The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	30 September 2021						
Title	Consultant Appointments						
Report of	Andy Welch, Medical Director						
Prepared by	Colin Sakhe, Senior HR Advisor (Medical & Dental)						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The content of this report outlines recent Consultant Appointments.						
Recommendation	The Board of Directors is asked to review the decisions of the Appointments Committee.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. People – Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☐	☐	☐	☒	☐	☐	☐
Impact detail	Ensuring the Trust is sufficiently staffed to meet the demands of the organisation.						
Reports previously considered by	Consultant Appointments are submitted for information in the month following the Appointments Panel.						

CONSULTANT APPOINTMENTS

1. APPOINTMENTS COMMMITTEE – CONSULTANT APPOINTMENTS

1.1 An Appointments Committee was held on 23 July 2021 and interviewed 1 candidate for 1 Consultant Paediatric Gastroenterologist post.

By unanimous resolution, the Committee was in favour of appointing Dr David Campbell.

Dr Campbell holds MBBS (St Bartholomew's Hospital) 1991 and FRCPCH (UK) 1995. Dr Campbell is currently employed as a Consultant Paediatric Gastroenterologist by the Sheffield Children's Hospital NHS Foundation Trust.

Dr Campbell is expected to take up the post of Consultant Paediatric Gastroenterologist in November 2021.

1.2 An Appointments Committee was held on 23 July 2021 and interviewed 1 candidate for 1 Consultant in Paediatric Intensive Care Medicine post.

By unanimous resolution, the Committee was in favour of appointing Dr Aimee Foster.

Dr Foster holds MBBS (University of Newcastle) 2009 and MRCPCH (UK) 2013. Dr Foster is currently employed as a Post CCT Fellow in Paediatric Cardiac Intensive Care and Mechanical Support based at the Freeman Hospital.

Dr Foster is expected to take up the post of Consultant in Paediatric Intensive Care Medicine in November 2021.

1.3 An Appointments Committee was held on 06 August 2021 and interviewed 1 candidate for 1 Consultant in Respiratory Medicine post.

By unanimous resolution, the Committee was in favour of appointing Dr Kishor Lekhak.

Dr Lekhak holds MBBS (University of Newcastle) 2011 and MRCP (UK) 2013. Dr Lekhak is currently employed as a Specialty Trainee based at the University Hospital of North Durham.

Dr Lekhak is expected to take up the post of Consultant in Respiratory Medicine in November 2021.

1.4 An Appointments Committee was held on 11 August 2021 and interviewed 4 candidates for 3 Consultant Emergency General Surgeon posts.

By unanimous resolution, the Committee was in favour of appointing Mr John Moir, Mr Rodrigo Figueiredo and Mr Alrawashdeh Wasfi.

Mr Moir holds MBBS (University of Newcastle) 2006 and FRCS (UK) 2020. Mr Moir is currently employed as a Senior clinical fellow based at the Freeman Hospital.

Mr Figueiredo holds MBChB (University of Dundee) 2008 and FRCS (UK) 2020. Mr Figueiredo is currently employed as a Specialty Trainee in Hepatobiliary and Transplant Surgery based at the Freeman Hospital.

Mr Wasfi holds MBBS (Jordan) 2000 and FRCS (UK) 2021. Mr Wasfi is currently employed as a Specialty Trainee based at the Freeman Hospital.

Mr Moir is expected to take up the post of Consultant Emergency General Surgeon in November 2021.

Mr Figueiredo is expected to take up the post of Consultant Emergency General Surgeon in November 2021.

Mr Wasfi is expected to take up the post of Consultant Emergency General Surgeon in November 2021.

1.5 An Appointments Committee was held on 13 August 2021 and interviewed 2 candidates for 1 Consultant Thoracic Surgeon.

By unanimous resolution, the Committee was in favour of appointing Mr Keng Ang.

Mr Ang holds MBBCh (University College Dublin) 1997, FRCSEd (UK) 2015 and PhD (UK) 2013. Mr Ang is currently employed as a Consultant Thoracic Surgeon by the University Hospitals of Leicester NHS Trust.

Mr Ang is expected to take up the post of Consultant Thoracic Surgeon in January 2022.

1.6 An Appointments Committee was held on 01 September 2021 and interviewed 1 candidate for 1 Consultant Paediatric Nephrologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Charles Pickles.

Dr Pickles holds MBBS (University College London) 2011 and MRCPCH (UK) 2015. Dr Pickles is currently employed as a Specialty Trainee based at the Royal Victoria Infirmary.

Dr Pickles is expected to take up the post of Consultant Paediatric Nephrologist in February 2022.

1.7 An Appointments Committee was held on 09 September 2021 and interviewed 5 candidates for 2 Consultant Cardiac and Transplant Surgeon posts.

By unanimous resolution, the Committee was in favour of appointing Mr Vamsidhar Dronavalli and Mr Muhammad Mydin

Mr Dronavalli holds MBBS (University College London) 2000, MRCS (UK) 2005 and PhD (University of Birmingham) 2015. Mr Dronavalli is currently employed as a Lung transplant surgery/ECMO Fellow by the Royal Papworth Hospital NHS Foundation Trust.

Mr Mydin holds MBChB (University of Dundee) 2003 and FRCSed (UK) 2018. Mr Mydin is currently employed as a Locum consultant cardiothoracic and transplant surgeon by the University of Toronto.

Mr Dronavalli is expected to take up the post of Consultant Cardiac and Transplant Surgeon in January 2022.

Mr Mydin is expected to take up the post of Consultant Cardiac and Transplant Surgeon in January 2022.

1.8 An Appointments Committee was held on 09 September 2021 and interviewed 3 candidates for 1 Consultant in Restorative Dentistry post.

By unanimous resolution, the Committee was in favour of appointing Mr Mark Ritchie.

Mr Ritchie holds BDS (University of Newcastle) 2012 and MFDS (UK) 2014. Mr Ritchie is currently employed as a Specialty Trainee based at the Newcastle Dental Hospital.

Mr Ritchie is expected to take up the post of Consultant in Restorative Dentistry in October 2021.

1.9 An Appointments Committee was held on 10 September 2021 and interviewed 1 candidate for 1 Consultant in Reproductive Medicine and Gynaecology post.

By unanimous resolution, the Committee was in favour of appointing Dr Rekha Neelakanta Pillai.

Dr Pillai holds MBBS (India) 2012 and MRCOG (UK) 2012. Dr Pillai is currently employed as a Specialty Trainee based at the Royal Victoria Infirmary.

Dr Pillai is expected to take up the post of Consultant in Reproductive Medicine and Gynaecology in November 2021.

2. RECOMMENDATION

1.1 – 1.9 – For the Board to receive the above report.

Report of Andy Welch
Medical Director
23 September 2021

THIS PAGE IS INTENTIONALLY BLANK

The Newcastle upon Tyne Hospitals NHS Foundation Trust

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 September 2021						
Title	NHS Emergency Preparedness, Resilience & Response (EPRR) National Assurance Process 2021 - 2022						
Report of	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Prepared by	Michael Clark, Head of Business Continuity & Emergency Planning						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	The Report highlights issues the Medical Director wishes the Board to be made aware of.						
Recommendation	The Board of Directors is asked to note the contents of the report.						
Links to Strategic Objectives	Putting patients at the heart of everything we do and providing care of the highest standard focusing on safety and quality.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☐	☐	☐	☐	☐
Impact detail	The Trust is required to meet legislative duties set out in the Civil Contingencies Act 2004.						
Reports previously considered by	The EPRR Core Standards Self-Assessment Board Report is submitted annually to the Trust Board						

NHS EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR) NATIONAL ASSURANCE PROCESS 2021-22

1. INTRODUCTION

The NHS is required to plan for, and respond to, a wide range of incidents, emergencies, threats and hazards that could impact upon the provision of healthcare. The last 18 months have highlighted the importance of this work as the Trust has navigated the COVID-19 pandemic and a number of supply chain disruptions. Other examples of threats include external incidents such as extreme weather conditions, a major transport accident or internal disruptions affecting IT or the estate. The Civil Contingencies Act (2004) and NHS England, via a set of national EPRR Core Standards, requires NHS organisations, and providers of NHS-funded care, to provide assurance that they can deal with such incidents while maintaining essential services.

The 2020/21 version of EPRR Core Standards was limited in scope to mitigate demand on EPRR Teams during the height of the pandemic. The 2021/22 Core Standards is more comprehensive and closely aligned to versions completed pre-pandemic, however the process continues to be condensed as the Training & Exercising domain is removed.

2. ASSURANCE REQUIREMENTS

The NHS England & Improvement Regional Team has written to the Trust requesting that the organisation's final overall assurance rating be:

- Formally reported to, and signed off by, the organisation's Board.
- Presented at a public Board meeting.
- Published in the organisation's annual report.

A declaration of the overall level of compliance – see table below for criteria.

Overall EPRR Assurance Rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are required to achieve.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve.

3. TRUST POSITION ON COMPLIANCE STATEMENT

The table below summarises the current Trust compliance position against all relevant domains within the 2021/22 Core Standards. Following the completion of the self-assessment process, the Trust is **Fully Compliant** across all domains.

DOMAIN	COMPLIANCE POSITION	WORK PLAN REQUIRED TO ACHIEVE COMPLIANCE
Governance	Fully compliant	N/A
Duty to Assess Risk	Fully compliant	N/A
Duty to Maintain Plans	Fully compliant	N/A
Command & Control	Fully compliant	N/A
Training & Exercising	Not Assessed in 2021/22 Core Standards	N/A
Response	Fully compliant	N/A
Warning & Informing	Fully compliant	N/A
Co-operation	Fully compliant	N/A
Business Continuity	Fully compliant	N/A
Chemical, Biological, Radiological, Nuclear (CBRN) & Hazardous Material (HAZMAT)	Fully compliant	N/A

The removal of assessment against a domain does not remove the need for the Trust to ensure appropriate action in this area. The annual EPRR work programme delivers continual improvement across all domains to ensure that the Trust is able to adapt and respond to evolving threats.

Training & Exercising remains an important part of EPRR and the department will continue to deliver appropriate training courses and exercises in line with requirements set out in previous versions of the Core Standards. Throughout the calendar year of 2021, the Head of Business Continuity & Emergency Planning – jointly with the Clinical Lead for Major Incident Planning – have continued to deliver table-top training exercises to the Corporate On-call Team to support major incident preparedness.

A R Welch FRCS
Medical Director
21st September 2021

THIS PAGE IS INTENTIONALLY BLANK

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	30 September 2021						
Title	A framework of quality assurance for responsible officers and revalidation Annex D – annual board report and statement of compliance						
Report of	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Prepared by	Michael Wright, Deputy Medical Director						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	The Report highlights issues the Medical Director wishes the Board to be made aware of.						
Recommendation	The Board of Directors is asked to note the contents of the report.						
Links to Strategic Objectives	Putting patients at the heart of everything we do and providing care of the highest standard focusing on safety and quality.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☐	☐	☐	☐	☐
Impact detail							
Reports previously considered by	Submitted annually to the Trust Board.						

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The Board of The Newcastle Upon Tyne Hospitals NHS Foundation Trust can confirm that:

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

Action from last year: Responsible Officer is in place and appropriately trained. Comments: The Medical Director is the Responsible Officer and is supported in this role by the Deputy Medical Director who is the Associate Responsible Officer and manages the operational delivery of the Appraisal and Revalidation programme. Action for next year: The Responsible Officer and Associate Responsible Officer will maintain appropriate training.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: Ensure ongoing support for the appraisal and Revalidation process. Comments: Medical appraisal and Revalidation is supported by 2 part time staff in the Medical Staffing Department (0.6 FTE Band 5 and 0.4 FTE Band 6) and the Head of Medical and Dental Staffing. The Associate Responsible Officer is supported by a Medical Appraisal Lead for the Trust who receives a responsibility allowance for this role. Appraisal of locally employed doctors (previously known as Trust doctors) is managed by the medical education team. A number of appraisers have retired and over the last 12 months. Training of a new group of appraisers to supplement the existing cohort is scheduled for November 2021. Appraisers are paid a responsibility allowance.

Action for next year: To complete training of new appraisers. Ensure ongoing support for the appraisal and Revalidation process. Review resource requirements for appraisal and Revalidation.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: To consolidate implementation and utilisation of the SARD appraisal and Revalidation system.

Comments: The SARD system is now fully implemented with all consultant and SAS staff completing appraisal using this software. The system has been welcomed by appraisers, appraisees and the Revalidation team. It has reduced the administrative burden for all concerned. The final component of the SARD system is currently being implemented- a link to the GMC connect portal. This will provide automatic update in SARD of information on doctors' Revalidation held by the GMC.

Work has been carried out with SARD to develop an online system for appraisal and Revalidation of locally employed doctors. This work continues and it is hoped that further progress will be made this year.

Action for next year: To complete the implementation of SARD/GMC connect link. Continue work to develop SARD subsystem for appraisal and Revalidation of locally employed doctors.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Review of policies following implementation of SARD system.

Comments: Appraisal Policy – Senior Medical and Dental Staff was updated on 15th June 2021 following review.

Action for next year: Further review of policy ahead of expiry date 18/3/2022.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year; External audit to be carried out with peer Trust.

Comments: An external audit with a peer Trust was not possible due to the COVID pandemic.

An audit was carried out by Audit One and a report issued on 1st June 2021.

An overall rating of substantial assurance was reached and three low priority recommendations made. An action plan is in place to meet all of these recommendations.

Action for next year: To complete action plan from internal audit.

To consider external audit with peer Trust.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: To complete the development of a module within the SARD system for locally employed doctors.

Comments: It has not been possible to complete this work due to the COVID pandemic. Locally employed doctors and long term locum junior doctors are supported by the medical education team. Locum consultant and SAS doctors are supported by the senior medical and dental appraisal and Revalidation team.

Action for next year: To re-consider development of a module within the SARD system for locally employed doctors.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical

outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: Continue monitoring of appraisal and develop monitoring processes within the SARD system.

Comments: All medical appraisal was suspended in March 2020 on instruction from the GMC in response to the COVID pandemic with a partial restart in October 2020 and a full restart in April 2021. We have not implemented the Appraisal 2020 template but have applied the principles of Appraisal 2020. These include a recommendation that there should be a reduced requirement for written documentation and an increased emphasis on verbal reflection and discussion. We maintained the opportunity for staff to have appraisals during the period of suspension and have continued to encourage verbal reflection, particularly on the effects of the COVID pandemic on individuals' clinical practice and their wellbeing.

Action for next year: To complete the full restart of appraisal and monitoring of completed appraisals.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: To further reduce delayed and missed appraisals.

Comments: It was not possible to complete this action because of the COVID pandemic. We have now restarted appraisal and monitoring. We are very aware of the ongoing pressures that all staff are under but continue to support medical and dental staff to take part in appraisal where this is not happening.

Action for next year: To achieve levels of medical and dental appraisal seen prior to March 2020.

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

Action from last year: Appraisal policy should be reviewed.

Comments: See section 1.4.

Action for next year: To review appraisal policy prior to expiry date March 2022.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Ensure appropriate numbers of appraisers are available.

Comments: See section 1.2.

Action for next year: To complete training of additional appraisers as scheduled in November 2021 to ensure there are adequate appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Develop additional performance monitoring matrices using the SARD system.

Comments: This has not been possible due to the suspension of appraisal in response to the COVID pandemic. We are currently reviewing the training of all appraisers following the restart of appraisal.

Action for next year: To develop additional performance monitoring matrices using the SARD system.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Annual report to be submitted to the Board by the RO. Comments: The appraisal and Revalidation process was assessed by Audit One and a rating of substantial assurance given (see section 1.5). Action for next year: To consider external review with a peer Trust.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: The Newcastle upon Tyne Hospitals NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2021	**1184**
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	**579**
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	**605**
Total number of agreed exceptions	**588**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: All recommendations to be made on time using appropriate protocol.

Comments: The GMC deferred most recommendations for Revalidation due to be made during the reporting period. Those recommendations which were required were all made in a timely manner according to RO protocol.

Action for next year: All recommendations to be made on time using appropriate protocol.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: All doctors to be contacted when recommendation is made.

Comments: All doctors are informed of outcome of the recommendation process.

Action for next year: All doctors to be contacted when recommendation is made.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: To maintain clinical governance structures.

Comments: The Trust has continued to operate all appropriate clinical governance structures during the reporting period despite the COVID pandemic.

Action for next year: To maintain clinical governance structures.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: To maintain existing process for responding to concerns and ensure appropriate actions are taken when necessary.

Comments: Information is provided to doctors for appraisal compiled by CGARD. Preparation of this information is under review.

Action for next year: To complete review of preparation of information for appraisal by CGARD.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: To review process for responding to concerns.

Comments: Concerns raised about a doctors are managed according to agreed protocol. Where there is a concern about a doctor's fitness to practice this is managed according to Trust Capability Procedure for Medical and Dental Staff which includes arrangements for investigation as required.

Action for next year: To continue to manage concerns according to agreed process.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: To review reporting process.

Comments: It has not been possible to complete this review due to the COVID pandemic.

Action for next year: To consider further analysis of concerns reporting.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: All concerns to be transferred at RO to RO or Associate RO to RO level. Comments: Action for next year: To continue with existing processes for transfer of information between ROs.

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

Action from last year: Ensure review of policies maintains freedom from bias and discrimination. Comments: All policies in the Trust are evaluated for freedom from bias and discrimination. Action for next year: To continue with current processes for review of policies.

Section 5 – Employment Checks

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

Action from last year: To maintain existing systems for pre-employment checking. Comments: All doctors employed undergo appropriate pre-employment checks prior to commencement. Action for next year: To continue existing systems for pre-employment checks.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report**
- The COVID pandemic and associated suspension of medical and dental staff appraisal and deferment of all recommendations for Revalidation slowed progress with further development of the appraisal and Revalidation system locally. Despite that progress has been made with full implementation of the SARD appraisal system and the recent establishment of a direct link to the GMC connect portal will further support this.
- An audit of the appraisal and Revalidation system was carried out in June 2021 and a substantial assurance rating granted.
- The appraisal process was maintained throughout COVID for those who wished to take part with a soft restart in October 2020 and full restart from 1/4/21. Emphasis has been placed on the importance of reflection on COVID and its effects on individuals practice and their wellbeing.
- **Actions still outstanding**
- Further work is required on the appraisal and Revalidation system for locally employed doctors and this is now being taken forward by Dr. Emma Lethbridge and the medical education team.
- Further work is required on the system for providing information to medical and dental staff for their appraisals on performance and activity.
- Capacity issues for all acute providers have made it impossible to complete a peer to peer review of appraisal and Revalidation this year but that will be considered again in 21/22.
- **Current Issues**
- We continue to attempt to reduce the administrative burden associated with appraisal and Revalidation. The introduction of the SARD/GMC link will help with this. When this is completed we will review our available support resource.
- New appraisers are required with a number having retired during the last 18 months. Training of the next cohort of appraisers is scheduled for November 2021.
- The appraisal and Revalidation team in HR are working with the medical education team to review processes the two teams.
- The deferral of all Revalidation recommendations from 2020 by the GMC was beneficial at the time however it has now resulted in very high numbers of recommendations to be processed during the rest of 2021. In essence we are dealing with two years of Revalidation recommendations in a single year, c. 450 recommendations.

- **New Actions:**

- We are in a period of reset following the suspension of appraisal and Revalidation during 2020. We have therefore agreed not to plan any new developments until the held over actions from last year are completed and the recommendation bulge is dealt with.

Overall conclusion:

The suspension of appraisal and Revalidation in 2020 by the GMC was the correct decision. We have successfully restarted the process and are dealing with the appraisal and recommendation backlog.

Further developments in appraisal process will be possible once this is completed and we will continue to work with the SARD team and senior medical and dental staff to facilitate these.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

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

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

A R Welch FRCS
Medical Director
21st September 2021

THIS PAGE IS INTENTIONALLY BLANK

Healthcare worker flu vaccination best practice management checklist

For public assurance via trust boards by December 2021

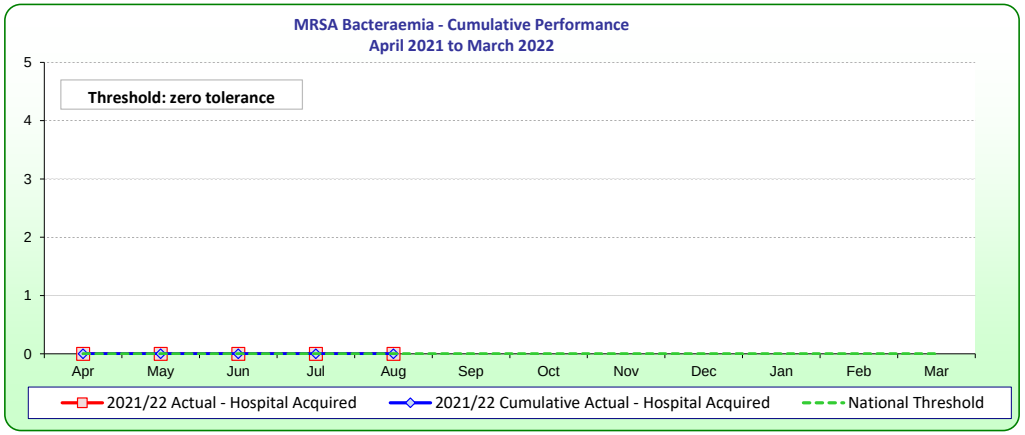
A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	100% ambition acknowledged
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	Yes – overseen by Vaccine Steering Group
A3	Board receive an evaluation of the flu programme 2020 to 2021, including data, successes, challenges and lessons learnt	Reported via DIPC report in January and March 2021
A4	Agree on a board champion for flu campaign	Yes, Maurya Cushlow, Executive Chief Nurse and Andy Welch, Medical Director
A5	All board members receive flu vaccination and publicise this	Yes in action plan
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Multi-professional Vaccine Steering Group well established with staff side representative requested and in receipt of minutes. Also discussed at Trust Consultative Group and Employment Partnership Forum.
A7	Flu team to meet regularly from August 2021	Vaccine Steering Group meeting weekly since July 2021
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trade unions	In place and overseen by Vaccine Steering Group
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	In place and overseen by Vaccine Steering Group
B3	Board and senior managers having their vaccinations to be publicised	In place and overseen by Vaccine Steering Group
B4	Flu vaccination programme and access to vaccination on induction programmes	In place and overseen by Vaccine Steering Group
B5	Programme to be publicised on screensavers, posters and social media	In place and overseen by Vaccine Steering Group
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Planned and will be overseen by Vaccine Steering Group
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Robust training program in place – all directorates supported
C2	Schedule for easy access drop in clinics agreed	In place and included in action plan. Clinics are booked clinics not drop in due to COVID-19 and need for social distancing

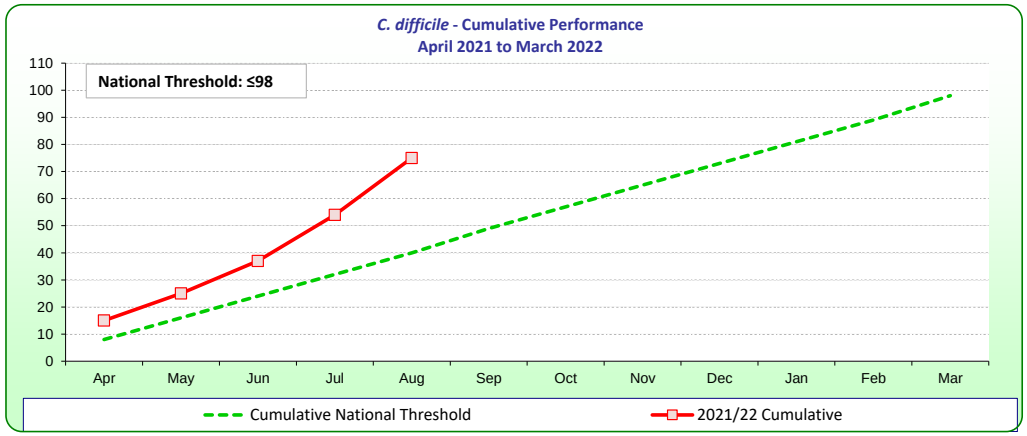
C3	Schedule for 24 hour mobile vaccinations to be agreed	Twilight shift, weekend and night duty shifts agreed via Staff Bank and Occupational Health Nurse team

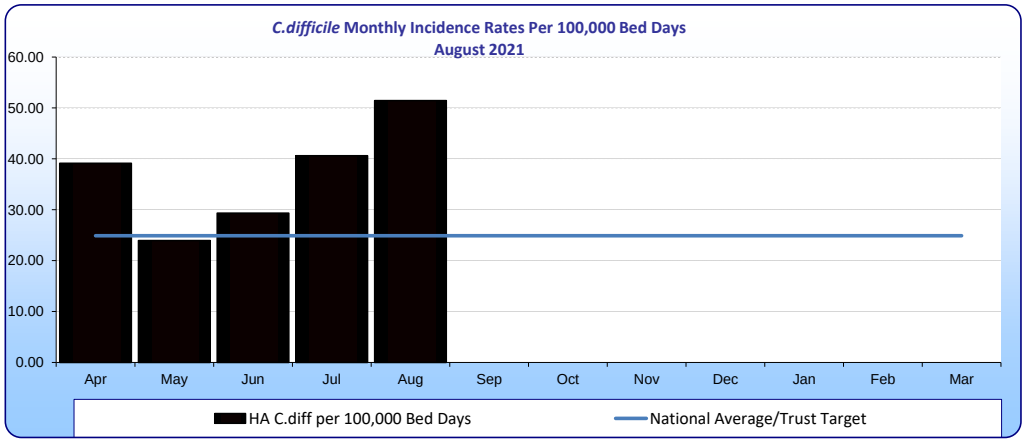
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Agreed – steering group are progressing with the Comms Team to finalise.
D2	Success to be celebrated weekly	In place and overseen by Vaccine Steering Group

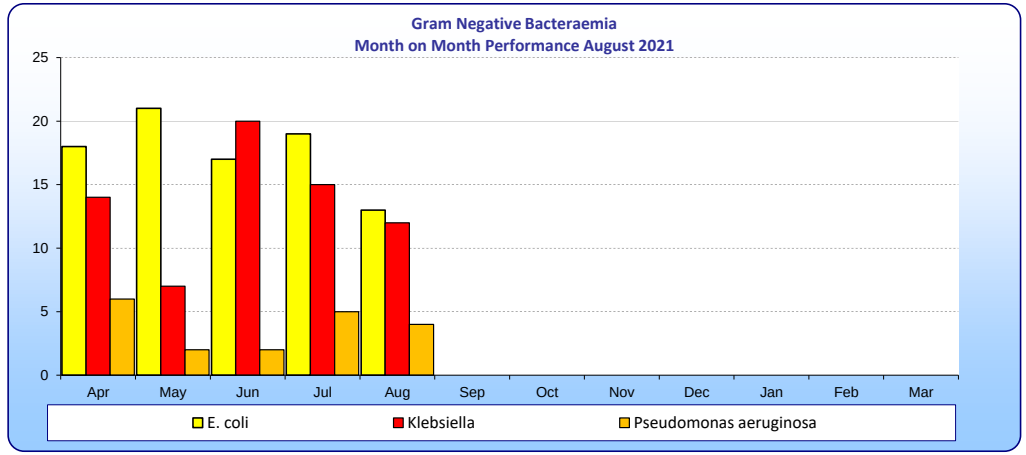
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

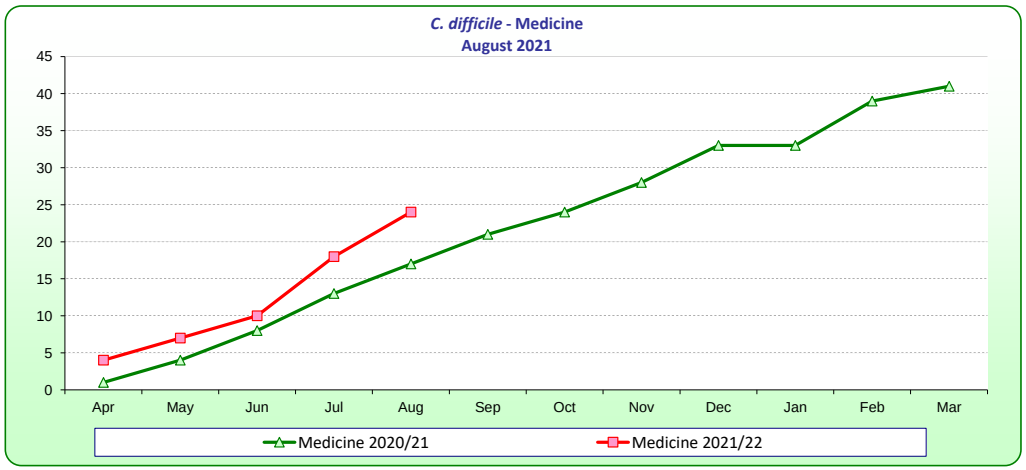
Healthcare-Associated Infections Report
August 2021

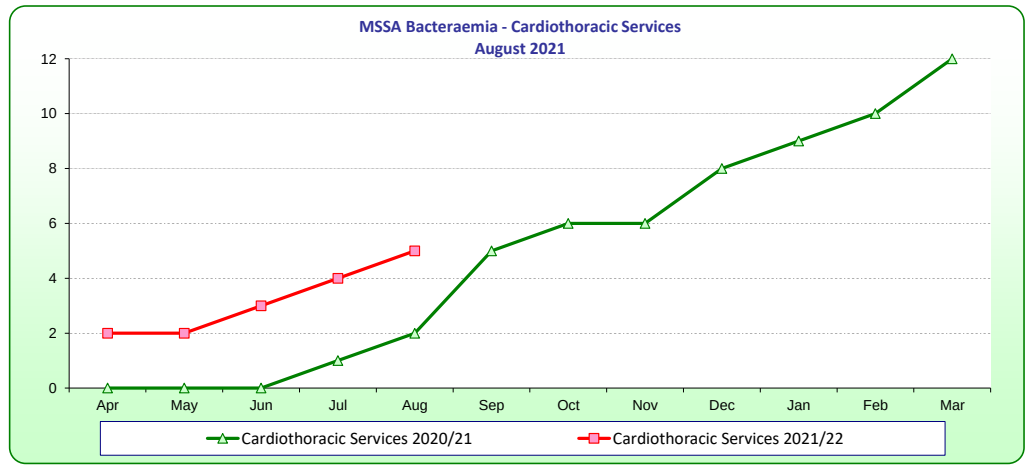

MRSA Bacteraemia - Cumulative Performance
April 2021 to March 2022
Threshold: zero tolerance
0
1
2
3
4
5
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2021/22 Actual - Hospital Acquired
2021/22 Cumulative Actual - Hospital Acquired
National Threshold

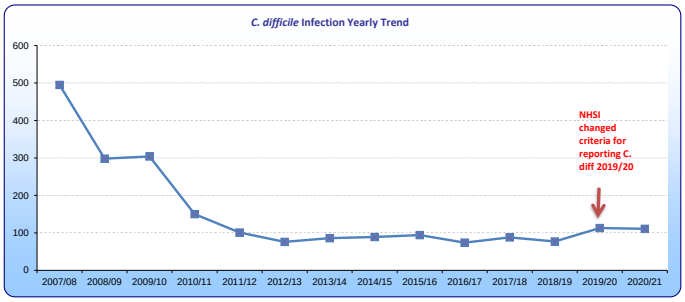

C. difficile - Cumulative Performance
April 2021 to March 2022
National Threshold: ≤98
0
10
20
30
40
50
60
70
80
90
100
110
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Cumulative National Threshold
2021/22 Cumulative

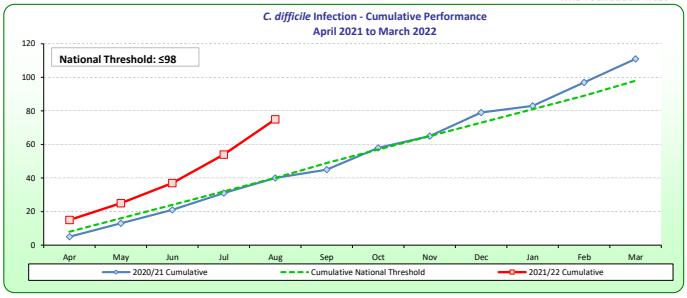

C.difficile Monthly Incidence Rates Per 100,000 Bed Days
August 2021
0.00
10.00
20.00
30.00
40.00
50.00
60.00
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
HA C.diff per 100,000 Bed Days
National Average/Trust Target

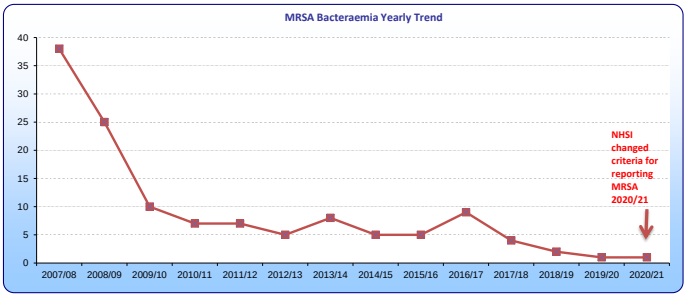

Gram Negative Bacteraemia
Month on Month Performance August 2021
0
5
10
15
20
25
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
E. coli
Klebsiella
Pseudomonas aeruginosa

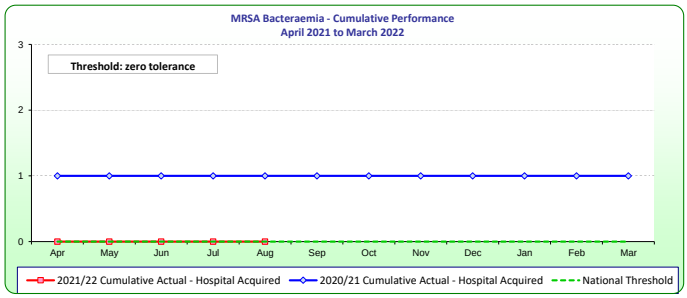

C. difficile - Medicine
August 2021
0
5
10
15
20
25
30
35
40
45
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Medicine 2020/21
Medicine 2021/22

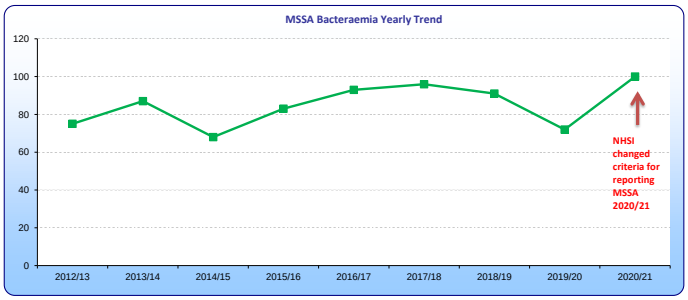

MSSA Bacteraemia - Cardiothoracic Services
August 2021
0
2
4
6
8
10
12
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Cardiothoracic Services 2020/21
Cardiothoracic Services 2021/22

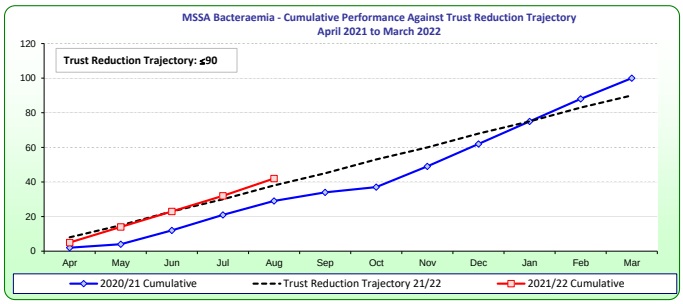

C. difficile Infection Yearly Trend
NHSI changed criteria for reporting C. diff 2019/20
2007/08 2008/09 2009/10 2010/11 2011/12 2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19 2019/20 2020/21

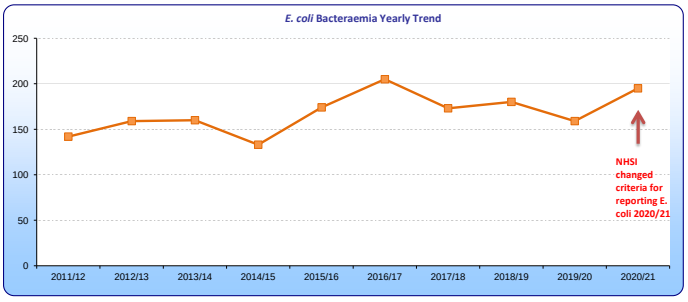

C. difficile Infection - Cumulative Performance
April 2021 to March 2022
National Threshold: ≤98
2020/21 Cumulative
Cumulative National Threshold
2021/22 Cumulative

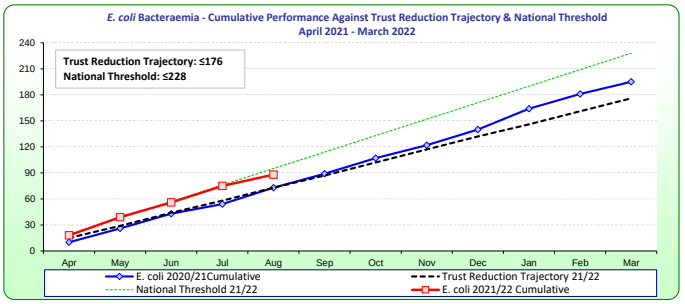

MRSA Bacteraemia Yearly Trend
NHSI changed criteria for reporting MRSA 2020/21
2007/08 2008/09 2009/10 2010/11 2011/12 2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19 2019/20 2020/21

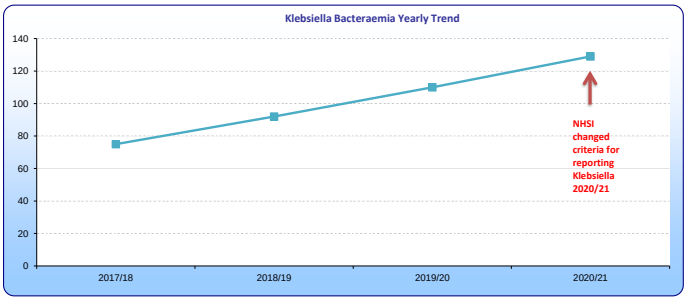

MRSA Bacteraemia - Cumulative Performance
April 2021 to March 2022
Threshold: zero tolerance
2021/22 Cumulative Actual - Hospital Acquired
2020/21 Cumulative Actual - Hospital Acquired
National Threshold

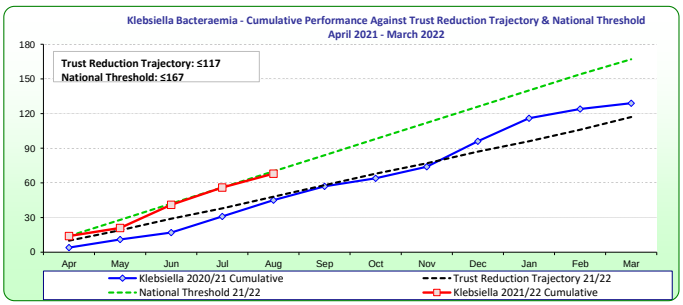

MSSA Bacteraemia Yearly Trend
NHSI changed criteria for reporting MSSA 2020/21
2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19 2019/20 2020/21

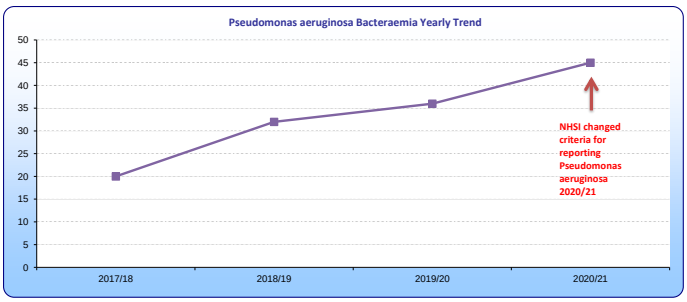

MSSA Bacteraemia - Cumulative Performance Against Trust Reduction Trajectory
April 2021 to March 2022
Trust Reduction Trajectory: ≤90
2020/21 Cumulative
Trust Reduction Trajectory 21/22
2021/22 Cumulative

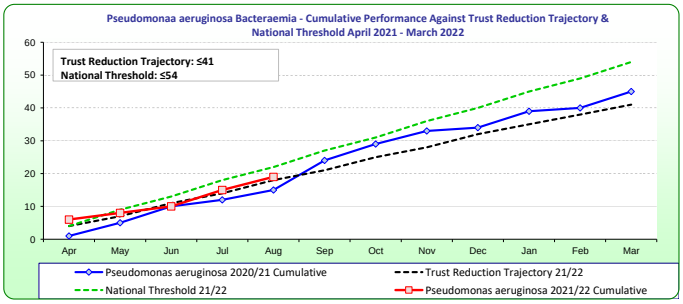

E. coli Bacteraemia Yearly Trend
NHSI changed criteria for reporting E. coli 2020/21
2011/12 2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19 2019/20 2020/21


E. coli Bacteraemia - Cumulative Performance Against Trust Reduction Trajectory & National Threshold
April 2021 - March 2022
Trust Reduction Trajectory: ≤176
National Threshold: ≤228
E. coli 2020/21Cumulative
Trust Reduction Trajectory 21/22
National Threshold 21/22
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 Trust Reduction Trajectory & National Threshold
April 2021 - March 2022
Trust Reduction Trajectory: ≤117
National Threshold: ≤167
Klebsiella 2020/21 Cumulative
Trust Reduction Trajectory 21/22
National Threshold 21/22
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 Trust Reduction Trajectory &
National Threshold April 2021 - March 2022
Trust Reduction Trajectory: ≤41
National Threshold: ≤54
Pseudomonas aeruginosa 2020/21 Cumulative
Trust Reduction Trajectory 21/22
National Threshold 21/22
Pseudomonas aeruginosa 2021/22 Cumulative

Healthcare-Associated Infection Report August 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	0								0
MRSA HA acquisitions	2	0	1	2	5								10
MSSA Bacteraemia - post-48 Hours Admission (local objective ≤90)	5	9	9	9	10								42
E. coli Bacteraemia - post-48 Hours Admission (local objective ≤176)	18	21	17	19	13								88
Klebsiella Bacteraemia - post-48 Hours Admission (local objective ≤117)	14	7	20	15	12								68
Pseudomonas aeruginosa Bacteraemia - post-48 Hours Admission (local objective ≤41)	6	2	2	5	4								19
C.diff - Hospital Acquired (objective ≤100)	15	10	12	17	21								75
C.diff related death certificates	2	0	1	0	0								3
Part 1	2	0	1	0	0								3
Part 2	0	0	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	-	-	-	-	1								1
Patients affected	-	-	-	-	2								2
C.diff - Hospital Acquired	3	2	5	1	3								14
Patients affected	6	4	8	2	7								27

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	6	7								17
Hospital onset Definite HC assoicated (≥15 days post admission)	-	-	-	7	2								9

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	-	-	1	0	0								1
Patients affected (total)	-	-	18	0	0								18
Staff affected (total)	-	-	12	0	0								12
Bed days losts (total)	-	-	5	0	0								5
Other Outbreaks	-	-	-	1	0								1
Patients affected (total)	-	-	-	5	0								5
Staff affected (total)	-	-	-	11	0								11
Bed days losts (total)	-	-	-	4	0								4
COVID Outbreaks	-	-	2	3	2								7
Patients affected (total)	-	-	8	9	3								20
Staff affected (total)	-	-	1	0	1								2
Bed days losts (total)	-	-	45	29	-								74

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	10:56	13:14								11:05
Laboratory Turnaround Time	02:28	03:15	03:38	03:25	04:39								03:29
Total to Result Availability	12:24	13:31	14:41	14:21	17:53								14:34

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%	88%	88%								88%

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%	57%	55%								56%

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Equality and Diversity People Update

September 2021

Healthcare at its best
with people at our heart

Public Sector Equality Duty

People Objective: To be the recognised employer and educator in the North East to enable all staff to liberate their potential
Goal: Employer of Choice
Strategy: Build an inclusive and diverse workforce
Measures: Increase BAME Diversity to 15%, Deliver Single Equality Action Plan, Improve Stonewall Ranking, Deliver Gender and Ethnicity Pay Gap report

The requirement to publish the 2020/21 data-set on the Trust's website will be completed by 30 September 2021

People Objectives 2020-2024

Objective	Action	Measure	Aim
Stonewall Work Place Equality Index	To be in the top 20 of employers listed in the Stonewall Equality Index by 2024	Top 20 Employer	March 2024
Workforce Race Equality Standard	Use the NHS WRES to understand the differences in staff experience between White and BME employees and inform improvement plans	Equal Staff Experience	March 2022
Workforce Disability Standard	Use the NHS WDES to understand the differences in staff experience between White and BME employees and inform improvement plans	Equal Staff Experience	March 2022
Disability Confident	Become accredited as a Disability Leader	Disability Leader Status	December 2023
Gender Pay Gap Reporting	Development of an equality dashboard with key performance indicators Equal experience, Clinical Excellence Awards	KPI's in place CEA Data	March 2024

Workforce Race Equality Standard

Introduction

The NHS Workforce Race Equality Standard (WRES) was introduced in 2015 to help prompt enquiry to better understand why it is that BAME staff often experience much poorer treatment than White staff and facilitate the closing of those gaps in experience. The nine WRES Indicators use data from the NHS Annual Staff Survey and data from the NHS Employee Staff Record (ESR).

Evidence in recent years has suggested BAME staff feel a lack of opportunities and career progression; and harassment, bullying or abuse from patients, relatives, the public, and staff discrimination at work from managers or colleagues.

From April 2016 onwards, progress on the WRES has been considered as part of the CQC's "Well-led" domain.

The NHS Equality and Diversity Council aims to ensure NHS staff from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The Council produces a report each year on the NHS WRES to highlight the challenges, and to start and identify steps the NHS needs to take to ensure any less favourable treatment of staff is removed.

Use the findings in the WRES Indicators to understand the differences experienced by our staff at Directorate/staff group level to focus attention on local priority actions

A targeted approach is being taken to achieve improvements and accelerate progress towards the overall aim of a workforce and workplace that is fair and equitable for all.

The HR team is leading on the work needed in collaboration with managers and key stakeholders, such as the BAME staff network group, WRES Sub Group and the People Committee

Results of Trust's Annual NHS Staff Survey for WRES Indicators

(Green represents better and red represents worse experience for BAME compared to White. Amber represents equal experience)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

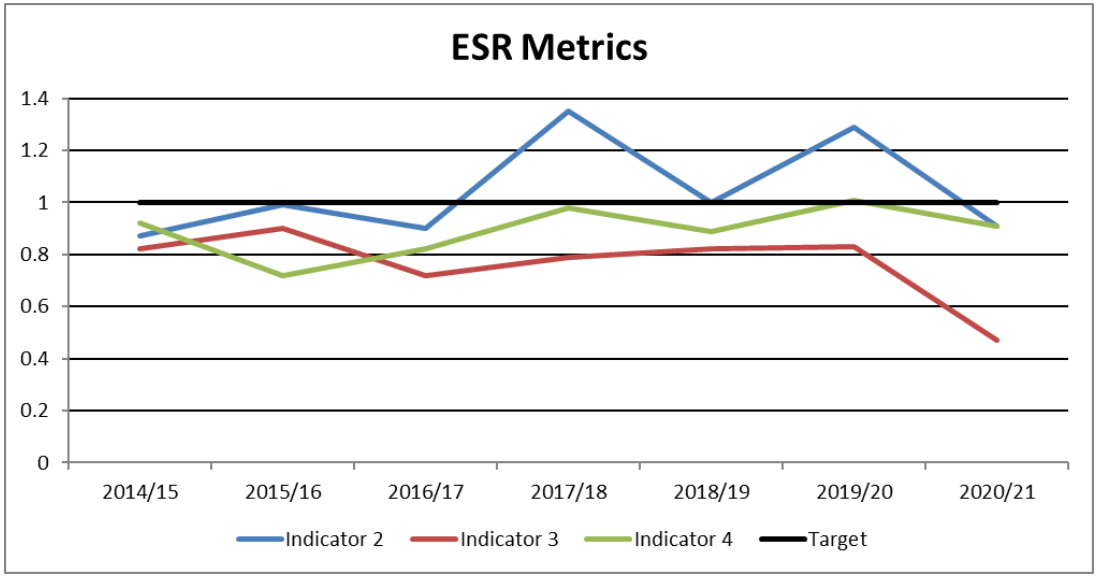
Description		Result 2014	Result 2015	Result 2016	Result 2017	Result 2018	Result 2019	Result 2020
Indicator 5 % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Low score is better	White 25% BAME 17% Gap 8%	White 22% BAME 22% Gap 0%	White 22% BAME 19% Gap 3%	White 24% BAME 19% Gap 5%	White 24% BAME 22% Gap 2%	White 22% BAME 22% Gap 0%	White 21% BAME 24% Gap 3%
Indicator 6 % of staff experiencing harassment, bullying or abuse from staff in last 12 months	Low score is better	White 21% BAME 22% Gap 1%	White 25% BAME 17% Gap 6%	White 20% BAME 30% Gap 10%	White 22% BAME 23% Gap 1%	White 21% BAME 22% Gap 1%	White 21% BAME 29% Gap 8%	White 20% BAME 32% Gap 8%
Indicator 7 % of staff believing that the organisation provides equal opportunities for career progression or promotion	High score is better	White 93% BAME 78% Gap 15%	White 91% BAME 94% Gap 3%	White 93% BAME 82% Gap 11%	White 91% BAME 83% Gap 8%	White 90% BAME 78% Gap 12%	White 91% BAME 72% Gap 19%	White 91% BAME 71% Gap 20%
Indicator 8 Experience discrimination at work from a manager/team leader or other colleagues in the last 12 months	Low score is better	White 8% BAME 17% Gap 9%	White 5% BAME 9% Gap 4%	White 4% BAME 16% Gap 12%	White 6% BAME 11% Gap 5%	White 4% BAME 14% Gap 10%	White 5% BAME 17% Gap 12%	White 5% BAME 17% Gap 12%

- Data relates to the 2020 staff survey
- The EDI data remains challenging at a National Level
- Trust continues to follow national trends

Indicator 9 looks at the difference between BME representation in the Trust and BME representation on the board, i.e. 0% BME board membership and 8.3% BME staff in your workforce, the indicator score will be calculated as 0% minus 8.3% which equal -8.3%. The idea is to be as close to zero as possible i.e. board representation is representative of the ethnic makeup in the workforce.

Description	Result 2014/15	Result 2015/16	Result 2016/17	Result 2017/18	Results 2018/19	Results 2019/20	Results 2020/21
Indicator 2 Relative likelihood of White staff being appointed from shortlisting compared to BAME	0.87 (White less likely)	0.99 (equal)	0.90 (White less likely)	1.35 (White more likely)	1.00	1.29	0.91
Indicator 3 Relative likelihood of BAME staff entering the formal disciplinary process compared to White	0.82 (BAME less likely)	0.90 (BAME less likely	0.72 (BAME less likely)	0.79 (BAME less likely)	0.82	0.83 (excl sickness)	0.47 (excl sickness)
Indicator 4 Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME	0.92 (White less likely)	0.88 (White less likely)	0.82 (White less likely)	0.98 (White less likely)	0.89	1.01	0.91
Indicator 9 Percentage difference between BAME representation in the workforce compared to the Board	-7.1	-7.6	-7.9	-8.3	-8.5	-8.1	-9.7

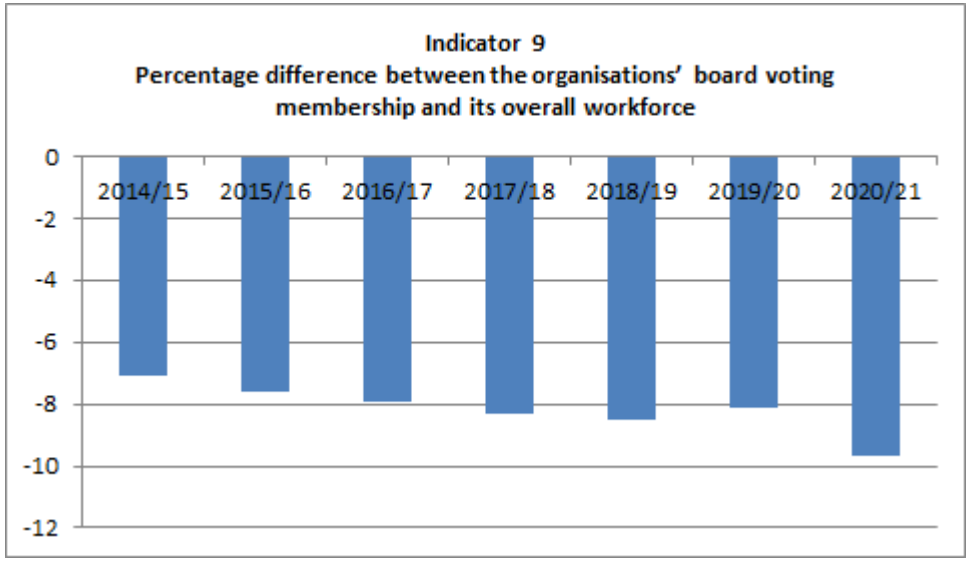
- Data is as at March 2021
- Trust is well placed nationally in respect of indicator as they relate to BME staff
- Requirement to reduce formal action for staff to return to non adverse range – A Fair Experience for All
- Anticipate improvements to indicator 9 in 2022



Indicator 2 Relative likelihood of White staff being appointed from shortlisting compared to BME staff improved for BME applicants

Indicator 3 Relative likelihood of BME staff entering the formal disciplinary process compared to White staff improved for BME staff but out-with the non adverse range of 0.80 and 1.25 at 0.47%

Indicator 4 Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff – improved for BME staff by 0.1%



- Identified both an Executive lead (Dee Fawcett) and Non-Executive Director 'champion' (Jill Baker)for equality and diversity.
- Revised and tailored approach to recruitment and selection with the explicit intention of 'recruiting for difference'
- ICHNE Recruitment for Diversity
- Positive action for all Executive and Non-Executive recruitment activity.
- Diverse panels in place April 2020

Key Considerations - WRES

Staff Survey

Percentage of staff experiencing bullying, harassment or abuse from patients/public in the last 12 months

- BME staff experience has worsened by 1.5% to 23.7%
- White staff has improved by 0.2% to 21.4%

Percentage of staff experiencing bullying, harassment or abuse from staff in the last 12 months

- BME staff experience has worsened by 2.8% to 31.9%
- White staff has improved by 0.4% to 20.2%

Percentage of staff experiencing discrimination at work from manager/team leader or colleagues in the last 12 months

- BME staff experience has worsened by 0.5% to 17.0%
- White staff experience has worsened by 0.4% to 5.4%

Within National Benchmark Group Trust retains a positive position in relation to white staff and a negative position in relation to BME Staff

ESR Data

Relative likelihood of BME staff entering the formal disciplinary process, improvements but Trust is out with the targets (non adverse range 0.8 – 1.25) 'A Fair Experience for All'. Our challenge to reduce the number of white staff going through disciplinary action

PROGRESS ON CURRENT WRES ACTION PLAN 2020-22

Objectives	Goals	Strategies	Measures	Progress
A workforce representative of the local population	▪ Deliver WRES aspirational targets for band 8 and above, including Board ▪ All our staff are enabled to support EDI ▪ EDI is a strategic priority for all our leaders/managers ▪ Increase inclusion to ensure our BAME workforce reflects the diversity of the local population ▪ Roll-out use of diverse interview panels	Develop an EDI strategy for an open and inclusive workforce	Deliver BAME recruitment event 2021/22	BAME recruitment event taking place October 2021
		Engage local communities	Implement BAME metrics and dashboard by April 2021	Equality Dashboard finalised and implemented
		Include BAME in EDI performance management framework to monitor progress	A workforce that is 15% BAME by end-March 2022	WRES data shows BME workforce increased to 10.40%
		Implement widening access campaign, including overhaul of recruitment and promotion practices	WRES Indicator 7 Improved in 2020 and sustained in 2021	ME staff experience has worsened by 1.1% to 70.7%
		Implement interventions to enable BAME staff to develop skills and competencies for career progression	BAME representative on all appointment panels for band 7 and above	Diverse recruitment panels in place 8c and above. Rolled out to band 6

PROGRESS ON CURRENT WRES ACTION PLAN 2020-22

Objectives	Goals	Strategies	Measures	Progress
A workforce representative of the local population	▪ Deliver WRES aspirational targets for band 8 and above, including Board ▪ All our staff are enabled to support EDI ▪ EDI is a strategic priority for all our leaders/managers ▪ Increase inclusion to ensure our BAME workforce reflects the diversity of the local population ▪ Roll-out use of diverse interview panels	Refresh training and awareness on unconscious basis and micro aggressions	WRES Indicator 6 improved in 2020 and sustained in 2021	BME staff experience has worsened by 1.5% to 23.7%
		Ensure all staff feel welcome and valued, have support when they need it and have opportunities to develop	Directorate action plans in place/staff survey results/ engagement score by 2021/22	Directorate action plans in place Staff engagement score remained at 7.3 (Above average)
		Implement development programme for BAME staff (band 5 and above)	WRES Indicator 8 improved in 2020 and sustained in 2021	BME staff experience has worsened by 0.5% to 17.0%
		Implement BAME mentorship programme to identify and address issues	Increased number of BAME staff in senior and leadership positions	Diverse recruitment panels in place 8c and above. Rolled out to band 6
		Implement HAWB risk assessment for BAME staff	All BAME staff offered HAWB risk assessment 2020/21	100% of BME staff offered risk assessment

PROPOSED WRES ACTION PLAN 2020-23

Objectives	Goals	Strategies	Measures	Aims
A workforce representative of the local population	▪ Deliver WRES aspirational targets for band 8 and above, including Board ▪ All our staff are enabled to support EDI ▪ EDI is a strategic priority for all our leaders/managers ▪ Increase inclusion to ensure our BAME workforce reflects the diversity of the local population ▪ Roll-out use of diverse interview panels	Develop an EDI strategy for an open and inclusive workforce	Deliver BAME recruitment event 2021/22	BAME recruitment event taken place October 2021
		Engage local communities	Increased engagement	A workforce that is 15% BAME by end-March 2022
		Include BAME in EDI performance management framework to monitor progress	Monitor BAME in EDI performance management framework monitor progress	Improvements across all Directorates (representative leadership and disparity ratio's)
		Implement widening access campaign, including overhaul of recruitment and promotion practices	Increased % BAME staff believing Trust provides equal opportunities for career progression / promotion	WRES Indicator 7 Improved in 2020 and sustained in 2021
		Implement interventions to enable BAME staff to develop skills and competencies for career progression	BAME representative on all appointment panels for band 6 and above	Improvements in the likelihood of being appointed (directorate and staff groups)

PROPOSED WRES ACTION PLAN 2020-23

Objectives	Goals	Strategies	Measures	Progress
A workforce representative of the local population	▪ Deliver WRES aspirational targets for band 8 and above, including Board ▪ All our staff are enabled to support EDI ▪ EDI is a strategic priority for all our leaders/managers ▪ Increase inclusion to ensure our BAME workforce reflects the diversity of the local population ▪ Roll-out use of diverse interview panels	Refresh training and awareness on unconscious basis and micro aggressions	Training and awareness on micro aggressions, development of cascade training	WRES Indicator 6 improved in 2020 and sustained in 2021
		Ensure all staff feel welcome and valued, have support when they need it and have opportunities to develop	Reduction in % of BAME staff experiencing discrimination from Manager/ colleagues	WRES Indicator 8 improved in 2021 and sustained in 2022
		Implement development programme for BAME staff (bands 2-5 band 5 and above)	Increased % BAME staff believing Trust provides equal opportunities for career progression / promotion	WRES Indicator 7 Improved in 2021 and sustained in 2022
		Evaluate BAME mentorship programme to identify and address issues	Use the findings to cascade learning across the wider Trust	Increased number of BAME staff in senior and leadership positions 2028
		Improve Trust disparity ratio, with targeted approach in N&M staff	Monitor BAME in EDI performance management framework monitor progress	Improved disparity ratio Trust wide and specifically N&M 2022/23

Workforce Disability Equality Standard

Workforce Disability Equality Standard

The Workforce Disability Equality Standard (WDES) is mandated by the NHS Standard Contract and applies to all NHS Trusts and Foundation Trusts from April 2019.

The WDES is a data-based standard that uses a series of measures (Metrics) to improve the experiences of Disabled staff in the NHS. The WDES comprises 13 Metrics. The WDES metrics are based on workforce data, primarily drawn from the Electronic Staff Survey and the NHS Staff Survey.

The Metrics have been developed to capture information relating to the experience of Disabled staff in the NHS. Research has shown that Disabled staff have poorer experiences in areas such as bullying and harassment and attending work when feeling ill, when compared to non-disabled staff. The 13 Metrics have been informed by research by Middlesex and Bedford Universities, conducted on behalf of NHS England, and by Disability Rights UK on behalf of NHS Employers.

The annual collection of the WDES Metrics allows Trusts to better understand and improve the employment experiences of Disabled staff.

The Trust is expected to adopt a strategy of closing the gap between disabled and non-disabled staff and taking steps to improve the experiences of disabled staff, in the interests of patients and their staff. A Trust action plan is in place having been developed in conjunction with Disability Staff Network.

Like the Workforce Race Equality Standard on which the WDES is in part modelled, it identifies good practice and compares performance regionally and by type of trust.

Workforce Disability Equality Standard - Staff Survey Metrics

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Staff Survey Metrics		Result 2018 *(benchmark comparator)*	Result 2019 *(benchmark comparator)*	Result 2020 *(benchmark comparator)*	RAG
Indicator 4a Percentage of staff experiencing harassment, bullying or abuse from service users their family of the public	Low score better	Disabled 29.7% *(32.3)* Non-disabled 22.7% *(24.9)*	Disabled 26.6% *(31.8)* Non-disabled 20.5% *(24.6)*	Disabled 28% *(30.9)* Non-disabled 20.% *(24.5)*	
Indicator 4a Percentage of staff experiencing harassment, bullying or abuse from managers	Low score better	Disabled 15.5% *(18.8)* Non-disabled 7.7% *(10.5)*	Disabled 15.9% *(17.7)* Non-disabled 7.5% *(10)*	Disabled 14.4% *(19.3)* Non-disabled 7.7% *(10.8)*	
Metric 4a Percentage of staff experiencing harassment, bullying or abuse from colleagues	Low score better	Disabled 25.8% *(26.4)* Non-disabled 14.5% *(16.2)*	Disabled 26.1% *(26.5)* Non-disabled 15.2% *(16)*	Disabled 24% *(26.9)* Non-disabled 15.4% *(17.8)*	
Metric 4b Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	High score better	Disabled 41.2% *(47.6)* Non-Disabled 42.6% *(46.1)*	Disabled 45.8% *(48.5)* Non-disabled 43.5% *(46.7)*	Disabled 47% *(47)* Non-disabled 45.2% *(45.8)*	

Workforce Disability Equality Standard - Staff Survey Metrics

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Staff Survey Metrics		Result 2018 (benchmark comparator)	Result 2019 (benchmark comparator)	Result 2020 (benchmark comparator)	RAG
Indicator 5 Percentage staff believing the Trust provides equal opportunities for career progression or promotion	High score better	Disabled 84.4% *(78.9)* Non-disabled 90.7% *(86.5)*	Disabled 83.7% *(79.7)* Non-disabled 90.7% *(87.1)*	Disabled 84.3% *(79.6)* Non-disabled 90.3% *(86.3)*	
Indicator 6 Percentage staff saying they have felt pressure from manager to come to work despite not feeling well enough	Low score better	Disabled 37.0% *(31.8)* Non-disabled 25.0% *(21.8)*	Disabled 34.5% *(32.5)* Non-disabled 21.4% *(21.3)*	Disabled 33.3% *(33)* Non-disabled 23.5% *(23.4)*	
Indicator 7 Percentage staff saying they are satisfied with extent the Trust values their work	High score better	Disabled 38.5% *(37.2)* Non-disabled 53.2% *(48.6)*	Disabled 42.9% *(39.3)* Non-disabled 53.8% *(50.1)*	Disabled 39.3% *(37.4)* Non-disabled 52.3% *(49.3)*	

Workforce Disability Equality Standard - Staff Survey Metrics

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Staff Survey Metrics		Result 2018 (benchmark comparator)	Result 2019 (benchmark comparator)	Result 2020 (benchmark comparator)	RAG
Indicator 8 Percentage staff saying Trust has made adequate adjustment(s) to enable them to carry out their work	High score better	Disabled 77.1% *(73.4)*	Disabled 77.0% *(73.5)*	Disabled 82.3% *(755)*	
Indicator 9a Sstaff engagement score for disabled staff compared to non-disabled and the overall engagement score for the Trust	High score better	Disabled 6.9% *(6.7)* Non-disabled 7.4% *(7.1)*	Disabled 6.9% *(6.7)* Non-disabled 7.4% *(7.2)*	Disabled 6.8% *(6.7)* Non-disabled 7.4% *(7.1)*	
Indicator 9b Has your Trust taken action to facilitate the voices of disabled staff to be heard? (Yes) or (No)		Yes	Yes	Yes	

Workforce Disability Equality Standard – ESR Metrics

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Description	Result 2019 Submission	Results 2020 Submission	Results 2021 Submission
Indicator 2 Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.	1.6 (disabled staff more likely)	1.76 (non-disabled staff more likely)	1.22 (non-disabled staff more likely)
Indicator 3 Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	1.89	4.28	4.00
Indicator 10 Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.	-3% -3%	-3% -3%	-3% -3%

Key Considerations - WDES

Staff Survey

- 39.3% of disabled staff don't feel valued this is higher than the national benchmark

Percentage of staff experiencing bullying, harassment or abuse

- From patients/service users, their relatives or members of the public - Disabled staff experience has worsened by 1.4% to 28% and Non-disabled staff has improved by 0.5% to 20%
- From managers - disabled staff experience has improved by 1.5% to 14.4% and Non-disabled staff has worsened by 0.2% to 7.7%
- From colleagues - Disabled staff experience has improved by 2.1% to 24% and Non-disabled staff has worsened by 0.2% to 15.4%
- Reporting - Disabled and Non-Disabled staff has improved by 1%
- Within National Benchmark Group Trust retains a positive position in relation to all BH&A disability metric

ESR Data

- Disabled staff are 4 times more likely to enter into formal capability processes (performance)
- The likelihood of disabled staff being appointed has improved but remains unequal

PROGRESS AGAINST CURRENT WDES ACTION PLAN 2020-22

Objectives	Goals	Strategies	Measures	Progress
A workforce representative of the local population	▪ All our staff are enabled to support EDI ▪ EDI is a strategic priority for all our leaders/managers ▪ Increase inclusion to ensure our workforce reflects the level of people in the general population that are disabled and working ▪ Eliminate nulls in our ESR data for disability status	Develop an EDI strategy for an open and inclusive workforce	Deliver recruitment event for people with disabilities 2021/22	Recruitment event planned for October 2021
		Engage local communities	20% of workforce have disclosed a disability by March 2022	Plans for Robotic Automation delayed (COVID)
		Use PRA to improve quality of data in ESR	Zero nulls in ESR for disability status by December 2021	Plans for Robotic Automation delayed (COVID)
		Implement widening access campaign, including overhaul of recruitment and promotion practices	Indicator 6 improved in 2020 and sustained in 2021	Indicator 6 improved by 1.2%

PROGRESS AGAINST CURRENT WDES ACTION PLAN 2020-22

Objectives	Goals	Strategies	Measures	Progress
A workplace where all staff can flourish and liberate their potential	▪ Eliminate disabled staff feeling pressure to attend work when not feeling well enough ▪ Increase number of disabled staff feeling valued ▪ Eliminate disabled staff complaints of bullying and harassment by other staff ▪ Disabled staff feel safe and enabled to report harassment, bullying or abuse at work	Ensure disabled staff feel safe to raise concerns at work and they are enabled to seek support	WDES Indicator 4b improved (2020) and sustained (2021)	WDES Indicator 4b improved by 1.1%
		Ensure all staff feel welcome and valued, have support when they need it and have opportunities to develop	WDES Indicator 6 improved (2020) and sustained (2021)	Indicator 6 improved by 1.2%
		Include disability in EDI performance management framework to monitor progress	Implement disability metrics and dashboard by April 2021	Dashboard finalised and implemented incorporating disparity ratio
		Refresh training and awareness on unconscious basis and micro aggressions	Provide resources for staff and share disabled staff experiences (e.g. personal stories) 2020/21	Disability Staff Conference Awareness Days took place

PROPOSED WDES ACTION PLAN 2020-23

Objectives	Goals	Strategies	Measures	Aims
A workforce representative of the local population	▪ All our staff are enabled to support EDI ▪ EDI is a strategic priority for all our leaders/managers ▪ Increase inclusion to ensure our workforce reflects the level of people in the general population that are disabled and working ▪ Eliminate nulls in our ESR data for disability status	Develop an EDI strategy for an open and inclusive workforce	EDI Strategy in place 2022	Strategy in place and Launched
		Engage local communities	Monitor Disability in EDI performance management framework monitor progress	Improvements in all Directorates 2023 (representative workforce and disparity rations)
		Implement widening access campaign, including overhaul of recruitment and promotion practices	Indicator 6 improved in 2020 and sustained in 2021	Indicator 6 improved in 2020 and sustained in 2021
		Use PRA to improve quality of data in ESR	Robotic Automation in place and in use	Zero nulls in ESR for disability status by December 2021
		To be recognised as a Disability Confident Leader	Action Plan in place by 2022	Achievement of Disability Confident Leaders by 2023

PROPOSED WDES ACTION PLAN 2020-22

Objectives	Goals	Strategies	Measures	Progress
A workplace where all staff can flourish and liberate their potential	▪ Eliminate disabled staff feeling pressure to attend work when not feeling well enough ▪ Increase number of disabled staff feeling valued ▪ Eliminate disabled staff complaints of bullying and harassment by other staff ▪ Disabled staff feel safe and enabled to report harassment, bullying or abuse at work	Ensure disabled staff feel safe to raise concerns at work and they are enabled to seek support	Reduction in the number of disabled staff experiencing BH&A from managers	WDES Indicator 4b improved (2020) and sustained (2021)
		Ensure all staff feel welcome and valued, have support when they need it and have opportunities to develop	Reduction in Disabled staff compared to staff saying that they have felt pressure to come to work,	WDES Indicator 6 improved (2020) and sustained (2021)
		Include disability in EDI performance management framework to monitor progress	Monitor Disability in EDI performance management framework monitor progress	Improvements in all Directorates 2023 (representative workforce and disparity rations)
		Refresh training and awareness on unconscious basis and micro aggressions	Training and awareness on micro aggressions in place and development of cascade training	WDES indicators 4b, 4c and 7 improved (2021) and sustained (2022)

Equality Delivery System

The Equality Delivery System

The Equality Delivery System (EDS) was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. It is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.

From April 2015, EDS2 implementation was made mandatory in the NHS Standard Contract and is explicitly cited within the CCG Assurance Framework.

At the heart of EDS2 are 18 outcomes, against which NHS organisations assess and grade themselves. They are grouped under four goals, as shown in the table on the following page. These outcomes relate to issues that matter to people who use, and work in, the NHS. Among other things they support the themes of, and deliver on, the NHS Outcomes Framework, the NHS Constitution, and the Care Quality Commission's key inspection questions set out in "Raising standards, putting people first.

Goal 3 Empowered, Engaged and Included Staff

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Outcome Measure	20/21	19/20	18/19	17/18	16/17	15/16	14/15	13/14	12/13	11/12
3.1 Fair NHS recruitment and selection processes lead to a more representative workforce										
3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations										
3.3 Training and Development opportunities are taken up and positively evaluated by staff										
3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source										
3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives										
3.6 Staff report positive experiences of their membership of the workforce										

Excelling – **Purple** Achieving – **Green** Developing – **Amber** Undeveloped – **Red**

Overall grade – Developing

Goal 4 – Inclusive Leadership at all Levels

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Outcome Measure	20/21	19/20	18/19	17/18	16/17	15/16	14/15	13/14	12/13	11/12
4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations										
4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed										
4.3 Middle Managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination										

Excelling – **Purple** Achieving – **Green** Developing – **Amber** Undeveloped – **Red**

Overall grade – Achieving

Rainbow Badge Pilot

Rainbow Badge Pilot – Quick Facts

The Newcastle upon Tyne Hospitals NHS Foundation Trust

The Rainbow Badge was introduced to NHS organisations across the country in 2019, to promote a message of LGBT+ inclusion and to show that participating organisations aim to be open, non-judgemental and inclusive places for LGBT+ people. This was adopted by Newcastle Hospitals in July 2019 to coincide with our first Pride Breakfast event for staff and their families

We are one of ten NHS Trusts to be selected to take part in a national pilot for phase two of the Rainbow Badge scheme, demonstrating its commitment to supporting and valuing LGBT+ staff and ensuring inclusive practices within its services.

- The pilot follows an accreditation and assessment model in part based on Stonewall but also Pride in Practice assessment criteria
- The pilot covers three areas; Policy Review, a Staff and Patient Survey and an assessment process covering patient services in selected areas and workforce
- Submission date – 6th August 2021
- Three Grading's – Bronze, Silver and Gold

Newcastle Hospitals was the only Trust to be awarded an overall Silver Accreditation

Key Achievements 2020/2021

The Newcastle upon Tyne Hospitals NHS Foundation Trust

- **Finalists in the HSJ awards for NHS Workplace Race Equality Awards** 2021
- **Shortlisted for Outstanding Corporate Achievement of the Years National BAME Health and Care Awards 2021**
- **Rainbow Badger Pilot -** Only Trust to awarded 'silver' accreditation
- **Completion and Evaluation of Reverse mentoring** – 52 members of staff participating over 6 months, fantastic engagement from the BME staff network and senior leaders and evaluated extremely positively. Format has been shared with other NHS organisations
- **Launched our inaugural Disability Talent Development Programme** and are supporting a second cohort vis charitable funds the first organisation to run a programme specifically for staff with a disability.
- **Recruiting for diversity ICHNE and Increasing Board diversity – new BAME NED commenced August 2021.**
- **Diverse recruitment panels rolled out** at band 6 and maintained Diverse panels for all posts band 8C and above including Medical and Dental Consultants
- **Expansion of Cultural Ambassadors role** to include any Disciplinary / Grievance with a race element – Supporting managers and BAME staff during disciplinary processes
- **Virtual disability staff conference** December 2020
- **LGBT / BME History Month** A programme of events for LGBT History Month and BME History Months invitations extended to local NHS Trusts
- **Celebrated a Week of Rainbows'** and NHS wide events of 12 virtual sessions open to the NHS working in partnership with other NHS organisations
- **Extension of our Project Choice placements** to ensure there was no disadvantage during the pandemic
- **Development of disability and carers passport**
- **Flexible Working** - responding to impact of covid and increasing opportunities for staff to work more flexibly

Key Achievements Health Inequalities 2020/2021

The activity supports the Trust strategic agenda of contributing to the health, wealth and wellbeing of the city, reducing health inequalities through providing great employment and training opportunities and generating wealth for the local economy, increasing the diversity of the workforce, as well as creating that sense of belonging and being valued. Also reflected in our WRES action plan.

- **'Staff Health & Wellbeing Strategy'** Equality, Diversity and Inclusion expressly incorporated into Trust published January 2021.
- **Ethnic minority staff risk assessments using robotic automation technology to deliver 'real time' results.** Achieving 100% of ethnic minority staff being offered risk assessments by August 2020
- **Working collaboratively and supporting the Local Authority to get key messages around COVID** out to the community in various languages, including dedicated staff engagement sessions about vaccine uptake – Trust identified as a national case study
- **ICHNE Recruitment** - Positive action to address health inequalities and increase workforce diversity through targeted local recruitment and build a sustainable workforce pipeline including;
  - Community engagement
  - Postal 'drop' in key areas with vacancy notifications
  - Diverse appointments panels
  - Assisted recruitment programmes
  - Research to assess impact of NHS jobs on people from disadvantaged communities.
- **Local partnership working** and collaboration to balance Trust aspirations, with influencing and supporting those of the wider system:

Key Priorities 2021/22

- **Implement the people equality dashboard into the performance management framework**
- **Review of Disparity Ratio's** - in general and Nursing and Midwifery in particular
- **Develop an equality, diversity and inclusion strategy**
- **Flexible and Agile Working** – refreshing policy framework and creatively expanding ways of working
- **Expand BAME representative recruitment panels to band 7**
- **Delivery of a virtual BAME/disability recruitment event October 2021**
- **Progress to Disability Confident Leader**
- **Further develop resources for staff who are also carers**
- **Develop and launch of BAME Career Development Programme (bands 2-5)**
- **Launch BAME Talent Development Programme (bands 5 and above)**
- **Host LGBTQ+ NHS Staff Conference**
- **Implement Rainbow Shield in procurement process**
- **Develop an equality, diversity and inclusion training package for managers**
- **Focus on behaviours, incivilities and addressing micro-aggressions and incivilities**
- **Evaluate the regional recruitment pilot and diverse recruitment panels**
- **NMAHP post holders** - working in partnership with the 2 post holders who are supporting professional development of this workforce group'

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Workforce Race Equality Standard (WRES) 2021

1. **Name of organisation**
   The Newcastle upon Tyne Hospitals NHS Foundation Trust

2. **Date of report**
   Month: August
   Year: 2021

3. **Name and title of Board lead for the Workforce Race Equality Standard**
   Dee Fawcett HR Director

4. **Name and contact details of lead manager compiling this report**
   Karen Pearce – Head of Equality, Diversity and Inclusion (People)

5. **Names of commissioners this report has been sent to**
   Co-coordinating commissioner - NHS England (Sanjay Shah sanjay.shah@nhs.net) Newcastle Gateshead CCG (Colin Smith colin.smith16@nhs.net).

6. **Name and contact details of coordinating commissioner this report has been sent to**
   North Tyneside CCG, Northumberland CCG, South Tees CCG, South Tyneside CCG, North Durham CCG, Durham, Dales, Easington & Sedgefield CCG, Hartlepool & Stockton CCG, Darlington CCG (Deborah O'Brien 07741 900529 deborah.obrien2@nhs.net), Sunderland CCG (Claire Miller - 0191 5297102), Cumbria CCG (Felicity Robson - 01768 245 459)

7. **Unique URL link on which this Report and associated Action Plan will be found**

   https://www.newcastle-hospitals.nhs.uk/about/trust/equality-diversity-and-inclusion/workforce-race-equality-standard/

8. **This report has been signed off by on behalf of the board on**
   Date: August 2021
   Name: Dee Fawcett, HR Director

Background narrative

9. **Any issues of completeness of data**
   A comparatively small number of unknown/null data relating to ethnicity of current staff remain

10. **Any matters relating to reliability of comparisons with previous years**
    None

11. Total number of staff employed within this organisation at the date of the report (March 2021)
16185

12. Proportion of BME staff employed within this organisation at the date of the report?
10.40% (FTE)

13. The proportion of total staff who have self–reported their ethnicity?
98.37%

14. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity?
Fully implemented Employee Self Service
Full roll out of the ESR employee portal complete.
Trust has the highest usage of the employee portal nationally – this has increased accessibility for staff to be able to input their personal information including ethnicity status.
Bespoke rolling adverts added within the portal to further encourage staff to update their personal information.

15. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity?

Plans to use robotic automation to increase staff reporting of ethnicity

Workforce data

16. What period does the organisation's workforce data refer to?
April 2020 - March 2021

Workforce Race Equality Indicators

17. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff

Data for reporting year: March 2021 Data (Headcount)

	Non Clinical staff in each band/grade		Clinical staff in each band/grade	
Pay band	% White (of total Workforce)	% BME (of total Workforce)	% White (of total Workforce)	% BME (of total Workforce)
Under Band 1	0.78	0.06	0.16	0.02
Band 1	0.22	0.00	0.00	0.00
Band 2	32.32	2.36	16.20	1.44
Band 3	21.78	0.83	5.41	0.36

Band 4	16.22	0.39	5.86	0.51
Band 5	9.46	0.45	22.71	4.80
Band 6	4.67	0.19	16.07	0.92
Band 7	4.67	0.17	10.48	0.42
Band 8A	1.92	0.14	2.49	0.15
Band 8B	1.50	0.00	0.78	0.02
Band 8C	1.06	0.00	0.37	0.00
Band 8D	0.28	0.00	0.07	0.00
Band 9	0.00	0.00	0.01	0.00
VSM	0.53	0.00	0.02	0.00
Medical Consultants			5.31	1.57
of which managers			0.23	0.02
Non-consultant Career Grades			1.77	0.96
Trainee grades			0.65	0.21
Other			0.00	0.00

Data for reporting year: March 2020 Data (Headcount)

	Non Clinical staff in each band/grade		Clinical staff in each band/grade	
Pay band	% White (of total non-clinical Workforce)	% BME (of total non-clinical Workforce)	% White (of total clinical Workforce)	% BME (of total clinical Workforce)
Under Band 1	0.55	0.00	0.18	0.02
Band 1	0.07	0.00	0.00	0.00
Band 2	8.02	2.18	14.53	0.71
Band 3	5.14	0.83	6.16	0.33

Band 4	4.16	0.34	4.06	0.17
Band 5	8.93	0.34	24.45	4.89
Band 6	4.34	0.14	17.22	0.96
Band 7	4.34	0.20	11.03	0.35
Band 8A	1.81	0.09	2.50	0.08
Band 8B	1.32	0.00	0.78	0.02
Band 8C	0.95	0.00	0.35	0.00
Band 8D	0.20	0.00	0.08	0.00
Band 9	0.03	0.00	0.01	0.00
VSM	0.55	0.00	0.02	0.00
Medical Consultants			5.74	1.56
of which managers			0.23	0.04
Non-consultant Career Grades			1.85	0.10
Trainee grades			1.20	0.16
Other			0.00	0.00

- 98.37% of staff have recorded their ethnicity.
- The figures referenced in the above tables do not include the small percentage of staff who have not shared their ethnicity, they have been excluded for the purposes of the data capture

18. Relative likelihood of staff being appointed from shortlisting across all posts.

Data for reporting year: 0.91

Data for previous year: 1.29

- There was a change to the WRES reporting for this metric. The requirement was amended, the data request for this indicator changed to a year end figure as opposed to a two-year rolling figure
- Recruitment data is analysed annually under Trust Public Sector Equality Duty requirements and the Equality Delivery System
- Diverse Panels in place for all band 8c and above posts including Executive/non-Executive Director and Medical and Dental Posts and band 6 posts

19. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Data for reporting year: 0.47

Data for previous year: 0.83

- There was a change to the WRES reporting for this metric. The requirement was amended, the data request for this indicator changed to a year end figure as opposed to a two-year rolling figure
- Trust data identifies BME members of staff are less likely to entre formal disciplinary processes.
- 0.47 is outside the Fair Experience for All requirements for NHS organisations to be within the non-adverse range of 0.8 and 1.25
- Employee Relations data is analysed annually under Trust Public Sector Equality Duty requirements and the Equality Delivery System
-

20. Relative likelihood of staff accessing non-mandatory training and CPD

Data for reporting year: 0.91

Data for previous year: 1.01

- Trust data identifies BME members of staff are more likely to access non-mandatory training and CPD.
- Access to training is analysed annually under Trust Public Sector Equality Duty requirements and the Equality Delivery System

Workforce Race Equality Indicators

21. KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

Data for reporting year:

White 21.4%

BME 23.7%

Data for previous year:

White 21.6%

BME 22.2%

- BME Staff Network continues to grow and engage in raising awareness.
- WRES sub group continues to meet monthly.
- Corporate objective in place.

22. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Data for reporting year:

White 20.2%

BME 31.9 %

Data for previous year:

White 20.6%

BME 29.1%

23. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion

Data for reporting year:

White 90.6%

BME 70.7%

Data for previous year:

White 90.6%

BME 71.8%

24. Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Data for reporting year:

White 5.4%

BME 17%

Data for previous year:

White 5%

BME 16.5%

Board representation indicator

25. Percentage difference between the organisations' Board voting membership and its overall workforce

Data for reporting year:

White 11.4

BME -9.7

Data for previous year:

White 10

BME -8.1

26. Are there any other factors or data which should be taken into consideration in assessing progress?
None

27. Organisations should produce a detailed WRES action plan, agreed by its board. It is good practice for this action plan to be published on the organisation's website, alongside their WRES data. Such a plan would elaborate on the actions summarised in this report, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at board level, such as EDS2. You are asked to provide a link to your WRES action plan in the space below.

https://www.newcastle-hospitals.nhs.uk/about/trust/equality-diversity-and-inclusion/workforce-race-equality-standard/

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | **Aug-21**

Corporate Governance Statement (FTs and NHS trusts)

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

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

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

Signature  **Signature** 

Name Dame Jackie Daniel **Name** Sir John Burn

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

A

Worksheet "Training of governors"

Financial Year to which self-certification relates | **Aug-21**

Certification on training of governors (FTs only)

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

Training of Governors

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

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

Signature		**Signature**	
Name	Dame Jackie Daniel	**Name**	Professor Sir John Burn
Capacity	Chief Executive Officer	**Capacity**	Chairman
Date	30.09.2021	**Date**	30.09.2021

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

A

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates Aug-21

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

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

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

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

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

EITHER:

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

OR

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

OR

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

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

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

The Trust has taken all necessary precautions as were necessary to comply with the conditions.
Transformation,performance and finance management arrangements are in place to support the delivery of the Trust Cost Improvement plans, overseeen by the Trust Finance Committee.
The Transformation, Performance and Finance Teams continue to work on the Trust's long-term sustainability and improvement programme.
The annual going concern assessment was presented to the Audit Committee in April 2021 and considered by the Trust Board members in April 2021.

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

Signature		**Signature**	
Name	Dame Jackie Daniel	**Name**	Professor Sir John Burn
Capacity	Chief Executive Officer	**Capacity**	Chairman
Date	30.09.2021	**Date**	30.09.2021

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