The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Public Trust Board of Directors' Meeting

Friday 31 January 2025, 10.15 – 11.45

Venue: Culture Centre Boardroom, RVI

Agenda

Item		Lead	Paper	Timing
1.	Apologies for absence and declarations of interest	Paul Ennals	Verbal	10:15 – 10:16
2.	Minutes of the Meeting held on 29 November 2024 and Matters Arising	Paul Ennals	Attached	10:16 – 10:17
3.	Chair's Report	Paul Ennals	Attached	10:17 – 10:23
4.	Chief Executive's Report	Jim Mackey	Dashboard	10:23 – 10:30
Strategic items:				
5.	Patient and Staff Stories	Annie Laverty	Attached	10:30 – 10:35
6.	Board Visibility Programme	Rachel Carter	Attached & Board Reading Room	10:35 – 10:40
7.	CQC update	Rob Harrison	Attached	10:40 – 10:50
8.	Integrated Board Report	Rob Harrison & Patrick Garner	Attached	10:50 – 11:00
9.	Research update including: i) Home-Grown Research ii) Clinical Research Network Update [Caroline Wroe and John Isaacs to present]	Vicky McFarlane Reid	Presentations	11:00 – 11:20
Items to receive *[NB for information – matters to be raised by exception only]*:				11:20 – 11:35
10.	Director reports: a. Joint Medical Directors Report; including: i) Guardian of Safe Working Report	Michael Wright & Lucia Pareja-Cebrian	Attached	
	b. Executive Director of Nursing Report; including: i) Spotlight on ACE Programme ii) Nurse Staffing Assurance Report iii) Winter Vaccination Programme Update iv) Practice Education Update	Ian Joy	Attached	

	c.	Maternity:		
		i) Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report	Ian Joy & Jenna Wall	Attached
		ii) Midwifery Staffing Report	Ian Joy & Jenna Wall	Attached
	d.	Director of Quality & Safety; including:		
		i) Mortality/Learning from Deaths	Rachel Carter	Attached
11.	Committee Chair Meeting Logs		Committee Chairs	Attached

Items to approve: 11:35 – 11:40

12.	Board Assurance Framework (BAF) 2024/25	Rob Harrison	Attached

Any other business: 11:40 – 11:45

13.	Meeting Action Log	Paul Ennals	Attached
14.	Any other business	All	Verbal

Date of next meeting:
Public Board of Directors – Friday 28 March 2025

Sir Paul Ennals, Interim Shared Chair

Sir Jim Mackey, Chief Executive Officer

Mr Rob Harrison, Deputy Chief Executive

Mr Ian Joy, Executive Director of Nursing

Dr Michael Wright, Joint Medical Director

Mrs Lucia Pareja-Cebrian, Joint Medical Director

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

Ms Annie Laverty, Chief Experience Officer

Mrs Rachel Carter, Director of Quality & Effectiveness

Mr Patrick Garner, Director of Performance and Governance

Mrs Jenna Wall, Director of Midwifery

Professor John Isaacs, Associate Medical Director for Research

Dr Caroline Wroe, Clinical Director North East and North Cumbria at NIHR Clinical Research Network (CRN)

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PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 29 NOVEMBER 2024

Present:	Sir Paul Ennals *[Chair]*	Interim Shared Chair
	Sir J Mackey	Chief Executive Officer [CEO]
	Mr R Harrison	Managing Director [MD]
	Dr M Wright	Joint Medical Director [JMD-W]
	Mrs L Pareja-Cebrian	Joint Medical Director [JMD-PC]
	Mrs J Bilcliff	Chief Finance Officer [CFO]
	Mr Ian Joy	Executive Director of Nursing [EDN]
	Dr V McFarlane Reid	Director for Commercial Development & Innovation [DCDI]
	Mr M Wilson	Chief Operating Officer [COO]
	Mr B MacLeod	Non-Executive Director (NED)
	Mr D Weatherburn	NED
	Mrs A Stabler	NED
	Mr B McCardle	Interim NED

In attendance:
Mrs K Jupp, Trust Secretary [TS]
Mrs A Laverty, Chief Experience Officer [CXO]
Mrs S McMahon, Chief Information Officer [CIO]
Mr P Garner, Director of Performance and Governance [DPG]
Mr R Jones, Deputy Director of Estates [DDoE]
Mrs J Wall, Director of Midwifery [DoM]
Ms J Samuels, Director of Infection, Prevention and Control [DIPC]

Observers:
Mr R Purwal, Healthcare Director C2-ai
Mr S Volpe, Newcastle Chronicle
Mr M Bridge, GP and North Tyneside GP Fellowship Clinical Lead

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

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

24/25 STANDING ITEMS:

i) Apologies for Absence and Declarations of Interest

Apologies were received from Non-Executive Directors Liz Bromley and Phil Kane, Mrs C Brereton, Chief People Officer, Mr R Smith, Director of Estates, Mrs C Docking, Director of Communications and Corporate Affairs and Ms L Hall, Deputy Director of Quality and Safety.

The Chair welcomed all to the meeting and explained that the Public Board of Directors meeting will now take place regularly prior to the Private Board of Directors meetings.

The Chair congratulated Mr R Harrison and Mr M Wilson on their appointments as Deputy Chief Executive and Director – Great North Healthcare Alliance and Strategy respectively.

No new declarations of interest were identified. The following historic declarations of interest were noted:

- Sir Paul Ennals as the Chair at Northumbria Healthcare NHS Foundation Trust (NHFT).
- Mrs Stabler as a Trustee at St Oswald's Hospice.
- Mrs Jenna Wall as Midwifery Clinical Lead for the North East North Cumbria Local Maternity and Neonatal System (LMNS).

It was resolved: to (i) **note** the apologies for absence and the declarations of interest.

ii) Minutes of the previous meeting held on 27 September 2024 and matters arising

The minutes of the meeting held on 27 September 2024 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 explained that Governors had asked to see further detail in relation to external engagement and key matters subject to discussion, which was now included within the report.

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

iv) Chief Executive's Report

The CEO highlighted the following points:

- In terms of elective performance, the Trust was generally doing well.
- Pressure continued in urgent and emergency care with a view that winter had arrived early.
- Recently some tragic incidents had occurred which have been managed extremely well by staff with compassion and humanity whilst under a great deal of pressure.
- With regards to the Care Quality Commission (CQC), actions were noted to be progressing well and there was active dialogue with CQC regarding re-inspection. Work continued on progressing the key aspects within the Well Led domain.
- In terms of looking to the future, internal work and conversations are taking place with regards to the Big Build, the Medium Term Financial Plan and Clinical Strategy.
- The staff survey closed today, with a fantastic responses rate at 64% which is an increase from 42% last year. Thanks were expressed to all colleagues who took the

time to complete the staff survey and work will take place to act on the responses in January 2025.

The Chair expressed his thanks to colleagues, on behalf of the Trust Board, and suggested sending out a communication to acknowledge the time taken by staff in responding to the staff survey **[ACTION01].**

Mr McCardle advised that comprehensive discussions had been taking place at the People Committee meetings and noted that the increased response rate was a measure of staff's willingness and confidence to speak up.

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

24/26 STRATEGIC ITEMS:

i) Relative and Staff Member Story

The Chair explained that the Relative and Staff Member story describes a relative's experience in the Emergency Department (ED) when the department was under extreme pressure, how the staff on duty responded at a time of maximum stress, and lessons that can be learned from the experience.

The CXO advised that the story demonstrates the commitment to transparency from the Trust Board with the story focussed not only on the waiting time but also on the way the patient and their relative waited. To provide some context, there was a major incident underway at the time which involved many members of the public and patients in the department, combined with police presence.

The department had used the story to focus on improving areas particularly in relation to patient safety and Infection Prevention Control (IPC). The team had reflected on the experience to focus on compassionate and safe care for patients, with several actions identified to progress. The importance of supporting staff especially in times of great stress was highlighted.

The Board was asked to receive the story for information and to note the Trust commitment to transparency and learning from all experiences of care.

Mrs Stabler queried if the relative had been back to the department since improvements had been made to which the CXO explained that the staff member was aware of the outcome of the story and the actions taken however she agreed to follow up to confirm **[ACTION02].**

The JMD-W highlighted the importance of the story and improvements needed. He noted that he had personally spent a day in the ED recently with his own family and it was evident that staff acted with compassion and delivered high quality care.

Mr MacLeod sought clarification with regards to the training available for reception staff on de-escalation techniques. The EDN advised that there are mechanisms in place for the management of violence and aggression, and this is being actively worked on. He noted that there was a need to strengthen this more broadly to set clear expectations for the public and ensuring staff have the correct skill mix in relation to the required escalations. The CXO noted that reception staff are the first point of contact and the staff had welcomed the feedback in terms of learning.

The MD explained that work is currently taking place with regards to communication and keeping patients and families informed, including patients on waiting lists. He highlighted that some patients are anxious regarding their waiting times and communication was important in alleviating such anxiety.

The Chair advised that he has received assurance that sufficient action had been taken, particularly in relation to support and training for staff handling sensitive issues and support to family and carers.

It was **resolved:** to **receive** the Relative and Staff Member Story.

ii) Board Visibility Programme

The TS advised that the report summarised the findings from the 18 NED walkabouts and visits undertaken during September and October. The feedback from the previous meeting was to add emerging themes and summary of issues for immediate action which was now included at the end of the report.

The Chair commented that the themes were interesting and thanked the team for providing the extra information. He suggested that the level of detail provided in the Board Reading Room could be further streamlined.

The CEO noted that the Executive Team and colleagues appreciated the presence of the NEDs in relation to the visits undertaken, and commented on the associated positive impact across the organisation.

Mrs Stabler advised that the NEDs are updated on actions identified during the visits, citing for example the NECTAR carpark action. She highlighted the great work taking place within the Trust to improve all areas for staff and patients.

Mr MacLeod noted that positive feedback had been received from staff as to the visits having taken place both during the day and during the evening, with staff sharing their feedback openly with the NEDs.

Mr McCardle explained that there are clear challenges however the passion and leadership from staff members is commendable and needs to be recognised.

Mr Weatherburn highlighted that there is an acceptance of the position that the organisation is in, post CQC inspection, and an understanding of the need to resolve the issues and move forwards.

The Chair explained that there has been a great deal of progress to increase Trust Board visibility which has a direct benefit and provides triangulation, strengthened governance and an appreciation from staff.

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

iii) Care Quality Commission (CQC) Update

The MD explained that the majority of the CQC actions had been completed, with regular reports into the Quality Committee. A key focus had been placed on service improvement with phase two focussed on testing the embeddedness of actions into current practices.

The MD advised that:

- AuditOne, the Trust Internal Auditors, are carrying out further reviews in relation to the service specific action plans and clinical board governance.
- The second cycle of Rapid Quality and Safety Peer Reviews commenced on 12 November, supported by external partners.
- The independent review by thevaluecircle (tvc) was progressing well and the final reports have been received from the ED and Surgery inspections which will be circulated to the Trust Board [**ACTION03**] and the actions will be discussed at the Quality Committee.

The EDN explained that there has been good staff engagement during the Rapid Quality and Safety Peer Reviews which will be continued until February 2025. Focussed work is taking place in certain areas across the organisation in relation to the themes (which were similar to those identified from the NED informal visits), and clear plans identified. A deep dive will take place at the December Quality Committee meeting.

The Chair sought clarification with regards to any emerging risks to which the MD advised that there was further work to do in relation to streaming in the Emergency Department and the waiting area. There was a clear focus on supporting teams to improve safety around waiting areas when busy and to manage safety when cubical space is not available. In depth discussions are taking place at the Quality Committee.

The Chair queried if there is any update on when the CQC plan to re-inspect the Trust to which the CEO advised that due to internal senior leadership changes within CQC the re-inspection may be delayed to January/February 2025. In addition, due to the significant improvements made within the organisation then re-inspection may not be seen as an urgent priority.

Mrs Stabler advised that from a Well Led perspective, she was comfortable with the progress made, however highlighted that some actions remained which required completion. The MD advised that there is a great deal of focus on making improvements in

the areas of concern, with some risks remaining however mitigations had been put in place which had resulted in the removal of the CQC licence conditions. The JMD-PC acknowledged that significant improvements had been made however in some cases it would take time for the actions to be fully embedded across the entire organisation.

The CXO advised that some staff feel they missed out on the opportunity to share their positive views during the previous CQC inspection.

The Chair acknowledged the significant progress made and noted that actions are moving towards business as usual. He highlighted the importance of ensuring robust processes for identifying risks and for the escalation of issues.

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

iv) Integrated Board Report

The Chair thanked the team for their work on developing the report and on refining the Executive Summary.

The MD advised that the performance team are reviewing their provision of information and reporting requirements to ensure that the information contained within the report allows robust discussion and triangulation across the Board Committees. Information 'deep dives' were being used, for example Diagnostics and Cancer targets were discussed in detail at the Finance and Performance Committee.

The DIPC advised that there had been a national increase in Clostridium difficile (C.diff) infection rates and that important themes were being addressed across the wards. She explained the difficulty when complex patients are presenting with C.diff on admission and the environmental considerations.

Mrs Stabler noted positivity in relation to the cleaning regimes on the ward visits she had conducted yesterday evening, with one ward having had a flu outbreak to manage.

The Chair highlighted that detailed discussions with regards to the cancer targets had taken place at the recent Council of Governor Workshop and the Board Committee meetings.

The EDN referred to a conversation that took place at the most recent Quality Committee with regards to the ability to report Datixs anonymously and that figures will be available in due course for reporting into the Committee.

The DPG explained that in terms of diagnostics, the Trust was seeing an improved position from previous months. Weekly performance improvement was currently being tracked for MRI and Audiology with a reduction of backlogs seen in both areas. The Chair queried if the new Clinical Diagnostic Centre (CDC) was contributing to the improvement to which the DPG advised that it was.

The MD noted that the DoM had spent time developing the maternity service metrics which would be discussed in detail at the Quality Committee.

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

v) Trust Strategy

The DPG advised that the report confirms the approach discussed at the October Trust Board Development Session to create an interim strategy focusing on the immediate goals and ambitions which will build on previous '5 Ps' – Patients, People, Partnerships, Performance & Pioneers framework.

The Strategic objectives for 2025/26 will be supported by:

- The developing Clinical Strategy;
- The Clinical Board Quality and Safety priorities and improvement plans; and
- The Big Signals and Trust Quality Priorities.

The delivery of the objectives will be enabled by the Trust supporting strategies, for example, the People Plan, Digital Strategy, Estates Strategy, SHINE Strategy, Research Strategy and Commercial Strategy. In addition the DPG advised that a 10-year Clinical Strategy is being developed, along with a Staff and Patient Engagement Strategy.

The development of the Interim Strategy will enable the Trust to carry out more meaningful engagement with staff, patients and stakeholders on the development of the new 5-year Strategy. The Chair highlighted that the Trust Board had previously agreed to the development of the Interim Strategy.

The DPG explained that further information will be shared at a future Public Board meeting in relation to the long-term strategy engagement plan. The MD advised that engagement had started with the Trust Management Group and Clinical Board teams. Discussions had also taken place this week at the Great North Children's Hospital (GNCH) and Urgent and Emergency Care meetings which were positive.

The Chair highlighted the importance of engagement and the positive direction of travel.

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

vi) Change NHS consultation response

The Chair explained that the Government had invited organisations and members of the public to comment on their consultation.

The COO advised that the Change NHS consultation had received significant public interest with circa 60,000 public responses and 1,000 responses from organisations. The closing date for responses was Monday 2 December. A response will be submitted on behalf of the Great North Healthcare Alliance (GHNA) which will encompass the view of all four partners. Governors and staff will be involved in suggestions during the next phase.

[The JMD-W left the meeting at 11:00]

The following suggested additions were discussed:

- The CEO suggested including a reference to ensuring a fair resource allocation between regions, particularly in relation to specialist commissioning, and referencing the need for further freedom in relation to the use of funding for local needs.
- The CXO referenced the opportunity for staff engagement and along with the EDN highlighted the need for a strong workforce plan to focus on staff engagement and development.
- Mrs Stabler recommended that a reference to social care be included in the response.
- The MD said that it would be useful to link how the Government allocate infrastructure investment to health inequalities, both in the short term and long term.
- Mr MacLeod referred to dentistry within the NHS and the importance of being transparent with the public regards to what can and cannot be done. He highlighted the need to encourage the public to take responsibility for their own preventative health.
- Mr McCardle recommended adding in some narrative regarding mental health, particularly paediatric mental health.

The Chair highlighted an opportunity to work with the Combined Authorities to support pilot programmes within the North East.

The COO requested volunteers from the Board members to run some engagement workshops which Mrs Stabler advised that she was happy to support.

It was resolved: to **receive** the report and **approve** the submission including the additional points highlighted above.

24/27 ITEMS TO RECEIVE

i) Director reports:
a. Joint Medical Directors (JMD) Report; including:
ii) Guardian of Safe Working (GoSW)

In relation to the GoSW report, the JMD-PC advised that there had been an increase in expectation reports within General Medicine and a decrease in breaches. Future reports will include SPC charts to identify themes [**ACTION04**].

The JMD-PC highlighted the following points from the JMD Report:

- Operationally activity continues to be busy. Diagnostic performance remains challenging, mainly due to a combination of increasing workload, as elective activity increases, and workforce pressures in key areas.
- In relation to Governance, operational policies and work plans have been received from most Multi-Disciplinary Teams (MDT). The terms of reference for an external MDT have been developed.

- There has been no national support programme for Martha's rule implementation which means that work has been taking place internally to review priorities and include actions as business as usual. The Trust Board will receive a further update at a future meeting.
- Regarding the Patient Safety Incident Response Framework, the priorities for year one will be closed shortly and work will commence on the priorities for year two. A future update would be shared with Board papers in relation to this. There has been an increased focus on MDTs and communication.
- For cancer metrics, performance is still markedly below the standards. Work commenced in October on the 8-week 'Perfect Pathway' project.
- The cardiothoracic action plan is reviewed through the Cardiac Oversight Group which reports into the Quality Committee.
- A review is underway on the way in which medical staff are job planned.

[The DOM joined the meeting at 11.08]

The MD referred to the GoSW report and advised that work is taking place to understand the increase in exception reports, particularly given the increase in the number of foundation doctors within the Medicine Clinical Board. The JMD-PC advised that the changes in the curriculum had impacted on some areas of medicine however she was working with the GoSW to understand the reasons behind the results.

[The JMD-W re-joined the meeting 11.14]

The JMD-W advised that a job planning oversight group meeting took place this morning to move the process forward. There has been significant engagement with the Local Negotiating Committee and there are also National meetings taking place with regards to job planning. It was aimed that 95% of job plans would be signed off by 31 March 2025 under the new process.

The Chair noted the progress in relation to the implementation of the job planning guidance and the ongoing concerns with regards to cancer.

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

b. Executive Director of Nursing Report; including:

i) Nurse Staffing Six Monthly Deep Dive Report

The EDN highlighted the following points:

- The Trust Vaccination programme was discussed at the most recent Quality Committee meeting as uptake has been lower than previous years. However it was reassuring to note that other organisations were in a similar position and that Newcastle Hospitals was ranked top for flu vaccination within the Integrated Care Board (ICB) and 6th in the North East and Yorkshire region. Work will continue to maximise uptake until the vaccination programme closes.

- In relation to safe staffing and workforce guidance, some risks are highlighted within the report, some relating to concerns around establishments with temporary mitigations in place. Requirements will be worked through for future years.
- The organisation had experienced difficulties with regards to sickness absence in recent weeks and increased pressures operationally.

Mrs Stabler sought clarification with regards to why Flu and COVID vaccination uptake was lower than in previous years. The EDN advised that it was expected to have a lower uptake of COVID vaccines. Some staff had decided not to share their views on why they had chosen not to get vaccinated however some feedback had been received in relation to time and capacity and personal choice. The numbers do not include vaccines performed elsewhere which will be included from December.

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

c. Maternity

i) Perinatal Quality Surveillance (PQSM) Report

The DoM advised that the report provided an update of the Trust's position with the required actions to fulfil the requirements, this included safe midwifery staffing.

Two infection outbreaks on the Neonatal Intensive Care Unit (NICU) were described, with Infection Prevention Control (IPC) actions being implemented. Several outbreak meetings have taken place to review and agree immediate and medium-term actions which are in place and continue to be closely monitored.

The DoM explained that the Trust is non-complaint with the minimum standards for each part of the smoking cessation element which poses a clinical risk due to the associated morbidity and mortality associated with smoking in pregnancy, and requires additional resource, such as antenatal scan appointments and consultations.

The DoM advised that there is a senior oversight of the estate issues and feasibility plans for decant and estate works are planned by reopening the Newcastle Birthing Centre. The DIPC noted that if the specialist cot beds are closed, this has a regional affect.

Mrs Stabler congratulated the Maternity team for the Maternity Survey results. The CXO advised that Newcastle were 38th in the country which is a great reflection on the leadership. The DoM explained that there was positive patient and staff experience and that the aspiration is to be ranked higher next year.

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

ii) Maternity Incentive Scheme (CNST) Progress Report

The DoM advised that the Trust cannot declare compliance with safety actions six and eight. The DoM advised that Recruitment has commenced for two Advanced Clinical Practitioners, which has attracted significant interest. Training for the obstetric workforce remains hugely

challenging due to consultant vacancies and sickness within the team. The Trust Board and Quality Committee are sighted on this issue. Work is taking place to ensure compliance.

Detailed discussions and deep dives are taking place through the Quality Committee and failure to comply with the ten safety action standards could impact negatively on maternity safety, resulting in financial loss from the incentive scheme due to potential claims.

Mr Weatherburn referred to the non-reporters in relation to Obstetric claims and noted that the financial focus is worth revisiting. The CFO explained that in terms of CNST, a review is taking place in the Alliance to look at the CNST provisions. The Chair suggested that Mr Weatherburn and the CFO discuss outside of the meeting to ensure that the CNST progress report includes financial figures and benchmarking against other organisations in future reports **[ACTION05]**.

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

iii) Maternity Safety Champion Report

The Chair highlighted the concern expressed in the report regarding the Maternity Estate and the MD noted that a review of the Maternity Estate was taking place.

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

[The DoM left the meeting at 11.31]

d. Director of Quality & Effectiveness; including:

i) Health and Safety Annual Report

The JMD-PC advised that the report highlighted the increase in violence and aggression incidents compared to previous years including an increase in verbal incidents and how this impacts different Directorates and Departments within the Trust. This was discussed in detail at the Quality Committee.

Mr MacLeod explained that during his NED visits, violence and aggression had been a topic of discussion specifically in the ED and Critical Care. He highlighted the importance of underpinning the emphasis with regards to psychological support for staff.

ii) Learning from Deaths Report

The JMD-PC explained that the report summarises the processes that are in place to provide assurance that all deaths are reviewed. The change in legislation was outlined regarding death certification legislation in England and Wales.

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

e. Committee Chair Meeting Logs

Mr MacLeod confirmed that there were no new matters to escalate from Mondays Finance & Performance Committee meeting. The meeting included a detailed discussion on cancer and diagnostics performance.

No new escalations were raised.

In relation to the Audit, Risk and Assurance Committee (ARAC), Mr Weatherburn highlighted that his observation was that it was clear as to what was being escalated from each Board Committee.

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

24/28 ITEMS TO APPROVE:

i) Board Assurance Framework (BAF) 2024/25

The MD advised that the BAF has been ratified at the previous ARAC meeting and the Trust Board were asked to approve.

Mr Weatherburn advised that a detailed discussion took place at the recent ARAC meeting and that a great deal of work had taken place to triangulate work in relation to strategic risks.

The Chair expressed thanks to those involved in the production/updating of the BAF.

It was **resolved**: to **receive** the report and **approve** the Board Assurance Framework.

24/29 ANY OTHER BUSINESS:

i) Meeting Action Log

The action log was received, and the content noted.

In relation to action 128, the TS advised that Mr J Dixon had attended the Executive Team meeting on 27 November 2024 and a discussion took place with regards to the risks. The Trust Board agreed to close the action.

ii) Any other business

There was no any other business to discuss.

The meeting closed at 11.37.

Date of next meeting:
Public Board of Directors – Friday 31 January 2025

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Agenda item A3

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	31 January 2025					
Title	Chair's Report					
Report of	Sir Paul Ennals, Interim Shared Chair					
Prepared by	Sir Paul Ennals, Interim Shared Chair Gillian Elsender, Corporate Governance Officer and PA to Chair and Trust Secretary Kelly Jupp, 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 Trust Board meeting in November, including: • Spotlight on Services • Informal Visits • Governor Activity • Trust Board • Alliance • Relationships with System Partners • Engagement with Regional Partners • Shared Chair Opportunities					
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

1. INTRODUCTION

I am now into my sixth month with the Trust, during which time I have continued to visit various departments and have met with many staff members and continue to be given a warm welcome.

2. SPOTLIGHT ON SERVICES

Since our last Board meeting in November 2024 meeting, we had our final Spotlight on Services on the Nursing Midwifery and Allied Health Professionals (NMAHP) Embedded Research Project which focused on NMAHP Researcher Development Institute work and was held remotely. The Spotlight on Services programme was launched during the pandemic in place of in person visits which allowed Non-Executive colleagues to stay connected with staff and departments. We have now returned to a full programme informal in person visits.

3. INFORMAL

I particularly enjoyed my full day of ward walk rounds at both the Royal Victoria Infirmary (RVI) and Freeman Hospital sites on 23rd December where I met staff in over a dozen wards, and had the opportunity to thank them for their input over the Christmas period. Across both sites the hospitals were extremely busy, but there was a purposeful and upbeat mood.

Earlier this month I spent a morning in the company of Dr Maria Clements, Consultant Paediatric Anaesthetist, Clinical Director, Health Inequalities & Clinical Lead, Paediatric Preassessment. I visited the Paediatric Theatres in the Great North Children's Hospital (GNCH), Paediatric wards and outpatients, and learnt about the pre-assessment process. I appreciated the opportunity to meet a range of staff from many different disciplines. Three notable things to highlight – the work of one of the paediatric consultants seeking to optimise the use of the operating theatres, who demonstrated how he hopes to increase the potential use of the theatres by up to 30%; the work with children with neurodiversity and with learning disability, exploring the potential for reasonable adjustments in our services; and the importance of our pre-assessment reviews, which can significantly reduce Did Not Attends (DNAs) and improve the clinical outcomes for children coming in for anaesthesia.

4. GOVERNOR ACTIVITY

I continue to work collectively with our Council of Governors both formally and informally and during this period we have held a Governor Workshop in December where we were updated on recent improvements in our Audiology Services. Of note, was waiting times for paediatric patients which have reduced significantly for both new and review patients.

In addition to the above, other Governor and Member activity since our last Board meeting has included:

- Our Members' event Bitesize: A Brush with Northeast Dentistry.
- With the help of Governors from the Nominations Committee we have held interviews and offered appointments for 3 new Non-Executive Directors and 1 Associate Non-Executive Director, subject to the completion of the required Fit and Proper Persons checks.
- Continuation with the Monthly Governor "Drop In" Sessions where I am encouraged by the willingness of governors to discuss ideas in a more relaxed way, and to enable me to test ideas and emerging thoughts amongst trusted friends.
- The "drop in" sessions, along with other informal interactions with governors, can often result in issues surfacing which get me thinking. For example, I have become conscious of concern about the tone of political discourse on social media and have asked our Director of Communications and Corporate Affairs to conduct a review of our use of social media.

5. TRUST BOARD

We have been lifting our sights above the horizon to plan for the period – hopefully soon – when the Care Quality Commission (CQC) returns and we achieve a higher rating. Our plans for the future then become ambitious and exciting, both within our own boundaries as a Trust and alongside our colleague trusts in the Great North Healthcare Alliance.

6. ALLIANCE

The development of the Alliance continues, and I continue to meet monthly with all the Chairs and Chief Executive Officers (CEOs), and additionally just with the Alliance Chairs. I also meet regularly with the two CEOs of Newcastle Hospitals and of Northumbria Healthcare NHS Foundation Trust ('Northumbria FT'), to monitor and review progress on developing our strands of joint working. There is tangible enthusiasm across the clinical cadres within the Trust for exploring these collaborative ways of improving our services to patients.

7. RELATIONSHIPS WITH SYSTEM PARTNERS

On 18th December 2025 I welcomed Prof Stuart Corbridge, the new Chair of the North East Ambulance Service. We discussed the importance of our trusts working effectively together and the opportunities for joint initiatives to improve patient outcomes. We then visited our Emergency Department where we met with many very busy staff who were nonetheless generous in their time to explain in practical terms the examples of good practice between North East Ambulance Service (NEAS) NHS Foundation Trust staff and ours, and some of the current barriers to progress. In March I will be visiting NEAS's Emergency Operations Centre where I hope to continue our discussions around strengthening our strategic partnership.

8. ENGAGEMENT WITH REGIONAL PARTNERS

During this period, I have continued to meet with the ICB Chair and CEO (and other senior ICB officers), along with the other ICB Foundation Trust (FT) Chairs. We have had significant discussions around the financial challenges facing the ICB as a whole, and the opportunities for sharing learning in addressing the demanding cost improvement targets we are all being set. We have discussed also the changing role of the ICB, and its changing relationship with NHSE, which is still not completely clear. We have also been sharing learning across the patch regarding strengthening relationships with neighbouring trusts; in addition to our work in creating the Alliance, the two trusts on each side of the Tees have become part of one NHS Group called "University Hospitals Tees", and the hospitals in County Durham are working more closely with Sunderland and South Tyneside. We envisage the ICB area being covered by 3 groupings of FTs.

9. SHARED CHAIR OPPORTUNITIES

I have been pleased to be able to continue to encourage the positive work being undertaken in the Joint Board between Newcastle and Northumbria, where Rob Harrison (our Deputy Chief Executive) works with the Northumbria CEO Birju Bartoli to make real the aspirations for closer working. I have been particularly pleased to note the progress in unifying some of the cancer pathways, and seeing evidence of reductions in waiting times as a result. Work on the pathways for Interstitial Lung Disease also looks very promising, as does the progress in Audiology. On top of that, the informal connections between staff at all levels in the two trusts throw up endless small examples where one trust is helping the other trust to improve their practice, or sharing vital equipment or human resources.

10. RECOMMENDATION

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

Report of Sir Paul Ennals
Interim Shared Chair
23 January 2025

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Agenda item A5

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	31 January 2025					
Title	Patient and Staff Stories					
Report of	Mrs Annie Laverty, Chief Experience Officer					
Prepared by	Annie Laverty following patient and staff interviews					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	Our patient story this month describes a patient's reflections of outstanding care provided by the congenital cardiac team at the Freeman Hospital. The story illustrates why excellence in healthcare really is a team sport. The grateful patient, who has been receiving care at the Freeman Hospital for more than 30 years acknowledges both the technical brilliance of cardiac surgery as well as the kindness and compassion of staff, and the impact that these behaviours had. Our staff story is from ward manager, Sophie Robson of Ward 37 at the Royal Victoria Infirmary (RVI), the first team to achieve gold accreditation status as part of the Accrediting Excellence (ACE) programme led by Ian Joy, Executive Director of Nursing. Sophie describes, with pride, what this recognition has meant for her and her team. The themes of excellence, teamwork, and person-centred care feature in both stories this month.					
Recommendation	The Board are asked to receive this story for information and to note our commitment to transparency and learning from all experiences of care.					
Links to Strategic Objectives	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]	Linked to key areas in the BAF relating to Effective Patient Safety and Workforce, these stories are associated with the strategic aims of putting patients at the heart of everything we do and providing care of the highest standard focussing on safety and quality.					
Reports previously considered by	Patient and People stories are a recurrent feature of all Public Board meetings.					

Patient story

I want to inform you of a recent experience of outstanding care with the congenital cardiac team at the Freeman Hospital, I wish to highlight several exceptional members of staff you have within your Trust. I have been a congenital cardiac patient under the care of Freeman hospital for over 30 years. I recently required a pulmonary valve replacement.

My recent journey began with a structured and informative consultation with Dr Jansen and outstanding follow up support by Joanne Wilson (Cardiology Senior Medical Secretary). My pre op in the Institute of Transplantation, was slick efficient and productive. I was admitted at 7am to ward 27, where the staff including staff nurse, Charlotte Sowerby, could not have been kinder or more professional. Dr Tony Hermuzi, (Interventional Cardiologist), was on the ward and running though my informed consent before 8am and I was in the catheterization lab, having my procedure, less than 45 minutes later. Ann Hasson, the recovery nurse, was compassionate as I woke from my anaesthetic in an unfamiliar environment.

Huge thank you to Dr Tony Hermuzi, who was kind, considerate, and took his time to manage my expectations. I know I have a demanding personality; however, no question or concern was too much, and I was never made to feel rushed or left without an answer. Tony checked on my progress regularly, providing insightful information at every opportunity, Tony is clearly an outstanding individual both with his technical and communication skills.

My experience and treatment within the Freeman Hospital has been world class, thank you. I hope this gives you reassurance of the excellent care which continues to be delivered, while the Trust faces significant winter pressures.

Staff Story: Going for Gold

I only took over as the full time Ward manager of Ward 37 in October and the opportunity to put ourselves forward for accreditation was presented as an option in December. I discussed it with the other sisters initially just to give them the heads up because they were probably the ones who were going to have to help and support me the most. They were, naturally, a bit excited but a little bit apprehensive, worried that the process might feel more like a judgement as opposed to something to celebrate.

We chatted about it a bit more and could see that this was different - a positive thing and an opportunity to try and prove what an excellent job we do. A chance to get recognition for all the other stuff that happens as well, outside of just the day-to-day. People really wanted to do well. So that was nice.

To be honest, it has been so helpful for me as a new ward sister. Going for accreditation has meant improving all the stuff that I knew I wanted to tackle anyway. It gave us a bit more of a drive and a push. Maybe I might not have pushed as hard trying to find my feet in a new role? So, it was useful.

On the day, I'll be totally honest, it felt a little overwhelming having so many visitors on the ward. A lot of the people arrived at the same time. Obviously, Holly Draper, Ma-Zeycel Dasig and Keri Bland are lovely, but you are just aware of the presence. You just want it to go well,

don't you? And you know that you have a lovely ward and that the team know what they're doing. Well, that has been proven now. I think for the staff as well, like it is nice to have something positive to celebrate. It's not like another audit, or somebody come around and checking that you haven't done this, or you haven't done that.

I was so proud of some of the nurses, who were, initially, very reluctant to speak to people. It wasn't because they didn't know what to say or that they don't know what they were doing at all. You might have all the information in your head but getting it out there is different. People don't want to let the team down. But then, of course it was lovely, because getting involved gave them so much personal satisfaction as well. They knew that they had done so well – I was grateful and able to thank them all for joining in and getting involved.

We gently let our patients know that there might be some people milling about to check that they were happy with that, but I didn't want to make too much of a thing of it all because, you know, these people are going through enough themselves with their own worries. All the patients that we had on the ward at the time were completely fine to be asked questions about our care.

I'm not naïve. I know on the burns unit that we do have the advantage of having a small footprint and we don't have 30 beds, and I know there's loads of nurses who would love to be able to give this level of attentive care. But I do think the fact that everybody on the team is really positive and does genuinely care about the patient care. If anybody new joins the team, then they quickly get a sense of that and fit in along with that kind of feeling. I think you would stand out like a sore thumb if you came to work here, and you did not have that kind of positive personality. It does make a difference if you're in a nice team, you feel more positive, and you can give back. Everyone is kind, and supportive of each other. So, the team dynamics are strong.

We do get ad hoc comments off the patients - there was one who said, as a team, you just know what the next person wants, without ever having to be asked. And that is how we work in this team. We do understand each other and you quickly gain that kind of knowledge about how other people work. So, it was nice for a patient to recognise that.

Getting the formal patient experience feedback report was lovely. We do get a lot of feedback informally from the patients. We are always getting lovely cards, and we will have grateful people coming back to visit us. A lot of our patients are with us for a long time, so often come back to see us if they have an outpatient appointment or they might come in at Christmas time. There are some who still visit when their care happened 10 or 15 years ago and it is lovely to know that you have had that kind of impact on someone's life, I suppose. But we have never had a formal measurement of that before. It is really nice to have that documented and recorded.

When I got news of our gold accreditation - I was absolutely ecstatic. It's the same as the feeling you get when you've had a job interview and you're waiting to find out whether you have the job or not. That was the feeling I could relate it to. So lovely. There was a lot of work and effort put in. The staff knew that I had high expectations of them. We probably would have got to this point anyway, I would imagine - that was my hope as a new ward sister. But I've maybe just nudged people along a little bit and that has been really positive for me.

There has been a lot of staff feedback about the positives that have come from accreditation. The general upkeep of the ward, everyone maybe chipping in just a little bit more. Everyone is taking a bit more pride in the workplace. It is so nice. Less clutter is so much nicer for our patients, and it is a much nicer environment for us to work in.

We have a bit of a running joke that we are actually 'Hotel 37' – our anecdotal name for the ward. We want it to feel like a hotel. And some people love it so much that they don't want to go home, which is the best reflection of the good care.

But yeah, it makes you feel like it's exactly what you come into the job for, doesn't it?

Sophie Robson on behalf of the Hotel 37 team.

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Agenda item A6

The Newcastle upon Tyne Hospitals NHS Foundation Trust

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	31 January 2025		
Title	Board Visibility Programme		
Report of	Rachel Carter, Director of Quality & Safety		
Prepared by	Fiona Gladstone, Clinical Effectiveness Advisor and Gavin Snelson, Head of Quality Assurance and Clinical Effectiveness		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	The objective of the Board Visibility programme is to provide a structure that enables identification of areas where care delivery may require improvement, support and expertise to address these more difficult issues that may be impacting on quality and safety of patients and staff. The walkabouts raise awareness of front-line issues and support the visibility and accessibility of senior leaders within the Organisation. This report provides an overview of the findings from the 17 walkabouts and visits undertaken during November and December 2024. During this time one scheduled Leadership Walkabout was cancelled due to an unexpected change in availability at short notice. Key themes identified include: - All areas visited were clean, tidy and welcoming. - Staff are proud of the patient care they are providing. - Staff feel able to raise concerns and feel supported. - Staff have excellent relationships with patients and families. - Space and capacity issues were identified as an issue affecting staff. - Staff identified issues related to the environment where improvements could be made to the estate. - Where staffing resource has been increased and short-term funding provided for posts, staff recognised the benefits and were keen for this to continue. - Increase in incidents in relation to patients with complex Mental Health Needs. - Staff identified where IT improvements could be made to upgrade some older Trust systems. There were no issues identified that required immediate escalation.		
Recommendation	The Trust Board is asked to note the contents of this report in relation to both positive feedback from Trust staff, and concerns/suggestions raised for improvements.		
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]	Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.					
Reports previously considered by	The previous Leadership Walkabouts and NED Informal Visits Report was presented to the Trust Board in November 2024.					

BOARD VISIBILITY PROGRAMME

1. INTRODUCTION

The objective of the Board Visibility programme is to provide a structure that enables identification of areas where care delivery may require improvement, support and expertise to address these more difficult issues that may be impacting on quality and safety of patients and staff. The walkabouts raise awareness of front-line issues and support the visibility and accessibility of senior leaders within the Organisation.

During 2023, Non-Executive Directors (NED) commenced an informal visits programme to supplement the pre-existing Leadership Walkabout programme. The informal visits are unaccompanied visits to areas/services across the Trust, with the areas selected generally identified by the individual NED. In addition, Executive Team members also undertake informal visits.

This report provides an overview of the findings from the 17 walkabouts and visits undertaken during November and December 2024. During this time one scheduled Leadership Walkabout was cancelled due to an unexpected change in availability at short notice.

2. PROCESS

The leadership walkabout programme involves two 'streams' which run in parallel each month:

Stream 1 [Leadership Walkabouts]: Two senior leaders (Executive Team, Directors of Operations, Board Chairs, Associate Directors of Nursing, *Heads of Nursing other senior managers within the Trust (8C and above) and senior managers from the Clinical Governance and Risk Department (CGARD)) participate in a one-hour joint visit to a pre-defined clinical or corporate area. Within this the Director of Operations and Clinical Board Chair are allocated a visit within their own Clinical Board with the aim of increasing visibility of the Board Leadership Team to staff working in that area.
*Heads of Nursing have been included in Stream 1 Leadership Walkabout Teams.

Stream 2 [NED informal visits]: NEDs undertake informal visits to a specific area within a Clinical Board that they are aligned to, or to an area that they are interested in visiting. In addition, the Chair undertakes regular informal visits to various areas/services across the organisation and the feedback from those visits is included within this report.

Management of the Leadership Walkabout schedule is co-ordinated by the Quality and Effectiveness team in CGARD (stream one) and the Corporate Governance Team (stream two).

The leadership walkabouts are announced, with the ward or area being notified of the walkabout, the team visiting and the time of their visit. The aim is to provide this information approximately one week prior to the visit.

A short guide is provided to the walkabout team/NED visits which offers a summary of the purpose of the visit and includes prompts to facilitate informal productive conversations.

For example:

- What does a great day here look like?
- What stops you having great days?
- What could be done to make things even better?

Following the visit, the walkabout team are asked to provide a free-text summary report which highlights what they felt were the most important themes from the staff they spoke to. The template allows the inclusion of brief details of any issues addressed during visits and if any further action is required. The data is then collated by the CGARD (combined with the NED visits information) and presented in this report.

3. SUMMARY OF FINDINGS

As part of the programme the aim is for a minimum of eight Leadership Walkabouts to take place each month. The table below summarises the 17 walkabouts undertaken at the Royal Victoria Infirmary (RVI) and Freeman Hospital (FH), six within stream one and eleven by the NEDs, as part of stream two. Further detail is provided in the Summary of Findings Report in the Board of Directors Reading Room.

Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
Stream One	Ward 23 Children's Heart unit	FH	Director of Operations and Head of Quality and Effectiveness	Ward Sister
	Radiology	RVI	Clinical Board Chair, Associate Director of Operations and Head of Patient Safety and Risk	Radiographers, Radiology Assistants, Consultant Radiologist
	Ward 52	RVI	Associate Director of Nursing and Head of Quality and Effectiveness	Sister, Staff Nurse
	Ward 7	FH	Associate Director of Operations and Quality and Assurance Lead	Sister
	Ward 9	RVI	Associate Director of Operations and Head of Quality and Effectiveness	Ward Sister, Specialist Stoma Nurse, Physiotherapist, Play Therapist
	Ward 35	FH	Associate Director of Operations and Patients Safety and Risk Manager	Sister, Staff Nurses, Healthcare Assistants, Domestic staff, Physiotherapist and Occupational Therapist

Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
Stream Two	All wards and departments in Freeman main block (9-11.30pm)	FH	2 x Non-Executive Directors	Not specified
	Haematology Outpatients, Ward 38, Ward 33, Ward 34, Chemotherapy Day Unit	FH	Non-Executive Director	Consultant Haematologist
	Ward 40	RVI	Non-Executive Director	Matron and Sister
	Theatres Leazes Wing and RVI Critical Care (18 & 38)	RVI	Non-Executive Director	Director of Operations and Head of Nursing, Senior Sister, Sister, Head of Department
	Day Treatment Centre and Institute of Transplantation	FH	Non-Executive Director	Director of Operations, Matron, Sister
	Wards 1, 2, 3,4 Urology, Emergency Admissions Suite, Stone Centre, Secretaries Office, Waiting List Team, Ear, Nose and Throat (ENT) Outpatients, ENT Casualty, Ward 10	FH	Non-Executive Director	Matron, Assistant Operational Service Manager
	Ward 31, Ward 32 Renal	FH	Non-Executive Director	Operational Service Manager, Sister
	Genetics and Fertility Centre	CFL	Non – Executive Director	Laboratory Lead, Consultant Clinical Geneticist, Operational Manager, Business Manager, Doctor, Sister, Staff Nurses
	Radiotherapy	FH	Non-Executive Director	Associate Director of Operations
	Emergency Department	RVI	Interim Chair, Chair NEAS	Associate Director of Operations, Consultant
	Pharmacy	RVI	Non- Executive Director	Associate Director of Operations, Research Pharmacists, Lead Surgical Pharmacist

Key themes identified include:

- All areas visited were clean, tidy and welcoming.
- Staff are proud of the patient care they are providing.
- Staff feel able to raise concerns and feel supported.
- Staff have excellent relationships with patients and families.
- Space and capacity issues were identified as an issue affecting staff.
- Staff identified issues related to the environment where improvements could be made to the estate.
- Where staffing resource has been increased and short-term funding provided for posts, staff recognised the benefits and were keen for this to continue.
- Increase in incidents in relation to patients with complex Mental Health Needs.
- Staff identified where IT improvements could be made to upgrade some older Trust systems.

There were no issues identified that required immediate escalation.

4. RECOMMENDATION

The Trust Board is asked to note the contents of this report in relation to both positive feedback from Trust staff, and concerns/suggestions raised for improvements.

Report of Rachel Carter, Director of Quality & Safety
Prepared by Fiona Gladstone, Clinical Effectiveness Advisor and Gavin Snelson, Head of Quality Assurance and Clinical Effectiveness

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Agenda item A7

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	31 January 2025		
Title	Care Quality Commission (CQC) Update		
Report of	Rob Harrison, Managing Director		
Prepared by	Elle Marshall, Project Manager		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	This report outlines a summary of key highlights including: • Phase 2 Improvement plan is progressing. • The third cycle of Quality and Safety Peer Reviews commence 30th January. This programme will continue throughout 2025/26. • Monthly engagement with CQC continues. • All Clinical Boards are updating their local Quality and Safety priority plans. • The evaluation for the Clinical Board Leadership Development Programme is underway. • A trust wide focus on estates, digital and communications. • Additional work around the well-led domain with Trust Board and Clinical Board triumvirates. • Further focused visits to be arranged with the support of external partners. • Following the independent stocktake review by thevaluecircle (TVC), the Emergency Department have a revised action plan, and the Surgical Boards have included recommendations into their local Quality and Safety priority plans. The recommendations from the North East & Cumbria Transport and Retrieval Service (NECTAR) report are being considered by the service with a view to hold a workshop to explore further improvement initiatives.		
Recommendation	The Trust Board is asked to note: i) The highlighted areas of progress; and ii) The developments since the stocktake review of Emergency Department, Surgical Services and NECTAR.		
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]	1.2 - Failure to implement effective governance systems and processes across the Trust to assess, monitor and drive improvements in quality and safety.
Reports previously considered by	Regular report.

Agenda item A7

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Public Trust Board
31 January 2025

Care Quality Commission (CQC) Update

Healthcare at its best
with people at our heart

Key Highlights

- Phase 2 Improvement Plan progressing with testing impact across the organisation
- Third cycle of Rapid Quality and Safety Peer Reviews commenced 30th January
- Monthly engagement continues with CQC
- Clinical Boards
  - Update to all quality and safety priority plans
  - Clinical Board Leadership Development Programme evaluation underway

Key Highlights

- Further focus:
  - Estates
  - Digital
  - Communications

- Working with Trust Board and Clinical Board triumvirates on Well-led

- Further focused visits with support of external partners

Independent review by The Value Circle

- Previously reported reviews carried out in Emergency Department and Surgical Services.
  - Updated ED action plan incorporates all recommendations.
  - Surgical Board have included the recommendations within their local quality and safety priority plans.

- NECTAR review carried out in December
  - Service is reviewing recommendations.
  - Workshop to be held to explore further improvement initiatives.
  - Action plan in development to support monitoring progress.

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Agenda item A8

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	31 January 2025					
Title	Integrated Board Report					
Report of	Rob Harrison, Managing Director Patrick Garner, Director of Performance & Governance Rachel Carter, Director of Quality & Safety					
Prepared by	Elliot Tame, Head of 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 committee on the Trust's performance against key Indicators relating to Quality & Safety, Access, People, Finance and Health Inequalities.					
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]						
Reports previously considered by	This is a regular paper provided to Trust Board.					

Agenda item A8

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

Quality, Performance, People, Finance, Health Inequalities

January 2025

Healthcare at its best
with people at our heart

Contents

Executive Summary

Quality

- November saw a further reduction in Clostridioides difficile infections compared to the previous month (15 v 16), remaining within the range of common cause variation. The case deemed avoidable was attributed to poor stool documentation and delay in isolation.
- In November there was an increase in adult falls compared to the previous month (231 v 236) in line with trends from previous years – this total remains below the mean (albeit slightly above target) and an overall sustained reduction has been maintained. Falls per 1,000 bed days whilst higher at 4.8 remain significantly under the Trust target of 6.0.

Performance

- In November the 77% 28 Day Faster Diagnosis Standard (FDS) was failed for the fourth successive month (74.7%). This is within the level of natural variation to be expected given recent historical trends. 31 Day performance has continued to deteriorate (76.7%) with performance outside the control limits for three successive months. 62 Day compliance was 62.0%, reflecting improving special cause variation despite an overall consistent failure to hit the target.
- Diagnostic performance against the 5% standard has improved for 3 successive months - 29.1% of patients were waiting over six weeks at the end of November. Audiology, Neurophysiology and MRI saw the biggest advances, however concerning variation continues with the target consistently failed.

People

- Total sickness absence remained at 5.42% in November against a target of 4.50%. Whilst common cause variation is identified within the data the Trust continues to consistently fail to meet target. Work is underway to agree year one priorities linked to gap analysis especially in the domain of psychological wellbeing, whilst an assessment visit was completed on 17 December for the Better Health at Work Award (Maintaining Excellence).
- Whilst there has been an improved position in appraisal compliance in November (84.74%), performance overall has declined since July and rates are consistently failing the target. A new appraisal process is to launch from April 2025 and will include a reminder system.

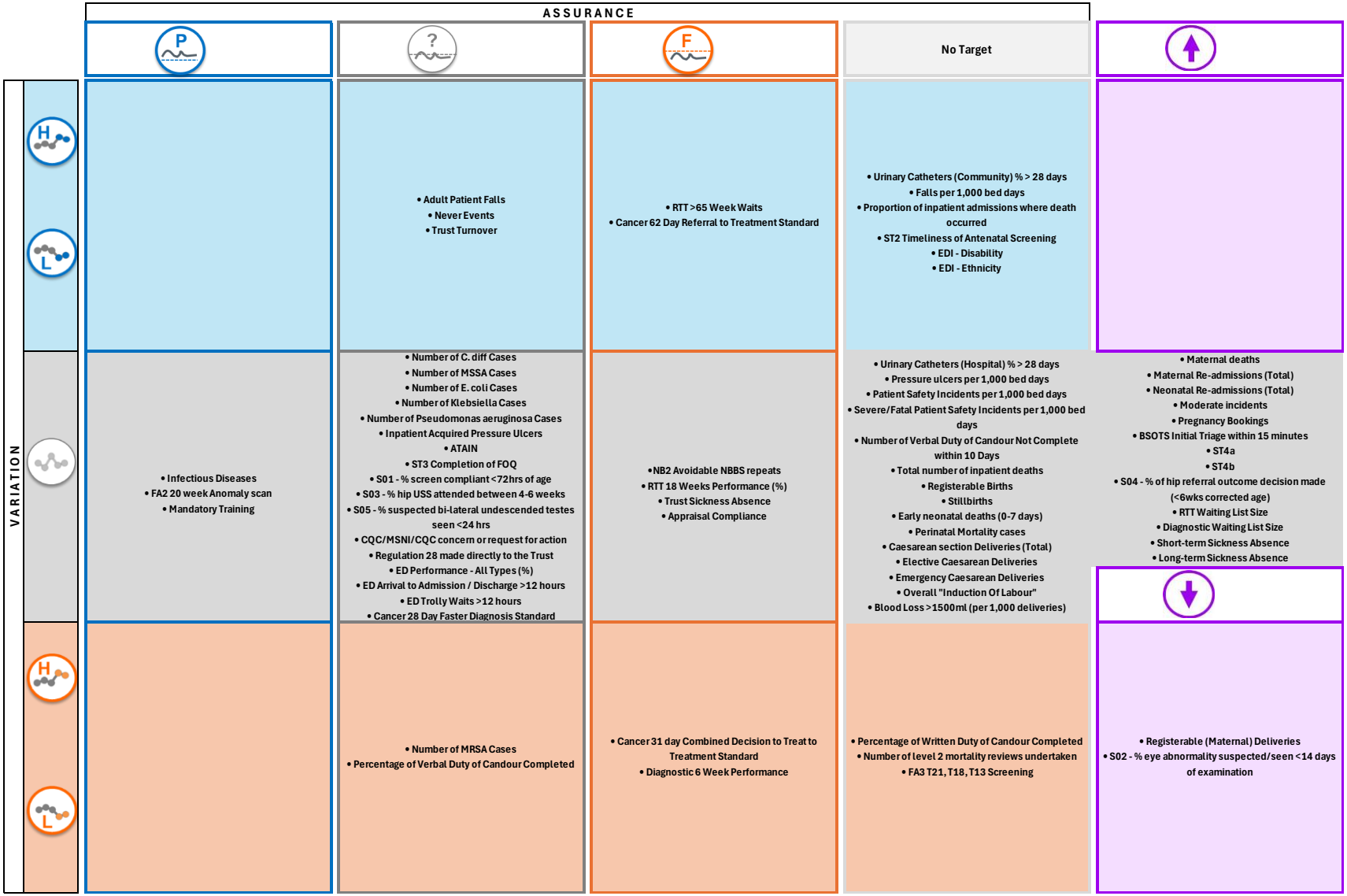
Finance

- As at month 8 the Trust is reporting an overspend of £3 million against the planned deficit of £3.5 million (after Control Total). This variance relates to the additional cost of the Junior Doctors Strike and the impact of the Pay Award (funding less than the costs incurred). The delivery of the plan has a significant Cost Improvement Plan (CIP) and includes a number of non-recurrent factors.

Health Inequalities

- There is evidence of significant socioeconomic disadvantage in children aged 0-10 who have experienced tooth extractions due to dental caries comparable to the catchment population. The proportion of 0-10s living in the most deprived quintile in 2019/20 & 2023/24 was 48% and 46% respectively, compared to almost 33% of the Trust catchment in Q1 2020. Please note the Health Inequalities update this month remains the same as that included in December 2024.

Statistical Process Control (SPC) Assurance Matrix



Quality

Quality Overview

Metric	Period	Actual	Target	Variation	Assurance
HCAI - MSSA	Nov-24	9	8		
HCAI – C. Diff	Nov-24	15	11		
Harm Free Care – Inpatient (IP) Acquired Pressure Ulcers	Nov-24	64	69		
Harm Free Care – Adult Patient Falls	Nov-24	231	203	L	
Stillbirths	Nov-24	0			
Blood Loss >1500ml (per 1,000)	Nov-24	40			
ATAIN	Nov-24	9%	5%		

Health Care Acquired Infections (HCAI)

- November saw a further reduction in Clostridioides difficile infection (CDI) cases compared to the previous month (15 v 16), within the common cause variation range.
- The number of Meticillin Susceptible Staphylococcus Aureus (MSSA) cases have remained static at 9, however this remains above the monthly target (10% reduction on previous year) with a current reduction of 3%.

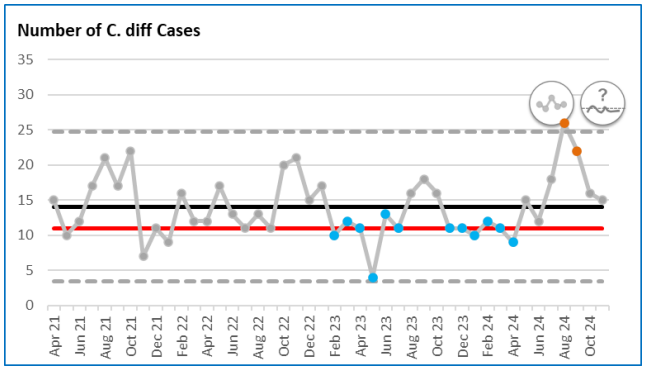
Harm Free Care

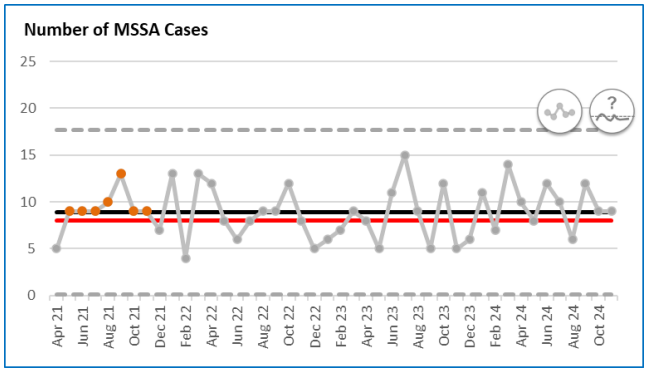
- There was a slight increase in the number of acute pressure ulcers reported in November (64 v 60). Following a sustained reduction, no special cause variation has been highlighted.
- In November there was a slight decrease in falls compared to the previous month (231 v 236) however this remains below the mean and a sustained reduction has been maintained.

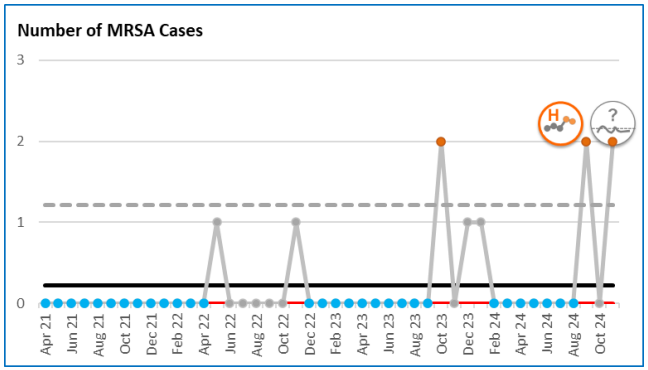
Perinatal Quality Surveillance

- In November 2024 there was one early neonatal death, an infant born extremely prematurely before 24 weeks of pregnancy (figures previously reported for term infants only). There were no stillbirths in November.
- The Avoiding Term Admissions Into Neonatal units (ATAIN) rate is 9%. The Trust previously reviewed cases where admission time on Neonatal Intensive Care Unit (NICU) was >4hours. The Trust is now reviewing all admissions including those babies who required minimal intervention leading to any period of separation from the mother and has commenced a deep dive into the admissions of the infants of diabetic mothers.

Healthcare Associated Infections (1/2)







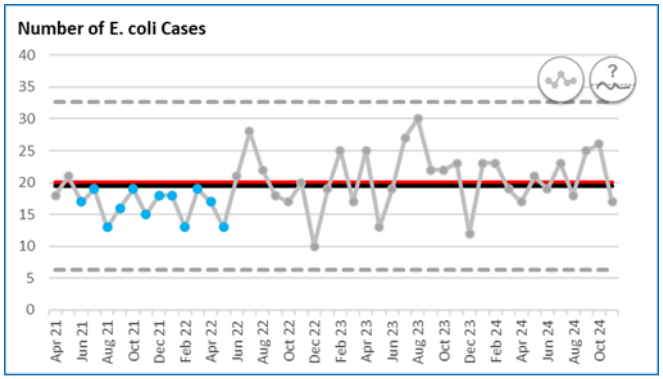
Standards

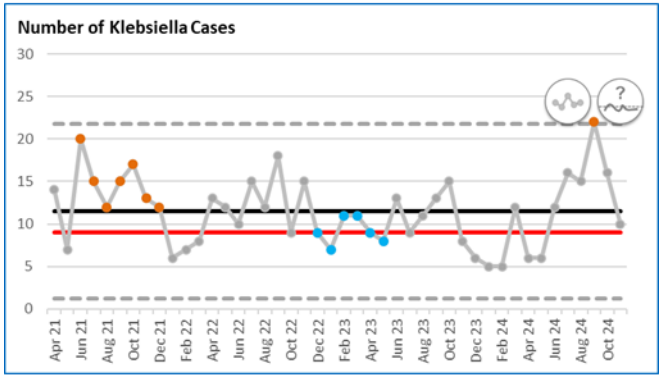
- **Zero methicillin-resistant staphylococcus aureus (MRSA)** cases.
- **No more than 98 MSSA** cases across the financial year (local target - 10% reduction from 2023/24).
- **No more than 136 CDIs, 247 E. coli** cases, **108 Klebsiella** cases or **39 Pseudomonas aeruginosa** cases across the financial year.

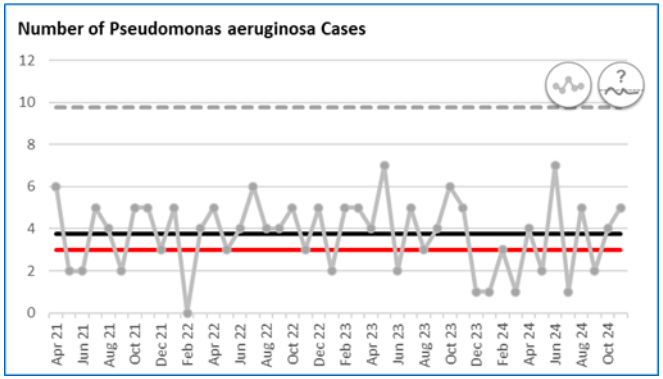
Current Position

- November saw a further slight reduction in CDI cases compared to the previous month (15 v 16), back within the range of common cause variation after July and August illustrated high data points. This summer increase is consistent with the nationally picture. 13 of these cases were Hospital Onset - Healthcare-Associated (HOHA)s, and 2 Community Onset - Healthcare-Associated (COHA)s (COHA cases are not routinely reviewed). Of the HOHA cases, 8 were deemed unavoidable, 1 avoidable and the remaining 6 cases are awaiting final Multidisciplinary Team (MDT) review. The case deemed avoidable was attributed to poor stool documentation and delay in isolation.
- The number of MSSA cases have remained at 9 this month, this remains in line with the mean but contradictory to the monthly reduction target (10%). Of these there were 8 HOHAs and 1 COHA. Of the HOHA cases 6 were deemed unavoidable and 2 are pending review.
- There were 2 MRSA cases were recorded in November, an infrequent occurrence. One of these cases was attributed to the Surgical and Associated Specialities Clinical Board where similar themes have been identified such as critical microbiology and result flags when prescribing antibiotics. The other case was attributed to the Family Health Clinical Board which highlighted issues with decolonisation.
- There was a reduction of *E. coli* bacteraemia cases (17) in November, within the realms of common cause variation. 2 were COHA cases and 15 HOHA, of which 13 were deemed unavoidable and 2 under review.
- The number of recorded Klebsiella bacteraemia cases reduced in November (10) (9 HOHA, 1 COHA). Upon investigation of the HOHA cases, 6 were deemed unavoidable, and 3 under review.
- There was a slight increase in Pseudomonas aeruginosa cases in November in line with common cause variation - 1 COHA and 4 HOHA (2 unavoidable and 2 under review).

Healthcare Associated Infections (2/2)



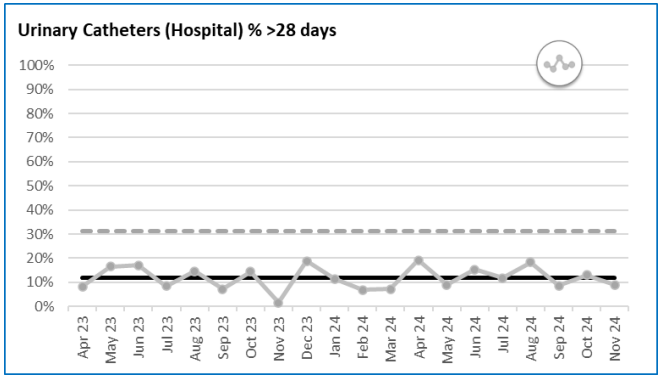


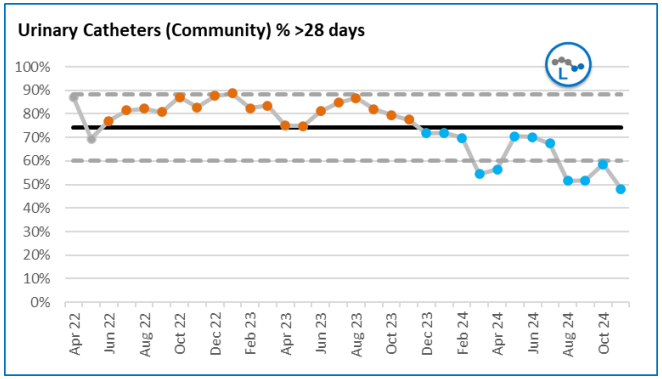


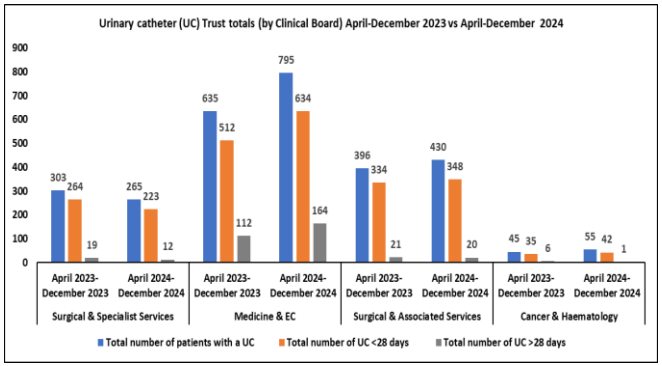
Action taken

- Focused work on CDI continues with increased oversight by Infection Prevention Control (IPC) and Clinical Teams, with additional oversight of Matrons, Heads of Nursing and Quality and Safety Leads. Weekly Healthcare-associated infections (HCAI) mandatory surveillance sitrep sent to Clinical Boards to ensure the sharing of current and ongoing investigations.
- Focussed CDI training module is nearly complete, with a requirement for ratification by the Learning and Development team, a realistic date of completion is February 2025.
- Learning from the MRSA cases within the Surgical and Associated Services Clinical Board indicated poor compliance with admission screening, review of previous history, critical microbiology and result flags when prescribing antibiotics. A task and finish group with key stakeholders (IT, Clinical Boards, Labs) with a particular focus for medical engagement is being formalised in January. Whilst this is being finalised, the Director of IPC (DIPC) is attending the clinical governance meetings being held by the clinical speciality.
- The case within the Family Health Board identified the need for expansion of decolonisation treatment to family members in addition to the patient. Key learning themes have been shared via the patient safety briefing Trust-wide, with the additional of a presentation at the Patient Safety Forum.
- The IPC Team continues to monitor, investigates and report all HCAIs. Findings are shared Trust wide via Clinical Board, Quality and Safety meetings, Quality Oversight Groups (QOG), Matrons and Clinical Leaders forums.
- Antimicrobial Stewardship (AMS) and medicine management continue to work together to develop and implement AMS strategies. Stakeholders Strategic meeting continues as a subgroup of the Patient Safety Group which reports into Medicines Management Optimisation Group.
- The DIPC continues to chair AMS strategic and operational group.
- Focus remains on delivering AMS teaching to wider staff groups.

Harm Free Care: Urinary Catheter Reduction







Background

- A monthly catheter surveillance across all adult inpatient and community areas is currently undertaken to support the reduction of urinary gram-negative bloodstream infections, specifically catheter associated and urinary tract infection (CAUTI), by implementing best practice clinical standards of care.

Standard

- Currently there is no national surveillance tool and therefore no national threshold is published.

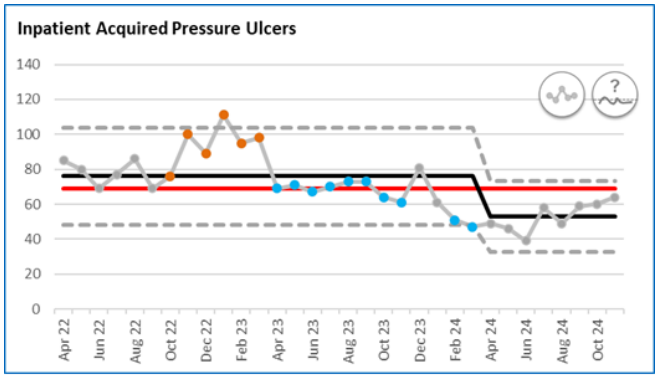
Current position

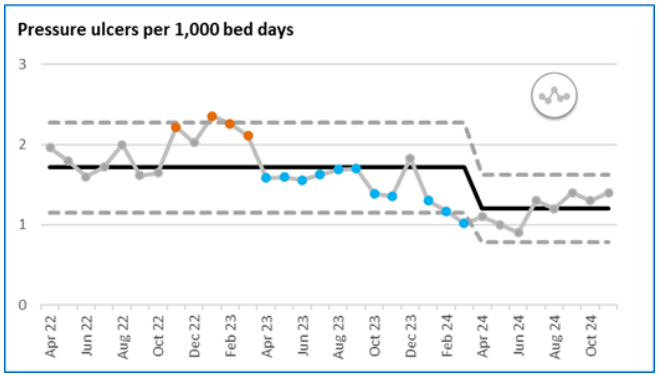
- The graphs demonstrate the percentage of patients with urinary catheters in situ for greater than 28 days across hospital and community settings respectively.
- Specialty teams have delivered a continually low running trend of urinary catheters in situ for greater than 28 days within the hospital setting.
- Within the community setting there is notable special cause variation of an improving nature, with the percentage remaining in situ over 28 days significantly decreasing. The daily risk of bacteriuria varies between 3-7% when a catheter remains in situ and 3.6% of those with CAUTI develop secondary infections such as bacteraemia or septicaemia which can be fatal.

Action taken

- Optimising the management of urinary tract infection (UTI) and CAUTI through several quality improvement clinical interventions and recommendations.
- Work continues with clinical boards to identify avoidable catheter use by undertaking patient reviews.
- The continence service presents on several education programmes and as a result staff are showing an increased recognition of the risks of urinary catheters and the assessment for the clinical need.
- An improvement project commenced in May 2024 within selected older peoples medicine wards and care homes, focused on the avoidance of urinary catheters with the aim to embed the HOUDINI framework and to improve the clinical standards of care in catheter management.

Harm Free Care: Pressure Damage





Standard

- A reduction target has been set at **20% year on year for pressure ulcers** at Category II and above.

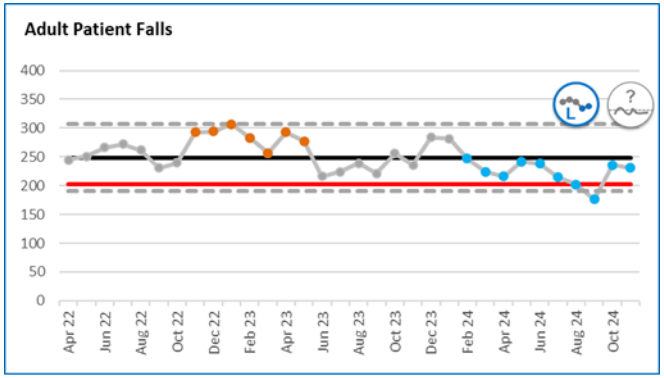
Current position

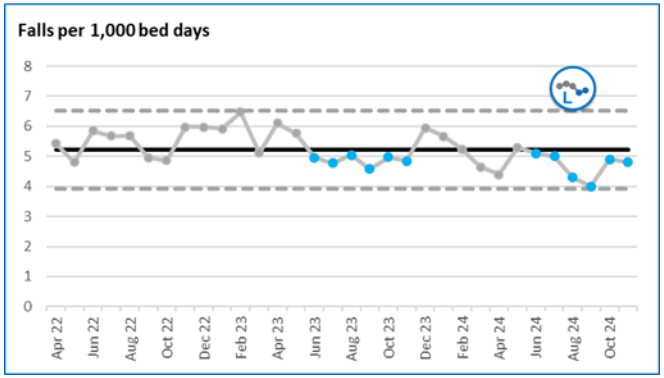
- There was a slight increase in November in the number of acute pressure ulcers reported from 61 to 64. The chart has been adapted to reflect a sustained reduction, therefore highlighting no special cause variation.
- There was a significant increase in Category III pressure ulcers in the month with 8 being reported. Investigations into these are underway. There was 1 Cat. IV reported which is the third Cat. IV reported in the past 18 months.
- The number of device related pressure ulcers increased slightly to 26 in November (25 Cat. II and 1 Cat. III).
- There were 1 Cat. III and 1 Cat. IV in Community in November.

Action taken

- Investigations into all of the Category III and IV pressure ulcers are underway.
- Trust mattress audit planned for early 2025.
- Training has taken place, including mattress training, Pressure Ulcer prevention and aSSKING, Wound Assessment and Dressing Selection and Advanced Practical Bandage Training. Further sessions are planned in the coming months.
- The Tissue Viability Team are working in collaboration with Family Health to develop a poster for parents regarding pressure ulcer prevention.

Harm Free Care: Falls





Standard

- A reduction target has been set at **20% year on year for adult patient falls**.

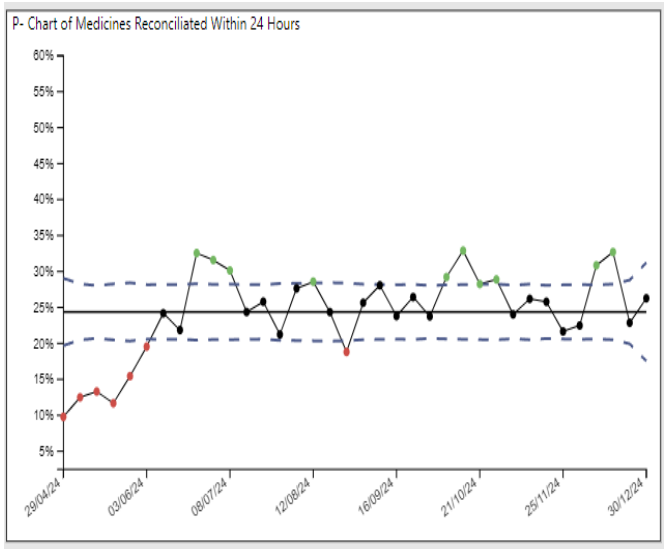
Current position

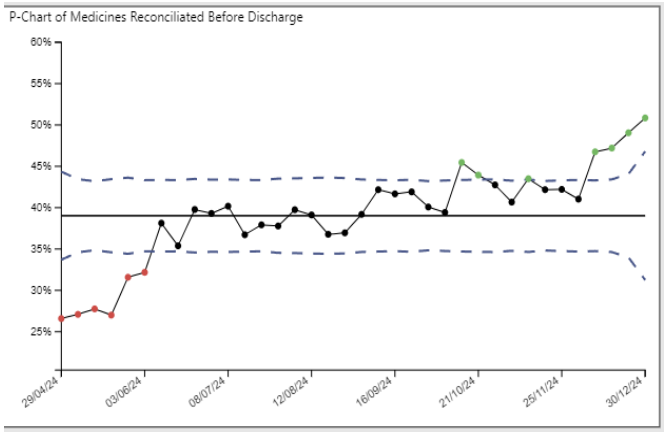
- In November there was a slight decrease in falls compared to the previous month (231 v 236), whilst falls with moderate or above harm were recorded as 3.9% (9) of all falls. The overall trend represents special cause variation of an improving nature. Of the 6 categorised as major, 1 was a head injury, 3 were fractured neck of femurs, 1 was a distal femoral fracture and the remaining 1 was a displaced hemi arthroplasty.
- The improvement and learning themes were around completing medication reviews whilst considering falls risk, the requirement to complete a 4AT Delirium Assessment for patients aged over 65years, in addition to training of the clinical areas based Moving and Handling Facilitators.

Action taken

- The Falls Prevention Coordinator is working with medical and pharmacy colleagues to improve compliance with 4AT Delirium assessments and documentation following medication reviews.
- Moving and Handling Facilitators training dates are available on the intranet - uptake is positive.
- Compliance with mandatory Falls Prevention training remains high at 97%.
- Enhanced Care Observation training has been rolled out across the Trust; November data shows 1003 staff had been trained. Training is ongoing Trust-wide.

Medicines Reconciliation





Standard

- Within 24 hours of admission - target **40% (with existing staffing)**; 60% after approval of phase 1 of staffing business case; 80% after approval of phase 3.

Current position

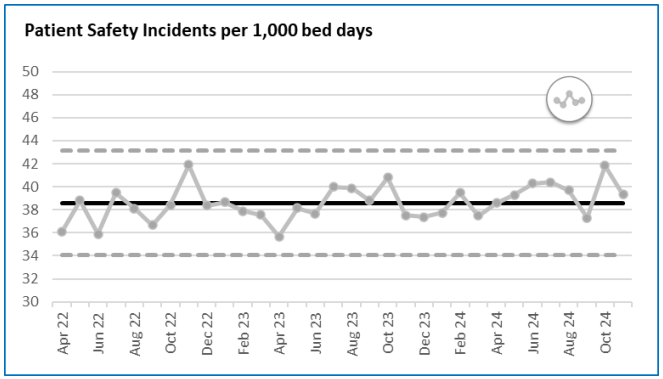
- Improvements visible, still not achieved 40% target.

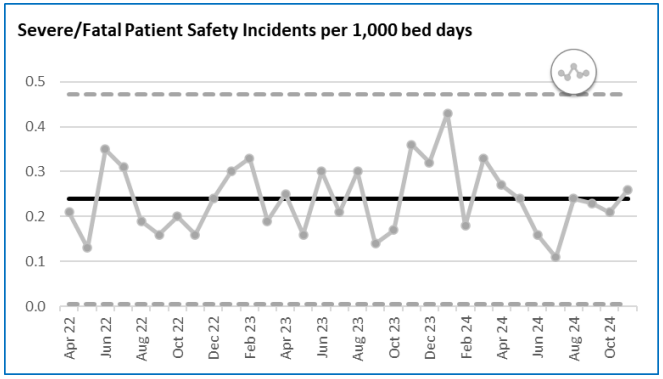
May 2024	12.59%	RED
June 2024	24.02%	RED
July 2024	27.20%	RED
August 2024	24..59%	RED
September 2024	25.89%	RED
October 2024	29.31%	RED
November 2024	24.23%	RED
December 2024	27.24%	RED

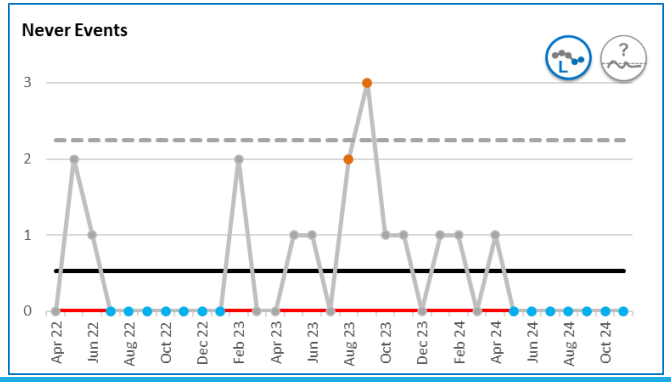
Action taken

- Quality Improvement (QI) project being undertaken to test different ways of working that aim to improve medicine reconciliation rates without adversely impacting other core services (e.g. patient flow, medicine supply, operational duties).
- Bed pressures and need to support rapid discharge is a competing priority to medicines reconciliation.
- The second chart shows the number of patients having their medicines reconciled before discharge has increased significantly (46% of patients in December). Work being undertaken to catch patients earlier during their admission.
- Phase 1 of the staffing business case to be discussed January 2025.

Incident Reporting







Standards

- Continued trend of **increased incident reporting** across the Trust.
- Aim to achieve a target of **zero Never Events**.

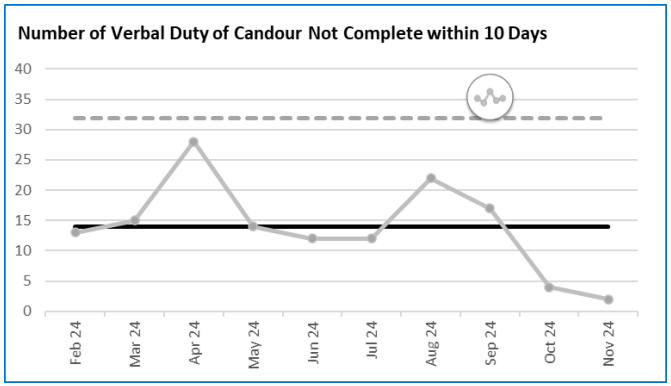
Current Position

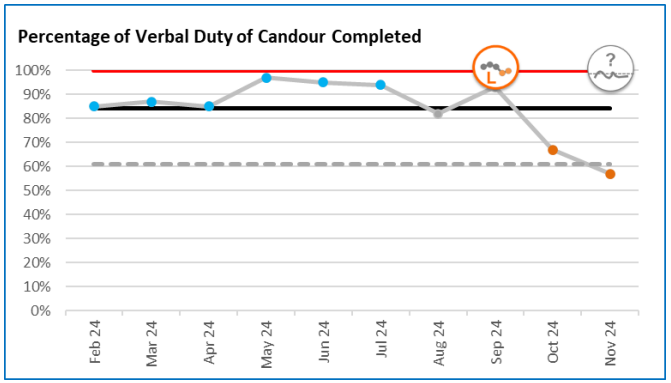
- The total number of patient safety incidents per 1,000 bed days reported in November 2024 decreased compared to October 2024.
- The number of severe/fatal safety incidents per 1,000 bed days remains in line with recent months.
- No never events were declared in November 2024.
- One After Action Review was declared in November 2024.
- One Patient Safety Incident Investigation was declared in November 2024.
- No Patient Safety Incident Response Framework (PSIRF) Priority incidents were identified in November 2024.

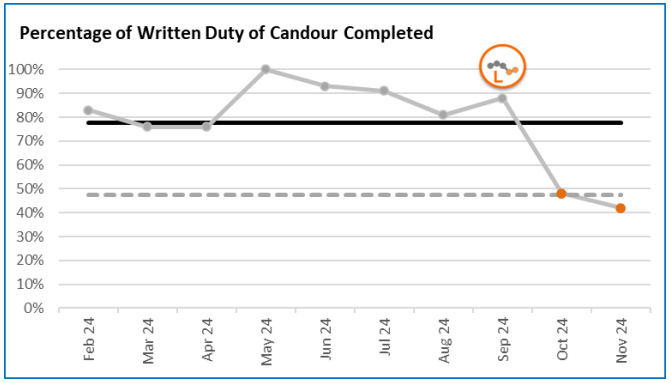
Action taken

- Incident reporting remains a mandatory element of Trust induction.
- Clinical Boards have access to incident reporting rates and have identified areas of low reporting, implementing targeted plans to address this.
- Raising awareness of incidents and dissemination the learning continues to take place through the Patient Safety Bulletin and the Patient Safety Briefings.
- The patient safety team joined the teaching faculty for the Year 5 Medical Student ‘Good Medical Practice’ patient safety education day to talk about how and why we report incidents as well as provide support with teaching on wider patient safety-related issues, such as surgical safety/the importance of checklists.
- The position on Never Events continues to be monitored Trust wide, with a specific improvement focus on Ophthalmology which is reported on as part of the Quality Account.

Duty Of Candour (DoC)







Standards

- Statutory Duty of Candour (notification of the relevant person of suspected or actual notifiable safety incidents) to be undertaken for all notifiable safety incidents
- To encourage openness and a timely apology, the trust's policy outlines verbal and written duty of candour should be completed within 10 days of the reported incident.

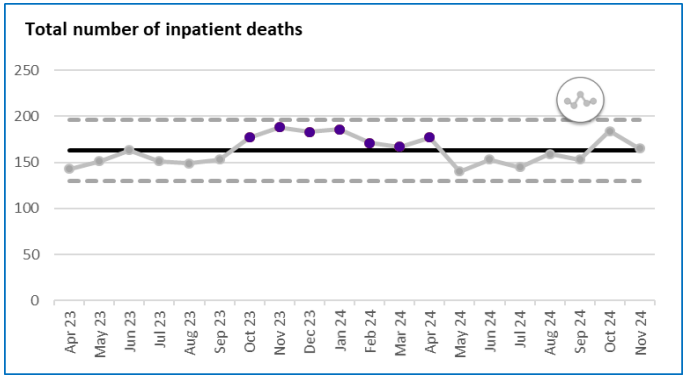
Current Position

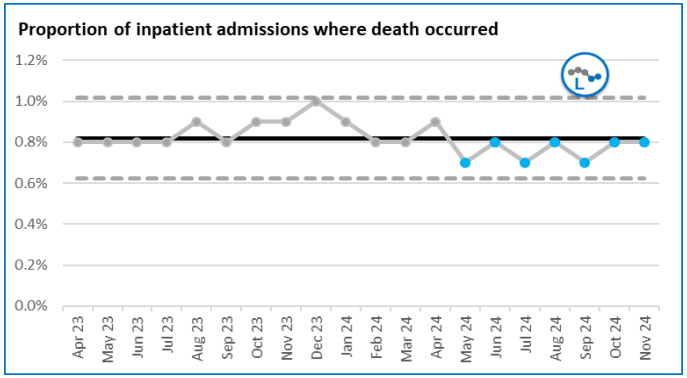
- Overall trust compliance for verbal duty of candour had increased to 74% for the reporting period compared with 68% the previous month.
- Overall trust compliance for written duty of candour had decreased to 64% for the reporting period compared with 67% the previous month.
- Compliance will continue to improve as incidents are reviewed, and apologies provided to patients and their families.

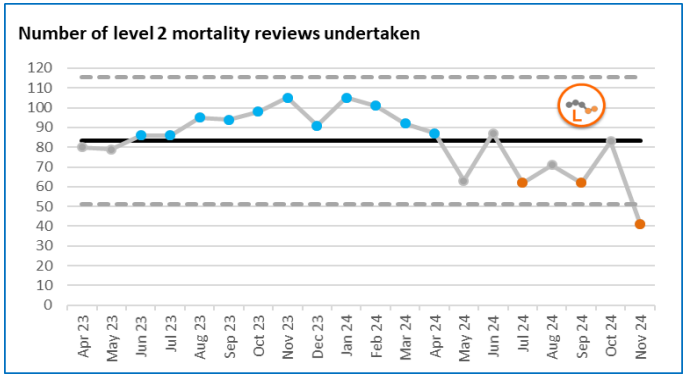
Action taken

- Learning Lab module on duty of candour being developed in conjunction with TEL team.
- Exploration of digital solutions to support improvements in compliance.
- A trust wide improvement plan is in development to agree process changes to ensure sustained compliance with DoC.

Mortality Indicators (1/2)







Standards

- Due to the recent changes nationally to the ME process, from September 2024 it is now a statutory requirement **all deaths are reviewed** by either the Coroner or Medical Examiner (level 1 mortality review criteria).

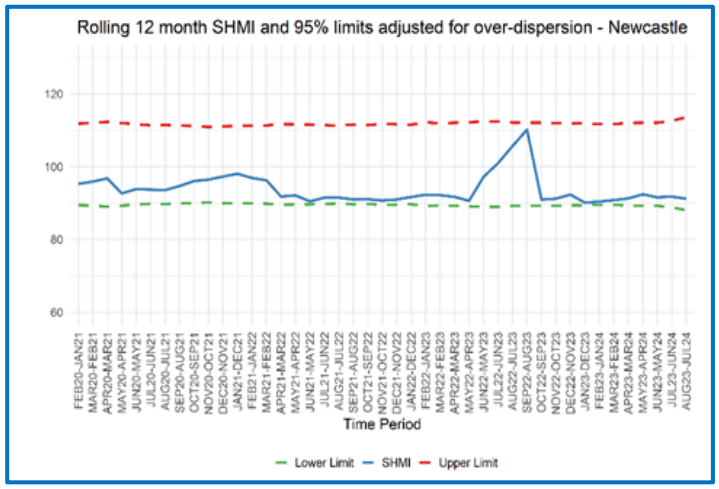
Current Position

- There were 165 inpatient deaths in total reported in November 2024, which is a decrease of 23 on the figure reported 12 months previously and within the parameters of common variation.
- The crude rate in November 2024 is 0.80%. This continues a reducing trend of an improving nature.
- Out of the 165 inpatient deaths reported, there are 41 level 2 mortality reviews entered into the Trust mortality review database.
- In November 2024, there were no patient deaths with a high HOGAN or NCEPOD grading.
- In November 2024, there was 1 patient death with an identified learning disability.

Action taken

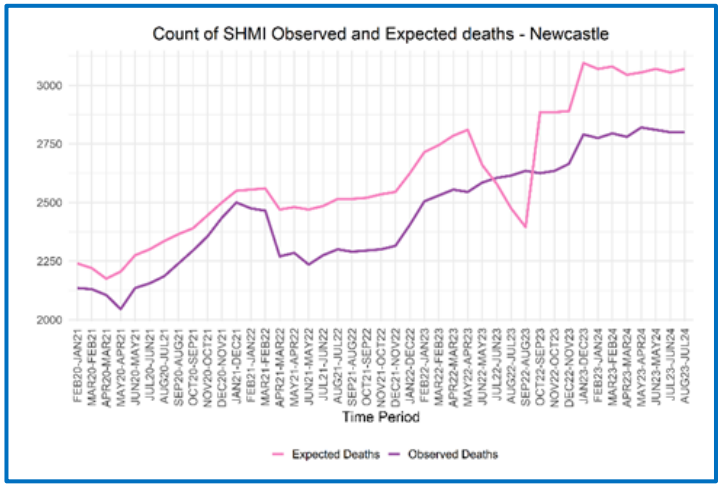
- All inpatient deaths are continually monitored.
- The number of level 2 mortality reviews will rise significantly over the coming months as Morbidity & Mortality (M&M) meetings continue to take place.

Mortality Indicators (2/2)



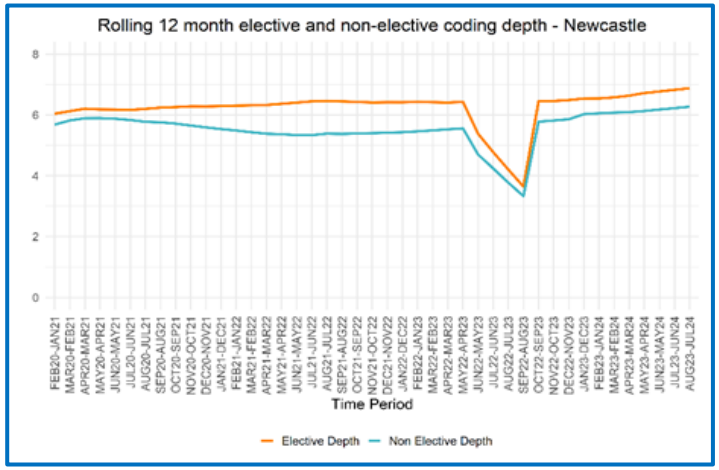
Hospital-level Mortality Indicator (SHMI)
Within the latest published SHMI data (August 2023 – July 2024) the Trust SHMI is at 0.91. This is within the "as expected" category.

Observed & Expected deaths
Between August 2023 – July 2024, the Trust has 2,800 observed deaths and 3,070 expected deaths.



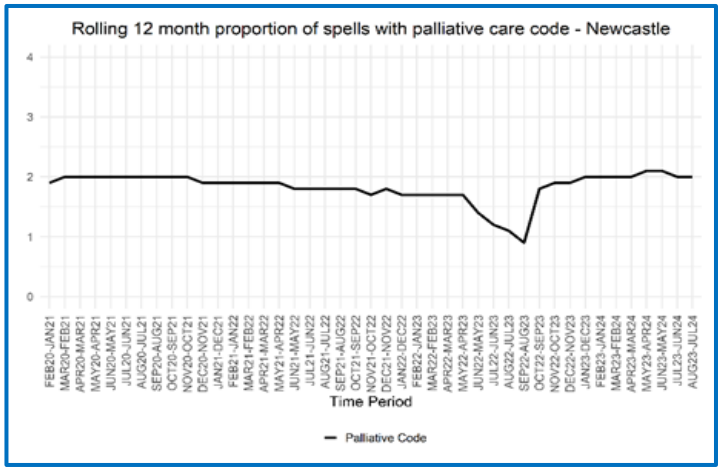
All data rolling 12 month periods. Data as reported by NHS England.

* An issue with the Trust's SUS data flow affected clinical coding completeness (now resolved).

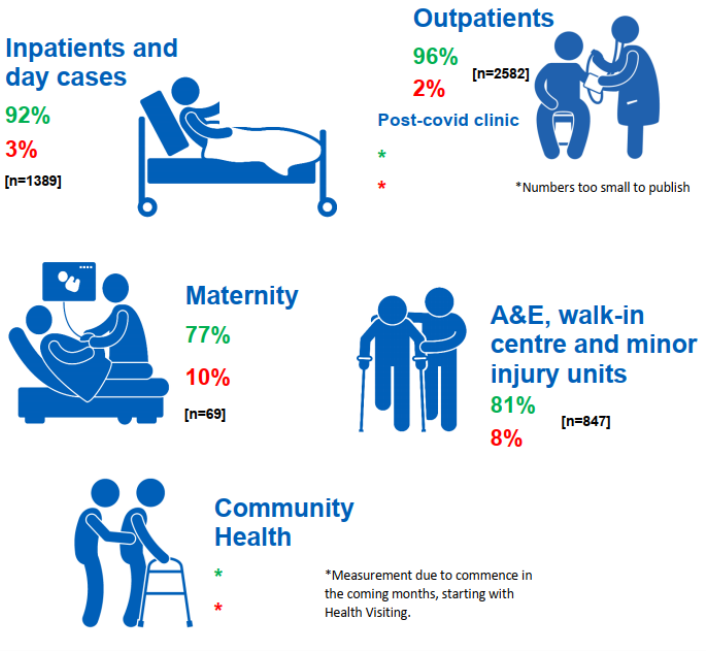


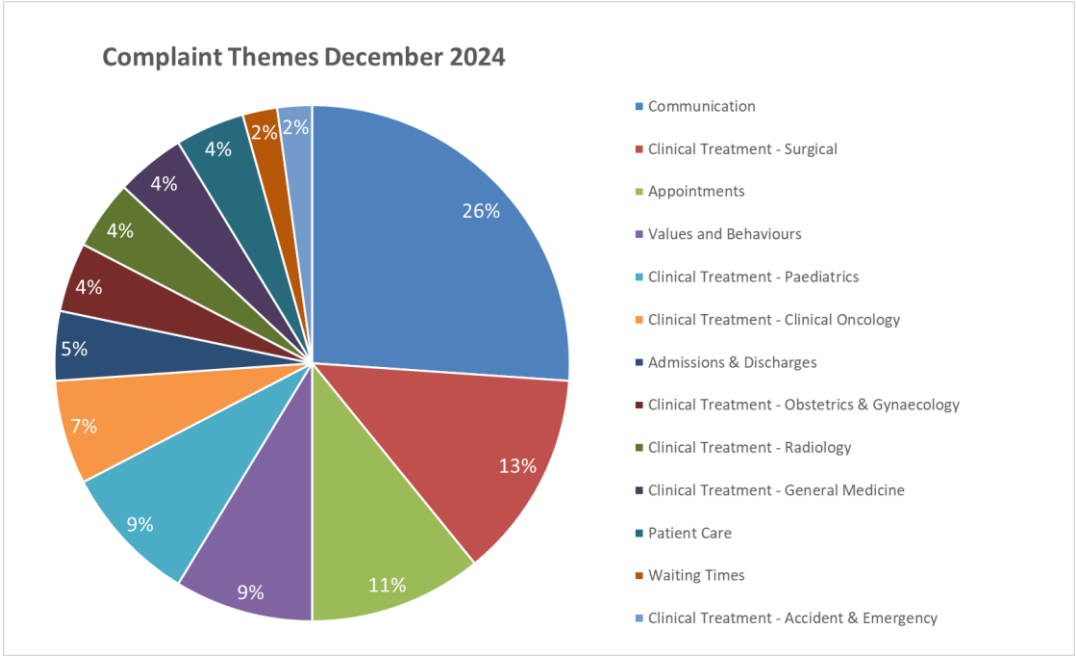
Coding Depth
Coding depth has a substantial impact on mortality indicators. Within the latest published SHMI data the Trust has an elective coding depth of 6.9 and a non-elective coding depth of 6.3*.

Spells with palliative code
Between August 2023 – July 2024, the Trust has a 2% palliative care coding rate.



Friends & Family Test / Complaints





Current Position

- There were 4,887 responses to the Friends and Family test from the Trust in September 2024 under the current pilot collection system.
- The infographic shows the proportion of patients who give a positive or negative rating of the care they received. The response rates are shown in black.
- The Trust has opened 46 formal complaints In December 2024. The average number of complaints opened this financial year is 53, which is five complaints higher than the Trust average for the previous financial year.

Patient Experience Surveys

October 2024 Responses

- Newcastle Hospitals carries out monthly surveys of all inpatients attending the Trust and patients attending the Emergency Departments/Outpatients. The surveys have been designed to include all of the key questions from the questionnaire used in the CQC national patient survey programme and the NHS England Friends and Family Test.
- The survey methodology is predominantly online – surveys are sent out by SMS to patients within a month of their attendance. Patients are offered the opportunity to opt out of the survey or request a paper copy of the questionnaire by post.
- This report includes all responses from patients attending or discharged during October 2024.

Inpatient Results

- The inpatient results for October 2024 are positive. On average the Trust is in the top 20% of all Trusts in England, with an average score of 79%, 1% below the previous month. The threshold for the top 20% is 76%.
- 91% of patients rate the Trust as very good or good (the Friends and Family Test (FFT) Question), and overall scores by the two main sites are very similar: Freeman Hospital 80% (750 respondents), the Royal Victoria Infirmary 78% (613). Overall results continue to be excellent in all areas, including waiting, noise at night, communication with staff, cleanliness, pain management, discharge planning, overall ratings and respect and dignity. Results could be improved in asking patients for their views on the quality of care.

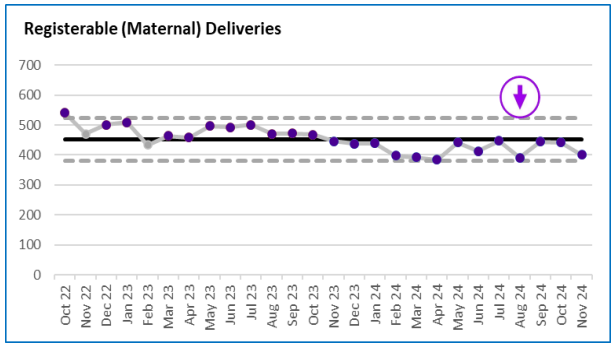
Outpatient Results

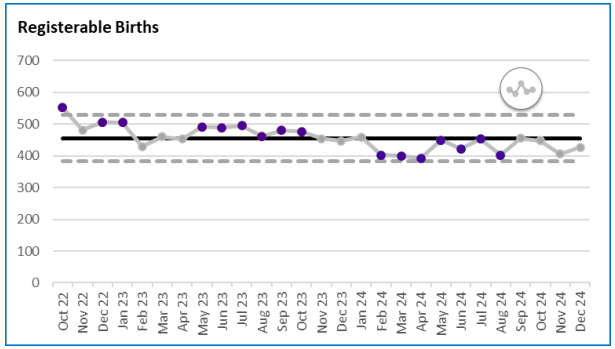
- The outpatient results for October 2024 continue to be positive. The average score was 89%, 1% down from the previous month, but nonetheless remains within the top 20% of all Trusts in England - the threshold for which is 84%.
- 96% of patients rate the Trust as very good or good (the FFT Question), and overall scores by the two main sites are very similar: Freeman Hospital 89% (3,142 respondents), The Royal Victoria Infirmary 88% (3,058). There is also little variation between Clinical Board and specialty.
- Overall results continue to be excellent in all areas, including all aspects of communication between doctors and patients (and information about discharge), cleanliness, involvement in decisions, discharge planning, letters copied to patients, overall ratings and respect and dignity. The one area for improvement is in information to patients about the length of the waiting time and the reason for the wait.

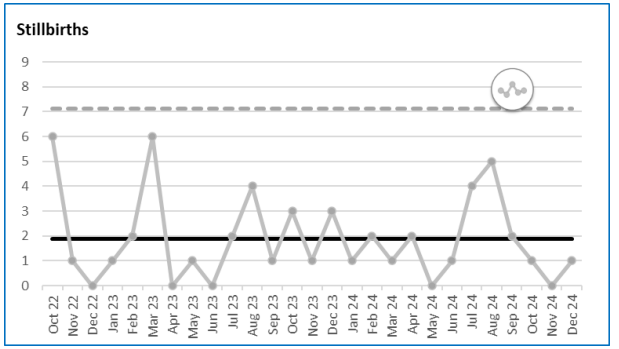
Emergency Department Results

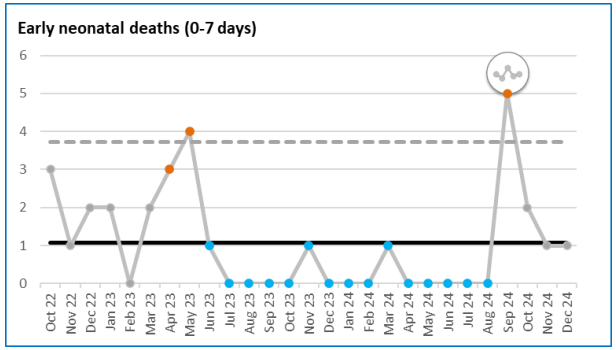
- Emergency Department results for October 2024 are positive and stable. The average score is marginally down from September (74.5 to 73.8), although there are no statistically significant changes. The Trust is in the top 20% of Trusts overall.
- Overall results are good in the following areas: information about waiting, communication with doctors and nurses, leaving the hospital, and overall ratings. Results could be improved in pain management, amount of information given, cleanliness and patients feeling bothered or threatened by other patients.

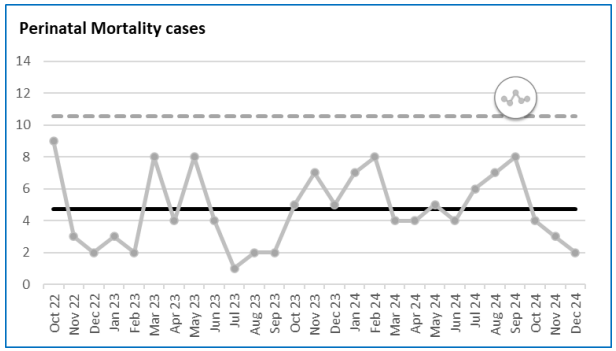
Perinatal Quality Surveillance: Births











Deliveries/Births

- There were 605,479 live births in England and Wales in 2022, a 3.1% decrease from 624,828 in 2021 and the lowest number since 2002. The impact of the reduced birth rate has been augmented by a reduction in market following the suspension of the Newcastle Birth Centre (NBC) services. This has had a significant impact on activity in other units and on patient safety. Mutual aid has been provided by Newcastle to neighbouring Trusts on a weekly basis. The NBC was re-opened 2 December 2024. Activity will be closely monitored.

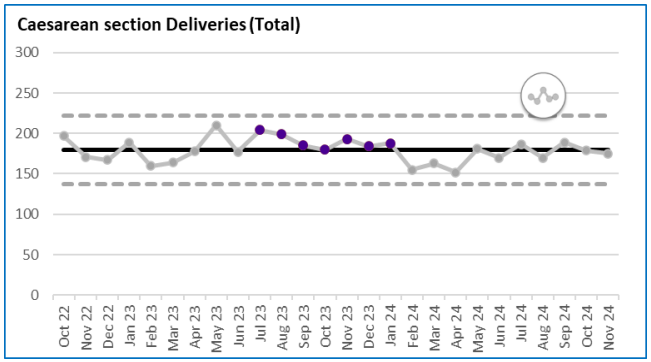
Stillbirths

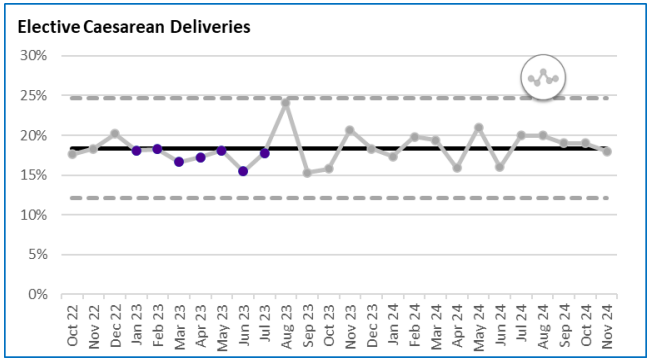
- Newcastle is a tertiary referral Fetal Medicine Unit, providing care to the most complex cases from across North East North Cumbria (NENC). This data includes termination for fetal anomalies >24 weeks gestation. There were no stillbirths in November 2024. (Average per 1,000 births: England 3.2, NENC 3.6).

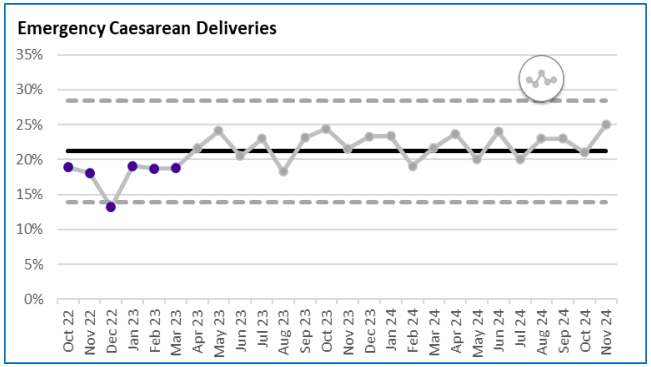
Early Neonatal Deaths

- These figures were previously reported for term infants only. The Trust are now reporting for liveborn infants from 20 weeks of pregnancy/weighing >400g (if unknown gestation) who received care by the Trust and sadly died within the first week of life, which accounts for the noted increase from September. The Trust has the highest level of neonatal intensive care provision supporting extremely premature babies. These deaths are reported to the Child Death Review panel who will have oversight of the investigation and review process. In November 2024 there was one early neonatal death of an extremely premature baby (born under 24 weeks gestation).

Perinatal Quality Surveillance: Deliveries







Caesarean section deliveries

- There is no defined national metric for caesarean section rates.
- National reports, including Ockenden and Reading the Signals (East Kent) have highlighted lower caesarean section rates do not reflect patient safety or the importance of offering individualised and personalised care where women's voices are heard.
- In England 42.9% of births are caesarean section, in the NENC this is 39.2%. The Trust is comparable with a caesarean section rate of 43% in November 2024.

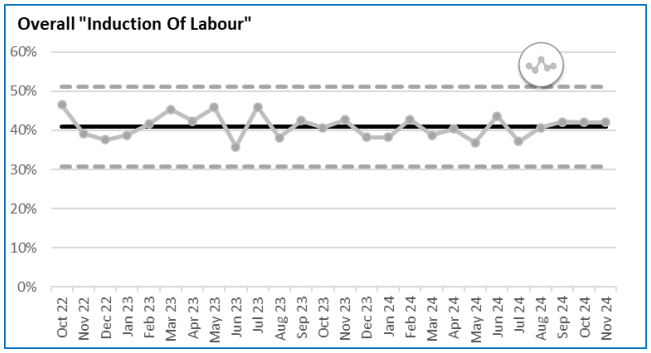
Elective Caesarean section

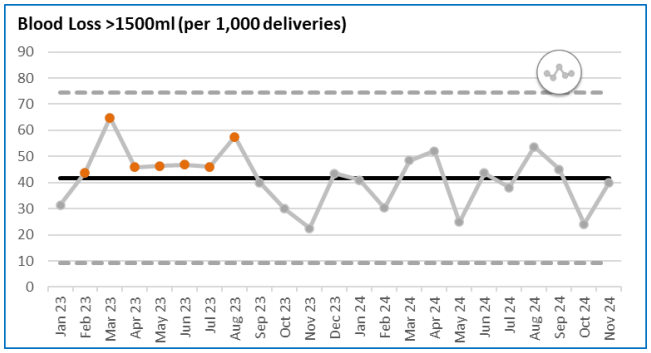
- The average England elective caesarean rate is 18.2%.
- The Trust elective caesarean rate was 18% in November.
- The rise in elective caesarean rates is partially due to an increasing proportion being undertaken due to maternal request in accordance with the NICE guidance.
- The Trust has a shared 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.

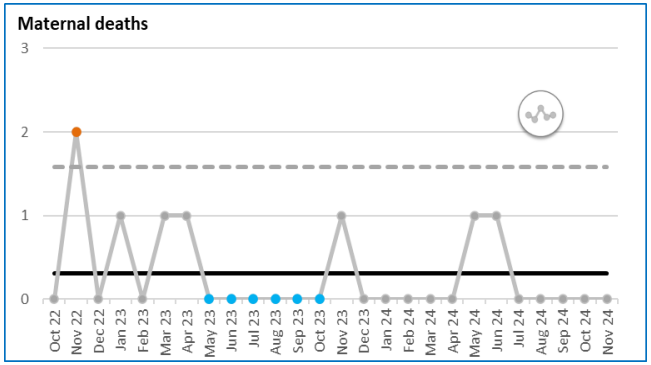
Emergency Caesarean section

- NHS Digital data for January 2024 47% of deliveries were spontaneous vaginal births, 10% had instrumental assistance, 19% were elective caesarean sections and 24% were emergency caesarean sections, the Trust is comparable with this national data.
- The Trust emergency caesarean rate in November was 25%. This is the highest it has been in the previous 12 months, but comparable with national performance.
- 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.

Perinatal Quality Surveillance: Labour







Induction of Labour

- The number of women being induced during pregnancy has increased due to changes in national guidelines. Evidence suggests that inducing women in additional risk groups would improve outcomes and has driven a further increase in the induction rate, for example women with hypertension, diabetes in pregnancy and advanced maternal age. England average for induction of labour Q1 2024-25 29.7% and NENC 33.8%. The Trust induction of labour rate has been 42% for the past 3 months. There is currently an Induction of Labour quality improvement plans (QIP) reviewing pathways and patient experience.

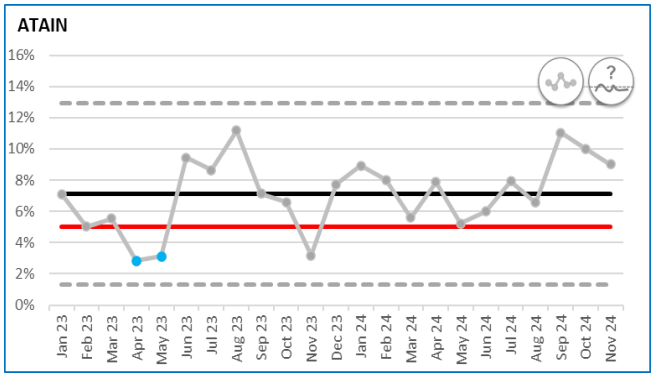
Blood Loss >1500ml

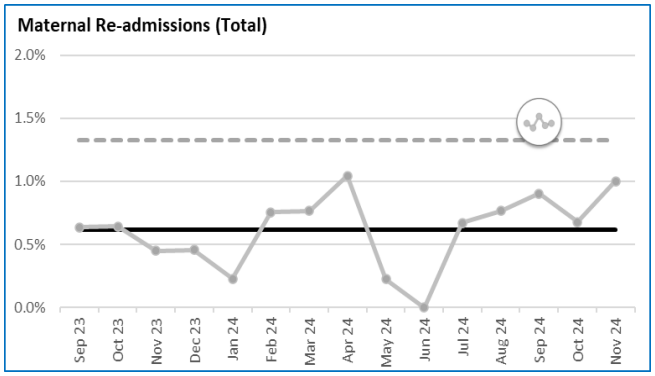
- In 2023 the Trust was highlighted as an outlier for postpartum haemorrhage >1,500ml per 1,000 births. The average Primary Postpartum Haemorrhage (PPH) rate for England is 30 per 1,000 and NENC average is 27 per 1,000. The Trust rate was 24 per 1,000 in October, lower than the previous 5 months. However, it was noted to be 40 per 1,000 in November. This will continue to be monitored closely.

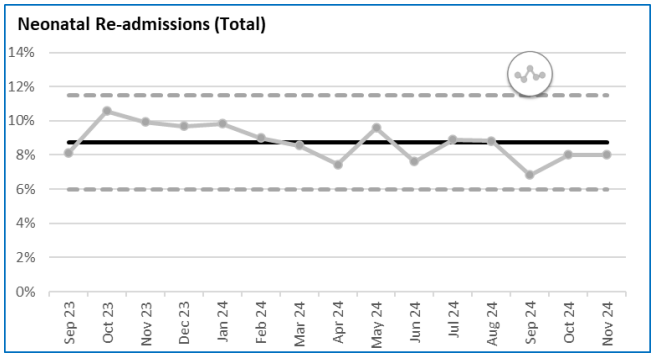
Maternal Deaths

- Maternal deaths are reported to MBRRACE-UK and an annual national report is provided. Early maternal deaths are 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 to 365 days of pregnancy. Direct deaths result 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 MNSI, investigation is dependent on certain criteria. There have been no maternal deaths reported between July and November 2024.

Perinatal Quality Surveillance: Admissions







Avoiding Term Admission into Neonatal Units (ATAIN)

- All unplanned admissions of term babies (37 – 41 weeks) into the neonatal unit are reviewed at a regular multi-disciplinary meeting and quality improvement themes identified. The Trust previously reviewed cases where admission time on NICU was >4hours. The Trust is now reviewing all admissions including those babies who a short period of separation from the mother. National benchmark for term admissions is 5%. The Trust are currently benchmarking term admission rates with other Tertiary units to understand our performance against similar units for this metric and has commenced a deep dive to review the admission of infants of diabetic mothers.

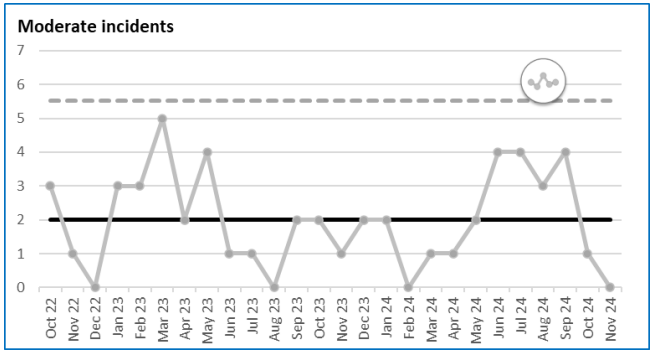
Maternal Readmissions

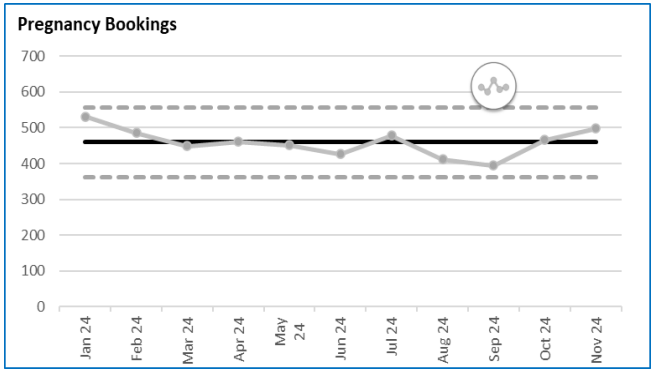
- This is a new metric; work is ongoing to benchmark performance with national parameters. From National Maternity & Perinatal Audit (NMPA) Report (2022) the maternal postnatal readmission rate for England was 3.3%, with rates being higher following c/s compared with vaginal birth (4.3% vs 2.9%). Maternal readmission rate for November remained at 1%.

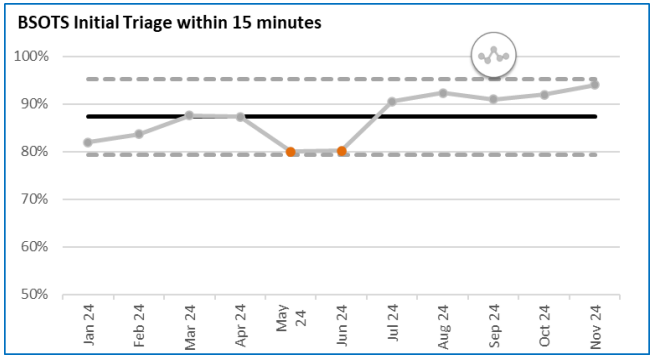
Neonatal Readmissions

- This is a new metric; work is ongoing to benchmark performance with national parameters. Clinical Quality Improvement Metrics (CQIM) for 'Babies readmitted to hospital who were under 30 days old' data is available for this indicator from March 2024- June 2024. The national rate for this period ranges from 5.3- 5.5%. Neonatal readmission rate for October and November was 8%.

Perinatal Quality Surveillance: Incidents, Bookings & Triage







Incidents

- There was no moderate (and above) incidents reported in maternity this month.
- The majority of moderate incidents are those cases that fit the criteria for referral to MNSI for external review. These include cases involving neonatal brain injury - Hypoxic Ischaemic Encephalopathy (HIE), Term Intrapartum Stillbirths, Early Neonatal deaths and Maternal deaths.

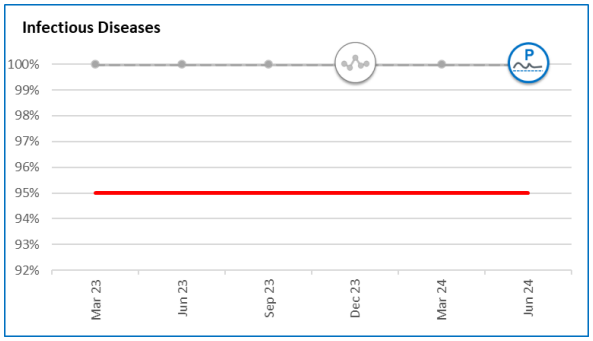
Pregnancy Bookings

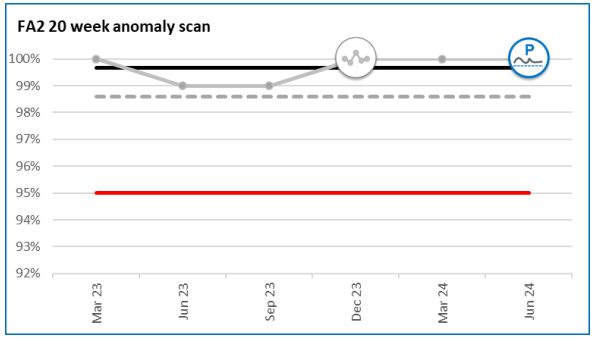
- The number of women choosing to book for care and delivery at the Trust has fallen steadily since January 2024. The Trust is aware that this decision has been influenced by the closure of the Newcastle Birthing Centre, this metric will be monitored closely following the re-opening of the service in December.

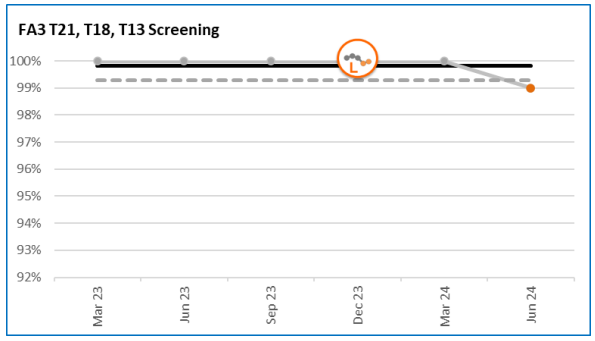
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

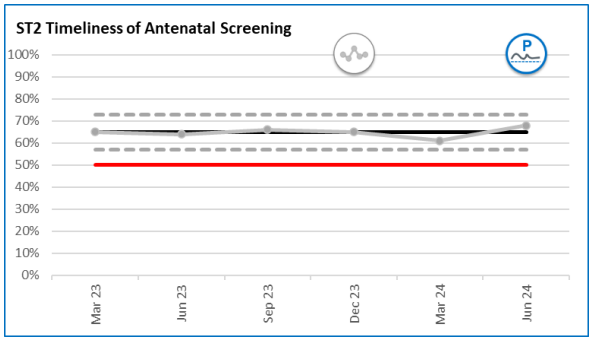
- The Trust implemented the BSOTS triage system in January 2024. Performance has been improving with initial triage times, further metrics are being developed regarding ongoing care and medical review, which remains challenged. Comprehensive action plan for improvement in place.
- NENC are implementing a regional dashboard for BSOTS compliance for future reporting and oversight. In November the compliance rate for triage within 15 minutes was 94%.

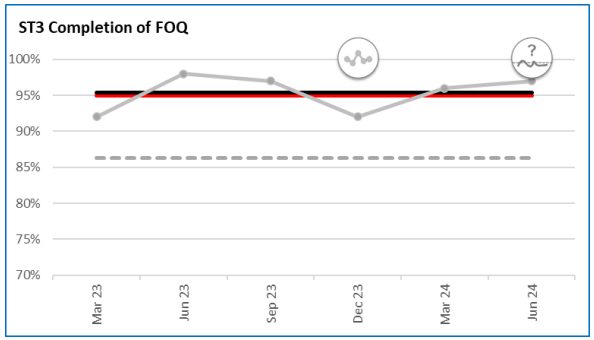
Perinatal Quality Surveillance: Antenatal Screening

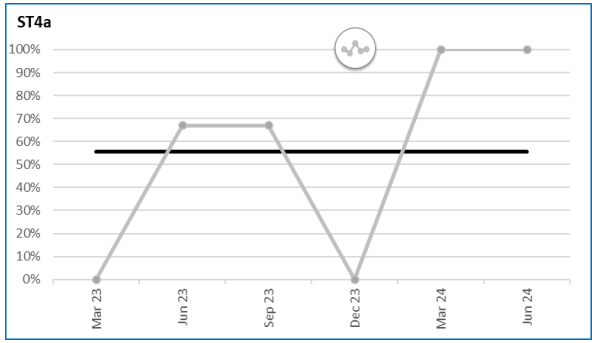


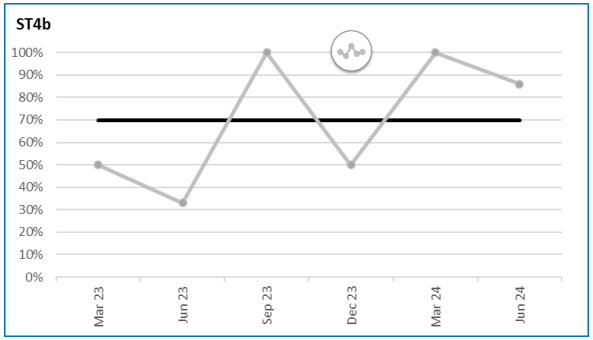


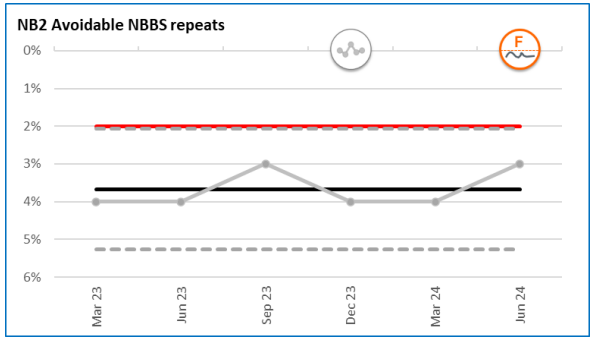






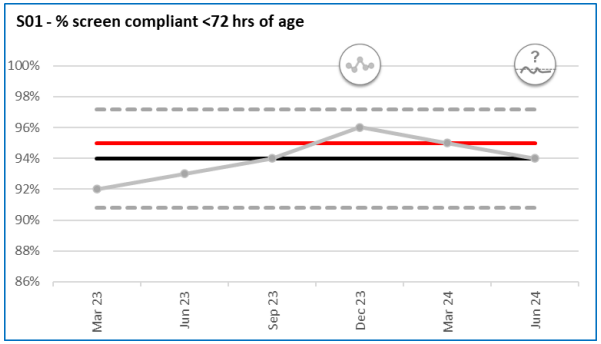


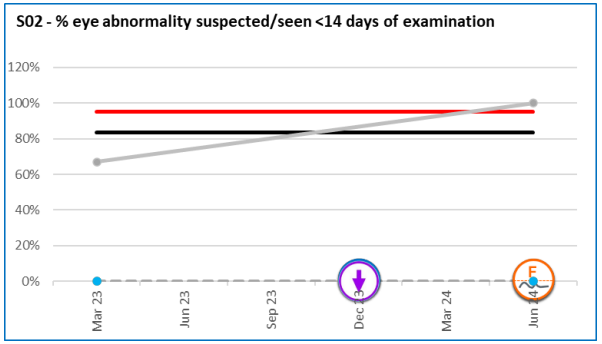


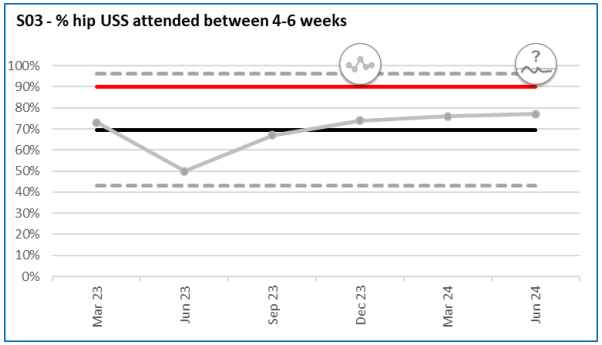


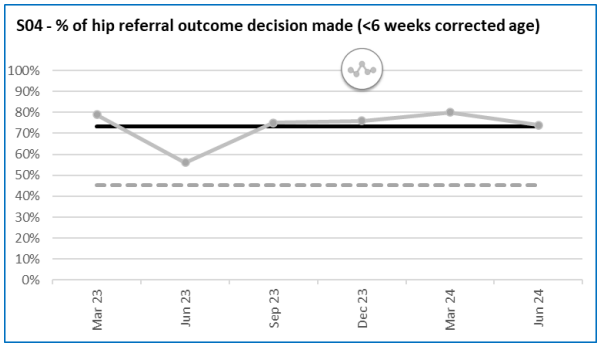
- 3 patient safety incident investigation (PSII) Underway.
- Comprehensive action plan in place. Incident oversight group with NHS England (NHSE) & Integrated Care Board (ICB) colleagues meeting fortnightly.
- Quality Improvement Plans (QIP) to review antenatal clinic patient flow, failsafe and administration processes underway.

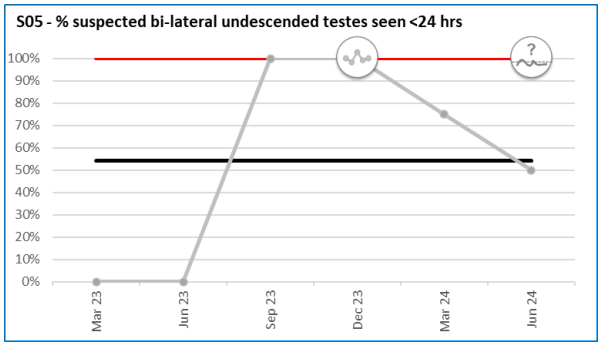
Perinatal Quality Surveillance: NIPE Screening



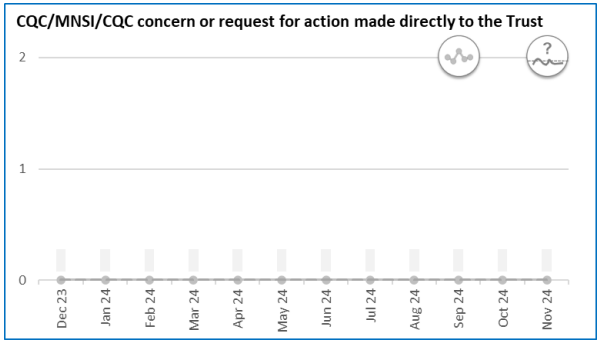


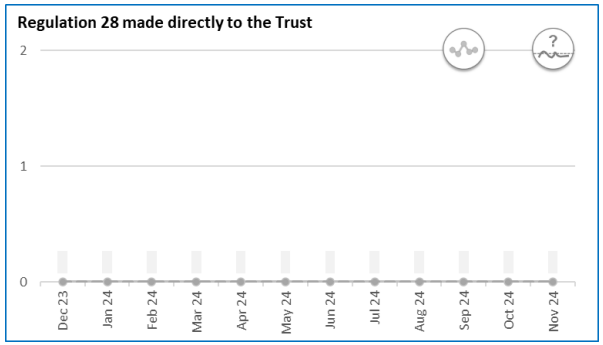




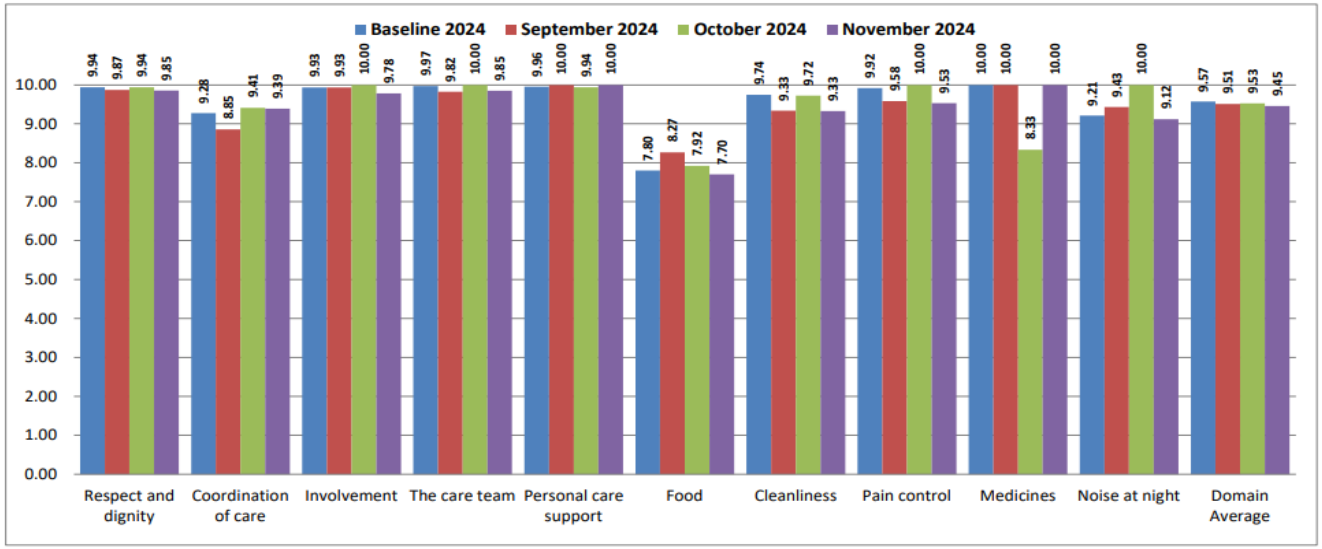


- There have been no Care Quality Care/Maternity and Newborn Safety Investigations (MNSI) concerns or requests for action in last 12 months.
- There have been no regulation 28 notices in the last 12 months.





Perinatal Quality Surveillance: Patient Experience



Ward Experience Surveys

Current Quality Improvement (QI) focus on postnatal ward experience from both a service user and staff perspective. 100% of the patients surveyed would recommend their overall experience on the ward during November.

Patient perspective

- Newcastle Hospitals carries out monthly surveys of all women giving birth in the previous month. The surveys have been designed to include all the key questions from the questionnaire used in the CQC national patient survey programme and the NHS England Friends and Family Test. The survey methodology is predominantly online – surveys are sent out by SMS to women within a month of the birth. Women are offered the opportunity to opt out of the survey or request a paper copy of the questionnaire by post.
- In November, 264 surveys were delivered, with 132 responding (50%). The Trust is in the top 20% of Trusts overall. It is in the top 20% on 43 questions, middle 60% on 13 questions and bottom 20% on 1 question. Overall, results are positive in the areas of communication with staff at all stages of pregnancy, cleanliness, help with feeding, and not leaving alone at a worrying time. Results could be improved in asking women about their mental health, involving partners, and staff introducing themselves. Action plans in place to address these areas.

Performance

Performance Overview

Metric	Period	Actual	Target	Variation	Assurance
A&E Arrival to Admission / Discharge	Nov-24	73.9%	78%	Common Cause	?
RTT 18 Weeks	Nov-24	68.4%	92%	Common Cause	F
>65 Week Waiters	Nov-24	130	0	L	F
Cancer 28 Day FDS	Nov-24	74.7%	77%	Common Cause	?
Cancer 31 Day	Nov-24	76.9%	96%	L	F
Cancer 62 Day	Nov-24	52.0%	70%	H	F
Diagnostic 6 Weeks	Nov-24	29.1%	5%	H	F

Emergency Care

- All types performance in November fell for the third consecutive month, dropping to 73.9% (-0.6%) - this is in line with common cause variation.
- In November, the target for less than 2% of patients to wait over 12 hours from Accident & Emergency (A&E) arrival to admission/discharge was not met at 2.6%. The target remains between the SPC process limits so there is no assurance as to when the target may be achieved.

Elective Waits

- November witnessed decreases in the number of >65 & >52 week waits at Newcastle Hospitals, though these changes remained in line with common cause variation. Demand continues to outstrip capacity within the Foot & Ankle service in Trauma & Orthopaedics (T&O), further impacted by consultant sickness.
- The total waiting list (WL) size decreased slightly but remained within the parameters of normal variation.

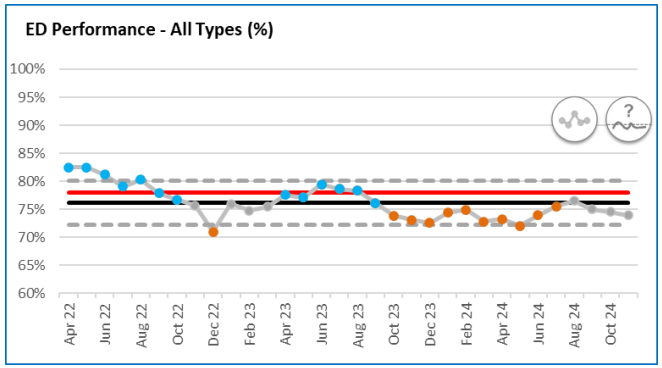
Cancer Care

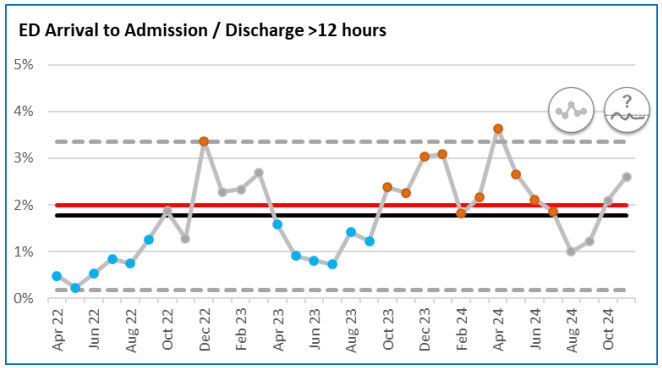
- In November, the 77% 28 Day Faster Diagnosis Standard (FDS) was failed for the fourth successive month (74.7%). This is within the level of natural variation to be expected given recent historical trends.
- 31 Day performance has continued to deteriorate (76.7% for November) with performance outside the control limits for three successive months.
- 62 Day compliance for November was 62.0%, reflecting improving special cause variation despite an overall consistent failure to hit the target.

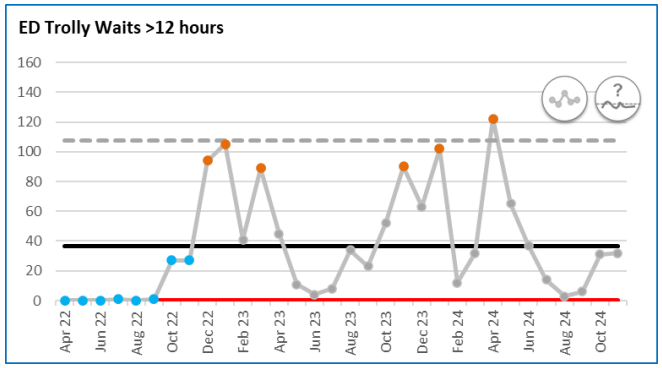
Diagnostics

- Performance has improved for 3 successive months - 29.1% of patients were waiting over six weeks at the end of November. Audiology, Neurophysiology and MRI saw the biggest advances, however concerning variation in performance continues with the target consistently failed.

Emergency Care







Standards

- 78% of patients to be admitted/transferred/discharged from A&E in <4 hours (by Mar-25).
- No ambulance handovers to A&E exceeding 60 minutes.
- Less than 2% of patients to wait over 12 hours from A&E arrival to admission/discharge.

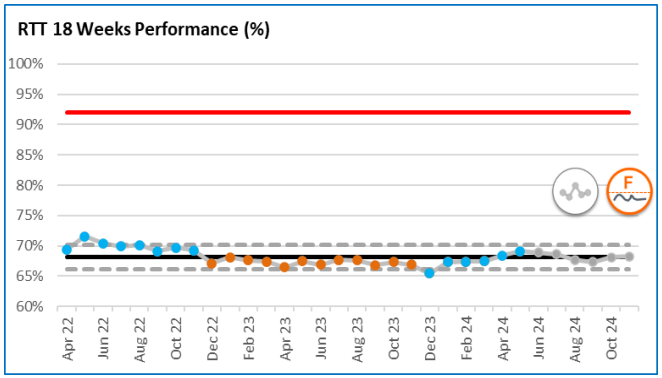
Current position

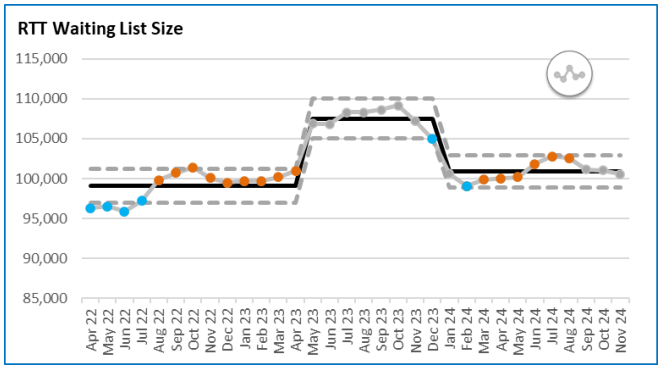
- Type 1 and overall performance in November fell for the third consecutive month, dropping to 58.2% (-1.9%) and 73.9% (-0.6%) - this is in line with common cause variation. There has been an increase in Type 1 attendances and the number of patients attending Emergency Department (ED) that require admission, placing the department and staff under significant pressure.
- In November, the target for less than 2% of patients to wait over 12 hours from A&E arrival to admission/discharge was not met at 2.6%. The target remains between the SPC process limits so there is no assurance as to when the target may be achieved.
- There were 32 Trolley waits > 12 hours, reaching the highest level since June 2024.
- Handovers >60 minutes saw a significant decrease with 68 seen compared to 114 in October, 2024 showing a 40% reduction. There were 530 handovers > 30 minutes.
- General and Acute Bed Occupancy for November reached the highest level since March 2023 at 93.19%. Higher occupancy increases likelihood of restricted patient flow, contributing to lower overall A&E performance for November.

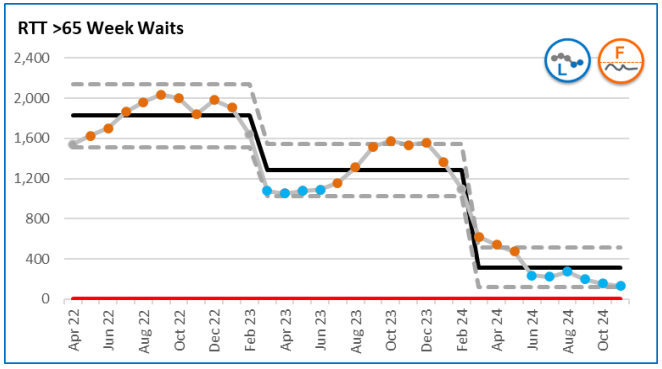
Action taken

- Continuous Flow is being embedded to support with decompressing ED and reducing overcrowding, with operational management daily rhythm in place to support with flow across the RVI and Freeman medicine.
- The winter ward has now opened at the Freeman Hospital, providing additional inpatient capacity. This is part of the wider winter plan which included additional transport and additional medical staff with any medical borders.
- The development of a co-located Urgent Treatment Centre (UTC) and the re-design of Same day emergency care (SDEC) are both progressing to help address estate issues. The Discharge Lounge in the RVI is now permanent and is supporting patient flow.

Elective Waits







Standards

- 92% of patients on incomplete Referral To Treatment (RTT) pathways to be waiting less than 18 weeks.
- Zero tolerance on incomplete RTT waits over 65 weeks (by Sep-24).

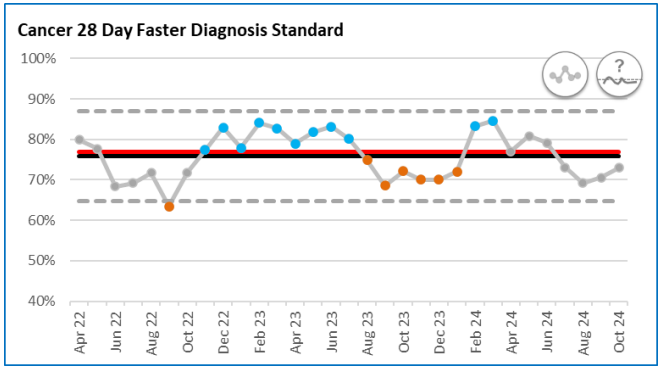
Current position:

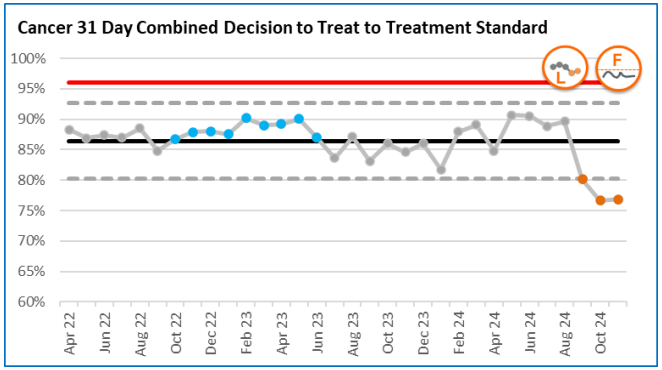
- November witnessed decreases in the number of >65 & >52 week waits at Newcastle Hospitals, though these changes remained in line with common cause variation. The total number of patients waiting >78 weeks dropped to 19, with 6 patients waiting for corneal graft surgery (national tissue shortage). The total number of patients waiting >65 weeks reduced to 130 (-28).
- While huge progress has been made in reducing long waiters throughout 2024/25, there remain some challenges at specialty and sub-specialty level that mean the Trust has been unable to completely eradicate its 78 & 65-week waiters, including:
    - Demand outstripping capacity within the Foot and Ankle service in T&O, further impacted by consultant sickness.
    - Capacity issues in the Adult Deformity Service (NEADS) in Spinal Surgery impacted by a recent pause in the service.
    - Continued demand for MOHs surgery in Dermatology as the sole regional provider.
- The total waiting list (WL) size decreased slightly but remained within the parameters of normal variation. The total number of patients waiting >18 weeks stood at 31,808, with RTT 18-week performance recorded at 68.4%.

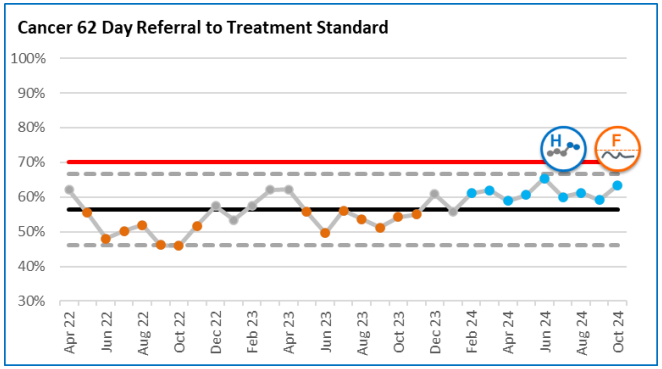
Action taken

- Demand & capacity work is being developed for the Foot and Ankle Service to determine estimated clearance times for the waiting list backlog.
- Mutual aid is in place with other local providers to support treatment of long waiters in T&O.
- An experienced additional locum has been appointed in Rheumatology with clinics established and a reduction in the number of long-waiting patients being seen already.
- Weekend WLI lists remain in place across specialties, including T&O Foot and Ankle and Spinal Neuro.
- The Trust's access policy continues to be rigorously and appropriately applied.

Cancer Care







Standards

- 77% of patients on a suspected cancer or breast symptomatic pathway to receive results/diagnosis within 28 days of referral (by Mar-25).
- 96% to wait no more than 31 days from diagnosis to first cancer treatment.
- 70% of patients to wait no more than 62 days from urgent/screening referral to first cancer treatment (by Mar-25).

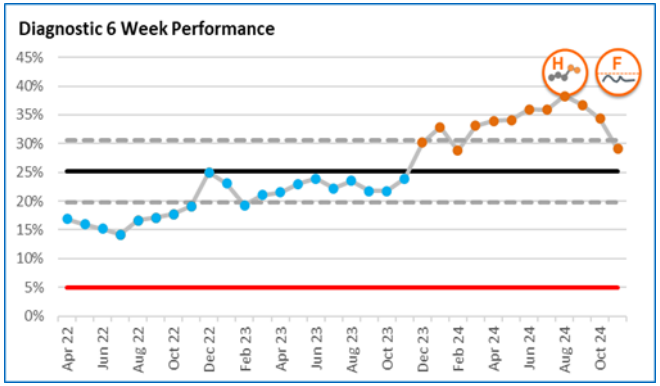
Current position:

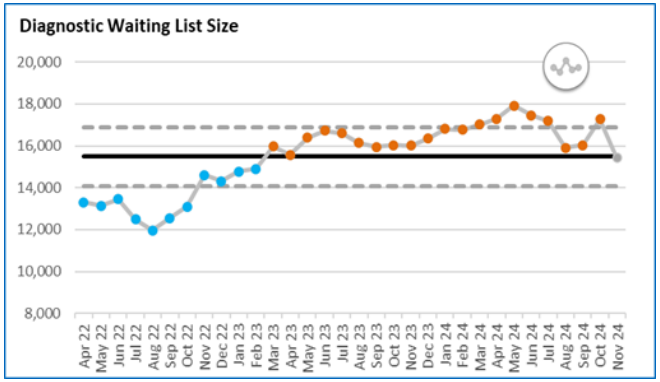
- In November, the 77% 28 Day Faster Diagnosis Standard (FDS) was failed for the fourth successive month (74.7%). This is within the level of natural variation to be expected given recent historical trends. Skin cancer performance has the largest impact of any singular tumour group on overall achievement – issues with engagement in teledermatology from primary care have led to empty digital clinics and longer waits for face-to-face appointments.
- 31 Day performance has continued to deteriorate – 76.7% for November, with performance now outside the control limits for three successive months. Radiotherapy performance has taken a significant dip since August 2024 due mainly to an increase in referrals and a reduction in capacity due to retirements and turnover across various sections of the radiotherapy pathway - specifically scheduling, dosimetry and treatment radiographers.
- 62 Day compliance for November was 62.0%, reflecting a continuation of improving special cause variation despite an overall consistent failure to hit the target.

Action taken

- Skin are currently scoping options to resolve issues with teledermatology take up, including paying primary care for good quality photos or hosting a photography hub in primary care.
- A locum consultant has been appointed within the Lung service to provide additional two week wait capacity.
- Improvement work has identified that efficiencies could be made in the scheduling process for patients on the 31-day pathway. Fortnightly capacity meetings have been established to ensure patients are clinically prioritised effectively and timely progressed to treatment. The Board are also considering private providers to assess potential for help with some patient cohorts.
- In depth perfect pathway analysis will be undertaken across a number of tumour groups, starting with Bladder and Colorectal, for data driven identification of delays.

Diagnostics





6 Week Diagnostic Performance by Modality – November 2024			
MRI	23.9%	CT	8.7%
Non-obs US	1.3%	DEXA	3.5%
Audiology	73.8%	ECHO	52.0%
Electrophysiology	6.7%	Neurophysiology	13.9%
Sleep Studies	69.0%	Urodynamics	13.3%
Colonoscopy	10.7%	Flexi-Sig	9.9%
Cystoscopy	12.0%	Gastroscopy	13.9%
Newcastle Hospitals Total			**29.1%**

Standards

- <=5% of patients on incomplete diagnostic pathways waiting six weeks or longer.

Current position:

- Performance against the 5% standard has improved for 3 successive months. 29.1% of patients were waiting over six weeks for their test at the end of November. This is the highest performance achieved in nine months and compares to 34.3% in October. Audiology, Neurophysiology and MRI saw the biggest improvements - however there continues to be special cause variation of a concerning nature and the target is consistently failed.
- Despite the overall progress, ECHO performance has declined considerably in recent months, worsening from 12.3% in July to 52.0% in November. This follows a reduction in insourcing.
- The volume of activity delivered per working day was 9.5% higher in November than in October, equating to 96 additional tests per day, with Audiology responsible for most of this growth.
- The waiting list size fell by 1,848 patients in November, the biggest drop in a single month for many years. This also means there is no longer special cause variation of a concerning nature and instead common cause variation is present. Aligned to the increased activity, the Audiology waiting list fell by 1,129 patients, with a particular reduction in patients waiting over 6 weeks.
- There was a sizable drop in the volume of patients waiting >13 weeks (2,390 in November from 3,573 in October). However, 1,842 >13 week waiters remain in Audiology, 77% of the Trust total.

Action taken

- Audiology direct access clinics are being run via insourcing and overtime to reduce the backlog.
- Numerous actions are also being taken to increase Audiology capacity by ensuring time is used as efficiently as possible. In November a validation exercise was conducted on the waiting list and in December a new screening tool is being piloted and changes made to clinic templates.
- The Community Diagnostic Centre (CDC) at the Metrocentre opened in October and has increased capacity in numerous tests. Recruitment to posts at the CDC is ongoing to reduce reliance on insourcing in echocardiogram (ECHO).
- Service improvement opportunities are being explored to create additional radiology capacity through making the turnaround times between patients shorter and more efficient.
- An agreement has been reached to use some spare MRI capacity at QE Gateshead from the end of January onwards, with a particular aim to reduce the Neuroradiology backlog.

Contractual & Planning Standards (1/2)

Theme	Standard	Aug-24	Sep-24	Oct-24	Nov-24	Num.	Den.	24/25 YTD
Activity & Elective Care								
Day Case	**100%** of 24/25 Plan (equivalent to 107% of 19/20 value-weighted activity)	102.5%	97.0%	100.0%	**99.1%**	10,976	11,081	**99.0%**
Elective Overnight		103.3%	90.2%	100.5%	**102.0%**	1,857	1,820	**99.0%**
Outpatient New		95.3%	93.6%	97.4%	**99.8%**	26,375	26,422	**96.3%**
Outpatient Procedures		105.8%	104.9%	107.2%	**99.5%**	19,843	19,944	**105.0%**
Outpatient Review	**N/A**	112.9%	111.6%	115.5%	**119.3%**	68,558	57,484	**114.1%**
Non-Elective		82.8%	90.1%	95.5%	**88.7%**	932	1,051	**88.7%**
Emergency		97.1%	105.9%	110.4%	**107.0%**	6,214	5,807	**105.1%**
RTT 18 Week Wait	**92%**	67.7%	67.3%	68.1%	**68.4%**	68,745	100,553	**68.3%**
>78 Week Waiters	**Zero**	32	21	23	**19**	19		
>65 Week Waiters	**Zero** (by Sep-24)	273	199	158	**130**	130		
>52 Week Waiters	As per submitted trajectory	2,560	2,420	2,130	**2,048**	2,048		
RTT Waiting List Size	As per submitted trajectory	102,589	101,162	101,025	**100,553**	100,553		
Diagnostic Activity	**120%** of 19/20 activity	112.5%	112.7%	111.1%	**120.7%**	23,132	19,258	**112.4%**
Diagnostic 6 week wait	<=**5%** (local target of <=15%)	38.3%	36.7%	34.3%	**29.1%**	4,486	15,423	**34.8%**
Day case rates (BADS procedures)	**85%**	**86.3%**	TBC	TBC	TBC			
Capped Theatre Utilisation	**85%**	75.5%	79.0%	77.9%	**78.80%**			
Urgent Ops. Cancelled Twice	**Zero**	0	0	0	**0**	0		**0**
Cancelled Ops. Rescheduled >28 Days	**Zero**	12	10	18	**7**	7		**91**
OP Activity Ratio: New/Procedure	**46%**	37.8%	42.3%	42.3%	**41.1%**	44,578	108,501	**41.6%**
>12 Week Waiters Validated	**90%**	79.5%	75.6%	75.6%	**72.7%**	20,941	28,803	**69.1%**
Outpatient Review Reduction	**25%** reduction vs 19/20 baseline	109.0%	109.9%	110.0%	**114.5%**	89,071	78,299	**146.4%**
PIFU Take-up (%)	>=**5%** of all OP atts. (by Mar-25)	2.2%	2.2%	2.3%	**2.4%**	2,899	120,701	**2.2%**

Contractual & Planning Standards (2/2)

Theme	Standard	Aug-24	Sep-24	Oct-24	Nov-24	Num.	Den.	24/25 YTD
Cancer Care								
28 Day Faster Diagnosis	**77%** (by Mar-25)	69.2%	70.6%	73.1%	**74.7%**	1,759	2,986	**43.7%**
31 Days (DTT to Treatment)	**96%**	89.6%	80.0%	76.7%	**76.9%**	1,019	1,401	**51.4%**
62 Days (Referral to Treatment)	**70%** (by Mar-25)	61.2%	59.4%	63.4%	**62.0%**	236	473	**34.6%**
>62 Day Cancer Waiters		211	223	221	**196**	196		
Urgent & Emergency Care								
A&E Arrival to Admission/Discharge	**>=78%** under 4 hours (by Mar-25)	76.5%	75.0%	74.5%	**73.9%**	15,194	20,563	**74.3%**
	<=2% over 12 hours	1.3%	1.2%	2.2%	**2.6%**	536	20,563	**2.2%**
A&E Decision to Admit to Admission	**Zero** over 12 hours	3	6	31	**32**	32		**310**
Adult General & Acute Bed Occupancy	**<=92%**	83.7%	89.6%	92.1%	**93.2%**	1,331	1,428	**89.2%**
Ambulance Handovers <15 mins	**65%**	59.9%	53.0%	55.7%	**49.8%**	1,653	3,317	**54.4%**
Ambulance Handovers <30 mins	**95%**	88.8%	84.2%	84.2%	**82.0%**	2,737	3,317	**85.1%**
Ambulance Handovers >60 mins	**Zero**	36	71	114	**68**	71		**552**
Urgent Community Response Standard	**>=70%** under 2 hours	77.3%	85.8%	87.6%	**88.5%**	409	462	**82.0%**
Safe, High Quality Care								
Mixed Sex Acommodation Breach	**Zero**	78	70	71	**86**	86		**701**
VTE Risk Assessment	**95%**	**88.6%**		TBC	TBC			
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour	**73.0%**		TBC	TBC			
Sepsis Screening Treat. (All)		**89.0%**		TBC	TBC			

People

People Overview

Metric	12-Month Rolling	Actual	Target	Variation	Assurance
Sickness	Nov-24	5.42%	4.5%		F
Short-term	Nov-24	2.23%			
Long term	Nov-24	3.52%			
Turnover	Nov-24	9.32%	10%	L	?
Mandatory training	Nov-24	92.40%	90%		P
Appraisal	Nov-24	84.74%	90%		F
Disabled staff	Nov-24	5.53%		H	
Ethnicity (BAME staff)	Nov-24	17.29%		H	

Staff in post (Whole Time Equivalent (WTE))

- November 15,189 wte: 1,760 wte (13.1%) above pre-Covid target and 541 wte (3.7%) above plan of 14,649 wte.
- Clinical staff (excl. M&D) highest increase +1,168 wte (13%).

Sickness

- Total sickness absence remained at 5.42% (consistently failing target).
- Top reasons for sickness: anxiety/stress/depression 32%; cold/cough/flu 10%; gastrointestinal 9.9%.
- Short-term sickness reduced in November to 2.32%, long term up to 3.52%.

Retention & Turnover

- Total turnover improved by -0.03% to 9.32%.
- Top reason for leaving: work-life balance 17.95%. Top destinations: no employment 40%; other NHS organisation 32% (includes retire-return).

Mandatory training

- Performance dropped by -0.06% to 92.40%.
- Lowest performance in Medical and Dental 83.71%.
- Paediatric basic life support is the only mandatory training below 80%.

Appraisal

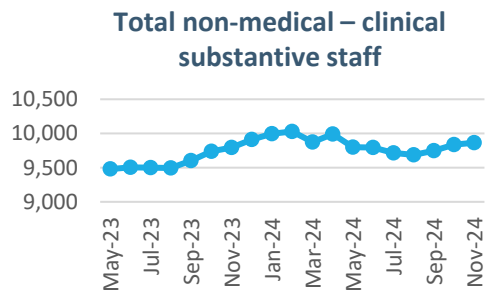
- Performance improved by +0.16% to 84.74%. Common cause variation but rates are consistently failing the target.

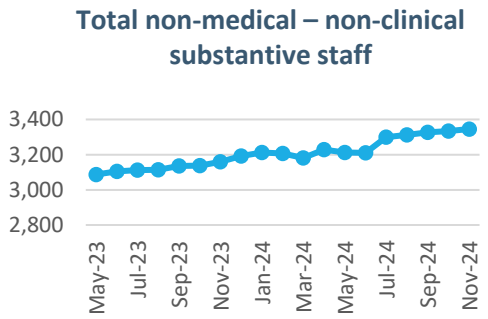
Equality & Diversity

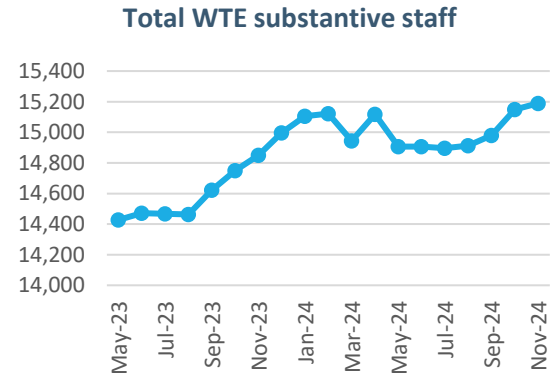
- Disabled staff increased by +0.07% to 5.53%, BAME staff increased by +0.19% to 17.29% (both metrics showing special cause improving variation).

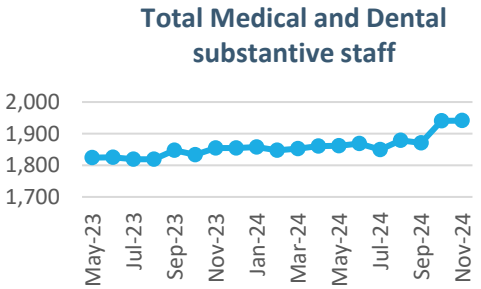
Provider Workforce Return (PWR)

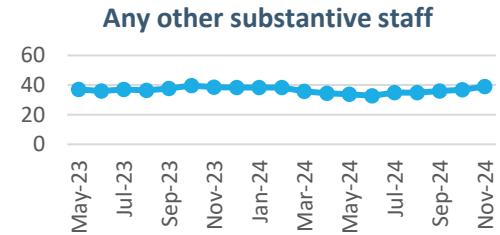
Metric	Benchmark January 2020	Plan (WTE) November 2024	Actual (WTE) November 2024	Difference Jan 20 Actual v Nov 24 Actual	Difference Nov 24 Plan v Nov 24 Actual
Total non-medical - clinical substantive staff	8,696	9,726	9,864	+ 1,168	+138
Total non-medical - non-clinical substantive staff	2,875	2,988	3,346	+ 471	+357
Total Medical and Dental substantive staff	1,722	1,896	1,941	+ 219	+46
Any other staff (substantive total)	135	39	39	- 97	0
Total WTE Substantive Staff	**13,429**	**14,649**	**15,189**	**+ 1,761 (13.11%)**	**+541 (3.69%)**







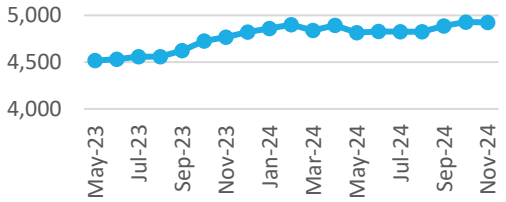




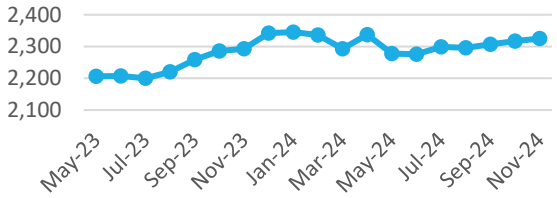
Provider Workforce Return (PWR) Staff Groups

Metric	Benchmark January 2020	Plan (WTE) November 2024	Actual (WTE) November 2024	Difference Jan 20 v Nov 24
Registered nursing, midwifery and health visiting staff (substantive total)	4,214	4,767	4,925	+ 712
Registered/qualified scientific, therapeutic and technical staff (substantive total)	1,993	2,277	2,325	+ 332
Support to clinical staff (substantive total)	2,489	2,682	2,614	+ 125
Total NHS infrastructure support (includes A&C, estates, managers) (substantive total)	2,875	2,988	3,346	+ 471
Medical and Dental (substantive total)	1,722	1,896	1,941	+ 219
Any other staff (substantive total)	135	39	39	- 97
Total WTE Substantive Staff	**13,429**	**14,649**	**15,189**	**+ 1,761 (13.11%)**

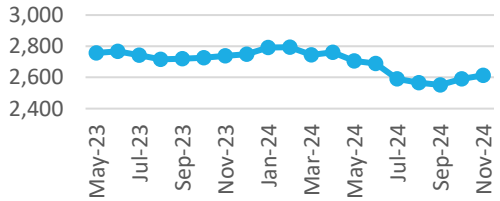
Registered nursing, midwifery and health visiting staff



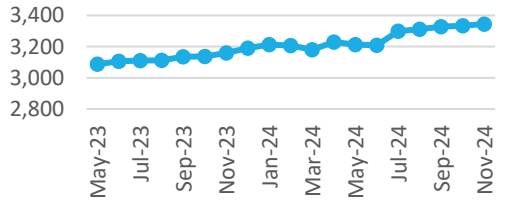
Registered/qualified scientific, therapeutic and technical staff



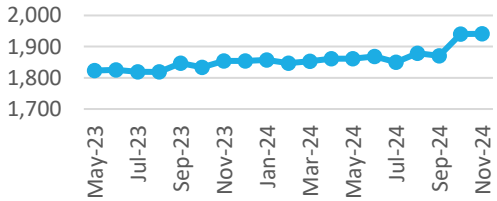
Support to clinical staff



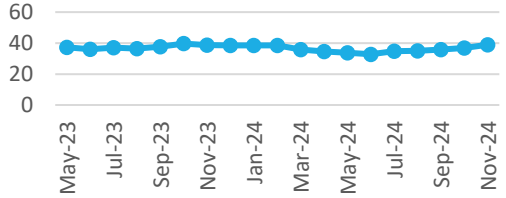
Total NHS infrastructure support



Medical and Dental

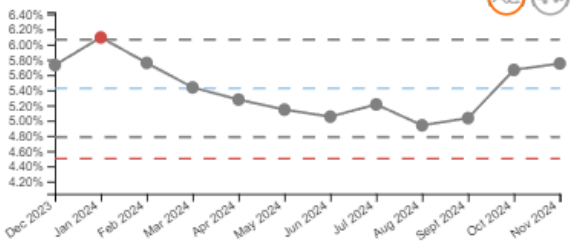


Any other staff



Sickness Absence

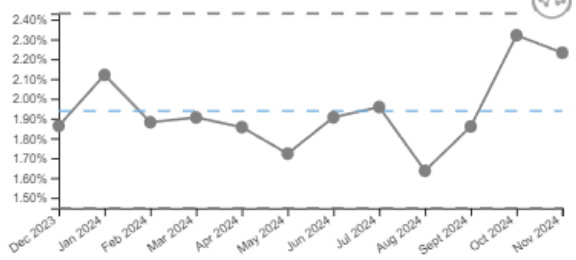
Trust Sickness %	12-Month Rolling	Value	Target
	Nov 24	5.42%	4.50%



Assurance: Consistently Fail Target

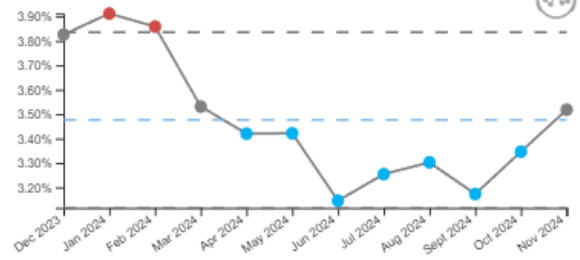
Variation: Common Cause Variation

Metric	Value
Short Term Sickness %	2.23%



Variation: Common Cause Variation

Metric	Value
Long Term Sickness %	3.52%



Variation: Special Cause Variation

Current Position:

- 12-month average to November 5.42%.
- November total sickness: 5.75%; short-term 2.23%; long-term 3.52%.
- Top reasons for sickness:
  - Anxiety/stress/depression 32%
  - cold/cough/flu 10%
  - Gastrointestinal 10%

Underlying Issues

- Main reason for staff sickness is anxiety/ stress/depression which accounts for 32% of all sickness absence and has an upward underlying trend since May 2023.
- Total full time equivalent days lost: 281,869.
- Average days lost per person: 17.
- Total cost of sick pay: £30.3m.
- Variation in sickness rates across Clinical Boards:
  - lowest is Clinical and Diagnostic Services 4.55%; short-term sick 2.05%; long term sick 2.50%
  - highest is Family Health 7.06%; short-term sick 2.55%; long term sick 4.52%

Actions Undertaken:

- Health and Wellbeing (HAWB) offer – Work in progress to agree year one priorities linked to gap analysis especially in the domain of psychological wellbeing including Mental Health First Aid Training and Staff Psychological Support.
- Better Health at Work Award (Maintaining Excellence) – assessment visit completed on 17 December; outcome expected before end-January.
- New HAWB policy being drafted in conjunction with Staff Side.

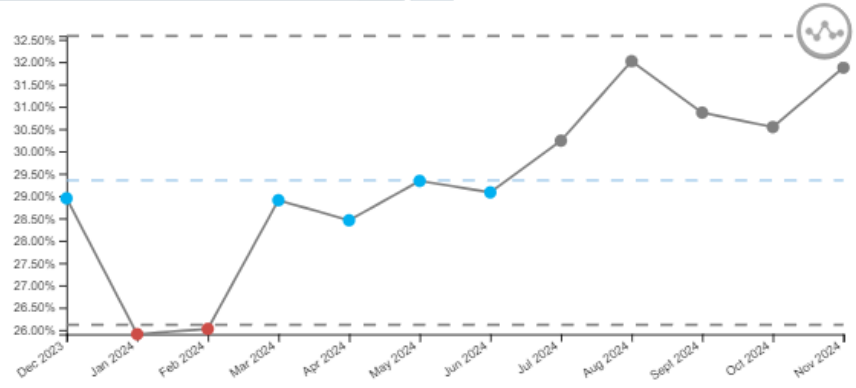
Sickness Absence – Absence reasons

Trust Sickness %	12-Month Rolling	Value	Target
	Nov 24	5.42%	4.50%

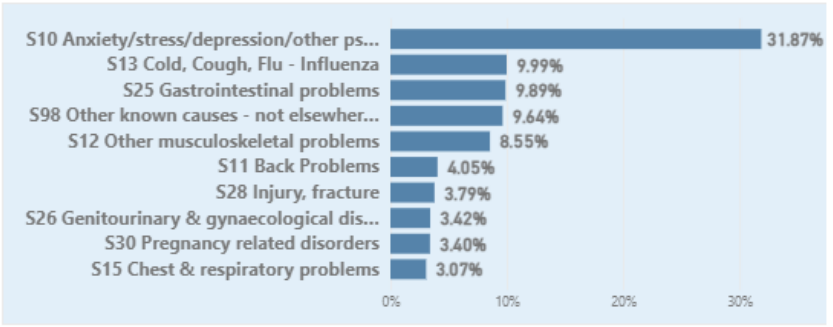
Sickness Reasons - SPC

S10 - Anxiety/stress/depression/ other psychiatric illness

31.87%

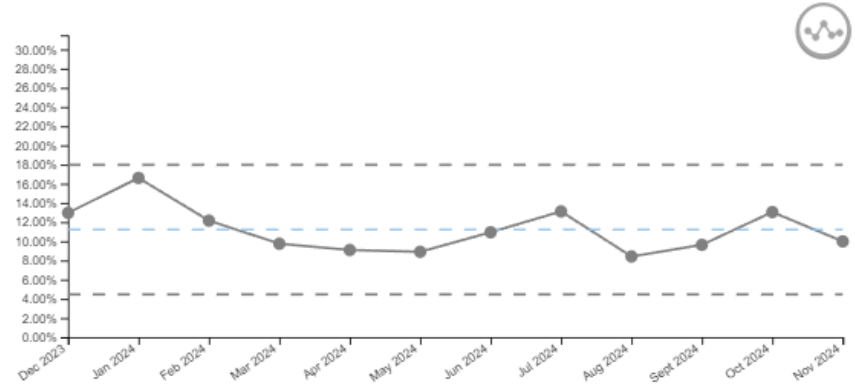


Top 10 Sickness Abscences



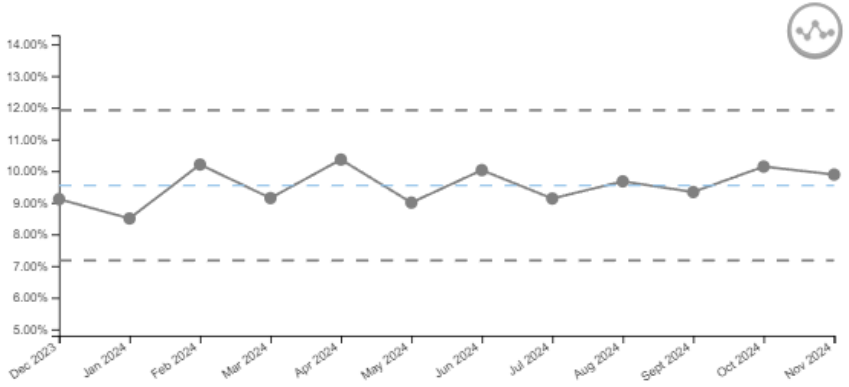
S13 - Cold, Cough, Flu - Influenza

9.99%



S25 - Gastrointestinal problems

9.89%



Sickness – Full Time Equivalent (FTE) working days lost & Formal Action

Sickness - FTE working days lost

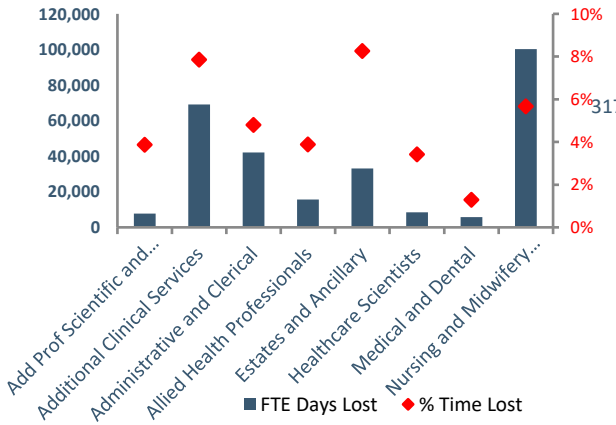
FTE Working Days Lost due to sickness

281,869

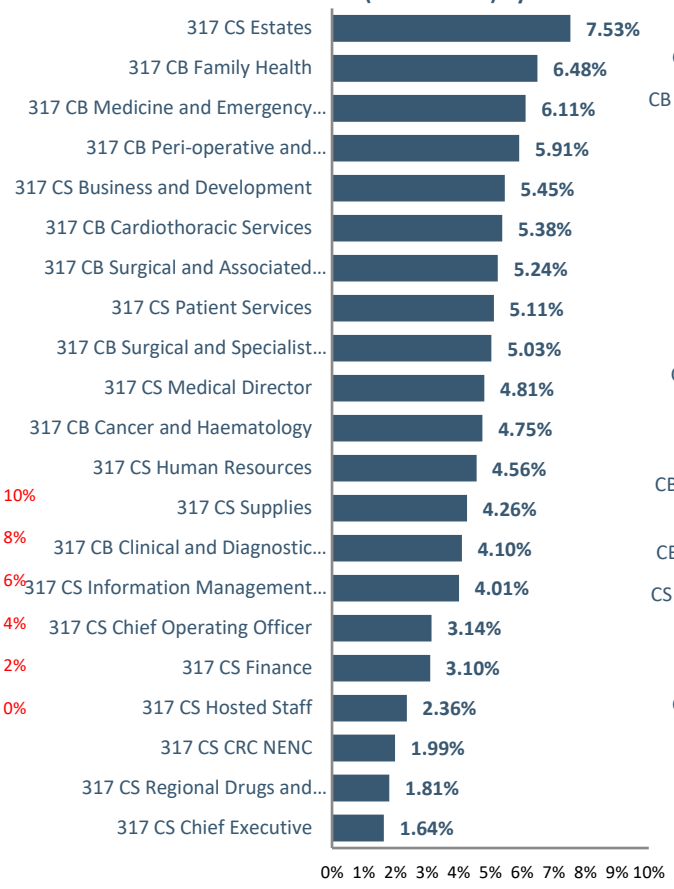
262,995

Compared to the previous year.

Sickness Absence by Staff Group

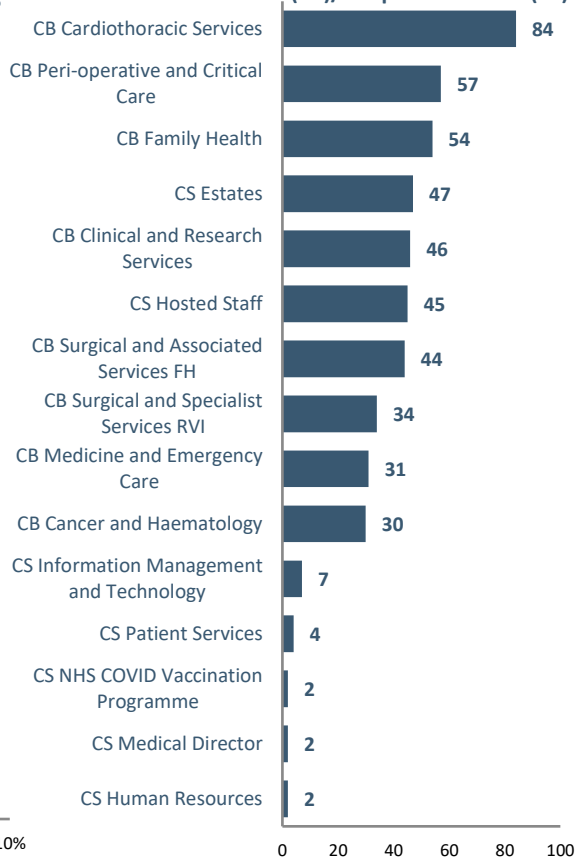


Sickness Absence (% Time Lost) by Clinical Board



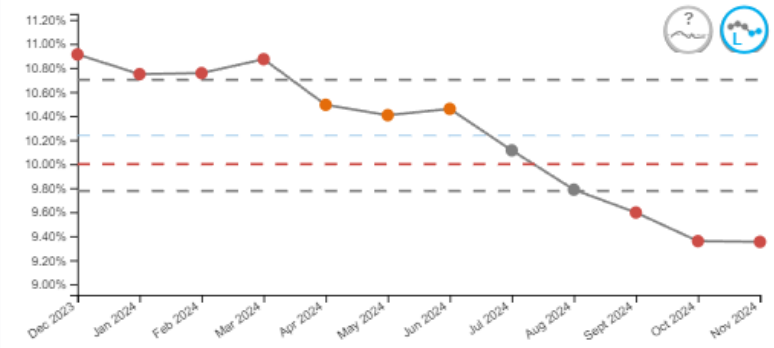
Sickness - Formal Action

Attendance Management – Formal Action by Clinical Board (CB)/ Corporate Service (CS)



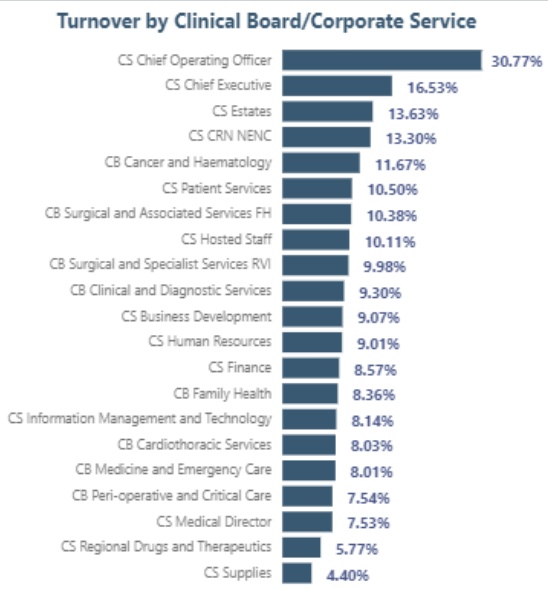
Turnover (1/2)

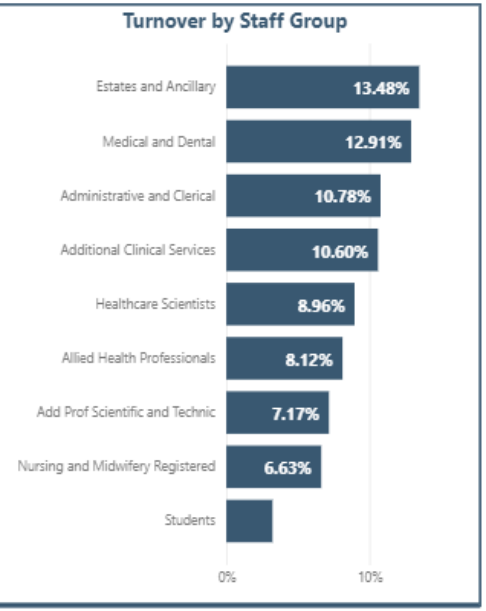
Trust Turnover %	12-Month Rolling	Value	Target
	Nov 24	9.32%	10.00%



Assurance: Hit or Misses Target

Variation: Common Cause Improving Variation





Current Position:

- 12-month average to November 9.32%.
- Chart shows performance is now meeting target with consistent downward trajectory.
- November 2024 shows reduction of 0.25% from September which is illustrated by continued positive outlier flags (red dots).

Underlying Issues

- 1,536 leavers in 12-months to November 2024: 23% were Nursing & Midwifery (359) and Additional Clinical Services 19% (299).
- Top destinations – No Employment (611, 40%); Other NHS organisation (493, 32%).
- Top reasons – Work life Balance (274, 18%); Retirement Age (210, 14%); Relocation (199, 13%)

Actions Undertaken:

- Flexible working – offer in place and encouraged.
- Exit process – under review; and 'stay conversations' being explored. Pilot to encourage exit interviews and facilitate stay conversations ongoing within Surgery & Associated Services and to be piloted within Medicine.
- Monitoring – daily information available to managers via People Dashboard; monthly performance reviews held with Clinical Boards; monthly meetings held between Human Resources (HR) and Clinical Boards/Corporate Services.

Turnover (2/2)

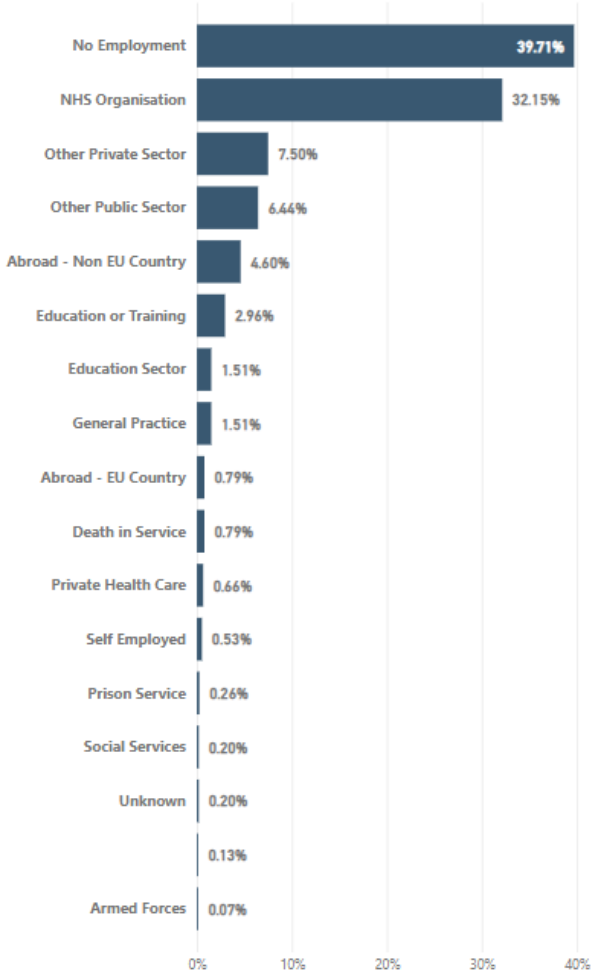
Trust Turnover %	12-Month Rolling	Value	Target
	Nov 24	9.32%	10.00%

Leaving Reasons

Leaving Reasons

Leaving Reason	Leaving Reason %
Voluntary Resignation - Work Life Balance	17.95%
Retirement Age	13.74%
Voluntary Resignation - Relocation	12.89%
Flexi Retirement	9.53%
Voluntary Resignation - Promotion	9.14%
End of Fixed Term Contract	5.79%
Voluntary Resignation - Health	5.39%
Voluntary Resignation - To undertake further education or training	4.08%
Voluntary Resignation - Incompatible Working Relationships	4.01%
Voluntary resignation - Pay and Reward Related	3.35%
Voluntary Resignation - Lack of Opportunities	2.50%
Dismissal - Capability	1.84%
End of Fixed Term Contract - Other	1.58%
Voluntary Resignation - Child Dependants	1.51%
End of Fixed Term Contract - Completion of Training Scheme	1.25%
Death in Service	0.99%
Dismissal - Conduct	0.85%
Voluntary Resignation - Other/Not Known	0.79%
Retirement - Ill Health	0.72%
Voluntary Early Retirement - with Actuarial Reduction	0.46%
Voluntary Resignation - Adult Dependants	0.39%
End of Fixed Term Contract - End of Work Requirement	0.33%
Dismissal - Statutory Reason	0.26%
End of Fixed Term Contract - External Rotation	0.20%
Voluntary Early Retirement - no Actuarial Reduction	0.20%
Redundancy - Voluntary	0.13%
Bank Staff not fulfilled minimum work requirement	0.07%
Employee Transfer	0.07%

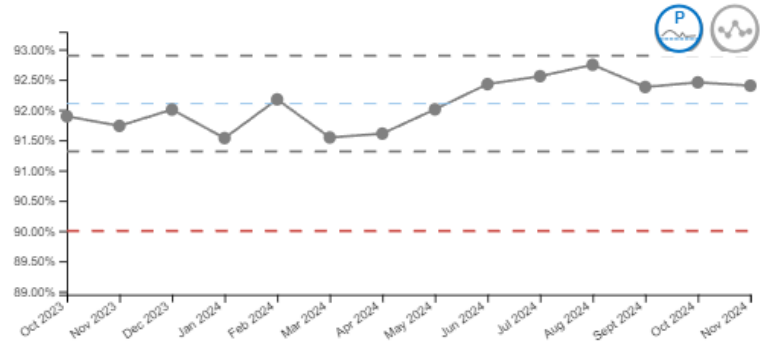
Destination on Leaving



Destination On Leaving	Destination On Leaving %
No Employment	39.71%
NHS Organisation	32.15%
Other Private Sector	7.50%
Other Public Sector	6.44%
Abroad - Non EU Country	4.60%
Education or Training	2.96%
Education Sector	1.51%
General Practice	1.51%
Abroad - EU Country	0.79%
Death in Service	0.79%
Private Health Care	0.66%
Self Employed	0.53%
Prison Service	0.26%
Social Services	0.20%
Unknown	0.20%
	0.13%
Armed Forces	0.07%

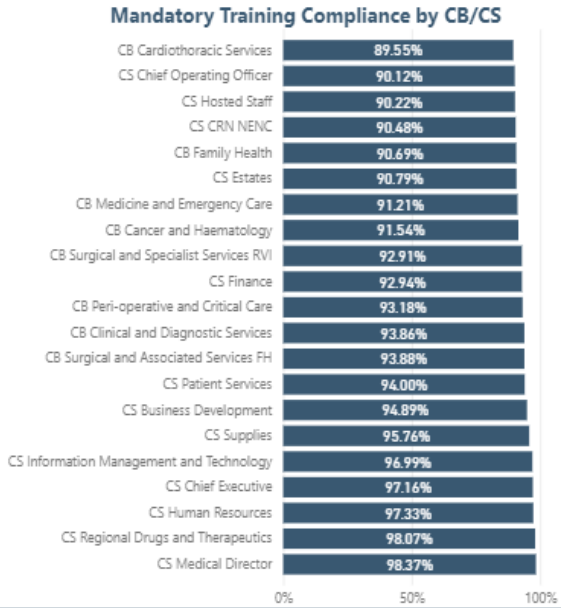
Mandatory Training (1/2)

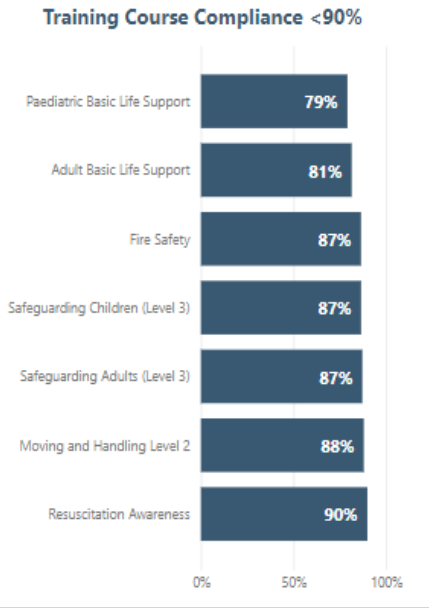
Mandatory Training Compliance	Month	Value	Target
	Nov 24	92.40%	90.00%



Assurance: Consistently Hit Target

Variation: Common Cause Variation





Current Position:

- Chart shows improvement with overall target consistently hit.

Underlying Issues

- Medical and Dental – have lowest overall compliance (84%) with low compliance in Adult Basic Life Support (69%), Paediatric Basic Life support (73%); Fire Safety (75%).
- Paediatric Life Support – overall compliance low at 79% for November 2024.
- Safeguarding Level 3 – improvement proposals presented at Learning and Education Group in November. Audiences and competency levels agreed, training needs analysis has been completed. E-learning package currently being redesigned for launch early 2025.
- Oliver McGowan – a regional pilot of Tier 1 and Tier 2 training has allowed the Trust to access a limited number of free places at both levels, feedback is due in early-January.

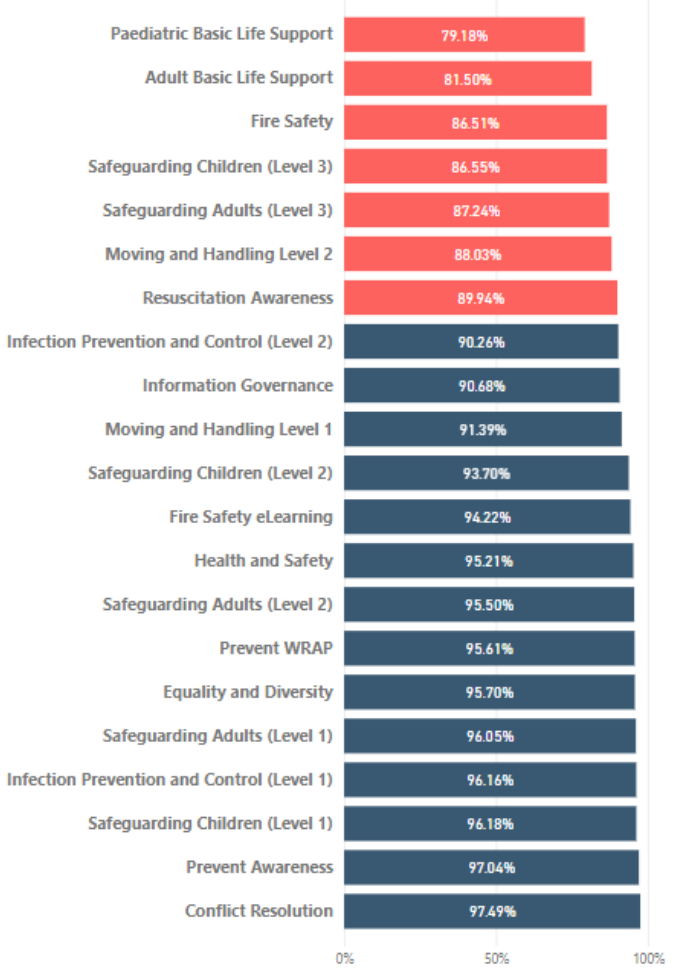
Actions Undertaken:

- Low compliance – automated email reminders and escalation route via managers in place; subject areas subject to a focussed improvement project.
- Resus – additional staffing capacity identified and team targeting hotspot areas.
- Statutory & mandatory training national review – a national policy framework is in development and likely to be introduced in 2025, this will replace Trust policy and align us to a national approach.
- National Subject Matter Expert Groups – being convened to lead the development of national packages/content and approaches.

Mandatory Training (2/2)

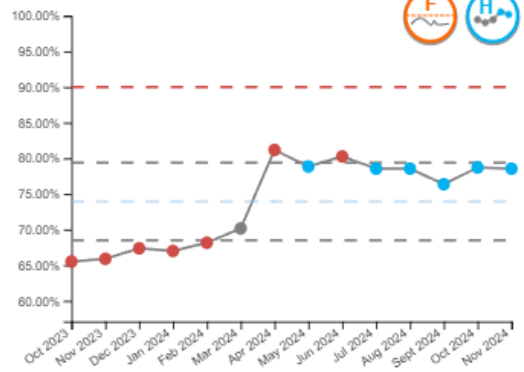
Mandatory Training Compliance	Month	Value	Target
	Nov 24	92.40%	90.00%

Training Course Compliance %

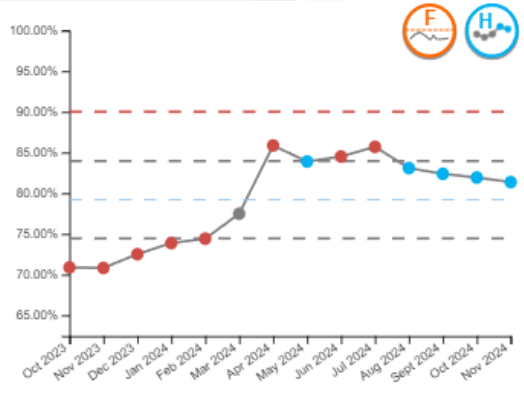


Lowest 4 Mandatory Training Compliance %

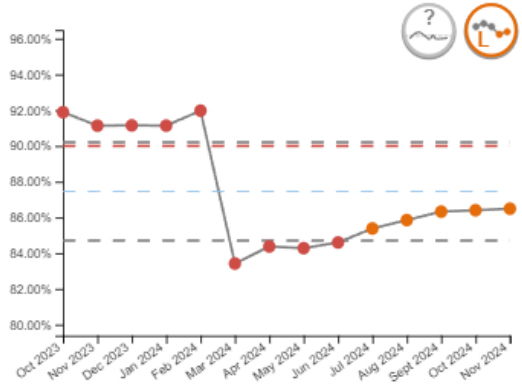
Paediatric Life Support 79%



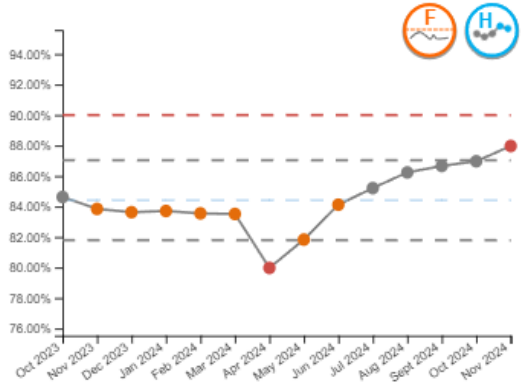
Adult Life Support 81%



Fire Safety 86%

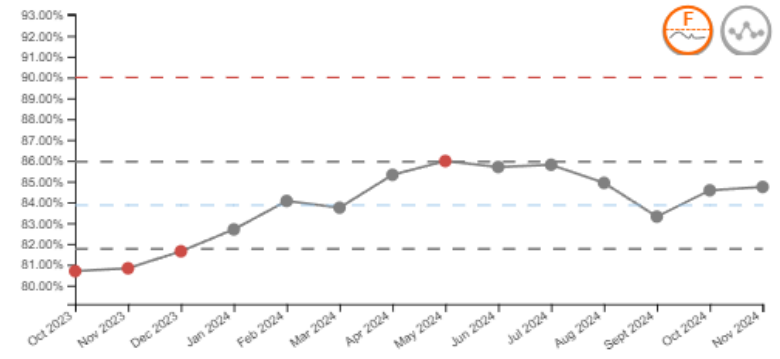


Moving and Handling Level 2 88%



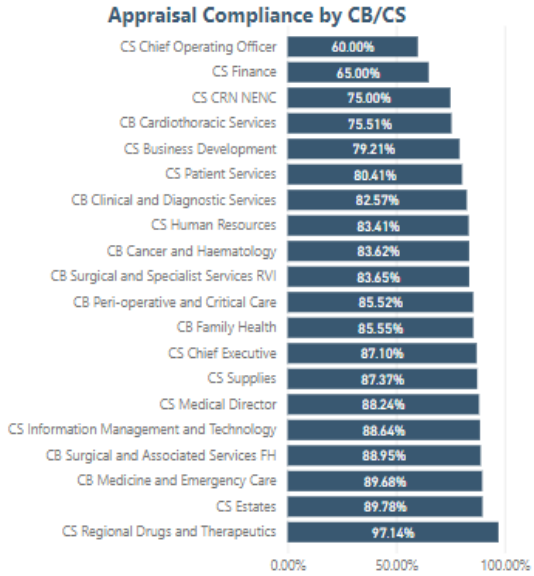
Appraisal Compliance

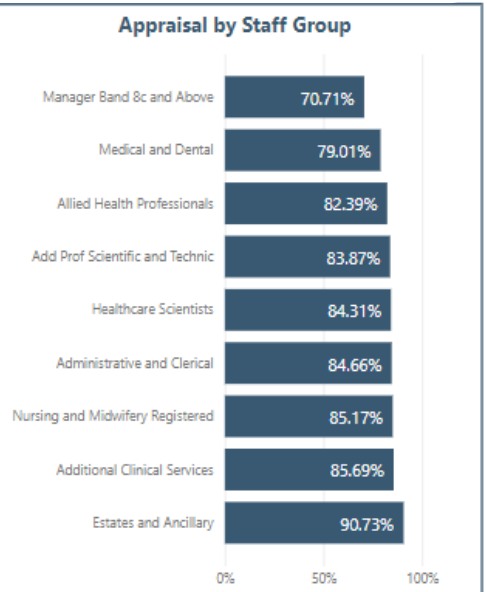
Appraisal Compliance	Month	Value	Target
	Nov 24	84.74%	90.00%



Assurance: Consistently Fail Target

Variation: Common Cause Variation





Current Position:

- Chart shows performance is not meeting target.
- April-July 2024 showed consistent performance illustrated by positive outlier flags (red dots, followed by a reduction in August & September, but regained improvement in October and November.

Underlying Issues

- 2,099 appraisals are overdue with highest numbers in Nursing and Midwifery (680) and Admin and Clerical (344).
- Clinical Board percentage compliance ranges from 75.64% to 89.74%.
- Corporate Service percentage compliance ranges from 60.00% to 97.14%.

Actions Undertaken:

- New appraisal process to launch from April 2025 and will include reminder system.

Bank Utilisation – (£)

Bank Utilisation (£)	12-Month period ending	Total Bank Expenditure (£)	Total Bank Difference (£)
	Nov 24	£17,067,875	-£948,550

Bank Utilisation (£)

Staff Group	Dec 22 to Nov 23	Dec 23 to Nov 24	Total Hours
Admin & Clerical	£1,114,835	£260,109	-£854,726
Ancillary	£385,589	£1,172,087	£786,498
Estates			
Nursing & Midwifery (Registered)	£6,399,339	£5,574,715	-£824,624
Nursing & Midwifery (Unregistered)	£8,965,898	£9,213,317	£247,419
Professional & Technical	£1,150,764	£847,647	-£303,117
Total	£18,016,425	£17,067,875	-£948,550

Current Position:

- Bank Usage has continued to reduce in the 12 months to November 2024 (£17,067,875) compared with the previous period ending November 2023 (£18,016,425).

Underlying Issues

- Notable reductions in Nursing & Midwifery (registered), Admin & Clerical and Professional & Technical.
- Notable increases in Ancillary and Nursing & Midwifery (unregistered).
- Ancillary costs due to recruitment and retention, and sickness absence.

Actions Undertaken:

- Work continues to reduce bank usage with effective rostering and direction.
- Aiming to reduce agency use for HCAs to zero by April 2025 by increasing bank, establishing a core team of HCAs on the bank to support deployment to areas requiring enhanced care, review and validation of enhanced care requirements through audit/training/ observation.

Agency Utilisation – (£)

Agency Utilisation (£)	12-Month period ending	Total Agency Expenditure (£)	Total Agency Difference (£)
	Nov 24	£3,783,388	-£542,747

Agency Utilisation (£)

Staff Group	Dec 22 to Nov 23	Dec 23 to Nov 24	Total Hours
Admin & Clerical	£615,061	£267,604	-£347,457
Ancillary	£15,211	£21,315	£6,105
Estates	£58,830	£16,291	-£42,539
Nursing & Midwifery (Registered)	£162,267	£255,611	£93,344
Nursing & Midwifery (Unregistered)	£2,626,876	£2,104,204	-£522,672
Professional & Technical	£847,891	£1,118,363	£270,472
Total	£4,326,135	£3,783,388	-£542,747

Current Position:

- Agency Usage has continued to reduce in the 12 months to November 2024 (£3,783,388) compared with the previous period ending November 2023 (£4,326,135).

Underlying Issues

- Notable reductions in Nursing & Midwifery (unregistered), Admin & Clerical and Estates
- Notable increases in Professional & Technical and Nursing & Midwifery (registered)
- Registered nurse agency use – hotspots in Theatres and Cardiothoracic Services for scrub and anaesthetic nurses until newly appointed staff meet the required competences. Pressures also continue for Nurse Practitioners.
- Professional and Technical increase due to pressure and recruitment in radiography and pathology.

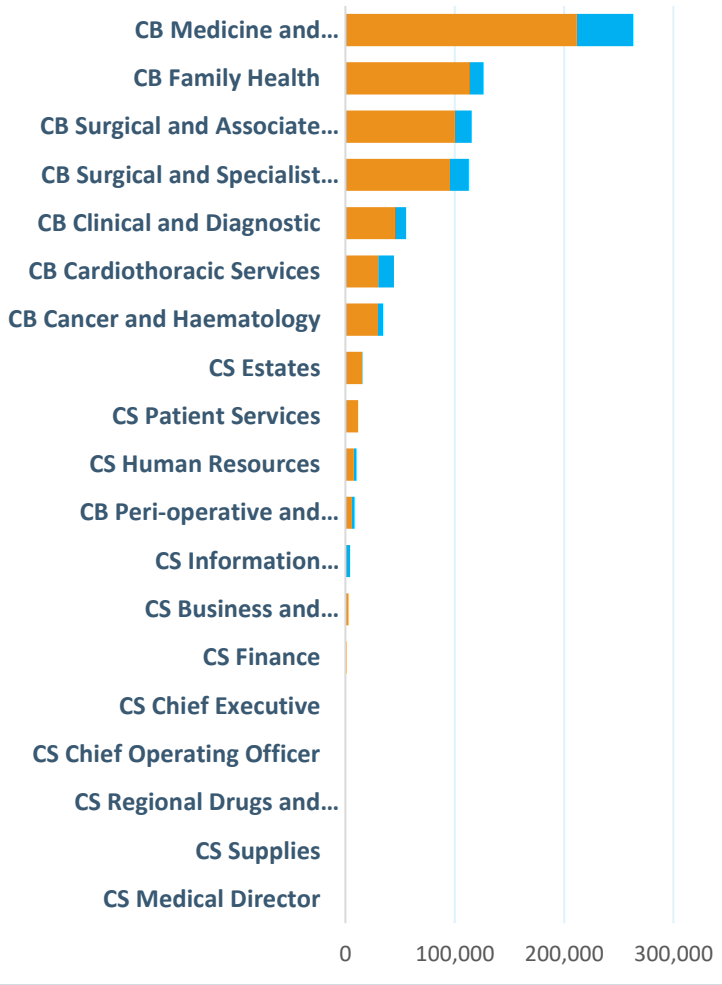
Actions Undertaken:

- Increasing bank availability to reduce agency use.
- Agency usage reviewed and challenged monthly.

Bank & Agency Utilisation - Hours

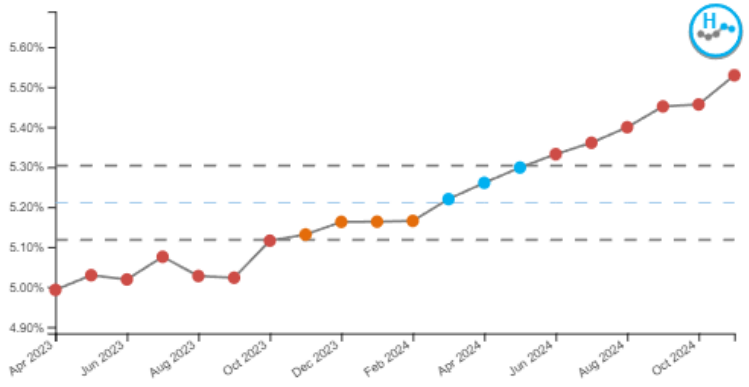
Bank & Agency	12-Month period ending	Total Bank and Agency Hours
	Nov 24	808,124

Clinical Board	Bank Hours	Agency Hours	Total Hours
CB Medicine and Emergency Care	211,602	51,832	263,434
CB Family Health	113,334	13,147	126,481
CB Surgical and Associate Services FH	100,115	15,470	115,584
CB Surgical and Specialist Services RVI	95,134	17,874	113,008
CB Clinical and Diagnostic	45,377	10,249	55,626
CB Cardiothoracic Services	30,070	14,342	44,411
CB Cancer and Haematology	29,228	5,221	34,449
CS Estates	15,527	147	15,673
CS Patient Services	11,649	0	11,649
CS Human Resources	7,633	2,494	10,127
CB Peri-operative and Critical Care	5,570	2,792	8,362
CS Information Management and Technology	0	4,453	4,453
CS Business and Development	2,950	0	2,950
CS Finance	1,005	0	1,005
CS Chief Executive	616	0	616
CS Chief Operating Officer	284	0	284
CS Regional Drugs and Therapeutics	13	0	13
CS Medical Director	0	0	0
CS Supplies	0	0	0

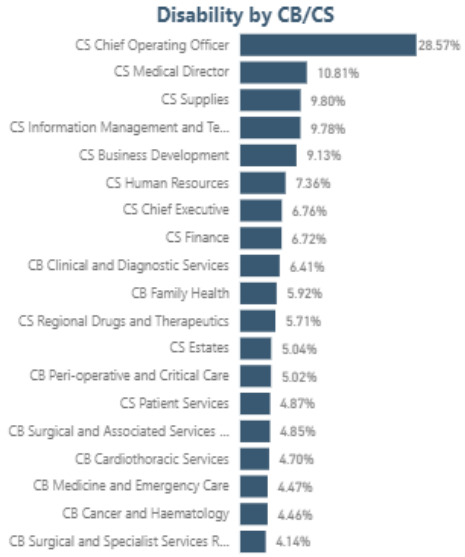


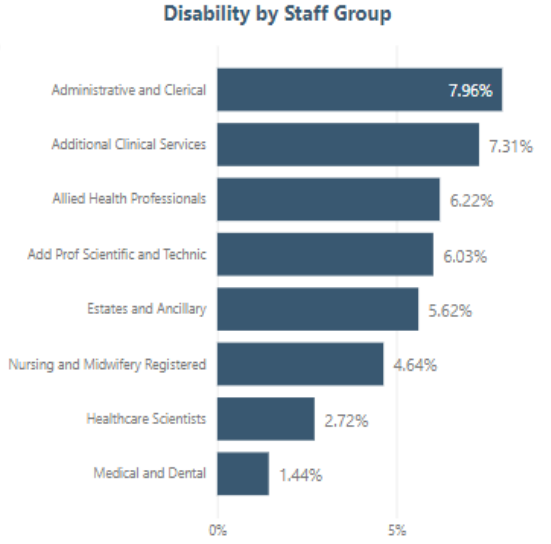
Equality, Diversity and Inclusion (EDI) - Disability

EDI - Disability	Month	Value	Trust Headcount
	Nov 24	5.53%	16,385

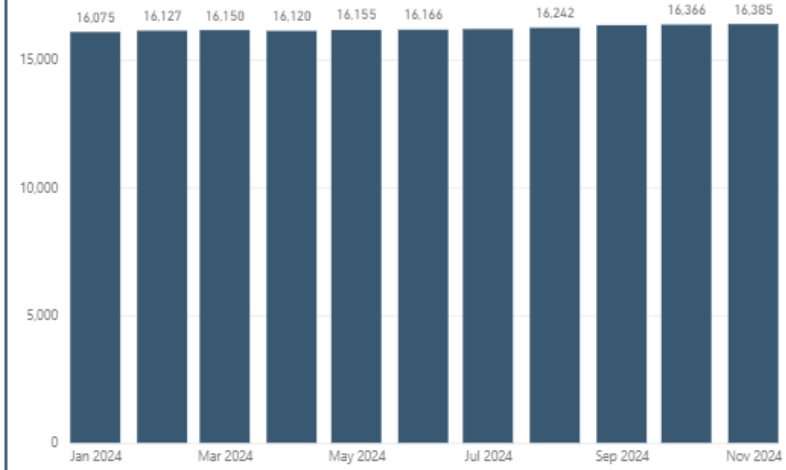


Variation: Common Cause Improving Variation





Trust Headcount Trend



Age Band

	Age Band	Disability %
1	<=20 Years	11.68%
2	21-25	10.47%
3	26-30	6.79%
4	31-35	5.80%
5	36-40	4.10%
6	41-45	4.43%
7	46-50	4.08%
8	51-55	4.64%
9	56-60	5.52%
10	61-65	5.03%
11	66-70	3.43%
12	>=71 Years	5.00%

Current Position:

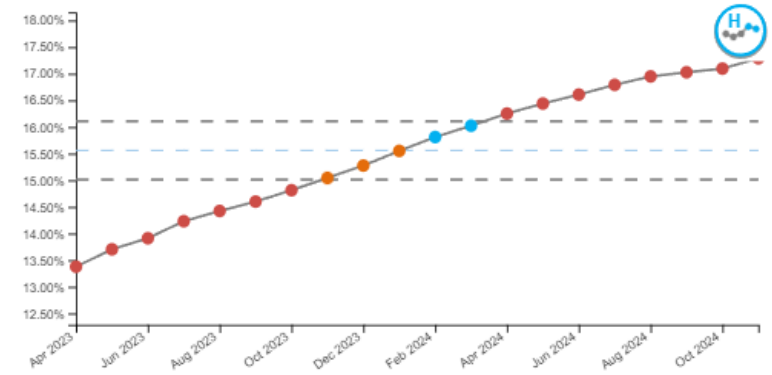
Charts show percentage of staff in post each month by those disclosing a disability.

Percentage of staff employed disclosing a disability continues to demonstrate a month-on-month increase with the latest reporting period increasing to 5.53%.

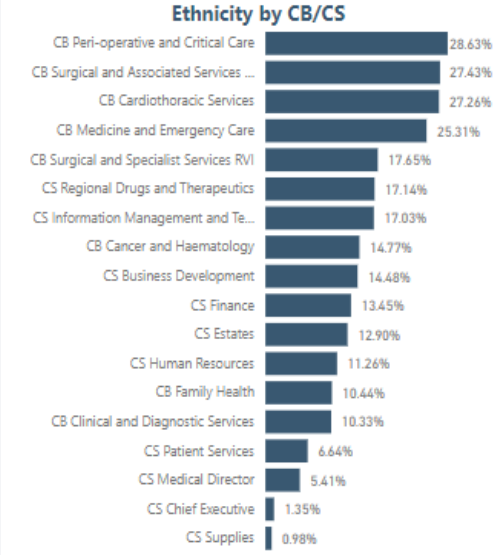
Percentage of staff who have not disclosed their status is 11%. An Equality Diversity and Inclusion (EDI) campaign is in place from October to encourage staff to update their EDI record in ESR.

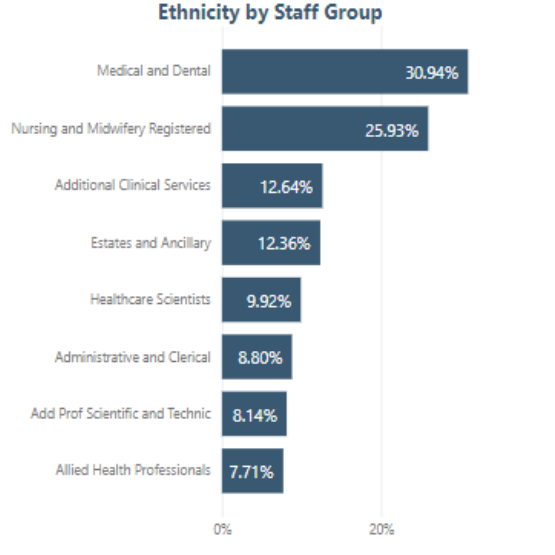
Equality, Diversity and Inclusion (EDI) - Ethnicity

EDI - Ethnicity	Month	Value	Trust Headcount
	Nov 24	17.29%	16,385

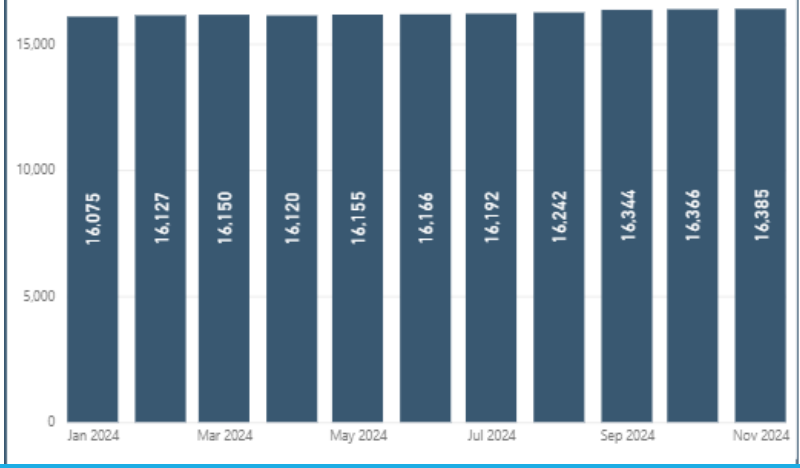


Variation: Common Cause Improving Variation





Trust Headcount Trend



Age Band

	Age Band	BME %
1	<=20 Years	15.33%
2	21-25	19.97%
3	26-30	23.95%
4	31-35	23.83%
5	36-40	21.02%
6	41-45	13.68%
7	46-50	19.84%
8	51-55	15.41%
9	56-60	7.99%
10	61-65	4.42%
11	66-70	5.58%
12	>=71 Years	3.33%

Current Position:

Charts show percentage of staff in post each month by ethnicity (BAME).

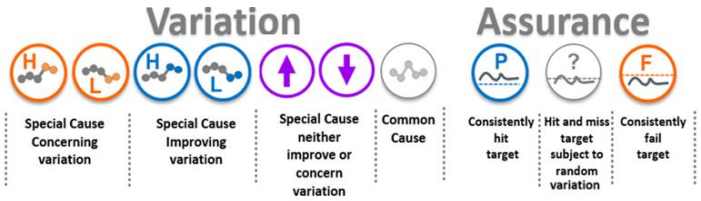
Percentage of BAME staff continues to demonstrate a month-on-month increase with the latest position reflecting BAME staff at 17.29% of the workforce.

Percentage of staff who have not disclosed their status is very low at 1%. An EDI campaign is in place from October to encourage staff to update their EDI record in ESR.

Finance

Finance Overview

Metric	Period	Actual	Plan
Income	Nov-24	£1,127.1m	£1,093.1m
Expenditure	Nov-24	£1,133.6m	£1,096.6m
Surplus /(Deficit)	Nov-24	(£6.5m)	(£3.5m)
I&E Margin	Nov-24	(0.6%)	(0.3%)
Cost Improvement – Recurrent	Nov-24	£21.8m	£44.3m
Cost Improvement – Non-Recurrent	Nov-24	£39.6m	£17.9m
Elective Income	Nov-24	£216m	£214m
Capital (CDEL)	Nov-24	£20.3m	£16.9m



Income & Expenditure

- Total income is £33.9 million ahead of plan, with pass through drugs, devices and deferred income at £24.3 million ahead of plan.
- Total expenditure is £34.7million ahead of plan, off-set by income above and pressure of Industrial Action, drugs growth and CIP.

Cost Improvement

- There is reliance on non-recurrent measures to bridge the recurrent CIP gap of £22.4 million.

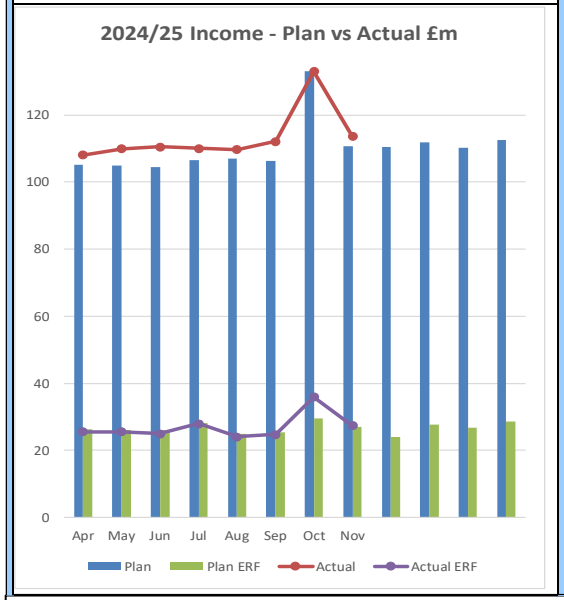
Elective Income

- The trust is ahead on the ERF income by around £2.2 million.

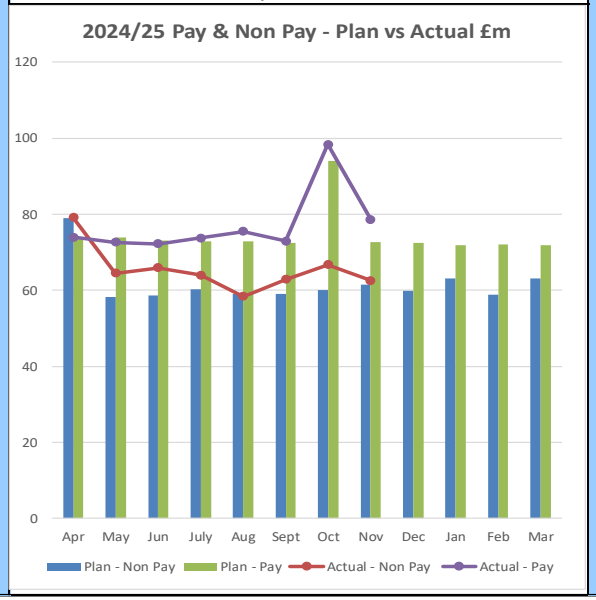
Overall Finance Position (1/4)

Financial Overview as at 30th November 2024

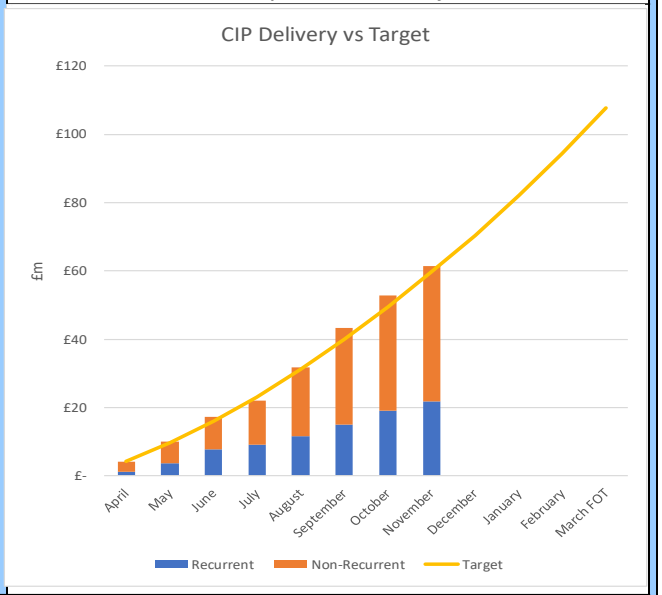
Income



Expenditure



Cost Improvement Analysis



This page summarises the financial position of the Trust for the period ending 30th November 2024. The Trust has agreed a Financial Plan for 2024/25 with a break-even position. As at Month 8 the Trust is reporting an overspend of £3 million against the planned deficit of £3.5 million (after Control Total). This variance relates to the additional cost of the Junior Doctors Strike and the impact of the Pay Award (funding less than the costs incurred). The financial information includes the costs of the Consultant Pay Reform agreement for 2023/24 paid in May, with a pressure on drugs, partly off-set with income. The delivery of the plan has a significant Cost Improvement Plan (CIP) and includes a number of non-recurrent factors. The graphs reflect the income and expenditure associated with the backdated Pay Award being paid in October.

Capital Expenditure - The Plan for November is £16.9 million and the year to date expenditure is £20.3 million creating a variance of £3.4 million to date.

Risks -

- Delivery of the required levels of activity compared with 2019/20 activity levels - Red
- Reliance on non-recurrent income and expenditure benefits - Amber
- Achievement of CIP targets - Amber
- Assumptions relating to inflation, subject to change and unfunded - Amber

Overall Finance Position (2/4)

Income & Expenditure Statement	In Month (November 2024)			Year To Date (November)		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Operating income from patient services	119,346	120,046	700	948,488	966,527	18,038
Other Patient Care - & Non NHS	2,315	2,556	241	18,524	20,960	2,436
Non Patient Care - Other Income	16,087	18,350	2,262	124,151	132,778	8,627
TOTAL OPERATING INCOME (WITHIN EBITDA)	**137,749**	**140,952**	**3,203**	**1,091,163**	**1,120,264**	**29,101**
Employee expenses	75,054	78,672	3,619	607,818	618,151	10,333
Drugs	24,604	21,380	(3,224)	186,285	193,822	7,537
Supplies & Services Clinical	13,666	16,482	2,816	107,594	117,556	9,962
Operating expenses excl. employee expenses	18,213	18,673	459	140,722	151,207	10,484
TOTAL OPERATING EXPENSES (WITHIN EBITDA)	**131,537**	**135,207**	**3,670**	**1,042,420**	**1,080,736**	**38,317**
NET FINANCE COSTS	**5,387**	**5,157**	**(230)**	**63,132**	**52,244**	**(10,888)**
OPERATING SURPLUS/(DEFICIT)	**825**	**589**	**(236)**	**(14,388)**	**(12,717)**	**1,671**
Control Total & IFRS16 PFI Adjustments	1,072	1,186	115	(10,904)	(6,224)	4,680
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR - CONTROL TOTAL	**(247)**	**(597)**	**(351)**	**(3,484)**	**(6,493)**	**(3,009)**

The reported performance for November 2024 is as follows:-

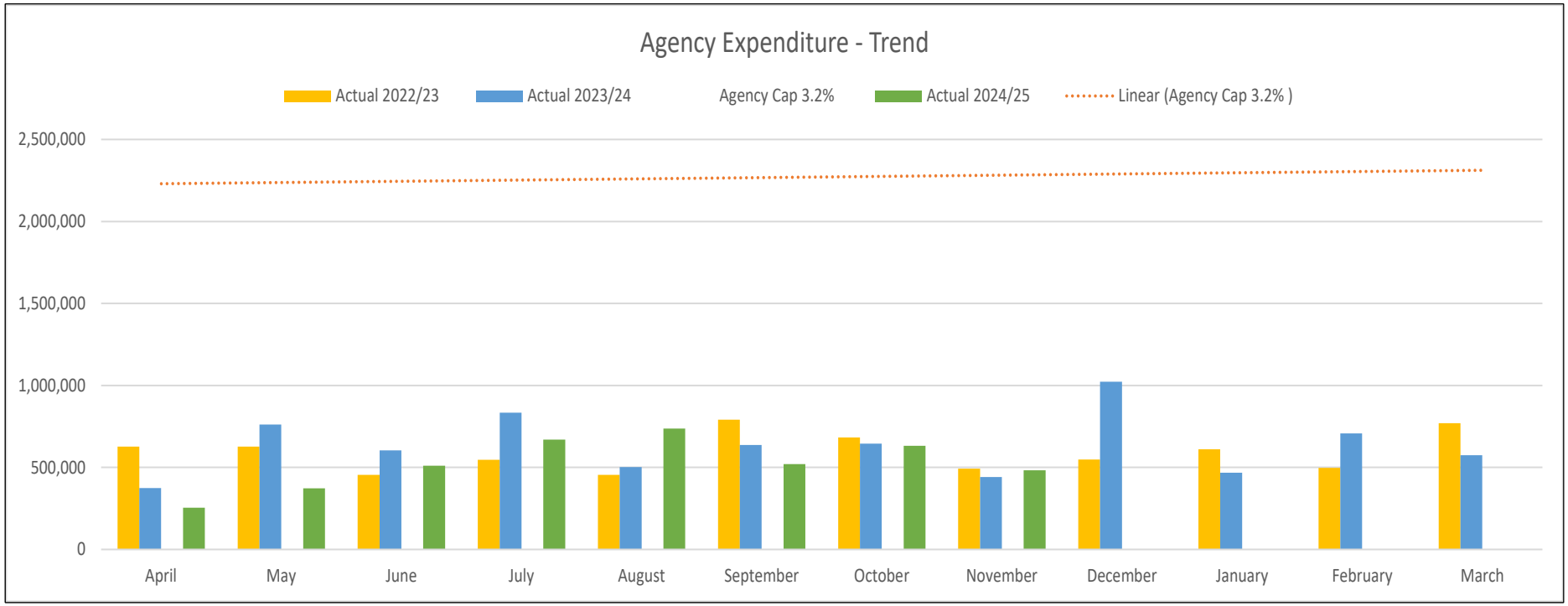
Income

- The in-month position is an overall favourable variance of £3,203k partly due to over-performance on matched drugs and devices and an over achievement on Non-recurrent income CIP. ERF income is on plan despite the impact of industrial action.

Expenditure

- Pay costs are £10.3m over plan at month 8 and include the costs associated with industrial action. Total operating expenditure is £28m above plan due to increased costs relating to drugs and clinical supplies (including circa £17m that is matched with income) and unachieved CIP (£18m behind on expenditure).

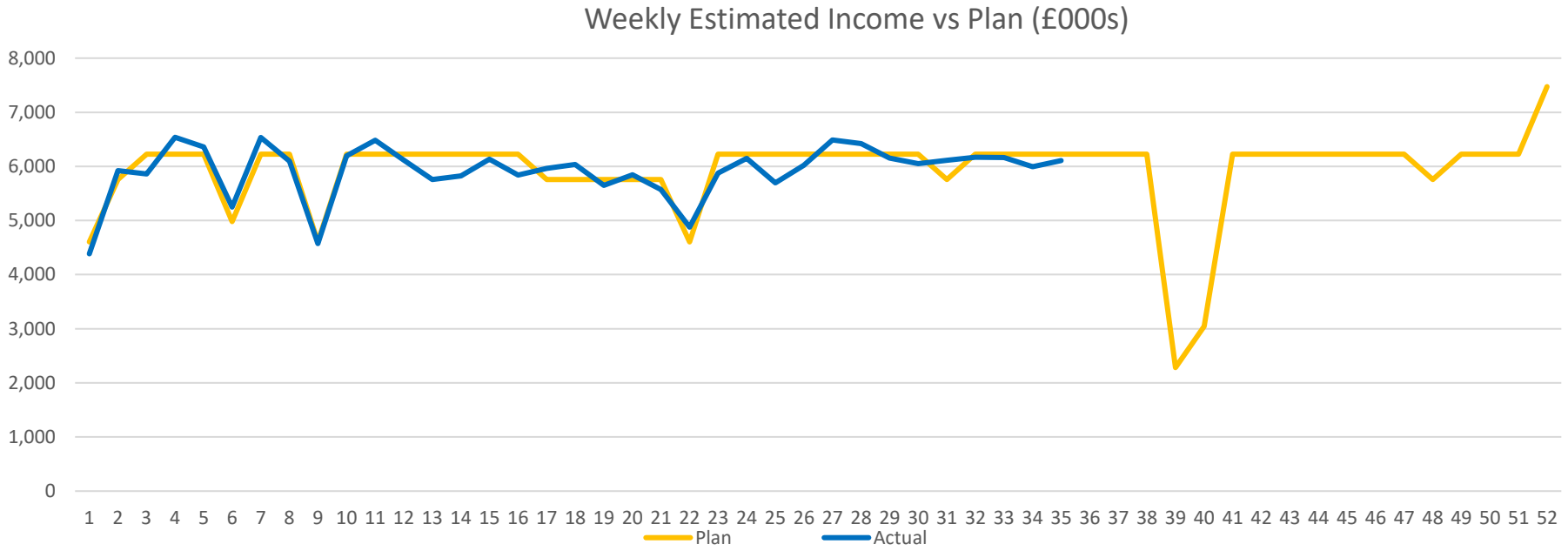
Overall Finance Position (3/4)



Agency

- This shows the overall trend in agency usage over the last two years. This is running at around 0.5% of the gross staff costs. This is below the national target set at 3.2%. Although this is positive compared with the national target, there continues to be medical agency usage across a number of specialties where it is proven difficult to recruit on a permanent/substantive basis. This will continue to be managed and monitored on an ongoing basis to reduce the reliance on agency, with a decrease in November (Month 8) compared to previous months.

Overall Finance Position (4/4)



Elective Recovery Performance

Background

- Elective income (Ordinary Elective, Day Case, Outpatient New and Outpatient Procedure Income) is paid on a tariff basis
- The Clinical Boards have committed to deliver a plan of £318m which is £4m higher than the nationally set target for elective activity. The graph above shows estimated performance against this plan.
- There is a time lag in recognising income relating to outpatient procedures - outpatient procedures attendances in review appointments default to outpatient reviews (which are outside of the ERF tariff payment) until they coded.

Current Position

- To week 30, total delivery is £1,310k away from the agreed plan (on the basis of the weekly model), however this is expected to improve back to target as outpatient procedures are coded.

Health Inequalities

Overview: Tooth extractions due to dental caries in children aged 0-10

- Tooth decay is the most common reason for hospital admission in children aged between 5 and 9 years. The North East Region had the highest rate of any region in England after Yorkshire and Humber of decayed tooth extraction episode rate per 100,000 population in 0 to 19 year-olds in the financial year 2022 to 2023 (397 per 100K population compared to the national average in England of 236 per 100K population). It is believed that the majority of cases could be prevented with better dental care and dentist intervention.
- According to the 2022 Health Related Behaviour Questionnaire 23.3% of primary students in Newcastle have not visited the dentist in the last year. This was a significant increase from previous years (JSNA Newcastle). In England tooth extractions with a primary diagnosis of tooth decay for 0 to 19 year-olds represented 66% of all tooth extractions for this age group in 2022/2023. A 17% increase has been observed in the number of episodes of decay-related tooth extractions in hospital for 0 to 19 year-olds compared to 2021-2022 (OHID, 2023). In 2022/23 decay-related tooth extraction episode rate for children and young people living in the most deprived communities was nearly 3 and a half times that of those living in the most affluent communities.
- The NHSE Statement on Information on Health Inequalities (duty under section 13SA of the NHS Act 2006) requires trusts to report and publish in their annual report key metrics such as tooth extractions in children aged 10 and under (at the start of the episode of care) due to tooth decay and disaggregated by sex, ethnicity and deprivation. For this report we further disaggregated age for the under 5s and 5-10 to inform targeted interventions for each group. There is also a requirement on provider trusts to address the backlog for tooth extractions in hospital in children aged 10 and younger (the Core 20 Plus 5 Framework for CYP. The indicator we describe here are spells of care rather than finished consultant episodes (FCEs) where a tooth extraction was performed on a child aged 10 years or under at the start of the episode of care, due to tooth decay. A spell is defined as a continuous period of time spent as a patient with the trust and may include more than one episode.
- The data sources used for this section include when mentioned OHID data on Trust catchment population, otherwise it would be and extracts from the inpatient CDS. For the trust data were presented for 2019/2020 (before the COVID Pandemic) and more recently for 2023/2024.

Figure 1: Trend in number of tooth extraction spells due to dental caries in children aged 0-4 & 5-10 (19/20-23/24)

Age Band	2019/20	2020/21	2021/22	2022/23	2023/24	Total
0-4 Years	225	230	217	203	186	**1061**
5-10 Years	960	758	928	961	796	**4403**
Total	**1185**	**988**	**1145**	**1164**	**982**	**5464**

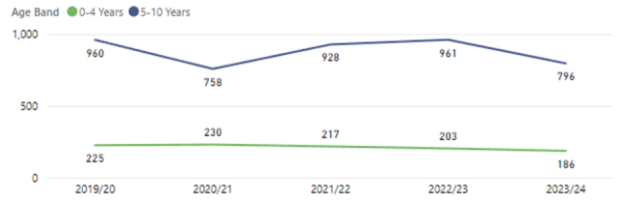
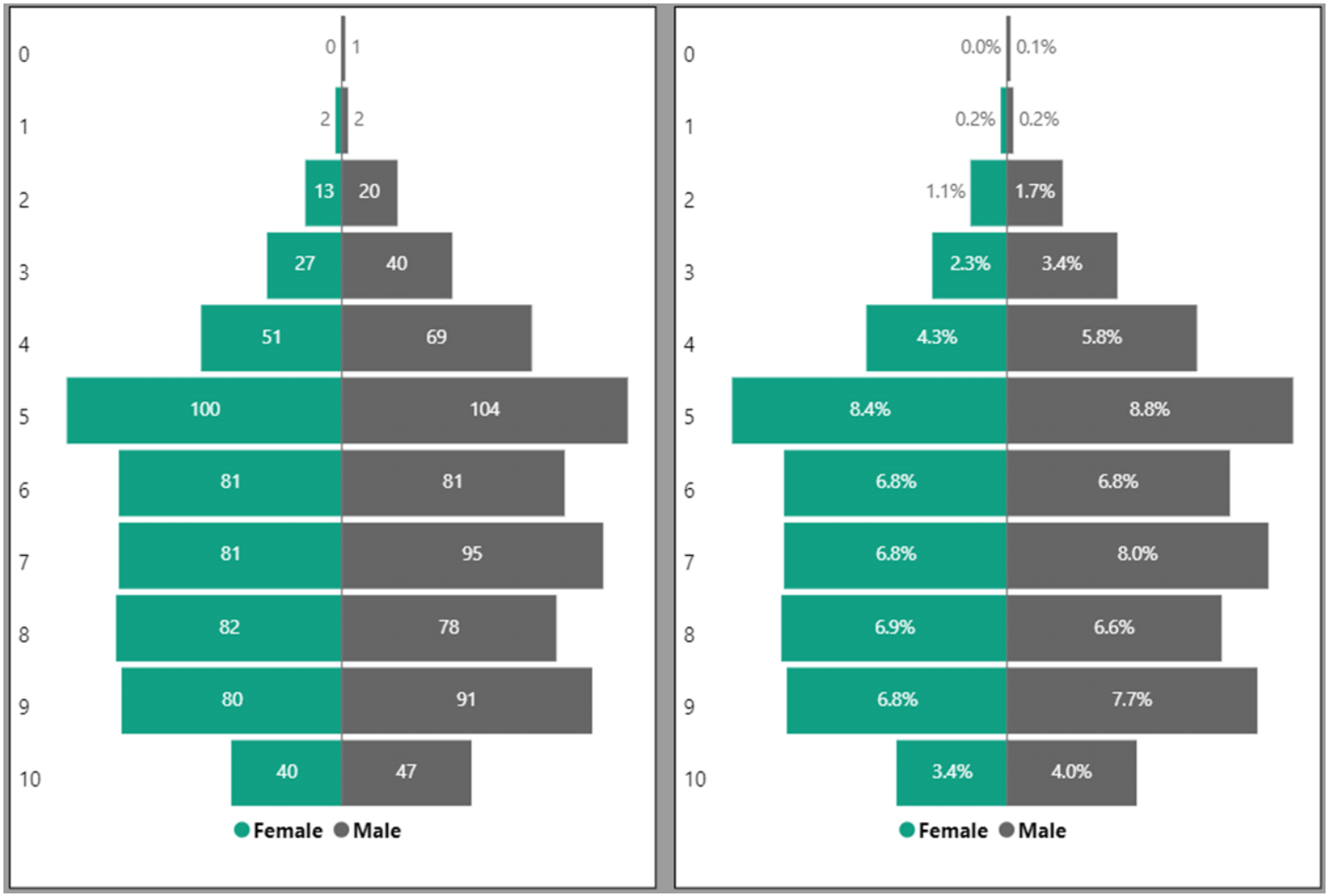


Figure 2: Point of delivery at hospital in tooth extractions due to dental caries in children aged 0-10 (19/20-23/24)

Point of Delivery	2019/20	2020/21	2021/22	2022/23	2023/24	Total
Elective	1.4%	0.9%	2.1%	1.9%	1.8%	**1.6%**
Emergency	1.7%	1.5%	0.7%	1.6%	2.0%	**1.5%**
Non-elective			0.1%			**0.0%**
Successful Day Case	96.2%	96.3%	96.1%	95.4%	95.6%	**95.9%**
Unsuccesful Day Case	0.8%	1.3%	1.0%	1.0%	0.5%	**0.9%**
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

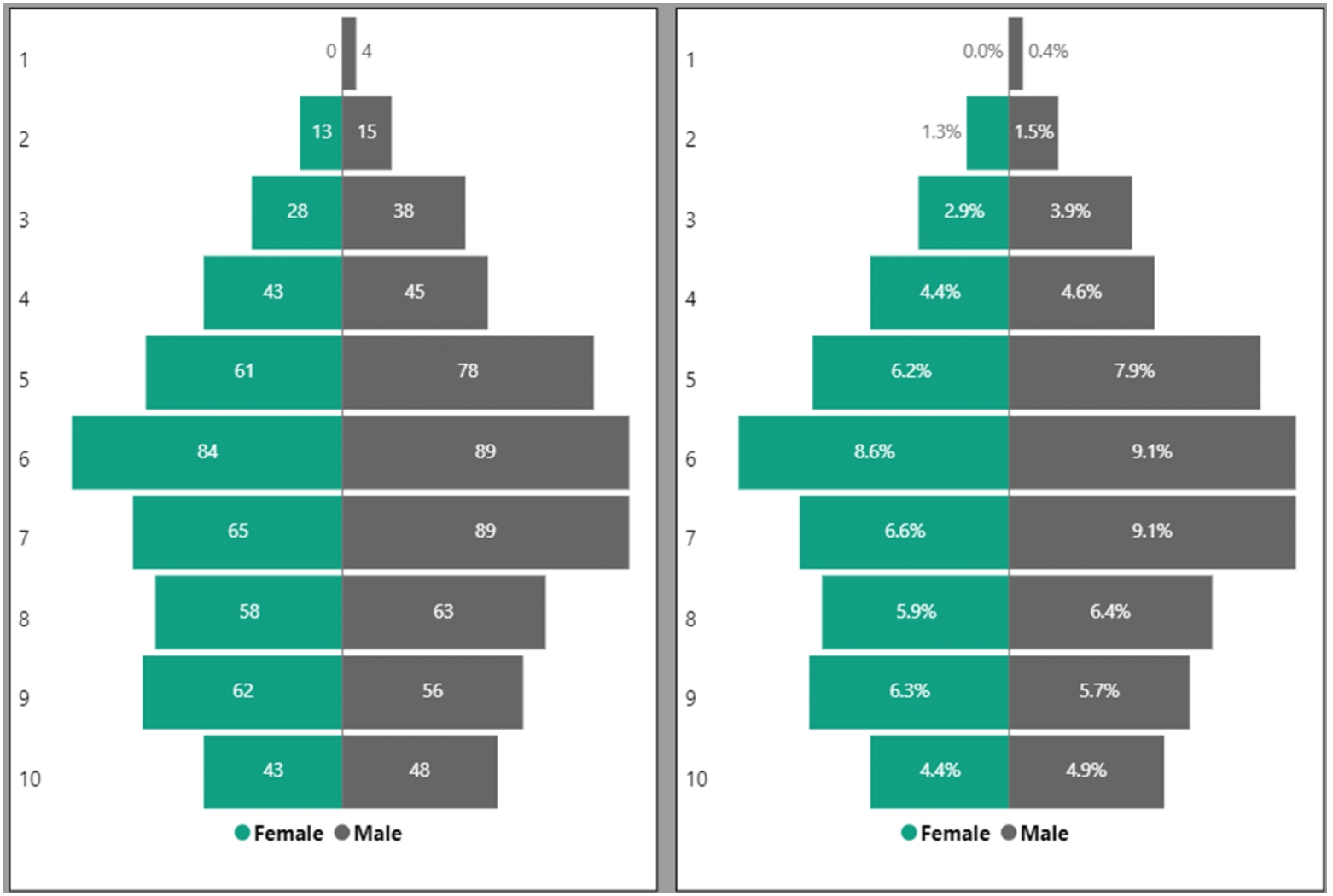
Age/Sex profile – Tooth Extraction in Children (2019/20)

Figure 3: Number & proportion of tooth extraction spells due to dental caries in children aged 0-10 by age band & sex



Age/Sex profile – Tooth Extraction in Children (2023/24)

Figure 4: Number & proportion of tooth extraction spells due to dental caries in children aged 0-10 by age band & sex



Teeth Extraction in children by Index of Multiple Deprivation

Figure 5 – 2019/20

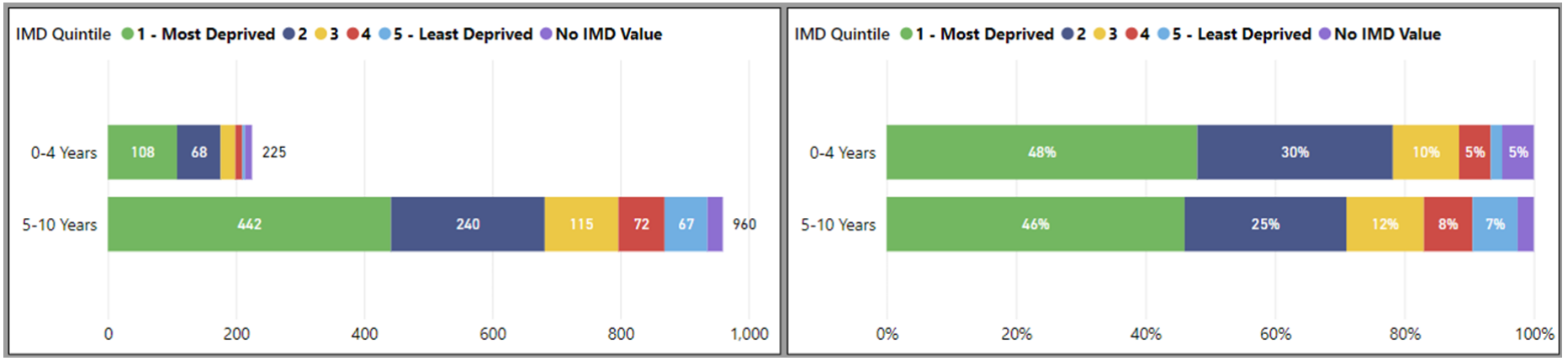
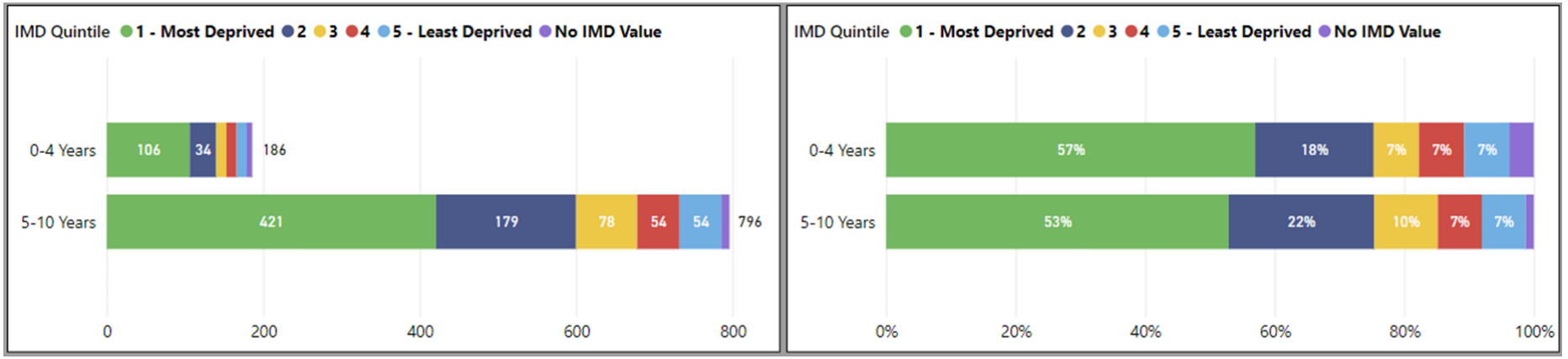
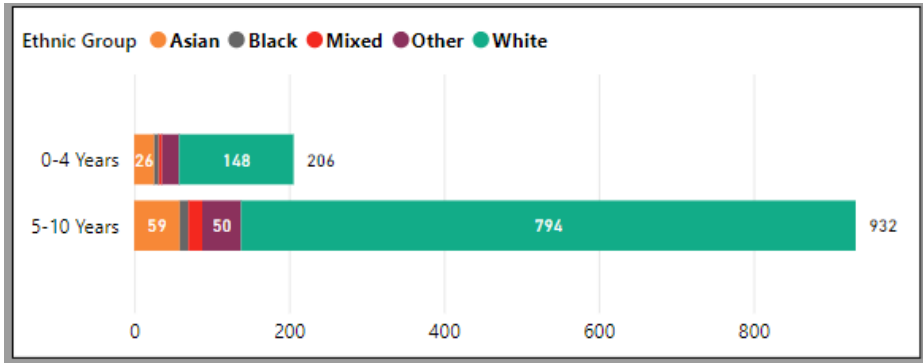


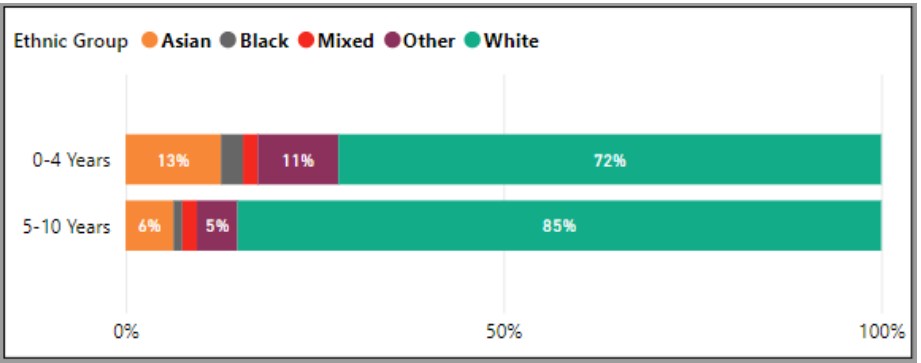
Figure 6 – 2023/24

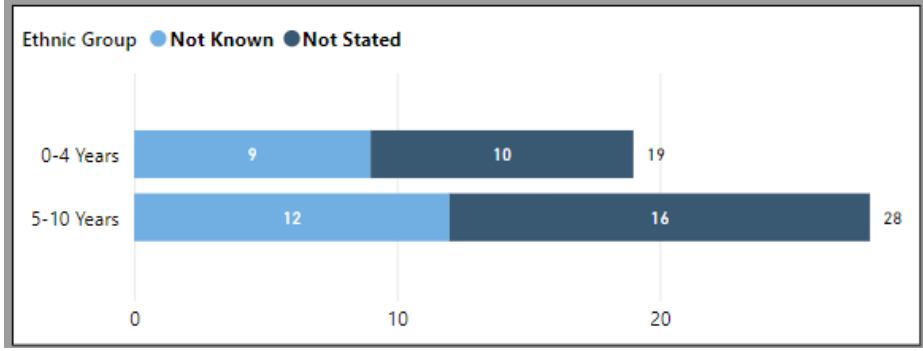


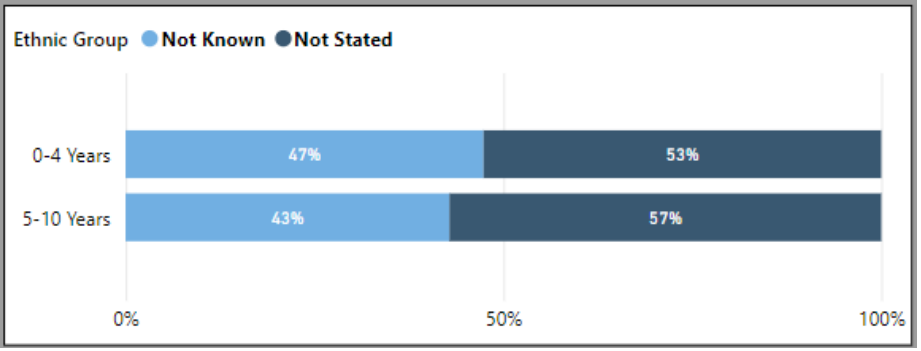
Teeth Extraction in children by Age & Ethnicity

Figure 7 – 2019/20



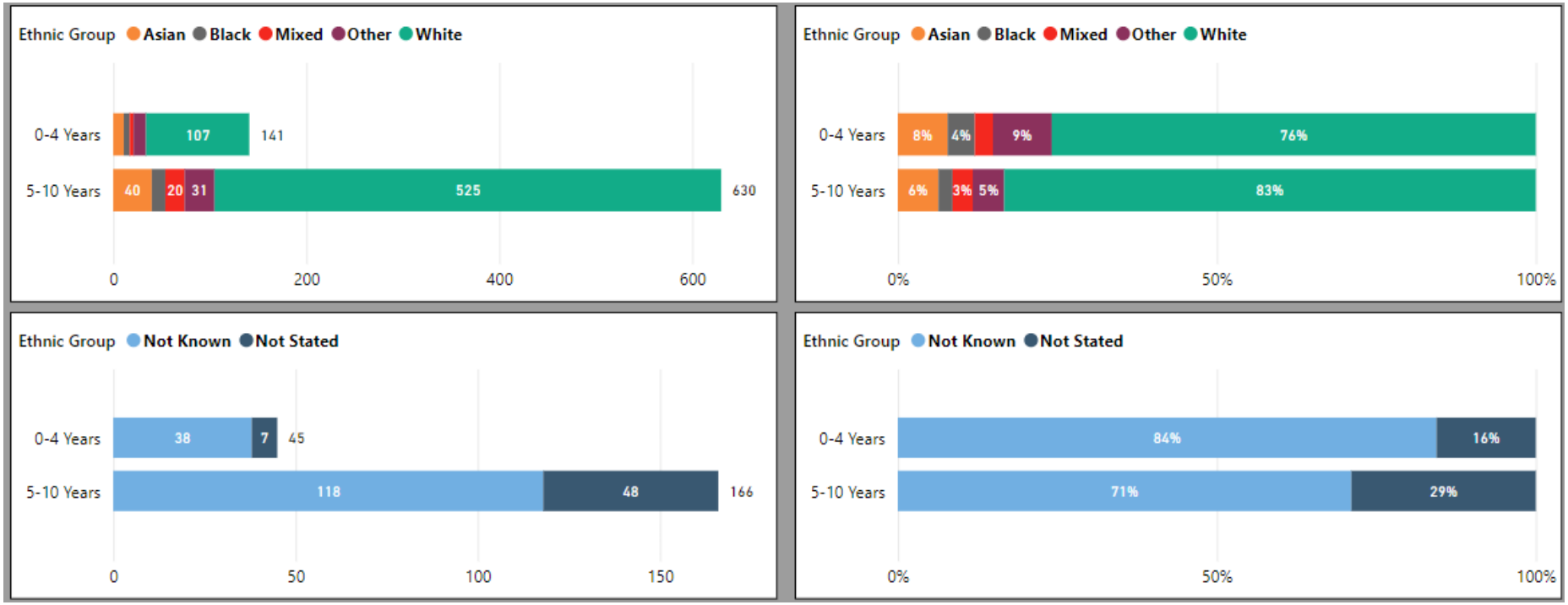






Teeth Extraction in children by Age & Ethnicity

Figure 8 – 2023/24



Health Inequalities Summary

- There has been a 17% reduction in the number of tooth extraction spells due to decay in children aged 10 and younger between 2019/2020 and 2022/2023. Although there has been a downward trend there has been fluctuations with only a very slight decrease in the number of spells between 2021-2023 from that recorded in 2019/2020. Over 95% of all spells are done as day cases (figure 2).
- 94% of all tooth extractions spells due to decay are performed under a General Anaesthetic (data not shown).
- On average just over a third of the activity (32%) relates to Newcastle residents with some variation up and down over the years (data not shown).
- In 2019/2020 and 2023/2024, across all age groups the number of the number of tooth extraction spells due to decay was higher in males compared to females.
- The proportion of spells of tooth extraction due to decay in children aged 4 and under of the total aged 10 and under was the same in both years 2019/2020 and 2023/2024. That is almost 1 in 5 spells of tooth extraction due to decay (19%) in children aged 4 and under.
- What is striking in figures 5 and 6 is the significant socioeconomic disadvantage in children aged 0-10 who have experienced tooth extractions due to dental caries (tooth decay) in 2019/2020 and 2023/2024 comparable to the trust catchment population. The proportion of the 0-4 and 5-10s living in the most deprived quintile using the Index of Multiple Deprivation (20% of areas nationally) in 2019/2020 was 48% and 46% respectively compared to almost 33% of the trust catchment living in Q1 in 2020.
- If anything among children aged 0-4 and 5-10 experiencing dental extractions due to tooth decay in 2023/2024 there was an obvious increase in the proportion living in the 20% most deprived areas nationally with more socioeconomic deprivation seen in those aged 4 and under (57% and 53% respectively). That is almost two thirds of the children aged 0-10 years who had tooth extractions due to dental decay in 2023/2024 living in the most deprived 20% of areas nationally. That is three quarters of those aged 0-4 years having tooth extractions in hospital due to dental decay living in the two most deprived quintiles nationally.
- In line with the ONS data there is considerable ethnic diversity observed in children who have had tooth extractions due to dental caries in 2023 and 2024 (Figure 7). This is particularly more pronounced in the 4 years old and under with over a quarter of those children being from an ethnic minority group (24% in 2023/2024).
- The proportion of ‘not known’ and not stated’ allows us to judge quality of data reporting for ethnicity. It is worth noting that the quality of ethnicity reporting seems to have been more robust in 2019/2020. Of all the spells of tooth extractions due to dental decay among 5-10 year-olds there were 2.9% ‘not known’ or ‘not stated’ in 2019/2020 compared to 20.5% in 2023/2024 (an almost 10-fold increase). We are exploring this finding further.

A Guide to SPC

SPC Icons & How to Interpret (1/4)

	Variation/Performance Icons		
Icon	**Technical Description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

SPC Icons & How to Interpret (2/4)

	Assurance Icons		
Icon	**Technical Description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

SPC Icons & How to Interpret (3/4)

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: (blank)
H	**Excellent** **Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** **Celebrate and Understand** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** **Celebrate but Take Action** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** **Celebrate** • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent** **Celebrate and Learn** • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** **Celebrate and Understand** • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** **Celebrate but Take Action** • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** **Celebrate** • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
(blank)	**Good** **Celebrate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** **Investigate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** **Investigate and Take Action** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average** **Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H	**Concerning** **Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** **Investigate** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.

SPC Icons & How to Interpret (4/4)

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: (blank)
Low	**Concerning** **Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** **Investigate** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
Improving				**Unsure** **Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event above the upper process limits; a continued upward trend or shift above the mean. • There is no target set for this metric.
Deteriorating				**Unsure** **Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event below the lower process limits; a continued downward trend or shift below the mean. • There is no target set for this metric.
(blank)				**Unknown** **Watch and Learn** • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

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Agenda item A9

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	31 January 2025		
Title	Regional Research Delivery Network Update Briefing		
Report of	Vicky MacFarlane-Reid, Executive Director of Commercial Development and Innovation		
Prepared by	Morag Burton, Network Director		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☒
Summary	This is a presentation of the newly commissioned hosted National Institute for Health and Care Research (NIHR) Regional Research Delivery Network (RRDN), which replaced the NIHR Clinical Research Network (CRN) in October 2024. Included is a brief presentation on the intended direction of the new Research Delivery Network and a summary of the transition and transformation activities that the team has undergone in the last 12 months. The top 3 points to note: • The remit of the RRDN is to ensure that research is embedded in everyday care and responsive to the needs of our population. • The NE&NC, although performing well in terms of research, has significant work to do to ensure that research relative to population needs is available – in particular the need to work collaboratively across organisational boundaries to deliver research closer to home is an imperative change. • This is an opportunity for national influence and leadership on behalf of the Trust as Host of the service, whilst learning from the effective change management processes and leadership behaviours of the staff, particularly with respect to staff wellbeing and positive culture. This hosted service needs to be understood as an independent asset which can support the new opportunities for research and care in the region, relative to our needs. It remains very much a separate organisation, but as a hosted team needs to feel an integral part of the Trust. The Board is asked to support with regards to its Host role, and as an active research institution and system partner, both developing and delivering research, and note the presentation.		
Recommendation	It is recommended that both this and other research organisations are able to increase the visibility of ongoing research activities, by regular presentations to the Board, and that support is given to positively embed research, as part of everyone's job and an option for care. In particular there is a pressing need to ensure that relationships with commercial companies are optimised in response to the O'Shaughnessy Review [https://www.gov.uk/government/publications/commercial-clinical-trials-in-the-uk-the-lord-oshaughnessy-review/commercial-clinical-trials-in-the-uk-the-lord-oshaughnessy-review-final-report], and Department of Health and Social Care commitment response		

<table>
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<tr><td>Links to Strategic Objectives</td><td colspan="6">Not applicable.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☒</td><td>☒</td><td>☐</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">Not applicable.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">This report is made bi-annually – a presentation once per year and then approval is sought for annual business plans and reports at the other meeting.</td></tr>
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Agenda item A9

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Research in Newcastle Hospitals

Professor John Isaacs
Director of Research

The Value of Research

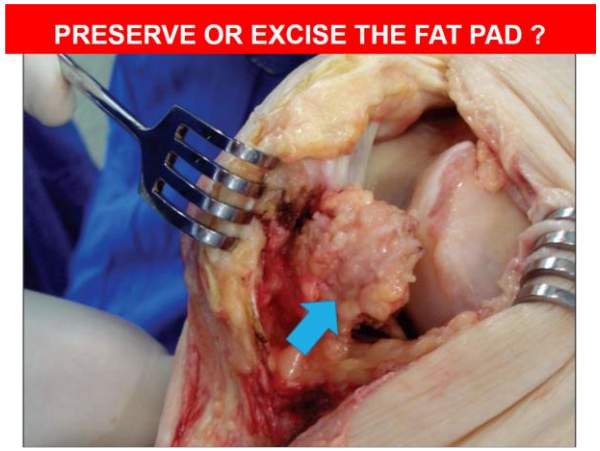
- Patient outcomes
- Staff experience – ALL staff can get involved in research – attract and retain great people
- Reputation
- £££

Different types of research

- Questionnaires/surveys – understanding attitudes, opinions
- Translational: e.g. drug/biomarker development
- Experimental medicine: improving disease understanding
- Clinical research: testing new drugs/technologies/approaches
  - Phase I – IV
  - Safety, proof of concept, efficacy, effectiveness
- Health Services research: developing how we deliver health services
- Epidemiology/public health – COVID-19

The Research Journey
It's all about the question …. and the team

- So much of what we do every day lacks an evidence base
- We may not immediately realise there is a research question waiting to be addressed
- We don't need to be the one to answer it
- Help is at hand…

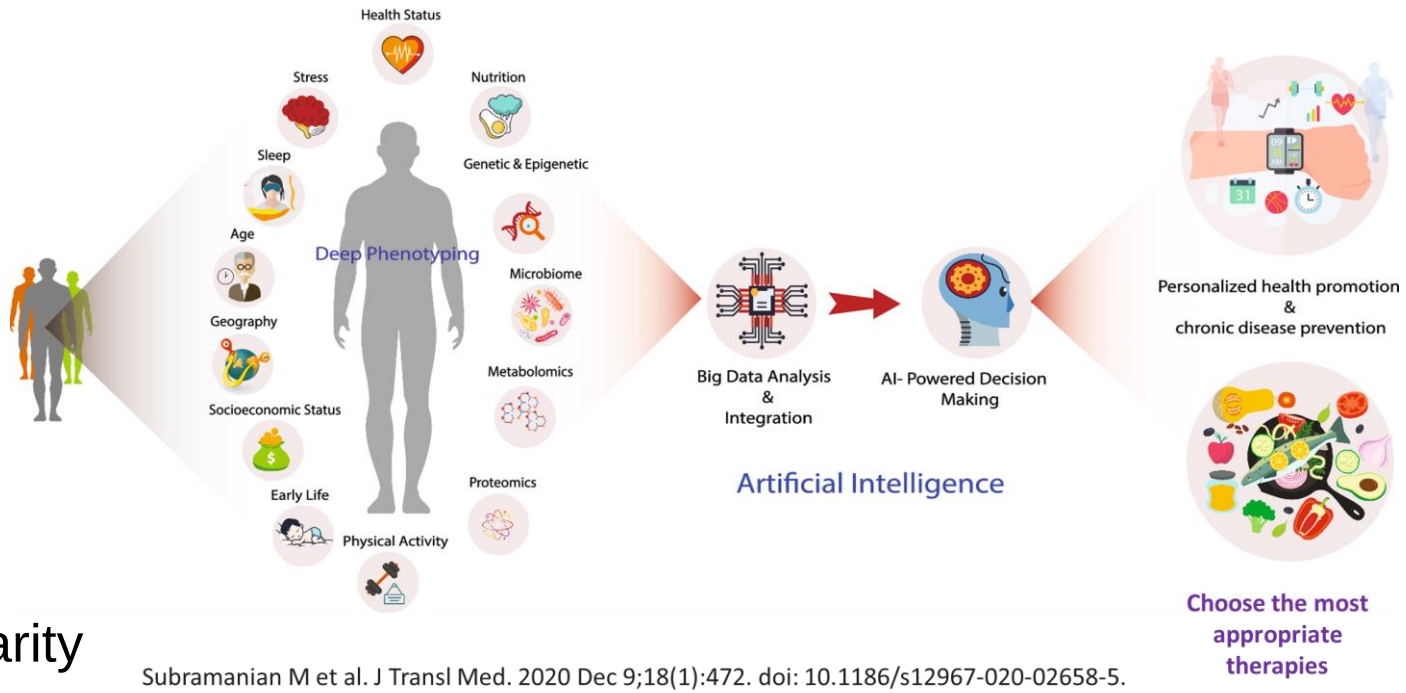


- Hypothesis – outcomes will be better if we retain the fat pad

The Research Journey
It's all about the question …. and the team

- The power of 'big' data
- Artificial intelligence
- Precision medicine

- Collaboration
- Interdisciplinarity



Subramanian M et al. J Transl Med. 2020 Dec 9;18(1):472. doi: 10.1186/s12967-020-02658-5.

Obtaining funding

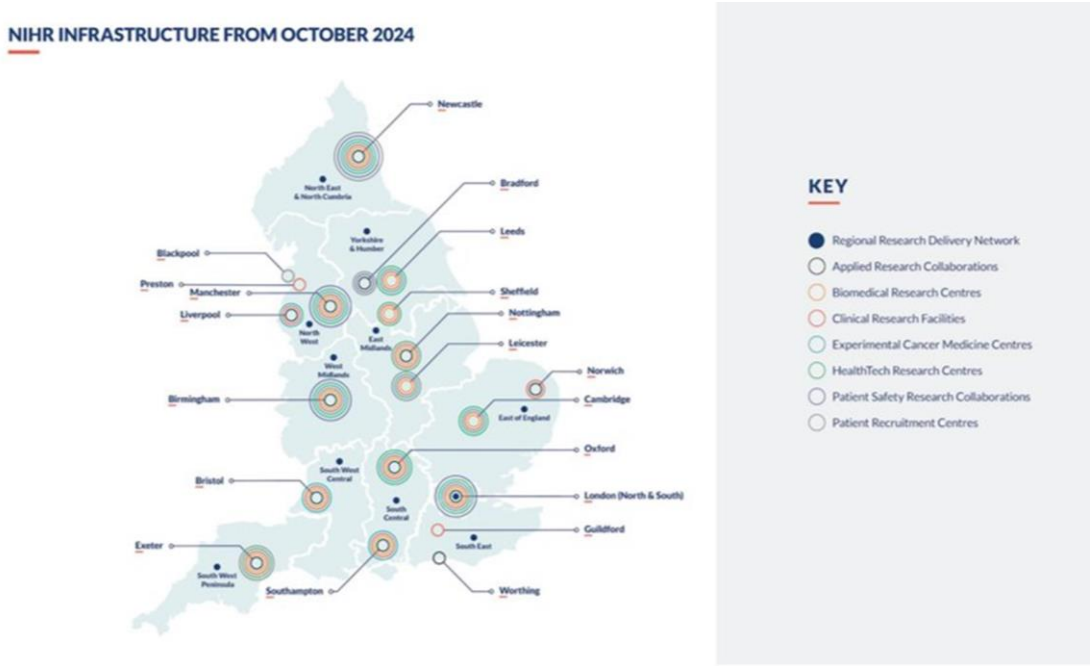
The Newcastle upon Tyne Hospitals NHS Foundation Trust

- Internal seed funding to provide time for:
  - Literature review
  - Data analysis
  - Generate pilot data
- External funding
  - NIHR, charities, UK Research & Innovation (UKRI), commercial
  - Plenty of local support at this stage
    - Joint Research Office
    - Research Support Service
    - Nhrp aCADEMY
  - Funding pays for the research, your time and that of the team, overhead

Where to do the research?

Research infrastructure

- Depends on the type of research
  - Clinical Research Facility – early phase clinical research
  - Commercial Research Delivery Centre – late phase commercial research
  - Biomedical Research Centre – translational research
  - Applied research collaborative – public health research
  - Experimental Cancer Medicine Centre
  - …….



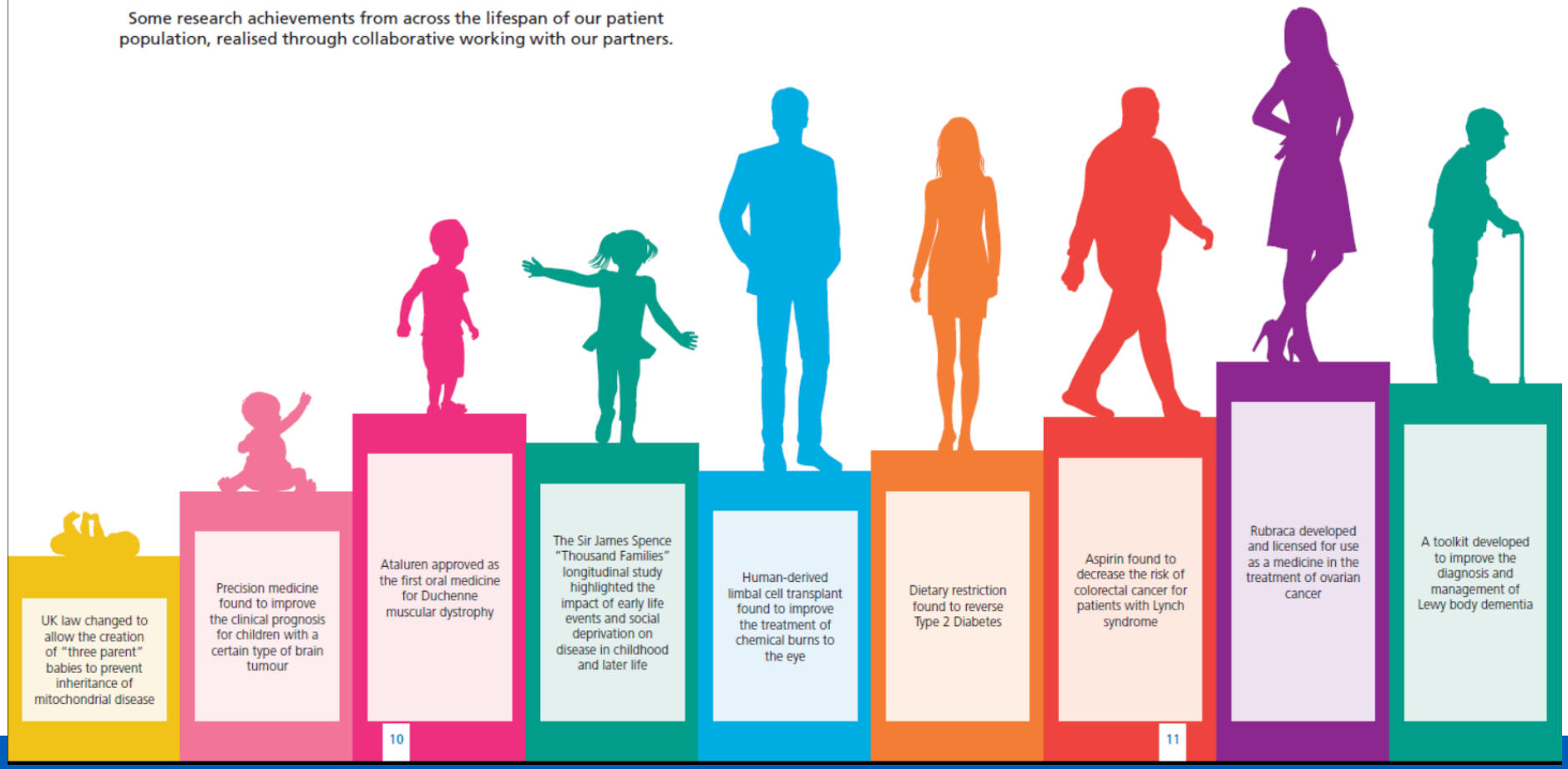
‘The Mayo Clinic of the North’

The Outcomes of Research

- A new drug or therapy
- A new practice guideline
- A new treatment pathway
- A new out-patient system
- New patient educational materials

Newcastle's proud research legacy

Some research achievements from across the lifespan of our patient population, realised through collaborative working with our partners.



Recent successes

- Research from Professor Chris Harding has resulted in changes to NICE guidance for treating urinary tract infections
- Research determined that methenamine hippurate is non-inferior to daily antibiotics.
- NICE guidance changed in December 2024 to reflect Chris's research findings

Charlie

First patient in the UK in a gene therapy clinical trial which aims to find treatments for Duchenne muscular dystrophy.

First patient in Europe to take part in a new clinical trial to assess if a stem cell infusion could calm down inflammation caused by a stroke.

Harrison and baby Kendrick

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Research in Newcastle Hospitals
The Mayo Clinic of the North

Professor John Isaacs
Director of Research


All patients are aware of the value of clinical research and the potential personal benefits of research participation.

Healthcare at its best
with people at our heart

NIHR | National Institute for Health and Care Research

NIHR Regional Research Delivery Network North East and North Cumbria

31st January 2025

Morag Burton - Network Director

Combined Regional (Network) map

NHS England Region	Regional Research Delivery Network (RRDN)		RRDN Hosts
North East and Yorkshire	A	North East and North Cumbria	The Newcastle upon Tyne Hospitals NHS Foundation Trust
	B	Yorkshire and Humber	Leeds Teaching Hospitals NHS Trust
North West	C	North West	Manchester University NHS Foundation Trust
Midlands	D	East Midlands	University Hospitals Of Leicester NHS Trust
	E	West Midlands	The Royal Wolverhampton NHS Trust
East of England	F	East of England	Norfolk and Norwich University NHS Foundation Trust
London	G	North London	Barts Health NHS Trust
	H	South London	Guy's & St Thomas' NHS Foundation Trust
South East	I	South Central	University Hospital Southampton NHS Foundation Trust
	J	South East	Royal Surrey NHS Foundation Trust
South West	K	South West Central	University Hospitals Bristol and Weston NHS Foundation Trust
	L	South West Peninsula	Royal Devon University Healthcare NHS Foundation Trust

NIHR RRDN NENC

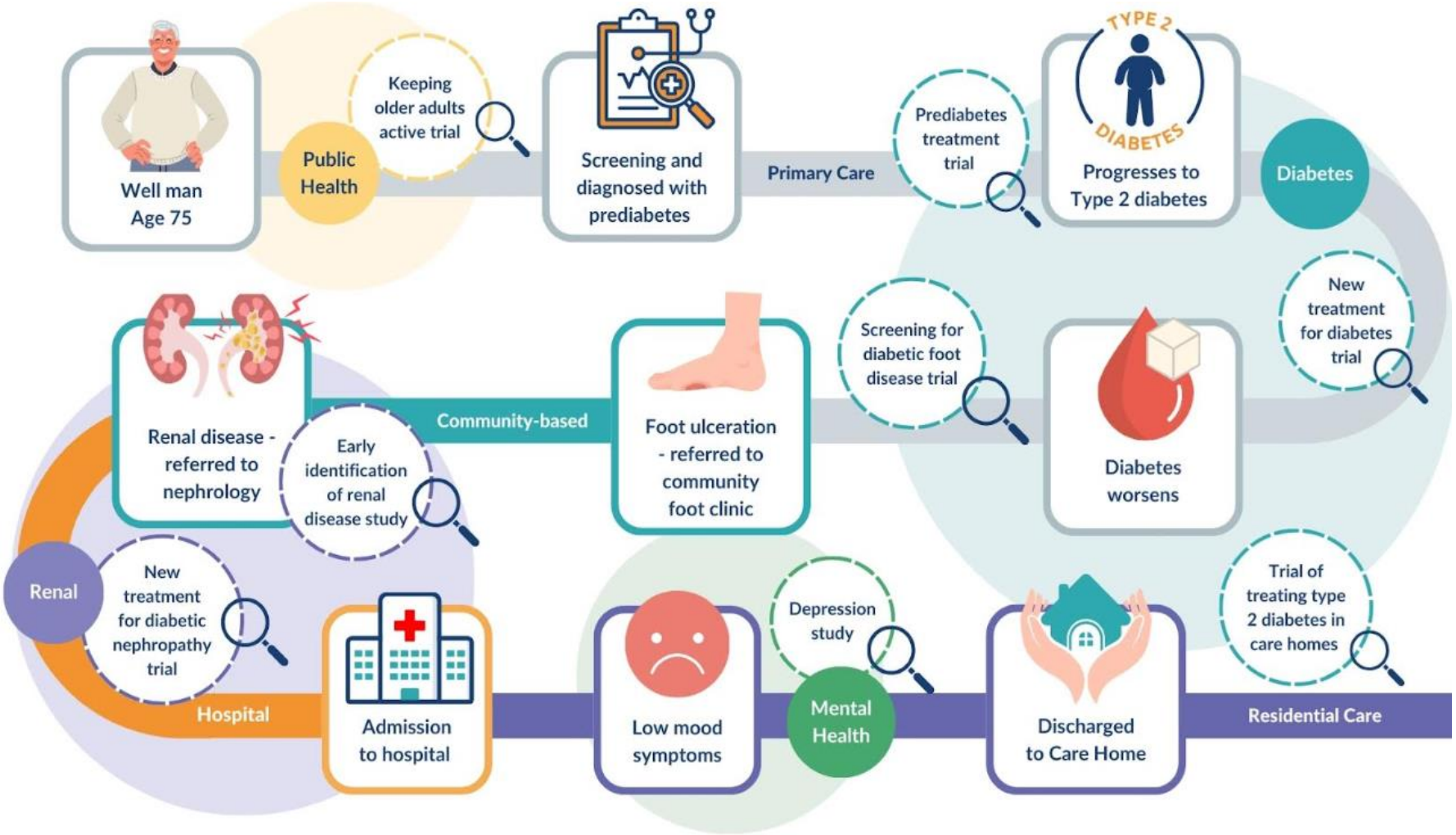
- Hosted by The Newcastle Upon Tyne Hospitals NHS FT - support Finance, HR, IS, Procurement and Contracting
- Contract from **April 2024 - March 2029**
- Approx Annual Value - **£26,000,000 per annum**
- Second smallest region in terms of population size and number of secondary care organisations; **third biggest region in terms of geographical size; poorest regional index of multiple deprivation (IMD)**
- Co terminus with Integrated Care System, Health Innovation Network, Applied Research Collaborative, Research Support Service - **service across secondary, primary, community and residential health and care providers**

Research Delivery Network

Vision

The UK is a global leader in the delivery of high quality, commercial and non commercial research that is **inclusive**, **accessible** and **improves health and care**.

NIHR RDN Vision - Research for All



NIHR | National Institute for Health and Care Research

LCRN NENC Transition to RRDN NENC

- National mandated structure (new organogram) released February 2024 (discussion)
- Final organogram June 2024
- Full management of change commencement end of July 2024
- Regional existing roles fit 1 from 79
- Overall, highly successful process.

LCRN NENC Transition to RRDN NENC

Fair

Transparent about appointment processes and consistent in application of decisions.

Swift

Move as quickly as possible through the process without compromising integrity.

Minimise burden

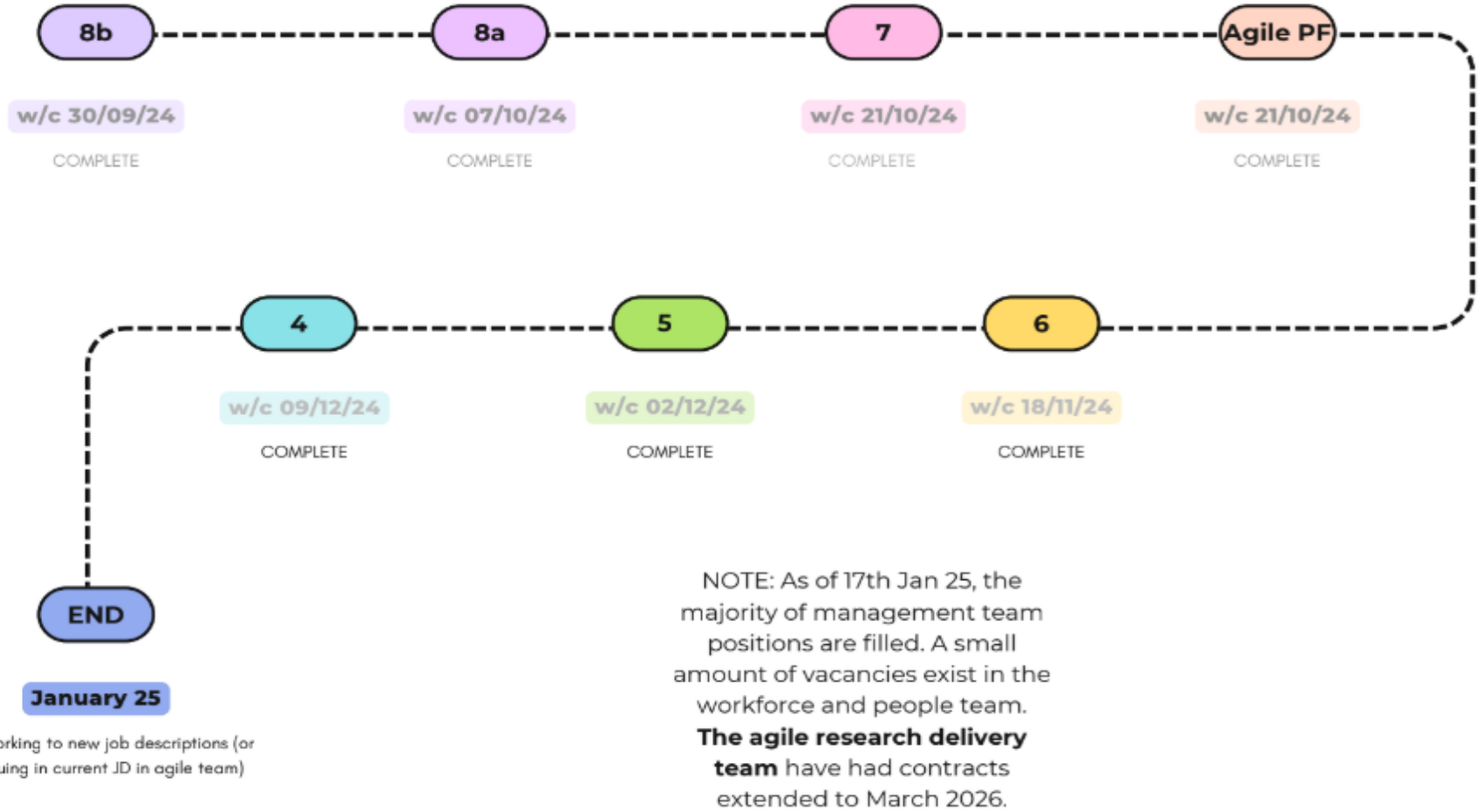
Ask as little of you as practically possible while ensuring processes are robust.

LCRN NENC Transition to RRDN NENC

Key Decisions:

- De-coupling Agile team
- Communication, communication, communication
- Sharing of outcomes via a live organogram

Timeline



NOTE: As of 17th Jan 25, the majority of management team positions are filled. A small amount of vacancies exist in the workforce and people team. **The agile research delivery team** have had contracts extended to March 2026.

NIHR | National Institute for Health and Care Research

morag.burton@nihr.ac.uk

nenc.rrdn@nihr.ac.uk

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Agenda item A10(a)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 January 2025					
Title	Joint Medical Directors (JMD) Report					
Report of	Lucia Pareja-Cebrian / Michael Wright					
Prepared by	Lucia Pareja-Cebrian, JMD Michael Wright, JMD Alison Greener, CEO Office					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	This report highlights issues the Joint Medical Directors wish the Board to be made aware of. The following items are described in more detail within this report: • Quality and Safety • Urgent and Emergency Care • Cancer performance • Medical Education • Job planning The progress being made in each of these areas is highlighted. There is ongoing concern about both cancer and urgent and emergency care performance with continued work to improve both of these. The report of the Guardian of Safe Working is attached for information.					
Recommendation	The Board are asked to note the contents of this report and: • Note ongoing concerns about performance against cancer targets and the actions being taken to improve this. • Note the actions being taken to improve urgent and emergency care performance. • Note the challenges related to resources due to the increase in size and scale of postgraduate training programmes, as well as workload for the undergraduate administrative team. • Note the actions being taken to implement the new job planning guidance.					
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

1. QUALITY AND SAFETY

1.1 Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework (PSIRF) has now been functional within Newcastle Hospitals for 1 year. The two major elements are:

- A streamlined patient safety incident investigation/response system; and
- A re-direction of resource into large scale, important and hitherto intractable safety issues as identified through our own data and intelligence – PSIRF priority projects:
    - Reducing the incidence of hospital acquired thromboses (HAT).
    - Reducing risk from lost internal referrals.
    - Reducing incidence of results not acted upon – radiology/lab.

The first element of this has bedded in relatively smoothly with, on the whole, effective processes at Clinical Board level to rapidly review moderate harms and above, and to report these at the weekly whole Trust response action review meeting. We have undertaken (or currently underway) 27 Patient Safety Incident Investigations (PSII), the highest level of investigation. This almost certainly represents 'over-triage' to PSII initially – recent rates of PSII declaration having slowed considerably.

Our three priority projects have made substantial progress. Of these the HAT team have implemented impressive intervention and, as importantly, real time data on performance at Clinical Board and shortly to be ward level.

A change to the e-record prompt/demand for a Venous Thromboembolism (VTE) risk assessment has improved compliance with this from 30% to close to 100%. Training has increased from 4 to 59% as this has become mandatory. An Artificial Intelligence (AI) software package has allowed immediate and effortless identification of all HATs (previously required human radiology report trawling). The key metric of HAT with preventable features is now displayed and utilised on PowerBI (and will be at ward level). Impact on actual reduction of preventable HAT will be easily demonstrable in the next 12 month period.

Major digital process overview is ongoing with priorities 2 and 3.

New safety priorities should be identified around Easter for project start in summer.

1.2 Martha's Rule - Call for Concern

We plan to implement 'Call for Concern' across adult wards on 17 February 2025. This new process aims to complement existing deteriorating patient detection and response systems and provides a mechanism for patients and families to directly seek a review by our critical care outreach teams. This is a major Trust communication challenge and implementation will be supported by a small, dedicated nursing team over 6 months funded with national pilot money.

We are not yet implementing in the Great North Children's Hospitals (GNCH). We do not have a paediatric intensive care outreach team and the Clinical Board have been unable to agree on an alternative until such time as we may have paediatric outreach. An alternative of response or triage by the in charge Paediatric Intensive Care Unit (PICU) nurse was considered and rejected. The call volume in paediatrics is likely to be low and a trial of one or more should be agreed. Discussions on this are ongoing.

1.3 Clinical Board Quality and Safety Structures

All Boards now have senior full time support (usually at Band 7) for Quality and Safety (Q+S) activity. Implementation of this has occurred at different times over the year. The first group meeting occurred, chaired by the Associate Medical Director (AMD) Q+S on 14 January 2025.

The structures to support and integrate this group, the medical Q+S leads and the Clinical Governance and Risk Department (CGARD) now needs to be reviewed to optimally set up for strategic and operations activity.

The Surgical and Associated Services (SAS) Clinical Board Medical Lead has changed – Mr Jeremy French, Consultant Hepatobiliary Surgeon, being replaced by very experienced governance colleague Ms Lucy Wales, Consultant Vascular Surgeon.

1.4 Quality Oversight Group Oversight

How Quality Oversight Group activity is overseen through the Quality Performance Reviews is under discussion, agreement for a dedicated session quarterly has not been reached yet. This should be resolved soon.

2. CANCER UPDATE

2.1 Performance

Cancer performance is still markedly below the standard required and that we would want to see. The performance figures documented highlight an increase in the number of patients waiting over 62 days to be treated from the date of referral. The total number of patients currently waiting >62 days still remains consistently just over 200. The national target is that 85% of patients are treated withing 62 days.

The most consistently challenged tumour groups in terms of 62 day performance are lower Gastrointestinal (GI), upper GI, lung and urology.

Month	J	F	M	A	M	J	J	A	S	O	N	D*
28 Day Faster Diagnosis Standard (FDS) %	72.0	83.2	84.9	77.0	80.8	79.2	73.0	68.4	68.9	71.8	73.0	75.0

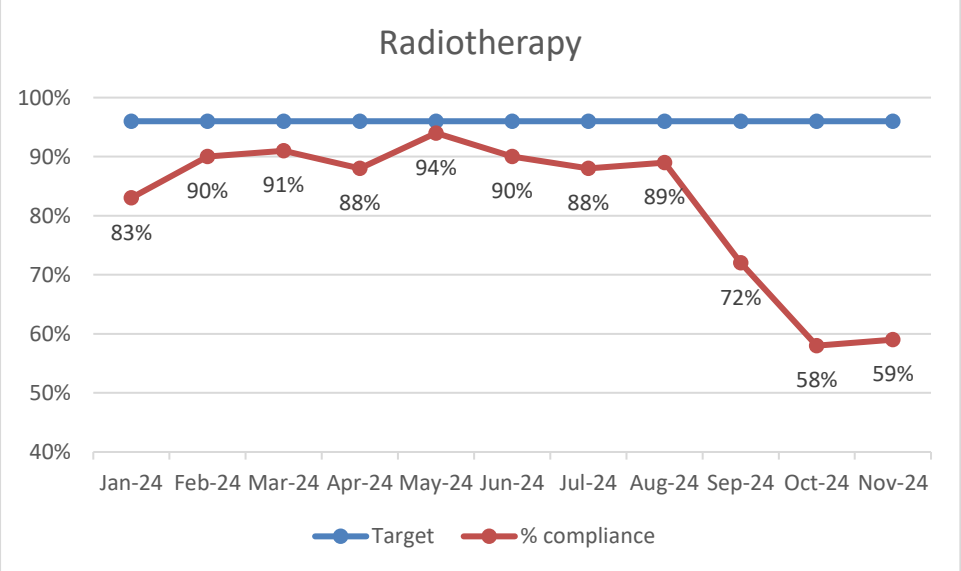
Month	J	F	M	A	M	J	J	A	S	O	N	D*
Number of Patients	2330	2340	2557	2620	3005	2831	2842	2727	2421	2962	2487	2318
62 Day %	56.1	60.9	61.6	58.9	60.6	65.3	60.0	64.8	68.9	64.3	65.7	66.8
62 Day by Tumour												
Breast	76.6	86.4	82.9	89.9	93.8	97.8	89.7	90.8	92.2	86.7	90.6	90.9
Lung	38.8	46.3	41.4	29.3	46.0	48.3	34.8	33.8	34.9	38.7	48.3	59.3
Head & Neck	82.8	73.5	75.4	80.0	66.7	79.4	80.0	78.6	75.7	77.4	75.4	66.7
Lower GI	41.2	46.3	52.6	25.3	46.4	28.8	49.3	49.0	50.0	34.3	49.1	27.6
Upper GI	47.4	32.7	26.0	37.9	29.3	40.4	36.7	64.8	47.5	48.9	51.2	46.3
Urology	32.2	28.6	50.8	46.0	36.1	50.0	46.9	42.5	48.1	53.9	55.3	65.8
Skin	67.6	83.3	88.2	80.5	87.9	87.9	83.5	89.0	81.6	87.2	77.0	75.0

**** Incomplete data as the full month verified data was not available at the time of production of this report***

2.2 <u>31 Day Target</u>

This target requires that 96% of patients should start treatment within 31 days of a decision to treat them.

We have historically performed steadily against this target with radiotherapy and chemotherapy achieving 96-98% compliance and surgery in the region of 75% compliance. Unfortunately radiotherapy performance has dipped significantly over the last 3 months (see below). This is principally due to shortfalls in key staff groups due to retirements, sickness and difficulties with recruitment.



A recovery plan is in place for radiotherapy performance but given the backlog it will take a circa 6-8 months to recover this position, assuming no increase in baseline referrals. The number of patients waiting to commence treatment and the average number of days to treatment are being monitored as proxy guides. Linear accelerator sessions are being extended including weekend working. All cases are being clinically prioritised in order to try to minimise any risk of harm at individual patient level.

In surgery, the main focus remains treating to 62 Day target and if we can achieve that then 31 Day performance will improve alongside.

2.3 Governance

The internal peer review rolling programme has been agreed and first meetings will happen with teams between January - March prior to further submission of peer review documentation including audit against national Multi-Disciplinary Team (MDT) standards April - June 2025.

Work to embed harm reviews continues. A complete dataset for March - September 2024 will be available in February 2025 with rolling completion thereafter.

2.4 Cancer Outcomes

This remains a difficult area with clear potential benefits from detailed understanding of cancer outcomes but a recognition that achieving this level of understanding will require significant investment. Our data is not refined enough i.e. collected to the right depth and completeness, to fully assess outcomes after cancer treatment. Survival figures are available nationally but they are often several years out of date and don't account for the nuance of tumour subtype nor indeed patient selection. Data suggest that patients want to know the outcomes for treatment at our site and clinicians certainly would want to be in a position to have this information. There are commercial providers who could and would collect this data, under appropriate information governance conditions, likely at minimal upfront cost to the Trust. These companies want to use the data to help develop large language AI algorithms and to commercialise those data for use particularly by pharma organisations.

An alternative approach is to invest in large scale data collection as a Trust. The complexity of data points required would mean that we would need to have a concerted investment in staff and training within each tumour group. This would provide outcome data and would also bolster the cancer tracking programme. Initially, at least, this would be a largely manual process. Questions remain as to whether AI can provide solutions in the future but it seems likely that an AI-based approach would need collaboration, likely with an industry partner. An options paper could be developed if the Trust Board felt that this should be considered.

3. URGENT AND EMERGENCY CARE ACTIVITY

Emergency Department performance remains below the national target of seeing and discharging / admitting 78% of patients within 4 hours. Type 1 performance has ranged from 57.7% - 62.48% per month since April 2024. Overall performance 72-76.49%.

Type 1 attendances, emergency admissions and ambulance arrivals have all increased in 2024 compared to 2023.

The average ambulance handover times remain below the regional and national average. During November 2024 the Trust average was 22.24 minutes with the Regional and National Average at 38 minutes. This is a testament to the commitment of the staff in the Emergency Department to prioritise the transfer of patients from ambulances into the department for the safety of the patient concerned and those waiting for ambulances in the community. Recent winter pressures have increased ambulance deflections and diverts to the Trust from surrounding trusts.

1.2% of our patients wait longer than 12 hours in the department. Regionally, the figure is 5.6% and Nationally is 7.2%. We continue to see particularly long waits for patients requiring mental health assessment and there are ongoing discussions with colleagues in other organisations in an effort to improve this situation which remains a source of significant concern.

Work has begun on the new co-located RVI Urgent Treatment Centre with a projected opening of late 2025. This will provide an alternative to Emergency Department attendance and will help improve both safety and quality of experience for patients attending the Trust in an urgent setting.

It is important to consider all options available to reduce Emergency Department attendance. Hospital avoidance strategies include the launch of a front door frailty service starting the week commencing 13 January and a single point of access for urgent community response.

Estate plans have been drafted to expand the RVI Same Day Emergency Care and a staffing model is being developed for this.

Ensuring adequate flow through the hospital also requires focus on discharge. Work on reforming the discharge process for patients requiring assessment and additional care in the community has reduced overall length of stay in Older People's Medicine wards by 2 days. There is a 6 day reduction in delays for patients being transferred from acute beds to community intermediate care beds and a 12 day reduction in delays for patients being transferred with specific dementia / behaviour needs to Byker Lodge. There is still a great deal of work to be done in this area.

4. MEDICAL EDUCATION UPDATE

4.1 Postgraduate Medical Education Update

Key achievements since September 2024 include:-

- Bid submitted to NHS England to support our Specialty and Associate Specialist (SAS) and Locally Employed Doctors (LED) with a view to create a local E-portfolio for LED doctors to use in line with national training - this is awaiting confirmation of approval.

- Our first refugee programme for doctors was completed in October 2024 with positive feedback from both the refugee doctors and those who supervised. We will look to hold further cohorts in the future.

Current challenges and risks:

- Training programmes continue to increase in size and curriculum changes with no additional resources to support the infrastructure of these changes. The Medical Education Team are currently struggling to deliver the current demands due to educator availability and size of the administration team. Currently scheduled quality visits by NHS England and the Foundation School will likely highlight the need for additional resources.
- Action plans are in placed with both Paediatric Cardiology and Cardiology at the Freeman Hospital in line with the recent General Medical Council (GMC) survey results. All departments with outliers will have a formal action plan attached to our review meeting cycle reports with NHS England.
- Time for Training remains an issue for those in a trainer role. This affects approximately 700 trainers. It is challenging to gain support with delivering teaching programmes and supporting the simulation element of the curriculum due to the lack of educational time in job plans. This will be addressed under the new job planning guidance.
- Due to changes in how foundation programme posts have been allocated nationally, we have had an increase in International Medical Graduates and doctors requiring additional support. This has caused increased pressure in departments to ensure adjustments are in place as well as additional supervision where required.

4.2 Undergraduate Medical Education Update

Key achievements since September 2024 include:

- The implementation of a monthly Undergraduate Medical Education Newsletter has been a welcome addition and a valuable mechanism for sharing information/updates with our Trust educators. It is an important line of communication enabling us to share curricula updates, upcoming opportunities etc. with a wider body of educators with the ultimate aim of increasing the engagement, involvement and understanding of undergraduate Medical Education within the Trust.
- The introduction of a weekly shared learning email to medical students in Years 3, 4 and 5 has equally boosted our lines of communication with respective stakeholder groups. It involves re-circulating Trust-wide communications such as Patient Safety Bulletins with our medical students in a way that is accessible and relevant to their role within the Trust, to ensure that organisational learning is shared with all Trust members on a weekly basis.

Current challenges and risks:-

- The use and governance of the Undergraduate Medical Student tariff is subject to regular reports and returns to NHS England. Transparency of the use of funding is important and has been a topic for discussion at the Annual Deans Quality Meeting. Conversations are ongoing with finance colleagues to ensure resource allocation is fully understood by all. Closer alignment to the demands of the undergraduate

medical student curriculum is required to ensure the curriculum is appropriately and well resourced.

- Educator availability has been a challenge whilst preparing for the 2024-25 academic year. The current teaching fellow cohort is not reflective of curriculum demand. Moreover, the structure and funding of these roles often lead to gaps in delivery as teaching fellows are misaligned to clinical areas students spend time in. The lack of clarity around funding for these roles makes coordination a challenge and risks future education delivery.
- The Undergraduate admin team continues to operate at less than full establishment. There are 9 substantive posts within the team; over the past 12 months, there has been a minimum of 1 vacant post at any one time. Consequently, workload for the team has increased, with the related risks to job satisfaction and to service delivery as certain workstreams have to be prioritised above others. Additionally there are several vacancies within the Senior Clinical Team that are currently being advertised. This is having a similar impact as above.

5. JOB PLANNING

It has been recognised that there is a need to improve the job planning process in Newcastle Hospitals to respond to changes in service delivery demands, support working arrangements for colleagues and standardise the process across the organisation. It is a frequently raised source of concern for both staff and clinical leaders. Comparisons between Newcastle Hospitals and other neighbouring organisations have highlighted unfavourable discrepancies, particularly in allocation of Supporting Professional Activity (SPA) time, training and education time and the minimum annual requirement for Direct Clinical Care (DCC) delivery, (currently 43 weeks in Newcastle Hospitals and 42 weeks in most other organisations). In addition, the perceived maximum of 12PAs in total for job plans, regardless of the amount of activity delivered, in some areas of the Trust, is a source of disagreement and frustration in clinical teams. Effective job planning is one of the tools to enable transparency and consistency that will contribute to improved quality of care and productivity. It will help the organisation to understand workforce capacity to inform service planning for 2025/2026.

There are currently circa. 1,190 medical consultants and SAS staff within the Trust that require job planning. Job plans are recorded on SARD, which is the online system used by the Trust to record Appraisal and Revalidation Information and Job Plan details for all senior medical and dental staff.

Prior to 2020, job plan review was completed on a regular basis across the Trust with compliance rates of annual job plan review of between 80 and 90% achieved. This was not done consistently during the pandemic. All Consultant and SAS staff have a job plan, however, in many cases, these have not been reviewed for several years post the COVID pandemic. This reset of job planning gives the opportunity to review all job plans including those which have not changed and to ensure that they reflect planned activity. This will also allow the job planning process to become prospective with an aim that job planning for future financial years will be completed in Quarter 4 of the preceding financial year.

The significant changes to be applied under the new job planning guidance to achieve parity with neighbouring organisations are:

- Clarity of expected activity delivery and resources required.
- Increase of 'core SPA' time from 1 to 1.5 SPA.
- Clear definition of activities undertaken during SPA time.
- Identification of specific time for teaching and training.
- Decrease of normal minimum expected annual DCC delivery from 43 to 42 weeks.
- Recognition of total activity required in job plan.

A workbook and set of frequently asked questions (FAQs) have been developed to provide updated guidance for job planning meetings under the new job planning guidance. This is currently going through an approval process with the Local Negotiating Committee (LNC).

Following the national guidance, a Job Planning Oversight Group has been established to monitor progress, assess risks to implementation and areas for escalation. The figure below outlines the oversight arrangements for which terms of reference are established for both the Job Planning Operational Group and the Job Planning Oversight Group.

Job Planning Oversight Arrangements

The financial implications of the agreed job plan guidance changes are being considered as part of the implementation process with support from finance colleagues. There is likely to be a short term increase in cost however experience of other organisations suggests that some of this will be offset by the gains in productivity achieved by detailed and consistent job planning discussions.

6. RECOMMENDATIONS

The Board is asked to note the contents of this report and:

i. Note the continuing work to implement PSIRF and Call for Concern (Martha's rule).
ii. Note ongoing concerns about performance against cancer targets and the actions being taken to improve this.
iii. Note the actions being taken to improve urgent and emergency care performance.
iv. Note the challenges related to resources due to the increase in size and scale of postgraduate training programmes, as well as workload for the undergraduate administrative team.

v. Note the ongoing work to implement revised job planning guidance for consultant and SAS medical and dental staff.
vi. Note the report of the Guardian of Safe Working.

L Pareja-Cebrian/M Wright
Joint Medical Directors
15 January 2025

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Agenda item A10(a)(i)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 January 2025					
Title	Guardian of Safe Working Quarterly Report (Q3 2024-25)					
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 2024 for consideration by 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 to the BAF. In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.					
Reports previously considered by	Quarterly report of the Guardian of Safe Working Hours. Report previously presented to the Trust People Committee.					

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

This quarterly report covers the period 27 September to 26 December 2024.

There are now 1,102 resident doctors on the New Contract and a total of 1,140 resident doctors in the Trust.

There were 134 exception reports in this period. This compares to 150 exception reports in the previous quarter.

The main area of exception reports is general medicine.

The main cause of exception reports is when there is a high clinical workload or low staffing levels.

2. INTRODUCTION / BACKGROUND

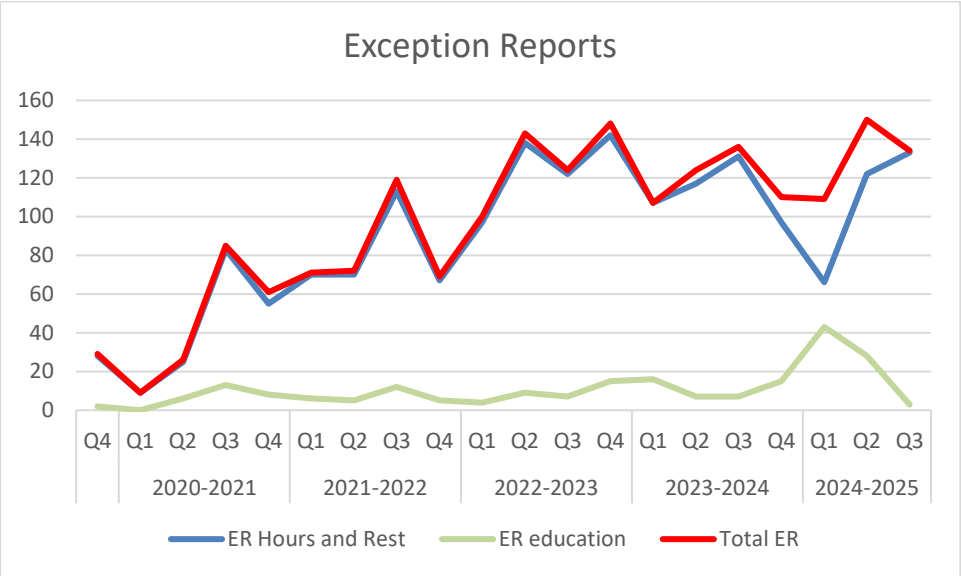
The 2016 New Junior Doctor Contract came into effect on 3 August 2016 and was reviewed in August 2019, with changes implemented in a staggered approach from August 2019 to October 2020. From August 2023 Locally Employed Doctors are also employed on a contract which mirrors the 2016 contract and allows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

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 Resident Doctors on New Contract	1,102	(1,138)
Total Number of Resident Doctors	1,140	(1,181)
Number of Exception reports	134	(150)
Number of Exception reports for Hours Breaches	133	(122)
Number of Exception reports for Educational Breaches	3	(28)
Fines	8	(2)
Admin Support for Role	Good	
Job Planned time for supervisors	Variable	

4. EXCEPTION REPORTS (ER)



4.1 Exception Report by Speciality (Top 4)

		(Previous quarter for comparison)
General Medicine	80	(121)
General Surgery	25	(9)
Urology	12	(3)
Ophthalmology	9	(2)

4.2 Exception Report (ER) by Rota/Grade

General medicine

Total	80	(121)
Hours and Rest	79	(93)
Education	2	(28)
RVI (Foundation 1/2)	30	(61)
RVI (Post foundation training)	4	(4)
FH (Foundation1/2)	16	(33)
FH (Post foundation training)	30	(23)

General Surgery

FH (F1) including HPB, colorectal, vascular	21	(6)
RVI (foundation and higher)	4	(3)

Urology		
F1	12	(3)
Ophthalmology		
StR	9	(2)

4.3 Example Themes from Exception Reports (ERs)

General Medicine RVI/FH

"We had minimal ward staffing (1 SHO +1 F1); many new and acute patients; 1 hour teaching; could not leave the ward on time as had to solve urgent problems that could not be handed over to on-call team"

General Surgery

"Minimum staffing; incredibly high number of jobs during the day shift. Very large volume of calls during the on call shift. Stayed late to complete day jobs that would be inappropriate to hand over to night team in an effort to try and prevent future issues the next day.
I did not initially raise these exception reports at the time. However; I attended a meeting with supervising tutors and the foundation team on Friday 18th October to discuss our experience of working as an F1 in general surgery at the Freeman. In this meeting I was encouraged to backdate and send in all occasions where I had stayed late. I have only included days when I stayed at least an hour late."

The high workload within General Surgery F1 at FH is well known. The increased number of ERs show that these issues are not fully resolved despite a previous drop in exception reporting numbers. However, the narrative suggests an environment where exception reporting is encouraged, which is positive.

Urology

"Very busy day on the ward. Stayed late to complete outstanding jobs."

Exception Reports submitted when there was excessive workload, or reduced staffing due to sickness.

5. EXCEPTION REPORT OUTCOMES

5.1 Work Schedule Reviews

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

5.2 Fines

8 fines have been issued:

- General Medicine (F2 Freeman) (1 fine): Rule breached "Late finish; Unable to achieve breaks; Exceeded the maximum 13-hour shift length. " Total fine money £50.39.
- Ophthalmology (5 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); Unable to achieve the minimum 8 hours total rest per 24-hour NROC shift." Total fine money £713.13.
- Paediatric Surgery (1 fine): 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); Unable to achieve the minimum 8 hours total rest per 24-hour NROC shift." Total fine money £780.03.
- Paediatrics (1 fine): "Late finish; Exceeded the maximum 13-hour shift length." Total fine money £45.52

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. Short notice sickness, and doctors required to leave the ward for teaching are commonly mentioned as reasons for reduced staffing.

6.2 Supervisor Engagement

Supervisor engagement is generally good. Weekly prompting by the medical staffing team has reduced supervisor response time.

6.3 Administrative Support

Administrative support is currently good.

7. ROTA GAPS

Unfortunately, due to sickness within the team, this data is not available at this time.

8. LOCUM SPEND

The purpose of reporting locum spend is as a source of information indicating where there is a workload/workforce imbalance.

LET Locum Spend

October to December (Q3 2024-25)	£585,008

July to September (Q2 2024-25)	£915,211

Comment from the finance team:
'In terms of expenditure, we rely on the 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 £330k between Q2 24/25 & Q3 24/25. Of this decrease, -£300k was Medicine & Emergency Care, Cardiothoracic & -£85k Surgical & Associated Specialties.'

Trust Locum Spend

October to December 2024 (Q3 2024-25)	£600,046
July to September 2024 (Q2 2024-25)	£769,247

Comment from the finance team:
'Based on information supplied by Medical Staffing this was made up predominately by decreases in vacancies (-£89k) & On-Call Cover (-£79k).

With regards to Clinical Boards the decrease of spend can be seen particularly in Cardiothoracic (-£105k), Surgical & Associated Specialties (-£36k) & Surgical & Specialist Services (-£19k).'

8. RISKS AND MITIGATION

The main risk remains medical workforce coverage across several rotas. This is exacerbated when clinical demand is high.

9. JUNIOR DOCTOR FORUM

Issues discussed included training bottlenecks and concerns for lack of employment for core training doctors, out of hours medical cover at the Freeman Hospital, issues with car parking and delays to renovations of the junior doctors' mess.

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

9 January 2025

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Agenda item A10(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	31 January 2025		
Title	Executive Director of Nursing (EDoN) Report		
Report of	Ian Joy Executive Director of Nursing		
Prepared by	Lisa Guthrie Deputy 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 Director of Nursing areas of responsibility. The content of this report outlines: • Spotlight on Accrediting Excellence (ACE) Accreditation programme. • Nursing and Midwifery Staffing Update. • Flu Vaccination Update. • Practice Education Update. The following key points/risks are noted for the Trust Board's attention: • Our ACE Programme recognises and celebrates excellence with a focus on clinical and professional standards. The Accreditation programme has now been launched and will create a culture of pride and accomplishment and have a clear set of standards. It will promote accountability by providing an evidence-based, standardised approach to support the delivery of excellence in nursing and midwifery care, improving quality and provide ward-to-board assurance on clinical and professional standards. • Trust nurse staffing escalation remains at level 2 due to utilisation of surge beds and sickness absence above 6%. Appropriate oversight, monitoring and supportive actions are in place. • Matron/Senior Nurse weekend cover was initiated in November 2024 to improve staffing and professional oversight out of hours, feedback received thus far has shown this to be an effective and valuable service improvement. • Several wards have required support at medium or high level since the last report to Board. Two wards have required high-level support with one being de-escalated from high to medium level support in December 2024. Action plans are in place for wards with additional peer support, education and resources provided, overseen by the Executive Director of Nursing team and relevant Clinical Boards. • Registered Nurse (RN) fill rates of <85% are reported to the Executive Director of Nursing monthly. The detail of those areas reporting <85% are contained in this report. RN dayshift fill rate has remained over 94%, and nightshift over 91% for the past three months with Healthcare Assistant (HCA) dayshift declining slightly over the past three months to 91%. • The current total RN and HCA Turnover is included in the repot with no concerns to escalate.		

<table>
<tr><td></td><td colspan="6">There is robust governance and oversight in place to ensure effective roll out of the staff vaccination programme. Uptake of both Flu and Covid vaccination is lower at this point when compared to last year. Actions are in place to improve uptake, and further detail is contained within the report.
The Practice Education Team continues to oversee all practice placement aspects of Nursing, Midwifery and Allied Health Professional (NMAHP) undergraduate training, ensuring students have access to high quality learning opportunities and experiences, in safe, effective learning environments. An overview of the team's work is included in the report.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Board of Directors is asked to note and discuss the content of this report.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Putting patients at the heart of everything we do. Providing care of the highest standards focusing on safety and quality.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">BAF risk ID 1.1 - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">The EDoN update is a regular comprehensive report bringing together a range of issues to the Trust Board.</td></tr>
</table>

EXECUTIVE DIRECTOR OF NURSING REPORT

1. SPOTLIGHT – Accrediting Excellence (ACE) Programme

Accreditation programmes in NHS organisations, enable and facilitate shared governance, by empowering wards and clinical departments, to develop and improve practice, enhance patient and staff experience and to recognise and celebrate excellence. NHS Improvement (NHSI) (2019) described accreditation as bringing together key measures of nursing and clinical care into one overarching framework to enable a comprehensive overview of the quality of care at department level.

1.1 Background

Historically, the Newcastle Hospitals Ward Accreditation Programme predominantly reflected achievement in the clinical assurance tool (CAT) for inpatient wards. Despite the limitation, the recognition was highly valued by staff and an appetite to relaunch the programme was clear. When used effectively, Accreditation programmes can drive continuous improvement in patient outcomes and increase patient satisfaction and staff experience at ward and unit level. Therefore, the aspiration was to develop, launch and embed an accreditation framework aligned to national best practice. This programme was kindly supported by Newcastle Hospitals Charity.

1.2 Framework

A draft accreditation framework was developed in June 2024 for Adult and Children and Young Peoples inpatient wards. The framework has been developed to reflect the key pillars in the Trust Nursing, Midwifery and Allied Health Professional (NMAHP) strategy with several accreditation standards sitting under of the following pillars:

- **Improving Quality and Reducing Avoidable Patient Harm**
- **Patient Experience**
- **Well Led - Staff Experience and Leadership**
- **Engagement for Improvement**
- **Increasing Research Opportunities**

With collaboration from key subject matter experts the draft framework has undergone a full systematic review during the month of November 2024. The current framework contains 131 standards with some small additions to be added over the coming months.

1.3 Process

Wards and clinical departments are invited onto the programme by the ACE team or can nominate themselves to start their accreditation journey.

Step 1. Baseline Support Offer - A member of the ACE team meets with the clinical lead and Matron for the department, 10 weeks in advance of the accreditation date. The meeting centres on reviewing the ACE standards, identifying any areas where the department requires additional support or improvement ahead of accreditation. It's also an opportunity to highlight any areas of excellence they are proud of and wish to start sharing. The ACE team provides a summary of the discussion including any suggested actions or support offers to address identified needs. This approach ensures the department is well prepared and feel supported in achieving accreditation.

Step 2. 15 - Step Visit - This is carried out unannounced within a 4-week period of the accreditation date. The 15 – Step visit is based on NHS England's 15 - Step Challenge tool kit (2017), designed to explore a setting through the eyes of patients and relatives, focusing on first impressions, the environment and how these influence their perception of the quality of care. The toolkit has been adapted to avoid duplication with the ACE standards. The findings from the 15-Step visit will contribute to the overall accreditation score, providing valuable insight into areas of excellence and potential improvement.

Step 3. Staff Survey - This will be sent out to all members of the department to complete within a week leading up to accreditation. This will contribute to the overall accreditation score.

Step 4. Accreditation Day - Key experts supported by the ACE team will visit the department to review their respective standards. Real time patient feedback will also take place on this day and form part of the overall accreditation score. Emphasis is placed on highlighting excellence and giving opportunity for the area to showcase what they are proud of. High level feedback will be provided at the end of the day, and the aim is to assign an overall outcome within 48 hours post accreditation.

Step 5. Post Accreditation Day Outcome Meeting - This will take place within 2 weeks post accreditation day. This will include recognising excellence but will also include recommendations to maintain the standard and what is required to progress to the next level of accreditation. The Matron and clinical lead for the department will then have local ownership of this plan, the ACE team will be available to review and support at intervals with the area's leading up to the next accreditation date.

Step 6. Accreditation Celebration - This will take place in the department and the team will be awarded their award by the Executive Director of Nursing supported by other members of the Executive Team. They will also receive a celebration plaque, cupcakes and fruit basket on the day.

1.4. Scoring

The scoring system has been through a robust review process. The scoring system assigns weights on both medals and standards. The weighting ensures that even though 94 out of 131 standards are under Harm Free Care, this domain will not over dominate other sections with fewer standards. Similarly, it gives confidence that 50% of the outcome is based on Harm Free Care. A further advantage is the recognition of earning gold medals rather than just treating them with similar weight. It incentivises gold and silver medals earned by

assigning 3 points to gold, 2 to silver, and 1 to bronze and it includes all achievements/medals accordingly.

Gold	90-100%
Silver	80-89%
Bronze	65-79%
Platinum	Maintained gold for two consecutive years

1.5. Progress and Next Steps

The first three wards involved in the trial of accreditation have received outcomes and they are in the process of receiving their well-deserved awards. Since November 2024, ten baseline assessments and three further accreditation days have been completed. A further 18 baseline support offers have been made and accreditation dates have been set up until June 2025.

Freeman Hospital (FRH) Ward 10	Silver
Royal Victoria Infirmary (RVI) Ward 50	Silver
Great North Children's Hospital (GNCH) Ward 11	Silver
FRH Ward 32	Bronze
Northern Centre for Cancer Care (NCCC) Ward 33	Silver
RVI Ward 49	Silver
RVI Ward 37	Gold

In regard to bespoke standards for other areas, the next steps are to work in collaboration with maternity and critical care areas. These areas will then be trialled in a similar way to the inpatient standards.

2. NURSING AND MIDWIFERY STAFFING UPDATE

2.1 Nurse Staffing Escalation

Newcastle Hospitals Nursing Safe Staffing Guidelines provide a framework to ensure safe nurse staffing governance and articulates a clear process for safe staffing escalation.
The Trust staffing escalation is currently at level two due to the following triggers:

- Sustained sickness absence greater than 6% for the registered nursing and midwifery workforce.
- Surge beds have been utilised periodically, which has created an increased staffing requirement.

The following actions are in place and are overseen by the Executive Director of Nursing:

- 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.
- Daily review of staffing red flags and incident (Datix) reports.

- Staff bank HCA pool is reviewed daily, using SafeCare to identify areas of shortfall and reduce agency requirement.

Weekend Matron/Senior Nurse cover was initiated in November 2024 which enhances staffing and professional oversight out of hours.

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

2.2 Nurse Staffing and Clinical Outcomes

The monitoring of safer staffing metrics against clinical outcomes/nurse sensitive indicators as mandated in national guidance continues via the Nurse Staffing and Clinical Outcomes Operational Group (NS&O). Safer Staffing Metrics are reviewed with nurse-sensitive indicators and patient experience on the Safer Staffing Dashboard (Appendix 1) alongside any concerns raised by professional judgement or following any incidents. These metrics are rag-rated and following discussion are categorised as; requiring no support; low, medium, or high-level support. Actions are agreed in line with level of escalation: low/medium (focused interventions for areas of concern), high (full action plan). Mid-point meetings are held to examine and support action plans. High and Medium (>2 months) level support areas are reported to Executive Director of Nursing every month. Wards are only de-escalated from high level support following a successful peer review.

Below is an overview of wards reviewed, and support levels required during the last quarter:

Month	Total	Clinical Board	High level support	Medium level support	Low level support
Sept-24		Family Health Services	2		5
		Surgical and Specialist Services RVI		1	1
		Perioperative Services			1
		Cardiothoracic Services			2
		Medicine and Emergency Care Services		2	7
		Surgical and Associated Services FRH		1	2
		Cancer and Clinical Haematology Services		1	
Total	**25**		**2**	**5**	**18**
Oct-24		Family Health Services	2		4
		Surgical and Specialist Services RVI		1	1
		Perioperative Services			1
		Cardiothoracic Services			3
		Medicine and Emergency Care Services			7
		Surgical and Associated Services FRH		1	2
		Cancer and Clinical Haematology Services		1	1
Total	**24**		**2**	**3**	**19**
Nov-24		Family Health Services	2		4
		Surgical and Specialist Services RVI		1	1
		Perioperative Services			1
		Cardiothoracic Services		1	4

Month	Total	Clinical Board	High level support	Medium level support	Low level support
		Medicine and Emergency Care Services			9
		Surgical and Associated Services FRH		1	2
		Cancer and Clinical Haematology Services		1	1
Total	**28**		**2**	**4**	**22**

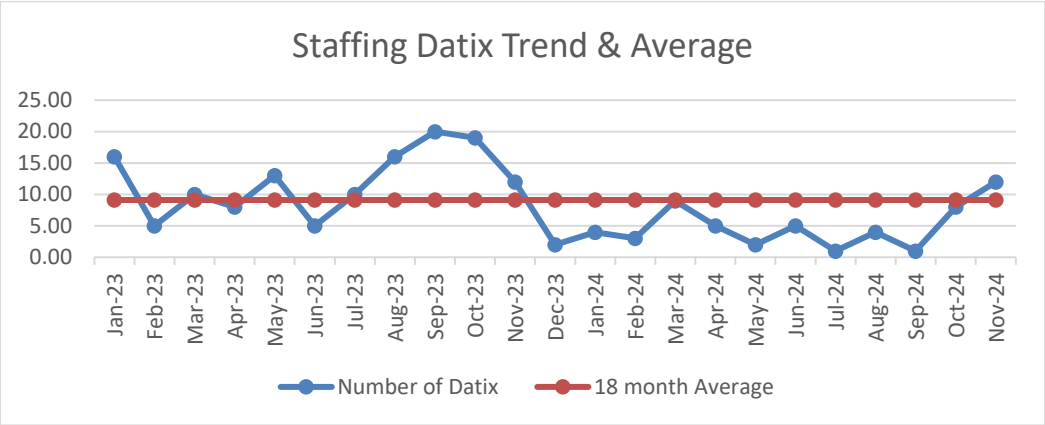
The key points from this group are noted below:

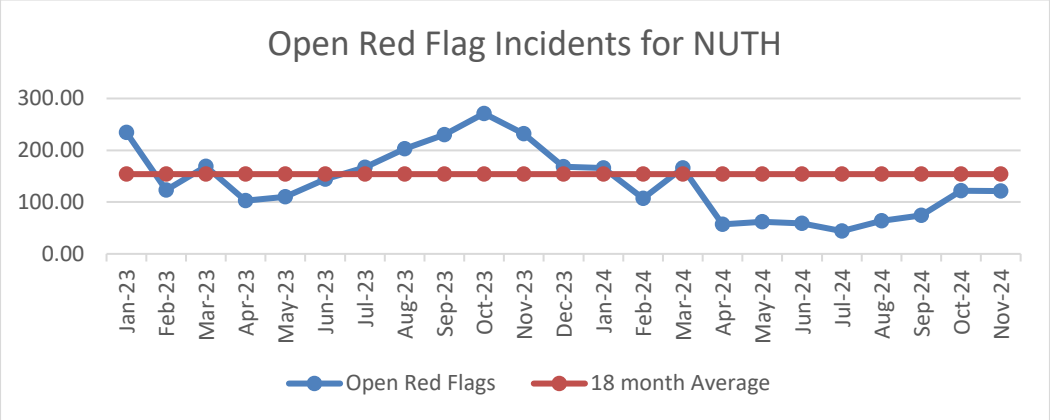
- Two wards (Wards 3 & 4 GNCH) have required high-level support over the last three months.
- Ward 4 GNCH had a peer review on 9 December 2024 and a staff survey on 30 December 2024. The results have been collated and this has resulted in Ward 4 being de-escalated from high to medium level support. An action plan will remain in place and includes improvement required in areas such as enhanced care observation, Infection Prevention and Control (IPC) practice, medication safety and staff experience/team communication.
- Ward 3 GNCH required high level support due to staffing concerns and concerns raised by learners in that department. These are unlikely to resolve until recruited staff commence employment and successfully complete their supernumerary period. This is being mitigated by closed beds and a supportive action plan.
- Wards under high-level support, have action plans in place led by the Heads of Nursing. The action plans are examined monthly at the NS&O mid-point review meeting, the outcome of which is fed back to the NS&O group. The wards of concern needing high-level support are discussed and presented at the Trust's Quality Committee for scrutiny and oversight.
- In addition to the high-level monitoring, oversight and assurance provided by the group, there continues to be a robust leadership and management framework led by the head of nursing and matron teams.

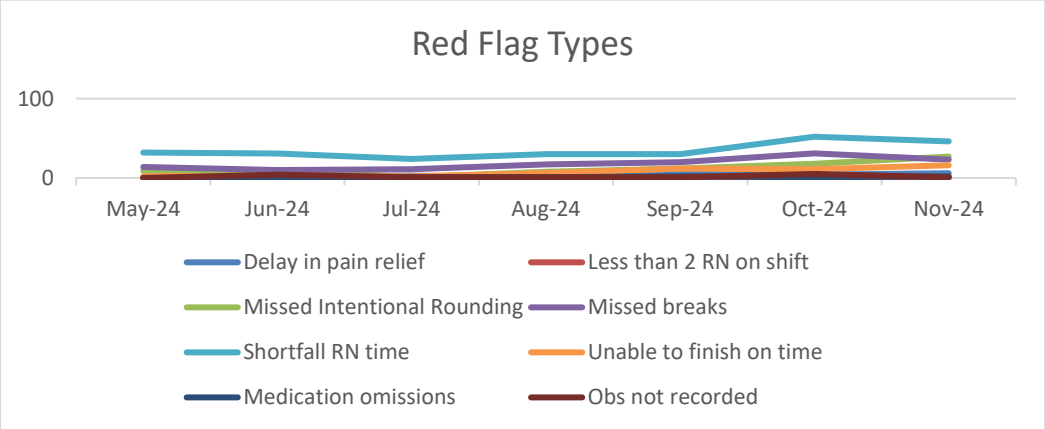
2.3 Datix and Red Flag data

Red flag and Datix incident data is reviewed daily (Monday-Friday) by the senior nursing team and reported as part of the daily staffing briefing. Red flag and Datix data are presented to the NS&O and group every month, highlighting trends and areas of concern. Staffing incident data is considered in nurse staffing reviews during discussions about future establishment requirement.

All staffing incidents reported on Datix are received by the senior nursing workforce team. In hours, the incidents are reviewed in real time, and out of hours, as soon as practicable. Reporters and Matrons are contacted to acknowledge receipt and gain greater understanding of themes, where appropriate. When incidents are being responded to in real time mitigations and resolution is sought. Work continues to encourage staff to submit Datix reports for staffing shortfalls.







Key points to note:

- There was a significant and sustained reduction in staffing Datix reports since December 2023. However, staffing Datix reports have increased since September 2024 which has been actively encouraged.
- An increase in staffing Datix has occurred predominantly in Medicine and Emergency Care Services, but also in Cardiothoracic Services.
- There has been a significant reduction in red flag incidents reported since March 2024, with the number of reports remaining below the 18-month average (137).
- The most reported reg flag type was “Shortfall in RN time”, with “Missed Breaks” and “Missed Intentional Rounding” also being regularly reported. Over the past three months there has been an increase in reporting of “unable to finish on time”.
- From August to November 2024, there were no unresolved red flags for “less than 2 RN on shift”.

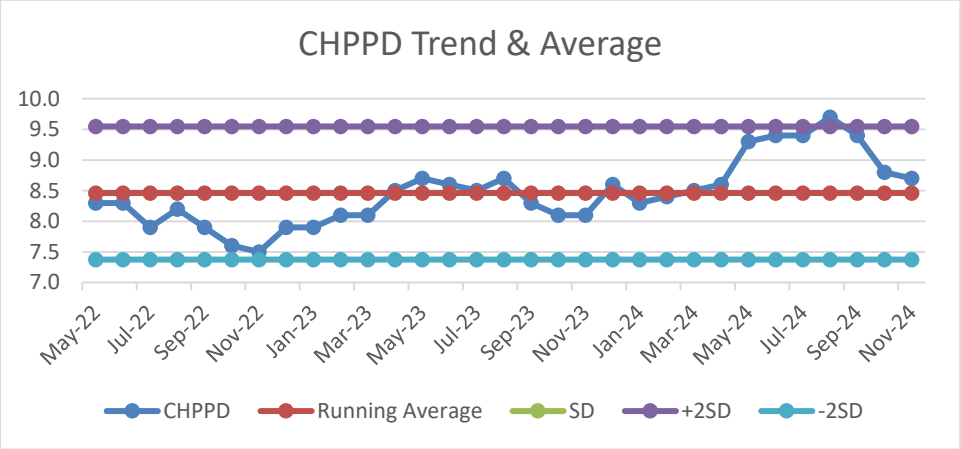
2.4 Care Hours Per Patient Day (CHPPD) data

Care hours per patient day (CHPPD) is the unit of measurement recommended in the Carter Report (2016) to record and report deployment of staff working on inpatient wards. This became the primary benchmarking metric from September 2019. It adds together Registered Nurse/Midwife and support worker hours, divided by midnight census. All acute Trusts have been required to report their actual monthly CHPPD, to NHS Improvement since May 2016.

There are some limitations to using CHPPD as a benchmark. Newcastle Hospitals has a high proportion of Critical Care beds which inflates the Trust overall average CHPPH score. In addition, the Trust has some highly specialised in-patient areas where there is no comparable benchmarking category, in these cases the wards are benchmarked to the closest comparable category.

The staffing team monitor Ward-specific CHPPD on the Safer Staffing Dashboard and is reviewed at the Nurse Staffing and Outcomes Group every month.

The Trust CHPPD trend data is detailed in the graph below:



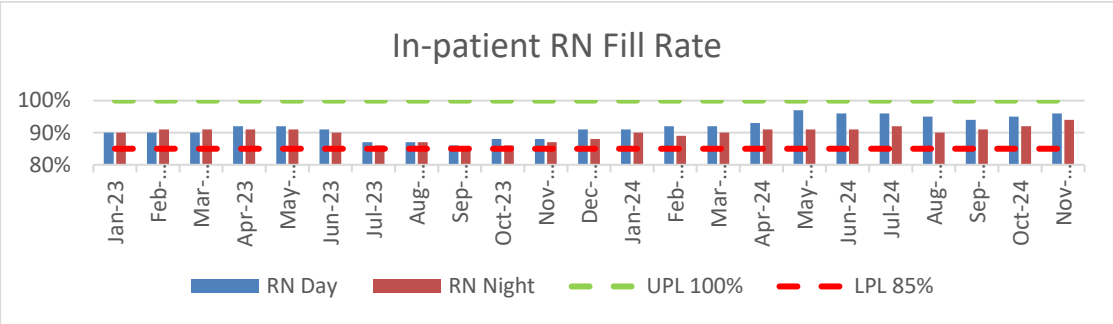
Key points to note:

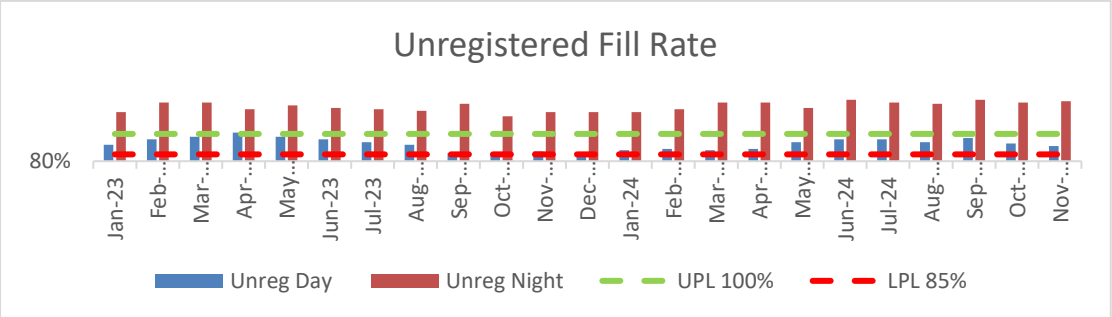
- The Trust CHPPD remains above average but has reduced in the past two months. This is consistent with an increase in sickness absence and an increase in bed occupancy, including utilisation of surge beds.

2.5 Planned versus actual hours (fill rates)

Planned staffing is the amount (in hours and minutes) of Registered Nurses (RN), Midwives, and additional clinical support time that each in-patient ward is planned to have on duty each day. This is based on maximum utilisation of their planned establishment. Actual staffing is the amount of time (in hours and minutes) worked on duty each day, separated into day and night shift. The planned staffing data is entered by the staffing team and adjusted for temporary bed closures or following any agreed nurse establishment change. The actual hours are generated by automated report via allocate health roster. This data is posted on the public website in line with NICE (2014) guidance.

The planned and actual staffing hours are converted into "fill rates" which are entered onto the safer staffing dashboard, rag rated and reviewed monthly by the Nurse Staffing and Clinical Outcomes group. RN fill rates <85% are reported to the Executive Director of Nursing every month.





Key points to note:

- RN dayshift fill rate has remained over 94%, and nightshift over 91% for the past 3 months.
- HCA dayshift has declined over the past 3 months, to 91% in November 2024.
- HCA nightshift fill rate has increased further to 123-125%, which is partially due to backfill for RN shortage and greater bank/agency healthcare uptake of shifts on nights, compared to days.
- A HCA shortfall on nightshift has been identified for some wards during the nurse staffing review process. To mitigate risk, these wards are rostering HCA staff to the agreed levels indicated in the nurse staffing review which is over their current establishment to maintain safety and quality of care.

2.6 Rostering Assurance (Check, Challenge & Coach)

The "Check Challenge and Coach" process 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 (KPI) are reviewed to identify areas for improvement and implement appropriate supportive action. The KPI currently being measured are annual leave approval, unused hours and roster approval.

Key points to note:

- The check, challenge and coach system has been effective in improving the timeliness of advance electronic rostering, which improves staff experience and provides advance staffing oversight.

- Unused hours have continued on a downward trajectory, this improves rostering efficiency and staff experience by ensuring that staff hours are maintained effectively.
- Annual leave compliance has remained variable, as it is complicated by variance in staff numbers through turnover, leave before or after maternity and requests granted pre-employment.
- KPI metrics are under review and the testing of two additional metrics will take place in January 2025.

2.7 Registered Nurse (RN) Recruitment

Key points to note:

- The current total RN turnover is 6.18%, based on Month 9 2024 data, this demonstrates a further reduction from the previously reported 8.37% in the same period last year.
- The current RN vacancy rate is 1.07%, based on the financial ledger at Month 9 2024 this is a remains stable from the 1.07% reported in Month 8 and is below the figure of 1.90% reported in the same period last year. This relates to current substantive staff in post and does not include those staff currently in the recruitment process.
- Where there are RN shortfalls in specialist areas these are recruited to with a bespoke, standalone approach.
- The NMAHP recruitment and retention group provides oversight of quality improvement work through enhancing and optimising workforce strategy, implementing and overseeing key priorities and work streams in relation to NMAHP recruitment and retention and monitor outcomes.

2.8 Healthcare Support Worker (HCSW) Recruitment

Key points to note:

- The Trust HCSW vacancy rate is currently 8.60%. This is an improvement from the November 2024 Board Report when the rate was 9.5%. It should be noted that the Trust Workforce report contains non-HCSW staff such as house keepers in the vacancy rate and so with those staff manually removed the HCSW vacancy rate is lower. Our number of unallocated Recruitment Control Group's (RCG) for Band 3 HCSW or 'actual live vacancies' is currently 22.85 WTE which would equate to a vacancy rate 1.80%.
- Based on December 2024 data, the HCSW turnover rate was 9.42% compared to 11.32% the previous year reflecting a reduction likely associated with the work of ongoing retention workstreams.
- Our monthly centralised recruitment was paused for January due to the low numbers of vacancies. Instead, the focus will be on HCSW Apprentice recruitment.

3. FLU VACCINATION PROGRAMME UPDATE

The Trust Staff Vaccination Programme commenced in early October 2024 primarily delivering the Flu vaccine shortly followed by Covid vaccine. Staff were encouraged to take up the offer of both vaccines to protect themselves, family and patients.

A mixed model delivery approach was adopted:

- Fixed clinics at the RVI, Freeman and Regent Point.
- Vaccinator 'floor walkers' visiting clinical areas.

- Bespoke 'pop up' clinics as requested.
- Peer vaccinators vaccinating within Clinical Boards.

Vaccinations are monitored daily, with information available by staff group and department on Business Intelligence. The accessible data is new for this year, and it is hoped that this will help inform clinical boards and encourage staff to take up the offer of the vaccinations.

Uptake of vaccines is also monitored against previous year. Uptake is lower than in previous years and this lower uptake is reflected in peer organisations and nationally therefore there was a request from Department of Health and Social Care to extend the offer of vaccination until the end of January 2025. The Trust continues to deliver the vaccination programme.

Communication highlighting the increased of prevalence of Flu across the region, the continued availability of vaccination together with 'myth busting' information has been circulated in Trust briefings. This has had a positive outcome as there has been a noticeable increase in clinic bookings early in January 2025. As of the 20 January 2025 the number of staff who have received the Flu vaccine are just over 9,600 (51.33% of staff). This is the highest number and percentage both regionally and nationally for Trusts with more than 10,000 staff. The total number of staff vaccinated against Covid was 5,037 (26.96% of staff). Although uptake is low this number compares favourably against both regional and national data.

4. PRACTICE EDUCATION UPDATE

4.1 Placement Capacity

The Practice Education Team continues to oversee all practice placement aspects of NMAHP undergraduate training, ensuring our students have access to the highest quality learning opportunities and experiences, in safe, effective learning environments. Work has continued throughout the year to develop and strengthen the portfolio of placements for our learners at Newcastle Hospitals, with particular emphasis on maintaining and raising quality, whilst working collaboratively with Higher Education Institutions (HEI). At present the Trust works predominantly with three HEIs with the team supporting placements for students from across the country who have requested to experience working at Newcastle Hospitals. Placements are co-ordinated by the team in conjunction with the education providers across the year to maximise capacity, ensuring an appropriate and fair allocation of students in each area. The Trust remains the largest provider of undergraduate nursing placements regionally and one of the largest nationally.

In the last year the Practice Education Team have focused on Midwifery Practice Education. The coaching approach to learning was implemented on the Post Natal ward which has greatly enhanced the student experience, increasing feelings of being valued and respected, whilst developing skills to provide high quality care for women, under safe supervision. This approach also enabled an increase in student capacity which has significantly helped to relieve some of the regions capacity challenges within midwifery education.

Within Occupational Therapy (OT), placement availability due to increased workforce pressures, has presented a challenge in supporting learners on placement. The Practice

Education Team have worked closely with the AHP Workforce Lead, Head of OT Service and educators to implement a capacity model which will enable a degree of forward planning and assurance to our HEI partners, ensuring an equitable allocation of learners into placement, whilst balancing the demands of clinical pressures.

An extended day, multi-professional placement model was also introduced for OT and Physiotherapy students allocated to the Motor Neurone Disease team, which allowed all students, including nursing students to work together and participate in multi-professional working and learning, enhancing the student learning experience. This is just one example of how alternative models of Practice Education have been implemented to enhance student experience with, AHP teams in receipt of a 'Models of Education' masterclass which was well received by educators.

4.2 Support to Learners and Staff

The Practice Education Team are fundamental in ensuring that all learners have a positive learning experience across a large portfolio of practice placements in both the acute and community setting. This year, the introduction of the Safe Learning Environment Charter (SLEC) has provided a framework for which the Team can support the development of positive safety cultures, aligned to the NHS People Promise, ensuring that learners are recognised as vital contributors to the workforce. Whilst this can be extremely challenging at times, positive relationships across the NMAHP professions internally, and with key stakeholders externally, ensures challenges are pro-actively managed.

The Practice Education Team, in conjunction with colleagues from local HEIs, have continued to provide face to face and online education and training for NMAHP staff, which is vital, ensuring staff remain informed and current when it comes to providing high quality support for learners in practice.

The Trust received non-recurrent funding from NHS England as part of their Enabling Effective Learning Environments project. The final allocation of funding was utilised this year, to enable the allocation of resources to Midwifery practice education, and to appoint two Practice Education Assessors temporarily until July 2025.

The AHP Workforce and Practice Development team, alongside the Practice Education Team, have delivered a pre-preceptorship programme for third year AHP students which has evaluated very positively and are now working in collaboration with preceptorship team to include all NMAHP learners across organisation in the year ahead.

Several strategies have been supported by the Practice Education team throughout the year to support the aforementioned SLEC and include:

- Student noticeboards have been established in Midwifery and Children's nursing as mechanism for communicating key messages with regard to student learning.
- The Student Voice, multi-professional forums, with a key focus each month, have continued with great success.
- Student inductions for new students have continued, preparing them for their roles within healthcare teams.

5. RECOMMENDATION

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

Report of Ian Joy
Executive Director of Nursing
23 January 2025

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	31 January 2025		
Title	Perinatal Quality Surveillance Report, including Maternity Incentive Scheme update		
Report of	Ian Joy, Executive Director of Nursing		
Prepared by	Jenna Wall, Director of Midwifery		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. The report details the Trusts self-assessed position against the Maternity Incentive Scheme 10 Safety Actions, compliance, any areas of risk and the mitigations in place. Key points/risks to note: • The 2024 CQC Maternity Survey results have been published. The 2024 performance is very similar to the 2023 results. The service is co-producing an improvement plan with the Maternity and Neonatal Voices Partnership (MNVP) Lead, which will be overseen by the Perinatal Engagement and Inclusion Group. The lowest scores were regarding choice in place of birth and the ability for partners to remain present for as long as they wished. The Newcastle Birthing Centre services have now been reinstated and the impact of this will be measured in future surveys. • The Trust triggered a safety signal from the North East North Cumbria clinical indicator dashboard for Appearance, Pulse, Grimace, Activity and Respiration (APGAR) score <7 at 5 minutes. The multidisciplinary review group has agreed the terms of reference and audit methodology, the review is due to conclude in January 2025. • The Trust will not achieve compliance with Safety Action 6 and 8. Progress meetings continue every two weeks within the Maternity Department to enable direct oversight and support from the Director of Midwifery and Head of Obstetrics. A further update will be provided in February regarding compliance with Safety Action 1 and 5. • Improved performance with triage within 15 minutes of attendance has been maintained at 94%. Midwifery review thereafter has also been maintained for the last 5 months across all categories of urgency. The North East and North Cumbria (NENC) Local Maternity and Neonatal System (LMNS) have agreed the targets for medical review at the LMNS Board in November 2025, the Trust performance will be benchmarked against these as a pilot site in January 2025. • The service is making good progress with the Care Quality Commission (CQC) action plan against exit criteria from Single Oversight Framework (SOF) enhanced surveillance, which includes several successful baby abduction drills. • There is currently a comprehensive Infection Prevention and Control (IPC) plan in response to the two infection outbreaks on the Neonatal Intensive Care Unit (NICU) Glycopeptide Resistant Enterococcus (GRE) in Quarter 3 2024/25. 2 High Dependency Unit (HDU) cots		

<table>
<tr><td></td><td colspan="7">were temporarily closed in November 2024 to facilitate isolation of the remaining 2 infants, these were reopened at the end of November.
• Issues have been identified with the screening pathways and are subject to investigation. The Incident Oversight Group, with the Integrated Care Board (ICB) and NHS England (NHSE) representation, continues to meet fortnightly. There has been no harm identified, duty of candour has been enacted as appropriate, and service users have been engaged in the patient safety incident investigation. Support from an Associate Director has been secured to lead the improvement project to support outpatient transformation and the revision of the failsafe pathways.</td></tr>
<tr><td>Recommendation</td><td colspan="7">Trust Board is asked to:

i. Receive and discuss the report.
ii. Note compliance with the Perinatal Quality Surveillance Model (PQSM) and the receipt of the minimum data measures.
iii. Note the progress with the CQC actions.
iv. Note the current risks and mitigations in place.
v. Note progress with Maternity Incentive Scheme 10 Safety Actions.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="7">Putting patients at the heart of everything we do. Providing care of the highest standards focussing on safety and quality.</td></tr>
<tr><td rowspan="2">Impact

(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Reputation</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☒</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="7">Principal Risk - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.

Threat - Failure to improve the safety and quality of patient and staff experience in Maternity Services.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="7">Previous reports have been presented to the Trust Board, Maternity Update, Midwifery staffing paper, Maternity Incentive Scheme (Clinical Negligence Scheme for Trusts (CNST)).</td></tr>
</table>

PERINATAL QUALITY SURVEILLANCE REPORT

1. INTRODUCTION

This report provides the Trust Board members with an overview of the Maternity Service compliance with the Perinatal Quality Surveillance Model (PQSM), based on the locally and nationally agreed measures to monitor maternity and neonatal safety. The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. The report details the Trusts self-assessed position against the Maternity Incentive Scheme 10 Safety Actions, compliance, any areas of risk and the mitigations in place.

2. MINIMUM DATA MEASURES

The planned development of the perinatal quality surveillance metrics reported in the Integrated Board Report has been completed and therefore the number of data measures incorporated in this report have been reduced.

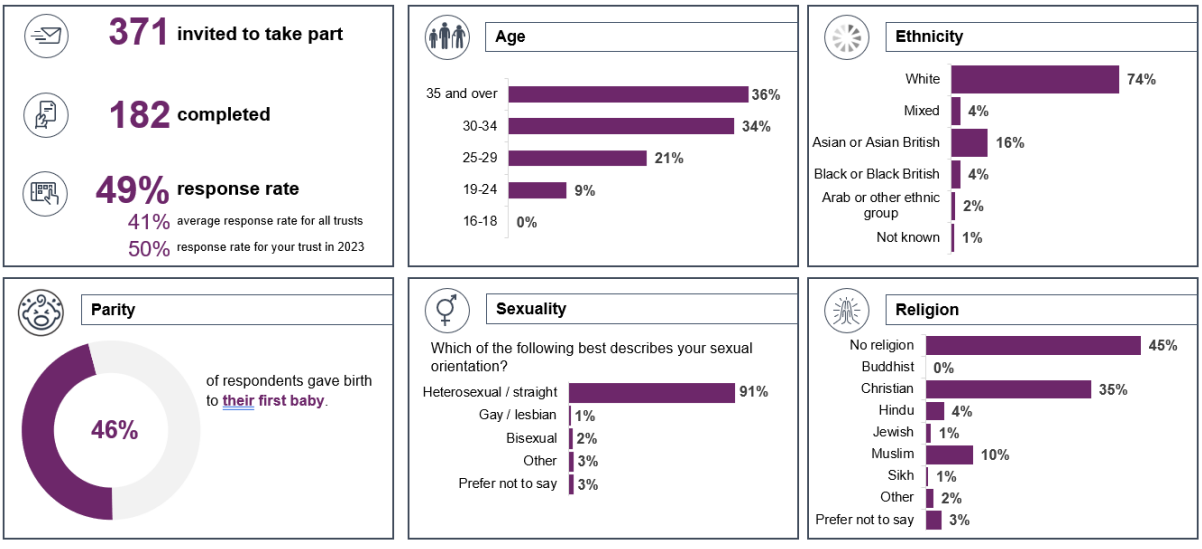
2.1 Service User Voice Feedback

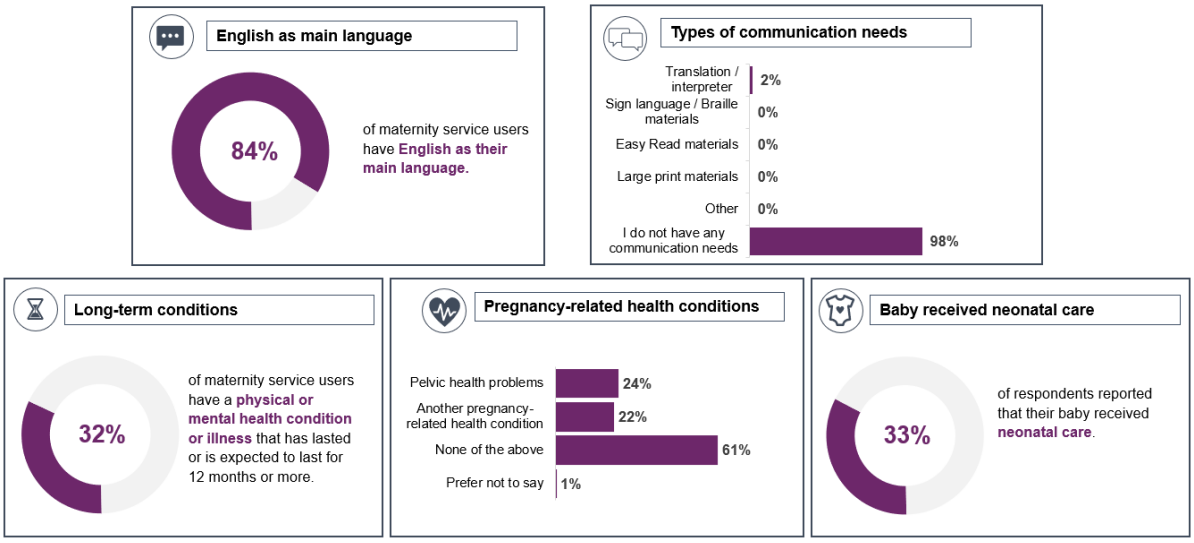
The 2024 Maternity Survey was the eleventh carried out to date. The CQC use results from the survey to build an understanding of the risk and quality of services. The Trust should use this valuable data to inform improvement plans and the quality and safety of care.

The Maternity Survey is split into four sections that ask questions about:

- Antenatal care
- Labour and birth
- Postnatal care
- Complaints

The response rate for the Trust was 49%, above the national average of 41%.

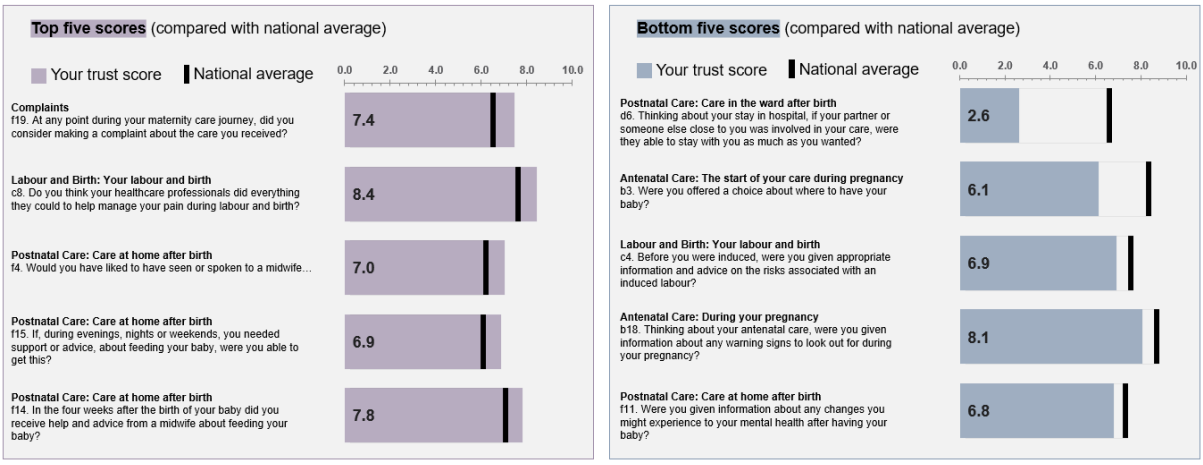




When comparing the 2024 survey results the Trusts with others:

- Much better than expected - 0.
- Better than expected - 4.
- Somewhat better than expected - 4.
- About the same - 47.
- Somewhat worse than expected - 1.
- Worse than expected - 1.
- Much worse than expected - 0.

The 2024 performance is very similar to the 2023 results, with 2 questions significantly better, and 2 significantly worse than last year's results.



The service is co-producing an improvement plan with the MNVP Lead, which will be overseen by the Perinatal Engagement and Inclusion Group.

The question 'Were you offered choice about where to have your baby?' scored second bottom of all the Trust responses. This is not surprising as at the time the survey was circulated the Newcastle Birthing Centre was closed and the homebirth service suspended, ultimately women had no choice in where to birth their baby. The services have now been reinstated and the impact of this will be measured in future surveys.

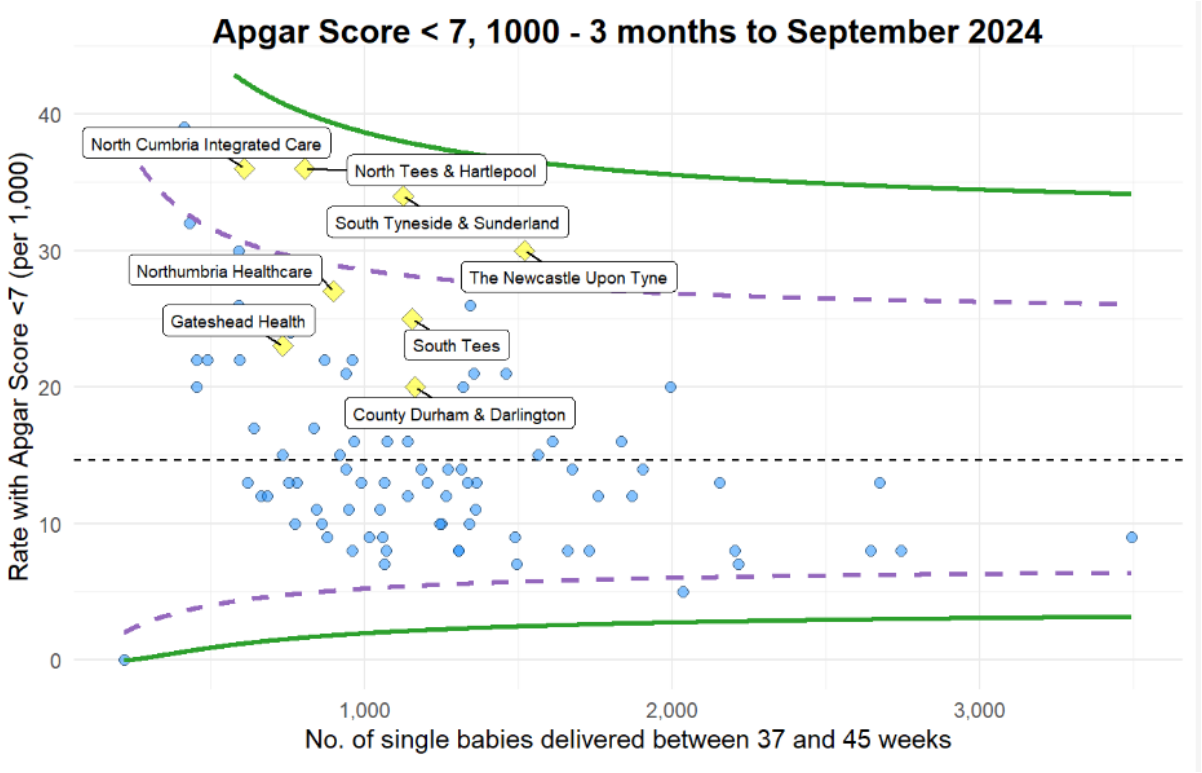
The lowest score in the survey was the ability for a partner to stay as much as wanted. This is not possible on the postnatal and transitional care ward due to the estate, with most postnatal beds in shared bays. The service provides a personalised approach, and the limited number of cubicles are allocated based on both physical and psychological need and to facilitate partners to stay overnight. The individual rooms on the Newcastle Birthing Centre means that partners can stay from admission to discharge, however, this creates inequality for high and low risk women.

The service has an active induction of labour quality improvement project underway; this group will consider the patient experience metrics relating to induction of labour.

The maternity service welcomes the results, and will endeavour to continue to improve the quality, safety, and experience for those accessing services, in advance of next year's survey.

2.2 Safety signal from NENC Clinical indicator dashboard

The Trust triggered a safety signal from the North East North Cumbria clinical indicator dashboard for APGAR score <7 at 5 minutes. The Trust is jointly reviewing this safety signal with South Tyneside and Sunderland NHS Foundation Trust who have also triggered a safety signal.



The multidisciplinary review group has agreed the terms of reference and audit methodology. The data collection will include:

- Maternal Postcode
- Maternal Pyrexia
- Liquor
- Anaesthetic Induction agent used
- Maternal Antidepressant use

- Term Infants with congenital anomaly to be included
- Birthweight centile
- Time of delivery
- Cardiotocography (CTG) abnormality in the last hour prior to delivery
- Delayed cord clamping
- Seniority of neonatal team present at delivery

The team plan to review 2 quarters of data by the end of January, to be reported to the LMNS Quality and Safety Group. Early indications are that APGAR is being underscored, but the data set and completed review are required to confirm this.

2.3 Progress in achievement of CNST Maternity Incentive Scheme (MIS) 10 safety actions

Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

- Notify all deaths: *All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days.*

There have been 64 cases reported since the 8 December 2023 and all (100%) have been notified within 7 days.

- Seek parents' views of care: *For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.*

Parents perspective is an integral part of the review process. The Trust is confident parents are given the opportunity to provide feedback and raise questions, however we are not as confident that this is captured and reported in a timely manner. Analysis of this data is currently being reviewed by MBRRACE and will be clarified in the next two weeks.

- Review the death and complete the review: *For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.*

98% (50/51) of cases the review had been started within two months. Compliance with completing and publishing the report within 6 months is 93%. There is concern that some of the questions had not been completed within the two-month time frame hence the Trust has sought clarification from MBRRACE, compliance for these two elements is yet to be confirmed.

The Neonatal Safety Champion has raised concerns regarding the volume and complexity of neonatal mortality cases which require review, this has been escalated to the LMNS and Operational Delivery Network (ODN) to explore system approaches to manage capacity across the ICB.

- Report to the Trust Executive: *Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.*

The quarterly PMRT reports for 2023/24 have been included in previous reports to the Board. The Quarter 3 report will be available for the next Trust Board in February 2025.

Confirmation as to whether Safety Action 1 has been achieved will be reported in February 2025.

Safety Action 2: Are you submitting data to the Maternity Service Data Set (MSDS) to the required standard?

This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.

a) *Trust Boards to assure themselves that at least 10 out of 11 MSDS-only. (see technical guidance) Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024.*

The Trust passed 11 out of 11 for the data submitted in July 2024.

b) *July 2024 data contained valid ethnic category (Mother) for at least 90% of women booked in the month.*

The Trust achieved 99% compliance in July 2024.

The Trust has confirmation that it has successfully passed Safety Action 2.

Safety Action 3: Can you demonstrate that you have Transitional Care (TC) Services in place and undertaking quality improvement to minimize separation of parents and their babies?

a) *Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice* or

Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards.

The Trust opened a stand-alone Transitional Care unit on the 22 April 2024. The pathway has been revised to reflect the new service in alignment with the BAPM Framework.

b) *Drawing on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and LMNS.*

A working group was established to agree the Quality Improvement (QI) project. The project has been registered with the Trust (project no. 16685). Progress on the project was presented to the Safety Champions on the 9 October 2024 and LMNS on the 15 October 2024. A further update will be provided to the LMNS on the 16 January 2025.

The Trust is compliant with Safety Action 3.

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

a) Obstetric medical workforce

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

I. Currently work in their unit on the tier 2 or 3 rota or

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

III. hold a certificate of eligibility (CEL) to undertake short-term locums.

Short term locums in Obstetrics and Gynaecology on Tier 2 or 3 have been appointed to cover periods of sickness and industrial action within the past year. All locums have been from within our current cohort, or in 1 case during October from the previous year's cohort (an ST6 on Tier 3). All hold eligibility through the Royal College of Obstetricians and Gynaecologists (RCOG) certificate. All Obstetric Consultant locum cover has been provided by the current Consultant cohort. The Trust has developed a Standard Operating Procedure to describe how this is achieved.

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-term locums-in-mate.pdf

The Trust has had two long term locums within Obstetrics within the past 6 months. There remain significant vacancies at consultant level. The Trust is compliant with the guidance and has developed a Standard Operating Procedure to describe how this is achieved.

3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. ***While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to***

address this guidance. *rcog-guidance-on-compensatory-rest.pdf*

The Trust provides 98-hour consultant resident presence for the acute service. To do so with a current vacancy factor (30%) requires a rota of 1 in 8.5 resident until 22.00hrs; all but one Consultant remains in residence for the 24-hour period. This is followed by a day of compensatory rest. The junior doctors work a 1 in 8 rota with fully compliant compensatory rest periods before and after their shifts. The compensatory rest period is included in the software package Medirota, which is used to roster all the shifts.

4) *Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service roles-responsibilities-consultant-report.pdf when a consultant is required to attend in person.*

The Consultant attendance audit continues to show overall attendance of 100%.
The Quarter 1 report was presented to the Maternity Board Level Safety Champions on the 9 October 2024 and was included with the papers for the November Trust Board report.
Quarter 3 incidents will be reviewed and included in the March Trust Board report.

b) Anaesthetic medical workforce

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1)

An audit of one month's rota (August 2024) was undertaken and findings discussed at the Obstetric Quality and Safety Group in October 2024. There were no concerns regarding the availability of a duty anaesthetist and the Trust is compliant with this requirement.

c) *Neonatal medical workforce*

The neonatal unit meets the relevant BAPM national standards of medical staffing or

the standards are not met, but there is an action plan with progress against any previously developed action plans.

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

A workforce paper was presented to the Maternity Board Level Safety Champions on the 12 June 2024 outlining the current position with the neonatal medical workforce. The Consultant workforce is compliant with the BAPM national standards. Funding has been approved to increase trainees and mitigate whole time equivalent (WTE) shortfalls in the speciality training rota gaps. Trainee rota compliance can vary with every 6 months rotation.

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards or

The standards are not met, but there is an action plan with progress against any previously developed action plans.

Any action plans should be shared with the LMNS and Neonatal ODN.

A Neonatal Nursing Workforce review was undertaken in July 2024 which demonstrated a deficit of nursing staff due to vacancy. There has been progress with the action plan with ongoing monitoring of the outstanding issues. The updated action plan has been shared with the LMNS and ODN. Work is ongoing to review the nursing establishment and ratios on Transitional Care.

The Trust is compliant with Safety Action 4.

<u>Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?</u>

a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.

The Trust completed the BirthRate+ workforce calculation in April 2024 and the report was shared with the Trust Board in July 2024.

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

The three yearly Birthrate Plus midwifery workforce report was received by the service in June 2024, a full workforce review has been completed by the Director of Midwifery. The Birthrate Plus report recommends a clinical midwifery staffing establishment of 257.47 WTE. There is a shortfall of 8.31WTE between the current funded establishment and the recommendations of the workforce review, additional midwifery recruitment will not occur until phase 1 and 2 of the workforce plans are completed. This includes a correction in skill mix and the expansion of core teams. Investment is required in Quarter 3 in advance of phase 3 in October 2025.

c) The midwifery coordinator in charge of labour ward must have supernumerary status;(defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator ***at the start of every shift****) to ensure there is an oversight of all birth activity with the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.*

A staffing dashboard for acute and community services has been developed to review the planned versus actual fill rates, acuity versus staffing and any associated safety metrics, such as red flag incidents, Datix reports and Clinical Assurance Toolkit (CAT) compliance. This is

monitored monthly by the senior midwifery team and reported to the Quality and Safety Group, with exception reporting to the Directorate Quality and Safety Group and Quality Oversight Group (QOG).
There have been sustained improvements in the fill rates across all clinical areas with no red flags in relation to one to one care in labour or the co-ordinator being supernumerary in November 2024. The Newcastle Birthing Centre opened as planned on 2 December 2024.

In the 12 month period from December 2023 to November 2024 there were 5 occasions whereby the co-ordinator was not supernumerary for part of the shift due to an escalation in activity for a short period of the shift, however the rota confirms they were supernumerary at the start of the shift, fulfilling this requirement.

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

In the 12-month period from December 2023 to November 2024 there were no occasions recorded whereby 1:1 care was not provided.

e) *Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.*

A midwifery biannual staffing report is submitted to Trust Board, in addition staffing updates are provided monthly in the Perinatal Quality Surveillance Reports to Trust Board. The biannual staffing paper has been submitted in January 2025.

The Trust expects to be compliant with Safety Action 5, this will be confirmed in the February 2025 update.

Safety Action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the 'Saving Babies Lives' Care Bundle Version 3?

Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.

The Trust has made significant progress over the last 6 months but is yet to achieve the minimum audit standard for several of the key indicators. Quality improvements discussions have taken place with the ICB/LMNS on 14 August 2024 and 20 November 2024. The next meeting is planned for 11 February 2025.

The Trust is not compliant with Safety Action 6.

SBL Measure	Description	Target	Rate							
			2023/24				2024/25			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
SBL_Element1_ProcessIndicator1	Recording of CO reading for each pregnant woman on Maternity Information System (MIS) and inclusion of this data in the providers' Maternity Services Dataset (MSDS) submission to NHS Digital	N/A	81.9%	85.7%	83.4%	85.1%	87.6%	89.5%		
SBL_Element1_ProcessIndicator2	Percentage of women where CO measurement at booking is recorded	90%	83.3%	84.6%	85.4%	83.2%	88.4%	90.5%		
SBL_Element1_ProcessIndicator3	Percentage of women where CO measurement at 36 weeks is recorded	80%	66.5%	69.0%	65.8%	57.4%	53.2%	76.6%		
SBL_Element1aiii	Percentage of women where smoking status is recorded at booking	80%	98.2%	98.0%	99.3%	99.5%	98.8%	99.1%		
SBL_Element1aiv	Percentage of women where smoking status at 36 weeks is recorded	80%	75.9%	77.8%	74.7%	65.6%	64.0%	83.6%		
SBL_Element1_OutcomeIndicator1	Percentage of women with a CO measurement ≥4ppm at booking	N/A	7.8%	9.1%	8.3%	7.5%	8.8%	7.3%		
SBL_Element1_OutcomeIndicator2	Percentage of women with a CO measurement ≥4ppm at 36 weeks	N/A	7.4%	6.4%	5.9%	4.0%	3.2%	5.6%		
SBL_Element1_OutcomeIndicator3	Percentage of women who have a CO level ≥4ppm at booking and <4ppm at the 36-week appointment	N/A	47.1%	55.9%	51.4%	75.5%	63.3%	56.3%		
SBL_Element2_ProcessIndicator2	Percentage of pregnancies where an SGA fetus is antenatally detected and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital	N/A	9.7%	9.3%	14.0%	12.9%	8.1%	5.8%		
SBL_Element2_OutcomeIndicator2e	Percentage of babies >3rd birthweight centile born <39+0weeks gestation, where growth restriction was suspected	N/A	5.2%	4.6%	7.8%	7.2%	4.0%	3.2%		
SBL_Element2_OutcomeIndicator1	Percentage of babies who are below the 3rd centile of weight born after 37+6 weeks gestation	N/A	35.2%	22.4%	39.7%	41.8%	44.1%	48.3%		
SBL_Element2_OutcomeIndicator2	Percentage of babies born after 39 weeks (+6 days) who are below the 10th centile of weight	N/A	10.1%	14.2%	12.8%	11.5%	11.7%	15.5%		
SBL_Element5_OutcomeIndicator1a	The incidence of women with a singleton live birth in the late second trimester (from 22+1 to 23+6 weeks), as a % of all singleton live births	N/A	0.2%	0.1%	0.1%	0.3%	0.3%	0.2%		
SBL_Element5_OutcomeIndicator1b	The incidence of women with a singleton live birth preterm (from 24+0 to 36+6 weeks), as a % of all singleton live births	N/A	7.1%	7.1%	7.3%	7.3%	7.3%	7.0%		

<u>Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services within users.</u>

1. *Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting:*

   a) Engagement and listening to families.
   b) Strategic influence and decision-making.
   c) Infrastructure.

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

The CQC Maternity Survey action plan has been shared with LMNS, and an update to LMNS Board is scheduled for January 2025.

The Trust is compliant with Safety Action 7.

<u>Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?</u>

90% of attendance in each relevant staff group at:

1. *Fetal monitoring training*
2. *Multi-professional maternity emergencies training*
3. *Neonatal Life Support Training*

This Trust delivers the NENC LMNS training syllabus, developed to fulfil the training requirements of the core competency Framework v2 and maternity incentive scheme.

Training for the obstetric workforce remains challenging due to consultant vacancies, whilst on track to achieve compliance with the Trust target, the Trust has not been able to achieve compliance with the Maternity Incentive Scheme (MIS) requirements. There is a plan in place to ensure all Consultants and medical staff receive the required training by the end of the financial year.

Obstetric emergency Training Day (including Newborn Basic Life Support (BLS))

Staff Group (SG)	No. staff in post (incl. Bank)	No. to train	No. trained as of 30 Nov 2024	% trained up to 30 Nov 2024	Target by 30 Nov 2024	Trust Target Adult/ Newborn BLS
Midwives'/sonographer/ Midwifery Managers/ Bank Midwives	333	309	292	94%	90%	95%
Maternity Support Worker/ Nursery Nurses/ HCA's	102	90	82	91%	90%	95%
Theatre staff	10	10	10	100%	90%	95%
Obstetric Consultants	13	13	11	85%	90%	95%
Anaesthetic Consultants	16	15	15	100%	90%	95%
Trainees	38	36	33	92%	90%	95%
Anaesthetic trainees	17	17	15	88%	70%	95%
Total	**529**	**490**	**458**	**93%**	**90%**	**95%**

Maternity Safety and Public Health in Practice Day (includes Level 3 Safeguarding update, Saving Babies Lives Care Bundle (SBLCB) and Core Competency Framework modules 1 and 4)

Staff Group	No. staff in post (incl. Bank)	No. to train	No. trained as of 30 Nov 2024	% trained up to 30 Nov 2024	Target by 30 Nov 2024	Trust Target SG
Midwives'/sonographer/ Midwifery Managers/ Bank Midwives	333	309	294	95%	90%	95%
Maternity Support Worker/ Nursery Nurses/ HCA's	102	90	86	96%	90%	95%
Theatre staff (includes DS)	10	10	9	90%	90%	95%
Total	**445**	**409**	**389**	**95%**	**90%**	**95%**

Fetal Wellbeing Training Day

Staff Group	Eligible staff	No. to train	No. trained as of 30 Nov 2024	% trained up to 30 Nov 2024	Target by 30 Nov 2024
Midwives'/sonographer/ Midwifery Managers/ Bank Midwives	302	281	262	93%	90%
Obstetric Consultants	13	13	11	85%	90%
Obstetric Trainees	31	29	24	83%	90%
Total	**445**	**409**	**389**	**95%**	**90%**

Neonatal Life Support training

Staff Group	Percentage trained
Neonatal Staff	98%
Midwives	94%

The Trust is not compliant with Safety Action 8.

Safety Action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on Maternity and Neonatal Safety and Quality issues.

a) *All Trust requirements of the PQSM must be fully embedded.*

b) *The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.*

c) *All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures.*

Regular safety champion meetings are embedded. The terms of reference were updated in October 2024 to ensure they fulfilled the national guidance.

The Trust has reviewed the Trust's claims scorecard alongside incident and complaint data. An overview was presented to the Maternity and Neonatal Safety Champions Group in June 2024 and a full report, based on the September 2024 Scorecard, has been completed.

New safety intelligence reporting has been developed and included within the Perinatal Quality Surveillance report section of the Integrated Board Report, in addition the service reports to Trust Board monthly.

The Trust is compliant with Safety Action 9.

Safety Action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notifications (EN) Scheme from 8 December 2023 to 30 November 2024?

a) *Reporting of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.*
b) *Reporting of all qualifying EN cases to NHS Resolution's Early Notification from 8 December 2023 until 30 November 2024.*
c) *For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that:*

   i. *the family have received information on the role of MNSI and NHS Resolution's EN scheme; and*
   ii. *there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.*

The Trust has reported 6 qualifying cases to MNSI and 2 cases to NHS Resolution since 8 December 2023, all the above requirements have been met.

The Trust is compliant with Safety Action 10.

Summary of 10 Safety Actions

The Trust will not achieve compliance with Safety Action 6 and 8. Progress meetings continue every two weeks within the Maternity Department to enable direct oversight and support from the Director of Midwifery and Head of Obstetrics. A further update will be provided in February regarding compliance with Safety Action 1 and 5.

2.4 Staff experience & feedback from frontline champions and walkabouts

The Trust has participated in the NHSE Perinatal Culture and Leadership programme, which was introduced in response to the Ockenden report, and is an action outlined in the Three-Year Plan for Maternity and Neonatal Care.

The results, and associated improvement plan, were agreed at the Perinatal People and Culture Group, which reports into the Obstetric Board and Family Health governance structure. A staff wellbeing champions group and communication task and finish group have been established in response to the survey results, with strong multidisciplinary representation from across the maternity and neonatal teams. Progress with the improvement plan will form part of the perinatal quality surveillance metrics.
Staff experience metrics need to be developed to track progress.

Early discussions with the Chief Experience Officer to plan the staff experience programme for the Perinatal Workforce to track impact of the culture and leadership actions.

3. PROGRESS WITH THE CQC ACTION PLAN AND EXIT CRITERIA

- Achieve compliance with the NENC triage performance metrics.

Month	Number of Triage Phonecalls	Number of Attendances	Initial Assessment within 15 mins	Green (4 hours)	Yellow (1 hour)	Orange (15 mins)	Red (immediate transfer)	Ongoing Midwifery care commenced within allocated time (GREEN)	Ongoing Midwifery care commenced within allocated time (YELLOW)	Ongoing Midwifery care commenced within allocated time (ORANGE)	Ongoing Medical care care met within 2 hours (GREEN)	Ongoing Medical Care meet within 1 hour (YELLOW)	Ongoing Medical Care met within 15 mins (ORANGE)	Immediate review by Medical Team (RED)
				Level of Urgency										
Jan-24	974	1069	876 (82%)	253	463	341	9	188 (74.3%)	358 (77.3%)	251 (73.6%)	46.70%	45.10%	34.20%	100%
Feb-24	827	986	825 (83.7%)	228	460	277	20	147 (63.9%)	351 (76.1%)	185 (66.8%)	33.30%	47.70%	35.90%	100%
Mar-24	867	1053	922 (87.6%)	194	539	301	15	138 (70.8%)	427 (79.4%)	214 (71.1)	36.20%	29.40%	33.90%	60%
Apr-24	759	1026	896 (87.3%)	158	522	334	9	110 (69.6%)	411 (78.9%)	236 (70.9%)	46.20%	38.60%	34.20%	33%
May-24	941	1067	854 (80%)	182	557	320	7	136 (74.7%)	455 (81.8%)	255 (79.7%)	50%	36%	36.90%	100%
Jun-24	1172	1149	921 (80.2%)	193	659	287	8	163 (84.5%)	593 (90%)	236 (82.2%)	56.50%	42%	29.90%	100%
Jul-24	1288	1196	1082 (90.5%)	196	678	306	15	193 (98.5%)	666 (98.2%)	281 (91.8%)	61.20%	55.60%	39.80%	100%
Aug-24	1206	1128	1041 (92.3%)	213	609	301	5	204 (95.8%)	581 (95.4%)	274 (91%)	77.70%	68.20%	50%	80%
Sep-24	1486	1203	1098 (91.3%)	182	763	245	13	174 (95.6%)	730 (95.7%)	224 (91.4%)	77.30%	50.60%	43.50%	100%
Oct-24	1749	1214	1125 (92.7%)	189	736	277	11	189 (100%)	729 (99%)	260 (93.9%)	73.90%	64.30%	38.80%	100%
Nov-24	1620	1192	1122 (94.1%)	187	723	275	6	187 (100%)	713 (98.6%)	258 (93.8%)	77.60%	60.70%	39.30%	100%

Improved performance with triage within 15 minutes of attendance has been maintained at 94% in November. Midwifery review thereafter has also been maintained for the last 5 months across all categories of urgency.

In November medical review performance within 15 minutes was 39%, within an hour 60% and within 2 hours was 77%. 100% compliance has been maintained for 3 months for women who require immediate review. Medical review compliance continues to be challenged by the obstetric staffing position, work is ongoing to maximise the medical capacity. Recruitment has concluded for 2 Trainee Advanced Clinical Practitioners, expected to come into post in February 2025. Patient safety is maintained by ensuring senior midwifery presence, with one-to-one care, and escalation if deterioration. The NENC LMNS have agreed the targets for medical review at the LMNS Board in November 2025, the Trust performance will be benchmarked against these as a pilot site in January 2025. Service user experience and metrics regarding telephone performance will also be collected as part of the overarching NENC LMNS Birmingham Specific Obstetric Triage System (BSOTS) dashboard. A recent MNSI report recommended that maternity triage calls are recorded at the Trust to enhance the accuracy of the information recorded and promote timely safe triage assessments. This is being explored by the BSOTS implementation group.

- Achieve compliance with Trust appraisal rate target for 2024/25.

The Maternity Service leadership team maintain oversight of appraisal rates and the associated action plans, the service is on track to achieve compliance.

- Embed baby abduction drills and required changes to policy, with evidence of successful drills over a 6 month period.

The Trust enacted a further baby abduction drill in December 2024, which was successful, demonstrating staff familiarity with the requirements of the updated policy and compliance. Further drills have been planned throughout the year, initially monthly, with a further drill planned for January, with a focus on processes in Newcastle Birthing Centre.

4. RISKS TO BE NOTED

4.1 Infection outbreaks NICU

There is currently a comprehensive IPC plan in response to the two infection outbreaks on the NICU Glycopeptide Resistant Enterococcus (GRE) in Quarter 2024/25. 2 HDU cots were temporarily closed in November 2024 to facilitate isolation of the remaining 2 infants, these were reopened at the end of November.

There have been regular senior clinical leadership meetings to review progress with the action plan and seek further guidance from IPC leadership team. There has been one further GRE case since the initial outbreak. There were some concerns regarding the delay in obtaining the GRE result and an extraordinary meeting was convened on 8 January 2025 to discuss.

It was agreed the service will continue:

- Weekly screening to continue.
- The Standing Operating Procedure (SOP) in place for transfer of babies elsewhere within the directorate and Great North Children's Hospital (GNCH) will continue.
- Deep Cleaning of intra-hospital and Northern Neonatal Transport Service (NNeTS) trollies will continue.
- Admission screening of GRE will continue for 6 months post final discharge home.
- Aprons and gloves will continue to be worn by parents for the foreseeable with no end date planned currently.
- The use of vancomycin will be reviewed at around 12 months.

A site visit of the services was conducted in November to begin the feasibility survey of decant options within the maternity estate to support the required NICU estate work. The service is awaiting an update on next steps.

4.2 Antenatal and newborn screening services

Issues have been identified with the screening pathways and are subject to investigation. The Incident Oversight Group, with ICB and NHSE representation, continues to meet fortnightly.

Nuchal and anomaly scans are offered as part of the Fetal Anomaly Screening Programmes (FASP). Routine antenatal scans are offered in the Antenatal Clinic, this is a very busy department caring for the 5,500 women each year. The sonography team perform scans for a variety of maternal and fetal indications, these include growth scans, cervical length scans and uterine artery dopplers in addition to the FASP scans.

As part of the FASP pathway if an anomaly scan cannot be completed (suboptimal view/fetal position) this needs to be repeated and completed prior to 23 weeks gestation. There is a SOP which outlines the process to follow to ensure scans are rearranged within the gestational window. If this SOP is followed correctly the Trust should achieve the key performance indicators (KPI).

When reviewing data for KPI it was identified that there were women who did not have a completed anomaly scan before 23 weeks gestation and that the process for identifying these cases was not robust. Initially 2 cases were identified as having had the anomaly scan performed after 23 weeks, this led to a more detailed review of scans performed over a 15-month period. The findings demonstrated that 1,175 women required a repeat scan after their initial anomaly scan due to it being recorded 'scan incomplete'. The findings showed that 88% of those women had a complete repeated anomaly scan performed before 23 weeks gestation. 7% were found to have the repeat scan performed after 23 weeks gestation, which falls outside of guidance. 4% were excluded when reviewed in more detail with mitigations. 4 women were not offered a repeat scan (0.5%) at all. These 4 cases all occurred between June to October 2023. The patient safety investigation is currently reviewing the administration and failsafe processes to prevent recurrence.

A second patient safety investigation is currently reviewing the sickle cell and thalassaemia screening programme (SCT). The investigation is reviewing the care of two women who consented to screening blood tests (antibodies, blood group and resus factor, chlamydia, full blood count, sickle cell and thalassaemia, hepatitis B, HIV, and syphilis). A Family Origin Questionnaire (FOQ) was completed and sent with each set of bloods. All booking blood samples were transferred to the Freeman Hospital on the same day via the GP courier before transfer to the RVI blood sciences reception for processing. The full blood count and sickle cell and thalassaemia blood samples were not booked into the blood sciences process, therefore the samples had to be repeated. The delay in obtaining the sickle cell and thalassaemia screening results is a breach in the nationally mandated antenatal screening pathway.

The investigation identified that.

- All booking bloods are currently requested on paper forms in the community setting.
- There are inconsistencies in the paper forms used for the requesting of repeat booking bloods in the community setting.
- There are different processes and documentation for booking bloods requested in the acute and community setting.
- There is currently no process to provide assurance that bloods requested on paper have been received by the GP Courier and onwards to Blood Sciences.
- There is an inadequate failsafe process for the booking of paper requested tests in Blood Sciences Reception.
- There is an inadequate failsafe process for the timely checking of blood sample results in both the community and acute setting.

Some of the areas for improvement include:

- Standardisation of booking blood ordering using paper request forms for all booking and repeat booking bloods taken in both the community and acute setting.
- The introduction of location codes for all community midwifery bases and acute locations to enable the centralised checking and actioning of all results within 72 hours.
- The introduction of a SOP applicable to all areas for the checking of all sample results.

- Exploration of the investment and digital enhancements required to digitalise the blood requesting process in the community setting.

There has been no harm identified, duty of candour has been enacted as appropriate, and service users have been engaged in the patient safety incident investigation. The learning from the final reports will be shared with the ICB, NHSE and LMNS. The NHSE screening team have identified a Subject Matter Expert (SME) to support the reviews, and the subsequent improvement actions. Support from an Associate Director has been secured to lead the improvement project to support outpatient transformation and the revision of the failsafe pathways for 2 days a week to support the midwifery leadership team.

5. CONCLUSION

The Trust Board members are provided with an update on the Maternity Service compliance with the Perinatal Quality Surveillance Model, and the main quality and safety considerations of the perinatal service, including progress with the Maternity Incentive Scheme 10 Safety Actions.

The Trust has embedded the six requirements to strengthen and optimise board oversight of perinatal safety, this has been supported by the further development of the integrated board report metrics and the visibility of the performance metrics, as included in this report, in relation to risks such as the infection outbreaks on NICU and antenatal and newborn screening programmes.

The Maternity Service is making good progress with the CQC action plan, the Quadrumvirate will continue to review progress as part of the enhanced oversight meetings with the ICB and LMNS, with a plan to review exit criteria compliance in March 2025.

There are robust improvement plans for the areas of risk for the service, performance is being tracked and progress monitored to ensure the mitigations in place are supporting patient safety.

6. RECOMMENDATIONS

Trust Board is asked to:

i. Receive and discuss the report.
ii. Note compliance with the PQSM and the receipt of the minimum data measures.
iii. Note the progress with the CQC action plan.
vi. Note the current risks and mitigations in place.
vii. Note progress with Maternity Incentive Scheme 10 Safety Actions.

Report of Ian Joy
Executive Director of Nursing
13 January 2025

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Agenda item A10(c)(ii)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	31 January 2025		
Title	Midwifery Staffing report		
Report of	Ian Joy, Executive Director of Nursing		
Prepared by	Jenna Wall, Director of Midwifery		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☒	☐
Summary	The purpose of this report is to provide the Trust Board with an overview of midwifery staffing and provide assurance that the Trust is compliant with national guidance in relation to safe staffing and the ongoing monitoring processes which support ensuring safe staffing levels are maintained, including Safety Action 5 of the Maternity Incentive Scheme (MIS). This report reviews data for Quarter 1 and 2 2024/25 and is informed by the detailed data generated by Birthrate Plus daily acuity tool and the Birthrate Plus report received in July 2024. The report will make recommendations for the future staffing model across the maternity services following a comprehensive workforce review. Key points/risks to note: • The perinatal service has seen significant pathway developments since the last Birthrate Plus report was completed in 2020, and therefore careful consideration of safe staffing levels across the complex services have been considered. • Despite the reduction in activity there has been a further increased in acuity, with a notably complex case mix, driven by both the Fetal Medicine Service, Maternal Medicine Service and general population health. • The midwifery and maternity support worker (MSW) staffing model requires transformation over the coming 12 months to address the needs and acuity of the current population and fulfil the Birthrate Plus staffing recommendations. There will be a three-phase approach to improve the midwifery staffing across the service. Professional judgement has been applied to address skill mix and the role of the shift lead and core team to support high quality and safe care. • The skill mix across the service should be corrected to ensure this is within recommended ratios for qualified and unqualified staff, with a reduction of 20 whole time equivalent (wte) posts Band 3 posts and an increase of 2wte Band 4 and 8wte Band 2 posts. • Organisational change consultation is required to introduce the MSW and Maternity Care Assistant (MCA) role in accordance with the national MSW framework. • An additional 8.3wte midwifery posts are required to progress phase 3 of the staffing plan in October 2025, the maternity service will not achieve compliance with the requirements of Safety Action 5 of the Maternity Incentive Scheme without support in principle for the proposal from the Board.		

<table>
<tr><td></td><td colspan="6">

- The service is compliant with the provision of one-to-one care in labour and the labour ward co-ordinator being supernumerary.
- The Trust that cannot meet the staffing requirements for the roll out of continuity of carer and will review this position in 12 months following the completion of phase 3 of the staffing plan.

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<tr><td>Recommendation</td><td colspan="6">

i) Receive and discuss the midwifery staffing report.
ii) Note compliance with the requirement for a Birthrate Plus review and application of professional judgement to plan staffing.
iii) Note compliance with the birth to midwife ratio, one to one care in labour and the labour ward co-ordinator being supernumerary.
iv) Note the risk of non-compliance with Safety Action 5 without support for the proposal from Quality Committee.
v) Note the progress made thus far, with phase 1 of the staffing plan enacted and the reinstatement of the Newcastle Birthing Centre service.
vi) Support, in principle, the additional midwifery posts required to achieve Birthrate Plus funded establishment, required for Maternity Incentive Scheme Safety Action 5 compliance.

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<tr><td>Links to Strategic Objectives</td><td colspan="6">

- Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality.

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<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">BAF risk ID 1.1 - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">The Perinatal Quality Surveillance report, incorporating midwifery staffing, and previous midwifery staffing reports are presented biannually to the Committee.</td></tr>
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MIDWIFERY STAFFING REPORT

1. INTRODUCTION

The purpose of this report is to provide the Board with an overview of midwifery staffing and provide assurance that the Trust is compliant with national guidance in relation to safe staffing and the ongoing monitoring processes which support ensuring safe staffing levels are maintained. NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) requires a bi-annual report that covers staffing and safety issues. The Developing Workforce Safeguards (2018) guidance clearly articulates the requirement to undertake an in-depth nursing and midwifery staffing review annually, with an update on actions highlighted to the Board on a six-monthly basis, this also fulfils the requirement for assurance as part of the Ockenden assessment and assurance tool regarding safe staffing levels. This report also forms part of the annual monitoring process for maternity services by NHS England and the Local Maternity and Neonatal System (LMNS).

This report reviews data for Quarter 1 and 2 2024/25 and is informed by the detailed data generated by Birthrate Plus daily acuity tool and the Birthrate Plus report received in July 2024. The report will make recommendations for the future staffing model across the maternity services following a comprehensive workforce review.

2. SETTING THE MIDWIFERY ESTABLISHMENT

Organisations must ensure they use systematic evidence-based workforce planning tools to assess the total multiprofessional staffing requirements (number and skill mix) for their maternity services. The National Quality Board expects the use of a workforce-planning tool to be cross-checked with professional judgement and benchmarking with peers.

National Institute for Health and Care Excellence (NICE) Guidance (NG4) on Safe Midwifery Staffing for Maternity Settings (2015) does not give specific recommendations on the ratios to use when planning midwifery staffing levels, however endorsed Birthrate Plus (BR+) as part of its review of evidence. The Birthrate Plus methodology looks not only at the midwife-to-birth ratio but considers the mother's and baby's acuity and complexity, making it maternity-unit specific. The Birthrate Plus report received in July 2024 has informed this staffing review.

3. MATERNITY INCENTIVE SCHEME SAFETY ACTION 5: CAN YOU DEMONSTRATE AN EFFECTIVE SYSTEM OF MIDWIFERY WORKFORCE PLANNING TO THE REQUIRED STANDARD?

The Maternity Incentive Scheme requires that a systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years and that, in line with midwifery staffing recommendations from Ockenden, Quality Committees must provide evidence (documented in Board minutes) of the funded establishment being compliant with outcomes of Birthrate Plus calculations. This paper will contain the evidence required to support compliance with the required standard of the safety action.

4. MATERNITY SERVICE CONFIGURATION

Newcastle Hospitals provides maternity services at the Royal Victoria Infirmary. The service is one of the biggest maternity units in the UK and provides maternal medicine and fetal medicine services to women from across the North East North Cumbria Integrated Care Board (NENC ICB). The neonatal intensive care unit is part of the Northern Neonatal Network and as a Level 3 unit provides specialised care for premature and sick newborn babies. The maternity services accept intrauterine transfers from across the NENC ICB to ensure babies who require specialist care are born in the right place.

The perinatal service has seen significant pathway developments since the last Birthrate Plus reported was completed in 2020, and therefore careful consideration of safe staffing levels across the complex services have been considered. The maternal medicine service, placenta accreta spectrum service, daycare unit and transitional care ward were not commissioned or provided at the time of the last staffing review.

5. MATERNITY ACTIVITY

In 2023, there were 591,072 live births in England and Wales, a decrease of 14,407 compared with the previous year (605,479), and the lowest number of live births on record since 1977 (569,259). There has been an overall decline in births in England and Wales since 2012. Despite a brief increase in live births in 2021, likely because of the effect of the coronavirus pandemic, the number of live births fell again in 2022 and 2023.

The total fertility rate (TFR) in England and Wales dropped to 1.44 children per woman, however the North East has the lowest change in TFR between 2022 and 2023 (-0.04%)

The 2023 TFR for Newcastle upon Tyne local authority district is 1.27, which is less than the England and Wales average, however 50% of pregnancy bookings are from women who reside in neighbouring local authorities where the rates are higher than the national average.

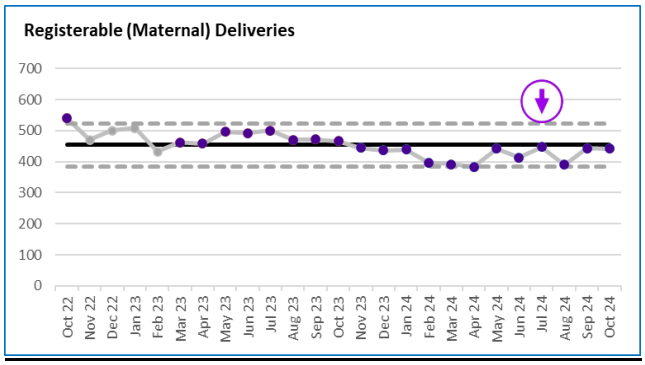
- Gateshead 1.46
- Northumberland 1.49
- South Tyneside 1.55
- Sunderland 1.50
- North Tyneside 1.39

The Office for National Statistics predicts this trend will not continue and the total fertility rate will stabilise and then increase to 1.59 in 2045.

In keeping with the national trends there has been a reduction in birth activity in recent years, following a period of heightened activity.

Number of rolling deliveries 1994-2024

The impact of the reduced birth rate has been augmented by a reduction in market share following the suspension of the Newcastle Birth Centre (NBC) services in 2023. This has had a significant impact on activity in other units, with implications for patient safety, including Gateshead Health NHS Trust capping bookings to residents of Gateshead to manage capacity safely.



The Birthrate Plus analysis was based on the following birth activity, which is reflective of the current activity within the service.

	Annual Total
Hospital	5,624
Home	31
Total	5,655

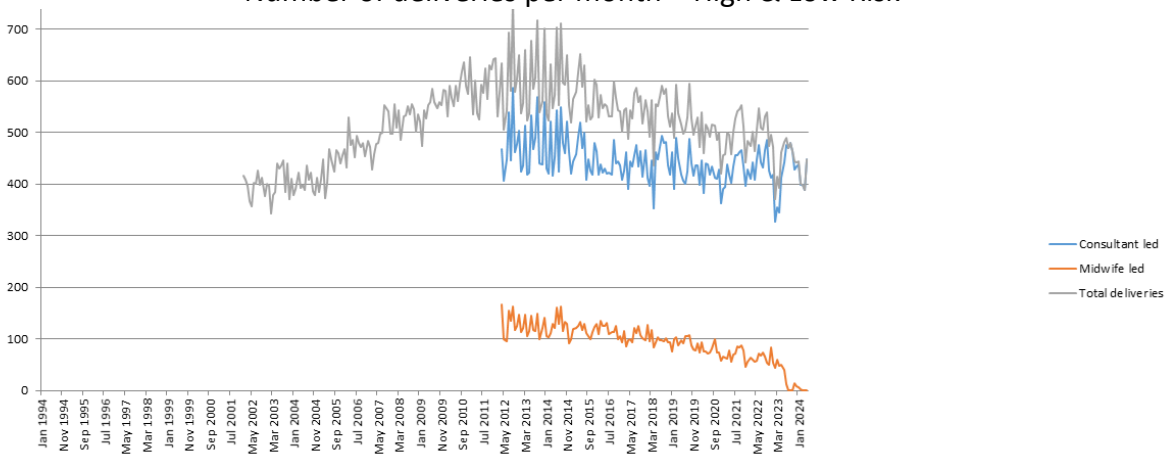
Despite the reduction in activity there has been a further increase in acuity, with a notably complex case mix, driven by both the Fetal Medicine Service, Maternal Medicine Service and general population health. There has been a change in acuity at bookings, with a reduction in those eligible for midwife led care, resulting in an increase in obstetric led high risk care.

Case mix	% Category I	% Category II	% Category III	% Category IV	% Category V
2023 Case mix	3.0	5.6	13.5	27.6	50.3
	22.1%			**77.9%**	
2020 Case mix	24.1%			75.9%	

There has been an increase in the acuity, with a further 2% increase in the highest categories of care, although changing acuity has been noted in most maternity units in the past 3 years, the tertiary service configuration has resulted in the most complex women booking for care and delivery at Newcastle, as reflected in the case mix data. Factors impacting upon the case mix include more multiple co-morbidities such as diabetes, poor mental health, high body mass index, increased induction rates usually in line with national clinical guidance, increase in operative deliveries and neonatal factors are some of the contributing reasons.

The split of in the type of care at delivery, Consultant led, or Midwife led, at delivery, has changed significantly. This is a result of a reduction in women eligible to receive low risk midwifery led care and the change in market share, with many low-risk women choosing to book for delivery in neighbouring Trusts secondary to the suspension of services at the NBC. The NBC reopened in December 2024, the impact on bookings and delivery activity will be closely monitored and reported in subsequent staffing papers.

Number of deliveries per month – High & Low Risk



During Q1 & Q2 the Birthrate Plus acuity tool data indicates demonstrates this clearly, with only 2% of intrapartum activity being of the lowest, midwifery led, category and 20% of all activity on the Delivery Suite providing induction of labour care.

Intrapartum & Non-Birthing Categories
01/04/2024 to 30/09/2024

Categories	Number in Categories	Percentage
Cat I	307	2%
Cat II	734	6%
Cat III	1411	11%
Cat IV	2151	17%
Cat V	1519	12%
Cat A2	707	6%
PN Readmission	31	0%
Cat PD1	332	3%
Cat PD2	884	7%
Cat PN	749	6%
Cat A1	839	7%
Cat X	449	4%
IOL	2592	20%
TOTAL	12705	

6. BIRTHRATE PLUS REVIEW

In 2024 a full and detailed midwifery workforce planning exercise was undertaken by an external workforce analysis company Birthrate Plus Consultancy. The Birthrate Plus report has been considered as part of this report (Appendix 1), with the application professional judgment and following consideration of care mix, acuity, and forecasted activity.

The Birthrate plus report, published in June 2024, is based on 2 months of concurrent data from 2024 and a birth rate of 5,655. This is the first report following the establishment of the maternal medicine and Placenta Accreta Spectrum service, transitional care ward and day care unit.

The report is based on a 25% uplift for registered staff and 20% for support staff, with 12.5% community travel included in the staffing figures. The 25% uplift is to ensure the Trust can release staff to complete the training requirements of the Core Competency Framework, published by NHS England (NHSE) following the Ockenden Report (2020), a requirement of the Maternity Incentive Scheme.

The breakdown of Birthrate Plus clinical staffing baseline is as follows.

Clinical Area	Recommended WTE
Intrapartum Services • Births • Antenatal Cases • Postnatal Readmissions • Inductions of labour • In-utero transfers out • Non-viable cases	87.83wte Registered Midwives (RMs)
Triage and Telephone Advice line	21.93wte RMs
Ward 41 • Antenatal admissions • Day Unit	 11.20wte RMs 5.60wte RMs
Wards 32/33/34 • Postnatal (PN) women • PN ward attenders • PN Re-admissions • Newborn and Infant Physical Examination (NIPE) sessions • Extra Care Babies	73.29wte RMs and PN MSWs
Outpatient Services • Specialist Midwife Clinics • Specialist Obstetric Clinics • Fetal Medicine	24.32wte RMs
Community Services:	33.30wte RMs and PN MSWs

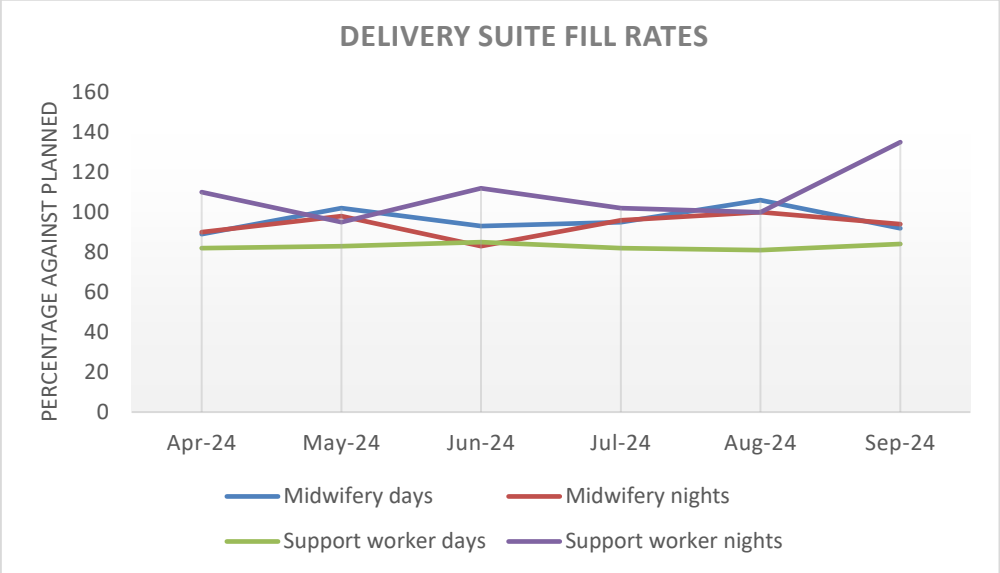
Clinical Area	Recommended WTE
• Home Births • Community Cases • Attrition Cases • Additional Safeguarding	
Total Clinical WTE	257.47wte RMs and PN MSWs

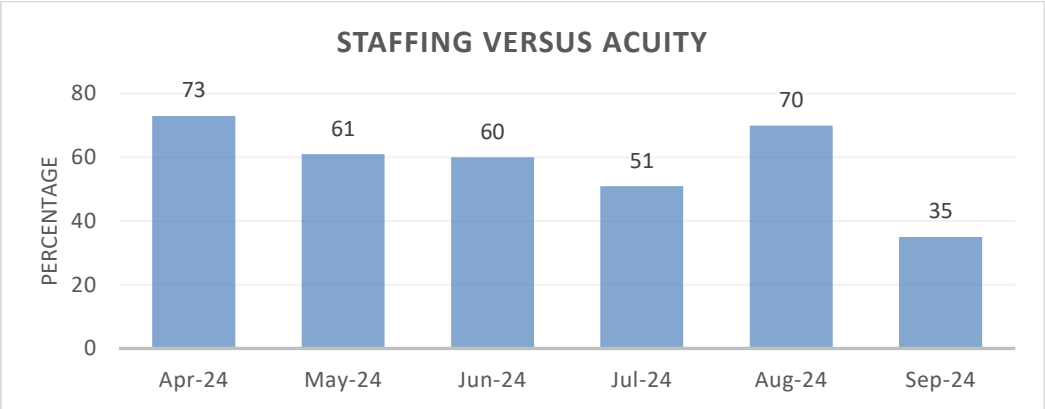
7. CURRENT MIDWIFERY STAFFING AND IMPACT

7.1 Intrapartum Services

The service has faced midwifery staffing challenges over the last 18 months because of sickness absence, vacancy and increased training requirements. In July 2023 the difficult decision was made to temporary suspend the Newcastle Birth Centre and home birth service to preserve safety across the acute and community services and consolidate midwifery staffing on the Delivery Suite. The Newcastle Birthing Centre reopened temporarily on 6 November 2023, however further instability of midwifery staffing resulted in an intermittent service, and there was a further suspension from the end of November 2023 until December 2024.

The planned staffing template for Delivery Suite was not amended following the closure of Newcastle Birthing Centre so although the fill rates have improved following the suspension of the low-risk services and centralisation of intrapartum care on the Delivery Suite, the staffing versus acuity data from the real time Birth Rate + acuity tool demonstrates that the midwifery staffing was still very challenged.





The staffing versus acuity data demonstrates that the Delivery Suite staffing templates were inadequate to manage the intrapartum acuity and activity, however it is reassuring that during Quarter 1 (Q1) & Quarter 2 (Q2) the co-ordinator maintained supernumerary status >99% of the time and there were with no occasions when one to one care could not be provided. This is testament to the skill and experience of those co-ordinating the Delivery Suite who have instigated clinical actions to ensure safety. The management and clinical actions taken by the co-ordinator maintain safety, in this instance, delaying induction of labour following admission until staff were available and it was safe to proceed.

Clinical actions to support safety

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Delay in commencing IOL	83	23%
CA2	Delay in continuing IOL	231	64%
CA3	Delay in Elective LSCS	9	2%
CA4	Refusal of in-utero transfers due to acuity	1	0%
CA5	Early discharge where possible	39	11%
TOTAL		363	

Delaying induction of labour until safe to proceed is a reasonable action, assuming this is for a short period, and is balanced against clinical risk. It is acknowledged that delays during induction of labour can lead to a poor patient experience. The delays in continuing induction of labour are women awaiting amniotomy, there were no delays of over 6 hours. NICE defines a red flag as a delay in *commencing* induction of labour of over 6 hours.

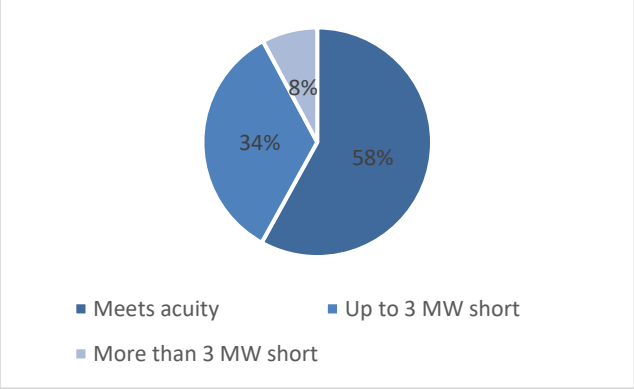
There were no safety issues or incidents as a result of delaying commencing or continuing induction of labour, all women received monitoring and surveillance in the intervening period and were prioritised based on clinical indication for induction of labour. There is a project team currently reviewing the induction of labour pathway, with input from the Maternity and Neonatal Voice Partnership Lead.

Managerial actions to support safety:

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy community MW	18	10%
MA2	Redeploy specialist MW	11	6%
MA3	Redeploy Matrons	0	0%
MA4	Staff sourced from bank	24	14%
MA5	Staff sourced from other directorates	66	38%
MA6	Practice support utilised for clinical duties	40	23%
MA7	Cancellation of training	1	1%
MA8	Cancellation of Band 7 admin	16	9%
MA9	Closure of MAU	0	0%
MA10	Divert	0	0%
TOTAL		176	

The managerial actions are self-explanatory, seeking additional staffing support from other areas and staff groups, and if indicated, escalating into the community midwifery teams for support. This occurred 18 times in Q1 & Q2, the escalations occurred prior to the reinstatement of the home birth services in June and therefore had no impact on service provision.

During Q1 & Q2 the staffing met acuity 58% of the time, was up to 3 midwives (MW) short 34% and more than 3 midwives short 8%. Indicating additional midwifery establishment is required to support the intrapartum services.



The clinical and managerial actions were appropriate to manage safety, as indicated by the red flags for this period. In this 6-month period there were 27 red flags (845) for a delay between admission for induction and beginning of process. There was only one occasion during the shift when the co-ordinator was not supernumerary in August, and one in July, however the co-ordinator was supernumerary at the start of the shift and so the Trust remains compliant with Safety Action 5 of the Maternity Incentive Scheme. There were no occasions when one to one care in labour was not provided.

The Obstetric Theatre nursing and Operating Department Practitioner (ODP) staffing is excluded from the BirthRate Plus review but is deemed to be appropriate based on the current theatre activity within the services.

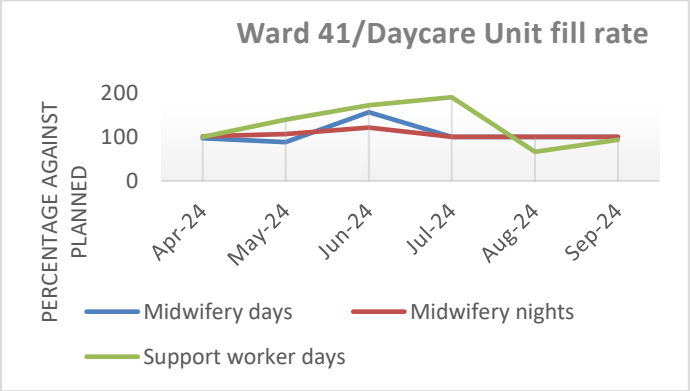
7.2 Maternity Assessment Unit (MAU)

The fill rates for the MAU are currently not reported as this is an outpatient area. The planned amendments to the Allocate templates will allow this to be reported in future reports. The staffing for MAU was increased in July 2024 following a clinical incident and secondary to the Birmingham Symptom-specific Obstetric Triage System (BSOTS) performance. There has been a significant improvement in the initial midwifery triage, and subsequent midwifery care across all categories following the introduction of the additional shift. This will be considered in the future staffing templates.

Month	Number of Triage Phonecalls	Number of Attendances	Initial Assessment within 15 mins	Green (4 hours)	Yellow (1 hour)	Orange (15 mins)	Red (immediate transfer)	Ongoing Midwifery care commenced within allocated time (GREEN)	Ongoing Midwifery care commenced within allocated time (YELLOW)	Ongoing Midwifery care commenced within allocated time (ORANGE)
				Level of Urgency						
Jan-24	974	1069	876 (82%)	253	463	341	9	188 (74.3%)	358 (77.3%)	251 (73.6%)
Feb-24	827	986	825 (83.7%)	228	460	277	20	147 (63.9%)	351 (76.1%)	185 (66.8%)
Mar-24	867	1053	922 (87.6%)	194	539	301	15	138 (70.8%)	427 (79.4%)	214 (71.1)
Apr-24	759	1026	896 (87.3%)	158	522	334	9	110 (69.6%)	411 (78.9%)	236 (70.9%)
May-24	941	1067	854 (80%)	182	557	320	7	136 (74.7%)	455 (81.8%)	255 (79.7%)
Jun-24	1172	1149	921 (80.2%)	193	659	287	8	163 (84.5%)	593 (90%)	236 (82.2%)
Jul-24	1288	1196	1082 (90.5%)	196	678	306	15	193 (98.5%)	666 (98.2%)	281 (91.8%)
Aug-24	1206	1128	1041 (92.3%)	213	609	301	5	204 (95.8%)	581 (95.4%)	274 (91%)
Sep-24	1486	1203	1098 (91.3%)	182	763	245	13	174 (95.6%)	730 (95.7%)	224 (91.4%)

7.3 Daycare Unit and Antenatal Ward 41

The fill rates for Daycare Unit and Ward 41 are reported, the service has good fill rates which are appropriate for the current bed capacity and activity in the Daycare Unit. The Birthrate Plus acuity report indicates that the acuity of the patients was met by the staffing 94% of the time.

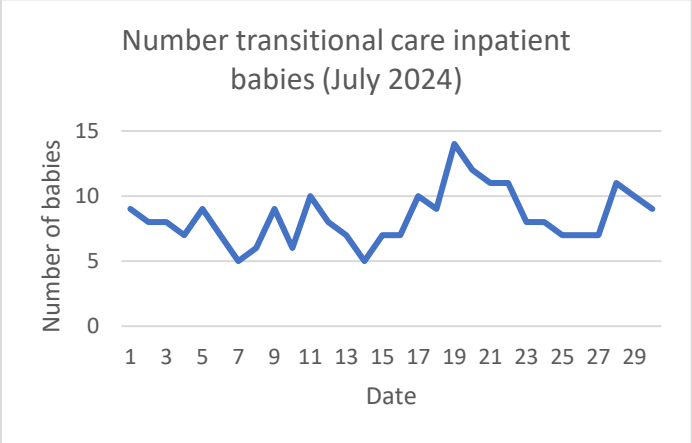


Bed capacity is currently being reviewed as bed occupancy is often 100%, with antenatal boarders being admitted to the postnatal ward. There is a strong likelihood that the output of the Neonatal Critical Care Review and change to gestational threshold for admission to the Level 1 units across the ICB, will increase the number of intrauterine transfers and antenatal admissions. This will be considered in the future staffing model as there is opportunity to increase the bed base on the antenatal ward.

7.4 Postnatal Ward & Transitional Care Ward

The Transitional Care Ward (34) opened in April 2024. There are 11 maternal beds, each mother may have twins or triplets, making the cot capacity/requirement variable, and uncapped. When the ward is full families are admitted to Ward 33, and the transitional care nurse would then support the care of babies on both Ward 33 and Ward 34.

The number of babies admitted to Ward 34 were reviewed against the planned staffing. The planned ratio for nursing staff to babies receiving transitional care is 1:4. Maternity support workers and nursery nurses can work to a ratio of 1:1 under the supervision of a nurse in accordance with the British Association of Perinatal Medicine (BAPM) guidance. If the ward is staffed as planned there is the capacity to provide care for 6 babies per shift. The service audit clearly demonstrates that activity exceeds this regularly. All admissions were appropriate, and length of stay was as expected. Examples from July as below.



The following table describes the length of stay of transitional care babies.

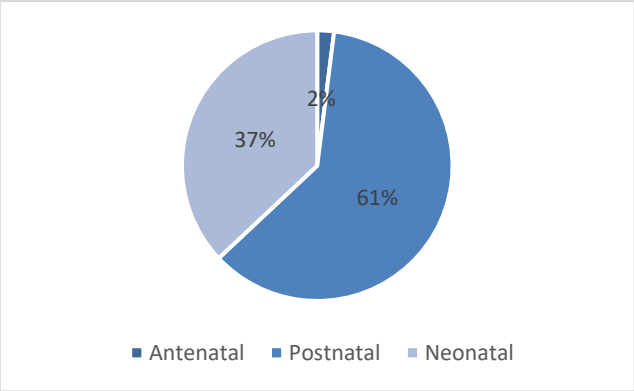
Total Admissions July to Transitional Care	38
Total Number of Days	116
Minimum Days	1
Maximum Days	7
Average Length of Stay	3

The current escalation plan to cover short term transitional care nursing team shortages, such as sickness, is to request a neonatal nurse to cover from Neonatal Intensive Care Unit (NICU), however this depletes their workforce and is not accounted for within their establishment.

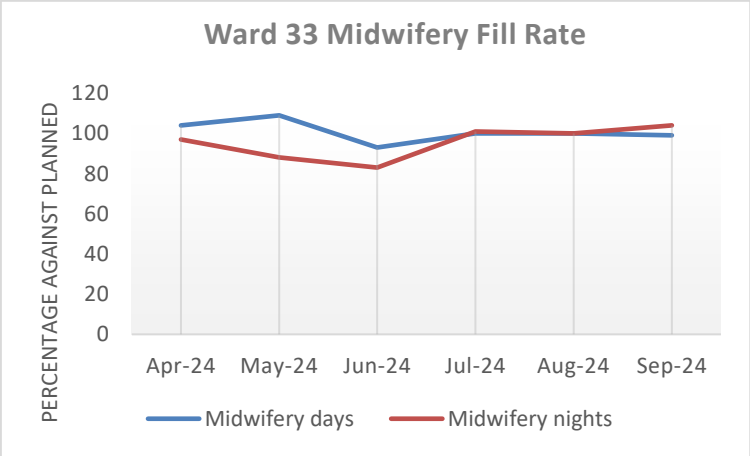
The midwifery staffing establishment for the transitional care ward is appropriate, the Birthrate Plus acuity tool has now been adopted on the Ward 34 and future reports will be able to consider the acuity and activity. The acuity tool describes the postnatal and neonatal care hours required based on the needs of the inpatients, which can then be considered by professional group. The majority of care hours are neonatal, the current nursing establishment does not fulfil the BAPM ratios for transitional care. The service must consider the nursing establishment and staffing model required to support transitional care based on activity, this should consider role development of the midwife to provide elements of transitional care alongside the specialist nurses.

There were 12 red flags in Q1 &2 for Ward 34, 46% associated with delayed time critical activity, 23% for delayed care, and 15% for delayed medication. None of the red flags were associated with patient safety incidents.

The postnatal ward (33) has 34 beds, care is provided to low and high-risk postnatal mothers and newborns. Due to capacity issues on Ward 41 & 34 antenatal women and babies requiring transitional care can also be admitted to the ward. During Q1 & Q2 care hours were split as outlined below.



The planned staffing only met the acuity of patients 41% of the time, indicating the staffing on the postnatal ward was inadequate as the fill rates against the planned were good. The skill mix of midwifery and unqualified staff is currently outside of the recommended ratios and will require adjustment to achieve 90/10 split. The quality of the data entry in the Birthrate Plus acuity tool for Ward 33 needs to be improved as the compliance during Q1&2 was only 61%.



Despite the midwifery staffing challenges the increased maternity support worker staffing establishment supported patient safety, however, the CQC maternity survey report indicated the quality of the services on the postnatal ward required improvement, hence the postnatal improvement plan and real time patient experience pilot which is monitored via the Quality and Safety Group and Perinatal Engagement and Inclusion Group.

Whilst there were concerns regarding patient experience and staffing pressures there were very few red flags, just 11 in Q1&2, with 91% being delayed time critical activity (such as

blood transfusion), there were no associated patient safety incidents or concerns. The postnatal staffing, including shift leadership and skill mix, will be considered and developed.

7.5 Community Services

The current caseload allocations are appropriate based on the whole time equivalent of the staff members, however there is no additional staffing allocation for complex caseloads, such as those who have a child protection plan. The city is divided into 4 geographical teams. There is a significant variance in the number of safeguarding issues in each community team, with East having 3 times more child protection cases than North. The future staffing should consider an enhanced ratio of 1.2 per patient for cases with child protection issues to ensure there is adequate capacity to support complex care planning, this is supported by the Birthrate Plus methodology.

The current skill mix of midwifery staff and maternity support workers (MSW) exceeded the suggested skill mix of 90/10 and this needs to be addressed. The role of the MSW needs to be developed to fulfil the NHSE MSW Framework via an organisational change consultation due to commence January 2025. Band 4 Public Health Assistants have been successfully piloted within the community teams to improve smoking cessation rates and ensure a reduction in the number women who smoke in pregnancy, along with other key public health interventions. This role should be embedded in every community team to support the Best Start in Life agenda and ensure compliance with the Saving Babies Lives Care Bundle.

7.6 Antenatal clinic and Fetal Medicine Unit

The Fetal Medicine Unit and Antenatal Clinic have an appropriate midwifery and maternity support worker staffing allocation to fulfil Birthrate Plus recommendations, however, the clinical leadership model needs to be further developed in the Fetal Medicine Unit and additional midwifery resource is required for the maternal medicine service due to an increase in referrals and activity in the Maternal Medicine service, specifically haematology, with an increased number of women accessing services with red cell disorders such as sickle cell and haemoglobinopathies as a result of a change in service user demographic.

8. FUTURE MATERNITY STAFFING MODEL

The midwifery and MSW staffing model requires transformation over the coming 12 months to address the needs and acuity of the current population and fulfil the Birthrate Plus staffing recommendations. There will be a three-phase approach to improve the midwifery staffing across the service. Professional judgement has been applied to address skill mix and the role of the shift lead and core team to support high quality and safe care. A staffing dashboard for acute and community services has been developed to review the planned versus actual fill rates, acuity versus staffing and any associated safety metrics, such as red flag incidents, Datix reports and Clinical Assurance Tool compliance. This is monitored monthly by the senior midwifery team and reported to the Quality and Safety Group, with exception reporting to the Directorate Quality and Safety Group and Quality Oversight Group (QOG). Phase 1 of the staffing transformation programme was enacted in December

2024, phase 2 is planned in April 2025, and subject to investment, Phase 3 in October 2025. The overall ratio is 22 births to wte midwife which reflects all hospital and home births. The Trust that cannot meet the staffing requirements for the roll out of continuity of carer and will review this position in 12 months following the completion of Phase 3 of the staffing plan.

8.1 Intrapartum services

The number of women eligible for low-risk midwifery care in the NBC has reduced in recent years, due to the reasons cited above. The service estimates (based on booking and pregnancy risk factors) that approximately 40-50 women will birth their baby on the NBC each month. To sustain the service, increase the market share, and maintain activity on the NBC, a responsive integrated intrapartum team has been successfully introduced in December 2024.

The integrated intrapartum model requires.

- The midwifery staff working in the NBC are experienced Band 6 midwives, with appropriate intrapartum skills and experience.
- All triage activity will be conducted on the MAU with only women attending in labour being admitted directly to NBC.
- A low-risk postnatal care model with planned 6-12 hour postnatal stay for women birthing in NBC, longer postnatal stay requires admission to Ward 33.

The intrapartum midwifery staffing will be increased to improve the acuity versus staffing and reduce the number of red flags, predominantly associated with delays in commencing or continuing induction of labour, which impact patient and staff experience. It is expected the proposed staffing template will sustain the NBC service whilst also reducing the number of red flags and delays and improving the quality and safety of care.

8.2 MAU

There has been a significant improvement in the initial midwifery triage, and subsequent midwifery care across all categories following the introduction of the additional shift. This will be maintained in the proposed staffing template, with an additional twilight shift to ensure performance is maintained across the 24 hours. Staffing has been planned in accordance with activity across the 24-hour period.

8.3 Daycare Unit and Antenatal Ward 41

No significant amendments are required to the staffing templates, the service will continue to explore the bed capacity on the antenatal ward to accommodate any increased activity generated by the Neonatal Critical Care Review (NCCR). If the ward bed base was to increase by 4 beds, the additional midwifery staffing requirements would be offset by a reduction in day care attendances.

8.4 Postnatal Ward & Transitional Care Ward

The service will consider the nursing establishment and staffing model required to support transitional care based on activity, this should consider role development of the midwife to

provide elements of transitional care alongside the specialist nurses. No additional midwifery staffing is required for the Transitional Care Ward at present.

The Postnatal Ward midwifery staffing will be increased to address the current shortfall and inappropriate skill mix, conversely the MSW staffing will be reduced. The service will also introduce the MCA role (Band 2) in accordance with the NHS MSW Framework. The midwifery staffing template will include the introduction of a shift lead role, development of the core team and a reduction in rotational staff to safeguard skill mix and provide consistent leadership and drive clinical standards and reduce red flags.

8.5 Community

The proposed staffing templates reduce both midwifery and maternity support worker establishments, bringing the caseloads in line with the recommended ratios whilst also introducing the additional multiplier for complex social cases of 1.2 per patient. The skill mix will be addressed to ensure this is compliant with 90/10 split for postnatal care. The Band 4 public health assistant role will be embedded in each team.

8.6 Antenatal clinic and Fetal Medicine Unit

The Fetal Medicine Unit midwifery and maternity support worker staffing templates do not require amendment however, the clinical leadership model needs to be further developed with the introduction of a Fetal Medicine Consultant Midwife.

The Antenatal Clinic staffing will see a reduction in the number of maternity support workers, with an increase in the number of specialist midwives required to support the Maternal Medicine service, specifically haematology, due to an increased number of women accessing services with red cell disorders such as sickle cell and haemoglobinopathies because of a change in service user demographic.

8.7 Specialist and management roles

The total clinical establishment as produced from Birthrate Plus is 257.47wte and this excludes the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services. 12% to the Birthrate Plus clinical whole time equivalent should be calculated to provide the staffing required to manage the quality and safety of the services giving the final staffing requirement of 288.37wte. The service currently has the minimum specialist midwifery staffing but is compliant with the Royal College of Midwives leadership manifesto with an appropriate midwifery leadership structure.

9. FUNDED ESTABLISHMENT

There is a requirement for additional investment in midwifery establishment with a variance of -8.31wte against the BirthRate+ funded establishment recommendation, a fully funded midwifery establishment is a requirement of Safety Action 5.

Current funded clinical, specialist and management WTE	BirthRate+ WTE	Variance WTE
280.06	288.37	-8.31

However, the skill mix of other staffing groups will offset this requirement.

Current funded establishment	Role	Variance WTE against planned
74.12	MSW	+20.52
4.0	MCA	-8.05
2 (temporary)	Public Health Assistant	-2.0

The financial impact of the phase 3 staffing templates is currently being costed.

10. CONCLUSION AND ACTIONS

From this midwifery staffing report, the following conclusions have been drawn:

- Organisational change consultation is required to introduce the MSW and MCA role in accordance with the national MSW framework.
- The skill mix across the service should be corrected to ensure this is within recommended ratios for qualified and unqualified staff, with a reduction of 20wte posts Band 3 posts and an increase of 2wte Band 4 and 8wte Band 2 posts.
- Competency based development of the transitional care midwifery team should be explored to support the neonatal care requirements.
- Antenatal bed capacity should be explored, and if increase required, how this can be supported within the current antenatal midwifery staffing allocation.
- The three phase staffing plan should be progressed to improve midwifery staffing, reduce the number of red flags and address the acuity requirements of the case mix.
- An additional 8.3wte midwifery posts are required to progress phase 3 of the staffing plan in October 2025, the maternity service will not achieve compliance with the requirements of Safety Action 5 of the Maternity Incentive Scheme without support for this proposal.
- The financial impact of the phase 3 staffing templates should be being costed.
- The service is compliant with the provision of one-to-one care in labour and the labour ward co-ordinator being supernumerary.
- The service currently has the minimum specialist midwifery staffing but is compliant with the RCM leadership manifesto with an appropriate midwifery leadership structure.
- The overall ratio is 22 births to wte midwife which reflects all hospital and home births.

11. RECOMMENDATIONS

The Trust Board are asked to:

i) Receive and discuss the midwifery staffing report.

ii) Note compliance with the requirement for a Birthrate Plus review and application of professional judgement to plan staffing.
iii) Note compliance with the birth to midwife ratio, one to one care in labour and the labour ward co-ordinator being supernumerary.
iv) Note the risk of non-compliance with Safety Action 5 without support for the proposal from Quality Committee.
v) Note the progress made thus far, with phase 1 of the staffing plan enacted and the reinstatement of the Newcastle Birthing Centre service.
vi) Support, in principle, the additional midwifery posts required to achieve Birthrate Plus funded establishment, required for Maternity Incentive Scheme Safety Action 5 compliance.

Report of Ian Joy
Executive Director of Nursing
23 January 2025

birthrateplus® | Safe Staffing for Maternity Services

Appendix 1

SUMMARY of DATA & REQUIRED WTE for

The Newcastle upon Tyne Hospitals NHSFT

Final version 26/06/2024
Annual Period 2023

Total Deliveries	5655
Total Community Cases	3000

2023 Casemix	Cat I	Cat II	Cat III	Cat IV	Cat V
%D/S Casemix	2.4	4.9	13.7	28.0	51.0
%Generic Casemix	3.0	5.6	13.5	27.6	50.3

		Annual Nos.	Required WTE	
Consultant Led Unit				
	Births	*5624*	77.53	**77.53**
Other DS Activity				
	Antenatal cases	*480*	3.98	**10.30**
	P/N Readmissions	*122*	0.45	
	Medical Inductions of Labour	*2747*	5.06	
	Escorted Transfers OUT	*24*	0.12	
	Non-viables	*56*	0.68	
Triage including Telephone Advice Line		*12354*	21.93	**21.93**
Ward 41	Antenatal admissions	*1645*	11.20	**11.20**
	Day Unit	*5509*	5.60	**5.60**
Wards 32/33/34	Postnatal women	*5624*	59.70	**73.29**
	Postnatal Ward Attenders	*360*	0.25	
	Postnatal Re-admissions	*561*	3.07	
	NIPE	*5346*	2.74	
	Extra Care Babies	*1102*	7.54	
Outpatient Services				
Antenatal Clinics	Specialist Midwife Clinics		14.76	**24.32**
	Specialist Obstetric Clinics		3.39	
	Fetal Medicine		6.17	
COMMUNITY SERVICES				
	Home Births and BBAs	*31*	0.92	**33.30**
	Community Cases *(own births)*	*2798*	28.84	
	Imports *(ante & postnatal care)*	*116*	1.20	
	Imports *(antenatal care only)*	*25*	0.14	
	Imports *(postnatal care only)*	*30*	0.12	
	Attrition Cases	*355*	0.49	
	Safeguarding Cases	*259*	1.59	
CLINICAL MIDWIFERY WTE REQUIRED				**257.48**
Additional management and specialist midwifery wte *(12%)*			30.90	
TOTAL CLINICAL, MANAGEMENT & SPECIALIST WTE			**288.37**	

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Agenda item A10(d)(i)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 January 2025					
Title	Learning from Deaths, Quarter 2 (Q2) (July 2024 – September 2024)					
Report of	Rachel Carter, Director of Quality and Safety					
Prepared by	Danielle Smith, Integrated Governance Manager – Patient Safety					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	This paper aims to provide assurance to the Trust Board that 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. This paper also summarises the processes that are in place to provide assurance to the Trust Board that all deaths are reviewed including those with potentially modifiable factors. The paper gives an overview of the Trust position with regards to: • Completed Level 1 mortality reviews. • Completed Level 2 mortality reviews, including where requested by the Medical Examiner (ME). • Completed Level 2 mortality reviews for patients with a recognised learning disability. The paper details the process for review and escalation of cases where concerns in the delivery of care are identified. A summary of cases considered to meet Learning from Death reporting criteria in Q2 2024/2025 is provided in section 3, with any learning arising from the subsequent investigation. The report is correct as of 09 January 2025 and covers data for Q2 of 24/25.					
Recommendation	(i) To note the report (ii) To note the learning actions taken and continued monitoring in line with national Learning from Deaths criteria.					
Links to Strategic Objectives	Putting patients at the heart of everything we do, providing care of the highest standards focused on safety and quality.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☐	☐	☒	☐
Link to Board Assurance Framework [BAF]	N/A					

Agenda item 10(d)(i)

Reports previously considered by	This report forms part of the regular quarterly reporting cycle for Learning from Deaths. Previous reports were presented to the Quality Committee in May, September 2024 and January 2025.

LEARNING FROM DEATHS

1. INTRODUCTION

In April 2017, following the CQC's recommendations on how the NHS investigates patient deaths, the National Quality Board (NQB) published a new national framework for NHS trusts, 'National Guidance on Learning from Deaths'. The purpose of this framework was to provide a more standardised approach to the way we identify, investigate and learn from deaths that occur under our care.

The Newcastle upon Tyne Hospitals NHS Foundation Trust publishes this quarterly report, in line with the NQB guidance, that details mortality quality metrics from inpatient deaths to provide assurance to the Quality Committee and Trust Board of the monitoring and review processes in place and our commitment to learning from any deaths where problems in care have been identified so that improvements can be made.

2. REVIEW OF INPATIENT DEATHS

The Trust's Reviewing and Monitoring Mortality Policy for Adults outlines the expectation that all clinical areas adopt the overarching principles of routine and systematic mortality review, including a review of all inpatient deaths. Within the Trust, mortality reviews are undertaken in two stages;

Level 1:
Trust policy outlines all deaths should be subject to a level 1 review. The aim of a level 1 review is to ascertain the type of scrutiny the death should receive and whether a more in-depth second stage review is necessary. Following national changes to the Medical Examiner process, from 9 September 2024 scrutiny of all deaths by either the Medical Examiner (ME) or H.M. Coroner is a statutory requirement before the death certificate can be issued. This now equates to a Level 1 review.

Level 2:
Deaths that meet the defined criteria for Level 2 review as outlined in the Trust policy, or where concerns have been identified in care during the Level 1 scrutiny are required to undergo a Level 2 review. Where applicable, a Level 2 review can be undertaken in one of two ways:

- A minimum of two ST5 grade practitioners, or above, undertaking a thorough review of the patient case notes for the last admission and any relevant clinical events in the patient's recent medical history. The findings are summarised and recorded within the Trust's mortality database and any learning points are shared across the department or wider organisation.
- Review undertaken as part of a multidisciplinary mortality and morbidity (M&M) meeting with the presence of at least two senior clinicians. Key findings to be presented and discussed to identify any learning for wider dissemination. The outcome is recorded on the mortality database.

Patients may have more than one Level 2 review recorded within the database if during the course of their final admission their care was delivered by multiple specialties. The ME or any specialty involved in the patient's care may make a referral to another specialty for a Level 2 review to be undertaken.

The Trust's Reviewing and Monitoring Mortality Policy for Adults is currently subject to review and update, to incorporate the changes to the ME scrutiny process in addition to changes made to mortality review processes since the Trust's transition to the Patient Safety Incident Response Framework (PSIRF) from January 2024.

For patients under the age of 18, deaths are reviewed as part of the statutory Child Death Review (CDR) process on behalf of the local Safeguarding board. The requirements of this process are detailed in the Reviewing and Monitoring Mortality Policy for Children and Young People Less than 18 Years.

2.1. Level 1 Reviews

Figure 1 details the percentage of deaths where a Level 1 review has been completed over the previous 12 months up until the end of August 2024. Due to the statutory changes from 9 September 2024 whereby all deaths are now subject to ME or Coronial scrutiny, no data is provided from September onwards within the graph. However, data collected from 1 – 8 September 2024 shows that 35 (23%) of the 153 deaths recorded in that month underwent Level 1 review prior to the statutory change.

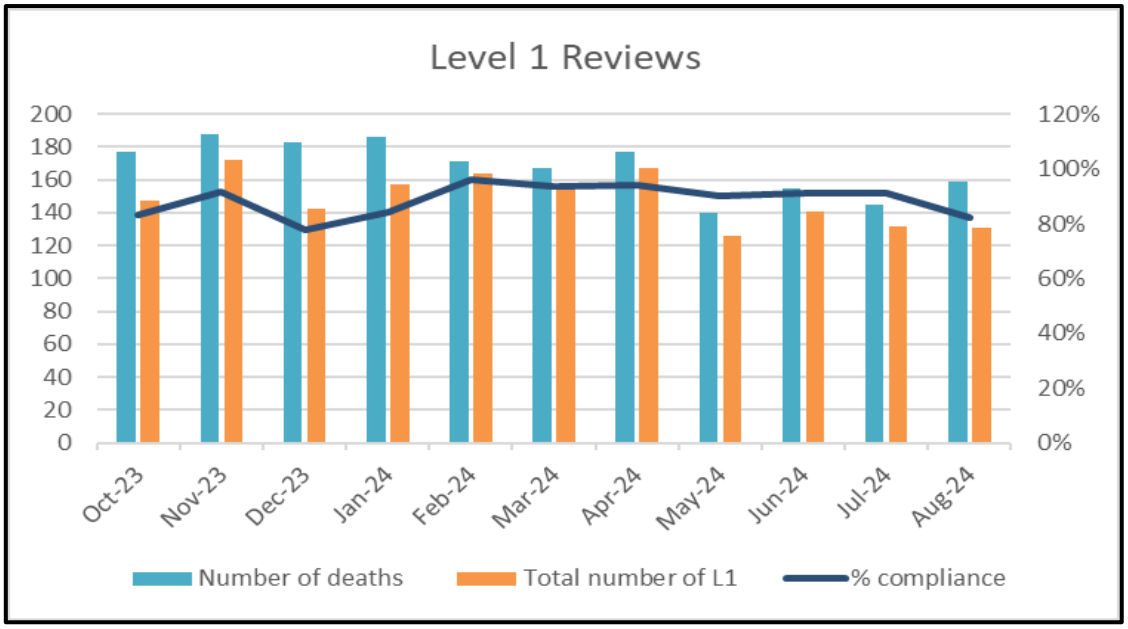
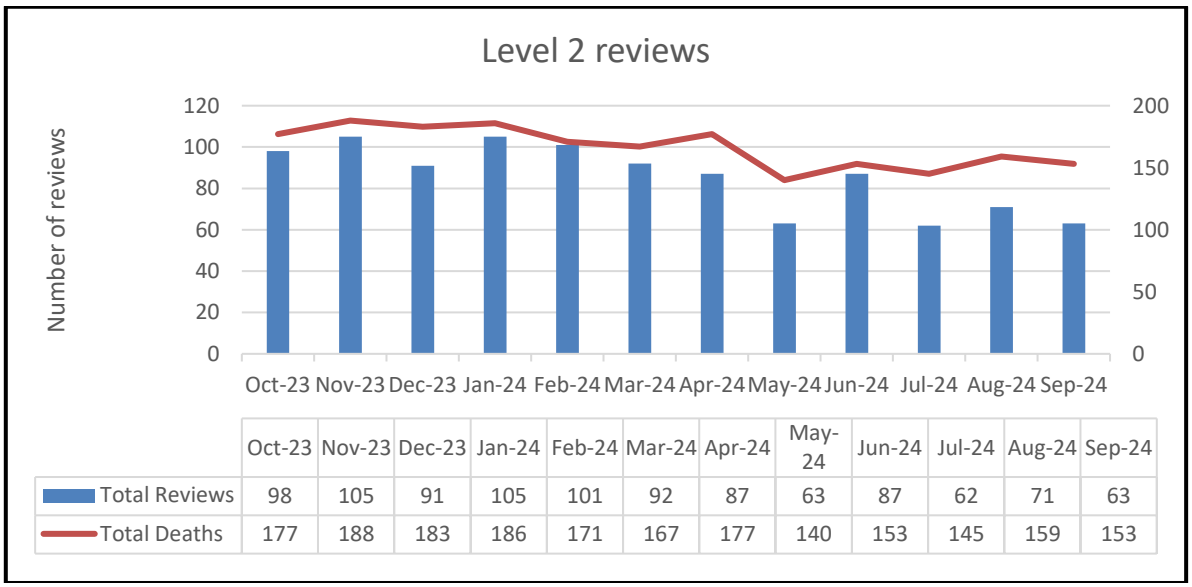


Figure 1: Level 1 Reviews and Compliance, Oct 23 - Aug 24

2.2. Level 2 Reviews

Deaths that meet a defined criteria as outlined in Trust policy are required to undergo a level 2 review. Level 2 reviews may also be requested by the ME if any concerns with the care provided are identified during the initial scrutiny.

The number of deaths that require a level two review will vary each month and there is no outlined target for this. Overall, the Trust is aiming to increase the number of level 2 reviews completed. The number of level 2 reviews completed each month over the previous 12 months up until the end of Q2 2024/2025 is detailed in figure 2 below. These are shown by the date the patient died and in some cases, include multiple level two reviews for the same patient.



	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Total Reviews	98	105	91	105	101	92	87	63	87	62	71	63
Total Deaths	177	188	183	186	171	167	177	140	153	145	159	153

Figure 2: Number of Completed Level 2 Reviews, Oct 23 - Sep 24

Although Q2 2024/2025 shows a lower number of completed Level 2 reviews compared to the preceding period, these figures are expected to rise as more M&M reviews are completed.

2.3. Medical Examiner Initiated Level 2 Reviews

The ME will inform Trust mortality leads if a level 2 review is to be undertaken in line with the Trust mortality policy. Many level 2 reviews are completed each month within the Trust, however only a small number of these come from the ME review process. Figure 3 below details the number of Level 2 reviews requested by the ME and subsequently completed by the relevant Clinical Board:

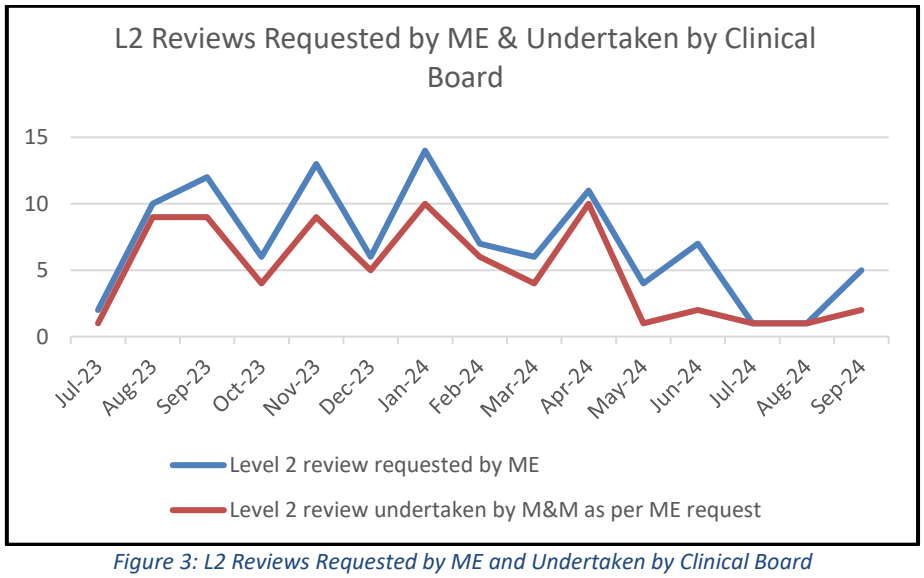


Figure 3: L2 Reviews Requested by ME and Undertaken by Clinical Board

2.4. Patients with Learning Disability

In line with Trust policy, a Level 2 review is mandatory for the death of any patient with a recognised learning disability. In addition to the Level 2 review undertaken by the clinical board, a second Level 2 review will be undertaken by the Learning Disability Mortality Review Panel and recorded into a national database in line with requirements for Learning Disability Mortality Review Programme (LeDeR) commissioned by NHS England.

Since October 2023, there have been 24 recorded deaths of patients with a recognised learning disability. Of these, 18 have received a Level 2 review by the LeDeR panel, as detailed below. The data excludes children who are reviewed by the Child Death Overview Panel (CDOP), as was agreed nationally to avoid duplication.

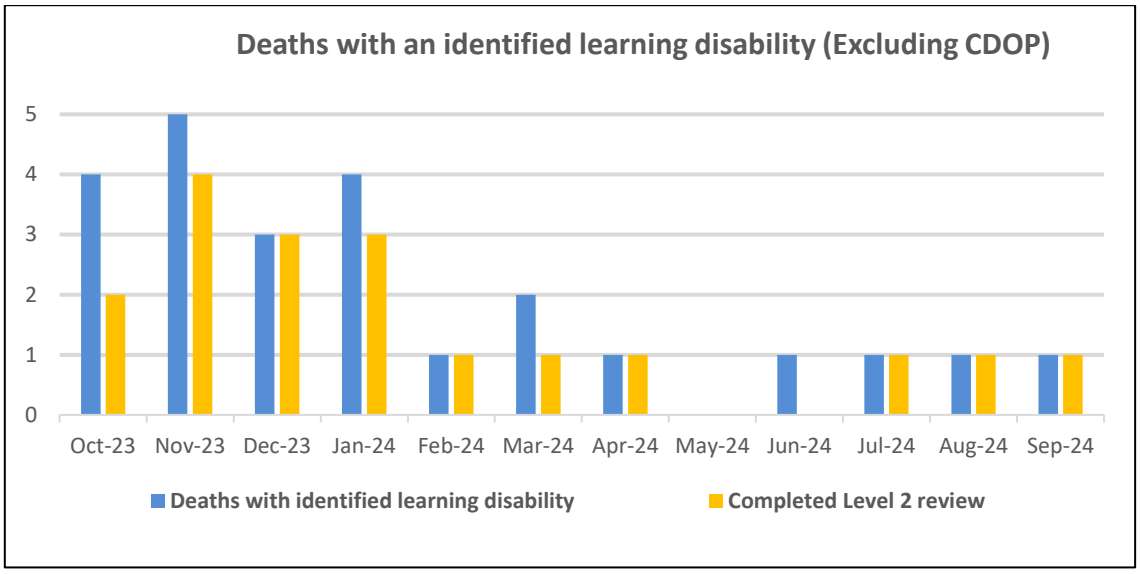


Figure 4: LeDeR Level 2 Reviews

3. LEARNING FROM DEATHS Q2 2024/2025

Where a level 2 review identifies concerns or problems with the care provided to the patient during their final admission, and is given a HOGAN score of 4 or above, or an National Confidential Enquiry into Patient Outcome and Death (NCEPOD) score of 3, this is considered to potentially meet the requirements for reporting as a Patient Safety Incident Investigation (PSII) under the Learning from Deaths criteria. This criteria states that where the patient's death is more likely than not due to problems with the delivery of care, these should be reported as a PSII.

Where identified, these cases are escalated to the Trust's weekly Rapid Action Review Meeting (RARM) for review, and recording of a PSII.

All HOGAN and NCEPOD gradings are presented collectively to the quarterly Mortality Surveillance Group, whilst all HOGAN ≥4 and NCEPOD 3 are discussed by the group on an individual basis.

3.1. HOGAN Scores

HOGAN scores, which are a guide as to the preventability of the death, are defined as follows:

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

In Q2 2024/2025, 196 Level 2 reviews were undertaken of the 457 deaths recorded in the Trust. This equates to 43% of all deaths recorded in the quarter however it should be noted that one patient may have more than one Level 2 review recorded. The below graphic details the number of reviews and HOGAN scores allocated by month:

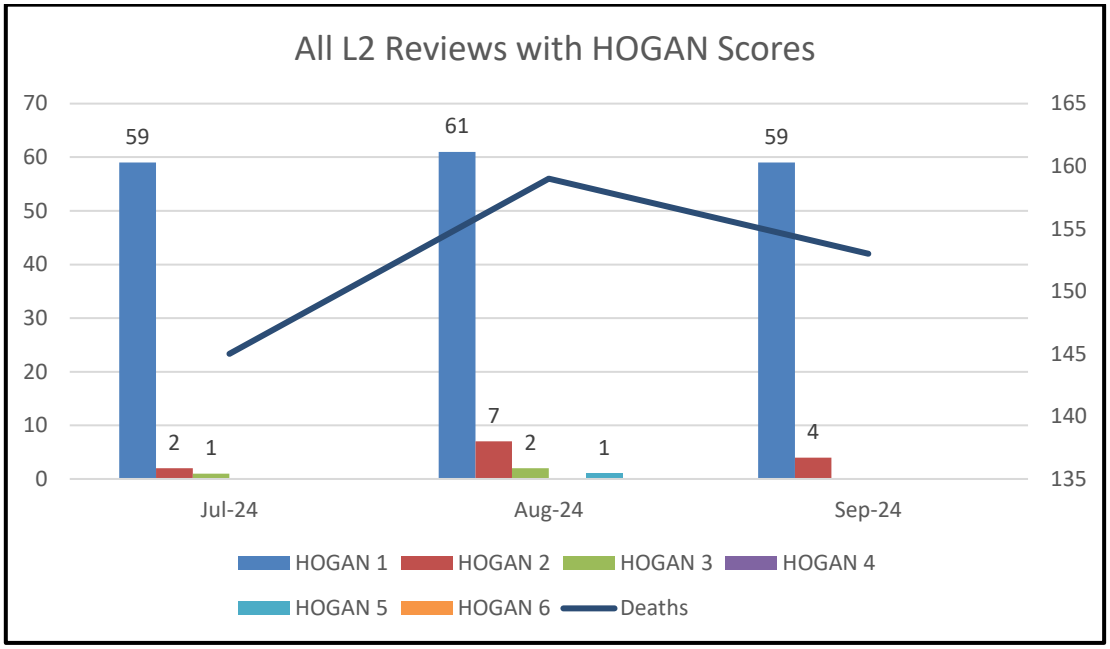


Figure 3: All Q2 Level 2 Reviews with HOGAN Scores

3.2 HOGAN >4 Scores

In Q2 2024/2025, one case undergoing Level 2 review received a HOGAN score of 5. This case was escalated to RARM and subsequently declared as a PSII in line with Learning from Death reporting criteria. The below table details the case summary, learning response and identified learning outcomes from the subsequent completed investigation:

Clinical Board	Case Summary	HOGAN Score	Learning Response	Learning Outcome and Actions
Surgery & Specialist Services	Inadvertent large vessel injury during corrective spinal surgery leading to catastrophic haemorrhage.	5	PSII	• Arrangements have been made for the presence of a vascular surgeon at both anterior lumbar interbody fusion (ALIF) and oblique lumbar interbody fusion (OLIF) procedures (previous agreement in place was for ALIFs only).

Clinical Board	Case Summary	HOGAN Score	Learning Response	Learning Outcome and Actions
				• Multidisciplinary Team (MDT) processes for spinal deformity cases have been strengthened. The team have sought Get It Right First Time (GIRFT) support, with an external peer review underway to review all patients currently on the waiting list. The next meeting with GIRFT is planned for 10/01/2025. • The number and location of emergency vascular trays in RVI theatre suites has been reviewed by the Vascular Theatre Sister. • Following one off audits of the North East Adult Deformity Service (NEADS) outcomes and interbody fusion outcomes undertaken by the Clinical Director for Patient Safety and Quality as part of the investigation, the spinal services team are planning to implement a programme of continuous audit going forward. The service has re-commenced but as yet no surgeries have been carried out.

3.3. Other Cases Meeting Learning from Death Criteria

The RARM panel reviews any event recorded as moderate or above patient harm in addition to cases escalated via the mortality review process. In Q2, two further deaths were reviewed following submission of a Datix and subsequent rapid review by the Clinical Board, and were declared as PSIIs, with investigations having commenced. Both patients have had a Level 2 review undertaken with HOGAN scores of 1 and 2 being allocated respectively.

3.4. NCEPOD Score 3

An NCEPOD score of 3 is defined as *"care was less than satisfactory. Several aspects of clinical and/ or organisational care that are/ were below what you would expect from yourself, your trainees and your institution."*

In Q2 2024/2025, no cases undergoing a Level 2 review received an NCEPOD score of 3.

4. RECOMMENDATIONS

To:

(i) Receive the report.

(ii) Note the actions taken following the learning identified from the cases detailed and continued monitoring as required by national Learning from Death criteria.

Report of Rachel Carter
Director of Quality and Safety
9 January 2025

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Agenda item A11

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	31 January 2025					
Title	Committee Chair Meeting Logs					
Report of	Bill MacLeod, Chair of the Finance and Performance Committee Anna Stabler, Chair of the Quality Committee Liz Bromley, Chair of the Digital and Data Committee Bernie McCardle, Chair of the People Committee Phil Kane, Chair of the Charity Committee David Weatherburn, Chair of the Audit, Risk and Assurance Committee					
Prepared by	Lauren Thompson, Corporate Governance Manager / Deputy Trust Secretary					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	The following Committee Chairs Logs are included since the last Public Trust Board meeting in November 2024: • Finance and Performance Committee – 25 November 2024 and 16 December 2024 • Quality Committee – 19 November 2024 and 10 December 2024 • Digital and Data Committee – 12 December 2024 *[To follow]* • People Committee – 19 November 2024 and 17 December 2024 • Charity Committee – 13 January 2025 • Audit, Risk and Assurance Committee – 26 November 2024					
Recommendation	The Trust Board is asked to note the contents of the Committee Chair Logs.					
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]	Detailed in the individual Committee Chairs Logs.					
Reports previously considered by	Present at each relevant Committee.					

Agenda item A11

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Finance and Performance (F&P) Committee - Chair's Log

Meeting: Finance and Performance Committee	**Date of Meeting**: 25 November 2024
Connecting to: Audit, Risk and Assurance Committee Trust Board	**Date of Meeting**: 28 January 2025 31 January 2025

Key topics discussed in the meeting

- Month 7 Finance Report - there is a reported variance against plan of £2.7m relating to unfunded industrial action costs and more significantly the in-year pay award, whilst some national funding has been provided, a shortfall remains. Further work is being undertaken in partnership with the Integrated Care Board (ICB).
- At month 7 the total capital expenditure to date was £22.8m against a plan of £15.3m. However, this included donated assets of £2.6m therefore the Trust is currently £4.7m ahead of plan from a Capital Departmental Expenditure Limit (CDEL) perspective.
- The Chief Finance Officer summarised the latest position on the Financial Recovery Plan. Elective Recovery Funding (ERF) is on target to be achieved however the Cost Improvement Programme (CIP) was under-performing recurrently.
- A deep dive into the Cancer and Haematology Clinical Board financial position was conducted. As at Month 7 the Clinical Board reported a £800k favourable variance against budget. The Clinical Board has CIP plans totalling £1,180k against a full year target of £702k.
- A Clinical Board / Corporate Service update was provided which included the continued focus on the CIP. Improvement planning had moved to phase 2 with a focus on testing the impact across the organisation.
- The Director of Performance and Governance presented the month 7 performance update within the Integrated Quality & Performance Report noting that there is a continuing trend of improvement for the 62-day cancer standard. Performance improved slightly against the 5% diagnostic standard in September, with 36.7% of patients waiting longer than six weeks for their test, however there is special cause variation of a concerning nature identified from the data and the target is not being achieved consistently.
- The Committee received an update on the Perfect Cancer Pathway for Colorectal and Bladder tumour pathways. A full diagnostic piece of work has been undertaken to identify the areas where the greatest improvements and impact on cancer waiting time targets can be made.
- The Medicine and Emergency Care Clinical Board attended to present the Emergency Department Staffing Investment Business Case which included a detailed update on progress made, performance and improvement plans.
- An update was provided on the Day Treatment Centre quarter two utilisation which included activity trends, session utilisation and in-session utilisation. Improvement work is underway to improve utilisation as well as to address the recommendations from the recent Get It Right First Time (GIRFT) accreditation visit in July 2024.

- Committee members considered the assurance levels and updates aligned to the three risks on the Finance and Performance Committee Board Assurance Framework/Risk Report. The Committee were assured that risk actions are progressing and approved the BAF for consideration at the November Audit, Risk and Assurance Committee and Trust Board meetings.
- A number of Tenders and Business Cases were approved.
- The amendments to the Capital Management Group (CMG) Terms of Reference were approved by the Committee.
- An update was provided on the developments and activity since the launch of the Commercial Strategy earlier in the year.
- The Committee received the following documents:
    - Minutes and Chairs Logs of the CMG in October, the Community Diagnostic Centre Strategic Oversight Group in October, the Supplies and Services Procurement Group in October and the Estates Strategy and Capital Investment Group in July.
    - The Month 7 Financial Recovery Report.

Actions agreed in the meeting	Responsibility / timescale
There were no new actions.	Not applicable
Escalation of issues for action by connecting group	**Responsibility / timescale**
There were no issues to escalate.	Not applicable
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Risk ID 6.1 - Failure to manage our finances effectively to improve our underlying deficit and deliver long term financial sustainability. • Risk ID 6.2 - Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care. • Risk ID 5.1 - Failure to maintain the standard of the Trust Estate, Environment, and Infrastructure could result in a disruption to clinical activities and impact on the quality of care delivered. • 4392 – IT – financial risk arising from a 5-year contract ending.	Not applicable

Agenda item A11

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Finance and Performance (F&P) Committee - Chair's Log

Meeting: Finance and Performance Committee	**Date of Meeting**: 16 December 2024
Connecting to: Audit, Risk and Assurance Committee Trust Board	**Date of Meeting**: 28 January 2025 31 January 2025
Key topics discussed in the meeting	

- In relation to the month 8 finance report, there is a reported variance against plan of £3m which relates to unfunded industrial action costs and more significantly the in-year pay award with further work taking place in partnership with the Integrated Care Board (ICB).
- At month 8, the total capital expenditure to date was £24.9m against a plan of £20.2m. However, this included donated assets of £2.7m therefore the Trust is currently £1.7m ahead of plan from a Capital Departmental Expenditure Limit (CDEL) perspective.
- A comprehensive discussion took place with regards to the Medium Term Financial Plan with the first iteration of the plan due to be submitted to the ICB by 19 December 2024, with an assumption of a significant Cost Improvement Programme (CIP).
- The Quality Performance Review (QPR) summary was available for information. A discussion took place in relation to the development of a distributed leadership model, based on greater devolution, autonomy and accountability for Clinical Boards.
- In terms of performance, October saw notable decreases in the number of 65 week waits and 52 week waits, though these reductions remain in line with common cause variation. The total waiting list size decreased and performance improved slightly against the 5% diagnostic standard, with 34.3% of patients waiting over six weeks for their test. Pressure continues within the Emergency Department however a reduction was seen in October and November. A deep dive will take place in relation to skin cancer tumour group in February 2025.
- The Committee received and noted the Board Assurance Framework (BAF) recommendations approved by the Trust Board relating to the Committees area of focus.
- A deep dive took place with regards to International Patients income which is one of the Trust's six commercial schemes for 2024/25. The discussion included current challenges, the requirements of the referring governments and exploring operational aspects and enablers with the Trust Clinical Boards to expand the service.
- A tender was ratified for Trust Board approval.
- The Committee received the following documents:
  - Minutes of the Capital Management Group in November, Supplies & Services Procurement Group in November and Estates Strategy and Capital Investment Group in October.
  - The month 8 Financial Recovery Report.

Actions agreed in the meeting	Responsibility / timescale
1. In relation to the financial and workforce controls review self-assessment, the Chief Finance Officer (CFO) agreed to review the PwC/AuditOne report recommendations and identify which recommendations align to which Board Accountable Committee [Action 255 on action log]. 2. Medium Term Plan - The Cost Reduction Programme to be included as an item of discussion on the Private Trust Board agenda in January 2025. 3. The development of a distributed leadership model, based on greater devolution, autonomy and accountability for Clinical Boards to be included on a future Board Development agenda. 4. The EDCDI to provide figures with regards to adult international referrals that the Trust has treated. 5. The EDCDI to follow up on the potential facilities available as part of the Ramsey project for international patients.	1. CFO / January 2025 2. CFO & Trust Secretary (TS) / January 2025 3. The Deputy Chief Executive (DCE) & TS / January 2025 4. The Executive Director of Commercial, Development and Innovation (EDCDI) / January 2025 5. The EDCDI / January 2025
Escalation of issues for action by connecting group	**Responsibility / timescale**
• The Medium-Term Financial Plan and the proposal for first submission to the ICB.	• The Chair of the Committee / December 2024
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Risk ID 6.1 - Failure to manage our finances effectively to improve our underlying deficit and deliver long term financial sustainability. • Risk ID 6.2 - Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care. • Risk ID 5.1 - Failure to maintain the standard of the Trust Estate, Environment, and Infrastructure could result in a disruption to clinical activities and impact on the quality of care delivered. • 4392 – IT – financial risk arising from a 5-year contract ending.	• Not applicable.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Quality Committee
Chair's Log

Meeting: Quality Committee	**Date of Meeting**: 19/11/2024
Connecting to: Audit Risk & Assurance Committee and Trust Board	**Date of Meeting**: 26/11/2024 and 29/11/2024
Key topics discussed in the meeting	

- National Patient Safety Strategy & Patient Safety Incident Response Framework Update.
- Quality Account - A six-month review of progress for all 2024/2025 Quality Account Priorities including results where available was provided. The Quality Committee noted the progress to date providing assurance to the Board that improvements are being made and, where necessary, appropriate measures are in place to address any deviation from the anticipated mid-year position.
- CQC – A general update on progress within the following areas were received:
    - Cardiac Oversight Group Update
    - Medicines Oversight Group
    - North East and Cumbria Transport and Retrieval (NECTAR) Action Plan
    - Emergency Department Action Plan Progress
    - Duty of Candour
- Marthas Rule – An update was provided with regard to current position and progress for the Martha's Rule pilot, identifying any key areas of progress or challenge.
- Management Group Reports for the following were presented:
    - Patient Safety Group (PSG)
    - Patient Engagement and Experience (PEEG)
    - Clinical Outcomes and Effectiveness Group (COEG)
- Annual Report for End of Life and Palliative Care. A report provided an update to the Quality Committee about key issues, progress and risks of the Palliative and End of Life Care Service within the Trust including:
    - The Palliative and End of Life Care Service report 2021-24
    - Deciding Right and Advance Care Planning
    - Digitalisation of the Caring for the Dying Patient Document-hospital
    - Freeman Hospital Haven
    - Gold Standards Framework, Ward accreditation, Ward 46 RVI
    - Specialist Palliative Medicine cover out of hours pilot
    - Delivery of Palliative & End Of Life Care education
    - Quality and Safety of Palliative & End of Life Care
- Perinatal Quality Surveillance Report including Clinical Negligence Scheme for Trusts (CNST) Update. An overview of the Maternity Service compliance with the Perinatal

Quality Surveillance Model, and updates on the main quality and safety considerations of the service was provided.

An update in relation to the progress made against the 10 Maternity Safety for NHS (CNST) was provided.

- Quarter 2 reports for
    - Safeguarding (including progress on training). An Executive Summary of the Quarter 2 (Q2) 2024/25 Safeguarding and Mental Capacity Act reports presented to the Trust Safeguarding Committee on 8 October 2024 was provided.
    - Learning Disability (including update on Quality Priority 3 and ICB Safety Alert). An update was provided in relation to the on-going work to agree a regional position on the provision of mandatory training for Learning Disabilities and Autism
- An update in relation to Clinical Board Quality and Safety Priorities was provided focussing on:
    - Cancer & Haematology
    - Surgical & Specialist Services
    - Perioperative & Clinical Care
    - Family Health including Children & Young People
- Patient and Staff Experience (Including Equality Delivery System (EDS) – Patients Annual Report). An update in relation to learning about the care experience from patient, carer, and family feedback was provided with results for October 2024 being shared.
- Wards of Concern. The report highlighted the key areas of concern as raised via the trusts established Nurse Staffing and Clinical Outcomes Group as well as the actions put in place to establish improvement.
- The Integrated Quality & Performance Report was presented which provided assurance to the committee on the Trust's performance against key Indicators relating to Quality & Safety, Access, People, Finance and Health Inequalities.
- Board Assurance Framework (BAF). The report aimed to support the Quality Committee to gain assurance that strategic risks aligned to the committee were being managed effectively; that risk have an appropriate action plan in place to mitigate them; and that risk scores are realistic and achievable.
- Legal Update. The report outlined any legal matters arising in the next 3 months which the Quality Committee should be aware of.
- Six monthly staffing deep dive report. The report fulfilled the recommendations of the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) and adhered to the recommendations set out by the National Quality Board (NQB 2016): How to ensure the right people, with the right skills, are in the right place at the right time.

Actions agreed in the meeting	Responsibility / timescale
1. A Training needs analysis of Statutory & Mandatory training to be undertaken following the national review following which an update will be provided to the Quality Committee.	1. Chief People Officer – once review has been undertaken

2. Delivery of Patient Safety Incident Response Framework (PSIRF) Training at Board level via Board Development Session.	2. Trust Secretary – to be added to Board Development schedule.
3. The next PSIRF update to include how the learning from the Patient Safety Incident Investigation (PSII) and After Action Reviews (AAR) is being embedded to provide assurance that anything is not being missed.	3. Deputy Director of Quality & Safety in next PSIRF update.
4. Medicines Management Action plan to be shared via the Quality Committee Reading Room for each meeting.	4. Director of Pharmacy – December 2024
5. Medicines Management – next update to include assurance as to the actions that are being taken to support staff & their patients to keep them safe while the new workforce plan is developed.	5. Director of Pharmacy – December 2024
6. Capacity / size of the Safeguarding Team when benchmarked against organisations of similar type and size to be raised with the ICB.	6. Executive Director of Nursing
7. The Patient Experience report to include experience of all groups represented by protected characteristics based on the capture of inpatient / outpatient, emergency department and maternity.	7. Chief Experience Officer – January 2025
Escalation of issues for action by connecting group/Trust Board	**Responsibility / timescale**
To note that compliance with safety actions 6 and 8 of the Maternity Incentive Scheme (MIS) will not be met for 2024/25 resulting in a potential loss from MIS Funds. Steps being taken now to rectify this for 2025/26.	Director of Midwifery – 2025/26
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
Detailed within the BAF	N/A

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Quality Committee
Chair's Log

Meeting: Quality Committee	**Date of Meeting**: 10/12/2024
Connecting to: Audit Risk & Assurance Committee (ARAC) and Trust Board	**Date of Meeting**: 19/12/2024 and 31/01/2025
Key topics discussed in the meeting	

- CQC – A general update on progress within the following areas were received:
  - Cardiac Oversight Group Update
  - Medicines Oversight Group
  - North East and Cumbria Transport and Retrieval (NECTAR) Action Plan
  - Emergency Department Action Plan Progress
  - Duty of Candour
- Rapid Quality and Safety Reviews Progress report - an overview of the Trust Peer Review Process was provided highlighting themes identified across the organisation around compliance with core standards.
- Management Group Reports for the following were presented:
  - Patient Safety Group (PSG) the most recent meeting focussed on Duty of Candour as well as reviewing legacy Serious Incident action plans which were on track to be closed out by 31st December 2024.
- Mental Health Committee Update. The Mental Health Committee met in November 2024 to review and discuss key workstreams relating to improving the care for patients with a mental health need. This was a new committee which had met four times over 2024 and was in its formative stage. It is scheduled to meet bi-monthly moving forward and as part of the membership there will be a patient representative with lived experience.
- Audiology Action Plan Update. A verbal update was provided following the development of a Management Group with the Integrated Care Board (ICB) in relation to the Paediatric Audiology Review and more specifically the Auditory Brainstem Response (ABR) in babies. In terms of routine screening within 6 weeks, there had been a 94% reduction which was testament to the hard work of the audiology staff.
- Perinatal Quality Surveillance Report including a Clinical Negligence Scheme for Trusts (CNST) Update. An overview of the Maternity Service compliance with the Perinatal Quality Surveillance Model, and updates on the main quality and safety considerations of the service was provided. The Newcastle Birthing Centre had re-opened. There had been some great patient experience feedback received to date and the activity within the service would continue to be closely monitored, learning form others within the ICB.
- Clinical Board Top 3 Quality & Safety issues to raise to Quality Committee. An overview of the top three priorities for the following Clinical Boards was provided:

- Clinical & Diagnostic Services
- Surgical Associated Services
- Medicine and Emergency Care
- Cardiothoracics

- The Integrated Quality & Performance Report was presented which provided assurance to the committee on the Trust's performance against key Indicators relating to Quality & Safety, Access, People, Finance and Health Inequalities.
- Board Assurance Framework (BAF). The report aimed to support the Quality Committee to gain assurance that strategic risks aligned to the committee were being managed effectively; that risks have an appropriate action plan in place to mitigate them; and that risk scores are realistic and achievable. The BAF had recently been reviewed and critiqued where more assurance was needed.

Actions agreed in the meeting	Responsibility / timescale
1. It was agreed that any audit reports would be added to agendas including any reports that are received after the agenda setting meeting.	1. Executive Director of Nursing / meeting secretariat when received.
2. Written feedback from the ICB visit on 6 December 2024 to be shared with the Committee once available.	2. Executive Director of Nursing when available
3. Appointments of Trust wide Freedom to Speak Up Champions to be progressed at pace and to be fed back to People Committee.	3. Chief People Officer – January 2025
4. Medicines Management Action plan – to re-write action in relation to gap in investment to incorporate the next stage to provide a continuing summary.	4. Interim Director of Pharmacy – next iteration of the report in January 2025
5. Summary report of the value of stock returned from wards to be presented to the Finance & Performance Committee.	5. Interim Director of Pharmacy – February 2025
6. An update on staffing with regard to the NECTAR service to be provided.	6. Director of Operations for Family Health Clinical Board
7. The latest iteration of the Patient Safety Group (PSG) Chairs Log to be added to Admincontrol	7. Deputy Director of Quality & Safety / meeting secretariat
Escalation of issues for action by connecting group/Trust Board	**Responsibility / timescale**
There were no escalations to ARAC or Trust Board, however there were two actions for referral to connecting committees as noted above in action 3 and 5.	See above.
Risks (Include ID if currently on risk register)	**Responsibility / timescale**

Detailed within the BAF	N/A

Agenda item A11

The Newcastle upon Tyne Hospitals NHS Foundation Trust

People Committee - Chair's Log

Meeting: People	**Date of Meeting**: 19 November 2024
Connecting to: Audit Risk and Assurance Committee Trust Board	**Date of Meeting**: 28 January 2025 31 January 2025
Key topics discussed in the meeting	

- The People Committee Board Assurance Framework (BAF) was discussed, and the Committee agreed to update the 'Staff do not speak up about issues that cause them concern' assurance rating to amber due to the progress made and recommended the BAF to the November Audit, Risk and Assurance Committee and Trust Board for approval.
- An update was provided with regards to the Care Quality Commission (CQC) delivery plan with all actions being on track. A new action has been created in relation to the implementation of the new policy for anti-racism.
- The Head of HR Strategy and Transformation provided an update with regards to the People Plan and year 1 deliverable actions. The staff survey to date has a 56.2% response rate.
- A Health and Wellbeing update was provided, and the following key points were discussed:
  - The work taking place in partnership with Newcastle Hospitals Charity to provide temporary support on Health and Wellbeing initiatives;
  - Reviewing the psychological support offer to staff; and
  - The work taking place to improve processes and closer alignment between the People Directorate and Occupational Health to ensure overall support.
- A Valued and Heard update was provided, and the following key points were discussed:
  - The importance of ensuring staff know how to speak up safely within their own teams, departments and to the Freedom To Speak Up Guardian (FTSUG);
  - Promoting and encouraging the use of the 'speak in confidence system' for anonymous feedback; and
  - Seeking feedback from staff and acting on the findings.
- An Equality, Diversity and Inclusion (EDI) update was provided, and the following key points were discussed:
  - EDI Improvement Plan;
  - Ethnicity Pay Gap reporting;
  - NHS Contract requirements which included the Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES) action plans; and
  - Legislative requirements including the Public Sector Equality Duty (PSED).
- The Integrated Board Report was received, and the content noted.
- A People and Culture dashboard summary was provided from the monthly performance reviews with Clinical Boards and monthly meetings between Human Resources (HR) and Corporate Services. A deep dive into the Family Health Clinical

Board took place which included information regarding the main reasons for absence and actions to help and support staff.

- Minutes of the Learning and Education Group (23 September 2024) and the Equality, Diversity and Inclusion Steering Group (31 October 2024) were received.
- There were no new and emerging risks.

Actions agreed in the meeting	Responsibility / timescale
1. The Committee agreed to update the 'Staff do not speak up about issues that cause them concern' assurance rating to amber **[ACTION01].**	The CPO & HCRA / December 2024
2. The CPO agreed to refresh the November and December 2024 dates for the next BAF iteration **[ACTION02]**.	The CPO & HCRA / December 2024
Escalation of issues for action by connecting group	**Responsibility / timescale**
No issues to escalate.	Not applicable.
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
Under risk ID 2.2, the Committee agreed to change the 'Staff do not speak up about issues that cause them concern' assurance rating to amber. Risk ID 2.1 - Failure to have sufficient capacity and capability in our workforce to deliver safe and effective care. Risk ID 2.2 - Failure to develop, embed and maintain an organisational culture in line with our Trust values and the NHS people promise. Risk ID 2.3 - Failure to effectively develop and implement a new approach to leadership and organisational development to ensure that everyone feels supported appropriately by the organisation.	

Agenda item A11

The Newcastle upon Tyne Hospitals NHS Foundation Trust

People Committee - Chair's Log

Meeting: People	**Date of Meeting**: 17 December 2024
Connecting to: ARAC Trust Board	**Date of Meeting**: 28 January 2025 31 January 2025

Key topics discussed in the meeting	

- An update was provided in relation to the Care Quality Commission (CQC) delivery plan and the People Plan overview of year 1 deliverable actions. The Committee were assured that detailed work is taking place with involvement from the staff networks, staff side representatives and communications colleagues. Actions are regularly reviewed and progressing well.
- The Committee received an update with regards to Behaviours and Civilities noting that the Civilities Charter has been integrated into people practices such as recruitment, induction, training and celebration.
- A Leadership and Management update was provided which detailed a clear view on next steps, including evaluating Cohorts 1 and 2 of the Compassionate Leadership Programme to the Executive Team and ascertain support for a large-scale roll-out, develop criteria to monitor improved leadership enablers and the development of the appraisal programme roll-out.
- A discussion took place with regards to the NHS staff survey and staff engagement. The 2024 staff survey response rate concluded at 64% which was 10,380 members of staff. The Committee expressed thanks to all members of staff who took part and who helped promote the staff survey. Work will take place early in the new year once the full set of data has been received.
- An update was received with regards to the Clinical Boards Quality Performance Review (QPR). The Committee initially raised some concerns with regards to the Zeal survey results but were subsequently assured by the great deal of work taking place.
- The Committee received and noted the Board Assurance Framework (BAF) recommendations approved by the Trust Board relating to the Committees area of focus.
- A Performance and Delivery update was provided by the Head of HR Services which included the People Integrated Board Report, People and Culture Data and Workforce Profiling and Demographics. A comprehensive discussion took place in relation to sickness absence and supporting staff to return to work, staff retention and the importance of triangulating data through each Board Accountable Committee. A detailed discussion took place in relation to workforce numbers and the 13% growth on the 2020 baseline. The Committee are keen to see this work progress over the coming months and triangulate with the Finance & Performance Committee and Quality Committee.
- The minutes from the November Learning and Education Group were received for information.

Actions agreed in the meeting	Responsibility / timescale

There were no new actions.	Not applicable.
Escalation of issues for action by connecting group	**Responsibility / timescale**
There were no issues for escalation.	Not applicable.
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
Risk ID 2.1 - Failure to have sufficient capacity and capability in our workforce to deliver safe and effective care. Risk ID 2.2 - Failure to develop, embed and maintain an organisational culture in line with our Trust values and the NHS people promise. Risk ID 2.3 - Failure to effectively develop and implement a new approach to leadership and organisational development to ensure that everyone feels supported appropriately by the organisation.	

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Charity Committee - Chair's Log

Meeting: Charity Committee – Funding only	**Date of Meeting**: 13 January 2025
Connecting to: Audit Risk and Assurance Committee Trust Board	**Date of Meeting**: 28 January 2025 31 January 2025
Key topics discussed in the meeting	

- Updates on previous funding applications were discussed.

- Summary of Proposals Processed by the Charity Utilising Restricted Funding:
  - *SA2729 – Legacy received to support Ophthalmology with emphasis but not exclusively for research - £468,859.*
  - *SA2801 – Individual Donation to establish a fellowship within the colorectal surgery department - £142,000.*
  - *SA2817 – Red Sky Foundation donated to support the cost of consumables for five child heart transplants using XVIVO device - £92,500.*

- £20k +Funding proposals were discussed in relation to:
  - *Clinical and Diagnostics Services - Movement for Change - £31,957 – Supported via Chairs action.*
  - *Sustainable Healthcare - RVI Ward 21 and Freeman Disablement Services Lighting installation, - £86,144 – Supported.*
  - *Silent closure bins and waste segregation refresh, Sustainable Healthcare- £38,250- Supported.*
  - *Health & Wellbeing - Temporary funding of a band 5 to assist with the health at work practitioner advance for 6 months - £22,868 – Supported.*
  - *Cancer & Haematology - Daft as a Brush (DAAB) Cancer Patient Care - £248,300- Supported.*
  - *Clinical and Research Services - Renewal of Sir Bobby Robson Unit (SBRU) Training nurses and medical posts for August 2025 - £437,266 - Supported.*
  - *Surgical and Associated Services - Oral Health Education - £36,602 – On-Hold.*
  - *Medicine and Emergency Care -Temporary Clinical Educator to support digital caring for the dying patient document launch, Palliative Care - £56,658 – On Hold.*
  - *Cardiothoracic Services - 3D Lung Cancer Treatment Equipment for Cardiothoracic Services - £160,094 – On Hold.*
  - *Peri-op & Critical Care - Paediatric pain service psychology and physiotherapy provision - £243,857 – Supported.*
  - *Freeman Ward 9 Inpatient Rehabilitation Unit Activity Co-ordinator Pilot - £67,860 - Not supported.*
  - *Strategic Comms for Cardiothoracic Services - £73,493 – Supported.*

- The summary of funding agreed since the last meeting was reviewed (bids up to £20k).

Report received.

Actions agreed in the meeting	Responsibility / timescale
Not applicable	Not applicable
Escalation of issues for action by connecting group	**Responsibility / timescale**
Not applicable	Not applicable
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
Not applicable	Not applicable

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Audit, Risk and Assurance Committee (ARAC) - Chair's Log

Meeting: ARAC	**Date of Meeting**: 26 November 2024
Connecting to: Board	**Date of Meeting**: 19 December 2024
Key topics discussed in the meeting	

- Escalation from other Board Committees to ARAC:
  - Quality Committee held on 19 November 2024, compliance with safety actions 6 and 8 of the Maternity Incentive Scheme (MIS) would not be met for 2024/25.
  - People Committee – the Chair noted that a deep dive in to health and wellbeing was presented to the People Committee and psychological support for staff was raised, with Critical Care and Accident and Emergency (A&E) as two of the main areas impacted.

- Clinical Board Deep Dives:
  - Surgical & Associated Services (SAS) – presentation covering a Deep Dive into Risk Register & Risk Management Processes for the SAS Clinical Board.
  - Peri-Operative and Critical Care – presentation on the work that had been undertaken with regard to the reviewing of risks since the Clinical Board was established to ensure triangulation of patient safety, quality improvement and risk management is embedded with data driven risks identified and actions directed by quality improvement methodology.
  - Clinical and Diagnostics Services 2 Year+ Risk action plan – an overview of the risk management governance for the Clinical Board was provided.

- Board Assurance Framework (BAF) Report – The BAF was presented noting that Current risk scores remain unchanged on all BAF Risks and several actions timescales have been amended and new actions have been added on all risks. The BAF had matured considerably, however whilst it was current and captured all actions to improve the assurance rating, there was now an opportunity to review the actions to ensure they were the most effective and would provide the biggest impact.

- Risk Management Report – an overview of the risk validation work was provided noting the evidence of improvement.

- Assessment of Overdue Internal Audit Recommendations – from the 25 overdue revised recommendations some targeted work had been undertaken with Executive Leads resulting in 19 being recommend for closure and all remaining recommendations were expected to be complete by December 2024.

- National Payroll Exercise - the Trust is one of 31 nationally who were identified as those who would benefit from some intensive support to improve their payroll processes. The programme started for the Trust at end of July and is split into three phases: Discovery

(completed); Design and Develop (to do); and Implementation (to do). Some initial findings have been identified which will be discussed in the newly established task and finish group.

- Assurance from the People Committee as to whether arrangements by which staff may raise concerns are operating effectively. There was good assurance that this was an area that was receiving good traction and on a good direction of travel. In terms of raising concerns and speaking up, there was a new Freedom to Speak up Guardian in post, and Executive Lead (Chief People Officer) as a NED Champion (Bernie McCardle). All three meet on a regular basis and were undertaking a comprehensive self-assessment and there would be significant stakeholder engagement over the next few months.

- The Committees Chairs Logs were received for the following Committee meetings:
    - Finance and Performance Committee – 21 October 2024
    - People Committee – 15 October 2024
    - Quality Committee – 15 October 2024
    - Charity Committee – 5 November 2024
    - Digital & Data Committee – 10 October 2024

In addition the minutes of the Compliance and Assurance Group meeting held on 7 November 2024 were received.

- Benchmarking the Head of Internal Audit Opinion for 2023/24 - the review was to compare and contrast the overall head of internal audit opinion given by AuditOne to its eleven member clients. The benchmarking had confirmed that the Trust was an outlier with a decline between the three years that were benchmarked.

Actions agreed in the meeting	Responsibility / timescale
1. De-escalation techniques as well as break away training which would include training for staff to deal with patients with complex learning difficulties to be included in the risk description for risk 4243.	1. Head of Risk & Assurance – January 2025
2. ICB External Review of Financial and Workforce Controls by AuditOne to be circulated by email once received.	2. Chief Finance Officer once received
3. Benchmarking of Head of Internal Audit Opinion for 2023/24 – internal audit to identify any lessons learned from other organisations in the peer group.	3. Senior Internal Audit Manager, AuditOne – once received
Escalation of issues for action by connecting group	**Responsibility / timescale**
There were no escalations.	N/a
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
Risk details were shared through the Clinical Board updates.	N/a

Agenda item A12

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	31 January 2025					
Title	Board Assurance Framework (BAF) Report					
Report of	Rob Harrison, Deputy Chief Executive. Patrick Garner, Director of Performance and Governance.					
Prepared by	Natalie Yeowart, Head of Corporate Risk and Assurance.					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☒	☐			
Summary	This report aims to support the Trust Board to gain assurance that strategic risks aligned to the Committees are being managed effectively; that risks have an appropriate action plan in place to mitigate them; and that risk scores are realistic and achievable. Key points to note: • Current risk scores remain unchanged on all Board Assurance Framework (BAF) Risks. • Several action timescales have been amended to provide more accurate timescales for delivery of actions. • New actions have been added to both the Finance, Quality and Digital & Data BAF risks. • 1 assurance rating has changed from Amber to Green relating to failure to improve maternity services. • 1 assurance rating has changed from Red to Amber relating to failure to deliver the required level of efficiency savings required in the Financial Recovery. • Full details of all changes to each risk can be found within section 3.					
Recommendation	The Trust Board are asked to: • Receive assurance from the Audit, Risk and Assurance Committee on the management of the Board Assurance Framework. • Provide any feedback or comments. • Approve the Board Assurance Framework document.					
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]	N/A					
Reports previously considered by	Executive Team and Committees of the Board.					

BOARD ASSURANCE FRAMEWORK REPORT

1. INTRODUCTION

The 2024/25 Board Assurance Framework (BAF) has been re-designed to ensure it can effectively capture all the relevant information to allow effective discussion and assurance to be received by each Committee and Trust Board. This approach will support and inform the committee agenda and regular management information received by the Committee, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be approved by the Audit, Risk and Assurance Committee and reported to the Trust Board, as well as identify any further actions required to mitigate risk.

The key elements of new BAF are:

- A description of each Principal (strategic) Risk, that forms the basis of the Trust's risk framework (with corresponding corporate and operational risks defined at a Trust-wide and service level if available).
- Risk ratings – initial, current and target levels.
- Clear identification of primary strategic threats that are considered likely to increase or reduce the Principal Risk.
- A statement of risk appetite for each risk to be defined by the Lead Committee on behalf of the Board – This field will be populated when the Trust risk Appetite Statement is agreed.
- Documented controls already have in place to reduce the likelihood of the threat.
- Sources of assurance incorporate the three lines of defence to demonstrate the assurance and confidence of the control in place.
- Key actions identified for each threat; each assigned a timescale for completion. These will be individually rated by the lead committee noting the level of assurance they can take that the actions will be effective in treating the risk.
- Clearly identified gaps in the primary control framework, with details of planned responses.
- The committee should provide a level of assurance for each threat based on the committee review of the Board Assurance Framework Risk.
- Levels of assurance are documented below.

2. BOARD ASSURANCE FRAMEWORK REVIEW PROCESS

A full BAF review cycle has now been completed. The process followed to complete the BAF review process is documented in the table below.

	Stage 1: The BAF is reviewed by the Executive Lead for each BAF risk on a quarterly basis. Each threat must be comprehensively reviewed, updated with any new control/actions and any new strategic risks or threats proposed. The Executive Lead is to recommend a level of assurance for each threat to the Committee of the Board.

	Stage 2: The BAF document is reviewed collectively at Executive Team Meeting prior to review at Committees of the Board.
	Stage 3: Committees of the Board review all BAF risks for which they are responsible quarterly at each committee meeting. The Executive Lead will discuss the assurance recommendation with the Committee. The Committee will then agree the recommendations and agreed levels of assurance will be reported the BAF risk report to the Audit, Risk and Assurance Committee.
	The Audit, Risk and Assurance Committee receive a BAF risk report including the full board assurance framework and recommendations proposed by Committee Chairs. The Audit, Risk and Assurance Committee will review and approve the recommendations or provide feedback/questions or queries back to the Committees for further consideration.
	The BAF is submitted to Trust Board following approval at Audit, Risk and Assurance Committee.

3. BAF RISK REVIEW

Below aims to give an overview of the Executive review and updates for each Committee.

Quality Committee

There is one strategic risk aligned to the Quality Committee, this relates to the inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.

This risk has been reviewed by the Executive Director of Nursing, Director of Quality and Safety and the Head of Corporate Risk and Assurance.

Following the risk review the key points to note are as follows

- The current risk score remains at a score of 15 (5x3).
- 5 controls have been added, 4 relating to care planning and 1 relating to rapid quality and safety peer review.
- 10 assurances have been added relating to staff survey response, rapid quality and safety peer review, Mental Capacity Act (MCA) audit data, Deprivation of Liberty Safeguards (DOLS), MCA/Mental Health Act (MHA) mandatory training, Care Quality Commission (CQC) maternity survey results, care planning documentation and training.
- Qualitative assurance have been added where possible.
- 15 actions have been added relating to the development of 2025/26 quality priorities, development of the patient safety strategy, compliance with MCA Level 2, monitoring and delivery of the self-harm programme, assurance framework for reasonable adjustments, development of the learning disability and autism 1 year

strategy, maternity services workforce review phase 2, Patient Safety Incident Response Framework (PSIRF) priorities, clinical board governance internal audit and Care planning and documentation.

- 2 action timescales have been revised relating to the development of quality and safety reporting mechanisms and patient correspondence/letter audit validation.
- 1 threat relating to the failure to improve the safety and quality of patients and staff experience in maternity services is recommended to move to a green level of assurance, there is reliable evidence to suggest the current risk treatment strategy is effectively addressing the threat. The progress indicator for this threat has also been updated to fully on plan across all actions.

People Committee

There are three strategic risks aligned to the People Committee, these relate to capacity and capability of the workforce (2.1), developing, embedding and maintaining organisational culture (2.2) and developing and implementing a new approach to leadership and organisational development (2.3).

Please note: The People Committee risks remain unchanged. A comprehensive review will be required at the next full Board Assurance Framework Review in March 2025.

Finance Committee

There are three strategic risks aligned to the Finance and Performance Committee, these relate to managing our finances effectively (6.1), failure to achieve high performance standards (6.2) and failure to maintain the standards of the Trust Estate (5.1).

The Finance and Performance Committee BAF risks has been reviewed by the Director of Performance and Governance, Director of Estates and the Chief Finance Officer. Following the risk review the key points to note are as follows:

- All current risk scores remain unchanged.
- Action timescales have been updated to ensure accurate and achievable for all three risks aligned to the Finance and Performance Committee.
- 6 new actions have been added, 5 on 6.1 managing our finances effectively, these relate to grip and control action plan, identification of recurrent measures, planning for 25/26 and long-term plan. 1 new action on 6.2 failure to achieve high performance standards this relates to cancer performance improvement plans.
- 6 actions have been completed, 3 on 6.2 failure to achieve high performance standards, these relate to further development of the Integrated Quality and Performance Report, validation of non-Referral to Treatment (RTT) long wait and Emergency Department (ED) workforce rota. 1 action has been completed on 5.1 failure to maintain the standards of the Trust Estate, relating to annual condition survey (20%) to determine condition of infrastructure in accordance with NHS Backlog. 2 actions have been completed on 6.1 managing our finances effectively, these relate to completion of the Grip and Control audit and review of capital plan.
- 1 assurance rated on 6.1 managing our finances effectively has not moved to amber, this relates to failure to deliver the required level of efficiency saving required in the financial recovery.

- 1 threat relating to Estates workforce retention and recruitment has been removed from the Estates BAF risk, this is currently being managed operationally through Estates and not felt to be a strategic threat.

Digital and Data Committee

The Digital and Data Committee BAF risk has been reviewed by the Chief Information Officer

Please note: the Digital and Data Committee Meeting planned for January 2025 was stood down. The Digital and Data Committee BAF risk will be presented to the next committee meeting planned for March 2025.

Audit, Risk and Assurance Committee

The Committee are asked to discuss the recommended assurance rating and agree an assurance level for each threat. The Executive Lead will present the risk for discussion.

Following the risk review the key points to note are as follows:

- The current risk score remains at a score of 16 (4x4).
- 3 action timescales have been amended relating to clinical board governance internal audit, BAF internal audit and the development of phase 2 CQC action plan.
- 1 control has been added relating to the internal audit of the phase one CQC action plan and the associated significant assurance received.
- Assurance ratings remain amber.
- Action progress indicators detail that 1 action relating to embedding escalation processes to ensure executive oversight is fully on plan across all actions and all other actions are defined progressing where delays are occurring interventions are being taken.
- There is one strategic risk aligned to the Audit, Risk and Assurance Committee for review, this relates to the implementation of effective governance systems and processes (1.2) the risk score remains unchanged, actions are identified to mitigate the risk, assurance rating remains amber.

5. RECOMMENDATIONS:

The Trust Board are asked to:

- Receive assurance from the Audit, Risk and Assurance Committee on the management of the Board Assurance Framework.
- Provide any feedback or comments.
- Approve the Board Assurance Framework document.

Report of:
Natalie Yeowart, Head of Corporate Risk and Assurance
22 January 2025

Agenda item A12

BOARD ASSURANCE FRAMEWORK 2024/2025 – JANUARY 2025

The Newcastle upon Tyne Hospitals NHS Foundation Trust

The 2024/2025 BAF

The 2024/25 BAF has been re-designed to ensure it can effectively capture all the relevant information to allow effective discussion and assurance to be received by each committee and Trust Board. This approach informs the agenda and regular management information received by the relevant committees, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be provided to the Trust Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, that forms the basis of the Trust's risk framework (with corresponding corporate and operational risks defined at a Trust-wide and service level if available).
- Risk ratings – initial, current and target levels.
- Clear identification of primary strategic threats and opportunities that are considered likely to increase or reduce the Principal Risk, within which they are expected to materialise.
- A statement of risk appetite for each risk to be defined by the Lead Committee on behalf of the Board (**Avoid** = Avoidance of risk; **Cautious**= ALARP (as little as reasonably possible)preference for ultra-safe delivery options; **Open** = willing to consider all potential delivery options where there is acceptable level of reward **Seek** = prepared to accept a higher level of risk in pursuit of higher business rewards despite greater inherent risk and confident to set high levels of risk due to controls, forward scanning and robust responsive systems).
- Documented controls we already have in place to reduce the likelihood of the threat.
- Sources of assurance incorporate the three lines of defence: (1) **Management** (those responsible for the area reported on); (2) **Risk and compliance functions** (internal but independent of the area reported on); and (3) **Independent assurance** (Internal audit and other external assurance providers) to demonstrate the assurance and confidence of the control in place.
- Key actions identified for each threat; each assigned a timescale for completion. These will be individually rated by the lead committee noting the level of assurance they can take that the actions will be effective in treating the risk (see below for key)
- Clearly identified gaps in the primary control framework, with details of planned responses.

Committee assurance ratings:

Green (significant) = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity
- no gaps in assurance or control AND current exposure risk rating = target
OR - gaps in control and assurance are being addressed
Amber (moderate) = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy
Red (limited) = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity.

Progress Indicators:

One progress indicator should be added in the assurance rating/progress indicator box for each threat to demonstrate progress.

1. **Fully on plan across all actions.**
2. **Actions defined- most progressing, where delays are occurring interventions are being taken.**
3. **Actions defined – work started but behind plan.**
4. **Actions defined -but largely behind plan.**
5. **Actions not yet fully defined.**

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.	**Strategic objective**	1. Quality of Care will be our main priority. We will improve our approach to safety, incident reporting, listening, and learning.

Lead Committee	Quality Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Nursing/Joint Medical Director	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Quality Safety
Date Added	01.05.2024	**Likelihood**	**4**	**3**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	10.01.2025	**Risk Score**	**20**	**15**	**5**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)	Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)	Actions and Timescales (Further actions required to manage risk)	Assurance rating and Progress Indicator
Failure to successfully develop and nurture a positive safety culture: including the promotion of incident reporting and learning; creating a psychologically safe environment and listening to staff and patients. (Linked to 2024/25 Quality Priority 1)	• The Patient Safety Incident Response. Framework (PSIRF) went live in January 2024. • Central supportive infrastructure for implementation and embedding of PSIRF • The Quality Governance Framework underpinned by Quality Oversight Groups (QOG's) in each Clinical Board. • Rapid review meetings. • Policies and Procedures. • Patient Safety Incident Forum. • Incident reporting system. • Clinical Risk Group. • Rapid Quality and Safety Peer Reviews.	• Rapid Review Meeting/Patient Safety Incident forum minutes and actions plans. • Monitoring of compliance with PSIRF timeframes for learning responses. Power BI dashboards shared at Clinical Board QOG's and Quality and Performance Reviews. • Regular PSIRF implementation reports to Patient Safety Group. • Integrated Quality Report to Quality Committee. • Oversight through Clinical Board Quality. Oversight Group, reported into performance reviews and the Executive Team. • CQC Delivery Group and CQC Assurance Group oversight. • Staff Survey – demonstrates increased response rate of 65%. • Clinical Risk Group reports and sharing of learning, national patient safety alerts etc. • Rapid Quality and Safety Peer Review Paper to Quality Committee December – demonstrates 93% trust compliance with assessment framework.	• Develop and embed a positive reporting and safety Culture evidenced by pulse survey and staff survey and monitoring of reporting–March 2025. • Delivery of CQC action plan – timescales dependant on action. • Development of Duty of Candour action plan to ensure compliance against Duty of Candour standards– Paper to Quality Committee Meeting January 2025. • Development of 25/26 Quality Priorities – April 2025. • Development of Trust-Wide Patient Safety Strategy – July 2025.	**2- Actions defined – most progressing, where delays are occurring interventions are being taken.**

Cont./….

Failure to safeguard and provide high quality personalised care for patients in mental health needs, those who lack capacity or those with a learning disability and/or autistic people. (Linked to 2024/25 Quality Priority 3)	• Mental Capacity Oversight Group. • Mental Health Committee. • PLT meetings with core services. • Restraint Review Group. • MCA Quarterly audit framework. • Health and Safety Committee. • Patient Experience and Engagement Group. • MCA training programmes/compliance. • Learning Disability Steering Group. • LeDeR review group. • Environment review completed on two areas of concerns highlighted in Trust CQC report. • Learning Disabilities and MCA oversight by Safeguarding Committee/Quality Committee/Trust Board. • Mental Health Awareness Training (specific packages for high-risk staff groups e.g. Security staff) • Core quarterly mental health assessment metrics agreed. • Self-Harm Risk Assessment Programme	• Quarterly MCA audit data demonstrating improved compliance with MCA. – Q2 data - 97% of patients requiring MCA had documented evidence (92% in Q1) • Increase in DOL's referrals represented of expected volume. • Compliance with mandatory training (96% Jan 25) and bite size training (Learning Disabilities, MCA and MH) • MHA provider review recommendations, action plan and evidence of completion. • Learning Disabilities and MCA reporting and minutes to Safeguarding Committee/Quality Committee and Trust Board. • Compliance with Mental Health Awareness Training. • Quarterly mental health assessment audit framework. • Self-Harm Risk Assessment Programme complete, Initial remediation work to commence in January.	• Level 2 MCA training programme launched and mandated for all relevant staff – ensure compliance of 90% by June 2025. • Agree long term training framework for Learning Disabilities and Autism, ICB and national position still awaited – expected in Q4. • Monitoring and delivery of Self Harm Programme of Estates works – April 2025. • Strengthen assurance framework for the documentation of reasonable adjustment and use of NHS passports – April 2025. • Develop draft of Learning disability and autism 1 year strategy – April 2025.	
Failure to achieve best practice standards e.g. NICE/GIRFT/recommendations from National Clinical Audit Capacity constraints within Clinical Boards quality oversight infrastructure impacting on the ability to undertake baseline assessments against best practice standards.	• Clinical Audit and Guidelines Group. • Clinical Outcomes and Effectiveness Group. • GIRFT oversight group. • Clinical Effectiveness metrics. • New Interventional Procedures Group. Review • Stocktake of progress with Clinical Board Quality Oversight Groups completed. • Stocktake of progress with clinical board QoGs. • Review of QoG activity presented to Quality Committee in October 2024.	• Clinical Audit and Guidelines Group minutes and Action plans. • Clinical Outcomes and Effectiveness Group (COEG)minutes and action plans. • Reports to Quality Committee. • Annual Clinical Audit Report to ARAC. • GIRFT Oversight Group reports and minutes. • Minutes and reports of New Interventional Procedures including Robotic Surgical Group- reports to COEG. • Quality Oversight Group dashboards. • Initial stocktake of QOG activity completed in May 2024-shared with CB's.	• Design and implement a standardised quarterly quality reporting mechanism/dashboard including communications and guidance for clinical boards to report into QPRs. This will include compliance with all metrics e.g. GIRFT/NICE via Inphase risk management system – July 2025 • Baseline review of Trust non-compliance with standards/guidelines, propose organisational approach to Quality Committee – April 2025. • Evaluate the implementation of revised integrated governance structure – Clinical Board Governance Internal Audit starting in November – audit report expected by March 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Gaps in assurance regarding compliance with policy and best practice relating to medication safety, storage, and security. This could directly impact care quality and safety	• Medication Safety Task and Finish Group providing oversight of key improvement actions. • Monthly audit framework measuring. compliance with policy to inform areas for improvement. • Internal peer review process. • Existing medication governance and oversight structures. • Medicine Management Policies and procedures.	• Monthly audit data of ward and department compliance with core standards with dissemination of learning and action. • Policy audits undertaken and reported through medicines management committee. • Datix data and trends relating to medicines management reported and reviewed. • Peer review and external review reports and audit data.	• Actions as outlined in MMOG Action Plan. • Spot Check audit framework – review of 6 months data – April 2024.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

	• Commissioned and completed expert external review to inform improvement work streams. • CQC Delivery Group. • Completed review of Medicines Reconciliation function across the Trust to identify urgent areas for improvement to attain to national best practice. • Revised medicines management action plan. • Established Medicines Management Oversight Group to ensure delivery of improvements • Increased nursing infrastructure to support medicines safety.	• CQC Delivery Group monitoring, reporting and minutes. • Compliance and Assurance Group reporting and minutes. • Quality Governance Structure via quality committee and Trust Board. • September Rapid Quality and Safety Review Audit Data.		
Failure to improve the safety and quality of patient and staff experience in Maternity Services., (Linked to 2024/25 Quality Priority 4a)	• CQC, Ockenden and Maternity Three-Year action plan in place. These are reported into Quality Committee and Trust Board. • Robust Maternity Governance Team in place • Midwifery Staffing and Clinical Outcomes group • Board Maternity Safety Champions • Incident Review Group • Family Health QOG • SOF quarterly meetings with ICB as part of Perinatal Mortality Surveillance monitoring • Monthly Maternity Staff meetings • Maternity Voices Partnership • LMNS (Local Maternity and Neonatal System) oversight of Perinatal Quality Surveillance metrics and Maternity Incentive Scheme. • Director of Midwifery appointed and in post. Real time patient/staff experience programme. • Workforce review including outputs of 2024 birthrate plus. • Refreshed perinatal governance structure aligned to themes of Three-Year Plan for Maternity and Neonatal care, reporting into Obstetric Board. • NENC Clinical Outcomes Dashboard and safety signal review process. • Review and refresh of Perinatal Quality Surveillance Metrics.	• Improvement action plan in place covering all core CQC must and should do. Signed off by ICB with monitoring and evidence reported exit criteria. – all actions, all on track to complete within timescale. • Staff wellbeing/Recruitment and Retention Improvement plan in place. KPI monitored and reported in Family Health Board and Executive Director of Nursing. • Obstetrics Board. • Reporting and oversight into Quality Committee and Trust Board • Maternity Services Quality Dashboard and NENC Clinical Outcomes Dashboard. • Annual CQC Maternity Survey results – improvement in some domains, no reduction in results, improved position in NENC ranking. • CNST/MIS compliance. • Incident data • Incident review group reporting and actions. • Family Health meeting minutes and QOG minutes. • Staff experience programme includes one post-natal maternity ward. • Workforce review outputs and report. • Peri-natal quality surveillance metrics monitored and reported to Quality Committee.	• Completion of service wide staffing review and enact the recommendations by – Paper to Quality Committee February 2025. • Maternity Services phase 2 investment plan – October 2025 • Update Allocate templates to evidence correct fill rate, skill mix and safe staffing against planned – April 2025.	**1. Fully on plan across all actions.**
Failure to embed the learning from external service reviews including Cardiothoracic Services and Ophthalmology	• Cardiac Oversight Group • Cardiothoracic Improvement plan, including improvement actions from CQC and other external reviews. • NUTH Quality Improvement Group • Quality and Performance Reviews • Review infrastructure of quality oversight and local governance groups.	• Executive Oversight Cardiothoracic Compliance and Assurance Group reporting and minutes. • Reports to Trust Board and Quality Committee • Maintenance of central external review log • Central oversight of implementation of recommendations and monitoring of action plan completion via Quality and Performance Reviews • Compliance and Assurance Group Reports and Minutes.	• Design and implement a standardised quarterly quality and safety reporting mechanism for clinical boards to report into QPRs to be developed as part of the Inphase Risk Management System Role out – July 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

Failure to achieve and embed improvements in relation to PSIRF priorities: • Lost to follow up from internal referrals. • Omissions and errors in thromboprophylaxis leading to VTE. • Acting on abnormal results from radiology.	• Endorsing documents on EPR QI project • Closed loop investigations QI project • VTE prophylaxis review. • Patient Safety Group, Clinical Board and corporate service engagement. Monitoring and oversight of PSIRF Priorities.	• Change management process - EPR. • Improvement Project report to PSG quarterly and sharing of updates via Clinical Risk Group and Clinical Policy Group. • Policy improvements and changes resulting from PSIRF priority work shared via CPG. • Quality Committee oversight of PSIRF priority topics • Monitoring of specific incident themes and trends via PSIRF processes • Patient Safety Group Report and Minutes. • Monitoring and oversight of PSIRF priorities at Quality Committee. – Lost to follow up incidents low, SPC charting demonstrates statistically meaningful trend.	• Review and development of PSIRF Priorities for 25/26.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Failure to deliver care optimisation improvements impacting on quality and safety.	• IT Town Hall, engagement sessions and Staff Roadshows. • Trust-wide adoption coaches appointed. • Digital Health Team Care optimisation project. • Digital leaders' group. • Care optimisation group. • Care Planning Task and Finish Group. • Review of core care plans. Standardisation of nursing documentation • Care planning training. • Nursing documentation audit framework.	• Presentations slides, staff roadshow sides and feedback from staff. • Supplier assessment based on site visit. • Power BI report of all discharge summaries in all areas in real time. • E-record reminders to clinicians of encounters that require discharge summary. • Care Planning Task and Finish Group Action Plan. • Review of core care plans – 6 core care plans released in to live system – increased usage of care plans since launch 40,265 used as at December 2024. • Standardisation of nursing documentation – end of shift inpatient, critical care and paediatrics introduced into live system. • Care planning training now available within the EPR – delivered to 1149 registered nurses as at December 2024. Nursing documentation audit framework – document standards now in place, aligned to trust guidelines.	• Completion of Care Planning Project – April 2026. End of shift evaluation revision due for roll out October 24 with evaluation at 6 months (April 2025) • Patient correspondence/letters audit to validate Clinical Board processes to maintain oversight of timeliness of completion of correspondence – discrepancies identified between process and system reporting audit extended to look back to August 24 – February 2025 • Secondary review of all systems functionality in relation to patient correspondence/letters -End of January 2025 • EPR induction training – review of post roll out training feedback to identify any areas for improvement – March 2025. • Review of compliance with nursing documentation standards using nursing documentation framework – April 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

Failure to embed effective systems and processes aimed at preventing avoidable Hospital Acquired Infections	• IPC Board Assurance Framework • Operational Group. • Integrated Quality and Performance Report. • IPC Committee and subgroups. • Clinical Board Governance Meetings and Quality Oversight Group. • Local and National Benchmarking. • IPC policies. • Clinical Board Improvement plans. • Clinical Assurance Toolkit Audits.	• IPC Board Assurance Framework document. • IPC Operational Group and Committee minutes and action logs • Integrated Quality Performance Report with overview ICP and HCAI metrics reporting to Quality Committee. • IPCC minutes and reports. • Reporting and oversight into Quality Committee and Trust Board • Local, regional and national benchmarking data • Clinical Board QOG and Governance meeting minutes and action logs • Clinical Assurance Toolkit results • Rapid Quality and Safety Peer review results and action plans demonstrates 93% trust compliance with assessment framework. • Screening compliance. • Quality and Performance review minutes and action log • Clinical Board improvement plans in place in areas of high occurrence of CDI.	• Continue the rollout of ICNET to improve surveillance and timely intervention - June 2025 • Review and revise central IPC Team roles and responsibilities to maximise visibility and engagement - by March 2025 • Review and refresh Antimicrobial Stewardship Framework January 2025 – In draft, awaiting final approval	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

Risk ID	1.1

Comments:

Agenda item A12

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to implement effective governance systems and processes across the Trust to assess, monitor and drive improvements in quality and safety.	**Strategic objective**	1. Quality of care will be our main priority. We will improve our approach to safety, incident reporting, listening, and learning.

Lead Committee	Audit, Risk and Assurance Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Performance and Governance	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	Compliance and Regulatory
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	10.01.2025	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating and Progress Indicator**
Failure to implement effective integrated governance focused on clinical quality, risk, finance, and performance. Ward to Board.	• Revised corporate governance structure and reporting arrangements in place. Clinical Board Governance arrangements established including QOGs/QPRs/directorates. • Audit, Risk and Assurance Committee established. • CQC delivery group established. • Risk Registers. • Risk Validation Group • Recovery Oversight Group • Cardiac Oversight Group • Clinical Assurance Group • Review of QoG activity presented to Quality Committee in October 2024.	• Terms of Reference – committees of Board. • Minutes of committee meetings. • Committee schedule of business. • Corporate Organograms. • Minutes of QOG/QPR and directorate governance meetings. • Effective governance system report to Trust Board. • CQC delivery group minutes and action plans. • Quality Performance Reviews and summary to Board and relevant committees. • External Tabletop Governance Report. • External leadership and governance review. • Feedback at IQIG	• Evaluate the implementation of revised integrated governance structure – Clinical Board Governance Internal Audit starting in November – audit report expected by March 2025. • Development of Phase 2 CQC action plan – January 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Failure to embed escalation processes and ensure executive oversight.	• Performance and accountability framework. • Standardised reporting and governance. • Clinical Board development plan in place. • Quality performance review process. • Executive Leads for clinical boards. • Reporting hub dashboards. • Quality Oversight Group Evaluation. • Risk Management Dashboard.	• Performance and accountability framework document. • Clinical board reporting and minutes. • Performance review reports and minutes. • Clinical Board Chairs update to Executive Team. • Quality Committee Quality Oversight Evaluation Report, June 2024. • QPRs report to Trust Board. • The value circle report on QPR process • The value circle report on effective governance	• Review issue escalation through new governance route to Exec, through Internal audit of BAF, Risk Management and Clinical Board Governance in November – report expected March 2025.	**1-Fully on plan across all actions.**

Failure to implement effective systems to identify incidents including severity of harm.	• Incident Dashboards created. • Review and closure of legacy serious incidents. • Review and improvements to Datix System. • Patient Safety Briefing. • PSIRF implementation in Clinical Boards. • Completed incident review of areas of under reporting. • Completed Review effectiveness of PSIRF implementation. • Completed review effectiveness of current rapid learning from serious incidents. • Review and implementation of incident escalation process.	• Monthly dashboards to clinical boards. • All legacy SIs completed and closed. • Datix User Survey. • PSIRF update to Quality Committee. • Data available to provide continued monitoring. • PSIRF implementation and assurance report June 2024, 90% of investigations closed within appropriate timeframe. • Incidents/Rapid review outcomes reported to Executive Team weekly. • Quality Committee Monthly Report. • CQC Delivery Group • Harm free care dashboards • Incident Communications Plan developed.	• Embed incident reporting communication plan – June 2025. • Report and ensure compliance against Duty of Candour – report to Quality Committee January 25.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Failure to implement effective risk management including clear escalation and accountability.	• New risk management policy. • Refresh of risk management governance and reporting. • Quality and Safety leads appointed. • Risk Validation Group established. • Audit, Risk and Assurance Group established. • Risk management dashboard. • Executive Team lead assigned to CBs. • Refresh of risk management training. • Engagement with clinical boards. • Implementation of risk decision tool -risk vs issue. • Risk Management SOP. • Refreshed Board Assurance Framework. Implementation/engagement risk refresher sessions provided to risk system users.	• Risk Management Policy document and associated guidance. • Reporting, accountability, and escalation structure. • Terms of reference and minutes for the risk validation group • Historical risk trajectory. • Risk management dashboard. • Reporting to CQC Delivery Group weekly. • Risk management training TNA. • Clinical board risk presentation. • Embedded into clinical board governance arrangements – qog minutes and reporting. • Audit, Risk and Assurance ToR, minutes, and Reports. • Clinical Risk reporting to Quality Committee. • Quality Performance Reviews and summary report to Board	• Implement further strategies to support ward/departmental level risk identification and documentation – Work now underway to roll out Inphase risk management system to include ward and department levels – Go live planned for April-June 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

Risk ID	1.2
Comments:	

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to manage our finances effectively to improve our underlying deficit and deliver long term financial sustainability.	**Strategic objective**	6. We will take our responsibilities as a public service seriously looking after patients and each other; managing our money, our performance, and our relationships with partners.

Lead Committee	Finance	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Chief Finance Officer	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Finance/VfM
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	20.01.2025	**Risk Score**	**25**	**20**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating and Progress Indicator**
Failure to achieve levels of activity required to support ERF expectations in Financial Recovery Plan.	• Activity targets produced for each speciality. • Funding has been delegated at the start of the year for specific areas where identified this is necessary for impact. • DOPs and Clinical Board Chairs accountability for delivery of activity targets. • Monthly reporting reinstated.	• Activity reporting via monthly performance reviews and corrective action agreed where possible. • Monthly reporting of targets, activity and financial impact to Finance and Performance Committee and Trust Board including obstacles and corrective action highlighted through trend analysis. • National reporting back to Trust of validated activity levels (quarterly) – assurance provided around validity of internal reporting • Internal and external audit of income levels • Finance Dashboard.	Review of clinical information within the EPR to improve clinical coding and ensure availability of information to increase completeness of coding – Outpatient improvement underway, completed by April 2025. Scoping exercise to follow to identify inpatient areas for improvement – June 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Insufficient capability / bandwidth and reduction in financial grip and control.	• Standardised governance framework in place. • Financial governance framework in place, • DFM meetings with DOPs. • Monthly performance reviews. • Capital Management Group. • Procurement Cttee controls. • CIP plan. • Budget setting principles and budgets in place • Day to day budget management processes in place. • Finance business partners for each CB.	• Budgetary oversight at DOP level • Monthly revenue report at CB and corporate service level. • Deviations from SFIs reported to SSPG committee including action taken. • Regular reporting of compliance through Internal Audit and monitoring of recommendations – Report to ARAC quarterly on Internal audit progress. • HFMA audit of control reported through to ARAC • Reporting framework to ICB / cost control framework implemented.	• ICB Grip and Control Audit Action Plan -31st March 2025. Report to Audit, Risk and Assurance Committee January 2025. • Strategy to improve financial awareness throughout Trust - discussion with Head of Comms, first financial specific comms issued throughout the organisation – March 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

	• Purchasing via procurement framework. • Enhancements to financial reporting. • DOPs reinforcing financial grip and control. through engagement with teams. • TMG engagement re Internal Reports and actions. • HFMA self-assessment report. • Annual Internal and External Audit complete • ICB Grip and Control investigation and intervention complete	• NHSE/I monthly finance monitoring • Going concern and financial controls audit. • Mazars external audit – satisfactory assurance, no issues re going concern. • Head of Internal Audit Opinion – reasonable assurance.		
Failure to deliver the required level of efficiency savings required in the Financial Recovery	• Agreed financial plan with ICB. • Financial Recovery Programme set with targets for trust wide schemes, CB and CS targets, commercial schemes and possible technical benefits all identified. • CIP programme risk assessed. • Deep dives with CFO/ DCFO/MD Month 1. • Commercial and Innovation board established. • Finance and Performance Cttee now moved to monthly. • Opportunities through Alliance conversations. • Risk assessments completed to set for 'course correction' if targets not being met. • Quarterly Performance Review. (QPR)	• Review and agreement of Financial Recovery Plans as part of annual financial planning process. • Monitoring and challenge of delivery of plans by FRSG, fortnightly. • Performance Review meetings co-ordinated by MD. • Revenue reporting and FRP reporting to Finance and Performance Cttee • Integrated Performance Report (IPR, refreshed) to Governors and Public Board of Directors • Annual external audit of Accounts and Value for Money report • Peer review and ICB focus as part of financial planning. • Work schedule for Finance and Performance Cttee refreshed to include DOPs attendance periodically and deep dive into financial recovery plans. • Escalation plans for course correction following FRSG, QPR and Finance and Performance Committee. • QPR finance focus, QPR data pack. • Deficiencies in recurrent achievement of plans supporting by the identification of non-recurrent solutions to enable financial balance.	• Repeat deep dives where necessary – Monthly deep dives agreed in cardiothoracic and medicine – ongoing - All schemes reviewed in October 24, plan for mitigation agreed but mainly through non recurrent measures – March 2025. • Continue to identify non recurrent measures to ensure the Trust achieves financial balance – March 2025. • Early planning of 25/26 financial recovery, plan to be finalised by February 2025.	**2- actions defined – most progressing, where delays are occurring interventions are being taken.**
Lack of longer-term planning framework and certainty of funding / reliance on non-recurrent income sources	• Attendance and contribution at ICB level DOFs meetings. • Proactive engagement with Shelford colleagues / influencing of national decision making. • Reduction of costs where n/rec funding an issue achievement of recurrent cost savings. • Contracting team and regular meetings with commissioners alongside finance colleagues • Business case process. • Financial Recovery Steering Group. • Long Term Plan.	• Reporting to FRSG. • Revenue reporting to Finance and Performance Committee. • Financial Recovery Steering Group minutes and papers. • Iteration of Long Term Plan reported to Finance and Performance Committee December 2024.	• Production of longer-term financial plan, initial draft completed and presented to finance committee in August 24. To be further refined in subsequent months, informed by outturn position and national guidance/assumptions – ongoing. • Await national planning guidance following budget – March 2025.	**1-Fully on plan across all actions.**

Further unplanned for emerging cost pressures such as inflation, pay awards.	• Horizon scanning • Proactive engagement with suppliers • Supply and procurement committee. • Financial governance framework • ICB DOFs meeting. • Shelford networking / understanding the environment. • Use of frameworks. • Opportunities through Alliance working. • Engagement with MTPF workstreams (ICS). • Annual Internal and External Audit complete.	• CB and CS finance reporting • Budget sign off • ICS updates through Finance report and CEO report to Committees and Board • Finance report to Board, Finance and Performance Committee identifies any unplanned pressures and actions. • Procurement report to Finance and Performance Committee identifies any cost pressures emerging through procurement activity. • Regional finance returns monthly. • Mazars external audit – satisfactory assurance, no issues re going concern. • Head of Internal Audit Opinion – reasonable assurance.	• Proactive engagement with ICB on increasing pressure relating to block drugs – initial meetings arranged. - ICB meeting held, further discussion at QIG, ICB have raised issue with national team March 2025. • ICB wide review of impact of pay ward, information/rationale provided, awaiting feedback from ICB on approach from National Team – February 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Insufficient capital funding required to invest in improvements to transform services and improve efficiency.	• Capital Management Group. • Capital Infrastructure Group. • Annual capital plan including estates, medical equipment, IT and health and safety plus IFRS16. • ICS Infrastructure Board. • Cash forecast. • Capital Plan.	• PLACE AND ERIC returns. • CMG report into Finance and Performance Committee • Capital management audit by internal audit – Level of control needed. • ICS Infrastructure plan • Review of capital plan to identifying any emerging pressures impacting CDEL balance through slippage, action plan now in place.	• Engagement with potential solutions to CDEL – March 2025, meeting held with PWC re PPP and other potential lenders. • CDEL Action Plan in place to hit year-end target – March 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Under delivery of commercial income and growth to support financial recovery.	• Commercial Strategy • Commercial Delivery and Innovation Group • Commercial delivery Operational Group • Dedicated Commercial team established. • Commercial Update report. • Data Partnership model. • Data Partnership Group. • Sales force implementation. • Commercial schemes identified by Clinical Boards and Corporate Directorates. • Commercial Dashboards. • Financial Recovery Steering Group.	• Strategy document and updates reported to Finance and Performance Committee. • Commercial update report to F&P. • Data Partnership Proposal accepted by F&P. under engagement with other committees and groups currently. • Data partnership group reporting to commercial delivery and innovation group. • Tracking commercial pipeline. • Commercial schemes reporting alongside financial recovery plans. • Commercial dashboard data suggests marginal growth, further actions required as per action plan. • Commercial reporting into FRS, minutes and actions.	• Strengthen commercial contracts and templates – March 2025. • Strengthen governance relating to IP protection and data access – February 2025. • Strengthen our job descriptions for senior staff to include data access alongside Intellectual Property - March 2026. • Mandate clinical board and commercial team oversight into the sign off of ‘co development’ contract with external parties where commercial opportunities are available – July 2025. • Develop commercial principles for external contracts for full scale adoption in order to maximise potential returns. Phase 1 focus NJRO – July 2025. • Ensure there is accountability at a clinical board level for commercial income generation – via planning process – April 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

			• Improve and strengthen governance for commercial income delivery – April 2025.	

Risk ID	6.1
Comments:	

Agenda item A12

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care.	**Strategic objective**	6. We will take our responsibilities as a public service seriously looking after patients and each other; managing our money, our performance, and our relationships with partners.

Lead Committee	Finance and Performance Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Performance and Governance	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	Compliance/Regulatory
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	10.01.2025	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating and Progress Indicator**
Failure to manage capacity and demand.	• PMO supported programme of demand and capacity planning across all surgical specialities. • Weekly Stand-up highlighting areas of focus. • Daily Site meetings and Site Handover. • Weekly speciality /tumour group PTL meetings for long waits and cancer. • Fortnightly performance meetings with operational leads for long waits and cancer. • Local A&E Delivery Board, supporting the management of non-elective patients across the system. • Weekly attendance at Provider Collaborative Mutual Support Co-ordination group facilitating patient transfers and collaboration amongst local providers to level demand, make use of system capacity. • Theatre reprofiling exercise. • 65-week cohort reduction trajectories with specialities completed. • Integrated Quality and Performance Report. • Validation of the non-RTT cohort of long waits. • Implementation of new ED rota.	• Accountability Framework. • Activity and Income reports. • Integrated Quality and Performance Board Report. • Monthly Integrated Quality Performance Reviews. • Theatre Demand and Capacity data. • CEO permutations to TMG including national performance comparisons • Theatre capacity and demand data for reprofiling. • Performance Improvement Plans monitored via Finance and Performance Committee. • Further development of the Integrated Quality and Performance Board Report – reported into Committees and Trust Board. • Validation of non-RTT cohort for long wait – all patients validated. • Implementation of new ED rota, report to Finance and Performance Committee - demonstrating improved safety.	• Develop Clinical Board Level reports – challenges identified in completing - April 2025. • Review current information and performance reports to ensure they are fit for purpose – • To improve waiting list booking process through a standardised SOP, training and implementation by July 25. • Outpatient capacity and demand analysis to be completed by the end of Q4 24/25. • Implement and evaluate new Emergency • Develop Service Review methodology and reviews, to start in April 25. • Review and monitor targeted cancer improvement plans. – 2 tumour groups via F&P. March 2025. • Cancer performance improvement plans – April 2025. **Cont/…**	**2 – Action defined- most progressing, where delays are occurring interventions are being taken.**

Utilising available resource effectively – workforce, estate, and equipment.	• Activity plans developed with Clinical Boards as part of the annual planning process. • Capital planning process through Capital Management Group. • Allocation of growth funding from commissioners to under pressure services, where available. • Revised annual planning process to incorporate approval of business cases for the coming financial year and utilisation. • Operational reports establishing weekly activity and value performance reports. • Diagnostic, Surgical and Outpatient Improvement Groups in place, with organisation wide scope to deliver improvements in effectiveness. • Short term radiology MRI resource plan.	• Integrated Quality and Performance Board Report. • Monthly Integrated Quality Performance Reviews. • TMG Updates. • Clinical Board meeting minutes. • Weekly Activity and ERF (income) reports.	• Develop a new workforce model for Cardiac Physiology –January 2025 • Maximise utilisation of CDC – February 2025. • Improve theatre utilisation to greater than 85% by the end of March 2025. • Develop sustainable workforce plans across histopathology specialisms by March 25.	**2 – Action defined- most progressing, where delays are occurring interventions are being taken.**
Failure to transform and change service models at pace.	• Clinical Board Improvement Plans. • Winter Plan. • Bespoke programmes of support to critical / fragile services. • Clinical Board Structure in place from April 2023 • Director team buddy system to support Clinical Board leadership teams. • Alliance working groups. • GIRFT engagement and sharing of alternatives models, tools, and support. • Outpatient Improvement Group. • Surgical Improvement Group. • Establishment or relaunch of the clinical lead Trust wide Improvement Groups. • Diagnostic Improvement Groups. • Surgical Improvement Group. • Urgent and Emergency Care Improvement Group. • Monthly meetings in place with primary care. • Winter planning.	• TMG Oversight. • Executive Team Oversight. • Quality Performance Reviews. • Monthly IPR to committees and Board. • Clinical Board meeting minutes. • Outpatient Improvement Group actions. • Surgical Improvement Group actions. • Diagnostic Improvement Group actions. • UEC Improvement Group actions. • Cancer Board actions. • Improvement and project management resource reprioritised to spot priority actions/service changes. • Winter Plan in place.	• Develop and implement co-located UTC – December 25. • Develop and implement extended SDEC capacity – March 25. • Establish effective Frailty model by March 25.	**2 - Action defined- most progressing, where delays are occurring interventions are being taken.**
Clinical service failure at neighbouring Trusts impacting on NUTH performance.	• Clinical Strategy work across the Alliance including a focus on vulnerable services. • Attendance at the Provider Collaborative Mutual Support Coordination Group and Alliance groups.	• Regular updates to TMG. • CEO attendance at Great North Care Alliance Steering Group and Minutes.	• Development and monitoring of Alliance plans for designated services – MD, CN and Ops leads identified – Initial tranche of projects agreed progressed/monitoring via the Bilateral Board –April 2025.	**1-Fully on plan across all actions.**

Risk ID	6.2
Comments:	

Agenda item A12

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to deliver digital systems, processes, and infrastructure to support the provision of safe effective patient care and our digital aspirations for the future.	**Strategic objective**	4. Our technology needs to improve so that it supports our work and patient care and does not hinder it.

Lead Committee	Digital and Data Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Chief Information Officer	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	Digital
Date Added	01.05.2024	**Likelihood**	**4**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	14..01.2025	**Risk Score**	**16**	**12**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating and Progress Indicator**
Lack of standardisation in clinical pathways, lack of capacity and capability resulting in failure to maximise our investment in E-record and digital systems.	• IT Town Hall, engagement sessions and Staff Roadshows. • Trust-wide adoption coaches appointed. • Digital Health Team Care optimisation project. • Digital leaders' group. • Care optimisation group. • Care Planning Task and Finish Group. • Review of core care plans. Standardisation of nursing documentation • Care planning training. • Nursing documentation audit framework.	• Presentations slides, staff roadshow sides and feedback from staff. • Supplier assessment based on site visit. • Power BI report of all discharge summaries in all areas in real time. • E-record reminders to clinicians of encounters that require discharge summary. • Care Planning Task and Finish Group Action Plan. • Review of core care plans – 6 core care plans released in to live system – increased usage of care plans since launch 40,265 used as at December 2024. • Standardisation of nursing documentation – end of shift inpatient, critical care and paediatrics introduced into live system. • Care planning training now available within the EPR – delivered to 1149 registered nurses as at December 2024. Nursing documentation audit framework – document standards now in place, aligned to trust guidelines.	• Implement Oracle/Cerner Remote Hosting project – February 25. • Upgrade current EPR version – September 2025 25. • Analysis of EPR Survey response rate and results -March 2025. • Completion of Care Planning Project – April 2026. End of shift evaluation revision due for roll out October 24 with evaluation at 6 months (April 2025) • Secondary review of all systems functionality in relation to patient correspondence/letters -End of January 2025 • EPR induction training – review of post roll out training feedback to identify any areas for improvement – March 2025.	**2 - Action defined- most progressing, where delays are occurring interventions are being taken.**

Failure to protect and prevent against cyber-attack.	• Cyber Security Team Established. • Regular external penetration audit testing. • Compliance with Cyber Essentials accreditation. • Multi Factor Authentication in place. • Upgraded Firewall. • Patch testing compliance. • Reports to Digital and Data Committee. • DSPT 2023/24	• IT Security and Service Management Report to Digital and Data Committee. • Cyber Essentials Accreditation certificate. • Digital and Data Committee Minutes. • DSPT 2023/24 – substantial assurance.	• Review of current Cyber Security Policies– December 2024. • Replace/update outdated systems and software, legacy hardware, and unsupported systems -dependent on funds, opportunity to consolidate at contract end periods – February 2025. • Implement process for the management of the inventory system – December 2024. • Plan to remove all devices over 5 years old – April 25	**1-Fully on plan across all actions. - Exception will be the removal of all devices over 5 yrs old.**
Lack of agreed digital strategy and aligned financial plan for digital investment.	• Prioritising IT capital allocation with support from Finance Department. • Ongoing allocation of capital budget and a replacement plan based on oldest out first. • IT CIP Plan.	• IM&T Senior Leadership Meeting and minutes. • Review and reporting at Digital and Data Committee. • Minutes of Digital and Data Committee.	• Develop 3-year Digital financial Plan – February 2025. • Develop Digital Strategy – April 2025. • Define measurability and track specific investments for Digital – June 2025.	**2 - Action defined- most progressing, where delays are occurring interventions are being taken.**

Risk ID	4.1
Comments:	

Agenda item A12

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to maintain the standard of the Trust Estate, Environment, and Infrastructure could result in a disruption to clinical activities and impact on the quality of care delivered.	**Strategic objective**	5. We want our buildings to be modern, environmentally sustainable, fit for purpose and great places to work and care for our patients.

Lead Committee	Finance and Performance	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Estates	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Compliance and Regulatory
Date Added	01.05.2024	**Likelihood**	**4**	**4**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	06.01.2025	**Risk Score**	**20**	**20**	**5**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating and Progress Indicator**
Insufficient capital funding to effectively manage the lifecycle replacement or upgrade of the Trust Estate, Environment and Critical Infrastructure assets (Backlog Maintenance).	• Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of backlog maintenance programme. • Annual capital investment plan including estates and medical devices. • Estates Strategy. • ICS Infrastructure plan. • Annual condition survey (20%) to determine condition of infrastructure in accordance with NHS Backlog Methodology.	• Estates Risk Management & Governance Group minutes and action logs. • ERIC/Model Health System. • Estates Investment, Planning, Strategy and Capital Investment Group. • CIR plan 2024/25 Capital programme. • Capital Management Group oversight. • CMG report - Finance and Performance Committee. • ICS Infrastructure Board.	• Align results of condition survey on Estates CAFM system -January 25. • Develop a risk-based asset report for Clinical Boards to inform risk-based prioritisation of backlog maintenance programme -January 25. • Develop a detailed 5-year Backlog Maintenance plan to feed into the Estates Strategy -March 25.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Compliance with fire safety regulations & standards - Failure to deliver fire safety systems remediation programmes.	• Risk based fire remediation programme. • Condition monitoring of fire safety assets undertaken annually to enable ongoing re-prioritisation of fire safety remediation programme. • Monthly fire safety remediation programme monitoring reports. • Fire Safety Reports. • Incident reporting system. • Estates Strategy. •	• Trust Fire Safety Group minutes and action logs. • Oversight by Estates Fire Directors Group. • Estates Risk Management & Governance Group minutes and action logs. • Quarterly report to Compliance & Assurance Group. • Reports to Capital Management Group. • Fire Safety report to Trust Board. •	• Investment plan in Fire Safety upgrades -Q2 2025. • Complete phase 2 passive fire remediation works to high-risk clinical areas -Q2 2025. • Tender/award contract for phase 3 of passive fire remediation works -delayed retender now March 2025. • Complete 24/25 upgrade programme of active fire system March 25. • Tender/award contract for 2025/26 upgrade of active fire systems -March 25.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

Failure of ageing critical estates M&E engineering infrastructure (Ventilation, Water, Electrical (HV & LV systems), Decontamination and Medical Gas Pipeline Systems).	• Regular planned preventive maintenance programme (PPM) in place in line with the requirements of SFG20 and Health Technical Memoranda (HTM) guidance. • Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of backlog maintenance programme. • Monthly HTM Compliance Monitoring Reports. • Health & Safety Reports. • Incident reporting system. • Capital Programme. • Estates Strategy. • Trust Policies and Procedures. • Annual condition survey (20%) to determine condition of infrastructure in accordance with NHS Backlog Methodology.	• Estates Operational Management Structures. • Estates Investment, Planning, Strategy and Capital Investment Group. • CIR plan 2024/5 Capital programme. • Oversight via Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety). • Estates Risk Management & Governance Group minutes and action logs. • Quarterly report to Compliance & Assurance Group. • Capital Management Group oversight. • IPCC oversight. • Independent Authorising Engineer annual HTM compliance Audit. • Trust Internal Audit Programme (AuditOne).	• Align results of condition survey on Estates CAFM system -January 25. • Develop a risk-based asset report for Clinical Boards to inform risk-based prioritisation of backlog maintenance programme - January 25. • Develop a detailed 5-year Backlog Maintenance plan to feed into the Estates Strategy -March 2025.	**1-Fully on plan across all actions.**
Insufficient capital funding to effectively manage the lifecycle replacement or upgrade of critical medical devices (Imaging assets, Theatre Equipment etc.).	• Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of capital replacement programme. • Annual capital plan includes medical devices. • 3-year medical device asset replacement.	• Medical Director medical device replacement oversight/prioritisation group. • Estates Investment, Planning, Strategy and Capital Investment Group. • Medical Device replacement plan 2024/5 Capital programme. • Capital Management Group oversight. • CMG report - Finance and Performance Committee. • Medical Device Steering Group. • medical device asset replacement monitored via Capital/Financial planning meetings.	• Develop a risk-based medical device asset report to inform Clinical Boards of lifecycle replacement priorities -Jan 2025.	**1-Fully on plan across all actions.**
Failure of ageing critical medical devices assets (Imaging assets, Theatre Equipment etc.).	• Regular planned preventive maintenance programme (PPM) in place in line with the requirements of MHRA guidance. • Monthly Compliance Monitoring Reports. • Incident reporting system. • Capital Programme. • Trust Policies and Procedures.	• EME Operational Management Structures. • Annual report to Medical Device Steering Group. • Estates Risk Management & Governance Group minutes and action logs.	• Analysis of CAFM medical device data to identify failure trends - March 2025. • Develop a risk-based medical device asset management and compliance report for Clinical Boards -Jan 2025.	• **Fully on plan across all actions.**
Failure to maintain the Quality and Safety of the care environment to meet CQC regulatory standards and deliver Trust priorities and ambitions including environments that are Dementia Friendly and free from Self Harm risks.	• Regular planned preventive maintenance programme (PPM) in place in line with the requirements of SFG20 and Health Technical Memoranda (HTM) guidance. • Health & Safety Audit Reports. • Incident reporting system. • Capital Programme. • Estates Strategy. • Trust Policies and Procedures	• Estates and Facilities Operational Management Structures. • Estates Risk Management & Governance Group minutes and action logs. • Quarterly report to Compliance & Assurance Group. • PLACE Assessments. • NHS Premises Assurance Model (PAM). • IPCC oversight. • CQC Delivery Group. • CQC Standards Assurance Group. • Trust Internal Audit Programme (AuditOne).	• Delivery of Estates & Facilities CQC action plan -timescales TBC. • PLACE Action Plan -March 25. • Review and implement agreed improvements relating to dementia Friendly standards (18–24-month programme). Review at August 2025. • Compliance with Self Harm Risk Assessment recommendations 18–24-month programme. April 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

			• Review and implement agreed improvements relating to Real Time Patient Satisfaction Surveys -ongoing. Q4 2025/2026.	
Lack of decant facility compromises the delivery of planned Estates objectives	• Estates Strategy. • Liaison meetings with Patient Services to minimise impact on clinical activity. • Project Management meetings.	• Senior Operational meetings. • Capital Management Group oversight. • Project Board oversight	• Co-ordinate with Patient Services to minimise impact on patient activity-timing project specific.	**5-Action not yet fully defined.**
Failure to maintain and invest in the PFI estate to keep it in a suitable and quality condition and at a safe level of compliance.	• Monitoring of PFI annual and 5-year lifecycle plan (Lifecycle investment is included within the Project Agreement and Unitary Charge for the PFI Estate). • Monitoring of PFI annual condition surveys. • Regular zonal and ad hoc inspections of PFI areas.	• PFI Monthly Review Meetings. • PFI Liaison Committee. • Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety). • Compliance & Assurance Group. • Trust Internal Audit Programme (AuditOne) • Independent Authorising Engineer annual HTM compliance Audit. • PLACE audits. • Monitor helpdesk reporting	• Continue zonal inspection processes to identify and remedy any slippage in condition. Checks to take place monthly until end of concession in 2043. • Performance of the PFI Centre of Best Practice condition survey process – March 2025.	**3-Action defined-work started but behind plan.**
Failure to effectively manage PFI partners resulting in disruption to clinical service delivery.	• Maintain meeting structures to ensure flow of dialogue. • Communications and correspondence to review matters and highlight and action concerns. • Adherence with contract management requirements outlined within the PFI Project Agreement. • Legal support if required to resolve any disagreements.	• PFI Liaison Committee. • Service Providers meeting. • Performance reports. • Performance report review meetings.	• Regular reviews of performance - takes place monthly. • Adherence to outlined performance parameters.	**3-Action defined-work started but behind plan.**
Failure to manage project delivery within PFI estate will impact the ability to transform services and improve efficiency.	• Follow variation procedure outlined with PFI Project Agreement. • Track works requests and escalate slippage. • Review progress within meeting structures. • Implement alternative routes if required. • Management of works requests.	• Review at monthly Variation meetings. • PFI Liaison Committee. • Track and manage works requests through variation procedure and meeting structure - takes place monthly.	• Implement alternative delivery models if required -further options by March 2025– under pressure to achieve.	**4-Actions defined -but largely behind plan.**
Reduced fire compliance during PFI Programme of fire remedial works.	• Obligations to perform and conclude fire remedial works set out in PFI Project Agreement and Settlement Agreement. • Maintain meetings structures to manage progress with the works.	• Independent certification for each zone when completed. • Ongoing compliance requirements contained within PFI Project Agreement. • PFI Fire Steering Group.	• Regular reviews of requirements and progress with the remedial works -April 2026.	**4-Actions defined -but largely behind plan.**
Non-compliance of elements of the Ventilation and Air Conditioning Systems	• Obligations to perform remedial works set out in PFI Project Agreement. • Legal support if required to resolve any disagreements.	• Compliance requirements contained within PFI Project Agreement. • Performance reports. • Performance report review meetings. • PFI Liaison Committee.	• Seek remedial scope and programme from PFI partners - Dec 24 – Q1 2026. • Manage terms of the PFI Project Agreement to conclude remedial works-remedial works through to Dec 26. • Negotiate settlement agreement with PFI partners committed to	**3-Action defined-work started but behind plan.**

			delivering remedial works to programme -March 2025.	
Non-compliance of elements of the Electrical Systems.	• Obligations to perform remedial works set out in PFI Project Agreement. • Legal support if required to resolve any disagreements.	• Compliance requirements contained within PFI Project Agreement. • Performance reports. • Performance report review meetings. • PFI Liaison Committee.	• Seek remedial scope and programme from PFI partners - March 2025. Manage terms of the PFI Project Agreement to conclude remedial works-remedial works through to Dec 26 – on track. Commence condition survey of electrical installations to fully define issues and required remedial actions -plan for March 2025, however under pressure at present.	**5- Actions not yet fully defined.**

Risk ID	5.1
Comments:	

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to have sufficient capacity and capability in our workforce to deliver safe and effective care.	**Strategic objective**	2. We want this to be a great place to work where everyone feels supported appropriately by the organisation and compassionate leaders. We will always be civil and respectful to each other so that relationships within and across the teams will improve.

Lead Committee	People Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Chief People Officer	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	People
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	29.10.2024	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)	Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)	Actions and Timescales (Further actions required to manage risk)	Assurance rating and Progress Indicator
Ability to attract and retain competent staff resulting in critical workforce gaps in some clinical services.	• Establishment control to identify vacancies. • Vacancy control panel. • Retention data. • Training and development of staff. • Exit interviews. • Appraisals. • Bank and agency teams. • Premium pay as required to cover shortage areas. • Clinical workforce plans. • Staff survey (national and local). • Flexible working. • Vacancy control monitored by CFO and MD.	• Monthly Performance review meetings. • Retention data and exit interviews to people committee. • People metric data via the Integrated Board Report. • Staff survey uptake and results reported to people committee and local areas. • Pay Issues Subgroup in place (exec subgroup) • Vacancy levels monitored through finance committee. • Training data to people committee. • ICB /HRD oversight group.	• People dashboards to be developed for corporate areas – further work to strengthen into clinical boards and corporate areas - November 24. • Plans to develop local oversight arrangements for clinical boards and support services – January 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Failure to develop workforce plans which identify current and future gaps (including new workforce models) to meet service demands.	• Establishment control. • Vacancy control panels. • Clinical board and corporate service establishment controls. • Rota plans. • Job plans for medical staff. • Bank and agency provision to cover rota gaps. • Safe staffing nursing models. • International recruitment. • Apprenticeship schemes in some areas of nursing. • Trainee intake and rotation. • Employment of local employed doctors.	• Monthly performance review groups. • Retention data and exit interviews to people. committee. • People metric data via the Integrated Board Report. • Staff survey uptake and results reported to people committee and local areas. • Vacancy levels monitored through finance. committee. • Training data to people committee. • ICB /HRD oversight group. • University placements. • NHS oversight of agency spend and control. •	• Development of workforce plans within clinical boards to understand gaps and ways in which to address them including apprenticeships and funding streams, international recruitment, university placement uptakes and new courses and Continued recruitment. • Implementation of workforce plan– ongoing monitoring at clinical board level to manage vacancy and staffing levels. - phase 1 develop from October 24, Phase 2 plans from January 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

Risk ID	2.1

Comments:

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to develop, embed and maintain an organisational culture in line with our Trust values and the NHS people promise.	**Strategic objective**	3. We want this to be a great place to work where everyone feels supported appropriately by the organisation and compassionate leaders. We will always be civil and respectful to each other so that relationships within and across the teams will improve.

Lead Committee	People Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Patient and Staff Experience/Chief People Officer	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	

Last Reviewed	29.10.2024	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**	

Threat **(what might cause this to happen)**	**Controls** **(what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance** **(Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales** **(Further actions required to manage risk)**	**Assurance rating and Progress Indicator**
Staff do not feel valued and heard by their managers and leaders and the Trust.	• People Plan with a dedicated theme of Valued and Heard – with year 1 deliverable actions • FTSUG in place with additional capacity from 1st May 24. • Implementation of a large-scale patient and staff experience programme as a cultural intervention • Transparent and timely sharing of all staff and patient feedback. • Opportunity for staff to provide anonymous concerns or feedback via work in confidence. • 100 days review: feedback from 4500 staff with qualitative analysis of staff concerns – feedback to all staff via video within 2 weeks of the survey closure. • Civility and micro-aggression training. • Staff and patient experience data developed. • FTSU policy and 8-point plan. • 3rd CEO Roadshows to commence in September 24 to include “you said we did” campaign to feedback progress to staff.	• People Programme Board (operational group) - minutes and highlight reports. • Reports and minutes of Executive Team. • Minutes from TMG. • People Committee reports and minutes – including updates on Value and Heard Bimonthly. • CQC oversight group. • QIP oversight group. • ICB regional group. • Clinical and Corporate Town Hall events • Focus Groups to hear staff views (with external facilitation. • Annual Staff survey (national). • Quarterly surveys aligned to the People Plan. • Direct access to the CEO. • CEO roadshows. • CQC feedback. • JLNC and EPF.	• FTSU champions to be advertised in October 2024 recruited in November 2024. • FTSU Champions training November and December 2024. • Promotion of behaviours and civilities charter across the Trust including bespoke training to be completed by February 2024. • Annual Staff Survey promotion Oct-November 2024. • Embedding a staff and patient experience improvement programme March 2026. • National FTSU policy to be implemented into the Trust by December 2024. • X2 stakeholder events for speaking up to be run in November 2024	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

Staff groups and areas in the Trust feel bullied and discriminated against.	• People Plan with theme of Civilities and Behaviours and year 1 deliverable actions • Staff network groups with executive sponsors. • Equality, Diversity, and Inclusion Steering Group • Work in confidence system to report concerns. • FTSUG in place to report concerns. • Civilities and micro-aggression training. • Training on the new published Civilities and Behaviours charter. • Quarterly internal staff survey to monitor and measure staff experience broken down by groups. represented by protected characteristics. • Executive Directors EDI objectives. • Sexual Misconduct Policy in place.	• People Programme Board (operational group) - minutes and highlight reports. • EDI dashboard information to clinical board and corporate areas. • Staff survey broken down by staff groups. • Minutes of EDI steering group. • Minutes of People Committee. • WRES/WDES action plans. • NHSI oversight. • WRES and WDES data. • Employee Relations data for People Committee.	• Action plan to improve WRES and WDES performance coproduced with staff networks – November 2024. • Review of Dignity and Respect Policy – with a focus on anti-racism – December 24. • Anti racism policy to be produced – December 24.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Behaviours and incivilities impacting negatively on the quality and safety of patient care, staff morale, retention, and organisational productivity.	• Dignity and Respect policy. • People Plan with theme of Civilities and Behaviours and year 1 deliverable actions • Facilitated conversations and mediation. • Grievance procedure to raise concerns. • WRES/WDES action plans. • Implementation of a behaviour and civility charter setting out standards of expected behaviours.	• EDI, HR and OD teams recorded complaints. • People Programme Board (operational group) - minutes and highlight reports. • Reports and minutes of Executive Team. • Minutes from TMG. • People Committee reports and minutes. • CQC oversight group. • QIP oversight group. • Evaluation from training. • Feedback from focus groups. • Guidelines for staff support- produced during the riots.	• Further embedding of the behavioural and civilities charter through people processes – November/December 2024 • Promotion campaign during September/October 2024 – completed by December.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Staff do not speak up about issues that cause them concern.	• New FTSUG in place from 1st May 2024 with increased capacity to 22.5 hours. • Datix system been reviewed to encourage staff to raise concerns. • Direct access to CEO including website with direct access to CEO, CPO, and Board chair. • Work in confidence system – concerns reported directly to the executive team. • A Speaking up 8-point plan which sets out key objectives for the period October 24 – March 25	• FTSU issues reported to People Programme board and workforce group. • FTSU reports on themes and issues reported to People committee. • Datix reports on themes issues to quality committee. • Work in confidence system reports on themes and issues reported to the People committee. • FTSU action plan presented at TMG on 4 September 2024. • Visibility of senior leaders – visits and walkabout schedule.	• Information sheets to be available for all staff to outline the various ways in which they can speak up safely – November/December 2024. • Implement speaking up 8-point plan programme from October 2024 – March 25. • Self-assessment on FTSU maturity to be undertaken -October 2024, report to Trust Board in January 2025. • Embed patient safety briefings encouraging more speak ups. • Analysis of staff survey feedback tracking psychological safety – trust wide report April 2025. • Anonymised, real time staff feedback piloted in summer 2024.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

Risk ID	2.2
Comments:	

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Failure to effectively develop and implement a new approach to leadership and organisational development to ensure that everyone feels supported appropriately by the organisation.	**Strategic objective**	4. We want this to be a great place to work where everyone feels supported appropriately by the organisation and compassionate leaders. We will always be civil and respectful to each other so that relationships within and across the teams will improve.

Lead Committee	People Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Chief People Officer	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	29.10.2024	**Risk Score**	**20**	**16**	**4**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating and Progress indicator**
Capability and capacity of leaders and managers to support staff.	• People Plan – identified theme of Leadership and Management with year 1 deliverable actions. • Training workshops for managers and leaders on people process issues aimed at supporting staff. • Interim leadership development strategy in place. • Job descriptions outlining leadership expectations. • Management structures in place within CB and corporate areas. • Clinical leadership model. • Data on people metrics: sickness, turnover, leadership, HWB. • Exit interviews. • Succession plans. • Leadership. competency framework for Board members. • Management skills sessions on HR processes.	• HR and OD support for managers. • Monthly operational performance review meetings. • Appraisals People Programme Board. (operational group) - minutes and highlight reports. • Minutes from TMG • Leadership data from staff and patient survey. • People Committee reports and minutes. • CQC oversight group. • QIP oversight group. • Staff survey (national and local). • WRES and WDES data.	• Review of appraisal process for leaders and managers linked to the four themes of the People Strategy – pilot to run from June 24 until December 24 to inform new process from April 25. • Leadership Development Training pilot to be run until December 2024. • Introduction of value/leadership competency into our recruitment processes – incrementally from June 24, fully implemented by March 2025. • Development of People Committee Internal Audit Report to track progress with recommendations and assurance – review in November/December 24. Roll out from January 2024.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

Failure to support staff with their health and wellbeing resulting in absence creating service pressures impacting their ability to deliver a high-quality service to patients.	• People Plan – identified theme of Health and Wellbeing with year 1 deliverable actions. • Health and wellbeing offer in place for staff. • Flexible working policy. • Flexible rotas. • Benefits programme for staff including salary sacrifice. • Attendance management policy. • Bank sand agency staff to cover shifts. • Access to occupational health. • Health workplace initiatives. • Seasonal food offers. • Mental first aiders in place (some areas). • Psychological support (some areas). • Health and Wellbeing co-ordinator. • HWB champions. • Charity supported HWB initiatives. • Gap analysis of HWB offer.	• HR and OD support. • HWB steering group – minutes. • Minutes from TMG. • People Committee reports and minutes. • CQC oversight group. • QIP oversight group.	• Health and Wellbeing bid to be made to the charity to support HWB plan – January 202. • Actions identified in people plan to be actioned.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
Current culture does not allow for flexible and responsive leadership to support staff and make them feel valued.	• Transformation of HR/OD focus. • Changes to board and key leadership roles • HR, OD support and intervention • Targeted and focussed OD support in hotspot areas • Leadership and management training in place • Staff Networks / EDI steering groups • FTSU guardian in place. • Sexual misconduct policy. • Leadership competency framework. Management skills training with focus on People over Process.	• HR and OD support • Monthly operational performance reviews • Appraisals • People Programme Board (operational group) - minutes and highlight reports. • Minutes from TMG • Leadership data from staff survey • People Committee reports and minutes • CQC oversight group • QIP oversight group • Staff survey (national and local) • TMG with focus on leadership	• Review of appraisal process for leaders and managers linked to the four themes of the People Strategy – pilot to run from June 2024 to December 2024 to inform new process from April 2025. • Leadership Development Training pilot to be run from June 2024 – December 2024. • for Board members – from April 2024. • Introduction of value/leadership competency into our recruitment processes – incrementally from June 2024, fully implemented by March 2025. • from August 2024 – November 2024. • Review of key HR policies and processes aimed at supporting staff – Ongoing from Sept- March 2025. • Review of dignity and respect policy – December 2024. • Anti-racism policy to be produced – December 2024.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

Risk ID	2.3

Board Assurance Framework 2024/2025

Principal Risk (what could stop us from achieving our strategic objective)	Inability to sufficiently influence priorities of key partnerships (including the Great North Healthcare Alliance, the ICB, Provider Collaborative and Newcastle place arrangements) or to deliver on agreed commitments due to capacity or culture, impacting on our ability to effectively deliver local and regional healthcare commitments.	**Strategic objective**	7. Our communities depend on us as the main regional centre, a key city partner and an employer. We acknowledge this responsibility and will make sure we deliver on our commitments.

Lead Committee	Trust Board	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Martin Wilson, Chief Operating Officer	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	Finance/VfM
Date Added	01.05.2024	**Likelihood**	**4**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	14.01.2024	**Risk Score**	**16**	**12**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Assurance rating and Progress Indicator**
Lack of appropriate Board, Executive and senior clinician capacity to influence the key partnerships and/or culture of the organisation resistant to working in effective partnerships.	• Great North Healthcare Alliance Steering Group Committees in Common established. • ICS Board. • Great North Healthcare Alliance Collaboration Agreement based around improving collaboration working whilst retaining organisational independence. • Provider collaborative leadership board. • Newcastle place based ICB sub-committee. • Alliance Case for Change.	• Chair and CEO member of Great North Healthcare Alliance Steering Group Committees in common. • CEO member of Provider Collaborative Leadership Board. • Lead director as part of Alliance Formation Team • Executive Directors leading appropriate Alliance work streams with peers. • Managing Director chairs Newcastle Place ICB Sub-Committee. • Alliance vision and 3 year work plan approved by Trust Board and supported by Council of Governors. • Great North Healthcare Alliance Steering Group Committees in Common Minutes • Great North Healthcare Alliance bi-monthly update to Trust Board and quarterly written update to Council of Governors. • ICB/Provider Collaborative and PLACE Minutes • Legal support to ensure legislative compliance with establishment of Great North Healthcare Alliance. • ICB supportive of Alliance Case for Change.	• Development of NUTH Clinical Strategy – April 2025. • Alliance updated Collaboration Agreement – February 2025.	**1-Fully on plan across all actions.**

Risk ID	7.1
Comments:	

Trust-Wide Risks Scored 15+ - Committee Mapping

Risk Tracker Key	
	New risk added since last BAF review.
	Current risk score reduced but still rated 15+
	Current risk score reduced below 15.
	Risk Tolerated - mitigated as low as reasonably possible.
	Current 15+ risk score increased.
	Risk fully mitigated and closed from operational risk register.

Quality Committee			
Risk ID	**Clinical Board/Corporate Directorate**	**Risk Description**	**Current Risk Score**
3079	Estates and Facilities	There is a risk to patient safety and people should they be exposed to contaminated water outlets in PFI estate. This is caused by water outlets where proliferation of thermostatic mixing valves (TMV), flow-straighteners and flexible hoses do not conform to HTM standards. This could result in: harm to, or death of, patients, staff or public.	15
3141	Cardiothoracic	There is a risk to quality safety which is caused by non-compliance with current treatment timeframes for adults with acute cardiac conditions. Which could result in immediate or higher risk of future adverse complicated cardiovascular events which has resulted in death and continues to do so.	16
3527	Estates and Facilities	There is a risk to patient safety and people in the event of a fire due to non-compliant active fire protection meeting the L1 standard which causes inadequate coverage. This is caused by the presence of obsolete components due to insufficient investment and maintenance of active fire safety systems at the Freeman Site. This could result in harm to, or death of, patients, staff or public; compromised fire safety standards, unplanned interruption of services.	15
3525	Estates and Facilities	There is a risk to patient safety and people at Royal Victoria Infirmary retained estate should fire and smoke spread in the event of a fire due non-compliant passive fire protection with compartmentation breaches within fire walls, floors, and ceilings. This is caused by significant defects and asset management systems regarding Fire Door sets and Dampers. This could result in harm to, or death of, patients, staff or public; compromised fire safety standards, unplanned interruption of services.	15
3535	Estates and Facilities	There is a risk to patient safety and people at NCCC (FH) should fire and smoke spread in the event of a fire due non-compliant passive fire protection with compartmentation breaches within fire walls, floors, and ceilings. This is caused by significant defects and asset management systems regarding Fire Door sets and Dampers. This could result in harm to, or death of, patients, staff or public; compromised fire safety standards, unplanned interruption of services; potential for legal enforcement notices through non-compliance with Regulatory Reform (Fire Safety Order)	15
3534	Estates and Facilities	There is a risk to patient safety and people at New Victoria Wing and COB (RVI) should fire and smoke spread in the event of a fire due non-compliant passive fire protection with compartmentation breaches within fire walls, floors, and ceilings. This is caused by significant defects and asset management systems regarding Fire Door sets and Dampers. This could result in: harm to, or death of, patients, staff or public; compromised fire safety standards, unplanned interruption of services; potential for legal enforcement notices through non-compliance with Regulatory Reform (Fire Safety Order)	15
3591	Estates and Facilities	There is a risk to patients and people due to the unexpected potential failure of critical ventilation infrastructure at the RVI. This is caused by underinvestment in the lifecycle replacement of ventilation infrastructure in certain areas of the Trust Estate. Limited central capital funding allocation has led to the aging and deteriorating condition of these assets which increases the likelihood of failure of the associated infrastructure. This could result in a direct impact on patient safety/satisfaction including increased risk of HCAI and unplanned disruption to clinical activity.	15
3634	Medicine and Emergency Care	There is a risk to quality safety for patients who present to ED with mental health issues, will experience deterioration in their MH and potentially to their physical safety, due to excessive periods of time in the ED awaiting mental health review. This is due to long waits for assessment by appropriate mental health services, lack of suitable mental health treatment options and shortage of mental health beds commissioned by CNTW. This results in a poor patient experience, negative impact on patient health and delays to treatment for patients in crisis.	16
3718	Clinical and Diagnostic Services	There is a risk to quality safety, which is caused by aging facilities and failing infrastructure in the BMT Unit within the William Leech Building (university owned) adjacent to the RVI. This could result in a significant critical incident, delay lifesaving BMT treatment to patients and impact on the Trust's ability to be a centre of excellence.	20
3886	Clinical and Diagnostic Services	There is a risk to Service/Business interruption/Environmental impact caused by terminal failure of the MPA pre-analytical element of the Roche lines which could result in significant delays to patient test result turnaround times in Blood Sciences RVI.	20
3937	Clinical and Diagnostic Services	There is a risk to quality safety that investigation results could be issued electronically without being endorsed and acknowledged in the electronic health record (EHR). This is caused by lack of assurance that investigation results, issued electronically, are appropriately endorsed, and acknowledged in the electronic health record (EHR). Significant problems currently affect every phase of the ordering and resulting process. This could result in results not being endorsed or acknowledged, which could lead to investigation results being reported to the incorrect Lead Consultant in e-record message centre. Without addressing the problems affecting each phase, patients under our care will remain at significant risk.	16
4000	Patient Services	There is a risk to quality safety caused by a lack of robust arrangements and clinical capacity to support antimicrobial stewardship which could result in the emergence of antimicrobial resistance adversely impacting on patient stay, patient safety and quality of care.	16

4155	Medicine and Emergency Care	There is risk to service delivery as well as pt and staff safety due to the environment on CAV site. The directorate has a number of services on CAV site including diabetes and older peoples medicine service. Pts with mobility issues are struggling to navigate the site which is getting further into dis-repair. There are regular estates issues with specific buildings e.g Belsay that regularly impact on service delivery and result in patient cancellations. This could result in delays to patient care, and issues with staff and patient safety.	16
4163	Estates and Facilities	There is a risk to patient safety and people in the event of a fire should fire dampers fail due to the PPM program to inspect and test fire dampers (as per the HTM 03-01, BS:9999 and BESA TR19/VH001) not being achieved. This is caused by resource constraints, access availability to all areas and asset management systems and financial constraints. This could result in: harm to, or death of, patients, staff or public; compromised fire safety standards, unplanned interruption of services; potential for legal enforcement notices through non-compliance with Regulatory Reform (Fire Safety Order)	15
4208	Family Health	There is a risk to patient safety, caused by inadequate pharmacy resource within GNCH which could result in patient herm, medication errors and lack of access to new medications. As well as additional impact on GNCH staffing and flow.	16
4225	Surgery and Specialist Services	There is a risk to quality safety for giving vulnerable patients a timely MRI under GA. This is caused by MRI scanner capacity and anaesthetics capacity to staff GA lists, and no other hospitals now providing this service. This could result in delayed diagnosis of serious conditions, poor patient experience, complaints, and accusations of inequitable access to health (as LD patients usually have MRIs under GA)	16
4221	Surgery and Specialist Services	There is a risk to patient quality and safety, caused by a mismatch of demand and capacity within the glaucoma subspecialty. This could result in patients not receiving timely treatment with resulting visual loss.	25
4448	Surgical and Specialist Services	There is a risk to patients' quality and safety. This is caused by the lack of a robust electronic appointment system for review patients. This could result in patients cannot access timely review appointments or treatment with resulting poor clinical outcomes/ visual loss.	15(25)
4224	Surgery and Specialist Services	There is a risk of patient quality and safety. This risk is caused by a demand and capacity mismatch across all ophthalmology specialties. This could result in patients not receiving timely treatment with resulting visual loss	16
4234	Patient Services	There is a risk to patient safety caused by the contamination of hand wash sinks in the clinical areas, which could result in increased infections and health and safety incidents.	16
4237	Clinical and Diagnostic Services	There is a risk to quality safety, which is caused by the aging blood culture analysers being out of service, and the inability to source parts for the analysers which means they cannot be fixed. There is a risk to service delivery if we are unable to source another analyser. This would impact on the delivery of the sepsis 6 pathway which could result in patient harm.	20
4262	Cardiothoracic	There is a risk to quality and safety regarding the KOKO lung function equipment that is used for assessing lung function in a range of patients, both out and in-patients. The tests are used to assess disease progression, effect of medication and for preoperative assessment. This is caused by the equipment failing on multiple occasions. It could result in patients needing to be rescheduled and could also mean that important information regarding lung function is not available for medical staff to discuss with the patient, potentially causing a delay to their treatment.	15
4312	Clinical and Diagnostic Services	There is a risk to Service/Business interruption/Environmental impact caused by acute staffing shortage which could periodically result in an inability to provide the Haematology/Transfusion service to the Trust.	20
4310	Medicine and Emergency Care	There is a risk to quality safety caused by overcrowding in ED which could result in acutely unwell patients not being appropriately identified or experience treatment delays.	20
4342	Family Health	There is a risk to patient safety which is caused by insufficient obstetric consultants which could result in inability to deliver timely and effective tertiary services as required by the region.	15
4378	Surgery and Specialist Services	There is a risk to patient quality and safety. This is caused by patients' appointment being cancelled during covid and this information being held on XL spreadsheets. This could result in patients not receiving timely treatment and resulting in visual loss.	10(25)
4389	Family Health	There is a risk to Quality Safety caused by delays in IAS medical procuring new ambulances for the NECTAR service which could result in ambulances breaking down, impacting on patient safety and delivery of care when in transit and inability to provide service.	8(15)
4422	Clinical and Diagnostic Services	There is a risk to quality safety for amputee patients, which is caused by increased volume and complexity of the amputee caseload, and no matched increase in Therapy / Rehab capacity, which could result in harm and poor outcomes to patients.	16
4429	Surgery and Specialist Services	There is a risk to Quality Safety for patients suffering major Trauma. This is caused by a failure to meet standards and ongoing underinvestment in the service and increasing patient numbers. Which could result in poor outcomes for patients.	16
4433	Patient Services	There is a risk to patient safety caused by non-compliance with HTM02-01 in relation nursing staff use of oxygen and related equipment. Which could result in patient harm.	15
4450	Surgery and Specialist Services	There is a risk to quality safety. This is caused by lack of long-term plan for cataract theatre provision and reliance of a temporary rented theatre at CAV. This could result inability to provide cataract surgery services, and resultant patient harm. (+financial loss)	15
4451	Surgery and Specialist Services	There is a risk to quality safety. This is cause by limited physical space- in clinic and theatre to see patients and offer appointments/treatment. This could result in patients not accessing timely treatment with resulting visual loss.	16
4452	Surgical and Associated Specialties	There is a risk to Quality safety caused by failure to achieve CQUIN standards which could result in major amputations, extended lengths of stay as well as a financial implication to the Trust	16
4460	Patient Services	There is a risk to Quality safety if we are unable to assess, respond and document effectively due to ineffective core clinical documentation and processes (digital and paper) to support individualised care planning which could result in patient harm, reduced quality of care, patient experience and the reputation damage to the Trust.	9(15)
4466	Clinical and Diagnostic Services	There is a risk to patient safety which is caused by inadequate pharmacy support for medicines reconciliation on admission, inpatient medicine review / monitoring and safe transfer of care. This results in avoidable medicines related harm and reduced quality of care.	15
4486	Family Health	There is a risk to patient safety which is caused by the NECTAR Service being unable provide consistent clinical cover out of hours due to sharing of consultants between NECTAR and PICU. This could result in patients waiting longer for retrieval and patient safety risks.	16
4496	Cardiothoracic	There is a risk to quality safety which is caused by the current Trust Telemetry system being reliant on Wi-Fi to operate. This could result in monitoring systems being compromised significantly impacting on patient safety, as the telemetry systems would stop working and stop recording patient observations.	15
4501	Medical Director	There is a risk to Quality Safety caused by falls from height risks across the organisation, which could result in death or serious injury. The Trust has a number of areas which may be used by patients or the public to self-harm by way of intentional falls from height. Specific areas include the New Victoria Wing (NVW) Atrium, NCCC Atrium, Claremont MSCP, balconies in Leazes Wing Wards (x6). There is also the potential in NVW for items to be rested on the balustrade ledges which may fall and injure those below. This is a specific issue outside Ward 8 where patients queue outside of this day case ward. Such events will have a significant impact on the organisation and those staff who are involved in responding.	15

4509	Cardiothoracic	There is a risk to quality and patient safety which is caused by there not being enough cardiac physiologists in post to maintain the region's critical PCI on call service. This is a service that is needed 24/7 with high significant patient demands. This has resulted in significant patient care. Catheter lists are now frequently being cancelled or cut short due to this lack of physiology cover.	20(15)
4524	Surgery and Specialist Services	There is a risk to patient safety and outcomes. This is caused by increasing demand not matched by capacity within the neuroradiology MRI department. This could result in delays to patient care (causing harm or suboptimal outcomes), targets being breached, patients staying in hospital longer than needed waiting for scans, staff burnout and additional cost to the Trust funding private sector scanners.	12(15)
4538	Peri-operative and Critical Care	There is a risk to quality safety which is caused by the lack of general medical cover within FRH medical wards out-of-hours which is subsequently covered by 2nd on-call for anaesthetics. This could result in 2nd on call anaesthetics being unable to provide ITU opinions, to deliver anaesthesia, and support anaesthetic and ITU trainees and may result in suboptimal management of the patient and or patient harm.	16
4547	Clinical and Diagnostic Services	There is a risk to patient safety, caused by GP Practices not adhering to prescribing and referral pathways relating foot infections including osteomyelitis in community. This could result in patient harm, worsening infections, and increased attendance via ED.	16
2596	Clinical and Diagnostic Services	There is a risk to quality effectiveness which is caused by the LIMS system having been built by a single member of staff, who is the only person with access codes, the knowledge to update and fix the database. This could result in genetic laboratory and clinical services becoming disrupted with the potential to result in outright system failure if there are no staff available with the training and competence to maintain clinical and laboratory LIMS.	16
3850	Surgical and Associated Specialties	There is a risk to patient safety due to increased risk to line infections. This is caused by not having a designated IF unit, and patients being cared for in sub-optimal across multiple wards due to lack of IF expertise on general wards. This results in long stays for patients and poor service provision across the region.	15
3945	Clinical and Diagnostic Services	There is a risk to quality effectiveness caused by a full-service review, it has been highlighted that ILM do not have the appropriate number of PA to effectively provide medic/consultant cover to the ILM directorate, this could impact on the safe and timely delivery of ILM services, patient safety and the health and wellbeing existing staff.	20 (16)
4007	Clinical and Diagnostic Services	There is a risk to patients' safety due to ageing Incumbent rapid gassing isolators and the frequency of system failures which could result in equipment failures and impact service delivery.	8 (16)
4056	Clinical and Diagnostic Services	There is a risk to quality effectiveness to children & young patients following critical illness, injury, post-surgical, and neuro-developmental patients, which is caused by extremely limited Therapy / Rehab / AHP & Psychology capacity. This could result in harm and poor outcomes to patients.	15
4057	Clinical and Diagnostic Services	There is a risk to quality effectiveness within the community following discharge from hospital, which is caused by extremely limited Therapy / Rehab / AHP & Psychology capacity in a number of community services which could result in harm and poor outcomes to patients.	10(15)
4058	Clinical and Diagnostic Services	There is a risk to quality effectiveness to patients, following critical illness, injury, or post-surgical patients which is caused by extremely limited Therapy / Rehab / AHP & Psychology capacity, which could result in harm and poor outcomes to patients.	15
4481	Clinical and Diagnostic Services	There is a risk to quality safety and compliance and regulatory from a potential CPE outbreak in NUTH. CPE is a type of multi-drug resistant bacteria which can to spread between patients and into the hospital environment, it is very difficult to treat with antibiotics. This is caused by the inability to implement CPE screening as per national guidelines due to insufficient laboratory resources. Which could result in untreatable infections and possible deaths.	15
4222	Surgery and Specialist Services	There is a risk to patients' quality and safety. This risk is caused by non-compliance with NICE guideline 2 week to treatment target. This could result in patients not receiving timely treatment with resulting visual loss	20
4525	Surgery and Specialist Services	There is a risk to the Trust's ability to provide mechanical thrombectomy to patients having strokes outside of 9-5 hours. This is caused by several factors, but in particular a lack of Interventional Neuroradiologists (INRs) (as the Trust needs a 6th before the hours of the service can be extended), and a lack of commitment from NHSE to fund more staff. This could result in people in the north east having limited access to life saving stroke interventions that are available in other regions during certain times of day, and in the Trust's ability to meet the expectations of NHSE (causing reputational damage).	16
4335	Clinical and Diagnostic Services	There is a risk to Quality Safety for patients with Diabetes developing Diabetic foot ulceration due to lack of podiatry appointments. Which is caused by more patients with complex foot disease and the Trust is unable to meet the demand. Patients are at risk of admission to hospital and possible need for surgery and amputation, which could be avoided by more podiatry availability.	20
4550	Cancer and Haematology	There is a risk to quality safety, which is caused by the lack of ventilation in the Henderson space which is used as chemotherapy day unit. Which could result in delays to patients starting treatment, interruptions to current treatment plans, and patients being treated in a suboptimal environment.	15
4551	Family Health	There is a risk to patient safety due to the lack of designated HDU/level 2 capacity and a paediatric critical care outreach team, this may result in patients not receiving the right level of care and intervention at the right time. In addition to this, there is a risk to overall GNCH bed capacity as managing level 2 patients on inpatient wards requires a higher level of nursing and this can often result in bed closures.	15(20)
4560	Surgical and Associated Specialties	There is a risk to patient outcomes caused by ineffective/inefficient pathway for pancreatic and cancer referrals. This could result in delays in treatment and adverse outcomes for patients across the HPB network with cancer	12(16)
4563	Family Health	There is a risk to patient safety and potential reputational damage caused by failure to follow agreed screening pathways/processes for screening, failure to meet screening KPIs and failure to accurately report on our screening data externally. This could result in missed opportunities for screening, missed diagnosis, late diagnosis and potential harm. This is an ongoing risk as we do not currently have a high level of assurance that it will not happen again/is not continuing to happen.	16
4565	Medical Director	There is a risk to quality and safety which is caused by the breakdown in provision of shared care pathways across the region. This could result in patients not receiving safe and effective continuing care, result in increased attendances to hospital and could lead to patient harm.	16
4569	Clinical and Diagnostic Services	There is a risk to quality and safety caused by gaps in fridge temperature recordings and sub optimal temperature monitoring equipment. Which could result in potential patient harm if spoiled medications are administered to patients. This could also result in a financial impact in relation to medication wastage.	15
4586	Medical Director	There is a risk to compliance due to an increased risk of potentially preventable hospital acquired thrombosis which could result in severe or fatal patient harm, increased incidents and/or increased claims.	16
4605	Cardiothoracic	There is a risk to Quality Safety and delivery of the Inherited Cardiac Conditions (ICC) Service, which is caused by a lack of funded capacity across the ICC Multi-disciplinary team, which is outweighed by service workload/demand. which could result in non-delivery of service standards, and increased risk to patient care due to delayed diagnostics and treatment times.	15
4608	Perioperative and Critical Care	There is a risk to compliance and regulation which is caused by inadequate facilities on ward 38, RVI, which fails to meet the standards outlined in GPICS v2.1 (2022) and the faculty of intensive care medicine (2019). The primary reasons for non-compliance are in relation to lack of space to accommodate the equipment required to care for patients in multi-organ failure or support patient	15

		rehabilitation. Inadequate storage for medicines also does not comply with the standards required of the HBN 00-033. This could result in a substandard patient and staff experience, poor compliance with NICE guidance for early rehabilitation and non-compliance with NHSE guidance for medicine storage.	
4615	Surgery and Specialist Services (Ophthalmology)	There is a risk to patient's patient safety, from being lost to follow up and not receiving appropriate clinic care. This risk is caused by being unable to identify who requires care from a cohort of 31000 open clinical pathways that have not been actioned correctly in the Ophthalmology department.	20
3711	Surgery and Specialist Services (Neuro)	There is a risk to quality safety that patients have delayed treatment for serious neurosurgical medical conditions. This is caused by an imbalance in reporting capacity from the neuroradiology team compared to increasing demand for MRIs, current reporting times breach the recommended standards. This could result in delayed diagnosis, delayed treatment, increased waiting times overall (as this time forms part of the overall patient 18 week pathway), increased expense due to huge reliance on outsourcing and WLIs.	15
4317	Family Health (GNCH)	There is a risk to quality effectiveness caused by end of life/failing lung function and sleep kit and lack of engagement to switch out the old for new kit (GNCH has kit onsite) which could result in inability to deliver an effective lung function and sleep service and result in patient harm.	15
4507	Cardiothoracic	There is a risk to quality safety, which is caused as the service continues not to meet the 62-day cancer target. This could result in further deterioration of patients care, causing further harm.	15(12)
4548	Cancer	There is a risk to quality safety, which is cause by a shortage in staffing capacity within the dosimetry team, therefore the waiting list will begin to build. This could cause delays to patients starting radiotherapy treatment, and will impact on the 31 day target for subsequent treatment for radiotherapy.	15(9)
4621	Clinical and Diagnostic Services (ILM)	There is a risk to patient safety due to hospital service and patient flow during winter 2024/25.Which is caused by reduced service provision by Microbiology & Virology RVI Hot Lab. Which could result in Inability to provide urgent respiratory/COVID testing on a 24/7 basis, leading to inappropriate patient management, and potential IPC complications.	16
4634	Surgical and Associated Services (Urology)	There is a risk to patient safety and quality of care which is caused by a lack of emergency theatre capacity which could result in patient harm with suboptimal outcomes; prolonged patients stay which exacerbates bed pressures.	16
4640	Medical Director (CGARD)	There is a risk to patient safety which is caused by the large number of features within our buildings that could be used as a ligature, anchor point, direct injury or ingestion of COSHH items that could result incidents of self-harm.	15
4120	Clinical and Diagnostic Services	There is a risk to the provision of a perinatal and paediatric service which is caused by the lack of capacity within the specialty team which could result in the inability to deliver timely diagnostic results to patients	20
4510	Medicine and Emergency Care	There is a risk of poor staff / patient experience on RVI ward 44, which is caused by no clarity for the future of the ward, causing instability, uncertainty, and staff dissatisfaction. This could lead to prescribing incidents, prolonged hospital admission, patients being lost to follow up, missing / delaying results / treatment, and medical incidents.	15
4556	Clinical and Diagnostic Services	There is a risk to quality safety relating to the accurate reporting of placentas and perinatal Postmortems, which is caused by evidential photographs being taken on a handheld camera then loaded up manually onto a PC. This could result in images being loaded up against the incorrect patient record or lost during the transfer.	16
4603	Clinical and Diagnostic Services	There is a risk to the microbiology and virology weekend service provision, which is caused by insufficient trained staff volunteering for weekend rotas. Which could result in delayed patient results impacting diagnosis and treatment.	16
4617	Surgery and Specialist Services	There is a risk to staffing competence. This risk is caused by a lack of sufficiently trained staff (nursing/doctors/allied health professions) to make appropriate clinical decisions in EED.	4617

Finance Committee

Risk ID	Clinical Board/Corporate Directorate	Risk Description	Current Risk Score
4392	Information Technology	There is a financial risk to the Trust, which is caused by a 5-year contract ending, meaning the Trust will be wholly responsible for future liabilities for licensing/funding, covered under this agreement after 31 March 2028. This could result in additional annual costs of £4.3M.	20
4505	Business and Development	There is a risk to Finance/VfM caused by a lack of Trust operational readiness (capacity, capability, infrastructure) to deliver the commercial income targets set as part of the 2024-2027 Financial recovery plan which could result in Non delivery and financial impacts on the Trust.	15

Audit, Risk and Assurance Committee

Risk ID	Clinical Board/Corporate Directorate	Risk Description	Current Risk Score
3774	Clinical and Diagnostic Services	There is a risk to compliance from a critical finding of the MHRA, which is caused by the lack of electronic health record and supporting processes for Clinical Diagnostic. This could result in suspension of all Clinical Diagnostic activity, patient safety issues due to other clinical services not being aware of Diagnostic activity, and reduction in Diagnostic income.	20 (15)

4261	Family Health	There is a risk to compliance and regulatory, which is caused by the introduction of accreditation standard (ISO 15189) for Sexual Assault Referral Centres (SARCs). There is Risk of failing to achieve compliance by October 2025 (extended from 2023 due to COVID), which could result in non-compliance with accreditation and commissioning standards, leading to decommissioning of service. Evidence not permissible in court if collected from a non-accredited service.	16
4428	Clinical and Diagnostic Services	There is a risk to compliance and regulatory and safeguarding the dignity of the deceased which is caused by insufficient fridge and freezer storage capacity for deceased patients, especially bariatric patients, which could result in the loss of our HTA Post-mortem licence and UKAS accreditation.	16
4620	Clinical and Diagnostic Services	There is a risk to our compliance with the HTA standard for tissue retention and disposal and to the Trust's reputation which is caused by a lack of a nominated individual to ensure tissue is disposed of correctly and in a timely manner which could result in tissue being disposed of incorrectly or kept with no lawful reason.	16
4640	Patient Services	There is a risk to patient safety which is caused by the large number of features within our buildings that could be used as a ligature, anchor point, direct injury or ingestion of COSHH items that could result incidents of self-harm.	15

People Committee			
Risk ID	**Clinical Board/Corporate Directorate**	**Risk Description**	**Current Risk Score**
4480	Medicine and Emergency Care	There is a risk of physical and psychological harm to staff in ED due to violence and aggression from patients and visitors. This is caused by long waits, overcrowding, and flow issues. This could result in incivility to all staff as a result of changing expectations and increased frustration with the performance of NHS services.	15
4499	Cardiothoracic	There is a risk to People and quality safety caused by a negative culture with the service. This is caused by staff behaviours and poor communication amongst teams, and with patients. This could result in patient care due to concerns of people not being able to speak up for fear of retribution or other negative impact on individuals. This negative impact may result in staff being concerns to work in this environment and affect recruitment and retention.	20
4137	Estates and Facilities	There is a risk to our people should the targets within the Climate Emergency Strategy not being achieved. This is caused by staffing resource shortages, and access to capital funding and further exacerbated by Trust's decisions on methods of estate expansion, energy centres outsourcing on performance, lack of national funding sources for the scale of investment required and CDEL restrictions. This could result in impacting on the Trust's contribution to the local population with subsequent ill health consequences and health inequalities as well as driving further global warming and the associated risks of passing climate tipping points and setting off irreversible runaway global warming. In addition, this would negatively impact the Trust reputation as a global leader in sustainable healthcare delivery.	20
4617	Surgery and Specialist Services	There is a risk to staffing competence. This risk is caused by a lack of sufficiently trained staff (nursing/doctors/allied health professions) to make appropriate clinical decisions in EED. This could result in unsafe staffing competence to delivery key objectiveness in EED	20.

Digital and Data Committee			
Risk ID	**Clinical Board/Corporate Directorate**	**Risk Description**	**Current Risk Score**
3909	Clinical and Diagnostic Services	There is a risk to compliance and regulatory guidelines, which is caused by the retention of the clinical 7 Genetics laboratory and clinical database residing on an Access 97 database, which breaches Cyber Essentials Guidelines. The inability to maintain and protect this database adequately could ultimately result in inappropriate access or database corruption which could ultimately lead to the complete failure of the system and hence an inability to support both Laboratory and Clinical Genetics service.	20
4417	Information Management and Technology	There is a risk to DSPT/CE compliance and Trust regulatory fulfilment, which is caused by Windows 2012 servers not decommissioned or on extended support by EoL date. This could result in the Trust being at significant risk of a cyber security incident.	16
4528	Family Health	There is a risk to patient safety, patient experience, staffing and reputational damage. This risk is caused by a wide-ranging digital immaturity within the women's health directorate which could result in; • ineffective use of clinical staff time. • inability to accurately report on our services externally • inability to communicate with GPs and patients in a timely and effective manner e.g. through discharge summaries • inability to identify deteriorating patients in a timely manner through lack of e-obs in MAU • inability to manage proactively plan and manage services using up to date accurate information e.g. via fit for purpose dashboards.	15
4616	Clinical Diagnostic Services	There is a risk to quality safety, finance and reputation which is caused by the fragility of the CIVALAB IT system. This could result in lack of calculation support for aseptically prepared pharmaceuticals and an inability to label these products correctly in line with MHRA standards.	16
4448	Surgery and Specialist Services	This is caused by the lack of a robust electronic appointment system for review patients. This could result in patients cannot access timely review appointments or treatment with resulting poor clinical outcomes/ visual loss.	15

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4496	Cardiothoracic	There is a risk to quality safety which is caused by the current Trust Telemetry system being reliant on Wi-Fi to operate. This could result in monitoring systems being compromised significantly impacting on patient safety, as the telemetry systems would stop working and stop recording patient observations.	15

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PUBLIC BOARD MEETINGS - ACTIONS

Agenda item A13

Log No.	BOARD DATE	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
129	29 November 2024	Staff Survey	Paul Ennals requested that a message be circulated on behalf of the Trust Board to all staff expressing thanks for taking the time to fill in the survey and the increased response rate [ACTION01].	CD			04.12.24 - Message circulated to all staff. Propose to close action.
130	29 November 2024	Staff Story	AL to check with the Staff member who shared their story as to whether they had revisited the ED to see how improvements are working in practice [ACTION02].	AL		ON HOLD	06.12.24 - AL confirmed that an offer has been made to the staff member however they are currently on leave. An update to be provided when the staff member returns and if the offer is accepted.
131	29 November 2024	Guardian of Safe Working Report	The report to be updated to include SPC charts going forwards. LPC to feedback to Henrietta Dawson [ACTION03].	LPC			05.12.24 - New exception reports chart now included. Propose to close action.
132	29 November 2024	Maternity Incentive Scheme progress report	To include financial figures and benchmarking against other organisations in future reports [ACTION04].	JW			05.12.24 - JW confirmed that this information will be included in future reports once all returns have been received.

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.