The Newcastle upon Tyne Hospitals NHS Foundation Trust

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 July 2021						
Title	Successful Improvement for Teams Applications						
Report of	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Prepared by	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☒		
Summary	The content of this report outlines the successful improvement for teams applications.						
Recommendation	The Board of Directors is asked to note the content of the report.						
Links to Strategic Objectives	Putting patients at the heart of everything we do and providing care of the highest standard focusing on safety and quality.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☒	☐	☐	☐
Impact detail	Detailed within the report.						
Reports previously considered by	New report.						

SUCCESSFUL IMPROVEMENT FOR TEAMS APPLICATIONS

Application Ref:	**Team**	**Directorate**	**Sponsor**	**Number of delegates in team**	Teams members	Senior Sponsor
T009	Theatre Utilisation Working Group (RVI and CAV), Ophthalmology	EPOD – Ophthalmology	Julie Graham, Matron Ophthalmology, EPOD	5	Barbara Bettany, Theatre Sister, Carol Hughes, WD 21 Sister, Julie Graham, Matron, Krishnamoorthy Narayanan, Clinical Lead, Consultant Ophthalmologist Leanne Chambers, Admin Manager	Julie Graham, Matron Ophthalmology, EPOD
T013	Nutrition team - implement an electronic meal ordering system	Therapies	Lisa Guthrie	5	James Callaghan Head of Service Nutrition and Dietetics Paula Coulson Nurse Specialist Nutrition and Hydration Iain Clarke Assistant Catering Manager Jen Taylor Clinical Dietetic Manager Michael Bowman Deputy Catering Manager	Lisa Guthrie
T017	NUTH Palliative Care Service/Deciding Right Steering Group	Cancer	Ashraf Azzabi, Clinical Director Cancer services Peter Towns, Associate Director of Nursing	5	Lizzy Zabrocki , Nurse Specialist in End of Life Care Alexa Clark, Consultant in Palliative Medicine Denise O'Neill, Palliative Care Nurse Specialist Joe Cosgrove, Consultant in Anaesthesia and Intensive Care Medicine and Deciding Right Lead Karen Hertwick, Palliative Care Nurse Specialist	Peter Towns, Associate Director of Nursing Ashraf Azzabi, Clinical Director Cancer services
T020	Create Vascular Access Team for the RVI	Peri-op	Andrew Watson and Gus Vincent, Directorate Manager and Clinical Director, Perioperative and Critical Care	5	Bethan Beharall, Vascular access nurse specialist Nicola McGahon, Staff nurse Piotr Lyba, Staff nurse Luke Foster, Staff nurse Barry Paul, Consultant in Anaesthesia and ICM	Andrew Watson and Gus Vincent, Directorate Manager and Clinical Director, Perioperative and Critical Care

T027	Recognition and Management of the Deteriorating Pregnant Woman	Women's	Angela O'Brien, Director of Quality and Effectiveness, MatNeo SIP Lead, Dr Paul Moran, Clinical Director	5	Nicky Mudd, Band 7 Midwife, Maternity Assessment Unit Sophie Rutherford, Band 6 Midwife, Maternity Assessment Unit Philippa Marsden, consultant obstetrician Nikky King, Band 7 Midwife, Delivery Suite Kitty Roberts, consultant obstetric anaesthetist	Angela O'Brien, Director of Quality and Effectiveness, MatNeo SIP Lead Dr Paul Moran, Clinical Director
T028	GRIP – GNBSI Reduction In PTBD (Percutaneous Transhepatic Biliary Drainage) related cases, Microbiology, IPC and IR	IPC, Labs, Radiology	Dr Lucia Pareja-Cebrian – DIPC Dr Julie Samuel, Clin Lead, Microbiology, Directorate ILM	5	Deepa Nayar, Consultant Microbiologist Ralph Jackson, Consultant IR Rob Williams, Consultant IR James Cheaveau, Spr in Microbiology Gillian Lishman, Matron IPCN	Dr Lucia Pareja-Cebrian – DIPC Dr Julie Samuel, Clin Lead, Microbiology, Directorate ILM

T029	ABSS-ED Emergency Department - Antibiotic within 1hr - Stewardship - Sepsis	Medicine	Lucia Pareja-Cebrian, DIPC, Consultant Microbiologist. Ashley Price Antimicrobial Stewardship LEAD, Consultant.	5	Melissa Burnside, Trust Deterioration/Sepsis Specialist Nurse Deepa Nayar, Consultant Microbiology Ashley Price, Consultant Physician, AMS Lead Bob Jarman, Consultant ED, ED Sepsis Lead, Lindsey Udberg, Senior Sister ED	Lucia Pareja-Cebrian, DIPC, Consultant Microbiologist. Ashley Price Antimicrobial Stewardship LEAD, Consultant.
T032	GNCH Long-Term Resident Children - A Cause to Smile Again!!	Dental & Children's	Dr Yincent Tse, Consultant Paediatric Nephrologist & Lead for Quality and Safety Dr G Walton Dental Clinical Director (prospective) Consultant in Special Care Dentistry Dr B Cole Dental Clinical Director (current) Consultant in Paediatric Dentistry	5	Nicky Lush, Consultant in Paediatric Dentistry Jadwiga Campbell Hewson, Paediatric Leukaemia Nurse Specialist Oli Sumner, ST5 Paediatric Dentistry Sunil Bhopal, Specialty Trainee General Paediatrics Specialty – RVI/GNCH Courtney Thom, Staff Nurse Ward 1b GNCH	Dr Yincent Tse, Consultant Paediatric Nephrologist & Lead for Quality and Safety Dr G Walton Dental Clinical Director (prospective) Consultant in Special Care Dentistry Dr B Cole Dental Clinical Director (current) Consultant in Paediatric Dentistry

T033	Delivering sustainable labour analgesia	Women's & SHINE	Mr James Dixon Head of sustainability, Newcastle Hospitals	5	Dr Chris Allen Anaesthetics registrar, national Fellow in Environmentally Sustainable Anaesthesia Dr Therese Hannon Consultant Fetal Medicine and Obstetrics, RVI Clinical Intrapartum Lead Ms Lynsey McKay, Matron, Delivery suite, RVI Mr Tom Rutherford, Engineer, Estates department, RVI Dr Katy Whitehouse, Consultant obstetric anaesthetists, RVI	Mr James Dixon Head of sustainability, Newcastle Hospitals
T034	Education Team, Rheumatology, MSK - develop patient educational resources	Musculoskeletal	Sophie Blakey; Deputy Matron	5	Gemma O'Callaghan – Rheumatology Speciality OT Wendy Ritchie – Assistant Out Patient Sister MSK OPD Julie Norris – CTD and Vasculitis Prescribing Nurse Specialist Ejaz Pathan – Consultant; Research Lead Alice Lorenzi – Consultant; Clinical Lead	Sophie Blakey; Deputy Matron
T037	Mouth Care Matters	Dental	Dr Graham Walton Consultant in Special Care Dentistry	5	Ailsa Nicol - Consultant in Restorative Dentistry Debora Howe – Oral Health Promotion Practitioner HEE-funded Mouth care matters lead clinician (to be appointed) Mary Gittins –Senior Dental Officer Fiona Marshall- Speech and Language Therapist (RVI)	Dr Graham Walton Consultant in Special Care Dentistry
T038	RUG – Reducing Urinary GNBSI, FH15 & FH18, Medical directorate	Medicine & IPC	Lisa Guthrie - Associate Director of Nursing Dr Lucia Pareja-Cebrian – DIPC	5	Jackie Rees, Nurse Consultant Linda Morgan, Matron Carol Gilhespy, Nurse Educator Rachel Black, IPCN Angela Cobb, IPC Lead	Lisa Guthrie - Associate Director of Nursing Dr Lucia Pareja-Cebrian – DIPC

TL006	CGARD - Self Harm Ward 43	CGARD	Angela O'Brien, Director of Quality and Effectiveness	5	Health, Safety and Risk Lead - Craig Newby Nurse Specialist Patient Safety – K Collingwood Matron - Kerry Bell Charge nurse - Matthew Crowther Trust Chaplain - Katie Watson2	Angela O'Brien Director of Quality and Effectiveness
T035	Finance - application of finance coding through the electronic procurement process	Finance	Gary Turner (Head of Financial Management)	5	Elias Boussakta (Assistant Accountant) Chris Quince (Deputy Directorate Accountant) Hilary Swinhoe (Assistant Directorate Accountant) Tanya Tomlinson (Assistant Directorate Accountant) Julie Trotter (Head of P2P and Operations)	Gary Turner (Head of Financial Management)
T046	On boarding and Induction Design and Quality Assurance Improvement Group	HR, Training, Comms	Dee Fawcett, Director of Human Resources Caroline Docking, Assistant Chief Executive Gill Long, Associate Director Education and Training and Workforce Development Donna Watson, Head of Workforce Engagement	5	lynn Oxley, Workforce Development Manager – Learning and Development Michelle Davies, Communications Officer Rachel Cockburn, HR Manager – Recruitment Steven Hewitt, Workforce Development Officer – Learning and Development Member of staff – Staff engagement – details to be confirmed	Dee Fawcett, Director of Human Resources Caroline Docking, Assistant Chief Executive Gill Long, Associate Director Education and Training and Workforce Development Donna Watson, Head of Workforce Engagement
T011	Frailty In reach Team	Medicine	Chris Gibbins/Keecia Bailey Clinical Director Medicine/Directorate Manager Medicine	5	Kelly Hunt, consultant geriatrician Amanda Kilsby, consultant geriatrician Claire Wilson, Associate specialist Seema Haridas, Senior Physiotherapist with Care Coordination Team Sinead McHugh, Lead Clinical Pharmacist for Older People's Medicine	Chris Gibbins/Keecia Bailey Clinical Director Medicine/Directorate Manager Medicine

T051	Deep Brain Stimulation and Neuromodulation Team	Neurosciences	Martin Duddy	5	Prof Nicola Pavese, Consultant Neurologist Dr David Ledingham, Consultant Neurologist Miss Claire Nicholson, Consultant Neurosurgeon Mr Mohammed Hussain, Consultant Neurosurgeon Mr Russell Mills, DBS Clinical Nurse Specialist	Dr Martin Duddy, Clinical Director

Report of Andy Welch
Medical Director
21st July 2021

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	29 July 2021						
Title	Consultant Appointments						
Report of	Andy Welch, Medical Director						
Prepared by	Colin Sakhe, 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 20 May 2021 and interviewed 3 candidates for 1 Consultant Cardiologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Mohammad Alkhalil.

Dr Alkhalil holds MD (University of Damascus) 2003 and MRCP (UK) 2009. Dr Alkhalil is currently employed as a Locum Consultant Cardiologist based at the Freeman Hospital.

Dr Alkhalil took up the post of Consultant Cardiologist in in July 2021.

1.2 An Appointments Committee was held on 21 May 2021 and interviewed 3 candidates for 2 Consultant Nephrologist posts.

By unanimous resolution, the Committee was in favour of appointing Professor Caroline Wroe and Dr Iain Moore.

Professor Wroe holds MbChB (University of Birmingham) 1997, MRCP (UK) 2000 and PhD (University of Newcastle) 2010. Professor Wroe is currently employed as a Consultant Nephrologist by the South Tees Hospitals NHS Foundation Trust.

Dr Moore holds MbChB (University of Birmingham) 1997, MRCP (UK) 2000 and PhD (University of Newcastle) 2010. Dr Moore is currently employed as a Consultant Nephrologist by the South Tees Hospitals NHS Foundation Trust.

Professor Wroe is expected to take up the post of Consultant Nephrologist in September 2021.

Dr Moore is expected to take up the post of Consultant Nephrologist in October 2021.

1.3 An Appointments Committee was held on 25 May 2021 and interviewed 4 candidates for 1 Consultant Neurosurgeon post.

By unanimous resolution, the Committee was in favour of appointing Mr Ian Craig Coulter.

Mr Coulter holds MBBS (University of Newcastle) 2008 and FRCS (UK) 2018. Mr Coulter was previously employed as a Locum Consultant Neurosurgeon based at the Royal Victoria Infirmary.

Mr Coulter took up the post of Consultant Neurosurgeon in June 2021.

1.4 An Appointments Committee was held on 27 May 2021 and interviewed 4 candidates for 3 Consultant Oncologist posts.

By unanimous resolution, the Committee was in favour of appointing Dr Jayshree Veeratterapillay, Dr Sally Hall and Dr Zin Win.

Dr Veeratterapillay holds MBBS (University of Newcastle) 2010 and FRCR (UK) 2018. Dr Veeratterapillay is currently employed as a Specialty Trainee based at the Freeman Hospital.

Dr Hall holds MBBS (University of Newcastle) 2008 and MRCP (UK) 2011. Dr Hall is currently employed as a Specialty Trainee based at the Freeman Hospital.

Dr Win holds MBBS (Myanmar) 2002, MRCP (UK) 2010 and FRCR (UK) 2020. Dr Win is currently employed as a Specialty Trainee based at the Freeman Hospital.

Dr Veeratterapillay, Dr Hall and Dr Win are all expected to take up the posts of Consultant Oncologists in October 2021.

1.5 An Appointments Committee was held on 01 June 2021 and interviewed 2 candidates for 1 Consultant Ophthalmologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Paul Meredith.

Dr Meredith holds MBBS (University of Cambridge) 2010, MRCP (UK) 2012 and FRCOphth (UK) 2018. Dr Meredith is currently employed as an Oculoplastic fellow by the Cardiff and Vale University Health Board.

Dr Meredith is expected to take up the post of Consultant Ophthalmologist in January 2022.

1.6 An Appointments Committee was held on 04 June 2021 and interviewed 1 candidate for 1 Consultant Adult Anaesthetist post.

By unanimous resolution, the Committee was in favour of appointing Dr Lucy Powell.

Dr Powell holds MBBS (King's College London) 2010 and FRCA (UK) 2016. Dr Powell is currently employed as a Specialty Trainee based at the Royal Victoria Infirmary.

Dr Powell is expected to take up the post of Consultant Adult Anaesthetist in September 2021.

1.7 An Appointments Committee was held on 14 June 2021 and interviewed 1 candidate for 1 Consultant Paediatric Haematologist post.

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

Dr Fletcher holds MBChB (University of Abereen) 1998, MRCPCH (UK) 2004 and FRCPath (UK) 2011. Dr Fletcher is currently employed as a Locum Consultant Paediatric Haematologist by the Birmingham Women's and Children's NHS Foundation Trust.

Dr Fletcher is expected to take up the post of Consultant Paediatric Haematologist in September 2021.

1.8 An Appointments Committee was held on 16 June 2021 and interviewed 2 candidates for 1 Consultant Spinal Surgeon post.

By unanimous resolution, the Committee was in favour of appointing Mr Mallikarjun Chandrappa.

Mr Chandrappa holds MBChB (India) 2002 and FRCS (UK) 2013. Mr Chandrappa is currently employed as Locum Consultant Spinal Surgeon based at the Royal Victoria Infirmary.

Mr Chandrappa is expected to take up the post of Consultant Spinal Surgeon in September 2021.

1.9 An Appointments Committee was held on 17 June 2021 and interviewed 2 candidates for 2 Consultant Cellular Pathologist posts.

By unanimous resolution, the Committee was in favour of appointing Dr Emma Spoor and Dr Mary Ferrier.

Dr Spoor holds MBBS (University of Newcastle) 2013 and FRCPath (UK) 2020. Dr Spoor is currently employed as a Specialty Trainee based at the Royal Victoria Infirmary.

Dr Ferrier holds MBChB (University of Leeds) 2012 and FRCPath (UK) 2020. Dr Ferrier is currently employed as a Specialty Trainee based at the Royal Victoria Infirmary.

Both Dr Spoor and Dr Ferrier are expected to take up the posts of Consultant Cellular Pathologists in December 2021.

1.10 An Appointments Committee was held on 23 June 2021 and interviewed 3 candidates for 2 Consultant in Emergency Medicine posts.

By unanimous resolution, the Committee was in favour of appointing Dr Jessica Ross and Dr Alastair Hogg.

Dr Ross holds MBChB (University of Leeds) 2007 and FRCEM (UK) 2018. Dr Ross is currently employed as a Trust Doctor in Emergency Medicine based at the Royal Victoria Infirmary.

Dr Hogg holds MBChB (University of Dundee) 2011 and FRCEM (UK) 2020. Dr Hogg is currently employed as a Specialty Trainee in Emergency Medicine based at James Cook University Hospital.

Dr Ross is expected to take up the post of Consultant in Emergency in October 2021.

Dr Hogg is expected to take up the post of Consultant in Emergency Medicine in October 2021.

1.11 An Appointments Committee was held on 24 June 2021 and interviewed 1 candidate for 1 Consultant Interventional Neuroradiologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Amar Chotai.

Dr Chotai holds MBBS (Kings College London) 2012 and FRCR (UK) 2018. Dr Chotai is currently employed as a Specialty Trainee based at the Royal Victoria Infirmary.

Dr Chotai is expected to take up the post of Consultant Interventional Neuroradiologist in November 2021.

1.12 An Appointments Committee was held on 08 July 2021 and interviewed 1 candidate for 1 Consultant Endocrinologist/ Diabetologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Maria de los Angeles Maillo-Nieto.

Dr Maillo-Nieto holds MBBS (Spain) 2012 and MSc Medical Education (University of Newcastle) 2022. Dr Maillo-Nieto is currently employed as a Consultant in Diabetes, Endocrinology and General Internal Medicine by the South Tees Hospitals NHS Foundation Trust.

Dr Maillo-Nieto is expected to take up the post of Consultant Endocrinologist/ Diabetologist in October 2021.

2. RECOMMENDATION

1.1 – 1.12 – For the Board to receive the above report.

Report of Andy Welch
Medical Director
20 July 2021

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	29 July 2021						
Title	Guardian of Safe Working Quarterly Report (Q1 2021-22)						
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours						
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	The terms and conditions of service of the new junior doctor contract (2016) require the Guardian of Safe Working Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant. The content of this report outlines the number and main causes of exception reports for the period 27 March to 26 June 2021, which was considered by the Trust People Committee on 16 July 2021, prior to submission to the Trust Board.						
Recommendation	The Trust Board is asked to note the contents of this report.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	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	Quarterly report of the Guardian of Safe Working Hours. Report considered at the People Committee on 16 July 2021.						

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

EXECUTIVE SUMMARY

This quarterly report covers the period 27 March to 26 June 2021.

There are now 828 trainees on the New Junior Doctor Contract and a total of 1,030 junior doctors in the Trust.

There were 71 exception reports in this period. This compares to 61 exception reports in the previous quarter.

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

The main cause of exception reports is when there is excessive workload which was not appropriate to hand over to on call teams. This is exacerbated when there are low staffing levels on the wards.

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. INTRODUCTION / BACKGROUND

The 2016 New Junior Doctor Contract came into effect on 3 August 2016 and was reviewed in August 2019, with changes implemented in a staggered approach from August 2019 to October 2020.

The TCS of the 2016 contract allows for exception reporting to raise reports on breaches of working hours and educational opportunities. These are ratified or rejected as appropriate by clinical supervisors and the process is overseen by the Guardian of Safe Working Hours.

The TCS require the Guardian of Safe Working Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant.

2. HIGH LEVEL DATA

		(Previous quarter data for comparison)
Number of Junior Doctors on New Contract	828	(897)
Number of Exception reports	71	(61)
Number of Exception reports for Hours Breaches	70	(55)
Number of Exception reports for Educational Breaches	6	(8)
Fines	2	(2)

Admin Support for Role	Good
Job Planned time for supervisors	Variable

3. EXCEPTION REPORTS

3.1 Exception Report by Speciality (Top 3)

General Medicine	43
General Surgery	13
Orthopaedics	6

3.2 Exception Report by Rota

General Medicine RVI F1/F2	24
General Medicine FH F1	10
General Surgery FH F1	8
Trauma & Orthopaedics RVI	6

General Surgery RVI F1	5
General Medicine FH SHO	5

3.3 Exception Report by Grade

Foundation Year 1	49
F2	6
SHO	7
IMT	6
SpR	3

3.4 Example Themes from Exception Reports

General Medicine RVI/FH

"Workload meant I was unable to finish ward round and jobs until later than scheduled finish time. Did not have any break during the day for lunch etc. Ongoing issue of high workload on the ward; have yet to leave on time whilst on the ward; this is a problem for all junior staff on the ward"

Issues of workload are exacerbated when there is minimum staffing on wards and doctors who are unfamiliar with the patients.

General Surgery Freeman/RVI F1

"Under minimum staffing for parts of the day (3 juniors minimum). Stayed 1.5 hours behind to finish jobs that required to be done that day."

Increasing workload has exacerbated issues with low staffing.

Trauma & Orthopaedics RVI F1

"Covering spinal team patients and paeds. No SHO cover for spinal team due to rota gaps. Unable to complete wards jobs in working hours."

4. EXCEPTION REPORT OUTCOMES

4.1 Work Schedule Reviews

There have been no work schedule reviews carried out due to exception reports.

4.2 Fines

2 fines have been issued:

- Oncology: £176.33. Rule breached "Whilst on-call a doctor must get 8 hours rest per 24 hours, of which 5 must be continuous between 2200 and 0700".

- Trauma & Orthopaedics RVI: £43.54. Rule breached "Unable to achieve 11 hours rest between resident shifts."

5. ISSUES ARISING

5.1 Workforce and workload

The recurring theme as to when exception reports are raised is when there is a reduction of trainee numbers on the ward or high workloads due to multiple unwell patients. Some wards, particularly the medical wards have experienced very high workloads. The surgical wards are seeing increasing workloads with gaps in staffing.

5.2 Supervisor Engagement

Supervisor engagement has improved with some positive solutions to help juniors to manage workload. Weekly prompting by the medical staffing team has reduced supervisor response time.

5.3 Administrative Support

Administrative support is currently excellent.

6. ROTA GAPS

Specialties and rotas with gaps as of June 2021 are outlined below.

Directorate	Site	Specialty/Sub Specialty	Grade	No. required on rota (at full complement)	Jun-21
Cancer Services		**Cancer Services**			
Cancer Services	FH	Oncology	ST3+	14	1.7
Cancer Services	FH	Palliative Medicine	F2/ST1+	13	3.1
Cancer Services	FH	Haematology / Oncology	F2/ST1/ST2	10	1
Cancer Services	FH	Haematology	ST3+	10 (from Jan 2021)	2
Cardiothoracic Services		**Cardiothoracic Services**			
Cardiothoracic Services	FH	Cardiology	F2/ST1-2	5	1
Cardiothoracic Services	FH	Cardiology	ST3+	15	1
Cardiothoracic Services	FH	Cardiothoracic Anaesthesia	ST3+	9	1
Cardiothoracic Services	FH	Cardiothoracic Surgery	ST3+	11	4
Cardiothoracic Services	FH	Cardiothoracic Transplant	ST3+	3	1

Directorate	Site	Specialty/Sub Specialty	Grade	No. required on rota (at full complement)	Jun-21
Cardiothoracic Services	FH	PICU	ST3+	9 (inc day cover with GNCH & Paeds Cardiology	0.2
Cardiothoracic Services	FH	Paediatric Cardiology 1st	F2/ST1/ST2	7	2
Cardiothoracic Services	FH	Paediatric Cardiology 2nd	ST3+	9 (from Jan 2021)	2.2
Children's Services		**Children's Services**			
Children's Services	RVI	Paediatric Surgery 2nd	ST3+	9 (8 from Nov 20)	1.8
Children's Services	RVI	Paediatrics 1st - ST1/ST2 (now inc Paeds Surgery)	F2/ST1/ST2	30	2.8
Children's Services	RVI	General Paediatrics	ST3+	21	2.8
EPOD		**EPOD**			
EPOD	FH	ENT	F2 / CST / ST1-2	6	1
EPOD	RVI	Plastic Surgery	F2/ST1/ST2	10	1
EPOD	RVI	Plastic Surgery	ST3+	13	2
EPOD	RVI	Ophthalmology	F2/ST1/ST2	6	1
EPOD	RVI	Ophthalmology	ST3+	24	6
EPOD	RVI	Dermatology	ST3+	9	1.8
Integrated Lab Medicine		**Integrated Lab Medicine**			
Integrated Lab Medicine	RVI	Histopathology	ST3+	13	3.5
Integrated Lab Medicine	RVI	Histopathology	ST1/2	8	2
Integrated Lab Medicine	C4L	Genetics	ST3+	4	1.7
Integrated Lab Medicine	RVI	MM rota integrated with ID and MV and GIM	ST1+	21	1.4
Medicine		**Medicine**			
Medicine	FH	General Internal Medicine	F2/GPVTS/CMT/TF	21	1.4
Medicine	RVI	Acute Medicine	Trust Doctors	9	4
Medicine	RVI	CMT BOH and FOH Combined (August 2019)	CMT	11	1.4
Medicine	RVI	General Internal Medicine	ST3+	25	1.5
Medicine	FH	Care of the Elderly	ST3+	5	2
Medicine	RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	20	2
Medicine	RVI	Accident & Emergency 2nd	ST3+	15 (14 from Nov 20)	2
Musculoskeletal		**Musculoskeletal**			

Directorate	Site	Specialty/Sub Specialty	Grade	No. required on rota (at full complement)	Jun-21
Musculoskeletal	FH	Orthopaedics	F2/ST1/ST2	6	2
Musculoskeletal	RVI	Orthopaedics	F2/ST1/ST2	5	1
Musculoskeletal	RVI/FRH	Orthopaedics	ST3+	19	1.2
Neurosciences		**Neurosciences**			
Neurosciences	RVI	Neurosurgery	F2/ST1/ST2	5	1
Neurosciences	RVI	Neurosurgery	ST3+	13	1
Neurosciences	RVI	Neurology	ST3+	13	0.2
Neurosciences	RVI	Neurophysiology	All grades	2	1.4
Peri-operative & Critical Care		**Peri-operative FH**			
Peri-operative & Critical Care	FH	Critical Care	F2 ST1-7	11	3
Peri-operative & Critical Care	FH	Anaesthetics General	ST1-7 CT1-2	29	1.2
Peri-operative & Critical Care		**Peri-operative RVI**			
Peri-operative & Critical Care	RVI	Critical Care	ST1+	18	3.2
Peri-operative & Critical Care	RVI	Anaesthetics	ST1-2 / ST3 +	44	0.6
Radiology		**Radiology**			
Radiology	RVI / FH	Radiology On Call	ST2 / ST3+	33	0.4
Radiology	RVI / FH	Neuroradiology	All grades	4	1
Surgical Services		**Surgical Services**			
Surgical Services	FH	Vascular	ST3+	10.5 (11 from May 2021)	2
Surgical Services	FH	Hpb / Transplant	ST3+	11	1
Surgical Services	RVI	General Surgery	F2/ST1/ST2	7	1
Surgical Services	RVI	General Surgery	ST3+	17	1.6
Surgical Services	FH	IoT - NSR & Teaching Fellows	ST1-2 NSR TFs	4	1
Urology		**Urology & Renal**			
Urology	FH	Renal Medicine	F2/ST1/ST2	5	1
Urology	FH	Renal Medicine	ST3+	9	1.2
Urology	FH	Urology	ST3+	11	1.2
Womens' Services		**Womens' Services**			
Womens' Services	RVI	Obstetrics & Gynaecology	F2/ST1/ST2	14	2.2
Womens' Services	RVI	Obstetrics & Gynaecology	ST3+	22	1.6
Womens' Services	RVI	Neonates	F2/ST1/ST2	7	1

7. LOCUM SPEND

LET Locum spend April – June 2021 (Q1 2021-22): £292,533.

Trust Locum spend April – June 2021 (Q1 2021-22): £699,617.

LET Locum spend Jan – March 2021 (Q4 2020-21): £406,153.18 (high due to early closedown of payroll for December and processing of claims prior to year-end, as explained in previous report).

Trust Locum spend Jan – March 2021 (Q4 2020-21): £692,362.

Values in previous reports have understated the true cost, as they represented basic salary only. Q4's Trust locum spend has therefore been recalculated to include NI and superannuation for comparison. (Figures supplied by Finance directorate).

8. REVISION TO 2016 JUNIOR DOCTOR CONTRACT

It is a recommendation of the contract that no rotas have a frequency of more than 1 in 3 weekends. There remains 3 rotas (PICU RVI, Neonates, Cardiothoracic transplant) where the weekend frequency exceeds 1 in 3. Plans are in place to rectify the PICU and Neonates rotas.

9. RISKS AND MITIGATION

The main risk remains medical workforce coverage across a number of rotas. Workload has increased this quarter, and in areas of high workloads junior doctors have stayed late and often missed breaks to ensure the work is completed. This is exacerbated when wards are on minimum staffing levels. Directorates are aware of the issues and where problems persist are looking for solutions.

10. JUNIOR DOCTOR FORUM

In addition to discussions around provision of hot food out of hours and rest facilities, the main area of discussion was around staffing levels. Medicine, surgery and paediatric surgery reported areas and times when low staffing levels have resulted in difficulty getting annual leave, study leave and educational opportunities. Gaps were being offered as locums, but at times these were not being filled.

11. RECOMMENDATIONS

I recommend that we continue to be proactive at assessing the workforce/workload balance, and continue to find local solutions to ensure that patient safety and excellent training are maintained.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
6 July 2021

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COVID-19 OCCUPATIONAL HEALTH SERVICE (OHS) ACTIVITY

Covid-19 related activity	Dates	Publication/clinical effectiveness/audit
Travel advice – returning travellers quarantine advice	Feb 2020-ongoing	All the OH team were involved in the early recognition of Covid-19 and implementation of very early Covid-19 advice.
PCR swabs -symptomatic staff	March 2020 - ongoing	Published papers: Editorial Membership of the Faculty of Occupational Medicine (MFOM) thesis for Peter McDowall Clinical effectiveness projects
PCR swabs -asymptomatic staff	April 2020-ongoing	OH team have developed clinical pathways and lead standard operating procedure development. Implementation of an electronic app, which was developed, by Dr Murphy, Consultant Physician in Occupational Health and Mr Steven Forster, Clinical Lead/Service Manager, was based on demographic questions following on from initial work of Peter McDowall.
Redeployment of staff during first wave		OH team have supported training and leadership of new members of the team including mentoring medical student volunteers.
Blood tests for antibody	April 2020	Thesis for Mark Leeming (Speciality Trainee).
Establishing a telephone helpline		The OH team establishes a rapid response telephone line which was supported by redeployed staff initially. The results were evaluated by the psychology team and published in 'Occupational Medicine'.
Posters and self-help materials- face masks, anxiety symptoms		Jenny Matthewson, Assistant Psychologist. Adopted nationally by NHS Trusts and London transport.
Evaluation and posters related to immediate health concerns		OH team have contributed to posters and service evaluation of Covid-19 associated activity.
Shielding advice	March 2020 December 2020 March 2021	All the team have been directly involved in developing advice and supporting those in the Shielding and clinically extremely vulnerable groups since the impact of Covid-19 has been understood on those at risk. All have been able to support staff to return to meaningful work in partnership with Human Resources and managers. This has resulted in national advice being developed based on audit of the Newcastle response.
Clinically extremely vulnerable	2020	Paper submitted to Dr Jenny Harries Deputy Chief Medical Officer (CMO).

Covid-19 related activity	Dates	Publication/clinical effectiveness/audit
Pregnancy guidance	March 2020 Aug 2020 October 2020	All the team have been involved in advising and responding to the guidance for pregnant health care workers including advice on remote working beyond 28 weeks.
Risk assessments	March 2020	Advising and responding to the guidance for risk assessment of health care workers including advice on remote working, use of PPE, social distancing, other risk reduction mechanisms including the potential impact of vaccination, self-testing.
Internal Test and trace	Aug 2020	The OH team were initially involved in support and management of internal outbreaks, clusters and other impacts of Covid-19 19 19 infection amongst Healthcare workers (HCW). This included advice on self-isolation, and the requirement for test and trace. Systems were developed which ultimately lead to a hand over to a bespoke Test &Trace team in November 2020.
Lateral flow testing/self-testing	Dec 2020	The OH team responded to individual queries regarding the impact of lateral flow testing and as such require a level of expertise in interpreting the guidance and results- this necessitates an understanding of the impact of disease prevalence, sensitivity and specificity in predictive values.
Covid-19 vaccinations	December 2020- ongoing	AUDIT- all the team have been involved in advising and supporting the mass Covid-19 vaccination programme for health care workers – 16,800 first doses & 16,800 second dose. Initial exclusion criteria were reviewed and presented as a poster. NHS England case study – best practice for access to vaccination for all.

Published papers

- Prior SARS-CoV-2 infection is associated with protection against symptomatic re infection.
  https://www.journalofinfection.com/article/S0163-4453(20)30781-7/abstract
  Letter to the Editor Journal of Infection
- Implementation and analysis of a telephone support service during Covid-19
  J Matthewson, A Tiplady, F Gerakios, A Foley, E Murphy
  Occupational Medicine, kqaa095, https://doi.org/10.1093/occmed/kqaa095
- Establishing a healthcare worker screening programme for **Covid-19** PDF
  Kate Boustead, Kiera McDowall, Kenneth F Baker, Lucia Pareja-Cebrian, Lewis Gibson
  Occupational Medicine, kqaa114, https://doi.org/10.1093/occmed/kqaa114

- First experience of Covid-19 -19 screening of health-care workers in England Ewan Hunter David A Price Elizabeth Murphy et al Published April 22 2020 Doi:10.1016/S0140-6736(20)30970-3
- https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(20)30970-3.pdf

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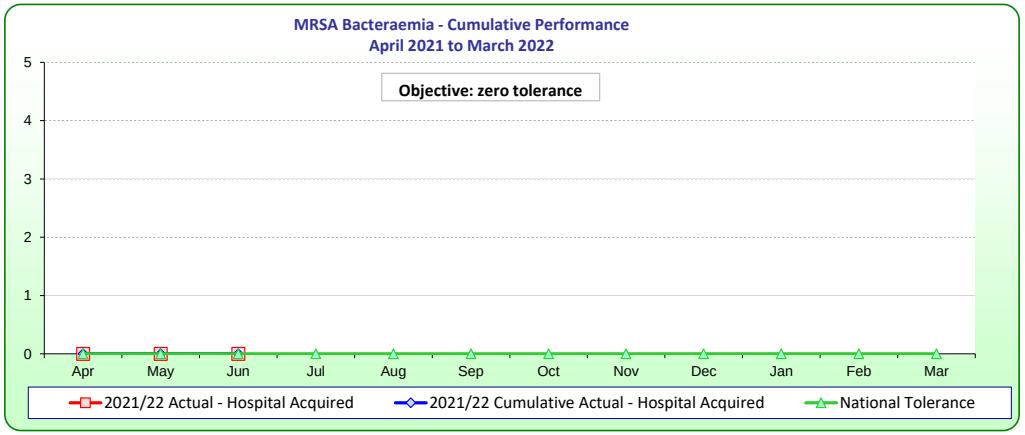
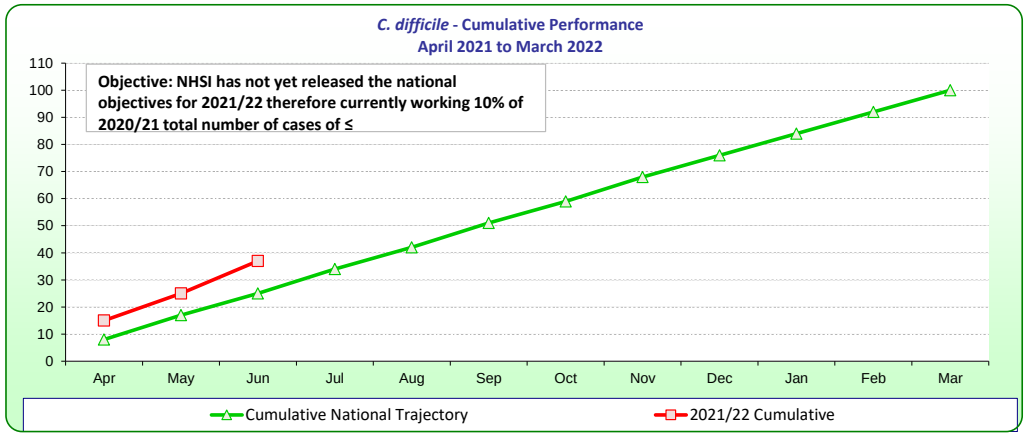
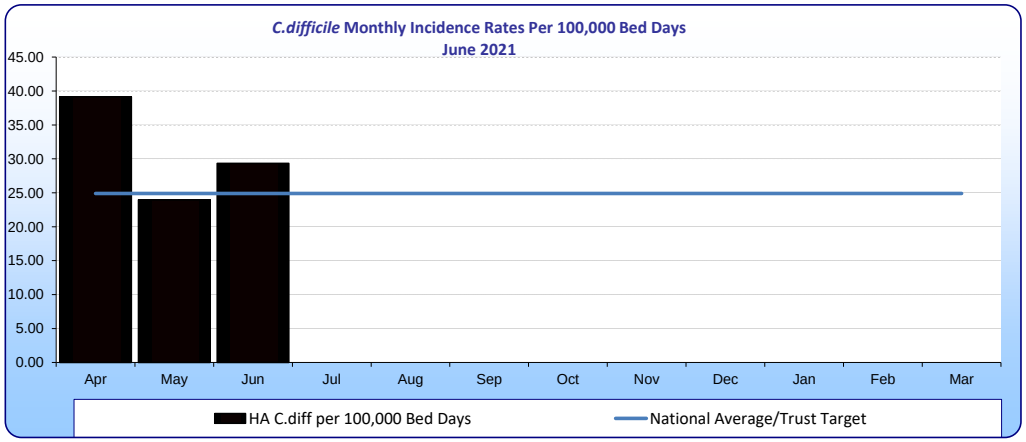
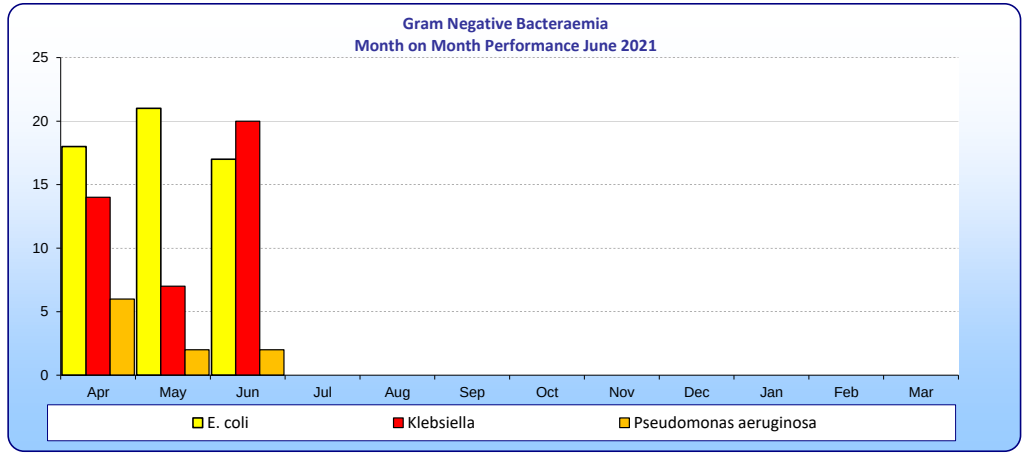
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

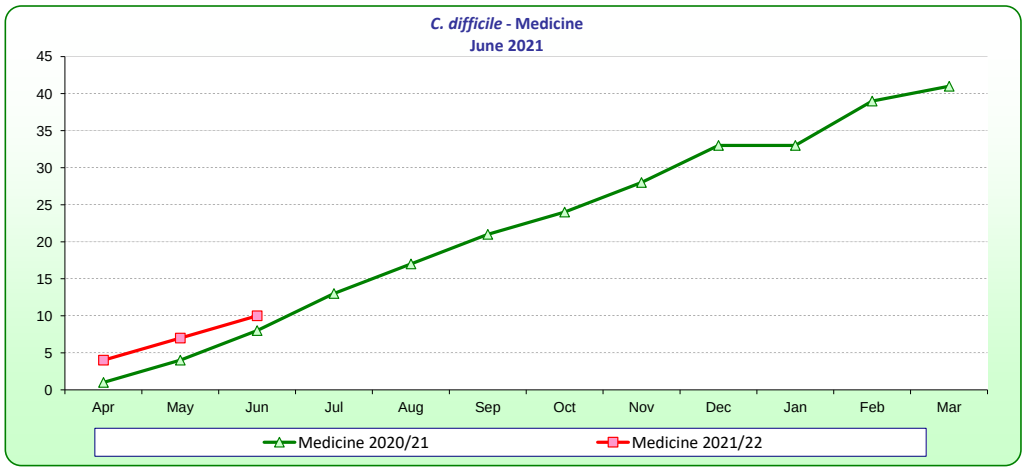
Healthcare-Associated Infections Report
June 2021


MRSA Bacteraemia - Cumulative Performance
April 2021 to March 2022
Objective: zero tolerance
0
1
2
3
4
5
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2021/22 Actual - Hospital Acquired
2021/22 Cumulative Actual - Hospital Acquired
National Tolerance


C. difficile - Cumulative Performance
April 2021 to March 2022
Objective: NHSI has not yet released the national objectives for 2021/22 therefore currently working 10% of 2020/21 total number of cases of ≤
0
10
20
30
40
50
60
70
80
90
100
110
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Cumulative National Trajectory
2021/22 Cumulative


C.difficile Monthly Incidence Rates Per 100,000 Bed Days
June 2021
0.00
5.00
10.00
15.00
20.00
25.00
30.00
35.00
40.00
45.00
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
HA C.diff per 100,000 Bed Days
National Average/Trust Target


Gram Negative Bacteraemia
Month on Month Performance June 2021
0
5
10
15
20
25
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
E. coli
Klebsiella
Pseudomonas aeruginosa


C. difficile - Medicine
June 2021
0
5
10
15
20
25
30
35
40
45
Apr
May
Jun
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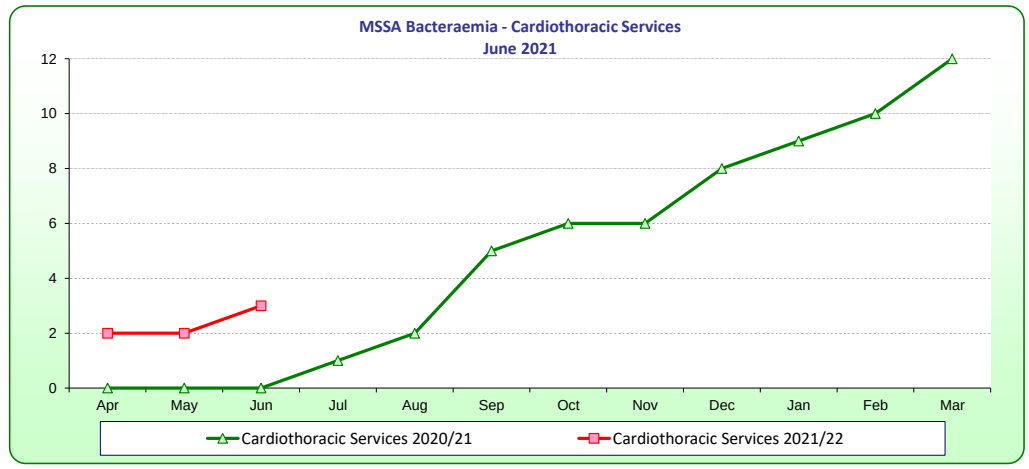
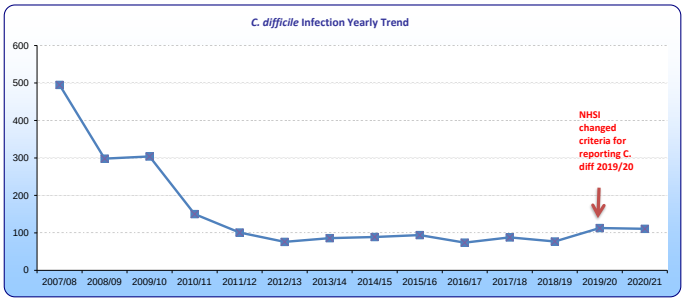
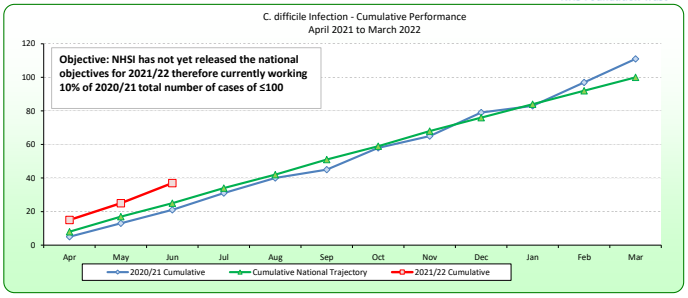
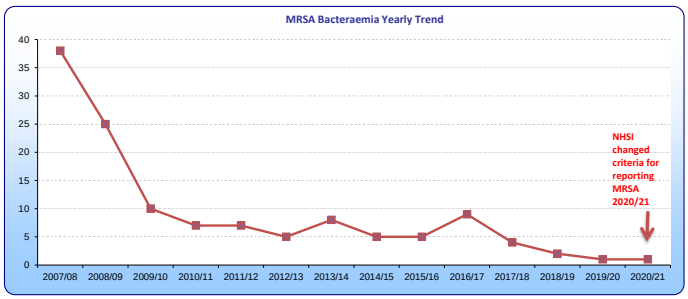
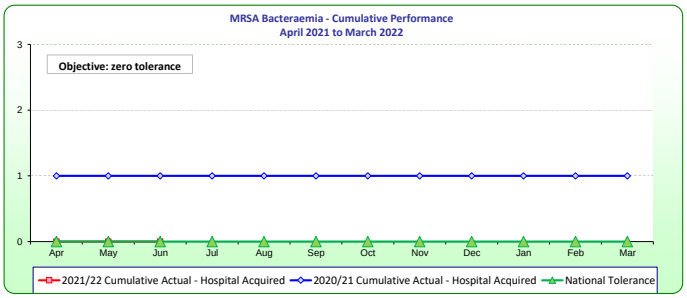
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Medicine 2020/21
Medicine 2021/22

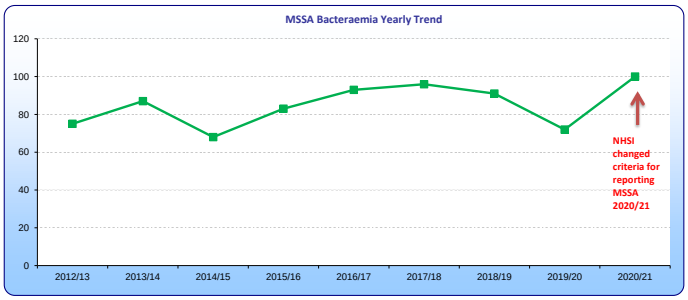

MSSA Bacteraemia - Cardiothoracic Services
June 2021
0
2
4
6
8
10
12
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Cardiothoracic Services 2020/21
Cardiothoracic Services 2021/22

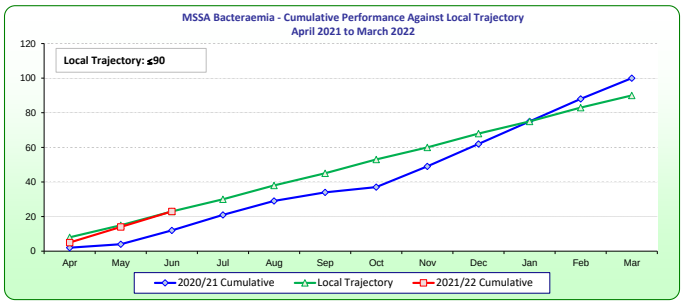

C. difficile Infection Yearly Trend
NHSI changed criteria for reporting C. diff 2019/20
2007/08 2008/09 2009/10 2010/11 2011/12 2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19 2019/20 2020/21

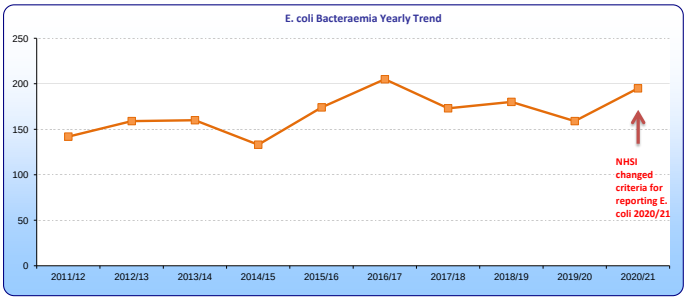

C. difficile Infection - Cumulative Performance
April 2021 to March 2022
Objective: NHSI has not yet released the national objectives for 2021/22 therefore currently working 10% of 2020/21 total number of cases of ≤100
2020/21 Cumulative
Cumulative National Trajectory
2021/22 Cumulative

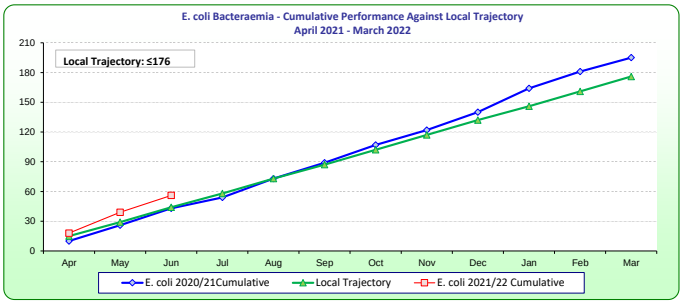

MRSA Bacteraemia Yearly Trend
NHSI changed criteria for reporting MRSA 2020/21
2007/08 2008/09 2009/10 2010/11 2011/12 2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19 2019/20 2020/21

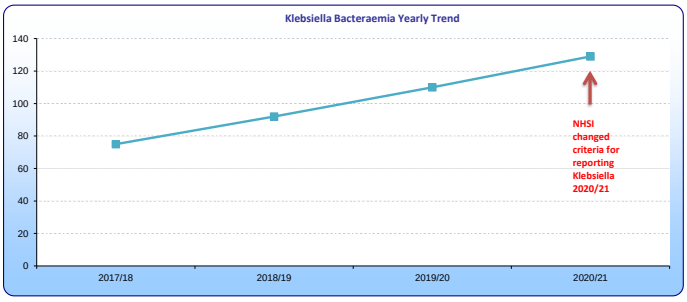

MRSA Bacteraemia - Cumulative Performance
April 2021 to March 2022
Objective: zero tolerance
2021/22 Cumulative Actual - Hospital Acquired
2020/21 Cumulative Actual - Hospital Acquired
National Tolerance

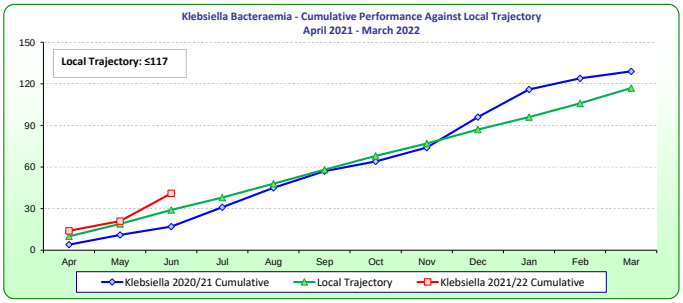

MSSA Bacteraemia Yearly Trend
NHSI changed criteria for reporting MSSA 2020/21
2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19 2019/20 2020/21

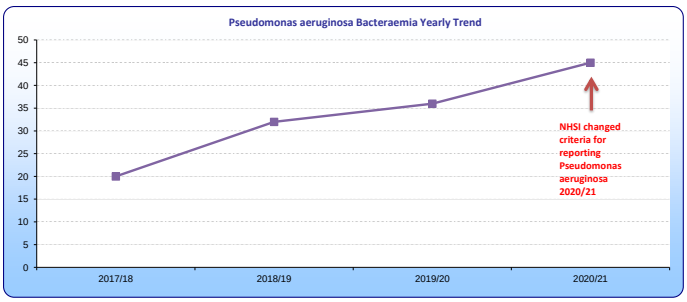

MSSA Bacteraemia - Cumulative Performance Against Local Trajectory
April 2021 to March 2022
Local Trajectory: ≤90
2020/21 Cumulative
Local Trajectory
2021/22 Cumulative

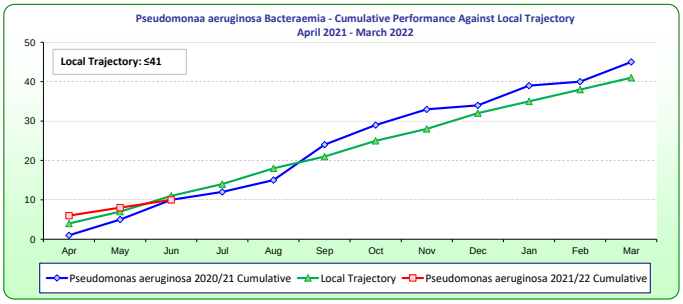

E. coli Bacteraemia Yearly Trend
NHSI changed criteria for reporting E. coli 2020/21
2011/12 2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19 2019/20 2020/21


E. coli Bacteraemia - Cumulative Performance Against Local Trajectory
April 2021 - March 2022
Local Trajectory: ≤176
E. coli 2020/21Cumulative
Local Trajectory
E. coli 2021/22 Cumulative


Klebsiella Bacteraemia Yearly Trend
NHSI changed criteria for reporting Klebsiella 2020/21
2017/18 2018/19 2019/20 2020/21


Klebsiella Bacteraemia - Cumulative Performance Against Local Trajectory
April 2021 - March 2022
Local Trajectory: ≤117
Klebsiella 2020/21 Cumulative
Local Trajectory
Klebsiella 2021/22 Cumulative


Pseudomonas aeruginosa Bacteraemia Yearly Trend
NHSI changed criteria for reporting Pseudomonas aeruginosa 2020/21
2017/18 2018/19 2019/20 2020/21


Pseudomonaa aeruginosa Bacteraemia - Cumulative Performance Against Local Trajectory
April 2021 - March 2022
Local Trajectory: ≤41
Pseudomonas aeruginosa 2020/21 Cumulative
Local Trajectory
Pseudomonas aeruginosa 2021/22 Cumulative

Healthcare-Associated Infection Report June 2021

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
MRSA Bacteraemia - Trust-assigned (objective 0)	0	0	0										0
MRSA HA acquisitions	2	0	1										3
MSSA Bacteraemia - post-48 Hours Admission (local objective ≤90)	5	9	9										23
E. coli Bacteraemia - post-48 Hours Admission (local objective ≤176)	18	21	17										56
Klebsiella Bacteraemia - post-48 Hours Admission (local objective ≤117)	14	7	20										41
Pseudomonas aeruginosa Bacteraemia - post-48 Hours Admission (local objective ≤41)	6	2	2										10
C.diff - Hospital Acquired (objective ≤100)	15	10	12										37
C.diff related death certificates	3	0	1										4
Part 1	2	0	1										3
Part 2	0	0	0										0

Periods of Increased Incidence (PIIs)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA HA acquisitions	-	-	-										0
Patients affected	-	-	-										0
C.diff - Hospital Acquired	3	2	5										10
Patients affected	6	4	8										18

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)	-	-	4										4
Hospital onset Definite HC assoicated (≥15 days post admission)	-	-	-										0

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	-	-	1										1
Patients affected (total)	-	-	11										11
Staff affected (total)	-	-	12										12
Bed days losts (total)	-	-	107										107
Other Outbreaks	-	-	-										0
Patients affected (total)	-	-	-										0
Staff affected (total)	-	-	-										0
Bed days losts (total)	-	-	-										0
COVID Outbreaks	-	-	2										2
Patients affected (total)	-	-	4										4
Staff affected (total)	-	-	1										1
Bed days losts (total)	-	-	-										0

C.diff Transit and Testing Times Target <18hrs	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Trust Specimen Transit Time	09:56	10:16	11:03										10:25
Laboratory Turnaround Time	02:28	03:15	03:38										03:07
Total to Result Availability	12:24	13:31	14:41										13:32

Hygiene Indicators/Audits (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT Trust Total	CAT currently suspended due to COVID-19 pandemic and awaiting new assurance tool												
Hand Hygiene Opportunity													
Hand Hygiene Technique													
Environmental Cleanliness													

Infection Control Mandatory Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Infection Control	89%	88%	88%										89%

Aseptic Non Touch Technique Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Nov	Jan	Feb	Mar	Average
ANTT (M&D staff only)	57%	56%	56%	32									56%

CRN North East and North Cumbria 2020/21 LCRN Annual Report Template

2020/21 LCRN Annual Reports consist of two parts; (1) a four page Annual Report which will be included in the CRN Annual Report to the Department of Health and Social Care, and (2) a number of data tables (which you are asked to update) which will contribute to the LCRN Fact Sheet.

The provisional deadline for LCRN Annual Reports is **12 noon on Wednesday 23 June.** Please email crncc.performance@nihr.ac.uk to indicate that both parts of the LCRN's Annual Report have been completed**.** Permissions have initially been set as per the 2021/22 LCRN Annual Plan.

Part 1: Four Page Summary (maximum)
Please provide a summary report of 2020/21 in the following six areas, with a total length of no more than four pages (guidance including length per section is provided below). Please

A. reference the 16 'Working Principles' as set out in A.3. of the 2020/21 Performance and Operating Framework, where relevant (e.g. 'Patient involvement', 'Partnership working', 'Collaborative national working', etc), and
B. frame the report in the context of how the LCRN contributed to/achieved success in very difficult circumstances due to COVID-19 (i.e. the CRN recruited approximately 1.5m people in 2020/21, notably more than previous years).

Sections and guidance

1. The LCRN's contribution to the national delivery of three Category 1A or Category 1B Priority studies of your choice (approximately one page in length)
    - 'Contribution' here is intended to be broader than recruitment, and could include intellectual property, systems and/or processes established to maximise recruitment, provision of operational and/or other support, etc.
2. Challenges recruiting to Urgent Public Health Prioritised studies (approximately half a page in length)
    - What measures did the LCRN put in place to maximise recruitment to badged studies. Please separate/differentiate your response by primary care, secondary care, vaccines, social care etc.
    - Did the LCRN have some areas/Trusts that were not able to recruit to any UPH badged studies? If so, what was the problem and what can be learned?
3. Workforce (approximately half a page in length)
    - What measures or activities did the LCRN undertake in relation to the workforce in terms of maintaining or increasing the capacity (numbers and location) or capability (skill, skill mix, knowledge or training) in order to maximise delivery of UPH badged studies. Were there any specific employment practices or relationships you benefited from? Please link case studies/materials if you have them
    - Did the LCRN manage to mitigate the impact of redeployment of staff to the frontline or adapt to high levels of sickness / shielding. If so how was this achieved?
    - What lessons have been learned and what might be the implications for future practice in terms of recruitment, retention, skill mix or training /development of the future workforce? Please be specific about location for application of these

and separate/differentiate your response by primary care, secondary care, vaccines, social care etc. if appropriate

4. Restart and Partner organisation engagement (approximately half a page in length)
    - Was the LCRN able to support non-badged (COVID and non-COVID) studies and badged studies? If so, please share any learnings as to how it managed to balance this?
5. Patient and Public Involvement and Engagement (PPIE) (Approximately half a page in length)
    - Please provide an update on how the LCRN supported public involvement in Urgent Public Health studies (including vaccine studies), and how it has adapted the Participant Research Experience Survey (PRES) and Research Champions programmes within the context of COVID-19
6. Selected non-COVID-19 LCRN achievements (approximately half a page in length)
    - This is an opportunity to highlight selected non-COVID-19 related achievement from 2020/21

Style guidance:

- Please use Arial font size 11
- Please do not include any tables or images
- Please refer to the LCRN by name (e.g. CRN Eastern) or 'the network' (please note lowercase) rather than 'we' or 'the LCRN'
- Please avoid reference to personally identifiable individuals by name, instead referring to role(s)
- Please reference study IDs using CPMS ID, e.g. Resolute (CPMS ID: 41222)
    - Reference of CPMS ID of Priority 1A and 1B study names and CPMS IDs
- Please expand in full any abbreviation which is not well embedded in health or clinical research, including those which are ambiguous (e.g. CI could be Chief Investigator or Continuous Improvement) the first time the abbreviation is used

Data guidance:

- Please use the '2020-21 CRN Performance Standards.qvw' ODP app as the source of data references (data references will be checked by the CRNCC Business intelligence team for accuracy). Please contact NIHR CRN Info Request (inforequest@nihr.ac.uk) with any questions on data or data sources
- As LCRNs were not performance managed on their performance against HLOs in 2020/21, please avoid reference to ranking your LCRN against that of others. Rather, please report absolute rather than relative figures. Should you wish to present comparative data please do so at the LCRN's Annual Performance Review Meeting

Part 2: Update of Data Tables which contribute to the LCRN Fact Sheet

General guidance:

- Please update the yellow-highlighted cells within this Google Sheet. Several yellow cells have been pre-filled with information from the LCRN Fact Sheet 2019/20, please ensure that this data is checked and updated if necessary
- Please do not edit any formulas or change any formatting options

- The full LCRN Fact Sheet will be made available to the LCRN Leadership Team for reference and comment as required ahead of the LCRN Year-end Review Meeting.

Data guidance:

- The data is intended to be a snap-shot of the LCRN at the end of the reporting year 2020/21, therefore please provide data accurate **as of 23:59 on 31 March 2021** (or as near as possible before this time). Please do not reflect any changes that occurred in 2021/22 to date

Section 1. The LCRN's contribution to three Category 1A or Category 1B Priority studies of your choice

RECOVERY: (CPMS ID: 45388) - opened in eight POs within the CRN NENC contributing over 3,300 participants, achieving the highest national recruitment per admission of 15%, exceeding the 10% goal. North Tees and Gateshead Foundation Trusts participated in the national pilot of weekend working. Funding was identified to support continuation of weekend working beyond the pilot. The Factors Affecting Recruitment to the RECOVERY study (FAR) investigated how organisations managed the setup of, and conducted the processes of the RECOVERY trial. This qualitative work started in November 2020 and ran alongside real time quality improvement work and enhanced engagement with PO's. The FARstudy was undertaken in partnership with the RECOVERY trial steering committee and the CRN Executive.

NOVAVAX: (CPMS ID: 46787) - the CRN NENC supported a research alliance between 3 PO's to host this study, core CRN NENC staff contributed co-PI and other medical support, research nurse & administrator time. The CRN team set up and ran the medical cover rota for the first 2 months of the study to support the POs until a system was in place. This included supporting newly retired previously research active medical staff to assist the study. The CRN NENC identified that many people had general information needs about vaccine research that left them undecided as to whether they would agree to sign up for vaccine research. The CRN NENC conducted focus groups with different audiences (accessed via Local Authorities, the TUC Workplace Health Leads, the Healthy Universities network) and developed a survey to support information needs. For example, by identifying the respondent's ethnicity CRN NENC was able to better structure and target the content of communications with different communities. CRN NENC partnered with CRN Y&H to create a multilingual animation based upon this knowledge and produced a multilingual series of C19 vaccine research "talking heads" that appear on #BeatCovidNE (the flagship COVID information site for 7 Local Authorities in the North East). This learning has evolved with time to reflect different trial designs (e.g. Com-COV2 (CPMS: 48968)) and the mass vaccination campaign and include a 'thank you' to all participants from a particular community. The impact of this approach is demonstrated as CRN NENC has a higher percentage of non-white British sign-ups to the Vaccine Registry per head of non-white British population than the national average.

BASIL C-19 (CPMS ID: 45854) pilot study & BASIL+ (CPMS ID: 47687) multicentre RCT were CRN NENC led. Potential participants were identified with support of LCRN via searches of GP practice patient lists and the intervention delivered by trained BASIL Support Workers within NHS and Non-NHS POs. CRN NENC supported the setup and delivery of the pilot study and main trial. The BASIL C-19 pilot study successfully delivered to time and target (96 participants in 4 months). It made use of the PRES 'OK to say no' to inform understanding of recruitment barriers (see section 5 below). CRN NENC supported the successful setup of The BASIL+ main trial across 12 sites in England and Wales and supported access to IT solutions and translation of study materials to ensure access to a wide range of populations. Recruitment to BASIL+ is currently underway and on target to complete in August 2021. Study website https://sites.google.com/nihr.ac.uk/basil/home

Section 2. Challenges recruiting to Urgent Public Health (UPH) Prioritised studies

All CRN NENC POs (inc. PC & Non-NHS settings) recruited to at least 1 UPH study.

Primary Care: GP PICs were identified and supported "permission to contact" activities. SSS and community NMAHP delivery resources were prioritised to UPH badged studies in primary care, community settings and secondary care. CRN NENC funding was used to initiate the coordination of GP text outs to feed into the research registries providing efficient pre-screening and timely recruitment into vaccine trials.

Secondary Care: CRN NENC & R&D Community meetings provided a forum focused on UPH activity, sharing practice & workforce discussions (see section 3). The frequency of these meetings varied according to need. R&D newsletters provided a means of updating on the status of UPH and vaccine studies. Research Operations Managers (ROMs) linked with POs to support setup of UPH studies. Additional financial support (e.g. Weekend Working Funding calls (see section 3)) were made available.

Vaccines: Vaccine Pump Prime funding was used to create 3 vaccine hubs. A regional model was created with a Vaccine Executive for oversight of a number of working groups, allowing for regional decision making on feasibility, study placement, workforce, training, operations and performance management.

Care Home Research: Existing infrastructure was enhanced. RDM leadership capitalised on the ENRICH initiative relaunch and ensured integrated study support and delivery resource through a dedicated senior research nurse from a CRN NENC PO. VIVALDI (CPMS ID: 45953) demonstrates the success of the approach. CRN NENC has a nationally leading position for both number of studies & of consented participants in research.

Challenges: Sustaining activity has been the single biggest challenge evidenced by the downward trend from the highly successful mid year performance to end of year performance.

Section 3. Workforce

Capacity and capability to maximise delivery of UPH studies: Examples here include; SGLs offering to cover shifts in Nightingale to recruit participants, retire & return medics (CRN NENC & POs agreed standard rates of pay to speed up processes), flow of staff between POs, redeployment of core team staff, flexible deployment of the primary care team, volunteers to meet and greet, bank staff, redeployment registers, engaging additional Research Fellows & identification of Associate PIs. CRN NENC made funding available to POs to support delivery of UPH studies where there were gaps in staffing & to invest in supporting IT infrastructure to aid remote/flexible working. CRN NENC implemented virtual wellbeing activities to support staff working remotely. Regular core team hangouts, surveys and 'wellness barometer' helped staff to feedback on physical & mental health wellbeing.

L&D/Training: The core & wider workforce was supported with activities such as:

- Shifting classroom training to virtual platforms
- Lead on national delivery of Informed Consent virtual training
- Offering short-notice 'just in time' training courses
- Vaccine Trials Training
- Informed Consent Process with UPH Research studies (bitesize module)
- Zoom/Teams facilitator training to enable effective & efficient use of technology

Implications for future practice include continuing use of virtual platforms and other technologies; being flexible and able to adapt rapidly to new environments; considering national reach and impact as well as local.

Section 4. Restart and Partner organisation engagement

Through a working group, CRN NENC liaised with POs and Sponsors to obtain monthly updates regarding the status of sponsored studies. This ensured data in CPMS and LPMS reflected changes and the current position. Decisions regarding Restart were made locally with each PO implementing a process to review studies. Of 137 studies paused at 21 May 2020, 90% were no longer paused at 31 March 2021. 59% of unpaused studies recruited after 1 June 2020. The RDM Single Point of Contact (SPoC) proved valuable, liaising with POs regarding Restart, maintaining close links and communication in an ever changing situation. SPoCs were kept abreast of progress via monthly update emails. Regular network and R&D Community meetings enabled engagement across all POs and facilitated communication (see section 2). 2020/21 saw significantly increased recruitment activity in Health Services Research and Mental Health Specialties. The CRN NENC COO was seconded into the Host Research Directorate (largest regional research portfolio) for 3 months to lead & support Restart to great effect.

Section 5. Patient and Public Involvement and Engagement (PPIE)

PRES: Using a digital solution removed many concerns around infection control in COVID in CRN NENC. PRES was used in all covid vaccine trials (response rate: 50%). Site level reported experience was shared with PI, CI and Sponsor. Near real time feedback identified issues with the 'check in' process for the COV002 (CPMS ID: 45551) trial. Appropriate changes were made as a result. PRES used mass 'email outs', saving time for busy research staff. This change has been incorporated into V2 of the app giving the ability to send emails directly. Having access to PRES ethnicity data in part informed the #BeatCovidNE resources and focus. The local '*OK to say no*' survey was run for BASIL+ (CPMS ID: 47687). During the pilot phase, data on reasons for declining to participate proved invaluable in identifying changes to the trial design prior to the definitive phase. Participant feedback showed that the design *per se* was not a barrier to participation so no unnecessary changes were made. The young people's PRES was used in 'What's the Story' (CPMS ID: 42523) with responses from all three age categories.

Support for UPH studies: The Senior Managerial lead for PPIE was a member of the CRN COV19 PPIE Action Group, providing advice to the Coordinating Centre in it's PPIE activities throughout the pandemic. They also supported Cluster D with focus groups to look at the acceptability and practicalities of a Covid-19 testing programme in schools (ToCS). They facilitated two sessions with head teachers and school business managers and provided a report on the output of the groups. Additionally, CRN NENC found volunteers to join both the UPH Panel, and the long covid focus group.

Research Champions (RCs): To support CRN NENC Research Champions, quarterly face to face meetings moved to monthly virtual information sharing sessions. Invited speakers talked about studies that were recruiting, that the RCs could share with their contacts and our local NIHR platforms attended to share the opportunities they had for involvement and engagement. The Communications Team produced monthly bulletins for RCs, sharing the latest information from the UPH studies and any new guidance or online events. CRN NENC and CRN Y&H co-developed and ran two online workshops on enabling under-served communities to become RCs and highlighting opportunities of how RCs could engage with other communities in the virtual and physical worlds.

Section 6. Selected non-COVID-19 LCRN achievement

Strategic investment in the Newcastle PRC meant that the CRN NENC track record of innovative digital solutions was further enhanced with the successful delivery of the PRC/CRN NENC supported Relieve IBS-D Virtual Trial (CPMS ID: 34032). This trial has received much publicity and was singled out for praise by the Minister for Innovation, Lord Bethell. Strategic funding from CRN NENC supported development and testing of the full end-to-end VT capability that was used to deliver the trial. Additionally, this funding was used to explore and describe learning from national digital media campaigns including effectiveness of different promotional approaches and the corresponding reach into the population.

#OPTIONS (CPMS ID: 44557) study measuring NHS staff awareness, attitudes and actions towards the recent change in organ donation law in England. It successfully recruited 4,793 participants in NENC.

The continuation of Exploring the Cause and Prevalence of Memory Problems in Mental Health (CPMS ID: 34815) - (which recruited more than 1,900 participants across Mental Health Trusts in NENC during 20/21).

The CRN NENC piloted and launched an Automated Expression of Interest system with associated process changes for Cancer and Mental Health Specialties. The system saves approximately 20 minutes of Core Team staff time per Site ID circulated and 30 minutes of Trust Delivery Team time per Site ID submitted. It has also significantly increased the quality of Site ID forms submitted, with 89% in Q4 meeting an agreed 'very high' quality standard.

The CRN NENC POs reported participant year of birth for studies in LPMS for over 27,700 participants. This equates to almost 80% of all specialty recruitment.

The Teenage Cancer Trust (TCT) Network Lead Nurse based at Newcastle Hospitals attends regional MDT, is a member of the CRN NENC Cancer Leadership team, the Northern Cancer Alliance Children & Young People Group and links regionally and nationally with other TYA nurses. She has worked in liaison with the Cancer Lead ROM to identify potential portfolio studies for discussion and identification of potential participants during MDT meetings. Using year of birth reported in LPMS, 14 participants were recruited in 2020/21, exceeding the predicted figure of 10 participants.

AUDIT COMMITTEE ANNUAL REPORT 2020-2021

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 2020-21, 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 2020 and 31 March 2021 and attendance was as follows:

	Attendance at ordinary meetings	Attendance at extraordinary meeting
Mr D Stout, Non-Executive Director (Committee Chair)	4 of 4	1 of 1
Mr J Jowett, Non-Executive Director	4 of 4	1 of 1
Professor K McCourt, Non-Executive Director	4 of 4	1 of 1
Mr S Morgan, Non-Executive Director	4 of 4	1 of 1
Mr B MacLeod, Non-Executive Director	2 of 2*	N/a

**Mr MacLeod joined the Trust Board as a Non-Executive Director on 30 July 2020. As agreed with the Trust's Chairman and Audit Committee Chair, Mr MacLeod observed the Committee*

meeting on 28 July 2020, before becoming a formal member of the Committee from his official commencement date (30 July 2020).

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 Corporate Risk & Assurance Manager.

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 2020/21. 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 Audit Committee Chair and the Executive Lead for the Committee.

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 2020).
- The Board Assurance Framework; being the underlying assurance processes that indicate the achievement of corporate objectives and the effectiveness of management of principal risks.
- Risk management arrangements.
- Other governance arrangements such as 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 on 1 May 2020.

*A detailed review of the Scheme of Delegation, Standing Orders and Standing Financial Instructions is undertaken annually. This was undertaken as scheduled during the year, with a particular focus on ensuring that the documents accurately reflected COVID-19 related developments such as establishment of the Nightingale Hospital North East (NHNE), creation of the Integrated COVID Hub North East (ICHNE) and changes to research governance.

The Board Assurance Framework (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 Manager. 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:

i) Executive Lead review undertaken during the previous 3 month period and any recommendations for risks held on the Board Assurance Framework aligned to that Committee;
ii) assurances received and any areas requiring Committee consideration;
iii) number of risks held on the BAF, movements in risks and the risks categorised by risk type;
iv) risks added/removed to the Executive Oversight Register during the period; and
v) operational risk profile.

The Trust Board's Risk Appetite Statement and tolerance levels were reviewed and updated in January 2021 as part of the annual review process, with final approval provided at the Board of Directors meeting held on 28 January 2021. The approved changes will be implemented from 1 April 2021.

During the year, the Trust's Board also received a standing update on Corporate Governance matters, these reports regularly included a section to provide further assurance over risk management arrangements in addition to the quarterly BAF reports.

Regular reporting of updates from the Finance, Quality and People Committee Chairs continued during the year through the inclusion of a standing agenda item. These updates allowed the Audit Committee to receive assurance over the work of those Committees.

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 and the Strategic Internal Audit Plan 2020/21 to 2022/23, including regular updates of performance against the Plan.
- Consideration of the major findings arising from internal audit work and management's responses.
- Receipt of the Internal Audit Annual Report and Head of Internal Audit Opinion.
- Monitoring progress with implementation of agreed audit recommendations.

The Committee received a report from the internal auditor at each of its Committee meetings which summarised the audit reports issued since the previous meeting.

The internal audit plan for 2020-21 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.

During June 2020 Committee, members were briefed on the findings from two limited assurance audit reports in relation to Directorate-level Risk Management and Fire Safety. Regular updates on the progress in relation to these audits were received by Committee members from management and internal audit.

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, ISA 260 report (Trust and Charity) and a reduced scope report on the Quality Report (2019/20) due to the change in reporting requirements arising from the COVID-19 pandemic. For 2020/21, there was no requirement to undertake audit procedures on the Quality Report.
- Received the Annual Audit Letter.

The Council of Governors has the statutory responsibility for the appointment of the external auditors, and this process is led by a sub-group of public Governors supported by

Trust officers and the Chair of the Audit Committee. During 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 – this option was taken via approval from the Trust's Council of Governors in October 2020. This followed a satisfactory review of external audit performance undertaken by the Audit Committee (discussed at the October 2020 Committee meeting).

The Mazars LLP external audit fees for 2020/2021:

- Statutory Accounts £54,300 (excluding VAT). A further fee of £12,860 (excluding VAT) was included to address the additional requirements set out within the new Code of Audit Practice. The total cost therefore being £67,160 (or £80,592 inclusive of VAT).
- Charity Accounts £12,000 (inclusive of VAT).

As reported in the 2019/20 Annual Report of the Audit Committee, the fee for the work on the Quality Report for 2019/20 was reduced to £3,080 (plus VAT) to reflect the requirement issued in March 2020 to no longer include the Quality Report in the Annual Report in response to the COVID-19 pandemic, with auditors being advised to cease assurance work on the Quality Report at that time. For 2020/21, there was no mandated required to undertake external audit procedures on the Quality Report.

The following additional fees were invoiced in 2020/21 but related to 2019/20 work performed:

- Work required regarding the new financial ledger implementation - £500 (excluding VAT);
- Whole of Government Accounts – additional procedures - £500 (excluding VAT); and
- Additional procedures undertaken due to the Covid-19 impact on asset valuations - £2,000 (excluding VAT).

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 2020/21.

The draft response to the External Audit TCWG request is included in Appendix 2 for review and approval.

7. MANAGEMENT

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

8. FINANCIAL AREAS OF REVIEW

The Committee has ensured that the systems for financial reporting to the Board are subject to review.

The Committee has achieved this primarily through review and approval of the Annual Accounts and TAC schedules, 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 2020-21, 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 audit matters and significant risks:

- Management over-ride of controls (Group and Trust);
- Property valuations (Trust); and
- Revenue recognition (Trust).

Other areas of management judgement/enhanced risks discussed related to the appropriateness of the estimate for incomplete patient spells at the year-end and accounting for the Trust's PFI arrangements.

These have been considered through the presentation of the external audit plan and discussions with the Trust's external auditors, Mazars LLP.

Significant matters discussed between External Audit and management during the year related to:

- Valuation guidance; useful economic lives; and
- Potential liabilities arising from 'the Flowers case'.

There was one medium priority internal control recommendation reported to the Audit Committee in June 2020 being: *'The Trust should review the process for identifying leavers so that they can be removed promptly from the general ledger system. Although this finding related to access to the Efin system, the Trust should consider it in light of its move to Oracle in March 2020.'*

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 and the Annual Report on counter fraud.
- Reviewed the minutes of associated Committees and Groups.
- 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. The refreshed Standards of Business Conduct Policy was approved in July 2020.
- 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 a detailed update on the Clinical Audit Process (January 2021).
- Received regular updates from the Chairs of the Quality, People and Finance Committees.
- Reviewed arrangements by which staff raise concerns and Annual Report (July 2020)
- Approved the Internal Audit Charter and Protocol 2020/21 (July 2020).
- Received further updates on:
    - The new ledger implementation (April 2020);
    - NHNE PwC PMO queries (April 2020);
    - Impact of the pandemic on the internal audit plan (April 2020);
    - The positive progress made in relation to the follow up of internal audit recommendations (April 2020);
    - The new Audit Code of practice via an additional briefing session from the Trust External Auditors (2 March 2021); and
    - The potential impact on the external audit opinion for 2019/20 as a consequence of non-attendance at the Trust stockcount, due to Covid-19 restrictions (April and June 2020).

10. PROGRESS FOR 2021-2022

The self-assessment checklist from the HFMA Audit Committee Handbook has been completed and attached in Appendix 1.

Recommendation: The Audit Committee is asked to review the self-assessment; provide any further feedback/commentary, particularly on the areas highlighted in bold, and agree the self-assessment as an accurate reflection of Committee effectiveness.

There are three key areas where the Committee will be revisiting during 2021/22 which are:

1. Continuing to build on the work performed during 2019/20 in refining the Trust's Governance Structure and Directorate-level risk management arrangements. Further work is required in terms of:
   - Further development of Directorate-level risk management, embedding the Risk Appetite and Accountability Framework to improve decision-making processes. The development and implementation of the newly procured Datix Cloud IQ Enterprise Risk Manager module is expected to commence in July 2021.
   - Re-evaluating the reporting and assurance arrangements specifically for the Quality Committee due to the large volume of information/reports considered at each Committee meeting.
   - Reviewing the Board Committee focus for 2021/22 in light of the impact of the COVID-19 pandemic and recovery objectives.
   - Taking a fresh look at the Trust's Policy Approval process (deferred from the prior year due to the Covid-19 pandemic).
   - Processes in place to address the requirements of the New Audit Code of Practice, specifically in relation to Value for Money.

   The Committee will need to seek assurance over the work outlined above and any further actions arising from the Committee review meetings scheduled.

2. The Standards of Business Conduct Policy was reviewed and updated in July 2020. The Committee will need to seek assurance over the implementation of the refreshed policy. Management actions in progress/planned include:
   - The production of a summary booklet for staff detailing the required standards in relation to Standards of Business Conduct.
   - Standards of Business Conduct Internal Audit planned for 2021/22.

3. Continuing to develop the Assurance Framework in place within the Trust. It was anticipated that this work would be undertaken during 2020/21 however this was delayed due to the COVID-19 pandemic. The following areas of work will therefore be rolled over into 2021/22:
   - the comprehensiveness of assurances in meeting the Board and Accounting Officer's needs;
   - the reliability and integrity of these assurances;
   - whether the assurance available is sufficient to support the Board and Accounting Officer in their decision taking and their accountability obligations; and
   - the implications of these assurances for the overall management of risk.

The Terms of Reference and Schedule of Business for the Committee are due for annual review at the next Committee meeting.

Report of Kelly Jupp
Trust Secretary
16 April 2021

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

Audit Committee Schedule of Business 2021/22

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			
Review arrangements by which staff may raise concerns and receive an annual report on the application of the Trust policy on raising concerns		X			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	
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		
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	
External Audit					
Approve the Annual Plan and 3 year Strategic Plan	x				
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	

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Audit Committee Schedule of Business 2021/22

Agenda Item / Issue	Jan	Apr	May/ June [EO]	Jul	Oct
Receive the Limited Assurance Report on the Quality Report			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	
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, Private Practice Committee, Payroll Consortia and Finance Committee.

EO = Extraordinary Committee meeting for approval of the Annual Report and Accounts

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.

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 routinely, at least once every two years;

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 Fraud Self Review Tool 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), the limited assurance report on the Quality Report 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 Committee will receive an annual report on the application of the Trust policy on raising concerns;

10.03 monitor and receive assurance on compliance with the Trust's Speaking Out Policy and 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 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, the People Committee, and the Payroll Consortium;

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 review matters pertaining to clinical risk management and satisfy itself on the assurance that can be gained from the Clinical Audit function, including receiving the Clinical Audit Annual Plan and Annual Report and other updates on progress twice a year to maintain process oversight;

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: 8 June 2021
Date approved: 8 & 9 June 2021 [Audit Committee] and TBC [Board]
Approved by: Audit Committee and Trust Board
Review date: May 2022

ANNUAL REVIEW OF THE CHARITY COMMITTEE 2020/21

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Charity Committee has met its key responsibilities for 2020/21, 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 Board of Directors to manage, on behalf of the Board, all charitable funds under the control of the Trust, considering the requirements of the Department of Health and Social Care, and the Charity Commission for England and Wales.

The key purpose of the Charity Committee is to:

i) 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');
ii) Manage the Trust's charitable funds in accordance with statutory requirements of the Charity Commission, Department of Health and Social Care 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
iii) 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 Charity Commission regulations.

It does this through 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 Board with a quorum being three members (with at least one Executive Director and one Non-Executive Director).

Four ordinary meetings and three extraordinary meetings were held between 1 April 2021 and 31 March 2021 and attendance was as follows:

	Attendance at ordinary meetings	Attendance at extraordinary meetings
Keith Godfrey, Non-Executive Director (Committee Chair until the 28 August 2020 meeting)	2 of 2	1 of 1
Jill Baker, Non-Executive Director (Committee Chair from 18 December 2020 meeting)	4 o 4	3 of 3
Jonathan Jowett, Non-Executive Director	2 of 4	2 of 3
Graeme Chapman, Non-Executive Director	2 of 2*	2 of 2
Dame Jackie Daniel, Chief Executive Officer (CEO)	0 of 1	0 of 1
Andy Welch, Medical Director and Deputy CEO	2 of 4	0 of 3
Angela Dragone, Finance Director	4 of 4	3 of 3
Caroline Docking, Assistant Chief Executive	1 of 4***	2 of 2

* Graeme Chapman joined as a member of the Committee on 18 December 2020.
** Following a review of the Terms of Reference, Dame Jackie ceased to be a member of the Committee on 1 May 2020.
*** Following a review of the Terms of Reference, Caroline Docking became a member of the Committee on 1 May 2020.

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

- The Charity Director;
- The Head of Charitable Funds;
- The Deputy Finance Director;
- The Financial Accountant, Newcastle Hospitals Charity; and
- The Trust Secretary and Deputy Trust Secretary who provide Secretariat Support to the Committee.

A number of the members of the Charity Team, including the Charity Communications and Development Officer and the Data and Operations Manager, have been in attendance to observe and provide relevant input as required.

4. EXTRAORDINARY MEETINGS

An extraordinary meeting of the Committee was convened on 2 April 2020 to consider how charitable funds could be utilised to support Trust staff and patients during the early stages of the COVID-19 pandemic. Actions of the Committee resulted in wellbeing packs being made available for staff/volunteers, along with covering the cost of emergency travel/accommodation/parking for staff/volunteers directly impacted by COVID-19. Additionally, charitable funding allowed for the creation of a 'float' managed by the Trust's Chaplaincy for staff/patients experiencing hardship.

A further two extraordinary meeting were held on 29 January and 26 February 2021. These meetings were convened to discuss the implementation of the Newcastle Hospitals Charity Strategy and to receive presentations from Withers Worldwide LLP and the Centre for Charity Effectiveness on Charity Governance.

5. CHARITY STRATEGY

Following the review undertaken by Tarnside Consultancy, a revised Newcastle Hospitals Charity Strategy was drafted and was approved by the Board of Directors during its meeting on 28 January 2021.

6. GRANT APPROVALS

During 2020/21, the Committee considered over 30 grant applications. The following were for over £100,000:

- Percutaneous Mitral Valve Repair Service - £165,000;
- Reconfiguration of the Cardiothoracic Department - £221,000;
- Funding for two Advanced Nurse Practitioners - £186,000;
- Quality Improvement Faculty (in collaboration with The Institute for Healthcare Improvement) - ~£1m (over two years);
- Daft as a Brush Patient Transport - £215,000; and
- Social Prescribing (Neurodisability) - £118,000.

7. KEY ACHIEVEMENTS

During 2020/21, the following matters have been considered by the Committee:

- As outlined the section 4 of this report, the Committee has addressed ways in which charitable funds could be utilised in supporting both Trust patients and staff during the pandemic. Routine COVID-19 updates were provided during the course of the first wave of the pandemic, providing updates on the distribution of offers of help and support and considered how staff wellbeing remained a priority during COVID and beyond.
- Similarly, regular updates were received on NHS Charities Together and the receipt of funding by the Trust.
- Teri Bayliss joined the Trust Charity as Charity Director from 1 June 2020.
- The refreshed Newcastle Hospitals Charity website was launched in year, with the Committee receiving a comprehensive update on progress at the May 2020 meeting.
- Angela O'Brien, Director for Quality and Effectiveness, attended the August 2020 meeting of the Committee and provided a comprehensive presentation supporting the bid for charitable funding to establish a quality improvement faculty in collaboration with The Institute for Healthcare Improvement.
- In relation to the creation of the Charity website, the Committee was notified that the mechanism for the processing of online donations would be facilitated by Pay 360, as part of the Trust's financial ledger.

- The draft Annual Report and Accounts of Newcastle Hospitals Charity were received at the August 2020 meeting of the Committee, and finally approved at the December 2020 meeting.
- The Committee were informed and remained updated on the creation of the Research and Innovation Infrastructure Projects Group, chaired by the Trust Chairman. The Charity Director attended group meetings as many of the projects under discussion were of interest to the Charity.
- As outlined in section five of this report, the Charity Strategy was drafted and was shaped by both the outcomes of the Tarnside Review and the ongoing pandemic. The Strategy also took into account feedback from stakeholders. Key areas for improvement were outlined as a part of this process, such as the creation of an integrated Charity team, more strategic grant making, and better use of technology to both increase Charity visibility and streamline the grant making process. A number of Key Performance Indicators were included which would be monitored by the Committee on a quarterly basis. The Trust Charity Strategy was ratified by the Board of Directors in January 2021.
- An operational plan for the implementation of the Strategy was approved at the February 2021 extraordinary meeting.
- The Charity Policy was approved at the December 2020 meeting of the Committee.
- The Committee received a presentation from Withers Worldwide at the January 2021 meeting to commence the review of the Charity's governance arrangements. This included the Board of Director's role as Corporate Trustee and ensuring that the requirements of the Charity Commission were met. Subsequently, an options appraisal was drafted and considered by the Committee and utilising the key priority areas, a Charity Governance Working Group, was established and would consider governance arrangements into the 2021/22 financial year.

8. FINANCIAL MANAGEMENT, CONTROL & REPORTING

The Committee has continued to ensure that the systems for financial reporting to the Board 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 18 December 2020.

Over the course of 2020/21, there were no significant issues that the Committee had to consider in relation to the financial statements.

The Committee continued to receive reports from the Trust's Investment Fund Managers, CCLA and Newton's.

9. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2020/21 and utilises a rolling programme and action log to track committee actions.

The Committee reviewed its Terms of Reference periodically throughout the year, most recently at the meeting on 26 March 2021. The Committee recognised that no formal review of the Terms of Reference had been undertaken since the summer of 2019 and had

agreed to make changes as required and the Terms of Reference would remain under consideration whilst the Charity Governance review was undertaken. The Terms of Reference agreed at the March 2021 meeting would be submitted to the Board of Directors for ratification in July 2021.

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

10. 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.

11. OTHER AREAS OF ACTION AND REVIEW

A significant amount of work was undertaken during the year to review the standing agenda items, streamline the Committee agenda, and reformat Committee reports in accordance with the Trust standard Committee reporting format.

12. PROGRESS FOR 2021/2022 & REVIEW OF EFFECTIVENESS

There are three key areas where the Committee will be revisiting during 2021/22 which are:

1. A method to assess progress against the aims of the Charity Strategy is required, with reporting arrangements agreed;
2. The successful implementation of the revised grant making procedure; and
3. Continuation of the Charity Governance review, to ensure sufficient oversight from the Board of Directors is maintained. This work will primarily be conducted by the newly formed Charity Governance Working Group, with regular updates to be provided to the Committee.

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

Report of Fay Darville
Deputy Trust Secretary
Teri Bayliss
Charity Director

17 June 2021

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Newcastle upon Tyne Hospitals NHS Charity	Jun-21	Aug-21	Dec-21	Feb-22	Comments: Committee scheduling amended
Charity Committee Schedule of Business					
<u>Regular items</u>					
Finance Reports - 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 are: 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 following conclusion of the Charity Governance Review.
<u>Annual reports</u>					
Annual Report & Accounts		x			Interim Report and Accounts to be presented at the August meeting.
Investment Management Review					To be agreed following the conclusion of the Charity Governance review.
JRE Scientific Committee -Recommendations		x		x	
<u>Ad hoc</u>					
Policies and procedures					
Terms of Reference (ToR)					ToR agreed in Mar 2021. To be reviewed throughout year in line with the charity governance developments.

TERMS OF REFERENCE – CHARITY COMMITTEE

1. CONSTITUTION OF THE COMMITTEE

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

2. PURPOSE AND FUNCTION

2.1 The Committee does not diminish in any respect the overall responsibility of the Board of Directors in terms of trusteeship and accountability, and the Charity Committee is responsible for scrutiny and providing assurance to the Trust Board on key issues allocated to them by the Trust Board.

2.2 Agendas are set to enable the Trust Board in its capacity as Corporate Trustee of the charity to be assured that robust processes are in place to enable statutory duties to be discharged, to enable the Trust's strategic objectives to be met and to address and mitigate risk.

2.3 The purpose and function of the Committee is to:

2.3.1 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 with 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');

2.3.2 manage the Trust's charitable funds in accordance with statutory requirements of the Charity Commission, Department of Health & Social Care 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

2.3.3 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 Charity Commission regulations.

3. AUTHORITY

The Committee is:

3.1 a 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 Finance Director has prime responsibility for the Trust's Charitable Funds as defined in the Trust's Standing Financial Instructions. The specific powers, duties and responsibilities delegated to the Finance Director are:

- administration of all existing charitable funds;
- identification of any new charity that may be created (of which the Trust is trustee);
- management of any legal steps that may be required to formalise the trusts of any such charity;
- provision of guidelines in respect of donations, legacies and bequests, fundraising and trading income;
- management of investment of funds;
- designation of appropriate banking services; and
- preparation of reports to the Trust Board including the Annual Report and Accounts.

3.5 Any Linked Charity will report to the Committee and must abide with the following:

- each linked charity will have a named person responsible for providing an Annual Report setting out how they have met their charitable objectives, including an overview of income, expenditure and approved projects;
- any request to become a linked charity must be made to the Committee;
- all linked charities must follow the Trust Standing Orders, Scheme of Delegation and Standing Financial Instructions, policies and procedures;
- all expenditure must be within their income; and
- any minutes of separate linked charity governance groups will be received by the Committee.

4. MEMBERSHIP AND QUORUM

Membership

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

4.02 The Committee's membership will comprise:

- three Non-Executive Directors;
- the Assistant Chief Executive;
- the Medical Director; and
- the Finance Director.

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

4.04 A further Non-Executive member of the Committee shall be appointed as Vice-Chair, likewise by the Trust Board of Directors.

4.05 The Medical Director shall act as the Executive Lead for the Committee.

4.06 The Deputy Finance Director, Head of Charitable Funds and Financial Accountant (Charitable Funds) and Charity Director will attend the Committee. 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 The Chair of the Board of Directors will not be a member of the Committee but may be in attendance.

4.08 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Alternate, or substitute, members may be agreed in advance with the Chair for a specific meeting but not for more than one.

4.09 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

4.10 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.

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

4.12 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.

4.13 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.

4.14 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.

Quorum

4.15 The quorum necessary for the transaction of business will be three members, including at least one Executive and one Non-Executive Director.

4.16 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.

4.17 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 Financial management and control

The Committee will:

5.1.1 ensure that a process is in place to review the arrangements for the registration of funds with the Charity Commission and ensure that all new sub-funds comply with the objects of the charity and the existing registrations;

5.1.2 ensure that all funds within the Charity umbrella are properly managed through the implementation of sound financial controls in accordance with the Standing Financial Instructions and meet the requirements of H.M. Revenue & Customs;

5.1.3 ensure that funds are effectively managed and utilised in accordance with the objects of the charity and purposes stipulated by the donors;

5.1.4 establish banking arrangements on the advice of the Finance Director;

5.1.5 ensure annual budgets are set (based on target spend allocations) for research grants available through the Joint Research Executive Scientific Committee (JRESC) and review and approve recommendations made by the JRESC. To consider the minutes of the JRESC and any additional reports submitted by them, and approve grants therefrom;

5.1.6 ensure that protocols are established for the receipt of all income due to the Charity and establish a fund-raising procedure for internal/external use;

5.1.7 ensure that all expenditure is properly authorised and reviewed through established procedures in accordance with delegated levels;

5.1.8 seek assurance that assets funded by the Charitable Funds are recorded on the Trust asset log to ensure that the location of any assets purchased with Charity funds is known; and

5.1.9 ensure a process is in place to review the usage of funds in accordance with their objects, and subsequently rationalise funds within the powers granted by the Charity Commission where the original objects have failed or are no longer relevant.

5.2 Fundraising and investment

The Committee will:

5.2.1 ensure a process is in place to initiate and promote a fundraising/marketing strategy for the Charity;

5.2.2 oversee the strategy for liaising with benefactors/donors with regard to potential sources of income and how it is applied and take appropriate legal advice on contentious or problematical bequests due to the Charity (where required);

5.2.3 establish and regularly review an investment strategy including the appointment of specialist advisors; and

5.2.4 agree the basis for apportioning of dividends/interest from investments and administrative charges.

5.3 Financial reporting

The Committee will:

5.3.1 review quarterly financial statements including Statement of Financial Activities and Balance Sheet: analysis of income; Investment reports; target spend and reserves; and schedule of all grants made in accordance with the Scheme of Delegation;

5.3.2 request/review any report on an ad-hoc basis, which the Committee feel is necessary;

5.3.3 ensure that the Annual Report & Accounts are produced in accordance with the latest accountancy practice and policy as laid down by the Charity Commission for England and Wales; and

5.3.4 review the Annual Report and Accounts prior to submission to the Trust Board for approval and adoption and subsequent circulation to the Charity Commission and other agencies (as required).

5.4 Governance, risk management and internal control

The Committee will:

5.4.1 agree and approve Audit (Internal/External) services provided to the Charity;

5.4.2 liaise with the Charity Commission on all matters affecting the governance of charitable funds and takes advice from supporting agencies (e.g. Association of NHS Charities) and appropriate legal advice where necessary;

5.4.3 review and implement periodic directives and guidance issued by the Charity Commission;

5.4.4 draw up Terms of Reference and / or associated constitutions for the Charlie Bear for Cancer Care, Great North Children's Hospital and Sir Bobby Robson Foundation(s). To consider the minutes of aforesaid meetings and review / approve recommendations. Maintain general oversight of these and any other specialist Committees;

5.4.5 ensure that the Annual Return required by the Charity Commission in respect of all charitable funds held by the Charity is completed as directed by the Finance Director;

5.4.6 determine the overall structure of the Charitable Funds team, as advised by the Finance Director and Assistant Chief Executive, and agree annual management and administrative charges levied by the Trust;

5.4.7 establish a Risk Assessment strategy for the Charity, covering all potential areas of risk and agree controls aimed at mitigating such risks. To review/agree on an annual basis;

5.4.8 review and implement new procedures as and when required by the Charity.

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

6.3 The Committee will review its effectiveness and compliance with these Terms of Reference annually, and report the outcomes of this review to the Board of Directors.

7. COMMITTEE ADMINISTRATION

7.1 The Committee will 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, will require allowing the Committee to discharge all of its responsibilities.

7.2 The Chairman 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, 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.

7.5 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.

7.6 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.

7.7 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.

7.8 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: 26 March 2021
Date approved: 26 March 2021 [Charity Committee] and TBC [Board]
Approved by: Charity Committee and Trust Board
Review date: February 2022

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FINANCE COMMITTEE ANNUAL REPORT 2020-2021

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 2020-21, 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 and the Strategy, Planning and Capital Investment 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 one extraordinary meeting were held between 1 April 2020 and 31 March 2021 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	0 of 1
Mr D Stout, Non-Executive Director (Audit Committee Chair)	5 of 6	1 of 1
Mr B MacLeod, Non-Executive Director (became a Committee member from 30 July 2020)	4 of 4	1 of 1
Mrs A Dragone, Finance Director	6 of 6	1 of 1
Mr M Wilson, Chief Operating Officer	6 of 6	1 of 1
Mr G King, Chief Information Officer	6 of 6	1 of 1
Mr R Smith, Estates Director	5 of 6	1 of 1
Dr V McFarlane-Reid, Director for Enterprise and Business Development (became a Committee member from 30 July 2020)	4 of 4	1 of 1

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

- The Director for Enterprise and Business Development (prior to formally joining the Committee as a member in July 2020);
- The Deputy Director for Business and Development;
- The Deputy Finance Director;
- The Project Director, Financial Improvement;
- The Assistant Director of Finance;
- The Procurement and Supply Chain Director;
- The Senior Business Development Manager – Performance;
- The Corporate Risk and Assurance Manager;
- Associate Director – Commercial Enterprise Unit;
- Senior Commercial and Finance Manager – Commercial Unit;

- The Trust Secretary, the Deputy Trust Secretary, the PA to the Finance Director and the Admin Manager who have provided secretariat support to the Committee.

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.
- Sought assurance over the financial management arrangements regarding:
  - The emergency COVID-19 financial regime and new income regimes;
  - The creation of the Nightingale Hospital North East;
  - The new Vaccine Hub programme; and
  - The establishment of the Integrated Covid Hub North East (ICHNE).
- Reviewed the Trust's closing financial position for 2019/20.
- Received a presentation on the outcome of the New Ledger Implementation exercise, with an overview of lessons learned provided.
- Was fully briefed on the financial aspects of the Restart, Reset and Recovery programme, including data processes and activity performance.
- Considered the reporting arrangements for Finance Management Groups.
- Sought and received regular updates from the Procurement and Supply Chain Director regarding the Procurement Plan.
- 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.
- Received updates on the 2020/21 Capital Programme and considered the 2021/22 Programme.
- Was fully briefed on the budget setting arrangements for 2020/21 and then 2021/22.
- Received updates from the Estates Director on:
  - Fire Risk Remediation Works, including Surveys and Costs;
  - The sale process for the Walkergate Hospital Site;
  - The RVI Energy Centre;
  - Fire Compartmentation and Asbestos Management; and
  - PFI matters.
- Approved investments/business cases in accordance with the delegated authority of the Committee.
- Sought assurance regarding the creation of the Commercial Enterprise Unit and the associated Commercial Strategy, challenging the criteria/assumptions used for assessing commercial projects.
- Received updates on Waiting List Initiatives, Cyber Essentials requirements, Brexit considerations and the use of the Earn'd app.
- Agreed that the Committee Chair attend the Trust's Charity Committee meeting when the Charity Investment Funds were due their annual review.
- Considered and approved the Terms of Reference for the new Commercial Strategy Group.

- Reviewed the content of the 2021/22 Financial Plan and sought assurances over the associated risks.

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2020/21 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, as well as cyber security requirements.

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 AREAS OF COMMITTEE FOCUS

There are three key areas which require Committee consideration during 2021/22 which are:

1. Deep Dive Reports – Committee members have expressed the need to consider assurances received/any gaps in assurance by receiving more regular 'deep-dive' reporting of capital project management and procurement areas, including receiving information on more routine transactional processes.
2. Strategic Areas of Focus - Committee members have highlighted the need to focus on the following strategic areas during 2021/22:
    a. The impact of Integrated Care System developments, COVID recovery and financial regime changes on long-term financial sustainability; and
    b. Capital Projects Funding.
3. Receipt of Regular Progress Updates regarding the delivery of Trust strategies which fall within the remit of the Committee, being:
    - Capital Strategy;
    - Investment Strategy;
    - Estates Strategy;
    - Infrastructure Strategy;
    - Commercial Strategy;
    - Information management and technology strategy; and

- Digital infrastructure, cyber and data security strategy.

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

Report of Kelly Jupp
Trust Secretary
3 June 2021

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Agenda item A10(i) BRP

Finance Committee		Jul-21	Sep-21	Nov-21	Jan-22	Mar-22	May-22
Regular reports							
Management Group reports	x	x	x	x	x	x	
Finance performance indicator report [In main finance report]	x	x	x	x	x	x	
CQUINs [In main finance report]	x	x	x	x	x	x	
Finance risks (BAF)	x	x	x	x	x	x	
Finance risks (CT) [In main finance report]	x	x	x	x	x	x	
Estates perf v Capital Plan [In main finance report]	x	x	x	x	x	x	
Transformation programme [In main finance report]	x	x	x	x	x	x	
Trust balance sheet position [In main finance report]	x	x	x	x	x	x	
SSPC minutes [when available]	x	x	x	x	x	x	
CMG minutes [when available]	x	x	x	x	x	x	
SPCIG minutes [when available]	x	x	x	x	x	x	
ICHNE SOG minutes [when available]	x	x	x	x	x	x	
Performance (against Finance and Operational Plans, contracts)	x	x	x	x	x	x	
Procurement Plan/Update [every other meeting from Sept]		x		x		x	
Capital Projects Update [Top 10 strategic projects] [every other meeting from July]	x		x		x		
Annual reports							
Annual Report & Accounts [May Annually]						x	
Reference Costs			x				
Terms of Reference	x					x	
Annual report / review of effectiveness	x					x	
Revenue and budget setting, CIP estimates							
Capital expenditure and strategy (longer term plan)	x					x	
Estates strategy, including PFI (and fire remedial works programme) update		x					
Ad-hoc reports to be considered							
COVID & Nightingale Update	x						
RRR Programme update [Twice a year]	x			x			
WLI [Twice a year]				x			
Charitable Funds Financial Update			x			x	
Maintenance deep dive					x		
Commercial strategy / Updates [twice a year]			x			x	

Policies and procedures e.g. Treasury management, Investment management
Business cases / investment proposals
GIRFT/Model Hospital
Business development / commercial activity
Transformation / Improvement initiatives e.g. GDE
Market Strategy/Intelligence
Digital Strategy
Finance strategy
Investment strategy - Trust and Charity
Infastructure strategy
KPI setting

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;
- Estates Strategy;
- Infrastructure Strategy;

- Commercial Strategy;
- Procurement Strategy; and
- Information Management and Technology Strategy.

3. Authority

The Committee is:

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

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

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

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

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

4. Membership and quorum

Membership

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

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

4.03 A further Non-Executive member of the Committee will be appointed as Vice-Chair, likewise by the Trust Board of Directors.

4.04 The membership of the Committee shall include:

- a Non-Executive member of the Audit Committee;
- the Director of Finance;

- the Chief Operating Officer;
- the Chief Information Officer;
- the Director of Estates; and
- the Director for Enterprise and Business Development.

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, following consultation and engagement with the Chairs of the People and Quality Committees;

5.2.4 provide advice and support on significant financial and commercial policies prior to their recommendation for Board approval. This will include policies relating to costing, revenue, capital, working capital, treasury management, investments and benefits realisation;

5.2.5 seek assurance that financial policies and plans are aligned to the Trust's agreed approach to the development of place-based, systems and regional working, and align with the Trust's strategic approach to commissioners and stakeholders;

5.2.6 identify sources of economic, financial, and related intelligence and data, relevant to the Trust in the context of the "place" of Newcastle and the North East to inform the work of the Committee and the Board of Directors; and

5.2.7 identify learning and development needs arising from the work of the Committee for consideration by the People Committee.

5.3 Annual Financial Plan

The Committee will:

5.3.1 review the Trust's Annual Financial Plan for recommendation and approval by the Board;

5.3.2 review progress and performance against the approved plan and any significant supporting plans and targets, and analyse the robustness of any corrective action required;

5.3.3 assess reports regarding future cost pressures and key financial risk areas;

5.3.4 review the Trust's Statement of Financial Position, with a particular focus on debtors, creditors, and asset valuations; and

5.3.5 receive and review an overview of financial and service delivery agreements and key contractual arrangements entered into by the Trust.

5.3.6 receive and review expenditure on waiting list initiatives against the annual plan and seek assurance on the processes in place for waiting list initiatives management.

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;
- charitable funds investment performance; 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 Quality and Performance 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 Integrated Covid Hub North East 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) Integrated Covid Hub North East 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;
- infrastructure;
- digital strategy, including digital, cyber, and data security.

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: 8 June 2021
Date approved: 8 June 2021 [Finance Committee] and [TBC] [Board]
Approved by: Finance Committee and Board
Review date: May 2022

PEOPLE COMMITTEE ANNUAL REPORT 2020/21

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 2020/21, 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 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 2020 and 31 March 2021. The meeting scheduled on 21 April 2020 was cancelled due to the onset of the COVID-19 pandemic.

Attendance at the meetings was as follows:

	Attendance at ordinary meetings
Jonathan Jowett, Non-Executive Director (Committee Chair)	5 of 5
Kath McCourt, Non-Executive Director	5 of 5
Keith Godfrey, Non-Executive Director	2 of 2*
Jill Baker, Non-Executive Director	4 of 5
Dee Fawcett, Director of Human Resources	5 of 5
Caroline Docking, Assistant Chief Executive	2 of 5
Martin Wilson, Chief Operating Officer	5 of 5

** Keith Godfrey left his role as a Non-Executive Director at the end of his term of office in September 2020.*

Other attendees at meetings have included:

- Deputy Head of Workforce;
- Head of Workforce Engagement & Information;
- Head of Human Resource Services;
- Associate Director – Education, Training, and Workforce Development;
- Workforce Development Manager;
- Freedom to Speak Up Guardian;
- Guardian of Safe Working Hours;
- Associate Director – Sustainability & Environment;
- Chief Information Officer;
- Corporate Risk & Assurance Manager; and

- The Trust Secretary and Deputy Trust Secretary who provide Secretariat Support to the Committee.

4. REPORTING

In light of the cancellation of the April meeting, the following meeting held in June predominantly focussed on the Trust's response to the COVID-19 pandemic and the impact on Trust staff. The meeting considered a variety of matters including:

- The significant redesign of the Trust's Education and Workforce Development offer to ensure continuity of service;
- The management of emergency COVID-19 related recruitment;
- The communications plan that had been enacted to ensure staff were routinely updated;
- The availability of COVID-19 testing for staff, as well as antibody testing; and
- The shielding of vulnerable staff groups; and the creation of a workforce framework for the Nightingale Hospital North East.

i) Regular Reports

Over the course of the year, Committee members received regular reports/updates on:

- The NHS People Plan – Following its launch on 30 July 2021, the Committee received regular reports on its application in the Trust, including the development of the Local People Plan and associated Action Plan;
- Board Assurance Framework (BAF) Assurance Report (with increased frequency following last year's Annual Report recommendation);
- Employee Relations Report;
- COVID-19 Updates – Committee members received updates on COVID-19 in relation to staff at each meeting, which included recruitment for the Integrated COVID Hub North East (ICHNE), staff testing, staff redeployment, and staff absence;
- Guardian of Safe Working Hours Quarterly Reports (prior to receipt at the Board of Directors);
- 'Flourish at Newcastle Hospitals' Updates;
- Education and Workforce Development Reports;
- People Dashboard;
- Legal Updates;
- Sustainability Reports; and
- NHS Staff Survey – including initial results and action plans.

ii) Annual Reports

The following Annual Reports were received by the Committee:

- Equality & Diversity Annual Report;
- Workplace Race Equality Standard (WRES) and Workplace Disability Equality Standard (WDES) Data and Action Plan (prior to approval at Trust Board); and
- Gender Pay Report.

iii) Ad-Hoc Reports

In addition to those reports listed above, a number of reports were received by the Committee. These included:

- Freedom to Speak Up Guardian Report;
- COVID-19 Wellbeing Pulse Survey Results;
- Health & Wellbeing Update;
- Systems Leadership Programme: Joint Health and Care Apprenticeships;
- Health Education Funding;
- Wi-Fi Provision;
- Workforce Age Profile and Demographics Update;
- Policy Monitoring & Compliance; and
- Communications Strategy.

In addition, during the year, Professor Kath McCourt, Non-Executive Director and Committee member, was designated Non-Executive Director Lead for Wellbeing.

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2020/21 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 2020/21, two new risks were added to the BAF, being:

- '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

During the spring of 2021, an exercise was undertaken to review the effectiveness of the Trust's Committee structure. In relation to this Committee, the following areas were highlighted:

- The vast remit of the Committee, to include education, workforce training, recruitment and retention, and sustainability, was highlighted;
- Despite adopting a bimonthly rather than quarterly meeting schedule during 2020/21, it was noted that time pressures persisted when ensuring that full Committee discussion of topics was facilitated;
- It was noted the Committee papers could be further summarised to become more meaningful and succinct, with less duplication;

- It was acknowledged that emerging areas of focus, including Equality, Diversity, and Inclusion, required increased Committee attention;
- Whilst the People Dashboard received at each meeting proved a useful tool to gain insight, it was felt that Committee members may benefit from a 'deep dive' into some of the non-standard metrics included within the report such as appraisal compliance; and
- Queries regarding Committee membership were raised to ensure full representation across all staff groups within the Trust.

7. NEXT STEPS AND ACTIONS FOR 2021/22

The following actions/next steps for consideration over 2021/22 were noted:

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;
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;
3. A review of the rolling agenda was required to prioritise key items for inclusion on the 2021/22 Schedule of Business; 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).

8. RECOMMENDATION

The Committee is asked to approve this report outlining 2020/21 work undertaken and note the key areas to revisit during 2021/22.

Report of Fay Darville
Deputy Trust Secretary
8 July 2021

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Agenda item A10(i) BRP

People	Apr-21	Jul-21*	Aug-21	Oct-21	Dec-21	Feb-22	Notes *June meeting rescheduled
Regular items							
Management reports	x	x	x	x	x	x	
People Dashboard	x	x	x	x	x	x	
Education and Workforce Deveopment report including medical education, LEG updates and Apprentices	x	x	x	x	x	x	
#Flourish at Newcastle Hospitals - Staff Experience	x	x	x	x	x	x	
Employee Relations			x	x	x	x	
Recruitment and retention	x	x	x	x	x	x	
Workforce planning			x	x	x	x	
Minutes	x	x	x	x	x	x	
Action log	x	x	x	x	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		
Susatinability		x		x	x (AR)	x	
Guardian of Safe Working	x (AR)	x		x		x	
COVID-19 Update	x	x	x	x	x	x	
Legal Update	x						
People Plan	x						
Annual Conversation with Executive Directors			x (Med&Dent)	x (NMAHP)	x (TBC)	x (TBC)	Scheduling underway.
Annual reports							
Annual report of the Committee (including effectiveness consideration)		x					
Education and training strategy				x			
Workforce Plan 2021/22				x			
People Strategy and priorities				x			
GMC training survey				x			
Communication strategy	x			x			
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		
Ad hoc							
Health and Wellbeing			x				
Policies and procedures							By exception
ToR & SOB		x					
Deep dives							By exception
Culture review							By exception
Pensions							By exception
Ethnic Pay Report							
RRR and Nightingale							

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 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 Quality Committee); 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 one Non-Executive Director 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), and advise the Board accordingly;

5.2.2 review the Trust's Leadership Development 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 and of the NHS Constitution;
- 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;
- Fit and Proper Persons Test; and
- Trade Union Faculty 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 and diversity;
- 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: 16 July 2021
Date approved: 16 July 2021 [People Committee] and [TBA] [Trust Board]
Approved by: Board of Directors [TBC]
Review date: May/June 2022

QUALITY COMMITTEE ANNUAL REPORT 2020/21

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 2020/21, 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 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, Safeguarding and Learning from Deaths, 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 2020/21, the Committee commenced a quarterly meeting cycle, however it was agreed at the September 2020 meeting that due to breadth of the Committee's remit, a bimonthly schedule would be reinstated.

Five ordinary meetings were held between 1 April 2020 and 31 March 2021. In addition, an extraordinary meeting took place in January 2021 to discuss the publication of the Ockenden Report. Attendance at the meetings was as follows:

	Attendance at ordinary meetings (Attendance at Extraordinary Meeting)
Kath McCourt, Non-Executive Director (Committee Chair)	5 of 5 (1 of 1)
Keith Godfrey, Non-Executive Director	3 of 3* (0 of 0)
Graeme Chapman, Non-Executive Director	3 of 3** (1 of 1)
David Stout, Non-Executive Director	2 of 2*** (1 of 1)
Andy Welch, Medical Director and Deputy CEO	4 of 5 (1 of 1)
Maurya Cushlow, Executive Chief Nurse	3 of 5 (1 of 1)
Martin Wilson, Chief Operating Officer	5 of 5 (0 of 1)
Angela O'Brien, Director of Quality and Effectiveness	5 of 5 (1 of 1)
Gus Vincent, Assistant Medical Director, Patient Safety & Quality	4 of 5 (1 of 1)
Liz Harris, Deputy Chief Nurse	2 of 5 (0 of 1)

*Keith left his role as a Non-Executive Director at the end of his term of office in September 2020.
** Graeme joined the Committee as a Member from the September 2020 meeting, having observed the July meeting prior to commencing his term of office.
***David joined the Committee as a Member from the November 2020 meeting.

Other attendees at the meetings have included:

- The Deputy Medical Director;
- The Assistant Medical Director – Research & Development;

- The Associate Medical Director – Quality & Patient Safety;
- The Director of Infection Prevention and Control;
- The Senior Business Development Manager – Performance;
- The Clinical Effectiveness Manager;
- The Deputy Director of Quality & Safety;
- The Chief Clinical Information Officer;
- The Chief Nursing Information Officer;
- The Clinical Director – Women's Services;
- The Directorate Manager for Women's Services;
- The Associate Director of Midwifery;
- The Trust Lead for Nursing, Midwifery, and Allied Health Professional Research;
- An Associate Director of Nursing; and
- The Trust Secretary and Deputy Trust Secretary who provide 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.

The Committee receives a Chair's report at each meeting detailing the activities of the Management Groups. 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, supported by a verbal report by the Assistant Medical Director – Research & Development at each meeting.

The Committee was established during 2019/20 following the review of the Trust's governance structure. During 2020/21, Committee members continued to review and refine the content, frequency, and scheduling of reports, particularly in light of the continuing management of the COVID-19 pandemic. A review of the Management Group structure was undertaken in the autumn of 2020.

5. REPORTING

i. Regular Reports

During the year, the following reports were received by the Committee:

- COVID-19 Update: A verbal report was provided at each meeting of the Committee to provide an update on the Trust's management of the COVID-19 pandemic. This also included updates pertaining to the Flu vaccination programme and the COVID-19 vaccination programme;
- 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;
- Restart, Reset, and Recovery Update;
- Ockenden Report: Following the extraordinary meeting held in January 2021, the Committee continued to receive progress updates; and
- Serious Incident Report.

ii. <u>Quarterly and Annual Reports</u>

The following Quarterly and Annual reports were received by the Committee during 2020/21:

- Safeguarding;
- Learning Disability;
- Patient Experience;
- Board Assurance Framework Report relating to the Committee's area of focus;
- Mortality and Learning from Deaths;
- Healthcare Associated Infections and Infection Prevention and Control;
- Health & Safety Annual Report;
- Quality Account 2019/20: The contents of the report were approved by the Committee at its September 2020 meeting;
- Clinical Audit and Guidelines Group Annual Report;
- External Agency visits, Inspections, and Accreditation Report;
- Clinical Research Quality Report; and
- Quality Account Bi-Annual Report.

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 include:

- *Nightingale Hospital North East:* At the May 2020 meeting, the Committee received an update on the creation of the facility from the Chief Operating Officer.
- *COVID-19 Infection Prevention and Control Board Assurance Framework:* The Director of Infection Prevention and Control presented the framework at the May 2020 meeting.
- *Paperlite Presentation:* The Chief Clinical Information Officer and the Chief Nursing Information Officer provided a presentation at the July 2020 meeting of the Committee to address areas of concern raised by Committee members.
- *Quality Improvement Faculty:* The Executive Chief Nurse briefed the Committee at the July 2020 meeting on the creation of the faculty, in collaboration for The Institute for

Healthcare Improvement. A further update was provided at the February 2021 meeting.

- *Emergency Preparedness, Resilience, and Response Cyber Exercise Update:* The Director of Quality and Effectiveness provided assurance to the Committee that work to ensure compliance was underway.
- *Nursing, Midwifery, and Allied Health Professional Research (NMAHP) Update:* The Trust Lead for NMAHP Research provided a progress update at the February 2021 meeting.
- *Proposed Quality Priorities for 2021/22:* The Director for Quality and Effectiveness presented the proposed priorities to the Committee during the February 2021 meeting.

An extraordinary meeting of the Committee was convened in January 2021 to discuss the preliminary outcomes of the Ockenden Report. The report had been published following the raising of concerns from bereaved families in 2017 at The Shrewsbury and Telford Hospital NHS Trust. The report was commissioned by NHS Improvement to assess the quality of investigations relating to newborn, infant, and maternal harm.

The Clinical Director for Women's Services, the Directorate Manager for Women's Services, and the Associate Director of Midwifery attended the meeting to provide assurance and detail next steps.

6. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2020/21 and utilised a rolling programme and action log to track committee actions.

As highlighted in Section 5(ii), the Committee received regular updates on risks recorded on the Board Assurance Framework (BAF) which related to the Committee's area of focus. There were four risks recorded on the BAF during 2020/21 relating to the Committee being:

- 'There is a risk of regulatory and legal action if we (the Trust) fail to maintain safe care and treatment (CQC Regulation 12) for those who use our services, which could impact on patient safety, quality of care and the reputation of the Trust';
- 'Due to the complexity of patient conditions, there is a risk of HCAI whilst in the care of the Trust which could result in harm, serious illness and affect the Trust's ability to achieve IPC standards of care';
- 'Due to the rising community acquired infectious diseases (e.g. influenza/COVID-19), 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'; and
- 'There is a risk that patients will acquire COVID-19 whilst in receipt of healthcare. This is due to the high prevalence during the pandemic. This risk is exacerbated in certain patients due to pre-existing conditions. This could result in serious illness or death, prolonged stay and damage to the reputation of the Trust'.

7. PROGRESS FOR 2021/22 & REVIEW OF EFFECTIVENESS

During the spring of 2021, an exercise was undertaken to review the effectiveness of the Trust's Committee structure. In relation to this Committee, the following areas were highlighted:

- There continued to be valuable input to the Committee from a clinical and nursing perspective, particularly from the Management Group Chairs;
- Given the Committee's large remit, each meeting had both a significant agenda and a large volume of papers/reports. This resulted in insufficient time being allocated to agenda items to allow for full discussion to take place. This was further exacerbated by the temporary move to a quarterly meeting cycle;
- The vast remit of the Committee also resulted in a significant administrative burden in both servicing the Committee and its Management Group structure;
- The need to separate out the agenda items/information that provides assurance over statutory requirements and the agenda items/information which were 'nice to have' was noted;
- The format of information provided requires significant manual input which resulted in difficulty to further interrogate information and view 'real time' reporting;
- The desire for Non-Executive Committee members to increase understanding of specific areas and operational detail about the management of risk was highlighted; and
- It was highlighted that there was difficulty in separating operational/executive tasks from assurance tasks.

8. NEXT STEPS AND ACTIONS FOR 2021/22

The following actions/next steps for consideration during 2021/22 were noted:

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;
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;
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;
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;
5. Consider the inclusion of an assurance report to be received by the Committee relating to Newcastle Improvement; and
6. Provide additional specific training for new members regarding areas of Committee focus.

9. RECOMMENDATION

The Committee are asked to approve this report outlining work undertaken in 2020/21 and note the key areas to revisit during 2021/22.

Report of Fay Darville

Deputy Trust Secretary
13 July 2021

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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 that the delivery of continuous quality improvement 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 approach to continuous quality improvement processes for all Trust services, 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 Leads 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 Medical Director and the Executive Chief Nurse shall act jointly as the Executive Leads 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 Integrated Quality, Performance, People & Finance Report 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;
- NICE Compliance 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. 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 Leads, 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: 13 July 2021
Date approved: 22 July 2021 [Quality Committee] and [TBA] [Board]
Approved by: Board of Directors [TBC]
Review date: May 2022

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Agenda item A10(i) BRP

Quality	May-21	Jul-21	Sep-21	Nov-21	Jan-22	Mar-22
Regular reports						
Management Group reports, includes updates on: - New interventional procedures - IPC - NCEPOD	x	x	x	x	x	x
Leadership walkabouts		x (Annual Report)	x	x	x	x
Health and Safety		x (Annual Report)		x		
External visits/CQC		x	x	x	x	x
Minutes	x	x	x	x	x	x
Action log	x	x	x	x	x	x
Integrated Quality & Performance report	x	x	x	x	x	x
Quarterly						
Safeguarding		x (Annual Report)	x	x		
Mortality	x	x	x		x	
BAF Committee Assurance Report	x		x		x	
Learning from deaths	x	x		x		x
Learning disability				x		x
Patient Experience			x	x		x
IPC (quarterly with main IPC report)		x		x		x
Bi-annual						
Medicines Management				x		
End of Life and palliative care				x		x
Research and Innovation			x			x
Quality Account		x		x		
Quality Improvement			x			x
Annual						
HCAI		x				
Serious Incidents					x	
Compliance/External accreditation		x				
Clinical Audit			x (Annual Report)			
NICE				x		
Review of effectiveness		x				
Annual report to Board		x				
Terms of Ref and SoB		x				
Quality Strategy		x				
Patient Safety & Harm reduction report				x		
ED & Human Rights report				x		
Clinical Strategy		x				
PLACE assessment update report						x
Ad-hoc						
Policies and procedures						
Minutes from SubGroups		x	x	x	x	x
COVID-19 update	x	x	x	x	x	x
Nightingale Update						

Matters for review by exception by the Committee:
Litigation report
Nursing and Midwifery strategy
New clinical pathways and roles
report
CQUIN/QI
GIRFT
CQC Fundamental Stds

Agenda item A10(ii)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	29 July 2021						
Title	Annual Statement on behalf of The Newcastle upon Tyne Hospitals NHS Foundation Trust 2021/22 - Modern Slavery and Human Trafficking Act 2015						
Report of	Dan Shelley, Procurement and Supply Chain Director Kelly Jupp, Trust Secretary						
Prepared by	Dan Shelley, Procurement and Supply Chain Director Kelly Jupp, Trust Secretary						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☒	☒	☐				
Summary	The content of this report outlines the Trust's commitment to preventing modern slavery and human trafficking in its supply chain. It demonstrates that the Trust have reviewed and met it's requirements in line with Section 54 of the Modern Slavery Act 2015. The changes from the previous Statement include updating the financial year reference, the Training section and adding 2021/22 Priorities. Further a draft Action Plan for 2021/22 has been developed and shared with Audit Committee members.						
Recommendation	The Board of Directors is asked to consider and approve this statement which demonstrates the Trust's continuing support of the requirements of the legislation.						
Links to Strategic Objectives	Performance – Being outstanding, now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☐	☒	☐	☐	☐	☐	☐
Impact detail	Maintain compliance with all regulatory requirements.						
Reports previously considered by	This is an Annual submission. The previous Report was approved by the Trust Board on 30 July 2020. Considered by the Audit Committee on 27 July 2021.						

ANNUAL STATEMENT ON BEHALF OF THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST 2021/22

MODERN SLAVERY AND HUMAN TRAFFICKING ACT 2015

EXECUTIVE SUMMARY

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

The changes from the previous Statement include updating the financial year reference, the Training section and adding 2021/22 Priorities.

Following feedback from Mr Jowett at a previous Audit Committee meeting, a meeting was scheduled with Mr Jowett, the Procurement and Supply Chain Director and the Trust Secretary to discuss the development of an Action Plan. A draft action plan has been developed for 2021/22, which will be discussed further with Mr Jowett. The Action Plan itself will not be attached to the Statement as will be a live document which will be continually updated.

The Audit Committee considered the Statement at their meeting on 27 July 2021. 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.

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 it's requirements in line with Section 54 of the Modern Slavery Act 2015.

2. THE ORGANISATION

The Newcastle upon Tyne Hospitals NHS Foundation Trust 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 13,500 members of staff making it one of the largest employers in the North East with an annual turnover of around £1billion. 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.

Members of the Procurement teams who are Chartered Institute of Procurement and Supply (CIPS) qualified, or studying to become qualified, abide by the CIPS code of ethics and undertake an annually revised CIPS Ethics Test.

A Trust programme to deliver Modern slavery training to all Procurement and Supplies teams was introduced in 2018, this has been refreshed as case law and best practice develops.

During 2021/22, the Trusts internal course will be replaced by the CIPS Corporate Ethics Training with all relevant staff within the Procurement & Supply Chain Department taking the annual ethics test.

The Trust will then seek to achieve the CIPS Corporate Ethics Accreditation Mark.

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
e) Volunteer
f) Prevention of Illegal Working
g) Locum Appointments Procedure (Medical and Dental)

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 2021/22

- Develop an annual Modern Slavery Action Plan. (Draft plan is included at Appendix 1)
- Continue to work with NHS Supply Chain to gain assurances on their supply Chains which supply the Trust.
- Review our procurement processes to ensure the Trust is meeting its commitments to eradicating modern slavery in its supply chains.
- Work with partners across the ICS to deliver a coordinated approach.

6. APPROVAL FOR THIS STATEMENT

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

Report of Dan Shelley, Procurement and Supply Chain Director, and Kelly Jupp, Trust Secretary
20 July 2021

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