The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Public Trust Board of Directors' Meeting

Thursday 28 March 2024, 14:00 – 16.00

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

Agenda

Item		Lead	Paper	Timing
1.	Apologies for absence and declarations of interest	Kath McCourt	Verbal	14:00 – 14:01
2.	Minutes of the Meeting held on 25 January 2024 and Matters Arising	Kath McCourt	Attached	14:01 - 14:02
3.	Chair's Report	Kath McCourt	Attached	14:02 – 14:07
4.	Chief Executive's Report; including: - CQC update	Jim Mackey	Presentation	14:07 – 14:17
Strategic items:				
5.	Patients: Patient Story	Annie Laverty	Attached	14:17 – 14:27
6.	Patients: Experience of Care Strategy [FOR APPROVAL]	Ian Joy & Annie Laverty	Attached	14:27 – 14:37
7.	People: Staff Survey results / People Programme	Annie Laverty & Christine Brereton	Attached	14:37 – 14:50
8.	Performance: Performance Report	Rob Harrison & Vicky McFarlane-Reid	Attached	14:50 – 15:00
9.	Performance: Planning 2024/25	Rob Harrison & Vicky McFarlane-Reid	Presentation	15:00 – 15:15
	Refreshments break			***15:15 – 15:20***
Business Items:				
10.	Director reports: a. Joint Medical Directors Report; including: (i) Consultant Appointments (ii) Guardian of Safe Working Quarterly Report (Quarter 3 2023/24)	Lucia Pareja Cebrian & Michael Wright	Attached	15:20 – 15:30
	b. Executive Chief Nurse; including: (i) Maternity Update Report	Maurya Cushlow / Ian Joy	Attached	15:30 – 15:37
	c. Learning from Deaths Q3 report	Angela O'Brien	Attached	15:37 – 15:42
	d. Healthcare Associated Infections (HCAI)	Julie Samuel	Attached	15:42 – 15:47
Items to approve				

11.	Gender Pay Gap Report	Christine Brereton	Attached	15:47 – 15:52
12.	Effective Governance System	Rob Harrison	Attached	15:52 – 15:57

Items to receive and any other business: 15:57 – 16:00

13.	Update from Committee Chairs	Committee Chairs	Attached
14.	Integrated Board Report	Rob Harrison	Attached
15.	Meeting Action Log	Kath McCourt	Attached
16.	Any other business	All	Verbal

Date of next meeting:
Public Board of Directors – Thursday 25 July 2024

Professor Kath McCourt, Interim Chair

Sir Jim Mackey, Chief Executive Officer

Mr Rob Harrison, Managing Director

Ms Maurya Cushlow, Executive Chief Nurse

Dr Lucia Pareja-Cebrian and Dr Michael Wright, Joint Medical Director

Dr Vicky McFarlane-Reid, Director for Commercial Development & Innovation

Mr Martin Wilson, Chief Operating Officer

Mrs Christine Brereton, Chief People Officer

Mrs Caroline Docking, Director of Communications and Corporate Affairs

Mrs Angela O'Brien, Director of Quality & Effectiveness

Ms Annie Laverty, Chief Experience Officer

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

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PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 25 JANUARY 2024

Present:	Professor K McCourt *[Chair]*	Interim Chair
	Sir J Mackey	Chief Executive Officer [CEO]
	Mr A Welch	Medical Director/Deputy Chief Executive Officer [MD/DCEO] *[from 13:20]*
	Mrs J Bilcliff	Chief Finance Officer [CFO]
	Ms Maurya Cushlow	Executive Chief Nurse [ECN]
	Dr V McFarlane Reid	Director for Commercial Development & Innovation [DCDI]
	Ms J Baker	Non-Executive Director [NED]
	Ms S Edusei	NED
	Mr J Jowett	NED
	Mr B MacLeod	NED
	Miss C Smith	NED
	Mr G Chapman	NED

In attendance:
Mrs C Docking, Director of Communications and Corporate Affairs [DCCA]
Mrs A O'Brien, Director of Quality and Effectiveness [DQE]
Mrs S McMahon, Chief Information Officer [CIO]
Mrs C Brereton, Chief People Officer [CPO]
Mr R C Smith, Director of Estates [DoE]
Mrs K Jupp, Trust Secretary [TS]
Mrs J Samuel, Director of Infection Prevention Control [DIPC]
Ms Catherine Carr, Head of Nursing *(for item 24/02i)*
Dr S Brown, Honorary Associate Medical Director for Mental Health *(for item 24/02iii)*

Observers:
Mrs P Yanez, Lead Governor
Dr A Dearges-Chantler, Public Governor
Professor P Home, Public Governor
Mrs C Watson, Public Governor
Mr S Maratos, Partner, Hempsons
Mr D Holland, Health Reporter – Chronicle Live
Ms Rachel Farmer, Business Development Director, Liaisongroup.com
Ms J Bene, Consultant, thevaluecircle *[from 13:31]*

Secretary:	Mrs G Elsender	Corporate Governance Officer and PA to the Chairman and Trust Secretary

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

24/01 STANDING ITEMS:

i) Apologies for Absence and Declarations of Interest

The Chair welcomed all to the meeting.

Apologies were received from Mrs L Bromley, NED, Professor David Burn, Associate NED (ANED) and Mrs P Smith, (ANED).

Mr Jowett declared an interest in that the spouse of one of the public observers was employed at his place of work.

It was resolved: to (i) **receive** the apologies for absence and (ii) **note** the new declaration of interest.

ii) Minutes of the previous meeting held on 30 November 2023 and matters arising

The minutes of the meeting held on 30 November 2023 were accepted as a true record of the business transacted.

It was resolved: to **agree** the minutes as an accurate record and to **note** there were no matters arising.

iii) Chair's Report

The Chair noted that this Board meeting marked her first as Interim Chair and took the opportunity to formally welcome Sir Jim Mackey following his appointment as CEO. She also welcomed Mrs Shauna McMahon as Chief Information Officer.

Since her appointment on 1 December 2023, the Chair had been involved in several Trust activities and highlighted the key areas of business as detailed in her report. This included Council of Governors meetings, a "Spotlight on Services" session hosted by Newcastle Hospitals Charity focusing on the Arts Programme, and a Board Development session which focussed on the current CQC inspection position and Clinical Board updates.

At a regional level, the Chair continued to engage with both Foundation Trust Chairs and the Integrated Care Board (ICB).

The Chair had also attended the launch event for the new Patient Safety Incident Reporting Framework (PSIRF).

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

[The MD/DCEO joined the meeting]

iv) Chief Executive's Report

The CEO noted that in the months prior to his appointment there had been a great deal of focus on the expected CQC report. He acknowledged that the report content was difficult to rea. There was significant improvement work to be undertaken, however there was appetite from staff within the Trust to deal with the issues raised in the report at pace.

The CEO had visited a number of departments that were delivering a high quality of services and had met with a number of staff, which were undertaking great work.

The CEO noted that a dashboard/infographic would be developed which would be used consistently in future Board of Directors meetings.

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

24/02 STRATEGIC ITEMS:

[Ms Catherine Carr joined the meeting]

i) Patients: People Story

The ECN introduced the people story and welcomed Ms Carr to the meeting.

Ms Carr had responsibility for Ward 12 at the Freeman Hospital. She relayed the contents of a thankyou letter received from a patient who had been admitted to the ward and had noted the care, kindness and compassion they had received from staff.

She then went on to describe the process for the establishment and preparation of the ward prior to its opening, noting liaison with various departments for supplies and equipment, onboarding and training of staff and communications.

Following a slight delay in the planned opening date/start dates, there had been some initial challenges in relation to the experience and confidence of staff. However, this had since been rectified with at least one experienced member of staff per shift, and with daily huddles and compassionate leadership, all staff were now more noticeably more confident.

[Ms J Bene joined the meeting]

A staff survey had been run half-way through the project and would be repeated at the end of the project on closure of the ward. There had been good feedback from senior leaders and despite the challenges staff felt privileged and proud of what had collectively been achieved and welcomed Board members to visit.

The Chair noted that she had visited the ward during the festive break when staffing had been challenging and queried whether the staffing complement had now been achieved. Ms Carr advised there was now a full complement of staff, with many wishing to remain working in older person medicine.

In noting that this ward was only temporary, Mr Chapman questioned if there was an option for the ward to remain open to which the ECN advised that the ward had been established

with additional funding, adding that this was the first time an additional dedicated Winter ward had been opened, where previously the number of beds had been extended in multiple wards.

Ms Baker noted that she had visited wards accommodating older people and was impressed by the leadership and ideas generated.

Ms Edusei congratulated Ms Carr on the success of the ward and questioned if there was any learning to be shared with regards to recruitment to which Ms Carr advised that feedback had been given to the Healthcare Academy regarding the expectations from staff working on this type of ward.

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

[Ms Carr left the meeting]

ii) Patients: CQC Report

The ECN advised that the final CQC report had been published the previous day. The next steps would be to assimilate the required actions and develop a comprehensive plan to respond.

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

iv) People: Industrial Action

The MD/DCEO noted the challenges as a result of the recent industrial action by Junior Doctors and gave thanks to those staff who remained at work to keep patients safe. Unfortunately some elective work had to be cancelled in order to prioritise patient safety during the period of industrial action.

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

v) Performance: Performance Report

The EDBDE presented the report which provided 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. The following points were noted:

- The December performance was particularly challenged, in part due to the rounds of industrial action held as well as a significant increase in Adult General and Acute average bed occupancy, causing significant difficulties in maintaining patient flow. Performance fell just short of the revised 103% elective target.
- Newcastle Hospitals delivered performance below the revised 4-hour Accident and Emergency (A&E) arrival to admission/discharge target, with performance standing at 72.5% against the 76% target. This was the third successive month that the Trust has failed to hit the target.
- The Trust failed all three newly consolidated cancer standards in November 2023,

This was largely due to the continuing high levels of demand on the Skin service, as well as late referrals from other organisations and ongoing diagnostic/theatre capacity issues.

The Trust was escalated into Tier 1 NHSE intervention for cancer performance in December as a consequence of the continuing distance between the volume of patients waiting over 62 days for treatment and the end of year 'fair-share' target (200). At the end of December 314 patients were experiencing this length of wait.

The Trust was working hard to develop a path to zero for 78 week waits by 31 March 2024 to improve the experience for patients and in turn to exit the Tier 1 intervention.

- At the end of October, the Trust had just 5 patients waiting >104 weeks, all waiting for spinal surgery. 322 patients had a waiting time of >78 weeks, with the majority waiting for non-Spinal care – the Trust had agreed a revised trajectory with NHSE to bring the number of patients waiting this length of time down to 167 by the end of March 2024, but has now gone further with the ambition to eliminate 78 week waits by the end of March 2024, as well as reduce 65WWs by a third.

Mr Jowett referred to the issues in relation to skin cancer and late referrals, and questioned if the Trust could influence a reduction in late referrals and in doing so what would be the subsequent impact on performance. The COO advised the system could be influenced by supporting primary care i.e. use of dermatoscopes and greater use of artificial intelligence. He added that there was an increase in demand nationally and therefore work was being undertaken to build capacity by using different workforce groups such Advanced Practitioners.

It was noted that approximately 50% of referrals were received later than the expected standard. Discussions were underway with the Northern Cancer Alliance to improve access to diagnostics.

The MD/DCEO noted that the use of dermatoscopes was the most effective method for faster diagnosis however there had been a problem in the supply of them to GPs.

Mr Macleod noted that delays in ambulance handovers were peaking and questioned if there was a route cause for this to which the COO advised that whilst there was a more challenging position than in previous years, the Trust was not an outlier compared to other Trusts. The Trust was also exploring opportunities for investment in the Emergency Department (ED) to improve patient flow.

Referring to skin cancer and late referrals Mr Chapman questioned if there was an option to change the method of referral to which the COO advised that discussions had taken place with another Trust who were using artificial intelligence / imaging in a community hub rather than within a GP practice. However the use of dermatoscopes was the chosen model in the North East. The Northern Cancer Alliance were reviewing referrals and access routes.

Miss Smith queried the cost of the dermatoscopes and if an increase in the number of those available would have a timely impact on reducing waiting times to which the COO noted

that the maintenance and replacement of the dermatoscopes was the main barrier. The COO would liaise with the ICB to explore the cost of addressing the maintenance contracts issue **[ACTION01].**

Ms Baker referred to the increased activity in the ED and questioned if there was scope to develop more discharge lounges. Whilst acknowledging the benefit of this, MC advised that space was an issue noting that at least 15 beds would be needed every day on both sites.

It was resolved: to **note** the performance detailed within the month 9 performance report.

[Dr Sarah Brown joined the meeting]

iii) Mental Health Strategy

The MD introduced Dr Brown who he advised had been instrumental in streamlining mental health processes within the Trust. Dr Brown provided an update highlighting the following points:

- Acknowledging the feedback in the CQC report, developing the strategy had taken longer than envisaged.
- The strategy produced was short and concise, being less than 10 pages long and very visual with infographics and images
- The title of the strategy is 'Mental Health Matters', which had been picked by the Steering Group established.
- The strategy is a friendly way of introducing Mental Health and is a 5 year plan with the intention of engaging Clinical Boards to implement their own strategy using this framework as a steer.
- The strategy was hoped to be launched in the new financial year.
- The steering group consisted of 2 experts by experience and 6 other members as an expert reference group covering both mental health and physical health expertise. The group has been very well supported by the organisation.

The Chair noted that the strategy will be of great benefit to the organisation and was an exciting development.

Ms Edusei welcomed the strategy and questioned the plans for implementation to which Dr Brown explained that there would be engagement with the Clinical Boards to support them to implement something meaningful for them. She added that an Associate Director of Nursing was already involved and there would be the development of a Mental Health Board to enhance governance and oversight.

The DCDI suggested engaging with the Enabled Network and agreed to introduce Dr Brown to the Chair of the Enabled Network **[ACTION02]**

In response to a question from Mr MacLeod as to whether the strategy would include provision for staff mental health, Dr Brown confirmed it did and cross-referenced other areas of support in relation to staff wellbeing.

The Chair thanked Dr Brown for the update and the progress made to date.

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

[Dr Brown left the meeting]

vi) Partnerships: Development of Collaborative Working Arrangements

The CEO noted the development of the relationships between the hospitals in the NENC region and the accelerated progress to form an alliance following the approval of the Trust Boards in December 2023. A plan would be developed by the end of March 2024 to set out the alliance structure, its purpose and give clarity over associated programmes of work. Chairs and Chief Executives of the organisations were meeting on a regular basis and an update on progress would be shared at a future Board meeting.

24/03 BUSINESS ITEMS:

i) Director Reports

a. Medical Director

The MD highlighted the following points:

- As referenced earlier the launch event for the PSIRF took place on 18 January 2024. PSIRF will see a more proportionate and pragmatic way of investigating incidents, the aspiration of which is to remove the element of 'blame'. The new framework will replace the previous process for investigating Serious Incidents.
- Harm reviews, for patients on cancer pathways who are not treated within 104 days, continue to be undertaken.
- Work continues towards delivery of a Trust Cancer Strategy and will include tackling health inequalities.
- Research is performing very well with notable highlights included in the supporting paper. In terms of commercial research, the team continues to be focussed on growing commercial activity and income in line with national priorities.

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

i. Consultant Appointments

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

ii. Guardian of Safe Working Quarterly Reports (GOSW) (Quarters 1 and 2 2023/24)

The MD/DCEO advised that the report identified a number of exception reports in relation to rota gaps. There is a good working relationship between the Medical Director team and the Junior Doctor Forum.

The Chair advised that the report is also presented to the People Committee and noted that good progress had been made.

Ms Edusei noted that the triangulation between long hours worked and any hots spots during consultant shortages. She added that the report was also a key part of the quality system as well as people.

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

[The DCCA left the meeting]

b. Executive Chief Nurse Report

The ECN presented the report drawing attention to the following:

- The Nurse Staffing and Clinical Outcomes Group work in triangulating data to improve outcomes for patients. The group looks at a series of clinical indicators as well as considering soft intelligence to identify if any escalation is needed for a particular ward. Wards of Concern are reported to the Quality Committee. There are also 2 Deep Dive reports undertaken every year.
- The current nurse vacancy rate stood at just under 2% which has significantly improved from the 5.76% in January 2023.

[The DCCA re-joined the meeting]

- Whilst recruitment has improved there remains several departments which are above the Trust average causing operational challenges. This is particularly noted in Paediatrics. An active workforce plan is in place overseen jointly by the Family Health Clinical Board and Corporate Nursing Team. This includes continued international recruitment, a new rotational development programme, focused additional education support for staff in post and several recruitment open days. Due to the deployment of international recruits the vacancy position will improve in the next 3 months but the staff will require several months of support and training and unlikely to positively impact on bed capacity imminently.

- The Maternity Service workforce has strengthened following the recruitment of 25 midwives since October 2023. There were currently no vacancies and a slight over recruitment.

- The Practice Education Team oversee all aspects of NMAHP undergraduate training, ensuring students at Newcastle Hospitals have access to the highest quality learning opportunities and experiences. The team work proactively to co-ordinate placements in conjunction with the education providers throughout the year. There is a current risk to capacity as Higher Education Institutions (HEIs) are increasingly moving to September cohort entries which impacts on the cross year recruitment pipeline of new graduates for Trusts.

The Chair expressed concern with regard to the pipeline not being filled in the Higher Education Institutions. It was noted that whilst international recruits make a fantastic contribution to the workforce outside factors could also limit their recruitment. The retention of nurses was also noted to be an area of concern.

The CPO recognised the contribution of international recruits but highlighted the Trust must also continue to explore other options including the utilisation of the apprenticeship levy.

Mr Chapman highlighted the Wards of Concern Report which was presented to Quality Committee and questioned if this could be replicated for other areas of concern, with Mr MacLeod citing podiatry as an example of difficulty regarding staff retention. The ECN advised that podiatry was an area particularly affected as staff often leave to enter into private practice.

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

i. Maternity Update

The paper provided the Trust Board with an overview and update for the leading priorities and quality considerations for the Maternity Service. The ECN highlighted the following points:

- Following a short CQC inspection in January 2023 where the Trust was given an overall rating for the Maternity service as 'requires improvement' the Maternity Service is subject to formal System Oversight Framework (SOF) arrangements. The ICB subsequently acknowledged the work undertaken by the service to strengthen compliance, monitoring, and assurance, in areas recommended by the CQC.

[The CFO left the meeting]

- During the Ockenden Assurance visit on 10 November 2023, the visiting team gave brief, high-level verbal feedback to the Trust at the end of the visit, focussing on areas of good practice and areas which may benefit from ICB/LMNS support. Overall, a positive visit was experienced by the review team. The final written report was received on 19 December 2023 which overall was a positive report. The Specialist Midwife Team was highlighted as being particularly passionate about their work.

- Following a Joint Commissioner Assurance Visit to the Neonatal Unit, the feedback the visiting team received from the conversations with parents was excellent and all spoke very positively about the care their baby received. The visiting team were impressed by the emphasis placed on quality improvement and the wide range of projects and initiatives that had been undertaken.

The Chair advised that Mrs Bromley would be moving in to the role of Maternity Safety Champion with effect from 1st February 2024.

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

[The MD/DCEO left the meeting]

c. Director of Quality & Effectiveness

i. Maternity Incentive Scheme (MIS) Year 5 CNST Compliance

The DQE presented the report noting this was the fourth update report regarding the 10 safety actions in the Year 5 scheme which were published on the 31 May 2023.

The DQE provided assurance that the Trust was on target to achieve full compliance with 8 out of 10 safety actions in year 5. Due to the additional training requirements this year and ongoing staffing challenges the required training compliance of 80% in all staff groups could not be achieved before the 5 December 2023.

The Trust should continue to submit the declaration form acknowledging compliance with 8 safety actions. The Trust may still be eligible for a small amount of funding to support ongoing progress and an action plan should be submitted with the Board declaration form. It was noted that NHS Resolution has reduced its compliance rate from 90% to 80%.

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

ii. Mortality / Learning from Deaths Q2 Report

The report provided assurance to the Trust Board that the processes for Learning from Deaths across the organisation were 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).

It also summarised the processes that are in place to provide assurance to the Trust Board 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.

The DQE advised that during July 2023 – September 2023 (Q2) there were 59 Serious Incidents reported to Commissioners via the Strategic Executive Information System (STEIS). Of these 59, there were nine patient deaths which identified potential modifiable factors which contributed to the death. Investigations are currently ongoing for six cases.

The DQE referred to Standardised Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) mortality rates and noted the latest SHMI publication for July 22 – June 23 shows the Trust to be at 1.01, which is within the national "expected levels". She added that new commissioning dataset was introduced into the Trust in April 2023. However, it recently came to light that only the patient's primary diagnosis was being uploaded. As SHMI and HSMR data are heavily dependent on secondary diagnosis to correctly risk adjust, this has hugely affected recent data publications, showing the Trust to have inaccurate negative data in regard to SHMI/HSMR and VLAD (Variable Life Adjustment Displays) data. This fault has now been rectified and the Trust should see accurate data being published within the forthcoming months.

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

[The MD/DCEO and the CFO re-joined the meeting]

d. Healthcare Associated Infections (HCAI)

The DIPC highlighted the following points in relation to Infection Prevention Control (IPC):

- One neonatal MRSA bacteraemia was attributed to the Trust in December 2023 which takes the Trust total to three against a target of zero.
- Post Infection Reviews of healthcare associated blood stream infections (BSI) continue to collate key themes around acquisition. Intravascular devices and catheter associated UTI remain the main preventable causes of infection followed by complex surgical infections contributing to community and hospital associated gram-negative blood stream infection (GNBSI). IPC staff, specialist teams and Clinical Boards are working together to implement improvement action plans with oversight from the IPC Operational and Quality Oversight groups.
- Key areas for improvement include IPC cascade training through Harm Free Care Leads and ensuring IPC actions are implemented through the Clinical Boards governance structures.
- The Antimicrobial Steering Group (AMSG) continue to provide governance and oversight relating to antimicrobial prescribing. A request for additional resource for senior clinical team support and data management had been previously submitted but requires further review and is being looked into by the AMSG chair and Clinical Board. This investment would ensure a robust governance process around compliance with audits (with the aim of improving compliance which had reduced), CQUIN and delivering national contracts.
- The process of implementing PSIRF principles and ICNet integration into IPC operations is underway. ICNet went live on 11 December 2023.

Mr Jowett referred to the uptake of staff vaccination and questioned if this impacted on absenteeism to which the ECN noted that vaccination rates were generally lower nationally (66%) but there was no correlation with staff absence.

The CEO noted that consideration must be given to single room occupancy during any future construction work.

Mr Chapman queried when there would be meaningful data available from ICNet to which the DIPC advised that this should be available in March 2024.

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

24/04 ITEMS TO RECEIVE AND ANY OTHER BUSINESS:

i) Update from Committee Chairs

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

Quality Committee
Mr Chapman noted that the regulatory feedback would be taken seriously and would be used to inform how the Committee shapes its agenda moving forward. For added assurance,

the Committee would be moving to a monthly cycle and a Maternity Sub Group would be established.

People Committee
Mr Jowett noted that the schedule of business and agenda would be reviewed to reflect the recommendations in the CQC report.

Charity Committee
Ms Baker noted the role of the Trust Board in relation to the Charity and reminded Board members that 4 Charity Committee meetings were held per year as well as grants only committee meetings. She noted that the shop within the Freeman Hospital had seen an increase in profits by 170% following the appointment of a retail manager. The Charity was in the process of sourcing suitable accommodation that would accommodate all charity employees in one location.

Finance Committee
Miss Smith noted robust conversations on financial planning and performance. She noted that the next meeting would focus on planning for 2024/25 and delivery of the finance plan for 2023/24.

Audit Committee
Mr MacLeod noted that the Board Assurance Framework would be reviewed and updated to reflect recommendations in the CQC report. He also noted the adoption of a new accounting standard and conversations underway with the External Auditors.

The Chair thanked the Committee Chairs for their input.

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

ii) Integrated Board Report

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

iii) Meeting Action Log

The action log was received and the content noted.

iv) Any Other Business

No other business was discussed.

Date and Time of Next Meeting

The next formal meeting of the Board of Directors is scheduled for **Thursday 28 March 2024** at the **Freeman Hospital Boardroom.**

There being no further business, the meeting closed at 14:50

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024		
Title	Chair's Report		
Report of	Professor Kath McCourt, Interim Chair		
Prepared by	Professor Kath McCourt, Interim Chair Jayne Richards, 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 Chair's activity and key areas of recent focus since the previous Board of Directors meeting, including:
	• Board Activity
	• Governor and Member Activity
	• "Spotlight on Services"
	  • The Stroke Unit
	  • Long Term Ventilation
	• Regional engagement with Foundation Trust Chairs of the North Integrated Care Partnership (ICP)
	• Engagement with the Integrated Care Board (ICB) Chair and Foundation Trust Chair Forum		

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	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.

CHAIR'S REPORT

EXECUTIVE SUMMARY

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

- Board Activity
- Governor activity
- "Spotlight on Services"
    - The Stroke Unit
    - Long Term Ventilation
- Regional engagement with Foundation Trust Chairs of the North Integrated Care Partnership (ICP)
- Engagement with the Integrated Care Board (ICB) Chair and Foundation Trust Chair Forum

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

CHAIR'S REPORT

It has been quite a year so far at Newcastle Hospitals. The details of the Care Quality Commission (CQC) inspection report have been shared and showed our overall rating dropped from outstanding to requires improvement which was a huge disappointment. Our main priority is to tackle the issues raised in the CQC report and make improvements in the areas included within the report. I know the whole organisation is focussed on this matter.

I would also like to formally welcome Rob Harrison to the Trust as our new Managing Director and Annie Laverty our new Chief Experience Officer - I am looking forward to working with you both. They will soon be getting out and about meeting with staff and patients.

I chaired the Council of Governors meeting on Thursday 14 February 2024. In addition to the regular agenda items the meeting included a Public Health Update presentation from Balsam Ahmad, Consultant in Public Health, and an overview of the ICB/Integrated Care System (ICS)/Provider Collaborative arrangements from Dan Jackson, Director of Governance and Partnerships, North East and North Cumbria ICB. In addition, our Chief Executive gave an update on the current position within the Trust. The meeting was well attended by our Governors, and we had some very good discussions.

In terms of Board activity, I chaired an Extraordinary Private Trust Board of Directors Meeting on 12 February 2024 to discuss and agree our CQC response.

I Chaired our Board Development Workshop took place on 29 February 2024 and was facilitated by representatives from The Value Circle. We focused on lessons learned from the CQC inspection, which included:

- Reviewing key themes and feedback from the individual Board 1:1 discussions with thevaluecircle.
- Group discussions, agreement of actions and next steps.
- An update for Non-Executive Directors on the CQC governance workstream.

Governor and Member activity since our last meeting has included:

- The Quality of Patient Experience (QPE) Working Group met on 6 February 2024 and noted the recent publication of the CQC inspection report. The Working Group terms of reference were presented for approval.

  The QPE Working Group met again on 5 March 2024 and discussions centred around the template for reporting on ward/department visits and its redesign; as well as a discussion on accommodation for patient's families.

- The Governor Mandatory Training session was held on 7th February 2024 at Eldon Court. This included training on Information Governance, Fire Refresher, Infection, Prevention Control (IPC), Equality, Diversity & Inclusion (EDI), Health & Safety, Anti bribery and Safeguarding.

- The Business & Development (B&D) Working Group met on 8 February 2024 and Julie Raine, Deputy Head of Workforce Development updated the Governors on the recent construction of the Eldon Court training facility and the refurbished Education Centre at the Freeman Hospital.

  The B&D Working Group met again on 14 March 2024 where Christine Smith, Non-Executive Director and Jo Mason, Deputy Chief Finance Officer joined to give a finance update.

- The People, Engagement and Membership (PEM) Working Group met on 13 February 2024 and discussed the spring newsletter. The Group noted the positive increase in the numbers of public members. Upcoming priorities include Governor elections and increasing diversity of the Trust membership.

- A Governor engagement session was held on the People Programme on 12 March 2024. This was led by Christine Brereton, Chief People Officer, and Donna Watson, Head of Workforce Engagement & Information, and gave governors the opportunity to share thoughts and input into the development of the Trust People Plan.

- A Members Event on End of Life/Palliative Care was held on 18 March 2024 which was well attended. This included presentations by the Palliative Care Team, Macmillan and the Chaplains, as well as some group discussion.

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

- **The Stroke Unit –** Members of The Stroke Unit Team, Dr Sophia Dima, Dr Anand Dixit, Nurse Practitioner Laurie Giraldo, and Nurse Specialist, Cara Hubbuck, delivered a short presentation explaining the unit's work.

- **Long Term Ventilation –** Ben Messer, Consultant Anaesthetist and Alison Armstrong from the North East Assisted Ventilation Service (NEAVS) shared a short presentation and answered questions. This was a really interesting presentation highlighting the history of treatment, equipment and its advances and how outcomes have improved. The service has also been awarded team of the year in 2023.

At a regional level, I attended the North Chairs/CEO meeting on 1 February 2024 and the North Sub ICP Chairs meetings on 8 February and 14 March 2024. I have also attended the ICS Foundation Trust (FT) Chairs meeting and the ICB Chair and FT Chairs Forum on 20 February 2024.

On 23 February 2024 I had the pleasure of being on the panel to interview for our new Medical Director. The process revealed that this was a lot for one person to undertake and as a result we decided on a joint/co-appointment and announced that Dr Lucia Pareja-Cebrian and Dr Michael Wright would be our new joint Medical Directors. In addition, Ian Joy was appointed our Executive Director of Nursing on an interim basis. Congratulations to you all!

On 1 March 2024 I was delighted to be invited to visit the Community Diagnostic Centre (CDC) at the Metrocentre where our CEO Jim Mackey and I signed a girder which would be installed as part of the building work.

On 7 March 2024 I undertook a late evening visit to wards at both the RVI and Freeman to meet and connect with staff who work through the night in our hospitals

Along with a number of Trust staff I attended an Emergency Care Conference organised by the Great North Healthcare Alliance on 22 March 2024. This was a real opportunity for the alliance organisations to focus on this key area of health and develop collaborative ideas and plans.

RECOMMENDATION

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

Report of Professor Kath McCourt
Interim Chair
21 March 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024					
Title	Patients and People: Patient Story					
Report of	Annie Laverty – Chief Experience Officer					
Prepared by	Annie Laverty					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	This is a story of a 64-year-old gentleman diagnosed with advanced bowel cancer in 2017. 'RS' emailed Trust Management in March 2024, he had read the CQC report and was motivated to get in touch, because the shortfalls in care described in the report did not reflect his own experience. He felt for the team and wanted to have his account of excellent care on record. I visited RS and his wife (MS) at home – they described the positive contributions of all members of the multidisciplinary team over 'hundreds of interactions' and the reasons why these encounters were so memorable.					
Recommendation	The Board are asked to receive the story and note the many factors contributing to high quality, compassionate and safe care.					
Links to Strategic Objectives	Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☐	☐	☐
Link to Board Assurance Framework [BAF]	No direct link.					
Reports previously considered by	Patient and People stories are a recurrent feature of all Board meetings. Future stories at Board will alternate to capture both patient and staff experience. With a focus on learning and transparency, we will also ensure we get the balance right by providing both positive and negative accounts.					

PATIENT STORY

Patient story: RS – 64-year-old gentleman with advanced bowel cancer

I was initially treated in Cumbria, but since the summer of 2017 I have been under the outstanding care of Dr Ian Pedley, Consultant Clinical Oncologist, and team. Care has been complex: I have had chemotherapy and immunotherapy, an ALPPS liver resection (associating liver partition and portal vein ligation for staged hepatectomy), a bowel resection plus further ablation and a lung operation.

Over the last few years, I have been an inpatient at both the Freeman and the RVI, as well as undergoing countless outpatient appointments, scans, chemotherapy, and other procedures. As a result, I do feel quite well positioned to offer a 'patient's eye view' of the Trust, and it is important to share my impressions with you now.

It would be invidious to single out too many individuals, because I can honestly say that everyone at all levels of the organisation have been nothing short of wonderful. I can recall numerous examples but suffice it to say that many members of your team have treated me in a way that goes far beyond any reasonable expectation: -

- When I first had chemotherapy, Fiona Holdsworth (Nurse Specialist) – I initially saw her on the unit in Hexham but she is now with Newcastle. She was warm, friendly but also so efficient ensuring I did not have to wait for anything, unnecessarily. A particularly good experience.

- When my mobility deteriorated, a fantastic physio inspired me – I don't recall her name, sadly, I was heavily medicated at the time, but she was so motivational.

- After major surgery I was in intensive care requiring 1:1 nursing. I had tubes everywhere and was unable to lie down in bed. There were lots of cannulas everywhere and it was very distressing for my wife to witness. One day she observed the way the nurse removed the cannula from my hand – despite being busy – she was so gentle, taking such care and attention as if I were a child of her own. Witnessing that level of care and compassion gave my wife such confidence that I was with the right team. She would stay with me for 12 hours a day and was never made to feel like she was in the way.

- I have been wheeled about by a lot of porters – who always manage to raise a smile. They have a knack of getting the tone exactly right – using humour to lighten the load in a way that worked for me.

- I observed the way the MDT behaved – the senior clinicians interacting with colleagues in an entirely collegiate and respectful way. I would be extremely concerned if we lost these skills due to an inability to retain existing staff.

- Ian has been fantastic – even when recently an issue emerged, after three years of being well – he went back to the last scan to see in retrospect if there was anything

that he missed. I find that level of humility in such a talented clinician very impressive.

- Always approachable, Ian has responded to my queries on a Saturday morning when away from work. Peter, who works alongside him, is some nurse. Standards of care seem extremely high – they always look like they are enjoying their work.

- Stephanie from Maggie's helped us with some important financial aspects – both of us have stopped working and there were benefits we didn't know we were entitled to. The Director of Pharmacy, Neil Watson supported access to additional treatment that we would not have been able to afford without his help.

Overall, there will have been hundreds of interactions, all of them making a difference and helping to keep me alive so long. Everyone we have dealt with has treated my wife and I as a unit. Our faith in the team and the standards of clinical care are such that we took the decision to move here – we wanted to be near a leading teaching hospital. We are extremely glad we made that decision.

I spent the better part of my working life as a journalist, novelist and documentary photographer and filmmaker, so I do have well-developed powers of observation. I have studied your clinicians at work, in my own way, in much the same way that they have studied me. Frankly, your people's level of technical skill and personal commitment demonstrates that these people have what can only be described as a vocation - and I can only hope that the CQC sees that in every part of the Trust on their next visit.

Currently I have a recurrence and Dr Pedley is liaising with Mr John Hammond, Consultant Transplant Surgeon, and his team in terms of next steps.

The Board is asked to receive this patient story and note progress made towards our strategic aims of putting patients at the heart of everything we do and providing care of the highest standard.

Report of Annie Laverty
Chief Experience Officer
16 March 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024					
Title	Experience of Care Strategy					
Report of	Maurya Cushlow, Executive Chief Nurse Ian Joy, Executive Director of Nursing					
Prepared by	Ian Joy, Executive Director of Nursing Annie Laverty Chief Experience Officer Tracy Scott Head of Patient Experience					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☐	☐			
Summary	This report provides the Trust Board with an overview of the development of the Experience of Care Strategy (Appendix 1) and outlines plans for the launch of this strategy in April 2024. This report includes: • Overview of the development of the strategy • Overview of the 5 key objectives • Development of a cohesive work plan and an overview of the work proposed by the Chief Experience Officer • Next steps					
Recommendation	The Trust Board is asked to: i) Note the process undertaken to develop the Experience of Care Strategy; ii) Review and approve the Experience of Care Strategy; and iii) Endorse the launch of the strategy in April 2024.					
Links to Strategic Objectives	Putting patients at the heart of everything we do. Provide care of the highest standard focused on quality and safety.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☐	☒	☐
Link to Board Assurance Framework [BAF]	None noted.					
Reports previously considered by	Stand-alone report.					

EXPERIENCE OF CARE STRATEGY

EXECUTIVE SUMMARY

This report provides the Trust Board with an overview of the development of Experience of Care Strategy (attached in Appendix 1) and outlines plans for the launch of this strategy in April 2024.

The report includes the following key points:

- In 2023, with the support of the Newcastle Hospitals Charity, building on work which commenced in 2022, we began a journey to develop a clear, cohesive and forward-thinking patient experience strategy which would be developed through meaningful engagement and listening.

- In April 2023, Stand (expert involvement practitioners and service change leaders) were commissioned to deliver on this important piece of work and a working group including members of the patient experience and communication teams along with governors guided the activities.

- A communications and involvement plan was drawn up to ensure that the activities planned gave wide-ranging opportunities to participate and include as many people as possible.

- The activities which took place in June and July 2023 and included:

1) A survey for patients, carers, staff, visitors and governors (458 responses)
2) A series of staff workshops targeting difference staff groups (84 attendees)
3) One-to-one interviews with staff members and partners and stakeholders (33 interviews)
4) Face-to-face engagement on hospital sites with patients, visitors and staff (116 discussions)

- Two co-design sessions were held to share the key themes from the involvement activity and with the aim of co-producing what the strategy should look like and a framework to meet the ambition for patient experience.

- The finalised Experience of Care Strategy (found in Appendix 1) outlines 5 key objectives with a number of commitment statements related to each. These are explained in depth in the report.

- Once the Experience of Care Strategy is endorsed by the Trust Board and subsequently shared and cultured with key groups such as the Council of Governors, the aim is to launch in April 2024 with a finalised work plan in place.

- One key aspect of delivering the aspirations of this strategy, is the exciting and innovative work plan of our new Chief Experience Officer, Annie Laverty. Annie plans

to roll out a real time patient and staff experience programme which will deliver many aspects of the 5 key objectives and commitment statements. More detail is included within the report.

- This strategy is ready for launch with key groups across the organisation and delivery will be supported by a comprehensive work plan.

Report of Maurya Cushlow
Executive Chief Nurse
18 March 2024

Ian Joy
Executive Director of Nursing

EXPERIENCE OF CARE STRATEGY

1. INTRODUCTION

This report provides the Trust Board with an overview of the development of Experience of Care Strategy and outlines plans for the launch of this strategy in April 2024.

2. BACKGROUND

As a Trust we are motivated and committed to improving the experience of patients, families, carers and visitors and are constantly learning from lived experiences. We want to truly understand what matters to people who access our services. In 2023, with the support of the Newcastle Hospitals Charity, building on work which commenced in 2022, we began a journey to develop a clear, cohesive, and forward-thinking patient experience strategy which would be developed through meaningful engagement and listening.

In April 2023, Stand (expert involvement practitioners and service change leaders) were commissioned to deliver on this important piece of work and a working group including members of the patient experience and communication teams along with governors guided the activities.

3. DEVELOPMENT OF STRATEGY

A communications and involvement plan was drawn up to ensure that the activities planned provided wide-ranging opportunities to participate and include as many people as possible.

A situation review was conducted to provide a background to patient experience approaches and strategies that have taken place around the country. The situation review detailed the guidance and support issued by bodies such as NHS England to date, a summary of academic studies that have been undertaken in this area and an analysis of best practice patient experience strategies where key themes were identified and collated.

A period of involvement was carried out between June and August 2023 as part of this review. The objective of the involvement activity was:

- To listen to patients, carers, visitors and public governors to gain an understanding of their views about how and when they would like to feed back their experiences of their treatment and care, and how they would like to find out what has happened as a result of them providing their feedback.
- To listen to staff, volunteers and staff governors to gather information about what currently happens in their area in relation to gathering, analysing and acting upon feedback, and to identify any suggestions for improvements or gaps.

The activities which took place in June and July 2023 included:

- A survey for patients, carers, staff, visitors and governors (458 responses)
- A series of staff workshops targeting difference staff groups (84 attendees)

- One-to-one interviews with staff members and partners and stakeholders (33 interviews)
- Face-to-face engagement on hospital sites with patients, visitors and staff (116 discussions)

Two co-design sessions were held to share the key themes from the involvement activity and with the aim of co-producing what the strategy should look like and a framework to meet the ambition for patient experience.

All those who had already participated or been invited to take part in the involvement activities, such as attending a workshop or taking part in an interview, were given the opportunity to be part of the co-design sessions. They were sent the feedback and themes in advance so they could come to the session prepared with some initial thoughts and ideas.

Attendees were taken through the key themes and in small groups were asked to explore the themes in terms of developing a strategy by discussing the objective of the theme, what the scope could be, the implementation timeframe and how it could be measured. All the output was gathered and put into a report which was used to develop the draft patient experience strategy.

The draft patient experience strategy developed from the co-design sessions was shared with the Patient Experience Team. A workshop was held on 2 October 2023 with the team to look at the objectives that emerged to think about how these could be achieved. The focus was to learn from the successes so far and to look at what opportunities there are to help the Trust make sure patient experience is a priority for everyone. Taking all the threads, themes, findings and feedback into account, the draft strategy was developed and renamed “Experience of Care Strategy”

4 THE EXPERIENCE OF CARE STRATEGY

The Experience of Care Strategy (found in Appendix 1) outlines 5 key objectives with a number of commitment statements related to each:

1) We take a patient-centred approach because patients should always be at the heart of everything we do.
2) We develop a listening culture, actively asking people what matters to them, encouraging feedback at each stage of their journey. We will demonstrate how feedback has led to change.
3) We develop patient experience opportunities that are easy to understand and access, which reflect the diverse range of people who access our services.
4) We champion innovation in patient experience and actively seek to be the best we can.
5) We use experience feedback to instil pride amongst patients, stakeholders and staff, celebrating contributions towards our overall success.

This strategy reinvigorates the Trust's commitment to having a patient centred approach and aligns to the value of "people at our heart". An operational work plan is currently being created to provide assurance that the strategy is delivering on the key objectives which will be monitored through the Patient Experience and Engagement Group.

5 NEXT STEPS

Once the Experience of Care Strategy is endorsed by the Trust Board and subsequently shared and cultured with key groups such as the Council of Governors, the aim is to launch in April 2024 with a finalised work plan in place.

One key aspect of delivering the aspirations of this strategy, is the exciting and innovative work plan of our new Chief Experience Officer, Annie Laverty. Annie plans to roll out a real time patient and staff experience programme which will deliver many aspects of the 5 key objectives and commitment statements. The aim of this work is to:

- Ensure the organisation has a systematic way of analysing patient and staff feedback in all its forms and dedicated analytics and intelligence support for its patient and staff experience data.
- Develop transparent and publicly accessible information about the feedback patients and staff have provided, with the organisation's response to this feedback.
- Train a team of patient coordinators to carry out hundreds of face-to-face interviews every month to enable a better understanding of the needs of inpatients whilst they are still with us; the results will be shared with staff within three to four hours of speaking to patients enabling a nimble response to any concerns.
- Deliver a 'right time' programme which will capture reflective feedback from patients two weeks after they are home. We will deliberately survey two weeks after leaving hospital, because we know that this is the time, statistically, when people are likely to be at their most dissatisfied – our greatest improvement opportunity.

Ongoing data analysis will allow for a demonstration of impact on a month-by-month basis. This work and the extensive work plan which sits underneath it, will be incorporated into the wider Experience of Care work plan to ensure there is a clear and co-ordinated delivery in practice.

6 SUMMARY AND RECOMMENDATIONS

The Experience of Care Strategy is the culmination of two years of work, achieved through extensive engagement with a wide variety of stakeholders. This strategy is ready for launch with key groups across the organisation and delivery will be supported by a comprehensive work plan. The innovative work proposed by our new Chief Experience Officer will help ensure the aspirations of this strategy are delivered at pace, complementing the wider strategy work plan.

The Trust Board is asked to:

iv) Note the process undertaken to develop the Experience of Care Strategy
v) Review and approve the Experience of Care Strategy
vi) Endorse the launch in April 2024

Report of Maurya Cushlow **Ian Joy**
Executive Chief Nurse **Executive Director of Nursing**
18 March 2024

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Experience of Care Strategy 2024–2029

Measuring, understanding and acting on experience feedback

Healthcare at its best with people at our heart

We want to truly understand **what matters to people** who access our services.

Our Strategy

We, as a Trust, are motivated and committed to improving the experience of patients, families, carers and visitors and are constantly learning from lived experiences. We want to truly understand what matters to people who access our services.

We know that listening to what patients, carers and the local communities tell us, makes the care we provide and the systems and processes we develop a much more positive and better experience for everyone.

We began the journey of developing this strategy by involving patients, staff and members of the public in a series of engagement and involvement events. Our objective was to listen carefully, to help gain a thorough understanding of views and opinions about how people would like to provide feedback.

We were particularly interested in views on how, and when people would like to feedback experiences of care and treatment, and also if they would be interested in finding about what has happened as a result of their feedback.

The involvement activities gave the opportunity to review systems and processes we currently use and helped explore any potential gaps and new opportunities to support the gathering, analysis and acting upon feedback.

4 key goals have emerged which included:

1 Engage

- Feedback should be proactively sought and not a reactive response
- We must consider offering a range of clear and easily accessible options for patients to offer real-time feedback
- We must be willing to listen and act on feedback

2 Co-Production/Design

- We must consider a collaborative approach and strengthen links with the local community
- We should develop systems and processes to support the involvement and engagement of patients at all levels of the organisation

3 Partnerships

- We should build trusting relationships with local communities particularly in respect of partnership working

4 Closing the loop

- We should develop mechanisms to close the loop and share what difference the feedback has made

Our aspiration is to develop a culture in which patient experience is embedded in what we all do, think, plan and deliver.

Patients have also told us that they want to know what happens to their feedback, so they know that it's made a difference.

Summary

This strategy reinvigorates the Trust's commitment to having a patient-centred approach and aligns to the value of "people at our heart".

During the development of this strategy staff and patients have told us that they want us to make sure that patient experience is a priority at all levels and that we should be more proactive in involving patients and staff in feedback processes, service design, and decision making.

We already know that the majority of the feedback we receive is positive. We want to build on this and make it easier to share experiences, both good and bad, and embrace this as an opportunity to celebrate and learn.

We acknowledge that giving and receiving negative feedback can be difficult, so we want to make sure patients feel safe to offer their experiences and staff are appropriately skilled and supported when receiving this.

People have told us they want us to be much more proactive in the way we seek feedback, and we should use a variety of mechanisms suited to different people's needs.

People told us they wanted to use digital solutions and that these tools should be user-friendly and accessible for everyone.

Patients have also told us that they want to know what happens to their feedback, so they know that it's made a difference.

This feedback has been core to the development of our experience of care strategy, but we are also very aware that patient experience cannot be viewed as a standalone strategy.

Throughout the next five years we will, in partnership with staff and people who access our services, constantly evaluate, amend and adapt, using quality improvement tools, to help ensure we are able to meet the objectives shared within this strategy.

Our 5 experience of care key objectives

1

We take a patient-centred approach because patients should always be at the heart of everything we do

- We will place patient experience on an equal footing with patient safety and quality
- We will strengthen the number and diversity of people's voices and communities into governance structures to enable involvement in decision making processes, service improvement and safety
- We will create a culture where everyone feels safe to share their feedback
- We will learn from patient experience data, patient stories and insights to better understand whether the needs of patients are being met
- We will involve patients and communities when reviewing and developing new services

2

We develop a listening culture, actively asking people what matters to them, encouraging feedback at each stage of their journey. We will demonstrate how feedback has led to change

- We will see feedback as an opportunity to celebrate, learn and grow
- We will encourage staff to gather feedback and evidence how this has led to improvement
- We will proactively plan annual programmes and initiatives to gather feedback and encourage more people to participate
- We will embrace the use of technology and digital innovations, ensuring they are user-friendly and accessible to everyone

3

We develop patient experience opportunities that are easy to understand and access, which reflect the diverse range of people who access our services

- We will actively include and do more to meet the needs of carers in the feedback process
- We will make it easier to access alternative formats, such as translated materials, so everyone has equal opportunity to provide their feedback
- We will develop strong partnerships with local communities; providing alternative opportunities for people to get involved, with support
- We will ensure reasonable adjustments are considered when this is required

4

We champion innovation in patient experience and actively seek to be the best we can

- We will develop skills and expertise within the patient experience team
- We will provide front line staff with training and relevant tools to support the measurement, analysis and acting upon patient experience
- We will develop real-time patient feedback mechanisms
- We will continuously seek and apply new knowledge and actively share our learning with our patients, staff, stakeholders and the wider NHS
- We will utilise validated frameworks to measure success

5

We use experience feedback to instil pride amongst patients, stakeholders and staff, celebrating contributions towards our overall success.

- We will ensure feedback is easily accessible and understandable for staff
- We will make sure there are clear and consistent communications about the positive impact patient experience has made
- We will celebrate and share successes
- We will nationally benchmark patient experience data
- We will recognise the importance of patient experience from "ward to board"
- We will encourage staff to adopt a quality improvement approach to ensure continuous reflection and learning

Acknowledgement and with many thanks

We appointed Stand, expert involvement practitioners and service change leaders with substantial experience in engagement to inform policy, strategy, service design and transformation, to run the involvement activities. They have been instrumental in ensuring this strategy was developed with, and for, people who access our services.

A working group including members of Stand, the Patient Experience Team, Trust Governors, and the Communications Team guided these activities.

A period of involvement was held between June and August 2023 consisting of surveys, one-to-one interviews, workshops and face-to-face engagement. The outputs were analysed and taken to two co-design sessions held with patients, staff, Governors and key stakeholders. We managed to speak to over 800 people whose views have guided the development of this strategy.

A situational review was also carried out which looked at the guidance and support issued by bodies such as NHS England, academic studies that have been undertaken in this area and an analysis of best practice patient experience strategies from other NHS Trusts with particular attention to the other Trusts in the Shelford Group.

Many thanks to everyone who has supported the co-production of this strategy.

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Healthcare at its best
with people at our heart

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024		
Title	People: Staff Survey Results / People Programme		
Report of	Christine Brereton – Chief People Officer and Annie Laverty – Chief Experience Officer		
Prepared by	Donna Watson, Christine Brereton, and Annie Laverty		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☐	☒
Summary	The National Staff Survey results (taken from feedback in September and October 2023) were published on the 7 March 2024, providing detailed results and benchmarking data. As we might expect, the Trust's results have seen a further deterioration. Benchmarked against all other acute and acute/community trusts – this represents a bottom decile position for the Trust, signalling a strong message from staff, and continuing the declining trend of recent years. Points of note: - ▪ 6,641 colleagues submitted responses - whilst, statistically, these results are representative, a response rate of 42% is disappointing from a staff engagement perspective and is 3% lower than the sector average (slide 2). ▪ The Trust scores below average in each of the 9 staff survey domains – worst in the country for the "we are a team" theme (slide 3). ▪ Worst nationally in 8 questions aligned to leadership and line management (slide 4). ▪ All feedback relating to culture, raising concerns, civility and respect, and staff engagement are entirely consistent with CQC findings, Trust roadshows and People Plan focus group consultations. ▪ Over 11,000 staff have given feedback through various routes in the last two years. This has informed the development of the Newcastle Hospital People Plan led by the Chief People Officer (slide 10). ▪ The People Plan and the associated year 1 action plan will be launched in late April aligned to outcomes within the staff survey (side 15). More positively, we do now have lots of good data to work with to highlight variation across the organisation, helping to point us to where we need to focus our improvement efforts. We have already started that work with Clinical Boards. The development of a comprehensive staff experience programme led by the Chief Experience Officer will provide greater and more frequent insight into our ability to create the conditions and environment where all staff feel welcome and valued.		
Recommendation	The Board is asked to receive the report for information and approve the next steps outlined to support implementation of the People Programme Strategy.		

Links to Strategic Objectives	People: We create an environment where all staff and volunteers feel welcome and valued					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	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.					
Reports previously considered by	This is a recurrent People report outlining annual staff survey results. The presentation has been discussed in Trust Management Group, Executive Team and People Committee. The presentation was also shared with Governors.					

2023 NHS Staff Survey

Summary – Including National Benchmarking

Board of Directors – 28 March 2024

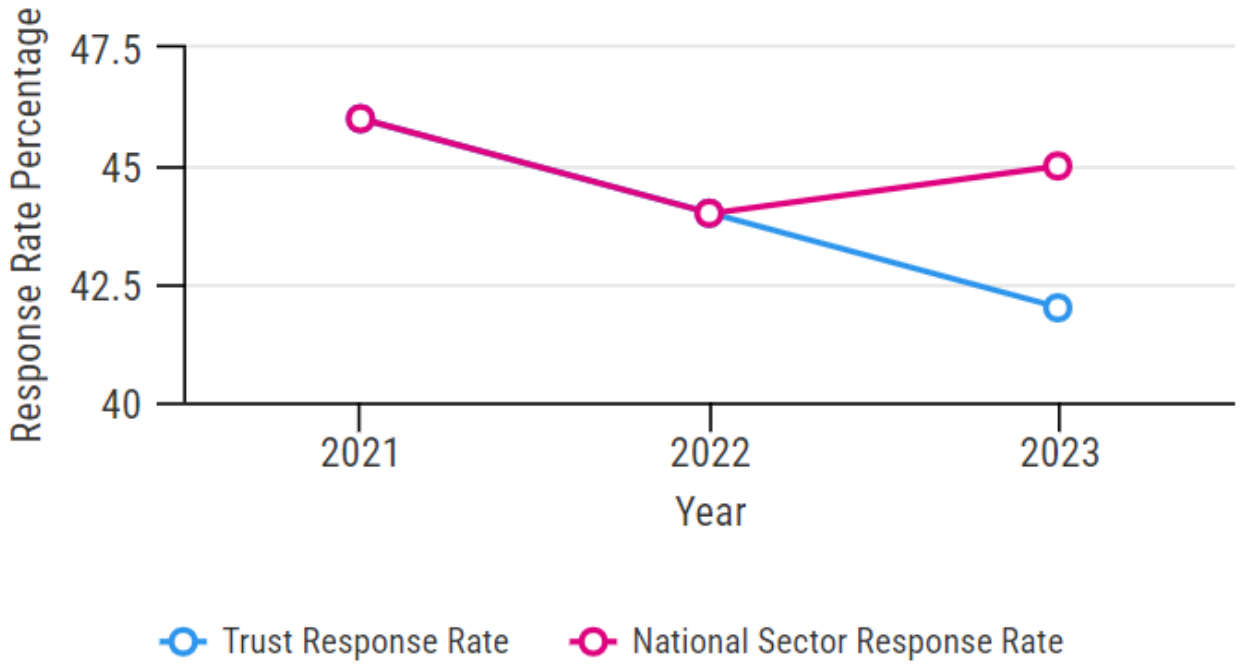
Christine Brereton – Chief People Officer

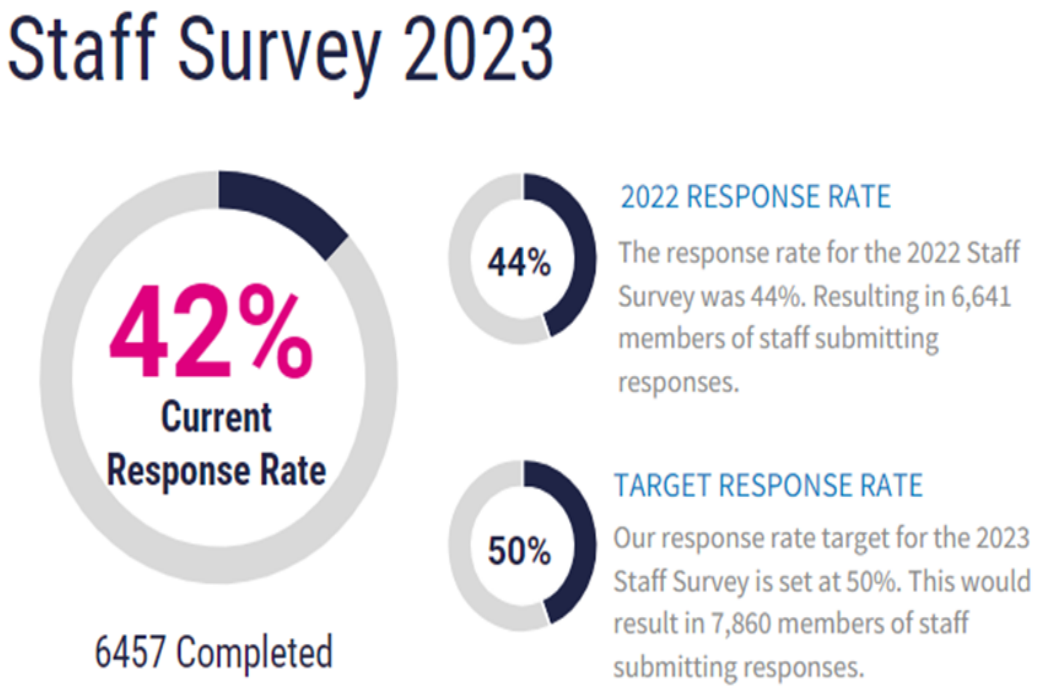
Annie Laverty – Chief Experience Officer

Response Rates since 2021

The Newcastle upon Tyne Hospitals NHS Foundation Trust

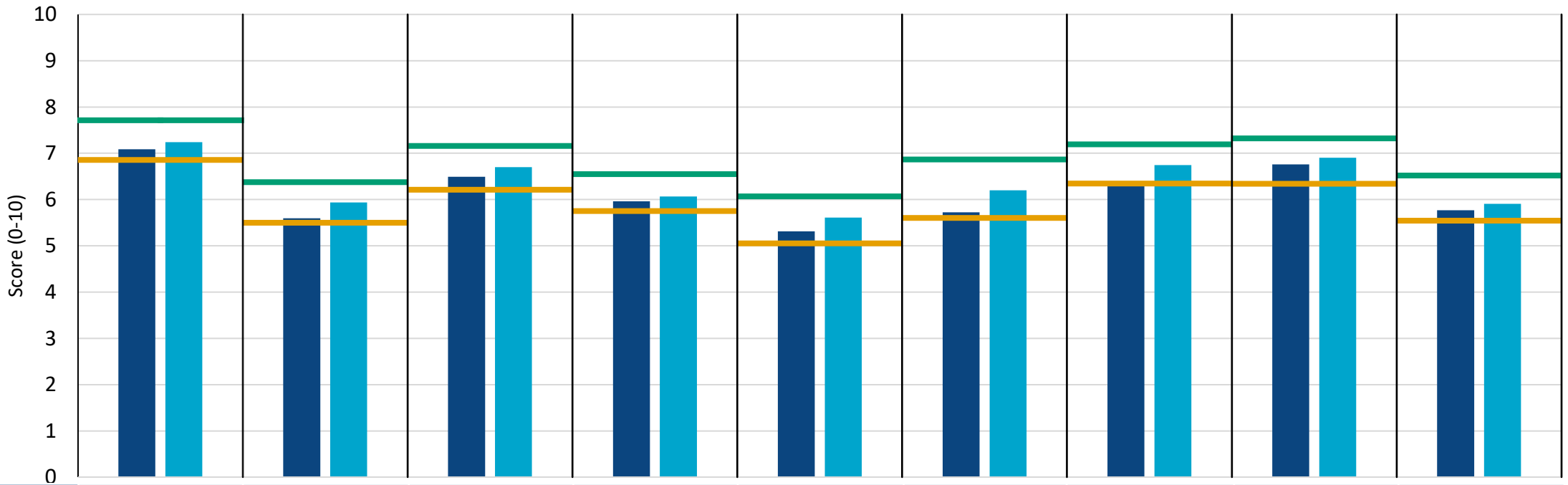
- The Trust has had a **declining response rate** since 2021.
- In 2021, and 2022 the Trust had the **same response rate** as the Sector average.
- In 2023, the Trust has a response rate **3% lower** than the Sector average.





Thematic Results

The Newcastle upon Tyne Hospitals NHS Foundation Trust



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.09	5.60	6.49	5.96	5.31	5.72	6.35	6.76	5.77
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	6444	6451	6375	6398	6258	6414	6420	6446	6452

National Benchmarking – Worst nationally

- The following 8 questions are showing the Trust as the worst nationally in these areas.
- They are all aligned to the leadership and management questions.
- The question advises on our score and below average % compared to the national average.

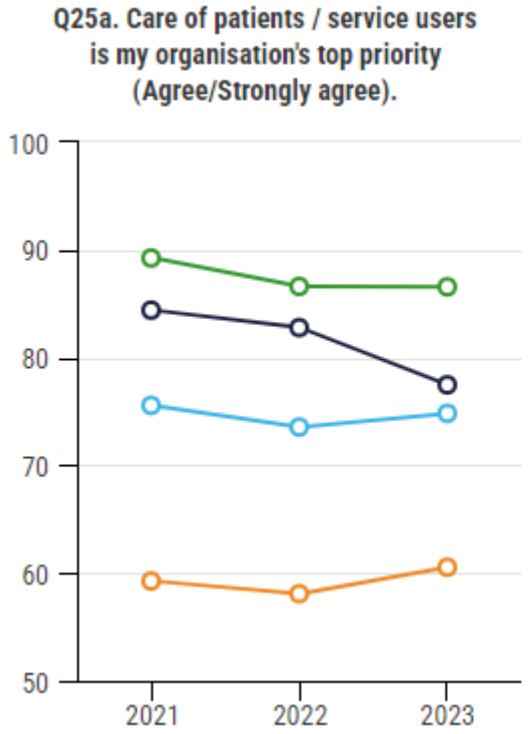
	Question	Score	% below average
Q9a	My immediate manager encourages me at work (Strongly disagree/Disagree).	65.29%	6.16%
Q9b	My immediate manager gives me clear feedback on my work (Strongly disagree/Disagree).	57.43%	7.53%
Q9d	My immediate manager takes a positive interest in my health and well-being (Strongly disagree/Disagree).	61.93%	7.17%
Q9e	My immediate manager values my work (Strongly disagree/Disagree).	65.51%	5.88%
Q9f	My immediate manager works together with me to come to an understanding of problems (Strongly disagree/Disagree).	61.17%	7.18%
Q9g	My immediate manager is interested in listening to me when I describe challenges I face (Strongly disagree/Disagree).	64.48%	6.51%
Q9h	My immediate manager cares about my concerns (Strongly disagree/Disagree).	62.95%	6.42%
Q9i	My immediate manager takes effective action to help me with any problems I face (Strongly disagree/Disagree).	58.68%	7.82%

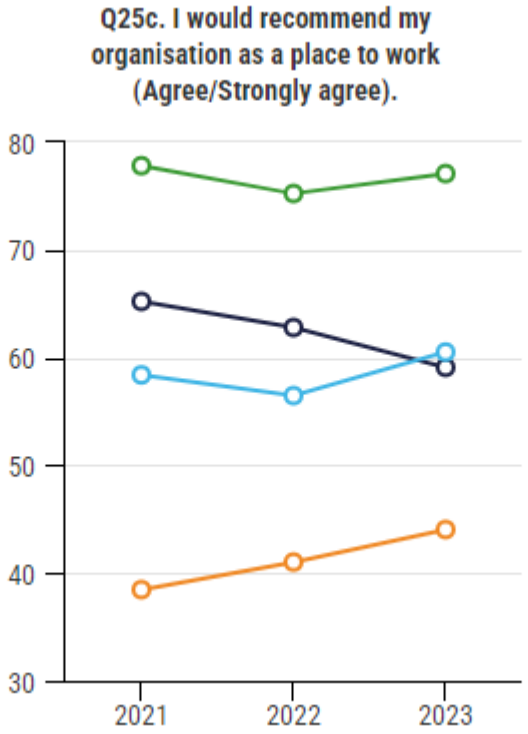
Bottom 10 Areas of Negative Decline % Compared to 2022

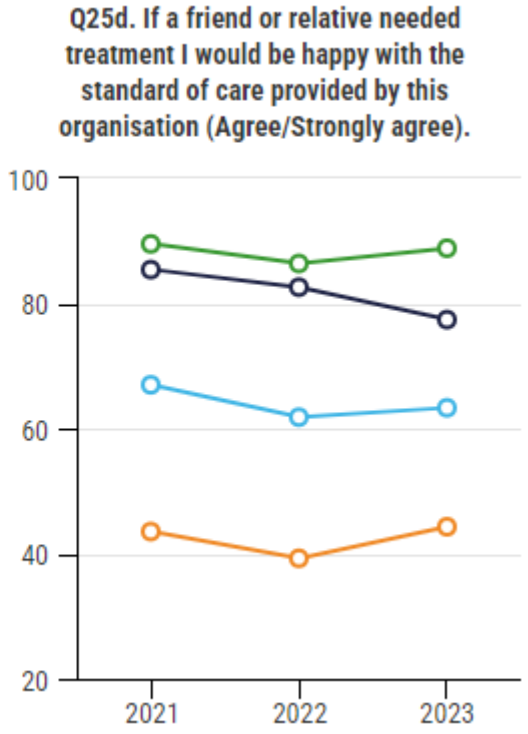
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Q11a. My organisation takes positive action on health and well-being (Strongly disagree/Disagree).	-6.93%
Q20b. I am confident that my organisation would address my concern (Strongly disagree/Disagree).	-6.80%
Q25f. If I spoke up about something that concerned me I am confident my organisation would address my concern (Strongly disagree/Disagree).	-6.17%
Q15. Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age (No).	-5.99%
Q25e. I feel safe to speak up about anything that concerns me in this organisation (Strongly disagree/Disagree).	-5.29%
Q25a. Care of patients / service users is my organisation's top priority (Strongly disagree/Disagree).	-5.24%
Q25d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Strongly disagree/Disagree).	-5.18%
Q20a. I would feel secure raising concerns about unsafe clinical practice (Strongly disagree/Disagree).	-5.04%
Q8a. Teams within this organisation work well together to achieve their objectives (Strongly disagree/Disagree).	-4.91%
Q21. I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc) (Strongly disagree/Disagree).	-4.87%

Staff Engagement - Advocacy







	Q25a			Q25c			Q25d		
	2021	2022	2023	2021	2022	2023	2021	2022	2023
Org	**84.41%**	**82.79%**	**77.48%**	**65.22%**	**62.80%**	**59.10%**	**85.48%**	**82.61%**	**77.41%**
Best	89.25%	86.61%	86.57%	77.82%	75.24%	77.09%	89.51%	86.38%	88.82%
Average	75.57%	73.56%	74.83%	58.40%	56.48%	60.52%	66.99%	61.82%	63.32%
Worst	59.27%	58.09%	60.55%	38.47%	41.03%	44.05%	43.54%	39.27%	44.31%

- **Steady decline** for the Trust over last **three years**.
- National picture shows an **increase** for the 2023 results.
- The Trust sits **above national average** for two elements of advocacy.
- The Trust sits **below** national average for recommending the Trust as a place to work.

Staff Survey 2023 (SS23): Raising Concerns

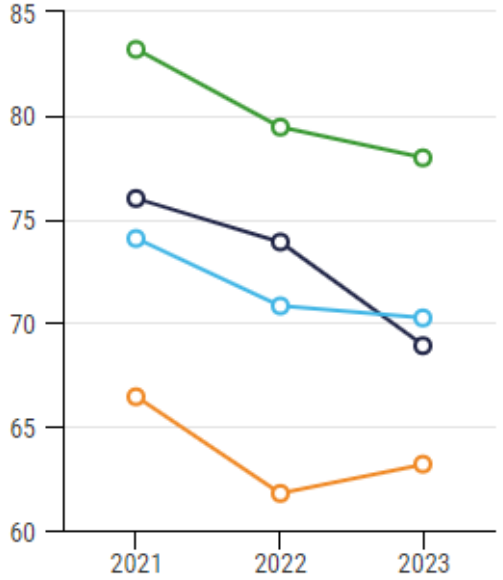
Strong theme from the CQC report as well as raised during focus groups

Showing significant decline

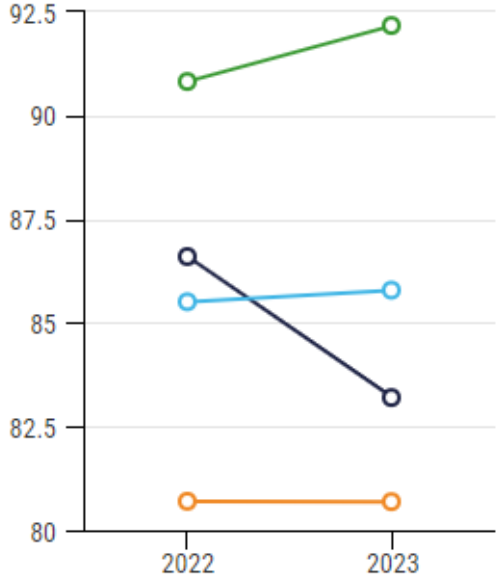
Raising Concerns

The Newcastle upon Tyne Hospitals NHS Foundation Trust

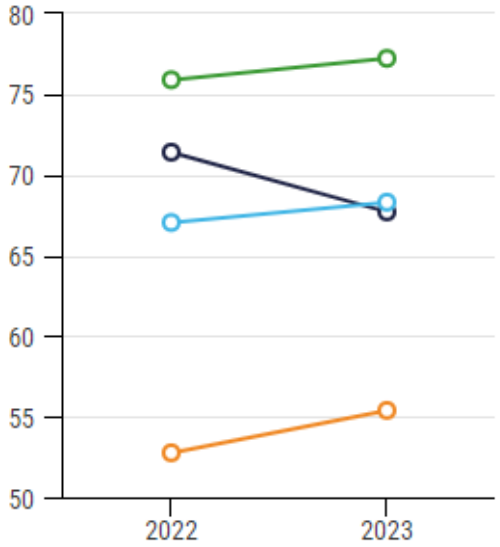
20a. I would feel secure raising concerns about unsafe clinical practice.



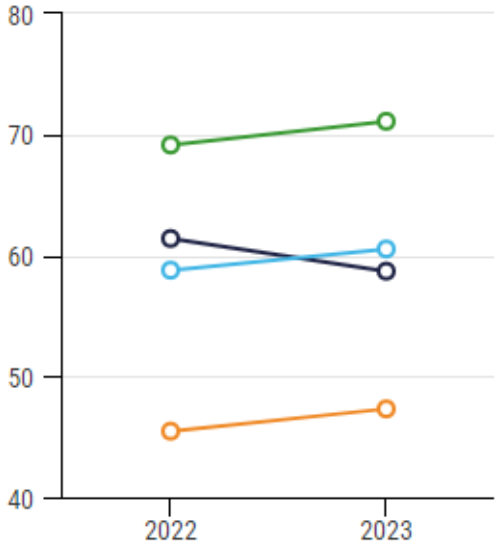
Q19b. My organisation encourages us to report errors, near misses or incidents. (Agree/Strongly agree0.



19c. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.



19d. We are given feedback about changes made in response to reported errors, near misses and incidents.

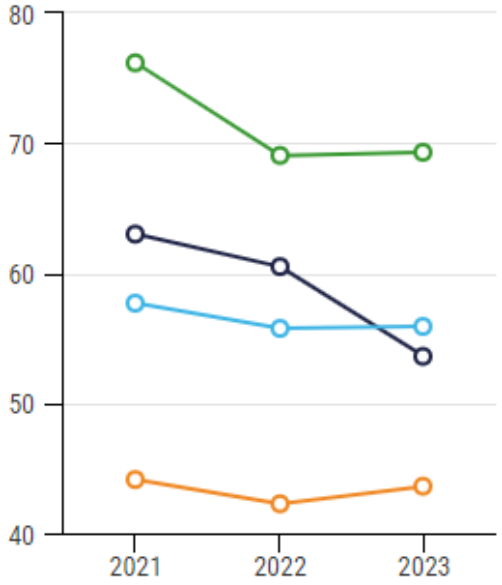


	Q20a			Q19b			Q19c			Q19d		
	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
Org	**76.54%**	**74.01%**	**69.00%**		**86.60%**	**83.24%**		**71.54%**	**67.78%**		**61.46%**	**58.77%**
Best	83.19%	79.44%	77.96%		90.82%	92.17%		75.89%	77.22%		69.13%	71.09%
Average	74.07%	70.82%	70.24%		85.51%	85.79%		67.04%	68.30%		58.78%	60.53%
Worst	66.44%	61.78%	63.19%		80.70%	80.69%		52.76%	55.39%		45.47%	47.31%

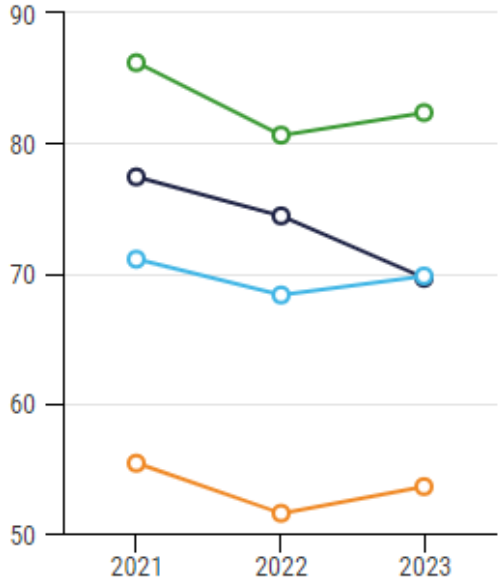
Raising Concerns

The Newcastle upon Tyne Hospitals NHS Foundation Trust

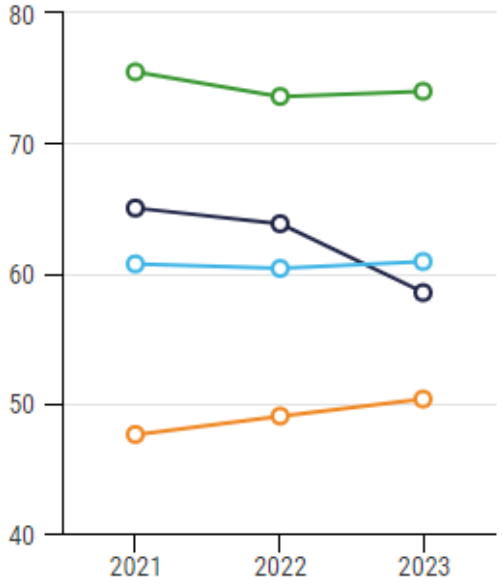
20b. I am confident that my organisation would address my concern.



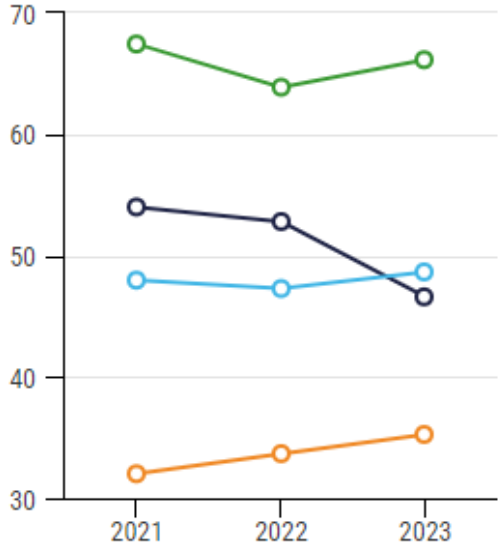
25b. My organisation acts on concerns raised by patients / service users.



25e. I feel safe to speak up about anything that concerns me in this organisation.



25f. If I spoke up about something that concerned me I am confident my organisation would address my concern.



	Q20b			Q25b			Q25e			Q25f		
	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
Org	**63.14%**	**60.60%**	**53.64%**	**78.07%**	**74.67%**	**69.90%**	**64.89%**	**63.95%**	**58.46%**	**54.42%**	**53.05%**	**46.73%**
Best	76.17%	69.05%	69.29%	86.18%	80.61%	82.34%	75.47%	73.58%	73.98%	67.43%	63.87%	66.13%
Average	57.69%	55.75%	55.90%	71.07%	68.32%	69.78%	60.71%	60.36%	60.89%	47.97%	47.28%	48.65%
Worst	44.13%	42.27%	43.62%	55.39%	51.54%	53.59%	47.60%	49.01%	50.32%	32.02%	33.68%	35.26%

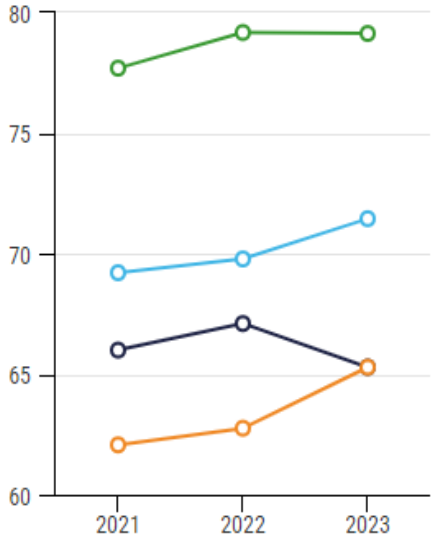
People Programme Framework

- SS23 feedback is correlating to the key themes from the focus groups and other People Plan feedback.
- Over 11,000 staff have given feedback through various routes including SS23 (and 22), Focus Groups, CQC, What Matters To You (WMTY), Staff Network, Staff Side and Freedom to Speak Up Guardian (FTSUG).
- The following slides provide a highlight of the SS23 data aligned to the four main pillars of the People Strategy as described in the infographic.
- The SS23 data also shows previous 3 years of results and national average, worst and best.

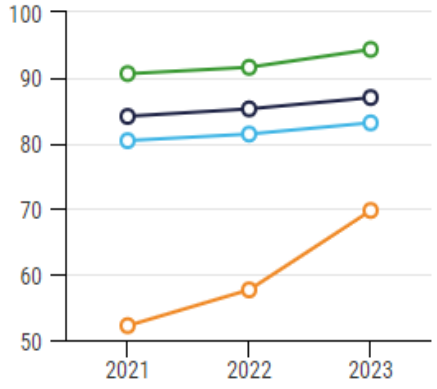
Leadership & Management

The Newcastle upon Tyne Hospitals NHS Foundation Trust

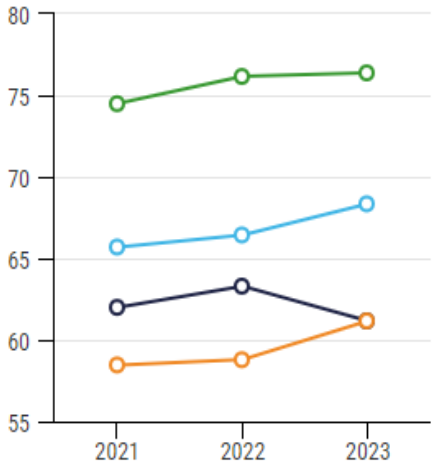
9a. My immediate manager encourages me at work.



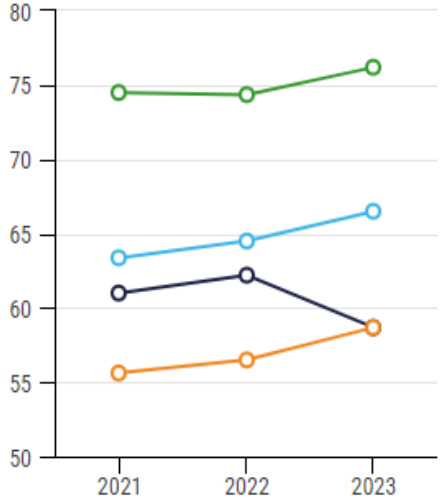
23a. In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?



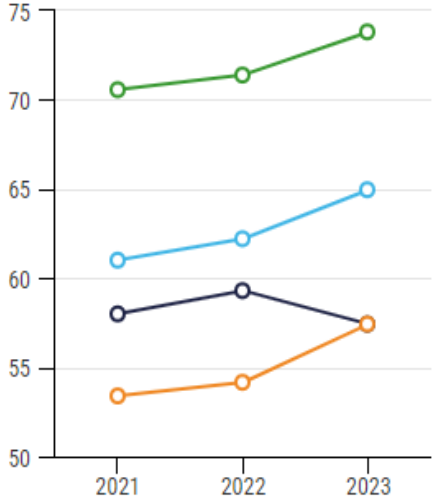
9f. My immediate manager works together with me to come to an understanding of problems.



9i. My immediate manager takes effective action to help me with any problems I face.



9b. My immediate manager gives me clear feedback on my work.

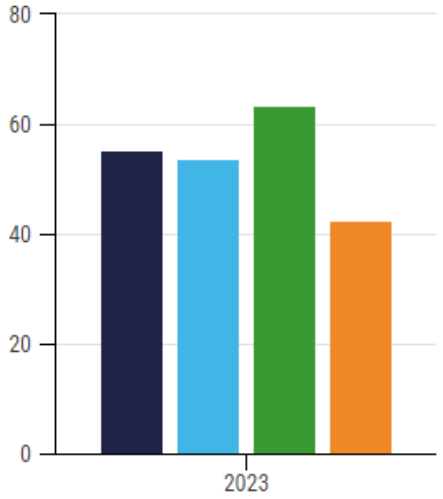


	Q9a			Q23a			Q9f			Q9i			Q9b		
	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
Org	**66.42%**	**67.46%**	**65.29%**	**84.10%**	**85.25%**	**86.98%**	**62.82%**	**63.47%**	**61.17%**	**61.65%**	**62.48%**	**58.68%**	**58.80%**	**59.60%**	**57.43%**
Best	77.69%	79.17%	79.13%	90.63%	91.59%	94.32%	74.49%	76.16%	76.38%	74.49%	74.35%	76.19%	70.57%	71.39%	73.81%
Average	69.21%	69.78%	71.45%	80.40%	81.41%	83.12%	65.70%	66.44%	68.35%	63.37%	64.50%	66.50%	61.01%	62.21%	64.96%
Worst	62.07%	62.76%	65.29%	52.20%	57.65%	69.76%	58.47%	58.79%	61.17%	55.62%	56.50%	58.68%	53.40%	54.16%	57.43%

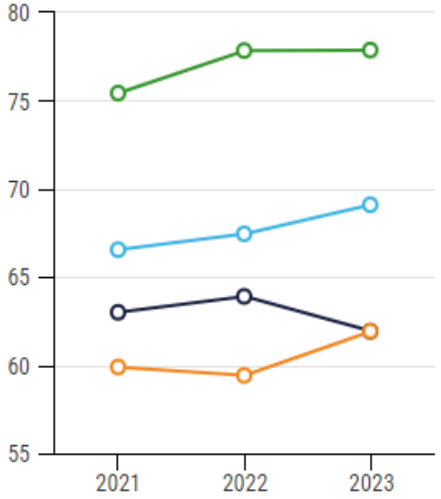
Health & Wellbeing

The Newcastle upon Tyne Hospitals NHS Foundation Trust

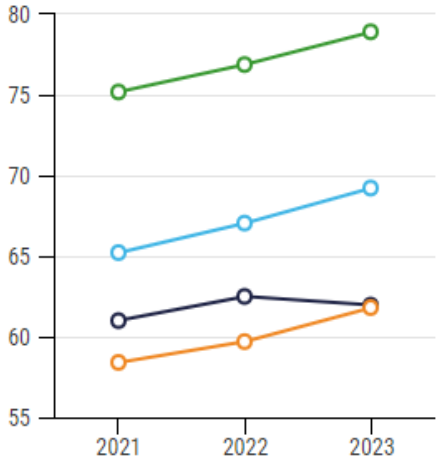
22. I can eat nutritious and affordable food while I am working.



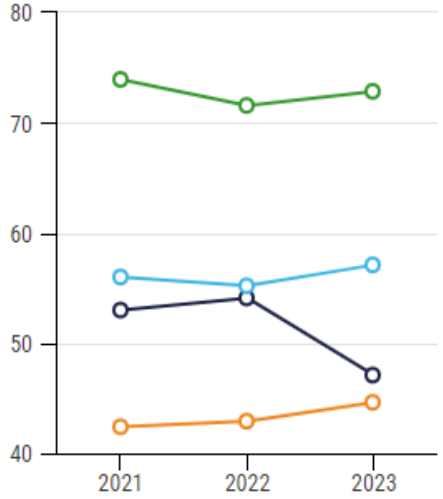
9d. My immediate manager takes a positive interest in my health and well-being.



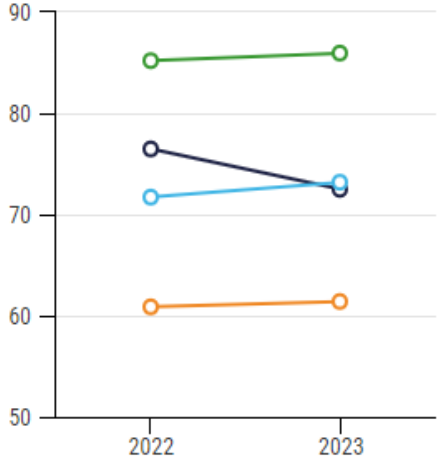
6d. I can approach my immediate manager to talk openly about flexible working.



11a. My organisation takes positive action on health and well-being.



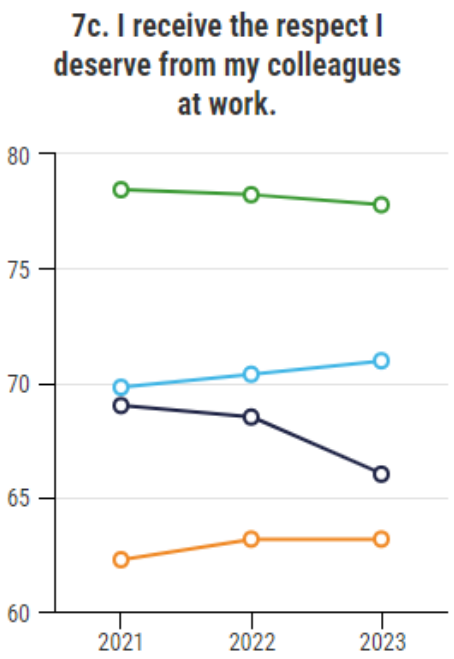
31b. Has your employer made reasonable adjustment(s) to enable you to carry out your work? (Yes)

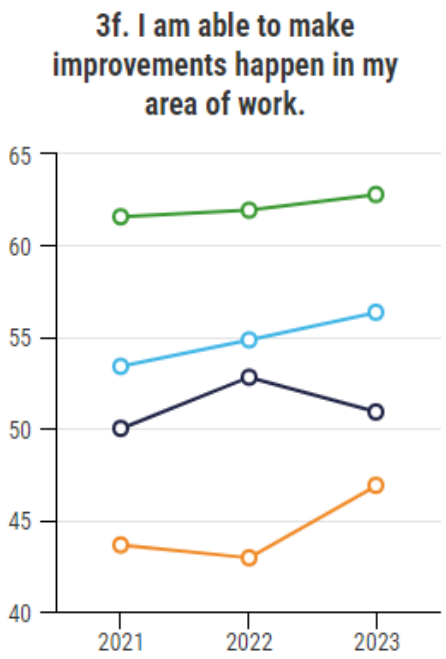


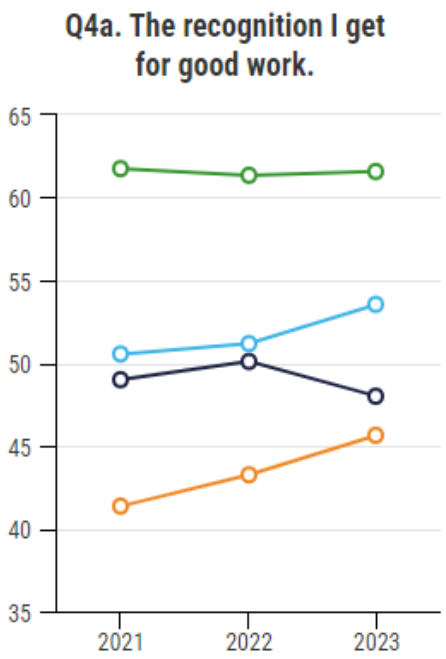
	Q22			Q9d			Q6d			Q11a			Q31b		
	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
Org			**55.04%**	**63.89%**	**64.11%**	**61.93%**	**61.61%**	**62.83%**	**61.96%**	**53.65%**	**54.24%**	**47.24%**		**76.48%**	**72.49%**
Best			63.59%	75.43%	77.84%	77.87%	75.18%	76.88%	78.91%	73.93%	71.57%	72.85%		85.20%	85.95%
Average			53.77%	66.55%	67.45%	69.10%	65.22%	67.05%	69.22%	56.44%	55.65%	56.95%		71.72%	73.19%
Worst			42.58%	59.90%	59.42%	61.93%	58.41%	59.70%	61.81%	42.41%	42.92%	44.63%		60.88%	61.41%

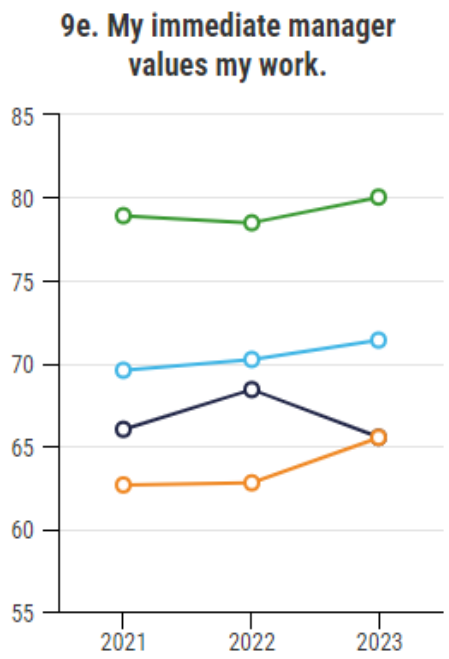
Feeling Valued

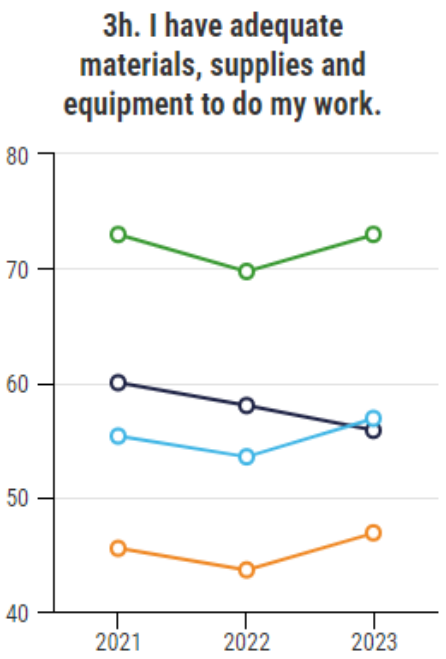
The Newcastle upon Tyne Hospitals NHS Foundation Trust







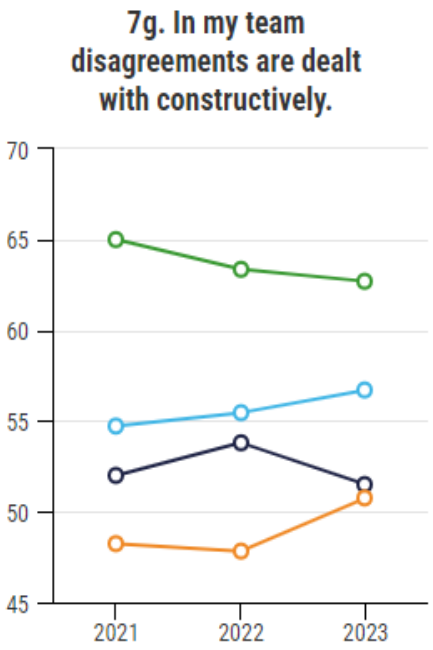


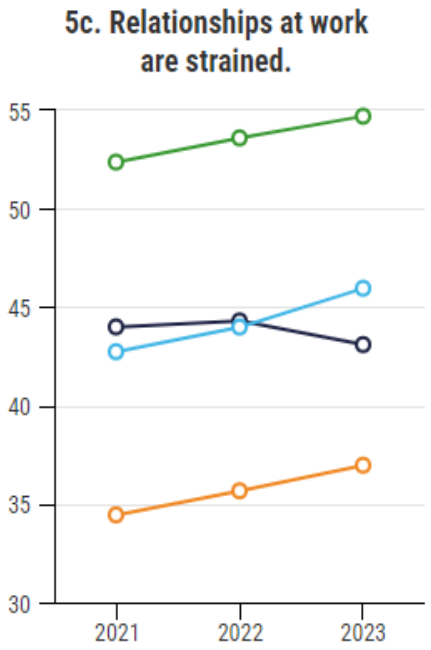


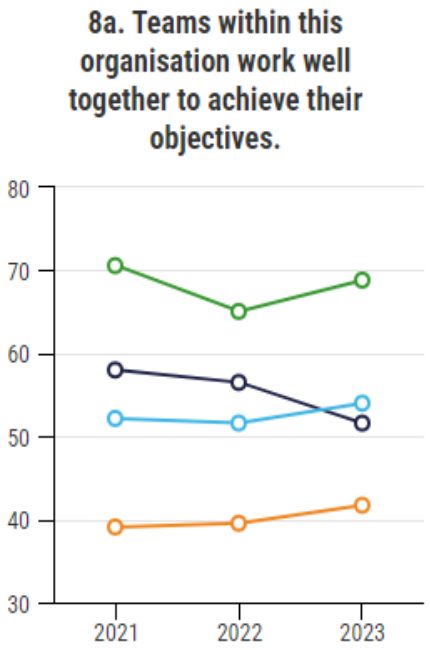
	Q7c			Q3f			Q4a			Q9e			Q3h		
	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
Org	**69.16%**	**69.58%**	**66.06%**	**50.81%**	**53.17%**	**51.09%**	**49.62%**	**50.36%**	**48.08%**	**66.78%**	**68.58%**	**65.51%**	**60.60%**	**58.04%**	**55.83%**
Best	78.44%	78.22%	77.78%	61.57%	61.93%	62.79%	61.75%	61.35%	61.58%	78.91%	78.48%	80.03%	72.96%	69.73%	72.97%
Average	69.80%	70.37%	70.96%	53.39%	54.84%	56.35%	50.55%	51.18%	53.55%	69.57%	70.22%	71.39%	55.33%	53.52%	56.88%
Worst	62.26%	63.16%	63.16%	43.63%	42.93%	46.89%	41.36%	43.25%	45.64%	62.64%	62.77%	65.51%	45.51%	43.63%	46.87%

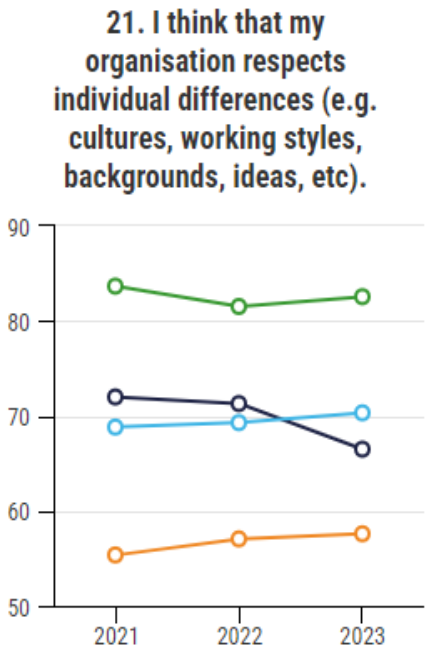
Behavior & Civility

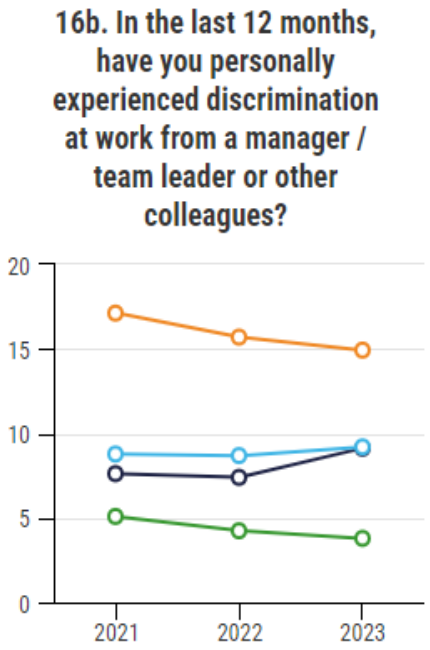
The Newcastle upon Tyne Hospitals NHS Foundation Trust











	Q7g			Q5c			Q8a			Q21			Q16b		
	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	2023
Org	**52.16%**	**54.16%**	**51.63%**	**44.24%**	**44.19%**	**42.89%**	**58.11%**	**56.66%**	**51.73%**	**71.85%**	**71.45%**	**66.37%**	**7.62%**	**7.40%**	**9.13%**
Best	65.00%	63.36%	62.70%	52.37%	53.60%	54.70%	70.58%	65.06%	68.83%	83.66%	81.52%	82.55%	5.09%	4.24%	3.79%
Average	54.72%	55.46%	56.71%	42.74%	43.99%	45.96%	52.17%	51.61%	54.00%	68.83%	69.29%	70.33%	8.78%	8.69%	9.20%
Worst	48.24%	47.83%	50.76%	34.45%	35.67%	36.97%	39.09%	39.54%	41.71%	55.37%	57.06%	57.60%	17.12%	15.70%	14.93%

Next steps

The Newcastle upon Tyne Hospitals NHS Foundation Trust

- **Release of Trust / Clinical Board SS23 results**
  - Further analysis of Trust level information following release of national benchmarking data
  - Sharing with senior leadership teams within Clinical Boards/Corporate Services
  - Red-Amber-Green (RAG) rating and ranking included for each element of SS23
  - Includes directorate breakdowns and bespoke reporting
- **Clinical Boards Data sense check to inform their local staff experience improvement plans**
  - Local Staff Experience plans implemented in 2021 aligned to performance reviews for governance
  - First release of SS23 in new Clinical Board Structure format
- **National Embargo was lifted on 7 March 2024**
  - Access to regional and national data will be available for local benchmarking
- **Upgrading of Staff Survey Power BI Dashboard**
  - Visually more appealing to enable instant visual analysis/trends
  - RAG ratings to understand areas of concern / declining %
  - Developing a more user-friendly model based on feedback
- **People Strategy and Action Plan Launch – Late April 2024 - aligned to outcomes from SS23**

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024					
Title	Trust Performance Report					
Report of	Rob Harrison, Managing Director Vicky McFarlane-Reid, Director of Commercial Development & Innovation					
Prepared by	Elliot Tame, Senior Business Development Manager (Performance)					
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	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.

- Provisional data suggests activity delivery levels (volumes) in February were below both plan and the revised 103% target across all points of delivery except for Day Cases (105.3%). Cumulatively for 2023/24 to date (months 1-11) total activity delivery stands at 102.7% of the re-based 19/20 baseline.
- Newcastle Hospitals delivered performance below the revised 4-hour Accident & Emergency (A&E) arrival to admission/discharge target, with performance standing at 74.9% against the 76% target. This was the fifth successive month that the Trust failed to hit the 76% target.
- The Trust failed all three newly consolidated cancer standards in January 2024, with metrics having been simplified into three clear targets - the 28 Day Faster Diagnosis Standard, 31 days from decision to treat to treatment (combined) and 62 days from referral to treatment (combined). The Trust was escalated into Tier 1 intervention and support measures by NHSE for cancer care in December due to below target performance delivery, having already been escalated into Tier 1 for elective care.
- More positively, the volume of patients waiting over 62 days for treatment fell to 212 at the end of the month, with a high level of confidence that this will further reduce to below the end of year target (200) by the end of March 2024.
- February saw the continued elimination of >104 week waits at Newcastle Hospitals, as well as a significant reduction in the number of patients waiting over 78 weeks for treatment (163 vs 308). The Trust had agreed a revised trajectory with NHSE to bring the number of patients waiting this length of time down to 167 by the end of March 2024, but has now gone further with the ambition to eliminate 78 week waits by the end of March 2024.
- The number of patients waiting over 65 weeks for elective treatment also improved significantly over February, down from 1,362 to 1,096. The H2 planning reset established an end of financial year target of 995, which the organisation is on track to meet and exceed delivery against.
- Organisational performance against the six week diagnostic standard improved in February, with 28.8% of patients now waiting over this length of time – although this remains some way short of the national ambition to improve to under 5% by the end of the financial year.

The Board of Directors is asked to receive the report.

Trust Performance Board Report

Produced: March 2024

Data: February 2024

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with people at our heart

NHSE Plan Requirements 23/24

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Metric	Requirement	Nov-23	Dec-23	Jan-24	Feb-24	RAG Rating: Feb-24* Plan	RAG Rating: Feb-24* Target
Cumulative Activity Delivery (Spec. Acute)							
Day Case	**103%** of 19/20 value-weighted activity (overall, monthly cumulative) **N.B. Currently being reported by volume, not VWA**	102.7%	102.8%	102.4%	**102.7%**	110.3%	103.0%
Elective Overnight		82.8%	83.0%	82.0%	**81.4%**	110.9%	103.0%
Outpatient New		99.1%	99.6%	99.7%	**99.4%**	103.3%	103.0%
Outpatient Procedures		109.4%	110.1%	110.4%	**109.6%**	107.9%	103.0%
Total		102.6%	103.0%	103.1%	**102.7%**	106.6%	103.0%
Urgent & Emergency Care							
A&E Arrival to Admission/Discharge	**>=76%** under 4 hours (by Mar-24)	73.1%	72.5%	74.3%	**74.9%**	79.5%	>=76%
Adult General & Acute Bed Occupancy	**<=92%**	91.3%	86.9%	91.1%	**90.2%**	91.7%	<=92%
Urgent Community Response Standard	**>=70%** under 2 hours	84.2%	84.5%	80.1%	**80.3%**	N/A	>=70%
Cancer Care							
>62 Day Cancer Waiters	Reduce to **<=200** (by Mar-24)	290	314	264	**212**	211	<=200
28 Day Faster Diagnosis	**>=75%** (by Mar-24)	70.0%	70.0%	**72.0%**	TBC	75.0%	75.0%
Elective Care							
>104 Week Waiters	**Zero**	12	5	0	**0**	0	0
>78 Week Waiters	**Zero**	269	322	308	**163**	0	0
>65 Week Waiters	**Zero** (by Mar-24)	1,533	1,558	1,362	**1,096**	258	0 (Mar-24)
>52 Week Waiters	**Reduction** (Zero by e/o Mar-25)	4,672	4,549	4,009	**3,478**	3,150	0 (Mar-25)
>12 Weeks Validation	**90%** (by Oct-23)	44.7%	38.5%	54.2%	**56.6%**	N/A	90% (by Oct-23)
Diagnostics							
Diagnostic Activity**	Appropriate levels to reduce waits	105.1%	113.6%	113.8%	**116.5%**	107.2%	N/A
>6 Weeks Waiters	**<=5%** (by Mar-25)	23.9%	30.1%	32.9%	**28.8%**	N/A	<=5%
Outpatient Transformation							
PIFU Take-up	**>=5%** of all OP atts. (by Mar-24)	3.2%	3.1%	2.4%	**2.5%**	4.5%	5.0% (Mar-24)
Outpatient Follow-up Reduction	**<=75%** of 19/20	106.7%	108.5%	98.8%	**101.2%**	101.7%	<=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	Nov-23	Dec-23	Jan-24	Feb-24	RAG Rating: Feb-24*
Urgent & Emergency Care						
Ambulance Handovers	**Zero** over 60 mins	44	65	36	**26**	
A&E Arrival to Admission/Discharge	**>=76%** under 4 hours (by Mar-24)	73.1%	72.5%	74.3%	**74.9%**	
	<2% over 12 hours	1.6%	3.0%	4.1%	**1.8%**	
Urgent Community Response Standard	**70%** under 2 hours	84.2%	84.5%	80.1%	**80.3%**	
Cancer Care						
28 Day Faster Diagnosis	**75%** (by Mar-24)	70.0%	70.0%	**72.0%**	TBC	
31 Days (DTT to Treatment)	**96%**	84.6%	85.9%	**82.5%**	TBC	
62 Days (Referral to Treatment)	**85%**	55.0%	60.8%	**55.9%**	TBC	
Elective Care						
18 Weeks RTT	**92%**	67.0%	65.5%	67.3%	**67.4%**	
>65 Week Waiters	**Zero** (by Mar-24)	1,533	1,558	1,362	**1,096**	
>6 Weeks Diagnostic Waiters	**<=1%**	23.9%	30.1%	32.9%	**28.8%**	
Cancelled Ops. Rescheduled >28 Days	**Zero**	4	16	9	**3**	
Urgent Ops. Cancelled Twice	**Zero**	0	0	0	**0**	
Other						
Duty of Candour	**Zero**	0	0	0	**0**	
Mixed Sex Acommodation Breach	**Zero**	114	99	114	**89**	
MRSA Cases	**Zero**	0	1	1	**0**	
C-Difficile Cases	**<=165** (FY Cumulative)	100	111	121	**133**	
VTE Risk Assessment	**95%**	96.2%	95.6%	95.5%	**95.9%**	
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour	56.0%	**56.0%**	TBC	TBC	
Sepsis Screening Treat. (All)		81.0%	**81.0%**	TBC	TBC	

*** 1 month prior for Cancer Care**

Other Metrics (1/2)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Metric		Nov-23	Dec-23	Jan-24	Feb-24
Emergency Care					
Ambulance Arrivals		3,056	3,127	3,066	**2,858**
Ambulance Handovers <15 mins		62.6%	61.5%	57.2%	**58.6%**
Ambulance Handovers <30 mins		89.3%	88.4%	88.5%	**89.3%**
Ambulance Handovers <60 mins		98.6%	97.9%	98.8%	**99.1%**
Type 1 Performance (A&E 4 hour)		57.4%	55.8%	57.9%	**59.9%**
Type 1 Attendances (Main ED)		12,733	12,362	11,981	**12,216**
Type 2 Attendances (Eye Casualty)		1,497	1,289	1,564	**1,563**
Type 3 Attendances (UTC)		5,206	5,413	5,148	**5,128**
Patient Flow					
Covid Inpatients (average)		23	21	37	**29**
Emergency Admissions		6,464	6,186	6,542	**6,065**
G&A Bed Occupancy		91.3%	86.9%	91.1%	**90.2%**
Critical Care Bed Occupancy		66.6%	64.7%	65.5%	**68.0%**
Bed Days Lost (average)		23	25	52	**48**
Medical Boarders		79	73	96	**67**
Length Of Stay >7 Days		762	742	916	**771**
Length Of Stay >21 Days		338	371	409	**376**

Other Metrics (2/2)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Metric		Nov-23	Dec-23	Jan-24	Feb-24
Planned Care					
2WW Referrals		2,539	1,992	2,819	**2,730**
Urgent Referrals		5,796	5,020	6,038	**5,750**
Routine Referrals		27,741	21,221	27,924	**25,146**
Specialist Advice Requests (% of New OP Atts.)		8.1%	8.7%	9.5%	**10.3%**
Day Case Activity (Specific Acute (SA))		11,258	9,367	11,161	**11,156**
Overnight Elective Activity (SA)		1,865	1,513	1,556	**1,741**
New Outpatient Attendances (SA)		23,880	18,489	23,555	**21,459**
Outpatient Procedure Activity (SA)		18,915	15,598	19,662	**17,165**
Review Outpatient Attendances (SA)		64,859	53,287	60,664	**59,612**
Diagnostic Tests		20,276	17,325	21,338	**20,851**
Outpatient DNA Rate		7.1%	7.7%	7.3%	**6.8%**
Virtual Attendances		13.4%	13.7%	13.9%	**12.7%**
RTT Waiting List Size		107,234	104,965	100,624	**99,066**

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024		
Title	Update on interim planning submission		
Report of	Vicky McFarlane-Reid, Director of Commercial Development & Innovation		
Prepared by	Charis Pollard, Assistant Director of Business, Planning & Strategy		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☐	☒
Summary	The annual planning round consists of three pillars – activity, workforce, and finance – which should triangulate together. This report outlines the contents of our interim submission as it relates to activity and workforce and is accompanied by the full interim submission documents. The NHS usually receives operational planning guidance including national targets, technical guidance etc. in December for an initial submission in late February. No operational planning guidance has been received to date, however planning activities have been going on without this guidance to ensure we are prepared albeit without clear national targets. For this, we have been working to our internal Newcastle Hospitals ambitions. A draft submission was submitted **Friday 15 March 2024** to the Integrated Care Board (ICB) for collation into the submission to the national team on the 21 March 2024. Final submission is expected to be on the **26April 2024** to the regional team to meet the national deadline of 2 May 2024.		
Recommendation	The Trust Board are asked to receive the report.		
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	Sustainability
	☒	☐	☐	☐	☐	☐

Link to Board Assurance Framework [BAF]	Strategic Risk SO5.8 [Activity delivery] The report relates to the levels of activity achieved by the Trust and therefore contributes to the quality of service received by patients. The impact of reduced activity, particularly where this results in increased waiting lists, has a reputational impact on the Trust.
Reports previously considered by	N/A

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Annual Planning Cycle – Interim submission

15th March 2024

Healthcare at its best
with people at our heart

Introduction – key activities and timelines

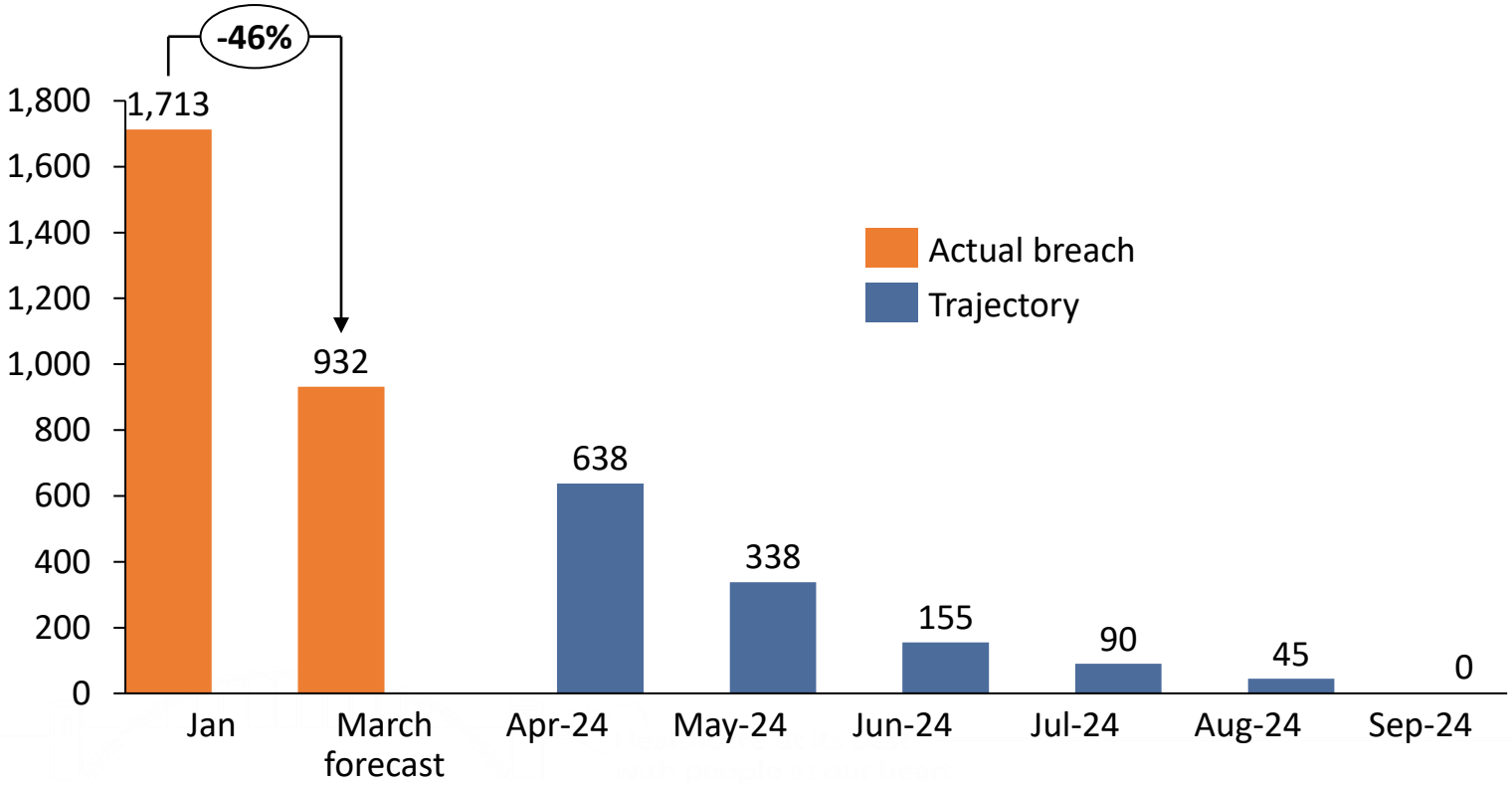
- Planning composed of three pillars – activity, workforce and finance – which should triangulate together.
- The NHS usually receives operational planning guidance including national targets, technical guidance etc. in December for an initial submission in late February.
- No operational planning guidance has been received to date
- Planning activities have been going on without this guidance to ensure we are prepared albeit without clear national targets.
- A draft submission was submitted **Friday 15th March** to the ICB for collation into the submission to the national team on the 21st March.
- Final submission is expected to be on the **26th April** to the regional team to meet the national deadline of 2nd May.

Submission headlines

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Waiting list metrics

- The submissions shows the elimination of 65 week-waits (ww) by the end of September 2024 – all except Spinal and Trauma & Orthopaedics (T&O) to be eliminated by June 2024



Taking the learning from 78 weeks Path to Zero:

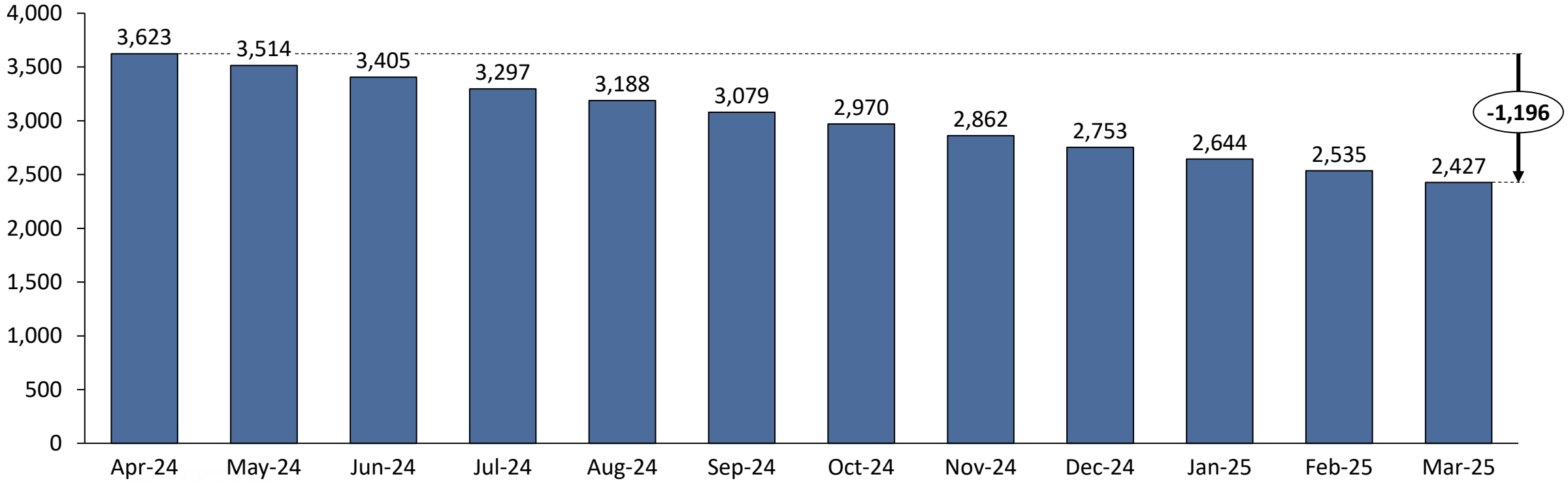
- Better monitoring of specialty owned trajectories
- Improved reporting
- Better use of targeted Waiting List Initiatives (WLIs)/Independent Sector (I.S)
- More rigorous validation and application of the access policy
- Improved pooling of patients
- More scrutiny in booking patients in order

Submission headlines

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Waiting list metrics

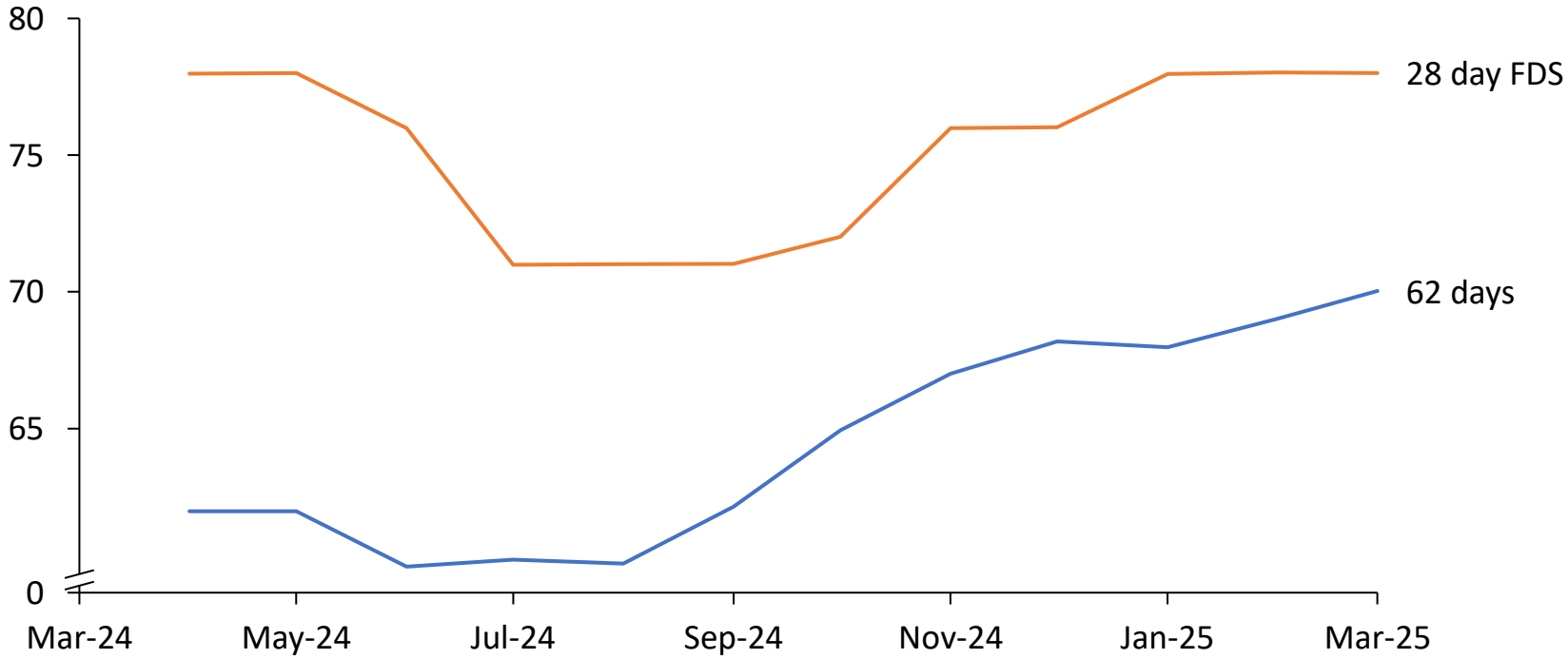
- The submissions also forecasts a reduction in the number of patients waiting 52 weeks.



Submission headlines

Cancer metrics

- 28-day performance of **75.1%** across the year, but with a dip in the summer
- 62-day performance of **70.2%** across the year, but also with a dip in the summer



Submission headlines

Accident and Emergency (A&E) metrics

- Type 1 performance has been modelled to deliver **72.8%** versus the standard across the year, with a staggered climb from current delivery levels to 75% in month 4, on the assumption of full implementation of the business case. Total expected attendances also have a 2% increase on 2023/24 levels projected. Breaches have been calculated as per the pre-determined performance trajectory.
- Type 2&3 attendances/breaches are modelled with on no increase in attendances for 2024/25 and a performance trajectory of **99.2%** each month.
- Combined, this results in overall Emergency Department (ED) performance of **83.0%** across the year with 84-85% performance across all months from July onwards.

Diagnostics

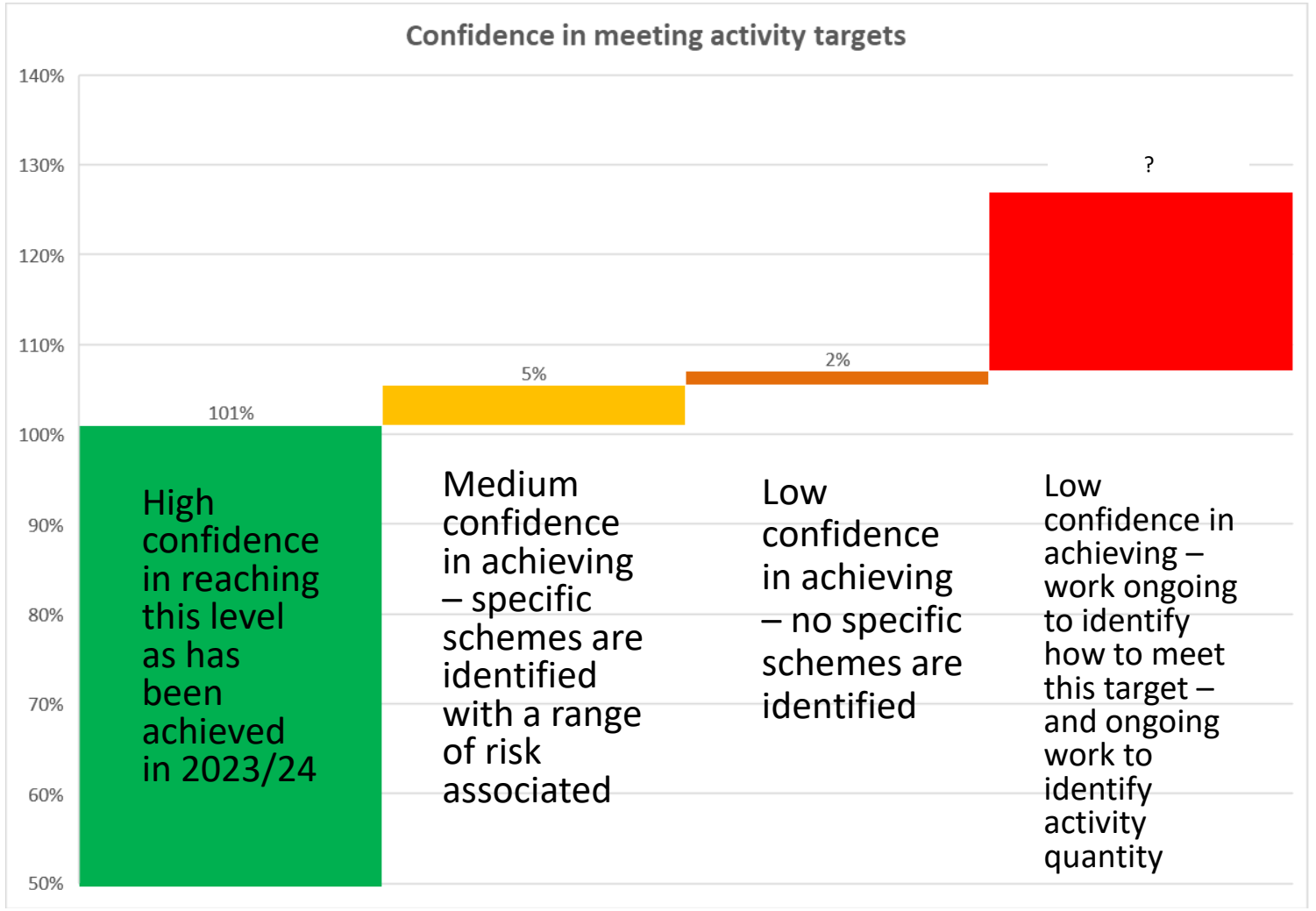
- Aim for audiology to get to 65% compliance by March 2025 from current level of 37% in January assuming continuation of insourcing and additional activity
- Endoscopy to reach 91% by March 2025

Activity Targets – Trust and national

1. No national targets have been shared with us, although we know that the baseline for the Elective Recovery Fund (ERF) will continue to be 2019/20.
2. We have shared a target of 107% of 2019/20 activity with clinical boards to support planning processes. This was chosen as it triangulates with the baseline needed to meet our finance ERF baseline.
3. This may be slightly different to national/regional targets but is sufficiently challenging to be a good point for the current stage of the process.
4. There are also ongoing processes, through the Elective Recovery Group and the overall Finance Recovery Plan to go further. These are not yet incorporated into the Plan. The ambition is to fully align these pieces of work for the full submission.

Activity

- Currently submission shows activity to reach 107% (by value) of ERF activity against the 2019/20 baseline to triangulate with the finance submission.
- This includes an uplift on 2023/24 activity of 5.5% of specific schemes or proposals identified by clinical boards. Examples of schemes are identified later in the slides.
- The remaining 1.5% has been added as a 'corporate adjustment' to the plan at this stage. Specific proposals to fill this gap are yet to be identified but will be worked on before the final submission.
- No assumptions have been included at this stage regarding theatre productivity or outpatient transformation.
- Other Points of Delivery (PODs) (Non-elective, follow up outpatients, emergency) are largely planned to be similar to 2023/24 levels except where specific changes are known.



Activity Plans

The Newcastle upon Tyne Hospitals NHS Foundation Trust

- The interim submission activity figures are broken down by clinical board as shown in the table below
- There will be adjustments before the final submission to ensure fair allocation of targets by Board and resolve any anomalies (such as the Cancer Board figures – however this is an area with complex interactions between activity and income)
- Please note the % comparison shown below is to 2023/24 as is expected to be the activity baseline for national planning and also includes all activity, not just ERF activity. This has been developed with the finance teams to ensure this will match the 107% of 2019/20 ERF target.

		Final figure for submission, including the corporate adjustment	This comparison is between 2023/24 and Plan submission
Clinical Board	**2023/24 Activity**	**Planned 2024/25 Activity**	**% increase activity**
Cancer & Haematology	224,342	195,177	87%
Cardiothoracic Services	108,345	111,749	103%
Clinical & Research Services	43,960	44,444	101%
Family Health	213,818	221,041	103%
Medicine & Emergency Care	317,154	323,257	102%
Peri-Operative & Critical Care	37,747	38,293	101%
Surgical & Associated Services	213,758	221,540	104%
Surgical & Specialised Services	403,253	414,721	103%
Total	1,562,378	1,570,223	101%

Examples of proposals to close the gap

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Board	Scheme	Impact	Risk level
Cancer & Haematology Services	Oncology Growth (NHS England commissioned)	667 new outpatient appointments Positive impact on non-ERF activity Maintain cancer performance targets	Medium – if approved would enable continued performance at current levels
Cross-board	Theatre optimisation	Still being calculated – potential to set against the corporate adjustment	High risk – not yet identified scale of impact or mechanisms to achieve
Surgical & Associated Services	Ear, Nose & Throat (ENT) & Audiology transformation	8,000 additional outpatient appointments and procedures from insourcing and process/coding improvements	Medium risk – insourcing is low risk but the process/coding improvements are yet to be quantified
Surgical & Associated Services	Endoscopy WLI	2,800 additional procedures	Low risk – continuation of existing practice
Surgical & Associated Services	Urology outsourcing	Botox injections – Tyneside Surgical Services (TSS)	Low risk – continuation of existing practice
Cardiothoracic Services	Outpatient schemes	Up to 620 new outpatient appointments in different specialties	Medium risk as still needs fully working up to identify timelines for delivery

There are currently 35 different schemes are that are being fully costed and risk assessed ahead of the final submission

Next steps

- Evaluation of planning guidance, once released, and how this impacts on our current plans
- Refining activity work including
  - WLI activity
  - IS activity
  - Confirming targets for individual boards and understanding where most recent data shows variance to the baselines in plan
  - Further schemes and actions to close the remaining gap to 107% (income)
  - Aligning with Cost Improvement Programme (CIP)/Finance Recovery Plans
- Refining diagnostic activity and performance metrics
- Ensuring full triangulation between activity, workforce and finance

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024					
Title	Joint Medical Directors Report					
Report of	Lucia Pareja-Cebrian / Michael Wright					
Prepared by	Lucia Pareja-Cebrian / Michael Wright, Joint Medical Directors					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	The Report highlights issues the Joint Medical Directors wish 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	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.					

JOINT MEDICAL DIRECTORS REPORT

EXECUTIVE SUMMARY

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

i) Joint Medical Director Responsibilities
ii) Quality & Patient Safety Update
iii) Cancer Update
iv) Industrial Action

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

JOINT MEDICAL DIRECTORS REPORT

1. JOINT MEDICAL DIRECTOR RESPONSIBILITIES

Mr Andy Welch stood down as Medical Director in January 2024 and following a competitive selection process Dr Lucia Pareja-Cebrian (LPC) and Dr Michael Wright (MW) were appointed as Joint Medical Directors with effect from 1 March 2024. They would like to thank Mr Welch for his leadership and commitment to the care of patients and wellbeing of staff in Newcastle Hospitals, throughout his tenure as Medical Director.

A review of the existing Medical Director and Associate Medical Director (AMD) portfolios has been undertaken. LPC and MW will hold joint overall Medical Director responsibility and will each lead on specific areas of the portfolio:

1.1 Shared responsibility

- Quality and Safety - LPC overall lead
- Engagement with staff and changing organisational culture
- Response to Care Quality Commission (CQC) reports
- Clinical Strategy Development and Implementation
- Improving performance against local and national standards

1.1.1 Dr Lucia Pareja-Cebrian

- Quality and Safety, Patient Safety Incident Response Framework (PSIRF), Get It Right First Time (GIRFT), Newcastle Improvement
- Accountable Emergency Officer
- Developing governance structures including Clinical Board Structures and organisational development
- Digital
- Estates Strategy

1.1.2 Dr Michael Wright

- Professional Standards - Responsible Officer (RO) and workforce development
- Information Governance – Caldicott Guardian
- CQC/Integrated Care Board (ICB)/Specialised Commissioning (Spec Comm)/ NHS England (NHSE)/Great North Care Alliance/Newcastle University
- Cardiothoracic Oversight
- Engagement with neighbouring organisations and primary care
- Capital Management and Financial Recovery, AMD and Clinical Board Chair roles and responsibilities are currently being reviewed and an update will be provided at the next Board meeting.

2. QUALITY AND PATIENT SAFETY

2.1 Board Quality and Safety (Q+S) Structure

All Clinical Boards have made good progress in establishing their Quality Oversight Groups (QOG) including appointment to the Medical lead roles.

The QOGs will oversee all governance activity within the Clinical Board that fall within the four major domains as presented previously to Trust Board.

i) Patient Safety
ii) Clinical Effectiveness
iii) Patient Experience
iv) Quality Improvement

In recent weeks, Board colleagues have been tasked with structuring their areas at directorate and departmental level to consistently address these domains. This very large piece of work will in some areas require relatively little tweaking and alteration of existing groups and meetings whilst in others, a greater degree of work establishing new structures will be needed.

Meetings have taken place with representatives from The Value Circle in relation to establishing a consistent meeting cycle from department to directorate to QOG to Board in all areas with agreed reporting and activity.

The oversight of QOG activity needs to be agreed – e.g. within Clinical Governance and Risk Department (CGARD), Quality Committee, Performance Review.

At a joint senior team CGARD meeting on 16 February 2024 attended by Rob Harrison, Managing Director, it was agreed that a piece of work, mapping existing resource within CGARD and Newcastle Improvement to ongoing and new work activity was required. It is becoming clear that dedicated resource within the Clinical Boards (as exists fortuitously within cardiothoracic, peri-ops and some areas of Family) is necessary to:

- Manage the processes around patient safety incidents and response
- Co-ordinate and assist investigation
- Data management, analyses and display pertinent to safety
- Oversee and ensure consistency of mortality review
- Work with harm free care initiatives
- Carry out bespoke safety design projects
- Deliver safety education at ‘middle management’ levels

2.2 Patient Safety Incident Response Framework (PSIRF)/ Serious Incident (SI) Backlog

Now 7 weeks into the process PSIRF is functioning well. The weekly rapid review meeting is well attended with good discussion and airing of issues.

Some feedback is that such a large group may be intimidating for a colleague to discuss a difficult adverse event. Hopefully though the atmosphere is supportive and enquiring.

We have a high rate of declaration of patient safety incident investigation (PSII) compared to many trusts but newer tools for investigation are being used well e.g. after action review.

Weekly PSIRF workshops are being held to allow drop in problem solving and discussion. We need to be aware of the accumulation of incidents, now the responsibility of the Clinical Boards, and that they are being dealt with in a timely manner.

The backlog of unfinished SI reports from the previous system remains a concern with 65 outstanding and 42 overdue. Plans are in place to address these. Completion of this task is important from a patient safety point of view and in the context of CQC review in April.

2.3 Martha's Rule

The Trust received notice from NHSE on 21 February 2024 regarding national plans for implementing Martha's Rule – a mechanism whereby patients and families can bypass usual channels of communication if they feel concerns are not being listened to and seek an urgent review on a 24/7 basis. There are three main components to the direction:

> The 3 proposed components of Martha's Rule are:
>
> 1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, which they can contact should they have concerns about a patient.
> 2. All patients, their families, carers and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital and more widely if they are worried about the patient's condition. This is Martha's Rule.
> 3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

A meeting of the implementation group took place on 19 March 2024 involving adult and paediatric colleagues and task and finish sub-groups established.

It is understood central funding is likely to be available to Trusts expressing End of Life (EoL) to become a pilot site (100 trusts expected). The nature and sums involved are not known and we have not yet heard how and when applications will be requested.

2.4 Incident Reporting

We have much better data and insight into how this varies through the organisation through the Power BI app. Acknowledging the need to address this quickly we must balance that with the knowledge that culture change will take some time. "Middle management" colleagues – Clinical Directors (CDs), Heads of Departments (HoDs), consultants, ward sisters and managerial colleagues are key in terms of education and delivery.

3. CANCER UPDATE

3.1 Cancer Performance

	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
2 week - wait (ww) (93%)	76.1	75.8	77.2	49.8	65.6	66.3	48.8	75.4	74.2	76.8	85.3
28 day Faster Diagnosis Standard (FDS) (75%)		81.9	83.1	80	74.7	68.8	69.8	68.5	68.7	70..1	81.5
62 day (85%)	61.1	53.9	47.2	55.2	56.5	53.7	52.6	53.1	55.7	56.7	55.6

Cancer performance remains a very significant challenge against targets as shown above. The current 62 day+ backlog is reducing. It reached 183 on 3 March 2024 but has increased to 201 as of 10 March 2024. This compares to 450 patients in September 2023 and 307 in December 2023.

The backlog is the principle focus of the cancer teams and all teams are working to provide treatment dates to the patients. The main specialities contributing, numerically, to the backlog are skin (35), urology (57) and upper GI including hepatobiliary (40). Backlogs in lung, lower gastrointestinal (lower GI), Gynaecological and Head and Neck (H&N) are 21, 30, 6 and 5 patients respectively as of 10 March 2024. In terms of numbers the improvement in skin backlog has very significantly contributed to overall improvement in last 2 months. The very significant focus on lung cancer by the lung team has likewise impacted the position.

National 'time to surgery' data has shown a reduction of 14 days in time from surgical referral to surgery for lung cancer over the last 3 months. Clearly the teams want to improve further but the impact made to date is nonetheless considerable. This has largely been driven by very active waiting list management and additional theatre sessions.

3.1.1 Harm Reviews

Harm reviews, for patients on cancer pathways who are not treated within 104 days, continue to be undertaken. This process is not yet fully embedded in departmental governance structures and this is the next phase of the work.

- Harm Reviews Undertaken June 2023 – February 2024 377
- Harm Reviews Outstanding 88
- Completed Reviews Identifying Serious Avoidable Harm 7 (6 lung and 1 H&N)

Main learning points from the cases where harm occurred were that decisions were made correctly based on original imaging but if treatment delays occur it is important to rescan to ensure the original treatment plan remains appropriate. This is particularly the case for the lung pathway and checks are being embedded around this. It is clear that the real way to solve this issue is to minimise delay to treatment. Whilst that is clearly the primary aim, it is useful to consider the complexity of some patient's pathways and rapid treatment may not be possible or appropriate. In these cases, it remains important to consider repeat imaging. Difficulties in embedding the harm review process are reported in all regional Trusts and is the focus of current Northern Cancer Alliance work. A reduction in backlog will help but Multidisciplinary Teams (MDTs) need to develop a process of case review and recording and this will require some clinician time.

3.1.2 Cancer Governance Framework

Whilst each MDT and clinician treating cancer sit within their Clinical Boards, the Corporate Cancer Team are developing a wrap-around governance framework with a rolling programme of audit and assurance in the form of:

- Audits of MDT outcome versus treatment delivered
- Audit against National MDT Transformation Standards
- Annual updates of MDT operation policies
- Annual report for each MDT including Quality Improvement
- Annual work plan for each MDT including Quality Improvement

These measures can be used alongside the National Cancer Patient Experience Survey and learning from Harm Reviews, to drive continual improvement.

3.1.3 Cancer Strategy

Clearly the key operational objectives are to overcome the backlog of patients waiting over 62 days for treatment and to become compliant with the 14 day, 28 day and 62 day treatment targets.

Work continues towards delivery of a Trust Cancer Strategy. The main themes identified to date are: personalising care for our patients; working better together across the system; recognising and addressing health inequalities; innovation and sustainability of services. The key enablers of change are judged to be: workforce fit for the future along with data and digital transformation.

An early draft has been produced and currently the group have gone out to consultation to MDTs to ensure each team's priorities for the next 5 years have been considered.

4. RESEARCH

4.1 Activity

In the last quarter clinical research was reporting a significant drop in activity Year To Date (YTD) compared with the previous year. The Research Informatics team have reviewed all studies and identified some activity that had not been recorded and the Directorate is now reporting as at 29 February 2024 a much improved position although the number of participants in commercial trials remains lower than 2022/23.

Recruitment Target Gauge comparing recruitment data from 2022/23 to 2023/24

Figure 1 All recruitment

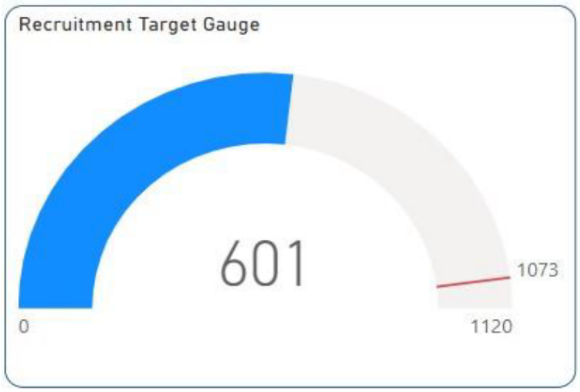


Figure 2 Commercial Recruitment

Figure 3 Recruitment over 2 years

This level of activity means that Newcastle Hospitals remains in the top 4 trusts in the country for the number of studies that have recruited one or more participants this year (2023/24).

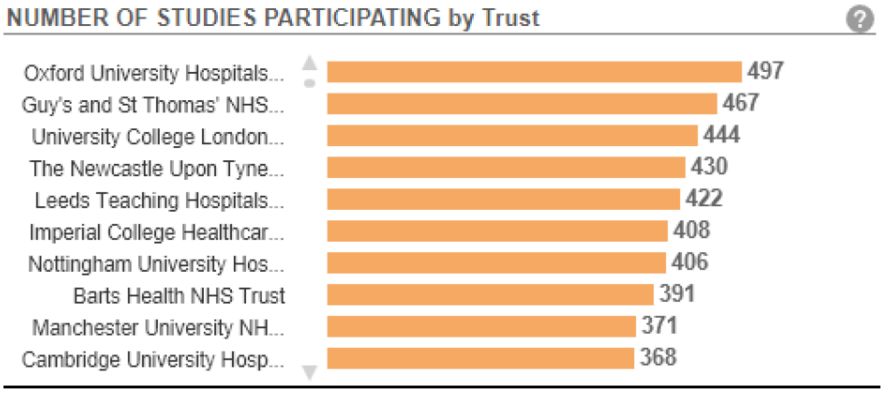


Figure 5 Number of all studies participating by trust 2023/24

Information supplied by Lesley McShane, Research Information Manager

4.2 Commercial Research

The Directorate continues to be focussed on growing commercial activity and income in line with national priorities.

Whilst the number of participants in commercial research this year is lower than 2022/23, the Trust remains in the top 4 performing trusts in the country for the number of commercial studies opened with one or more participant recruited in 2023/24 and 36% of all studies approved this year (255 studies YTD) are commercially funded.

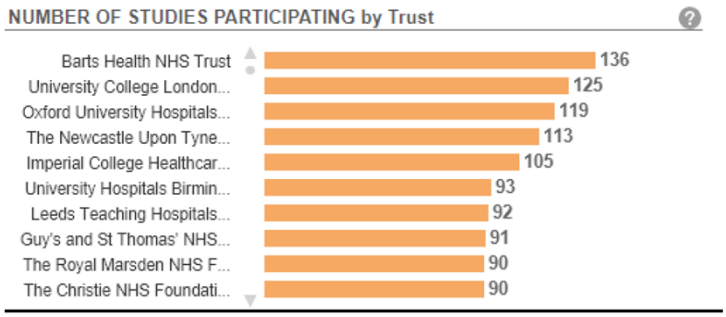
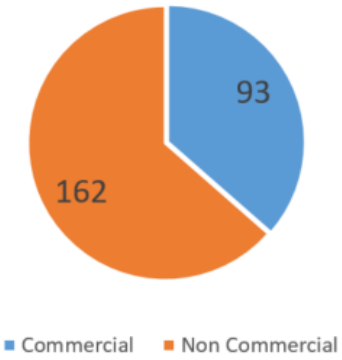


Figure 6 Number of all commercial studies participating by trust 2023/24



4.3 Some notable highlights in the last quarter

- A number of journal publications including:
  - KIWE Study, The Lancet (epilepsy in children)
  - Pancreatic cancer recurrence study, Annals of Surgery

- Newcastle Hospitals was in the top 5 recruiting sites in Europe for the PIONEER IV study, which is testing a stent that delivers a drug to reduce the chances of narrowing/blockage of vessels that cause a heart attack.
- Working closely with the digital team the use of remote access to external monitors was rolled out in January 2024, a sustainability initiative, which reduces travel time and costs and also provides a robust audit trail of information reviewed.
- The John Walton Muscular Dystrophy Centre was awarded centre of excellence status by Muscular Dystrophy UK.
- A new 'working with us' brochure was published for use with industry and commercial partners.
- Consultant Orthopaedic Surgeon, Kenny Rankin was awarded researcher of the year at the Bone Idols Awards 2024.
- The Ophthalmology team recruited the first patient in the UK to the TED study. The purpose of this study is to assess the use of specific drugs in participants with thyroid eye disease (TED).
- The 1,049th baby (Freddie) was enrolled as the final participant into the SiNT1A study at the Clinical Research Facility in February. The aim of the study is to prevent the development of type 1 diabetes in infants with an increased risk of developing type 1 diabetes.
- The first patients were recruited into the AuToDeCRA-2 study, an innovative cellular therapy developed in Newcastle, designed to 'switch off' rheumatoid arthritis.

The Directorate also celebrated the career of Matron Aileen Burn who is retiring at the end of March 2024.

5. INDUSTRIAL ACTION

There was a further period of industrial action by junior medical staff from 24 to 28 February inclusive. There was an excellent response from many staff once again to ensure that patients remained safe and received good care. Elective activity was reduced significantly to ensure that senior medical staff could be released to provide cover in other areas.

6. APPENDED DOCUMENTS

Appended to this report are the following documents to note:

i) Consultant Appointments
ii) Guardian of Safe Working Quarter 3 report

7. RECOMMENDATION

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

L Pareja-Cebrian/ M Wright
Joint Medical Directors
19 March 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024					
Title	Consultant Appointments					
Report of	Michael Wright, Medical Director and Lucia Pareja-Cebrian, Medical Director					
Prepared by	Claudia Sweeney, Senior HR Advisor					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	The content of this report outlines recent Consultant Appointments.					
Recommendation	The Board of Directors is asked to review the decisions of the Appointments Committee.					
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. People – 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	Sustainability
	☐	☐	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	Ensuring the Trust is sufficiently staffed to meet the demands of the organisation.					
Reports previously considered by	Consultant Appointments are submitted for information in the month following the Appointments Panel.					

CONSULTANT APPOINTMENTS

1. APPOINTMENTS COMMITTEE – CONSULTANT APPOINTMENTS

1.1 Appointments Committees were held between 19 January 2024 to 18 March 2024 and by unanimous resolution, the Committees were in favour of appointing the following:

Name	Job title	Start Date
Dr Sharadaprasad Suryaprakash	Consultant Cardiothoracic Anaesthetist / Intensivist	08-Mar-24
Mr Konstantinos Oikonomou	Consultant Neurosurgeon	01-Apr-24
Dr Rachael Crombie	Consultant Gynaecologist - Interest in TOP, Menopause & Acute Gynae	06-Apr-24
Mr Anders Andreasson	Consultant Thoracic Surgeon	15-Apr-24
Mr Ahmed Hussien	Consultant Ophthalmologist	01-May-24
Dr Yiannis Skarparis	Consultant Interventional Radiologist	03-Jun-24
Dr Noreen Zainal Abidin	Consultant in Respiratory Paediatrics	12-Aug-24
Dr Navjeet Chohan	Consultant Gynaecologist - Subspecialist in Urogynaecology	06-Aug-24
Dr Roberta Bugeja	Consultant Gynaecologist - Subspecialist in Urogynaecology	06-Aug-24
Dr Paul Kemp	Consultant in Intensive Care Medicine & Anaesthesia	21-Aug-24
Dr Caroline Harris	Consultant in Respiratory Paediatrics	23-Sep-24
Dr Christopher Carey	Malignant Consultant Haematologist	ASAP
Dr Wan N. Wan Montil	Consultant in Paediatric Intensive Care & Critical Care Transport	ASAP

2. RECOMMENDATION

1.1– For the Board to receive the above report.

Report of Michael Wright and Lucia Pareja-Cebrian
Medical Directors
18 March 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024					
Title	Guardian of Safe Working Quarterly Report (Q3 2023-24)					
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	The terms and conditions of service of the new junior doctor contract (2016) require the Guardian of Safe Working Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant. The content of this report outlines the number and main causes of exception reports for the period 27 September to 26 December 2023 for consideration by the Trust People Committee, prior to submission to the Trust Board.					
Recommendation	The Trust Board is asked to note the contents of this report.					
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link. In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.					
Reports previously considered by	Quarterly report of the Guardian of Safe Working Hours. This report was presented to the People Committee on 20 February 2024.					

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

This quarterly report covers the period 27 September 2023 to 26 December 2023.

There are now 950 postgraduate doctors in training on the New Junior Doctor Contract and a total of 1,040 postgraduate doctors in the Trust.

There were 136 exception reports in this period. This compares to 124 exception reports in the previous quarter.

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

The main cause of exception reports is when the staffing levels available are insufficient for the workload.

2. INTRODUCTION / BACKGROUND

The 2016 New Junior Doctor Contract came into effect on 3 August 2016 and was reviewed in August 2019, with changes implemented in a staggered approach from August 2019 to October 2020. From August 2023 Locally Employed Doctors are also employed on a contract which mirrors the 2016 contract.

The TCS of the 2016 contract allows for exception reporting to raise reports on breaches of working hours and educational opportunities The Guardian of Safe Working Hours must provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant.

3. HIGH LEVEL DATA

		(Previous quarter data for comparison)
Number of Junior Doctors on New Contract	950	(957)
Total Number of Junior Doctors	1,040	(1,062)
Number of Exception reports	136	(124)
Number of Exception reports for Hours Breaches	131	(117)
Number of Exception reports for Educational Breaches	7	(7)
Fines	14	(18)
Admin Support for Role	Good	
Job Planned time for supervisors	Variable	

4. EXCEPTION REPORTS

4.1 Exception Report by Speciality (Top 5)

		(Previous quarter for comparison)
General Medicine	51	(52)
General Surgery	48	(34)
Otolaryngology	12	(1)
Paediatric Surgery	6	(16)
Haematology/oncology	7	(7)

4.2 Exception Report by Rota/Grade

General Surgery

FH (F1) including HPB, colorectal, vascular	45
RVI (F1)	3

General medicine

RVI (F1)	19
RVI (F2/CT2/IMT)	11
FH (F1) Older person's medicine	10
CT/IMT/LED Older person's medicine	11

Otolaryngology

F1	11
StR	1

Haematology/Oncology

F2	7

Paediatric Surgery

ST3+	6

4.3 Example Themes from Exception Reports

General Surgery FH

"Very busy day on vascular with lots of outlying patients. Minimum staffing for F1s. Several patients were very unwell needing reviewing and some patients who were made End of Life needed family discussions and fast track discharge paperwork. All this resulted in no breaks for the duration of the shift and having to stay 50minutes after handover to document these discussions and reviews. Shift was 7.45am to 9.20pm (usual time 7.45am-8.30pm)."

The high workload and staffing issues within general surgery F1 at Freeman are well known to the Executive Team.

General Medicine RVI/FH

‘‘The ward was on minimum staffing with 30 inpatients on the ward plus medical outliers. I stayed over an hour late to complete day tasks not suitable to handover. It was not suitable to leave these jobs until the following day.”

Exception reports submitted when there was excessive workload for the workforce available – either due to clinical complexity of patients or reduced staffing levels.

Otolaryngology

“Exceptionally busy with routine ward tasks; both FY1s stayed behind to finish tasks.”

Haematology/Oncology

“Busy ward; currently 20 oncology patients; multiple discharges; list had not been updated since I was last on ward; no plebs came round (datix put in); too busy to take lunch break; cardiac arrest on W31 late afternoon; stayed late to refer patients to TWOC clinic; finish documenting; put in DoLS; update list; and put out bloods.”

Exception reports appear to be submitted due to high clinical demands. No mention of staffing issues.

Paediatric Surgery

Unable to achieve minimum overnight continuous rest of five hours between 22:00 and 07:00 during a non-resident on-call (NROC).

5. EXCEPTION REPORT OUTCOMES

5.1 Work Schedule Reviews

No work schedule reviews were completed on the back of exception reports.

5.2 Fines

14 fines have been issued:

- Paediatric Surgery (6 fines): Rule breached “Unable to achieve minimum overnight continuous rest of five hours between 22:00 and 07:00 during a non-resident on-call (NROC)” or “Unable to achieve the minimum 8 hours total rest per 24-hour NROC shift.” Total fine money £2,626.72 (1 fine still to be calculated).
- General Surgery F1 Freeman (4 fines): Rule breached “Late finish; Unable to achieve breaks; Exceeded the maximum 13-hour shift length.” Total fine money £236.17.

- Haematology/Oncology (1 fine): Rule breached "Late finish; Exceeded the maximum 13-hour shift length." Total fine money £100.78.
- Paediatrics (1 fine): Rule breached "Late finish; Exceeded the maximum 13-hour shift length; Unable to achieve the minimum 11 hours rest between resident shifts." Total fine money £226.71.
- General Medicine RVI (2 fines): "Late finish; Exceeded the maximum 13-hour shift length." Total fine money £6.96 (1 fine still to be calculated).

6. ISSUES ARISING

6.1 Workforce and workload

The recurring theme as to when exception reports are raised is when there is a reduction of doctor numbers on the ward or high workloads.

6.2 Supervisor Engagement

Supervisor engagement is generally good. Weekly prompting by the medical staffing team has reduced supervisor response time. There are still issues in some departments of a lack of job planned time for supervisors. High numbers of exception reporting increases the burden on consultants who are already experiencing high clinical demand.

6.3 Administrative Support

Administrative support is currently good.

7. ROTA GAPS

Specialties and rotas with vacancies are outlined below.

Directorate	Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Dec-23	Nov-23	Oct-23
		Cancer Services					
Cancer Services	FH	Oncology	ST3+	18	5	5	6.4
Cancer Services	FH	Palliative Medicine	F2/ST1+	13	0.8	0.8	0.8
Cancer Services	FH	Haematology / Oncology	F2/ST1/ST2	12	0.6	0.6	1.4
Cancer Services	FH	Haematology	ST3+	9	0.8	0.8	0.8
		Cardiothoracic Services					
Cardiothoracic Services	FH	Cardiology	ST3+	15	1.2	1.2	1.2
Cardiothoracic Services	FH	Cardiothoracic Anaesthesia	ST3+	10	2	2	2

Directorate	Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Dec-23	Nov-23	Oct-23
Cardiothoracic Services	FH	Cardiothoracic Surgery	ST3+	11	2	1	1
Cardiothoracic Services	FH	Cardiothoracic Transplant	ST3+	3	1	1	1
Cardiothoracic Services	FH	PICU	ST3+	8	0.2	0.2	0.2
Cardiothoracic Services	FH	Paediatric Cardiology 1st	F2/ST1/ST2	7	1.4	1.4	1.4
Cardiothoracic Services	FH	Paediatric Cardiology 2nd	ST3+	9	1	1	1
		Children's Services					
Children's Services	RVI	Paediatrics 1st - ST1/ST2 (now inc Paeds Surgery)	F2/ST1/ST2	25	2	2	2
Children's Services	RVI	General Paediatrics	ST3+	23	2.2	2.2	2.2
Children's Services	RVI	Paediatric Oncology	ST3+	6	0.2	0.2	0.2
Children's Services	RVI	Paediatric ICU (PICU)	ST3+	8	0.4	0.4	0.4
		EPOD					
EPOD	RVI	Plastic Surgery	F2/ST1/ST2	8	0.2	0	0
EPOD	RVI	Plastic Surgery	ST3+	13	1	1	1
EPOD	RVI	Ophthalmology	F2/ST1/ST2	6	0.2	0.2	0.2
EPOD	RVI	Ophthalmology	ST3+	25	1	1	1
EPOD	RVI	Dermatology	F2	1	1	1	1
EPOD	RVI	Dermatology	ST3+	7	0.4	0.4	0.4
EPOD	RVI	Dermatology	GPSTR	1	0.2	0.2	0.2
		Integrated Lab Medicine					
Integrated Lab Medicine	RVI	Histopathology	ST3+	16	0.9	0.9	0.9
Integrated Lab Medicine	RVI	Histopathology	ST1/2	8	0.2	0.2	0.2
Integrated Lab Medicine	RVI	MM rota integrated with ID and MV and GIM	ST1+	21	2.6	2.6	2.6
		Medicine					
Medicine	FH	General Internal Medicine	F2/GPVTS/CMT/TF	12	0.2	0.2	0.2
Medicine	RVI	CMT Acute- ACU (August 2019)	CMT	2	1	1	1
Medicine	RVI	ACCS on Assessment Suite Only	ACCS	2	1	1	1
Medicine	RVI	General Internal Medicine	ST3+	25	1.2	1.2	1.2
Medicine	RVI	Clinical Immunology	ST3+	3	1	1	1

Directorate	Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Dec-23	Nov-23	Oct-23
Medicine	FH	Gastroenterology	ST3+	6	0.2	0.2	0.2
Medicine	FH	Care of the Elderly	ST3+	5	1	1	1
Medicine	RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	20	1	1	1
Medicine	RVI	Accident & Emergency 2nd	ST3+	15	4.2	4.2	2.8
Medicine	RVI	Accident & Emergency	F2 GP Placement	12	0.4	0.4	0.4
		Musculoskeletal					
Musculoskeletal	FH	Rheumatology	ST3+	5	0.6	0.6	0.6
Musculoskeletal	FH	Orthopaedics	F2/ST1/ST2	4	1	1	0
Musculoskeletal	RVI/FRH	Orthopaedics	ST3+	19	1.2	1.2	1.2
		Neurosciences					
Neurosciences	RVI	Neurosurgery	F2/ST1/ST2	5	0.2	0.2	0.2
Neurosciences	RVI	Neurology	ST3+	13	0.2	0.2	0.6
		Peri-operative FH					
Peri-operative & Critical Care	FH	Anaesthetics General	ST1-7 CT1-2	27	3.6	3.6	4.6
		Peri-operative RVI					
Peri-operative & Critical Care	RVI	Critical Care	ST1+	16	3	3	3
Peri-operative & Critical Care	RVI	Anaesthetics	ST1-2 / ST3 +	40	3.2	3.2	3.2
		Radiology					
Radiology	RVI / FH	Radiology On Call	ST2 / ST3+	33	1	1	2
		Surgical Services					
Surgical Services	FH	General Surgery	F2/ST1/ST2/ST3+	7	1	1	1
Surgical Services	FH	Vascular	ST3+	10	0	0	1
Surgical Services	FH	Hpb / Transplant	ST3+	11	0.2	0.2	1
Surgical Services	RVI	General Surgery	F2/ST1/ST2	7	0	0	1
Surgical Services	RVI	General Surgery	ST3+	15	1.8	1.8	1.6
		Urology & Renal					
Urology	FH	Renal Medicine	ST3+	6	0.4	0.4	0.4
		Women's' Services					
Women's' Services	RVI	Obstetrics & Gynaecology	F2/ST1/ST2	14	1.4	1.4	1.4
Women's' Services	RVI	Obstetrics & Gynaecology	ST3+	22	2.6	2.6	2.6

Directorate	Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Dec-23	Nov-23	Oct-23
Women's Services	RVI	Neonates	F2/ST1/ST2	7	1.4	1.4	1.4
Women's Services	RVI	Neonates	ST3+	13	1.8	1.8	1.8

7.1 Locum Spend

LET Locum Spend

October to December (Q3 2023-24)	£346,038
July to September (Q2 2023-24)	£2,343,585
April to June (Q1 2023-24)	£1,120,006

Comment from finance team:

"In terms of expenditure we rely on invoices from the LET and so there are differences between the actual incidence of spend and the Trust being invoiced for it. There was a decrease of £2m between Q2 202324 and Q3 202324. Of this decrease, £594k was Internal Medicine £422k was in Childrens & £220k Cardiothoracic. "

"For reference, although there is a significant decrease between Q2 23/24 and Q3 23/24, when comparing Q3 23/24 to Q3 22/23, there is a decrease of £22k."

Trust Locum Spend

October to December (Q3 2023-24)	£586,415
July to September (Q2 2023-24)	£3,027,246
April to June (Q1 2023-24)	£974,966

Comment from finance team:

"Based on information supplied by Medical Staffing this was made up of decreases of £655k on On-Call cover, £652k Increased Workload, £412k Vacancies, £360k Major Incident, £230k Industrial Action Cover, £70k Sickness & £41k Specialist Workload Cover.

With regard to Clinical Boards the decrease in spend can be seen as being significant within all of the boards, in particular £595k Medicine & Emergency Care, £486k Surgical & Specialist Services & £236k Cardiothoracic.

For reference, although there is a significant decrease between Q3 23/24 and Q2 23/24, when comparing Q3 23/24 to Q3 22/23, there is a decrease of £60k. This is driven mainly by decreases of £78k on Vacancies, £21k Sickness and offset by increases of £12k Covid, £11k On-Call & £9k Industrial Action Cover. "

8. RISKS AND MITIGATION

The main risk remains medical workforce coverage across a number of rotas. As previously highlighted, this is exacerbated by changes in working patterns due to alterations of the TCS of the Junior Doctor Contract, and changes in training requirements.

9. JUNIOR DOCTOR FORUM

Issues discussed included parking, Wi-Fi, staffing and locum rates. There were also updates on the junior doctor mess refurbishments at RVI.

10. RECOMMENDATIONS

I recommend that we continue to review the workforce workload balance to ensure safe and sustainable staffing.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
06 February 2024

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Agenda item A10(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024					
Title	Executive Chief Nurse (ECN Report)					
Report of	Maurya Cushlow, Executive Chief Nurse Ian Joy, Executive Director of Nursing					
Prepared by	Ian Joy, Executive Director of Nursing 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 Nursing, Midwifery and Allied Health Professional Preceptorship • Nursing and Midwifery Safer Staffing • Safeguarding and Mental Capacity Act Quarter 3 update (Q3) • Learning Disability Q3 update • Patient Experience Q3 update					
Recommendation	The Board of Directors is asked to note and discuss the content of this report.					
Links to Strategic Objectives	• Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. • We will be an effective partner, developing and delivering integrated care and playing our part in local, national, and international programmes. • Being outstanding, now and in the future.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	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 focusing 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 the Trust Board.					

EXECUTIVE CHIEF NURSE REPORT

EXECUTIVE SUMMARY

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

Section 1: Spotlight on Nursing, Midwifery Allied Health Professional (NMAHP) Preceptorship.

Section one of the report contains this month's 'Spotlight' section which provides an overview of the Trust's Nursing, Midwifery Allied Health Professional (NMAHP) Preceptorship Programme.

Preceptorship is a period of support which meets the needs of new registrants during the first year of employment. It provides vital knowledge to build confidence and competence, benefiting patient safety and clinical outcomes. Preceptorship supports retention of new registrants and lays the foundations for lifelong learning. The Preceptee is an early career registrant who is a Nurse, Midwife or Allied Health Professional (NMAHP) and the Preceptor is a registered practitioner, who is responsible for developing others professionally, to achieve their full potential by providing guidance and support.

We have recently reviewed and updated our preceptorship offer to ensure it aligns with national best practice. This includes a Preceptorship Programme consisting of five study days over the first year of practice, and covers aspects such as:

- Imposter phenomenon
- Professional roles and responsibilities
- Professional accountability
- Self-reflection and emotional intelligence

The clinical day includes education relating to:

- The identification of the deteriorating patient
- Safe Staffing and escalation of concerns
- Infection prevention and control
- Nutrition and Hydration
- Medication and Insulin Safety

In the subsequent days a range of subjects are covered including:

- Human factors
- Clinical supervision/Professional Nurse Advocates
- Leadership
- Conflict resolution
- NMAHP Research
- Raising Concerns

Additionally, each preceptee is asked to undertake a Quality Improvement Project in their clinical area.

In January 2024 organisations were invited to submit an assessment to the National Preceptorship Team for the interim Nursing Preceptorship Quality Mark. The Trust was awarded the Quality Mark in February 2024. The requirements to be met included an identified Preceptorship Lead to co-ordinate the programme. A dedicated Preceptorship Lead is a new post for the Trust and has been funded for one year initially and is currently in the recruitment process. The Preceptorship Lead will work with both preceptors and preceptees to provide development and support to both groups. The Preceptorship Lead will provide assurance against the Preceptorship Quality Mark and monitor completion rates of the Preceptorship programme. They will also measure and report on the impact of Preceptorship on both staff retention and engagement.

Sections 2 and 3: Nursing and Midwifery Safer Staffing

Sections two and three highlight areas of risk and details actions and mitigation to assure safer staffing in line with agreed escalation criteria for nursing (section two) and midwifery (section three).

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 nursing safer staffing metrics against clinical outcomes/nurse sensitive indicators as stipulated in national guidance continues via the Nurse Staffing and Clinical Outcomes Operational Group (NS&O).

The following key points from this group are noted below:

- Three wards have required high-level support over the last three months.
- One ward has successfully transitioned from high-level to medium-level support after demonstrating consistent improvement in staffing metrics and clinical outcomes. This was assessed through a comprehensive peer review inspection commissioned by the Executive Chief Nurse.
- The two wards requiring high-level support have action plans in place led by the Heads of Nursing. The action plans are reviewed by the NS&O group and overseen by the Associate Directors of Nursing. The wards of concern requiring high-level support are discussed and presented at the Trust's Quality Committee for scrutiny and oversight.
- Red flag reporting has been higher in the last month than in the same period last year but reduced from the previous 3 months. The reporting increase may be due to increased awareness of the importance of documenting red flags, as part of the nurse staffing escalation process.
    - December meeting: (November red flags) 221 flags
    - January meeting: (December red flags) 150 flags
    - February meeting: (January red flags) 170 flags

- There was a significant reduction in staffing Datix reported during the past 3 months, compared with the previous 3 months and the same period last year. Each incident is reviewed individually, and there were no reports of harm that would meet moderate criteria. Staff are encouraged to report staffing shortfalls and each report reviewed involves feedback directly to the submitting team/individual. In the last quarter the number of DATIX submitted were:
    - December 2
    - January 4
    - February 3

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

The following key points are contained within the report:

- The current RN vacancy rate is 2.59%, based on the financial ledger at Month 10 this is a slight increase from the 1.90% reported in October 2023. This relates to current substantive staff in post and does not include those staff currently in the recruitment process. The current pipeline of adult RN is 45 (headcount) and for paediatric RN there is 8 (head count) in the recruitment process.
- Based on Month 10 data the current RN and Midwifery workforce combined turnover is 8.74%, this demonstrates a reduction from the previously reported 10.05% in the same period last year.
- The vacancy position across Paediatrics remains of particular concern impacting on the delivery of commissioned bed capacity. Paediatric IR has been successful with 48 staff deployed in the last 13 months but these RNs will require extensive training and supervision and will not integrate fully into the workforce unsupervised for up to 6 months. A training and supervision plan is in place.
- The current HCSW vacancy rate is 5.06% with 58 (head count) candidates in the recruitment pipeline. This is a reduction from the previous vacancy rate reported in January 2024 of 6.6%. Following the large-scale widening participation recruitment event and the subsequent innovative approach, the current HCSW vacancy rate is favourable regionally.
- A target for IR of RN/RM was set at 224 candidates for 2023/24. All posts have been appointed to and all candidates due to be deployed by the end of March. At this point no further IR is planned as we focus on supporting the candidates who have been deployed over the last year.

Section 3 provides an overview of the current midwifery staffing position. The following key points are noted:

- The Maternity Service has maintained its positive workforce position with a Registered Midwife vacancy rate of 0%. Some workforce pressures continue due to long and short-term sickness absence and maternity leave, as well as the demands of supernumerary time for newly appointed staff.

- Recruitment will continue towards a position of 20 whole-time equivalent (wte) above the funded establishment to mitigate gaps for maternity leave and sickness absence.
- Turnover rates (as reported by NHS England (NHSE) Workforce Intelligence Portal) are currently 8.6%, broadly in line with the national average of 8.3%. Four midwives have left the service during January and February, for reasons including work-life balance, retirement and relocation.
- From 1 January 2024 to 29 February 2024, there have been zero occasions against a possible 351 episodes recorded, where the midwife has been unable to provide continuous one-to-one care and support to a woman in established labour; and zero occurrences where the delivery suite coordinator has not remained supernumerary and has resulted in the co-ordinator being the named midwife for a woman.
- In January and February 2024, the number of red flags recorded on Delivery Suite was seven and two respectively. This represents a sustained monthly decrease from October 2023 onwards. All red flags in this period were for 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.
- The resource required to achieve the nationally mandated increase in training requirement for all Maternity staff as part of the Core Competency Framework v2 in 2023 has placed increased pressure on the service. In order to maintain the training schedule required to meet Maternity Incentive Scheme (MIS) training compliance and to have the assurance of a safe maternity workforce and service, local escalation in response to acuity has led to the closure of Newcastle Birthing Centre (NBC) for 53 days during January and February 2024, in order to maintain safe staffing across the unit. A Quality Impact Assessment (QIA) has been undertaken which indicates that this process supports the safety of women and babies.
- The homebirth service has been suspended since 17 July 2023 as part of local escalation initially in response to staffing deficits and subsequently due to non-compliance with intrapartum clinical updates over the past 12 months. Due to the improved workforce position, Community Midwives are now undertaking a 3 month 'sprint' to ensure all are compliant with the necessary intrapartum clinical updates to reinstate the service in June 2024.

Section 4: Safeguarding and Mental Capacity Act Q3 Summary

Section 4 of the report provides a Q3 summary update of Safeguarding and Mental Capacity Act (MCA) activity throughout the Trust and includes references to activity, education and training and audit and assurance.

Activity for Q3 evidences the following key high-level points:

- In Adult Safeguarding there was a significant increase in activity when compared to the previous quarter. 1,100 referrals/cause for concern were received against a total of 980 in Q2. The increased activity has been challenging for the team to respond to and has impacted on other improvement and audit work streams.

- The Children's Safeguarding Team have seen a slight reduction in the overall safeguarding activity in Q3 2023/24 compared to Q2. It is also noted that the method of safeguarding referral has changed quite significantly. The team have been dealing with a higher volume of safeguarding calls and have seen a fall in the number of Cause for Concerns (CFC's) received electronically. This is being closely monitored but is likely due to the significant work undertaken in Q2 to raise the profile and visibility of the team.
- In Q3 there were 201 reported MCA and Deprivation of Liberty Safeguard (DoLS) - related enquiries, with 7 regarded as complex. This is a significant increase from 107 in Q2. 'Complex' can be where external legal advice has been required and/or have cases that have been put before the Court of Protection.
- Q3 numbers for Urgent DoLS applications received and sent to Local Authorities is sustained at high levels, which has been an ongoing trend since May 2023. For each month in Q3, numbers have remained consistently at 180 applications, with November reaching 217. Q1, 2 & 3 numbers combined currently stand at 1,518, which is significantly higher than any previous full financial year (921)

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

- In Adults and Children, Level 1 and Level 2 training demonstrates good compliance with 96% and 95% respectively for adults and 97% and 96% for Children.
- Level 3 compliance remains lower than expected at 80% for Adults and 82% for Children. Work remains in progress to maximise compliance across all Clinical Boards and workforce groups.
- In Q1, the Trust 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 currently stands at 94%. In addition to this, Level 2 DoLS and separate MCA training is being developed, with scenario-based videos already recorded and in the process of being edited.

The report also includes an overview of audits reported during Q3. The MCA/DoLS audit demonstrates a reduction in compliance of MCA assessment prior to DoLS (93% to 83%) and quality of Best Interest Decision documentation when compared to Q2. Audit actions have been agreed and the results shared across Clinical Boards. The Q4 audit is in progress.

Section 5: Learning Disabilities Q3 Summary

This section of the report provides a Q3 summary update regarding the work of the Learning Disability Liaison Team.

The following activity trends are noted for Q3:

- There were 972 referrals into the team in 3 compared to 898 in Q2. This is a 25% increase compared to the same period last year where there were 737 referrals in Q3.

- There is a 27% increase in Emergency Department (ED) attendances in Q3 2023/24 in comparison to Q3 2022/23.

This increase in referrals into the team is creating operational pressure and impacting on improvement workstreams. Temporary resource has been identified to support from April 2024.

The report includes an overview of training and education and audit. The following key points are noted:

- There has been no further national update following The Code of Practice (Health and Social Care Act 2008) consultation paper which closed in September 2023. The final outcome will outline the national mandatory requirements for learning disability and autism training.
- The Trust implemented the Diamond Standards Mandatory eLearning training for Learning Disabilities and Autism which is the current regionally endorsed programme. Trust compliance with e-learning Diamond Standards is at 93.3%. This training was developed by the Learning Disability Northeast and Cumbria Network and designed specifically for acute Trusts.
- The Trust has participated in the regional pilot of the Oliver McGowan Mandatory Training on Learning Disabilities and Autism led by the Learning Disability North-East and North Cumbria Network.
- It is recognised that the Trust will either need to adopt the Oliver McGowan Training or significantly develop the Diamond Standard Training and enhance the autism content in the e-learning package. If this is not addressed the current training will not be compliant with national standard. This work is being discussed through the regional network.
- Audits undertaken in Q3 demonstrated an improvement in compliance with documenting a diagnosis of a learning disability on admission (+28%) and a small improvement (+3%) in consideration and documentation of reasonable adjustments. Whilst these are improvements, they are below expected standard.
- Additional temporary capacity for the team has been agreed to support real time auditing and ward walking to increase understanding and impact care in real time. Further education materials are being designed to support staff to understand the use and re-use of hospital passports which will be available in April 2024.

Section 6: Patient Experience Q3 Summary

Section 6 provides a summary of the Patient Experience Q3 Report. The report provides an in-depth appraisal of the following high level points:

- The Trust has opened 152 formal complaints in Q3, which is an increase of 10% from the previous quarter. The Trust has received, on average, 46 formal complaints per month, which is consistent with the overall average for 2022/23.
- In Q3, 159 formal complaints were closed, which is an increase of 25% from the previous quarter. Of these, 28 complaints were upheld, 31 were partially upheld, 79

were not upheld and 21 were withdrawn. The report includes a breakdown of the 28 upheld complaints between Clinical Boards and categories. Medicine and Emergency Care have the most upheld complaints with 10, accounting for 36% of all upheld complaints for this period. The most frequent category is communication with 25% of upheld complaints across five Clinical Boards.

- The report also includes an overview of the recently released National Maternity Survey Results. The survey took place in February 2023 and asked women about their experiences of care at three different stages of their maternity journey, antenatal care, labour and birth and postnatal care; 281 women who accessed maternity care at the Royal Victoria Infirmary took part. Results show maternity services at Newcastle Hospitals were rated much better than most trusts for **1** question, better than most trusts for **4** questions, somewhat better than most trusts for **1** question. Results were about the same as other trusts for **48** questions. Although the Trust did not score 'worse' or 'much worse' than most other trusts for any question, there are 49 questions in the survey that were comparable to 2022, seven of these questions had a statistically significant decrease for the Trust. An overview of these is included within the report.
- Over the past few months, there have been multiple cases of transgender patients requesting their name and gender marker on their hospital record to be changed to the name and gender they identify as. These cases have highlighted multiple challenges for both patients and staff to ensure changes made are in line with the law, are safe and provides a good patient experience. A task and finish group has been established to progress this work.
- The hospital charity application submitted in September 2023 to work with Skills for People over two years to engage with people with a learning disability has been successful. This programme of work will have three overlapping areas of focus, which are:

1) Engagement and focus group work with people with a learning disability
2) User-led service audits of specialties, called Quality Checks
3) Developing Easy Read information

The work was launched with an event in February at Skills for People, with prior communications and advertisement of the opportunity to people to get involved in this project.

7. RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
21 March 2024

Ian Joy
Executive Director of Nursing

EXECUTIVE CHIEF NURSE REPORT

1. SPOTLIGHT – NURSING, MIDWIFERY ALLIED HEALTH PROFESSIONAL (NMAHP) PRECEPTORSHIP

Preceptorship is a period of support which meets the needs of new registrants during the first year of employment. It provides vital knowledge to build confidence and competence, benefiting patient safety and clinical outcomes. Preceptorship supports retention of new registrants and lays the foundations for lifelong learning. The Preceptee is an early career registrant who is a Nurse, Midwife or Allied Health Professional (NMAHP) and the Preceptor is a registered practitioner, who is responsible for developing others professionally, to achieve their full potential by providing guidance and support.

1.1 Preceptorship Context

The challenge in retaining NMAHP staff has been well recognised nationally and there has been a growing emphasis on the need for targeted intervention for different career stages, one being early career. The NHS Long Term Workforce Plan (2023) endorses the National Preceptorship Framework, recognising that good quality Preceptorship is key for the wider workforce. Retention is a key Trust priority, in particular, early career retention is vital to grow the workforce. The loss of a registrant can affect the safety and care provided to patients, impact staff morale and have a significant financial impact. Having an accessible, robust and quality Preceptorship offer, increases the likelihood of new registrants remaining within the Trust.

1.2 The New Preceptorship Programme

The Trust NMAHP Strategy aims to support our staff to liberate their full potential and to nurture the next generation of clinical leaders who are equipped to lead their teams with compassion and inclusivity. To ensure compliance and delivery of best practice the Trust Preceptorship principles have been reviewed and realigned to the national strategy and guidance provided in the Nursing Preceptorship Framework published in 2022, the Midwifery Preceptorship Framework and the Allied Health Professional Preceptorship and Foundation Support Principles in 2023. The Trust Preceptorship Policy underpins expectations of all parties.

To support effective preceptorship, there are five protected study days spread throughout the preceptee's first year in practice. There are currently 517 new registrants on a Preceptorship Programme and 149 booked to start. There are 16 Preceptorship Programmes planned (April to December 2024), to meet anticipated demand.

To provide a consistent approach to preceptorship we have developed an electronic preceptorship resource pack, issued to all preceptees at the beginning of their 12 month preceptorship period. This is to support the supernumerary period/protected learning time

which is a minimum 75 hours. For each preceptee a Transitional Learning Needs Analysis is completed and progress is monitored at regular intervals.

The programme supports transition from student to registrant covering imposter phenomenon, roles and responsibilities, accountability, self-reflection and emotional intelligence. The clinical day includes education on identification of the deteriorating patient, safe staffing and escalation of concerns, infection prevention and control, nutrition and hydration, medication and insulin safety. In the subsequent days a range of subjects are covered including human factors, clinical supervision/Professional Nurse Advocates, leadership, wellbeing, conflict resolution, make space for research, NMAHP strategy and raising concerns. Additionally, each preceptee is asked to undertake a Quality Improvement Project in their clinical area.

1.4 Interim Nursing Preceptorship Quality

In January 2024 organisations were invited to submit an assessment to the National Preceptorship Team for the interim Nursing Preceptorship Quality Mark, the Trust was awarded the Quality Mark in February 2024. The Preceptorship Quality Mark is a prestigious nationally recognised award and demonstrations the Trust commitment to supporting new registrants. The Preceptorship Quality Mark will be what new registrants will seek when choosing an employer and will therefore support us in attracting new staff. The requirements to be met included an identified Preceptorship Lead to co-ordinate the programme, maintain attendance registers, and monitor progression and measure effectiveness. A dedicated Preceptorship Lead is a new post for the Trust and has initially been funded for one year and is currently in the recruitment process. The Preceptorship Lead will work with both preceptors and preceptees; to provide development and support to both these groups.

1.5 Preceptorship Programme Evaluation

The Preceptorship Lead role will provide assurance against the Preceptorship Quality Mark and monitor completion rates of the Preceptorship programme. They will measure and report on the impact of Preceptorship on both staff retention and engagement.

The work of the Preceptorship programme is overseen by the Preceptorship Development and Oversight Group and is a collaborative group which ensures a global overview of the Trust Preceptorship offer. Reporting governance is through the Learning and Education Group (LEG). Preceptorship is also a standing agenda item on the NMAHP Practice Development and Clinical Educator Meetings. This collaborative approach has supported the development of an organisational NMAHP Preceptorship offer, which has content applicable to all new registrants and encourages shared learning across professions. This is one of the gold standards of the Preceptorship Quality Mark.

The Preceptorship programme will continue to develop and respond to the needs of our staff, to deliver quality early career support to registrants which is paramount in retaining staff within our organisation and empowers them to use their growing knowledge and experience to benefit patient safety and clinical outcomes.

2. NURSING AND MIDWIFERY STAFFING UPDATE

2.1 Nurse Staffing Escalation

The Trust's Nursing and Midwifery Safe Staffing Guidelines provide a robust framework to ensure safe staffing governance is maintained and articulates a clear process for safe staffing escalation. The Trust staffing escalation is currently operating at level two due to the following triggers:

- Sustained sickness absence greater than 5% for the nursing and midwifery workforce and 7% for additional clinical services.
- Winter-preparedness surge beds remain in operation.
- An increase in staffing Datix and red flags

The following actions remain in place and are overseen by the Executive Chief Nurse:

- Senior nursing team provide a twice daily staffing review which is reported into the Trust operational and tactical control teams.
- SafeCare (daily deployment tool) is utilised to deploy staff within and across Clinical Boards.

In the past six months, escalation to the senior nursing team to redeploy staff across Clinical Boards has reduced. This is a result of nursing leadership within the Clinical Boards from the Heads of Nursing and Matron teams, along with an improved vacancy position. However, level two escalation will remain in place until the de-escalation criteria has been met.

2.2 Nurse Staffing and Clinical Outcomes

The Nurse Staffing and Clinical Outcomes (NS&O) Group meets monthly, to review wards where there is a staffing or clinical outcome concern based on identified risk and professional judgement. The group utilises and maintains a dashboard, which reviews staffing metrics, nurse sensitive indicators and patient experience information to identify potential areas of risk. The wards reviewed are identified as requiring low, medium, or high-level support. Any ward requiring medium-level support for two consecutive months or any ward requiring high-level support are highlighted to the Executive Chief Nurse each month.

The key points from this group are noted below:

- Three wards have required high-level support over the last three months.
- One ward has successfully transitioned from high-level to medium-level support after demonstrating consistent improvement in staffing metrics and clinical outcomes. This was assessed through a comprehensive peer review inspection commissioned by the Executive Chief Nurse. The peer review findings confirmed the improvements noted in the NS&O dashboard.

- The two wards requiring high-level support have action plans in place led by the Heads of Nursing. The action plans are reviewed by the NS&O group and overseen by the Associate Directors of Nursing. The wards of concern needing high-level support are discussed and presented at the Trust's Quality Committee for scrutiny and oversight.
- Red flags are raised in the SafeCare module by nursing staff to report staffing incidents in line with NICE guidance. These, 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 with the ward staff, Heads of Nursing and Matrons.
- Red flag reporting has been higher in the last month than in the same period last year but reduced from the previous 3 months. The reporting increase may be due to increased awareness of the importance of documenting red flags, as part of the nurse staffing escalation process.
    - December meeting: (November red flags) 221 flags
    - January meeting: (December red flags) 150 flags
    - February meeting: (January red flags) 170 flags
- There was a significant reduction in staffing Datix reported during the past 3 months, compared with the previous 3 months and the same period last year. Each incident is reviewed individually, and there were no reports of harm that would meet moderate criteria. Staff are encouraged to report staffing shortfalls and each report reviewed involves feedback directly to the submitting team/individual. In the last quarter the number of DATIX submitted were:
    - December 2
    - January 4
    - February 3

Below is an overview of the wards reviewed and level of support required for the last quarter:

Month	Total Wards Reviewed	Clinical Board	High level support	Medium level support	Low level support
Dec-23		Family Health: WOM x 2, CHI x 3	1	3	1
		Surgery & Specialist Services: T&O x 3, NEU X 1		2	2
		Cardiothoracics: CAR x 3	1		2
		Medicine & Emergency Care: INT x 7, REN x 1		2	6
		Surgical and Associated Services FRH: URO x 1, SUR x 1		2	
Total	**22**		**2**	**9**	**11**
Jan-24		Family Health: WOM x 2, CHI x 6	1	5	2

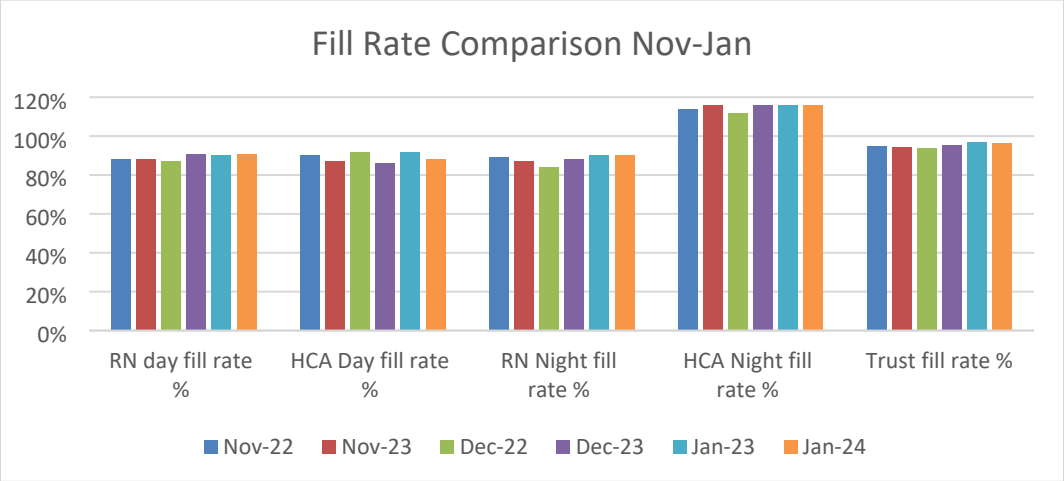
Month	Total Wards Reviewed	Clinical Board	High level support	Medium level support	Low level support
		Surgery & Specialist Services: T&O x 3, NEU X 2		3	2
		Peri-operative and Critical Care: POCC x1			1
		Cardiothoracic Services: CAR x 3	1	1	1
		Medicine & Emergency Care : INT x 5, REN x 1			6
		Surgical and Associated Services FRH: URO x 2, SUR x 1			3
		Cancer & Haematology: CAN x1			1
Total	**29**		**2**	**9**	**16**
Feb-24		Family Health : WOM x 2, CHI x 6	1	5	2
		Surgery & Specialist Services RVI: T&O x 2, NEU X 2		1	3
		Peri-operative & Critical Care: POCC x1			1
		Cardiothoracic Services CAR x 3	1	1	1
		Medicine & Emergency Care: INT x 3, REN x 1			4
		Surgical & Associated Services FRH : URO x 1, SUR x 1, IOT x 1			3
Total	**29**		**2**	**7**	**14**

2.3 Trust Fill Rates and Care Hours Per Patient Day (CHPPD) data

The Trust level fill rates and CHPPD are detailed below:

Month	CHPPD	RN day fill rate %	HCA Day fill rate %	RN Night fill rate %	HCA Night fill rate %	Trust fill rate %
November 2023	8.1	88%	87%	87%	116%	94.50%
December 2023	8.6	91%	86%	88%	116%	95.25%
January 2024	8.3	91%	88%	90%	116%	96.25%

The Trust fill rates have consistently improved over the past three months. Below is the comparison data for this year and the same period last year. Of note the RN fill rate is impacted by vacancy, added to that this year there has been staff movement to support winter-surge areas. This includes the opening of 27 acute inpatient beds on ward 12 (winter ward) Freeman Hospital and a discharge lounge at the RVI. For both RN and Healthcare Assistants (HCA) there is workforce who are "away" for other reasons such as sickness and maternity leave but these percentages have remained stable.



During the same time-period last year, the fill rates were reflective of the temporary reduction of 28 adult beds to mitigate risk due to staffing. There are currently six adult beds closed at the Freeman Hospital due to staffing skill mix but there are 27 winter surge beds open also at the Freeman Hospital. There are a total of six cots closed in Neonatal Care and in Great North Childrens Hospital there are currently a total of 14 beds closed due to workforce vacancy and awayness. A robust workforce plan is in place.

The "Check Challenge and Coach" process which was initiated in November 2023 aims to maximise rostering potential and improve fill rates. A coaching approach is taken supported by Quality Improvement methodology with a focus on achieving goals, identifying skills, tools and training to drive improvement. Monitoring is through bi-monthly meetings and e-roster dashboards for each Clinical Board. Key performance indicators are reviewed to identify potential risk and implement appropriate supportive action to mitigate.

2.4 Recruitment and IR

2.4.1 RN Recruitment

The current RN vacancy rate is 2.59%, based on the financial ledger at Month 10 this is a slight increase from the 1.90% reported in October 2023. This relates to current substantive staff in post and does not include those staff currently in the recruitment process. Currently there are 58 (head count) RN in the recruitment process with being 45 adult and 8 paediatric.

Based on Month 10 data the current RN and Midwifery workforce combined turnover is 8.74%, this demonstrates a reduction from the previously reported 10.05% in the same

period last year.

Bespoke and IR over the last 12 months has complimented the successful generic recruitment. Those areas with remaining vacancy have been supported with high-quality communications and social media options to promote their job opportunities. As the vacancy rate has significantly reduced much of the recruitment has been bespoke and led by the specialty teams with the support of the nursing workforce team. This approach has evaluated well with the clinical teams and has led to positive outcomes in terms of successful appointments. This process will remain in place, overseen and approved by the nursing workforce and HR teams, who continue to work collaboratively.

To optimise and ensure accuracy of vacancy data, quarterly Head of Nursing meetings are in place to cleanse the active Trac (vacancy) data. The identified workforce priority is with Children and Young Peoples services who have a workforce plan in place which is reviewed weekly by the Clinical Board. In March 2024 a successful open day took place to showcase specialist services and role diversity. Paediatric IR continues successfully with 48 staff deployed in the last 13 months. It is acknowledged that these RNs will require extensive training and supervision and will not integrate fully into the workforce unsupervised for up to 6 months and so training and supervision plan is in place.

2.4.2 HCSW Recruitment

The current HCSW vacancy rate is 5.06% with 53 (head count) candidates in the recruitment pipeline. This is a reduction from the previous vacancy rate reported in January 2024 of 6.6%. Following the large-scale widening participation recruitment event and the subsequent innovative approach, the current HCSW vacancy rate is favourable regionally. Work streams are aligned to the national HCSW programme and include quality in workforce reporting; benchmarking recruitment; improving the apprenticeship offer and attracting staff new to care.

A HCSW Steering Group continues to take place monthly to review and monitor performance. The current phase of the programme is focusing on retention, professional development, and pastoral support of HCSWs across the organisation. This includes the provision of high-quality induction, a career conversation for all HCSWs and a programme of training including clinical and non-clinical days, deteriorating patient study days and the chance to gain a mentorship qualification.

2.4.3 IR

Since June 2022 the Trust has deployed 444 Adult nurses, 80 Paediatric nurses and 7 midwives to mitigate against band 5 vacancy and turnover. This investment was partially funded by NHSE. This saw deployment of 305 staff in 2022/23 and 224 staff in 2023/24. The total number staff deployed will be 531 by the end of March 2024. The IR team have also successfully supported six internationally educated home grown talent candidates from our HCSW Trust workforce to registration.

The internationally educated nurses offer high calibre nursing expertise, along with a

diversity of skills and experience which has complimented the clinical teams that they have joined. The successful large-scale deployment demonstrates the value and significance of IR as a key NMAHP workforce strategy. The NHS Long Term People Plan recommends a focus on retention with the aim of reducing our reliance on IR in the next three to five years. In response there are a number of retention workstreams led by the nursing workforce team.

The Trust has been awarded the prestigious NHS Pastoral Care Quality Award which is in recognition of the quality work in IR and our commitment to providing high-quality pastoral care to all our internationally educated nurses and midwives during their recruitment process and employment.

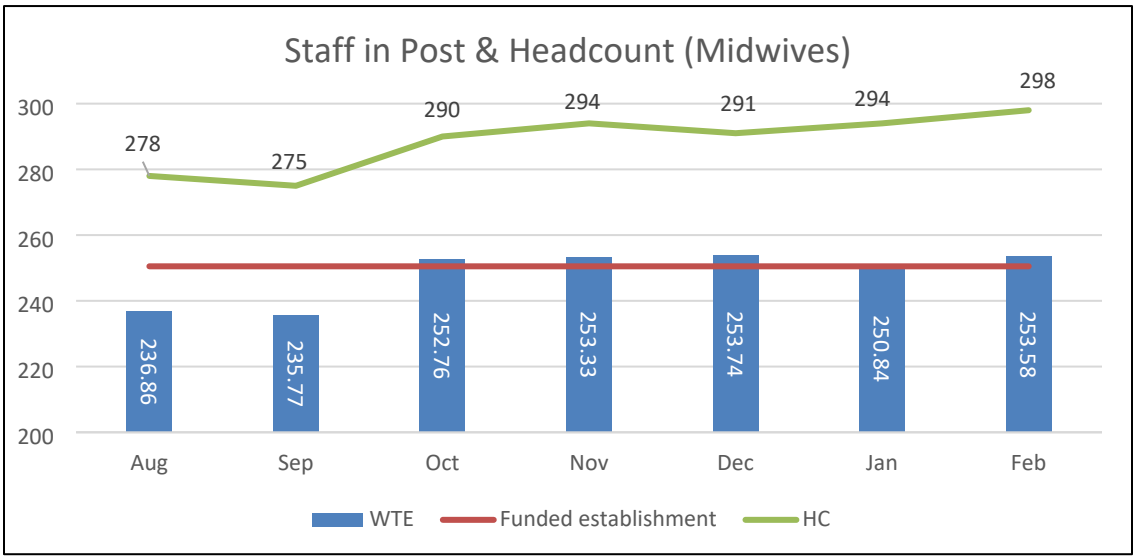
3 Midwifery Staffing Position

3.1 Current Staffing Position

The Maternity Service has maintained its positive workforce position in the first two months of 2024. Figure 1 illustrates the current midwifery staffing position, including frontline clinical staff and those in specialist and management roles. This highlights the current 253.58wte midwives against the funded establishment of 250.50wte. A rolling recruitment programme continues to further increase up to the Trust approved permanent 20wte over establishment; to allow for increased levels of maternity leave and to support the delivery of maternity specific core competency training above Trust mandatory training. This has helped to ensure a consistent, sustainable position within the large midwifery workforce at Newcastle.

An additional internationally educated midwife was appointed in January 2024, taking the total recruited to 8. This takes the service 1 above our commitment to recruit 7 internationally educated Midwives over the last 2 years which has been a valuable opportunity to diversify our workforce.

Figure 1: Midwives in Post (WTE and Headcount) against funded establishment August 2023 to February 2024



The impact of increased staffing numbers has not yet been fully realised since the single annual university output in September 2023 of newly qualified Midwives, due to long-term sickness absence (3.3%), short-term sickness absence (4.58%) and maternity leave (5.16%). Targeted work has been undertaken within the service to understand and support the needs of the workforce in order to reduce sickness absence. This has had a positive impact to reduce long term absence associated with stress and anxiety that was found to correlate with peaks in acuity and activity. This will be further explored and supported by the return of a Clinical Psychologist to Women's Service for 2 days per week in April 2024.

Additional pressure has been felt by the service as the Trust is supporting 27 newly qualified Midwives who have joined the Trust since the single annual university output in September 2023 with a comprehensive preceptorship package comprised of a 2 week bootcamp style training followed by a 10 week programme of bespoke supernumery supported rotations to ensure newly qualified Midwives joining the Trust receive individualised appropriate support, training and professional development, and supervision as necessary to carry out their duties within each area of Maternity Services.

Midwifery turnover rates, reported by NHSE Workforce Intelligence Portal, are currently 8.6%, broadly in line with the national average of 8.3%. Four midwives have left the service during January and February, for reasons including work-life balance, retirement and relocation.

Continued focus on recruitment and retention initiatives in line with the Workforce Improvement Strategy, has seen the introduction in February of monthly Maternity Careers Conversation Drop-Ins to provide a platform to capture improvement and development ideas and bespoke experiences and career planning on a confidential 1:1 basis.

3.2.1 Red Flags: 1:1 Care in Labour and Supernumerary Status of the Labour Ward Coordinator

From 1 January 2024 to 29 February 2024, there have been zero occasions against a possible 351 episodes recorded, where the midwife has been unable to provide continuous one-to-

one care and support to a woman in established labour and zero occurrences where the delivery suite coordinator has not remained supernumerary and has resulted in the coordinator being the named midwife for a woman.

In January and February 2024, the number of red flags recorded on Delivery Suite was seven and two respectively. This represents a sustained monthly decrease from October 2023 onwards. All red flags in this period were for 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.

3.2.2 Risk and Mitigation

Whilst there has been a reduction in workforce pressures due to sickness absence in recent months, the sustained pressure to support the preceptorship of newly qualified Midwives has resulted in a challenging period of time for the service.

The resource required to achieve the nationally mandated increase in training requirement for all Maternity staff as part of the Core Competency Framework v2 in 2023 has placed increased pressure on the service. In order to maintain the training schedule required to meet MIS training compliance and to have the assurance of a safe maternity workforce and service, local escalation in response to acuity has led to the closure of NBC for 53 days during January and February 2024, in order to maintain safe staffing across the unit.

During periods of closure, 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 QIA has been undertaken which indicates that this process supports the safety of women and babies.

Intermittent closure creates uncertainty for patients and families, and potentially impacts patient satisfaction as partners are unable to stay overnight on the postnatal ward in contrast to their expected experience on the Birth Centre. Regular consultation and communication with service users via the Maternity and Neonatal Voices Partnership (MNVP) has been prioritised, in order to provide patients with the information that they need.

The homebirth service has been suspended since 17th July 2023 as part of local escalation initially in response to staffing deficits and subsequently due to non-compliance with intrapartum clinical updates over the past 12 months. Due to the improved workforce position, Community Midwives are now undertaking a 3 month ‘sprint’ to ensure all are compliant with the necessary intrapartum clinical updates to reinstate the service in June 2024.

Daily monitoring of staffing levels in line with the North East North Cumbria daily SitRep continues in order to ensure escalation measures can be stepped down as soon as safe staffing across the unit is assured.

4. SAFEGUARDING AND MENTAL CAPCITY ACT Q3 REPORT

This summary provides a Q3 update of safeguarding activity throughout the Trust and includes references to developments in practice as well as an overview of national practice developments and the Trust's compliance with these recommendations.

4.1 Activity

Safeguarding activity for Q3 evidences the following key high-level points:

- In Adult Safeguarding when compared to the previous quarter there was a significant increase. 1100 referrals/cause for concern were received against a total of 980 in Q2. Activity has been challenging for the team to respond to and has impacted on other improvement and audit work streams.
- The Children's Safeguarding Team have seen a slight reduction in the overall safeguarding activity in Q3 2023/24 compared to Q2, but it is also noted that the types of safeguarding activity have changed quite significantly. The team have been dealing with a higher volume of safeguarding calls and have seen a fall in the number of Cause for Concerns (CFC's) received electronically. This is being closely monitored but is likely due to the significant work undertaken in Q2 to raise the profile and visibility of the team.
- In Q3 there were 201 reported MCA and DoLS-related enquiries, with 7 regarded as complex. This is a significant increase from 107 in Q2. 'Complex' can be where external legal advice has been required and/or have cases that have been put before the Court of Protection.
- Q3 numbers for Urgent DoLS received and sent to Local Authorities is sustained at high levels, which has been an ongoing trend since May 2023. For each month in Q3, numbers have remained consistently at 180 applications, with November reaching 217. Q1,2&3 numbers combined currently stand at 1,518, which is significantly higher than any previous full financial year (921)

4.2 Education and Training

Safeguarding Adults and Children training compliance continues to be closely monitored. Level 1 and Level 2 training demonstrates good compliance with 96% and 95% respectively for adults and 97% and 96% for Childrens. Level 3 compliance remains lower than expected at 80% for adults and 82% for Childrens. Work remains in progress to maximise compliance across all Clinical Boards and workforce groups.

In Q1, the Trust 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 currently stands at 94%. In addition to this, Level 2 DoLS and separate MCA training is being developed, with scenario-based videos already recorded and in the process of being edited. This has not yet been launched as expected in Q3 due to some delays in editing but is in progress. An 'expert by experience' interview session was also recorded and will be incorporated.

4.3 Audit and Assurance

A number of audit reports were presented to the Safeguarding Committee in Q3 for review and discussion. This included the following:

- The Children's Safeguarding Team have been involved in a Multi-agency Thematic audit with Newcastle Safeguarding Children's Partnership to review the Risk Factors relating to Serious Youth Violence, the initial findings for NUTH are very positive and the final audit report is due to be published imminently and will be presented at the Q4 Safeguarding Committee.
- Q3 audit demonstrated 83% completed assessments of capacity for patients subject to Urgent DoLS, noting this is slightly down on Q2 of 93%. 72% of assessments are seen as good or meeting minimal requirements, compared to Q2 as 86%. Audit results have been shared across the Clinical Boards and presented across relevant forums in Q4. The Q4 audit is in progress and a number of Clinical Boards have undertaken local audits which will be presented back to the MCA Steering Group.

5. LEARNING DISABILITY

5.1 Activity

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

The following activity trends are noted for Q3:

- There were 972 referrals into the team in 3 compared to 898 in Q2. This is a 25% increase compared to the same period last year where there were 737 referrals in Q3.
- There is a 27% increase in ED attendances in Q3 2023/24 in comparison to Q3 2022/23.

This increase in referrals into the team is creating operational pressure and impacting on improvement workstreams. Temporary resource has been identified to support from April 2024.

5.2 Education and Training

There has been no further national update following The Code of Practice (Health and Social Care Act 2008) consultation paper which closed in September 2023. The final outcome will outline the national mandatory requirements for learning disability and autism training. The Trust implemented the Diamond Standards Mandatory eLearning training for Learning Disabilities and Autism which is the current regionally endorsed programme. Trust compliance with e-learning Diamond Standards at 93.3%. This training was developed by the

Learning Disability Northeast and Cumbria Network and designed specifically for acute Trusts.

The Trust has participated in the regional pilot of Oliver McGowan Mandatory Training on Learning Disabilities and Autism led by the Learning Disability North-East and North Cumbria Network. This has exposed several challenges in relation to how this training is to be delivered and how training spaces can be booked. There will be more training spaces available, and the Trust Task and Finish Group will co-ordinate uptake of these spaces with specific teams.

It is recognised that to be compliant the Trust will either need to adopt the Oliver McGowan Training or significantly develop the Diamond Standard Training and enhance the autism content in the e-learning package. If this is not addressed the current training will not be compliant with national standard. This work is being discussed through the regional network.

5.3 Audit and Assurance

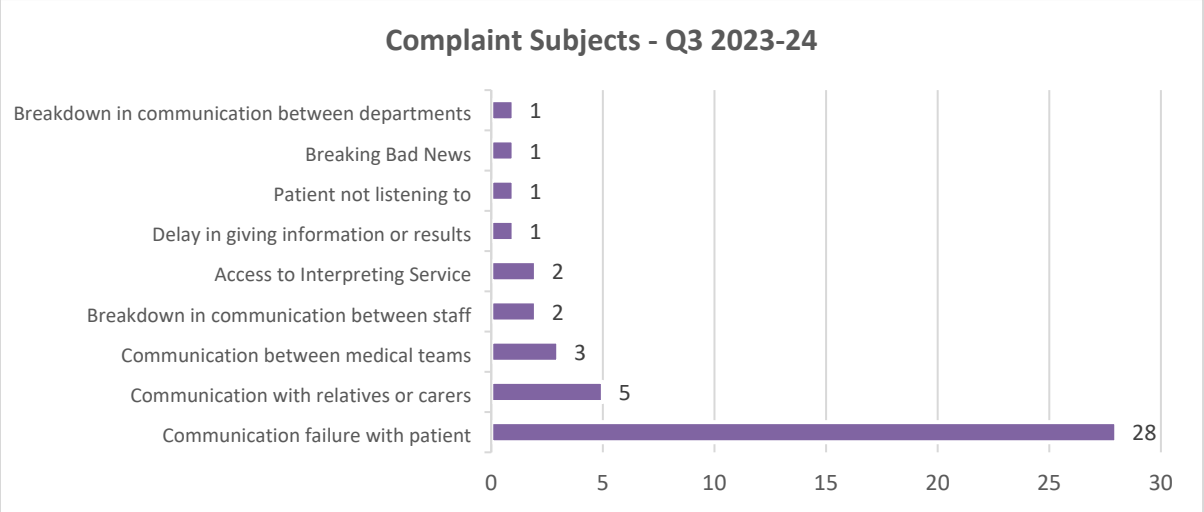
Audits undertaken in Q3 demonstrated an improvement in compliance with documenting a diagnosis of a learning disability on admission (+28%) and a small improvement (+3%) in consideration and documentation of reasonable adjustments. Whilst these are improved, they are below expected standard. Additional temporary capacity for the team has been agreed to support real time auditing and ward walking to increase understanding and impact care in real time. Further education materials are being designed to support staff to understand the use and re-use of hospital passports which will be available in April 2024. The Q4 audit is in progress.

6. PATIENT EXPERIENCE QUARTER 3 REPORT

6.1 Complaints Activity

The Trust has opened 152 formal complaints in Q3, which is an increase of 10% from the previous quarter. The Trust has received, on average, 46 formal complaints per month, which is consistent with the overall average for 2022/23.

In Q3, Medicine & Emergency Care received the most formal complaints, with 43 (28%), which is an increase of 6 complaints on the previous quarter.



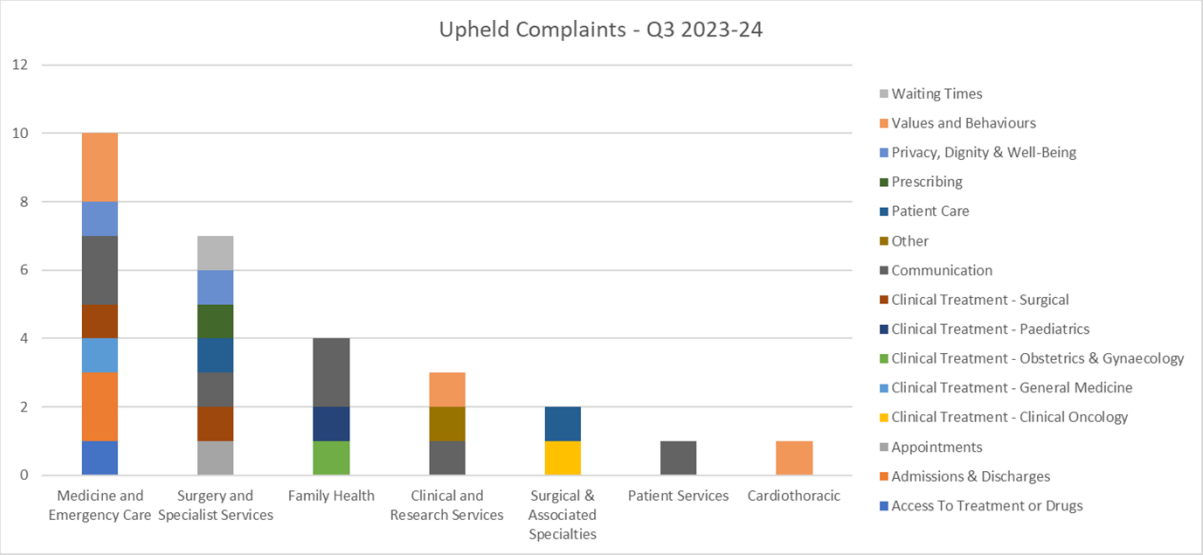
In accordance with previous quarters, 44 complaints (29%) opened in this quarter with a primary concern of 'communication'. Within this category, 64% related to 'communication failure with patient' and 11% related to 'communication failure with relatives or carers'.

The remaining complaints are split between: 'communication between medical teams,' 'breakdown in communication between staff,' 'access to interpreting service,' 'delay in giving information or results,' 'patient not listening to,' 'breaking bad news' and 'breakdown in communication between departments.'

6.2 KO41 Mandatory Return

This quarter, 159 formal complaints were closed, which is an increase of 25% from the previous quarter. Of these, 28 complaints were upheld, 31 were partially upheld, 79 were not upheld and 21 were withdrawn.

The table below shows the breakdown of the 28 upheld complaints between clinical boards and categories. Medicine and Emergency Care have the most upheld complaints with 10, accounting for 36% of all upheld complaints for this period. The most frequent category is communication with 25% of upheld complaints across five directorates: Surgical and Specialist Services (RVI), Clinical & Research Services, Medicine and Emergency Care, Patient Services and Family Health.



6.3 National Maternity Survey 2023

The Care Quality Commission (CQC) has published the results of the national maternity survey on 9 February 24 which have shown that Newcastle Hospitals has been rated as much better, better, or somewhat better than most trusts in a number of categories.

The survey took place in February 2023 and asked women about their experiences of care at three different stages of their maternity journey, antenatal care, labour and birth and postnatal care; 281 women who accessed maternity care at the Royal Victoria Infirmary took part.

Results show maternity services at Newcastle Hospitals were rated much better than most trusts for **1** question, better than most trusts for **4** questions, somewhat better than most trusts for **1** question. Results were about the same as other trusts for **48** questions.

The Trust was rated as:

- 'Much better' than others at asking about mental health after giving birth.
- 'Better' than others at providing help and advice to women who have given birth about feeding their baby and offering support and advice about a baby's health and progress.
- 'Somewhat better' than others at doing everything they could to help manage pain during labour and birth.

Although the Trust did not score 'worse' or 'much worse' than most other trusts for any question, there are 49 questions in the survey that were comparable to 2022, Seven of these questions had a statistically significant decrease for the Trust. These questions were:

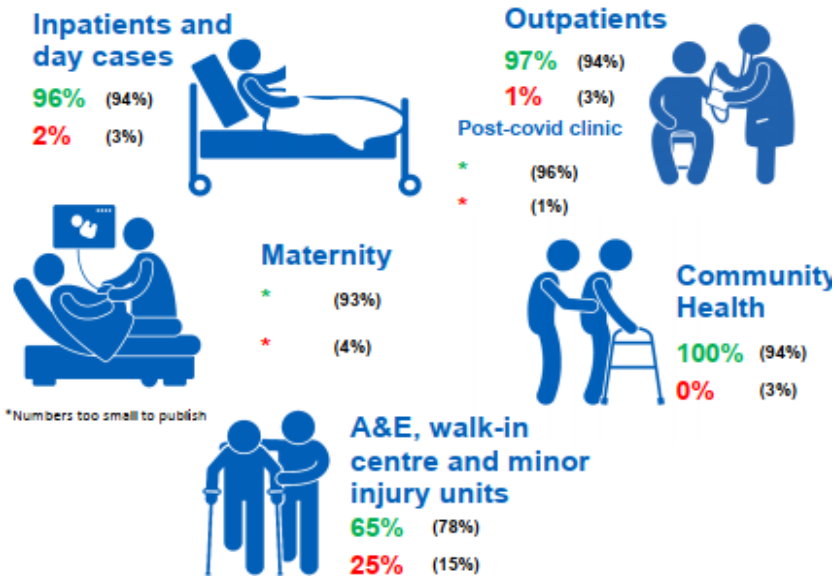
- Did you have confidence and trust in the staff caring for you during your antenatal care?
- On the day you left hospital, was your discharge delayed for any reason?
- If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?

- Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?
- Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?
- Did you have confidence and trust in the midwife or midwifery team you say or spoke to after going home?
- If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?

Results of the maternity survey are reported alongside other patient experience measures at the Maternity Feedback Forum and an action plan is in place to address the areas for improvement including actions around information provision, care planning and antenatal communication. The midwifery team have presented this action plan to the Patient Experience Monitoring Group.

6.4 NHS Friends and Family (FFT)

The following infographic displays the overall positive and negative ratings for the services in Dec 2023 (published February 2024). In December 2023 there were just 664 responses to the Friends and Family compared to 1,488 in the previous month. This drop in responses was due to an earlier collection date due to the Christmas period and some areas awaiting stock refresh.



6.5 PATIENT INVOLVEMENT AND ENGAGEMENT

6.5.1 Advising on the Patient Experience (APEX)

This quarter, APEX were only able to meet once where they were they heard about the quality improvement project underway in the Trust to improve the discharge process and were asked for their thoughts and experiences and to provide their comments on the information which would be provided on the Trust website.

APEX also heard about a research project looking into parent's anxieties around their child's food allergy; specifically, what makes them worried and what it is like for parents to live with the uncertainty of a food allergy.

6.5.2 Maternity Voice Partnership

Co-production has continued as the 'golden thread' with collaborative work continuing between Maternity Services and the MNVP but also extending to include other community and charity organisations.

Baby Loss Awareness Week was marked within the Trust a listening event with SANDs cemented MNVP links and were a valuable opportunity to hear the experiences and reflections of service users who have lived through pregnancy and infant loss, to inform the services and care provided to these families and potential for improvement.

The MNVP quarterly meeting provided a further opportunity for service user and stakeholder engagement with a focus on experiences in the postnatal period. Service user feedback captured through the Maternity Feedback Forum and CQC Maternity Survey indicates there is scope for improvement in this area, particularly postnatal ward experiences, and discussions within the meeting centered around what would improve this inpatient stay.

Representing the service user voice has continued as a central priority for the MNVP this quarter providing input to the drafting of the Maternity Strategy and an anaesthetic evaluation of analgesia used in the postnatal period. There has been significant emphasis on communication around the flexing availability of some of our services during times of surge resulting in the collective review of our communication strategy and the issuing of a co-produced position statement to provide centralised communication that ensures clarity and reassurance for our service users.

6.6 EQUALITY, DIVERSITY & INCLUSION (EDI)

6.6.1 Transgender Patient Clinical Policy

Over the past few months, there have been multiple cases of transgender patients requesting their name and gender marker on their hospital record to be changed to the name and gender they identify as. These cases have highlighted multiple challenges for both patients and staff to ensure changes made are in line with the law, are safe and provides a good patient experience.

Multiple discussions have taken place with services in the Trust, and it has been agreed that a Trust wide policy is required to determine the procedure upon a patient's request, how IT systems have to operate and the discussions that should be had with individual patients. This will ensure the Trust complies with its legal duties and can provide safe care that is decided with patients.

A task and finish group has been established to develop this with multiple service representatives, including medical records, IT, patient safety, radiology, laboratory medicine, maternity and paediatrics. There will also be engagement work with Be-North, a local trans charity, to consult on policy suggestions to ensure it delivers an excellent patient experience and individuals are involved in decision making. There will also be engagement with members of the staff PRIDE network who may also have lived experience as patients.

6.6.2 Engagement with people with learning disabilities

The hospital charity application submitted in September 2023 to work with Skills for People over two years to engage with people with learning disabilities has been successful. This programme of work will have three overlapping areas of work, which are:

1) Engagement and focus group work with people with learning disabilities
2) User-led service audits of specialties, called Quality Checks
3) Developing Easy Read information

The work was launched with an event in February at Skills for People, with prior communications and advertisement of the opportunity to people to get involved in this project.

Focus groups will start taking place from March and will be roughly every 6-8 weeks focusing on people's lived experience, their improvement suggestions and consulting on service improvements. Recruitment to the focus groups will be a continuous activity with the group open to new members at any point throughout the project. Trust patient information leaflets have also been identified and prioritised to start putting into Easy Read. Services in the Trust will also be approached and invited to take part in Quality Checks.

7. RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
21 March 2024

Ian Joy
Executive Director of Nursing

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024		
Title	Maternity Update Report		
Report of	Maurya Cushlow, Executive Chief Nurse Ian Joy, Executive Director of Nursing		
Prepared by	Lucy Patterson, Head 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 following the Care Quality Commission (CQC) inspection of the Maternity Service in January 2023, whose findings were published in May 2023. The maternity service was graded 'requires improvement' against the domains of 'well-led' and 'safe' as part of the national maternity inspection programme. The Trust met with the Integrated Care Board (ICB) on 12 February 2024 as part of the ongoing monitoring and assurance of progress against the action plan agreed as part of the System Oversight Framework (SOF) in December 2023. Trust Board are provided with an update against the SOF action plan. • Findings of the unannounced CQC core inspection of the Maternity Service in July 2023 were published on 24 January 2024. An update on the findings and actions from the July inspection is provided to Trust Board which includes a second action plan to be monitored as part of the continuing SOF. • Future papers will report Trust progress toward implementing the 'Three year delivery plan for Maternity and Neonatal Services' bi-annually as previously agreed. As previously reported the 'Three year plan' was published by NHS England (2023) in response to findings and recommendations from National maternity investigations including Ockenden.		
Recommendation	Trust Board is asked to: i) Receive and discuss the report; ii) Note the ongoing oversight and assurance from the ICB through the System Oversight Framework (SOF) in response to the final report of the CQC inspection in January 2023; iii) Note the formal findings of the CQC core inspection of Maternity in July 2023 published in January 2024 and the additional action plan to be monitored through the SOF; iv) Note future papers will report Trust progress in implementing the 'Three year plan'. v) Note the associated risks involved.		
Links to Strategic Objectives	Putting patients at the heart of everything we do. Providing care of the highest standards focussing on safety and quality.		

Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link. Risks are detailed within the main body of the report.					
Reports previously considered by Trust Board	Previous reports have been presented to Trust Board on Ockenden, The Kirkup Report, and The Maternity Incentive Scheme (CNST).					

MATERNITY SERVICES UPDATE

EXECUTIVE SUMMARY

This paper provides Trust Board members with an overview and update of the main 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 as part of the national maternity inspection programme, the results were published on 12 May 2023. The domains of 'safe' and 'well-led' were inspected resulting in an overall rating for the Maternity service as 'requires improvement'.

As previously reported to Trust Board, the Maternity Service continues to be monitored through a formal System Oversight Framework (SOF) by the ICB. Progress against the SOF agreed action plan (Appendix 1 Tab 1) is reported, through the Family Health Clinical Board's governance framework and detailed within this paper.

The Maternity Service received a further unannounced CQC core services inspection between 25-27 July 2023. Findings were published on 24 January 2024. The two key domains from the previous inspection were revisited, resulting in a reduction from 'good' to 'requires improvement' for well led. The inspection maintained the 'requires improvement' rating for safe. Trust Board are provided with an overview of additional findings from this inspection. The findings and recommendations were presented to the Director of Nursing and Midwifery for the ICB in a meeting with the Senior Maternity Leadership Team on 12 February 2024. Further actions have been developed into a second action plan (Appendix 1 Tab 2) to be monitored as part of the formal SOF.

Section 3 Trust Board are asked to note future papers will continue to report the Trusts' monitoring of compliance against implementing the 'NHS Three Year Plan for Maternity and Neonatal Services' on a bi-annual basis as previously agreed. Details of the 'Three year plan' were presented to Trust Board in May 2023 following publication in March 2023, with initial Trust benchmark status presented in July 2023. The 'Three year plan' was developed in response to national reports (Ockenden and Kirkup) with the intention that Trusts focus on one clear plan comprising four high-level themes divided into twelve objectives, a detailed progress update will be provided in future papers.

MATERNITY SERVICES UPDATE

1. INTRODUCTION

This paper provides Trust Board members with an overview and update of the main and quality considerations for the Maternity Service. This paper specifically relates to the actions undertaken in response to recent CQC inspections and progress on those actions.

2. CQC MATERNITY INSPECTION UPDATE

Trust Board members will recall that the Maternity services received a CQC inspection in January 2023. The national maternity inspection focused on the domains of 'safe' and 'well-led' and an overall rating of 'requires improvement' was published in May 2023.

As previously reported to Trust Board, the Maternity Service is subject to a formal SOF provided by the ICB due to the overall rating of 'requires improvement'. The Maternity CQC action plan (Appendix 1 Tab 1) has been developed in collaboration with the ICB to ensure robust monitoring and assurance is provided through agreed standards. The Maternity Action Plan was agreed by the ICB on 12 February 2024.

The Maternity service underwent an additional CQC core inspection in July 2023. The final report was published on 24 January 2024. The two key domains from the previous inspection were revisited, resulting in a reduction from 'good' to 'requires improvement' for well led. The inspection maintained the 'requires improvement' rating for safe. The findings and recommendations were presented to the Director of Nursing and Midwifery for the ICB in a meeting with the Senior Maternity Leadership Team on 12 February 2024. Further actions have been developed into a second action plan (Appendix 1 Tab 2) to be monitored as part of the formal SOF. Given the short timeframe from report publication in January 2024 to SOF meeting in February 2024, exit criteria for each action plan will be agreed at the next ICB quarterly review meeting in May 2024.

There were ten findings from the CQC core inspection relating to breach of statutory regulatory requirements that the Trust **must** action:

1. **The service must assess, monitor, and improve the quality and safety of the services and mitigate the risks relating to the health, safety and welfare of women, birthing people, and babies.**

The risk assessment recorded on the maternity electronic patient record (Badgernet) has become a mandatory field for completion at each contact with a health professional, in line with the Ockenden recommendations, to ensure personalised care is embedded within the service and women feel valued. Assurance will be monitored with a monthly audit to assess compliance. Results will be reviewed and monitored at the monthly Multi-Disciplinary Team (MDT) departmental meeting and feature as part of 'Three Year Plan' reporting to Trust Board.

2. **The service must ensure they are delivering fundamental standards of care that meets the needs of women, birthing people, and babies. This includes assessing the health and safety risks and doing all that is reasonably practicable to mitigate any such risks. This includes but is not limited to staffing, risk assessments and security.**

3. **The service must ensure that there are sufficient numbers of competent, skilled, and experienced midwifery and medical staff to meet minimum staffing levels and meet the care and treatment needs of women, birthing people, and babies. This includes but is not limited to ensure that the skill mix supports the acuity of patients.**

A BirthRate+ Midwifery and Support Staff workforce review was commissioned by the Trust in October 2023 in line with the nationally recommended three-year review timeframe, the outcome of this is expected in April 2024 and will be reported to Trust Board in future papers. Maternity Services undertake a comprehensive daily staffing to acuity assessment in correlation with the NENC Escalation Policy to ensure the service meets the needs of women, birthing people, and babies and mitigate risks associated with staffing via responsive local escalation as required. This is monitored at monthly Staffing vs Outcome meetings introduced to Maternity Services in January 2024 to align with monitoring processes in the wider Trust to ensure learning and quality improvements are made.

A Business Case has been submitted and approved to increase Obstetric Consultant capacity to enable a 52-week model of service delivery, with recruitment ongoing.

As above (2.1) pregnancy risk assessment completion is now mandated at each contact with a health professional with a monthly audit programme implemented for monitoring and assurance.

The security of Maternity Services has been collaboratively reviewed with the Security Team and the Baby Abduction exercise frequency increased to quarterly from annually to increase staff knowledge and vigilance; with the next exercise in March 2024. Security surveillance audits were introduced in January 2024 and are undertaken twice per month to monitor adherence to the Baby Abduction Policy with findings reported immediately to the Leadership Team to act upon as required. A further update will be provided in future papers.

4. **The service must ensure there are sufficient quantities of cardiotocography (CTGs), central monitoring equipment and cleaning equipment to ensure the safety of women, birthing people, and babies.**

The Trust have undertaken a gap analysis of cardiotocography (CTG) machines with a business case approved to secure 19 further CTG machines and replace 7 older CTG machines to ensure appropriate resource is available to enable timely, safe care of women, birthing people and babies and mitigate human factors via the consistency of the CTG fleet. Delivery is expected in March/April 2024 at which time central monitoring systems will be

installed to the Antenatal Ward, Daycare and Maternity Assessment Unit. An update will be provided in future papers.

5. **The service must ensure that mandatory and core competency training compliance meets the trust target.**

Targeted work is ongoing within the Maternity Service to ensure that mandatory training compliance meets the Trust target by 31 March 2024 and is maintained thereafter. The service aims to ensure that core competency training compliance meets nationally agreed targets within the Maternity Incentive Scheme timeframe for Year 6, expected to be December 2024-25. Wider work is in progress to understand the impact of increased training requirements on the core workforce. An update will be provided to the Executive Team and Trust Board once this work is completed.

6. **The service must ensure premises are safe. This includes but is not limited to ensuring storeroom doors are not left open or unlocked.**

As this was highlighted widely across the Trust at the time of core service inspection, midwifery leaders responsively raised awareness across the workforce and senior leaders continue to monitor on an ad hoc basis when walking around the maternity unit. As part of the wider Trust work in response to the CQC core services inspection Electronic & Biomedical Engineering (EBME)Estates Engineering have been requested to implement ward based zonal inspection and develop a compliance reporting mechanism for Clinical Boards, including non-patient doors security checks in zonal inspections.

7. **The service must ensure it encourages the identification, reporting and investigation of incidents and risks in a timely fashion and shares learning to improve safety and quality of the service.**

The Trust are in the process of developing a targeted and reactive approach to areas of under reporting. Working in collaboration with Quality and Safety (Q&S) Leads, Clinical Directors for Quality and Safety, Heads of Nursing/Midwifery and Matron's to provide proactive support to promote and encourage incident reporting and learning. Within Maternity Services the Non-Executive Director (NED) role as Patient Safety Champion has been reviewed and a programme of engagement and increased awareness will be implemented in March and April 2024 to strengthen understanding of the role with the output shared in future papers.

8. **The service must ensure newly qualified midwifery staff receive the appropriate support, training, professional development, and supervision as is necessary to enable them to carry out their duties.**

The Maternity Service offers a comprehensive preceptorship package comprised of bootcamp style training followed by bespoke supernumery supported rotations to ensure newly qualified midwifery staff receive individualised appropriate support, training, professional development, and supervision as is necessary to carry out their duties within

each area of the service. Regular touchpoint meetings are offered and conducted when accepted with newly qualified midwives in the first year of employment by the Recruitment, Retention and Pastoral Care Midwife, Practice Development Midwife and individual Team Leads.

9. **The service should ensure the guidance within their post-partum haemorrhage PPH policy is clear about defining and grading maternal blood loss in accordance with national guidance.**

Following the CQC inspection, a guideline review was undertaken and found to be compliant with national guidance, with findings presented regionally for further assurance. Communication has been shared widely within Maternity Services regarding the grading of PPH in accordance with the National Reporting and Learning System (NRLS) and a monthly audit programme has been introduced for 3 months following this communication to monitor understanding and consistency of grading within the workforce; audit findings will be shared in future papers.

10. **The service should ensure that clinical sharps waste bins are dated and labelled in accordance with national guidance.**

Maternity Services are included in the work ongoing within the wider Trust to ensure clinical sharps waste bins are labelled in accordance with national guidance. However, communication has been shared locally within Maternity Services to raise awareness and ensure understanding of clinical expectations with a 3-month ad hoc audit programme to be undertaken to ensure compliance.

A meeting was held with the ICB on 12 February 2024 to review the Trust's position against the existing action plan and SOF in view of the additional findings and recommendations made by the CQC's core inspection report. It was acknowledged these should be reviewed in totality when agreeing exit criteria from the Framework and to ensure alignment with the work underway more widely across the Trust and it is therefore expected this exercise will be undertaken in May 2024.

3. THREE YEAR PLAN

Trust Board are asked to note future updates will report progress quarterly against implementing the 'NHS Three Year Plan for Maternity and Neonatal Services' as previously agreed. Trust Board members will recall, details of the 'Three year plan' were presented in May 2023 following publication in March 2023, with initial Trust benchmark status presented in July 2023. The 'Three year plan' was developed in response to national reports (Ockenden and Kirkup) with the intention that Trusts focus on one clear plan comprising four high-level themes divided into twelve objectives, a detailed progress update will be provided in future papers as workstreams are aligned with the CQC action plan to form an overarching quality improvement plan for Maternity Services.

4. CONCLUSION

Trust Board members are provided with an update against the CQC action plan relating to the January 2023 maternity inspection findings via the action plan developed and agreed as part of the ICB SOF. The Trust continue to monitor and progress the action plan and reports through the Family Health Clinical Board and externally on a quarterly to the ICB as part of the SOF.

The findings of the additional unannounced core inspection undertaken in July 2023 were published on 24 January 2024, where the two key domains from the previous inspection were revisited, resulting in a reduction from 'good' to 'requires improvement' for well led. The inspection maintained the 'requires improvement' rating for safe. The findings and recommendations were presented to the Director of Nursing and Midwifery for the ICB in a meeting with the Senior Maternity Leadership Team on 12 February 2024. Further actions have been developed into a second action plan to be monitored as part of the formal SOF with exit criteria expected to be agreed with the ICB in May 2024.

Trust Board are asked to note future papers will report the Trusts' monitoring of compliance against implementing the 'NHS Three Year Plan for Maternity and Neonatal Services'. The Trust benchmark status against the 'Three Year Plan' were presented in July 2023 and in subsequent papers reported to Trust Board. The intention of the 'Three Year Plan' is to focus Trusts on one clear plan comprising four high-level themes divided into twelve objectives, a detailed progress update will be provided in future papers as all workstreams are aligned together with the CQC action plan to form an overarching quality improvement plan for Maternity Services.

5. RECOMMENDATIONS

Trust Board is asked to:

i) Receive and discuss the report;
ii) Note the ongoing oversight and assurance from the ICB through the SOF in response to the final report of the CQC inspection in January 2023;
iii) Note the formal findings of the CQC core inspection of Maternity in July 2023 which were published on 24 January 2024 and the associated actions and ongoing oversight and assurance with ICB SOF;
iv) Note that future updates will report Trust implementation and monitoring against the 'Three year plan';
v) Note the associated risks involved.

Report of Maurya Cushlow **Ian Joy**
Executive Chief Nurse **Executive Director of Nursing**
22 March 2024

Maternity Report

Unique Action ID	Action	Action Owner	Must Do Desc	Regulation	Theme	Within report 2 - Maternity	Trust Wide or Board Specific	1 - Family Health
A-016	We will ensure staff complete daily checks of emergency equipment, and ensure equipment used by staff and women and birthing people is in date, checked regularly and safe for the intended purpose.	Lucy Patterson (Head of Midwifery)	The trust must ensure staff complete daily checks of emergency equipment. They must ensure equipment used by staff and women and birthing people is in date, checked regularly and safe for the intended purpose. Regulation 12(1)(2)(e)			Yes	Board Specific	Yes
A-017	We will ensure staff appraisal rates meet the Trust target of 95% by March 2024 and compliance is maintained thereafter.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations)	The trust must ensure all staff receive such appraisal as is necessary to carry out their duties. Regulation 18 (1)(2)(a)	18 (1)(2)(a)	NOT ASSIGNED	Yes	Board Specific	Yes
A-018	We will ensure the proper and safe management of medicines, ensuring out of date medicines are removed and medicines are stored securely.	Lucy Patterson (Head of Midwifery)	The trust must ensure the proper and safe management of medicines, ensuring out of date medicines are removed and medicines are stored securely. Regulation 12 (1)(2)(g)	12 (1)(2)(g)	NOT ASSIGNED	Yes	Board Specific	Yes
A-019	We will ensure that mandatory training compliance including the appropriate level of safeguarding adults and children training meets the Trust target by March 2024 and is maintained thereafter.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations)	The Trust should ensure that all staff complete the required mandatory training including the appropriate level of safeguarding adults and children training. (Regulation 12)			Yes	Board Specific	Yes
A-020	We will ensure all areas are clean and staff use control measures to prevent the spread of infection.	Lucy Patterson (Head of Midwifery) Tara Robinson (Hotel Services Manager)	The Trust should ensure all areas are clean and staff use control measures to prevent the spread of infection. (Regulation 12)			Yes	Board Specific	Yes
A-021	We will ensure sufficient midwifery staff deployed to keep women, birthing people, and babies safe.	Lucy Patterson (Head of Midwifery) Lisa Jordan (Associate Director of Operations)	The Trust should ensure sufficient midwifery staff are deployed to keep women, birthing people and babies safe. (Regulation 18)			Yes	Board Specific	Yes

A-022	We will 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.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations) Rob Smith (Director of Estates)	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. (Regulation 15)			Yes	Board Specific	Yes
A-023	We will ensure staff fully complete all aspects of modified obstetric early warning scores in order to assess the risks to women and birthing people.	Rhona Collis (Quality and Clinical Effectiveness Midwife)	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.			Yes	Board Specific	Yes
A-024	We will continue to monitor the security of the unit in line with national guidance.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations)	The Trust should continue to monitor the security of the unit to be reviewed in line with national guidance.			Yes	Board Specific	Yes
A-025	We will introduce a robust formal triage and escalation process within the maternity assessment unit.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations)	The Trust should continue work to introduce a robust formal triage and escalation process within the maternity assessment unit.			Yes	Board Specific	Yes

Unique Action ID	Progress Updates	Completion Status	Timescale for Completion	Action RAG	Link to Additional Resources
A-016	1) The Trust implemented immediate actions to meet with this requirement following CQC inspection in January 2023. Clinical Standards Checklists for each area/ward were standardised and embedded across every department in line with Trust wide templates since June 2023. 2) An additional interim local operational SOP has been introduced in January 2024 for enhanced assurance of daily compliance. Increased oversight is established with a supporting framework for compliance tolerance targets and responsive actions led by the responsible Midwifery Matron. Weekly oversight of Trust wide compliance tolerance targets and responsive actions are monitored via the Director of Midwifery Meeting with data then feeding into the monthly Nursing and Midwifery Professional Meeting with the Director of Operations and Clinical Board Chair. 3) Compliance for February 2024 was as follows: Adult Resus 100%, Neonatal Resus 97%.	Live	Enhanced weekly monitoring to be implemented until the end of March 2024; practice expected to be embedded and compliance maintained with step down to CAT Tool only for monthly monitoring from April 2024.	Compliant with mechanism for ongoing monitoring and reporting to ensure practice is embedded.	Clinical Standards Checklists Weekly Leaders Assurance Checklist Interim Local SOP for enhanced assurance Weekly DoM Meeting Minutes Enhanced Weekly Audit / CAT Tool Results
A-017	1) The Trust immediately undertook targeted work to improve appraisal rates towards the Trust target of 95%. 2) The appraisal process for Midwifery and Support Staff was reviewed in Q3 2023 and the 'Maternity Family Tree' for Midwifery and Support Staff launched in February 2024 alongside expectation and process guidance for both appraisers and appraisees. 3) The appraisal rate in February 2024 was as follows: Medical Staff 60%, Midwives 84%, Support Staff 84%. Actions are in place to meet with Trust compliance target by 31st March 2024.	Live	Trust Target of 95% compliance met and sustained by 31st March 2024.	Partial Compliance with mechanism for ongoing monitoring with a trajectory for compliance to be achieved and sustained.	Midwifery and Support Staff Appraisal Process and 'Maternity Family Tree' DMT Meeting Minutes Monthly HR Dashboard Monthly Consultants Meeting Minutes
A-018	1) The Trust implemented immediate actions to meet with this requirement following CQC inspection in January 2023. The storage of medication and IV Fluids was reviewed in each area in collaboration with the Estates Department and necessary action taken to ensure all are stored in locked cupboards behind a locked door in each area/ward. Fridge and Freezer temperature monitoring templates for each area/ward were standardised and embedded across every department in line with Trust wide templates since June 2023. 2) An additional interim local operational SOP has been introduced in January 2024 for enhanced assurance of daily compliance. Increased oversight is established with a supporting framework for compliance tolerance targets and responsive actions led by the responsible Midwifery Matron. Weekly oversight of Trust wide compliance tolerance targets and responsive actions are monitored via the Director of Midwifery Meeting with data then feeding into the monthly Nursing and Midwifery Professional Meeting with the Director of Operations and Clinical Board Chair. 3) Maternity fridge temperature monitoring compliance for February 2024 was 99%.	Live	Enhanced weekly monitoring to be implemented until the end of March 2024; practice expected to be embedded and compliance maintained with step down to CAT Tool only for monthly monitoring in April 2024.	Compliant with mechanism for ongoing monitoring and reporting to ensure embedded practice.	Fridge and Freezer Monitoring Checklist Interim Local SOP for enhanced assurance Weekly DoM Meeting Minutes Monthly Consultant Meeting Minutes
A-019	In February 2024 Trust wide mandatory training compliance was as follows: Midwives 88%, Support Staff 93% and Medical Staff 80%. Safeguarding Children Level 3 90%.	Live	Trust wide mandatory training target of 95% compliance met and sustained by 31st March 2024. Maternity specific training compliance will follow the requirements of MIS.	Partially Compliant	DMT Meeting Minutes Monthly HR Dashboard Monthly Consultants Meeting Minutes Quality Committee Paper Trust Board Paper
A-020	1) The Trust implemented immediate actions to meet with this requirement following CQC inspection in January 2023. Clinical Standards Checklists for each area/ward were standardised and embedded across the department in line with Trust wide templates since June 2023. Clinical Standards are monitored and reported through the Trust-wide monthly Clinical Assurance Tool (CAT). 2) In March 2024 a departmental programme for Ward Manager peer review of clinical areas has been introduced bimonthly in addition to the quarterly peer review by an external Matron as part of the Trust peer review process. 3) To further strengthen the assurance process in maternity services, environment cleaning standards are triangulated on a monthly basis with Domestic Services Supervisor.	Live	Monthly monitoring ongoing to maintain compliance.	Compliant, with mechanism for ongoing monitoring and reporting to ensure embedded practice.	Clinical Standards Checklists Weekly Leaders Assurance Checklist Weekly DoM Meeting Minutes CAT Tool Results Monthly Maternity Cleaning Standards Meeting
A-021	1) A BirthRate+ staffing review was commissioned in October 2023, data is currently being collected and a report is expected in Spring 2024. Daily staffing to acuity assessments are undertake in correlation with NENY Escalation policy and shared regionally and monitored at the monthly Staffing vs Outcome oversight meeting with remedial actions plans as required. 2) Midwifery and support staffing skill mix were be reviewed in March 2024 and baseline requirements agreed for each ward/area. 3) The Trust have introduced a quarterly rolling midwifery recruitment programme and the introduction of the Midwifery Workforce Improvement Strategy in October 2023.	Live	BirthRate+ Staffing Review; Daily NENY Sitrep; Monthly Staffing vs Oversight Group Monitoring Template; Midwifery and Support Staffing skill mix assessment; Midwifery staff baseline for each area/ward; medical staffing business case	Compliant with a mechanism in place for monitoring and reporting.	NENC Daily SitRep and SOP Daily Monitoring and Mitigation Action Log Staffing vs Outcome Meeting Minutes Workforce Improvement Strategy ECN Slides

A-022	1) Estates and environmental work across the service is a priority, however, the existing estate has limitations which requires significant change to bring resolution. Bespoke work is currently being explored to refurbish the bereavement facilities on Delivery Suite to improve the provision of privacy and dignity for families. Architect drawings have been completed outlining proposals for the bereavement suite which will be evaluated by staff and service users for comment. 2) A Delivery Suite focused 15 steps will be prioritised as part of the 2024-25 MNVP Workplan, currently being drafted.	Live	The timescale for completion is expected to be 2024.	Partially Compliant	Architectural Drawings for the Halcyon Suite Risk Register Service User 15 steps output
A-023	1) The Trust introduced an electronic Modified Early Warning Score (MEWS) system e-obs in July 2023. This has enabled a continuous process of review in relation to completion of MEWS, and greater quality assurance through audit. 2) The compliance rate in February 2024 is significantly below Trust compliance target. Compliance will significantly improve with the introduction of the interface between eobs and Badgernet due to the removal of data duplication and therefore improved audit accuracy in, the interface is in the testing as at 01.03.24 .	Live	Trust Target of 90% compliance met and sustained by April 2024.	Partially Compliant	Monthly audit of eobs Monthly audit of MEWS documentation in Badgernet for Outpatient Areas Quality and Safety Clinical Board Minutes Staffing vs Outcome Action Log
A-024	1) Estates improvements from the learning from 2022 annual Baby Abduction Drill undertaken and tested in the October 2023 Baby Abduction Drill. 2) The programme of Baby Abduction Drills has increased to quarterly frequency for 2024 with the next drill to take place in March 2024. The drill programme this year will include the Neonatal Intensive Care Unit.	Live	To undertake review of 3 month audit findings in March 2024 pending action plan.	Partially Compliant	2022 Baby Abduction Report and Action Plan 2023 Baby Abduction Report and Action Plan Monthly Audit Infographics General Meeting Minutes
A-025	The Trust implemented a bespoke electronic Maternity Triage system (BSOTS) in December 2023. A monthly audit programme has been implemented with a monthly oversight group for quality improvement review and oversight.	Live	To undertake review of 3 month audit following implementation findings in March 2024 pending action plan.	Partially Compliant	BSOTS SOP BSOTS Dashboard BSOTS Monthly Oversight Group Action Log Staffing vs Outcome Action Log ECN Slide Deck

	Maternity Specific - Core						
Unique Action ID	**Action**	**Action Owner**	**INTERNAL - Additional Action Information**	**Must Do Desc**	**SRO**	**Trust Wide or Board Specific**	**1 - Family Health**
A-167	The risk assessment recorded on Badgernet will become a mandatory field for completion at each contact with a health professional in line with the Ockenden IEA's with a monthly audit undertaken to monitor compliance for review at the monthly MDT Ockenden departmental meeting.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director)		The service must assess, monitor, and improve the quality and safety of the services and mitigate the risks relating to the health, safety and welfare of women, birthing people, and babies. Regulation 17(1)(2)(a)(b).	1	Board Specific	Board Specific
A-168	We will ensure we are meeting the needs of women, birthing people, and babies and mitigate risks associated with staffing, pregnancy risk assessments and security through monthly audit, monitoring of findings and remedial action plans as required.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations)		The service must ensure they are delivering fundamental standards of care that meets the needs of women, birthing people, and babies. This includes assessing the health and safety risks and doing all that is reasonably practicable to mitigate any such risks. This includes but is not limited to staffing, risk assessments and security. Regulation 12 (1)(2)(a)(b).		Board Specific	Board Specific
A-169	Ensure there are sufficient numbers of competent, skilled and experienced midwifery and medical staff to meet minimum staffing levels and meet the care and treatment needs of women, birthing people, and babies.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations)		The service must ensure that there are sufficient numbers of competent, skilled, and experienced midwifery and medical staff to meet minimum staffing levels and meet the care and treatment needs of women, birthing people, and babies. This includes but is not limited to ensure that the skill mix supports the acuity of patients. Regulation 18 (1)(2)(a).		Board Specific	Board Specific
A-170	Undertake a gap analysis of cardiotocography (CTGs), and cleaning equipment and prepare a business case to secure funding based on need to ensure the safety of women, birthing people, and babies.	Lucy Patterson (Head of Midwifery) Lisa Jordan (Associate Director of Operations)		The service must ensure there are sufficient quantities of cardiotocography (CTGs), central monitoring equipment and cleaning equipment to ensure the safety of women, birthing people, and babies. Regulation 12 (1)(2)(f).	2	Board Specific	Board Specific
A-171	We will ensure that mandatory training compliance meets the Trust target by March 2024 and is maintained thereafter. The service will ensure that core competency training compliance meets nationally agreed targets within the MIS timeframe for Year 6, expected to be December 2023-24.	Lucy Patterson (Head of Midwifery) Paul Moran (Clinical Director) Lisa Jordan (Associate Director of Operations)		The service must ensure that mandatory and core competency training compliance meets the trust target. Regulation 12 (1)(2)(c).	2	Board Specific	Board Specific

A-172	EBME/Estates Engineering to implement ward based zonal inspection and develop compliance reporting mechanism for clinical boards including non-patient doors security checks in zonal inspections	Lucy Patterson (Head of Midwifery) Lisa Jordan (Associate Director of Operations)	To be compared against the Trust level action when populated	The service must ensure premises are safe. This includes but is not limited to ensuring storeroom doors are not left open or unlocked. Regulation 12 (1)(2)(d).	2		
A-173	Develop a targeted and reactive approach to areas of under reporting, and with Q & S Leads, CDs for Quality and Safety and Heads of Nursing/Matron's provide proactive support to promote and encourage incident reporting and learning.	Rhona Collis (Quality and Clinical Effectiveness Midwife)	To be compared against the Trust level action when populated	The service must ensure it encourages the identification, reporting and investigation of incidents and risks in a timely fashion and shares learning to improve safety and quality of the service. Regulation 17 (2)(b).			
A-298	We will ensure newly qualified midwifery staff receive the appropriate support, training, professional development, and supervision as is necessary to carry out their duties. Note link to trust wide action	Lucy Patterson (Head of Midwifery)		The service must ensure newly qualified midwifery staff receive the appropriate support, training, professional development, and supervision as is necessary to enable them to carry out their duties. Regulation 18 (1) (2) (a)		Board Specific	Board Specific
A-299	We will ensure the guidance within the PPH policy is clear about the definition and grading of maternal blood loss in accordance with national guidelines.	Paul Moran (Clinical Director)		The service should ensure the guidance within their PPH policy is clear about defining and grading maternal blood loss in accordance with national guidance.		Board Specific	Board Specific
A-300	We will ensure clinical sharps waste bins are labelled in accordance with national guidance.	Lucy Patterson (Head of Midwifery)		The service should ensure that clinical sharps waste bins are dated and labelled in accordance with national guidance.		Board Specific	Board Specific

Unique Action ID	How will compliance be evidenced		Progress Updates	Completion Status	Timescale for Completion	Link to Additional Resources
A-167	Monthly audit		1) The risk assessment field within the EPR will become mandatory from 19.02.24; with a monthly audit undertaken thereafter.	Not live yet	Ongoing with audit schedules to monitor compliance	Monthly audit
A-168	Birth Rate Plus Staffing Review; a daily staffing to acuity assessment in correlation with NENC Escalation Policy will be undertaken and shared regionally; with findings monitored at monthly Staffing vs Outcome oversight meeting Pregnancy risk assessment monthly audit Monthly security audit and quarterly baby abduction drills		1) A BirthRate+ staffing review was commissioned in October 2023, data is currently being collected and a report is expected in Spring 2024. Daily staffing to acuity assessments are undertake in correlation with NENY Escalation policy and shared regionally and monitored at the monthly Staffing vs Oversight meeting with remedial actions plans as required. 2) The risk assessment field within the EPR will become mandatory from 19.02.24; with a monthly audit undertaken thereafter. 3) A monthly security audit programme commenced in January 2024 to monitor compliance with the Baby Abduction Policy with findings shared with the workforce. The frequency of Baby Abduction Drills increased in 2024 with a drill planned to be undertaken quarterly and report shared with the Quality Oversight Group within the Family Health Clinical Board.	Live	Current governance processes are robust but will be strengthened by these actions. BirthRate+ Staffing Review data collection to be completed in March 2024, with report expected April 2024.	BirthRate+ Staffing Review; Daily NENY Sitrep; Monthly Staffing vs Oversight Group Monitoring Template; Pregnancy Risk Assessment Audit; Monthly Security Audit and Quarterly Baby Abduction Drill reported to QOG within Family Health Clinical Board
A-169	Birth Rate Plus Staffing Review; a daily staffing to acuity assessment in correlation with NENC Escalation Policy will be undertaken and shared regionally; with findings monitored at monthly Staffing vs Outcome oversight. Sufficient medical staff will be employed to support delivery of a 52 week model of service delivery.		1) A BirthRate+ staffing review was commissioned in October 2023, data is currently being collected and a report is expected in April 2024. Daily staffing to acuity assessments are undertake in correlation with NENY Escalation policy and shared regionally and monitored at the monthly Staffing vs Oversight meeting with remedial actions plans as required. Midwifery and support staffing skill mix were reviewed in March 2024 and baseline requirements agreed for each ward/area. 2) In January 2024 a scoping exercise of medical staffing was undertaken, and a business case approved. Recruitment is ongoing.	Live	Current governance processes are robust but will be strengthened by these actions. BirthRate+ Staffing Review data collection to be completed in March 2024, with report expected April 2024.	BirthRate+ Staffing Review; Daily NENY Sitrep; Monthly Staffing vs Oversight Group Monitoring Template; Midwifery and Support Staffing skill mix assessment; Midwifery staff baseline for each area/ward; medical staffing business case; Obstetric medical workforce planning document and Safety Champion Meeting Minutes
A-170	A dedicated CTG machine will be available in each antenatal or high risk intrapartum bedspace within maternity services, at each station within Maternity Triage and Daycare, and 2 available on Newcastle Birthing Centre if required. Central monitoring equipment will be available within each antenatal and high risk intrapartum area and adequate cleaning equipment will be available when required.	CTG and central monitoring scoping exercise, gap analysis and Business Case; cleaning equipment scoping exercise	1) In January 2024 a scoping exercise was undertaken to ascertain 19 new CTG's, 7 replacement CTG's and 3 central monitoring facilities were required to meet demand. A business case approved in February 2024 with equipment expected to be delivered in March/April 2024. 3) A cleaning equipment scoping exercise will be undertaken in March 2024.	Live	31st March 2024 for delivery of any outstanding equipment	CTG business case Gap analysis
A-171	Midwifery and Support Staff Trust wide mandatory training is monitored on a monthly basis at the Directorate Management Group in collaboration with HR Manager, and medical staff at the monthly Consultants Meeting. Monthly monitoring of core competency training compliance against MIS target is undertaken at a monthly maternity training meeting and trajectory for achieving and sustaining agreed. This is reported bi-monthly to Quality Committee and Trust Board.	Trust wide mandatory training and core competency training compliance and trajectory for achievement.	1) As at 05.02.24 Trust wide mandatory training compliance is as follows: Midwives 88%, Support Staff 93% and Medical Staff 80%. 2) As at 27.02.24 core competency training compliance is as follows: Obstetric Emergencies Training Day 82%, Maternity Safety and Public Health in Practice Day 62% and Fetal Wellbeing Training Day 61%; the service is on target to achieve MIS compliance within the nationally agreed timeframe and is currently scoping the resource required to increase the nationally mandated 4th core competency training day in the future.	Live	Trust wide mandatory training target of 95% compliance to be met by 31st March 2024 and sustained thereafter. Maternity specific training compliance will meet the requirements of MIS.	DMT Meeting Minutes Monthly HR Dashboard Monthly Maternity Training Meeting Minutes Monthly Consultants Meeting Minutes Quality Committee Paper Trust Board Paper

A-172			Further discussion with Estates colleagues to be undertaken to finalise actions and timeframes.	Not live yet	TBC	
A-173						
A-298	The service has a robust preceptorship programme comprised of bootcamp style training followed by bespoke supervised supernumary supported rotations in each area of maternity services tailored as required on an individual basis to the needs of the midwife. Regular touch point meetings are offered and conducted when accepted with newly qualified midwives throughout the first year of employment by the Recruitment Retention and Pastoral Care Midwife, Practice Development Midwife and Team Leaders.	Preceptorship programme for supervision and support in place for each newly qualified Midwife with evaluation a 6 and 12 months post recruitment.	As at February 2024, over the past 12 months 20 midwives have undertaken the preceptorship programme and have evaluated their experience highly. A further 26 midwives have commenced the programme in Q3 and are currently being supported with evaluation pending.	Live	Ongoing in line with rolling recruitment programme	Preceptorship Programme Preceptorship Experience Evaluation at 6 and 12 months
A-299	A PPH audit was undertaken and Badgernet documentation reviewed.		1) A guideline review was undertaken in November 2023 and found to be compliant with national guidance. A PPH audit and Badgernet documentation review was undertaken in Q3 and highlighted double recording of PPH MBL on Badgernet . 2) In February 2024 communication will be shared widely within the maternity team to ensure clarity of datix grading in accordance with the NRLS system and a monthly audit undertaken in the following 3 months to monitor consistency of grading and clarity of understanding by staff.	Live	May-24	Maternity Dashboard 3 month audit data
A-300	Monthly adhoc audits will be undertaken within each clinical area for 3 months to monitor compliance.		A Briefing in a minute was circulated on 08.03.24 to all staff working within maternity services and a monthly audit is scheduled for the 3 months following this communication to monitor compliance in each clinical area.	Live	May-24	Briefing in a Minute 3 month audit data

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024					
Title	Learning from Deaths (October 2023 – December 2023)					
Report of	Angela O'Brien, Director of Quality and Effectiveness					
Prepared by	Pauline McKinney, Quality & Assurance Lead					
Status of Report	Public		Private		Internal	
	☒		☐		☒	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☒		☐	
Summary	This paper aims to provide assurance to the 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 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 Board is asked to (i) receive the report and (ii) note the actions taken to further develop the mechanisms for sharing learning across the Trust.					
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					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☐	☒	☐
Link to Board Assurance Framework [BAF]	Provision of 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 Quality Committee on 19 March 2024.					

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 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

Learning from deaths is essential and links to our Trust values. Reviewing the care provided to people can help improve services for all patients by identifying problems. associated with poor care, and working to understand how and why these occurred so that meaningful action can be taken.

Although this view has always been a priority for The Newcastle upon Tyne NHS Foundation Trust, the National Quality Board (NQB) published its first guidance in 2017 on Learning from Deaths. This guidance framework focused on how NHS Trusts and Foundation Trusts are to identify, report, investigate and learn from deaths in care.

In keeping with NQB guidance, this report details mortality quality metrics, which are used to reassure the Quality Committee and Trust Board that the Trust is committed to monitoring inpatient deaths and learning from any unfortunate outcomes.

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 and Clinical Boards. The database captures all mortality reviews and centralises the findings in one place for all level 2 mortality reviews.

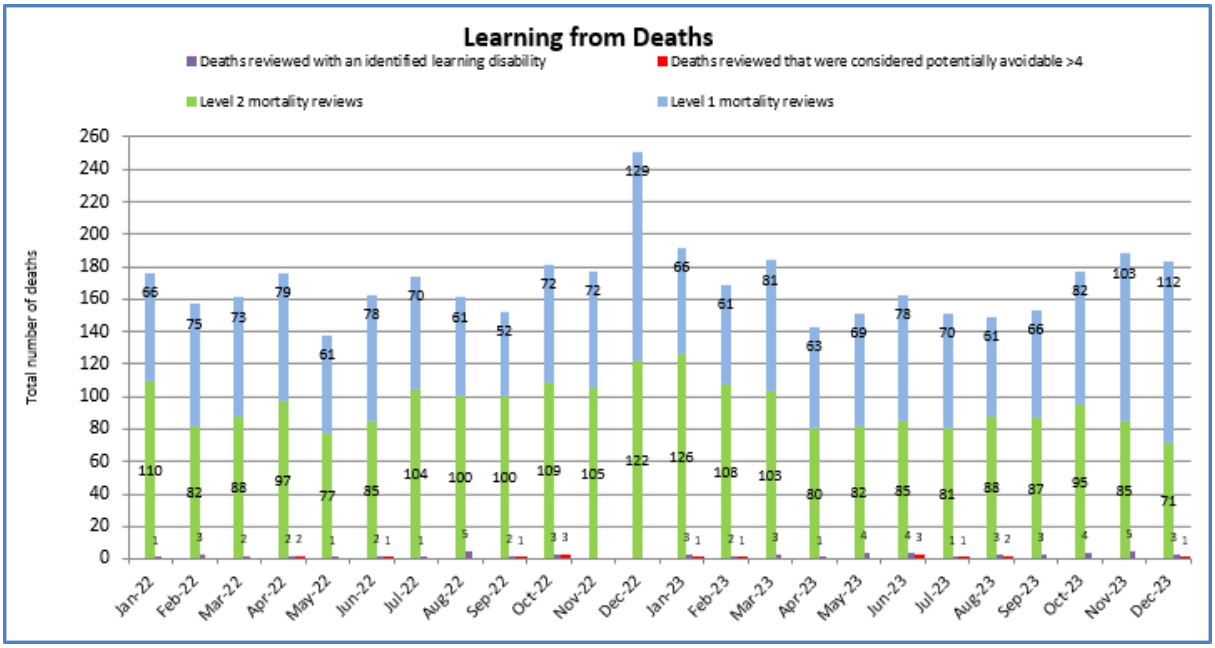
Level 1: The reviewer reviews the cause of death and discusses with the certifying doctor and Medical Examiner.

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.

2.1 Inpatient Deaths

In the 12-month period (January 2023 – December 2023), 2,003 patients died within Newcastle Hospitals, with 1,000 (49%) of those patients receiving a level 2 mortality review. There is a possibility that these mortality review figures will 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 (January 2022 – December 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.



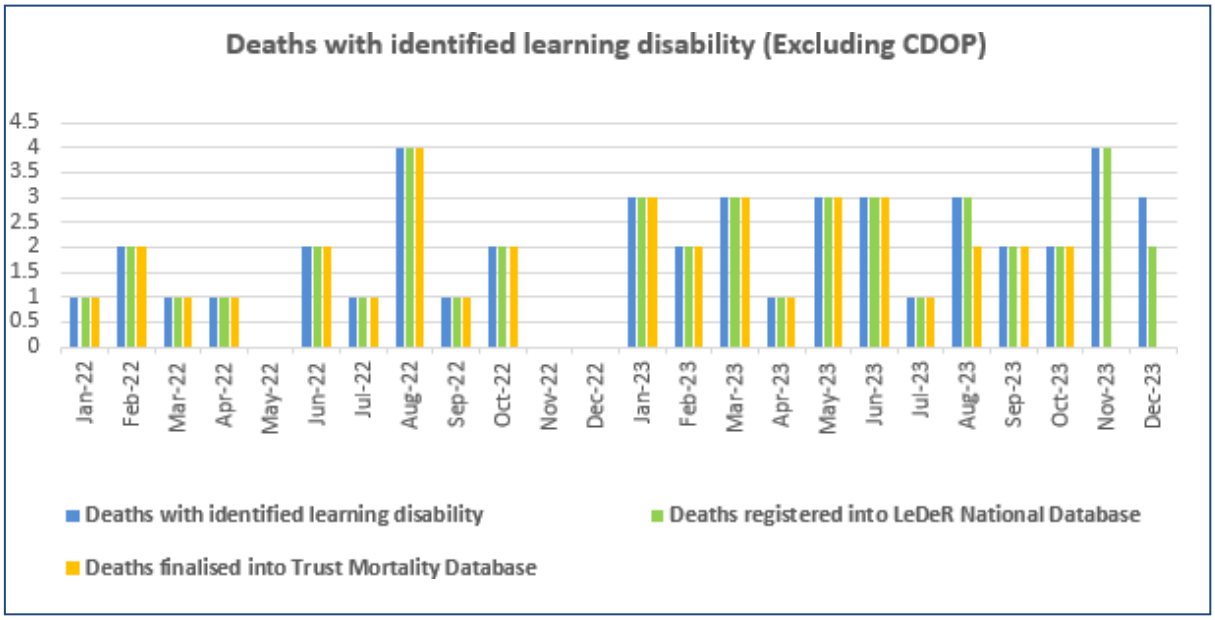
2.2 Patients identified with a Learning Disability

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 (January 2023 – December 2023), 36 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.

It was agreed by the National LeDeR programme in June 2023, that any patient <18years, are no longer required to be registered into the National LeDeR database, this is due to duplication within the Child Death Overview Panel (CDOP) investigation.

The graph below shows the data for the past 24 months (January 2022 – December 2023) and includes those patients who have been registered into the national LeDeR database and Trust mortality review database.



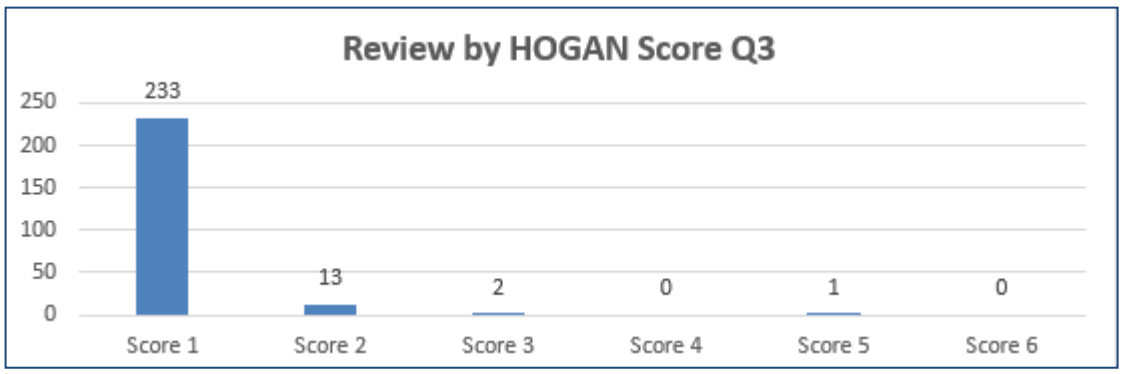
2.3 Outcome of Case Reviews – Hogan Score

Throughout Q3 (October 2023 – December 2023), 545 patients died, of which 249 have received a full case note review (Level 2), which was undertaken by a multidisciplinary team, and findings recorded into 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 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 Q3 are summarised in the graph below:



The graph shows one patient was recorded as HOGAN 5 in Q3. The patient who was graded a HOGAN 5 received an in depth discussion at the serious incident triage panel, the panel agreed the incident required reporting as a serious incident and an investigation is currently underway.

3. KEY LEARNING POINTS

The National Quality Board (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 Q3 are detailed below, together with what action has been taken. Clinicians from each Directorate are also encouraged to share relevant learning from local mortality reviews with their own Clinical Board and any other Clinical Board throughout the Trust that may benefit from the learning identified.

Learning points identified from case reviews undertaken in Q3.

Directorate	Speciality	Summary	Learning Point	Outcome
Peri-operative and Critical Care	Critical Care	Noted to have very high lipid levels and these could be the result of propofol infusion syndrome, propofol stopped and alternative sedation started.	Consider the risks of propofol infusion syndrome especially in patients with risk factors. Monitor triglyceride levels as per sedation guideline and consider switch to alternative sedative.	Review of sedation practices in critical care review is in progress.

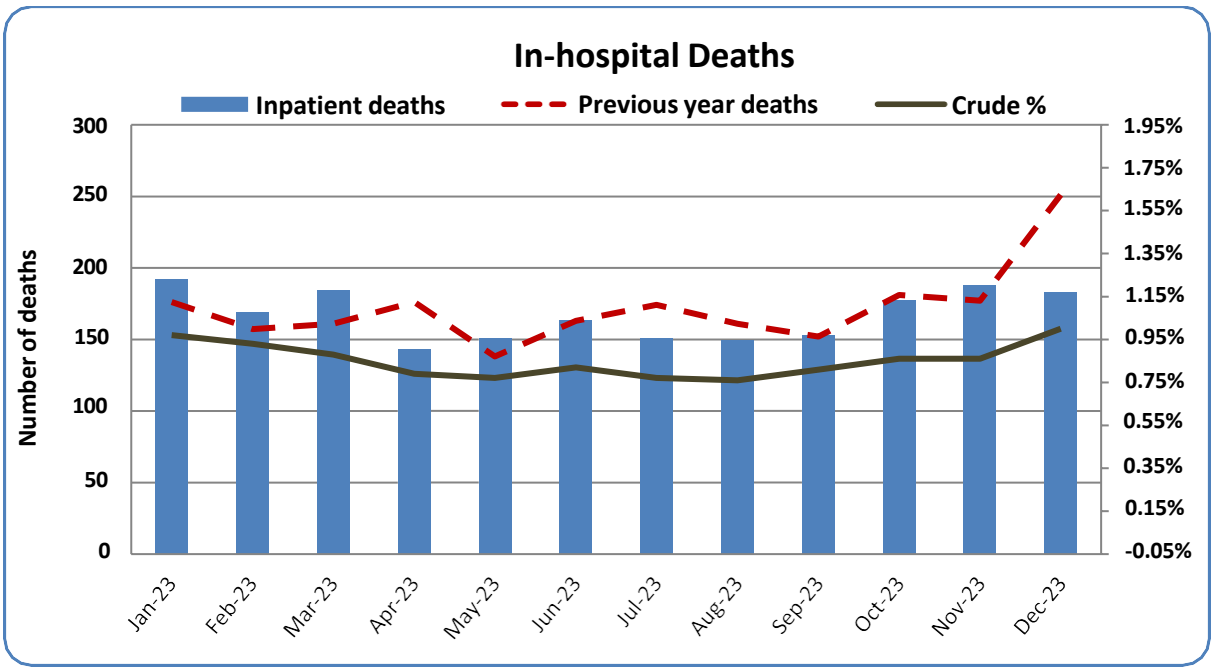
Directorate	Speciality	Summary	Learning Point	Outcome
Peri-operative and Critical Care	Critical Care	NEWS trigger whilst on Surgical ward did not create a timely response to Critical Care outreach team.	News trigger is to be responded to in line with Trust policy.	Surgical M&M lead has been asked to undertake a level 2 review.
Internal Medicine	Infectious Diseases	Multiple admissions over a prolonged period of time. Multiple antibiotic reviews, commencement and discontinuation of treatment.	In complex patients a clear handover is necessary.	Highlighted at M&M meeting and Clinical Governance meeting.
Internal Medicine	Respiratory	Admitted with fall and multiple rib fractures, Covid negative on admission. Duty of Candour discussion regarding hospital acquired Covid wasn't carried out in a timely manner.	Duty of Candour policy to be followed in all cases of hospital acquired Covid deaths.	Highlighted to team at M&M meeting.
Learning Disability	Learning Disability (LD)	Patient with learning disability admitted but LD team unaware of admission as patient was incorrectly flagged on E-record.	LD flag placed on E-record, not placed by LD team.	Newly appointed Learning Disability Champions now highlights the correct process of placing a Learning Disability flag onto e-record at Departmental meetings within their clinical areas. In addition, digital screening questions highlight the need to ensure staff check if there is a flag and if not, it directs them to contact the Learning Disability Liaison Team to do this. The Learning Disability Team monitor for incorrect flagging and work closely with that particular clinical team, providing training and education on the correct process.
Medicine and Emergency Care	Renal	Cardiac arrest during histology procedure. Problems occurred with certification of death process.	Incomplete documentation led to problems with death certification.	Discussed in Renal M&M 19/12/2023. Education for the medical team - added to induction programme.

4. CRUDE MORTALITY

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 January 2023 – December 2023, which clearly shows a decrease in deaths in relation to the same period the previous year.



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 diagnostic groups within the data are individually monitored and all findings are presented to the Trust Mortality Surveillance Group on a quarterly basis. Any diagnostic group that flags as a concern is raised with the relevant Clinical Board to ensure an in-depth analysis is undertaken and findings recorded into the mortality review database. All learning from this analysis is shared with Clinical Boards and presented to the Mortality Surveillance Group.

The latest SHMI publication for October 2022 – September 2023 shows the Trust to be at 0.91, which is within the national "expected levels".

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

6. NEQOS

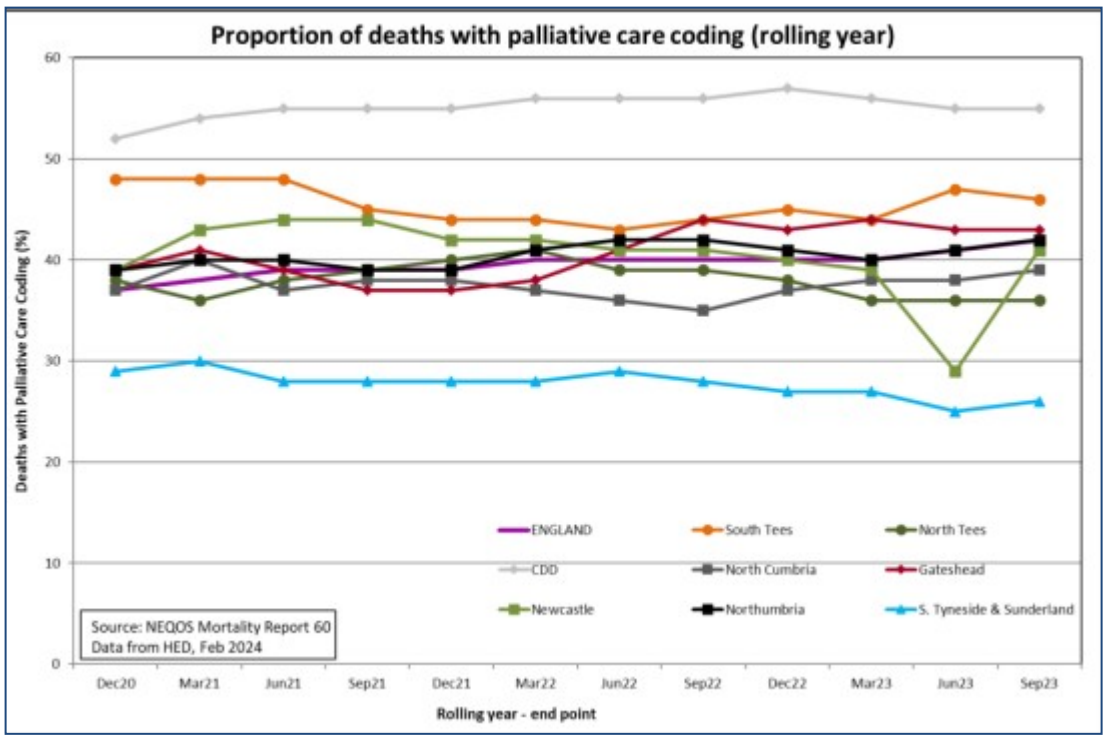
The Northeast Quality Observatory Service (NEQOS) is published quarterly and presents analysis showing the SHMI mortality indices including a high level for Trusts identifying variation from the norm (outliers); trends through time; and using more granular analysis in order to describe contributing factors.

The latest NEQOS SHMI publication is up to September 2023. Overall, the table below shows the Trust to be below the national average, as well as being the lowest regionally.

Provider	October 2021 - September 2022			October 2022 - September 2023			SHMI Change	Observed Difference	Expected Difference
	Observed	Expected	SHMI	Observed	Expected	SHMI			
County Durham and Darlington NHS FT	2875	2645	109	3015	2455	123	14.1	4.9%	-7.2%
North Tees and Hartlepool NHS FT	1770	1800	98	1830	1915	96	-2.8	3.4%	6.4%
South Tees Hospitals NHS FT	2420	2275	106	2595	2340	111	4.5	7.2%	2.9%
Gateshead Health NHS FT	1250	1395	90	1310	1405	93	3.6	4.8%	0.7%
South Tyneside and Sunderland NHS FT	3005	2795	108	3125	2730	114	7.0	4.0%	-2.3%
The Newcastle Upon Tyne Hospitals NHS FT	2400	2575	93	2625	2885	91	-2.2	9.4%	12.0%
Northumbria Healthcare NHS FT	2625	2805	94	2850	3095	92	-1.5	8.6%	10.3%
North Cumbria Integrated Care NHS FT	1785	1670	107	1810	1775	102	-4.9	1.4%	6.3%

7. PALLIATIVE CARE CODING

The graph below is published within the NEQOS quarterly report and is currently presented up to September 2023. 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. The dramatic decline in palliative care coding in June 2023 is part of an upload issue between the Trust and NHS Digital. Patient comorbidities and palliative care status were sporadically uploaded into the new Trust dataset and therefore not being included, or risk adjusted by NHS Digital. This issue has now been resolved and we hope to see the data with a more positive outcome for June 2023 within the next published NEQOS report.



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 serious incidents (SI) 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 Q3 are shown below:

- During October 2023 – December 2023 (Q3) there were 59 SIs reported to Commissioners via the Strategic Executive Information System (STEIS).
- Of these 59, there were nine patient deaths which identified potential modifiable factors which contributed to the death. Investigations are currently ongoing for six cases.

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

2023/17857 – HCAI MSSA
• Education and support given to improve documentation, which will be audited monthly, findings fed back in real time. • Management of complex MSSA: Antimicrobial duration guidelines under review, expected completion date end of February 2024.

2023/14708 – Unexpected Death
• Ongoing continued education of all new medical and nursing staff at the time of induction, including information about how and when to escalate cases for consultant review. • Update local handbook and ensure all new staff receive a copy before they start

2023/8217 – Medical Device
• Patients were contacted and advice and support given. • Yellow card notification to MHRA completed.

2023/17067 – Delayed Missed Diagnosis
• Educational material developed and displayed on the ward. • Safety Checklist amended to ensure patient/carer have appropriate training on equipment to be used at home.

2023/14717 – TAVI
• Correct process for introducing new interventions within the Clinical Board discussed and agreed. • Processes reviewed and strengthened to ensure more robust planning for complex surgery including embedding a mechanism for escalation when required

2023/17075 – Unexpected Death
• Review of induction/education delivered and training compliance.

2023/11806 – PACU/ERAS
• Protocol updated to include mandating senior anaesthetic and surgical review in the face of escalating vasopressors. • SOP revised and amended in relation to escalation process for deteriorating post-operative patients. • Metaraminol infusion guideline updated.

9. MEDICAL EXAMINER

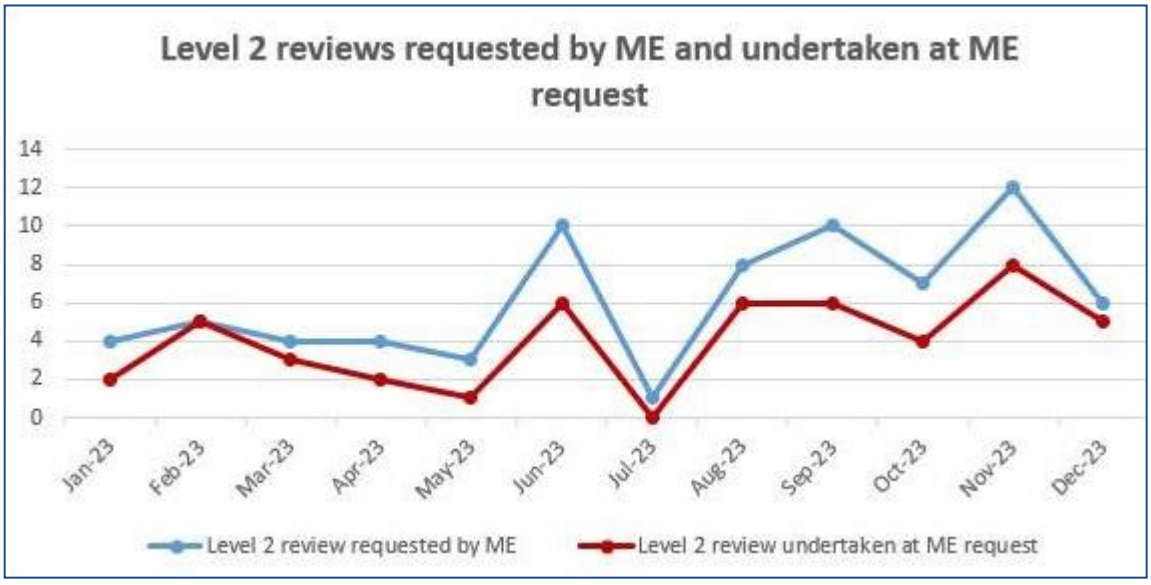
Since January 2023, Medical Examiners have started scrutinising all inpatient deaths other than those referred to the coroner's office.

The Medical Examiner process had planned to incorporate all community deaths by April 2024 in line with NHS England Guidance.

Medical Examiners are currently scrutinising some community deaths, however not all GPs and hospices are fully incorporated into the process. This will become mandatory by April 2024. The Trust Medical Examiner office is offering training to all GPs and hospices in order for them to understand the scrutiny process.

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 in line with the Trust mortality policy. This will provide additional assurance that all patients who are required to have a level 2 review, receive a review. This process will continue to be monitored by the Clinical Governance & Risk Department with data presented at the mortality surveillance group. This data is also shared with Clinical Boards and presented at their Quality Oversight Groups.

The graph below shows patients referred for a level 2 review by a Medical Examiner and how many were undertaken.



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 March 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024					
Title	Healthcare Associated Infections (HCAI) Director of Infection Prevention and Control Report					
Report of	Maurya Cushlow Executive Chief Nurse Ian Joy Executive Director of Nursing					
Prepared by	Dr Julie Samuel, Director of Infection Prevention & Control (DIPC), Consultant Microbiologist Mrs Lesley Wilson, Infection Prevention and Control (IPC) Matron Mrs Cheryl Teasdale Associate Director of Nursing					
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 February 2024. Trend data in Appendix 1 (HCAI Report and Scorecard February 2024) is included 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	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 [NHS core standards]. ii) SO1.10 [infections]					
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:

- One MRSA bacteraemia was attributed to the Trust in January 2024 which takes the Trust total to four against a target of zero. Details of the investigation are provided within the report.

- This period identified HCAI themes relating to intra-vascular infections in patients on parenteral nutrition; cancer patients on chemotherapy and patients with lower Urinary Tract Infection (UTI). Details of reviews and control measures are outlined in the report.

- Reduction of avoidable urinary catheter insertion and associated *E. coli* bacteraemia reduction will be reviewed as a Quality Improvement initiative in collaboration with Newcastle Improvement.

- The Patient Safety Incident Response Framework (PSIRF) and ICNet integration into IPC operations are underway with the aim for full implementation by April 2024.

RECOMMENDATIONS

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

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

1. KEY POINTS FOR JANUARY/FEBRUARY 2024

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.

1.1 *Clostridioides difficile* Infections (CDI)

At the end of February, a total of 133 cases were attributed to the Trust (106 cases Hospital Onset Healthcare Associated (HOHA); 27 cases Community Onset Healthcare Associated (COHA)) – see Table 1. This places the Trust under the national threshold (≤152) by 19 cases as shown in Table 2, and demonstrates a sustained improved position compared to the same period last year. Month on month trend graphs are included in the Integrated Board Report. The sustained reduction is attributed to a combination of factors: Increased compliance with antimicrobial audits and collaborative working between IPC, clinical teams and Estates.

Table 1: Number of CDI attributed to Newcastle Hospitals from March 2022 to February 2024

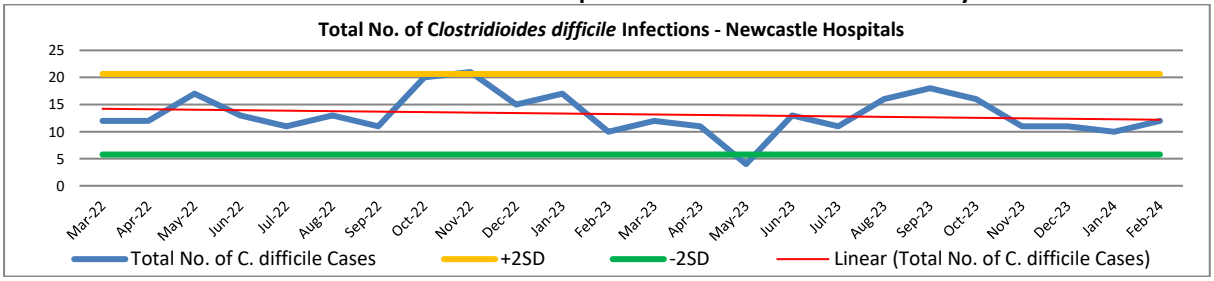
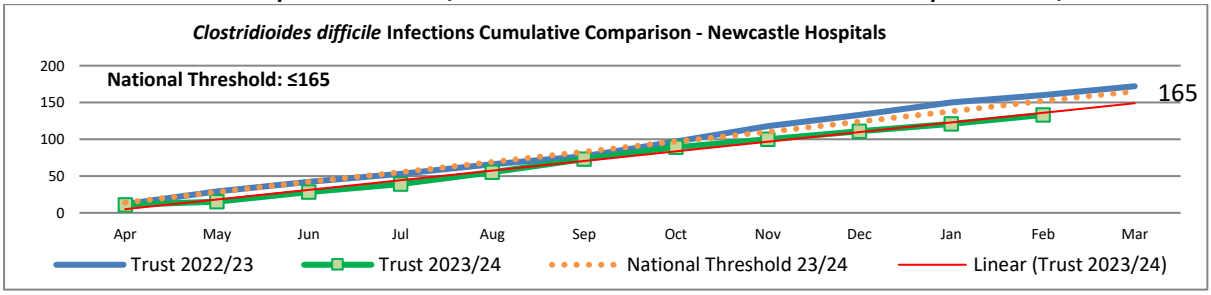


Table 2: Cumulative comparison of 2023/24 National Threshold with Newcastle Hospitals' 2022/23 CDI total



Tables 3 and 4 show the Trust's CDI infections compared with the Shelford Group for time periods between April 2022 and January 2024. Whilst there has been a reduction in CDI infections internally, the benchmark against the Shelford Group remains unchanged.

Table 3: CDI comparison data for Shelford group April 2023 – January 2024

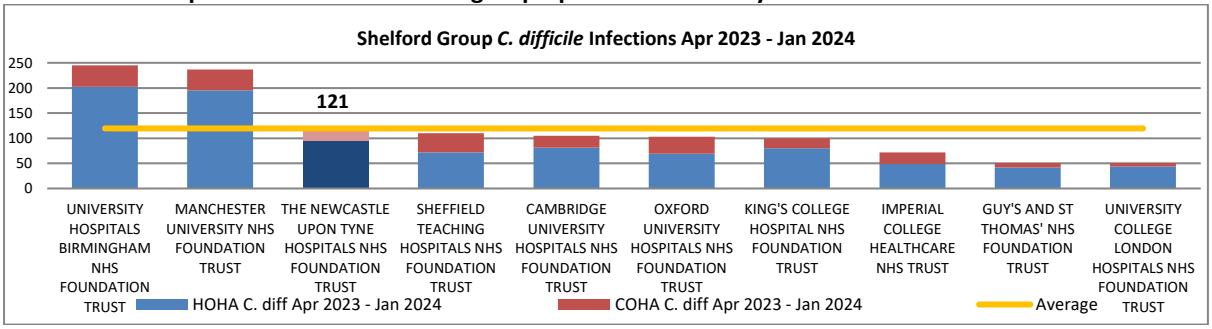
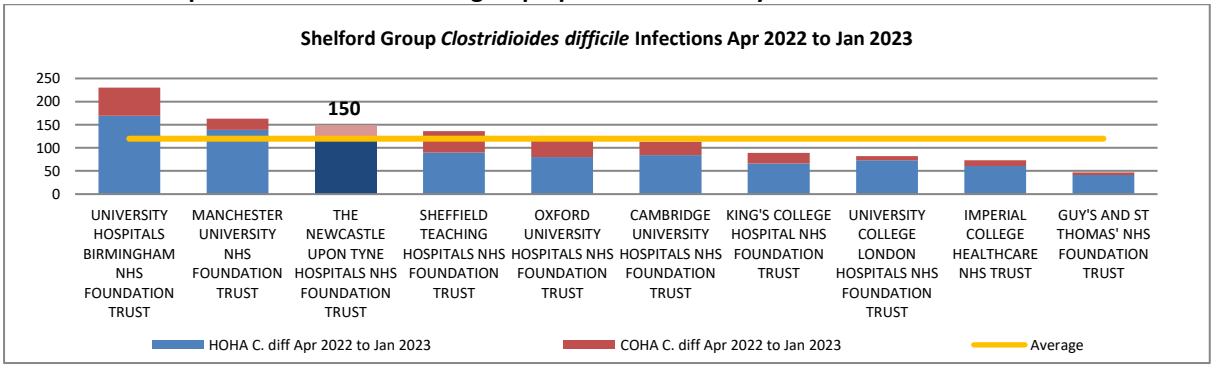


Table 4: CDI comparison data for Shelford group April 2022 – January 2023



1.2 Patient Safety Incident Response Framework (PSIRF)

PSIRF is in the process of being embedded into Infection Prevention and Control (IPC). CDI and Blood stream infection (BSI) attributed to the Trust and considered as moderate harm are investigated by Infection Specialists, IPC and clinical teams. The focus of investigation is: review of diarrhoea management, care of IV devices and urinary catheters. Themes collated are discussed at Quality Oversight Groups and shared widely through various forums e.g. Harm Free Care (HFC), Matrons and governance meetings.

1.3 MRSA / MSSA Blood stream infection (BSI)

The Trust had a further HOHA case of MRSA bacteraemia in January 2024 bringing the total to 4 cases. Initial investigation identified issues with patient non-compliance with antiseptic washes and multiple co-morbidities leading to difficult intra-vascular access. A MRSA screening compliance audit is being carried out to ensure compliance with our local policies and procedures, results will be reviewed at the IPC Operational group in April.

At the end of January 2024, a total of 94 MSSA bacteraemia cases were attributed to the Trust (74 HOHA cases; 20 COHA cases). This places the Trust over our local trajectory by 7 cases (≤83 - no national threshold for MSSA), as outlined in table 5. Monthly trend graphs are included in the Integrated Board Report and performance against trajectories (table 6) and Shelford benchmarking (table 7) are included below for reference.

Table 5: Total MSSA Bacteraemia at Newcastle Hospitals March 2022 - February 2024

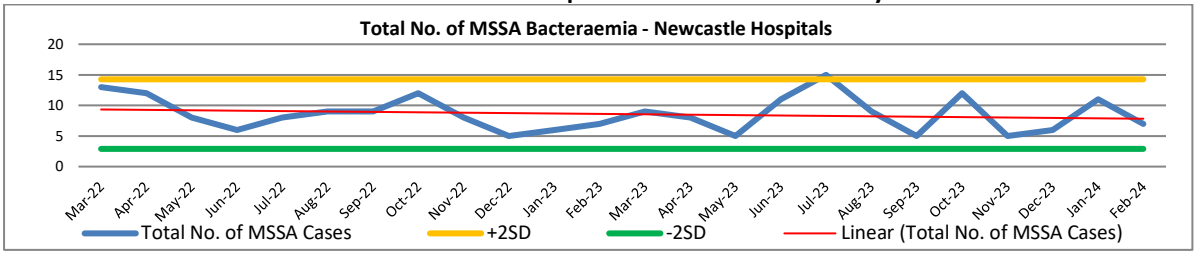


Table 6: MSSA cumulative comparison April 2022- end of March 2023 and April 2023 – February 2024

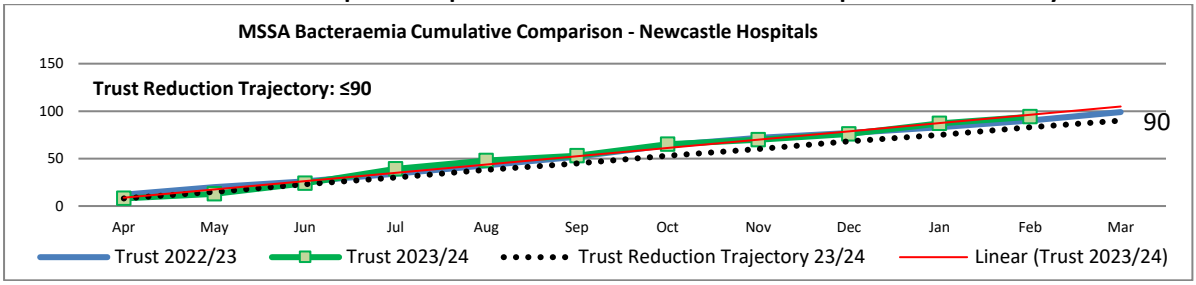
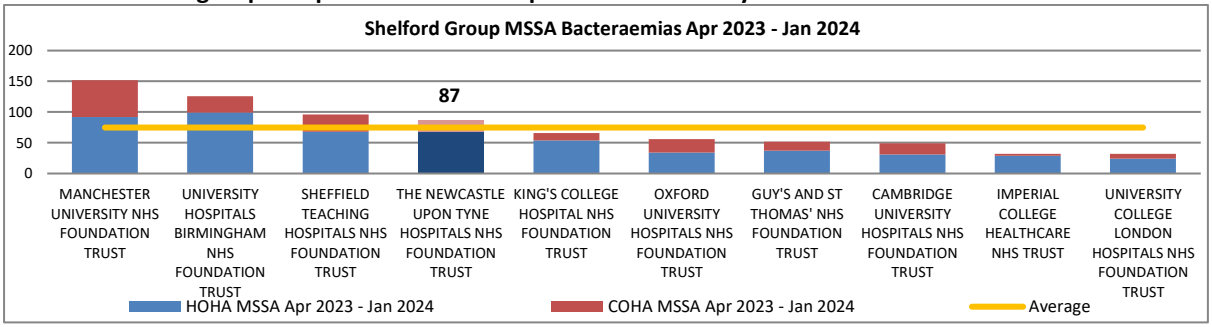


Table 7: Shelford group comparison for MSSA April 2023 – February 2024



Intravascular devices remain the primary source of hospital associated bacteraemia. An emerging theme in this period was the high rates of infection in patients on parenteral nutrition. Clinical, IPC and IV specialists are working with clinical educators to review patient pathways and audit management of long-term devices used in this clinical setting. IV audits carried out in RVI Assessment Suite during February 2024 saw a significant improvement in line insertion and assessment documentation. Line care management will remain under continuous surveillance through a line care dashboard planned for Trust-wide rollout in May/June 2024. In April, a Spring Clean collaborative initiative is planned to promote patient personal hygiene with focus on Octenisan/patient washing and mouth care.

1.4 Gram Negative Blood stream infection BSI GNBSI (*E. coli,* Klebsiella, Pseudomonas aeruginosa)

There is a national ambition to reduce GNBSI year-on-year and an internal year-on-year reduction ambition in CAUTI (commencing in one specific clinical board with the intention to then rollout across the Trust) to achieve a 5% reduction in avoidable use of urinary catheters. This will be a registered Quality Improvement (QI) initiative which will be undertaken with support from Newcastle Improvement.

Table 8 compares GNBI rates against national thresholds and as illustrated, numbers exceed current national trajectory. Tables 9, 10 and 11 illustrate in graph format performance against trajectory.

Table 8: The table(s) below outlines the Trust figures up to the end of February 2024

	E. coli	Klebsiella	Pseudomonas aeruginosa
Cumulative No. cases to end of February 2024	**239 cases**	**102 cases**	**41 cases**
National Threshold for February 2024	**≤174 Over by 65**	**≤120 Under by 18**	**≤34 Over by 7**

Table 9: Total *E. coli* bacteraemia April 2022- end of March 2023 and April 2023 – February 2024

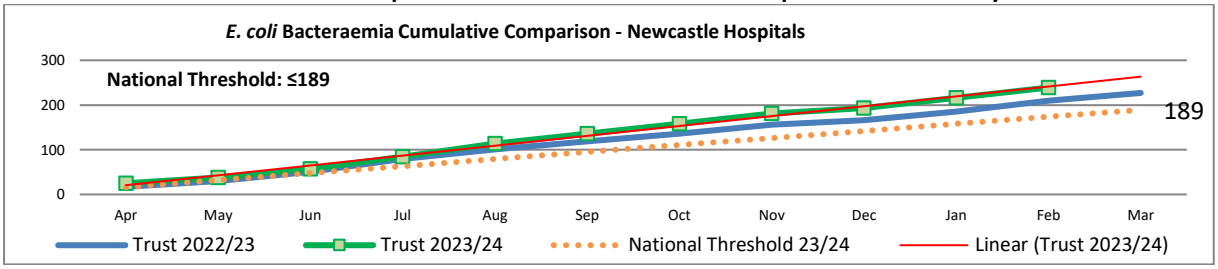


Table 10: Total Klebsiella bacteraemia April 2022- end of March 2023 and April 2023 – February 2024

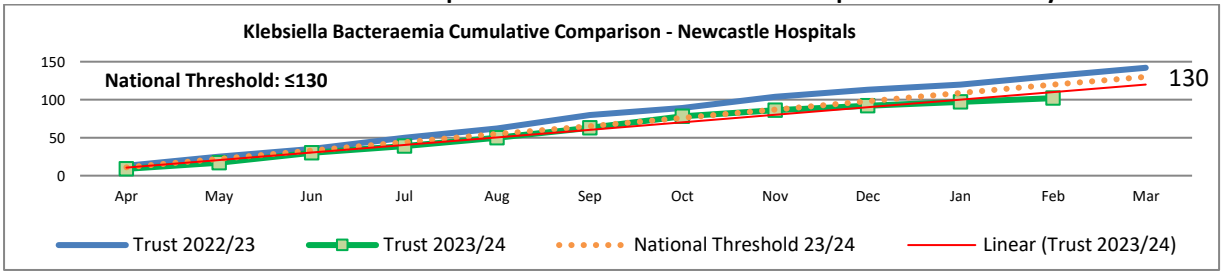
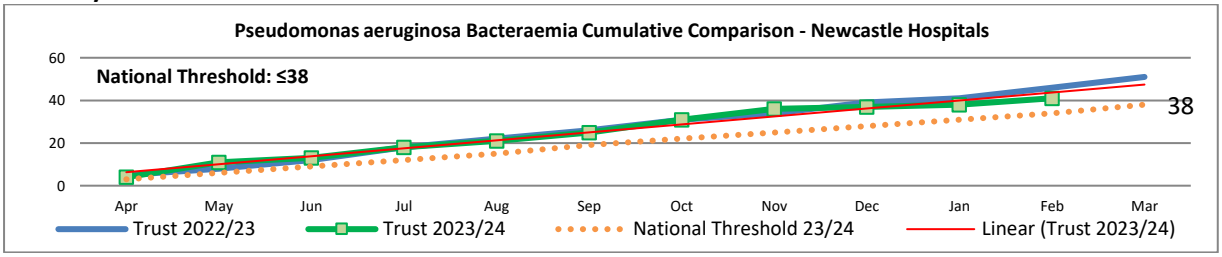


Table 11: Total Pseudomonas aeruginosa bacteraemia April 2022- end of March 2023 and April 2023 – February 2024



BSI reviews in this period identified themes around line infection in cancer patients associated with bone marrow suppression related to chemotherapy and lower urinary tract infection. Both themes are under continuous review through our current processes as discussed above.

1.5 Incidence of Respiratory Viruses Including COVID-19

There was a significant rise in the number of reported COVID-19 HCAI cases in January 2024 (73 cases) compared to December 2023 (50 cases). However, this was followed by a sharp decrease in the number of cases reported in February 2024. This significant rise of cases corresponded with an increase in the number of outbreaks declared during this period.

The seasonal increase in community Flu A correlated with a significant increase in cases being reported in the Trust. This sharp rise was predominately seen in January 2024 resulting in 13 outbreaks being declared compared to the 2 outbreaks declared in February 2024.

1.6 Incidence of viral diarrhoeas illnesses including Norovirus

There were 2 outbreaks of Norovirus and an outbreak of Adenovirus declared in January and February 2024 which resulted in 188 lost bed days. The incidence of norovirus outbreaks for the months of January and February 2024 were significantly less compared to the previous year's data (2023) where we had 8 confirmed norovirus outbreaks.

1.7 Measles Prevention

Since 1 October 2023, there has been an increase in measles cases across England. Measles is an infection that spreads very easily and can cause serious problems in some people. Having the MMR vaccine is the best way to protect someone from becoming seriously unwell with measles. In collaboration with our Occupational Health Service (OHS) we reviewed our current policies to align with national guidance to provide assurance for high-risk staff / patients and communicated key messages Trust wide for early identification and management. This proactive work has resulted in pop up clinics; blood tests and vaccines being offered to staff with an uptake of 92 staff receiving their MMR in February.

1.8 Staff Winter Vaccination Programme

The vaccination programme for 2023/24 demonstrated that 11,852 (67%) staff received their Flu vaccination with an increased uptake of 404 compared to the previous year's programme (11,448). Nationally the Trust are only required to report on vaccination of specific staff groups which demonstrated 9,568 (70%) were vaccinated.

In comparison, there was a decrease in uptake of 1,066 for the COVID-19 Booster vaccination where only 9,365 (54%) staff chose to have the vaccine compared to the previous year (10,431). Similarly, the Trust is only required to report certain staff groups nationally which demonstrated 7,395 (55%) were vaccinated. The Trust performed well both regionally and nationally, especially against trusts where the headcount is greater than 10,000. Final vaccination position data is not yet finalised, and we are anticipating this information being released after 22 March 2024.

1.9 Antimicrobial Stewardship (AMS)

AMS teams continue to work collaboratively with IPC and provide quarterly updates to Clinical Boards through the oversight groups. Antibiotic guidelines with high risk and high-cost drugs are also under review. Oversight for these processes requires strategic leadership from the AMS team which is under resourced to deliver this effectively. An investment proposal for the team is currently being re-submitted.

1.10 Water Ventilation and Decontamination

Trust Safety groups continue to oversee and provide assurance through the IPC Committee with actions implemented by the Operational sub groups.

2.0. RECOMMENDATIONS

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

Report of

Maurya Cushlow
Executive Chief Nurse

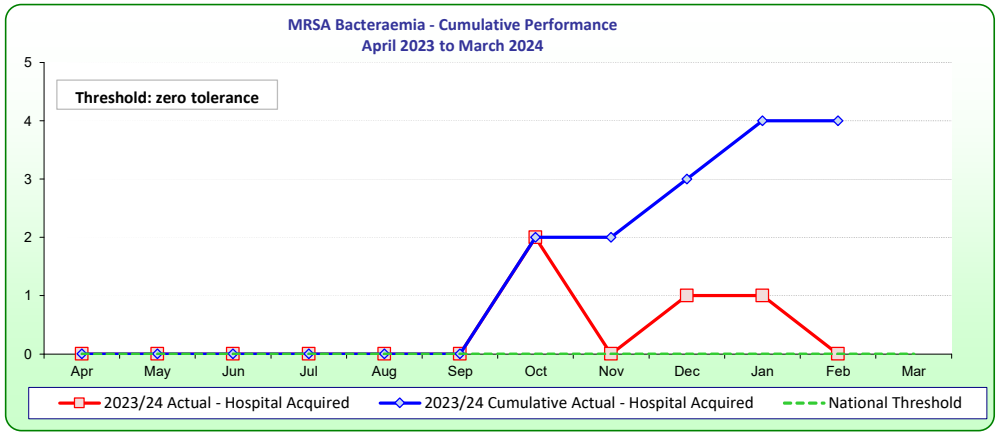
Ian Joy
Executive Director of Nursing

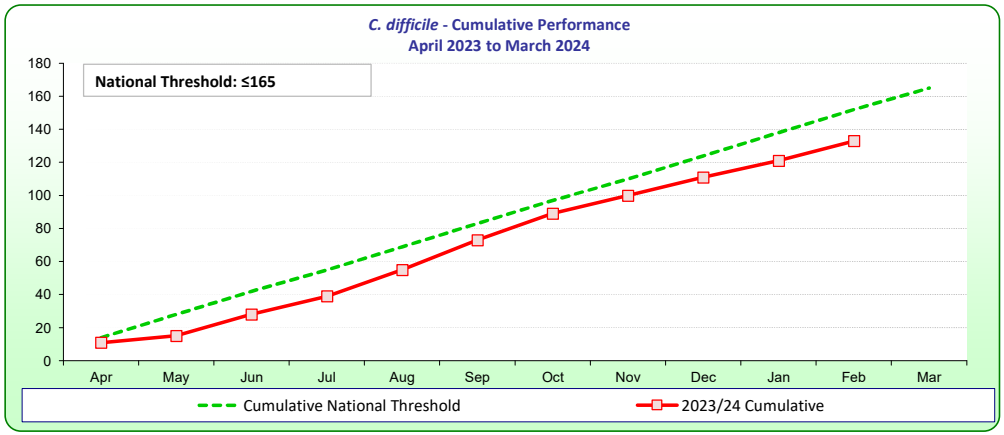
Dr Julie Samuel
Director of Infection Prevention & Control ((DIPC)

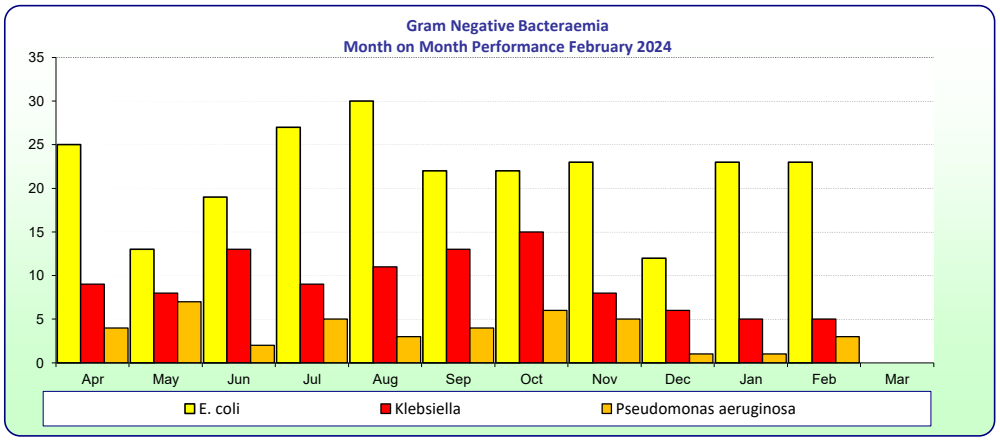
21 March 2024

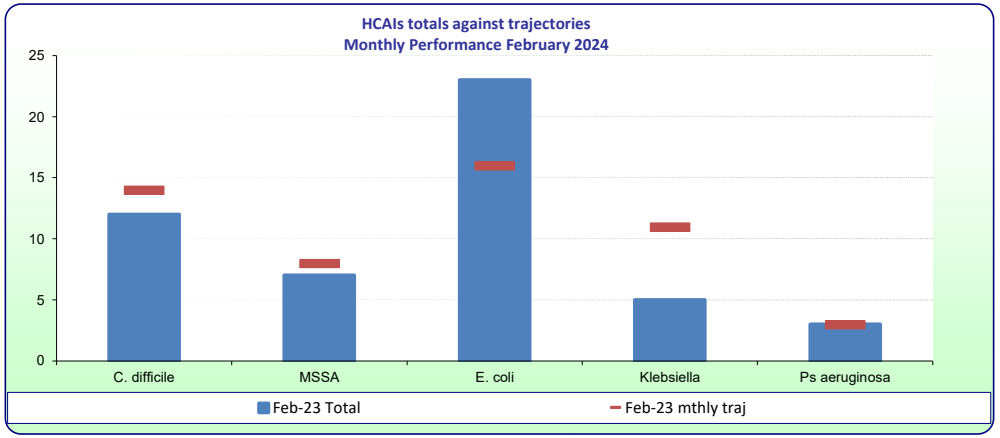
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

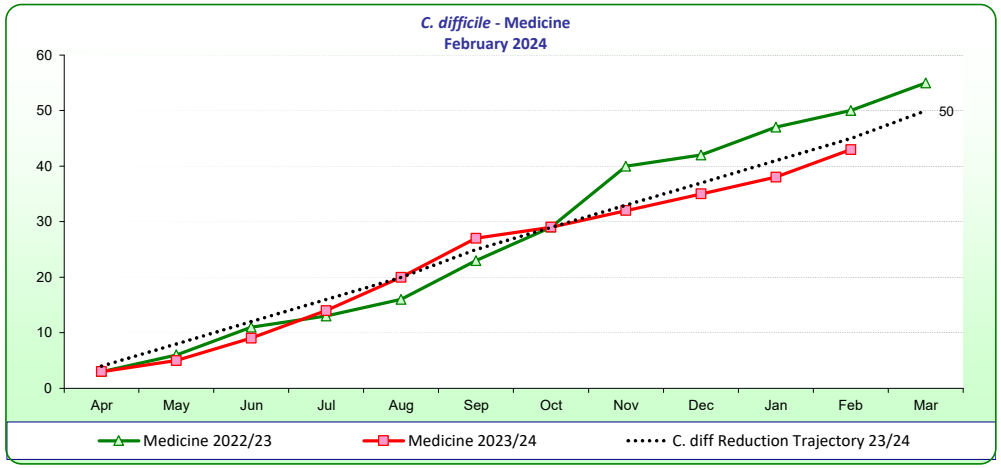
Healthcare-Associated Infections Report
February 2024

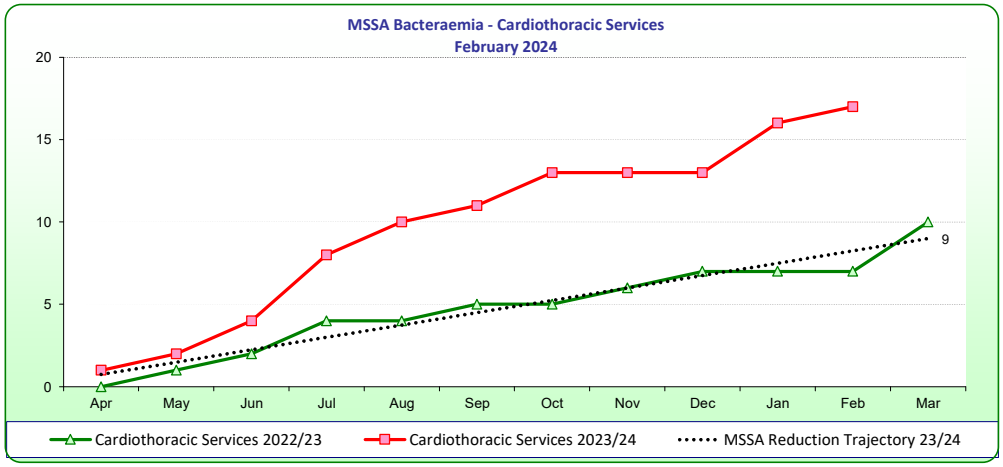

MRSA Bacteraemia - Cumulative Performance
April 2023 to March 2024
Threshold: zero tolerance
0
1
2
3
4
5
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2023/24 Actual - Hospital Acquired
2023/24 Cumulative Actual - Hospital Acquired
National Threshold


C. difficile - Cumulative Performance
April 2023 to March 2024
National Threshold: ≤165
0
20
40
60
80
100
120
140
160
180
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Cumulative National Threshold
2023/24 Cumulative

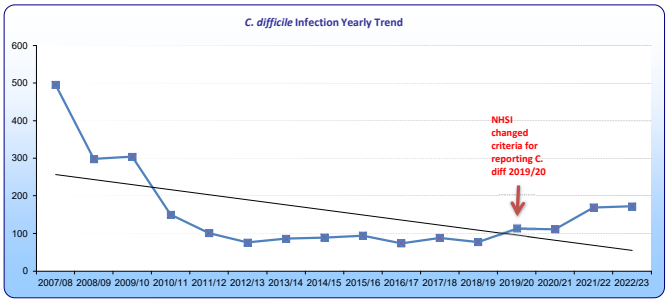

Gram Negative Bacteraemia
Month on Month Performance February 2024
0
5
10
15
20
25
30
35
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
E. coli
Klebsiella
Pseudomonas aeruginosa

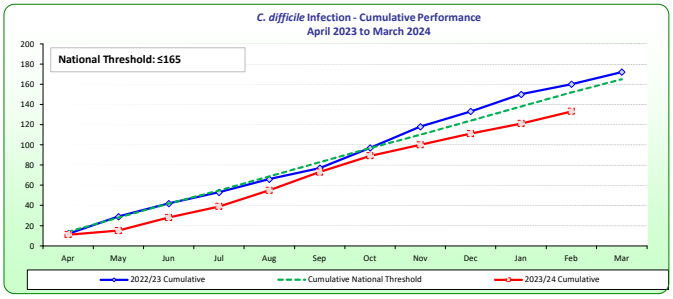

HCAIs totals against trajectories
Monthly Performance February 2024
0
5
10
15
20
25
C. difficile
MSSA
E. coli
Klebsiella
Ps aeruginosa
Feb-23 Total
Feb-23 mthly traj

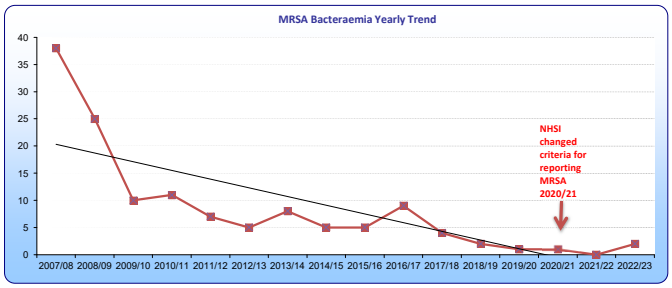

C. difficile - Medicine
February 2024
0
10
20
30
40
50
60
50
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Medicine 2022/23
Medicine 2023/24
C. diff Reduction Trajectory 23/24

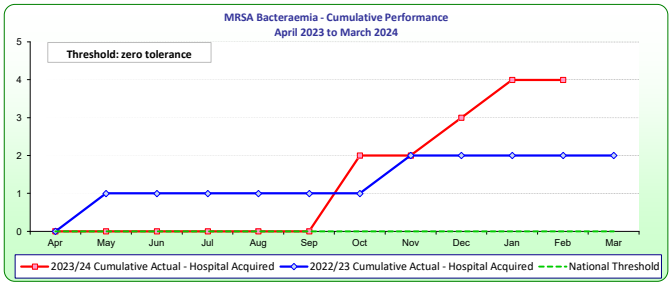

MSSA Bacteraemia - Cardiothoracic Services
February 2024
0
5
10
15
20
9
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Cardiothoracic Services 2022/23
Cardiothoracic Services 2023/24
MSSA Reduction Trajectory 23/24

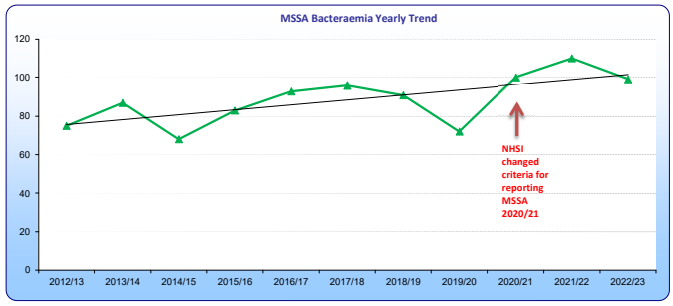
The Newcastle upon Tyne Hospitals NHS Foundation Trust

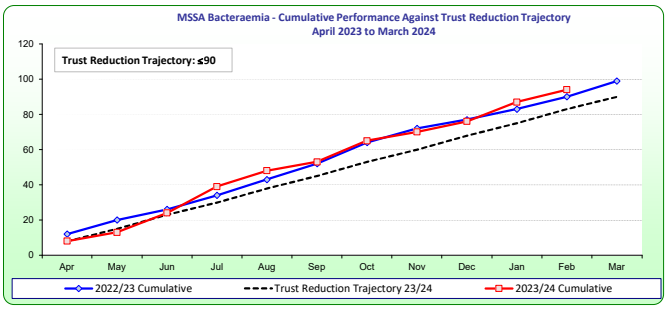


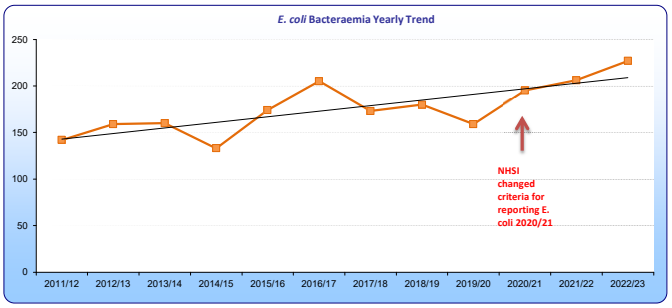


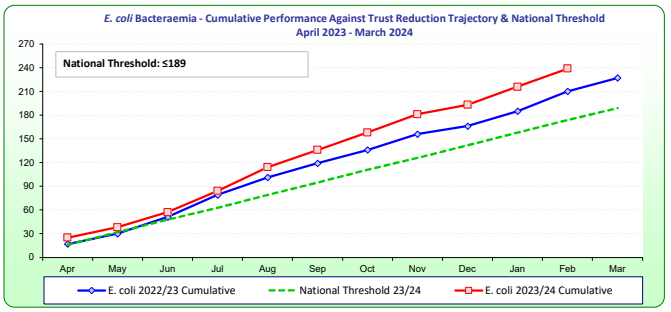


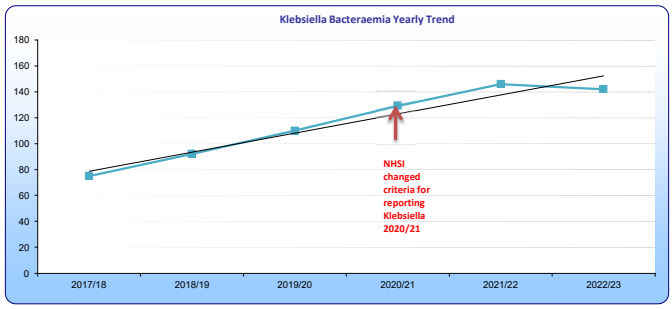


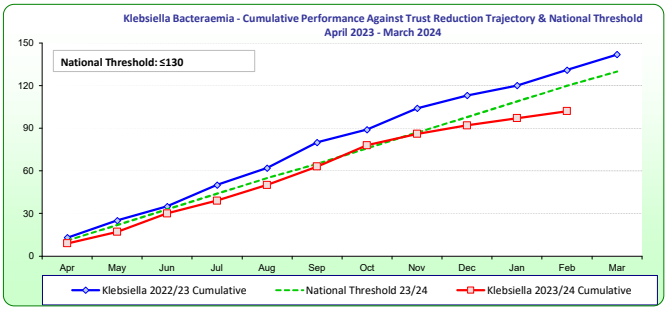


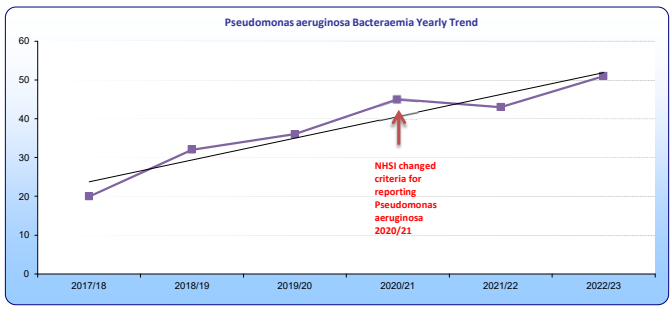


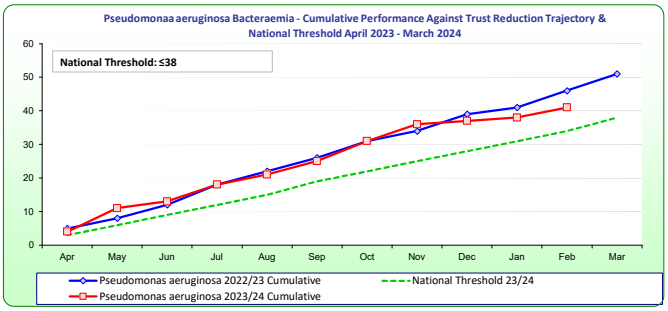












The Newcastle upon Tyne Hospitals NHS Foundation Trust

Bacteraemia / Infections

IPC indicators (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA Bacteraemia - non-Trust	0	0	2	0	1	0	0	0	0	1	1		5
MRSA Bacteraemia - Trust-assigned (objective 0)	0	0	0	0	0	0	2	0	1	1	0		4
MSSA Bacteraemia - Healthcare Associated (local objective ≤90)	8	5	11	15	9	5	12	5	6	11	7		94
E. coli Bacteraemia - Healthcare Associated (National Threshold ≤189)	25	13	19	27	30	22	22	23	12	23	23		239
Klebsiella Bacteraemia - Healthcare Associated (National Threshold ≤130)	9	8	13	9	11	13	15	8	6	5	5		102
Pseudomonas aeruginosa Bacteraemia - Healthcare Associated National Threshold ≤38)	4	7	2	5	3	4	6	5	1	1	3		41
C. diff - Hospital Acquired (national threshold ≤165)	11	4	13	11	16	18	16	11	11	10	12		133
C. diff related death certificates	2	0	1	0	0	1	0	0	0	0	0		4
Part 1	2	0	1	0	0	1	0	0	0	0	0		4
Part 2	0	0	0	0	0	0	0	0	0	0	0		0

Periods of Increased Incidence (PIIs)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
C. diff - Hospital Acquired	0	2	2	1	3	4	2	4	1	1	1		21
Patients affected	1	2	6	1	6	12	7	8	5	1	3		52
COVID-19 - Hospital Acquired	1	1	1	0	5	0	2	0	0	4	0		14
Patients affected	2	3	2	0	11	0	6	0	0	8	0		32

Healthcare Associated COVID-19 cases (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Hospital onset Probable HC assoicated (8-14 days post admission)	23	8	6	1	30	25	28	13	17	18	5		174
Hospital onset Definite HC assoicated (≥15 days post admission)	39	20	7	0	32	37	46	20	20	26	12		259

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	2	1	0	0	0	1	0	0	1	1	1		7
Patients affected (total)	18	8	0	0	0	5	0	0	13	24	21		89
Staff affected (total)	4	7	0	0	0	3	0	0	2	2	7		25
Bed days losts (total)	126	3	0	0	0	0	0	0	59	24	88		300
Other Outbreaks	0	0	1	0	0	0	0	0	1	10	3		15
Patients affected (total)	0	0	18	0	0	0	0	0	3	33	8		62
Staff affected (total)	0	0	6	0	0	0	0	0	0	2	0		8
Bed days losts (total)	0	0	51	0	0	0	0	0	0	14	0		65
COVID Outbreaks	8	2	1	0	8	5	5	3	5	6	2		45
Patients affected (total)	38	18	4	0	63	37	43	23	23	40	6		295
Staff affected (total)	0	4	0	0	0	1	0	0	0	0	0		5

C.diff Transit and Testing Times Target <18hrs	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Trust Specimen Transit Time	13:47	13:55	11:53	12:09	12:41	11:36	11:53	11:54	13:07	12:18	12:34		12:31
Laboratory Turnaround Time	03:23	03:08	02:55	01:53	02:10	01:56	01:42	03:41	02:36	02:07	01:55		02:29
Total to Result Availability	17:10	17:03	14:48	14:02	14:51	13:32	13:35	15:35	15:43	14:25	14:29		15:01

Clinical Assurance Tool (CAT)

Clinical Assurance Indicators/Audits (%) - Trust as a whole	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Adult IP; Children's IP; Community HV/SN; Community Nursing; Critical Care; Day Procedure; Dental; Maternity; OP; Theatres) Trust Total	95%	94%	93%	95%	92%	88%	92%	91%	95%	95%	93%		93%
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Trust Total	96%	96%	93%	94%	91%	89%	91%	89%	96%	95%	95%		93%
Invasive Device Care Audit Trust Total	95%	96%	92%	93%	93%	92%	95%	95%	98%	97%	95%		95%
Matron Checks (IP; OP/Community/Dental; Theatres) Trust Total	94%	96%	91%	97%	93%	92%	95%	94%	92%	96%	90%		94%

Clinical Assurance Indicators/Audits (%) - Acute side only	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Adult IP; Children's IP; Critical Care; Day Procedure; Dental; Maternity; OP; Theatres) Acute only Total	95%	93%	93%	94%	91%	85%	92%	90%	94%	94%	91%		92%
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Acute only Total	96%	95%	93%	94%	91%	89%	91%	89%	96%	96%	94%		93%
Invasive Device Care Audit Acute only Total	96%	96%	92%	93%	93%	92%	96%	95%	98%	98%	94%		95%
Matron Checks (IP; OP/Community/Dental; Theatres) Acute only Total	94%	96%	91%	97%	92%	92%	95%	94%	92%	96%	90%		94%

Clinical Assurance Indicators/Audits (%) - Community side only	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Community HV/SN; Community Nursing; OP) Community only Total	97%	98%	96%	94%	97%	100%	95%	74%	99%	77%	96%		93%
Standard IPC Precautions (incl HH, ANTT, PPE) Community only Total	91%	100%	95%	93%	92%	96%	91%	91%	100%	93%	100%		95%
Invasive Device Care Audit Community only Total	78%	100%	100%	100%	100%	100%	78%	98%	100%	100%	100%		96%
Matron Checks (OP/Community/Dental) Community only Total	98%	99%	99%	100%	98%	95%	100%	81%	90%	98%	96%		96%

Education & Training

23/05/2023

Infection Control Mandatory Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Infection Control (Level 1)	95%	93%	94%	94%	95%	95%	95%	95%	96%	96%	95%		95%

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

ANTT compliance levels

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

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

Aug/Sep 2023 re ANTT in the Learning Lab - TEL team have advised there have been some updates to the way ANTT is assigned. It has now been assigned as a 3 year renewal to anyone who also has Adult Resus Level 2 assigned to them. The Power BI dashboard has now been updated to include this 3 year renewal ANTT certification, which replaces the old one, but currently only 36 staff are compliant, making the compliance rate less than 1% therefore August's total is not recorded here

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024					
Title	Gender Pay Gap Report 2023/24					
Report of	Christine Brereton, Chief People Officer					
Prepared by	Karen Pearce, Head of EDI (People)					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☐	☐			
Summary	Under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 the Trust is required to produce and publish an annual report of gender pay gap information. This paper includes the Trust's gender pay gap report for the 'snapshot' date of 31 March 2023 plus a supporting narrative and action plan. The report must be published on the government's gender pay gap service website and the Trust's website within a year of the snapshot date (i.e. before 30 March 2024).					
Recommendation	To approve the contents of the paper to approve publication on the Trust's website before 30 March 2024.					
Links to Strategic Objectives	People Strategy					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☒	☒
Link to Board Assurance Framework [BAF]	No direct link.					
Reports previously considered by	People Committee on 20 February 2024.					

GENDER PAY REPORT 2023/24

EXECUTIVE SUMMARY

This report shows the Trust's gender pay gap data for the 'snapshot' date of 31 March 2023 and includes a supporting narrative and action plan.

Gender pay reporting is about showing the difference in average pay and bonus payments between male and female staff.

22% of our workforce are male, 78% are female.

The gap in the average [mean] hourly pay rate between males (£23.34) and females (£18.10) is 22.44%. The gap has increased slightly by 0.02% since 2022.

The gap in average [mean] bonus pay between males (£12,038.50) and females (£2,484.38) is 79.36%. The gap has decreased by 0.3% since 2022. The average [median] gap in bonus pay increased from 0% to 96.68% due to the inclusion in last year's return of the Covid 'thank you' which the Trust paid as a bonus to all staff excluding the Board.

The Trust's overall gender pay gap remains strongly influenced by the pay and gender make-up of the medical and dental staff group. This group is predominantly male and their higher pay relative to other staff increases the level of male average pay compared to females. Proportionally more males hold senior positions than females.

Local Clinical Excellence Awards for the period 2018-2020 were captured in our gender pay data in 2022. The Trust will adopt equal distribution to all eligible consultants for both the 2022/23 and 2023/24 rounds. Data by ethnicity and gender will be reviewed to ensure the Trust maintains an equal likelihood of application and award.

Gender Bonus Gap

Work was undertaken during the last reporting period to refresh the employer-based awards committee (EBAC) to better represent the diversity of the consultant body and this achieved a positive result as at 31 March 2022.

- Males are more represented in the higher CEA categories attracting higher award values.
- The difference in the mean and median bonus payments remains strongly influenced by the pay and gender make-up of the medical and dental staff group.

GENDER PAY GAP REPORT 2023/24

1. INTRODUCTION

The gender pay gap measures the difference between the pay rates of all male and female staff across the Trust irrespective of their role and seniority. It should not be confused with equal pay where males and females performing similar roles or work of equal value must be paid equally. Under the Equality Act 2010 it is unlawful to pay people unequally because they are male or female.

We are committed to ensuring our workforce is representative of the community we serve. We aim to attract and retain talented staff from a wide range of backgrounds and with diverse skills and experience to operate in a workplace. We regularly publish information on the wider diversity of our workforce, including the Trust's Annual Report and Accounts, Public Sector Equality Duty report, Workforce Race Equality Standard report and Workforce Disability Equality Standard report.

2. OUR COMMITMENT TO EQUALITY, DIVERSITY, AND INCLUSION (EDI)

As a Trust we are committed to supporting people from different backgrounds with different perspectives and different ways of working to succeed and help us provide the best possible service to our patients.

We are committed to advancing equality, recognising diversity and promoting social inclusion. We recognise our responsibility to provide equal opportunities, eliminate discrimination and foster good relations in our activities as an employer, service provider and partner. The measures we will take are set out in our local People Plan and supporting EDI and Health and Wellbeing (HWB) plans.

Salaries within the Trust for staff employed on Agenda for Change are determined through the NHS Job Evaluation Scheme and NHS terms and conditions of service. Salaries for Medical and Dental Staff are in accordance with NHS terms and conditions of service for this staff group.

Staff undertaking the same job are paid the same irrespective of gender. In 2020 the Appointments and Remuneration Committee took positive action to ensure the opportunities for recognition and reward were open to all in relation to Local Clinical Excellence Awards (LCEAs); this was retrospectively applied to 2018 and we have seen positive results in relation to both gender and ethnicity. We are an equal pay employer.

3. DECLARATION

I confirm this report is accurate to the best of my knowledge and belief. It reflects a snapshot of our organisation on 31 March 2023. We have a number of actions in place

which are intended to address our gender pay gap. We will publish our data by 30 March 2024.

Signed: Date:

Name: Sir Jim Mackey

Designation: Chief Executive

4. OUR GENDER PAY GAP DATA

4.1 Gender profile

Profile	Male 2023	Female 2023	Male 2022	Female 2022	Male 2021	Female 2021
All staff	**22%**	**78%**	23%	77%	22%	78%

4.2 Gender pay gap

Profile	Male 2023	Female 2023	Pay Gap 2023	Male 2022	Female 2022	Pay Gap 2022	Male 2021	Female 2021	Pay Gap 2021
Mean hourly pay rate (all staff)	**£23.34**	**£18.10**	**22.44%**	£22.29	£17.30	22.42%	£21.49	£16.13	24.91%
Median hourly pay rate (all staff)	**£17.24**	**£16.84**	**2.29%**	£16.39	£15.12	1.65%	£15.56	£14.93	4.00%

The mean hourly pay gap has increased by 0.02%.

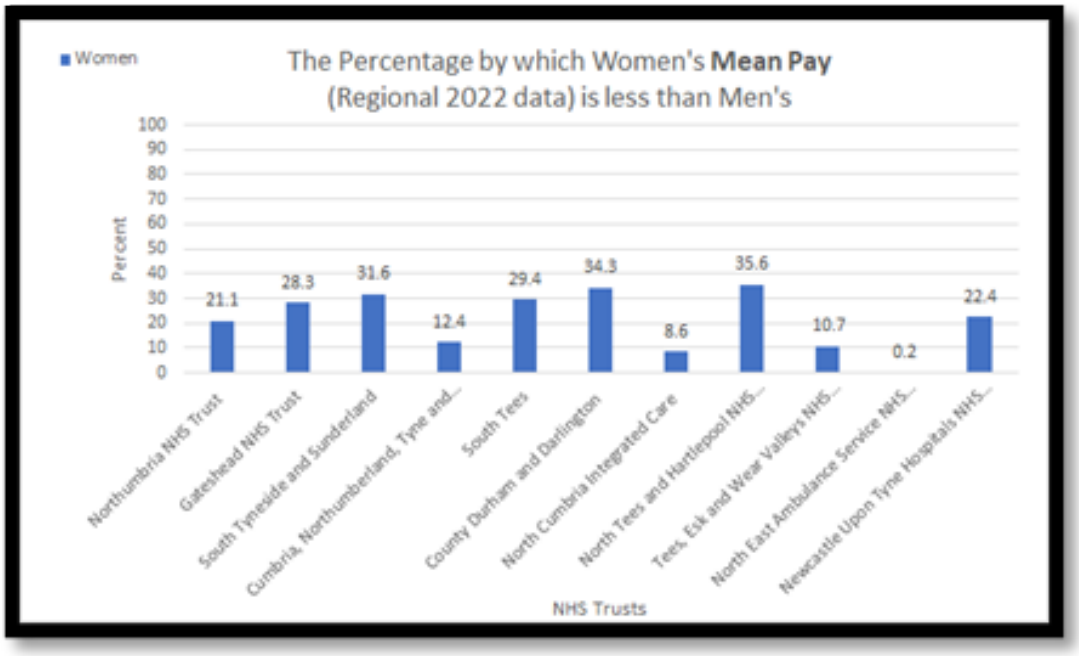
The median hourly pay rate gap has increased by 0.64%.

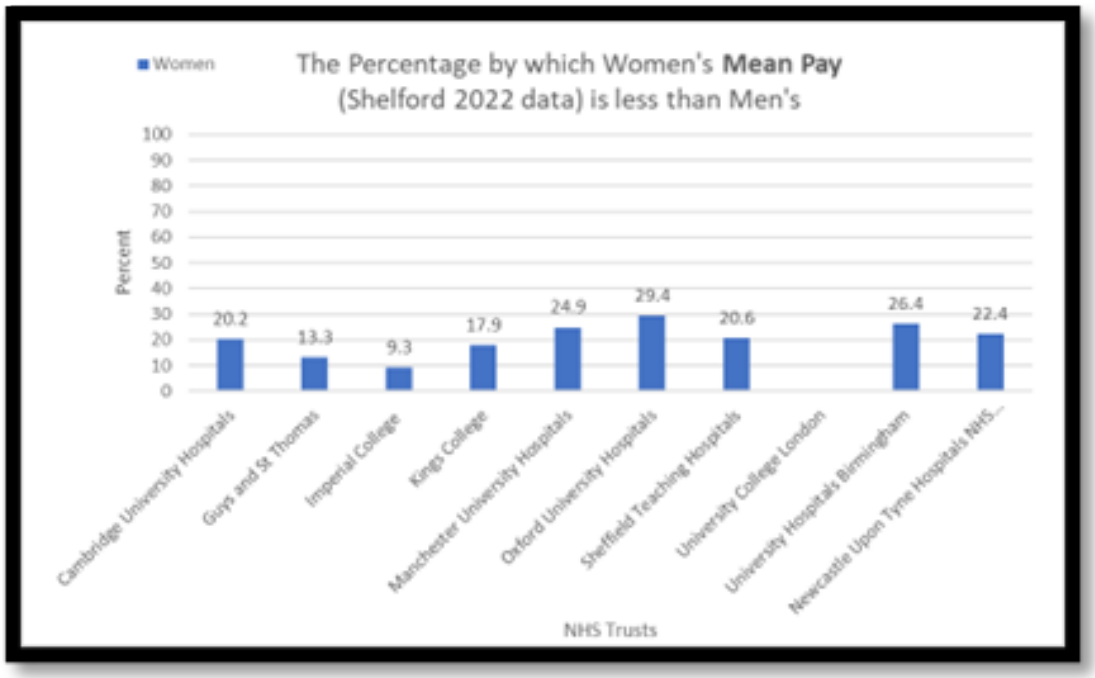
The Trust's mean gender pay gap is strongly influenced by the pay and gender make-up of the medical and dental staff group which is predominantly male and their higher pay relative to other staff increases the level of male average pay compared to females.

Gender pay gap by staff group

Staff Group	Male	Female	Difference	Pay gap
Add Prof Scientific and Technic	£22.03	£20.13	£1.90	8.61%
Additional Clinical Services	£12.30	£12.28	£0.02	00.16%
Administrative and Clerical	£17.52	£14.83	£2.69	15.34%
Allied Health Professionals	£19.75	£19.86	-£0.11	-0.58%
Estates and Ancillary	£13.83	£12.71	£1.12	8.09%
Healthcare Scientists	£22.72	£20.90	£1.82	8.02%
Medical and Dental	£49.51	£44.45	£5.06	10.22%
Nursing and Midwifery Registered	£19.54	£19.47	£0.07	0.35%
Students	£12.88	£13.17	-£0.29	-2.26%

Gender pay comparison – region and Shelford (most recent data available is as at 31 March 2022):





4.3 Bonus pay

Bonus payments which the Trust is required to include in gender pay reporting are:

Bonus payment	Staff who are eligible
Clinical excellence awards (CEA)	Consultant medical and dental staff
Excellence awards	Senior staff employed on a Trust senior staff contract
Performance-related pay	Executive directors and very senior managers (VSMs)

Performance	Pharmacy Production Unit (PPU)
Long service awards	All staff

Gender bonus pay gap

Profile	Male 2023	Female 2023	Bonus pay gap 2023	Male 2022	Female 2022	Bonus pay gap 2022	Male 2021	Female 2021	Bonus pay gap 2021
Mean bonus pay	**£12,038.50**	**£2,484.38**	**79.36%**	£1,009.03	£205.24	79.66% (* 77.24% without thank you bonus)	£15,075	£4,721	68.9%
Median bonus pay	**£6,032.04**	**£200.00**	**96.68%**	£147.05	£147.05	0% (* 90.78% without thank you bonus)	£8,225	£1,985	75.9%
Proportion of staff in receipt of bonus	**7.27%**	**2.35%**		92.41%	94.06%		6.85%	1.13%	

The mean bonus pay gap has reduced by 0.3%.
The median bonus gap has increased by *96.68%.

(* In December 2021 all staff excluding the Board received a one-off bonus payment as a Covid 'thank you' which heavily impacted the bonus pay gap as at 31 March 2022).

The "Thank you Bonus" is included in the 2022 data. Because this bonus was paid to such a large number of staff, the mean bonus pay is much lower than in previous years.

Proportion of male and female who receive bonus pay by staff group

Staff Group	Gender	Staff paid bonus	Total relevant staff	%
Add Prof Scientific and Technic	**Female**	50	524	9.54%
	Male	22	141	15.60%
Additional Clinical Services	**Female**	56	2,615	2.14%
	Male	26	562	4.63%
Administrative and Clerical	**Female**	54	1,977	2.73%
	Male	20	625	3.20%
Allied Health Professionals	**Female**	4	985	0.41%
	Male	2	221	0.90%
Estates and Ancillary	**Female**	0	775	0.00%
	Male	3	617	0.49%

Healthcare Scientists	**Female**	10	441	2.27%
	Male	10	269	3.72%
Medical and Dental	**Female**	70	574	12.20%
	Male	172	714	24.09%
Nursing and Midwifery Registered	**Female**	66	4,879	1.35%
	Male	7	443	1.58%
Totals	**Female**	310	12,771	2.45%
	Male	262	3,592	7.39%

Like the Trust's mean gender pay gap, the mean gender bonus pay gap is also strongly influenced by the pay and gender make-up of the medical and dental staff group which is predominantly male and their higher pay relative to other staff increases the level of male average pay compared to females. The 'Additional Prof Scientific and Technical' staff group shows a relatively high proportion of males receive bonus than females which is largely due to the payment of a performance bonus in the Pharmacy Production Unit.

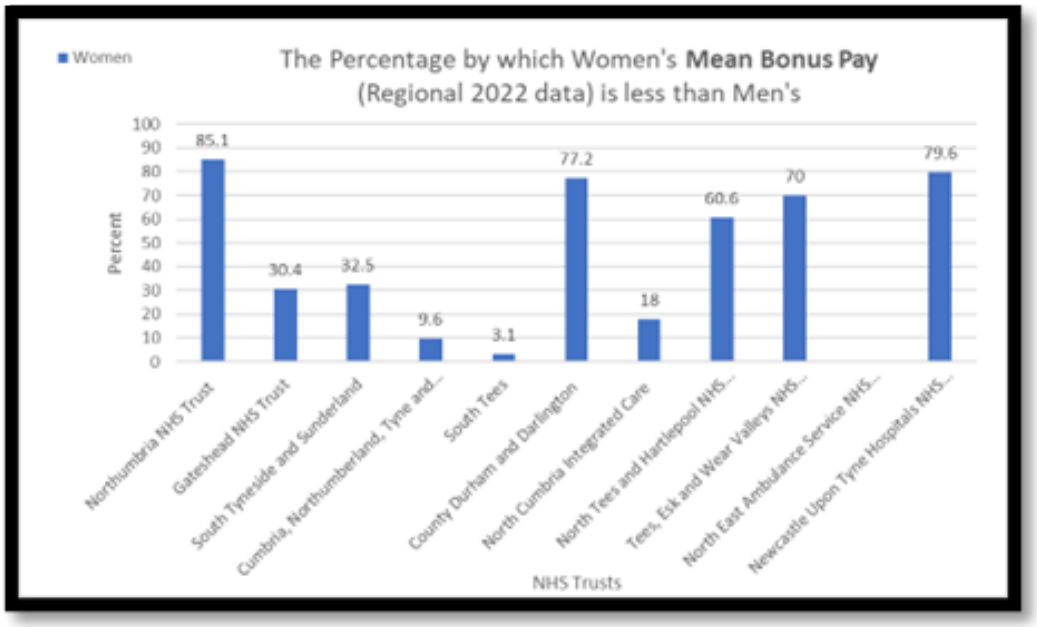
No CEA's have been awarded in the reporting period. In the last reporting period the total value of CEAs paid by the Trust by gender was: male £3.14m; female £0.63m. (The 2022/23 round has not yet been concluded)

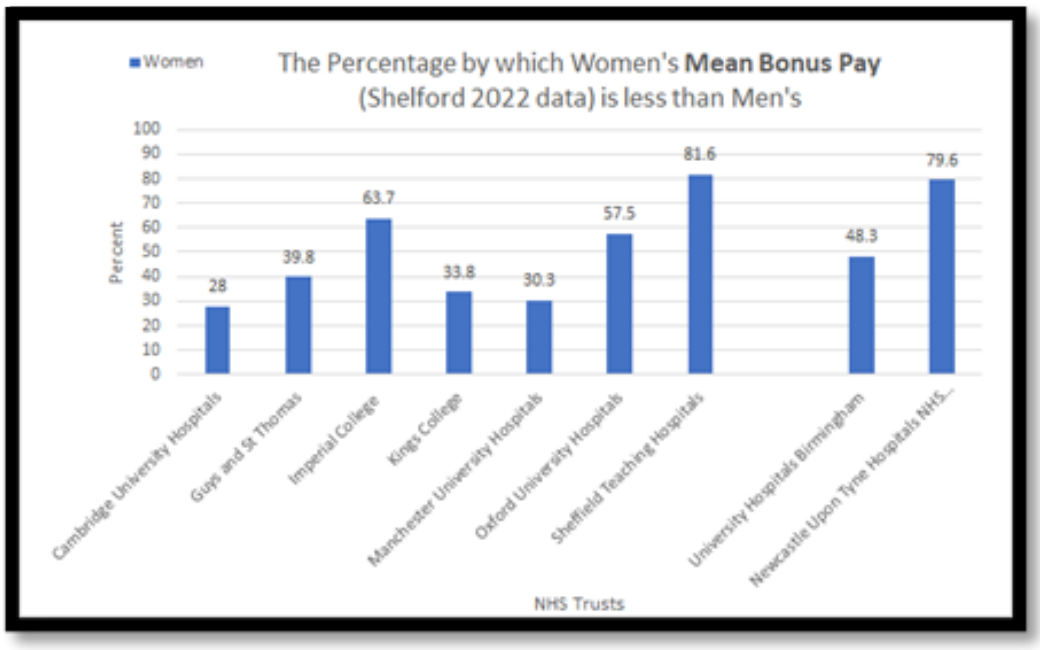
The number of consultants in receipt of a platinum, gold or silver national CEA is: male 19; female zero.

4.4 Bonus paid 1 April 2022 - 31 March 2023

Bonus Type	Female	Male	Total
Clinical Excellence Awards	70	163	233
Excellence Award	40	24	64
Performance Related Pay	3	3	6
Performance	42	34	76
Long Service Awards	159	45	204
TOTALS	314	269	583

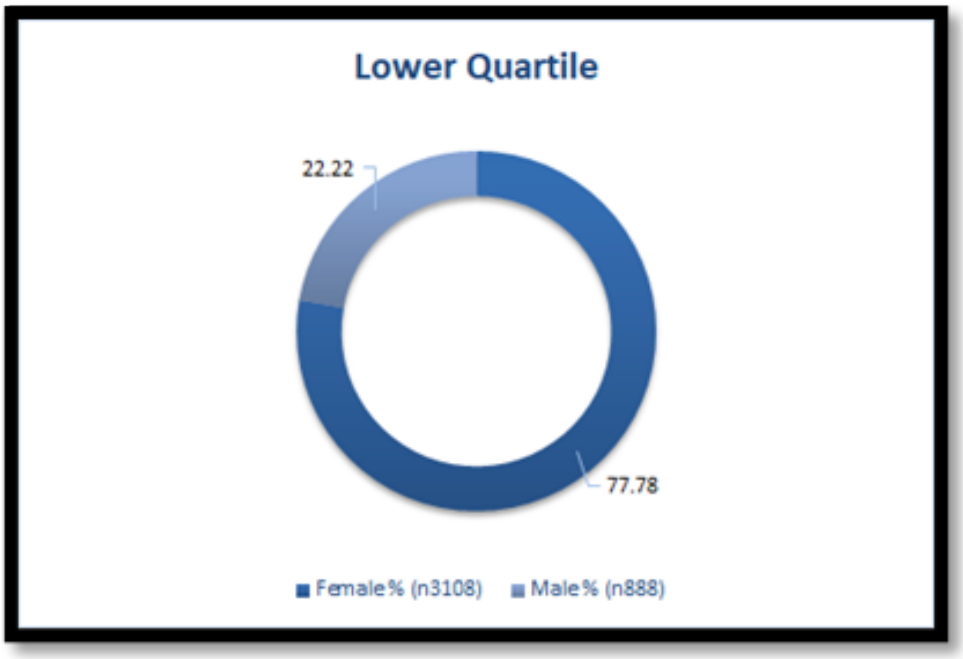
Bonus Pay Comparison – Region and Shelford (most recent data available is as at 31 March 2022)

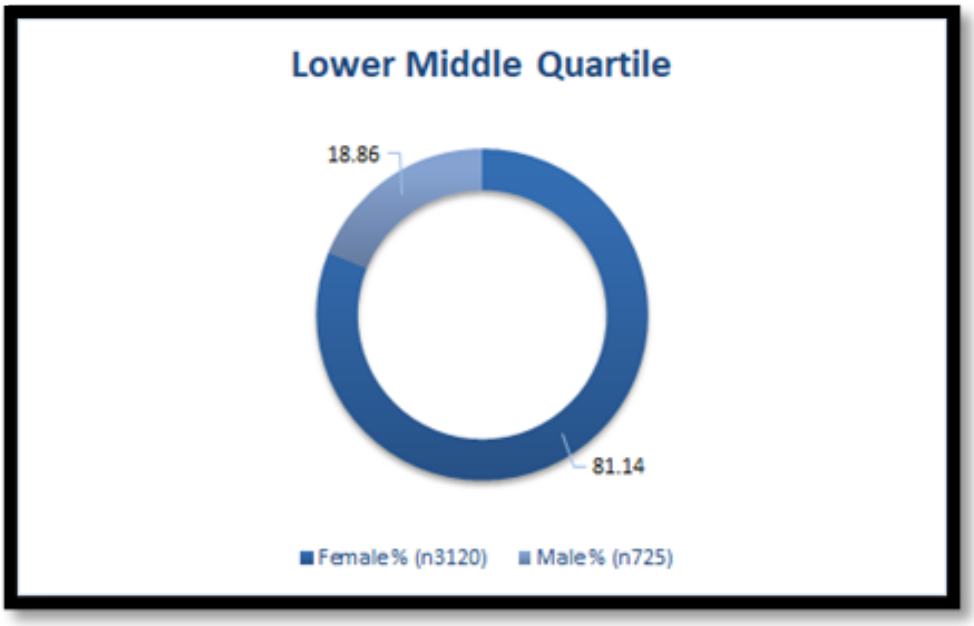


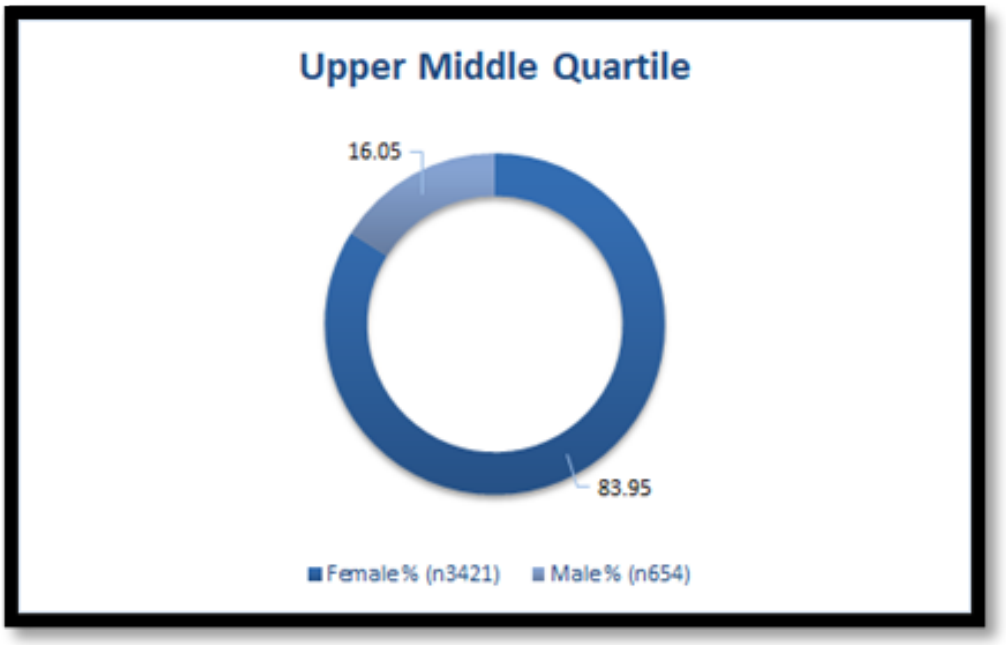


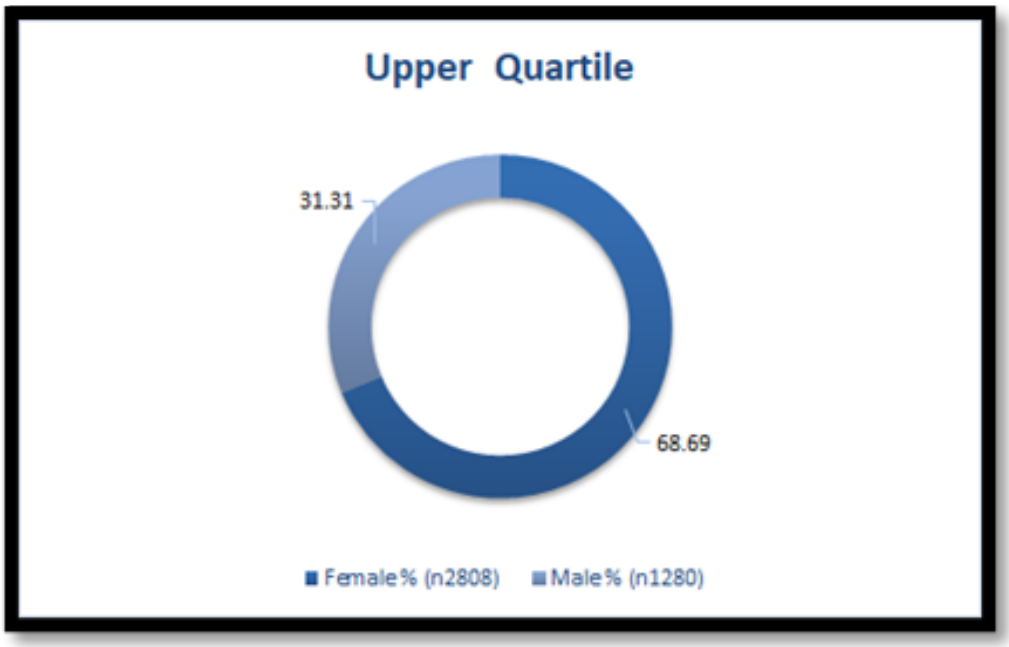
4.5 Pay distribution by quartiles

The data below is achieved by dividing the workforce into four equal parts (quartiles). All staff are ranked from the lowest hourly rate of pay to the highest. The rank order is then divided into four sections with an equal number of staff in each. With a female workforce of 78% they should ideally make up 78% of each quartile. However, females are under-represented in the upper quartile and over-represented in the lower and upper middle quartiles. The medical and dental workforce is predominantly in the upper quartile and has a higher percentage of males (706) compared to females (548).


Lower Quartile
22.22
77.78
Female % (n3108)
Male % (n888)


Lower Middle Quartile
18.86
81.14
Female % (n3120)
Male % (n725)



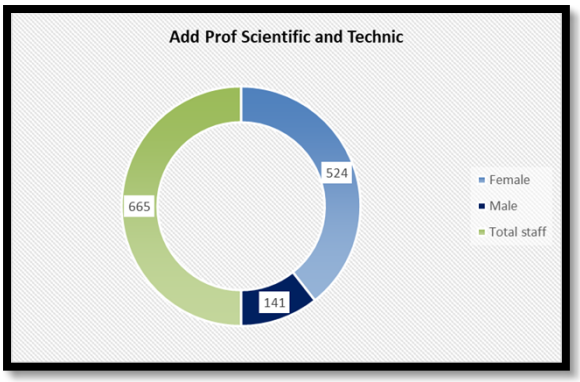


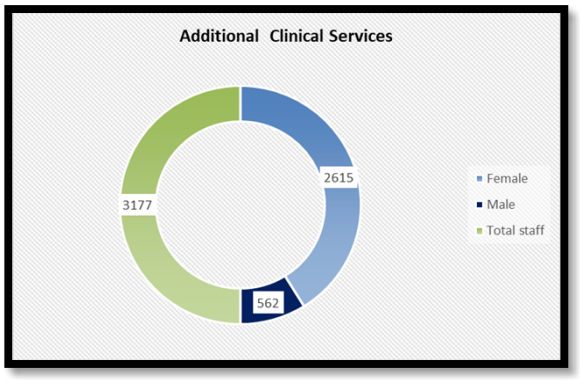
- 79.4% (6,228) of all staff in the lower and lower middle quartiles are female – a negative increase from 78% last year.
- 76.3% (6,229) of all staff in the upper middle and upper pay quartiles are female – a positive increase from 76% last year.
- 20.5% (1,613) of all staff in the lower and lower middle quartiles are male – a negative decrease from 22% last year.
- 23.6% (1,934) of all staff in the upper middle and upper pay quartiles are male – a positive decrease from 24% last year.

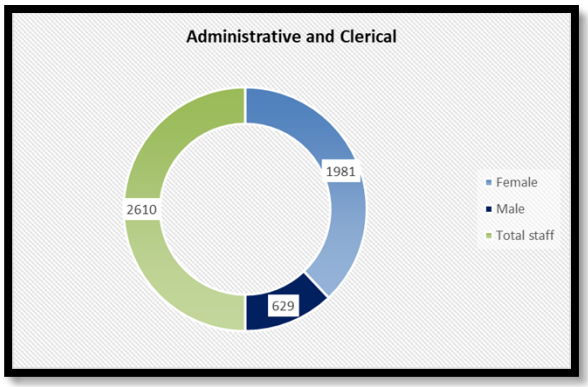
Proportionally more males hold senior positions than females:

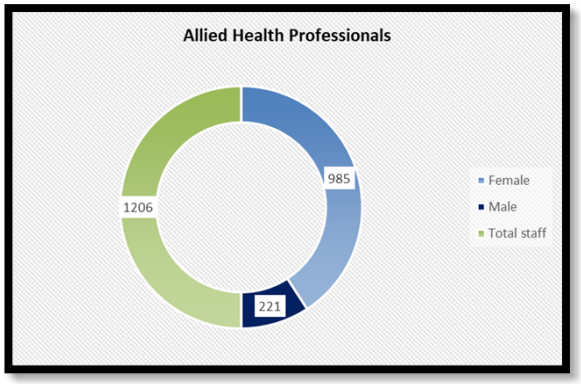
	Percentage of total male in upper quartile	Percentage of total female in upper quartile
March 2021	34.42%	22.24%
March 2022	34.70%	22.13%
March 2023	36.09%	22.54%

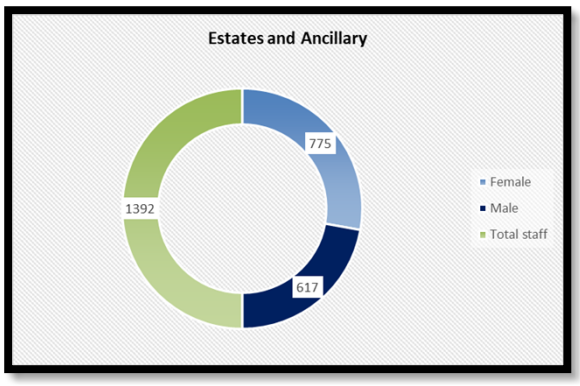
4.6 Gender profile by staff group

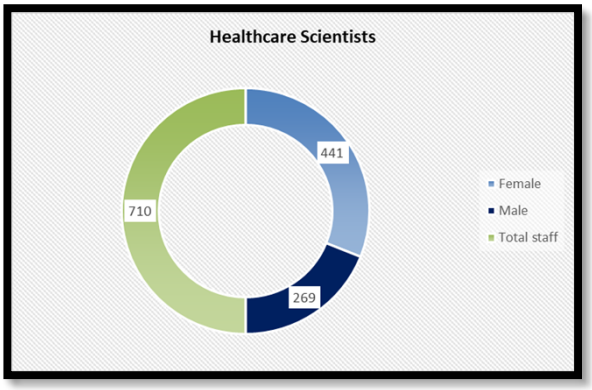


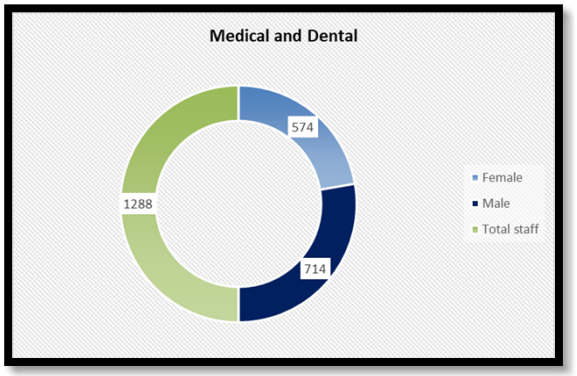


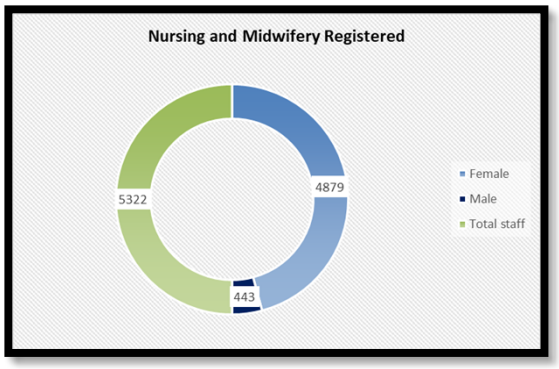


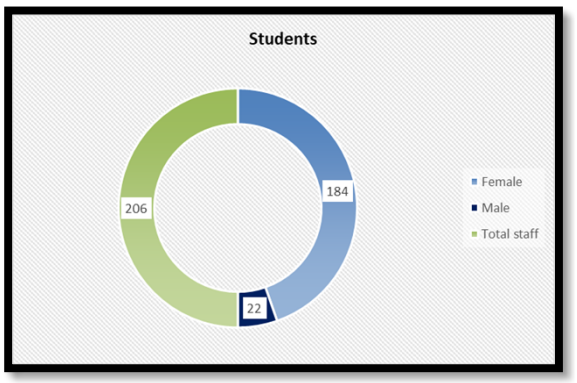












- The majority of females are in nursing and midwifery (4,879), additional clinical services (2,615) and admin and clerical (1,981).
- The majority of males are in medical and dental (714), admin and clerical (629) and estates/ancillary (617).

4.7 Percentage of the total female and male workforce (by staff group) in each of the quartiles

	lower quartile	lower quartile	lower middle quartile	lower middle quartile	upper middle quartile	upper middle quartile	upper quartile	upper quartile
staff group	male	female	male	female	male	female	male	female
Add Prof Scientific and Technic	0.08%	0.36%	0.72%	1.09%	1.24%	0.86%	1.85%	1.73%
Additional Clinical Services	10.97%	13.46%	3.65%	6.20%	0.86%	0.49%	0.06%	0.03%
Administrative and Clerical	6.12%	7.62%	3.57%	4.38%	3.46%	1.61%	4.15%	1.65%
Allied Health Professionals	0.08%	0.03%	1.22%	1.45%	2.85%	3.30%	1.96%	2.82%
Estates and Ancillary	7.46%	3.10%	6.83%	2.11%	1.88%	0.71%	0.88%	0.05%

Healthcare Scientists	0.19%	0.08%	0.80%	0.59%	2.35%	1.12%	4.09%	1.61%
Medical and Dental	0.03%	0.00%	0.08%	0.05%	0.11%	0.15%	19.51%	4.23%
Nursing and Midwifery Registered	0.06%	0.11%	3.15%	7.89%	5.69%	19.32%	3.34%	10.33%
Students	0.06%	0.16%	0.55%	1.22%	0.00%	0.04%	0.00%	0.00%

4.8 Gender pay gap by band/pay scale as at March 2023

Payscale	Male	Female	Pay Gap
	mean average hourly rate	mean average hourly rate	
Band 1	£10.75	£12.72	-18.34%
Band 2	£12.01	£11.88	1.09%
Band 3	£12.18	£12.05	1.05%
Band 4	£13.16	£13.16	-0.05%
Band 5	£16.30	£16.91	-3.76%
Band 6	£19.09	£19.65	-2.94%
Band 7	£22.95	£23.29	-1.48%
Band 8a	£26.01	£25.95	0.21%
Band 8b	£31.39	£30.77	1.98%
Band 8c	£37.18	£37.08	0.26%
Band 8d	£46.94	£44.59	5.01%
Band 9		£55.79	-100.00%
Other	£46.50	£41.26	11.27%
M&D Consultant	£54.38	£51.37	5.54%
M&D SAS	£34.76	£34.54	0.64%
M&D Trainee	£29.83	£26.60	10.81%

5. ACTION TO REDUCE THE GENDER PAY GAP

We are committed to embedding diversity and inclusion in our People Strategy and in everything that we do. This includes ensuring women of all backgrounds have equal opportunity to develop and progress.

We are addressing the gender pay gap through a range of actions within workstreams, including:

- Creating an inclusive culture through our People Strategy.
- Ensuring delivery of the NHS EDI Improvement Plan.
- Including an EDI dashboard in our performance management framework with a focus on specific metrics, targets and disparity ratios to support the recruitment of a

representative workforce and leadership, the likelihood of being appointed and promoted and flexible working.

- Ensuring fairness and equality of recruitment, including anonymised processes, diverse interview panels, availability of flexible working and an aim to achieve equal likelihood of appointment to senior positions at band 8 and above.
- Actions focussed on supporting equality in the workplace:
  - Disability Confident employer – working on providing the best offer possible
  - Carer Confident – work towards the employers for carers benchmarking scheme
  - Better Health at Work Award
  - Fair, consistent and inclusive ways of working supported by flexible working policies, including agile working, retire-return, self-rostering and shared parental leave
  - Reviewing our appraisal process
- Providing managers with people management skills, training and coaching to help embed fairness and equality in their approach to all matters relating to our workforce.
- Delivery of a talent management plan to improve the diversity of senior leadership, widen access to development programmes across a range of grades and for staff from diverse ethnic backgrounds as well as staff with disabilities.
- Improving our apprenticeship offer to widen access.
- Continuing to partner with key external stakeholders to increase diversity.
- Implementing a people plan that supports delivery of the NHS People Promise and addresses the findings from our annual Staff Survey and staff focus groups.
- Supporting our newly formed Clinical Boards through programmes covering people systems and data, HR business partnering and training and development needs.
- Equal distribution of CEAs for the 2022/23 round to all eligible consultants and reviewing the data by ethnicity and gender to ensure there is equal likelihood of application and award.

6. RECOMMENDATION

To note the content of this paper and agree the contents for publication on the government's gender pay gap service website and the Trust's website before 30th March 2024.

Karen Pearce
Head of EDI (People)

Christine Brereton
Chief People Officer

21 March 2024

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024					
Title	Effective Governance System					
Report of	Rob Harrison, Managing Director					
Prepared by	Kelly Jupp, Trust Secretary					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☒		☐		☐	
Summary	This report summarises the recent work undertaken in conjunction with The Value Circle to implement an effective governance system.					
Recommendation	The Board of Directors are asked to **approve** the: 1. New Committee structure set out in Appendix 1 to this report. 2. Updated Performance and Accountability Framework detailed in Appendix 2 of this report; 3. Terms of Reference and Schedules of Business for both the Digital and Data Committee, and the combined Audit, Risk and Assurance Committee (set out in Appendix 3 and Appendix 4 to this report); 4. Draft Board Development Programme for 2024/25, noting that this will be further refined throughout the course of the year (Appendix 5).					
Links to Strategic Objectives	Performance – Being outstanding now and in the future.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link.					
Reports previously considered by	New report.					

EFFECTIVE GOVERNANCE SYSTEM

EXECUTIVE SUMMARY

During 2023-24, the Care Quality Commission (CQC) undertook several inspections of Trust services and imposed conditions on the Trust's registration. One of the conditions required the Trust to implement an effective governance system. This report summarises the recent work undertaken in conjunction with The Value Circle to implement an effective governance system.

The Board of Directors are asked to **approve** the:

1. New Committee structure set out in Appendix 1 to this report.
2. Updated Performance and Accountability Framework detailed in Appendix 2 of this report;
3. Terms of Reference and Schedules of Business for both the Digital and Data Committee, and the combined Audit, Risk and Assurance Committee (set out in Appendix 3 and Appendix 4 to this report);
4. Draft Board Development Programme for 2024/25, noting that this will be further refined throughout the course of the year.

EFFECTIVE GOVERNANCE SYSTEM

1. BACKGROUND

During 2023-24, the Care Quality Commission (CQC) undertook a number of inspections of Trust services and imposed conditions on the Trust's registration. One of the conditions required to Trust to implement an effective governance system.

The Trust commissioned the services of The Value Circle (tvc) in early 2024 in order to provide advice and support in developing an effective governance system for Newcastle Hospitals which:

- Articulates a streamlined and simplified governance structure with clear information flows, lines of reporting and assurance, as well as accountability.
- Sets out the underpinning principles for integrated governance which includes quality, performance, finance, patient safety and risk management.
- Ensures key governance forums/meetings and structures are in place and functioning effectively, with clear Terms of Reference and Schedules of Business.
- Provides clarity over roles and responsibilities and is easily understood by staff, patients and stakeholders.
- Moves to a model of collaboration and collective accountability across Clinical Boards.

2. OVERVIEW OF RECENT WORK

In response to the CQC inspection findings, a significant amount of work has been undertaken in conjunction with tvc. This has included:

- The development of a new Committee structure (Appendix 1) to incorporate:
    - The creation of a new Digital and Data Committee;
    - Expanding the remit of the Audit Committee to incorporate Risk and Assurance; and
    - Renaming the Finance Committee as the 'Finance and Performance' Committee to better reflect the remit of the Committee.

  Both Committees are chaired by a Non-Executive Director.
  Terms of Reference (ToR) and Schedules of Business have been developed and included within Appendices 3 and 4.

  The remit of the Audit Committee ToR has been expanded to specifically include 'Risk and Assurance elements relating to:
    - Risk management strategy, policies and processes, including changes to the profile and scoring of risks in the Board Assurance Framework (BAF), robustness of the risk reporting and escalation process, risk appetite and risk training.
    - Compliance with legislation, regulatory standards and licence conditions.
    - The findings from external reviews.
    - Processes regarding clinical litigation claims and policy reviews.

Regular meeting attendees have also been added to the ToR.

- Reviewing and updating the Performance and Accountability Framework (Appendix 2) to provide clarity on the governance structure, accountabilities and responsibilities. The main changes being:
    - Removed/updated outdated references e.g. replaced 'delivery goals' with 'annual objectives' and renamed the 'Monthly Performance Reviews' as 'Quality and Performance Reviews (QPRs)' .
    - Introduced a key element of the Framework, being 'distributed leadership' with the frequency of reviews dependent on the autonomy level assigned and further detail added regarding the escalation process.
    - Added refreshed diagrams/pictures for the accountability structure, Committee structure and 'Who What Where' chart.
    - Updated the different governance groups/forums to reflect the current position e.g. removal of the Trust Leadership Group and updating the reference to the revised Risk Validation Group.
    - Amended the domains used for the QPRs and provided greater clarity regarding how the QPRs function, including the use of Chairs action logs.
    - Updated job titles/roles and responsibilities.
    - Minor amendments to the Terms of Reference appended to the Framework.

- The development of a new Board Development Programme for 2024/25. On 29 February 2024 a Board Development session was held, facilitated by representatives from tvc to focus on lessons learned from the CQC inspections and discuss the findings from the work of tvc to date.
- Holding workshops with Clinical Board leaders to strengthen the Clinical Board governance structures and move to a more devolved accountability model.

- Reviewing the format and content of the current Integrated Board Report and the Performance Report with the aim of producing a new Integrated Quality and Performance Report for the Trust Board meeting in May 2024.

- Developing a skills audit template to be utilised to assist with succession planning for Board members.

- Increased visibility of Board members, through scheduled leadership walkabouts and informal Non-Executive Director, Chair, Chief Executive and Executive Team member visits to services/departments.

- Reviewing the Committee meeting cycle and making changes to realign our Corporate meetings to ensure that the reporting of risk and assurances flows appropriately from Ward to Board.

3. RECOMMENDATIONS

The Board of Directors are asked to **approve** the:

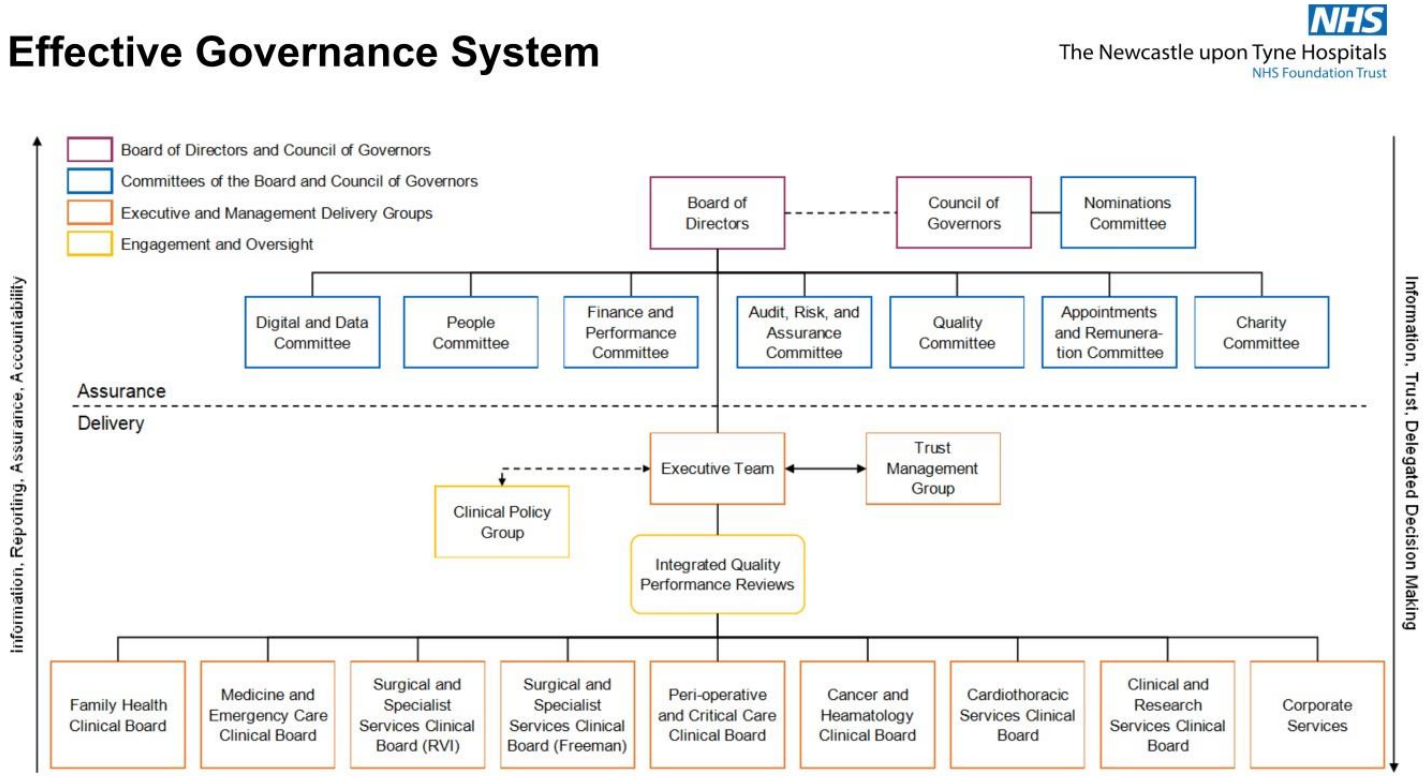
1. New Committee structure set out in Appendix 1 to this report.

2. Updated Performance and Accountability Framework detailed in Appendix 2 of this report;
3. Terms of Reference and Schedules of Business for both the Digital and Data Committee, and the combined Audit, Risk and Assurance Committee (set out in Appendix 3 and Appendix 4 to this report);
4. Draft Board Development Programme for 2024/25, noting that this will be further refined throughout the course of the year.

Report of Rob Harrison Managing Director, and
Kelly Jupp, Trust Secretary
15 March 2024

Appendix 1 – Committee Structure Chart

Overarching schematic



Appendix 2 – Performance and Accountability Framework

Performance and Accountability Framework

Version: 2.0

This version issued: March 2024

Executive Team approved: [TBA]

Trust Board approved: [TBA]

Review date: [TBA]

Owner: Rob Harrison, Managing Director

Contents:

Scope

1.1 This document sets out the overarching approach to performance management and the accountability arrangements in place within Newcastle Hospitals. This performance and accountability framework is a Trust-wide document which applies equally to all members of staff.

Purpose and key aims

1.2 The purpose of this Performance and Accountability Framework (the 'Framework') is to support the achievement of the Trust's objectives in a way which is consistent with the strategy and organisational values, by providing clarity on how the Trust is organised, where responsibilities for decision making lie, how issues and risks are escalated, and how progress is reported and monitored in an open and transparent way.

1.3 It is the framework by which the Board, Executive Team, the Clinical Boards and corporate functions are held to account for their performance.

1.4 The key aims of the Framework are to promote good governance to support the Trust in:

- Assessing performance against clear standards, goals and targets.
- Driving and supporting successful and sustainable delivery of national standards for performance, contractual targets, quality requirements and the annual objectives agreed as part of the Trust's planning round.
- Predicting future performance and forecast outturn.
- Informing strategic decisions and supporting continuous improvement.
- Focussing resources and improvement efforts in required areas.
- Holding effective Quality and Performance Reviews (QPRs) that include escalation/intervention as necessary and appropriate, or enabling the use of available autonomy.

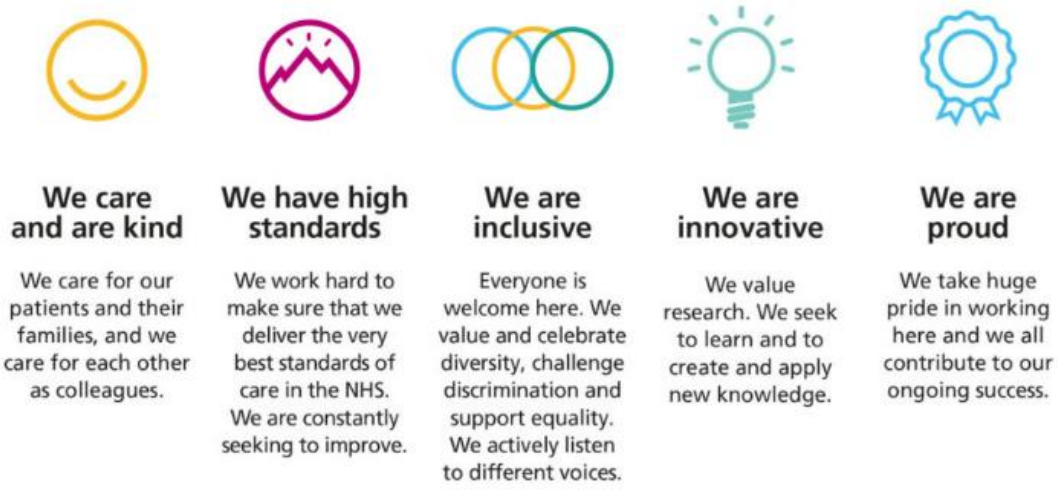
Introduction

1.5 At Newcastle Hospitals our vision is **'achieving local excellence and global reach through compassionate and innovative healthcare, education and research'**. This is supported by the Trust's five-year strategic framework which comprises five 'P's.

- **Patients** - Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality.
- **People** - We will ensure that each member of staff is able to liberate their potential.

- **Partnerships** - We will be an effective partner, developing and delivering integrated care and playing our part in local, regional, national and international programmes.
- **Pioneers** - Ensuring that we are at the forefront of health innovation and research.
- **Performance** - Being outstanding, now and in the future.

1.6 The way in which we work as an organisation to achieve this vision and deliver the strategy will be driven by our values of:



These values define how we will behave towards our patients, our partners and each other.

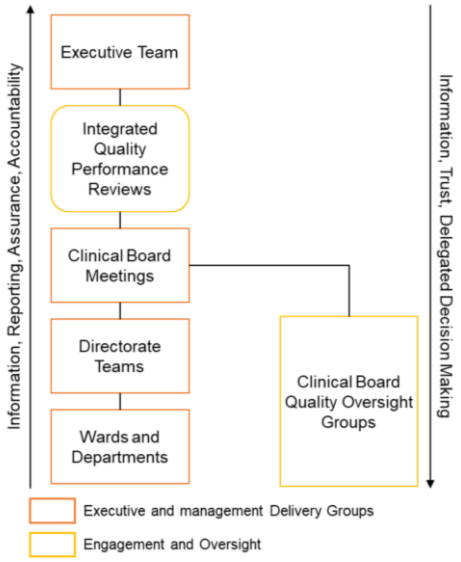
1.7 The Trust's strategy is underpinned by medium-term objectives that describe what success will look like over a five-year period, and annual objectives to support the strategy in the short-term.

1.8 A key element of the Framework is distributed leadership which is supported through accountability and autonomy – being clear about where there is authority to make decisions independently, where decisions must be escalated and under what circumstances this may be reviewed and changed accordingly.

1.9 As important as the framework and process itself is the organisational culture within which it operates. The Trust continues to invest in leadership development, to strengthen leadership capacity and capability and drive a culture where staff feel empowered and supported to take responsibility. The Newcastle Way describes this in more detail in Appendix 1.

Organisational and governance structure

1.10 As part of the Trust's planning cycle the Trust Board will set the strategic direction and the annual objectives for the organisation, utilising a range of intelligence including current performance. The diagram below shows the accountability structure. There should be a clear alignment to the strategic direction of what teams and individuals are required to do.



1.11 The Ward to Board organisational structure is underpinned by the overarching governance structure, to support and ensure that all patients, staff and key stakeholders have the opportunity to influence and inform the way in which the organisation works and its future vision and strategy.

1.12 The organisational structure is included in Appendix 2 and Appendix 3 shows the governance structure.

1.13 The Terms of Reference of the Clinical Boards, the QPR meetings and the Trust Management Group are included in appendices 4 to 6.

Trust Board of Directors

1.14 The Board of Directors (Trust Board) has overall responsibility for leadership, strategic direction, control and risk management. It is accountable, through our Chair and Chief Executive Officer (CEO), as the accountable officer, to NHS England (NHSE), the Care Quality Commission (CQC) and the Secretary of State for Health and Social Care.

1.15 The Trust Board, comprising Executive and Non-Executive Directors (NEDs), operating as a Unitary Board, has collective responsibility for the overall performance of the Trust and setting the organisational strategy. The key roles and

responsibilities of the Board of Directors are set out in the Standing Orders of the Board of Directors. While reserving responsibility for certain specific matters, many functions and responsibilities are delegated by the Board to the CEO and other Executive Directors through the Scheme of Delegation. The Scheme of Delegation also specifies the delegated authority levels. These documents can be found in the Governance section and the policies database on the Trust intranet.

1.16 The Trust Board has established a number of assurance committees (Quality; Finance; Audit, Risk and Assurance; People; Digital & Data; Charity and Appointments and Remuneration), chaired by NEDs, the key role of which are to provide **assurance** to the Board on the effective performance and operation of the Trust. The Board Committees oversee key strategic Board level risks. Committees provide more space and time for issues to be considered in further detail than can be achieved in full Board meetings. Committees receive written reports and in-person updates from senior staff who chair relevant management groups. Committees report directly into Trust Board meetings via minutes and updates from NED chairs and lead Executive Directors, to provide assurance or highlight any gaps in assurance for consideration. The Appointments and Remuneration Committee is responsible for overseeing the appointment and remuneration of the CEO, Executive Directors and other Very Senior Managers.

1.17 When necessary or needed Strategic Oversight Groups (SOGs) may be set up as time limited sub committees of a Trust Board Committee comprising NEDs and Executive Team members who are convened to oversee a specific significant development or matter. Such Groups are established by the Board where it is identified that the nature of the development/matter requires more dedicated oversight than can be met by an existing Committee either due to time commitment, level of risk or that the development/matter requires a cross committee membership due to its impact on several committees. SOGs are chaired by a NED and often include NED members from more than one Committee. SOGs typically receive written reports and in-person updates from the appropriate Executive Team member and other senior staff. SOGs report directly into one or more Board Committees and where appropriate provide updates to Board Meetings via the relevant NED and Executive Director leads.

Council of Governors

1.18 The Council of Governors represents the interests of members and partner organisations in the local community and holds the Board of Directors to account for the performance of the Trust (primarily through the NEDs). Governor's exercise this holding to account through a number of channels including the work of the Council of Governors and the Governor Working Groups and observing the work of Board Committees.

1.19 The Council of Governors also have a number of specific statutory duties, as set out in the Trust's Constitution and Standing Orders of the Council of Governors (these can be found on the Trust website).

1.20 The Council of Governors meets regularly, with a minimum of 4 formal meetings a year, and are chaired by the Trust Chair with Governors and Board members in attendance. The meetings provide an opportunity for the Governors to seek assurance and provide independent challenge to the Board of Directors. Their overriding statutory duty is to hold the NEDs to account for the performance of the Board.

1.21 The Trust has 36 Governor seats. NHS Foundation Trust Governors are the direct representatives of local communities and do not manage the operations of the trusts.

1.22 The Trust has three Governor Working Groups (WG), being: Business and Development (B&D) [Aligned to the Finance and Audit, Risk and Assurance Committees]; People, Engagement and Membership (PEM) [Aligned to the People Committee]; Quality of Patient Experience (QPE) [Aligned to the Quality Committee]. The Governor WGs are aligned to the Board Committees and are a forum for Governors to obtain assurance and information on specific areas relevant to their statutory roles e.g. the appointment of the external auditor.

Chief Executive Officer (CEO)

1.23 The CEO is the Accountable Officer, responsible for the overall running of the organisation. This includes ensuring that the Trust meets all quality, operational performance and financial requirements.

Executive Team

1.24 The Executive Team supports the CEO in delivering the Trust's strategic objectives and has overall responsibility for the approval, and implementation, of the Performance and Accountability Framework.

1.25 The Executive Team consists of Executive Directors and other Directors who attend the Trust Board meetings.

1.26 The Executive Team is responsible for ensuring appropriate oversight mechanisms and processes for the management of performance, including the application of corrective actions in relation to:

- Delivery of strategic priorities, including focused improvements, Trust programmes, and task and finish projects.

- Operational, quality and financial performance.
- Organisational capability and capacity to deliver the priorities, including an appropriately skilled and supported workforce.
- Compliance with statutory, mandatory and regulatory requirements.

1.27 The Executive Team is the senior executive decision-making body of the Trust and is accountable to the Trust Board of Directors for the executive oversight and performance of the organisation. Meetings are held weekly and are chaired by the CEO. The Executive Team are responsible for executive oversight of the Trust and are accountable through the CEO to the Trust Board.

Trust Management Group (TMG)

1.28 The TMG meets every 2-weeks to bring together senior leaders of the Trust (as defined in the Terms of Reference in Appendix 6) to maintain the overall effectiveness of the Trust by ensuring the robust, effective and efficient operational management.

Executive led management groups – such as the Financial Recovery Steering Group

1.29 Executive led management groups are subgroups of the Executive Team where either the CEO or a member of the Executive Team oversees progress and management of key organisational priorities or tasks. Accountability is through the chair of the meeting with issues escalated to the Executive Team as required. NED input is not directly required as these groups focus on operational matters. Board-level oversight is maintained through the Committee structure and/or regular Board reporting

Management Groups – e.g. Clinical Outcomes and Effectiveness Group, Supplies and Services Procurement Group

1.30 Management Groups are regular groups consisting of a range of staff including senior members of staff who oversee significant issues and themes. They are chaired by Executive Team members or appropriate deputies/senior leaders and are not attended by NEDs.

1.31 The Groups report operationally to their lead Executive Director who is accountable for their work programme. Where relevant the Groups provide assurance updates to the Executive Team, and then if required to Board Committees via minutes and/or verbal updates from the Management Group chair or relevant Executive Director.

Risk Validation Group

1.32 The Risk Validation Group provides an additional check and challenge of changes to risks in the Trust. This includes considering risks proposed for acceptance and/or closure based on Risk Appetite and attainment of the Target Risk Score. The Group validates information which is then presented to the Executive Team and Audit, Risk and Assurance Committee.

Strategic command

1.33 A function utilised by the Executive Team to allow directors to focus on significant issues of business continuity linked to extreme operational pressure or incidents. The meetings are held when necessary or needed and are chaired by the assigned Medical Director who is the Accountable Emergency Officer. Meetings can also be convened by the Strategic On-Call Director acting within the Emergency Preparedness, Resilience and Response (EPRR) policy, and are administered by the Head of Business Continuity and Emergency Planning. Accountability of this subgroup is through the chair of the meeting with issues escalated to the Executive Team/CEO/Board as required.

Tactical command

1.34 Convened when necessary and needed, tactical command is a daily meeting of senior operational and clinical leads or in the case of major incident to provide short term strategic leadership as per the EPRR policy. Chaired by the Deputy Chief Operating Officer (COO) or equivalent. Accountable to Strategic command and the Executive Team via the Joint Medical Directors or the Managing Director.

Clinical Policy Group

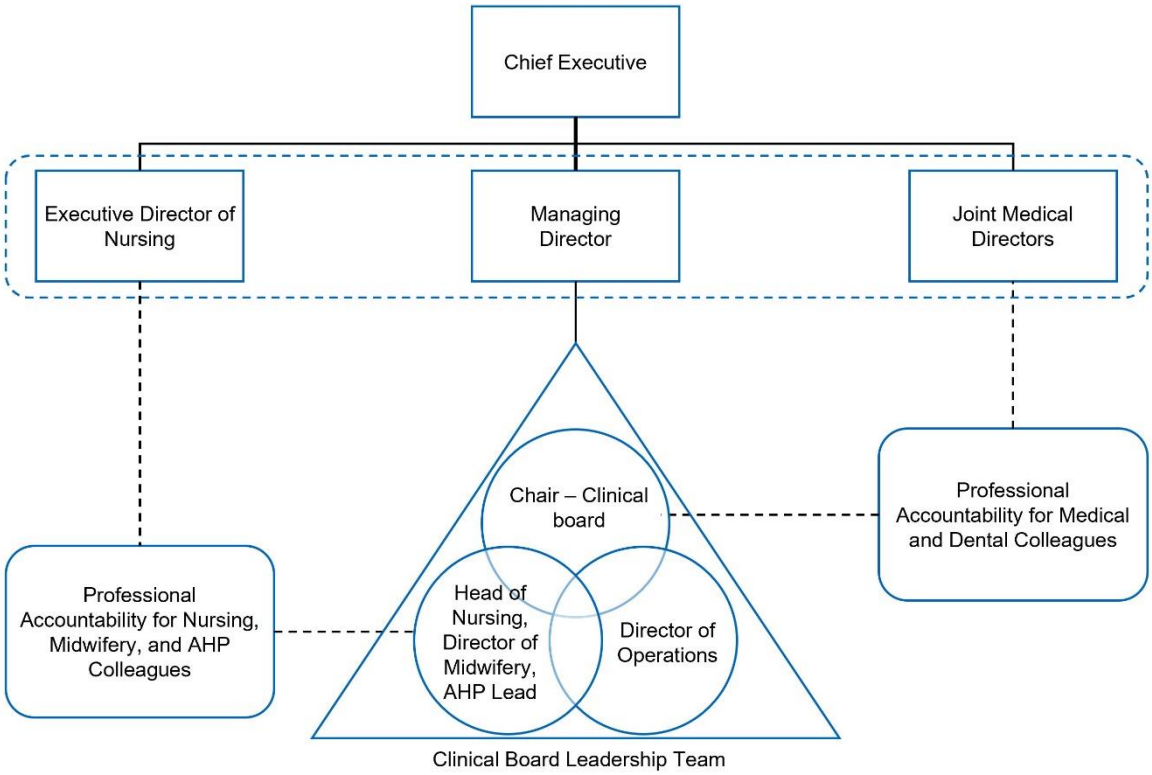
1.35 A regular monthly meeting chaired by the Joint Medical Directors and including all Associate Medical Directors, Clinical Board Chairs and Corporate Clinical Directors and selected senior clinical leaders. Attended by Executive Team members. Responsible for developing and implementing clinical policy across the Trust. Accountability is through the chair of the meeting with issues escalated to Executive Team as required.

Clinical Boards and directorates

1.36 The Board of Directors is committed to a model of strong clinical and distributed leadership, and the eight Clinical Boards are the vehicle for ensuring delivery of operational priorities.

1.37 Clinical services operated by the Trust are organised across eight Clinical Boards. The Trust is committed to a clinical leadership model and each Clinical Board is led by a Clinical Board Chair who is a senior clinician and is accountable to the Executive Team (via the Managing Director, the Joint Medical Directors and the Executive Director of Nursing) for the performance of the Clinical Board across all aspects of its agreed Clinical Board business plan.

1.38 Clinical Board Accountability Structure:



1.39 The Clinical Board Chair is responsible for leadership of the Clinical Board to support the delivery of patient care according to the Trust vision and strategy and is responsible for ensuring that quality and safety of patient care remains the primary objective of all staff of the Clinical Board. The Clinical Board Chair is also responsible for ensuring robust quality and safety arrangements in place, in accordance with the overarching Newcastle Hospitals 'Clinical Board Quality and Safety Framework'.

1.40 As agreed with the Executive Team Clinical Boards may also provide Corporate organisational leadership for specific strategic areas, such as Urgent and Emergency Care, Elective Care, Out of Hospital Care, Cancer and Diagnostic Care.

1.41 The Clinical Board Chair is accountable for all aspects of the performance of the Clinical Board and chairs the Clinical Board meetings. They also have line management responsibility for the Director of Operations and Clinical Directors.

1.42 Reporting to the Clinical Board Chair and Managing Director, the Director of Operations is responsible for overall operational delivery, interpreting and delivering

overall health service policy and strategy, and has a key role in supporting the Clinical Board Chair in the leadership of a group of Specialties and Directorates. The Director of Operations is also responsible for providing high-level operational and strategic business planning and leadership to ensure that the Clinical Board provides high quality patient care and achieves its performance objectives.

1.43 The Clinical Board Director of Operations has line management responsibility for the Head of Nursing (with professional accountability to the Executive Director of Nursing).

1.44 The Clinical Directors within each Clinical Board are accountable to the Clinical Board Chair for the performance of the Specialties and Directorates in their sphere of responsibility. The Clinical Directors, who are members of the Clinical Board, have line management responsibility for the specialty leads within their clinical directorate and have access to appropriate resources to support necessary performance and governance outputs. This includes responsibility for the budget of the clinical directorate.

1.45 The Clinical Board triumvirate (the Clinical Board Chair, the Director of Operations and the Head of Nursing/AHP leadership) is responsible for overseeing effective operation and delivery of services across all the Clinical Board's activities including operational performance, quality, workforce and finance. It is also responsible for ensuring that there are robust governance arrangements in place throughout the Clinical Board (including within clinical directorates and specialties) to ensure that key issues and risks are identified, managed and escalated as necessary in an effective way.

1.46 Each Clinical Board will be managed in accordance with a common governance framework, specifically in relation to arrangements for quality governance. The following section outlines how the Clinical Boards are held to account for the delivery of their business plans.

Corporate directorates

1.47 Each member of the Executive Team leads a corporate directorate comprising teams with functional responsibilities for providing corporate support to the organisation as a whole. The Executive Team is accountable to the CEO for the performance of their corporate directorates.

1.48 While this Framework focuses on the levels of the organisational structure outlined above, it is important to recognise that clarity of accountability is vital at all levels of the organisation, including teams and individuals within Newcastle Hospitals who should all have clear objectives which are linked to the organisational objectives.

1.49 Corporate Directorates will organise their teams to align to each of the Clinical Boards to ensure that the Clinical Boards have the right level of resource, capacity and expertise to deliver their functions.

Holding to account

1.50 The primary means by which the Executive Team holds the Clinical Board and corporate directorates to account for progress against contractual and national performance requirements is through regular QPRs. These meetings are equally an important mechanism through which Clinical Board and corporate directorates can escalate issues to and seek support from the management executive.

1.51 QPR meetings take place with each of the eight Clinical Boards. They are chaired, and administered, by the Managing Director, with an expectation that the following Executive Directors are present as a minimum: Executive Director of Nursing, Joint Medical Directors, Chief Finance Officer, Chief People Officer and Director for Commercial Development and Innovation. From each Clinical Board, it is expected that the Clinical Board representation will be led by the Clinical Board Chair and will comprise of the Director of Operations, Head of Nursing/AHP Lead, as well as the quality and safety, finance, information, performance and workforce leads. Clinical Directors and Associate Directors of Operations /General Managers will also be invited to attend as appropriate. Other members of the clinical leadership team are also free to attend where appropriate.

1.52 Other members of the Executive Team are free to attend all meetings. Core attendees should prioritise these meetings but, if they are not available, they should send a representative who is appropriately briefed in order to participate fully in the meeting. It is expected that core members of each QPR (as outlined above) should attend a minimum of 75% of meetings a year.

1.53 The Clinical Board QPRs focus on five domains (including any risks associated with each):

- Quality and safety.
- Performance – including activity and access targets.
- People merits and progress in the implementation of the People Plan.
- Finance including current year position and financial recovery.
- Service developments and horizon scanning.

1.54 Key summary metrics within each of these domains will be developed and will be used to track progress. This underpins the key principle of distributed leadership and autonomy, with those Clinical Boards performing well against KPIs or recovery trajectories having less frequent reviews compared to those who need more support.

1.55 The focus of the Clinical Board QPRs should be on issues and metrics that need to be raised by exception for discussion, with the information and data provided for reference at the meeting taken as read. To get the most from QPRs, the Clinical Board leadership team will prepare a pack of information circulated 3 working days in advance to enable the QPR attendees to have the information required to undertake the review to the appropriate depth. This will be supported by Corporate Teams as required and cover all aspects of the agenda. Notes and action points will be circulated in a timely way by the Corporate Performance Team and the nominated action owners will be responsible for following up their actions ahead of the next meeting.

1.56 A comprehensive action log will be maintained and this will be supported by an active risk register for each Clinical Board.

1.57 It is expected that each Clinical Board will have in place a formal structure for regular QPR review meetings with their clinical services and this should report directly into their Clinical Board.

1.58 Following each round of QPRs with the Clinical Boards, the key quality and performance issues arising from the meetings will be drawn together by the Chair of the QPRs and discussed by the Executive Team. This provides an opportunity for key issues to be escalated, particularly where they might involve or impact on more than one Clinical Board. This in turn will help inform the discussion of quality and performance by the relevant Board Committees, and/or the Trust Board. A Chairs action log from the QPRs will be produced/maintained which will be included with the papers for the Quality and Finance Committees.

1.59 The Executive Team will monitor and review the need for additional training, support and capacity to facilitate the effective operation of the Performance and Accountability Framework.

Performance Management and Reporting

1.60 A Trust-wide Integrated Quality and Performance Report (IQPR) providing data at Board level, with selective key performance indicators (KPIs) will form the basis for the QPRs with the Clinical Boards. These reports will be regularly updated as performance expectations change, and new targets set. In addition, each Clinical Board will receive an additional set of metrics relevant to their service areas within their IQPR to inform action and decision making at the QPRs. The KPIs and thresholds for performance success will be set by the Managing Director, Joint Medical Directors and Executive Director of Nursing, and signed off by the Executive Team.

1.61 Where Clinical Boards demonstrate an ability to maintain high levels of performance, the principle of maximum autonomy will apply. The levels of autonomy are outlined below:

Autonomy level	Assessment criteria	Mandated frequency of reviews
1. Maximum autonomy	Consistently high performing across the review domains.	Quarterly QPRs No specific support needs
2. Enhanced autonomy	Majority of the review domains are high performing and improvement plans are in place for the other domains	Bi-monthly QPRs Specific support needs on request of the Clinical Board
3. Reduced autonomy	Where a Clinical Board is under delivering on most domains, or where underperformance on a specific domain is having a significant impact on overall Trust performance	Monthly targeted QPRs and additional oversight as required, with ability to move to fortnightly if required Additional support from relevant Corporate Teams

Triggering and managing performance escalations

1.62 There are several layers and routes of escalation:

1.63 Stepping up of QPRs:

- Clinical Board to escalate in-quarter of any deterioration across the IQPR that impacts on their level of autonomy.
- Trust-wide oversight and performance monitoring identifies a Clinical Board concern.
- IQPR identifies a need for a focussed review of finance, workforce, quality and patient safety or operational performance. These meetings will be scheduled in between quarterly meetings with members of the corporate team and the Clinical Board Triumvirate.

1.64 To the Executive Team:

- Specific items of escalation for the Executive Team to note i.e. breach of a national requirement however assurance can be provided that a recovery action plan is place and will no longer be an issue within a specified time-frame.
- Specific items of escalation for the Executive Team to action i.e. breach of a national requirement and there is no credible recovery plan in place and support is required. The Executive Team will agree the next course of action directly with the Clinical Board.
- Clinical Boards and other corporate leadership teams can make a direct escalation to an appropriate forum, i.e. a Senior Leadership Forum or directly into the Executive Team rather than wait for a QPR.

- If there is ongoing slippage against the action plan, there will be a further escalation to the Managing Director and the relevant Executive Director pending the nature of the escalation.

- A further escalation can be made to include the CEO to mediate a resolution or set out the next steps.

1.65 As the framework relies on robust governance arrangements being in place, any governance concerns can and should be highlighted through other routes including, the Risk Validation Group and Clinical Effectiveness and Audit Group as examples. Members in attendance are expected to triangulate information and raise concerns if there is contradictory information presented. In this instance, the Executive Team will review and determine whether a governance review of the Clinical Board is required.

Risk Management

1.66 This Framework aims to align with the Risk Management Policy and Strategy. The Trust recognises that there are unavoidable and inherent risks to providing healthcare services and are committed to supporting a dynamic, proactive, and transparent approach to risk management throughout the organisation.

1.67 The Board of Directors with the support from its Committees of the Board have a key role in ensuring robust risk management systems and processes are effectively implemented, and maintained, as well as to promote a culture whereby risk management is fully embedded across all Trust activities through its policy, strategy and management plans.

1.68 All Clinical Board leadership teams are responsible for ensuring the implementation of the Risk Management Policy within their clinical boards including establishing effective risk management governance to support the continual management of risks and risk registers as set out within the Risk Management Policy which can be found in the Trust policy directory.

1.69 All staff play a vital role in considering risk and helping to ensure it does not prevent the delivery of care. Effective risk management is the responsibility of every member of staff and the escalation of risk should be encouraged and managed separately using an appreciative enquiry approach.

Monitoring compliance with and the effectiveness of this document

1.70 The Framework will be reviewed annually.

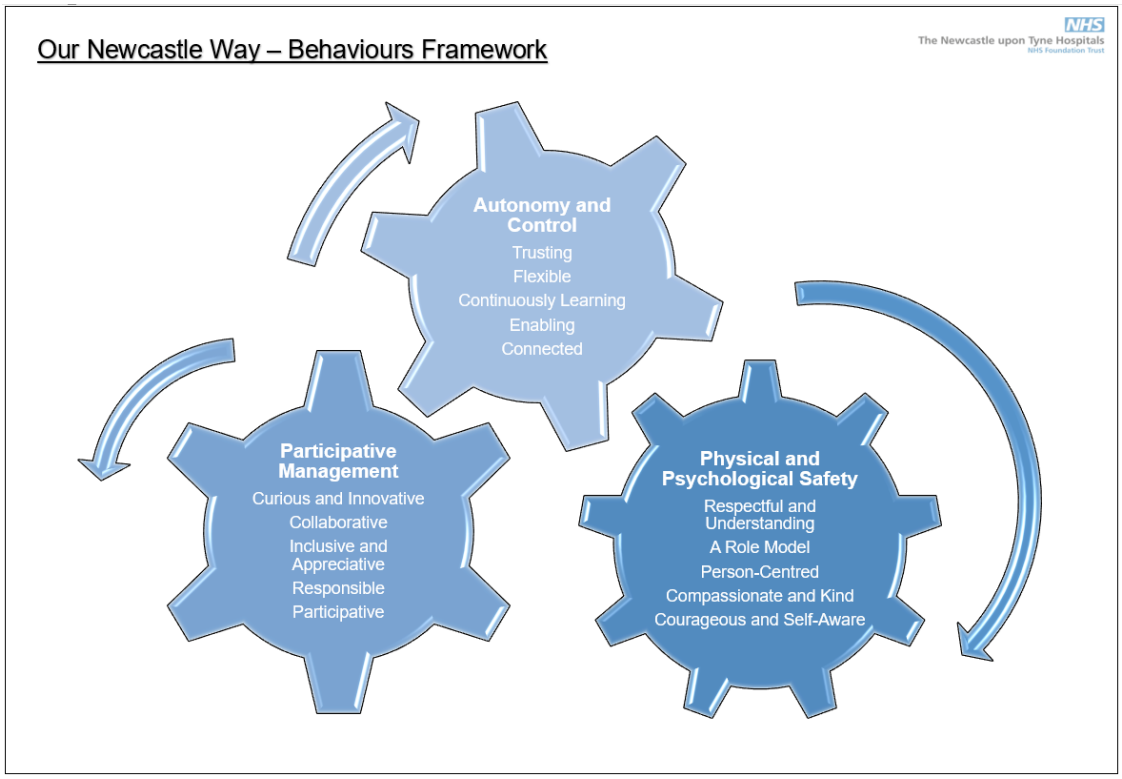
Equality and diversity statement

1.71 This document complies with the Newcastle Hospitals equality and diversity statement.

Disclaimer

It is the responsibility of the individual to ensure that the most recent version of this document is being used. This can be checked in the electronic library version control section.

Appendix 1 – Our Newcastle Way

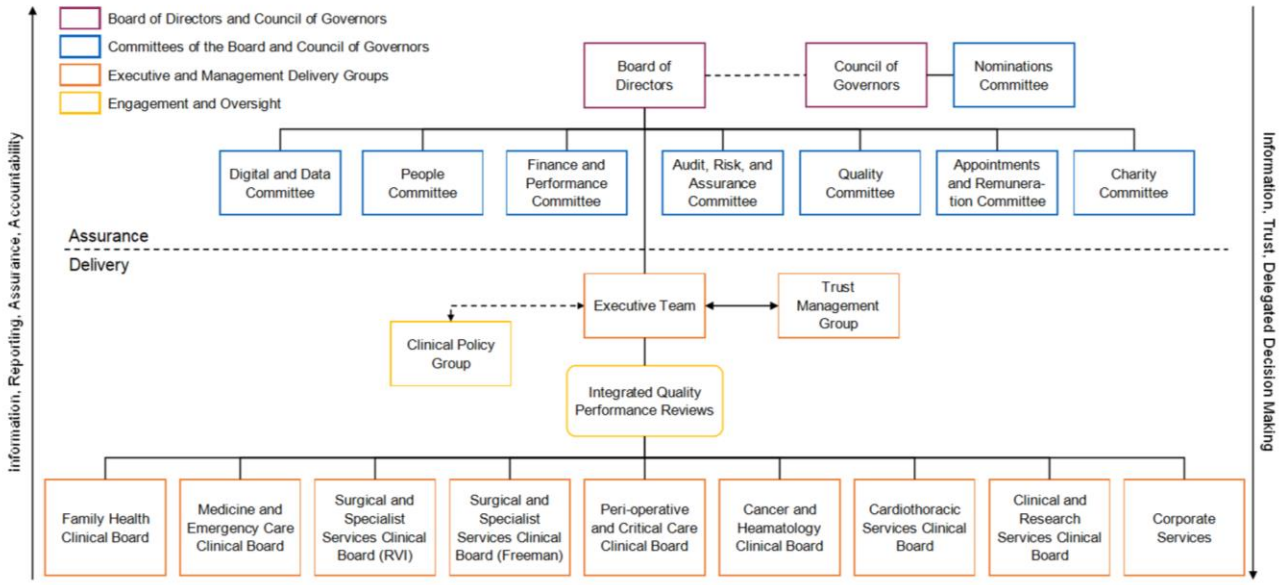


Our Newcastle Way – Behaviours Framework

Autonomy and Control		Participative Management		Physical and Psychological Safety	
Behaviour	What does it mean?	Behaviour	What does it mean?	Behaviour	What does it mean?
Trusting	I support an environment where others can do their job Others trust me to do what I promise	***Curious and Innovative***	I encourage suggestions for improvement I explore innovative solutions I am open to all ideas	***Respectful and Understanding***	I treat others with respect and dignity I actively listen to seek understanding of different perspectives
Flexible	I am open to new and different ways of working	***Collaborative***	I partner with others to achieve the best for our patients and population I invite others' participation and input	***A Role Model***	I inspire others to do their best I demonstrate integrity and authenticity
Continuously Learning	I demonstrate a growth mindset and pursue continuous improvement I use intelligence and best evidence to inform decisions	***Inclusive and Appreciative***	I ensure everyone's voice is heard and contribution is valued I work intentionally to develop equitable practices I recognise and value everyone's contribution	***Person-Centred***	I focus on patients, families and the wider population and individuals within the team
Enabling	I create psychological safety I use coaching to help others be at their best	***Responsible***	I accept responsibility for own actions I am accountable	***Compassionate and Kind***	I treat everyone with compassion, acknowledging that we all make mistakes and are human I practice self-compassion
Connected	I show unwavering resolve to our shared purpose I am clear about purpose and demonstrates our values	***Participative***	I am interested in others' opinion and ideas I co-produce solutions with others	***Courageous and Self-Aware***	I stand up under conditions of uncertainty I challenge the status quo I am comfortable with ambiguity I understand and reflect on the impact of my own behaviours

Appendix 2 – Leadership and Clinical Board organisational structure chart

Appendix 3 – Governance structure



Appendix 4 – Clinical Board Terms of Reference

CLINICAL BOARD

TERMS OF REFERENCE

1. CONSTITUTION

1.1 All clinical services in the trust are part of one of eight Clinical Boards, which is led by a Clinical Board Chair (a senior clinician), a Director of Operations (a senior manager) and a Head of Nursing (referred to as the leadership triumvirate). Each of these Clinical Boards have been established for the purpose of bringing together its most senior leaders to create a culture of collective leadership, to role model the Trust values and to work in an integrated way to deliver conditions that support staff to deliver the strategic objectives of the Trust.

1.2 The Clinical Board is accountable to the Executive Team through the Clinical Board Chair and Director of Operations who are accountable to the Managing Director. The Joint Medical Directors and the Executive Director of Nursing have professional accountability in relation to all aspects of medical and nursing care.

2. DUTIES

2.1 In particular the Clinical Board will:

a) Oversee and facilitate delivery of Trust objectives, incorporating the annual objectives set each year along with the Clinical Board and Directorate / specialty business plans by:
   - Delivering the agreed Clinical Board strategy.
   - Providing assurance on action plans for variances that are either serious in extent or common across the Clinical Board.
   - Maintaining and reviewing an action tracker.
   - Identifying, managing and escalating (as appropriate) risks in line with the risk management policy.

b) Facilitate learning across clinical boards from successful initiatives and the review of adverse events utilising the Patient Safety Incident Response Framework.

c) Ensure robust management and monitoring of performance metrics, quality and safety issues within the Clinical Board until they are resolved.

d) Discuss the Clinical Board's quality and performance and agree actions where necessary to address any issues arising.

e) Ensure the Clinical Board's financial position remains within the agreed budget, delivering the Cost Improvement target set and take action where necessary when variances occur to minimise the impact.

f) Manage key workforce issues and agree actions where necessary.
g) Collaborate with clinical and corporate teams on developments in the wider Trust to deliver the Trust strategic objectives.
h) Agree and implement research and education priorities and activities within the board.
i) Report to the Executive Team matters by exception (noting that performance and finance are routinely reported through Trust information packs).
j) Agree a communication plan within the board on significant matters and initiatives.

3. MEMBERSHIP & ATTENDANCE

5.3 The Clinical Board will include the following members:

a) Clinical Board Chair (Chair)
b) Director of Operations
c) Associate Directors of Operations
d) Associate Medical Director
e) Head of Nursing
f) Clinical Directors (CD)
g) Clinical Board finance lead
h) Clinical Board workforce lead
i) Clinical Board information lead
j) Quality and Safety lead

3.2 The members will meet monthly, and an appropriate member of the admin team will be in attendance to take notes of the Clinical Board meetings. Other personnel may be invited by the Chair to attend the meetings on an ad-hoc basis as appropriate.

3.3 Deputies may be nominated to attend prior to the meeting, with the Chair's approval.

4. RESPONSIBILITY OF MEMBERS AND ATTENDEES

Members of the Clinical Board have a responsibility to:

a) attend meetings, having read all papers beforehand;
b) when matters are discussed in confidence at the meeting, to maintain such confidences;
c) at the start of the meeting, declare any conflicts of interest / potential conflicts of interest in respect of specific agenda items (even if such a declaration has previously been made in accordance with the Trust's policies and procedures);

d) produce and maintain a Clinical Board Chairs log which can be shared with/used by the Trust Management Group or Executive Team, or within the QPRs.

5. QUORUM

5.1 Quorum for the monthly Clinical Board meetings will be six members. Of which, two should be members of the triumvirate and there should be at least three Senior Clinical Leaders e.g. CD and Q&S lead in attendance.

5.2 When considering if the meeting is quorate, only those individuals who are voting members as listed in 3.1 above can be counted.

5.3 Meetings will normally take place monthly on a [day to be inserted].

6. AUTHORITY

The Clinical Board is authorised to: i) act within the Standing Orders, Standing Financial Instructions and Scheme of Delegation, ii) carry out activities and receive assurance on any activity within these terms of reference, iii) make recommendations to the Executive Team; iv) seek any information is requires from any member of staff and v) promote a learning culture, which is open and transparent.

7. REVIEW

The Terms of Reference will be reviewed at least every three years by the Trust Secretary and Managing Director, with recommendations on changes submitted to the Executive Team for approval.

Date Approved and issued	March 2024
Version Number:	Draft Version 2
Next Review:	March 2027
To be approved by:	Executive Team
Executive Responsibility:	Managing Director

Appendix 5 – Quality & Performance Review Meetings Terms of Reference

QUALITY AND PERFORMANCE REVIEW MEETINGS

TERMS OF REFERENCE

1. PURPOSE

1.1 The purpose of Quality and Performance Reviews (QPRs) are to ensure that Clinical Boards and Directorates are progressing in line with their strategic aims and objectives, national and local reporting requirements, as well as addressing areas of under-performance and acknowledging areas of strong performance.

1.2 The Clinical Board leadership team will prepare a pack of information circulated 3 working days in advance to enable the QPR attendees to have the information required to undertake the review to the appropriate depth. This will be supported by Corporate Teams as required and cover all aspects of the agenda. The process will ensure that key issues and risks are being appropriately managed.

1.3 As well as playing an important role in the overall Accountability Framework for the Trust, the QPR process provides Clinical Boards an opportunity to discuss and escalate updates and concerns to members of the Executive Team and other Senior Managers as part of the review.

2. DUTIES

2.1 QPR meetings take place (at a frequency determined in accordance with the autonomy level assigned) with each of the eight Clinical Board.

2.2 The Clinical Board QPRs focus on four domains:

- Quality and safety.
- Performance – including activity and access targets.
- People merits and progress in the implementation of the People Plan.
- Finance including current year position and financial recovery.
- Service developments and horizon scanning.

3. MEMBERSHIP & ATTENDANCE

3.1 QPR Meetings will include the following members:

a) Managing Director (Chair)
b) Joint Medical Directors

c) Executive Director of Nursing
d) Chief Finance Officer
e) Chief People Officer
f) Director for Commercial Development & Innovation
g) Clinical Board Chair
h) Director of Operations
i) Head of Nursing
j) Associate Directors of Operations (optional)
k) Clinical Directors (optional)
l) Clinical Board finance lead
m) Clinical Board workforce lead
n) Clinical Board information lead
o) Clinical Board quality lead
p) Performance Lead

3.2 An appropriate member of the performance team will be in attendance to take notes of the meetings.

3.3 Deputies may be nominated to attend prior to the meeting, with the Chair's approval.

3.4 The Managing Director will chair all QPRs in the first instance, with a member of the Executive Team nominated to act as Vice Chair. Additionally, the Deputy Chief Operating Officer will endeavour to attend in these circumstances to ensure consistency and representation from the Managing Director team across all reviews.

4 RESPONSIBILITY OF MEMBERS AND ATTENDEES

4.1 Members of the QPR Meetings have a responsibility to:

- attend meetings, having read all papers beforehand;
- when matters are discussed in confidence at the meeting, to maintain such confidences; and
- at the start of the meeting, declare any conflicts of interest / potential conflicts of interest in respect of specific agenda items (even if such a declaration has previously been made in accordance with the Trust's policies and procedures).

4.2 If unable to attend, members must inform the Chair and the Corporate Performance team, as well as assigning a Deputy to attend on their behalf.

4.3 Meeting Chairs will ensure there is a consistent approach to QPRs by following the issues specified in the agenda, as approved by the Executive Team.

5 RELATIONSHIPS AND REPORTING ARRANGEMENTS

5.1 Reviews will be scheduled at least 6 weeks prior to the proposed date.

5.2 Reports for the meeting should be submitted by the agreed deadlines.

5.3 Information providers must secure sign-off from the Directors of Operations before providing the document to the Performance Team - once a document is received it will be assumed that it has been signed-off.

5.4 The Performance Team will then collate, check, clarify and format documents with the aim of distributing a complete ahead of the review date to all attendees. Post-review, it will be the responsibility of the performance team to circulate draft minutes and action logs in a timely manner.

5.5 The Clinical Board will provide a presentation pack 3 working days in advance to lead the review meeting attendees through the exception reports.

5.6 To co-ordinate QPRs, flexibility will be required on behalf of all members and administration teams should make every effort to ensure these are a priority.

6 REPORTING OUTCOMES AND BOARD FEEDBACK

6.1 It is expected that each Clinical Board will have in place arrangements for similar review meetings with their clinical directorates ahead of the Clinical Board performance review meeting.

6.2 Following each round of QPR meetings with the Clinical Boards, the key performance issues arising from the meetings will be drawn together by the Managing Director and discussed by the Executive Team. This provides an opportunity for key issues to be escalated, particularly where they might involve or impact on more than one Clinical Board. This in turn informs the discussion of performance by the Board of Directors' Committees, and the Board itself. The Chairs log from the QPR meetings will be included with the papers for the Quality and Finance Committees.

7. QUORUM

7.1 Quorum will be six members. Of which, at least two should be Executive Team members and at least two should be Clinical Board members.

7.2 The frequency of meetings will depend on which autonomy level the Clinical Board is assigned to.

8. REVIEW

8.1 The Terms of Reference will normally be reviewed at least every three years, with recommendations on changes submitted to the Executive Team for approval.

Date Approved and issued	March 2024
Version Number:	Draft Version 2
Next Review:	March 2027
To be reviewed by:	Trust Management Group
To be approved by:	Executive Team
Executive Responsibility:	Managing Director

Appendix 6 – Trust Management Group Terms of Reference

TRUST MANAGEMENT GROUP

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Trust Management Group is a forum which has been established for the purpose of bringing together clinical and senior leaders to maintain the overall effectiveness of the Trust by ensuring robust, effective and efficient operational management.

1.2 The Trust Management Group operates within the Trust Corporate Governance Framework established by the Board of Directors and acts as a forum:

a) To provide scrutiny and challenge on significant reports, business cases, service developments, organisational decisions and future plans before they are presented to the Trust Board or relevant Committee.
b) To discuss key risks to the Trust e.g. achievement of the Trust Plan and Transformation/Change Programme;
c) To provide assurance on Clinical Board performance and any significant service issues or service changes;
d) To consider performance against key targets and any remedial actions required;
e) For discussing progress on key corporate metrics and the Trust overarching strategy;
f) To consider transformation and improvement plans which will drive improvement across the Trust;
g) For group members to bring significant matters/issues to the attention of the Executive Team;
h) For sharing feedback from Board members and Board Committees; and
i) To ensure that staff are kept up to date on Trust wide issues.

1.3 Meetings will normally take place fortnightly on a Wednesday.

2. DUTIES

2.1 In particular the Trust Management Group will:

a) ensure the robust, effective and efficient operational management of the Trust;
b) support the development of, and improvements to, services across the Trust including the adoption of new technologies and innovations;
c) contribute to the review and development of the Trust's vision, purpose and strategic direction;

d) consider operational risk and related quality & patient safety issues, ensuring that any emerging risks are identified, assessed and managed appropriately;
e) contribute to creating a positive Trust culture by upholding the agreed Trust values and behaviours;
f) support improvement of communication and involvement of staff; and
i) consider the overarching Trust performance against key performance indicators.

3. MEMBERSHIP & ATTENDANCE

3.1 The Trust Management Group will include the following members:

a) Chief Executive Officer (CEO) (Chair);

b) All Executive Team members and some deputies (as agreed with the Chair);

c) All Clinical Board Chairs;

d) All Associate Medical Directors;

e) All Associate Directors of Nursing, Midwifery and Allied Health Professionals;

f) All Directors of Operations; and

g) All Heads of Nursing.

3.2 The Trust Secretary, or a member of the Corporate Governance Team, will be in attendance to take notes and capture key actions arising from the meetings. Other personnel may be invited by the Chair to attend the meetings as appropriate.

3.3 Attendees should not send deputies unless there are exceptional circumstances or acting up arrangements have been put in place. Where this is the case, approval must be sought from the Chair.

4. RESPONSIBILITY OF MEMBERS AND ATTENDEES

Members of the Trust Management Group have a responsibility to:

e) attend meetings, having read all papers beforehand;
f) when matters are discussed in confidence at the meeting, to maintain such confidences.
g) at the start of the meeting, declare any conflicts of interest / potential conflicts of interest in respect of specific agenda items (even if such a declaration has previously been made in accordance with the Trust's policies and procedures).

5. QUORUM

TMG is not a decision-making forum and therefore a quorum is not required.

6. AUTHORITY

The Trust Management Group is authorised to: i) carry out activities within its terms of reference, ii) make recommendations to the Executive Team.

7. REVIEW

The Terms of Reference will normally be reviewed at least every two years, with recommendations on changes submitted to the Executive Team for approval.

Date Approved and issued:	October 2018 (V1), June 2023 (V2)
	January 2024 (V3), March 2024 (V4)
Version Number:	Version 4
Next Review:	March 2026
To be reviewed by:	Trust Management Group
To be approved by:	Executive Team
Executive Responsibility:	CEO

Appendix 3 – Audit, Risk and Assurance Committee Terms of Reference and Schedule of Business

TERMS OF REFERENCE – AUDIT, RISK AND ASSURANCE COMMITTEE

1. CONSTITUTION OF THE COMMITTEE

The Audit, Risk and Assurance Committee (ARAC) is a statutory Committee established by the Board of Directors to monitor, review and report to the Board on the suitability and efficacy of the Trust's provisions for governance, risk management and internal control. In addition the Committee will provide assurance to the Trust Board regarding compliance with standards, policies and procedures relating to clinical governance, corporate governance and risk management.

2. PURPOSE AND FUNCTION

The purpose and function of the Committee is to:

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

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

2.3 gain assurance that the Trust risk management strategy, associated policies and processes are in place, fit for purpose, working effectively and are regularly reviewed;

2.4 ensure that the Trust has appropriate policies in place to seek assurance over compliance with relevant legislation (e.g. Health and Safety, and Emergency Planning), regulatory standards and the conditions of its licences e.g. Care Quality Commission (CQC) and Human Tissue Authority (HTA);

2.5 receive the findings from any External Reviews and seek assurance sought over the delivery of any required actions;

2.6 ensure that the process for responding to clinical litigation claims is robust and that appropriate actions are taken to address any areas for improvement, including the identification of any themes and the sharing of lessons learned;

2.7 ensure that processes are in place to verify that policies are regularly reviewed and compliance is monitored, in accordance with the Trust policy on writing policies;

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

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

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

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

3. AUTHORITY

The Committee is:

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

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

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

4. MEMBERSHIP AND QUORUM

MEMBERSHIP

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

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

4.03 The Committee Chair will have recent relevant financial experience, assessed as being appropriate to the role by the Nominations Committee, on behalf of the Board of Directors. It is expected that at least one member will have a formally recognised professional accountancy qualification.

4.04 The membership will include:

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

4.05 Meeting attendees for specific agenda items will include:

- Chief Finance Officer;
- Managing Director;
- Joint Medical Directors;
- Executive Director of Nursing;
- Director of Quality and Effectiveness;
- Chief People Officer;
- Chief Information Officer;
- Director of Communications and Corporate Affairs;
- Trust Secretary;
- Head of Corporate Risk and Assurance;
- Assistant Finance Director – Financial Services; and
- Ops Directors.

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

4.07 The Senior Independent Director of the Board of Directors will not be Chair of the Audit, Risk and Assurance Committee.

4.08 Only members of the Committee have the right to attend Committee meetings. Alternate, or substitute, members may be agreed in advance with the Chair of the Committee for a specific meeting but not for more than one and will not count towards the quorum. Other non-Committee members may be invited to observe Committee meetings, or to attend and assist the Committee from time to time, according to particular items being considered and discussed.

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

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

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

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

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

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

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

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

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

QUORUM

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

4.19 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will count towards the quorum.

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

5. DUTIES

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

6. FINANCIAL REPORTING

The Committee will:

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

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

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

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

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

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

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

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

7. GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL

The Committee will:

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

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

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

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

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

7.6 review any changes to the profile and scoring of risks included in the Board Assurance Framework, as well as any proposed new risks or risks proposed for closure, as determined by the Board and the Board Committees;

7.7 seek assurance on behalf of the Board of Directors that risks of all types are identified, and managed to an acceptable level, and to undertake a deep dive of

significant risks (those with a residual score of 20 or above)/review Clinical Board governance reports;

7.8 seek assurance that risk management systems and processes are continually developed and monitored to support high standards of clinical care;

7.9 ensure that there is an effective mechanism for reporting, managing and escalating risks to the Board or senior management in accordance with the agreed Risk Management Policy;

7.10 receive a report to identify any approved changes to the Board Assurance Framework, as well as summarising assurances received/gaps in assurance in relation to the identification, management and escalation of risks;

7.11 advise the Trust Board on defining 'acceptable' risk in terms of the Trust Boards risk appetite;

7.12 ensure the risk management process is underpinned by a culture of open and honest reporting and management of any situation that may threaten the quality of the patient experience, staff, visitor, or public safety;

7.13 ensure there are mechanisms in place for training and the dissemination of information on risk management and issues, to all stakeholders, to raise awareness and understanding of risk management for all Trust employees;

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

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

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

8. INTERNAL CONTROL AND COUNTER FRAUD

The Committee will:

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

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

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

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

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

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

8.07 consider the effectiveness of Counter Fraud services annually;

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

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

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

9. EXTERNAL AUDIT

The Committee will:

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

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

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

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

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

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

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

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

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

10. OTHER BOARD ASSURANCE FUNCTIONS

The Committee will:

10.01 seek assurance on policy compliance and on the maintenance of the policy framework of the Trust and review any significant breaches of the policies (non-financial);

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

raised for the attention of the Audit, Risk and Assurance Committee by the People Committee Chair;

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

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

10.05 seek assurance that the findings from External reviews are acted upon (where required) and that any lessons learned are disseminated;

10.06 receive regular reports regarding compliance with Business Continuity, Emergency Preparedness and Health and Safety standards/legislation;

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

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

10.09 receive assurance in relation to work of the Clinical Audit function;

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

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

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

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

10.14 In fulfilling its responsibilities, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated

governance, risk management and internal control, together with indicators of their effectiveness.

10.15 Consider matters referred to the Assurance and Risk Committee by the Board, any Board Committee or any Assurance and Risk Committee sub-committee; and

10.16 Refer matters to any committee of the Trust for further consideration/review.

11. REPORTING AND ACCOUNTABILITY

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

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

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

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

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

11.5 The Chair of the Committee shall provide, as a minimum annually, an update to the

Council of Governors on the work of the Committee.

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

11.7 The Committee will approve the terms of reference and membership of any of its reporting sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee the work of those sub-committees, receiving reports from them as specified by the ARAC in the sub-committees' terms of reference for consideration and action as necessary;

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

12. COMMITTEE ADMINISTRATION

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

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

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

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

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

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

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

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

Procedural control statement: 22 March 2024
Date approved: [TBA] [Audit, Risk and Assurance Committee] and [TBA] [Board]
Approved by: Audit, Risk and Assurance Committee and Trust Board
Trust Board Review date: March 2025

Committee / Group:	**Audit, Risk and Assurancce Committee (ARAC)**
Chair:	**Bill Macleod**
Annual Cycle Covered:	**2024/25**

Red font - reflects Risk and Assurance (R&A) additions

Focus:			Audit	R & A	Audit	Audit	R & A	Audit	R & A	Audit	R & A	R & A	
	Lead	**Authors / contacts of the report**	**Apr-24**	**May-24**	**June-24 EXTRAORDINARY**	**Jul-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Notes**
Standing Items													
Apologies for absence	Bill Macleod		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Declaration of interests	Bill Macleod		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Bill Macleod	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Action log	Bill Macleod	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Committee minutes - Finance - Quality - People	Committee Chairs/members Graeme Chapman Graeme Chapman Jonathan Jowett	Kelly Jupp / Lauren Thompson	✓			✓		✓		✓			
Escalations from other Board Committees to ARAC/Escalations from ARAC to other Committees	Committee Chairs	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Escalations to TB	Bill Macleod	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Assurance and Risk Management													
Compliance and Assurance Group report (covering assurances and exceptions)	Michael Wright	Michael Wright		✓	✓		✓		✓		✓	✓	
Risk Register report	Caroline Docking	Natalie Yeowart		✓	✓		✓		✓		✓	✓	
Risk profile by Clinical Board and Corporate Departments (annual)	Rob Harrison	Natalie Yeowart	✓										
Risk Appetite	Caroline Docking	Natalie Yeowart										✓	
Clinical Board risk deep-dive	Rob Harrison	Natalie Yeowart		✓	✓		✓		✓		✓	✓	1 or 2 Boards per meeting - risk profile by Board to be used to decide order of attendance. To cover: - focus on risks scored 20+ - training, approach, scoring, effectiveness of controls/actions to mitigate risks - to ask the Clinical Boards to provide in adbance
New guidance or mandatory documents	Kelly Jupp	Kelly Jupp											As an when required
Scheme of Delegation/SFIs/SOs	Jackie Bilcliff	Chris Haynes / Kelly Jupp				✓							Review annually as a minimum
Modern Slavery Act Statement	Dan Shelley / Kelly Jupp	Dan Shelley / Kelly Jupp				✓							Review annually as a minimum
Annual Board Assurance Framework and Risk Management Report	Caroline Docking	Natalie Yeowart	✓										
Board Assurance Framework (BAF) and Risk Register Report	Caroline Docking	Natalie Yeowart	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Review findings of other significant assurance functions (outwith internal and external audit)	Kelly Jupp	Kelly Jupp											As and when required - for example the CQC, NHSI and NHS Resolution

Committee Self-Assessment of effectiveness and Audit Committee Annual Report	Kelly Jupp	Kelly Jupp / Lauren Thompson	✓										
Committee Terms of Reference and Schedule of Business	Kelly Jupp	Kelly Jupp / Lauren Thompson	✓										
Annual Governance Statement	Caroline Docking	Natalie Yeowart	✓(Draft)		✓(Final)								
Review of the Clinical Audit Process	Angela O'Brien	Steve Stoker				✓				✓			
Financial reporting systems	Jackie Bilcliff	Chris Haynes / Jo Mason	✓										
Assurance from the People Committee as to whether arrangements by which staff may raise concerns are operating effectively	Jonathan Jowett	Christine Brereton						✓					Annual - in accordance with the Trust policy on raising concerns
SIRO Report	Caroline Docking	Natalie Yeowart				✓				✓			Six-monthly
Financial Governance													
Financial Statements timetable and plans	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓(Update)							✓			
Review Accounting issues raised as part of the Financial Statements audit	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓		✓								
Trust Annual Financial Statements and TACs	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓(Draft/Update)		✓(Final)								Prior to Board approval
Charity Annual Financial Statements	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity				✓(Draft)		✓(Final)					Prior to Board approval
Annual Report (including Quality Account)	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity			✓								Prior to Board approval
Corporate Governance Manual update	Caroline Docking	Kelly Jupp											As and when required
Schedule of Losses and Compensation report	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓			✓		✓		✓			
Standards of Business Conduct Annual Report, including the Chairman's fit & proper persons declaration	Caroline Docking	Natalie Yeowart				✓							
Annual Report - Register of Directors' Interests	Kelly Jupp	Kelly Jupp / Lauren Thompson			✓ (As part of the Annual Report)								
Annual Review of Special Severance Payments / Settlement Agreements	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓										
Debtors and Creditors balances report	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓			✓		✓		✓			
Schedule of Approval of Single Tender Action	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓			✓		✓		✓			
External/Internal Audit Protocol	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity				✓							
Financial Statements Accounting Policies, Estimates and Judgements	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓		✓								
Going Concern Position	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓										
Internal Audit													
Annual Plan	Internal Audit	Internal Audit	✓(Final)							✓(Draft)			
Outcome of Audit Work / Progress Update	Internal Audit	Internal Audit	✓		✓	✓		✓		✓			
Head of Internal Audit Opinion	Internal Audit	Internal Audit	✓(Draft)		✓(Final)								
Annual Report and IA Charter	Internal Audit	Internal Audit				✓							
Internal Auditor performance	Internal Audit	Internal Audit				✓							
External Audit													

Annual Plan and 3-year Strategic Plan	External Audit	External Audit	✓							✓			For approval
Outcome of Audit Work	External Audit	External Audit											As and when required
Management Letter / ISA260 report to the Trust	External Audit	External Audit			✓								
Management Letter / ISA260 report to the Charity	External Audit	External Audit						✓					
Annual Audit Letter	External Audit	External Audit				✓							
External Auditor Performance	External Audit	External Audit				✓							
Counter Fraud													
Annual Plan and Annual Fraud Self Review Tool	Ivan Bradshaw	Ivan Bradshaw	✓										For approval
Fraud Response Log /Fraud register	Ivan Bradshaw	Ivan Bradshaw	✓			✓		✓		✓			
Activity Report	Ivan Bradshaw	Ivan Bradshaw	✓			✓		✓		✓			
Annual Report	Ivan Bradshaw	Ivan Bradshaw				✓							
Counter Fraud Performance	Ivan Bradshaw	Ivan Bradshaw				✓							

✓	On agenda and discussed
	Item deferred

Appendix 4 – Digital & Data Committee Terms of Reference and Schedule of Business

Draft Terms of Reference – Digital and Data Committee

1. Constitution of the Committee

The Digital and Data Committee is a non-statutory Committee established by the Trust Board of Directors to:

- Provide assurance to the Board on the development and implementation of the Digital Strategy, including the delivery of associated workplans;
- Oversee the delivery of significant digital transformation projects, procurement of major or critical digital systems or equipment and the development of the Trust's digital infrastructure; and
- Assure the Trust Board on compliance with legislation/relevant regulations for information governance, cyber security and information security, as well as on the governance of the Trust's data quality.

2. Purpose and function

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

2.01 that the Digital Strategy enables improvements in the efficiency and safety of patient and staff experience, as well as in corporate processes;

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

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

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

2.05 that the Trust's digital resources and assets are being used and maintained effectively and efficiently to ensure value for money;

2.06 on the Trust's compliance with current digital statutory and external reporting standards and requirements;

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

2.08 on the robustness of systems and processes for prioritisation of investments related to the Digital Strategy, including digital infrastructure;

2.09 on compliance with legislation/relevant regulations for information governance and information security, as well as on the governance of the Trust's data quality; and

2.10 on the robustness of processes for review of any Digital and/or Data incidents.

3. Authority

The Committee is:

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

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

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

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

3.5 The Terms of Reference must be approved by the Board of Directors and be reviewed on an annual basis.

4. Membership and quorum

Membership

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

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

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

4.04 In addition to the Non-Executive Chair and Vice Chair of the Committee, the membership of the Committee shall include the:

- Chief Information Officer (Executive Lead);
- Managing Director;
- Joint Medical Directors;
- Associate Medical Director – Digital
- Senior Information Risk Owner (SIRO);
- Chief Finance Officer;

- Chief Operating Officer;
- Director for Commercial Development and Innovation;
- Chief Experience Officer;
- Deputy Chief Nurse;
- Chief Clinical Information Officer;
- Chief Nursing Information Officer;
- Director of Operations – Clinical & Research Services Clinical Board;
- Head of Digital Innovation & Delivery;
- Head of Corporate Risk & Assurance/Head of Information Governance;
- Head of Risk, Compliance and Assurance; and
- Head of IT Service Management.

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

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

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

4.08 The Chief Information Officer shall act as Executive Lead for the Committee.

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

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

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

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

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

Quorum

4.14 The quorum necessary for the transaction of business shall be four members as defined in 4.01 and 4.04 above, including the Chair or Vice Chair.

4.15 Members unable to attend a meeting of the Committee may nominate a suitably qualified deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will count towards the quorum.

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

5. Duties

5.1 Cycle of Business

The Committee will:

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

5.2 Strategies and policies

The Committee will:

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

5.2.2 review guidance for the development and delivery of the digital aspects of the annual planning round;

5.2.3 review, and recommend to the Board of Directors, the Digital Strategy, including key digital performance indicators;

5.2.4 provide advice and support on significant digital policies and transformation programmes prior to their recommendation for approval;

5.2.5 seek assurance that digital policies and plans are aligned to the Trust's agreed approach to the development of place-based, systems and regional working; and

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

5.3 Annual Digital Workplan

The Committee will:

5.3.1 review the Trust's Annual Digital Workplan for recommendation and approval by the Board; and

5.3.2 review progress and performance against the approved workplan and any significant supporting plans and targets and analyse the robustness of any corrective action required.

5.4 Risk

The Committee will:

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

5.4.2 To receive the Executive Oversight Report for information.

5.5 Performance and progress reporting

The Committee will:

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

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

- the Trust's strategic digital priorities;
- cyber security;
- national data targets; and
- risk mitigation.

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

5.5.4 provide regular reports to the Board on assurance around key areas of digital strategy performance, risk, and corrective actions, both retrospectively and prospectively;

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

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

5.5.7 ensure the alignment and consistency of Board assurances, use of data and intelligence, by working closely with the other Board Committees;

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

- Annual Digital Workplan; and
- Digital Strategy Update Reports to Trust Board.

5.5.9 review and approve the Terms of Reference for, and receive the minutes of, the:

- Digital Technology & Delivery Group;
- Data Protection and Security Risk Group.; and
- Medical Records Group.

5.5.10 receive for information and assurance any Internal Audit reports and external review reports pertaining to the remit of the Committee.

5.6 New technologies and digital innovations

The Committee will:

5.6.1 seek assurance on the development and implementation of new technologies and digital innovations, including Artificial Intelligence (AI).

5.6.2 provide support and advice on the policies and strategies associated with the development and implementation of new technologies and digital innovations for the Trust.

5.6.3 seek assurance over the implementation of digital transformation/change programmes and associated outcomes/benefits.

5.6.4 assure the Trust Board, on a regular basis, of the effectiveness of, and compliance with, any new technologies and innovation strategies and related policies, including the effective prioritisation of innovation projects, the robustness of processes and rigour of decision-making regarding innovations, and report on this as part of the Committee's Annual Report to the Board.

5.7 **Data Quality and Security, Cyber Security and Information Governance**

The Committee will:

5.7.1 seek assurance that the Trust has in place appropriate arrangements for ensuring that technology is secure and up-to-date and that digital systems are protected from cyber threats in accordance with national requirements;

5.7.2 seek assurance on data quality relating to the Trust's systems and processes, including the data quality of mandated and local datasets, Data Protection Impact Assessments, Information Assets and the effectiveness of digital clinical systems;

5.7.3 seek assurance over performance against key information governance standards and requirements, including Freedom of Information requests, data breaches and mandatory information governance training;

5.7.4 provide assurance to the Trust Board that the Trust is compliant with the relevant Data Security and Protection Toolkit standards and national requirements; and

5.7.5 seek assurance over the appropriate storage and processing of records across the Trust including compliance with the General Data Protection Regulation requirements, local policy and subject access requests.

5.8 Investment Prioritisation

The Committee will:

5.8.1 consider and agree the priorities for digital investment to be included in the 3-year investment plan (to be considered by the Capital Management Group), based on recommendations from management using an agreed system/process for prioritisation.

5.9 Statutory compliance

The Committee will:

5.9.1 ensure, on behalf of the Board, that current digital statutory and regulatory compliance and reporting requirements are met;

5.9.2 ensure future digital legislative and regulatory and reporting requirements are identified and appropriate action taken;

5.9.3 consider, and recommend for approval by the Audit Committee, any proposed changes to Trust Standing Financial Instructions, Standing Orders and Scheme of Delegation in relation to the Digital Strategy; and

5.9.4 consider any reports/correspondence from the Information Commissioner relating to digital technology and information governance.

6. Reporting and accountability

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

6.2 The Committee will provide an Annual Report to the Board to inform and / or accompany the Trust's Annual Report. This shall include an assessment of compliance with the Committee's Terms of Reference and a review of the work and effectiveness of the Committee.

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

6.4 The terms of reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

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

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

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

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

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

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

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

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: 1 March 2024
Date approved: 18 March 2024
Approved by: Trust Board [TBC – March 2024]
Trust Board Review date: March 2025

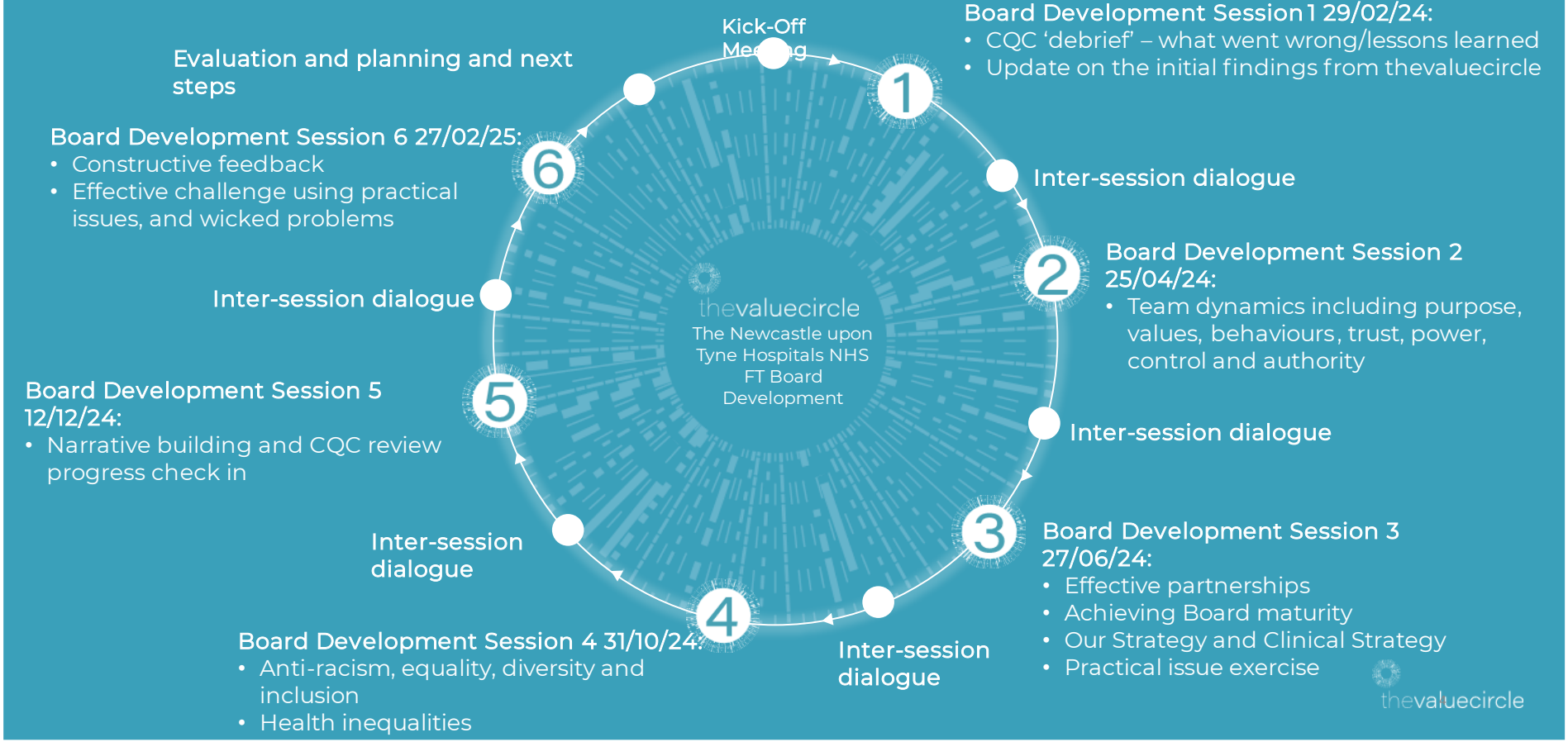
Committee / Group:	**Data and Digital Committee**
Chair:	**Graeme Chapman**
Annual Cycle Covered:	**2024/25**

	Lead	Authors / contacts of the report	Initial formation meeting Mar-24	Apr-24	Jun-24	Aug-24	Oct-24	Dec-24	Feb-25	Apr-25	Notes
Standing Items											
Apologies for absence and Declarations of interest	Graeme Chapman		✓	✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Graeme Chapman	Angela Halliday		✓	✓	✓	✓	✓	✓	✓	
Action log	Graeme Chapman	Lauren Thompson/Kelly Jupp		✓	✓	✓	✓	✓	✓	✓	
Meeting debrief	Graeme Chapman		✓	✓	✓	✓	✓	✓	✓	✓	
Matters requiring escalation and AOB	Graeme Chapman	Lauren Thompson/Kelly Jupp	✓	✓	✓	✓	✓	✓	✓	✓	
Regular Reports											
CIO Report, including digital performance report and partnerships update	Shauna McMahon	Angela Halliday	✓	✓	✓	✓	✓	✓	✓	✓	To cover any data quality matters by exception.
Data Security & Protection (DSPT), Information Governance and Cyber Security	Natalie Yeowart	Natalie Yeowart		✓		✓	✓		✓	✓	To cover any IG breaches/reports to the ICO, any significant sharing agreements etc.
BAF/risk report & emerging risks	Natalie Yeowart	Natalie Yeowart	✓(Emerging risks only)	✓(Emerging risks only)	✓(Emerging risks only)	✓	✓	✓(Emerging risks only)	✓	✓	
Digital financial plan/position/investments	David Byrom	David Byrom		✓	✓	✓	✓	✓	✓	✓	
Digital Transformation Update (projects by rotation)	Shauna McMahon	Angela Halliday		✓(Digital Change Projects overview)	✓(Tech & AI initiatives)	✓(Tech /Digital Achievements & Challenges)	✓(Updates on two Digital Change Projects)	✓(Updates on two Digital Change Projects)	✓(Examples/ evidence of projects impact on quality, safety, employee/patient experience/digital inclusion)	✓(Digital Change Projects overview)	
Digitial/Data incident review	Shauna McMahon	Angela Halliday		✓	✓	✓	✓	✓	✓	✓	As and when required
Annual Reports (AR) or updates											
Strategic Digital & Data Priorities/Updates	Shauna McMahon	Angela Halliday		✓	✓	✓	✓	✓	✓	✓	
Annual Digital Workplan/Annual Digital Strategy	Shauna McMahon	Angela Halliday				✓			✓		
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Shauna McMahon / Kelly Jupp / Lauren Thompson	Kelly Jupp / Lauren Thompson	✓(ToR and SoB)							✓	To include effectiveness consideration
Ad Hoc reports (tabled as required)											
Draft standing agenda	Shauna McMahon / Kelly Jupp	Kelly Jupp / Lauren Thompson	✓								
External/Internal audit/review reports related to Digital & Data	Shauna McMahon	Angela Halliday		✓	✓	✓	✓	✓	✓	✓	E.g. data quality, penetration testing etc
	✓	On agenda and discussed									
		Item deferred									

Appendix 5 – Board Development Programme

Framing your Board development

Below is an initial view of how we intend the Board development programme to look. Sessions will include a set of topics that have been agreed by your team and will be tailored as we move through the programme.



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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024					
Title	Update from Committee Chairs					
Report of	Non-Executive Director Committee Chairs					
Prepared by	Miss Jayne Richards, PA to Chairman and Trust Secretary / Corporate Governance Officer					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	The report includes updates on the work of the following Trust Committees that have taken place since the last meeting of the Trust Board in January 2024: • People Committee – 20 February 2024 • Quality Committee –27 February and 29 March 2024 • Digital & Data Committee – 18 March 2024 • Finance Committee – 25 March 2024 • Charity Committee – 12 February 2024 and Charity Committee Grants meeting 11 March 2024					
Recommendation	The Board of Directors is asked to (i) receive the update and (ii) note the contents.					
Links to Strategic Objectives	Links to all strategic objectives					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☒	☐
Link to Board Assurance Framework [BAF]	No direct link.					
Reports previously considered by	Regular report.					

UPDATE FROM COMMITTEE CHAIRS

EXECUTIVE SUMMARY

This report provides an update to the Board on the ongoing work of the Trust's Committees for those meetings that have taken place since the last meeting of the Board of Directors in January 2024.

UPDATE FROM COMMITTEE CHAIRS

1. PEOPLE COMMITTEE

A meeting of the People Committee took place on 20 February 2024. During the meeting, the main areas of discussion included:

- A Nursing, Midwifery and AHP update.
- Emerging 'People' themes from the CQC inspection report.
- A People Priorities Delivery Update.
- The Equality, Diversity and Inclusion Improvement plan (EDI).

- The Head of Workforce Engagement & Information demonstrated the People and Culture Dashboard and explained statistical process control charts (SPC).
- The Head of Resource Services gave an overview of a paper – Internal Audit matter regarding Visas.
- Items to consider included Industrial Action, the People Committee Risk Report (BAF) and New and Emerging Risks.
- Draft minutes of the Learning and Education Group were received for the 29 January 2024 meeting, and minutes from the Sustainable Healthcare Committee were received for the 11 January 2024 meeting.

The next formal meeting of the Committee will take place on Tuesday 16 April 2024.

2. QUALITY COMMITTEE

- Meetings of the Quality Committee took place on 27 February 2024 and 19 March 2024.
- During the meeting on 27 February 2024, the main area of discussion was a Patient Safety Incident Response Framework (PSIRF) Implementation Update.
- The main areas of focus during the meeting on 19 March 2024 included:
  - The Quality Committee Risk Report (BAF)
  - Management Group Chair Reports:
    - Patient Safety Group
    - Clinical Outcomes & Effectiveness Group
    - Patient Experience & Engagement (PEEG)
  - Clinical Research Biannual Report
  - Cardiac Oversight Group Update
  - Board Reports:
    - Quality (IBR)
    - Performance
  - Mortality / Learning from Deaths Q3 Report
  - Quarter 3 Report for Safeguarding and Learning Disability
  - Leadership Walkabouts Update
  - Maternity Update
  - Receipt of Minutes from:
    - Clinical Outcomes & Effectiveness Group - 08 December 2023

- Compliance & Assurance Group - 14 November 2023 [FINAL] & 08 February 2024 [DRAFT]

The next meeting of the Quality Committee will take place on 23 April 2024.

3. DIGITAL & DATA COMMITTEE

The inaugural meeting of the Digital & Data Committee took place on Monday 18 March 2024. During the meeting, the main areas of discussion included:

- The Committee Terms of Reference & Schedule of Business
- The Proposed Standing meeting agenda
- Chief Information Officer (CIO) Report
- Emerging risks

The next meeting of the Digital & Data Committee will take place on 18 April 2024.

4. FINANCE COMMITTEE

A meeting of the Finance Committee took place on Monday 25 March 2024. During the meeting, the main areas of discussion included:

- Month 11 Revenue and Capital Update
- Month 11 Performance Report
- Draft Planning Submission 2024/25 Incorporating Path to Zero for 78 ww to 31 March 2024
- Financial Plan 2024/25
- Tenders (PR) and Business Cases (BC) for approval included:
  - Microsoft Licensing
  - Emergency Department
- Receipt of minutes from:
  - Capital Management Group – 9 January 2024
  - Community Diagnostics Centre Strategic Oversight Group – 28 November 2023
  - Supplies & Services Procurement Group – 4 December 2024

The next meeting of the Finance Committee will take place in April 2024.

5. CHARITY COMMITTEE

A meeting of the Charity Committee took place on 12th February 2024. During the meeting, the main areas of discussion included:

- Grant Making for Nurses, Midwives & Allied Health Professionals (NMAHP) Research Programme Update
- Grant Programmes
- Charity Director Update

- Investment Project update
- Sir Bobby Robson Institute (SBRI) Proposal
- Finance Reports – Month 6 Accounts
- Summary of Investments to June 2023 including Summary Investment Report
- Dashboard re Operational KPI's and Communication
- Charity Risk Statement
- Connected Charities Checklist

A Charity Committee Grants meeting took place on 11 March 2024 where the following grants were approved:

- SA2012 - Continuous Cardiac Output Monitors, £64,650
- SA2056 - Prospective assessment of Sarcopenia in severe pancreatitis with blood and stool biomarkers, £27,702
- EXT049 – SPACE (Social Prescribing and Community Resources for Children and Young People) Pilot, 54,978

Report of Jayne Richards
PA to Chairman and Trust Secretary / Corporate Governance Officer
15 March 2024

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2024		
Title	Integrated Board Report		
Report of	Angela O'Brien- Director of Quality and Effectiveness		
Prepared by	Victoria Smith, Head of Quality Assurance & Clinical Effectiveness		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	This paper is to provide assurance to the Board on the Trust's performance against key Indicators relating to Quality, People and Finance.		
Recommendation	For assurance.		
Links to Strategic Objectives	Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. Supported by flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential. Performance – Being outstanding now and in the future.		

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

Link to Board Assurance Framework	Strategic risk SO1.1 [Capacity and Demand] Strategic risk SO1.4 [Core standards – patient safety and quality of care] Details compliance against national access standards which are written into the NHS standard contract. Details compliance against key quality targets
Reports previously considered by	Regular Report.

INTEGRATED BOARD REPORT

EXECUTIVE SUMMARY

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

1. Throughout the month of February 2024, the numbers of Trust onset MSSA and MRSA Bacteraemia have decreased since the previous publication, whilst C. difficile and Pseudomonas have increased. E. coli and Klebsiella have remained the same.
2. January 2024 shows a decrease in inpatient acquired pressure ulcers since the previous publication.
3. There were 6 patient safety incident investigations (PSIIs) reported in February 2024. Duty of Candour has been initiated for all cases.
4. There was one Never Event reported in February 2024, bringing the number of Never Events reported to date in 2023/24 to 12.
5. There has been an increase in incidents in relation to violence and aggression against staff, compared to the previous month.
6. Total sickness absence reduced from 6.10% (March 2022 to February 2023) to 5.25% (March 2023 to February 2024).
7. Retention of staff with over 1-year service increased from 85.42% (February 2023) to 87.10% (February 2024).
8. Mandatory training compliance is 93.20% compared to target of 95%.
9. As of month 11 the Trust is reporting an adverse variance of £2.3million against a planned deficit of £0 million.

The Trust Board is asked to receive the report.

Angela O'Brien
Director of Quality and Effectiveness
15 March 2024

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

Quality, People and Finance

March 2024

Healthcare at its best
with people at our heart

Executive Summary

Purpose

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

Current Operating Environment

Challenges remain in early March in terms of demand and patient flow with the Trust continuing to experience winter pressures alongside planning for and the management of Industrial Action during February.

The number of patients with infections, is currently low - COVID 10-20, Flu <5 and RSV <10.

Quarter 4 performance remains below the national standard of 76%, and consequently the year-to-date position has also now dropped just below 76%. There remains good management of ambulance handovers and fewer 12-hour trolley waits in the last two months. There remains over 100 patients who are medically optimised with their discharge delayed due to social pressures.

There has been no significant adverse impact on the elective programme which is dynamically reviewed for the week ahead, and on the day with the exception of the periods of industrial action when activity has been reduced.

Work is now underway to plan for the safe withdrawal of the additional winter capacity.

Report Highlights

1. Throughout the month of February 2024, the numbers of Trust onset MSSA and MRSA Bacteraemia have decreased since the previous publication, whilst C. difficile and Pseudomonas have increased. E. coli and Klebsiella have remained the same.
2. January 2024 shows a decrease in inpatient acquired pressure ulcers since the previous publication.
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8. Mandatory training compliance is 93.20% compared to target of 95%.
9. As of month 11 the Trust is reporting an adverse variance of £2.3million against a planned deficit of £0 million.

Contents: March 2024

Quality

- Healthcare Associated Infections
- Harm Free Care – Pressure Damage
- Harm Free Care - Falls
- Incident Reporting
- Serious Incidents & Never Events
- Serious Incident Lessons Learned
- Mortality
- Friends and Family Test and Complaints
- Health and Safety
- Maternity
- National Clinical Audits
- Quality Account (Next update April 2024)

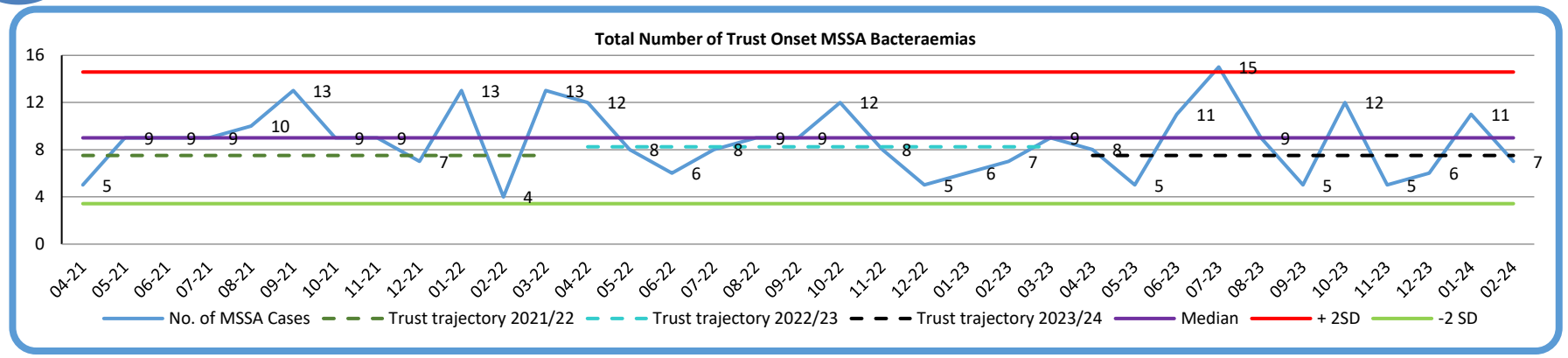
People

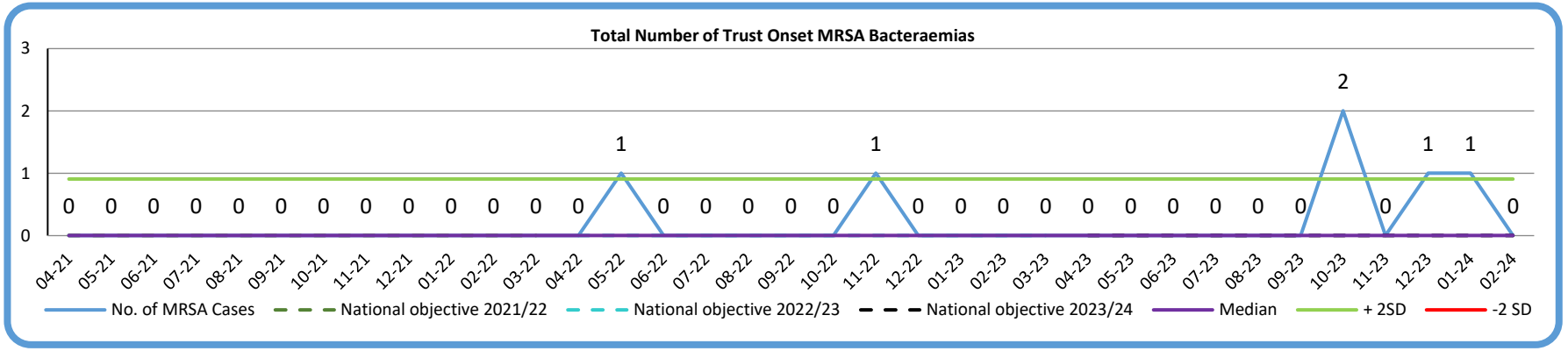
- Sickness Absence
- Equality and Diversity
- Sustainable Workforce Planning
- Excellence in Education & Training

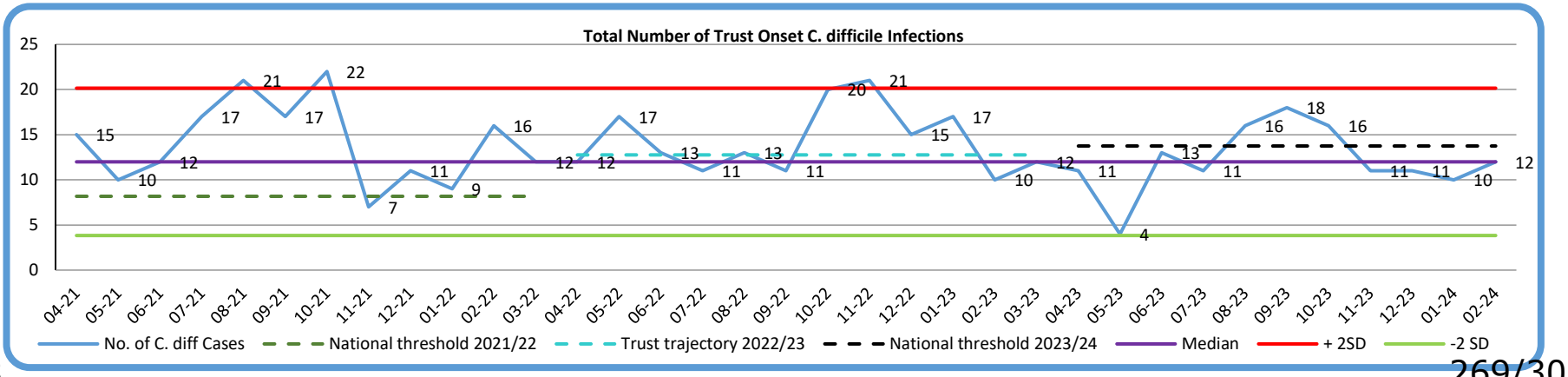
Finance

- Overall Financial Position

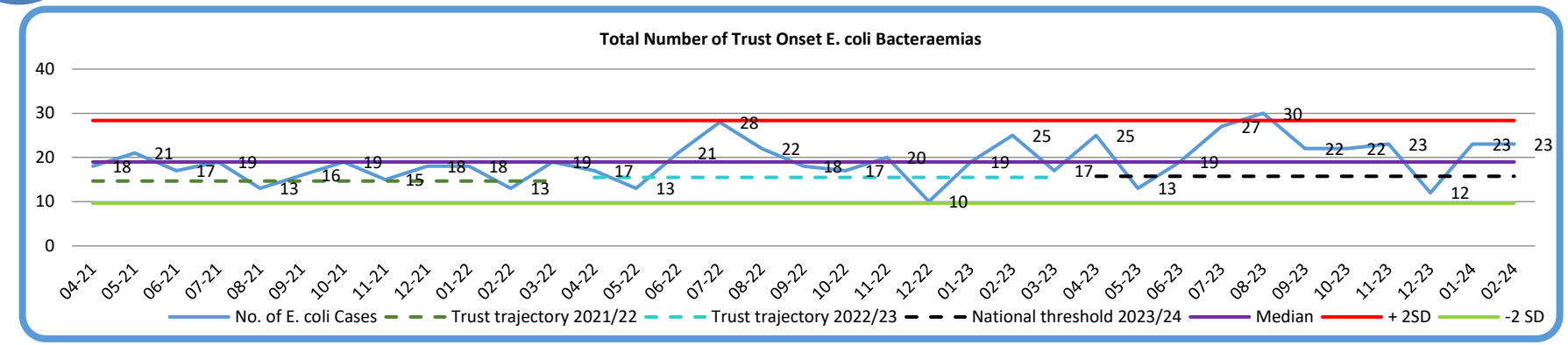
Quality: Healthcare Associated Infections 1/2

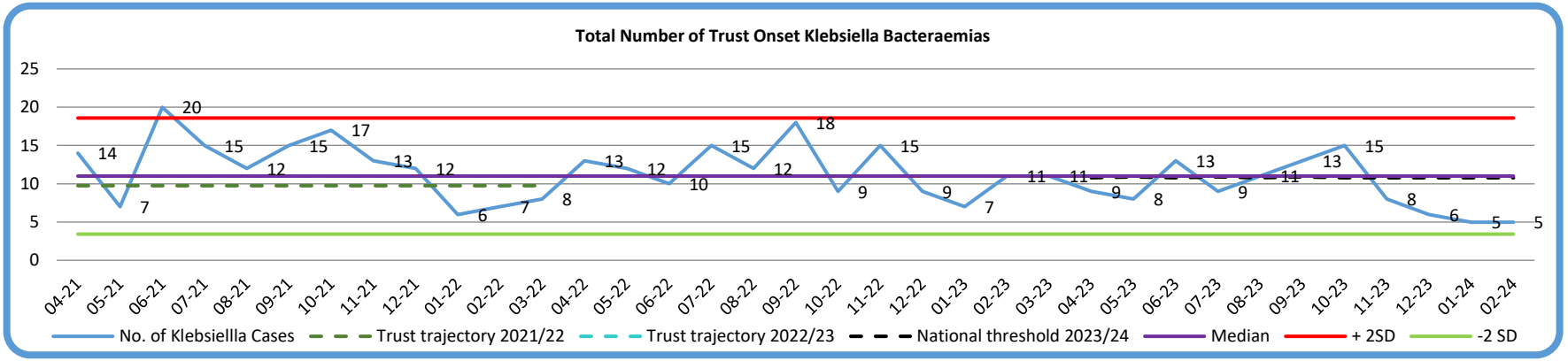


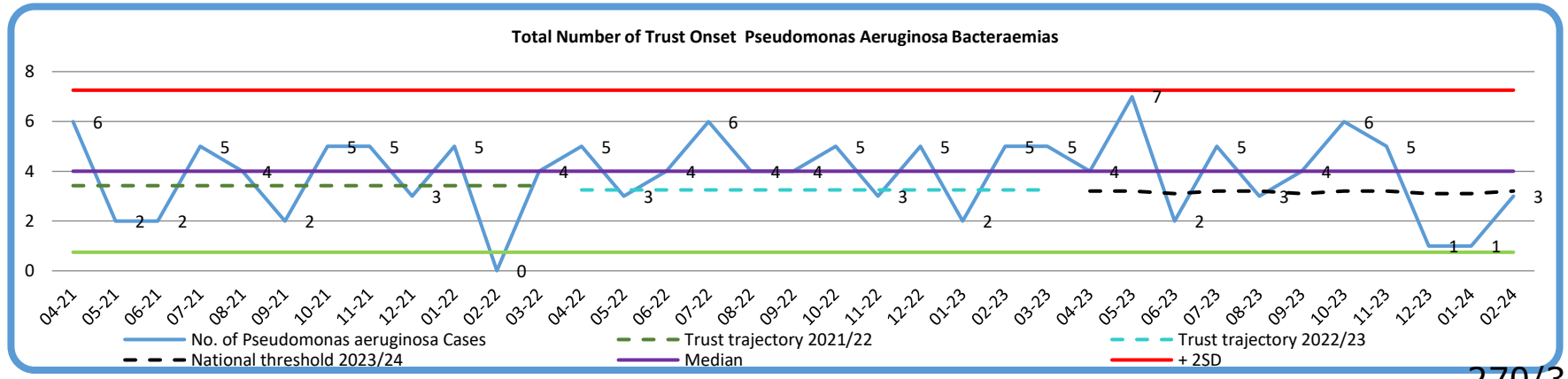




Quality: Healthcare Associated Infections 2/2



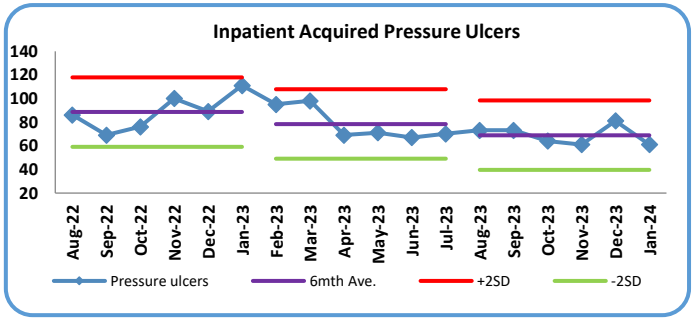


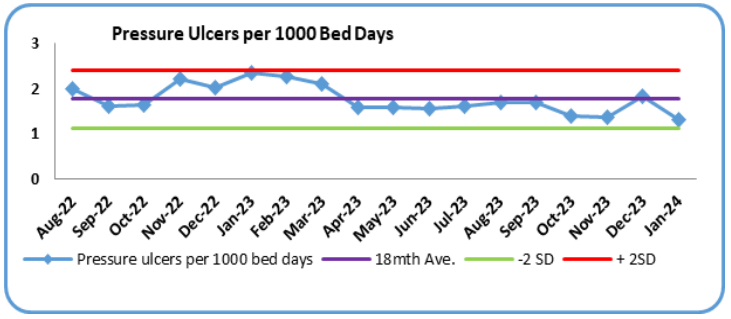


Quality: Harm Free Care – Pressure Damage

Current position:

- Since April 2023, there has been a sustained decrease in Trust acquired pressure ulcers, with the exception of December 2023, whereby a rise occurred. This is consistent with previous years whereby incidence increases in the winter months.
- Pressure ulcers per 1,000 bed days in January is 1.29, this is the lowest rate since April 2020.
- The number of pressure ulcers causing serious harm (category III) also fell in the month of January 2023 to two.
- The Trust has not reported an inpatient acquired Category IV or above pressure ulcers since June 2022.





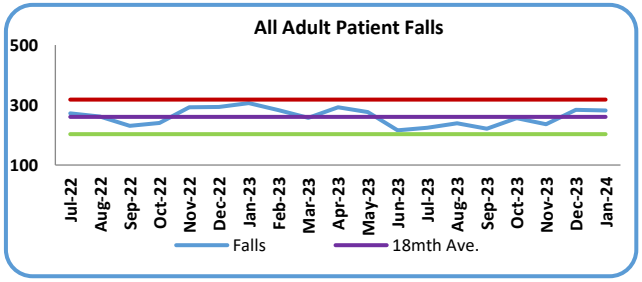
Current actions in place:

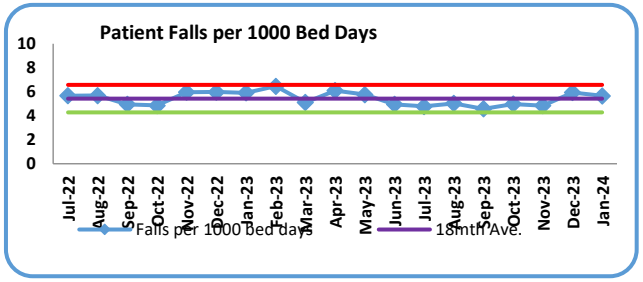
- Tissue Viability have implemented a structured programme of education for 2024 reflecting the themes identified through Root Cause Analysis (RCA). This includes both E-learning and face to face sessions.
- The Trust has introduced the Patient Safety Incident Response Framework (PSIRF). PSIRF offers an effective framework to respond to patient safety issues, such as pressure damage taking a co-ordinated approach which recognises a system-based approach to learning. Thematic reviews will identify patterns in data to help answer questions, show links, or identify concerns. The Tissue Viability Team (TVT) will use the data gathered to populate thematic review reports on a bimonthly basis which will be received by the Trust Clinical Standards meetings.

Quality: Harm Free Care - Falls

Current position:

- Total falls reported in the Trust have fallen very slightly to 282 in January 2024. Of the total falls reported, there were 266 in inpatient areas. (There has been a decrease for the second consecutive month n=263). This is consistent with previous years, with increased numbers in the winter months.
- The national target for falls per 1,000 bed days is 6.6, with the Trusts target for falls per 1,000 bed days being 6.0. In January 2024 we reported 5.7 falls per 1,000 bed days with an 18-month average of 5.4, both below the set targets.

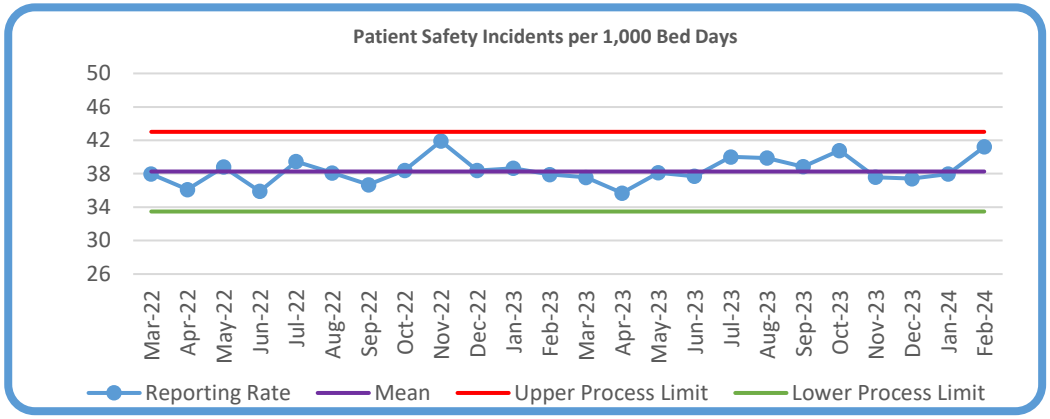




Current actions in place:

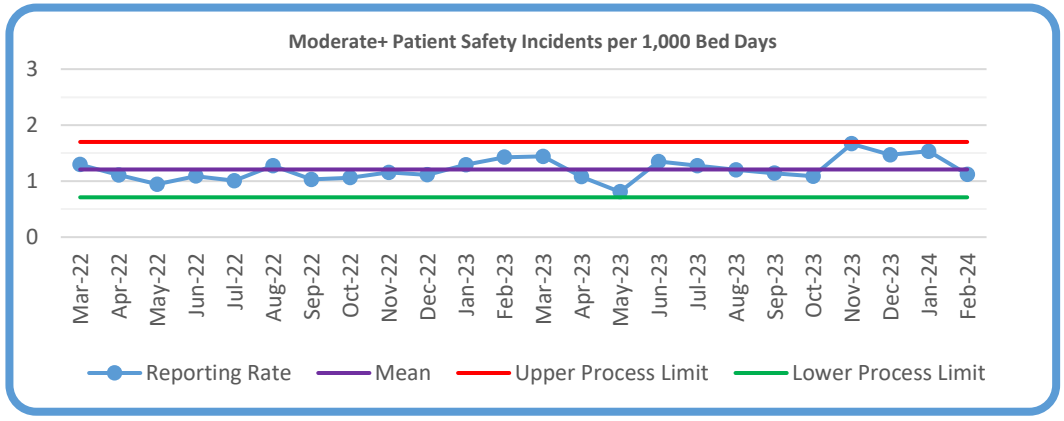
- The Falls Prevention Co-Ordinator (FPC) continues to review ward level data on a monthly basis. Wards with the highest incidence of falls are reviewed to identify contributory factors and understand any learning or potential quality improvements.
- Falls is also part of the PSIRF process. This requires an initial debrief to ensure that the patient and those involved in the patient's care are given an opportunity to provide their account of the fall. Information about the circumstances surrounding the fall will be collected to enable an after-action review (AAR).
- To support data collection for the National Audit of Inpatient Falls (NAIF) the after-action review provides the multi-disciplinary team with the opportunity to participate in open discussion about the circumstances leading up to and the management of the fall, to help develop insights into how patient safety might be improved as a result of this discussion.
- Clinical Boards will receive thematic review reports in addition to the Harm Free Dashboard data bimonthly. They will be required to develop an action plan with support from the Falls Prevention Co-ordinator. Action plans will be monitored, and progress reviewed at Clinical Standards Board Meetings, as well as within the Clinical Board - Quality Oversight Groups. The Clinical standards and Quality Improvement Lead will attend meetings where opportunities for learning and progress against action plans are discussed.

Quality: Incident Reporting



All patient incidents: The number of patient safety incidents per 1,000 bed days reported in February 2024 has increased, this may suggest that reporting culture within the Trust is improving.

There is currently a significant amount of work underway within the Trust to improve incident reporting rates and support staff in this process. This includes:
- Communication of a safety message of the week, taken from incidents reported in the week prior.
- Weekly Q&A sessions for staff in relation to incident reporting and the new PSIRF.
- Ward visits by the PSIRF implementation lead and patient safety team to highlight PSIRF and the importance of incident reporting.



Moderate and above harm incidents: The number of moderate and above harmful incidents has decreased between January and February 2024 and is now very similar to the number reported in October 2023. The spike in number of moderate and above harm incidents in November 2023 coincided with the introduction of Learn From Patient Safety Events (LFPSE) and a change in harm grading definitions. The downward trend in the moderate harm and above incidents coincides with the introduction of PSIRF (see next page) and so could be explained by the new incident response framework, which is leading to a more timely review and management, including appropriately amending harm gradings, of incident reports that have been submitted within each Clinical Board.
This process is being closely monitored by the Patient Safety team.

Quality: Patient Safety Incident Response framework

On 31st January 2024 the PSIRF replaced the Serious Incident Framework. This change is a key part of the NHS Patient Safety Strategy and one of the biggest changes in patient safety since the NHS was founded. PSIRF integrates four key aims:

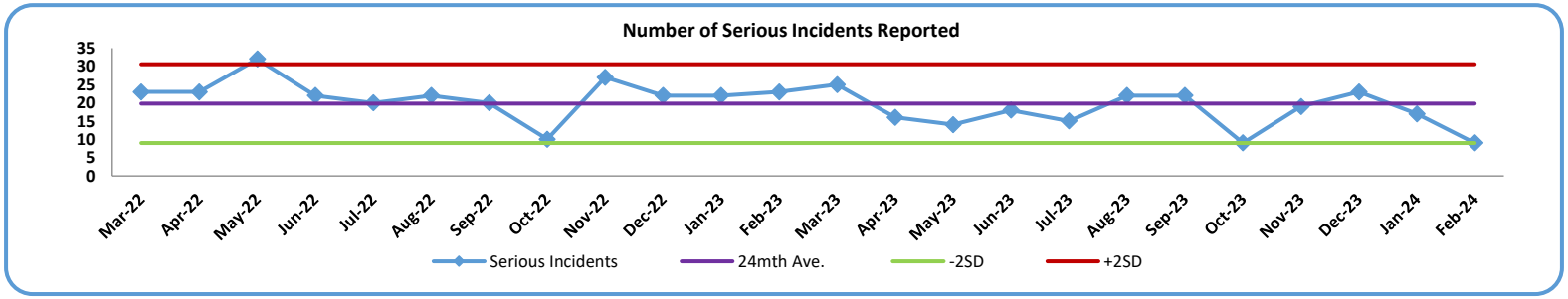
1. Compassionate engagement and involvement of those affected by incidents
2. Application of a range of system-based approaches to learning from incidents
3. Considered and proportionate responses to incidents
4. Supportive oversight focussed on strengthening response system functioning, learning and improvement

In practical terms, this means that NHS Trusts no longer report Serious Incidents and as such this will be the last the Integrated Board Report which includes information about the number of Serious Incidents that have been reported.

Instead of having specific criteria resulting in a prescribed response, PSIRF allows organisations to review moderate and above harm incidents and agree a proportionate response on a case by case basis. Within NUTH, the proportionate responses are Local Investigation, an AAR and a PSII. Of these responses, the PSIIs are externally reportable and so will be included in the commentary of future Integrated Board Reports.

It should be noted that the definition of a Never Event remains unchanged and will be reported and investigated as a PSII.

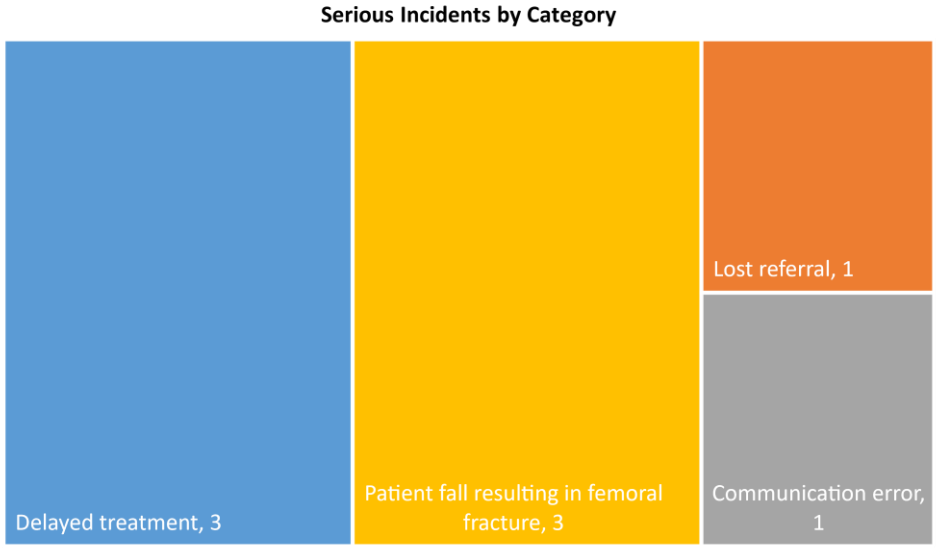
Quality: Serious Incidents and Never Events



There were eight Serious Incidents (SIs) reported in February 2024. This was expected due to the transition from the old SI framework to PSIRF.

These eight incidents were discussed at the final SI triage meeting under the old framework, however, were not reported to StEIS until the beginning of February 2024 due to the decision-making approval process in place prior to commencing PSIRF.

The Duty of Candour (DoC) process has been initiated for all cases reported in February 2024.



The categories of reported SIs for February 2024 are displayed in the table above. The highest number of SIs relate to delayed treatment, of which there were three.

Quality: Patient Safety Incident Investigations and Never Events

PSIIs

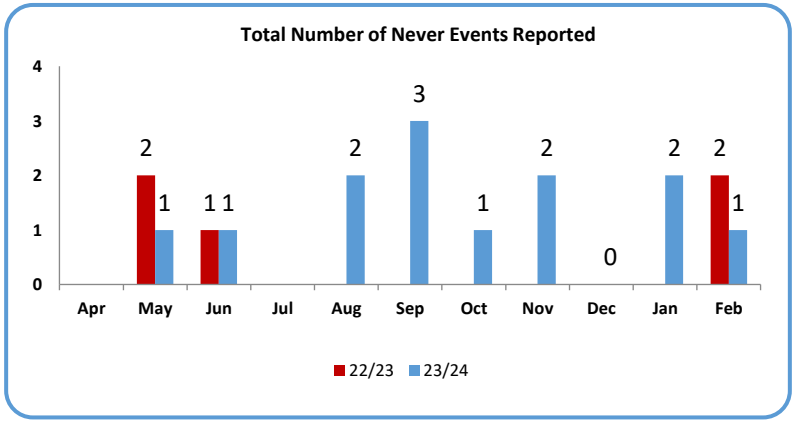
There were 6 PSIIs identified in February 2024. The Duty of Candour (DoC) process has been initiated in all of these cases.

Month	Number of PSIIs reported
February	6

Of the 6 PSIIs, four related to delayed treatment, one related to missing specimens and one was a Never Event.

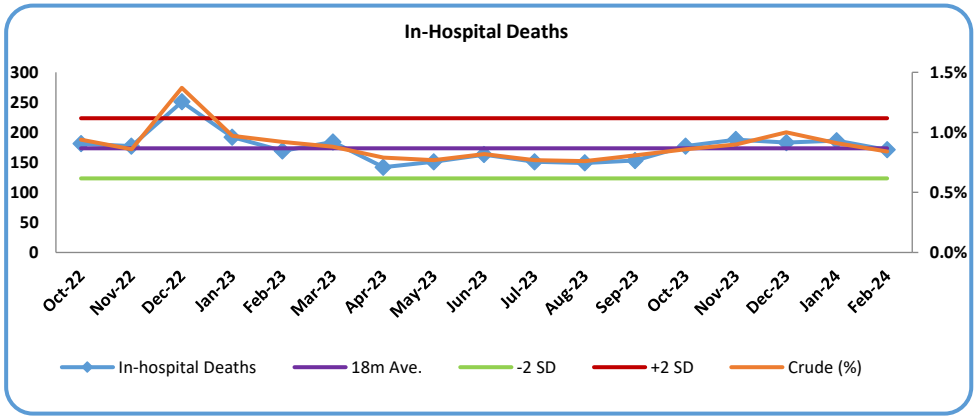
Never Events

One Never Event was de-registered in January 2024 and one Never Event was declared in February, bringing the total number to 12 so far this year.

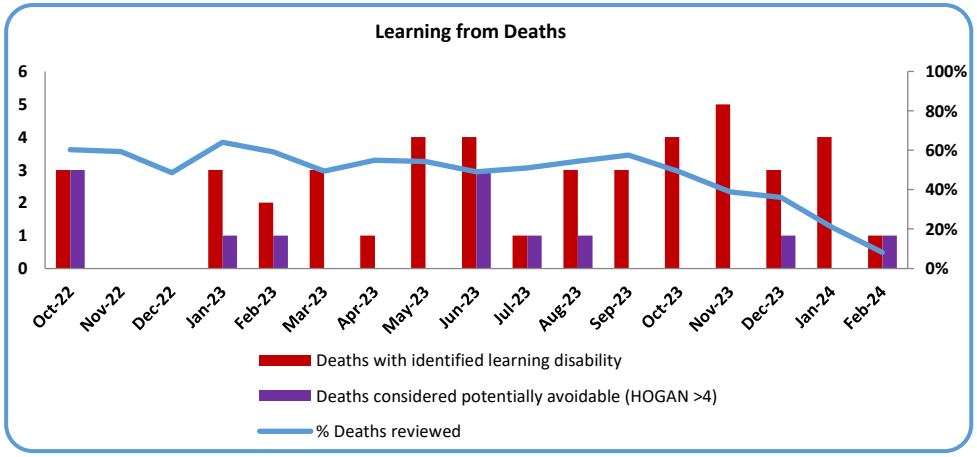


Quality: Mortality Indicators (1/2)

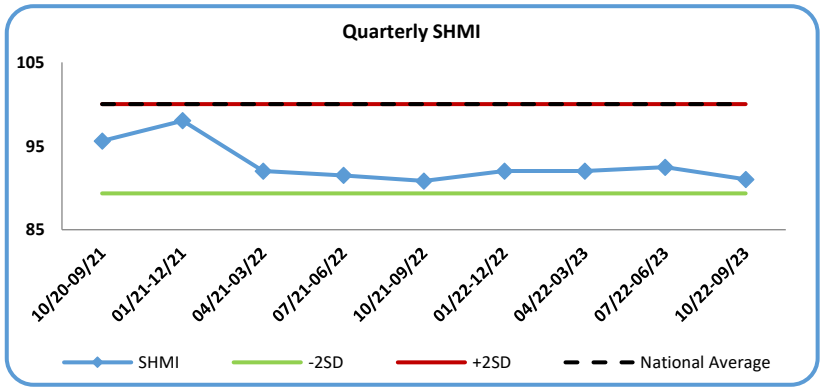
In-hospital Deaths: In total there were 171 deaths reported in February 2024, which is more than the amount reported 12 months previously (n=169). Nationally the deaths were high in December 2022, with influenza reported to be the main cause of death. The crude rate in February 2024 is 0.84%.

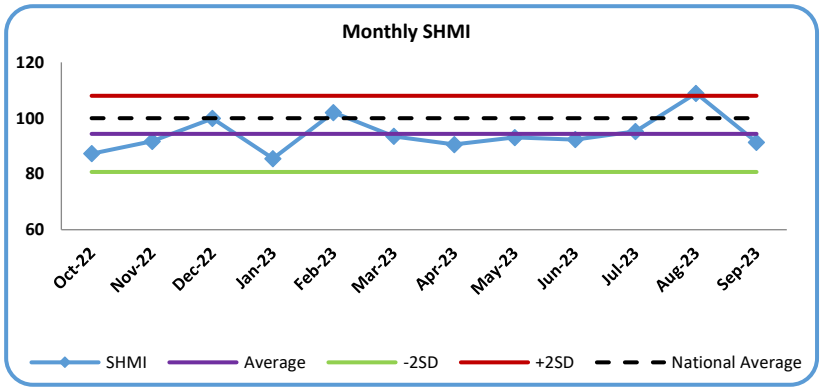


Learning from Deaths: Out of the 171 deaths reported in February 2024, 14 patients have, to date, received a level 2 mortality review. However, these figures will continue to rise due to ongoing M&M meetings held over the forthcoming months. All figures will continue to be monitored and modified accordingly. In February 2024, one patient had an identified learning disability, and one patient had a HOGAN grading >4. This patient has been discussed at the Rapid Action Review meeting and the outcome was to report this as a Patient Safety Incident Investigation.



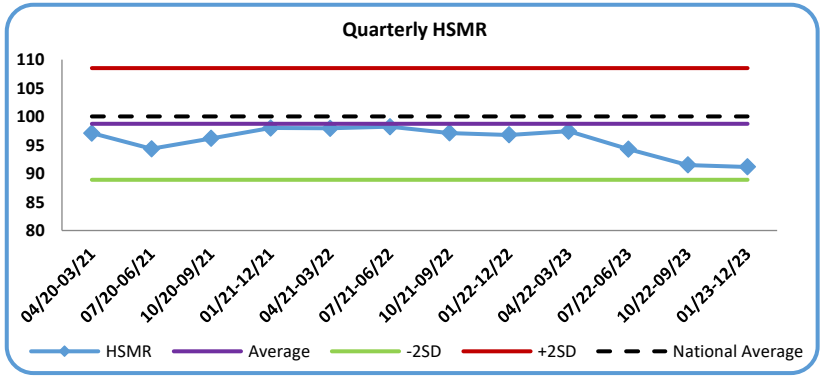
Quality: Mortality Indicators (2/2)

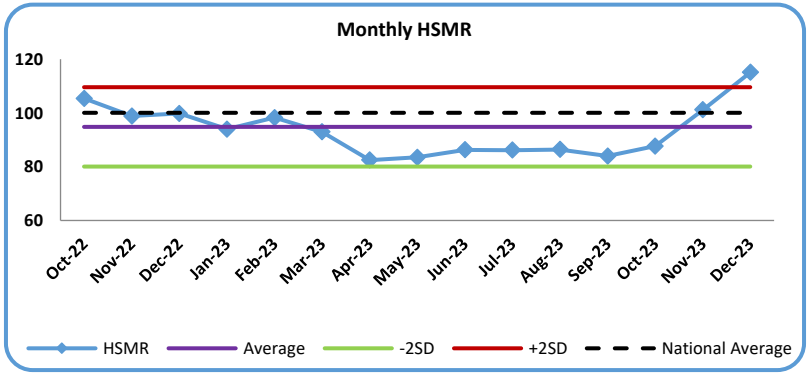




SHMI: The latest published quarterly SHMI data from NHS England shows the Trust has scored 91 from months October 2022 to September 2023. This is below the national average and within the "as expected" category. Monthly SHMI data is published up to September 2023 and shows the Trust to be below the national average and within “expected limits”. This will be continually monitored and amended accordingly.

The previous technical issue where secondary diagnoses were not being uploaded into the Trust commissioning data set has been resolved and all SHMI data has been retrospectively updated by NHS England.



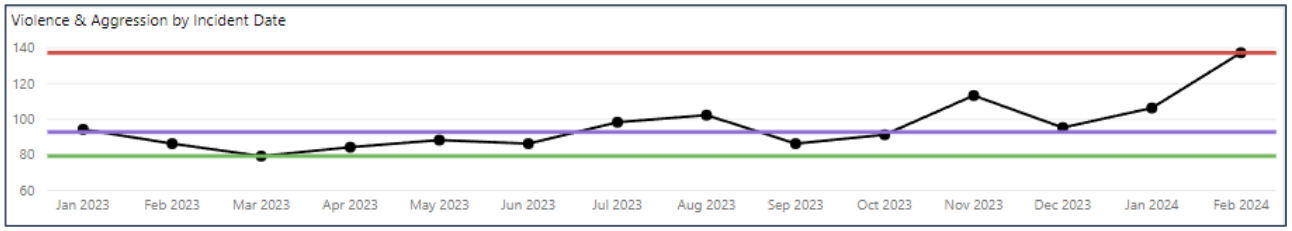


HSMR: The HSMR data shows a 12-month rolling score by quarter as well as monthly. Monthly HSMR is published up to December 2023. This is shown an increase in December 2023 and has triggered a negative alert. Initial investigations have highlighted a delay receiving the updated data into HSMR after the previous technical issue highlighted above. This is due to HSMR data being received into the Trust via a different external source (Imperial College). We hope to see HSMR data rectified by the next IBR published report. This will be continue to be closely monitored and amended accordingly.

Quality: Health and Safety (1/2)

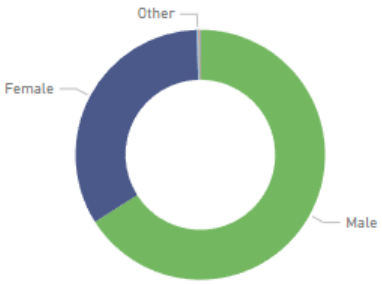
Staff Safety: Violence and Aggression (Thematic Review)

Violence and Aggression incidents: Within the financial year a slight decrease is forecasted in physical assaults in comparison to the previous year; however non-physical aggression has increased by 23% in comparison to year 22-23. The Emergency Department continue to report the highest levels of physical assault. Outside of ED, there's a wide spread of reported assaults across a varied range of disciplines and specialities. Staff feedback highlights the negative impact this behaviour has on morale, absence and retention rates, etc.

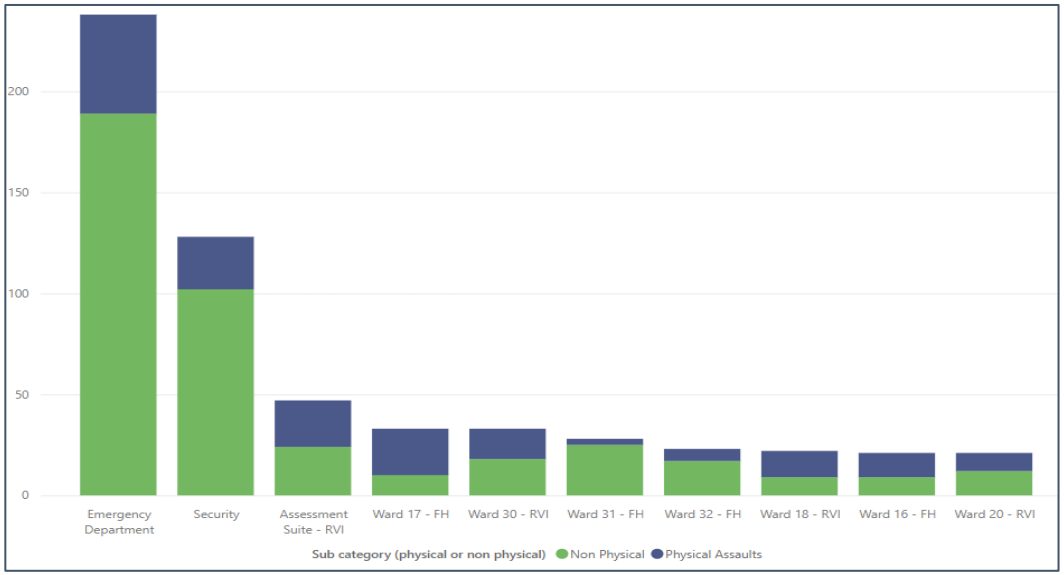


The above chart shows the sustained rate of incidents reported over a longer period. The increase in incidents more recently is in relation to disruptive / aggressive non-physical behaviour. Incident forms submitted in the last 12 months, show that mental health, alcohol, dementia and delirium make up 60% of the recorded contributory factors. Over the same period, males are recorded as the perpetrators in 66% of incidents and ED continues to see higher levels of violence and aggression than other areas.

Perpetrator of Violence and Aggression by Gender



Violence and Aggression – Higher Reporting areas



Quality: Health and Safety (2/2)

National Initiatives:

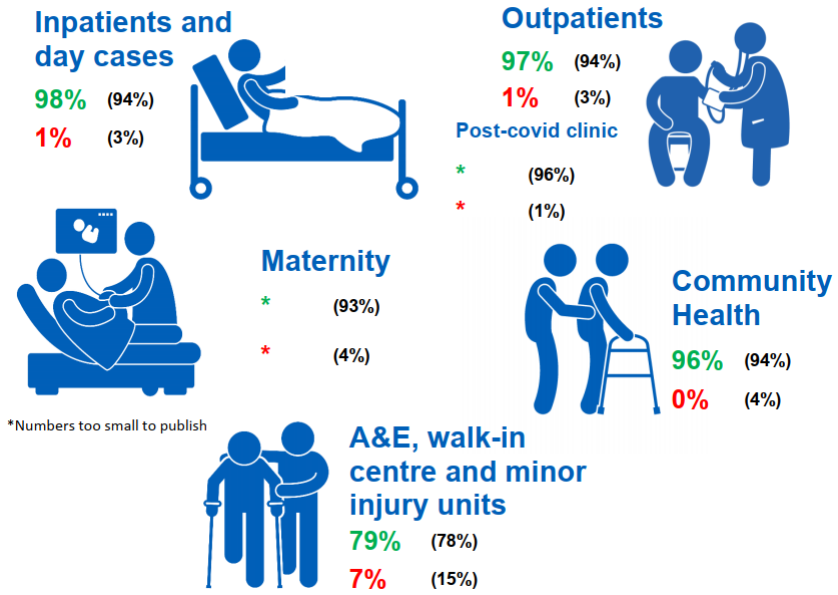
There is a nationally recognised workstream for organisations to use the Public Health model to reduce violence and aggression. NUTH are reviewing this model and using incident data and staff feedback to help develop Trust wide and localised reduction plans, which will be monitored over a period of time. The contributory factors are not always under the Trust's control and the Public Health model promotes a multi-agency approach to violence reduction, for example, the Emergency Department have recently employed Violence Reduction Navigators. Following extensive trials in Scotland, this evidence-based approach to dealing with challenging behaviour, looks to introduce social prescribing and support to those more likely to be either the victim or perpetrator of violence and aggression.

All organisations with NHS contracts are now expected to meet National Violence Reduction Standards. NUTH score well against these standards. Our recent CQC inspection highlighted a focus around the use of restrictive interventions such as physical restraint. The main reason for the use of physical restraint is in the management of violence and aggression. We therefore look to use primary initiatives to prevent the use of physical restraint, which would include for example: improving patient experience, providing suitable environments, raising awareness of mutual expectations, reduction of boredom and sleep hygiene.

Trust Initiatives:

- CGARD (Health and Safety Team) are re-evaluating ward / department-based risk assessments using a comprehensive risk assessment tool for higher risk / higher frequency areas. This work is due to be completed by end March 24.
- Specific staff-based wellbeing / violence reduction surveys have been undertaken on Wards 20, 23 and 47 RVI. The aim is to use the results of these surveys to develop localised violence reduction plans, using recognised quality improvement tools. This will be extended to other areas within the current financial year.
- The data from Ward 47 RVI has been analysed and discussed with staff. Psychiatric Liaison Team and Substance Misuse Team are currently facilitating bitesize staff awareness sessions covering topic areas highlighted on the survey such as trauma, personality disorder, addictions, self-harm / suicide. This work will be evaluated using QI methodology before considering the next initiative. This provides more of a bottom-up approach to violence reduction.
- Further discussion is taking place to seek ongoing funding for breakaway training, which has recently been re-introduced and is covered on the Trust training needs analysis.
- Improve the reporting culture across the organisation to ensure we have an accurate record of actual activity and work closely with those areas where tolerance to violence and aggression is deemed to be too high. As this work progresses it's probable the number of incidents will increase before plateauing and then reducing over time. The use of QR codes providing the ability to report incidents via a mobile device is due to be rolled out this month.
- Working closely with other agencies to ensure violence and aggression is addressed holistically e.g. work progressing with Northumbria Police Violence Reduction Unit to partially fund ED Navigators.
- Review the Exclusion from Treatment of Violent or Abusive Patients Policy and align this to a re-formatted 'Violent Patient Marker' group.
- Provide lone worker devices to those staff working in the community.
- Continued support for staff who have been the victims of violence and aggression at work.

Quality: FFT and Complaints



Friends and Family Test

There were 1,344 responses to the Friends and Family test from the Trust in January 2024 (published March 2024) compared to 664 in the previous month.

The infographic shows the proportion of patients who give a positive or negative rating of the care they received. The national average results are shown in brackets for comparison.

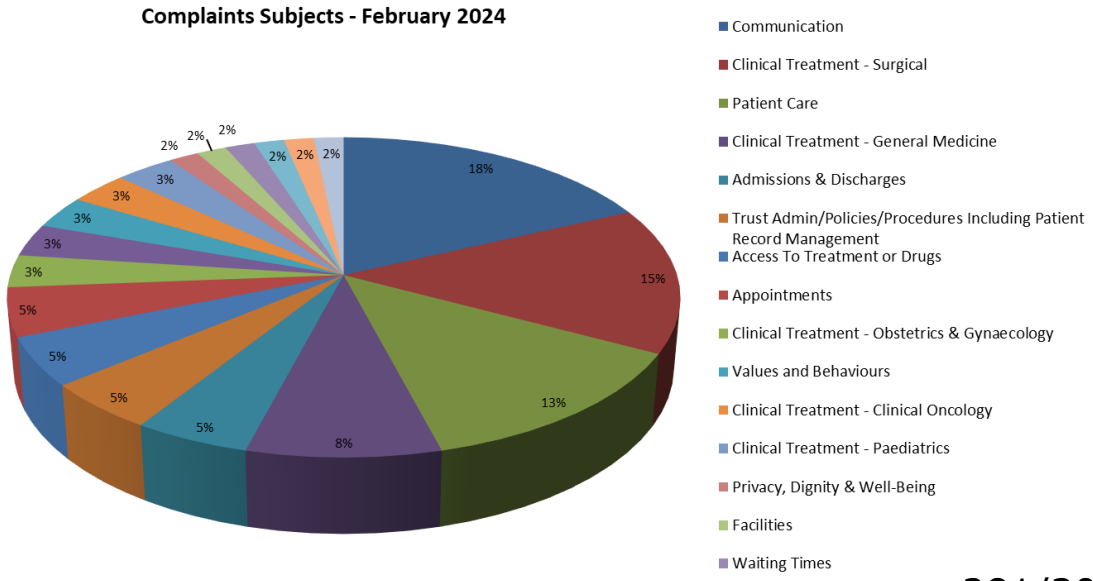
All data is available at: www.england.nhs.uk/fft/friends-and-family-test-data/

*numbers too small to publish

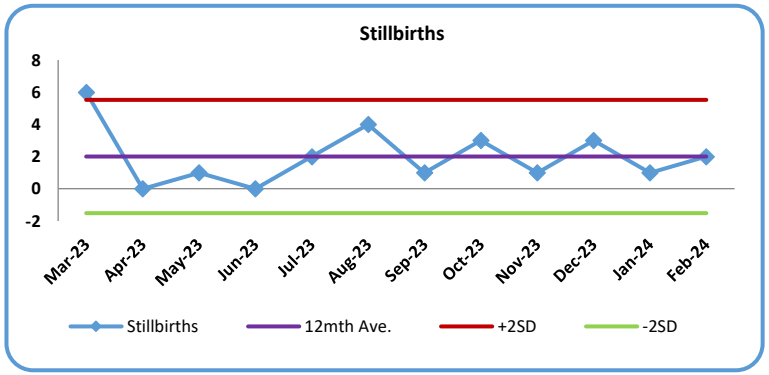
Formal Complaints

The Trust has opened 516 formal complaints for the financial year up to February 24, which is an increase of 61 complaints from the previous month. The Trust has received on average 47 formal complaints per month, which is up by one complaint on the overall average for 2022/23.

The chart opposite summarises the 61 complaint themes for February 24, with communication and clinical treatment – surgical being the primary concerns with eleven and eight complaints respectively.

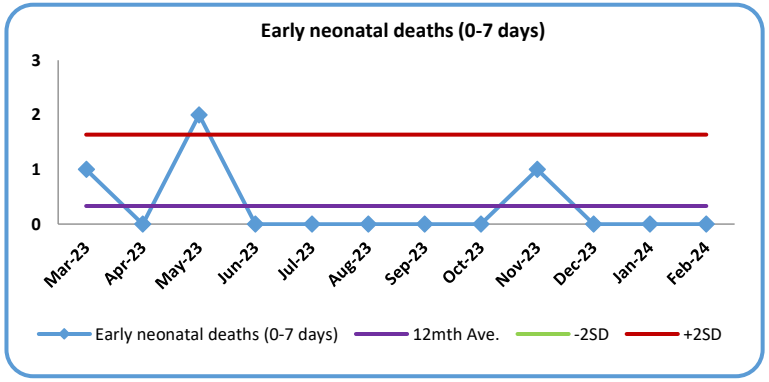


Quality: Maternity (1/3)



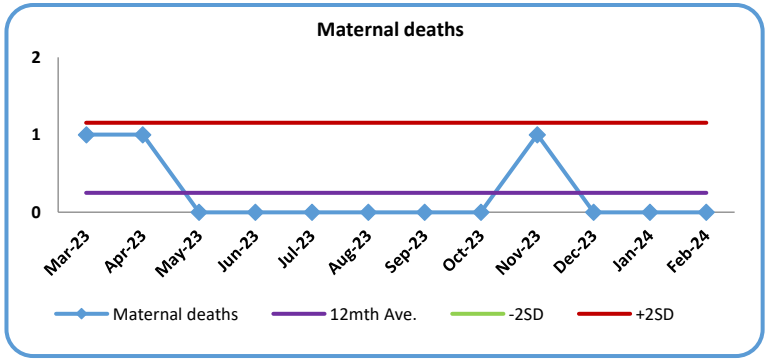
Stillbirths

As NuTH is a tertiary referral Fetal Medicine Unit, complex cases are often referred to the Trust from other units within the region, with women opting to deliver here rather than return to their local unit. This data therefore includes termination for fetal anomalies > 24 weeks gestation. All cases undergo an initial local review and then a more detailed multidisciplinary team review including external input. Findings and actions required, as a result of reviewing each case, are then shared with the family involved. There were two stillbirths in February 2024.



Early Neonatal Deaths

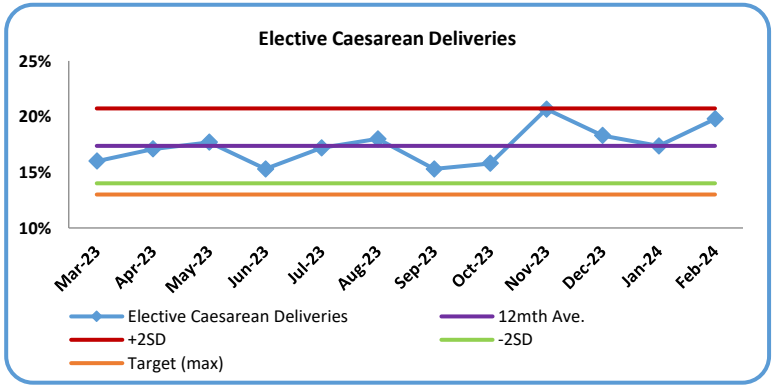
These figures are for term infants (born between 37 and 41 weeks) who delivered at the Trust but sadly died within the first week of life. These deaths are reported to the Child Death Review panel (as are all neonatal deaths regardless of gestation) who will have oversight of the investigation and review process. Neonatal deaths of term infants are also reported to Maternity and Newborn Safety Investigations (MNSI was HSIB) and the Coroner. A post-mortem examination may be requested to try and identify the cause of death. In January and February 2024 there were no term early neonatal deaths.



Maternal Deaths

Maternal deaths are reported to MBRRACE-UK and a national report is provided annually. Early maternal deaths are categorised as the death of a woman while pregnant or within 42 days of pregnancy (including termination of pregnancy). Late maternal deaths are reported from 42 days and within a year of pregnancy. Direct deaths are those resulting from obstetric complications of the pregnant state. Indirect deaths are those from pre-existing disease or disease that developed but has no direct link to obstetric cause and was aggravated by pregnancy.
Early maternal deaths are also reported to Maternity and Newborn Safety Investigations (MNSI previously known as HSIB), investigation is dependent on certain criteria. There have been no maternal deaths reported in 2024.

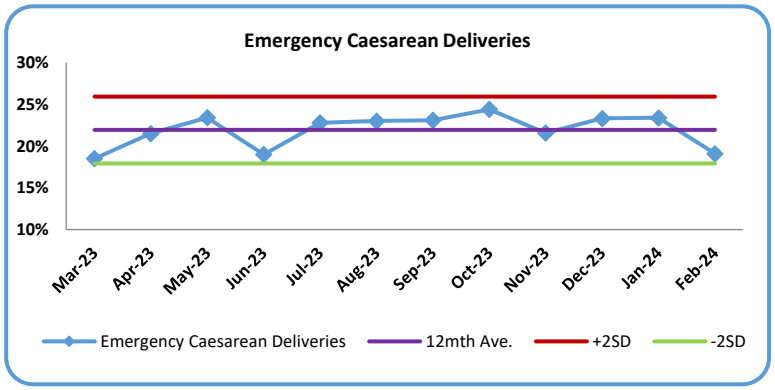
Quality: Maternity (2/3)



Elective Caesarean section

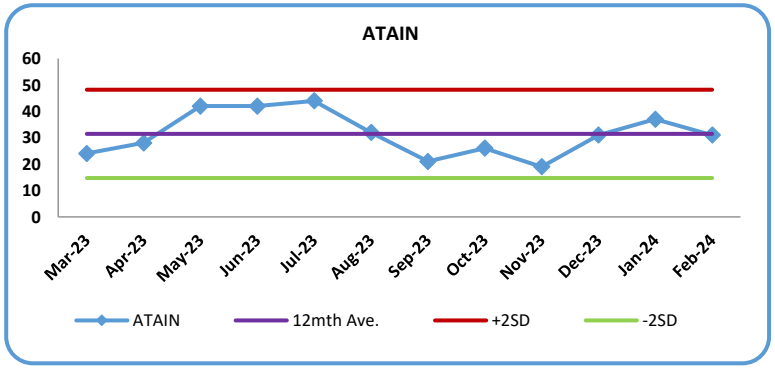
Maternity at the Trust is an outlier for elective Caesarean section compared to other UK Trusts. However, the rates are comparable to that of other tertiary centres in the UK.

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



Emergency Caesarean section

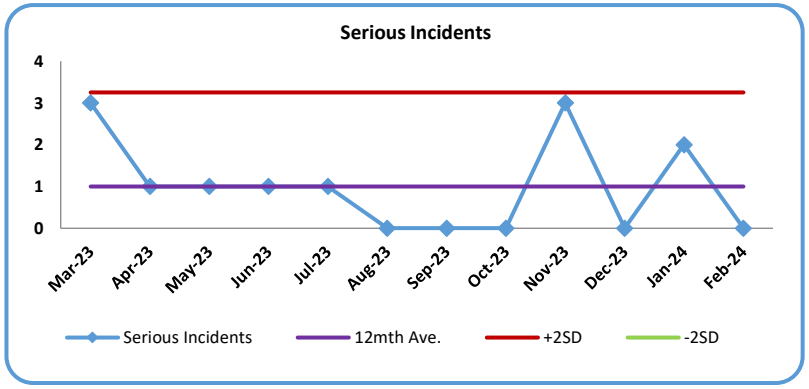
The emergency Caesarean section rate is comparable to other Trusts. Maternity is a consultant led service with dedicated consultant presence on Labour Ward 8am-10pm daily, consultant led multi-disciplinary ward rounds occur twice daily. The majority of obstetric consultants remain onsite overnight, from 10pm-8am and are involved with all decisions for emergency Caesarean section.



Avoiding Term Admission into Neonatal Units (ATAIN)

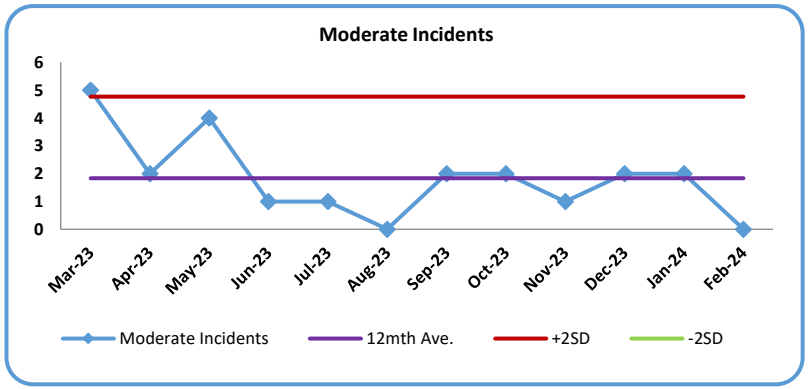
All unplanned admissions of term babies (37 – 41 weeks) into the neonatal unit are reviewed at a weekly multi-disciplinary meeting and a quarterly report is produced and shared. Following review, some cases will be investigated in more detail if they have been identified as a Serious Incident. Analysis for Quarter 3 (Oct-Dec) term admissions highlighted 6 avoidable admissions from a total of 89, with a rate of 6.7%, this is a small rise from the previous quarter of 6%. Themes from the Quarter 3 avoidable admissions include thermoregulation, hypoglycaemia and communication of risk factors. Learning and actions from Quarter 3 have been shared through the ATAIN Quarterly Newsletter to all maternity staff.

Quality: Maternity (3/3)



Serious Incidents

There have been 12 Serious Incidents within the last 12 months. These include cases of potential or confirmed Hypoxic Ischaemic Encephalopathy (HIE), neonatal death, intrapartum stillbirth, antepartum intrauterine death and maternal death. The HIE, Intrapartum Stillbirths, Neonatal deaths and Maternal deaths were all reported to Maternity and Newborn Safety Investigations (MNSI was previously known as HSIB) for external review. There have been no new Serious Incidents declared by the Trust in February 2024.



Moderate incidents

There were no moderate (and above) incidents reported in Maternity this month. Working within the newly implemented Patient Safety Incident Response Framework (PSIRF), all moderate and above incidents will be reviewed by the maternity governance team and a multidisciplinary team rapid review undertaken. These cases will then be presented to a weekly Trust 'Rapid Action Review' meeting to agree grading, identify immediate learning/action and agree a proportionate response to each incident. Thematic learning from incidents will also be gathered through this process.

Quality: National Audits (1/2)

Audit / NCEPOD	Date of Report	Areas of Good Practice	Areas for improvement	Baseline Assessment complete
National Prostate Cancer Audit	12/01/23	• High volume prostate cancer surgery centre • Offer range of treatment options to patients • Opportunity for patients to be involved in research	• None	Yes – presented at Clinical Audit and Guidelines Group
National Cardiac Surgery Audit	08/06/23	• Waiting times for elective coronary artery bypass graft: 81.5 days, target 84 days, FH in upper quartile. • Proportion of patients receiving a blood transfusion following isolated coronary artery bypass grafting: 9%, national average 46%. • Proportion of mitral valve repair discussed pre-operatively at MDT meeting: 75%, national average 37%.	National recommendation: • Hospitals not reaching the Day-of-Surgery-Admission (DOSA) target should undertake a review of their processes to identify the barriers to achieving this target (such as introducing pre-assessment clinics). Freeman currently in upper quartile nationally.	Yes – presented at Clinical Audit and Guidelines Group
Serious Hazards of Transfusion (SHOT)	04/07/23	• Patient Information Leaflet embedded in Trust • Implemented closed loop blood transfusion digital system • Digital system includes collection of blood components, electronic checking systems and smart refrigerators are in place to support safe practice • Major Haemorrhage Protocol good practice, regional Trusts have adopted NUTH pathway • Patient ID in digital system to support patient safety	• None	Yes – presented at Clinical Audit and Guidelines Group
National Congenital Heart Disease Audit	08/06/23	• Quality of data submitted to audit was excellent quality >99.5% for Freeman Hospital.	• None	Yes – presented at Clinical Audit and Guidelines Group
Myocardial Ischaemia National Audit Project	08/06/23	• 95.94% of patients admitted to a cardiac ward, national target 80%. • 100% of patients seen by a Cardiologist on index admission, national target 90%. • 99.81% of patients discharged on all secondary prevention drugs for which they were eligible, national target 90%. • 98.76% of all patients eligible were referred for cardiac rehabilitation at time of discharge home, national target 85%.	• Freeman Hospital performed 28.75% of angiograms during patients' admission. • Freeman Hospital performed 35.48% of PCI procedures for patients with NSTEMI within 72 hours (not meeting standard of 60%).	Yes – presented at Clinical Audit and Guidelines Group
National Audit of Cardiac Rhythm Management	08/06/23	• Re-intervention rates within a year of a first pacemaker implant 1.94%, national standard 5%. • 95.2% of pacemaker implants were dual chamber (pacing in AV block) • 95.8% of ICD implants for secondary prevention were documented to meet at least one of the NICE criteria • Simple pacemaker re-interventions within first year following implant – 4.08% • Complex pacemaker re-interventions within first year following implant – 4.61%	• None	Yes – presented at Clinical Audit and Guidelines Group
National Heart Failure Audit	08/06/23	• Input from Consultant Cardiologist 76% vs 52% national average • Input from specialist 86% vs 82% national average • Angiotensin Converting Enzyme Inhibitor (ACEI) on discharge 70% vs 63% national average • Angiotensin Converting Enzyme Inhibitor (ACEI); Angiotensin Receptor Blocker (ARB); Angiotensin Receptor/ • Neprilysin Inhibitor (ARNI) on discharge 88% vs 87% national average • Beta blocker on discharge 93% vs 90% national average • Received discharge planning 100% vs 93% national average	National recommendations: • Improve access to echo within 48 hours of admission • Ensure higher risk patients have access to cardiology ward • Improve access to early specialist follow-up, Increase number of Heart Failure Specialist Nurse (HFSN) in line with GIRFT recommendations of 3-4 per 100,000 population. Currently 5.5 Whole Time Equivalent HFSN (community and inpatient). Review of current workforce and capacity in progress	Yes – presented at Clinical Audit and Guidelines Group

Quality: National Audit (2/2)

Audit / NCEPOD	Date of Report	Areas of Good Practice	Areas for improvement	Baseline Assessment complete
UK Renal Registry	30/06/2023	• NuTH was performing at the mid-point of the UK for all parameters apart from one.	• One outlying result performing below the target; the proportion of prevalent dialysis patients with a urea reduction ratio (URR) >65%, a measure of dialysis adequacy, NuTH ranked 46th of 58 reporting units based on median URR quality metrics.	Yes – presented at Clinical Audit and Guidelines Group
MBRRACE – Perinatal Mortality Surveillance report 2019 - Stillbirth perspective	14/09/2023	• The Trust has implemented all national initiatives to reduce stillbirth and neonatal deaths and monitoring the impact on reducing preterm birth. • Compliant with all 5 elements of Saving Babies Lives Care Bundle 2: Preterm prevention, Fetal Growth Restriction, reduced Fetal Monitoring, Fetal monitoring training and champions. Dedicated Fetal Monitoring lead midwife focusing on each element of Saving Babies Lives Care Bundle Version 2. • Stillbirth rate very low compared to national average.	• Explore local variation in post-mortem uptake by different population groups, particularly by ethnicity and deprivation, and tailor training for consent takers based on the local population. • Undertake placental histology for all babies admitted to a neonatal unit, preferably by a specialist perinatal pathologist.	Yes – presented at Clinical Audit and Guidelines Group
MBRRACE - Maternal Mortality Report – Saving Lives, Improving Mothers Care:	12/10/2023	• Psychiatrist and perinatal mental health services. • Robust bespoke electronic VTE risk assessment for Maternity and joint Obstetric Haematology ANC with Haematologist for MDT input and planning for women with VTE in pregnancy • Maternal Medicine Specialists coordinate care of pregnant women with cancer. Individualised MDT planning	• Ensure there are clear and explicit pathways into specialist perinatal mental health care, which take into account all other aspects of perinatal mental health provision, including specialist roles within midwifery and obstetric services, in order to avoid any confusion over roles and responsibilities • Women with substance misuse are often more vulnerable and at greater risk of relapse in the postnatal period, even if they have shown improvement in pregnancy. Ensure they are reviewed for re-engagement in the early postpartum period where they have been involved with addictions services in the immediate preconception period or during pregnancy.	Yes – presented at Clinical Audit and Guidelines Group
National Audit of Dementia	10/08/2023	• Pain assessment 100% and reassessment within 24hours 100% compared to national average of 92% • Carer rating overall care quality 79% for RVI and Freeman compared to national average of 66% • Staff with tier 1 dementia training for the trust at 97% compared to national average of 86% • Delirium screen including noted on admission 95% for RVI (Freeman 90%) compared to national average of 87% • Carer rating communication 67% for RVI (70% for freeman) compared to national average of 60% • Patients were on the right ward for their need 98.8% compared to national average of 92.5% • Fewer patients were discharge to a new long term care placement 4% at RVI (this was higher at 22% for Freeman) compared to national average of 13%	• Percentage of personal information for people with dementia completed (forget me not cards or similar) was lower at 25% compared to the national average of 46%. • Percentage of staff with tier 2 dementia training was lower for the trust at 22% compared to the national average of 45%. • The use of alternative pain assessment tools for people with dementia e.g. Abby pain scale – trust score 1% , national 10%.	Yes – presented at Clinical Audit and Guidelines Group
National Audit of Care at the End of Life	13/07/2023	• Communication with the dying person 9.2 vs 8 national average • Communication with families and others 7.9 vs 7.1 national average • Involvement in Decision making 9.9 vs 9.2 national average • Individualised plan of care 8.6 vs 7.6 national average • Needs of families and others 6.7 vs 5.5 national average • Families and others experience of care 7.8 vs 6.3 national average • Workforce/specialist palliative care 10 vs 8.1 national average • Staff confidence 7.9 vs 7.5 national average • Staff support 7.7 vs 7.1 national average • Care and culture 8.1 vs 7.6 national average	No specific recommendations for the Trust were made within the report.	Yes – presented at Clinical Audit and Guidelines Group

People: Executive summary

(Data is for year-ending February 2024 unless otherwise stated)

Sickness

- Total sickness absence reduced from 6.10% (March 2022 to February 2023) to 5.25% (March 2023 to February 2024)
- Top three reasons for sickness absence are 'anxiety/stress/depression/other psychiatric illnesses' (26%), 'cold/cough/flu' (12%) and 'gastrointestinal problems' (10%)

Retention & turnover

- Staff in post increased by 3.87% compared to previous year with biggest increase in nursing & midwifery, allied health professionals
- Retention of staff with over 1-year service increased from 85.42% (February 2023) to 87.10% (February 2024)
- Turnover has been reducing since May 2023 and stands at 10.62% (February 2024) compared to target of 8%
- Top reason for leaving was 'work-life balance' 16.22%
- Top destinations on leaving were: 'no employment' 37.10% (half were accounted for by retirement, health and temporary contract); and other 'NHS organisation' 31.50%

Mandatory training and appraisal

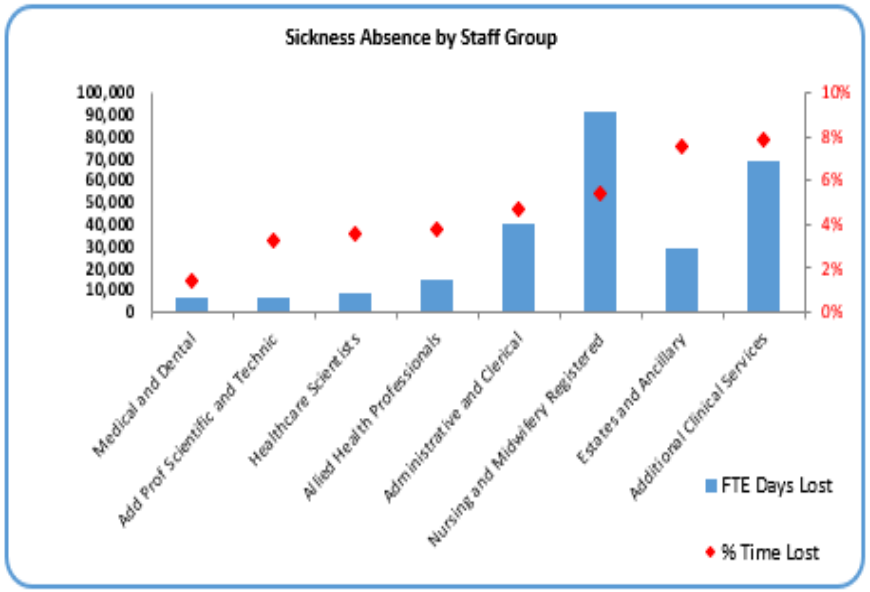
- Mandatory training compliance is 93.20% compared to target of 95%
- Lowest rate of compliance is medical and dental staff 87.32%
- Mandatory training courses below 80% compliance: 'local induction' 73.41%; 'paediatric basic life support' 68.15%; 'adult basic life support' 74.42%
- Appraisal compliance is 84.07% compared to target of 95%

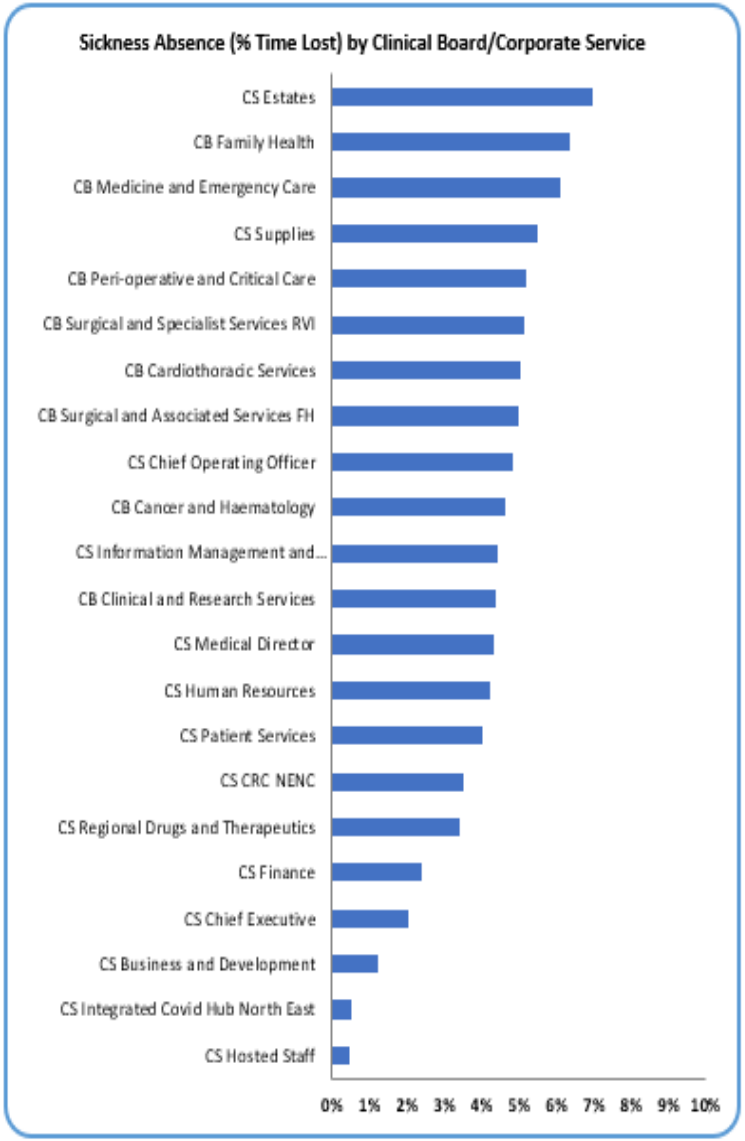
People: Sickness absence (Staff Group and Clinical Board) 1/3

265,257 FTE working days were lost due to sickness, compared to 298,697 for the previous year - a reduction of 11%

Total sickness absence reduced from 6.10% (March 2022 to February 2023) to 5.25% (March 2023 to February 2024).

The top three reasons for sickness absence are S10 Anxiety/stress/depression/other psychiatric illnesses (26%), S13 Cold, Cough, Flu - Influenza (12%), and S25 Gastrointestinal problems (10%).



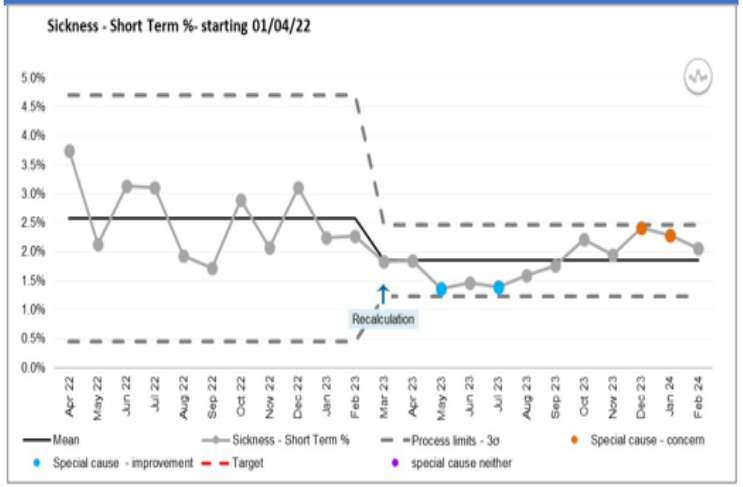


People: Sickness absence – February 2024 (target 3%) 2/3

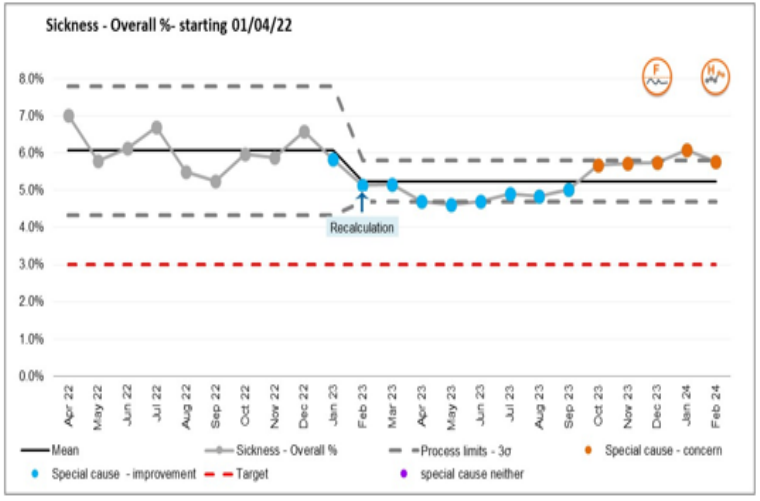
Metric	Assurance		Variation	
Sickness – Overall %	F	Consistently fail target	H	Special Cause Concerning Variation
Sickness – ST %				Common Cause
Sickness – LT %				Common Cause

Latest monthly sickness absence is 5.77%, demonstrating a continued increase away from the 3.00% target, with long term sickness the main contributing factor.

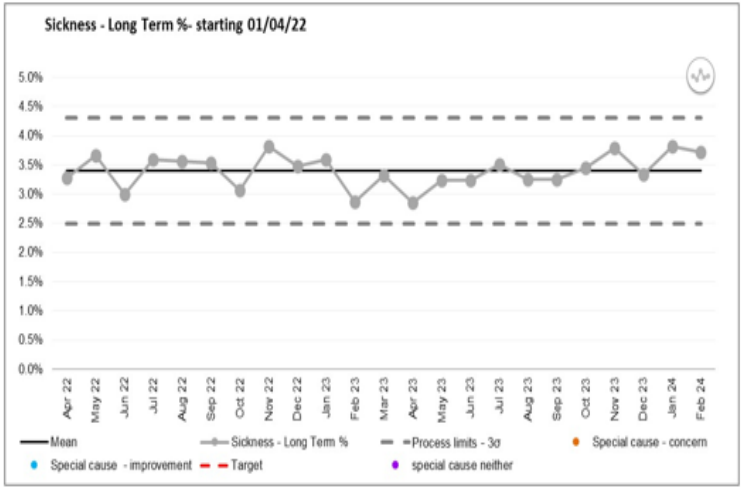
Sickness – Short Term % 2.06%



Sickness – Overall % 5.77%



Sickness – Long Term % 3.71%

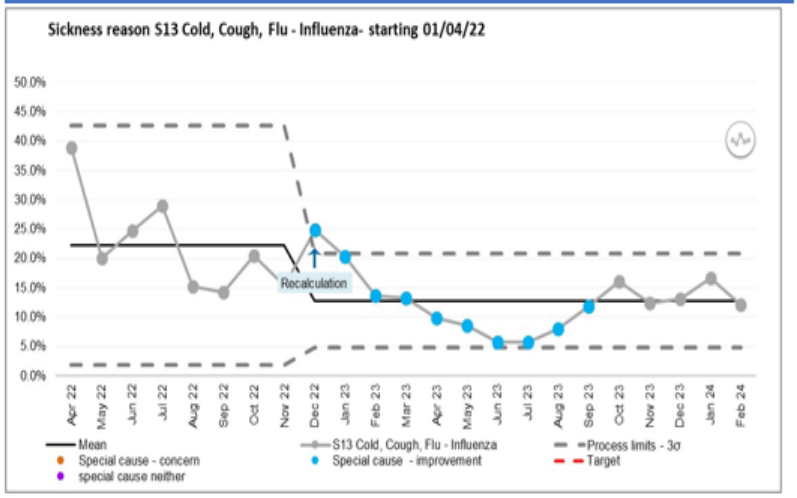


People: Sickness absence reason - Top 3 sickness reasons April 2022 to February 2024 (%FTE)

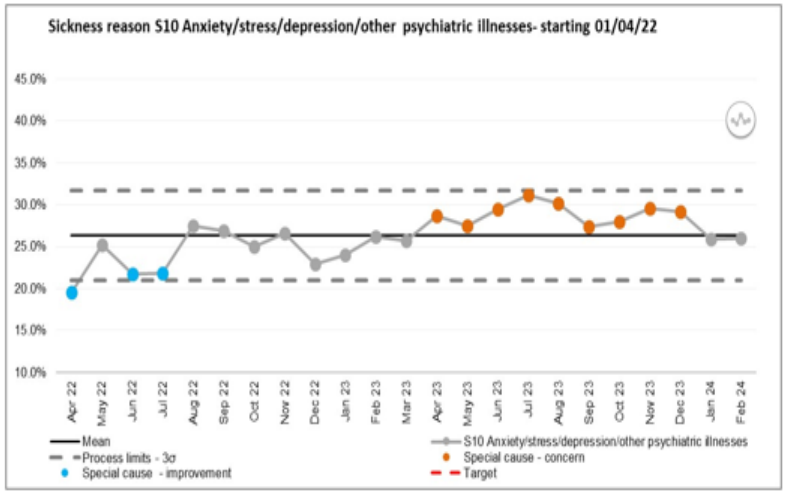
Metric	Variation
S10 Anxiety/stress/depression/other psychiatric illnesses	Common cause
S13 Cold, Cough, Flu – Influenza	Common cause
S25 Gastrointestinal problems	Common cause

Overall sickness absence for Anxiety/stress/depression/other psychiatric illnesses is 26.05%, this has remained at 'Common Cause variation'. Cold, Cough and Flu has seen a reduction to 12.16% in February 24 from 16.61% in January 24.

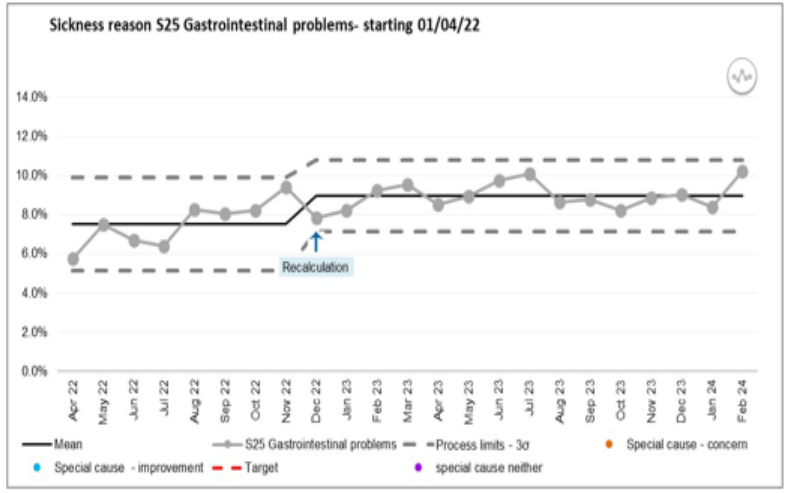
S13 Cold, Cough, Flu - Influenza 12.16%



S10 Anxiety/stress/depression/other psychiatric illnesses 26.05%



S25 Gastrointestinal problems 10.21%



People: Equality and diversity

The tables identify by disability and ethnicity the recruitment outcome of applicants during the twelve months ending February 2024.

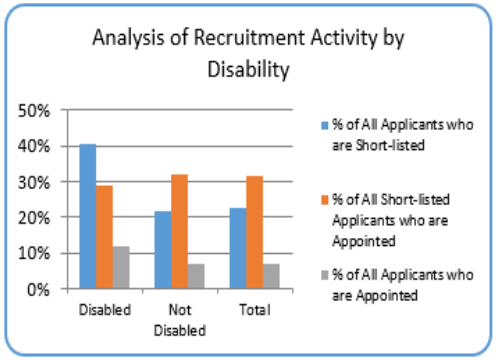
Disability %	February 2023	February 2024	
Yes	4.59%	4.76%	↑
No	80.58%	82.05%	↑
Not recorded	14.83%	13.19%	↓

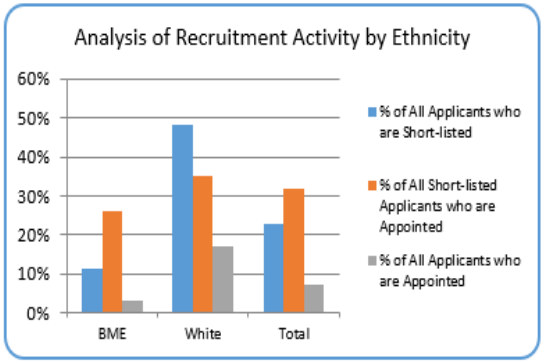
Ethnicity %	February 2023	February 2024	
BME	12.88%	15.74%	↑
White	85.74%	82.96%	↓
Not recorded	1.38%	1.29%	↓

The charts identify, by headcount, the percentage of staff in post in February 2023 and February 2024 by disability and ethnicity.

The percentage of staff employed disclosing a disability has increased (year on year) from 4.59% to 4.76% and the percentage of BAME staff has increased from 12.88% to 15.74%

Recruitment





People: Workforce staff in post and staff retention

Staff in Post

Staff Group	February 2023	February 2024	% Variation
Add Prof Scientific and Technic	528	540	2.24%
Additional Clinical Services	2370	2438	2.87%
Administrative and Clerical	2302	2381	3.43%
Allied Health Professionals	1034	1078	4.25%
Estates and Ancillary	1056	1046	-1.01%
Healthcare Scientists	668	684	2.44%
Medical and Dental	1179	1188	0.72%
Nursing and Midwifery Registered	4525	4837	6.89%

Staff in post has increased by **3.87%** since February 2023. The staff groups with the largest increase are Nursing and Midwifery and Allied Health Professionals.

Retention for staff over 1 year service is **87.10%**, an increase from 85.42% in February 2023.

Staff Retention

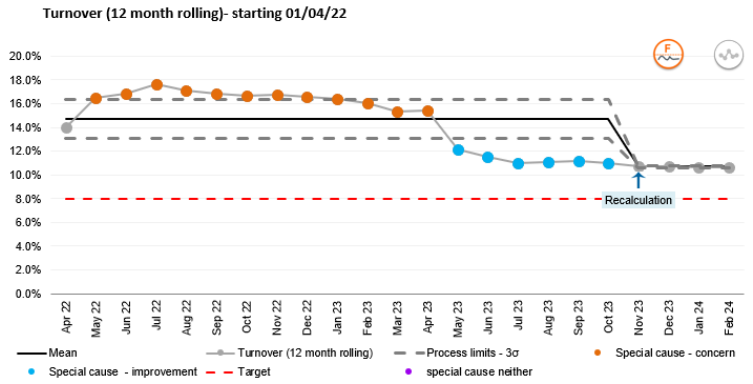
Category	2022	2023	2024
Over 1 year service	84.10%	85.42%	87.10%
Less than 1 year service	15.18%	14.58%	12.90%

Staff Group (2024)	Over 1 year service	Less than 1 year service
Add Prof Scientific and Technic	89.25%	10.75%
Additional Clinical Services	84.15%	15.85%
Administrative and Clerical	86.32%	13.68%
Allied Health Professionals	88.49%	11.51%
Estates and Ancillary	89.23%	10.77%
Healthcare Scientists	93.09%	6.91%
Medical and Dental	85.35%	14.65%
Nursing and Midwifery Registered	88.50%	11.50%

People: Workforce turnover (target 8%)

Turnover (rolling 12 months)	10.62%	
Clinical Board	**Turnover**	**Achieved**
317 CS CRC NENC	7.25%	✓
317 CB Cancer and Haematology	7.47%	✓
317 CB Peri-operative and Critical Care	8.64%	✗
317 CB Medicine and Emergency Care	8.65%	✗
317 CS Business and Development	9.23%	✗
317 CS Patient Services	9.73%	✗
317 CB Surgical and Specialist Services RVI	10.18%	✗
317 CB Surgical and Associated Services FH	10.29%	✗
317 CB Clinical and Research Services	10.31%	✗
317 CB Cardiothoracic Services	10.69%	✗
317 CS Estates	11.50%	✗
317 CS Finance	11.50%	✗
317 CB Family Health	13.19%	✗
317 CS Chief Executive	13.24%	✗
317 CS Human Resources	14.05%	✗
317 CS Supplies	14.19%	✗
317 CS Information Management and Technology	14.29%	✗
317 CS Regional Drugs and Therapeutics	14.93%	✗
317 CS Hosted Staff	15.15%	✗
317 CS Medical Director	17.50%	✗
317 CS Integrated Covid Hub North East	28.57%	✗
317 CS Chief Operating Officer	30.00%	✗
317 CS NHS COVID Vaccination Programme	66.67%	✗
Trust Total	10.62%	✗

Metric	Assurance	Variation
Turnover (rolling 12 months)	Consistently fail target	Common Cause

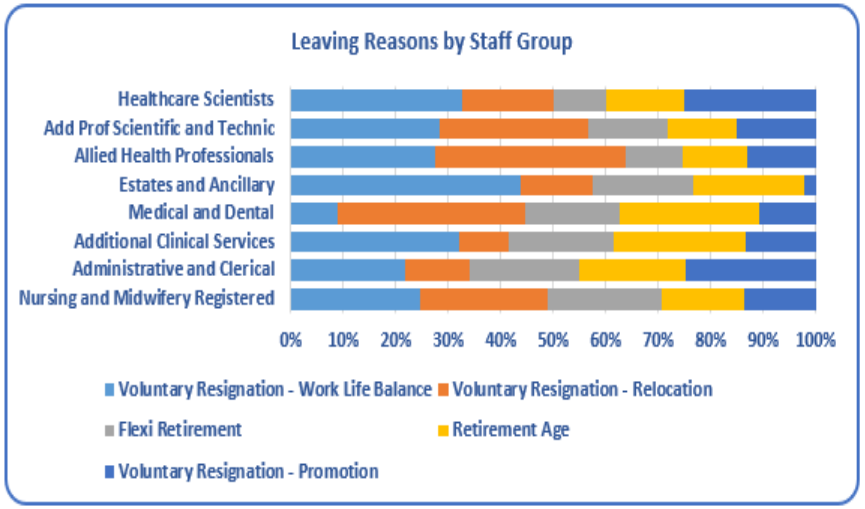


Staff turnover has decreased from 16.01% in February 2023 to 10.62% in February 2024, target is 8.0%. Due to the consistent below the mean values since May 2023, the data has been recalculated from November 2023 (7th point of values consistently below the mean). This recalculation has changed the variation to 'Common Cause' from 'Special Cause Improving Variation'.

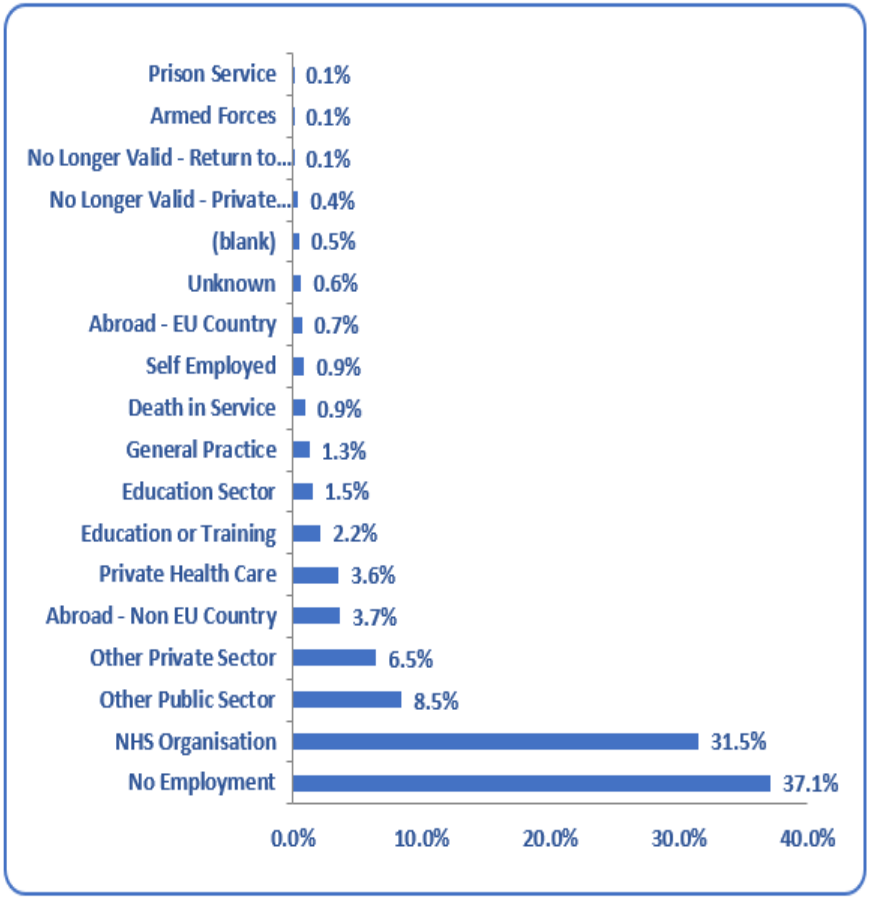
The total number of leavers in the period March 2023 to February 2024 was 1,713.

People: Workforce turnover (reasons and destination) 3/3

Top 5 Leaving Reasons



Destination on Leaving



31.5% of leavers across the Trust disclosed they were going to another NHS organisation.

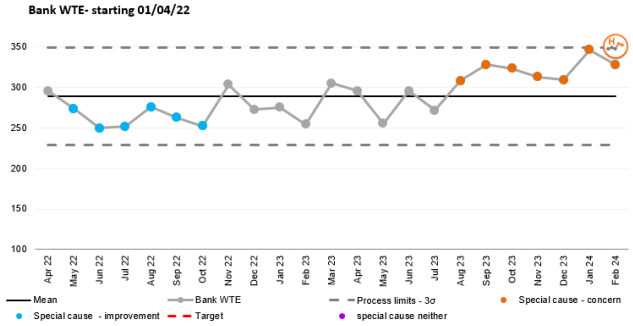
People: Workforce Bank/Agency

Bank (Whole Time Equivalent - wte)

Metric	Variation
Bank WTE	Special Cause Concerning Variation

Bank wte is demonstrating 'Special Cause Concerning' Variation. This is present when a random pattern of variation with all points within the control limits.

When a control chart shows common cause variation, a process measure is said to be in statistical control or stable.



Bank Staff Group	Variation
Admin & Clerical Bank	Common cause
AHP Bank	Special Cause Improving Variation
Band 2 Nurse Bank	Special Cause Improving Variation
Band 3 Nurse Bank	Special Cause Concerning Variation
Band 4 Nurse Bank	Common cause
Band 5 Nurse Bank	Special Cause Concerning Variation
Band 6 Nurse Bank	Common cause
Band 7 Nurse Bank	Common cause
Band 8 Nurse Bank	Special Cause Improving Variation
Healthcare Scientist	Special Cause Improving Variation
Scientific, Therapeutic & Technical	Common cause
Support Staff	Common cause

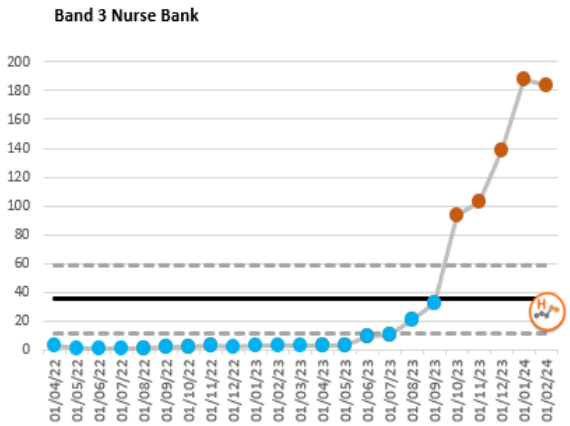
Outlier(s)

Staff Group	Variation
Band 3 Nurse Bank	Special Cause Concerning Variation

There is 'Special Cause Concerning' Variation for Band 3 Nurse Bank staff.

Special causes are a signal to act to make the process improvements necessary to bring the process measure back into control.

Note, increase is due to Band 2 Nurse bank staff being re-banded to Band 3 Nurse Bank since July 23.



People: Workforce Bank/Agency

Bank Utilisation (£)

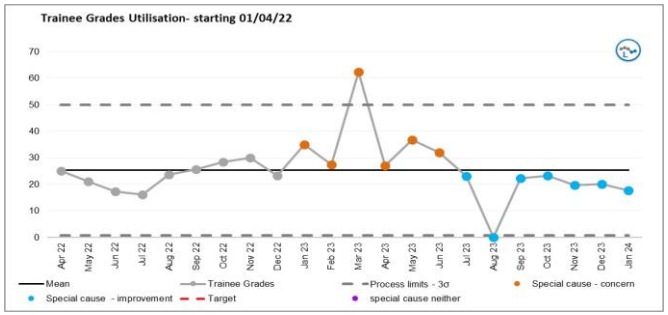
Staff Group	Jan 22 – Dec 22	Jan 23 – Dec 23	Difference
Admin & Clerical	£1,399,828	£359,387	-£1,040,442
Ancillary	£337,941	£1,145,144	£ 807,203
Estates			£ -
Nursing & Midwifery (Registered)	£6,020,812	£6,095,574	£74,762
Nursing & Midwifery (Unregistered)	£7,362,632	£9,144,586	£1,781,954
Professional & Technical	£1,437,813	£1,027,321	-£410,491

Agency Utilisation (£)

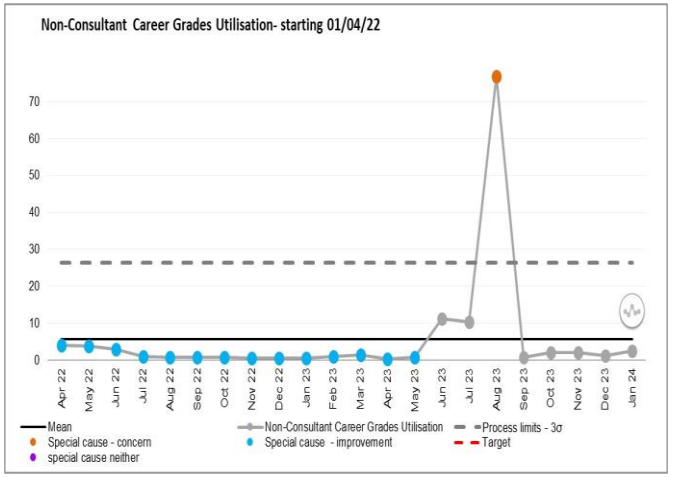
Staff Group	Jan 22 – Dec 22	Jan 23 – Dec 23	Difference
Admin & Clerical	£963,549	£722,446	-£241,103
Ancillary	£40,858	£239,827	£198,968
Estates	£95,488	£62,131	-£33,357
Nursing & Midwifery (Registered)	£34,504	£248,325	£213,821
Nursing & Midwifery (Unregistered)	£2,501,797	£3,257,189	£755,392
Professional & Technical	£1,149,265	£537,184	- £612,081

Internal Medical & Dental Bank Utilisation

Metric	Variation
Trainee Grades	Special Cause Improving Variation



Metric	Variation
Non-Consultant Career Grade	Common Cause



People: Delivering excellence in education and training – mandatory training 1/2

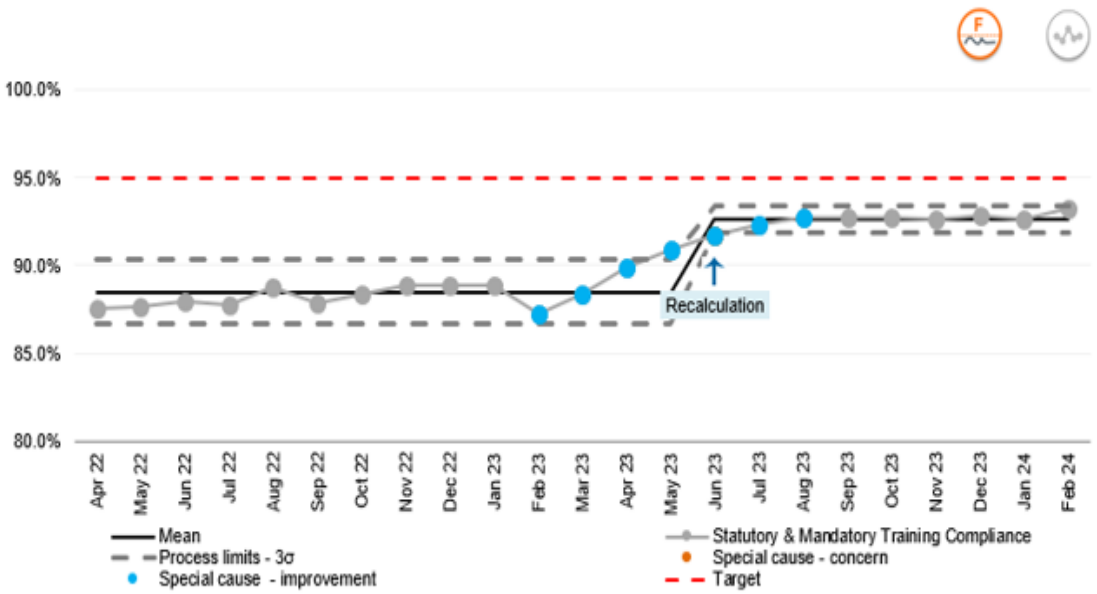
Mandatory Training Compliance (target 95%)			93.20%
Metric	**Assurance**		**Variation**
Mandatory Training Compliance %	Consistently fail target		Common Cause

Mandatory training compliance is 93.2% at end February 2024, target is 95%.

Medical and Dental are the staff group with the lowest training compliance at 87.32%

Staff Group	Compliance	Achieved
Medical and Dental	87.32%	✗
Nursing and Midwifery Registered	92.29%	✗
Allied Health Professionals	92.81%	✗
Senior Staff (Band 8c and Above)	92.91%	✗
Additional Clinical Services	93.65%	✗
Healthcare Scientists	94.04%	✗
Add Prof Scientific and Technic	94.91%	✗
Estates and Ancillary	95.25%	✓
Administrative and Clerical	96.15%	✓

Mandatory Training Compliance (target 95%)



People: Delivering excellence in education and training – mandatory training 2/2

Mandatory Training Compliance (target 95%)	93.20%	✗
Mandatory Training	**Compliance**	**Achieved**
Paediatric Basic Life Support	68.15%	✗
Local Induction	73.41%	✗
Adult Basic Life Support	74.42%	✗
Moving and Handling Level 2	83.55%	✗
Infection Prevention and Control (Level 2)	89.32%	✗
Information Governance	90.65%	✗
Fire Safety	91.97%	✗
Trust Induction	94.01%	✗
Infection Prevention and Control (Level 1)	95.11%	✓
Prevention of Patient Falls	95.54%	✓
Prevent WRAP	95.90%	✓
Safeguarding Adults (Level 1)	96.03%	✓
Moving and Handling Level 1	96.13%	✓
Safeguarding Children (Level 1)	96.35%	✓
Prevent Awareness	96.57%	✓
Equality and Diversity	96.68%	✓
Conflict Resolution	97.08%	✓
Health and Safety	97.20%	✓
Anti-Bribery and Corruption	97.46%	✓

Lowest Two Mandatory Training Compliance %		
Staff Group	**Paediatric Basic Life Support**	**Local Induction**
Feb-24	**68.15%**	**73.41%**
Add Prof Scientific and Technic	76%	74%
Additional Clinical Services	65%	79%
Administrative and Clerical	80%	76%
Allied Health Professionals	65%	88%
Estates and Ancillary		80%
Healthcare Scientists	61%	72%
Medical and Dental	64%	19%
Senior Staff (Band 8c and Above)	33%	45%
Nursing and Midwifery Registered	71%	81%

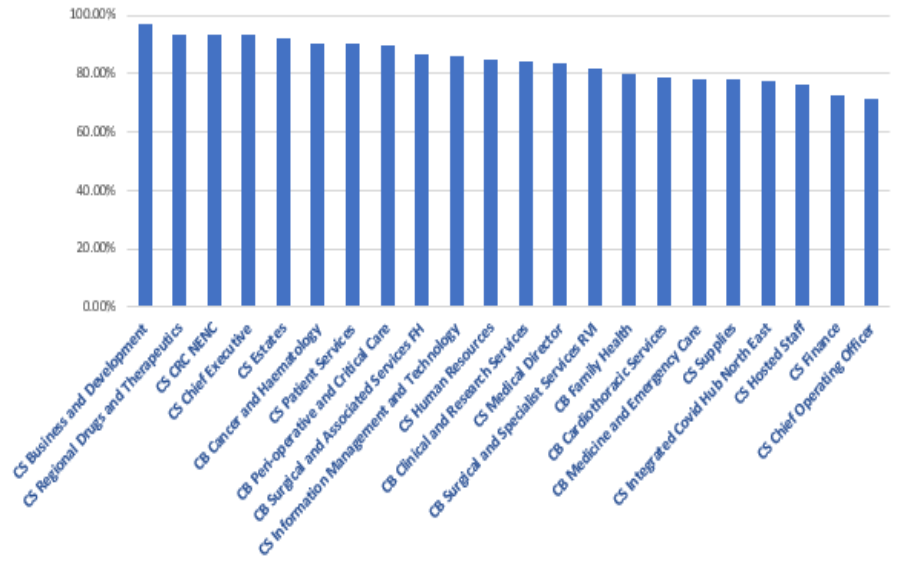
At end February 2024, mandatory training compliance was 93.20%

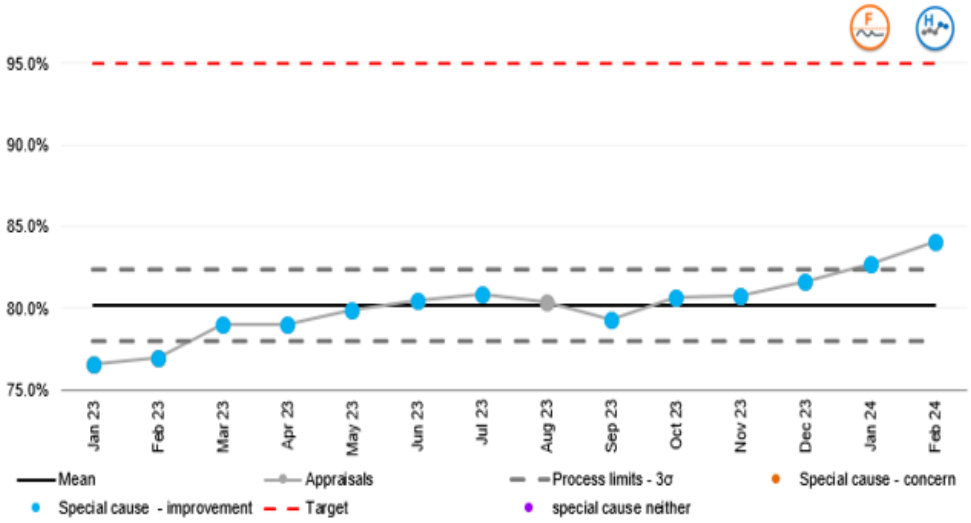
People: Delivering excellence in education and training – appraisal compliance 1/1

Appraisal Compliance (target 95%)		84.07%
Staff Group	**Compliance**	**Achieved**
Medical and Dental	77.95%	
Additional Clinical Services	81.73%	
Healthcare Scientists	83.70%	
Nursing and Midwifery Registered	83.89%	
Administrative and Clerical	83.94%	
Allied Health Professionals	85.07%	
Add Prof Scientific and Technic	85.77%	
Estates and Ancillary	92.65%	
Manager Band 8c and Above	94.17%	

Appraisal compliance stands at 84.07% at end February 2024, target is 95%.

Appraisal Compliance by Corporate Service / Clinical Board





Metric	Variation
Appraisal Compliance	Special Cause Improving Variation

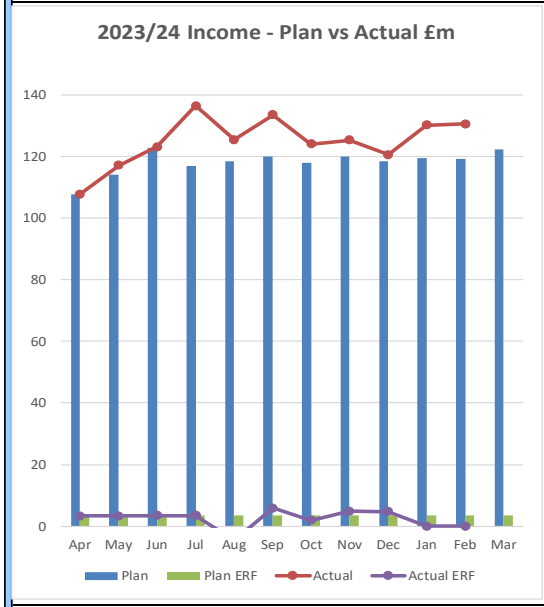
Appraisal compliance is demonstrating 'Special Cause Improving' Variation. This is present when a pattern of variation demonstrates a consistent improvement.

However, the reported values consistently fail to meet the target of 95%.

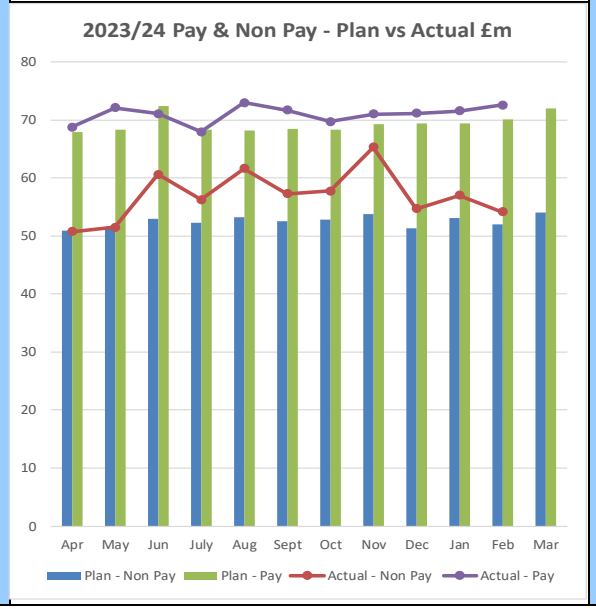
Finance: Overall Financial Position

Financial Overview as at 29th February 2024

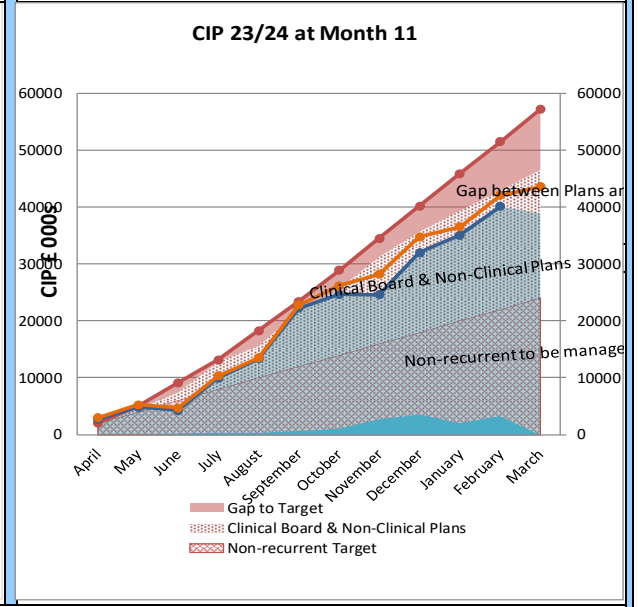
Income



Expenditure



Cost Improvement Analysis



Commentary

This page summarises the financial position of the Trust for the period ending 29th February 2024. The Trust has agreed a Financial Plan for 2023/24 with a break-even position. As at Month 11 the Trust is reporting an adverse variance of £2.3 million against a planned deficit of £0 million. The financial impact of industrial action has been removed with additional funding received nationally at Month 8 but includes the actuals for January and an estimate of the February Industrial Action.
The delivery of the plan relies on a number of factors which are subject to significant risk

- Delivery of required levels of activity compared with 2019/20 activity levels.
- Reliance on non-recurrent income and expenditure benefits
- Achievement of CIP targets
- Assumptions relating to inflation, subject to change and unfunded

Capital Expenditure

The Plan for February is £37.7 million and the year to date expenditure is £28.1 million creating a variance of £9.6 million to date. This is expected to catch up.

Risk

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BOARD MEETINGS - ACTIONS

Log No.	BOARD DATE	PRIVATE / PUBLIC	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
105	27 July 2023	PUBLIC	23/14 STRATEGIC ITEMS c. Partnerships: Partnerships update	The CEO suggested that the Collaborative Newcastle plan be discussed in more depth at a future Board Development Workshop [**ACTION03**].	MW/KJ			19.09.23 - MW and KJ to agree which Board Development session date will be the most appropriate for the Collaborative Newcastle plan discussion (pencilled in for the December session). 24.11.23 - Topic included on the Forward Plan for the 2024 Board Development Programme to be agreed with the new CEO and Interim Chair. 22.02.24 - Revised Board Development programme developed for 2024/25 in conjunction with The Value Circle - refer to agenda item A12. Propose close action.
112	25 January 2024	PUBLIC	24/02 STRATEGIC ITEMS v) Performance: Performance Report	Miss Smith queried the cost of the dermatoscopes and if an increase in the number of those available would have a timely impact on reducing waiting times to which the COO noted that the maintenance and replacement of the dermatoscopes was the main barrier. The COO would liaise with the ICB to explore the cost of addressing the maintenance contracts issue [ACTION01]	MW/KJ			22.03.24 - Update requested.
113	25 January 2024	PUBLIC	24/02 STRATEGIC ITEMS iii) Mental Health Strategy	The DCDI suggested engaging with the Enabled Network and agreed to introduce Dr Brown to the Chair of the Enabled Network. [ACTION02]	VMR			22.03.24 - VMR has emailed Dr Brown and introduced her to the members of the Enabled Staff Network. Propose close action.

KEY

NEW ACTION	To be included to indicate when an action has been added to the log.
ON HOLD	Action on hold.
OVERDUE	When an action has reached or exceeded its agreed completion date. Owners will be asked to address the action at the next meeting.
IN PROGRESS	Action is progressing inline with its anticipated completion date. Information included to track progress.
COMPLETE	Action has been completed to the satisfaction of the Committee and will be kept on the 'in progress' log until the next meeting to demonstrate completion before being moved to the 'complete' log.