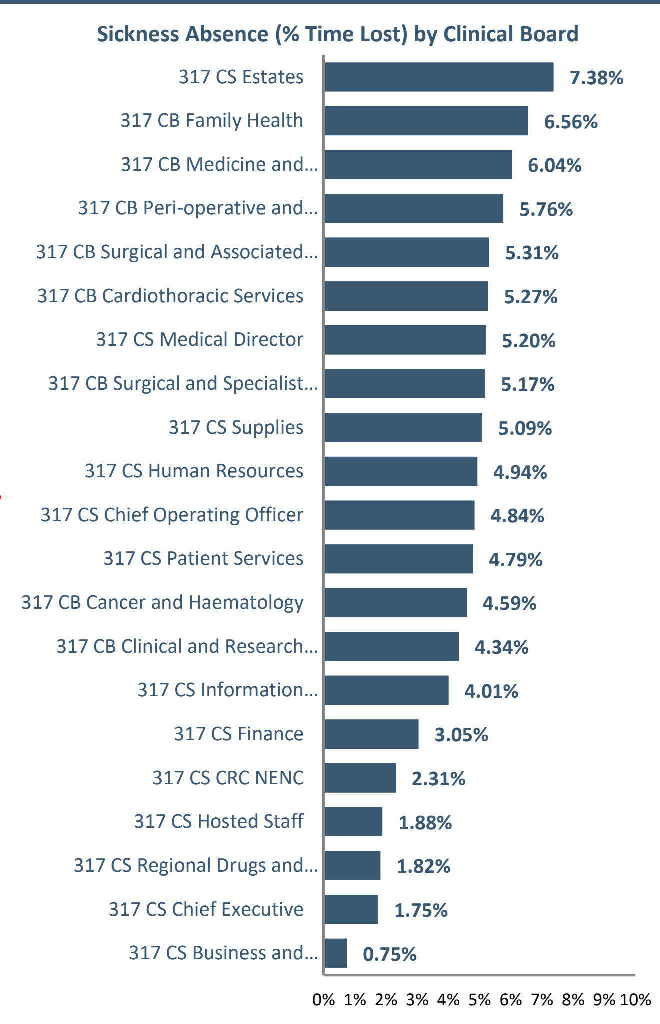
FTE Working Days Lost due to sickness

280,131

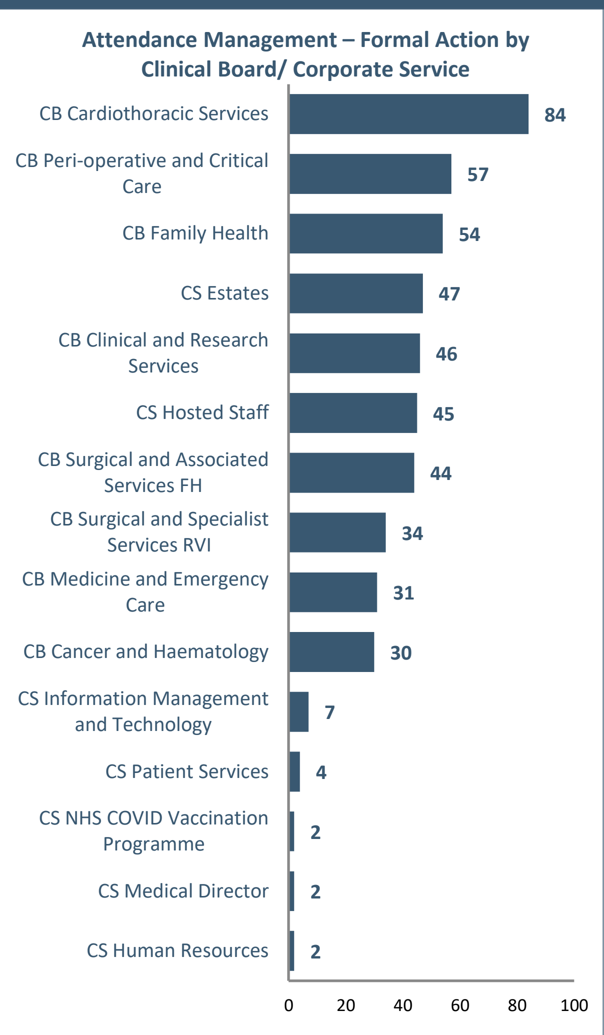
262,965

Compared to the previous year.

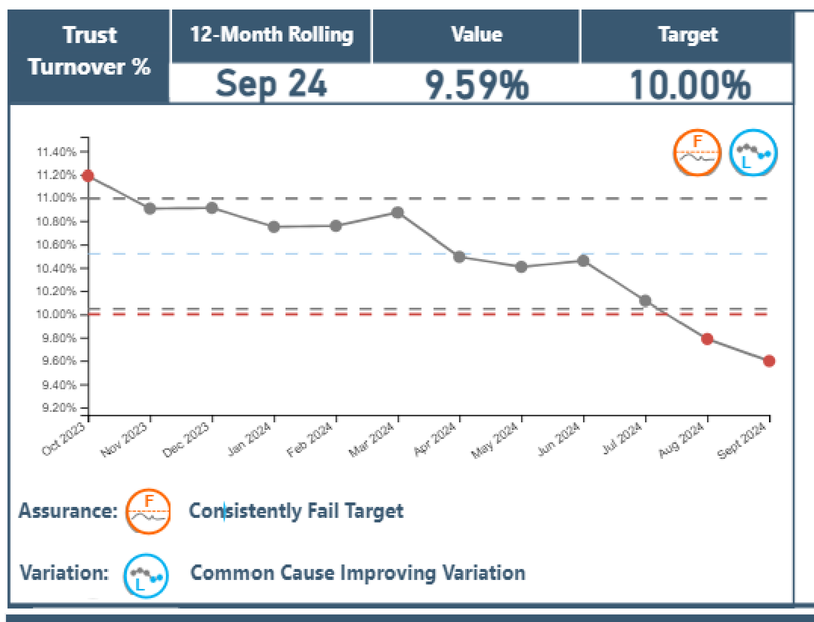


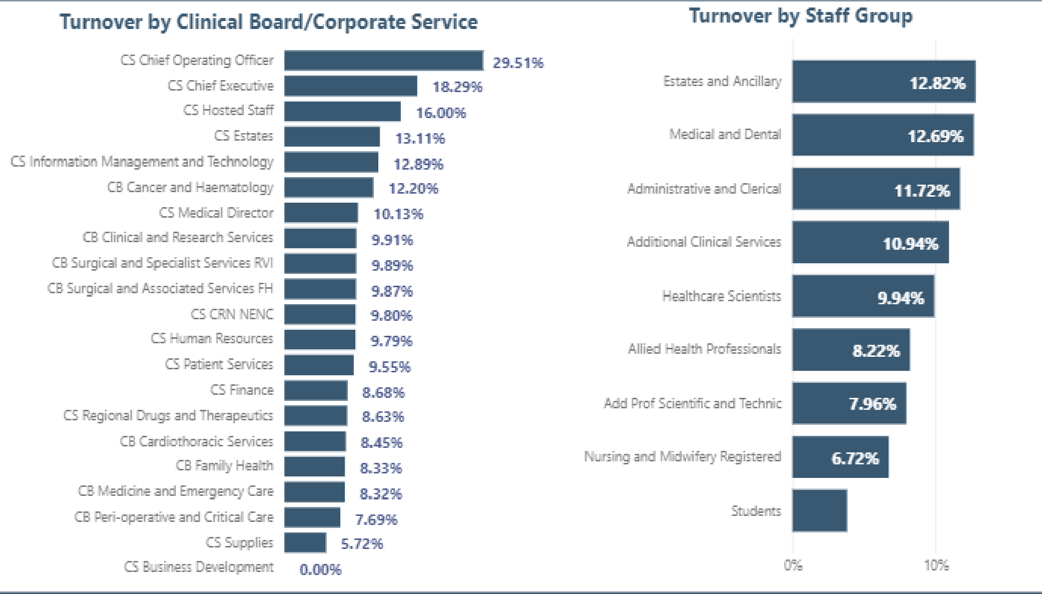


Sickness - Formal Action



Turnover (1/2)





Current Position:

- 12-month average to September 9.59%.
- Chart shows performance is now meeting target with consistent downward trajectory.
- September 2024 shows reduction of 0.11% from August which is illustrated by continued positive outlier flags (red dots).

Underlying Issues

- 1,568 leavers in 12-months to September 2024: 23% were Nursing & Midwifery (368) and Administrative and Clerical 20% (316).
- Top destinations – No Employment (610, 39%); Other NHS organisation (515, 33%).
- Top reasons – Work life Balance (286, 18%); Relocation (204, 13%) Retirement Age (202, 13%)

Actions Undertaken:

- Flexible working – offer in place and encouraged.
- Exit process – under review; and 'stay conversations' being explored. Pilot to encourage exit interviews (and facilitate stay conversations) completed in Surgery & Associated Services and to be evaluated to consider potential wider roll-out.
- Monitoring – daily information available to managers via People Dashboard; monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards/Corporate Services.

Turnover (2/2)

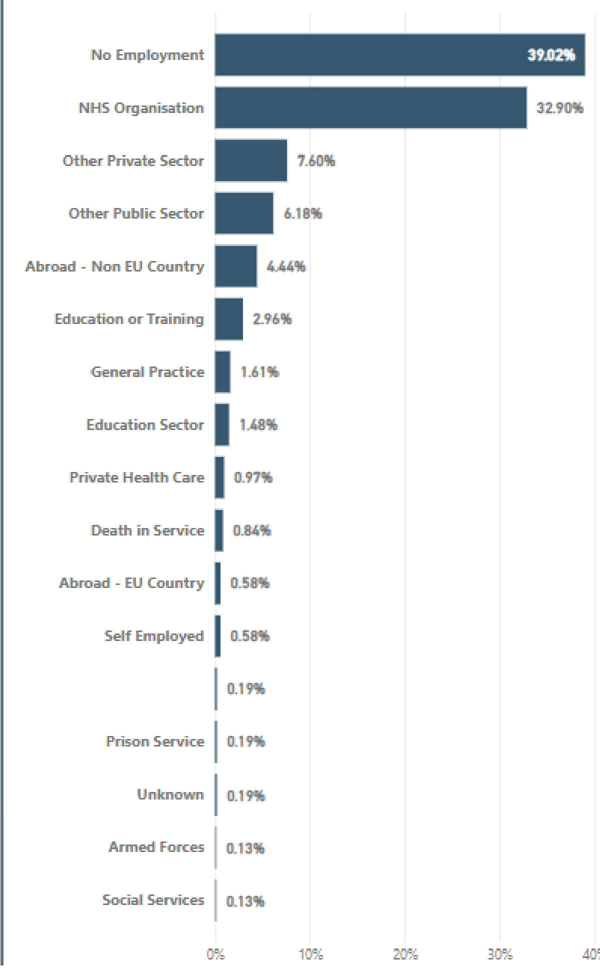
Trust Turnover %	12-Month Rolling	Value	Target
	Sep 24	9.59%	10.00%

Leaving Reasons

Leaving Reasons

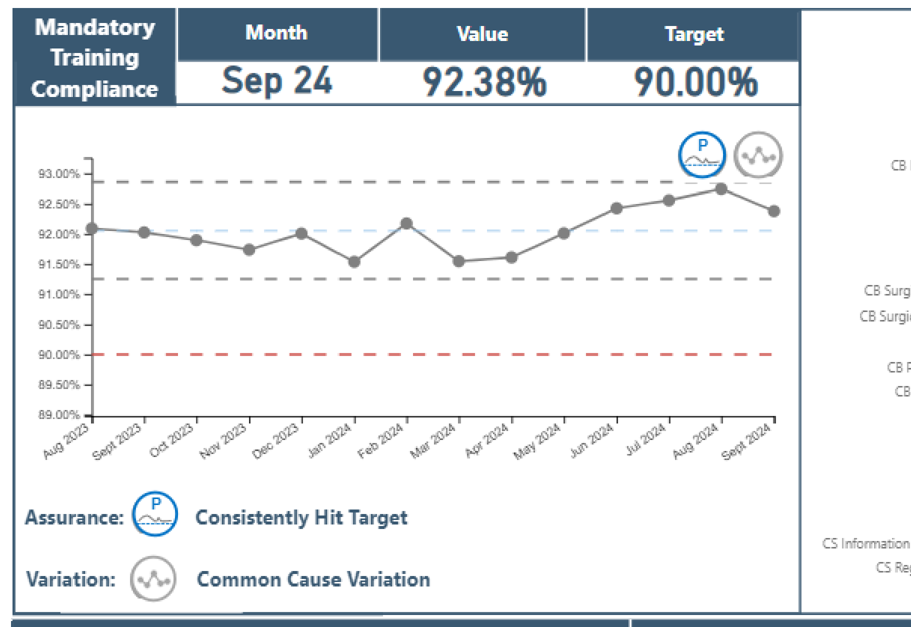
Leaving Reason	Leaving Reason %
Voluntary Resignation - Work Life Balance	18.35%
Retirement Age	12.94%
Voluntary Resignation - Relocation	12.94%
Flexi Retirement	10.05%
Voluntary Resignation - Promotion	9.40%
End of Fixed Term Contract	5.80%
Voluntary Resignation - Health	5.22%
Voluntary Resignation - To undertake further education or training	4.12%
Voluntary Resignation - Incompatible Working Relationships	3.61%
Voluntary resignation - Pay and Reward Related	3.41%
Voluntary Resignation - Lack of Opportunities	2.38%
Dismissal - Capability	2.06%
End of Fixed Term Contract - Other	1.48%
Voluntary Resignation - Child Dependants	1.48%
End of Fixed Term Contract - Completion of Training Scheme	1.16%
Death in Service	1.09%
Dismissal - Conduct	0.90%
Voluntary Resignation - Other/Not Known	0.77%
Retirement - Ill Health	0.64%
End of Fixed Term Contract - End of Work Requirement	0.45%
Voluntary Early Retirement - with Actuarial Reduction	0.45%
Voluntary Resignation - Adult Dependants	0.45%
Dismissal - Statutory Reason	0.32%
End of Fixed Term Contract - External Rotation	0.19%
Redundancy - Voluntary	0.13%
Voluntary Early Retirement - no Actuarial Reduction	0.13%
Employee Transfer	0.06%

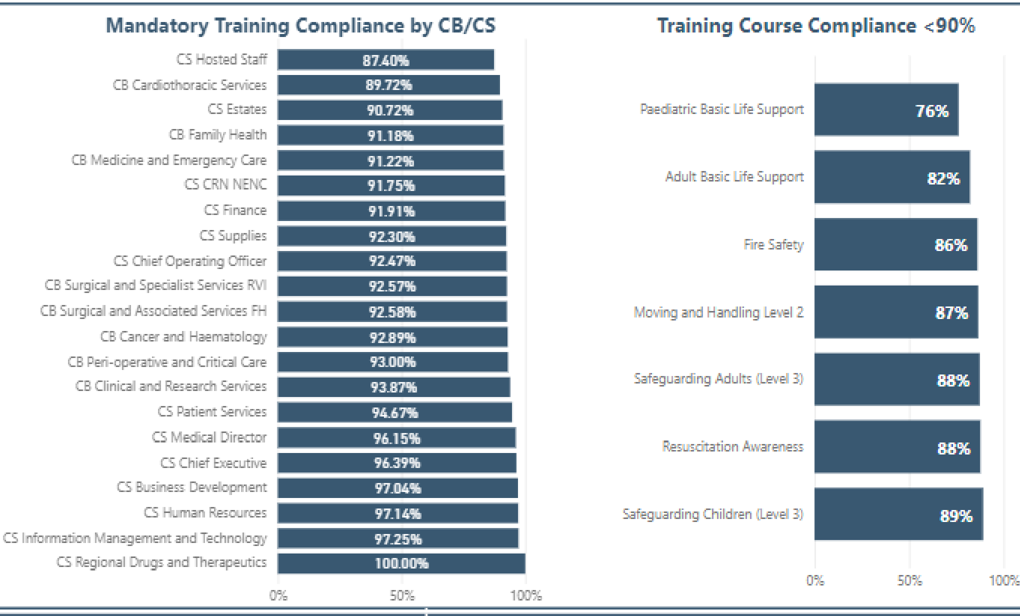
Destination on Leaving



Destination On Leaving	Destination On Leaving %
No Employment	39.02%
NHS Organisation	32.90%
Other Private Sector	7.60%
Other Public Sector	6.18%
Abroad - Non EU Country	4.44%
Education or Training	2.96%
General Practice	1.61%
Education Sector	1.48%
Private Health Care	0.97%
Death in Service	0.84%
Abroad - EU Country	0.58%
Self Employed	0.58%
	0.19%
Prison Service	0.19%
Unknown	0.19%
Armed Forces	0.13%
Social Services	0.13%

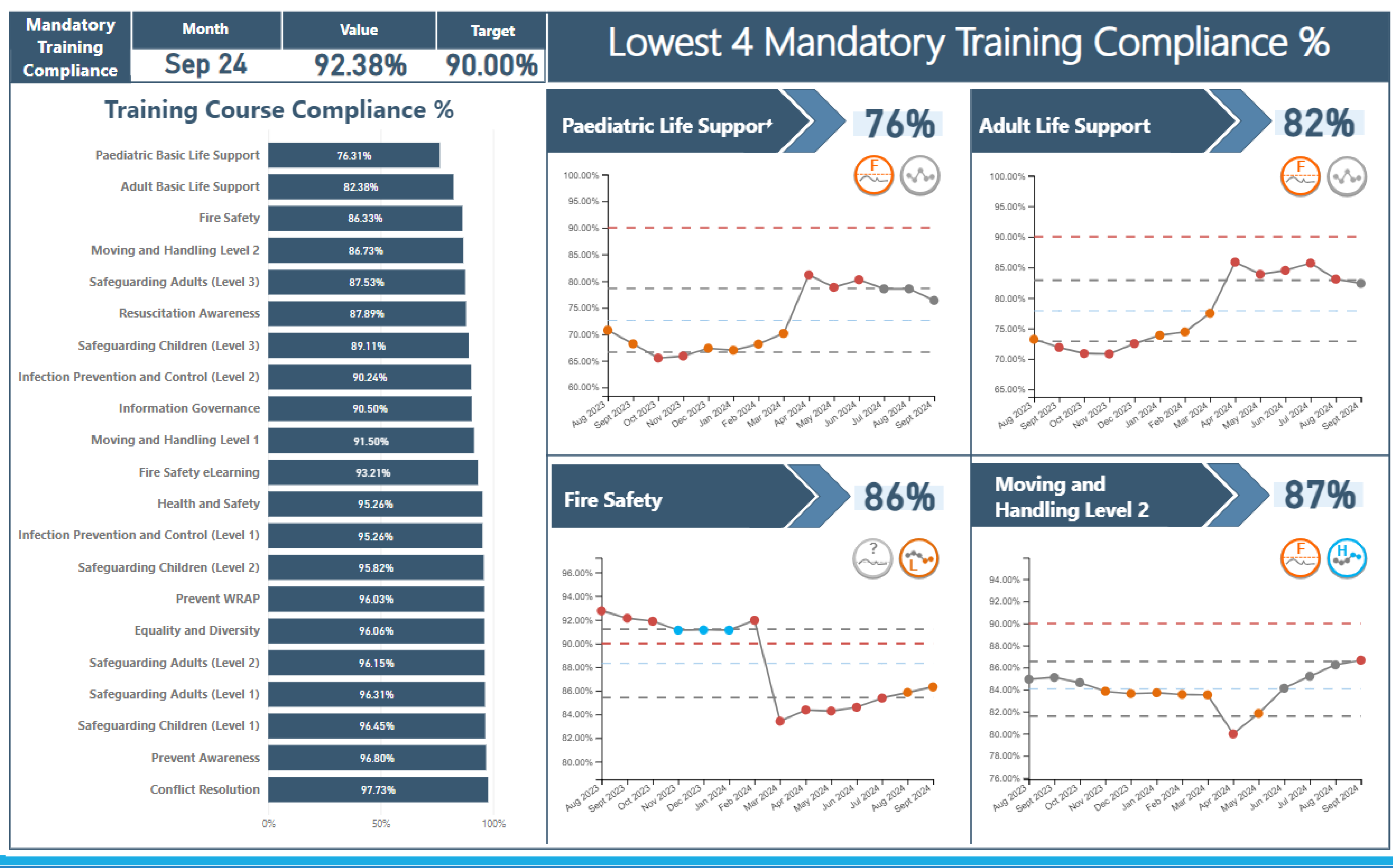
Mandatory Training (1/2)



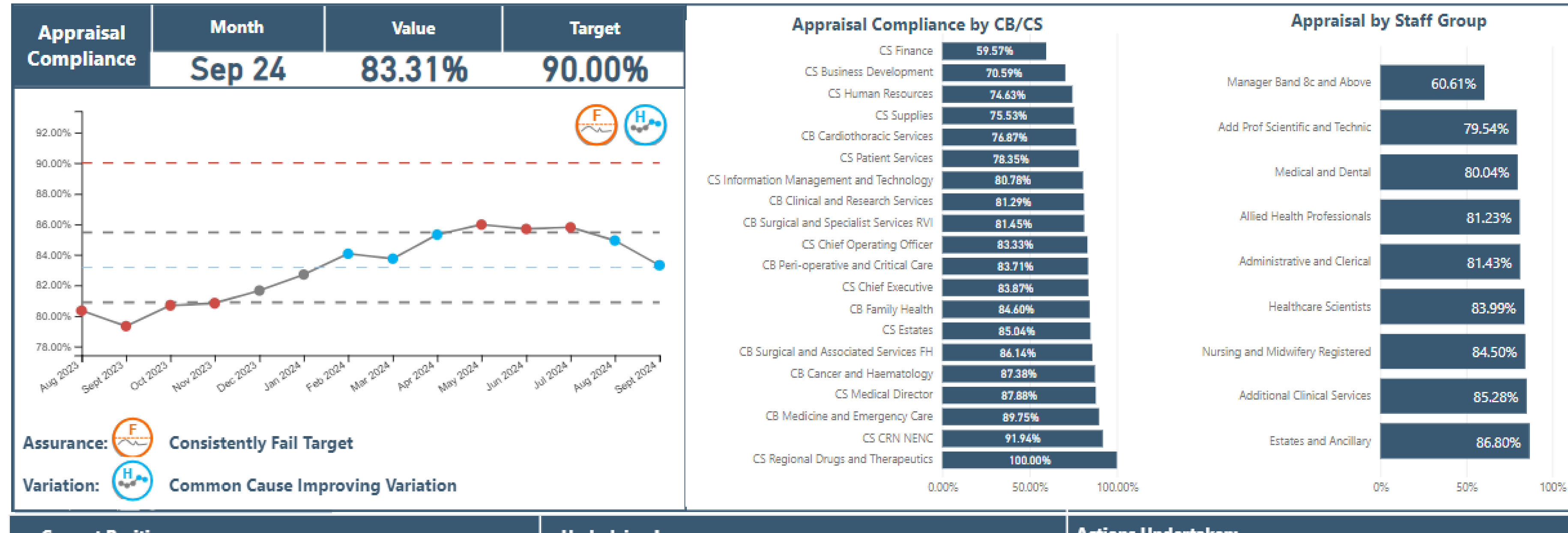


Current Position:	Underlying Issues	Actions Undertaken:
• Chart shows improvement with overall target consistently hit.	• Medical and Dental – have lowest overall compliance (84%) with low compliance in Adult Basic Life Support (68%), Fire Safety (74%); Paediatric Basic Life support (77%). • Paediatric Life Support – overall compliance low at 76% for September 2024. • Safeguarding Level 3 – courses being re-assessed for content; concerns delivery must be face-to-face, multi-agency and continuous; Safeguarding team no longer have a trainer post. • Venous Thromboembolism (VTE) – now live; on 3-yearly update; part of Tier 3 (Trust-level) mandatory training. • Oliver MacGowan – awaiting national instruction/ guidance.	• Low compliance – automated email reminders and escalation route via managers in place; subject areas subject to a focussed improvement project. • Resus – additional staffing capacity identified and team targeting hotspot areas. • Statutory & mandatory national review – awaiting outcome and next steps. • Moving & handling – under review to improve capacity. • Monitoring – daily information available to managers via People Dashboard; monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards/Corporate Services.

Mandatory Training (1/2)



Appraisal Compliance



Current Position:

- Chart shows performance is not meeting target.
- April-July 2024 showed consistent performance illustrated by positive outlier flags (red dots) with a reduction since August.

Underlying Issues

- 2,290 appraisals are overdue with highest numbers in Nursing and Midwifery (704) and Admin and Clerical (412).
- Clinical Board percentage compliance ranges from 77.00% to 89.79%.
- Corporate Service percentage compliance ranges from 57.69% to 100.00%.

Actions Undertaken:

- Audit report – rated compliance with policy as ‘Reasonable’; action plan in place to address recommendations including launch of a new policy and approach April 2025.
- Monitoring – daily information available to managers via People Dashboard; monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards/Corporate Services.

Bank & Agency Utilisation – (£)

Bank Utilisation (£)	12-Month period ending	Total Bank Expenditure (£)	Total Bank Difference (£)
	Sep 24	£16,767,519	-£1,339,696

Bank Utilisation (£)

Clinical Board	Oct 22 to Sep 23	Oct 23 to Sep 24	Total Hours
Admin & Clerical	£1,141,836	£268,150	-£873,687
Ancillary	£372,904	£1,162,487	£789,583
Estates			
Nursing & Midwifery (Registered)	£6,722,743	£5,465,942	-£1,256,801
Nursing & Midwifery (Unregistered)	£8,675,803	£9,044,542	£368,738
Professional & Technical	£1,193,929	£826,398	-£367,530
Total	£18,107,215	£16,767,519	-£1,339,696

Agency Utilisation (£)	12-Month period ending	Total Agency Expenditure (£)	Total Agency Difference (£)
	Sep 24	£4,026,185	-£464,032

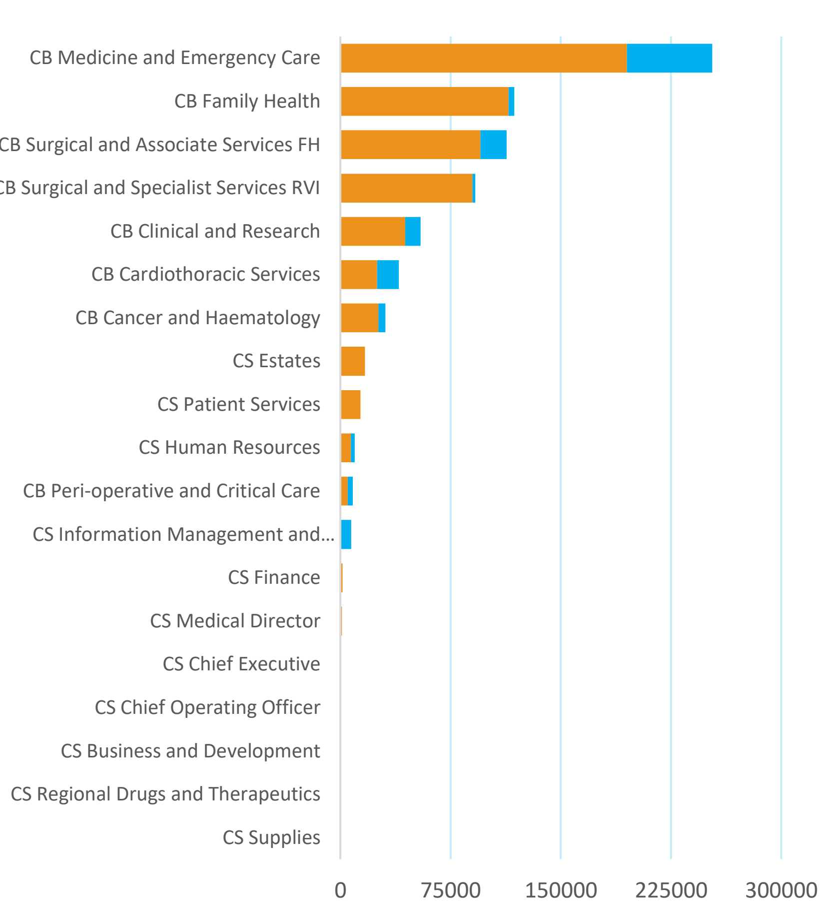
Agency Utilisation (£)

Clinical Board	Oct 22 to Sep 23	Oct 23 to Sep 24	Total Hours
Admin & Clerical	£541,953	£349,561	-£192,392
Ancillary	£18,447	£23,029	£4,582
Estates	£65,509	£26,475	-£39,034
Nursing & Midwifery (Registered)	£102,502	£220,225	£117,724
Nursing & Midwifery (Unregistered)	£2,789,408	£2,348,265	-£441,143
Professional & Technical	£972,399	£1,058,629	£86,230
Total	£4,490,217	£4,026,185	-£464,032

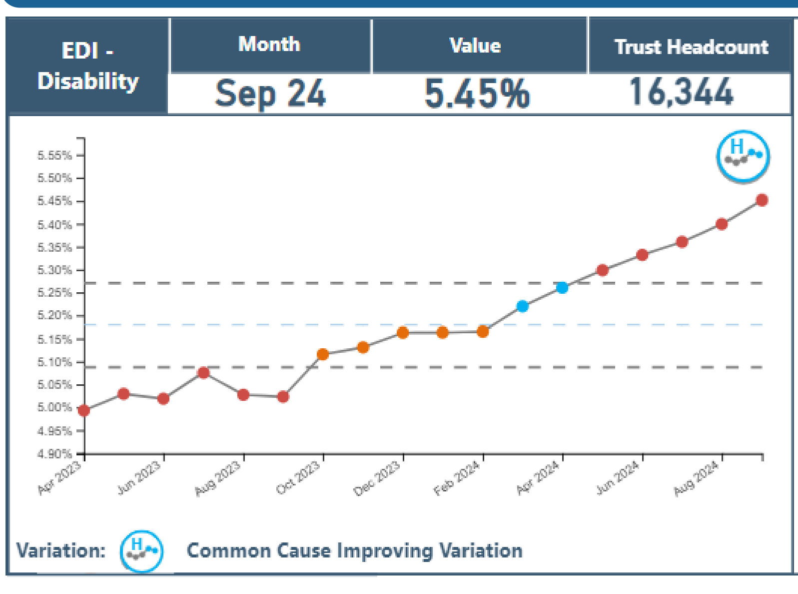
Bank & Agency Utilisation - Hours

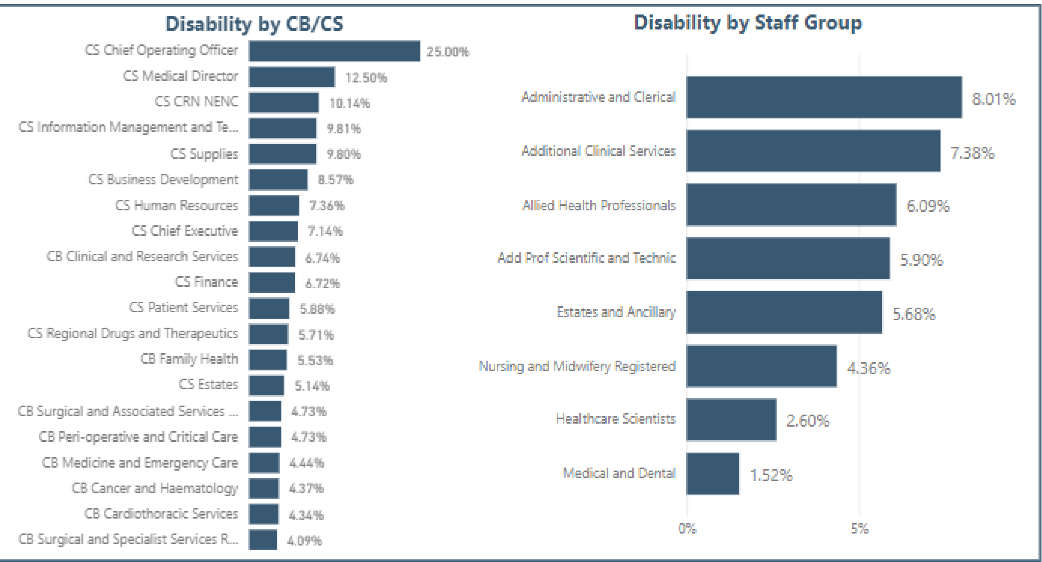
Bank & Agency	12-Month period ending	Total Bank and Agency Hours
	Sep 24	760,949.09

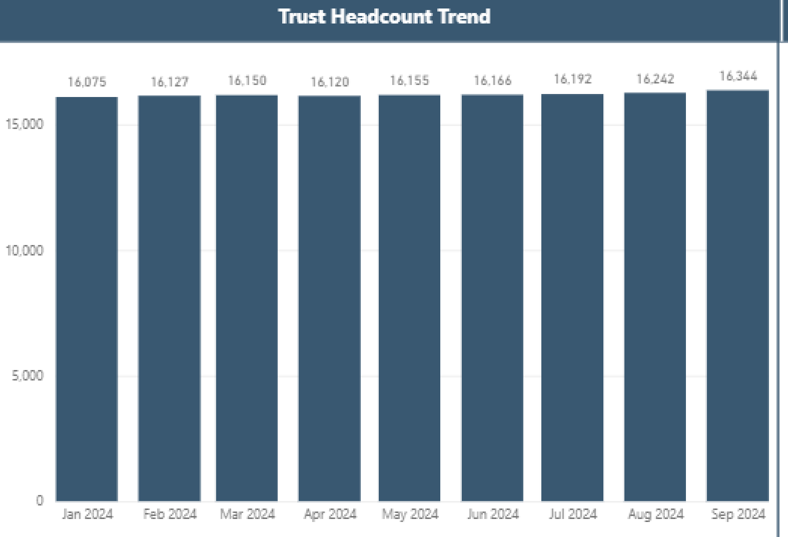
Clinical Board	Bank Hours	Agency Hours	Total Hours
CB Medicine and Emergency Care	195,054	58,004	253,058
CB Family Health	114,333	3,955	118,288
CB Surgical and Associate Services FH	95,346	17,878	113,224
CB Surgical and Specialist Services RVI	89,782	2,003	91,785
CB Clinical and Research	44,242	10,352	54,595
CB Cardiothoracic Services	24,981	14,781	39,762
CB Cancer and Haematology	25,856	4,778	30,634
CS Estates	16,790	0	16,790
CS Patient Services	13,782	0	13,782
CS Human Resources	7,168	2,525	9,693
CB Peri-operative and Critical Care	4,921	3,527	8,448
CS Information Management and Technology	0	7,306	7,306
CS Finance	1,567	0	1,567
CS Medical Director	1,053	0	1,053
CS Chief Executive	482	0	482
CS Chief Operating Officer	370	0	370
CS Business and Development	101	0	101
CS Regional Drugs and Therapeutics	13	0	13
CS Supplies	0	0	0



Equality, Diversity and Inclusion (EDI) - Disability







Age Band

	Age Band	Disability %
1	<=20 Years	13.04%
2	21-25	10.12%
3	26-30	6.98%
4	31-35	5.49%
5	36-40	4.09%
6	41-45	4.46%
7	46-50	3.97%
8	51-55	4.61%
9	56-60	5.51%
10	61-65	5.00%
11	66-70	2.69%
12	>=71 Years	3.33%

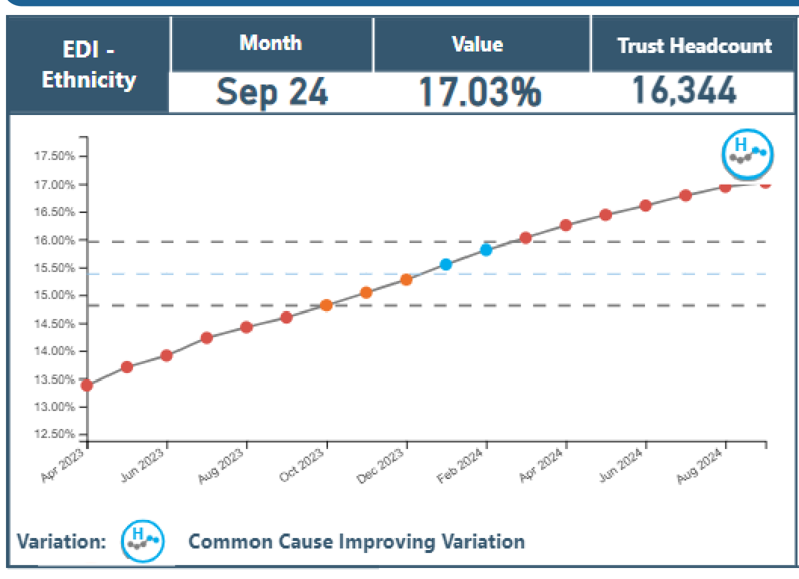
Current Position:

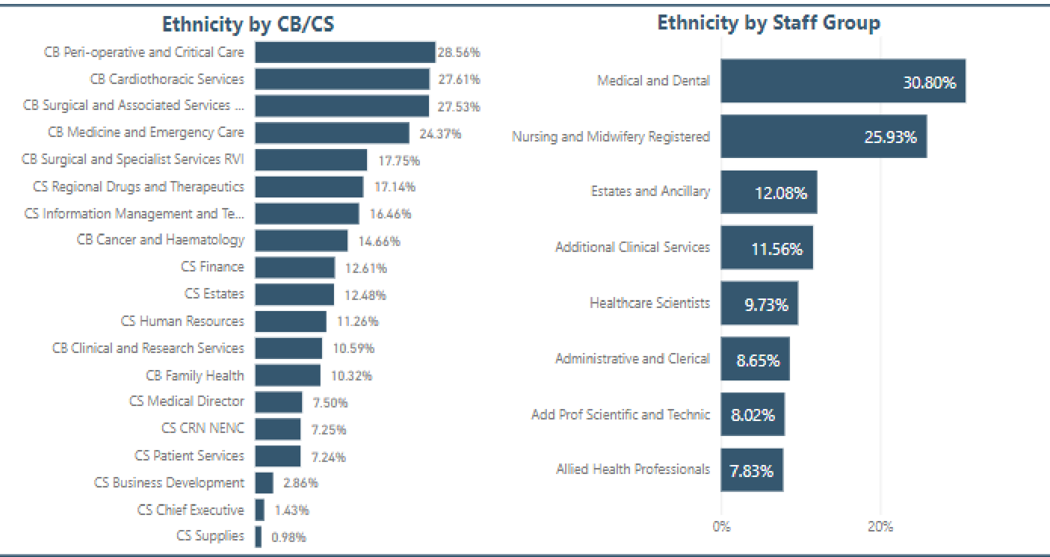
Charts show percentage of staff in post each month by those disclosing a disability.

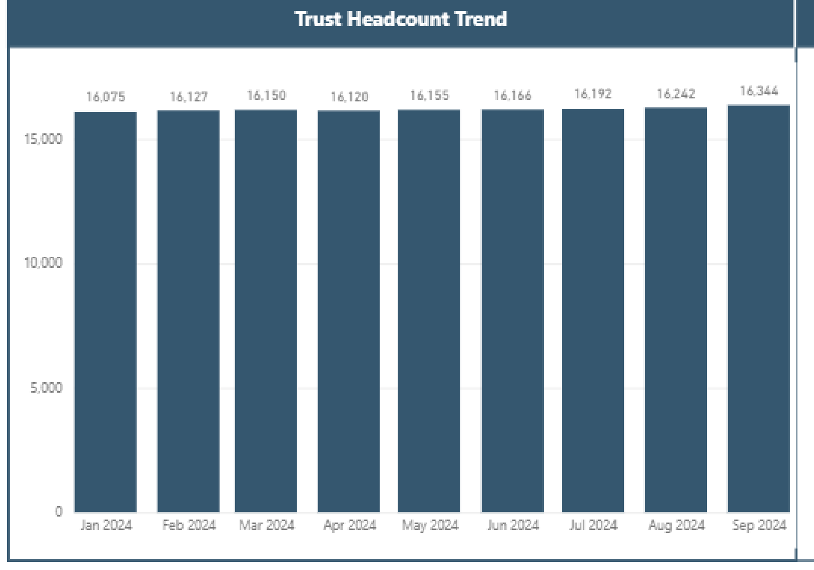
Percentage of staff employed disclosing a disability continues to demonstrate a month-on-month increase with the latest reporting period increasing to 5.45%.

Percentage of staff who have not disclosed their status is 11%. An EDI campaign is in place from October to encourage staff to update their EDI record in Electronic Staff Record (ESR)

Equality, Diversity and Inclusion (EDI) - Ethnicity







Age Band

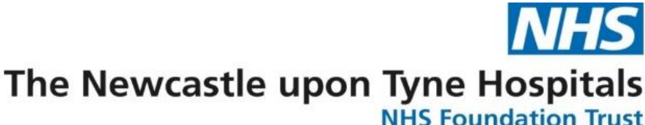
	Age Band	BME %
1	<=20 Years	13.77%
2	21-25	21.72%
3	26-30	23.12%
4	31-35	23.49%
5	36-40	20.05%
6	41-45	13.98%
7	46-50	19.52%
8	51-55	15.34%
9	56-60	7.57%
10	61-65	4.31%
11	66-70	4.93%
12	>=71 Years	3.33%

Current Position:

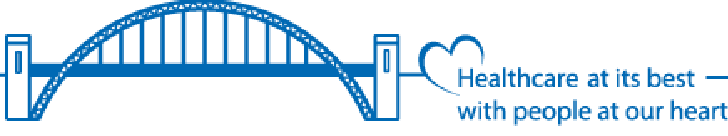
Charts show percentage of staff in post each month by ethnicity (BAME).

Percentage of BAME staff continues to demonstrate a month-on-month increase with the latest position reflecting BAME staff at 17.03% of the workforce.

Percentage of staff who have not disclosed their status is very low at 1%. An EDI campaign is in place from October to encourage staff to update their EDI record in ESR.



Finance



Finance Overview

Metric	Period	Actual	Plan
Income	Sep-24	£818.2m	£792.5m
Expenditure	Sept-24	£824.9m	£798.9m
Surplus /(Deficit)	Sept-24	(£6.7m)	(£6.3m)
I&E Margin	Sept-24	(0.8%)	(0.8%)
Cost Improvement – Recurrent	Sept-24	£14.8m	£29.7m
Cost Improvement – Non-Recurrent	Sept-24	£28m	£10.2m
Elective Income	Sept-24	£153.1m	£151.8m
Capital (CDEL)	Sept-24	£12.9m	£11m

Variation

Special Cause Concerning variation

Special Cause Improving variation

Special Cause neither improve or concern variation

Common Cause

Assurance

Consistently hit target

Hit and miss target subject to random variation

Consistently fail target

Income & Expenditure

- Total income is £25.7 million ahead of plan, with pass through drugs, devices and deferred income at £13.3 million ahead of plan.
- Total expenditure is £26million ahead of plan, off-set by income above and pressure of Industrial Action, drugs growth and CIP.

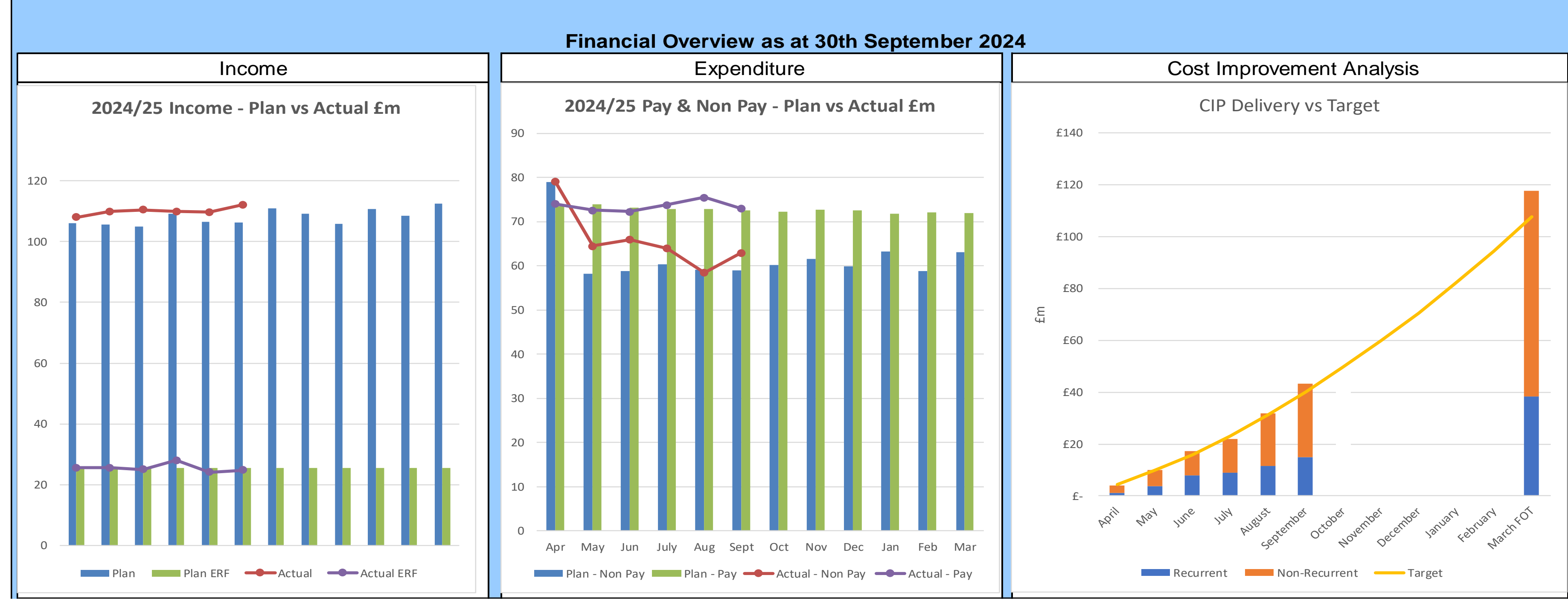
Cost Improvement

- There is reliance on non-recurrent measures to bridge the recurrent CIP gap of £13.5 million.

Elective Income

- The trust is slightly ahead on the ERF income by around £1.3 million.

Overall Finance Position (1/4)



This page summarises the financial position of the Trust for the period ending 30th September 2024. The Trust has agreed a Financial Plan for 2024/25 with a break-even position. As at Month 6 the Trust is reporting an overspend of £0.3 million against the planned deficit of £6.4 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. Delivery of the plan has a significant Cost Improvement Plan (CIP) and includes a number of non-recurrent factors.

Capital Expenditure - The Plan for September is £12.9 million and the year to date expenditure is £11 million creating a variance of £1.9 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 (September 2024)			Year To Date (September)		
	Plan	Actual	Variance	Plan	Actual	Variance
Income & Expenditure Statement	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Operating income from patient services	113,766	118,276	4,510	686,249	699,488	13,239
Other Patient Care - & Non NHS	2,271	2,148	(122)	13,623	15,811	2,188
Non Patient Care - Other Income	15,588	16,535	947	91,100	97,630	6,530
TOTAL OPERATING INCOME (WITHIN EBITDA)	**131,625**	**136,960**	**5,335**	**790,972**	**812,930**	**21,958**
Employee expenses	72,473	72,933	461	435,012	441,064	6,052
Drugs	23,187	23,958	771	137,832	146,872	9,040
Supplies & Services Clinical	13,116	14,740	1,624	80,567	85,303	4,736
Operating expenses excl. employee expenses	17,071	18,830	1,759	104,832	112,566	7,734
TOTAL OPERATING EXPENSES (WITHIN EBITDA	**125,846**	**130,462**	**4,615**	**758,244**	**785,806**	**27,562**
NET FINANCE COSTS	**5,174**	**4,584**	**(590)**	**52,276**	**42,456**	**(9,820)**
OPERATING SURPLUS/(DEFICIT)	**604**	**1,914**	**1,309**	**(19,548)**	**(15,332)**	**4,216**
Control Total & IFRS16 PFI Adjustments	1,070	1,279	208	(13,114)	(8,599)	4,515
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR - CONTROL TOTAL	**(466)**	**635**	**1,101**	**(6,434)**	**(6,733)**	**(300)**

The reported performance for September 2024 is as follows:-

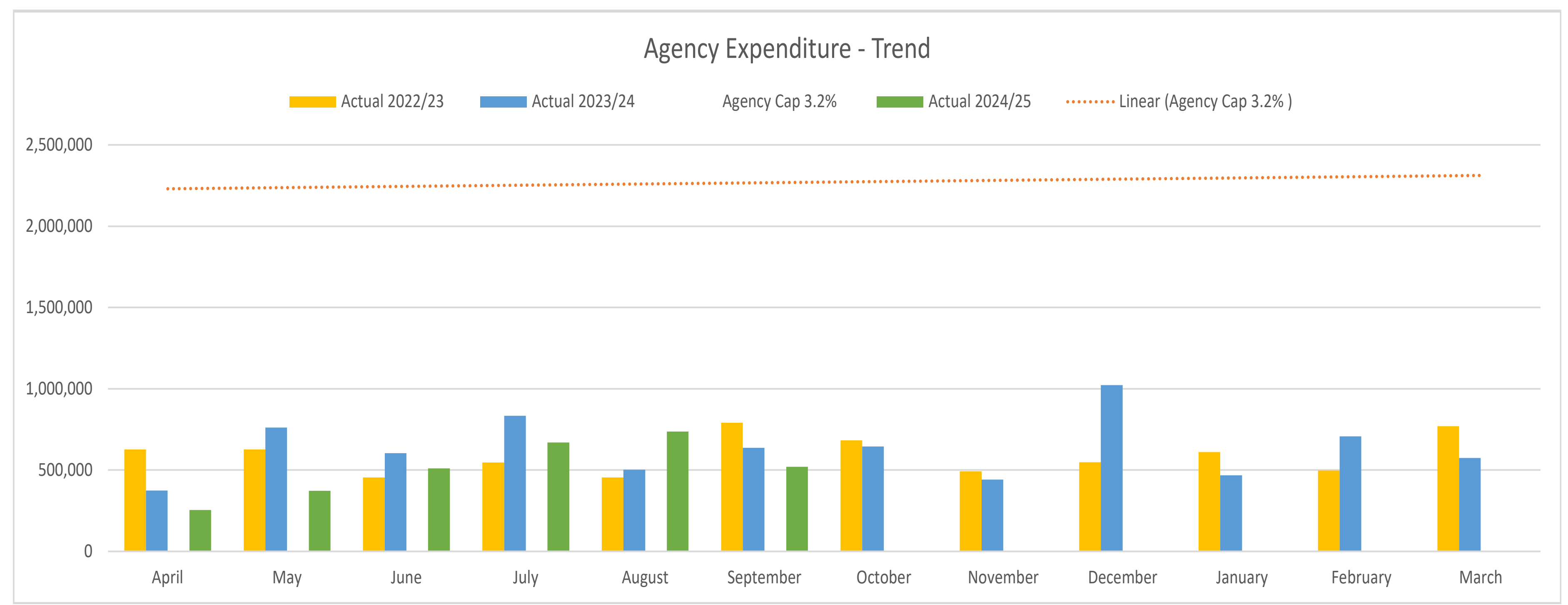
Income

- The in-month position is an overall favourable variance of £5,335k 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 £6m over plan at month 5 and include the costs associated with industrial action. Total operating expenditure is £21.5m above plan due to increased costs relating to drugs and clinical supplies (including circa £9.3m that is matched with income) and unachieved CIP (£4.2m behind on expenditure).

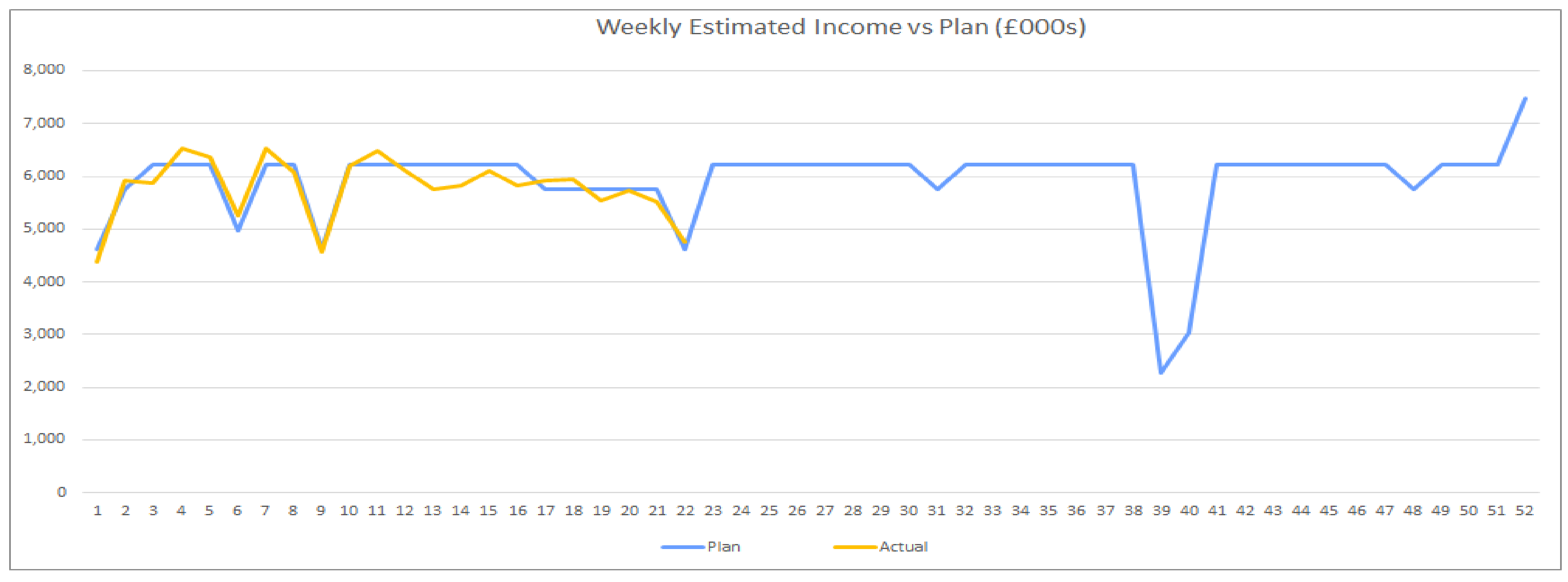
Overall Finance Position (3/4)



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 decrease in September (Month 6) compared to previous months.

Overall Finance Position (4/4)



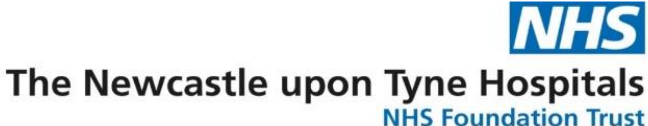
Elective Recovery Performance

Background

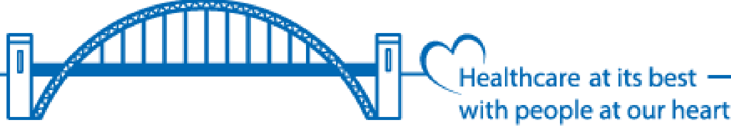
- Elective income (Ordinary Elective, Day Case, Outpatient New and Outpatient Procedure Income) is paid on a tariff basis.
- The clinical boards have committed to deliver a plan of £307m which is £4m higher than the nationally set target for elective activity. The graph above shows estimated performance 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 Elective Recovery Fund (ERF) tariff payment) until they coded.

Current Position

- To week 22, total delivery is £904k 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.



Health Inequalities



Overview: Tobacco Dependency in Acute Inpatient Pathways

- Smoking is a leading cause of morbidity and mortality and a key driver of health inequality in our population.
- In October 2021 funding received from NHSE and the ICB (top up funding) supported the establishment and delivery of in-house tobacco dependence treatment services (TDTS) in the trust in maternity and in inpatients in 2022 in line with the NHS Long Term Plan (LTP) commitments around prevention.
- Establishing tobacco dependency treatment services in provider trusts meets the recommendations in NICE guidance particularly guidance (PH48) and the British Thoracic Society (BTS) audit as well as Saving Babies Lives Version 3 in Maternity.
- A regulatory requirement for NHS providers is to demonstrate compliance with NICE guidance and national audit requirements. There are also expectations for publishing performance data and metrics with the recent NHSE statement on Health Inequalities duty under section 13SA of the NHS Act 2006 requiring NHS providers to report and publish in their annual report key metrics such as Tobacco Dependency Treatment data disaggregated by age, sex, ethnicity and deprivation.
- This report focuses on data relevant to the in-house Tobacco Dependency Treatment Service in the acute pathways. A better understanding of the demographic profile of smokers accessing the service and how this compares to all smokers admitted as well as all admitted patients in the same period (here chosen as April 2023-September 2024) allows us to use an equity lens to inform future delivery of the service and where resource needs to be prioritised.
- The data sources used for this section include when mentioned Office for Health Improvement and Disparities (OHID) data on Trust catchment population, otherwise it would be and extracts from the inpatient Commissioning Data Sets (CDS). For the trust data these were presented by financial year 2023/2024 and 2024/2025.

Table 1 - Inpatient hospital admissions where smoking status is recorded (April 2023 to September 2024)

	Number	Percentage
Total number of smokers	14,884	16.3%
Non-smokers	76,470	83.7%
Total Admission where smoking status is recorded	**91,354**	**100%**
Patients consented to treatment by the TDTS	4207	18.2%

Table 2 - Inpatient smokers and smokers seen by TDTS April 2023 - September 2024 by local authority of residence

	Newcastle residents		Non- Newcastle residents		Total	
Admitted smokers	10,988	49%	11,529	51%	**22,471**	**100%**
Inpatient smokers consented to be seen by TDTS	1,974	47%	2,233	53%	**4,207**	**100%**

Age/Sex profile - Admitted patients (Apr 2023 - Sep 2024)

Figure 1: Total number of admissions

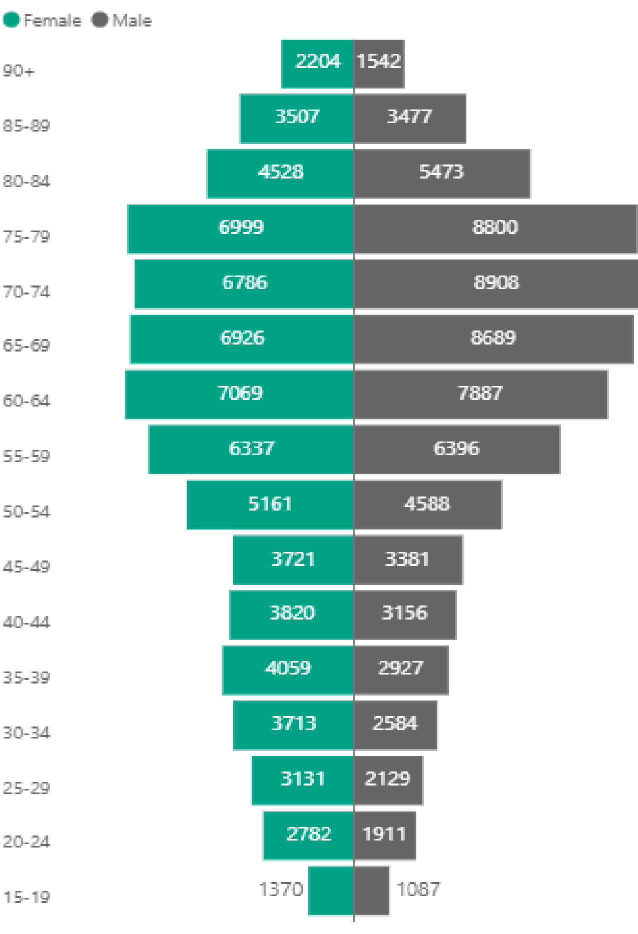
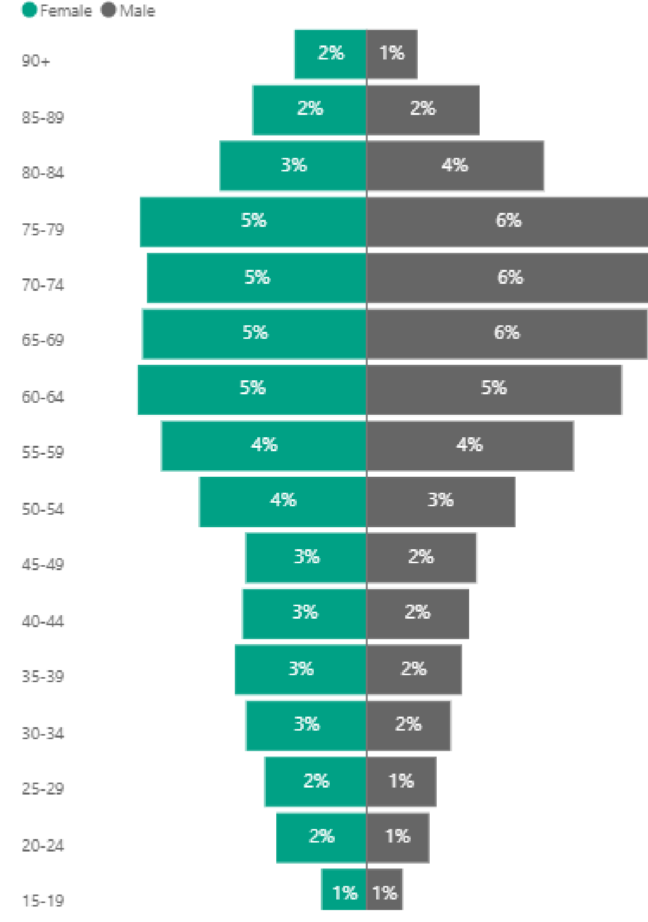


Figure 2: Total percentage of admissions



Age/Sex profile – NuTH Admitted smokers (Apr 2023 - Sep 2024)

Figure 3: Total number of smokers

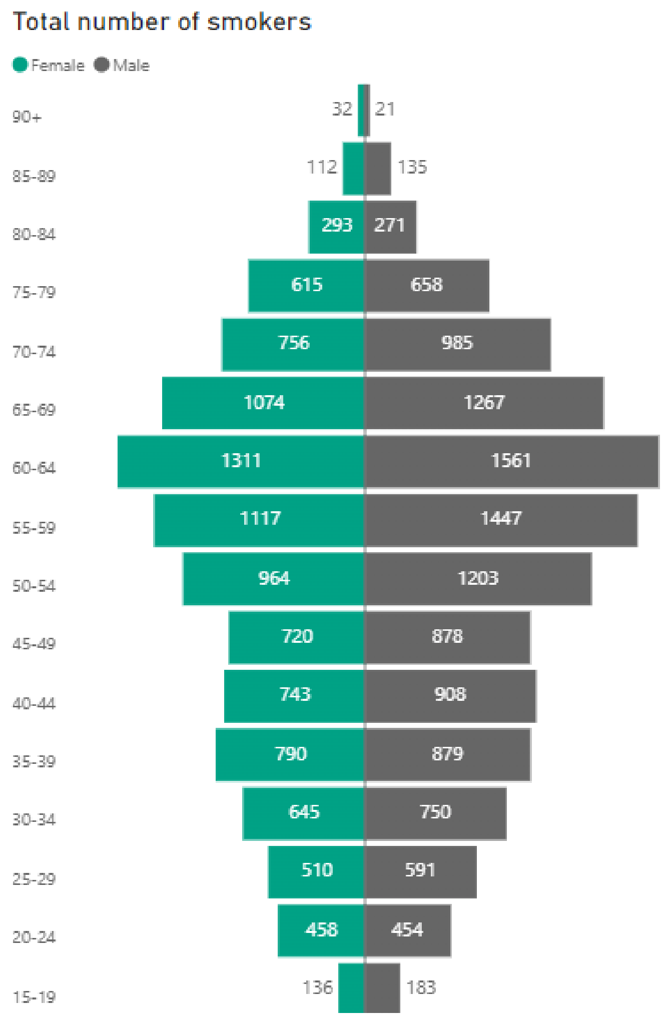
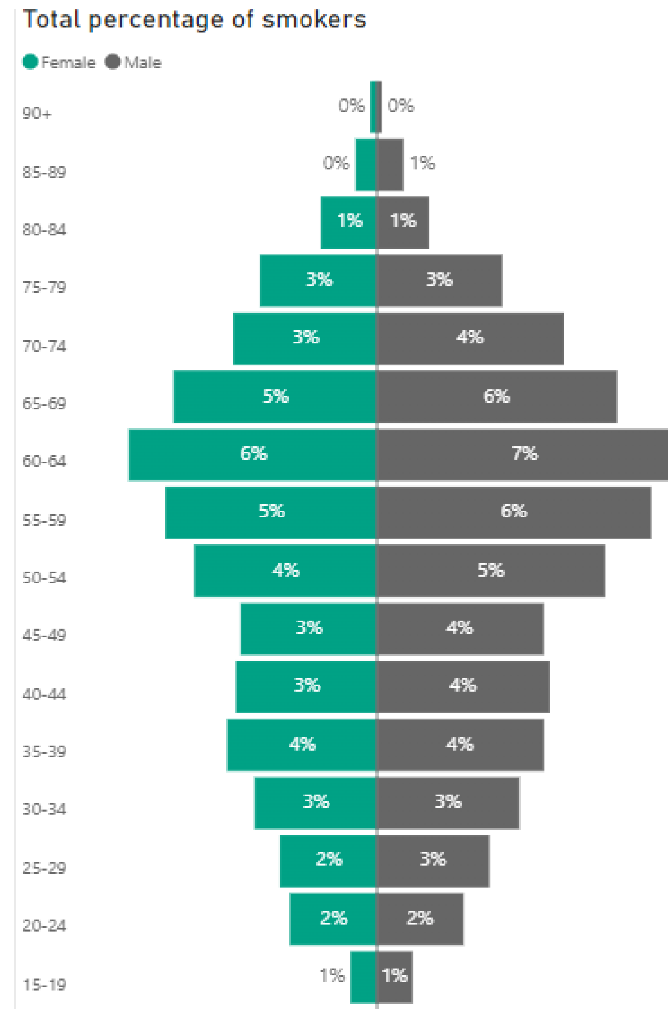


Figure 4: Total percentage of smokers



Age/Sex profile – Smokers seen by TDTS (Apr 2023 - Sep 2024)

Figure 5: Total number of smokers seen by TDTS

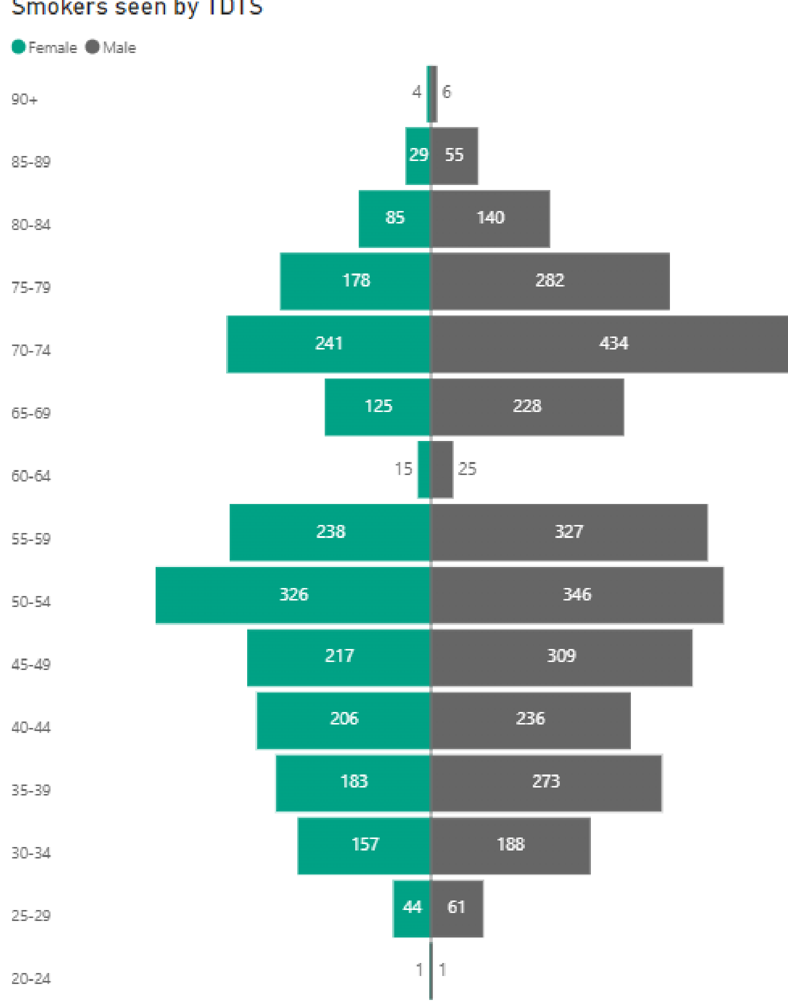
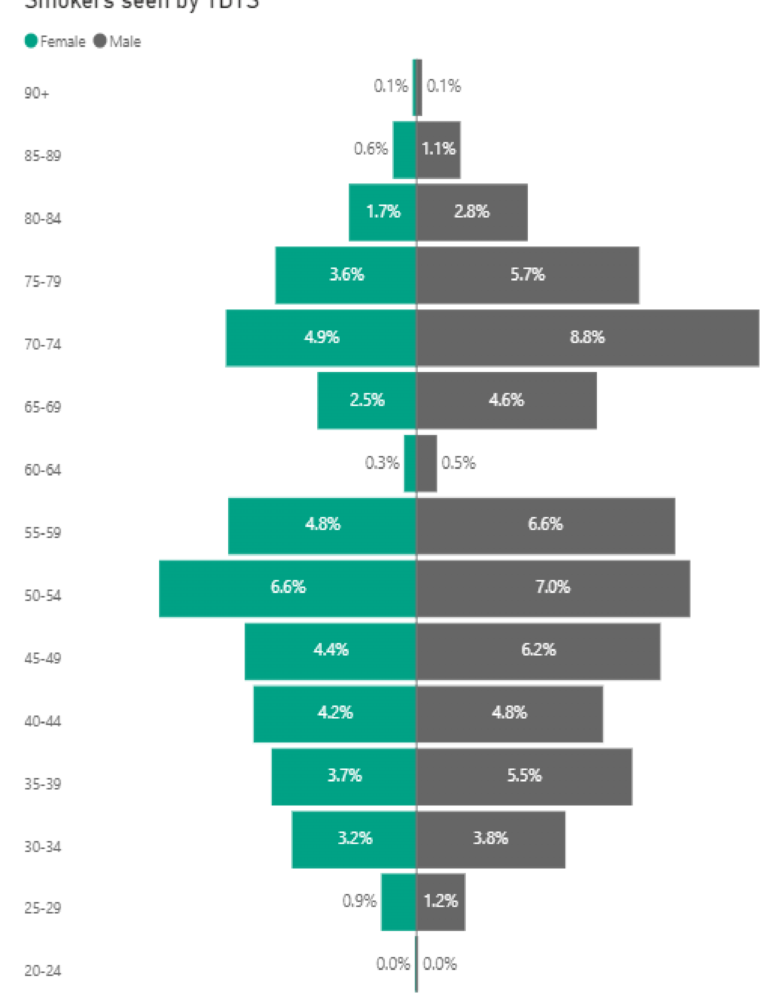
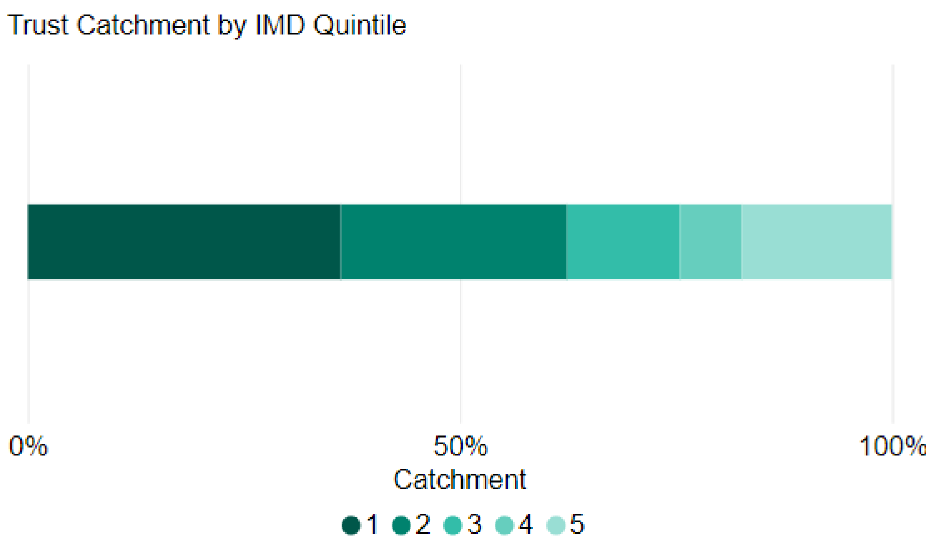


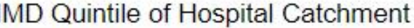
Figure 6: Total percentage of smokers seen by TDTS

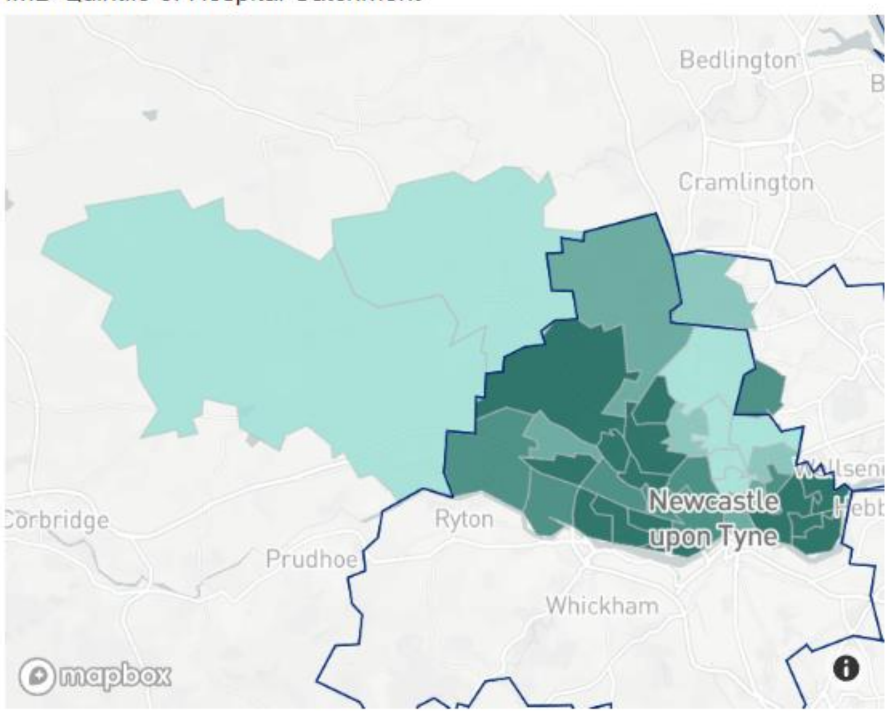


Trust catchment population by Index of Multiple Deprivation (IMD) quintiles

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%)

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Includes only Middle layer Super Output Areas (MSOAs) where the majority of patients are admitted to the Trust

Smokers admitted/accepted referral to TDTS by IMD quintile

Figure 8

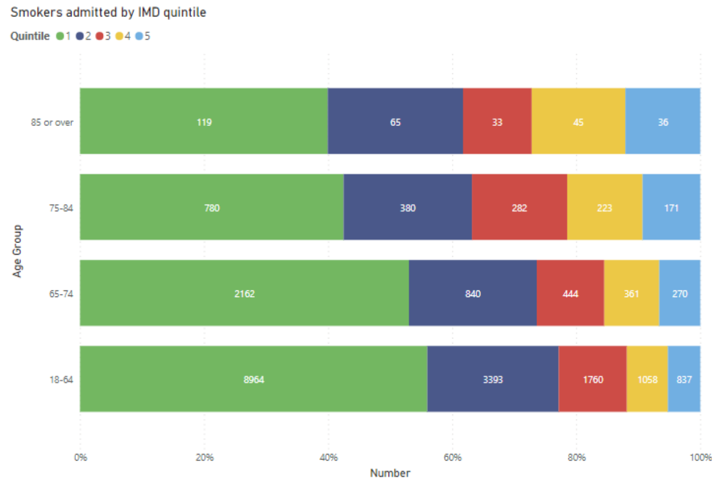
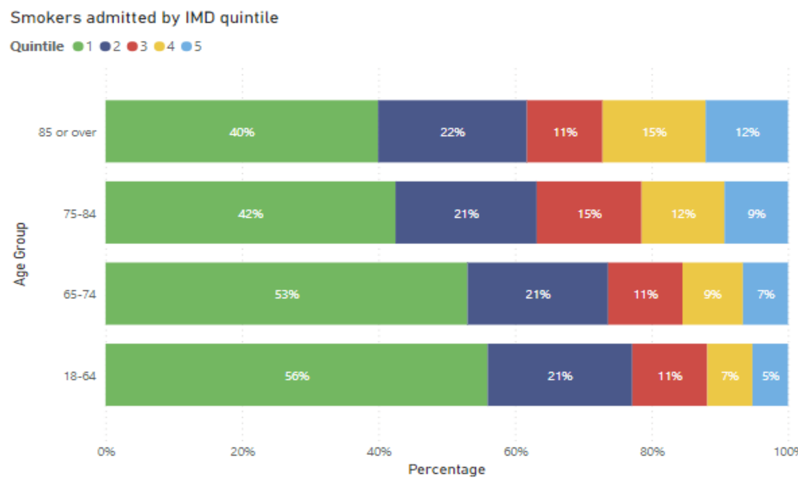


Figure 9



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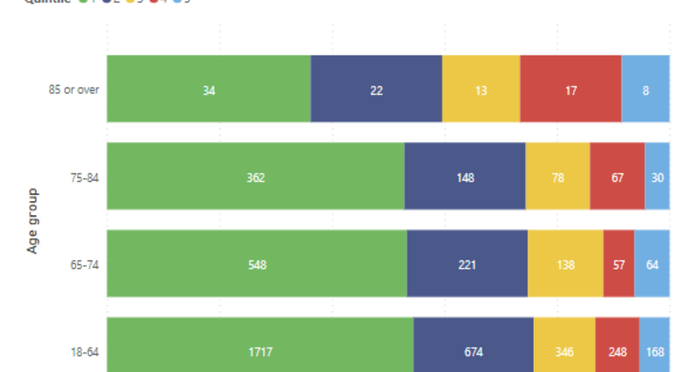
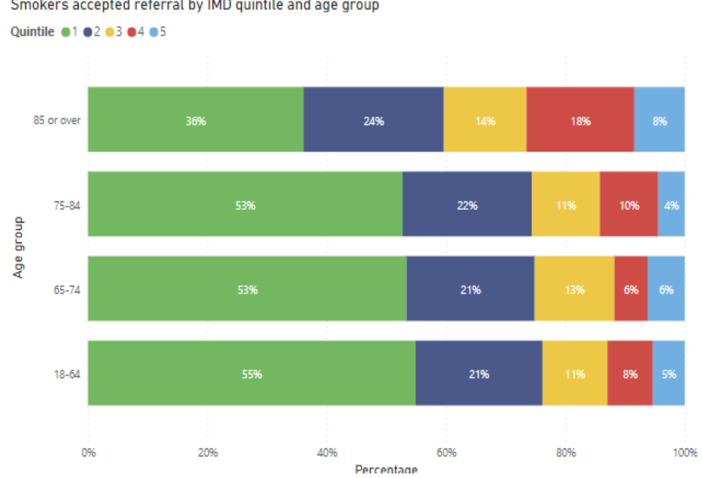
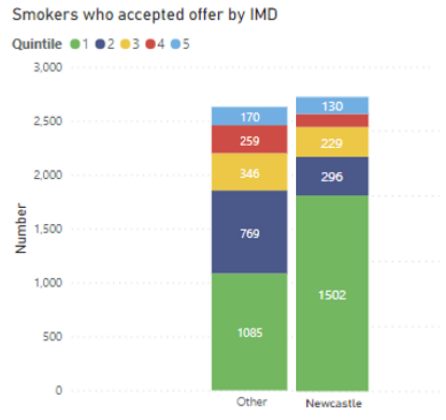


Figure 11



Patient smokers engaging with TDTS by electoral ward

Figure 12



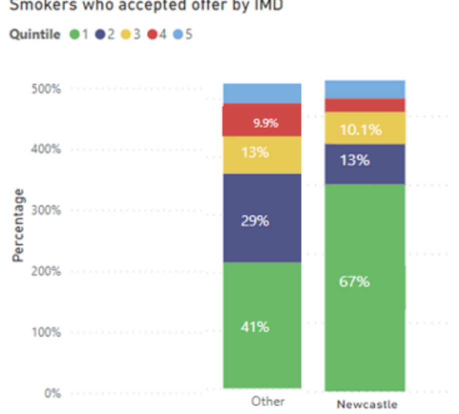
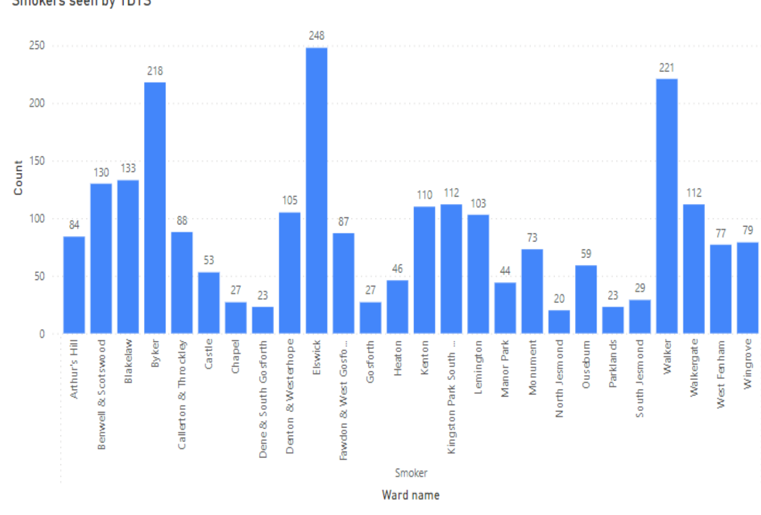
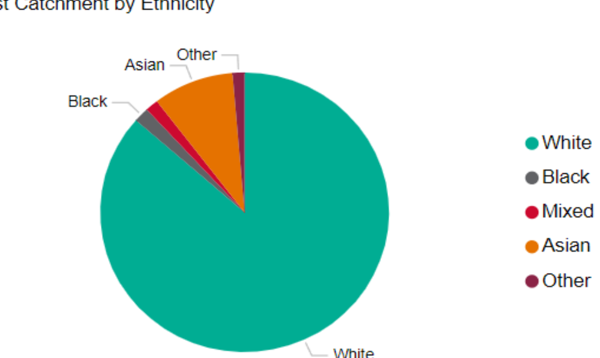


Figure 13



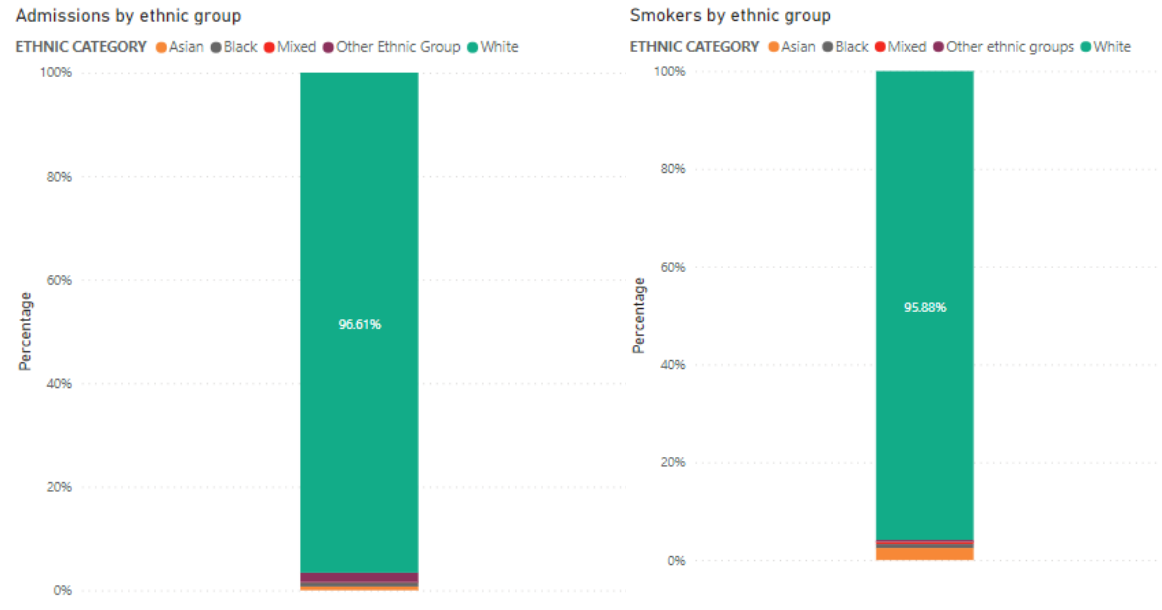
Trust Catchment by Ethnicity

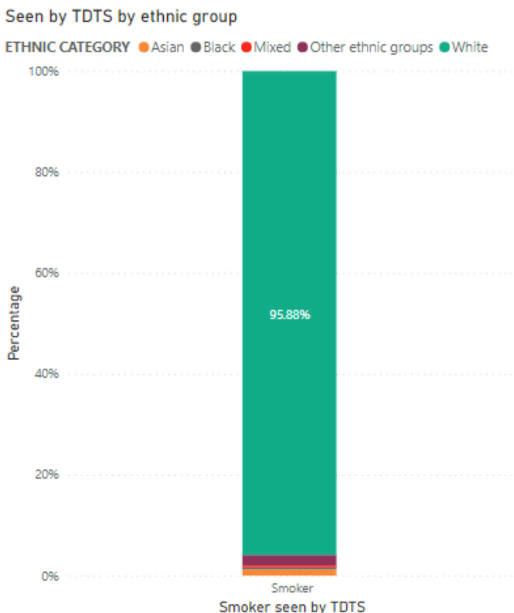
Figure 14 – Trust Catchment by Ethnicity (2020)



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

Figure 15





Health Inequalities Summary (1/2)

- Despite evidence (not shown here) that 2 out of 3 smokers referred from Newcastle Hospital to Newcastle Stop Smoking Service – Change Grow Live (CGL) have been referred from the Trust Tobacco Dependency Treatment Service (TDTS) in the acute inpatient pathways less than 20% (or 1 in 4 inpatient smokers referred to the service) opt in for a treatment plan and onward referral to Community Stop Smoking Service (Table 1). Understanding the barriers to uptake of the offer and interventions to improve is being undertaken as part of the review of the TDTS.

- It is worth noting that all patients identified as smokers on admission are given Very Brief Advice (VBA) by frontline staff and supported for temporary abstinence by prescribing Nicotine Replacement Therapy (NRT) or supplying an NRT patch as per Trust NRT Protocol.

- The crude prevalence of smoking in the inpatient population in the period April 2023 to September 2024 is 16.3% (Table 1) which is higher than that in the general population of the North East of England and Newcastle. It is also over three times as high as the target set by Fresh and the ICB to reduce smoking prevalence to 5% or less by 2030.

- The Age and Sex Pyramid for all admissions between April 2023 and September 2024 and inpatient smokers are somehow comparable. However, this is not the case for smokers who accepted a treatment plan by the TDTS in April 2023-September 2024. The highest proportion of smokers engaging with the service is from males in the 70-74 age category and those between 50-59 years old. A very low proportion of patients in the 60-64 age category seem to have engaged with the service in the period April 2023-September 2024.

- Inpatient smokers admitted in the period between April 2023-September 2024 are more socioeconomically disadvantaged compared to the Trust catchment population and that applies to all age categories especially the 18-64 year olds (Figures 8-9). Smokers aged 18-64 and 65-74 accepting the TDTS offer between April 2023-September 2024 are comparable to inpatient smokers in socioeconomic disadvantage (i.e. over 50% reside in the 20% more deprived areas nationally based on the index of multiple deprivation). However, inpatient smokers aged 75-84 that engaged with the TDTS in this period were more socioeconomically deprived than the same age group in inpatient smokers (53% living in the 20% most deprived areas nationally compared to 42%).

Health Inequalities Summary (2/2)

- Patients who live in Newcastle and who have engaged with the TDTS in April 2023-September 2024 were considerably more socioeconomically deprived than those from outside Newcastle (67% lived in the 20% most deprived areas compared to 41% for those from outside the area) (figure 12).

- For the smokers who engaged in the service in this period and were referred onwards to the community Stop Smoking Service in Newcastle the majority came from electoral wards with considerable socioeconomic disadvantage such as Elswick, Byker and Walker. Insights from these data will help inform service development in collaboration with the Commissioners of the Community Stop Smoking Service and with NHSE for the uptake of the Advanced Pharmacy Offer maximising referrals when possible to community pharmacists in these wards and hence giving patients more choice to get support in quitting smoking.

- Figure 15 shows that ethnicity for patients admitted to Newcastle Hospitals in the period April 2023-September 2024 compares to admitted smokers and smokers who took up the offer by the TDTS. The ethnic profiles are similar in that the majority (over 95%) are White British. These differ from that of the catchment population for NuTH (based on the OHID data in 2020 but also that of the population in Newcastle that is ethnically more diverse with 86% White British).

- There is no patient level data to allow us to look at the cohorts of patients who quit at 4 and 12 weeks (outcome data). These data are collected by the Community Stop Smoking Service and reported to us as aggregate figures. Currently the in TDTS in the acute inpatient pathways and the Community Stop Smoking Service commissioned by Public Health at Newcastle City Council are undergoing a service review in anticipation of recommissioning. The contracts have been extended until end of September 2025. This offers an opportunity to plan our services in a way that takes into account population needs and equity of uptake and outcomes.

A Guide to SPC

SPC Icons & How to Interpret (1/4)

Icon	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.
F	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.
P	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: (no target)
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.
(no change)	**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: P (pass)	Assurance: ? (hit or miss)	Assurance: F (fail)	Assurance: no target
Concerning low (L)	**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.
Upward variation				**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.
Downward variation				**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.
Insufficient data				**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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Agenda item A9

TRUST BOARD

<table>
<tr><td>Date of meeting</td><td colspan="6">29 November 2024</td></tr>
<tr><td>Title</td><td colspan="6">Trust Strategy</td></tr>
<tr><td>Report of</td><td colspan="6">Patrick Garner, Director of Performance and Governance</td></tr>
<tr><td>Prepared by</td><td colspan="6">Lisa Jordan, Assistant Director of Strategy and Planning</td></tr>
<tr><td rowspan="2">Status of Report</td><td colspan="2">Public</td><td colspan="2">Private</td><td colspan="2">Internal</td></tr>
<tr><td colspan="2">☒</td><td colspan="2">☐</td><td colspan="2">☐</td></tr>
<tr><td rowspan="2">Purpose of Report</td><td colspan="2">For Decision</td><td colspan="2">For Assurance</td><td colspan="2">For Information</td></tr>
<tr><td colspan="2">☒</td><td colspan="2">☐</td><td colspan="2">☒</td></tr>
<tr><td>Summary</td><td colspan="6">This report provides Trust Board with an update on the development of a Trust Interim Strategy whilst a full engagement programme is carried out to develop the Trust longer term strategy.

The key points to note are:
• An Interim Strategy to cover the next 12-24 months will be consulted on and published early in 2025.
• Other strategies under development are the Trust Clinical Strategy and Staff and Patient Engagement Strategy.
• The Trust long term strategy will be reset in the context of national, regional and local developments and will be engaged on widely with stakeholders.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Trust Board is asked to receive this report and continue to support the development of the Trust Interim Strategy and Longer Term Strategy as outlined in the report.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Links to all Strategic objectives.</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">Links to the full BAF.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Previous report shared at the May 2023 Trust Board meeting.</td></tr>
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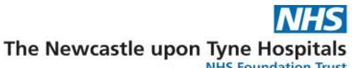

TRUST STRATEGY

1. INTRODUCTION

The current Trust 5-year Strategy expires in 2024. The Trust has seen some significant changes during 2024 with serious concerns raised by the Care Quality Commission (CQC) in January 2024 following their inspection of services in 2023, and a new Chief Executive and Board members appointed.

Since January, the Trust has been focussed on the two things that matter the most – how we can provide the best care for our patients, and how we can significantly improve the experience that our staff have at work.

The Trust has also undergone a large restructure, moving from 21 ‘directorates’ to 8 ‘Clinical Boards’, because of these changes it was not considered the right time to develop another multi-year Trust strategy during 2024. Instead, the Board have committed to developing an Interim Strategy focussing on some of the more immediate goals and ambitions to be achieved in the next 12-24 months.

This will allow the next 12 months to be spent on developing a meaningful longer term strategic direction for the organisation, in collaboration with staff, patients and other stakeholders.

2. INTERIM STRATEGY

The interim strategy will build on the previous Trust Strategy and continue to be centred around the 5 Ps – Patients, People, Partnerships, Performance & Pioneers (Figure 1).

The Strategic objectives for 2025-26 will be underpinned by:

- The developing Clinical Strategy.
- Clinical Board Quality and Safety priorities and improvement plans.
- The Big Signals and Trust Quality Priorities.

The delivery of the objectives will be enabled by the Trust supporting strategies, for example, the People Plan, Digital Strategy, Estates Strategy, SHINE Strategy, Research Strategy and Commercial Strategy.

A draft Interim Strategy will be consulted on within the organisation, with Trust Board, Governors and Staff, before being published early in the new year.

The 5 'P's of our strategic framework

Patients
Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality

People
Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential

Partnerships
We will be an effective partner, developing and delivering integrated care and playing our part in local, regional, national and international programmes

Pioneers
Ensuring that we are at the forefront of health innovation and research

Performance
Being outstanding, now and in the future

Figure 1. 2019-2024 Trust Strategy 5Ps

3. OTHER SUPPORTING STRATEGIES

In addition to the supporting strategies already mentioned, the Trust is developing a 10-year Clinical Strategy and a Staff and Patient Engagement Strategy.

3.1 Clinical Strategy

The Joint Medical Directors and the Director - Great North Healthcare Alliance and Strategy, are leading the development of the Trust's Clinical Strategy through a Steering Group and clinically led supporting workstreams. This work supports, and will build on, the development of Medium-Term Plans across the Trust. The Clinical Strategy work includes a focus on how best to deliver the three 'shifts' that frames much of the new Government's important policy in relation to the NHS (Figure 2):

- From treatment to prevention.
- From hospital to community.
- From analogue to digital.

The Clinical Strategy Steering Group has reviewed the interdependencies of clinical specialties at the Royal Victoria Infirmary and Freeman Hospital to identify opportunities to

improve quality, safety and patient and staff experience through how and where services are organised. Working with Clinical Boards, staff and stakeholders this work will help ensure that services are in the right place, unnecessary duplication is minimised, and that unplanned and planned care can both be delivered efficiently and effectively. This work will shape the organisation's Estate Strategy in relation to any future new buildings and refurbishments.

The valuable input from the Board of Directors and Council of Governors into this work via recent workshops is much appreciated. Further such workshops are planned.

3.2 Patient and Staff Experience Strategy

Our people are central to improving the quality and delivery of safe and compassionate care. How they experience the culture of the organisation and how they feel about their workplace directly impacts on their ability to care for patients, their team, themselves, and their families.

In most NHS organisations, patient experience remains the weakest of the three arms of quality. It does not get the same attention as safety and clinical effectiveness and still tends to be seen as an add-on.

We know that patients have a positive experience where there is a culture of safety that puts the patient first, and gives patient experience the highest priority with the implementation of real-time patient feedback. Information about real-time patient experience displayed on all wards and clinic areas gives added evidence of priority.

Although patient experience is currently captured through the Friends and Family test and national surveys, there has been remarkably little improvement in NHS patient experience data since surveys were introduced in 2002 – we aren't always measuring the right things, feedback is not representative or timely enough, and we don't get information to staff in ways that motivate them to act on results.

The Chief Experience Officer will lead the development of a three-year strategy designed to provide visibility and momentum for a new trust-wide patient and staff experience programme. The programme is ambitious and designed to touch every part of the organisation. This is a cultural intervention that is focused on understanding and improving the behaviours that matter most to patients and staff.

Our ambition is to develop a patient and staff experience improvement programme at Newcastle Hospitals that is the most comprehensive in the NHS. Performance will be captured at a site, Clinical Board, team, and ward level. The introduction of individual consultant-level data to inform annual appraisals is relatively unique in the NHS, this will elevate the programme and help to ensure senior medical ownership.

This work builds on the previous funding provided by the charity to develop the patient experience of care. Patients told us they wanted to be asked about their experience, they wanted their feedback to visible and they wanted to know how their feedback made a difference. This programme will therefore let us deliver the aims set out in the Experience of Care Strategy.

4. LONGER-TERM STRATEGY

The longer-term Trust Strategy needs to be reset in the context of national guidance, including the Darzi Report and the Future NHS 10-year plan, as well as regional developments such as the Great North Healthcare Alliance and the Trust's Clinical Strategy.

There will be comprehensive engagement across the Trust and with internal and external stakeholders to set the Trust strategic framework and direction for the next 3-5 years.

It is vital that this engagement is done properly, and the intention is to make this an organisational development exercise, as well as a strategic planning process.

3 key shifts which are required of the NHS:

"from treatment / sickness to prevention"

"from hospital to community"

"from analogue to digital"

Figure 2. The Government's commitment to the 3 strategic shifts required for the future of the NHS.

5. RECOMMENDATION

The Trust Board is asked to receive this report and continue to support the development of the Trust Interim Strategy and Longer Term Strategy as outlined above.

Report of Patrick Garner
Director of Performance and Governance
18 November 2024

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Agenda item A10

TRUST BOARD

<table>
<tr><td>Date of meeting</td><td colspan="6">29 November 2024</td></tr>
<tr><td>Title</td><td colspan="6">The NHS National Change Consultation (change.NHS: Help to build a health service fit for the future)</td></tr>
<tr><td>Report of</td><td colspan="6">Caroline Docking, Director of Communications and Corporate Affairs</td></tr>
<tr><td>Prepared by</td><td colspan="6">Caroline Docking, Director of Communications and Corporate Affairs</td></tr>
<tr><td rowspan="2">Status of Report</td><td colspan="2">Public</td><td colspan="2">Private</td><td colspan="2">Internal</td></tr>
<tr><td colspan="2">☒</td><td colspan="2">☐</td><td colspan="2">☐</td></tr>
<tr><td rowspan="2">Purpose of Report</td><td colspan="2">For Decision</td><td colspan="2">For Assurance</td><td colspan="2">For Information</td></tr>
<tr><td colspan="2">☐</td><td colspan="2">☐</td><td colspan="2">☒</td></tr>
<tr><td>Summary</td><td colspan="6">This paper provides information on the Governments NHS Change consultation and suggests key points to include in our response.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Trust Board is requested to consider the suggested contributions and highlight any additional points to submit to the consultation.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Not applicable.</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">Not applicable.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">New report.</td></tr>
</table>

THE NHS NATIONAL CHANGE CONSULTATION
(change.NHS: Help to build a health service fit for the future.)

1. INTRODUCTION

The NHS has been a cornerstone of healthcare in the UK for 76 years, providing essential services to millions of citizens. As the new Government was elected in July, they announced and have now launched a public consultation exercise into the future of the NHS, to support it to be fit for the future.

As the complexities and challenges of healthcare needs evolve, so too must the systems and processes that underpin the NHS. The NHS National Change Consultation represents an important step in this evolution, allowing stakeholders—ranging from healthcare professionals to patients and the wider public—to contribute their perspectives and ideas for change to influence the next 10 year health plan.

Ideas and suggestions can be submitted by anyone through a dedicated web channel change.nhs.uk and via social media. In addition, a number of regional events will take place. We are also expecting resources to enable local teams to undertake structures involvement events with local people.

The Engagement is structured around the 3 ‘shifts’ – ‘big changes to the way health and care services work – that doctors, nurses, patient charities, academics and politicians from all parties broadly agree are necessary to improve health and care services in England’:

- Shift 1: moving more care from hospitals to communities
- Shift 2: making better use of technology in health and care
- Shift 3: focussing on preventing sickness, not just treating it

2. OUR CONTRIBUTION

All NHS trusts and Foundation trusts have been invited to submit responses during the initial phase of engagement on 5 questions:

1. What does your organisation want to see included in the 10-Year Health Plan and why?
2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?
3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?
4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?
5. Please share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example: Quick to do, that is in the next year or so / In the middle, that is in the next 2 to 5 years / Long term change, that will take more than 5 years

In discussion with Alliance partners, Chief Executives have asked us to prepare and submit a response on behalf of the Great North Healthcare Alliance (GNHA), encompassing the views of all partners. Responses need to be submitted by Monday 2 December, and it is envisaged that this will be an early opportunity for the NHS to influence a more extensive programme of engagement with the wider public.

A suggestion of the key points that we would wish to include in this response are included below. This has been based on existing discussions across the organisation over recent months. Board members are asked to highlight any additional areas to include. Once agreed, we will work with Alliance partners to submit a response which will be agreed by Chief Executives.

Key areas to include:

What do you want to see included in the 10-Year Health Plan and why?	• We welcome the direction of travel described in the 3 shifts, and the clear intention to put patient experience at the heart of the new plan. • Suggestion to include clear end goals to aim for and local flexibility for how they are best achieved. • Suggestion to include a focus on inequalities that recognises need for differential resourcing for the most deprived communities (and parts of the country). • Suggestion that a clear understanding of the importance of highly specialist services for those who need them, is essential.
What do you see as the biggest challenges and enablers to move more care from hospitals to communities?	• A challenge is space and quality of estate in community, including in primary care to physically accommodate services. • A challenge is that lots of ideally placed existing NHS owned estate is held by NHS Property Services (NHSPS) and commercial terms mean that NHS providers can't afford to use them – this hampers integration of multiple providers into one place. • A challenge is that acute activity is paid on tariff per activity, whereas community is on block so there is a disincentive to shift work to community. • An enabler would be interoperable IT systems across secondary and primary care. • An enabler is virtual care, where clinician remains in hospital and patient in their own home – for secondary and more specialist services.

What do you see as the biggest challenges and enablers to making better use of technology in health and care?	• A challenge is how to make NHS IT systems be designed around the users such that they make it quicker and easier to do things rather than slow people down. • A challenge is how to have interoperable IT systems when patients are often moving between providers and many consultants work in multiple organisations. To quantify this, within GNHA 20% of patient hospital spells are not at the local hospital trust – this is due to specialist services and patient choice. • A challenge is funding – for example to enable the most up to date equipment for example surgical robots which require large capital outlay.
What do you see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?	• A challenge is that prevention work is best done before people become patients and this means a focus on communities and populations rather than individual patients. The only resources that are currently focussed on population level health activities are in public health teams that have been significantly depleted. There are very few links between council public health teams, Primary Care Networks (PCNs) and hospital clinical teams • A challenge is that NHS activity and information systems are based on contacts and events, i.e. who receives what care, rather than who are the people that should have accessed care but haven't (including targeting people that Did-Not-Attend (DNA) not from a perspective of avoiding waste but rather on the basis that they are missed opportunities to improve the health of those people). • An enabler is how to use information to identify who should have accessed and/or been referred for care and hasn't been. • An enabler could be clear health improvement interventions to improve all round health – diet/smoking etc for those already in touch with services, (for example on waiting lists).
Please specific policy ideas for change.	• The Department of Health and Social Care (DHSC) and NHS England (NHSE) could provide clear end goals to aim for and leave local flexibility for how they are best achieved, working across local health and social care systems. • All NHS estate to be managed locally rather than lots being managed nationally by NHSPS. • Financial incentive to reward work to prevent population health deterioration rather than just for treating sickness. • A google / Apple / Amazon style user experience and design lab be created to take existing NHS information systems and redesign them to increase staff productivity and patient experience/useability.

3. RECOMMENDATIONS

The Trust Board is requested to consider the suggested contributions and highlight any additional points to submit to the consultation.

Caroline Docking, Director of Communications and Corporate Affairs
Martin Wilson, Director - Great North Healthcare Alliance & Strategy
21 November 2024

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TRUST BOARD

<table>
<tr><td>Date of meeting</td><td colspan="6">29 November 2024</td></tr>
<tr><td>Title</td><td colspan="6">Joint Medical Directors (JMD) Report</td></tr>
<tr><td>Report of</td><td colspan="6">Lucia Pareja-Cebrian / Michael Wright</td></tr>
<tr><td>Prepared by</td><td colspan="6">Lucia Pareja-Cebrian / Michael Wright, Joint Medical Directors</td></tr>
<tr><td rowspan="2">Status of Report</td><td colspan="2">Public</td><td colspan="2">Private</td><td colspan="2">Internal</td></tr>
<tr><td colspan="2">☒</td><td colspan="2">☐</td><td colspan="2">☐</td></tr>
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<tr><td colspan="2">☐</td><td colspan="2">☒</td><td colspan="2">☒</td></tr>
<tr><td>Summary</td><td colspan="6">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) Diagnostics
iii) Activity
iv) Job Planning
v) Cancer Update
vi) Cardiothoracic Update
vii) Digital

The Guardian of Safe Working Quarterly Report (Quarter 2 2024-25) is a separate report.</td></tr>
<tr><td>Recommendation</td><td colspan="6">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 progress with the implementation of the revised job planning guidance.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Putting patients at the heart of everything we do and providing care of the highest standard focusing 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>
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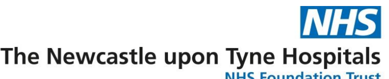
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">No direct link.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">This is a regular report to Board. Previous similar reports have been submitted.</td></tr>
</table>



JOINT MEDICAL DIRECTORS REPORT

1. QUALITY AND PATIENT SAFETY (Q&PS)

The Non Emergency Adult Deformity Service service (NEADS) remains paused. Following review of the cases, a report will be completed by Mr Mike Clarke, Clinical Director (CD) Quality and Safety, which will form the basis of learning and development of any further actions. An external review of these reports will be sought to confirm agreement with those actions and it will be helpful to:

- Review indication and plans for patients on the current waiting list.
- Review our reports, learning and agreed actions prior to service re-start.

A key component of the recommendations will be a Multi Disciplinary Team (MDT) with external representation for additional assurance. This situation has been discussed with Tim Briggs (National Getting It Right First Time (GIRFT) lead) who has involved colleagues to assist, potentially with enhanced MDT with Leeds, Sheffield. Terms of Reference (TORs) have been agreed between GIRFT and Newcastle Hospitals (NUTH) for an external MDT.

1.1 Martha's Rule

There will be 3 x band 7 secondments for the rollout of the programme. Nationally Trusts will be free to name this service individually and at Newcastle Hospitals it will be known as "Call for concern."

1.2 National Safety Standards for Invasive Procedures (NASIPS) 2

We continue to roll out NASIPS 2 and digital consent; the oversight of this will be provided by the Patient Safety Group and reported to the Quality Committee.

We have undertaken a review of the patient safety oversight governance framework. This is a significant piece of work which will be finalised in the New Year and proposed for ratification and approval at the Quality Committee.

1.3 Patient Safety Incident Response Framework (PSIRF)

PSIRF priorities work will soon have been underway for a year at which point these will be reviewed with consideration to close if appropriate and open new projects, triangulating information from the risk register, Datix reporting and Quality Oversight Group (QOG) feedback.

2. DIAGNOSTICS

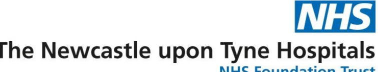
Diagnostic performance within the Trust continues to remain under significant pressure, mainly due to a combination of increasing workload, as elective activity increases, and workforce pressures in key areas. However, priority continues to be given to cancer performance with the time to perform and report a cancer waiting target (CWT) scan being consistently less than 10 days and we consistently achieve the 80% target for the analysis of CWT specimens within cellular pathology. We continue to work with the operational teams to address areas of decreased performance, such as MRI scanning and reporting within neuroradiology, for which the main radiology directorate is now providing mutual aid. The Trust has recently facilitated investment in new technology including only the UK's second photon counting CT scanner, which will be installed at the Freeman Hospital before the end of the financial year. The Trust is also working closely with Gateshead Health NHS Foundation Trust following the recent opening of the Community Diagnostic Centre, which will provide a significant increase in CT, MRI, US, echocardiography, phlebotomy and sleep study capacity.

3. ACTIVITY

Emergency Care performance remains challenged. While attendances remain higher than the historical baseline, they are comparable with 2023/24. Type 1 performance has improved slightly since earlier this year from a Type 1 of 56% in May to 60.68% in September. This is still far below the standard we would want and in August additional investment in junior and middle grade medical staff has expanded the workforce. This has eliminated most Emergency Department (ED) rota gaps and reduced reliance on locum and bank staff as well as delivering a higher predictable number of clinician hours in both adult and paediatric ED.

There has been beneficial effects on the care of patients outwith the 4 hour performance measurement. For comparison, in May 2024 (1,698 Type 1 attendances) the time to nurse assessment was 14 minutes. This had reduced to 8 minutes in September (1,644 Type 1 attendances). In May 2024, the average time to clinician assessment was 3 hours and 35 minutes. In September, it was 1 hour 49 minutes. We also have a much lower rate of patients waiting over 12 hours in the department at 0.8% of attendances compared to a regional rate of 4.0% and national rate of 5.7%.

There remains concern about the ability of the department to offer effective safe care going into winter with significant challenges of high hospital occupancy, infection control issues limiting bed availability and nurse staffing gaps, but these are challenges that will be actively managed to mitigate against the greatest risk.



4. REVISED JOB PLANNING PROCESS IMPLEMENTATION

There is ongoing work to implement the revised job planning guidance developed in association with the Local Negotiating Committee (LNC). This new guidance is more in line with that which is in place in other local organisations and across the region.

An oversight group chaired by one of the Medical Directors and an implementation group chaired by one of the Associate Medical Directors have been formed. Representatives from the Clinical Boards, performance and operational teams, medical staffing, finance and the LNC will be involved in these groups.

Full implementation of the new guidance is planned for April 2025.

The financial implications of the implementation will be monitored carefully and reviewed regularly throughout the process.

5. CANCER UPDATE

5.1 Cancer Performance

Month	1/24	2/24	3/24	4/24	5/24	6/24	7/24	8/24	9/24	10/24
28-Day Faster Diagnosis Standard (FDS) %	72	83.2	84.9	77	80.8	79.2	73	68.4	68.9	71.8
Number of Patients	2,330	2,340	2,557	2,620	3,005	2,831	2,842	2,727	2,421	2,962
62-Day %	56.1	60.9	61.6	58.9	60.6	65.3	60.0	64.8	68.9	64.3
62-Day by Tumour										
Breast	76.6	86.4	82.9	89.9	93.8	97.8	89.7	90.8	92.2	86.7
Lung	38.8	46.3	41.4	29.3	46.0	48.3	34.8	33.8	34.9	38.7
Head & Neck	82.8	73.5	75.4	80.0	66.7	79.4	80.0	78.6	75.7	77.4
Lower Gastrointestinal (GI)	41.2	46.3	52.6	25.3	46.4	28.8	49.3	49.0	50.0	34.3
Upper GI	47.4	32.7	26.0	37.9	29.3	40.4	36.7	64.8	47.5	48.9
Urology	32.2	28.6	50.8	46.0	36.1	50.0	46.9	42.5	48.1	53.9
Skin	67.6	83.3	88.2	80.5	87.9	87.9	83.5	89.0	81.6	87.2

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 221 down from 239 in September but still clearly too high.

The most consistently challenged tumour groups in terms of 62D performance are lower GI, upper GI, lung and urology.

Clearly work continues in all pathways to minimise delay, streamline pathways wherever possible and maximise capacity. There is a fundamental problem that working with a backlog prevents us working in real time with the newly referred cases. All Clinical Boards are tasked with defining 'to-come-in' (TCI) dates for patients waiting over 104 days on a cancer pathway then working on patients who are going to 'tip in' to that bracket.

We have launched the 'Perfect Pathway' project to run for 8 weeks from 14 October. Meetings have been held with all key stakeholders for both pathways. Actions have been identified in communication of patient risk between teams, need for easy access to cancer waiting time data, we need to monitor waits for pre-op assessments then take action if waits are unduly long. One aim of the project is to create useful data dashboards that are meaningful to teams and can improve performance monitoring.

5.2 Governance

Operational policies and a work plans have been received from most MDTs. The cancer services team aim to review these and begin a rolling programme of internal peer review discussions before Christmas. 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 for this metric.

6. CARDIOTHORACIC UPDATE

Progress towards completion the cardiothoracic action plans developed in response to previous reports from external organisations, continues. This is monitored through the Cardiac Oversight Group reporting to Quality Committee and to the Quality Improvement Group Meetings (QIG) attended by the Integrated Care Board (ICB), Care Quality Commission (CQC) and NHS England (NHSE). A report on the completed actions in the plans and review of assurance that monitoring of these compliance with these actions is now embedded in the normal business of the Clinical Board has been prepared for the Quality Committee.

Recommendations on future governance arrangements for Cardiothoracics oversight will be presented to a future Trust Board after consideration by the Quality Committee.

7. DIGITAL

John Crossman, Associate Medical Director (AMD), chairs the recently formed Care Optimisation Group, consisting of senior Information Technology (IT) / clinical members of staff reporting to the Data and Digital Committee via the Data and Technology Group.

The aim of the group is to support / implement / oversee changes to the Electronic Patient Record (EPR) to improve clinical effectiveness / quality of system / ways of working.

This is in response to recognition that EPR has to function in a way that supports all clinical staff caring for patients to deliver high quality / safe care, and an acknowledgement that some parts of the EPR are less than optimal in design and operation, and frustrate clinical staff.

The group is evolving process for field testing / threats and error management of changes introduced to EPR and has prioritised improvements to EPR including:

- The part of the EPR supporting correspondence, discharge summaries and operation notes.
- Electronic review of results.
- Internal referrals.
- Changes to EPR requested by staff in a recent survey undertaken by OracleCerner.

8. 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 progress with the implementation of the revised job planning guidance.

L Pareja-Cebrian/ M Wright
Joint Medical Directors
18 November 2024

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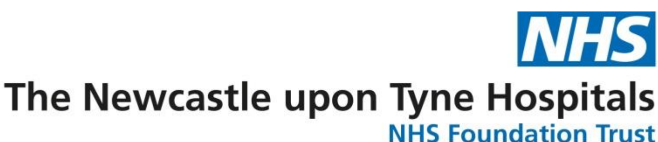
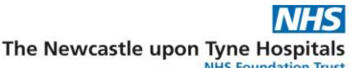
Agenda item A11(a)(i)



TRUST BOARD

Date of meeting	29 November 2024					
Title	Guardian of Safe Working Quarterly Report (Q2 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 June to 26 September 2024 for consideration by the Trust People Committee, prior to submission to the Trust Board.					
Recommendation	The Trust Board is asked to note the contents of this report.					
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link to the BAF. In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.					
Reports previously considered by	Quarterly report of the Guardian of Safe Working Hours – previously presented to the October 2024 People Committee meeting.					



GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

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

There are now 1,138 resident doctors in training on the New Contract and a total of 1,181 resident doctors in the Trust.

There were 150 exception reports in this period. This compares to 109 exception reports in the previous quarter. When compared to other Trusts in the region, these numbers are equivalent or lower per resident doctor than our neighbouring Trusts.

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 prior to August changeover. This issue is now resolved.

2. INTRODUCTION / BACKGROUND

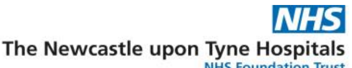
The 2016 New Junior Doctor Contract came into effect on 3 August 2016 and was reviewed in August 2019, with changes implemented in a staggered approach from August 2019 to October 2020. From August 2023 Locally Employed Doctors are also employed on a contract which mirrors the 2016 contract and allows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

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 Resident Doctors on New Contract	1,138	(1,025)
Total Number of Junior Doctors	1,181	(1,084)
Number of Exception reports	150	(109)
Number of Exception reports for Hours Breaches	122	(66)
Number of Exception reports for Educational Breaches	28	(43)
Fines	2	(7)

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 Medicine	121	(79)
General Surgery	9	(8)
Paediatrics/Paeds Surgery	7	(6)

4.2 Exception Report (ER) by Rota/Grade

General Medicine

Total	121
Hours and Rest	93
Education	28
Royal Victoria Infirmary (RVI)	
F1/F2/Locally Employed Doctor	61
Internal Medicine Training	4
Freeman Hospital (FH)	
F1/F2/Locally Employed Doctor (LED)	33
Internal Medicine Training (IMT)/Specialty Registrar (StR)	23

NB F1 is Foundation year 1, F2 is Foundation year 2

General Surgery

FH (F1) including Hepatobiliary (HPB), colorectal, vascular	6
RVI (F1/Specialty Registrar)	3

Paediatrics/Paediatric Surgery

Specialty Registrar	4
Senior House Officer	3

4.3 Example Themes from Exception Reports (ERs)

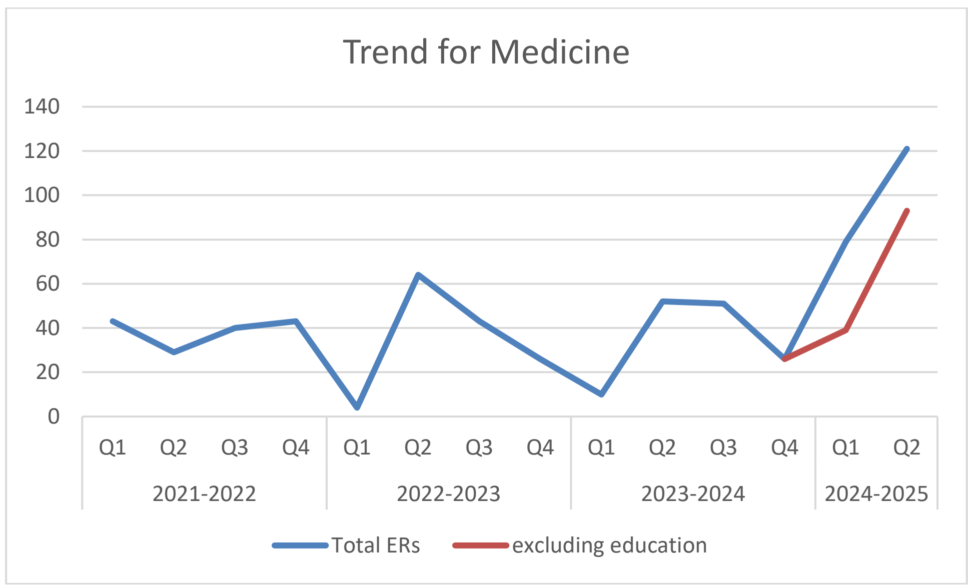
General Medicine RVI/FH

“High workload needing to be completed; inappropriate for on-call team; hence had to stay back until around 6.45pm to complete jobs (i.e. 2h 15mins extra)”

Doctors exception report when there is a high workload, particularly when they have additional medical boarders, or when there is low staffing levels.

28 exception reports were due to being unable to take self-development time. The arrangements for this changed in August in response to high numbers of exception reports, and the issue appears to have resolved.

Reviewing previous reports, there is often an increase in exception reports in Quarter 2. This is likely due to factors associated with August and September being the largest changeover of doctors and the commencement in post of the new F1 doctors. This results in time lost from clinical duties due to induction, additional training, and the learning curve of starting a new job. However, this spike in exception reports is exceptional. On reviewing the individual reports and discussion with the directorate, there was no obvious clinical factors, except perhaps an increase in reporting exceptions and an increased amount of short-term sickness absence resulting in short notice rota gaps.



General Surgery

The ERs from general surgery are when there is either excessive workload or staff shortages. The high number of exception reports from Freeman F1 have resolved with the additional resource put into this area.

Paediatrics/Paediatric Surgery

"No available SHO during the day (12 hours); due to sickness."

6/7 of the exceptions related to issues with the paediatric surgery SHO rota. These issues have been highlighted to the department.

5. EXCEPTION REPORT OUTCOMES

5.1 Work Schedule Reviews

No work schedule reviews were completed on the back of exception reports. Changes to self-development time were implemented on the back of exception reports.

5.2 Fines

Two fines have been issued:

- General Medicine (F1 Freeman): Rule breached "Late finish; Unable to achieve breaks; Exceeded the maximum 13-hour shift length. " Total fine money £108.78.
- Ophthalmology: Rule breached "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 £238.80.

6. ISSUES ARISING

6.1 Workforce and workload

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

6.2 Supervisor Engagement

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

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)	Sep-24	Aug-24	Jul-24
		Cancer Services					
Cancer Services	FH	Oncology	ST3+	22	4	4	4.2
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	1.4	1.4

Directorate	Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Sep-24	Aug-24	Jul-24
		Cardiothoracic Services					
Cardiothoracic Services	FH	Cardiology	ST3+	15	0.2	0.2	0.2
Cardiothoracic Services	FH	Cardiothoracic Anaesthesia	ST3+	10	3	3	3
Cardiothoracic Services	FH	Cardiothoracic Surgery	ST3+	11	2	2	3
Cardiothoracic Services	FH	Cardiothoracic Transplant	ST3+	3	1	1	1
Cardiothoracic Services	FH	Paediatric Intensive Care Unit (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 includes Paeds Surgery)	F2/ST1/ST2	25	1.4	1.4	1.4
Children's Services	RVI	Paediatric Oncology	ST3+	6	1	1	1
Children's Services	RVI	PICU	ST3+	10	1	1	2
		ENT, Plastics, Ophthalmology, Dermatology					
EPOD	FH	Ear, Nose and Throat (ENT)	F2 / CST / ST1-2	5	0	0	1
EPOD	FH	ENT	ST3+	9	2	2	0
EPOD	RVI	Plastic Surgery	F2/ST1/ST2	8	1	1	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	0	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	Core Medical Training	CMT	2	1	1	1
Medicine	RVI	Acute Care Common Stem on Assessment Suite Only	ACCS	2	0.2	0.2	0.2
Medicine	RVI	General Internal Medicine	ST3+	25	1	1	1.9
Medicine	RVI	Clinical Immunology	ST3+	3	1	1	1

Directorate	Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Sep-24	Aug-24	Jul-24
Medicine	FH	Gastroenterology	ST3+	6	1	1	0
Medicine	FH	Care of the Elderly	ST3+	5	1	1	0
Medicine	RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	20	1	1	1
Medicine	RVI	Accident & Emergency 2nd	ST3+	15	2	2	2.4
Medicine	RVI	Accident & Emergency	F2 GP Placement	12	1	1	0
		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	2.8	2.8	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
Radiology	RVI / FH	Neuroradiology	All grades	4	0	0	0
		Surgical Services					
Surgical Services	FH	General Surgery	F2/ST1/ST2/ST3+	7	1	1	1
Surgical Services	FH	Vascular	ST3+	10	1	1	0
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
		Women's Services					
Women's Services	RVI	Obstetrics & Gynaecology	F2/ST1/ST2	14	1.4	1.4	1.4
Women's Services	RVI	Obstetrics & Gynaecology	ST3+	22	2	2	2
Women's Services	RVI	Neonates	F2/ST1/ST2	7	1	1	1
Women's 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

July to September (Q2 2024-2025)	£915,211
March to June (Q1 2024-2025)	£1,435,902

Comment from the finance team:

"In terms of expenditure, we rely on the invoices from the Lead Employer Trust (LET) and so there are differences between the actual incidence of spend and the Trust being invoiced for it. There was a decrease of £521k between Q1 24/25 & Q2 24/25. Of this decrease, -£233k was Cardiothoracic, -£152k was Medicine & Emergency Care & -£100k was Family Health."

Trust Locum Spend

May to June 2024	£605,525
July to August 2024	£519,645

Comment from the finance team:

"The information for this was only available for July & August, so comparison is against these two months to the final two months of Q1 for fair comparison.

Spend on Trust locums between these periods decreased by £86k.

With regards to Clinical Boards the decrease of spend can be seen particularly in Medicine & Emergency Care (£-£58k) & Surgical & Associated Specialties (-£31k). This is partially offset by increase in Cardiothoracic (£38k)."

8. RISKS AND MITIGATION

The main risk remains medical workforce coverage across a number of rotas. This is exacerbated when clinical demand is high.

9. JUNIOR DOCTOR FORUM

Issues discussed included out of hours medical cover at the Freeman Hospital, issues with car parking, renovations to the junior doctors' mess at the RVI, and discussions regarding the change of name from 'junior doctor' to 'resident doctor' as suggested by the BMA.

10. RECOMMENDATIONS

I recommend that we continue to review the workforce workload balance to ensure safe and sustainable staffing.

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

9 October 2024

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Agenda item A11(b)

TRUST BOARD

Date of meeting	29 November 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 covers the following areas: • Section 1: Spotlight on Trust Vaccination Programme • Section 2: Safeguarding and Mental Capacity Act/Deprivation of Liberty Safeguards (DoLS) Quarter 2 highlight report • Section3: Learning Disability Quarter 2 highlight report • Section 4: Equality Delivery System Annual Report (Patients) The following key points/risks are noted for the Trust Board's attention: • There is robust governance and oversight in place to ensure effective roll out of the staff vaccination programme. Uptake of both Flu and Covid vaccination is lower at this point when compared to last year. Actions are in place to improve uptake, and further detail is contained within the report. • Staffing capacity in the Safeguarding Team is affecting the ability to deliver on all aspects of good practice with patient care being prioritised. This risk has been reviewed using the risk evaluation tool and will be added to the risk register with key actions to be agreed and implemented. • Compliance with policy audits has been challenging due to capacity in the adult safeguarding team. The team is now fully recruited to, with the plan to ensure policy audits are progressed in Quarter 4. A policy audit compliance report is now tabled as part of the agenda for the Safeguarding Committee to ensure progress is robustly monitored. • Safeguarding training compliance continues to be closely monitored. Level 1 and 2 Adult and Children compliance are above Trust target. Level 3 adult and children compliance is below the 90% threshold with actions in place to improve compliance. • Due to an increase in both activity and complexity of patients being referred into the Learning Disability Liaison Team work is required to ensure the infrastructure matches demand and complexity. This is logged on the risk register and work underway to increase team capacity. • It is positive to note the involvement of Skills for People in our improvement work for those with a Learning Disability or who are autistic which has been extremely beneficial as we ensure those with lived experience shape our services. The impact of their work is		

<table>
<tr><td></td><td colspan="6">contained within the report.
• The Trust's response to the Integrated Care Board (ICB) Safety Alert regarding care of patients with a Learning Disability in Critical Care Units is included in the report. This was discussed and reviewed in the Trust's Quality Committee. One area for development is in progress.
• The Equality Delivery System is a mandatory tool from NHS England (NHSE) to help trusts to improve their performance for individuals and groups protected by the Equality Act 2010. An annual report is required for the Trust to grade their performance against set goals by NHSE and to set new objectives. The report was discussed in the Patient Experience and Engagement Group in October and the Quality Committee in November.
• It was noted that whilst good progress was made during this time, the Equality, Diversity and Inclusion manager left the post earlier this year. This important work has continued but at a slower pace than was initially anticipated. The Patient Experience and Engagement Group therefore recommend that the objectives and action plan remain until March 2025. During this time the Trust will recruit and appoint into the vacant post and work in collaboration with stakeholders to agree the objectives and actions for the next four years.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Board of Directors is asked to note and discuss the content of this report.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">• Quality of Care will be our main priority. We will improve our approach to safety, incident reporting, listening, and learning.</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">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.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">The EDoN update is a regular comprehensive report bringing together a range of issues to the Trust Board.</td></tr>
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EXECUTIVE DIRECTOR OF NURSING

1. SPOTLIGHT – TRUST VACCINATION PROGRAMME

The Trust has delivered a Staff Vaccination Programme successfully for many years, initially the Flu vaccination was offered and with the advent of the pandemic, the Covid vaccination has been included for staff. The aim of the programme has been to ensure we maximise vaccination uptake and that staff receive information regarding vaccination to support them in making the choice to receive their vaccinations in line with national guidance. The program is underpinned by robust governance and assurance processes.

1.1 2024/25 Programme Overview

In the 2023/2024 program, the uptake for the vaccines was 67% for Flu and 54% for Covid which was slightly lower than the previous year but comparable nationally. The Trust had the highest delivery of vaccine in trusts who employed more than 10,000 staff.

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 noted that organisations may wish to offer the Covid vaccine to benefit their workforce. The Department of Health and Social Care recommend that Covid and Flu vaccinations be administered together to frontline staff, and this has been adopted by the Trust.

1.2 Oversight, Governance and Delivery

The Vaccination Steering Group oversees vaccination delivery. The group meets weekly and co-ordinates all aspects of the programme including vaccine supply, workforce, training, communications, physical estate as well as monitoring compliance and reporting both internally and externally. The day to day operational and professional oversight is provided by Occupational Health Department and an Associate Director of Nursing. The Occupational Health Department team are supplemented by trained bank staff and peer vaccinators.

The programme was launched at the beginning of October, delivering Flu vaccinations only. This was due to the delay in the publication of the Covid vaccine training, national protocol and distribution of the vaccine for administration. Therefore, the commencement of the Covid vaccinations did not start until 9 October 2024.

To deliver the service, fixed clinics were established at the Royal Victoria Infirmary (RVI), Freeman, Regent Point and in the community. Additionally, peer vaccinators provided vaccination in their own clinical areas. Last year peripatetic vaccinators conducted walkarounds which proved very successful and has therefore been re-instated this year. Pop – up clinics have been held in areas such as the Dental Hospital and the Centre for Life to increase access to vaccinations for our staff. Vaccinators have also worked weekends and twilights, again increasing accessibility to those staff working across all shifts.

1.3 Vaccination Progress

Uptake of both vaccines is monitored daily with information available on the Business Intelligence reporting software and is broken down by staff group and departments. This is an innovation for this year, and it is hoped that this timely and relevant data can help support Clinical Boards and Corporate Services to encourage staff to take up the offer of the vaccinations. Vaccination rates are also monitored against the previous year.

At the time of writing, uptake is lower at this point when compared to last year. This is multifactorial including the fact that the programme has commenced a week later and last year there was a period of industrial action from resident doctors which released vaccinator staff and space to run large clinics increasing uptake early in the programme. Early indications are that this lower uptake is reflected in neighbouring trusts across the region and nationally, but formal benchmarking data is still awaited. Current delivery (as of 20/11/2024) is 6,595 (40%) for Flu vaccination and 3,676 (22%) for Covid vaccination. Work is underway through communications and Clinical Boards to encourage uptake.

Operationally the team are agile and respond quickly to requests for support in specific areas. As the programme progresses, the focus is on data cleansing and capturing information for staff who have been vaccinated elsewhere. It is envisaged that the programme will wind down in the middle of December but can be extended into the New Year if required, and if the vaccine is available.

2. SAFEGUARDING AND MENTAL CAPACITY ACT (MCA) QUARTER 2 (Q2)

This summary of key points provides a Q2 update of Safeguarding (Adult, Children's and Maternity) and Mental Capacity activity throughout the Trust. This detail was presented to the Safeguarding Committee (October) and to the Quality Committee (November).

2.1 Activity and Service Capacity

The following key points were noted.

- Self-neglect continues to be a significant element of adult case work with the recurrent and persistent nature of these concerns leading to distressing circumstances for individuals.
- In Children's Safeguarding, substance misuse, domestic abuse, physical harm, neglect, parent/carer overdose and emotional abuse were the main categories of cause for concern referrals, all of which are key priority areas of Safeguarding Practice for Newcastle Children's Safeguarding Partnership (NSCP).
- The Maternity Dashboard demonstrated activity has remained relatively stable. However, for cases where a Child Protection plan is in place the complexity of the workload has increased.
- Staffing capacity in the Safeguarding Team is affecting the ability to deliver on all aspects of good practice with patient care being prioritised. This risk has been reviewed using the risk evaluation tool and will be added to the risk register with key actions to be agreed and implemented.
- The MCA/DoLS lead and safeguarding teams receive varied contacts requiring advice and at times direct support with work in Mental Capacity/DoLS enquiries, complex cases

(including Court of Protection) and Independent Mental Capacity Advocacy (IMCA). In Q2 there were 456 reported MCA and DoLS-related enquiries with some being regarded as complex and duly escalated within the Trust.
- In Q2 numbers for Urgent DoLS received and sent to Local Authorities is sustained at high levels, which has been an ongoing trend since 2023. For each month in Q2, numbers have remained at an average of 189 applications, which is 8% higher than Q1. The team also gathers the numbers of DoLS applications received from wards and having been triaged, a decision has been for the application not to be forwarded to the Local Authority. This number for Q2 is 137, 75% higher than Q1. There continues to be a need to expertly scrutinise DoLS forms prior to submission to Local Authorities. Feedback is routinely given to wards where applications do not meet the required standards.

2.2 Audit and Assurance

Key points to note:
- Compliance with policy audits has been challenging due to capacity in the adult team. The team is now fully recruited to, with the plan to ensure policy audits are progressed in Q4. A policy audit compliance report is now tabled as part of the agenda for the Safeguarding Committee to ensure progress is robustly monitored.
- The team has contributed to the Newcastle Safeguarding Adults Board (NSAB) multi-agency audit around domestic abuse. Learning from the audit will be reviewed with the safeguarding adults team and alongside action plans from Domestic Homicide Review (DHR) and Safeguarding Adults Reviews (SAR) to ascertain if there are any additional actions required.
- Routine audit has been gathered and shared at the MCA Steering group. Results demonstrate continued improvement in the application of the Mental Capacity Act in practice.

2.3 Education and Training

Key points to note:

- Safeguarding Adults training compliance continues to be closely monitored. Currently Level 1 training demonstrates good compliance with 96.1% and Level 2 95.65%. Safeguarding Adult Level 3 compliance is 87.5% and below the Trust 90% standard. All staff have been contacted to prioritise their Level 3 training. Focused work has been undertaken with the Medicine and Emergency Care Clinical Board to improve accessibility and compliance with training, which is currently 83%.
- Safeguarding Children Level 1 compliance rates are 96.23% and Level 2 92%. Level 3 Safeguarding Children compliance is 87% which is also below the required standard. Support has been provided to the team from the Learning and Development Unit to improve training compliance rates across the Trust.
- A bespoke in-depth review of training compliance aligned to the intercollegiate guidelines is complete with the final recommendations presented to the Learning and Education Group for consideration and endorsement in November. A risk/benefit analysis has been undertaken and a further update will be provided in future reports.
- Level 1 MCA mandatory training for all clinical and patient facing staff is in place. Compliance currently sits at 95%. In addition to this, Level 2 DoLS and MCA e-learning is nearing completion. Level 2 training is being aligned with Safeguarding Adults & Children Level 3. Additional face-to face supervision and training sessions continue, with good

uptake and feedback noting that staff felt this to be of benefit and helped to provide some reassurance.

The Trust has also contributed to the NSAB annual report, which has now been published and is in the Board reading room for information.

3. LEARNING DISABILITY QUARTER 2 (Q2) SUMMARY REPORT

This summary of key points provides a Q2 update of Learning Disabilities activity and practice development throughout the Trust. This detail was presented to the Safeguarding Committee (October) and to the Quality Committee (November).

3.1 Activity and Service Pressures

Key points to note:

- There continues to be an increase in both referrals and contact with the Learning Disability Team. Q2 figures demonstrate an increase from Q1 by approximately 200 attendances across elective, urgent care and out-patients.
- In Q2 there continues to be planning required for complex cases with several requiring support from the Trust legal team for potential Court of Protection applications. There has been a noticeable increase in Q2 with referrals and advice being sought for young people between 16 and 17 years. Whilst this is positive and is representative of a greater understanding from the workforce regarding advice for reasonable adjustments and admission planning, this is having a significant impact on the capacity in the team.
- It is also noted that at present, there is no dedicated resource to further develop the work around autism where there has also been an increase in referrals. Mitigations are in place overseen by the Associate Director of Nursing and work is on-going to identify funding to prioritise recruitment into this team.
- The service risks have been evaluated and two risks have been entered onto the risk register and continue to be closely monitored.

3.2 Mandatory training for Learning Disability and Autism

Key point to note:

- Current compliance with the Diamond Standard Mandatory Training is at 94.4% and this includes the newly implemented Maternity Diamond Standard training. This is for all Clinical staff and non-clinical staff in patient facing roles. Following the agreement through the Learning and Education Group this training will also be mandated for all Trust staff with a date for commencement to be agreed.
- There is ongoing discussion taking place with the ICB regarding the system-wide approach to the delivery of learning disability and autism training. The Associate Director of Nursing with oversight of Learning Disabilities in the Trust has been asked to participate in the regional stakeholder group meetings led by the ICB to determine and influence the agreed North East and North Cumbria (NENC) approach to mandatory training.
- Separately, funding has been agreed internally to deliver six one-hour sessions (via TEAMS) by Northeast Autism Society. These sessions will focus on managing distressed behaviours

and specific groups of staff will be encouraged to attend. Dates for the sessions will be circulated across the organisation in due course.

3.3 Care Quality Commission (CQC) Action Plan

The Learning Disability CQC Action Plan is overseen by the Learning Disability Steering Group at bi-monthly meetings. The following key points are noted:

- One action which continues throughout the year relates to project work with Skills for People which is proving extremely beneficial. The focus of the work is targeted at Easy Read documentation with significant changes being proposed for the 'Complaints leaflet' to make the process clearer for people with a learning disability. A letter of acknowledgment has been sent in recognition of the Skills for People contribution.
- As part of the Skills for People work there will be 'Quality Checkers' invited to the organisation and they have requested to walk through Urgent and Emergency Care in the first instance. Dates and organisation are to be agreed before year end.
- A significant action in the action plan is to ensure audit of compliance with admission assessment to improve the assessment and documentation of reasonable adjustments, aligned to our quality priority. Q2 audit analysis is underway and will be presented to the Learning Disability Steering Group in November but preliminary review demonstrates limited further improvement from Q1. Co-production work with Skills for People is underway to test our reasonable adjustment documentation and processes to provide guidance from those with lived experience.

3.4 The Trust's response to the ICB safety alert relating to patient with a Learning Disability and/or Autism received in August 2024

An ICB System Safety Alert was received in August 2024. The Safety Alert relates to patients with a learning disability being cared for in critical care units. Trust Boards were asked to be assured regarding five key points and asked to present this detail to the Trust Quality Committee. The Learning Disabilities and Corporate Nursing team, supported by key stakeholders across the Trust and in critical care have reviewed the alert. The detail was provided and discussed in the Quality Committee in November 2024. Whilst no concerns were noted, further work is underway to develop and embed a standard operating procedure for the management of discharge from the Intensive Treatment Unit (ITU) for those patients with complex needs.

3.5 NENC Learning Disability Network Visit

On 19 September, the Learning Disability Network visited the Trust and met with members of the Executive Team, Non-Executive Directors and the Learning Disability Team. This gave an opportunity for the Trust to highlight current workstreams, actions in response to CQC report and have a discussion regarding improving the experience of patients with complex needs. There was also the opportunity to discuss challenges faced by the Trust. The visiting team were able to have a walk about and meet some of the Learning Disability Team in clinical areas. Actions were agreed from a post visit discussion which will be discussed at the Learning Disability Steering Group. The network encouraged the team to nominate some of our staff for the Regional Diamond Standards Awards. Dr Tom Payne Doris (Consultant in Intensive Care Medicine & Anaesthesia) and the Security Team have both been shortlisted for awards in two of the categories.

4 EQUALITY DELIVERY SYSTEM (EDS) ANNUAL REPORT (Patients)

The EDS is a mandatory NHS Improvement tool from NHSE to help trusts to improve their performance for individuals and groups protected by the Equality Act 2010.

The 2024 Annual report is required for the Trust to grade their performance against set goals by NHSE and to set new objectives. The Trust is required to publish the annual report on the Trust website and the report also fulfils the Trust's legal Public Sector Equality Duties set out in the Equality Act 2010. This annual report looks at the patient focused outcomes of the EDS.

The grading used within the annual report has involved:

- Collating qualitative and quantitative data in relation to the needs of people with protected characteristics.
- Collating evidence of work within the Trust to address needs.
- Working in partnership with third sector and voluntary organisations to review trust performance and evidence.

The report was discussed in the Patient Experience and Engagement Group in October and the Quality Committee in November. It was noted that the EDS objectives and action plan were agreed by the working groups for the two-year period 2022 to 2024. Whilst good progress was made during this time, the Equality, Diversity and Inclusion manager left the post earlier this year. This important work has continued but at a slower pace than was initially anticipated. The Patient Experience and Engagement Group therefore recommend that the objectives and action plan remain until March 2025. During this time the Trust will recruit and appoint into the vacant post and work in collaboration with stakeholders to agree the objectives and actions for the next four years.

It was therefore recommended and agreed that the ratings of the four domains remain the same:

- 1A Developing: Patients have required levels of access to the service.
- 1B Achieving: Individual patients health needs are met.
- 1C Achieving: When patients use the service, they are free from harm.
- 1D Achieving: Patients report positive experience of the service.

5. RECOMMENDATION

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

Report of Ian Joy
Executive Director of Nursing
21 November 2024

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Agenda item A11(b)(iv)

TRUST BOARD

<table>
<tr><td>Date of meeting</td><td colspan="3">29 November 2024</td></tr>
<tr><td>Title</td><td colspan="3">Nursing Staffing Review Paper</td></tr>
<tr><td>Report of</td><td colspan="3">Ian Joy, Executive Director of Nursing</td></tr>
<tr><td>Prepared by</td><td colspan="3">Lisa Guthrie, Deputy Director of Nursing
Peter Towns, Associate Director of Nursing
Lindsey Cooper, Senior Nurse: Nurse & Midwifery Staffing</td></tr>
<tr><td rowspan="2">Status of Report</td><td>Public</td><td>Private</td><td>Internal</td></tr>
<tr><td>☒</td><td>☐</td><td>☐</td></tr>
<tr><td rowspan="2">Purpose of Report</td><td>For Decision</td><td>For Assurance</td><td>For Information</td></tr>
<tr><td>☐</td><td>☒</td><td>☒</td></tr>
<tr><td>Summary</td><td colspan="3">This report comprises both the Nurse Staffing six-month review (2024/25 Quarters 1 and 2) and the quarterly safe staffing assurance report.

The report fulfils the recommendations of the NHS Improvement ‘Developing Workforce Safeguards’ guidance (October 2018) and adheres to the recommendations set out by the National Quality Board (NQB 2016): How to ensure the right people, with the right skills, are in the right place at the right time. It updates the Board in relation to the following:

Nurse Staffing Review Update including:
• Actions agreed in the Quarter 1 and 2 2024/25 Staffing Report.
• Setting evidenced based staffing establishments.
• In-patient Skill Mix.

Three-month Safe Staffing Assurance Report including:
• Vacancy and turnover data.
• Red flags and Datix.
• Planned and actual staffing fill rates.
• Care Hours Per Patient Day (CHPPD) figures.
• Recruitment and Retention.

Key points/risks

• In line with national guidance, the Safer Nursing Care Tool (SNCT) data capture has been completed and the results triangulated with professional judgment. The staffing establishments in the majority of clinical areas remain broadly fit for purpose.
• There are a number of areas highlighted in this report, which may necessitate additional resource. Temporary mitigations are in place; options are being explored to identify funding from within Clinical Boards and if this cannot be achieved, will be discussed with the Executive Team to agree an investment strategy. Based on risk, areas will be prioritised as required.
• Robust staffing oversight remains in place through the Nurse Staffing and Clinical Outcomes Group. Two wards have required high-level support and have been discussed in the Quality Committee. Action plans remain in place and a peer review to agree de-</td></tr>
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<tr><td></td><td colspan="6">escalation in both areas is being progressed.
• The vacancy and turnover rates have improved for registered nurses and healthcare support worker staff. This is evidenced through fill rates, reduction in red flags and CHPPD metrics. Whilst this is positive, the skill and experience of the workforce remains a concern and close monitoring is in place.
• There are opportunities to optimise roster management to maintain fair and transparent rostering for staff. To support this check, challenge and coach meetings are in place.</td></tr>
<tr><td>Recommendation</td><td colspan="6">Trust Board is asked to:
i) Receive and review the deep dive staffing review report.
ii) Comment on the content of this approach, which has been prepared in line with national guidance.
iii) Acknowledge and comment on actions outlined within the document.
iv) Receive and review the quarterly staffing and outcomes review from July, August, and September 2024.</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">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.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">The Board has previously received the annual nurse staffing review report, the six-month review report and quarterly safer staffing assurance reports.</td></tr>
</table>

NURSE STAFFING REVIEW PAPER

1 INTRODUCTION/BACKGROUND

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

Nurse staffing continues to be affected by the nationally recognised workforce pressures, including absenteeism and the sustained increase in patient acuity and dependency. The vacancy position for nursing has improved, however, challenges remain in ensuring the skill mix across wards and departments is appropriate and safe, whilst supporting new staff in clinical practice.

2 2024/25 NURSE STAFFING REVIEW (NSR) UPDATE

2.1 Progress of review

A comprehensive nurse staffing review of all in-patient areas is underway throughout October and November 2024. An in-depth nurse staffing review of non-bed holding wards and departments took place from April to October 2024. It was noted that many of the wards and departments nursing establishments have been impacted by service changes, skill mix adjustments and changes in patient acuity and dependency. The complexity of these variations has resulted in a comprehensive undertaking in some areas which will be ongoing into the next financial year.

The corporate nursing team co-ordinate the Nurse Staffing Reviews (NSR) to explore the results of the evidence-based staffing tools (Safer Nursing Care Tool – SNCT, Community Nursing Safer Staffing Tool – CNSST) with nurse-sensitive indicators and professional judgement to inform recommendations for staffing establishments. Demand template work from these discussions determine the impact of these establishment recommendations before consideration by Executive Director of Nursing for approval.

SNCT data is collected 6-monthly for most in-patient wards, with the exception of critical care areas and wards under 12 beds, where the tool is not recommended for use. An Emergency Department (ED) SNCT tool is used for Paediatric and Adult Majors ED. Unfortunately, there is no evidence-based nurse establishment setting tool recommended for out-patients, theatres, day units and small wards and departments, therefore a professional judgement framework alongside any national guidance is utilised.

2.2 Adult In-Patient Wards and Assessment Suite

SNCT (Adult In-patient Wards and Adult Assessment Unit) is the evidence-based establishment-setting tool for adult in-patient nursing establishments used in the Trust.

The SNCT tool assumes at least 22% uplift when setting establishments for annual leave, sickness and study leave. This Trust funds a 20% uplift for in-patient areas (14% annual leave, 3% sickness and 3% study leave). However, there is no formal allocation of maternity leave in the uplift calculation. To mitigate this risk, over-recruitment agreements remain in place and maternity leave posts offered substantively for Band 3 Healthcare Support Workers (HCSW) and Band 5 Registered Nurse (RN) posts, to maximise the available workforce. This means that the SNCT calculation will always include a 2% differential. This is recognised and is not viewed as a risk. In line with national guidance, SNCT metrics are triangulated with nurse-sensitive indicators, staffing metrics and professional judgement, to inform establishment setting. However, it should be noted that the 3% sickness absence allowance is consistently exceeded which will impact either on the study time allowance, or staffing levels.

In accordance with national guidance an SNCT capture was undertaken across eligible Adult and Assessment Suite in-patient areas in September 2024. The in-depth nurse staffing reviews, considering this data with Heads of Nursing, Director of Operations and Finance Managers (or their delegates) are taking place throughout October and November 2024. This is the second data collection with a new tool; therefore, some reviews have identified an additional training and validation need before it can be used to guide any establishment decision making.

A summary of findings to date is listed below:

- **Family Health Services**: the NSR process has demonstrated an inconsistency in the staffing and delivery of in-patient, day unit and emergency gynaecology services. Work is ongoing to review demand for all these services, alongside a review of processes and activity. The service is reliant on temporary staff to mitigate risks at current levels and further work is required on patient pathways to determine the future staffing model.
- **Surgical and Specialist Services Royal Victoria Infirmary (RVI)**: NSR combined with information from the Nurse Staffing and Outcomes Group has indicated a staffing shortfall in trauma and orthopaedic wards at the RVI due to acuity and dependency profiles. A potential staffing model has been developed and costed, but it has been identified that further training and validation required. Additional temporary staffing is being deployed to mitigate any current risk.

  The other establishments are broadly fit for purpose pending some further review in specific areas.
- **Perioperative and Critical Care Services**: NSR process recommends that establishment can meet basic requirements for bedside nursing with some minor skill mix adjustments and movement of unregistered resource across departments to ensure consistency and equity of staffing levels between the critical care units. These are being costed and will be reviewed by the Executive Director of Nursing for approval. It has been acknowledged that there are some elements of the Guidelines for the Provision of Intensive Care Services (GPICS) standards which the units are not compliant with. This will be evaluated in future nurse staffing reviews, alongside their GPICS peer review reports, when these become available.
- **Cardiothoracic Services**: The respiratory ward at Freeman Hospital (FH) requires the use of temporary staffing to support their higher acuity patients. The staffing shortfall may be resolved by potential efficiencies, predominantly from Cardiology at the RVI. The other bed-holding area’s establishments appear fit for purpose, with some minor

adjustments. It is noted that the Cardiothoracic services is currently undergoing a service transformation exercise to review their bed holding capacity, which may require significant establishment changes.

Adult Cardiothoracic Critical Care establishment is compliant with GPICS standards; however the bed capacity can be limited by providing Extra Corporeal Membrane Oxygenation (ECMO) treatment to patients which is under review.

- **Medicine and Emergency Care Services**: The NSR process is still underway for medicine and emergency care services, but it has identified that some medical wards are not established for their enhanced care observation requirement. Risk is currently mitigated through use of bank and agency HCSW.

  The review of Assessment Suite has demonstrated an establishment gap and a 3-stage demand template is being costed, which was developed collaboratively with the ward leaders and matron team. Temporary mitigations remain in place.
- **Surgical and Associated Services Freeman**: Professional judgement and benchmarking data recommends additional night shift registered nurse on nightshift in two areas. This can be partially mitigated by a reduction in unregistered staffing and is in the process of being reviewed. NSR are still underway for surgery at Freeman.

  Ward 44 RVI has changed its nursing establishment due to a change in function from surgical to medical patients and has been agreed by the Executive Director of Nursing. Further data capture is required to ensure that the establishment is fit for purpose. The remaining wards at the RVI and ward 38 FH nursing establishments appear broadly fit for purpose.
- **Cancer and Clinical Haematology Services**: NSR has demonstrated that nursing establishment is broadly fit for purpose. Work is planned to ensure that the wards are compliant with Joint Accreditation Committee ISCT & EBMT (JACIE) transplant standards.

2.3 Children and Young People (CYP) In-Patient Wards

The Trust uses SNCT (CYP) as the evidence-based establishment-staffing tool for CYP in-patient nursing establishments. In accordance with national guidance a minimum 30-day data SNCT capture was undertaken across eligible CYP in-patient areas in September 2024. The in-depth nurse staffing reviews which discuss this data with Heads of Nursing, Director of Operations and Finance Managers (or their delegates) are taking place throughout October and November 2024. Findings to date are summarised below:

- The children's haematopoietic stem cell transplant unit's establishment appears to be fit for purpose. The ward has significant staffing shortages caused by vacancy, as described in the nurse staffing and outcomes section, where an action plan is in place.
- It was recognised at the 2023/24 NSR that the trauma and orthopaedic ward establishment provided less leadership allocation than other wards. This has been reviewed by financial management and a skill mix change can be achieved, while maintaining safe staffing levels without any additional investment and will be actioned following sign off from the Executive Director of Nursing.

- The Burns and Plastics ward underwent a peer review but the outcome was not available at the time of the nurse staffing review. It was recognised that there is a shortfall in administrative time for the burns lead nurse and this is being considered.
- The Paediatric Intensive Care Unit (ICU) RVI currently falls short of national standards in terms of uplift (which is partially mitigated by over-recruit into maternity leave), play staff, critical care outreach services, and clinical educator posts. A staged approach to compliance is being worked through.

2.4 Adult and Paediatric Emergency Departments

The Trust uses SNCT (ED) as the evidence-based establishment-staffing tool for the ED nursing establishments. Nurse staffing reviews had been delayed following data captures in March (Adult) and May (Paediatric).

The adult review recommended separation of adult major and minor injuries department budgets and demand templates to better understand staffing requirements and improve oversight. Further training will be undertaken prior to the next data capture before any recommendations can be made for nursing establishments. A staged demand template has been developed for the paediatric ED and assessment unit to improve staffing to respond to department attendance, which would aim to meet the national guidance. Both templates are with finance for review.

2.5 Community (CNSST)

The new national acuity and dependency tool for community district nursing services was launched in 2022. An in-depth nurse staffing review took place in February 2024 following two periods of data collection in 2023. Service activity has demonstrated a significant increase in patient referrals since 2020, particularly in relation to support of patients with diabetes, without reciprocal investment. There have also been several skill mix changes to support recruitment and retention. The CNSST data has given a consistent outcome at both data collections, which suggests an increase in nursing establishment, although professional judgement has advised that the establishment would be able to meet the needs of the service with an increase of about half of the recommended amount. However, the CNSST programme has now been nationally paused for review and is planned to be relaunched at a later date. A staged approach to reach staffing levels guided by professional judgement and service activity are being developed.

2.6 Non-bed holding areas.

In-depth nurse staffing reviews have taken place from April – October 2024 for all outpatient, community, day unit and theatre areas to review nursing establishment using a professional judgement framework. A preliminary overview of any exceptions is presented below:

- **Family Health Services**: the emergency gynaecology service is currently funded for registered nurses only and for a daytime service. However, the service is provided 24 hours and requires unregistered provision to provide chaperone services. Pending work on patient pathways will guide demand template work.

- **Surgical and Specialist Services RVI**: The emergency eye casualty department has a staffing pressure due to consistent late closures of the department. An extension to nursing hours is recommended to mitigate this but would require additional resource. Late closures are currently being managed with a combination of overtime and time off in lieu.
- **Perioperative and Critical Care Services**: A high-level nurse staffing meeting regarding theatres has recognised that theatres staffing models require a detailed review. The staffing team, in collaboration with Perioperative Services senior nursing and management teams will work together to create a staffing model, which is likely to be a lengthy process due to the number of theatres and complexity of some of the services offered.
- **Cardiothoracic Services**: There is an ongoing increase in transcatheter aortic valve implantation (TAVI) work, which has created a demand for Cardiac Catheter Laboratory services to be opened to capacity which are not fully funded for the nursing establishment. This is under review.

  Paediatric Outpatients Department has increased activity year-on-year without additional nursing resource. This is likely to be resolved within Clinical Board.
- **Medicine and Emergency Care Services**: The Dialysis Unit has increased activity and a change in patient demographic which has increased nursing demand. Patient numbers are expected to continue to rise, in line with national predictions. A business case is currently being prepared by the Clinical Board which is likely to include nursing resource.
- **Surgical and Associated Services FH**: The emergency admissions suite has a smaller leadership team compared with other comparable departments and an inconsistency in staff provision on nightshift across 7-days. These will require additional resource to resolve which is being mapped to determine any impact.
- **Clinical and Research Services:** Interventional radiology (IR) procedures are increasing nationally. Currently the IR nursing establishment does not meet IR nursing care guidelines relating to number of staff in theatres and on call. Plans to extend nursing hours to match medical staff will reduce unplanned extended shifts but will create additional staffing demand. This is being reviewed.

  There has been reliance on agency staffing has been replaced by Specialist Nurses to backfill nursing team. The OPD at Freeman has demonstrated increased activity, without associated increase in nursing resource, creating staffing shortfall creep. The service have requested a shift pattern to extend closing time to 6pm, which would create additional demand, but reduce unplanned extended shifts. The Corporate Staffing Team will work with the Clinical Board to assess the demand.

2.7 Nursing Skill Mix

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

Key points to note:

- A high-level nurse staffing meeting regarding theatres has recognised that theatres staffing models may not be compliant with national guidance. The Corporate Staffing Team, in collaboration with Perioperative Services senior nursing and management teams will work together to create a staffing model, acknowledging that due to the complexity this will be a lengthy process.
- A report will be submitted to the Executive Director of Nursing in December identifying the wards and departments with evidence of potential staffing risk, and associated costs using a stepwise progressive approach to rectify these year-on-year.
- All skill mix changes requested to demand templates are subjected to a quality impact assessment and costed by the Clinical Board finance team. The updated demand template and subsequent costings are then shared with the Head of Nursing, Matron and Senior Sister/Charge Nurse/Operating department practitioners (ODP) prior to changes being made to the demand template or business case submission being made.
- During the current nurse review process, skill mix changes have been explored in many areas to embed the nursing associate role where this is clinically appropriate.

2.8 Nurse Staffing and Clinical Outcomes

The Nurse Staffing and Clinical Outcomes Operational Group reviews safer staffing metrics alongside nurse-sensitive indicators and patient experience information in the Safer Staffing Dashboard, this is in line with national guidance. The group also considers any concerns raised by professional judgement or any incidents which have been reported over the previous month. The metrics are rag-rated and following discussion, wards are categorised as; requiring no support; low, medium, or high-level support. Actions are agreed in line with the appointed level of escalation: low/medium (focussed interventions for areas of concern) and high (full action plan). Mid-point monthly meetings are held to scrutinise and support action plans. Wards which have required high level support for any length of time and those requiring medium level support for more than two months are reported to Executive Director of Nursing monthly. Wards are only de-escalated from high level support following a successful peer review.

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

Month	Total	Clinical Board	High level support	Medium level support	Low level support
Jul-24		Family Health Services	1	1	3
		Surgical and Specialist Services RVI		2	2
		Perioperative Services		1	1
		Cardiothoracic Services	1		3
		Medicine and Emergency Care Services		1	4
		Surgical and Associated Services FH		1	1
		Cancer and Clinical Haematology Services		1	
Total	**23**		**2**	**7**	**14**

Month	Total	Clinical Board	High level support	Medium level support	Low level support
Aug-24		Family Health Services	2		3
		Surgical and Specialist Services RVI		1	1
		Perioperative Services			
		Cardiothoracic Services		1	2
		Medicine and Emergency Care Services		1	6
		Surgical and Associated Services FH		1	2
		Cancer and Clinical Haematology Services		1	
Total	**21**		**2**	**5**	**14**
Sept-24		Family Health Services	2	0	5
		Surgical and Specialist Services RVI		1	1
		Perioperative Services			1
		Cardiothoracic Services			2
		Medicine and Emergency Care Services		2	7
		Surgical and Associated Services FH		1	2
		Cancer and Clinical Haematology Services		1	
Total	**25**		**2**	**5**	**18**

Key points to note:

- There are 2 wards currently requiring high level support: Ward 4 Great North Children's Hospital (GNCH) & Ward 3 GNCH.
- Ward 29 FH was de-escalated to medium and then low level support following a successful peer review.
- Ward 4 GNCH has made steady progress, and a peer review has been arranged for December 2024. An update with the outcome of this review will be provided in subsequent reports.
- Ward 3 GNCH was escalated to high level support in August 2024 and an improvement plan is in place.
- The wards with high-level support have been highlighted and discussed in the Quality Committee. Action plans are in place for these areas in collaboration with the Heads of Nursing and nursing teams. Additional support, education and resources are provided, overseen by the Executive Director of Nursing.
- In addition to the 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.

2.9 <u>Planned and Actual Staffing *(April 2024- September 2024)*</u>

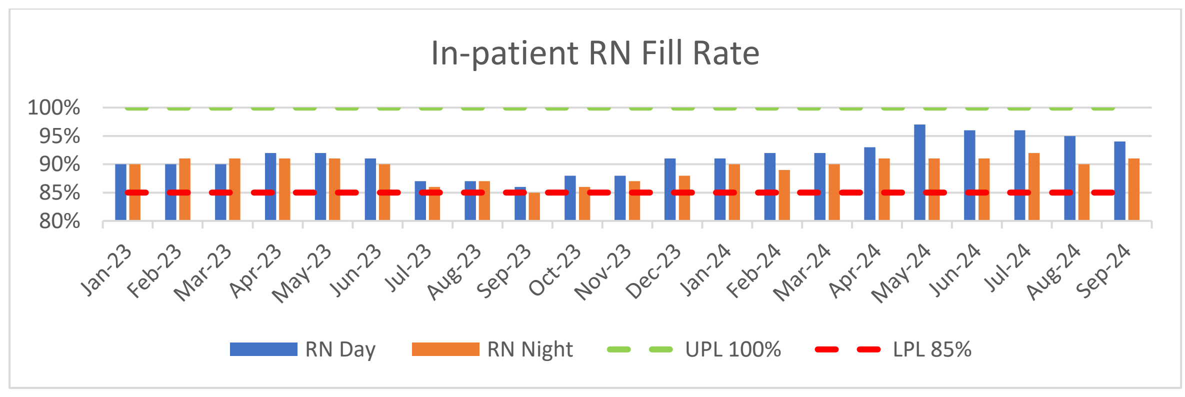
"Planned staffing" is the number of nursing, midwifery and clinical support staff hours that each in-patient ward and department plan to have on duty each shift. This is based on maximum utilisation of their planned establishment. "Actual staffing" is the number of nursing, midwifery and clinical support staff who worked on each shift. Planned staffing data is maintained by the staffing team and adjusted for temporary bed closures or any agreed nurse establishment change.

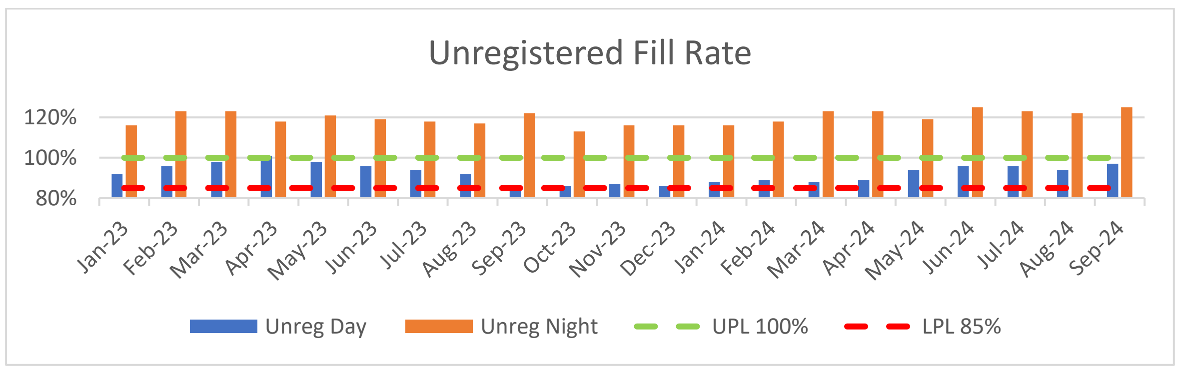
The Trust fill rate table and charts below are reported as averages. This means it does not represent outlier wards with particularly high or low fill rates. However, individual ward fill rate data is reviewed at the Nurse Staffing and Clinical Outcomes Group.

Key points to note:

- Day shift RN fill rates peaked in May at 97% and have declined through September to 94%, following a similar pattern to the previous year.
- Night RN fill rates have remained largely static from April to September (90-92%) and have increased from the same period last year (85-91%).
- Day Healthcare Assistant (HCA) fill rates have increased steadily since April (89-97%), whereas there was a decrease over the same period last year (101-86%).
- Night HCA fill rates have largely remained above 120% since April (119-125%). This may be partially due to enhanced care observation and backfill where there is shortfall in registered nursing. This is slightly increased from the same period last year (118-122%).
- The staffing team work alongside matrons and ward leaders to improve rostering consistency to improve fill rates across 24-hours.

Fill Rate Table						
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
RN Day	93%	97%	96%	96%	95%	94%
RN Night	91%	91%	91%	92%	90%	91%
HCA Day	89%	94%	96%	96%	94%	97%
HCA Night	123%	119%	125%	123%	122%	125%





2.10 Care Hours per Patient Day (CHPPD) *(April 24- September 24)*

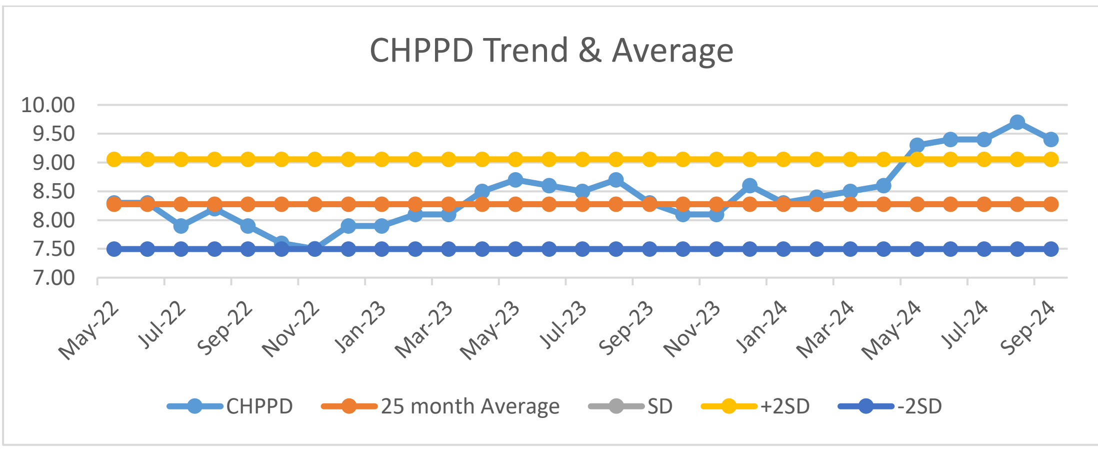
CHPPD is the unit of measurement recommended in the Carter Report (2016) to record and report deployment of staff working on inpatient wards. This became the primary benchmarking metric from September 2019. It adds together RN and support worker hours, divided by midnight census. All acute Trusts have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

There are some limitations to using CHPPD as a benchmark. Newcastle Hospitals has a high proportion of Critical Care beds which inflates the Trust overall average CHPPH score. In addition, 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 staffing team monitor Ward-specific CHPPD on the Safer Staffing Dashboard and is reviewed at the Nurse Staffing and Outcomes Group every month.

Key points to note:

- The Trust average CHPPD has been on an upward trajectory since October 2022 and a marked increase in CHPPD from May 2024. This may be related to improved accuracy since automating the nursing hours data.
- CHPPD peaked in August at 9.7 and has dropped to 9.4 in September 2024.
- CHPPD is in the 4th quartile of the group of recommended peers on model hospital. The Trust value is 9.4 compared with a peer median of 8.3. This may be reflective of the number of critical care, paediatric and highly specialised beds in the Trust.



2.11 Red Flags and Datix *(April 2024-September 2024)*

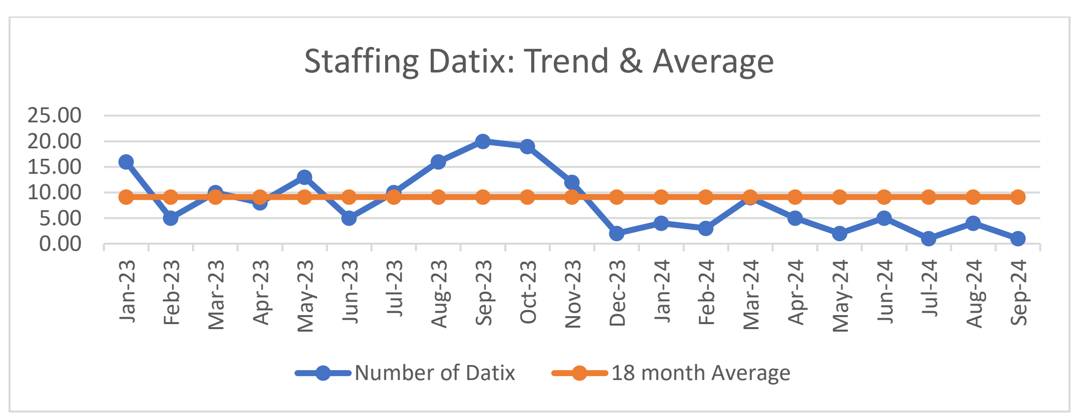
Red flag and Datix incident data are reviewed daily by the Corporate Senior Nursing Team and reported as part of the daily staffing briefing. Red flags continue to be presented to the Nurse Staffing and Clinical Outcomes group monthly to highlight areas of concern. This data is available at a Ward, Clinical Board and Trust level. Staffing incident data is considered in nurse staffing reviews during discussions about future establishment requirements.

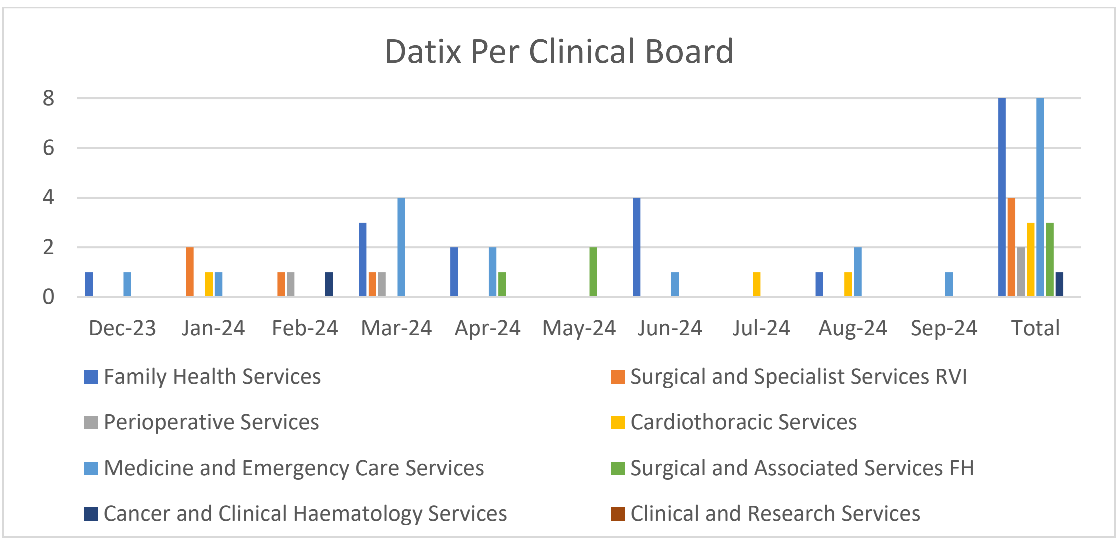
All staffing incidents reported on Datix are received by the Deputy Director of Nursing, Associate Director of Nursing, and the Senior Nursing Workforce Team. In hours, the incidents are reviewed in real time, and out of hours, as soon as practicable. Reporters and Matrons are contacted to acknowledge receipt and gain greater understanding of themes. When incidents are being responded to in real time mitigations and resolution is sought. Work continues to encourage staff to submit Datix reports for staffing shortfalls.

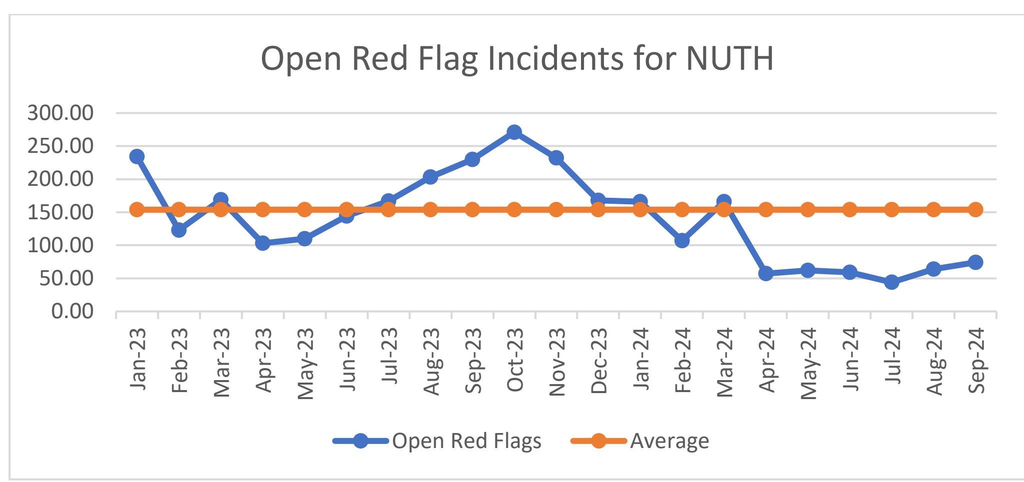
Red flags in the SafeCare application continue to be utilised effectively in conjunction with professional judgement. Red Flags are acted upon/mitigated where possible in real time and reported to the Executive Director of Nursing and Deputy Executive Director of Nursing and into silver command as required.

Key points from the last 6 months:

- Datix reports related to staffing incidents have demonstrated significant and sustained reduction since September 2023, with numbers of 1-5 reports per month since April 2024 (overall average is 9 reports per month for the preceding year).
- Over the past 6-month period, Datix staffing incident reports were submitted most frequently from Family Health Services, mostly attributable to low staffing levels in Ward 3 GNCH which has a high level of vacancies, the effect of which was compounded by short-term sickness. Ward 3 is currently being supported at a high level through Nurse Staffing and Clinical Outcomes group, aiming to improve their staffing situation and has agreement for short-term bed closure of 2 beds to mitigate the shortfall.
- Open Red Flag incidents for the Trust, average at 154. However, open red flags have reduced to between 44-74 per month since April 2024.
- The mostly commonly reported red flag is “shortfall in RN time” reported both on day and nightshift.
- There are no open red flags for “less than 2 RN on shift” since the last board report in September.







3. RECRUITMENT AND RETENTION

3.1 Registers Nurse (RN) Recruitment

Key points to note:

- The current RN vacancy rate is 3.36% based on Month 6 financial ledger, this is a slight increase from the 2.65% reported in Month 5, however it is still below the figure of 4.96% 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 current RN turnover is 6.16%, this demonstrates a continued reduction from the previously reported 8.83% in the same period last year.
- The Trust have interviewed and successfully employed 240 nursing students who commenced their posts in September and October 2024.
- The Executive Director of Nursing receives a monthly financial report providing an overview of nursing spend per ward and department and run rate. This is analysed on a quarterly basis to identify areas which may require support.

- There a several areas where enhanced care requirements are greater than the funded establishment which has led to a cost pressure. A number of controls are in place such as daily corporate oversight of redeployment and discussion/challenge through performance reviews. Check, Challenge and Coach Meetings are undertaken with nursing leaders in Clinical Boards on a bi-monthly basis. The purpose of these meetings, in combination with e-roster dashboards, is to support inpatient areas in their use of e-rostering to provide safe, effective, and fair rosters.

3.2 Healthcare Support Worker (HCSW) Recruitment

Key points to note:

- The Trust HCSW vacancy rate reported on the Provider Workforce Report (PWR) is currently 9.5%. It should be noted that the PWR contains non-HCSW staff such as house keepers in the reported vacancy rate and so with those staff manually removed the HCSW vacancy rate is lower. A solution is being sought with finance and human resources colleagues to address this issue and this has also been highlighted to NHS England.
- The number of unallocated Recruitment Control Group (RCG) posts for Band 3 Healthcare HCSW is 68.01 whole-time equivalent (WTE) which would make our vacancy rate 5.34%.
- The HCSW Steering Group continues to take place on a bi-monthly basis to review and monitor performance. The current phase of the programme is focussing on retention, professional development and pastoral support of HCSWs across the organisation.
- The current HCSW turnover rate is 7.97% % compared with 11.25% in the same point in the previous year.
- After being successful in gaining funding from NHS England, the HCSW Planning Committee are currently finalising the programme for a HCSW Conference, which is planned for the 25 November 2024 at the Crown Plaza Hotel.

4. CONCLUSIONS AND ACTIONS

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

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

CHPPD metrics. Whilst this is positive, the skill and experience of the workforce remains a concern and close monitoring is in place.
- There are opportunities to optimise roster management to maintain fair and transparent rotas for staff. To support this check, challenge and coach meetings are in place.

The following actions are proposed:

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

5. RECOMMENDATIONS

The Trust Board is asked to:

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

Report of Ian Joy
Executive Director of Nursing
19 November 2024

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TRUST BOARD

Date of meeting	29 November 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 including; • Perinatal Quality Surveillance minimum data measures. • Progress with the CQC action plan against exit criteria from Strategic Oversight Framework (SOF) enhanced surveillance. • Progress with the Ockenden Immediate and Essential Actions. • Current clinical risks and mitigations. **Section 2** provides an update of the Trusts position with the required actions and safety intelligence to fulfil the requirements, this includes safe midwifery staffing. **Section 3** provides an overview of progress with the Care Quality Commission (CQC) maternity action plan. **Section 4** outlines the current risk, namely the infection outbreaks on the Neonatal Intensive Care Unit (NICU), antenatal and newborn screening failsafe processes and smoking cessation services, and the mitigations in place.		
Recommendation	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. Note the progress with the CQC action plan. iv. Note the current risks and mitigations in place		
Links to Strategic Objectives	Putting patients at the heart of everything we do. Providing care of the highest standards focussing on safety and quality.		

Impact	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability

(please mark as appropriate)	☒	☐	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	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.					
Reports previously considered by	Previous reports have been presented to the Trust Board, Maternity Update, Midwifery staffing paper, Maternity Incentive Scheme (CNST).					

PERINATAL QUALITY SURVEILLANCE REPORT

1. INTRODUCTION

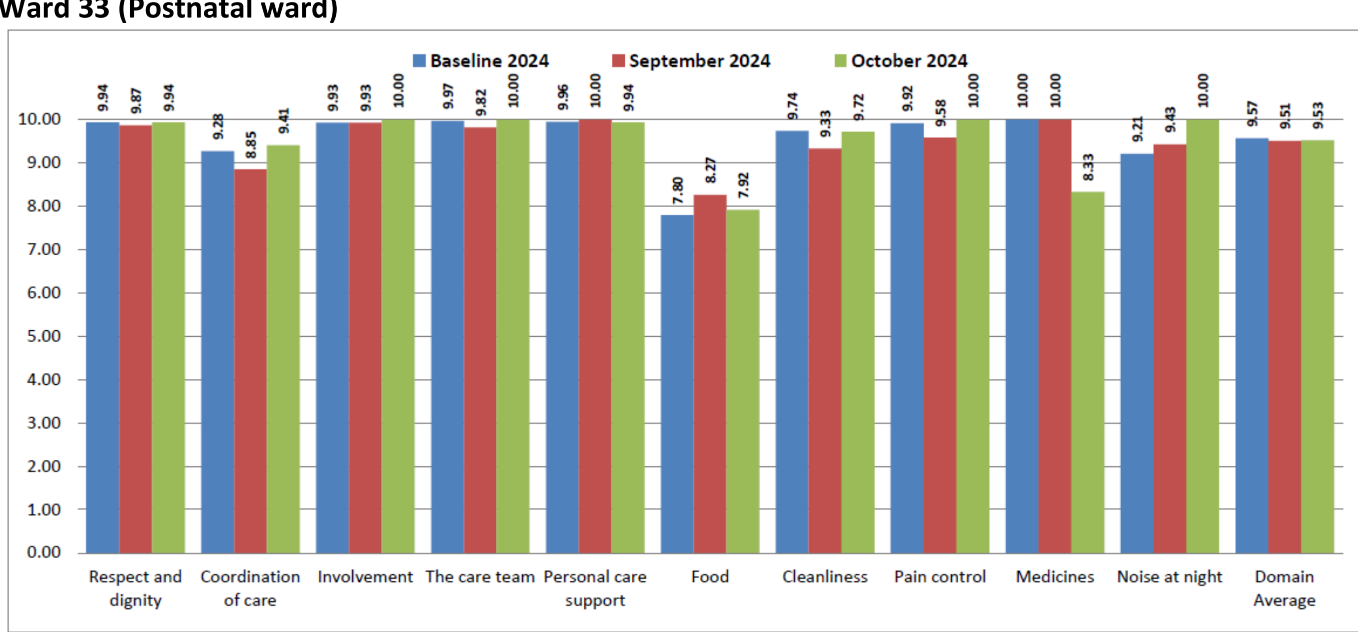
This report provides the Trust Board members with an overview of the Maternity Service compliance with the Perinatal Quality Surveillance Model, based on the locally and nationally agreed measures to monitor maternity and neonatal safety. The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. The information within the report reflects actions in line with Ockenden and progress made in response to any identified concerns at provider level.

2. MINIMUM DATA MEASURES

2.1 Service User Voice Feedback

Real time patient experience programme has been introduced in the postnatal ward, transitional care ward and delivery suite to capture feedback from service users regarding their care and experience. This is generating rich qualitative and quantitative feedback, in addition to the Right-Time Feedback. The patient experience data has been reviewed by the Perinatal Inclusion and Engagement Group, with service user voice representation, to inform key areas for improvement such as the postnatal care quality improvement action plan and induction of labour pathways.

Ward 33 (Postnatal ward)



100% of the patients surveyed would recommend their overall experience on the ward during October.

''It has been a really pleasant experience. The staff are really supportive. My mum did find it hard to find the ward as she came in at the other side of the hospital - maybe a map for visitors would be helpful.''

''It is excellent here. The staff are so accommodating and approachable.''

The postnatal care quality improvement action plan is a core item on the Postnatal Forum agenda, with oversight of the Ward Manager and core team midwives, progress is reported to Obstetric Board. The action plan addresses the themes of timely analgesia and medication, delayed discharge and nutrition. Following the completion of the staffing review a shift lead will be introduced in December, who will be responsible for completing a medicine round and will maintain oversight of eObservation compliance and escalation.

Ward 34 (Transitional care ward)

	Baseline 2024	September 2024	October 2024
Respect and dignity	9.96	10.00	10.00
Coordination of care	9.43	9.81	10.00
Involvement	9.91	9.90	9.92
The care team	9.86	10.00	9.88
Personal care support	9.50	10.00	10.00
Food	8.32	7.28	9.06
Cleanliness	9.49	9.74	9.86
Pain control	10.00	10.00	10.00
Medicines	9.95	10.00	10.00
Noise at night	9.19	9.17	10.00
Domain Average	9.56	9.59	9.87

The transitional care ward opened in April 2024 to support the national ambition to minimise separation of parents and their babies. Mothers and babies have a physiological and emotional need to be together in the hours and days following birth, this is important for physiological stability of baby and initiation of maternal infant interaction. There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child, hence the importance of transitional care provision to minimise neonatal admission to the NICU.

The patient experience is overwhelmingly positive, and parents are appreciative of the care provided to ensure they can stay together as a family. Admission activity has exceeded projections and the staffing ratios (both nursing and midwifery) are included in the perinatal workforce review to ensure they are appropriate, and fulfil British Association of Perinatal Medicine (BAPM) and BirthRate+ recommendations.

2.2 Training compliance

This Trust delivers the North East North Cumbria (NENC) Local Maternity and Neonatal Systems (LMNS) training syllabus, developed to fulfil the training requirements of the core competency Framework v2 and maternity incentive scheme. The Trust is on track to achieve compliance with the Trust target and the requirements of the maternity incentive scheme for midwives, nurses and maternity support workers.

Training for the obstetric workforce remains hugely challenging due to consultant vacancies and sickness within the team. Compliance will only be achieved if all obstetric consultants scheduled to attend the training can be released from clinical duties, this is only feasible if all consultants are present. The Head of Obstetrics and Clinical Director have oversight, but this is a risk. All consultants have had the required fetal wellbeing and obstetric emergency training within the last 12 months, but for some this is not within the period considered by the Maternity Incentive Scheme (MIS), as such, there is no clinical risk but a financial risk associated with the MIS.

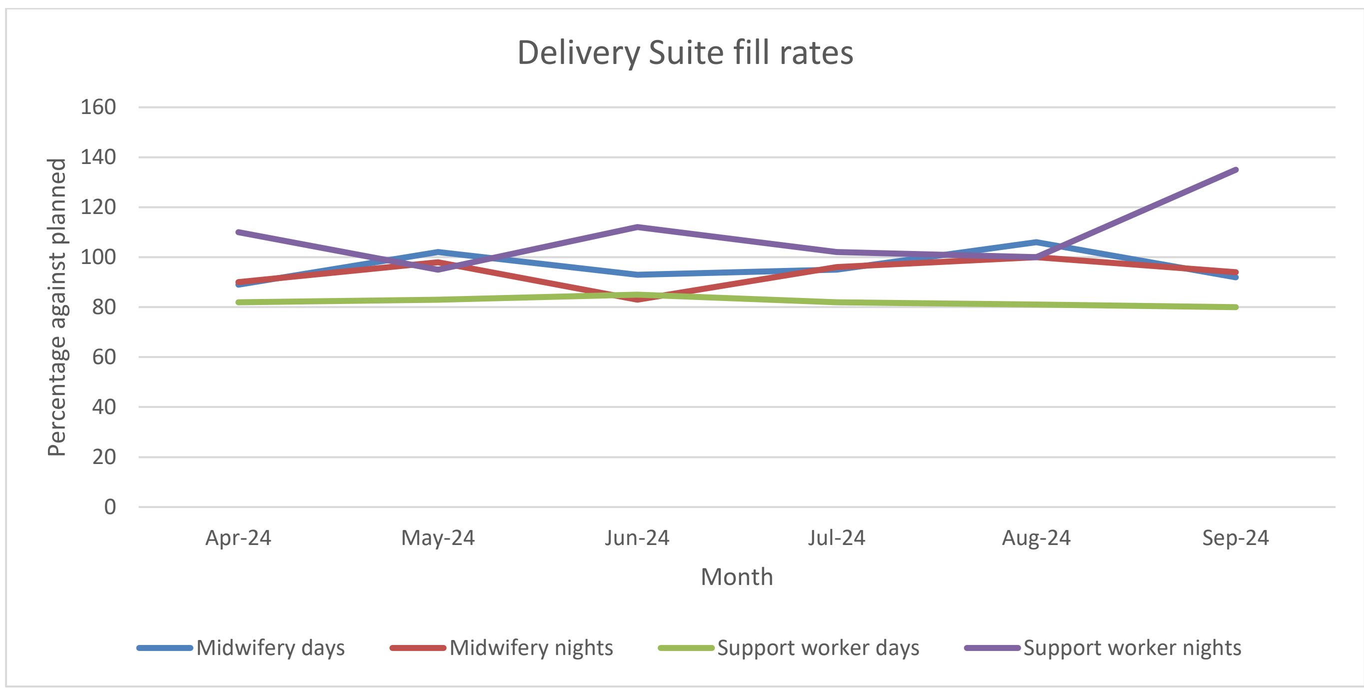
2.3 Minimum safe staffing

Organisational requirements for safe midwifery staffing for maternity settings (National Institute for Health and Care Excellence (NICE) 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to provide safe care at all times to women and babies in all settings. Midwifery staffing is reported separately to the Trust Board biannually to meet the requirements for the maternity incentive scheme.

The Trust Board are familiar with the midwifery staffing challenges the service has faced over the last 12 months, and the development of a midwifery staffing model to support sustainable intrapartum services within the Newcastle Birthing Centre (NBC) and Delivery Suite from December 2024. The service is on track to re-open services as planned.

A staffing dashboard for acute and community services has been developed to review the planned versus actual fill rates, acuity versus staffing and any associated safety metrics, such as red flag incidents, Datix reports and Consolidated Audit Trail (CAT) compliance. This is monitored monthly by the senior midwifery team and reported to the Quality and Safety Group, with exception reporting to the Directorate Quality and Safety Group and Quality Oversight Group (QOG).

Fill rates – planned versus actual Delivery Suite



The planned staffing for Delivery Suite was not amended following the closure of Newcastle Birthing Centre so although the fill rates have improved following the suspension of the low risk services and centralisation of intrapartum care on the Delivery Suite, the staffing versus acuity data from the real time Birth Rate + acuity tool demonstrates that the midwifery staffing is still very challenged. There are some concerns regarding variance regarding how the acuity is scored, a review to ensure consistency is underway. Staffing and acuity will be closely monitored following the re-opening of the Newcastle Birthing Centre. The integrated intrapartum team model will increase staffing across the intrapartum services and ensure the staffing reflects the acuity and activity.

The number of red flag incidents reported in September were minimal, with no occasions when one to one care could not be provided, and no occasions during the shift when the co-ordinator was not supernumerary. There were 16 red flags reported in relation to delays between admission and commencing the induction of labour process. This is ensure to one to one care was provided in labour and the staffing was deployed in accordance with activity and acuity. Although this can result in a poor patient experience, it supports safety and should be the first line clinical action used to manage fluctuations in activity or expected staffing concerns. The Director and Head of Midwifery and management team continue to monitor the patient experience data and Maternity and Neonatal Voices Partnership (MNVP) feedback closely following engagement and feedback sessions with service users. A project to review current induction of labour pathways, to reduce red flags, improve patient experience, and to address estate issues, has been established and is expected to provide recommendations to the Obstetric Board in March 2025.

2.4 Care Quality Commission (CQC)/MNSI/CQC concern or request for action made directly to the Trust

Nil

2.5 Findings of the review of all perinatal deaths using the Perinatal Mortality Review Tool (PMRT)

Please refer to Q2 2024/25 PMRT report submitted with Maternity Incentive Scheme (MIS) Year 6 (CNST) paper and can be found in the Quality Committee reading room.

2.6 Regulation 28 made directly to the Trust

Nil

2.7 Progress in achievement of CNST MIS 10 safety actions.

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

2.8 Staff feedback from frontline champions and walkabouts

Please refer to the Non-Executive Director Maternity Safety Champion report.

2.9 Staff experience

The Trust has participated in the NHS England (NHSE) Perinatal Culture and Leadership programme, which was introduced in response to the Ockenden report, and is an action outlined in the Three Year Plan for Maternity and Neonatal Care. The final component of the programme is the SCORE Culture Survey, an independently facilitated programme with team and quadrumvirate debriefing sessions to co-design the cultural improvement actions identified. The data collection phase was completed in April and the report was received in August 2024. The Trust received a 49% response rate, with 382 staff completing the survey.

The results, and associated improvement plan, were discussed at the Perinatal People and Culture Group, which reports into the Obstetric Board and Family Health governance structure. A staff wellbeing champions group and communication task and finish group have been established in response to the survey results, with strong multidisciplinary representation from across the maternity and neonatal teams. Progress with the improvement plan will form part of the perinatal quality surveillance metrics. A service wide Teams channel has been established to share all key documents in an open and inclusive manner, to encourage participation and transparency.

2.10 MNSI/PSII reports

A requirement of Immediate and Essential Action (IEA) 1 of the Ockenden report, and a core element of the Perinatal Quality Surveillance Model, is to share all serious incident (SI), Patient Safety Incident Investigations (PSII) and MNSI reports with the Trust Board. These are included within the papers in the Board Reading Room, along with any associated improvement action plans.

3. PROGRESS WITH THE CQC ACTION PLAN AND EXIT CRITERIA

Agreed exit criteria

- Achieve compliance with the NENC triage performance metrics

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%	100%
Aug-24	1206	1128	1041 (92.3%)	213	609	301	5	204 (95.8%)	581 (95.4%)	274 (91%)	77.70%	68.20%	50%	80%
Sep-24	1486	1203	1098 (91.3%)	182	763	245	13	174 (95.6%)	730 (95.7%)	224 (91.4%)	77.30%	50.60%	43.50%	100%

Improved performance with triage within 15 minutes of attendance has been maintained at 91% in September (August 92%). Midwifery review thereafter has also been maintained for the last 3 months across all categories of urgency.

In August, medical review performance within 15 minutes was 50%, within an hour 68% and within 2 hours was 78%. This performance has also been broadly maintained in September. Medical review compliance continues to be challenged by the obstetric staffing position, work is ongoing to maximise the medical capacity. Recruitment has commenced for two Advanced Clinical Practitioners, which has attracted significant interest. Patient safety is maintained by ensuring senior midwifery presence, with one to one care, and escalation if deterioration. The NENC LMNS is yet to agree the targets for medical review, the Trust performance will be benchmarked against these once agreed. A proposal is expected at the LMNS Board meeting in November.

- 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

Good progress with fill rates as detailed above, the service wide staffing review will ensure the fill rates across all acute and community teams are sufficient and will be reported in the next update, alongside acuity and caseloads.

- Achieve compliance with Trust appraisal rate target for 2024/25

The Maternity Service leadership team maintain oversight of appraisal rates and the associated action plans, the service is on track to achieve compliance.

- Achieve compliance with Trust and CNST MIS training targets across all multidisciplinary teams for 2024/25

The Trust is on track to achieve compliance with the Trust target, with the risk associated to medical attendance and the requirements of the maternity incentive scheme as per the update in this paper.

- Embed baby abduction drills and required changes to policy, with evidence of successful drills over a 6 month period.

The Trust enacted a further baby abduction drill on the 3 October 2024, which was successful, demonstrating staff familiarity with the requirements of the updated policy and

compliance. Further drills have been planned throughout the year, initially monthly, with a further drill planned for the end of November.

4. RISKS TO BE NOTED

4.1 Infection outbreaks NICU

There are currently two infection outbreaks on the NICU Glycopeptide Resistant Enterococcus (GRE) and pseudomonas.

In September a urine sample from a baby reported GRE. Infection Prevention Control (IPC) precautions were implemented. A second and third case were identified in late September, and an outbreak declared on 1st October 2024. All babies were initially thought to be associated with a single bay on NICU. A further 2 cases were identified via contact tracing. GRE outbreak is thought to be multifactorial in relation to:

- NICU environmental challenges.
- Over use of Vancomycin in preterm infants.
- Concerns regarding inadequate parental hand washing technique.
- Concerns regarding bedside equipment risk of cross contamination.

There have been several outbreak meetings to review and agree immediate and medium-term actions which are in place and continue to be closely monitored.

A site visit of the NICU has been conducted to review the NICU estate and explore feasibility plans within the perinatal services footprint to support decant and estates work. A follow up meeting is planned at the end of November.

4.2 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. The Incident Oversight Group, with ICB and NHSE representation, continues to meet fortnightly.

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. The NHSE screening team have identified a Subject Matter Expert (SME) to support the reviews, and the subsequent improvement actions.

4.3 Smoking cessation services

The Trust performance against the Saving Babies Lives Care Bundle V3 (SBLCBV3) Element 1: Reducing smoking in pregnancy is a risk.

Element 1 focuses on reducing smoking in pregnancy by implementing NHS-funded tobacco dependence treatment services within maternity settings, in line with the NHS Long Term Plan and NICE guidance. This includes carbon monoxide testing and asking women about their smoking status at the antenatal booking appointment, as appropriate, throughout pregnancy. Women who smoke should receive an opt-out referral for in-house support from a trained tobacco dependence adviser who will offer a personalised care plan and support throughout pregnancy.

The Trust is non-compliant with the minimum standards for each part of this element. This poses a clinical risk, due to the associated morbidity and mortality associated with smoking in pregnancy, and requires additional resource, such as antenatal scan appointments and consultations. The new pathway model is being introduced, but it is unlikely this will improve performance by the end of this year's Maternity Incentive Scheme but will ensure the maternity service has the correct staffing resource, skill, education and infrastructure to improve performance, and ultimately reduce the number of women who are still smoking at the time of delivery moving forward.

5. 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 perinatal service.

The Trust is embedding the six requirements to strengthen and optimise board oversight of perinatal safety, this will be supported by the further 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 infection outbreaks on NICU, antenatal and newborn screening performance and smoking cessation. The minimum data measures will be shared with the Trust Board on a monthly basis in the interim.

The Maternity Service is making good progress with the CQC action plan, the Quadrumvirate will continue to review progress as part of the enhanced oversight meetings with the ICB and LMNS, with a plan to review exit criteria compliance in March 2025.

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. There is senior oversight of the estate issues in relation to the outbreaks in NICU and feasibility plans for decant and estate works are planned.

6. 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. Note the progress with the CQC action plan.
v. Note the current risks and mitigations in place

Report of Ian Joy
Executive Director of Nursing
19 November 2024

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Agenda Item A11(c)(ii)

TRUST BOARD

<table>
<tr><td>Date of meeting</td><td colspan="3">29 November 2024</td></tr>
<tr><td>Title</td><td colspan="3">Maternity Incentive Scheme (MIS) Year 6 (CNST)</td></tr>
<tr><td>Report of</td><td colspan="3">Ian Joy, Executive Director of Nursing</td></tr>
<tr><td>Prepared by</td><td colspan="3">Rhona Collis, Quality and Clinical Effectiveness Midwife/ Jenna Wall, Director of Midwifery</td></tr>
<tr><td rowspan="2">Status of Report</td><td>Public</td><td>Private</td><td>Internal</td></tr>
<tr><td>☒</td><td>☐</td><td>☐</td></tr>
<tr><td rowspan="2">Purpose of Report</td><td>For Decision</td><td>For Assurance</td><td>For Information</td></tr>
<tr><td>☒</td><td>☒</td><td>☐</td></tr>
<tr><td>Summary</td><td colspan="3">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.

This is the fourth report regarding the Year 6 scheme which was published on the 2 April 2024. Good progress is being made with Safety Actions 1, 2, 3, 4, 7, 9 and 10.

<u>Risk of non-compliance</u>

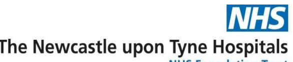
Safety Action 5 Midwifery Workforce
The three yearly Birth Rate+ midwifery workforce report was received by the service in June 2024, a full workforce review has been conducted by the Director of Midwifery. The Birth Rate+ report recommends a clinical midwifery staffing establishment of 257.47 whole-time equivalent (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 in January 2025.

Safety Action 6 Saving Babies Lives Care Bundle
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 resulted in positive progress, however, the current performance does not meet the minimum national standards.

Safety action 8
The Trust has strived to achieve full compliance with all staff groups for Year 6 and there has been considerable planning and organisation to ensure staff were rostered onto the specific training days. Despite this the Trust is unlikely to achieve full compliance with safety action 8 due to the vacancies within the Obstetric Consultant workforce. It has been an extremely challenging year for this group of staff and although this is disappointing the majority of staff have been trained appropriately throughout the MIS year.</td></tr>
<tr><td>Recommendation</td><td colspan="3">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>
</table>

<table>
<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 fourth report for Year 6 of this Maternity Incentive Scheme.</td></tr>
</table>



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

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

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

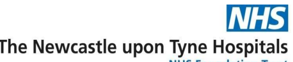
NHS Resolution is operating a sixth year of the CNST Maternity Incentive Scheme which continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths,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

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

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

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

In Year 5 the Trust declared full compliance with 8 of the safety actions. The Trust had been informed of the challenges with achieving full compliance with the two safety actions – 6 and 8, throughout the year and it was disappointing to be in this position despite robust planning to achieve all ten safety actions. 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.*

There have been 49 cases reported since the 8 December 2023 and all (100%) have been notified within 7 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.*

Parents perspective is an integral part of the review process – 100% have been given the opportunity to provide feedback and raise questions.

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.*

Compliance for these two elements is currently 96% for both. In two of the cases (47/49) although the review had been started within two months some of the essential questions had not been completed. Greater vigilance will be given in the last month of the Year 6 time frame.

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 report for Quarter 2 (Q2) 2024/25 is included in this report as per the requirements of this safety action and can be found in the Quality Committee Reading Room.

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 ensure the cases are completed within the stipulated time restraints of the guidance.

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 passed 11 out of 11 for the data submitted in July 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 99% compliance in July 2024.

The Trust has confirmation that it has successfully passed Safety Action 2.

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 was presented to the Safety Champions on the 9 October and the LMNS on the 15 October. A further update will be provided to the LMNS on the 16 January 2025.

The Trust should achieve full compliance with Safety action 3.

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

a) Obstetric medical workforce

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

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

or

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

or

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

Short term locums in Obstetrics and Gynaecology on Tier 2 or 3 have been appointed to cover periods of sickness and industrial action within the past year. All locums have been from within our current cohort, or in 1 case during October from the previous year's cohort (an ST6 on Tier 3). All hold eligibility through the Royal College of Obstetricians and Gynaecologists (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 two long term locums within Obstetrics within the past 6 months. There remain significant vacancies at Consultant level. A business case was agreed for 3 further

Consultants, in addition to the 2 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. The Trust has requested mutual aid from the region and a Consultant from another Trust is undertaking some clinical activity in the Fetal Medicine Unit one day per week.

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 (30%) requires a rota of 1 in 8.5 resident until 22.00hrs; all but one Consultant remains in residence for the 24hr period. 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.

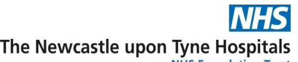
4). *Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service roles-responsibilities-consultant-report.pdf 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 due to the emergency of the situation.

A summary report was presented to the Maternity Board Level Safety Champions meeting on the 12 June 2024. A further report of Q1 incidents was presented to the Maternity Board Level Safety Champions on the 9th October 2024. The audit undertaken in Q1 is included in the papers within the Quality Committee Reading Room for November 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)

An audit of one month's rota (August 2024) was undertaken and findings discussed at the Obstetric Quality and Safety Group in October 2024. There were no concerns regarding the availability of a duty anaesthetist and the Trust is compliant with this requirement.

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 WTE shortfalls in the speciality training rota gaps. Trainee rota compliance can vary with every 6 months rotation.

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 continued to show a deficit of nursing staff. There has been progress with the action plan with ongoing monitoring of the outstanding issues. The updated action plan has been shared with the LMNS and ODN and can be found in the Quality Committee Reading Room. Work is ongoing to review the nursing establishment and ratios on Transitional Care, and will be provided in future papers.

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 has been 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 in January 2025.

*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 October 2023 to September 2024 there were 7 occasions whereby the co-ordinator was not supernumerary for part of the shift due to an escalation in activity for a short period of the shift, 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 October 2023 to September 2024 there were no occasions recorded whereby 1:1 care was not provided.

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 with further staffing updates provided monthly in the Perinatal Quality Surveillance Reports to Trust Board. The next biannual staffing paper will be submitted in January 2025.

2.6 <u>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?</u>

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 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. The second meeting is scheduled to take place on the 20 November 2024.

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

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:*

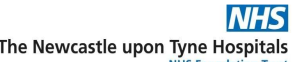
    a) *Engagement and listening to families*
    b) *Strategic influence and decision-making.*
    c) *Infrastructure.*

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

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 had been allocated with an achievable trajectory. The current position is (MIS period to date – 1 Dec 23 to 31 Oct 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	87%
Obstetric Consultants	67%
Obstetric trainees	60%

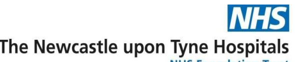
There are 3 more training days scheduled until the end of the relevant time period. The midwife compliance rate should be above 90% by the end of November 2024.

MIS amended the target for obstetric trainees if they had received the training at another local Trust. A compliance of <90% will be accepted if there is plan in place for them to complete the Training by February 2025. This should be achievable.

The Consultant attendance has improved from the last Board report and of the remaining 4, 2 of them have dates scheduled to attend before the 30 November 2024. However, due to the staffing challenges it is unlikely that the remaining 2 will be able to be released from clinical activity hence the >90% compliance will not be achieved in this group of staff.

Table 2. Multi-professional maternity emergencies training

Staff Group	Percentage trained
Midwives including Midwifery Managers, Matrons, Community Midwives, Midwifery Led Unit	87%



Midwives and Bank Midwives	
HCA/MSW/NN	84%
Theatre Staff	80%
Obstetric Consultants	75%
Anaesthetists	87%
Obstetric Trainees	83%
Anaesthetic trainees	67%

There are 4 training days scheduled until the end of the relevant time period. If all staff attend their allocated training day the compliance will be achieved with the exception of the Consultant Obstetricians.

Table 3. Neonatal Life Support training

Staff Group	Percentage trained
Neonatal Staff	98%
Midwives	87%

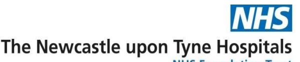
The Trust has strived to achieve full compliance with all staff groups for year 6 and there has been considerable planning and organisation to ensure staff were rostered onto the specific training days. Despite this the Trust is unlikely to achieve full compliance with safety action 8 due to the vacancies within the Obstetric Consultant workforce. It has been an extremely challenging year for this group of staff and although this is disappointing the majority of staff have been trained appropriately throughout the MIS year.

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, a review of the current meeting format, terms of reference and agenda has been completed ensure this fulfils the national guidance and was ratified at the meeting in October 2024.

The Trust has reviewed the Trust's claims scorecard alongside incident and complaint data. A brief over view was presented to the Maternity and Neonatal Safety Champions Group in June 2024 and a full report, based on the September 2024 Scorecard, is included with the papers.

New safety intelligence reporting has been developed and included within the Perinatal Quality Surveillance report section of the Integrated Board Report, in addition the service reports to Trust Board on a monthly basis.

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.

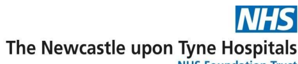
The Trust has reported 6 qualifying cases to MNSI and 2 cases to NHS Resolution since 8 December 2023. All of the above requirements have been met.

3. CONCLUSION

It is acknowledged that to achieve full compliance with all ten safety actions remains a challenge, and it is unlikely the Trust will achieve compliance with Safety Action 6 and 8. 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 Ian Joy
Executive Director of Nursing
19 November 2024

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Agenda Item A11(c)(i)

TRUST BOARD

Date of meeting	29 November 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 shared at the September Board meeting.					
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 Public Board meeting on 27 September 2024. This report was shared at the October Private Board meeting.					

MATERNITY SAFETY CHAMPION REPORT FOR SEPTEMBER – OCTOBER 2024

I have undertaken two departmental visits during the period covered by this report. I enjoyed a walk round in September with Jenna Wall, Director of Midwifery, who introduced me to various teams then left me to talk with them more privately.

I conducted an unaccompanied walkround in October. It is clear that the tone and atmosphere in the department is on an upward trajectory with staff being more open and confident in their feedback and commentary on what it is like to be working there. I was informed that the most senior staff (including Jenna) have been working overnight and on out of hours shifts - this has built their credibility and also their familiarity to staff, which is a key element of engagement and leading by example.

Senior staff are being given more responsibility for shaping their own destiny and some are finding this unnerving. They are juggling the challenges of change with workload and expectations of rising standards, and there is some concern about the impact of the transition, although everyone seems to recognise that the journey is towards the right new destination. However, staff are generally happy with the changes that are evident in the department, and with the new leadership and standards. Visibility of senior staff is somewhat compromised by the volume of work going on in Committees and meetings to get the new governance arrangements up and running and to ensure optimal clinical practice. However, it is understood that this groundwork will lead to everyone doing a better job and improving patient outcomes / experience / safety.

The consistent issue that is raised now is the estate - cramped areas, insufficient space for an adequate number of beds to give patients a good experience in terms of privacy and space for family members to visit and support, the layout and style of accommodation is old fashioned and, in some spaces, no longer fit for purpose. Some corridors have trollies in them, although these are carefully managed to ensure that they are not in places where there is visitor footfall. The staff room is inadequately equipped in terms of furniture and fridge capacity to serve a high number of staff. Work stations are lacklustre (ward 34 as an example). Some areas are simply too cold for patients and new or sick babies, including ward 41 where the sonographers work. There is also awareness that some theatres on Level 5 (general, gynae, plastics) have been refurbished and this casts a darker shadow on the areas that have not yet been refurbished.

The department is very aware of the need for patients to have privacy and dignity but this is challenging in the current accommodation, combined with the demands on the service, and the Board should be aware of this limitation. Estates issues to be addressed also include non-clinical areas. There is an understanding that the Big Build project presents a long term strategic solution for the Trust, but there is a feeling that things could be done now that would have a material impact / improvement in situation and patient and staff experience.

The Intensive Care Unit and neonatal areas are particularly tight for space and are not fit for purpose. Babies do not have their own space, facilities are insufficient and there is only one space for end of life care which is inappropriate for a department of this size, serving the

complex needs that so many babies have here (refer again to the need for privacy and dignity). The antenatal clinic feels a long way away from the other areas of the department.

Workload issues continue to be a specific challenge in this area. A Non-Executive Director (NED) spotlight walkround in the department took place in October and picked up on many of these issues. Some have been considered subsequently by the Quality Committee, although the Director and her team are well aware of all the issues and are working on an Estates plan for the short and longer terms. One such issue was around infection control which is a critical area for patient outcomes; again, the risks that come from an inadequate estate are there, and well known, but at this point the risks are being managed and there are no patient infections present at this time.

I spoke with student midwives on placement in the department. They are challenged by parking availability and costs (£23 per day for one student I spoke with) with no option for them to have student parking passes. This compromises student experience and has the potential to give a poor perception of working at the Royal Victoria Infirmary (RVI) in the longer term. The closure of the Campus for Ageing and Vitality (CAV) carpark has now caused issues with parking for permanent staff too, having to contend with charges of up to £16 per day.

There continues to be a number of patients with care plans presenting to the department as in-patients, who have complex needs in relation to addiction, home life, support systems and mental health and well-being. Concern was expressed about the apparent gap between hospital and community care services, and how it is possible for safeguarding to be assured when such gaps exist. There is concern about support for managing and caring for these complex patients out of hours and at weekends. The number of homeless mothers is rising, with refuges unable to support due to their difficult lifestyles. The impact of poverty on complex cases takes its toll too on the staff who are responsible for care giving, and their mental and physical health is often tested. Some staff worry about bumping into patients and their partners outside of the hospital in case of negative reactions.

The issue of no consultant dedicated to the increasingly busy Maternity Assessment Unit (MAU) continues, and has a negative effect on an otherwise very positive element of the department. Only one Matron in three is currently at work (sickness absence), although one midwife has been promoted to Matron specifically to oversee the Birthing Centre. This also impacts on the workload of colleagues.

There is an ambition for the Birthing Centre to open for December 2024 which will bring choice to patients.

The return of the Consultant Midwife for maternal medicine has been welcomed with lots of referrals coming in and lots of coordination of care required. Her networks – which will be enabled by the Alliance – will be critical to this work.

Another staffing issue was raised by a sonographer about the lack of staff to act as chaperones during examinations, or to act as assistants inputting data (because the scanning equipment does not link directly to the BadgerNet system). This potentially places both

patients and staff at risk, and should therefore be addressed. However, the locum Obstetrician is also a great addition to the department and shows that when consultant resource is provided, the service improves for both patients and staff alike.

On 20 September I attended the Quality and Safety Group as an observer. Much of the detail was clinical discussion and thus my observations are superficial. It is clear that there is robust discussion about policy and practice, what works and what does not. There was robust challenge for activity that does not deliver expected outcomes and an appetite to call such issues out and improve both policies and systems. My perception was that while there was much discussion and analysis of clinical issues, this was a meeting that was action focussed and determined to make things work better, including having better data quality and systems to ensure that outcomes and impact can be monitored and clinical practice kept under consistent review. Items under discussion included continuity of care pathways; progress against action plans; benchmark misses for breast feeding as first feed choice; Care Quality Commission (CQC) action plan update; lack of a lead bereavement consultant; audits and findings; Key Performance Indicators (KPIs) and standards review; near misses; need for accurate data input to BSOTS; use of data analytics; guidelines, best practice and escalation of risks.

I have also met privately with the Director and I continue to be impressed by her ambition, her comprehensive knowledge of what is needed and how to get there, and her capacity for prolonged hard work. She is proving to be a strong and popular leader, building up credibility at all levels, being open and accessible to her staff and leading by example. Although she was disappointed by the cultural staff survey feedback she is using this positively as a baseline from which to focus on the positive changes that have come into place since the survey was taken. Much of her time, and that of the Assistant Director of Operations, is working with Estates to get to a place where the accommodation problems are managed down to ensure a safe environment for patients. She is now about to develop the SAR (Self-Assessment Report) and will be looking at reporting data, reviewing embedded processes and using the new governance structures to help with ‘what’s next’.

My reflections

The Maternity Department continues to deliver life changing work under difficult circumstances. The priority area has moved from staffing (which remains a high priority and a risk in terms of resourcing) to the estate which is presenting an increasing number of challenges to the work environment and thus to patient safety. The cultural and leadership transformation is well underway and whilst the transition period can be unnerving for some of the players, there is uniform agreement that the vision and direction of travel is the right one. The Board should be aware of the risks presented by the inadequate estate and should be minded to listen to and support business cases for short term improvements whilst the Big Build project is in the planning stages.

Liz Bromley, Maternity Safety Champion
October 2024

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Agenda item A11(d)(i)

TRUST BOARD

<table>
<tr><td>Date of meeting</td><td colspan="7">29 November 2024</td></tr>
<tr><td>Title</td><td colspan="7">Health and Safety Annual Report 2023-24</td></tr>
<tr><td>Report of</td><td colspan="7">Angela O'Brien, Director of Quality and Effectiveness</td></tr>
<tr><td>Prepared by</td><td colspan="7">Craig Newby, Health, Safety and Risk Lead</td></tr>
<tr><td rowspan="2">Status of Report</td><td colspan="3">Public</td><td colspan="2">Private</td><td colspan="2">Internal</td></tr>
<tr><td colspan="3">☒</td><td colspan="2">☐</td><td colspan="2">☐</td></tr>
<tr><td rowspan="2">Purpose of Report</td><td colspan="3">For Decision</td><td colspan="2">For Assurance</td><td colspan="2">For Information</td></tr>
<tr><td colspan="3">☐</td><td colspan="2">☒</td><td colspan="2">☐</td></tr>
<tr><td>Summary</td><td colspan="7">The purpose of this report is to provide the Trust Board with an update on health and safety activity across the organisation during 2023-24.
• The report highlights effective assurance around the compliance with health and safety legislation. Moving and Handling compliance has dipped slightly following staffing and capacity issues within the Moving and Handling Team; however, this has subsequently improved.
• Health and safety incidents remain relatively stable and within the upper and lower control levels; however, there have been slight increases in violence and aggression compared to previous years. Violence and aggression incident profile shows increases in non-physical aggression and a decrease in physical assaults.
• Lone worker device use has increased across the organisation in comparison to previous years following further awareness raising and training.
• Further slight decrease in RIDDOR reportable incidents in 23-24. The number of RIDDOR reportable incidents for the period falls between the upper and lower control levels.</td></tr>
<tr><td>Recommendation</td><td colspan="7">The Trust Board are asked to note the content of the report and its findings.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="7">• Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality.
• Maintain compliance with all regulatory requirements.</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>Reputation</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☒</td><td>☐</td><td>☐</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Impact detail</td><td colspan="7">• Potential for harm to patients, staff and/or the public
• Enforcement action from regulatory bodies.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="7">This report is an annual health and safety update and has been presented to both the Health and Safety Committee and the Compliance and Assurance Group.</td></tr>
</table>

HEALTH AND SAFETY ANNUAL REPORT 2023/2024

1. INTRODUCTION

The Health & Safety annual report covers the period 1 April 2023 to 31 March 2024. The annual report outlines key developments and the work that has been undertaken during this reporting period as well as a review of all health and safety related incidents. It reflects the Trust's compliance with the Board of Directors approved 'Statement of Intent' and Health & Safety Policy Statement, which requires those responsible for health and safety within the organisation and during Trust activities to:

- Comply with health and safety legislation.
- Implement health and safety arrangements.
- Comply with monitoring and reporting mechanisms appropriate to internal and external key stakeholders and statutory bodies.
- Develop partnership working and to ensure health and safety arrangements are maintained for all.

In progressing the management strategy of health and safety throughout the Trust, the Compliance and Assurance Team continues to observe the HSG65 model "Managing for Health and Safety". The key components of the Plan, Do, Check, Act (PDCA) framework can be summarised, as follows:

Plan Determine policy, plan for implementation.
Do Profile health and safety risks, organise for health and safety management, and implement the plan.
Check Measure performance, investigate accidents and incidents.
Act Review performance, apply learning. This framework directly maps with the SASH+ methodology, Plan, Do, Study, Act

2. MEETINGS & ATTENDANCE

The Health and Safety Committee has met four times during the period 1 April 2023 to 31 March 2024 and achieved an attendance rate of 86%.

Members	10/05/23	21/09/23	22/11/23	07/03/24
Chairman: Head of Risk, Compliance and Assurance		X	X	X
Vice Chairman: Deputy Director of Quality & Safety	X	X		
Director of Quality and Effectiveness				X
Health Safety and Risk Lead	X	X	X	X
Associate Director of Nursing	X		X	X
Health and Safety Advisors	X	X	X	X
Health and Safety Administrator	X	X	X	X
Integrated Governance Manager	X	X	X	X
Occupational Health Clinical Lead	X	X	X	X
Estates Compliance and Risk Manager	X	X	X	X

Portering and Security Manager	X	X	X	X
Senior Human Resources Manager	X		X	X
Workforce Development Manager	X	X	X	X
Directorate Manager	X	X	X	X
Lead Moving and Handling Coordinator	X	X	X	X
Integrated Laboratory representative	X	X	X	X
Newcastle University Safety Advisor			X	X
Staff Side Representatives	X	X	X	X

3. TERMS OF REFERENCE

The Terms of Reference for the Health and Safety Committee were reviewed and approved by the Committee on 10th May 2023.

4. POLICIES & PROCEDURES

The policies below were ratified by the Health and Safety Committee during the period 1st April 2023 to 31st March 2024.

Policy/Procedure	Date Approved
Noise at Work Policy	10/05/2023
Security Policy	10/05/2023
Wheelchairs: Use Provision and Management of Trust Wheelchairs Policy	10/05/2023
Control of Substances Hazardous to Health Policy	21/09/2023
Lone Worker Policy	21/09/2023
Hand Arm Vibration Policy	07/03/2024

Quarterly and annual reports received at the Health and Safety Committee during 1st April 2023 to 31st March 2024.

Quarterly Reports	Annual Reports / Strategies
Training Health and Safety Compliance Inspection Programme Health and Safety Incidents Sharps Incidents Security Moving and Handling Health and Safety Risks Occupational Health	Radiation Protection Security Stress Management Health and Safety Moving and Handling Safer Sharps Dental Health and Safety Violence Prevention and Reduction Strategy First Aid Young Workers

Minutes for the following committees and groups were reviewed quarterly in 1st April 2023 to 31st March 2024.

Related Committee Minutes
Trust Security Group Stress in the Workplace Review Group Radiation Protection Committee Dental Health & Safety Committee Laboratory Health and Safety Committee Violence Reduction Group Safer Sharps Review Group Datix User Group Latex Safety Group

5. TRAINING

The Health and Safety Team has successfully delivered 36 training courses during 1st April 2023 to 31st March 2024.

Courses	Number of Sessions
Risk Assessor	12
COSHH Assessor	12
Stress Training for Managers	12
Mental Health First Aid Courses	0

In addition to these courses, 328 staff also completed the Datix e-learning training and over 100 staff received ad-hoc lone worker device training comprising of both e-learning and face to face sessions.

6. LEGAL COMPLIANCE

The table below outlines the main Health & Safety legislation and identifies the proactive work that the Trust has carried out in order to comply:

Legislation		Description of actions/compliance
Health & Safety at Work Act 1974		Compliant, specific areas of assurance include: • Competent persons in place to help discharge legal duties. • Health and Safety (H&S) Committee held 4 times a year – which are well attended. During 23-24 the Committee met four times, in line with expectations.
Management of Health & Safety at Work Regulations 1999		Compliant, specific areas of assurance include: • H&S Inspection programme, all clinical areas audited on a 2-year cycle, requires audit actions to be addressed at service level within given timescales to ensure full compliance. Where possible these actions are completed during the inspection process. • Risk assessment training is provided to all areas and risk assessment paperwork has recently been reviewed. Requirement for role

Legislation		Description of actions/compliance
		specific risk assessments, production, and quality of these is monitored via the audit / inspection programme. • The most recent Health and Safety Compliance audit showed the number of departments that have a trained risk assessor was 93%.
Control of Substances Hazardous to Health (COSHH) 2005		Compliant, specific areas of assurance include: • COSHH policy has been revised with enhanced guidance on the risk assessment process e.g. Dangerous Substances and Explosive Atmospheres Regulations (DSEAR). • COSHH Risk assessment form simplified in order to improve compliance with Regulation 6. • COSHH awareness included in all H&S Awareness training, Induction Training. • Specific half-day COSHH training provided monthly. • COSHH compliance reviewed in Ward areas as part of health and safety audit / inspection programme. • Post CQC work undertaken to ensure COSHH products, in clinical areas, are stored in line with policy. • The most recent Health and Safety Compliance audit showed the number of departments that have a trained COSHH risk assessor at 96%.
Display Screen Equipment Regulations 1992 Moving and Handling Operations Regulations 1992		Compliance and specific areas of assurance include: • This policy aims to ensure that effective arrangements are in place for working with display screen equipment and to meet the requirements of the Display Screen Equipment (DSE) Regulations 1992 (amended 2003). To safeguard staff safety and comfort whilst working with DSE. • Moving and Handling (M&H) Level 1 Training Figures - The required standard is 95% compliance with the overall compliance for the year being 90%. • Moving and Handling Level 2 Training Figures - The required standard is 95% compliance with the overall compliance for the year being 80%. • Current Compliance Audit M&H compliance score is 95%. • Office Chair Assessment Service - There have been a total of 235 referrals in 2023/2024 compared with 282 referrals in 2022/23 • Overall, 28% of all departmental assessments were completed.
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)		Minor non-compliance with reporting timeframes • 87% of the reported incidents meet the over 7 day absence criteria. • Learning from all RIDDOR incidents is shared at the Trust Health & Safety Committee and other respective assurance meetings. • Ongoing work undertaken to remind managers of reporting timeframes.
Health and Safety (Sharp Instruments		Compliance and specific areas of assurance include:

Legislation		Description of actions/compliance
in Healthcare) Regulations 2013		• The Trust continues to monitor ordering practices to ensure compliance with the Regulations and use of safe sharps devices wherever reasonably practicable. Work continues to "mask" non-safe sharps devices from the NHS Supply Chain Catalogue to reduce ordering practices where not supported by underlying risk assessment. • Where safe sharps are not reasonably practicable, we continue to ensure and have taken steps to enhance robust risk assessment and mitigation measures are in place. The modified Medical Sharps risk assessment tool has been embedded across the organisation as risks are migrated over from the previous template. All new risk assessments are completed using this template. • Sharps disposal remains a priority and the Safer Sharps Review Group continues to advocate the use of point of care disposal and use of SharpSmart sharps boxes. SharpSmart on wheels is now embedded in the Trust and our entire fleet of SharpSmarts continues to be updated systematically across all areas of the Trust. • Safer Sharps Review Group meet Bi-monthly with representation from a variety of Trust departments including Clinical Education, Procurement, Supplies, Sustainability & Waste and Patient Safety. • The Trust is currently on the 8th edition of the Safer Sharps Inventory. • The Datix system is integrated with a live dashboard to allow in-depth analysis of sharps related incidents to identify incident reduction initiatives across the organisation. • A new Safer Sharps e-learning package has been developed with the intention to roll this out mid 2024-25.
Health & Safety Information for Employees Regulations (Amendment) 2009 Health & Safety Consultation with Employees Regulations 1996 Safety Representatives and Safety Committees Regulations 1977		Compliance and specific areas of assurance include: • The H&S intranet page has been revised with a proposed move to a new intranet provision in 2024-25. • Trade Union (TU) H&S Representatives are in place. • Health and Safety Committee held four times a year is well attended by Managers, Trust Competent Persons, TU Representatives and H&S Coordinators: • Reports on Audits, Action Plan progress, Key Performance Indicators (KPIs) and Risk Register. • Health and Safety Committee acts as consultative committee for H&S policies, audit reports, action plan progress, and health and safety related risk register entries. • Staffside representatives also attend key sub groups to the Health and Safety Committee such as the Stress at Work Review Group.
Lifting Operations and Lifting Equipment		Compliance and specific areas of assurance include: • Trust Lifting Operation and Lifting Equipment (LOLER) Policy introduced in November 2021.

Legislation		Description of actions/compliance
Regulations (LOLER) 1998		• Moving and Handling Team have a system related to gantry hoists that are assembled in a cubicle of a bariatric patient. • Electronics and Medical Engineering (EME) currently ensure all LOLER equipment meets the requirements of the regulations and are currently looking to introduce a new system, which would make them the first point of contact as opposed to the service company. • Estates have a comprehensive maintenance programme for all lifts ensuring this meets all LOLER requirements. • Passenger lifts falling under LOLER legislation are managed via the Estates Directorate including maintenance and records. Quarterly and annual Lift Safety Reports are presented to the Trust Electrical Safety Group.
Provision and Use of Work Equipment Regulations (PUWER) 1998		Compliance and specific areas of assurance include: • Trust Provision and Use of Work Equipment (PUWER) Policy introduced in November 2021. • The Health and Safety Compliance audit includes a section for Estates around PUWER. The directorate scored 93% against the standards. Actions are in place to increase this to 100%. • Workshops have a general workshop risk assessment in place and a template task/equipment risk assessment has been issued for comment and feedback with a view to implementation for all fixed work equipment, this will address specific PUWER requirements for each individual item. Workshop equipment issues continue to be discussed at both site and Estates wide H&S groups with training delivered to all joinery staff on their woodworking equipment. Estates are looking to source a suitable maintenance/training provider for mechanical workshop equipment due to the retirement of the previous service provider. Work continues, to improve identified housekeeping issues within Estates workshops.

7. HEALTH & SAFETY COMPLIANCE

Health & Safety Compliance audit results are reported quarterly to the Trust Health and Safety Committee for each Directorate. This compliance tool is an indicator of risk assessment completion across 16 common areas of health and safety which also include radiation and fire safety. The most recent report for Quarter 3 2023-2024 indicates that compliance across the Trust for the 16 general areas of health and safety is at 93% overall. There is ongoing work to further improve the quality of risk controls and close gaps in associated arrangements at service level.

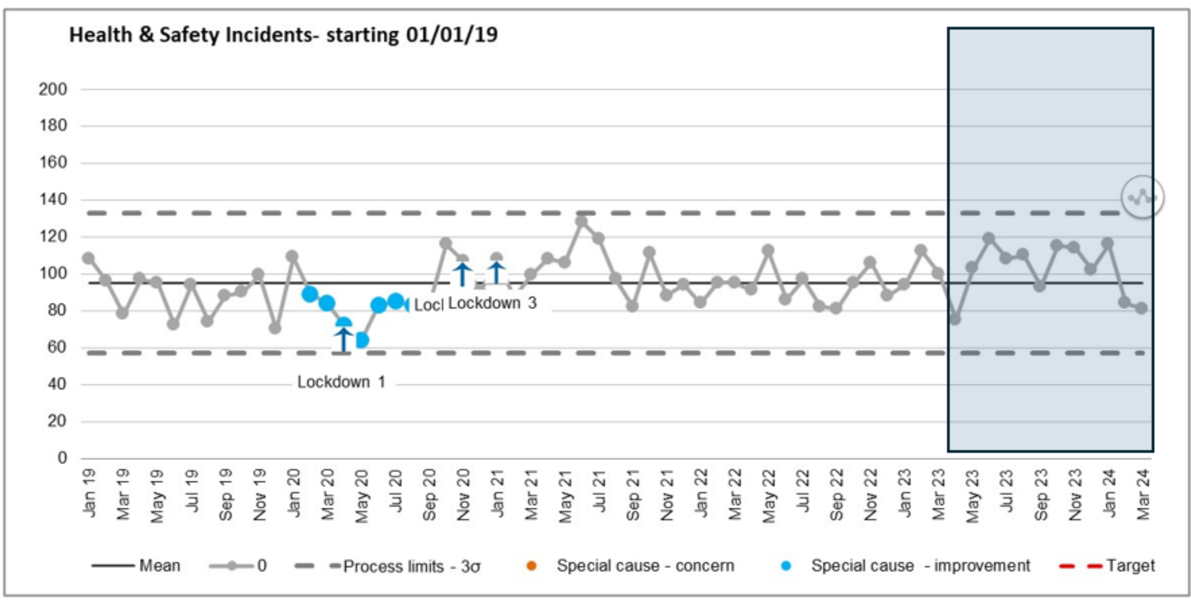
All Departments are subject to a health and safety Inspection as part of a 24-month cycle to support local risk assessors and validate information collected under the compliance audit tool. Departments are provided with an action plan following each inspection. There have been 208 Health and Safety inspections undertaken during this period. The inspections

have been undertaken across all Clinical Boards as part of the current programme. Along with other measures, it is envisaged that the compliance and inspection arrangements will support an overall reduction in harm over the coming years. The inspection programme plays an important role in validating compliance, the development of safe systems of work, leading to improved risk controls whilst supporting services.

The Compliance and Assurance department continue to work closely with the Estates department supporting the review of governance, monitoring and assurance measures around the Estates related functions of the Trust. Health and safety representation on key committees and groups continues to be provided.

8. HEALTH AND SAFETY INCIDENTS

The number and type of staff related incidents for each Directorate during the period of 1st April 2023 to 31st March 2024 is shown in table below. There is an overall 6% increase in reported health and safety incidents for 2023 – 2024 compared to the previous year, showing no statistical cause for concern.



The above Statistical Process Chart (SPC) shows health and safety incidents to continue to track close to the mean more recently and there are no 'special cause' concern data trends over the previous 12 months.

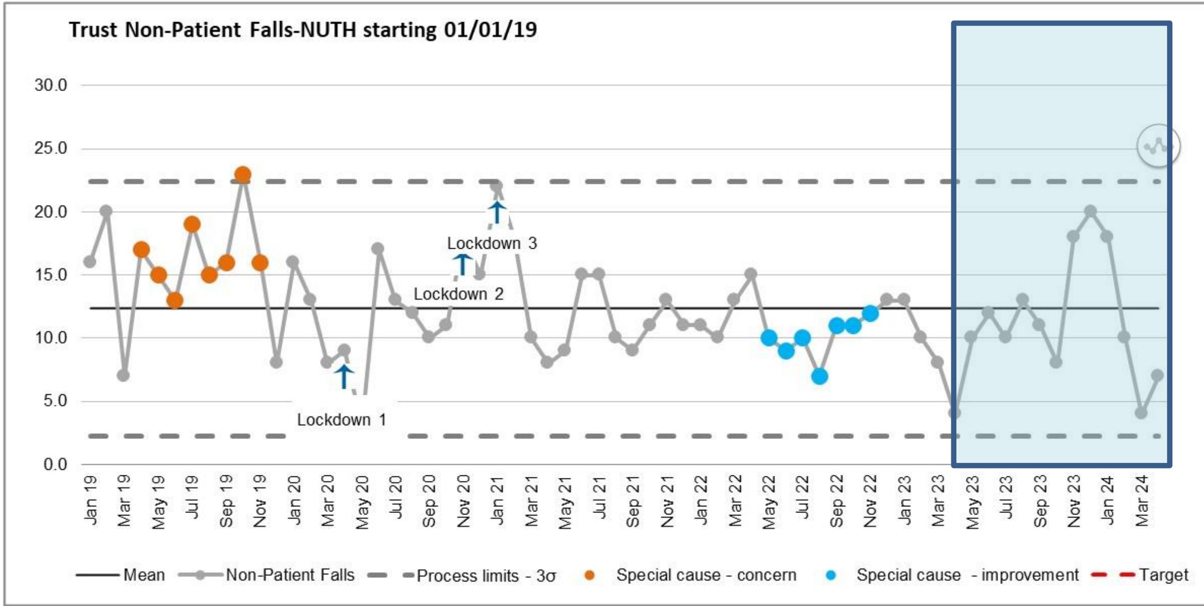
Health and Safety Incidents by Category 23-24

	Accident (involving staff, visitors etc.)	Buildings, Infrastructure or Environment	Exposure to Hazardous Substance	Facilities	Moving & Handling	Non-Patient Slip, Trip or Fall	Total
Estates & Facilities	101	153	14	1	17	39	325
Human Resources	2	2	0	0	0	1	5
IT	3	1	0	0	0	0	4
Medical Director	1	2	0	0	0	2	5
Patient Services	1	0	0	0	0	4	5
Supplies	4	0	1	0	0	0	5
Family Health	93	17	18	0	11	10	149
Surgery and Specialist Services	68	1	8	0	6	14	97
Peri-Operative & Critical Care	95	2	20	0	11	13	141
Cardiothoracic	37	1	18	0	2	11	69
Medicine and Emergency Care	90	7	13	0	16	18	144
Surgical & Associated Specialties	43	2	12	0	2	10	69
Cancer and Haematology	17	18	4	0	0	1	40
Clinical and Research Services	83	16	39	0	9	15	162
Total	638	222	147	1	74	138	1220

Incidents logged against Estates include incidents that occurred in general areas and do not reflect the number of incidents related to Estates staff. The number of incidents categorised under 'Accident (involving staff, visitors etc.)' includes needlestick injuries, which make up a majority of incidents within this category. These incidents are picked up in more detail in section 11 below.

9. SLIPS, TRIPS AND FALLS

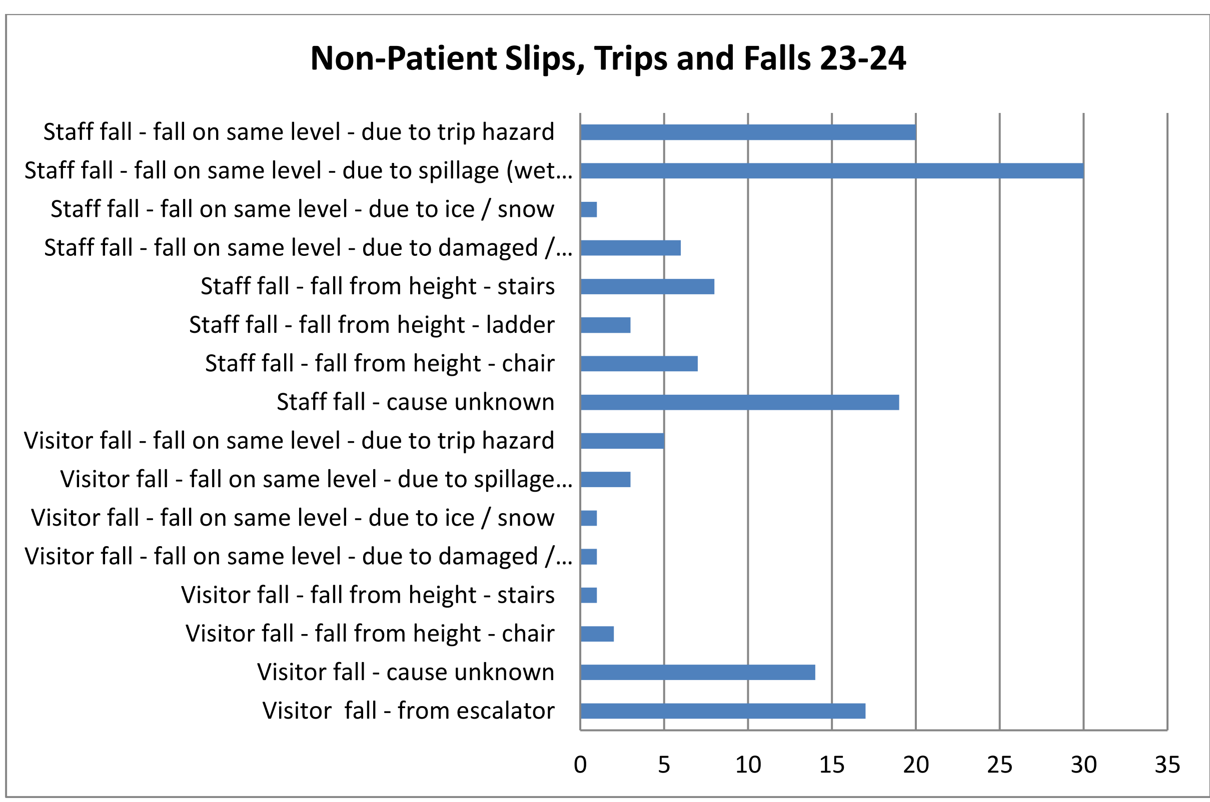
A comparison of key slip, trip and fall types for staff and visitors for the period 2019 – 2024 is shown in the SPC chart below.



Non-patient slips, trips and falls have reduced this year from 129 in 2022-23 to 138 in 2023-24. This shows a slightly increasing trend but still within the upper and lower control limits, shown above. The increase during winter identified several incidents in relation to inclement weather; however, there were no significant themes and incidents were investigated and dealt with appropriately. During quarter 4 of the same period incident numbers fell significantly to below average levels.

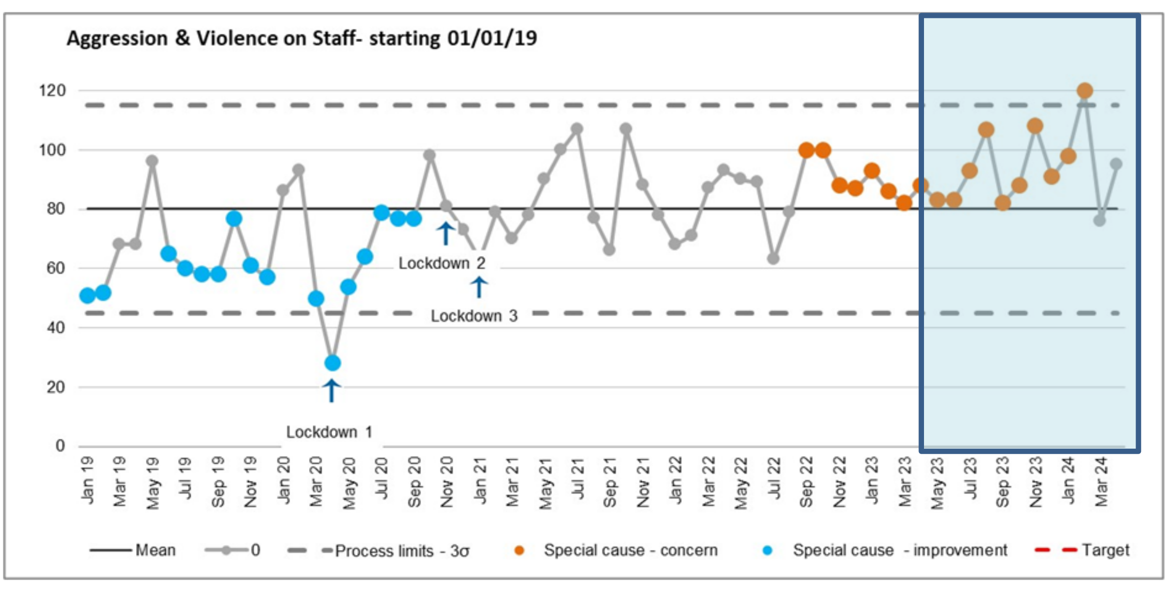
During the period a decision was made to stand down the Slips, Trips and Falls Group with an agreement that regular monitoring would take place and the group be re-established should incidents rates increase significantly, or common themes were found to be contributing to falls. External zonal inspections continue to take place across main hospital sites, helping to identify and rectify any contributory factors and the non-patient slips trips and falls dashboard continues to provide valuable information for incident trends and analysis. All RIDDOR reportable falls have been investigated fully and where necessary lessons have been shared.

The chart below shows all non-patient slips, trips and falls by sub category during period 23-24:



10. VIOLENCE AND AGGRESSION

Violence and aggression rates have continued to fluctuate over the period; however, incidents have increased overall by 8% this year in comparison to 22-23. The data shows a 16% decrease in physical assaults on staff but a 25% increase in non-physical aggression towards staff.



	17-18	18-19	19-20	20-21	21-22	22-23	23-24
Non-Physical	482	584	588	602	637	579	725
Racial	8	11	11	15	17	22	30
Sexual	8	9	13	11	17	23	28
Physical	247	259	273	257	305	387	331
Total	745	863	885	885	976	1011	1113

Further analysis of data shows the Emergency Department and Security team reported almost 1 in 3 of all violence and aggression related incidents during period 1st April 2023 – 31st March 2024. The chart below showing the top 10 reporting areas during the same period. There's a strong correlation around the increased number of Psychiatric Liaison referrals and violence and aggression within the Emergency Department (ED). This factored alongside challenging wait times generally, including delays for psychiatric assessment, a challenging environment, and delays in finding beds (both acute and mental health), creates a unique dynamic reflected in the incident data. Some of these issues fall outside the organisations control and regular dialogue with other agencies such as Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW), Northumbria Police and social services are essential. Security plays a pivotal role in supporting the management of violence and aggression in clinical areas; particularly ED, which is supported in the figures below.

The Violent Marker Panel has approved the marking of 169 patient records during 2023/2024; this represents a decrease from the previous year, which is in line with the 16% decrease in physical assaults on staff. The conflict resolution training programme is a requirement for all staff with a regular patient facing role. This programme equips staff to recognise the ways that violence escalates, helps identify the behavioural and physical signs in people and provides a range of de-escalation techniques. At end of the period the training compliance for Conflict Resolution was 98% across the organisation.

A review of physical intervention (restraint) training provision for security staff was undertaken in 2018 and a more sustainable training model implemented General Services Administration (GSA). Since COVID-19, training compliance has increased steadily reaching 77% during the period. Further work is currently underway to establish the best possible method to deliver this training.

One of the key objectives of the Compliance and Assurance team is the reduction of violence / aggression and restrictive interventions. Several workstreams are currently ongoing, for example:

- The Trust Violence Reduction Group continues to meet every quarter.
- Compliance with the NHS England national standards for Violence Reduction has continued to improve over the period.
- **Risk Assessments** – All wards and departments have violence and aggression risk assessments. In addition to this the wards / departments with the highest levels of violence and aggression have been assessed using an enhanced risk assessment tool.

Risk assessment compliance is monitored via the quarterly health and safety compliance audit and the health and safety inspection programme.

- **Violence Reduction Programme** – Following a successful Institute for Healthcare Improvement (IHI) project on Ward 43, the Health and Safety Department have been rolling out the Violence Reduction Programme, which now includes Wards 47 Royal Victoria Infirmary (RVI), 20 RVI, 23 RVI and more recently Renal Services Freeman Hospital (FH). These areas were identified following difficult admissions and negative impacts on staff.
- The programme seeks the views of staff, at all ward levels, around the management of challenging behaviour and how that impacts on their wellbeing. The results of the initial survey are shared before deciding with the teams what initiatives can be adopted to help prevent and manage violence and aggression. For example, Ward 47 highlighted gaps in awareness around mental health, learning disability, personality disorders and addictions. Psychiatric Liaison then provided eight bitesize training sessions over a month, which were well attended and well evaluated.
- This programme will be rolled out to other areas this year. Planning has started to consider how this programme encapsulates some of the unique issues found within the Emergency Department and Security Team.
- **Lone Working** – Over 900 lone worker devices are in operation across the organisation, primarily with staff who work alone in a community setting. The devices provide staff with an easy and discrete method of raising the alarm and getting a rapid response from emergency services if required. Work continues to raise awareness with staff and ensure the devices are used to their maximum capacity.
- **Poster Campaign** – Preliminary discussions have started around developing posters using the strap-line 'No Excuse for Abuse'. Since the demise of NHS Protect the Trust haven't had any poster campaigns around reducing violence and aggression.
- **Patient Record Flagging System** – A task and finish group has been set up to improve the alert flags on all electronic patient systems, which includes flags around violence risks. This remains a concern as flags are regularly missed; particularly where systems are loaded with both clinical and non-clinical flags.
- **ED Navigators** – ED Navigators have recently been introduced to ED. Our Navigator roles are based around reducing violent crime and engaging with patients who may be the perpetrators or victims of violent crime. Their aim, using tools such as social prescribing, is to support patients to lead lives away from violent crime.
- **Cosmic Officer** – The role of the Northumbria Police Cosmic Officer in ED has recently been extended. The Trust funds this role to act as both a deterrent and to help manage challenging behaviour in ED during busy times of the week.

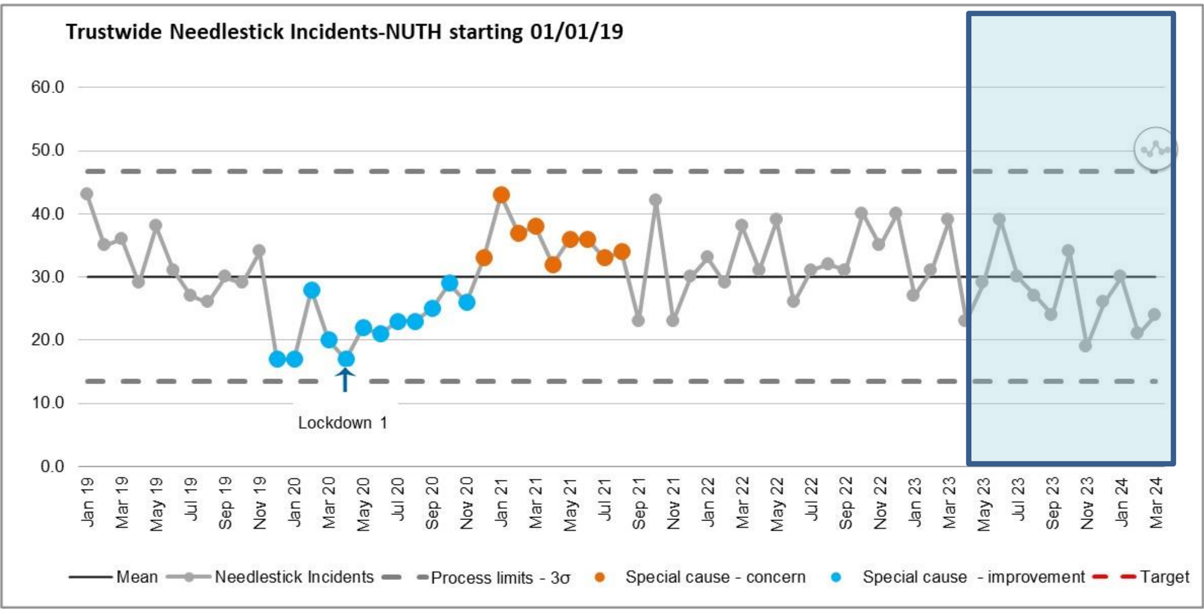
11. SHARPS INCIDENTS

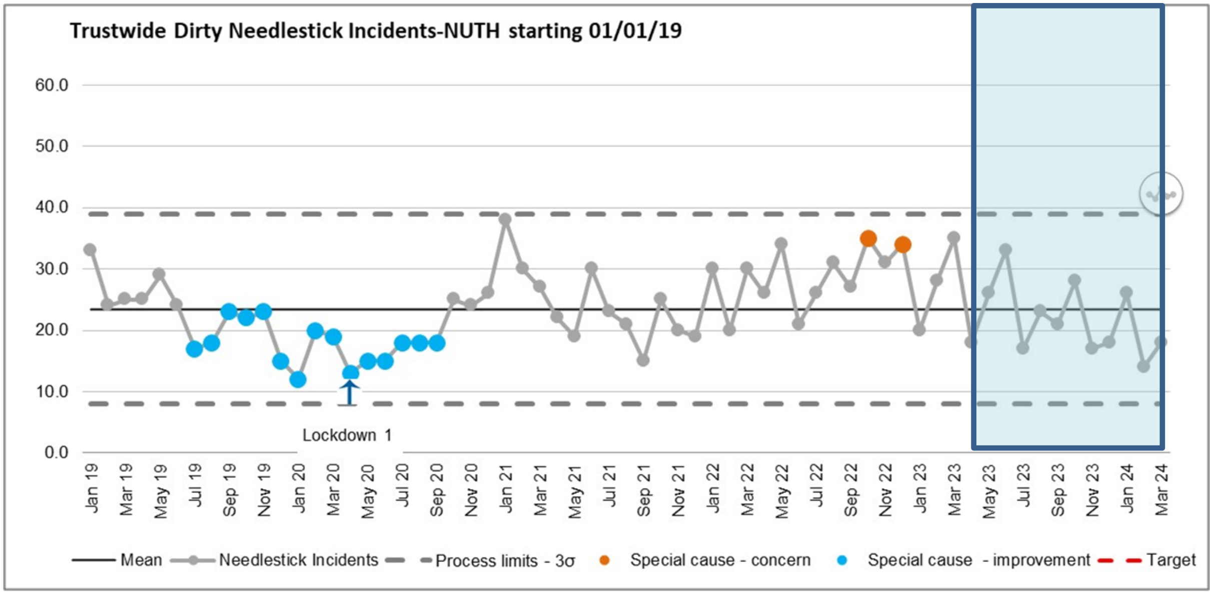
The Safer Sharps Review Group (SSRG) met five times during 2023-24. During this time period the group has refreshed its membership and Terms of Reference (Jan 2024) and has an extensive work plan for 2023-24. Work to date has focused on reviewing current assurance regarding the use of safer sharps devices in all appropriate clinical areas and

ensuring risk assessments for use of non-safety devices (where reasonably practicable) are up to date and reflect robust safety practice. There continues to be a significant amount of work to improve the collection, analysis and evaluation of sharps data, including the development of a sharp's dashboard, with the aim of providing clinical boards and the SSRG with thematic data, in order to be able to target interventions to reduce sharps injuries in the Trust. A further focus for the group is standardising and improving sharps education across the Trust, initially via an eLearning package and corporate induction.

A programme of work is planned to commence in May 2024, led by the Trust Medical Devices Co-ordinator and Senior Procurement Specialist, to review and update version eight of the Trust Safer Sharps inventory. The waste management team continue to contribute to the SSRG as a core member, recently trialling and implementing several different initiatives to reduce sharps related clinical waste in addition to reducing injuries related to disposal of sharps.

There were 327 sharps incidents during the period, of these 259 (25% decrease on previous year) relate to dirty sharps with the remainder being clean or non-medical sharps incidents. None of these incidents were reported to the Health and Safety Executive (HSE) under RIDDOR requirements. The Trust is currently on the 8th edition of the Safer Sharps Inventory.





Further analysis of this data will be provided separately to the Health and Safety Committee and the Sharps Annual Report will be presented at the August 2024 meeting.

12. STRESS MANAGEMENT

The Stress in the Workplace Review Group (SWRG) met twice during 2023-24. Membership includes H&S, Occupational Health Service (OHS), Human Resources (HR), Staff Development, Health Improvement, Chaplaincy and Staff Side. The terms of reference will be reviewed in the early part of 2024-25 to reflect the current membership and challenges around quoracy. The Group reports to the Trust Health and Safety Committee. Its role is to ensure that the requirements of the stress policy are met and progress the development of arrangements to prevent and manage stress. (The terms of reference for the group have been updated and amended, and all changes accepted by the group). The Stress Prevention Intranet site has been updated to include the up-to-date list of Mental Health first aid staff members and latest information. The stress risk assessment process remains the main mechanism to manage work related stress including areas of stress related sickness absence. The HR Department promote the process of supporting Clinical Boards in the completion of both service level and individual risk assessments. The Trust Stress risk assessment process is included in the manager induction programme. There has also been an ongoing series of monthly training sessions held across the Trust to instruct all mangers in the risk assessment process, run by the H&S team. The group continues to take account of the findings of the annual staff survey and incorporate any actions into the SWRG action plan. The SWRG action plan is a rolling plan designed to achieve set actions within an annual time frame. The plan is monitored and amended as actions are completed at the group meetings.)

Mental Health First Aid (MHFA) training was introduced across the organisation in 2016. The MHFA course teaches attendees to recognise the early signs of a mental health problem and the knowledge to provide help and support to staff across the organisation.

A review of support for staff is currently underway (June 2024), which includes the ongoing provision and sustainable funding of the MHFA programme.

13. LONE WORKING

The Trust acknowledges the number of staff working in higher risk environments such as community-based nursing teams. During 20-21 the LWS lone worker system was rolled out across the organisation originally covering 800 lone workers and replacing the Look Out Call system. During 23-24 further devices have been added to the system with around 950 devices now active across the Trust. During the year, further work has been undertaken to increase usage rates and ensure staff use the devices correctly.

Staff usage rates are based on staff leaving yellow alerts at each location they visit, leaving vital location information. During the period staff have activated 35,321 yellow alerts, almost 100% higher than the previous year. Further work is due to take place this year to enhance this further and continually work with staff teams to raise awareness around the importance of the lone worker system and the safety benefits it provides staff.

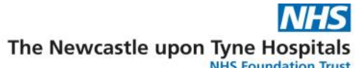
There have been no genuine red alerts during the period.

The results of this year's Lone Worker Survey highlighted a significant majority (84%) of staff find the device easy to use and 83% of staff carry their devices when working out in the community.

The Compliance and Assurance Team have provided continued support during the period and ensure the submission of new devices and user information was both accurate and timely.

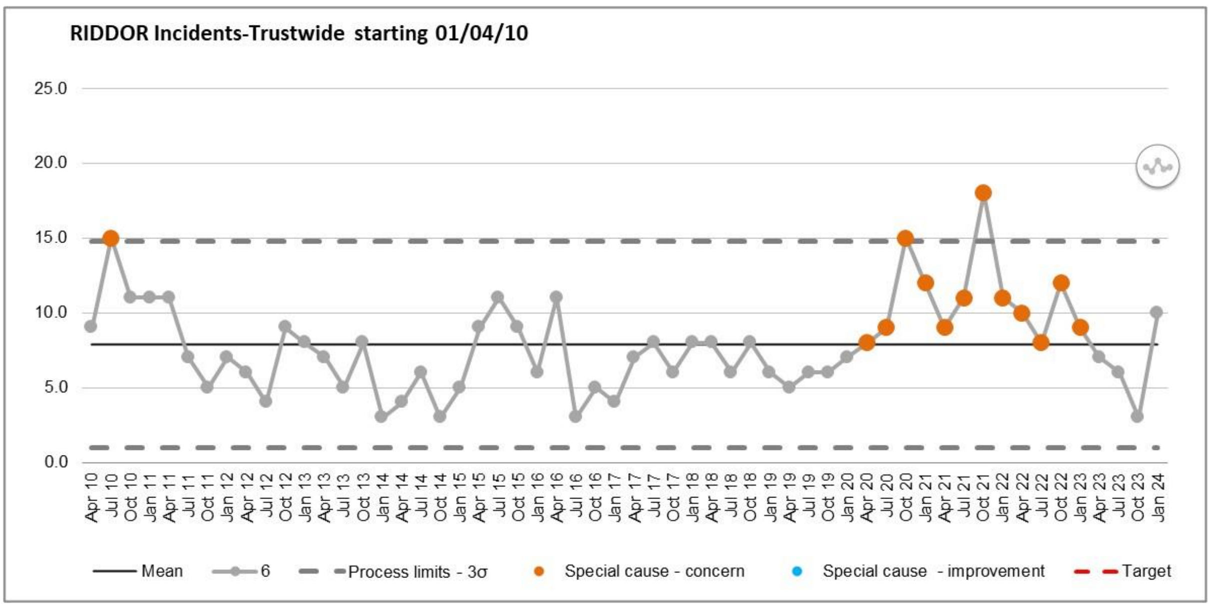
14. REPORTING OF INJURIES DISEASES & DANGEROUS OCCURRENCES REGULATIONS

There has been a decrease in the number of RIDDOR incidents compared to 2022 - 2023 from 34 to 31 incidents in 2023 - 2024. There were 3 specified (major) injuries reported to the Health and Safety Executive. The remaining incidents reported were categorised as resulting in an over 7-day absence from work as a result of an injury. Eight of these absences have resulted from moving and handling incidents (all of which have been investigated by the Trust Moving and Handling Team). One incident was related to violence and aggression, which is a significant decrease on the previous year. All RIDDOR incidents are investigated by the reporting directorate and the followed up by the supporting Health and Safety Advisor under the continuous monitoring and support arrangements undertaken by the Health and Safety Team.



	Aggression & Violence	Accident (involving staff, visitors etc.)	Accident (involving patients)	Moving & Handling	Non-Patient Slip, Trip or Fall	Total
Apr 2023	0	1	0	0	0	1
May 2023	0	1	0	1	0	2
Jun 2023	0	1	0	0	2	3
Jul 2023	0	0	0	1	0	1
Sep 2023	0	1	0	1	2	4
Oct 2023	0	1	0	1	0	2
Nov 2023	0	0	0	1	1	2
Dec 2023	0	2	0	1	3	6
Jan 2024	0	3	0	1	0	4
Feb 2024	1	2	1	1	0	5
Mar 2024	0	0	0	0	1	1
Total	1	12	1	8	9	31

The SPC chart below shows the trend around RIDDOR reporting since quarter one of 2010. It highlights that since COVID the number of reports remain in the upper control limit and therefore higher than normal over a longer period dating back to 2010. Further analysis of the latest financial year found a range of different types of incidents across several Directorates. There were no significant themes or trends to indicate why numbers remain relatively high.



15. EXTERNAL INVESTIGATIONS

HSE attended Freeman site on 7th February 2024 as part of their regular surveillance programme to assess our compliance with Control of Asbestos Regulations 2012. Formal feedback was not provided from the visit as the inspector did not find any areas of

concern to follow up on but commented that our areas of focus as outlined within the Asbestos Management Plan (AMP) were appropriate and well thought through. The inspector was impressed with the AMP which he felt was a thorough document meeting our legal requirements as well as providing a clear strategy for our approach to asbestos management going forward. The inspector expressed concerns over our asbestos registers in terms of accessibility and ease of use for both in-house maintenance teams and external contractors. This has already been identified as an area for improvement. Actions already taken include the purchase of the MICAD asbestos module and improving accessibility for in-house maintenance teams with access to key information via SharePoint. A detailed review has been conducted of our existing/archived survey and removal information to ensure relevance and suitability with a view to moving to a 'live asbestos management model' on the MICAD platform and using the MICAD portal to provide access to the information for maintenance staff and contractors. The inspector queried our approach to ensuring the competence of our external asbestos contractors and we outlined how the Trust used ISO17020/ISO17025 accredited companies and used RESET to verify the competence of individual operatives, HSE were assured by the evidence provided and the benefits of using the RESET system. On the basis that the asbestos management processes are implemented Trust-wide consideration will be made by the HSE to remove the RVI site visit from the current schedule as they were sufficiently reassured that there was a consistent approach across our 2 main sites.

16. RISK REGISTER

A Risk Management update report is provided at each meeting of the Health and Safety Committee.

This is for Committee oversight, as the management and review of risks is the responsibility of each Clinical Board/Speciality through their Governance Meeting structures.

The report details Trust-wide high rated risks (12+) that are aligned to the Health and Safety Committee's areas of focus. The report also reflects the Trust's Risk Appetite for those risks linked to Quality Outcomes – **Safety**, Effectiveness, Experience where the Risk Appetite is *" Low"* (*) and the Risk Tolerance Score is between 6 to 10, namely *"We have a LOW appetite for risk taking in relation to Quality Outcomes. We will take measured and considered risks to improve and deliver quality outcomes where there is potential for long term benefit, however we will not compromise the quality of care we provide or the safety of the patients in our care".*

The Committee will also receive details and the rationale for any closed risks.

17. DATIX DEVELOPMENTS

During 23-24 the Datix Team have developed dashboards on Trust reporting hub platform using PowerBI, replacing the current Yellowfin platform that has been used previously. There are currently nine incident dashboards available, including Clinical Board Incident Dashboards. Further development has taken place around dashboards for Claims, Complaints and Risk Register to provide a greater overview of governance within the Clinical Boards.

A Ward dashboard for sisters, matrons and heads of nursing, has been rolled out, to use for incident trends at ward level and there are also a number of dashboards to support Trust groups and committees such as Violence Reduction Group, Fatigue Management and Sharps Review Group.

Learn From Patient Safety Events (LFPSE) for Incidents was implemented on 1st November 2023, which has replaced the previous National Reporting and Learning System (NRLS) to meet the new NHS England reporting requirements.

The Datix Team have also assisted with the roll out of the Patient Safety Incident Response Framework (PSIRF) in January 2024 by developing additional fields as part of the assurance process for the rapid review procedure that must be carried out for any incidents reported as moderate or above and have also developed the clinical board incident dashboard to include PSIRF to allow Clinical Boards to have an oversight of their PSIRF incidents and the governance process around this.

Several initiatives have been implemented to help speed up incident reporting and improve incident reporting rates across the organisation. This has included:

- A user survey and focus groups.
- Streamlining the incident reporting fields where possible.
- Exploring remote access
- Creation of Clinical Board Patient Safety Data Analysis Data-pack
- Working closely with RL Datix to resolve performance issues.
- Provide Datix access via clinical carts.
- Implement single sign on to save time.

18. RECOMMENDATIONS

The Trust Board is requested to receive the report and endorse the developments.

Report of Angela O'Brien
Director of Quality and Effectiveness
20 June 2024

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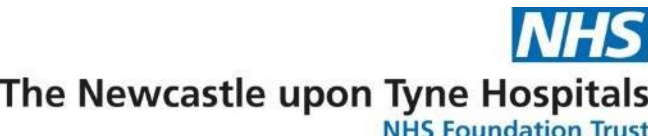
Agenda item A11(d)(ii)



TRUST BOARD

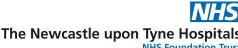
<table>
<tr><td>Date of meeting</td><td colspan="6">29 November 2024</td></tr>
<tr><td>Title</td><td colspan="6">Learning from Deaths - Quarter 1 (April 2024- June 2024)</td></tr>
<tr><td>Report of</td><td colspan="6">Louise Hall, Deputy Director of Quality and Safety</td></tr>
<tr><td>Prepared by</td><td colspan="6">Jenny Simpson, Patient Safety Manager / PSIRF Lead
Jo Ledger, Head of Patient Safety</td></tr>
<tr><td rowspan="2">Status of Report</td><td colspan="2">Public</td><td colspan="2">Private</td><td colspan="2">Internal</td></tr>
<tr><td colspan="2">☒</td><td colspan="2">☐</td><td colspan="2">☐</td></tr>
<tr><td rowspan="2">Purpose of Report</td><td colspan="2">For Decision</td><td colspan="2">For Assurance</td><td colspan="2">For Information</td></tr>
<tr><td colspan="2">☐</td><td colspan="2">☒</td><td colspan="2">☐</td></tr>
<tr><td>Summary</td><td colspan="6">This paper aims to provide assurance to the Board that processes for Learning from Deaths across the organisation are in line with best practice as defined in the National Quality Boards (NQB) National Guidance on Learning from Deaths (LFD) March 2017.

This paper also summarises the processes that are in place to provide assurance to the Committee that all deaths are reviewed including those with potentially modifiable factors.

The paper gives an overview of the Trust position with meeting the requirements for Level 1 reviews following patient deaths, as outlined in current Trust policy. The report further outlines new statutory requirements, as outlined in the new Department of Health Death Certification Reforms, for independent scrutiny of all in-patient deaths from 09 September 2024 and the Trust's current position towards this.

The report is correct as of 09 September 2024 and covers data for Q1 of 24/25.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Board asked to (i) receive the report and (ii) note the actions taken to further develop the mechanisms for sharing learning across the Trust.</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.
Put patients and carers first and plan services around them.</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">Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.</td></tr>
</table>

Reports previously considered by	This is a recurrent report and was previously presented to Trust Board on 14 May 2024. This report has been updated to reflect the required changes to the mortality review process that are required from 09 September 2024.



LEARNING FROM DEATHS

EXECUTIVE SUMMARY

Learning from deaths of people who receive inpatient care and treatment can help the Trust improve the quality of the care we provide to patients and their families and identify where we could do more. In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.

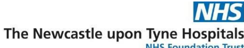
From 9 September 2024, it will become mandatory for all deaths to be reviewed by either a Medical Examiner (ME) or a Coroner before a Medical Certificate of Cause of Death (MCCD) can be issued. The changes, form part of the Department of Health's Death Certification Reforms which were outlined in April 2024.

The Trust currently uses a framework of level one and level two reviews. Level one reviews include a ME or coronial review. Over the last 12 months an average of 85% of inpatient deaths have undergone a level one mortality review. This figure has fluctuated however has improved from the Q2 in 2023/24. Work is ongoing within the Medical Examiners service to achieve the requirement for all deaths to be reviewed by the Coroner or Medical Examiner. However, there may be a risk that the required standard will not be met, and this will be closely monitored.

The introduction of the Patient Safety Incident Response Framework (PSIRF) within the Trust at the start of 2023/24 Q4, has strengthened the process for integrating learning from deaths. Any death that meets the learning from death criteria i.e. where problems with care have been identified, is required to undergo an in- depth review under PSIRF, in the form of a Patient Safety Incident Investigation (PSII), which focuses on a systems approach to investigation and learning.

Regional mortality metrics are provided to the Trust by the North East Quality Observatory Service (NEQOS). The latest metrics provided show that the Trust is within the national expected levels for The Summary Hospital-level Mortality Indicator (SHMI).

The Trust Board is asked to (i) receive the report and (ii) note the actions taken to further develop the mechanisms for sharing learning across the Trust.



LEARNING FROM DEATHS

1. BACKGROUND

Learning from deaths of people who receive inpatient care and treatment can help the Trust improve the quality of the care we provide to patients and their families and to identify where improvement could be made.

A CQC review in December 2016, 'Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England' found some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in the quality of care.

In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care. In keeping with this guidance, this report details mortality quality metrics, which are used to assure the Trust Board and Trust Board that the Trust is committed to monitoring inpatient deaths and learning from them.

2. REVIEWING AND LEARNING FROM IN- PATIENT DEATHS

All Clinical Boards are expected, as part of their governance arrangements, to adopt the overarching principles of routine and systematic mortality review, which includes initial assessment of all inpatient deaths, completing of a summary of death form (information to support proposed cause of death) as well as assessment of those deaths that may require a more in-depth review.

Within the Trust, mortality reviews are undertaken in two stages:

Level One:
The aim of a level one review is to ascertain the type of scrutiny the death should receive and whether a more in-depth second stage review is necessary. A level one review consists of:

- A qualified Attending Practitioner (AP) proposing the cause of death (in a summary of death form).
- If applicable, death referred to the Coroner in a timely manner.
- Medical Examiner to scrutinise all non-coronial referrals.
- Consider if a further level 2 (in-depth) review is required.

Level Two:
Deaths that meet a defined criteria or where concerns with care are identified in the level one review, are required to undergo a level two review. A patient can have more than one level 2 review undertaken if they have received care from more than one speciality within their last episode of care.

2.1 Level One Reviews

Trust policy currently outlines that all patient deaths should have a level one review undertaken, which includes ME review or Coronial review, including completion of summary of death form by attending practitioners.

Figure 1 below highlights the breakdown of level one reviews over the last 12 months. The highest proportion of these were undertaken by Medical Examiners.

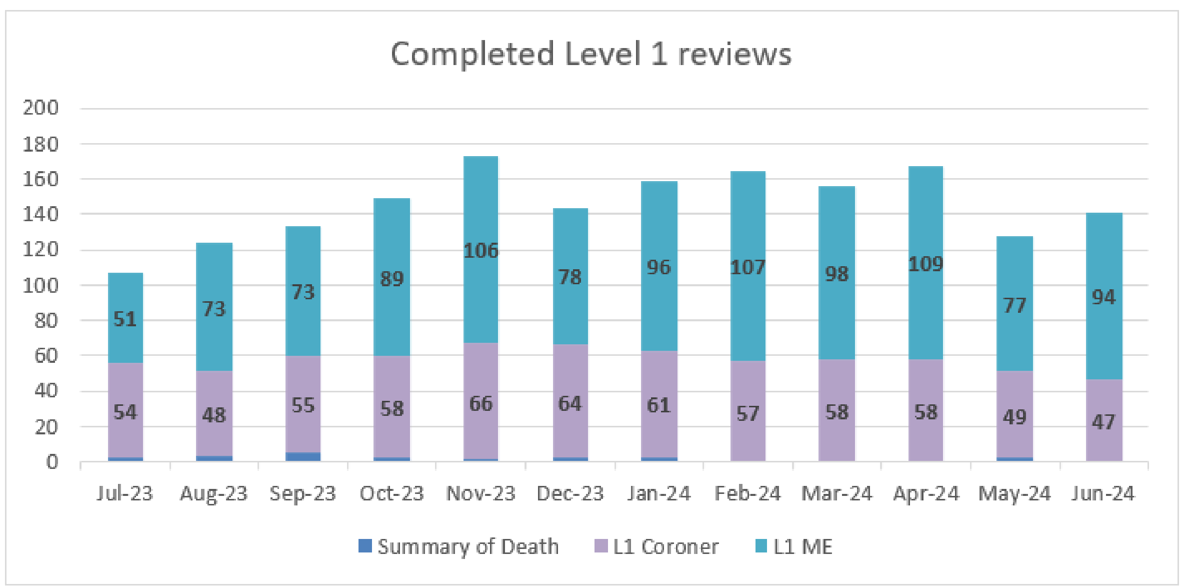


Figure 1: Number of completed level one reviews and source of the review July '23 to June '24.

In the 12-month period (July 23 - June 24), 1,977 patients died within Newcastle Hospitals, during the same period 1692 (85%) level one reviews were undertaken, excluding those where only a summary of death form was completed. Completion of a summary of death alone, would not meet the requirements outlined in the Death Certification Reforms.

Figure 2 details the percentage of deaths where a level one review has been completed, either by the ME or as a coronial review, for the period July 2023 to June 2024. There has been an increase in ME reviews over the last 12 months and plans have been developed to continue to increase the number over the subsequent months, and to ensure that from 09 September 2024, all patient deaths will have received a level 1 review.

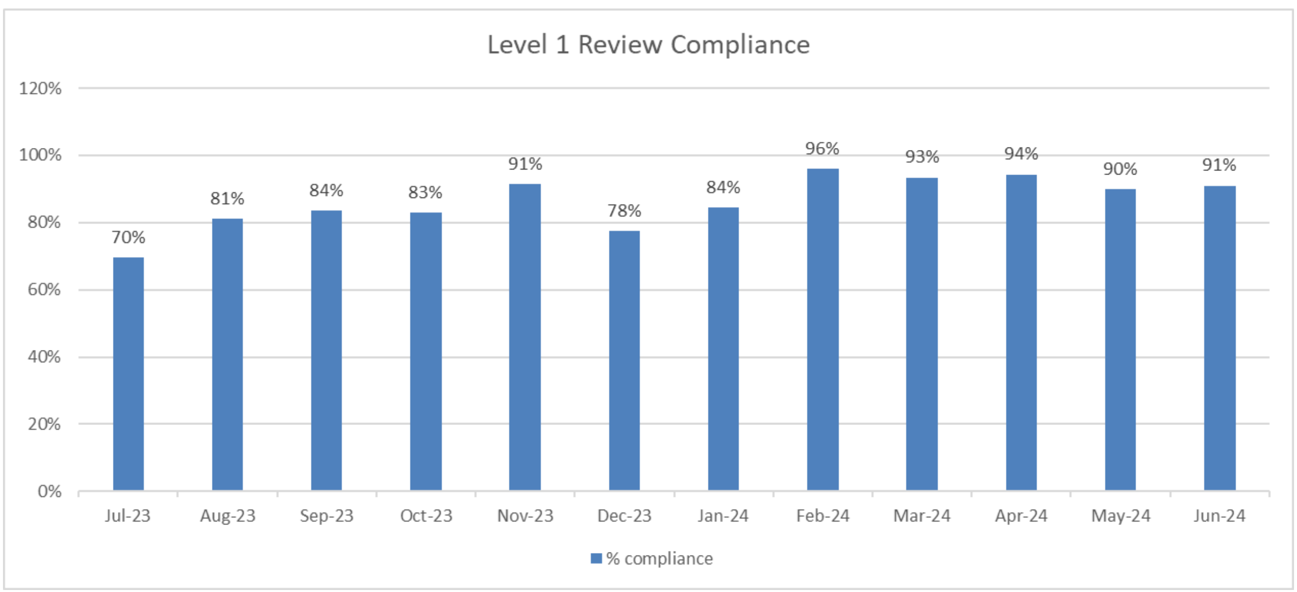


Figure 2: Percentage of completed level one mortality reviews (Medical Examiner and Coronial Review) July 23 to June 24.

2.2 New statutory requirements from 9 September 2024 – Level One Reviews

Changes to death certification legislation in England and Wales, along with the introduction of Medical Examiners, provide a process for routine independent scrutiny of deaths. Medical Examiners have been implemented on a non-statutory basis with ME scrutiny increasingly becoming standard practice nationally from 2019, with the Trust hosting and running the ME process in the Trust effectively, for in-patient deaths.

From 9 September 2024, there is a statutory requirement for all in-patient deaths to be reviewed by either a Medical Examiner (ME) or a Coroner, without exception, before a Medical Certificate of Cause of Death (MCCD) can be issued. These changes form part of the Department of Health's Death Certification Reforms which were outlined in April 2024 and this is now underpinned in law.

The main change is that attending practitioners (AP) must share the MCCD and proposed cause of death with a ME. The ME will scrutinise each case and work with doctors to help ensure the MCCD is accurate and to highlight any concerns about the care of the deceased person prior to their death, before submission to the register. This is a change to the current system where the MCCD is sent to the Registrar by the AP.

In addition, if the Coroner decides that there is no duty to investigate, they will refer a case back to the AP to then refer for Medical Examiner scrutiny (level 1 review) and process before a MCCD can be completed. From 9 September there will be no option for allowing MCCD completion without Coroner or ME countersignature, with compliance required for all patient deaths.

In preparation for the above statutory changes, guidance and support for Trust medical staff undertaking the Attending Practitioners (AP) role is provided on an ongoing basis, led by the Trust Lead Medical Examiner and supported by the Medical Examiner Office, with key differences to process prior to September outlined.

From 09 September 2024, it is required that ALL in-patient deaths will have a level 1 review undertaken as per legal requirements.

Compliance with these statutory requirements will continue to be monitored and with national data submissions made to the national ME portal by the Trust's Medical Examiner Office.

2.3 Level Two Reviews

Deaths that meet a defined criteria are required to undergo a level two review. Level two reviews are also completed where concerns with care are identified by the Medical Examiner in the level one review.

The number of deaths that require a level two review will vary each month and there is no outlined target for this. Overall, the Trust is aiming to increase the number of level two reviews completed. The number of level two reviews completed each month is detailed in figure 3, these are shown by the date the patient died and include multiple level two reviews for the same patient.

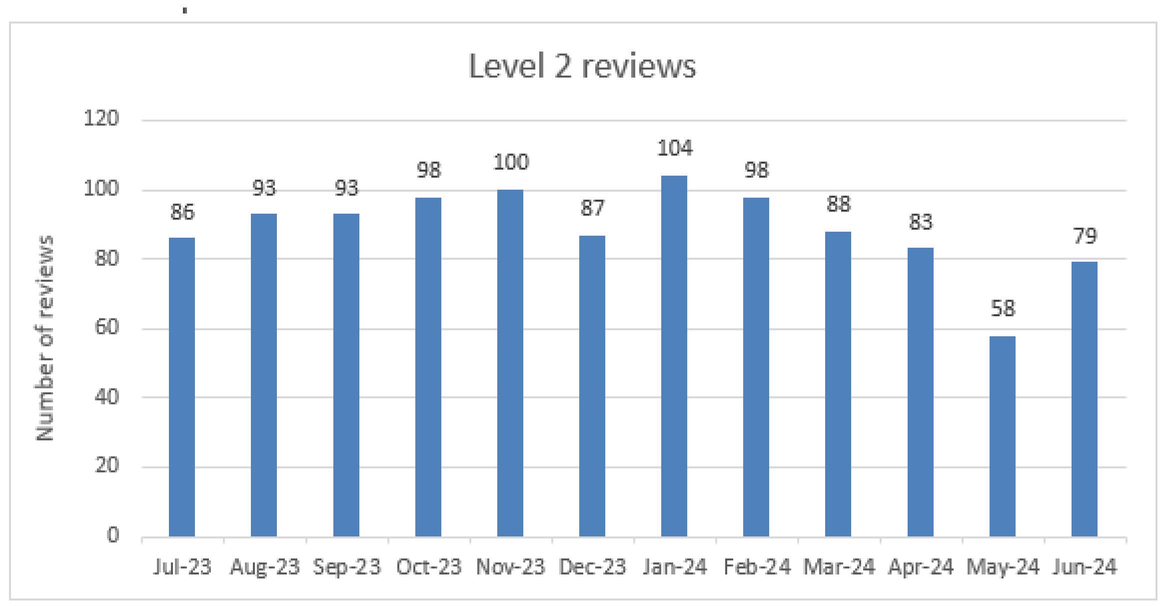


Figure 3; Number of level two reviews completed each month over the last 12 months.

The number of level two reviews has dropped over Q1, however this will increase in line with previous months as more departmental Morbidity and Mortality (M&M) reviews are completed over the subsequent months.

2.4 Medical Examiner Initiated Level Two Reviews

Medical Examiners (ME) will inform Trust mortality leads if a level two review is to be undertaken in line with the Trust Mortality Review Policy. Many level two reviews are completed each month within the Trust, however only a small number of these come from the ME review process. Work is ongoing within the ME team to increase this number.

Numbers of level two reviews requested by the ME and the number of reviews completed is detailed in figure 4.

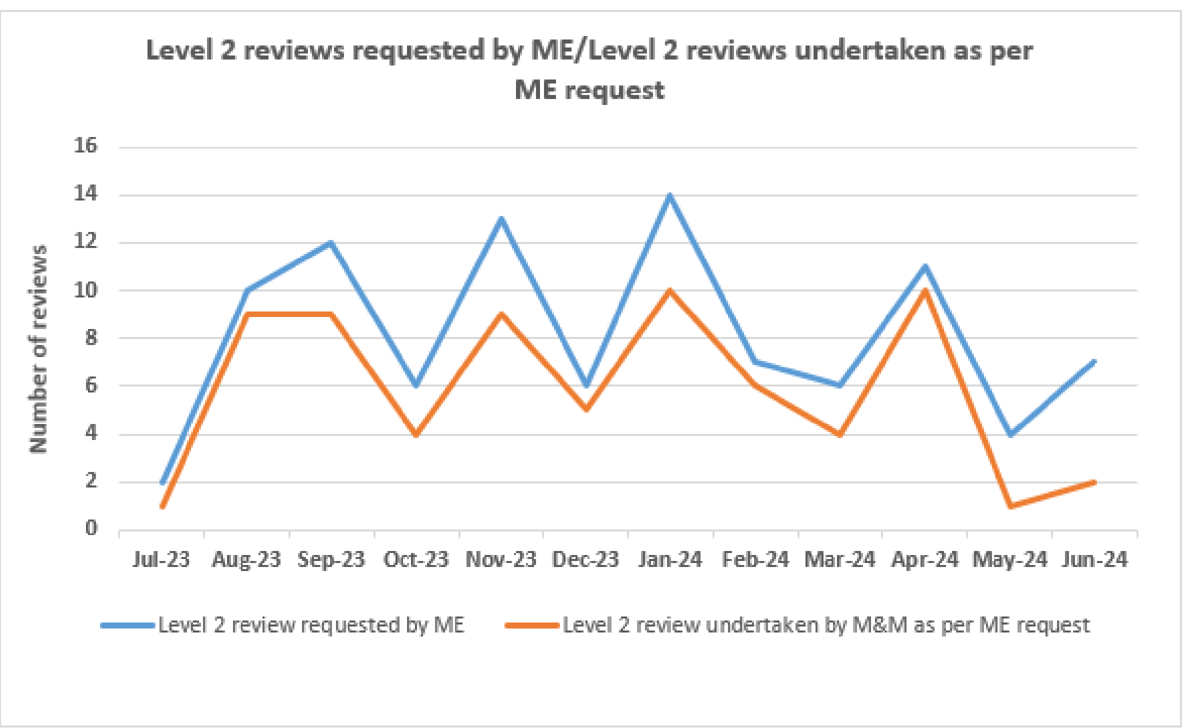


Figure 4; Level 2 reviews requested by the ME and completed by the relevant speciality M&M.

As more level one reviews are completed in line with the new death certification reforms, the number of level two reviews requested by the MEs are likely to increase in parallel to this.

2.5 Patients identified with a Learning Disability

In the 12-month period (July 23 – June 24), 24 patients who died within Newcastle Hospitals were identified as having a learning disability. Within the Trust, whenever a patient with a learning disability dies, their death is reviewed by the clinical team, in the form of a level two review. Further reviews are undertaken by the Learning Disability Mortality Review Panel which feeds into the LeDeR National Database.

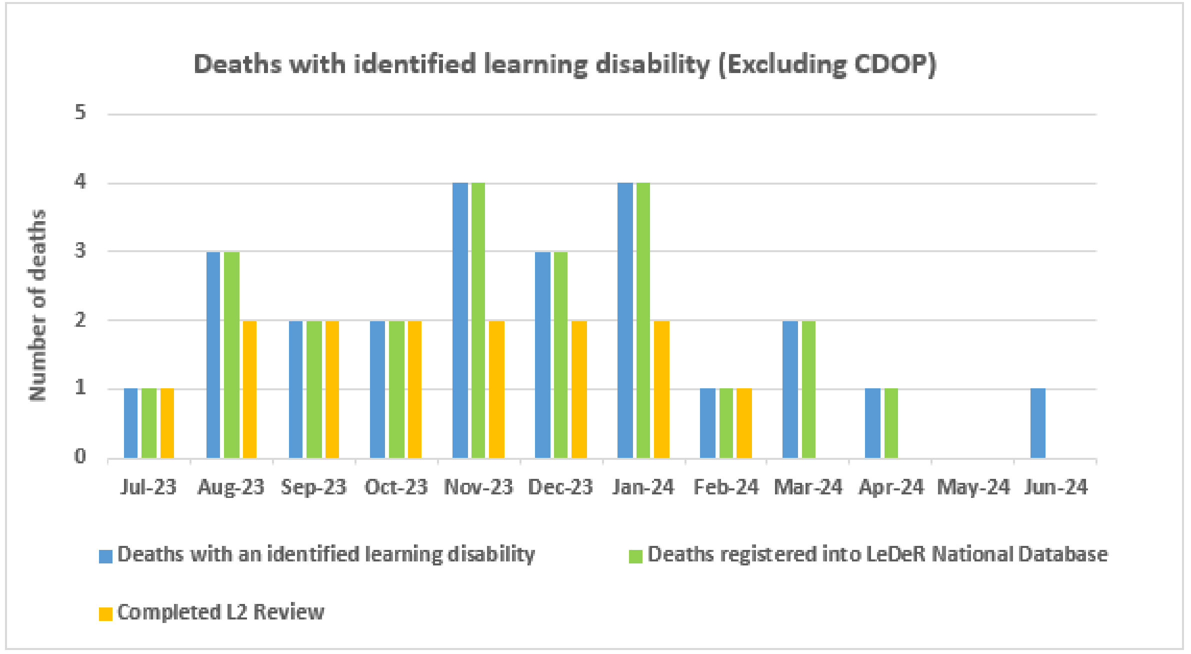


Figure 5; Deaths with identified Learning Disabilities.

Figure 5 shows the data for the past 12 months (July 23 – June 24) and includes those patients who have been registered into the national LeDeR database. The data excludes children who are reviewed by the Child Death Overview Panel (CDOP), as was agreed nationally to avoid duplication.

3. LEARNING FROM DEATHS

Throughout Q1, 472 patients died. During the same period 220 level two reviews were completed for 175 patients. A patient can have more than one level 2 review undertaken.

Level two reviews are undertaken by a multidisciplinary team with each death undergoing an evaluation of the care delivered to the patient prior to their death, or discharge if the patient died within 30 days of discharge. The reviewing team consider all they know about the patient's admission to establish the quality of healthcare received from the Trust. A score is determined following the review using the Hogan scale from 1, 'definitely not preventable' to 6, 'definitely preventable'.

A Hogan score of greater than 4 suggests 'strong evidence of preventability'. Where this occurs, the case is reviewed as part of the Trusts Patient Safety Incident Response Framework (PSRIF). Each case graded 4 or above is also presented on an individual basis at quarterly Mortality Surveillance Group.

The outcomes of level two reviews undertaken for deaths that occurred in Q1 and all reviews completed during this period are summarised in figure 6.

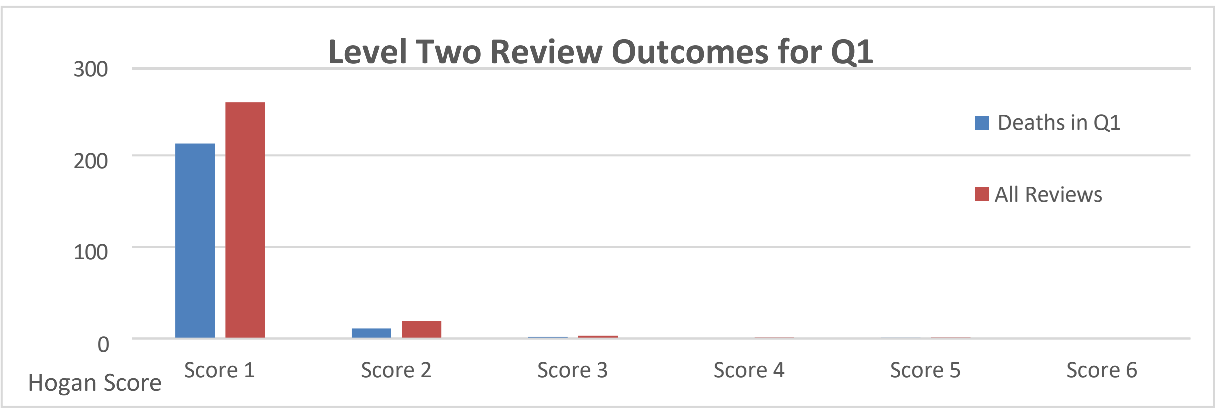


Figure 6: Mortality review outcomes by Hogan Score for deaths that occurred Q1 and all reviews undertaken in the same period.

Significant learning points identified following level two M&M reviews in Q1, for reviews with a Hogan Score of $\geq$ 3 are detailed in figure 7. The trust has several forums where learning is sharing including Clinical Risk Group. Learning is also disseminated through Clinical Board Quality Oversight Groups and Directorate quality and safety meetings.

Clinical Board	Speciality	Summary	Key Learning Points
Peri – Op & Critical Care	Critical Care	Patient brought to ED with suspected drug overdose. Intubated and treated on critical care. Developed hypotensive shock and could sadly not be resuscitated.	The person leading the cardiac arrest is responsible for deciding if a family member can be present during CPR. Relatives need to be supported by a dedicated person who can explain what is happening.
Cardiothoracic	Cardiology	Patient with severe symptomatic Aortic Stenosis awaiting urgent transcatheter aortic valve implantation (TAVI).	Timely recognition of patient deterioration and acting on this deterioration. Alternative access TAVI program logistics to be reviewed. This case is also being reviewed as a Patient Safety Incident Investigation (PSII), with learning awaited.

Figure 7; Summary of significant learning identified from deaths with Hogan score $\geq$ 3 and or NCEPOD 3 for L2 Mortality Reviews completed in Q1.

3.1. Patient Safety Incident Response Framework

All unexpected patient deaths, or deaths with possible modifiable factors, are reviewed by the clinical boards, recorded on Datix and escalated via the Rapid Action Review Meeting for consideration as one of the four identified learning responses. The introduction of the Patient Safety Incident Response Framework (PSIRF) at the start of 2023/24 Q4, has strengthened the

process and oversight in relation to learning from deaths. Any death that meets the learning from death criteria due to identified concerns with care, is required to undergo a thorough review in the form of a Patient Safety Incident Investigation (PSII) which focuses on a systems approach to investigation and learning.

Outcomes for in-patient deaths are discussed at RARM in Q1 are summarised in figure 8.

ID	Reported date	Clinical Board	Outcome of Rapid Review
79234	18/04/2024	Surgery & Specialist Services	PSII
79521	22/04/2024	Surgery & Specialist Services	PSII
81983	23/05/2024	Cardiothoracic	PSII
82285	28/05/2024	Cardiothoracic	After Action Review
82543	31/05/2024	Cardiothoracic	PSII

Figure 8: Rapid Action Review outcomes for in-patient deaths reviewed in Q1 (excluding IPC).

Completed learning responses are scrutinised at the Trusts Patient Safety Incident Response Forum (PSIF) to identify if suitable learning from reviews has taken place. Learning from completed events is shared at relevant forums including Clinical Risk Groups and Patient Safety Briefing.

4. CRUDE MORTALITY

Crude mortality rate is the percentage of in-hospital mortality from all hospital admissions.

The crude mortality rate for Newcastle Hospitals is normally very low (averaging less than 1%), however differences in crude mortality rates between hospitals are not only caused by differences in hospital performances but also by differences in the case-mix of patients that are admitted. A hospital that admits on average a higher number of older patients and performs a larger proportion of higher risk procedures is likely to have a higher in-hospital crude mortality rate than a hospital with an average younger population.

Figure 9 details the crude mortality rates for the period July 23 - June 24 and shows a decrease in the crude death rate in relation to the previous year.

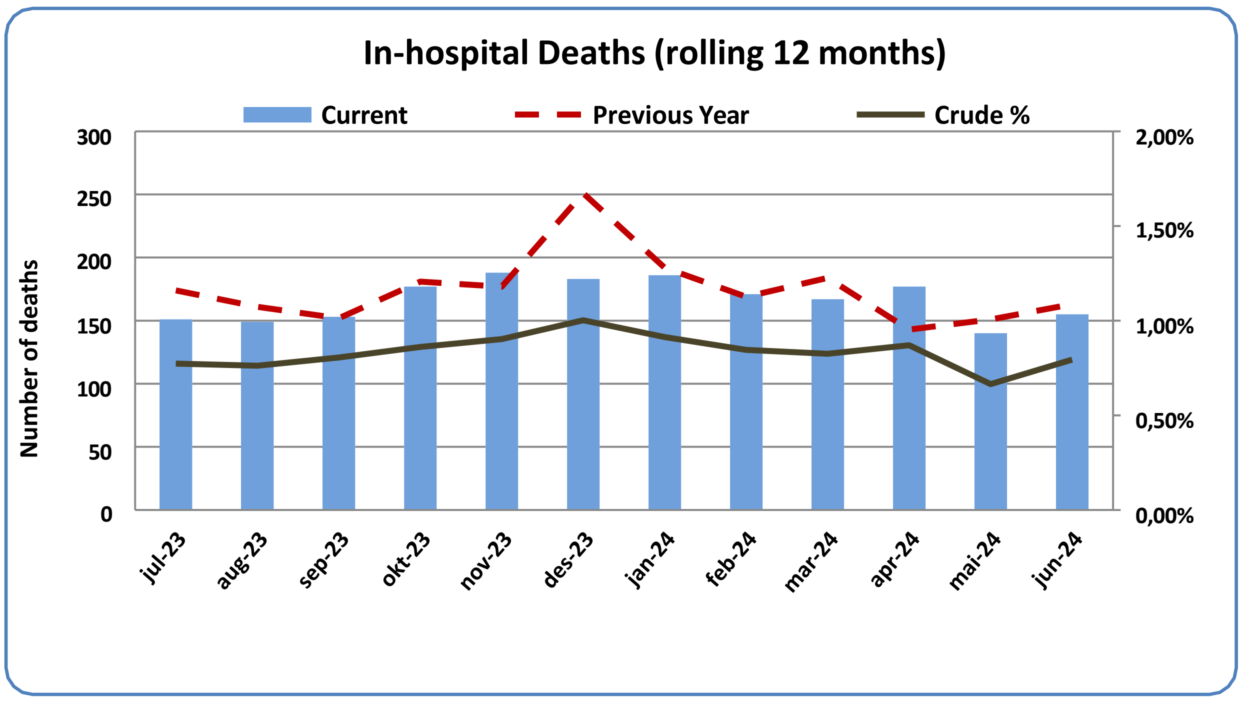


Figure 9; Crude mortality rates for the period July 2023 to June 2024

5. THE SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR (SHMI) AND VARIABLE LIFE ADJUSTED DISPLAYS (VLADS)

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published monthly as a National Statistic by NHS England.

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI is currently composed of 142 different diagnosis groups, and these are aggregated to calculate the overall SHMI value for each trust.

The latest SHMI publication for April 2023 to March 2024 shows the Trust to be at 0.91, which is within the national expected levels and is comparable, with other Trusts in the region for the period January to December 2023, as shown in figure 10.

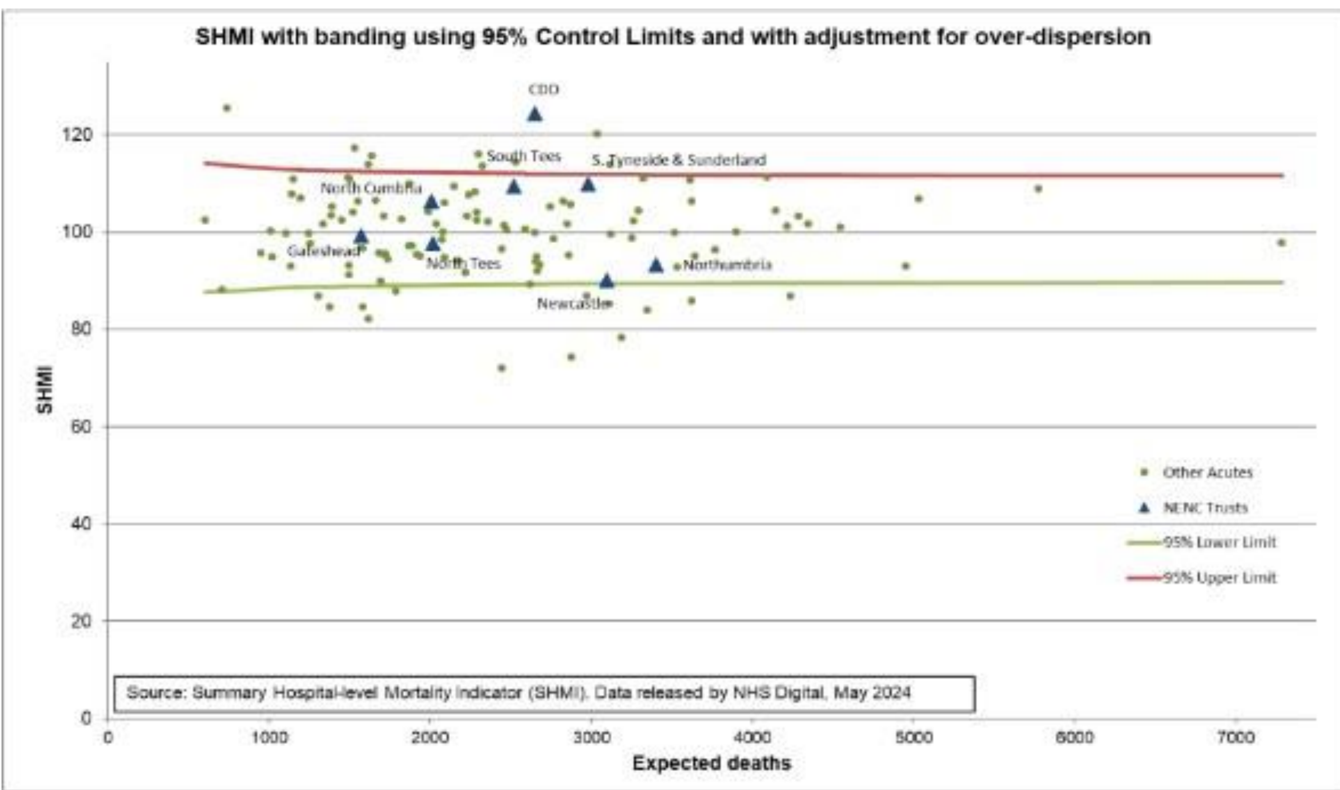


Figure 10; SHMI funnel plot using 95% CLs with over-dispersion adjustment for January to December 2023 (Source; NEQOS Report 61 Hospital Mortality Monitoring).

Variable life adjusted displays (VLADs) are a form of Cusum control chart. Consecutive cases are plotted within a selected SHMI diagnosis group over 12 months. Using the observed and expected mortality for individual patients, changes in the pattern of outcomes are detected using statistical control limits that generate alerts which acute Trusts need to investigate.

Information on the Trusts VLADs in collated and shared by the North East Quality Observatory Service (NEQOS). Figure 11 shows a summary of VLAD signals across selected diagnostic groups over the twelve months April 23 to March 24.

Diagnosis Groups	Deaths	Cases	% Deaths	SHMI	VLAD Signals	
					Positive	Negative
Septicemia	150	615	24.4%	123	0	2
Lung Cancer - **Low**	60	595	10.1%	72	2	0
Secondary malignancies	105	965	10.9%	86	1	0
Fluid & Electrolyte Disorders	45	890	5.1%	94	0	0
Acute MI	75	1330	5.6%	86	0	0
Heart Failure	90	985	9.1%	90	0	0
Stroke	170	1425	11.9%	85	2	0
Pneumonia	305	2825	10.8%	88	2	0
Acute Bronchitis	30	2010	1.5%	89	0	0
COPD	60	1390	4.3%	80	1	0
GI Hemorrhage	20	555	3.6%	74	0	0
Renal	70	540	13.0%	117	0	0
Urinary Tract Infections	60	1740	3.4%	100	0	0
#NOF	50	515	9.7%	121	0	0
Intracranial injury	65	520	12.5%	118	0	1
COVID-19	40	555	7.2%	80	1	0

Figure 11; Trust VLAD signals for 16 diagnostic groups (Source; NEQOS Newcastle Hospitals

VLADs, August 24)

For the period April 2023 to March 2024, there were nine positive VLAD signals across seven diagnostic categories. There were three negative VLAD signals across two diagnostic categories, including sepsis and intracranial injury.

SHMI data and VLAD signals are reviewed on publication to determine any areas that may raise concern. All diagnostic groups within the data are individually monitored and all findings are presented to the Trust Mortality Surveillance Group on a quarterly basis. Any diagnostic group that flags as a concern is raised with the relevant clinical area or specialist teams to ensure an in-depth analysis is undertaken. All learning from this analysis is shared with Clinical Boards and presented to the Mortality Surveillance Group.

5.1. Palliative Care Coding

The SHMI methodology does not make any adjustment for patients who are recorded as receiving palliative care. This is because there is considerable variation between trusts in the way that palliative care is recorded. Contextual indicators on the percentage of provider spells and deaths reported in the SHMI where palliative care was recorded at either treatment or specialty level are produced to support the interpretation of the SHMI. Palliative care coding includes those who have died within 30 days of discharge. Data published by NEQOS outlines palliative care coding within the Trust is comparable to other Trusts in the region, as detailed in figure 12.

The reduction in palliative care coding in June 2023 was part of an upload issue between the Trust and NHS Digital, which has now been resolved. Patient comorbidities and palliative care status were sporadically uploaded into the new Trust dataset and therefore not being included, or risk adjusted by NHS Digital.

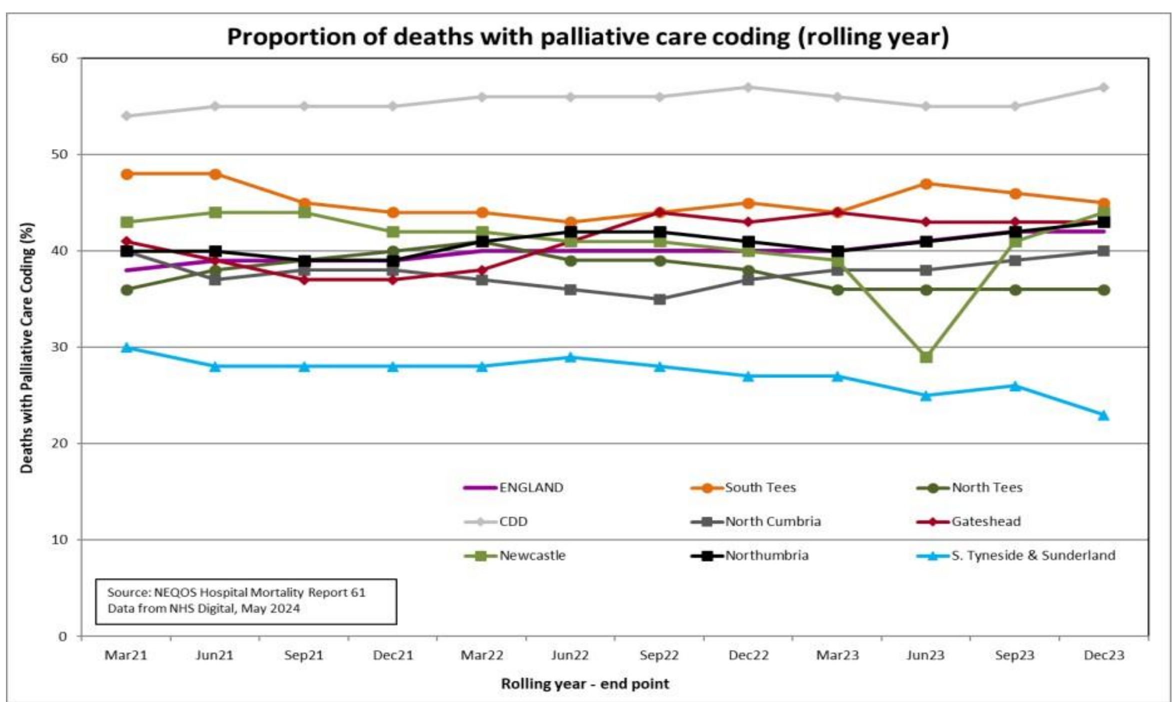


Figure 12; Trend in deaths with palliative coding, rolling year ending March 2021 to December 2023. (Source; NEQOS Report 61, Hospital Mortality Monitoring).

6. RECOMMENDATIONS

To (i) receive the report and (ii) note the actions taken to further develop the mechanism for sharing learning across the Trust.

Report of Angela O'Brien
Director of Quality & Effectiveness

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Agenda item A12

TRUST BOARD

Date of meeting	29 November 2024					
Title	Committee Chair Meeting Logs					
Report of	Bill MacLeod, Chair of the Finance and Performance Committee 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					
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 Public Trust Board meeting in September 2024: • Finance and Performance Committee – 23 September 2024 and 21 October 2024 • Quality Committee – 17 September 2024 and 15 October 2024 • Digital and Data Committee – 10 October 2024 • People Committee – 17 September 2024 and 15 October 2024 • Charity Committee - 19 September 2024 and 5 November 2024 • Audit, Risk and Assurance Committee – 24 September 2024 and 22 October 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]	Detailed in the individual Committee Chairs Logs.					
Reports previously considered by	Present at each relevant Committee.					

Agenda item A12

Finance and Performance (F&P) Committee - Chair's Log

Meeting: Finance and Performance Committee	**Date of Meeting**: 23 September 2024
Connecting to: Audit, Risk and Assurance Committee Trust Board	**Date of Meeting**: 22 October 2024 24 October 2024 [Private Board] 29 November 2024 [Public Board]
Key topics discussed in the meeting	

- Month 5 Finance Report – the Trust is reporting a £7.4m deficit as a direct result of industrial action which led to increased costs and loss of income. Non-recurrent measures have been brought forward to mitigate both emerging pressures and slippage on recurrent cost improvement plans.
- Capital Expenditure - at month 5 the total to date was £9.2m against a plan of £8.4m however this included donated assets of £2.4m therefore the Trust is currently £1.8m behind plan from a Capital Departmental Expenditure Limit (CDEL) perspective.
- The work taking place with regards to the Medium-Term Financial Plan was discussed including modelling 52 week waits and Referral to Treatment Waiting Times (RTT), activity levels, targets in relation to waiting times and Cost Improvement Programme (CIP).
- The Chief Finance Officer provided an update in relation to the Integrated Care Board (ICB) external review of Financial and Workforce Controls. It was agreed that the outcome of this would be discussed at the November Committee meeting.
- A deep dive into the Family Health Clinical Board financial position was undertaken with the key adverse budget variances being against medical staff pay and clinical supplies & services.
- A further deep dive on the Cardiothoracic Clinical Board financial position was conducted with the key issues being the Clinical Board being overspent due to unachieved year to date CIP and further pressures including medical staffing pay, drugs and other non-pay.
- The Managing Director provided a performance overview which included an update on the 'Perfect Week', Emergency Care, Elective Performance, Cancer and Diagnostics. Huge effort continues to reduce waiting lists and to deliver the 62-day performance target.
- A Clinical Board and Corporate Services update was provided which included the Winter Plan 2024/25 and the Clinical Board Quality Performance Reviews (QPR). The Winter Plan and associated costs in support of delivery of the Emergency Department (ED) performance standard trajectory and maintaining Elective care throughout winter were approved by the Committee.
- A progress update with regards to three projects that are part of the 2024/25 Capital Programme.
- A Capital Programme 2024/25 Deep Dive report was discussed which included a financial summary of the forecast position against original budget/CDEL allocation.

- An update on the Community Diagnostic Centre (CDC) which is due to open in October 2024. A future update will be provided to the Committee with regards to delivery of capacity and activity.
- The three risks aligned to the Committee on the Board Assurance Framework (BAF) and Committee members considered the assurance levels aligned to the risks. The Committee were assured that risk actions are progressing and approved for consideration at Audit, Risk and Assurance Committee and Trust Board.
- A number of Tenders and Business Cases were approved.
- The Committee received the following documents:
  - The Month 5 – Financial Recovery Plan Report.
  - The National Cost Collection.
  - A list of business cases not approved and the reasoning for this.
  - A number of management group meeting minutes including the Capital Management Group, the CDC Strategic Oversight Group, the Supplies and Services Procurement Group and the Strategy, Planning and Capital Investment Group, all of which took place in July.
- The Procurement and Supply Chain Director provided a verbal update on the delay regarding the new Procurement Act 2023.

Actions agreed in the meeting	Responsibility / timescale
1. CFO to share the financial and workforce controls review self-assessment with the Committee members and to bring an update to the November Committee meeting [ACTION01]. 2. International referrals deep dive to be added to a future agenda [ACTION02]. 3. DCDI to present a further CDC update to the Committee in relation to the delivery of capacity and activity [ACTION03]. 4. DoE to arrange a separate meeting to discuss Private Finance Initiative (PFI) [ACTION04].	1. Chief Finance Officer (CFO) / November 2024 Committee 2. DCDI / December 2024 Committee 3. Director of Commercial Development and Innovation (DCDI)/ February 2025 4. Director of Estates (DoE) / October 2024 Committee
Escalation of issues for action by connecting group	**Responsibility / timescale**
The Committee agreed to escalate the following: 1. Capital overrun and the potential consideration required regarding CDEL consequences. 2. General challenges with regards to the delivery of the financial plan and recurrent CIP delivery.	1. CFO & DoE/ September 2024 2. CFO / September 2024
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• No new risks were identified. • Risk ID 6.1 - Failure to manage our finances effectively to improve our underlying deficit and deliver long term financial sustainability.	Not applicable.

• Risk ID 6.2 - Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care. • Risk ID 5.1 - 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.	

Finance and Performance (F&P) Committee - Chair's Log

Meeting: Finance and Performance Committee	**Date of Meeting**: 21 October 2024
Connecting to: Audit, Risk and Assurance Committee Trust Board	**Date of Meeting**: 24 October 2024 29 November 2024
Key topics discussed in the meeting	

- Month 6 Finance Report – At Month 6 there was no reported variance against plan except for £0.3m relating to unfunded industrial action costs. Non-recurrent measures continue to mitigate both emerging pressures (e.g. drugs and clinical supplies costs) and slippage on recurrent cost improvement plans. The forecast year end position was discussed, particularly in relation to cash management.
- A key focus of work was on planning for 2025/26.
- Capital Expenditure – At month 6 the total capital expenditure to date was £16.9m against a plan of £11.7m. However, this included donated assets of £2.5m therefore the Trust is currently £2.6m ahead of plan from a CDEL perspective. Discussions continue with the Integrated Care Board (ICB) regarding capital spend.
- The Chief Finance Officer summarised the latest position on the Financial Recovery Plan. The Elective Recovery Funding (ERF) was on target to be achieved however the Cost Improvement Programme (CIP) was under-performing, with non-recurrent benefits used to support the position. The Executive Team were scheduled to discuss measures required to be undertaken to rectify the position.
- The Executive Director of Nursing (EDN) provided an update in relation to the Equality and Quality Impact Assessments (EQIA) for CIP schemes, with three schemes requiring EQIA panel review and discussion. An audit will be undertaken of those completed but that did not require panel review to ensure risk/benefit is captured effectively and any learning shared.
- A deep dive into the Medicine and Emergency Care Clinical Board financial position was undertaken whereby it was noted that the Board had a current overspend however the projected year end position was expected to be an improvement on the prior year outturn. A summary of the status of the CIP schemes was shared.
- A further deep dive on the Peri-Operative & Critical Care Clinical Board financial position was conducted. An ERF surplus had been generated however there were challenges with achievement of the CIP schemes, particularly on a recurrent basis. All acknowledged the impact on the Clinical Board when other Boards undertake excess/additional surgical activity.
- A Clinical Board and Corporate Services update was provided with three main themes highlighted – non-recurrent CIP usage, theatre utilisation and cancer and diagnostics performance.

- The Director of Performance and Governance provided a performance overview which included an update on Emergency Care and Elective Performance. It was highlighted that corneal grafts would now be made available nationally for long waiting patients. Huge effort continues to reduce waiting lists and to deliver the performance targets.
- A detailed update was shared regarding Cancer and Diagnostics performance, with performance against the national standards for cancer and diagnostics being below target (and below the current planning trajectory). Improvement actions are in place and being reviewed).
- The Committee received and noted the Board Assurance Framework (BAF) recommendations approved by the Trust Board relating to the Committees area of focus.
- A number of Tenders and Business Cases were approved.
- The Committee received the following documents:
    - The Month 6 forecast.
    - The Integrated Board Report.
    - A list of business cases not approved and the reasoning for this.
    - The meeting minutes from the Capital Management Group meetings in August and September, the Community Diagnostics Centre Strategic Oversight Group meeting in August and the Supplies and Services Procurement Group meeting in September.

Actions agreed in the meeting	Responsibility / timescale
1. The DPG to arrange a separate meeting with the Committee Chair and MD to discuss/agree the performance reporting into the Committee.	1. DPG – 25 November 2024 Committee
2. Agenda items to be added for the November Committee meeting: - UTC Business Case (MD) - Update on the ED Business Case (Clinical Board) - Therapies staffing – temporary contracts/funding non-recurrent posts (EDN) - Performance – one cancer tumour team to present per month (DPG to identify) - Pharmacy subsidiary governance arrangements (MD/Chief Finance Officer)	2. Trust Secretary to add to the agenda – 15 November 2024
3. The MD to feedback to the Corporate Governance Team as to when the Quality Committee will discuss 7-day working arrangements.	3. MD – 25 November 2024
4. Detailed Tender information to be included in the Reading Room going forwards.	4. Director of Supplies and Services Procurement and Corporate Governance Team - 25 November 2024 Committee

Escalation of issues for action by connecting group	Responsibility / timescale
The Committee agreed to escalate the following:	• Committee Chair – October/November 2024

1. Harm review resourcing requirements in relation to Cancer and Diagnostic (noting Quality Committee role). 2. Capital overrun and the potential consideration required regarding CDEL consequences. 3. General challenges with regards to the delivery of the financial plan and recurrent CIP delivery.	
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• No new risks were identified. • Risk ID 6.1 - Failure to manage our finances effectively to improve our underlying deficit and deliver long term financial sustainability. • Risk ID 6.2 - Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care. • Risk ID 5.1 - 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. • 4392 – IT – financial risk arising from a 5-year contract ending.	• Not applicable.

Quality Committee Chair's Log

Meeting: Quality Committee	**Date of Meeting**: 18/09/2024
Connecting to: ARAC Trust Board	**Date of Meeting**: 22 September 2024 24 October 2024 [Private Board] 29 November 2024 [Public Board]
Key topics discussed in the meeting	

- Cardiac Oversight Group Update – An update was shared on the small number of outstanding actions from within the two actions plan. Key points noted included:
  - An Admin Manager appointed was now in place and reviewing waiting list processes.
  - The staff survey had been conducted by Zeal with a summary of the emerging themes shared. A more detailed report would be shared at the November Committee meeting.
  - Work was continuing to facilitate the return of trainees into the Cardiac Surgery Department and in reviewing revascularisation MDT processes.
  - The new Director of Operations had commenced in role.
- CQC – A general update on progress was shared following the re-routing of the CQC Delivery Group into the Quality Committee and the disbanding of the CQC Recovery and Oversight Group. Updates on Medicines Management and NECTAR were shared. Two actions were noted to be behind plan regarding Medicines Management and the Director of Pharmacy gave an update on progress of the actions which included the establishment of the new Medicines Oversight Group (working well), circulation of the Safety Briefings, a Stakeholder Workshop to review the Medicines Management governance structure and developments regarding the Data Dashboard. Some business cases were noted to be in development.
- Maternity Update including the Perinatal Quality Surveillance Report and the CNST report. Work continued to refine the maternity metrics included within the Integrated Quality and Performance Report. Plans in place to re-open the Birthing Centre later in the calendar year and processes to capture patient experience are being refreshed. Training compliance remains an area of challenge but plans are in place to achieve the required compliance levels. The Committee Chair provided cover for the Maternity Safety Champion during a short period of sickness absence.
- Clinical Research Update – Research activity had reduced since the previous reporting period, in part due to capacity challenges and changes within the team. The Medicines and Healthcare products Regulatory Agency (MHRA) visited in March to inspect a commercial sponsor. Learning points identified in relation to electronic data capture. Future updates to focus on specific Quality and Safety assurances.

- Clinical Board Quality & Safety Escalation Report - Representatives from each of the Clinical Boards, provided the Committee with a description of the priorities and risks together with the actions taken in mitigation.
- Wards of Concern – an update was shared on the two areas requiring high level support.
- An overview of the Rapid Quality & Safety Reviews for September was shared.
- Health Inequalities – data continues to be developed/refined within the Integrated Quality and Performance Report. Governance arrangements under review.
- Patient Harm Reviews – challenges with resourcing were outlined.
- The Quarterly Reports on:
  - Safeguarding and Mental Capacity Act (MCA). Updated internal audit report received. Work ongoing regarding improving training compliance levels and policy audits.
  - Learning Disability and Autism. Strategic Improvement Plan to be developed. Refinements made to the process regarding reasonable adjustments.
  - Mortality/Learning from Deaths. Discussed the change in statutory requirements relating to Level 1 reviews.
- The Integrated Quality & Performance Report
- The Annual Report of the Clinical Outcomes and Effectiveness Group (COEG) was shared and the Chair of the Patient Safety Group (PSG) provided an update on recent Group activity/areas of focus. Committee members discussed compliance with NICE guidelines.
- The BAF and Quality Committee Risk Report were reviewed.
- The Leadership Walkabouts/Spotlight on Services Update/Non-Executive Director (NED) Informal Visits Report was received, along with the Legal Update and minutes from both the PSG and the COEG. Future Leadership Walkabout reports will go directly to the Trust Board.

Actions agreed in the meeting	Responsibility / timescale
1. Trust Secretary to email ICB colleagues to follow up outstanding actions 125,126, 159, 163, 170, 174 and 184 in the action log.	Trust Secretary – October 2024
2. A number of items were agreed to be added to future Committee meeting agendas – Schedule of Business to be updated.	Trust Secretary – October 2024
3. Medicines Management – Update on Fridge Temperature Monitoring.	Director of Pharmacy – October 2024
4. 'Reading room' to be established for Quality Committee members.	Trust Secretary, Executive Director of Nursing [EDoN] and Committee Chair – October 2024
5. Research reporting arrangements into the Tier 1 and 2 Committees/Groups to be clarified.	EDoN, JMD-W, Director of Commercial Development and Innovation (DCDI) and Associate Medical Director, Research – October 2024

6. Future Clinical Outcomes and Effectiveness Group (COEG) reports to include assurances regarding the work of the Clinical Ethics Advisory Group.	Associate Medical Director, Quality and Patient Safety – November 2024
7. Use of Chairs Log template to be rolled out across Tier 2 Groups and used for management group reports into the Committee.	EDoN and Joint Medical Directors (JMD) – October 2024
8. Contract for the Diabetes Foot Clinic to be reviewed (activity and funding).	Associate Director of Allied Health Professionals & Therapy Services – October 2024
9. Emergency Department waiting room and challenges with corridor care – risk entries/scores to be reviewed.	EDoN – October 2024
10. Health Inequalities governance arrangements – reporting arrangements to be clarified.	JMD-PC and Consultant in Public Health – October 2024
11. Patient Harm data to be extracted from Data and discussed at a future Committee meeting.	Associate Medical Director (Cancer) – October 2024
12. Three key messages – EDoN to consider and discuss further with Committee Chair.	EDoN – September 2024
Escalation of issues for action by connecting group/Trust Board	**Responsibility / timescale**
1. Matters to be discussed amongst the Executive Team: A. Cardio Improvement Plan – The grading system for actions. B. Patient Safety Group (PSG) Chair report – Chair/Group member roles for the feeder groups are not recognised in job plans/funded. C. Executive Lead for Health Inequalities. 2. Matters to be escalated to the Trust Board: o Feedback from the MHRA visit. o Wards of Concern - support and encouragement to speak up in the Wards of Concern has positively impacted on the culture in neighbouring/other wards o Increased activity in the Diabetic Foot Clinic has resulted in a reduction in available podiatry appointments (movement away from preventative services).	Managing Director (MD)/ EDoN – 18 September 2024 Committee Chair – 27 September 2024
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Detailed within the BAF and Risk report, as well as several of the action plans e.g. Medicines Management.	• N/a

• NECTAR – new risk regarding new governance framework and that this needs embedding, and neonatal transport service. • Risk ID 3773 – Risk of critical finding from MHRA: Paperlite Processes	

Agenda item A12

Quality Committee
Chair's Log

Meeting: Quality Committee	**Date of Meeting**: 22/10/2024
Connecting to: ARAC Trust Board	**Date of Meeting**: 26/11/2024 29/11/2024
Key topics discussed in the meeting	

- Quality Priority 2 – Ophthalmology Never Events– An update was provided on the quality priority, the aim of which is to achieve a reduction in the incidence of surgical 'never events'. There is a specific focus of how success would be measured including training regarding injection techniques, peer reviews and audits.
- CQC – A general update on progress within the following areas were received:
  - Cardiac Oversight Group Update
  - Medicines Oversight Group
  - NECTAR Action Plan
  - Digital Update
  - Rapid Quality and Safety Reviews
- Duty of Candour Update (DoC). A compliance update was provided noting that there had been a significant decrease in compliance from the last quarter to this however it was felt that the concern was related to measurement compared to the process. As such, a snap shot audit for August and September would be undertaken to identify if there was a recording or compliance issue.
- Management Group Reports for the following were presented:
  - Patient Safety Group (PSG) Annual Report detailing the challenges experienced during 2023/24, Serious Incidents and Learning, implementation of the Patient Safety Incident Review Framework (PSIRF), Duty of Candour, Governance of National Patient Safety Alerts, Risks rated 12 or above and Feeder Group activity
  - Patient Safety Group (PSG) Chairs Log detailing the key topics discussed from the meeting of 13 September 2024 including PSIRF performance and assurance metrics, PSIRF priority updates all of which were progressing well.
  - Clinical Outcomes and Effectiveness Group (COEG) Chairs Log detailing the key topics discussed at the meeting of 23 August 2024 including Non-compliant NICE guidelines rated 12 or greater, New Interventional Procedures – Requests for approval and Clinical Role Development Group Annual Report 2023/24.
- An update on Patient and Staff Experience which detailed the quarterly update on learning from patient, carer, and family feedback. The Trust has made excellent progress in rolling out a new and extensive patient experience programme. Highlights over the last three months included:

    - A pilot of real time feedback across 14 wards. A total of 674 patients have been interviewed about their care with feedback to clinical teams within hours of speaking to patients. Results are very good, a domain average of 9.43 / 10 achieved in September 2024.
    - Inpatients, outpatients and emergency care users provided feedback about their experience of care during the 'Perfect Week' providing strong results overall benchmarking in the top 20% for inpatient, outpatient, and emergency care.
    - Complaints data for the quarter was presented which showed there had been a significant increase in the number of complaints being upheld or partially upheld which was to be welcomed.
    - The next steps for the Patient experience programme are shared with the committee for information – this involves the development of a new 3-year plan for measuring and improving patient and staff experience.
- Perinatal Quality Surveillance Report providing 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 including
    - Perinatal Quality Surveillance minimum data measures.
    - Progress with the CQC action plan against exit criteria from SOF enhanced surveillance.
    - Progress with the Ockenden Immediate and Essential Actions
    - Current clinical risks and mitigations.
- Allied Health Professional Workforce Report which noted there had been positive progress with overall growth and turnover rate, noting Occupational Therapy and Speech & Language Therapy as professions of current concern and significant efforts to develop the AHP workforce strategy to support future workforce planning, training needs and practice development approaches.
- An update on Therapy Services Clinical Directorate – system and service risks focussing on the main range of services, pathways, staffing and clinical issues which included risks and challenges that impact on patient quality, outcomes and experience as well as impacting on the staff.
- An update on progress in relation to the Breast Screening Quality Assurance Action Plan was provided.
- A report on Equality and Quality Impact Assessment for CIP schemes was provided which detailed an overview of the Trust process for the completion and oversight. A position summary was also provided.
- The Integrated Quality & Performance Report was presented which provided assurance to the committee on the Trust's performance against key Indicators relating to Quality & Safety, Access, People, Finance and Health Inequalities.
- Board Assurance Framework (BAF). The report provided the Quality Committee with the Trust Board approved BAF risks relating to the Quality Committee's area of focus. All committee recommendations proposed to the Audit, Risk and Assurance Committee and Trust Board were agreed in full and the BAF was approved at Trust Board on 27th September 2024.
- An update on Waiting List management was provided. It was noted that the Trust has reviewed its practice against the Improvement Support Team (IST) Exemplar waiting list management gap analysis tool. The Exemplar focuses on reporting, governance and validation. Whilst this identified that a significant amount of good practice was in place, it also demonstrated a number of gaps, which have and continue to be addressed.

- Audiology – the report provided an update on the Integrated Care Board (ICB) incident management process, action plan and provided assurance on progress of both.
- A comprehensive HTA/Mortuary report was received covering regulatory compliance and the mortuary improvement plans.

Actions agreed in the meeting	Responsibility / timescale
1. Deep Dive in to into research and its governance including systems and process	• EDCDI – January Committee
2. Deep Dive into Ophthalmology including methodology of audits and SOPs	• JMD-PC – January Committee
3. CQC original action plan completed and being reviewed by Internal Audit. Once reviewed will present to the committee.	• MD – November or December Committee
4. Write off value of out-of-date drugs to be taken through Finance & Performance Committee.	• Chair of the Finance & Performance Committee – October Finance & Performance Committee 21 October 2024
5. Update on status of FTSU Champions.	• CPO – November Quality Committee meeting
6. Update on Duty of Candour to be included with the monthly CQC updates.	• MD – November Quality Committee meeting
7. Heads of Nursing/Medical Directors to have conversations within the Clinical Boards regarding the importance of enacting and recording Duty of Candour correctly and to discuss via QOG.	• Heads of Nursing/Medical Directors - November Quality Committee meeting
8. Escalation to Board in relation to status of Duty of Candour and the actions that have been agreed to improve.	• Chair of the Quality Committee – October Private Board
9. Importance of Duty of Candour process to be communicated via the Patient Safety Bulletin.	• DCCA – November Quality Committee Meeting
10. For August and September there needed to be a snapshot audit undertaken to identify if there was a system and process recording issue rather than a compliance issue against DoC.	• DDQE – November Quality Committee meeting
11. DCCA to attend Patient Safety Group and/or generic meeting to talk about different communications strategy.	• DCCA – November / December Committee Meeting
12. JW also noted the effectiveness of patient story boards and would welcome some story board	• DCCA and DMW to meet

templates for consistency. DMW and DCCA to discuss outwith the meeting.	
13. 3-year plan and strategy for measuring and improving patient and staff experience to be added to agenda.	• CXO will advise - either December or January agenda
14. Carry on conversation around estate (particularly maternity) at Board incorporating, planning, Big Build - what the plans will look like and what might need to be considered in the interim.	• NEDs and MD – Board Development in October 2024.
15. Discussion centered on the SLA (Service Level Agreement) where RH advised that a bilateral Board would be established for all of the relationships with NCIC for oversight. RH would ensure that this piece of work would be included in the bilateral Board.	• MD
16. CIP Equality Impact Assessments (EQIA) Summary Report to be reported into Finance and Performance Committee.	• EDN/MD – paper going to finance & performance Committee on 21 October 2024.
17. Another CIP EQIA Summary Report to be provided for the Committee.	• EDN – February or March 2025 – EDN to advise
18. IPC Action plans to be provided for upload to reading room in Admin control.	• EDN – November Quality Committee
Escalation of issues for action by connecting group/Trust Board	**Responsibility / timescale**
• Write off value of out-of-date drugs to be taken through Finance & Performance Committee. • Escalation to Board in relation to status of Duty of Candour and the actions that have been agreed to improve. • Workforce issues in relation to Allied Health Professionals. • MHRA self-declaration of non-compliance to Audit, Risk and Assurance Committee and Trust Board.	• Chair of the Finance & Performance Committee – Finance & Performance Committee • Chair of the Quality Committee – October Private Board • Chair of the Quality Committee – October Private Board • Chair of the Quality Committee – October Private Board
Risks (Include ID if currently on risk register)	**Responsibility / timescale**

• Research and its governance including systems and process • Ophthalmology including methodology of audits and SOPs • Duty of Candour recording.	See Action Above See Action Above See Action Above

Digital and Data Committee Chair's Log

Meeting: Digital and Data Committee	**Date of Meeting**: 10 October 2024
Connecting to: Board Meeting	**Date of Meeting**: 29 November 2024
Key topics discussed in the meeting	
• Saudi Memorandum of Understanding – Cloud Solutions • Recognising risks of Path5 changes • Recognising operational changes with telephony changes • Recognising the value of the Alliance and sharing of Electronic Paper Records (EPR) experiences and beyond • Benefits of optimisation and how to communicate to staff • Dental hospital benefits and to use as case study of good practice and a way of showing benefits realisation after business case • Good progress around CQC action plan • Challenges around cultural shift • Challenges around ophthalmology upgrade to Medisight causing delays but being worked through • CIP gap recognised • Digital Plan to be aligned with finance and clinical/operational plans • BAF recommendations • Data Partnerships • Patient Engagement Platform	
Actions agreed in the meeting	Responsibility / timescale
1. **Remote Hosting of Oracle/Cerner** - It was agreed by the Committee to add as an action to monitor the business case for remote hosting **[Action35].** 2. **EPR Useability Survey** – AND-GE to share the first analytics from the EPR end user survey looking at staff experience to the Committee around January 2025. **[Action37]**	1. Chief Information Officer – Timescale: Update after second Quarter of 2025 2. ADN-GE - Timescales: Update at February 2025 Committee meeting (12/01/2025).

3. **EPR Useability Survey** -. HDID to bring back a plan on the digital dictation fluency direct with timescales to for standard use across the organisation. Areas not using to be identified and the reason. **[Action38]** 4. **Benefits Realisation Report** - Reports to be brought back to the Committee going forward. HDID to meet with MD/CFO to discuss Benefits realisation outside of the meeting. **[Action 39]** 5. **GDE** – Digital dictation - It was noted that a plan will be brought back to the Committee at a future meeting to discuss what the plan will be from the Care Optimisation Group. To be discussed at a future meeting. **[Action40]**	3. HDID/Digital IT Managers – To provide future plan to the Committee meeting timescales: To bring back to a future Committee meeting. 4. HDID – Timescales: To organise outside of Committee meeting 5. HDID to provide future plan to Committee meeting Timescales – To bring back to future Committee meeting.
Escalation of issues for action by connecting group	**Responsibility / timescale**
None identified	Not applicable
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
None identified	Not applicable

People Committee - Chair's Log

Meeting: People	**Date of Meeting**: 17 September 2024
Connecting to: ARAC Trust Board	**Date of Meeting**: 22 October 2024 24 October 2024 [Private Board] 29 November 2024 [Public Board]
Key topics discussed in the meeting	

- The Chief People Officer provided an update in relation to the CQC delivery plan which is currently being shared through the Chief Executive Roadshows as well as other platforms. The Committee were assured that detailed work is taking place in the background.
- An update was received on the People Plan and Year 1 deliverable actions.
- A detailed discussion took place in relation to Health and Wellbeing including a gap analysis. The main points were to ensure staff have access to current resources, developing a comprehensive Health and Wellbeing Plan and reviewing the psychological support available to staff.
- The Committee received an update in relation to the current position and actions being taken for Speaking Up and Freedom to Speak Up (FTSU). An 8-point plan has been produced, shared with the national guardian's office and approved by the Executive Team and shared for action at the most recent Trust Management Group (TMG). The FTSU Guardian noted the increasing number of contacts with the service as a result of investment, promotional work and consistency of messaging.
- The Chief People Officer provided a detailed update with regards to the key timelines and promotional campaign of the NHS Staff Survey 2024.
- The Board Assurance Framework (BAF) was reviewed to determine if the assurance ratings were appropriate. There are three strategic risks aligned to the People Committee which were discussed in detail. The BAF was considered and recommended for Audit, Risk and Assurance Committee and Trust Board approval.
- The Maternity Safety Champion provided an overview of her observations whilst visiting Maternity Services. She noted the strong management and staff engagement.
- The Committee received the People and Culture Data including an updated on the progress made in relation to Statutory and Mandatory training.
- The minutes from the Sustainable Healthcare Committee were received for information.
- The Integrated Board Report was received, and the content noted.

- The Guardian of Safe Working Quarterly Report for the period of March to June 2024 was received.
- No new or emerging risks were identified.
- The Committee received the Annual Shine Report 2023/24 and Newcastle Hospitals' Carbon Reduction Plan and recommended for Trust Board approval subject to further discussion outside of the meeting in relation to the materiality of the risks.
- The updated People Committee Schedule of Business was received and recommended for Trust Board approval.

Actions agreed in the meeting	Responsibility / timescale
1. Further discussion to take place in relation to the pay award funding at the Finance and Performance Committee **[ACTION01].**	Chief People Officer and Deputy Trust Secretary/ October & November
2. The Committee agreed to have the Board Assurance Framework (BAF) as a main item at the November People Committee **[ACTION02]**.	Head of Corporate Risk and Assurance, Chief People Officer and Deputy Trust Secretary / November
3. The Committee recommended the Annual Shine Report 2023/24 and Newcastle Hospitals' Carbon Reduction Plan for Trust Board approval subject to further discussion outside of the meeting in relation to the materiality of the risks detailed within the report **[ACTION03].**	Managing Director, Head of Corporate Risk and Assurance & Associate Director - Sustainability / September

Escalation of issues for action by connecting group	Responsibility / timescale
There were no matters requiring escalation.	Not applicable.

Risks (Include ID if currently on risk register)	Responsibility / timescale
No new or emerging risks were identified. Risk ID 2.1 - Failure to have sufficient capacity and capability in our workforce to deliver safe and effective care. Risk ID 2.2 - Failure to develop, embed and maintain an organisational culture in line with our Trust values and the NHS people promise. Risk ID 2.3 - Failure to effectively develop and implement a new approach to leadership and organisational development to ensure that everyone feels supported appropriately by the organisation.	Not applicable.

People Committee - Chair's Log

Meeting: People	**Date of Meeting**: 15 October 2024
Connecting to: ARAC Trust Board	**Date of Meeting**: 26 November 2024 29 November 2024
Key topics discussed in the meeting	

- An update was provided in relation to the Care Quality Commission (CQC) delivery plan and the 'you said we did' approach. The Committee were assured that detailed work is taking place in the background.
- An update was received on the People Plan and Year 1 deliverable actions. The Head of HR Strategy and Transformation provided a verbal update on the staff survey uptake since going live with over 3000 responses received to date.
- A comprehensive deep dive update was provided in relation to Behaviours and Civilities and Leadership and Management. The Civility Charter is being embedded into the Trusts people practices for example recruitment, induction, and training. A new Leadership and Management training programme is currently being piloted with a focus on compassionate and responsive leadership. This will be fully evaluated by the Executive Team later in the year.
- The Committee received an update on the key people areas from the September 2024 Clinical Board Quality Performance Reviews which included their approach to the new People Plan, identifying work life balance and retirement as the most common reason for turnover and the new appraisal system pilot.
- A comprehensive update was received in relation to employee relations.
- A verbal Communications Strategy update was provided, and it was agreed that a further update will be presented at a future Committee meeting once the work on the Strategy has progressed.
- A detailed update was received in relation to the GMC Training Survey. The Director of Medical Education is working closely with the Clinical Boards to create action plans and to address outlier areas. It was noted that the mess facilities at the RVI are currently being upgraded and the Wi-Fi connectivity has recently been improved.
- An update was provided on progress made since the Joint Medical Directors were appointed in March 2024 which included the setup of a Concerns Oversight Group, job planning, and meetings attended within the Clinical Boards.
- In relation to the People Committee Board Assurance Framework (BAF), all People Committee recommendations proposed to the Audit, Risk and Assurance Committee and Trust Board were agreed in full and the Board Assurance Framework was approved at Trust Board on 27 September 2024. The Committee noted the contents within the BAF.
- A People and Culture dashboard summary was provided from the monthly performance reviews with Clinical Boards and monthly meetings between Human Resources (HR) and Corporate Services.

- The minutes from the Learning and Education Group, Equality, Diversity and Inclusion (EDI) Steering Group and the Health & Wellbeing Steering Group were received for information.
- The Integrated Board Report was received, and the content noted.
- The Guardian of Safe Working (GoSW) Quarterly Report for the period of June 2024 to September 2024 was received.

Actions agreed in the meeting	Responsibility / timescale
1. CD agreed to circulate the Communications update presentation to Committee members [ACTION01].	DCCA / October
2. The Committee agreed to bring a deep dive back to a future meeting in relation to the GMC Training survey and for this to include detail on the hot spot areas [ACTION02].	DTS/JMDs / Timescale TBC
3. A discussion to take place outside of the meeting regarding the GMC survey results linked with themes from the GoSW report to determine narrative inclusion on the People BAF [ACTION03].	The CPO/MD/HRCA / November

Escalation of issues for action by connecting group	Responsibility / timescale
1. GMC Training survey results and the linked themes in the GoSW report.	The CPO/Chair of Committee / October

Risks (Include ID if currently on risk register)	Responsibility / timescale
Please see [ACTION02] above. Risk ID 2.1 - Failure to have sufficient capacity and capability in our workforce to deliver safe and effective care. Risk ID 2.2 - Failure to develop, embed and maintain an organisational culture in line with our Trust values and the NHS people promise. Risk ID 2.3 - Failure to effectively develop and implement a new approach to leadership and organisational development to ensure that everyone feels supported appropriately by the organisation.	The CPO/MD/HCRA / November

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Charity Committee - Chair's Log

<table>
<tr><td>Meeting: Charity Committee</td><td>Date of Meeting: 19 September 2024</td></tr>
<tr><td>Connecting to: ARAC and Board</td><td>Date of Meeting: 22 September 2024
24 October 2024 [Private Board]
29 November 2024 [Public Board]</td></tr>
<tr><td>Key topics discussed in the meeting</td><td></td></tr>
<tr><td colspan="2">• Updates on previous funding applications were discussed.
• Funding proposals were discussed in relation to:
  ○ Cardiothoracic, Refurbishment of Ward 27, Heart Failure Unit - £51,000 - Approved
  ○ Peri-operative & Critical Care, Reusable Theatre Hats - £23,098 - Approved
  ○ Cancer & Haematology, Wall Art in Chemotherapy Unit - £22,726.91- Approved
• The summary of funding agreed since the last meeting was reviewed (bids up to £20k).
• An update on the funding bid for the Junior Doctors facilities was given.
• The Charity Annual Accounts were discussed and approved.
• The Associate Director (Funding and Partnerships) provided a Funding Programmes overview.
• The Charity Director gave an update and overview of the Sir Bobby Robson Institute (SBRI) campaign plan.</td></tr>
<tr><td>Actions agreed in the meeting</td><td>Responsibility / timescale</td></tr>
<tr><td>1. The Associate Director (Funding and Partnerships) agreed to speak to estates regarding sharing cost of additional costs for the Junior Doctors Mess project [ACTION01].
2. Committee Non-Executive Directors asked for further legal clarification on strategic funding [ACTION02].
3. A further session is required on the strategic funding position [ACTION03].</td><td>Associate Director (Funding and Partnerships)

Charity Director

Charity Director/Charity Operations Manager</td></tr>
<tr><td>Escalation of issues for action by connecting group</td><td>Responsibility / timescale</td></tr>
<tr><td>Documents requiring Trust Board consideration:
• Charity Annual Accounts
• SBRI Fundraising Campaign Plan
• Strategic Funding Programmes</td><td>Charity Director – September/October</td></tr>
<tr><td>Risks (Include ID if currently on risk register)</td><td>Responsibility / timescale</td></tr>
</table>

None identified	Not applicable

Charity Committee - Chair’s Log

Meeting: Charity Committee	**Date of Meeting**: 5 November 2024
Connecting to: ARAC and Board	**Date of Meeting**: 26 November 2024 29 November 2024
Key topics discussed in the meeting	

- An update on the Sir Bobby Robson Institute Fundraising Campaign was given.
- Draft Funding Criteria was received and discussed.
- The Associate Director (Funding and Partnerships) provided a Funding Programmes overview.
- The Charity Financial Accountant presented the finance reports, to 30 September 2024, Month 6 Accounts and an update on the cashflow for 2024/25.
- The summary investment reports were shared.
- The Funds committed and not yet drawn down quarterly report was discussed.
- An update on Charity banking and investments including review of signatories was given.
- Updates on previous funding applications were discussed.
- A discussion took place regarding Funding Programmes including RVI Changing Facilities.
- Funding proposals were discussed in relation to:
  - Cardiothoracic, Artificial Intelligence and Machine Learning in Heart and Lung Transplantation - £80,000 - Approved
  - Peri-operative & Critical Care, Caremed Alruick Chairs - £39,194.40 - Approved
- The summary of funding agreed since the last meeting was reviewed (bids up to £20k).
- An update was given and a discussion took place on monitoring and evaluation of funded proposals.
- The Charity Risk Statement was received.
- The Charity Annual Report and Accounts 2023/24 were approved.
- The minutes of associated meetings were received.

Actions agreed in the meeting	Responsibility / timescale
1. Charity Director to share requested Legal Guidance re the legalities of the Funding Programmes to Charity Committee [ACTION01]	Charity Director – November 2024
2. Committee to send comments regarding Funding Criteria Guidance to Charity Operations Manager [ACTION02] to inform next iteration and Associate Director (Funding and Partnerships) to bring	Charity Operations Manager / Associate Director (Funding and Partnerships) – February 2025

examples of worked through applications to next committee [ACTION03] 3. CFA to look at adding Forecast Line to Finance Report [ACTION04] 4. CFA to update NED signatories [ACTION05] 5. As agreed at the SBRF Meeting on 31 July 2024, CFA to move all cash and Sir Bobby Robson funds into higher interest account [ACTION06] 6. The CPO to follow up with Executive Team regarding decision regarding RVI Changing Facilities [ACTION07]	CFA – February 2025 CFA – November 2024 CFA – November 2024 The CFO – November 2024
Escalation of issues for action by connecting group	**Responsibility / timescale**
There are no documents requiring escalation.	
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
The Charity Risk Statement was discussed - Two managed risks and three tolerated risks on the register.	

Agenda item A12

Audit, Risk and Assurance Committee (ARAC) - Chair's Log

Meeting: ARAC	**Date of Meeting**: 24 September 2024
Connecting to: Board	**Date of Meeting**: 24 October 2024 [Private Board] 29 November 2024 [Public Board]
Key topics discussed in the meeting	

- A detailed presentation was received from the Medicine and Emergency Care Clinical Board on their quality and safety priorities, patient safety actions and risks. The Clinical Board risks were discussed at length in relation to the nature of the risks and the mitigating actions.
- Committee members discussed the Board Assurance Framework and risk management report, which were received for assurance. The risk management report gave an overview of the Trust Risk Profile and provided assurance from the Risk Validation Group relating to the areas validated by the Group. Committee members reviewed risk ID1.2, the progress indicators and the assurance rating recommendations (see escalation section below).
- A report was shared on the work of the Compliance and Assurance Group which covered a summary of the reports received and considered by the Group, along with policies approved and issues escalated to the Quality Committee. The Group now routinely reports into the ARAC rather than the Quality Committee, and the Director of Performance and Governance would take over the chair arrangements for the Group going forwards.
  The Joint Medical Director (Wr), outgoing Group Chair, outlined the significant changes required in relation to additional training for senior staff responding to major incidents, capacity constraints within the Emergency Preparedness, Resilience and Response team, the Estates risks at the Campus for Ageing and Vitality site and the storage considerations at the Baliol facility.
- A detailed report was given by the Designated Individual for the Mortuary service in relation to regulatory compliance and improvement plans. The findings of the Human Tissue Authority inspection and the UK Accreditation Service visit in March were discussed, as well as actions being taken. An overview of the work undertaken in relation to the Fuller report was provided.
- Thevaluecircle were commissioned to undertake an independent rapid review of quality Governance and in particular to seek assurance around the implementation of an effective governance system following the Notice of Decision issued in December 2023 by the CQC, imposing conditions on the Trust licence. A summary report was produced by thevaluecircle with key findings and recommendations and shared with the Committee, along with an action plan. Progress against the plan will be monitored through the CQC Delivery Group.
- The Charity Annual Accounts for 2023/24 were approved.
- A verbal update was shared on the Integrated Care Board (ICB) external review of Financial and Workforce Controls which was due to be commenced by AuditOne and PwC.

• There were no matters escalated from other Board Committees for consideration by the ARAC other than the capital programme pressures were highlighted from the Finance and Performance Committee Chair.	
Actions agreed in the meeting	**Responsibility / timescale**
1. Charity Reserves Policy to be shared with the Interim Shared Chair. 2. The Chairs Logs for the meetings include further narrative in relation to the BAF. 3. For future meeting papers, the minutes of the other Committees will be added into the documents folder within AdminControl rather than being linked directly to the meeting papers. 4. Update on the ICB external review to be shared at the next Committee meeting.	1. Director of Communications and Corporate Affairs – September 2024. 2. Trust Secretary and Committee – October 2024. 3. Trust Secretary – October 2024. 4. Chief Finance Officer – October 2024.
Escalation of issues for action by connecting group	**Responsibility / timescale**
1. Finance & Performance Committee escalation to ARAC (for onward escalation to the Trust Board) regarding the pressures on the Trust Capital Programme. 2. Confirm to the Trust Board that: a. The ARAC approved the assurance rating recommendations proposed by the Finance, People and Quality Committees. b. The ARAC agreed the recommended assurance rating and assurance level for risk ID1.2 [Effective Governance System]. 3. Recommend the Charity Annual Accounts for 2023/24 are approved by the Trust Board as Corporate Trustee.	1. Committee Chair – September Trust Board meeting
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
1. The following risks were discussed in detail from the Medicine and Emergency Care Clinical Board risk register: • Risk ID 3634 Medicine [Mental Health reviews in the Emergency Department] • Risk ID 4155 Medicine [Campus for Ageing and Vitality site] • Risk ID 3863 Dermatology [Waiting times] • Risk ID 4310 Emergency Medicine [ED attendance levels] • Risk ID 4457 Emergency Medicine [ED waiting room] • Risk ID 4480 Emergency Medicine [Violence and aggression] • Risk ID 4344 Renal [Haemodialysis]	As defined in the risk register.

• Risk 4377 Acute Medicine [Mixed Sex accommodation] • Risk ID 4427 Stroke [Service resilience] • Risk ID 4510 Clinical Pharmacology [Ward 44] 2. BAF - risk ID1.2 [Effective Governance System].	

Agenda item A12

Audit, Risk and Assurance Committee (ARAC) - Chair's Log

Meeting: ARAC	**Date of Meeting**: 22 October 2024
Connecting to: Board	**Date of Meeting**: 29 November 2024
Key topics discussed in the meeting	

- Escalation from other Board Committees to ARAC:
  - Quality Committee – Duty of Candour performance, Allied Health Professionals workforce shortages and research records documentation/digitisation (referred to the Medicines and Healthcare products Regulatory Agenda (MHRA)).
  - Finance & Performance Committee – Cancer and Diagnostics performance.

- Board Assurance Framework (BAF) Report – The BAF was reviewed and approved at Public Board on 27 September 2024 except for the Digital and Data Committee aligned risk which was reviewed and discussed at the Digital and Data Committee Meeting on 10 October 2024. No changes were proposed to the risk score or the assurance rating. An update was shared on the Committee review of the risk and the BAF was proposed for approval by the Trust Board.

- Internal Audit Update – Six final reports have been issued since the ARAC meeting in July 2024 and seven reports are currently at draft/review stage. Of the reports issued:
  - 3 were given reasonable assurance ratings (appraisals, management of slips, trips and falls, WHO surgical checklist)
  - 2 were given good assurance ratings (new clinical interventional procedures, IT services ticket management)
  - 1 was an un-rated advisory report (fundamentals of care)

  Internal Audit shared an overview of the high and medium recommendations identified within the report. Committee members discussed the status of/received updates on the recommendations.

  The following changes to the internal audit plan for 2024/25 were agreed:
  - Cancellation of the Financial Recovery Plan audit and replacement with NHS England / Integrated Care Board (ICB) Financial Controls review; and
  - Cancellation of the Payroll Controls audit (due to overlap with a national payroll exercise undertaken). Audit days to be redirected to the CQC action plan review.

  There were no overdue internal audit recommendations where an update was required and there were a further 26 overdue recommendations with revised target implementation dates.

62 recommendations had been implemented since the July Committee meeting and 12 remained open (not yet due).

- ICB External Review of Financial and Workforce Controls – Internal Audit shared a short progress update and agreed to circulate the reports from the review for the next Committee meeting.

- Management Letter/ISA260 Report on the Charity Accounts 2023/24 – the external auditor report was shared which gave a 'clean' audit opinion. Committee members discussed the status of a large donation and the associated gift aid claim.

- Counter Fraud Report – the increasing volume of investigations were discussed, particularly relating to instances of staff members working elsewhere during periods of sickness absence from the Trust.

  Committee members discussed a particular case relating to a contractor and it was agreed that a brief note be drafted for the next Committee meeting to set out the decision not to pursue any further action.

- Health & Safety Annual Report 2023/24 – An overview of the report was shared, which covered the following areas:
  - Compliance with health and safety legislation. Moving and Handling compliance has reduced slightly due to resourcing issues however this had subsequently improved.
  - The numbers of health and safety incidents remain relatively stable and within the upper and lower control levels; however, there have been slight increases in violence and aggression compared to previous years (increases in non-physical aggression and a decrease in physical assaults).
  - Mental Health First Aid Training delivery.
  - Feedback from the Health and Safety Executive visit to Estates and the recent CQC IRMER inspection in August.
  - A positive increase in incident reporting.

- Schedule of approval of single tender action and breaches and waivers exception report – there were no breaches reported during the quarter, and the listing of the 26 waivers was shared.

- Debtors and creditors balances – the main debtor and creditor balances were noted to relate the PFI contract.

- Schedule of losses and Compensation – an overview of the bad debts written off was shared, with the majority relating to overseas visitor debts which were uneconomical to recover.

- The Committees Chairs Logs were received for the following Committee meetings:
  - Finance and Performance Committee – 23 September 2024
  - People Committee – 17 September 2024
  - Quality Committee – 17 September 2024
  - Charity Committee – 19 September 2024

In addition the minutes of the Compliance and Assurance Group meeting held on 12 September 2024 were received.

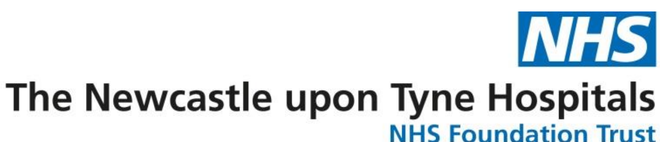
Actions agreed in the meeting	Responsibility / timescale

1. The Chief Finance Officer (CFO), the Director of Performance and Governance (DPG) and the Head of Corporate Risk and Assurance (HCRA) agreed to meet to discuss the monitoring/reporting route for overdue internal audit recommendations and to feedback at the next committee meeting. 2. Chief People Officer (CPO) to share a progress update on the national payroll exercise at the next Committee meeting. 3. Regarding the 26 overdue internal audit recommendations, it was agreed that the CFO, the DPG and HCRA conducts an assessment of those recommendations still valid/recommendations to be prioritised for completion for the next Committee meeting. 4. Internal Audit to provide the Managing Director with a list of which theatres were included in the WHO checklist audit. 5. November Committee meeting agenda to include the reports from the external review of financial and workforce controls. 6. Feedback to be shared with the Charity Director regarding ensuring future fundraising campaigns incorporate an easy to follow gift aid process. 7. Fraud Specialist Manager (FSA) and CFO to draft a brief note for the next Committee meeting to set out the decision not to take any further action regarding the contractor case discussed. 8. CFO and TS to progress the review of the Standing Financial Instructions, Scheme of Delegation and the Standing Orders. 9. The CFO agree to follow up the reasons for the increase in pharmacy stock losses and feedback at the next Committee meeting.	1. DPG and HCRA – 26 November 2024. 2. CPO – 26 November 2024. 3. CFO, DPG and HCRA – 26 November 2024. 4. AuditOne – 26 November 2024 5. The Trust Secretary (TS) and AuditOne – 26 November 2024. 6. TS – 26 November 2024. 7. FSA and CFO – 26 November 2024. 8. CFO and TS – 26 November 2024. 9. CFO – 26 November 2024.
Escalation of issues for action by connecting group	**Responsibility / timescale**
1. Quality Committee escalations to ARAC (for onward escalation to the Trust Board (TB)) regarding Duty of Candour performance, Allied Health Professionals workforce shortages and research records documentation/digitisation (referred to the MHRA). 2. Finance & Performance Committee escalation to ARAC (for onward escalation to the TB) – Cancer and Diagnostics performance. 3. Confirm to the Trust Board that: a. The ARAC approved the risk score and assurance rating recommendations proposed by the Digital and Data Committee. b. The BAF was recommended for approval.	1. AS - October/November Trust Board meeting 2. BMa - October/November Trust Board meeting 3. DW – October/November Trust Board meeting

Agenda item A12

Risks (Include ID if currently on risk register)	Responsibility / timescale
1. BAF risk - Failure to deliver digital systems, processes, and infrastructure to support the provision of safe effective patient care and our digital aspirations for the future (risk 4.1).	As defined in the BAF.

Agenda item A13



TRUST BOARD

<table>
<tr><td>Date of meeting</td><td colspan="6">29 November 2024</td></tr>
<tr><td>Title</td><td colspan="6">Board Assurance Framework Report</td></tr>
<tr><td>Report of</td><td colspan="6">Rob Harrison, Deputy Chief Executive</td></tr>
<tr><td>Prepared by</td><td colspan="6">Natalie Yeowart, Head of Corporate Risk and Assurance</td></tr>
<tr><td rowspan="2">Status of Report</td><td colspan="2">Public</td><td colspan="2">Private</td><td colspan="2">Internal</td></tr>
<tr><td colspan="2">☒</td><td colspan="2">☐</td><td colspan="2">☐</td></tr>
<tr><td rowspan="2">Purpose of Report</td><td colspan="2">For Decision</td><td colspan="2">For Assurance</td><td colspan="2">For Information</td></tr>
<tr><td colspan="2">☐</td><td colspan="2">☒</td><td colspan="2">☐</td></tr>
<tr><td>Summary</td><td colspan="6">This report aims to support the Trust Board to gain assurance that strategic risks aligned to the committee are being managed effectively; that risks have an appropriate action plan in place to mitigate them; and that risk scores are realistic and achievable.

• Current risk scores remain unchanged on all BAF Risks.
• Several actions timescales have been amended.
• New actions have been added on all risks.
• 1 assurance rating has changed from red to amber relating to speaking up on risk 2.2, all other assurance rating remain unchanged.
• Full details of all changes to each risk can be found within section 3.</td></tr>
<tr><td>Recommendation</td><td colspan="6">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 document.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Links to all strategic objectives.</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">N/A</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Executive Team, Committees of the Board and Audit, Risk and Assurance Committee.</td></tr>
</table>

1.0 INTRODUCTION

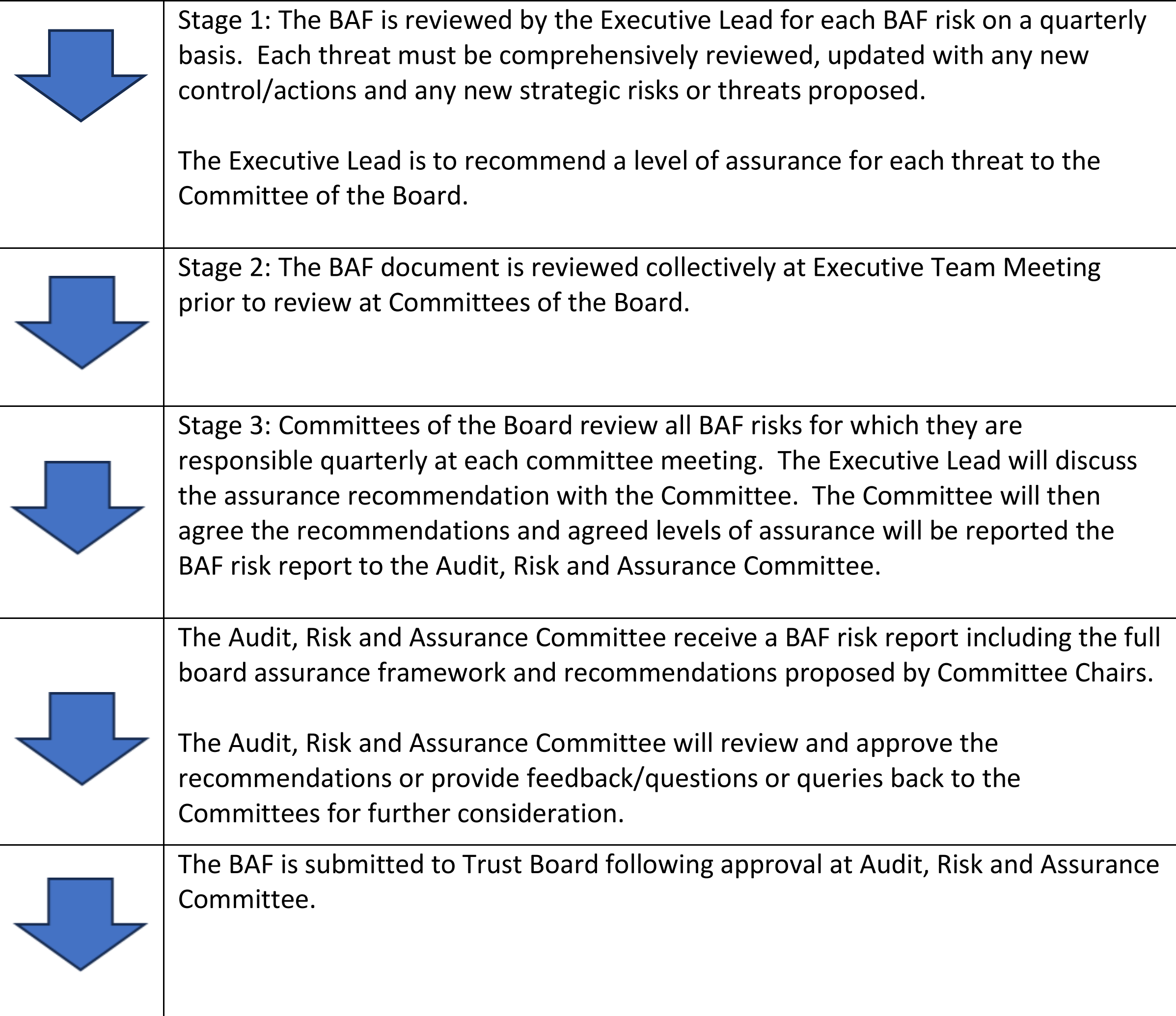
The 2024/25 Board Assurance Framework (BAF) has been re-designed to ensure it can effectively capture all the relevant information to allow effective discussion and assurance to be received by each Committee and Trust Board. This approach will support and inform the committee agenda and regular management 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.

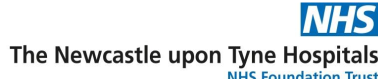
3.0 BAF RISK REVIEW

All BAF risks have been reviewed by each Executive Lead in November 2024. Below aims to give an overview of the Executive review and updates for each Committee.

Quality Committee

There is one strategic risk aligned to the Quality Committee, this relates to the inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients (1.1).

This risk has been reviewed by the Executive Director of Nursing and the Joint Medical Director. Following the risk review the key points to note are as follows:



- The current risk score remains at a score of 15 (5x3)
- 1 new threat has been identified and added to the Quality BAF relating to the Failure to embed effective systems and processes aimed at preventing avoidable Hospital Acquired Infections.
- 4 controls have been added, 3 relating to maternity services and 1 relating to the completion of a review of QoG activity.
- 4 actions timescales have been revised relating to baseline review of Trust non-compliance with standards/guidelines, clinical board leadership models, Level 2 MCA training programme and embedding real time learning disabilities audit framework.
- 1 new action has been added relating to the development of a Clinical Board QoG improvement action plan.
- Assurance ratings remain between amber and red.
- Action progress indicators - all actions are defined and are most progressing, where delays are occurring interventions are being taken.

People Committee

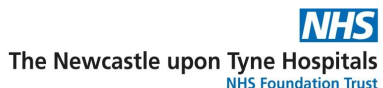
There are three strategic risks aligned to the People Committee, these relate to capacity and capability of the workforce (2.1), developing, embedding and maintaining organisational culture (2.2) and developing and implementing a new approach to leadership and organisational development (2.3).

These 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.
- 1 assurance rating relating to speaking up has been moved from Red to Amber.
- 5 Controls have been added relating to people plan, training workshops for managers and leaders, induction messages re behaviours, sexual misconduct policy and work in confidence system.
- 9 actions timescales have been revised, these relate to review of Privacy and Dignity policy (2 actions), Anti-racism policy, self-assessment of FTSU maturity, speak up information sheets, WRES and WDES action plan, FTSU champions recruitment and training (2 actions) and embedding of behavioural and civilities charter.
- Action progress indicators detail that all actions are defined and are most progressing, where delays are occurring interventions are being taken.
- 2 new actions have been added in relation to leadership development programme pilot and health and wellbeing bid to charity to support Health and wellbeing plan.

Finance and Performance Committee

There are three strategic risks aligned to the Finance and Performance Committee, these relate to managing our finances effectively (6.1), failure to achieve high performance standards (6.2) and failure to maintain the standards of the Trust Estate (5.1).



The Finance and Performance Committee BAF risks have been reviewed by the Director of Performance and Governance, Director of Estates and the Chief Finance Officer.

Following the risk review the key points to note are as follows:

- All current risk scores remain unchanged.
- 5 action timescales have been adjusted, 4 on 6.2 relating to failure to achieve high performance standards and 1 on 5.1 relating to failure to maintain the standards of the Trust estates.
- 4 new actions have been added to 6.1 managing our finances effectively, these relate to depth of clinical coding, financial sustainability, national budget setting and the further iteration of the long-term financial plan.
- 5 actions have been completed 4 on 6.2 failure to achieve high performance standards, these relate to capacity and demand analysis, short term plan for mobile MRI/CT, revised winter plan and confirmation of initial alliance projects. 1 action has been completed on 5.1 failure to maintain the standards of the Trust Estate, relating to completion of 3-year medical device asset replacement plan.
- Assurance ratings are predominately amber and red.

Digital and Data Committee

The Digital and Data Committee BAF risk has been reviewed by the Chief Information Officer however is not due to be reviewed by the Digital and Data Committee until December 2024.

An update will be provided following discussion at the Digital and Data Committee in on 12 December 2024.

Audit, Risk and Assurance Committee

There is one strategic risk aligned to the Audit, Risk and Assurance Committee, this relates to the failure to implement effective governance systems and processes (1.2).

Following the risk review the key points to note are as follows:

- The current risk score remains at a score of 16 (4x4).
- 3 action timescales have been amended relating to embedding incident reporting action plan, ward and department risk management and clinical board QoG improvement action plan.
- 3 new actions have been added relating to the Board Assurance Framework and Risk Management Internal audit assessment and the roll out of the new risk management system.
- 2 controls have been added relating to the review of QoG activity and the completion of the phase one corporate CQC action plan.
- 1 assurance has been added in relation to CQC action plan internal audit, substantial assurance received.
- Assurance ratings remain amber.
- Action progress indicators detail that all actions are defined and progressing where delays are occurring interventions are being taken.

5.0 RECOMMENDATIONS:

The Trust Board are asked to:

- Receive assurance from the Audit, Risk and Assurance Committee on the management of the Board Assurance Framework.
- Provide any feedback or comments.
- Approve the Board Assurance Framework document.

Report of:
Natalie Yeowart
Head of Corporate Risk and Assurance
21.11.2024

BOARD ASSURANCE FRAMEWORK
2024/2025 – NOVEMBER 2024.

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	05.11.2024	**Likelihood**	**4**	**3**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	05.11.2024	**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 -December 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. • Bi-annually learning disability assessment audit framework.	• Launch level 2 MCA training programme and mandate for all relevant staff by the December. • 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, ICB and national position still awaited – expected in Q4. • Embed quarterly real time learning disabilities audit framework. Q1 now complete, real-time process to commence October 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 Audit and Guidelines 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. • Stocktake of progress with clinical board QoGs. • Review of QoG activity presented to Quality Committee in October 2024.	• Clinical Audit and Guidelines 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 – Q4 Jan-March 2025. • Baseline review of Trust non-compliance with standards/guidelines, propose organisational approach to Quality Committee – December 2024. • Recruit and embed quality governance roles – January 2025. • Clinical Board QoG action plan – December 2024.	**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. • Existing medication governance and oversight structures. • Medicine Management Policies and procedures.	• Monthly audit data of ward and department compliance with core standards with dissemination of learning and action. • Policy audits undertaken and reported through medicines management committee. • Datix data and trends relating to medicines management reported and reviewed. • Peer review and external review reports and audit data.	• Actions as outlined in MMOG Action Plan. • Spot Check audit framework – review of 6 months data – April 2024.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

	• 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.	• CQC Delivery Group monitoring, reporting and minutes. • Compliance and Assurance Group reporting and minutes. • Quality Governance Structure via quality committee and Trust Board. • September Rapid Quality and Safety Review Audit Data.		
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 • Incident 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 of Perinatal Quality Surveillance metrics and Maternity Incentive Scheme. • Director of Midwifery appointed and in post. Real time patient/staff experience programme. • Workforce review including outputs of 2024 birthrate plus. • Refreshed perinatal governance structure aligned to themes of Three-Year Plan for Maternity and Neonatal care, reporting into Obstetric Board. • NENC Clinical Outcomes Dashboard and safety signal review process.	• Improvement action plan in place covering all core CQC must and should do. Signed off by ICB with monitoring and evidence reported exit criteria. • Staff wellbeing/Recruitment and Retention Improvement plan in place. KPI monitored and reported in Family Health Board and Executive Director of Nursing. • Obstetrics Board. • Reporting and oversight into Quality Committee and Trust Board • Maternity Services Quality Dashboard and NENC Clinical Outcomes Dashboard. • Annual CQC Maternity Survey results • CNST/MIS compliance. • Pulse survey results. • Incident data • Incident 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 Perinatal Quality Surveillance Metrics reported into Quality Committee – on track for completion, Phase one now complete, further development in Q3 – December 2024. • Completion of service wide staffing review and enact the recommendations by February 2025	**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 • Review infrastructure of quality oversight and local governance groups.	• 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.	• Design and implement a standardised quarterly quality and safety reporting mechanism for clinical boards to report into QPRs to commence Q4 Jan-March 2025.	**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 of PSIRF Priorities at Quality committee to ensure completion of key actions – 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 (April 2025) • Patient correspondence/letters audit to validate Clinical Board processes to maintain oversight of timeliness of completion of correspondence – December 2024. • Secondary review of all systems functionality in relation to patient correspondence/letters -January 2025 • Endorsing of laboratory results SOP to be agreed and approved – December 24.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Failure to embed effective systems and processes aimed at preventing avoidable Hospital Acquired Infections	• IPC Operational Group • IPC Committee and sub groups • Risk Register • Clinical Board Governance Meetings and Quality Oversight Group • IPC policies	• IPC Board Assurance Framework • IPC Operational Group and Committee minutes and action logs • Integrated Quality Performance Report with overview of HCAI metrics • Reporting and oversight into Quality Committee and Trust Board • Local, regional and national benchmarking data • Clinical Board QOG and Governance meeting minutes and action logs • Clinical Assurance Toolkit results • Rapid Quality and Safety Peer review results and action plans • Screening compliance • Quality and Performance review minutes and action log	• Ensure robust corporate and Clinical Board improvement plans in place in areas of high occurrence of CDI by November 2024 • Continue the rollout of ICNET to improve surveillance and timely intervention - June 2025 • Review and revise central IPC Team roles and responsibilities to maximise visibility and engagement - by March 2025 • Review and refresh Antimicrobial Stewardship Framework – November 2024.	**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	05.11.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	05.11.2024	**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 • Review of QoG activity presented to Quality Committee in October 2024. • CQC Corporate Action Plan	• 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 • CQC Corporate Action Plan Internal Audit – Substantial Assurance.	• Evaluate the implementation of revised integrated governance structure – Clinical Board Governance Internal Audit starting in November – audit report expected by January. • Clinical Board QoG action plan following review of QoG activity in October 2024 – December 2024. • Completion of TVC Governance Action Plan – December 2024.	**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, through Internal audit of BAF, Risk Management and Clinical Board Governance in November – report expected January 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.	• Embed incident reporting communication plan – June 2025. • 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 – Work now underway to roll out Inphase risk management system to include ward and department levels – Go live planned for April/May 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	Chief Finance Officer	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Finance/VfM
Date Added	01.11.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	01.11.2024	**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. Further work commissioned to look at depth of coding. Led by Clinical Coding Manager but ICB wide. Review end Nov 24.	**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. Draft report received, awaiting final following accuracy check -QIG meeting in mid-November (14th) to focus on financial sustainability • 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 – ongoing - All schemes reviewed in October 24, plan for mitigation agreed but mainly through non recurrent measures	**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. • Await national planning guidance following budget. • Further iteration of longer-term financial plan to take to Finance and Performance Committee in December 2024	**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. - ICB meeting held, further discussion at QIG, ICB have raised issue with national team, awaiting feedback • ICB wide review of impact of pay ward by end November 2024.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Insufficient capital funding required to invest in improvements to transform services and improve efficiency.	• Capital Management Group. • Capital Infrastructure Group.	• PLACE AND ERIC returns. • CMG report into Finance and Performance Committee	• Engagement with potential solutions to CDEL. Ongoing, meeting held with PWC re PPP.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

	• Annual capital plan including estates, medical equipment, IT and health and safety plus IFRS16. • ICS Infrastructure Board. • Cash forecast.	• Capital management audit by internal audit – Level of control needed. • ICS Infrastructure plan	• Review of annual capital plan required to ensure emerging pressures impacting CDEL are balanced through slippage - December 24.	**Cont/…**

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	05.11.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	05.11.2024	**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. • 62-day cancer performance improvement plans and trajectories. • 65-week cohort reduction trajectories with specialities completed.	• 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. • Performance Improvement Plans monitored via Finance and Performance Committee.	• Further development of the Integrated Quality and Performance Board Report next key update November 2024. • Develop Clinical Board Level reports – December 2024. • Review current information and performance reports to ensure they are fit for purpose – March 2024. • 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 January 25. • Outpatient capacity and demand analysis to be completed by the end of Q4 24/25. • Implement and evaluate new Emergency Department workforce rota, report to Finance and Performance Committee in November 2024. • Develop Service Review methodology and reviews, to start in April 25. • Review and monitor targeted cancer improvement plans. – 2 tumour groups via F&P. March 2025. **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. • Short term radiology MRI resource plan.	• Integrated Quality and Performance Board Report. • Monthly Integrated Quality Performance Reviews. • TMG Updates. • Clinical Board meeting minutes. • Weekly Activity and ERF (income) reports.	• Develop a new workforce model for Cardiac Physiology –January 2024 • Maximise utilisation of CDC – February 2025. • 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. • Winter planning.	• 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. • Winter Plan in place.	• Development of GP leadership roles for UEC and Community Care – December 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 and monitoring of Alliance plans for designated services – MD, CN and Ops leads identified – Initial tranche of projects agreed progressed/monitoring via the Bilateral Board.	**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	05.11.2024	**Likelihood**	**4**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	05.11.2024	**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. • Documentation Audit – Assurance level requested. • Staff Satisfaction Survey – Results requested	• Implement Oracle/Cerner Remote Hosting project – February 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 2023/24	• IT Security and Service Management Report to Digital and Data Committee. • Cyber Essentials Accreditation certificate. • Digital and Data Committee Minutes. • DSPT 2023/24 – substantial assurance.	• Review of current Cyber Security Policies– December 2024. • replace/update outdated systems and software, legacy hardware, and unsupported systems – TBC. • Implement process for the management of the inventory system – December 2024. • Plan to remove all devices over 5 years old – April 25 (residual estates expected to be 2027 devices)	**1-Fully on plan across all actions. - Exception will be the removal of all devices over 5 yrs old.**
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 – April 2025. • Develop Digital Strategy – April 2025. • Define measurability and track specific investments for Digital – December 2024.	**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	06.11.2024	**Likelihood**	**4**	**4**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	06.11.2024	**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 -delayed retender now Q4 2024. • 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. • 3-year medical device asset replacement.	• 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. • medical device asset replacement monitored via Capital/Financial planning meetings.	• Develop a risk-based medical device asset report to inform Clinical Boards of lifecycle replacement priorities -Jan 2025.	**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.	• 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.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

		• CQC Standards Assurance Group. • Trust Internal Audit Programme (AuditOne).	• Review and implement agreed improvements relating to Real 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 -plan for December 24, however under pressure at present.	**5- Actions not yet fully defined.**

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	29.10.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	29.10.2024	**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. • Premium pay as required to cover shortage areas. • Clinical workforce plans. • Staff survey (national and local). • Flexible working. • Vacancy control monitored by CFO and MD.	• Monthly Performance review meetings. • Retention data and exit interviews to people committee. • People metric data via the Integrated Board Report. • Staff survey uptake and results reported to people committee and local areas. • Pay Issues Subgroup in place (exec subgroup) • Vacancy levels monitored through finance committee. • Training data to people committee. • ICB /HRD oversight group.	• People dashboards to be developed for corporate areas – further work to strengthen into clinical boards and corporate areas - November 24. • Plans to develop local oversight arrangements for clinical boards and support services – January 2025.	**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.	• Monthly performance review groups. • Retention data and exit interviews to people. committee. • People metric data via the Integrated Board Report. • Staff survey uptake and results reported to people committee and local areas. • 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 new courses and Continued recruitment. • Implementation of workforce plan– ongoing monitoring at clinical board level to manage vacancy and staffing levels. - phase 1 develop from October 24, Phase 2 plans from January 2025.	**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	29.10.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	29.10.2024	**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.	• People Plan with a dedicated theme of Valued and Heard – with year 1 deliverable actions • 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 staff to provide anonymous concerns or 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. • 3rd CEO Roadshows to commence in September 24 to include "you said we did" campaign to feedback progress to staff.	• People Programme Board (operational group) - minutes and highlight reports. • Reports and minutes of Executive Team. • Minutes from TMG. • People Committee reports and minutes – including updates on Value and Heard Bimonthly. • CQC oversight group. • QIP oversight group. • ICB regional group. • Clinical and Corporate Town Hall events • Focus Groups to hear staff views (with external facilitation. • Annual Staff survey (national). • Quarterly surveys aligned to the People Plan. • Direct access to the CEO. • CEO roadshows. • CQC feedback. • JLNC and EPF.	• FTSU champions to be advertised in October 2024 recruited in November 2024. • FTSU Champions training November and December 2024. • Promotion of behaviours and civilities charter across the Trust including bespoke training to be completed by February 2024. • Annual Staff Survey promotion Oct-November 2024. • Embedding a staff and patient experience improvement programme March 2026. • National FTSU policy to be implemented into the Trust by December 2024. • X2 stakeholder events for speaking up to be run in November 2024	**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.	• People Plan with theme of Civilities and Behaviours and year 1 deliverable actions • Staff network groups with executive sponsors. • Equality, Diversity, and Inclusion Steering Group • Work in confidence system to report concerns. • FTSUG in place to report concerns. • Civilities and micro-aggression training. • Training 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. • Sexual Misconduct Policy in place.	• People Programme Board (operational group) - minutes and highlight reports. • 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. • Employee Relations data for People Committee.	• Action plan to improve WRES and WDES performance coproduced with staff networks – November 2024. • Review of Dignity and Respect Policy – with a focus on anti-racism – December 24. • Anti racism policy to be produced – December 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.	• Dignity and Respect policy. • People Plan with theme of Civilities and Behaviours and year 1 deliverable actions • Facilitated conversations and mediation. • Grievance procedure to raise concerns. • 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.	• Further embedding of the behavioural and civilities charter through people processes – November/December 2024 • Promotion campaign during September/October 2024 – 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 staff to raise concerns. • 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 8-point plan 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.	• Information sheets to be available for all staff to outline the various ways in which they can speak up safely – November/December 2024. • Implement speaking up 8-point plan programme from October 2024 – March 25. • Self-assessment on FTSU maturity to be undertaken -October 2024, report to Trust Board in January 2025. • 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	29.10.2024	**Likelihood**	**5**	**4**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	29.10.2024	**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.	• People Plan – identified theme of Leadership and Management with year 1 deliverable actions. • Training workshops for managers and leaders on people process issues aimed at supporting staff. • Interim leadership development strategy in place. • Job descriptions outlining leadership expectations. • Management structures in place within CB and corporate areas. • Clinical leadership model. • Data on people metrics: sickness, turnover, leadership, HWB. • Exit interviews. • Succession plans. • Leadership. competency framework for Board members. • Management skills sessions on HR processes.	• HR and OD support for managers. • Monthly operational performance review meetings. • 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.	• 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 until December 2024. • 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 – review in November/December 24. Roll out from January 2024.	**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.	• People Plan – identified theme of Health and Wellbeing with year 1 deliverable actions. • 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. • Gap analysis of HWB offer.	• HR and OD support. • HWB steering group – minutes. • Minutes from TMG. • People Committee reports and minutes. • CQC oversight group. • QIP oversight group.	• Health and Wellbeing bid to be made to the charity to support HWB plan – January 202. • Actions identified in people plan to be actioned.	**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/OD focus. • 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. • Leadership competency framework. Management skills training with focus on People over Process.	• 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	• Review of appraisal process for leaders and managers linked to the four themes of the People Strategy – pilot to run from June 2024 to December 2024 to inform new process from April 2025. • Leadership Development Training pilot to be run from June 2024 – December 2024. • for Board members – from April 2024. • Introduction of value/leadership competency into our recruitment processes – incrementally from June 2024, fully implemented by March 2025. • from August 2024 – November 2024. • Review of key HR policies and processes aimed at supporting staff – Ongoing from Sept- March 2025. • Review of dignity and respect policy – December 2024. • Anti-racism policy to be produced – December 2024.	**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	29.10.2024	Likelihood	4	3	2	Risk Appetite Tolerance	
Last Reviewed	29.10.2024	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.	• Chair and CEO member of Great North Healthcare Alliance Steering Group Committees in common. • CEO member of Provider Collaborative Leadership Board. • Lead director as part of Alliance Formation Team • Executive Directors leading appropriate Alliance work streams with peers. • Managing Director chairs Newcastle Place ICB Sub-Committee. • Alliance vision and 3 year work plan approved by Trust Board and supported by Council of Governors. • Great North Healthcare Alliance Steering Group Committees in Common Minutes • Great North Healthcare Alliance bi-monthly update to Trust Board and quarterly written update to Council of Governors. • ICB/Provider Collaborative and PLACE Minutes • Legal support to ensure legislative compliance with establishment of Great North Healthcare Alliance	• Development of NUTH Clinical Strategy – April 2025. • ICB engagement exercise with wider Alliance stakeholders to assure broader support – December 2024. • Alliance case for change and potentially updated Collaboration Agreement – January 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	
(blue)	New risk added since last BAF review.
(amber)	Current risk score reduced but still rated 15+
(green)	Current risk score reduced below 15.
(yellow)	Risk Tolerated - mitigated as low as reasonably possible.
(red)	Current 15+ risk score increased.
(grey)	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
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 Diagnostic 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 Diagnostic 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.	12 (20)
3886	Clinical and Diagnostic 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 Diagnostic 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.	4(8)

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 Diagnostic 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 Diagnostic 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
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
4422	Clinical and Diagnostic 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
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 Diagnostic 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
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.	12(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

4518	Surgery and Specialist Services	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.	12(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).	12(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.	12(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).	8(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.	12(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
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.	12(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 Diagnostic 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 Diagnostic 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 Diagnostic 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)
4007	Clinical and Diagnostic 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 Diagnostic 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 Diagnostic 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 Diagnostic 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 Diagnostic 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 Diagnostic 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).	12(15)

		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.	
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 Diagnostic 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.	12(16)
4569	Clinical and Diagnostic 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
4586	Medical Director	There is a risk to compliance due to an increased risk of potentially preventable hospital acquired thrombosis which could result in severe or fatal patient harm, increased incidents and/or increased claims.	16
4605	Cardiothoracic	There is a risk to Quality Safety and delivery of the Inherited Cardiac Conditions (ICC) Service, which is caused by a lack of funded capacity across the ICC Multi-disciplinary team, which is outweighed by service workload/demand. which could result in non-delivery of service standards, and increased risk to patient care due to delayed diagnostics and treatment times.	15
4608	Perioperative and Critical Care	There is a risk to compliance and regulation which is caused by inadequate facilities on ward 38, RVI, which fails to meet the standards outlined in GPICS v2.1 (2022) and the faculty of intensive care medicine (2019). The primary reasons for non-compliance are in relation to lack of space to accommodate the equipment required to care for patients in multi-organ failure or support patient rehabilitation. Inadequate storage for medicines also does not comply with the standards required of the HBN 00-033. This could result in a substandard patient and staff experience, poor compliance with NICE guidance for early rehabilitation and non-compliance with NHSE guidance for medicine storage.	15
4615	Surgery and Specialist Services (Ophthalmology)	There is a risk to patient's patient safety, from being lost to follow up and not receiving appropriate clinic care. This risk is caused by being unable to identify who requires care from a cohort of 31000 open clinical pathways that have not been actioned correctly in the Ophthalmology department.	20

Finance Committee			
Risk ID	**Clinical Board/Corporate Directorate**	**Risk Description**	**Current Risk Score**
4392	Information Technology	There is a financial risk to the Trust, which is caused by a 5-year contract ending, meaning the Trust will be wholly responsible for future liabilities for licensing/funding, covered under this agreement after 31 March 2028. This could result in additional annual costs of £4.3M.	20

Audit, Risk and Assurance Committee			
Risk ID	**Clinical Board/Corporate Directorate**	**Risk Description**	**Current Risk Score**
3774	Clinical and Diagnostic 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 Diagnostic. This could result in suspension of all Clinical Diagnostic activity, patient safety issues due to other clinical services not being aware of Diagnostic activity, and reduction in Diagnostic 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 Diagnostic 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
4620	Clinical and Diagnostic Services	There is a risk to our compliance with the HTA standard for tissue retention and disposal and to the Trust's reputation which is caused by a lack of a nominated individual to ensure tissue is disposed of correctly and in a timely manner which could result in tissue being disposed of incorrectly or kept with no lawful reason.	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 Diagnostic 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 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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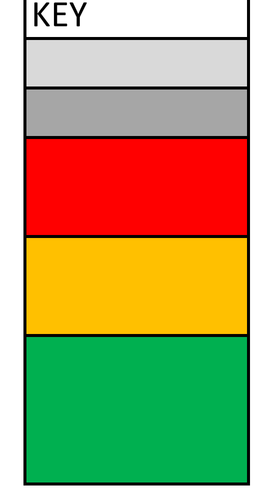
PUBLIC BOARD MEETINGS - ACTIONS

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. 27.10.24 - Agreed to close this action. Reports will no longer be presented to the Trust Board as they do not require approval.
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. 27.09.24 - CB advised that key messages were now being shared from the Staff Facebook page, increased staff communications and triangulated with other feedback mechanisms. The staff survey will launch on 7 October and the impact of the People Plan will be discussed regularly at the People Committee. Agreed to close this action.
124	27 September 2024	Consultant Appointments	KJ to facilitate the signing of the agreed Appraisal and Revalidation Annual Report and Compliance Statement by the CEO.	KJ			02.10.24 - Action complete. Propose to close.
125	27 September 2024	Guardian of Safe Working	KJ to feedback the request to the GOSW to include s summary of trends in the report to show how the data differs to the previous quarter.	KJ			02.10.24 - Action complete. Propose to close.
126	27 September 2024	EDoN Report	Ian Joy and Christine Brereton agreed to share in more detail with Liz Bromley the work underway to maximise apprenticeships and some of the challenges faced in sustainable delivery.	IJ/CB			03.10.24 - IJ to contact LB to discuss. 29.10.24 - A meeting has been arranged to discuss following the Trust Board on 29 November. Propose to close action.
127	27 September 2024	Board Visibility Programme	KJ to feedback the request to include key themes in the main Public Board report and to ensure that the detailed Appendix is included in the Reading Room going forwards.	KJ			02.10.24 - Action complete. Propose to close.
128	27 September 2024	SHINE Report	PE requested that the Executive Team discuss the risks highlighted in James Dixons presentation and feedback to Board members thereafter.	VMR			03.10.24 - VMR & JD to meet on 22 October and confirm a date to be presented at the Executive Team / Board. 28.10.24 - JD will be attending the Executive Team Meeting on 27 November to discuss 'Sustainability: Risks and Governance update'.

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.