BRP - Agenda item A7			
Annual Financial Business Plan (Financial Management)			
n0	Please confirm the LCRN name	CRN North East and North Cumbria	
n1	Please confirm the funding principles of the LCRN 2022/23 local funding model	The principles have changed from the previous model. We moved away from an 80% fixed/20% variable (using historical Complexity Adjusted Recruitment - CAR) model. For the 2022/23 local funding model we retained an 80% fixed/20% variable approach, but (for part of the variable element) we benchmarked Partner Organisations (PO) against their own historical performance using the average number of accruals per quarter in a 12 month period (Q3 2020-21 to Q2 2021-22) as their benchmark. Data on a) predicted recruitment & b) potential pipeline were combined to produce a 'forecast figure'. If this figure was greater than or equal to the benchmark figure (for Q4 2021/22 and Q1 2022/23) the full 20% variable allocation would be made to the PO. Should the pipeline figure be below (i.e. forecasting to do less recruitment activity) then from the 20% variable element we removed 5% (approximately equivalent to 1% of total baseline budget). The monies that this generated was made available to all POs as part of a larger contingency funding call in Q4 2021/22 to be released on 1st April 2022/23.	
n2	In respect of the LCRN 2022/23 **loca**l funding model, please complete the following table* by entering the proportion of LCRN funding (%) within the funding elements detailed. If there are any other elements to the model please describe what this is for and the proportion of funding allocated to this		
n3	As stated in the LCRN Minimum controls, the Local Funding Model must be publicly available in a stand-alone document.	Text found here https://docs.google.com/document/d/1B00HilzPe2TuzqetaWKVCXNx5N88d-1QD9sUROr0hXM/edit) This is in the process of being added to the LCRN web pages as occurs annually.	
n4	Please provide the pros and cons of the 2022/23 LCRN local funding model, and include constraints you face whilst determining the model	Pros: This new model has given us the opportunity to move away from making future investment on historical performance. It ensures stability of the research delivery workforce (maintaining the 80% fixed income) and maximises opportunities for growth including responding to in year opportunity (contingency funding available in Q1 gives an meaningful funding timeframe for team/portfolio growth). UPH research skewed CAR to the 'non-NHS portfolio' so this needed to be balanced by redistributing this 'pro rata' across Partners who had contributed to UPH research. This favoured some Partners and so a cap was applied to ensure a proportion of this additional funding was added to the contingency funding and open to all. This is a model that allows an element of investment for growth. Partners are now 'competing' against themselves rather than other partner organisations. This model encourages partners to enter accurate study data (targets and dates) into LPMS and reinforces the need to actively manage their portfolio and to enable us to better plan and support growth. Cons: One concern/drawback about 'future' recruitment is that Partners may not deliver on their pipeline. The projected recruitment activity will be monitored to ensure that what was planned to happen does happen. Should there be slippage due to issues outside the direct control of the PO (e.g. a large study closes early) then this will be taken in to account. The model requires POs to maintain accurate data in LPMS and therefore we need to have continued engagement and support to do this if the approach is to be sustained longer term.	
n5	In which financial year did your previous internal audit take place?	2021/22 (Audit conducted March 2022 - awaiting outcome).	
n6	If the next internal audit is due in 2022/23, please give the estimated date of the audit	N/A - see above	

n7	Please provide detail to explain how the 2% ring fenced budget for under-served communities will be allocated to LCRN core team / LCRN partners, including the proposed initiatives. Link to final guidance	Link to local plan and national projects. Funding specifically for a Targeting Health Needs (THN) call for 2022/23 (£273k) and continuation of awards made in 2021/22 (£118k). 2 LA Research Operations Officers (£79k), Social Internship Scheme (£62k), Deepened Project (Primary Care Deprived Communities) (£24k), VONNE PPI Role (£5k). Total spend = £561k (2% spend = £399,533 minimum)
n8	Please describe the expected outputs and/or outcomes of the 2% ringfenced budget for under-served communities, including the relevant financial period in which the outputs/outcomes will be achieved. Link to final guidance	*Link to local plan and national projects.* https://docs.google.com/document/d/12zMF6vjtWY72FYTd9T-SZjkwVrd8zHtF_61eJaSJ3OM/edit and https://docs.google.com/document/d/1ISQHgp0Anv0DSxT-oTgXp_Qny-UZ1sXHFaZfg0aNxXE/edit?usp=sharing The aim of the THN awards is to support the development of research that addresses the unmet health needs of local populations based on two categories: Category A) Bringing clinical & applied research to underserved communities with major health needs (i.e. specialties, especially: cancer including surgical oncology, diabetes, respiratory, heart disease, stroke, mental health and dementia) Category B) Building capacity & capability in preventative, public health & social care research (public health, non-NHS and social care) Outcomes expected from end of 2022-23 depending on the nature of the planned activity. Outputs from the investments into the Local Authority ROO posts and the Internship Scheme include their evaluation and recommendation as to the impact of these roles will be available in Q4. Deepened Practice paper https://docs.google.com/document/d/1oO2TRXJYeNRocYd4BF26KRsIqFwg48sT/edit?usp=sharing&ouid=114441790456847989973&rtpof=true&sd=true Support for link role in Voluntary Sector to facilitate access to marginalised communities across the region https://docs.google.com/document/d/1vVo9pLPDGqErO9MX5yvsA9GrpqHwjVqf/edit?usp=sharing&ouid=114441790456847989973&rtpof=true&sd=true
*Notes	1. It is assumed that the local funding model is net of any national top-sliced funding as this is pass through cost	
	2. If the funding element category is not applicable to your local funding model, please enter 0%	
	3. The percentages (%) entered in the table should equate to 100%	

Funding Element	Examples	Description of model	% of Total CRN Funding Budget 2022/23 Budget (Please note that these should total
Host Top-sliced element	Core Leadership team,	Funding to support IT/HR and Finance in Host Org. Leadership and	14.67%
Block Allocations	Primary care, Clinical	Partner Orgs determine level of funding to support	0.38%
Activity-based	Recruitment, number of	may not yield noticeable change in recruitment number, study number or	17.38%
Historic Allocations	PO funding previously	To maintain staffing stability funding is allocated to PO based on 80% of	52.05%
Performance-based	Performance metric, i.e.		0%
Population-based	Adjustments for NHS		0%
Contingency / Strategic Funds	Funds to meet	Strategic funding available to Executive Group to support initiatives in-	3.34%
Agile Workforce	Transformation	A new Direct Delivery Team has been created in 2021/22 to include	4.14%
Other funding allocations		Support for Principal Investigators top-sliced (£1.6m for 2022-23) and	8.04%
Total			100.00%
Cap and Collar	Please provide your upper and lower limits if applicable	not required in current model	

Comments

2021/22 CRN North East and North Cumbria Highlight Report (Annual Report)

Industry:

- Investigator Initiated Trials and MedTech Studies -
  - The MedConnect North service (collaboration between CRN NENC & AHSN NENC, hosted by South Tees NHS FT) supported funding applications totalling £2,862,720.00. Over 90% of applications were successful securing £2,581,222 of funding for the region.
- Automated Expression of Interest (AEOI) system -
  - The CRN NENC digital AEOI system was successfully adopted. It removes much burden from the process and increases quality and consistency, resulting in an 8% increase in EOI submissions from Partner Organisations.
- Commercial First Patients Recruited (Study level) - 2 Global, 1 European, 13 UK

Primary Care:

- More than 50% of CRN NENC GMPs are NIHR research active -
  - Nationally noted performance on the PRINCIPLE trial - 213 recruits & PANORAMIC - 310 participants across 5 Hubs to the Molnupiravir arm
- Barriers and facilitators to primary care research -
  - CRN NENC work with GP Trainees & Trainers was published in the BJGP Open.

EDI:

- Targeting Health Needs Awards -
  - 12 projects awarded funding (£261,744) to support research in agreed local priority areas based upon regional needs
- Palliative Care -
  - Successful collaboration with Newcastle University is securing funding for an NIHR Palliative and End of Life Care Research Partnership
- Care Home Research
  - 29 new Care Homes signed up to ENRICH in year, 25 were research active

Pan NIHR working:

- Research Partnerships Coordinator post -
  - A collaboration between the ARC, BRC, RDS, LCRN funded a new post in VONNE (Voluntary Organisations' Network North East).
- NIHR NENC infrastructure brochure -
  - The NIHR Regional Communications group (CRN NENC led) compiled and launched the first comprehensive 'Who's who' in NIHR NENC.
- Targeting scoping exercise to showcase examples of existing good practice -
  - A collaboration with ARC (Research Fellow) and Strategic Theme Co-Lead

Investment in future Leaders:

- NIHR-AoMRC Clinician Researcher Credentials Framework -
    - Effective working relationships between CRN NENC and the Universities of Newcastle and Exeter to develop and promote 2 Postgraduate Certificate courses. 41 applications have been received to date for the Newcastle programme.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022						
Title	Guardian of Safe Working Hours Annual Report						
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours						
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The terms and conditions of service of the new junior doctor contract (2016) require a consolidated annual report on rota gaps, and the plan for improvement to reduce these gaps to be included in the Trust's Quality Account. This report addresses the requirement for the year from April 2021 to March 2022 for consideration by the Board of Directors.						
Recommendation	The Trust Board is asked to note the content of this report for inclusion in the Trust's Quality Account.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☐	☐
Impact detail	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	Extract included in the Annual Report and Accounts presented at the Trust Board on 31 May 2022. Annual Report of the Guardian of Safe Working Hours. Report presented to the June People Committee meeting.						

GUARDIAN OF SAFE WORKING ANNUAL REPORT

1. EXECUTIVE SUMMARY

The purpose of this annual report is to highlight the vacancies in junior doctor rotas and steps taken to resolve these during the year from April 2021 to March 2022.

Rota gaps on actual working rotas are also influenced by sickness absence, individualised working requirements, and changes in working patterns due to changes in educational and rest requirements. These additional factors influencing the gaps in service coverage are not outlined in this report.

Where vacancies exist, the gaps in service coverage are mainly addressed by rewriting work schedules, redeployment of doctors to areas of greatest clinical need and the use of locums, mainly from the internal locum bank. In some areas we are seeing trainee shifts being covered by consultants when junior doctor locums are unavailable.

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

- Cardiothoracic surgery – due to the postgraduate doctors in training removal by the Lead Employer Trust.
- Ophthalmology – due to the large numbers of locally employed doctors required resulting in recurrent recruitment drives
- Acute Medicine – due to the large numbers of doctors required to accommodate the workload.

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

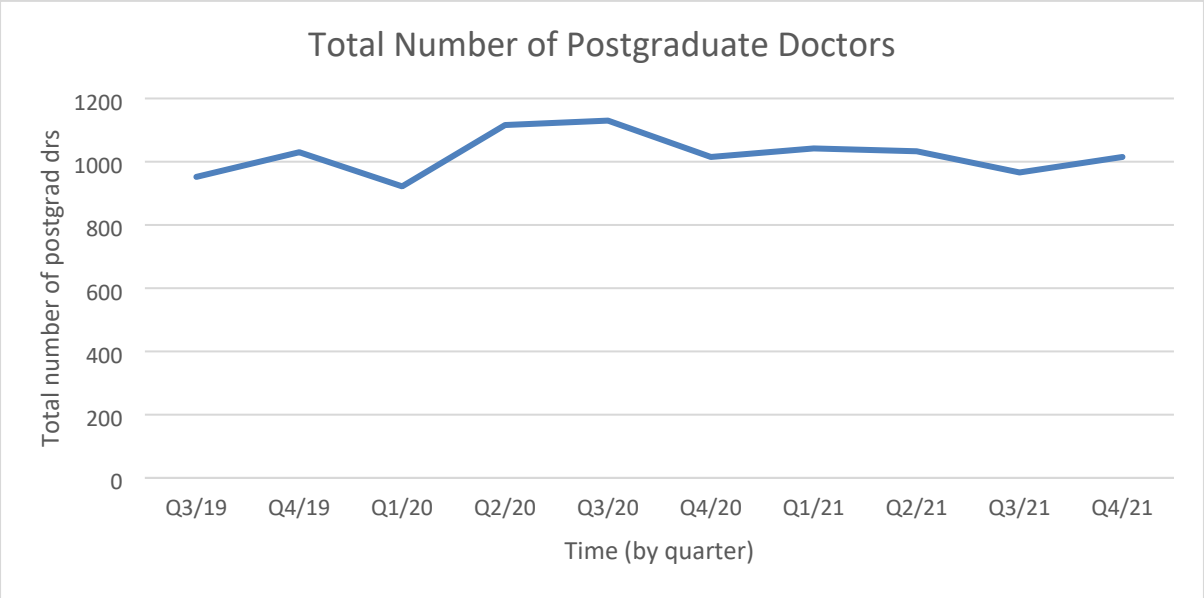
2. INTRODUCTION / BACKGROUND

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

3. HIGH LEVEL DATA

Number of postgraduate doctors / dentists in training on 2016 TCS:	800
Number of postgraduate doctors on 2002 TCS:	205
Total number of postgraduate doctors / dentists:	1,005

3.1 Trend of Number of Postgraduate doctors by quarter:



This data shows a stable number of postgraduate doctors within the Trust. Personal communication and the opinion of medical staffing is that they have seen a reduction of postgraduate doctors leaving due to travel restrictions caused by COVID-19. There was a reduction in overseas recruitment prior to the pandemic caused by Brexit.

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

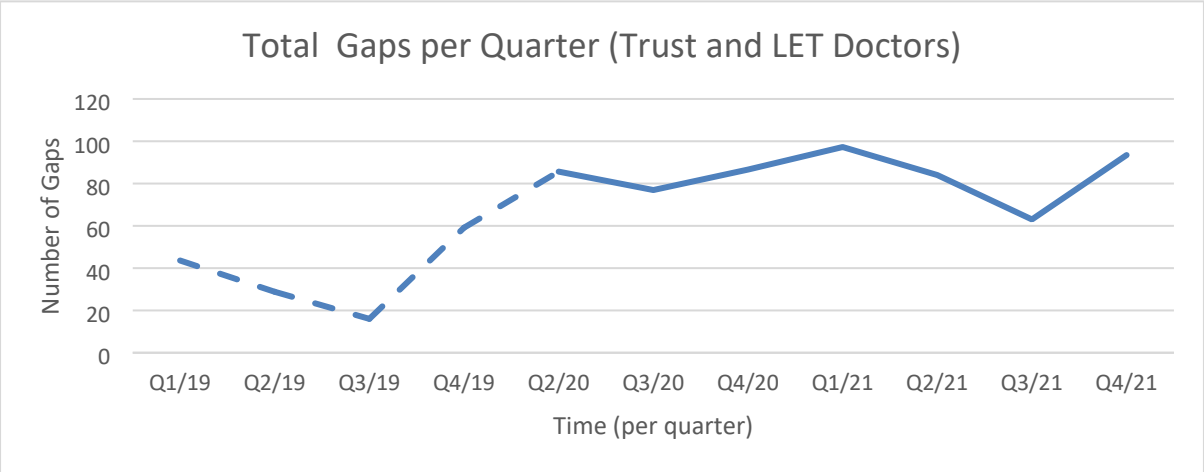
Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Q4	Q3	Q2	Q1
	Cancer Services						
FH	Oncology	ST3+	14	0.6	1	1.2	1.3
FH	Palliative Medicine	F2/ST1+	13	1.1	1.1	2.5	3.1
FH	Haematology / Oncology	F2/ST1/ST2	10	1.6	1	0.3	1
FH	Haematology / Oncology	CMT	4	1.2	0	0.1	0
FH	Haematology	ST3+	10 (from Jan 2021)	1	1	2	1.7
	Cardiothoracic Services						
FH	Cardiology	F2/ST1-2	4	1	1	1	1
FH	Cardiology	ST3+	15	1.6	0.6	1	1
FH	Cardiothoracic Anaesthesia	ST3+	9	3	0	1	1
FH	Cardiothoracic Surgery	F2/ST1-2	2	2	2	1.3	0
FH	Cardiothoracic Surgery	ST3+	11	2.6	3	2.3	4
FH	Cardiothoracic Transplant	ST3+	3	1	0	0.3	1

Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Q4	Q3	Q2	Q1
FH	PICU	ST3+	9 (inc day cover with GNCH & Paeds Cardiology	0.8	0.8	0.6	0.5
FH	Paediatric Cardiology 1st	F2/ST1/ST2	7	0.4	0	0	2
FH	Paediatric Cardiology 2nd	ST3+	9 (from Jan 2021)	0	0	0.7	2.5
FH	Respiratory Medicine	ST3+	11 (rotate with RVI)	0	0	0.4	0
	Children's Services						
RVI	Paediatric Surgery 2nd	ST3+	9 (8 from Nov 20)	1	0.6	1.6	1.1
RVI	Paediatrics 1st - ST1/ST2 (now inc Paeds Surgery)	F2/ST1/ST2	30	2	0	2.2	2.8
RVI	General Paediatrics	ST3+	20	1	1.1	1.7	3.5
RVI	Paediatric ICU (PICU)	ST3+	9	1.4	0	1	0
	Dental						
RVI	Oral Maxillofacial Surgery	ST1/ST2	8	0	0.6	0.6	0
	EPOD						
FH	ENT	F2 / CST / ST1-2	6	2	1	0.3	1
FH	ENT	ST3+	9	0.2	0	0.4	0
RVI	Plastic Surgery	F2/ST1/ST2	10	2	2.3	2.3	1
RVI	Plastic Surgery	ST3+	14	1	1	2	2
RVI	Ophthalmology	F2/ST1/ST2	5	0.1	0.7	1	1
RVI	Ophthalmology	ST3+	24	2.9	1.2	4.4	5.6
RVI	Dermatology	ST3+	9	2.4	1	1.5	1.8
RVI	Dermatology	CMT	2	0.2	0	0	0
	Integrated Lab Medicine						
RVI	Histopathology	ST3+	14	2.3	2	2.5	3.5
RVI	Histopathology	ST1/2	8	1.6	0	2	2
C4L	Genetics	ST3+	4	0.4	0	1.7	1.7
RVI	Medical Microbiology integrated with Infectious Diseases and Medical Virology and General Internal Medicine	ST1+	21	2	0	0.5	1.4
	Medicine						
FH	General Internal Medicine	F2/GPVTS/CMT/TF	19	2	0	0.6	1.2
RVI	Acute Medicine	Trust Doctors	9	2	2	2.6	4
RVI	Core Medical Training	CMT	11	0	0	0.5	0.9

Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Q4	Q3	Q2	Q1
FH/RVI	F2	F2	4 (3 posts December to March)	0.2	0.2	0	0
RVI	Core Medical Training – Acute Care	CMT	3	0	2	0	0
RVI	ACCS on Assessment Suite Only	ACCS	3	0.1	0	0	0
RVI	General Internal Medicine	ST3+	23	3.5	3.2	3.1	3
FH	Gastroenterology	ST3+	7	0	0	0	1.4
FH	Care of the Elderly	ST3+	5	0.2	0.6	2	1.8
RVI	Accident & Emergency 1st	F2	7	0	0	0	0
RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	21	3.6	2.7	2.4	1.3
RVI	Accident & Emergency 2nd	ST3+	15 (14 from Nov 20)	4	4	3	2
RVI	Accident & Emergency	F2 GP Placement	12	0	0	0	0
	Musculoskeletal						
FH	Rheumatology	ST3+	5	1	0	0.6	0.3
FH	Rheumatology	CMT1-2	4	2	0	0.3	0
FH	Orthopaedics	F2/ST1/ST2	6	1.6	1.3	1	1.6
RVI	Orthopaedics	F2/ST1/ST2	5	1	0.6	0.3	1
RVI/FRH	Orthopaedics	ST3+	19	1	0	0.7	1.4
RVI	Spinal Surgery	ST3+	1	1.6	0	1.3	0
	Neurosciences						
RVI	Neurosurgery	F2/ST1/ST2	7	2	0.6	0	1.3
RVI	Neurosurgery	ST3+	14	1	1.5	1.7	1.3
RVI	Neurology	ST3+	13	0.2	0.2	0.4	0.5
RVI	Neurology	IMT/CMT	3	0	0.6	0	0
RVI	Neurophysiology	All grades	2	1.2	0	0.8	1.4
	Peri-operative FH						
FH	Critical Care	F2 ST1-7	11	3	0	2.3	2.3
FH	Anaesthetics General	ST1-7 CT1-2	29	2.4	2.2	1.4	1.4
	Peri-operative RVI						
RVI	Critical Care	ST1+	19	5.4	2.6	3.7	2.5
RVI	Anaesthetics	ST1-2 / ST3 +	44	3.6	2.2	2.4	1.6
	Radiology						
RVI / FH	Radiology On Call	ST2 / ST3+	33	0.4	0.4	0.4	0.7
RVI / FH	Neuroradiology	All grades	3	0	0	0.3	0.6
	Surgical Services						

Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Q4	Q3	Q2	Q1
FH	General Surgery	F2/ST1/ST2/NSR	7	1	0.3	0.6	0
FH	Vascular	ST3+	10.5	1	1	1.3	2.1
FH	Hpb / Transplant	ST3+	11	0	0.6	0.3	1
RVI	General Surgery	F2/ST1/ST2	7	2	2.6	1.6	0.3
RVI	General Surgery	ST3+	13	0.4	2	1.8	1.3
FH	IoT - NSR & Teaching Fellows	ST1-2 NSR TFs	4	0	0	0.3	0.6
	Urology & Renal						
FH	Renal Medicine	F2/ST1/ST2	5	0	0	0.3	0.7
FH	Renal Medicine	ST3+	9	0	0	0.4	1
FH	Urology	F2/ST1/ST2	8	0	1	0.6	0
FH	Urology	ST3+	11	0.6	0	0.4	1
	Womens' Services						
RVI	Obstetrics & Gynaecology	F2/ST1/ST2	14	0.6	1	0.7	2
RVI	Obstetrics & Gynaecology	ST3+	22	0	1	1.2	2.2
RVI	Neonates	F2/ST1/ST2	7	0	0	0.3	1.1
RVI	Neonates	ST3+	13	0.8	0.8	0	0.2
	Foundation Year 1						
FH	General Internal Medicine - BOH	F1	8	1	0	0	0

4.1 Trends in rota gaps



The total rota gaps have remained quite stable since Quarter 2 (Q2) 2020. Quarter 1 (Q1) 2020 data is not available, as this was the time of mass redeployment of doctors. The data prior to 2020 must be interpreted with caution, as the data gathered was incomplete. Further trends in areas of persistent or recurrent concerns are detailed in the Appendix to this report.

5. ISSUES ARISING

The purpose of this report is to highlight any current issues or concerns, including the reasons for the gaps, obstacles in resolving this and actions taken to resolve the issues. Travel restrictions due to the COVID-19 pandemic has resulted in difficulties in recruitment of overseas doctors. This has impacted more on specialties which rely on overseas doctors to fill vacancies.

LED = Locally Employed Doctor
LET = Lead Employer Trust
ACCP = Advanced Critical Care Practitioner

Site	Specialty/Sub Specialty	Reason for Gap	Obstacles to Recruitment	Actions taken to overcome obstacles
	Cancer Services			
FH	Haematology/ Oncology	Teaching fellow left, less than full time staff in full time posts	Lack of suitable candidates	Creation of posts with specialist interest (research) and short-term cover from internal locum bank
	Cardiothoracic Services			
FH	Cardiothoracic Anaesthesia	LEDs leaving	Difficulty in recruitment of suitable candidate. Issues with overseas recruitment due to ongoing pandemic and visa issues	Recent appointment and further interviews pending
FH	Cardiothoracic surgery/ transplant	Postgraduate trainees removed by LET	Difficulty in recruitment of suitable candidates. Overseas candidates – visa issues	Use of Agency locum
	Children's Services			
RVI	General Paediatrics	Unknown		Accommodating workload within current workforce. Creation of new posts with specialist interest (sustainability)
RVI	PICU	LET gaps	Problems recruiting suitable candidates	LED appointed, ACCPs appointed – in training
	Plastic Surgery & Ophthalmology			

Site	Specialty/Sub Specialty	Reason for Gap	Obstacles to Recruitment	Actions taken to overcome obstacles
RVI	Ophthalmology	LEDs leaving (contract expired) /Natural turnover. Increased numbers required to tackle backlog of work	High numbers required	LED posts advertised
FH	ENT	Unknown		Accommodating workload within current workforce. Internal locum cover
RVI	Plastic Surgery	Unknown		Accommodating workload within current workforce
RVI	Dermatology	Unknown		Accommodating workload within current workforce
	Laboratory Medicine			
RVI	Histopathology	Unknown		Accommodating workload within current workforce
RVI	Medical Microbiology	Unknown		Accommodating workload within current workforce
	General Internal Medicine			
RVI /FH	General Internal Medicine/Care of the Elderly	LEDs leaving, LET gaps, GP training gaps. Extra LEDs advertised to accommodate COVID	Full 'Covid' cohort not recruited.	Teaching fellows, working with available workforce to cover workload
	Accident & Emergency			
RVI	Accident & Emergency	New jobs approved, not yet recruited, LET gaps, natural turnover	-	Further Trust Grade and fellow posts advertised. Use of locums.
	Musculoskeletal			
FH	Orthopaedics	LED leaving, gaps in local training scheme, LET gaps	-	Teaching fellow advertised
FH	Rheumatology	LED leaving		New post approved 'digital fellow'
	Neurosciences			

Site	Specialty/Sub Specialty	Reason for Gap	Obstacles to Recruitment	Actions taken to overcome obstacles
RVI	Neurosurgery	unknown		Working with available workforce to cover workload
	Perioperative			
RVI	Critical Care	LET gaps and LEDs leaving (contracts expired). Extra LEDs approved to accommodate covid but not recruited to may make numbers of gaps appear artificially high	Full 'Covid' cohort not recruited.	LEDs recruited. Accommodating workload within current workforce. Use of internal locums
RVI	Anaesthetics			
FH	Critical Care			
	General Surgery			
RVI	General Surgery	LET and LEDs leaving	Visa issues for overseas candidates	Teaching fellows, Specialty fellows and Newcastle surgical rotation appointments

5.1 Actions taken to resolve these issues

The Trust takes a proactive role in management of vacancies with a coordinated monthly junior doctor recruitment and education meeting. Members of this group include the Director of Medical Education, as well as finance and medical staffing representatives.

In addition to recruitment to postgraduate doctor posts, the Trust runs a number of successful Trust based training fellowships and a teaching fellow programme.

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

5.2 Locum Spend 01.04.21 – 31.03.22

Lead Employer Trust: £1,572,158
NUTH: £2,605,543

Total:	£4,177,701

Locum Spend 01.04.20 – 28.02.21

Lead Employer Trust:	£844,508
NUTH:	£1,422,739
Total:	£2,267,247

6. SUMMARY

Vacancies are present on a number of different rotas. This is due to both gaps in the regional training rotations and lack of recruitment of suitable locally employed doctors.

Overseas recruitment often results in a delay between recruitment and appointment due to visa issues.

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

Whilst this report outlines vacancies, this is only part of the picture of where gaps are on actual working rotas. Short term sickness, individualised working requirements, and the requirement for postgraduate doctors in training to spend increased time on non-patient facing activities all impact the numbers of doctors working on the ward and on patient facing duties.

Locum use is high in many areas, and many directorates reported consultants covering junior doctor shifts. Short term staffing issues have been exacerbated by the Coronavirus pandemic and high levels of sickness absence. The use of internal locums has an impact both on training and workload of junior doctors. The use of consultants to cover these shifts will also impact on the workload of consultants.

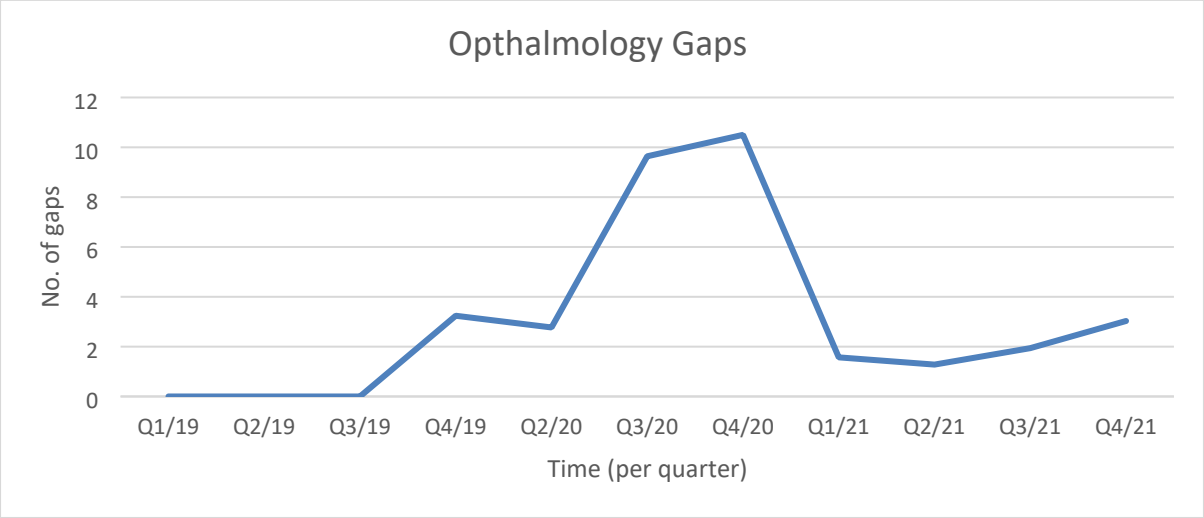
7. RECOMMENDATIONS

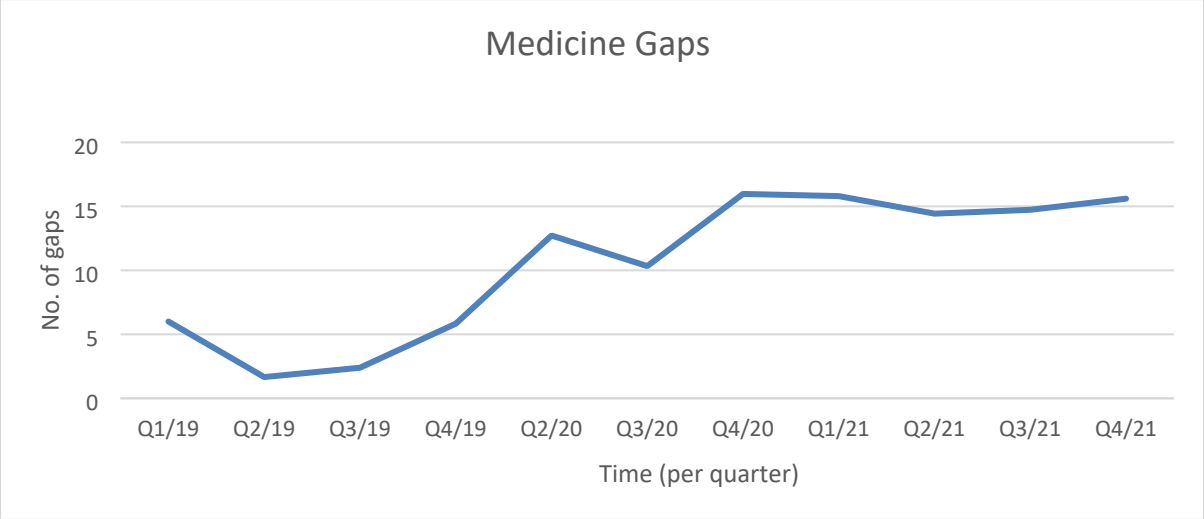
The Board of Directors are asked to (i) note the content of this report for inclusion in the Trust's Annual Quality Account and (ii) to encourage pro-active recruitment of doctors to reduce vacancies (iii) to consider the impact of changes to the rest and educational requirements of postgraduate doctors in training on the workforce workload balance, and encourage proactive recruitment of doctors to mitigate for this to ensure continued safe and sustainable staffing levels.

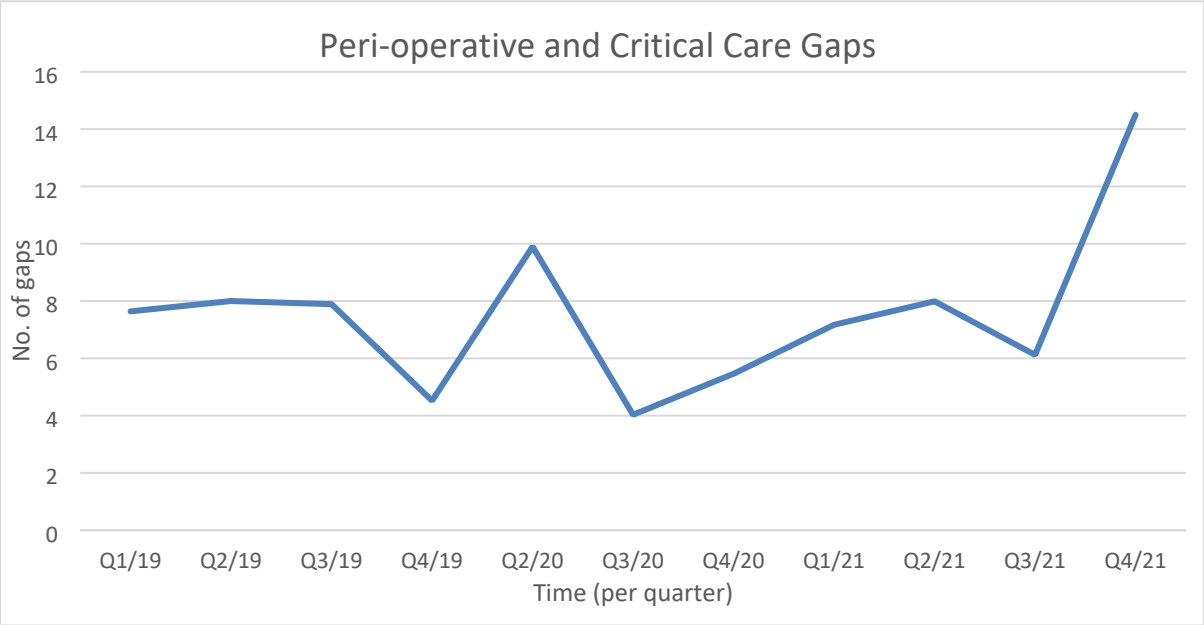
Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
6 June 2022

Trends in Rota Gaps in Areas of concern

These graphs outline the trends in rota gaps since 2019. As explained in my report, data from 2019 must be interpreted with caution, as the methods of capturing this were being refined. The data may therefore be inaccurate.

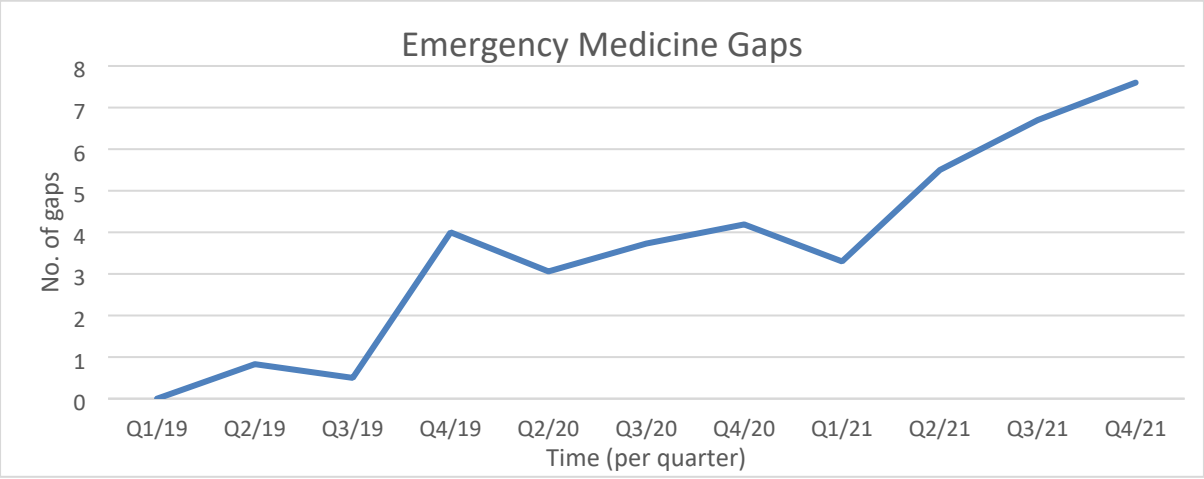






Site	Specialty/Sub Specialty	No of posts establis hed for	Grade	2019	2022
	Perioperative and Critical care				
RVI	**Critical Care**	**11**	**ST3+**	**11**	**19**

The current appearance of an increase in gaps in perioperative and critical care may be due to increased numbers of available posts. Extra posts were approved in anticipation of extra critical care capacity requirement for Covid. The large increase in Q4 ’21 may be due to these approved posts not being required, and therefore not being filled.



In Emergency medicine, new posts were created to accommodate changes in the rota required for compliance with the Junior Doctor Contract. Some of the increase in gaps can therefore be explained by the increase in available posts which have not been filled, rather than a reduction in actual numbers of doctors.

THIS PAGE IS INTENTIONALLY BLANK

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022						
Title	Consultant Appointments						
Report of	Andy Welch, Medical Director						
Prepared by	Claudia Sweeney, Senior HR Advisor (Medical & Dental)						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The content of this report outlines recent Consultant Appointments.						
Recommendation	The Board of Directors is asked to review the decisions of the Appointments Committee.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. People – Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☐	☐	☐	☒	☐	☐	☐
Impact detail	Ensuring the Trust is sufficiently staffed to meet the demands of the organisation.						
Reports previously considered by	Consultant Appointments are submitted for information in the month following the Appointments Panel						

CONSULTANT APPOINTMENTS

1. APPOINTMENTS COMMMITTEE – CONSULTANT APPOINTMENTS

1.1 An Appointments Committee was held on 21 March 2022 and interviewed 1 candidate for 1 Consultant Paediatric/Perinatal Pathologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Craig Platt.

Dr Platt holds MBChB (University of Leicester) 1984 and MRCPath (UK) 1993. Dr Platt is currently employed as a Locum Consultant Perinatal Pathologist at Nottingham University Hospital NHS Trust.

Dr Platt is expected to take up the post of Consultant Nephrologist in July 2022.

1.2 An Appointments Committee was held on 24 March 2022 and interviewed 1 candidate for 1 Consultant Plastic and Reconstructive Surgeon post.

By unanimous resolution, the Committee was in favour of appointing Mr Juan Enrique Berner Gomez.

Mr Berner Gomez holds Doctor of Medicine (Pontificia Universidad Catolica de Chile) 2012, MRCS (England) 2016 and FRCS (UK) 2021. Mr Berner Gomez is currently employed as a Locum Consultant Plastic Surgeon at Barts Health NHS Trust.

Mr Berner Gomez is expected to take up the post of Consultant Plastic and Reconstructive Surgeon post in September 2022.

1.3 An Appointments Committee was held on 24 March 2022 and interviewed 2 candidates for 1 Consultant Paediatric and ACHD Cardiologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Akintayo Adesokan.

Dr Adesokan holds MBBS (St. George's University of London) 2011 and MRCPCH (London) 2014. Dr Adesokan is currently employed as an Interventional Catherisation Fellow at The Hospital for Sick Children, Canada.

Dr Adesokan is expected to take up the post of Consultant Paediatric and ACHD Cardiologist in August 2022.

1.4 An Appointments Committee was held on 31 March 2022 and interviewed 1 candidate for 1 Consultant Medical Oncologist (with interest in Gynaecological Cancers) post.

By unanimous resolution, the Committee was in favour of appointing Dr Sunita Gemmell.

Dr Gemmell holds MBChB (University of Liverpool) 2021 and MRCP (UK) 2016. Dr Gemmell was previously employed as a Specialty Trainee in Medical Oncology on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Gemmell took up the post of Consultant Medical Oncologist (with interest in Gynaecological Cancers) on 30 May 2022.

1.5 An Appointments Committee was held on 1 April 2022 and interviewed 1 candidate for 1 Consultant Otolaryngologist post.

By unanimous resolution, the Committee was in favour of appointing Mr Hassan Mohammed.

Mr Mohammed holds MD (University of Damascus) 2007, MRCS (England) 2008 and FRCS (England) 2014. Mr Mohammed is currently employed as a Senior Clinical Fellow (skull base surgery) at Cambridge University Hospital.

Mr Mohammed is expected to take up the post of Consultant Otolaryngologist in October 2022.

1.6 An Appointments Committee was held on 1 April 2022 and interviewed 1 candidate for 1 Consultant Otolaryngologist (Head and Neck/Laryngology) post.

By unanimous resolution, the Committee was in favour of appointing Mr Benjamin Cosway.

Mr Cosway holds MBBCh (Cardiff University) 2012 and FRCS (England) 2021. Mr Cosway is currently employed as a Training Interface Group Fellow in Head and Neck Surgical Oncology at the South Tees NHS Foundation Trust.

Mr Cosway is expected to take up the post of Consultant Otolaryngologist (Head and Neck/Laryngology in September 2022.

1.7 An Appointments Committee was held on 4 April 2022 and interviewed 2 candidates for 2 Consultant Geriatrician posts.

By unanimous resolution, the Committee was in favour of appointing Dr Clare Patchett and Dr Mayuri Madhra.

Dr Patchett holds MBBS (University of Newcastle) 2008 and MRCP (UK) 2013. Dr Patchett is currently employed as a Specialty Trainee in Geriatric Medicine on behalf of the Lead Employer Trust, at North Tyneside General Hospital.

Dr Patchett is expected to take up the post of Consultant Geriatrician in November 2022.

Dr Mayuri Madhra holds MBBS (University of Newcastle) 2012 and MRCP (UK) 2016. Dr Madhra is currently employed as a Specialty Trainee in Geriatric Medicine on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Madhra is expected to take up the post of Consultant Geriatrician in September 2022.

1.8 An Appointments Committee was held on 6 April 2022 and interviewed 1 candidate for 1 Consultant Gastroenterologist (Endoscopy) post.

By unanimous resolution, the Committee was in favour of appointing Dr Jamie Catlow.

Dr Catlow holds MBChB (University of Glasgow) 2010, MRCP (UK) 2013 and Post-Graduate Diploma of Medical Education (University of Newcastle) 2018. Dr Catlow currently employed as a Specialty Trainee in Gastroenterology and Hepatology on behalf of the Lead Employer Trust, at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr Catlow is expected to take up the post of Consultant Gastroenterologist (Endoscopy) in October 2022.

1.9 An Appointments Committee was held on 6 April 2022 and interviewed 1 candidate for 1 Consultant Gastroenterologist (part-time [7 PAs]) post.

By unanimous resolution, the Committee was in favour of appointing Dr Suzanne Sweeney.

Dr Sweeney holds MBBS (University of Newcastle) 2009 and MRCP (UK) 2013. Dr Sweeney is currently employed as a Specialty Trainee in Gastroenterology and Hepatology on behalf of the Lead Employer Trust, at North Tyneside General Hospital.

Dr Sweeney is expected to take up the post of Consultant Gastroenterologist in July 2022.

1.10 An Appointments Committee was held on 6 April 2022 and interviewed 1 candidate for 1 Consultant Gastroenterologist-IBD post.

By unanimous resolution, the Committee was in favour of appointing Dr Andrew King.

Dr King holds MBBS (University of Newcastle) 2011, and MRCP (UK) 2017. Dr King is currently employed as a Specialty Trainee in Gastroenterology and Hepatology on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr King is expected to take up the post of Consultant Gastroenterologist-IBD in October 2022.

1.11 An Appointments Committee was held on 7 April 2022 and interviewed 2 candidates for 1 Consultant Haematologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Sajida Kazi.

Dr Kazi holds MBBS (University of Mumbai) 2003, MRCP (UK) 2010 and FRCPath (UK) 2018. Dr Kazi is currently employed as a Locum Consultant Haematologist at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr Kazi is expected to take up the post of Consultant Haematologist in July 2022.

1.12 An Appointments Committee was held on 25 April 2022 and interviewed 1 candidate for 1 Consultant in Neuromuscular Diseases -Northern Genetics Service post.

By unanimous resolution, the Committee was in favour of appointing Dr Maha El Seed.

Dr El Seed holds MBBS (University of Khartoum, Sudan) 1994 and MRCPCH (UK) 2002. Dr El Seed is currently employed as a Specialty Doctor in Clinical Neuromuscular Disorders at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr El Seed is expected to take up the post of Consultant in Neuromuscular Diseases-Northern Genetics Service in May 2023.

1.13 An Appointments Committee was held on 26 April 2022 and interviewed 2 candidates for 1 Consultant Cardiologist Advanced Heart Failure and Heart Transplantation post.

By unanimous resolution, the Committee was in favour of appointing Dr Oscar Gonzalez Fernandez.

Dr Gonzalez Fernandez holds LMS (Universidad Autonoma de Madid, Spain) 2011 and PhD in Medicine and Surgery (Universidad Autonoma de Madrid, Spain). Dr Gonzalez Fernandez was previously employed as a Consultant in Cardiology at Sistema Nacional de Salud, Madrid, Spain.

Dr Gonzalez Fernandez took up the post of Consultant Cardiologist Advanced Heart Failure and Heart Transplantation in July 2022.

1.14 An Appointments Committee was held on 10 and 11 May 2022 and interviewed 5 candidates for 2 Consultant Trauma and Orthopaedic Surgeon posts.

By unanimous resolution, the Committee was in favour of appointing Mr Philip Dobson and Mrs Sarah Rawlings.

Mr Dobson holds MBBS (University of Newcastle) 2007, MRCS (England) 2009, PhD (University of Newcastle) 2018 and FRCS (England). Mr Dobson is currently employed as an Orthopaedic Trauma Fellow at Hunter New England Health, Australia.

Mr Dobson is expected to take up the post of Consultant Trauma and Orthopaedic Surgeon in January 2023.

Mrs Rawlings holds MBBCh (Cardiff University) 2008, MRCS (Edinburgh) 2013 and FRCS (Edinburgh) 2019. Mrs Rawlings is currently employed as a Consultant in Trauma and Orthopaedics at North Cumbria Integrated Care NHS Foundation Trust.

Mrs Rawlings is expected to take up the post of Consultant Trauma and Orthopaedic Surgeon in September 2022.

1.15 An Appointments Committee was held on 18 May 2022 and interviewed 1 candidate for 1 Consultant in Community Paediatrics post.

By unanimous resolution, the Committee was in favour of appointing Dr Kim Barrett.

Dr Barrett holds MBChB (University of Glasgow) 1998 and RCPCH (UK) 1996. Dr Barrett is currently employed as a Consultant Community Paediatrician at South Tyneside and Sunderland NHS Foundation Trust.

Dr Barrett is expected to take up the post of Consultant in Community Paediatrics in October 2022.

1.16 An Appointments Committee was held on 23 May 2022 and interviewed 2 candidates for 1 Consultant Dermatologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Remus Winn.

Dr Winn holds MBBS (Imperial College London) 2013 and MRCP (UK) 2015. Dr Winn is employed as a Specialty Trainee in Dermatology on behalf of the Lead Employer Trust, at the Royal Victoria Infirmary.

Dr Winn is expected to take up the post of Consultant Dermatologist in September 2022.

1.17 An Appointments Committee was held on 23 May 2022 and interviewed 1 candidate for 1 Consultant Dermatologist and Mohs Surgeon post.

By unanimous resolution, the Committee was in favour of appointing Dr Dominic Tabor.

Dr Tabor holds MBChB (University of Leeds) 2010 and MRCP (UK) 2015 and MRCP-Dermatology (UK) 2016. Dr Tabor was employed as a Locum Consultant Dermatologist and Mohs Surgeon at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr Tabor took up the post of Consultant Dermatologist and Mohs Surgeon in July 2022.

1.18 An Appointments Committee was held on 9 June 2022 and interviewed 3 candidates for 3 Consultant Anaesthetist posts.

By unanimous resolution, the Committee was in favour of appointing one candidate, Dr Anna Louise Wahed.

Dr Wahed holds MBBS (University of Newcastle) 2009 and FRCA (UK) 2014. Dr Wahed is currently employed as a Specialty Trainee in Anaesthetics on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Wahed is expected to take up the post of Consultant Anaesthetist in September 2022.

1.19 An Appointments Committee was held on 13 June 2022 and interviewed 3 candidates for 1 Consultant Hepatologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Laura Jopson.

Dr Jopson holds MBChB (University of Sheffield) 2007 and MRCP (Edinburgh) 2010. Dr Jopson is employed as a Consultant Gastroenterologist at Northumbria Healthcare Foundation Trust.

Dr Jopson is expected to take up the post of Consultant Hepatologist in October 2022.

1.20 An Appointments Committee was held on 16 June 2022 and interviewed 1 candidate for 1 Consultant Radiologist (Diagnostic) Upper GI post.

By unanimous resolution, the Committee was in favour of appointing Dr Ishaana Munjal.

Dr Munjal holds MBBS (University of Newcastle) 2014 and FRCR (UK) 2021. Dr Munjal is currently employed as a Specialty Trainee in Clinical Radiology on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Munjal is expected to take up the post of Consultant Hepatologist in October 2022.

1.21 An Appointments Committee was held on 16 June 2022 and interviewed 1 candidate for 1 Consultant Radiologist (Paediatrics) post.

By unanimous resolution, the Committee was in favour of appointing Dr Thomas McDonald.

Dr McDonald holds MBBS (University of Newcastle) 2013 and FRCA (UK) 2020. Dr McDonald is currently employed as a Specialty Trainee in Clinical Radiology on behalf of the Lead Employer Trust, at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr McDonald is expected to take up the post of Consultant Radiologist (Paediatrics) in September 2022.

1.22 An Appointments Committee was held on 16 June 2022 and interviewed 1 candidate for 1 Consultant Radiologist (ENT) post.

By unanimous resolution, the Committee was in favour of appointing Dr Khaled Kallas.

Dr Kallas holds MD (University of Latvia) 2009 and FRCR (UK) 2021. Dr Kallas is currently employed as Specialty Trainee in Clinical Radiology on behalf of the Lead Employer Trust, at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr Kallas is expected to take up the post of Consultant Radiologist (ENT) in November 2022.

1.23 An Appointments Committee was held on 16 June 2022 and interviewed 1 candidate for 1 Consultant Radiologist (HPB) post.

By unanimous resolution, the Committee was in favour of appointing Dr Kimsien Lang Ping Nam.

Dr Lang Ping Nam holds MBBS (University of Newcastle) 2013, MRCP (UK) 2016 and FRCR (UK) 2021. Dr Lang Ping Nam is currently employed as a Specialty Trainee in Clinical Radiology on behalf of the Lead Employer Trust, at the Freeman Hospital.

D Lang Ping Nam is expected to take up the post of Consultant Radiologist (HPB) post in October 2022.

1.24 An Appointments Committee was held on 22 June 2022 and interviewed 1 candidate for 1 Consultant in Respiratory Medicine and Home Ventilation Service post.

By unanimous resolution, the Committee was in favour of appointing Dr Nicholas Lane.

Dr Lane holds MBBS (University of Newcastle) 2011, MRCP (UK) 2013 and PhD (University of Newcastle) 2021. Dr Lane is currently employed as a Locum Consultant Respiratory Physician at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr Lane is expected to take up the post of Consultant in Respiratory Medicine and Home Ventilation Service post in August 2022.

1.25 An Appointments Committee was held on 22 June 2022 and interviewed 1 candidate for 1 Consultant Urological Surgeon (Newcastle and Gateshead).

By unanimous resolution, the Committee was in favour of appointing Mr Jonathan Barclay.

Mr Barclay holds MBBS (University of Newcastle) 2009 and FRCS (London) 2021. Mr Barclay is currently employed as a Consultant Urologist at South Tees Hospitals NHS Foundation Trust.

Mr Barclay is expected to take up the post of Consultant Urological Surgeon in October 2022.

1.26 An Appointments Committee was held on 22 June 2022 and interviewed 2 candidates for 1 Consultant Urological Surgeon (Newcastle and Northumbria).

By unanimous resolution, the Committee was in favour of appointing Mr Angus Luk.

Mr Luk holds MBBS (University of Sheffield) 2013, MRCS (Edinburgh) 2016 and FRCS (Edinburgh) 2021. Mr Luk is currently employed as a Fellow in Endo-urology and Stone Surgery at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Mr Luk is expected to take up the post of Consultant Urological Surgeon in January 2023.

1.27 An Appointments Committee was held on 24 June 2022 and interviewed 1 candidate for 1 Consultant in Acute Medicine (7 PAs) post.

By unanimous resolution, the Committee was in favour of appointing Dr Lynsey Threlfall.

Dr Threlfall holds MBBS (University of Newcastle) 2008 and MRCP (London) 2011. Dr Threlfall is currently employed as a Specialty Trainee in Acute Medicine on behalf of the Lead Employer Trust, at Sunderland Royal Hospital.

Dr Threlfall is expected to take up the post of Consultant in Acute Medicine post in September 2022.

1.28 An Appointments Committee was held on 28 June 2022 and interviewed 1 candidate for 1 Consultant Medical Virologist (5 PAs) post.

By unanimous resolution, the Committee was in favour of appointing Dr Helena Christi-Anne Ellam.

Dr Ellam holds BMBCh (University of Oxford) 2004 and FRCPath (UK) 2014. Dr Ellam is employed as a Locum Consultant Virologist at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr Ellam is expected to take up the post of Consultant Medical Virologist post in August 2022.

1.29 An Appointments Committee was held on 28 June 2022 and interviewed 1 candidate for 1 Consultant Gynaecologist with Subspecialty in Urogynaecology post.

By unanimous resolution, the Committee was in favour of appointing Dr Priyanka Krishnaswamy.

Dr Krishnaswamy holds MBBS (Rajiv Gandhi University of Health Science, India) and MRCOG (UK) 2017. Dr Krishnaswamy is currently employed as a Subspecialty Trainee in Urogynaecology at the Queen Elizabeth University Hospital, Glasgow.

Dr Krishnaswamy is expected to take up the post of Consultant Gynaecologist with Subspecialty in Urogynaecology post in August 2022.

1.30 An Appointments Committee was held on 30 June 2022 and interviewed 1 candidate for 1 Consultant Diagnostic Neuroradiologist (7.5 PAs) post.

By unanimous resolution, the Committee was in favour of appointing Dr Mudassara Munir.

Dr Munir holds MBBS (University of Punjab, Pakistan) 2005 and FRCR (UK) 2020. Dr Munir is currently employed as a Specialty Trainee in Radiology on behalf of the Lead Employer Trust, at the Royal Victoria Infirmary.

Dr Munir is expected to take up the post of Consultant Diagnostic Neuroradiologist in September 2022.

1.31 An Appointments Committee was held on 6 July 2022 and interviewed 1 candidate for 1 Consultant Anaesthetist with Special Interest in Intensive Care post.

By unanimous resolution, the Committee was in favour of appointing Dr Gavin Hardy.

Dr Hardy holds MBBS (University of Newcastle) 2010, FRCA (UK) 2018 and FFICM (UK) 2018. Dr Hardy is currently employed as a Specialty Trainee in Anaesthesia and Intensive Care Medicine on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Hardy is expected to take up the post of Consultant Anaesthetist with Special Interest in Intensive Care in September 2022.

1.32 An Appointments Committee was held on 8 July 2022 and interviewed 4 candidates for 2 Consultant Cardiologist with an interest in Cardiac Electrophysiology posts.

By unanimous resolution, the Committee was in favour of appointing Dr Kadhim Kadhim and Dr Hanney Gonna.

Dr Kadhim holds MBChB (Baghdad University, Iraq) 2007, MRCP (UK) 2013 and PhD (University of Adelaide) 2022. Dr Kadhim is currently employed as a Specialty Trainee in Cardiology on behalf of the Lead Employer Trust, at James Cook University Hospital.

Dr Kadhim is expected to take up the post of Consultant Cardiologist with an interest in Cardiac Electrophysiology post in September 2022.

Dr Gonna holds MBBS (University of London) 2003 and MRCP (UK) 2006. Dr Gonna is currently employed as a Cardiac Electrophysiology Fellow at Toronto General Hospital, Canada.

Dr Gonna is expected to take up the post of Consultant Cardiologist with an interest in Cardiac Electrophysiology post in September 2022.

1.33 An Appointments Committee was held on 14 July 2022 and interviewed 1 candidate for 1 Consultant Breast Surgeon post.

By unanimous resolution, the Committee was in favour of appointing Miss Jane Carter.

Miss Carter holds MBChB (University of Bristol) 2007, MRCS (England) 2010, PhD (University of Louisville) 2016 and FRCS (England) 2021. Miss Carter is employed as a Specialty Trainee in General Surgery on behalf of the Lead Employer Trust, at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Miss Carter is expected to take up the post of Consultant Breast Surgeon post in September 2022.

1.34 An Appointments Committee was held on 14 July 2022 and interviewed 1 candidate for 1 Consultant Colorectal Surgeon post.

By unanimous resolution, the Committee was in favour of appointing Mr Kamran Khatri.

Mr Kharti holds MBBS (University of Karachi, Pakistan) 2002, MRCS (Edinburgh) 2009 and FRCS (Edinburgh) 2021. Mr Kharti is currently employed as a Specialty Trainee in General Surgery at Queen Elizabeth University Hospital, Glasgow.

Mr Kharti is expected to take up the post of Consultant Colorectal Surgeon post in September 2022.

1.35 An Appointments Committee was held on 14 July 2022 and interviewed 1 candidate for 1 Consultant Hepato-Pancreatic Biliary (HPB) Surgeon post.

By unanimous resolution, the Committee was in favour of appointing Mr Rohan Thakkar.

Mr Thakkar holds MBBS (University of Navi Mumbai, India) 2002, MRCS (Edinburgh) 2014and FRCS (Edinburgh) 2017. Mr Thakkar is currently employed as a Locum Consultant in HPB and Transplant Surgery at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Mr Thakkar is expected to take up the post Consultant Hepato-Pancreatic Biliary Surgeon post in September 2022.

1.36 An Appointments Committee was held on 15 July 2022 and interviewed 1 candidate for 1 Consultant Paediatric Gastroenterologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Sally Buxton.

Dr Buxton holds MBBS (University of Newcastle) 2011 and MRCPCH (UK) 2016. Dr Buxton is currently employed as a Specialty Trainee in General Paediatrics on behalf of the Lead Employer Trust, at the Great North Children's Hospital.

Dr Buxton is expected to take up the post Consultant Paediatric Gastroenterologist post in November 2022.

2. RECOMMENDATION

1.1 – 1.36 – For the Board to receive the above report.

Report of Andy Welch
Medical Director
28 July 2022

THIS PAGE IS INTENTIONALLY BLANK

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust







SCAN ME!

Scan the QR code to visit our NMAHP webzone

Our Nursing, Midwifery and Allied Health Professionals Strategy 2022 - 2027

Healthcare at its best
with people at our heart

Our strategy

As the largest collective workforce, the nurses, midwives and allied health professionals of Newcastle Hospitals are made up of almost 7000 individuals working across acute and community care settings.

The uniqueness of our contribution as highly specialised professionals is delivered through our shared vision of achieving local excellence and global reach through compassionate and innovative healthcare, education and research.

This, combined with our values and our pride and professionalism is what makes Newcastle's nurses, midwives and allied health professionals so proud and passionate about who we are and what we do.

We held the Big Event in March 2020 which provided a creative platform to bring together and listen to the collective voice of our nurses, midwives and allied health professionals, enabling us to reflect on our history and share views on what the future holds.

Little did we know that we were about to experience significant challenges as a result of the Covid-19 pandemic where our professional skill and clinical expertise have been vitally important in our Trust's response.

Our collective experiences in our professional role, our health and wellbeing, our aspirations alongside the learning from the last two years have helped us to develop the narrative to shape and inform this strategy.

Together we pledge to work collaboratively to deliver on these aspirations and commitments by having an accessible, visible and understandable strategy.

A strategy which recognises both the exclusivity and uniqueness of our individual professional groups, whilst demonstrating what makes nurses, midwives and allied health professionals across Newcastle outstanding.

We are proud to have been rated as outstanding twice by the CQC, most recently in May 2019

This is our strategy and through-out the next five years, we will continually engage and communicate with staff and agree together our high impact actions each year to lead us towards our goals.

We will work together to continuously improve the quality of care for our patients and ensure all of our staff are supported to liberate their potential and be the best they can be.

Our aspiration is to develop Newcastle Hospitals locally, nationally and internationally as a centre of excellence for nurses, midwives and allied health professional leadership, education, clinical practice and academic research.

This strategy outlines six key priority areas, and how we propose to achieve our aspirations.

Our key priorities

Improve quality and reduce patient harms

Patients

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

We are committed to ensuring our staff have the autonomy to influence decisions on how care is structured and delivered to create a culture of innovation, whilst continually striving to generate opportunities to improve clinical outcomes in a supportive culture.

We will focus on using evidence, research and best practice to underpin our delivery of patient care to reduce avoidable harm. Our Harm Free Care Leaders in each clinical area will have expert knowledge and skills to lead improvement and reduce patient harm.

We will continue to provide the highest quality, compassionate care to our patients and their families demonstrating continuous improvement year on year, measured by local, national and international clinical and professional standards.

We will support patients to make informed choices about their own health and wellbeing whilst continually learning from their experience to improve quality of care and the services we provide, in our hospitals, our outreach clinics and in the community.

Develop a nursing, midwifery and allied health professional workforce strategy, plan and metrics for improvement

Performance

Be outstanding, now and in the future

We are recognised for strong professional leadership, committed to safe staffing frameworks and empowering everyone to understand their role and contribution.

We will have a nursing, midwifery and allied health professional workforce plan reflective of the right numbers, skill mix and training to deliver excellent care with clear improvement measures.

We will be the employer of choice for nurses, midwives and allied health professionals, and be known as a high quality training provider, both now and in the future, supporting staff to liberate their potential through the delivery of innovative education and lifelong learning.

We will ensure our nurses, midwives and allied health professionals at every level is representative of the local population.

Develop leadership capacity, capability and resilience

People

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

We are encouraging and empowering our nursing, midwifery and allied health professional leaders to influence and shape high quality care locally, regionally, nationally and internationally.

We will design and deliver innovative and bespoke training to nurture our current and next generation of clinical leaders ensuring they are confident, capable and equipped to lead their teams and services with compassion and inclusivity.

We will have an inclusive, visible, credible framework of leadership across nursing, midwifery and allied health professionals modelling the range of potential career progression and leadership opportunities across the professions.

Engagement for improvement

Partnerships

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

We are actively engaging with our staff, to learn from them, ensuring they feel valued, listened to, respected and supported to contribute and shape care provision.

We will continue to develop capability and capacity for improvement specifically in front line nurses, midwives and allied health professionals, supporting staff of all levels to access opportunities and training to facilitate clinical effectiveness and improvements in care.

We will nurture an open and collaborative workforce known locally, regionally and nationally for quality improvement.

We will build on our sense of pride in the place that we work and the care that we give ensuring staff feel a sense of genuine belonging, empowering them to influence and shape the way care is delivered.

Increase research opportunities and impact, whilst strengthening our academic links

Pioneers

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

We are a strong research partner with a growing reputation as a national leader fostering innovative clinical academic careers, and attracting external funding and national fellowships through our unique mentorship approach and collaborative working.

We will continue to attract, cultivate and retain a research informed and active workforce, who autonomously engage in, lead and translate research into practice at any level.

We will influence regionally and nationally to remove perceived barriers, and enable research activity within clinical roles and the progression of clinical academic careers.

We will strengthen our research capacity through innovative research related training and development opportunities, through internally led programmes and partnership with Higher Education Institutions.

We will support our NHS partners to build research capacity, by sharing our expertise and experience, development opportunities and maximising opportunities for cross-organisational collaboration on research priorities.

Lead the digital healthcare agenda

Pioneers

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

We are using digital technology to improve patient safety, clinical practice and most importantly patient experience.

We will be attentive to the impact of technology and to the change in care delivery ensuring we utilise technology to augment professional practice and care.

We will empower nurses, midwives and allied health professionals to shape and drive digital transformation through education, leadership and support, to allow them to provide clinical expertise in all aspects of the patient journey.

We will explore and implement new innovative digital technologies to provide safer effective care for our patients, supported through real time reporting and improvement, freeing up time to care and improving patient outcomes.

We will embrace pioneering digital technologies to provide clinical decision support, explore the use of artificial intelligence and advanced devices to provide enhanced communications, interactive digital collaboration and sharing of knowledge.

Making it happen

Our Strategy's key priorities are borne out of The Big Event held in March 2020 and reflect the collective vibrant and positive voices of our nurses, midwives and allied health professionals.

It is important therefore, that the key priorities in this document help support and shape actions at a Trust-wide level and within individual wards and departments.

High impact actions

Each year we will set a number of Trust wide high impact actions which are deliverable and can be measured.

Whilst we want to ensure these high impact actions are relatable to all staff, due to the diverse nature of our clinical services, individual departments or professional groups can also agree their own local high impact actions.

Sharing best practice

It is also important that we recognise, celebrate and share best practice.

A key focus each year will be to capture and share examples of outstanding practice so that we can demonstrate and celebrate the high quality care we strive to provide, and the compassionate, pioneering spirit our professions are so proud of.


NHS STAFF

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Find out more

www.newcastle-hospitals.nhs.uk/home/NMAHPs

www.twitter.com/NewcastleNMAHPs

Contact us

nuth.nmahps@nhs.net

SCAN ME!

Scan the QR code to visit

Healthcare at its best
with people at our heart

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Improving safety together

You said, together we have …..

Angela O'Brien, Director of Quality and Clinical Effectiveness and our Board-level Maternity Safety Champion, Prof. Kathleen McCourt, one of our Non-Executive Director and Deputy Chair, accompanied by Lucie Johnson, Assistant Directorate Manager (GMTS) and/or one of our Matrons, walk around our clinical areas monthly and meet with you, our maternity and neonatal staff, to listen to you and to give you the opportunity to raise any concerns you may have in relation to the safety of our services or the care we provide to our patients.

Here are some concerns raised by you over recent months and actions that have been taken to address them:

Staff Wellbeing

At each of our visits we ask staff about their wellbeing and how well supported they feel. Support with staffing due to sickness and employment were raised several times. Workload pressure was also mentioned, with many staff describing how it feels like women's demands are becoming greater and more complex which has a greater impact on time and resources.

Escalation and requesting support from other areas was a common theme over these past winter months. Within some areas, such as Community and MAU, escalation and staffing support has impacted on teams and their working week, while others have raised no concerns specifically but recognised how it has been a tough winter for staffing.

Some teams voiced how they would appreciate better communication and acknowledgement from management when they have implemented further care and processes in an already busy frontline workload. When we asked about their immediate teams, most staff felt pride for their colleagues and how they support one another, as well as support from other teams within the Trust when needed (e.g. safeguarding).

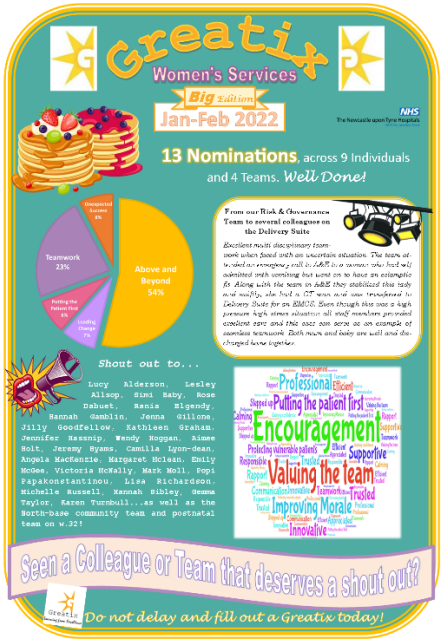
Our response:

These walkabouts have highlighted a continuous theme of pride and support amongst colleagues and their immediate team. This is heart-warming to hear.

We recognise and acknowledge that the difficulties with staff shortages due to annual leave, sickness and vacancies still remain. Ward Managers, Co-ordinators, and Matrons having been working hard to elevate the impact on frontline staff, and at times this has required following the escalation pathway. We appreciate that escalation does impact on teams, but is required to meet safety demands on Maternity Services as whole. We hope with further posts being filled and the reconfiguration as part of Maternity Transformation will aid in improving staffing levels in the needed areas.

We strive to provide an environment where staff feel acknowledged for their hard work and commitment. We have seen a variety of shout-outs and successes through our Greatix submissions over the past year, highlighting the wonderful work our colleagues have achieved and we have shared this through monthly posters in staff rooms and with team leads and management (a display of all posters currently made can be seen in the Fetal Seminar Room). Submitting a Greatix to recognise excellence is available to all staff through the intranet at: http://nuth-intranet/cms/GeneralInformation/ClinicalGovernanceRiskDepartment/GREATIX.aspx

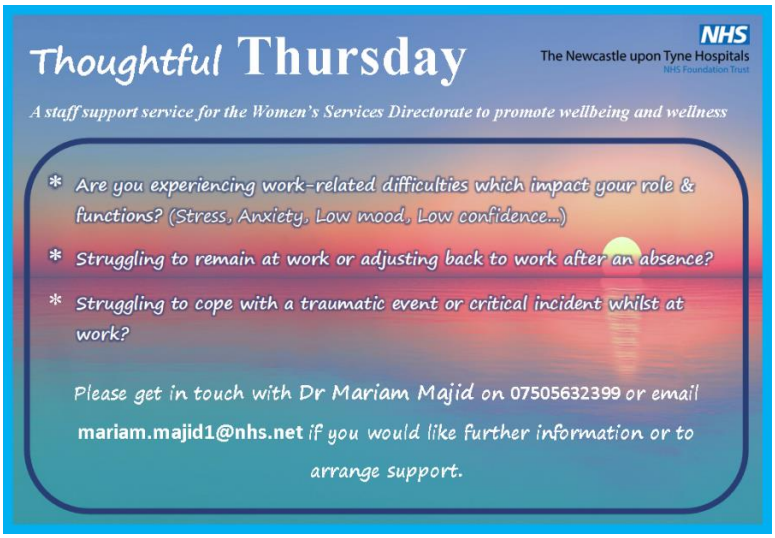
Greatix
Learning from Excellence



We also appreciate that staff want further communication from management. As part of the postnatal IHI and '*What matters to you'* project which began in late autumn 2021, staff have been exploring new ways of communicating with one another that is inclusive of the whole team. So far a series of mini surveys, team information boards and weekly verbal *comms.* in postnatal and written *comms.* to all Midwives have been utilised. If you have further communication ideas and solutions please do share them with your line manager. We want

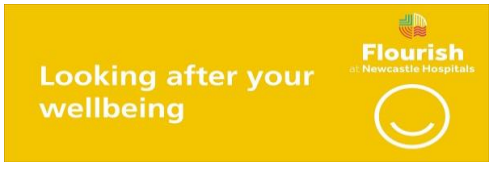
to promote innovation amongst our staff and improve how we communicate with each other!

The challenges faced by us all over the last couple of years has also been felt and experienced by our patients. Compounded with waiting times for support from GPs or others healthcare or social services has seen women turn to their midwife and/or other clinical staff for additional support. A variety of specialist midwife roles have been successfully funded and recently appointment to, including a pastoral support midwife, Emily Robson, and perinatal mental health midwife, Abigail Spencer, to help provide specialist support for our staff and our women when needed. Some of the upcoming changes described further below in this newsletter also aim to improve time and resource demands so staff can focus on providing the excellent care for their women.



If you feel you would like further support with managing stress, anxiety, resilience or trauma, please we have our *Thoughtful* **Thursday** staff support service with Dr Mariam Majid (contact details can be found on several posters displayed around the maternity staff areas or in the above image). Group sessions are also available upon request. In addition to the staff support we have within the directorate and departments, there are Trust resources available on the intranet to help you look after yourself:

http://nuth-intranet/cms/GeneralInformation/CoronavirusInformation/Staffwellbeing.aspx



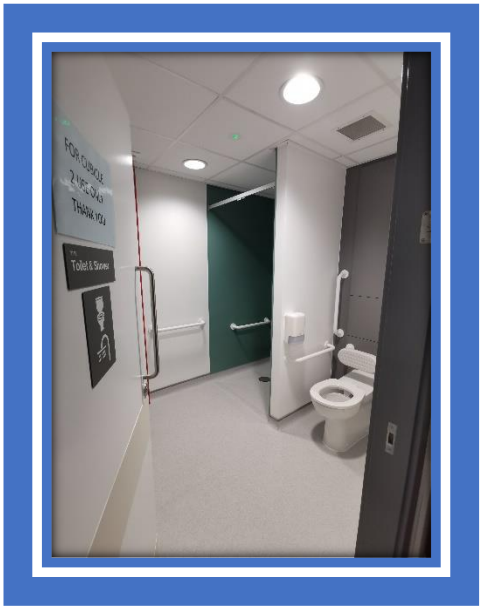
Estate

There have been ongoing refurbishments in several areas across Maternity and Neonatal Services. Staff have raised the disparity felt by patients between the NBC and the Delivery Suite and Postnatal Ward, as well as how some of the refurbishments have been noisy, inconvenient and sometimes felt like an additional pressure for staff. However, staff have recognised the long-term planning required to make improvements and have commented on how the estate workers have been pleasant. Many also enquired about progress with our application for a New-Build Specialist Hospital at NuTH, in which Maternity Services is part of.

Our response:

We have recently seen the opening of ward 41 with new outpatient day care unit and inpatient antenatal ward. Staff moved in on 04.03.22 and have complimented the space and environment. The majority of the cubicles come with their own *en-suite* facilitates and the Omnicell drug cabinet has been described as feeling safer and more secure. The addition of assessment rooms and quiet room in the outpatient day care unit have also been complimented.

Displayed are a selection of photos from our newly refurbishment Ward 4. Several sections have themed colours and motifs of famous sites from across the region. A big thank you to the our staff who helped organise and facilitate the move onto ward 41, as well as to the Estates team and other Trust teams for all their hard work to make this happen!



Refurbishments continue within the remaining areas in Maternity and Neonatal services and are progressing well. Estates work to renovate the rooming in flats and make them into multifunction single patient spaces is underway within Neonates, along with a change of use of ward 34. Ward 34 will be changing to a combination of, an expansion of the footprint of ward 35 to facilitate future expansion of HDU capacity, and transitional care which will be co-located beside the neonatal service.

Staff may have heard increased noise disturbance due to the ongoing Estates work with Leazes Wings lift shafts. The transfer of high risk patients using the Leazes Wing lifts is on our Risk Register for Maternity Services. The improvements being made to these lifts aim to improve the risk & safety of all who use them and, although noisy, are a welcomed necessity.

Maternity continues to support the planning work for the New Specialist Hospital build on Richardson Road (which will be a 5-7 year project); we are awaiting feedback and confirmation of our progression onto the next stage and, once known, we will happily share news on future walkabouts.

Thank you to all staff for your ongoing patience and tolerance of the noise and disturbance whilst these improvements progress.

Paperwork & Systems

Staff have raised how they feel paperwork has grown expediently over the years and there is a growing frustration at the amount of duplication required. Community teams have also voiced how they feel that any additional audits/ capturing of data falls upon them to complete. Staff have raised concerns over the allocation of new laptops and smart phone and how they have felt inconsistent. The 'little' inconveniences, such as printing problems and finding keys, add up and take their toll on workload and morale for staff.

Our response:

Many staff members should be aware of the upcoming implementation of Badgernet as our EPR. This will include the transition into a paperless way of working which will reduce duplication across the whole pregnancy, intrapartum and postnatal pathway as information is shared electronically. Information will be accessible at the point of care, allow for easier collation of data for quality assurance and audit requirements and, as an added bonus, will help reduce the Trust's carbon footprint. We now have lead Midwife Corinne Johnson for Digital Health, and work continues in progressing an implementation plan for a go live date in December 2022. We hope the implementation of Badgernet will improve and reduce the time spent on documentation which then will allow staff to focus on what they do best - patient-centred care.

Over the past couple of years the demand for digital devices has risen dramatically in light of them pandemic. There has been a Trust-wide delay in accessing equipment due to country-wide procurement issues. This has resulted in equipment being release in batches, therefore priorities needed to be made based on existing digital infrastructure. We acknowledge that to some this may have felt inconsistent, but resources had to go to those who lacked the necessary equipment to begin with. Over the past few months any known issues have been resolved and we continue to order equipment and allocate resources for all areas that need them.

We are aware of some printer issues within the Directorate which are in the process of being reviewed as part of this ongoing Trust project recently announced in a recent **In Brief** communication email. Printers across the Trust are set to be replaced with better, more efficient Xerox models, and we hope to see improvement once installed. Please do continue to raise any issues with IT via 21000 or Trust Intranet via Click.

The Better Births view for Maternity: Continuity of Carer (CoC)

Over the past few months, we have been asking staff about the Maternity Transformation Programme, together with the Continuity of Carer (CoC) model. Some staff have voiced how they felt well versed in the national requirement to move towards Continuity, others have raised feelings of uncertainty, the practicalities of CoC working, upskilling staff and the impact to staff morale, particularly after the past 2-years of the pandemic. Many recognised that personal opinions on the CoC model varied.

Our response:

Staff consultation with regard to the proposed CoC Model for women in Newcastle and how it is staffed began on the 07/02/22. Documentation has been released to all those maternity staff affected by the changes and the 9 initial group meetings were held in February, all with good attendance. This allowed information on the proposals to be disseminated and discussed, with opportunity for Q and A. Staff side representatives and HR have been present at all meetings. Further revisions and an extension have been made to the consultation timeline to ensure that time was afforded for further engagement at the request of staff and a large number of 1:1 meeting with our Maternity Matrons and HR for all staff who requested one during our consultation period have occurred.

The Directorate appreciates and understands that staff will feel uncertain and vulnerable throughout the transformation process and that there are a variety of different opinions and feelings in relation to the national directive with regard to Continuity, and the model being proposed at Newcastle. A selection of engagement sessions, focusing on particular themes, continued to run over several weeks, culminating in closure of formal consultation on 6th June. We thank all staff who have taken the time to engage and air their thoughts and views of this important work.

Thank you

Since the last *Improving Safety Together* in early autumn, we have seen the lifting of Covid-19 restrictions, with masks being removed in June. This has been welcomed by many and it is lovely to be able to see people's smiles, rather than behind the mask.

Maternity and Neonates have continued to provide outstanding care to patients and their families. We would like to thank all staff for their dedication, resilience and professionalism over the winter and spring periods and brought significant challenges with staffing.

As we enter the new financial year, we still want to encourage all staff to take time off to look after their own wellbeing and continue to strive for a good work/life balance so we can be ready to meet with the changes and challenges that we continue to face.

If you feel that you wish to receive additional support with regard to your health and wellbeing, please discuss with your line manager who will be pleased to provide the relevant information.

Reducing Stillbirths Care Bundle Elements		Newcastle	
		Survey 5	Current Position April 2022 If you respond 'no' to any question, please provide an update on any planned activity to enable your Trust to respond 'yes' in future
Element 1: Reducing smoking in pregnancy by carrying out a Carbon Monoxide (CO) test at booking to identify smokers (or those exposed to tobacco smoke) and referring to stop smoking service/specialist as appropriate	**1ai. Are you meeting all requirements of the modified Element 1 of the care bundle which was changed due to the COVID-19 pandemic?**	**Yes**	
	1aii Once CO2 testing is reintroduced, will your Trust meet all the requirements of Element 1?	**Yes**	
	1b. Are you carrying out any improvement activity designed to reduce smoking in pregnancy?	**Yes**	
	1c. Does your standard operating procedure (e.g. guidelines) include the following: i. CO monitoring at booking and additional CO testing throughout pregnancy including the 36 week antenatal appointment, with the outcome recorded?	**Yes**	
	ii. Referring expectant mothers, with elevated CO levels (4ppm or above), to a trained stop smoking specialist, based on an opt out system with a pathway that includes feedback and follow up processes?	**Yes**	
	1d. Do the improvement activities include training all maternity staff on the use of the CO monitor and having a brief and meaningful conversation with women about smoking?	**Yes**	
	1e. Have all recorded outcomes of CO testing in pregnancy relating to element 1 activities been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	**Yes**	
	1f. If you answered "no" to question 1b, are you planning on introducing this type of intervention / improvement activity? Please provide commentary.	N/A	**Insert commentary here**
Element 2: Identification and surveillance of pregnancies with fetal growth restriction	**2ai. Are you meeting all requirements of the modified version Element 2 of the care bundle, which was changed due to the COVID-19 pandemic? NB the modified version of element 2 should only be implemented in the case of significant COVID-19 related staff shortages**	**Yes**	
	2aii In the case of you having no significant COVID related staff shortages, do you meet all the requirements of Element 2 of the care bundle?	**Yes**	
	2b. Are you carrying out any improvement activity designed to risk assess and manage babies at risk of Fetal Growth Restriction (FGR)?	**Yes**	

2c. Does your standard operating procedure (e.g. guidelines) include the following: i. Assessing women at booking to determine if a prescription of aspirin is appropriate using the algorithm given in Appendix C of the care bundle or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	**Yes**	
ii. Risk assessment and surveillance of women at increased risk of FGR, with triage of women at increased risk of FGR into an appropriate clinical pathway?	**Yes**	
iii. Risk assessment and management of growth disorders in multiple pregnancy in compliance with NICE guidance or a variant agreed locally following advice from the provider's Clinical Network?	**Yes**	
2d. Regarding women not undergoing serial ultrasound scan surveillance of fetal growth does your standard operating procedure (e.g. guidelines) include assessment performed using antenatal symphysis fundal height (SFH) charts by clinicians trained in their use?	**Yes**	
2e. Does your standard operating procedure (guidelines) include differentiation between the management of the SGA and growth restricted fetus in accordance with the pathways and guidance outlined in version 2 of the Saving Babies Lives Care Bundle?	**Yes**	
2f. Does your standard operating procedure (e.g. guidelines) include the following: i. Following recommended guidance on the frequency of ultrasound review of estimated fetal weight (EFW) when SGA is detected, in accordance with appendix D of SBLCBv2 or a variant agreed locally following advice from the provider's Clinical Network?	**Yes**	
ii. Maternity care providers caring for women with FGR identified prior to 34+0 weeks having an agreed pathway for management which includes network fetal medicine input (for example, through referral or case discussion by phone)?	**Yes**	
2g. Accepting the proviso that all management decisions should be agreed with the mother in the cases of fetuses <3rd centile and with no other concerning features does your standard operating procedure (e.g. guidelines) include the following principles: - Initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation. - Delivery <37+0 weeks can be considered if there are additional concerning features, but these risks must be balanced against the increased risk to the baby of birth at earlier gestations.	**Yes**	
2h. Does your standard operating procedure (e.g. guidelines) include individualised care of fetuses between 3rd – 10th centile using a risk assessment including Doppler investigations, assessment for the presence of any other high risk features such as recurrent reduced fetal movements, and the mother's wishes ; and in the absence of any high risk features the offer of delivery or the initiation of induction of induction of labour at 39+0 weeks?	**Yes**	
2i. Have all findings of small for gestational age fetuses been recorded on your MIS enabling their submission in MSDS v2.0 monthly submissions?	**Yes**	
2j. If you answered "no" to 2b, are you planning on introducing this type of intervention / improvement activity?	**N/A**	

	Please provide commentary to detail any barriers your maternity service is experiencing in implementing element SBLCBv2 or submitting the required data to MSDSv2; and to provide details of any learning developed as a result of the implementation.		
Element 3: Raising awareness amongst pregnant women of the importance of detecting and reporting reduced fetal movement (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.	**3a. Are you meeting all requirements of Element 3 of the care bundle?**	**Yes**	
	3b. Are you carrying out any improvement activity designed to raise awareness among pregnant women of the importance of Reduced Fetal Movement (RFM)?	**Yes**	
	3c. Do the improvement activities include providing pregnant mothers with information and an advice leaflet on reduced fetal movement based on current evidence, best practice and clinical guidelines?	**Yes**	
	3d. Do the improvement activities include giving pregnant mothers this information by 28 weeks of pregnancy at the latest?	**Yes**	
	3e. Do the improvement activities include discussing RFM with pregnant mothers at every subsequent contact?	**Yes**	
	3f. Do the improvement activities include making use of an approved checklist to manage the care of pregnant woman who report reduced fetal movement, in line with national evidence-based guidance?	**Yes**	
	3g. Have all findings of reduced fetal movement been recorded on your MIS enabling their submission as Coded Clinical Entry in MSDS v2.0 monthly submissions?	**No**	**A fully electronic patient recorded is not yet in use, though this is expected within the next year. Therefore we are unable to record findings of RFM on our MIS at present.**
	3h. If you answered "no" to 3b, are you planning on introducing this type of intervention / improvement activity?	N/A	N/A
	Please use the free text box below to detail any barriers your maternity service is experiencing in implementing element SBLCBv2; and to provide details of any learning developed as a result of the implementation.		
Element 4: Effective fetal monitoring during labour	**4a. Are you meeting all requirements of Element 4 of the care bundle?**	**Yes**	
	4b. Are you carrying out any improvement activities designed around effective fetal monitoring during labour?	**Yes**	
	4c. Do your improvement activities include annual multidisciplinary training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation for staff who care for women in labour?	**Yes**	
	4d. What is the percentage of staff who care for women in labour that have undertaken this training in the last 12 months?		**K2 = compliance is 42.5% for midwives and 54.2% for medical staff. Face to face Clinical Skills day = 50.6% with 17 days cancelled over last 1 months due to staffing pressures and COVID restrictions.**
	4e. Do you have a system that, irrespective of place of birth, assesses risk at the onset of labour to determine the most appropriate fetal monitoring method, as described in SBLCBv2?	**Yes**	

	4f. Do your improvement activities include a review at least every hour of fetal well-being incorporating the following: i. CTG or Intermittent Auscultation	**Yes**	
	ii. reassessment of fetal risk factors	**Yes**	
	iii. a fresh eyes/buddy system	**Yes**	
	iv. clear guideline for escalation if concerns are raised through the use of a structured process?	**Yes**	
	4g. Do your improvement activities include identifying a Fetal Monitoring Lead for a minimum of 0.4WTE per consultant led unit during which time it is their responsibility to improve the standard of intrapartum risk assessment and fetal monitoring?	**Yes**	
	4h. If you answered "no" to 4b, are you planning on introducing this type of intervention / improvement activity?	**N/A**	
	Please provide commentary to detail any barriers your maternity service is experiencing in implementing element SBLCBv2; and to provide details of any learning developed as a result of the implementation.		**Insert commentary here**
Element 5: Reducing preterm births	**5ai. If you are using the modified version of element 5 of the care bundle, are you meeting all of the requirements?**	**Yes**	
	5aii Are you meeting all of the requirements of element 5 of the care bundle?	**Yes**	
	5b. Are you carrying out any improvement activity designed around reducing the number of preterm births and optimising care when preterm delivery cannot be prevented?	**Yes**	
	5c. Does your standard operating procedure (e.g. guidelines) include the following: i. Assessing all women at booking for the risk of preterm birth and stratifying to low, intermediate and high-risk pathways as per the criteria in Appendix F of the SBLCB v2 of the care bundle document; or an alternative which has been agreed with local commissioners (CCGs) following advice from the provider's Clinical Network?	**Yes**	
	ii. Assessing women with a history of preterm birth to determine whether this was associated with placental disease and a discussion about prescribing aspirin with the woman based upon her personalised risk assessment?	**Yes**	
	iii. All women being offered screening for asymptomatic bacteriuria by sending off a midstream urine (MSU) for culture and sensitivity at booking, and a repeat MSU to confirm clearance following any positive culture?	**Yes**	
	iv. Having access to transvaginal cervix scanning (TVCS) and a clinician with an interest in preterm birth prevention with a clinical pathway for women at risk of preterm birth that is agreed with local commissioners (CCGs) following advice from the provider's clinical network (for example, UK Preterm Clinical Network guidance or NICE guidance)?	**Yes**	
	5d. Does your standard operating procedure (e.g. guidelines) include risk assessment and management in multiple pregnancy compliant with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network?	**Yes**	

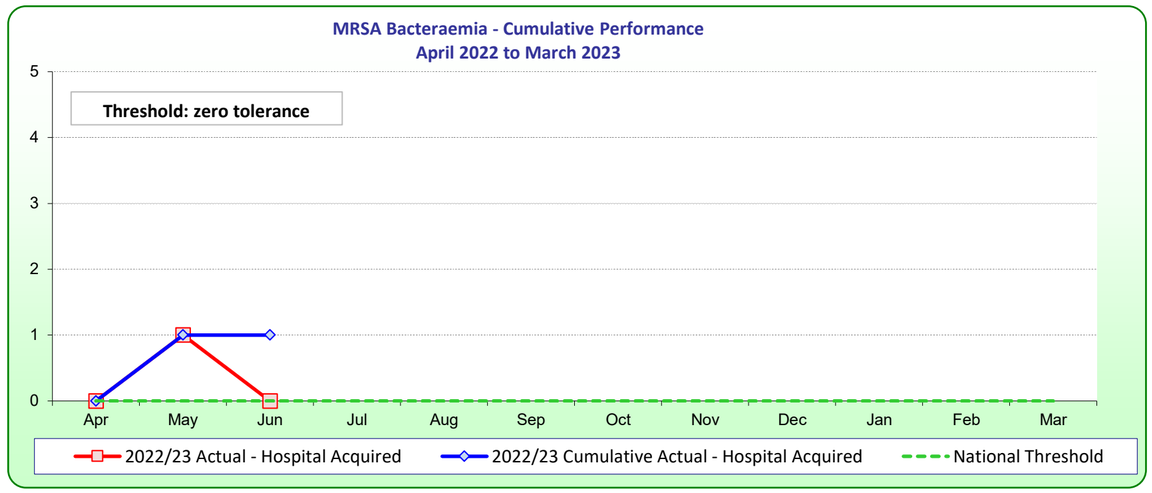
5e. Does your standard operating procedure (e.g. guidelines) include the following: i. every provider having referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories including access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage?	**Yes**	
ii. women at imminent risk of preterm birth being offered transfer to a unit with appropriate and available neonatal cot facilities when safe to do so and as agreed by the relevant neonatal Operational Delivery Network (ODN)?	**Yes**	
iii. offering Antenatal corticosteroids to women between 24+0 and 33+6 weeks, optimally at 48 hours before a planned birth?	**Yes**	
iv. offering Magnesium Sulphate to women between 24+0 and 29+6 weeks of pregnancy; and considering offering Magnesium Sulphate for women between 30+0 and 33+6 weeks of pregnancy, who are in established labour or are having a planned preterm birth within 24 hours? If so to what extent have you implemented this improvement activity?	**Yes**	
v. ensuring the neonatal team are involved when a preterm birth is anticipated, so that they have time to discuss options with parents prior to birth and to be present at the delivery?	**Yes**	
vi. holding a multidisciplinary discussion before birth between the neonatologist, obstetrician and the parents about the decision to resuscitate the baby for women between 23 and 24 weeks of gestation?	**Yes**	
5f. Have all instances of maternal antenatal administration of corticosteroids for fetal lung maturation been recorded on your MIS enabling its submission as in MSDS v2.0 monthly submissions?	**No**	A fully electronic patient recorded is not yet in use, though this is expected within the next year. Therefore we are unable to record administration of steroids on our MIS at present.
5g. If you answered "no" to 5b, are you planning on introducing this type of intervention / improvement activity?	**N/A**	
Please provide commentary to detail any barriers your maternity service is experiencing in implementing element SBLCBv2 or submitting the required data to MSDSv2; and to provide details of any learning developed as a result of the implementation.		**Insert commentary here**

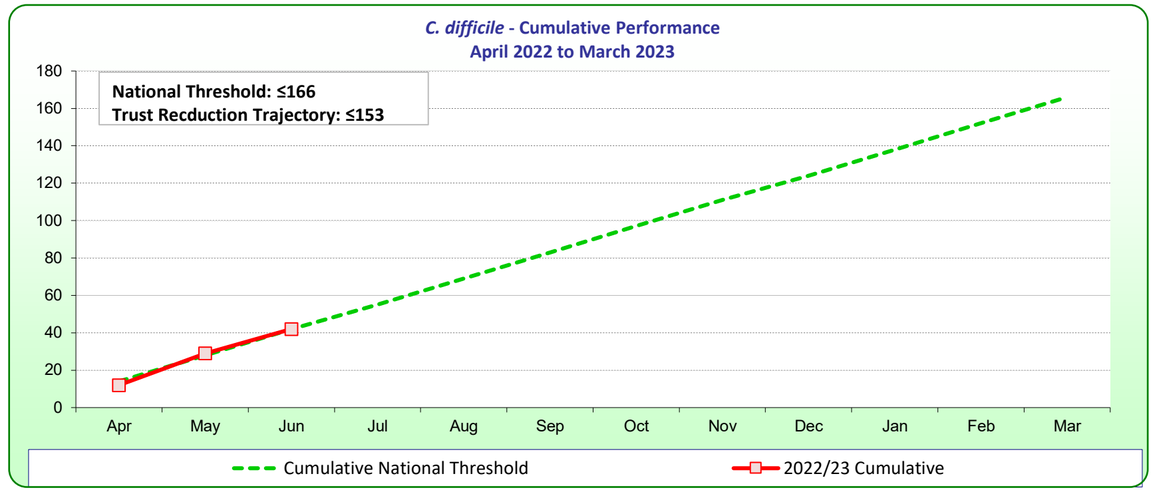
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

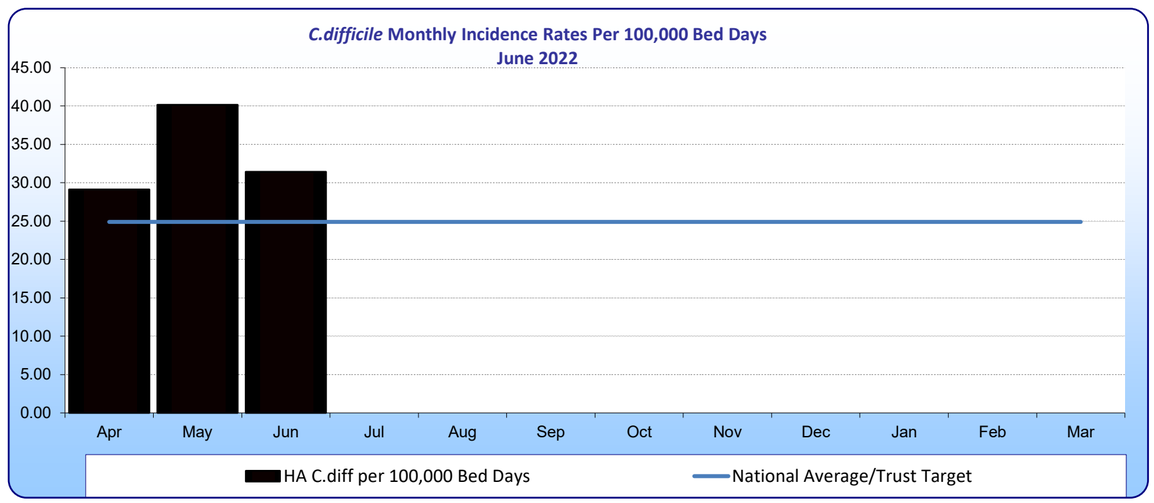
Healthcare-Associated Infections Report
June 2022

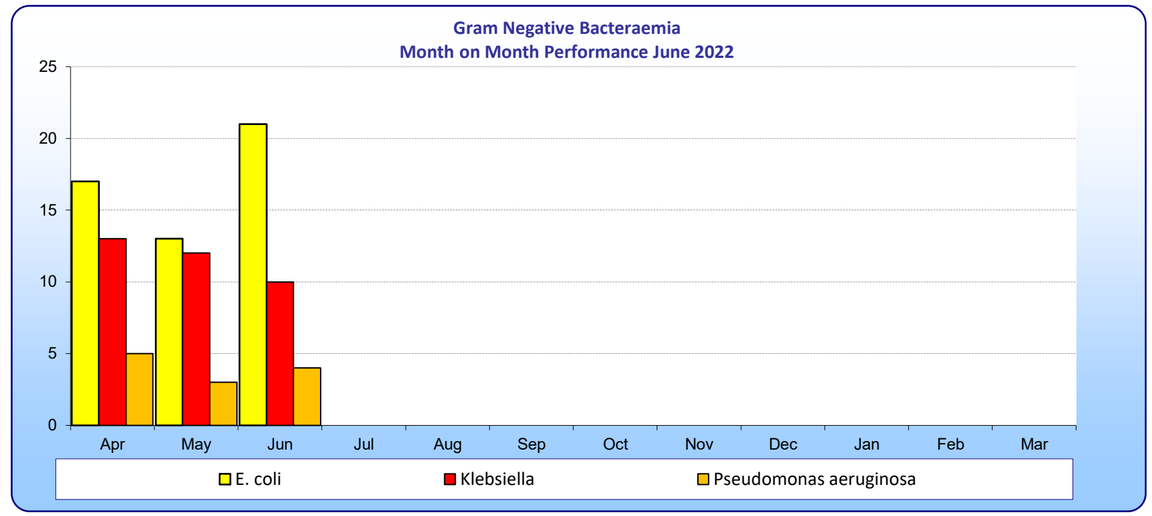
Healthcare-Associated Infection Report June 2022

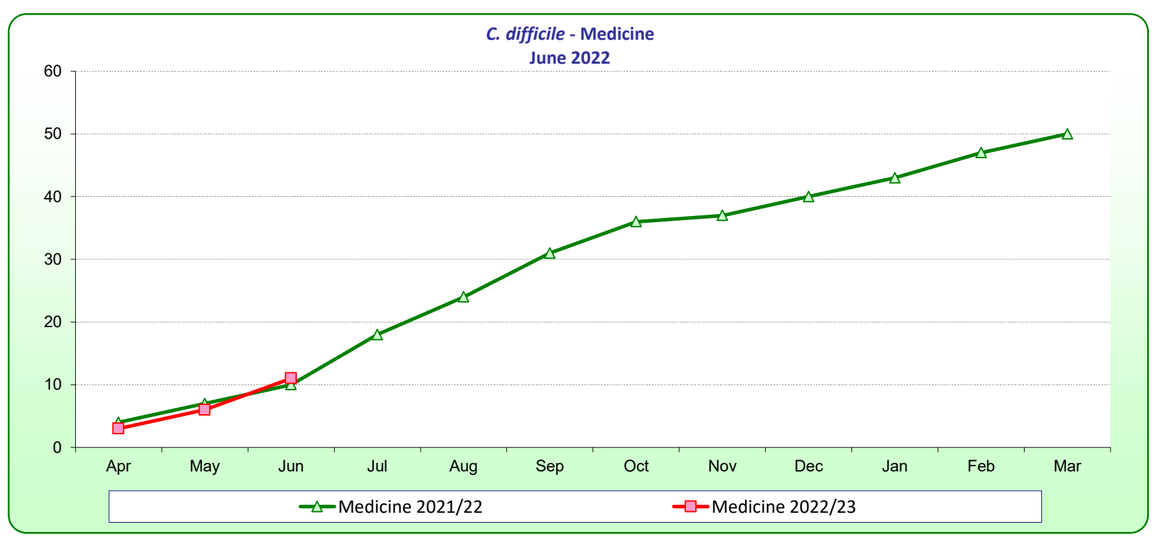
The Newcastle upon Tyne Hospitals NHS Foundation Trust

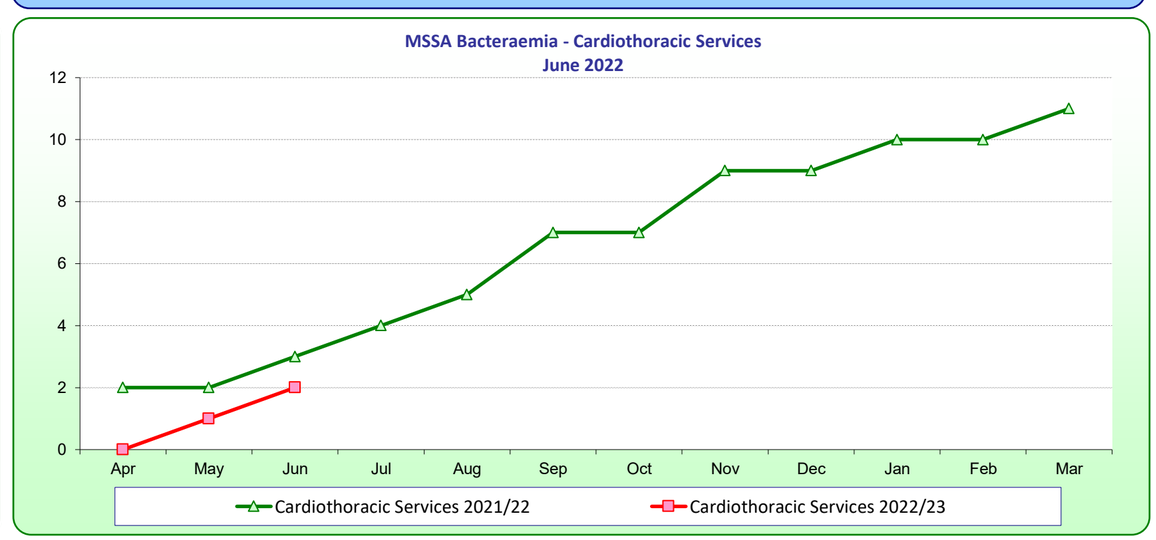






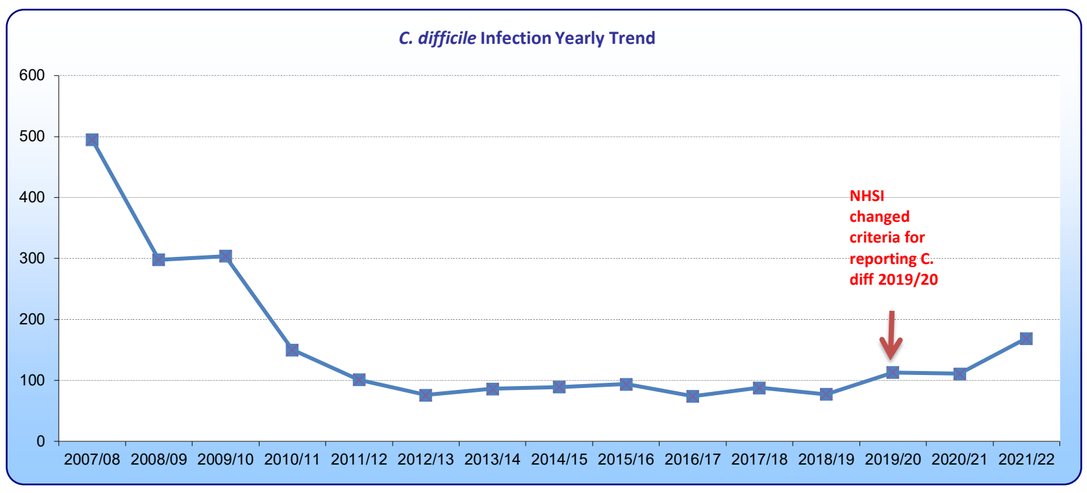


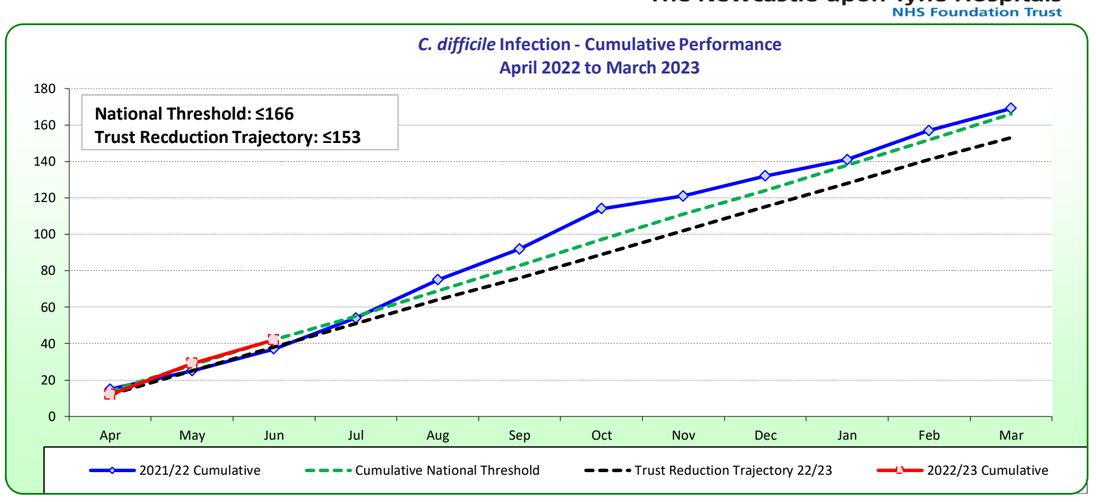


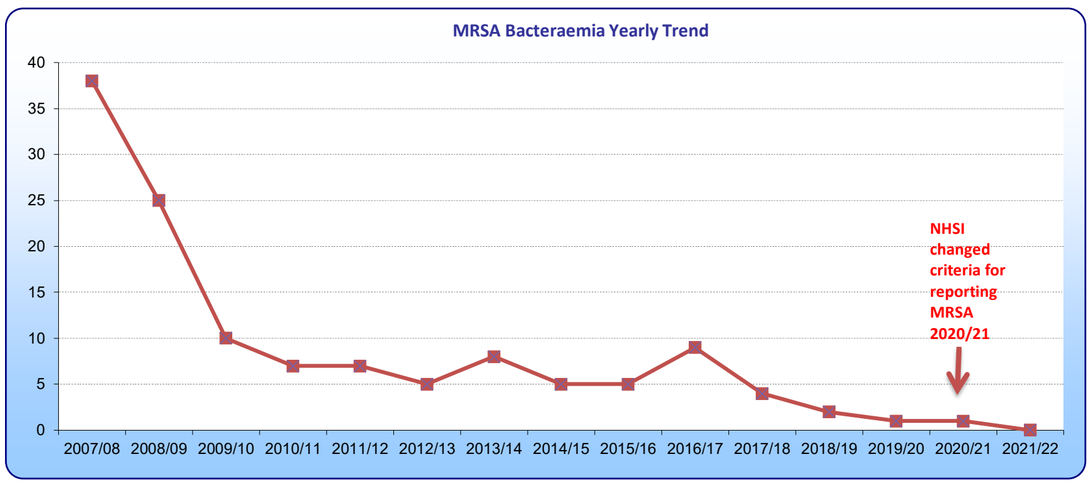


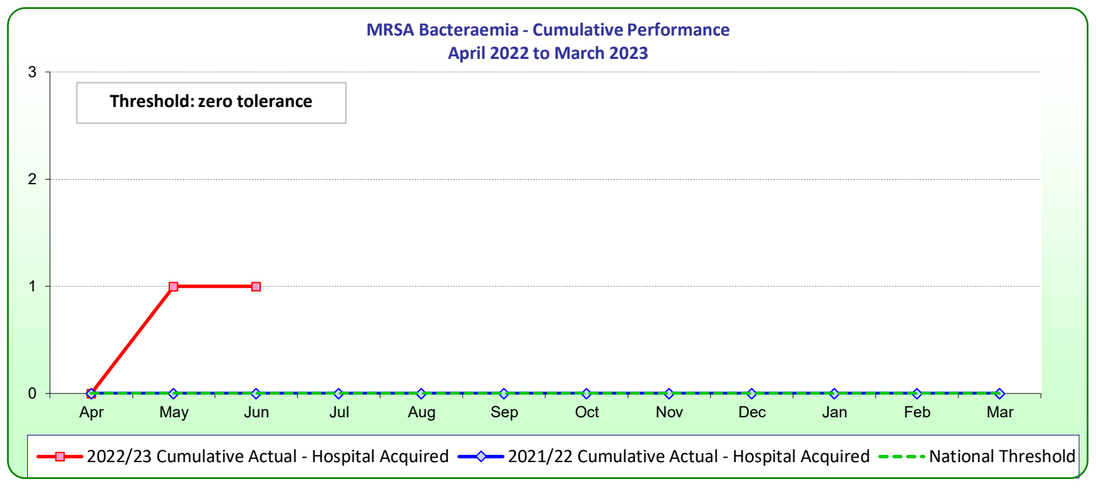
Healthcare-Associated Infection Report June 2022

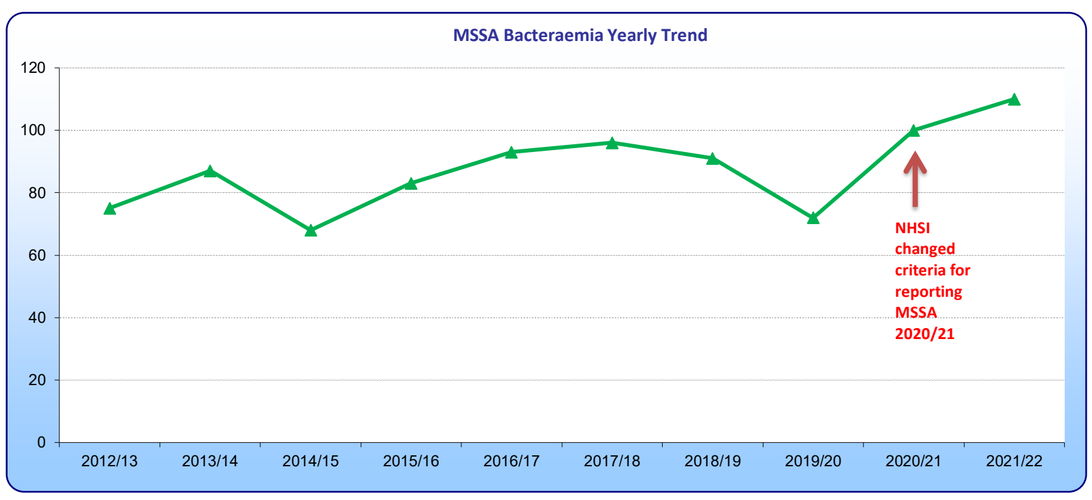
The Newcastle upon Tyne Hospitals NHS Foundation Trust

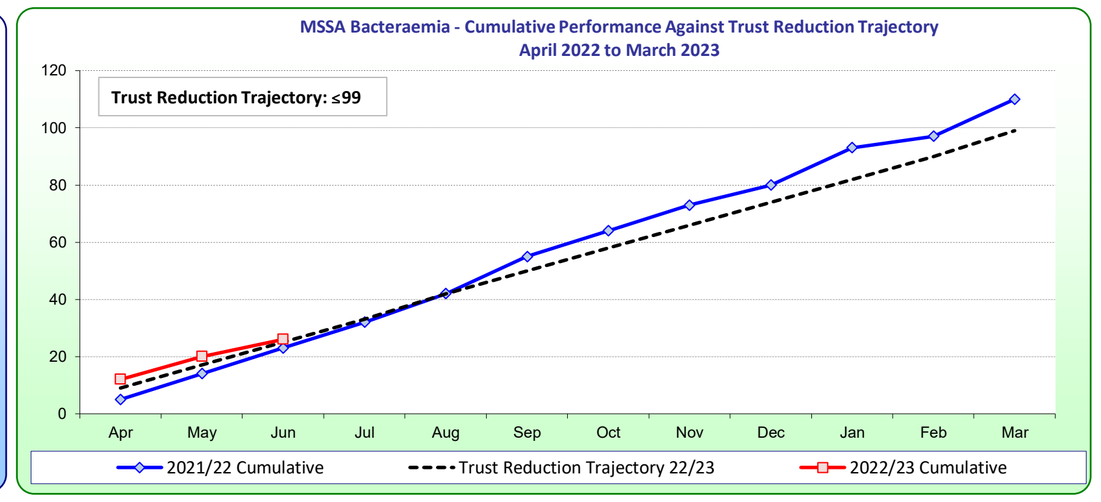


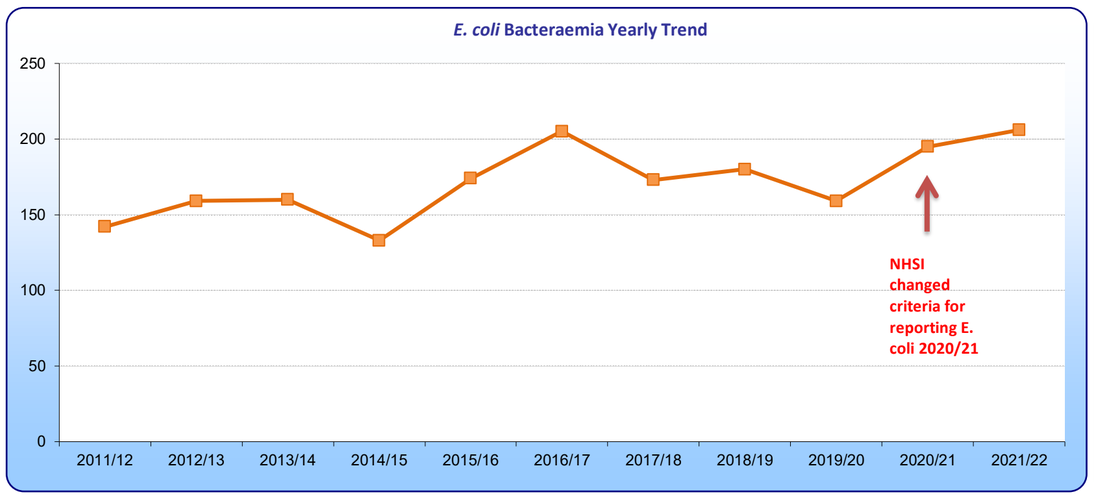


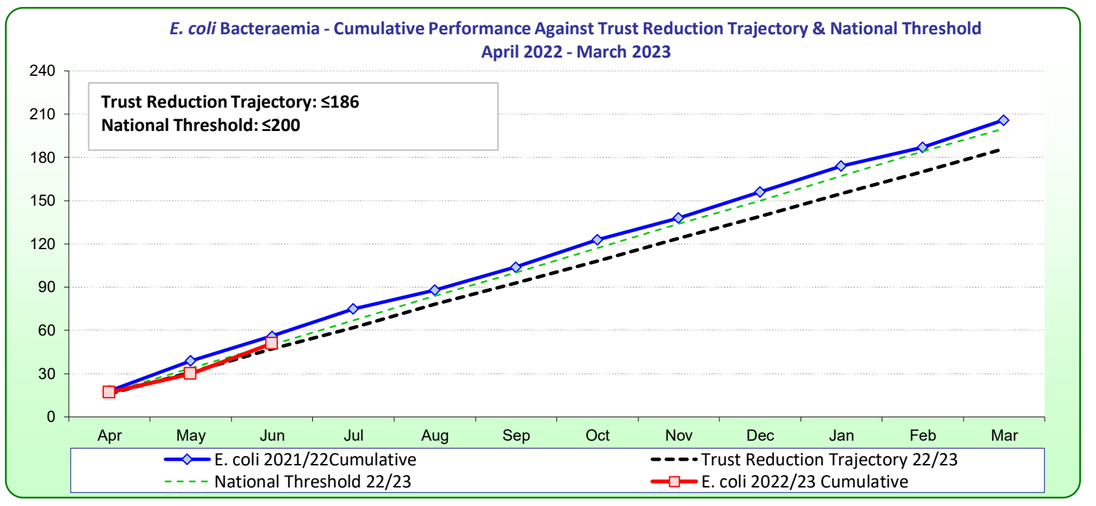


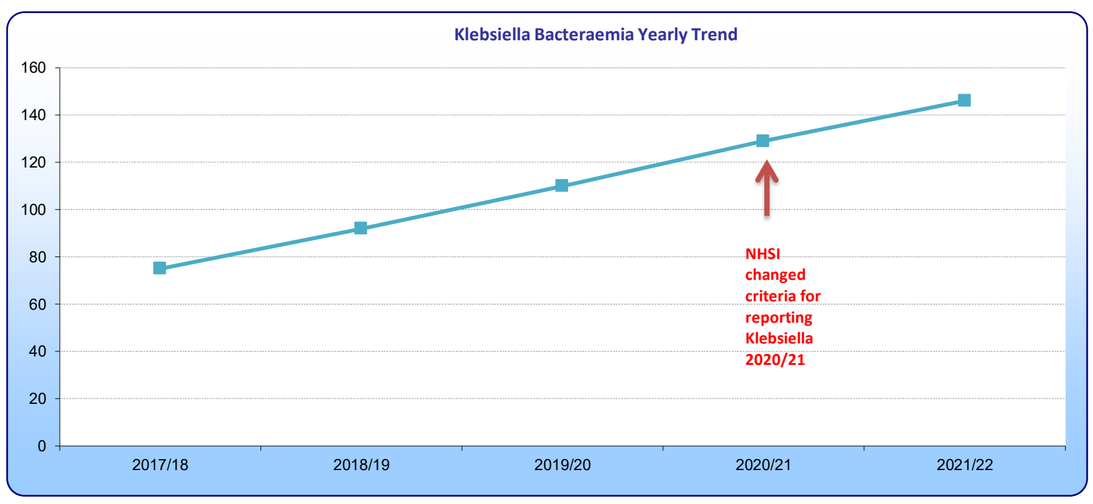


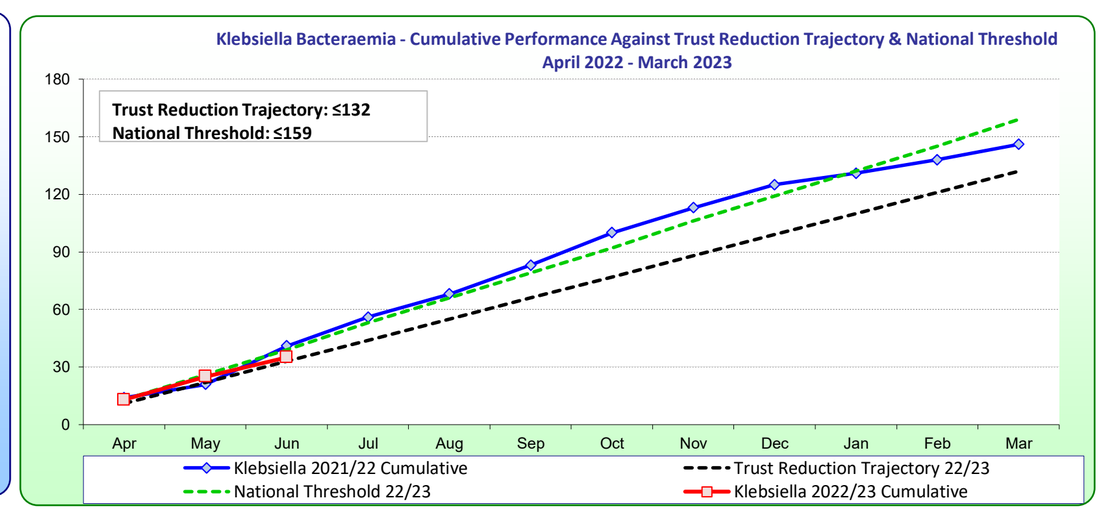


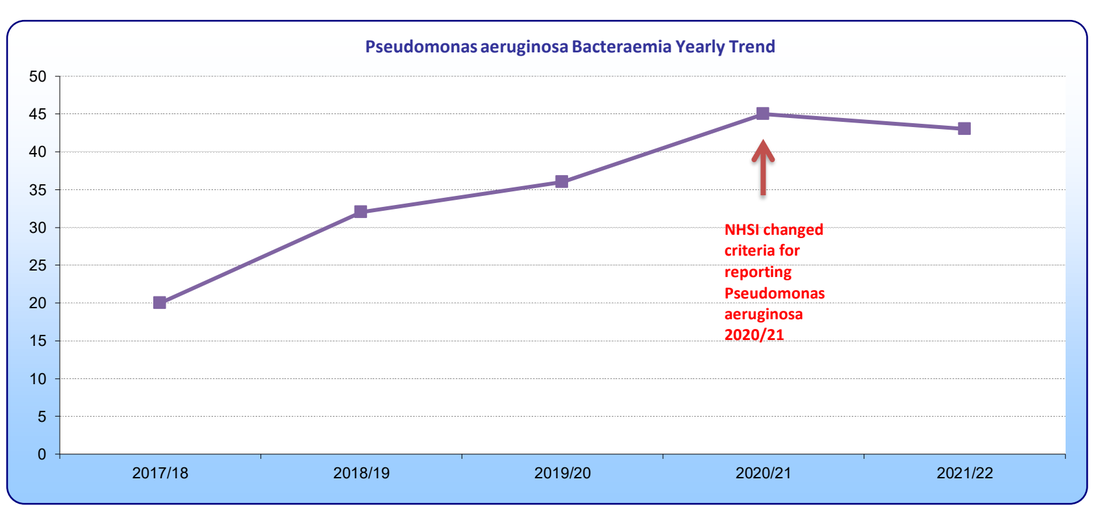


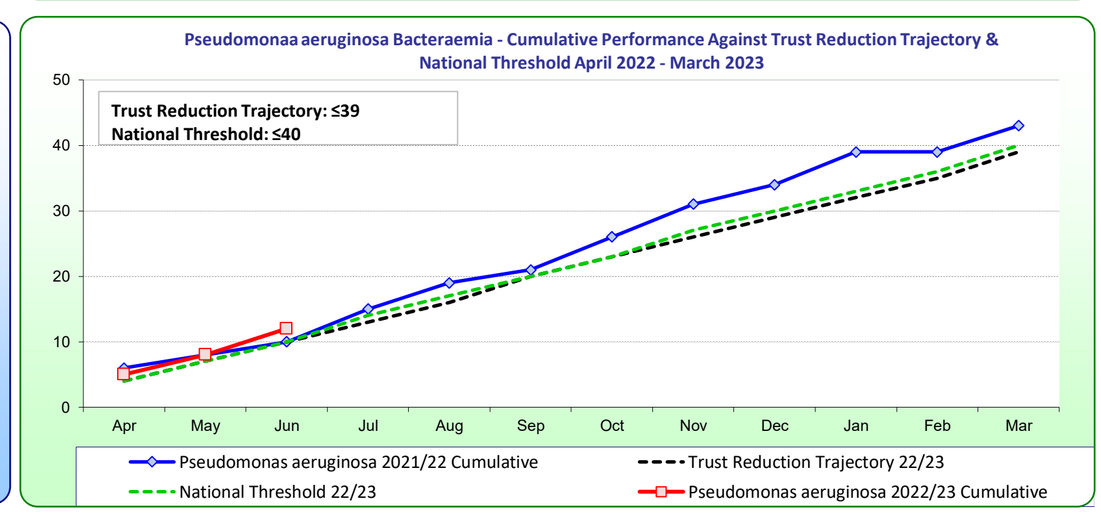












Healthcare-Associated Infection Report June 2022

The Newcastle upon Tyne Hospitals NHS Foundation Trust

IPC indicators (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA Bacteraemia - non-Trust	0	0	0										0
MRSA Bacteraemia - Trust-assigned (objective 0)	0	1	0										1
MRSA HA acquisitions	1	0	1										2
MSSA Bacteraemia - Healthcare Associated (local objective ≤99)	12	8	6										26
E. coli Bacteraemia - Healthcare Associated (local objective ≤186)	17	13	21										51
Klebsiella Bacteraemia - Healthcare Associated (local objective ≤132)	13	12	10										35
Pseudomonas aeruginosa Bacteraemia - Healthcare Associated (local objective ≤39)	5	3	4										12
C. diff - Hospital Acquired (national threshold not yet know; local objective ≤153)	12	17	13										42
C. diff related death certificates	-	-	1										
Part 1	-	-	-										
Part 2	-	-	1										

Periods of Increased Incidence (PIIs)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
C. diff - Hospital Acquired	2	4	1										7
Patients affected	5	8	3										16
COVID-19 - Hospital Acquired	8	1	2										11
Patients affected	25	2	4										31

Healthcare Associated COVID-19 cases (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Hospital onset Probable HC assoicated (8-14 days post admission)	49	19	33										101
Hospital onset Definite HC assoicated (≥15 days post admission)	63	22	49										134

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	-	-	-										0
Patients affected (total)	-	-	-										0
Staff affected (total)	-	-	-										0
Bed days losts (total)	-	-	-										0
Other Outbreaks	2	0	0										2
Patients affected (total)	16	0	0										16
Staff affected (total)	0	0	0										0
Bed days losts (total)	48	0	0										48
COVID Outbreaks	4	2	9										15
Patients affected (total)	32	15	71										118
Staff affected (total)	0	2	0										2

C.diff Transit and Testing Times Target <18hrs	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Trust Specimen Transit Time	12:36	12:44	14:41										13:20
Laboratory Turnaround Time	04:04	02:43	03:06										03:17
Total to Result Availability	16:40	15:27	17:47										16:38

Clinical Assurance Indicators/Audits (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Adult IP; Children's IP; Community HV/SN; Community Nursing; Critical Care; Dental; Maternity; OP; Theatres) Trust Total	58%	67%	67%										64%
Hand Hygiene Audit Trust Total	68%	85%	82%										78%
Invasive Device Care Audit Trust Total	64%	71%	70%										68%
Matron Checks (IP; OP/Community/Dental; Theatres) Trust Total	73%	78%	87%										79%

Infection Control Mandatory Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Infection Control	89%	90%	90%										90%

Aseptic Non Touch Technique Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
ANTT (M&D staff only)	55%	57%	57%										56%

ANTT compliance levels

It should be noted that this compliance is only monitored in medical staff. Work is progressing to include the recording of ANTT assessment for all staff who undertake procedures requiring ANTT.

There may be several factors contributing to the low level of ANTT compliance in medical staff, these include staff pressure due to staffing levels, access to ANTT assessors and also the lack of an electronic form for medical staff to register their ANTT assessment. The latter was using a survey monkey link on the intranet however this is no longer available. Currently a copy of the completed assessment form has to be sent to Education and Workforce Development. Education and Workforce Development are in the process of developing a new electronic system for recording this assessment.

8TH JULY 2022

1. COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST
2. CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST
3. GATESHEAD HEALTH NHS FOUNDATION TRUST
4. THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
5. NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TUST
6. NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST
7. NORTH TEES AND HARTLEPOOL HOSPITALS NHS FOUNDATION TRUST
8. NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST
9. SOUTH TEES HOSPITALS NHS FOUNDATION TRUST
10. SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST
11. TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST

COLLABORATION AGREEMENT

FOR THE NORTH EAST AND NORTH CUMBRIA PROVIDER COLLABORATIVE

No	Date	Version Number	Author
1	140322	1	Hill Dickinson (EV)
2	240322	2	Hill Dickinson (EV)
3	290422	3	PvCv (NS)
4	270622	4	PvCv (NS)
5	300622	5	PvCv (NS)
6	060722	6	PvCv (MB)

Contents

Overarching Note

This Collaboration Agreement is based on a memorandum of understanding approach to provide an overarching, non-legally binding, framework for collaboration between the Trust parties.

The Agreement sets out the current purpose, objectives, and initial priorities of the Collaborative. It also sets out its initial governance structure for the Trusts to come together to make aligned decisions in specific areas. The format of the Agreement is designed to work alongside existing services contracts held by the Trusts such as the NHS Standard Contract (the Services Contract), and does not affect or override any of the current Services Contracts in any way.

Some areas of the Agreement will need significant development around the nature and function of the Collaborative over time, as outlined in the Operating Model in Schedule 4. In particular, the Integrated Care Board (ICB) and Provider Collaborative have set out the need for a Responsibility Agreement, to define agreed areas of work, accountability, escalation and resourcing. This Responsibility Agreement will set out the part that the Provider Collaborative plays in the context of the wider system and will be developed throughout the Summer of 2022, following the formal establishment of the ICB.

The Integrated Care Board Executive team has supported the content of this Collaboration Agreement.

Date: **8th July 2022**

This **Collaboration Agreement** ("**Agreement"**) is made between:

1. **County Durham and Darlington NHS Foundation Trust** of Darlington Memorial Hospital Hollyhurst Road, Darlington, County Durham, DL3 6HX;

2. **Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust** of St. Nicholas Hospital, Jubilee Road, Gosforth, Newcastle upon Tyne NE3 3XT;

3. **Gateshead Health NHS Foundation Trust** of Queen Elizabeth Hospital, Sheriff Hill, Gateshead NE9 6SX;

4. **The Newcastle Upon Tyne Hospitals NHS Foundation Trust** of Freeman Hospital, Freeman Road, High Heaton, Newcastle upon Tyne, NE7 7DN;

5. **North Cumbria Integrated Care NHS Foundation Trust** of NCIC Trust HQ, Pillars Building, Cumberland Infirmary, Infirmary Street, Carlisle, CA2 7HY;

6. **North East Ambulance Service NHS Foundation Trust** of Bernicia House, Goldcrest Way Newburn Riverside, Newcastle upon Tyne, NE15 8NY;

7. **North Tees and Hartlepool Hospitals NHS Foundation Trust** of Hardwick Road, Hardwick, Stockton-on-Tees TS19 8PE;

8. **Northumbria Healthcare NHS Foundation Trust** of 7, Northumbria House, Cobalt Business Park, 8 Silver Fox Way, Newcastle upon Tyne NE27 0QJ;

9. **South Tees Hospitals NHS Foundation Trust** of The James Cook University Hospital, Marton Road, Middlesbrough, Cleveland, TS4 3BW;

10. **South Tyneside and Sunderland NHS Foundation Trust** of Sunderland Royal Hospital, Kayll Road, Sunderland, SR4 7TP;

11. **Tees, Esk and Wear Valleys NHS Foundation Trust** of Trust Headquarters, West Park Hospital, Edward Pease Way, Darlington, Durham, DL2 2TS,

together referred to in this Agreement as the "**Trusts**" and "**Trust**" shall be construed accordingly.

BACKGROUND

1. The white paper published by the Department of Health and Social Care in February

2021[1] (the "**White Paper**") builds on the NHS Long Term Plan vision of integrated care and sets out the key components of a statutory integrated care system ("**ICS**"). One of these components is a provider collaborative, a partnership arrangement involving two or more trusts working across multiple places to realise the benefits of mutual aid and working at scale. The Health and Care Bill 2021 implements proposals from the White Paper with effect from 1 July 2022, including new mechanisms to enable provider NHS trusts to make joint decisions.

2. Guidance[2] states that provider collaboratives should have a shared purpose and effective decision-making arrangements to:

   (a) reduce unwarranted variation and inequality in health outcomes, access to services and experience;

   (b) improve resilience by, for example, providing mutual aid; and

   (c) ensure that specialisation and consolidation occur where this will provide better outcomes and value.

3. The Trusts have been working together informally as a provider collaborative since 2020 (the "**Collaborative"**). With the NHS North East & North Cumbria Integrated Care Board ("**ICB**") established on 1 July 2022 pursuant to the Health & Care Bill, there is a need for the Collaborative to formalise its governance arrangements and ways of working to ensure it can be proactive in setting its relationship with the ICB, and other stakeholders, moving forward.

4. Aligned to the Collaborative's agreed purpose, the Trusts have agreed to undertake several initial programmes of work that they will pursue through the Collaborative governance (see Schedule 3). The Trusts have also agreed a plan for the further development of the Collaborative from the Commencement Date, as detailed in the Operating Model in Schedule 4.

5. This Agreement provides an overarching governance framework for the Trusts to work and make decisions together on matters within the remit of the Collaborative. The framework set out is intended to enable, and not prevent, smaller groups of Trusts to come together on specific programmes of work where it makes sense for them to do so.

---

[1] *Integration and Innovation: working together to improve health and social care for all* (Integration and Innovation: working together to improve health and social care for all (publishing.service.gov.uk)

[2] *Working together at scale: guidance on provider collaboratives* (NHS England, August 2021)

6. While, through this Agreement, the Trusts are documenting their agreed governance arrangements for the Collaborative as at the Commencement Date, the governance model is likely to evolve over time as the Trusts develop their working relationships further and as the ICB's operating model develops. A Responsibility Agreement will be developed to define the relationship between the ICB and the Collaborative. New governance mechanisms will become available when the Health & Care Bill becomes law, including the ability for the Trusts to form joint committees with each other, and with the ICB. The Collaborative will also need to evolve to be capable of receiving, delivering and providing assurance to the ICB on the exercise of any ICB functions delegated to or commissioned from the Collaborative, alongside any existing programmes agreed by the Trusts. It is therefore anticipated that this Agreement will be reviewed and updated regularly by agreement of the Trusts.

OPERATIVE PROVISIONS

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement, capitalised words and expressions shall have the meanings given to them in Schedule 1.

1.2 In this Agreement, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

1.2.2 a reference to a "**Trust**" includes its personal representatives, successors or permitted assigns;

1.2.3 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted;

1.2.4 any phrase introduced by the terms "**including**", "**include**", "**in particular**" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms; and

1.2.5 a reference to writing or written includes faxes and e-mails.

2. PURPOSE AND EFFECT OF THE AGREEMENT

2.1 The Trusts have agreed to work together to form a single voice and act in concert to bring further improvements to care in their combined areas of operation. The Trusts wish to record the basis on which they will collaborate with each other in this Agreement and intend to act in accordance with its terms.

2.2 This Agreement sets out:

2.2.1 the agreed purpose, strategic objectives and principles of the Collaborative;

2.2.2 the initial Key Delivery Priorities for the Collaborative;

2.2.3 the governance structures the Trusts will put in place;

2.2.4 the programme management arrangements for the Collaborative;

2.2.5 the respective roles and responsibilities of the Trusts; and

2.2.6 a plan for the further development of the Collaborative for 2022/23, which the Trusts will work together to implement through this Agreement.

2.3 The Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this Agreement, this Agreement shall not be legally binding. The Trusts enter into this Agreement intending to honour all their obligations to each other.

3. ACTIONS TAKEN PRIOR TO AND POST THE COMMENCEMENT DATE

3.1 Each of the Trusts acknowledges and confirms that as at the date of this Agreement it has obtained all necessary authorisations to enter into this Agreement.

4. DURATION

4.1 This Agreement shall commence on the Commencement Date and will continue for the Initial Term, unless and until terminated in accordance with its terms.

4.2 On the expiry of the Initial Term this Agreement will expire automatically without notice unless, no later than 6 months before the end of the Initial Term, the Trusts agree in writing that the term of the Agreement will be extended for a further term to be agreed between the Trusts ("**Extended Term**").

4.3 The Trusts will review progress made by the Collaborative against the Key Delivery Priorities and the terms of this Agreement no later than 12 months following the Commencement Date and at such intervals thereafter as the Trusts may agree, but at

least annually. The Trusts may agree to vary the Agreement to reflect developments as appropriate in accordance with Clause 16 (*Variations*).

5. THE COLLABORATIVE PURPOSE, OBJECTIVES AND PRIORITIES

5.1 The Trusts have agreed that the common purpose for the Collaborative is to bring together the Trusts in order to:

5.1.1 improve the health and wellbeing of the North East and North Cumbria population, with particular focus on improving health inequalities that exist within the region;

5.1.2 optimise the delivery, quality and efficiency of local health and care services provided by the Trusts; and

5.1.3 support the Trusts by taking the necessary collaborative, or where possible, collective, action, including mutual aid and support,

the "**Collaborative Purpose**".

5.2 The Trusts have agreed to work together to perform their obligations under this Agreement in order to achieve the Collaborative Purpose, and more specifically, have agreed the following objectives for the Collaborative:

5.2.1 development of a strategic approach to clinical services focusing on vulnerable services and a strategic response to clinical networks and associated cross system working arrangements;

5.2.2 delivery of elective recovery (covering inpatient, diagnostics and cancer) to meet or exceed national benchmarks, standards and targets;

5.2.3 delivery of urgent care standards and requirements across providers and local systems to reduce variation and improve consistency of response;

5.2.4 building capacity and capability in clinical support services to achieve appropriate infrastructure in place to deliver strategy clinical aims; and

5.2.5 establishing and delivering appropriate corporate strategies to enhance integration and tackle variation including approaches to collective planning, rationalised and aligned estates / capital processes and development of underpinning approaches to workforce,

(the "**Objectives**").

5.3 The Trusts have agreed a number of Key Delivery Priorities for 2022/23 in pursuit of the Objectives, as set out in Schedule 3. The Trusts will agree any changes to the Key

Delivery Priorities during the NHS financial year 2022/23 if required, and will review and refresh the Key Delivery Priorities in any event in advance of each new NHS financial year.

5.4 Each programme of work within a Key Delivery Priority will be sponsored by a Trust Chief Executive as Senior Responsible Owner ("**SRO**"). SRO roles will be distributed across the Trust Chief Executives. Each SRO will be responsible to the Provider Leadership Board for the planning and delivery of their work programme and will be supported by the Programme Management Office.

5.5 The Trusts acknowledge and confirm that the success of the Collaborative will depend on the Trusts' ability to effectively co-ordinate and combine their expertise, workforce, and resources as providers in order to deliver the Key Delivery Priorities and achieve the Objectives.

5.6 Each Trust acknowledges that in order to achieve the Collaborative Purpose, it will need to collaborate with the other Trusts to provide mutual aid and solve challenges in line with the Collaborative Principles. Where practicable, the Trusts will work together to agree a joint plan for tackling such challenges which will also set out the agreed roles and responsibilities of each Trust.

5.7 The work of the Collaborative will be in the context of the Integrated Care System, in close partnership with the ICB, and will conducted in line with statutory and legislative requirements, such as the guidance on service change in the NHS[3].

6. THE COLLABORATIVE PRINCIPLES

6.1 The aim of this Clause 6 is to identify the high level collaborative principles which underpin how the Trusts will work together for the delivery of the Objectives and Key Delivery Priorities under this Agreement and to set out key factors for the success of the Collaborative.

6.2 The principles referred to in Clause 5.1 are that the Trusts will work together in good faith and, unless the provisions in their individual Services Contract(s) or this Agreement state otherwise, through the Collaborative the Trusts will:

6.2.1 look to provide mutual aid and support to each other in pursuit of the Collaborative Purpose and Objectives;

[3] *Planning, assuring and delivering service change for patients* (NHS England, amended May 2022)

6.2.2 make collective decisions that speed up service changes and transformation, whilst ensuring that these are discussed with system partners, as relevant; and compliant with statutory and legislative requirements

6.2.3 challenge and hold each other to account through agreed systems, processes and ways of working;

6.2.4 act collaboratively and in good faith with each other in accordance with Guidance, the Law and Good Practice to achieve national priorities and the Objectives having at all times regard to the welfare of the population of the North East and North Cumbria;

6.2.5 actively promote a culture that facilitates integrated working and empowers staff to work collaboratively with other Trust staff to deliver better outcomes for the population of the North East and North Cumbria;

6.2.6 ensure strong clinical leadership is built into the Collaborative governance and work programmes;

6.2.7 engage with and involve the population and wider stakeholders in the ICB area in relation to the work of the Collaborative, primarily through each Trust's membership of place-based partnerships within the ICB area;

6.2.8 support each other (informally and publicly) in taking decisions in the best interests of the North East and North Cumbria population;

6.2.9 take responsibility for and manage the risks in delivering the Key Delivery Priorities together as a Collaborative;

6.2.10 promote and develop a co-operative and high performing culture, and way of working across the Collaborative:

(i) that promotes and drives co-operation, innovation and continuous improvement;

(ii) where information is shared;

(iii) where communication is honest and respectful; and

(iv) which is founded upon ethical and responsible behaviour and decision making,

without losing sight of each Trust's corporate and statutory accountability;

together these are the "**Collaborative Principles**".

7. PROBLEM RESOLUTION AND ESCALATION

7.1 The Trusts agree to adopt a systematic approach to problem resolution between them on matters which relate to the Collaborative which recognises the Collaborative Principles, the Objectives and Key Delivery Priorities (set out in Clauses 5 and 6).

7.2 If a problem, issue, concern or complaint comes to the attention of a Trust in relation to the Key Delivery Priorities or any matter within the scope of this Agreement, such Trust shall notify the other Trusts and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion between the relevant affected Trusts.

7.3 Save as otherwise specifically provided for in this Agreement, any dispute arising between the Trusts out of or in connection with this Agreement will be resolved in accordance with Schedule 5 (*Dispute Resolution*).

7.4 If any Trust receives any formal inquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier) in relation to the Key Delivery Priorities or other work of the Collaborative, the Trust will liaise with the Provider Leadership Board as to the contents of any response before a response is issued.

8. OBLIGATIONS AND ROLES OF THE TRUSTS

8.1 Each Trust acknowledges and confirms that:

8.1.1 it remains responsible for performing its obligations and functions for delivery of services to the Commissioners in accordance with its Services Contract(s);

8.1.2 it will be separately and solely liable to the Commissioners for the provision of services under its own Services Contract; and

8.1.3 the intention of the Trusts is to work together with each other, and with the Commissioners, to achieve better use of resources and better outcomes for the population of the North East and North Cumbria initially in respect of the Key Delivery Priorities and to create a collaborative culture in, and between, their organisations.

8.2 Each Trust undertakes to co-operate in good faith with the others to facilitate the proper performance of this Agreement and in particular will:

8.2.1 use all reasonable endeavours to avoid unnecessary disputes and claims against any other Trust;

8.2.2 not interfere with the rights of any other Trust and its servants, agents, representatives, contractors or sub-contractors (of any tier) on its behalf in performing its obligations under this Agreement nor in any other way hinder or prevent such other Trust or its servants, agents, representatives, or sub-contractors (of any tier) on its behalf from performing those obligations; and

8.2.3 (subject to Clause 8.3) assist the other Trusts (and their servants, agents, representatives, or sub-contractors (of any tier)) in performing those obligations so far as is reasonably practicable.

8.3 Nothing in Clause 8.2 shall:

8.3.1 interfere with the right of each of the Trusts to arrange its affairs in whatever manner it considers fit in order to perform its obligations under this Agreement in the manner in which it considers to be the most effective and efficient; or

8.3.2 oblige any Trust to incur any additional cost or expense or suffer any loss in excess of that required by its proper performance of its obligations under this Agreement.

8.4 Each of the Trusts severally undertakes that it shall:

8.4.1 subject to the provisions of this Agreement, comply with all Laws applicable to it which relate to the Key Delivery Priorities; and

8.4.2 inform the Provider Leadership Board as soon as reasonably practicable if at any time it becomes unable to meet any of its obligations and in such case inform, and keep the Provider Leadership Board informed, of any course of action to remedy the situation recommended or required by NHS England, the Secretary of State for Health and Social Care or other competent authority,

provided that, to avoid doubt, nothing in this Clause shall in any way fetter the discretion of the Trusts in fulfilling their statutory functions.

8.5 The Trusts have not agreed to share risk or reward between them under this Agreement and any future introduction of such provisions will require additional legally binding provisions to be agreed between the relevant Trusts.

9. COLLABORATIVE PROGRAMME MANAGEMENT RESOURCE

9.1 The Trusts have agreed that the Collaborative will be supported by a programme management office ("**PMO**"). The PMO will support each SRO in respect of the work programmes and Key Delivery Priorities. The initial PMO structure is set out in Schedule 4 (*Operating Model*).

9.2 For the financial year 2022/23, PMO costs will be met through a financial contribution to the Collaborative from the NHS North East Commissioning Support Unit. The Trusts acknowledge that the funding of the PMO and any other proposed supporting infrastructure for the Collaborative for NHS financial year 2023/24 and beyond will need to be discussed and agreed by the Trusts and may comprise or include financial or other resource contributions from the Trust members of the Collaborative.

10. REPORTING REQUIREMENTS

10.1 Each of the Trusts will during the Term:

10.1.1 promptly provide to the PMO or to any other Trust involved in the delivery of the Key Delivery Priorities, such information about their work in respect of such Key Delivery Priorities and such co-operation and access as the PMO or other Trust may reasonably require from time to time in line with the Collaborative Principles, provided that if the provision of such information, co-operation or access amounts to a change to this Agreement then it will need to be proposed as such to the Provider Leadership Board and the variation procedure set out in Clause 16 will apply; and

10.1.2 identify and obtain all consents necessary for the fulfilment of its obligations in respect of the Key Delivery Priorities,

limited in each case to the extent that such action does not cause a Trust to be in breach of any Law, its obligations under Clause 12 (*Information Sharing and Conflicts of Interest*) Clause 17 (*Confidentiality*) or any legally binding confidentiality obligations owed to a third party.

11. GOVERNANCE

11.1 The Trusts all agree to establish the Provider Leadership Board ("**PLB**"). For the avoidance of doubt the PLB shall not be a committee of any Trust or any combination of Trusts.

11.2 The PLB is the group responsible for leading and overseeing the Trusts' collaborative approach to the Key Delivery Priorities and working in accordance with the Collaborative Principles. The PLB may establish supporting and/or task and finish groups to take forward programmes in respect of the Key Delivery Priorities as appropriate, ensuring a strong clinical voice and involving input from a range of functions across the Trusts. The PLB will have other responsibilities as defined in its terms of reference set out in Schedule 2 (Provider Leadership Board – Terms of Reference).

11.3 The PLB will invite the Chairs of each Trust's board to a meeting of the PLB at 6 monthly intervals in order to brief the Chairs on the Collaborative's work and progress against the Objectives and Key Delivery Priorities.

11.4 The Trusts will communicate with each other clearly, directly and in a timely manner to ensure that the members of the PLB are able to make effective and timely decisions.

11.5 The Trusts will ensure appropriate attendance from their respective organisations at all meetings of the PLB and that their representatives act in accordance with the Collaborative Principles.

11.6 The Trusts acknowledge that they each participate in other collaborative arrangements outside of the Collaborative, including with other providers on a sector basis, and at place level. The Trusts will work together to ensure that the governance arrangements under this Agreement are streamlined and do not unnecessarily duplicate decision-making arrangements in other collaboratives.

12. INFORMATION SHARING AND CONFLICTS OF INTEREST

12.1 The Trusts will provide to each other all information that is reasonably required in order to deliver the Key Delivery Priorities and achieve the Objectives.

12.2 The Trusts have obligations to comply with competition law. The Trusts will therefore make sure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law and, accordingly, the PLB will ensure that the exchange of Competition Sensitive Information will be restricted to circumstances where:

12.2.1 it is essential;

12.2.2 it is not exchanged more widely than necessary;

12.2.3 it is subject to suitable non-disclosure or confidentiality agreements which include a requirement for the recipient to destroy or return it on request or on termination or expiry of the Agreement; and

12.2.4 it may not be used other than to achieve the Collaborative Purpose and Objectives under this Agreement in accordance with the Collaborative Principles.

12.3 The Trusts acknowledge that it is for each Trust to decide whether information is Competition Sensitive Information but recognise that it is normally considered to include any internal commercial information which, if it is shared between Trusts who are providers, would allow them to forecast or co-ordinate commercial strategy or behaviour in any market.

12.4 The Trusts will make sure the PLB establishes appropriate non-disclosure or confidentiality agreements between and within the Trusts so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Trusts who need to see it for the purposes of the better delivery of the Key Delivery Priorities and Objectives and for no other purpose whatsoever so that they do not breach competition law.

12.5 It is accepted that the involvement of the Trusts in this Agreement may give rise to situations where information will be generated and made available to the Trusts, which could give them an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one Trust with a commercial advantage over a separate Trust). The Trusts therefore recognise the need to manage the information referred to in this Clause 12.5 in a way which maximises their opportunity to take part in competitions operated by the Commissioners by putting in place appropriate procedures, such as appropriate non-disclosure or confidentiality agreements in advance of the disclosure of information.

12.6 Where there are any Patient Safety Incidents or Information Governance Breaches relating to the Key Delivery Priorities, for example, the Trusts shall ensure that they each comply with their individual Services Contract and work collectively and share all relevant information for the purposes of any investigations and/or remedial plans to be put in place, as well as for the purposes of learning lessons in order to avoid such Patient Safety Incident or Information Governance Breach in the future.

12.7 The Trusts will:

12.7.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or the delivery of the Key Delivery Priorities, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Trust or any person employed or retained by them for or in connection with the delivery of the Key Delivery Priorities or Objectives;

12.7.2 not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this Agreement (without the prior consent of the other Trusts) before they participate in any decision in respect of that matter; and

12.7.3 use best endeavours to ensure that their representatives on the PLB and other Collaborative governance groups also comply with the requirements of this Clause 12 when acting in connection with this Agreement.

12.8 The Trusts shall comply with their obligations under the Data Protection Legislation.

13. TERMINATION, EXCLUSION AND WITHDRAWAL

13.1 The PLB may resolve to terminate this Agreement in whole where:

13.1.1 a Dispute cannot be resolved pursuant to the Dispute Resolution Procedure;

13.1.2 automatically and immediately where there exists just one Trust that remains party to this Agreement; or

13.1.3 where the Trusts agree for this Agreement to be replaced by a formal legally binding agreement between them.

Exclusion

13.2 A Trust may be excluded from this Agreement on written notice from all of the remaining Trusts in the event of a material or a persistent breach of the terms of this Agreement by the relevant Trust which has not been rectified within 30 calendar days of notification issued by the remaining Trusts or which is not reasonably capable of remedy. In such circumstances this Agreement shall be partially terminated in respect of the excluded Trust.

Voluntary withdrawal of a Trust

13.3 Any Trust may withdraw from this Agreement by giving at least 60 calendar days' notice in writing to the other Trusts.

Consequences of termination / exclusion / withdrawal

13.4 Where a Trust is excluded from this Agreement, or withdraws from it, the excluded Trust shall procure that all data and other material belonging to any other Trust shall be delivered back to the relevant Trust, deleted or destroyed as soon as reasonably practicable and confirm to the remaining Trusts when this has been completed.

14. INTRODUCING NEW PROVIDERS

14.1 Additional providers may become parties to this Agreement on such terms as the Trusts will jointly agree, acting at all times in accordance with the Collaborative Principles. Any new provider will be required to agree to the terms of this Agreement before admission.

15. CHARGES AND LIABILITIES

15.1 Except as otherwise provided, the Trusts shall each bear their own costs and expenses incurred in complying with their obligations under this Agreement, including in respect of any losses or liabilities incurred due to their own or their employees' actions.

15.2 Except as otherwise provided, no Trust intends that any other Trust shall be liable for any loss it suffers as a result of this Agreement.

16. VARIATIONS

16.1 The provisions of this Agreement may be varied at any time by a Notice of Variation signed by the Trusts in accordance with this Clause 16.

16.2 If a Trust wishes to propose a variation to this Agreement ("**Variation**"), that Trust must submit a draft notice setting out their proposals in accordance with Clause 16.3 (a "**Notice of Variation**") to the other Trusts and the Chair of the PLB to be considered at the next meeting (or when otherwise determined by the Trusts) of the PLB.

16.3 A draft Notice of Variation must set out:

16.3.1 the Variation proposed and details of the consequential amendments to be made to the provisions of this Agreement;

16.3.2 the date on which the Variation is proposed to take effect;

16.3.3 the impact of the Variation on the achievement of the Key Delivery Priorities and Objectives; and

16.3.4 any impact of the Variation on any Services Contracts.

16.4 The PLB will consider the draft Notice of Variation and either:

16.4.1 accept the draft Notice of Variation (all Trusts consenting), in which case all Trusts will sign the Notice of Variation;

16.4.2 amend the draft Notice of Variation, such that it is agreeable to all Trusts, in which case all Trusts will sign the amended Notice of Variation; or

16.4.3 not accept the draft Notice of Variation, in which case the minutes of the relevant PLB shall set out the grounds for non-acceptance.

16.5 Any Notice of Variation of this Agreement will not be binding unless set out in writing and signed by or on behalf of each of the Trusts.

17. CONFIDENTIAL INFORMATION

17.1 Each Trust shall keep in strict confidence all Confidential Information it receives from another Trust except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Trust. Each Trust shall use any Confidential Information received from another Trust solely for the purpose of delivering the Key Delivery Priorities and complying with its obligations under this Agreement in accordance with the Collaborative Principles and for no other purpose. No Trust shall use any Confidential Information received under this Agreement for any other purpose including use for their own commercial gain in services outside of the Key Delivery Priorities or to inform any competitive bid for any elements of the Key Delivery Priorities without the express written permission of the disclosing Trust.

17.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Trust or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Trust may have in respect of such Confidential Information.

17.3 The Parties agree to procure, as far as is reasonably practicable, that the terms of this Clause 17 (*Confidential Information*) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Agreement.

17.4 Nothing in this Clause 17 (*Confidential Information*) will affect any of the Trusts' regulatory or statutory obligations, including but not limited to competition law.

18. INTELLECTUAL PROPERTY

18.1 In order to meet the Collaborative Purpose and Objectives each Trust grants to each of the other Trusts a fully paid up non-exclusive licence to use its existing Intellectual Property provided under this Agreement insofar as is reasonably required for the sole purpose of the fulfilment of that Trusts' respective obligations under this Agreement.

New Intellectual Property

18.2 If any Trust creates any new Intellectual Property through the operation of the Collaborative, the Trust which creates the new Intellectual Property will grant to the other Trusts a fully paid up non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Trusts' obligations under this Agreement.

19. FREEDOM OF INFORMATION

19.1 If any Trust receives a request for information relating to this Agreement or the Integrated Services under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004, it shall consult with the other Trusts before responding to such request and, in particular, shall have due regard to any claim by any other Trust to this Agreement that the exemptions relating to commercial confidence and/or confidentiality apply to the information sought.

20. NOTICES

20.1 Any notice or other communication given to a Trust under or in connection with this Agreement shall be in writing addressed to that Trust at its principal place of business or such other address as that Trust may have specified to the other Trust in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery or commercial courier.

20.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 20.1; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; or, if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

21. NO PARTNERSHIP

21.1 Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Trusts, constitute any Trust the agent of another Trust, nor authorise any Trust to make or enter into any commitments for or on behalf of any other Trust except as expressly provided in this Agreement.

22. COUNTERPARTS

22.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this Agreement scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Trust has executed at least one counterpart.

23. GOVERNING LAW AND JURISDICTION

23.1 This Agreement, and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and, subject to Clause 6, the Trusts irrevocably submit to the exclusive jurisdiction of the courts of England.

Signed by .....

for and on behalf of **COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf of **CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST** [ ]

Signed by

for and on behalf of **GATESHEAD HEALTH NHS FOUNDATION TRUST** .....

[ ]

Signed by

for and on behalf of **THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST** .....

[ ]

Signed by

for and on behalf of **NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST** .....

[ ]

Signed by

for and on behalf of **NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST** .....

[ ]

Signed by

for and on behalf of **NORTH TEES AND HARTLEPOOL HOSPITALS NHS FOUNDATION TRUST** .....

[ ]

.....

Signed by [ ]

for and on behalf of **NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST**

Signed by .....

for and on behalf of **SOUTH TEES HOSPITALS NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf of **SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf **TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST** [ ]

SCHEDULE 1

Definitions and Interpretation

1 The following words and phrases have the following meanings in this Agreement:

Agreement	this collaboration agreement incorporating the Schedules
Collaborative	the provider collaborative formed by the Trusts and as detailed pursuant to this Agreement
Collaborative Principles	the collaborative principles for the Collaborative as set out in Clause 6.2
Collaborative Purpose	the common purpose for the Collaborative as set out in Clause 5.1
Commencement Date	1 April 2022
Commissioners	Pre 1 July 2022: Clinical commissioning groups in the North East and North Cumbria ICS area Post 1 July 2022: the ICB
Competition Sensitive Information	Confidential Information which is owned, produced and marked as Competition Sensitive Information by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Trust, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions

Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement, including Commercially Sensitive Information and Competition Sensitive Information;
Data Protection Legislation	all applicable Laws relating to data protection and privacy including without limitation the UK GDPR; the Data Protection Act 2018; the Privacy and Electronic Communications Regulations 2003 (SI 2003/2426); the common law duty of confidentiality and the guidance and codes of practice issued by the Information Commissioner, relevant Government department or regulatory in relation to such applicable Laws
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it
Dispute Resolution Procedure	the procedure set out in Schedule 5 (*Dispute Resolution Procedure*) to this Agreement
Extended Term	has the meaning set out in Clause 4.2
Good Practice	has the meaning set out in the Services Contracts
Guidance	any applicable health or social care guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Trusts have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Trust by a Commissioner and/or any relevant regulatory body
ICB	NHS North East and North Cumbria Integrated Care Board, expected to be established on 1 July 2022
IG Guidance for Serious Incidents	NHS Digital's Checklist Guidance for Information Governance Serious Incidents Requiring Investigation June 2013,

	available at Data Security and Protection Toolkit - NHS Digital
Information Governance Breach	an information governance serious incident requiring investigation, as defined in the IG Guidance for Serious Incidents
Initial Term	3 years from the Commencement Date
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world
Key Delivery Priorities	the priorities of the Collaborative, the initial priorities being those set out in Schedule 3, as may be amended from time to time by a Notice of Variation
Law	(a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; (b) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; (c) any applicable judgment of a relevant court of law which is a binding precedent in England; (d) Guidance; and (e) any applicable code in each case in force in England and Wales, and "Laws" shall be construed accordingly

NHS Standard Contract	the NHS Standard Contract as published by NHS England from time to time
Notice of Variation	has the meaning set out in Clause 16.2
Objectives	the objectives for the Collaborative as set out in Clause 5.2, as may be amended from time to time
Operational Days	a day other than a Saturday, Sunday or bank holiday in England
Patient Safety Incident	any unintended or unexpected incident that occurs in respect of a Service User, during and as a result of the provision of the Services, that could have led, or did lead to, harm to that Service User
Programme Management Office or PMO	the programme management office for the Collaborative, as further described in Clause 9.1 and Schedule 4 (*Operating Model*)
Operating Model	Document that describes how the Collaborative will work summarised in in Schedule 4 (*Operating Model*)
Provider Leadership Board or PLB	the group established by the Trusts pursuant to Clause 11.1, the terms of reference for which are set out in Schedule 2 (*Governance*)
Senior Responsible Owner or SRO	a Trust Chief Executive responsible for the planning and delivery of a work programme pursuant to a Key Delivery Priority
Services	the services provided, or to be provided, by a Trust to a Commissioner pursuant to its respective Services Contract which may include services which are the subject of one or more Key Delivery Priorities for the Collaborative
Services Contract	a contract entered into by one of the Commissioners and a Trust for the provision of Services, and references to a Services Contract include all or any one of those contracts as the context requires

Service User	a patient or service user for whom a Commissioner has statutory responsibility and who receives Services under any Services Contract
Term	the Initial Term of this Agreement plus any Extended Term(s) agreed in accordance with the terms of this Agreement
UK GDPR	has the meaning given to it in section 3(1) (as supplemented by section 205(4) of the Data Protection Act 2018
Variation	a proposed variation to this Agreement, effected in accordance with Clause 16
White Paper	has the meaning set out in Background paragraph 1.

SCHEDULE 2

Governance

Terms of Reference for the Provider Leadership Board

NORTH EAST AND NORTH CUMBRIA PROVIDER COLLABORATIVE PROVIDER LEADERSHIP BOARD Terms of Reference	
Version	**1.0**
Implementation Date	**1 April 2022**
Review Date	**1 April 2023**
Approved By	**Trust boards**
Approval Date	**8 July 2022**

REVISIONS			
Date	**Section**	**Reason for Change**	**Approved By**

1.	Purpose	The purpose of the Provider Leadership Board ("PLB") is to provide strategic leadership of the North East and North Cumbria Provider

		Collaborative (the "Collaborative") in setting its strategic direction and priorities. The PLB will oversee the delivery of the Collaborative Purpose, Objectives and Key Delivery Priorities (as set out in the Agreement and Operating Model).
2.	Status and authority	The PLB is established by the Trusts, each of which remains a sovereign organisation, to provide a governance framework for the further development of collaborative working between the Trusts in line with the Collaborative Principles. The PLB is not a separate legal entity, and as such is unable to take decisions separately from the Trusts, or bind any one of them; nor can one Trust 'overrule' any other on any matter. As a result, the PLB will operate as a place for discussion of issues with the aim of reaching consensus between the Trusts to make recommendations and proposals to statutory Trust boards as necessary. The PLB will function through engagement and discussion between its members so that each of the Trusts makes a decision in respect of, and expresses its views about, each matter considered by the PLB. The decisions of the PLB will, therefore, be the decisions of the individual Trusts, the mechanism for which shall be authority delegated by the individual Trusts to their members on the PLB. Each Trust will ensure that their designated member: - is appointed to attend and represent their Trust on the PLB with such authority as is agreed to be necessary for the PLB to function effectively in discharging its responsibilities as set out in these terms of reference which is to the extent necessary, recognised in the relevant Trust's respective scheme of delegation - has equivalent delegated authority to the designated representatives of all other Trusts comprising the PLB (as confirmed in writing and agreed between the Trusts); and - understands the status of the PLB and the limits of their responsibilities and authority.
3.	Accountability	The PLB is accountable to each of the boards of the Trusts.

4.	Responsibilities	The PLB is responsible for leading the Trusts' collaborative approach to the Collaborative Objectives and Key Delivery Priorities working in accordance with the Collaborative Principles, in line with the terms of the Agreement. The PLB members will make decisions together at PLB meetings in respect of the Key Delivery Priorities, including in relation to recommendations from supporting/working groups as may be established by the PLB from time to time. The PLB will also be responsible for developing the Trusts' collaborative approach across the North East and North Cumbria and beyond the initial Key Delivery Priorities. When making decisions together at PLB meetings, the PLB members will act in line with the Collaborative Principles and their respective obligations under the Agreement. The PLB may establish working groups and/or task and finish groups to support its agreed functions.
5.	Membership and attendance	The PLB will include the following members: - The Chief Executive or nominated deputy from each Trust signatory to the Agreement as notified to the PLB from time to time. It is important that members or their deputies commit to attending PLB meetings. Where a member cannot attend a meeting, the member may nominate a named deputy to attend, provided that the member gives reasonable notice of the deputy attending to the chair. Deputies must be able to contribute and make decisions on behalf of the Trust they are representing. The PLB may invite others to attend, observe and/or participate in PLB meetings, as agreed by the members from time to time. Such attendees shall not participate in decision-making or count towards the quorum.
6.	Quorum	The PLB will be quorate if eight (8) of the Trust members of the PLB, one of whom is the chair, are present.
7.	Chairing	Meetings of the PLB will be chaired by a member, initially selected by a vote of attending members at the first meeting of the PLB and

	arrangements	thereafter on an agreed schedule where the chair is rotated to each member in turn with each carrying out the role for a twenty four (24) month period, with a potential extension for a further twenty four months (to align with ICB representative requirements). The successor chair in line with the agreed schedule will be the vice-chair for the preceding twenty four (24)month period to their appointment as chair.
8.	Decision making	The PLB will aim to achieve consensus wherever possible. Each member of the PLB will be representing their appointing Trust and will only make decisions at the PLB in respect of their own Trust in accordance with any delegated authority. Not all decisions within the remit of the PLB will affect all of the Trusts. Where this is the case, and the members of the PLB agree which of the Trusts are affected by a decision, then the relevant decision will be taken by the members of the affected Trusts, with the aim of achieving consensus.
9.	Conduct of business	Meetings of the PLB will be held monthly or such other frequency as may be agreed between the Trusts. Meetings may be held by telephone or video conference. Members of the PLB may participate (and count towards quorum) in a face-to-face meeting via telephone or video-conference. Any member may call extraordinary meetings of the PLB at their discretion subject to providing at least five working days' notice to PLB members. Circulation of the meeting agenda and papers via email will take place at least five working days prior to the meeting from the Chair. In the event members wish to add an item to the agenda they must notify the Chair. Requests made less than 7 working days before a meeting may be included on the agenda at the discretion of the Chair. The PLB will have administrative support from the Programme Management Office of the Collaborative to: - take minutes of the meetings and keep a record of matters arising and issues to be carried forward; and - maintain a register of interests of PLB members.

		Draft minutes of PLB meetings will be sent to the Trust's representative members within 14 days of each meeting. Approval of the minutes of the previous meeting of the PLB will be a standing item on each meeting agenda. It will be the members' responsibility to disseminate minutes and notes from the PLB inside their respective Trusts.
10.	Conflicts of interest	The members of the PLB must refrain from actions that are likely to create any actual or perceived conflicts of interests. PLB members must disclose all actual, potential or perceived conflicts of interest to the Chair in advance of each meeting to enable appropriate management arrangements to be put in place and ensure that such conflicts are managed in adherence with their organisation's conflict of interest policies and statutory duties. All members are required to uphold the Nolan Principles and all other relevant NHS requirements applicable to them. If there is any conflict between these terms of reference and the Agreement, the latter will prevail.
11.	Review	These terms of reference will be reviewed on an annual basis.

SCHEDULE 3

Key Delivery Priorities for 2022/23

The Trusts have identified the initial Key Delivery Priorities for the Collaborative (as may be agreed and amended from time to time) below.

The inclusion of any additional Key Delivery Priorities under this Schedule may only be made with the mutual written consent of all the Trusts.

NENC PvCv will:

- Optimise the resource available for healthcare (by collectively organising, managing and deploying workforce where appropriate, utilising the full NHS estate to best effect, sharing risk and gains financially to deliver an overall balanced position etc)
- Standardise pathways and interventions to reduce unwarranted clinical variation, thereby achieving improved outcomes for patients and more efficient use of the capacity available
- Leverage the assets within the PC that Trusts offer to attract inward investment (e.g. AHSC, Centre for Ageing, BRC, TREE, innovation appetite and opportunity) but this needs to be part of a coherent approach playing to the academic strengths of the member Trusts
- Facilitate data sharing to enable the NHS and care resource to be targeted more closely to need; to reduce inequalities and improve the equity of patient outcomes across the ICS and to enable prediction and prevention of health and care demand.
- Support member Trusts individually in their role as anchor institutions with the PvCV acting as a bridge aid economic recovery and the prevention agenda (through providing employment opportunities, local procurement and commitment to overall NE achievement of carbon net zero)

Given this overarching approach the PvCv will operate across four strategic objectives (underpinning work for 2022-25):

<u>Clinical Programmes</u>

1. Development of strategic approach to clinical services focusing on vulnerable services and a strategic response to clinical networks and associated cross system working arrangements

2. Delivery of elective recovery (covering inpatient, diagnostics and cancer) to meet or exceed national benchmarks, standards and targets

3. Delivery urgent care standards and requirements across providers and local systems to reduce variation and improve consistency of response

<u>Clinical Support Programmes</u>

4. Building capacity and capability in clinical support services to achieve appropriate infrastructure in place to delivery strategic clinical aims

Corporate Programmes

5. Establish and deliver appropriate corporate strategies to enhance integration and tackle variation including approaches to collective planning, rationalised and aligned estates/capital process and development of underpinning approaches in workforce.

Provider Collaborative Development

6. To continue to build capacity and capability within and across the PvCv to meet ongoing requirements.

NENC Key Delivery Priorities for 2022/23

Key delivery priority	How will we deliver it?	Q in which it will be achieved?	How will we know it has been achieved?	Current Delivery Mechanism
Clinical Programmes				
Strategic Objective 1				
1. Strategic Approach to Clinical Services *Development of strategic approach to clinical services focusing on vulnerable services and a strategic response to clinical networks and associated cross system working arrangements*	Working with ICB to develop overarching clinical strategy/approach in line with system priorities. Focus action on agreed risk/vulnerable areas (e.g. Clinical Oncology)	Tbc	Overarching clinical aligned clinical strategy in place. Agreed action delivered for identified areas: non-surgical medical oncology revised arrangements in place with evaluation complete by q4 22/23 with view to sustainable system approach for 23/24	Range of groups support clinical strategy with ICS/B focus through Optimising Health group. Specific mechanisms targeted for work include Cancer Alliance. Clinical Networks range of responsibility/accountability arrangements linked to commissioning.
Strategic Objective 2				
2. Elective recovery *Delivery of elective recovery (covering inpatient, diagnostics and cancer) to meet or exceed national benchmarks, standards and targets*	Working through established COOs and associated mechanism formally brought under PvCv (with ICB agreement). Elective Board established	In line with national milestones	Performance in line (or exceeding) national milestones Development of elective centres, management of waiting list and associated innovations	SRO leadership from PvCv. Elective Board reporting to ICB established with operational delivery through PvCv COOs group. Requirement to establish mechanism for longer term transformation. (Note linkages to wider system groups e.g. 'Waiting Well'.
Strategic Objective 3				
3. Urgent Care *Delivery urgent care standards and requirements across*	Working through established locality and system groups PvCv will take overview through SRO putting in place action at	In line with national milestones	Performance in line (or exceeding) national milestones	SRO lead from PvCv Established locality structure feeding through to ICP and system level group

Key delivery priority	How will we deliver it?	Q in which it will be achieved?	How will we know it has been achieved?	Current Delivery Mechanism
providers and local systems to reduce variation and improve consistency of response	system levels as necessary			
Clinical Support Programmes				
Strategic Objective 4: *Building capacity and capability in clinical support services to achieve appropriate infrastructure in place to delivery strategic clinical aims*				
1.Clinical Support Services – Diagnostics & Pathology	Establish working groups under auspices of agreed SRO	Tbc	Delivery in line with plans	Program developed under Optimising Health with CEO SRO leadership for specific elements
2.Clinical Support Services – Aseptics Pharmacy	Time limited project group established to lead work	Q2 – delivery of outline business case Q4 – Full service model & plan	Agreement of approach to aseptic services across provider collaborative Plan and delivery of revised (agreed) model	Project established under auspices of PvCv with SRO leadership in place
Corporate Support Programmes				
Strategic Objective 5: *Establish and deliver appropriate corporate strategies to enhance integration and tackle variation including approaches to collective planning, rationalised and aligned estates/capital process and development of underpinning approaches in workforce.*				
1.Corporate Strategy – assessment of requirements	Review of existing mechanism to establish opportunities, requirements and potential approaches with development of agreed programme	Q2 – Delivery of proposal	Establishment of work programme with clear reporting and associated requirements	Tbc
2.Corporate strategy – Estates/finance/planning	Establishment of agreed approach to capital	As per agreed milestones	As per agreed outcomes	SRO for Capital/Estates work established, agreed planning

Key delivery priority	How will we deliver it?	Q in which it will be achieved?	How will we know it has been achieved?	Current Delivery Mechanism
	prioritisation, finance and planning to deliver collective response			approach for 22/23.
Provider Collaborative Development				
1. Establish the collaborative as a vehicle for our joint work with appropriate governance, methods of working (with CEOs leading work streams) and a resource plan	Formalisation of PvCv as a Provider Leadership Forum with associated governance arrangements	Q1 22/23	Sign off by PvCv with updates agreed via constituent Trust boards	
2. Development of appropriate programme management structures and support to deliver programmes (including reporting and associated oversight)	Identification of resource needs and requirements on a rolling basis (noting some elements will link to existing programmes, require support as part of ICS changes as well as utilisation of internal resource)	Rolling implementation based on agreed programmes and support Established reporting and associated structures	Clear, accountable SRO arrangements for programmes agreed for the PvCv delivery with agreed support implemented	

SCHEDULE 4

Operating Model

The Operating Model is the overarching document that describes what the Collaborative is, its purpose and how it works. Along with the Collaborative's Ambitions document the Operating Model has two core functions/purposes to provide:

1. A summary of what the Collaborative is, how it works and its membership in order to support discussion and agreement of the role the Collaborative will play in the NENC integrated care system as well as facilitating the agreement of the specific system objectives the Collaborative will be leading on and supporting. This is detailed in the Operating Plan but also set out in the Ambitions document.
2. Detail on the mechanism and approaches the Collaborative will use describing the programmes and detailing the specific requirements for delivery.

The Operating Model recognises that the Collaborative's role within the NENC ICS has three dimensions:

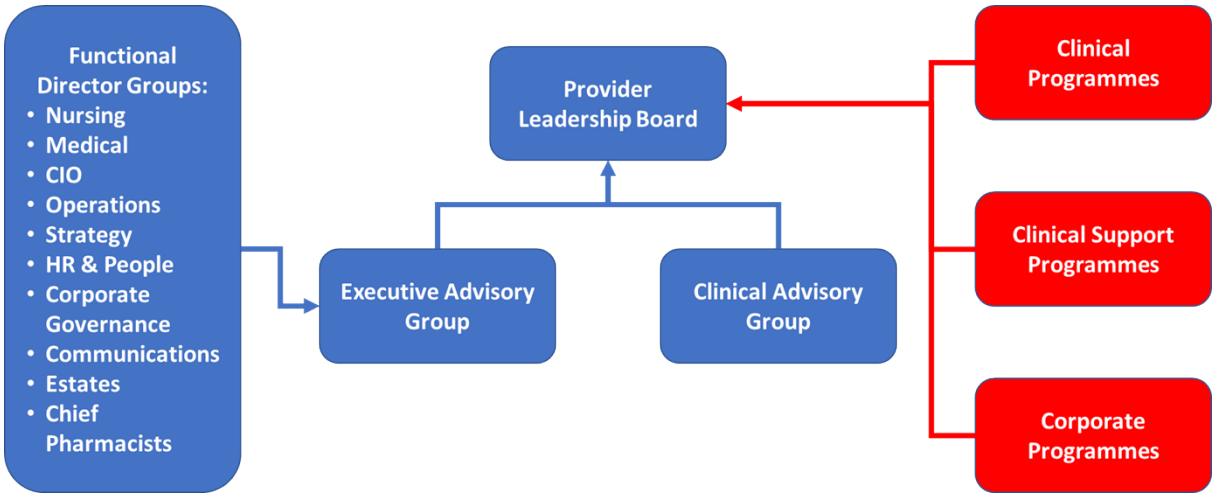
- Where the PvCv is leading on agreed objectives, with delegated authority and responsibility from the ICB
- Where the PvCv is working jointly, in partnership with ICB; working through existing mechanisms and/or groups (either leading or supporting) or as a joint committee of the ICB

It is recognised that depending on the issue, objective and requirement there may be different approaches needed for delivery

- In addition to the work to delivery ICS objectives there will be elements of the PvCv work that reflects the member's needs, requirements and priorities.

The following graphic summarises the PvCv operational model (as at April 2022), with full details found in the Operating Model and Ambitions document

Figure 1: Summary of NENC Provider Collaborative Operating Model



SCHEDULE 5

Dispute Resolution Procedure

1 Avoiding and Solving Disputes

1.1. The Trusts commit to working co-operatively to identify and resolve issues to mutual satisfaction so as to avoid so far as possible dispute or conflict in performing their obligations under this Agreement. Accordingly, the Trusts shall collaborate and resolve differences between them in accordance with Clause 7 (*Problem Resolution and Escalation*) of Agreement prior to commencing this procedure.

1.2. The Trusts believe that:

1.2.1. by focusing on the Collaborative Principles;

1.2.2. being collectively responsible for all risks; and

1.2.3. fairly sharing risk and rewards,

they will reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with the Key Delivery Priorities.

1.3. The Trusts shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement (each a "**Dispute**") when it arises.

1.4. The Provider Leadership Board shall seek to resolve any Dispute to the mutual satisfaction of each of the Trusts involved in the Dispute.

1.5. The Provider Leadership Board shall deal proactively with any Dispute in accordance with the Collaborative Principles and this Agreement so as to seek to reach a unanimous decision. If the Provider Leadership Board reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Trusts involved in the Dispute of its decision by written notice.

1.6. The Trusts agree that the Provider Leadership Board may determine whatever action it believes is necessary including the following:

1.6.1. if the Provider Leadership Board cannot resolve a Dispute, it may select an independent facilitator to assist with resolving the Dispute; and

1.6.2. the independent facilitator shall:

1.6.2.1. subject to the provisions of this Agreement, be provided with any information they request about the Dispute;

1.6.2.2. assist the Provider Leadership Board to work towards a consensus decision in respect of the Dispute;

1.6.2.3. regulate their own procedure and, subject to the terms of this Agreement, the procedure of the Provider Leadership Board at such discussions;

1.6.2.4. determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed; and

1.6.2.5. have their costs and disbursements met by the Trusts involved in the Dispute equally or in such other proportions as the independent facilitator shall direct.

1.6.3. If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 5 and only after such further consideration again fails to resolve the Dispute, the Provider Leadership Board may decide to:

1.6.3.1. terminate the Agreement; or

1.6.3.2. agree that the Dispute need not be resolved.

NHS
Provider Collaborative
North East and North Cumbria ICS

North East and North Cumbria
Provider Collaborative

Operating Model

May 2022

Operating Model

The eleven FTs in North East and North Cumbria (NENC) have set out how they will work together as the NENC Provider Collaborative, along with their purpose, principles and objectives in a memorandum of understanding ("Collaboration Agreement").

This document is intended to supplement the Collaboration Agreement with some more specific operational practicalities.

Provider Leadership Board

As set out in the Memorandum of Understanding, the eleven Foundation Trusts across North East and North Cumbria have agreed to establish a Provider Leadership Board (PLB), which is the group responsible for leading and overseeing the Trusts' collaborative approach to the Key Delivery Priorities and working in accordance with the Collaborative Principles.

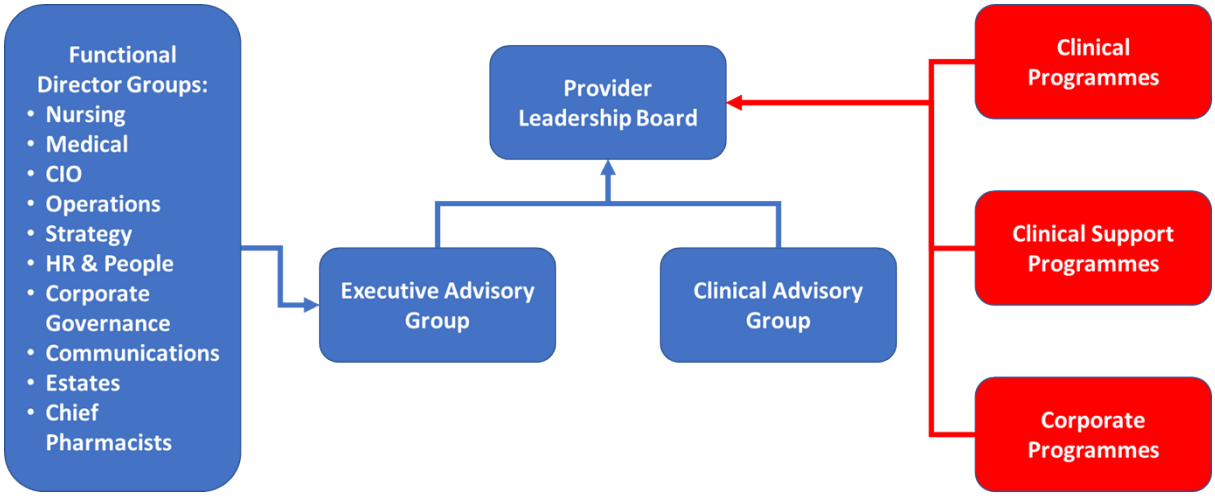
The PLB features all 11 CEOs and it is anticipated that CEOs will keep FT Boards regularly updated, supported by periodic written papers from the Provider Collaborative. The MoU sets out that Chairs of the FT Boards should be invited to meetings of the PLB at 6 monthly intervals, to discuss the work programme and progress with delivery.

The PLB may establish supporting and/or task and finish groups to take forward programmes in respect of the Key Delivery Priorities as appropriate, ensuring a strong clinical voice and involving input from a range of functions across the Trusts.

The Provider Collaborative determined that subgroups would be necessary to deliver key functions and the work programme. There is, however, a clear risk of overlap with the ICS and particularly the previous clinical advisory machinery established to support commissioning. As a consequence, this will need to be considered iteratively in the context of broader conversations with the ICB team. It was also noted that the subgroup structure should be mindful of bureaucratic burden.

For now, it is proposed that the programmes of work report directly to the Provider Leadership Board and that it is supported by an Executive Advisory Group and a Clinical Advisory Group. The Provider Leadership Board has been established, with the Executive and Clinical Advisor Groups to be put in place during Summer 2022.

In addition, the PLB will be strongly supported by nested collaboratives, such as those for mental health and at sub-regional geographies, to ensure decision making, direction and delivery take place at the right levels.



Clinical Advisory Group

The purpose of the Clinical Advisory Group is to ensure that the Provider Collaborative has strong clinical leadership and a constant focus on the key areas of collective clinical concern. The Clinical Advisory Group would draw on and provide a point of escalation for clinical networks.

Membership would need to feature clinical leads from all FTs with good medical, nursing and AHP leadership. Initial conversations with the ICB have suggested that this could be a joint body with the ICB, co-chaired by clinical leadership from within the Provider Collaborative and the ICB Medical Director, to align clinical input across the ICS. In this case, having wider clinical views, such as from general practice and community pharmacy, could support broader transformational work and enable the group to support both the Provider Collaborative and the ICB. PCN clinical leaders would be key in this.

As the ICB develops, consideration can be given as to whether it is feasible for this group to drive the strategic approach to clinical services, and the opportunity to align clinical groups generally, including the ICS Optimising Health Services Group. It should also be noted that the role and responsibility of the Provider Collaborative in the development of the ICS clinical strategy still needs to be worked through and agreed with the ICB and partners.

Executive Advisory Group

The purpose of the Executive Advisory Group is to provide a mechanism for strategic clarity across and through the Provider Collaborative FTs, making sure that a full range of functional perspectives are considered throughout the work programmes. The Executive Advisory Group will provide a sounding board and point of professional escalation for Managing Director and PMO on programmes and projects, facilitating quick access to appropriate functional expertise, in addition to being tasked with the delivery of specific projects.

This creates a mechanism to check and challenge proposals going to Provider Leadership Board, in addition to a coordinated approach to identifying risks or opportunities for collaborative work.

It is anticipated that membership of this group would be the chairs of the directors' networks, including a Director of Nursing, Medical Director, CIO, COO, Director of Finance, Director of Planning & Performance, Director of Workforce, Director of Corporate Governance, Director of Communications, Director of Estates and Chief Pharmacist.

Work Programme

Each programme of work within a Key Delivery Priority will be sponsored by a Trust Chief Executive as Senior Responsible Owner ("SRO"). SRO roles will be distributed across the Trust Chief Executives. Each SRO will be responsible to the Provider Leadership Board for the planning and delivery of their work programme and will be supported by the Programme Management Office. It is anticipated that Provider Collaborative SROs will lead some of the ICS workstreams, where appropriate.

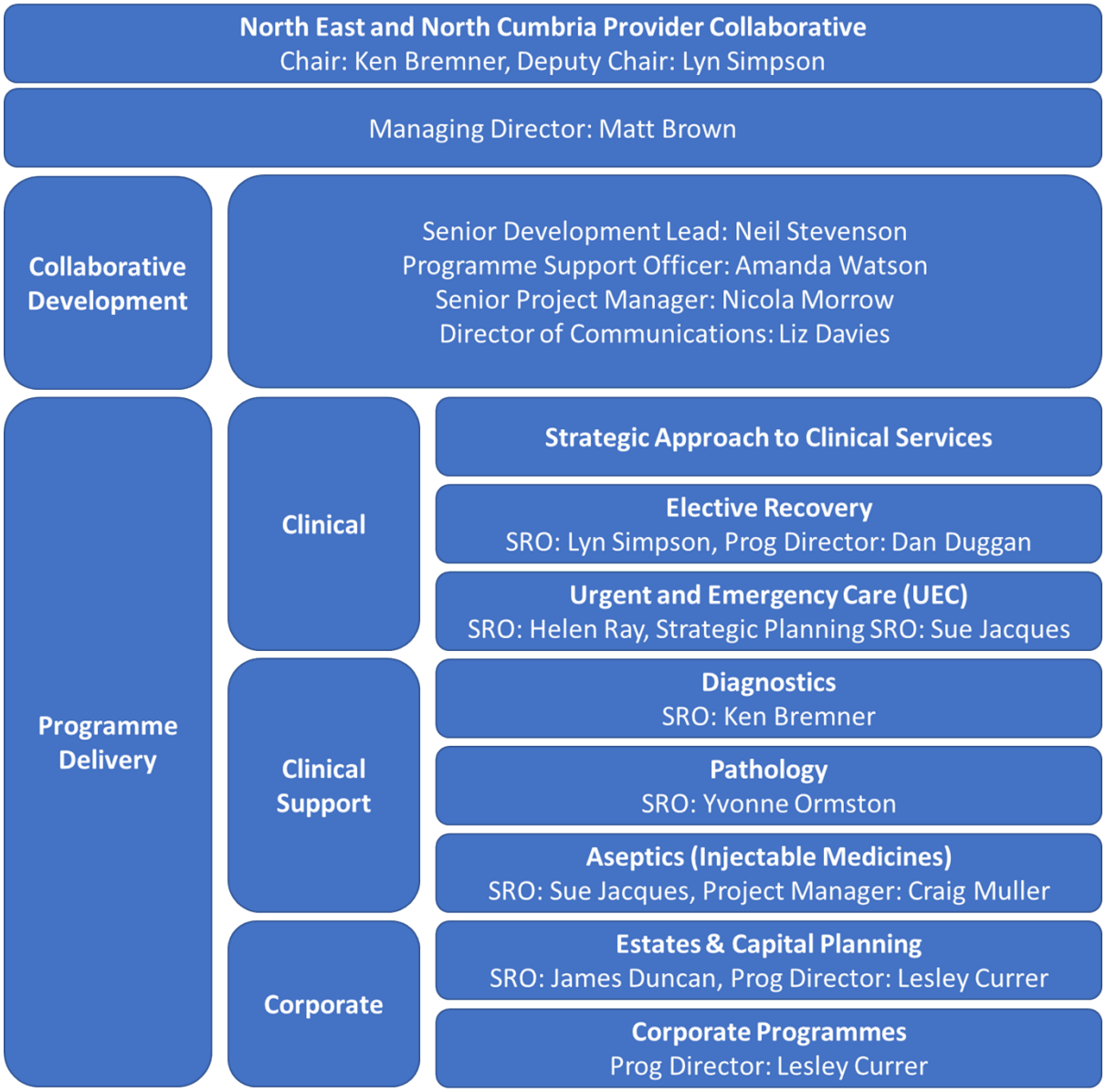
The SRO will effectively work as a Chair for the supporting programme infrastructure, with a dedicated programme management support and it is intended that there should be a designated Programme Director for each Key Delivery Priority. The Programme Director should work extremely closely with the SRO to ensure progress, direction, reporting and communication. The governance structure will be different for each Key Delivery Priority.

These teams will be supported by a general pool of project management capacity and a small core collaborative team.

Each of the five Key Delivery Priorities will report to the Provider Leadership Board on a monthly basis, using a programme highlight report, to be distributed one week before the meeting. This will focus on progress, key risks and issues for escalation. The Provider Leadership Board will ensure clear objectives and scope under each Key Delivery Priority.

The Managing Director will work closely with the SROs and Programme Directors to ensure oversight and coordination across the Key Delivery Priorities.

The following chart reflects the capacity specifically deployed by Provider Collaborative, but there are other people from the system involved in the work programmes already, such as in supporting the UEC, diagnostics and pathology ICS programmes.



Clinical Programmes – Strategic Approach to Clinical Services

It is proposed that this programme is focussed on developing a strategic approach to clinical services across North East and North Cumbria, supporting nested collaborative working. This should focus initially on tackling vulnerable services, unwarranted clinical variation and providing coordination & escalation for clinical networks. The output of this programme should be heavily informed by population health management and help guide strategic decision making on collaborative opportunities and challenges around estates, technology and workforce.

Programme infrastructure needs to be developed for this Key Delivery Priority. It is proposed that the governance for this has two forums, one clinically-led focussed on the clinical challenges and solutions through the Clinical Advisory Group, one managerially-led focussed on the corporate governance support required.

Clinical Programmes – Elective

The elective programme has a duality of focus, on the performance management aspects of elective recovery in the here and now, particularly on long waits, alongside the transformation requirements for the years ahead. In doing so, the programme seeks to tackle health inequalities, particularly of access and outcomes.

A Strategic Elective Care Board has been in established to take this work forward, with oversight of performance management, clinically-led transformation programmes, independent sector strategy, strategic productivity and collaborative opportunities (eg capitalising on GIRFT and Model Hospital) and ensuring connection to the broader programmes such as waiting well and health literacy.

Clinical Programmes – Urgent and Emergency Care

In 2022/23, the UEC Network has prioritised the long-term plan, operating guidance and national 10-point recovery plan. Specific priorities focus on UEC operating models, including community care, digital and hospital discharge.

Governance arrangements are being revised with the establishment of a UEC Board, which will provide NENC oversight, leadership on winter planning, assurance to ICB and direct connection with LADBs for place-based delivery.

Clinical Support Programmes

There are a number of key strands of work under Clinical Support programmes, particularly around diagnostics and pathology. In addition, a steering group with dedicated project management is overseeing the development of a business case for aseptics (injectable medicines) production facility for the Provider Collaborative.

The NENC Diagnostic Programme Board reports directly into the Optimising Health Services Group, then into the ICS Management Group, with a dotted line to the Provider Collaborative. The Pathology Network Board reports into the Diagnostic Programme Board.

Corporate Programmes

There are a range of active, and potential, work programmes across the Corporate Key Delivery Priority, including work on strategic planning for capital and estates. There is great potential here to make efficiencies but also to harness and maximise the many assets that exist across North East and North Cumbria. The intention is to adopt a series of evidence based programmes designed to get added value for every pound spent. These might include in the short term - redesigning and standardising care pathways, optimising sites, optimising workforce, supporting staff with cost of living pressures, adoption of innovation at pace and scale, sharing and adoption of best practice, but could also include in the longer term policies on workforce, digital innovation, back office support cost reduction, taking a rigorous approach to anchor institution development and so forth.

It is proposed that specific programme infrastructure is established for the Key Delivery Priority, with oversight, identification of opportunities and challenges through the Executive Advisory Group.

Provider Collaborative Leadership and Management Resource

The Managing Director will be accountable to the Chief Executives through the Chair of the Provider Leadership Board and will oversee the collaborative team and Programme Management Office. This team will include a secretariat function to provide administration and support across all Provider Collaborative programmes, specific programme management capacity, transformation resource, analytical capacity and communications and engagement resource. The Provider Collaborative is keen to ensure that access to, and shared leadership of, quality improvement capability.

Access to data has been determined to be a key element of being able to deliver the evidence based programmes required, in particular the use of cross system, multi sectoral data to allow benchmarking and analysis of warranted and unwarranted variation. It is anticipated that much of this will come through FTs, with analytical support from NECS and NEQOS, supported by other sources such as GIRFT and Model Hospital.

The PMO will be accountable to the Managing Director, who will have oversight across all Key Delivery Priorities.

The collaborative team will have a combination of specific staff and seconded staff, both clinical and managerial, to meet programme requirements. For the majority of collaborative programmes, the team will work with FTs to support them in delivery.

The Provider Collaborative team will need to develop over time, in line with resourcing, and alongside the Integrated Care Board (ICB).

It is expected that there will be a phased development of resources in line with increase in development and responsibilities. In the first instance, a sum of £400k has been allocated from NECS for the Provider Collaborative to draw down in 21/22, with a further £500k in 22/23.

In future years, there will need to be consideration of future funding arrangements, depending on the extent of allocated funding from either NECS or the ICB, likely to be as part of negotiation of the Responsibility Agreement. The Provider Collaborative has expressed a desire for FTs to engage collective capacity and an appetite for subscription or other contribution models.

The Development of the Provider Collaborative, including both OD and governance, will be led by the Chair and Vice-Chair. This will explicitly seek to take a strategic approach to talent management and development of a culture of collaboration.

Key Role Descriptions

NENC Provider Leadership Board Chair and Deputy

The Chair and Deputy Chair will act as convenors for the Collaborative, bringing together Chief Executives from the constituent FTs through the Provider Leadership Board, in line with the working arrangements set out in the Collaborative Agreement.

The Chair and Deputy will work with colleagues identifying issues for consideration and action by the Collaborative, facilitating discussion across the Collaborative to reach collective agreement on agreed action and ensuring appropriate assurance mechanisms are in place to ensure timely delivery. This will be achieved through distributed leadership, ensuring that all Chief Executives are appropriately involved in and leading Collaborative programmes. The Chair and Deputy will Provide direction, oversight and support to the Managing Director.

The position of Chair/Deputy will be elected from the constituent members and it is expected that the Chair will serve a tenure of 12-15 months. The Deputy will then step into the role of Chair, with a new Deputy nominated.

Senior Responsible Officer (SRO)

To deliver the Collaborative's work programme, a distributed leadership model will be enacted, with a Chief Executive fulfilling the Senior Responsible Officer (SRO) role in leading and facilitating delivery of agreed programmes.

The SRO will effectively act as Chair for the programme, with a designated programme director, and be responsible for ensuring that a programme or project meets its objectives and delivers the projected benefits. The SRO will act as the visible owner of the programme and the key leader in driving forward.

Managing Director

The Managing Director is responsible for leading the foundation and development of the Provider Collaborative through the establishment of governance arrangements and working infrastructure, including staffing/resourcing. The Managing Director will lead the development and delivery of the agreed work programme in line with the priorities established by the Provider Leadership Board.

The MD will ensure the leadership, development and success of the Collaborative's work programme and its contribution to the NENC ICS, coordinating the Collaborative as a membership organisation, working closely and fairly with all its constituent Trusts and ensuring it is established as a credible, robust and respected membership organisation across the North East and North Cumbria.

Programme Director

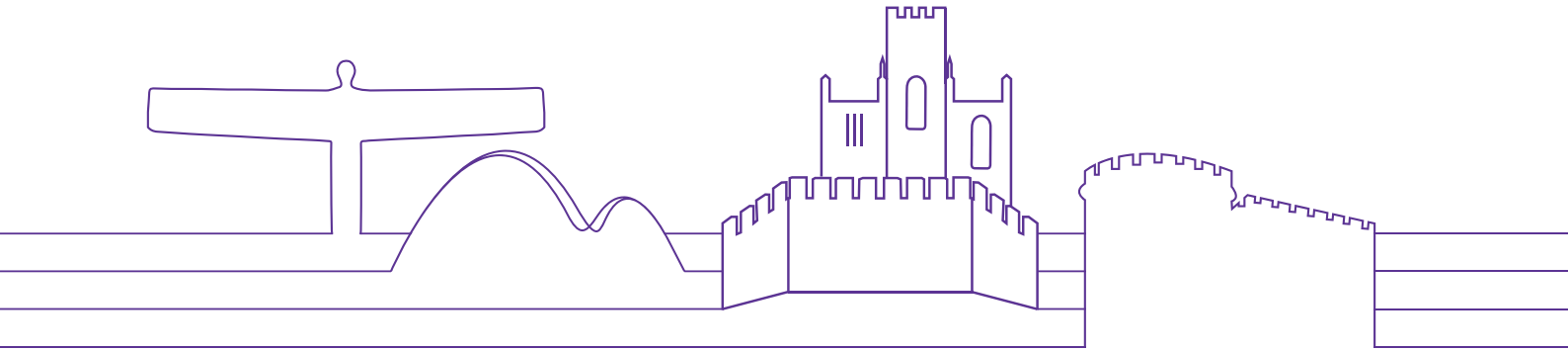
The Programme Director will work to the Programme SRO to oversee and ensure every aspect of programme delivery, from conception to implementation. Responsibilities include developing and deploying the project team, securing appropriate resources to support delivery, developing the programme business case and milestones and ensuring that the programme meets the objectives and requirements to agreed timescales and resources. The Managing Director will have oversight of the Programme Directors.

North East and North Cumbria
Provider Collaborative

WORKING TOGETHER TO IMPROVE HEALTH, WEALTH AND WELLBEING

Setting out our ambitions for the future

May 2022



WHO ARE WE?

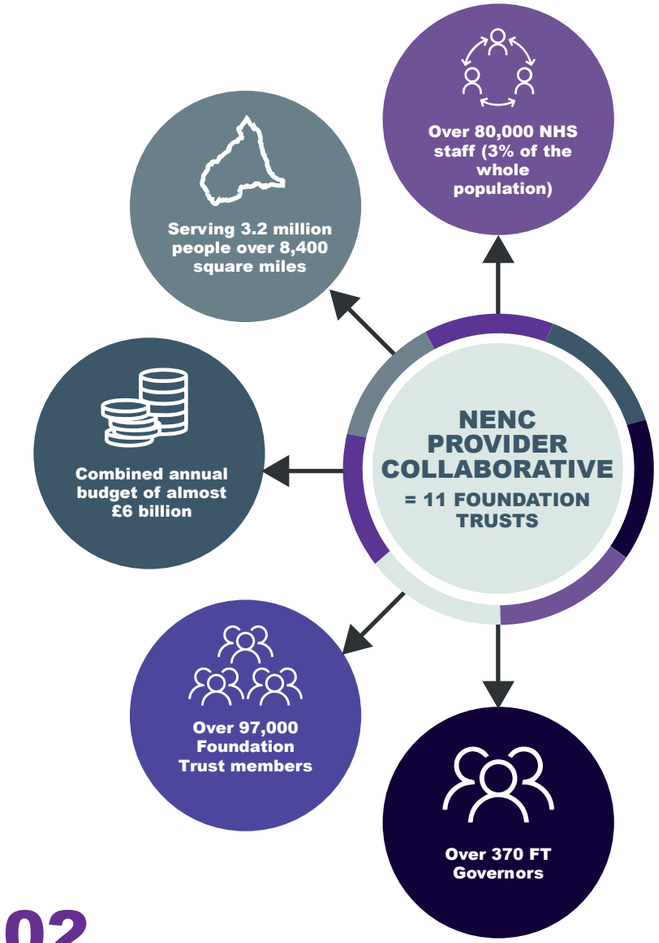
The North East and North Cumbria (NENC) Provider Collaborative is a formal partnership of all 11 NHS Foundation Trusts (FTs)* in the region. Together we cover the entire geographical footprint of the Integrated Care System and, between us, we provide the vast majority of all secondary NHS care services with millions of patient interactions every single day. This includes:

- **Community care and mental health services**
- **Acute hospital services and highly specialist care**
- **Ambulance, patient transport and emergency response services**

Our workforce is the largest in the region and we are major employers within our communities providing significant opportunities for local people. We are very proud of our strong track record, over many years, for providing some of the very best care, patient outcomes and organisational performance across the whole NHS. But we know there is more to do and especially as we recover from the impact of the pandemic.

Through the NENC Provider Collaborative our collective focus now is to ensure we consistently provide the highest quality of care right across our region and the best possible experience for our staff. Given the sheer size and scale of our organisations, we also have a significant role to play in improving the overall health, wealth and wellbeing of the local population.

OUR IMPACT



NENC Provider Collaborative Members:

- Northumbria Healthcare NHS Foundation Trust
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Gateshead Health NHS Foundation Trust

- South Tyneside and Sunderland NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust

- North Tees and Hartlepool NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust

- North Cumbria Integrated Care NHS Foundation Trust

- North East Ambulance Service NHS Foundation Trust
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust

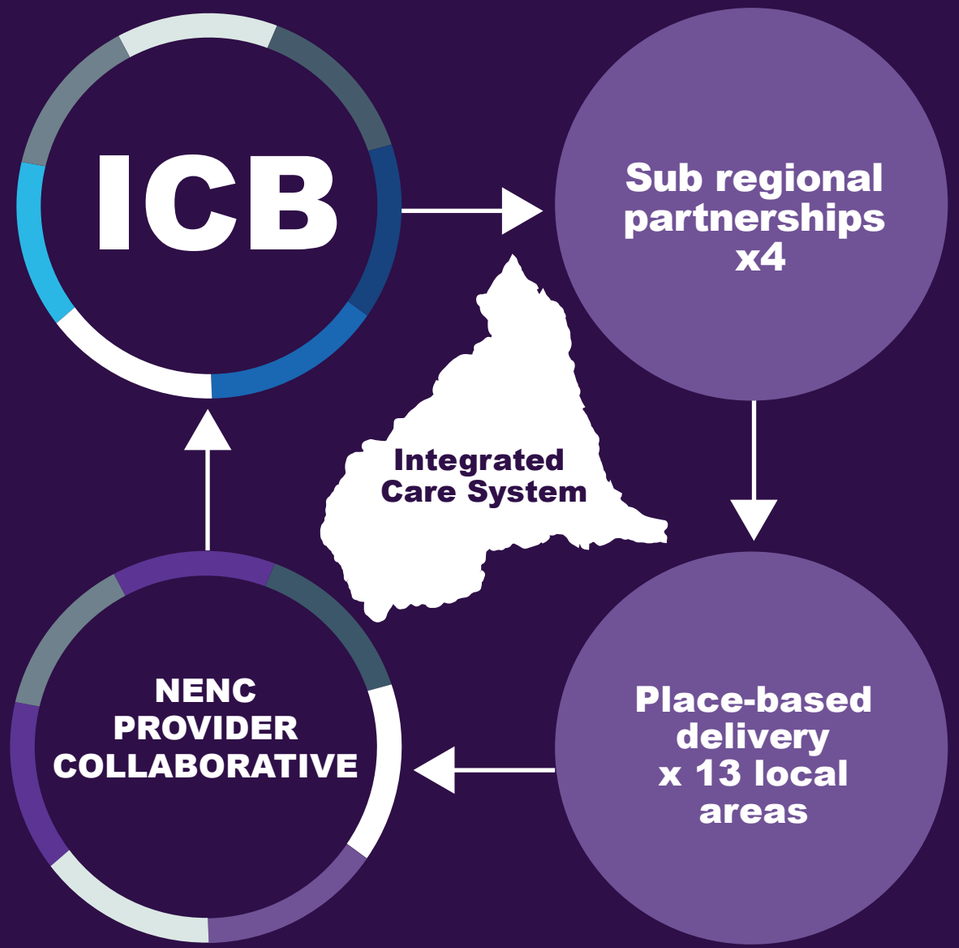
WHAT IS THE ROLE OF PROVIDER COLLABORATIVES?

Provider Collaboratives are an important part of our new system architecture. By July 2022, all NHS Foundation Trusts and NHS Trusts are expected to be part of one or more formal Provider Collaboratives, working together to agree plans for the future and deliver benefits at scale.

Our region was one of the first in England to form a Provider Collaborative ahead of national requirements. Since September 2019 all 11 of our NHS Foundation Trusts have been working together formally to discuss and address many challenges facing us all and, most importantly, to start to plan together as one for the future.

As a collective, we believe we have to continue to think differently about the way we deliver services if we want to be one step ahead and able to face the challenges, as well as the opportunities, the future presents to us.

The NENC Provider Collaborative now provides us with the formal mechanism for us to make collective decisions, to coordinate action on important issues and take forward programmes to improve health and care through collaboration. We will act on behalf of, and take decisions that represent the views of our 11 FTs collectively, rather than being a separate formal entity in our own right. We are a key component of how our new Integrated Care System will work.



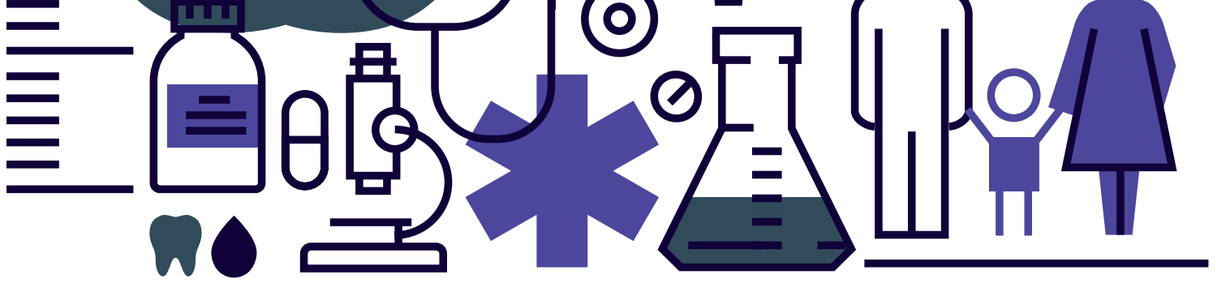
WHAT DO WE WANT TO ACHIEVE?

Our ambition as the NENC Provider Collaborative is simple:

“We want to further improve the quality of care across our Integrated Care System and use our influence to support the wider determinants of health, wealth and wellbeing across the region. We seek nothing less than for patients and the wider population within the North East and North Cumbria to have the highest possible standards of physical and mental health outcomes and positive life experiences.”

As major anchor organisations within our local communities, we recognise that we have a wider responsibility and impact across our Integrated Care System. Not only in the way we offer and deliver health and care services, but also in how we employ staff, how we procure goods and how we do business locally and achieve value for money.

As a NENC Provider Collaborative, we commit to doing all that we can to take collective action to improve health and health care services and support wider economic recovery, providing employment opportunities and local procurement.



We will work in partnership with the Integrated Care Board and share the same strategic objectives to:

Improve outcomes in population health and healthcare by focusing on improving health inequalities that exist within the region.

Tackle inequalities in outcomes, experience and access by optimising the delivery, quality and efficiency of local health and care services provided through our 11 FTs.

Enhance productivity and value for money by taking necessary collaborative. action, including mutual aid and support.

Help the NHS support broader social and economic development by providing opportunities and harnessing our collective strength to influence change.

OUR PRINCIPLES AND WAYS OF WORKING

We have ten principles which outline how we will work together. These will guide everything we do. They will help us to develop an even stronger culture of collaboration between our 11 NHS Foundation Trusts.

1.	**We will support each other and provide mutual aid in times of pressure.**
2.	**We will make shared decisions to speed up transformation and change.**
3.	**We will challenge each other and hold each other to account.**
4.	**We will always act in good faith and in the best interests of the people we serve.**
5.	**We will empower staff to work with other Trust staff to improve care.**
6.	**We will make sure there is strong clinical leadership and governance in all of our work.**
7.	**We will actively involve staff, patients, the public and wider stakeholders.**
8.	**We will show solidarity when making decisions for the local population.**
9.	**We will take responsibility for delivering on agreed priorities and manage risks together.**
10.	**We will promote a high performing culture of teamwork, innovation and continuous improvement. To do this we will share information, communicate honestly and respectfully and act ethically with responsible behaviour and decision making.**

KEY PRIORITIES

We have identified five key delivery priorities which will form the focus of our work in 2022/23 and beyond. This will be via three programmes of work:

Clinical Programmes

1. To develop a strategic approach to clinical services encompassing acute, mental health, learning disabilities and community. This will focus on vulnerable services and thinking about a strategic response to clinical networks and associated cross system working arrangements.

2. To deliver on elective recovery including all service aspects of inpatient, diagnostics and cancer care, as well as mental health and learning disabilities. Our aim is to meet or exceed national benchmarks, standards and targets.

3. To deliver urgent care standards (including ambulance standards) and requirements across all NENC providers and local systems to reduce variation and improve consistency of response.

Clinical Support Programmes

4. To build capacity and capability in clinical support services (in particular diagnostic capacity) to ensure appropriate infrastructure is in place to deliver the above clinical priorities.

Corporate Programmes

5. To support the wider ICS in sustainable transformation, establishing and delivering appropriate corporate strategies to enhance integration and tackle variation. This will include approaches to collective planning, rationalised and aligned estates/capital processes, the development of underpinning approaches in workforce and a commitment to the ICS green strategy.

WORKING AS PART OF THE WIDER ICS

In our role as the NENC Provider Collaborative we will take collective responsibility for the delivery of agreed service improvements and standards across FTS in the North East and North Cumbria. These will be agreed with the ICB.

We will facilitate horizontal collaboration between FTs, but that work will in no way reduce the primacy of place or hamper provider organisations playing full roles within their relevant place based partnerships. We recognise the crucial importance of place-based working, where our FTs work closely with local communities and partner organisations.

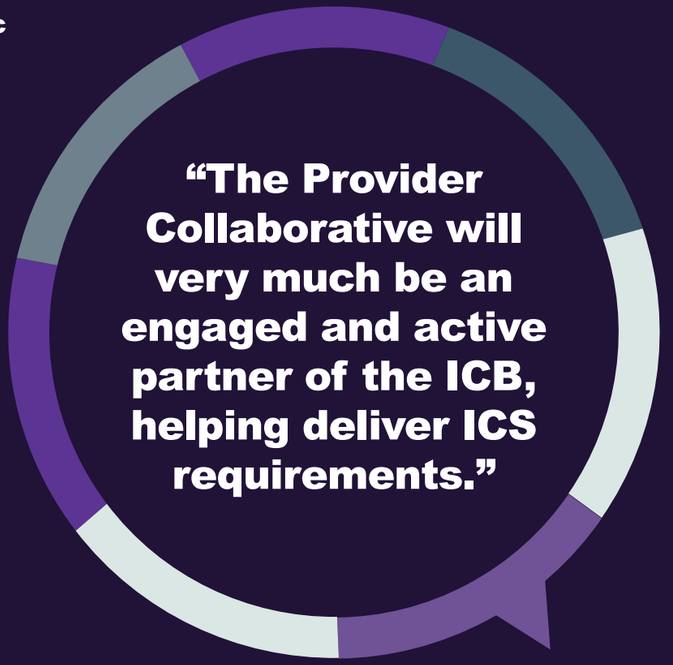
There will also be different collaborative arrangements (see page 12) where individual FTs will continue to work with each other on a geographical or sectoral basis All of this good work will not stop. Our role is not to cut across any of this, but to act as an enabler.

Our strength as the NENC Provider Collaborative will be through operating as a whole system collaborative when a response is best done once, together and at scale. This might be because the issue is complex, there is a need for critical mass, or requires standardisation to reduce unwarranted variation across multiple FTs.

To work effectively with the ICB we need to agree responsibilities as to how we can best contribute to the overall success of the ICS and meet the strategic objectives we all share.

We believe the NENC Provider Collaborative is best placed to lead on the priority areas identified on page 9. This includes:

- **Action to deliver recovery, specifically in tackling long waits in elective care and other services** with the development of longer term transformation solutions.
- **Addressing system level action to bring the urgent care system back to pre-pandemic levels of performance and above.**
- **Taking forward a strategic approach to clinical service development,** particularly where there are service vulnerabilities, or opportunities, that require at-scale consideration. This would include discussion and agreement around Clinical Networks and formal hosting and/or leadership arrangements.
- **Opportunities for at-scale solutions and strategic improvements to unwarranted variation or inefficiencies** within and across the 11 FTs (see page 7).



WORKING WITH HEALTH AND CARE PARTNERS

As the NENC Provider Collaborative, we are just one of a number of partnership arrangements that will work with the ICB to deliver the overall aims and objectives of the Integrated Care System. These are shown opposite.

We may interact with these other collaboratives acting as the NENC Provider Collaborative, or as individual FTs, depending on the nature of discussions taking place. However we collaborate, we want to interact and support the work of others as we collectively strive to plan, deliver and transform health and health care services for the future in our region.

DRIVING INNOVATION & IMPROVEMENT

As NENEC providers we have a high appetite for innovation and will seek a coherent approach which plays to the academic, commercial and industrial strengths of our FTs.

As part of this we will support and drive the development of research and continue our close working with vital partners. This includes working with Health Education England, education partners and professional bodies to provide high quality education and training, recruiting and retaining the workforce of today and attracting the workforce of tomorrow.

We aim to go much further than our role in directly improving health and delivering healthcare. We aim to capitalise on the substantial opportunities we have across our organisations and with our partners.

Academic Health Sciences Network	**North East Quality Observatory System**	**Biomedical Research Centre**
Academic Health Sciences Centre	**Universities of Northumbria, Newcastle, Durham, Sunderland and Teesside**	**NIHR Applied Research Collaborative**

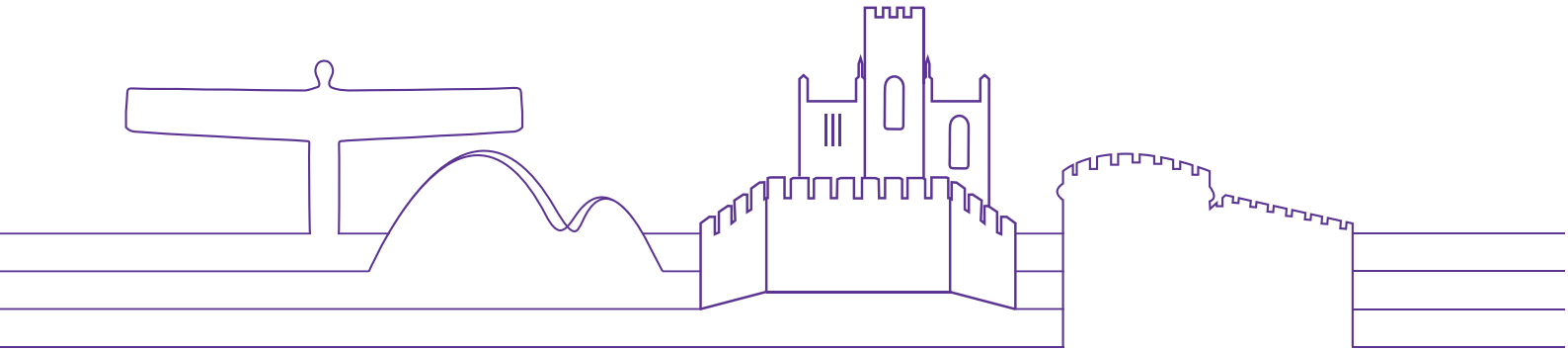
WHAT NEXT?

This document sets out our aspirations for the future and the ways of working we have developed so far as the NENC Provider Collaborative.

As work gathers pace towards our new structures and system architecture coming into place formally from July 2022, we will speak to partners about the role of the NENC Provider Collaborative and where you think we can add value to drive forward innovation and improvement.

In the coming months, we will work with the ICB to jointly agree how we can best support the delivery of ICS objectives and best use our skills and capabilities as we strive to maximise the flexibilities and freedoms of the new Health Bill when enacted. We recognise this can be achieved in several ways and we want to agree the appropriate mechanism, recognising that the basis of this working relationship will flex issue by issue.

We look forward to involving and engaging with you all along the way and building on the strengths of our relationships here in the North East and North Cumbria.



Newcastle Hospitals Charity **Committee Schedule of Business 2022/23**	May-22	Sep-22	Nov-22	Mar-23	
<u>Regular items</u>					
Finance Report - to include SoFA, Target Spend Report, & Income Report	x	x	x	x	
Grant Applications & Recommendations from Grants Panel	x	x	x	x	
Summary of Investment Performance/Investment Reports	x	x	x	x	
Summary of Grants agreed since last meeting	x	x	x	x	
Minutes & Action Log	x	x	x	x	
Sub-Committee Minutes	x	x	x	x	Currently Connected Charities - Sir Bobby Robson Foundation, Great North Childrens Hospitals Foundation, and Charlie Bear Cancer Care
Notes of the Charity Governance Working Group	x	x	x	x	
Charity Director Update	x	x	x	x	Annual Deep Dive timing to be agreed.
Charity Risk Statement	x	x	x	x	
Charity Governance Working Group Update	x				
Charity Dashboard	x	x	x	x	As outlined in March 22 minutes.
<u>Annual reports</u>					
Annual Report & Accounts		x (DRAFT)	x (FINAL)		Based on timings in 2021/22
Investment Management Review					To be agreed as part of Governance review.
JRE Scientific Committee Recommendations		x		x	TBC
<u>Ad hoc</u>					
Policies and procedures					
ToRs					ToR to be reviewed following conclusion of CGWG work.

PUB BRP A11(i)								
	EXTRAORD		EXTRAORD					
Finance Committee	Apr-22	May-22	Jun-22	Jul-22	Sep-22	Nov-22	Jan-23	Mar-23
<u>Regular reports</u>								
Finance report [Including KPIs, CIP, cquins, risks, capital summary, balance sheet updates]		x		x	x	x	x	x
Quarterly BAF report		x			x		x	x
Cost Improvement Programme Plan				X	x	x	x	x
Capital Plan and capital projects update [Top 10 strategic projects - every other meeting]		x		x		x		x
SSPC minutes [when available]	x	x	x	x	x	x	x	x
CSG minutes [when available]	x	x	x	x	x	x	x	x
CMG minutes [when available]	x	x	x	x	x	x	x	x
SPCIG minutes [when available]	x	x	x	x	x	x	x	x
DTC SOG minutes [when available]	x	x	x	x	x	x	x	x
Performance (against Finance and Operational Plans, contracts, B&D activity)		x		x	x	x	x	x
Procurement Plan/Update [every other meeting]		x			x		x	
<u>Annual reports</u>								
Annual Report & Accounts Update/Draft/Final	X	x	x					
Terms of Reference			x					
Annual report / review of effectiveness		x						
Revenue and budget setting, CIP estimates				x				
Capital expenditure and strategy (longer term plan)		x			x			
PFI (and fire remedial works programme) update					x			
<u>Ad-hoc reports to be considered</u>								
Month 12/year-end report	X							
Plan update	X							
WLI [Twice a year]				x			x	
Maintenance deep dive								x
Commercial strategy / Updates [twice a year]		x				x		

Policies and procedures e.g. Treasury management, Investment management as required in accordance with the SFIs/SoD								
Business cases / investment proposals [as and when required in acordance with the SoD/SFIs/SoD]	x	x	x	x	x	x	x	x
GIRFT/Model Hospital [to report by exception as required]								
Digital Strategy						x		
Finance and Investment strategies					x			

PUB BRP A11(i)
Schedule of Business (SoB):

People Committee 2022/23	Apr-22	Jun-22	Aug-22	Oct-22	Dec-22	Feb-23*	*meeting to be scheduled
<u>Regular items</u>							Notes
Minutes	x	x	x	x	x	x	
Action log	x	x	x	x	x	x	
People Dashboard	x	x	x	x	x	x	
Education and Workforce Development report including medical education, LEG updates and Apprentices	x	x	x	x	x	x	
#Flourish at Newcastle Hospitals - Staff Experience - including WMTY and staff health and wellbeing	x	x	x	x	x	x	
Employee Relations			x		x		
Recruitment and retention	x		x		x		
Workforce planning			x		x		
People dashboard	x	x	x	x	x	x	
People risks - BAF report		x	x		x	x	
NHS Staff survey & engagement plans/updates	x	x	x		x		
Sustainability		x		x	x (AR)	x	
Guardian of Safe Working	x	x (AR)		x		x	
COVID-19 Update	x	x	x	x	x	x	
Six monthly strategic communications and engagement update						x	New addition arising from an internal audit recommendation to increase the reporting to provide oversight and assurance over the effectiveness of the Trusts external communications and engagement activities.
<u>Annual Reports (AR) or updates</u>							
Leadership Strategy			x				
Annual report of the Committee (including effectiveness consideration), including Terms of Reference and Schedule of Business review		x					
Education and training strategy				x			
Workforce Plan 2021/22				x			
People Strategy and priorities				x			
GMC training survey				x			
Communication strategy			x				Verbal update at April meeting to advise re strategy development timeline.
Freedom to speak up Guardian		x					
Gender Pay Report			x				
WRES & WDES			x				
Apprenticeship Update		x					
Equality and Diversity - including action plans			x				
Workforce Age Profile & Demographics update					x		
People Strategy and priorities					x		
Legal Update	x						
Annual Conversation with Executive Directors			x (Med&Dent)		x (NMAHP)		
Trade Union Faculty Time Report		x					Report annually received by the Committee but was not previously listed in the SoB therefore added in (identified as part of an internal audit recommendation).
<u>Ad Hoc reports</u>							
Directorate Management Structure review updates	x		x		x		
Learning and Education Group and Sustainable Healthcare Committee minutes to be received during the year							

Worksheet "FT4 declaration"

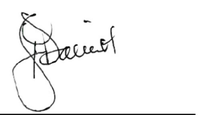
Financial Year to which self-certification relates | **Jun-22**

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.		Confirmed. No material risks identified. Assurances include Annual Report (declaration of compliance with Code of Governance and Annual Governance Statement, both are subject to independent review and scrutiny by External Audit as part of the year end external audit). CQC Inspection of 'Well Led' Domain assessed as 'Outstanding'.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time		Confirmed. No material risks identified. Key documents are highlighted/circulated to the Board through the Chief Executive Update report, items to note and agenda items.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.		No material risks identified. The CQC reviewed the effectiveness of the Board and confirmed Committee structure as part of the 'Well Led' review, assessed as 'Outstanding'. There are a wide range of controls in place, including: an approved Scheme of Delegation, Standing Financial Instructions, Board approved committee structure and terms of reference in place, a Board member appraisal process is in place, agreed Executive portfolios and clear organisational structure/reporting lines.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		Confirmed. No material risks identified. There are a range of systems and/or processes in place which evidence the Trust's on-going compliance with this requirement, including: - Trust Board meetings. - Routine Integrated Board Reports and focussed performance reports. - Regular meetings of the Trust Executive Team, Executive Risk Group, Finance, Quality, Audit and People Committees. - Board approved terms of references and schedules of business. - Board approved Annual Plan. - Regular detailed Board finance report. - Board Assurance Framework and Risk Registers. - External and Internal audit annual opinion and Internal Audit annual plan approved by the Audit Committee.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		Confirmed. No material risks identified. There are a range of systems and/or processes in place which evidence the Trust's on-going compliance with this requirement, including: - Trust Board composition includes Chief Executive Officer, Chief Operating Officer, Medical Director, Director for Business, Development and Enterprise, Finance Director and Executive Chief Nurse - Annual Quality Account produced - Patient/staff stories digital presented at Board meetings as a regular agenda item - Board line of sight as part of Leadership Spotlight on Services / Walkabouts - Positive external stakeholder feedback (re Quality Account) - Routine Integrated Report to Trust Board (including SIRI reporting) - Quality Committee meetings to seek assurance over quality of care including scrutiny of SIRIs and Never Events - Clinical Audit Plan - Mortality Surveillance Group
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.		There are a range of controls in place to mitigate staffing risks, including: Directorate Ward staffing reviews and a single centralised bank for nursing and midwife posts.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature 

Name Dame Jackie Daniel

Signature 

Name Sir John Burn

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Worksheet "Training of governors"

Financial Year to which self-certification relates Jun-22

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Dame Jackie Daniel	**Name**	Professor Sir John Burn
Capacity	Chief Executive Officer	**Capacity**	Chairman
Date	28.07.2022	**Date**	28.07.2022

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates Jun-22

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	

OR

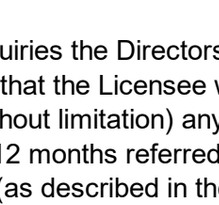
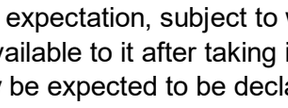
3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust has taken all necessary precautions as were necessary to comply with the conditions.
Transformation/Quality Improvement, performance and financial management arrangements are in place to support the delivery of the Trust plans, overseen through the Trust governance structure. Specific reports on the Trust Activity and Financial Plans are presented routinely to the Finance Committee, with updates to the Trust Board.
The Newcastle Improvement, Performance and Finance Teams continue to work on the Trust's long-term recovery programme.
The annual going concern assessment was presented to the Audit Committee in April 2022 and considered by the Trust Board members in May 2022. This is updated annually.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Dame Jackie Daniel	**Name**	Professor Sir John Burn
Capacity	Chief Executive Officer	**Capacity**	Chairman
Date	28.07.2022	**Date**	28.07.2022

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

FINANCE COMMITTEE ANNUAL REPORT 2021-2022

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Finance Committee has met its key responsibilities for 2021-22, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. COMMITTEE RESPONSIBILITIES

The Finance Committee is a non-statutory Committee established by the Trust Board of Directors to provide assurance to the Board on the delivery of the financial aspects of the Trust's annual Operational Plan, including financial strategy and planning, transformation and sustainability, the financial performance of the Trust, and on commercial and procurement activity, strategic investments and the development of the Trust's digital and estates infrastructure.

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors, that:

- the strategic financial principles, priorities, risk and performance parameters are aligned and support the Trust's strategic objectives and its long-term sustainability;
- the Trust's degree of exposure to financial risk, and any potential to compromise the achievement of the strategic objectives is being effectively managed;
- reporting on the financial performance of the Trust is being triangulated against agreed plans, progress and performance measures, reporting on progress to the Trust Board;
- the Trust's resources and assets are being used and maintained effectively and efficiently;
- financial management and planning information is robust, credible and high quality, and that such information is reviewed and triangulated by the Committee;
- the Trust complies with current statutory and external reporting standards and requirements, including NHS and Treasury policies and procedures;
- the Trust's capital investment programme is fully developed, effectively managed and delivered, and that it is fit for purpose;
- mitigations and action plans as set out in the Board Assurance Framework specific to the Committee purpose and function are effective;
- procurement decision-making and documentation is robust; and
- Committee associated strategies are developed and delivered.

It does this through the receipt of assurances from management groups in the form of updates from Executive Team members and receipt of minutes from the Capital Management Group, the Supplies and Services Procurement Group, the Strategy, Planning and Capital Investment Group, the ICHNE Strategic Oversight Group and the Commercial Strategy Group. In addition, the Committee receives regular reports relating to areas which

impact the financial position of the Trust and considers reports on the management of risks relating to the Committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of six members (noting a minimum of six members is required as per the Terms of Reference), drawn from the Non-Executive Directors and members of the Executive Team.

The Committee's quorum is four members and include the Chair or Vice-Chair and at least one other Non-Executive Director.

Six ordinary meetings and two extraordinary meetings were held between 1 April 2021 and 31 March 2022 and attendance was as follows:

	Attendance at ordinary meetings	Attendance at extraordinary meetings
Mr S Morgan, Non-Executive Director (Finance Committee Chair)	6 of 6	2 of 2
Mr D Stout, Non-Executive Director, until 31 July 2021	2 of 2	1 of 1
Mr G Chapman, Non-Executive Director, joined the Committee from September 2021	4 of 4	1 of 1
Mr B MacLeod, Non-Executive Director	6 of 6	2 of 2
Mrs A Dragone, Finance Director	6 of 6	2 of 2
Mr M Wilson, Chief Operating Officer	5 of 6	1 of 2
Mr G King, Chief Information Officer	6 of 6	1 of 2
Mr R Smith, Estates Director	6 of 6	1 of 2
Dr V McFarlane-Reid, Director for Enterprise and Business Development	5 of 6	1 of 2

The Committee met for the minimum number of six meetings per year and other attendees at the meetings have included:

- The Deputy Director for Business and Development;
- The Deputy Finance Director;
- The Assistant Director of Finance;
- The Procurement and Supply Chain Director;
- The Deputy Director of Estates;
- The Head of Corporate Risk and Assurance;
- Associate Director – Commercial Enterprise Unit;
- The Head of IT Service Management
- Senior Commercial and Finance Manager – Commercial Unit; and
- The Trust Secretary, the PA to the Finance Director and the Corporate Governance Officer, who have provided secretariat support to the Committee.

In addition, the Chair of the Governor Business and Development Working Group observed a Committee meeting during the year.

4. REPORTING & AREAS OF REVIEW

During the year, the Committee:

- Received, and constructively challenged the content of the regular reports on the Trust financial position, including the closing position for the year, the Draft and Final Annual Accounts for 2020/21.
- Discussed in detail two matters raising by the External Auditors during the audit of the 2020/21 accounts in relation to ICHNE asset accounting and the inclusion of the fire provision in the accounts.
- Sought assurance over the financial management arrangements regarding:
    - The H1/H2 financial regime;
    - Cash management/forecasting;
    - The Commercial Business Model; and
    - The closedown of the Nightingale Hospital North East and the Integrated Covid Hub North East (ICHNE).
- Requested 'deep dives' into a number of areas e.g. Commercial Enterprise Unit, Recovery Schemes and CDEL risks. The deep dive items were either included in the finance report or added as a separate agenda item.
- Was fully briefed on the financial aspects of the Restart, Reset and Recovery programme, including activity performance and improvement schemes.
- Sought and received regular updates from the Procurement and Supply Chain Director regarding the Procurement Plan.
- Received assurance over the Trust Cyber Essentials status.
- Considered the capital and revenue plans for future periods, seeking assurances over the validity of the assumptions and risks detailed within.
- Received updates on Directorate activity performance against plan and queried variances arising.
- Was briefed on, and considered, investment into two spin-out companies in which the Trust had a shareholding (ScubaTX and AMLo Biosciences).
- Received updates on the 2021/22 Capital Programme (including investments and developments) and considered the 2022/23 Programme.
- Approved investments/business cases in accordance with the delegated authority of the Committee. This included a detailed consideration of the Business Case for the Elective Treatment Centre (subsequently renamed as the Day Treatment Centre).
- Reviewed the content of the Financial Plan, considered the NHSE priorities and sought assurances over the associated risks.
- Received an update on the 2020/21 National Cost Collection exercise.
- Approved updates to the Trust Intellectual Property Policy.
- Was fully briefed on changes in the IFRS 16 Less Accounting Standard.

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2021/22 and utilised a rolling programme and action log to track committee actions.

The Committee receives regular updates on risks recorded on the Board Assurance Framework which relate to the Committee's area of focus. Discussions have included those pertaining to the changes to the financial regimes.

During the year, the Committee has reviewed:

- Its Terms of Reference and Schedule of Business; and
- The quarterly Board Assurance Framework (BAF) Assurance Reports.

6. MANAGEMENT

The Committee has challenged the assurance process when appropriate and has requested and received assurance reports/verbal updates from Trust management throughout the year.

7. FUTURE AREA OF COMMITTEE FOCUS

Good progress has been made since the prior year in embedding 'deep dive' areas and strategic areas of focus into Committee agendas. However, this has resulted in additional time pressures resulting in some Committee meetings overrunning slightly or items being deferred. To accommodate this, additional monthly meetings were instigated from April 2022 and Committee meeting timings amended as appropriate.

It is recommended that this position is reviewed in July 2022 to ascertain whether the monthly meetings will continue to be required or whether the meeting timings require revisiting.

Report of Kelly Jupp
Trust Secretary
16 May 2022

ANNUAL REVIEW OF THE NEWCASTLE HOSPITALS CHARITY COMMITTEE 2021/22

1. PURPOSE

The purpose of this report is to provide assurance to the Trust's Board of Directors (BoD) that the Charity Committee has met its key responsibilities for 2021/22, in line with its terms of reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. COMMITTEE RESPONSIBILITIES

The Charity Committee is a statutory committee established by the BoD to manage, on behalf of the BoD, all charitable funds under the control of the Trust, considering the requirements of the Department of Health and Social Care (DHSC), and the Charity Commission (CC) for England and Wales.

The key purpose of the Charity Committee is to:

- Apply the Trust's charitable funds in accordance with their respective governing documents and ensure that funds are used in accordance with the charity's objectives – all within the budget, priorities, and spending criteria determined by the Trust Board as trustees and consistent with the Charities Act 2011 and the Charities (Protection and Social Investment) Act 2016 (the 'PSI Act 2016');
- Manage the Trust's charitable funds in accordance with statutory requirements of the CC, DHSC guidance and the Trust's Standing Orders, Reservation of Powers to the Board and Delegation of Powers, the Scheme of Delegation and Standing Financial Instructions; and
- Make decisions, on behalf of the Corporate Trustee, involving the sound investment of charitable funds in a way that both preserves their capital value and produces a proper return consistent with prudent investment and ensures compliance with the Trustees Act 2000, the Charities Act 2011, the PSI Act 2016 and CC regulations.

The committee fulfils this responsibility through the receipt of assurances from management, investment managers, and other sources.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the board and consists of five members of the BoD with a quorum being three members, with at least one Executive Director (ED) and one Non-Executive Director (NED) in attendance.

Four ordinary meetings were held between 1 April 2021 and 31 March 2022. No extraordinary meetings of the committee were required. Attendance was as follows:

	Attendance at ordinary meetings
Jill Baker, NED and Committee Chair	4 of 4
Jonathan Jowett, NED	3 of 4
Graeme Chapman, NED	4 of 4
Andy Welch, Medical Director and Deputy Chief Executive	1 of 4
Angela Dragone, Finance Director	4 of 4
Caroline Docking, Assistant Chief Executive	4 of 4

The Committee met the minimum number of four meetings per year and other attendees at the meetings included:

- The NHC Director;
- The Financial Accountant – NHC;
- The Data & Operations Manager – NHC;
- The Deputy Finance Director;
- The Arts Programme Manager – NHC;
- The Deputy Trust Secretary;
- The Operations Lead – NHC;
- The Corporate Risk and Assurance Manager; and
- The Head of Grant Programmes – NHC.

In early 2022, it was agreed that the secretariat support to the committee would be provided by the charity department rather than the Corporate Governance team.

4. CHARITY GOVERNANCE WORKING GROUP

In June 2021, a Charity Governance Working Group (CGWG) was convened to primarily consider the recommendations following the review undertaken by Withers LLP to ensure good and effective governance whilst NHC delivered its five year strategy. The recommendations included:

- Ensuring the Trust's BoD was fully aware of its role as corporate trustee;
- Considering both the terms of reference and composition of the committee to ensure the necessary degree of independence;
- Ensuring that the Trust's BoD was kept sufficiently informed and involved in the work of the NHC and the committee;
- Undertaking a review of the grant making policy and subsequent processes, and to ensure that these were well communicated;
- Undertaking a review of both the charity's fundraising and public profile;
- Developing a charity conflicts policy;

- Reviewing the charity's investment and spending policies and the possibility of convening sub-committees to the charity structure to support this; and
- Considering the potential options available for full independence.

The CGWG is routinely attended by:

- Jill Baker;
- Jonathan Jowett;
- Bill MacLeod, NED and Chair of the Audit Committee;
- Caroline Docking;
- Teri Bayliss, NHC Director;
- David Reynolds, Deputy Finance Director;
- Fay Darville, Deputy Trust Secretary; and
- Amanda Waterfall, Operations Lead - NHC.

During 2021/22, the group met on seven occasions and the group will continue to meet regularly until reviews of each of the areas of recommendation have been completed.

The committee was kept up to date with CGWG developments at each meeting throughout 2021/22.

5. KEY ACHIEVEMENTS

During 2021/22, the following matters were considered by the committee:

- In June, an update was provided by Angela O'Brien, Director of Quality and Effectiveness, on the charity grant awarded to the Institute of Healthcare Improvement in August 2020. The committee agreed to utilise this format to inform the process for future large grant awards going forward.
- The Charity Director, Teri Bayliss, provided a comprehensive update at each of the meetings of the committee in relation to progress against the charity strategy. Such updates included:
    - In June, an update in relation to recruitment was provided, which included the appointment of key roles such as the Charity Operations Lead and the Head of Grant Programmes.
    - In August, progress was noted against the five priority actions for 2021/22, which focussed on team development and improving visibility of the charity both within the Trust and the wider community. This included a review of the NHC retail 'offer'. A case study on the Big Tea event was provided, which was participated in by over 13,000 of the Trust's staff.
    - In December, it was agreed that the current systems and processes in place required further work to support the charity in meeting its grant making and fundraising aspirations in the longer term. This would be further considered within the remit of the CGWG.
    - In March, Teri Bayliss reported that recruitment within the charity team was now complete, work was underway to reconsider the charity's financial procedures, and outlined the areas of focus for 2022/23, to include a focus on regular giving and corporate engagement.

- In June, Chris Ham, Data & Operations Manager – NHC, provided an update on the options being considered for a new charity system. The aim being to remove unnecessary duplication and allow for a more streamlined approach. Agreement was provided to proceed with the preferred supplier, Beacon, with updates provided on the progress throughout the year.
- As outlined in section 6, the committee considered grants for approval over £25,000. In year, the grant consideration process was further refined to allow for robust discussion of the applications submitted. Applications presented now include a recommendation from the charity team as to whether the committee should approve an application, and whether an application was in keeping with the charity's aims.
- The presentation of finance reports had been streamlined over the course of 2021/22 to include a single report, which included the statement of financial accounts and income updates. The report continued to provide good assurance on the management of charity finances, and included detail such as income over expenditure, total fund values, and legacies. As outlined in section 4, the CGWG had been tasked with considering the Trust's ongoing investment strategy.
- In year, the committee discussed ongoing provision of staff Christmas lunches and decided to not consider this provision but instead to provide a voucher to all members of staff. Discussions commenced in early in the 2022 calendar year regarding the 2022 festive period offering.
- The committee continued to receive minutes from the following associated groups and committees:
    - Sir Bobby Robson Foundation;
    - GNCH Foundation; and
    - Charlie Bear for Cancer Care.

  Work continued throughout the year to further define the purpose of these groups and their ongoing role and relationship with NHC.
- The charity risk statement was presented and considered in year, with further detail outlined in section 8.
- The Charity Annual Report and Accounts were presented to the December meeting of the committee and approved.
- Discussion had taken place in year in relation to the agreement of the approach to realising asset gains. This would be considered as part of the investment strategy required, which was under the remit of the CGWG.
- Katie Hickman, Arts Programme Manager, provided a comprehensive update on the work of the programme and the impact on patients and staff. The arts programme was subsequently embedded as a core charity activity going forward.
- Jon Goodwin, Head of Grant Programmes, attended his inaugural meeting in December, where an overview of the charity's grant making approach was provided. The next steps to develop this were provided and endorsed by the committee. A draft grant agreement template was considered by the committee in March.
- In March, a skills gap audit was undertaken for members of the committee following the recommendation from Withers. This highlighted areas of both strength (including people management, stakeholder engagement and relationship building) and areas for development (including voluntary sector and fundraising). It was agreed that a development programme be established for the committee.
- In March, the committee considered the ongoing role and function of the Joint Research Executive Scientific Committee (JRESC) to allow for increased availability and

flexibility of the application approval process. This continued to be under review and would be further discussed in 2022/23.

6. GRANT APPROVALS

During 2021/22, the Committee considered 45 grant applications for approval, with 33 approved. Of those approved, the following grants were over £100,000:

- Great North Children's Hospital (GNCH) Outreach Coordinator Newcastle United Football Club Foundation - £150,000.
- Daft as a Brush Cancer Patient Transport - £215,000.
- Duplication to Personalisation - £982,000.
- Haven at the Freeman Hospital - £235,000.
- Nursing, Midwifery, and Allied Health Professionals Researcher Development Institute - £3,192,246.
- Embedding physical activity within the healthcare system: A pilot of an acute hospitals approach to improving the health and wellbeing of Newcastle Hospitals' patients - £138,756.
- Staff support and supervision for GNCH/Community 0-19 service - £164,492.
- Hub@Newcastle Hospitals - £203,000.
- Child Bereavement Support Workers - £374,579.
- Childhood Cancer Research Core Grant - £205,017.
- RVI Medicinema Social Cinema Screenings - £128,648.
- Clinical Sustainability Fellowships: Paediatrics and oncology pilot – £396,359.

Applications that exceed £1m were required to be considered by the BoD in advance of committee approval.

7. FINANCIAL MANAGEMENT, CONTROL & REPORTING

The committee continued to ensure that the systems for financial reporting to the BoD are reviewed and has achieved this primarily through the review and approval of the Annual Report & Accounts, which were signed off at the meeting on 03 December 2021.

Over the course of 2021/22, there were no significant issues that the committee had to consider in relation to the financial statements.

The committee continued to receive regular reports from the Trust's Investment Fund Managers, CCLA and Newton's, as well as the charity's own financial report.

8. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

Three areas of strategic risk were outlined in the charity risk statement presented through the year. These were:

- Governing principles (relating to the Charity Commission);
- Financial Strategies; and

- Potential impact on fundraising as a result of the pandemic.

The risk appetite for each risk area was considered and agreed and would continue to be reviewed in light of developments in relation to the CGWG. Additional controls in place were outlined.

The committee had a schedule of business for 2021/22 and utilised a rolling programme and action log to track committee actions. When the CGWG was convened, it was agreed to postpone the review of the terms of reference for the committee until the work of the group was complete.

The business transacted in 2021/22 was in accordance with the current terms of reference for the committee, which were approved by the Trust's Board on 29 July 2021.

There were no matters arising during the course of the year that required reporting to the Charity Commission.

9. PROGRESS FOR 2022/23 & REVIEW OF EFFECTIVENESS

Key areas to be revisited during 2022/23 are:

- Performance against the key areas of focus in the charity strategy for 2022/23. This includes the need to ensure that the committee are kept abreast of any areas of potential risk to this and where strategic aims are unlikely to be achieved.
- As noted in relation to the Skills Audit, the development programme for committee members should be produced and approved by both the committee as well as by an external agency with expertise in this area.
- The ongoing role of the JRESC and its relationship to the committee, and the process by which this is managed, should be reviewed and agreed by the committee.
- Following the conclusion of the work of the CGWG, an update on the outputs should be received by the BoD.
- The terms of reference for the committee will require a robust review following the conclusion of the work undertaken by the CGWG. This will include a review of the committee membership, as well as executive lead arrangements.

The Committee will be required to receive assurances regarding the activities outlined above.

10. RECOMMENDATION

The Committee is asked to approve this report outlining 2021/22 work undertaken and note the key areas and priority actions to revisit during 2022/23.

Report of Fay Darville
Deputy Trust Secretary
25 April 2022

TERMS OF REFERENCE – AUDIT COMMITTEE

1. CONSTITUTION OF THE COMMITTEE

The Audit Committee is a statutory Committee established by the Board of Directors to monitor, review and report to the Board on the suitability and efficacy of the Trust's provisions for governance, risk management and internal control.

2. PURPOSE AND FUNCTION

The purpose and function of the Committee is to:

2.1 monitor the integrity of the financial statements of the Trust and Group, any formal announcements relating to the Trust's financial performance, and review significant financial reporting judgements contained in them;

2.2 monitor, review and report to the Board of Directors on the adequacy of the processes for governance, assurance, and risk management, and facilitate and support the attainment of effective processes through its independence;

2.3 review the effectiveness of the Trust's internal audit function, counter fraud services and external audit function;

2.4 provide assurance to the Board of Directors that an appropriate system of internal control is in place to ensure that Trust business is conducted in accordance with legal and regulatory standards, and affairs are managed to secure economic, efficient and effective use of resources with particular regard to value for money;

2.5 report to the Board of Directors on the discharge of its responsibilities as a Committee; and

2.6 provide assurance to the Board of Directors that the Trust has policies and procedures in place to protect the organisation from/related to, fraud and corruption.

3. AUTHORITY

The Committee is:

3.1 a statutory Non-Executive Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference;

3.2 authorised by the Board to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required; and

3.3 authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Lead of the Committee and / or the Trust Secretary).

4. MEMBERSHIP AND QUORUM

MEMBERSHIP

4.01 Members of the Committee will be appointed by the Trust Board of Directors and the Committee will be made up of at least four members.

4.02 All members of the Committee will be independent Non-Executive Directors. One of the members will be appointed by the Trust Board of Directors as the Chair of the Committee and a second member will be appointed as Vice-Chair by the Trust Board of Directors.

4.03 The Committee Chair will be a financially experienced professional/executive possessing relevant postgraduate, Chief Financial Officer, or accountancy credentials, assessed as being appropriate to the role by the Nominations Committee, on behalf of the Board of Directors. It is expected that at least one member will have a formally recognised professional accountancy qualification.

4.04 The membership will include:

- a Non-Executive member of the Finance Committee;
- a Non-Executive member of the Quality Committee; and
- a Non-Executive member of the People Committee.

4.05 The Chair of the Board of Directors will not be a member of the Committee but may be in attendance.

4.06 The Senior Independent Director of the Board of Directors will not be Chair of the Audit Committee.

4.07 Only members of the Committee have the right to attend Committee meetings. Alternate, or substitute, members may be agreed in advance with the Chair of the Committee for a specific meeting but not for more than one and will not count towards the quorum. Other non-Committee members may be invited to attend and

assist the Committee from time to time, according to particular items being considered and discussed.

4.08 In the absence of the Committee Chair, the Vice-Chair will chair the meeting.

4.09 Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by electronic means will count towards the quorum.

4.10 The Director of Finance will act as the Executive lead for the Committee and will attend all meetings, or notify the Committee Chair in advance if a nominated Deputy is required to attend the meeting in their absence.

4.11 The Chief Executive and other members of the Executive team should be invited to attend as appropriate with an expectation that if invited they should attend in person. In addition, the Chief Executive should be required to attend, at least annually, to discuss the process for assurance that supports the Annual Governance Statement.

4.12 External Audit and Internal Audit representatives, and the Trust Fraud Specialist Manager will be invited to attend meetings of the Committee at the discretion of the Chair. In addition, they will be invited to meet Committee members prior to the formal conduct of the business of the meeting without members of the Executive present.

4.13 The Council of Governors may nominate up to two governors to attend one meeting of the Committee annually to observe proceedings. The observation of Board assurance committees by governors will be subject to conditions agreed by the Board of Directors. The Chair of the Committee may in exceptional circumstances exclude governors from being present for specific items.

4.14 The Trust Secretary, or their designated deputy, will act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, will attend all meetings of the Committee.

4.15 All members of the Committee will receive training and development support where required before joining the Committee, and on a continuing basis as required, to ensure their effectiveness as members, supported by the process of annual appraisal, as agreed by the Board of Directors.

4.16 An attendance record will be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board of Directors.

QUORUM

4.17 The quorum necessary for the transaction of business will be two members, both of whom will therefore be Non-Executive Directors, as specified in 4.02 and 4.04 of these Terms of Reference.

4.18 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee.

4.19 A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

5. DUTIES

5.1 The Committee will undertake the duties detailed in the NHS Audit Committee Handbook (HFMA latest edition) and will have regard to the Audit Code for NHS Foundation Trusts. The Committee will carry out the duties below for the Foundation Trust and major subsidiary undertakings as a whole, as appropriate. The Committee will set an annual plan for its work to form part of the Board's Annual Cycle of Business, and report to the Board on its progress. The duties of the Committee will include:

6. FINANCIAL REPORTING

The Committee will:

6.1 ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided;

6.2 ensure the integrity of the Annual Report and Financial Statements of the Trust and Group before submission to the Board of Directors, and any other formal announcements relating to its financial performance, reviewing significant reporting issues and judgements that they contain, and including the meaning and significance of the figures, notes and significant changes; accounting policies and practices followed, and significant changes; explanation of estimates or provisions having material effect; the schedule of losses and special payments and any reservations and disagreements between internal and external auditors, and the executive directors, which are not resolved;

6.3 review summary financial statements, Trust Accounts Consolidation (TAC) data, the Annual Report and Accounts, including the Annual Governance Statement;

6.4 review the consistency of, and changes to, accounting policies across the Trust and its subsidiary undertakings including the operation of, and proposed changes to, the

Corporate Governance Manual, Standing Orders, Standing Financial Instructions, Scheme of Delegation and Reservation of Powers, Matters Reserved to the Board and Standards of Business Conduct, including maintenance of registers and the Fraud Response Plan;

6.5 review the methods used to account for significant or unusual transactions where different approaches are possible (including unadjusted mis-statements in the financial statements);

6.6 receive and review an annual report on special severance payments made during the year via a settlement agreement;

6.7 review whether the Trust has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of the External Auditor; and

6.8 review the clarity of disclosure in the Trust's financial reports and the context in which statements are made.

7. GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL

The Committee will review:

7.1 the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

7.2 the risk environment of the Trust to ensure that the governance system is adequately addressing the full range of current, and potential future, risks;

7.3 the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, together with the Head of Internal Audit Opinion, External Audit Opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors;

7.4 the effectiveness of systems and processes for risk management in the Trust, in accordance with the Risk Management Strategy and Policy approved by the Committee, including arrangements for the development and review of the Board Assurance Framework and the Corporate Risk Register;

7.5 the Board Assurance Framework and processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

7.6 the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, any related reporting and self-certifications, and work related to counter fraud and security, as required by the NHS Counter Fraud Authority;

7.7 via the Quality Committee, that there are robust processes/policies for managing and investigating complaints and legal claims against the Trust, including referrals to the NHS Resolution; and

7.8 the Register of Directors' Interests; and Register of Gifts and Hospitality on a regular basis, and not less than annually.

8. INTERNAL CONTROL AND COUNTER FRAUD

The Committee will:

8.01 ensure that there is an effective Internal Audit function that meets the *Public Sector Internal Audit Standards* and provides appropriate independent assurance to the Committee, Chief Executive, and Board of Directors;

8.02 consider and approve the Internal Audit Strategy and Annual Plan, and ensure it has adequate resources and access to information, including the Board Assurance Framework, to enable it to perform its function effectively and in accordance with the relevant professional standards. The Committee will also ensure the function has adequate standing and is free from management or other restrictions;

8.03 review all reports on the Trust from the Internal and External Auditors which identify "limited assurance" or "no assurance";

8.04 review and monitor, on a sample basis, the Executive Management's responsiveness to the findings and recommendations of audit reports, and ensure coordination between Internal and External Auditors to optimise use of audit resource;

8.05 meet the Head of Internal Audit on a formal basis, at least once a year, without Executive Directors or management, to consider issues arising from the internal audit programme and its scope and impact. The Head of Internal Audit will be given the right of direct access to the Chair of the Committee, Chief Executive, Board of Directors, and to the Committee;

8.06 assure itself that the Trust has policies and procedures for all work related to fraud and corruption as required by the NHS Standard Contract and NHS Counter Fraud Authority (NHS CFA);

8.07 consider the effectiveness of Counter Fraud services annually;

8.08 monitor the implementation of the policy on standards of business conduct for directors and staff (i.e. Codes of Conduct and Accountability) in order to offer assurance to the Board of Directors on probity in the conduct of the Trust's business;

8.09 consider and approve the Annual Fraud Plan, and ensure that adequate resources and access to information enables the Fraud Team to perform its work effectively and in accordance with the relevant professional standards and the NHS Counter Fraud Manual; and

8.10 approve the contents of the annual Counter Fraud Functional Standard Return prior to submission to the NHS CFA.

9. EXTERNAL AUDIT

The Committee will:

9.1 consider and make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the Trust's External Auditor;

9.2 work with the Council of Governors to manage the selection process for new auditors. If an auditor resigns, the Committee will investigate the reasons, and make any associated recommendations to the Council of Governors;

9.3 obtain assurance of External Auditor compliance with the Audit Code for NHS Foundation Trusts;

9.4 approve the External Auditor's remuneration and terms of engagement, including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted;

9.5 agree and review the policy regarding the supply of non-audit services by the External Auditor and monitor that service, taking into account relevant ethical guidance;

9.6 review and monitor the External Auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work;

9.7 meet the External Auditor at least once a year, without management being present; to discuss their remit and any issues arising from the audit;

9.8 establish with the External Auditors, the nature and scope of the audit, as set out in the annual plan before the audit commences; and

9.9 review all External Audit reports for the Trust and Charity, including the reports to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

10. OTHER BOARD ASSURANCE FUNCTIONS

The Committee will:

10.01 oversee the maintenance of the policy framework of the Trust, in particular the Policy for the Development of Procedural Documents and the Corporate Governance Manual, and review any significant breaches of the procedures. The Quality Committee, via the Compliance and Assurance Group, receive assurance on policy compliance;

10.02 review arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. The People Committee will receive an annual report on the application of the Trust policy on raising concerns, with any associated matters to be raised for the attention of the Audit Committee by the People Committee Chair;

10.03 receive assurance on compliance with the Trust's Speaking Out Policy, via the Trust People Committee, to ensure that the policy allows for proportionate and independent investigation of such matters and appropriate follow-up action;

10.04 review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the Trust. These will include, but not be limited to, any reviews undertaken by the Department of Health and Social Care Arms-Length Bodies, Regulators, and professional bodies with responsibility for the performance of staff or functions;

10.05 review the work, and receive the minutes, of other Committees within the organisation and its subsidiaries, whose work can provide relevant assurance to the Audit Committee's own scope of work and in relation to matters of quality affecting the Board Assurance Framework, including the Quality Committee, the Finance Committee and the People Committee;

10.06 ensure there is no duplication of effort between the Committees, and that no area of assurance is missed as part of its responsibility for reviewing the Annual Governance Statement prior to submission to the Board of Directors;

10.07 via the Quality Committee, receive assurance in relation to work of the Clinical Audit function;

10.08 receive information on Single Tender Waivers, as approved by the Chief Executive, to gain assurance that such waivers were appropriate;

10.09 receive a schedule of losses and compensations and approve appropriate write-offs;

10.10 review registers relating to the Standards of Business Conduct Policy and consider any breaches and action taken; and

10.11 review every decision by the Council of Governors or the Board of Directors to suspend their respective Standing Orders.

10.12 In fulfilling its responsibilities, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

11. REPORTING AND ACCOUNTABILITY

11.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

11.2 The Committee will report to the Trust Board annually on its work in support of the Annual Governance Statement. The Annual Report will:

- set out clearly how the committee is discharging its responsibilities;
- include a statement referring to any non-audit services provided by the external auditors, and if so, how auditor objectivity and independence is safeguarded;
- set out details of the full auditor appointment process, and where the Council of Governors decide not to accept the recommendations of the Committee, a statement setting out (a) an explanation of the Committee's recommendation in relation to the appointment, re-appointment or removal of the external auditor and (b) the reasons the Council of Governors has chosen not to accept those reasons;
- provide explanatory details, where during the year the External Auditor's contract is terminated in disputed circumstances, on the removal process and the underlying reasons for removal;
- be signed by the Chair of the Audit Committee; and
- be presented to the Annual General Meeting, with the Chair of the Audit Committee in attendance to respond to any stakeholder questions on the Committee's activities.

11.3 The Chair of the Committee will write to the Independent Regulator of NHS Foundation Trusts (NHS Improvement) in those instances where the services of the External Auditor are terminated in disputed circumstances.

11.4 Where exceptional, serious and improper activities have been revealed by the Committee, the Chair of the Committee will write to NHS Improvement, if insufficient action has been taken by the Board of Directors after being informed of the situation.

11.5 The Chair of the Committee shall provide, as a minimum annually, an update to the Council of Governors on the work of the Committee.

11.6 The Terms of Reference shall be reviewed by the Committee and approved by the Board of Directors on a minimum basis of every two years.

12. COMMITTEE ADMINISTRATION

12.1 The Committee will meet a minimum of five times a year and at such other times as the Chair of the Committee, in consultation with the Trust Secretary, will require allowing the Committee to discharge all of its responsibilities.

12.2 The Chairman may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

12.3 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

12.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, will be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers will be made available no later than three working days before the date of the meeting.

12.5 Committee papers will include an outline of their purpose and key points in line with the Trust's committee protocol, and make clear what actions are expected of the Committee.

12.6 The Chair will establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure these are recorded in the minutes accordingly.

12.7 The Committee Secretary will minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft

minutes of Committee meetings will be made available promptly to all members of the Committee, normally within ten working days of the meeting.

12.8 The Committee will, at least once a year, review its own performance, using a process agreed for all Board Committees by the Board of Directors.

Procedural control statement: 12 April 2022
Date approved: 26 April 2022 [Audit Committee] and TBA [Board]
Approved by: Audit Committee and Trust Board
Review date: April 2023

Terms of Reference – Finance Committee

1. Constitution of the Committee

The Finance Committee is a non-statutory Committee established by the Trust Board of Directors to provide assurance to the Board on the delivery of the financial aspects of the Trust's annual Operational Plan, including financial strategy and planning, transformation and sustainability, the financial performance of the Trust, and on commercial and procurement activity, strategic investments and the development of the Trust's digital and estates infrastructure.

2. Purpose and function

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors:

2.01 that the strategic financial principles, priorities, risk and performance parameters are aligned and support the Trust's strategic objectives and its long-term sustainability;

2.02 that the Trust's degree of exposure to financial risk, and any potential to compromise the achievement of the strategic objectives is being effectively managed;

2.03 that reporting on the financial performance of the Trust is being triangulated against agreed plans, progress and performance measures, reporting on progress to the Trust Board;

2.04 that the Trust's resources and assets are being used and maintained effectively and efficiently;

2.05 on the robustness, credibility and quality of financial management and planning information, which is reviewed and triangulated by the Committee;

2.06 on the Trust's compliance with current statutory and external reporting standards and requirements, including NHS and Treasury policies and procedures;

2.07 on the development, effective management, and delivery of the Trust's capital investment programme, and that this is fit for purpose;

2.08 to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the committee purpose and function; and

2.09 on the robustness of procurement decision-making and documentation.

2.10 The Committee will provide the Trust Board of Directors with advice and support on the development and delivery of the following strategies:

- Capital Strategy;
- Investment Strategy (regarding investments in services and business cases);
- Estates Strategy, including estates infrastructure;
- Commercial Strategy;
- Procurement Strategy; and

- Digital Strategy, including digital infrastructure.

3. Authority

The Committee is:

3.1 a non-statutory Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference;

3.2 authorised by the Board of Directors to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required; and

3.3 authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Lead of the Committee and / or the Trust Secretary).

3.4 The Committee shall be able, in exceptional circumstances, to establish sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility, if approved by the Trust Board. In accordance with the Trust's Standing Orders and Scheme of Delegation, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the Board of Directors.

3.5 The Terms of Reference, including the reporting procedures, of any sub-committees or task and finish group, must be approved by the Board of Directors and be reviewed on an annual basis.

4. Membership and quorum

Membership

4.01 Members of the Committee shall be appointed by the Trust Board of Directors and shall be made up of at least six members drawn from Non-Executive Directors (three members minimum) and members of the Executive Team (three members minimum).

4.02 One of the Non-Executive members will be appointed by the Trust Board of Directors as the Chair of the Committee.

4.03 A further Non-Executive member of the Committee will be appointed as Vice-Chair, likewise by the Trust Board of Directors.

4.04 The membership of the Committee shall include:

- a Non-Executive member of the Audit Committee;
- the Director of Finance;
- the Chief Operating Officer;
- the Chief Information Officer;
- the Director of Estates; and

- the Director for Business, Development and Enterprise.

4.05 The Chief Executive, as the Trust's Accountable Officer, shall have the right to attend the Committee at any time. Otherwise, only members of the Committee have the right to attend Committee meetings. Other non-committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.06 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year.

4.07 The Director of Finance and the Chief Operating Officer shall act as joint Executive Leads for the Committee.

4.08 Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by electronic means will count towards the quorum.

4.09 The Council of Governors may nominate up to two governors to attend one meeting of the Committee annually to observe proceedings. The observation of Board assurance committees by governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may, in exceptional circumstances, exclude governors from being present for specific items.

4.10 The Trust Secretary, or their designated deputy, shall act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, shall attend all meetings of the Committee.

4.11 All members of the Committee shall receive training and development support before joining the committee where required and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

4.12 An attendance record shall be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

4.13 The Chair of the Board of Directors will not be a member of the Committee but may be in attendance.

Quorum

4.14 The quorum necessary for the transaction of business shall be four members as defined in 4.01 and 4.04 above, including the Chair or Vice Chair and at least one Non-Executive Director.

4.15 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will not count towards the quorum.

4.16 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers, and discretions delegated to the Committee.

5. Duties

5.1 Cycle of Business

The Committee will:

5.1.1 set an annual set of objectives and an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

5.2 Strategies and policies

The Committee will:

5.2.1 review the Trust's financial strategy, planning assumptions, and related delivery plans and transformation programmes, and provide informed advice to the Board of Directors on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact;

5.2.2 review guidance for the development and delivery of the financial aspects of annual operational, service, and financial planning, including assumptions on revenue, budgets, capital, working and associated targets, and parameters on efficient and effective use of resources;

5.2.3 review, and recommend to the Board of Directors, the Annual Financial Plan, including key financial performance indicators;

5.2.4 provide advice and support on significant financial and commercial policies prior to their recommendation for Board approval. This will include policies relating to costing, revenue, capital, working capital, treasury management, investments and benefits realisation;

5.2.5 seek assurance that financial policies and plans are aligned to the Trust's agreed approach to the development of place-based, systems and regional working, and align with the Trust's strategic approach to commissioners and stakeholders;

5.2.6 identify sources of economic, financial, and related intelligence and data, relevant to the Trust in the context of the "place" of Newcastle and the North East to inform the work of the Committee and the Board of Directors; and

5.2.7 identify learning and development needs arising from the work of the Committee for consideration by the People Committee.

5.3 Annual Financial Plan

The Committee will:

5.3.1 review the Trust's Annual Financial Plan for recommendation and approval by the Board;

5.3.2 review progress and performance against the approved plan and any significant supporting plans and targets, and analyse the robustness of any corrective action required;

5.3.3 assess reports regarding future cost pressures and key financial risk areas;

5.3.4 review the Trust's Statement of Financial Position, with a particular focus on debtors, creditors, and asset valuations; and

receive and review an overview of financial and service delivery agreements and key contractual arrangements entered into by the Trust.

5.4 Risk

The Committee will:

5.4.1 Receive the risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit Committee with assurance on the effectiveness of the management of principal risks relating to the Committees purpose and function.

5.4.2 To receive the Executive Oversight Report for information.

5.5 Performance and progress reporting

The Committee will:

5.5.1 monitor the effectiveness of the Trust's financial and operational performance reporting systems, ensuring that the Board is assured of continued compliance through its annual reporting processes, reporting by exception where required to the Board;

5.5.2 agree a succinct set of key performance and progress measures relating to the full assurance purpose and function of the Committee, including:

- the Trust's strategic financial priorities;
- national performance and statutory targets;
- consolidated financial performance summaries and related budgets;
- statement of financial position;
- working capital performance;
- cash flow status;
- progress on capital investment programme;
- use of resources ratings; and
- risk mitigation;

5.5.3 triangulate progress against these measures and seek assurance around any performance issues identified, including proposed corrective actions;

5.5.4 provide regular reports to the Board, including as part of the bi-monthly Integrated Board Report, on assurance around key areas of Trust performance, risk, and corrective actions, both retrospectively and prospectively;

5.5.5 agree a programme of benchmarking activities and reference points to inform the understanding and effectiveness of the Committee and its work;

5.5.6 be assured of the credibility of sources of evidence and data used for planning and progress reporting to the Committee, and to the Board, in relation to the Committee's purpose and function;

5.5.7 ensure the alignment and consistency of Board assurances, use of data and intelligence, by working closely with the Audit Committee, Quality Committee and People Committee;

5.5.8 review the following formal reports to the Board as part of the Annual Cycle of Business:

- Annual Financial Plan;
- Finance Reports;
- Capital Investment Policy; and
- Annual Report and Accounts (Group, Trust and Charity);

5.5.9 receive regular updates, and be assured as to the financial performance of the Day Treatment Centre and

5.5.10 review and approve the Terms of Reference for, and receive the minutes of, the:
i) Supplies and Services Procurement Group;
ii) Capital Management Group;
iii) Strategy, Planning and Capital Investment Group;
iv) Commercial Strategy Group; and
v) Day Treatment Centre Strategic Oversight Group.

5.6 Capital, investments, acquisitions and disposals

The Committee will:

5.6.1 review the Trust's capital and investment policies against appropriate benchmarks prior to recommendation for Board approval;

5.6.2 agree a consistent and robust methodology for the assessment of proposed capital expenditure, acquisitions, joint ventures, equity stakes, major property transactions, mergers, and formal or informal alliances with other Institutions;

5.6.3 review business cases and proposals over the threshold specified within the Trust Scheme of Delegation, and provide advice to the Board accordingly;

5.6.4 assure the Trust Board, on a regular basis, of the effectiveness of, and compliance with, the capital and investment strategies and related policies, including the effective prioritisation of investment decisions, the robustness of processes and rigour of investment decision-making, and report on this as part of the Committee's Annual Report to the Board;

5.6.5 monitor the performance of investments, and commission and review reports on the benefits realisation of infrastructure and service improvement investments made; and

5.6.6 exercise delegated responsibility on behalf of the Board in line with the Standing Financial Instructions for proposals for acquisition and disposal of assets in accordance with Trust policy.

5.7 Infrastructure, estates and digital

The Committee will:

5.7.1 review the following policies and plans, in order to provide informed and authoritative advice to the Board:

- estates; and
- digital strategy.

5.8 Commercial strategy

The Committee will:

5.8.1 provide support and advice on the development and implementation of the commercial strategy for the Trust.

5.8.2 assure the Trust Board, on a regular basis, of the effectiveness of, and compliance with, the commercial strategy and related policies, including the effective prioritisation of commercial decisions, the robustness of processes and rigour of commercial decision-making, and report on this as part of the Committee's Annual Report to the Board.

5.9 Statutory compliance

The Committee will:

5.9.1 ensure, on behalf of the Board, that current statutory and regulatory compliance and reporting requirements are met, including compliance with treasury policies and procedures and the appropriate safeguards for security of the Trust's funds as an NHS Foundation Trust;

5.9.2 ensure the proper reporting of actions deemed "high-risk" by regulators, or actions with an equity component, which entail a potentially significant risk to reputation or to the stability of the business of the Trust, or which create material contingent liabilities;

5.9.3 ensure future legislative and regulatory and reporting requirements are identified and appropriate action taken; and

5.9.4 consider, and recommend for approval by the Audit Committee, any proposed changes to Trust Standing Financial Instructions, Standing Orders and Scheme of Delegation.

6. Reporting and accountability

6.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Committee will provide an Annual Report to the Board to inform and / or accompany the Trust's Annual Report. This shall include an assessment of compliance with the Committee's Terms of Reference and a review of the work and effectiveness of the Committee.

6.3 The Chair of the Committee shall provide as a minimum, an annual update to the Council of Governors on the work of the Committee.

6.4 The terms of reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

7.1 The Committee will meet a minimum of six times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

7.2 The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than three working days before the date of the meeting.

7.5 Committee papers shall include an outline of their purpose and key points in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

7.7 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten working days of the meeting.

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: 13 June 2022
Date approved: 17 June 2022 [Finance Committee] and TBA [Board]
Approved by: Finance Committee and Board
Review date: May 2023

PEOPLE COMMITTEE ANNUAL REPORT 2021/22

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the People Committee has met its key responsibilities for 2021/22, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. COMMITTEE RESPONSIBILITIES

The People Committee is a non-statutory Committee established by the Board of Directors to monitor, review and report to the Board on the cultural and organisational development of the Trust, the strategic performance of people and workforce priorities, and the impact of the Trust as a significant employer, educator and partner in health, care and research.

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors, that:

- The strategic people and workforce priorities for the Trust as a significant employer and as a partner in training, education, and development of health and care capacity in the region and nationally are identified;
- The organisation has a clear understanding of strategic workforce needs (including well-being, recruitment, retention, development of people, and organisational capacity) and the quality and effectiveness of plans to deliver them;
- The commitments of the NHS Constitution, the NHS People Promise, and the stated values of the Trust and standards of behaviour, are being practiced throughout the organisation, based on evidence;
- The approach to all aspects of employment and culture in the Trust are informed by relevant and up-to-date research on innovation and practice;
- The effectiveness of mitigations and action plans as set out in the Board Assurance Framework are reviewed, assessed and assurances obtained specific to the committee purpose and function;
- Legislative and regulatory compliance is achieved as an employer, including anticipation of, and planning for, future requirements;
- Staff governance in the organisation is fully developed, including staff engagement processes;
- Strategic communications and engagement are developed, and reputation management is robust with internal and external stakeholders, local communities and partners;
- The impact on workforce of changing professional and organisational practices is considered, including those involved in increased system-based and partnership working (in collaboration with the Quality Committee); and
- The Trust fulfils its leadership and influencing role on service quality standards and practice, as an organisation of national importance, as a significant service provider in

the North East, and as a partner in training, education and development of health and care capacity in the region (in collaboration with the Quality Committee).

It does this through the receipt of assurances from management, the receipt of regular reports relating to areas which impact Trust staff, as detailed in section 4 below, and discussions and reports on the management of risks relating to the Committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of six members (as specified in the Terms of Reference), drawn from the Non-Executive Directors and members of the Executive Team.

The Committee's quorum is four members, with at least one Non-Executive Director present.

Meetings are held bi-monthly. Five ordinary meetings were held between 1 April 2021 and 31 March 2022. The meeting scheduled on 24 August 2021 was postponed and instead a further Committee was arranged on 16 September 2021 to incorporate a 'deep-dive' on education and training.

Attendance at the meetings was as follows:

	Attendance at ordinary meetings
Jonathan Jowett, Non-Executive Director (Committee Chair)	6 of 6
Kath McCourt, Non-Executive Director	6 of 6
Jill Baker, Non-Executive Director	5 of 6
Dee Fawcett, Director of Human Resources	6 of 6
Caroline Docking, Assistant Chief Executive	3 of 6
Martin Wilson, Chief Operating Officer	5 of 6

Other attendees at meetings have included:

- Head of Human Resource Services;
- Head of Equality, Diversity & Inclusion – People;
- Head of Workforce Engagement & Information;
- Head of Workforce Advisory Service;
- Associate Director – Education, Training, and Workforce Development;
- Freedom to Speak Up Guardian;
- Guardian of Safe Working Hours;
- Associate Director – Sustainability & Environment;
- Executive Chief Nurse;
- The Deputy Director of Medical Education;
- Deputy Chief Nurse;
- Head of Communications;

- Head of Corporate Risk & Assurance; and
- The Deputy Trust Secretary who provided Secretariat Support to the Committee.

Mrs Judy Carrick, Public Governor and Chair of the People, Engagement and Membership (PEM) Working Group, observed one Committee meeting during the year.

4. REPORTING

i) Regular Reports

Over the course of the year, Committee members received regular reports/updates on:

- The Trust People Plan and progress against delivery;
- Board Assurance Framework (BAF) Report;
- Employee Relations Report;
- COVID-19 Updates – Committee members received regularly updates on COVID-19 in relation to staff matters, which included the closure of the Integrated COVID Hub North East (ICHNE), staff redeployment, vaccination as a condition of employment (VCOD) and staff absence;
- Guardian of Safe Working Hours Quarterly Reports (prior to receipt at the Board of Directors);
- 'Flourish at Newcastle Hospitals' Updates, including Employee Wellbeing, NHS Staff Survey and engagement plans/updates and 'What Matters To You Organisational Development';
- Education and Workforce Development Reports, covering e.g. Medical Education, Education Space, Leadership Development Offer and Apprenticeships;
- People Dashboard;
- Legal Updates; and
- Sustainability Reports.

ii) Annual Reports

The following Annual Reports were received by the Committee:

- Workplace Race Equality Standard (WRES) and Workplace Disability Equality Standard (WDES) Data and Action Plan (prior to approval at Trust Board);
- Gender Pay Report;
- GMC training survey;
- Communication strategy;
- Freedom to speak up Guardian;
- Sustainable Healthcare in Newcastle (SHINE) Annual Report;
- Trade Union Faculty Time Report; and
- Annual Report of the Committee, Committee Terms of Reference and Schedule of Business.

iii) Ad-Hoc Reports

In addition to those reports listed above, a number of reports were received by the Committee. These included:

- Key People risks and mitigations;
- Raising concerns triangulation report;
- Foundation Trust membership report;
- Project Choice update;
- NHS Future Report; and
- Winter 21/22 Preparedness – Nursing and Midwifery Safe Staffing.

In addition, during the year 'deep dives' were also undertaken on:

- Workforce Age Profile and Demographics; and
- Education and Training.

Also the Committee received the minutes of both the Learning and Education Group and the Sustainable Healthcare Committee.

The Schedule of Business for the year 2021/22 included an annual conversation with the Executive Chief Nurse and Medical Director (separately). The annual conversation with the ECN was held in December 2021. The annual conversation with the Medical Director was deferred and will be held in August 2022.

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2021/22 and utilised a rolling programme and action log to track committee actions.

As highlighted in Section 4(i), the Committee receives regular updates on risks recorded on the BAF which related to the Committee's area of focus. During 2021/22, the two risks included in the BAF and regularly discussed at the Committee were:

- 'COVID-19 and associated government guidance has the potential to significantly affect our staffing capacity. This in turn could impact on our ability to deliver safe effective services, increases the likely use of bank or agency staff, and necessitates the need to increase expenditure, as well as add additional pressure on existing staff'; and
- 'Due to the resurgence of COVID-19, there has been a local rise of issues relating to staff health and wellbeing. There is a risk that we fail to maintain focus on the wellbeing and investment in our staff'.

The Committee received regular updates on mitigations in place.

6. PROGRESS FOR 2021/22 & REVIEW OF EFFECTIVENESS

In the Annual Report of the Committee for 2020/21, the following areas were identified as for action during 2021/22, with progress updates highlighted in italic font:

1. Further liaison was required between the Chair, Executive Lead, and Corporate Governance Team to ensure that sufficient time was allocated for agenda items that were of significant importance, were likely to stimulate fuller discussions, or presented an area of significant risk – *The scope of this Committee is broad and the difficulty in ensuring sufficient time to obtain assurance is acknowledged. Timings are discussed regularly as part of the agenda setting process during 2021/22 and the Chair*

takes the opportunity to reflect at the end of each meeting, on both the quality of discussion and content;

2. The Executive Lead, in collaboration with the Corporate Governance Team, to provide further advice and guidance to report authors to ensure Committee papers were both meaningful and succinct, and during Committee meetings, to encourage presenters to highlight only the key points of their reports to allow for the allocated time on the agenda to be utilised for Committee member queries/discussion. *Good progress made in relation to reports presented and the adoption of presentation style reports. This will continue to be a process of improvement.*
3. A review of the rolling agenda was required to prioritise key items for inclusion on the 2021/22 Schedule of Business – *action completed*; and
4. Consideration was required regarding an annual conversation with relevant Executive Directors at meetings to allow for a discussion on key issues and remedial actions for specific staff groups (such as Medical and Dental, Nursing, Midwifery and Allied Health Professionals, Administrative and Clerical) – *actioned in part with the ECN attending the December 2021 meeting*.

7. NEXT STEPS AND ACTIONS FOR 2022/23

The following actions/next steps for consideration over 2022/23 were noted:

1. The Committee Chair, Executive Lead and Trust Secretary to develop a 'deep-dive' schedule to cover the year ahead.
2. Focus on preparation for a CQC Well Led Assessment, metrics and activities specific to the workforce in general.
3. Oversight of the ongoing implementation of the 'What Matters to You' improvement programme, and use of appropriate tools to enhance the staff experience and ensure the People 'Breakthrough Objectives' are achieved.
4. Production of a cohesive Equality, Diversity and Inclusion Strategy.
5. A refresh of the Leadership Development and Talent Management Strategy.

8. RECOMMENDATION

The Committee is asked to approve this report outlining 2021/22 work undertaken and note the key areas to revisit during 2022/23.

Report of Kelly Jupp
Trust Secretary
10 June 2022

QUALITY COMMITTEE ANNUAL REPORT 2021/22

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Quality Committee has met its key responsibilities for 2021/22, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during 2022/23.

2. COMMITTEE RESPONSIBILITIES

The Quality Committee is a non-statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience.

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors, that:

- The Trust has appropriate quality governance structures, systems, processes and controls in place and to meet Trust legal and regulatory requirements;
- The Trust delivers continuous quality improvements;
- Any shortcomings in the quality and safety of care are identified and addressed;
- The Trust's approach to continuous quality improvement processes for all Trust services, the Trust's research and development activities and its clinical practice, and assurances on robust mechanism of research governance which is subject to regular scrutiny and monitoring;
- The quality impact of changing professional and organisational practices;
- Ensuring the Trust fulfils its leadership and influencing role on service quality standards and practice; and
- Effective mechanisms were in place for the involvement of patients and the public, staff, partners and other stakeholders in improving quality assurance and patient safety.

It does this through the receipt of assurances from the management groups, the receipt of regular reports relating to areas which impact the quality of care provided to patients, such as Infection Prevention and Control (IPC), Safeguarding and Learning from Deaths (LfD), and discussions and reports on the management of risks relating to the committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of nine members (noting a minimum of 7 members is required as per the Terms of Reference), drawn from the Non-Executive Directors, members of the Executive Team and other senior staff members.

The Committee's quorum is four members and includes the Chair or Vice-Chair, and at least one other Non-Executive Director.

During 2021/22, the Committee met on a bimonthly schedule and six ordinary meetings were held between 1 April 2021 and 31 March 2022. Attendance at the meetings was as follows:

	Attendance at ordinary meetings
Graeme Chapman, Non-Executive Director (Committee Chair from 1 November 2021)	6 of 6
Kath McCourt, Non-Executive Director (Committee Chair until 31 October 2021)	6 of 6
Steph Edusei, Non-Executive Director (Committee member from 1 September 2021)	2 of 4
David Stout, Non-Executive Director (Committee member until 31 July 2021)	2 of 2
Andy Welch, Medical Director and Deputy CEO	4 of 6
Maurya Cushlow, Executive Chief Nurse	6 of 6
Martin Wilson, Chief Operating Officer	4 of 6
Angela O'Brien, Director of Quality and Effectiveness	6 of 6
Gus Vincent, Assistant Medical Director, Patient Safety & Quality	3 of 6
Ian Joy, Deputy Chief Nurse	2 of 6

Other attendees at the meetings have included:

- The Deputy Medical Director;
- The Associate Medical Director for Research;
- The Associate Medical Director – Quality & Patient Safety;
- The Director of Infection Prevention and Control;
- The Clinical Director for Quality and Safety (Chair of Patient Safety Group);
- The Infection Prevention and Control Lead;
- The Clinical Effectiveness Manager;
- The Deputy Director of Quality & Safety;
- The Clinical Director – Women's Services;
- The Directorate Manager for Women's Services;
- The Associate Director of Midwifery;
- A Consultant in Palliative Medicine;
- The Head of Patient Safety & Risk;
- A Head of Projects;

- The Head of Corporate Risk and Assurance;
- A Patient Safety Advisor;
- The Public Governor Chair of the Quality of Patient Experience Working Group; and
- The Deputy Trust Secretary and Governor and Membership Engagement Officer who provided Secretariat Support to the Committee.

4. MANAGEMENT GROUPS

To ensure that the Committee maintained adequate oversight of the management of quality related matters across the Trust, a series of Management Groups were established and continued to report into the Committee:

- Patient Safety;
- Patient Experience and Engagement;
- Clinical Outcomes and Effectiveness; and
- Compliance and Assurance.

During the year the Committee agreed to alter the frequency of the management group reports from receiving a report for each group at every meeting to receiving a report from two groups at each meeting and rotating across the course of the year. The reports detail the activities of the Management Groups and any risks/matters requiring escalation to the Committee. Additionally, the minutes of the Management Groups are received by the Committee at each meeting.

The Terms of Reference for each of the Management Groups, which clearly define the remit of each of the groups, were approved by the Committee.

In addition, a bi-annual Research and Development report is received by the Committee.

The Committee was established during 2019/20 following the review of the Trust's governance structure. During 2021/22, Committee members continued to review and refine the content, frequency, and scheduling of reports, particularly post COVID-19 pandemic.

5. REPORTING

i. Regular Reports

During the year, the following reports were received by the Committee:

- The Integrated Quality and Performance Report;
- Management Group Chair Updates;
- Leadership Walkabouts/Spotlight on Services;
- Care Quality Commission Update Report and Action Plan;
- Legal Cases Update; and
- Ockenden Report Progress Updates and Maternity CNST Reports.

ii. Quarterly, Biannual and Annual Reports

The following Quarterly and Annual reports were received by the Committee during 2021/22:

- Safeguarding;
- Learning Disability;
- Patient Experience;
- Board Assurance Framework Report relating to the Committee's area of focus;
- Mortality and Learning from Deaths;
- Research & Innovation Bi-Annual Governance/Assurance Report;
- Health & Safety Annual Report;
- Clinical Audit Annual Report;
- End of Life and Palliative Care Bi-Annual Report;
- Quarterly Performance Review Process;
- PLACE assessment annual report; and
- Quality Account Bi-Annual.

iii. <u>Ad-Hoc Reports</u>

In addition to those reports listed above, a number of ad-hoc reports have been received by the Committee. These included:

- *COVID-19 Update:* The Committee received a verbal update on the latest position regarding COVID-19 cases, including an update on the vaccination programme.
- *Cardiothoracic Quality Assurance Review:* In July 2021, the Medical Director gave a verbal update to Committee members regarding the process established to undertake an internal review of patient outcome data.
- *Maternity Safety Action 6:* The Director of Quality and Effectiveness presented a report to the Committee in July 2021 regarding the statement for assurance and confirmation of compliance with Element 4, Standard a).
- *VTE/ IPC Investment:* The Medical Director provided a verbal update to Committee members in September in relation to investments required in Infection Prevention and Control (IPC), Venous Thromboembolism (VTE), and pressure damage.
- *Feedback on CQC visit to Paediatric Sexual Assault Referral Centre:* In September 2021 the Director of Quality and Effectiveness provided a verbal update on feedback from the CQC visit, highlighting in particular the positive feedback and areas for further development/action.
- *Presentation on the National Patient Safety Strategy:* The Director of Quality and Effectiveness provided a detailed presentation on the requirements of the new strategy and implications for the Trust in January 2022.
- *Patient Safety and Quality Peer Review:* In January 2022, the Deputy Director of Quality & Safety presented a report detailing the internal Patient Safety and Quality Review process, Peer Review methodology and outcomes on the 2020/21 inspection cycle.
- *Risk* Briefing – Research Passports: Committee members received a briefing in January 2022 on action taken following an internal audit on the Research Passport policy.
- *Safeguarding Reporting into Quality Committee:* In January 2022, the Executive Chief Nurse outlined a proposed change to the Safeguarding reporting arrangements which was approved.

6. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee developed a revised Schedule of Business during 2021/22 and utilised a rolling programme and action log to track committee actions.

As highlighted in Section 5(ii), the Committee received regular updates on risks recorded on the Board Assurance Framework (BAF) which related to the Committee's area of focus. There were five risks recorded on the BAF during 2021/22 relating to the Committee being:

- There is a risk of regulatory and legal action if we fail to maintain safe care and treatment for those who use our services, which could impact on patient safety, quality of care and the reputation of the Trust. (CQC Regulation 12);
- There is a risk that patients will acquire infections including but not restricted to MRSA, C Difficile, MSSA, E Coli, CPE or other harmful pathogens whilst in receipt of healthcare.
- Failure to achieve required CQC standards could impact on the Trust's ability to remain "Outstanding''; and
- Due to the rising community acquired infectious diseases (e.g. influenza) there is a risk of increased numbers of patient admissions, coupled with a reduced staff capacity could create additional pressures on the Trust and impact our ability to provide safe standards of patient care.
- There is a risk that patients and staff could acquire COVID HCAI. This is due to potential risk of exposure from other patients/staff who have COVID symptoms or are asymptomatic carriers and transmission of the infective virus. This could result in harm to patients and staff, outbreak resulting in loss of pt. activity, shortage of staff.

7. PROGRESS FOR 2021/22 & REVIEW OF EFFECTIVENESS

In the prior year Committee Annual Report, the following areas were identified to progress in 2021/22 – updates are shown in italic text below:

1. Revisit the agenda setting process and refocus on the BAF risks/CQC Insight report 'red-flag' areas, as well as strategic areas linked to the Trust's breakthrough objectives.

   Agreed this has been completed - the agenda setting process has been reviewed and changes to the way reports are presented have been implemented. Reports are now clearly marked as 'for information' or 'for discussion' with an explicit note to members to have read the reports in advance of the meeting. This has released time on the agenda for more robust and constructive discussion of priority agenda items.

2. Receive a deep-dive presentation into key aspects of quality governance at alternate meetings. Topics to include the Mortality Review process, Infection Prevention and Control Assurance, Serious Incident Management and Quality Assurance Mechanisms – Three deep dives were undertaken during the year being:
   - *July 2021 – Committee members undertook a deep dive into Mortality and Learning from Deaths;*

- *November 2021 – Committee members focussed on Infection Prevention & Control Projects; and*
- *March 2022 – Committee members undertook a deep dive into serious incident management*.

3. Two Management Group Chair Reports to be considered in depth at each meeting on a rolling cycle. Reports from other Groups to be received by exception – *Agreed this was actioned during the year 2021/22;*

4. Consider the inclusion of a regular agenda item to provide an overview of risks considered at the Clinical Risk Review Group which had the potential to impact clinical quality – *this happens by exception i.e. if the risk is so significant that it requires escalation to the Quality Committee. The Clinical Risk Review Group reports into the Executive Risk Group which is the mechanism for escalating risks and transferring onto the Corporate Risk Register if appropriate.*

5. Consider the inclusion of an assurance report to be received by the Committee relating to Newcastle Improvement – *Committee members agreed that biannual reports be provided, and this is included in the refreshed Schedule of Business;* and

6. Provide additional specific training for new members regarding areas of Committee focus – *agreed completed - the 'deep dive' sessions were implemented to provide greater knowledge and understanding of Committee areas of focus for new Committee members.*

8. NEXT STEPS AND ACTIONS FOR 2022/23

The key areas of focus/actions to undertake during 2022/23 are:

1. Following on from point 2 in section 7 above, separate deep dive sessions will be scheduled in the months in between the formal Committee meetings in order to build knowledge and understanding, and provide further time for constructive challenge on specific topics.
2. At every formal Committee meeting, an update will be provided on the Trust performance against each Quality Priority included in the Trust Quality Account.
3. Further work is underway to restart/refresh the Executive Team member Leadership Walkabouts. For the Trust Non-Executive Directors, the virtual Spotlights on Services have transitioned to a hybrid model of both a virtual and in person element.
4. A recent internal audit on the Trust Governance structure highlighted some recommendations and areas for consideration in relation to the Terms of Reference and reporting of business to ensure that the Committee appropriately discharges its assigned functions. A meeting will be scheduled with the Committee Chair and the Executive Lead of the Committee to discuss the recommendations/areas for consideration, in particular to consider areas of duplication/overlap with the People Committee e.g. compliance with Statutory and Mandatory training. This may result in further amendments required to the Committee Terms of Reference and Schedule of Business.

9. RECOMMENDATION

The Committee are asked to approve this report outlining work undertaken in 2021/22 and note the key areas to revisit during 2022/23.

Report of Kelly Jupp
Trust Secretary
28 June 2022

QUALITY COMMITTEE SCHEDULE OF BUSINESS

Reports	May 2022	July 2022	September 2022	November 2022	January 2023	March 2023
Business Items						
Minutes of the last meeting	X	X	X	X	X	X
Action Log	X	X	X	X	X	X
Minutes of management groups	X	X	X	X	X	X
Quality and Patient Safety						
Management Group Chair Reports – to focus on two areas per meeting	X	X	X	X	X	X
• Patient Safety Group (PSG)	X	AR~	X		X	
• Patient Experience & Engagement Group (PEEG)	X^		X	X		X
• Clinical Outcomes & Effectiveness Group (COEG)		AR~/X		X		X
• Compliance & Assurance Group (CAG)			X	AR**/X		X
Committee Deep Dives*						
Safeguarding	Q4/AR		Q1	Q2		Q3
Mortality/Learning from Deaths	Q4/AR		Q1		Q2	Q3
Learning Disability	Q4/AR		Q1	Q2		Q3
End of Life and Palliative Care	BAR			BAR		
Ockenden Report Update, to include Maternity CNST Quarterly Report when available		X	X	X	X	X
Place Assessment Update Report						AR
Performance						
Integrated Quality & Performance Report	X	X	X	X	X	X

Reports	May 2022	July 2022	September 2022	November 2022	January 2023	March 2023
Assurance Reports						
Leadership Walkabouts/Spotlight on Services Update	X	AR	X	X	X	X
Health & Safety Annual Report		AR				
CQC Action Plan Update		X			X	
BAF Assurance Report	Q4/AR		Q1		Q2	Q3
Legal Update	X		X	X	X	
Clinical Research			X			X
Quality Account	X			X		
Newcastle Improvement	BAR			BAR		
Annual Report of Committee, including review of Schedule of Business and Terms of Reference		X				
Clinical Audit#						
Strategy						
National Patient Safety Strategy (NPSS)		BAR			BAR	
Quality Strategy (QS)		QS Update and Quality Priority 1 focus	Quality Priority 2	Quality Priority 3	Quality Priority 4	Quality Priority 5
Clinical Strategy – AD HOC						
Nursing, Midwifery, and Allied Health Professional Strategy – AD HOC						
Other						
Feedback from Royal College Reviews and associated progress updates – AD HOC	X	X				

(AR – Annual Report)
(BAR – Bi-Annual Report)

~ In 2023/24 these reports will be presented to the May 2023 Committee meeting.

*** In 2023/24 this report will be presented to the July 2023 Committee meeting.*

^ Historically the PEEG has not produced an Annual Report however an Annual Report will be produced for 2023/24, with the first one scheduled May 2023.

**In July 2022 the Committee Chair and Executive Lead agreed to a new approach to undertaking 'deep dive' sessions whereby a 2-hour deep dive meeting will be scheduled in the opposite months to when the Committee meetings will be held. These meetings will cover 2 topics as follows:*

- *August 2022 – Ockenden, Maternity and technical requirements and Urology*
- *October 2022 – Outpatients and Newcastle Improvement*
- *December 2022 – HCAIs and Learning from Deaths/Mortality reporting*
- *February 2023 – Children and Young People services (including mental health), to cover current services and future ambitions/aims and deteriorating patient alert system*

Requested attendees for the sessions are: the Committee Chair, NEDs, Director of Quality & Effectiveness, Deputy Director of Quality & Safety, subject matter experts and any external presenters (as required). Other Committee members/regular attendees do not need to attend the deep dive sessions unless they wish to do so.

 # The Annual Clinical Audit Report and regular updates feed into the COEG Chair updates/Annual Reports.

Terms of Reference – People Committee

1. Constitution of the Committee

The People Committee is a non-statutory Committee established by the Board of Directors to monitor, review and report to the Board on the cultural and organisational development of the Trust, and on the strategic performance of people and workforce priorities, and impact of the Trust as a significant employer, educator and partner in health, care and research.

2. Purpose and function

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors:

2.01 on the identification of strategic people and workforce priorities for the Trust as a significant employer in the North East and as a partner in training, education, and development of health and care capacity in the region and nationally;

2.02 in relation to the organisation's understanding of strategic workforce needs (including well-being, recruitment, retention, development of people, and organisational capacity) and the quality and effectiveness of plans to deliver them;

2.03 that the commitments of the NHS Constitution, the NHS People Promise, and the stated values of the Trust and Professional Leaderships Behaviours, are being practiced throughout the organisation, based on evidence;

2.04 that the approach to all aspects of employment and culture in the Trust are informed by relevant and up-to-date research on innovation and practice;

2.05 to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the Committee purpose and function;

2.06 on the Trust's legislative and regulatory compliance as an employer, including anticipation of, and planning for, future requirements;

2.07 on the development of staff governance in the organisation, including staff engagement processes, with the Committee acting as the oversight Committee;

2.08 on the development of strategic communications and engagement, and reputation management with internal and external stakeholders, local communities and partners, with the People Committee acting as the oversight Committee;

2.09 on the impact on workforce of changing professional and organisational practices, including those involved in increased system-based and partnership working (in collaboration with the other Committees of the Trust Board as appropriate); and

2.10 that the Trust fulfils its leadership and influencing role on service quality standards and practice, as an organisation of national importance, as a significant service provider in the North East, and as a partner in training, education and development of health and care capacity in the region (in collaboration with the Quality Committee).

2.11 The Committee will agree progress reporting and information requirements relating to its remit on behalf of the Board of Directors, and will oversee the resulting performance.

3. Authority

The Committee is:

3.1 a non-statutory Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference;

3.2 authorised by the Board of Directors to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required; and

3.3 authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Lead of the Committee and / or Trust Secretary).

3.4 The Committee shall have the power to establish, in exceptional circumstances, sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility, if approved by the Trust Board. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the Trust Board of Directors.

3.5 The Terms of Reference, including the reporting procedures of any sub-committees or task and finish groups, must be approved by the Trust Board of Directors and reviewed on an annual basis.

4. Membership and quorum

Membership

4.01 Members of the Committee shall be appointed by the Trust Board of Directors and shall be made up of at least six members drawn from Non-Executive Directors (three members minimum) and members of the Executive Team (three members minimum).

4.02 One of the Non-Executive members will be appointed by the Trust Board of Directors as the Chair of the Committee.

4.03 A further Non-Executive member of the committee shall be appointed as Vice-Chair, likewise by the Trust Board of Directors.

4.04 The membership shall be:

- the Director of Human Resources;
- the Chief Operating Officer; and

- the Assistant Chief Executive.

4.05 The Chair of the Board of Directors shall not be a member of the Committee but may be in attendance.

4.06 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.07 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year.

4.08 The Director of Human Resources shall act to fulfil the role of Executive lead for the Committee.

4.09 Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by electronic means will count towards the quorum.

4.10 The Council of Governors may nominate up to two governors to attend one meeting of the Committee annually to observe proceedings. The observation of Board assurance committees by governors will be subject to conditions agreed by the Board of Directors. The Chair of the Committee may in exceptional circumstances exclude governors from being present for specific items.

4.11 The Trust Secretary, or their designated deputy, shall act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, shall attend all meetings of the Committee.

4.12 All members of the Committee shall receive training and development support as required to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

4.13 An attendance record shall be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

Quorum

4.14 The quorum necessary for the transaction of business shall be four members, as defined in 4.01 and 4.04 above, with at least two Non-Executive Directors present.

4.15 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies shall not count towards the quorum.

4.16 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

5. Duties

5.1. Cycle of Business

The Committee will:

5.1.1 set an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

5.2 People Strategy and policies

The Committee will:

5.2.1 assess the strategic priorities and investments needed to support the knowledge, skills and capacity of the people in the Trust (human capital), delivery of the local People Plan, and advise the Board accordingly;

5.2.2 review the Trust's Leadership Development and Talent Management Strategy, Education and Workforce Development Strategy, Education Quality Strategy and Apprenticeship Strategy, and related delivery plans and programmes, providing informed advice to the Board of Directors on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact;

5.2.3 provide advice and support on the development of significant people-related policies [those which have a significant impact on staff e.g. health and wellbeing] prior to their adoption. It is expected that this will relate to a small number of policies by exception in any given year, which will be agreed in advance as part of the cycle of business for the Committee;

5.2.4 review by exception, people-related policies against benchmarks to ensure that they are comprehensive, up-to-date, and reflect best practice;

5.2.5 review strategic intelligence, research evidence on people and work, and distil their relevance to the Trust's strategic priorities (including, where necessary, commissioning research to inform its work) relating to:

- the impact of changing working practices;
- the potential and impact of technology on working lives;
- models of employment practice drawn from multiple sectors;
- organisational and work design;
- incentives and rewards;
- developments and best practice in delivery of education, training and development;
- national, regional and local workforce and population trends; and
- other dynamics affecting the future development of the health and care workforce;

5.2.6 review the development and effective use of shared intelligence and data with partners on local health and care skills to shape the growth of future capacity in the "place" of Newcastle and the North East.

5.2.7 be assured of the integrity of the Trust's processes and procedures relating to the introduction of new clinical roles.

5.3 Risk

The Committee will:

5.3.1 receive risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit Committee with assurance on the effectiveness of the management of principal risks relating to the Committee's purpose and function.

5.3.2 to receive the Executive Oversight Report for information.

5.4 # Flourish At Work - Staff Experience and Engagement including organisational culture

The Committee will:

5.4.1 agree and oversee a credible process for assessing, measuring and reporting on the "culture of the organisation" on a consistent basis over time;

5.4.2 oversee the coherence and comprehensiveness of the ways in which the Trust engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications, to the Board of Directors;

5.4.3 act as the oversight Committee for the coherence and alignment of different codes of personal and professional behaviour and conduct, (considering, for example, Professional and Leadership Behaviours, the Standards of Business Conduct Policy, and The Nolan Principles), covering all permanent and temporary staff acting in the name of, or on the business of, the Trust;

5.4.4 take an oversight role on behalf of the Board of Directors in:

- securing positive progress on equality and diversity, including shaping and setting direction, monitoring progress and promoting understanding inside and outside the Trust;
- evaluating the impact of work to promote the values of the organisation, the NHS Constitution and the NHS People Promise;
- promoting staff engagement and partnership working; and
- developing a consistent working environment where people feel safe and able to raise concerns, and where bullying and harassment are visibly and effectively addressed.

5.5 Organisational capacity – sustainability and strategic transformation

The Committee will:

5.5.1 ensure the systems, processes and plans used by the Trust have integrity and are fit for purpose in the following areas:

- strategic approach to growing the knowledge, skills and capacity of the people (human capital) in the Trust;

- analysis and use of sound workforce, employment and demographic intelligence;
- the planning of current and future workforce capacity;
- effective recruitment and retention;
- new models of care and roles;
- flexible working;
- identification of urgent capacity problems and their resolution;
- continuous development of personal and professional skills; and
- talent management.

5.5.2 review the productivity of permanent and temporary staff by exception, including the effectiveness and efficiency of their deployment, the best use of skills, and the flexibility and maturity of working practices in the Trust;

5.5.3 consider the coherence and pace of Trust plans to secure the benefits for the Trust and its staff from:

- transformational change, service redesign and pathways of care;
- new and innovative ways of working;
- use of tools and technology;
- environmental sustainability;
- opportunities for changing practices and skills across traditional professional boundaries;
- joint working with partners both in health and social care and other sectors; and
- the value of apprenticeships.

5.5.4 review plans for ensuring the development of leadership and management capacity, including the Trust's approach to succession planning.

5.6 Education and training

The Committee will:

5.6.1 review the Trust's current and future educational and training needs to ensure they support the strategic objectives of the organisation in the context of the wider health and care system;

5.6.2 review the Trust's strategic contribution to the development of the health and care workforce;

5.6.3 secure the necessary assurances about the Trust's compliance with the practice requirements of professional and regulatory bodies for all staff;

5.6.4 ensure the development of an annual education and training programme to meet the education and workforce development priorities described within the Trust's Strategy.

5.7 Communications

The Committee will:

5.7.1 provide advice and support on the development of the Trust's engagement and communications strategies and related programmes of work, and review the effectiveness of internal communications and engagement;

5.7.2 ensure engagement and consultation processes with staff, stakeholders and communities both reflect the ambition and values of the Trust and also meet statutory requirements;

5.7.3 agree and oversee a credible process for assessing, measuring and reporting on the reputation of the organisation as an employer and workplace of choice;

5.7.4 review the appropriateness and effectiveness of stakeholder and partnership development in supporting strategic goals and programmes of work related to the purpose and function of the People Committee, and report to the Board of Directors accordingly.

5.8 Performance and progress reporting

The Committee will:

5.8.1 establish a succinct set of key performance and progress measures relating to the full purpose and function of the Committee, including:

- the Trust's strategic priorities on people;
- national performance targets;
- organisational culture;
- workforce utilisation;
- staff health and well-being; and
- strategic communications.

5.8.2 review progress against these measures, and their impact, and seek assurance around any performance issues identified, including proposed corrective actions;

5.8.3 agree a programme of benchmarking activities to inform the understanding of the Committee and its work;

5.8.4 ensure the credibility of sources of evidence and data used for planning and progress reporting to the Committee, and to the Board of Directors in relation to the Committee's purpose and function;

5.8.5 ensure alignment of the Board assurances and consistent use of data and intelligence, by working closely with the Audit Committee, Quality Committee and Finance Committee;

5.8.6 review and shape the people -related content of the bi-monthly Integrated Board Report;

5.8.7 review the following formal reports to the Board of Directors as part of the Annual Cycle of Business:

- Annual People report;
- Equality and Diversity Reports and Action Plans – e.g. Gender Pay, WRES, WDES and Ethnic Pay etc.;

- NHS Staff Survey Results; and
- Trade Union Facility Time report.

5.9 Statutory compliance

The Committee will:

5.9.1 ensure, on behalf of the Board of Directors, that current statutory and regulatory compliance and reporting requirements are met:

- standards of professional conduct and practice (including consideration of Professional and Leadership Behaviours, the Standards of Business Conduct Policy, and The Nolan Principles);
- Freedom to Speak Up Guardian;
- Guardian of Safe Working Hours;
- Equality, diversity and inclusion;
- health and safety; and
- consultation on service change.

5.9.2 ensure future legislative and regulatory requirements, which are to be placed on the Trust as an employer, are identified and appropriate action taken.

6. Reporting and accountability

6.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting, on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Committee shall report to the Trust Board annually on its work in support of the Annual Report. The Annual People Report shall:

- set out clearly how the Committee is discharging its responsibilities; and
- be presented to the Annual General Meeting with the Chair of the Committee in attendance to respond to any stakeholder questions on the Committee's activities.

6.3 The Annual People Report shall include an assessment of compliance with the Committee's Terms of Reference and a review of the effectiveness of the committee.

6.4 The Chair of the Committee shall provide an annual update to the Council of Governors on the work of the Committee.

6.5 The Terms of Reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

7.1 The Committee shall meet a minimum of four times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

7.2 The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees to ensure it fulfils its duties and responsibilities in an open and transparent manner.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than three working days before the date of the meeting.

7.5 Committee papers shall include an outline of their purpose and key points, in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

7.7 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten working days of the meeting.

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: 13 June 2022
Date approved: 23 June 2022 [People Committee] and TBA [Trust Board]
Approved by: People Committee and Board
Review date: May/June 2023

Appendix 1

Modern Slavery Action Plan – Procurement & Supply Chain 2022/2023

Priority	Action	Owner(s)
Strategy	Develop a strategy to set out our priorities and actions which seek to go beyond the Annual Statement requirements.	Procurement & Supply Chain Director And Trust Secretary
Regional Coordination	Engage with the ICS and Collaborative Newcastle partners to network and share best practice and develop a coordinated approach across the system.	Procurement & Supply Chain Director
Supplier mapping	Map our suppliers and categorise according to risk of modern slavery in the supply chain.	Head of Procurement
Gain assurances around 2nd tier suppliers to the Trust	Receive verification from the NHS supply chain manufacturer visits.	Head of Procurement
Enhance the Contract Management and Audit process to include Modern Slavery assurances.	Develop and deliver a risk-based programme of due diligence in the Trust's own business and its supply chain (to include seeking assurances from suppliers re MS, reviewing existing contracts etc.)	Head of Procurement
Continually review our procurement processes to ensure that NUTH is meeting its commitment to eradicating Modern Slavery in its supply Chains.	Procurement SOP's to be updated to include defined responsibilities. Investigate the use of the central government MSAT in assuring suppliers	Head of Procurement
CIPS Corporate Ethics Accreditation CIPS CORPORATE ETHICS 07823/ VALID TO 01.11.2022	Ensure Training and development of team to maintain CIPS Ethics Accredited Status in 2022/23	Procurement & Supply Chain Director

THIS PAGE IS INTENTIONALLY BLANK

ANNUAL STATEMENT ON BEHALF OF THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST 2021/22

MODERN SLAVERY AND HUMAN TRAFFICKING ACT 2015

1. INTRODUCTION

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

2. THE ORGANISATION

The Newcastle upon Tyne Hospitals NHS Foundation Trust is one of the most successful NHS Teaching Trusts in the country. It offers the second highest number of specialist services of any group of hospitals in the UK. The Trust's hospitals have over 2,250 beds and it manages over 1.72 million patient 'contacts' every year. The Trust provides innovative, high-quality healthcare, including community services and primary care, and was rated "Outstanding" by the Care Quality Commission in June 2016 and again in 2019. Services are provided locally, regionally, nationally and internationally.

The Trust employs around 18,000 members of staff making it one of the largest employers in the North East with an annual turnover of around £1.4billion. The core values of the organisation are:

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

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

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

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

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

3. STAFF TRAINING

Modern Slavery awareness training is included for all staff as part of the Trusts Level 1 Adult Safeguarding Training.

In November 2021, the Trust was the first Acute provider to Gain the Chartered Institute of Procurement & Supply (CIPS) Corporate Ethics Accreditation.

Members of the Procurement teams with responsibility for Procurement have all completed the annual CIPS ethics test and abide by the CIPS code of ethics and undertake an annually revised CIPS Ethics Test.

This will continue in 2022/23.

4. THE TRUST'S POLICY FRAMEWORK

The Trust has a number of policies in place which support this agenda including:-

i) Contractors – Guidance in the use of Contractors.

ii) Speak up We're Listening Policy – the Trust Whistleblowing Policy to enable staff to raise concerns.

iii) Safeguarding Policies
   a) Safeguarding Adults Policy and Guidelines
   b) Child Protection and Safeguarding Children: Policies and Procedures
   c) Responding to Patients, Carers, Public who are Victims of Domestic Abuse Policy

iv) Recruitment and Selection Policies
   a) Non-Medical staff
   b) Senior Medical and Dental Staff
   c) Junior Medical and Dental Trust Doctors Posts
   d) Staff Bank AND Agency Workers

e) Volunteer
f) Prevention of Illegal Working
g) Locum Engagement Procedure (Medical and Dental)
h) Domestic Abuse

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

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

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

If the worker shows one of the original documents, or combinations of documents contained in List B, it indicates that they only have limited leave to work in the UK. The contractor must evidence that checks have been repeated before the expiry date of the document/s, at which point the worker must produce evidence that they have applied for further right to work and/or leave to remain or cease working for the contractor".

5. PRIORITIES FOR 2022/23

- Further refine and update the annual Modern Slavery Action Plan (Current plan is included at Appendix 1).
- Continue to work with NHS Supply Chain to gain assurances on their supply Chains which supply the Trust.
- Continually review procurement processes to ensure the Trust is meeting its commitments to eradicating modern slavery in its supply chains.
- Work with partners across the NENC ICS to deliver a coordinated approach.

6. APPROVAL FOR THIS STATEMENT

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

Report of Dan Shelley, Procurement and Supply Chain Director, and Kelly Jupp, Trust Secretary
19 July 2022

Terms of Reference – Quality Committee

1. Constitution of the Committee

The Quality Committee is a non-statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience.

2. Purpose and function

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors:

2.1 that the Trust has appropriate quality governance structures, systems, processes and controls in place to achieve consistently safe high-quality care and to meet the Trust's legal and regulatory obligations;

2.2 on the Trust's approach to, and delivery of, continuous quality improvement so that is a hallmark of the way the Trust and its people work, recognised by stakeholders, including partners and the public;

2.3 that any shortcomings in the quality and safety of care against agreed standards are being identified and addressed in a systematic and effective manner;

2.4 on the Trust's research and development activities and its clinical practice, acting as a guardian and advocate; and to seek assurance that the Trust has a robust mechanism of research governance which is subject to regular scrutiny and monitoring;

2.5 on the quality impact of changing professional and organisational practices, including those involved in increased system-based and partnership working (in collaboration with the People Committee);

2.6 that the Trust fulfils its leadership and influencing role on service quality, standards and practice, as an organisation of national importance, as a significant service provider and as a partner in training, education and development of health and care capacity in the region (in collaboration with the People Committee) and beyond;

2.7 around current and future statutory and mandatory quality and patient safety standards, such as Care Quality Commission (CQC) Fundamental Standards, and the actions needed to meet them;

2.8 on the effectiveness of mechanisms used for the involvement of patients and the public, staff, partners and other stakeholders in improving quality assurance and patient safety at the Trust, and report on their value and impact to the Board; and

2.9 to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the committee purpose and function.

3. Authority

The Committee is:

3.1. a non-statutory Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference;

3.2 authorised by the Board of Directors to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required; and

3.3 authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Lead of the Committee and / or the Trust Secretary).

3.4 The Committee shall have the power to establish sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility, if approved by the Trust Board. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the Trust Board of Directors.

3.5 The Terms of Reference, including the reporting procedures of any sub-committees or task and finish groups must be approved by the Trust Board of Directors and reviewed on an annual basis.

4. Membership

4.01 Members of the Committee shall be appointed by the Board of Directors and shall be made up of least seven members drawn from Non-Executive Directors (three members minimum) and members of the Executive team (four members).

4.02 One of the Non-Executive members will be appointed by the Trust Board of Directors as the Chair of the Committee.

4.03 A further Non-Executive member of the Committee shall be appointed as Vice-Chair, likewise by the Trust Board of Directors.

4.04 The membership shall include:

- the Medical Director;
- the Executive Chief Nurse;
- the Chief Operating Officer;
- the Director of Quality and Effectiveness;
- the Associate Medical Director, Patient Safety and Quality; and
- the Deputy Chief Nurse

4.05 The Chair of the Board of Directors and the Chief Executive shall not be members of the Committee, but may be in attendance.

4.06 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

Additional (non-core) membership will be drawn from the senior clinical leadership teams within the Trust, including the Deputy Medical Director and Assistant Medical Director – Research and Development), to provide the depth and breadth of experience required to inform the committee to complete its business effectively.

4.07 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings.

4.08 The Director of Quality and Effectiveness shall act as the Executive Lead for the Committee.

4.09 Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by electronic means will count towards the quorum.

4.10 The Council of Governors may nominate up to two governors to attend one meeting of the Committee annually to observe proceedings. The observation of Board assurance committees by governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may exclude governors from being present for specific items.

4.11 The Trust Secretary, or their designated deputy, shall act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, shall attend all meetings of the Committee.

4.12 All members of the Committee shall receive training and development support before joining the Committee and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

4.13 An attendance record shall be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

Quorum

4.14 The quorum necessary for the transaction of business shall be four members, as defined in 4.01 and 4.04 above, including the Chair or Vice Chair, and at least one other Non-Executive Director.

4.15 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will not count towards the quorum.

4.16 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

5. Duties

5.1 Cycle of Business

The Committee will:

5.1.1 set an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

5.2 Strategy

The Committee will:

5.2.1 advise and contribute to the strategic quality priorities and investments needed to support high-quality clinical outcomes and improve clinical effectiveness in the Trust, and advise the Board accordingly;

5.2.2 review the Trust's Quality Strategy, Quality Account and related delivery plans and programmes, and provide informed advice to the Board on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact;

5.2.3 take note of international intelligence and research evidence on clinical safety and practice and distil their relevance to the Trust's strategic quality priorities (including where necessary commissioning research to inform its work);

5.2.4 be assured around the monitoring of the Trust's suite of quality-assurance policies against benchmarks to ensure they are comprehensive, up-to-date and reflect best practice; and

5.2.5 scrutinise and triangulate advice on the development of significant clinical and quality policies prior to their adoption.

5.3 Risk

The Committee will:

5.3.1 receive risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit Committee with assurance on the effectiveness of the management of principal risks relating to the Committees purpose and function.

5.3.2 to receive the Executive Oversight Report for information.

5.4 Outcomes and processes

The Committee will:

5.4.1 review the Quality Account to be assured it reflects the integration of clinical quality and patient safety improvement processes;

5.4.2 be assured of the integrity of the Trust's control systems, processes and procedures relating to critical areas, to include:

- high quality care (through the Trust's quality review processes);
- compliance with fundamental standards of quality and safety;
- patient safety and harm reduction;
- safeguarding – adults and children
- infection prevention and control;
- clinical audit;
- introduction of new clinical pathways and procedures;
- introduction of new clinical roles (in conjunction with the People Committee);
- dissemination and implementation of statutory guidance;
- escalation and resolution of quality concerns; and
- patient and carer involvement and engagement.

5.4.3 ensure the effective operation of processes relating to clinical practice and performance, including early detection of issues and problems, escalation, corrective action and learning.

5.5 Learning and communication

The Committee will:

5.5.1 be assured of the effectiveness of systems and processes used for continuous learning, innovation and quality improvement, establishing ways of gaining assurance that appropriate action is being taken;

5.5.2 be assured that the robustness of procedures ensure that adverse incidents and events are detected, openly investigated, with lessons learned being promptly applied and appropriately disseminated in the best interests of patients, of staff and of the Trust;

5.5.3 be assured that evidence-based practice, ideas, innovations and statutory and best practice guidance are identified, disseminated and applied within the Trust;

5.5.4 develop and oversee a programme of activities to engage Board members directly in quality assurance processes and to ensure that such processes include the establishment of a procedure to review, distil and implement the learning from these activities, including 'walk-abouts', reviews, focus groups and deep-dives; and

5.5.5 be assured of the effectiveness of communication, engagement and development activities designed to support patient safety and improve clinical governance.

5.6 Patient and public engagement

The Committee will:

5.6.1 be assured of the effectiveness of a credible process for assessing, measuring and reporting on the 'patient experience' in a consistent way over time, including the appropriateness and effectiveness of processes for patient engagement in support of the Trust's strategic goals and programmes of work.

5.7 Research

The Committee will:

5.7.1 triangulate through assurance the robustness of quality-assurance processes relating to all research undertaken in the name of the Trust and / or by its staff, in terms of compliance with standards and ethics, and clinical and patient safety improvement processes.

5.8 Progress and performance reporting

The Committee will:

5.8.1 review a range of evidence and data from multiple sources, including management and executive committees and groups, on which to arrive at informed opinions on:

- the standards of clinical, service quality and patient safety in the Trust;
- compliance with agreed standards of care and national targets and indicators; and
- organisational quality performance measured against specified standards and targets;

5.8.2 review a succinct set of key performance and progress measures relating to the full purpose and function of the Committee;

5.8.3 review progress against these measures on a regular basis and seek assurance around any performance issues identified, including proposed corrective actions and reporting any significant issues and trends to the Board of Directors;

5.8.4 review and shape the quality-related content of the bi-monthly Quality and Performance Reports to the Board of Directors;

5.8.5 agree the programme of benchmarking activities to inform the understanding of the Committee and its work;

5.8.6 be assured of the credibility of sources of evidence and data used for planning and progress reporting to the Committee and to the Board in relation to the Committee's purpose and function;

5.8.7 ensure alignment of the Board assurances and consistent use of data and intelligence, by working closely with the Audit Committee, People Committee and the Finance Committee;

5.8.8 review the following formal reports prior to submission to the Board of Directors as part of the Annual Cycle of Business:

- an Annual Quality Report to inform and / or accompany the Trust's Annual Report;
- Infection Prevention and Control Annual Report;

- Safeguarding Annual Report; and
- the process for management review of specific service reports.

5.9 Statutory and regulatory compliance

The Committee will:

5.9.1 be assured of the arrangements for ensuring maintenance of the Trust's compliance standards specified by the Secretary of State, the CQC, NHS England, and statutory regulators of health care professionals.

6. Reporting and Accountability

6.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Committee shall report to the Trust Board annually on its work in support of the Annual Report. An overview of the Annual Report of the Quality Committee shall:

- set out clearly how the Committee is discharging its responsibilities; and
- be presented to the Annual Members Meeting / Annual General Meeting, with the Chair of the Committee in attendance to respond to any stakeholder questions on the Committee's activities.

6.3 The Annual Report of the Quality Committee shall include an assessment of compliance with the Committee's Terms of Reference and a review of the effectiveness of the committee.

6.4 The Chair of the Committee shall provide an annual update to the Council of Governors on the work of the Committee.

6.5 The Terms of Reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

7.1 The Committee shall meet a minimum of six times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

7.2 The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than three working days before the date of the meeting.

7.5 Committee papers shall include an outline of their purpose and key points in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure these are recorded in the minutes accordingly.

7.7 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten days of the meeting.

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: 11 July 2022
Date approved: 19 July 2022 [Quality Committee] and TBA [Board]
Approved by: Quality Committee and Board
Review date: June 2022

The Newcastle upon Tyne Hospitals NHS Foundation Trust

AUDIT COMMITTEE ANNUAL REPORT 2021-2022

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Audit Committee has met its key responsibilities for 2021-22, in line with its terms of reference and the requirements of the Audit Committee Handbook.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. AUDIT COMMITTEE RESPONSIBILITIES

The key purpose of the Audit Committee is to provide the Board with:

- an independent and objective review of financial and organisational controls, the system of integrated governance and risk management systems and practice across the whole of the organisation's activities (both clinical and non-clinical);
- assurance of value for money;
- compliance with relevant and applicable law;
- compliance with all applicable guidance, regulation, codes of conduct and good practice; and
- advice as to the position of the Trust as a "going concern."

It does this through receipt of assurances from auditors, management and other sources.

3. AUDIT COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board from the Non-Executive Directors of the Trust and consists of five members with a quorum being two members.

Four ordinary meetings and one extraordinary meeting were held between 1 April 2021 and 31 March 2022 and attendance was as follows:

	Attendance at ordinary meetings	Attendance at extraordinary meeting
Mr D Stout, Non-Executive Director (Committee Chair until 31 July 2021)	2 of 2*	1 of 1
Mr B MacLeod, Non-Executive Director (Committee Chair from 1 August 2021)	4 of 4	1 of 1
Mr J Jowett, Non-Executive Director	4 of 4	1 of 1
Mr S Morgan, Non-Executive Director	4 of 4	1 of 1

Professor K McCourt, Non-Executive Director	4 of 4~	1 of 1
Mr G Chapman, Non-Executive Director	1 of 1~	N/a

**Mr Stout's final 3-year term of office as a Trust Non-Executive Director ended on 31 July 2021.*

~ Mr Chapman took over as Chair of Quality Committee in November 2021 therefore replaced Professor McCourt as a member of the Audit Committee from this date.

The Committee met the minimum number of five meetings per year and other attendees at the meetings have included:

- External and Internal Audit at all meetings;
- The Trust's Fraud Specialist Manager;
- Management, represented by the Finance Director, Assistant Chief Executive and the Chief Operating Officer. The Executive Chief Nurse, Medical Director and Director of Quality and Effectiveness are permitted to attend as required;
- The Trust Secretary and Deputy Trust Secretary who also provide Secretariat Support to the Committee; and
- The Head of Corporate Risk & Assurance.

During 2021/22, the following training sessions were provided to Committee members (and offered to all Board members)

- 27 July 2021 – session hosted by PwC and provided training in relation to the role of the Audit Committee (specifically covering the Committees role regarding the BAF and Risk), Common Pitfalls, Current Hot Topics and a Comparison of Public/Private Sector Audit Committees.
- 13 September 2021 – session hosted by Sintons and provided an overview of key legislation pertinent to the role of the Committee and NEDs, including the Health and Safety at Work Act, Directors Disqualification, Corporate Manslaughter, Gross Negligence Manslaughter, Data Protection and Disciplinary Appeals.

In addition a further briefing was scheduled at a Board Development session during 2021 on Fire Safety following discussion of risks regarding fire protection at the RVI at an Audit Committee meeting.

4. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee is required to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities that supports the achievement of the Trust's objectives, internal control and risk management.

The Audit Committee had a Schedule of Business for the year. There were some slight deviations from the schedule of business during the year as a consequence of the COVID-19 pandemic. These deviations were discussed and agreed during the regular Committee agenda setting meetings with the Committee Chair and the Executive Lead.

The Audit Committee uses a rolling programme and action log to track committee actions.

The Committee has reviewed:

- Its Terms of Reference and Schedule of Business.
- The Head of Internal Audit opinion (June 2021).
- The Board Assurance Framework (BAF); being the underlying assurance processes that indicate the achievement of corporate objectives and the effectiveness of management of principal risks.
- Risk management arrangements and the BAF Risk Management Annual Report.
- Amendments required to the Scheme of Delegation, Standing Financial Instructions and Standing Orders.
- The response to the External Auditors on:
    - ISA+240: Audit Committee responsibilities for preventing fraud in the Annual Accounts.
    - ISA+250: Audit Committee responsibilities for being satisfied that the Annual Accounts comply with laws and regulations.
    - ISA+501: Specific consideration of the potential for, and actual, litigation and claims affecting the financial statements.
    - ISA+570: Consideration for the Going Concern Assumption in an audit of financial statements.

  Committee members agreed the response for submission to the External Auditors for the year 2020/21.

The BAF focuses on the key risks against achievement of the strategic objectives. The BAF is a 'live' document which is continuously reviewed and updated by the Corporate Risk & Assurance Department. Each meeting of the Committee is updated on the BAF and Register.

Each Committee of the Board has a responsibility to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the BAF specific to the Committee purpose and function. Quarterly each Committee of the Board receives a report detailing the:

- Executive Lead review undertaken during the previous three month period and any recommendations for risks held on the BAF aligned to that Committee;
- Assurances received and any areas requiring Committee consideration;
- Number of risks held on the BAF, movements in risks and the risks categorised by risk type;
- Risks added/removed to the Executive Oversight Register during the period; and
- Operational risk profile.

The Trust Board's Risk Appetite Statement was last updated in January 2021 and is currently being reviewed. The Statement will be presented to the May 2022 Board meeting for consideration.

During the year, the Trust's Board also received a standing update on Corporate Governance matters.

Updates from the Finance, Quality and People Committee Chairs continues to appear as a standing agenda item on the Audit Committee agenda, with any matters raised for the Committee members' attention by exception.

The BAF and Corporate-level risk management internal audit reports received a substantial assurance rating from AuditOne, with no issues of note.

The Committee is satisfied that the system of risk management in the organisation is adequate in identifying risks and allows the Board of Directors to understand the appropriate management of those risks. The Committee believes there are no areas of significant duplication or omission in the systems of governance (that have come to the Committee's attention) that have not been adequately resolved.

5. INTERNAL AUDIT

The Committee has ensured that there is an effective internal audit function established by management that meets mandatory Internal Audit Standards and provides appropriate independent assurance. The Trust receives its internal audit service from AuditOne.

This was achieved by:

- Reviewing and approving the Internal Audit Plan 2021/2022, including regular updates of performance against the Plan.
- Consideration of the major findings arising from internal audit work and management's responses.
- Receipt of the Internal Audit Annual Report and Head of Internal Audit Opinion.
- Monitoring progress with implementation of agreed audit recommendations.

The Committee received a report from the internal auditor at each of its meetings which summarised the audit reports issued since the previous meeting.

The internal audit plan for 2021/22 was based on a risk assessment approach centred on discussions with senior staff and Directors and was linked to the organisation's assurance framework. Assurances from Internal Audit reports are, where possible, mapped to the BAF clearly in the BAF document itself.

Good progress continued to be made during the year in relation to the completion of historic internal audit recommendations.

The following limited assurance reports relating to 2020/21 were followed up and reported to/discussed by the Audit Committee during the year 2021/22:

- Mobile Device Management. The follow up report was rated 'good'; and

- Data Security and Protection (DSP) Toolkit (Interim). The final report was rated as 'substantial' as the initial findings had been addressed.

Eleven high priority recommendations were identified by Internal Audit and reported during 2021/22, these covered the following internal audits:

- BAF and Risk Management – one recommendation (reported April 2021).
- Payroll Controls – one recommendation (reported April 2021).
- Mobile Device Management – two recommendations (reported April 2021).
- Fire Safety (Follow Up) – one recommendation (reported June 2021).
- Data: Cancer Faster Diagnosis Standard audits – one recommendation (reported June 2021).
- Data Security and Protection Toolkit – three recommendations (reported July 2021).
- Performance Monitoring / Data Quality – Belsay Unit – one recommendation (reported July 2021).
- PFI Contract Monitoring – one recommendation (reported October 2021).

Regular updates on the progress in relation to limited assurance audits and high priority recommendations were received by Committee members during the year from management and internal audit.

The COVID-19 pandemic, along with more general workforce challenges in relation to some long-term staff sickness and leavers within AuditOne, significantly impacted the delivery of internal audit and Technology Risk Assurance (TRA) audits throughout 2021/22. This resulted in some changes made to the Internal Audit Plan for the year, as discussed and agreed with Committee members. Internal Audit performance against Plan was discussed at every Committee meeting during the year, with agreement reached to focus delivery on the core audits required to fulfil the Head of Internal Audit Opinion requirements.

During the year, Committee members also discussed the strategy for delivering digital and technology assurance audits and the need for specialist expertise in this area.

An external assessment of AuditOne was commissioned through the Institute of Internal Auditors (IIA), who appointed an external independent assessor to complete the assessment and AuditOne received the highest rating of "Generally Conforms" against Internal Auditing Standards.

6. EXTERNAL AUDIT

The Committee has reviewed the work and findings of external audit and considered the implications and management responses to their work.

This was achieved by:

- Discussing and agreeing with the external auditor the nature and scope of the audit as set out in the External Audit Annual Plan.

- Reviewing external audit reports, together with the appropriateness of management responses.
- Receiving the year-end Audit Opinion and ISA 260 report (Trust and Charity). For 2021/22, there was no requirement to undertake audit procedures on the Quality Report. During 2021/22, the Value for Money Conclusion certificate was signed separate to the Audit Opinion, at a later point during the financial year.
- Receiving the Annual Audit Letter.

The Council of Governors has the statutory responsibility for the appointment of the external auditors, and this process is led by a sub-group of public Governors supported by Trust officers and the Chair of the Audit Committee. During 2018, a robust procurement and evaluation process was undertaken regarding the external audit contract with Mazars LLP appointed as the Trust's external auditors with effect from 1 October 2018 for 3 years to 30 September 2021. The contract included an option to extend for a further 1 year after the 3 years – the extension was taken via approval from the Council of Governors in October 2020. A report was presented to the Governors in October 2021 to award up to a two year extension to the current contract in place with Mazars LLP. Governors agreed to approve for one year and reconsider during 2022. This followed a satisfactory review of external audit performance undertaken.

The Mazars LLP external audit fees for 2021/2022:

- Statutory Accounts £67,160 (excluding VAT) which is consistent with the statutory fee invoiced for 2020/21.
- Charity Accounts £12,600 (inclusive of VAT).

For 2021/22, there was no mandated requirement to undertake external audit procedures on the Quality Report and therefore no fee was charged in relation to this.

To ensure that the independence of the external auditors is not compromised where work outside the scope of the Audit Code has been procured from the external auditors, the Trust has a policy which requires that no member of the team conducting the external audit may be a member of the team carrying out any additional work and their lines of accountability must be separate.

During 2019/20, the Trust's policy on Non-Audit Work was reviewed and updated. This was approved at the April 2020 Committee meeting and then by the Council of Governors electronically.

No additional services/non-audit work was carried out by Mazars LLP during 2021/22.

An additional £5,550 (including VAT) was paid to Mazars LLP during 2021/22 which related to the 2020/21 accounts, being:

- ICHNE additional work £4,950; and
- Sampled component by the National Audit Office (NAO) £600.

7. MANAGEMENT

The Committee has challenged the assurance process when appropriate and has requested and received assurance reports/verbal updates from Trust management throughout the year.

Following changes in data security requirements, the structure of the Trust's information governance (IG) and data security provision was reviewed and updated during the year. Further the associated reporting arrangements were revised, with changes reported to the Audit Committee in January 2022. It was agreed at that time that regular updates would continue to be provided to the Committee going forward on Information Governance and Cyber Security.

8. FINANCIAL AREAS OF REVIEW

The Committee has ensured that the systems for financial reporting to the Board are subject to review.

The Committee has achieved this primarily through review and approval of the Annual Accounts, including those of the Newcastle upon Tyne Hospitals NHS Charity. The Committee also reviewed the External Audit Opinion and fed back relevant comments for consideration by the external auditors.

In the course of 2021/22, there were no significant issues that the Committee had to consider in relation to the financial statements. During the year, the Committee reviewed the following key areas of management judgement and significant risks:

- Accounting for PFI (Trust);
- Management over-ride of controls (Group and Trust);
- Property, Plant and Equipment Valuation (Trust); and
- Revenue recognition (Trust).

Other areas discussed between External Audit and Management during the year, and reported to the Audit Committee, related to:

- Accounting for the ICHNE;
- Valuation guidance: useful economic lives;
- Fire remedial work provision; and
- Expenditure recognition.

These have been considered through the presentation of the external audit plan, associated progress updates and discussions during Committee meetings.

The Annual Accounts and Annual Report were originally due for submission to NHSE/I on 15 June 2021, however, due to some specific isolated issues with the accounts (being ICHNE asset accounting and the provision made for Fire remediation works), the Trust had applied

for and was granted an extension to 29 June 2021. Additional time was required to ensure consistent accounting treatment across several NHS bodies regarding ICHNE operations.

9. OTHER AREAS OF ACTION AND REVIEW

The Committee has:

- Reviewed details of all Losses and Compensation Payments.
- Received reports on approved single tender actions where applicable.
- Reviewed regular debtors and creditors reports.
- Received regular reviews of the Counter Fraud Work plan, the Fraud response log, associated progress reports, the Annual Report on Counter Fraud, updates on the requirements of the Government Functional Standard 013: Counter Fraud and the refreshed NHS Counter Fraud Authority Strategy.
- Reviewed the minutes of associated Committees.
- Reviewed the content of the statutory Annual Report (including the Annual Governance Statement).
- Reviewed and endorsed changes to the Trust Scheme of Delegation, Standing Orders and Standing Financial Instructions.
- Received the Annual Accounts preparation timetable and subsequently the Annual Accounts and Going Concern Review.
- Received an annual report on special severance payments/settlement agreements.
- Approved the Trust's Annual Modern Slavery Act Statement.
- Received updates on Standards of Business Conduct, including declarations of interest, fit and proper persons and the annual review of the register of gifts and hospitality.
- Received a report on waivers and breaches of the Trust Standing Financial Instructions.
- Received an action log to follow up previous Committee meeting actions.
- Received an update on the Clinical Audit Process.
- Received updates from the Chairs of the Quality, People and Finance Committees.
- Approved the Internal Audit Charter and Protocol 2021/22 (April 2021).
- Discussed changes proposed to changes to delegated powers for authorised signatories within the Joint Research Office and agreed further work was required before a decision be made as to the changes proposed.
- Received further updates on:
    - The positive progress made in relation to the follow up of internal audit recommendations;
    - The new Audit Code of practice;
    - Corporate Records;
    - Procurement and supplies activity;
    - The impact on the Annual Report and Accounts submission deadline of two specific accounting matters for 2020/21 remaining under discussion close to the required submission date; and

- Changes in accounting requirements as a result of changes made to International Financial Reporting Standard (IFRS) 16 Leases.

10. PROGRESS FOR 2022-2023

The self-assessment checklist from the HFMA Audit Committee Handbook (the 2018 version being the latest version) has been completed and attached in Appendix 1.

Recommendation: The Audit Committee is asked to review the self-assessment; provide any further feedback/commentary and agree the self-assessment as an accurate reflection of Committee effectiveness.

The following two areas of focus have been identified for 2022/23:

1. Continuing to build on the work performed during 2021/22 in revising the Trust's Information Governance and Cyber Security/Digital reporting arrangements.

2. Completion of the Trusts self-assessment and action plan in relation to preparations for an external Well-led review.

The Terms of Reference and Schedule of Business for the Committee have been reviewed and minor changes proposed as appended. Committee members are asked to approve the proposed changes highlighted in tracked changes.

Report of Kelly Jupp
Trust Secretary
26 April 2022

Agenda Item / Issue	Jan	Apr	May/ June [EO]	Jul	Oct
Assurance and Risk Management					
Receive governance documents: - Scheme of Delegation/SFIs/SOs (Annual Review) – min annually - Modern Slavery Act Statement – min annually - New guidance or mandatory documents - as and when required	x	x		X x x	x
Review of the full Assurance Framework for the completed year and the year ahead	x	x		x	x
Monitor the Board Assurance Framework (BAF) to ensure identified gaps in controls or assurances are addressed (min twice a year)		x		x	
Review findings of other significant assurance functions (outwith internal and external audit), for example the CQC, NHSI and NHS Resolution– as and when required	x	x		x	x
Undertake a Self-Assessment of the Committee's Effectiveness and produce an Audit Committee Report for the main Board setting out how the Committee has met its Terms of Reference. This should support the Annual Governance Statement.		x		x	
Review the Risk Register Report	x	x		x	x
Review the Committee's Terms of Reference		x			
Review the Draft and Final Annual Governance Statement		X (D)	X (F)		
Note the business of other governance committees	x	x		x	x
Review Clinical Audit Process		x			x
Receive assurance over systems for financial reporting to the Trust Board		X			
Receive annual assurance from the People Committee as to whether arrangements by which staff may raise concerns are operating effectively, in accordance with the Trust policy on raising concerns					X
Financial Governance					
Agree the Financial Statements timetable and plans	x				
Review Accounting issues raised as part of the Financial Statements audit		x	x		
Approve draft and final Trust Annual Financial Statements, prior to Board approval and TACs		X (D)	X (F)		
Approve draft and final Charity Annual Financial Statements, prior to Board approval				X (D)	X (F)
Approve the draft and final Annual Report (inc Quality Account) text, prior to Board approval		X (D)	X (F)		
Review and recommended to the Board, changes to the Corporate Governance Manual – as and when required	x	x		x	x
Review the Schedule of Losses and Compensation	x	x		x	x
Annual Review of the Register of Gifts and Hospitality				x	
Annual Review of Register of Directors' Interests		X [as part of the Annual Report]	X [as part of the Annual Report]	X	
Annual Review of Special Severance Payments / Settlement Agreements		x			
Review the report of Debtors and Creditors balances	x	x		x	x
Review the Schedule of Approval of Single Tender Action	x	x		x	x
Receive the External/Internal Audit Protocol		x			
Consider Financial Statements Accounting Policies, Estimates and Judgements		X	X		
Review of Going Concern Position		X			
Internal Audit					
Review the draft and approve the final Annual Plan	X (D)	X(F)			
Receive the Outcome of Audit Work / Progress Update	x	x	x	x	x
Receive the draft and final Head of Internal Audit Opinion		X (D)	X (F)		
Receive the Annual Report and IA Charter		x			
Committee to review annually the performance of the Internal Auditor				X	
External Audit					
Approve the Annual Plan and 3-year Strategic Plan	x	x			

Agenda Item / Issue	Jan	Apr	May/ June [EO]	Jul	Oct
Receive the Outcome of Audit Work – as and when required	x	x	x	x	x
Receive the Management Letter / ISA260 report to the Trust			x		
Receive the Management Letter / ISA260 report to the Charity					x
Receive the Annual Audit Letter				x	
Committee to review annually the performance of the External Auditor				X	
<u>Counter Fraud</u>					
Approve the Annual Plan and Annual Fraud Self Review Tool		x			
Receive the Fraud Response Log /Fraud register	x	x		x	x
Receive the Activity Report	x	x		x	x
Receive the Annual Report				x	
Committee to review annually the performance of Counter Fraud				X	
Additional Assurance areas for Committee consideration annually:					
Policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements (5.3.6) *Policies for managing and investigating complaints and legal claims against the Trust, including referrals to NHS Resolution (5.3.7)* *Oversee the maintenance of the policy framework of the Trust and review any significant breaches of the procedures (5.6.1)*					

NB – Receive at every meeting the minutes (for approval) from the previous meeting and action log.
NB – At every meeting, receive minutes of Quality, People and Finance Committee.

EO = Extraordinary Committee meeting for approval of the Annual Report and Accounts

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022						
Title	Integrated Board Report						
Report of	Martin Wilson – Chief Operating Officer, Angela O'Brien- Director of Quality and Effectiveness.						
Prepared by	Louise Hall- Deputy Director of Quality and Safety, Peta Le Roux- Business Analysis.						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	This paper is to provide assurance to the Board on the Trust's performance against key Indicators relating to Quality, People and Finance.						
Recommendation	For assurance.						
Links to Strategic Objectives	Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. Supported by flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential. Performance – Being outstanding now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☒	☐	☐	☐
Impact detail	Details compliance against national access standards which are written into the NHS standard contract. Details compliance against key quality targets.						
Reports previously considered by	Regular report.						

INTEGRATED BOARD REPORT

EXECUTIVE SUMMARY

This report provides an integrated overview of the Trust's position across the domains of Quality, People and Finance.

1. The Trust has had **no cases of MRSA bacteraemia in June 2022**.
2. There were **23 Serious Incidents (SIs) reported in June 2022**. This is a reduction from May and now within common cause variation. The Trust reported **one Never Event in June**.
3. There was **one maternal death in May**. It was reported to the Coroner, MBRRACE-UK and Healthcare Safety Investigation Branch (HSIB).
4. The Trust has received a total of 117 (114 with identified patient activity) formal complaints up to June 22, an increase of 38 on last month's opened complaints.
5. There were 2,266 responses to the Friends and Family Test from the Trust in May 2022 (published July 2022) compared to 1,346 in the previous month.
6. Overall sickness absence (including COVID-19 related sickness) is 6.13%, which is down from end of Apr 2022 position of 7.02% (% FTE Time Lost).
7. The Trust submitted a financial Plan to NHSE for 2022/23 in April, for a deficit of £5.5m for the year. However, there has been agreed additional funding made available and a revised plan was submitted in June with plan surplus of £10.7 million.

The Board of Directors is asked to receive the report.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

Quality, People and Finance

July 2022

Healthcare at its best
with people at our heart

Executive Summary

Purpose

This report provides an integrated overview of the Trust's position across the domains of Quality, People and Finance.

Current Operating Environment

The Trust has experienced an increase in patients in hospital with COVID-19. The proportion of these patients being admitted for treatment of COVID-19 has increased steadily over the last two weeks and currently stands at 40%. The numbers of staff testing positive has been increasing for the last few weeks from the lowest number since summer 2020 to 1.4% of the total workforce. There are still significant pressures being placed on the Trust's bed base due to the increase in emergency admissions and delayed discharges due to pressures in Social Care. We have more beds open now since before the pandemic due to better staffing levels reduced COVID-19 outbreaks and IPC requirements. The overall position of the Trust remains challenged while balancing the focused effort of recovery, increased emergency activity ongoing COVID-19 cases along with the potential increase in Monkey pox cases. This will impact further on medical beds and staffing as we will need to respond as part of the national incident escalation plan as a specialist commissioned Highly Infectious Diseases Unit.

The Newcastle Plan

- In light of the COVID-19 pandemic and the commitment to address extended waits the Trust has developed The Newcastle Plan, and an overarching Delivery Board chaired by the Chief Executive.

Report Highlights

1. The Trust has had **no cases of MRSA bacteraemia in June 2022**.

2. There were **23 Serious Incidents (SIs) reported in June 2022**. This is a reduction from May and now within common cause variation. The Trust reported **one Never Event in June**.

3. There was **one maternal death in May**. It was reported to the Coroner, MBRRACE-UK and HSIB.

4. The Trust has received a total of 117 (114 with identified patient activity) formal complaints up to June 22, an increase of 38 on last month's opened complaints.

5. There were 2,266 responses to the Friends and Family Test from the Trust in May 2022 (published July 2022) compared to 1,346 in the previous month.

6. Overall sickness absence (including COVID-19 related sickness) is 6.13%, which is down from end of Apr 2022 position of 7.02% (% FTE Time Lost).

7. The Trust submitted a financial Plan to NHSE for 2022/23 in April, for a deficit of £5.5m for the year. However, there has been agreed additional funding made available and a revised plan was submitted in June with plan surplus of £10.7 million.

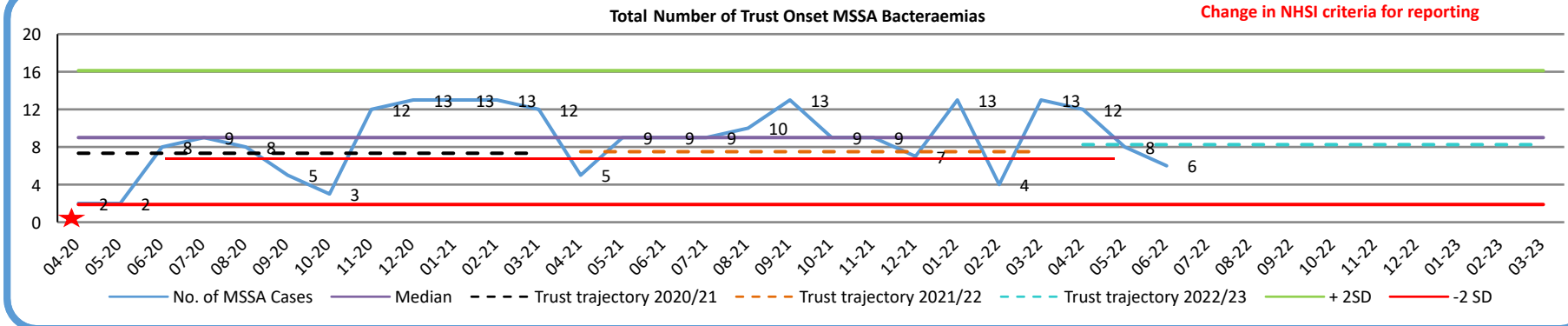
Contents: July 2022

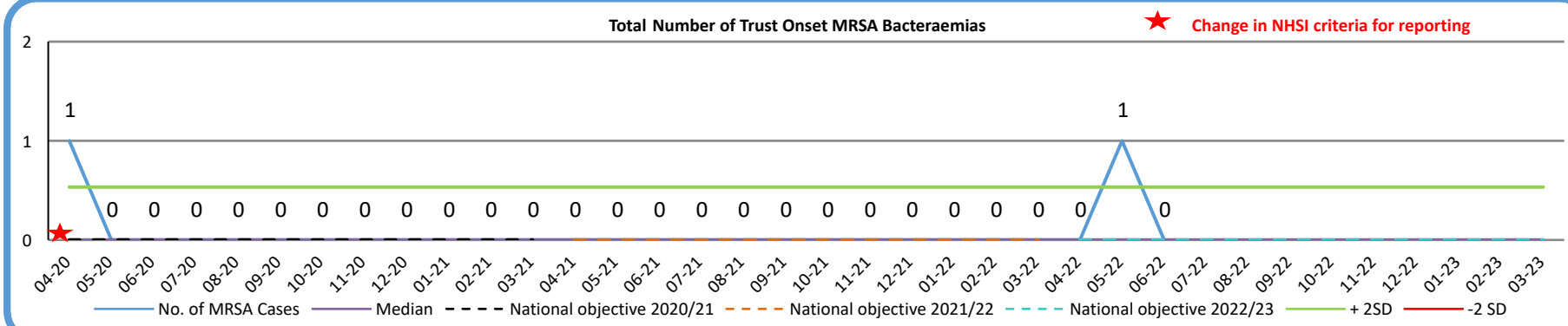
Quality

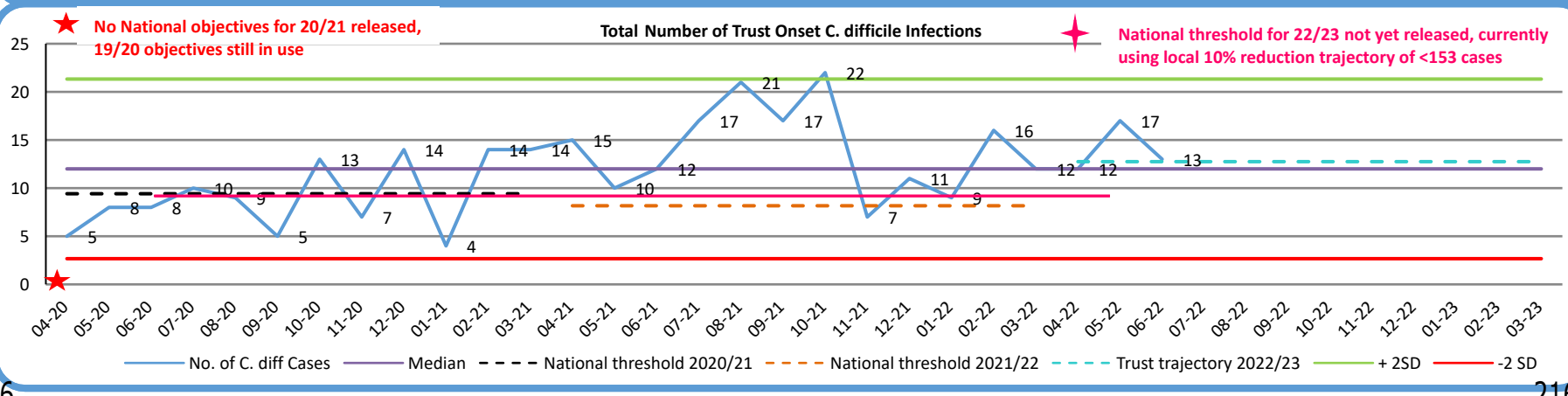
People

Finance

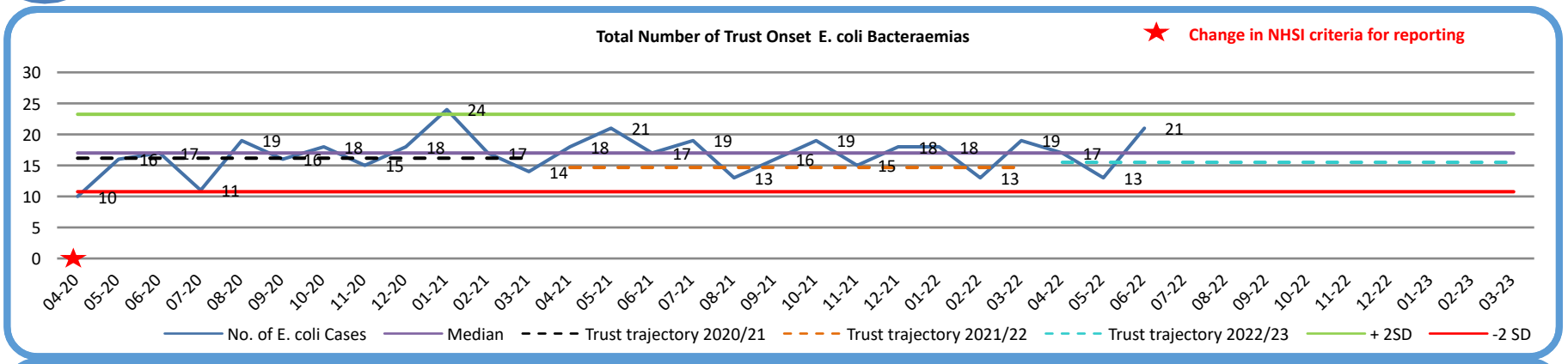
Quality: Healthcare Associated Infections 1/2

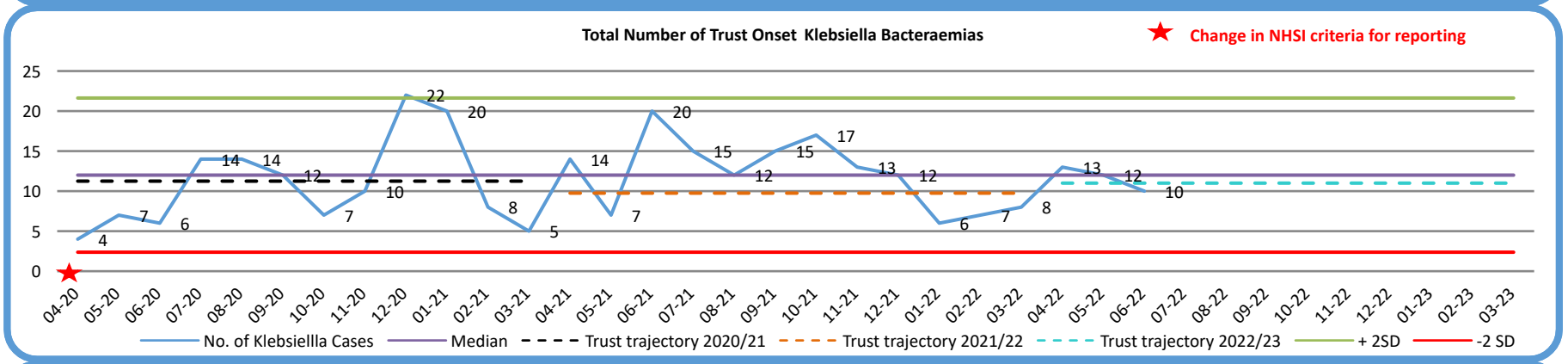


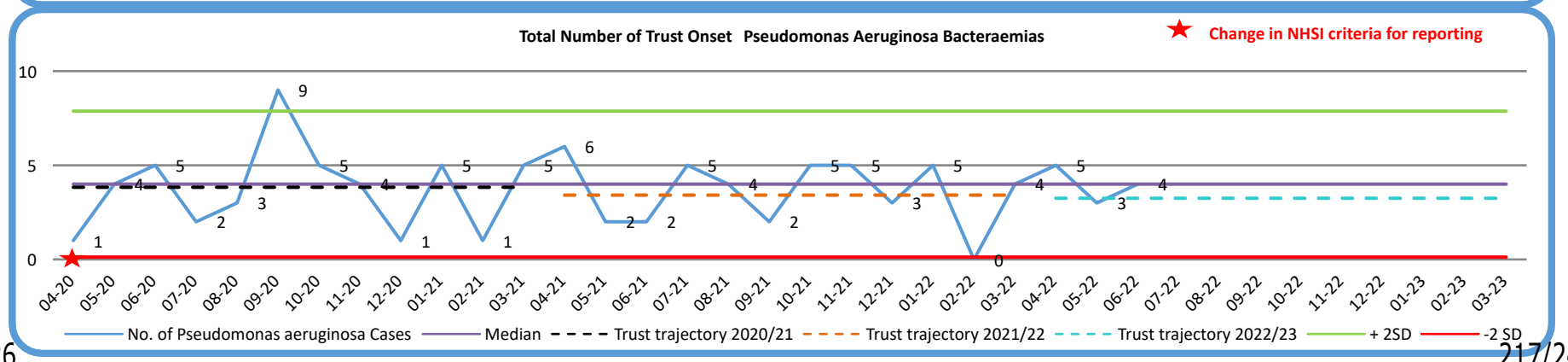




Quality: Healthcare Associated Infections 2/2



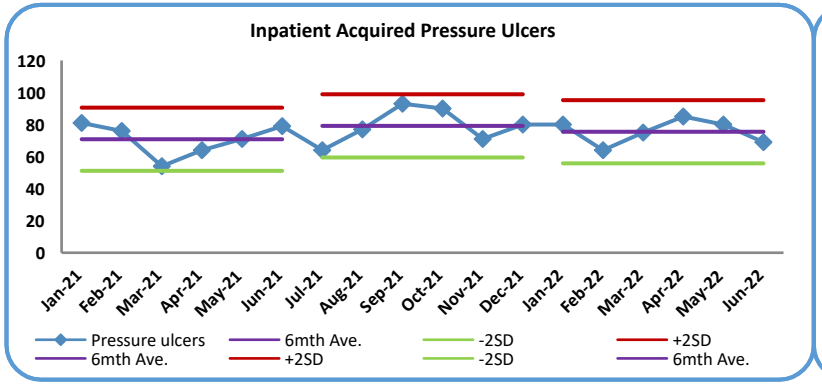


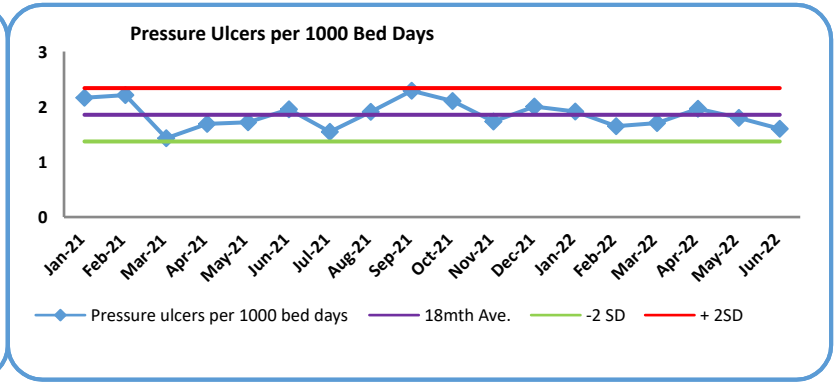


Quality: Harm Free Care – Pressure Damage

The graphs below indicates a slight reduction in overall incidence of pressure ulcers in the last 6 months, however overall rates remained higher than pre-pandemic levels in the month of June there has been a significant decrease.

From August through to October 2021 a steep increase is evident, this directly correlates with surges in COVID-19 activity. This is also apparent in October 2020 through to February 2021, whereby waves two and three occurred. The Trust safe care data illustrates the acuity of patients is significantly higher than pre-pandemic levels. In addition, there has been an increase in patients presenting to the Trust with significant existing damage, or at risk of skin deterioration. This is consistent in both other Trusts in the Shelford group and indeed the National picture.



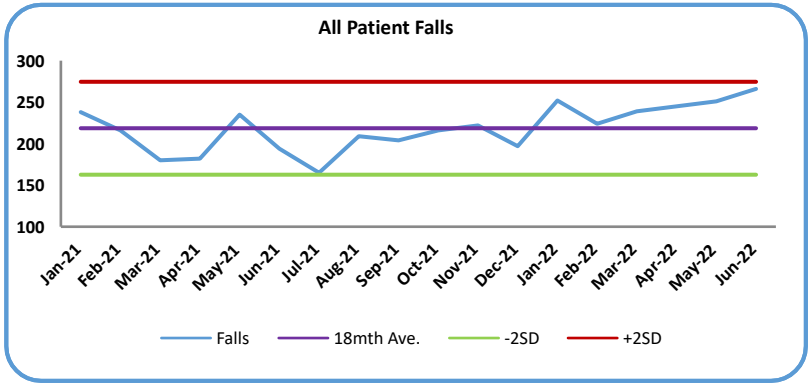


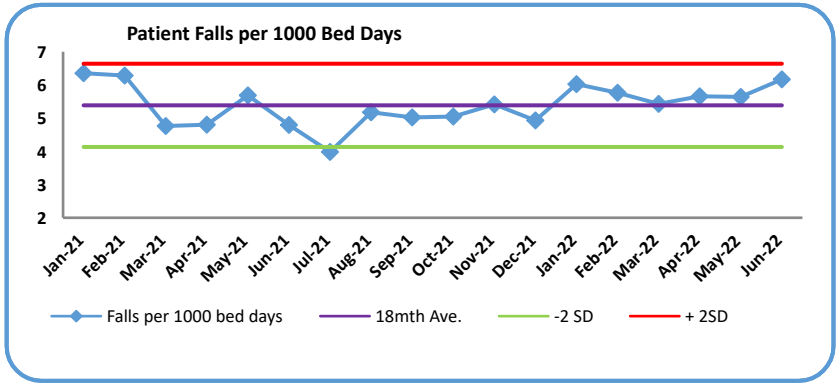
Quality: Harm Free Care - Falls

There has been a peak in falls this month carrying on the upward trend since February 2022. However overall there has been a reduction in inpatient falls over the past 18 months, with the exception of peaks in December 2020 through to February 2021, then again in May and November 2021. This has however remained consistent with the 18 month average per 1000 bed days, and falls with harm remain low and consistent. This reflects previous years, however also draws a parallel with periods of a surge in COVID-19 activity.

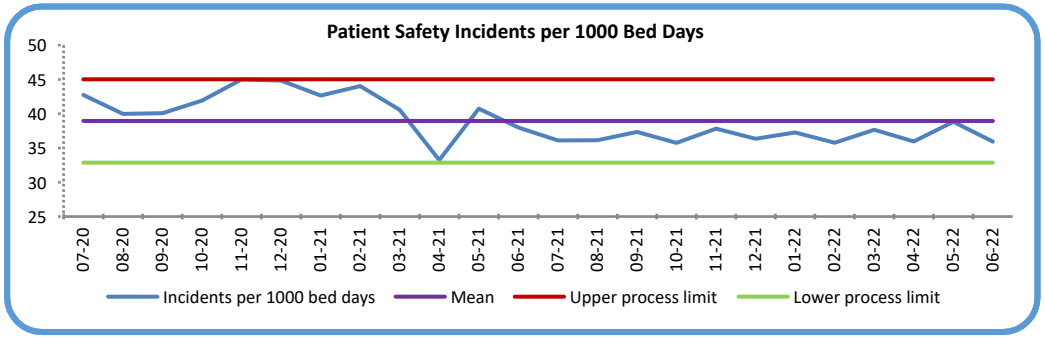
This year the Trust has experienced significant pressures, particularly in relation to bed occupancy levels, which have remained high throughout. Significant increases in the cohort of medical patients, particularly those over 65 are evident and did lead to the requirement to convert many surgical wards to medicine, and have remained so for the last two years. Evidence produced by the National Falls Audit (2021) illustrates rates of deconditioning in our elderly population as a result of periods of lockdowns and COVID-19 infection, has led to significant increases in both levels of patients at risk and incidents of falls. Incidents within the Trust reflect this, whereby a high proportion of falls occur in our patients who are over 65.

The Falls Coordinator has commenced work identifying, on a monthly basis, the wards with the highest incidence of falls, identifying causes and looking at solutions with the aim to reduce numbers. There has been a sustained success in relation to reducing serious harm from falls, as the Trust continues to report less incidents resulting in serious injury.

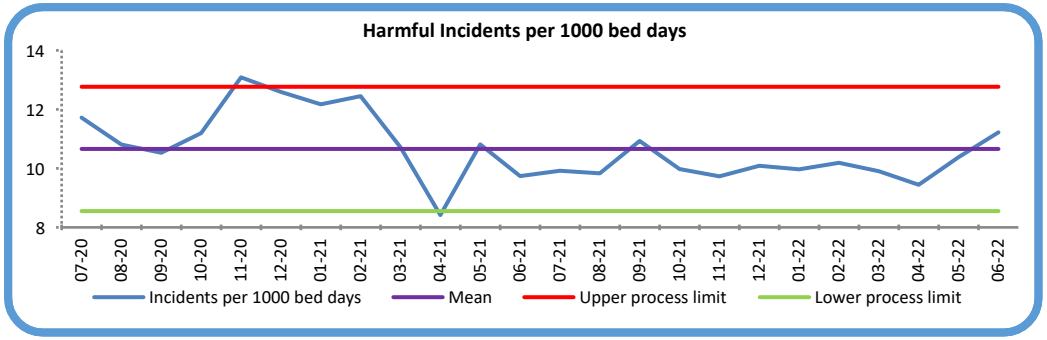




Quality: Incident Reporting

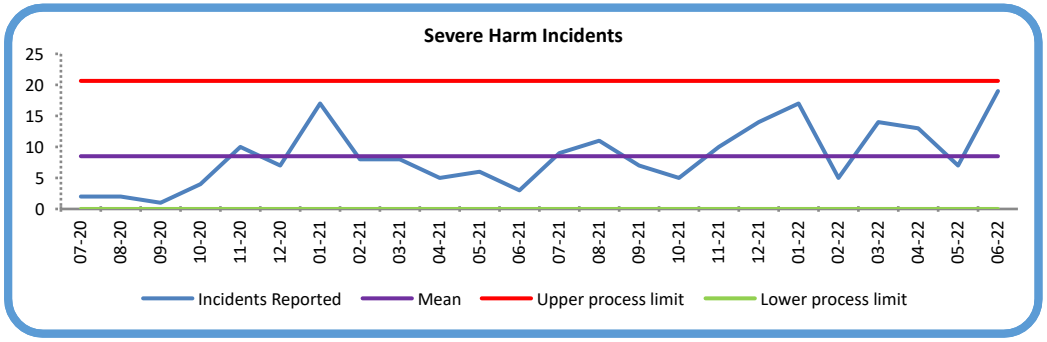


All patient incidents: There has been a slight decrease in the rate of patient incidents reported between June 2021 – June 2022, demonstrating a continued shift below the mean. This however remains within the expected common cause variation.



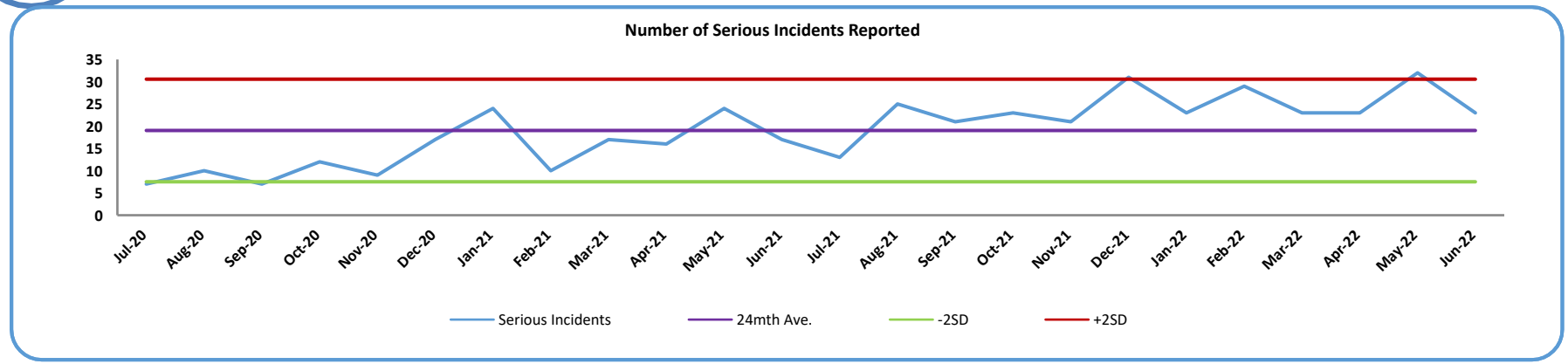
Harmful incidents: There has been a slight increase, above the mean, in the number of *harmful patient safety incidents per 1000 bed days. This remains within the common cause variation expected.

**includes all levels of harm from minor to catastrophic. Excludes patient safety incidents that resulted in no patient harm.*

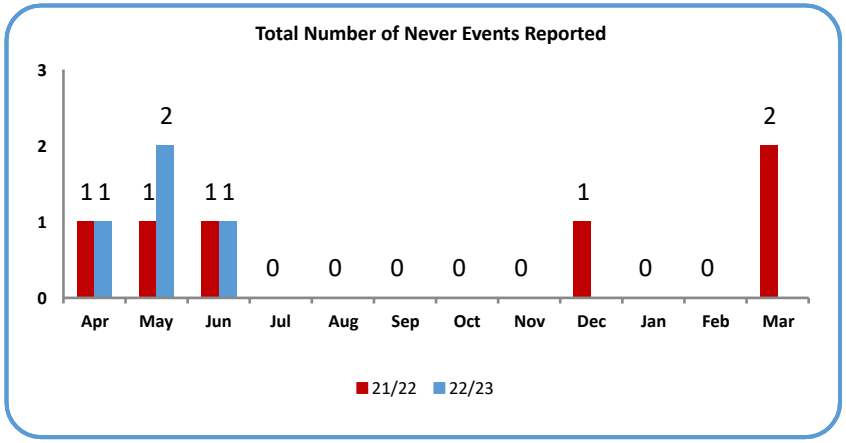


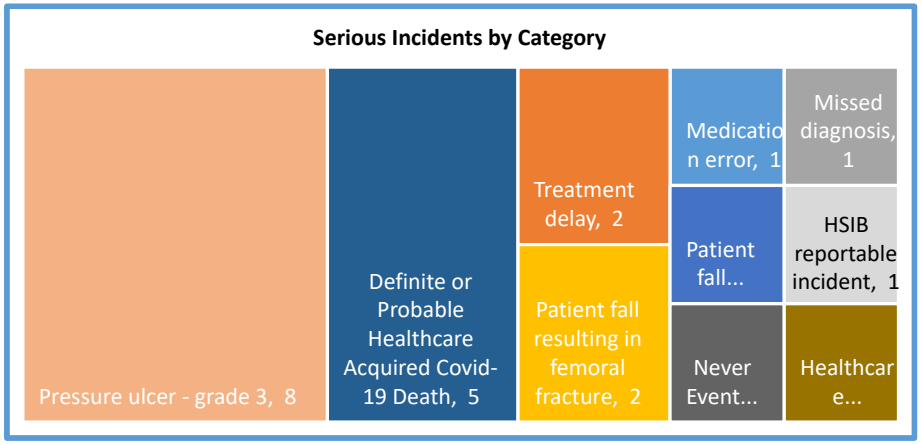
Severe harm incidents: There were 19 patient safety incidents reported which resulted in severe harm in June 2022. This is a increase in the number of severe harm incidents, above the mean, which remains within the common cause variation.
Severity grading of reported incidents may be modified following investigation and is therefore subject to change in future reports.

Quality: Serious Incidents & Never Events



There were 23 Serious Incidents (SIs) reported in June 2022, demonstrating a decrease towards the mean. The increase in the numbers of SIs since July 2021 can be attributed to a return to pre-pandemic bed occupancy alongside higher acuity of patients in the Trust and an increase in COVID-19 prevalence. The statutory requirement Duty of Candour (DoC) applies to patient safety incidents that occur when providing care and treatment that results in moderate, severe harm or death and requires the Trust to be open and transparent with patients and their families. The DoC process has been initiated in all cases reported in June 2022.



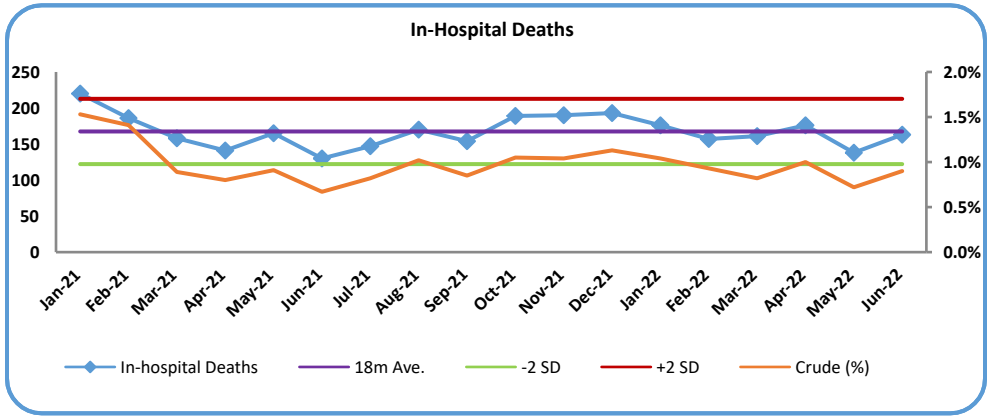


*The Trust started reporting patients who have died with definite or probable hospital onset COVID-19 as serious incidents from 1st January 2021. This is following new NHSE reporting guidance which aims to standardise reporting by all trusts nationally.

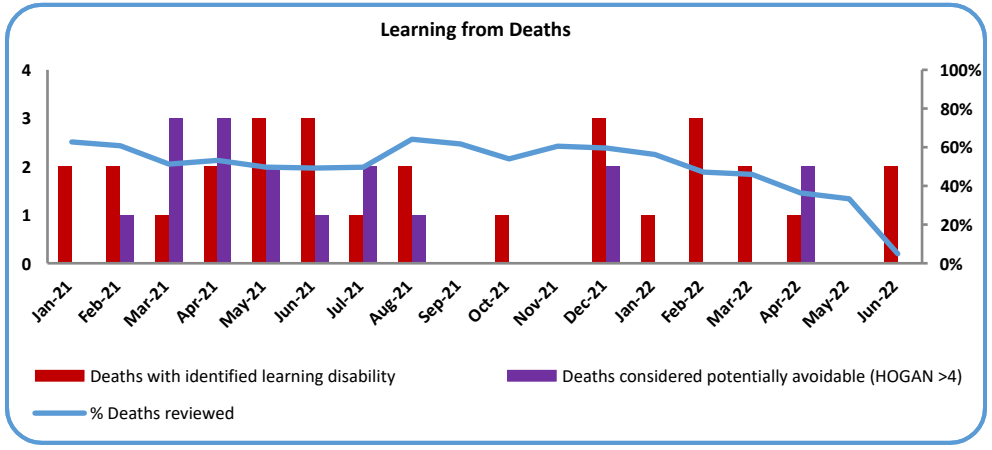
** Since April 2019 all 'Each Baby Counts' reportable cases are now externally investigated by the Healthcare Safety Investigation Branch (HSIB) as part of their national programme.

Quality: Mortality Indicators 1/2

In-hospital Deaths: In total there were 163 deaths reported in June 2022, which is higher than the amount reported 12 months previously (n=130). Crude death rate is 0.90%. Historically, crude death rate has consistently remained under 1% with the exceptions of COVID-19 pandemic peaks.

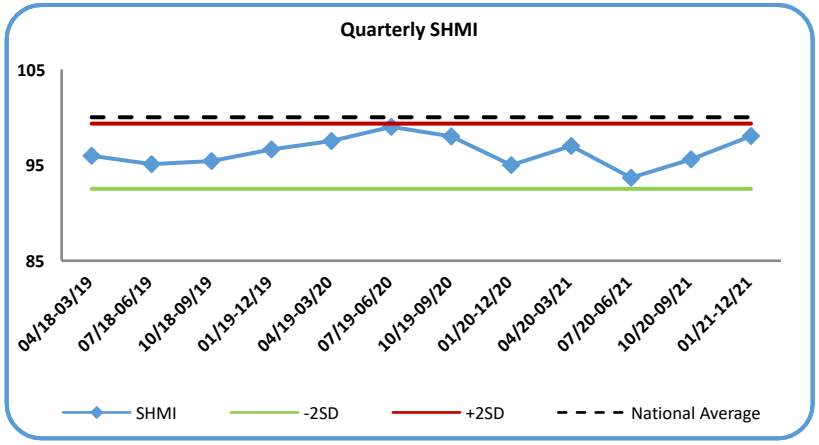


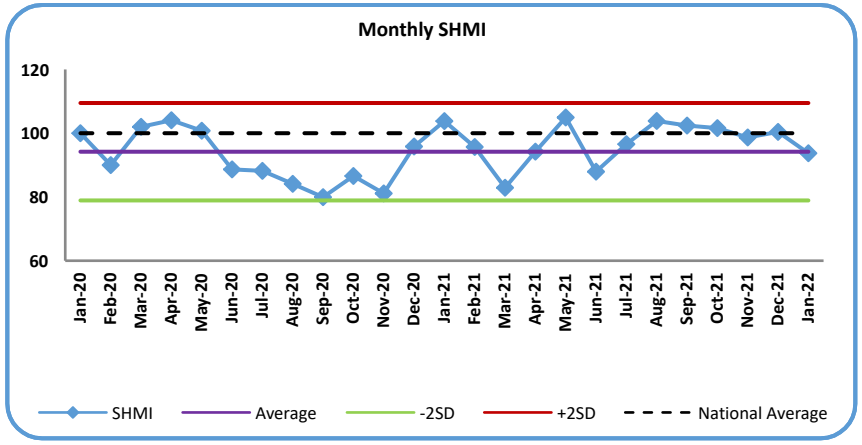
Learning from Deaths: Out of the 163 deaths reported in June 2022, Eight patients have received a level 2 mortality review. However, these figures will continue to rise due to ongoing M&M meetings held over the forthcoming months. All figures will continue to be monitored and modified accordingly.



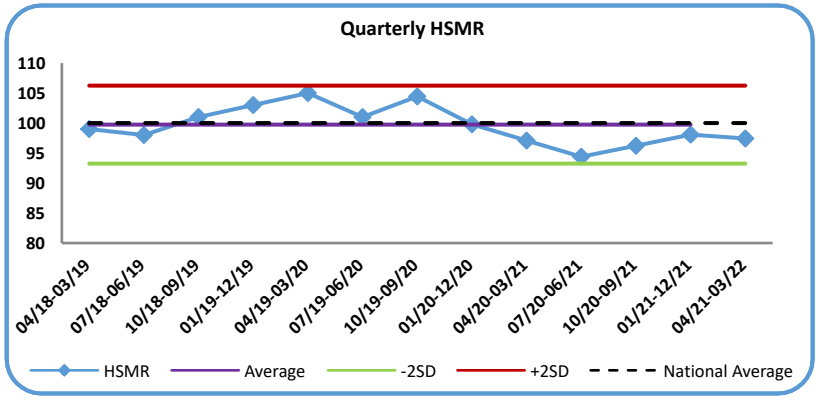
Quality: Mortality Indicators 2/2

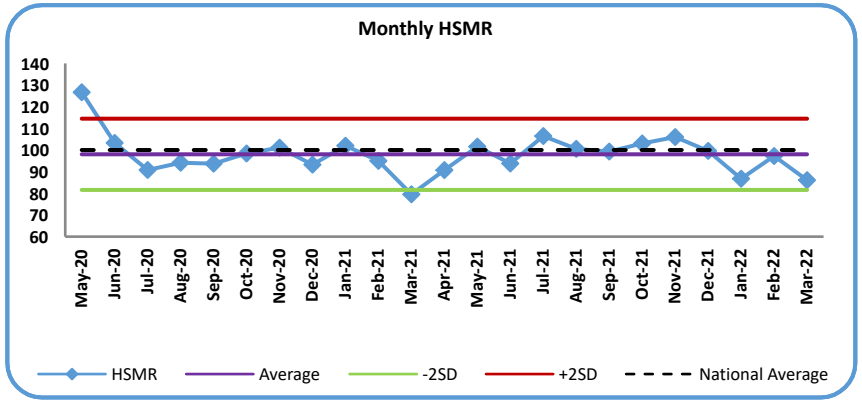
SHMI: The most recent published SHMI quarterly data from NHS Digital shows the Trust has scored 98 from months January 2021 – December 2021. This is below the national average and is within the "as expected" category. Monthly SHMI shows the Trust to be within the “as expected” category. COVID-19 data continues to be excluded from SHMI data published from NHS Digital.



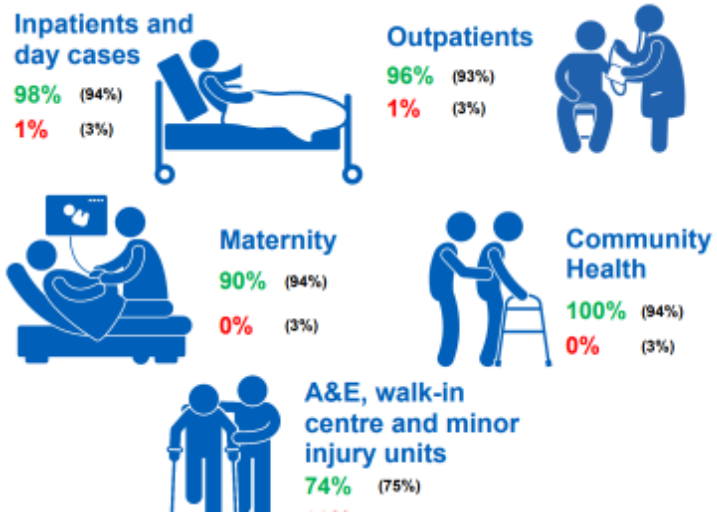


HSMR: The HSMR data shows a 12 month rolling HSMR score by quarter as well as monthly data. Monthly HSMR data is available up to March 2022, and is showing to be the below the national average, however this number may rise or fall as the percentage of discharges coded increases. All figures will continue to be monitored and modified accordingly.





Quality: FFT and Complaints



Friends and Family Test

The published data shows that there were 2,266 responses to the Friends and Family test from the Trust in May 2022 (published July 2022) compared to 1,346 in the previous month.

The following infographic shows the proportion of responses that reflect a positive or negative experience from the feedback provided by our patients. The national average results are shown in brackets.

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

*numbers too small to publish

Trust Complaints 2022-23

The Trust has received a total of 117 (114 with identified patient activity) formal complaints up to June 22, an increase of 38 on last month's opened complaints.

The Trust has received an average of 39 new formal complaints per month, which is 7 complaints per month lower than the 46 per month average for the last full financial year 2021-22.

Taking into consideration the number of patients seen and areas with patient contact, the highest percentages of patients complaining to date are within Medicine with 0.07% (7 per 10,000 contacts). The lowest complaint percentages are with Dental who are yet to receive a complaint.

	2022-23				
Directorates	Complaints	Activity	Patient % Complaints	Ratio (YTD)	21-22 Ratio (Full Year)
Cardiothoracic	4	27,259.00	0.015%	1:6815	1:3128
Children's Services	7	19,921.00	0.035%	1:2846	1:3275
Community Services	1	5,880.00	0.017%	1:5880	1:4546
Dental Services	0	27,952.00	0.000%	1:	1:10120
Medicine	10	14,108.00	0.071%	1:1411	1:3053
Medicine (ED)	6	49,778.00	0.012%	1:8296	1:4866
ENT, Plastics, Ophthalmology & Dermatology (E	8	97,971.00	0.008%	1:12246	1:7356
Musculoskeletal Services	2	29,044.00	0.007%	1:14522	1:3505
Cancer Services & Clinical Haematology	10	47,083.00	0.021%	1:4708	1:6347
Neurosciences	12	26,857.00	0.045%	1:2238	1:3067
Patient Services	32	11,187.00	0.286%	1:350	1:1934
Peri-operative & Critical Care	4	9,333.00	0.043%	1:2333	1:3499
Surgical Services	8	20,588.00	0.039%	1:2574	1:1698
Urology & Renal Services	1	17,602.00	0.006%	1:17602	1:3090
Women's Services	9	36,971.00	0.024%	1:4108	1:3341
Trust (with activity)	114	441,534.00	0.026%	1:3873	1:3994

"Communication" is the highest primary subject area of complaints at 24% of all the subjects Trust wide.

Quality: Health and Safety

Overview

There are currently 1,201 health and safety incidents recorded on the Datix system from the 1st July 2021 to 30th June 2022. This represents an overall rate per 1,000 staff of 73.3. The Directorate with the highest number of incidents is Peri-operative & Critical Care reporting 166 health and safety incidents over this period. Directorate rates per 1,000 staff for the highest reporting services are Integrated Covid Hub North East (777), Estates (524), NHS Covid Vaccination Programme (202), Supplies (141) and Women's Service (78).

Incidents of Violence & Aggression to Staff

In addition to the health and safety incidents, there are 986 incidents of physical and verbal aggression against staff by patients, visitors or relatives recorded on the Datix system from the 1st July 2021 to 30th June 2022. This represents an overall rate per 1,000 staff of 60.1 per 1,000 staff during this period. The Trust Violence Reduction Group met for the first time in July 2022. A number of initiatives are already underway, for example 'We Can Talk' in Children's Directorate which is a training package used to upskill staff in effective communication skills with patient suffering from mental health issues. Staff in Reception areas have also received additional training in face to face and telephone conflict resolution.

Sharps Incidents

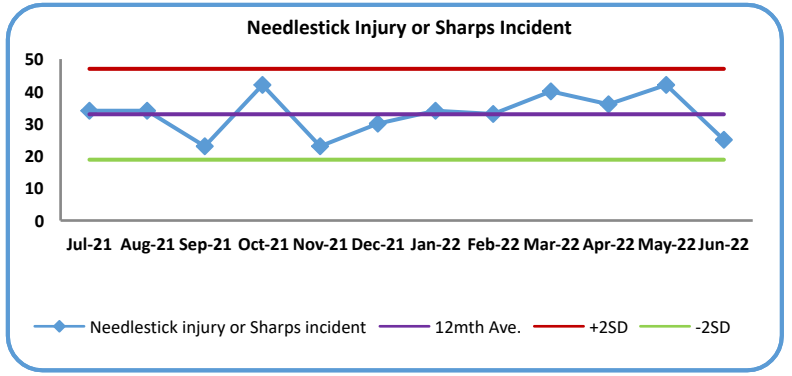
The recent sustained increase lines up with a number of factors, which are currently being discussed at the Trust Safer Sharps User Group. These factors include increased activity / acuity, supply issues meaning staff are using alternative devices and clinical educator vacancies.

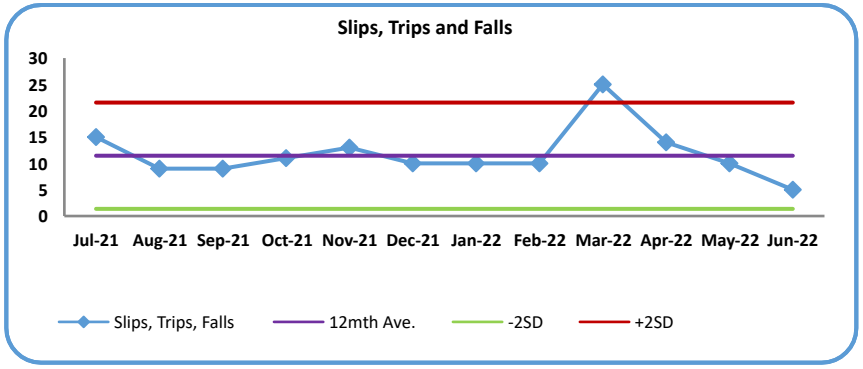
Slips, Trips and Falls

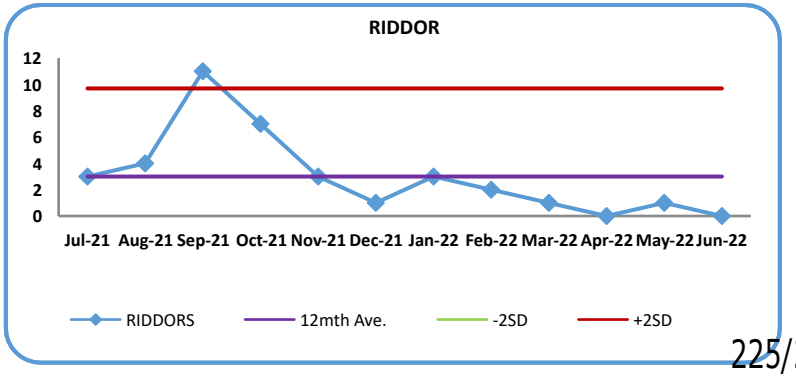
Slips on wet surface, fall on level ground and tripped over an object collectively account for 49% of falls between 1st July 2021 to 30th June 2022. Fall from height; fall up or down stairway and falls from a chair account for 7% of the incidents recorded.

RIDDOR

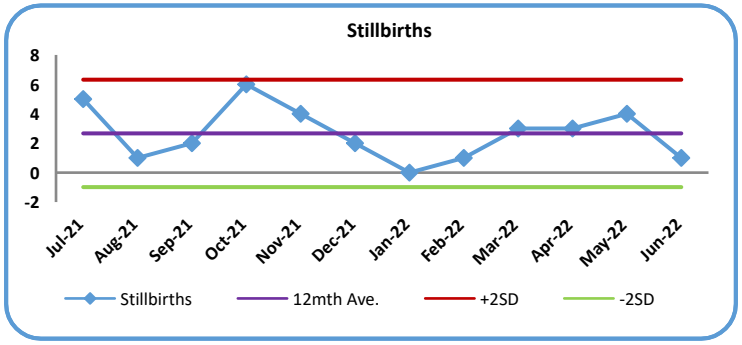
There have been 43 RIDDOR incidents reported between 1st July 2021 to 30th June 2022 The most common reasons of reporting accidents and incidents to the HSE within the period are Moving and Handling (12), Accidents (involving staff, visitors etc.) (10), Slips, Trips and fall (11) and Aggression & Violence (7), and These account for 96% of reportable accidents over the period.





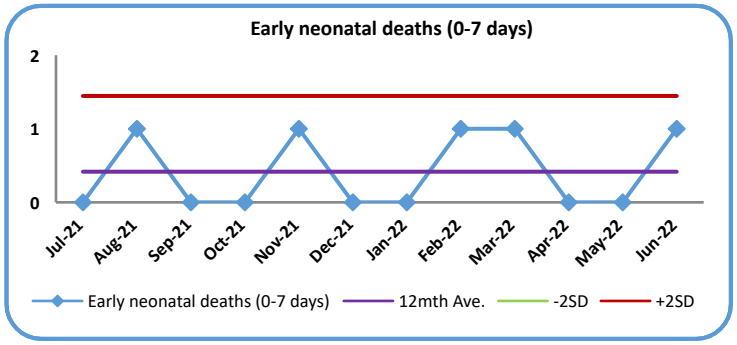


Quality: Maternity (1/3)

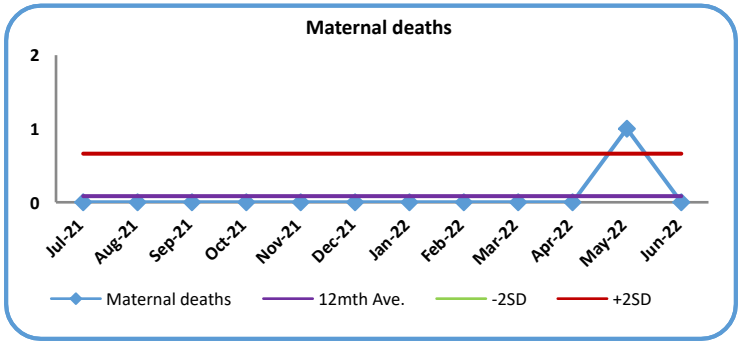


Perinatal deaths
All Perinatal deaths (Stillbirths and Neonatal Deaths) are reported to MBRRACE-UK who produce an annual National report which includes our local data.

Stillbirths
As we are a tertiary referral Fetal Medicine Unit often complex cases are referred to us from other units within the region and the women opt to deliver here rather than return to their local unit. All cases undergo an initial local review and then a more detailed review including external input, once we have the investigation results.

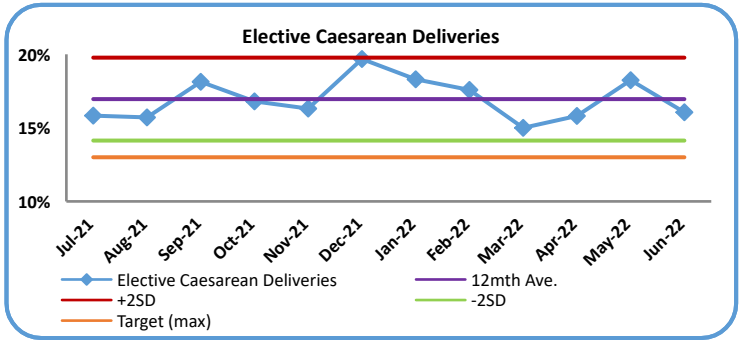


Early Neonatal Deaths
These figures are for term infants (born between 37 and 41 weeks) who delivered at the Trust but sadly died unexpectedly within the first week of life. These deaths are reported to the Child Death Review panel who will have oversight of the investigation and review process. These cases are also usually reported to the Coroner. A post mortem examination may be requested to try and identify the cause of death.



Maternal Deaths
Maternal deaths are reported to MBRRACE-UK and a national report is provided annually. Maternal deaths can be categorised as Direct or Indirect. It is rare to have a direct Maternal death in Newcastle. Tragically in May, a woman died after suffering complications shortly after delivery. The case has been reported to the Coroner, MBRRACE-UK and HSIB. HSIB have started their investigations. It is anticipated that the report will be available within 6 months. A local review to consider immediate actions was undertaken within 72hrs of the death.

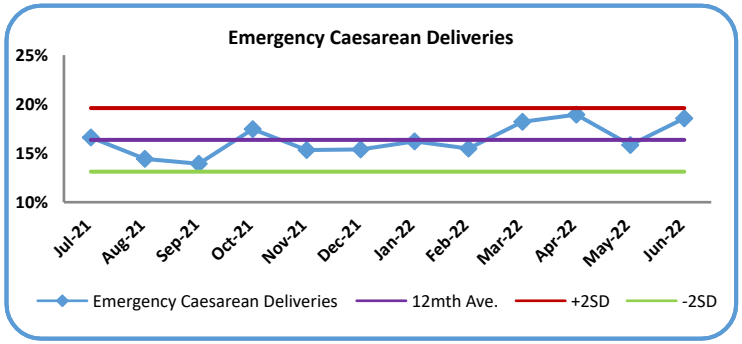
Quality: Maternity (2/3)



Elective Caesarean section

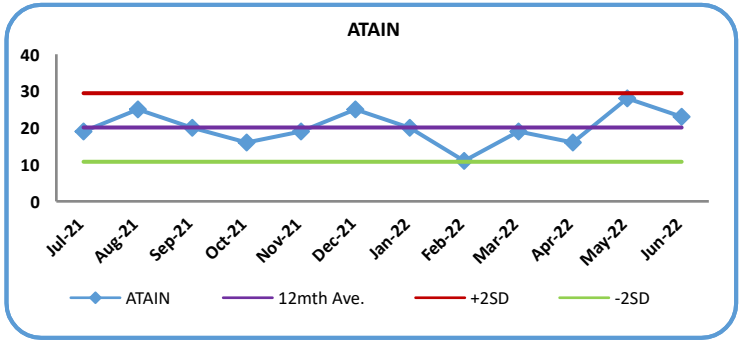
Maternity at the Trust is an outlier for elective Caesarean section compared to other UK Trusts. However, the rates are comparable to rates of other tertiary centres in the UK.

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



Emergency Caesarean section

The emergency Caesarean section rate is comparable to other Trusts. Maternity is a consultant led service with 98-hour dedicated consultant sessions for Delivery Suite (8am-10pm daily), twice daily consultant ward rounds and consultant obstetricians being involved with all decisions for emergency Caesarean section.



ATAIN

All unplanned admissions of term babies (37 – 41 weeks) into the neonatal unit are reviewed at a weekly multi-disciplinary meeting and a quarterly report is produced and shared. Some of these cases will be reviewed in more detail if they have been identified as a Serious Incident. An annual audit report is presented at the Directorate Audit meeting with lessons learnt/ key themes/ change to practice being shared across obstetrics and neonatology.

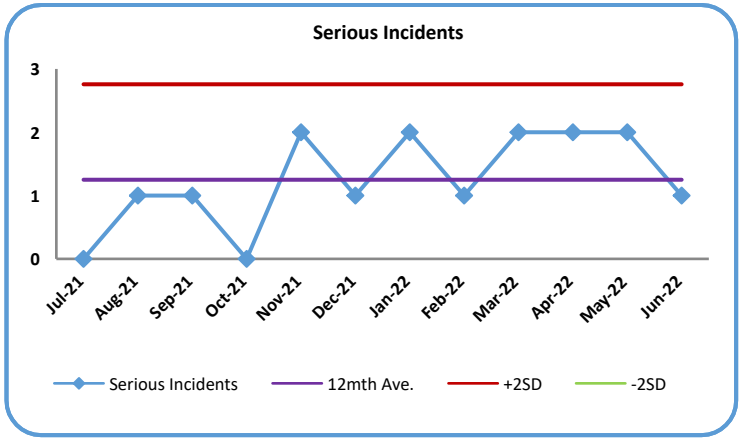
Quality: Maternity (3/3)

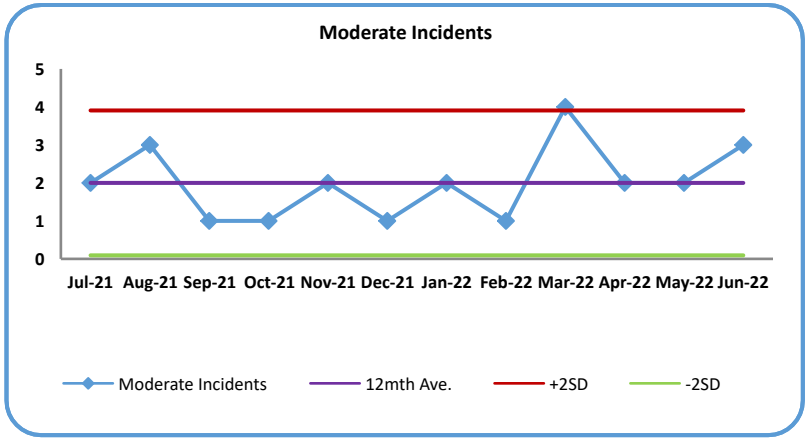
Serious Incidents

There have been 14 incidents escalated as Serious Incidents to the Trust in the past 12 months. These include 8 cases of potential Hypoxic Ischaemic Encephalopathy (HIE), 2 neonatal deaths, 1 baby fall, 1 bowel injury, 1 intrapartum stillbirths and 1 direct maternal death. The HIE, Intrapartum Stillbirth case and Maternal death were all reported to HSIB (Healthcare Safety Investigation Branch) for external review. A summary of the HSIB cases was presented to the Serious Incident Panel in May .

Moderate incidents

All incidents are carefully reviewed by the Maternity Governance team and are graded appropriately after completion of a rapid review (48hr report). In the past 12 months the majority of the moderate graded incidents were babies that needed to receive 'therapeutic hypothermia' in order to minimise the risk of a brain injury. Although graded moderate these babies may have no long term injury but they require a two year follow up in order to assess their neurological status. Moderate incidents will be investigated as a Serious Learning Event and involve parental input to the investigation and follow up with a Consultant and Senior Midwife 6-8 weeks after the incident.

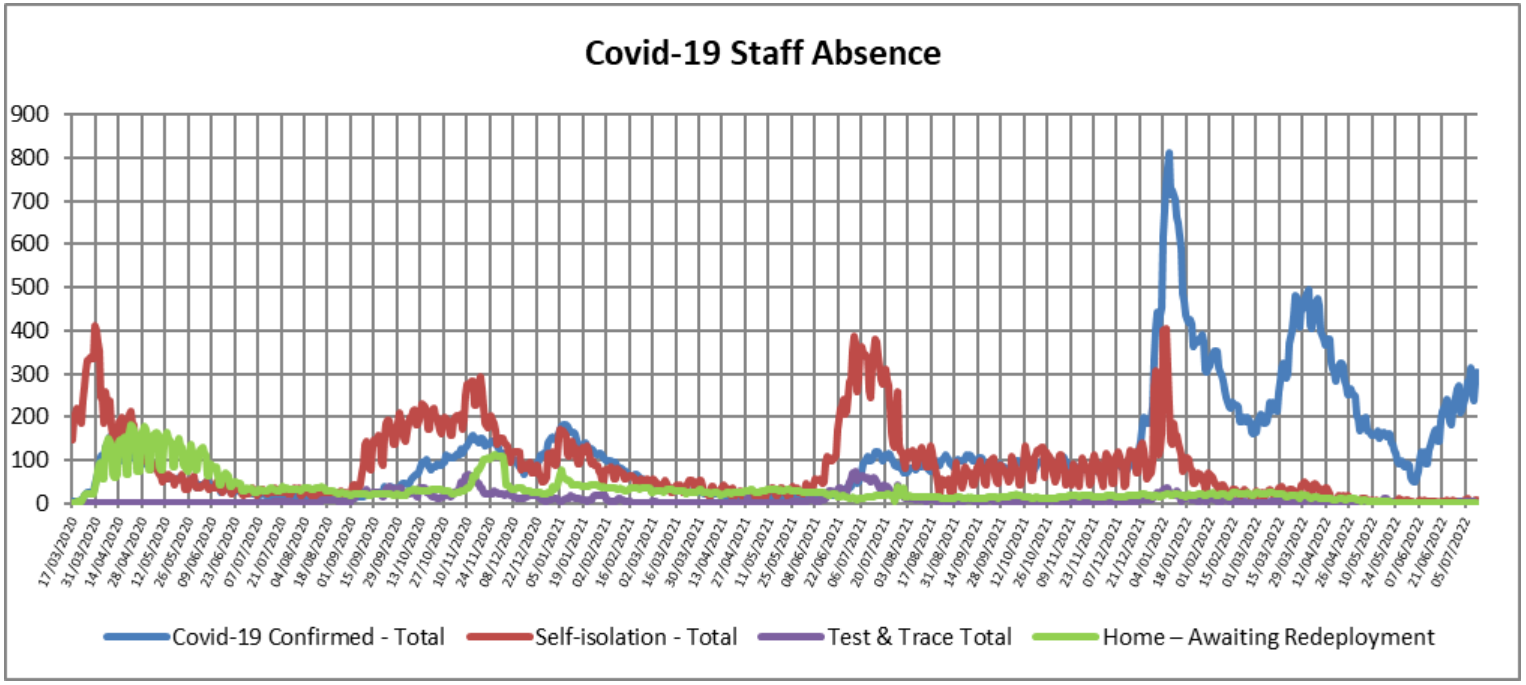




People – COVID-19

Figures quoted are by headcount

- The graph below identifies the number of COVID-19 related absences taken by Trust staff between 17 March 2020 and 30 June 2022. Some staff may have had more than one episode of COVID-19 related absence during this period.



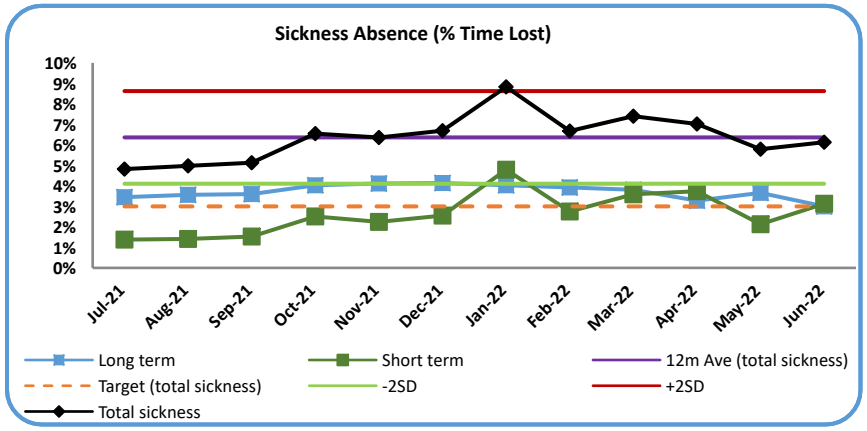
- Risk Assessments have been made available to all Trust staff – staff in 'high risk' category prioritised.

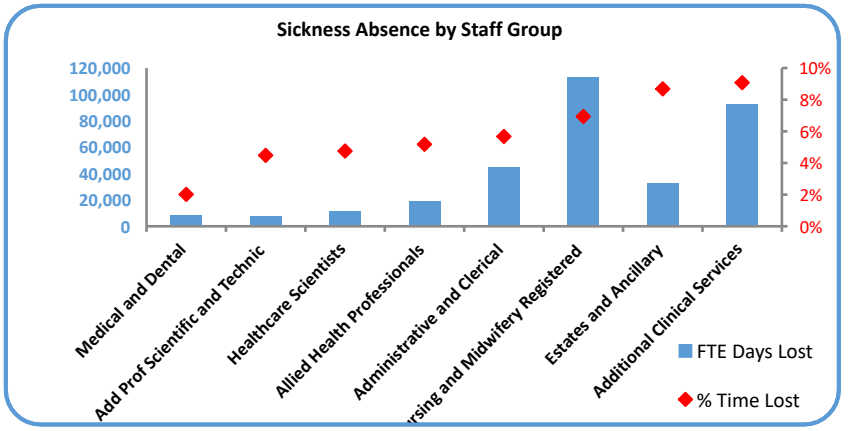
People – Sickness Absence 1/2

- Year to year comparison for sickness absence (including COVID-19 related sickness (rolling 12 months):

	Jun-21	Jun-22	
Long-term	3.49%	3.90%	↑
Short-term	1.33%	2.68%	↑
Total	4.82%	6.58%	↑

- 329,985 FTE working days were lost due to sickness (including COVID-19 related sickness) in the year to June 2022, compared to 227,623 for the previous year, 31% increase.
- Overall sickness absence (including COVID-19 related sickness) is 6.13%, which is down from end of Apr 2022 position of 7.02% (% FTE Time Lost).
- The top three reasons for non-COVID related sickness absence are Anxiety/stress/depression/other psychiatric illnesses (28.09%) Gastrointestinal problems (8.63%), and other musculoskeletal (12.3%).
- The top reason for "Other" absences is Maternity Leave (49% of total absence.
- Nursing and Midwifery have the highest number of Maternity Leave at 4% (%FTE Lost).

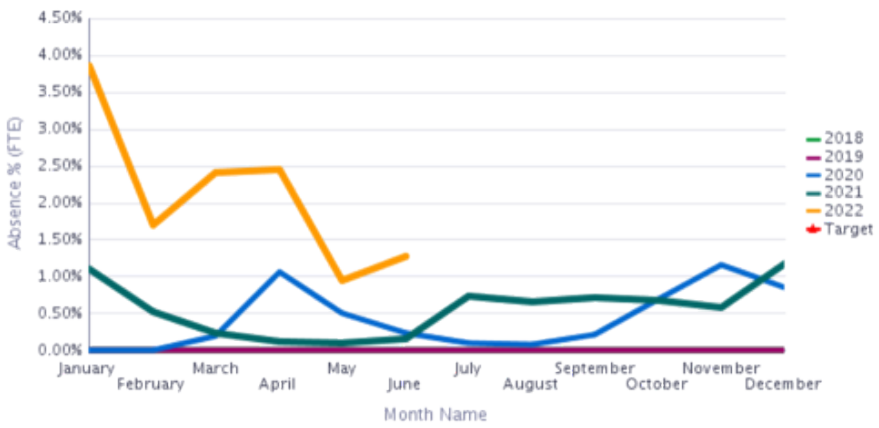




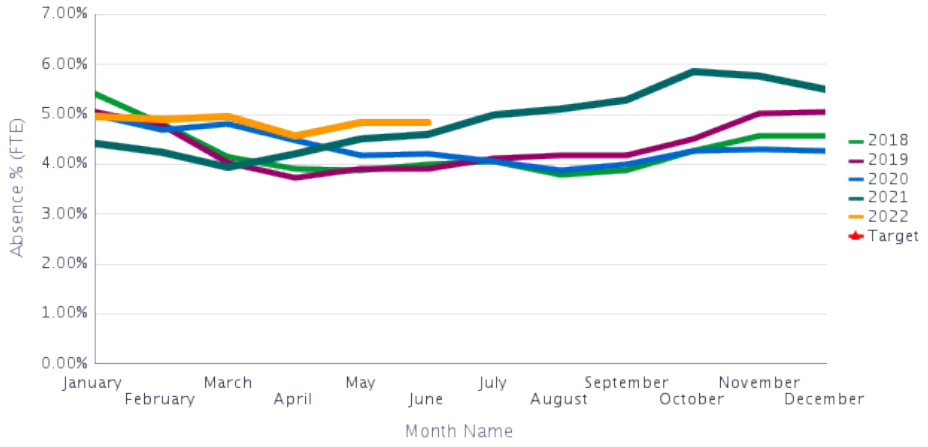
*COO Directorate includes Outpatients / ABC Service

People – Sickness Absence 2/2

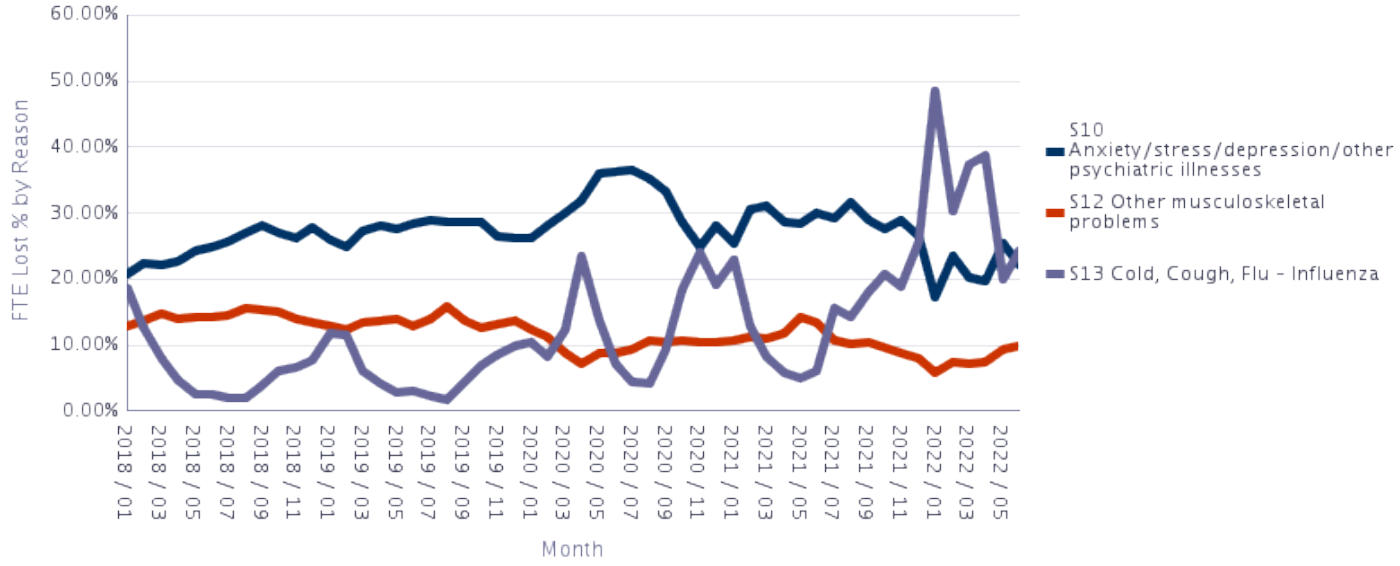
COVID-19 Related Sickness Jan 2018 - Jun 2022 (%FTE)



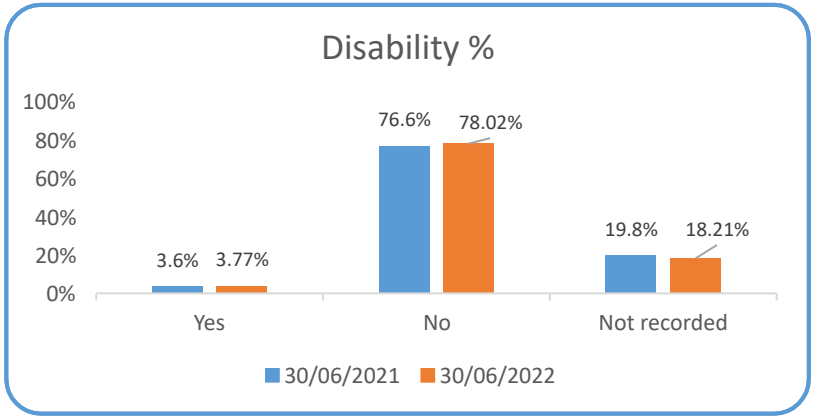
Non-COVID-19 Related Sickness Jan 2018 - Jun 2022 (%FTE)

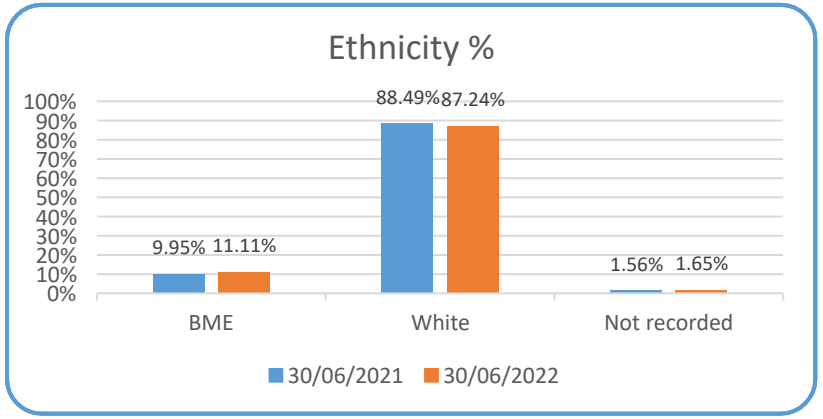


Top 3 Sickness Reasons Jan 2018 - Apr 2022 (%FTE)

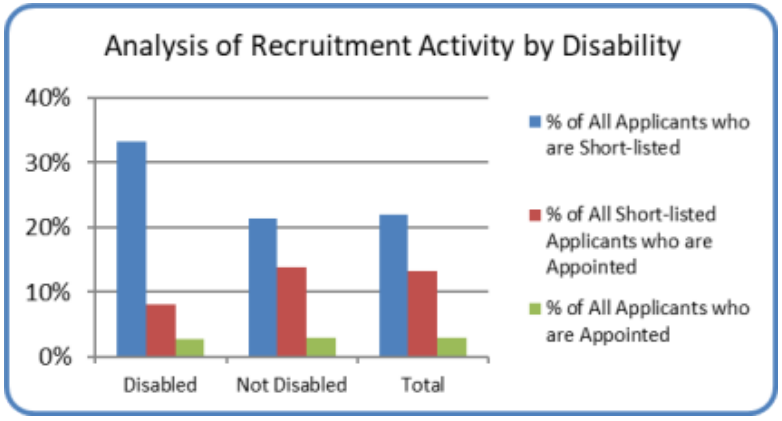


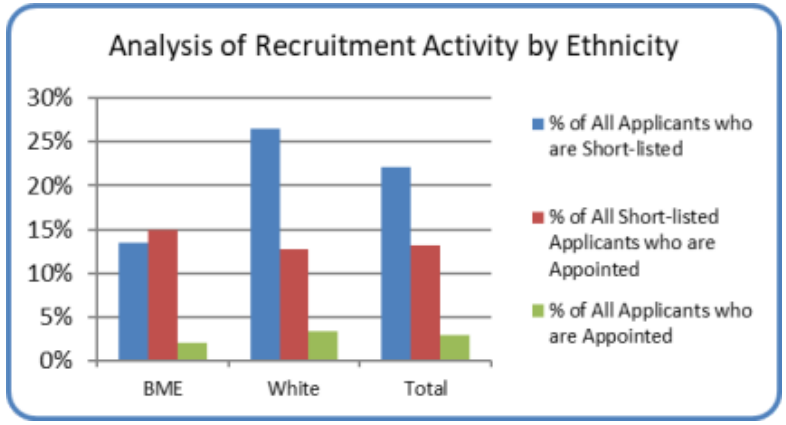
People – Equality and Diversity 1/2





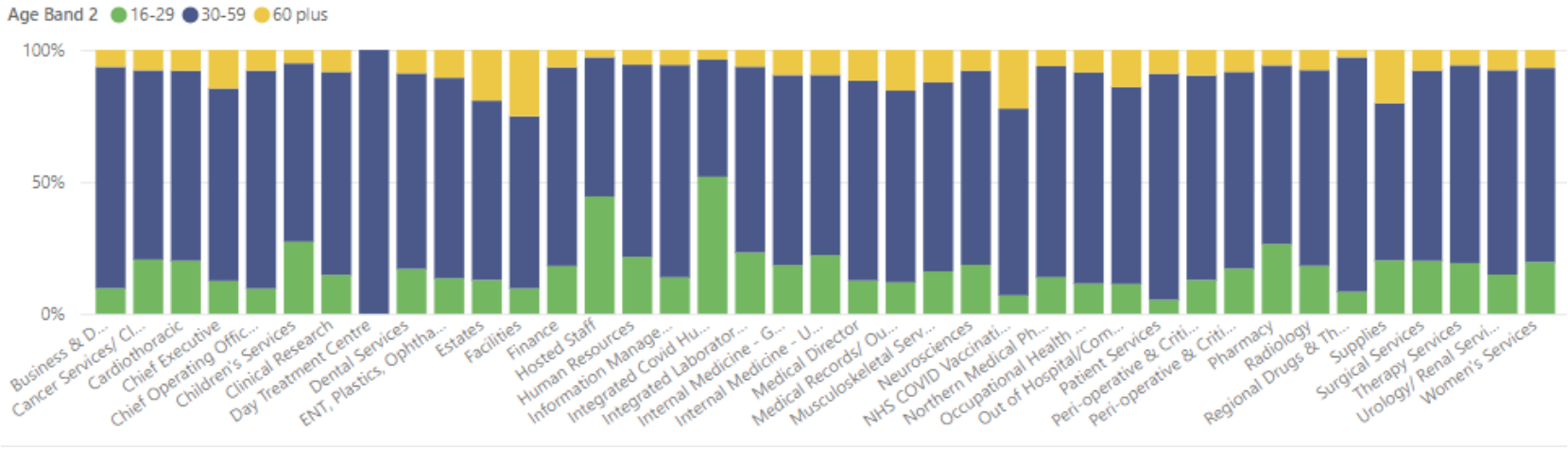
- The graphs above identify, by disability and ethnicity, the recruitment outcome of applicants during the twelve months ending June 2022.





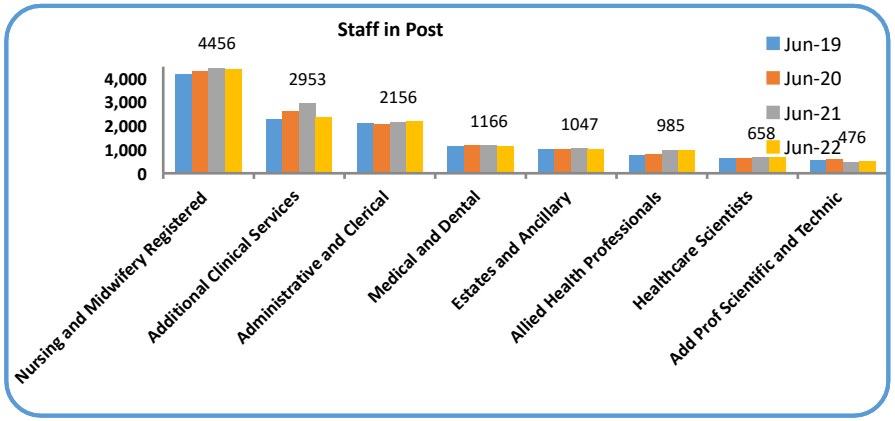
- The graphs above identify, by headcount, the percentage of staff in post in June 2021 and June 2022 by disability and ethnicity. The percentage of staff employed disclosing a disability has improved from 3.62% to 3.77% and the percentage of BAME staff has increased from 9.95% to 11.11%.

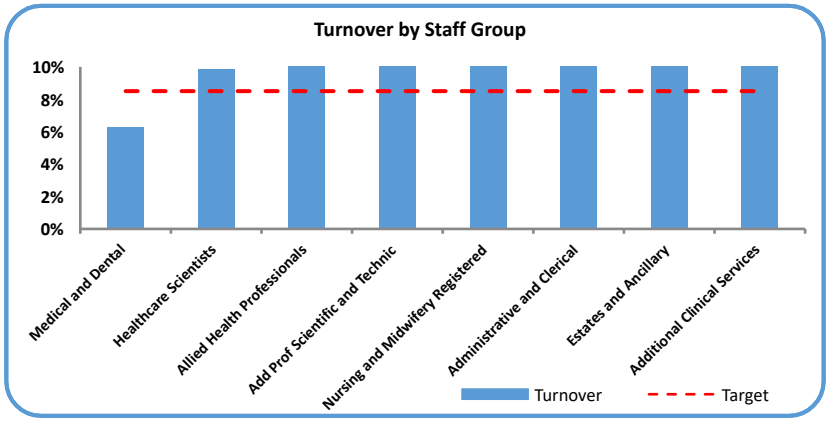
People – Equality and Diversity 2/2

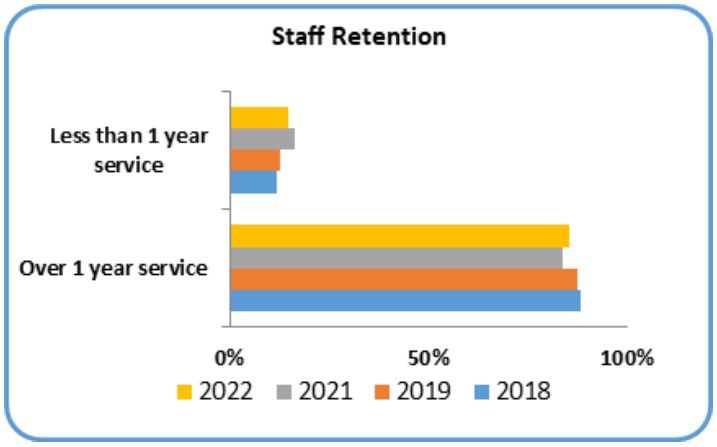


- Estates and Ancillary have the highest proportion of staff aged 55 and over (45%).
- Medical and Dental have 20% of staff aged 55 and above and 7% of staff aged 60 and above.

People – Workforce 1/4







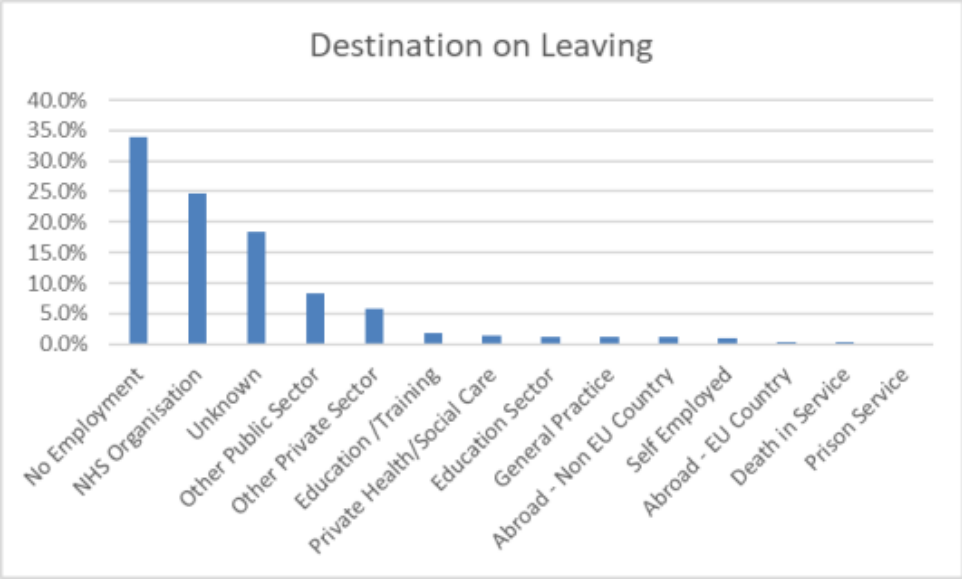
- Staff in post has increased by 5.43% since June 2019. The staff groups with the largest increase are Additional Clinical Services and Allied Health Professionals.
- Staff turnover has increased from 9.89% in June 2021 to 16% in June 2022, against a target of 8.5%.
- The total number of leavers in the period July 2021 to June 2022 was 2,505.
- Retention for staff over 1 year service is 85.5%, an increase from 83.8% in June 2021. Excluding ICHNE and COVID Vaccination staff this is 85.9%.

People – Workforce 2/4

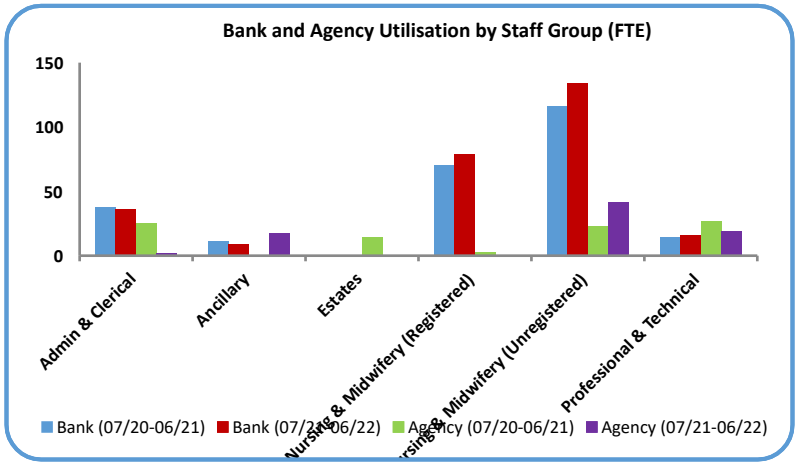
Turnover by Directorate

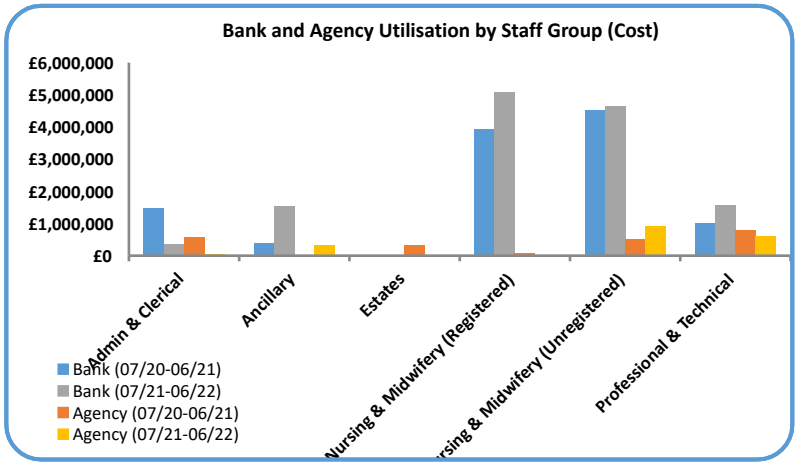
Day Treatment Centre	0.00%
Chief Executive	5.17%
Neurosciences	6.25%
Peri-operative & Critical Care - FH	7.84%
Musculoskeletal Services	7.88%
Surgical Services	8.65%
Medical Director	8.78%
Medical Physics	8.84%
Urology & Renal Services	9.56%
Internal Medicine - Urgent Care	9.78%
Business & Development	10.00%
Integrated Laboratory Medicine	10.25%
Peri-operative & Critical Care - RVI	10.27%
Chief Operating Officer	10.55%
Cancer Services/ Clinical Haematology	10.73%
ENT, Plastics, Ophthalmology & Dermatology	11.04%
Cardiothoracic	11.13%
Radiology	11.66%
Women's Services	11.76%
Internal Medicine - General	11.83%
Dental Services	11.83%
Pharmacy	12.04%
Information Management & Technology	12.30%
Children's Services	12.81%
Clinical Research	12.90%
Patient Services	13.09%
Community Services	13.43%
Regional Drugs & Therapeutics	13.89%
Finance	14.16%
Estates	14.34%
Human Resources	20.22%
Supplies	27.38%
NHS COVID Vaccination Programme	86.05%
North East Integrated Covid Hub	79.73%

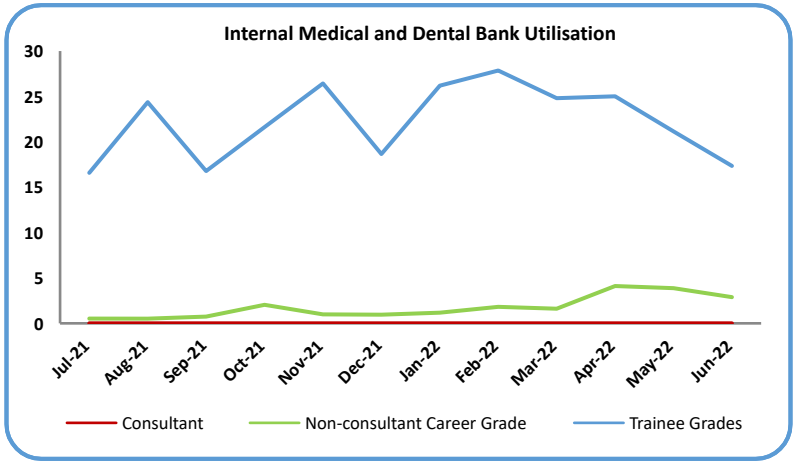
- The NHS Covid Vaccination Programme have had the highest turnover between June 2021 and June 2022, a total of 527 leavers.
- Only 25% of leavers across the Trust disclosed they were going to another NHS organisation.



People – Workforce 3/4

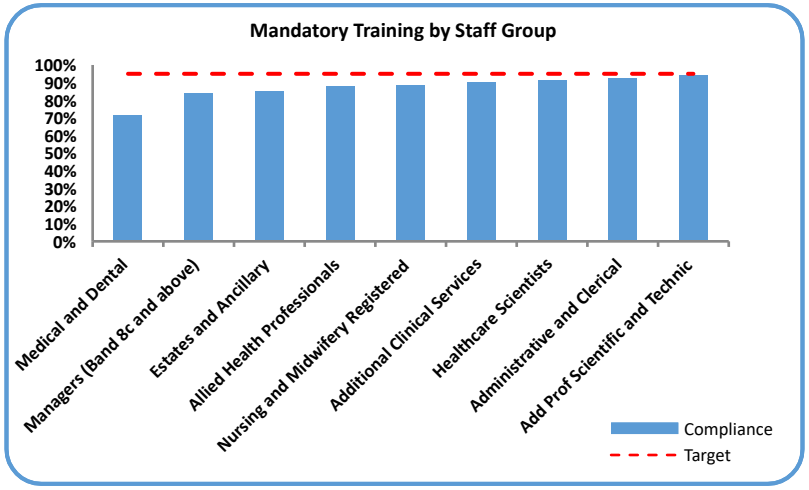


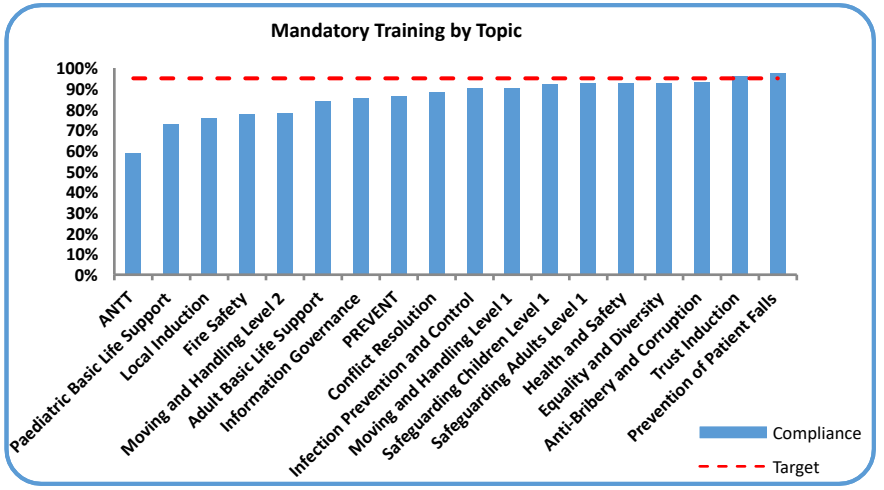


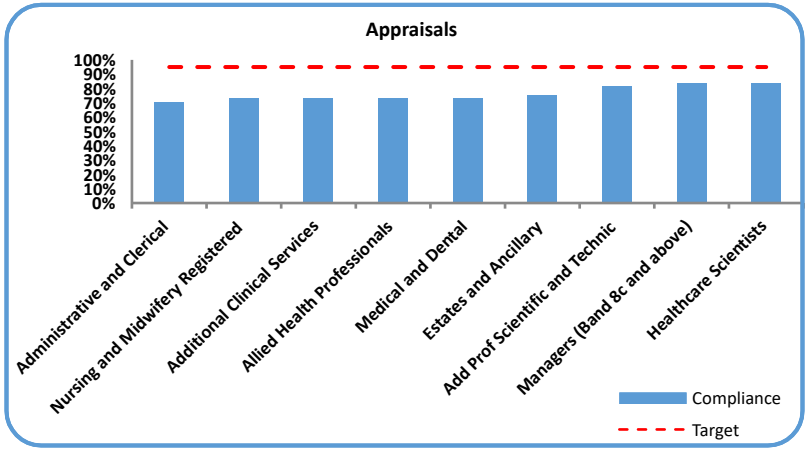


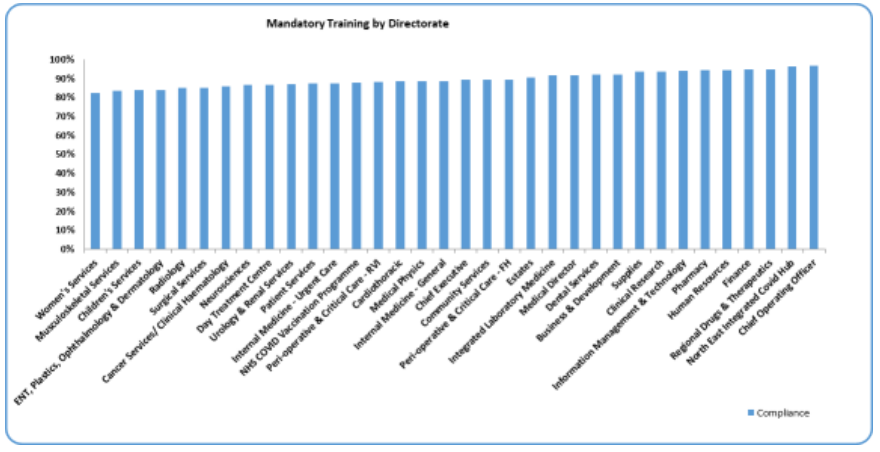
- Comparing the periods May 2020 – April 2021 to May 2021 – April 2022 , overall bank utilisation has increased from 249 wte to 273 wte and agency utilisation has decreased from 92 wte to 79 wte.
- No update for Bank and agency is currently available for this month (July 2021 – June 2022)

People: Delivering Excellence in Education & Training









- Mandatory training compliance stands at 88.0% at end of June 2022, against an end of year target of 95%. The June 2021 position was 87.7%.
- Medical and Dental are the staff group with the lowest training compliance at 71.6% in June 2022 compared to 71.7% in June 2021.
- Appraisal compliance stands at 73.6%, at end of June 2022, against an end of year target of 95%. The June 2021 position was 78.8%. Interventions are in hand to improve this.

Finance: Overall Financial Position

This page summarises the financial position of the Trust for the period ending 30 June 2022.

The Trust submitted a financial Plan to NHSE for 2022/23 in April, for a deficit of £5.5m for the year. However, there has been agreed additional funding made available and a revised plan was submitted in June with plan surplus of £10.7 million. There are a number of assumptions made, including the delivery of a challenging Cost Improvement Programme, delivery of the Elective Recovery Plan and reducing long waits.

In the period to 30th June 2022 the Trust incurred expenditure of £339.6 million, and accrued income of £339.8 million on mainstream budgets and incurred expenditure of £2.3 million on the programmes outside the block envelope (vaccine roll-out programme), leading to a small surplus of £0.2 million. ICHNE is being treated on an 'Agent Basis' and is excluded for both income and expenditure, the figure is £3.1 million.

It should be noted that all financial risk ratings and use of resources metrics continue to be suspended and are not reported here.

To 30th June the Trust had spent £12.1 million capital, £8.8 million behind Plan.

	Month 3 Budget £'000	Month 3 Actual £'000	Month 3 Variance £'000
Income	338,528	339,798	1,270
Expenditure	338,577	339,552	975
I & E position (excl impairment) - Deficit/(Surplus)	49	(245)	(294)
Capital Programme	20,945	12,114	(8,831)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

BOARD MEETING

Date of meeting	28 July 2022						
Title	A summary of Newcastle Hospital's patient and public involvement activity in relation to capital projects						
Report of	Caroline Docking, Assistant Chief Executive						
Prepared by	Caroline Docking, Assistant Chief Executive						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☒		☐		☐		
Summary	This report covers the Trust's patient and public involvement to date for the new build projects: • The New Specialist Hospital Building (NSHB), and • The Children's Heart Centre (CHC). It provides the background and context to the projects and to the Trust's statutory duty to involve and makes recommendations which will facilitate meaningful and productive involvement of staff, stakeholders, patients, and the public.						
Recommendation	The Board are asked to note the content of the report and recommendations which are: • To note the Trust's statutory duty to involve people in service change. • To endorse our commitment to wide and open engagement with staff, patients and families involved with care at the Children's Heart Centre and with the specialties moving into the New Specialist Hospital Building. • To support early and proactive involvement planning and activities in future change programmes to help identify issues and assist with risk management.						
Links to Strategic Objectives	Links to all Trust objectives.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	X	X	☐	☐	X	X	☐
Impact detail	Included in the report.						
Reports previously considered by	Links to previous reports on capital projects.						

A SUMMARY OF NEWCASTLE HOSPITAL'S PATIENT AND PUBLIC INVOLVEMENT ACTIVITY IN RELATION TO CAPITAL PROJECTS

EXECUTIVE SUMMARY

The Newcastle upon Tyne Hospitals NHS Foundation Trust is currently progressing three large scale capital projects. These are the Day Care Treatment Centre (DTC), the proposed New Specialist Hospital Building (NSHB) and the new Children's Heart Centre (CHC). The DTC is currently being built at the Freeman site and will open later in 2022. The proposed NSHB and the CHC will both be located on the RVI site, with projected timescales for build activity during 2023-25.

This report details a summary of the recent patient and public involvement activity for both NSHB and the CHC. Up to date information on all three estates projects can be found on the Newcastle Hospitals website under the Trust's 'Ambitions' page at https://www.newcastle-hospitals.nhs.uk/about/ambitions/.

NHS bodies have a statutory duty to involve people who may be affected by plans for changes to services. The duty requires the Trust to make arrangements to involve service users in planning services, in developing and considering changes to services, and in decisions about services[1]. By doing so, the Trust can gather and document information and insight which is used to help make better, more informed decisions.

To meet this duty, Newcastle Hospitals is delivering a range of involvement activities to ask for feedback on how the NSHB and the CHC will be developed. Specialist Patient and Public Involvement organisation PPI Stand (https://wearestand.co.uk/about-stand/) has been appointed to provide expertise and management capacity to help the Trust to achieve this.

Initial involvement in the programmes was primarily in response to project management timescales, specifically linked to the process of applying for planning permissions. A range of targeted communication and involvement activities highlighted the plans and offered people the opportunity to comment on them. Building on this activity, there is further targeted involvement directly with patients, families, staff and key stakeholders as well as in partnership with key representatives and patient and public involvement bodies for each project.

The Board is asked to endorse the involvement activity as an essential need for Trust business, including a public-facing clinician-led communications approach.

[1] NHS Act 2006 s242/13Q/14Z2

A SUMMARY OF NEWCASTLE HOSPITAL'S PATIENT AND PUBLIC INVOLVEMENT ACTIVITY IN RELATION TO CAPITAL PROJECTS

1. BACKGROUND

Public and patient involvement "*…is about enabling everyone who uses services or may do so in the future, including carers and families, to voice their views, needs and wishes, and to contribute to plans, proposals and decisions about services*."[2]

The Trust has a statutory duty to involve people who may be affected by these plans. The public involvement duty means that NHS bodies must make arrangements to ensure that individuals to whom the services are being or may be provided are involved through[3]:

(a) the **planning** of services;
(b) the **development & consideration** proposals for service change; and
(c) **decisions** about implementing service change.

The public involvement duty is **not** about public consultation; the legislation allows other ways to involve people. Levels of involvement can vary depending into which of these three areas the group or stakeholder has been categorised:

1. **Involve**: Key players - groups and people who are critical to the project and those who need to be ***involved*** to meet the Trust's statutory duties.
2. **Engage**: Important partners - to be ***engaged.*** We would like to have input from these partners.
3. **Inform**: Wider stakeholders - from whom input is welcome but not required. These groups will be kept ***informed.***

2. OVERVIEW OF PROJECTS

Up-to-date information on both the NSHB and the CHC can be found on Newcastle Hospitals' website under the 'Ambitions' section (as referenced in the Executive Summary). There are also dedicated project webpages for both the Children's Heart Centre (https://www.newcastle-hospitals.nhs.uk/about/ambitions/estate-strategy/childrens-heart-centre/), where animations and 'fly through' artists' impressions can be viewed and for the proposed New Specialist Hospital building (https://www.newcastle-hospitals.nhs.uk/about/ambitions/estate-strategy/specialist-hospital-building-plans/) where details of the building and artists impressions can be viewed. Questions or queries on the projects can be submitted at any time through the dedicated email and postal address.

[2] Patient and Public Participation in Commissioning Statutory Guidance, NHS England, 2017
[3] NHS Act 2006 s242/13Q/14Z2

2.1 The proposed New Specialist Hospital building

The RVI is a major provider of highly specialised services for the North East and North Cumbria Integrated Care System. Approximately 40% of the Trust's services are from specialised commissioning, and these 'anchor services' operate from different buildings across the estate. These buildings are in need of upgrading and refurbishment and many of the environments fall short of current Health Building Notes (HBN) and Clinical Network standards.

The proposed new building will be a purpose-built home for many of these highly specialist services including Adult Critical Care, Burn Care, the North East Assisted Ventilation Service, specialist maternity services, and services for patients living with Cystic Fibrosis. It will also provide more ward and theatre space.

Funding for the new building is not yet secured, with Newcastle Hospitals having applied to the Government's Health Infrastructure Programme (HIP) for the cost of the build. An announcement on whether the bid will progress to the next round of applications is expected soon.

To be as well prepared as possible, Newcastle Hospitals have continued to progress with the design and plans for the building. This also includes the creation of a communications and engagement plan which includes a full stakeholder analysis and a comprehensive activity plan.

The aim of the communications and engagement plan is to raise awareness of the new building amongst key stakeholders, including staff, patients and carers and the community and voluntary sector. The plan includes key engagement activities to enable stakeholders to have the opportunity to give their views on the proposed new building.

Initially this activity has been linked to the local council planning process which engaged neighbours (both residential and business), patients and families on the wards and in outpatient areas, and the public through wider communication.

The three week *'pre-planning consultation'*[4], which is defined by the formal planning process, offered an opportunity for people to review the proposed plans, within the planning timeline set out by the project planning team. Feedback from this formed part of submissions to Newcastle City Council's planning department.

Following the three-week pre-planning activity in November/December 2021, communication and engagement has continued. Most recently, this has included:

- March/April 2022
  - Presentations to key organisations and patient groups within the community and voluntary sector.
- April/May 2022
  - Involvement updates presented to the NSHB Project Team.

[4] A pre-planning consultation is a specific requirement of the local authority planning process and is different to the consultation process required for NHS service change.

- June
  - A targeted online patient and public survey (including easy read and screen-reader friendly versions) and paper versions within each of the specialist areas was conducted to capture experiences of current users as well as exploring what is important to them in the new Specialist Hospital building.
  - A staff survey exploring the level of knowledge and understanding about the new building and asking what is important to staff as they work in their new environment.

The surveys are now closed and in total 579 responses were received: 354 from staff and 225 from patients. Analysis of the responses is underway and a key findings report, highlighting themes and considerations, will be available to inform the Full Business Case.

Plans for engagement between now and September 2022 includes:

- July 2022
  - Maternity Voices Partnership 'a day in my shoes' walk through, capturing user experience.
- August 2022
  - Engagement on what is termed as 'Group 3' design elements (interior design/decoration, patient entertainment/digital systems). This will be developed in liaison with the 'Trust Patient Environment Group' for this project.

2.2 The new Children's Heart Centre

The decision to co-locate the new CHC next to and as part of the Great North Children's Hospital (GNCH) was taken following a formal NHS England consultation process in 2017. This was publicly endorsed by Newcastle Hospitals Trust Board in 2018.

Key stakeholders were contacted during the pre-planning engagement, including local organisations such as The Sick Children's Trust, Children's Heart Unit Fund (CHUF) and the North East and North Cumbria Congenital Heart Disease Network (the Network).

Involvement work has already begun and a strategy for patient and public involvement and engagement (PPIE) has been developed and approved by the Project Board in Autumn 2021, led by Great North Youth Collective Engagement Coordinator at the GNCH. This involvement activity contributes to the objectives cited in that strategy, for patients and families/clinical teams respectively, which are to:

- Engage with patients and families in a way they feel comfortable with and can actively engage with to gain their insight and aspirations for the project (patients and family's objective); and
- Support the clinical team to embed true engagement with patients in order to deliver projects with significant impact (clinical teams' objective).

Engagement with patients, parents/families/carers and key stakeholders, as well as staff, is where the rich feedback sought by the Trust will be found. The Trust is keen to make this as

inclusive as possible, working both within and beyond the hospital setting and alongside networks and communities more widely across the North East and North Cumbria, reflecting the service's regional role.

Following the three-week pre-planning activity, further activities have been progressed, building on the Involvement strategy developed. A series of involvement activities with patients, their parents/families/carers, key stakeholders and staff have also taken place in May, where people were engaged via the Network to take part in online group sessions and 121 telephone interviews and were asked what's important to them about the services provided and what they would like to see in the new building.

Initially, four online sessions have spoken to a total of seven young patients, parents and adult patients and six telephone interviews took place. The feedback on both best ways to engage and elements of the move itself were collated and presented at the CHC Project Board on 1 June.

The feedback has led to the establishment of a standing involvement group who have contributed to the development of ongoing engagement during June and July which includes:

- June 2022
  - Session with key Trust staff to gather their feedback on specific areas of the interior design of the Centre - playroom, sitting room and inpatient bedrooms[5].
  - Presentation at CHC Project Board meeting.
- July 2022
  - Presentation at Trust Advising on the Patient Experience (APEX) group.
  - Presentation for CHC Services staff (Team meeting).
  - Face to face engagement with young people at Young Persons Advisory Group (YPAG) end of year event (gathering views on interior design).
  - Face to face engagement in Ward 23, PICU and outpatients, led by YPAG (gathering views on interior design).
  - Telephone calls with parents identified from Comms engagement and the CHD network.
  - Online workshop event for CHD network members (gathering views on interior design.

Other activities currently being scoped for July/August 2022 include:

  - Online workshop with CHUF parents and CHD network members.
  - Meeting with founder parents of CHUF.
  - Direct Trust communications with key stakeholders and out to the system.
  - Programme of 'Talking Heads' videos for social media.

3. LEARNINGS FROM INVOLVEMENT

As a Trust, we value feedback from those with lived experience and who have used our services. Patient experience has always been a critical component to ensuring the ongoing

[5] The format for this session was then replicated in some of the engagement.

quality and safety of our services. These projects have allowed a proactive approach to involvement to enable us to discharge our duties, collecting good insight and information to inform decisions.

It will be vital to demonstrate clearly how the insights that we gain from this work translate into concrete changes and improvements to the schemes we are pursuing so that we create services which meet the need of those who use them which will be highlighted in future reports.

We are also committed to learning from the engagement work delivered to date which will help inform how we can improve the way we involve patients, service users, parents and carers, staff, stakeholders and the wider public. We would also like to enhance our practice so that involvement creates momentum for change, and ensures that staff, clinical, patient, public and wider stakeholder involvement is sequenced and linked together.

In particular, there is more scope to provide opportunities to engage with patients and carers in particular throughout the project timeline. Involvement of patients, their carers and the public - to offer valuable lived experience - as well as other stakeholders and staff, needs to be as early as possible and built in as an integral part of the project timeline.

4. RECOMMENDATIONS

The Board are asked to note the content of the report and recommendations which are:

1. To note the Trust's statutory duty to involve people in service change.
2. To endorse our commitment to wide and open engagement with staff, patients and families involved with care at the Children's Heart Centre and with the specialties moving into the New Specialist Hospital Building.
3. To support early proactive involvement planning and activities in future change programmes.

Report of Caroline Docking
Assistant Chief Executive
20 July 2022

THIS PAGE IS INTENTIONALLY BLANK

BOARD MEETINGS - ACTIONS

Agenda item A14

Log No.	BOARD DATE	PRIVATE / PUBLIC	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
83	25/11/2021	PUBLIC	21/54 PIONEERS i) CIO Annual Report	The CIO noted that the Chair of the Audit Committee at Sunderland University had notified peers of a cyber-attack within their organisation and the CIO recommended undertaking a deep dive in relation to this. The CIO agreed to action and facilitate via the TS **[ACTION04].**	CIO/TS			12/01/22 - Date for the deep-dive to be agreed. 18/03/22 - Update requested. 24/03/22 - An update has been requested from the Chair of the Audit Committee at Sunderland University regarding the matter. 19/05/22 - Update requested from GK. 22/07/22 - Update requested from GK
87	31/03/2022	PUBLIC	iii) Director reports: a. Medical Director: including: • Quarterly Guardian of Safe Working Report • Consultant Appointments	In the GoSW report, Ms Baker requested examples of the identified local solutions to rota gaps and whether these learnings were shared with other wards and departments. The MD/DCEO agreed to request this information from the GOSW [ACTION01].	MD/DCEO			05/04/22 - The GoSW has confirmed that further examples of local solutions are included in the Annual GoSW report. This will be presented to a future Trust Board meeting. In addition the GoSW has agreed to share further examples during her regular presentation to the Trust People Committee. 20/05/22 - Awaiting submission of GOSW report. 22/07/22 - Annual Report included in BRP.
89	31/03/2022	PUBLIC	iii) Director reports: e. Human Resources Director • Gender Pay Gap Report 2021/22	Ms Edusei requested that the information contained within the report be disaggregated further to allow for greater interrogation of the data. This would allow for the review of medical and dental staff as separate groups, as well as other staff groups and via protected characteristics. The HRD advised that this information would be made available to Board members and advised that the contents of the report met with the requirements for national reporting [ACTION03].	HRD			19/05/22 - Update requested from DF. 22/07/22 - Call to be scheduled between DF and SE to clarify the action required.
91	31/03/2022	PUBLIC	iv. Health Inequalities Update	The Chairman requested a future 'spotlight on services' on the hub and spoke model utilised for the Children and Families Newcastle programme. The TS agreed to schedule this [ACTION05].	TS			19/05/22 - GE contacted the Directorate Manager for the Great North Children's Hospital and Community Services to provide dates for Spotlights for the year to schedule in session. 22/07/22 - Spotlight took place on 19/07/2022 and was well received by the Chairman and NEDs.
92	31/05/2022	PUBLIC	iii) Director Reports: Executive Chief Nurse	Being mindful of the results of the CQC 2021 National Maternity survey highlighting support for mental health as an area for improvement, Ms Baker questioned if any links had been established with the Maternal Mental Health Alliance. The ECN advised that work was being undertaken and agreed to include a summary in a future Board report [ACTION01].	MC			22/07/22 - Email circulated to MC as a reminder for the next Board Report.

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.