The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Public Trust Board of Directors' Meeting

Tuesday 26 September 2023, 13:15 – 16.00

Venue: Freeman Boardroom for Board members only, all others to dial in via MS Teams

Agenda

Item		Lead	Paper	Timing
Standing items:				
1.	Apologies for absence and declarations of interest	Sir John	Verbal	13:15 – 13:16
2.	Minutes of the Meeting held on 27 July 2023 and Matters Arising	Sir John	Attached	13:16 - 13:18
3.	Chairman's Report	Sir John	Attached	13:18 – 13:23
4.	Chief Executive's Report	Dame Jackie	Attached	13:23 – 13:33
Strategic items:				
5.	Patients: Digital People Story	Ian Joy	Attached	13:33 – 13:43
6.	Patients: Care Quality Commission (CQC) update	Martin Wilson	Verbal	13:43 – 13:48
7.	Patients: Winter Plan	Martin Wilson	Presentation	13:48 – 13:58
8.	People: People Update	Christine Brereton	Attached	13:58 – 14:13
9.	Performance: (i) Performance Report; (ii) Quarter 1 Delivery Goal progress	 Vicky McFarlane-Reid & Martin Wilson Vicky McFarlane-Reid	 Attached Attached	14:13 – 14:30
10.	Partnerships: Charity update	Teri Bayliss	Attached	14:30 – 14:40
	Refreshment break			***14:40 – 14:50***
Business Items:				
11.	Director reports: a. Medical Director; including: (i) Consultant Appointments (ii) Annual Revalidation Report	Andy Welch	Attached & BRP	14:50 – 15:00
	b. Executive Chief Nurse; including: (i) Maternity Services update	Ian Joy	Attached & BRP	15:00 – 15:10
	c. Director of Quality & Effectiveness; including; (i) Maternity Incentive Scheme (MIS) Year 5 CNST Compliance (ii) Health and Safety Annual Report	Louise Hall	Attached & BRP	15:10 – 15:20

	(iii) Mortality and Learning from Deaths			
	d. Healthcare Associated Infections (HCAI)	Julie Samuel	Attached & BRP	15:20 – 15:25
12.	Sustainable Healthcare in Newcastle (SHINE) Annual Report	James Dixon	Attached	15:25 – 15:35
13.	Fit and Proper Persons Test Framework	Caroline Docking & Christine Brereton	Attached	15:35 – 15:40

Items to receive and any other business: 15:40 – 16:00

14.	Update from Committee Chairs	Committee Chairs	BRP
15.	Charity Committee Annual Review including Terms of Reference and Schedule of Business *[For approval]*	Caroline Docking	BRP
16.	Integrated Board Report	Martin Wilson	BRP
17.	Fit for the Future Programme Update	Martin Wilson	BRP
18.	Meeting Action Log	Sir John	BRP
19.	Any other business	All	Verbal

Date of next meeting: Thursday 30 November 2023

Professor Sir John Burn, Chairman

Dame Jackie Daniel, Chief Executive Officer

Mr Andy Welch, Medical Director/Deputy Chief Executive Officer

Dr Vicky McFarlane-Reid, Executive Director for Business, Development & Enterprise

Mr Martin Wilson, Chief Operating Officer

Mrs Christine Brereton, Chief People Officer

Mrs Caroline Docking, Assistant Chief Executive

Mr Ian Joy, Deputy Chief Nurse

Mrs Louise Hall, Deputy Director of Quality & Safety

Ms Julie Samuel, Director of Infection Prevention and Control

Mr Jonathan Jowett, Non-Executive Director/Chair of People Committee

Mr Graeme Chapman, Non-Executive Director/Chair of Quality Committee

Mr Bill MacLeod, Non-Executive Director/Chair of Audit Committee

Ms Jill Baker, Non-Executive Director/Chair of Charity Committee

Miss Christine Smith, Non-Executive Director/Chair of Finance Committee

Ms Teri Bayliss, Charity Director

Mr James Dixon, Associate Director - Sustainability & Environment

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PUBLIC TRUST BOARD OF DIRECTORS MEETING
DRAFT MINUTES OF THE MEETING HELD 27 JULY 2023

Present:	Professor Sir J Burn *[Chair]*	Chairman
	Dame J Daniel	Chief Executive Officer [CEO]
	Mr A Welch	Medical Director/Deputy Chief Executive Officer [MD/DCEO]
	Ms M Cushlow	Executive Chief Nurse [ECN]
	Mrs J Bilcliff	Chief Finance Officer [CFO]
	Dr V McFarlane Reid	Executive Director of Business, Development & Enterprise [EDBDE]
	Mr M Wilson	Chief Operating Officer [COO]
	Mr G Chapman	Non-Executive Director (NED)
	Mr B MacLeod	NED
	Professor K McCourt	NED
	Mrs L Bromley	NED
	Ms J Baker	NED
	Mr J Jowett	NED
	Ms S Edusei	NED
	Miss C Smith	NED

In attendance:
Mrs C Docking, Assistant Chief Executive [ACE]
Mr G Evans, Deputy Director of Estates [DDE]
Mrs C Brereton, Chief People Officer [CPO]
Mrs K Jupp, Trust Secretary [TS]
Mrs J Samuel, Director of Infection Prevention and Control [DIPC]

Observers:
Professor P Home, Public Governor
Mr I Frenette-Wood, Public Governor
Dr A Dearges-Chantler, Public Governor
Mrs C Watson, Public Governor
Mr M Discombe, Health Service Journal (HSJ)
Ms Danielle Hurlbutt, Member of the Public
Ms Sarah Mackie, Medtronic

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

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

23/13 STANDING ITEMS

i) Apologies for Absence and Declarations of Interest

Apologies for absence were received from Associate NEDs David Burn and Pam Smith, Rob Smith, Estates Director (ED) and Lisa Sewell, Interim Chief Information Officer (ICIO).

ii) Minutes of the Meeting held on 25 May 2023 and Matters Arising

The minutes from the meeting held on 25 May 2023 were agreed to be an accurate record subject to the correction of two minor typographical errors, the first regarding Mr Jowett incorrectly being recorded both as in attendance and providing apologies, and the second regarding the spelling of Professor Pearson's surname. There were no matters arising.

It was resolved: to **agree** the minutes as an accurate record following the correction of the two matters highlighted above, and to **note** there were no additional matters arising.

iii) Chairman's Report

The Chairman presented the report, noting:

- He had attended a Spotlight on Services session with Mr MacLeod at the Dental Labs where a demonstration took place on the world class reconstruction prostheses made by expert technicians who work with three dimensional reconstructions alongside the maxillofacial surgical team.
- He had attended a further Spotlight on Services session with several of the NEDs with the Chaplaincy team where Katie Watson, Head of Chaplaincy delivered a presentation outlining the role of her team. The presentation demonstrated the hard work and commitment of the Chaplaincy team.

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

iv) Chief Executive's Report

The CEO presented the report, highlighting the following points:

- With regards to industrial action, gratitude was expressed to all involved in the planning/preparation for each round of industrial action, as well as to all staff providing additional cover and support during the action periods. The CEO acknowledged the significant impact on the Trust's operations, particularly elective activity and outpatient appointments. The focus during the periods of industrial action has continued to remain on patient safety and reducing the impact of the action on both patients and staff.
- The NHS Long Term Workforce Plan was published at the end of June 2023, which sets out key areas of focus for NHS organisations. It was noted that the CPO, ECN and MD/DCEO will be heavily involved in 'localising' the national Workforce Plan, as well as continuing to develop the Newcastle Hospitals workforce plan.
- In relation to the Care Quality Commission (CQC) unannounced inspection, thanks were expressed to all staff involved and the engagement that has taken place to date. It was noted that CQC had requested a significant amount of data as part of their inspection which had impacted on team resources.

- Newcastle Hospitals in partnership with Gateshead Health NHS Foundation Trust have now signed a long-term lease with the Metrocentre for the new Community Diagnostic Centre (CDC). The impressive joint working between the two organisations was noted.
- In June, the trust's food and drink strategy for 2022 to 2027 was launched, which outlines Newcastle Hospitals' ambitions in delivering high quality nutrition and hydration care, recognising the importance of offering healthy, balanced food and drink choices for patients, visitors, carers, volunteers and staff.

  Ms Baker highlighted that the on-site Fruit and Vegetable stalls had been funded by Newcastle Hospitals Charity.

  Ms Baker commented that the ward sisters are impressed with the Trusts food and drink strategy for 2022 to 2027. She referred to the NHS Long Term Workforce Plan and said that it would be beneficial to think about career pathways and mentoring for medical staff.

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

23/14 STRATEGIC ITEMS

i) Patients: Digital People Story

The ECN introduced the digital people story noting that the story highlights an improvement project undertaken in conjunction with one of the local care homes to help prevent, and manage, Urinary Tract Infections (UTIs).

Mrs Bromley queried if the Trust collates data from the project to demonstrate a positive impact in reducing the number of infections. The ECN confirmed that this is part of the process and the project has been highlighted in recent learning and sharing events. She agreed to share the data/information available **[ACTION01]**. The DIPC advised that discussions take place at the Gram Negative Steering Group in relation to reducing Gram Negative bacteraemia infections and the group are working through how to share data with the Clinical Boards.

It was resolved: to **receive** the digital people story.

ii) Patients: Care Quality Commission (CQC) update

The ECN advised that the CQC commenced an unannounced inspection on 27 June 2023. The inspection is currently in its final stages, with the CQC inspectors having visited several core service areas as well as conducting focus groups with staff. The 'well-led' interviews were held this week and high-level feedback will be received later today.

The ECN confirmed that any issues arising during the inspection have been actively addressed as part of normal practice.

Ms Edusei explained that several of the NEDs have been interviewed by inspectors and expressed her gratitude to the Executive Team and all staff involved in the inspection, acknowledging the additional pressure/anxiety which can arise during any inspection.

It was resolved: to **receive** the CQC update.

iii) Partnerships: Partnership Update

The COO, EDBDE, ACE and ECN provided the update, highlighting the following points:

- As a major tertiary and quaternary provider, the Trust is a key member of the Provider Collaborative and the North East and North Cumbria (NE&NC) Integrated Care System (ICS).

  Mr Jowett queried what services sit under 'quaternary' to which the COO confirmed that he will share a breakdown of the tertiary and quaternary services. He noted that 20% of beds are occupied by tertiary and quaternary services **[ACTION02].**
- An internal review of acute collaborations showed that there are 121 acute collaborations which Newcastle Hospitals is involved with, ranging from on-call rotas to Multi-Disciplinary Teams (MDTs) and joint service provision. Some examples of partners providing mutual aid include:
  - Working with Northumbria Healthcare NHS Foundation to reduce the number of patients waiting over 78 week waits and 104 week waits for spinal surgery and foot and ankle surgery; and
  - Working with Gateshead Health NHS Foundation Trust on the development of the new CDC and working closer on Pathology Services.
- Collaborative Newcastle, a partnership of NHS, local government and voluntary and community sector, won a Health Service Journal (HSJ) award for effective partnership working to support care homes and their staff during the pandemic.

  Collaborative Newcastle was established to improve health outcomes and tackle inequality for residents within Newcastle. A significant area of focus of Collaborative Newcastle has been on improving healthy life expectancy, primarily because life expectancy in Newcastle is circa 5.5 years less than the England average and 20% of that gap is driven by access to healthcare, with the remainder relating to homes, jobs, friends, communities and the environment. Drivers of deprivation all contribute to ill health.

  Collaborative Newcastle has five priorities, being:
  - Cost of living and health protection;
  - Collaborative service transformation;
  - Learning to lead together;
  - Newcastle neighbourhoods; and
  - Duplication to personalisation.

There is a joint Director team which demonstrates the depth of commitment and enables real transformation. The ACE confirmed that robust governance arrangements are in place through the Collaborative Newcastle Agreement.

- A number of strategies are in place across the region, for example Newcastle City Council have three key strategies, being the:
  - Inclusive Economy strategy;
  - Anti-Poverty strategy; and
  - Health and Wellbeing strategy.

  In addition the ICS strategy has been discussed at the Board of Directors meetings and a joint forward plan is currently being worked on, alongside a Newcastle Place Plan.
- The Integrated Care Board (ICB) have appointed a Director of Place, with whom the CEO will meet to further understand the role in relation to the health and care needs of people within the city.
- The cities Academic Health Science Centre (AHSC), one of eight in the country and being the only one to comprise of a partnership between the City Council, Newcastle University and two provider Trusts, is a huge benefit but does not have a direct funding associated. The AHSC plays a significant role in the delivery of high quality research and innovation and has an explicit focus across the next two years on targeting research and innovation programmes on areas of equity.
- Newcastle Hospitals entered into a formal partnership agreement three years ago with the Institute for Healthcare Improvement (IHI) with the aim of strengthening quality improvement methodology and embedding clinical and quality improvement across the organisation. The focus of the 3-year programme was to build capacity and capability, work on leadership, engagement and improvement methodology which in turn will all improve care for patients. The Trust is now in a strong position to drive forward the programme independently having successfully built capacity and capability.

  A national approach to quality improvement has recently been published by NHS England (NHSE) and all organisations have been asked to self-assess against a Quality Improvement Framework. IHI have been supporting NHSE with the development of this national approach.

Mr MacLeod referred to the new combined authority coming into place and queried if there is an opportunity to work collaboratively in terms of creating an inclusive economy and on anti-poverty. The CEO advised that Newcastle Hospitals is working closely with colleagues in the seven local authorities across the region, and sits within the largest ICB in the country, with work taking place to consider opportunities for collaborative working in these areas.

Mrs Bromley queried the role of education providers in relation to the work of Collaborative Newcastle to which the COO advised that education is a significant part of the children and families workstream within the Collaborative Service Transformation programme.

Ms Baker sought clarification with regards to the role of housing providers in Collaborative Newcastle, particularly when considering support for increased rental charges and housing issues. The COO advised that there is a programme in place for homelessness and

discussions are underway with a large social housing provider as to whether they will become a partner member of Collaborative Newcastle. Ms Baker noted that the Newcastle Hospitals Charity contributed to the work and therefore the Charity logo should be displayed accordingly.

Mr Jowett noted the fantastic work of the Collaborative Newcastle partnership and asked that consideration be given as to how to measure the success of the various partnerships. He highlighted that another sector which could positively contribute was the Community Hubs within the private sector. The CEO suggested that the Collaborative Newcastle plan be discussed in more depth at a future Board Development Workshop **[ACTION03]**.

Ms Edusei referred to her role as a Board member of the North East Chamber of Commerce and queried how Collaborative Newcastle support current staff and the importance of focussing on public health prevention. The COO advised that work is taking place with regards to asset-based community development and people acquiring the skills and knowledge required.

The Chairman highlighted that the NE&NC ICS covers a large area which spans four different local authorities and queried whether equivalent 'Collaborative Newcastle arrangements' were in place to which the COO confirmed that the EDBDE was the key liaison lead between the different stakeholders and work was underway with Gateshead to explore the development of an equivalent programme.

It was resolved: to **receive** the Partnership update.

iv) <u>Performance: Performance Report</u>

The EDBDE presented the report, highlighting the following points:

- Overall, activity levels for June 2023 dropped across all points of delivery compared to May 2023.
- 28 days of industrial action have now taken place since the start of 2023, with other dates in the pipeline, and planning actively takes place to ensure patient safety and minimise disruption.
- In terms of Urgent and Emergency Care (U&EC), the target of 76% has been achieved for the past three months.
- With regards to cancer, the focus is trying to reduce the 62-day cancer waits backlog to pre-COVID-19 pandemic levels. The Trust is making positive progress in terms of the 28-day faster diagnosis standard.
- At the end of May 2023, the Trust had 13 patients waiting >104 weeks, with 11 of these patients waiting for spinal surgery which has been acknowledged nationally as an area of challenge due to capacity issues; and 103 patients waiting >78 weeks. This position represents a significant improvement from the previous month and the financial year 2022/23. The Trust remains in the NHSE tier 1 review process.

The COO advised that from October 2023, the Sexual Health Service in Newcastle will transfer to a new provider as the Trust was unable to continue the high-quality service delivery within the reduced financial envelope specified in the tender. The Trust is

disappointed with the outcome and are working hard to support staff at New Croft House. Gratitude was expressed to all of the staff at New Croft House and communication will take place with external stakeholders during the transition process.

Ms Edusei said that it would be useful to see further detail as to what services are provided within the community by Newcastle Hospitals. The COO confirmed that he will share a breakdown of services provided by Community Services or bring members of the Family Health Clinical Board to a future Board/Board Development session to provide a service overview **[ACTION04].**

Mr Jowett highlighted the success of the DTC in contributing to elective recovery. The EBDBE confirmed that there is still further opportunity to maximise the facility to its fullest through expanding the number of specialties using the centre but confirmed that the Trust is utilising the facility well.

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

v) People: Industrial Action

The CPO advised that the Royal College of Nursing (RCN) industrial action had concluded but Junior Doctors and Consultant strike action continued. The dates of industrial action for Junior Doctors have been announced as 11 August 2023 to 15 August 2023 and for the Consultants from 24 August 2023 and 25 August 2023. It was anticipated that this would have a significant impact on services.

The mandate for Junior Doctors industrial action expires mid-August but it is anticipated that a re-ballot will occur.

The MD/DCEO advised that patients safety remains the key priority during any industrial action periods, with the Associate Medical Directors actively involved in the preparation for each period of action. Concerns remain with regards to the industrial action to take place over the school summer holidays, but preparations are underway, and work is ongoing to maximise the elective programme where possible, with patients categorised as P1 and P2 a priority.

The COO expressed his apologies to all patients that have been impacted and that the Trust is committed to doing everything possible to reschedule cancelled appointments.

Miss Smith said that it would be useful to see examples of learning from the periods of industrial action, potentially at a future Board Development session. The MD/DCEO confirmed that the Trust is actively reviewing lessons learned and it was agreed that feedback in relation to lessons learned would be circulated in a short briefing to the Board members **[ACTION05]**.

[The CEO, ECN, CPO and DQE left the meeting at 14.20 to attend a CQC inspection feedback meeting].

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

23/15 BUSINESS ITEMS

i) Director reports:

a. Medical Director; including:

The MD/DCE presented the report, highlighting the following points:

- The quality and safety structures within the new Clinical Board structures continues to develop which will oversee the key domains within the quality and safety agenda. In addition, it explicitly brings together the functions of our Clinical Governance and Risk Department (CGARD) with the function of Newcastle Improvement.
- A Quality Oversight Framework has been developed and each Clinical Board will form a Quality Oversight Group to oversee four domains, being patient safety, clinical effectiveness, patient experience and quality improvement. An Associate Medical Director will be aligned to each Clinical Board.
- The Clinical Outcomes and Effectiveness Group (COEG) which reports into the Quality Committee has published its annual report.
- In relation to the Patient Safety Incident Response Framework (PSIRF), non-recurrent funding for 12 months for Consultant input and a PSIRF Implementation Lead has been secured. A shortlist of the major safety topics to investigate in included in the report.
- With regards to Cancer performance, the Targeted Lung Health Check programme has been successful with early diagnosis and the ambition is to develop new ways of working including pooled patient lists to try to maximise efficiency. Some challenges with demand for the lung cancer service and thoracic surgery department had arisen due to a rise in cases within the region.
- Newcastle Hospitals is performing well in terms of research and the MD/DCEO noted his appreciation for the success and reputation the Trust has gained, and gave credit to the Associate Medical Director lead, Professor John Isaacs.

Ms Edusei sought clarification with regards to the Lung Health Check programme regarding the uptake of patients using the programme and the resulting outcomes in terms of early or late stage lung cancer diagnosis. The MD/DCEO highlighted that if a cancer is picked up at a late stage, it is more likely that extra Palliative Care will be needed and that initially uptake for the screening wasn't as high as anticipated, particularly within Newcastle City.

Ms Baker sought clarification with regards to the timeline for the Mental Health strategy production. The MD/DCEO advised that a timeline is currently being established taking into account the extent of the staff and patient input required and agreed to share the timeline separately [**ACTION06**]. The ACE noted that the Newcastle Hospitals Charity had funded some co-production activities which would result in the timeline for production being extended to enable effective collaboration and engagement. Further updates will be provided to the Board of Directors.

Professor McCourt referred to the Consultant Appointments paper included in the BRP and acknowledged the amount of work that has taken place to recruit new consultants, including three Ophthalmologists.

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

i. Guardian of Safe Working Report

The MD/DCEO presented the report and highlighted that there were now over 1,000 post graduates in position within Newcastle Hospitals, with just over 800 in training on the new Junior Doctor contract.

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

ii. Consultant Appointments

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

c) Director of Quality & Effectiveness CNST Quarterly Report

The ACE presented the report on behalf of the DQE noting that the Year 5 scheme invites Trust's to provide evidence of their compliance using a self-assessment against ten maternity safety actions. NHS Resolution published new guidance in relation to the 10 safety actions on the 31 May 2023 which is detailed within the report. Significant feedback had been given by maternity provider trusts regarding the new requirements and therefore a further final/updated version was anticipated within the next 1-2 months.

The ACE advised that a fully updated report against the new CNST requirements will be presented at the September Quality Committee and Board meetings **[ACTION07].**

The Board of Directors was asked to approve the self-assessment to date to enable the Trust to provide assurance that the required progress with the standards outlined are being met.

It was resolved: to (i) **receive** the report and (ii) **approve** the CNST self-assessment to date.

d) Healthcare Associated Infections (HCAI)

The DIPC presented the report, highlighting the following points:

- Whilst HCAI performance against trajectories remains challenging, some improvements have been noted in *Clostridioides difficile* infections and it remains a key priority for the organisation. Infection Prevention and Control (IPC) nurses continue to visit wards weekly and are focusing on 'going back to basics' regarding prevention/treatment of non-COVID-19 related infections.
- The Trust has received national trajectories for Gram negative bloodstream infections (GNBSI) reduction which are being reviewed.
- The Antimicrobial Stewardship (AMS) compliance report is discussed at the Clinical Board Serious Infection Review Meetings (SIRMs) which take place quarterly.

- The Board Assurance Framework (BAF) compliance report is a robust framework and is included in the Board Reference Pack (BRP) for information.
- An IPC Assurance Lead has been appointed which will help provide further support for the management of IPC governance.
- The same themes are evident nationally and within the ICB in relation to the challenges with isolation facilities, the need to provide continued education and increase awareness and the ongoing challenges in delivering HCAI reduction within the current NHS operational pressures.
- In terms of MRSA bacteraemia, Newcastle Hospitals performed extremely well. Regarding MSSA Bacteraemia, a total of 24 cases were assigned to the Trust which is over the local trajectory by one case.
- The Paediatric line management dashboard was being expanded to cover adult line management.
- New guidance for emergency admissions has been introduced and is currently being worked through.

Mr MacLeod sought clarification on whether there is a geographical factor evident regarding Clostridioides difficile and if learning can be sought from other Trusts. The DIPC advised that Guys and St Thomas' NHS Foundation Trust have the same processes but have lower Clostridioides difficile infections and therefore further engagement was taking place to understand any differences in approach. The Chairman noted that the age profile of patients was a further differentiating factor.

Mr Chapman referred to the progress with the ICNET implementation and the DIPC advised that it was anticipated that use of ICNET would release more nursing capacity and would provide benefits in relation to data analysis and surveillance.

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

e) <u>Chief People Officer; including</u>:

i. <u>NHSE Equality, Diversity and Inclusion Improvement Plan</u>

The COO presented the report on behalf of the CPO noting that extensive work has taken place regarding Equality, Diversity and Inclusion (EDI) and an initial self-assessment had been produced against the national EDI plan. The report includes a copy of the national guidance, required actions of the EDI improvement plan, and proposed next steps.

[The CEO and CPO re-joined the meeting at 14.59].

The CPO advised that the WRES and WDES data was discussed at the Board of Directors meeting in May 2023. An initial high level gap analysis was undertaken to address how the Trust measures against the six high impact actions and areas to focus attention on.

The CPO explained that an EDI Steering Group is currently in development supported by Executive Team colleagues as sponsors of the network groups, to focus on key issues and to have a central point of discussion. This work will form part of the People Plan.

[The ECN and DQE re-joined the meeting at 15.01].

Ms Edusei noted the interesting amount of work detailed within the self-assessment and the importance of being able to measure the impact of all of the actions in one consolidated plan. She referred to 'The Promises of Giants' book and highlighted the importance of modelling behaviours regarding EDI and being mindful of the impact of what team members do and don't do to others. The CPO agreed, highlighting that EDI is a joint responsibility for all of the Executive Team and the team have a joint EDI annual objective set by the CEO.

Miss Smith thanked the team for the turnaround of work and noted the importance of having a common understanding of EDI, particularly regarding inclusivity. Ms Baker added that often organisations focus solely on protective characteristics and there is a need to focus more broadly. She recommended that discussing EDI at a future Board Development session would be helpful.

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

ii. Trade Union Facility Time Report 2022/23

The CPO advised that the report is to comply with the annual requirement in the Trade Union (Facility Time Publication Requirements) Regulations 2017 for public sector employers to collect and publish a specific set of data on the use and spend of Trade Union facility time by their staff. The report covers the period from 1 April 2022 to 31 March 2023 and requires Board of Directors approval to publish the data on the government portal and publish the data on the Trust's website.

It was resolved: to (i) **receive** the report and (ii) **approve** the publication of data onto the government portal and Trust's website.

23/16 ITEMS TO APPROVE

a. Standards of Business Conduct including fit and proper persons statement

The ACE advised that the purpose of the report is to provide an annual review and update on standards of business conduct for 2022/23 and includes the annual Fit and Proper Persons Statement from the Chairman.

The ACE noted that significant work has taken place to raise awareness across staff members and a robust digital system in place to record and complete declarations.

AuditOne completed a benchmarking exercise in February 2023 by way of a survey relating to standards of business conduct compliance however only a small number of organisations responded and therefore it was difficult to obtain meaningful comparisons.

The ACE referred to the Disclosure and Baring Checks (DBS) which are carried out once on appointment within Newcastle Hospitals. She highlighted that discussions are taking place nationally in relation to the guidance regarding the frequency of undertaking such checks and the ACE and CPO will meet to discuss further and to ensure all guidance is being considered **[ACTION08]**.

It was resolved: to (i) **receive** the report and (ii) **approve** the fit and proper persons statement.

23/15 BUSINESS ITEMS

b. Executive Chief Nurse; including:

The ECN presented the report, highlighting the following points:

- A real time ward compliance safety assessment dashboard has been developed. The current clinical assurance framework is well established through the clinical assurance toolkit which is actively used to measure and monitor nursing-related indicators by the matrons. The development of the Electronic Patient Record (EPR) provides an opportunity to enhance the work further providing data in real time. The Chief Nursing Information Officer (CNIO) has led the Digital Health Team in collaboration with colleagues from Information Management and Technology (IM&T) to develop the dashboard. Work has focused initially on building a platform which will display compliance over a number of key risks assessments including nutrition and hydration, skin, falls and moving and handling. After building, testing and receiving feedback from key stakeholders, the Ward Compliance Safety Assessment Dashboard was launched on the 5 June 2023. Early learning recognises it will not be possible to ensure 100% compliance across all domains and sisters will be able to take action at ward level regarding any further action/education required. The tool will be run for three months and then revisited to include 'reasonable' tolerances.

  Mr Chapman sought clarification with regards to drilldown reporting to which the ECN confirmed that the ward sisters can see what has and has not taken place for each patient.

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

ii. Freedom to Speak Up Guardian Report

The ECN advised that the report details the activity undertaken by the Trust's Freedom to Speak Up Guardian (FTSUG), Andy Pike over the past year. Between June 2022 and March 2023, the FTSUG has managed 73 cases which required intervention beyond advice and support being given to the complainant. It is hoped that the FTSU Strategy will raise further awareness and encourage further staff to become FTSU champions.

The CEO referred to the current context regarding the pressures in elective recovery and industrial action, noting that an increase in demand for FTSUG activity was expected. She

recommended that it would be useful to see the outcomes from the focus on raising awareness and asked that a further update be brought back to the next Board meeting to summarise the actions being undertaken and the different channels available to staff for raising any concerns. The ECN highlighted the importance of the FTSU champions who are reporting to, and supported by, the FTSUG.

Mr Jowett advised that the People Committee receive a comprehensive regular update on the FTSUG activity and highlighted the dedicated work, commitment and passion displayed by the FTSUG.

Ms Edusei noted the importance of succession planning and in expanding the FTSUG network. The ECN highlighted that the FTSUG liaises with staff from all areas within the Trust and attends the Corporate Induction to raise awareness.

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

b. <u>Executive Chief Nurse; including:</u>

MC highlighted the following key points in relation to Nursing and Midwifery (N&M) safer staffing:

- The nurse staffing escalation remains at level two due to appropriate criteria being met. Four wards in total have required high-level support over the last three months and all wards have action plans in place, overseen by the Nurse Staffing and Clinical Outcomes Group and by the ECN Team. The detail is discussed at the Quality Committee and additional DATIX reports are reviewed, and action is taken where necessary.
- With regards to recruitment and retention, the current turnover is 9.61% which is an improved position from previous reports. The Band 5 Registered Nursing vacancy rate is 4.66% based on the financial ledger at Month 2 and relates to current substantive staff in post. It was noted that there are still nurses in the pipeline that have been recruited to posts.
- The Trust had an ambitious plan supported with NHSE funding through international recruitment for the deployment of 300 nurses and 5 midwives for 2022/23 and have successfully completed this recruitment plan. It has also been agreed to recruit an additional 74 nurses to be deployed by the end of March 2024 bringing the additional total of international recruits to 224 nurses which is a strong position for winter.
- The Health Care Support Workers (HCSWs) community event based at the Beacon Centre in the west of the city funded by the NHSE 'Widening Access Transformational project' has taken place in May 2023. Close working was undertaken with the recruitment team and attendance on the day was very positive, with some further learnings identified for future events.
- Newcastle Improvement continues to support the Trust aim to embed a culture of continuous quality improvement and successful work is taking place with Collaborative Newcastle, with learnings identified.

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

23/16 ITEMS TO APPROVE

b. Annual Modern Slavery Declaration

The TS advised that the Modern Slavery Declaration is an annual statement which demonstrates the Trust's continuing support of the requirements of the legislation. An action plan is appended to the report with some actions being rolled forward into 2023/24. The report was discussed in detail at the recent Audit Committee meeting and support/assistance had been provided by Mr Jowett in relation to his private sector expertise.

The Board of Directors is asked to consider and approve the statement prior to final sign off by the Trust's Chief Executive Officer.

It was resolved: to (i) **receive** the report and (ii) **approve** the Annual Modern Slavery Declaration.

23/17 ITEMS TO RECEIVE

i) Update from Committee Chairs

The report was received, with the following additional points to note:

Charity Committee
Ms Baker advised that the Committee approved grant applications which totalled £238,295.00 at the June meeting. She referred to the People First (PF) Café: a place of 'happiness and hope' application which is an example of different areas to fund and to help people with learning disabilities into employment.

People Committee
Mr Jowett noted the focus of the last meeting on people-related Industrial Action matters and the positive progress made with regards to the two risks on sickness absence and Statutory and Mandatory Training. The FTSUG, and Henrietta Dawson, Guardian of Safe Working (GoSW) attended the Committee meeting to provide an update on their areas. The next Committee meeting will focus on the People Plan and Equality, Diversity and Inclusion and plans in place to improve on these areas.

Quality Committee
Mr Chapman noted the healthy discussion in relation to Quality Risks on the BAF. He acknowledged the work of the management groups reporting in to the Committee and the extensive work that takes place in relation to the National Institute for Health and Care Excellence (NICE) guidelines. Mr Chapman thanked staff involved in the conducting the leadership walkabouts, Committee deep dives and Spotlight on Services which provide Committee members with further insight.

Finance Committee

Miss Smith advised that at yesterday's Committee meeting, robust conversations were held on financial and activity performance, capital projects and the Cost Improvement Programme (CIP). The COO presented a close out report for the Nightingale Hospital North East (NHNE), the Integrated Covid Hub North East (ICHNE), the North East and North Cumbria Covid-19 Vaccination Programme and the Newcastle Hospitals Day Treatment Centre (DTC) which reflected the positive work that has taken place.

Audit Committee
Mr MacLeod advised that an extraordinary meeting took place in June to approve the Annual Report and Accounts for 2022/23. An ordinary meeting was held in July, considering the Standing Financial Instructions (SFIs) which were approved, Board Assurance Framework, annual review of the Clinical Audit process, review of the performance of Internal Audit, External Audit and Counter Fraud and a discussion in relation to the internal Capital process.

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

23/15 BUSINESS ITEMS

i. Maternity Update

The ECN advised that following the Maternity CQC inspection, the findings were published on 12 May 2023. The service was graded 'requires improvement' overall with the domains of 'well-led' and 'safe' being focused upon as part of the national maternity inspection programme. An action plan in response to the three breaches in regulation has been implemented and is ongoing to ensure the Trust meets with the regulatory requirements and service improvements. The three breaches being:

1. Regulation 12(1)(2); 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.
2. Regulation 18(1)(2)(a); the Trust must ensure all staff receive such appraisal as is necessary to carry out their duties.
3. 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.

The ECN confirmed that the Trust is partially compliant regarding the Medicines Management breach listed in point 3 above and is pending further work on IV fluids, with the other two breach areas now being fully compliant. The action plan and work taking place is discussed in detail at the Quality Committee.

The ECN advised that the report provides members of the Trust Board with a brief overview of the Trust's current position and the three-year delivery plan for maternity and neonatal services.

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

23/17 ITEMS TO RECEIVE

ii) Integrated Board Report

The Integrated Board Report (IBR) was received.

It was resolved: to **receive** the report and note the contents within.

iii) Meeting Action Log

It was resolved: to **note** that there were no outstanding actions.

iv) Any Other Business

There were no further matters to discuss at this time.

v) Date and Time of Next Meeting

The next meeting of the Committee is on **26 September 2023** at **13:15-16:00** in **Freeman Boardroom/MS Teams.**

There being no further business, the meeting closed at 15.33.

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023						
Title	Chairman's Report						
Report of	Professor Sir John Burn, Chairman						
Prepared by	Gillian Elsender, Corporate Governance Officer and PA to the Chairman and Trust Secretary						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☐	☒				

Summary	This report outlines a summary of the Chairman's activity and key areas of focus since the previous Board of Directors meeting, including:
	• CQC Update
	• Board activity
	• "Spotlight on Services"
	  • Pharmacy Production Unit
	  • Command Centre
	• Governor Activity
	• Regional engagement with Foundation Trust Chairs of the North Integrated Care Partnership (ICP)
	• National engagement with Integrated Care Board (ICB) Chairs
	• Celebratory Events						

Recommendation	The Trust Board is asked to note the contents of the report.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. Pioneers – Ensuring that we are at the forefront of health innovation and research.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☒	☐
Link to the Board Assurance Framework [BAF]	No direct link however provides an update on key matters.						
Reports previously considered by	Previous reports presented at each meeting.						

CHAIRMAN'S REPORT

EXECUTIVE SUMMARY

This report outlines a summary of the Chairman's activity and key areas of focus since the previous Board of Directors meeting, including:

- CQC Update
- Board activity
- "Spotlight on Services"
    - Pharmacy Production Unit
    - Command Centre
- Governor Activity
    - Patient Experience Strategy Workshop
    - Council of Governors
    - Equality, Diversity and Inclusion Governor Workshop/Discussion
- Regional engagement with Foundation Trust Chairs of the North ICP
- National engagement with ICB Chairs
- Celebratory Events
    - Long Service Awards
    - People at Our Heart Annual Celebration
    - Celebrating Excellence Awards
    - Give a Kidney

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

CHAIRMAN'S REPORT

The Care Quality Commission (CQC) decision to make their unannounced visit has dominated activity in the past three months and will be the subject of continued discussion in our meetings. I will not contribute to the detail except to record my admiration for the manner in which the whole executive team have conducted themselves through this challenging time which has included requests for over a thousand documents and reports. Needless to say, we await the CQC report with great interest.

In June, Dame Jackie informed me of her difficult decision to stand down as Chief Executive of the Trust at the end of this calendar year. She wanted to give us the maximum time to prepare for the appointment of her successor. That process is now well underway. Dame Jackie has steered the organisation through some unprecedented times as well as leading the organisation to fantastic achievements. I will return to this in my November report.

We have enjoyed two "spotlight on services" since the last Board meeting:

- **Pharmacy Production Unit -** Neil Watson, Director of Pharmacy and colleagues from the Commercial Enterprise team delivered a short presentation on the growth of the unit and the next steps for potential commercial opportunity.

- **Command Centre –** I was joined by Bill McLeod and Christine Smith, Non-Executive Directors, on a visit to the Newcastle System Command Centre. Michael Clark, Head of Business Continuity/Emergency Planning and Melanie Cunningham, Associate Director of Operations guided us through a suite of near-real time dashboards integrating data from The Newcastle upon Tyne Hospitals NHS Foundation Trust and key partners. The dashboards are designed to facilitate effective multi-agency working by making pressures within the system more visible and to improve patient experience through better patient flow. The high level of activity in the Emergency Department (ED) during our visit at what would be expected to be a quiet time was striking.

Governor and Member activity since our last meeting has included:

- **A Patient Experience Strategy Workshop** was held on 1 August. We were joined by members of the Patient Experience Team and STAND, a community of experienced engagement practitioners and service change leaders, who have been involving people to inform policy, strategy, service design and transformational change programmes for more than 25 years. We explored methods of feedback available to patients and ways the Trust could improve on the current offering.

- Our **Council of Governors** met on 17 August, chaired by Professor McCourt in my absence. In addition to regular updates from our Lead Governor and Working Group Chairs, Executive colleagues provided a comprehensive update on the Trust's current performance and delivery. Stella Wilson, Director of Operations for the Family Health Clinical Board delivered a short presentation on paediatric waiting lists followed by a

briefing on staff survey results and People Plan Developments, delivered by Christine Brereton, Chief People Officer.

- An **Equality, Diversity and Inclusion Governor Workshop/Discussion** was held on 15 September where we were joined by Karen Pearce, Head of Equality, Diversity and Inclusion (People) who delivered a very informative and interactive session on Incivilities, Microaggression & Hate Crime.

At a regional level, I continue to engage with both Foundation Trust Chairs and the ICP and enjoyed an introductory meeting with Sir Paul Ennals CBE, new Chair of Northumbria Healthcare NHS Foundation Trust together with Alison Marshall, Chair in Gateshead Health NHS Foundation Trust.

I participated in a meeting of with the North Sub ICP Chairs, Local Authority Leaders, Primary Care and Voluntary and Community Sector Representatives held on 14 September where we received updates on Flu/Covid vaccine plans, preparation for winter utilising virtual wards and the future development of the ICB.

At a national level, on 6 September, I attended an event hosted by NHS England. NHS England's Chair Richard Meddings hosted the first ever event to bring together all ICB and Trust chairs and chief executives. The session explored the "polycrisis" through which the NHS is travelling and ways in which the collective leadership could mitigate risk.

I have also attended a number of celebratory events including:

- **Long Service Awards** - The Trust has grown immensely over the last 35 years and it this was an opportunity to thank the "25ers" and the "35ers" for being such loyal participants on this journey. There was over 495 years of combined service in the room!

- **People at Our Heart Annual Celebration** - I was delighted to be invited to this annual celebration of the stars presented with individual awards over the last year. It is important to celebrate those who go the extra mile and display such talent.

- Our **Celebrating Excellence Awards** on 15 September provided an opportunity to reflect on and acknowledge the fantastic work happening across Newcastle Hospitals. A particular joy was the opportunity to award the Chairman's Prize to our lead governor Pam Yanez OBE whose lifetime of service to our organisation and the NHS made her a worthy winner.

- **Give a Kidney** I joined North of Tyne Mayor Jamie Driscoll on 18 September to lead the welcome party at the Institute of Transplantation for an intrepid team of fund-raising cyclists on the first stop of their 500-mile Transplant Tour from Edinburgh to Oxford via renal transplant departments in Manchester, Sheffield and Birmingham. as they call in Newcastle on Monday 18 September, the first day of Organ Donation Week. The cycle was part of an initiative to raise awareness of living kidney donation.

RECOMMENDATION

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

Report of Professor Sir John Burn
Chairman
19 September 2023

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023						
Title	Chief Executive's Report						
Report of	Dame Jackie Daniel, Chief Executive Officer (CEO)						
Prepared by	Caroline Docking, Assistant Chief Executive Lewis Atkinson, Principal Advisor Alison Greener, Executive PA to the CEO						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☐	☒				
Summary	This report sets out the key points and activities from the Chief Executive. They include: • Her announcement that she will be leaving Newcastle Hospitals; • A Care Quality Commission (CQC) inspection update; • The NHS response to the Letby trial; • Winter planning; • Headlines from other key areas, including the Chief Executive Officer's networking activities, our awards and achievements.						
Recommendation	The Board of Directors are asked to note the contents of this report.						
Links to Strategic Objectives	This report is relevant to all strategic objectives and the direction of the Trust as a whole.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☐	☐	☐	☐	☐	☐	☐
Link to Board Assurance Framework [BAF]	This is a high-level report from the Chief Executive Officer covering a range of topics and activities.						
Reports previously considered by	Regular report.						

CHIEF EXECUTIVE'S REPORT

EXECUTIVE SUMMARY

The content of this report outlines a summary of Chief Executive activity and key areas of focus since the previous Board meeting, including:

- Dame Jackie's announcement that she will be leaving Newcastle Hospitals;
- A CQC inspection update, including feedback, key actions and work on the Trust's people plan;
- The NHS response to the Letby trial;
- Maintaining operational resilience during industrial action and winter;
- The national cancer patient experience survey;
- Appointment of our new Chief Information Officer;
- Service visits;
- Staff awards and achievements;
- Research and innovation highlights.

The Board of Directors are asked to note the contents of this report.

CHIEF EXECUTIVE'S REPORT

1. OVERVIEW

Leaving Newcastle Hospitals

In August I publicly announced that I would be stepping down as Chief Executive of Newcastle Hospitals at the end of 2023. While I informed the Chairman and the Board about my decision in June, we agreed to delay public announcement to avoid distraction from the important work of responding to ongoing industrial action and our CQC inspection.

The Board, led by the Chairman and its Appointments and Remuneration Committee, were able to open the process to recruit my successor immediately upon this public announcement. The coming months will continue to be business as usual for me as I continue to lead the Trust in the challenging environment that the whole NHS faces and conduct a handover with the thoroughness required.

I have loved being Chief Executive of Newcastle Hospitals and it has been a privilege to have led this organisation for the last five years, including through some truly unprecedented times. I will not be retiring, but I have decided that I would like to spend the next few years supporting the NHS in a different way. I am so proud of what this organisation has achieved and the difference we continue to make to the lives of the people of the North East every day.

During the pandemic, it was the whole Newcastle Hospitals team pulling together that got us through. From treating the UK's first Covid patients through to the delivery of 8 million vaccine doses, the expertise and incredible hard work of the whole team delivered excellent care and support in hospital, in the community and remotely. Since then, it has been the dedication of staff that has led the recovery of services: continuing to care for patients through the most pressured winter I remember in my 40-year NHS career; working to deliver the greatest possible levels of elective activity to help cut the longest waits by 84%.

All healthy organisations must continually evolve as they learn and respond to a changing world. Over the last five years it has been a particular joy to see and support the Trust becoming more diverse, open, and empowered. With a new management structure of eight clinical boards in place, I am confident we have established the foundations for a better way of working in the future: staff empowered to make change in their area of work, greater clinical leadership, working openly with partner organisations in the city and region.

It is important to recognise that the context in which the Trust operates is significantly different to that of 2018. Post-pandemic, there is an overall 'hotter' operational environment across the whole NHS. Bed occupancy has notably increased, workforce shortages are greater, and there are significant restrictions on funding. Whereas in the past this Trust balanced the books and funded investment in services by increasing activity and thus income, the changed NHS financial architecture means that our ability to generate income is severely constrained and that doing more with less is now required. This creates a significant strategic and cultural challenge for the organisation.

Significant system-wide operational, financial and workforce pressures, including unprecedented ongoing industrial action, means that sadly we are not fully where I would want us to be as I prepare to leave the organisation, but there is never a perfect moment to leave a role like this, and there is always more to do.

After a long career as an NHS Chief Executive, I know that the job of continuing to develop organisations is always ongoing. Newcastle Hospitals will, and must, continue to change and develop. I am confident that in the coming months and years it will do, so it can continue to provide the best possible care for the people across the North East, and beyond, that it serves.

CQC inspection

As I reported in my last Board report, the CQC commenced an inspection of our urgent and emergency medicine, surgery and North East and Cumbria Transport and Retrieval (NECTAR) services in June, which was followed by a Trust well-led inspection in July. A wide range of staff engagement events were held by the CQC and a significant volume of information requests made to the Trust. This is normal for a Trust of our size and complexity, but I do want to recognise how demanding and time-consuming the inspection process has been for staff and the senior leadership team.

We expect to receive a draft report in coming months, but we have received some initial feedback from the CQC. This suggests that the CQC saw a large amount of skilful and caring interactions with patients throughout their visit and heard many experiences of personalised care being reported from patients. In children's services, inspectors saw that the care offered to young people was personalised to their needs and that families were appropriately involved in decision making. They also positively commended our safeguarding practices.

However, the CQC have also identified some areas where they suggest improvements need to be made. These include points in relation to medicines management and storage of some cleaning substances (which has been rectified and monitored with ongoing audits), observation of the emergency department waiting room, which has been addressed, and elements of how we use our electronic patient record – a work in progress.

Through our 'care for me with me' programme of work, we continue to focus on the quality and safety of care for patients with mental health needs, a learning disability and / or autism. The CQC have noted that progress has been made since their focused inspection on our application of the principles of Mental Health Act and mental capacity assessments earlier in the year, but we know there is more to do to ensure all our staff have the confidence, knowledge, skills and training needed to meet these requirements consistently in every part of the Trust.

We've also received some feedback about the culture in the organisation and have been asked to share information and consider how we further support staff to raise concerns, speak up freely and report problems. It is important that the organisation takes these challenges seriously and takes action to address them. When I reflect on our cultural change journey over the last five years, I know that staff are more confident to raise concerns than they were – but this change takes time. We also know that, across the whole

NHS, daily pressures and frustrations are significantly higher for all staff than they were before the pandemic and industrial action.

Over the last five years, we have put considerable effort and resource into developing our Freedom to Speak Up approach, 'What Matters To You' programme and our staff networks, and in that time, we have seen some positive indicators in the associated questions in our staff survey. However, we recognise and accept that there is more we need to do. We need to ensure that our staff consistently feel confident to speak up and raise concerns, safe in the knowledge that our leaders will listen and act, including tackling poor behaviours. We know that if we do this, it will make us all feel even prouder to work at Newcastle Hospitals.

When our new Chief People Officer, Christine Brereton, started her role in January, I agreed with her that a key priority was the development of a new Trust 'People Plan'. This will put actions in place to address the issues that we know are troubling our staff. It is vital that we build this **'with'** staff, and Christine and her team have formed a steering group with wide representation and are progressing work through an extensive series staff engagement and co-production sessions. A key element of this work is embedding 'our Newcastle Way' – the behaviours we expect to see from everyone in the trust, which flow from our values. These were developed by staff and are widely recognised, but we need to do more to share them through our new clinical board structures and embed them in the expectations we have about the way we will all work – focussing on our 'people' rather than our 'processes' and putting fairness and kindness at the centre of all we do.

NHS response to the Letby trial

Since the last Board meeting, the outcome of the Letby case has brought shock and horror across the NHS. Everyone's thoughts are with the families and victims in this very tragic case. Amanda Pritchard, CEO of NHS England, has committed the whole NHS to a series of actions designed to ensure that nothing like this can ever happen again. Maurya Cushlow, our Executive Chief Nurse, and her team is leading this work in our Trust and more information will be provided as part of the People update under agenda item 8.

We have communicated with all staff specifically in response to the case, reinforcing our commitment to responding to concerns in relation to patient or staff safety and reiterating the mechanisms available to do so. All staff should feel confident and supported to raise concerns at any time.

Operational resilience, preparation for winter and industrial action

Work continues to maintain operational resilience which we know is especially challenged during periods of industrial action and in winter. As I write, further industrial action is imminent by both consultant and junior doctor members of the British Medical Association (BMA), including the first occasion when both groups of staff will strike together on the same day (Wednesday 20th September).

The continuing dispute between the government and BMA continues to have significant impact on our ability to provide the best possible care for patients and on the reduction of elective waiting times in particular. As part of the Shelford Group, the Chairman and I signed an open letter to Prime Minister Rishi Sunak and BMA Council Chair Professor Philip

Banfield, which conveyed our profound concerns at the risks that ongoing strikes pose to the care and safety of patients, and to call for renewed efforts from government and unions to find a path to resolution (https://shelfordgroup.org/shelford-ceos-and-chairs-letter-on-industrial-action/).

With winter fast approaching, we continue to work both within the Trust and with colleagues across the North East and Cumbria to complete our operational and surge planning so we are maximising the capacity available to meet in demand in a range of different winter scenarios. Coronavirus and flu will likely again cause significant illness and resulting pressures on the NHS, so I would urge all staff and residents to accept the vaccination when this is offered.

Publication of research and report relating to sexual misconduct in the UK surgical workforce

Research, led by a collaboration between the University of Exeter, the University of Surrey and the Working Party on Sexual Misconduct in Surgery, has been published on the extent of sexual misconduct within the UK surgical workforce in the last five years. The Working Party on Sexual Misconduct in Surgery (WPSMS) has also published an independent yet associated report.

While the research and report are incredibly difficult reading, they present clear evidence of why we must take more action to better understand and address this issue. Although these documents focus on the surgical workforce, we know that this behaviour affects other staff groups too. We remain ever committed to ensuring the NHS is a place in which sexual misconduct, violence, harassment, or abuse will not be tolerated. Our Chief People Officer, Christine Brereton and Medical Director, Andy Welch have already commenced a programme of work to understand and take action on this issue.

National Cancer Patient Experience Survey 2022

I was delighted to receive the outcomes of this annual survey which monitors patient experience of cancer care across the NHS. Our results for Newcastle Hospitals are again very positive, with 19 questions being above the results we would expect – a fantastic result which helps our patients have confidence in the care we provide. These include:

- 91% of patients said they were always treated with respect and dignity while in hospital.
- 91% said the administration of their care was very good or good.
- 86% said that hospital staff always did what they could to help the patient control pain.

The survey results are a credit to our fantastic cancer teams across the trust and everyone who contributes to our cancer pathways in whatever way. We continue to focus on reducing waits for cancer treatment which we know is crucial for supporting excellent patient experience and outcomes.

Chief Information Officer (CIO) Appointment

I am pleased to confirm that, following a competitive recruitment process, Shauna McMahon, has been appointed as our new Chief Information Officer to lead our strategic

digital development and innovation across the trust. She will join us in January from North Lincolnshire and Goole NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust where she is currently its Group CIO and Senior Information Risk Owner (SIRO). Shauna will be responsible for developing and delivering Newcastle's information and technology strategy, as well as leading digital innovation and service change throughout the organisation. My thanks also to Lisa Sewell, who will continue as acting CIO until Shauna joins us, for providing continued leadership during this transition.

Northern Pride

In July, a large team from Newcastle Hospitals took part in Northern Pride in support of our LGBTQ+ colleagues and members of our community. The event began with 70 of our staff joining the Blue Light Breakfast at the Civic Centre, which was held jointly with the North East Ambulance Service, Northumbria Police and the Tyne and Wear Fire and Rescue Service, before a march through the city.

This was our biggest ever staff turn out for Pride and it was great that the Lord Lieutenant, the Lord Mayor, the Police and Crime Commissioner and the Leaders of the local councils came along to pay tribute for the work that all our staff and partners in the emergency services do for the people of the North East. Also at the event was a large team from our sexual health services who offered screening for sexually transmitted infections and advice to attendees – which is a much valued service. School nurses, our breast screening services, and a number of other clinical teams also had a presence in the health and wellbeing tent. My thanks go to all those who took part in celebrating diversity and supporting our community.

Geordie Hospital

This month saw the return of Geordie Hospital, our Channel 4 series which focusses on the expert clinicians and compassionate support teams across our organisation. The format of the programme remains the same and follows individuals during a typical shift and it provides a glimpse into the care and compassion that our teams provide every day.

Despite the challenges facing the NHS, at the core of all our services are people who want to do their very best for patients and that warmth, dedication and commitment really comes across. I'm very grateful to everyone who gave their time to help make this programme.

Service visits and meetings

In the last two months I have continued my regular programme of service visits and meetings alongside my regular programme of leadership meetings with colleagues across the Trust and region.

In August, I visited ward 38 in the Institute of Transplantation which supports patients who have had, or who are waiting for, a range of solid organ transplants. The team often form a lifelong relationship with their patients who may return for future care and treatment in relation to their transplants and I was struck by how incredibly proud they are of both their service and the entire multi-specialty team.

I also met a group of truly inspirational women who work in the field of neonatal care in the Trust and wider region and are leading our ambition to provide 'family integrated care.' The neonatal intensive care unit can be an overwhelming and stressful environment for families who often unexpectedly find that their newborn babies need specialised medical care.

A best practice model from the British Association of Perinatal Care called Family Integrated Care (FIC) aims to support them through this experience and promote a culture of partnership between families and staff and real progress has been made in Newcastle over the last five years. The team has made some fundamental changes to how they work – both clinically and with the environment – to develop these family partnerships, an outstanding example of personalised care and innovation that we hope to share with other Neonatal Intensive Care Units (NICUs).

2. RECOGNITION AND ACHIEVEMENTS

Our staff continue to provide the very best services for our patients, with many innovations and examples of excellence recognised at regional and national level.

Staff awards

This month we hosted our annual People at our Heart Awards – our staff and volunteer recognition scheme that enables patients, relatives, colleagues, and the public, to express their gratitude and provide recognition for their outstanding efforts. It's a great opportunity for us to recognise their achievements and the difference they make. Congratulations to this year's overall winners who are:

- Individual of the year – Charlotte Bratt, Staff Nurse Ward 21 Cardiothoracic ITU, Freeman Hospital
- Team of the year – Dawn, Donna, Debbie & Joyce, Domestics at New Croft House
- Volunteer of the year – Nicola Smith, Splish Splash Bounce Volunteer

We also hosted our Annual Celebrating Excellence Awards on Friday 15 September at the Civic Centre in Newcastle. Sadly, I was not able to attend this year's award but was delighted to virtually present my Chief Executives Award to Audrey Tapang, our Senior Nurse for International Recruitment. Audrey was nominated to represent the Trust at the Royal Garden party earlier this year in recognition of her commitment to leading the organisation's international recruitment offer, a role she has excelled in to such a degree that she won last year's Nursing Times Overseas Nurse of the Year Award. Congratulations to all of our finalists and winners.

HSJ Awards

Congratulations to our teams who are finalists in two categories of the Health Service Journal Awards. Collaborative Newcastle, our innovative partnership which aims to transform the health, wealth and wellbeing of people living in Newcastle, is shortlisted in 'Place-based Partnership and Integrated Care' with their 'Learning to Lead Together' program.

This is part of ongoing work to bring together knowledge, expertise and resources from across public and third sector partners, to enhance and improve health and care, as well as growth and prosperity in the city.

The National Renal Complement Therapeutic Centre is also recognised for the prestigious 'Acute Sector Innovation of the Year' recognising an outstanding contribution to healthcare. This highly dedicated team of specialist aHUS nurses have had a transformative effect in preventing death from meningococcal sepsis in our patients.

Nursing Times Workforce Awards

We also have two teams shortlisted in this year's Nursing Times Workforce Awards in the following categories:

- **Best workplace for Learning and Development** – for our 'Paediatric OSCE bootcamp' a collaborative effort between our Clinical Educators at the Great North Children's Hospital and the International Recruitment team as they welcome and support new paediatric nurses from overseas who have made the life changing decision to leave their homeland to start afresh in Newcastle.

- **Best recruitment experience** – for our community-based Widening Access for Healthcare Support Worker (HCSW) recruitment event earlier this year. Held in the west end of Newcastle, the team aimed to recruit people from our local communities and in particular from under-represented groups, with the aspiration of employing new recruits. The event received an overwhelming response, attracting hundreds of interested individuals seeking to kickstart a healthcare career with the Trust.

Community hero

Clinical trials associate Dianne Turner, who works in late phase cancer clinical trials at the Freeman Hospital, has been named a 'community hero' for her incredible commitment to setting up 'A New Chapter North East' which helps others experiencing grief. The group, whose first meeting in late 2022 was attended by six people, now has over 360 members.

Queen's Nurse Initiative Award

Newcastle Health Visitor Caitlin McCord was awarded the Dora Roylance Memorial Prize – an academic prize dedicated to outstanding students who have completed their SCPHN Health Visitor programme at a university in England, Wales or Northern Ireland.

Innovation and research highlights

- Newcastle eye surgeons became the first in the UK to carry out a pioneering implant for patients with late-stage age-related macular degeneration (AMD). Consultant Vitreoretinal Surgeon and theatre lead for ophthalmology at the RVI, Sandro Di Simplicio, successfully implanted a miniature telescope into a handful of patients which enlarges objects in the centre of the visual field and, essentially, gives them back their vision and freedom.

- Newcastle Hospitals' biggest study to date - known as INGR1D2 – is helping to identify infants at high risk of developing Type 1 diabetes and studying new treatments with the aim of preventing the development of the condition. Led by Honorary Consultant Obstetrician Stephen Robson, Professor of Fetal Medicine at Newcastle University, the study is delivered by the trust's reproductive health and paediatric research teams.

- Newly published research led by David Kavanagh, Professor of complement therapeutics at Newcastle University and an honorary consultant nephrologist at the Trust has shown a pioneering drug, eculizumab, prevents organ failure in a type of rare kidney disease, significantly improving outcomes for patients.

3. RECOMMENDATION

The Board of Directors are asked to note the contents of this report.

Report of Dame Jackie Daniel
Chief Executive
18 September 2023

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023		
Title	Digital People Story		
Report of	Maurya Cushlow, Executive Chief Nurse		
Prepared by	Tracy Scott, Head of Patient Experience Caroline McGarry, Patient Experience Officer		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	This month's digital people story shares the experience and impact on a patient's life of groundbreaking non-lesional epilepsy surgery provided in the Epilepsy Service at the RVI. The patient talks about his condition, the decision to have surgery and the impact on his quality of life. Mr Hussain, Consultant Neurosurgeon provides further details about the technique used by the multidisciplinary team to identify the area of the brain affected as well as the potential development of epilepsy surgical techniques to benefit patients in the future. The digital story evidences the strategic commitment to putting patients at the heart of everything we do by involving patients and their family/carers in the decision-making process. The story outlines the development of epilepsy surgery to ensure the Trust stays at the forefront of health innovation		
Recommendation	To listen and reflect on the patient experience.		
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 • Learning and continuous improvement is embedded across the organisation Pioneers • Ensuring that we are at the forefront of health innovation and research 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]	No risks identified linked to either the strategic risks or BAF.
Reports previously considered by	This patient/staff story is a recurrent bi-monthly report.

PEOPLE STORY

EXECUTIVE SUMMARY

Epilepsy is a common condition with about 1 in every 100 people in the UK developing it at some point in their life. There are many causes of epilepsy and specialist tests are required to find out why patients develop the condition and how best to treat it.

The Newcastle Epilepsy Service is a regional service providing multi-disciplinary care for patients referred to the Trust by their GP or via clinical teams within Medicine or the Emergency Department. The service runs a number of specialist multidisciplinary team (MDT) clinics including the Epilepsy Surgery Clinic which sees around 125 patients per year, around 75 of whom go on to have epilepsy surgery.

This digital story hears from Anthony, a 36-year-old pharmacy accuracy checking technician whose life and career ambitions were changed dramatically through increasing seizures. He was diagnosed with epilepsy at the age of 12 and with a family history of the condition, Anthony's parents knew what to expect and were aware how much his life would be impacted by this condition.

Over the years, Anthony's condition worsened despite trying numerous medication regimes. Anthony's seizures resulted in personal injury on a number of occasions and the seizures were so regular and long lasting that he struggled to hold a conversation, and this greatly affected his independence and freedom. In his story, Anthony describes how the consultant had a meeting with him, his wife and parents to discuss the options, the risks and benefits of the craniotomy surgery and took time to understand the effect that the condition had on his life.

Epilepsy surgery has previously been based on lesional epilepsy where scans have clearly shown the area of the brain affected. Over the past five years, a small number of neurosurgical units across the country including the Royal Victoria Infirmary (RVI) Epilepsy Service have expanded to include a non-lesional stream so that surgery can be an option for more patients. This treatment involves detailed investigations including the placement of intracranial electrodes and observation of patient seizure activity to identify the part of the brain suspected to be the area responsible for the seizures. The development of this surgery in Newcastle has allowed us to develop new innovative intraoperative techniques such as neurophysiological monitoring and mapping on an awake patient. The techniques developed for this surgery have also been transferred to the area of Neurooncology surgery to help bring the service in line with standards which allowed the Trust to acquire the Tessa Jowell Centre of Excellence status.

Anthony had a left craniotomy, and temporal lobectomy including awake speech mapping in June 2022 to remove the part of the brain where the seizures were suspected to be coming from. Following surgery, there has been a marked change in the seizures that Anthony has and a reduction in their frequency. In addition, Anthony can recognise when an episode is coming and can take action to improve his personal safety. He has no speech or memory deficits as a result of the surgery and is very happy with the outcome. Anthony works full-time in a pharmacy in his hometown and has recently moved home.

Mr Hussain, Anthony's neurosurgical consultant talks about the epilepsy service and the development of a less invasive approach to non-lesional surgery. It is recognised that although patient numbers are relatively small due to the specialist nature, the impact on the patient and their quality of life is evidenced by Anthony's story. This story and the work of the MDTs within the Epilepsy service is in line with the Trust strategic objectives of:

- Ensuring that we are at the forefront of health innovation and research.
- Being outstanding now and in the future.

RECOMMENDATION

The Board of Directors are asked to:

i) Listen to the patient experience; and
ii) Acknowledge and reflect on the impact of the development of the non-lesional service.

Report of Maurya Cushlow
Executive Chief Nurse
26 September 2023

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023						
Title	People Directorate Update						
Report of	Christine Brereton, Chief People Officer						
Prepared by	Christine Brereton, Chief People Officer						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The purpose of this report is to provide the Trust Board with an update on People Directorate activities.						
Recommendations	Trust Board is asked to note the contents of this report and the planned actions						
Links to Strategic Objectives	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]	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. SO2.5 - Due to the increasing likelihood of industrial action including strike action, there is a risk of service disruption which could impact on patient safety and quality of care. In addition both industrial relations and reputation could be adversely impacted Impact on staff morale.						
Reports previously considered by	People Committee						

PEOPLE UPDATE

EXECUTIVE SUMMARY

The purpose of this report is to provide the Trust Board with an update on People Directorate activities, with a specific focus on:

- People Priorities 23/24 – including the roll out of the people plan and workforce planning;
- Focus on Freedom to Speak Up (FTSU);
- Industrial Action; and
- Other activities.

PEOPLE UPDATE

1. INTRODUCTION

The purpose of this report is to provide the Board with an update on activities of the People Directorate and Trust wide People priorities following the appointment of the new Chief People Officer in January 2023.

2. PEOPLE PRIORITIES 2023/2024

2.1 Context

A presentation was made to the Trust Management Group and People Committee in April 2023 outlining the draft key priorities of the People Directorate for 2023/24. These have been subsequently finalised by the Executive Team and regular updates will be submitted to the People Committee for assurance on delivery and progress.

The main key priorities of the People Directorate for 2023/24, support the delivery of the Trust priorities against the 5 p's specifically those relating to people (Appendix 1 outlines in further detail). These are:

- Workforce Planning (to support delivery of the national workforce plan – with a view of attracting new staff).
- Developing a People Plan – putting people at the heart (to inform our People Strategy for 2024 and beyond) – with a view to retaining and looking after our current staff.
- Supporting the clinical boards and fit for the future programme.
- Developing the People Directorate as a function.

2.2 Workforce Planning

A Trust workforce plan has been identified as a key priority in ensuring we have the right staff, with the right skills, in the right place and the right time. An initial working group has been established that includes key professional and operational leads across the Trust. A workforce planning workshop took place in May 2023 to identify key areas of focus as well as understanding challenges and enables to each area. The following was discussed:

- Stakeholder and Partners
- Governance and Oversight
- Current Workforce Gaps
- Apprenticeships
- Stock-Take Current Offer

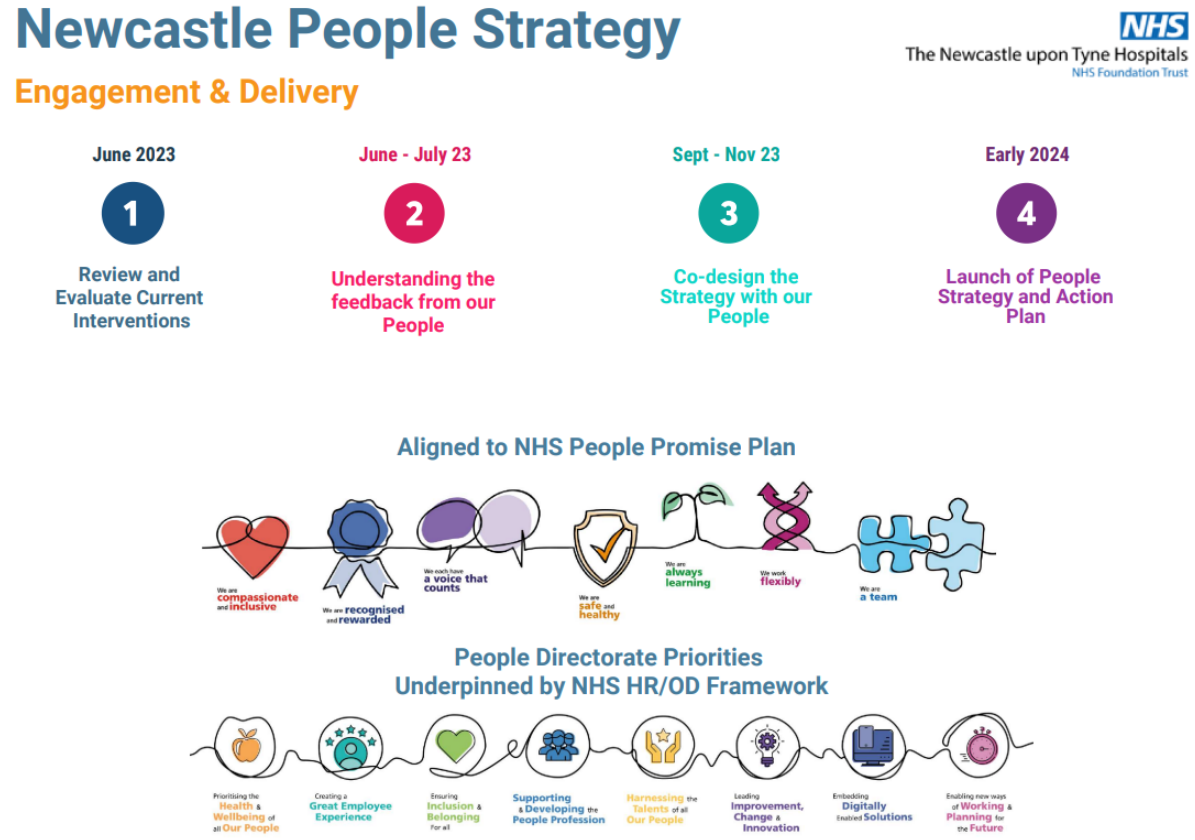
The development of vacancy data was identified as a key gap in supporting the development of a workforce plan aligned to demand. Development discussions are in progress with Finance and Human Resources (HR) to identify options to develop vacancy data set.

It is acknowledged that this is a long-term strategy, and we will ensure links with the Integrated Care Board (ICB) to develop this work further.

2.3 Newcastle People Plan (People at our Heart)

To support the development of our new People Strategy (due for review and renewal in 2024) we have already started to roll out actions to support its development and implementation. We are bringing together all people data and intel to understand what our people are telling us they want and need from us. From this we will be able to shape our next People Strategy identify short- and longer-term actions, all in one. We will use the People promise framework to support this work.

Our approach and timeline are identified as follows:



To ensure overall governance of the programme we have established a People Programme Board which will oversee the development of the Strategy and delivery of the actions identified. This will ensure that it is given strategic oversight linked to the Trust's priorities.

We have the following stages now underway:

Stage 1: Review and Evaluate Current Interventions.

We have drawn together a list of all the current interventions that we offer to staff, from Health and Wellbeing (WB), flexible working and training and development. Things that we know are important to our staff. The collation is now complete, but we are doing further

work to identify themes and offers so that we can use this when we speak to staff in focus groups (stage 3).

Stage 2: Understanding the Feedback from our People.

The Trust has significant amounts of feedback from our people through a range of different engagement activities. To further supplement this and support the co-design of the strategy, this data will be pulled into one area to provide a holistic view rather than separated feedback loops. This information is currently being collated and transferred into a single folder across the Trust to help inform the co-design element. This includes data from What Matters To You (WMTY), staff survey, FTSU, pulse surveys and recent Care Quality Commission (CQC) information.

Stage 3: Co-Design of the People Strategy with our People

We are planning a series of focus groups that will be multi-purpose. To show case what we have (as outlined at stage 1), to show case and accept what we know (stage 2) and to action plan (stage 3). Our approach will be acknowledged, listen, act.

The approach to these focus groups have been heavily influenced by our newly developed steering groups for Equality, Diversity and Inclusion and Health and wellbeing and through discussion with our FTSU Guardian (FTSUG). These will be facilitated by external facilitators and offer a safe space for staff to speak up and help to shape actions that they would like to see in our developing People Strategy.

The focus groups will be rolled out in October and November. We hope that this will start to get a focus on the right things which will work to improving our culture.

2.4 Supporting the Clinical Boards

Clinical Boards are becoming more embedded through structure, governance and delivery. A monthly performance review meeting takes place to review performance and delivery. From a people perspective a people dashboard is produced with a supporting Equality, Diversity and Inclusion (EDI) dashboard. This allows the clinical boards to understand their people activity but also allows the People Directorate to focus on hotspots areas so can support.

2.5 Developing the People Function

A HR Business Partner (HRBP) model is needed to fully support the Boards and work is underway to consider how this can best be achieved with the resources that are available.

Further engagement with the Clinical boards will take place shortly to further explore how the People Directorate can best support.

3. FREEDOM TO SPEAK UP

The Trust has good arrangements in place for Freedom to Speak Up with an identified Guardian (Andy Pike) and supporting champions. This is overseen by an Executive Director (Chief Nurse – Maurya Cushlow and supported by the Chief People Officer (CPO) – Christine Brereton) and Non-Executive Director, Steph Edusei. A report was submitted to the People Committee and referenced at the last Board meeting on the ongoing activity of the Guardian.

Given the events identified in the recent Lucy Letby case, and identified through our recent CQC inspection, the Trust has strengthened its communication to FTSU for all staff, and specifically in areas that have identified concerns and issues. The FTSUG will make himself available to staff in these areas so that staff can feel comfortable and confident about raising any concerns they have. The staff focus groups identified above will also afford staff the opportunity to raise issues and concerns confidentially through our on-line platform "speak in confidence".

We also intend to undertake a review of FTSU strategy to ensure that we prioritise actions to support and enable a FTSU culture within the Trust. To assist with this, we will review our self-assessment document on FTSU at a board development day to ensure that this has board oversight and assurance. We have also identified through the People Committee the need to invest resource to support our current FTSU Guardian and this is in current development.

Lastly, the ICB have indicated a system wide approach to FTSU, and the Trust will be proactively engaged in this work once the framework is developed.

4. INDUSTRIAL ACTION (IA)

Unfortunately, IA for consultants and Junior Doctors continues with more planned IA in September and early October. Contingency plans continue to be made in each of the affected areas, but as previously reported this has significant impact on providing services to patients and staff involved in taking IA. The impact of this will continue to be reviewed and will be reported as appropriate. The timeline for IA is as follows:

- Junior Doctors – 20-22nd September and 2-4th October. The mandate runs until January 2024 (Hospital Consultants and Specialists Association) and February 2024 (British Medical Association).
- Consultants – 19-20th September and 2-4th October. The mandate runs until 26th December.

5. OTHER ACTIVITIES

- The **Local Negotiating Committee (LNC) for medical staff has been reestablished** with the Medical Director and Chief People Officer. Terms of reference and working arrangements are being finalised.

- An **EDI steering group** has been established, which has members of the staff network groups. This has met twice and has a direct link into the People Programme board. This will also have oversight of delivery of the EDI improvement plan discussed at the last board meeting.
- A **HWB steering group** has been established which has members including staff side representatives, occupational health and chaplaincy. Its purpose will be to identify key HWB priorities. With a focus on developing a set of actions for delivery in 2023/24. As identified by staff via the focus groups.
- A **review of Leadership Development programmes** will be undertaken to support the development of the People Strategy, which aims to focus on developing leadership and management skills and capability.
- A **Leadership Event – "Leading with People at our Heart"** and supported by the Institute for Healthcare Improvement (IHA) will take place on 19 October 2023.
- The **NHS annual staff survey will commence on 2 October 2023** and run through to November. We will undertake our usual high-level campaign to encourage staff to complete the survey. This year to support a higher return in Estates and Facilities (low compliance) and listening to specific feedback we will allow access to paper copies for those that need them. The staff survey campaign will be tied into our People Plan approach.
- To support recent national research and findings, national guidance has been developed to support the introduction **of sexual harassment charter**. This will support the work that had already commenced within the Trust with the introduction of a task and finish group to consider this issue more widely.

6. RECOMMENDATIONS

The Board are asked to note the report and ongoing activities.

Report of Christine Brereton
Chief People Officer
19 September 2023

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023						
Title	Quarter 1 review of 2023/24 Delivery Goals						
Report of	Vicky McFarlane Reid – Executive Director for Business, Development and Enterprise						
Prepared by	Vicky McFarlane Reid – Executive Director for Business, Development and Enterprise						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	• The Trust has a 5 year strategy which spans the time period 2019-2024. • At the start of each new financial year, the Chief Executive Officer (CEO) and Executive Team jointly agree a set of annual objectives, each aligned to the 5 strategic P's. • In previous years these have been called 'Break through objectives', this year we changed the terminology to 'Delivery Goals'. 13 Goals were initiated in Quarter 1 (Q1). • The continued industrial action and the unintended consequences of the unannounced CQC inspection may impact progress in future reports.						
Recommendation	The Trust Board are asked to receive the report and comment upon the content.						
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]	This report provides a summary of performance against the delivery goals for 2022/23.						
Reports previously considered by	Regular updates are provided to the Trust Board on progress against the delivery of the Trust Strategy.						

QUARTER 1 REVIEW OF 2023/24 DELIVERY GOALS

1. INTRODUCTION

The Trust has a 5-year strategy which spans the time period 2019-2024.

At the start of each new financial year, the CEO and Executive team jointly agree a set of annual objectives, each aligned to the 5 strategic P's.

In previous years these have been called 'Break through objectives', this year we changed the terminology to 'Delivery Goals'.

In another change with previous iterations, three of the Delivery Goals for 2023/24 have shared ownership among the entire Executive Team.

The progress toward each goal is reviewed on a quarterly basis and the information contained within this report relates to time period 1st April to 30th June 2023.

2. SUMMARY OF Q1 PROGRESS

A summary of the Q1 progress is shown in **Appendix 1**. The table links each Delivery Goal to a strategic P, an Executive lead, and an expected end of year outcome. Q1 progress can be seen in the far-right hand column.

In summary, 13 goals were developed and 3 were identified as shared Executive Goals, being:

1. Implementing a People Plan which supports delivery of the NHS People Promise and addresses our Staff Survey results.
2. Investment in bed capacity and pathway transformation to reduce bed occupancy by 2 % points.
3. Delivery of the 2023/24 financial plan and improve financial sustainability through a significant increase in recurrent Cost Improvement Plans (CIPs).

All goals commenced in Q1 and several new processes, plans and programmes were initiated. These include the establishment of the framework for Patient Safety Incident Response Framework (PSIRF), Care for me with Me, and the Newcastle Change Board. This will undoubtedly provide the Trust with strong foundations and a bedrock for the remainder of the year.

There are two critical points to note that have occurred since the end of Q1 and that are not immediately apparent reading the summary in **Appendix 1**.

Firstly, at the end June 2023, whilst Industrial Action (IA) was taking place, the Trust had only undergone 15 days of strike activity and therefore the additional cumulative impact of

continued IA had not really been experienced. Each continued day of IA not only leads to direct loss of activity, which is seen in appointment cancellations, but there is also a huge indirect impact across the organisation. The predication would be therefore that when reviewing the Q2 progress, we will undoubted see a greater detrimental impact across all Delivery Goals. To put this into perspective, by 4th October the total number of lost days to IA will have topped 36. At the time of writing this report, there is no immediate resolution of IA.

Secondly, on 27th June, the Care Quality Commission (CQC) commenced a full and unannounced inspection of Newcastle Hospitals. The inspection, the focus groups, and the request for documents have been an additional and unplanned burden for the organisation.

3. SUMMARY AND RECOMMENDATIONS

Q1 showed signs of a good start for the organisation, but it very likely that progress in subsequent quarters will not be as positive due to the wider disruptive implications of continued IA. Additionally, we might want to review the nature and content of the goals in light of a pending CQC report. Therefore, it would be sensible to keep this process under review, and to ensure that we are prioritising effort where it can have the greatest impact to the organisation.

Report of Vicky McFarlane Reid
Director for Enterprise and Business Development
13th September 2023

Appendix 1. **Delivery goals – progress versus plan for Q1 2023/24**

Strategic P	Delivery Goal	Exec Lead	Expected end of year outcome	Q1 progress (April – June)
Patients	**Implementing Care for me, with me**	MC	• The Trust will have demonstrated improvement in line with the CQC recommendations and regulatory notice. • The Trust is assured it is delivering its statutory responsibility in regard to the Mental Health Act and Mental Capacity Act across all services. • There is a clear strategy with robust action plans to continuously improve the care for those patients with a mental health concern and those patients with a Learning Disability and/or autism.	• Established workstreams are in place to deliver the immediate and essential actions. • Significant changes made to the electronic patient record to optimise processes such as capacity assessments and mental health assessments. • New training launched for Learning Disabilities (current compliance 83% as of 9th July). • New training launched for Mental Capacity Act (current compliance 84% as of 9th July). • Bitesize education sessions and ward leaders development programme launched. • Audit programme in place to monitor improvements and inform education strategy.
	Implementing the National Patient Safety Strategy and PSIRF to further reduce avoidable patient harms	AW/AOB	• PSIRF to be fully implemented in the Trust, with policies submitted and approved by the Integrated Care Board (ICB).	• 12 month funding secured for 5PAs for Consultant Medical Leadership and 1 whole-time-equivalent PSIRF Implementation Lead.

Strategic P	Delivery Goal	Exec Lead	Expected end of year outcome	Q1 progress (April – June)
			• Clinical Boards to have appointed Quality and Safety (Q&S) Leads to support the implementation of PSIRF. • PSIRF Training Curriculum is progressing in accordance with the Training Needs Analysis (TNA).	• Clinical Board Quality Oversight Function includes delivery of PSIRF. • Commenced development of Patient Safety Incident Response Plan (document in draft).
	Co-design the development of an ambitious & vibrant Patient and Public Engagement (PPE) strategy	MC	• A high quality Patient Experience Strategy launched which has been co-produced. • Clear actions for corporate teams and clinical boards to implement the strategy in practice. • Clear method to measure impact. • Strong patient voice throughout the Trust.	• WeAreStand commissioned to undertake patient, public and staff engagement • Engagement sessions planned throughout June/July/August. • Analysis scheduled through August and co-production sessions x2 planned for September 2023.
People	**Implementing a People Plan which supports delivery of the NHS People Promise and addresses our Staff Survey results***	CB	• The People Plan will be launched and in its early stages of delivery against the year 1 action plan.	• 4 stage framework in place to develop new people strategy. Stage 1 and 2 have commenced.
	Further embedding our "Newcastle Way" into our people processes	CB	• Our Newcastle Way shared through a formal communications programme within the organisation, with an agreed plan and timeline as to how to embed in relevant policies and	• Draft graphics consulted on and updated – awaiting final approval via engagement to commence wider communications.

Strategic P	Delivery Goal	Exec Lead	Expected end of year outcome	Q1 progress (April – June)
			approaches e.g. recruitment and selection.	
	Reviewing our Health and Wellbeing offer to support staff	CB	Maintain the Better Health at Work Award (BHAWA) status 'Maintaining Excellence'.	• Health Improvement Practitioner post now full-time and person appointed – starts July. • Evidence for BHAWA being collated. • Workforce Group on 21 June 2023 to scope and shape the Health and Wellbeing Board (HAWB) steering group, including terms of reference and membership.
	Enhancing and Celebrating Diversity and Inclusion	CB	Equality, Diversity and Inclusion (EDI) Improvement Plan (and gap analysis) in place, to include: • EDI Steering Group • EDI Commitment Charter • Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans • Gender pay gap report and action plan • Black and Minority Ethnic (BME) Coaching Programme	• EDI Plan being drafted. • Initial meeting held August 2023. • WRES and WDES data submitted. Staff networks will co-produce action plans.

Strategic P	Delivery Goal	Exec Lead	Expected end of year outcome	Q1 progress (April – June)
			• Second internal cohorts of Impact Leadership Development Programmes ran (Ethnicity and Disability)	
Partnerships	**Using the Newcastle Change Programme and Strong system working to transform patient pathways for Spines, Dermatology and Ophthalmology and identifying sustainable solutions for service delivery**	VMR	• ***Newcastle Change Board*** established as the forum for medium to long term change. • 7 Prioritised programmes of work to be stood up. • Standard methodology to be applied (combined Programme Management Office and Newcastle Improvement) to identify 'candidate projects' that will deliver benefits to Patients and the organisation over the medium to long term.	• NCB stood up & Prioritised programmes of work identified. • 3 Programmes stood up Q1 (CIP, Theatre Productivity and Outpatients). • Senior Responsible Officers (SROs) appointed. • Candidate projects identified.
Pioneers	**Investment in bed capacity and pathway transformation to reduce bed occupancy by 2ppts (Medicine clinical board) ***	MW	• Bed occupancy 2 percentage points below the counterfactual trend. Wards appropriately configured to optimise flow in each clinical board. At least one ward upgraded.	• Project team established. • Review of ward costs and budgets complete. • Bed modelling almost completed. • List of clinical board asks for ward changes collated.
	Roll out of the Care Coordination System (CCS)	MW	• Theatre utilisation increased by 2 percentage points – through a combination of increased session	• Urology pilot launched and very positive progress made.

Strategic P	Delivery Goal	Exec Lead	Expected end of year outcome	Q1 progress (April – June)
	and 6-4-2 theatre scheduling to increase theatre utilisation by 2ppts (combination of session and in-session utilization) (2 surgical & periop clinical boards)		utilisation and in-session utilisation. CCS rolled out Trust wide.	• Strong interest from other specialties in wider roll out. • Agreed next specialties for implementation in Q2. • Additional temporary staff recruited.
	Use improvement methodology to increase efficiency, reduce length of stay (LOS) and provide a better discharge experience for both patients and staff	MC	• To be assured that internal discharge processes are efficient, optimised and in line with best practice guidance. There will be evidence of reduced length of stay and improvement and reduction in complaints relating to discharge	• Discharge improvement facilitator employed and in place. • Improvement group established with terms of reference, regular meetings and action plan in place.
Performance	**Delivering a clean performance, treating all >65 week waits (WW), reducing the cancer back log and achieving our activity targets so that we can reinvest Elective Recovery Funding into Quality**	VMR	• All long waiters over 65 weeks to receive treatment by the end of 2024, except complex spinal or those that decline choice. • Progress (and course correction where required) against quarterly plans monitored at ***Performance, activity and delivery*** *(PAD)* meeting.	• Long waits - Current performance is just off track at 15 >104 ww (13 Spinal and 2 Non spinal (NS)) and 107 >78 ww, (53 Spinal and 54 NS) • Activity - achieved planned levels in April, missed in May. Strikes impacted for 1/3 lost activity in May. • Cancer – off trajectory. • Governance - PAD set up. Focus is in-year delivery.

Strategic P	Delivery Goal	Exec Lead	Expected end of year outcome	Q1 progress (April – June)
	Deliver the financial plan for 2023/24 and improve financial sustainability through a significant increase in recurrent CIP*	JB	• Achievement of year-end balanced revenue position. Improved in year CIP and move towards recurrent CIP rather than non-recurrent.	• Plan for the first two months was achieved, however for month 3, the Trust moved away from plan due to unplanned costs of industrial action and unfunded national changes such as Microsoft licence impact. • Year-end forecast of breakeven still in place. • Improved identification of CIP overall, further work needed to move from recurrent to non-recurrent but longer term schemes launched through Change Board (see above).

(* - indicates shared Executive Delivery Goal)

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023						
Title	Newcastle Hospitals Charity Update						
Report of	Teri Bayliss, Charity Director						
Prepared by	Teri Bayliss, Charity Director						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	This report contains a high-level summary of progress made in achieving the strategic aims of the Charity Strategy to 2026, and the summary priorities for the year 2023/24.						
Recommendation	The Board are asked to note the contents of this report.						
Links to Strategic Objectives	1. Putting patients at the heart of everything we do.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☒	☒
Link to Board Assurance Framework [BAF]	No risks linked to BAF.						
Reports previously considered by	6-monthly report to Board.						

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Newcastle Hospitals Charity

Charity Strategy to 2026

Summary of progress, September 2023

Healthcare at its best
with people at our heart

Charity Strategy to 2026

The Newcastle upon Tyne Hospitals NHS Foundation Trust

To be an enabler to improving the health and wellbeing of the patients, people and wider communities of Newcastle Hospitals, providing support for compassionate and innovative healthcare, education and research, locally and nationally

Goals		
Improve the patient and visitor experience, enhancing care for patients and the wider community	Improve staff health, wellbeing and development	Tackle health inequalities and key health issues for our region and nationally

Strategic Aims				
Aim 1: Enhance the patient experience and environment	**Aim 2:** Support the health, wellbeing and professional development of the staff of Newcastle Hospitals	**Aim 3:** Fund major developments and health related clinical research and innovation	**Aim 4:** Develop place-based partnerships to tackle health inequalities and to create healthier communities	**Aim 5:** Be a trusted charity partner with connected and engaged supporters and volunteers





Healthcare at its best with people at our heart

Progress and priorities

Strategic Aim 1	Enhance the patient experience and environment
Objective	Increase opportunities to improve patient and visitor experience across the Trust, enhancing the highest quality of care
Impact	• Improvements to the patient environment • Excellent patient experience and engagement • Creative patient and community engagement opportunities
Priorities	1. Design & deliver effective, accessible funding programmes to support Trust improvements to services and patient environment 2. Establish a funding programme dedicated to supporting patients and families experiencing severe financial difficulties during their treatment 3. Establish Art engagement programme for patients, staff and local community
2022/23 Progress	1. £3M (42.8%) of all funding committed to this goal in 22/23 2. Arts programme embedded
2023/24 Priorities	1. Further develop funding framework for this goal with input from Trust and patients 2. Significantly grow Arts programme for benefit of patients and staff 3. Launch 'everyday impact' funding programme for straightforward access to funding for initiatives >£500

Progress and priorities

Strategic Aim 2	Support the health, wellbeing and professional development of the staff of Newcastle Hospitals
Objective	Increase support for staff wellbeing initiatives as well as clinical excellence
Impact	• Health, wellbeing and morale boosting activities • Increased opportunities for Trust staff • Enhanced clinical knowledge/practice and enhanced patient outcomes
Priorities	1. Support Trust's flagship wellbeing and recognition programmes 2. Support for research programmes for staff, supporting career progression while supporting the Trust to be at the forefront of health innovation and research 3. Support staff initiatives within 'Sustainable Healthcare in Newcastle' (SHINE)
2022/23 Progress	1. £0.9m committed to staff-focused wellbeing activity 2. Ongoing success of £3.2m (over 5 years) NMAHP researcher development institute 3. 5 SHINE initiatives supported
2023/24 Priorities	1. Develop a framework / funding programme for wellbeing and recognition with Wellbeing steering group 2. Launch 'everyday impact' programme for straightforward access to funding for initiatives up to £500

Progress and priorities

Strategic Aim 3	Fund major development and health related clinical research and innovation
Objective	Support research and innovation leads the way in delivering world class healthcare and treatment
Impact	• Catalyst funding for strategic priorities • Ability to leverage charitable funding for key initiatives
Priorities:	1. Fund / fundraise for major projects within the Trust and / or where the Trust is a key partner 2. Provide / secure funding for cutting edge clinical research and innovation, particularly where no other source is available
2022/23 Progress	1. Secured £1m single donation which made possible a £1.8m grant in support of a major expansion of the Trust's robotic surgery programme 2. Overall £545,000 committed to other research and innovation projects in 22/23
2023/24 Priorities	1. Co-design funding programme for research and innovation funding programme with Trust staff and partners, to launch in 2024

Progress and priorities

Strategic Aim 4	Tackle health inequalities and key health issues for our region and nationally
Objective	Actively seek and strengthen partnerships at a regional and national level to tackle health inequalities and to create healthier communities
Impact	• Collaborative approach to addressing health inequities and prevent interventions • Proactive in influencing policy for addressing health inequalities
Priorities:	1. Build and strengthen partnerships with key health and Voluntary, Community and Social Enterprise (VCSE) organisations to deliver greater impact 2. Work with the NHS Charities Together (NHSCT) network to influence national NHS charity funding priorities 3. Establish Newcastle Hospitals Charity as a regional partner for collaborative prevention initiatives
2022/23 Progress	1. Worked in partnership with NHS charities and VCSE partners in North East North Cumbria (NENC) to secure / distribute £1.5m NHSCT partnership grant (including Barnardo's, Coping with Cancer North East, Family Action, Middlesbrough & Stockton Mind, Wearside Women in Need, and Your Voice Counts) 2. Further 14 partnership initiatives funded in 2022/23 3. Inaugural 'Charities Forum' brought together 20+ charities supporting our hospitals to discuss partnership opportunities
2023/24 Priorities	1. Further strengthen 'Charities Forum' and partnership working 2. Establish focus for partnership working with NHS charities across ICS

Progress and priorities

Aim 5	Be a trusted charity partner with connected and engaged supporters and volunteers
Objective	Increase engagement with people across the Trust and become more visible as the official Charity of Newcastle Hospitals
Impact	• Efficient and effective charity governance and operations • Charity a household name in the region • Significant increase in fundraising income from a diverse range of income streams • Loyal and informed supporter base
2022/23 Priorities	1. Ensure excellent governance and ethical standards of charity practice 2. Develop and resource professional, ethical fundraising programmes to deliver our ambition 3. Develop brand to ensure that our ability to deliver impact is understood
2022/23 Progress	1. (a) Charity Policy ratified; (b) Governance Working Group review/assessment/action on governance; 2. (a) fundraising plan in place and 73% over target in 22/23; (b) systems review and implementation to ensure professional standards and regulatory compliance; (c) fundraising standards; gift acceptance and due diligence procedures in place 3. Significantly improved visibility of Charity across Trust with 49% of staff surveyed 'very aware' of Charity 4. Key themes agreed : Child Health; Cancer; Green & Healthy Hospitals; Research & Innovation
2023/24 Priorities	1. Further strengthen Charity branding and key messaging 2. Supporters feel valued and know impact 3. Agree strategic fundraising priorities with Trust

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023						
Title	Medical Director's Report						
Report of	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Prepared by	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☒	☒				
Summary	The Report highlights issues the Medical Director wishes the Board to be made aware of.						
Recommendation	The Board of Directors is asked to note the contents of the report.						
Links to Strategic Objectives	Putting patients at the heart of everything we do and providing care of the highest standard focusing on safety and quality.						
Impact (Please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☐	☐
Link to Board Assurance Framework [BAF]	No direct link.						
Reports previously considered by	This is a regular report to Board. Previous similar reports have been submitted.						

MEDICAL DIRECTOR'S REPORT

EXECUTIVE SUMMARY

The following items are described in more detail within this report:

i) Quality & Patient Safety Update
ii) Cancer Update
iii) Industrial Action
iv) Infection Prevention and Control
v) Urgent and Emergency Care
vi) Research
vii) Medical Appraisal and Revalidation

Included within the Board Reference Pack (BRP) are the following documents to note:

i) Consultant Appointments
ii) Annex D – Annual Board Report and Statement of Compliance

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

MEDICAL DIRECTOR'S REPORT

1. QUALITY AND PATIENT SAFETY

1.1 Clinical Board Quality and Patient Safety Structure

Development of new structures for quality and safety and adoption of the agreed new framework for this area of work are underway within the Clinical Boards, with all roles/posts having now been advertised and some appointed to their medical lead positions. Resource availability is currently being sourced.

The work to re-organise governance arrangements within the four specific domains of patient safety, clinical effectiveness, patient experience and quality improvement will be challenging and requires the understanding of and support from senior trust management.

It is hoped that all Clinical Boards will have held their first Quality Oversight Group meetings by November and at their first meeting they will have agreed their terms of reference, membership and initial work streams.

1.2 Patient Safety Incident Response Framework (PSIRF)

The transition to PSIRF from our current Serious Incident (SI) framework is planned to be completed by January 2024. Final agreement of PSIRF priorities will be ratified by the Trust Board but are likely to be:

- Reduction in medication errors relating to anti-coagulation
- Improvements in the internal referral process – see below
- Ensuring action is taken when abnormal results arise – radiology

Transition also depends upon:

- Adequate resource, support and skillset for incident investigation being available at Clinical Board and Directorate level.
- Mechanisms for sifting and categorising incidents.
- Ensuring a robust structure for central oversight of significant investigations.

1.3 Internal Referral

A number of recent SIs have highlighted the need for improvements to be made in internal referrals, the process by which departments refer patients between each other within this organisation.

There is no standardised means for this and whilst in certain cases this will be appropriate there are many occasions when agreed formal pathways will be more robust and secure. Some specialities have already adopted online tools such as Refer A Patient which mandate a referral to be online within an app and there may be mileage in looking at this or similar solutions more widely.

This will likely be a PSIRF priority for 2024, with focussed investigation on issues in this area.

2. CANCER UPDATE

- 2ww performance for April, May, June and July is 76.1%, 75.8%, 77.2% and 49.8% respectively.
- 62 day treatment performance is 61.1%, 53.9%, 47.2% and 55.2% respectively for the same period
- 28 day faster diagnosis target sits consistently 80-83%.

The main challenge, affecting the July figures, has been a very significant excess of referrals to the skin service in June (around 1,800 referrals). This is higher than the usual predicted summer peak and higher than we have ever experienced previously. The team are working through the backlog and are clinically prioritising cases for review to minimise risks. Referral numbers for July are lower. Recruitment continues into posts for the funded business case in Dermatology and it is anticipated that once recruitment is complete the situation will improve.

Considerable work has been undertaken in Cardiothoracic Surgery to reduce the time to surgery for patients with lung cancer. The waiting time has been reduced from 7.6 weeks in June to 4.3 weeks currently. The team have been able to secure some additional theatre time and have developed a system for the pooling of referrals. A cancer care co-ordinator commenced in post in September which will enhance the patient pathway.

The combined upper and lower gastrointestinal (GI) referral pathway for suspected cancers commenced 1 September. A primary care education session has been arranged for 20 September 2023. This pathway, alongside modification of skill mix of nursing staff, is intended to improve the resilience of the pathway overall and to maximise the efficient use of equipment, rooms and time.

The Cancer Team are meeting with all tumour groups on a 1-2 monthly basis to ensure action plans are in place to improve the time to treatment for patients and to support the implementation and monitoring of the action plans over time. We continue to encourage staff to complete harm review documentation for any patients who breach 104 days but would emphasise that clinical acuity and risk are monitored very frequently, at least weekly at Patient Tracking List (PTL) meetings, for patients as they move through the pathway in order to clinically prioritise treatment.

The cancer team will facilitate a meeting on 22 September for any staff with a role in providing care of patients with cancer. This meeting is being delivered alongside Newcastle Improvement with the goal of determining the main strands for our 5 year cancer strategy.

3. INDUSTRIAL ACTION

Preparation is well underway for the combined junior doctor and consultant action on 19-22 September 2023, and for the forthcoming consultant action in October. Further disruption is inevitable with patient safety remaining the absolute priority. P1 and P2 elective cases will continue as circumstances permit.

4. INFECTION PREVENTION AND CONTROL

COVID numbers in the community are rising and a new strain circulating (BA2.8.6), but there is no evidence at this stage of increased transmissibility, pathogenicity or immune evasion. The UK Health Security Agency (UKHSA) have advised vaccinations are to be brought forward.

Point of care tests and hot labs are available for testing symptomatic patients to enhance Emergency Department (ED) flow.

5. URGENT AND EMERGENCY CARE

ED, with associated non-planned admissions has continued to be busy during the summer months, with no real respite and continuing high numbers of boarders.

Plans are in progress to facilitate more rapid flow though ED and the Assessment Suite (AS) with diversion of some patients directly to the specialities.

Given the high prevalence of flu in Australia, it is likely that there will be severe pressure in the UK during the winter season.

6. RESEARCH

6.1 Activity

Recruitment to research studies is currently lower than the previous year, due to a number of factors:

- Impact of industrial action; and
- The COVID vaccine study in 2022/23 with very high recruitment figures (see May/June figures for 2022/23 below).

Commercial research trial recruitment remains at a high level, in line with national priorities.

6.2 Partnerships

We continue to strengthen our commercial partnerships. This month Bristol Myers Squibb selected Newcastle as one of two UK pilot partnership sites alongside University College

London Hospitals (UCLH) – one of only 8 internationally alongside Yale and Dana Farber in the US and two sites each in Canada and Australia.

6.3 Dragons Den

We were delighted to receive 17 applications for our inaugural Dragons Den initiative launched in June. A group of staff from across the Trust, University and Newcastle Health Innovation Partners (NHIP) reviewed these applications in August and 6 have been shortlisted to present to the 'Dragons' on 22 September 2023. It should be noted that those not shortlisted have been signposted to other avenues of support including Newcastle Joint Research Office, the Academic Health Science Network (AHSN), the NHIP and the Trust Commercial Enterprise Unit.

6.4 Digitisation of Clinical Research Records

Working with the digital team, user acceptance testing of the new clinical research encounter on eRecord has been completed and training is underway for a launch of key functionality for our late phase oncology research team this month. The full roll out will take up to 12 months, but it is encouraging to see these first steps and reduce the existing risk of paper clinical research records.

6.5 Upcoming plans for next quarter

- The NHIP visit to the Biomedical Research Centres (BRC) and Clinical Research Facilities (CRF) on 26 September 2023.
- Working with Integrated Laboratory Medicine (ILM) and Radiology we are currently preparing bids for additional research resources for pathology and radiology to the National Institute for Health and Care Research (NIHR).
- We will hold our first Research Directorate staff conference in October 2023.
- Research will be presenting an interactive session at the Trust members event in November 2023.

7. MEDICAL APPRAISAL AND REVALIDATION

The annual compliance statement for Medical Appraisal and Revalidation required under the Responsible Officer Regulations, is attached to this report.

Medical Appraisal and Revalidation continue to be delivered effectively in Newcastle Hospitals with appraisal rates now similar to those achieved pre-pandemic. There are currently 1,290 doctors with a prescribed connection to Newcastle Hospitals for Revalidation with 1,054 senior staff including substantive consultant staff, SAS doctors and honorary contract holders who are linked to Newcastle Hospitals for Revalidation and 236 junior staff. Whilst the figures reported in the compliance statement suggest an overall appraisal rate of 77% (996/1,290) this does not take into account staff unable to complete an appraisal due to sickness absence, maternity leave or where the appraisal was delayed for an agreed reason e.g., staff who have recently joined the Trust. When these 'agreed

exceptions' (200) are taken into account the corrected appraisal rate is (996+200)/1,290) 93%.

In the coming year there will be particular emphasis on appraisal processes for locally employed doctors and those working solely on the staff bank. An initial review of processes for these groups of doctors suggests that further consideration of the most appropriate model to support effective appraisal and Revalidation for them, is required.

A review will be carried out of the resource required and available to deliver appraisal and Revalidation effectively in the coming years. The number of doctors with a prescribed connection to Newcastle Hospitals has continued to rise (1,026 in 2017 c.f. 1,290 in 2022/23). The available resource to manage the appraisal and Revalidation process has not increased in this time. Whilst appraisal and Revalidation continue to be delivered effectively at this point it is likely that we will see further increases in medical staff in the coming years. It is therefore important to consider what additional resource will be required to support these processes in the future.

8. BOARD REFERENCE PACK DOCUMENTS

Included within the BRP are the following documents to note:

i) Consultant Appointments
ii) Medical Appraisal and Revalidation

9. RECOMMENDATION

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

A R Welch FRCS
Medical Director
15 September 2023

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 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 the Clinical Assurance Toolkit • Nursing and Midwifery Safer Staffing • Patient Experience Quarter one (Q1) Summary • Safeguarding and Mental Capacity Act Q1 summary • Learning Disabilities Q1 summary • Flu/Covid vaccination overview						
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 standardfocusing on safety and quality. • We will be an effective partner, developing and delivering integrated care and playing ourpart 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]	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 [Capacity and Demand] ii) SO1.4 [NHS core standards - patient safety and quality of care]						

Reports previously considered by	The ECN Update is a regular comprehensive report bringing together a range of issues to theTrust 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:

Section one of the report contains this month's 'Spotlight' section which provides an overview of the Trust's Clinical Assurance Toolkit (CAT).

Maintaining high clinical standards is fundamental to professional practice. When high standards are delivered and maintained, care quality and outcomes are improved, and the patient experience is optimised. Leadership of clinical and professional standards at a ward and departmental level is pivotal with monitoring and audit supporting local ownership and improvement.

The CAT was originally introduced within Newcastle Hospitals in 2010/11 as a Trust-wide tool to provide continuing clinical oversight and assurance of performance for each ward and department. It remains one of the most fundamental Trust audit tools for assurance that the highest clinical and professional standards are met.

The CAT audit is undertaken monthly by Ward Sisters and Charge Nurses with a separate audit undertaken by Matrons to assess how their teams are performing in relation to core standards. Questions and observations relate to subjects ranging from:

- The cleanliness of the ward/environment.
- Compliance with the monitoring of equipment such as medication fridges and resuscitation equipment.
- Observations of clinical practice including a review of standard Infection Prevention and Control (IPC) precautions, hand hygiene and Aseptic Non-Touch Technique (ANTT) compliance.
- Review of patient notes and documentation and risk assessments compliance.
- Invasive device care compliance comprising of assessing device care bundles, completion of required documentation and evidence of ongoing care, as per policy.
- Testing of staff knowledge through focused questions.

Results are produced on completion and are visible to staff immediately. To support appropriate scrutiny and audit data accuracy, the Matrons undertake a peer review twice a year with feedback provided peer to peer. This has been a pivotal part of the process, ensuring a 'fresh eyes' assessment of standards in clinical areas.

The report includes an overview of the August CAT results which demonstrate that whilst performance remains high in most areas, further work is required to ensure all audits are completed as required and robust action plans are created to increase compliance.

Oversight and assurance are provided through the following mechanisms.

- The clinical teams have responsibility for completion of the audits to promote ownership, drive improvement and positive reinforcement.
- To ensure completion, areas that have not yet completed near month end are highlighted and the Associate Directors of Nursing follow this up with Matrons and teams to action.
- Action plans for improvement are the responsibility of the Matron and Ward management team and are held at local level.
- Results and action plans to address areas of concern are discussed in Matrons monthly 1 to 1's with the Associate Directors of Nursing.
- Results are presented and discussed bi-monthly in the ECN Meeting. Areas of concern are highlighted and followed up by the appropriate Associate Director of Nursing for that area.

It has recently been recognised that further work is required to strengthen the work regarding assurance around the actions taken in response to low scores and areas for improvement at a local level. Work is underway with the company who designed the tool to strengthen internal reporting and governance and explore the most effective way in which to report, monitor and document compliance to support sustained improvement.

Section 2: Nursing and Midwifery Safer Staffing

Section two highlights' areas of risk and details actions and mitigation to assure safer staffing in line with agreed escalation criteria.

The nurse staffing escalation remains at level two due to appropriate criteria being met. The necessary actions in response to this are in place and continue to be overseen by the ECN.

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

The following key points from this group are noted below:

- Three wards have required high-level support over the last three months, two of which have now stepped down to medium level. All wards have action plans in place, overseen by the Nurse Staffing and Clinical Outcomes Group and by the ECN Team.
- Where beds have been closed due to staffing concerns, a weekly documented review with the ECN Team remains in place and will continue until all commissioned bed capacity is safely opened.
- Red flags generated within the SafeCare module by the nursing staff in conjunction with professional judgement have provided valuable triangulation of data alongside DATIX reports. These alerts are responded to promptly by members of the Senior Nursing Team directly with the ward staff and Matrons and are reported daily into the ECN Team. In the last three months, 545 red flags have been generated across the Trust which is similar to the previous quarter (n=535). The highest numbers are from across Medical Wards (n=155), Cardiothoracic Wards (n=103) and Childrens Wards (n=80).
- All staffing related DATIX reports have been reviewed and were graded no harm, low/minor or moderate. The last three months datix sustained the previous quarters average of 10 per month and are listed below:

June: 5
July: 10
August: 16

- New guidelines for roster optimisation "Check, Challenge and Coach" have been developed and are currently under review. This process will provide assurance of nursing roster optimisation and will support nursing leaders, by providing clear expectations, along with supportive education and training where required.

Recruitment and Retention remain a priority workstream and the report provides an update on the current pipeline of Registered Nurses and Healthcare Support Workers (HCSWs). International Recruitment (IR) remains an important focus.

The following key points are contained within the report:

- The current total Registered Nursing and Midwifery workforce combined turnover is 8.65%. This is based on Month 4 data and demonstrates a reduction from 9.61% reported in July. This compares favourably with the national median of 12.45%.
- The Band 5 Registered Nurse (RN) vacancy rate is 4.99% based on the financial ledger at Month 4 and current substantive staff in post. This is a favourable position when compared to the Month 4 vacancy rate of 10.9% in 2022. It does not include those nurses currently in the recruitment process, where there is a pipeline of 306 (head count) and does not include internationally recruited staff across adult and Paediatrics.
- There are areas where the vacancy rate remains above the Trust average, and this particularly relates to Paediatrics where a number of commissioned beds remain closed.
- The Nursing, Midwifery and Allied Health Professions (AHP) Recruitment and Retention Group provides oversight and analysis of the staffing data to determine additional requirements in the short, medium, and longer term. The focus for the next 12 months will be on the retention of staff to replicate the good practice and lessons learned from the HCSW retention work.
- The Trust made a successful bid for 2023/24 NHS England (NHSE) funding to continue with the ambitious international nursing recruitment plan for the deployment of 180 nurses by the 10 January 2024. The Trust also pledged to add a further 44 nurses to this plan to be deployed by the end of March 2024, giving a total of 224 nurses to add to the nursing and midwifery workforce. Recruitment and deployment remain on track.
- An essential component of the NHSE funding and the release of second tranche of funding requires the Trust to apply and submit evidence of the pastoral care provided to the international nursing recruits; this has been submitted and is awaiting approval.
- The national HCSW programme requires Trusts to achieve a zero-vacancy position. The HCSW vacancy rate is 5.3% based on the financial ledger at Month 4 and relates to current substantive staff in post. It does not include those HCSW's currently in the recruitment process, where there is a pipeline of 100 (headcount).

Section Two also includes an overview of the midwifery staffing position.

The following key points are contained within the report:

- The Maternity Service has continued to experience midwifery workforce pressures through Q1 and Q2. A combination of increased long and short-term sickness absence, maternity leave, and high turnover has contributed to these challenges.
- The current Registered Midwife vacancy rate is 7%. There are 31 whole-time-equivalent (wte) Midwives due to commence in post by November which will lead to an over recruited position and mitigate gaps for maternity leave and sickness absence once staff have completed their supernumerary period.
- Increased turnover rates continue at 12.4%, with attrition for a variety of reasons. Tables 2 and 3 show the percentage of Midwives leaving the Trust by band, and their reasons for doing so. The most common reasons for leaving are retirement, consistent with an ageing workforce, work-life balance, and relocation. The service's newly published retention action plan identifies key actions and targeted interventions for staff at all stages of their career, from students, through early and mid-career, to late-career midwives approaching retirement.
- From 1 February 2023 to 31 July 2023, there have been 4 occasions against a possible 1,086 episodes, recorded where the midwife has been unable to provide continuous one-to-one care and support to a woman in established labour; and four occurrences where the delivery suite coordinator has not remained supernumerary and has resulted in the coordinator being the named midwife for a woman. On these occasions, a review of the acuity and activity was undertaken, and together with professional judgement, the most appropriate utilisation of the available workforce resource has been made, thereby preserving, and maintaining safety.
- In June and July 2023, the number of red flags recorded on Delivery Suite was 25 and 24 respectively. This represents an increase on the monthly average which is usually below 10. The most common red flag reported is the delay between admission for, and commencement of, induction of labour. 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.
- Due to the increased staffing pressures experienced in July, August and into September, following senior clinical review and discussion, a decision was made to temporarily close the Newcastle Birth Centre (NBC). Women eligible and expressing a wish to use the Birth Centre are diverted to Delivery Suite where a low-risk midwifery service is being provided. A Quality Impact Assessment has been undertaken which indicates that this process supports the safety of women and babies.

Section 3: Patient Experience Q1 Summary

Section three provides a Q1 summary of the work of the Patient Experience team.

The Trust has opened 119 formal complaints in Q1, which is a decrease of 13% from the previous quarter and a 13% decrease from the previous year, when an average of 46 complaints were received each month.

This quarter, 167 complaints were closed, which is an increase of 11% from the previous quarter. Of these, 26 complaints were upheld, 34 partially upheld and 107 not upheld.

The report provides an overview of several patient experience initiatives, improvements and work streams. This includes a detailed overview of the following:

- Sophie's Legacy - Earlier this year, the Trust was granted £10,000 by the Children's Hospital Alliance to implement a pilot aimed at improving the food provision for parents/carers of child in hospital. A multi-disciplinary task and finish group was established to assess current provision and implement any changes required. The group reviewed current provision on all Great North Childrens Hospital (GNCH) wards, undertook a survey of parents to find out what would help them during their stay and initiated a pilot of free lunch and evening meals for a three-week period. The pilot has evaluated very positively, and the working group are now exploring options for continuing this support for parents.
- Learning Disability Fun Day – Took place on 23 June 2023 at the Royal Victoria Infirmary (RVI) to celebrate the learning disability week. The Patient Experience Team had a stall asking staff, patients and visitors of their experience when coming into hospital with a learning disability. The team asked people what has worked well, and three things would they like to see improved. This feedback will be provided to the Learning Disability Steering Group to help drive forward improvements in the Learning Disability Passport and use of Easy Read information.
- Communication Support for Patients with a Learning Disability - The Patient Experience Team and Learning Disability Liaison Team are working closely with Skills for People to develop Easy Read information for patients. Skills for People is a local charity based in Byker supporting people with a learning disability and/or autism, and they have expertise in developing Easy Read information which is co-led by people with learning disability.

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 to ensuring developments in services are patient led.

Section 4: Safeguarding and Mental Health Capacity Act (MCA) Q1

Section four of the report provides a Q1 summary update of Safeguarding and Mental Capacity Act activity throughout the Trust and includes references to activity, education and training. and audit and assurance.

Safeguarding activity for Q1 evidences the following key high-level points:

- In Adult Safeguarding, 1,052 referrals/cause for concerns were received in Q1 which is 100 more than the same period last year and an 11% increase in activity. Self-neglect continues to be the most significant case for referral accounting for 513 of the concerns received in Q1. Recent investment into the team is in progress, and the impact will be closely monitored.
- The Safeguarding Children's team continue to see an increase overall in activity since the pandemic. In Q1, there has been over a 12% increase in activity in comparison to Q1 last year. Child self-harm/overdose/substance misuse, Neglect and Domestic Abuse all feature high in the categories of referral. Maternity activity remains relatively stable.

- In Q1 there were 45 reported MCA enquiries, with 15 regarded as complex. 'Complex' can be where external legal advice has been required and/or have cases that have been put before the Court of Protection.
- Q1 Urgent Deprivation of Liberty Safeguard (DoLS) applications received and sent to Local Authorities continues to increase monthly, which has been an ongoing trend since October 2022. DoLS numbers for May and June were significantly greater than those of any month since the DoLS dashboards were created.

The report includes an update in relation to compliance with Safeguarding and Mental Capacity Act training requirements which continues to be closely monitored.

- In Adults and Children, Level 1 and Level 2 training demonstrates good compliance with 97% and 94% respectively for both programmes.
- Whilst Level 3 compliance has improved over the last 2 quarters, it remains lower than expected at 81% in adults and 83% in Childrens. Work remains in progress to maximise compliance across all Clinical Boards and workforce groups.
- In Q1, the Trust has embarked on a significant mandatory and best practice MCA training programme. This has been achieved through a level 1 MCA mandatory training for all clinical and patient facing staff. Compliance as of the 3 September sits at 89%. Regular updates have been provided to leaders across the Trust via the operational meetings to increase compliance.

Section 5: Learning Disabilities Q1

This section of the report provides a Q1 summary update regarding the work of the Learning Disability Liaison Team.

In Q1, there were 783 referrals, a slight increase in comparison to 763 in the previous quarter but a substantial 26% increase when compared to 623 in Q1 of 2022/2023. Whilst the Liaison Team has recently increased in size, this increased activity impacts on the team, and is being closely monitored. There have been 329 inpatients and 339 Accident and Emergency (A&E) attendances in Q1 demonstrating an increase of 41 from the previous quarter.

The report includes an overview of the work undertaken in response the Care Quality Commission (CQC) report which highlighted concerns around record keeping of reasonable adjustments for people with a Learning Disability. The Liaison Team and the Digital Health Team worked at pace and implemented alterations to the triage and admission documentation with regard to the diagnosis of a learning disability and subsequently documenting reasonable adjustments. Audit demonstrates that compliance is improving but remains lower than required. Further adjustments to the digital system have been made with focused education being undertaken by a temporary Clinical Educator.

The Code of Practice (Health and Social Care Act 2008) consultation paper pertaining to mandated training on learning disability and autism has been released and an overview of the proposed requirement is provided within the report. The training proposal is very prescriptive to be led by a 'Trio' of three trained individuals – a facilitator, a person with lived experience of learning disability and a person with lived experience of autism. The consultation paper closed on 19 September.

The Trust has been asked by the A2A (a North and East and North Cumbria Regional Learning Disabilities Network) to participate in a regional pilot to support the evaluation of the training to understand the potential barriers in achieving the proposed compliance. A Task and Finish Group has been developed to consider the implications of the pilot and further updates will be provided to the Trust Board in future reports.

Section 6: Flu/Covid Vaccination

Section six of the report contains an overview of the planned Covid and Flu winter vaccination programme.

The Joint Committee on Vaccination and Immunisation (JCVI) advises that the Covid vaccination programme should be brought forward to September 2023, in light of new variants to maximise protection for those who are most vulnerable to serious infection ahead of the winter months. Recent government announcements have confirmed the eligible cohorts for this programme which includes front line health and social care workers. Winter influenza vaccines are also to be delivered in the autumn in line with the normal yearly vaccination programme.

At the time of writing, it is expected that the vaccination programme will commence on the 25 September for both vaccines.

The delivery of both vaccines will be closely monitored with high level data broken down to Clinical Board level and regular reporting to the Executive Team and Trust Board.

The Department of Health and Social Care (DHSC), together with Public Health England (PHE) have previously outlined their expectation to Trusts regarding Flu vaccine uptake. This included completion of a 'self-assessment checklist' published in Board papers at the start of the flu season. This has not been received this year, but the Trust has used previous versions to ensure all necessary preparations are in place.

RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
26 September 2023

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 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	The purpose of this paper is to provide the Trust Board with an update against the national drivers and priorities for maternity services, including: • An update of the actions identified in response to the findings from the Care Quality Commission (CQC) inspection of the Maternity Service in January 2023, published in May 2023. This inspection was part of the national programme of inspections for maternity services and the maternity service was graded overall as 'requires improvement', following inspection under the domains of 'well-led' and 'safe'. Reference is made to the further unannounced CQC core inspection of the Maternity Services which occurred in July 2023. • An update on progress against the Ockenden report detailing current compliance. Detail with regard to the Ockenden Assurance visit planned for 1 November 2023 led by the Local Maternity and Neonatal System (LMNS) and including representation from key stakeholders is also provided. The visit in intended to focus on providing evidence against compliance of the 7 Immediate and Essential Actions (IEAs) from the interim report. • The Trust's position against the actions identified within the 'Three-year delivery plan for maternity and neonatal services' published by NHS England (NHSE) in March 2023. The Three-year delivery plan's four key themes are divided into twelve priority actions/objectives working toward the provision of safer, more personalised, and more equitable care. There are 42 actions identified for Trusts for which compliance is required to be reported. Achievement of the 'Three year plan' is interdependent on support from the Integrated Care Board (ICB) and NHSE. Support from the North East and North Cumbria (NENC) LMNS has		

<table>
<tr><td></td><td colspan="7">commenced to promote regional collaboration. Further work is required to align ongoing actions from Ockenden with those from the 'Three Year Plan'.

• This paper also reports on the development of a 'Maternity Strategy – 5 Year Forward View' which must also align with the key drivers and priorities highlighted to the Trust Board within this paper.

• An update regarding correspondence received from the Healthcare Safety Investigation Branch (HSIB) dated 14 August 2023.

The supporting appendices are included in the Board Reference Pack (BRP).</td></tr>
<tr><td>Recommendation</td><td colspan="7">The Trust Board is asked to:
i) Receive and discuss the report;
ii) Note the findings of the final report of the CQC inspection and the actions taken and ongoing in response to this;
iii) Note the current level of assurance against the interim and final Ockenden recommendations;
iv) Note the planned assurance visit for 1 November 2023 led by the NENC LMNS;
v) Note the position against the 'Three year delivery plan for maternity and neonatal services' and that further detailed work is required to identify outstanding actions required to ensure full compliance;
vi) Note the associated risks involved.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="7">Putting patients at the heart of everything we do. Providing care of the highest standards focussing on safety and quality.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Reputation</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☒</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="7">Links to strategic risk SO1.11 – failure to achieve required CQC standards could impact on the Trust's ability to remain outstanding.</td></tr>
<tr><td>Reports previously considered by Trust Board</td><td colspan="7">Previous reports have been presented to the Trust Board on Ockenden, The Kirkup Report, and The Maternity Incentive Scheme (CNST).</td></tr>
</table>

MATERNITY SERVICES UPDATE

EXECUTIVE SUMMARY

This paper provides the Trust Board with an overview and update for the leading priorities and quality considerations for the Maternity Service.

Section 2 provides an update on the actions arising from the CQC maternity inspection undertaken in January 2023, reported 12 May 2023. As part of the national maternity inspection programme, the two key domains of 'safe' and 'well-led' were inspected resulting in an overall rating for the Maternity service as 'requires improvement'. A rating of 'good' was declared for well-led and 'requires improvement' for safe.

As previously reported, an action plan has been implemented to enable the monitoring of key actions against the findings. An immediate response has been required by the Trust to comply with legal obligations for three regulations. All regulatory actions have now been completed and systems and processes are in place to ensure embedding of the changes to practice.

Additional areas were highlighted for improvement. Actions which remain outstanding are as follows (full details are included in section 2):

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

- *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* - Partially Compliant.

- *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* - Partially Compliant.

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

This paper reports by exception those elements that require further work to ensure full compliance for all areas highlighted for improvement by the CQC's January inspection.

The Trust Board are asked to note that the Maternity service was required to submit additional evidence to the CQC during and following a further unannounced core inspection which occurred between 25-27 of July 2023. The report on the findings of this additional inspection is awaited and will be presented to the Board in a future paper as part of the Trust-wide response to the CQC when published.

Section 3 provides an update on the Trust's position in relation to the recommendations from both the interim and final Ockenden reports. Full compliance is now demonstrated at 79.1%, partial-compliance 19.8%, and 1.1% of recommendations remain non-compliant.

An Ockenden assurance visit is due to take place on 1 November 2023. The visiting team includes representatives from NHSE, the ICB, the LMNS, the Maternity and Neonatal Voices Partnership (MNVP) as well as peer reviewers from South Tees Hospitals NHS Foundation Trust.

Following on from last year's insight visit, the purpose of this review is to provide evidence and assurance of progression and compliance in relation to all 7 IEAs highlighted by the Interim Ockenden report (2020). The Trust have received the terms of reference for the visit and a request for pre-visit data submission and work is in progress to prepare for this review.

Section 4 references the 'Three-year delivery plan for maternity and neonatal services' published by NHSE on 30 March 2023. The plan was developed in response to findings and recommendations from recent maternity reports (Ockenden 2020 and 2022, East Kent 2022, and previously Morecambe Bay 2015).

There is nothing further to update at present, however, the Trust is progressing benchmarking against the specific actions required of providers which will also inform the Maternity Service Quality Improvement Plan. The Maternity Service Five Year Strategy, currently in development, will align to the ambitions and actions of the Three year plan.

As previously highlighted to the Trust Board, achievement of the plan is interdependent on National and Regional ICB support.

Section 5 reports on the development of the 'Maternity Strategy: Five Year Forward View' which is in progress to support and promote the vision, direction, and development of the service. The Strategy considers national influences and priorities (detailed in section 5).

It is anticipated that the Strategy will be launched in the Autumn and more detail will be provided in future papers.

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.

The Board are provided with an update of the outstanding actions as highlighted by the findings reported by the CQC's January inspection.

The Board of Directors are also asked to note that the Maternity service was required to submit additional evidence to the CQC during a further unannounced core inspection which occurred between 25–27 July 2023. The findings of this additional inspection are awaited and will be presented in a future paper.

An update is provided in relation to current compliance with the recommendations of both the interim and final Ockenden reports (2020 and 2022). The Trust Board is provided with detail of the Ockenden Assurance Visit planned for 1 November 2023. The visit led by the LMNS will focus on Trust compliance and assurance of the 7 IEAs from the Interim Ockenden Report (2020) and follows on from last year's insight visit.

The Board are further presented with an update of the Trusts position against the 12 priority actions and objectives set out by NHSE's 'Three-year delivery plan for maternity and neonatal services' published on 30 March 2023.

This paper also presents the development of a 'Maternity Strategy – Five Year Forward View' which will consider the recommendations and national drivers discussed in this paper, alongside the vision and direction for the Trust.

2. CQC JANUARY 2023 INSPECTION UPDATE

As previously reported to the Trust Board, a short notice CQC inspection of the Maternity services was undertaken on 10 and 11 January 2023 as part of the national maternity inspection programme. This inspection focused on the two key domains of 'safe' and 'well-led.' The CQC report was published on 12 May 2023 with an overall rating for the Maternity service as 'requires improvement'. A rating of 'good' was declared for 'well-led' and 'requires improvement' for safe.

An action plan has been implemented in response to the CQC inspection findings (Appendix 1) and this report advises on progress to date. An immediate response was required by the Trust to comply with legal obligations for three regulations, all of which are now completed. Additional processes have been implemented to ensure continued monitoring and reporting and to provide assurance on embedding new systems into practice.

In addition, the following areas were highlighted for further improvement:

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

  As previously reported, Maternity Services Mandatory Training comprises of Trust level mandatory training and maternity specific 'Core Competency' training. Figures as of 1 September stand at:

  - Trust level Mandatory Training: 87.36% against a target of 96%
  - Children's Safeguarding Level 3: 87.93% against a target of 95%
  - Core Competency Training Clinical Skills: 80% against a target of 90%
  - Core Competency Training Safety and Public Health in Practice: 67% against a target of 90%

  The service is on a trajectory to deliver against the existing schedule of core competency training by the Maternity Incentive Scheme (MIS) deadline of December 2023. However, of note are the additional requirements which have been nationally recommended through the newly published Core Competency Framework v2.

  The additional resource required to deliver this increased maternity specific training has been reviewed and the Trust have developed an implementation plan in response to the regional ICB request. Further work is required however to establish the implications and financial resource which is required to provide this increased ask, and this detail will be presented in November's paper.

  Trust self-assessed as partially compliant pending further work to implement revised training plan.

- **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.**

  As previously reported, the Maternity service continues to progress planned refurbishment work to the Bereavement facilities. There continues to be work required to maintain and upgrade the facilities within maternity. Working with the estates team the Trust are responding to areas of risk as they arise, however, the Board of Directors will note that the optimum solution requires a full service refurbishment which is still to be resolved.

  Trust self-assessed as partially compliant pending continuous refurbishment.

- **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 Maternity service has now implemented e-obs to support improved monitoring and risk assessment using the Modified Early Obstetric Warning Score (MEOWS). A future interface with the electronic patient record BadgerNet will be implemented

later this year. The Maternity service remains partially compliant until audit of the system provides sufficient evidence and assurance that recording of MEOWS via e-obs is embedded within practice.

Trust assessed as partially compliant pending audit of newly implemented system.

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

  As previously reported, work continues to progress the implementation of the bespoke maternity triage system (BSOTS). Due to the additional training requirements a revised 'go-live' date of 5 November 2023 has been agreed. In the meantime, a paper based solution is in place together with an audit schedule, to identify risks and areas for improvement.

  Trust assessed as partially compliant.

3. OCKENDEN

The final Ockenden Report was published on 30 March 2022 and highlighted a number of IEAs and recommendations to be implemented by all maternity services in England.

The Trust's position and ongoing compliance with Ockenden has been reported in separate Ockenden papers to Trust Board up until May 2023. Work continues to progress the recommendations of the combined reports (Appendix 2); full compliance is now demonstrated at 79.1%, partial-compliance 19.8%, and 1.1% of recommendations remain non-compliant.

The one remaining non-compliant action is:

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

This work has been delayed due to the requirement to now combine this with the work which is in progress to evaluate the significant additional resource required to meet with the recommendations of the Core Competency Framework v2. However, early indications are that this will require significantly more resource to deliver through an enhanced maternity workforce which will need to be the subject of a full business case. An update will be presented to the Trust Board in November.

There remain seven partially compliant recommendations from the Interim Report which the Trust continues to progress, detailed in Appendix 3. These will be a focus for the Ockenden Assurance visit scheduled for 1 November 2023 and pertain to the requirements for audit and website improvement. As previously reported, audit was reliant on the implementation and embedding of the electronic patient record, BadgerNet. Work is progressing to scrutinise the level and quality of data available from BadgerNet. Further changes to the mandatory

data fields within BadgerNet may be needed to provide the required evidence and assurance levels for Ockenden reporting purposes, particularly evidencing ongoing risk assessment and personalised care and support planning, and work is in progress in this regard.

The Ockenden Assurance visit scheduled for 1 November 2023 follows last year's insight visit and includes representatives from NHSE, the ICB, the LMNS, the Maternity and Neonatal Voices Partnership (MNVP) as well as peer reviewers from South Tees Hospitals NHS Foundation Trust. The primary aim is to receive evidence and assurance of compliance with all 7 IEAs highlighted by the Interim Ockenden report (2020). The Trust have received the terms of reference for the visit and requests for pre-visit data submissions evidencing compliance. Work is ongoing to prepare for the visit and provide the requested evidence.

4. THREE YEAR DELIVERY PLAN FOR MATERNITY AND NEONATAL SERVICES

NHSE published the 'Three-year delivery plan for maternity and neonatal services' on 30 March 2023, in response to the Ockenden (2022), East Kent (2022) and previously Morecambe Bay (2015) reports which highlight continued failures and inequalities in maternity care.

As previously reported, the ambition of the Three year plan is to improve maternity and neonatal care in England; ensuring safer, more personalised, and more equitable care for women, babies, and families.

There are no specific further updates at present, however, the Trust continues to benchmark and review the actions within the plan alongside existing and ongoing work-streams (Appendix 4). The objectives will also be considered within the revised Maternity quality improvement plan.

Achievement of the Three year delivery plan continues to be dependent on support from the LMNS and NHSE in implementing their' respective deliverables. The Trust Board are also asked to note that local performance outcomes and measures are to be agreed and must align to those metrics that will be used at LMNS and National level to monitor progress and compliance.

5. MATERNITY STRATEGY: 5 YEAR FORWARD VIEW

The Maternity Service has commenced work towards development of a 'Maternity Strategy: Five Year Forward View.' This strategy outlines the forward vision, direction, and development of the service with consideration of national influences and key priorities. Six domains have been identified as a focus for the Strategy, to include:

- Research
- Digital Health
- Personalised Care
- Education and Training

- Workforce
- Collaboration and Communication

Work is ongoing and an Autumn launch is anticipated. Further detail will be provided in future papers.

6. HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB)

Of note, the Trust received a letter from the HSIB, dated 14 August, regarding concerns related to implementation of learning from HSIB maternity investigations. The Executive Chief Nurse (ECN) met with the regional inspector quickly in response to establish any immediate issues of concern which required action. This meeting clarified that the reference point for HSIB was from incidents in 2019/20 reported in 2021 and current reports which have not yet been shared with the Trust. Follow up meetings between HSIB and the Maternity team are being scheduled to work through the detail and any required action. An update will be provided in future reports to the Trust Board.

7. CONCLUSION

The final report following the CQC inspection of Maternity services in January was received on 12 May 2023. An action plan in response to the requirements and recommendations arising from the report has been implemented and compliance achieved with breaches in regulation. There remain four of the seven recommendations for improvement outstanding which the service continue to progress. The Trust await feedback from the re-inspection made of the Maternity service during the CQCs unannounced inspection in July and updates will be provided in future papers.

Progress against the interim and final Ockenden recommendations is reported and there remains 1 non-compliant action that the Trust is progressing alongside the remaining partially compliant recommendations. Preparation is underway for an Ockenden Assurance visit scheduled for 1 November, to be led by the LMNS, to include visitors from NHSE, ICB, MNVP and the Quadrumvirate from South Tees as peer reviewers. The purpose of this visit is to provide evidence and assurance of Newcastle's compliance with the 7 IEAs from the Interim Report (2020).

The Ockenden actions must also be aligned to the objectives set out in the 'Three-year delivery plan for maternity and neonatal services.' Detailed benchmarking continues; achievement of the 'Three year plan' requires the Trust to be supported through implementation of actions from the ICB and NHSE. Work has commenced in this regard.

Both the Ockenden and Three year delivery plan are considered within the development of the Trusts' Maternity Strategy. This will ensure a consistency and focus are maintained in developing the 5 year vision and direction of the service in line with national policy.

A further update will be provided in November 2023.

7. RECOMMENDATIONS

The Trust Board is asked to:

i) Receive and discuss the report;
ii) Note the findings of the final report of the CQC inspection and the actions taken and ongoing in response to this;
iii) Note the current level of assurance against the interim and final Ockenden recommendations;
iv) Note the planned assurance visit for 1 November 2023 led by the NENC LMNS;
v) Note the position against the 'Three year delivery plan for maternity and neonatal services' and that further detailed work is required to identify outstanding actions required to ensure full compliance;
vi) Note the associated risks involved.

Report of Maurya Cushlow
Executive Chief Nurse
26 September 2023

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023						
Title	Maternity Incentive Scheme (MIS) Year 5 (CNST)						
Report of	Angela O'Brien, Director of Quality and Effectiveness						
Prepared by	Rhona Collis, Quality and Clinical Effectiveness Midwife/ Jane Anderson, Director of Midwifery						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☒		☒		☐		
Summary	The NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity incentive scheme invites Trusts, in this Year 5 scheme, to provide evidence of their compliance using self-assessment against ten maternity safety actions. The scheme intends to reward those Trusts who have implemented all elements of the 10 Maternity Safety Actions. This is the second update report regarding the 10 safety actions in the Year 5 scheme which were published on the 31 May 2023.						
Recommendation	The Trust Board are asked to note the contents of this report and approve the self-assessment to date to enable the Trust to provide assurance that the required progress with the standards outlined are being met.						
Links to Strategic Objectives	Putting patients first and providing care of the highest standard focusing on safety and quality. Enhancing our reputation as one of the country's top, first class teaching hospitals, promoting a culture of excellence in all that we do.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☐	☐	☒	☐
Link to Board Assurance Framework [BAF]	No direct link to the BAF however failure to comply with the ten safety action standards could impact negatively on maternity safety, result in financial loss to the Trust from the incentive scheme and from potential claims.						
Reports previously considered by	This is the second report for Year 5 of this Maternity Incentive Scheme.						

MATERNITY INCENTIVE SCHEME (MIS) YEAR 5 (CNST): MATERNITY SAFETY ACTION COMPLIANCE

EXECUTIVE SUMMARY

The NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) invites Trusts, in this Year 5 scheme, to provide evidence of their compliance using self-assessment against ten maternity safety actions. The scheme intends to financially reward those Trusts who have implemented all elements of the 10 Maternity Safety Actions. In addition, completion of all 10 Safety Actions upholds the reputation of the Trust in relation to the quality of care provision within the Maternity Service.

The Year 5 CNST safety actions were published on the 31 May 2023. There have been several amendments made and an updated version of the safety actions was published in July 2023.

For Year 5 Safety Actions 1,2,3,4,5,7 and 10 the relevant time period is between 30 May and 7 December 2023. For Safety Actions 6 and 9 it is prior to the submission date of the 1 February 2024. For safety action 8 (Multi-professional training) the time period is from 6 December 2022 to 5 December 2023. This report will be the second report to the Trust Board since the publication of the Year 5 scheme on the 31 May 2023.

MATERNITY INCENTIVE SCHEME YEAR 5 (CNST): MATERNITY SAFETY ACTION COMPLIANCE

1. BACKGROUND TO CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) MATERNITY INCENTIVE SCHEME – YEAR 5

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

NHS Resolution is operating a fifth year of the CNST MIS to continue to support the delivery of safer maternity care. The scheme incentivises ten maternity safety actions and invites acute Trusts to provide evidence of their compliance against these.

The expectation by NHS Resolution is that implementation of these actions will improve Trusts' performance on improving maternity safety and reduce incidents of harm that lead to clinical negligence claims.

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

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

The Trust Board declared full compliance with all 10 maternity safety actions for Years 1 to 4 of this scheme. Confirmation of the Trust's achievement in fully complying with all 10 standards, was confirmed by NHS resolution and the Trust was rewarded, for Year 1, Year 2, Year 3, and Year 4, with £961k, £781k, £877k and £707k respectively in recognition of this achievement.

This paper provides an update on the progress of all the 10 Safety Actions and the requirements to achieve full compliance by the 1 February 2024.

2. SAFETY ACTION UPDATE

This paper intends to report by exception only.

2.1 SAFTEY ACTION 1: ARE YOU USING THE NATIONAL PERINATAL MORTALITY REVIEW TOOL (PMRT) TO REVIEW PERINATAL DEATHS TO THE REQUIRED STANDARD?

a) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days and the surveillance information should be completed within one calender month of the death.

b) For 95% of all deaths of babies in the Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought.

c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.

d) Quarterly reports should be submitted to the Trust Executive Board from the 30 May 2023.

The quarterly PMRT report for Q4 is included in this report as per the requirements of this safety action and can be found in the Private Board Reference Pack (BRP).

The Trust is confident that full compliance with the 4 elements of this safety action can be achieved.

2.2 SAFETY ACTION 2: ARE YOU SUBMITTING DATA TO THE MATERNITY SERVICES DATA SET (MSDS) TO THE REQUIRED STANDARD?

1) *Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIM's) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trust: Scorecard" for data submission relating to activity in July 2023. Final data for July 2023 will be published during October 2023.*

2) July 2023 data contained valid ethnicity category (Mother) for at least 90% of women booked in the month.

3) *Trust boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trust: Scorecard" for data submission relating to activity in July 2023 for the following metrics:*

Midwifery Continuity of Carer (MCoC)

i. Over 5% of women have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.

ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.

Final data for July 2023 will be published during October 2023.

4) Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.

5) Trusts to have at least two people registered to submit MSDS data to the SDCS Cloud who must still be working in the Trust.

The Trust is confident that full compliance of all 5 elements of this safety action can be achieved within the timeframe.

2.3 SAFETY ACTION 3: CAN YOU DEMONSTRATE THAT YOU HAVE TRANSITIONAL CARE SERVICES IN PLACE TO MINMISE SEPARATION OF MOTHERS AND THEIR BABIES?

a) *Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.*

b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery and operational lead) as well as the Trust Board, LMNS and ICB.

c) Drawing on insights from the data recording undertaken in Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late pre-term and term babies. There should be a clear, agreed timescale for implementing this pathway.

The Trust is confident that full compliance with all 3 elements of this safety action can be achieved. The action plan for Q4 2022/23 'Term admissions to the Neonatal Unit' is included within the Private BRP.

2.4 SAFETY ACTION 4: CAN YOU DEMONSTRATE AN EFFECTIVE SYSTEM OF CLINICAL WORKFORCE PLANNING TO THE REQUIRED STANDARD?

a) Obstetric medical workforce

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

a. currently work in their unit on the tier 2 or 3 rota

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

c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

4). *Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document. Episodes where attendance has not been possibl should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.*

b) Anaesthetic medical workforce

A duty anaesthetist is immediately available for the obstetric unit 24hours a day and should have clear lines of communication to the supervising consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients.

c) Neonatal medical workforce

The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of medical staffing.

If the requirements had not been met in year 3 and or year 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies.

If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards.

If the requirements had not been met in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies.

If the requirements had been met previously without the need of developing an action plan to address deficiencies, however they are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies.

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

The Trust is confident that full compliance with all four elements of this safety action can be achieved. A report regarding monitoring of Consultant attendance at clinical situations will be presented to the Board Safety Champions in October 2023.

2.5 SAFETY ACTION 5: CAN YOU DEMONSTRATE AN EFFECTIVE SYSTEM OF MIDWIFERY WORKFORCE PLANNING TO THE REQUIRED STANDARD?

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.

d) All women in active labour receive one-to-one midwifery care.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.

In the six months from 1 February 2023 to 31 July 2023, there have been four occasions reported for failure to provide 1:1 midwifery care in labour. There were also 4 occasions whereby the midwifery coordinator did not remain supernumerary. This is against a possible 1,086 episodes. The Trust is therefore compliant as these are not considered to be regular events.

2.6 SAFETY ACTION 6: CAN YOU DEMONSTRATE THAT YOU ARE ON TRACK WITH COMPLIANCE FOR ALL ELEMENTS OF THE SAVING BABIES LIVES CARE BUNDLE VERSION THREE?

1) Provide assurance to the Trust Board and ICB that you are on track to fully implements all 6 elements of SBLv3 by March 2024.

2) Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available.

The Trust must demonstrate implementation of 70% of interventions across all six elements overall, and implementation of at least 50% of interventions in each individual element. These percentages are calculated within the new national implementation tool, which has just been made available to all Trusts.

The Trust submitted the data using the newly published implementation tool for July 2023 and achieved an overall compliance of 75%, with all 6 elements achieving >50%.

A meeting was held on the 1 August 2023 with the Integrated Care Board (ICB) to discuss progress to date.

The Trust is confident that full compliance with all elements of this safety action can be achieved.

2.7 SAFETY ACTION 7: LISTEN TO WOMEN, PARENTS AND FAMILIES USING MATERNITY AND NEONATAL SERVICES AND CO-PRODUCE SERVICES WITH USERS (MNVP)?

1) *Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance. Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.*

2) Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication, including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.

3) Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews and themes and subsequent actions monitored by local safety champions.

The Newcastle Maternity and Neonatal Voices Partnership (NMNVP) is well established and actively seeks the views of service users and feeds this back to the maternity and neonatal services.

The Trust is confident that full compliance with this safety action can be achieved.

2.8 SAFETY ACTION 8: CAN YOU EVDIENCE THE FOLLOWING 3 ELEMENTS OF LOCAL TRAINING PLANS AND 'IN-HOUSE' MULTI-PROFESSIONAL TRAINING?

1) *A local training plan is in place for implementation of Version 2 of the Core Competency Framework.*

2) The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ ICB.

3) The plan is developed based on the "how to" Guide developed by NHS England.

Achieving full compliance with the training requirements continues to be the most significant challenge for Year 5. The training requirements have increased with the expectation that, as a minimum, staff will each receive 3 to 5 days training per year. Currently staff receive 2 days training and the Trust found achieving these requirements in Year 4 a significant challenge.

In collaboration with the Local Maternity and Neonatal System (LMNS), the Trust has agreed to introduce a third training day with a focus on Fetal Surveillance. The position with regard to training was presented to the Board Level Safety Champions in August outlining the challenges faced with implementing this, which has a regional recommendation that this commences from the 4 September 2023. Six days have been scheduled for the additional fetal surveillance training; however, attendance is dependent on staff availability and resources. The provision of clinical care will remain a priority to preserve safety across the maternity service.

Training compliance for the existing schedule of a 2-day offer – Clinical Skills Emergency Drills and the Safety and Public Health in Practice day – is on target to achieve compliance provided that all the training sessions are delivered as planned over the next 3 months.

The provision of clinical care will remain a priority to preserve safety across the maternity service. In the event that a training day is required to be postponed due to staffing pressures and/or increased activity and acuity, achieving the required compliance will be challenging.

Table 1 and 2 illustrate the current position with regard to the current schedule of core competency training.

Table 1. Clinical Skills Day up to 31 August 2023

Staff Group	Number of eligible staff in post	Number Attended Clinical Skills Day	Percentage trained
Midwives including Midwifery Managers, Matrons, Community Midwives, Midwifery Led Unit Midwives and Bank Midwives	241	205	85%
Healthcare Assistants (HCA)/Maternity Support Worker (MSW)/Neonatal Nurse (NN)	70	57	81%
Theatre Staff	9	7	78%
Obstetric Consultants	13	7	54%
Anaesthetists	12	13	100%
Trainees (commencing 01.08.23)	34	16	47%
Total	**379**	305	**80%**

Table 2 Maternity Safety and Public Health in Practice Day

Staff Group	Number of eligible staff in post	Number Attended Training	Percentage trained
Midwives including Midwifery Managers, Matrons, Community Midwives, Midwifery Led Unit Midwives and Bank Midwives	241	170	71%
HCA/MSW/NN	70	40	57%
Theatre Staff	9	4	44%
Total	**320**	214	**67%**

2.9 SAFETY ACTION 9: CAN YOU DEMONSTRATE THAT THERE ARE ROBUST PROCESSES IN PLACE TO PROVIDE ASSURANCE TO THE BOARD ON MATERNITY AND NEONATAL SAFETY AND QUALITY ISSUES?

a) *All six requirements of Principle 1 of the Perinatal Surveillance Model must be fully embedded.*

b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in minutes of Board, LMNS/ICS/Local and Regional Learning System meetings.

c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.

The quadrumvirate will be attending Wave 5 of the NHS England Perinatal Culture and Leadership Programme commencing in October 2023. This will become an agenda item at the Maternity Board Level Safety Champions meeting bi-monthly and evidence of the support they can provide to the quadrumvirate will be minuted in future board reports.

The requirements from year 4 have been continued. The Trust is confident that full compliance with this safety action can be achieved.

2.10 SAFETY ACTION 10: HAVE YOU REPORTED 100% OF QUALIFYING CASES TO HSIB AND TO NHS RESOLUTION'S EARLY NOTIFICATION SCHEME ?

The Trust is confident that full compliance with this safety action can be achieved.

3. CONCLUSION

It is acknowledged that there remain some significant challenges with safety action 8 – Training requirements - in order to achieve full compliance prior to the submission date of 1 February 2024.

Monthly progress meetings continue to be held every two weeks within the Maternity Department to enable direct oversight and support by the Director of Midwifery and Clinical Director. Bi-monthly meetings with the Maternity Board Level Safety Champions continue and issues of concern in relation to CNST compliance are discussed.

In November, a more detailed report on progress of all the elements will be provided for the Trust Board.

4. RECOMMENDATIONS

To (i) note the content of this report, (ii) comment accordingly and (iii) approve.

Report of Angela O'Brien
Director of Quality & Effectiveness
19 September 2023

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023		
Title	Health and Safety Annual Report 2022-23		
Report of	Angela O'Brien, Director of Quality and Effectiveness		
Prepared by	Craig Newby, Health, Safety and Risk Lead		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	The purpose of this report is to provide the Trust Board with an update on health and safety activity across the organisation during 2022-23. In summary: • It covers compliance with health and safety legislation. • Health and safety incidents remain relatively stable; however, significant increases in violence and aggression incidents have arisen compared to previous years. • Lone worker device use is increasing across the organisation. • There has been a decrease in RIDDOR reportable incidents in 2022-23		
Recommendation	The Trust Board is asked to note the content of the report and its findings.		
Links to Strategic Objectives	• Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. • Maintain compliance with all regulatory requirements.		

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

Link to Board Assurance Framework [BAF]	SO1.6 if we fail to maintain Trust estates and environments there is a risk to the safety of patients, staff and visitors which could impact on the quality of care and reputation of the Organisation. This is further exacerbated for 2023/24 due to the Capital Departmental Expenditure Limit (CDEL) restrictions and an increase in critical infrastructure backlog.
Reports previously considered by	This report is an annual update on the activity associated with the Trust Board. The report was previously shared at the Trust's Health and Safety Committee on 10 May 2023, the Compliance and Assurance Group (CAG) on 20 July 2023 and the Quality Committee on 19 September 2023.

HEALTH AND SAFETY ANNUAL REPORT 2022/2023

EXECUTIVE SUMMARY

The purpose of this report is to provide the Trust Board with an update on health and safety activity across the organisation during 2022-23.

To note:

- Good compliance with health and safety legislation.
- Health and safety incidents remain relatively stable; however, there has been a significant increase (+28%) in violence and aggression incidents compared to previous years. This is particularly around physical assaults to staff. Verbal abuse has reduced slightly; however, the data from the previous year was skewed as it included an increase in the number of abusive patients related to the post COVID restart programme.
- Lone worker device use increased across the organisation following additional work to support staff and raise awareness.
- A decrease in RIDDOR reportable incidents in 22-23 compared to the previous year, with no significant themes identified.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

HEALTH AND SAFETY ANNUAL REPORT 2022/2023

1. INTRODUCTION

The Health & Safety annual report covers the period 1 April 2022 to 31 March 2023.

The annual report outlines key developments and the work that has been undertaken during this reporting period as well as a review of all health and safety related incidents.

It reflects the Trust's compliance with the Board of Directors approved 'Statement of Intent' and Health & Safety Policy Statement, which requires those responsible for health and safety within the organisation and during Trust activities to:

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

In progressing the management strategy of health and safety throughout the Trust, the Compliance and Assurance Team continues to observe the HSG65 model "Managing for Health and Safety".

The key components of the Plan, Do, Check, Act (PDCA) framework can be summarised, as follows:

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

2. MEETINGS & ATTENDANCE

The Health and Safety Committee has met four times during the period 1 April 2022 to 31 March 2023.

The Trust Health & Safety Committee achieved an attendance rate of 84% during the period of 1 April 2022 to 31 March 2023.

Members	13/05/21	12/08/21	11/02/21	23/02/22
Chairman: Head of Risk, Compliance and Assurance	X	X	X	X
Vice Chairman: Deputy Director of Quality & Safety	X	X	X	X
Director of Quality and Effectiveness	X		X	
Health Safety and Risk Lead	X	X	X	X
Associate Director of Nursing		X		X
Health and Safety Advisors	X	X	X	X
Health and Safety Administrator		X	X	X
Integrated Governance Manager	X	X	X	
Occupational Health Clinical Lead	X	X	X	X
Estates Compliance and Risk Manager	X	X	X	X
Portering and Security Manager	X	X	X	X
Strategic Fire Safety Lead	X	X	X	X
Senior Human Resources Manager	X	X	X	X
Workforce Development Manager	X	X		
Directorate Manager			X	X
Lead Moving and Handling Coordinator	X	X	X	X
Newcastle University Safety Advisor	X	X		
Contract Compliance Officer (Mitie)	X	X	X	X
Staff Side Representatives	X	X	X	X

3. TERMS OF REFERENCE

The Terms of Reference were reviewed and approved by the Committee on 18 May 2022 and reflect key changes to the governance arrangements within Estates.

4. POLICIES & PROCEDURES

The policies below were ratified by the Health and Safety Committee during the period 1 April 2022 to 31 March 2023.

Policy/Procedure	Date Approved
Use Provision and Management of Wheelchairs Policy	22/02/2023
First Aid Policy	22/02/2023
Management of Stress in the Workplace Policy	22/02/2023
Security Management Policy	22/02/2023
Young Persons and Work Experience Students Under 18 Years of Age Policy	O4/10/2022

The following quarterly and annual reports received at the Health and Safety Committee during 1 April 2022 to 31 March 2023:

Quarterly Reports	Annual Reports / Strategies
Training Health and Safety Compliance Inspection Programme	Radiation Protection Security Stress Management

Health and Safety Incidents	Health and Safety
Sharps Incidents	Moving and Handling
Security	Safer Sharps
Moving and Handling	Dental Health and Safety
Health and Safety Risks	Violence Prevention and Reduction
Occupational Health	Strategy

The minutes for the following committees and groups were reviewed quarterly in 1 April 2022 to 31 March 2023:

Related Committee Minutes
Trust Security Group
Stress in the Workplace Review Group
Radiation Protection Committee
Dental Health & Safety Committee
Laboratory Health and Safety Group
Slip, Trips and Falls Group
Violence and Aggression Reduction Group
Safer Sharps Review Group
Datix User Group
Latex Awareness Advisory Group

5. TRAINING

The Health and Safety Team has successfully delivered 44 training courses during 1 April 2022 to 31 March 2023.

Courses	Number of Sessions
Risk Assessor	14
COSHH Assessor	16
Stress Training for Managers	10
Mental Health First Aid Courses	4

In addition to these courses, 251 staff also completed the Datix e-learning training and ad-hoc lone worker device training comprising of both e-learning and face to face sessions.

6. LEGAL COMPLIANCE

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

Legislation		Description of actions/compliance
Health & Safety at Work Act 1974		Compliant, specific areas of assurance are: • Competent persons in place to provide compliance advice.

Legislation		Description of actions/compliance
		• Health and Safety (H&S) Committee held 4 times a year – which are well attended. During 2022-23 the Committee met four times, in line with expectations. • Increased availability of induction training sessions for new recruits, both induction and update sessions include reminders of the requirement to risk assess.
Management of Health & Safety at Work Regulations 1999		Compliant, specific areas of assurance are: • H&S Inspection programme, all clinical areas audited on a 2-year cycle, requires audit actions to be addressed at service level within given timescales to ensure full compliance. Where possible these actions are completed during the inspection process. • Risk assessment training is provided to all areas and risk assessment paperwork has recently been reviewed. Requirement for role specific risk assessments, production, and quality of these is monitored via the audit / inspection programme. • The most recent H&S Compliance audit showed the number of departments that have a trained risk assessor was 93%.
Control of Substances Hazardous to Health (COSHH) 2005		Compliant, specific areas of assurance are: • COSHH policy has been revised with enhanced guidance on the risk assessment process e.g. DSEAR. • COSHH Risk assessment form simplified in order to improve compliance with Regulation 6. • COSHH awareness included in all H&S Awareness training, Induction Training. • COSHH compliance reviewed in Ward areas as part of health and safety audit / inspection programme. • The most recent H&S Compliance audit showed the number of departments that have a trained COSHH risk assessor at 95%.
Display Screen Equipment Regulations 1992 Moving and Handling Operations Regulations 1992		Compliance and specific areas of assurance are: • This policy aims to ensure that effective arrangements are in place for working with display screen equipment and to meet the requirements of the Display Screen Equipment (DSE) Regulations 1992 (amended 2003). To safeguard staff safety and comfort whilst working with DSE. • Moving and Handling (M&H) Level 1 Training Figures - The required standard is 95% compliance with the overall compliance for the year being 91.56%. • M&H Level 2 Training Figures - The required standard is 95% compliance with the overall compliance for the year being 78.18%. • Current Compliance Audit M&H compliance score is 93%. • Office Chair Assessment Service - There have been a total of 282 referrals in 2022/2023 compared with 306 referrals in 2021/22.

Legislation		Description of actions/compliance
		• Overall, 28% of all departmental assessments were completed. Compliance has been affected by the introduction of a new system for departmental risk assessments - it is expected numbers will increase next year when system is embedded.
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)		Minor non-compliance with reporting timeframes: • 90% of the reported incidents are (Staff member off over 7 days). • Learning from all RIDDOR incidents is shared at the Trust H&S Committee and other respective assurance meetings. • Further work undertaken to remind managers of reporting timeframes.
Health and Safety (Sharp Instruments in Healthcare) Regulations 2013		Compliance and specific areas of assurance are: • The Trust continues to monitor ordering practices to ensure compliance with the Regulations and use of safe sharps devices wherever reasonably practicable. Work continues to "mask" non-safe sharps devices from the NHS Supply Chain Catalogue to reduce ordering practices where not supported by underlying risk assessment. • Where safe sharps are not reasonably practicable, we continue to ensure and have taken steps to enhance robust risk assessment and mitigation measures are in place. A new Medical Sharps risk assessment tool has been released this year to replace the generic Trustwide risk assessment tool. This new tool puts an emphasis on safe systems of work, training and monitoring to obviate risks from using non-safety devices. All new risk assessments are completed using this tool and older risk assessments are being transferred as they fall due for review. • Sharps disposal remains a priority and the Safer Sharps Review Group continues to advocate the use of point of care disposal and use of SharpSmart sharps boxes. The new SharpSmart on wheels is now embedded in the Trust and our entire fleet of SharpSmarts continues to be updated systematically across all areas of the Trust. • Safer Sharps Review Group meet Bi-monthly with representation from a variety of Trust departments including Clinical Education, Procurement, Supplies, Sustainability & Waste and Patient Safety. • The Trust is currently on the 8th edition of the Safer Sharps Inventory. • The Datix system has been expanded and a live dashboard has been developed to allow in-depth analysis of sharps related incidents to identify incident reduction initiatives across the organisation. • A new Safer Sharps e-learning package has been developed with the intention to roll this out mid 2023-24. • All Non-safe sharps risk assessments have been reviewed this year.

Legislation		Description of actions/compliance
Health & Safety Information for Employees Regulations (Amendment) 2009 Health & Safety Consultation with Employees Regulations 1996 Safety Representatives and Safety Committees Regulations 1977		Compliance and specific areas of assurance include: • The H&S intranet page has been revised. • H&S Coordinators and Trade Union (TU) H&S Representatives in place. • H&S Committee held four times a year is well attended by Managers, Trust Competent Persons, TU Representatives and H&S Coordinators: • Reports on Audits, Action Plan progress, Key Performance Indicators (KPIs) and Risk Register. • H&S Committee acts as consultative committee for H&S policies.
Lifting Operations and Lifting Equipment Regulations (LOLER) 1998		Compliance and specific areas of assurance are: • Trust Lifting Operation and Lifting Equipment (LOLER) Policy introduced in November 2021. • M&H Team have a system related to gantry hoists that are assembled in a cubicle of a bariatric patient. • Electronics and Medical Engineering (EME) currently ensure all LOLER equipment meets the requirements of the regulations and are currently looking to introduce a new system, which would make them the first point of contact as opposed to the service company. • Estates have a comprehensive maintenance programme for all lifts ensuring this meets all LOLER requirements.
Provision and Use of Work Equipment Regulations (PUWER) 1998		Compliance and specific areas of assurance are: • New Trust Provision and Use of Work Equipment (PUWER) Policy introduced in November 2021. • The H&S Compliance audit undertaken in quarter 4 of 2022-23 includes a section for Estates around PUWER. The directorate scored 100% against the standards. • Workshop inspections are ongoing with a heavy emphasis on PUWER. Actions arising from these inspections are regularly discussed at Estates H&S groups, allocated suitable timescales and improvement effectiveness monitored. Housekeeping remains a challenge due to the lack of suitable storage space, but initiatives are ongoing to address identified issues. Workshop equipment maintenance has been carried out and all recommendations actioned. Training on the installed equipment has also been carried out and a review of the overall workshop training provision is underway.

7. H&S COMPLIANCE

H&S Compliance audit results are reported quarterly to the Trust H&S Committee for each Directorate. This compliance tool is an indicator of risk assessment completion across 12 common areas of H&S which also include radiation and fire safety. The most recent report for Quarter 4 2022-2023 indicates that compliance across the Trust for the 12 general areas of health and safety is at 94% overall. There is ongoing work to further improve the quality of risk controls and close gaps in associated arrangements at service level.

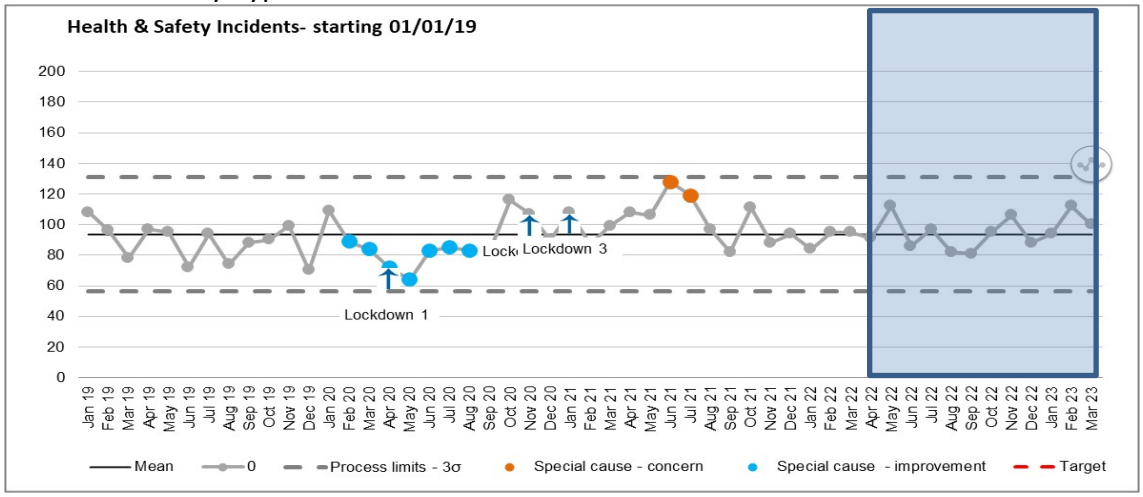
All Departments have been subject to a H&S Inspection since 2013 as part of a 24-month cycle to support local risk assessors and validate information collected under the compliance audit tool. Departments are provided with an action plan following each inspection. There have been 115 H&S inspections undertaken during this period. The inspections have been undertaken in 9 Directorates in the current programme. Along with other measures, it is envisaged that the compliance and inspection arrangements will support an overall reduction in harm over the coming years. The inspection programme plays an important role in validating compliance, the development of safe systems of work, leading to improved risk controls whilst supporting services.

The Compliance and Assurance department continue to work closely with the Estates department supporting the review of governance, monitoring and assurance measures around the Estates related functions of the Trust. Those H&S related risk register entries that have an Estates related component and are shown in section 8 below. H&S representation on key committees and groups continues to be provided.

8. H&S INCIDENTS

The number and type of staff related incidents for each Directorate during the period of 1 April 2022 to 31 March 2023 is shown in table below. There is an overall 5% decrease in reported H&S incidents for 2022 – 2023 compared to the previous year.

H&S Incidents by Type and Directorate 2022-23:



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

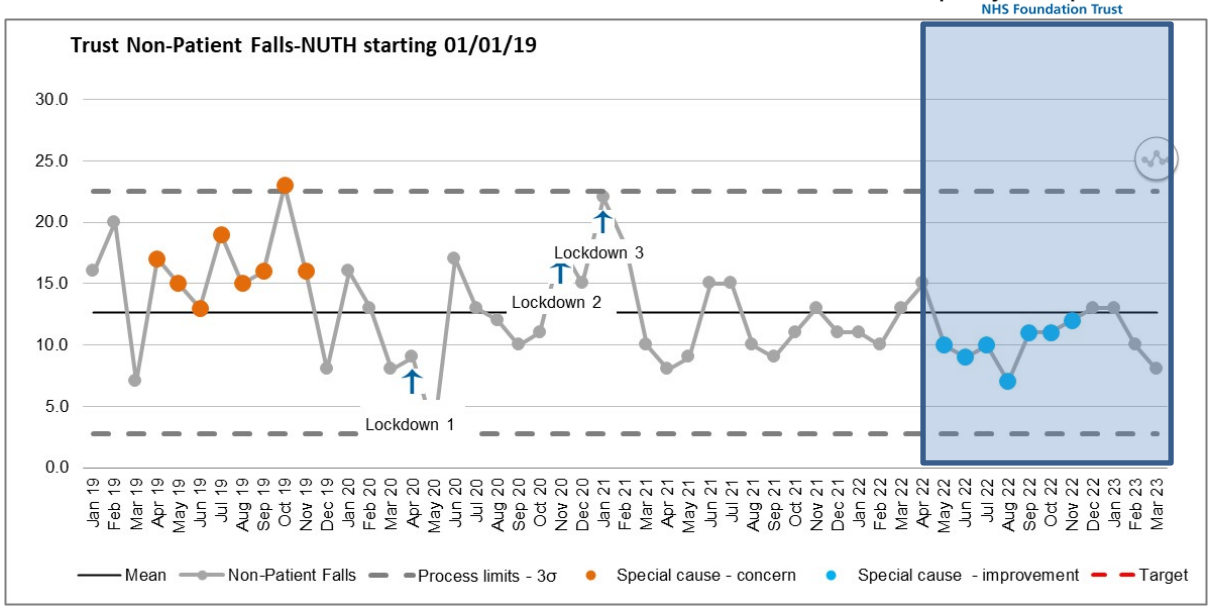
Health and Safety Incidents by Category 2022-23:

Directorate	Accident (involving staff, visitors etc.)	Buildings / Infrastructure	Exposure to Hazardous Substance	Facilities	Moving & Handling	Non-Patient Slip, Trip or Fall	Grand Total
Cancer Services	19	1	0	0	2	4	26
Cardiothoracic	36	5	8	0	3	6	58
Chief Operating Officer	9	2	0	0	0	3	14
Children's Services	38	1	1	0	3	5	48
Clinical Research	5	1	0	0	0	1	7
Community Services	25	5	2	0	10	7	49
Covid Vaccination Programme	9	2	2	0	0	4	17
Day Treatment Centre	1	0	0	0	1	4	6
Dental	26	2	3	0	0	6	37
ENT	8	0	1	0	1	1	11
ePOD	29	2	2	0	1	4	38
Estates	34	110	2	0	1	17	164
Human Resources	3	0	0	0	1	0	4
Information Management & Technology	3	0	0	0	0	0	3
Integrated Laboratory Medicine	22	5	11	0	0	4	42
Medical Director	2	0	0	0	0	0	2
Medicine	70	5	7	0	8	9	99
Musculoskeletal Services	20	1	0	0	2	3	26
Neurosciences	10	0	2	0	2	0	14
Northern Medical Physics & Clinical Engineering	3	1	1	0	0	0	5
Patient Services	75	18	4	1	13	24	135
Peri-Operative	118	1	19	0	8	10	156
Pharmacy	12	0	11	0	1	3	27
Radiology	7	1	8	0	2	4	22
Regional Drugs & Therapeutics	0	1	0	0	0	0	1
Supplies	3	5	0	0	1	0	9
Surgical Services	26	1	6	0	1	5	39
Urology & Renal	33	0	4	0	3	1	41
Women's Services	38	0	4	0	3	4	49
Grand Total	684	170	98	1	67	129	1149

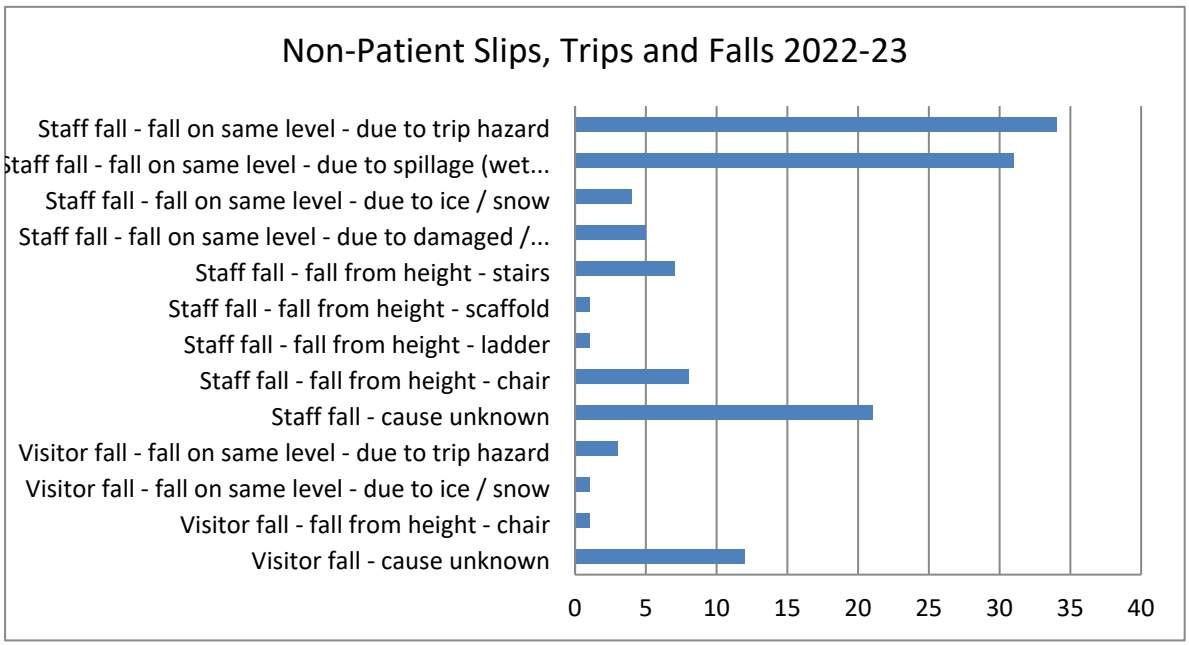
Incidents logged against Estates include incidents that occurred in general areas and do not reflect the number of incidents related to Estates staff. The number of incidents categorised under 'Accident (involving staff, visitors etc.)' includes needlestick injuries, which make up a majority of incidents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

9. SLIPS, TRIPS AND FALLS

A comparison of key slip, trip and fall types for staff and visitors for the period 2019 – 2023 is shown in the SPC chart below.



Non patient slips, trips and falls have reduced this year from 135 in 2021-22 to 129 in 2022-23. This continues a downward trend and more recently the rates in the SPC chart show seven continuous points of special cause improvement. During the period the Slips, Trips and Falls Group has been established to look at incident data, themes, and assurance processes. External zonal inspections have been implemented and a Slips, Trips and Falls data dashboard has been developed. All RIDDOR reportable falls have been investigated fully and where necessary lessons have been shared.



10. VIOLENCE AND AGGRESSION

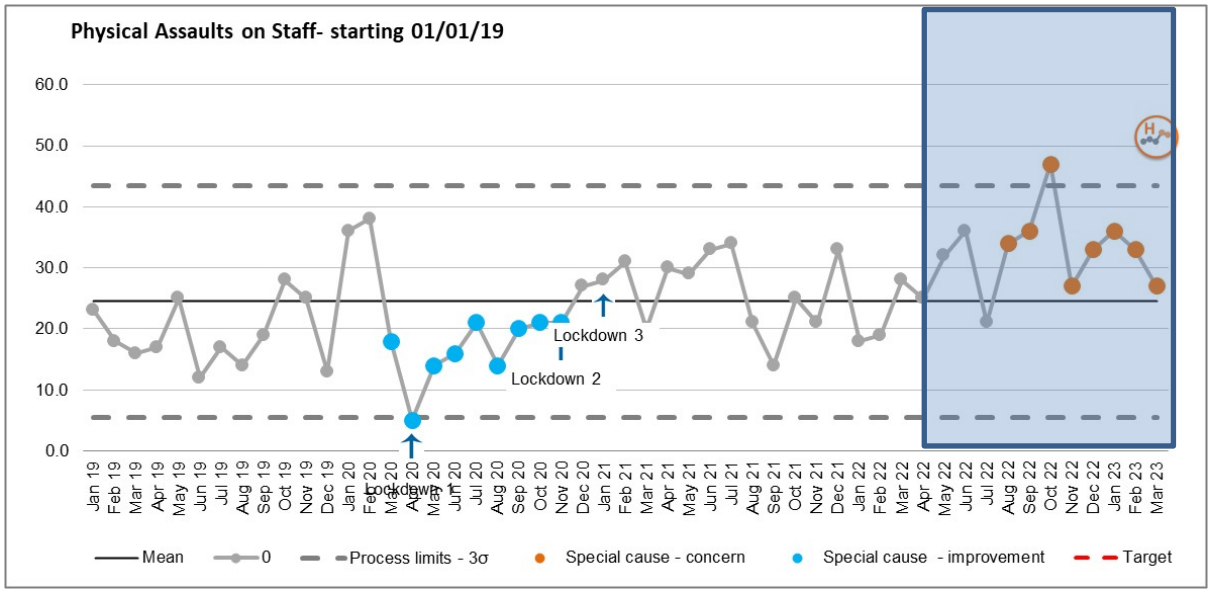
Violence and aggression rates have continued to fluctuate over the period; however, incidents have increased overall by 4% this year in comparison to 2021-22. Unfortunately, the data shows a 10% decrease in verbal incidents but a 28% increase in physical assaults on

staff. This reflects a difficult period as restrictions were lifted and hospital activity increased. There has been an increase in the amount of challenging behaviour in relation to delayed treatment, longer than normal waiting times and increases in the number of patients with mental health problems accessing emergency care. During this period the Emergency Department (ED) have also seen an unprecedented increase in demand for the service including a disproportionate increase in those attending with challenging behaviour.

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Non-Physical	482	584	588	602	637	579
Racial	8	11	11	15	17	22
Sexual	8	9	13	11	17	23
Physical	247	259	273	257	305	387
Total	745	863	885	885	976	1,011

A huge amount of work has been undertaken this year to reduce restrictions and waiting times, where possible e.g. visiting arrangements. The Trust have undertaken a well evaluated training programme for staff around conflict resolution, focussing mainly for staff in reception areas and dealing with patients via telephone. This resilience training has also been extended to clinical staff. Mental Health Awareness training is now mandatory for all staff which is delivered via e-learning or face to face. During the period Breakaway training was re-introduced and several initiatives have been planned for the Emergency Department to help reduce violence and aggression to staff.

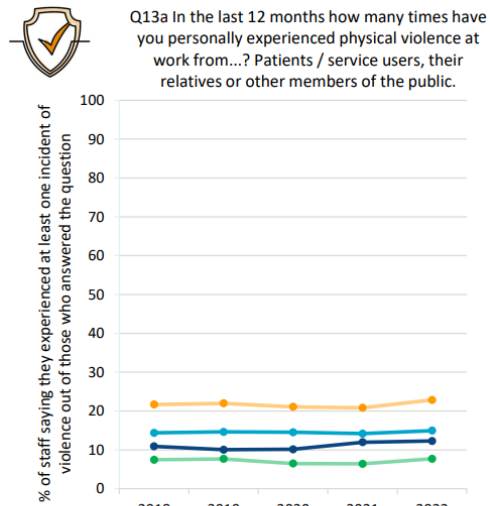
Assaults on staff have continued to increase during the period as shown in the SPC chart below.



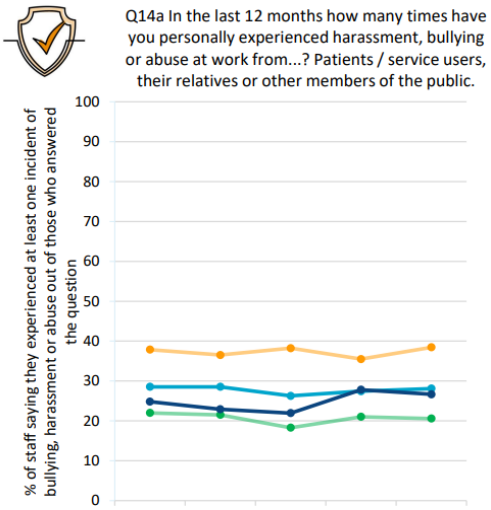
Data received from the NHS staff survey and shown in the extract below provides some indication of levels of violence and aggression experienced by staff. Q13a below suggests Trust staff are increasingly being exposed to violence which seems to be in line with national trends. Q14a suggests staff are being exposed to abuse, bullying and harassment from patients, relatives, and the public at a slightly lower rate than the national average.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Extract from 2022 NHS Staff Survey for NUT



	2018	2019	2020	2021	2022
Your org	10.9%	10.0%	10.2%	12.0%	12.3%
Best	7.5%	7.7%	6.5%	6.4%	7.7%
Average	14.4%	14.6%	14.5%	14.2%	15.0%
Worst	21.7%	22.0%	21.1%	20.8%	22.8%
Responses	6532	6365	7035	7316	6625



	2018	2019	2020	2021	2022
Your org	24.8%	22.9%	21.9%	27.8%	26.6%
Best	22.0%	21.5%	18.3%	21.0%	20.6%
Average	28.5%	28.5%	26.3%	27.4%	28.1%
Worst	37.9%	36.5%	38.2%	35.5%	38.5%
Responses	6536	6361	7032	7287	6606

The Violent Marker Panel has approved the marking of 204 patient records during 2022/2023; this represents virtually the same level as the previous year. The conflict resolution training programme is a requirement for all staff with a regular patient facing role. This programme equips staff to recognise the ways that violence escalates, helps identify the behavioural and physical signs in people and provides a range of de-escalation techniques. At end of the period the training compliance for Conflict Resolution was 94% across the organisation.

A review of physical intervention (restraint) training provision for security staff was undertaken in 2018 and a more sustainable training model implemented (GSA). Since COVID-19, training compliance has increased steadily reaching 100% during the period. Further work is currently underway to establish the best possible method to deliver this training.

One of the key objectives of the Compliance and Assurance team is the reduction of violence / aggression and restrictive interventions. Several ongoing initiatives will feature within this work. For example:

- The Trust Violence Reduction Group has now been established with agreed terms of reference, reporting into the Trust H&S Committee.
- Compliance with the NHS England national standards for Violence Reduction has continued to improve over the period.

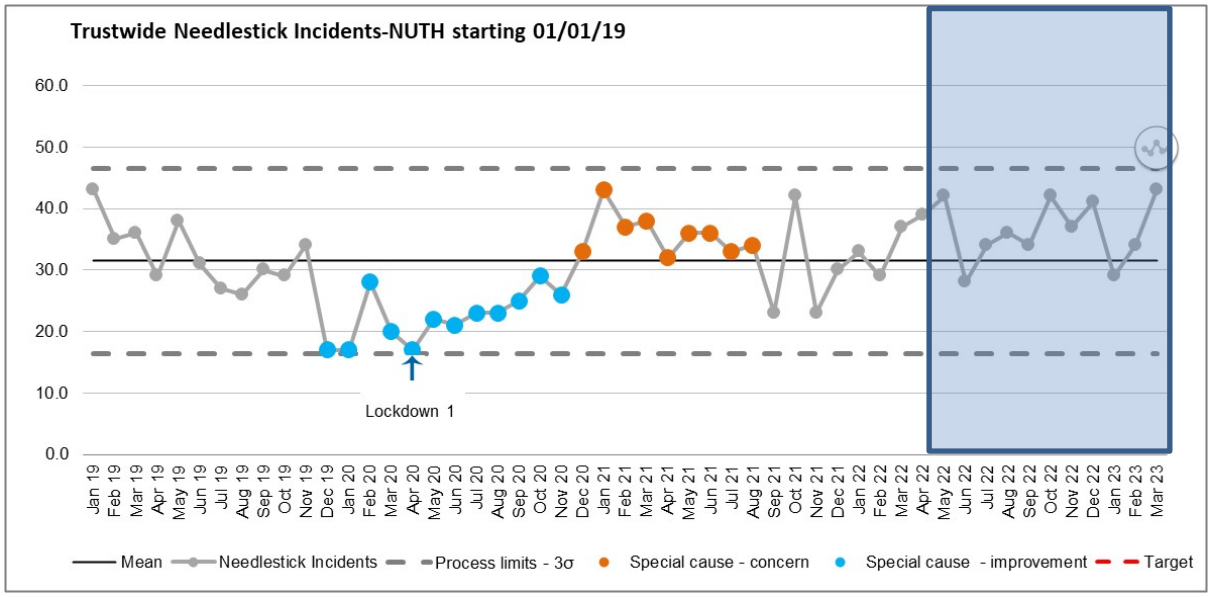
- The Trust Violence Reduction Strategy 2023-26 has been developed and is due to be introduced in the early part of 2023-24.
- The Datix system Yellowfin business intelligence tool was used to develop a violence and aggression dashboard, which has been shared at the Trust Security Group and Trust Violence Reduction Group.
- A revised Restraint Policy is due to be introduced in early 2023-24 and will be rolled out in conjunction with revised guides around the use of rapid tranquilisation.
- The Restrictive Intervention Review Panel was established in May 2022 to monitor and discuss all restrictive interventions (also highlighted in the revised Restraint Policy). The main objective of the group is ensuring the appropriate application of restrictive interventions ensuring they are legal and proportionate as well as ensuring lessons are learnt and shared across the organisation.
- Within ED a form has been introduced and recently reviewed to provide security with the legal rationale for restraint or detention within the department. This information is completed by ED staff, shared with security staff and entered onto E-Record. This forms part of the revised Restraint Policy and therefore rolled out to all areas in early 2023-24. Following the approval of funding from Northumbria Police Violence Reduction Unit, it is anticipated ED Navigators will be introduced in the early part of 2023-24 to work with both victims and perpetrators of violent crime.
- The 'We Can Talk' initiative, which provides support and training to Trust staff to improve their knowledge, skills and confidence when working with children and young people who are experiencing mental health difficulties whilst in hospital or attending Accident & Emergency (A&E) in a mental health crisis, is now well established across children's and young people's services.

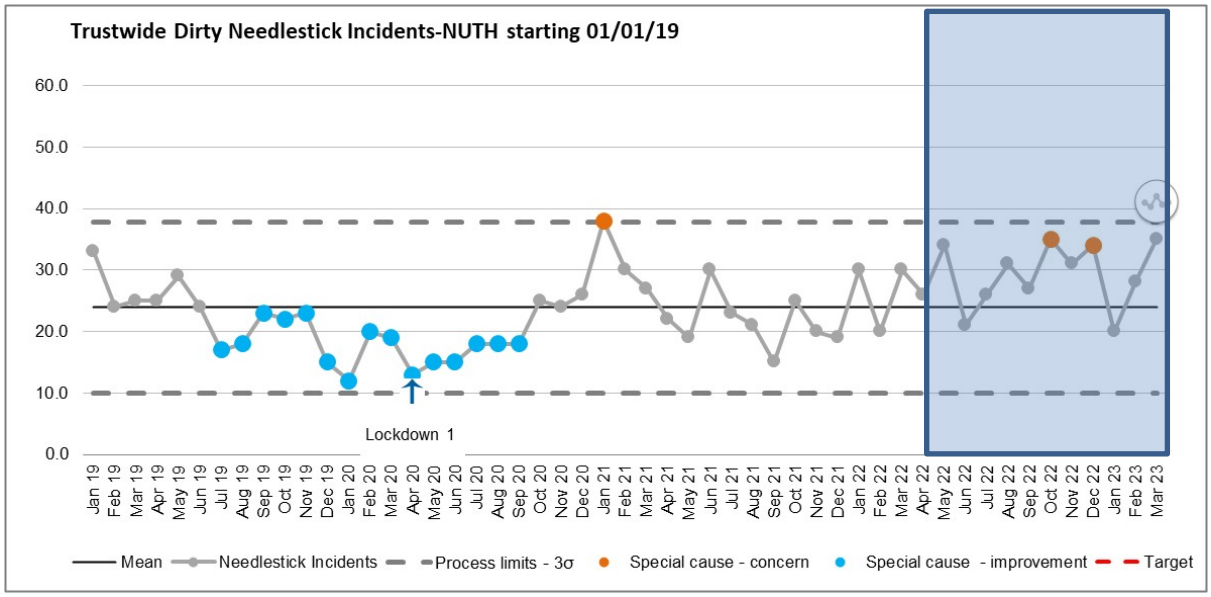
11. SHARPS INCIDENTS

The Safer Sharps Review Group (SSRG) met five times during 2022-23. During this time period the group has refreshed its membership and Terms of Reference (January 2023) and has an extensive work plan for 2023-24. Work to date has focused on reviewing current assurance regarding the use of safer sharps devices in all appropriate clinical areas and ensuring risk assessments for use of non-safety devices (where reasonably practicable) are up to date and reflect robust safety practice. There continues to be a significant amount of work to improve the collection, analysis and evaluation of sharps data, including the development of a sharp's dashboard, with the aim of providing clinical boards and the SSRG with thematic data, in order to be able to target interventions to reduce sharps injuries in the Trust. A further focus for the group is standardising and improving sharps education across the Trust, initially via an eLearning package and corporate induction.

A programme of work is planned to commence in May 2023, led by the Trust Medical Devices Co-ordinator and Senior Procurement Specialist, to review and update version eight of the Trust Safer Sharps inventory, considering the ongoing supply chain challenges. The waste management team continue to contribute to the SSRG as a core member, recently trialling and implementing several different initiatives to reduce sharps related clinical waste in addition to reducing injuries related to disposal of sharps.

There were 439 sharps incidents during the period, of these 348 relate to dirty sharps with the remainder being clean or non-medical sharps incidents. None of these incidents were required to be reported to the H&S Executive (HSE) under RIDDOR requirements. The Trust is currently on the 8th edition of the Safer Sharps Inventory.





Further analysis of this data was provided separately to the H&S Committee and the Sharps Annual Report was presented at the August 2023 meeting.

12. STRESS MANAGEMENT

The Stress in the Workplace Review Group (SWRG) met four times during 2022-23, which is in line with the Terms of Reference. During this period work progressed around several stress related areas such as risk assessment and training. Membership includes H&S, Occupational Health Service (OHS), Human Resources (HR), Staff Development, Health Improvement, Chaplaincy and Staff Side. It reports to the Trust H&S Committee. Its role is to

ensure that the requirements of the stress policy are met and progress the development of arrangements to prevent and manage stress. (The terms of reference for the group have been updated and amended, and all changes accepted by the group. The Stress Prevention Intranet site has been updated to include the up-to-date list of Mental Health first aid staff members and latest information. The stress risk assessment process remains the main mechanism to manage work related stress including areas of stress related sickness absence. The HR Department are actively involved in the process of supporting directorates in the completion of both service level and individual risk assessments. The Trust Stress risk assessment process is included in the manager induction programme. There has also been an ongoing series of monthly training sessions held across the Trust to instruct all managers in the risk assessment process, run by the H&S team. The group continues to take account of the findings of the annual staff survey and incorporate any actions into the SWRG action plan. The SWRG action plan is a rolling plan designed to achieve set actions within an annual time frame. The plan is monitored and amended as actions are completed at the group meetings.)

Mental Health First Aid (MHFA) training was introduced in 2016 and work continued throughout 2022-23 to improve the service. Four face-to-face training sessions were facilitated in 2022-23 bringing the total trained across the Trust as of May 2023 to 205. Further development work is planned for 2023 – 2024 including further training sessions and refresher courses. The MHFA course teaches attendees to recognise the early signs of a mental health problem and the knowledge to provide help and support to staff across the organisation.

13. LONE WORKING

The Trust acknowledges the number of staff working in higher risk environments such as community-based nursing teams. During 2020-21 the Lone Worker System (LWS) was rolled out across the organisation originally covering 800 lone workers and replacing the Look Out Call system. During 2022-23 further devices have been added to the system with around 950 devices now active across the Trust. During the year, further work has been undertaken to increase usage rates and ensure staff use the devices correctly. Staff usage rates are based on staff leaving yellow alerts at each location they visit, leaving vital location information. During the period staff have activated 18,282 yellow alerts, 22% higher than last year. Further work is due to take place this year to enhance this further and continually work with staff teams to raise awareness around the importance of the LWS and the safety benefits it provides staff.

There have been no genuine red alerts during the period.

The results of this year's Lone Worker Survey highlighted a significant majority (80%) of staff find the device easy to use and 83% of staff carry their devices when working out in the community.

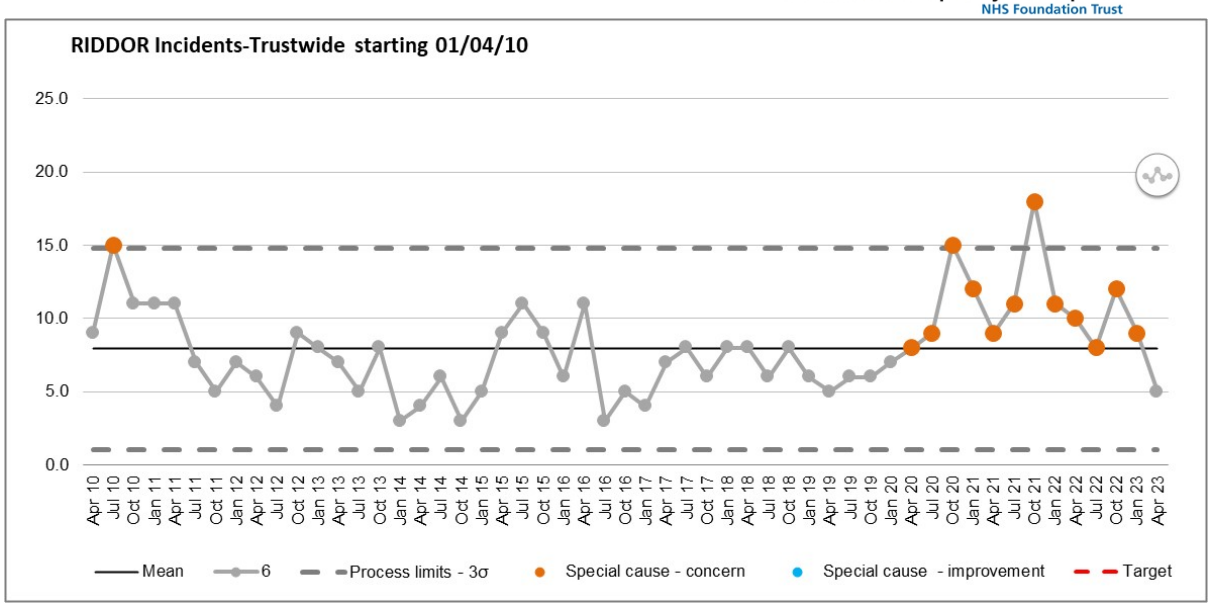
The Compliance and Assurance Team have provided continued support during the period and ensured the submission of new devices and user information was both accurate and timely.

14. REPORTING OF INJURIES DISEASES & DANGEROUS OCCURRENCES REGULATIONS

There has been a decrease in the number of RIDDOR incidents compared to 2021 - 2022 from 50 to 34 incidents in 2022 - 2023. There were 6 specified (major) injuries reported to the H&S Executive. Five where in relation to fractures following falls and one in relation to being struck by an object. The remaining incidents reported were categorised as resulting in an over 7-day absence from work as a result of an injury. Eleven of these absences have resulted from moving and handling incidents (all of which have been investigated by the Trust M&H Team). Six incidents were related to violence and aggression, which is a slight decrease on the previous year. All RIDDOR incidents are investigated by the reporting directorate and the followed up by the supporting H&S Advisor under the continuous monitoring and support arrangements undertaken by the H&S Team.

	Aggression & Violence	Accident (involving staff, visitors etc.)	Accident (involving patients)	Moving & Handling	Non-Patient Slip, Trip or Fall	Security	Total
Apr 2022	0	0	0	0	2	0	2
May 2022	0	0	0	1	0	0	1
Jun 2022	0	1	0	3	1	0	5
Jul 2022	0	0	1	1	2	0	4
Aug 2022	2	0	0	1	0	0	3
Sep 2022	1	1	0	2	1	0	5
Oct 2022	0	0	0	0	0	1	1
Nov 2022	0	3	0	1	0	0	4
Dec 2022	0	1	0	0	3	0	4
Jan 2023	1	0	0	0	0	0	1
Feb 2023	0	0	0	0	0	0	0
Mar 2023	2	0	0	2	0	0	4
Total	6	6	1	11	9	1	34

The SPC chart below shows the trend around RIDDOR reporting since quarter one of 2010. It highlights that since COVID the number of reports remain in the upper control limit and therefore higher than normal over a longer period dating back to 2010. Further analysis of the latest financial year found a range of different types of incidents across several Directorates. There were no significant themes or trends to indicate why numbers remain relatively high. More generally post COVID, activity increased across the Trust and at the same time the Trust have took on several additional services such as the Integrated Covid Hub North East (ICHNE) and North Cumbria Cancer Services.



15. EXTERNAL INVESTIGATIONS

During the period the H&S Executive have visited the Microbiology Department at Freeman Hospital as part of their scheduled Category 3 Laboratory three yearly inspection programme. A great deal of preparatory work took place in anticipation of this visit and the expected HSE standards. Other than a small number of minor actions, the inspection was deemed a success and reflected the hard work undertaken prior to the visit.

16. RISK REGISTER

A Risk Management update report is provided at each meeting of the H&S Committee. This is for Committee oversight, as the management and review of risks is the responsibility of each Directorate (now Clinical Board/Speciality) through their Governance Meeting structures.

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

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

As at 21 April 2023, the Trust held 495 open risks with 43 risks (8.7%) aligned to the interests of the H&S Committee. Of the 495 open risks 304 were rated 12 or above, with 30 risks (9.9%) aligned to the interests of the H&S Committee. There are 5 risks rated as 'high' risks (rated 20) which were included in the Quality Committee report.

17. DATIX DEVELOPMENTS

During 2022-23 the Datix Team have been developing dashboards in Yellowfin to provide incident data back to Directorates to support then during their governance meetings and also rolling out broadcasting functionality. There has been a significant amount of work dedicated to the development of incident dashboards, using Yellowfin Business Intelligence, to support wider trust initiatives led by groups such as the Safer Sharps Review Group and the Violence Reduction Group.

During the period, the Datix Team have been rebuilding the system to ensure it aligns to the Trust restructuring from Directorates to Clinical Boards. This work is reflected across for both Datix Cloud IQ (DCIQ) and also Datix Web for Risks, ensuring all permissions and data are transferred from legacy Directorates to the new structures.

We are waiting for enhancements for the Enterprise Risk Manager module which are expected in the summer and once these have been rolled out, we will look to roll this module out by the end of 2023.

18. RECOMMENDATIONS

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

Report of Angela O'Brien
Director of Quality and Effectiveness
8 September 2023

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023		
Title	Learning from Deaths (April 2023 – June 2023)		
Report of	Angela O'Brien, Director of Quality and Effectiveness		
Prepared by	Pauline McKinney, Integrated Governance Manager – Quality		
Status of Report	Public	Private	Internal
	☒	☐	☒
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	This paper aims to provide assurance to the Trust Board that the processes for Learning from Deaths across the organisation are in line with best practice as defined in the National Quality Boards (NQB) National Guidance on Learning from Deaths (LFD) March 2017, and guidance on working with bereaved families and Carers (July 2018). This paper also summarises the processes that are in place to provide assurance to the Board of Directors that all deaths are reviewed including those with potentially modifiable factors. All deaths that require a more in-depth review (level 2) are recorded into the mortality review database to ensure lessons are learned and shared.		
Recommendation	The Public Trust Board is asked to receive this paper for information and discuss the learning identified from mortality reviews.		
Links to Strategic Objectives	Putting patients first and providing care of the highest standard focusing on safety and quality • Put patients and carers first and plan services around them • Maintaining our 'Outstanding' CQC rating		

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

Link to Board Assurance Framework [BAF]	No direct link to the BAF. The report provides assurance that patient outcomes are reviewed, and lessons learned to include deaths of people with learning disabilities.
Reports previously considered by	This is a recurrent report and was previously presented to Public Trust Board on 25 May 2023.

LEARNING FROM DEATHS

EXECUTIVE SUMMARY

The objective of this report is to provide the Trust Board with assurance that there is a robust process in place to review unexpected deaths, as well as those deaths with potentially modifiable factors, and that mechanisms are in place to ensure lessons are learned and shared.

For the purpose of this paper 'modifiable factors' are defined as factors identified that may have contributed to the death and which by means of locally or nationally achievable interventions could be modified to reduce the risk of future deaths.

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

LEARNING FROM DEATHS

1. BACKGROUND

The Care Quality Commission (CQC) report 'Learning, candour and accountability', published in December 2016, detailed concerns about the way NHS Trusts investigate and learn from deaths of people in their care, and the extent to which families of the bereaved are involved in the investigation process.

The guidance released in March 2017 by the National Quality Board (NQB) set clear expectations for how Trusts should engage meaningfully and compassionately with bereaved families and carers at all stages of responding to a death and described Trust boards' responsibilities for ensuring effective implementation of this guidance. The Trust implemented the Learning from Deaths (LFD) guidance by the September 2017 deadline and has the required framework in place to facilitate learning from deaths within the Trust.

The NQB report 'Learning from Deaths: Guidance for NHS trusts on working with bereaved families and carers', published in July 2018 consolidated the existing guidance and provided perspectives from family members who have experienced bereavement within the NHS. This additional guidance sets out how organisations should support and engage families after a loved one's death in their care but has also been written with the intention of being a resource for families to refer to.

The guidance released in July 2018 by the Department of Health and Social Care published the government's response to consultation on the "Introduction of Medical Examiners and Reforms to Death Certification in England and Wales". This guidance outlined the intention that the Medical Examiner system would be enshrined in statute and Medical Examiners would be based in all acute Trusts by 2021 with a view to start scrutinising community deaths by 2023.

2. MORTALITY REVIEW DATABASE – DATA SUMMARY

Current Morbidity and Mortality (M&M) meetings provide a robust forum for multidisciplinary discussion of inpatient deaths. The mortality review database was launched in June 2017 and has improved the ease at which lessons identified within M&M meetings can be shared between Directorates. The database captures all mortality reviews and centralises the findings in one place for all level 2 mortality reviews.

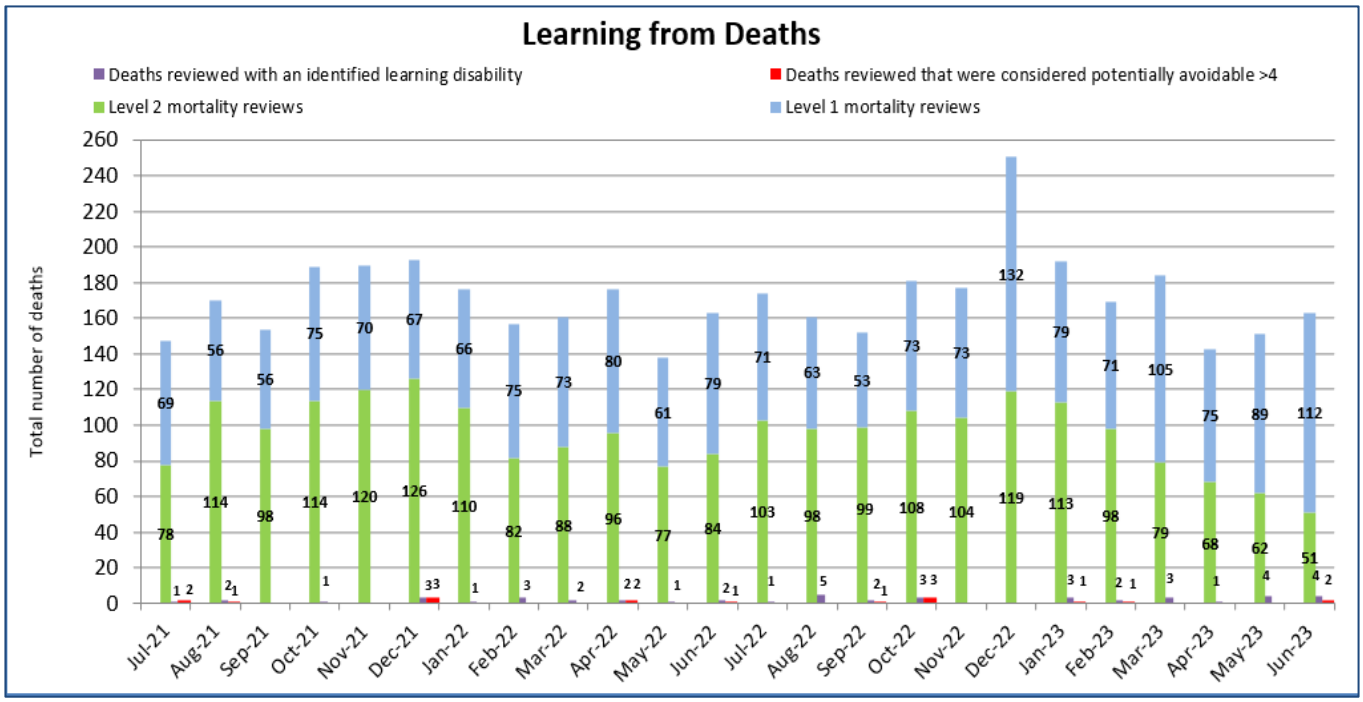
Level 1: The reviewer reviews the cause of death and discusses with the certifying doctor and Medical Examiner.

Level 2: In addition to the level 1 actions, the reviewer also considers documents and health records associated with the death and records findings into the Trust-wide mortality review database, in-line with Trust Mortality Policy.

The mortality review database received an upgrade on 1 September 2023. The upgrade includes the option for patients to be recorded using their NHS number, which will support the community medical examiner scrutiny.

2.1 Inpatient Deaths

In the 12-month period (July 2022 – June 2023), 2,098 patients died within Newcastle Hospitals, with 1,102 (53%) of those patients receiving a level 2 mortality review. It is likely that these mortality review figures will also continue to rise due to further M&M meetings being held over the forthcoming months. These figures will continue to be monitored and modified accordingly. The graph below shows the total number of deaths over a 24-month period (July 2021 – June 2023) as well as level 2 mortality reviews. There was a rise in inpatient deaths in December 2022. This was noted nationally as well as locally, with initial data showing influenza to be the cause of death.



2.2 Patients identified with a Learning Disability

The National Learning Disabilities Mortality Review (LeDeR) Programme was established as a response to the recommendations from the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD 2013). CIPOLD reported that people with learning disabilities are three times more likely to die from causes of death that could have been avoided with good quality healthcare.

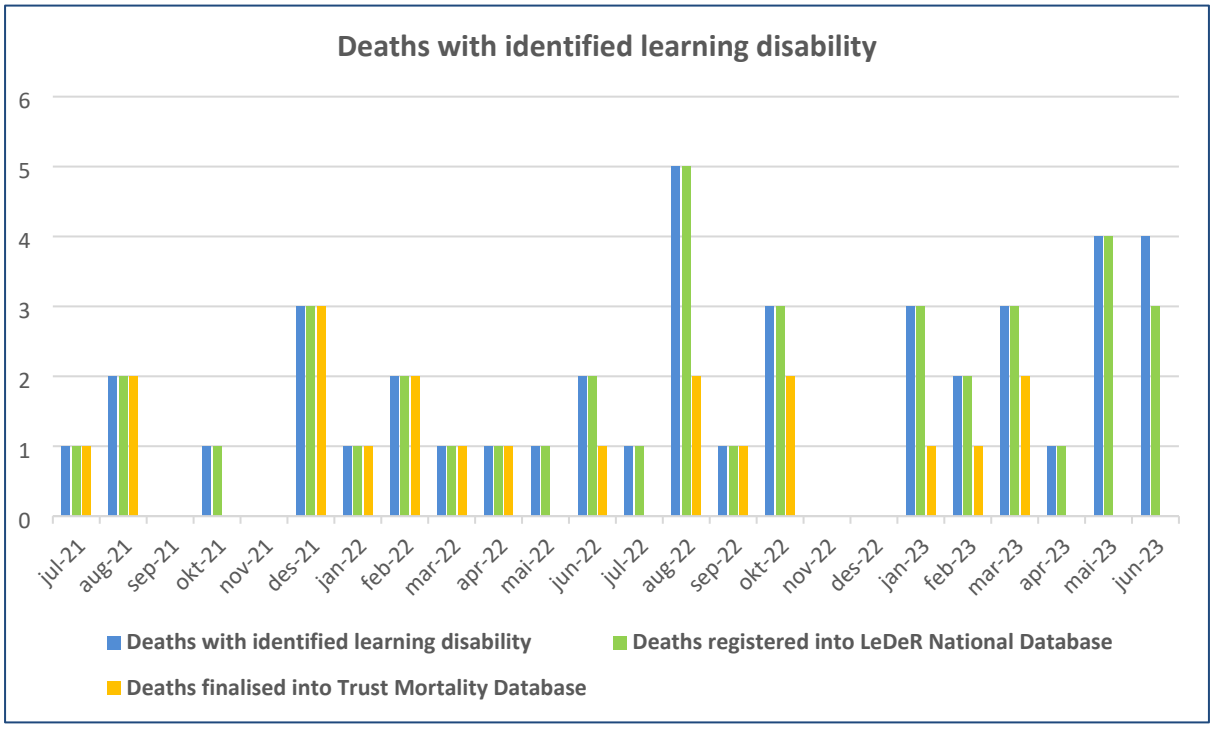
In the 12 month period (July 2022 – June 2023), 27 patients who died within Newcastle Hospitals were identified as having a learning disability. Within the Trust, whenever a patient with a learning disability dies, their death is reviewed by the clinical team along with the Learning Disability (LD) Team. There is a further in-depth case review at the Learning Disability Mortality Review Panel and the outcome of the case review is entered onto the Trust Mortality Review Database as well as into the LeDeR National Database. An update is provided from the Associate Director of Nursing at each quarterly Mortality Surveillance

Group meeting and lessons learned are shared using various methods, which includes presenting at the Clinical Risk Group and via Patient Safety Bulletins.

The current backlog of LeDeR case reviews requiring completion and recording into the Trust mortality review database has been supported by specialist LD nurses. The LD nurses have recently started to expand their role and undertake case reviews and present the findings to the Learning Disability Group.

Although there continues to be a backlog, this support has significantly helped to reduce the number of outstanding mortality reviews for people with LDs requiring completion, and it is anticipated that it will continue to do so. The backlog will continue to be monitored and presented to the quarterly Mortality Surveillance Group.

The graph below shows the data for the past 24 months (July 2021 – June 2023) and includes those patients who have been registered into the national LeDeR database and Trust mortality review database.



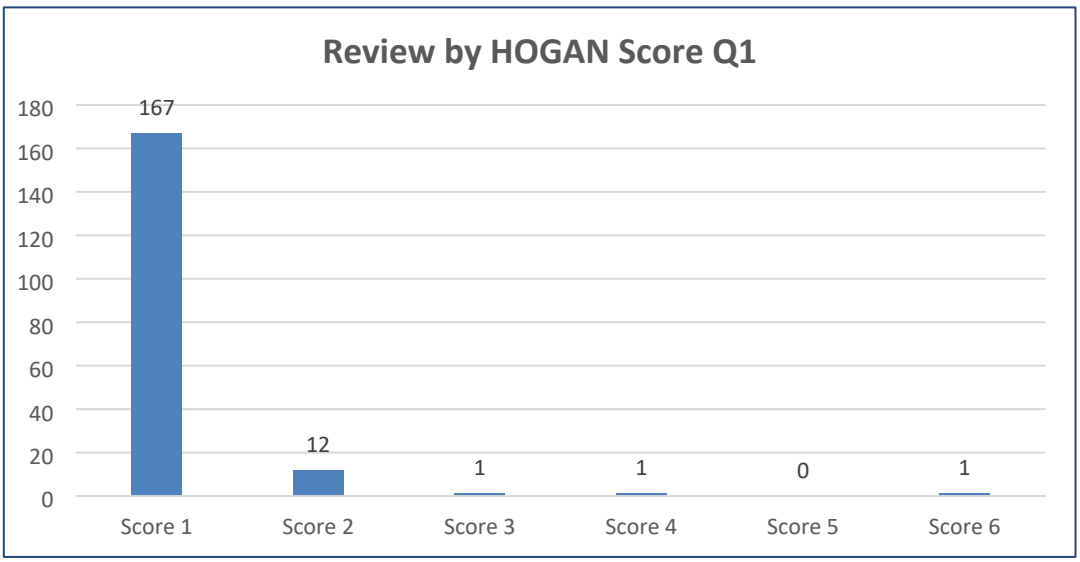
2.3 Outcome of Case Reviews – Hogan Score

Throughout Q1 (April 2023 – June 2023), 457 patients died, of which 182 have received a full case note review (Level 2), which was undertaken by a multidisciplinary team, and findings recorded in the Trust-wide mortality review database. This number will continue to rise as more M&M meetings go ahead over the forthcoming months.

Case notes were reviewed estimating the life expectancy on admission and any identified problems in care contributing to death. The Hogan scale, ranging from 1 (definitely not preventable) to 6 (definitely preventable), was used to determine if deaths were potentially avoidable, taking into account a patient's overall condition at the time.

1	Definitely not preventable
2	Slight evidence for preventability
3	Possibly preventable, but not very likely, less than 50-50 but close call
4	Probably preventable more than 50-50 but close call
5	Strong evidence of preventability
6	Definitely preventable

A score of ≥4 suggests 'strong evidence of preventability'. Where this occurs, Trust processes mandate that an investigation is initiated to determine if serious harm has occurred and a subsequent serious incident (SI) is to be reported. Each case graded 4 or above is also presented on an individual basis at quarterly mortality surveillance group. The outcomes of the cases reviewed in Q1 are summarised in the graph below:



The graph shows two patients were recorded as HOGAN 4 or above. The patient who was graded a HOGAN 4 received an indepth discussion at serious incident triage panel, the panel agreed the incident does not require reporting as a serious incident. The second patient was graded a HOGAN 6, the panel agreed a serious incident was to be reported and an investigation is currently underway.

3. KEY LEARNING POINTS

The NQB recommendations state that providers should have systems for deriving learning from reviews and investigations and act on this learning. In addition, learning should be shared with other services where it is perceived this will benefit future patients.

Following a death, information gathered using case record reviews or investigations should be used to inform robust clinical governance processes. The findings should be considered with other information and data including complaints, clinical audit information, patient safety incident reports and outcomes measures. This information resource can then inform the Trust's wider strategic plans and safety priorities.

The learning points identified following M&M reviews in Q1 are detailed below, together with how learning has been shared and what action has been taken. Clinicians from each Directorate are also encouraged to share relevant learning from local mortality reviews with any other Directorates throughout the Trust.

Learning points identified from case reviews undertaken in Q1.

Directorate	Speciality	Summary	Learning Point	Outcome
Renal & Urology	Renal	Patient admitted with worsening foot ulceration, requiring surgery (patient on haemodialysis). Surgery was scheduled but then delayed due to high demand for theatre over a weekend. There was no robust plan for perioperative dialysis. Routine blood monitoring did not happen until the patient attended theatre, which showed abnormal results. The patient deteriorated post operatively.	Reorganisation of the senior vascular team responsibilities to enable senior daily review. Improved communication required when dialysis patients admitted to non-renal areas; digital options being explored. Improved F1 induction around management of dialysis patients.	Serious Incident was reported, and investigation is currently ongoing.
Internal Medicine	Respiratory	Patient was re-admitted 2 days after a prolonged admission for acute exacerbation of previously undiagnosed Interstitial Lung Disease (ILD) and deteriorated rapidly.	The patient was not referred to the ILD team on second admission due to rapid deterioration.	All cases with ILD to be discussed with the ILD team in case risk assessment or modified management could be given.
Internal Medicine	Gastro FH	Patient expressed wishes to donate his body for research; staff were unsure how to facilitate this.	Staff liaised with mortuary team to ensure appropriate procedures and documentation were in place.	Ensure the ward has the correct documents and nursing and medical staff understand the correct procedure prior to the patient death, to comply with their wishes.
Internal Medicine	Gastro FH	HPB ward team were not informed of acceptance of patient from transferring hospital.	Prior notice required for patients being admitted onto ward.	Discussed at Governance meeting and processes changed to include documenting when accepting team is informed of admission.

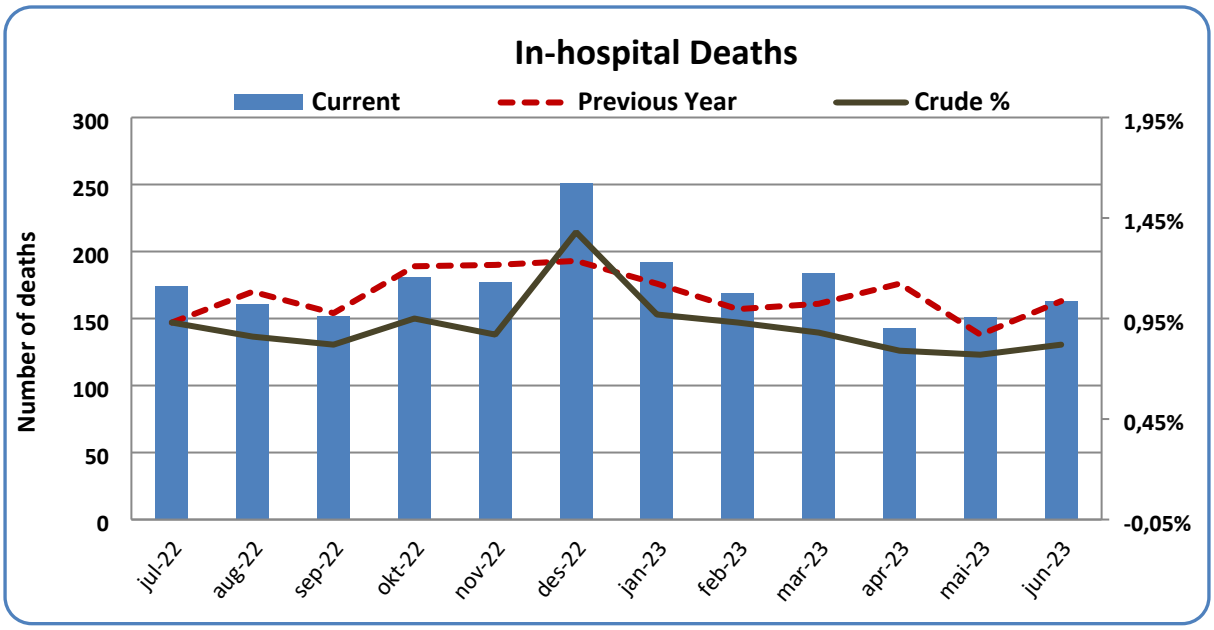
Directorate	Speciality	Summary	Learning Point	Outcome
Internal medicine	Gastro FH	Patient with deteriorating acute liver failure died with a cause of death categorised as 1a pneumonia. Family upset that liver failure was not recorded as 1a on death certificate.	Family should be made aware that MCCD is a legal document, and the primary cause of death must be recorded on the death certificate.	Discussed at Governance meeting and junior doctors meeting.

4. CRUDE MORTALITY

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

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

The graph below shows the crude mortality rates for period July 2022 – June 2023. The in-hospital deaths show an increase in December 2022. This rise was recorded nationally and was predominately related to influenza as the cause of death.



5. SHMI AND HSMR MORTALITY RATES

Standardised Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) mortality rates are published quarterly by NHS Digital, however due to the time delay between data being uploaded by each individual Trust and primary care, the data is published approximately six months retrospectively.

SHMI and HSMR data is scrutinised on publication to determine any areas that may raise concern. All groups within the data are individually monitored and all findings are presented to the Trust Mortality Surveillance Group on a quarterly basis. Any group that flags as a concern is raised with the relevant Directorate to ensure an in-depth analysis is undertaken and findings recorded into the mortality review database. All learning from this analysis is shared with Directorates and presented to the Mortality Surveillance Group.

The latest SHMI publication for April 2022 – March 2023 shows the Trust to be at 92, which is below the national average and within "expected levels".

All mortality data including SHMI, HSMR and Variable Life Adjustment Displays (VLADS) are closely monitored.

6. NEQOS

The Northeast Quality Observatory Service (NEQOS) is published quarterly and presents analysis showing the SHMI mortality indices including; a high level for Trusts identifying variation from the norm (outliers); trends through time; and using more granular analysis in order to describe contributing factors.

The latest NEQOS publication is up to December 2022. Overall, the table below shows the Trust to be consistently below the national average for SHMI and one of the lowest regionally.

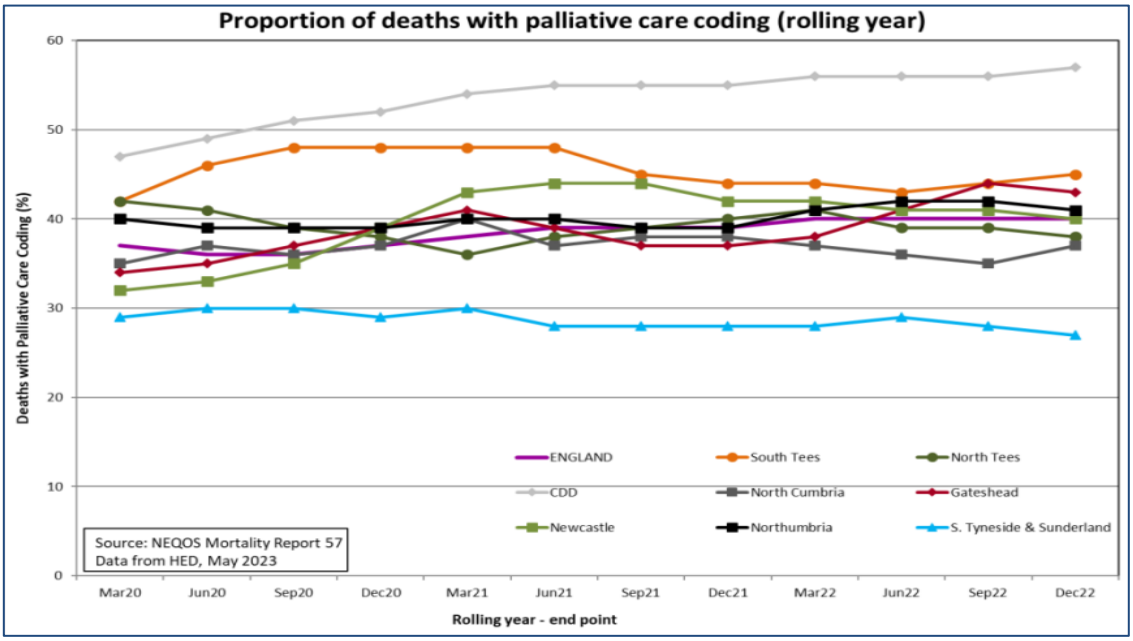
SHMI, total discharges, observed and expected deaths for January 2022 – December 2022.

Provider	Discharges	Observed	Expected	**SHMI**	Category
County Durham and Darlington NHS FT	80530	2900	2650	109	as expected
North Tees and Hartlepool NHS FT	55150	1800	1860	97	as expected
South Tees Hospitals NHS FT	75255	2460	2280	108	as expected
Gateshead Health NHS FT	33780	1210	1400	86	lower than expected
South Tyneside and Sunderland NHS FT	75370	3040	2805	108	as expected
The Newcastle Upon Tyne Hospitals NHS FT	102825	2405	2625	92	as expected
Northumbria Healthcare NHS FT	92560	2615	2865	91	as expected
North Cumbria Integrated Care NHS FT	41520	1730	1660	104	as expected

7. PALLIATIVE CARE CODING

The graph below is published within the NEQOS quarterly report and is currently presented up to December 2022. The graph below shows deaths with a palliative care coding which includes those who have died within 30 days of discharge. Palliative care coding was

historically low within Newcastle upon Tyne Hospitals in comparison to regional Trusts. A rise in palliative care coding throughout 2020/21 can be explained by the rise in deaths during the pandemic.



8. OUTCOME OF INVESTIGATIONS LINKED TO SERIOUS INCIDENTS

All unexpected patient deaths, or deaths with possible modifiable factors, are routinely escalated for review as potential SIs via the Trust incident reporting system (Datix). Deaths of this nature are subject to a detailed review, facilitated by a Clinical Director and often include members of the clinical team directly involved in the patients care. For deaths identified and reported externally as an SI, a comprehensive investigation is undertaken, which includes an analysis of the care provided to identify any learning and determines whether any modifiable factors contributed to the patient's death. Key learning points are identified, and action plans generated. A summary of investigation outcomes linked to SIs in Q1 are shown below:

- During April 2023 – June 2023 (Q1) there were 50 SIs reported to Commissioners via the Strategic Executive Information System (STEIS).
- Of these 50, there were seven patient deaths which identified potential modifiable factors which contributed to the death. Investigations are currently ongoing for four cases.

The incidents that have resulted or contributed to a patient's death, that have completed their investigation since the previous report submitted on 16 May 2023, are listed below and the learning is as follows:

2022/23260 – Unexpected Death
• Clear process now in place whereby staff are pooled from two adjoining wards and stationed where staff are most needed, increasing safety, flexibility and additional staff support where needed.

2023/8352 – Surgical Complication
• The Antimicrobial Policy has been updated and is online with advice on the use of all prophylactic antibiotics drawing specific attention to patients on DMARDs and risk stratification. • The Directorate have reviewed their current guidance for DMARDS, and this has been re-circulated to the pre-assessment clinics and is now available on the Trust Intranet Clinical Guidelines database. • Prophylactic antibiotics policy for has been updated, indicating the taking of DMARDs as an independent high-risk factor.

2023/8912 – Fall
• Ward to conduct regular safety assessment audits to ensure compliance in line with Falls Trust policy and national guidelines. • Ward managers to review compliance on dashboard with support from Clinical Educators. • Staff to be supported to undertake falls risk training.

2022/20584 – Failure to identify deteriorating patient
• Ongoing development of the PEWS electronic observations to fine tune IT functionality, identified both locally and nationally. • Development of an electronic proforma to be completed as part of the escalation of need for senior nursing and medical input into the care of the deteriorating patient. • Ongoing education of all nursing and medical staff in the role of PEWS and identification of the deteriorating patient.

9. MEDICAL EXAMINER

The Medical Examiners (ME) role went live in January 2021 as part of an initial test period, scrutinising patients' medical notes and discussing the care pathway with the ward clinician for all patients who died within two specified wards at the Freeman Hospital (FH). As the test period was considered a success, the project moved to the next stage in March 2021, which involved scrutinising all deaths at FH and finally including all deaths at Royal Victoria Infirmary (RVI) in August 2021.

Since January 2023, Medical Examiners have started scrutinising all inpatient deaths other than those referred to the coroner's office.

The Medical Examiner process had planned to incorporate all community deaths by April 2023 in line with National Guidance. However, NHS England have deferred this date until April 2024.

Newcastle Hospitals have approached all 29 regional GP practices and two hospices regarding the Medical Examiner process. The two hospices and approximately eight GP practices are now fully embedded within the ME service. However, as this service is not mandated until April 2024, many practices are deferring the training offered by Newcastle Hospitals. The Regional Medical Examiner has been approached by the Trust Lead Medical Examiner to address this situation in order to avoid multiple practices requesting training at the same time.

A new process has commenced in July 2023, whereby the Medical Examiners inform the Trust mortality leads if a level 2 review is to be undertaken. This will provide additional assurance that all patients who are required to have a level 2 review, receive a review.

Although the process is working well, the data does not show a substantive increase or a decrease in recording of level 2 reviews. However, as this is a new process and some Directorates undertake quarterly M&M meetings, the data may change in forthcoming months. This process will be monitored by the Clinical Governance & Risk Department and data presented to the quarterly Mortality Surveillance Group.

10. RECOMMENDATIONS

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

Report of Angela O'Brien
Director of Quality & Effectiveness
19 September 2023

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023		
Title	Healthcare Associated Infections (HCAI) Director of Infection Prevention and Control Report		
Report of	Maurya Cushlow, Executive Chief Nurse		
Prepared by	Dr Julie Samuel, Director of Infection Prevention & Control (DIPC), Consultant Microbiologist Mr Ian Joy, Deputy Chief Nurse Mrs Gillian Lishman, IPC Quality and Assurance Lead		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	This paper is the bi-monthly report on Infection Prevention & Control (IPC). It complements the regular Integrated Board Report and summarises the current position for the Trust to the end of August 2023. Trend data in Appendix 1 (HCAI Report and Scorecard August 2023) is enclosed in the Public Board Reference Pack (BRP), which details the performance against targets where applicable.		
Recommendation	The Board of Directors is asked to (i) receive the briefing, note and approve the content and (ii) comment accordingly.		
Links to Strategic Objectives	Achieving local excellence and global reach through compassionate and innovative healthcare, education and research. Patients - Putting patients at the heart of everything we do and providing care of the highest standards focussing on safety and quality. Partnerships - We will be an effective partner, developing and delivering integrated care and playing our part in local, regional, national and international programmes. 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)	<u>Strategic Objective: 1</u> Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality. Strategic Risk Description: i) SO1.4 - 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. ii) SO1.10 - 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, Multidrug 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.

Reports previously considered by	This is a bimonthly update to the Board on Healthcare Associated Infections (HCAI).

HEALTHCARE ASSOCIATED INFECTIONS (HCAI) DIRECTOR OF INFECTION PREVENTION & CONTROL (DIPC) REPORT

EXECUTIVE SUMMARY

This paper provides bimonthly assurance to the Trust Board regarding Healthcare Associated Infections (HCAIs). The following key points are noted in the report:

- Clostridiodes Difficle (CDI) infections remain under national trajectory, despite an increase in cases in August. The Infection Prevention and Control (IPC) teams continue to work collaboratively with clinical boards to ensure appropriate initiatives and improvements are implemented.

- MSSA blood stream infections remain over local trajectory. The Vascular Access Team are working in collaboration with the IPC team on initiatives that have been developed following themes from infection reviews.

- Gram Negative Blood Stream Infection (GNBSI) rates are over trajectory and remain under close surveillance. The main sources of these infections are urosepsis and hepatobiliary infections. The Trust GNBSI group provides oversight and monitoring to ensure compliance with the reduction strategies.

- IPC/Antimicrobial Stewardship (AMS) integration into Clinical Boards' governance framework is in progress and will be a key part of each Clinical Board assurance and oversight. Action plans for improvement are developed for areas with poor compliance with support and oversight from IPC and AMS operational teams. There have been significant improvements in surgical antimicrobial prescribing following interventional audits carried out by Antimicrobial Pharmacists.

RECOMMENDATIONS

The Board of Directors is asked to (i) receive the briefing, note and approve the content and (ii) comment accordingly.

HEALTHCARE ASSOCIATED INFECTIONS (HCAI) DIRECTOR OF INFECTION PREVENTION & CONTROL (DIPC) REPORT

1. KEY POINTS FOR JULY/AUGUST 2023

This paper provides a bi-monthly overview to the Trust Board regarding the Healthcare Associated Infections (HCAI). This includes:

- Current performance against national HCAI reduction trajectories. This includes benchmarking with performance across Shelford Trusts.
- Overview of Trust actions and work streams to support HCAI monitoring and reduction strategies.
- Overview of the work undertaken to support antimicrobial stewardship.
- Trust assurance frameworks.

1.1 *Clostridioides Difficile* Infections (CDI)

At the end of August 2023, a total of 55 cases were attributed to the Trust (40 cases Hospital Onset Healthcare Associated (HOHA); 15 cases Community Onset Healthcare Associated (COHA)) – see Table 1. This places the Trust under the national threshold (≤69) by 14 cases as shown in Table 2, and demonstrates an improved position compared to the same period last year. Month on month trend graphs are included in the Integrated Board Report.

Table 1: Number of CDI attributed to Newcastle Hospitals from September 2021 to August 2023

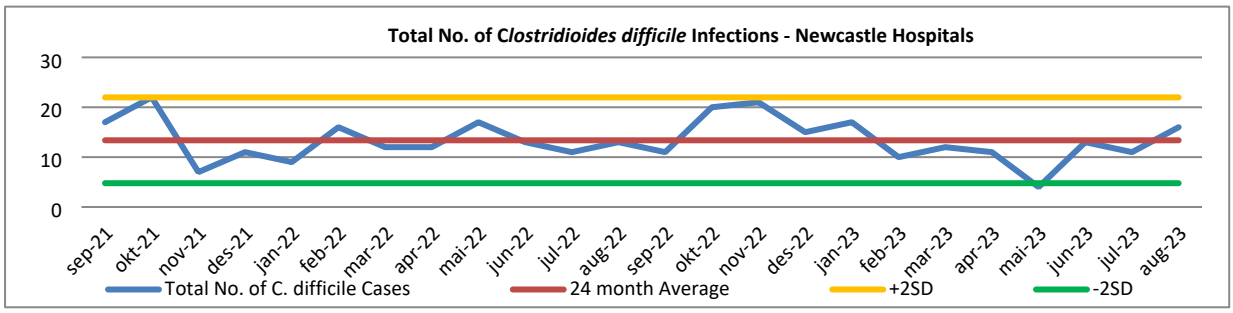
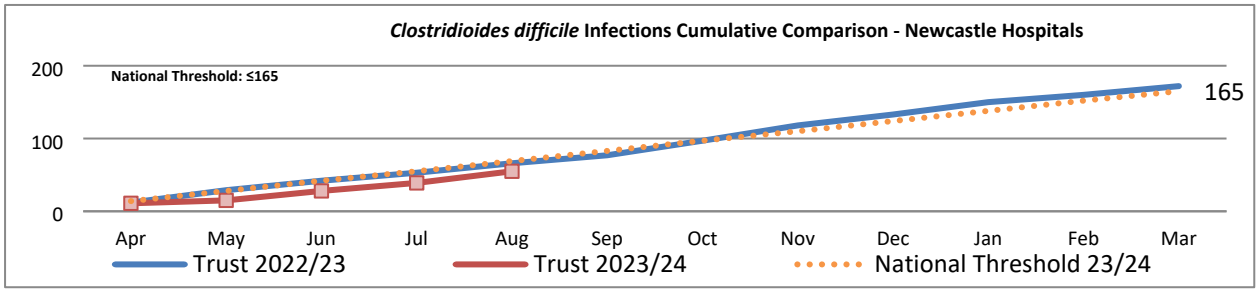


Table 2: Cumulative comparison of 2023/24 National Threshold with Newcastle Hospitals' 2022/23 CDI total



The Trust continues to collaborate with the Integrated Care Board (ICB) to incorporate lessons learnt into local initiatives.

Tables 3 and 4 show the Trust's *Clostridioides difficile* infections compared with the Shelford Group for time periods between April – July 2022 and 2023.

Table 3: CDI comparison data for Shelford group April – July 2023

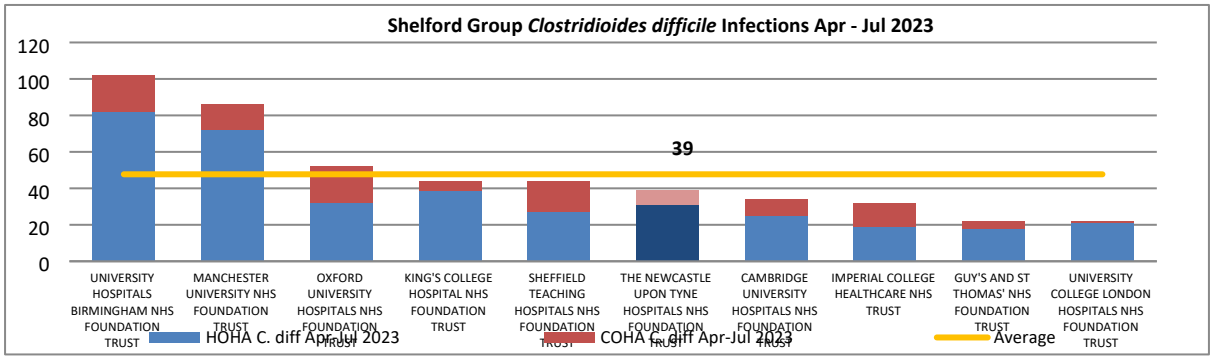
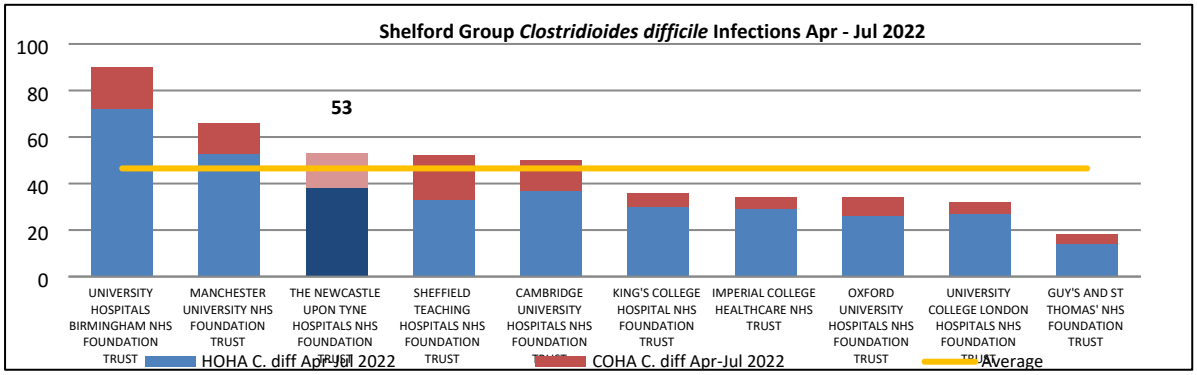


Table 4: CDI comparison data for Shelford group April – July 2022



IPC continue to work collaboratively with clinical teams and Antimicrobial Leads to ensure the CDI reduction strategies are continuously implemented with particular focus in surgery. Four of the Six C. *diff* toxins reported in surgery between April and June this year were classified as unavoidable. Outcome data helps prioritise initiatives which will help sustain improvements across HCAI.

1.2 MRSA / MSSA Bacteraemia

The Trust had no further MRSA bacteraemia to the end of August and at the time of reporting, the Trust has had no cases to report since the end of November 2022 (9 months). Newcastle remains the only Trust in the Shelford group that has had no Trust attributed MRSA bacteraemia in this financial year.

At the end of August, a total of 48 MSSA bacteraemia cases were attributed to the Trust (39 HOHA cases; 9 COHA cases). As indicated in Table 6, this places the Trust over our local trajectory by 10 cases (≤38 - no national threshold for MSSA).

Monthly trend graphs are included in the Integrated Board Report and performance against trajectories and Shelford benchmarking are included below for reference.

Table 5: Total MSSA Bacteraemia at NUTH September 2021 - August 2023

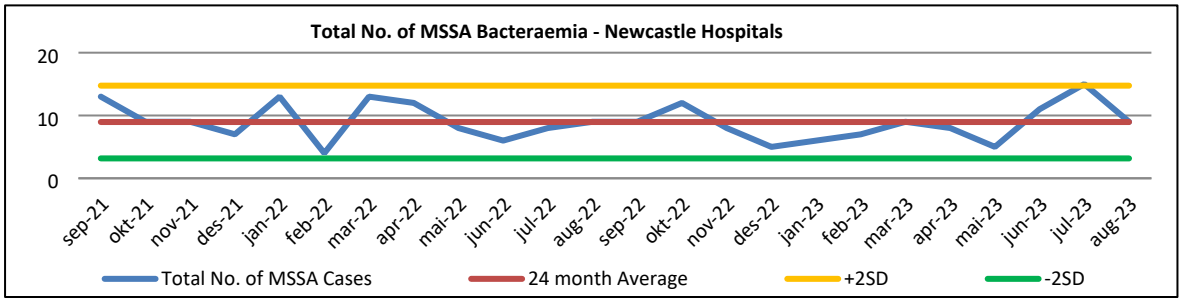


Table 6: MSSA cumulative comparison April 2022- end of March 2023 and April – June 2023

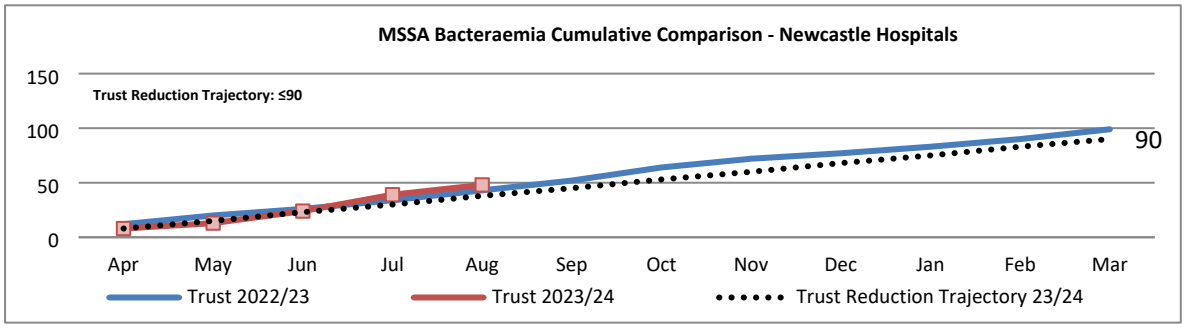
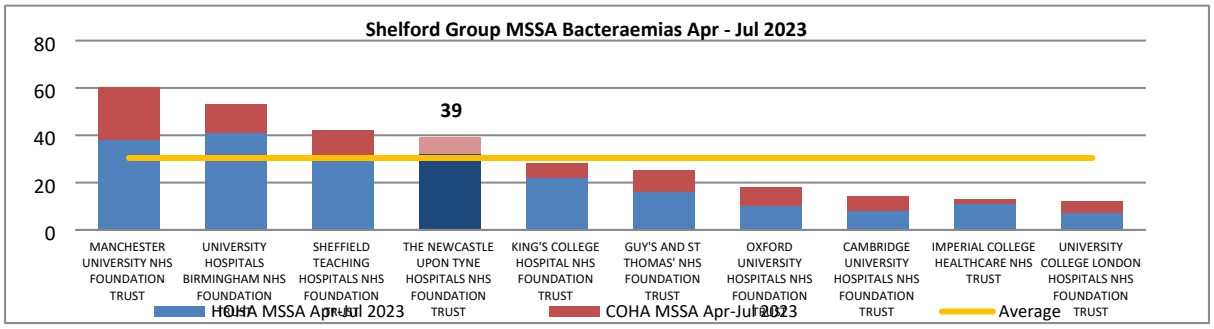


Table 7: Shelford group comparison for MSSA April – July 2023-(August's figures not yet finalised nationally)



The Trust Vascular Access Team continues to work collaboratively with IPC to target areas with high numbers of MSSA mainly focussing on vascular access management. Lessons learnt from post infection reviews are used to improve pathways in areas of concerns and disseminated across Clinical Boards.

A new electronic dashboard to support monitoring of line management is due to be launched by the end of the year. This dashboard will enable teams to work proactively with wards and departments, to monitor trends and improve gaps in line care management. The addition of ICNet systems in 2024 will further enhance surveillance systems.

1.3 Gram Negative Bacteraemia (*E. coli,* Klebsiella, Pseudomonas aeruginosa)

The Newcastle Hospitals Gram Negative Blood Stream infection (GNBSI) group continue to provide oversight across all aspects of GNBSI. Urosepsis and hepatobiliary /surgical infections continue to be the key sources of *E. coli*. Reduction strategies have been targeted to Catheter Associated Urinary Tract Infections (CAUTI) prevention. The bladder and bowel nurse specialist team are working alongside Clinical Boards to ensure appropriate use of

urinary catheters, which is a known source of urinary GNBSI. In addition, antimicrobial leads are working with Antimicrobial Stewardship Group (AMSG) leads auditing antimicrobial prescribing for complex surgical infections.

Table 8 compares GNBSI rates for the North East and North Cumbria ICB. As shown Newcastle have a higher annual threshold, and higher incidence given the complexity and the specialist nature of the Trust.

Table 8

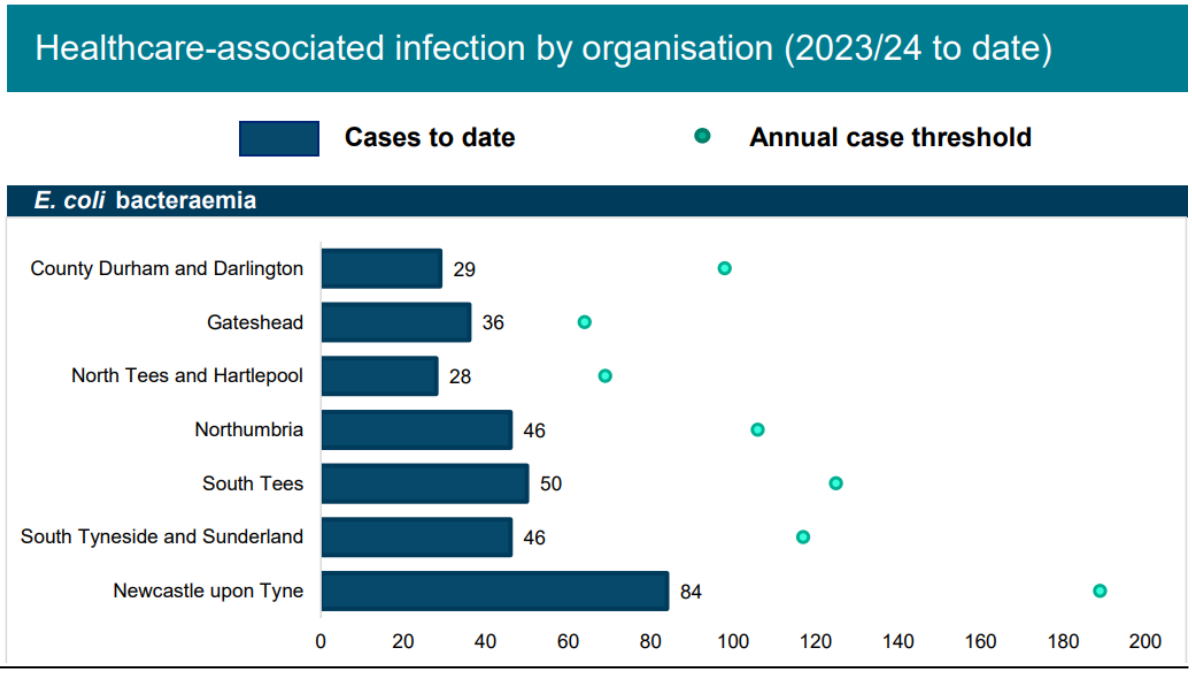


Table 9 compares GNBI rates against national thresholds. As illustrated, with the exception of Klebsiella, numbers exceed current national trajectory. Tables 10, 11 and 12 illustrate in graph format performance against trajectory.

Table 9: The table(s) below outlines the Trust figures up to the end of August 2023:

	E. coli	Klebsiella	Pseudomonas aeruginosa
Cumulative No. cases to end of August 2023	**114 cases**	**50 cases**	**21 cases**
National Threshold for August 2023	**≤79 Over by 35**	**≤55 Under by 5**	**≤15 Over by 6**

Table 10: Total *E. coli* bacteraemia April 2022 - end of March 2023 and April – June 2023

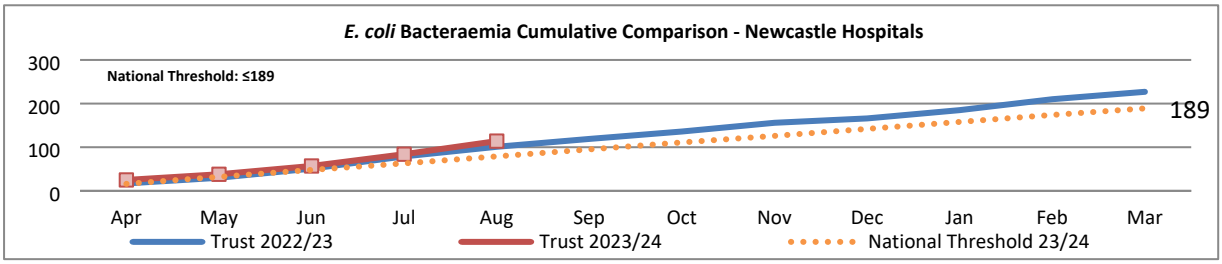


Table 11: Total Klebsiella bacteraemia April 2022 - end of March 2023 and April – June 2023

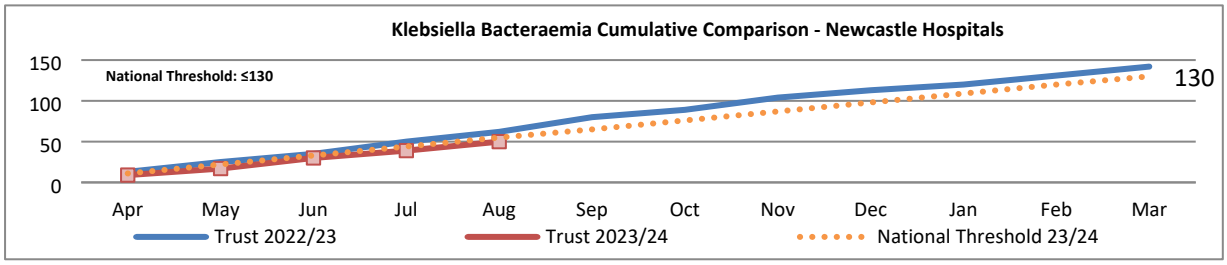
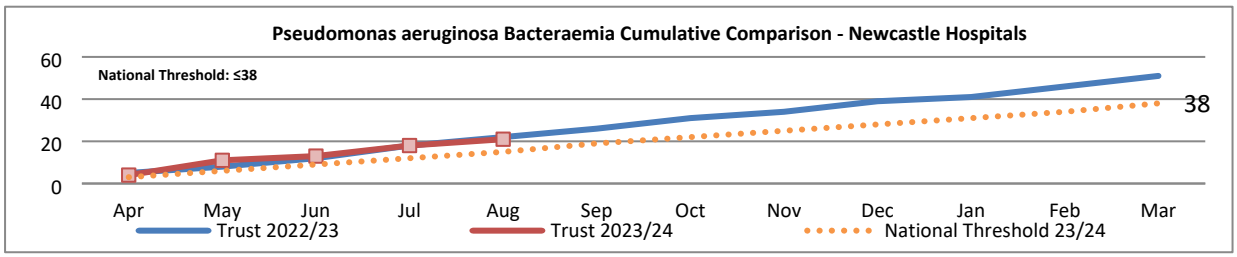


Table 12: Total Pseudomonas aeruginosa bacteraemia April 2022 - end of March 2023 and April – June 2023



1.4 Management of respiratory viruses including COVID-19

The increase in COVID- 19 admissions nationally correlates with the increase in COVID-19 admissions to the Trust. This has resulted in a number of outbreaks. The efficient management of these has resulted in minimal disruption to services.

1.5 Patient Safety Incident Response Framework (PSIRF)

In August 2023, NHS England wrote to all Trusts outlining the requirement to align IPC processes with those outlined in the PSIRF. PSIRF aligns to wider systems working that considers the complexity of clinical care pathways. This approach promotes systematic, compassionate and proportionate responses to patient safety incidents. Moving away from a linear 'one-size-fits-all' Root Cause Analysis (RCA) approach towards the use of a broader system-based learning response toolkit. This is to support organisations to use their incident response resources to maximise improvement rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited. The IPC Team are working towards full implementation by the end of 2023 and progress updates will be provided to the Trust Board in future reports.

1.6 IPC Board Assurance Framework (BAF)

A full quarterly review of the BAF will be undertaken at the end of quarter 2.

Progress continues to be made across the criterion. A review of Trust cleanliness standards processes has been undertaken and recommendations made to improve further multidisciplinary team working and address the gaps in relation to high level cleaning. This will improve overall assurance for the Trust to this standard.

The monitoring elements of IPC policies are being reviewed to ensure assurance systems are fully monitored.

1.7 Antimicrobial Stewardship (AMS)

The Severe Sepsis Guidance for Empirical Antibiotics for Adult patients presenting to the Emergency Department (ED) has been amended (considering real time bacteraemia resistance profiles) and has now been implemented after engagement with key stakeholders in the department. This will enable improved outcomes for severe sepsis in adult patients and help us achieve a reduction in Tazocin prescriptions.

Although the Trust is not taking on the IV to Oral switch CQUIN, the AMSG will carry out audits on appropriateness of intravenous antimicrobial prescribing. (Reference: Commissioning for Quality and Innovation (CQUIN): 2023/24 Guidance Version 1.1, 6 January 2023).

The two new antimicrobial pharmacists have been carrying out real time prescribing interventions since February this year leading to optimal prescribing and reduction in use of broad-spectrum agents. Other roles include detailed antibiotic audits in areas with high *C. Diff* rates and poor audit compliance. One such interventional audit completed for Vascular/HPB/Colorectal surgery has led to significant improvements in antibiotic prescribing in that area.

Clinical staff engagement with the Take 5 audit had increased to 50% in June but saw a reduction in participation in July. This is being addressed by the AMS team with the Antimicrobial and Governance Leads for each clinical board.

1.8 Water Ventilation and Decontamination

Respective strategic/safety groups continue to provide oversight and report by exception to IPCC.

2. RECOMMENDATIONS

The Board of Directors is asked to (i) receive the briefing, note and approve the content and (ii) comment accordingly.

Report of Maurya Cushlow
Executive Chief Nurse

Dr Julie Samuel
Director of Infection Prevention & Control (DIPC)

September 2023

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023						
Title	Shine (Sustainable Healthcare in Newcastle) Update						
Report of	Vicky McFarlane Reid, Executive Director for Business, Development & Enterprise (Exec Lead for Sustainability)						
Prepared by	James Dixon, Associate Director - Sustainability						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☒		☐		☒		
Summary	Climate breakdown is the greatest threat to health in the 21st century. Newcastle Hospitals declared a 'Climate Emergency' in June 2019 to highlight this threat and stimulate urgent action. The Trust adopted a leadership position in becoming the first healthcare organisation in the world to do so, joining our Newcastle civic partners in collaborative action. This paper updates the Board of Directors on work to deliver on the commitments contained in the Board approved Climate Emergency Strategy 2020-2025 (bit.ly/CEStrategy_NUTH) and presents the Annual Shine Report 2022-23 for consideration and approval to publish.						
Recommendation	The Board of Directors are recommended to receive the Annual Shine Report 2022-23 and approve publication.						
Links to Strategic Objectives	**Pioneering** – first healthcare organisation in the world to declare a Climate Emergency, ambitious aim for net zero by 2030 for our footprint and 2040 for our footprint plus **Performance** – continuing as leaders in healthcare environmental sustainability **People** – sustainable healthcare is a priority for our staff (99% rate it as important in our most recent survey)						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☐	☒	☒	☒	☐	☒	☒
Link to Board Assurance Framework [BAF]	**Board Assurance Framework Risk ID** - SO5.6: Climate Emergency (Rated 20) **Financial** – reducing carbon, by reducing energy and fuel use, saves on the bottom line however there is a significant need for spend-to-save investment in order to achieve our ambitious carbon reduction targets **Legal** – the Climate Change Act makes it a statutory requirement to decarbonise our services **Human Resources** – workforce inspired and empowered to deliver sustainable healthcare **Reputation** – positive partnership with other civic/regional/national leaders and recognition as pioneers of environmentally sustainable healthcare **Sustainability** – cement leadership position and deliver on lower carbon healthcare services						

Reports previously considered by	Annual report of progress towards aims and objectives in Trust Climate Emergency Strategy 2020-2025, covering the financial year 2022/23. This report was considered by the People Committee at their meeting in August 2023.

SHINE (SUSTAINABLE HEALTHCARE IN NEWCASTLE) UPDATE

EXECUTIVE SUMMARY

In 2019 Newcastle Hospitals became the first healthcare organisation in the world to publicly declare a climate emergency, committing to fast-tracking decarbonisation of our services a decade ahead of government targets. In October 2020 the Trust Climate Emergency Strategy was published (bit.ly/CEStrategy_NUTH) clearly setting out our vision, long-term goals and action plan for 2020-25.

This report presents an overview of current Sustainability governance arrangements and presents a full annual update on performance and achievements, across all Shine priority areas, for the financial year 2022/23 (in the form of our Annual Shine Report).

It also highlights significant risks to achieving the Trust sustainability targets at the halfway point of our Climate Emergency Strategy 2020-2025 (lack of dedicated capacity, lack of dedicated funding and significant increases in Trust energy costs from April 2024 onwards).

The Board of Directors are recommended to receive this update report for information and approve the publication of our Annual Shine Report 2022-23 (appended).

SHINE (SUSTAINABLE HEALTHCARE IN NEWCASTLE) UPDATE

1. BACKGROUND

In 2019 Newcastle Hospitals became the first healthcare organisation in the world to publicly declare a climate emergency, committing to fast-tracking decarbonisation of our services a decade ahead of government targets. In January 2020, in recognition of our commitment to this work, Dame Jackie Daniel was invited by Sir Simon Stevens to sit on the NHS Net Zero Expert Panel (the group of leading experts tasked with identifying how soon the NHS can get to net zero carbon, and how). This culminated in publication of the 'Delivering a Net Zero NHS' report in October 2020, making the NHS the first healthcare system in the world to commit to net zero carbon. Our own Climate Emergency Strategy was subsequently published on 22 October 2020 (bit.ly/CEStrategy_NUTH) clearly setting out our vision, long-term goals and action plan for 2020-25.

2. GOVERNANCE AND REPORTING

Arrangements for sustainability governance and reporting are outlined in the Climate Emergency Strategy (https://bit.ly/CEStrategy_NUTH - page 19). The Sustainable Healthcare Committee meets quarterly to monitor progress towards commitments in the strategy, with subsequent updates to People Committee six-monthly (previously quarterly). A comprehensive performance report, known as the Shine Report, is published annually and is signposted to from the Trust Annual Report. The Trust Flourish internet site includes a Shine page with links to these resources: https://www.flourishatnewcastlehospitals.co.uk/flourish-key-themes/sustainable-healthcare

2.1 Sustainable Healthcare Committee (SHC)

The SHC meets quarterly and is chaired by Dr Vicky McFarlane Reid, Director for Business, Development & Enterprise and Executive Lead for Sustainability. The committee aim is to drive forward action on climate emergency projects to achieve the Trust's Climate Emergency Strategy aims and to provide a forum for the discussion, review and over-arching management of sustainability across the Trust, on behalf of the Trust Board. Summary updates from each sub-group are presented to SHC and incorporated into performance reports.

2.2 Executive Oversight Group (EOG) for Climate Emergency

The EOG meets monthly and is also chaired by Dr Vicky McFarlane Reid. It aims to provide Executive oversight on the strategic direction and actions to deliver on the Trust's climate emergency priorities, to facilitate swift decision making to empower workstream leads into taking actions. Projects that have directly benefited from this swift governance include: the ban on diesel for all fleet, hire and lease vehicles; the Shine Rewards app; government funding for heat decarbonisation plans and agreement to limit personal salary sacrifice vehicles to Ultra-low & Zero Emission Vehicles only.

2.3 Newcastle City Net Zero Governance

Newcastle City Council's Climate Change Committee and Net Zero Taskforce have not met since 2021. Net Zero is one of three priority areas for Collaborative Newcastle, but governance and reporting arrangements have been at a hiatus since the change in council leadership. Informal collaboration continues productively, with the city heat network project a highlight.

3. FULL ANNUAL UPDATE ON PROGRESS (SHINE REPORT 2022-23)

A comprehensive update on progress towards the targets and actions in our Climate Emergency Strategy is produced in our Annual Shine Reports. The attached document '***Shine Report 2022-23_Final Draft_v9***' is presented to Trust Board of Directors for consideration and approval for publication, having been recommended for release by People Committee on 22 August 2023.

4. RISKS

There is a Board Assurance Framework risk entry for Climate Emergency (Ref SO5.6: Rated 20) which highlights that the Trust is currently overshooting our carbon budget and are not on track to achieve our Net Zero by 2030 target (for the emissions we control). This risk is dominated by the challenges in decarbonising our hospital heat and power, the lack of national funding to support this and capital allocation constraints. In mitigation of this risk the Executive Team have authorised the recruitment of additional Net Zero Engineering capacity within Estates (though repeated rounds of recruitment have so far failed to recruit to this team).

Additional risks that hinder progress towards achieving the goals and targets within the Trust Climate Emergency Strategy include:

- **Lack of Dedicated Capacity** – both within the Sustainability department (funded for 6.5 whole-time-equivalents (WTE) though with 2.0 WTE, soon to be 3.0 WTE, vacancies) and within key stakeholder departments i.e. Procurement, Pharmacy and Clinical Boards. Whilst charitable funding has provided much-welcomed temporary capacity in the form of Clinical Sustainability Fellows, further capacity is needed to deliver the transformational change required to achieve our strategic goals.

- **Lack of Dedicated Finance** – there is no operational budget for the Sustainability department or for Climate Emergency Strategy programme delivery. Successes and achievements to date have been delivered through non-recurrent pay underspend, regional Greener NHS funding or successful bids to Newcastle Hospital charities – this is not sustainable and will not lead to the transformational change required to achieve our strategic goals. In addition to this, there is no ring-fenced capital funding allocated to estates decarbonisation projects in the Trust Capital Plan (unlike peer organisations Newcastle University and Cumbria, Northumberland, Tyne and Wear (CNTW) NHS Foundation Trust who have £15m and £1.5m per year, respectively, allocated to this).

- **Significant Increases in Energy Costs Incoming** – from 1 April 2024 the Trust will be exposed to a significant increase in the revenue costs of energy for our sites. Currently this costs the Trust £16m each year and our forward procurement strategy has protected us from recent market volatility. However, current estimates put our 2024/25 revenue costs for energy at £32-£36m (a cost pressure of £16-£20m). Investing in energy demand reduction projects now will reduce the impact of this cost pressure whilst also reducing carbon emissions.

5. RECOMMENDATIONS

The Board of Directors is recommended to:

i) receive this report for information, noting the progress to date and the highlighted risks,
ii) approve the publication of the Trust's Annual Shine Report 2022-23.

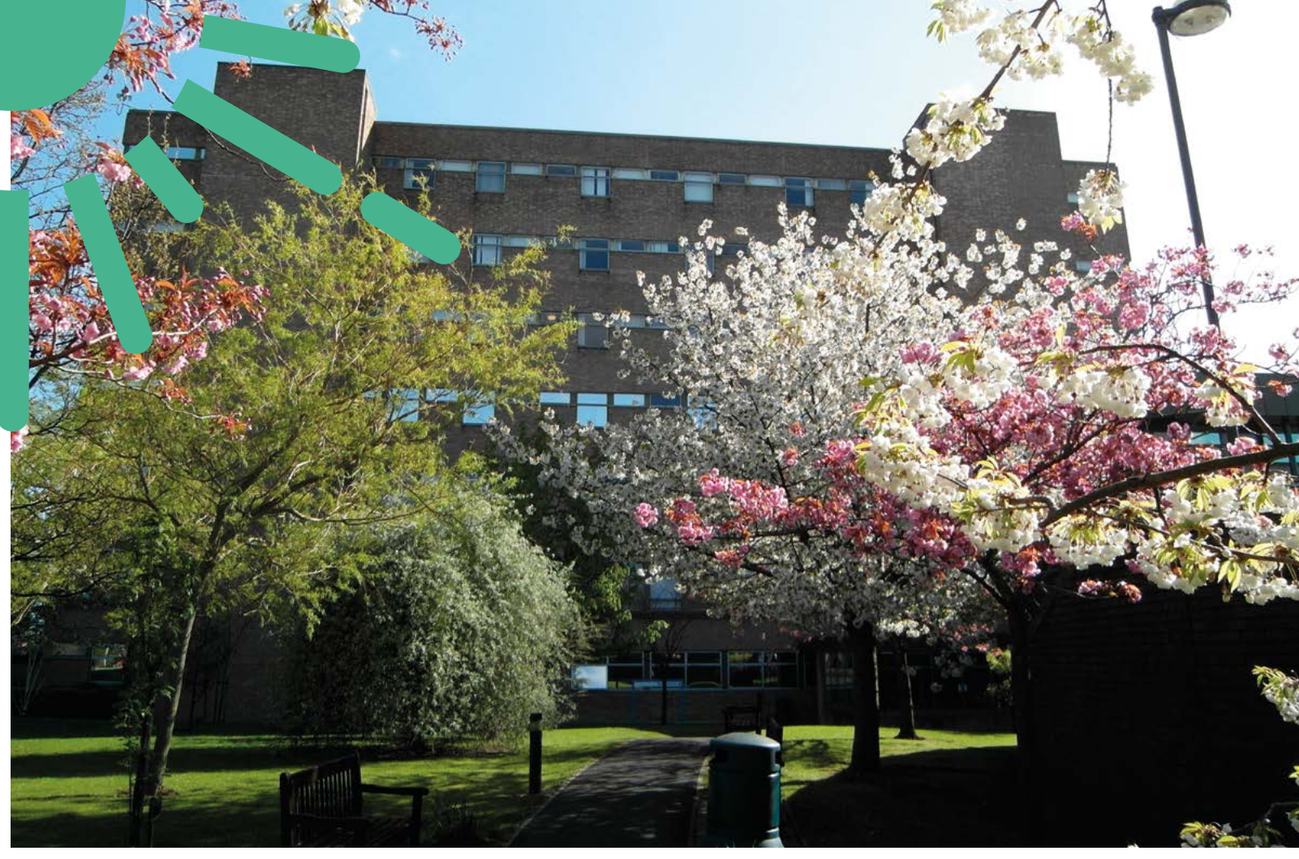
Report of James Dixon, Associate Director - Sustainability
15 September 2023


NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust
Shine
Sustainable Healthcare in Newcastle
Towards Net Zero
Sustainable Healthcare in Newcastle (Shine) Annual Report 2022-23

Contents

1. Foreword

Last year's Shine Report was titled the 'Red Flag Report', because despite many staff-led improvements, we continued to see our carbon footprint at Newcastle Hospitals increase. This year, we are still very worried about the speed of change BUT there are reasons to be hopeful.



I'm pleased to confirm that we have reduced our controllable carbon emissions and we are hopeful that last year's increase, fuelled by our pandemic response, will have been our peak for those emissions.

In this year's report we want to paint a different picture and think about a very different vision for 2040.

If we are successful in achieving our vision, when you walk around Newcastle Hospitals in 2040 you will be in a modern and efficient health service, delivered at hospital sites which are powered by clean technologies. We will have transitioned our existing estate away from old-fashioned, expensive, and unhealthy fossil fuels, and our new buildings will have been cleverly designed with planetary health as a priority – delivering **ZERO CARBON CARE**.

But the most remarkable change of all is that in this version of 2040 ill health associated with air pollution, currently the fourth largest killer in the UK, has reduced

Internal spaces will be comfortable, light and airy. Externally these buildings will be surrounded by flourishing, biodiverse green spaces which are accessible to patients, visitors, staff and the local community.

In these spaces nature will be allowed to thrive, patients' recovery will be enhanced, visitors will be able to take a moment for themselves, and staff will rest and replenish their energy reserves.

As we deliver our services in this version of the future, we always champion re-use over single-use and carefully consider the earth's resources – achieving our goal of **ZERO WASTE**.

People will naturally work with planetary health, as well as patient health, in mind. Care pathways are thought through to conserve resources in a more 'circular' economy supported by efficient digital healthcare which benefits patient and planet. Our policies and procedures across the organisation support everyone to effortlessly do the right thing. Nourishing, healthy, low-carbon food is provided as standard.

By 2040, NHS suppliers have had 10 years experience of demonstrating their progress to Net Zero, aligned with Greener NHS targets. Here at Newcastle Hospitals, our suppliers have led the way by aligning their carbon reduction plans five years ahead of the NHS target. Now we are confident that the money we spend on critical supplies and services goes to organisations that have demonstrated significant reductions in their greenhouse gas emissions.

As our wider society has also continued its transition to Net Zero, more people are making their journeys to us using public transport, cycling and walking. The use of cycling and zero tailpipe emission vehicles for the delivery of our care services has completely replaced the use of polluting fossil fuel vehicles. Children can't believe the stories they hear from grown-ups about how our neighbourhoods and streets were previously dominated by life-limiting 'pollution cars'.

If we are successful in achieving our vision, when you walk around Newcastle Hospitals in 2040 you will be in a modern and efficient health service, delivered at hospital sites which are powered by clean technologies

This, along with the fact that all deliveries to our sites can only be made by zero emission vehicles, has resulted in **CLEAN AIR** and a healthier environment for anyone accessing our facilities, or living or working locally.

But the most remarkable change of all is that in this version of 2040 ill health associated with air pollution, currently the fourth largest killer in the UK, has reduced. Impacting positively on the most vulnerable members of society – including children and older people.

If we dare to extend our vision even further and imagine a world that has achieved this extraordinary feat, we will be able to see a planet which has avoided the worst effects of climate breakdown and adapted well to the unavoidable changes in our climate. This means a healthier global population, a reduced risk of pandemics, famine and drought, and a reduced risk of displacement from conflict related to resource scarcity, or areas becoming uninhabitable due to sea level rises and desertification.

We have a set of shared values here at Newcastle, and I have taken a moment to expand on each of these:

We care and are kind – to our people and planet

We have high standards – and sustainability is critical to delivering high quality care

We are inclusive – everyone plays a role

We are innovative – in our approach to achieving net zero carbon, clean air and zero waste

We are proud – of the position we have taken on the climate and health emergency

Of course, here in 2023 this is simply a vision, but a vision I'm certain we can all get behind. We are on the first steps of the journey towards Net Zero and it is going to be a challenging journey. If we work together and act now, I truly believe we can make this a reality.

Dame Jackie Daniel
Chief Executive

2. Introduction

As a result of the findings in last year's Red Flag Report a mandate was given to the Executive Oversight Group (EOG) for Climate Emergency to address these concerns with renewed urgency.

As Chair of that group, and Executive Lead for Climate Emergency I am grateful to the many stakeholders that provided input to that report. A number of key themes were identified, and these requirements, we believe, are so important that without addressing them it will be impossible for us to reach Net Zero and stay within our carbon budget.

1. Dedicated resource to drive urgent change
2. Sustainability considerations in all decision making
3. Significantly increased investment in estate decarbonisation
4. Leadership to signal that action on the Climate Emergency is a Trust priority
5. Action to eliminate waste and wastefulness of resources – moving towards zero waste

These priorities have allowed the EOG to focus attention on the key areas which will drive the transformation of the organisation towards Net Zero, and I am pleased to be able to tell you about some progress we have made.

Within Estates there is an exciting plan to recruit a dedicated Net Zero Engineering team, who will be able to drive the transition from fossil fuels to renewable energy. There are also two Clinical Sustainability Fellows which have been appointed through the Newcastle Hospitals Charity who have been making exciting changes happen in their areas of expertise.

We have titled this year's report 'Towards Net Zero' as we aim to set out our journey to Net Zero, and present you with the potential interventions that we believe could get us to that goal

In order to integrate sustainability into decision making a Climate Emergency Charter is being drafted, and a 10-step framework for Departments and Directorates has been rolled out to early adopters.

Aligned to that, and to help demonstrate commitment to sustainability at a leadership level there are plans to present at the Board Development Day in partnership with IEMA (Institute for Environmental Management and Assessment) to ensure responsibilities at Director level are well understood. There have also been regular inclusions in Dame Jackie's blog and other Trust-wide communications throughout the year.

As well as the above some really exciting partnership working has been developing with NHS Supply Chain to begin to address common issues and start working towards operating a more circular economy approach to resources.

There is still lots of progress to be made and in some areas, such as the need to significantly increase investment in estate decarbonisation, we have not been able to make much progress. However we were excited to find out we had been successful in our application for the Public Sector Decarbonisation Scheme to transition away from fossil fuels at our Regent Point office site.

We still consider the five priorities to be the key areas for action, and we recently highlighted the lack of dedicated capacity, and lack of dedicated finance as risks to achieving the goals and targets of the Climate Emergency Strategy to our People Committee[1].

Despite these ups and downs, and against a turbulent backdrop of many challenges the NHS is currently facing, we are encouraged by being to be able to report a small reduction in the carbon footprint related to the emissions within our direct control.

We have titled this year's report 'Towards Net Zero' as we aim to set out our journey to Net Zero, and present you with the potential interventions that we believe could get us to that goal.

In order to integrate sustainability into decision making a Climate Emergency Charter is being drafted, and a 10-step framework for Departments and Directorates has been rolled out to early adopters

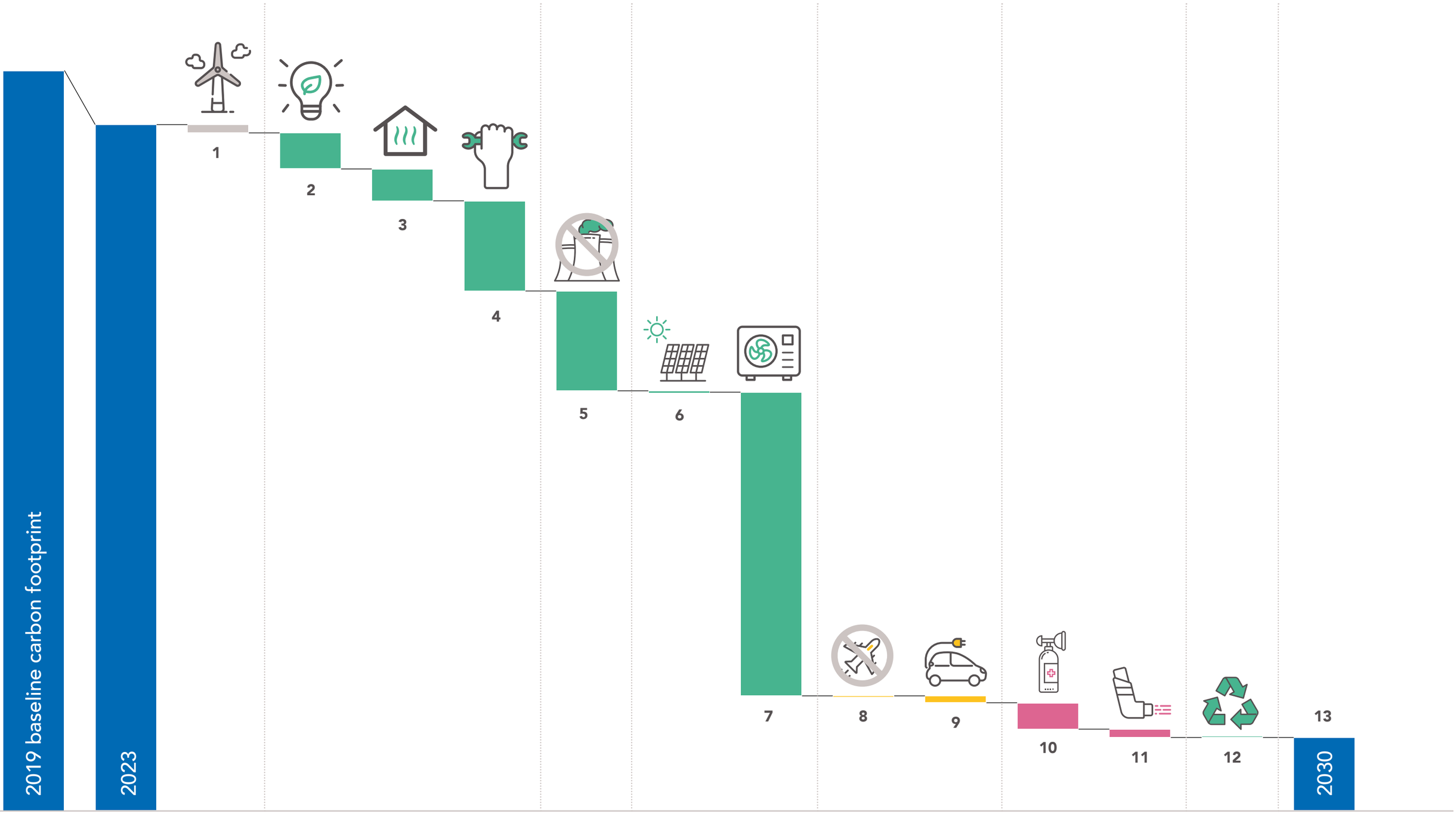
As well as the overall picture of performance, the report will highlight achievements made this year in each of the key themes, as well as our plans for next year.

Throughout the report we will direct you to more information being held online, at our web pages https://www.flourishatnewcastlehospitals.co.uk/flourish-key-themes/sustainable-healthcare/ where you will find detailed case studies and more detailed information on the progress that has been made in key areas over the year.

Victoria McFarlane Reid
Executive Director Lead
for Sustainability

[1] People Committee - feeds directly into the Trust Board and sits above the Sustainable Healthcare Committee in the governance hierarchy.

What could the journey to Net Zero by 2030, for our controllable emissions, look like?



Explaining our journey to Net Zero

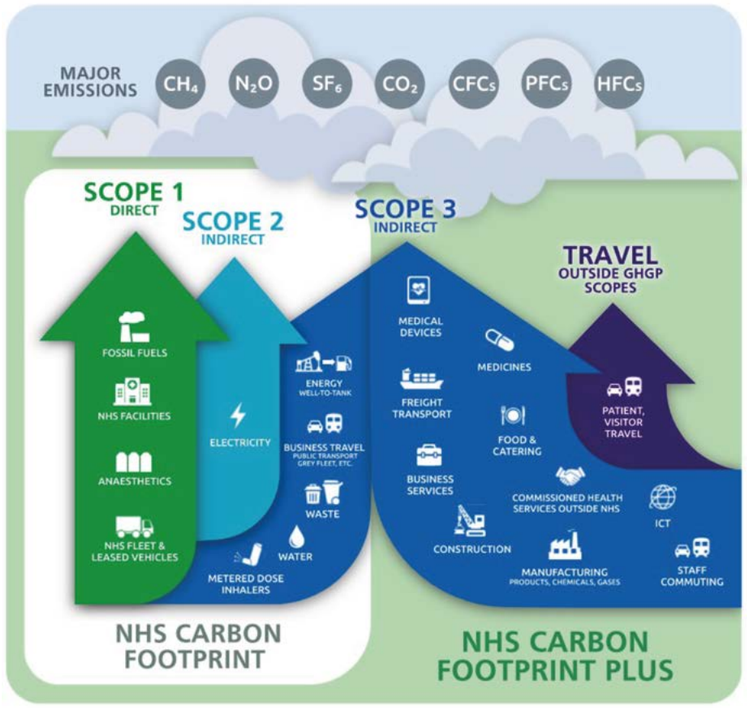
1		The continuing decarbonisation of grid electricity
2		Improvements to lighting and controls, including LED lighting and improvements to the building management system (BMS)
3		Upgrades to building fabric to improve energy efficiency, for example insulation and improved glazing
4		Engineering upgrades, for example upgrades to air handling units to increase energy optimisation
5		Disconnect Combined Heat and Power (CHP) and switch to grid electricity and/or zero carbon power purchase agreements
6		Install solar photovoltaic panels (PV) on available roof space and car park car ports
7		Install heat pumps and link in with city low carbon district heat network
8		Eliminate unnecessary travel by air e.g. flights within the UK
9		Replace petrol and diesel vehicles used in delivery of care with zero tailpipe emission vehicles e.g. through electric pool cars and bikes
10		Transition to lower carbon anaesthetics, eliminate desflurane and increase the use of anaesthetic gas capture and destruction technology
11		Transition to lower carbon Dry Powder Inhalers (DPI) and optimise inhaler use
12		Continue to improve waste management to decrease the amount of waste incirenated at high temperatures
13		For us to achieve Net Zero Carbon we must reduce our carbon emissions to a maximum of 10% of the 2019 baseline. We anticipate that this remaining 10% will be from the following sources in order of significance: building energy, inhalers, anaesthetic gases, rail and flights, refrigerant gases, and waste

3. Explaining Our Goals

In 2019 we were the first healthcare organisation in the world to declare a climate and health emergency and in 2020 we published our Climate Emergency Strategy for 2020-2025. The strategy is available on the Trust website (bit.ly/CEStrategy_NUTH) and sets out the plans we've developed, across all eight Shine themes, towards three long term goals.

Three years on from the publication of that strategy we are now in a position to be able to add clarity to those statements and explain in more detail exactly what we intend to achieve by 2030, and 2040.

We are mirroring the Greener NHS definitions of 'carbon footprint' and 'carbon footprint plus' which were published in their Delivering a Net Zero NHS Strategy. The sources of carbon included under those definitions are shown in the diagram. In addition, we have also continued to calculate and present our carbon performance in line with the global best practice framework of the Greenhouse Gas Protocol.



1. Zero Carbon Care

• By 2030 the emissions we control will be net zero – our 'Newcastle Hospitals Carbon Footprint'[2]	This means we will reduce the controllable carbon emissions caused by the delivery of our service as much as possible, and offset the remainder – which will be a maximum of 10% against a 2019 baseline year We are also committed to staying within our total carbon budget – see opposite.
• By 2040 the emissions we can influence will be net zero – our 'Newcastle Hospitals Carbon Footprint Plus'[3]	This means we will reduce the influenceable carbon emissions associated with the delivery of our service as much as possible, and offset the remainder – which will be a maximum of 10% against a 2019 baseline year. This includes the requirement for all suppliers to have also reached Net Zero for their organisational performance by 2040.

2. Clean Air

• By 2030 our operational transport activities generate no harmful air pollution	This means that 100% of the transport directly related to our activities will be completed by zero tailpipe emissions modes of travel.
• By 2040 our healthcare facilities are accessed by only zero emission travel	This means that, with the exception of the helicopter, only zero emission modes of travel will be able to access our healthcare facilities.

3. Zero Waste

• By 2030 we will reuse and repair everything that can be reused and repaired	This means that we will maximise the use of all existing re-use and repair routes and where possible increase the capacity of these to meet service demands. Simultaneously we will transition away from single-use where credible alternatives exist.
• By 2040 we will produce no waste. We will manage resources within the circular economy, with items surplus to requirements becoming a resource in another part of the system	This means that we will focus on waste prevention measures and increase to 100% the amount of waste that is either reused, recycled or, as a last resort, sent to an energy from waste facility. No waste will be sent to landfill or incineration without energy recovery.[4]

[2] As per definition of NHS Carbon Footprint published in Delivering a Net Zero NHS Strategy.
[3] As per definition of NHS Carbon Footprint Plus published in Delivering a Net Zero NHS Strategy.
[4] Current legislation requires certain waste types (such as cytotoxic and anatomical waste) to be treated in permitted facilities which do not have energy recovery.

Why have we set these goals?

Climate change is the greatest global health threat facing the world in the 21st century. Scientists agree that global warming should be capped at 1.5°C – a threshold which has been set to avoid the worst impacts of climate change[5].

It is now more likely than not that the world will overshoot this global temperature increase at least once by 2027[6].

Dr Chris Jones a Met Office climate science fellow and a lead author of IPCC's AR6 synthesis report[7] said:

"We know that climate change is already happening, and the world has already witnessed extreme events associated with the relatively modest warming we have seen so far. In fact, the world now is the coolest it is going to be, at least for many decades."

Prof. Petteri Taalas, the secretary general of the World Meteorological Organization (WMO), said:

"This report does not mean that we will permanently exceed the 1.5°C specified in the Paris agreement, which refers to long-term warming over many years. However, WMO is sounding the alarm that we will breach the 1.5°C level on a temporary basis with increasing frequency."

It is still possible to meet the goal of keeping global warming under 1.5°C and our goals are designed with this in mind.

In our Climate Emergency Strategy we stated that we have incorporated the principle of carbon budgets into our plans, calculating a limit on how much carbon dioxide we can emit over the rest of the century, with the emphasis on immediate action.

Climate change is the greatest global health threat facing the world in the 21st century

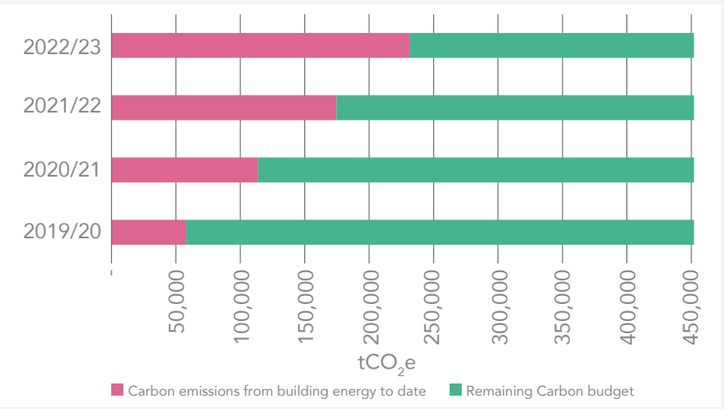
HOW MUCH OF OUR CARBON BUDGET HAVE WE USED?

The Tyndall Centre for Climate Change Research uses the principles of science and equity that are aligned with the commitments in the United Nations Paris Agreement to set budgets at national and sub-national levels, providing local authorities with recommendations that translate the 'well below 2°C and pursuing 1.5°C' global temperature target.

We took that method and applied it at our organisational level for Newcastle Hospitals to calculate our own carbon budget – giving us the absolute total amount of carbon dioxide we can emit – 450,000 tCO_2e.

As has been reported previously, we have not achieved a sufficient reduction for the last two years. This means the level of action required to stay within the carbon budget is now even greater, otherwise we are at risk of exceeding our total budget.

We have already emitted 231,450 tCO_2e out of our total carbon budget for building energy. If we continue at the current rate we will exceed the budget in under 4 years.



[5] Intergovernmental Panel on Climate Change (IPCC)'s Special Report – Global Warming of 1.5°C https://www.ipcc.ch/sr15/chapter/spm/
[6] https://public.wmo.int/en/media/press-release/global-temperatures-set-reach-new-records-next-five-years
[7] Intergovernmental Panel on Climate Change (IPCC)'s AR6 Synthesis Report - https://www.ipcc.ch/report/sixth-assessment-report-cycle/

4. Overall Performance

In our Climate Emergency Strategy we set out three long term goals, and the actions we planned to take by 2025 for the eight Shine themes.

This is an overall summary of how we are progressing towards those goals, and the published actions. More detailed progress reports are included for each area later in this report, and regular progress reports are published on https://www.flourishatnewcastlehospitals.co.uk/flourish-key-themes/sustainable-healthcare/ throughout the year.

KEY

Red
Not on track and at serious risk of not being achieved

Amber
Not on track but still achievable by 2030

Green
On track to be achieved by 2030

GOAL	RAG RATING	DESCRIPTION
Zero Carbon Care		By 2030 the emissions we control will be net zero – our 'Newcastle Hospitals Carbon Footprint'
Clean Air		By 2030 our operational transport activities generate no harmful air pollution
Zero Waste		By 2030 we will reuse and repair everything that can be reused and repaired

SHINE THEME	RAG RATING	Actions published in our Climate Emergency Strategy to be achieved by 2025
Energy & Water		• Improve energy, water and carbon data availability, analysis and reporting • Assess our buildings, and supporting infrastructure, for opportunities to increase energy and water efficiency • Increase investment in energy decarbonisation and water efficiency projects, seeking funding from a variety of internal and external sources • Strategically review how low and zero carbon energy sources can replace our existing fossil fuel energy infrastructure and start implementing priority phases of work • Increase energy and water awareness and carbon literacy of staff • Collaborate with delivery partners and anchor institutions across the city to accelerate energy decarbonisation • Develop and maintain supporting management systems, with strong governance for ongoing energy decarbonisation • Research and investigate innovative carbon offsetting, or insetting, options for our residual carbon emissions
Buildings & Land		• Achieve Passivhaus Standard and BREEAM Outstanding for the two new hosptial buildings proposed for the RVI site • Deliver sustainability training for our Capital Projects staff to enhance sustainability knowledge and carbon literacy • Develop a sustainability policy and design criteria for new builds and refurbishments • Produce a biodiversity action plan for our whole estate, maximising opportuntities for green space creation and enhancing the biodiversity of existing green space • Create an edible wellbeing garden at Freeman Hospital for staff and patients • Collaborate with local experts to establish a biodiversy metric to track progress • Include the need for climate change adaptation and resilience in planning our green spaces • Support green social prescribing, Trust Green Gym and green space expansion via 'Nature Connect - Newcastle Hospitals'
Procurement		• Proactively engage with suppliers to support their transition to decarbonised services • Standardise sustainability criteria for suppliers • Introduce a requirement within contracts for key suppliers to commit to take action on the climate emergency • Increase carbon literacy and sustainable procurement awareness in our Procurement Team • Collaborate and engage with industry, research centres of excellence and other key partners to develop solutions for low carbon services • Collaborate with external experts to improve the accuracy of our supply chain carbon emissions data and focus action on carbon hotspots • Achieve Silver Food for Life Award for our in-house catering services

SHINE THEME	RAG RATING	Actions published in our Climate Emergency Strategy to be achieved by 2025
Models of Care		• Collaborate and engage with industry, research centres of excellence and other key partners to lower the carbon of our care pathways • Trial use of innovative technologies to capture and destroy environmentally damaging anaesthetic gases • Bring together expertise externally and internally to understand and reduce the impact of inhalers on our carbon footprint • Embed sustainability (SusQI) within our Improvement Faculty processes • Develop and implement training, tools and resources to enable clinicians to improve the sustainability of their models of care • Work with service leads and Business Continuity colleagues to ensure our patients continue to receive outstanding care in the face of a changing climate • Ensure business development and investment decisions undertake a formal Sustainability Impact Appraisal (SIA)
People		• Include climate emergency and Shine references in job descriptions, recruitment adverts and professional leadership behaviours • Review Trust policies for their sustainability impact and compatibility with the climate emergency • Carry out a programme of Climate Emergency engagement and communications • Deliver sustainability training to all new starters at induction • Deliver an advanced training programme for Sustainability Ambassadors • Launch a Shine Rewards scheme to encourage sustainable staff behaviours • Launch a Climate Emergency Action Fund to help kick start staff sustainability projects • Engage with local, regional and national networks to learn, share and extend climate emergency action beyond our boundaries
Journeys		• Become a Clean Air Hospital - rated Excellent on the Clean Air Hospital Framework by 2025 • Continue to expand our fleet of electric vehicles and bicycles whilst increasing access to electric charging points • Work with our business and staff lease car provider to ensure only low and zero emission vehicles are available for our staff • Work with our civic partners to reduce the imapct of vehicular traffic on our air quality, promoting active travel and the use of public transport to achieve this • Seek to establish an off-site consolidation centre, coupled with zero emission deliveries, to reduce the need for fossil-fuelled vehicle deliveries to our sites • Increase access to the Trust's cycle-to-work scheme and discounted public transport passes • Improve facilities to encourage more staff to actively travel to work • Provide information to patients and visitors on active and sustainable travel options available to those accessing our sites • Continue to lead on the digital healthcare transition through our Digital Exemplar Strategy, positively transforming our delivery of care

SHINE THEME	RAG RATING	Actions published in our Climate Emergency Strategy to be achieved by 2025
Waste		• Deliver waste reduction projects focusing on single-use plastics, food and consumables with the aim of a 20% reduction in these waste categories • Rollout a Trustwide furniture and equipment reuse system • Develop the metrics required to report on existing cleaning, repairing, reusing and refurbihsment systems • Explore and implement further repair and reuse initiatives • Expand our food waste recycling segregation across our hospital sites • Investigate and implement innovative treatment solutions for our clinical and non-clinical waste

4.1 Carbon Footprint

This year we are encouraged to be able to report a small decrease in our Newcastle Hospitals carbon footprint. There has been a 7% reduction in the carbon footprint compared to both the previous year, and the baseline year.

This is mainly due to reductions in energy consumption, and changes to anaesthetic gas use, including banning the use of desflurane in almost all cases, and the introduction of new technology to capture and destroy Entonox. These interventions are explained further later in the report.

Category	Sub-category	Total tCO_2e				% change from previous year	% change from baseline year
		2019-20	2020-21	2021-22	2022-23		
Newcastle Hospitals carbon footprint	**Scope 1**						
	Building energy – fossil fuels	54,858	53,901	55,626	52,742	-5	-4
	Refrigerant gases	477	246	246	246	0	-48
	Anaesthetic gases	4,336	3,345	3,360	2,381	-29	-45
	Trust fleet	112	42	25	12	-52	-89
	Scope 2						
	Building energy - purchased electricity[4]	4,933	4,924	6,394	4,943	-23	0
	Scope 3						
	Water	441	454	229	204	-11	-54
	Waste	105	99	113	518	359	396
	Inhalers	1,399	903	1,331	1,341	1	-4
	Business Travel	1,278	724	657	1,015	54	-21
Newcastle Hospitals Carbon Footprint Total		**67,939**	**64,638**	**67,980**	**63,401**	**-7**	**-7**
Medicines, medical equipment and other supply chain	Medicines and chemicals	67,952	75,126	108,614	73,272	-33	8
	Other supply chain	39,094	56,380	51,466	42,158	-18	8
	Medical equipment	42,415	39,204	44,526	40,577	-9	-4
	Procurement total	**149,462**	**170,710**	**204,606**	**156,007**	**-24**	**4**
Personal travel	Staff commute	14,863	13,089	10,338	11,601	12	-22
	Outside GHGP scope						
	Patient and visitor travel	24,127	16,520	22,264	19,231	-14	-20
Newcastle Hospitals Carbon Footprint Plus Total		**256,391**	**264,957**	**305,189**	**250,230**	**-18**	**-2**
Patient numbers		1,788,469	14,432,307	1,837,107	1,819,965	28	2
Carbon intensity (tCO_2e per patient contact)		**0.143**	**0.185**	**0.166**	**0.137**	-10	-4

Table 1: Breakdown of Total Newcastle Hospitals Carbon Footprint

[4] Current legislation requires certain waste types (such as cytotoxic and anatomical waste) to be treated in permitted facilities which do not have energy recovery.

NEWCASTLE HOSPITALS CARBON FOOTPRINT

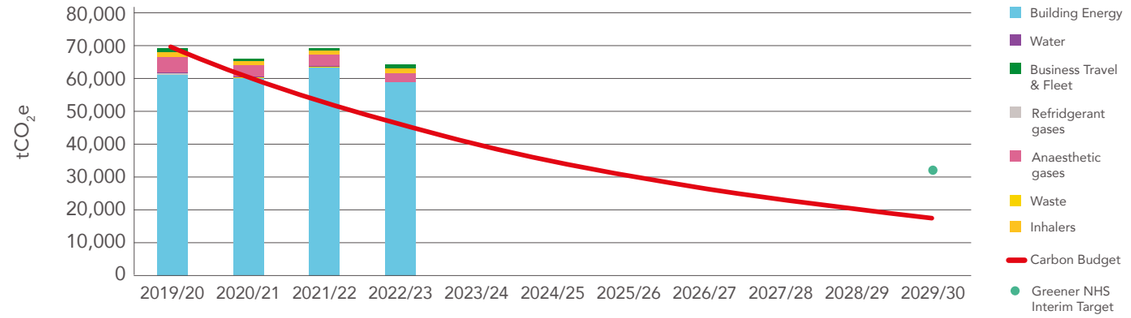


Figure 1: Newcastle Hospitals Carbon Footprint

NEWCASTLE HOSPITALS CARBON FOOTPRINT PLUS

We are also able to report a small decrease in the carbon footprint plus.

Although we are adopting a new methodology to calculate and report the carbon emissions related to the products and services we buy, at this point the majority of the carbon footprint is still calculated using a spend-based methodology. Therefore the reduction in carbon footprint is mainly due to a reduction in expenditure this year.

We have also used inflation adjusted carbon factors this year, and re-calculated each year back to our baseline to present a more accurate picture. Click here for further detail.

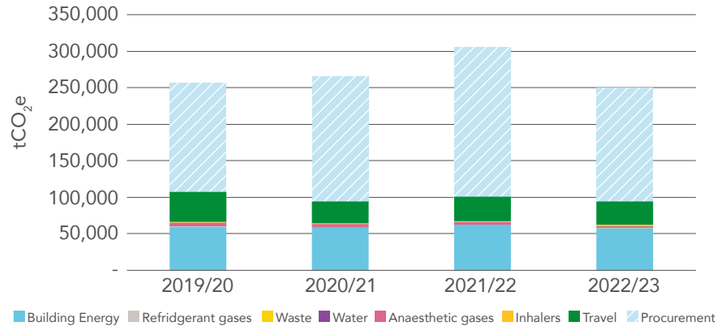
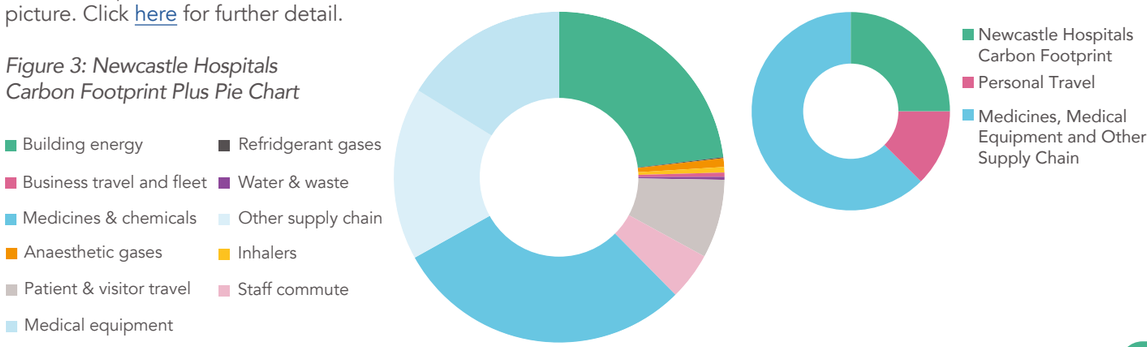


Figure 2: Newcastle Hospitals Carbon Footprint Plus

Figure 3: Newcastle Hospitals Carbon Footprint Plus Pie Chart



4.2 Red Flag Register

As a result of the findings in last year's Red Flag Report a red flag register was compiled, which identified several key themes we believe must be addressed in order for us to progress towards Net Zero and most importantly remain within our carbon budget.

As we anticipate another extremely challenging year ahead for the NHS and Newcastle Hospitals, we remain focused on the red flags as the key to unlocking transformational change.

1. DEDICATED RESOURCE TO DRIVE URGENT CHANGE

Achievements

Recruitment has begun for a dedicated Net Zero Engineering team to drive the decarbonisation of the estate.

Focus for 2023-24

Onboarding the Net Zero Engineering team will be a main focus of the rest of 2023, as well as prioritising a detailed estates decarbonisation pathway and applying for funding to deliver schemes.

2. SUSTAINABILITY CONSIDERATIONS IN ALL DECISION MAKING

Achievements

Sustainability is built into Business Development & Investment proposal assessment, and procurement processes.

Focus for 2023-24

We will work to embed sustainability into emerging clinical boards through the Shine 10-step framework.

A Board approved Climate Charter will be developed which will highlight major policy commitments to a wide audience.

3. SIGNIFICANTLY INCREASE INVESTMENT IN ESTATE DECARBONISATION

Achievements

Awarded Public Sector Decarbonisation Scheme funding to decarbonise Regent Point.

Focus for 2023-24

As already outlined a Net Zero Engineering team is being recruited into Estates. Begin to deliver decarbonisation work at Regent Point, which includes air source heat pumps.

As we anticipate another extremely challenging year ahead for the NHS and Newcastle Hospitals, we remain focused on the red flags as the key to unlocking transformational change

4. LEADERSHIP TO SIGNAL THAT ACTION ON THE CLIMATE EMERGENCY IS A TRUST PRIORITY

Achievements

We secured executive level approval for investment in a Net Zero Engineering team despite significant financial pressures.

There is regular reference to sustainability in Trust communications and Dame Jackie's blog.

Focus for 2023-24

Deliver Board Development training supported by IEMA (Institute for Environmental Management and Assessment) using an IEMA guidance note.

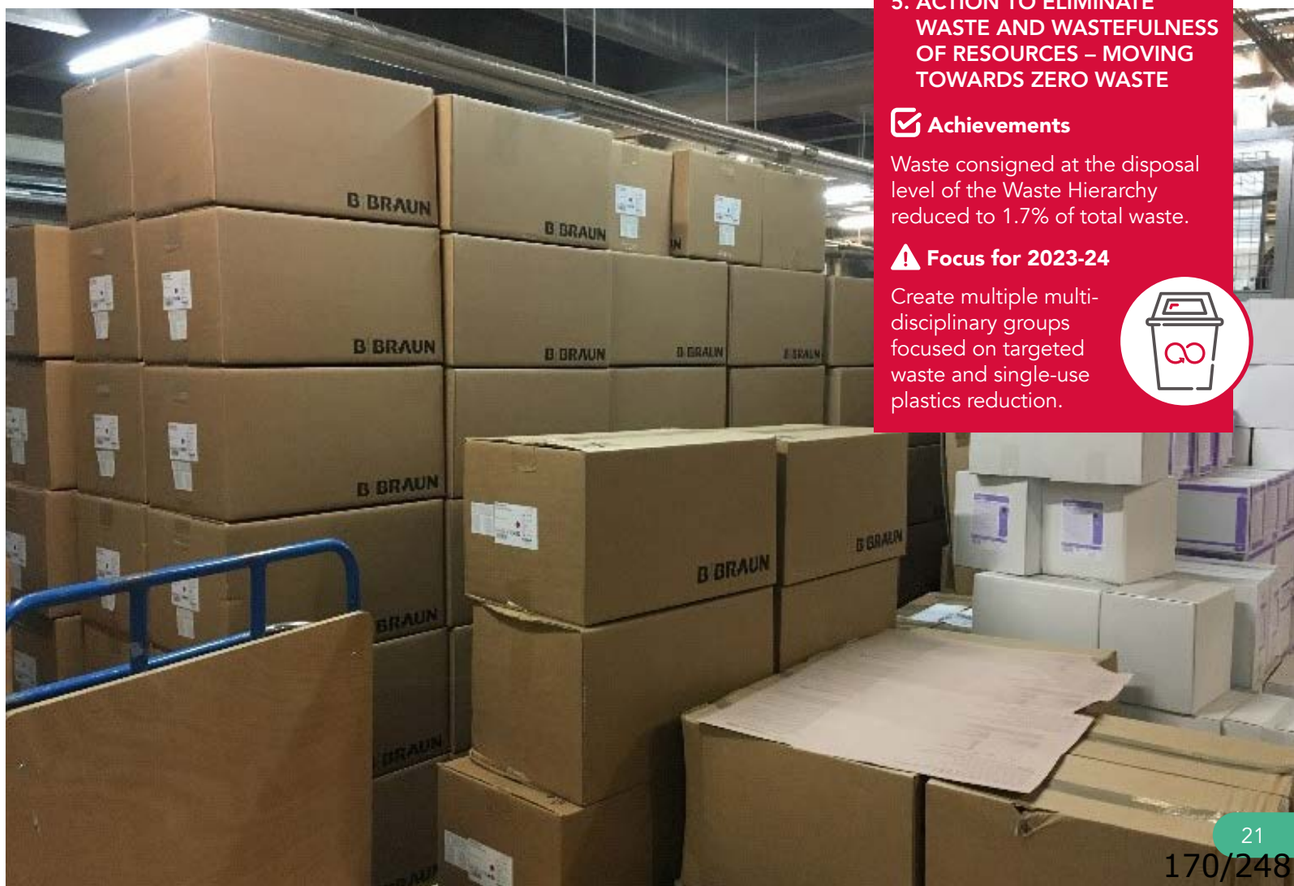
5. ACTION TO ELIMINATE WASTE AND WASTEFULNESS OF RESOURCES – MOVING TOWARDS ZERO WASTE

Achievements

Waste consigned at the disposal level of the Waste Hierarchy reduced to 1.7% of total waste.

Focus for 2023-24

Create multiple multi-disciplinary groups focused on targeted waste and single-use plastics reduction.



5. Stakeholder Engagement

STAFF SUSTAINABILITY SURVEY

Every year we ask our staff a number of questions in our annual staff sustainability survey. Over 90% of staff say that it is important for the Trust to work in a more sustainable way.

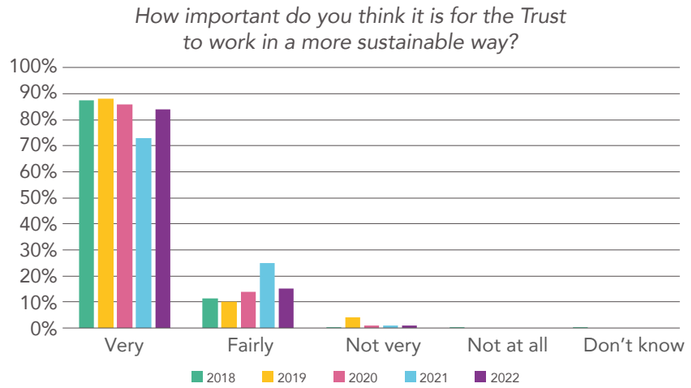


Figure 4: Staff survey – how important do you think it is for the Trust to work in a more sustainable way?

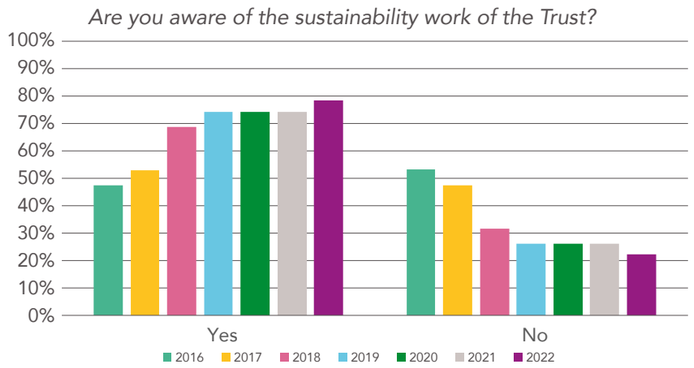


Figure 5: Staff survey – are you aware of the sustainability work of the Trust?

This year we asked a new question:

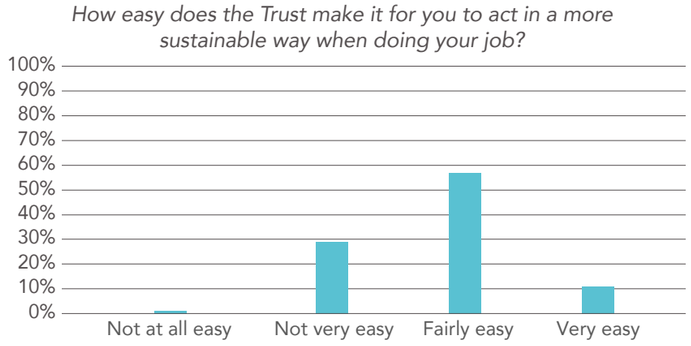


Figure 6: Staff survey – how easy does the Trust make it for you to act in a more sustainable way?

This tells us that whilst there remains a high level of enthusiasm for sustainability amongst our people, we could be doing more to convert that enthusiasm into action.

We have developed some initiatives to support staff led action which are detailed in the 'People' section of this report.

We will continue to ask this question and hope to see the results move towards more people saying we make it 'very easy' to act in a more sustainable way at work.

STAKEHOLDER SURVEY

As well as engaging with our staff, this year we have also carried out a stakeholder engagement survey for the first time.

This clearly demonstrates that action on sustainability is of importance to stakeholders which include patients, visitors and families, members of the local community and so on.

Worryingly, 76% of stakeholders said they are concerned about the impact of climate change on their health, or the health of a loved one. And just over 50% said they are very concerned.

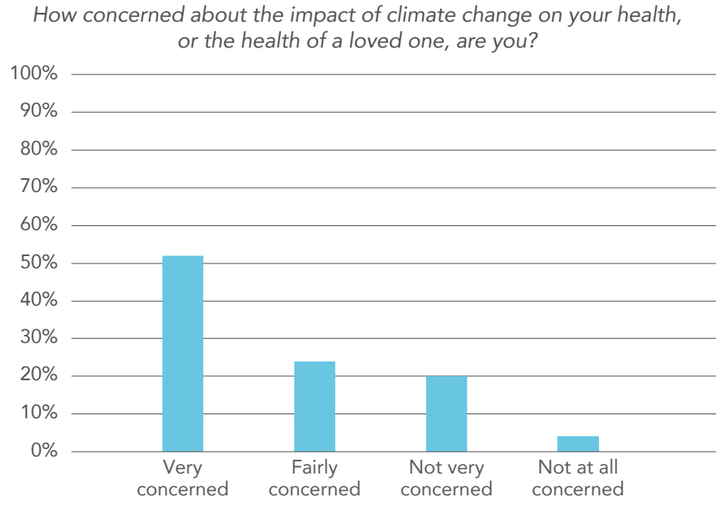


Figure 7: Stakeholder survey – how concerned about the impact of climate change on your health, or the health of a loved one, are you?

Climate change is already impacting the health of people living in Newcastle and the North East of England

Worryingly, 76% of stakeholders said they are concerned about the impact of climate change on their health, or the health of a loved one. And just over 50% said they are very concerned

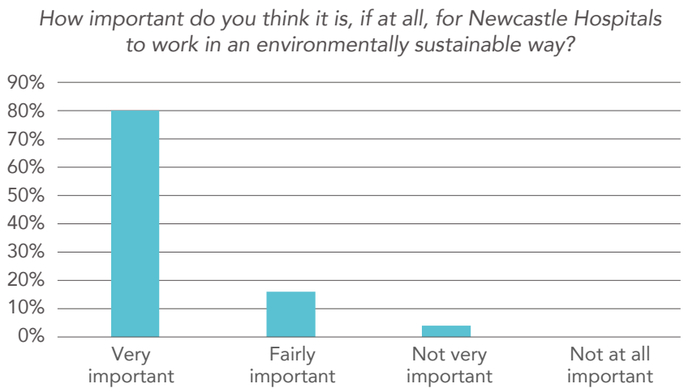


Figure 8: Stakeholder survey – how important do you think it is for Newcastle Hospitals to work in a more sustainable way?

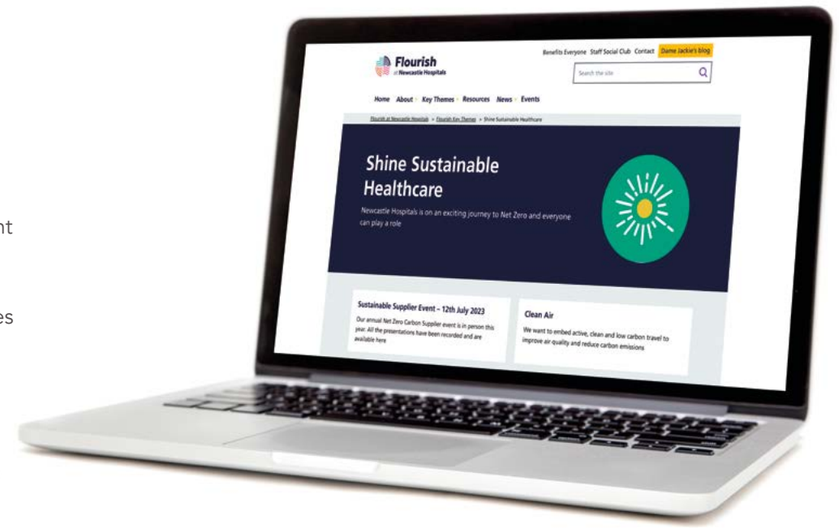
WHY IS THIS INFORMATION IMPORTANT?

Climate change is already impacting the health of people living in Newcastle and the North East of England.

Service users and staff are at the heart of all our decision making. This data tells us that our key stakeholders share concerns about the climate emergency and think sustainability should be an important part of the way we deliver our services.

We will commit to providing updates on our progress against our three goals and the actions identified within the Climate Emergency strategy so that these stakeholders can remain informed, and can hold us to account against what we have stated we will achieve.

To be more transparent we are publishing regular progress reports on the website: https://www.flourishatnewcastlehospitals.co.uk/flourish-key-themes/sustainable-healthcare/



6. Leadership, partnerships and collaboration

6.1 City

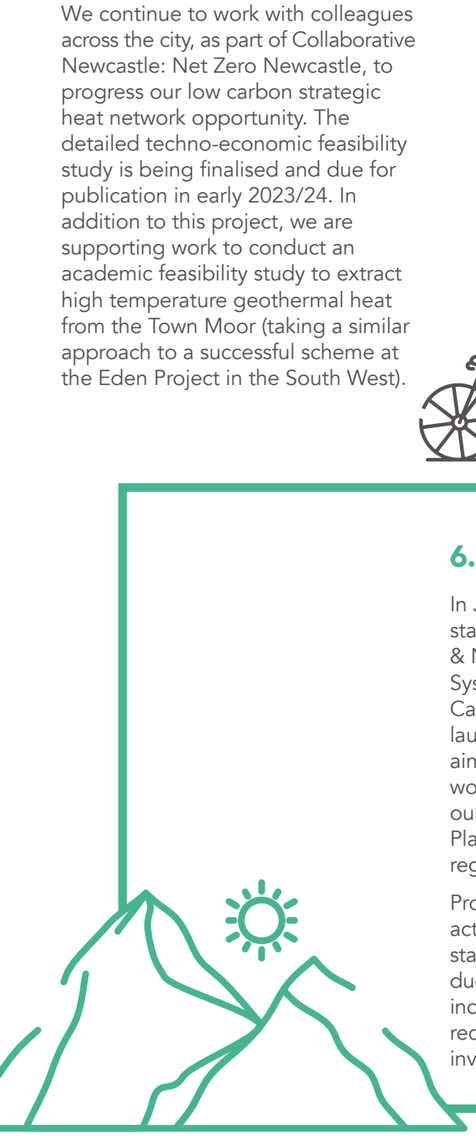
We continue to work with colleagues across the city, as part of Collaborative Newcastle: Net Zero Newcastle, to progress our low carbon strategic heat network opportunity. The detailed techno-economic feasibility study is being finalised and due for publication in early 2023/24. In addition to this project, we are supporting work to conduct an academic feasibility study to extract high temperature geothermal heat from the Town Moor (taking a similar approach to a successful scheme at the Eden Project in the South West).

6.2 Region

In July 2022, shortly after the statutory formation of the North East & North Cumbria Integrated Care System (NENC ICS) our Integrated Care Board (ICB) approved and launched the ICS Green Plan. This aims to bring together our system to work collaboratively, over and above our individual provider Trust Green Plans, to achieve a more sustainable regional healthcare system.

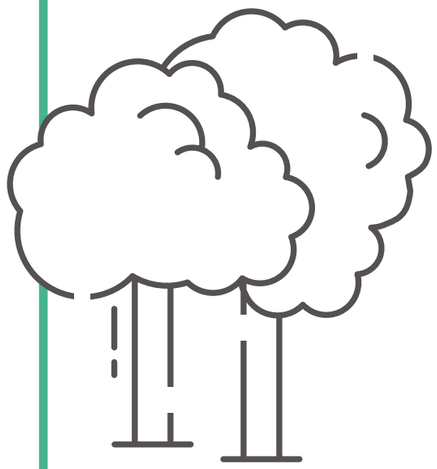
Progress towards achieving the actions in the ICS Green Plan has stalled over the autumn & winter, due to the competing priorities including winter pressures, elective recovery and funding constraints. An investment paper prepared for the ICB, citing the resources required to progress the ICS Green Plan in the short-term and medium-term, was deferred a number of times as a consequence. At the time of publishing this report, the ICS is still without dedicated capacity and funding to progress actions in the ICS Green Plan (the NHS England-funded NENC ICS Senior Net Zero Programme Manager).

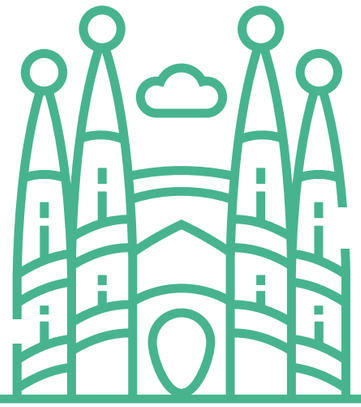
Provider Collaborative Sustainability meetings continue to take place, where NENC ICS provider Trusts meet regularly to share best practice across a wide variety of sustainability focus areas (energy, waste, travel, biodiversity and lower carbon care).



6.3 National

We continue to share our work and collaborate with other partners across the country. This includes co-chairing the Shelford Group's Sustainability Leads sub-group, attending the NHS England & Improvement (NHSEI) Medicines Sustainability Board as a system representative, hosting the UK's Sustainable Anaesthesia Fellow and actively contributing to the National Performance Advisory Groups for Sustainability Leads, Waste Managers and Active & Sustainable Travel.





6.4 International

As early signatories of the Global Green & Health Hospitals network, in 2011, we have worked with other progressive health systems from across the globe with the support of Health Care Without Harm. In July 2022 our Sustainability Team hosted a visit of Spanish hospitals and regional health ministries at our RVI site, as a follow-up to our work with the British Embassy in Madrid in March 2022. We were able to share our experience of securing Board-level support for our Climate Emergency Strategy, our innovative work on nitrous oxide cracking in Maternity and moving our healthcare waste segregation practices up the waste hierarchy. Our in-house catering team also showcased a fantastic seasonal vegan menu for the delegates.

7. Key Action Areas

This section explores the progress made in each of our Shine action areas which feed into our three Climate Emergency Strategy goals, and the plans for next year and beyond.

Following the 2020 'Delivering a Net Zero NHS' report, all NHS Trusts were asked to produce a strategy in the form of a Green Plan by January 2022 to outline how they plan to work towards Net Zero. As our Climate Emergency Strategy was published within the previous two years, we were not required to produce a new green plan, however the guidance for producing a green plan included core chapters which are: workforce and system leadership, sustainable models of care, digital transformation, travel and transport, estates and facilities, medicines, supply chain and procurement, food and nutrition, and adaptation.

We have mapped action across these areas within our existing eight Shine themes.

Energy
Minimise energy use and replace fossil fuels with zero carbon energy sources

Water
Minimise water use

Waste
Dispose of less, reuse and recycle more

Buildings & Land
Provide healthy, sustainable and biodiverse spaces

Journeys
Embed active, clean, low carbon travel

Procurement
Work with our supply chain to decarbonise

Care
Develop low carbon care pathways adapted to our changing climate

People
Inspire, inform and empower our people to deliver sustainable healthcare

7.1 Energy & Water

AIM

Reduce carbon emissions from energy use, in line with science informed budgets, to be on track for net zero by 2030:

- Use less energy.
- Replace fossil fuels with low and zero carbon energy sources.
- Investigate options to offset, or inset, our residual carbon emissions.

AIM

Minimise water use in our buildings:

- Eliminate wasted water.
- Increase water efficiency.

Carbon emissions from building energy for 2022/23 are 7% lower than in 2021/22 which, although encouraging, still falls short of our science-aligned carbon budget target

PERFORMANCE

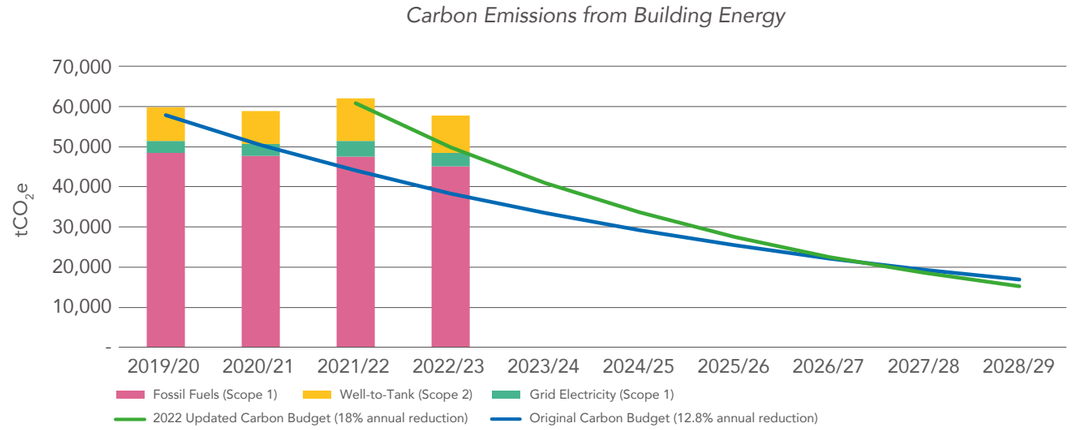


Figure 9: Total carbon footprint from building energy use

CASE STUDY:

We have changed our Energy Centre CHP run strategy to save over 1,000tCO_2e -
Click here to learn more

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

Carbon emissions from building energy for 2022/23 are 7% lower than in 2021/22 which, although encouraging, still falls short of our science-aligned carbon budget target.

Factors influencing this reduction include:

- Change to Freeman Energy Centre operational strategy – reducing the running hours of our fossil fuel Combined Heat and Power (CHP) to match our demand, with no export to the grid.
- Continued reduction in energy use and eventual closure of the Integrated Covid Hub North East (ICHNE) Baltic Labs.
- Extended CHP engine downtime at RVI resulting from unplanned maintenance (gaining benefit from cleaner grid electricity import).

Other activities carried out this year include:

- A successful bid was made for £1.7m Public Sector Decarbonisation Scheme funding to fully decarbonise Regent Point. This will include air source heat pumps, solar panels, LED lighting and Building Management System upgrades.
- Engagement with Senior Estates Management on decarbonisation and delivered Net Zero briefings for Estates.
- We are a key partner in the City Heat Network feasibility study.
- Continued to improve energy and water metering.

Carbon emissions from water have reduced due to revised UK Government carbon factors for water supply and water treatment.

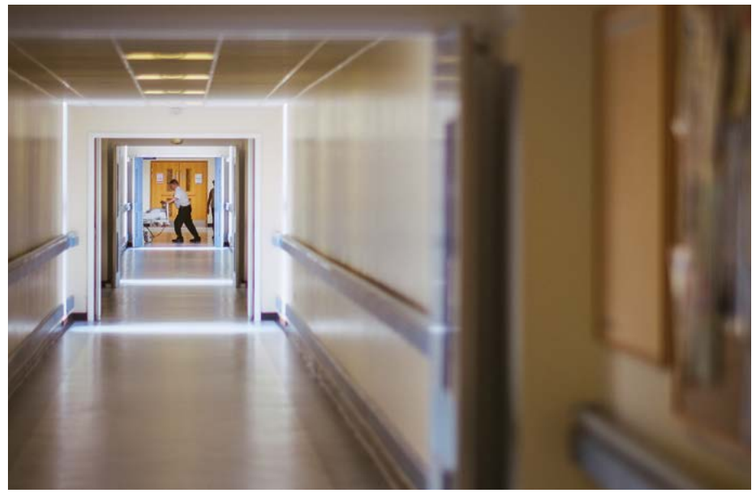
Water consumption has also reduced. Factors influencing this reduction include:

- Identifying and fixing a substantial leak at our CAV site in 2021.
- Reduced activity at ICHNE Baltic Labs.
- More accurate automatic water metering and supplier invoicing.

The result is that carbon emissions from Trust water use is 65% lower in 2022/23, compared to the baseline year 2019/20.

PLANS FOR THE NEXT YEAR

- Low Carbon Skills Fund application to further develop our heat decarbonisation plans for the RVI and Freeman Hospital.
- Continue to work as a partner in the development of a City Heat Network for Newcastle
- There are significant capacity issues within the Energy Team so it is a high priority to fill vacancies and onboard the Net Zero engineering team.
- Develop prioritised estates decarbonisation plan and seek external capital funding to deliver.



7.2 Journeys & Clean Air

AIM

Embed active, clean and low carbon travel to improve air quality and reduce carbon emissions from journeys:

- Reduce air pollution and carbon emissions from our owned and commissioned transport operations
- Use our influence to help fast-track the decarbonisation of transport in our supply chain
- Increase the proportion of people accessing our sites by active and sustainable travel methods
- Provide more care closer to, or at, home

PERFORMANCE

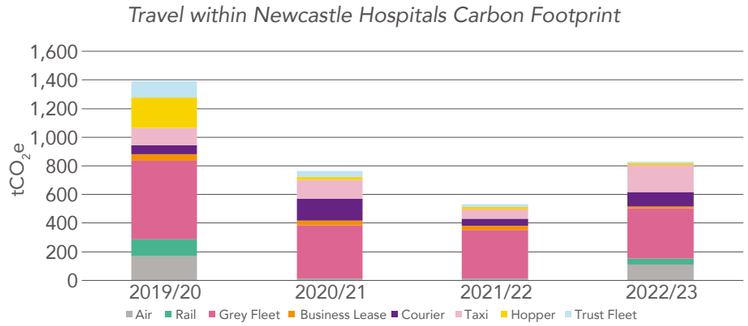


Figure 10: Carbon footprint from travel within the Newcastle Hospitals Carbon Footprint

We worked with mobilityways[9] to survey Newcastle Hospitals employees on their travel to and from work. These are the key findings:

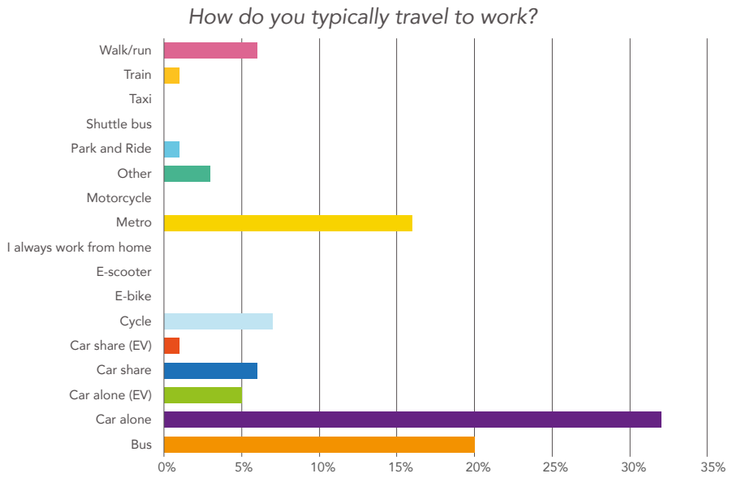


Figure 11: Staff journeys – how do you typically travel to work?

- 71% of employees work full time, commuting an average of 4 days per week, for an average of 10 miles each way
- 32% of respondents commute in a car, alone
- 49% of respondents were interested in joining a car share database, and 80% would like to receive a Personal Travel Plan
- 32% of employees would be encouraged to use public transport if there were more frequent reliable services and 26% if fares were cheaper
- The main way to encourage employees to walk would be to improve the showering and changing facilities on site, chosen by 7% of respondents
- The main way to encourage employees to cycle would be to improve the safety of routes and increase the provision of secure bike parking. as stated by 25% and 20% of respondents, respectively

[9] Mobilityways platform allows employers to measure, reduce and report commuter carbon emissions - mobilityways.com

CASE STUDY:

We have jointly recruited a four year PhD student to support our Clean Air Hospital project work, installing air quality monitoring equipment, analysing data and recommending interventions to clean up the air in and around our hospitals. - Click here to learn more

32% of employees would be encouraged to use public transport if there were more frequent reliable services and 26% if fares were cheaper

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

Our partnership work with Global Action Plan and Boehringer Ingelheim, in developing the first ICS Clean Air Framework (https://www.actionforcleanair.org.uk/health/ics-framework), was shortlisted for an HSJ Partnership Award in the Environmental Sustainability Project category.

PLANS FOR THE NEXT YEAR

- Monitor ambient and indoor air quality at numerous locations at the RVI and Freeman Hospitals
- Increase the number of onsite active travel support facilities such as bike parking facilities.
- Increase awareness of active and sustainable travel amongst staff and visitors, including the development of a digital map of the RVI and Freeman Hospitals to highlight facilities.
- Develop and provide personalised travel plans to staff and work on integrating within the staff onboarding process.
- Include air quality as part of staff induction.
- Increase the business milage delivered by zero tailpipe emissions vehicles.

7.3 Waste

AIM

Generate less waste; reuse and recycle more, and ensure unavoidable waste is disposed of in the most sustainable way:

- Reduce the amount of waste we create by working and purchasing in more resource-efficient ways
- Increase the number of items we reuse with a focus on reducing single-use plastics
- Repair or reuse more items that can be repaired or reused
- Increase the amount of waste that we reuse or recycle to 35% of consigned waste by volume

Almost 90 waste audits were completed, allowing the opportunity to ensure consistency, compliance and engagement with nursing and clinical staff

PERFORMANCE

Figure 12: total waste disposed of by category

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

Overall waste volumes are 6% lower than last year, however they are slightly higher than our 2019-20 baseline year. The decrease in waste volumes this year is largely due to the reduction in activity at Integrated Covid Hub North East (ICHNE) Baltic Labs. Other site waste volumes are approximately back to pre-pandemic levels, and work is required to reduce these volumes.

The majority of our waste is sent for energy recovery and 29% of waste is currently recycled. None of our waste has been sent to landfill since 2011.

Less than 2% of waste is sent for incineration without energy recovery - the lowest level of the waste hierarchy. This is a 40% reduction on the previous year and over 50% lower than our baseline year.

Almost 90 waste audits were completed, allowing the opportunity to ensure consistency, compliance and engagement with nursing and clinical staff.

Established single-use metal instrument recycling in theatres and key departments to enable greater recycling of single use metal instruments.

Supported a quality improvement project to reduce the volume of medicines being disposed of, through looking at training and information, improving storage, and providing dedicated staff resource.

PLANS FOR THE NEXT YEAR

- Embed waste management into corporate induction and improve local induction guidance, including specialised training for key departments.
- Develop metrics for measuring and reporting waste prevention and re-use.
- Incorporate waste management training into the Healthcare Assistant Academy.
- Increase opportunities for recycling and implement the non-infectious waste steam (where it is not already present) in our community sites.
- Remove disposable coffee cups from Regent Point café to reduce overall waste volumes, improve recycling and reduce the number of single use plastics used at that site.
- Remove disposable cutlery and crockery from wards except where there is a specific patient need.
- Work with clinical departments to identify opportunities for waste reduction and removal of single use items.
- Expand food waste recycling at our main hospitals.

CASE STUDY:

We have been working with Sharpsmart to move waste up the waste hierarchy – Click here to learn more.

7.4 Procurement

AIM

Embed sustainability and support for climate emergency action into all purchasing decisions, working towards a net zero carbon supply chain:

- Consume less
- Embed carbon reduction into our procurement processes
- Establish positive relationships with key suppliers
- Engage in research and innovation in order to reduce impact across whole value chain
- Improve confidence in our supply chain carbon data
- Invest more in our local supply chain
- Increase the amount of sustainable, local, healthy food available to staff, patients and visitors

764 of our suppliers (22%) have engaged in our supplier Net Zero programme, with 87% supporting our Net Zero by 2040 goal

PERFORMANCE

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

- Built Government and NHSE mandates on social value & net zero into our procurement processes.
- 764 of our suppliers (22%) have engaged in our supplier Net Zero programme, with 87% supporting our Net Zero by 2040 goal.
- 5-step Net Zero Supplier Framework awarded the Net Zero Award at the NHS Innovate Awards and gained an Honourable Mention at the International Hospital Federation Awards. This framework was formalised as a mandatory contractual requirement for all suppliers.
- Sustainable Suppliers webpage created to be accessed by suppliers to view webinars and read supplier case studies.
- Developed a partnership with Supply Chain Ltd to improve the reporting of supply chain carbon emissions, and focus effort on low cost, high volume consumable products.
- Sustainability included as a key priority in the refreshed Trust Food and Drink Strategy.

PLANS FOR THE NEXT YEAR

- Work on developing a regional furniture re-use scheme
- Include social value criteria in every tender
- Develop a sustainable partner programme for suppliers
- Improve training and upskill staff across the procurement directorate.
- Develop focus groups to address key issues, such as championing re-use over single-use, bringing together expertise from procurement, clinical care, sustainability and Infection, Prevention and Control.

CASE STUDY:

As part of the initiative to reduce supply chain carbon emissions, we visited the NHS Supply Chain distribution site at Normanton. Click here to read more about the challenge of reporting our scope 3 carbon emissions.

Newcastle Hospitals Charity

7.5 Models of Care

AIM

Develop low carbon care pathways adapted to our changing climate:

- Engage in research and innovation in order to lower carbon across our care pathways
- Lead on the systematic reduction of anaesthetic gas environmental impact across all care pathways
- Collaborate to reduce the carbon footprint of respiratory care through a detailed review of inhaler prescription and use
- Empower our clinicians to improve the sustainability of their models of care

PERFORMANCE

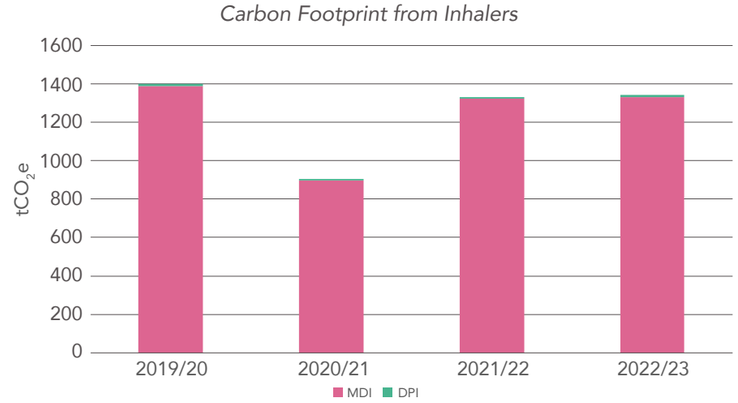


Figure 13: Carbon footprint from inhaler prescribing at Newcastle Hospitals

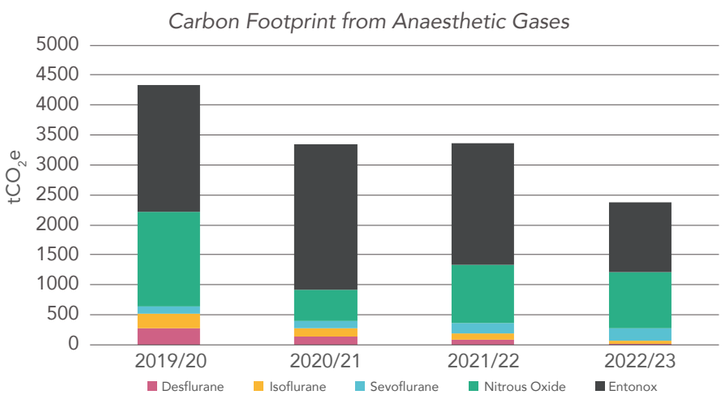


Figure 14:Carbon emissions from anaesthetic gas use at Newcastle Hospitals

We will continue to embed sustainability into Newcastle Improvement resources so that sustainability becomes a recognised domain of quality

CASE STUDY:

We are starting to see the impact of implementing Entonox cracking technology in RVI midwifery - Click here for more info

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

We have seen a 37% reduction in the carbon footprint from anaesthetic gases compared to last year. Desflurane use is at a negligible level, and we are beginning to see the impact of Entonox capture and cracking technology.

Following a successful UK-first trial the Trust has invested in technology to safely crack the exhaled Entonox, used by birthing mums in our Delivery Suite & Newcastle Birthing Centre, into inert Oxygen and Nitrogen. This project was also shortlisted in the Environmental Sustainability Project category of the HSJ Partnership Awards 2023.

Two Newcastle Hospitals Charity funded Sustainability Fellows came in to post, one in Children's Medicine and one in Oncology.

Work continues to embed sustainability into the work of Newcastle Improvement. With the support of the Paediatric Clinical Sustainability Fellow and the Centre of Sustainable Healthcare, sustainability is now included as one of the six domains of quality. Sustainability is now part of Newcastle Improvement training and resources.

Sustainable Anaesthesia Fellow continues to lead work on volatile anaesthetic gas capture, energy reduction in theatres through heating, ventilation and air conditioning (HVAC) optimisation, and programme to switch off Nitrous Oxide manifolds, reducing waste through leakage – with a staff health and wellbeing benefit.

PLANS FOR THE NEXT YEAR

Hold a number of focus groups bringing together a multi-disciplinary team around an issue for example reducing single-use items, following the model that has been used to start to address the medicines waste (see case study).

Continue to embed sustainability into Newcastle Improvement resources so that sustainability becomes a recognised domain of quality.

Recruit a second year of Clinical Sustainability Fellows, funded by the Newcastle Hospitals Charity, and seek to expand the programme to include a Nursing, Midwifery and Allied Health Professional (NMAHP) Fellow.

CASE STUDY:

A multi-disciplinary team bringing together expertise from Nursing, Pharmacy and Quality Improvement was established to reduce the volume of wasted medicines generated at ward level. Click here to access a case study as work progresses.

7.6 Buildings and Land

AIM

Provide healthy, sustainable and biodiverse spaces for patients, staff and visitors:

- Include opportunities for sustainability innovations in all new builds and refurbishments based on recognised standards
- Build climate adaptation and resilience into our management of existing estate as well as all new builds and refurbishments
- Expand our green space and enhance the biodiversity of our land

This year there have been a number of areas identified by staff for a 'Green the Grey' charity-supported project, to improve biodiversity of, and access to, various courtyard areas

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

- Sustainability included as a critical element of two major new build projects. Both on track to achieve BREEAM 'outstanding' and Net Zero in-use.
- Established a biodiversity metric to allow us to track progress annually.
- Biodiversity action plan completed for the green spaces at the RVI and Freeman Hospital and some habitat improvements have been made – see case study.
- A number of areas identified by staff for a 'Green the Grey' charity-supported project, to improve biodiversity of, and access to, various courtyard areas.
- Progress made on development of Ismail's garden – see case study.
- Working with the Centre for Sustainable Healthcare we hosted a Nature Recovery Ranger to support staff engagement in the projects.

PLANS FOR THE NEXT YEAR

- Complete two Green the Grey projects which have funding allocated and apply for funding for an ambitious green spaces project to include a Freeman Garden, and the remaining courtyards, extending to some community sites.
- Complete Ismail's garden project

Our aim is to expand our green space and enhance the biodiversity of our land

CASE STUDY: Freeman biodiversity

The Biodiversity Action Plan has led to the implementation of site improvements which has enhanced the Biodiversity Metric Score. Click here to learn more.

CASE STUDY: Ismail's garden

Inspired by a letter from a patient in the Children's Hospital asking for a 'Place to & Grow'. This garden is being designed young patients themselves. Click here to read more about this project and the of our 'Green Spaces' work.

7.7 People

AIM

Inspire, inform and empower our people to deliver sustainable healthcare:

- Embed Shine and climate emergency action into the culture of our organisation, demonstrated in staff behaviours
- Upskill our workforce and ensure capacity to address the climate emergency

- Empower our people to make the most sustainable choice
- Extend our reach to influence action amongst our wider stakeholders, including patients

PERFORMANCE

- 37 Green Champions Plus
- 388 Green Champions
- 22 new Sustainability Ambassadors
- Over 80,000 Shine Reward Actions
- 13 Climate Emergency Action Fund projects approved
- 1,406 @sustainableNUTH Twitter followers
- 99% of staff think sustainability is important

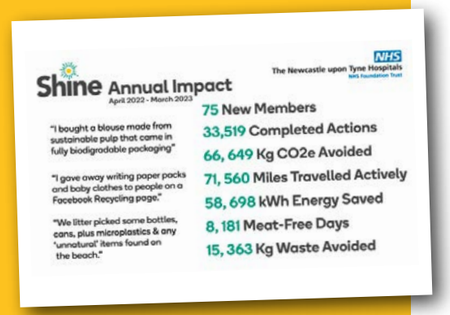
ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

We have developed a 10-step sustainability framework for directorates to embed sustainability into their own strategies and departmental culture. This has been taken up by 10 departments.

Our training programme has continued to be rolled out with the fourth cohort of Sustainability Ambassadors trained, and bi-monthly 'Leading in the Transition to Net Zero' courses delivered.

Training to reach all Estates staff has been approved, this is significant because this staff group that has responsibility for almost 90% of our controllable carbon emissions (building heat and power).

Our staff engagement programme, Shine Rewards, continues to recruit staff with over 1000 signed up undertaking over 86,000 sustainable actions. We have kicked off a dedicated campaign linking sustainable behaviours with financial wellbeing to help support staff in the cost of living crisis.



With Executive Oversight Group support this year we offered a £50,000 Climate Emergency Action Fund to help kick start small-scale staff led sustainability projects which was spent by the end of the year on projects including:

- Development of innovations to reduce use of single-use plastics in the cleaning of portable, reusable equipment.
- Indoor planting to improve indoor air quality, temperature regulation and wellbeing
- A warming cabinet to allow reusable blankets to be used in theatre recovery
- 'Sensational thinking' sensory garden
- Sustainability workshops to increase engagement in Integrated Laboratory Medicine
- Newcastle Improvement sustainability appraisal from Centre for Sustainable Healthcare
- Estates outdoor air quality monitoring equipment

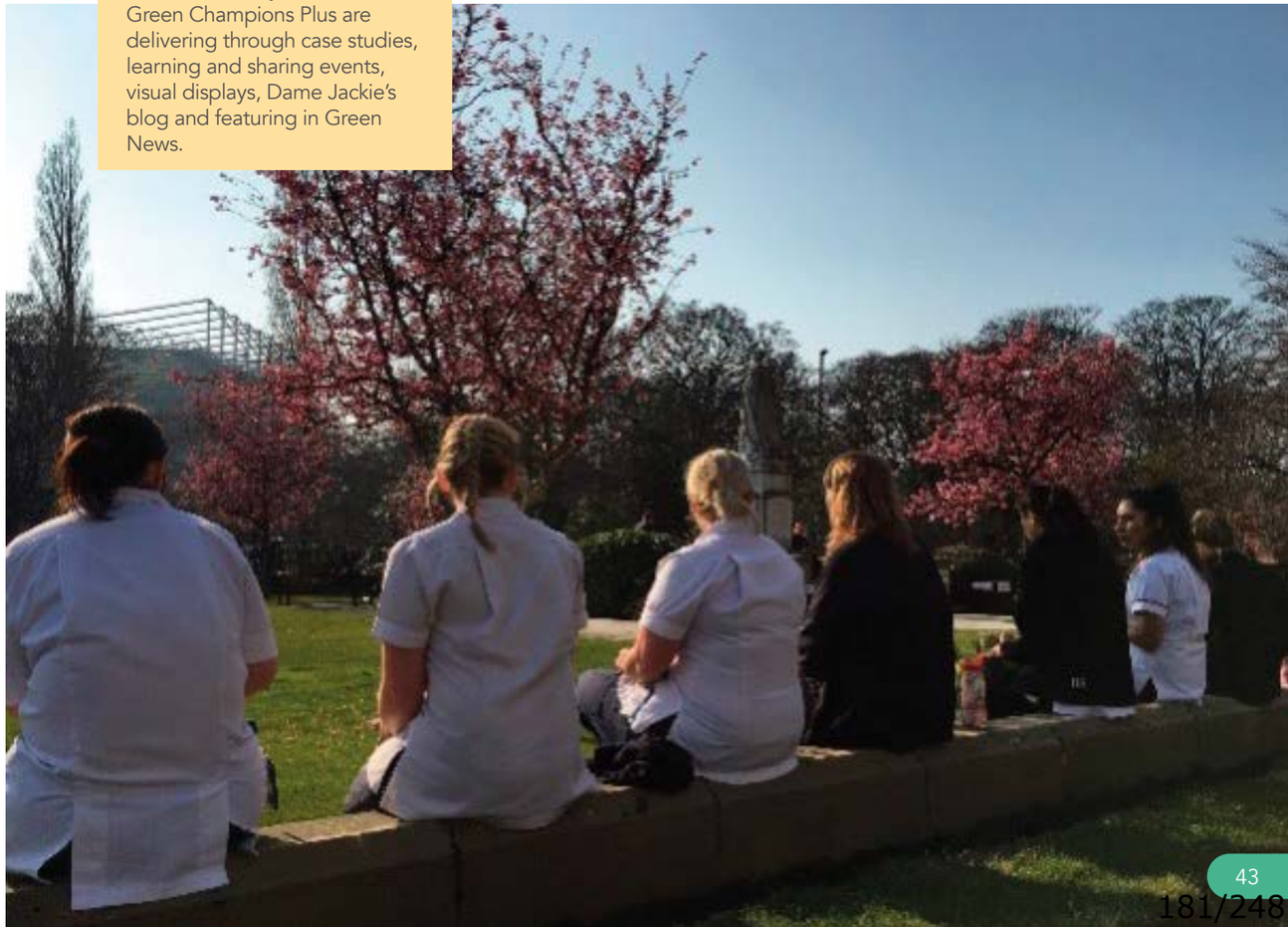
The Green Champions and Green Champions Plus networks have continued to grow this year – see case study for more information on these staff groups.

PLANS FOR THE NEXT YEAR

- Continue to expand Green Champions and Green Champions Plus, building the Green Champions Plus group into a network of knowledgeable and motivated staff who can lead change in their own areas of work.
- Support that group by facilitating partnerships and assisting with upscaling and spreading successes.
- Increase visibility of the work the Green Champions Plus are delivering through case studies, learning and sharing events, visual displays, Dame Jackie's blog and featuring in Green News.

CASE STUDY: Embedding sustainability

A programme of employee engagement and training has been developed, growing from a group of Green Champions to a tiered network of engaged and motivated staff, mobilised and empowered to take action. Click here for a case study on this project.



8. Technical Appendix

In our Climate Emergency Strategy 2020-2025 we included a commitment to measure our performance across each of our eight Shine themes and report this publicly.

We appreciate that this level of detail would make our Annual Shine Report very lengthy and hard to read, so we have included some headline performance data within this report and have made our full key performance indicators available separately on our website.

This is updated annually along with our SECR compliant carbon footprint, and is available here.

9. Contact Details

This Annual Report has been produced by the Sustainability Team at Newcastle Hospitals but reflects work taking place across the Trust. All information contained within it is, to the best of our knowledge, accurate at the time of publishing.

If you wish to contact the Sustainability Team please email **nuth.environment@nhs.net**

Or write to us at:

Sustainability Team (Estates Department)
Royal Victoria Infirmary
Queen Victoria Road
Newcastle upon Tyne
Tyne and Wear
NE1 4LP

You can follow us on Twitter: **@SustainableNUTH**

Let us know your thoughts on this report, and how it could be improved

10. Glossary

BREEAM – Building Research Establishment Environmental Assessment Method used to assess, rate and certify the sustainability of buildings.

Carbon dioxide equivalent (CO_2e) – A carbon dioxide equivalent or CO_2e, is a metric measure used to compare the emissions from various greenhouse gases on the basis of their global-warming potential (GWP), by converting amounts of other gases to the equivalent amount of carbon dioxide with the same global warming potential.

CHP – Combined Heat and Power, the production of electricity or power from a single source of energy, in this case gas.

Climate emergency – A climate emergency declaration is action taken to acknowledge that humanity is in a climate emergency, and urgent action is required to reduce or halt climate change and avoid potentially irreversible damage resulting from it.

DPI – Dry Powder Inhalers deliver medication to the lungs as you inhale through the device.

Flourish – Newcastle Hospitals' cornerstone programme to support all employees to liberate their potential at work and create the best NHS organisation possible.

Greenhouse gas protocol – global standardised framework to measure and manage greenhouse gas emissions.

Hybrid method – used to calculate emissions from purchased goods and services. Method uses a combination of supplier-specific activity data (where available) and secondary data to fill the gaps. This method involves collecting allocated scope 1 and scope 2 emission data directly from suppliers; and using secondary data to calculate upstream emissions wherever supplier-specific data is not available.

ICS – a statutory committee jointly convened by Local Authorities and the NHS, comprised of a broad alliance of organisations and other representatives as equal partners concerned with improving the health, public health and social care services provided to their population.

NHS E&I Net Zero Supplier Roadmap & Evergreen Framework – NHS England and NHS Improvement (NHS E&I) work together as a single organisation. In September 2021 a supplier roadmap was approved to help suppliers align with the NHS net zero ambition. The Evergreen sustainable supplier assessment is the mechanism for suppliers to engage with the NHS on the requirements of the roadmap. https://www.england.nhs.uk/greenernhs/get-involved/suppliers/

PPN 06/20 – Procurement Policy Note 06/20 (PPN06/20) applies to procurements covered by the Public Contracts Regulations 2015 and requires a minimum of a 10% weighting for social value questions.

PPN 06/21 – Public Procurement Notice 06/21 (PPN06/21) requires all companies and organisations who apply for central government contracts (above £5m framework value) to publish a Carbon Reduction Plan and demonstrate their alignment with the government's 2050 Net Zero goals.

PSDS – The Public Sector Decarbonisation Scheme (PSDS) provides grants for public sector bodies to fund heat decarbonisation and energy efficiency measures.

Shelford Group – The Shelford Group is a collaboration between ten of the largest teaching and research NHS hospital trusts in England.

Spend-based method – used to estimate emissions from purchased goods and servicesby collecting data on the economic value of goods and services purchased and multiplying it by relevant secondary (e.g. industry average) emission factors.

Waste hierarchy – The waste hierarchy ranks waste management options according to what is best for the environment.

11. End Notes

Notes about methodology:

- *Newcastle Hospitals NHS Foundation Trust has adopted an operational control approach to establishing the boundary. The methodology adopted in line with the Greenhouse Gas Protocol1 and the BEIS Environmental Reporting Guidelines. The calculations were completed on the SmartCarbon™ Calculator using the latest UK Government emissions factors.*
- *CO_2e is the universal unit of measurement to indicate the global warming potential (GWP) of Greenhouse Gases (GHGs), expressed in terms of the GWP of one unit of carbon dioxide. There are seven main GHGs that contribute to climate change, as covered by the Kyoto Protocol: carbon dioxide (CO_2), methane (CH4), nitrous oxide (N2O), hydrofluorocarbons (HFCs), perfluorocarbons (PFCs), sulphur hexafluoride (SF6) and nitrogen trifluoride (NF3). Different activities emit different gases. Using CO_2e allows all greenhouse gases to be measured on a like-for-like basis.*
- *For National grid electricity consumption, Newcastle Hospitals NHS Foundation Trust has included factors for the transmission and distribution of electricity (T&D) losses, which occur between the power station and site(s). The emissions from T&D has been accounted for in Scope 3. As with other Scope 3 impacts, reporting T&D is voluntary but is recommended standard practice by UK Government.*
- *Well-to-tank (WTT) fuels conversion factors have been included to account for the upstream Scope 3 emissions associated with extraction, refining and transportation of the raw fuel sources to an organisation's site (or asset), prior to combustion. As with other Scope 3 impacts, reporting WTT is voluntary but is recommended standard practice by UK Government.*
- *Procurement carbon emissions are calculated using a hybrid method – deducting known scope 1 & 2 reported carbon data from suppliers from the carbon footprint calculated using a spend based method - £ spent in eclass spend categories multiplied by average carbon factors for those categories.*
- *A full SECR compliant report is available on request.* https://sciencebasedtargets.org/resources/files/Net-Zero-Standard.pdf


The time
for action
is now!

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023						
Title	Trust Performance Report						
Report of	Martin Wilson, Chief Operating Officer Vicky McFarlane-Reid, Director of Business, Development & Enterprise						
Prepared by	Elliot Tame, Senior Performance 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 the Trust's elective recovery progress as well as performance against NHS England (NHSE) priorities for 2023/24 and key operational indicators.						
Recommendation	For assurance.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality. Performance – Being outstanding now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☒	☐
Link to Board Assurance Framework [BAF]	Strategic Risk SO1.1 [Capacity and demand pressures] Strategic Risk SO5.8 [Activity delivery] Details compliance against NHSE plan priorities for 2023/24. Details compliance against national access standards which are written into the NHS standard contract.						
Reports previously considered by	Regular report.						

TRUST PERFORMANCE REPORT

EXECUTIVE SUMMARY

This report provides an overview of the Trust's continuing recovery of elective activity as well as performance against both contracted national access standards and the priorities for the year outlined by NHS England (NHSE) as part of the 2023/24 planning round.

- Overall, activity delivery levels for August remained similar across all points of delivery compared to July but sit short of both trajectory and target. The Trust delivered day case activity equivalent to 101.4% of the re-based 2019/20 baseline in August (adjusted for working days and changes in service provision). Overnight elective activity delivery measured at 87.9%, the highest in-month delivery recorded this financial year despite ongoing strike action – though August usually sees reduced volumes of scheduled activity as a consequence of the school summer holidays.
- New outpatient activity was delivered at an equivalent of 102.4% of 2019/20, whilst outpatient procedure delivery for August is currently forecast at 88.9% - although this figure is subject to potential improvement as the Trust is currently managing a slight coding backlog.
- Newcastle Hospitals achieved the 76% 4-hour Accident & Emergency (A&E) standard in August with overall performance of 78.3%.
- Eight out of nine cancer standards fell short of target in July 2023, with only the 28 Day Faster Diagnosis Standard (FDS) being met – for the ninth consecutive month.
- Among these nine cancer standards, Newcastle Hospitals did not meet the key operational standard that 85% of patients wait no more than 62 days from urgent GP referral to first cancer treatment, as 55.2% of patients were treated within 62 days. Upper GI (31.8%), Lung (34.7%) and Urology (37.7%) were the lowest performing tumour groups against the 85% target. The Trust is experiencing issues with late tertiary referrals in particular, which are impacting performance levels - around 50% are received from other Trusts after their 38 day target.
- NHS England's 2023/24 planning guidance stated the requirement for Newcastle Hospitals to reduce the backlog of cancer patients waiting over 62 days to 200 by March 2024 (below pre-pandemic volumes). The volume of patients waiting >62 days for cancer treatment increased in July to 328, which lies below trajectory (291). Growing backlog figures were anticipated this month due to the usual seasonal influx of skin cancer referrals - 111 patients are now waiting >62 days in Skin.
- At the end of August the Trust still had 15 patients waiting >104 weeks, with 14 of these patients waiting for spinal surgery, a service suffering from nationally acknowledged capacity issues. 156 patients had a waiting time of >78 weeks, with 109 of these waiting for non-Spinal care – the Trust had been asked by NHSE to reduce waiters in this category to zero by the end of June 2023.
- Newcastle Hospitals did not meet the standard that 92% of patients on incomplete RTT pathways wait less than 18 weeks, as compliance was 67.6% in August.

The Board of Directors is asked to receive the report.

Trust Performance Board Report

Produced: September 2023
Data: August 2023

Healthcare at its best
with people at our heart

NHSE Plan Requirements 2023/24

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Metric	Requirement	May-23	Jun-23	Jul-23	Aug-23	RAG Rating: Aug-23*	
						Trajectory	Target
Cumulative Activity Delivery (Spec. Acute)							
Day Case	**109%** of 19/20 value-weighted activity (overall, monthly cumulative) **N.B. Currently being reported by volume, not VWA**	105.1%	102.6%	103.0%	**102.6%**	111.2%	109.0%
Elective Overnight		82.1%	79.2%	81.0%	**82.3%**	111.1%	109.0%
Outpatient New		99.7%	100.0%	100.4%	**100.6%**	102.5%	109.0%
Outpatient Procedures		99.3%	92.7%	93.3%	**92.3%**	104.3%	109.0%
Total		99.9%	97.2%	97.7%	**97.5%**	105.2%	109.0%
Urgent & Emergency Care							
A&E Arrival to Admission/Discharge	**>=76%** under 4 hours (by Mar-24)	77.1%	79.5%	78.6%	**78.3%**	79.5%	>=76%
Adult General & Acute Bed Occupancy	**<=92%**	88.6%	88.1%	85.5%	**87.2%**	91.7%	<=92%
Urgent Community Response Standard	**>=70%** under 2 hours	85.0%	84.0%	87.0%	**TBC**	N/A	>=70%
Cancer Care							
>62 Day Cancer Waiters	Reduce to **<=200** (by Mar-24)	278	259	255	**328**	291	<=200
28 Day Faster Diagnosis	**>=75%** (by Mar-24)	81.9%	83.1%	**80.0%**	TBC	70.0%	75.0%
Elective Care							
>104 Week Waiters	**Zero**	17	13	15	**15**	11	0
>78 Week Waiters	**Zero**	170	103	114	**156**	17	0
>65 Week Waiters	**Zero** (by Mar-24)	1,078	1,090	1,157	**1,310**	996	0 (Mar-24)
>52 Week Waiters	**Reduction** (Zero by e/o Mar-25)	4,149	4,135	4,152	**4,296**	3,900	0 (Mar-25)
Diagnostics							
Diagnostic Activity**	Appropriate levels to reduce waits	110.4%	103.9%	113.3%	**109.2%**	110.5%	N/A
>6 Weeks Waiters	**<=5%** (by Mar-25)	23.0%	23.9%	22.2%	**23.5%**	N/A	<=5%
Outpatient Transformation							
PIFU Take-up	**>=5%** of all OP atts. (by Mar-24)	2.0%	2.3%	2.6%	**2.8%**	2.25%	5.0% (Mar-24)
Outpatient Follow-up Reduction	**<=75%** of 19/20	109.5%	98.4%	108.2%	**106.1%**	100.4%	<=75%

*** 1 month prior for 28 Day FDS**

** CT, MRI, Non-obs US, Endoscopy & ECHO.

Operational Standards

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Metric	Standard	May-23	Jun-23	Jul-23	Aug-23	RAG Rating: Aug-23*
Urgent & Emergency Care						
Ambulance Handovers	**Zero** over 60 mins	10	7	17	**16**	
A&E Arrival to Admission/Discharge	**>=76%** under 4 hours (by Mar-24)	77.1%	79.5%	78.6%	**78.3%**	
	<2% over 12 hours	0.9%	0.8%	0.7%	**1.4%**	
Urgent Community Response Standard	**70%** under 2 hours	85.0%	84.0%	87.0%	**TBC**	
Cancer Care						
Two Week Wait (Suspected Cancer)	**93%**	77.4%	78.2%	**49.4%**	TBC	
Two Week Wait (Breast Symptomatic)	**93%**	37.6%	48.2%	**50.9%**	TBC	
28 Day Faster Diagnosis	**75%** (by Mar-24)	81.9%	83.1%	**80.0%**	TBC	
31 Days (First Treatment)	**96%**	85.7%	83.9%	**82.9%**	TBC	
31 Days (Subsq. Treat. - Surgery)	**94%**	71.8%	78.5%	**58.7%**	TBC	
31 Days (Subsq. Treat. - Drugs)	**98%**	98.1%	96.6%	**95.5%**	TBC	
31 Days (Subsq. Treat. - Radiotherapy)	**94%**	96.6%	88.1%	**84.0%**	TBC	
62 Days (Treatment)	**85%**	53.9%	47.2%	**55.2%**	TBC	
62 Days (Screening)	**90%**	86.5%	75.5%	**80.2%**	TBC	
Elective Care						
18 Weeks RTT	**92%**	67.6%	67.0%	67.8%	**67.7%**	
>65 Week Waiters	**Zero** (by Mar-24)	1,078	1,090	1,157	**1,310**	
>6 Weeks Diagnostic Waiters	**<=1%**	23.0%	23.9%	22.2%	**23.5%**	
Cancelled Ops. Rescheduled >28 Days	**Zero**	3	7	9	**8**	
Urgent Ops. Cancelled Twice	**Zero**	0	0	0	**0**	
Other						
Duty of Candour	**Zero**	0	0	0	**0**	
Mixed Sex Acommodation Breach	**Zero**	65	70	70	**Data unavailable**	
MRSA Cases	**Zero**	0	0	0	**0**	
C-Difficile Cases	**<=165** (FY Cumulative)	15	28	39	**55**	
VTE Risk Assessment	**95%**	96.1%	95.3%	**95.2%**	TBC	
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour	91.0%	**91.0%**	TBC	TBC	
Sepsis Screening Treat. (All)		66.0%	**66.0%**	TBC	TBC	

*** 1 month prior for Cancer Care**

Other Metrics (1/2)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Metric		May-23	Jun-23	Jul-23	Aug-23
Emergency Care					
Ambulance Arrivals		2,978	2,822	3,056	**2,976**
Ambulance Handovers <15 mins		68.8%	74.5%	68.1%	**64.0%**
Ambulance Handovers <30 mins		93.5%	94.5%	94.0%	**91.9%**
Ambulance Handovers <60 mins		99.7%	99.8%	99.4%	**99.5%**
Type 1 Performance (A&E 4 hour)		62.5%	66.9%	65.5%	**65.0%**
Type 1 Attendances (Main ED)		12,539	11,768	11,839	**11,265**
Type 2 Attendances (Eye Casualty)		1,598	1,589	1,562	**1,585**
Type 3 Attendances (UTC)		5,655	5,089	5,124	**4,858**
Patient Flow					
Covid Inpatients (average)		23	11	4	**30**
Emergency Admissions		6,189	6,102	6,158	**6,098**
G&A Bed Occupancy		88.6%	88.1%	85.5%	**87.2%**
Critical Care Bed Occupancy		66.2%	67.5%	64.9%	**63.7%**
Bed Days Lost (average)		27	56	31	**41**
Medical Boarders		87	46	31	**59**
Length Of Stay >7 Days		782	747	701	**717**
Length Of Stay >21 Days		352	349	331	**328**

Other Metrics (2/2)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Metric		May-23	Jun-23	Jul-23	Aug-23
Cancer Care					
2WW Appointments		2,425	2,514	**2,676**	TBC
Cancer First Treatments		561	616	**526**	TBC
Planned Care					
2WW Referrals		2,826	3,254	3,039	**2,957**
Urgent Referrals		6,102	5,864	5,615	**5,651**
Routine Referrals		25,857	26,514	24,439	**24,572**
Specialist Advice Requests (% of New OP Atts.)		8.9%	9.2%	8.9%	**9.3%**
Day Case Activity (Specific Acute (SA))		10,502	10,669	10,337	**10,565**
Overnight Elective Activity (SA)		1,665	1,769	1,687	**1,756**
New Outpatient Attendances (SA)		22,351	23,595	21,916	**21,950**
Outpatient Procedure Activity (SA)		15,417	15,773	15,875	**15,053**
Review Outpatient Attendances (SA)		62,593	62,247	60,787	**60,632**
Diagnostic Tests		19,792	20,777	20,157	**20,440**
Outpatient DNA Rate		8.3%	8.6%	7.2%	**6.7%**
Virtual Attendances		14.4%	14.1%	13.5%	**13.6%**
RTT Waiting List Size		106,847	106,801	108,281	**108,298**

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	26 September 2023						
Title	Fit and Proper Persons Framework 2023						
Report of	Caroline Docking, Assistant Chief Executive Christine Brereton, Chief People Officer						
Prepared by	Natalie Yeowart, Head of Corporate Risk and Assurance						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	This paper includes the new Framework issued by NHS England on the Fit and Proper Person Test (FPPT) (for board members), published on 2 August 2023.						
Recommendation	The Board is asked to support the implementation of the new FPPT requirements.						
Links to Strategic Objectives	Performance – to be 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]	SO1.11 – Failure to achieve required CQC and regulatory standards could impact on the Trust's ability to remain "Outstanding".						
Reports previously considered by	New report – previously considered by the Executive Team.						

FIT AND PROPER PERSONS FRAMEWORK 2023

EXECUTIVE SUMMARY

NHS England has developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles.

Work is being undertaken by the Corporate Risk and Assurance and Human Resources Teams to conduct a 'self-assessment' against the new framework with plans well underway for introduction within the timescales required. A verbal update will be provided at the Board meeting.

The full Fit and Proper Persons Framework can be found in Appendix 1.

Classification: Official

Publication reference: PRN00238_i

NHS England Fit and Proper Person Test Framework for board members

2 August 2023

NHS England has developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles.

In the foreword to his review, Tom Kark KC stated that “The culture and management of each hospital Trust flows from the management team. Thus, the quality and culture of the management team is of the greatest significance to the ethos and success of the hospital, the effectiveness, and the working conditions (in the widest sense) of its staff, and ultimately the care, comfort, and safety of the patients to whom the Trust provides health services.”

The framework will introduce a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.

This framework should be read in conjunction with associated guidance documents.

Contents

Section 1: Introduction

1.1 Background

The Kark Review (2019) was commissioned by the government in July 2018 to review the scope, operation and purpose of the Fit and Proper Person Test (FPPT) as it applies under the current Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This included looking at how effective the FPPT is:

> "… in preventing unsuitable staff from being redeployed or re-employed in the NHS, clinical commissioning groups, and independent healthcare and adult social care sectors."

The review highlighted areas that needed improvement to strengthen the existing regime.

The specific recommendations from the Kark Review (2019) have been detailed in Appendix 1.

1.2 Purpose and benefits

This document supports the implementation of the recommendations from the Kark Review, and promotes the effectiveness of the underlying legal requirements by establishing a Fit and Proper Person Test Framework (also known as the 'Framework'). The purpose is to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

The Framework is effective from 30 September 2023 and should be implemented by all boards going forward from that date. NHS organisations are not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward.

The Framework should be read in conjunction with the NHS Constitution, NHS People Plan, People Promise and forthcoming NHS Leadership Competency Framework for leaders at board level. This Framework supports transparency and should be the start of an ongoing dialogue between board members about probity and values. It should be seen as a core element of a broader programme of board development, effective

appraisals and values-based (as well as competency-based) appointments – all of which are part of the good practice required to build a 'healthy' board.

The aim of strengthening the FPPT is to prioritise patient safety and good leadership in NHS organisations. The Framework will help board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations.

The Framework will be fair and proportionate and has been developed with the intention to avoid unnecessary bureaucratic burden on NHS organisations.

Ensuring high standards of leadership in the NHS is crucial – well-led NHS organisations and better-led teams with both strong teamwork and strong governance translate into greater staff wellbeing and better clinical care. This requires accountable board members with both outstanding personal conduct and professional capabilities to effectively oversee NHS organisations that are often under significant financial restraint and operating in a highly regulated environment with public and political scrutiny.

As the FPPT assessment is on an individual basis, rather than in relation to the board as a whole, it is envisaged that aspirant board members who can demonstrate the characteristics described above should not be deterred from seeking to join the board of a more challenged NHS organisation. The FPPT assessment is one of general competence to act as a board member, and situational context should therefore be taken into account.

Ensuring that board members are demonstrating the right behaviours will help the NHS drive its cultural initiatives: namely, to foster a culture of compassion, respect and inclusion, and a feeling of belonging; as well as setting the tone at the top to encourage a listening and speaking up culture.

1.3 Applicability

The Framework applies to the board members of NHS organisations. Within this guidance, the term 'board member' is used to refer to:

- both executive directors and non-executive directors (NEDs), irrespective of voting rights
- interim (all contractual forms) as well as permanent appointments

- those individuals who are called ‘directors’ within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Those individuals who by virtue of their profession are members of other professional registers, such as the General Medical Council (GMC) or Nursing and Midwifery Council (NMC), should still be assessed against this Framework if they are a board member at an NHS organisation.

The Framework is designed to assess the appropriateness of an individual to effectively discharge their duties in the capacity of a board member.

It is recognised that some organisations may want to extend the FPPT assessment to other key roles, for example, to those individuals who may regularly attend board meetings or otherwise have significant influence on board decisions. The annual submission requirement is, however, limited to board members only.

Within this guidance, the term ‘NHS organisations’ refers to those institutions to which the Framework will apply; for the purposes of this Framework, this includes:

- NHS trusts
- NHS foundation trusts
- integrated care boards (ICBs)
- the following arm’s length bodies in the first instance:
  - Care Quality Commission (CQC)
  - NHS England.

ICB chairs will need to consider FPPT assessment on a member-by-member basis and take into account assurance received from other recruiting/appointing organisations, for example, in the case of partner members.

1.4 Personal data

Personal data relating to the FPPT assessment will be retained in local record systems and specific data fields in the NHS Electronic Staff Record (ESR). The information contained in these records will not routinely be accessible beyond an individual’s own organisation. There will be no substantive change to the data controller arrangements from those already in place for ESR.

Although, as set out below, NHS England will not have day-to-day access to the system or its content, NHS England recognises that it may be considered a (joint) controller of the ESR fields because as the commissioner of the ESR module and author of the Framework, it has a role in determining the nature and purposes of processing.

The organisations that are uploading the content (and determining what is said about each board member), and the NHS Business Services Authority (as the main commissioner of ESR), will also each be a data controller. For the purposes of Article 26 UK GDPR, NHS England has put in place 'transparent arrangements' to set out its responsibilities in this respect.

NHS England has established that the most relevant lawful basis for processing the FPPT data contained in ESR is set out in Article 6(1)(e) UK GDPR. This is on the basis that the processing of personal data is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller (that is, the employer, or indeed NHS England in connection with any role it fulfils as a joint controller).

The aim of the maintaining a record of FPPT outcomes in ESR is to significantly improve the management of the NHS, and ultimately the experience and outcomes for patients, and is therefore in the public interest and done as part of the exercise of the functions of the organisation concerned.

As special category data would be processed as part of the maintenance of the ESR FPPT data fields, controllers will also rely on one of the lawful bases for processing set out in Article 9 UK GDPR: Articles 9(2)(b) – employment; 9(2)(g) – statutory/public functions; and 9(2)(h) (read with Schedule 1, paragraph 2 of the Data Protection Act 2018). This covers processing that is 'necessary for the management of the health service.'

NHS England recognises the requirements of Article 5(1) UK GDPR, and that personal data should be processed lawfully, fairly and transparently. In line with all other ESR data fields, fair processing information will be available to the users of the ESR system. Current ESR fair processing information can be found in the NHS Electronic Staff Record (ESR) privacy notice. The Framework and related guidance documents also help discharge transparency-related obligations.

Information that is the personal data of the applicant is exempt from the Freedom of Information Act under section 40(1) and any request should be processed under section

7 of the DPA. Regulation 5(3) of the EIR is the equivalent provision and has the same effect.

Arrangements for dispute resolution or request for review of content of data (in ESR and local records), or relating to the FPPT assessment outcome, are set out in the guidance document for chairs.

The launch of the Framework will involve NHS England and participating data controllers (NHS trusts, foundation trusts and integrated care boards) communicating to all board members in their organisation whose details will be included in ESR, in advance of the FPPT Framework (and standard reference tools) going live on 30 September 2023. By doing so directors will be afforded the opportunity to object if they have concerns regarding the proposed use of their data, and NHS England and participating data controllers will be able to consider these concerns and amend their approach if necessary. An example of a board member FPPT privacy template is attached at Appendix 6. Organisations should ensure that an appropriate policy document is in place in relation to special category data.

Section 2: Context

2.1 Current fit and proper persons regulations

In 2014, the government introduced a 'fit and proper person' requirement, via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 'Regulations').

This sets out the requirements for a FPPT which applies to directors and those performing the functions of, or functions equivalent or similar to the functions of, a director in all NHS organisations registered with the CQC, which includes all licence holders and other NHS organisations to which licence conditions apply. For the purposes of this guidance, we have referred to these individuals as 'board members'.

Regulation 5 recognises that individuals who have authority in NHS organisations that deliver care are responsible for the overall quality and safety of that care. The regulation requirements are that:

a) the individual is of good character

b) the individual has the qualifications, competence, skills and experience that are necessary for the relevant office or position or the work for which they are employed

c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed

d) the individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity

e) none of the grounds of unfitness specified in part 1 of Schedule 4 apply to the individual.

The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged

b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland

c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986

d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it

e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland

f) the person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

The good character requirements referred to above in Regulation 5 are specified in Part 2 of Schedule 4 to the Regulated Activities Regulations, and relate to:

a) whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence

b) whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

Integrated care boards (ICBs) are statutory bodies with the general function of arranging for the provision of services for the purposes of the health service in England and are NHS bodies for the purposes of the 2006 Act. The main powers and duties of ICBs are to commission certain health services as set out in sections 3 and 3A of the 2006 Act.

ICBs, together with the CQC and NHS England, are within scope of this Framework. One of the recommendations made by Tom Kark KC was to extend the scope of the FPPT into certain arm's length bodies (ALBs) to:

> "…bolster the strength and width of the test, as well as to put a stop to 'the revolving door,' the FPPT should be extended to commissioners as well as other arms-length bodies. It was described as 'incongruous' that it did not apply to commissioners."

2.2 Related principles and values

This section summarises relevant principles and values that underpin the Framework and provide additional context to understand its aims.

2.2.1 NHS Constitution

The NHS Constitution states:

> The NHS belongs to the people.
>
> It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives.
>
> It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need when care and compassion are what matter most.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

2.2.2 NHS guiding principles

The seven guiding principles that govern the way the NHS operates, and define how it seeks to achieve its purpose:

1. The NHS provides a comprehensive service, available to all.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism.
4. The patient will be at the heart of everything the NHS does.
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities, and the wider population.
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair, and sustainable use of finite resources.
7. The NHS is accountable to the public, communities, and patients that it serves.

2.2.3 NHS values

These principles are underpinned by the core NHS values, which have been derived from extensive discussions with staff, patients and the public. The values are integral to creating a culture where patients come first in everything the NHS does.

These values are not intended to be limiting. Individual NHS organisations should use them as a basis on which to develop their own values, adapting them to local circumstances. The values should be taken into account when developing services with partner NHS organisations, patients, the public and staff.

The six core values are:

1. Working together for patients.
2. Respect and dignity.
3. Commitment to quality of care.

4. Compassion.
5. Improving lives.
6. Everyone counts.

2.2.4 The Nolan Principles of Standards in Public Life

NHS board members, in their capacity as public office holders, are expected to abide by the 'Nolan Principles' as defined by the Committee on Standards in Public Life:

1. Selflessness
   - Holders of public office should act solely in terms of the public interest.
2. Integrity
   - Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family or their friends. They must declare and resolve any interests and relationships.
3. Objectivity
   - Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
4. Accountability
   - Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
5. Openness
   - Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
6. Honesty
   - Holders of public office should be truthful.
7. Leadership

- Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

Section 3: FPPT Framework

The Framework sets out:

- When the full FPPT assessment is needed, which includes self-attestations (see sections 3.2 and 3.3).
- New appointment considerations (section 3.4).
- Additional considerations in specific situations such as joint appointments, shared roles and temporary absences (section 3.5).
- The role of the chair in overseeing the FPPT (section 3.6).
- The FPPT core elements to be considered in evaluating board members (section 3.7).
- The circumstances in which there will be breaches to the core elements of the FPPT (regulation 5) (section 3.8).
- The requirements for a board member reference check (section 3.9).
- The requirements for accurately maintaining FPPT information on each board member in the ESR record[1] (section 3.10).
- The record retention requirements (section 3.11).
- Dispute resolution (section 3.12).
- Quality assurance over the Framework (section 4).

Ultimate accountability for adhering to this framework will reside with the chair of an NHS organisation.

Throughout this document and the associated guidance, the term ‘ESR’ refers to the FPPT data fields in ESR. It is important to note that:

- Information held in ESR about board members is accessible by a limited number of senior individuals within their own organisation only.
- There is no access to FPPT information about board members in one organisation by another organisation or individual.

ESR provides a tool for individual organisations to record that testing has been carried out for the chair, who has overall accountability for the FPPT within their organisation. It

[1] For the purpose of the FPPT framework, ‘ESR’ refers to the FPPT data fields in ESR.

also records that testing is complete and enables reports to be run at local level as an audit trail of completed testing and sign off.

ESR is not a public register – there is no access to it by the public/externally. It provides a tool to help support chairs record some of their key FPPT requirements and provides a sign-off facility in one place. It is good practice for NHS organisations to report on the high-level outcome of the FPPT assessments in the annual report or elsewhere on their websites.

3.1 FPPT overview

The duty to take account of 'fit and proper person' requirements is pervasive, continuous and ongoing. However, for the purposes of the Framework, NHS England considers it appropriate for NHS organisations to be able to consistently demonstrate, on an annualised basis, that a formal assessment of fitness and properness for each board member has been undertaken. NHS organisations should consider carrying out the assessment alongside the annual appraisal.

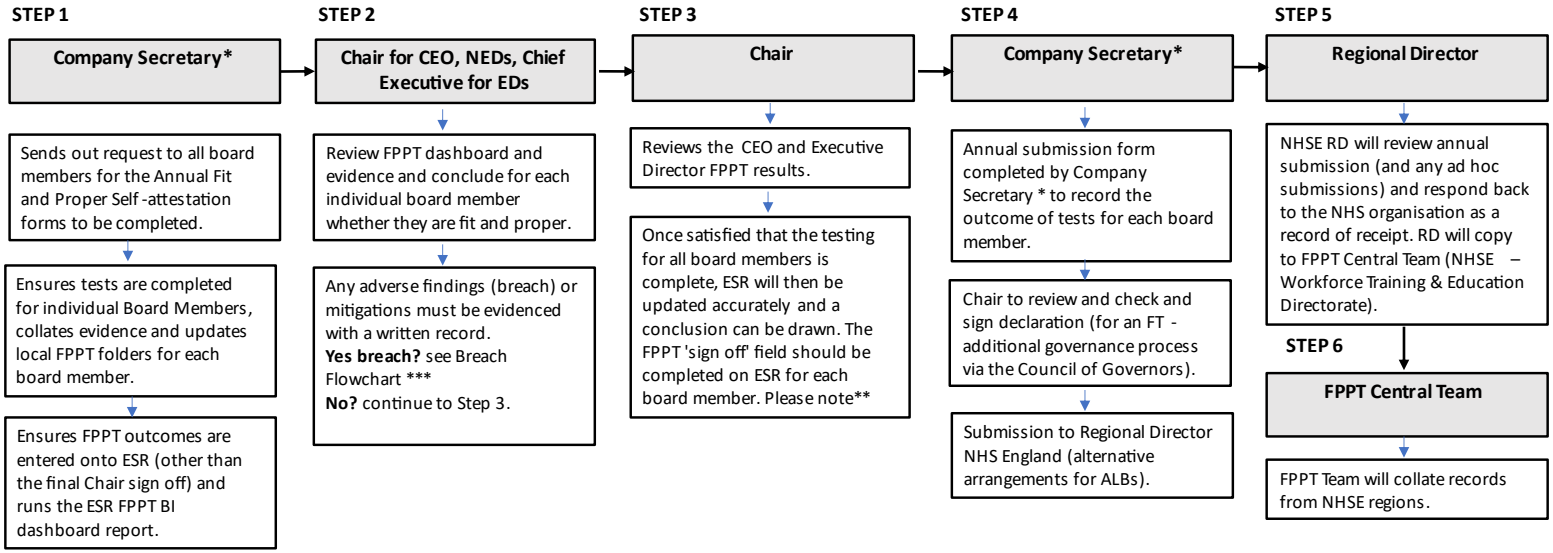
Chairs should ensure that their NHS organisation can show evidence that appropriate systems and processes are in place to ensure that all new and existing board members are, and continue to be, fit and proper (that is, the board members meet the requirement of Regulation 5), and that no appointments breach any of the criteria set out in Schedule 4 of the regulations.

Such systems and processes include (but are not limited to) recruitment, induction, training, development, performance appraisal, governance committees, disciplinary and dismissal processes.

As such, the chair in each NHS organisation will be responsible for ensuring that their organisation conducts and keeps under review a FPPT (in line with the list in section 3.2 below) to ensure board members are, and remain, suitable for their role.

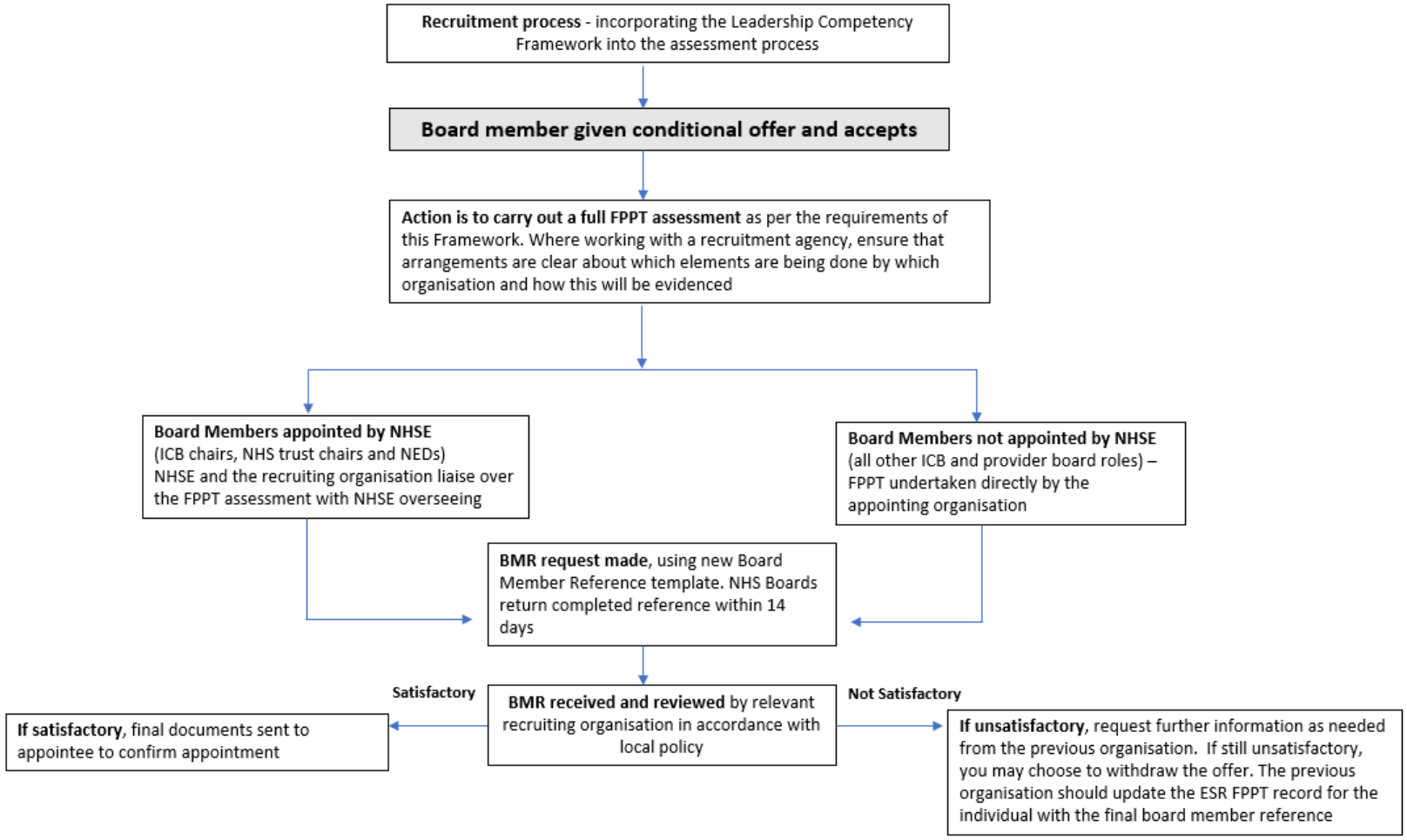
In evaluating a board member's fitness, a decision is expected to be reached on the fitness of the board member that is in the range of decisions that a reasonable person would make. NHS England recognises that chairs will need to make judgements about the suitability of board members and will support balanced judgements made in the spirit of the Framework.

The suggested approach to the assessment, including the Board Member Reference process, is set out in the three flow charts below and is also described in more detail in the supporting chairs' guidance document.

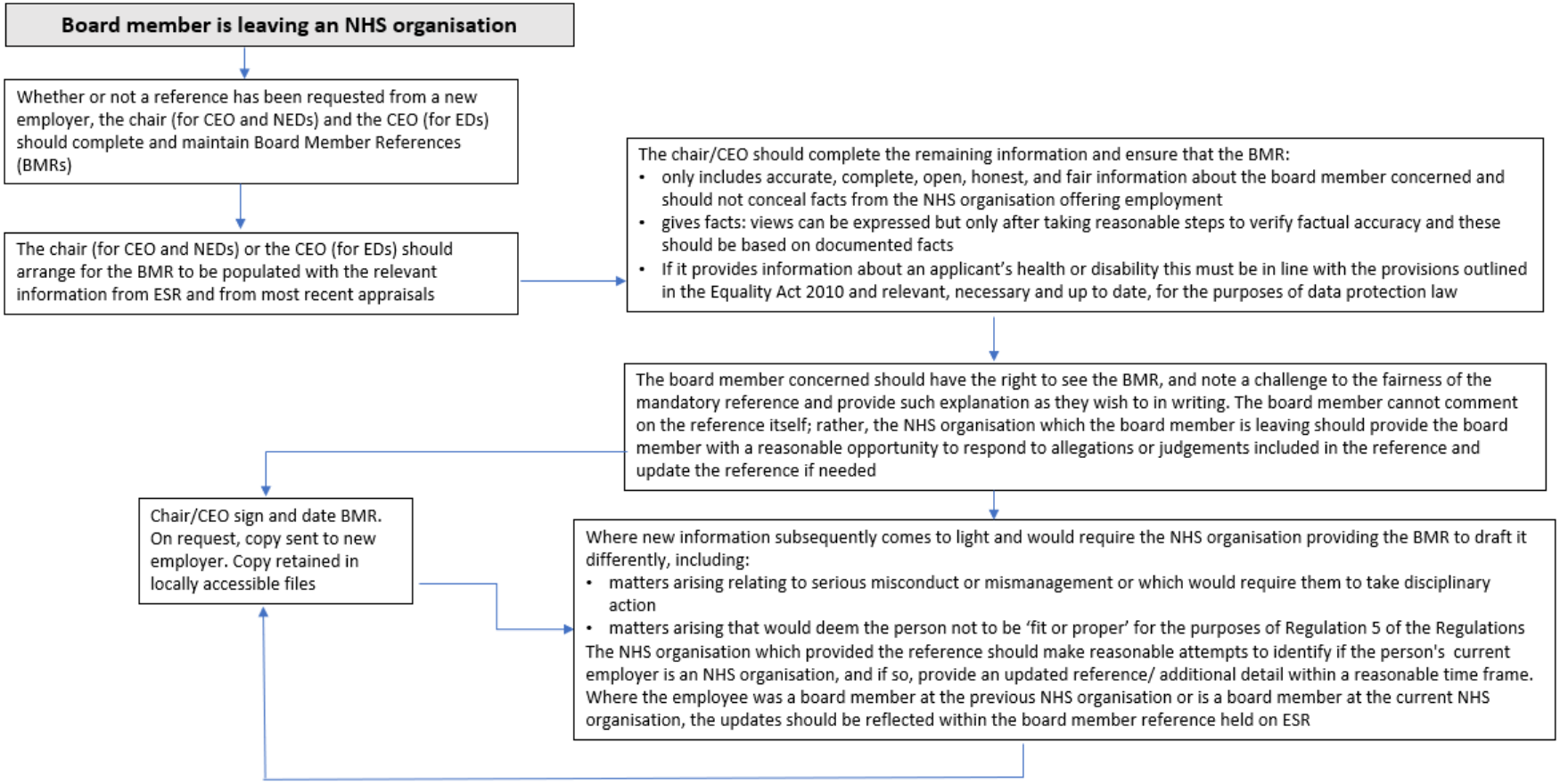


*Or senior member of staff nominated by and behalf of, the Chair, e.g., HRD
** SID/Deputy Chair to carry out FPPT on the Chair and 'sign off'
*** Please refer to the Chairs Guidance for the Breach Flowchart
SID = Senior Independent Director
ESR= Electronic Staff Record

Board Member Reference (BMR) – for appointments



Board Member Reference (BMR) – for leavers



3.2 Full FPPT assessment

A documented, full FPPT assessment – a complete assessment by the employing NHS organisation against the core elements (detailed in section 3.7) – will be needed in the following circumstances:

1. New appointments in board member roles, whether permanent or temporary, where greater than six weeks, this covers:
    a. new appointments that have been promoted within an NHS organisation
    b. temporary appointments (including secondments) involving acting up into a board role on a non-permanent basis
    c. existing board members at one NHS organisation who move to another NHS organisation in the role of a board member
    d. individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside the NHS.

2. When an individual board member changes role within their current NHS organisation (for instance, if an existing board member moves into a new board role that requires a different skillset, eg chief financial officer).

3. Annually; that is, within a 12-month period of the date of the previous FPPT to review for any changes in the previous 12 months.

Note: for points 1a – 1b above (new appointments) the full FPPT will also include a board member reference check (see section 3.9).

For points 2 and 3 above, the board member reference check will not be needed.

The exact requirements for the initial FPPT assessment versus the annual FPPT assessment thereafter are detailed in section 3.10.1.

3.3 Self-attestation

Every board member will need to complete an annual self-attestation, to confirm that they are in adherence with the FPPT requirements. Self-attestations will be a necessary step that forms a part of the full FPPT assessment (see Appendix 3).

3.4 New appointments

NHS organisations should be able to demonstrate that appointments of new board members are made through a robust and thorough appointment process.

As such, no new appointments should be made to the post of board member unless the appointee concerned can demonstrate they have met the FPPT requirements as detailed in section 3.7 of this document.

As part of conducting the initial appointment process for a board member, an inter-authority transfer (IAT)[2] could be submitted to identify any of the applicant's previous or current NHS service/employment history. Alternatively, other arrangements could be made to collate the relevant information. This should also help identify any potential duplicate employment accounts for the appointee, eg when someone has more than one NHS role on ESR.

For the initial appointment of NHS trust chairs and ICB chairs only, once the NHS organisation has obtained board member references and completed the fit and proper person assessment, FPPT approval should be sought from the NHS England Appointments Team before they commence their role.

3.5 Additional considerations

There will be additional considerations when applying the FPPT for joint appointments across NHS organisations, shared roles within the same NHS organisation and periods of temporary absence. These additional considerations have been detailed below.

3.5.1 Joint appointments across different NHS organisations

Additional considerations are needed where there are joint appointments to support closer working between NHS organisations in the health and care system.

For instance, where joint appointments of a board member can help foster joint decision-making, enhance local leadership and improve the delivery of integrated care. Joint appointments may occur where:

- two or more NHS organisations want to create a combined role

[2] An IAT is an electronic way of gathering information from an employer for an applicant's previous or current NHS service using the ESR system. How to complete an Inter Authority Transfer (IAT) check in NHS Jobs user guide (nhsbsa.nhs.uk)

- two or more NHS organisations want to employ an individual to work across the different NHS organisations in the same role.

In the scenario of joint appointments, the full FPPT would need to be completed by the designated host/employing NHS organisation and in concluding their assessment they will need input from the chair of the other contracting NHS organisation to ensure that the board member is fit and proper to perform both roles.

The host/employing NHS organisation will then provide a 'letter of confirmation' (Appendix 4) to the other contracting NHS organisation to confirm that the board member in question has met the requirements of the FPPT.

The chair of the other contracting NHS organisation has the responsibility to keep the host/employing NHS organisation abreast of changes and any matters that may impact the FPPT assessment of the board member.

Where there is a joint appointment, the host/employing NHS organisation responsible for the FPPT should also lead on conducting the joint appraisal and ensure adequate input from the other contracting NHS organisation.

Where the joint appointment results in a new board member (for the NHS organisation in question), it will constitute a new appointment and as such, the host/employing NHS organisation should provide a 'letter of confirmation' to the other NHS organisation(s).

For the avoidance of doubt, where two or more organisations employ or appoint (in the case of a chair or NED) an individual for two or more separate roles at the same time, each organisation has a responsibility to complete the FPPT.

If the FPPT assessment at one organisation finds an individual not to be FPP, the chair should update their counterpart of any other NHS organisation(s) where the individual has a board-level role and explain the reason. To note, the issue at one organisation may be one of role-specific competence, which may not necessarily mean the individual is not FPP at the other organisation.

3.5.2 Shared roles within the same NHS organisation

Where two individuals share responsibility for the same board member role (eg a job share) within the same NHS organisation, both individuals should be assessed against the FPPT requirements in line with sections 3.2 and 3.3.

3.5.3 Temporary absence

For the purpose of the FPPT process, a temporary absence is defined as leave for a period of six consecutive weeks or less (eg sick leave, compassionate leave or parental leave) and where the NHS organisation is leaving the role open for the same board member. As such there is no requirement to approve another permanent individual for the role of board member.

Where there is a temporary absence, it is expected that the HR director/company secretary will liaise with the chair and chief executive to ensure temporary cover is provided; and to ensure that local internal systems are adequately updated to record the start and projected end date of the temporary absence.

Where an individual is appointed as temporary/interim cover and is not already assessed as fit and proper, the NHS organisation should ensure appropriate supervision by an existing board member.

A full FPPT assessment should be undertaken for an individual in an interim cover role exceeding six weeks. Therefore, if the interim cover is expected to be in post for longer than six weeks, the NHS organisation should look to commence the FPPT assessment as soon as possible. Where the period of temporary absence is extended beyond six weeks, the FPPT assessment should commence as soon as the NHS organisation is aware of the extension. This FPPT assessment should be carried out in line with the requirements under section 3.2.

3.6 Role of the chair in overseeing FPPT

Chairs are accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of their NHS organisation is maintained to support an effective FPPT regime. As such, chairs' responsibilities are as below:

a) Ensure the NHS organisation has proper systems and processes in place so it can make the robust assessments required by the FPPT.

b) Ensure the results of the full FPPT, including the annual self-attestations for each board member, are retained by the employing NHS organisation.

c) Ensure that the FPPT data fields within ESR are accurately maintained in a timely manner.

d) Ensure that the board member references/pre-employment checks (where relevant) and full FPPT (including the annual self-attestation) are complete and adequate for each board member.

e) Ensure an appropriate programme is in place to identify and monitor the development needs of board members.

f) On appointment of a new board member, consider the specific competence, skills and knowledge of board members to carry out their activities, and how this fits with the overall board.

g) Conclude whether the board member is fit and proper.

h) Chairs will also complete an annual self-attestation that they themselves are in continued adherence with the FPPT requirements. On an annual basis, chairs should confirm that all board members have completed their own FPPT self-attestation and that the FPPT is being effectively applied in their NHS organisation.

i) Ensure that for any board member approved to commence work or continue in post despite there being concerns about a particular aspect of the FPPT, they document the reason(s) as to why there has been an issue about whether a board member might not be fit and proper and the measures taken to address this. A local record of this should be retained. A summary of this should also be included in the annual FPPT submission form (Appendix 5) to the relevant NHS England regional director.

Accountability for ensuring a new board member meets the FPPT assessment criteria will reside with the chair. In making such decisions the chair will be supported by existing processes and committees.

In considering their overall assessment of board members, chairs should confirm points d) and g) are adequately addressed, and where relevant for point i), appropriate action has been taken to address any concern.

It is good practice for the chair to present a report on completion of the annual FPPT in accordance with local policy, to the board in a public meeting and, where applicable, to the Council of Governors for Non-Executive Directors, for information.

3.6.1 Overseeing the role of the chair

Chairs will be subject to the same FPPT requirement, as per sections 3.2 and 3.3. In completing their own annual self-attestation, chairs will effectively be confirming that they have adequately addressed points a), b), c), e), f) and h) of section 3.6 above.

The accountability for ensuring that chairs in NHS trusts, foundation trusts and ICBs meet the FPPT assessment criteria will reside with NHS England regional directors, as is also the case for the chairs' annual appraisals.

For the chairs of NHS England and the CQC, this accountability will reside with the Department of Health and Social Care (DHSC).

Annually, the senior independent director (SID) or deputy chair will review and ensure that the chair is meeting the requirements of the FPPT.

If the SID and deputy chair are the same individual, another NED should be nominated to review the chair's FPPT on a rotational basis.

Once the NHS organisation has completed their annual FPPT assessment of the chair, they should sign this off within ESR. The annual FPPT submission, which summarises the results of the FPPT for all board members in the organisation, is then sent to the relevant NHS England regional director.

In relation to foundation trusts, there are no proposed changes to the Council of Governors' responsibilities in relation to the chair's FPPT assessment as it is not within the scope of the Framework to do so. However, as the chairs' annual appraisals are presented to the Council of Governors for information, the same should be the case for a summary of the outcome of the FPPT for non-executive board members.

This information can be retained by the Council of Governors as part of future considerations for any reappointments. Similarly, the Council of Governors should be informed of a satisfactory initial FPPT assessment for new chair and NED appointments.

3.7 FPPT assessment – core elements

This section of the Framework details the core elements that should be included in an FPPT assessment. The checks that underpin the core elements reflect the assessment criteria per Regulation 5 and Schedule 4 of the Regulations.

The full FPPT assessment will constitute an assessment against each of the core elements detailed below and should be conducted in accordance with section 3.2. Individual board members should complete self-attestations to confirm they are fulfilling the core elements of the FPPT assessment, as described below.

NHS organisations should assess board members against the following three core elements when considering whether they are a fit and proper person to perform a board role:

- Good character.
- Possessing the qualifications, competence, skills required and experience.
- Financial soundness.

Note: the FPPT checks relating to these core elements will be in addition to standard employment checks, as per the NHS organisation's recruitment and selection procedures and NHS Employers' pre-employment check standard. This can include CV checks, self-declarations, Google searches, proof of qualifications, proof of identity, right to work, etc.

The section below, which considers both Regulation 5 and Schedule 4 of the Regulations, explains matters that the NHS organisation should take account of in relation to the three core elements.

When an NHS organisation assesses a board member against these core elements in relation to being a fit and proper person, they should consider the nature, complexity and activities of their NHS organisation.

3.7.1 Good character

There is no statutory guidance as to how 'good character' in Regulation 5 of the 2014 Regulations should be interpreted. Chairs should be aware of the elements to consider when assessing good character (as detailed below).

To encourage openness and transparency, these should not be considered as a strict checklist for compliance, but rather as points for a conversation between the chair (or chief executive for executive board members) and a prospective board member during the appointment process. This will in turn emphasise the ongoing benefits of openness and transparency among board members.

When assessing whether a person is of good character, NHS organisations should follow robust processes to make sure that they gather appropriate information, and must have regard to the matters outlined in Part 1 and Part 2 of Schedule 4, namely:

- Convictions of any offence in the UK.
- Convictions of any offence abroad that constitutes an offence in the UK.
- Whether any regulator or professional body has made the decision to erase, remove or strike off the board member from its register, whether in the UK or abroad.

As such, NHS organisations should conduct:

- A search of the Companies House register to ensure that no board member is disqualified as a director.
- A search of the Charity Commission's register of removed trustees.
- A Disclosure and Barring Service (DBS) check in line with their local policy requirements:
  - each NHS organisation should outline within their local policy the relevant DBS check (basic, standard, enhanced or enhanced with barred lists) required for each individual board member role
  - in defining the required DBS level, NHS organisations should identify those board roles that fall within the definition of a 'regulated activity', as defined by the Safeguarding Vulnerable Groups Act 2006, as required barred list checks.
- A check with the relevant professional bodies where appropriate.

It is not possible to outline every character trait that a person should have, but it is expected that processes followed take account of a person's honesty, trustworthiness, reliability, integrity, openness (also referred to as transparency), respectfulness and ability to comply with the law.

Furthermore, in considering that a board member is of 'good character,' the relevant NHS organisation should also consider the following in relation to the individual in question:

- Compliance with the law and legal processes.
- Employment tribunal judgements relevant to the board member's history.

- Settlement agreements relating to dismissal or departure from any healthcare-related service or NHS organisation for any reason other than redundancy.
- A person in whom the NHS organisation, CQC, NHS England, people using services and the wider public can have confidence.
- Adherence to the Nolan Principles of Standards in Public Life.
- The extent to which the board member has been open and honest with the NHS organisation.
- Whether the person has been the subject of any adverse finding or any settlement in civil proceedings, particularly in connection with investment or other financial business, misconduct, fraud or the formation or management of a body corporate.
- Whether the person has been involved – as a director, partner or concerned in management – with a company, partnership or other organisation that has been refused registration, authorisation, membership or a licence to carry out a trade, business or profession.
- Whether the person has been a director, partner or concerned in the management of a business that has gone into insolvency, liquidation or administration while the person has been connected with that organisation or within one year of that connection.
- Whether the person involved as a director, partner or concerned with management of a company has been investigated, disciplined, censured, suspended, or criticised by a regulatory or professional body, a court or tribunal, whether publicly or privately.
- Any other information that may be relevant, such as an upheld/ongoing or discontinued (including where a board member has left the NHS organisation prior to an investigation being completed):
  - disciplinary finding
  - grievance finding against the board member
  - whistleblowing finding against the board member
  - finding pursuant to any trust policies or procedures concerning board member behaviour.

3.7.1.1 Serious mismanagement or misconduct

To comply with Regulation 5, consideration of good character should also ensure, as far as possible, the individual has not been responsible for, contributed to or facilitated any

serious misconduct or mismanagement (whether unlawful or not) in the course of delivering CQC-regulated activity, in England or equivalent activities elsewhere.

In determining what amounts to 'serious misconduct or mismanagement,' beyond the decision by a court or professional regulators regarding individuals, context is paramount. Normally these would require to be findings of serious misconduct or mismanagement that are upheld after a disciplinary process.

NHS organisations should consider the mismanagement and misconduct behaviours in relation to the services they provide, the role of the board member/individual and the possible adverse impact on the NHS organisation or confidence in its ability to carry out its mandate and fulfil its duties in the public interest.

As part of reaching an assessment as to whether any actions or omissions of the board member amount to 'serious misconduct or mismanagement', NHS organisations should consider whether an individual board member played a central or peripheral role in any wider misconduct or mismanagement.

The NHS organisation should also consider whether there are any aggravating or mitigating factors; for instance (including but not limited to):

- The extent to which the conduct was deliberate and reckless.
- The extent to which the conduct was dishonest.
- Whether the issues are frequent or have continued over a long period of time.
- If lack of experience contributed to the issue that has been remediated through training.
- The extent to which the board member (or aspirant board member) demonstrates insight and self-reflection in relation to the conduct/issues identified.

Although NHS organisations have information on when convictions, bankruptcies or similar matters are to be considered 'spent', there is no time limit for considering serious misconduct or responsibility for failure in a previous role, for the purposes of Regulation 5.

Below are some examples of misconduct and mismanagement that NHS organisations would be expected to conclude as amounting to serious misconduct or

mismanagement, unless there are exceptional circumstances that make it unreasonable to determine that there is serious misconduct or mismanagement.

It is impossible to produce a definitive list of all matters that would constitute serious misconduct or mismanagement and, as such, the list below is not exhaustive.

This list sets the minimum expectations and should be read in conjunction with local policy expectations/requirements to determine whether or not a board member has been involved in serious misconduct or mismanagement:

- Fraud or theft.
- Any criminal offence other than minor motoring offences at work (although this and the issues set out in this section may be relevant to assessing whether an individual is of good character more generally).
- Assault.
- Sexual harassment of staff.
- Bullying or harassment.
- Discrimination as per the Equality Act 2010.
- Victimisation (which falls within the scope of the Equality Act 2010) of staff who raise legitimate concerns.
- Any conduct that can be characterised as dishonest, including:
  - deliberately transmitting information to a public authority or to any other person, which is known to be false
  - submitting or providing false references or inaccurate or misleading information on a CV.
- Disregard for appropriate standards of governance, including resistance to accountability and the undermining of due process.
- Failure to make full and timely reports to the board of significant issues or incidents, including clinical or financial issues.
- Repeated or ongoing tolerance of poor practice, or failure to promote good practice, leading to departure from recognised standards, policies or accepted practices.
- Continued failure to develop and manage business, financial or clinical plans.

In assessing whether misconduct or mismanagement was ‘serious’, regard should be had to all the circumstances. For instance, an NHS organisation could consider isolated

incidences of the following types of behaviour to amount to misconduct or mismanagement that does not reach the threshold of seriousness:

- Intermittent poor attendance.
- Failure to follow agreed policies or processes when undertaking management functions where the failures had limited repercussions or limited effects or were for a benevolent or justifiable purpose.

3.7.2 Qualifications, competence, skills required and experience

NHS organisations need to have appropriate processes for assessing and checking that the candidate holds the required qualifications and has the competence, skills and experience required.

For instance, where possible, checking the websites of the professional bodies to confirm that where required the board member holds the relevant and stated qualification.

Where NHS organisations consider that a board member role requires specific qualifications (for example, the chief financial officer being an accredited accountant, or the chief medical officer being a GMC-registered doctor), they should make this clear and should only appoint those candidates who meet the required specification, including any requirements to be registered with a professional body.

As such, job descriptions and person specifications should be clear in detailing required skills and relevant qualifications and/or memberships. These should be reviewed to ensure that they are appropriate and tailored for each board role.

In assessing competence, skills and experience for the purposes of the FPPT, the NHS organisation should look to use the outcome of their appraisal processes for board members, which will be based on the NHS Leadership Competency Framework (LCF) for board level leaders: a framework that will apply to all NHS organisations.

Given the appraisal process will feed into the full FPPT assessment, the appraisal process should be of an appropriate frequency and should give due consideration to assessing good character and conduct (that is, a behavioural assessment).

The NHS LCF provides guidance for the competence categories against which a board member should be appointed, developed and appraised. The LCF covers the following six competence categories:

- Setting strategy and delivering long term transformation.
- Leading for equality.
- Driving high quality, sustainable outcomes.
- Providing robust governance and assurance.
- Creating a compassionate and inclusive culture.
- Building trusted relationships with partners and communities.

In assessing whether a board member has the competence, skills and experience to be considered fit and proper, the FPPT assessment will:

- not just consider current abilities, but also have regard to the formal training and development the board member has undergone or is undergoing
- take account of the NHS organisation (its size and how it operates) and the activities the board member should perform
- consider whether the board member has adequate time to perform and meet the responsibilities associated with their role.

Regarding formal training:

- NHS organisations should ensure any necessary training is undertaken by board members where gaps in competency have been identified.
  - As such, a tailored learning development plan and training framework should support board members.
  - Both the development plan and training should be updated and delivered respectively with an appropriate frequency.

- Training constitutes continued development for board members.
  - Those consistently failing to undergo required training in a timely manner should be deemed to have missed an important obligation, and appropriate action should be taken in line with the NHS organisation's policies and procedures.
  - In turn, this may mean that a board member is not fit and proper.

3.7.2.1 Reasonable adjustments

In assessing if a board member can properly perform tasks to the requisite level of competence and skill for the office or position for which they are appointed,

consideration will be given to their physical and mental health in accordance with the demands of the role and good occupational health practice.

This means all reasonable steps must be made to make adjustments for people to enable them to carry out their role. As a minimum, these must be in line with requirements to make reasonable adjustments for employees under the Equality Act 2010; to prevent discrimination as defined by the Act.

Hence when appointing a person to a role, NHS organisations should have processes for considering their physical and mental health in line with the requirements of the role.

As such, NHS organisations should undertake occupational health assessments (OHA) for potential new board member appointments, in circumstances where the individual in question has indicated a physical or mental health condition as part of pre-employment checks (eg medical assessment questionnaire).

The results of the OHA should be evaluated, and relevant reasonable adjustments should be made in line with the requirements under the Equality Act 2010, so an individual can carry out their role.

While the OHA will not form part of the annual FPPT, it is an integral component of the recruitment process checks to ensure that the NHS organisation can demonstrate that they have taken account of and made any such reasonable adjustments for those in board member roles. This obligation is ongoing in relation to those with disabilities for the purposes of the Equality Act 2010.

The statutory duty to make reasonable adjustments must be considered on an ongoing basis and applies where a disabled person is put at a substantial disadvantage.

3.7.3 Financial soundness

NHS organisations must seek appropriate information to assure themselves that board members do not meet any of the elements of the unfit person test set out in Schedule 4 Part 1 of the regulations.

Robust processes should be in place to assess board members in relation to bankruptcy, sequestration, insolvency and arrangements with creditors. This, as a minimum, will include search of the insolvency and bankruptcy register and checks over county court judgement (CCJ) or high court judgement for debt.

3.8 Breaches to core elements of the FPPT (Regulation 5)

Regulation 5 will be breached if:

1. A board member is unfit on the grounds of character, such as:
   - an undischarged conviction
   - being erased, removed or struck-off a register of professionals maintained by a regulator of healthcare, social work professionals or other professional bodies across different industries
   - being prohibited from holding a relevant office or position (see section 3.7.1).

2. A board member is also unfit on the grounds of character if they have been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying out a regulated activity.

3. A board member is unfit should they fail to meet the relevant qualifications or fail to have the relevant competence, skills and experience as deemed required for their role.

4. A board member is unfit on grounds of financial soundness, such as a relevant undischarged bankruptcy or being placed under a debt relief order.

5. An NHS organisation does not have a proper process in place to make the robust assessments required by the Regulations.

6. On receipt of information about a board member's fitness, a decision is reached on the board member that is not in the range of decisions a reasonable person would be expected to reach.

With regards to the above points, it is acknowledged that there could be circumstances where, for instance, board members are deemed competent but do not hold relevant qualifications.

In such circumstances there should be a documented explanation, approved by the chair, as to why the individual in question is deemed fit to be appointed as a board member, or fit to continue in role if they are an existing board member. This should be recorded in the annual return to the NHS England regional director (Appendix 5 part 2).

Furthermore, there may be a limited number of exceptional cases where a board member is deemed unfit (that is, they failed the FPPT) for a particular reason (other than qualifications) but the NHS organisation appoints them or allows them to continue their current employment as a board member.

In such circumstances there should be a documented explanation as to why the board member is unfit and the mitigations taken, which is approved by the chair. This should be submitted to the relevant NHS England regional director for review, either as part of the annual FPPT submission for the NHS organisation, or on an ad hoc basis as a case arises.

The NHS organisation shall determine breaches based on points 1 to 4, whereas any regulatory inspections, such as a CQC inspection will determine breaches of points 5 and 6.

3.9 Board member references

3.9.1 Content of the references

A standardised board member reference is being introduced to ensure greater transparency, robustness and consistency of approach when appointing board members within the NHS.

The aim of this is to help foster a culture of meritocracy, ensuring that only board members who are fit and proper are appointed to their role, and that there is no recycling of unfit individuals within the NHS.

The Leadership Competency Framework will help inform the ‘fitness’ assessment in FPPT. This is in line with the Kark Review’s (2019) recommendations on professional standards.

The Leadership Competency Framework references six competency domains which should be incorporated into all senior leader job descriptions and recruitment processes. It will also form the core of board appraisal frameworks, alongside appraisal of delivery against personal and corporate objectives.

The competency domains in the Leadership Competency Framework should be taken into account when the board member reference is written. It is recognised that no board director will be able to demonstrate how they meet all the competencies in the framework. What is sought as part of the board member reference is evidence of broad

competence across each of the six competency domains, and to ensure there are no areas of significant lack of competence which may not be remedied through a development plan.

Board level leaders will be asked to attest to whether they have the requisite experience and skills to fulfil minimum standards against the six competency domains. This attestation will be reviewed by the board director's line manager and overseen by the organisation's chair. The attestation record will be captured on ESR.

The annual attestation by board members is expected to be undertaken at the same time as the annual appraisal process and assessment of competence against the six competency domains will also be used to guide the board member's development plan for the coming year. The line manager will also capture stakeholder feedback as part of the appraisal process and summarise competence against each of the six competency domains. (A board member appraisal framework will be published ahead of the 2023/2024 appraisal process to support this process.) The annual appraisals of the past three years will then be used to guide the board member's reference.

NHS organisations will need to request board member references, and store information relating to these references (see section 3.10) so that it is available for future checks; and use it to support the full FPPT assessment on initial appointment.

NHS organisations should maintain complete and accurate board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and board member references should be retained locally.

Board member references will apply as part of the FPPT assessment when there are new board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks; specifically:

a. New appointments that have been promoted within an NHS organisation.
b. Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.
c. Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside of the NHS.

d. Individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.

It is important that board member references checks are carried out in accordance with the data protection principles, as set out within data protection law. In particular, the process should be undertaken fairly, and the information generated should be accurate and up to date.

Requests for board member references should not ask for specific information on whether there is a settlement agreement/non-disclosure agreement in place.

The board member reference request instead asks for any further information and concerns about an applicant's fitness and propriety, relevant to the FPPT to fulfil the role as a director, be it executive or non-executive.

Information on settlement agreements should be retained locally (where applicable) and included in the overall consideration of the fit and proper status of the individual in question.

If there is a historical settlement agreement/non-disclosure agreement already in place which includes a confidentiality clause, NHS organisations should seek permission from all parties prior to including any such information in a board member reference.

Going forward, NHS organisations should consider inclusion of a term in any proposed settlement agreement to state that information about the settlement agreement can be included in ESR, and in doing so will not be a breach of confidence.

The existence of a settlement agreement does not, in and of itself determine that a person is not fit or proper to be a board member.

The board member reference is based on the standard NHS reference and includes additional requests for information as follows (relevant to the FPPT):

- Information regarding any discontinued, outstanding, or upheld complaint(s) tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the organisation's policies and procedures (for example, under the trust's equal opportunities policy).

- Confirmation of any discontinued, outstanding or upheld disciplinary actions under the trust's disciplinary procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct.

- Any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the FPPT to fulfil the role as a director, be it executive or non-executive.

Discontinued investigations are included in the reference request to identify issues around serious misconduct and mismanagement and to deliberately separate them from issues around qualifications, competence, skills, and experience (which it is believed can be remedied) and health (which it is believed can improve), unless such competence and/or health issues could potentially lead to an individual not meeting the requirements of the FPPT.

Investigations (irrespective of reason for discontinuance) should be limited to those which are applicable and potentially relevant to the FPPT, and examples are as follows (this is not an exhaustive list and consideration will be needed on a case-by-case basis):

- Relating to serious misconduct, behaviour and not being of good character (as described in the FPPT Framework).
- Reckless mismanagement which endangers patients.
- Deliberate or reckless behaviour (rather than inadvertent behaviour).
- Dishonesty.
- Suppression of the ability of people to speak up about serious issues in the NHS, eg whether by allowing bullying or victimisation of those who speak up or blow the whistle, or any harassment of individuals.
- Any behaviour contrary to the professional Duty of Candour which applies to health and care professionals, eg falsification of records or relevant information.

The reason for discontinuing (including not commencing) an investigation should be recorded, including whether an investigation was not started or stopped because a compromise, confidentiality or settlement agreement was then put in place (recognising that such an agreement is not necessarily a conclusion that someone is not fit and proper for the purposes of the FPPT).

It will be necessary as a matter of fairness for the employee to have had an opportunity to comment on information that is likely to be disclosed as part of any reference request i.e., as part of any disciplinary procedures/action. NHS organisations should develop local policy about who provides references, when they are provided and what will/will not be included.

NHS organisations should take any advice that they deem necessary in an individual case where they have assessed that the employee or prospective employer is likely to bring a claim.

3.9.2 Obtaining references

At least one board member reference should be obtained when an NHS organisation is appointing a board member.

- For board members:
  - An NHS organisation should obtain a minimum of two board member references (using the board member reference template) where the individual is from outside the NHS, or from within the NHS but moving into the board role for the first time.
  - These two references should come from different employers, where possible.

- For an individual who moves from one NHS board role to another NHS board role, across NHS organisations:
  - Where possible one reference from a separate organisation in addition to the board member reference for the current board role will suffice.
  - This is because their board member reference template should be completed in line with the requirements of the framework so that NHS organisations can maintain accurate references when a board member departs.

- For a person joining from another NHS organisation:
  - The new employing/appointing NHS organisation should take reasonable steps to obtain the appropriate references from the person's current employer as well as previous employer(s) within the past six years.
  - These references should establish the primary facts as per the board member reference template.

- Where an employee is entering the NHS for the first time or coming from a post which was not at board member level:

- The new employing NHS organisation should make every practical effort to obtain such a reference which fulfils the board member reference requirements.
- In this scenario, the NHS organisation will determine their own reasonable steps to satisfy themselves they have pursued relevant avenues to obtain the information on potential incoming individuals through alternative means.
- For example, if a chief financial officer is joining from financial services, they can check the financial services register, or request for a mandatory reference under the financial services regulations.

It is acknowledged that where the previous employer is not an NHS organisation, there may be greater difficulty in obtaining a standardised NHS board member reference.

Nonetheless, for new appointments from outside of the NHS, employers should seek the necessary references to validate a period of six consecutive years of continuous employment (or provide an explanation for any gaps), or training immediately prior to the application being made.

In such cases where references from previous employers are unattainable for the previous six years, additional character or personal references should be sought. Character and personal references should be sought from personal acquaintances who are not related to the applicant, and who do not hold any financial arrangements with that individual.

References should never be used as the sole grounds for assessing an applicant's suitability for a post. Where negative issues are included in a reference, information should be carefully considered and weighed up against the wider range of evidence gathered as part of the recruitment process.

NHS organisations should aim to investigate negative information by sensitively raising it with the individual concerned, giving them the opportunity to explain the situation in more detail and/or, where appropriate, give them a chance to outline any learning from past mistakes or experiences to obtain the necessary assurances about their suitability for a role.

If a reference reveals something which is incompatible with the requirements of Regulation 5 of the Regulations, the individual should not be appointed to the role.

An NHS organisation should obtain references before the start of the board member's appointment. The NHS organisation requesting the reference should make it clear that this is being requested in relation to a person being appointed to the role of board member, or for other purposes linked to the board member's current employment.

The obligation to obtain a reference for a potential candidate for employment/ appointment in the role of board member applies irrespective of how the previous employment ended, for instance, resignation, redundancy, dismissal or fixed term work or temporary work coming to an end.

Where a potential candidate for employment/appointment in the role of board member has a gap between different employments, all reasonable efforts should be made to ensure that references covering those periods/gaps are obtained.

References should be obtained in writing (either via hardcopy or email) and NHS organisations will need to satisfy themselves that both the referee and the organisation are bona fide.

From time to time the information provided in a reference may contradict the information provided by board members.

There may be a reasonable explanation for apparent discrepancies and NHS organisations should proceed sensitively to seek the necessary assurances directly with the board member. In exceptional circumstances where there is serious misdirection, employers may feel it appropriate to report their concerns to the NHS Counter Fraud Authority.

Where an NHS organisation is unable to fully evidence that the incoming board member is fit and proper because of gaps in the board member reference, they may continue to hire the individual but should clearly document within ESR the gaps in relation to the board member reference and the reasons/mitigations for being comfortable with employing/appointing the board member.

In this scenario, the employing NHS organisation also should be able to demonstrate that they have exercised all reasonable attempts to obtain the missing information.

3.9.3 Providing references

An NHS organisation should aim to provide a reference to another NHS organisation within a 14-day period, which starts from the date that the reference request was

received. However, it should be acknowledged that there are occasions of exceptional circumstances, and references may take more than 14 days to provide.

The references referred to above are for a request made in relation to the individual being appointed to the role of board member, or for other purposes linked to the board member's current employment.

Where a current board member moves between different NHS organisations, a board member reference form following a standard format (Appendix 2) should be completed by the employer and signed off by the chair of that NHS organisation.

The previous NHS organisation should provide information in relation to that which occurred:

- in the six years before the request for a reference
- between the date of the request for the reference and the date the reference is given
- in the case of disciplinary action, serious misconduct and/or mismanagement at any time (where known).

NHS organisations should also consider when providing the reference:

- That the process captures accurate, complete, open, honest and fair information about the board member concerned.
  - As such, references should not conceal facts from the NHS organisation offering employment.
- References should give established facts that are part of the history of the person.
  - It is unfair to give partial facts if those result in the offer being withdrawn, for example where this causes the recipient NHS organisation to assume the information is missing because it is negative, so the offer is withdrawn.
  - Views can be expressed but only after taking reasonable steps to verify factual accuracy and should be based on documented facts.
- The reference should be fair, such that the employee concerned should have the right to note a challenge to the fairness of the mandatory reference and provide such explanation as they wish to in writing.
  - This does not mean that the board member can comment on the reference itself; rather, that the NHS organisation (which the board member is leaving)

has provided those board members with a reasonable opportunity to respond to allegations or judgements upon which the reference is based.

  - Hence a board member's opinions are not required to be included within the reference, but should be appropriately considered when drafting them.
  - Where the NHS organisation providing the reference has not offered the employee the opportunity to previously (at the time the matter occurred) comment on the allegation, they ought to do so before including that allegation within the reference, rather than leaving the allegation out of the reference.
- Where the reference provides information about an applicant's health or disability this must be in line with the provisions outlined in the Equality Act 2010 and be relevant, necessary, and up to date, for the purposes of data protection law.

3.9.4 Revising references

If an NHS organisation has provided a reference to another NHS organisation about an employee or former employee, and has subsequently:

- become aware of matters or circumstances that would require them to draft the reference differently
- determined that there are matters arising relating to serious misconduct or mismanagement
- determined that there are matters arising which would require them to take disciplinary action
- concluded there are matters arising that would deem the person not to be 'fit or proper' for the purposes of Regulation 5 of the Regulations,

the NHS organisation that provided the reference should make reasonable attempts to identify if the person's[3] current employer is an NHS organisation and, if so, provide an updated reference/additional detail within a reasonable timeframe.

Where the employee was a board member at the previous NHS organisation or is a board member at the current NHS organisation, the updates should be reflected within the board member reference.

[3] For the avoidance of doubt, this refers to executive board members employed by an NHS organisation and non-executive board members who have been appointed.

Revised references between NHS organisations should cover a six-year period from the date the initial board member reference was provided, or the date the person ceased employment with the NHS organisation, whichever is later. The exception to this are matters that constitute serious misconduct or mismanagement: details of such events should be provided irrespective of time period.

3.9.5 Board member reference template

The board member reference template provided should be used by NHS organisations.

This Framework, along with the board member reference template, sets out the minimum requirements for a reference. An NHS organisation can provide information in relation to additional matters if it deems it necessary to do so.

If references are provided for the role of board member, or for other purposes linked to the board member's current employment, the NHS organisation providing the reference should look to complete all sections of the template even where the NHS organisation requesting the reference does not specifically ask for it.

As mentioned previously, NHS organisations should maintain board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer.

Therefore, the template should be completed, and retained locally in an accessible archive, for departing board members even where they have indicated they are moving onto a non-NHS role and/or performing a role that is not on the board, or where they have indicated they are to retire.

Often in these circumstances the individual may go on to act in the capacity of a board member at a future date, even if it is just on a temporary basis, for example to cover staff shortages.

3.10 Electronic Staff Record (ESR)

NHS Business Services Authority (NHSBSA) hosts ESR on behalf of the NHS, as commissioned by the Department for Health and Social Care.

New data fields in ESR will hold individual FPPT information for all board members operating in the NHS and will be used to support recruitment referencing and ongoing development of board members. The FPPT information within ESR is only accessible within the board member's own organisation and there is no public register.

ESR will hold information about each board member in line with the criteria detailed below in section 3.10.1.

NHS England will use its network of regional directors in a direct oversight role to ensure that individual NHS organisations (within the designated regions) are completing their FPPT, via annual submissions to the NHS England regional directors.

The CQC will continue in its regulatory role and as such may determine that reviews are required over the data integrity and controls that a particular NHS organisation has in relation to the records held in ESR.

There should be limited access to ESR in accordance with local policy and in compliance with data protection law. It is reasonably expected that the following individuals have access to the FPPT fields in ESR:

- chair
- chief executive officer (CEO)
- senior independent director (SID)
- deputy chair
- company secretary
- human resources director (HRD)/chief people officer (CPO).

Access will also be provided to relevant individuals within the CQC at a local level, where this information is necessary for their roles, noting the CQC's ability to require information to be provided to it under Regulation 5(5) of the Regulations.

The ESR FPPT data fields need to be maintained to ensure information about the serving board member is current. This will mean that ESR is specifically updated for:

- all board members within an NHS organisation
- new board members who have been appointed within an NHS organisation
- whenever there has been a relevant change to one of the fields of FPPT information held in ESR (as per section 3.10.1 below)
- updates for annual completion of the full FPPT
- annual completion of FPPT confirmed by chairs.

It will be the responsibility of each NHS organisation to ensure that ESR remains current and is updated for relevant changes in a timely manner. As a minimum it is expected

that each NHS organisation conducts an annual review to verify that ESR is appropriately maintained.

The chair will be accountable for ensuring that the information in ESR is up to date for their organisation.

NHS organisations will need to establish policies and procedures for collating the relevant information in an accurate, complete and timely manner for updating ESR.

NHS organisations will need to establish a process for individuals to access and exercise their rights in connection with the information held about them, in accordance with the requirements of data protection law.

3.10.1 Information held in ESR

The information that ESR will hold about board members is detailed below and also summarised in the FPPT checklist.

The supplementary guidance document provides specific step-by-step instructions for NHS organisations to update and maintain ESR.

The FPPT assessment on initial appointment of a board member will cover all points mentioned below:

- First name*
- Second name/surname*
- Organisation* (that is, current employer)
- Staff group*
- Job title* (that is, current job description)
- Occupation code*
- Position title*
- Employment history:*
  - This would include detail of all job titles, organisation departments, dates, and role descriptions.
  - Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, would not need to be explained.
- Training and development
- References:*

  - Available references from previous employers, board member references, including resignations or early retirement.
- Last appraisal and date
- Disciplinary findings
  - That is, any upheld finding pursuant to any trust policies or procedures concerning employee behaviour, such as misconduct or mismanagement relevant to FPPT, this includes grievance (upheld) against the board member, whistleblowing claims against the board member (upheld) and employee behaviour upheld finding.
- Any ongoing and discontinued investigations relating to Disciplinary/ Grievance/Whistleblowing/Employee behaviour should also be recorded.
- Type of DBS disclosed* †
- Date DBS received* †
- Disqualified directors register check
- Date of medical clearance* (including confirmation of OHA)
- Date of professional register check (eg membership of professional bodies)
- Insolvency check
- Self-attestation form signed
- Social media check
- Employment tribunal judgement check
- Disqualification from being a charity trustee check
- Board member reference*
- Sign-off by chair/CEO.

It should also be noted that the national insurance number is an additional check where there may have been a change of name highlighted in the initial or annual assessment.

The annual FPPT requires an NHS organisation to validate all fields above – except for:

* Fields marked with an asterisk (*) – these do not require validation as part of the annual FPPT unless a specific reason arises. However, these fields should still be updated in the event of a change to the information held.

† While not requiring annual validation, DBS checks will be done on a three-year cycle.

3.11 Record retention

The ESR FPPT data fields will retain records of completed tests to support the FPPT assessments. All supporting documents/records in relation to the FPPT will be held locally by each individual NHS organisation.

As such, an NHS organisation should establish, implement and maintain adequate policies and procedures to comply with GDPR and the NHS Records Management Code of Practice.

The NHS Records Management Code of Practice sets out expectations in relation to retaining actual staff documents/records for a period of six years.

However, NHS organisational case documents/records may be retained for longer than the standard six years, based on the facts of the case. This will be a local decision for each NHS organisation.

When determining how long to retain documents/records in relation to disciplinary and similar cases and where applicable, NHS organisations should make an assessment as to the severity of the misconduct and/or mismanagement and its impact to the FPPT. The more serious the issue the longer the retention period should be.

In relation to ESR, the information and accompanying references should be kept career long, which at a minimum should be until the 75th birthday of the board member.

3.12 Dispute resolution

1. Data and information

Where a board member identifies an issue with data held about them in relation to the FPPT, they should request a review which should be conducted in accordance with local policies in the first instance.

Where this does not lead to a satisfactory resolution for the board member, the following options are available:

- For NHS England-appointed board members (NHS trust chairs and NEDs and ICB Chairs) – the matter should be escalated to the NHS England Appointments Team.
- For chairs not appointed by NHS England – a further request for review can be made to the SID or deputy chair who would establish a process proportionate to

the matter being considered; for example, establishing a panel with at least one independent member.

- For all other board members (including NHS England-appointed board members, and chairs not appointed by NHS England where the above processes have not led to a satisfactory conclusion), the options could include:
  - referring the matter to the ICO
  - (For executive director roles only*) taking the matter to an employment tribunal (ET)
  - instigating civil proceedings.

2. Outcome of FPPT assessment

Where a board member disagrees with the outcome of the FPPT assessment and they have been deemed 'not fit and proper,' the following options are available:

- For NHS England-appointed board member roles – the matter should be escalated to the NHS England Appointments Team for investigation in accordance with extant policy and procedure.
  - Where this results in a board member being terminated from their appointed role, a BMR** must be completed and retained by the local organisation in accordance with the Framework.
- For non-NHS England-appointed roles (executive and non-executive) – local policy and constitution arrangements should be followed first.
  - NHS organisations may wish to take their own legal advice or seek advice from NHS England.

At any point, employees have the right to take the matter to an ET*.

* Chair and non-executive board members cannot take their organisation to ET unless in relation to discrimination, but they can instigate civil proceedings.

** Exit BMR to be drafted by local chair for non-executive directors [NEDs] (with support from the NHS England Appointments Team), and by the NHS England Appointments Team for chairs.

Section 4: Quality assurance and governance

To ensure that the FPPT is being adequately embedded within NHS organisations there will need to be quality assurance checks conducted by the CQC, NHS England and an external/independent review. The quality assurance checks over the various parts of the FPPT Framework have been detailed below.

4.1 CQC quality assurance

The CQC's role is to ensure NHS organisations have robust processes in place to adequately perform the FPPT assessments, and to adhere to the requirements of Regulation 5 of the Regulations. As such, as part of the Well Led reviews, CQC will consider the:

- quality of processes and controls supporting the FPPT
- quality of individual FPPT assessments
- board member references, both in relation to the new employing NHS organisation but also in relation to the NHS organisation which wrote the reference
- collation and quality of data within the database and local FPPT records.

In doing so the CQC will have regard to the evidence that exists as to whether the board members meet the FPPT. For example, this includes, but is not limited to, checking the following forms of evidence:

- That the NHS organisation in question is aware of the various guidelines on recruiting board members and that they have implemented procedures in line with this best practice.
- Personnel files of recently appointed board members (including internal appointments of existing staff).
- Information or records relating to appraisals for board members.
- References and personal development plans.

The CQC may intervene where there is evidence that proper processes have not been followed or are not in place for FPPT. While the CQC does not investigate individual board members, it will pass on all information of concern that is received about the fitness of a board member to the relevant NHS organisation.

The CQC will notify NHS organisations of all concerns relating to their board member and ask them to assess the information received. The board member to whom the case refers will also be informed.

NHS organisations should then detail the steps they have taken to assure the fitness of the board member and provide the CQC with a full response within 10 days. The CQC will then carefully review and consider all information.

Where the CQC finds that the NHS organisation's processes are not robust, or an unreasonable decision has been made, they will either:

- contact the NHS organisation for further discussion
- schedule a focused inspection
- take regulatory action in line with their enforcement policy and decision tree if a clear breach of regulation is identified.

4.2 NHS England quality assurance

NHS England will have oversight through receipt and review of the annual FPPT submissions to the relevant NHS England regional director from NHS organisations.

4.3 Internal audit/external review

Every three years, NHS organisations should have an internal audit to assess the processes, controls and compliance supporting the FPPT assessments. The internal audit should include sample testing of FPPT assessment and associated documentation.

NHS organisations should consider inclusion of FPPT process and testing in the specification for any commissioned Well-Led/board effectiveness reviews.

4.4 Governance

For good governance, organisations should be clear about the reporting arrangements across the FPPT cycle. This is likely to include:

- an update to a meeting of the board in public to confirm that the requirements for FPPT assessment have been satisfied at least annually
- consideration by the Audit Committee, for example where there is a related internal or external audit review included in the audit programme

- relevant information to the Council of Governors (CoG) in an NHS foundation trust as described in section 4.5 below.

4.5 NHS foundation trusts – appointment and removal of the chair and non-executive directors

The document 'Your statutory duties- A reference guide for NHS foundation trust governors' refers to the role of the CoG in appointing and removing the chair and NEDs. The FPPT Framework should be considered alongside this document and the local trust constitution. The CoG in an NHS foundation trust:

- Should continue to make chair and NED appointments in accordance with their statutory duties and local constitution. These continue to be subject to satisfactory recruitment checks, and this will now include consideration of the initial FPPT assessment.
- Should continue to '…receive performance information for the chair and other non-executive directors as part of a rigorous performance appraisal process …' in accordance with their local constitution. Performance appraisals will now include application of the LCF in accordance with the Framework.
- Should be advised of any outcome from a non-executive board member (including the chair) FPPT assessment as 'not fit and proper.' Dependent on the circumstances and in accordance with the local constitution, the CoG would be involved as appropriate with any subsequent removal process, where applicable.

The CoG should receive support from the SID and/or the company secretary and use the governance arrangements already in place in their trusts, such as the nomination committee.

4.5 Integrated care boards

ICBs should apply the Framework alongside relevant statutory requirements and the existing requirements of their organisation's constitution.

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