The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	25 May 2023						
Title	Consultant Appointments						
Report of	Andy Welch, Medical Director						
Prepared by	Claudia Sweeney, Senior HR Advisor (Medical & Dental)						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The content of this report outlines recent Consultant Appointments.						
Recommendation	The Board of Directors is asked to review the decisions of the Appointments Committee.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. People – Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☐	☐	☐	☒	☐	☐	☐
Link to Board Assurance Framework [BAF]	There are no direct links to the BAF. Ensuring the Trust is sufficiently staffed to meet the demands of the organisation.						
Reports previously considered by	Consultant Appointments are submitted for information in the month following the Appointments Panel.						

CONSULTANT APPOINTMENTS

1. APPOINTMENTS COMMMITTEE – CONSULTANT APPOINTMENTS

1.1 An Appointments Committee was held on 15 March 2023 and interviewed 1 candidate for 1 Consultant Gastroenterologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Bidour Mohamed Ali Awadelkarim.

Dr Awadelkarim holds MBBS (University of Khartoum) 2010, MRCP (UK) 2014, and ESEGH (UK) 2019. Dr Awadelkarim is currently employed as a Senior Clinical Fellow in Hepatology Trials and Pancreato-Biliary Endoscopy at the Freeman Hospital.

Dr Awadelkarim is expected to take up the post of Consultant Gastroenterologist in August 2023.

1.2 An Appointments Committee was held on 17 April 2023 and interviewed 4 candidates for 2 less than full-time Consultant in Palliative Care Medicine posts.

By unanimous resolution, the Committee was in favour of appointing Dr Anne-Marie Bourke and Dr Kate Howorth.

Dr Bourke holds MBBS (University of Newcastle) 2006, MRCP (UK) 2009, and FRCP (UK) 2020. Dr Bourke is currently employed as a Consultant in Palliative Medicine at Marie Curie Hospice.

Dr Bourke is expected to take up the post of Consultant in Palliative Care Medicine in September 2023.

Dr Kate Howorth holds MBBS (University of Newcastle) 2011 and MRCP (UK) 2015. Dr Howorth is currently employed as a Specialty Trainee in Palliative Care on behalf of the Lead Employer Trust, at Queen Elizabeth Hospital and Marie Curie Hospice.

Dr Howorth is expected to take up the post of Consultant in Palliative Care Medicine in November 2023.

1.3 An Appointments Committee was held on 17 April 2023 and interviewed 3 candidates for 2 Consultant Anaesthetist posts.

By unanimous resolution, the Committee was in favour of appointing Dr Nicholas John Francis and Dr Sarah Anne Todd.

Dr Francis holds MBBS (University of Newcastle) 2013, and FRCA (UK) 2019. Dr Francis is currently employed as a Specialty Trainee in Anaesthetics on behalf of the Lead Employer Trust, at James Cook University Hospital.

Dr Francis is expected to take up the post of Consultant Anaesthetist in August 2023.

Dr Todd holds MBBS (University of Newcastle) 2014, and FRCA (UK) 2019. Dr Todd is currently employed as a Specialty Trainee in Anaesthetics on behalf of the Lead Employer Trust, at Northumbria Hospitals.

Dr Todd is expected to take up the post of Consultant Anaesthetist in April 2024.

1.4 An Appointments Committee was held on 21 April 2023 and interviewed 1 candidate for 1 Consultant Dermatologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Alison Havelin.

Dr Havelin holds MBBCh (National University of Ireland) 2013, and MRCP (UK) 2020. Dr Havelin was most recently employed as a Locum Consultant Dermatologist at the Royal Victoria Infirmary.

Dr Havelin is expected to take up the post of Consultant Dermatologist in June 2023.

1.5 An Appointments Committee was held on 24 April 2023 and interviewed 3 candidates for 1 Consultant Paediatric Neurologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Júlia Rúbies Olives.

Dr Rúbies Olives holds LMS (Universidad de Lleida) 2012. Dr Rúbies Olives is currently employed as a Locum Consultant Paediatric Neurologist at the Royal Victoria Infirmary.

Dr Rúbies Olives is expected to take up the post of Consultant Paediatric Neurologist in May 2023.

1.6 An Appointments Committee was held on 24 April 2023 and interviewed 3 candidates for 1 Consultant Paediatric Neurologist (Mitochondrial Disease) post.

By unanimous resolution, the Committee was in favour of appointing Dr Albert Zishen Lim.

Dr Lim holds MBBS (University of Newcastle), and PhD (University of Newcastle) 2022. Dr Lim is currently employed as a Specialty Trainee in Paediatric Neurology on behalf of the Lead Employer Trust, at the Royal Victoria Infirmary.

Dr Lim is expected to take up the post of Consultant Paediatric Neurologist (Mitochondrial Disease) in May 2023.

1.7 An Appointments Committee was held on 27 April 2023 and interviewed 1 candidate for 1 Consultant Paediatric Oncologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Tasnim Arif.

Dr Arif holds MBBS (University of Leicester) 2005, and MRCPCH (UK) 2011. Dr Arif is currently employed as Locum Consultant Paediatric Oncologist at The Great North Children's Hospital.

Dr Arif is expected to take up the post of Consultant Paediatric Oncologist in June 2023.

1.8 An Appointments Committee was held on 27 April 2023 and interviewed 1 candidate for 1 Consultant Physician in Infectious Diseases post.

By unanimous resolution, the Committee was in favour of appointing Dr Bijan James Ghavami-Kia.

Dr Ghavami-Kia holds MBBCh (University College Dublin) 2009, and MRCP (UK) 2015. Dr Ghavami- Kia is currently employed as Locum Consultant in Infectious Disease at the Royal Victoria Infirmary.

Dr Ghavami-Kia commenced the post of Consultant Physician in Infectious Diseases in May 2023.

2. RECOMMENDATION

1.1 – 1.8– For the Board to receive the above report.

Report of Andy Welch
Medical Director
25 May 2023

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 May 2023						
Title	Executive Chief Nurse (ECN) Report						
Report of	Maurya Cushlow, Executive Chief Nurse						
Prepared by	Ian Joy, Deputy Chief Nurse Diane Cree, Personal Assistant						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	This paper has been prepared to inform the Board of Directors of key issues, challenges, and information regarding the Executive Chief Nurse areas of responsibility. The content of this report outlines: • Spotlight on our Allied Health Professions (AHP) Workforce, Education and Practice Development • Palliative Care and End of Life Care Bi-annual update • Safeguarding Quarter 4 (Q4) update • Learning Disability update (Q4) • Patient Experience update (Q4)						
Recommendation	The Board of Directors is asked to note and discuss the content of this report.						
Links to Strategic Objectives	• Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. • We will be an effective partner, developing and delivering integrated care and playing our part in local, national and international programmes. • Being outstanding, now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	<u>Strategic Objective One</u> Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality. <u>Strategic Risk Description</u> i) SO1.1 - Extreme capacity and demand pressures may impact the Trust ability to achieve important operational and regulatory standards including securing income.						

	SO1.4 - There is a risk of regulatory intervention if we are unable to comply with mandatory NHS core standards which could impact on patient safety, quality of care and the reputation of the Trust.
Reports previously considered by	The ECN Update is a regular comprehensive report bringing together a range of issues to the Trust Board.

EXECUTIVE CHIEF NURSE REPORT

EXECUTIVE SUMMARY

This paper is a regular update, providing the Board of Directors with a summary of key issues, achievements, and challenges within the Executive Chief Nurse (ECN) portfolio.

Section 1:

This month's 'Spotlight' section provides an overview of the work to develop an Allied Health Professions (AHP) Workforce, Education and Practice Development strategy, specifically outlining the work of two new fixed-term posts - AHP Practice Education and Workforce Lead and Education and Practice Development Lead for Therapy Services.

AHPs are the third largest clinical workforce in the NHS, recognised in the NHS Long-Term Plan as having an essential role in supporting services to meet current and future demand. Having an AHP Workforce that is 'fit for purpose' is high on the national agenda, however AHP services have often lacked structured workforce development and educational infrastructure and therefore limited opportunity to pro-actively develop services and workforce strategy.

The report contains an overview of the current AHP workforce profile in the Trust and the current and future challenges we face as a Trust regarding the AHP workforce. The report outlines key work streams that are in place to try and address the current pipeline, recruitment and retention challenges which are co-ordinated and ley by the two posts outlined above. An overview of a number of the workstreams included in the report are highlighted below:

- Staff Engagement - Engagement has been a key priority in the development of the AHP Workforce Strategy, with a commitment to engage, listen and co-produce. To date, four surveys focusing on career progression, education, retention and learning have been collated and analysed, with a further seven workforce workshops enabling a deep dive into these topics.
- Widening Participation is a key priority of both local and national agenda, and at Newcastle Hospitals we have developed an AHP Career Ambassador Network that is fundamental to creating resources and supporting career promotional events across Newcastle and the wider region. There is a particular focus on schools and colleges and targeting those harder to reach minorities across the local community.
- Retention remains a top priority given the rising rate of attrition across AHPs, and particular focus has been given to early career retention and preceptorship. Extensive work has been undertaken to benchmark the AHP Preceptorship process across the organisation and deliver on a new Nursing, Midwifery and Allied Health Professions (NMAHP) collaborative offer. In addition to this, an Institute for Healthcare Improvement (IHI) project has been undertaken to develop a Learning Needs Framework across the AHP workforce to standardise and simplify access to learning and development opportunities relevant for specific roles and banding.

- AHPs have specialist skills and unique training needs related to each individual profession and job role. This creates a unique set of challenges in the delivery and governance of Education and Practice Development for AHPs across the trust. Having these two posts has enabled AHPs to build an oversight of the educational and development needs and priorities across the organisation, and to produce a portfolio of educational projects that have the potential to be commercialised moving forwards. There has also been targeted mapping work completed around uptake of the NMAHP Continuing Professional Development (CPD) funding, with promotional activity successful in significantly increasing AHP access over a twelve-month period.

The report includes a section outlining the future of this work. Continued investment in AHP Workforce and Practice Development is required and work is ongoing to identify funding to ensure the continuation of the two fixed term posts which have shown to be critical in ensuring the sustainable and successful progression and development of our AHP Workforce and Strategy.

Section 2: End of Life and Palliative Care Update

This section provides the bi-annual update into the work of the End of Life and Palliative Care Teams across the Trust. The Palliative and End of Life Care Service are committed to following national and regional guidelines and achieving the Trust's Strategic Goals. The team aim is to support the delivery of high-quality best practice palliative and end of life care to patients and carers in Newcastle hospitals and community. Highlighted within the report are several key workstreams and achievements over the recent months.

This includes the following:

- The Fourth round of the National Audit for Care at the End of Life (NACEL) was published in February 2023 from data collected from April 2022 to September 2022. The audit comprised of an organisational level audit, 50 case note reviews, 41 quality surveys (bereaved families survey) and 115 staff reported measures (staff survey). The report demonstrates that the scores from the Trust are above the National results in all domains and reflects the high-quality care delivered by staff working across the Trust.
- As previously reported to the Trust Board, the Trust is progressing with the roll out of the Gold Standards Framework (GSF). The GSF provides training for generalist frontline staff in health and social care to enable the provision of 'gold standard' care for all people nearing end of life. Relevant staff have completed the online webinars and we welcomed the national GSF team to our Trust on the 19 and 20 April 2023. The team were visiting the 10 participating wards to offer and provide further support in the implementation of the learning thus far.
- Due to the demands on space within the Freeman Hospital, the creation and development of the Freeman Haven has been delayed. However, a suitable space for the Freeman Haven (with easy access to refreshment, ward areas and to the outside) has now been identified and agreed and a full brief of the project has been completed. The concept design based on the Royal Victoria Infirmary (RVI) Haven has been approved by stakeholders in principle.

Section 3: Safeguarding and Mental Capacity Act Quarter 4 (Q4) Update

Section 3 of the report provides a Q4 summary update of Safeguarding and Mental Capacity Act activity throughout the Trust and includes references to developments in practice.

Safeguarding activity for Q4 evidences the following key high-level points:

- In adult safeguarding, data demonstrates a 5% increase in activity compared to the same quarter last year. It is noted that partner agencies have also experienced an increase, the reasons for which are multifactorial, thought to include the impact of the cost-of-living crisis, growing awareness of safeguarding along with changes and stressors arising from the impact of the pandemic.
- In children's safeguarding, it is noted that the Trust has continued to see an increase in overall activity from 2019/20 (pre-pandemic period). In Q4 there has been over a 15% increase in comparison to Q3 and in March 2023 safeguarding activity reached an all-time high of 1,096 contacts/referrals. Neglect, child self-harm/overdose, parental self-harm/overdose, physical harm, and domestic abuse continue to be the main sources of referral.
- Recent investment has been agreed into the Safeguarding Teams which will in part mitigate this increase in activity but will need to be monitored regularly. The recruitment process is nearly complete with some staff already in post.

The report includes an update in relation to compliance with Safeguarding training. At the time of writing the following key points are noted:

- Safeguarding Level 1 Adult and Children remains above 95% compliant.
- Safeguarding Level 2 Adult and Children both stand at 92%.
- Safeguarding Adults and Children Level 3 both remain of concern at 81% and 82% respectively though it is noted that compliance has increased since Q3 were they stood at 76% and 73%. A number of actions are in place to improve compliance with staff being provided both face to face training and eLearning to maximise the flexibility in training options.

Considering the focused Care Quality Commission (CQC) inspection last year which included a review of systems and process relating to the application of the Mental Capacity Act, the report includes an update on progress on agreed actions.

Mental Capacity Act training is now mandatory for identified clinical and patient facing staff and was launched in March 2023. At the time of writing 75% of relevant staff have completed this training. This training will be followed up in due course with Level 2 training for relevant staff and the content of the training has been finalised recently.

There has been an increase in the number of cases requiring legal involvement in Q4. There have been 15 complex cases and 8 of these cases have gone to the Court of Protection. Deprivation of Liberty Safeguards (DoLS) have also increased in comparison to previous years which is positive to see as this ensures patients are appropriately cared for in line with the Mental Capacity Act. There has been a total of 920 activated Urgent DoLS applications,

with a further 60 applications received but not submitted, following triage. This marks an increase of 135 active DoLS from this point in 2021-2022.

Section 4: Learning Disability Q4 update

This section of the report provides a Q4 summary update regarding the work of the Learning Disabilities Liaison Team. The team continues to develop practice to improve care for people with Learning Disabilities, building on the existing infrastructure and the dedicated expertise of the Learning Disability Liaison Team

In Q4 the team received 763 referrals, a slight rise from Q3 and an increase of 120 referrals from Q4 2022, representing a 16% upturn in activity. Q4 has continued to be particularly challenging as there have been several individuals who required direct intervention. The Trust has on average 35 patients at any one time with between 10 and 12 of those being highly complex, requiring greater team coordination potentially between multiple services.

The report includes an overview of the recently implemented Diamond Standards Learning Disabilities training for all clinical and patient facing staff. At the time of writing there is a 74% training compliance. The Learning Disability Liaison Team continues to contribute to the regional work to develop a strategy to support people (Children and Young People (CYP) and Adult) with autism. Autism awareness training sessions were launched in April 2023 with particular emphasis on care in urgent and emergency care settings.

In response to the CQC report which highlighted concerns around record keeping of reasonable adjustments for people with a Learning Disability, a significant piece of work has commenced to ensure evidence of 'reasonable adjustment' is documented. The Learning Disability Liaison Team and the Digital Health Team are working collaboratively and at pace, whilst giving consideration to utilising 'Health Passports' to ensure the appropriate individualised information is both discussed with patients and families and documented appropriately.

Section 5 Patient Experience Q4 update

Section 5 contains a Q4 summary of the work of the Patient Experience team.
The Trust has opened 137 formal complaints in Q4, which is a decrease of 5% from the previous quarter. The Trust has received on average 43 formal complaints per month, which is a 7% decrease from the previous year where the average was 46 complaints per month. Of the complaints that opened in this quarter, 23% had a primary concern with regards to communication.

From the 150 closed complaints in Q4, 22 complaints were upheld, 29 complaints were partially upheld and 99 were not upheld.

Included within this report is an update on the Patient Experience and Engagement Strategy. Following preliminary patient and staff consultation in summer 2022 the Trust is keen to explore and develop its patient experience strategy. With support from Newcastle Charities, WeAreStand; expert involvement practitioners and service change leaders, have been commissioned to help drive this exciting piece of work and are working in collaboration with the patient experience team.

The report also contains an overview of patient experience and engagement work with an overview of work undertaken by the Advising on the Patient Experience Group (APEX) and the Maternity Voice Partnership. The work of these groups remains fundamental in ensuring developments in services are patient led.

The final part of Section 5 provides an overview of the vital work of our Chaplaincy Team. The team continue to provide support for both patients and staff, delivering 2,239 contacts in Q4. In Q4 the team have conducted 313 chapel of rest, police identifications and coroners' cases in and out of hours. Our chaplains who are drawn from different faiths, beliefs and world views have been alongside 687 dying patients and their relatives; and conducted the appropriate rites, rituals and funeral services.

RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
25 May 2023

EXECUTIVE CHIEF NURSE REPORT

1. SPOTLIGHT – ALLIED HEALTH PROFESSIONS (AHP) WORKFORCE, EDUCATION AND PRACTICE DEVELOPMENT

AHPs are the third largest clinical workforce in the NHS, recognised in the **NHS Long-Term Plan** as having an essential role in supporting services to meet current and future demand. Having an AHP Workforce that is 'fit for purpose' is high on the national agenda, however AHP services have often lacked structure workforce development and educational infrastructure and therefore limited opportunity to pro-actively develop services and workforce strategy.

Using Trust and external funding, two fixed-term posts (AHP Practice Education and Workforce Lead and Education / Practice Development Lead for Therapy Services) have been created at Newcastle Hospitals to develop and embed a collaborative and sustainable AHP strategy of workforce planning and development, and to scope educational and practice development priorities through workforce engagement. This spotlight provides an overview of their work and progress on this important agenda.

1.1 Background

The AHP Workforce at Newcastle Hospitals encompasses both registered professionals and support workers, and totals 1,450 staff. The deployment and scope of AHP roles is broad and spread across several clinical directorates, with approximately 70% of the AHP workforce sitting in Therapy Services.

The main supply pipeline for AHPs are new graduates (>95%) emphasising the importance of AHP Practice Education and the continued priority of increasing practice placement capacity which has been a focus of Practice Education and Workforce Lead role. The health of this as a sole pipeline varies across professions, but with the number of job applications per vacancy falling across some AHPs, there are concerns about future sustainability of this workforce supply. Across some AHP professions, graduate supply is falling short of demand, and highlights the importance of growing alternative workforce supply options.

Demand for the AHP workforce remains high, with AHPs playing central roles in multiple pathways across the organisation. Increasing operational demand combined with a recruitment and retention challenges and unpredictable supply as outlined above, is contributing to this high demand and poses a risk to retention and sustainability of the AHP workforce.

These two roles are pivotal in working to address some of these complex issues and provide a clear and cohesive strategy with tangible actions moving forward.

1.2 AHP Workforce: Staff Engagement

Staff Engagement has been a key priority in the development of the AHP Workforce Strategy, with a commitment to engage, listen and co-produce. To date, four surveys focusing on career progression, education, retention, and learning have been collated and analysed, with a further seven workforce workshops enabling a deep dive into these topics. The information obtained in this engagement work, as well as analysis of the staff survey, has informed the workforce strategy to date and will continue to do so.

1.3 AHP Workforce Strategy

Development of our detailed AHP Workforce Strategy has focused on both growing and developing the AHP workforce at Newcastle Hospitals. The strategy is separated into four pillars; supply, demand, retention and performance, and there is a focus on equality, diversity, and inclusion across each pillar. The strategy is underpinned by detailed analysis of workforce data, and each pillar contains several initiatives that focus on the individual aspect of the strategy, consistent with the foundational principles of 'The People Promise'. The strategy feeds into and informs workforce planning for each AHP Profession but is also shaped by the risks and challenges of each workforce.

1.4 Recruitment and Retention Initiatives

A number of initiatives have been developed as part of the AHP Workforce Strategy that focuses on recruitment and supply of AHPs. Widening Participation is a key priority of both local and national agenda, and at Newcastle Hospitals we have developed an AHP Career Ambassador Network that is fundamental to creating resources and supporting career promotional events across Newcastle and the wider region. There is a particular focus on schools and colleges and targeting those harder to reach minorities across the local community.

We have also been successful in obtaining a funding bid of £50,000 from what was Health Education England to recruit 10 international AHPs across Diagnostic Radiography and Podiatry. This has created an additional supply pipeline into those at-risk professions and has increased the Podiatry establishment by nearly 20% in terms of registered staff.

An AHP Practice Education mission statement has been developed focusing on implementation of a whole time equivalent (wte) placement model to ensure equitable provision of practice placements across Physiotherapy and Occupational Therapy and to support a sustainable growth in practice placement capacity. Work has also been done on developing various practice placement models, including a student job plan, to support clinical educators in providing quality placements.

Retention remains a top priority given the rising rate of attrition across AHPs, and particular focus has been given to early career retention and preceptorship. Extensive work has been undertaken to benchmark the AHP Preceptorship process across the organisation and deliver on a new NMAHP collaborative offer. In addition to this, an IHI project has been undertaken to develop a Learning Needs Framework across the AHP workforce to standardise and simplify access to learning and development opportunities relevant for

specific roles and banding. This will enable future planning of training needs across AHP services. There have also been successful bids for funding to upskill the workforce, including £40,000 for AHP staff working into Critical Care pathways and a regional bid to upskill Support Workers working into elective recovery pathways.

1.5 Education and Practice Development

AHPs have specialist skills and unique training needs related to each individual profession and job role. This creates a unique set of challenges in the delivery and governance of Education and Practice Development for AHPs across the trust. Having these two posts has enabled AHPs to build an oversight of the educational and development needs and priorities across the organisation, and to produce a portfolio of educational projects that have the potential to be commercialised moving forwards. There has also been targeted mapping work completed around uptake of the NMAHP CPD funding, with promotional activity successful in significantly increasing AHP access over a twelve-month period.

1.6 Looking Forward

Focus over the upcoming months is to develop a robust career pathway for all AHPs that considers both early and mid-late career retention strategies. This will include accessible models for both enhanced and advanced practice, and more defined entry level routes for support workers. There will be particular emphasis around developing a volunteer to career pathway, which aims to increase diversity of the workforce and accessibility for the local community, as well as an expansion of the current AHP apprenticeship model to step up sustainable supply.

Detailed workforce planning will be considered across the AHP workforce, in line with regional and national work streams, and this will feed into the overall workforce strategy. Uptake of Preceptorship will be increased across the AHP workforce, and an NHS AHP on-boarding programme will be developed for support workers, volunteers, and international recruits.

Collaboration with Higher Education Institutions (HEIs) will continue to support the development of innovative practice placement models, along with unlocking of placement tariff to help build capacity.

Work will continue around career progression and retention, with the introduction of career conversations and the analysis of an AHP Retention Survey.

Continued investment in AHP Workforce and Practice Development is required and work is ongoing to identify funding to ensure the continuation of the two fixed term posts which have shown to be critical in ensuring the sustainable and successful progression and development of our AHP Workforce and Strategy.

2. END OF LIFE AND PALLIATIVE CARE

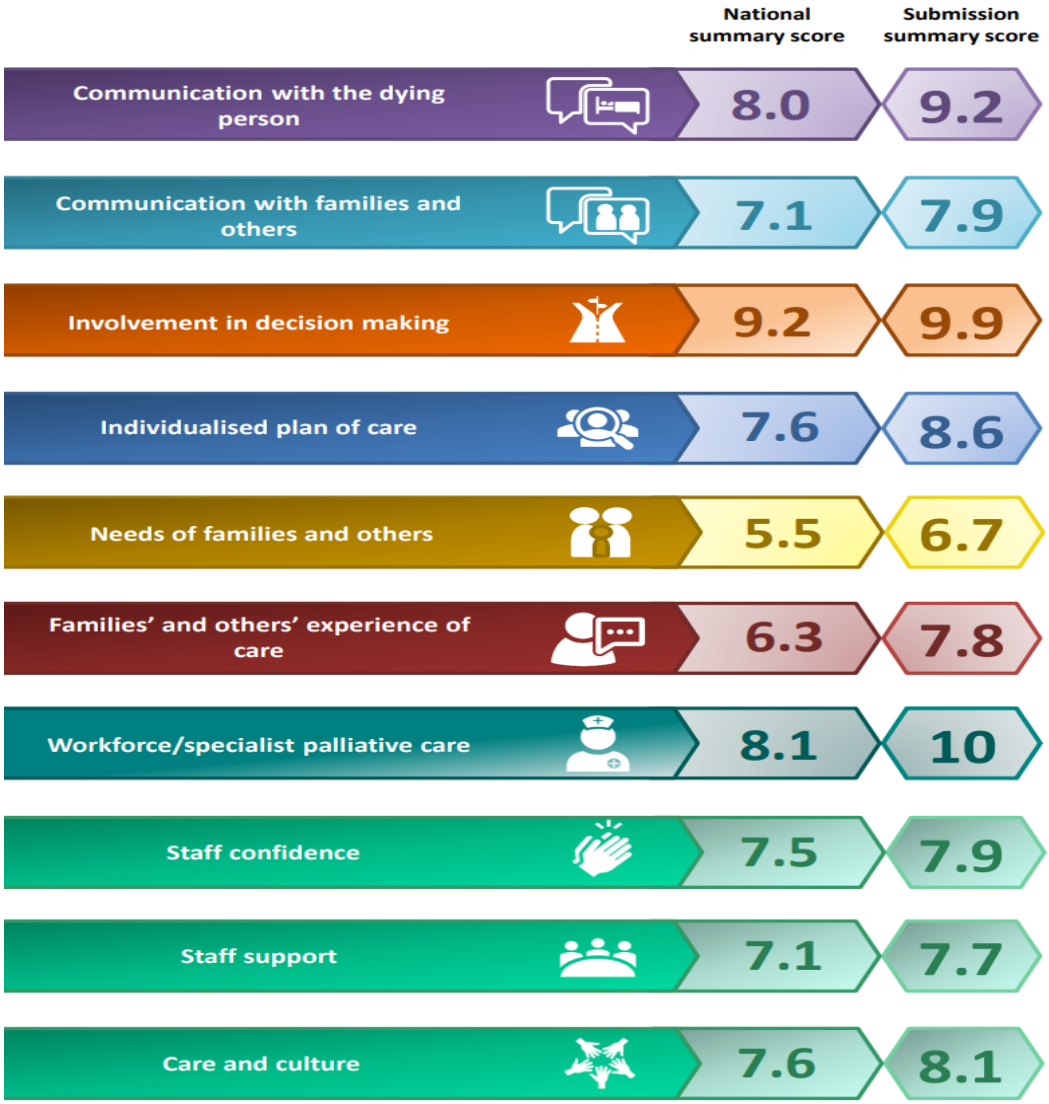
The Palliative and End of Life Care Service are committed to following national and regional guidelines and achieving the Trust's Strategic Goals. The team aim to support the delivery of

high-quality best practice palliative and end of life care to patients and carers in Newcastle hospitals and community. Highlighted below are several key workstreams and achievements over the recent months.

2.1 NATIONAL AUDIT OF CARE AT THE END-OF-LIFE 2022/2023 – ROUND FOUR

The Fourth round of the National Audit for Care at the End of Life (NACEL) was published in February 2023 from data collected from April 2022 to September 2022. The audit comprised of an organisational level audit, 50 case note reviews, 41 quality surveys (bereaved families survey) and 115 staff reported measures (staff survey).

The report demonstrates that the scores from the Trust are above the National results in all domains and reflects the high-quality care delivered by staff working across the Trust.
The Trust also one of the few Trusts to be allocated scores in all domains due to our high response rate.



We are expecting the national recommendations from NACEL to be published in July 2023. In the interim, the service is developing an action plan focusing on:

- Ensuring that staff can access appropriate training.
- Supporting staff to improve documentation within the individualised plan of care, namely hydration/nutrition, medications, spiritual needs, and preferred place of death.
- Improving communication with families and carers, listening to them, and understanding their perception of care.

2.2 GOLD STANDARDS FRAMEWORK (hospitals)

As previously reported to the Trust Board, the Trust is progressing with the roll out of the Gold Standards Framework (GSF). The GSF provides training for generalist frontline staff in health and social care to enable the provision of 'gold standard' care for all people nearing end of life. Relevant staff have completed the online webinars and we welcomed the national GSF team to our Trust on the 19 and 20 April 2023. The team were visiting the 10 participating wards to offer and provide further support in the implementation of the learning thus far.

2.3 FREEMAN HAVEN

Due to the demands on space within the Freeman Hospital, the creation and development of the Freeman Haven has been delayed. However, a suitable space for the Freeman Haven (with easy access to refreshment, ward areas and to the outside) has now been identified and agreed. The concept design based on the RVI Haven has been approved by stakeholders in principle.

3. SAFEGUARDING AND MENTAL CAPACITY ACT QUARTER 4 (Q4)

This summary provides a Q4 update of Safeguarding and Mental Capacity Act activity throughout the Trust and includes references to developments in practice.

3.1 Safeguarding Activity

Safeguarding activity for Q4 evidences the following key high-level points:

- In adult safeguarding data demonstrates a 5% increase in activity compared to the same quarter last year. It is noted that partner agencies have also experienced an increase which is multifactorial, thought to include the impact of the cost-of-living crisis, growing awareness of safeguarding along with changes and stressors arising from the impact of the pandemic.
- In children's safeguarding, it is noted that the Trust has continued to see an increase in overall activity from 2019/20 (pre-pandemic period). In this Q4 there has been over a 15% increase in comparison to Q3 and in March 2023 safeguarding activity reached an all-time high of 1,096. Neglect, child self-harm/overdose, parental self-harm/overdose, physical harm and domestic abuse continue to be the main sources of referral.

- Recent investment has been agreed into the Safeguarding Teams which will in part mitigate this increased in activity but will need to be monitored regularly. The recruitment process is nearly complete with some staff already in post.

3.2 Safeguarding Mandatory Training

The compliance relating to Safeguarding training continues to be closely monitored. At the time of writing the following key points are noted:

- Safeguarding Level 1 Adult and Children remains above 95% compliant.
- Safeguarding Level 2 Adult and Children both stand at 92%.
- Safeguarding Adults and Children Level 3 both remain of concern at 81% and 82% though it is noted that compliance has increased since Q3 were they stood at 76% and 73% respectively. Several actions are in place to improve compliance with staff being provided both face to face training and eLearning to maximise the flexibility in training options.

3.3 Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS)

Mental Capacity has seen a significant focus following the CQC inspection. Mental Capacity training is now mandatory for identified clinical staff and was launched in March 2023. At the time of writing 75% of relevant staff have completed this training. This training will be followed up in due course with Level 2 training for relevant staff and the content of the training has been finalised recently. Bespoke sessions for staff groups continue which supports the exploration of what can be highly complex and challenging situations.

There has been an increase in the number of cases requiring legal involvement in Q4. There have been 15 complex cases and 8 of these cases have gone to the Court of Protection. Ensuring that the dashboards reflect key performance indicators that demonstrate how the Trust is meeting the requirements for the Mental Capacity Act is a focus of work for Q1 2023-2024 and is in progress.

Deprivation of Liberty Safeguards (DoLS) have also increased in comparison to previous years which is positive to see as it ensures patients are appropriately cared for in line with the Mental Capacity Act. There has been a total of 920 activated Urgent DoLS applications, with a further 60 applications received but not sent on, following triage. This marks an increase of 135 active DoLS from this point in 2021-2022.

Additional infrastructure has been agreed in the Mental Capacity Act function with the appointment of an MCA Practitioner who will critically support the MCA Lead and the MCA agenda across the Trust.

4. LEARNING DISABILITY QUARTER 4 (Q4)

4.1 Activity

The team continues to develop practice to improve care for people with Learning Disabilities, building on the existing infrastructure and the dedicated expertise of the Learning Disability Liaison Team.

The following activity trends have been noted in Q4:

- In Q4 there were 763 referrals, a slight rise from Q3 and an increase of 120 referrals from Q4 2022, representing a 16% upturn in activity.
- Q4 has continued to be particularly challenging as there have been several individuals who required direct intervention. The Trust has on average 35 patients at any one time with between 10 and 12 of those being highly complex, requiring greater team coordination potentially between multiple services.
- There is currently a higher than average number of patients in the Trust, with 39 patients who have complex needs requiring support from the Learning Disability Liaison Team. For many patients' input is required from an MCA Practitioner Lead and Trust Legal Services to ensure robust planning and delivery of safe care from admission through to discharge.

4.2 Training and Education

It is important that the skills and competencies of Trust staff are developed through training, education and sharing lessons learnt from case reviews to be assured that individuals with a Learning Disability receive the highest quality of care when accessing Trust services. The Diamond Standard Learning Disabilities Training (a regionally recognised programme) was launched in the Trust in March across the Trust and at time of writing there is a compliance of 74% for clinical and patient facing staff.

The Learning Disability Liaison Team continues to contribute to the regional work to develop strategy to support people (CYP and Adult) with autism. Autism awareness training sessions were launched April 2023 with particular emphasis on care in urgent and emergency care settings.

Nationally it is anticipated that the updated Code of Practice (Health and Social Care Act 2008) will be published in Autumn 2023. The expectation is that it will mandate Learning Disability and Autism Training and the work we have done to date in response to the recent CQC inspection is an important start in this process.

4.3 CQC Focused Inspection

The unannounced inspection undertaken by the CQC in December 2022 included a review into the quality and safety of the care provided to patients with a learning disability and/or autism.

In response to the CQC report highlighting concerns around record keeping for reasonable adjustments for people with a Learning Disability, a significant piece of work has commenced to ensure evidence of 'reasonable adjustment' is documented. The Learning Disability Liaison Team and the Digital Health Team are working collaboratively and at pace, whilst giving consideration to utilising 'Health Passports' to ensure the appropriate individualised information is both discussed with patients and families and documented appropriately.

Other actions for the Learning Disability Liaison Team include the development of a Learning Disability and Autism Strategy, a greater visibility at forums across the organisation and supporting bespoke training sessions for clinical leaders. This work has been commenced and the Trust Board will be provided with regular updates moving forward.

5. PATIENT EXPERIENCE QUARTER 4 (Q4) UPDATE 2022-2023

5.1 Complaints Activity

The Trust has opened 137 formal complaints in Q4, which is a decrease of 5% from the previous quarter. The Trust has received on average 43 formal complaints per month, which is a 7% decrease from the previous year where the average was 46 complaints per month.

Of the complaints that opened in this quarter, 23% had a primary concern with regards to communication. This further breaks down into sub-subjects; communication failure with patient is the most common issue (n10), communication with relatives or carers (n9), communication with patients with Autism/Aspergers, method or style of communication, patient not being listened to (n2) incorrect, or no information given, access to interpreting services, breakdown between medical teams, breaking bad news, inadequate record keeping, and breakdown regarding appointments (n1).

From the 150 closed complaints in Q4, 22 complaints were upheld, 29 complaints were partially upheld and 99 were not upheld.

Women's Services and Medicine account for 45% of the upheld complaints for this period. The communication primary subject category accounts for 23% of complaints upheld in the Trust across five directorates.

5.2 PALS

1,055 issues have been raised with PALS over this period. This compares to 927 in the previous quarter a 14% increase, 38 enquiries were from carers. There has been an increase in the number of enquiries regarding appointments and issues categorised as care & treatment.

5.3 NHS Choices

The Trust received 33 items of feedback with most comments being in relation to Medicine (n8) and Cardiothoracic (n7) directorates. The Trust received the maximum score rating of five stars from 79% (n26) of comments received.

5.4 NHS Friends and Family Test (FFT)

The latest published FFT data shows that there were 1,240 responses from the Trust in January 2023 (published March 2023). Reassuringly 99% of in patients and day cases would recommend the service to their friends and family. Work continues to review FFT results, identify areas for improvement and opportunities to increase the number of responses.

5.5 Advising on the Patient Experience (APEX)

This quarter, APEX have given their views on the revised Visiting policy and supporting documents to ensure that the policy reflects the view of visitors and information provided to patients has been co-produced with patients. The Group also took some time to hear about the re-organisation of clinical board management structures in the Trust and discuss future plans for the way in which APEX Group meetings will run in 2023.

5.6 Maternity Voice Partnership and Connie e-Midwife

National Maternity Voices have provided a two-part training opportunity for multi-disciplinary attendance which sought to broaden general understanding of Maternity Voice Partnerships, their set up, governance and work planning methods as well as highlight the value of co-production. The sessions facilitated rich discussion and shared learning around how to effectively reach service users from all backgrounds and champion co-production within maternity services.

Newcastle Hospitals Maternity Services and the MVP have facilitated a '15 Steps' visit to the RVI. The event was well attended with a diverse cohort of 16 service user and stakeholder participants sharing their real-time feedback and lived experience in service user facing areas including, Newcastle Birthing Centre, Maternity Assessment, Antenatal Clinic, Fetal Medicine, and Postnatal Wards. Feedback was captured with a focus on how well our services and spaces are welcoming and informative, safe and clean, friendly and personal, organised and calm as well as looking more generally at the environment and accessibility. The feedback received was positive with participants reporting feeling very safe during their visit and finding staff friendly, considerate, and approachable, with areas clean and well organised. Suggestions for improvement will be shared at the forthcoming Maternity Feedback Forum and actions identified accordingly.

An extension of MVP activity, Connie E-Midwife has continued her central role in facilitating ongoing, regular service user engagement this quarter. Her weekly question and answer sessions continue to be well utilised with the option for direct messenger also remaining a popular service. As well as providing service change and development updates, Connie has worked with our Public Health and Infant Feeding Midwives to share information on local breastfeeding support networks, safe sleeping and smoking cessation support.

5.7 Young Persons Advisory Group (YPAGne)

During this quarter, two PPI meetings took place, reviewing five research projects. Six new people joined the group. The Great North Youth Forum held two meetings, reviewing two quality improvement projects and continue to work on the youth led project looking at exam access requirements for young people with long term conditions.

5.8 Patient Experience and Engagement Strategy

Following preliminary patient and staff consultation in summer 2022 the Trust is keen to explore and develop its patient experience strategy. With support from Newcastle Charities, WeAreStand; expert involvement practitioners and service change leaders, have been commissioned to help drive this exciting piece of work and are working in collaboration with

the patient experience team. The proposal has been shared in the Private Board of Directors meeting.

Plans are in place to carry out a two phased approach:

- Phase 1 will include a review of best practice and existing patient experience, involve and gather feedback from patients' visitors, carers and staff, analyse feedback to help identify and assess key themes, identity gaps and opportunities and propose and scope options for actions. Phase 1 commenced in April 23 and aims to be completed by September 2023.
- Phase 2 will include the design of the patient experience strategy, plan for delivery (sustainability), implementation, pilot and test and final review against success criteria.

Consideration will be given of how patient experience links into organisational governance, strategic communication and wider stakeholder engagement. Process of the plan will be closely monitored by a newly developed strategic group which includes representation from the public governors.

5.9 Interpretation and Translation Contract

After a competitive tender process for the spoken and non-spoken interpretation contracts, both contracts have been awarded to Language Empire which will commence from 1st May 2023.

Language Empire are a well-established interpretation supplier with numerous contracts with NHS organisations and customers in other sectors. Their current contracts include interpretation for primary care in the North East ICS, so they have a thorough understanding of the area, local communities and have an established pool of freelance and employed interpreters.

5.10 Disability Awareness e-Learning

In partnership with Disability North and We Are All Disabled with support from Newcastle Hospitals Charity, the Patient Experience Team have developed Disability Awareness eLearning that is available for all staff on the Learning Lab. This is following a complaint from a disabled patient and one of the actions was to provide training to staff in holistically caring for disabled patients and supporting patient autonomy when in hospital. Focus groups took place with service users from the two organisations to understand what patients would like staff to improve on, what the eLearning aims should be and the eLearning content.

The main aims of the eLearning are to improve staff communication skills, recognise individual needs of disabled patients and consider implicit biases. The training also covers the different models of disability to view disability from different lenses and as an alternative to medicalising disability. Feedback will be gathered from staff who have completed it and there will be continuous communications about the eLearning to encourage staff to do the eLearning.

5.11 Chaplaincy

The chaplaincy team continue to provide support for both patients and staff, delivering 2,239 contacts in Q4. The team have provided funds and practical support to patients, relatives and staff from foodbank vouchers to clothing to sanitary products. In collaboration with the catering department, they have continued to develop the Helping Hands Stable of Care to include “too good to throw fridges” and received good and often heart-breaking thanks for the “Porridge for the staff”.

In Q4 the team have conducted 313 chapel of rest, police identifications and coroners’ cases in and out of hours during what has been unprecedented pressures on the mortuaries and chapels of rest.

Our chaplains who are drawn from different faiths, beliefs and world views have been alongside 687 dying patients and their relatives; and conducted the appropriate rites, rituals and funeral services.

6. RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
25 May 2023

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 May 2023		
Title	Maternity Update Report		
Report of	Maurya Cushlow, Executive Chief Nurse		
Prepared by	Jane Anderson, Director of Midwifery Jeanette Allan, Senior Risk Management Midwife		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	NHS England (NHSE) published the 'Three-year delivery plan for maternity and neonatal services' on 30 March 2023 https://www.england.nhs.uk/long-read/three-year-delivery-plan-for-maternity-and-neonatal-services/ The 'Three-year delivery plan' was published in response to learning and actions set out from the: • Ockenden (2020 and 2022), • East Kent (2022), and previously • Morecambe Bay (2015) Maternity reports which have highlighted concerns for families experiencing poor care, in particular families from minority groups. The plan sets out the ambitions for maternity and neonatal care to be made safer, more personalised, and more equitable for women, babies, and families. It highlights four key themes broken down into twelve priority actions to be delivered over the next three years. The plan details specific actions required of Trusts, Local Maternity and Neonatal Systems (LMNS) and/Integrated Care Boards (ICBs) whilst also detailing the National support to be provided from NHSE. The purpose of this paper is to provide members of the Trust Board with an overview of the 'Three-year delivery plan for maternity and neonatal services'. The four key themes are presented along with the twelve priority actions/objectives. Responsibility for each action is detailed with reference to ownership at Trust, LMNS/ICB and National level. The Plan also details how Maternity and Neonatal services will be monitored and measured in achieving the actions and these are referenced for the Trust Board to note. This paper includes the next steps for the Trust in benchmarking existing services against the ambitions of the three-year plan, identifying work that has already begun and is ongoing as a result from Ockenden, and align this with the plan whilst identifying outstanding actions required to fully comply with the three-year plan. This paper also provides an update on progress against both the interim and final Ockenden report recommendations detailing current Trust compliance. This paper also provides the Trust Board with an overview of the Trust's achievement of the 10 Safety Actions required to meet the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 4 compliance. This paper reports on the outcome of the Care Quality Commission (CQC) inspection of the Newcastle Upon Tyne NHS Hospitals Maternity Service in January 2023 under the domains of 'well-led' and 'safe' as part of their national maternity inspection programme.		

	Detail with regard to workforce previously reported within the Ockenden paper is presented through the Nursing and Midwifery Staffing paper. The Ockenden Report (30 March 2022) can be found at: https://www.gov.uk/government/publications/final-report-ofthe-ockenden-review The East Kent Maternity Report (Reading the signals - Maternity and neonatal services in East Kent – the Report of the Independent Investigation, 2022) can be found at: https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report
Recommendation	The Trust Board is asked to: i) Receive and discuss the report; ii) Note the current level of assurance against the interim and final Ockenden recommendations; iii) Recognise the significance of the 'three-year delivery plan for maternity and neonatal services' for the Maternity Service and that further detailed work is required to identify outstanding actions required to ensure full compliance; iv) Note the findings of the final report of the CQC inspection and the work required in response to this; and v) Note the associated risks involved.
Links to Strategic Objectives	Putting patients at the heart of everything we do. Providing care of the highest standards focussing on safety and quality.

Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☒	☐	☒	☐

Link to Board Assurance Framework [BAF]	<u>Strategic Objective One</u> Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality. <u>Strategic Risk Description</u> i) SO1.1 - Extreme capacity and demand pressures may impact the Trust ability to achieve important operational and regulatory standards including securing income. ii) SO1.4 - There is a risk of regulatory intervention if we are unable to comply with mandatory NHS core standards which could impact on patient safety, quality of care and the reputation of the Trust. iii) SO1.11 - Failure to achieve required CQC standards could impact on the Trust's ability to remain "Outstanding" <u>Strategic Objective: 2</u> Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential - sustainable workforce planning. i) SO2.2 - Trust sickness absence has not returned to pre-pandemic levels. There is a risk that we are unable to fill staffing gaps across our services which could create additional operational pressure across the Trust and impact on quality of care we deliver.
Reports previously considered by Trust Board	Previous reports have been presented to members of the Trust Board on Ockenden, The Kirkup Report, and The Maternity Incentive Scheme (CNST).

MATERNITY SERVICES UPDATE

EXECUTIVE SUMMARY

The purpose of this paper is to:

i) update on progress against both the interim and final Ockenden report recommendations detailing current Trust compliance.

ii) provide the Trust Board with an overview of the Trust's achievement of the 10 Safety Actions required to meet the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 4 compliance.

iii) report on the outcome of the Care Quality Commission (CQC) inspection of the Newcastle Upon Tyne NHS Hospitals Maternity Service in January 2023 under the domains of 'well-led' and 'safe' as part of their national maternity inspection programme

iv) provide members of the Trust Board with an overview of the 'three-year delivery plan for maternity and neonatal services'

Section 2 provides a current position on progress against i) both the interim and final Ockenden recommendations Ockenden compliance has previously been reported in separate papers to Trust Board with full compliance now demonstrated at 75.6%, partial-compliance 22.1%, and 2.3% of recommendations remaining non-compliant.

Of note compliance has now been achieved for**: (**Recommendation 3.1) Conflict of clinical opinion escalation policy which has now been ratified and published on the Trust Intranet.

Thirteen partially compliant recommendations remain from the original group of thirty-two which the Trust continue to progress, and these are detailed in *Appendix 1*. There is nothing to report by exception.

Section 3 reports on ii) Year 4 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) which began in August 2021 and had a final submission date of 2 February 2023. The Trust submitted the Board declaration on the 25 January 2023, declaring full compliance with all ten safety actions. The Trust was notified by NHS Resolution on the 5 April 2023 on the success of achieving all ten safety actions. The Trust awaits details of the year 5 scheme which will be reported to the Trust Board in a separate paper.

Section 4 reports on the iii) Care Quality Commission (CQC) inspection announced at short notice on 6 January 2023 as part of the national maternity inspection programme which focused only on two key domains of 'safe' and 'well-led'. This programme aims to give an up-to-date view of hospital maternity care across the country, to help the CQC understand what is working well, supporting learning and improvement at a local and national level.

An on-site inspection was made on 10 and 11 January and, the inspection team conducted interviews with the senior leaders and reviewed the feedback from women and families, together with a review of the evidence provided by the Trust.

The overall rating for the Maternity service has been declared as 'requires improvement' given a rating of 'good' for well-led and 'requires improvement' for safe. The remaining three domains of caring, responsive, and effective will be the focus for inspection at a later date.

The report provides evidence of some outstanding practice within the maternity service, together with some extremely positive findings, for example, robust governance frameworks, and staff assessing and responding to risks. However, there are three areas which the Trust 'Must Do' to ensure compliance with regulatory obligations.

'Must Do' Areas identified for improvement to comply with legal obligations are as follows:

- Regulation 12(1)(2)(e); the Trust must ensure staff complete daily check of emergency equipment. They must ensure equipment used by staff and women and birthing people is in date, checked regularly and safe for the intended purpose.

- Regulation 18(1)(2)(a); the Trust must ensure all staff receive such appraisal as is necessary to carry out their duties.

- Regulation 12(1)(2)(g); the Trust must ensure the proper and safe management of medicines, ensuring out of date medicines are removed and medicines are stored securely.

'Should Do' areas have been identified which do not breach regulation but which should be considered further, and improvements made:

- The Trust should ensure that all staff complete the required mandatory training, including the appropriate level of safeguarding adults and children training.

- The Trust should ensure all areas are clean and staff use control measures to prevent the spread of infection.

- The Trust should ensure sufficient midwifery staff are deployed to keep women, birthing people, and babies safe.

- The Trust should ensure estates and facilities in the delivery suite are suitable to meet the needs of women, birthing people and families and protect their privacy and dignity.

- The Trust should act to ensure staff fully complete all aspects of modified obstetric early warning scores in order to assess the risks to women and birthing people.

- The Trust should continue to monitor the security of the unit continues to be reviewed in line with national guidance.

- The Trust should continue work to introduce a robust formal triage and escalation process within the maternity assessment unit.

An action plan has been implemented and work has already commenced to improve all areas identified as requiring improvement. Further updates and assurance will be provided via the Quality Committee to Trust Board.

Section 5 provides members of the Trust Board with an overview of iv) the 'Three-year delivery plan for maternity and neonatal services. The 'Three-year delivery plan' was published on 30 March 2023 in response to learning and actions set out from the Ockenden (2020 and 2022), East Kent (2022), and previously Morecambe Bay (2015) Maternity reports which have highlighted concerns for families experiencing poor care, in particular families from minority groups.

The plan sets out the ambitions for maternity and neonatal care to be made safer, more personalised, and more equitable for women, babies, and families. It highlights four key themes broken down into twelve priority actions (objectives) to be delivered over the next three years. The plan details specific action required of Trusts, Local Maternity and Neonatal Systems (LMNS) and/Integrated Care Boards (ICBs) whilst also detailing the National support to be provided from NHSE. The Plan also details how Maternity and Neonatal services will be monitored and measured in achieving the actions and these are referenced for the Trust Board to note.

The four key themes and 12 priority actions/objectives are:

Theme 1: Listening to women and families with compassion which promotes safe care.
Objective 1: Provide care that is personalised.
Objective 2: Improve equity for mothers and babies.
Objective 3: Work with service users to improve care.

Theme 2: Supporting our workforce to develop their skills and capacity to provide high-quality care.
Objective 4: Grow our workforce.
Objective 5: Value and retain our workforce.
Objective 6: Invest in skills.

Theme 3: Developing and sustaining a culture of safety to benefit everyone.
Objective 7: Develop a positive safety culture.
Objective 8: Learning and improving.
Objective 9: Support and oversight.

Theme 4: Meeting and improving standards and structures that underpin our national ambition.
Objective 10: Standards to ensure best practice.

Objective 11: Data to inform learning**.**
Objective 12: Make better use of digital technology in maternity and neonatal services.

This paper includes the next steps for the Trust in benchmarking existing services against the ambitions of the Three-year plan, identifying work that has already begun and is ongoing as a result from Ockenden, and align this with the Trust's existing plan, whilst identifying outstanding actions required to fully comply with the three-year plan. The identification of any associated risks will become more evident as the Trust progresses the benchmarking exercise, which will also rely on the interdependency of the ambition through National and ICB support. An update will be presented to the Trust Board in July 2023.

RECOMMENDATIONS

The Trust Board is asked to:

i) Receive and discuss the report;
ii) Note the current level of assurance against the interim and final Ockenden recommendations;
iii) Recognise the significance of the 'three-year delivery plan for maternity and neonatal services' for the Maternity Service and that further detailed work is required to identify outstanding actions required to ensure full compliance;
iv) Note the findings of the final report of the CQC inspection and the work required in response to this and
v) Note the associated risks involved.

Report of Maurya Cushlow
Executive Chief Nurse
25 May 2023

MATERNITY SERVICES UPDATE

1. INTRODUCTION

This paper provides the Trust Board with an overview and update for the leading priorities and quality considerations for the Maternity Service and outlines the Trust's position in relation to compliance against the recommendations from both the interim and final Ockenden reports (2020 and 2022), that have been previously reported within separate Ockenden papers to Trust Board.

Also referenced for the Trust Board to note is confirmation of the achievement of the 10 Safety Actions from Year 4 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

The Newcastle Upon Tyne Hospitals Maternity Services were inspected by the Care Quality Commission (CQC) in January 2023 and a high-level update on the final report and overall outcome is provided for the Trust Board within this paper.

This paper introduces the Trust Board to the 'Three-year delivery plan for maternity and neonatal services' published on 30 March 2023 by NHS England. The aim of the 'Three-year delivery plan' is to combine findings and recommendations from previous maternity reports (Ockenden, East Kent and Morecambe Bay) into a single set of actions for Trusts to implement and report against. The plan has four key themes, split into twelve priority actions, and details the overarching ambition for maternity and neonatal services to work towards, whilst highlighting the expectations and responsibilities for each action at Trust, Local Maternity and Neonatal System (LMNS)/Integrated Care Board (ICB) and National level. The Three-year delivery plan outlines the measures that will be used to monitor achievement and compliance of the twelve priority actions.

2. OCKENDEN UPDATE

As members of the Trust Board are aware, the final Ockenden Report published on 30 March 2022, is the report of an inquiry commissioned by the former Secretary of State, Jeremy Hunt, who requested an independent review of the quality of investigations, and implementation of the recommendations of a number of alleged avoidable neonatal and maternal deaths, and harm, at The Shrewsbury and Telford NHS Trust.

Following on from the initial interim report, published in December 2020, the final publication presents the findings, conclusions, and a number of essential actions for providers of maternity services across England. Endorsed by NHS England and Improvement (NHSE/I), the Immediate and Essential Actions complement and expand upon the Immediate and Essential Actions issued in the first Ockenden report. The Trust has continued to progress outstanding actions from the interim and final Ockenden reports through a

combined high level action plan. *Appendix 1* provides an updated action plan incorporating both the interim and final Ockenden reports.

2.1 Outstanding Non-Compliant Final Report Recommendations

The two non-compliant recommendations from the final report (of the original group of 7) which the Trust continues to work toward are:

- **(Recommendation 1.3) A locally calculated uplift of midwifery staff based on previous 3 years.**

Work has commenced in reviewing the midwifery staffing position across the previous three years, considering a number of challenges which have presented themselves throughout this period of time, including the COVID pandemic and the Maternity Transformation Programme.

This work, led by the Director of Midwifery, incorporates, and maps the additional core training requirements required for staff within the maternity service, which has evolved considerably across a five-year period. Of importance to note is the additional activity and increased acuity of patients as a result of the quality improvement work in relation to the Maternal Medicine Network, implemented since the last Birthrate Plus workforce review in 2020.

This three-year review will inform discussion regarding a locally calculated uplift for Newcastle Hospitals, to be presented to the Trust Board at a later date. In the interim, mitigation for any shortfall is made through the approval of a 20wte over established position.

- **(Recommendation 5.4) Change in practice as a result of a Serious Incident (SI) to be seen within 6 months and audited to ensure a change has occurred.**

Work is progressing strengthening the Maternity services audit programme. The 6-month timescale remains challenging for all Serious Incidents due to reporting timeframes for those investigated by Healthcare Safety Investigation Branch (HSIB). Improvement work continues for those SIs that are within the remit of the Trust to investigate, to enable audits to be undertaken to demonstrate that change is embedded within practice.

Progress for Non-Compliant Final Report Recommendations

The remaining two recommendations that are now graded partially compliant (from the original group of seven non-compliant) which the Trust continues to work toward are:

- **(Recommendation 1.7) Labour ward coordinators to attend Nationally Recognised Course (including advanced decision making, human factors, psychological safety etc)**

As previously reported, two of Newcastle's labour ward coordinators have started the newly developed course at Teesside University and are near completion, with a further two staff members scheduled to start in May 2023. A plan is in place to ensure all those coordinating the labour ward will attend this programme when future dates are released from the university.

- **(Recommendation 10.2) Midwifery-led units must complete yearly operational risk assessments.**

Newcastle's Birth Centre operational risk assessment continues to be developed through collaborative work alongside the national task and finish group. Once completed, this document will be ratified through the maternity governance assurance framework and an update provided in future papers.

Compliance for original Non-Compliant Final Report Recommendations

Of note compliance has now been achieved for:

- **(Recommendation 3.1) Conflict of clinical opinion escalation policy**

Newcastle Upon Tyne Hospitals NHS Foundation Trust Maternity Conflict of Clinical Opinion policy has now been ratified and published on the Trust Intranet.

Previously reported Partial Compliant recommendations:

Thirteen partially compliant recommendations remain from the original group of thirty-two which the Trust continue to progress, and these are detailed in *Appendix 1*. There is nothing to report by exception.

3. CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) UPDATE

The NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) invites Trusts to provide evidence of their compliance using self-assessment against ten maternity safety actions. The scheme intends to reward those Trusts who have implemented all elements of the 10 Maternity Safety Actions. The Trust has been successful in achieving full compliance in the previous 3 years.

Year 4 of the Clinical Negligence Scheme began in August 2021 with an initial submission date of June 2022. Due to ongoing challenges nationally, predominantly due to the pandemic, the scheme was paused for 4 months, and a final submission date was agreed for 2 February 2023.

The Trust submitted the Board declaration on 25 January 2023, declaring full compliance with all ten safety actions. As presented in previous Trust Board reports, achieving full compliance with all ten safety actions has been challenging, given a number of pressures experienced by the Maternity service throughout the duration of Year 4.

The most challenging safety action to achieve has been safety action 8 which focusses on core training requirements for Maternity staff. Following a programme of closely monitored training events, the Trust was able to achieve the required competencies for all staff groups within the required timeframe.

The Trust was notified by NHS Resolution on the 5 April 2023 on the success of achieving all ten safety actions. The Trust awaits details of the year 5 scheme which will be reported to the Trust Board in a separate paper.

4. CARE QUALITY COMMISSION (CQC) JANUARY 2023 INSPECTION UPDATE

The CQC announced an intention to undertake a short notice inspection on 6 January 2023 as part of the national maternity inspection programme. Focussing on two key domains of 'safe' and 'well-led', this programme aims to give an up-to-date view of hospital maternity care across the country, and to help the CQC understand what is working well, supporting learning and improvement at a local and national level.

An on-site inspection was made on 10 and 11 January and, thereafter, the inspection team conducted interviews with the senior leaders and reviewed the feedback from women and families, together with a review of the evidence provided by the Trust.

The draft CQC report was received by the Trust in March and returned to the CQC following checking of factual accuracy. The final report was published on 12 May. The final rating and content of the report was shared with members of the maternity and neonatal service prior to publication.

The report provides evidence of some outstanding practice within the maternity service, together with some extremely positive findings, for example, robust governance frameworks, and staff assessing and responding to risks. However, there are three areas which the Trust must take to ensure compliance with regulatory obligations.

'Must Do' areas identified for improvement for the Trust in order to comply with legal obligations are as follows:

- Regulation 12(1)(2)(e); the Trust must ensure staff complete daily check of emergency equipment. They must ensure equipment used by staff and women and birthing people is in date, checked regularly and safe for the intended purpose.

- Regulation 18(1)(2)(a); the Trust must ensure all staff receive such appraisal as is necessary to carry out their duties.

- Regulation 12(1)(2)(g); the Trust must ensure the proper and safe management of medicines, ensuring out of date medicines are removed and medicines are stored securely.

'Should Do' areas have been identified which do not breach regulation, should be considered further and improvements made:

- The Trust should ensure that all staff complete the required mandatory training, including the appropriate level of safeguarding adults and children training.

- The Trust should ensure all areas are clean and staff use control measures to prevent the spread of infection.

- The Trust should ensure sufficient midwifery staff are deployed to keep women, birthing people, and babies safe.

- The Trust should ensure estates and facilities in the delivery suite are suitable to meet the needs of women, birthing people and families and protect their privacy and dignity.

- The Trust should act to ensure staff fully complete all aspects of modified obstetric early warning scores in order to assess the risks to women and birthing people.

- The Trust should continue to monitor the security of the unit continues to be reviewed in line with national guidance.

- The Trust should continue work to introduce a robust formal triage and escalation process within the maternity assessment unit.

An action plan has been implemented and work has already commenced to improve all areas identified as requiring improvement. A further update will be presented to the Trust Board in July 2023.

5. THREE YEAR DELIVERY PLAN FOR MATERNITY AND NEONATAL SERVICES

NHS England published the 'Three-year delivery plan for maternity and neonatal services' on 30 March 2023, exactly a year from the publication of the final Ockenden report (2022). The Three-year delivery plan has been created in response to the Ockenden (2022), East Kent (2022) and previously Morecambe Bay (2015) reports, which combined highlight continued failures in care for families, especially those from ethnic minorities. The plan emphasises

that "*while the birth of a baby represents the happiest moment of many people's lives, some families have experienced unacceptable care, trauma, and loss, and with incredible bravery have rightly challenged the NHS to improve*."

The Three-year plan defines how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. The plan has four key themes, split into twelve priority actions, and details the overarching ambitions for maternity and neonatal services to work towards. The plan details the expectations and responsibilities for each action at Trust, LMNS/ICB and National level. The Three-year delivery plan also outlines the measures that will be used to monitor progress, achievement, and compliance of the twelve priority actions. A full breakdown of actions, responsibilities and measures are detailed in *Appendix 2.*

Four Key Themes and Twelve Objectives From the Three-Year Delivery Plan

The Three-year plan determines that safer, more personalised, and more equitable care will be achieved through four, high level themes comprising twelve objectives:

THEME 1: LISTENING TO WOMEN AND FAMILIES WITH COMPASSION WHICH PROMOTES SAFE CARE

Objective 1: Provide care that is personalised.

Personalised care provides women with choice and control over how their care is planned and delivered. Care should be based on evidence, what matters to each individual whilst accounting for their specific risk factors and needs. This detail can be included in each woman's personalised care and support plan (PCSP) to prevent them having to repeat their story. This theme identifies actions for personalised care, reducing inequalities through improving equity, and working with service-users to improve.

Objective 2: Improve equity for mothers and babies.

Improving equity involves implementing midwifery continuity of carer (in line with safe staffing principles), particularly for women from minority ethnic communities and from the most deprived areas. Women and babies from these groups experience greater health inequalities and worse outcomes.

Objective 3: Work with service users to improve care.

Collaborative working and co-production are key to improving care and providing services that are responsive and aligned to the needs of the local community.

THEME 2: GROWING, RETAINING, AND SUPPORTING OUR WORKFORCE

Objective 4: Grow our workforce.

High-quality care requires skilled teams with sufficient capacity and capability. NHSE recognise services require continued staffing growth to achieve the ambitions of the plan.

Objective 5: Value and retain our workforce.

The Three-year plan wants staff to feel valued and fulfilled through sustainable careers, and to improve the experience of all staff to increase retention.

Objective 6: Invest in skills.

Training and developing staff makes them feel valued and enabled to deliver high-quality care.

THEME 3: DEVELOPING AND SUSTAINING A CULTURE OF SAFETY, LEARNING, AND SUPPORT

The ambition of the plan is for staff to be part of a positive safety culture, which will improve care experiences and outcomes for women and babies and will encourage staff to thrive.

Objective 7: Develop a positive safety culture.

Cultural change is enabled through leadership that is compassionate, diverse, and inclusive.

Objective 8: Learning and improving.

Promoting safer care requires continuous learning from when things go well and when they do not.

Objective 9: Support and oversight

The plan highlights that good oversight from trusts and ICBs is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise.

THEME 4: MEETING AND IMPROVING STANDARDS AND STRUCTURES THAT UNDERPIN OUR NATIONAL AMBITION

Maternity and neonatal teams need to be supported by clear standards and structures and have access to quality data and digital tools that enable the flow of information.

Objective 10: Standards to ensure best practice.

Care should be offered in line with best practice using existing nationally defined guidance.

Objective 11: Data to inform learning.

Accurate, up to date information is needed to identify concerns and to learn, act and improve from.

Objective 12: Make better use of digital technology in maternity and neonatal services.

Digital technology will make it easier for women to access the information they need, and for services to offer safe and personalised care.

5.1 THREE-YEAR PLAN NEXT STEPS

Next steps require the Trust to benchmark existing services against the ambitions of the Three-year plan, identifying work that has already begun and is ongoing as a result from Ockenden, and align this with the plan, whilst identifying outstanding actions required to fully comply with the Three-year plan.

The LMNS have commenced a regional collaborative process for supporting and implementing the Three-year delivery plan, with Trusts from North East North Cumbria (NENC) having been invited to attend the first workshop on 10 May. Invitees are from a broad and diverse ward to Board membership.

6. CONCLUSION

The Trust continues to make progress against the interim and final Ockenden recommendations. The ongoing work from Ockenden must now be aligned to the ambitions and objectives set out in the 'Three-year delivery plan for maternity and neonatal services'.

The maternity service will now progress work in completion of a gap analysis against the Three-year delivery plan, benchmarking against work already in existence, reviewing objectives and revising actions accordingly. The identification of any associated risks will become more evident as the Trust progresses the benchmarking exercise, which will also rely on the interdependency of the ambition through National and ICB support.

Collaborative work has commenced within the NENC LMNS to ensure a regional approach is taken in implementing and achieving the plans recommendations. A further update will be provided to the Trust Board in July 2023.

The Trust have received confirmation of achievement of the Year 4 safety actions required by the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS). The Trust await Year 5 of the CNST MIS to be published.

The final report following the CQC inspection in January has now been received and work is in progress to ensure that the Trust meets with the requirements for improvement as identified by inspectors. Three key regulatory areas identified are those with regard to the checking of emergency equipment, increasing the appraisal rate, and safe storage of medication.

7. RECOMMENDATIONS

The Trust Board is asked to:

vi) Receive and discuss the report;
vii) Note the current level of assurance against the interim and final Ockenden recommendations;
viii) Recognise the significance of the 'Three-year delivery plan for maternity and neonatal services' for the Maternity Service and that further detailed work is required to identify outstanding actions required to ensure full compliance;
ix) Note the findings of the final report of the CQC inspection and the work required in response to this; and
x) Note the associated risks involved.

Report of Maurya Cushlow
Executive Chief Nurse
25 May 2023

APPENDIX 1

Ockenden Interim Report			
Immediate Essential Action		Brief Descriptor	Compliance
Section 1		IEA 1-7	**(added regrading from regional insight visit feedback)**
IEA 1: Enhanced Safety	Q1	Local Maternity System (LMNS) regional oversight to support clinical change – internal and external reporting mechanisms for key maternity metrics in place.	Compliant
	Q2	External clinical specialist opinions for mandated cases.	Compliant (regraded partial compliance)
	Q3	Maternity Serious Incident (SI) reports sent jointly to members of the Trust Board (not sub board) & LMNS quarterly.	Compliant
	Q4	National Perinatal Mortality Review Tool (PMRT) in use to required standard.	Compliant
	Q5	Submitting required data to the Maternity Services Dataset.	Compliant
	Q6	Qualifying cases reported to HSIB & NHS Resolution's Early Notification scheme	Compliant
	Q7	A plan to fully implement the Perinatal Clinical Quality Surveillance Model (Trust/LMNS/ICS responsibility).	Compliant
	Q8	Monthly sharing of maternity SI reports with members of the Trust Board, LMNS & HSIB.	Compliant
IEA 2: Listening to Women and Families	Q9	Independent Senior Advocate Role to report to Trust and LMNS.	n/a Awaiting appointment
	Q10	Advocate must be available to families attending clinical follow up meetings.	n/a Awaiting appointment
	Q11	Identify a non-executive director for oversight of maternity services – specific link to maternity voices and safety champions.	Compliant
	Q12	National Perinatal Mortality Review Tool (PMRT) in use to required Ockenden standard (compliant with CNST).	Compliant

	Q13	Robust mechanism working with and gathering feedback from service users through Maternity Voices Partnership (MVP) to design services.	Compliant
	Q14	Bimonthly meetings with Trust safety champions (obstetrician and midwife) & Board level champions.	Compliant
	Q15	Robust mechanism working with and gathering feedback from service users through MVP to design services.	Compliant
	Q16	Identification of an Executive Director & non-executive director for oversight of maternity & neonatal services.	Compliant
IEA 3: Staff Training & Working Together	Q17	Evidence of multidisciplinary team (MDT) training and working validated by LMNS 3 times a year. All professional groups represented at all MDT and core training.	Compliant
	Q18	Twice daily (over 24hrs), 7-days a week consultant-led multidisciplinary ward rounds.	Compliant
	Q19	Trust to ensure external funding allocated for the training of maternity staff is ring-fenced.	Compliant
	Q20	Effective system of clinical workforce planning (see section 2).	Compliant
	Q21	90% attendance for each staff group attending MDT maternity emergencies training session (with LMNS oversight and validation).	Compliant
	Q22	Twice daily (over 24hrs), 7-days a week consultant-led multidisciplinary ward rounds	Compliant
	Q23	Evidence of multidisciplinary team (MDT) training and working validated by LMNS 3 times a year. All professional groups represented at all MDT and core training.	Compliant
IEA 4: Managing Complex Pregnancy	Q24	Maternal Medicine Centre (MMC) Pathway referral criteria agreed with trusts referring to NUTH for specialist input.	Compliant (regraded partial compliance due to need for audit)
	Q25	Women with complex pregnancies (whether MMC or not) must have a named consultant lead.	Partial Compliance (regraded compliant)
	Q26	Early specialist involvement and management plans must be agreed where a complex pregnancy is identified.	Compliant (regraded partial compliance due to need for audit)

	Q27	Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle (SBLCBv.2)	Compliant
	Q28	Continuation of Q25: mechanisms to regularly audit compliance.	Compliant (regraded partial compliance due to need for audit)
	Q29	Trust supporting the development of maternal medicine specialist centre.	Compliant
IEA 5: Risk Assessment Throughout Pregnancy	Q30	All women must be formally risk assessed at every antenatal contact.	Partial Compliance (regraded compliant)
	Q31	Risk assessment must include ongoing review of the intended place of birth.	Compliant (regraded partial compliance due to need for audit)
	Q32	Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle (V.2).	Compliant
	Q33	Regular audit mechanisms are in place to assess Personalised Care & Support Plan compliance.	Compliant (regraded partial compliance due to need for audit)
IEA 6: Monitoring Fetal Wellbeing	Q34	Dedicated Lead Midwife and Lead Obstetrician to champion best practice in fetal wellbeing.	Compliant
	Q35	Leads must be sufficiently senior with demonstrable expertise to lead on clinical practice, training, incident review and compliance of Saving Babies' Lives care bundle (V.2)	Compliant
	Q36	Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle (V.2).	Compliant
	Q37	90% attendance for each staff group attending MDT maternity emergencies training session (with LMNS oversight and validation).	Compliant
	Q38	Implement the Saving Babies Lives care bundle: identify a lead midwife and a lead obstetrician (as Q34)	Compliant
IEA 7: Informed Consent	Q39	Ensure women have access to accurate information, enabling informed choice for place and mode of birth.	Compliant (regraded partial compliance due to need for website review)
	Q40	Accurate evidence-based information for maternity care is easily accessible, provided to all women and MVP quality reviewed.	Compliant (regraded partial compliance as above)

	Q41	Enable equal participation in all decision-making processes and Trust has method of recording this.	Compliant (regraded partial compliance – need for audit of 'true' service user informed choice.
	Q42	Women's choices following a shared & informed decision-making process must be respected and evidence of this recorded.	Compliant (regraded partial compliance as above)
	Q43	Robust mechanism working with and gathering feedback from service users through Maternity Voices Partnership (MVP) to design services.	Compliant
	Q44	Clearly described pathways of care to be posted on the trust website and MVP quality reviewed.	Compliant (regraded partial compliance due to need for website review)
Section 2			
Workforce Planning	Q45	Effective system of clinical workforce planning – twice yearly review against Birth Rate Plus (BR+) at board level, LMNS/ICS input.	Compliant
	Q46	Confirmation of a maternity workforce gap analysis AND a plan in place (with timescales) to meet BR+ standards with evidence of board agreed funding.	Compliant
Midwifery Leadership	Q47	Director/Head of Midwifery is responsible and accountable to an executive director.	Compliant
	Q48	Organisation meets the maternity leadership requirements set out by the Royal College of Midwives in "Strengthening midwifery leadership manifesto".	Partial Compliance
NICE Maternity Guidance	Q49	Providers review their approach to NICE maternity guidelines, provide assurance of assessment and implementation. Non-evidenced based guidelines are robustly assessed before implementation, ensuring clinically justified decision.	Compliant

Residual actions from Interim Report		
Immediate Essential Action	Brief Descriptor	Compliance
IEA 3: Staff Training & Working Together	90% attendance for each staff group attending MDT maternity emergencies training session (with LMNS oversight and validation).	Compliant
IEA 4: Managing Complex Pregnancy	Women with complex pregnancies (whether MMC or not) must have a named consultant lead, receive early intervention and audits in place for compliance.	Partial Compliance
IEA 5: Risk Assessment Throughout Pregnancy	All women must be formally risk assessed at every antenatal contact, audit in place for compliance.	Partial Compliance
IEA 6: Monitoring Fetal Wellbeing	90% attendance for each staff group attending MDT maternity emergencies training session (with LMNS oversight and validation).	Compliant
IEA7: Informed consent	Ensure women have easy access to accurate, evidence-based information to support informed choice and informed consent.	Partial Compliance (added following Insight visit feedback)
Midwifery Leadership	Organisation meets the maternity leadership requirements set out by the Royal College of Midwives in "Strengthening midwifery leadership manifesto".	Partial Compliance

Ockenden Final Report **Immediate Essential Action**		Brief Descriptor IEA 1-15	Compliance
1. Workforce Planning and Sustainability: Financing a safe maternity workforce The recommendations from the Health and Social Care Committee	1.1	To fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.	n/a Awaiting information on further funding

Report: The safety of maternity services in England must be implemented.	1.2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	Compliant
	1.3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave, and maternity leave.	Non- compliant
	1.4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.	n/a Awaiting direction from National bodies
Workforce Planning and Sustainability: Training We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.	1.5	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.	Compliant
	1.6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	n/a National direction has changed since publication of Final report
	1.7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision making, learning through training in human factors, situational awareness, and psychological safety, to tackle behaviours in the workforce.	Partial compliance
	1.8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Compliant
	1.9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	Partial compliance

	1.10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.	Partial compliance
	1.11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	n/a
2. Safe Staffing: All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels	2.1	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.	Compliant
	2.2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.	n/a
	2.3	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	Compliant
	2.4	All trusts must review and suspend, if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.	Compliant
	2.5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction.	n/a
	2.6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.	Compliant

	2.7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	Partial compliance
	2.8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	Compliant
	2.9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	Compliant
	2.10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.	Compliant
3. Escalation and Accountability: There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	3.1	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between professionals.	Compliant
	3.2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	Compliant
	3.3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Compliant
	3.4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	Compliant
	3.5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	Compliant
4. Clinical Governance: Leadership:	4.1	Members of the Trust Board must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.	Compliant

Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	4.2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.	Partial compliance
	4.3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Compliant
	4.4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	Partial compliance
	4.5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis, and family engagement.	Partial compliance
	4.6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	Compliant
	4.7	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	Compliant
5. Clinical Governance – Incident investigation and complaints Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	5.1	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.	Compliant
	5.2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	Partial compliance
	5.3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.	Partial compliance
	5.4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	Partial compliance
	5.5	All trusts must ensure that complaints which meet SI threshold must be investigated as such.	Compliant

	5.6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	Compliant
	5.7	Complaint's themes and trends must be monitored by the maternity governance team.	Compliant
6. Learning from Maternal Deaths Nationally all maternal PM examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	6.1	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.	n/a
	6.2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff, and seek external clinical expert opinion where required.	n/a
	6.3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	To action once implemented by external stakeholder
7. Multidisciplinary Training Staff who work together must train together Staff should attend regular mandatory training. Rotas & Job planning need to ensure all staff can attend.	7.1	All members of the multidisciplinary team working within maternity should attend regular joint training, governance, and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	Partial compliance
	7.2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	Compliant
	7.3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	Compliant
	7.4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Compliant

Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	7.5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	Compliant
	7.6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	Compliant
	7.7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	Compliant
8. Complex Antenatal Care: Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to preconception care. Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	8.1	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes, and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	Compliant
	8.2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Compliant
	8.3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	Partial compliance (Regraded non-compliant)
	8.4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	Compliant (to audit)
	8.5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	Compliant
9. Preterm Birth:	9.1	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	Compliant

The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	9.2	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	Compliant
	9.3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	Compliant
	9.4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	Compliant
10. Labour and Birth: Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	10.1	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made	Compliant
	10.2	Midwifery-led units must complete yearly operational risk assessments.	Partial compliance
	10.3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	Partial compliance
	10.4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.	Partial compliance
	10.5	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	Compliant
	10.6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	Compliant

11. Obstetric Anaesthesia: A pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	11.1	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain, and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.	Compliant
	11.2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	Compliant
	11.3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC	Compliant
	11.4	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.	n/a
	11.5	The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.	Compliant
	11.6	The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.	Compliant
	11.7	The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.	n/a
	11.8	Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.	Compliant
12. Postnatal Care: Trusts must ensure that women readmitted to a postnatal ward and	12.1	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward	Compliant
	12.2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.	Compliant
	12.3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.	Compliant

all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times	12.4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	Compliant
13. Bereavement Care: Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	13.1	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.	Compliant
	13.2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	Compliant
	13.3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.	Compliant
	13.4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	Compliant
14. Neonatal Care: There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce, and enhance the	14.1	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	Compliant
	14.2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.	Compliant
	14.3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	Compliant
	14.4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example, senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	Compliant

experience of families. This work must now progress at pace.	14.5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	n/a
	14.6	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	Compliant
	14.7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.	Compliant
	14.8	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	Partial compliance
15. Supporting Families: Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	15.1	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	Compliant
	15.2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	Compliant
	15.3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.	Compliant

	Nov 22	Nov 22	Jan 23	Jan 23	March 23	March 23	May 23	May 23
Total Number of Recommendations (interim and final report combined)	97	100%	98 *	100%	98	100%	98	100%
Non-applicable	12	n/a	12	n/a	12	n/a	12	n/a
Compliant	46	54.1%	56	65.1%	61	71.0%	65	75.6%
Partial Compliance	36	41.4%	27	31.4%	23	26.7%	19	22.1%
Non compliance	3	3.5%	3	3.5%	2	2.3%	2	2.3%

*additional IEA added following Insight Visit Feedback

Appendix 2

Responsibilities for achieving the ambition of the 'Three-year delivery plan for maternity and neonatal services' (March 2023)

	Trust Responsibilities	ICB Responsibilities	National Responsibilities
Theme 1: Listening to and working with women and families with compassion **Measures: Indicators from CQC Maternity Survey / Perinatal pelvic health services in place / UNICEF BFI accreditation / Number of women accessing perinatal mental health services / CQC inspection / CNST Maternity Incentive Scheme**			
1. Care that is personalised	• Providing staff with the time, training, tools, and information, to deliver the ambitions. • Undertaking regular audits, seeking feedback, acting on findings. • Consideration of implementing midwifery continuity of carer (with safe staffing levels). • Achieving the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding by March 2027.	Commissioning, monitoring & implementation of: • Personalised care for every woman. • Perinatal pelvic health services (March 2024) • Community perinatal mental health services	• Co-producing standardised information to aid decision-making with service users. • Supporting Trusts yet to achieve UNICEF BFI accreditation. • Publishing national postnatal care guidance by the end of 2023. • Publishing national service specification and implementation guidance for perinatal pelvic health services. • Creating a patient reported experience measure (PREM) by 2025 to help trusts and ICBs monitor and improve personalised care. • Acting on findings from the evaluation of independent senior advocate pilots as set out in the interim Ockenden report by March 2024. • Investing in bereavement services to provide availability 7 days a week by the end of 2023/24.

2. Improve equity for mothers and babies	• Providing services that meet the needs of their local population, with particular attention to health inequalities. This includes facilitating informed decision-making, access to interpreter services, adhering to the Accessible Information Standard in maternity and neonatal settings. • Collecting and disaggregating local data and feedback by population groups, monitoring differences in outcomes and experiences for women and babies from different backgrounds. Make changes using this data to address any inequity or inequalities identified, to improve care.	• Publishing and leading implementation of their LMNS equity and equality action plan alongside neonatal ODNs, working across organisational boundaries. • Commissioning MNVPs to reflect the ethnic diversity of the local population and reach out to seldom heard groups.	• Providing support for the implementation of LMNS equity and equality action plans. • Piloting and evaluating new service models designed to reduce inequalities, including enhanced midwifery continuity of carer, and from 2023, culturally sensitive genetics services for couples practising close relative marriage in high need areas. • Continuing to work with the Maternity Disparities Taskforce, exploring disparities in maternity care and identifying how to improve outcomes. • Publishing the National Review of Health and Social Care in Women's Prisons (Spring 2023).
3. Work with service users to improve care	• Involving service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services.	• Commissioning and funding MNVPs for each trust, reflecting the diversity of the local population. • Remunerating and supporting MNVP leads. • Ensuring service user representatives are members of the LMNS board	• Co-producing national policy and quality improvement initiatives with national and • regional service user representatives and MNVP leads. • Supporting parent representation in the governance of neonatal services through operational delivery networks.

			• Funding clinical leadership and programme management of ICBs, including funding to support service user involvement.
Theme 2: Growing, retaining, and supporting our workforce **Measures: Staff surveys / education & medical training surveys / vacancy & turnover rates for staff groups / CQC inspection / CNST Maternity Incentive Scheme**			
4. Grow our workforce	• Undertaking regular local workforce planning, understaffing to be filled by 2027/28. • Implementing local plan to fill vacancies. • Provide administrative support to free up pressured clinical time.	• Commissioning and funding safe staffing across system. • Agreeing staffing levels with trusts for groups where existing staffing tools do not exist. • Align commissioning of services to meet the ambitions of the delivery plan with the available workforce capacity. • Assuming delegated responsibility for the commissioning of neonatal services from 2024/25. • Maximising student placement capacity, working	• Assisting trusts and regions with workforce growth plans by providing direct support, including through operational delivery networks for neonatal staffing. • Boosting midwifery workforce supply across undergraduate training, apprenticeships, postgraduate conversion, return to midwifery programmes, and international recruitment. • Increasing medical training places across obstetrics and gynaecology and anaesthetics, to expand the consultant workforce in maternity services. • Collaborating with the Royal College of Obstetricians and Gynaecologists (RCOG) to support their work developing an obstetric

		with Trusts and higher education providers.	workforce planning tool, to be published in 2023/24.
5. Value and retain our workforce	• Identifying and addressing local retention issues and develop a retention improvement action plan. • Implementing equity and equality plan actions to reduce workforce inequalities. • Creating an anti-racist workplace. • Identifying and addressing issues highlighted in student and medical trainee feedback. • Offering preceptorship programmes for all newly registered midwives and mentors to support all newly appointed Band 7 and 8 midwives. • Developing future leaders via succession planning; reflecting the ethnic background of the wider workforce.	• Sharing best practice for retention and staff support. • Highlighting common or high-impact retention challenges to the national team to enable consideration of a national approach.	• Supporting retention with funding to continue a retention midwife in every unit during 2023/24, with ICBs maintaining the focus on retention thereafter. • Continuing to invest in neonatal operational delivery network (ODN) education and workforce leads to support the recruitment and retention of neonatal staff. • In 2023/24, provide funding to establish neonatal nurse quality and governance roles within trusts, to support cot-side clinical training and clinical governance. • In 2023/24, strengthen neonatal clinical leadership with a national clinical director for neonatal and national neonatal nurse lead. • Continuing to address workforce inequalities through the Workforce Race Equality Standard. • Providing national guidance for implementation of the A-Equip model and for the professional midwifery advocate role to provide restorative clinical supervision in local services. • By July 2023, develop a safe clinical learning environment charter for trusts; by April

			2024, develop models for coaching; and, by October 2024, embed a framework to support the standards of supervision and assessment for midwifery students. These initiatives will help to ensure high quality clinical placements for those training to be midwives.
6. Invest in skills	• Undertaking an annual training needs analysis, make training available to all staff in line with the core competency framework. • Ensuring junior, speciality and associate specialist obstetricians, and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively. • Ensuring temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums		• Refreshing the curriculum for maternity support workers (MSWs) by June 2023. • Providing tools to support implementation of the MSW competency, education, and career development framework by September 2023. • Working with RCOG to develop leadership role descriptors for obstetricians by summer 2023 to support job planning, leadership, and development. • Establishing a sustainable national route for the training of obstetric physicians, to support the development of maternal medicine networks. • Working with professional organisations to address the challenges involved in recruiting and training the future neonatal medical workforce. • Through action set out above to grow the workforce, help to address pressures on backfill for training.

Theme 3: Developing and sustaining a culture of safety, learning, and support **Staff surveys / education & medical training surveys / appreciative inquiry / CQC inspection**			
7. Develop a positive safety culture	• Ensuring maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the plan's ambition. This includes time to engage stakeholders, including MNVP leads. • Supporting all senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes (by April 2024), identifying and sharing examples of best practice. • At board level, regularly reviewing progress and supporting implementation of a focused plan to improve and sustain culture, including alignment with their FTSU strategy. • Supporting staff with clear and structured routes for the escalation of clinical concerns, based on frameworks such as the	• Monitoring impact of work to improve culture, provide additional support when needed. • Providing opportunities for leaders to come together across organisational boundaries to learn from and support each other.	• By April 2024, offer the perinatal culture and leadership programme to all maternity and neonatal leadership quadrumvirates including the neonatal, obstetric, midwifery and operational leads. This includes a diagnosis of local culture and practical support to nurture culture and leadership.

	Each Baby Counts: Learn and Support escalation toolkit. • Ensuring all staff have access to FTSU training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways.		
8. Learning and improving	• Establishing and maintaining effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. These should include the principles of duty of candour and a single point of contact for ongoing dialogue with the trust. • Understanding 'what good looks like' to meet the needs of our local populations and learn from when things go well and when they do not. • Responding effectively and openly to patient safety incidents using PSIRF. • Acting, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback,	• Sharing learning and good practice across all trusts in the ICS. • Overseeing implementation of the PSIRF safety improvement plan during 2023/24, monitoring the effectiveness of incident response systems in place.	• Supporting the transition to PSIRF through national learning events, throughout 2023. • Sharing insights between organisations to improve patient safety incident response systems and improvement activity, through regional teams.

	audits, incident investigations, and complaints, as well as learning from where things have gone well. • Ensuring there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale. • Considering culture, ethnicity and language when responding to incidents.		
9. Support and oversight	• Maintaining open and honest reporting and sharing of information on the safety, quality, and experience of their services. • Regularly reviewing the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the PQSM and informed by the national maternity dashboard.	• Commissioning services that enable safe, equitable, and personalised maternity care for the local population. • Overseeing quality in line with the PQSM and NQB guidance, with maternity and neonatal services included in ICB quality objectives. • Leading local collaborative working, including the production of a local quality dashboard that brings together intelligence from trusts.	• Listening to the local NHS and frontline staff voices and continue to work with RCOG, RCM, BAPM, and others Through our regional teams. • Continuing to work closely with national bodies, ICBs, and trusts to address issues escalated to national level. • Providing nationally consistent support for trusts that need it through the Maternity Safety Support Programme (MSSP). • Working to align the MSSP with the NHS oversight framework, improve alignment with the recovery support programme, and evaluate the programme by March 2024.

	• Appointing an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions. • Involving the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends. • At board level, listening to and acting on feedback from staff, including Freedom to Speak Up data, concerns raised, and suggested innovations in line with the FTSU guide and improvement tool.		• During 2023/24, test the extent to which the PQSM has been effectively Implemented By March 2024, provide targeted delivery of the maternity and neonatal board safety champions continuation programme to support trust board assurance, oversight of maternity and neonatal services, and a positive safety culture.
Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care **Measures: existing safety ambition themes – maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, preterm births / implementation of saving babies lives care bundle v3 / avoiding term admissions to NICU / CQC inspection / CNST Maternity incentive scheme**			

10. Standards to ensure best practice	• Implementing version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025. • Regularly reviewing and acting on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services. • Ensuring staff are enabled to deliver care in line with evidence-based guidelines, with due regard to NICE guidance. • Completing the national maternity self-assessment tool if not already done, and use the findings to inform maternity and neonatal safety improvement plans.	• Prioritising areas for standardisation and co-produce ICS-wide clinical policies such as for implementation of the Saving Babies' Lives Care Bundle. • Oversight and be assurance of trusts' declarations to NHS Resolution for the maternity incentive scheme. • Monitoring and support trusts to implement national standards. • Commissioning care with due regard to NICE guidelines.	• Keeping best practice up to date through version 3 of the Saving Babies Lives Care Bundle and the MEWS and NEWTT-2 tools, as well as developing tools to improve the detection and response to suspected intrapartum fetal deterioration. • Supporting the integration of MEWS, NEWTT-2, and other clinical tools into existing digital maternity information systems by autumn 2024. • Providing support to capital projects to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25. • Over the next 3 years, undertake a national maternity and neonatal unit infrastructure compliance survey and report, to determine the level of investment needed for an environmentally sustainable development of the maternity and neonatal estate across England. • Continue to learn from research and evaluation as set out in the National Maternity Research Plan available on the Future NHS platform.
11. Data to inform learning	• Reviewing available data to draw out themes and trends and identify and promptly address areas of concern including	• Use data to compare their outcomes to similar systems and understand any variation	• At a regional level, understand any variation in outcomes and support local providers to address identified issues.

	consideration of the impact of inequalities. • Ensuring high-quality submissions to the maternity services data set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and national perinatal epidemiology unit.	and where improvements need to be made.	• Convening a taskforce to progress the recommendation from the Kirkup report for an early warning system to detect safety issues within maternity and neonatal services, reporting by autumn 2023. • Creating a single notification portal by summer 2024 to make it easier to notify national organisations of specific incidents.
12. Make better use of digital technology in maternity and neonatal services	• Defining and implementing a digital maternity strategy and digital roadmap in line with the NHS England what good looks like framework. • Procuring an EPR system – that complies with national specifications and standards, including the digital maternity record standard and the maternity services data set and can be updated to meet maternity and neonatal module specifications as they develop. • Ensuring any neonatal module specifications include	• Having a digital strategy and, where possible, procure on a system-wide basis to improve standardisation and interoperability. • Supporting women to set out their personalised care and support plan through digital means, monitoring uptake and feedback from users. • Supporting regional digital maternity leadership networks.	• Set out the specification for a compliant EPR, including setting out the requirements for maternity by March 2024. • Publish a refreshed digital maternity record standard and maternity services data set standard by March 2024. • Grow the digital leaders' national community, providing resources, training, and development opportunities to support local digital leadership. • Incorporating pregnancy-related data and features into the NHS App to enhance the facility for women to view their patient records via the NHS app. • Developing facets of a digital personal child health record with service user-facing tools

	standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set.		to support neonatal and early years health by March 2025

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 May 2023		
Title	Nursing and Midwifery Staffing		
Report of	Maurya Cushlow, Executive Chief Nurse		
Prepared by	Ian Joy, Deputy Chief Nurse Lisa Guthrie, Associate Director of Nursing		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	This report comprises of the Nursing and Midwifery Staffing (2022/23 Quarters 3 and 4) six-month review and the quarterly safe staffing assurance report. It fulfils the recommendations of the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) and adheres to the recommendations set out by the National Quality Board (NQB 2016): How to ensure the right people, with the right skills, are in the right place at the right time. It updates the Board in relation to the following: • Actions agreed in the Quarter 1 and 2 2022/23 Nursing and Midwifery Staffing Review • Setting evidenced based staffing establishments • Maternity Safe Staffing update • In-patient Skill Mix • Vacancy and turnover data for Nursing and Midwifery • Red flags and Datix • Planned and actual staffing fill rates • Care Hours Per Patient Day (CHPPD) figures • Three monthly staffing assurance review		
Recommendations	The Board of Directors is asked to: • Receive and review the six-month review from November 2022 - March 2023. • Review and note the progress with the actions from April to October 2022/23 six month review. • Comment on the content of this approach which has been prepared in line with national guidance. • Acknowledge and comment on actions outlined within the document. • Receive and review the quarterly staffing and outcomes review from January, February and March 2023.		
Links to Strategic Objectives	• To put patients at the heart of everything we do and providing care of the highest standard focussing on quality and safety. • Supported by Flourish, our cornerstone programme, we will ensue that each member of staff is able to liberate their potential performance. • Being outstanding, now and in the future.		

Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☒	☐	☒	☒
Link to Board Assurance Framework [BAF]	Strategic Objective One Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality. Strategic Risk Description i) SO1.1 - Extreme capacity and demand pressures may impact the Trust ability to achieve important operational and regulatory standards including securing income. ii) SO1.4 - There is a risk of regulatory intervention if we are unable to comply with mandatory NHS core standards which could impact on patient safety, quality of care and the reputation of the Trust. iii) SO1.11 - Failure to achieve required CQC standards could impact on the Trust's ability to remain "Outstanding" Strategic Objective: 2 Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential - sustainable workforce planning. i) SO2.2 Trust sickness absence has not returned to pre-pandemic levels. There is a risk that we are unable to fill staffing gaps across our services which could create additional operational pressure across the Trust and impact on quality of care we deliver.						
Reports previously considered by	The Board has previously received the annual Nursing and Midwifery Staffing Review report, the six-month review report and quarterly safer staffing assurance reports.						

NURSING AND MIDWIFERY STAFFING SIX MONTH REVIEW

EXECUTIVE SUMMARY

This report combines the Nursing and Midwifery staffing six-month review report with the quarterly safe staffing assurance report. The purpose is to provide assurance that the Trust remains compliant with national guidance in relation to safer staffing.

The impact of ongoing emergency pressures and industrial action, combined with the current challenges faced across the NHS, continues to influence some of the detailed actions and outcomes contained within the report. There is robust professional leadership in place, supported by safer staffing governance frameworks and clear escalation guidance and accompanying actions. It is clear however that the staffing situation remains challenging due to high bed occupancy, increased patient acuity and dependency, balancing emergency and elective capacity and the focus to continue to deliver the highest possible standard of care. As such safe staffing escalation in line with our governance processes has remained in place since the last report.

Section 2 of the report highlights progress on agreed actions as outlined in the six month review presented to the Trust Board in November 2022. All actions have been addressed where possible and an update on progress is provided within the report.

Section 3 provides an update of the recent acuity and dependency data capture undertaken across in-patient areas in March 2023. The Trust uses the Safer Nursing Care Tool (SNCT) and the Safer Nursing Care Tool Children and Young People (SNCT C&YP) as the evidence-based establishment-staffing tool. The normal Trust process (aligned to national guidelines) is to triangulate these results with professional judgment and clinical outcomes with Ward Sisters, Charge Nurses, and Matrons as part of the nurse staffing review process. These meetings took place throughout November and December and the Senior Nursing Team had planned to meet with the Directorate Management Team by April 2023 to understand and areas of risk and agree where investment may be required through the business case process. However, the meetings were delayed due to operational pressures and industrial action but are now progressing. Further analysis and actions will be presented to the Trust Board in November 2023 once the above process has been completed. A review of other key services utilising newly released tools (Emergency Department and Community District Nursing) is in progress.

Whilst this is in progress, it is important to highlight key themes from a review of the March data capture.

Key points to note:

- Acuity and dependency continues to be high compared to pre-pandemic. Data suggests that there is up to a 20% increase in average acuity and dependency which is being closely monitored through our review process. Pressures from emergency admissions, increased medical bed occupancy and enhanced care observation continue to compound this issue.

- There are early indications that further analysis is required for some specific areas in Medicine such as the Assessment Suite and Care of the Elderely Wards across both sites where additional staff is required specifically associated with enhanced observation requirements. This is currently mitigated with additional bank and agency use.
- Cardiothoracic Services and Musculoskeletal Services remain broadly fit for purpose and aligned to SNCT recommendations. One area for each service requires further analysis where data suggests that additional staff may be required but this will be discussed in the review process to ensure this triangulates with professional judgement.
- Surgical Services remain broadly fit for purpose except for one ward which due to caring for an increased number of medical patients requiring enhanced observation, has required additional staffing. This was known as part of our winter planning process and is temporarily mitigated through additional bank use and rostering above the normal demand levels.
- Cancer Services, Neurosurgery, Gynaecology, ENT, Plastics and Ophthalmology all remain broadly fit for purpose and aligned to SNCT recommendations.
- Based on the SNCT data, three wards in Paediatrics require further analysis where data suggests that additional staff may be required but this will be discussed in the review process to ensure this triangulates with professional judgement.

Section 3.4 includes an update regarding Midwifery Services with reference to the increased scrutiny due to findings from public inquiries and various governing and regulatory bodies. The three-year plan for maternity and neonatal services defines how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families and emphasises the importance of workforce strategies which support greater improvement in care provision. The Trust has a number of key workstreams within the maternity service which work towards those requirements, the findings of which will be presented to the Trust Board in July 2023.

With regard to Midwifery staffing, including frontline clinical staff, and those in specialist and management positions, the actual establishment is marginally above that of the funded establishment and recruitment is into turnover vacancy only. This service has a permanently approved 20 whole time equivalent (wte) over-recruitment to allow for increased levels of maternity leave and to ensure a consistent, sustainable position within the large Midwifery workforce at Newcastle. Recent recruitment has been successful, in particular with those due to qualify as Midwives in September 2023. Recruitment activity will continue regularly to maintain a fully established or marginally over-recruited position moving forward.

Sickness absence rates remain elevated with a combined sickness absence rate currently of 5.7%. However, this is an improved picture against the previously reported 8% and broadly represents that as benchmarked against a Shelford peer rate of 6%.

In the six months 1 October 2022 to 31 March 2023, there have been nine occasions out of a possible 1,092 episodes where the midwife has been unable to provide continuous one-to-one care and support to a woman in established labour. There have been eight occurrences

where the delivery suite coordinator has not remained supernumerary and has resulted in the coordinator being the named midwife for a woman. The most common red flag to be reported consistently each month is the delay between admission for induction of labour and the beginning of the process. On average the Trust performs 2,600 inductions of labour in a six month period. There were eighty-nine red flags recorded in this time period for delay between admission and the beginning of the process, equating to 3.4%. The rationale for this delay can vary such as acuity, unexpected clinical priorities and bed capacity. A review is taken at the time to ensure any clinical risk is identified and mitigated.

Where red flags and shortfalls against plan were noted on the occasions described above, this was escalated to the senior team and a review of the acuity and activity undertaken and managed through internal redeployment within the service. Together with professional judgement, the most appropriate utilisation of the available workforce resource has been made, thereby preserving, and maintaining safety.

Workforce challenges to meet acuity, and the impact that this has had on the closure of the Newcastle Birthing Centre (NBC), have been reported to the Trust Board previously within the Ockenden paper in January 2023. During the period of 4 March 2023 until 21 April 2023, the NBC closed on one occasion for a period of 32.5 hours. This closure affected five women in total, all whom received 1:1 care on the Delivery Suite. A quality impact assessment is undertaken at the time of any closure which indicates no risk to the safety of mother or baby, although the patient experience may be altered due to the environmental provision on the Delivery Suite in contrast to that on the Birthing Centre.

Section 4 of the report provides an update on skill mix requirements as recommended by the Developing Workforce Safeguards (2018) guidance, professional judgement and evidence-based tools. Skill mix reviews are conducted as part of annual nurse staffing reviews, or if a ward has altered from their primary function. Changes to skill mix are subjected to a quality impact assessment and are costed by the directorate finance team. The updated demand template and subsequent costings are shared with the Matron and Senior Sister prior to being altered on the demand template, or business case submission. No significant skill mix changes have been undertaken since the previous review.

Section 5 of the report provides an overview of Nurse Staffing Metrics (Recruitment, Retention, Red Flags and Datix, Staffing Fill Rates, Care Hours Per Patient Day (CHPPD)) between October 2022 and March 2023. The following key points are noted:

- Strategic work continues via the Nursing and Midwifery Recruitment and Retention Group with a focus on improving the vacancy and turnover position with an agreed work plan in line with NHSE retention guidance.
- The Trust has completed the NHSE Nursing and Midwifery Retention Self-assessment and this has been shared with the Integrated Care Board (ICB) lead. This will facilitate development of high impact actions and inform future work plans.
- The Band 5 Registered Nurse (RN) vacancy rate sits at 3.1%, compared to 7.9% for this period last year. This figure is based on the financial ledger and relates to current substantive staff in post and does not include those staff currently in the recruitment process.

- The total registered nursing turnover rate is 11.8%. which compares favourably with the national median of 13.1%. This turnover position does impact on the departments being able to staff to their full required demand and focused work remains on-going to further reduce the turnover position.
- Since March 2022, 300 internationally educated recruits have been deployed from the Philippines and India. A further 102 candidates have been appointed and are in the recruitment pipeline, with further interviews booked.
- There has been continued focus on recruitment of Health Care Support Workers. It remains challenging to achieve a sustained operationally zero vacancy position. With pro-active recruitment campaigns the Trust has approximately 43wte staff in pipeline, with widening participation workstreams being prioritised.
- Datix submission related to staffing incidents are on average 20 per month. The majority relating to unfilled shifts, staff sickness and high acuity and dependency of patients.
- Red flags in the SafeCare application continue to be utilised effectively in conjunction with professional judgement. Red Flags are reviewed daily and acted upon/mitigated where possible in real time.
- There has been an increase in the staffing fill rates overall from November (95%) to March (100%). The reason for this is a reduction in vacancy and an improved sickness absence position.
- Fill rates for Registered Nurses on days are on 89% and on night shift have an average fill rate of 89%. This is an improvement compared to the previously reported position. This gap however cannot be fully mitigated and impacts on both staff and patient experience.
- The Trust average CHPPD in January 2023 was 7.9 which is slightly lower than the peer average and the national average or 8.1. These averages are marginally lower than our last report for the Trust and nationally.
- The staffing team continue to monitor CHPPD in SafeCare to enable the mitigation of risks form staffing shortfalls.

This section also contains the quarterly update from the Nurse Staffing and Clinical Outcomes Group. The Trust remains in level 2 safe staffing escalation.

A number of wards have required support at medium or high level since the last report to Board and the detail has been highlighted via the Quality Committee. Action plans are in place for these areas in collaboration with the ward staff and additional clinical support, education and resources provided, overseen by the Executive Chief Nurse Team and Directorate Teams.

Where beds have been closed due to staffing concerns, weekly review with the Executive Chief Nurse Team remains in place and will continue until all commissioned bed capacity is safely opened.

CONCLUSION AND ACTIONS

From this six month review, the following conclusions have been drawn:

- Complete the nurse staffing review meetings across the Trust and sign off 2023/24 staffing requirements.
- Complete the review of the Emergency Department using the new acuity and dependency tool and provide data analysis in the November 2023 report.
- Complete the review of the new Community Nursing Services Safer Staffing Tool following the first data capture and provide data analysis in the November 2023 report.
- Continue to provide scrutiny and oversight regarding the re-deployment of staff to respond to continued service pressures based on the level of staffing escalation.

RECOMMENDATIONS

The Board of Directors are asked to:

i) Receive and review the six monthly staffing review update
ii) Review and note the progress with the actions from the annual review.
iii) Comment on the content of this approach which has been prepared in line with national guidance.
iv) Acknowledge and comment on actions outlined within the document.
v) Receive and review the quarterly staffing and outcomes review from January, February and March 2023.

Report of Maurya Cushlow
Executive Chief Nurse
May 2023

NURSING AND MIDWIFERY STAFFING REVIEW REPORT
SIX MONTHLY REVIEW

1. INTRODUCTION/BACKGROUND

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

The impact of ongoing emergency pressures and industrial action, combined with the current challenges faced across the NHS, continues to influence some of the detailed actions and outcomes contained within the report. There is robust professional leadership in place, supported by safer staffing governance frameworks and clear escalation guidance and accompanying actions. It is clear however that the staffing situation remains challenging due to high bed occupancy, increased patient acuity and dependency, balancing emergency and elective capacity and the focus to continue to deliver the highest possible standard of care. As such safe staffing escalation in line with our governance processes has remained in place since the last report.

2. 2021/22 NURSING AND MIDWIFERY STAFFING REVIEW UPDATE

2.1 Progress since 2021/2022 Annual review

A comprehensive and thorough staffing review was presented to the Trust Board in November 2022. A number of actions were proposed and an update on relevant actions is provided below:

- **Complete the nurse staffing review meetings across the Trust and sign off 2023/24 staffing requirements in quarter 4 –** In line with National Guidance and normal Trust process during the nurse staffing review process, local leaders (Matrons/Ward Sisters/Charge Nurses) are met with to review and validate the results and make recommendations based on professional judgment for consideration. This was completed as planned in November and December 2022. It was planned that subsequent meetings with the Directorate Management Teams would be scheduled over February and March 2023 to formally sign off staffing establishments for the year ahead and determine if a case for additional investment would be required through the business case process. Due to industrial action over this time these meetings have not progressed within the nomal timeline. These meetings are now planned for Quarter One with a focus on those areas where existing acuity and dependency metrics demonstrate notable variance from existing budgeted establishment.

- **Undertake a review of the Emergency Department using the new acuity and dependency tool** – update can be found in section 3.2
- **Undertake a review of Community services once the Community Nursing Services Safer Staffing Tool (CNSSST) –** update can be found in section 3.3
- **Continue to provide scrutiny and oversight regarding the re-deployment of staff to respond to continued service pressures** – update can be found in section 5.5

3. SETTING EVIDENCED BASE ESTABLISHMENTS (October 2022 - April 2023)

3.1 Adult and Paediatrics

The Trust uses the Safer Nursing Care Tool (SNCT) and the Safer Nursing Care Tool Children and Young People (SNCT C&YP) as the evidence-based establishment-staffing tool.

The SNCT tool assumes at least 22% uplift when setting establishments, i.e., headroom for annual leave, sickness, training etc. Within this Trust, the uplift is currently included in establishment and funded as 20% for in-patient areas. There is no formal allocation of maternity leave in the uplift calculation. To mitigate any risk from this, over-recruitment agreements remain in place and maternity leave posts are offered substantively for Band 2 Healthcare Support Workers (HCSW) and Band 5 Registered Nurse (RN) posts, to maximise the available workforce.

This means the SNCT outputs and recommendations will always include a 2% differential requirement. This is well known and understood and is not viewed as a risk; SNCT metrics are always interpreted and triangulated with professional judgement and other safe staffing metrics to inform establishment setting.

Under the SNCT licence agreement and in line with guidance, all matrons and senior ward staff are required to complete inter-rater reliability scoring to assure validity of the levels of care identified by staff for establishment setting. This is in place and assured through records kept by the staffing team.

3.1.2 Outcome of the data review

In accordance with national guidance a minimum 20-day data SNCT capture was undertaken across all in-patient areas (adult and paediatrics) in March 2023. As noted above, meetings are being scheduled with Clinical Boards and the March 2023 data will be included for discussion.

Whilst this work is in progress, it is important to highlight key themes from a review of the March 2023 data capture. The data has been compared with the last two data captures to demonstrate any consistent/average variance which may require review and action. It is also important to note that any analysis is based on the funded establishment and not the current staff in post. Therefore, any ward budget which is fit for purpose may not be represented in practice due to staffing gaps.

Key points to note from the March 2023 data:

- Acuity and dependency continues to be high compared to pre-pandemic. Data suggests that there is up to a 20% increase in average acuity and dependency which is being closely monitored through our review process. Pressures from emergency admissions, increased medical bed occupancy and enhanced care observation continue to compound this issue.
- There are early indications that further analysis is required for some specific areas in Medicine such as the Assessment Suite and Care of the Elderely Wards across both sites where additional staff is required specifically associated with enhanced observation requirements. This is currently mitigated with additional bank and agency use.
- Cardiothoracic Services and Musculoskeletal Services remain broadly fit for purpose and aligned to SNCT recommendations. One area for each service requires further analysis where data suggests that additional staff may be required but this will be discussed in the review process to ensure this triangulates with professional judgement.
- Surgical Services remain broadly fit for purpose except for one ward which due to caring for an increased number of medical patients requiring enhanced observation, has required additional staffing. This was known as part of our winter planning process and is temporarily mitigated through additional bank use and rostering above the normal demand levels.
- Cancer Services, Neurosurgery, Gynaecology, ENT, Plastics and Ophthalmology all remain broadly fit for purpose and aligned to SNCT recommendations.
- Based on the SNCT data, three wards in Paediatrics arequire further analysis where data suggests that additional staff may be required but this will be discussed in the review process to ensure this triangulates with professional judgement.

Further analysis and actions will be presented to the Trust Board in November 2023 once the above process has been completed.

3.2 Emergency Department

In 2022 substantial investment was agreed to increase the number of nursing staff in the adult emergency services, particularly at Band 5 RN which relalised a near 30% establishment increase. In lieu of a nationally endorsed acuity and dependency tool for Emergency Departments (ED) at that time, this was based on professional judgment. At present there are 2.53wte vacancies (3% vacancy rate) and recruitment is on-going.

Subsequent to this investment, the national team have released the ED Safer Nursing Care Tool to support accurate establishment setting. Training of the staff in the new tool has been completed and the first data capture has been completed in November 2022 and the second in March 2023. These results are being analysed and cross referenced with budgeted establishment. An update will be provided in November 2023.

3.3 Community District Nursing Services

The new national acuity and dependency tool for community district nursing services was launched in mid-2022 and is in the process of being rolled out regionally. Trust staff are in the process of attending training in the tool with the majority of staff now trained. Due to the number of staff requiring training to employ the tool the first data collection commenced on 17 April 2023 and remains in progress into May when analysis will then be undertaken.

3.4 Maternity Review

As previously reported to the Trust Board, Maternity Services in England continue to be under intense and increasing scrutiny due the findings of various governing and regulatory bodies, and specifically the public inquiries of Donna Ockenden (2022), together with the report of Dr Bill Kirkup (October 2022) on the findings of the East Kent inquiry.

The 'Three-year delivery plan for maternity and neonatal services' published by NHS England on 30 March 2023, has been created in response to the Ockenden (2022), East Kent (2022), and previously Morecambe Bay (2015) reports, which combined highlight continued failures in care for families. The three year plan defines how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families.

The plan has four key themes, split into twelve priority actions, and details the overarching ambitions for maternity and neonatal services to work towards. Detailing the expectations and responsibilities for each action at Trust, LMNS/ICB and National level, the plan outlines measure that will be used to monitor progress, achievement, and compliance of the twelve priority actions, one of which emphasises the importance of workforce strategies which support greater improvement in care provision.

Theme 2 brings focus to growing, retaining, and supporting the maternity workforce, with a clear focus on the following objectives:

Grow our workforce.

In order to grow the workforce, Trusts are responsible for:

- Undertaking regular local workforce planning, understaffing to be filled by 2027/28.
- Implementing local plan to fill vacancies.
- Provide administrative support to free up pressured clinical time.

Value and retain our workforce.

The three year plan wants staff to feel valued and fulfilled through sustainable careers, and to improve the experience of all staff to increase retention.

In order to value and retain our workforce, Trusts are responsible for:

- Identifying and addressing local retention issues and develop a retention improvement action plan.
- Implementing equity and equality plan actions to reduce workforce inequalities.
- Creating an anti-racist workplace.
- Identifying and addressing issues highlighted in student and medical trainee feedback.
- Offering preceptorship programmes for all newly registered midwives and mentors to support all newly appointed Band 7 and 8 midwives.
- Developing future leaders via succession planning that reflects the ethnic background of the wider workforce.

The Trust already has a number of key workstreams within the maternity service which work towards those requirements laid down within the three-year plan; however, the Department are currently undertaking a comprehensive gap analysis against the newly published recommendations, the findings of which will be presented to the Trust Board in July 2023.

Current Staffing Position

Table 1 illustrates the current position with regard to Midwifery staffing, including frontline clinical staff, and those in specialist and management positions.

As indicated, the actual establishment is marginally above that of the funded establishment. As previously reported, the Trust has a permanently approved 20wte over-recruitment to allow for increased levels of maternity leave and to ensure a consistent, sustainable position within the large Midwifery workforce at Newcastle.

Table 1.

Funded Establishment	Actual Establishment as at 31.03.23	New Starters March - April	Birthrate Plus Recommendation
250.50 wte (+ 20wte allowance to over-recruit)	253.34 wte (+2.84 wte) (1.1%)	0 wte	254.62 wte
Sickness Absence (long term)	**Sickness Absence (short term)**	**Sickness Absence (total)**	**Maternity Leave**
2.1% (5.32 wte)	3.6% (9.21 wte)	5.7% (14.53 wte)	5% (13.09 wte)

Sickness absence rates remain elevated with a combined sickness absence rate currently of 5.7%, however, this is an improved picture against the previously reported 8% and broadly represents that as benchmarked against a Shelford peer rate of 6%. The service continues to note a significant number of absences attributed to psychological and anxiety related disorders following what has been an extremely challenging 3 years for staff. The position is closely monitored by the Directorate and improved engagement work continues to ensure that the retention of staff remains a key priority, with particular focus on measures to increase the support offered in relation to the health and wellbeing of our people.

In April, a total of 97 applications were received from midwives wishing to work at Newcastle Hospitals; 43 of these were shortlisted for interview, of which 31 (wte) have been appointed. A large majority of those shortlisted are Newly Qualified Midwives (NQM) and, therefore will not be deployed until later in the year. Based on known and expected staff turnover and accounting for staff promotions etc, this will maintain the current fully established position.

Identified Risks and escalations.

- Although there is a reduction in short and long-term sickness absence, the combined impact of sickness, maternity leave rates, and temporary secondment vacancies remains a challenge for the service. This continues to be closely monitored.
- Heightened acuity and activity, together with the impact of increasing number of referrals to Maternal Medicine Centre with some very complex cases. Work is in place to enable a more accurate picture on the impact which this has on the service.
- Inaccuracies in Electronic Staff Record (ESR) data continues to inhibit straight forward workforce data capture, analysis, and reporting. Ongoing work is required to further cleanse the data to ensure that reporting is dynamic and demonstrates accuracy to external stakeholders.

Key Activities

- Active recruitment of Band 5 and Band 6 Midwives for Rotational and Community Posts has been expanded resulting in the positive increase in number from across the country.
- Ongoing collaborative work with Workforce Information to ensure accuracy in the Provider Workforce Return (PWR) data capture for both registered and non-registered staff.
- Ongoing staff engagement with several activities in progress to support retention and investment into staff health and wellbeing.
- Creation of Band 4 Maternity Support Worker (MSW) Development Lead; this post will support the Trust's MSW training and development plan – 'novice to apprentice'.
- Development of maternity specific careers team and maternity workforce publicity information with positive results.
- International recruits currently 5 Midwives with a further 2 in the pipeline.
- LMNS/ICB reporting continues in relation to Continuity of Carer and other generic workforce metrics.

Red flags, 1:1 care in labour, and supernumerary status of the Labour Ward Coordinator.

In the six months 1 October 2022 to 31 March 2023, against a possible 1,092 episodes, there have been nine occasions recorded where the midwife has been unable to provide continuous one-to-one care and support to a woman in established labour; and eight occurrences where the delivery suite coordinator has not remained supernumerary and has resulted in the coordinator being the named midwife for a woman.

Where red flags and shortfalls against plan were noted, a review of the acuity and activity has been undertaken. Together with professional judgement, the most appropriate utilisation of the available workforce resource has been made, thereby preserving, and maintaining safety.

The most common red flag to be reported consistently each month is the delay between admission for induction of labour and the beginning of the process. Delay is an ill-defined metric and often reported subjectively, however, in an attempt to bring consistency to reporting, a regional approach to the definition of delay is in the process of being agreed. On average the Trust performs 2,600 inductions of labour in a six month period. There were eighty-nine red flags recorded in this time period for delay between admission and the beginning of the process, equating to 3.4%. As induction of labour is a planned, elective procedure, the decision to commence the process is based on the judgement of the clinical team on duty following a review of the variable nature of clinical activity and acuity at the time. The clinical needs of individuals are prioritised and assessed as part of this process in mitigation of risk.

Workforce challenges against acuity, and the impact that this has had on the closure of the Newcastle Birthing Centre (NBC), have been reported to the Trust Board previously within the Ockenden paper in January 2023. During the period of 4 March 2023 until 21 April 2023, the NBC closed on one occasion for a period of 32.5 hours. This closure affected five women in total, all who received 1:1 care on the Delivery Suite. A quality impact assessment is undertaken at the time of any closure which indicates no risk to the safety of mother or baby, although the patient experience may be altered due to the environmental provision on the Delivery Suite in contrast to that in the Birthing Centre.

Support staff are a crucial and valuable element in maximising the workforce, and an important part of the maternity workforce review is optimising skill-mix and further developing our non-registered staff with education and training offers which align to the national ambition. The MSW training plan has been developed and as was required, submitted to the NENC LMNS in December 2022. Additional work in is progress to implement the training strategy which provides a framework to enable MSWs to commence their careers in a non-registered capacity, and progress through to midwifery apprenticeship.

In line with national guidance the Midwife to birth ratio is also monitored and reviewed. The current ratio is 1:27 which is broadly aligned to national recommendations. This ratio excludes roles which are leadership and/or specialist positions, illustrating the ratio of clinical midwives to the number of births at Newcastle Hospitals.

Of note is the increased demand in core competency training for all members of the multi-disciplinary team and this impacts further on the available resource for both registered and non-registered staff to meet with the mandated requirements. A recommendation from Ockenden is that the uplift for staff working within Maternity Services is reviewed in line with the additional training requirements. The Directorate continues to review the evolving core competency requirements and to revise the Training Needs Analysis to further inform the Trust's position in relation to uplift. There has been an unavoidable delay to this work and an update will be made to the Trust Board in July 2023.

At the time of the last Birthrate Plus review in October 2020, the Maternal Medicine Centre (MMC) had not been formally set up; the Maternal Medicine Network (MMN) North East and North Cumbria (NENC) and the regional Maternal Medicine Centre are hosted and led by Newcastle Hospitals. The aim of the Network is to ensure that all women within the network footprint, who have significant medical problems as defined by the Maternal Medicine network service specification NHS (2021), receive timely specialist care and advice before, during and after pregnancy. The MMC receives referrals from nine maternity units distributed across the region, all of which support both chronic and acute maternity caseloads. A multidisciplinary team, including a newly created role of Consultant Midwife, lead these services.

Referrals to the MMC for regional multidisciplinary review and care planning commenced in September 2021, the NENC Maternal Medicine Network has been fully operational since February 2022. Since September 2021, 363 women have been referred to the service, of which 95 have category C complexity (*care led by the maternal medicine centre*) and 170 category B complexity (*review, advice, and guidance from maternal medicine centre).* The care of category B and C service users across the service represents a significant and complex caseload.

In addition to regional referrals a proportion of women with category B and C complexity live in the Newcastle area and book for maternity care at Newcastle and are not currently captured in the regional data. The maternal medicine team have been working collaboratively with Clevermed, providers of BadegrNet, to integrate the NHS Maternal Medicine Service Specification categories into the BadgerNet platform. We are informed that this will take place in the May 2023 national BadgerNet update. This is significant, as it will enable a robust process of identification for women with medical complexity locally, regionally, and nationally against the service specification and capture acuity within maternity services and the impact that this is having for Newcastle on staffing.

The Birthrate Plus Workforce Review Tool is currently undergoing a process of review, subsequent to the recommendations of Ockenden. Once this review is complete, it is recommended that in view of the increased activity and acuity arising from maternal medicine, and the period of time since the last formal review, that a repeat external workforce review is undertaken.

Neonatal Services

Neonatal Intensive Care (NICU) at the RVI has 34 Cots. This is made up of 12 Intensive Treatment Unit (ITU) cots, 8 High Dependency Unit (HDU) cots and 14 low dependency cots;

this includes 4 low dependency cots that were opened at the end of January 2023 and the final 4 low dependency cots to be opened over the next few months. As part of regional transformation work there is a plan to open up an additional 4 High dependency cots which would create a total of 42 NICU cots.

The only nationally endorsed tool to analyse staffing and establishment setting across neonatal services is the Dinning tool. The most recent data capture was completed earlier this month (May 2023).

May 2023 data demonstrates that the current establishment is largely fit for purpose regarding whole time equivalent establishment. The tool was applied against 34 cots and indicates a variance of approximately 2.50wte (less than 2% variance) and no increase in wte required.

However, in line with previous Dinning tool reviews there remains a difference in the recommended skills mix between Band 5-7. This will be reviewed with the clinical teams and to determine what action is required.

4. IN-PATIENT SKILL MIX

Skill mix requirements form part of the triangulation of data as recommended by the Developing Workforce Safeguards (2018) guidance gathered from the evidence-based tools used for establishment setting and professional judgement. Skill mix reviews are conducted as part of the annual nurse staffing reviews or if a ward has altered from their primary function.

***Key points to note**:*

All skill mix changes requested to demand templates are subjected to a quality impact assessment and costed by the directorate finance team. The updated demand template and subsequent costings are then shared with the Matron and Senior Sister prior to changes being altered to the demand template or business case submission.

No significant skill mix changes have been undertaken since the previous review. Of note Respiratory Support Unit, Ward 49 which was stepped up as part of the Pandemic response is currently under review given the requirement to meet the increased patient acuity.

5. NURSE STAFFING METRICS

5.1 Vacancy and Turnover Data

The updated vacancy and turnover data have been reviewed. Key points to note include:

- Strategic work continues via the Nursing and Midwifery Recruitment and Retention Group with a focus on improving the vacancy and turnover position with an agreed work plan in line with NHSE retention guidance. A Trust careers open day was held in

March 2023 with Nursing, Midwifery and Operating Department Practitioner representation. A further careers event is planned in May 2023 between International Day of the Midwife and International Day of the Nurse to showcase Nursing, Midwifery and Operating Department Practitioner roles. An engagement event is planned on the same day for new registrants who will commence employment with the Trust in October 2023.

- The Trust has completed and updated the NHSE Nursing and Midwifery Retention Self-assessment and this has been shared with the Integrated Care Board (ICB) lead. This will facilitate development of high impact actions and inform future work plans.
- Monthly generic recruitment for Band 5 RN continues with bespoke recruitment agreed as required. The Band 5 RN vacancy rate sits at 3.1%, compared to 7.9% for this period last year. This figure is based on the financial ledger and relates to current substantive staff in post and does not include those staff currently in the recruitment process.
- The total registered nursing turnover rate is 11.8%. which compares favourably with the national median of 13.1%. This turnover position does impact on the departments being able to staff to their full required demand. Following a Matron consultation led by the Associate Director of Nursing (Workforce) and HR colleagues a Matrons Recruitment and Retention QI group has been established.
- Since March 2022, 300 internationally educated recruits have been deployed from the Philippines and India. A further 102 candidates have been appointed and are in recruitment pipeline, with further interviews booked. The 2022/23 deployment has been prolonged due to the nationally recognised challenge in gaining suitable rental accommodation. Recruitment of internationally educated nurses and midwives will continue for 2023/24 with an aim of deploying 224, with 150 having funded support from NHSE. Significant work is undertaken by the International Recruitment Team, HR and business colleagues to ensure the quality of experience for new nurses is not compromised and appropriate accommodation has been secured for the 2023/24 deployment.
- There has been continued focus on recruitment of HCSWs. It remains challenging to achieve a sustained operationally zero vacancy position. However, with pro-active recruitment campaigns the Trust has approximately 43wte staff in pipeline. With widening participation workstreams being prioritised. The large-scale widening participation community event will take place at the Beacon Centre in the west of the city in May 2023 where we will utilise innovative recruitment solutions while working with community partners with the aim of having a representative workforce which impacts positively on health inequalities.

5.2 Red Flags and Datix *(November 2022-March 2023)*

Red flag and Datix incident data are reviewed daily by the Senior Nursing Team and reported as part of the daily staffing briefing. Red flags also continue to be presented to the Nurse Staffing and Clinical Outcomes Group monthly to observe trends and highlight areas of concern. Red flag escalation has recently also been enabled for the Emergency Department. This data is available at a Ward, Directorate and Trust level. Frequency and themes inform responsive and planned nurse staffing reviews and inform future establishment requirement.

Key points from the last 6 months:

- Datix submission related to staffing incidents have reduced to on average 20 per month compared with an average of 25 in the preceding six month period. Themes are reviewed and feedback provided with the majority of reports relating to unfilled shifts, staff sickness and high acuity and dependency of patients.
- Red flags in the SafeCare application continue to be utilised effectively in conjunction with professional judgement. Red Flags are reviewed daily and acted upon/mitigated where possible in real time by the corporate senior nursing team and reported to the Chief Nurse and Deputy Chief Nurse and into silver command as required.
- Datix and Allocate software companies have merged into one company 'RLDatix' which means in the future there may be interoperability between the two platforms. This will provide potential opportunities for data cross reference between the two systems such as numbers on shifts when incidents were reported and red flags raised via SafeCare. In the meantime, the oversight from the senior nursing team will continue.

5.3 Planned and Actual Staffing *(November 2022 - March 2023)*

Planned staffing is the amount (in hours and minutes) of RN, Midwives, and HCA staff time that each ward plans to have on duty each day. This is based on maximum utilisation of their funded establishment. Actual staffing is the amount of staff time (in hours) actually on duty each day. These are broken down by day and night shift.

The ward fill rates are reviewed monthly by the Senior Nurse (Nursing and midwifery staffing) reviews the ward fill rates monthly and presents the wards of concern to the Nurse Staffing and Clinical Outcomes group. Data from these wards is triangulated with other staffing metrics.

Key points to note:

- There has been an increase in the overall staffing fill rates from November (95%) to March (100%). This is a result of a reduction in absence, successful international recruitment and the increased requirement for enhanced care leading to increased Healthcare Assistant (HCA) deployment.
- RN fill rates have increased but remain a concern. For the day shift there is an increased average fill rate to 89% and on night shift the average fill rate has remained at 89%. This is reviewed regularly with some temporary bed closures employed to mitigate the risk, which are reviewed on a weekly basis. This gap however cannot be fully mitigated and impacts on both staff and patient experience.
- In December, the RN dayshift fill rate decreased to 87% and RN nightshift fill rate decreased to 84%. The reason for this was increased sickness absence at 6.69%
- The senior nursing team and ERA team are working with the matrons in surgery and two pilot wards in surgery to download the nursing fill rate data from SafeCare. It is envisaged this will provide improved data collection for the fill rates.

5.4 Care Hours per Patient Day (CHPPD) *(November 2022 - May 2023)*

Care hours per patient day (CHPPD) is the unit of measurement recommended in the Carter Report (2016) to record and report deployment of staff working on inpatient wards. As stated previously, this is to become the primary benchmarking metric from September 2019. It is made up of Registered Nurses and support worker hours. All acute Trusts have been required to report their actual monthly CHPPD, based on the midnight census per ward to NHS Improvement since May 2016. It is calculated using the formula below.

Key points to note:

- The Trust average CHPPD for January 2023 is 7.9 which is slightly lower than the peer and national average of 8.1. These averages are marginally lower than our last report for the Trust and nationally.
- The staffing team continue to monitor CHPPD in SafeCare to enable the mitigation of risks form staffing shortfalls.
- The Trust continues to have wards which have changed their primary function to accommodate the increase in medical emergency admission. This has altered the accuracy of ward level and speciality level benchmarking via Model Hospital. We broadly remain aligned with no areas of concern with all metrics reviewed as part of the nurse staffing review process.
- Specialist areas continue the re-occurring theme of demonstrate the greatest variance against the national average. This trend is well understood locally and nationally.

5.5 November 2022 to May 2023 Nurse Staffing and Clinical Outcomes Review

5.5.1 Staffing Escalation

The Trust continues to work within the framework of the Nursing and Midwifery Safe Staffing guidelines to ensure a robust process for safe staffing escalation and governance, as reported to the board in March.

The nurse staffing escalation level remains at level two due to the following triggers being met:

- Pre-emptive rosters demonstrate a significant shortfall in planned staffing.
- Regular reporting of red flags and/or amber or red risk on SafeCare with reduced ability to move staff to mitigate risk.

The increased requirement for enhanced care continues, in addition to acuity and dependency remaining high across all service areas.

The following actions remain in place:

- Daily staffing review by the corporate nursing team and reported into the Executive Chief Nurse.
- SafeCare (daily staffing deployment tool) utilised to deploy staff across directorates based on need.
- Daily review of staffing red flags and incident reports.
- Weekend staffing support cover has been provided by Matrons on voluntary rotational basis since January. This is currently a temporary arrangement and is under review.

Level 2 escalation will remain in place until the de-escalation criteria has been met.

Workforce support remains in place from the senior nursing team for the clinical areas where staffing levels continue to impact on the ability to maintain commissioned bed activity. Staffing and bed capacity remains challenging across the organisation with robust professional leadership from the Deputy Chief Nurse and Associate Directors of Nursing in place.

5.5.2 Nurse Staffing and Clinical Outcomes

The monitoring of safer staffing metrics against clinical outcomes/nurse sensitive indicators as stipulated in national guidance continues via the Nurse Staffing and Clinical Outcomes Operational Group. Wards reviewed by the group at the monthly meeting are categorised as; requiring no support; monitoring; low level; medium level or high-level support. This is in line with the agreed escalation criteria when supportive actions are implemented. In addition, any wards which have altered from their primary function, are also reviewed.

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

Month	No. of Wards Reviewed	Directorate	Monitor	Low Level Support	Medium Level Support	High Level Support	No Further Support
January	14	X1 Musuloskeletal Services X4 Internal Medicine x 2 Cardiothoracic Services x2 Urology and Renal Services 5 x Children's Services	4	2	5	3	0
February	14	X1 Musculoskeletal Services X5 Internal Medicine X2 Cardiothoracic Services X4 Children's Services X2 Urology and Renal Services	4	2	5	3	0
March	20	X 3 Neurosciences X6 Internal Medicine X 2 Cardiothoracic Services X 2 Urology and Renal Services X5 Children's Services X 2 Musculoskeletal services	10	2	6	2	0

Key points to note:

- A number of wards have required support at medium or high level since the last report to Board and have been highlighted via the Quality Committee. Action plans are in place for these areas in collaboration with the ward staff and additional clinical support, education and resources provided, overseen by the Executive Chief Nurse Team and Directorate Teams.
- Where beds have been closed due to staffing concerns, weekly review with the Executive Chief Nurse Team remains in place and will continue until all commissioned bed capacity is safely opened.
- Despite the high-level monitoring, oversight and assurance provided by the group there continues to be a robust leadership and management framework led by the Matron team who manage the wards staffing. However, it is worth noting that the staffing picture remains challenging with the potential to impact staff wellbeing.

6. CONCLUSIONS AND ACTIONS

From this annual review, the following conclusions have been drawn:

- In line with national guidance, the SNCT data capture has been completed. These results need to be triangulated with professional judgment. From initial data review, there is an increasing patient acuity and dependency across a number of areas which may necessitate additional investment.
- Maternity workforce transformation and safer staffing management remains a high priority as outlined in this report and the Ockenden update report/public inquiries.
- New acuity and dependency tools have been recently released for the Emergency Department and Community District Nursing. Data has now been collected and is awaiting analysis.
- The responsive movement of staff to respond to emergency pressures of high patient volumes and industrial action, has been overseen by the Senior Nursing Team and is based on existing evidence-based tools and assurance processes.
- Safer staffing management continues to be challenging due to existing vacancies, sickness absence levels and increased patient acuity and dependency. This has impacted on Trust level fill rates and CHPPD figures, although improved is impacting on patient care and staff wellbeing.

The following actions are proposed:

- Complete the nurse staffing review meetings across the Trust and sign off 2023/24 staffing requirements in Quarter 1.
- Complete the review of the Emergency Department using the new acuity and dependency tool and provide data analysis in the November 2023 report.
- Complete the review of the new Community Nursing Services Safer Staffing Tool following the first data capture and provide data analysis in the November 2023 report.

- Continue to provide scrutiny and oversight regarding the re-deployment of staff to respond to continued service pressures based on the level of staffing escalation.

7. RISK AND MITIGATION

This report describes the mandated nursing and midwifery staffing review process which has been undertaken in accordance with national guidance. It highlights the ongoing challenges presented by increased acuity in providing safer staffing across our services. The most recent SNCT data capture has highlighted an increase in the acuity and dependency across some core services and this is being triangulated with professional judgment. It is likely that further investment will be required in some areas. In the interim, the risk is mitigated through additional bank staff/overtime/additional hours requests based on patient acuity and dependency.

There are some highlighted areas which require further work to improve assurance and actions are outlined to address this. There will be challenges and risk in the year ahead in balancing patient demand and capacity, workforce availability and the need to deliver high quality patient care. This is in part mitigated by the robust governance processes already in place but will require pro-active workforce planning and strong working relationships internally and externally to deliver this effectively.

It is evident from the nurse staffing metrics that there is a continued risk to the Trust due to the local and national shortage in the registered and support workforce, which is being closely monitored with proactive recruitment plans in place. It is therefore necessary to continue to explore mechanisms to maximise external recruitment, alongside retention strategies to reduce the total vacancy rate. International recruitment remains a key part of the overall workforce plan and continues at pace.

8. RECOMMENDATIONS

The Board of Directors are asked to:

i) Receive and review the mid-year six monthly staffing review update.
ii) Review and note the progress with the actions from annual review.
iii) Comment on the content of this approach which has been prepared in line with national guidance.
iv) Acknowledge and comment on actions outlined within the document.
v) Receive and review the quarterly staffing and outcomes review from January, February and March 2023.

Report of Maurya Cushlow
Executive Chief Nurse
25 May 2023

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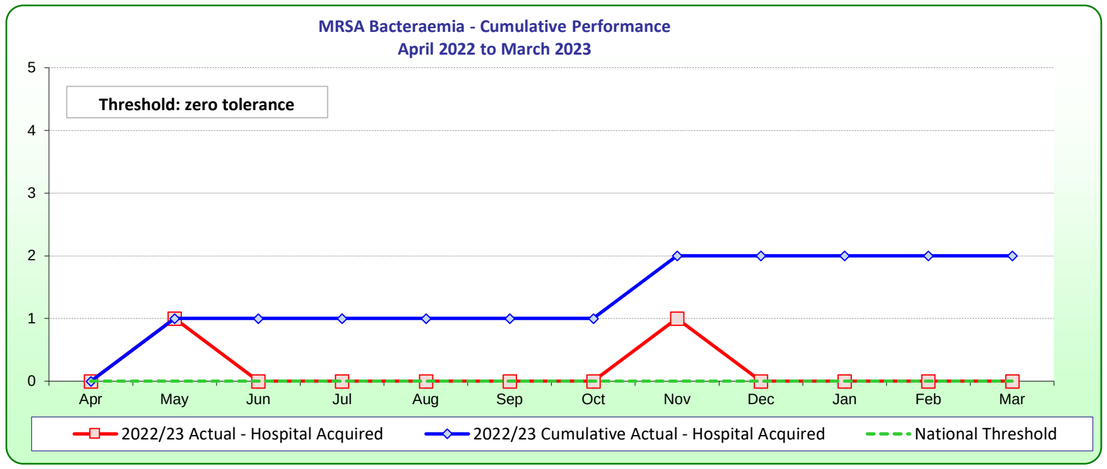
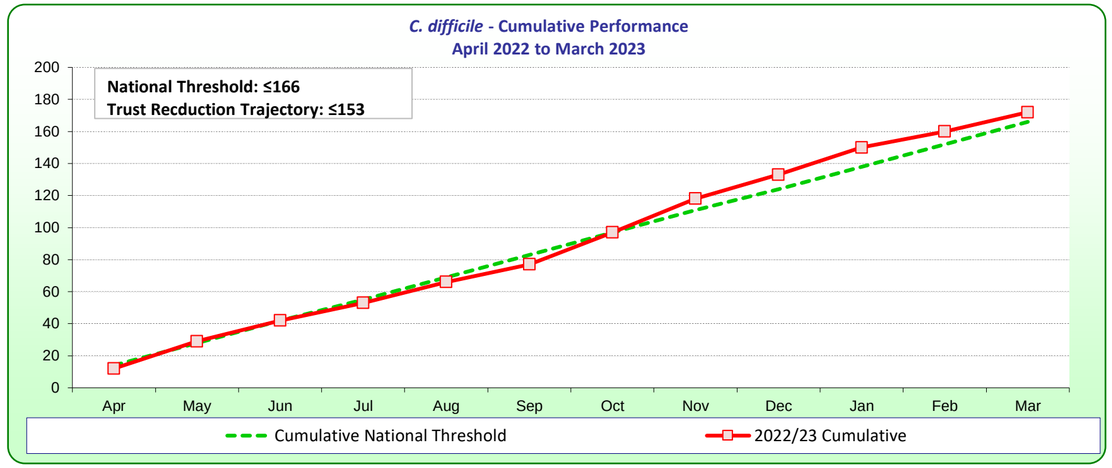
The Newcastle upon Tyne Hospitals NHS Foundation Trust

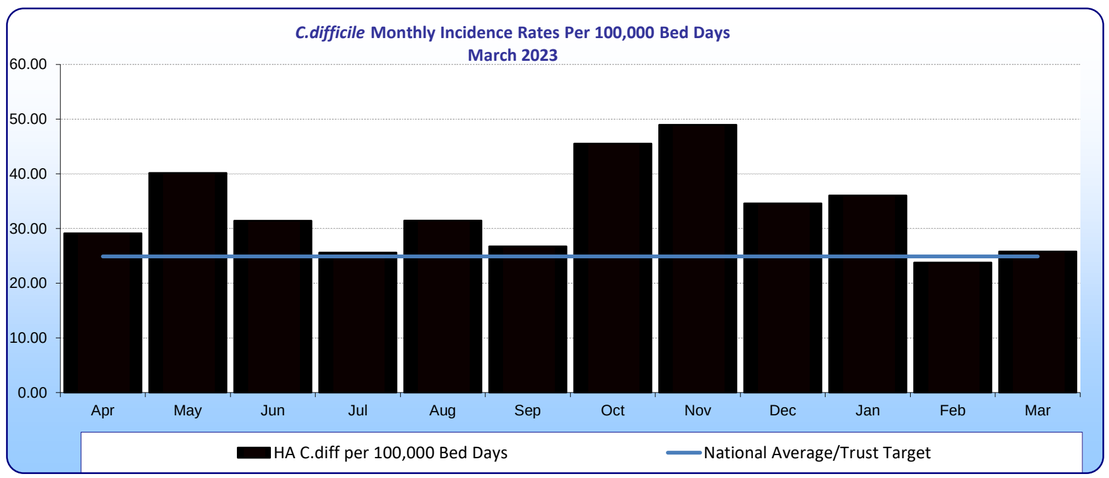
Healthcare-Associated Infections Report
March 2023

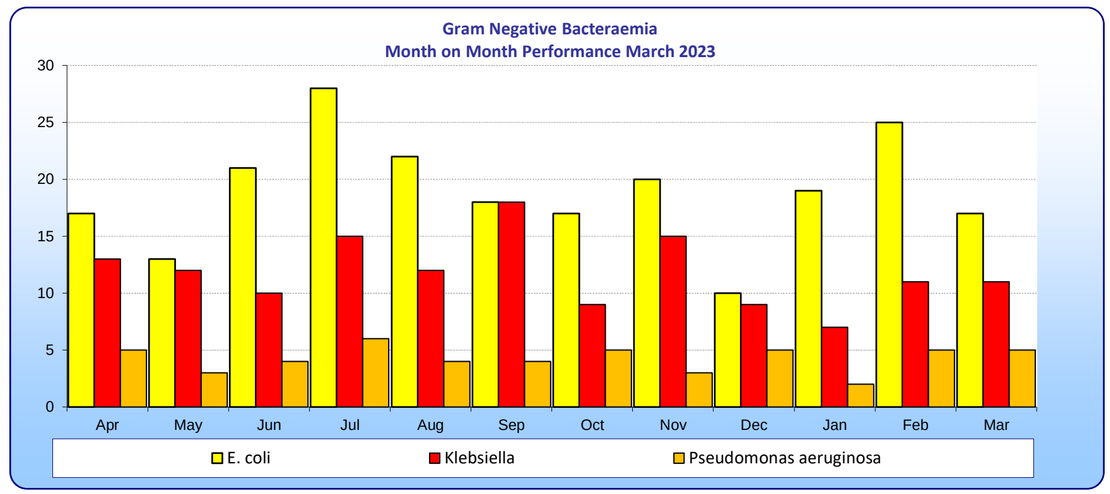
Healthcare-Associated Infection Report March 2023

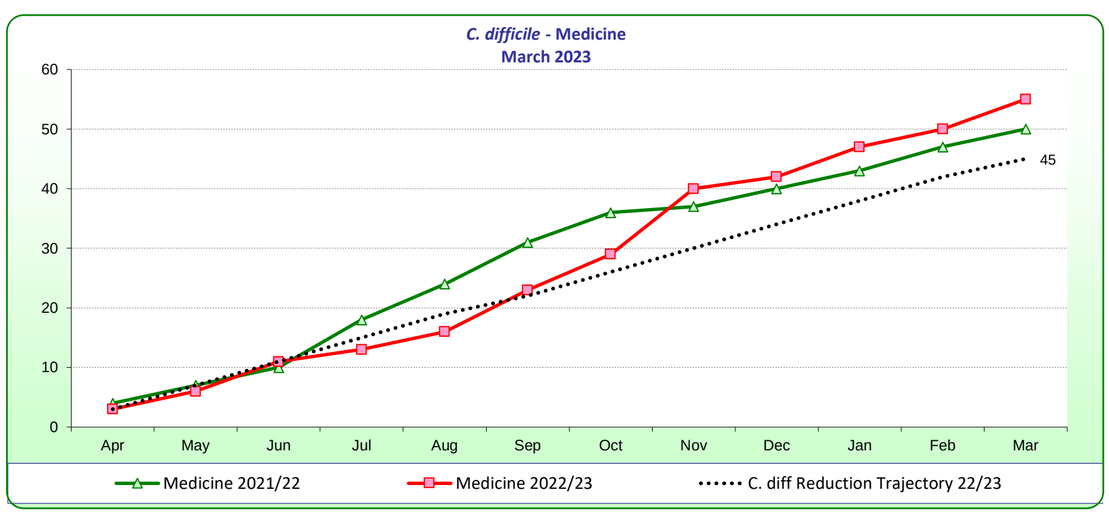
The Newcastle upon Tyne Hospitals NHS Foundation Trust

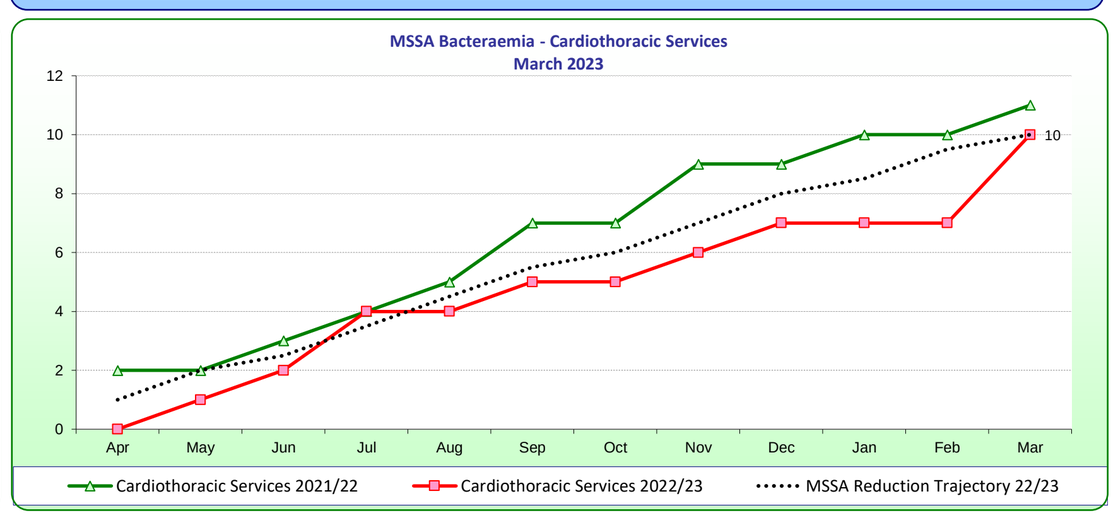












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Healthcare-Associated Infection Report March 2023

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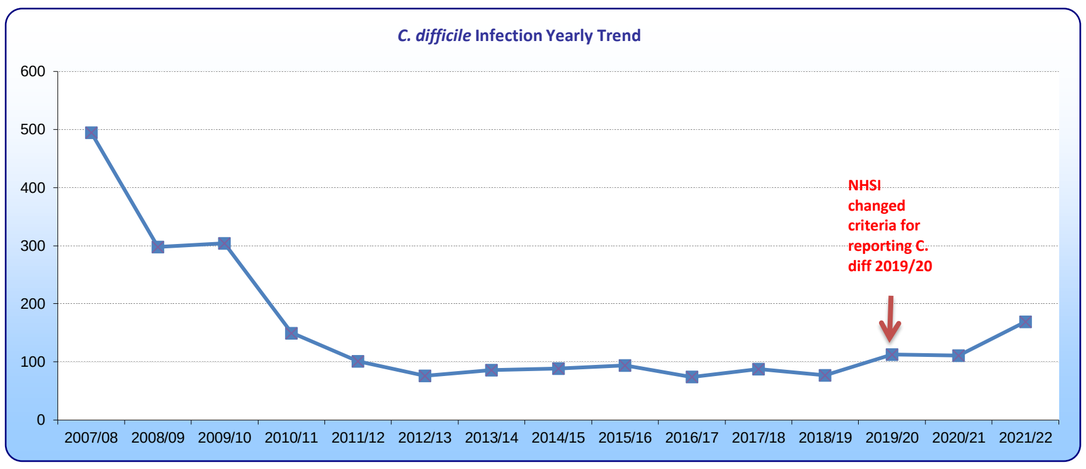

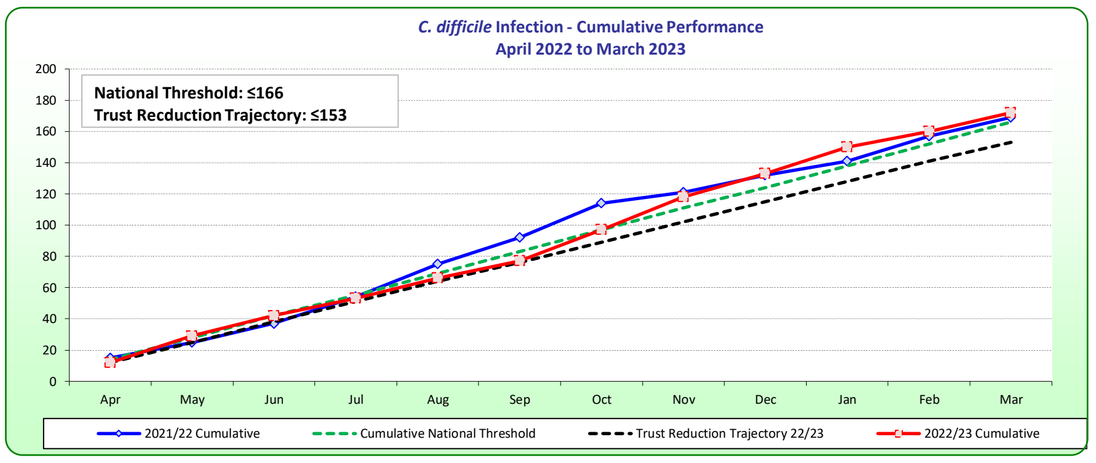

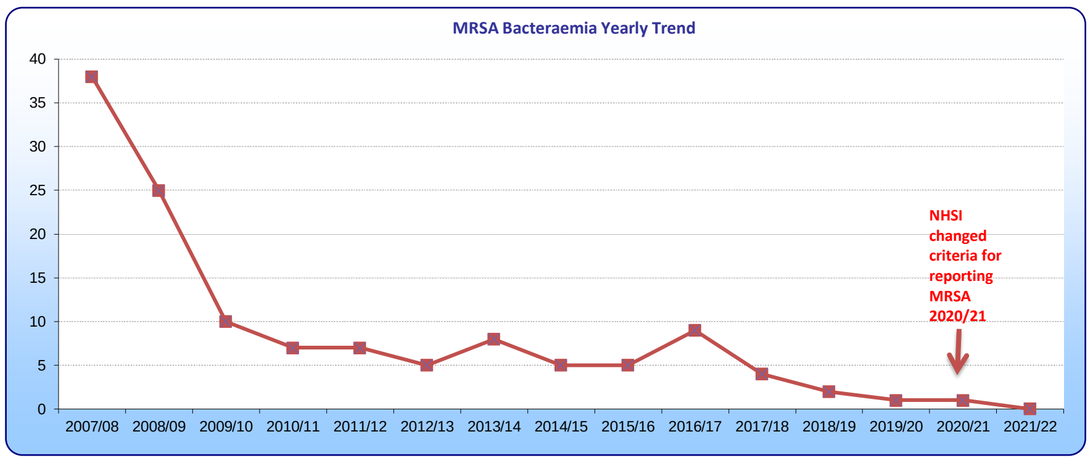

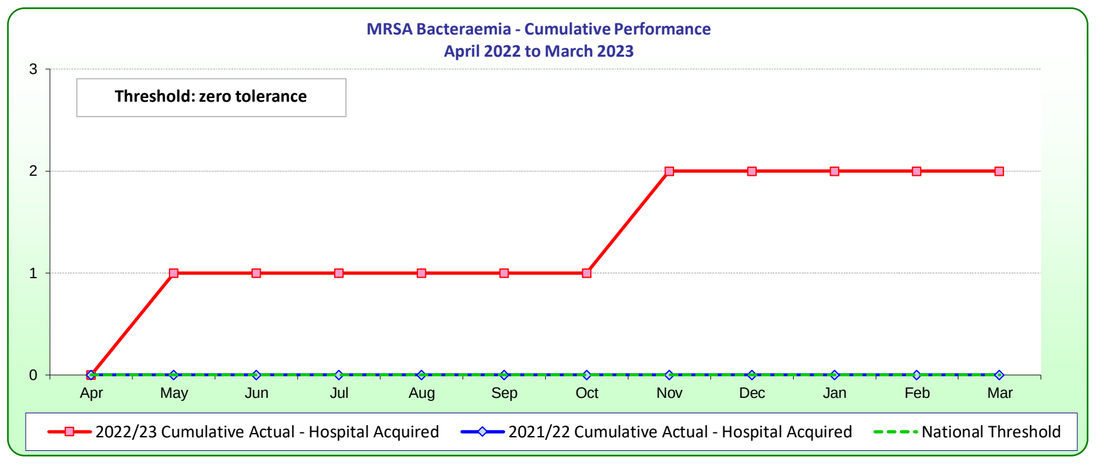

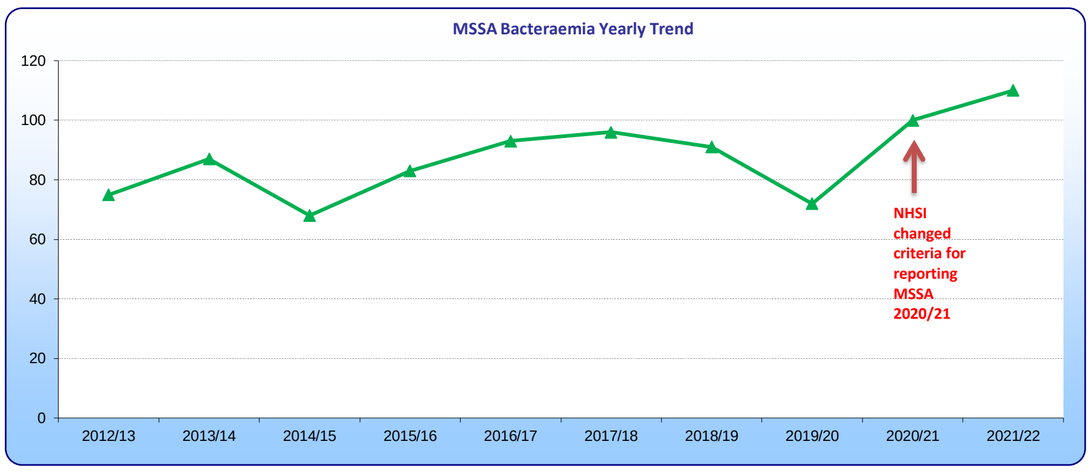

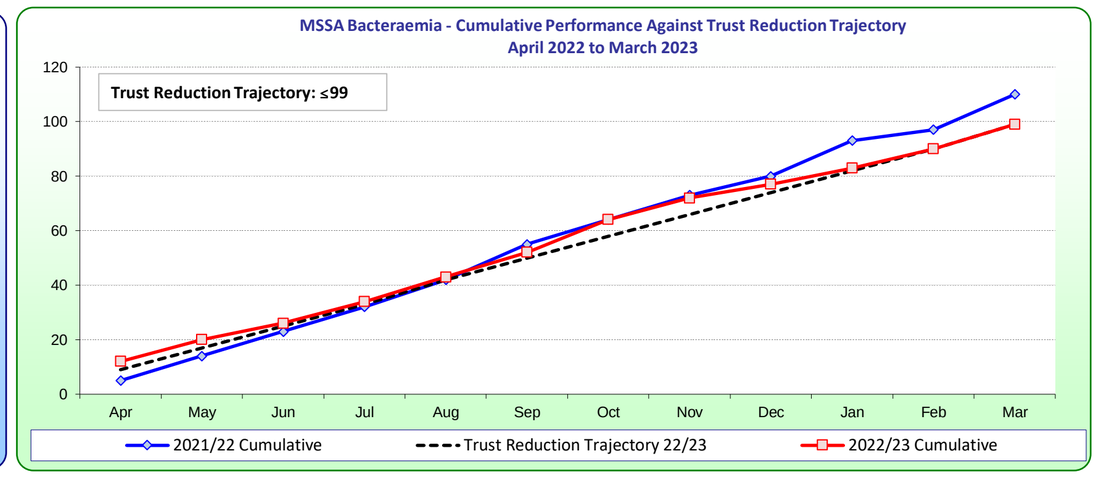

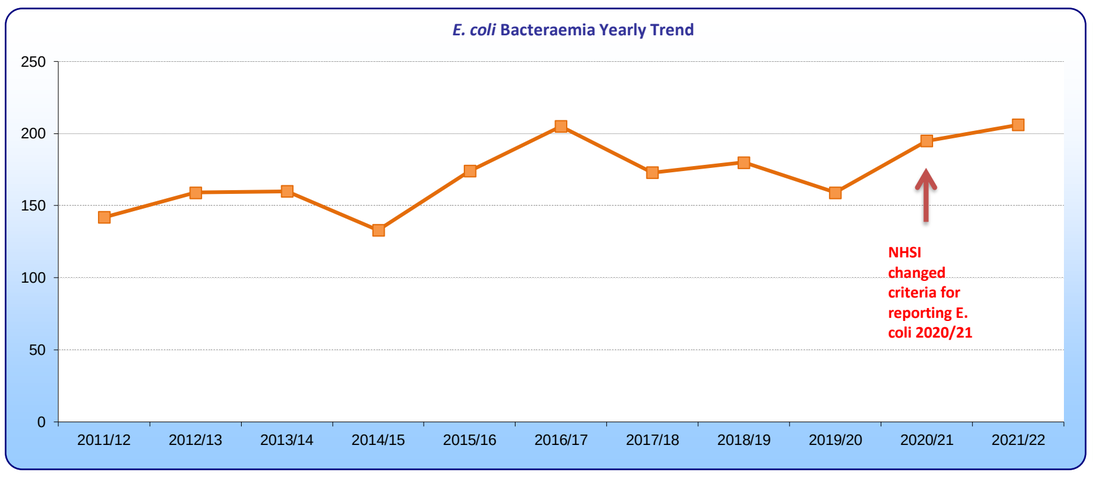

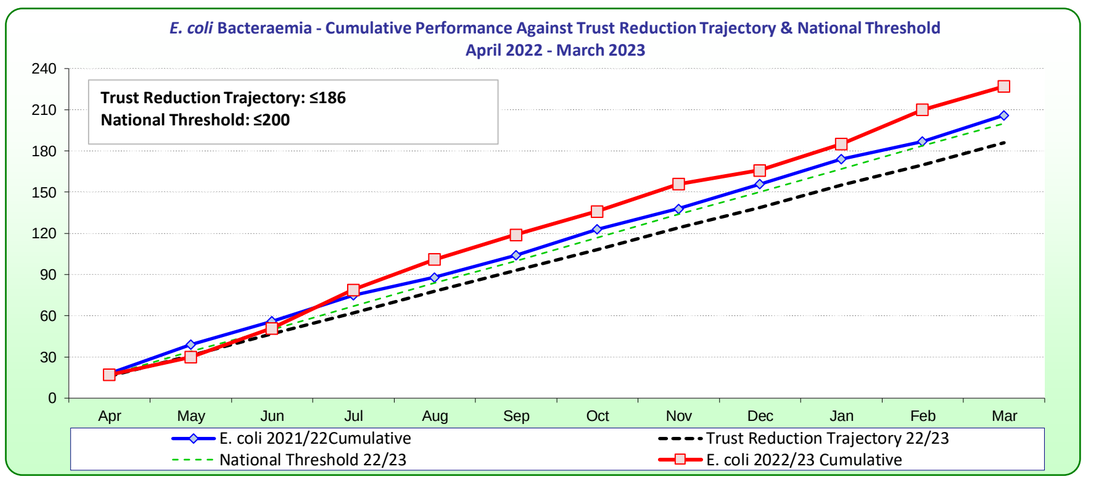

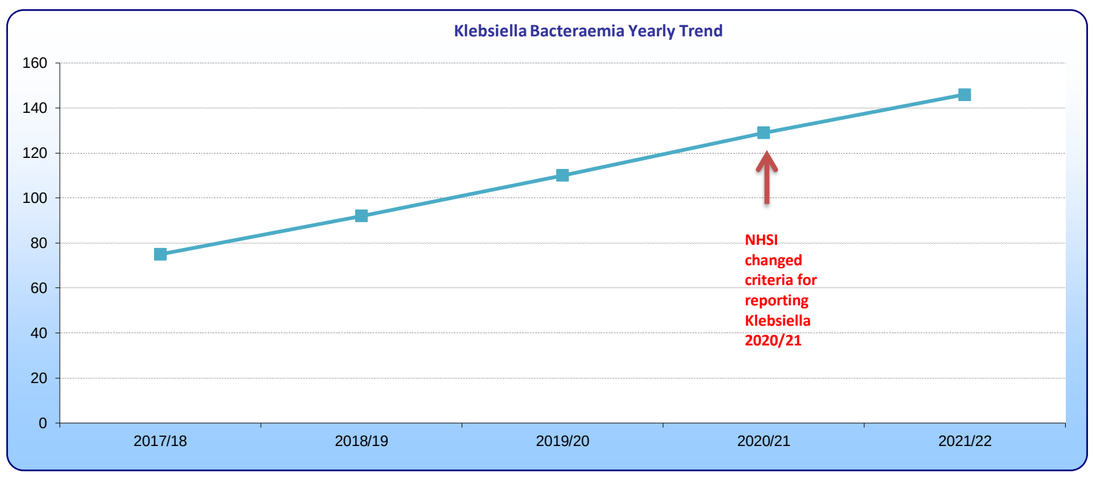

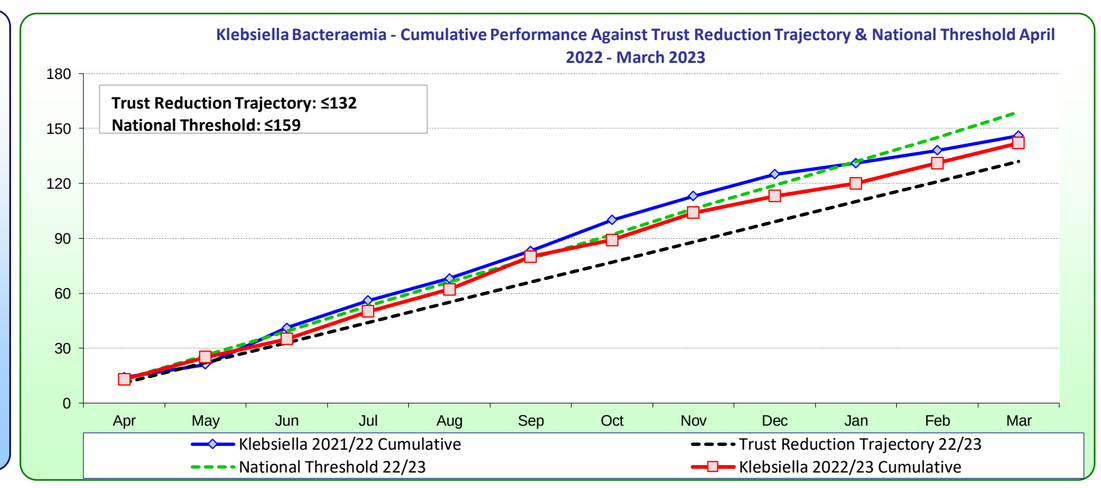

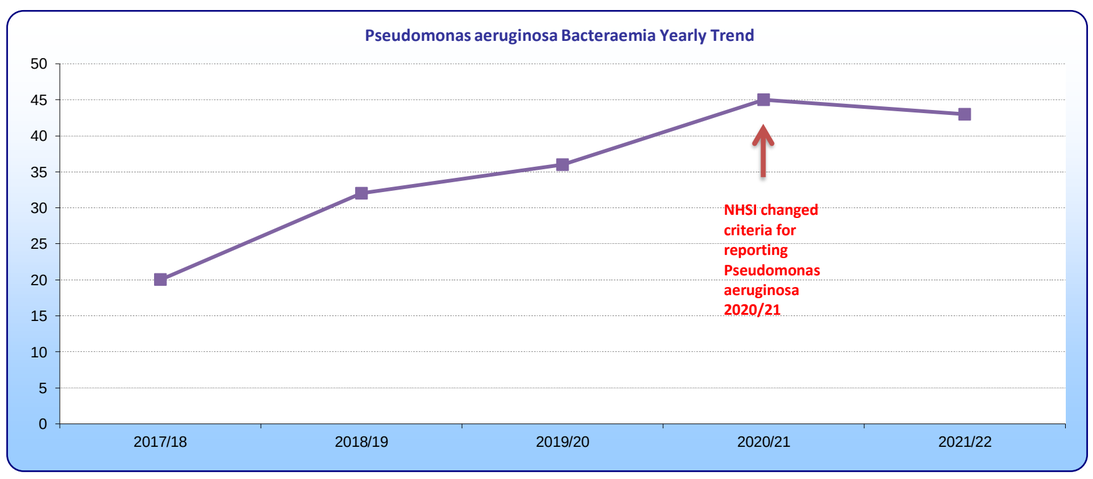

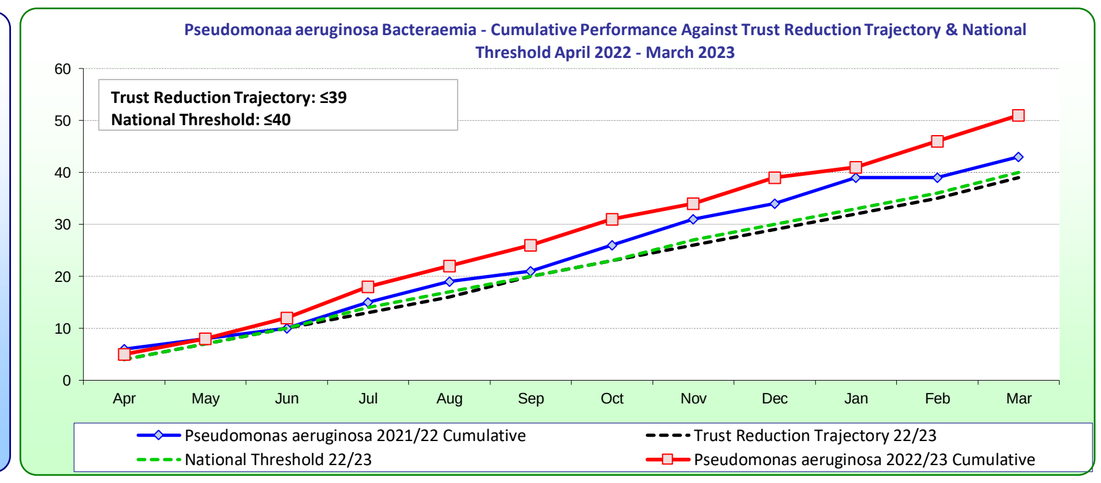

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Healthcare-Associated Infection Report March 2023

Bacteraemia / Infections

IPC indicators (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA Bacteraemia - non-Trust	0	0	0	0	0	0	1	0	0	0	0	0	1
MRSA Bacteraemia - Trust-assigned (objective 0)	0	1	0	0	0	0	0	1	0	0	0	0	2
MRSA HA acquisitions	1	0	1	0	0	0	0	0	0	0	1	0	3
MSSA Bacteraemia - Healthcare Associated (local objective ≤99)	12	8	6	8	9	9	12	8	5	6	7	9	99
E. coli Bacteraemia - Healthcare Associated (local objective ≤186)	17	13	21	28	22	18	17	20	10	19	25	17	227
Klebsiella Bacteraemia - Healthcare Associated (local objective ≤132)	13	12	10	15	12	18	9	15	9	7	11	11	142
Pseudomonas aeruginosa Bacteraemia - Healthcare Associated (local objective ≤39)	5	3	4	6	4	4	5	3	5	2	5	5	51
C. diff - Hospital Acquired (national threshold ≤166; local objective ≤152)	12	17	13	11	13	11	20	21	15	17	10	12	172
C. diff related death certificates	-	-	2	3	0	0	0	2	0	2	1	1	11
Part 1	-	-	1	0	0	0	0	2	0	2	1	1	7
Part 2	-	-	1	3	0	0	0	0	0	0	0	0	4

Periods of Increased Incidence (PIIs)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
C. diff - Hospital Acquired	2	4	1	0	1	2	5	6	2	4	2	3	32
Patients affected	5	8	3	0	1	4	8	14	11	7	5	8	74
COVID-19 - Hospital Acquired	7	1	2	1	1	1	2	3	0	0	0	4	22
Patients affected	22	2	4	4	6	2	7	7	0	0	0	14	68

Healthcare Associated COVID-19 cases (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Hospital onset Probable HC assoicated (8-14 days post admission)	49	19	33	56	15	13	26	19	27	22	35	27	341
Hospital onset Definite HC assoicated (≥15 days post admission)	63	22	49	84	13	36	62	41	53	38	40	52	553

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	-	-	-	-	-	-	-	-	1	6	1	2	10
Patients affected (total)	-	-	-	-	-	-	-	-	11	54	3	11	79
Staff affected (total)	-	-	-	-	-	-	-	-	5	29	1	8	43
Bed days losts (total)	-	-	-	-	-	-	-	-	1	99	0	0	100
Other Outbreaks	2	0	0	0	0	0	0	0	5	3	1	2	13
Patients affected (total)	16	0	0	0	0	0	0	0	28	23	5	20	92
Staff affected (total)	0	0	0	0	0	0	0	0	12	2	0	7	21
Bed days losts (total)	48	0	0	0	0	0	0	0	3	17	0	101	169
COVID Outbreaks	4	2	10	11	3	6	9	5	7	5	10	10	82
Patients affected (total)	32	15	92	110	12	41	59	34	32	47	47	46	567
Staff affected (total)	0	2	4	0	13	9	4	2	5	0	0	0	39

C.diff Transit and Testing Times Target <18hrs	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Trust Specimen Transit Time	12:36	12:44	14:41	11:50	11:27	13:17	12:28	12:20	13:48	13:31	11:37	11:17	12:38
Laboratory Turnaround Time	04:04	02:43	03:06	03:03	03:18	03:05	03:19	03:30	04:03	03:48	02:44	03:38	03:21
Total to Result Availability	16:40	15:27	17:47	14:53	14:45	16:22	15:47	15:50	17:51	17:19	14:21	14:55	15:59

Clinical Assurance Tool (CAT)

Clinical Assurance Indicators/Audits (%) - Trust as a whole	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Adult IP; Children's IP; Community HV/SN; Community Nursing; Critical Care; Day Procedure; Dental; Maternity; OP; Theatres) Trust Total	58%	67%	67%	82%	83%	79%	81%	86%	84%	82%	92%	96%	80%
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Trust Total	68%	85%	82%	81%	85%	81%	80%	86%	83%	87%	90%	95%	84%
Invasive Device Care Audit Trust Total	64%	71%	69%	81%	80%	80%	83%	80%	86%	89%	91%	98%	81%
Matron Checks (IP; OP/Community/Dental; Theatres) Trust Total	73%	78%	87%	73%	86%	85%	88%	90%	90%	91%	91%	95%	86%

Clinical Assurance Indicators/Audits (%) - Acute side only	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Adult IP; Children's IP; Critical Care; Day Procedure; Dental; Maternity; OP; Theatres) Acute only Total	57%	68%	62%	77%	81%	85%	88%	89%	83%	82%	90%	96%	80%
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Acute only Total	71%	86%	83%	81%	86%	83%	84%	87%	82%	88%	89%	95%	85%
Invasive Device Care Audit Acute only Total	63%	70%	68%	80%	80%	81%	87%	79%	87%	90%	90%	98%	81%
Matron Checks (IP; OP/Community/Dental; Theatres) Acute only Total	73%	80%	83%	74%	86%	87%	91%	90%	91%	93%	91%	95%	86%

Clinical Assurance Indicators/Audits (%) - Community side only	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Community HV/SN; Community Nursing; OP) Community only Total	39%	73%	86%	98%	91%	74%	74%	83%	91%	87%	99%	99%	83%
Standard IPC Precautions (incl HH, ANTT, PPE) Community only Total	37%	68%	69%	75%	82%	62%	50%	73%	90%	81%	99%	99%	74%
Invasive Device Care Audit Community only Total	86%	94%	88%	100%	68%	60%	20%	100%	60%	58%	100%	98%	78%
Matron Checks (OP/Community/Dental) Community only Total	48%	61%	92%	80%	89%	72%	46%	87%	79%	40%	95%	98%	74%

Education & Training

Infection Control Mandatory Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Infection Control (Level 1)	89%	90%	90%	89%	90%	88%	89%	89%	91%	97%	88%	89%	90%

Aseptic Non Touch Technique Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
ANTT (M&D staff only)	55%	57%	57%	57%	58%	58%	60%	61%	66%	67%	65%	66%	61%

ANTT compliance levels

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

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

The Newcastle upon Tyne Hospitals NHS Foundation Trust

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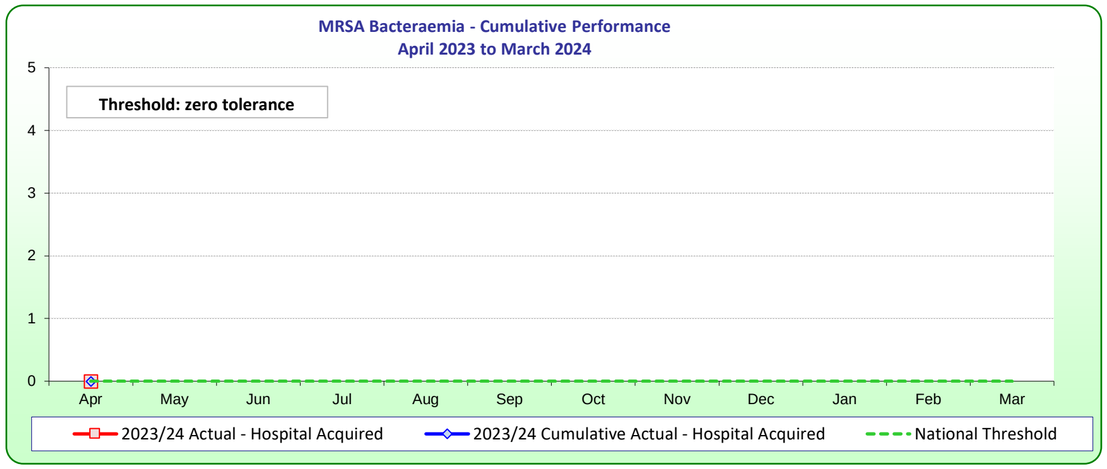
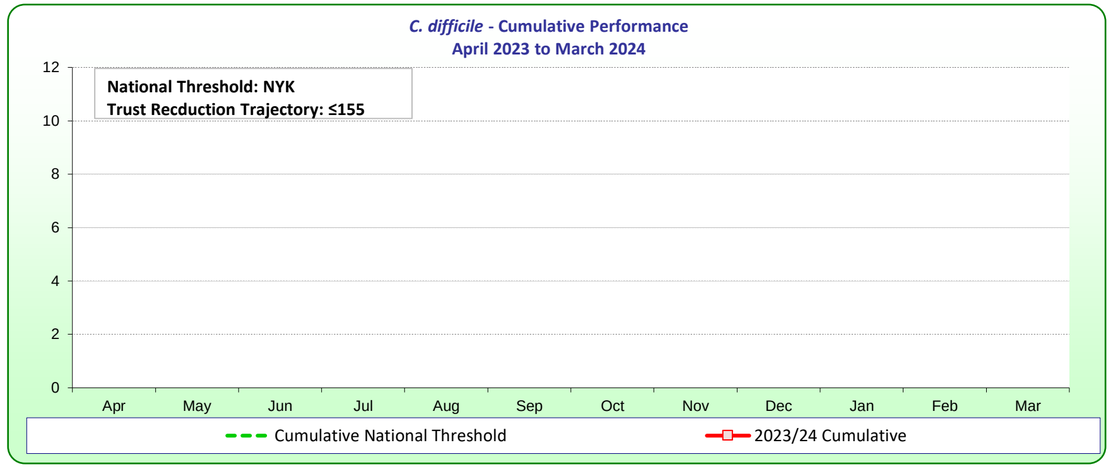
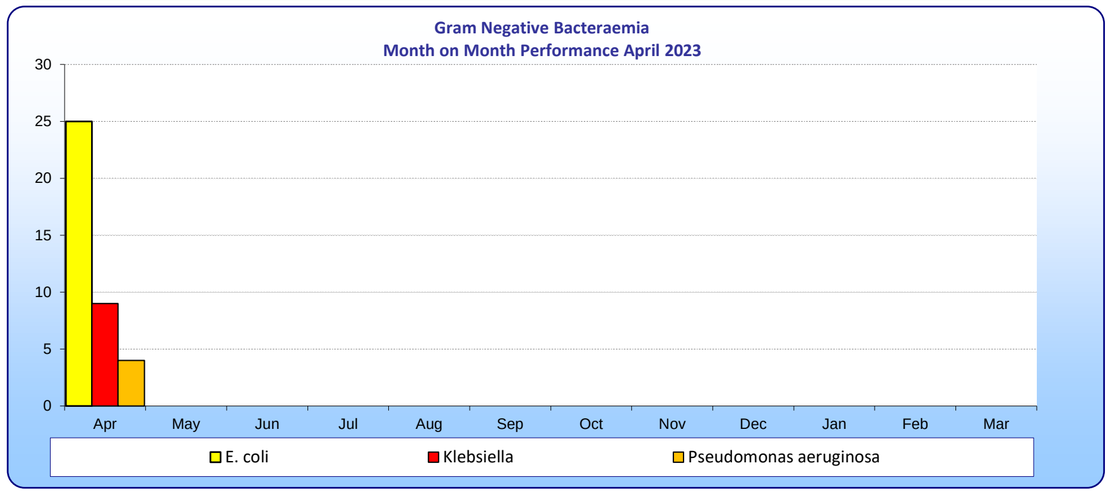
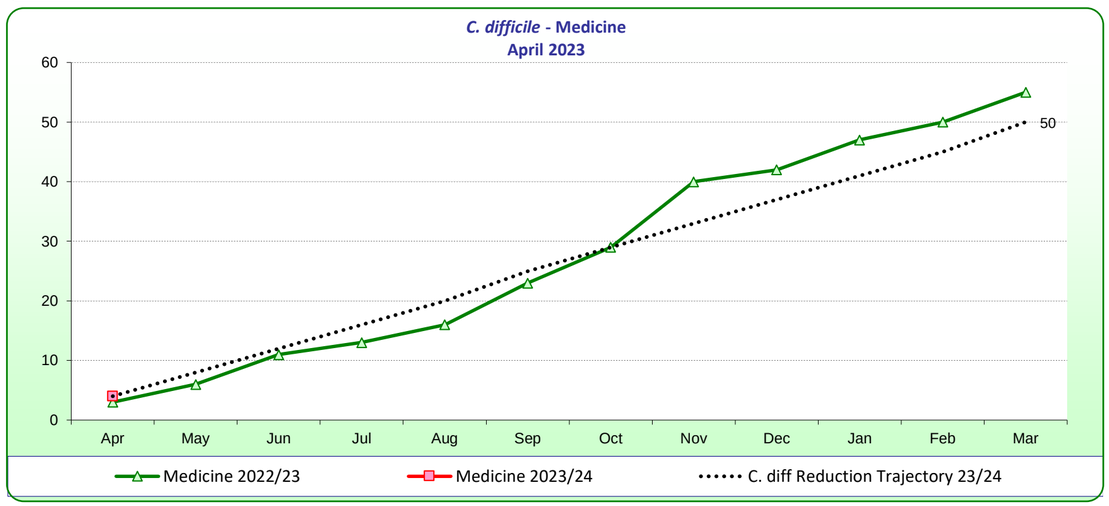
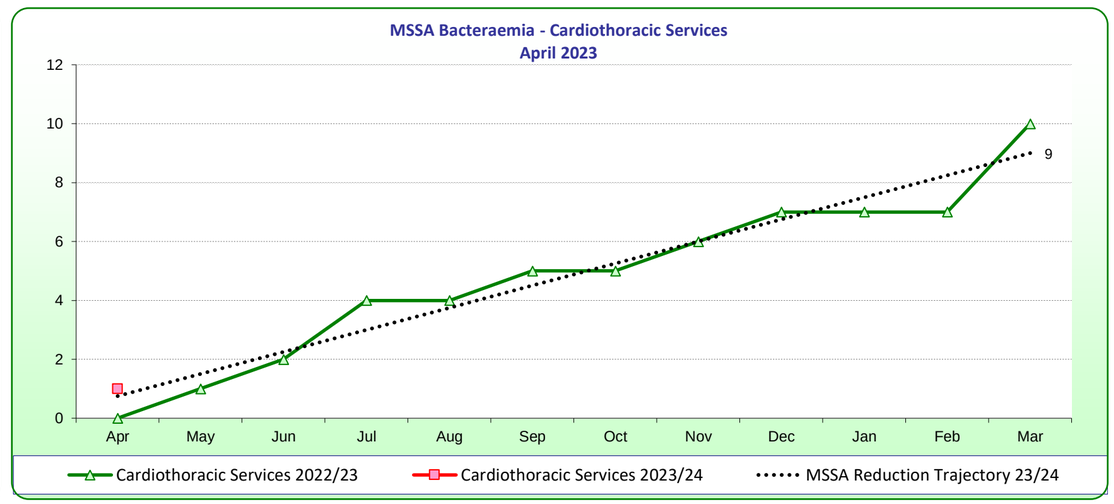
The Newcastle upon Tyne Hospitals NHS Foundation Trust











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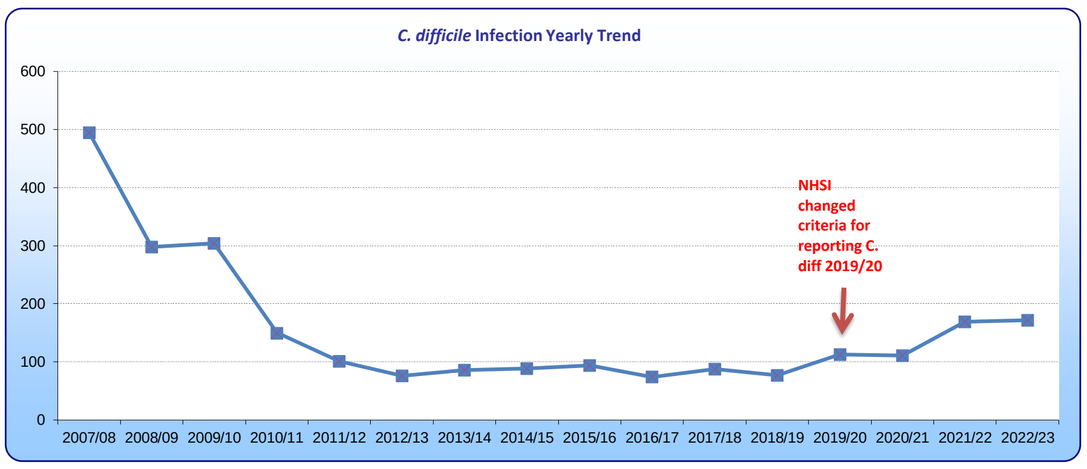

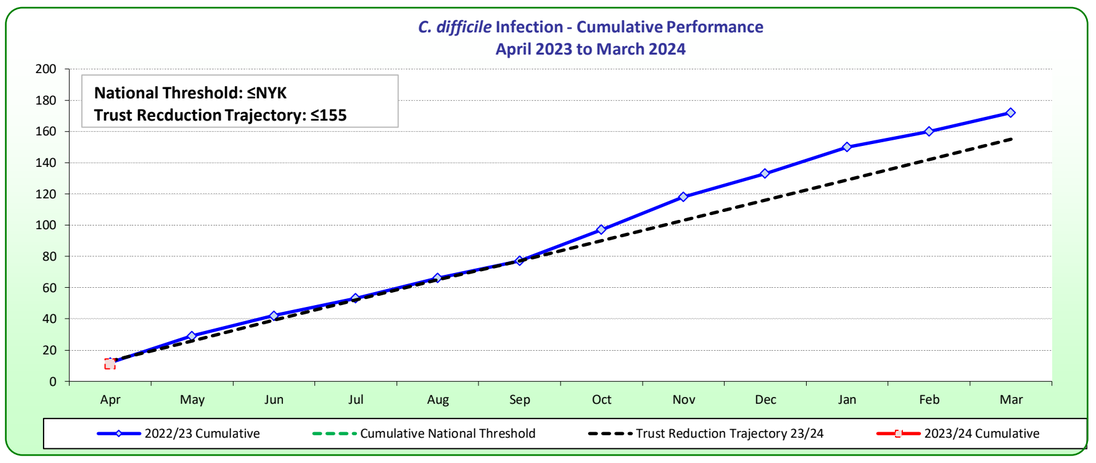

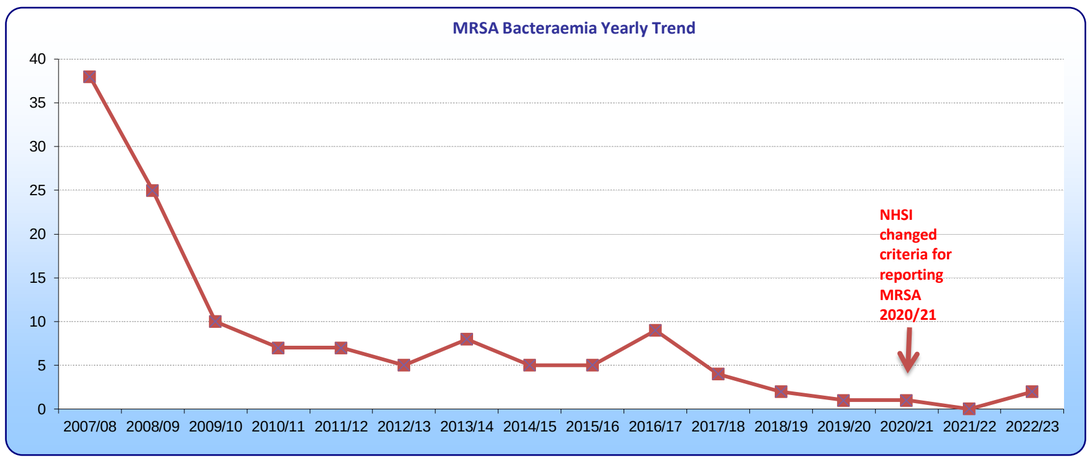

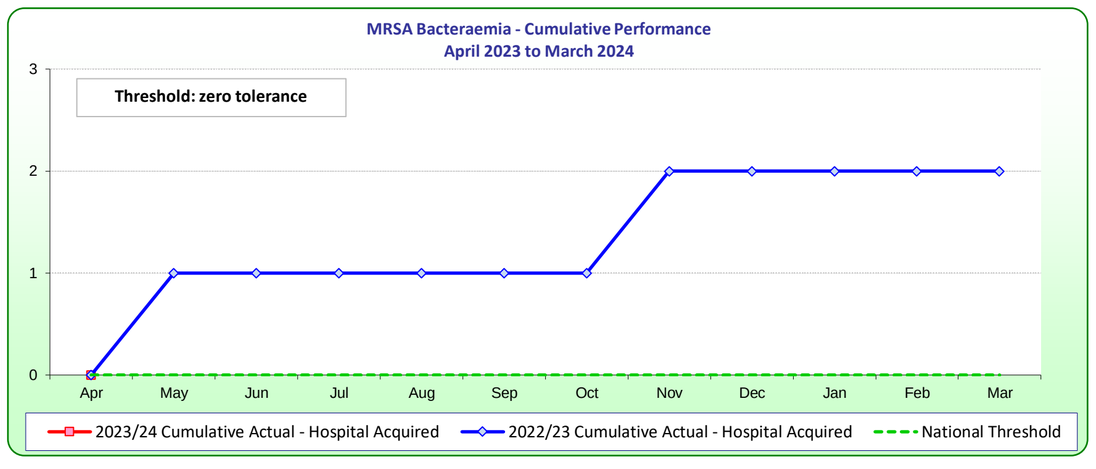

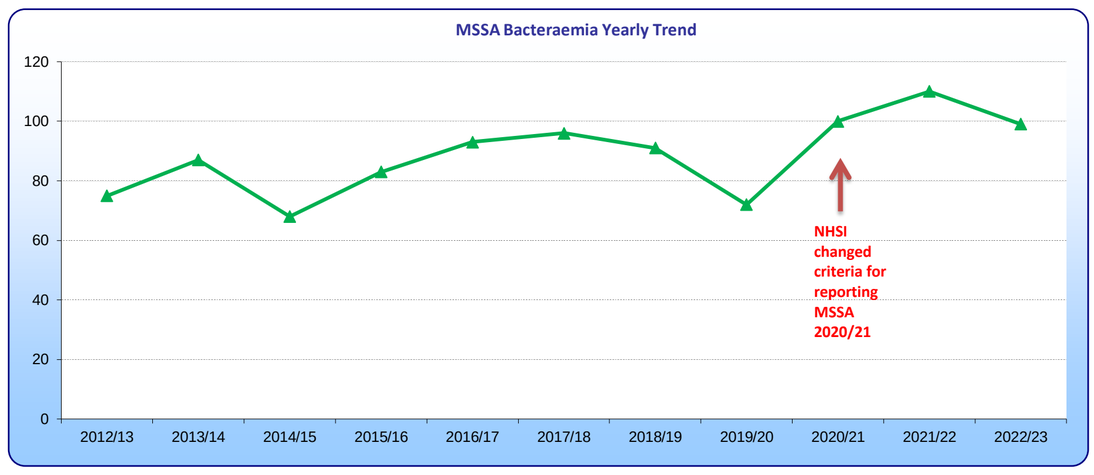

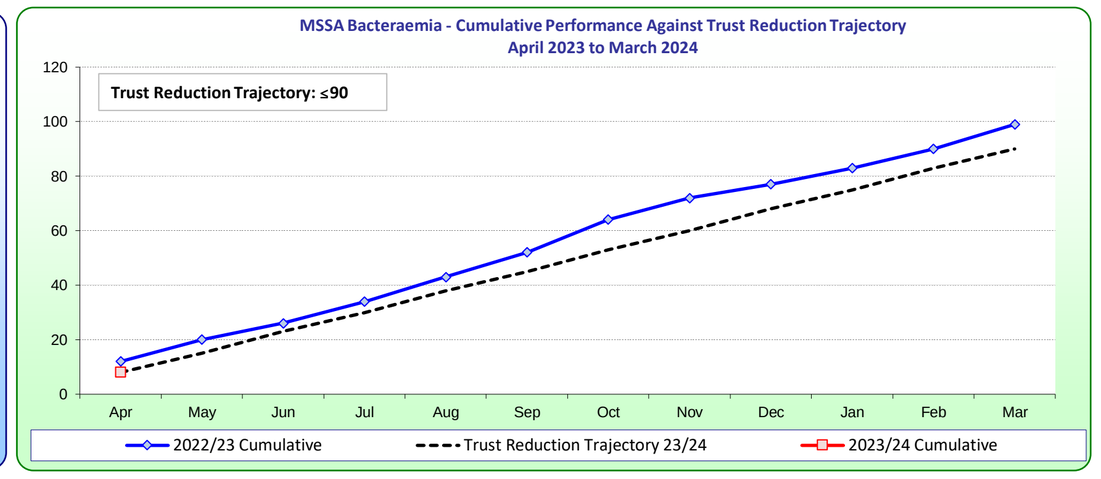

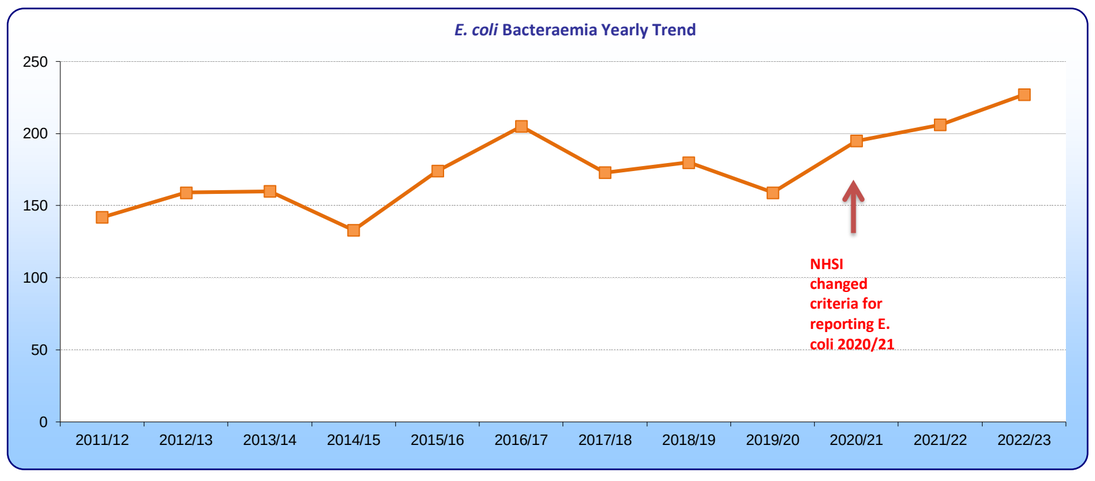

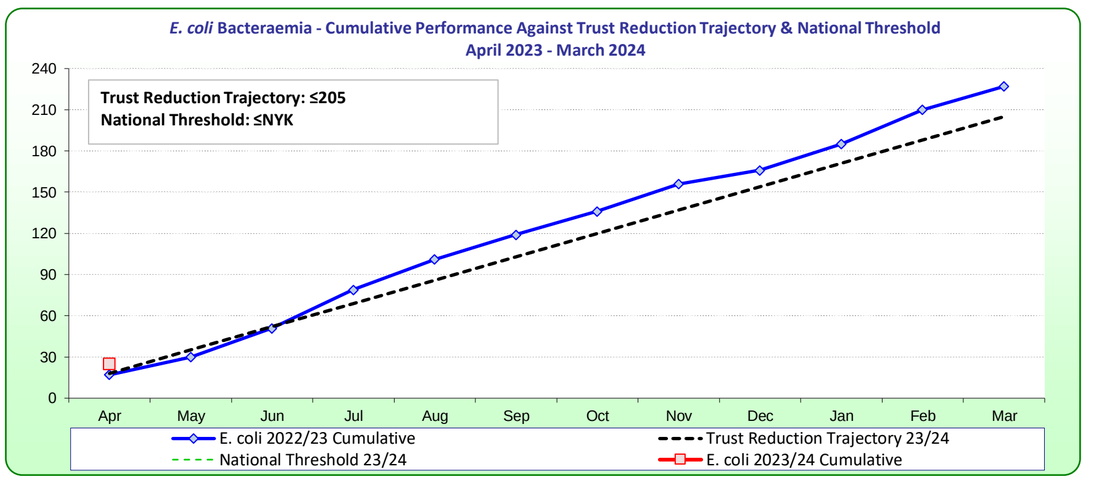

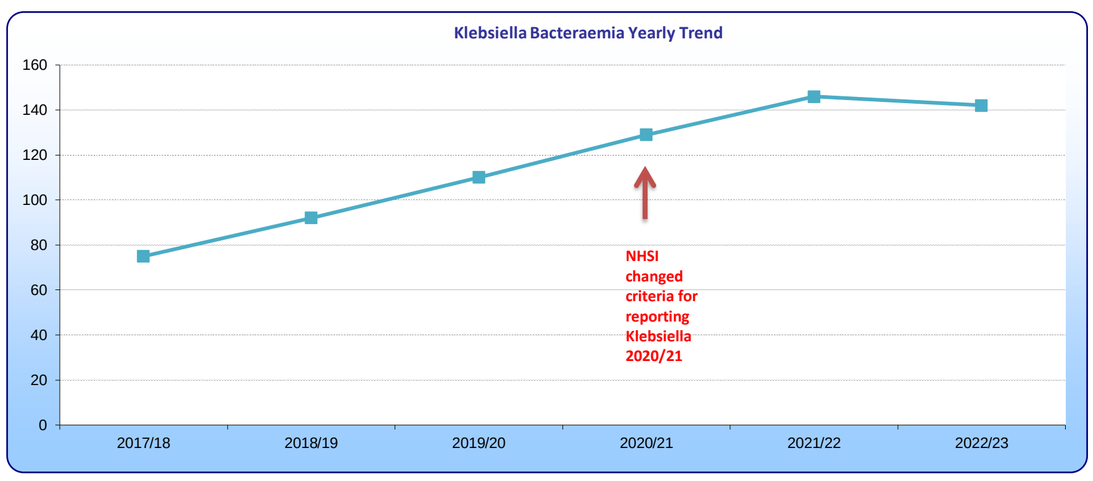

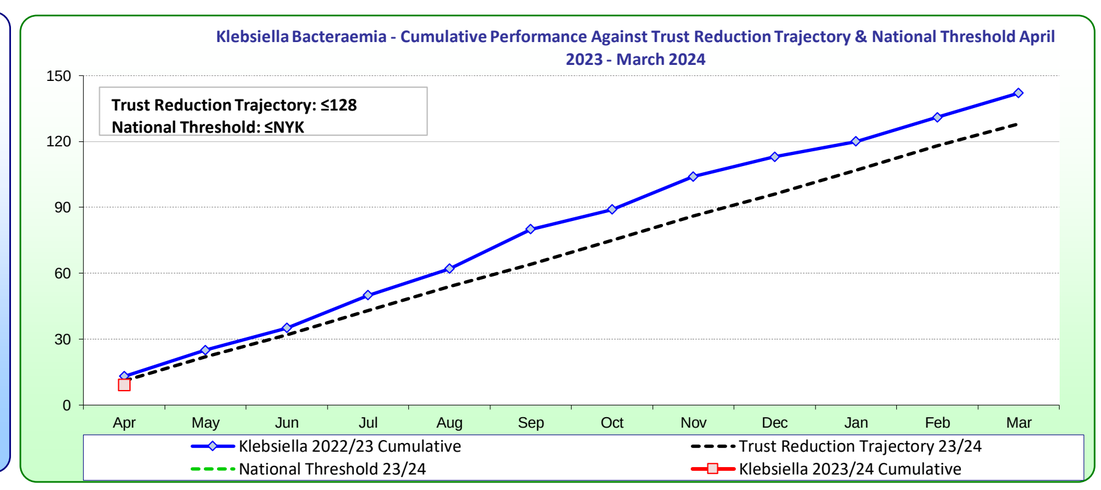

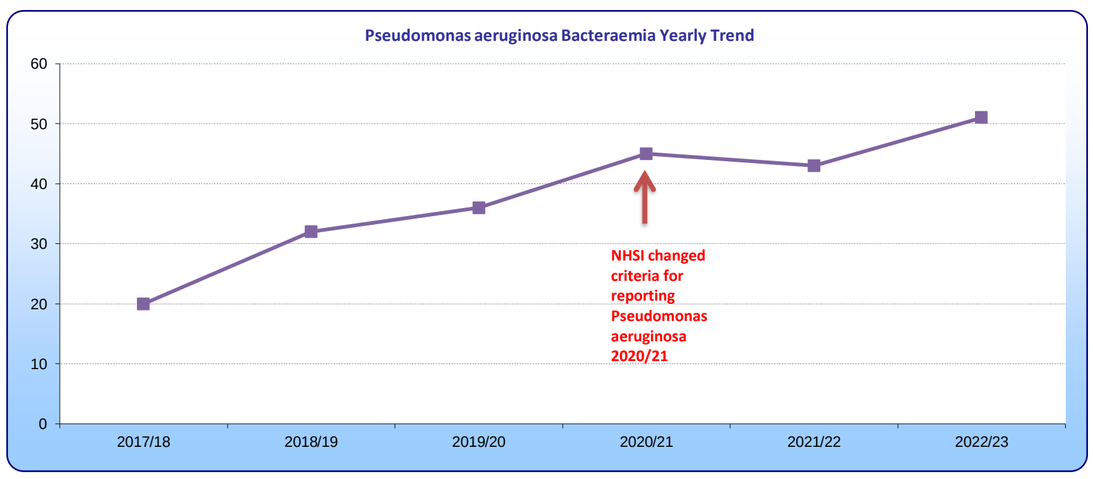

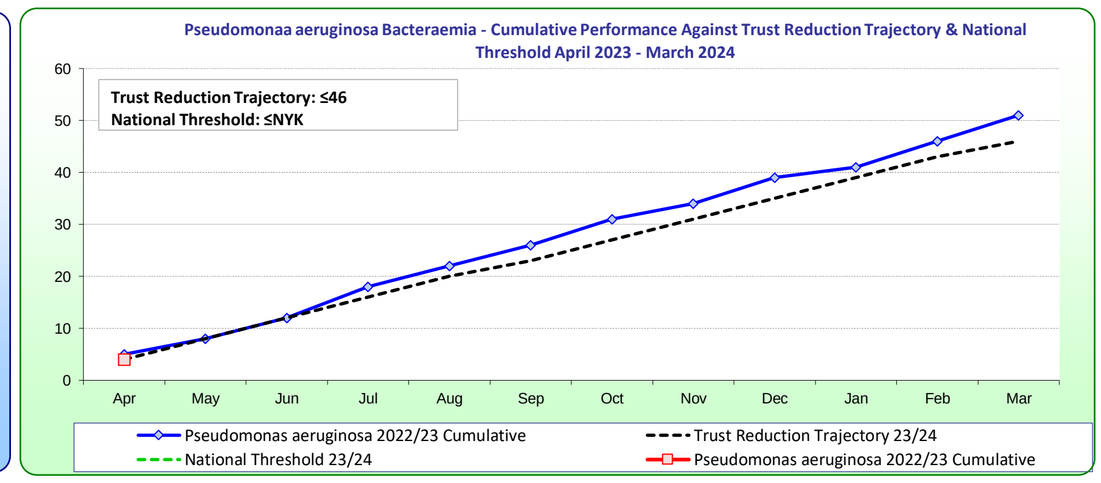

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Healthcare-Associated Infection Report April 2023

Bacteraemia / Infections

IPC indicators (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA Bacteraemia - non-Trust	0												0
MRSA Bacteraemia - Trust-assigned (objective 0)	0												0
MSSA Bacteraemia - Healthcare Associated (local objective ≤99)	8												8
E. coli Bacteraemia - Healthcare Associated (local objective ≤186)	25												25
Klebsiella Bacteraemia - Healthcare Associated (local objective ≤132)	9												9
Pseudomonas aeruginosa Bacteraemia - Healthcare Associated (local objective ≤39)	4												4
C. diff - Hospital Acquired (national threshold ≤166; local objective ≤152)	12												12
C. diff related death certificates	1												
Part 1	1												
Part 2	0												

Periods of Increased Incidence (PIIs)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
C. diff - Hospital Acquired	0												0
Patients affected	1												1
COVID-19 - Hospital Acquired	1												1
Patients affected	2												2

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)	23												23
Hospital onset Definite HC assoicated (≥15 days post admission)	39												39

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	2												2
Patients affected (total)	18												18
Staff affected (total)	4												4
Bed days losts (total)	126												126
Other Outbreaks	0												0
Patients affected (total)	0												0
Staff affected (total)	0												0
Bed days losts (total)	0												0
COVID Outbreaks	8												8
Patients affected (total)	38												38
Staff affected (total)	0												0

C.diff Transit and Testing Times Target <18hrs	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Trust Specimen Transit Time	13:47												
Laboratory Turnaround Time	03:23												
Total to Result Availability	17:10												

Clinical Assurance Tool (CAT)

Clinical Assurance Indicators/Audits (%) - Trust as a whole	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Adult IP; Children's IP; Community HV/SN; Community Nursing; Critical Care; Day Procedure; Dental; Maternity; OP; Theatres) Trust Total	95%												95%
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Trust Total	96%												96%
Invasive Device Care Audit Trust Total	95%												95%
Matron Checks (IP; OP/Community/Dental; Theatres) Trust Total	93%												93%

Clinical Assurance Indicators/Audits (%) - Acute side only	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Adult IP; Children's IP; Critical Care; Day Procedure; Dental; Maternity; OP; Theatres) Acute only Total	95%												95%
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Acute only Total	96%												96%
Invasive Device Care Audit Acute only Total	96%												96%
Matron Checks (IP; OP/Community/Dental; Theatres) Acute only Total	93%												93%

Clinical Assurance Indicators/Audits (%) - Community side only	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Community HV/SN; Community Nursing; OP) Community only Total	97%												97%
Standard IPC Precautions (incl HH, ANTT, PPE) Community only Total	91%												91%
Invasive Device Care Audit Community only Total	78%												78%
Matron Checks (OP/Community/Dental) Community only Total	98%												98%

Education & Training

Infection Control Mandatory Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Infection Control (Level 1)	95%												95%

Aseptic Non Touch Technique Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
ANTT (M&D staff only)	65%												65%

ANTT compliance levels

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

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

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	25 May 2023						
Title	Update from Committee Chairs						
Report of	Non-Executive Director Committee Chairs						
Prepared by	Lauren Thompson, Deputy Trust Secretary / Corporate Governance Manager						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☒	☐	☒				
Summary	The report includes updates on the work of the following Trust Committees that have taken place since the last meeting of the Trust Board in March 2023: • People Committee – 18 April 2023; • Charity Committee – 6 April 2023 and 11 May 2023; • Quality Committee – 16 May 2023; • Finance Committee – 26 April 2023 [Extraordinary] and 24 May 2023; and • Audit Committee – 25 April 2023.						
Recommendation	The Board of Directors is asked to (i) receive the update and (ii) note the contents.						
Links to Strategic Objectives	Links to all strategic objectives						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☒	☒	☒	☐
Link to Board Assurance Framework [BAF]	No direct link.						
Reports previously considered by	Regular report.						

UPDATE FROM COMMITTEE CHAIRS

EXECUTIVE SUMMARY

This report provides an update to the Board on the ongoing work of the Trust's Committees for those meetings that have taken place since the last meeting of the Board of Directors in March 2023.

UPDATE FROM COMMITTEE CHAIRS

1. PEOPLE COMMITTEE

A meeting of the People Committee took place on 18 April 2023. During the meeting, the main areas of discussion included:

- An industrial action status update was provided.
- The People Committee Risk report was received and discussed.
- The Chief People Officer shared the WRES and WDES submission.
- A presentation with regards to the People Priorities for 2023/24 was provided.
- A detailed update was provided in relation to the 2022 staff survey results and next steps.
- A comprehensive annual update in relation to apprenticeships was received.
- The People dashboard was received and discussed.
- The Freedom to speak up Guardian gave a comprehensive update.
- A Legal Cases update was received.
- The Committee ratified the Annual Report of the Committee, including review of Schedule of Business and Terms of Reference.

The next formal meeting of the Committee will take place on 22 June 2023.

2. CHARITY COMMITTEE

A meeting of the Charity Committee took place on 6 April 2023. The meeting was convened primarily to discuss several grant applications in advance of the next formal meeting.

During the meeting, the Committee approved applications which totalled £263,667.60 as follows:

- Cancer Services: Cancer Treatment Scalp Cooling Machines - £38,433.00.
- Patient Services: Replacement of Ward / Departments 'How We Are Doing' Boards - £84,257.60.
- Chief Executive Directorate: GA045 – Celebrating Excellence Awards 2023 - £25,037.00.
- Developing a Patient Public & Engagement Strategy - £115,940.00.

A meeting of the Charity Committee took place on 11 May 2023. During the meeting, the main areas of discussion included:

- The Charity finance reports were received and discussed.
- The Committee discussed the summary of investments to 31 March 2023 including the quarterly summary investment reports from:
    - Newton's; and
    - CCLA.

- The Charity Director provided a general charity update.
- An update on the Arts programme was received.
- The following grants were approved:
    - Chief Executive Directorate: NHS 75 – up to £37,281.14;
    - New Writing North: Writer in Residence, Newcastle Hospitals – up to £25,000;
    - Cancer Services: Purchasing Wall Art for Ward 35 – up to £28,304.30;
    - EPOD: Optos California Diagnostic Device – up to £35,000;
    - Children's Services/Cancer Service: Clinical Sustainability Fellowships: Paediatrics and Oncology Pilot – up to £226,399; and
    - Chief Executive Directorate: Provision of Freeview TV across the RVI and Freeman Hospitals – up to £50,000.
- The Committee received the Dashboard of operational Key Performance Indicators (KPI's), the Operational Plan for 2023/24, an update on the draft progress against the Strategy and the Charity Risk Statement.

The next meeting of the Committee will take place on 10 August 2023.

3. QUALITY COMMITTEE

A meeting of the Quality Committee took place on 16 May 2023. During the meeting, the main areas of discussion included:

- The Patient Experience and Engagement Group report was received and discussed.
- The Deputy Director of Quality and Safety provide an update on the quality account consultation.
- The Director of Infection, Prevention and Control, the Deputy Director of Quality and Safety and the Chief Operating Officer presented the quality and performance elements of the Integrated Board Report.
- An update was provided with regards to the National Patient Safety Strategy.
- The Committee received a Minimising Nitrous Oxide Exposure update.
- An update was provided in relation to the Trust's response to the recent Care Quality Commission (CQC) inspections.
- The Committee received and discussed three quarter 4 reports:
    - Safeguarding;
    - Learning Disability; and
    - Mortality/Learning from Deaths.
- The End of Life and Palliative Care Bi-annual report was received and discussed.
- The Committee received a legal update and an update on leadership walkabouts / spotlight on service.
- An update was received in relation to Maternity including the Ockenden report.
- The Chief Nurse provided an update on the proposed Patient and Public Engagement Strategy launch.
- The Committee ratified the Annual Report of the Committee, including review of Schedule of Business and Terms of Reference.

The next meeting of the Committee will take place on 18 July 2023.

4. FINANCE COMMITTEE

An extraordinary meeting of the Finance Committee took place on 26 April. During the meeting, the main areas of discussion included:

- The Chief Finance Officer provided an update on the month 12 / year end finance position.
- The Chief Finance Officer and Executive Director of Business, Development and Enterprise updated on the 2023/24 plan position.
- The 2022/23 draft Annual Accounts were discussed in detail.
- The Committee ratified the Annual Report of the Committee, including review of Schedule of Business and Terms of Reference.

A meeting of the Finance Committee took place on 24 May 2023. During the meeting, the main areas of discussion included:

- The Head of Corporate Risk and Assurance presented the Committee Risk Report.
- An update on the financial and performance position was providing including the following:
  - Productivity & Efficiency Programme;
  - Capital Programme 2023/24 update;
  - Month 12 Performance Report including activity recovery; and
  - Commercial Strategy update.
- A procurement update was provided by the Procurement and Supply Chain Director.
- Tenders and Business Cases were presented for approval.
- The Chief Operating Officer provided an update on the Integrated Covid Hub for the North East (ICHNE), Nightingale Hospital North East (NHNE) and the Day Treatment Centre (DTC).
- An update was provided in relation to the Community Diagnostic Centre (CDC).

The next meeting of the Committee will take place on 26 July 2023.

An extraordinary meeting is scheduled on 27 June 2023 to approve the annual report / accounts.

5. AUDIT COMMITTEE

A meeting of the Audit Committee took place on 25 April 2023. During the meeting, the main areas of discussion included:

- Committee Chairs provided updates relating to risk and assurance in relation to their specific areas of focus.

- The Assistant Chief Executive presented the Board Assurance Framework (BAF) risk management annual report including the risk appetite statement and the draft Annual Governance Statement (AGS).
- The financial statements including draft accounts 2022/23 and going concern statement 2022/23 were discussed.
- An update was provided from Internal Audit (IA) which included the IA progress report, draft head of opinion 2022/23, IA charter and final annual plan 2023/24.
- Counter Fraud provided an update report including the fraud response log and the annual plan / Counter Fraud financial standard return.
- Mazars LLP provided an update on External Audit including the audit strategy memorandum – Trust and Charity/Annual Audit Plan and those charged with governance (TCWG) request – Trust and Charity.
- The Audit Committee annual report and self-assessment which included the draft TCWG response, Committee Terms of Reference and Schedule of Business were reviewed.
- The Non-Audit Services policy was reviewed, and changes approved.
- The Committee received a number of reports including:
    - Review of schedule of approval of single tender action and breaches and waivers exception report;
    - Debtors and creditors balances;
    - Schedule of losses and Compensation; and
    - Annual review of special severance payments/settlement agreements.

The next meeting of the Committee will take place on 25 July 2023.

Am extraordinary meeting is scheduled on 28 June 2023 to approve the annual report / accounts.

6. RECOMMENDATIONS

The Board of Directors is asked to (i) receive the update and (ii) note the contents.

Report of Lauren Thompson
Corporate Governance Manager / Deputy Trust Secretary
18 May 2023

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 May 2023						
Title	Integrated Board Report						
Report of	Angela O'Brien - Director of Quality and Effectiveness.						
Prepared by	Louise Hall - Deputy Director of Quality and Safety, Peta Le Roux- Business Analysis.						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	This paper is to provide assurance to the Board on the Trust's performance against key Indicators relating to Quality, People and Finance.						
Recommendation	For assurance.						
Links to Strategic Objectives	Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. Supported by flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential. Performance – Being outstanding now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☒	☐	☐	☐
Link to the Board Assurance Framework [BAF]	Details compliance against national access standards which are written into the NHS standard contract. Details compliance against key quality targets.						
Reports previously considered by	Regular report.						

INTEGRATED BOARD REPORT

EXECUTIVE SUMMARY

This report provides an integrated overview of the Trust's position across the domains of Quality, People and Finance.

1. Throughout the month of April 2023, the Trust has had **no cases of MRSA bacteraemia.** The number of **E.coli bacteraemias has decreased by 8 cases.**
2. In April 2023 there has been an **increase in the number of falls across the Trust (n= 293) and a reduction in pressure ulcers (n=69).**
3. There were **16 Serious Incidents (SIs)** reported in April 2023.
4. The Trust has opened a total of **31 (29 with identified patient activity) formal complaints in April 23.** There were **1,220 responses to the Friends and Family test** from the Trust in February 2023 (published April 2023) compared to 1,240 in the previous month.
5. There was a **reduction in sharps incidents** throughout April 2023 (n=24).
6. The was **one indirect maternal death in April 2023.**
7. Overall **sickness absence (including COVID-19 related sickness) is 5.72%, which is down from end of Dec 2022** position of 6.45% (% FTE Time Lost).
8. **Staff turnover has increased from 11% in February 2022 to 14.29% in April 2023**, against a target of 8.5%.
9. **Mandatory training compliance stands at 89.95%** at end of April 2023, against an end of year target of 95%. **Appraisal compliance stands at 79.05%**, at end of April 2023, against an end of year target of 95%.
10. In the period to 30 April the Trust incurred expenditure of £119.5 million, and received/accrued income of £111.9 million, leaving a deficit in line with the Plan of £7.6 million.

The Board of Directors is asked to receive the report.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

Quality, People and Finance

May 2023

Healthcare at its best
with people at our heart

Executive Summary

Purpose

This report provides an integrated overview of the Trust's position across the domains of Quality, People and Finance.

Current Operating Environment

Operational pressures continue to persist. The main challenges are patient discharge, leading to a high occupancy rate, and overall flow out of ED into specialty base ward beds. The teams work hard to achieve one of the better performances for the Emergency Department four-hour standard both regionally and nationally, and there remains good management of ambulance handovers, with few delays occurring.

The elective programme continues to be impacted by ongoing periods of Industrial Action.

Report Highlights

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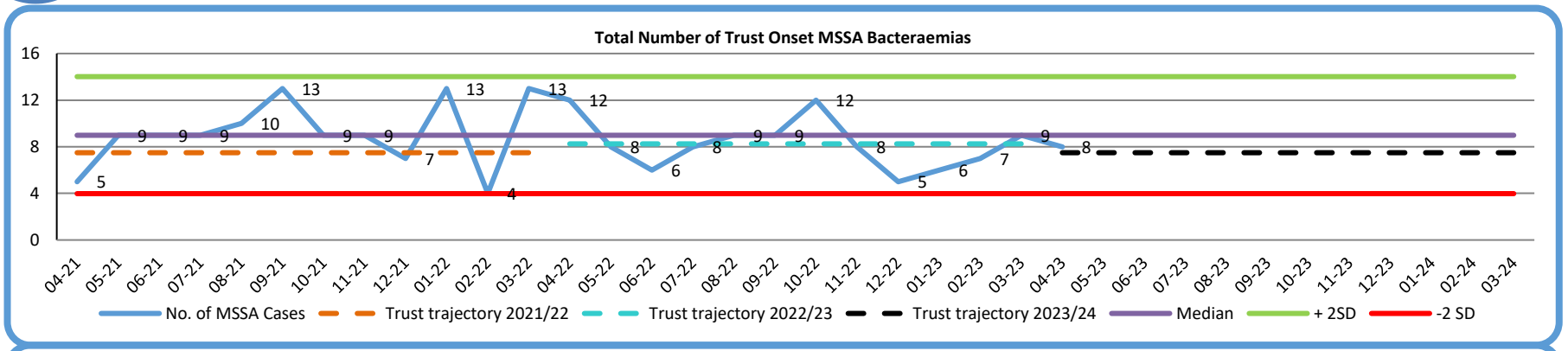
Contents: May 2023

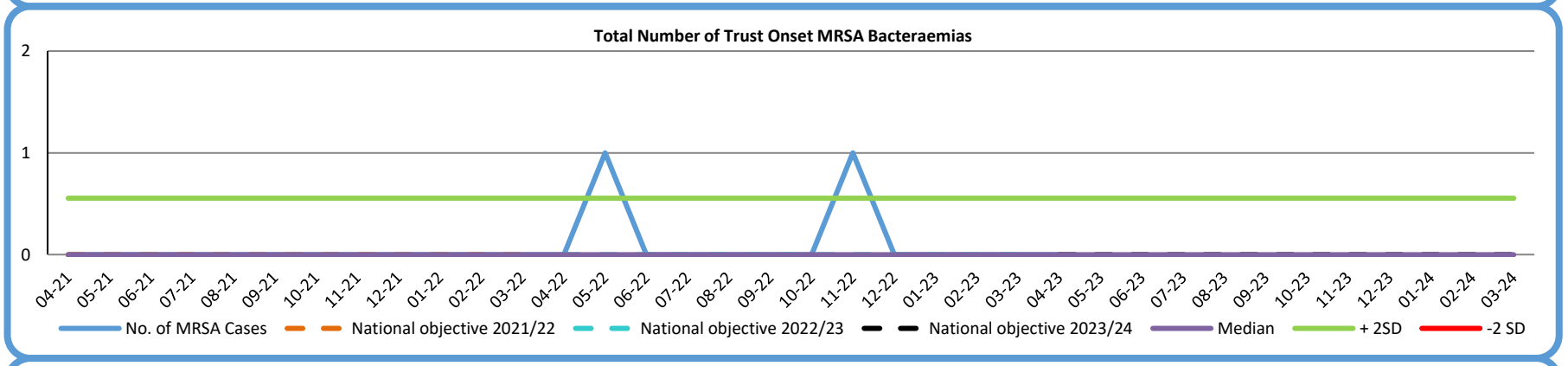
Quality

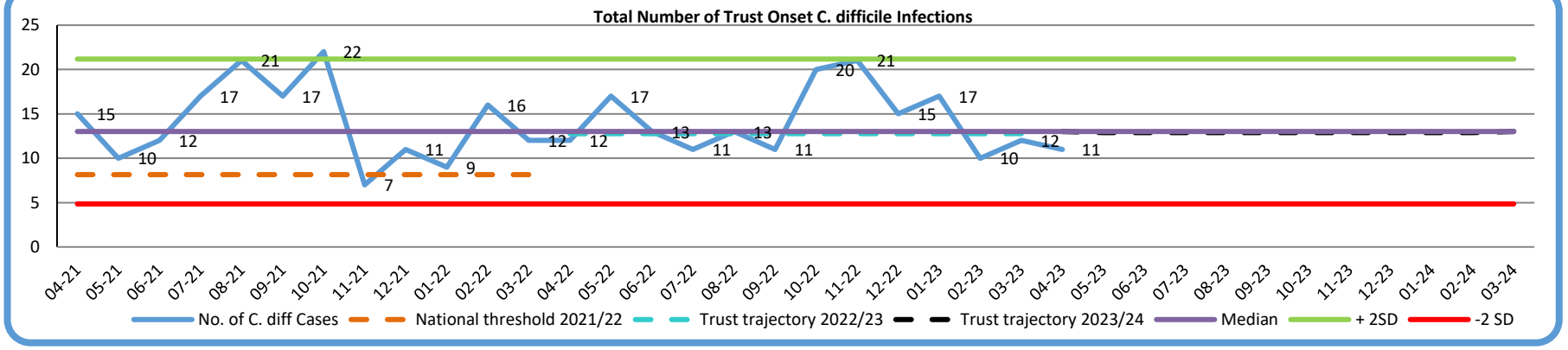
People

Finance

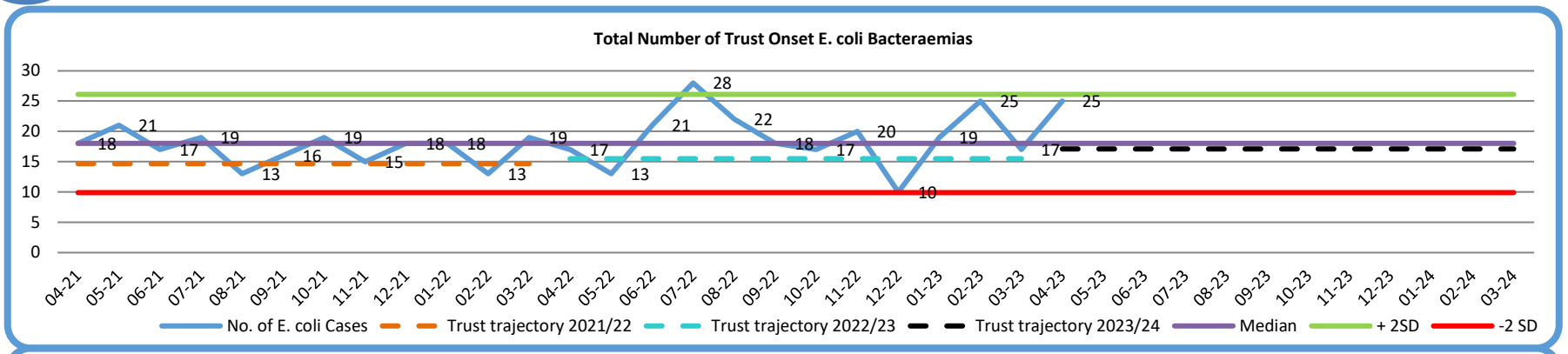
Quality: Healthcare Associated Infections 1/2

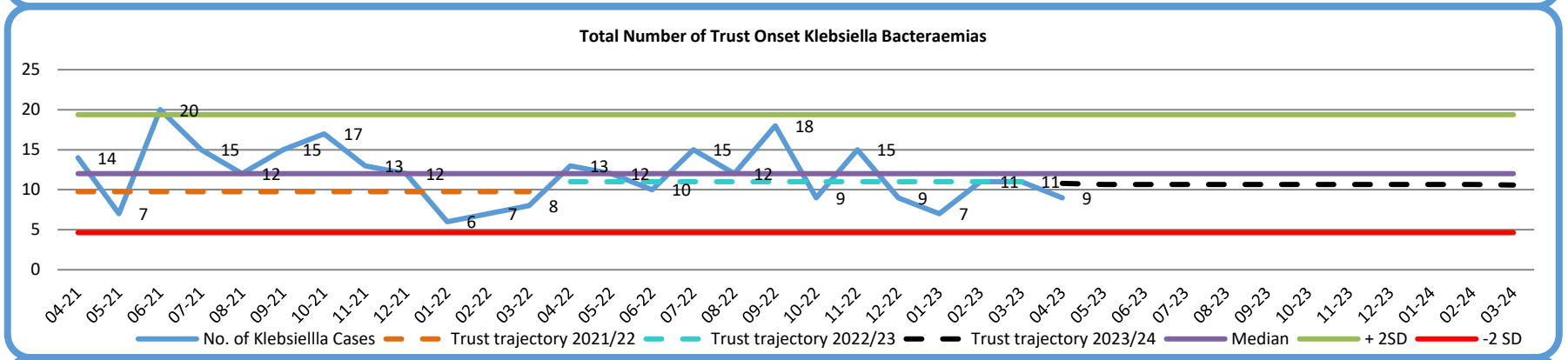


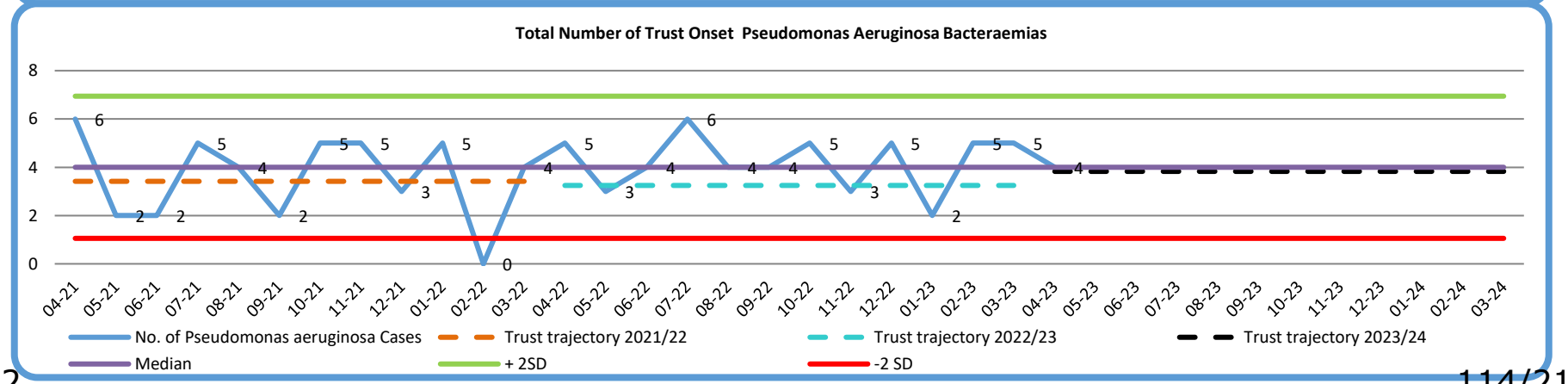




Quality: Healthcare Associated Infections 2/2







Quality: Harm Free Care – Pressure Damage

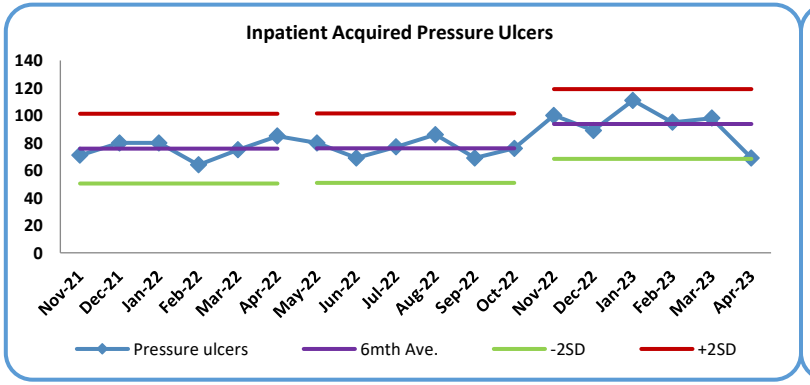
The number of inpatient pressure ulcers has significantly decreased in the month of April 2023 to 69. There was also a decrease in serious incidents requiring root cause analysis (RCA) from March (10) to April (3).

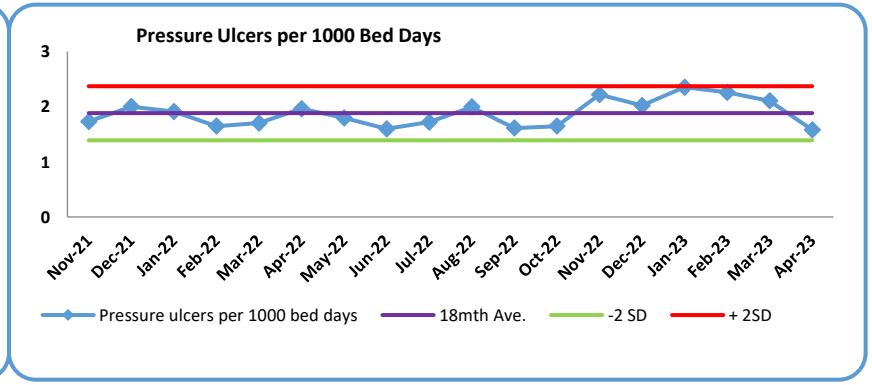
During February 2022 we had a dip to 60, however the six month average (November 21-April 22) was 80, so this was a one off low score. For the following 6 months (May 22-October 22) the average remained at 80. This did increase from November 2022 to April 2023 to an average of 90, with a high data point in January 2023 of 110. Pressure Ulcers were 69 this month so this will bring the average back down. It was noted that from the February 2022 figures to January 2023 the average number of pressure ulcers nearly doubled. However these would be classed in data as 'special causes' and not statistically representative of the six month average.

The Trust safe care data illustrates that the acuity of patients is significantly higher than pre-pandemic levels. In addition, there has been an increase in patients presenting to the Trust with significant existing damage, or that are at risk of skin deterioration. There has been and continues to be a high number of medical borders across the Trust.

The tissue viability team are undertaking focussed work in wards and departments with the highest incidence of pressure damage, focussing on education.

A pilot has commenced, introducing a new risk assessment tool called PURPOSE T, this would replace Braden and support staff to identify and plan care for those patients at risk of pressure damage.



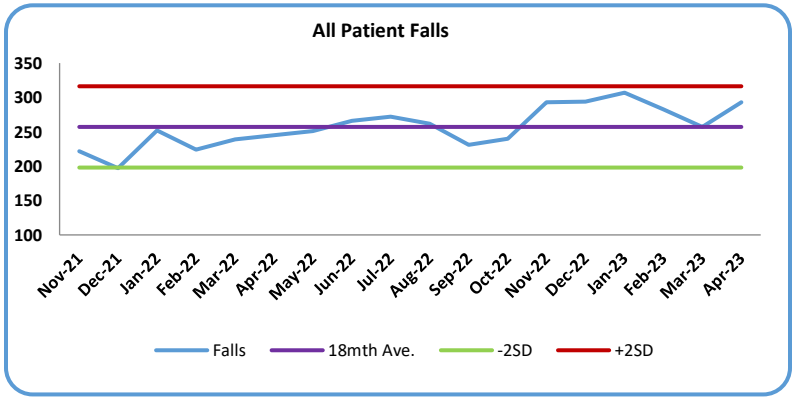


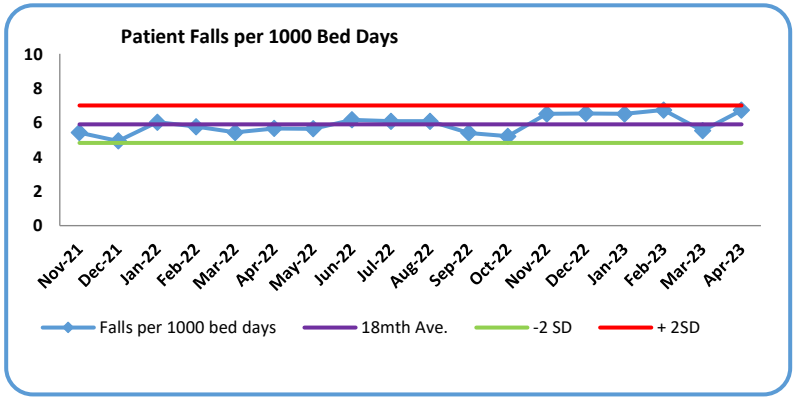
Quality: Harm Free Care - Falls

The number of inpatient falls during April 2023 has increased to 293. There was 1 moderate and 1 major fall in April.

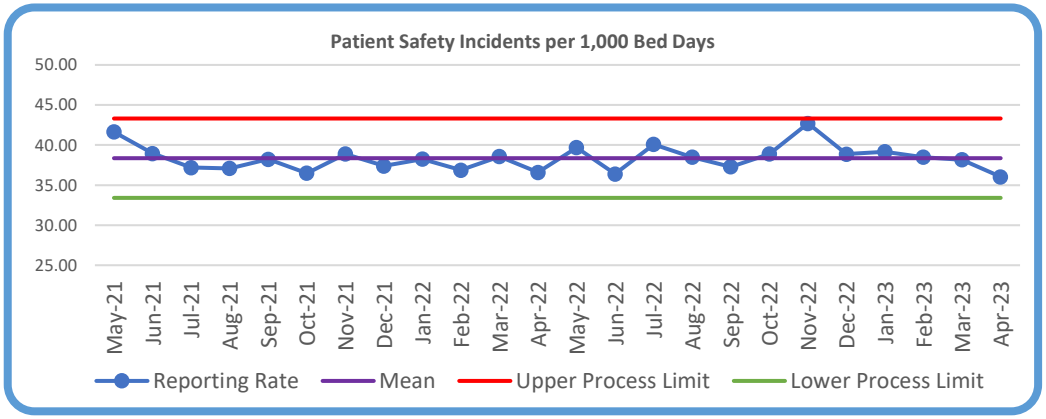
In 2022 the Trust experienced significant pressures, particularly in relation to bed occupancy levels, which have remained high throughout. Significant increases in the cohort of medical patients, particularly those over 65 were evident and led to the requirement to convert many surgical wards to medicine, and have remained so for the last two years. Evidence produced by the National Falls Audit (2021) illustrates higher rates of deconditioning in our elderly population as a result of periods of lockdowns and COVID-19 infection. This has led to significant increases in both levels of patients at risk and incidents of falls. Incidents within the Trust reflect this, whereby a high proportion of falls occur in our patients who are over 65.

The Falls Prevention Coordinator has continued with work identifying, on a monthly basis, the wards with the highest incidence of falls, recognising contributing factors and identifying learning and solutions, with the aim to reduce numbers of falls in the Trust.

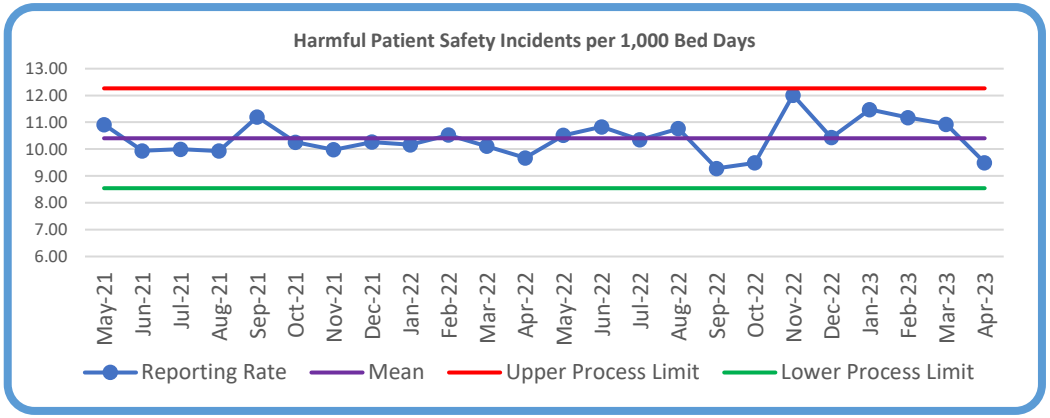




Quality: Incident Reporting

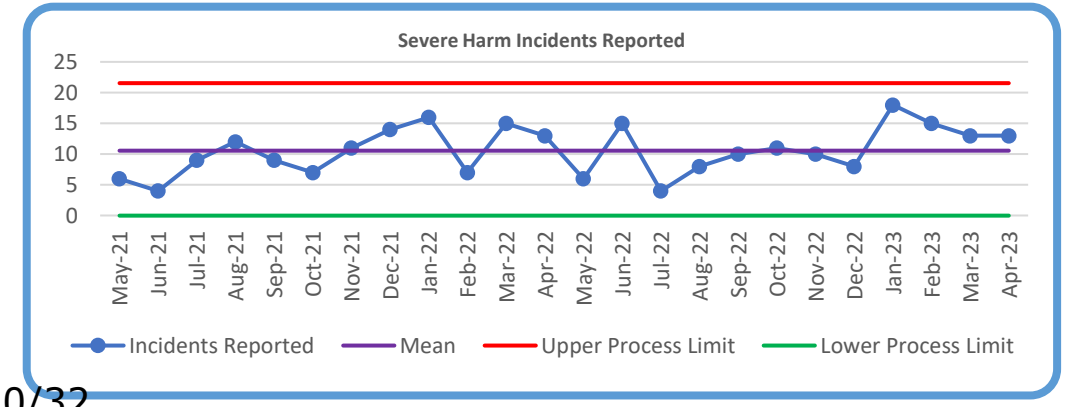


All patient incidents: The number of patient safety incidents reported per 1,000 bed days continues to remain within close proximity to the mean from December 2022, with a slight reduction in April 2023. This remains well within the expected common cause variation.



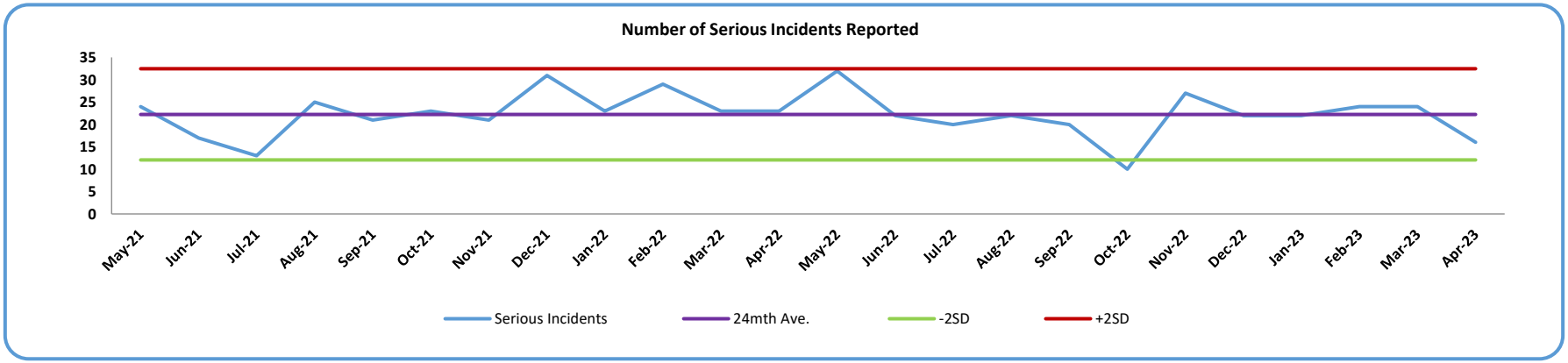
Harmful incidents: The number of *harmful patient safety incidents per 1,000 bed days shows a decrease below the mean in April 2023, but remains within the expected common cause variation.
Severity grading of reported incidents may be modified following investigation and is therefore subject to change in future reports.

**includes all levels of harm from minor to catastrophic. Excludes patient safety incidents that resulted in no patient harm.*

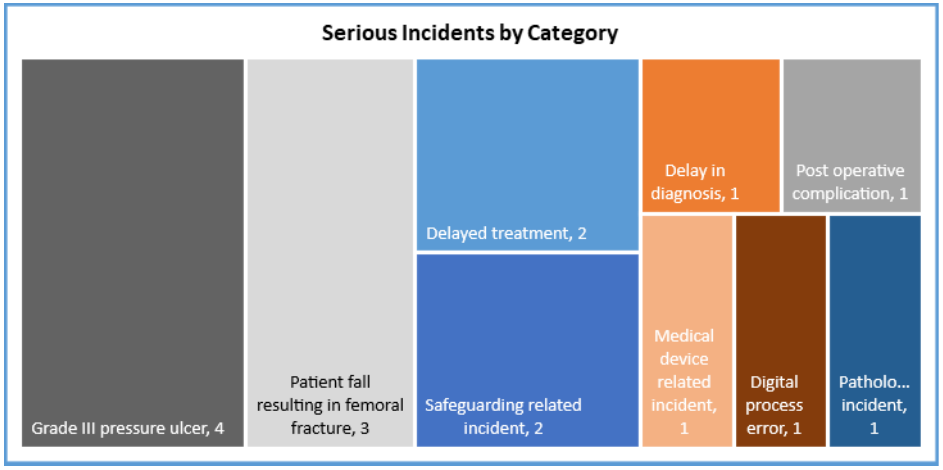


Severe harm incidents: There were 13 patient safety incidents reported that resulted in severe harm in April 2023. This remains within close proximity to the mean and is a decrease from January 2023, well within the common cause variation. Severity grading of reported incidents may be modified following investigation and is therefore subject to change in future reports.

Quality: Serious Incidents

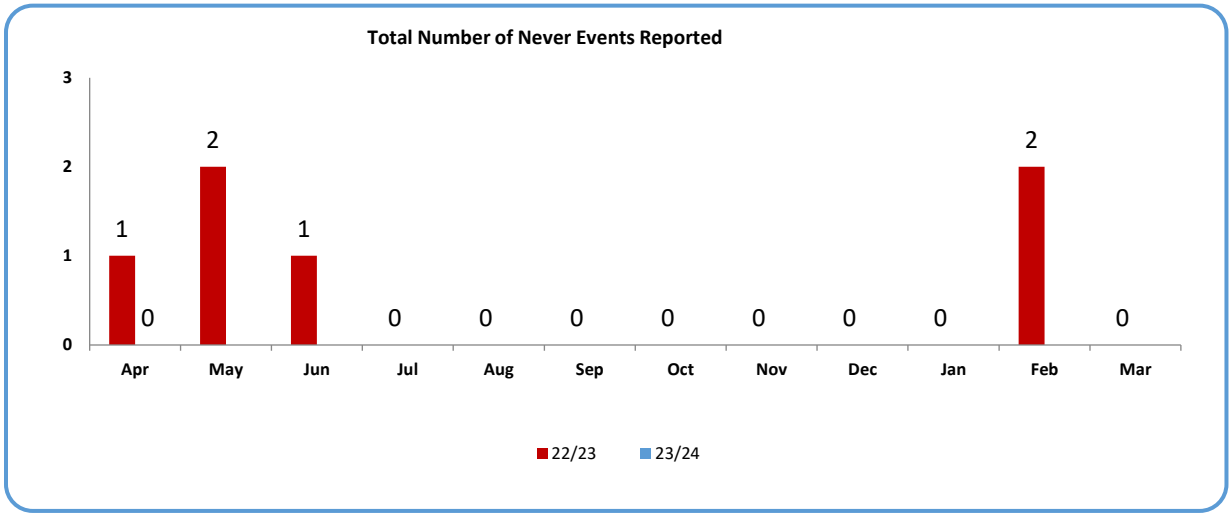


There were 16 Serious Incidents (SIs) reported in April 2023, which is below the mean and well within the accepted common cause for variation. The statutory requirement Duty of Candour (DoC) applies to patient safety incidents that occur when providing care and treatment that results in moderate, severe harm or death and requires the Trust to be open and transparent with patients and their families. The DoC process has been initiated for all cases reported in April 2023.



The categories of reported SIs for April 2023 are displayed in the table to the left. The highest number of SIs relate to grade III pressure damage, followed by patient falls resulting in harm.

Quality: Never Events



There were 6 Never Events reported in the Trust in 2022/23 and to date no never events reported in 2023/24

Quality: Serious Incident Lessons Learned

Learning identified from Serious Incident (SI) & Never Event (NE) investigations completed between 01.01.2023 – 30.04.2023

The following section outlines key learning from the 38 SI investigations completed between 1 January 2023 to 30 April 2023. This data excludes information on falls, pressure ulcers, deaths as a result of definite or probable hospital acquired Covid-19 and any SI cases subsequently de-registered during this period.

Maternity reportable case – 7 cases

- Local policies strengthened to improve support to staff when caring for high-risk women and complex presentations
- Debriefs re-enforced as routine practice to offer effective staff support in distressing cases
- Bereavement checklist enhanced to ensure early family support and counselling is consistently offered
- Escalation processes clearly defined and enhanced training in place to re-enforce expected practice
- Antenatal CTG classification differences highlighted in training and audits of practice
- Language appropriate information leaflets consistently provided to ensure equality of information provided to all women
- NEWTT chart use and audit of practice undertaken to promote early detection of deterioration regardless of antenatal risk factors
- SBAR to be incorporated into new maternity electronic patient record (Badgernet) functionality to strengthen handover & communication
- Strengthened MAU triage clinical assessment process put in place to improve prioritisation of women on presentation
- Clarity on MDT roles & responsibilities for antibiotic prescribing and administration to better facilitate timely response to the sepsis six pathway

Incorrect treatment – 2 cases

- Coding and cross-checking processes reviewed and updated to further strengthen laboratory treatment pathways
- Trust wide environmental checking processes improved, and requirements disseminated to all relevant clinical staff to ensure robust practice in place

Missed/delayed diagnosis or treatment – 5 cases

- Enhanced provision of Point of Care pregnancy testing equipment and use re-enforced to communicate expected practice
- Strengthened profession-specific clinical assessments to support clear documentation and handover in relation to identified concerns regarding elderly patients
- Processes for requesting investigations re-enforced to ensure correct information is included to enable results to be reported to appropriate clinician
- Paper-based junior doctor checklist developed during Covid to ensure that VTE risk assessments are consistently undertaken when patients' admission varies from usual pathway

Missed patient deterioration – 2 cases

- Trust level Quality Improvement work commenced to identify system improvements in relation to IV fluid management, prescribing & recording
- Ongoing development of the PEWS electronic observations system to strengthen and incorporate senior escalation functionality, modelled on the existing Trust adult patient proforma

Quality: Serious Incident Lessons Learned

Complication of treatment – 5 cases

- Local guideline reviewed and expected practice agreed in relation to post procedure monitoring for high-risk patients
- Appropriate storage and equipment identification clarified and communicated to all theatre staff
- WHO checklist processes re-enforced and audited to ensure consistent engagement by the full multidisciplinary team
- Local guideline and training strengthened to support prompt escalation of concern and Consultant led review of imaging
- Trust-wide policy & practice review underway to address and strengthen checking procedures to mitigate against risk of retained guidewires, in the absence of a nationally engineered solution
- Review of national and local practice undertaken, with local practice and training amended in accordance with findings

Complication of surgery – 6 cases

- Excellent practice, leadership and MDT engagement identified in relation to investigation into complex processes, resulting in effective preventative measures being put in place
- Clear escalation & out of hours processes agreed to ensure prompt clinical assessment and communication with microbiology in urgent cases
- Strengthened communication and collaborative working between surgical specialty teams to support clinical decision making for patients at higher risk of complication
- Consent requirements re-enforced to ensure reconfirmation takes place on day of surgery as appropriate
- Pre-op and WHO checklist processes for bilateral surgery reviewed and roles and responsibilities clarified to ensure all theatre team are aware of surgical plan

Fall from bed/trolley – 2 cases

- Enhanced education provided to staff and information displayed in wards in relation to falls awareness and prevention
- ED admission safety assessment tool updated to include falls risk assessment, with work underway with digital team to launch electronic version

Medication related incidents – 4 cases

- E-Record functionality and e-prescribing training improved, highlighting a new default view of medication list to reduce risk of prescribing errors
- Trust-wide work overseen by Trust Medication Safety Group, to support prescribers managing patients at risk of harmful drug interaction

Lost to follow-up – 4 cases

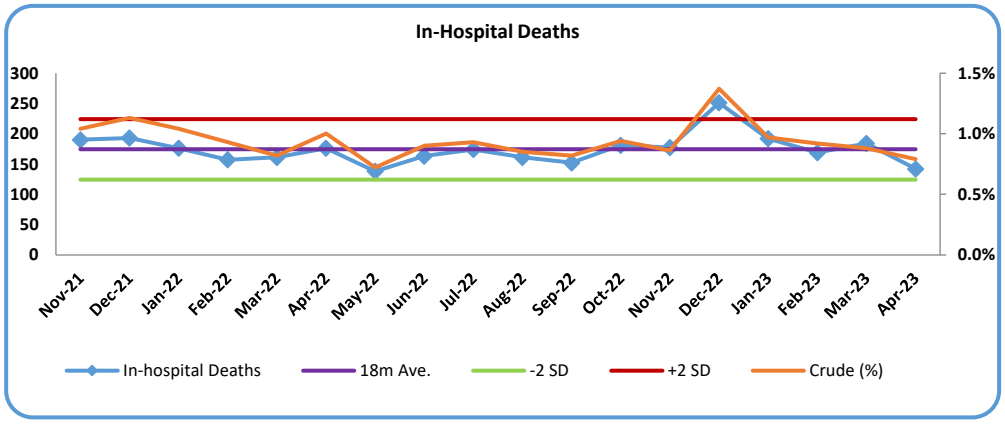
- Strengthen communication processes, including implementation of electronic referral systems, to ensure patients are provided with appointments and followed up appropriately
- Strengthened, centralised, appointment booking system now established, whereby specialty teams are notified of cancellations and processes audited

Safeguarding related incident – 1 case

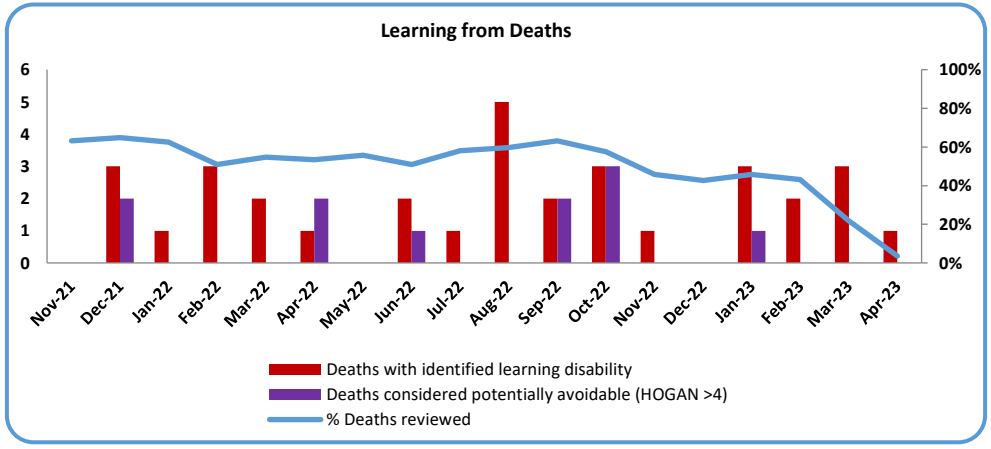
- Review of policies, procedures and training underway as part of the Trust 'Care for me, with me' workstream, to inform best practice when caring for vulnerable patients

Quality: Mortality Indicators 1/2

In-hospital Deaths: In total there were 142 deaths reported in April 2023, which is lower than the amount reported 12 months previously (n=176). The crude death rate is 0.79%. Nationally the deaths were high in December 2022, with influenza reported to be the main cause of death

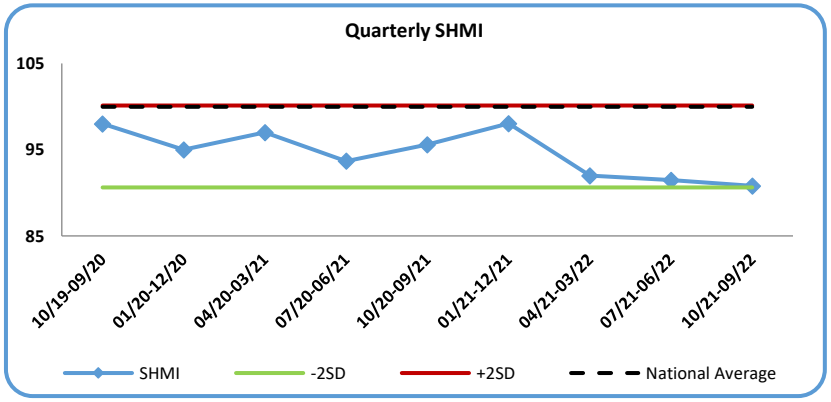


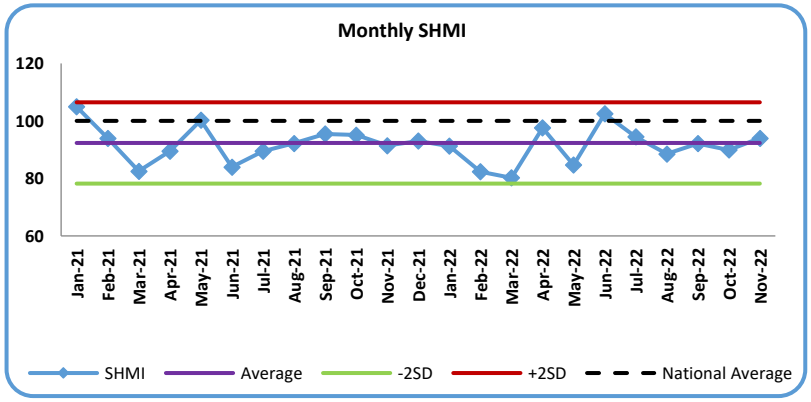
Learning from Deaths: Out of the 142 deaths reported in April 2023, five patients have, to date, received a level 2 mortality review. However, these figures will continue to rise due to ongoing M&M meetings held over the forthcoming months. All figures will continue to be monitored and modified accordingly.



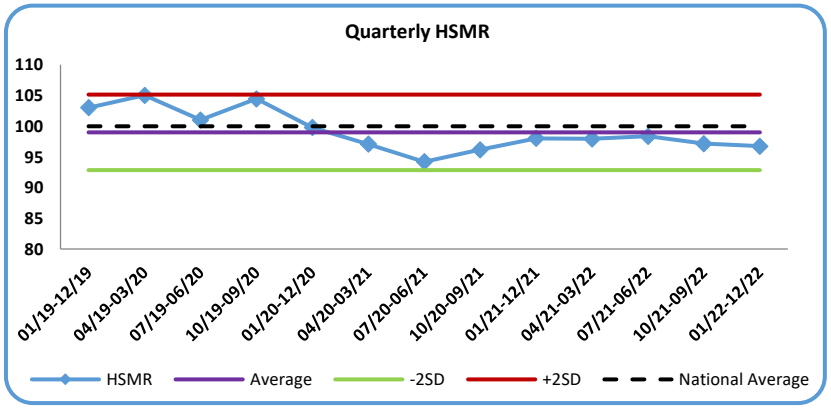
Quality: Mortality Indicators 2/2

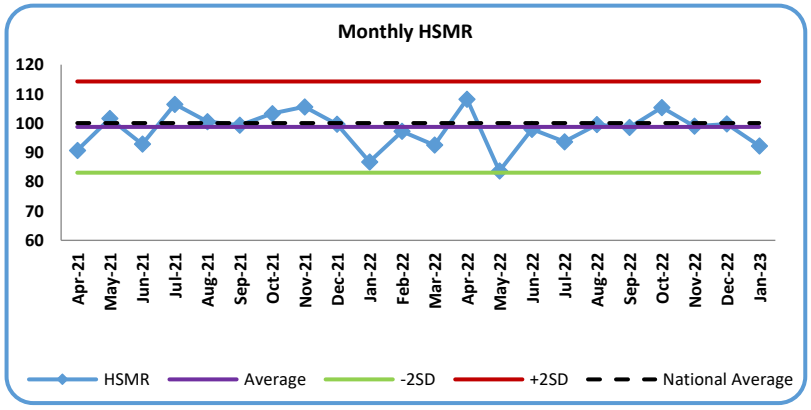
SHMI: The most recent published SHMI quarterly data from NHS Digital shows the Trust has scored 92 from months January 2022 – December 2022. This is below the national average and is within the "as expected" category. Monthly SHMI is published up to November 2022 and shows the Trust to be below the national average and within the “as expected” category. COVID-19 data continues to be excluded from SHMI data published from NHS Digital.



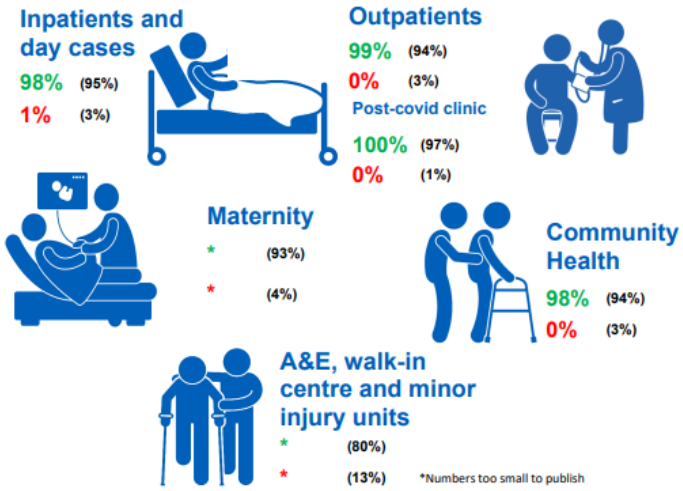


HSMR: The HSMR data shows a 12 month rolling HSMR score by quarter as well as monthly data. HSMR data is published up to December 2022 for quarterly data and January 23 for monthly data, and is showing just below the national average. However, this number may rise or fall as the percentage of discharge coding increases. All figures will continue to be monitored and modified accordingly. Unlike SHMI data, HSMR data does not include deaths within 30 days of discharge.





Quality: FFT and Complaints



Friends and Family Test

The published data to date shows that there were 1,220 responses to the Friends and Family test from the Trust in February 2023 (published April 2023) compared to 1,240 in the previous month.

The following infographic shows the proportion of responses that reflect a positive or negative experience from the feedback provided by our patients. The national average results are shown in brackets.

All data is available at: www.england.nhs.uk/fft/friends-and-family-test-data/

*numbers too small to publish

Trust Complaints 2023-24

The Trust has opened a total of 31 (29 with identified patient activity) formal complaints in April 2023.

The Trust has opened an average of 31 new formal complaints per month, which is 2 less than the average complaints for the last full financial year 2022-23.

Taking into consideration the number of patients seen and areas with patient contact, the highest percentages of patients complaining to date are within Medicine (ED) with 0.05% (5 per 10,000 contacts). The lowest complaint percentages are with Perioperative Care and Cancer Services who are yet to receive a complaint.

	2023-24				
Directorates	Complaints	Activity	Patient % Complaints	Ratio (YTD)	22-23 Ratio (Full Year)
Cardiothoracic	2	7,572.00	0.026%	1:3786	1:3974
Children's Services	1	5,418.00	0.018%	1:5418	1:2137
Community Services	1	5,880.00	0.017%	1:5880	1:7837
Dental	1	6,543.00	0.015%	1:6543	1:15521
Medicine	3	10,062.00	0.030%	1:3354	1:2780
Medicine (ED)	7	14,108.00	0.050%	1:2015	1:5184
ENT, Plastics, Ophthalmology & Dermatolog	6	28,378.00	0.021%	1:4730	1:8802
Musculoskeletal	1	7,241.00	0.014%	1:7241	1:3883
Cancer Services & Clinical Haematology	0	11,588.00	0.000%	1:0	1:8154
Neurosciences	1	7,848.00	0.013%	1:7848	1:3280
Patient Services	2	3,290.00	0.061%	1:1645	1:544
Peri-operative & Critical Care	0	2,752.00	0.000%	1:0	1:3167
Surgery	1	4,675.00	0.021%	1:4675	1:1845
Urology & Renal	1	4,994.00	0.020%	1:4994	1:2926
Women's Services	2	10,967.00	0.018%	1:5484	1:3304
Trust (with activity)	29	131,316.00	0.022%	1:4528	1:3759

"Communication" is the highest primary subject area of complaints at 26% of all the subjects Trust wide.

Quality: Health and Safety

Overview

There are currently 1,131 health and safety incidents recorded on the Datix system from the 1 May 2022 to 30 April 2023. This represents an overall rate of 72 per 1,000 staff. The Clinical Boards with the highest number of health and safety incidents over this period are Clinical Board 8 (155), Clinical Board 3 (150) and Clinical Board 1 (143).

Incidents of Violence & Aggression to Staff

In addition to the incidents above, there are 1,012 incidents of physical and verbal aggression against staff by patients, visitors or relatives recorded on the Datix system from 1 May 2022 to 30 April 2023. This represents an overall rate of 65 per 1,000 staff during this period. 406 of these incidents involved physical assaults on staff. The Trust Violence Reduction Group meets every quarter. A number of initiatives to reduce these incidents are already underway, for example:

- The Trust Violence Reduction Strategy has been developed and will be ratified at May's Health and Safety Committee
- Further improvements to the overall compliance of the National Violence Reduction Standards
- Violence data dashboards have been further developed to provide improved analysis
- Introduction of ED Navigators in Spring 2023

Sharps Incidents

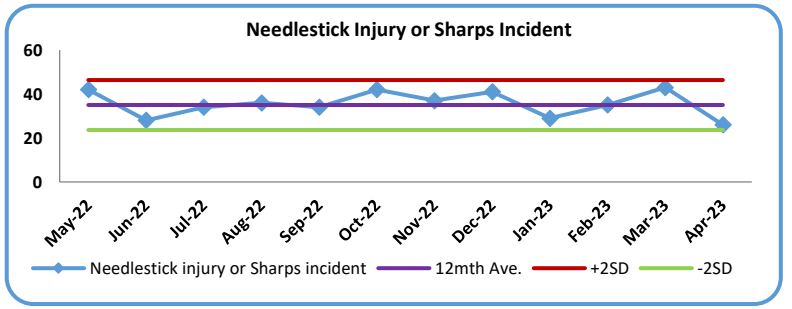
There have been 427 incidents during 1 May 2022 to 30 April 2023 (average 36 incident per month, 79% of these involve used needles) a slight reduction in comparison to previous months, which have been higher than usual. The recent sustained increase aligns with a number of factors, which are currently being discussed at the Trust Safer Sharps User Group. These include increased activity and acuity, supply issues meaning staff are using alternative devices and clinical educator vacancies. Further work is underway to expand the Datix Cloud IQ system to incorporate greater detail and the ability to analyse sharps incidents further in addition to producing an online education package for staff.

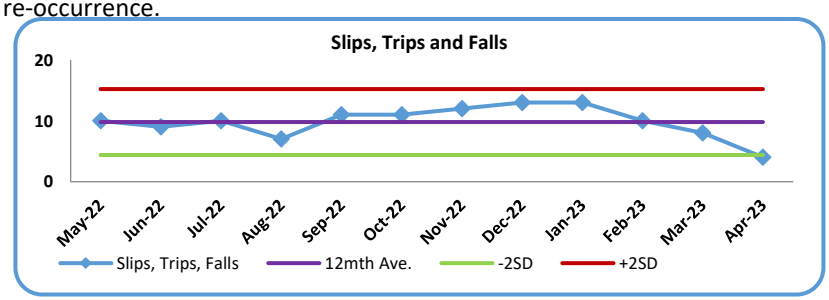
Slips, Trips and Falls

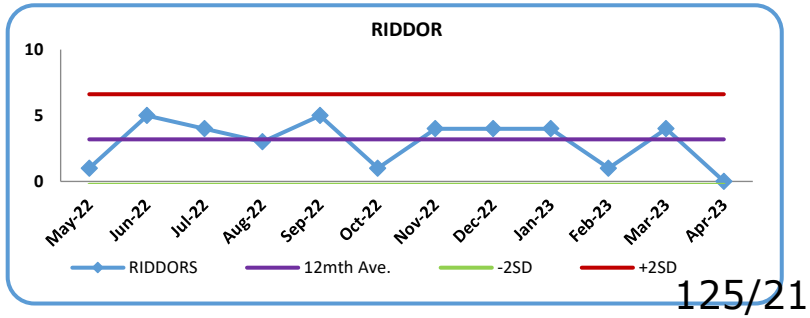
118 incidents were reported between 1 May 2022 to 30 April 2023. 60% of these incidents were related to trips and slips. Regular zonal inspections take place every month and data analysis is acted upon, feeding into the Slips, Trips and Falls Group, which currently meets quarterly. For example, issues were raised following incidents within Catering at Freeman and following this, further work has been identified around housekeeping and control of contractors. Generally the trend for this type of incident is reducing and with no thematic findings.

RIDDOR

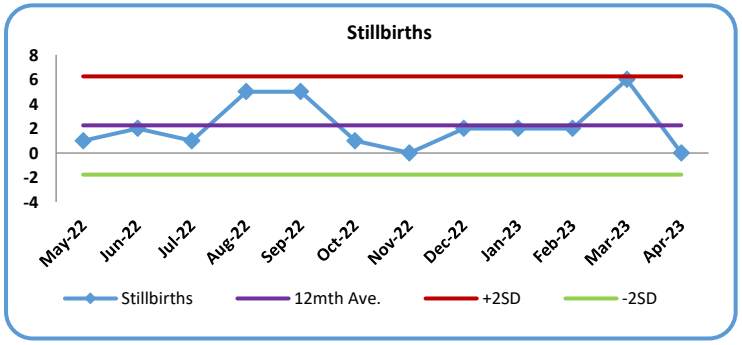
There have been 32 RIDDOR incidents reported between 1 May 2022 to 30 April 2023. The most common reasons of reporting accidents and incidents to the HSE are; Moving and Handling (11), Slips, Trips and falls (7), Accidents involving staff, visitors etc. (6) and Aggression & Violence (6). All RIDDOR reportable incidents are investigated fully and, where necessary, remedial actions are undertaken to prevent re-occurrence.





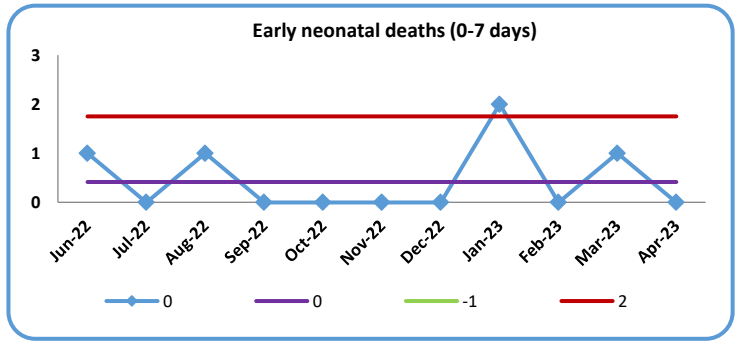


Quality: Maternity (1/3)

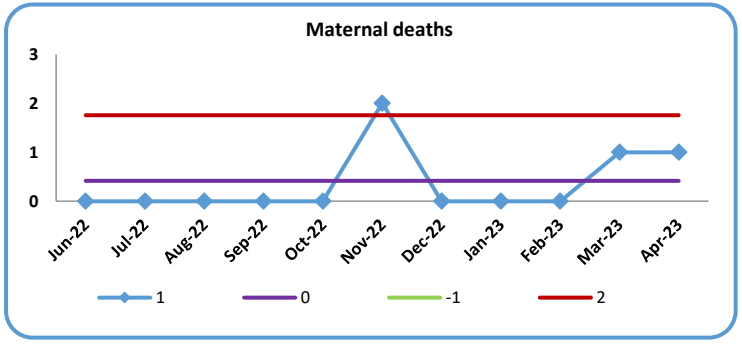


Perinatal deaths
All Perinatal deaths (Stillbirths and Neonatal Deaths) are reported to MBRRACE-UK who produce an annual National report which includes our local data.

Stillbirths
As NuTH is a tertiary referral Fetal Medicine Unit, complex cases are often referred to the Trust from other units within the region, with women opting to deliver here rather than return to their local unit. This data includes termination for fetal anomalies > 24 weeks gestation. All cases undergo an initial local review and then a more detailed multidisciplinary team review including external input. Findings and actions required as a result of reviewing each case are then shared with the family involved.

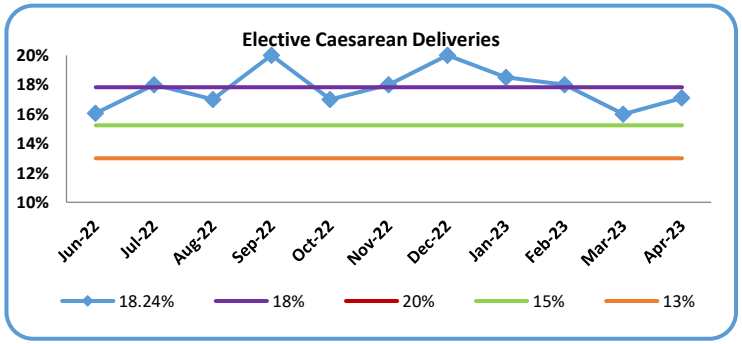


Early Neonatal Deaths
These figures are for term infants (born between 37 and 41 weeks) who delivered at the Trust but sadly died within the first week of life. These deaths are reported to the Child Death Review panel who will have oversight of the investigation and review process. These cases are also reported to HSIB and the Coroner. A post mortem examination may be requested to try and identify the cause of death.



Maternal Deaths
Maternal deaths are reported to MBRRACE-UK and a national report is provided annually. They are also reported to HSIB if the woman died during pregnancy or before 42 days postpartum. An investigation is dependant on certain criteria. Maternal deaths can be categorised as Direct or Indirect. It is rare to have a direct Maternal death in Newcastle. In May 2022 there was one direct maternal death. Sadly there have been 4 more deaths reported since then but these have all been indirect deaths. One of these deaths has been accepted by HSIB and is under investigation.

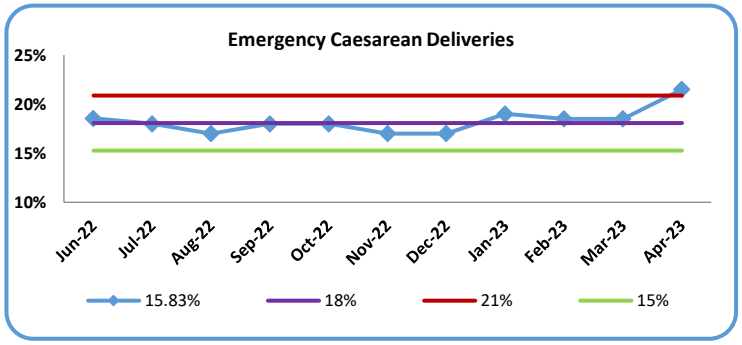
Quality: Maternity (2/3)



Elective Caesarean section

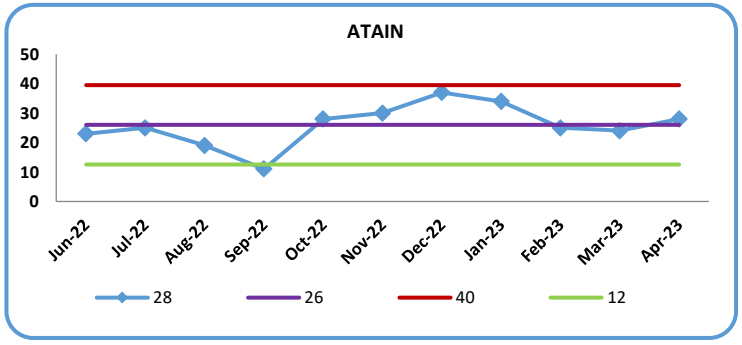
Maternity at the Trust is an outlier for elective Caesarean section compared to other UK Trusts. However, the rates are comparable to that of other tertiary centres in the UK.

The service also has at its heart a shared decision making philosophy and offers informed, non-directive counselling for women over mode of delivery. There is an obstetrician/midwifery specialised clinic to facilitate this counselling and patient choice.



Emergency Caesarean section

The emergency Caesarean section rate is comparable to other Trusts. Maternity is a consultant led service with 98-hour dedicated consultant sessions for Delivery Suite (8am-10pm daily), twice daily consultant ward rounds and consultant obstetricians being involved with all decisions for emergency Caesarean section.



ATAIN

All unplanned admissions of term babies (37 – 41 weeks) into the neonatal unit are reviewed at a weekly multi-disciplinary meeting and a quarterly report is produced and shared. Some of these cases will be reviewed in more detail if they have been identified as a Serious Incident. In quarter 3 (Oct-Dec) there was an increase in the number of term admissions and these have all been reviewed. Admissions in March and April have reduced. Work is ongoing to identify learning and improvement to reduce avoidable term admissions.

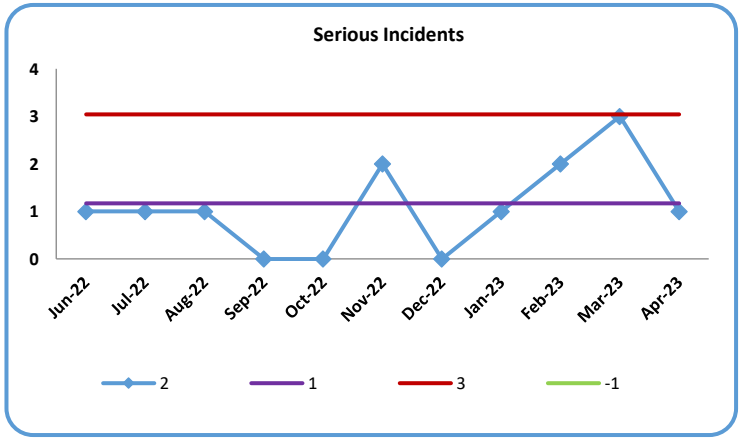
Quality: Maternity (3/3)

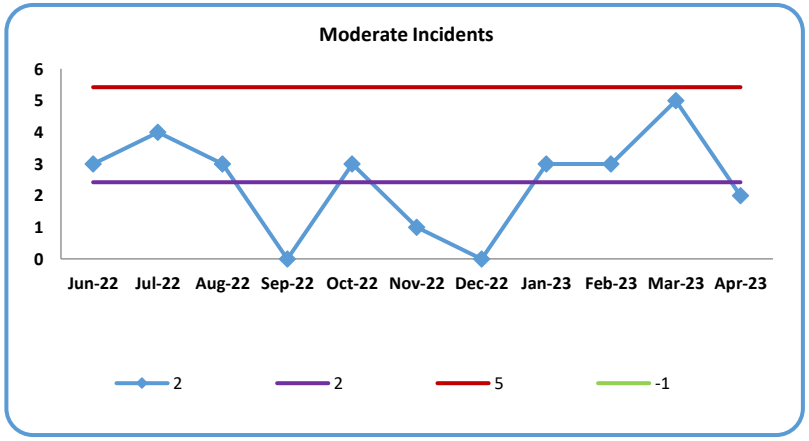
Serious Incidents

There have been 14 incidents escalated as SI's within the last 12 months. These include cases of potential or confirmed Hypoxic Ischaemic Encephalopathy (HIE), neonatal death, maternal bowel injury, intrapartum stillbirth, antepartum intrauterine death and maternal death. The HIE, Intrapartum Stillbirths, Neonatal deaths and Maternal deaths were all reported to HSIB (Healthcare Safety Investigation Branch) for external review. Lesson learnt from Serious Incidents in Maternity are highlighted on page 11.

Moderate incidents

There were two moderate incidents reported in Maternity this month. All incidents are carefully reviewed by the Maternity Governance team and are graded appropriately after completion of a rapid review (48hr report). In the past 12 months the majority of the moderate graded incidents were babies that needed to receive 'therapeutic hypothermia' in order to minimise the risk of a brain injury. Although graded moderate these babies may have no long term injury but they require a two year follow up in order to assess their neurological status. Moderate incidents will be investigated as a Serious Learning Event and involve parental input to the investigation and follow up with a Consultant and Senior Midwife 6-8 weeks after the incident.





Quality: Audit 1/2

Audit / NCEPOD	Date of Report	Areas of Good Practice	Areas for improvement	Action Plan Developed
National Bowel Cancer Audit	12 January 2023	• 94% of patients had complete pre-treatment staging (national average 86%) • 99% of patients had their performance status recorded (national average 88%) • 95% data completeness for patients having major surgery (national average 87%) • 89% of patients seen by clinical nurse specialist (national average 85%) • 100% of colon cancer patients had the number of lymph node involvement recorded (national average 94%) • 100% of patients undergoing surgery had their margin status recorded (national average 89%) • Risk adjusted length of stay >5 days: 69% (national average 56%) • Observed 90-day mortality: 2.7% (national average 2.9%) • Adjusted 90-day mortality: 2.6% (national average 2.9%) • Observed 2-year mortality rate: 14.4% (national average 17.7%) • Adjusted 2-year mortality rate: 13.8% (national average 17.7%) • Observed Cancer Specific 2-year mortality rate: 11.6% (national average 14.3%) • Adjusted Cancer Specific 2-year mortality rate: 11.2% (national average 14.3%)	• 30-day unplanned return to theatre: 10.8% (national average 7.6%) • Administration of adjuvant chemotherapy following major resection for stage III cancer: 37% (national average 60%)	Discussed at March 2023 Clinical Audit and Guidelines Group
UK Parkinson's Audit	1 February 2023	• National data available only, therefore no recommendations or Trust level data published.		Discussed at April 2023 Clinical Audit and Guidelines Group

Quality: Audit 2/2

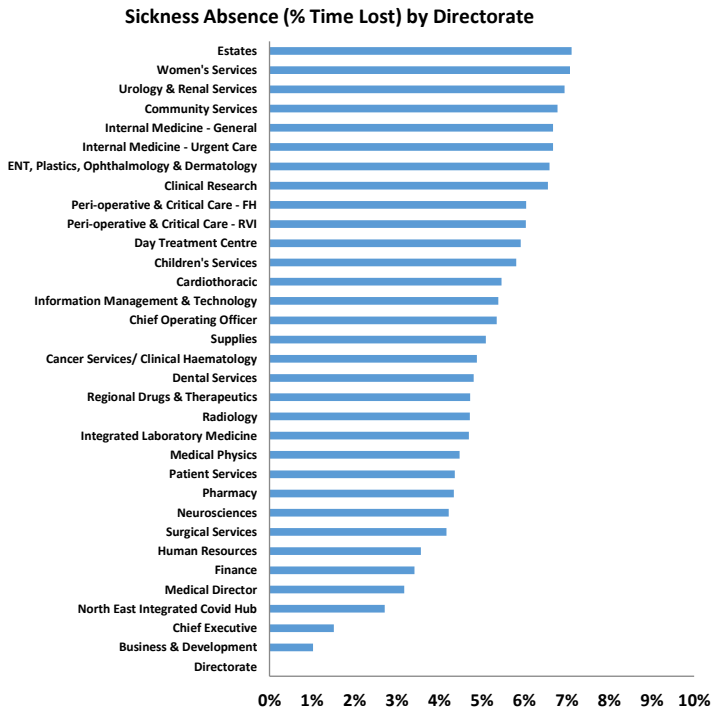
Audit / NCEPOD	Date of Report	Areas of Good Practice	Areas for improvement	Action Plan Developed
National Oesophago-Gastric Cancer Audit	9 December 2021 & 12 January 2023	• 100% of first diagnosis confirmed by second pathologist (national average 88.7%) • 100% of High Grade Granular Dysplasia plans discussed at MDT (national average 91.9%) • First treatment surveillance rate: 22.7% (national average 11.9%) • 99% of patients had staging CT scan recorded (national average 85.9%) • 63.4% of patients had a plan for non-curative treatment (national average 60.6%) • 48.5% of patients with non-curative plans had chemotherapy or radiotherapy (national average 42.8%) • Length of Stay: 10 days (national average 11 days) • 99% of operations examined 15 or more lymph nodes (national average 87.9%) • 30-day postoperatively mortality: 0.8% (national average 1.6%) • 90-day postoperative mortality: 2% (national average 3.2%)	• Re-examine pathways in relation to stage 4 cancer for earlier diagnostic opportunity and discussion at MDT. • Review patients diagnosed after emergency admission and undertake root cause analysis where appropriate to identify opportunities to reduce rates of emergency diagnosis.	Discussed at April 2023 Clinical Audit and Guidelines Group

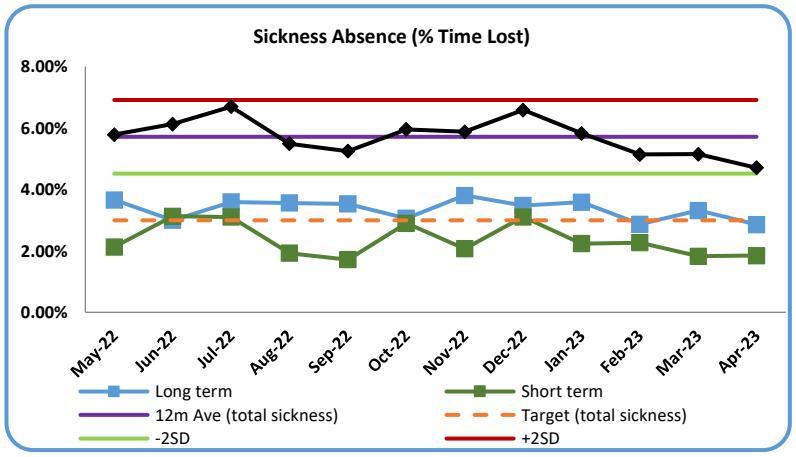
People: Sickness Absence 1/2

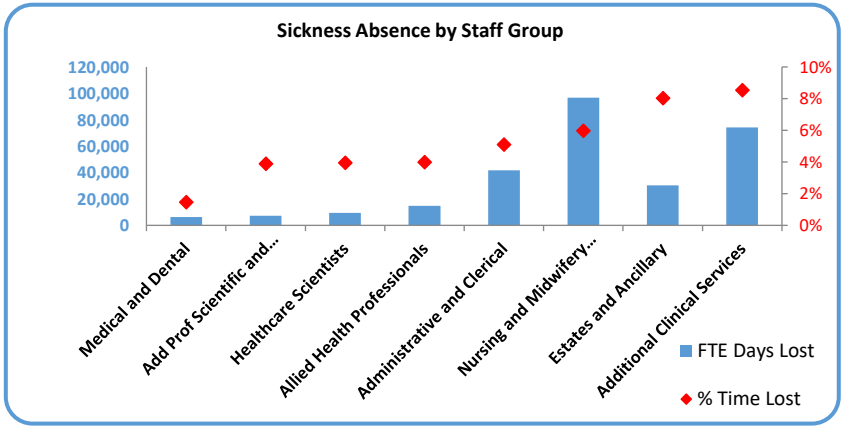
- Year to year comparison for sickness absence (including COVID-19 related sickness (rolling 12 months):

	Apr-22	Apr-23	
Long-term	3.90%	3.36%	↓
Short-term	2.44%	2.36%	↓
Total	6.34%	5.72%	↓

- 281,911 FTE working days were lost due to sickness (including COVID-19 related sickness) in the year to April 2023, compared to 323,724 for the previous year.
- Overall sickness absence (including COVID-19 related sickness) is 5.72%, which is down from end of Dec 2022 position of 6.45% (% FTE Time Lost).
- The top three reasons for non-COVID related sickness absence are Anxiety/stress/depression/other psychiatric illnesses (25%), Other Musculoskeletal (11%), and Cold, Cough, Flu (9%).
- The top reason for "Other" absences is Maternity Leave (50% of total absence.
- Nursing and Midwifery have the highest number of Maternity Leave at 3.78% (%FTE Lost).



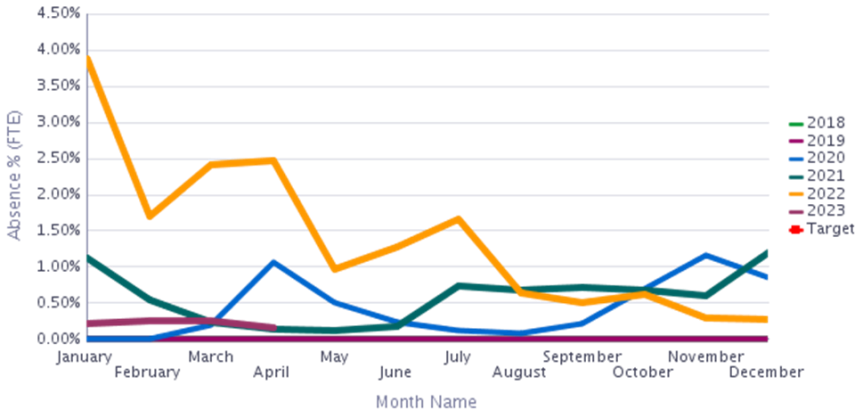




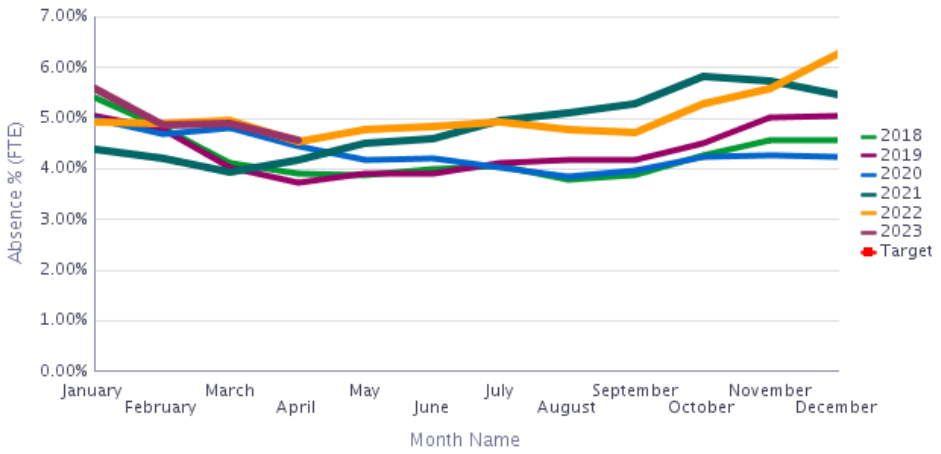
*COO Directorate includes Outpatients / ABC Service

People: Sickness Absence 2/2

COVID-19 Related Sickness January 2018 – April 2023 (%FTE)

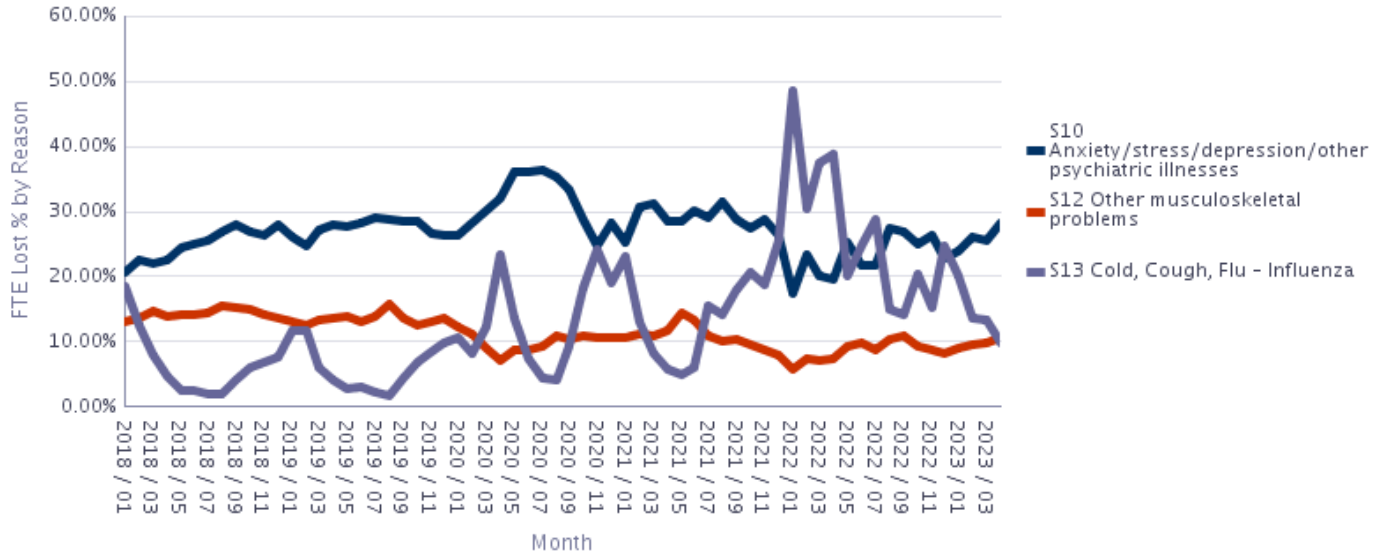


Non-COVID-19 Related Sickness January 2018 – April 2023 (%FTE)

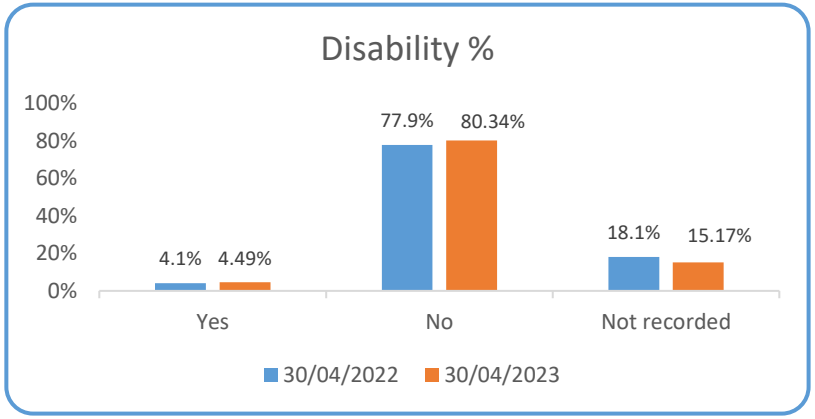


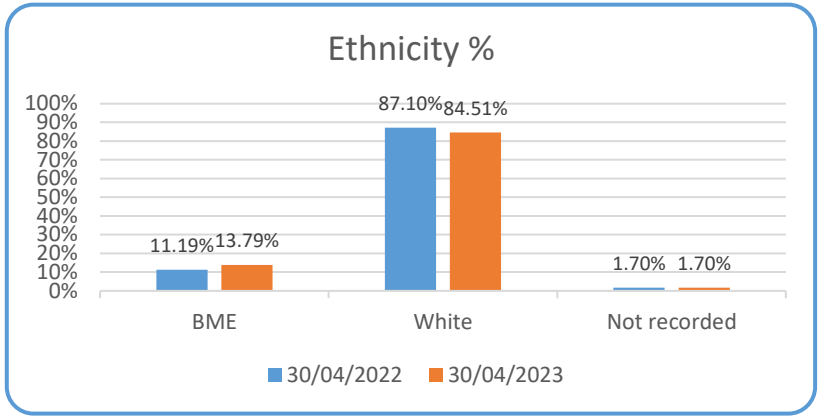
Top 3 Sickness Reasons January 2018 - February 2023 (%FTE)

S13 includes Covid sickness

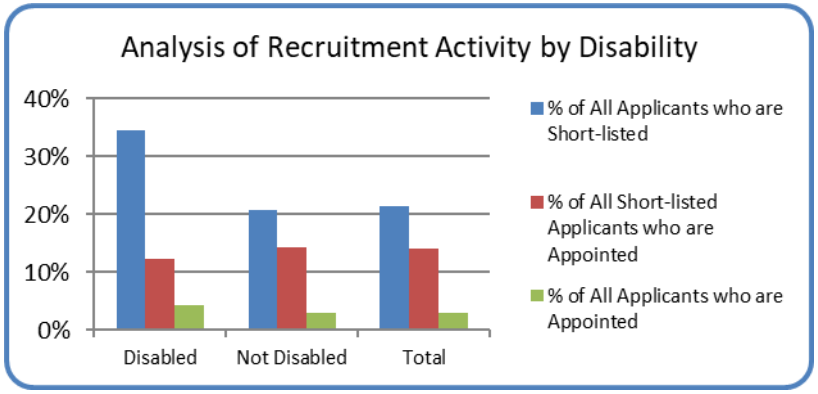


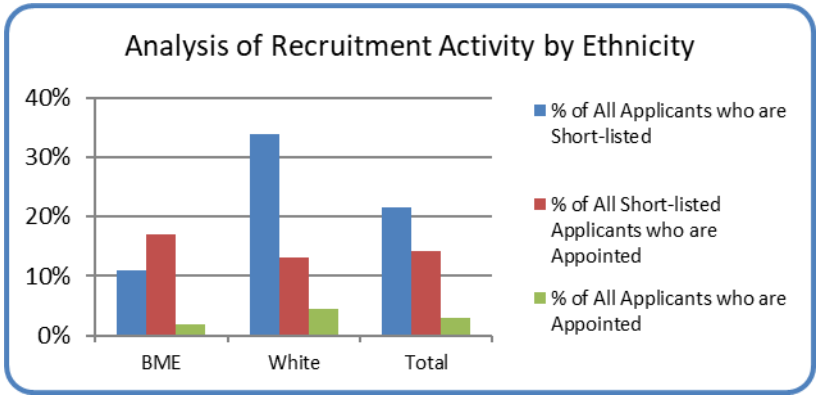
People: Equality and Diversity





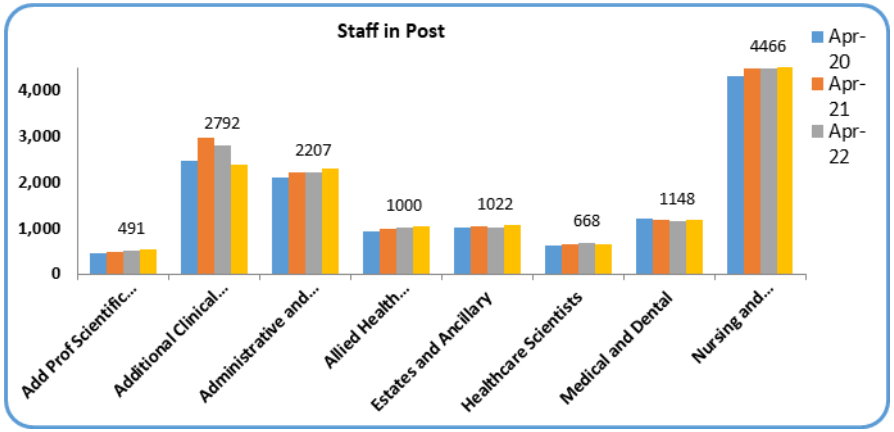
- The graphs above identify, by disability and ethnicity, the recruitment outcome of applicants during the twelve months ending April 2023.

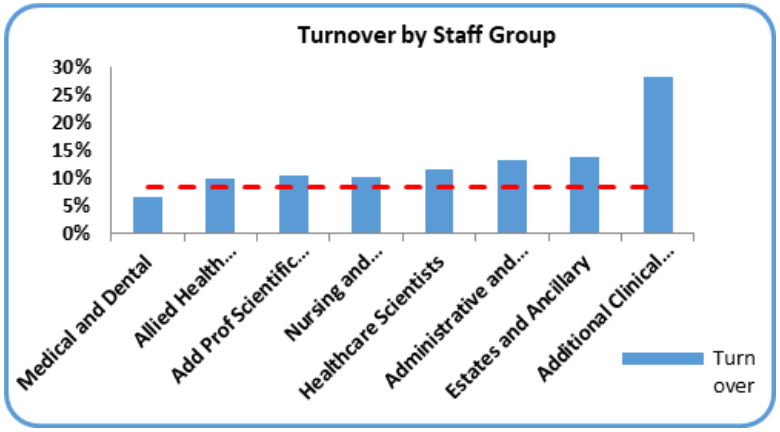


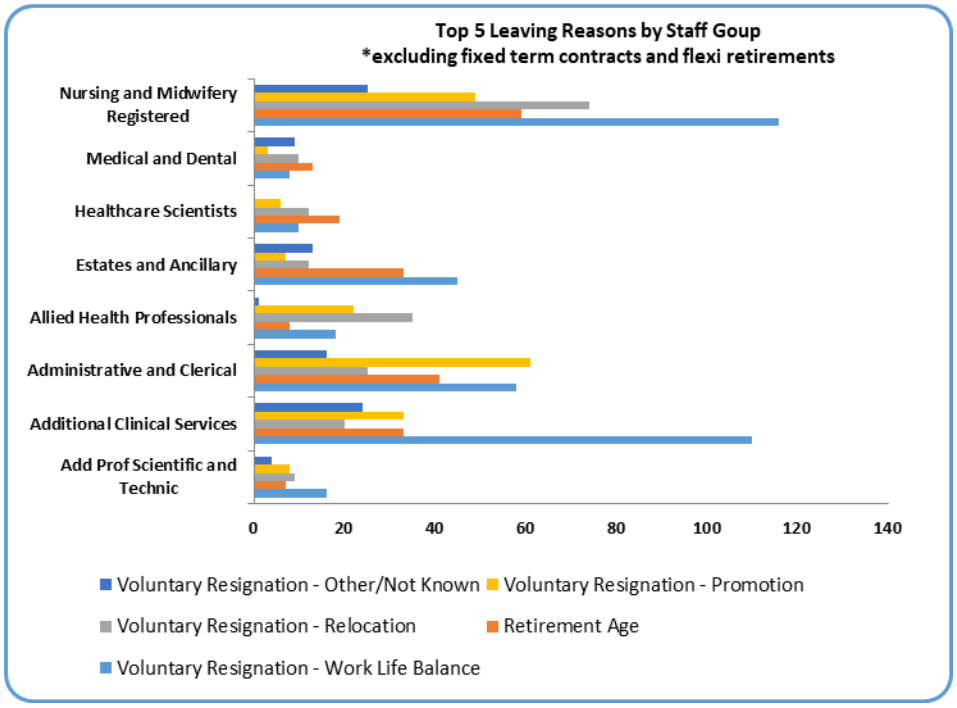


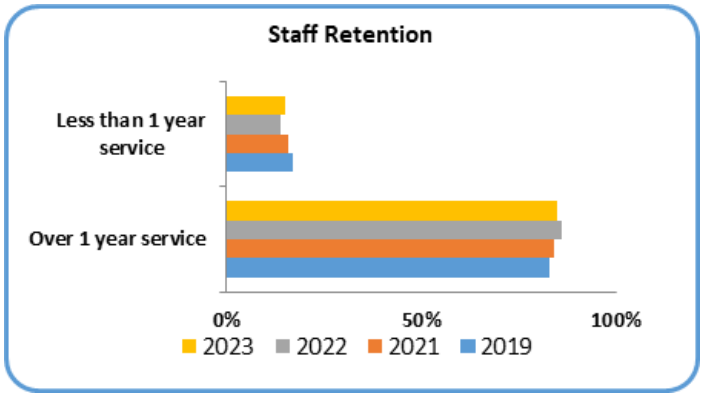
- The graphs above identify, by headcount, the percentage of staff in post in April 2022 and April 2023 by disability and ethnicity. The percentage of staff employed disclosing a disability has increased from 4.07% to 4.49% and the percentage of BAME staff has increased from 11.19% to 13.79%.

People: Workforce 1/3









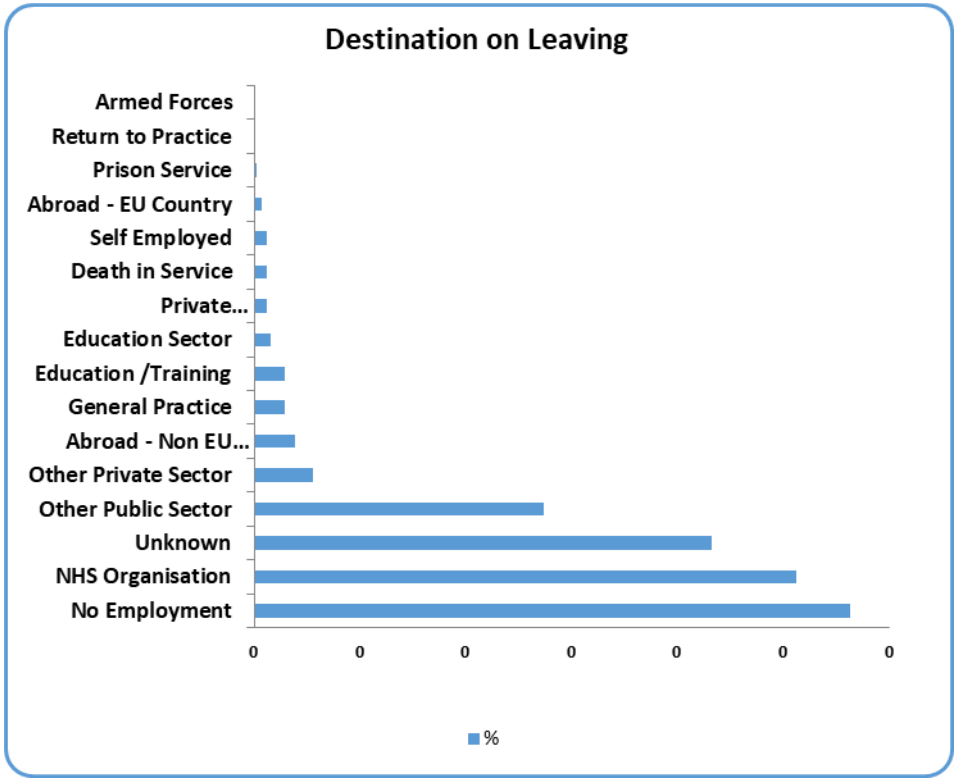
- Staff in post has increased by 4.72% since April 2020. The staff groups with the largest increase are Additional Scientific and Allied Health Professionals.
- Staff turnover has increased from 11% in February 2022 to 14.29% in April 2023, against a target of 8.5%.
- The total number of leavers in the period March 2022 to February 2023 was 2,237.
- Retention for staff over 1 year service is 85%, an decrease from 86.04% in April 2022.

People: Workforce 2/3

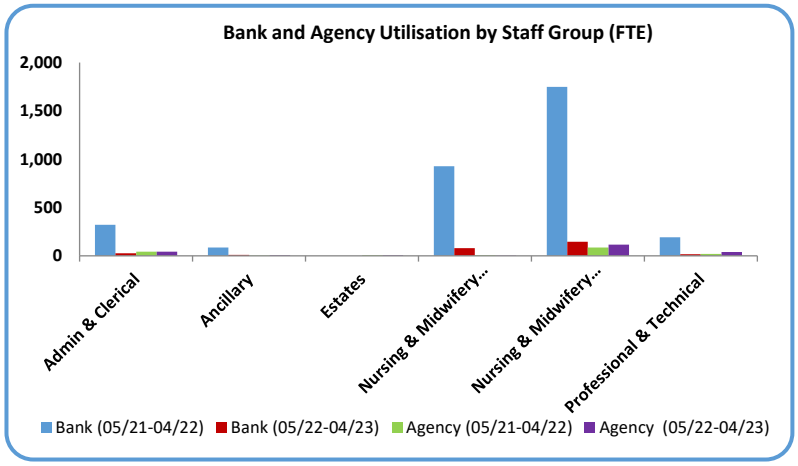
Turnover by Directorate

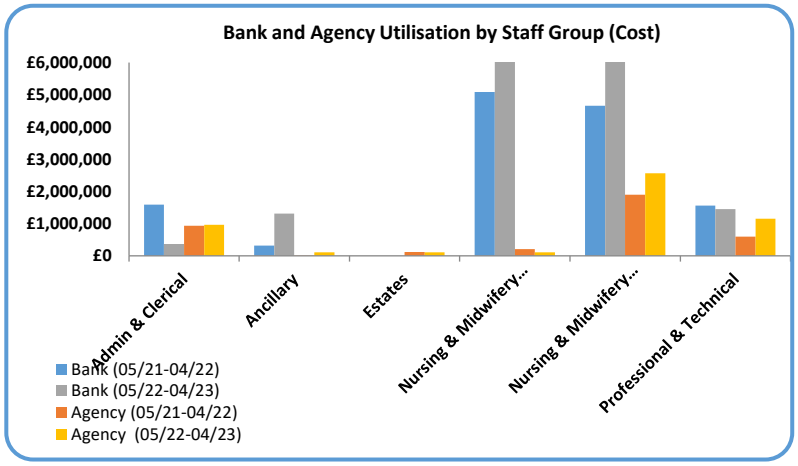
Directorate	Turnover
Day Treatment Centre	0.00%
Medical Director	4.72%
Regional Drugs & Therapeutics	5.48%
Urology & Renal Services	7.17%
Peri-operative & Critical Care - FH	7.37%
Neurosciences	8.70%
Surgical Services	8.85%
Musculoskeletal Services	8.96%
ENT, Plastics, Ophthalmology & Dermatology	8.97%
Internal Medicine - Urgent Care	9.12%
Clinical Research	9.28%
Business & Development	9.84%
Internal Medicine - General	9.93%
Medical Physics	10.04%
Dental Services	10.17%
Cancer Services/ Clinical Haematology	10.21%
Radiology	10.29%
Children's Services	10.51%
Peri-operative & Critical Care - RVI	10.53%
Cardiothoracic	10.64%
Integrated Laboratory Medicine	10.78%
Pharmacy	11.58%
Women's Services	11.85%
Chief Executive	12.08%
Community Services	12.99%
Chief Operating Officer	13.11%
Patient Services	13.29%
Information Management & Technology	14.72%
Estates	15.82%
Finance	18.58%
Human Resources	19.31%
Supplies	24.69%
Trust Total	**14.29%**

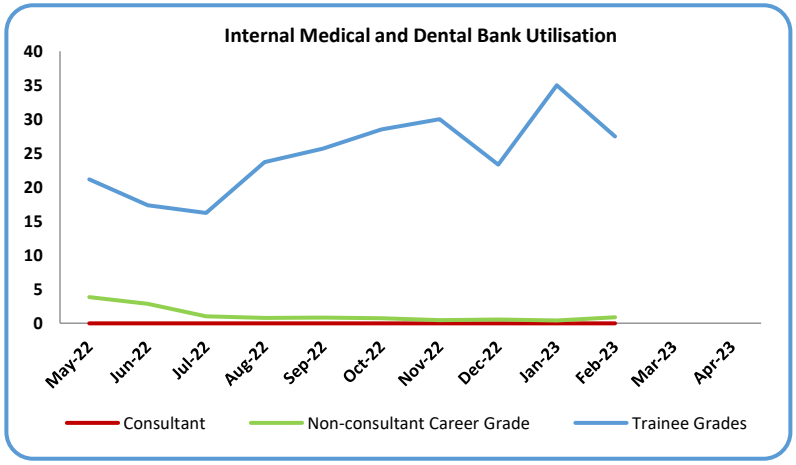
- Only 26% of leavers across the Trust disclosed they were going to another NHS organisation.



People: Workforce 3/3

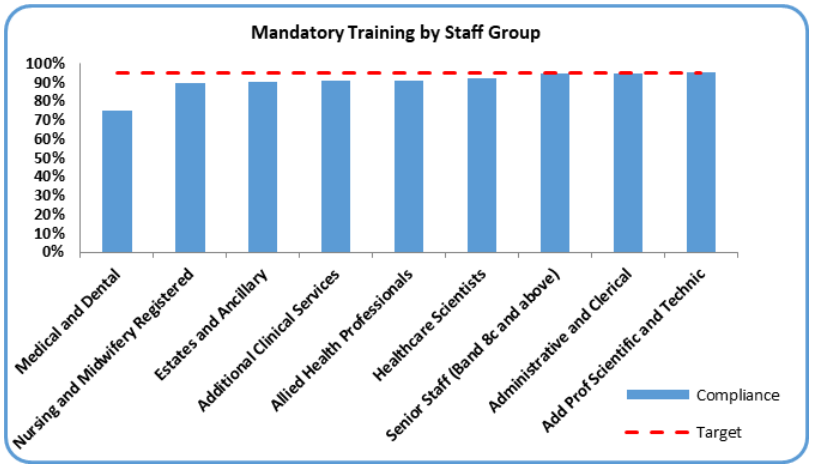


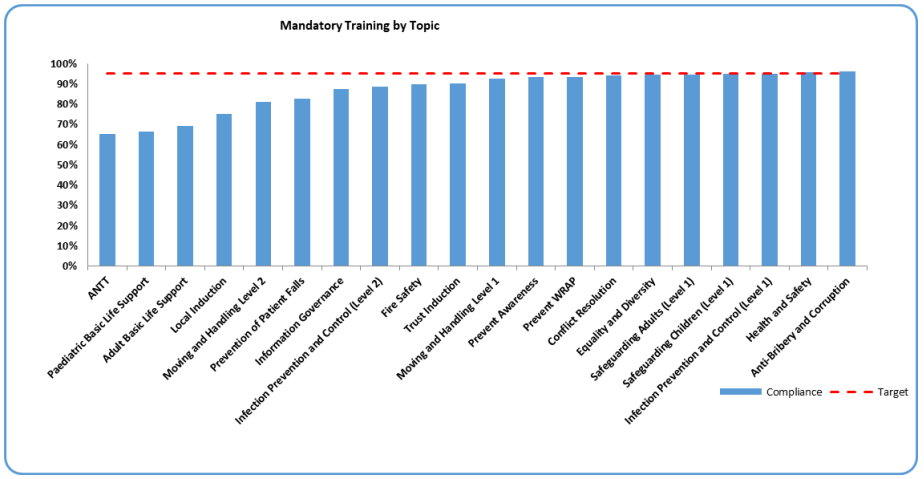


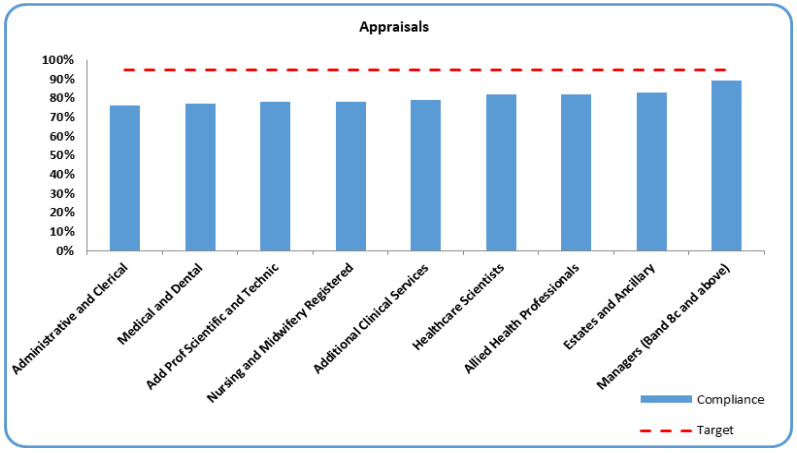


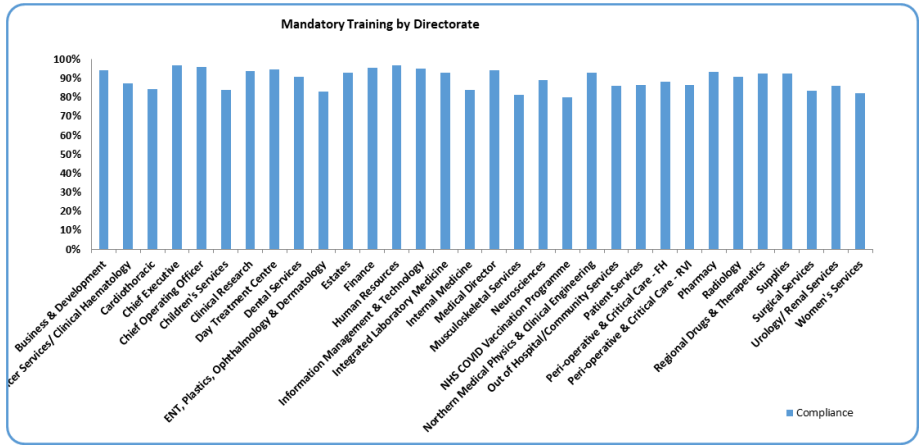
Comparing the periods May 2021 – April 2022 to May 2022 – April 2023, overall bank utilisation decreased from 277 wte to 272 wte and agency utilisation has increased from 155 wte to 209 wte.

People: Delivering Excellence in Education & Training









- Mandatory training compliance stands at 89.95% at end of April 2023, against an end of year target of 95%. The April 2022 position was 87.5%.
- Medical and Dental are the staff group with the lowest training compliance at 75.1% in April 2023 compared to 69.6% in April 2022.
- Appraisal compliance stands at 79.05%, at end of April 2023, against an end of year target of 95%. The April 2022 position was 72%. Interventions are in hand to improve this position.

Finance: Overall Financial Position

This page summarises the financial position of the Trust for the period ending 30 April 2023.

The Trust has agreed a Financial Plan for 2023-24 with a break-even position.

The Plan relies upon recurrent (£33 million) and non-recurrent (£24 million) of Cost Improvements Programmes (CIP), ERF funding, non-recurrent support from the ICP, and some non-recurrent benefit from the balance sheet. The Plan has been converted into an income Plan and operational budgets issued to Clinical Boards, along with their CIP targets. That allows the Trust to set up the standard monthly reporting structure that forms the basis of the monthly reporting. This report covers Month 1 - clearly, as this is just the first month there is little movement from budget.

In the period to 30 April the Trust incurred expenditure of £119.5 million, and received/accrued income of £111.9 million, leaving a deficit in line with the Plan of £7.6 million. There are a number of risks that will be monitored and managed throughout the course of the year.

It should be noted that all financial risk ratings are not being reported here, although the Trust has been included in NHS Provider Segmentation of 1 on the Use of Resources metrics (Oversight Framework). This means there are no specific support needs.

The Capital Programme is yet to be agreed.

	Month 1 Budget £'000	Month 1 Actual £'000	Month 1 Variance £'000
Income	111,161	111,857	696
Expenditure	118,757	119,453	695
I & E position (excl impairment) - (Deficit)/Surplus	(7,596)	(7,596)	0
Capital Programme - Not included	0	0	0

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 May 2023						
Title	Committee Annual Reports, including 2023/24 Schedules of Business and updated Terms of Reference						
Report of	Kelly Jupp, Trust Secretary						
Prepared by	Kelly Jupp, Trust Secretary Lauren Thompson, Corporate Governance Manager / Deputy Trust Secretary						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☒	☐	☐				
Summary	The purpose of this report is to provide assurance to the Trust Board that the Audit, Finance, Quality and People Committees have met their key responsibilities for 2022/23, in line with their Terms of Reference. The Committee Annual Reports outline overall achievements throughout the year and action points for continuing development during the coming year. The Annual Reports have been considered at the relevant Committee meetings. The Committee Terms of Reference (ToR) and 2023/24 Schedules of Business have been discussed at each respective Committee meetings. Minor changes have been made to the ToRs to update role titles and to reflect in guidance and regulations. The Charity Committee Annual Report, Terms of Reference and Schedule of Business will be submitted to the Trust Board in September 2023.						
Recommendation	The Trust Board is asked to: i) Approve the Committee Annual Reports, outlining 2022/23 work undertaken and note the key areas to revisit during 2023/24; and ii) Approve the updated Terms of Reference and 2023/24 Schedules of Business.						
Links to Strategic Objectives	Performance – Being outstanding, now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☒	☐	☒	☒
Link to Board Assurance Framework [BAF]	Risk 4050 - CQC 'Well Led' – potential impact on 'outstanding' rating for NHS Trusts.						

Reports previously considered by	Annual review.

AUDIT COMMITTEE ANNUAL REPORT 2022-2023

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Audit Committee has met its key responsibilities for 2022-23, in line with its terms of reference and the requirements of the Audit Committee Handbook.

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

2. AUDIT COMMITTEE RESPONSIBILITIES

The key purpose of the Audit Committee is to provide the Board with:

- an independent and objective review of financial and organisational controls, the system of integrated governance and risk management systems and practice across the whole of the organisation's activities (both clinical and non-clinical);
- assurance of value for money;
- compliance with relevant and applicable law;
- compliance with all applicable guidance, regulation, codes of conduct and good practice; and
- advice as to the position of the Trust as a "going concern."

It does this through receipt of assurances from auditors, management and other sources.

3. AUDIT COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board from the Non-Executive Directors of the Trust and consists of five members with a quorum being two members.

Four ordinary meetings and one extraordinary meeting were held between 1 April 2022 and 31 March 2023 and attendance was as follows:

	Attendance at ordinary meetings	Attendance at extraordinary meeting
Mr B MacLeod, Non-Executive Director (Committee Chair from 1 August 2021)	4 of 4	1 of 1
Mr J Jowett, Non-Executive Director	4 of 4	1 of 1
Mr S Morgan, Non-Executive Director*	3 of 4	1 of 1
Mr G Chapman, Non-Executive Director	4 of 4	1 of 1

* Mr Morgan stood down as a Trust Non-Executive Director on 31 January 2023.

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

- External and Internal Audit at all meetings;
- The Trust's Fraud Specialist Manager;
- Management, represented by the Chief Executive Officer, the Finance Director (until her retirement in July 2022 and then the Chief Finance Officer from September 2022), Assistant Chief Executive, the Chief Information Officer and the Chief Operating Officer. The Executive Chief Nurse, Medical Director and Director of Quality and Effectiveness are permitted to attend as required;
- The Trust Secretary and Corporate Governance Manager / Deputy Trust Secretary who also provide Secretariat Support to the Committee;
- The Head of Corporate Risk & Assurance;
- The Clinical Effectiveness Manager; and
- Senior finance and procurement team members.

During 2022/23, the following training sessions were provided to Committee members (and offered to all Board members)

- 20 July 2022 – Newcastle Joint Research Office (NJRO) / Contracting Briefing.

In addition, a further briefing was scheduled at a Board Development session during 2022 on Information Governance (IG)/Cyber Security following discussion at an Audit Committee meeting.

4. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee is required to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities that supports the achievement of the Trust's objectives, internal control and risk management.

The Audit Committee had a Schedule of Business for the year and uses a rolling programme and action log to track committee actions.

The Committee has reviewed:

- Its Terms of Reference and Schedule of Business.
- The Head of Internal Audit opinion (June 2022).
- The Board Assurance Framework (BAF); being the underlying assurance processes that indicate the achievement of corporate objectives and the effectiveness of management of principal risks.
- Risk management arrangements and the BAF Risk Management Annual Report.
- Amendments required to the Scheme of Delegation.
- The response to the External Auditors on:
    - ISA+240: Audit Committee responsibilities for preventing fraud in the Annual Accounts.
    - ISA+250: Audit Committee responsibilities for being satisfied that the Annual Accounts comply with laws and regulations.

- ISA+501: Specific consideration of the potential for, and actual, litigation and claims affecting the financial statements.
- ISA+570: Consideration for the Going Concern Assumption in an audit of financial statements.

Committee members agreed the response for submission to the External Auditors for the year.

The BAF focuses on the key risks against achievement of the strategic objectives. The BAF is a 'live' document which is continuously reviewed and updated by the Corporate Risk & Assurance Department. Each ordinary meeting of the Committee is updated on the BAF and Register.

Each Committee of the Board has a responsibility to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the BAF specific to the Committee purpose and function. Quarterly each Committee of the Board receives a report detailing the:

- Executive Lead review undertaken during the previous 3 month period and any recommendations for risks held on the Board Assurance Framework aligned to that Committee;
- Assurances received and any areas requiring Committee consideration;
- Number of risks held on the BAF, movements in risks and the risks categorised by risk type;
- Risks added/removed to the Executive Oversight Register during the period; and
- Operational risk profile.

The Trust Board's Risk Appetite Statement was presented to the April 2023 Audit Committee meeting for consideration.

During the year, the Trust's Board also received regular updates on Corporate Governance matters.

Updates from the Finance, Quality and People Committee Chairs continues to appear as a standing agenda item on the Audit Committee agenda, with any matters raised for the Committee members' attention by exception.

The BAF internal audit report received a good assurance rating from AuditOne, with no high-risk recommendations included. The Corporate-level risk management audit for 2022/23 is currently at the fieldwork stage.

The Committee is satisfied that the system of risk management in the organisation is adequate in identifying risks and allows the Board of Directors to understand the appropriate management of those risks. The Committee believes there are no areas of significant duplication or omission in the systems of governance (that have come to the Committee's attention) that have not been adequately resolved.

5. INTERNAL AUDIT

The Committee has ensured that there is an effective internal audit function established by management that meets mandatory Internal Audit Standards and provides appropriate independent assurance. The Trust receives its internal audit service from AuditOne.

This was achieved by:

- Reviewing and approving the Internal Audit Plan 2022/2023, including regular updates of performance against the Plan.
- Consideration of the major findings arising from internal audit work and management's responses.
- Receipt of the Internal Audit Annual Report and Head of Internal Audit Opinion.
- Monitoring progress with implementation of agreed audit recommendations.

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

The internal audit plan for 2022/23 was based on a risk assessment approach centred on discussions with senior staff and Directors and was linked to the organisation's assurance framework. Assurances from Internal Audit reports are, where possible, mapped to the BAF clearly in the BAF document itself.

Good progress continued to be made during the year in relation to the completion of historic internal audit recommendations.

There were no limited assurance reports reported to/discussed by the Audit Committee during the year 2022/23.

Five high priority recommendations were identified by Internal Audit and reported during 2022/23, these covered the following internal audits:

- 2021/22 Consultant Job Planning – Reasonable Assurance – one recommendation (reported July 2022).
- 2021/22 IT Starters and Leavers – Reasonable Assurance – one recommendation (reported July 2022).
- 2021/22 ICHNE Coordination and Response (Track and Trace) – Reasonable Assurance – one recommendation (reported October 2022).
- 2021/22 High rated follow up – one recommendation (reported October 2022).
- Pharmacy: Ordering and Receipt (c/f) – Reasonable Assurance – one recommendation (reported January 2023).

Regular updates on the progress in relation to high priority recommendations were received by Committee members during the year from management and internal audit.

Internal Audit performance against Plan was discussed at every Committee meeting during the year, along with updates on the workforce position within AuditOne. Workforce effort during the year was concentrated on completing the core audits required to deliver the internal audit plan.

During the year, Committee members also discussed the waivers benchmarking report and AuditOne governance proposals.

An external quality assessment of AuditOne was commissioned through the Institute of Internal Auditors (IIA), who appointed an external independent assessor to complete the assessment in 2020/21. AuditOne received the highest rating of "Generally Conforms" against Internal Auditing Standards. The next external quality assessment is due in 2025/26.

6. EXTERNAL AUDIT

The Committee has reviewed the work and findings of external audit and considered the implications and management responses to their work.

This was achieved by:

- Discussing and agreeing with the external auditor the nature and scope of the audit as set out in the External Audit Annual Plan.
- Reviewing external audit reports, together with the appropriateness of management responses.
- Receiving the year-end Audit Opinion and ISA 260 report (Trust and Charity). For 2022/23, there was no requirement to undertake audit procedures on the Quality Report. During 2022/23, the Value for Money Conclusion certificate was signed separate to the Audit Opinion, at a later point during the financial year.
- Received the Annual Audit Letter.

The Council of Governors has the statutory responsibility for the appointment of the external auditors, and this process is led by a sub-group of public Governors supported by Trust officers and the Chair of the Audit Committee. During 2018, a robust procurement and evaluation process was undertaken regarding the external audit contract with Mazars LLP appointed as the Trust's external auditors with effect from 1 October 2018 for 3 years to 30 September 2021. The contract included an option to extend for a further 1 year after the 3 years – the extension was taken via approval from the Trust's Council of Governors in October 2020. A report was presented to the Trust Governors in October 2021 to award up to a two-year extension to the current contract in place with Mazars LLP. Governors agreed to revisit during 2023. This followed a satisfactory review of external audit performance undertaken.

The Mazars LLP external audit fees for 2022/2023:

- Statutory Accounts £67,160 (excluding VAT) which is consistent with the statutory fee invoiced for 2021/22.

The audit of the Charity Accounts is undertaken separately, with fees currently under discussion.

For 2022/23, there was no mandated requirement to undertake external audit procedures on the Quality Report and therefore no fee was charged in relation to this.

To ensure that the independence of the external auditors is not compromised where work outside the scope of the Audit Code has been procured from the external auditors, the Trust has a policy which requires that no member of the team conducting the external audit may be a member of the team carrying out any additional work and their lines of accountability must be separate.

During 2019/20, the Trust's policy on Non-Audit Work was reviewed and updated. This was approved at the April 2020 Committee meeting and then by the Council of Governors electronically. The policy requires review every three years and therefore has been reviewed during 2022/23 and was considered at the April 2023 Audit Committee meeting.

No additional services/non-audit work was carried out by Mazars LLP during 2022/23.

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

7. MANAGEMENT

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

8. FINANCIAL AREAS OF REVIEW

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

The Committee has achieved this primarily through review and approval of the Annual Accounts, including those of the Newcastle upon Tyne Hospitals NHS Charity. The Committee also reviewed the External Audit Opinion and fed back relevant comments for consideration by the external auditors.

In the course of 2022/23, there were no significant issues that the Committee had to consider in relation to the financial statements. During the year, the Committee reviewed the following key areas of management judgement and significant risks:

- Accounting for PFI (Trust);
- Management over-ride of controls (Group and Trust);
- Property, Plant and Equipment Valuation (Trust);
- Revenue recognition (Trust); and
- Accounting for leases under IFRS16.

Other areas discussed between External Audit and Management during the year, and reported to the Audit Committee, related to:

- Accounting for the Integrated Covid Hub North East (ICHNE);
- Fire remedial work provision;

- The outcome of the Flowers versus East of England Ambulance Care Trust legal case and treatment as a special payment;
- Value for money work;
- Expenditure recognition.

Committee members were briefed on the revised auditing standard for identifying and assessing the risks of material misstatement: ISA (UK) 315 (Revised 2019).

These have been considered through the presentation of the external audit plan, associated progress updates and discussions during Committee meetings.

9. OTHER AREAS OF ACTION AND REVIEW

The Committee has:

- Reviewed details of all Losses and Compensation Payments.
- Received reports on approved single tender actions where applicable.
- Reviewed regular debtors and creditors reports.
- Received and approved the Counter Fraud annual plan, as well as regular updates in the form of the Fraud response log, associated progress reports, the Annual Report on Counter Fraud, the requirements of the Government Functional Standard 013: Counter Fraud and the refreshed NHS Counter Fraud Authority Strategy.
- Discussed counter fraud work undertaken in relation to the Association of British Pharmaceutical Industry (ABPI) reporting process and the data from the National Fraud Initiative (NFI).
- Reviewed the minutes of associated Committees.
- Reviewed the content of the statutory Annual Report (including the Annual Governance Statement).
- Reviewed and endorsed changes to the Trust and Charity Scheme of Delegation.
- Received the Annual Accounts preparation timetable and subsequently the Annual Accounts, TACs and Going Concern Review.
- Received an annual report on special severance payments/settlement agreements.
- Approved the Trust's Annual Modern Slavery Act Statement.
- Received updates on Standards of Business Conduct, including declarations of interest, fit and proper persons and the annual review of the register of gifts and hospitality.
- Received a report on waivers and breaches of the Trust Standing Financial Instructions.
- Received an action log to follow up previous Committee meeting actions.
- Received an update on the Clinical Audit Process.
- Received regular updates on information governance, information management and technology (IM&T) and cyber security from the joint Senior Information Risk Owners (SIROs).
- Received updates from the Chairs of the Quality, People and Finance Committees.
- Approved the Internal Audit Charter and Protocol 2022/23 (July 2022).
- Approved the updated Fit and Proper Persons Policy.

- Discussed changes proposed to changes to delegated powers for authorised signatories within the Joint Research Office.
- Reviewed the performance of Internal Audit, External Audit and Counter Fraud.
- Received further updates on:
    - Progress made in relation to the follow up of internal audit recommendations;
    - The Charity Policy and Scheme of Delegation;
    - The HFMA checklist;
    - The No Purchase Order No Pay Timeline;
    - Governance documents published; and
    - Corporate Records.

10. PROGRESS FOR 2023-2024

The self-assessment checklist from the HFMA Audit Committee Handbook (the 2018 version being the latest version) has been completed and was agreed at the April 2023 Committee meeting.

The following area of focus has been identified for 2023/24:

1. Considering the implementation of the new management structure and potential impacts on risk management, controls and governance processes, including associated updates to key documentation e.g. updating the Scheme of Delegation, Standing Orders and Standing Financial Instructions.

The Terms of Reference and Schedule of Business for the Committee have been reviewed and minor changes agreed at the Committee in April 2023 – these have been appended for approval by the Trust Board.

Report of Kelly Jupp
Trust Secretary
14 April 2023

Committee / Group:	**Audit Committee**
Chair:	**Bill Macleod**
Annual Cycle Covered:	**2023/24**

	Lead	Authors / contacts of the report	Apr-23	June-23 EXTRAORDINARY	Jul-23	Oct-23	Jan-24	Notes
Standing Items								
Apologies for absence	Bill Macleod		✓		✓	✓	✓	
Declaration of interests	Bill Macleod		✓		✓	✓	✓	
Minutes and matters arising	Bill Macleod	Kelly Jupp / Lauren Thompson	✓		✓	✓	✓	
Action log	Bill Macleod	Kelly Jupp / Lauren Thompson	✓		✓	✓	✓	
Committee minutes: - Finance - Quality - People	Committee Chairs Graeme Chapman (Interim) Graeme Chapman Jonathan Jowett	Kelly Jupp / Lauren Thompson	✓		✓	✓	✓	
Assurance and Risk Management								
New guidance or mandatory documents	Kelly Jupp	Kelly Jupp						As an when required
Scheme of Delegation/SFIs/SOs	Jackie Bilcliff	Chris Haynes / Kelly Jupp			✓			Review annually as a minimum
Modern Slavery Act Statement	Dan Shelley / Kelly Jupp	Dan Shelley / Kelly Jupp			✓			Review annually as a minimum
Annual Board Assurance Framework and Risk Management Report	Caroline Docking	Natalie Yeowart	✓					
Board Assurance Framework (BAF) and Risk Register Report	Caroline Docking	Natalie Yeowart	✓		✓	✓	✓	
Review findings of other significant assurance functions (outwith internal and external audit)	Caroline Docking	Kelly Jupp						As and when required - for example the CQC, NHSI and NHS Resolution
Committee Self-Assessment of effectiveness and Audit Committee Annual Report	Kelly Jupp	Kelly Jupp / Lauren Thompson	✓					
Committee Terms of Reference and Schedule of Business	Kelly Jupp	Kelly Jupp / Lauren Thompson	✓					
Annual Governance Statement	Caroline Docking	Natalie Yeowart	✓(Draft)	✓(Final)				
Review of the Clinical Audit Process	Angela O'Brien	Steve Stoker			✓		✓	
Financial reporting systems	Jackie Bilcliff	Chris Haynes / Jo Mason	✓					
Assurance from the People Committee as to whether arrangements by which staff may raise concerns are operating effectively	Jonathan Jowett	Christine Brereton				✓		Annual - in accordance with the Trust policy on raising concerns

SIRO Report	Caroline Docking / Graham	Natalie Yeowart			✓		✓	Six-monthly
Financial Governance								
Financial Statements timetable and plans	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓(Update)				✓	
Review Accounting issues raised as part of the Financial Statements audit	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓	✓				
Trust Annual Financial Statements and TACs	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓(Draft/Update)	✓(Final)				Prior to Board approval
Charity Annual Financial Statements	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity			✓(Draft)	✓(Final)		Prior to Board approval
Annual Report (including Quality Account)	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity		✓				Prior to Board approval
Corporate Governance Manual update	Caroline Docking	Kelly Jupp						As and when required
Schedule of Losses and Compensation report	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓		✓	✓	✓	
Standards of Business Conduct Annual Report, including the Chairman's fit & proper persons declaration	Caroline Docking	Natalie Yeowart			✓			
Annual Report - Register of Directors' Interests	Kelly Jupp	Kelly Jupp / Lauren Thompson		✓ (As part of the Annual Report)				
Annual Review of Special Severance Payments / Settlement Agreements	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓					
Debtors and Creditors balances report	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓		✓	✓	✓	
Schedule of Approval of Single Tender Action	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓		✓	✓	✓	
External/Internal Audit Protocol	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity			✓			
Financial Statements Accounting Policies, Estimates and Judgements	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓	✓				
Going Concern Position	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓					
Internal Audit								
Annual Plan	Internal Audit	Internal Audit	✓(Final)				✓(Draft)	

Outcome of Audit Work / Progress Update	Internal Audit	Internal Audit	✓	✓	✓	✓	✓	
Head of Internal Audit Opinion	Internal Audit	Internal Audit	✓(Draft)	✓(Final)				
Annual Report and IA Charter	Internal Audit	Internal Audit			✓			
Internal Auditor performance	Internal Audit	Internal Audit			✓			
External Audit								
Annual Plan and 3-year Strategic Plan	External Audit	External Audit	✓				✓	For approval
Outcome of Audit Work	External Audit	External Audit						As and when required
Management Letter / ISA260 report to the Trust	External Audit	External Audit		✓				
Management Letter / ISA260 report to the Charity	External Audit	External Audit				✓		
Annual Audit Letter	External Audit	External Audit			✓			
External Auditor Performance	External Audit	External Audit			✓			
Counter Fraud								
Annual Plan and Annual Fraud Self Review Tool	Ivan Bradshaw	Ivan Bradshaw	✓					For approval
Fraud Response Log /Fraud register	Ivan Bradshaw	Ivan Bradshaw	✓		✓	✓	✓	
Activity Report	Ivan Bradshaw	Ivan Bradshaw	✓		✓	✓	✓	
Annual Report	Ivan Bradshaw	Ivan Bradshaw			✓			
Counter Fraud Performance	Ivan Bradshaw	Ivan Bradshaw			✓			

✓	On agenda and discussed
	Item deferred

TERMS OF REFERENCE – AUDIT COMMITTEE

1. CONSTITUTION OF THE COMMITTEE

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

2. PURPOSE AND FUNCTION

The purpose and function of the Committee is to:

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

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

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

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

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

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

3. AUTHORITY

The Committee is:

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

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

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

4. MEMBERSHIP AND QUORUM

MEMBERSHIP

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

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

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

4.04 The membership will include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

QUORUM

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

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

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

5. DUTIES

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

6. FINANCIAL REPORTING

The Committee will:

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

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

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

6.4 review the consistency of, and changes to, accounting policies across the Trust and its subsidiary undertakings including the operation of, and proposed changes to, the Corporate Governance Manual, Standing Orders, Standing Financial Instructions, Scheme of Delegation and Reservation of Powers, Matters Reserved to the Board and Standards of Business Conduct, including maintenance of registers, and the Fraud Response Plan;

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

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

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

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

7. GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL

The Committee will review:

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

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

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

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

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

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

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

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

8. INTERNAL CONTROL AND COUNTER FRAUD

The Committee will:

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

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

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

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

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

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

8.07 consider the effectiveness of Counter Fraud services annually;

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

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

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

9. EXTERNAL AUDIT

The Committee will:

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

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

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

9.4 have oversight of the External Auditor's remuneration and terms of engagement (approved by the Council of Governors), including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted;

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

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

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

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

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

10. OTHER BOARD ASSURANCE FUNCTIONS

The Committee will:

10.01 oversee the maintenance of the policy framework of the Trust and review any significant breaches of the procedures. The Quality Committee, via the Compliance and Assurance Group, receive assurance on policy compliance;

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

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

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

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

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

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

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

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

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

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

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

11. REPORTING AND ACCOUNTABILITY

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

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

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

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

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

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

11.6 The Terms of Reference shall be reviewed by the Committee and approved by the Board of Directors annually.

12. COMMITTEE ADMINISTRATION

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

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

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

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

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

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

12.7 The Committee Secretary will minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings will be made available promptly to all members of the Committee, normally within ten working days of the meeting.

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

Procedural control statement: 17 April 2023
Date approved: [25 April 2023] [Audit Committee] and [TBA] [Board]
Approved by: Audit Committee and Trust Board
Trust Board Review date: May 2024

FINANCE COMMITTEE ANNUAL REPORT 2022-2023

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Finance Committee has met its key responsibilities for 2022-23, in line with its Terms of Reference.

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

2. COMMITTEE RESPONSIBILITIES

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

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

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

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

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

3. COMMITTEE MEMBERSHIP AND MEETINGS

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

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

Six ordinary meetings and seven extraordinary meetings were held between 1 April 2022 and 31 March 2023. Three of the extraordinary meetings were arranged to discuss a small number of items for approval which required actioning before the year end. The attendance was as follows:

	Attendance at ordinary meetings	Attendance at extraordinary meetings
Mr S Morgan, Non-Executive Director (Finance Committee Chair) until 31 January 2023	5 of 5	3 of 7
Mr G Chapman, Non-Executive Director, interim Committee Chair from 1 February 2023	6 of 6	7 of 7
Mr B MacLeod, Non-Executive Director	6 of 6	7 of 7
Mrs L Bromley, Non-Executive Director – Interim Committee member from 1 February 2023	1 of 1	2 of 4
Mrs A Dragone, Finance Director, until 31 July 2022	2 of 2	2 of 2
Mrs J Bilcliff, Chief Finance Officer, from 5 September 2022	4 of 4	5 of 5
Mr M Wilson, Chief Operating Officer	6 of 6	5 of 7
Mr G King, Chief Information Officer	5 of 6	4 of 7
Mr R Smith, Estates Director	5 of 6	3 of 7
Dr V McFarlane-Reid, Director of Business, Development and Enterprise	6 of 6	5 of 7

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

- The Deputy Director for Business and Development;
- The Deputy Finance Director and the Interim Deputy Finance Director;
- The Interim Assistant Director of Finance;
- The Procurement and Supply Chain Director;
- The Deputy Director of Estates;
- The Head of Corporate Risk and Assurance;
- Associate Director – Commercial Enterprise Unit;
- The Head of Digital Innovation & Delivery;

- The Strategic Finance Advisor;
- The Chairman and a Non-Executive Director;
- The Procurement Lead for Major Projects;
- The Director of PMO;
- A representative from PwC as part of the external well-led review; and
- The Trust Secretary, the Deputy Trust Secretary and the Governor and Membership Engagement Officer, who have provided secretariat support to the Committee.

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

4. REPORTING & AREAS OF REVIEW

During the year, the Committee:

- Received, and constructively challenged the content of the regular reports on the Trust financial position, including the closing position for the year, the Draft and Final Annual Accounts for 2021/22.
- Discussed the ongoing position regarding the dispute with HMRC over the PFI VAT recovery and received a PFI update.
- Sought assurance over the financial management arrangements regarding:
    - The Productivity and Improvement Programme/Cost Improvement Programme;
    - Development of the Financial and Activity Plans;
    - The financial regime/system funding;
    - Cash management/forecasting;
    - The Day Treatment Centre;
    - The Commercial Strategy and Commercial Enterprise Unit; and
    - Earlier Financial Reporting.
- Requested 'deep dives' into a number of areas and risks e.g. Capital Programme and maintenance. The deep dive items were either included in the finance report or added as a separate agenda item.
- Received and discussed frequent updates on the Productivity and Efficiency Programme.
- Sought and received regular updates from the Procurement and Supply Chain Director regarding the Procurement Plan/Procurement activity.
- Received and discussed a Commercial Project Report example and an update from the Commercial Enterprise Team.
- Considered the capital and revenue plans for future periods, seeking assurances over the validity of the assumptions and risks detailed within.
- Received updates on Directorate activity performance against plan, queried variances arising and discussed the impact on Elective Recovery Funding.
- Received updates on the 2022/23 Capital Programme (including investments and developments) and considered the 2023/24 Programme.
- Considered Waiting List Initiative Spend which had been incurred during the year.
- Approved tenders, investments and business cases in accordance with the delegated authority of the Committee. This included AMLo Biosciences, ICNET, Medicine Front of House, Spines, Robotics and 7-Day Cancer service.
- Endorsed the Annual National Cost Collection Exercise.

- Reviewed the content of the Financial Plan and ongoing delivery, as well as having considered the NHSE priorities and sought assurances over the associated risks.

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2022/23 and utilised a rolling programme and action log to track committee actions.

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

During the year, the Committee has reviewed:

- Its Terms of Reference and Schedule of Business as part of the production of its Annual Report.
- The quarterly Board Assurance Framework (BAF) Assurance Reports.

6. MANAGEMENT

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

7. FUTURE AREA OF COMMITTEE FOCUS

Good progress has been made since the prior year in embedding 'deep dive' areas and strategic risks into Committee agendas. In addition, during the year the Committee incorporated a standing agenda item regarding 'new and emerging risks' in order to ensure sufficient time was given to considering any such risks.

It is recommended that the Trust Secretary works with the Chief Finance Officer to develop a more detailed review of Committee effectiveness to incorporate assurances gained and a survey of Committee members to seek views on for example:

1.	Membership of the Committee is appropriate
2.	Scope of the Committee is clear and well defined
3.	Frequency of the meetings enables business to be conducted effectively
4.	Committee has had a positive impact on the Trust
5.	Committee agendas are clearly aligned to the duties articulated in the terms of reference
6.	There is constructive debate and challenge at the Committee
7.	Papers clearly articulate the key issues and assurance
8.	The Committee is assured that identified actions are completed in line with agreed timescales

9.	It is clear how the committee contributes to the Trust's strategic objectives and annual goals
10.	Strengths, weaknesses and suggestions for improvements

Given the significant financial challenges anticipated in 2023/24, it is recommended that the Committee ensures sufficient time is allocated on each meeting agenda to reviewing delivery regarding the Productivity and Efficiency Programme, Activity and Financial Performance. In addition, the Committee scheduling/timing will be revisited in discussion with the incoming Chair of the Committee, the Interim Committee Chair and the Chief Finance Officer.

The Terms of Reference and Schedule of Business for the Committee have been reviewed and minor changes agreed at the Committee in April 2023 – these have been appended for approval by the Trust Board.

Report of Kelly Jupp
Trust Secretary
17 April 2023

Committee / Group:	**Finance Committee**
Chair:	**Graeme Chapman (interim)**
Annual Cycle Covered:	**2023/24**

	Lead	Authors / contacts of the report	Apr-23 EXTRAORDINARY	May-23	June-23 EXTRAORDINARY	Jul-23	Sep-23	Nov-23	Jan-24	Mar-24	Notes
Standing Items											
Apologies for absence	Graeme Chapman		✓	✓	✓	✓	✓	✓	✓	✓	
Declaration of interests	Graeme Chapman		✓	✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Graeme Chapman	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	
Action log	Graeme Chapman	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	
Meeting debrief, matters requiring escalation and AOB	Graeme Chapman		✓	✓	✓	✓	✓	✓	✓	✓	
Regular Reports											
Finance report [Including KPIs, CIP, cquins, risks, capital summary, balance sheet updates]	Jackie Bilcliff	Claire Garrity / Jo Mason / Chris Haynes		✓		✓	✓	✓	✓	✓	
Finance Committee Risk Report	Natalie Yeowart	Natalie Yeowart		✓			✓		✓	✓	
Cost Improvement Programme Plan / Updates	Daryl Perry	Daryl Perry		✓		✓	✓	✓	✓	✓	
Capital Plan and capital projects update (Top 10 strategic projects) [every other meeting]	Rob Smith / Jackie Bilcliff	Claire Garrity / Lynsey Allen		✓		✓		✓		✓	
Performance (against Finance and Operational Plans, contracts, B&D activity)	Vicky McFarlane-Reid / Martin Wilson	Kerry Leonard		✓	✓	✓	✓	✓	✓	✓	
Procurement Plan/Update [every other meeting]	Dan Shelley	Dan Shelley		✓			✓		✓		
Management Group Minutes:											
- Supplies & Service Procurement Group (SSPC) minutes [when available]	Graeme Chapman	Dan Shelley		✓	✓	✓	✓	✓	✓	✓	
- Commercial Strategy Group (CSG) minutes [when available]	Graeme Chapman	Kerry Leonard		✓	✓	✓	✓	✓	✓	✓	
- Capital Management Group (CMG) minutes [when available]	Graeme Chapman	Lynsey Allen		✓	✓	✓	✓	✓	✓	✓	
- Strategy, Planning and Capital Investment Group (SPCIG) minutes [when available]	Graeme Chapman	Lynsey Allen		✓	✓	✓	✓	✓	✓	✓	
- Any Strategic Oversight Group minutes as required	Graeme Chapman	Kelly Jupp		✓	✓	✓	✓	✓	✓	✓	
Annual Reports (AR) or updates											
Annual Report & Accounts Update/Draft/Final	Jackie Bilcliff	Claire Garrity / Jo Mason / Chris Haynes	✓		✓						
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Kelly Jupp	Kelly Jupp / Lauren Thompson	✓							✓	
Revenue and budget setting	Jackie Bilcliff	Claire Garrity		✓						✓	
Capital expenditure and strategy (longer term plan), including PFI	Rob Smith / Jackie Bilcliff	Claire Garrity / Lynsey Allen / Russell Jones / Chris Haynes		✓			✓				
Month 12/year-end report	Jackie Bilcliff	Claire Garrity / Jo Mason	✓								
Plan /Plan updates	Jackie Bilcliff	Claire Garrity / Jo Mason	✓						✓	✓	

Ad-hoc reports to be considered											
Commercial strategy / Updates [twice a year]	Vicky McFarlane-Reid	Kerry Leonard		✓				✓			
Policies and procedures e.g. Treasury management, Investment management as required in accordance with the SFIs/SoD	All	Kerry Leonard / Dan Shelley / Lisa Jordan / Kelly Jupp									
Business cases / investment proposals [as and when required in accordance with the SoD/SFIs/SoD]	Vicky McFarlane-Reid / All	Kerry Leonard / Dan Shelley / Lisa Jordan		✓	✓	✓	✓	✓	✓	✓	
GIRFT/Model Hospital [to report by exception as required]	Martin Wilson	Hannah Morrison		✓							
Digital Strategy	Graham King	Graham King / Lisa Sewell						✓			
Finance and Investment strategies	Jackie Bilcliff	Claire Garrity / Jo Mason / Chris Haynes					✓				

✓	On agenda and discussed
	Item deferred

Terms of Reference – Finance Committee

1. Constitution of the Committee

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

2. Purpose and function

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

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

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

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

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

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

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

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

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

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

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

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

- Procurement Strategy; and
- Digital Strategy, including digital infrastructure.

3. Authority

The Committee is:

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

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

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

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

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

4. Membership and quorum

Membership

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

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

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

4.04 The membership of the Committee shall include:

- a Non-Executive member of the Audit Committee;
- the Chief Finance Officer;
- the Chief Operating Officer;

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

4.05 The Chief Executive, as the Trust's Accountable Officer, shall have the right to attend the Committee at any time. Otherwise, only members of the Committee have the right to attend Committee meetings. Other non-committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.06 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year.

4.07 The Chief Finance Officer shall act as Executive Lead for the Committee.

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

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

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

4.11 All members of the Committee shall receive training and development support before joining the committee where required and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

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

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

Quorum

4.14 The quorum necessary for the transaction of business shall be four members as defined in 4.01 and 4.04 above, including the Chair or Vice Chair and at least one Non-Executive Director.

4.15 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will not count towards the quorum.

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

5. Duties

5.1 Cycle of Business

The Committee will:

5.1.1 set an annual set of objectives and an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

5.2 Strategies and policies

The Committee will:

5.2.1 review the Trust's financial strategy, planning assumptions, and related delivery plans and transformation programmes, and provide informed advice to the Board of Directors on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact;

5.2.2 review guidance for the development and delivery of the financial aspects of annual operational, service, and financial planning, including assumptions on revenue, budgets, capital, working and associated targets, and parameters on efficient and effective use of resources;

5.2.3 review, and recommend to the Board of Directors, the Annual Financial Plan, including key financial performance indicators;

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

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

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

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

5.3 Annual Financial Plan

The Committee will:

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

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

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

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

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

5.4 Risk

The Committee will:

5.4.1 Receive the risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit Committee with assurance on the effectiveness of the management of principal risks relating to the Committees purpose and function.

5.4.2 To receive the Executive Oversight Report for information.

5.5 Performance and progress reporting

The Committee will:

5.5.1 monitor the effectiveness of the Trust's financial and operational performance reporting systems, ensuring that the Board is assured of continued compliance through its annual reporting processes, reporting by exception where required to the Board;

5.5.2 agree a succinct set of key performance and progress measures relating to the full assurance purpose and function of the Committee, including:

- the Trust's strategic financial priorities;
- national performance and statutory targets;
- consolidated financial performance summaries and related budgets;
- statement of financial position;
- working capital performance;
- cash flow status;
- progress on capital investment programme;
- regulatory oversight ratings; and
- risk mitigation;

5.5.3 triangulate progress against these measures and seek assurance around any performance issues identified, including proposed corrective actions;

5.5.4 provide regular reports to the Board, including as part of the bi-monthly Integrated Board Report, on assurance around key areas of Trust performance, risk, and corrective actions, both retrospectively and prospectively;

5.5.5 agree a programme of benchmarking activities and reference points to inform the understanding and effectiveness of the Committee and its work;

5.5.6 be assured of the credibility of sources of evidence and data used for planning and progress reporting to the Committee, and to the Board, in relation to the Committee's purpose and function;

5.5.7 ensure the alignment and consistency of Board assurances, use of data and intelligence, by working closely with the Audit Committee, Quality Committee and People Committee;

5.5.8 review the following formal reports to the Board as part of the Annual Cycle of Business:

- Annual Financial Plan;
- Finance Reports;
- Capital Investment Policy; and
- Annual Report and Accounts (Group, Trust and Charity); and

5.5.9 review and approve the Terms of Reference for, and receive the minutes of, the:
i) Supplies and Services Procurement Group;
ii) Capital Management Group;
iii) Strategy, Planning and Capital Investment Group;
iv) Commercial Strategy Group; and
v) Any time-limited Strategic Oversight Groups created which are aligned to the Committee.

5.6 Capital, investments, acquisitions and disposals

The Committee will:

5.6.1 review the Trust's capital and investment policies against appropriate benchmarks prior to recommendation for Board approval;

5.6.2 agree a consistent and robust methodology for the assessment of proposed capital expenditure, acquisitions, joint ventures, equity stakes, major property transactions, mergers, and formal or informal alliances with other Institutions;

5.6.3 review business cases and proposals over the threshold specified within the Trust Scheme of Delegation, and provide advice to the Board accordingly;

5.6.4 assure the Trust Board, on a regular basis, of the effectiveness of, and compliance with, the capital and investment strategies and related policies, including the effective prioritisation of investment decisions, the robustness of processes and rigour of investment decision-making, and report on this as part of the Committee's Annual Report to the Board;

5.6.5 seek assurance that a process is in place to monitor the performance of investments, which incorporates a review of the benefits realised as part of infrastructure and service improvement investments made; and

5.6.6 exercise delegated responsibility on behalf of the Board in line with the Standing Financial Instructions for proposals for acquisition and disposal of assets in accordance with Trust policy.

5.7 Infrastructure, estates and digital

The Committee will:

5.7.1 review the following policies and plans, in order to provide informed and authoritative advice to the Board:

- estates; and
- digital strategy.

5.8 Commercial strategy

The Committee will:

5.8.1 provide support and advice on the development and implementation of the commercial strategy for the Trust.

5.8.2 assure the Trust Board, on a regular basis, of the effectiveness of, and compliance with, the commercial strategy and related policies, including the effective prioritisation of commercial decisions, the robustness of processes and rigour of commercial decision-making, and report on this as part of the Committee's Annual Report to the Board.

5.9 Statutory compliance

The Committee will:

5.9.1 ensure, on behalf of the Board, that current statutory and regulatory compliance and reporting requirements are met, including compliance with treasury policies and procedures and the appropriate safeguards for security of the Trust's funds as an NHS Foundation Trust;

5.9.2 ensure the proper reporting of actions deemed "high-risk" by regulators, or actions with an equity component, which entail a potentially significant risk to reputation or to the stability of the business of the Trust, or which create material contingent liabilities;

5.9.3 ensure future legislative and regulatory and reporting requirements are identified and appropriate action taken; and

5.9.4 consider, and recommend for approval by the Audit Committee, any proposed changes to Trust Standing Financial Instructions, Standing Orders and Scheme of Delegation.

6. Reporting and accountability

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

6.2 The Committee will provide an Annual Report to the Board to inform and / or accompany the Trust's Annual Report. This shall include an assessment of compliance with the Committee's Terms of Reference and a review of the work and effectiveness of the Committee.

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

6.4 The terms of reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

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

7.2 Extraordinary meetings will be scheduled if required during quarter 4 to approve items by exception (e.g. tenders) which require actioning before the year-end.

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

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

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

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

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

7.8 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten working days of the meeting.

7.9 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: 17 April 2023
Date approved: [26 April 2023] [Finance Committee] and [TBA] [Board]
Approved by: Finance Committee and Board
Trust Board Review date: May 2024

PEOPLE COMMITTEE ANNUAL REPORT 2022/23

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the People Committee has met its key responsibilities for 2022/23, in line with its Terms of Reference.

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

The Terms of Reference and Schedule of Business for the Committee have been reviewed and minor changes agreed at the Committee in April 2023 – these have been appended for approval by the Trust Board.

2. COMMITTEE RESPONSIBILITIES

The People Committee is a non-statutory Committee established by the Board of Directors to monitor, review and report to the Board on the cultural and organisational development of the Trust, the strategic performance of people and workforce priorities, and the impact of the Trust as a significant employer, educator and partner in health, care and research.

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

- The strategic people and workforce priorities for the Trust as a significant employer and as a partner in training, education, and development of health and care capacity in the region and nationally are identified;
- The organisation has a clear understanding of strategic workforce needs (including well-being, recruitment, retention, development of people, and organisational capacity) and the quality and effectiveness of plans to deliver them;
- The commitments of the NHS Constitution, the NHS People Promise, and the stated values of the Trust and standards of behaviour, are being practiced throughout the organisation, based on evidence;
- The approach to all aspects of employment and culture in the Trust are informed by relevant and up-to-date research on innovation and practice;
- The effectiveness of mitigations and action plans as set out in the Board Assurance Framework are reviewed, assessed and assurances obtained specific to the committee purpose and function;
- Legislative and regulatory compliance is achieved as an employer, including anticipation of, and planning for, future requirements;
- Staff governance in the organisation is fully developed, including staff engagement processes;
- Strategic communications and engagement are developed, and reputation management is robust with internal and external stakeholders, local communities and partners;

- The impact on workforce of changing professional and organisational practices is considered, including those involved in increased system-based and partnership working (in collaboration with the Quality Committee); and
- The Trust fulfils its leadership and influencing role on service quality standards and practice, as an organisation of national importance, as a significant service provider in the North East, and as a partner in training, education and development of health and care capacity in the region (in collaboration with the Quality Committee).

It does this through the receipt of assurances from management, the receipt of regular reports relating to areas which impact Trust staff, as detailed in section 4 below, and discussions and reports on the management of risks relating to the Committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of six members (as specified in the Terms of Reference), drawn from the Non-Executive Directors and members of the Executive Team.

The Committee's quorum is four members, with at least one Non-Executive Director present.

Meetings are held bi-monthly. Six ordinary meetings were held between 1 April 2022 and 31 March 2023. The meeting scheduled on 20 December 2022 was postponed and instead a further Committee was arranged on 6 January 2023.

Attendance at the meetings was as follows:

	Attendance at ordinary meetings
Jonathan Jowett, Non-Executive Director (Committee Chair)	6 of 6
Kath McCourt, Non-Executive Director	6 of 6
Jill Baker, Non-Executive Director (left the Committee in October 2022)	2 of 3
Steph Edusei, Non-Executive Director (joined the Committee in October 2022)	3 of 3
Dee Fawcett, Director of Human Resources (retired from the Trust in November 2022)	4 of 4
Christine Brereton, Chief People Officer (commenced in post in January 2023)	2 of 2
Caroline Docking, Assistant Chief Executive	5 of 6
Martin Wilson, Chief Operating Officer	5 of 6

Other attendees at meetings have included:

- Head of Human Resource Services;
- Head of Equality, Diversity & Inclusion – People;

- Head of Workforce Engagement & Information;
- Associate Director – Education, Training, and Workforce Development;
- Freedom to Speak Up Guardian;
- Guardian of Safe Working Hours;
- Associate Director – Sustainability & Environment;
- Executive Chief Nurse;
- The Medical Director/Deputy Chief Executive Officer;
- Director of Medical Education;
- Head of Corporate Risk & Assurance;
- The Senior Workforce Development Officer;
- The Branch Secretary of UNISON and Chair of Staff Side;
- The Trust Secretary;
- The Corporate Governance Manager / Deputy Trust Secretary who provided Secretariat Support to the Committee; and
- Corporate Governance Officer and PA to the Chairman and Trust Secretary.

Mrs Judy Carrick, Public Governor and Chair of the People, Engagement and Membership (PEM) Working Group, observed one Committee meeting during the year.

4. REPORTING

i) Regular Reports

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

- The Trust People Strategy/Plan and progress against delivery;
- People Committee Risk Report;
- Employee Relations Report;
- Guardian of Safe Working Hours Quarterly Reports and Annual Report (prior to receipt at the Board of Directors);
- 'Flourish at Newcastle Hospitals' Updates, including Employee Health and Wellbeing, NHS Staff Survey results and engagement plans/updates and 'What Matters To You Organisational Development';
- Education and Workforce Development Reports, covering e.g. Statutory and Mandatory Training, Medical Education and Apprenticeships. A demonstration of the Virtual Learning Environment was provided;
- People Dashboard;
- Legal Updates; and
- Sustainability Reports.

ii) Annual Reports

The following Annual Reports were received by the Committee:

- Workplace Race Equality Standard (WRES) and Workplace Disability Equality Standard (WDES) Data and Action Plan (prior to approval at Trust Board). A demonstration of the Equality, Diversity and Inclusion dashboard was also provided;
- Gender Pay Report;

- Leadership Development and Talent Management Strategy;
- General Medical Council (GMC) training survey;
- Communication strategy;
- Freedom to speak up Guardian (FTSU) annual report, and the FTSU Strategy which was approved;
- Trade Union Faculty Time Report; and
- Annual Report of the Committee, Committee Terms of Reference and Schedule of Business.

iii) Ad-Hoc Reports

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

- COVID-19 Update, including Vaccination Hub and Vaccination as condition of deployment (VCOD);
- Integrated COVID Hub North East (ICHNE) Termination of Contract – People Impact;
- Emerging People risks;
- Staff Side Presentation on Trade Union Activity/Partnership Working;
- Medical and Dental Update;
- Industrial action updates;
- Workforce Age Profile and Demographics update;
- Recruitment and Retention update including Trust headcount;
- Nursing, Midwifery and AHP update including Healthcare support worker re-banding; and
- Clinical Directorate Review / Management Restructure update.

In addition, during the year 'deep dives' were also undertaken on:

- GMC Training Survey / Training and Education; and
- Staff Turnover.

The Committee also received the minutes of both the Learning and Education Group and the Sustainable Healthcare Committee as a standing item.

The Schedule of Business for the year 2022/23 included an annual conversation with the Executive Chief Nurse (ECN) and Medical Director (MD) (separately). The annual conversation with the ECN was held in January 2023 and the annual conversation with the MD was held in October 2022.

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2022/23 and utilised a rolling programme and action log to track committee actions.

As highlighted in Section 4(i), the Committee receives regular updates on risks recorded on the BAF which related to the Committee's area of focus. During 2022/23, the four risks included in the BAF and regularly discussed at the Committee were:

- Trust sickness absence has not returned to pre-pandemic levels, there is a risk that we are unable to fill staffing gaps across our services which could create additional operational pressures across the Trust and impact on the quality of care we deliver.
- There is a risk that we may fail to achieve the targets within the Climate Emergency Strategy, which could impact on the Trust's contribution to reducing local population ill health consequences and health inequalities as well as negatively impacting the Trust reputation as a global leader in sustainable healthcare delivery. This is further exacerbated by energy centres outsourcing on performance, lack of national funding sources for the scale of investment required and CDEL restrictions.
- There is a risk that the Trust fails to maintain compliance with Statutory and Mandatory training requirements, which could impact on quality and safety and impact the reputation of the Organisation.
- Due to the increasing likelihood of industrial action including strike action between November 2022-May 2023, there is a risk of operational service disruption which could impact on patient safety and quality. In addition, both industrial relations and reputation could be adversely impacted.

The Committee received regular updates on mitigations in place.

6. PROGRESS FOR 2022/23 & REVIEW OF EFFECTIVENESS

In the Annual Report of the Committee for 2021/22, the following areas were identified as for action during 2022/23, with progress updates highlighted in italic font:

1. The Committee Chair, Executive Lead and Trust Secretary to develop a 'deep-dive' schedule to cover the year ahead.

   Two dedicated deep-dive sessions were held during the year as detailed in section four above.

2. Focus on preparation for a CQC Well Led Assessment, metrics and activities specific to the workforce in general.

   Preparation for CQC inspection continued throughout the year with detailed sessions held for Trust Board members.

3. Oversight of the ongoing implementation of the 'What Matters to You' improvement programme, and use of appropriate tools to enhance the staff experience and ensure the People 'Breakthrough Objectives' are achieved.

   Committee members received regular updates on the implementation of the WMTY programme during the year.

4. Production of a cohesive Equality, Diversity and Inclusion (EDI) Strategy.

   EDI strategy launched in 2022.

5. A refresh of the Leadership Development and Talent Management Strategy.

An interim refresh of the Leadership Development and Talent Management Strategy was undertaken and discussed at the Committee in June 2022.

7. NEXT STEPS AND ACTIONS FOR 2023/24

The following actions/next steps for consideration over 2023/24 were noted:

- The Trust Secretary to work with the Chief People Officer to develop a more detailed review of Committee effectiveness to incorporate assurances gained and a survey of Committee members to seek views on for example:

1.	Membership of the Committee is appropriate
2.	Scope of the Committee is clear and well defined
3.	Frequency of the meetings enables business to be conducted effectively
4.	Committee has had a positive impact on the Trust
5.	Committee agendas are clearly aligned to the duties articulated in the terms of reference
6.	There is constructive debate and challenge at the Committee
7.	Papers clearly articulate the key issues and assurance
8.	The Committee is assured that identified actions are completed in line with agreed timescales
9.	It is clear how the committee contributes to the Trust's strategic objectives and annual goals
10.	Strengths, weaknesses and suggestions for improvements

- To further develop the Schedule of Business and shape Committee meeting agendas around the strategic risks aligned to the Committee [refer to the updated schedule of business for 2023/24].

Report of Kelly Jupp
Trust Secretary

Lauren Thompson
Corporate Governance Manager / Deputy Trust Secretary
12 April 2023

Committee / Group:	**People Committee**
Chair:	**Jonathan Jowett**
Annual Cycle Covered:	**2023/24**

	Lead	Authors / contacts of the report	Apr-23	Jun-23	Aug-23	Oct-23	Dec-23	Feb-24	Notes
Standing Items									
Apologies for absence and Declarations of interest	Jonathan Jowett		✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Jonathan Jowett	Lauren Thompson	✓	✓	✓	✓	✓	✓	
Action log	Jonathan Jowett	Lauren Thompson	✓	✓	✓	✓	✓	✓	
Meeting debrief	Jonathan Jowett		✓	✓	✓	✓	✓	✓	
Matters requiring escalation and AOB	Jonathan Jowett	Lauren Thompson	✓	✓	✓	✓	✓	✓	
New and emerging risks	Jonathan Jowett		✓	✓	✓	✓	✓	✓	
Regular Reports									
People and Culture Dashboard	Christine Brereton/Paul Turner	Deb Stuart	✓	✓	✓	✓	✓	✓	
Education and Training Update (including an annual update on Apprenticeships in April)	Christine Brereton/Gill Long	Deb Stuart	✓		✓		✓		Biannual report plus an annual apprenticeships update.
People Priorities Delivery Update	Christine Brereton	Deb Stuart		✓	✓	✓	✓	✓	To focus on a specific area at each meeting i.e. Health and Wellbeing, Recruitment and Retention, Staff Engagement and Experience.
Employee Relations	Paul Turner	Deb Stuart			✓			✓	Biannual updates scheduled - further updates to be shared if required.
Workforce Planning	Christine Brereton	Deb Stuart			✓			✓	
People Committee Risk Report (BAF)	Caroline Docking / Natalie Yeowart	Natalie Yeowart	✓		✓		✓	✓	Quarterly report.
NHS Staff survey & Staff engagement plans/updates	Christine Brereton/Donna Wat	Donna Watson	✓		✓		✓		3x a year updates.
Sustainability	James Dixon	James Dixon			✓(AR)			✓	JD to attend twice a year.
Guardian of Safe Working	Henrietta Dawson	Henrietta Dawson		✓(AR)			✓		HD to attend twice a year.
Freedom To Speak Up (FTSU) Guardian	Andy Pike	Andy Pike	✓			✓			AP to attend twice a year.
Communications strategy/strategic communications and external engagement update	Caroline Docking	Ellspeth Marshall			✓			✓	
Annual Reports (AR) or updates									
People Strategy and priorities	Christine Brereton	Paul Turner / Deb Stuart	✓						
Leadership Development, Talent and Succession Planning	Christine Brereton	Gill Long / Deb Stuart			✓				
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Kelly Jupp / Lauren Thompson /Christine Brereton	Kelly Jupp / Lauren Thompson	✓						To include effectiveness consideration
GMC training survey	Andy Welch / Ifti Haq	Ifti Haq						✓	
Gender Pay Report	Christine Brereton	Deb Stuart			✓				
WRES & WDES	Christine Brereton	Karen Pearce / Deb Stuart	✓						
Equality and Diversity Update/EDS - including action plans	Christine Brereton	Karen Pearce / Deb Stuart			✓				
Workforce Profile & Demographics update	Christine Brereton/Paul Turner	Paul Turner / Deb Stuart					✓		
Legal Update	Paul Turner	Deb Stuart	✓						
Annual Conversation with Executive Directors	Andy Welch / Maurya Cushlow					✓ (M&D)		✓ (NMAHP)	
Trade Union Faculty Time Report	Paul Turner	Paul Turner / Deb Stuart		✓					
Ad Hoc reports (tabled as required)									
Directorate Management Structure review updates	Martin Wilson / Paul Turner	Deb Stuart							
Learning and Education Group and Sustainable Healthcare Committee minutes to be received during the year	Jonathan Jowett	Michelle Cruickshanks / Estates Admin Team							Minutes to be included when available
Pensions Update	Christine Brereton	Paul Turner / Deb Stuart							
Industrial Action	Martin Wilson / Paul Turner	Paul Turner / Deb Stuart	✓						

✓	On agenda and discussed
	Item deferred

Terms of Reference – People Committee

1. Constitution of the Committee

The People Committee is a non-statutory Committee established by the Board of Directors to monitor, review and report to the Board on the cultural and organisational development of the Trust. It also reviews the strategic performance of people and workforce priorities and considers the impact of the Trust as a significant employer, educator and partner in health, care and research.

2. Purpose and function

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

2.01 on the identification of strategic people and workforce priorities for the Trust as a significant employer in the North East and as a partner in training, education, and development of health and care capacity in the region and nationally;

2.02 in relation to the organisation's understanding of strategic workforce needs (including well-being, recruitment, retention, development of people, and organisational capacity) and the quality and effectiveness of plans to deliver them;

2.03 that the commitments of the NHS Constitution, the NHS People Promise, and the stated values of the Trust and its Leadership Behaviours, are being practiced throughout the organisation, based on evidence;

2.04 that the approach to all aspects of employment and culture in the Trust are informed by relevant and up-to-date research on innovation and practice;

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

2.06 on the Trust's legislative and regulatory compliance as an employer, including anticipation of, and planning for, future requirements;

2.07 on the development of staff governance in the organisation, including staff engagement processes, with the Committee acting as the oversight Committee;

2.08 on the development of strategic communications and engagement, and reputation management with internal and external stakeholders, local communities and partners, with the People Committee acting as the oversight Committee;

2.09 on the impact on workforce of changing professional and organisational practices, including those involved in increased system-based and partnership working (in collaboration with the other Committees of the Trust Board as appropriate); and

2.10 that the Trust fulfils its leadership and influencing role on service quality standards and practice, as an organisation of national importance, as a significant service provider in the North East, and as a partner in training, education and development of health and care capacity in the region (in collaboration with the Quality Committee).

2.11 The Committee will agree progress reporting and information requirements relating to its remit on behalf of the Board of Directors, and will oversee the resulting performance.

3. Authority

The Committee is:

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

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

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

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

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

4. Membership and quorum

Membership

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

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

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

4.04 The membership shall be:

- the Chief People Officer;
- the Chief Operating Officer; and

- the Assistant Chief Executive.

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

4.06 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.07 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year.

4.08 The Chief People Officer shall act to fulfil the role of Executive lead for the Committee.

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

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

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

4.12 All members of the Committee shall receive training and development support as required to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

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

Quorum

4.14 The quorum necessary for the transaction of business shall be four members, as defined in 4.01 and 4.04 above, with at least two Non-Executive Directors present.

4.15 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies shall not count towards the quorum.

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

5. Duties

5.1. Cycle of Business

The Committee will:

5.1.1 set an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

5.2 People Strategy and policies

The Committee will:

5.2.1 assess the strategic priorities and investments needed to support the knowledge, skills and capacity of the people in the Trust (human capital), delivery of the local People Plan, and advise the Board accordingly;

5.2.2 review the Trust's Leadership Development and Talent Management Strategy, Education and Workforce Development Strategy, Education Quality Strategy and Apprenticeship Strategy, and related delivery plans and programmes, providing informed advice to the Board of Directors on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact;

5.2.3 provide advice and support on the development of significant people-related policies [those which have a significant impact on staff e.g. health and wellbeing] prior to their adoption. It is expected that this will relate to a small number of policies by exception in any given year, which will be agreed in advance as part of the cycle of business for the Committee;

5.2.4 review by exception, people-related policies against benchmarks to ensure that they are comprehensive, up-to-date, and reflect best practice;

5.2.5 review strategic intelligence, research evidence on people and work, and distil their relevance to the Trust's strategic priorities (including, where necessary, commissioning research to inform its work) relating to:

- the impact of changing working practices;
- developments and updates on pensions and pensions reform;
- the potential and impact of technology on working lives;
- models of employment practice drawn from multiple sectors;
- organisational and work design;
- incentives and rewards;
- developments and best practice in delivery of education, training and development;
- national, regional and local workforce and population trends; and
- other dynamics affecting the future development of the health and care workforce;

5.2.6 review the development and effective use of shared intelligence and data with partners on local health and care skills to shape the growth of future capacity in the "place" of Newcastle and the North East.

5.2.7 be assured of the integrity of the Trust's processes and procedures relating to the introduction of new clinical roles.

5.3 Risk

The Committee will:

5.3.1 receive risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit Committee with assurance on the effectiveness of the management of principal risks relating to the Committee's purpose and function.

5.3.2 to receive the Executive Oversight Report for information.

5.4 # Flourish At Work - Staff Experience and Engagement including organisational culture

The Committee will:

5.4.1 agree and oversee a credible process for assessing, measuring and reporting on the "culture of the organisation" on a consistent basis over time;

5.4.2 oversee the coherence and comprehensiveness of the ways in which the Trust engages with staff and with staff voices, including the staff survey, and report on the intelligence gathered, and its implications, to the Board of Directors;

5.4.3 act as the oversight Committee for the coherence and alignment of different codes of personal and professional behaviour and conduct, (considering, for example, Leadership Behaviours, the Standards of Business Conduct Policy, and The Nolan Principles), covering all permanent and temporary staff acting in the name of, or on the business of, the Trust;

5.4.4 take an oversight role on behalf of the Board of Directors in:

- securing positive progress on equality and diversity, including shaping and setting direction, monitoring progress and promoting understanding inside and outside the Trust;
- evaluating the impact of work to promote the values of the organisation, the NHS Constitution and the NHS People Promise;
- promoting staff engagement and partnership working; and
- developing a consistent working environment where people feel safe and able to raise concerns, and where bullying and harassment are visibly and effectively addressed.

5.5 Organisational capacity – sustainability and strategic transformation

The Committee will:

5.5.1 ensure the systems, processes and plans used by the Trust have integrity and are fit for purpose in the following areas:

- strategic approach to growing the knowledge, skills and capacity of the people (human capital) in the Trust;
- analysis and use of sound workforce, employment and demographic intelligence;

- the planning of current and future workforce capacity;
- effective recruitment and retention;
- new models of care and roles;
- flexible working;
- identification of urgent capacity problems and their resolution;
- continuous development of personal and professional skills; and
- talent management.

5.5.2 review the productivity of permanent and temporary staff by exception, including the effectiveness and efficiency of their deployment, the best use of skills, and the flexibility and maturity of working practices in the Trust;

5.5.3 consider the coherence and pace of Trust plans to secure the benefits for the Trust and its staff from:

- transformational change and service redesign;
- new and innovative ways of working;
- use of tools and technology;
- environmental sustainability;
- opportunities for changing practices and skills across traditional professional boundaries;
- joint working with partners both in health and social care and other sectors; and
- the value of apprenticeships.

5.5.4 review plans for ensuring the development of leadership and management capacity, including the Trust's approach to succession planning.

5.6 Education and training

The Committee will:

5.6.1 review the Trust's current and future educational and training needs to ensure they support the strategic objectives of the organisation in the context of the wider health and care system;

5.6.2 review the Trust's strategic contribution to the development of the health and care workforce;

5.6.3 secure the necessary assurances about the Trust's compliance with the practice requirements of professional and regulatory bodies for all staff;

5.6.4 ensure the development of an annual education and training programme to meet the education and workforce development priorities described within the Trust's Strategy.

5.7 Communications

The Committee will:

5.7.1 provide advice and support on the development of the Trust's engagement and communications strategies and related programmes of work, and review the effectiveness of internal communications and engagement;

5.7.2 ensure engagement and consultation processes with staff, stakeholders and communities both reflect the ambition and values of the Trust and also meet statutory requirements;

5.7.3 agree and oversee a credible process for assessing, measuring and reporting on the reputation of the organisation as an employer and workplace of choice;

5.7.4 review the appropriateness and effectiveness of stakeholder and partnership development in supporting strategic goals and programmes of work related to the purpose and function of the People Committee, and report to the Board of Directors accordingly.

5.8 Performance and progress reporting

The Committee will:

5.8.1 establish a succinct set of key performance and progress measures relating to the full purpose and function of the Committee, including:

- the Trust's strategic priorities on people;
- national performance targets;
- organisational culture;
- workforce utilisation;
- staff health and well-being; and
- strategic communications.

5.8.2 review progress against these measures, and their impact, and seek assurance around any performance issues identified, including proposed corrective actions;

5.8.3 agree a programme of benchmarking activities to inform the understanding of the Committee and its work;

5.8.4 ensure the credibility of sources of evidence and data used for planning and progress reporting to the Committee, and to the Board of Directors in relation to the Committee's purpose and function;

5.8.5 ensure alignment of the Board assurances and consistent use of data and intelligence, by working closely with the Audit Committee, Quality Committee and Finance Committee;

5.8.6 review and shape the people -related content of the bi-monthly Integrated Board Report;

5.8.7 review the following formal reports to the Board of Directors as part of the Annual Cycle of Business:

- Annual People Committee report;
- Equality and Diversity Reports and Action Plans – e.g. Gender Pay, WRES, WDES and Ethnic Pay etc.;
- NHS Staff Survey Results; and
- Trade Union Facility Time report.

5.9 Statutory compliance

The Committee will:

5.9.1 ensure, on behalf of the Board of Directors, that current statutory and regulatory compliance and reporting requirements are met:

- standards of professional conduct and practice (including consideration of Leadership Behaviours, the Standards of Business Conduct Policy, and The Nolan Principles);
- Freedom to Speak Up Guardian;
- Guardian of Safe Working Hours;
- Equality, diversity and inclusion; and
- consultation on service change.

5.9.2 ensure future legislative and regulatory requirements, which are to be placed on the Trust as an employer, are identified and appropriate action taken.

6. Reporting and accountability

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

6.2 The Committee shall report to the Trust Board annually on its work in support of the Annual Report. The Annual People Committee Report shall set out clearly how the Committee is discharging its responsibilities.

6.3 The Annual People Committee Report shall include an assessment of compliance with the Committee's Terms of Reference and a review of the effectiveness of the committee.

6.4 The Chair of the Committee shall provide an update to the Council of Governors on the work of the Committee at least annually.

6.5 The Terms of Reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

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

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

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

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

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

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

7.7 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten working days of the meeting.

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: 12 April 2023
Date approved: [18 April 2023] [People Committee] and [TBA] [Trust Board]
Approved by: People Committee and Board
Trust Board review date: May 2024

QUALITY COMMITTEE ANNUAL REPORT 2022/23

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Quality Committee has met its key responsibilities for 2022/23, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during 2023/24.

2. COMMITTEE RESPONSIBILITIES

The Quality Committee is a non-statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience.

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

- The Trust has appropriate quality governance structures, systems, processes and controls in place and to meet Trust legal and regulatory requirements;
- The Trust delivers continuous quality improvements;
- Any shortcomings in the quality and safety of care are identified and addressed;
- The Trust's approach to continuous quality improvement processes for all Trust services, the Trust's research and development activities and its clinical practice, and assurances on robust mechanism of research governance which is subject to regular scrutiny and monitoring;
- The quality impact of changing professional and organisational practices;
- Ensuring the Trust fulfils its leadership and influencing role on service quality standards and practice; and
- Effective mechanisms were in place for the involvement of patients and the public, staff, partners and other stakeholders in improving quality assurance and patient safety.

It does this through the receipt of assurances from the management groups, the receipt of regular reports relating to areas which impact the quality of care provided to patients, such as Infection Prevention and Control (IPC), Safeguarding and Learning from Deaths (LfD), and discussions and reports on the management of risks relating to the committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of nine members (noting a minimum of 7 members is required as per the Terms of Reference), drawn from the Non-Executive Directors, members of the Executive Team and other senior staff members.

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

During 2022/23, the Committee met on a bimonthly schedule and six ordinary meetings were held between 1 April 2022 and 31 March 2023. In addition, during the year two deep-dive sessions were held for Committee members on agreed topics. Attendance at the meetings was as follows:

	Attendance at ordinary meetings
Graeme Chapman, Non-Executive Director (Committee Chair)	6 of 6
Kath McCourt, Non-Executive Director	6 of 6
Steph Edusei, Non-Executive Director	4 of 6
Andy Welch, Medical Director and Deputy CEO	4 of 6
Maurya Cushlow, Executive Chief Nurse	5 of 6
Martin Wilson, Chief Operating Officer	5 of 6
Angela O'Brien, Director of Quality and Effectiveness	6 of 6
Gus Vincent, Assistant Medical Director, Patient Safety & Quality	3 of 6
Ian Joy, Deputy Chief Nurse	6 of 6

Other attendees at the meetings have included:

- The Deputy Medical Director;
- The Associate Medical Director for Research;
- The Associate Medical Director – Quality & Patient Safety;
- The Director of Infection Prevention and Control;
- The Clinical Director for Quality and Safety (Chair of Patient Safety Group);
- The Infection Prevention and Control Lead;
- The Clinical Effectiveness Manager;
- The Deputy Director of Quality & Safety;
- The Associate Director of Midwifery;
- The Head of Patient Safety & Risk;
- A Head of Projects;
- The Head of Corporate Risk and Assurance;
- A Patient Safety Advisor;
- The Public Governor Chair of the Quality of Patient Experience Working Group; and

- The Corporate Governance Manager / Deputy Trust Secretary and PA to Chairman and Trust Secretary / Corporate Governance Administrator who provided Secretariat Support to the Committee.

4. MANAGEMENT GROUPS

To ensure that the Committee maintained adequate oversight of the management of quality related matters across the Trust, a series of Management Groups were established and continued to report into the Committee:

- Patient Safety;
- Patient Experience and Engagement;
- Clinical Outcomes and Effectiveness including updates from the Clinical Ethics Advisory Group; and
- Compliance and Assurance.

The Committee receive a report from two groups at each meeting, rotating across the course of the year. The reports detail the activities of the Management Groups and any risks/matters requiring escalation to the Committee. Additionally, the minutes of the Management Groups are received by the Committee at each meeting.

The Terms of Reference for each of the Management Groups, which clearly define the remit of each of the groups, were approved by the Committee on establishment, with any changes captured in the minutes of the groups shared with the Committee routinely.

In addition, a bi-annual Research and Development report is received by the Committee.

The Committee was established during 2019/20 following the review of the Trust's governance structure. During 2022/23, Committee members continued to review and refine the content, frequency, and scheduling of reports.

5. REPORTING

i. Regular Reports

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

- The Integrated Quality and Performance Report;
- Management Group Chair Updates;
- Leadership Walkabouts/Spotlight on Services;
- Care Quality Commission Update Reports and the latest Action Plan position;
- Legal Cases Update; and
- Ockenden Report Progress Updates and Maternity CNST Reports.

ii. Quarterly, Biannual and Annual Reports

The following Quarterly and Annual reports were received by the Committee during 2022/23:

- Safeguarding;
- Learning Disability;
- Patient Experience;
- People Committee Risk Report relating to the Committee's area of focus;
- Mortality and Learning from Deaths;
- Research & Innovation Bi-Annual Governance/Assurance Report;
- Health & Safety Annual Report;
- Clinical Audit Annual Report;
- End of Life and Palliative Care Bi-Annual Report;
- Quarterly Performance Review Process;
- PLACE assessment annual report;
- Newcastle Improvement Bi-Annual Report;
- Annual Peer Review Process Report;
- National Patient Safety Strategy Bi-Annual Report; and
- Quality Account Bi-Annual.

iii. Ad-Hoc Reports

In addition to those reports listed above, a number of ad-hoc reports have been received by the Committee. These included:

- National Patient Safety Strategy: Newcastle Hospitals response/plan.
- New and emerging risks: Escalation from Nurse Staffing and Clinical Outcomes Group.
- Reporting of Mixed Sex Accommodation.
- Wards of concern.
- Trust response to CQC MH/MCA report.
- Paediatric SARC report.
- Governor query – Dietetics Service.

6. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee developed a revised Schedule of Business during 2022/23 and utilised a rolling programme and action log to track committee actions.

As highlighted in Section 5(ii), the Committee received regular updates on risks recorded on the Board Assurance Framework (BAF) which related to the Committee's area of focus. There were three risks recorded on the BAF during 2022/23 relating to the Committee being:

- There is a risk that patients may present with or acquire infections including but not restricted to COVID-19, Influenza, MRSA, C Difficile, MSSA, GNBSI, Multi-resistant bacteria (e.g. CPE) or other harmful pathogens whilst in receipt of healthcare. This could result in harm to staff and patients, IPC outbreaks, shortage of staff and impact our ability to provide safe standards of patient care.
- There is a risk of regulatory intervention if we are unable to comply with mandatory NHS core standards which could impact on patient safety, quality of care and the reputation of the Trust.
- Failure to achieve required CQC standards could impact on the Trust's ability to remain "Outstanding".

The Committee received regular updates on the mitigating actions in relation to the three risks above and sought assurance that the risks were being managed effectively.

7. PROGRESS FOR 2022/23 & REVIEW OF EFFECTIVENESS

In the prior year Committee Annual Report, the following areas were identified to progress in 2022/23 – updates are shown in italic text below:

1. Following on from point 2 in section 7 above, separate deep dive sessions will be scheduled in the months in between the formal Committee meetings in order to build knowledge and understanding and provide further time for constructive challenge on specific topics.

   Agreed action completed – two deep dive sessions were held during the year and further deep dive sessions are scheduled during 2023/24. The topics for the sessions are agreed in advance with the Committee Chair and Executive Lead for the Committee.

2. At every formal Committee meeting, an update will be provided on the Trust performance against each Quality Priority included in the Trust Quality Account.

   Agreed action completed.

3. Further work is underway to restart/refresh the Executive Team member Leadership Walkabouts. For the Trust Non-Executive Directors, the virtual Spotlights on Services have transitioned to a hybrid model of both a virtual and in person element.

   Agreed action completed – the Leadership Walkabout programme was refreshed and recommenced during 2022/23. In addition, Spotlights on Services continued throughout 2022/23 and are scheduled for 2023/24.

4. A recent internal audit on the Trust Governance structure highlighted some recommendations and areas for consideration in relation to the Terms of Reference and reporting of business to ensure that the Committee appropriately discharges its assigned functions. A meeting will be scheduled with the Committee Chair and the Executive Lead of the Committee to discuss the recommendations/areas for consideration. This may result in further amendments required to the Committee Terms of Reference and Schedule of Business.

   Agreed action completed – meeting held, and changes incorporated during the year.

8. NEXT STEPS AND ACTIONS FOR 2022/23

The key areas of focus/actions to undertake during 2023/24 are:

- Ensuring items for escalation from the management groups are appropriately raised with the Committee and/or ensuring assurance is sought that actions identified in the management groups are actioned accordingly, with action tracking in place.

- Seeking assurance on the development of the new Trust Quality Strategy/PSIRF implementation.
- Seeking assurance regarding the process for evaluating the risk to Quality from deferred or declined business cases.
- Ongoing focus on past and future CQC inspections and recommendations.

The Terms of Reference and Schedule of Business for the Committee have been reviewed and minor changes agreed at the Committee in May 2023 – these have been appended for approval by the Trust Board.

Report of Kelly Jupp
Trust Secretary
7 May 2023

Committee / Group:	**Quality Committee**
Chair:	**Graeme Chapman**
Annual Cycle Covered:	**2023/24**

	Lead	Authors / contacts of the report	May-23	Jul-23	Sep-23	Nov-23	Jan-24	Mar-24	Notes
Standing Items									
Apologies for absence	Graeme Chapman		✓	✓	✓	✓	✓	✓	
Declaration of interests	Graeme Chapman		✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Graeme Chapman	Lauren Thompson	✓	✓	✓	✓	✓	✓	
Action log	Graeme Chapman	Lauren Thompson	✓	✓	✓	✓	✓	✓	
Meeting debrief and matters requiring escalation	Graeme Chapman	Lauren Thompson	✓	✓	✓	✓	✓	✓	
Regular Reports									
Minutes of management groups	Mike Clarke / Michael Wright / Gus Vincent / Maurya Cushlow	As below	✓	✓	✓	✓	✓	✓	
Management Group Chair Reports – to focus on two areas per meeting			✓	✓	✓	✓	✓	✓	
• Patient Safety Group (PSG)	Mike Clarke	Steve Stoker	✓		✓(AR)	✓		✓	
• Patient Experience & Engagement Group (PEEG)	Maurya Cushlow	Tracy Scott / Diane Cree	✓		✓		✓		Quarter 4 report includes the summary for the year
• Clinical Outcomes & Effectiveness Group (COEG)	Gus Vincent	Steve Stoker		✓(AR)	✓	✓		✓	July 2023 - AR and Chairs Report
• Compliance & Assurance Group (CAG)	Michael Wright	David Edwards			✓	✓(AR)	✓		
Safeguarding	Maurya Cushlow	Ian Joy / Diane Cree	✓(Q4 AR)		✓(Q1)	✓(Q2)		✓(Q3)	
Mortality/Learning from Deaths	Angela O'Brien	Louise Hall / Pippa Breakspear-Dean	✓(Q4 AR)		✓(Q1)		✓(Q2)	✓(Q3)	
Learning Disability	Maurya Cushlow	Ian Joy / Diane Cree	✓(Q4)		✓(Q1)	✓(Q2)		✓(Q3)	
Ockenden Report Update, to include Maternity CNST Quarterly Report when available	Maurya Cushlow / Angela O'Brien	Ian Joy / Diane Cree / Pippa Breakspear-Dean	✓		✓		✓		
Integrated Quality & Performance Report	Angela O'Brien / Martin Wilson / Julie Samuels	Louise Hall / Pippa Breakspear-Dean	✓	✓	✓	✓	✓	✓	
Leadership Walkabouts/Spotlight on Services Update	Angela O'Brien	Jack Bell	✓	✓(AR)	✓	✓	✓	✓	
CQC Updates	Maurya Cushlow / Angela O'Brien	Pippa Breakspear-Dean	✓(All)	✓(MH & LD)	✓(Maternity)	✓(All)	✓(MH & LD)	✓(Maternity)	
Quality Committee Risk Report	Natalie Yeowart	Natalie Yeowart		✓	✓		✓	✓	
Legal Update	Angela O'Brien	Pippa Breakspear-Dean	✓		✓	✓	✓		
Wards of concern	Maurya Cushlow / Ian Joy	Diane Cree		✓		✓		✓	
Annual/Biannual Reports									
PLACE Inspection Update Report	Maurya Cushlow	Ian Joy / Diane Cree	✓						
Health & Safety Annual Report	Craig Newby	Craig Newby		✓					
End of Life and Palliative Care	Maurya Cushlow	Ian Joy / Diane Cree	✓			✓			
Clinical Research	John Isaacs	John Isaacs			✓			✓	
Quality Account	Angela O'Brien	Louise Hall / Pippa Breakspear-Dean	✓			✓			
Newcastle Improvement	Iain Bestford	Iain Bestford	✓			✓			
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Kelly Jupp / Lauren Thompson	Kelly Jupp / Lauren Thompson	✓						
Clinical Audit#									
Strategy									
National Patient Safety Strategy (NPSS)	Angela O'Brien	Jo Ledger / Pippa Breakspear-Dean	✓(BAR)			✓(BAR)			
Quality Strategy (QS)	Angela O'Brien	Louise Hall / Pippa Breakspear-Dean		✓(Including Quality Priority 1)	✓(Including Quality Priority 2)	✓(Including Quality Priority 3)	✓(Including Quality Priority 4)	✓(Including Quality Priority 5)	
Patient and Public Engagement Strategy	Maurya Cushlow	Diane Cree	✓						
Clinical Strategy – AD HOC	Andy Welch	Ruth Hall							
Nursing, Midwifery, and Allied Health Professional Strategy – AD HOC	Maurya Cushlow	Diane Cree							
Ad Hoc reports to be considered									
Cardiac Oversight Group Report	Andy Welch	Caroline Docking / Ellspeth Marshall	✓	✓	✓	✓	✓	✓	
Policies/Internal audit reports [as and when required]	Exec Lead	Exec PA	✓						
Minimising nitrous oxide exposure update	Angela O'Brien	Louise Hall	✓						
Clinical Boards update including Governance	Martin Wilson	Margaret Gray / Hannah Morrison			✓			✓	

✓	On agenda and discussed
	Item deferred

The Annual Clinical Audit Report and regular updates feed into the COEG Chair updates/Annual Reports.

Requested attendees for the sessions are: the Committee Chair, NEDs, Director of Quality & Effectiveness, Deputy Director of Quality & Safety, subject matter experts and any external presenters (as required). Other Committee members/regular attendees do not need to attend the deep dive sessions unless they wish to do so.

Terms of Reference – Quality Committee

1. Constitution of the Committee

The Quality Committee is a non-statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience.

2. Purpose and function

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

2.1 that the Trust has appropriate quality governance structures, systems, processes and controls in place to achieve consistently safe high-quality care and to meet the Trust's legal and regulatory obligations;

2.2 on the Trust's approach to, and delivery of, continuous quality improvement so that is a hallmark of the way the Trust and its people work, recognised by stakeholders, including partners and the public;

2.3 that any shortcomings in the quality and safety of care against agreed standards are being identified and addressed in a systematic and effective manner;

2.4 on the Trust's research and development activities and its clinical practice, acting as a guardian and advocate; and to seek assurance that the Trust has a robust mechanism of research governance which is subject to regular scrutiny and monitoring;

2.5 on the quality impact of changing professional and organisational practices, including those involved in increased system-based and partnership working (in collaboration with the People Committee);

2.6 that the Trust fulfils its leadership and influencing role on service quality, standards and practice, as an organisation of national importance, as a significant service provider and as a partner in training, education and development of health and care capacity in the region (in collaboration with the People Committee) and beyond;

2.7 around current and future statutory and mandatory quality and patient safety standards, such as Care Quality Commission (CQC) Fundamental Standards, and the actions needed to meet them;

2.8 on the effectiveness of mechanisms used for the involvement of patients and the public, staff, partners and other stakeholders in improving quality assurance and patient safety at the Trust, and report on their value and impact to the Board; and

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

3. Authority

The Committee is:

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

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

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

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

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

4. Membership

4.01 Members of the Committee shall be appointed by the Board of Directors and shall be made up of least seven members drawn from Non-Executive Directors (three members minimum) and members of the Executive team (four members).

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

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

4.04 The membership shall include:

- the Medical Director;
- the Executive Chief Nurse;
- the Chief Operating Officer;
- the Director of Quality and Effectiveness;
- the Associate Medical Director, Patient Safety and Quality; and
- the Deputy Chief Nurse

4.05 The Chair of the Board of Directors and the Chief Executive shall not be members of the Committee, but may be in attendance.

4.06 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

Additional (non-core) membership will be drawn from the senior clinical leadership teams within the Trust, including the Deputy Medical Director, the Director of Midwifery and Assistant Medical Director – Research and Development), to provide the depth and breadth of experience required to inform the committee to complete its business effectively.

4.07 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings.

4.08 The Director of Quality and Effectiveness shall act as the Executive Lead for the Committee.

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

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

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

4.12 All members of the Committee shall receive training and development support before joining the Committee where required and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

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

Quorum

4.14 The quorum necessary for the transaction of business shall be four members, as defined in 4.01 and 4.04 above, including the Chair or Vice Chair, and at least one other Non-Executive Director.

4.15 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will not count towards the quorum.

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

5. Duties

5.1 Cycle of Business

The Committee will:

5.1.1 set an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

5.2 Strategy

The Committee will:

5.2.1 advise and contribute to the strategic quality priorities and investments needed to support high-quality clinical outcomes and improve clinical effectiveness in the Trust, and advise the Board accordingly;

5.2.2 review the Trust's Quality Strategy, Quality Account and related delivery plans and programmes, and provide informed advice to the Board on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact;

5.2.3 take note of international intelligence and research evidence on clinical safety and practice and distil their relevance to the Trust's strategic quality priorities (including where necessary commissioning research to inform its work);

5.2.4 be assured around the monitoring of the Trust's suite of quality-assurance policies against benchmarks to ensure they are comprehensive, up-to-date and reflect best practice; and

5.2.5 scrutinise and triangulate advice on the development of significant clinical and quality policies prior to their adoption.

5.3 Risk

The Committee will:

5.3.1 receive risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit Committee with assurance on the effectiveness of the management of principal risks relating to the Committees purpose and function.

5.3.2 to receive the Executive Oversight Report for information.

5.4 Outcomes and processes

The Committee will:

5.4.1 review the Quality Account to be assured it reflects the integration of clinical quality and patient safety improvement processes;

5.4.2 be assured of the integrity of the Trust's control systems, processes and procedures relating to critical areas, to include:

- high quality care (through the Trust's quality review processes);
- compliance with fundamental standards of quality and safety;
- patient safety and harm reduction;
- safeguarding – adults and children
- infection prevention and control;
- clinical audit;
- introduction of new clinical pathways and procedures;
- introduction of new clinical roles (in conjunction with the People Committee);
- dissemination and implementation of statutory guidance;
- escalation and resolution of quality concerns; and
- patient and carer involvement and engagement.

5.4.3 ensure the effective operation of processes relating to clinical practice and performance, including early detection of issues and problems, escalation, corrective action and learning.

5.5 Learning and communication

The Committee will:

5.5.1 be assured of the effectiveness of systems and processes used for continuous learning, innovation and quality improvement, establishing ways of gaining assurance that appropriate action is being taken;

5.5.2 be assured that the robustness of procedures ensure that adverse incidents and events are detected, openly investigated, with lessons learned being promptly applied and appropriately disseminated in the best interests of patients, of staff and of the Trust;

5.5.3 be assured that evidence-based practice, ideas, innovations and statutory and best practice guidance are identified, disseminated and applied within the Trust;

5.5.4 develop and oversee a programme of activities to engage Board members directly in quality assurance processes and to ensure that such processes include the establishment of a procedure to review, distil and implement the learning from these activities, including 'walk-abouts', reviews, focus groups and deep-dives; and

5.5.5 be assured of the effectiveness of communication, engagement and development activities designed to support patient safety and improve clinical governance.

5.6 Patient and public engagement

The Committee will:

5.6.1 be assured of the effectiveness of a credible process for assessing, measuring and reporting on the 'patient experience' in a consistent way over time, including the appropriateness and effectiveness of processes for patient engagement in support of the Trust's strategic goals and programmes of work.

5.7 Research

The Committee will:

5.7.1 triangulate through assurance the robustness of quality-assurance processes relating to all research undertaken in the name of the Trust and / or by its staff, in terms of compliance with standards and ethics, and clinical and patient safety improvement processes.

5.8 Progress and performance reporting

The Committee will:

5.8.1 review a range of evidence and data from multiple sources, including management and executive committees and groups, on which to arrive at informed opinions on:

- the standards of clinical, service quality and patient safety in the Trust;
- compliance with agreed standards of care and national targets and indicators; and
- organisational quality performance measured against specified standards and targets;

5.8.2 review a succinct set of key performance and progress measures relating to the full purpose and function of the Committee;

5.8.3 review progress against these measures on a regular basis and seek assurance around any performance issues identified, including proposed corrective actions and reporting any significant issues and trends to the Board of Directors;

5.8.4 review and shape the quality-related content of the bi-monthly Quality and Performance Reports to the Board of Directors;

5.8.5 agree the programme of benchmarking activities to inform the understanding of the Committee and its work;

5.8.6 be assured of the credibility of sources of evidence and data used for planning and progress reporting to the Committee and to the Board in relation to the Committee's purpose and function;

5.8.7 ensure alignment of the Board assurances and consistent use of data and intelligence, by working closely with the Audit Committee, People Committee and the Finance Committee;

5.8.8 review the following formal reports prior to submission to the Board of Directors as part of the Annual Cycle of Business:

- an Annual Quality Report to inform and / or accompany the Trust's Annual Report;
- Infection Prevention and Control Annual Report;

- Safeguarding Annual Report; and
- the process for management review of specific service reports.

5.9 Statutory and regulatory compliance

The Committee will:

5.9.1 be assured of the arrangements for ensuring maintenance of the Trust's compliance standards specified by the Secretary of State, the CQC, NHS England, and statutory regulators of health care professionals.

6. Reporting and Accountability

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

6.2 The Committee will provide an Annual Report to the Board to inform and / or accompany the Trust's Annual Report. This shall include an assessment of compliance with the Committee's Terms of Reference and a review of the effectiveness of the committee.

6.3 The Chair of the Committee shall provide an annual update to the Council of Governors on the work of the Committee.

6.4 The Terms of Reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

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

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

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

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

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

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

7.7 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten days of the meeting.

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: 7 May 2023
Date approved: 16 May 2023 [Quality Committee] and [TBA] [Board]
Approved by: Quality Committee and Board
Trust Board Review date: May 2024

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	25 May 2023						
Title	CIO - Quarterly Board Report						
Report of	Graham King, Chief Information Officer						
Prepared by	Lisa Sewell, Head of Digital Innovation and Delivery, Joanne Field Head of Information services, Bob Beckwith, Infrastructure Manager						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☐	☒				
Summary	This paper is to provide assurance to the Board on progress against the Trust's Digital Strategy. This is a Quarterly report summarising key developments over the previous quarter. The Report covers the six key strategic development areas: • Digital Patient Journey – to transform the way in which we engage with our patients to improve their experience and better engage them in their care. • Staff and Digital Services – optimise systems to improve experience, efficiency, and safety • Research – how digital and data services are being developed to support clinical and academic research • National & Regional – progress being made in the development and delivery of local and national initiatives • Data to Intelligence – progress on the development of data, services and skills to better enable planning and predictive analysis • Innovation – development of programmes to explore future capabilities to improve safety and efficiency						
Recommendation	The Board is requested to receive the report and note the progress made.						
Links to Strategic Objectives	This request links to all Strategic Objectives outlined by the Trust.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☒	☒	☒	☒
Link to Board Assurance Framework [BAF]							
Reports previously considered by	Quarterly CIO Report.						

CIO - QUARTERLY BOARD REPORT

EXECUTIVE SUMMARY

During the period January to May 2023 several initiatives have been progressed and new services introduced to improve our patient's digital experience and optimising how our staff manage their workload more effectively and handle external requests. This report provides an update on benefits identified and a summary of new services introduced.

The reporting period saw the introduction of the following notable service enhancements and achievements:

- **Clinical Coding** – the clinical coding team received 'exceeds standards' in the external audit as part of the Trust's assessment against the national Data Security Protection Toolkit requirement.
- **A digitised Subject Access Request process** – this streamlines the process reducing administrative overhead and makes it easier for requestors to track progress.
- **Care Coordination System** – The provision of near real time data to support elective care coordination and theatre utilisation.
- **Outpatient Transformation** – implementation of the Patient Engagement Platform allowing patients to access and manage their appointments digitally, via the NHSApp.
- **Closed Loop Blood 2nd phase** – measurement of the anticipated benefits has demonstrated efficiency, quality and cost reduction improvements.
- **Care for Me, With Me –** this was a short agile project supporting the Executive Chief Nurse in responding to Care Quality Commission inspection comments.
- **Great North Care Record –** the regional shared care record, delivered by Newcastle, has now passed 10 million user views together with enhanced data flows making all community data visible across the region.

Next quarter activity is focused on:

- **Digital Virtual Wards** – finalise procurement and implementation of the Digital Platform to support the delivery of support for patients who are cared for within a Virtual Ward Care Model.
- **Ward Managers Compliance Dashboard** - The development of automated reporting for clinical safety metrics supporting ward leaders and senior nurses to monitor compliance.
- **Cyber Security** – replacement and upgrade of several components of the Trust's cyber defences.
- **Discharge Process Enhancements** – this is a prerequisite to implementation of Optica, NENC Patient Flow; a regional solution providing greater visibility of patient status at a NENC level and supports improved discharge of patients to an appropriate care setting.

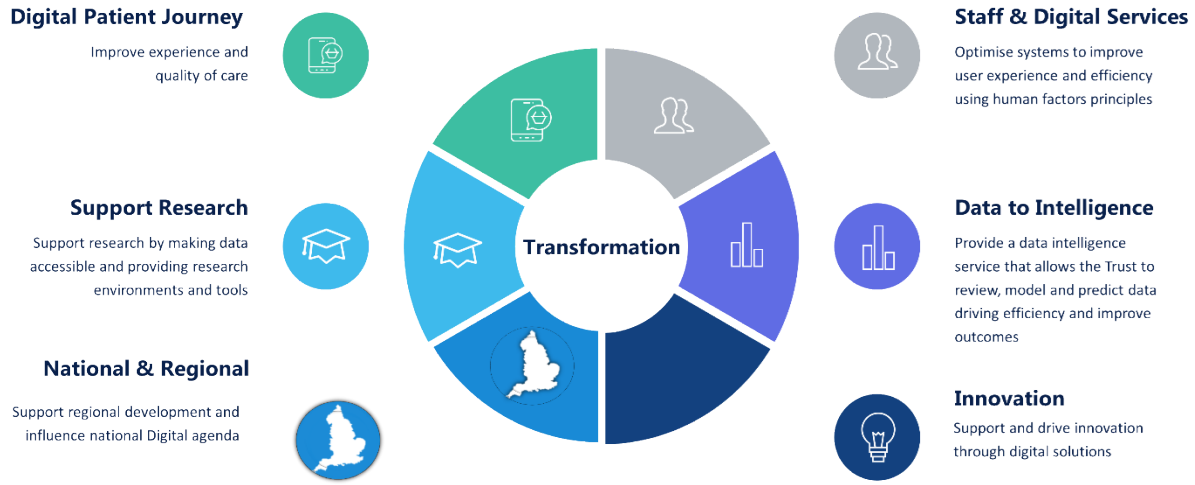
Further detail is provided under the Digital Strategy headings in the main body of the report. The Board is asked to note the contents of the report and the progress made in each area.

Report of Graham King
Chief Information Officer
May 2023

CIO - QUARTERLY BOARD REPORT

1. SUMMARY

This report sets out the strategic initiatives underway in support of the six Digital Strategy themes. The Strategy is supported by a revised resource profile and team structure set out in the Digital Investment Case underpinning the strategy.



2. STAFF & DIGITAL SERVICES

Closed Loop Bloods Transfusion

The second phase of the project introducing full closed loop management from patient to product is underway. Rollout is progressing with Theatres the final area for implementation. The benefits identified to date are:

- Positive Patient Identification and Wrong Blood in Tube (WBIT)
  - Prevention of sample labelling errors and WBIT events.
  - Sample rejection rate reduced from 2.5% in March 2022 to 1.3% in March 2023.
- Staff time
  - Reduction in second person checking on transfusion commencement.
  - 20% reduction in quarterly transfusion related Datix submissions.
- Reduction in blood wastage, due to digital stock management
  - 34% less wastage and financial saving of approximately £7,500 a month.
- Traceability of blood products – MHRA compliance
  - Improved from 99.0% (2021-22) to 99.79% (2022-23).
- Reducing scanning in medical records
  - 54% reduction in transfusion document scanning.

Care for Me, With Me

The Care for Me, with Me workstream has made enhancements to make the documentation of patients that require a Mental Capacity Assessment and/or Best Interests decision more robust. The Mental Capacity Assessment must now be documented at the same time as any changes to a patient's resuscitation status and treatment escalation plan. These changes were released in April 2023 in response to CQC feedback.

Receiving Lead Clinician for Investigations, Results, Actions

By default, the eRecord system sends the results of investigations to the lead clinician associated with an episode of care. This is not always the most appropriate recipient and could potentially delay the delivery of appropriate care.

A mandatory "clinician to receive report" field for MRI and CT reports was added in November 2022. This significantly increased the proportion of results going immediately to the right clinician. With the expected benefits realised in the initial area. The process has been expanded to encompass all imaging tests, including all radiology and echocardiography requests over first quarter of 2023.

Consultation is underway on the process to extend this to all investigations across the Trust, and to standardise the process of viewing and endorsing new results.

Digital Handover

Historically, handover has been a paper-based process across the NHS. With the adoption of the digital systems in eRecord in the Trust, it is possible to enhance the process in line with BMA and Royal College recommendations. The Digital Handover project reviewed all handover processes across the Trust, consulted all stakeholders and reviewed national guidance from the Royal Colleges and British Medical Association:

Royal college of physicians	*'define common core principles for handover*, which can be adapted locally. For example, *a standardised proforma for written handover is essential*, preferably in conjunction with face-to-face verbal handover. …*where possible, electronic handover processes should be encouraged.'*
Royal college of surgeons	*The potential for using electronic information sharing should be explored* (e.g. personal digital assistants, *'live lists' of patients* and their responsible consultant surgeon on hospital PCs), but whiteboards and paper-based handovers also work well.
BMA, safe handover, safe patients	*An electronic information-sharing system that works effectively can be time neutral for junior doctors compared with traditional paper based or verbal handover. It may also contribute to safety*

To improve process a live ward review screen was implemented which shows patient details including location, coded diagnoses, National Early Warning Score (NEWS), the most recent vital signs and laboratory results, resuscitation status, Venous Thrombo-Embolism status, and handover actions to be completed.

The process was evaluated on a single ward with rollout continuing across medical, surgical, and paediatric wards, with Trust wide rollout and its longer-term support being planned.

Cyber Security

The annual renewal of the Trust's Data Security and Protection Toolkit (DSP) compliance is in progress with evidence of processes, policies and working procedures relating to data security and protection being submitted to external Auditors to complete the annual assessment and assurance.

In line with the refresh policy a review of the present PC device estate (desktops and laptops) is underway to assess and plan the refresh and replacement of aged PC devices. Any device that is either out of warranty, does not meet the current approved minimum specification or is over 5 years old is considered for refresh as part of this activity.

Cyber security compliance is continually monitored for the Microsoft Windows client (desktops and laptops) and server IT estate. Compliance of the estate continues to be above required minimum standard as required by the DSP.

Multi Factor Authentication (MFA) is being enabled to prevent unauthorised use of accounts and maximise cyber security compliance. Introduction of new services to replace aging technology to provide Anti-Virus, Internet & Email protection, and Mobile Device Management (MDM) is in process.

3. DATA TO INTELLIGENCE

A key aim of the Digital Strategy is to use clinical information captured within a patient record to develop clinical audit and research capability. The implementation of the Clinical Data Warehouse is nearing completion and already provides near real-time data reporting across a full range of clinical data held within the electronic patient record. The implementation provides access to data that was previously only possible by auditing paper case notes and gives the Trust the opportunity to expand the scope and volume of clinical audit across our patient pathways. Visibility of this data is vital in terms of clinical performance management, patient safety and supports Newcastle Improvement initiatives.

The development of priority clinical safety metrics is underway through the Ward Managers Compliance Dashboard, this will allow ward leaders and senior nurses to monitor compliance of the following:

Phase 1 – In final testing

- Safety Assessment
- Falls Assessment
- Risk of pressure ulcer assessment
- Nutritional assessments
- Moving and Handling Assessment
- Skin Assessment

Phase 2 – Under development

- Admission Assessment
- Intravenous line (IV) checks
- Nasogastric (NG) Tube checks
- Urinary Catheter checks
- Venous thromboembolism (VTE) assessment

Clinical Coding Audit

The Clinical Coding department recorded fantastic results and feedback when they were externally audited against the Department of Health and Social Care's Data Security Standards, earlier this year.

The results from the audit provided assurance that our clinical coding is of an exceedingly high standard. This positively reflects our data quality and confirms we are delivering a data intelligence service that allows the Trust to review, model and predict data, which drives efficiency and improves outcomes.

Care Coordination System

Every year, over 60,000 people have an elective procedure carried out in a surgical theatre at Newcastle Hospitals. With patients travelling from across the city, region and further afield to be treated, it is crucial every theatre list is utilised as best as possible.

A new Care Coordination System (CCS) has been introduced to support the optimising of our theatre capacity. This relies on our use of data to support clinicians and hospital staff to treat patients more efficiently. The system is being piloted in the Urology service, as we look to see how it can be fine-tuned before being rolled out trust wide.

Currently, information is captured on the EPR, but does not flow to clinicians or schedulers to inform the booking process. CCS is designed to provide a single consistent waiting list that is visible to everyone. It enables consultants, schedulers, pre-assessment, and data quality teams to have clean, validated information, created from a single 'source of truth' derived from live data and synced with the electronic patient record. The CSS will routinely display booking instructions to ensure patients are scheduled in the right order, at the right time on the right list.

4. SUPPORTING RESEARCH

The Trust is partnering with Newcastle University and other national research bodies on high-profile studies, including AI-Multiply, ADMISSION and the Biomedical Research Centre themes, which focus on multi-morbidity, polypharmacy and precision medicine. Each of these is enabled by access to rich healthcare information. The Trust's Information Services team has created a clinical data warehouse to enable data extraction for research projects and complete real-time clinical audit.

A Data Science Manager has been appointed and funding secured for data analysis to support this work. The Directorate is now actively working in the regional team with the Integrated Care Board, Academic Health Science Network, regional Universities, North of England Commissioning Support Unit, and healthcare providers, to secure long-term funding from NHS England for the North East and North Cumbria Secure Data Environment. This will be transformational in our ability to improve patient care and safety using routinely collected clinical data for research, audit and quality improvement.

5. ARTIFICIAL INTELLIGENCE PROJECTS

As part of our development partnership with 3M Healthcare, we are using the clinical artificial intelligence natural language understanding system, Follow-Up Finder, to undertake a quality improvement project with the Trust thrombosis service. Instead of the nursing team spending time reviewing the radiology reports of the investigations most likely to identify important thromboses, they will be presented with a list of all patients with reports of thromboses so that they can immediately take the appropriate action and release time to care.

Training of the AI model has completed with activity now focused on adjusting its sensitivity and specificity. Design of the data interfaces and display within eRecord for clinicians is in progress, with a plan for QI evaluation in July 2023. The expectation is for this methodology to be extremely valuable across eRecord to highlight important clinical findings and improve clinical safety.

6. NATIONAL & REGIONAL

The Great North Care Record (GNCR) continues to increase its coverage across the region and has surpassed over 10 million user views since its launch in 2020.

The GNCR electronically connects patient information from GPs, local hospitals, ambulance service (NEAS), social care, community, hospices and mental health teams together across the region, helping to make more effective patient care.

There are currently 25 projects in delivery, which have been considered as part of the NENC ICS priorities. Hospices and the 0-19 Services recently onboarded to the GNCR framework. Other key deliverables for the region include GP Connect integration which will provide full structured data for all primary care information and direct integration with the regional maternity system, BadgerNet.

Next phase work is now focused on supporting the end-of-life pathway to bring greater visibility of patient choice to organisations involved in their care.

7. DIGITAL PATIENT JOURNEY

The Trust has committed to become fully digitally enabled and is leading the way in health informatics and digital services at a regional and national level. The **Patient Engagement Platform** (PEP) supports the improvement of patient experiences as they interact with the service, whilst also providing efficiency savings to the NHS. On 14 March 2023 Newcastle Hospitals successfully deployed with a First of Type solution connected to the National NHS App, providing a trial for a selected cohort of patients across selected Rheumatology clinics. Patients now engaging digitally with our Appointment Booking Centre through the NHS App, to amend, and cancel their appointments.

Forthcoming updates to the platform will include updated messaging processes to encourage and remind patients of upcoming appointments, along with in-app notifications and business logic driven model to encourage digital adoption in advance of traditional postal methods. This core technology will also in time support Virtual Wards and digital Preassessment Clinics to allow patients to complete questionnaires on-line.

New Subject Access Request Portal
The SAR team launched a cloud-hosted portal, which collects documents in an online repository. It allows patients, and their representative, to submit requests and access sets of medical record documents online. The portal also allows requesters to track their request progress and speak with the team via a secure messaging system.

8. INNOVATION

Clinical Documentation Improvement (CDI Engage). Engagement has commenced with 3M for the utilisation of Natural Language Understanding (NLU) Artificial Intelligence, (AI) to automatically identify the most common documentation deficiencies at the time of clinical document creation. The aim is to use the AI to reduce documentation gaps and improve the quality of information in real time.

Information Services will identify documentation deficiencies where maximum benefits can be gained.

The Trust and 3M / M*Modal are working collaboratively on a first of type pilot in the UK of Follow Up Finder. The software uses 3M's Clinical Documentation Exchange and Catalyst software platform to identify patients requiring follow up appointments. The proof-of-concept trial was selected based upon a Quality Improvement proposal from the Thrombosis team. Follow Up Finder will identify patients with four types of thrombosis, Deep Vein Thrombosis, Pulmonary Embolism, Superficial Thrombus / Thrombophlebitis and Venous Thromboembolism. The benefits will be the capture of new thrombosis will be more complete and timelier, allowing nursing time to be spent on clinical care. Early patient and clinician support from the thrombosis nurse specialists supports the optimisation of thrombosis management. Follow Up Finder could be utilised in other areas of the Trust if the pilot proves successful.

9. KEY ACTIVITIES NEXT QUARTER

The next quarter activity is directed to supporting the Trust recovery activity through the implementation of several key initiatives:

- **Waiting List Validation** – the provision of two-way text service to communicate with patients to confirm status.
- **Optica, NENC Patient Flow** - implementation of a Regional Solution that supports greater visibility of patient status at a NENC level and supports improved discharge of patients to an appropriate care setting.
- **ICNET** – implementation of a solution for maintaining and achieving a sustainable reduction in healthcare associated infections (HCAI), and a viable antimicrobial stewardship (AMS) programme.
- **Digital Virtual Wards** – implementation of a Digital Platform that supports the delivery of at home personalised care for appropriate patients who would benefit from the Virtual Ward Care Model.
- **Outpatient Transformation** – further implementation of the Patient Engagement Platform to make appointments available digitally, via the NHSApp.
- **Pharmacy Acuity Tool** – this provides greater visibility of high-risk patients to facilitate pharmacy review with the intent to reduce medication errors. Implementation is scheduled for September 2023.
- **MASEY** – improving the capture of colposcopy data to improve national reporting and support quality assurance of the service.
- **Newcastle Hospitals Intranet** – new and improved internal staff intranet which can be accessed remotely, providing superior navigation functionality, allows for customisation and is easy for editors to manage content.
- **Education Centre –** two new education centres for staff based at the Freeman Hospital and Eldon Court.
- **Medicus (Ward Watcher Replacement) -** replacement of Wardwatcher in Peri-Ops and ICU.

Alongside the delivery of the programme of work the Directorate is reviewing the prioritisation criteria to align these with the Business Case process and re-align the governance and assurance process to the proposed Clinical Boards.

10. RECOMMENDATION

The Board is requested to receive the report and note the progress made.

Report of Graham King
Chief Information Officer
May 2023

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