The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Public Trust Board of Directors' Meeting

Friday 28 March 2025, 10.15 – 12.30

Venue: Piano Room, Royal Victoria Infirmary

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 31 January 2025 and Matters Arising	Paul Ennals	Attached	10:16 – 10:17
3.	Chair's Report	Paul Ennals	Attached	10:17 – 10:22
4.	Acting Chief Executive's Report	Rob Harrison	Attached	10:22 – 10:30
Strategic items:				
5.	Patient and Staff Stories	Annie Laverty	Attached	10:30 – 10:35
6.	Patient and Staff Experience including: i) Patient Experience Right Time Results ii) Staff Survey 2024	Annie Laverty & Rob Harrison	Attached	10:35 – 10:45
7.	Board Visibility Programme	Rachel Carter	Attached & Board Reading Room	10:45 – 10:50
8.	Freedom to Speak Up Guardian Report	Jill Taylor	Attached	10:50 – 11:05
9.	Alliance progress update	Martin Wilson	Attached	11:05 – 11:10
10.	CQC update	Ian Joy	Attached	11:10 – 11:20
11.	Integrated Board Report	Patrick Garner	Attached	11:20 – 11:30
	Refreshments Break			***11:30 – 11:35***
12.	Sustainable Healthcare in Newcastle	Vicky McFarlane-Reid & James Dixon	Attached	11:35 – 11:45
13.	Equality, Diversity and Inclusion (EDI) update	Annie Laverty & Caroline Docking	Attached	11:45 – 11:50
14.	Update on a Public Health / Health Inequalities Strategy	Lucia Pareja-Cebrian	Attached	11:50 – 11:55
Items to receive *[NB for information – matters to be raised by exception only]*:				11:55 – 12:10
15.	Director reports: a. Joint Medical Directors Report	Michael Wright & Lucia Pareja-Cebrian	Attached	

	b. Executive Director of Nursing Report	Ian Joy	Attached & Board Reading Room	
	c. Maternity:			
	i) Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report	Ian Joy & Jenna Wall	Attached & Board Reading Room	
	ii) Maternity Safety Champion Report	Liz Bromley	Attached	
	d. Mortality/Learning from Deaths	Rachel Carter	Attached	
16.	Committee Chair Meeting Logs	Committee Chairs	Attached	
Items to approve:				
17.	Board Assurance Framework (BAF) 2024/25	Patrick Garner	Attached	12:10 – 12:15
18.	Gender Pay Gap report	Vicky McFarlane-Reid & Donna Watson	Attached	12:15 – 12:20
19.	Governance documents: i) Board Committee Terms of Reference and Schedules of Business ii) Public, Private and Charity Board of Directors Schedules of Business iii) Accountability Framework	Kelly Jupp	Attached	12:20 – 12:25
Any other business:				
20.	Meeting Action Log	Paul Ennals	Attached	12:25 – 12:27
21.	Any other business	All	Verbal	12:27 – 12:30

Date of next meeting:
Public Board of Directors – Friday 23 May 2025

Sir Paul Ennals, Interim Shared Chair

Mrs Liz Bromley, Non-Executive Director

Mr Rob Harrison, Acting 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

Mr Martin Wilson, Director - Great North Healthcare Alliance & Strategy

Ms Annie Laverty, Chief Experience Officer

Mrs Rachel Carter, Director of Quality & Safety

Mr Patrick Garner, Director of Performance and Governance

Ms Donna Watson, Acting Associate Director of People and Organisational Development

Mrs Jenna Wall, Director of Midwifery

Ms Jill Taylor, Freedom to Speak Up Guardian

Mr James Dixon, Associate Director - Sustainability

Mrs Kelly Jupp, Trust Secretary

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PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 31 JANUARY 2025

Present:	Sir Paul Ennals *[Chair]*	Interim Shared Chair
	Sir J Mackey	Chief Executive Officer [CEO]
	Mr R Harrison	Deputy Chief Executive Officer [DCEO]
	Dr M Wright	Joint Medical Director [JMD-W]
	Mrs L Pareja-Cebrian	Joint Medical Director [JMD-PC]
	Mr Ian Joy	Executive Director of Nursing [EDN]
	Dr V McFarlane Reid	Director for Commercial Development & Innovation [DCDI]
	Mr B MacLeod	Non-Executive Director (NED)
	Mrs L Bromley	NED
	Mr D Weatherburn	NED
	Mrs A Stabler *[until 10:59]*	NED
	Mr B McCardle	NED
	Mr P Kane	NED
	Ms W Balmain	NED

In attendance:
Dr N Adetuberu, Associate NED
Mr M Wilson, Director - Great North Healthcare Alliance & Strategy
Mr R Smith, Director of Estates [DoE]
Mr P Hanson, Director of Estates, Facilities and Strategic Partnerships [DEFSP]
Mrs C Docking, Director of Communications and Corporate Affairs [DCCA]
Mrs R Carter, Director of Quality and Safety [DQS]
Mrs K Jupp, Trust Secretary [TS]
Mrs A Laverty, Chief Experience Officer [CXO]
Mr P Garner, Director of Performance and Governance [DPG]
Mrs J Mason, Deputy Chief Finance Officer [DCFO]
Mrs J Wall, Director of Midwifery [DoM]
Professor J Isaacs, Associate Medical Director [AMD] *(for item 25/02 v))*
Ms M Burton, Network Director NIHR Regional Research Delivery Network North East and North Cumbria *(for item 25/02 v))*

Observers:
Mr H Kajee, incoming NED
Professor P Home, Public Governor
Mrs S Mawdesley, Public Governor
Mr R Purwal, Healthcare Director C2-ai
Mr M Bridge, GP and North Tyneside GP Fellowship Clinical Lead
Mr T Bell, Author, Consultant, Educator, Speaker, Patient Safe Culture Specialist
Ms K Hurst, Head of Strategic Relationships HBS UK

Ms D Jones, Trust Member
Miss V Champion, PA to Chair and Trust Secretary / Corporate Governance Officer

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.

25/01 STANDING ITEMS:

The Chair welcomed Ms Balmain, Mr Kajee, Dr Adetuberu and Mr Hanson to their first Public Board meeting.

i) Apologies for Absence and Declarations of Interest

Apologies were received from Mrs J Bilcliff, Chief Finance Officer, Mrs C Brereton, Chief People Officer and Mrs S McMahon, Chief Information Officer. There were no new declarations of interest raised.

It was resolved: to (i) **note** the apologies for absence and that there were no new declarations of interest.

ii) Minutes of the previous meeting held on 29 November 2024 and matters arising

The minutes of the meeting held on 29 November 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 Chairs Report was received for information.

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

iv) Chief Executive's Report

The CEO highlighted the following points:

- In relation to the Quality and Safety standards, there was a great deal of work taking place to increase staff focus on improving outcomes and standards.
- A focus was on securing reinspection from the Care Quality Commission (CQC), with the aim of improving the overall Trust inspection rating.
- With regards to patient and staff experience, there had been significant progress and focus for the future.
- Pressures continued with regards to winter, the financial position and operational performance standards. It was noted that the teams within the Trust managed the

peak of the winter period well and that planning for next winter will commence as soon as is possible.

The Chair referred to the operational performance standards and highlighted that despite the variability in performance, overall the Trust was in a better position than this time last year.

Mrs Bromley asked if there were any issues the Trust Board should be aware of. The CEO advised that the main areas of concern related to the national financial position and the underlying deficit for the Trust, building on Freedom to Speak Up work and reducing sickness absence rates. He highlighted the importance of all clinical and operational teams having the correct support and that operational pressures including patient demand, bed availability and the discharge process were having an impact both on staff and patients.

Mr MacLeod sought clarification with regards to the planning guidance and the implications with regards to national targets. The CEO advised that previously, Trusts have been able to assume efficiency savings of 2% as part of the medium term financial planning however there was a significant increase needed in relation to the level of savings required. He highlighted that COVID cost growth and other variables meant that planning was increasingly difficult.

A discussion ensued regarding the delivery of the national targets, changing priorities and the expectations for Trusts.

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

25/02 **STRATEGIC ITEMS:**

i) **Patient and Staff Stories**

The CXO explained that the story was a positive reflection from a grateful patient who had been receiving care at the Freeman Hospital for more than 30 years. The story illustrated the excellent care from the congenital cardiac team, the consistent compassion shown and the sense of pride and purpose.

The staff story was shared by ward manager, Sophie Robson of ward 37 at the Royal Victoria Infirmary (RVI).

The EDN referred to the Accrediting Excellence (ACE) programme and noted that high standards are extremely important for the quality and safety for staff and patients. He highlighted the sense of pride in relation to the care delivered on the wards and departments. Just over 10 wards had been accredited and Trust Board members had been invited to the celebration events to see the ward accreditations in practice.

Mr Kane acknowledged the positive progress made and queried if further accreditations should be sought e.g. for research staff and staff running clinical trials. The EDN advised that

the national direction of travel was being observed and this could be considered once the ACE programme was fully embedded. The DCCA noted the support received from the Newcastle Hospitals Charity and the positive impact on quality of patient care.

The Chair advised that he sends cards on behalf of the Trust Board to thank staff members for their input into the patient and staff stories. He highlighted the importance of positive feedback and the constructive balance needed between receiving both positive and negative stories.

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

ii) Board Visibility Programme

The DQS advised that the report detailed the activity from November and December 2024 with 17 walkabouts and visits having been undertaken during this period. She noted that two NEDs had carried out a visit to the full Freeman Hospital Main ward block.

The DQS explained that feedback from the walkabouts and visits was collated, and findings included in the report, with further detail added to the Trust Board Reading Room. Recent feedback received was that staff were willing to talk openly during the visits, and if an issue was raised, the staff felt confident that they would be listened too, and overall staff were proud to work at Newcastle Hospitals.

The Chair sought clarification with regards to how the teams respond when there was a specific issue raised during a walkabout or visit. The DQS advised that an urgent issue would be escalated at the most appropriate point by the individual conducting the visit, however the team would also check if the ward had escalated the issue through internal processes and if not, then this would be encouraged.

Mr MacLeod noted that he carried out a late-night Ward visit with Mrs Stabler with positive feedback received.

The EDN advised that clear actions are in place, and they are triangulated were appropriate.

Mrs Stabler highlighted that she always sends a copy of her visits report to the EDN and if there is anything urgent, she will contact the EDN before the report is sent to the Corporate Governance Office.

The Chair highlighted the importance of Executive Team member walkabouts and NED informal visits, and noted that both positive and negative issues should be raised, and actioned where appropriate.

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

iii) Care Quality Commission (CQC) Update

The DCEO highlighted the following points:

- The CQC Delivery Group continued to report into the Quality Committee. The DQS, the DPG and teams have worked hard on the delivery of the actions in the CQC action plan.
- Work was ongoing with regards to the required Estates matters which would be completed by the end of this quarter.
- Further focus had been placed on the digital improvements needed, and to ensure that sufficient reporting was in place. There was a great deal of work underway with regards to the switch to remote hosting via the Cloud, with planning support from Emergency Preparedness Resilience and Response (EPRR) team members.

  The JMD-PC advised that everything was planned for the changeover and that it would provide greater resilience. There would be a 12-to-14-hour period where the electronic access to patient records would not be available, with workaround processes planned.

  The Chair queried if discussion had taken place at the Digital and Data Committee on the remote hosting switchover to which Mrs Bromley advised that detailed discussion had taken place at the Committee in relation to the process and risks associated.

  The DCEO advised that the transition to remote hosting will resolve some of the issues experienced by staff with regards to system speed and that internal communications would be circulated once the changeover has been conducted. He noted that there has been good collaboration across the organisation in relation to the change to remote hosting.
- The positive development of the Ward Accreditation Programme which was one of the fundamentals needed following the CQC inspection to drive forward the delivery of the best possible care for patients.
- The importance of patient care and supporting staff. Quality and Safety priorities were regularly discussed with the Clinical Boards and feedback was received through the Quality Committee.
- Further focused visits would take place with the support of external partners.
- The importance of triangulation and to embed 'CQC processes' as business as usual.

The Chair welcomed the movement to business as usual through effective and embedded processes, learning from the CQC inspection outcomes.

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

iv) <u>Integrated Board Report (IBR)</u>

The Chair noted that good progress had been made regarding the development of the IBR.

The DECO highlighted the following points:

- Maternity metrics were now included routinely within the IBR.
- Improvements had been seen in some quality metrics including C-difficile infection rates and the rate of falls.

- In relation to operational performance, cancer and diagnostics performance remained a concern. Both areas were now a standard agenda item at the Finance and Performance Committee meetings, with a recent comprehensive update focussed on the areas for improvement and associated actions.
- Work was taking place in relation to improving appraisal and statutory and mandatory training rates, which were being actively discussed with the Clinical Boards and at the People Committee.
- With regards to the frailty pilot, there were 98 patients seen over a period of 12 days, of which 28 were able to be discharged straight home. It was noted that evidence suggested that there may be long term care implications when patients remain in hospital for long periods of time. Support from the Local Authority for the pilot had been excellent and the development of the Better Care Fund programme for 2025/26 was noted to be crucial to the success of this work.

The Chair advised that discussions had taken place through the relevant Committees.

Mr MacLeod noted the positive review held previously at the Finance and Performance Committee in relation to elective performance for Paediatric waiting times.

Mrs Stabler advised that there had been a reduction in pressure ulcers and falls which triangulates with the improved staffing position. The concerns in relation to cancer performance were being discussed at the relevant Committee meetings.

Mr Kane sought clarification with regards to recruitment and retirement challenges for Dosimetrists and the Royal College of Radiology Accreditation Programme. The JMD-PC advised that she would find out further information with regards to the Royal College of Radiology Accreditation Programme however highlighted that the teams involved were aware of the importance of recruitment and retirement planning **[ACTION01]**. In relation to sickness absence, there were some complex issues which were being addressed.

The DCEO shared an example of retirement planning that had taken place in Ophthalmology, citing the unique/specialist nature of some of the posts which were hard to recruit into. All agreed the importance of succession planning, and in ensuring that this is built into the overarching workforce plan.

The JMD-W advised that retirement planning takes place in the areas that are known however sometimes it was difficult to identify at an early stage to allow sufficient planning.

The CXO noted the developments with frailty and highlighted that there was an associated Alliance initiative in relation to patient experience real time reporting into the Emergency Department.

The Chair highlighted that the Statistical Process Control (SPC) charts were helpful with a focus on cancer and diagnostics. In summary, he noted that the succession planning work was ongoing and that Health Inequalities developments will progress over the coming months, especially when all of the new NEDs were in post.

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

v) Research update including:

a) Home-Grown Research

b) Clinical Research Network Update

The DCDI introduced Professor Isaacs and Ms Burton to the meeting and highlighted the importance of research which results in better outcomes for patients. She advised that the governance arrangements for research had now changed with joint oversight from herself and the JMD-W.

Professor Isaacs highlighted the following points:

- In relation to the value of research, patient outcomes were better, staff were able to get involved in research, and organisations that conduct research generally receive positive reputational benefits.
- Examples of the different types of research and the benefits of research were provided.
- Having a strong evidence base helps in the identification of the most appropriate treatment for patients and in generating new ideas.
- The power of data and artificial intelligence in improving patient outcomes.
- The positive collaborations with Public Health, Newcastle University and Newcastle Hospitals.

[Mrs Stabler left the meeting]

- Data was collected from individual patients to help inform the best treatment.
- Newcastle City Council now has included research within their infrastructure.
- The strength of having Mayo Clinics, with none available in the North.
- Examples were shared in relation to the outcomes of research for example the development of new drugs or therapy, new guidelines and new treatment pathways.

The Chair acknowledged the significant progress that had been made.

Ms Burton highlighted the following points:

- The impact report was shared with the Trust Board which described the impacts of the work carried out across the 12 regions included in the Regional Research Delivery Network (RRDN).
- Newcastle Hospitals was the host organisation for the local RRDN.
- The contract was from April 2024 to March 2029 with an annual value of circa £26,000,000 per annum.
- The network was linked to the Integrated Care System, the Health Innovation Network, the Applied Research Collaborative and the Research Support Service (service across secondary, primary, community and residential health and care providers).
- The vision was for the UK to be a global leader in the delivery of high quality, commercial and non-commercial research that is inclusive, accessible and improvements health and care. If successful, any patient would have access to a research opportunity.

- The Local Clinical Research Network (LCRN) North East North Cumbria (NENC) transitioned to the RRDN NENC and the national mandated structure released in February 2024. The transition process overall had been successful, with key decisions outlined. Engagement with the Trust Human Resources (HR) staff and the DCDI's team was noted to have been helpful during the transition period.
- As of 17 January 2025, most management team positions were filled. A small number of vacancies exist in the workforce and people team.
- The importance of thinking about opportunities, working in collaboration and delivering better outcomes.

Mrs Bromley sought clarification with regards to role of the Alliance in relation to research and how Newcastle Hospitals Trust Board can support the research agenda. Ms Burton explained that the Alliance would be helpful in driving the research agenda and many research collaborations were in place. The initial focus had been on ensuring national synergy.

Mr MacLeod queried the staff engagement arrangements and the strategy for research. Professor Isaacs advised that there was a research strategy in place and the team encourage staff to be involved in research. In addition commercial research can generate additional funding. There was a finance exercise taking place with nurses and doctors carrying out Doctor of Philosophy's (PhD) to analyse the income generated and associated expenditure.

The DCDI thanked Professor Isaacs and Ms Burton for their work and expressed her gratitude to Wendy Johnson from the Trust HR team for her support during the transition to the RRDN NENC.

Mr Kane queried how easy it was to enter into research activity to which Professor Isaacs explained that seed funding was available to help individuals and the National Institute for Health and Care Research (NIHR) receive capital funding for research. He highlighted the importance of awareness and research being part of staff roles.

Mr Kane sought clarification with regards to if the network has to be hosted to which Ms Burton advised that it was a requirement that the network be hosted by an NHS Trust.

Mr Weatherburn explained that the Corporate Induction for new staff does include information in relation to research.

The Chair noted the importance of outcomes for staff and patients and the connection between the Trust, Newcastle University and the network.

The DCDI highlighted the importance of increasing the visibility of ongoing research activities, through regular presentations to the Board, and that support was given to positively embed research as part of everyone's role and an option for care. It was agreed that the governance and reporting would be discussed separately outside of the meeting **[ACTION02]**.

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

[JI left the meeting at 11:23].

25/03 ITEMS TO RECEIVE

i) Director reports:

a. Joint Medical Directors (JMD) Report; including:

The JMD-W highlighted the following points:

- The ongoing quality and safety work with regards to the Patient Safety Incident Response Framework (PSIRF) which had now been functional within Newcastle Hospitals for one year.
- The Trust planned to implement 'Call for Concern' Martha's Rule across adult wards on 17 February 2025 which aims to complement the existing deteriorating patients detection and response systems. The implementation would be supported by a small team over six months which it was hoped would be funded with national pilot funding however this was not yet secured.
- Urgent and Emergency care remained a challenge throughout Winter. Work was taking place with regards to the new Urgent Treatment Centre (UTC) and the front door frailty service.
- Key achievements for postgraduate Medical Education and undergraduate Medical Education for September 2024 were detailed within the report.
- In relation to job planning, work was ongoing with Dr C Dipper, Associate Medical Director and the Local Negotiation Committee (LNC) regarding guidance and processes for Medical and Dental staff. A Job Planning Oversight Group had been established to monitor progress, assess risks to implementation and identify areas for escalation. The implications were detailed within the report and it was noted that the work will help clarify capacity for Medical and Dental staff.

The Chair highlighted that discussions had taken place with regards to job planning at both the Quality Committee and People Committee.

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

i) Guardian of Safe Working (GoSW) Report

The JMD-W advised that the GoSW report had been shared for the Trust Boards information.

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

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

The EDN highlighted the following points:

- Information was included with regards to the Accrediting Excellence (ACE) Programme and it was agreed that the website link would be shared with Trust Board members **[ACTION03]**.
- Several wards had required support at medium or high level due to the increase in patients since the last report to Trust Board. The EDN thanked all staff for helping during this difficult Winter period. Two wards had required high-level support with one being de-escalated from high to medium level support in December 2024 which was highlighted at the Quality Committee.
- Uptake of both Flu and Covid vaccinations was lower at this point when compared with previous years. Although uptake was low the Trust numbers compared favourably against both regional and national data which was testament to the hard work of staff.

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

c. Maternity

i) Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report

The DoM highlighted the following points:

- The 2024 CQC Maternity Survey results had been published. The service was co-producing an improvement plan with the Maternity and Neonatal Voices Partnership (MNVP) Lead, which would be overseen by the Perinatal Engagement and Inclusion Group. The lowest scores were in relation to choice in place of birth and the ability for partners to remain present for as long as possible.
- The Newcastle Birthing Centre services had now been reinstated and the impact of this would be measured in future surveys.
- The Trust triggered a safety signal from the North East North Cumbria clinical indicator dashboard which had resulted in a joint review of this safety signal with South Tyneside and Sunderland NHS Foundation Trust who had also triggered a safety signal.
- In relation to the Maternity Incentive Scheme, challenges with the obstetric medical workforce continued and safety action 8 had not been achieved as a consequence of this.

The Chair sought clarification with regards to how confident the DoM was to achieve the 100% compliance in the future to which the DoM advised that she was confident 100% could be achieved next year.

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

ii) Midwifery Staffing Report

The DoM highlighted the following points:

- There had been a reduction in activity however an increase in complexity with regards to case mix and the team continued to closely monitor choice metrics.

- The staffing review recommended a correction in skill mix and to ensure the roles were fully embedded within the teams. This included consideration with regards to clinical leadership and senior leadership capacity.
- In the Newcastle Birthing Centre 36 babies were born in December 2024 and 38 in January.
- The service was compliant with the provision of one-to-one care in labour and the labour ward co-ordinator being supernumerary.
- Phase 2 of the staffing transformation programme was planned in April 2025 which was currently on track.
- Phase 3 of the staffing transformation programme required additional midwifery posts and this was planned in October 2025.

The Chair noted that he fully supported the need to increase the number of midwifery posts. Mrs Bromley added her support and highlighted the positive shift with regards to data, cultural change, quality improvement and patient safety. She highlighted that this was evidence of progression when the Trust Board supports change.

The Trust Board supported, in principle, the additional midwifery posts required to achieve Birthrate Plus funded establishment, required for Maternity Incentive Scheme Safety Action 5 compliance.

It was **resolved**: to **receive** the report and **approve** in principle the additional midwifery posts required as outlined within the report.

d. Director of Quality & Safety; including:

i) Mortality/Learning from Deaths

The DQS noted that the format of the Mortality/Learning from Deaths paper had been updated and advised that the Quality Committee had discussed the content in detail at the last Committee meeting.

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

ii) Committee Chair Meeting Logs

The Trust Board received the Committee Chair Meeting Logs for information.

In relation to the Finance and Performance Committee, Mr MacLeod highlighted the challenges with regards to financial planning.

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

25/04 ITEMS TO APPROVE:

i) Board Assurance Framework (BAF) 2024/25

The DCEO advised that the BAF has been ratified at the previous Audit, Risk and Assurance Committee (ARAC) meeting and the Trust Board were asked to approve.

Mr Weatherburn advised that the BAF remained a live and actively discussed document at the ARAC. The DCEO noted that the BAF was strategic framework which included risks to the Trusts strategic objectives. It was not anticipated that there would be significant changes to the BAF from one report to the next however a great deal of work had been carried out to develop the document.

The DCEO explained that one assurance rating had changed from amber to green relating to failure to improve maternity services.

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

25/05 ANY OTHER BUSINESS:

i) Meeting Action Log

The action log was received, and the content noted.

In relation to action 132 *[financial figures and benchmarking against other organisations for the Maternity Incentive Scheme progress report]* - the DoM advised that she would continue to try and obtain the required information from finance colleagues.

ii) Any other business

There was no any other business discussed.

The meeting closed at 11:44.

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

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Agenda item A3

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025					
Title	Chair's Report					
Report of	Sir Paul Ennals, Interim Shared Chair					
Prepared by	Sir Paul Ennals, Interim Shared Chair Victoria Champion, 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 January, including: • 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.					

CHAIRS REPORT

I am now into my eight month with the Trust, during which time I have continued to visit various departments, meet with system partners, attend the full range of Board Committees, Governor workshops and a Board Development Session facilitated by thevaluecircle (TVC).

In recent weeks we have heard the announcement from Government as to the abolition of NHS England which will transition into the Department of Health and Social Care. Sir Jim Mackey will lead the organisation's transition and I would like to take this opportunity to thank Jim for the work he has done to transform Newcastle Hospitals since his appointment in January 2024 as Chief Executive, and to wish him well in his new interim role. He will be coming back, though!

I would also like to welcome Mr Rob Harrison as our new Acting Chief Executive and previous Deputy Chief Executive who I am sure will continue the good work. I am most grateful to the whole Executive Team who have really stepped up to the challenge, and are providing excellent support to Rob.

Very pleased also with how our new Non-Executive Directors (NEDs) and Associate NED – Wendy Balmain, Hassan Kajee and Nini Adetuberu have settled into the flow of the work of the Board.

INFORMAL VISITS

I particularly enjoyed my night visit at the Royal Victoria Infirmary (RVI) on the 13 February 2025, where I met staff from different wards. It was illuminating to speak and engage with staff and patients from these wards and to get their feedback.

Earlier this month I spent time at the Community Diagnostic Centre in the Metrocentre which offers patients a range of scans and tests outside the main hospital settings. Services at the centre are provided by Newcastle Hospitals and Gateshead Health NHS Foundation Trust (GHFT) which is another example of our collaborative working.

I was pleased this month to introduce our People at Heart Awards event. The awards celebrate staff and volunteers that make us proud. A big congratulations to all our award winners.

Pleased, also, to introduce our charity's inspiring event on 19 March, promoting the work that the charity has been funding at the Great North Children's Hospital. Good attendance from governors, staff and many others.

ACTIVITY WITH GOVERNORS

I continue to work collectively with our Council of Governors both formally and informally and during this period we held a Governor Workshop in February where in addition to the workshop topics discussed we received an update on the activity of the recent Nominations Committee meeting including consideration of the re-appointment of Mrs Liz Bromley, NED

(and Interim Vice Chair). I am delighted that Governors have approved Liz's re-appointment and look forward in continuing to work with her.

We have also had some changes within the Council of Governors including a change in our Lead Governor following the decision of Mrs Pam Yanez to step down from the Lead Governor role in February. I would like to formally thank Pam for all of her work, dedication and commitment whilst serving as Lead Governor and wish her well in her future endeavours once her Governor term ends in May 2025. I am pleased to welcome Mrs Judy Carrick, our new Lead Governor and look forward to working with her.

I continue to find the drop in sessions provide a good opportunity for me to be aware of issues raised by our Governors, as well as offering me the chance to sound out trusted friends on emerging issues. Issues that have been highlighted to me recently include: a request for governor visits to include support services (acted upon); some equality and diversity issues around gender of clinicians (will be considered as part of our wider EDI review); concern about the oversight of corridor care (added to our May Governor meeting agenda), and a request to meet Governors from other Alliance partners (actioned for 8 April). Last week we talked substantially about the national changes and their impact on the Trust (elsewhere on this agenda); communications around the new Call for Concern system; discussion of the staff survey returns and consideration of how staff can contribute to the need for us to increase our productivity.

TRUST BOARD

Our Board development session in February focussed on the key themes emerging from the 'mock' well-led interviews conducted by TVC in preparing for the CQC re-inspection. A really fruitful discussion, with two key new actions emerging – we will be bringing regular reports on Freedom to Speak Up work to the Board, and we are fast tracking our review of Equality, Diversity and Inclusion (EDI), see agenda item A13.

ALLIANCE

The work of the Alliance continues to progress well, with monthly meetings to monitor and review progress on developing our strands of joint working.

In February I attended the Big Conversation on Research and Innovation. There were presentations given from the different parts of the region and a discussion about what we could do better together. An inspiring session, with great promise for the future, where Newcastle's powerful research base is exploring opportunities to expand our reach through working in partnership across our patch.

RELATIONSHIPS WITH SYSTEM PARTNERS

Earlier this month I spent time at North East Ambulance Service (NEAS) NHS Foundation Trust Emergency Operations Centre, in the company of Stuart Corbridge, NEAS Chair, and Chris Dawson, Deputy Chief Operating Officer for Operations Management. This followed a visit that Stuart undertook to the RVI. We are starting some Alliance-wide discussions about

how we can move the work of the ambulance service more “upstream”; how we can assist paramedics to make more effective medical assessments on site, or on the call, and how we can reduce inappropriate attendances at the Accident and Emergency (A&E) Department if there are high quality alternative services available for some patients.

ENGAGEMENT WITH REGIONAL PARTNERS

I attended a systemwide event together with several Non-Executive colleagues on 24 February 2025, where we met NEDs from across the ICB. As well as encouraging dialogue and interchange, we were brought up to date with developments from the Chair and CEO of the ICB, with additional presentations on the “three shifts” and what they might mean for our patch.

I have continued to contribute to various groups within the North East Combined Authority. The Net Zero Board gives us a great opportunity to identify areas of collaboration between the NHS and colleagues in local government and business. The Rural, Environmental and Coastal Advisory Group provides a platform for considering how we can play into improving the quality of healthcare available in rural settings across our wider patch. And the North East Child Poverty Commission enables us to ensure that we are fully sighted on the implications of child poverty for the health and wellbeing of children in our area.

SHARED CHAIR OPPORTUNITIES

Recruitment to a permanent Shared Chair for Newcastle Hospitals NHS Foundation Trust, Northumbria Healthcare NHS Foundation Trust and GHFT has commenced, with the role being out to advert.

RECOMMENDATION

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

Report of Sir Paul Ennals
Interim Shared Chair
19 March 2025

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Agenda item A5

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025					
Title	Patient and Staff Stories					
Report of	Annie Laverty – Chief Experience Officer					
Prepared by	Annie Laverty – Chief Experience Officer					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	In the month that our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data is published, our stories this month are themed around Equality, Diversity and Inclusion (EDI). The experience of a person who faces emergency surgery and must rapidly adjust, physically and emotionally, to life with a stoma. Our staff story, captured on International Woman's Day, outlines the reflections of Lee Ann Naidoo, the new Chair of our Race Equality Network (REN). **Patient story:** After a 25-year struggle with Crohn's Disease, JS had no option but to have emergency ileostomy surgery. A series of severe flare-ups and life-threatening complications culminated in a hospital visit that would see 90% of his bowel removed. JS describes this period as some of the darkest moments of his life. Post-surgery, his mental health deteriorated as he battled infection, depression, and the prospect of life as an inactive father. His reflections provide invaluable learning for clinical teams. **Staff story:** Lee Ann describes the reasons she stepped forward to become the new REN Chair, why this work is so important and what's giving her hope for the future.						
Recommendation	The Board are asked to receive both stories for information and note our commitment to Equality, Diversity and Inclusion.					
Links to Strategic Objectives						
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 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've had Crohn's Disease for roughly 27 years now. During this time, I've had to learn to live with constant fatigue, crippling abdominal pain, numerous surgical procedures, and pretty much every prescriptible drug you can imagine. To say it's been difficult would be an understatement.

My health took a turn for the worst at the age of 34; at this point I was taking a combination of biological drugs (that suppressed my immune system) and a heavy dose of steroids. Naturally, I knew I was quickly running out of treatment options and that a stoma was looking likely. I just didn't realise that it was going to happen so soon.

Perhaps the toughest mental challenge for me during this period was dealing with workmates who perceived me as lazy, and who thought that I was taking time away from my job for no reason. These experiences have taught me that you should never push yourself to the breaking point for fear of how others may perceive you; you can't change their opinion, so you should focus energy on yourself.

In September 2024, my body had finally given up. What I thought was going to be a routine trip to the hospital, turned out to be one of the most traumatic experiences of my life. My body had rejected my bowel, and it just wouldn't wake up. In turn, the surgical team told me that the only option was to remove 90% of my large intestine and have a permanent ileostomy.

As you might imagine, this news tipped my mental state over the edge. I was terrified and fragile. I believe I would have benefitted from far more support and reassurance from staff, particularly during the early days on the ward. I didn't know what to expect from my new body. I was also scared that I wasn't asking the right questions – and even more frustrating, that I didn't know what these questions were!

In an ideal world, I would have been prepared for surgery and had plenty of time to withdraw from all the biological drugs I was taking. But the situation was too severe not to act immediately, and I was left with an already weak body trying to recover from a serious surgery. For much of my time in hospital, I couldn't move from my bed; I was continually fighting infection while unable to take in any food or drink.

This was the darkest moment of my life, both physically and mentally. At my lowest point, I would acquiesce at the prospect of tomorrow never arriving. Not just for me, but for my close family too. I couldn't imagine what I was putting them through. I regularly pondered being a disabled person, laid inert in a bed for the rest of my life, merely being a burden to my wife and children. All this was too much to take in.

I received amazing support from my family during those days in hospital - I really appreciated a loved one being able to stay later than the allotted visiting hours. My wife was juggling her life, a job, and three children at the same time as caring for me, while my sister would spend long hours by my side in a hard hospital chair. My parents also showed me the most incredible encouragement. With their help, I started to believe in my future. I can say

with retrospect that if it wasn't for the love and guidance of my family, I think the outcome would have been very different.

During this period, I also took the hard decision not to let my 9-year-old daughter see me in hospital. It was one of the hardest decisions I've ever made, and it severely impaired my mental health. My wife would bring my nine-week-old boy into the hospital, which certainly helped to lift me, but it would also cement my concerns that maybe I would be this ill forever – unable to be the supportive, fun, active dad that I always dreamed of being. I was so unwell and mentally exhausted that I seemed to turn everything into a negative.

For anyone who is starting their ostomy journey, I'd say don't be too hard on yourself. It's okay to be angry, upset, or embarrassed. These tough new life lessons may make you hate your stoma, but they'll give you the tools to make tomorrow more manageable. Living with an ostomy is very much like learning to ride a bike; you must stumble a bit and make a few mistakes to go forward.

If I had a key point of learning for clinical teams, I would remind them that what we don't understand often creates false scenarios in our minds. Give us quality information, help us to navigate the uncertainty we're thrown into. Patients have so much time to ruminate whilst immobile on the ward. These thoughts go on to shape our reality, thus causing unnecessary depression and mental struggles. It's not until we play the game for real that we realise it's not all endless negativity. I didn't realise this until after my surgery.

STAFF STORY

Taking on the role of Chair of the Race Equality Network wasn't something I took lightly. I stepped into it after shadowing Odeth, the previous Network Chair — someone I deeply admire for her strength, wisdom, and resilience. I watched her carry a heavy load as the point of reference for all things related to race across the organisation.

I also saw how that responsibility wore her down. I watched how she felt defeated and exhausted, trying repeatedly to create change in a system that didn't always seem ready to listen. She gave her all, but the burden wasn't one persons to carry—and yet she did, with grace. So, when I stepped into her shoes, I didn't just inherit a title. I inherited the weight. And I felt it.

The landscape wasn't easy. There was a collective feeling of being let down—a lack of trust in whether things would ever truly change. That hill felt steep. But I was determined not to let any of that discourage me.

With change in leadership, I saw an opportunity. I had to believe that something different was possible. But I also knew belief wasn't as a driver of change, not just a voice on the sidelines. Enough—we needed strategy. The Race Equality Network had to move from being reactive to being part of the Trust's wider vision. It needed to be recognised. Our members matter. Their voices matter. And the people we serve especially those from the global majority in our communities deserve to be seen, heard, and understood. Right now, many aren't. And that must change.

And now, for the first time in a long time, I can feel change in the air. There is a shift—a willingness to listen, to engage, and to act. That feeling fuels me. It reminds me why I wanted to take on the role and stay in the organisation. I am determined to be part of the solution and to finally use the voice of the network in the way it was always meant to be used— not just as a support system, but as a force for real, lasting change. This work is hard. It is often unpaid. It happens in the margins of our days and the late hours of our nights. But I show up, because if I don't, I cannot expect change to just happen. I have to be part of the solution.

What gives me hope? Seeing leaders who don't support us in words but who actively listen, act and hold themselves accountable. When leadership leans in change will always follow. Seeing people from underrepresented groups step into leadership roles or be seen for their impact as this provides evidence that we belong at every level of the organisation. A hope that anti-racism is just written down as a strategy but is a lived practice and commitment. When it starts shaping our recruitment, our disciplinary processes and day to day behaviours. When people that have been let down and stopped engaging, start to return to conversations because they believe change might actually happen this time. When we are brought into conversations, early, to co-produce and not after the decisions have been made. Small changes in conversations, whether it's someone saying, 'I never thought of it that way', a new voice at the table, all of these things bring me hope.

My commitment is to keep showing up, to keep pushing, and to never lose sight of the people this work is for. Because they deserve more—and so do we.

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Agenda item A6(i)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Public Trust Board of Directors

Patient Experience – right time results

Annie Laverty

Chief Experience Officer

28th March 2025

Healthcare at its best with people at our heart

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Patient Experience Real Time Programme

Healthcare at its best
with people at our heart

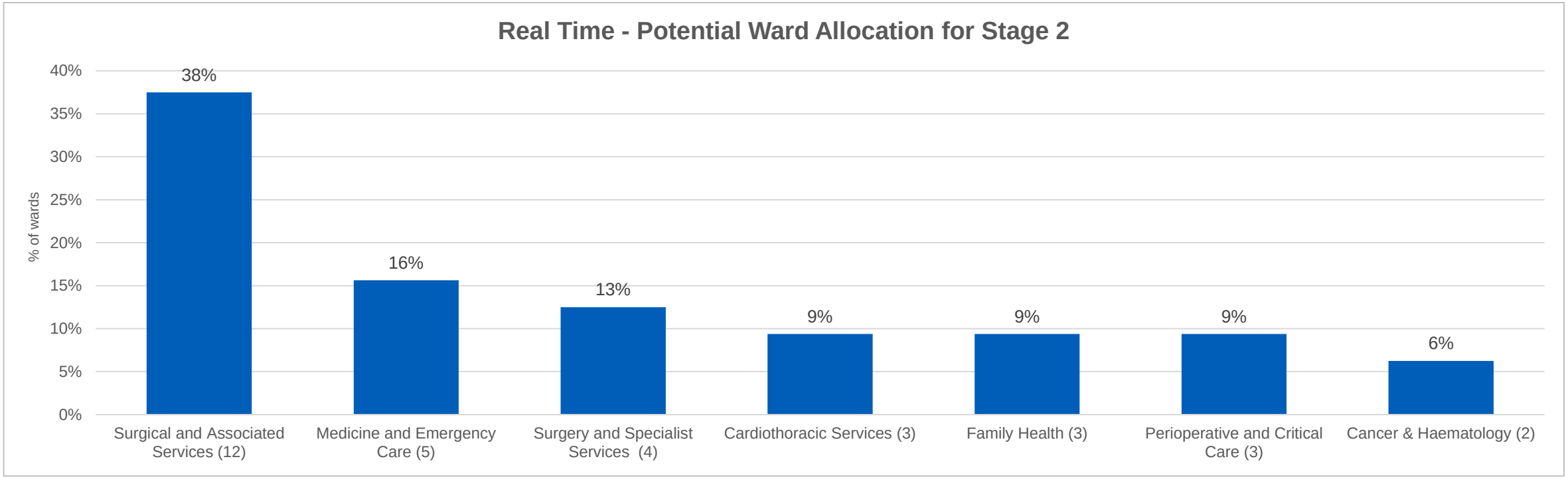
Real time programme

- Successful pilot
- 5.8 w.t.e. (whole time equivalent) feedback facilitators recruited
- Roll out plan : original 14 wards + 26 new wards
- Transparency of reporting through new patient and staff experience intranet page

An Update on the Real Time Programme

The Newcastle upon Tyne Hospitals NHS Foundation Trust

We've reached out to each of the Clinical Boards to find out which wards they would like us to prioritise for stage 2 of the programme. The table below shows the current distribution of wards split by Clinical Board:



NHS
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NHS Foundation Trust

Patient Experience Right Time Programme

Healthcare at its best
with people at our heart

The Right Time Journey

- Right time measurement has come a long way since its introduction to Newcastle Hospitals in September 2024.
- We've received feedback from just under 70,000 patients since the start of the programme, providing us with a great insight on the quality of care we deliver across inpatient, outpatient, day-case, emergency care, maternity and community services.
- We've recently adapted our inpatient and emergency care surveys to replicate exactly what's asked in their respective national surveys – allowing us to better forecast and benchmark results at a national level.
- Summary reports have been shared with Clinical Board leads and executives each month. We plan to split the results by ward and specialty at Clinical Board level going forward to ensure Clinical Boards are getting the most out of their patient experience data.
- Right time results will also be hosted on the new patient experience intranet page, along with the real time results, for any member of staff to access.

A Summary of our Right Time Data

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Overall results are good and include feedback received from a total of 68,438 patients:

Service	Returns	Overall Score	National Position
Inpatients	7,225	**80** out of **100**	**Top 20% Position**
Outpatients	45,045	**89** out of **100**	**Top 20% Position**
Day-Case	7,953	**91** out of **100**	**No National Benchmark Data**
Maternity	684	**85** out of **100**	**Top 20% Position**
Emergency Department	7,531	**75** out of **100**	**Top 60% Position**

Key Messages

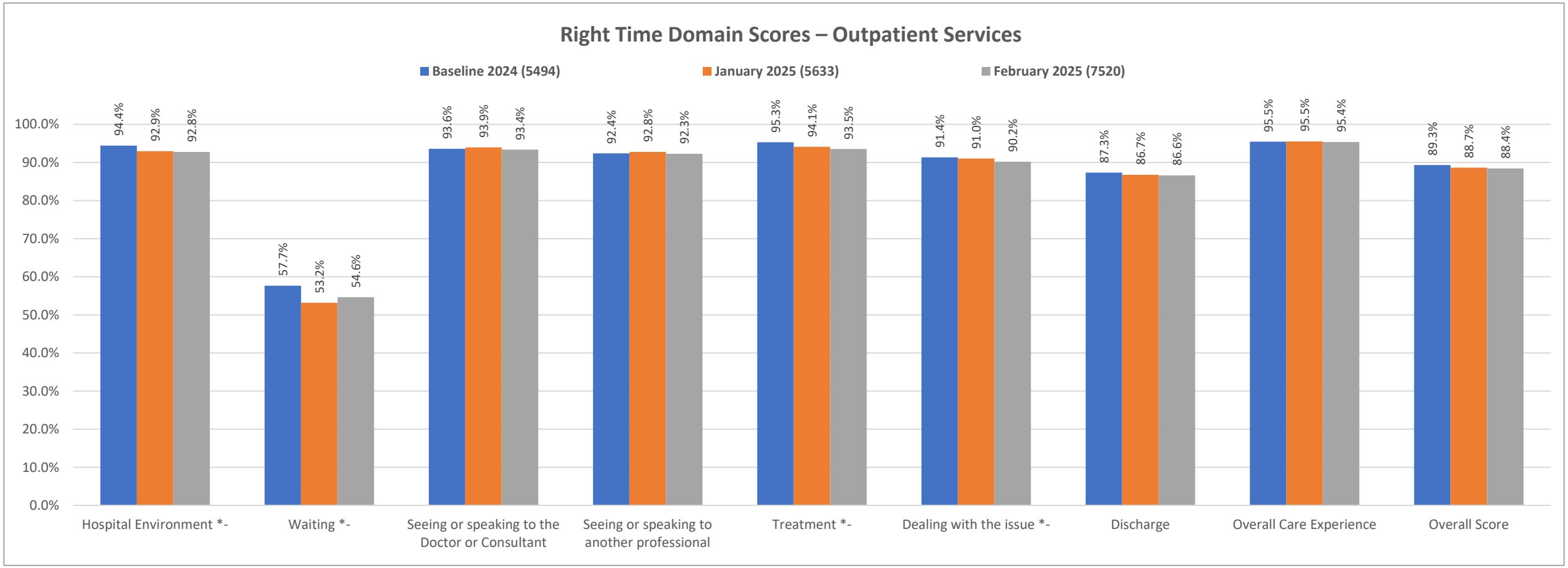
There is a very consistent message about the quality of care from thousands of patients…

What our patients would like us to improve:

- **Outpatients:** The one area for improvement remains in information to patients about the length of waiting time and the reason for the wait
- **Emergency Care:** Privacy at reception • Feeling safe around other patients • Getting food and drinks • Discussing whether further health or social care may be required
- **Inpatients:** Sleep prevented due to room temperature • Hospital food • Patients having enough to drink during their stay in hospital
- **Maternity:** Asking women about their mental health • Elements of postnatal care in hospital • Postnatal follow-up

Right Time – Outpatients

The Newcastle upon Tyne Hospitals NHS Foundation Trust



Significant Variation: Baseline 2024 vs February 2025: (*+) POSITIVE or (*-) NEGATAVE [95% confidence]

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Friends and Family Test

Healthcare at its best
with people at our heart

Friends & Family Test (FFT)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

In February 2025 we received 11,179 responses for the Friends & Family Test:

- **95%** of 2770 **inpatient / day case** respondents rated their care as either **good** or **very good**
- **96%** of 7105 **outpatient** respondents rated their care as either **good** or **very good**
- **84%** of 236 **maternity services** respondents rated their care as either **good** or **very good**
- **78%** of 1044 **emergency care** respondents rated their care as either **good** or **very good**
- **100%** of 24 **health visiting service** respondents rated their care as either **good** or **very good**

Since the introduction of the Right Time Programme, FFT responses have increased by over 500% (calculated over a rolling 6-month period)

Additional Survey Work

Additional Survey Work – a learning organisation

The Newcastle upon Tyne Hospitals NHS Foundation Trust

It's encouraging to see that we're now being approached by a number of teams that are interested in learning about the specific needs of their own patients, current examples include:

- **Dietetics:** Adult Weight Management Survey, Prehabilitation Survey
- **Pharmacy:** Pharmacy Appointment Feedback Survey
- **Cardiology and Cardiothoracics:** Cardiothoracic Surgery (Adults & Children) Surveys
- **Rheumatology:** Outpatient Prescriptions for Disease Modifying Drugs Survey
- **Physiotherapy Services:** Home Exercise Programme Survey, Motor Neurone Disease Patient Survey
- **Psychology Service:** Cardiothoracic Transplant Unit Survey, Evaluation of the Food Challenge Service
- **Maternity:** Home Monitoring Programme for Vulnerable Babies Survey
- **Urology:** Urodynamics Patient Feedback Survey
- **Emergency Department:** Paediatric Emergency Department (ED) Survey

Improvement priorities

- Emergency care – real time monitoring with improved waiting experience
- Maternity: Community engagement and inclusion
- Support for ward accreditation programme with roll out of real time measurement on 40 wards
- Understanding the experience of bereaved relatives
- Capturing the patient experience of those waiting for elective care: end to end improvement in orthopaedics
- Working with Newcastle Carers to understand the carer experience of an inpatient stay
- Secure HIV Confident accreditation for our hospitals
- For Clinical Board accountability: triangulated patient experience, patient safety and performance data to report through Quality Performance Review (QPR) process

Thank you…

Any questions?

National Staff Survey Results 2024

Public Trust Board of Directors

28th March 2025

Donna Watson and Annie Laverty

2023 NHS Staff Survey Overview

The Newcastle upon Tyne Hospitals NHS Foundation Trust

- The data shared in this presentation is aligned to the sector average of Acute and Acute Community Trusts national Staff Survey 2024 data.
- The NHS Staff Survey is aligned to the 7 NHS **People Promises** and 2 main themes of **Staff Engagement and Morale.**
- There are **108 questions :** Background info (1) People in your organisation (4) Health, wellbeing and safety (43) Your Job (23), Your managers (9), Your organisation (9), Personal development (10) and your Team (9)

NHS staff survey responses since 2021

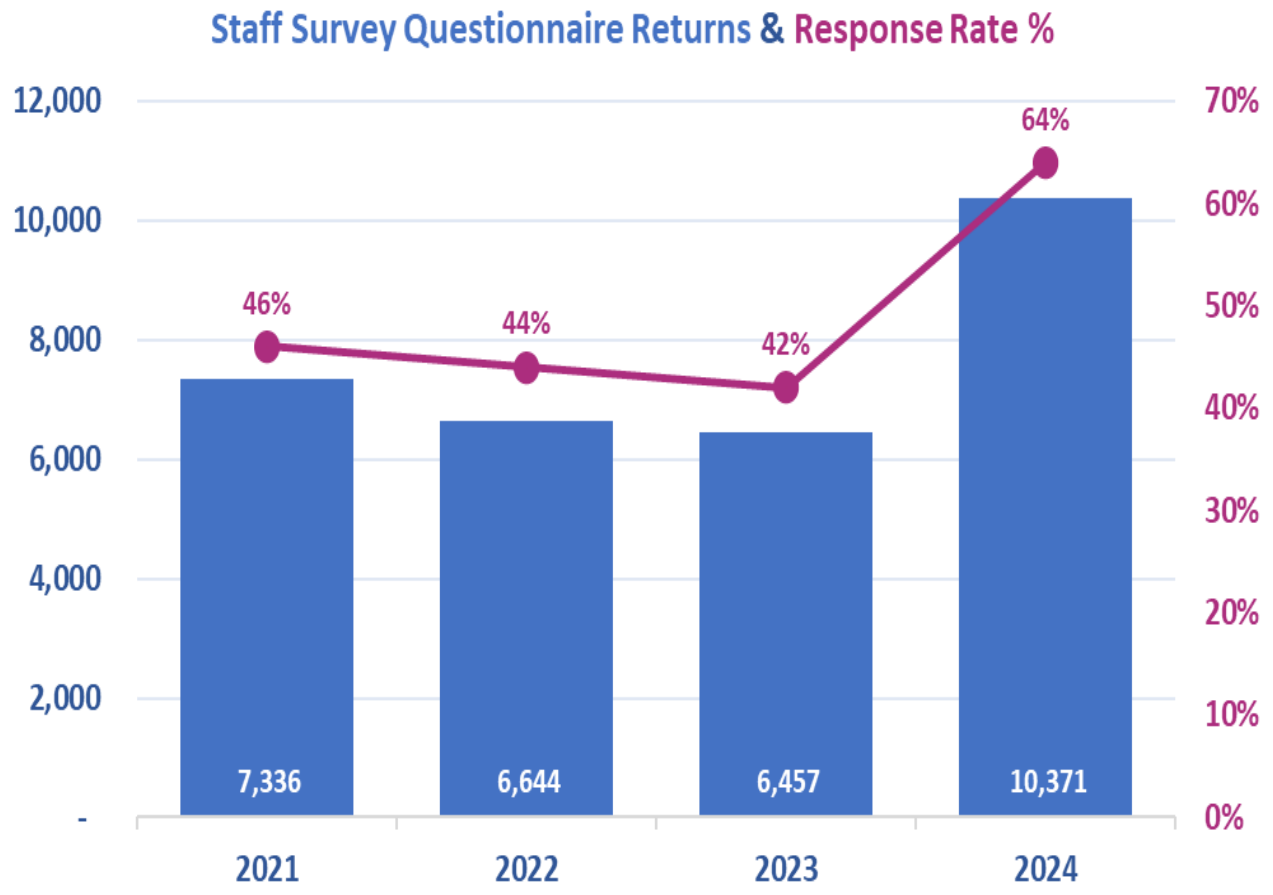
The Newcastle upon Tyne Hospitals NHS Foundation Trust

The Trust experienced a declining response rate from 2021 to 2023 but then saw a significant increase in 2024. In 2024 the response rate increased to **64%.**

In 2024, the Trust received **10,371** responses, up from 6,457 in 2023 - a 60.62% improvement. The number of paper-based responses also increased substantially, doubling from 307 in 2023 to 613 in 2024 (99.67% improvement).

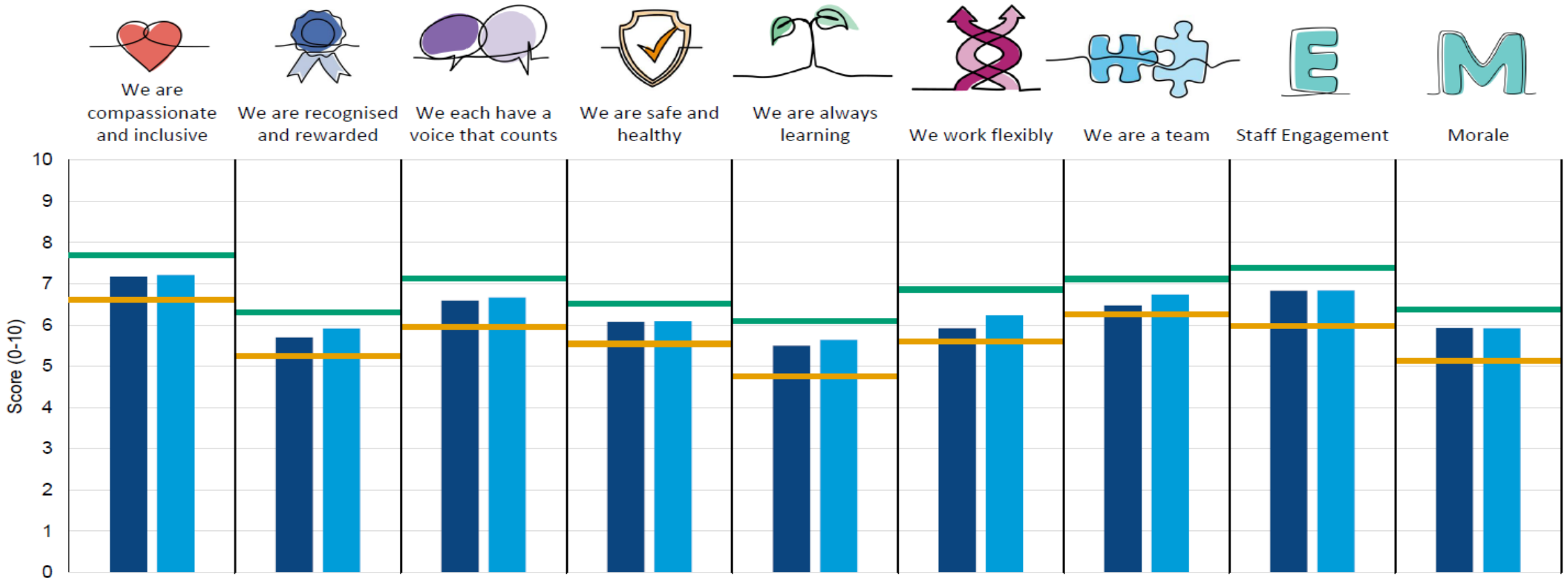
2024 Trust and Benchmarking Sector Response Rates

Year	Trust Response %	Average National Sector Response %	Highest Response %
2021	46%	46%	80%
2022	44%	44%	69%
2023	42%	45%	69%
2024	64%	49%	71%



People Promise 2024 – Trust

The Newcastle upon Tyne Hospitals NHS Foundation Trust



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.17	5.70	6.59	6.08	5.50	5.93	6.48	6.83	5.93
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	10334	10337	10236	10266	9919	10252	10305	10350	10348

People Promise 2024 – Trust Summary (weighted data)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

All seven People Promise elements are recording higher scores in 2024 compared to 2023, with **two** People Promise sections showing statistically significant improvement, these are: **'We are always learning'** and **We work flexibly'**.

ID	People Promise	2023	2024	*T-test
PP1	We are compassionate and inclusive	7.09	7.17	Same as
PP2	We are recognised and rewarded	5.59	5.70	Same as
PP3	We each have a voice that counts	6.49	6.59	Same as
PP4	We are safe and healthy	5.95	6.08	Same as
PP5	We are always learning	5.32	5.50	Better
PP6	We work flexibly	5.72	5.93	Better
PP7	We are a team	6.34	6.48	Same as

All sections within the Sub-Score elements of the People Promise showed higher scores, with **six** sub-scores showing statistically significant improvement from the 2023 results:

ID	Metric	2023	2024	*T-test
PP1_2	Compassionate leadership	6.46	6.66	Better
PP4_1	Health and safety climate	5.18	5.40	Better
PP5_2	Appraisals	4.37	4.65	Better
PP6_1	Support for work-life balance	5.76	6.01	Better
PP6_2	Flexible working	5.67	5.84	Better
PP7_2	Line management	6.30	6.45	Better

***Same as** – No Statistically Significant change; **Better** – Statistically Significant positive change

Thematic Results - Sub Themes 2023 v 2024

The Newcastle upon Tyne Hospitals NHS Foundation Trust

People Promise	ID	Metric	2023	2024	T-test
We are compassionate and inclusive	**PP1**	**We are compassionate and inclusive**	**7.09**	**7.17**	**Same as**
	PP1_1	Compassionate culture	7.18	**7.26**	Same as
	PP1_2	Compassionate leadership	6.46	**6.66**	Better
	PP1_3	Diversity and equality	8.11	**8.16**	Same as
	PP1_4	Inclusion	6.59	**6.62**	Same as

People Promise	ID	Metric	2023	2024	T-test
We are recognised and rewarded	**PP2**	**We are recognised and rewarded**	**5.59**	**5.70**	**Same as**

People Promise	ID	Metric	2023	2024	T-test
We each have a voice that counts	**PP3**	**We each have a voice that counts**	**6.49**	**6.59**	**Same as**
	PP3_1	Autonomy and control	6.75	**6.82**	Same as
	PP3_2	Raising concerns	6.23	**6.37**	Same as

Thematic Results - Sub Themes 2023 v 2024

People Promise	ID	Metric	2023	2024	T-test
We are safe and healthy	**PP4**	**We are safe and healthy**	**5.95**	**6.08**	**Same as**
	PP4_1	Health and safety climate	5.18	**5.40**	Better
	PP4_2	Burnout	4.85	**4.96**	Same as
	PP4_3	Negative experiences	7.82	**7.87**	Same as

People Promise	ID	Metric	2023	2024	T-test
We are always learning	**PP5**	**We are always learning**	**5.32**	**5.50**	**Better**
	PP5_1	Development	6.25	**6.34**	Same as
	PP5_2	Appraisals	4.37	**4.65**	Better

People Promise	ID	Metric	2023	2024	T-test
We work flexibly	**PP6**	**We work flexibly**	**5.72**	**5.93**	**Better**
	PP6_1	Support for work-life balance	5.76	**6.01**	Better
	PP6_2	Flexible working	5.67	**5.84**	Better

People Promise	ID	Metric	2023	2024	T-test
We are a team	**PP7**	**We are a team**	**6.34**	**6.48**	**Same as**
	PP7_1	Team working	6.39	**6.50**	Same as
	PP7_2	Line management	6.30	**6.45**	Better

People Promise - Clinical Board/Corporate Services Scores

The Newcastle upon Tyne Hospitals NHS Foundation Trust

	Returns	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	People Promise Average Score
Organisation (Trustwide)	10350	7.17	5.70	6.59	6.08	5.50	5.93	6.48	**6.21**

Clinical Board/Corporate Service	Returns	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	People Promise Average Score
Hosted Staff	25	7.22	6.16	6.48	6.31	5.08	6.05	6.45	**6.25**
Business & Development	34	7.59	6.38	6.50	6.70	5.65	7.32	7.29	**6.78**
Supplies	64	6.99	5.31	6.45	6.36	4.86	6.70	6.20	**6.12**
Regional Drugs & Therapeutics	27	8.08	6.76	7.52	7.33	6.03	7.90	7.87	**7.36**
Patient Services	187	7.36	6.31	6.75	6.43	5.99	6.86	7.08	**6.68**
Medical Director	40	6.99	5.99	6.45	6.17	5.25	5.37	6.31	**6.08**
Information Management & Technology	258	7.58	6.24	6.70	6.84	5.87	6.78	7.04	**6.72**
Human Resources	201	7.18	5.86	6.52	6.21	5.14	6.24	6.72	**6.27**
Finance	107	7.79	6.73	7.05	7.07	6.15	7.50	7.41	**7.10**
Estates	836	6.82	5.46	6.31	6.29	4.99	5.75	5.98	**5.94**
Clinical Research Network (NE) North East and North Cumbria (NENC)	55	8.26	7.51	7.61	7.82	6.40	8.83	7.87	**7.76**
Chief Executive	60	7.14	5.90	6.53	6.16	5.27	6.42	6.67	**6.30**
Cancer & Haematology	390	7.17	5.72	6.70	6.04	5.32	5.99	6.35	**6.18**
Cardiothoracic Services	601	6.84	5.21	6.33	5.83	5.16	5.77	6.09	**5.89**
Clinical & Diagnostic Services	2556	7.28	5.90	6.69	6.20	5.50	5.87	6.62	**6.29**
Family Health	1361	7.24	5.64	6.61	5.95	5.52	5.71	6.42	**6.16**
Medicine & Emergency Care	1098	7.14	5.60	6.61	5.69	5.68	5.90	6.43	**6.15**
Peri-Operative & Critical Care	909	6.96	5.26	6.38	5.76	5.43	5.47	6.24	**5.93**
Surgery & Associated Services Freeman Hospital (FH)	680	7.13	5.62	6.67	6.00	5.70	5.82	6.44	**6.20**
Surgery & Specialist Services Royal Victoria Infirmary (RVI)	871	7.11	5.60	6.52	6.14	5.38	5.81	6.37	**6.14**

(+)tive signifance vs Trust | (-)tive signifance vs Trust | No significance vs Trust

People Promise – Staff Engagement

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Team	Headcount	Score
Trauma & Orthopaedics - Ward 23 Major Trauma Centre - RVI	13	**8.78**
Surgical and Associated Services FH Management - Other	11	**8.38**
Urology - Ward 2 Urology - FH	16	**8.28**
Finance - Financial Services Corporate	21	**8.27**
Surgical Services - Ward 45 General Surgery Day Ward - RVI	17	**8.20**
Surgical and Specialist Services RVI Management - Other	11	**8.18**
Therapy Services - Corporate	12	**8.15**
Information Management and Technology - Clinical Coding	51	**8.10**
Patient Services - Workforce	18	**8.04**
Cancer Services/ Clinical Haematology - Ward 33 Clinical Haematology - FH	17	**8.00**
Cardiothoracic Services - Perfusion	10	**7.92**
Outpatients - Outpatient Nursing - RVI & Cresta	23	**7.83**
Day Treatment Centre - Other	62	**7.82**
Children's Services - Ward 8 Paediatric Surgery Day Unit - RVI	13	**7.80**
Institute of Transplant (IOT) - Transplantation - Admin	18	**7.79**
Clinical Research - Infectious Diseases	19	**7.78**
Clinical Research - Clinical Research Facility	18	**7.78**
Children's Services - Paediatric Renal Medicine Specialty - RVI	13	**7.69**
Radiology - Breast	36	**7.68**
Pharmacy - Newcastle Advanced Therapies - RVI	16	**7.67**

Team	Headcount	Score
Estates - Facilities - Domestic Services Victoria Wing RVI	65	**5.96**
Peri-operative & Critical Care - Plastics Theatres - RVI	32	**5.95**
Surgical Services - Ward 8 Vascular Surgery - FH	20	**5.94**
Pharmacy - FH	48	**5.93**
Neurosciences - Neurosurgery Specialty - RVI	22	**5.90**
Cardiothoracic Services - Ward 27	11	**5.88**
Cardiothoracic Services - Ward 30	12	**5.86**
Ear Nose and Throat (ENT) - Outpatient Administration	36	**5.72**
Cardiothoracic Services - Physiology	33	**5.68**
Estates - Facilities - Portering & Security FH	52	**5.68**
Assessment Suite - Assessment Suite - RVI	38	**5.67**
Peri-operative & Critical Care - Anaesthesia Theatres - FH	33	**5.66**
Surgical Services - Ward 6 General Surgery - FH	20	**5.58**
Outpatients - Reception, Bereavement & Medical Examiners Officer (MEO)	23	**5.54**
ENT - Outpatient Nursing	10	**5.53**
Estates - Facilities - Catering FH & Regent Point (RP)	20	**5.41**
Peri-operative & Critical Care - Sterile Services	53	**5.33**
ENT - Audiology	25	**5.12**
Estates - Facilities - Catering FH	10	**5.01**
Information Management and Technology - Switchboard	21	**4.17**

Most improved question scores in 2024

The Newcastle upon Tyne Hospitals NHS Foundation Trust

The 2024 NHS Staff Survey consists of **108** questions, Trust scores are **up in 90 questions**, **down in 16,** with **2 remaining the same** as 2023

Staff survey question.	Difference between 2023 to 2024
• We are given feedback about changes made in response to reported errors, near misses and incidents (Agree/Strongly agree).	**Up 4.32%**
• The last time you experienced physical violence at work, did you or a colleague report it (Yes).	**Up 3.76%**
• I achieve a good balance between my work life and my home life (Agree/Strongly agree).	**Up 3.59%**
• My organisation takes positive action on health and well-being (Agree/Strongly agree).	**Up 3.54%**
• Has your employer made reasonable adjustment(s) to enable you to carry out your work (Yes).	**Up 3.43%**
• I am able to access the right learning and development opportunities when I need to (Agree/Strongly agree).	**Up 3.38%**
• My organisation is committed to helping me balance my work and home life (Agree/Strongly agree).	**Up 3.11%**
• My immediate manager takes effective action to help me with any problems I face (Agree/Strongly agree).	**Up 3.08%**
• I have adequate materials, supplies and equipment to do my work (Agree/Strongly agree).	**Up 3.04%**
• I can approach my immediate manager to talk openly about flexible working (Agree/Strongly agree).	**Up 2.87%**

Top 5 year on year improvements

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Question.	2021	2022	2023	2024	Difference 2023 to 2024
We are given feedback about changes made in response to reported errors, near misses and incidents (Agree/Strongly agree).	0.00%	61.59%	58.93%	63.25%	**4.32%**
The last time you experienced physical violence at work, did you or a colleague report it (Yes).	60.86%	63.67%	61.33%	65.09%	**3.76%**
I achieve a good balance between my work life and my home life (Agree/Strongly agree).	49.88%	49.01%	49.73%	53.32%	**3.59%**
My organisation takes positive action on health and well-being (Agree/Strongly agree).	53.57%	54.14%	47.13%	50.67%	**3.54%**
Has your employer made reasonable adjustment(s) to enable you to carry out your work (Yes).	0.00%	76.45%	72.44%	75.87%	**3.43%**

Questions evidencing year-on-year decline

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Question.	2021	2022	2023	2024	Difference 2023 to 2024
On what grounds have you experienced discrimination? Ethnic background (Yes).	31.43%	34.85%	35.21%	42.64%	7.43%
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public (One or more times).	12.19%	12.52%	10.64%	12.39%	1.75%
In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives or other members of the public (One or more times).	0.00%	0.00%	6.80%	7.71%	0.91%
On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours (More than 0 hours).	34.80%	39.13%	34.21%	34.76%	0.55%
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public (Yes).	5.42%	5.18%	6.10%	6.57%	0.47%

Questions attracting the lowest scores in 2024

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Staff survey question – positively phrased question	2023	2024
• My level of pay (Satisfied/Very satisfied).	30.36%	31.59%
• There are enough staff at this organisation for me to do my job properly (Agree/Strongly agree).	29.12%	31.52%
• The appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) left me feeling that my work is valued by my organisation (Yes, definitely).	27.69%	29.75%
• I have unrealistic time pressures (Never/Rarely).	26.45%	27.71%
• The appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) helped me to improve how I do my job (Yes, definitely).	19.02%	21.50%

Staff survey question – negatively phrased question where a higher score is worse	2023	2024
• In the last three months have you ever come to work despite not feeling well enough to perform your duties (Yes).	56.76%	56.69%
• On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours (More than 0 hours).	54.80%	49.32%
• How often, if at all, do you feel worn out at the end of your working day/shift (Often/Always).	46.69%	44.47%
• During the last 12 months have you felt unwell as a result of work-related stress (Yes).	43.40%	40.16%
• How often, if at all, does your work frustrate you (Often/Always).	40.46%	38.36%

Discrimination & unwanted behaviour 2024

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Staff survey question	2023	2024	Difference
• In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public (Yes).	6.10%	6.57%	↓ 0.47%
• In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues (Yes).	9.17%	8.42%	↑ 0.75%
• On what grounds have you experienced discrimination? Ethnic background (Yes).	35.21%	42.64%	↓ 7.43%
• On what grounds have you experienced discrimination? Gender (Yes).	4.48%	4.56%	↓ 0.08%
• On what grounds have you experienced discrimination? Religion (Yes).	4.48%	4.56%	↓ 0.08%
• On what grounds have you experienced discrimination? Sexual orientation (Yes).	6.14%	5.24%	↑ 0.90%
• On what grounds have you experienced discrimination? Disability (Yes).	12.45%	10.72%	↑ 1.73%
• On what grounds have you experienced discrimination? Age (Yes).	22.12%	18.06%	↑ 4.06%
• On what grounds have you experienced discrimination? Other (Yes).	26.98%	25.32%	↑ -1.66%
• In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users, their relatives or other members of the public (One or more times).	6.80%	7.71%	↓ 0.91%
• In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from staff / colleagues (One or more times).	4.31%	3.93%	↑ -0.38%

Workforce Race Equality Standards (WRES)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

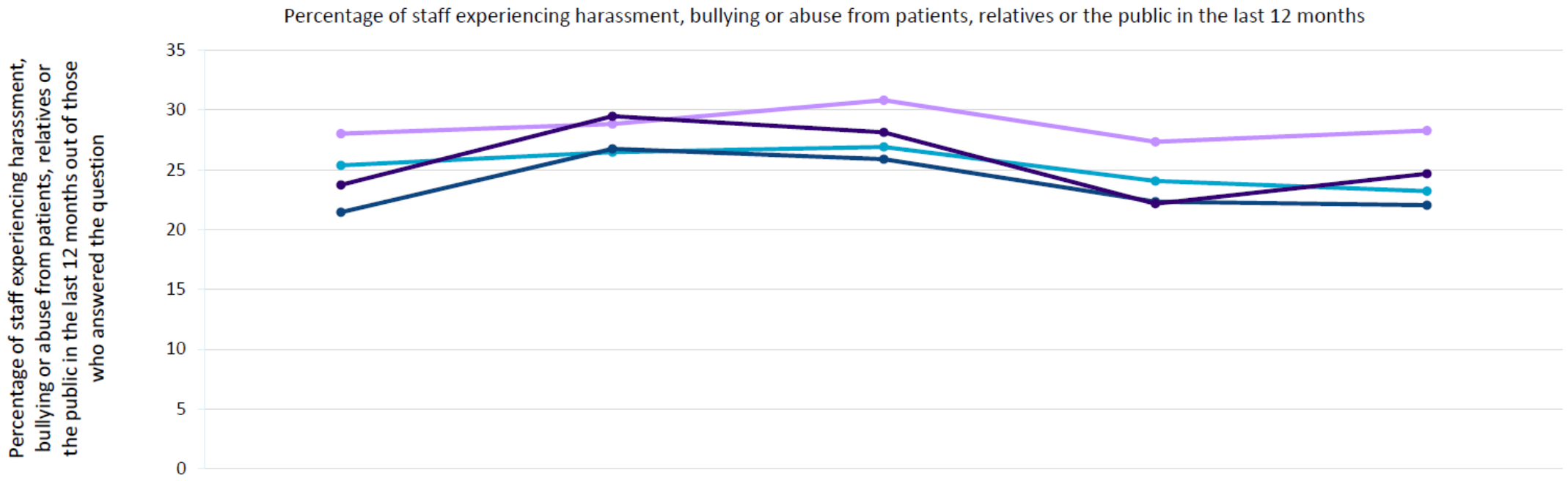
WRES Questions	2023 Trust Result - White	2024 Trust Result - White	Difference – 2023/24	2023 Trust Result - BME	2024 Trust Result - BME	Difference 2023/24
WRES 5 - % of staff experiencing harassment, bullying or abuse from patients / service users, their relatives or the public in the last 12 months.	22.34%	22.03%	-0.31%	22.15%	24.66%	2.51%
WRES 6 - % of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	23.01%	20.95%	-2.06%	32.62%	26.98%	-5.64%
WRES 7 - % of staff believing that there are equal opportunities for career progression / promotion.	57.84%	57.04%	-0.80%	45.45%	47.24%	1.79%
WRES 8 - % of staff who in the last 12 months personally experienced discrimination from any of the following: Manager / team leader or other colleagues.	7.58%	6.31%	-1.27%	21.81%	19.11%	-2.70%

Improved position

Worsened position

BME: Black and Minority Ethnic

WRES - 5



	2020	2021	2022	2023	2024
White staff: Your org	21.44%	26.75%	25.89%	22.34%	22.03%
All other ethnic groups*: Your org	23.73%	29.48%	28.13%	22.15%	24.66%
White staff: Average	25.36%	26.47%	26.91%	24.05%	23.21%
All other ethnic groups*: Average	28.01%	28.84%	30.82%	27.34%	28.27%
White staff: Responses	6432	6646	5948	5677	8639
All other ethnic groups*: Responses	531	597	608	650	1565

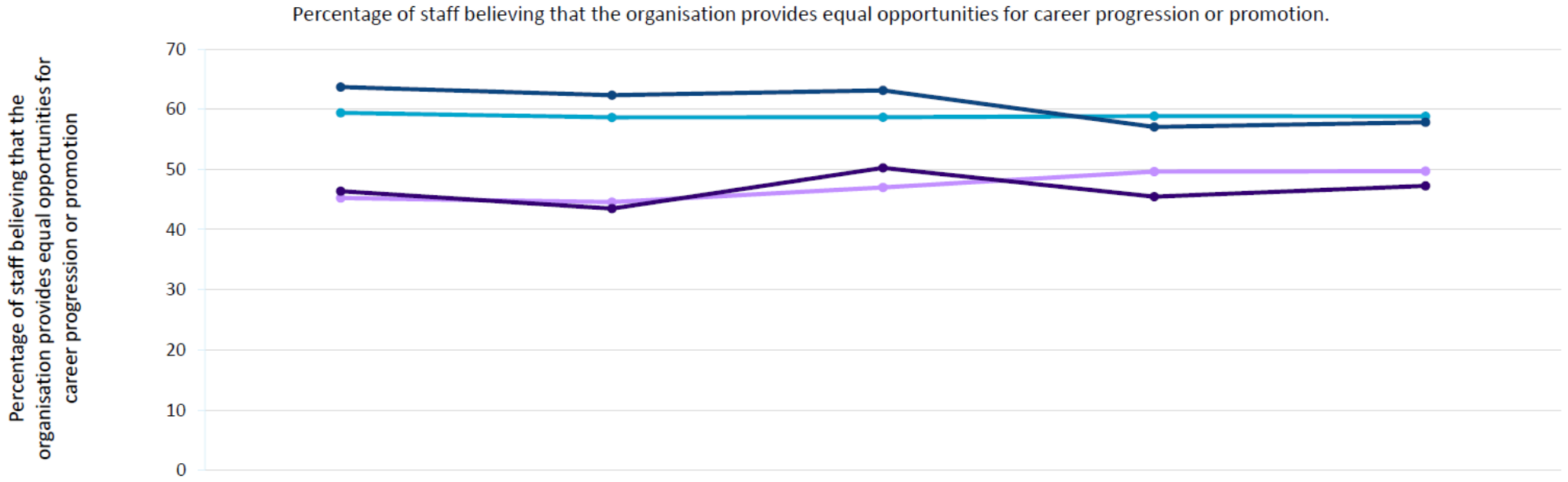
*Staff from all other ethnic groups combined

WRES - 6

	2020	2021	2022	2023	2024
White staff: Your org	20.20%	22.67%	22.15%	23.01%	20.95%
All other ethnic groups*: Your org	31.89%	32.83%	30.33%	32.62%	26.98%
White staff: Average	24.37%	23.65%	23.25%	22.12%	21.53%
All other ethnic groups*: Average	29.07%	28.53%	28.81%	25.16%	24.78%
White staff: Responses	6442	6664	5956	5677	8635
All other ethnic groups*: Responses	533	597	610	653	1564

*Staff from all other ethnic groups combined

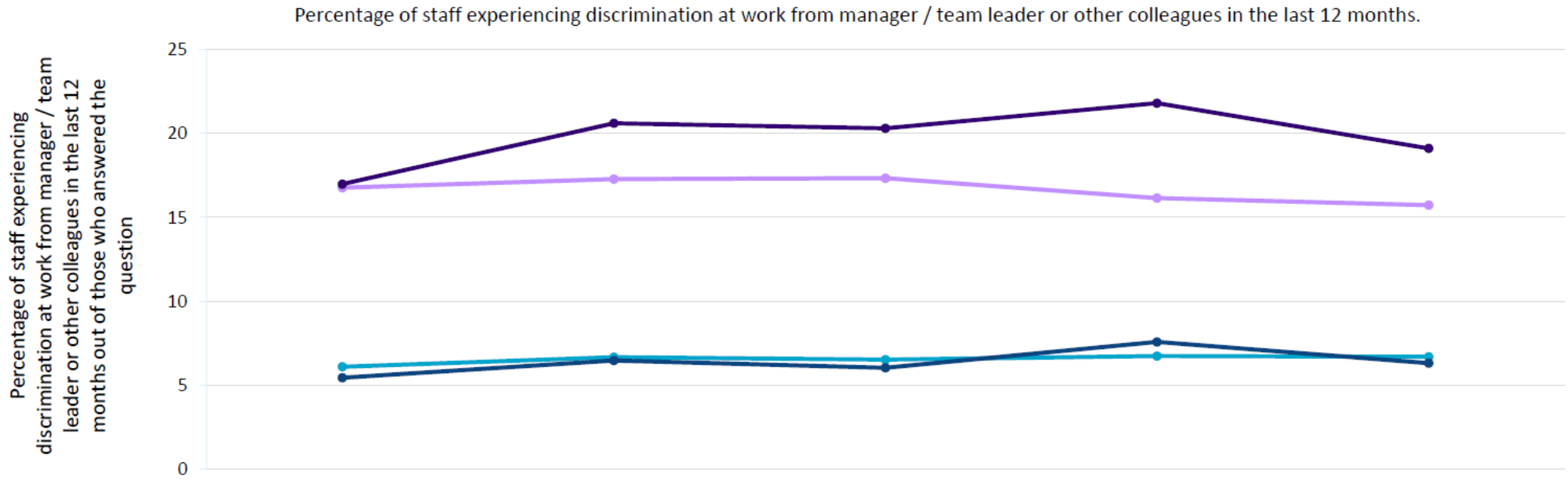
WRES - 7



	2020	2021	2022	2023	2024
White staff: Your org	63.68%	62.33%	63.12%	57.04%	57.84%
All other ethnic groups*: Your org	46.37%	43.48%	50.25%	45.45%	47.24%
White staff: Average	59.39%	58.64%	58.65%	58.84%	58.82%
All other ethnic groups*: Average	45.24%	44.56%	47.00%	49.64%	49.70%
White staff: Responses	6431	6652	5952	5652	8581
All other ethnic groups*: Responses	537	598	609	649	1556

*Staff from all other ethnic groups combined

WRES



	2020	2021	2022	2023	2024
White staff: Your org	5.44%	6.46%	6.03%	7.58%	6.31%
All other ethnic groups*: Your org	16.98%	20.61%	20.30%	21.81%	19.11%
White staff: Average	6.09%	6.67%	6.52%	6.73%	6.69%
All other ethnic groups*: Average	16.77%	17.28%	17.33%	16.14%	15.72%
White staff: Responses	6380	6640	5923	5663	8588
All other ethnic groups*: Responses	530	592	606	642	1544

*Staff from all other ethnic groups combined

Workforce Disability Equality Standards (WDES)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

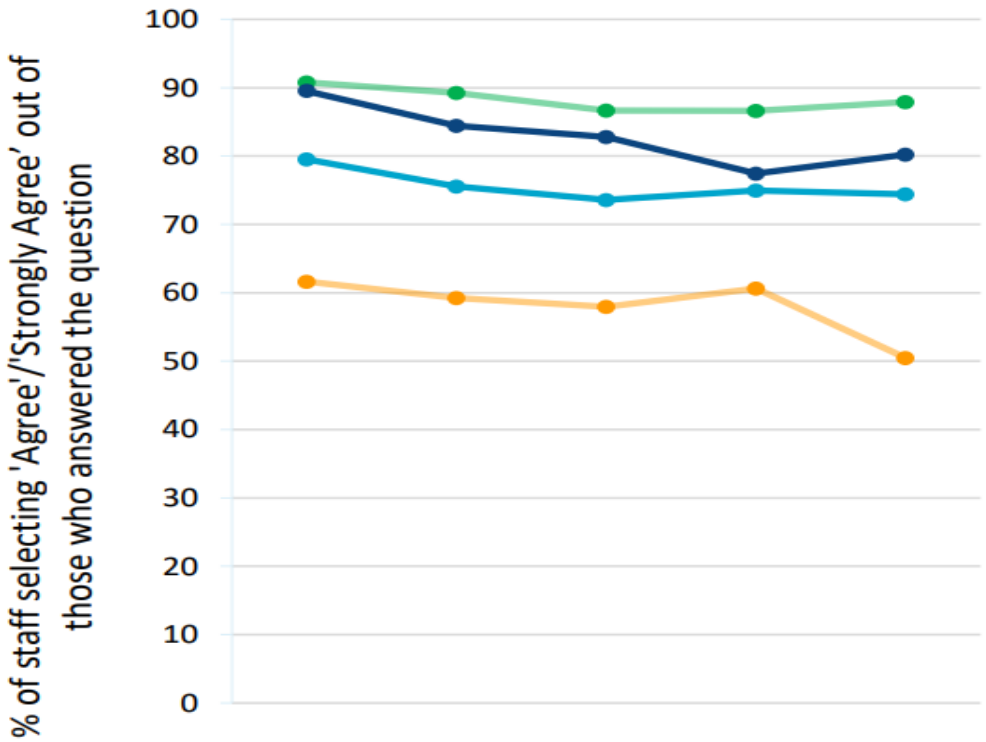
WDES Questions	2023 Trust Result - LTC	2024 Trust Result - LTC	Difference – 2023/24	2023 Trust Result – No LTC	2024 Trust Result – No LTC	Difference 2023/24
WDES 4a - % of staff who experienced at least one incident of harassment, bullying or abuse from: Managers.	16.00%	13.81%	-2.19%	8.79%	8.15%	-0.64%
WDES 4a - % of staff who experienced at least one incident of harassment, bullying or abuse from: Other colleagues.	26.12%	25.18%	-0.94%	16.98%	15.74%	-1.24%
WDES 4a - % of staff who experienced at least one incident of harassment, bullying or abuse from: Patients / service users, their relatives or other members of the public.	29.80%	28.00%	-1.80%	19.40%	20.40%	1.00%
WDES 4b - % of staff saying they, or a colleague, reported harassment, bullying or abuse.	45.21%	50.64%	5.43%	45.11%	47.54%	2.43%
WDES 5 - % of staff who believe that their organisation provides equal opportunities for career progression / promotion.	49.77%	51.15%	1.38%	57.92%	57.72%	-0.20%
WDES 6 - % of staff who have felt pressure from their manager to come to work despite not feeling well enough to perform duties.	33.52%	26.24%	-7.28%	24.00%	19.28%	-4.72%
WDES 7 - % of staff satisfied with the extent to which their organisation values their work.	28.51%	30.36%	1.85%	40.78%	41.85%	1.07%
WDES 8 - % of disabled staff who said their employer has made adequate adjustments to enable them to carry out their work.	72.79%	75.66%	2.87%			0.00%
WDES 9a - Staff Engagement score (0-10).	6.35	6.43	0.08	6.9	6.95	0.05

Improved position

Worsened position

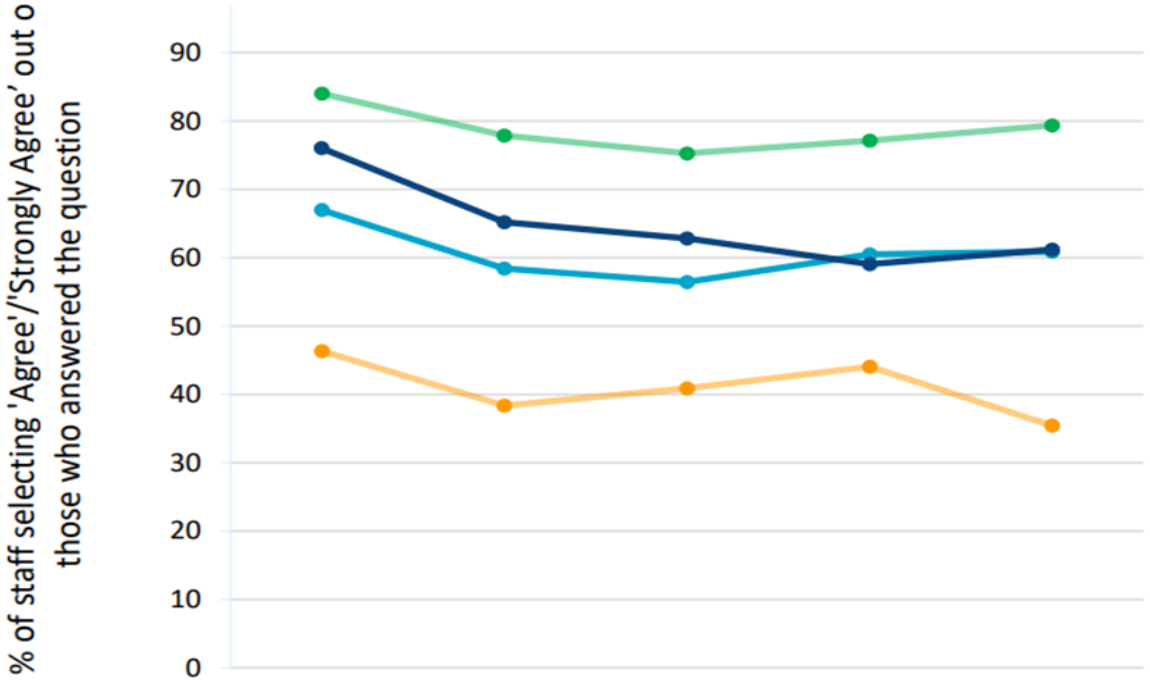
LTC: long term condition

Care of patients is my organisations top priority



	2020	2021	2022	2023	2024
Your org	89.50%	84.43%	82.78%	77.45%	80.23%
Best result	90.78%	89.26%	86.67%	86.62%	87.89%
Average result	79.52%	75.57%	73.60%	74.95%	74.42%
Worst result	61.64%	59.23%	57.97%	60.62%	50.48%
Responses	7036	7298	6620	6420	10296

I would recommend this Trust as a place to work



	2020	2021	2022	2023	2024
Your org	76.02%	65.23%	62.81%	59.08%	61.18%
Best result	84.01%	77.87%	75.29%	77.14%	79.38%
Average result	66.98%	58.40%	56.46%	60.53%	60.90%
Worst result	46.35%	38.38%	40.89%	44.05%	35.43%
Responses	7022	7284	6620	6418	10292

In summary

The Newcastle upon Tyne Hospitals NHS Foundation Trust

- A 60% improvement in staff survey responses is to be celebrated – recognising the voices of 10,000+ colleagues, with feedback that is more representative of ALL staff groups than ever before.
- Our results, overall, are in line with the NHS average when benchmarked against other acute and acute & community Trusts.
- The statistically significant gains in compassionate leadership, health and safety climate, support for work-life balance, flexible working and relationships with line managers are encouraging.
- The worrying year-on-year decline that has been evident since 2020 appears to have been halted: there are gains in 90 out of 108 survey questions (83%).
- We need a concerted focus on culture and Equality, Diversity and Inclusion (EDI) – both WRES and WDES results have improved in 2024 but remain a long way from where we need them to be.
- We need to do more to protect colleagues from increasing levels of violence, aggression and discrimination from patients and the public.
- Improvements in staff experience and engagement must be targeted at relationships within and across teams – the association with patient safety, patient experience and performance is clear.
- 2024 results will directly inform the Year 2 objectives in the People Plan and be shared widely across Clinical Boards and Corporate services. NHS Staff Survey 2024 PowerBI dashboards will be updated in April 2024.

Agenda item A7

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025		
Title	Board Visibility Programme		
Report of	Rachel Carter, Director of Quality & Safety		
Prepared by	Fiona Gladstone, Clinical Effectiveness Advisor & Gavin Snelson, Interim Head of Quality and Effectiveness		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☒	☐
Summary	This report gives an overview of Board Visibility programme walkabouts which occurred in January and February 2025. The walkabouts raise awareness of front-line issues and support the visibility and accessibility of senior leaders within the Organisation. Key themes identified include: - Staff were always welcoming and friendly and wards were calm and organised. - Staff talked about kind and compassionate leadership. - Managers are approachable and staff feel comfortable raising concerns in most areas. - Flexible working opportunities were available, and staff felt supported with work life balance. - Staff in the Community feel more engaged with the Trust and are happy with training and development opportunities. - Some concerns were raised about medicine management and challenges with repatriation of patients. - Staff were open about challenges with complex patients and dealing with episodes of violence and aggression. - Some outstanding Estates issues were identified and areas for improvement identified. - Incivility was reported in three areas. Issues for escalation include: - Update required from Estates in relation to configuration of works to create additional consultation rooms at Ponteland Road. - Ensuring old equipment is being collected more regularly. - Arrange additional Civility Training for Community Services staff. - Deterioration of End-of-Life service in Community to be escalated to Quality Committee and Integrated Care Board (ICB). - Review issues raised in relation to IT including the infection alerts and the radiology platform for home reporting.		
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 Quality Committee and Trust Board in January 2025.					

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.

Since 2023, Non-Executive Directors (NEDs) 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 12 walkabouts and visits undertaken during January and February 2025. During this time two scheduled Leadership Walkabouts were 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.

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, if there are any urgent issues identified, these are escalated to the relevant member(s) of the Executive Team. The walkabout team are also 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

The table below summarises the 12 walkabouts undertaken at the Royal Victoria Infirmary (RVI) and Freeman Hospital (FH), Regent Point, Community and Centre for Life, four within stream one and eight 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 25/a, Ward 30	Freeman	Clinical Board Chair, Director of Operations, Associate Director of operations, Head of Nursing	Not Specified
	IT- Digital and Technology Services	Regent Point	Deputy Director Of Quality and Safety, Head of IT Service Management	Not Specified
	Ward 15	Royal Victoria Infirmary	Clinical Board Chair, Associate Director of Operations,	Sister
	Ward 37, 38, 47, 49	Royal Victoria Infirmary	Director for Commercial Development and Innovation, Assistant Director of Operations and Matron	Not specified
Stream Two	Urgent Treatment Centre	Ponteland Road - Community	Non – Executive Director	Matron, Deputy Matron, Nurse Practitioner, Administration Staff

Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
	Central and West	Newburn – Community	Non – Executive Director	Matrons
	Ward 31, Ward 32, Ward 4, Ward 35, Ward 37, PICU, Ward 25, Wards 29, Ward 30, Ward 24/24a, Ward 23, Emergency Admissions	Freeman Hospital (9pm-11.45pm)	2 x Non-Executive Director	Sisters, Staff Nurses, Health Care Assistant, Doctors Trainee Doctor
	Radiology	Royal Victoria Infirmary	Non-Executive Director	Clinical Board Chair, Director of Operations, Associate Director of Operations, Radiologists
	Genetics Laboratory	Centre for Life	Non-Executive Director	Head of Laboratory, Business Manager, Consultant
	Ward 21	Freeman	Non-Executive Director	Matron, Associate Director of Operations, Sister
	Palliative Care	Freeman	Non-Executive Director	Head of Service, Senior Nurse, Nurse Specialist
	Ward 30, Ward 31, Ward 31a, Birthing Unit, Critical Care Unit, Ward 36, Ward 37, Ward 49, Ward 50, Ward 52, Ward 47, Ward 44, Ward 40, Ward 43, Ward 42, Assessment Suite, Emergency Department	Royal Victoria Infirmary (9pm – 12am)	Chairman and 2x Non-Executive Director	Sister, Staff Nurse,

Key themes identified include:

- Staff were always welcoming and friendly and wards were calm and organised.
- Staff talked about kind and compassionate leadership.
- Managers are approachable and staff feel comfortable raising concerns in most areas.
- Flexible working opportunities were available, and staff felt supported with work life balance.
- Staff in the Community feel more engaged with the Trust and are happy with training and development opportunities.

- Some concerns were raised about medicine management and challenges with repatriation of patients.
- Staff were open about challenges with complex patients and dealing with episodes of violence and aggression.
- Some outstanding Estates issues were identified and areas for improvement identified.
- Incivility was reported in three areas.

Issues for escalation include:

- Update required from Estates in relation to configuration of works to create additional consultation rooms at Ponteland Road.
- Ensure old equipment is being collected more regularly.
- Arrange additional Civility Training for areas identifying incivility issues.
- Deterioration of End-of-Life service in Community to be escalated to Quality Committee and ICB.
- Review issues raised in relation to IT including the infection control alerts and the radiology platform for home reporting.

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, Interim Head of Quality and Effectiveness

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Agenda item A8

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025					
Title	Freedom to Speak Up Guardian (FTSUG) April 2024 – December 2025					
Report of	Vicky McFarlane-Reid, Executive Lead for People and Organisational Development (OD)					
Prepared by	Jill Taylor, Freedom to Speak Up Guardian					
Status of Report	Public	Private	Internal			
	☒	☐	☒			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	This report provides a summary of the activity undertaken by the Trust's Freedom to Speak Up Guardian for quarter 1-3 (2024-2025). In summary: 1. It has been recognised that the FTSUG should attend/directly report to the Trust Board more regularly 2. This paper is a digest of the report versus this time last year. 3. The next steps will involve a change in the nominated individual and positioning within the organisation.					
Recommendation	The Board is asked to receive the report, reflect on the themes raised in the staff concerns and continue to support the Freedom to Speak Up function within the Trust.					
Links to Strategic Objectives	People Plan: Health and Wellbeing, Behaviours and Civility, Valued and Heard and Leadership and Management					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☒	☐
Link to Board Assurance Framework [BAF]	Risks: 2.1 - Failure to have sufficient capacity and capability in our workforce to deliver safe and effective care. 2.2 - Failure to develop, embed and maintain an organisational culture in line with our Trust values and the NHS people promise. 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 A8

Reports previously considered by	Trust Board - May 2024

FREEDOM TO SPEAK UP GUARDIAN REPORT

1. INTRODUCTION

This report provides detail of the activity undertaken by the Trust's Freedom to Speak Up Guardian (FTSUG) since April 2024, outlining the number and nature of concerns raised. Further, it provides the Trust Board with broad themes arising from the concerns raised for consideration and an update on the ongoing development of the service.

1.1 Activity

Between April 2024 and January 2025, the FTSUG has managed 142 cases which required intervention beyond advice and support being given to the complainant. This is an increase of 67% against the same period in the previous year (57 cases in 2023 Q1-Q3 compared to 142 cases in Q1-Q3 2024).

Data	Total	Anonymous	Patient safety	Worker safety	Bullying & Harassment	Behaviour and attitudes	Detriment
Q1	11	1	0	0	2	1	0
Q2	20	0	3	0	2	3	0
Q3	26	3	1	2	7	1	0
Q4	25	0	5	2	3	1	6
Q1	35	4	5	12	10	18	1
Q2	59	5	2	14	11	32	0
Q3	48	9	5	15	15	31	3

This increasing level of activity, and the greater number of concerns being raised with a degree of seriousness which required significant intervention, reflects the increasing credibility of the service. This demonstrates that staff are feeling increasingly confident in speaking up and, although there is significant work still to be done in many areas, psychologically safer to do so. Feedback from questionnaires does reference an apprehension to initial access with staff continuing to express concerns about possible repercussions for speaking up, particularly when the issue relates to their line manager. Many wish to remain anonymous which makes addressing issues more complex.

All staff using the service were given the opportunity to feedback via a questionnaire, however, response rates are very low. Results demonstrate excellent satisfaction post intervention and confidence from staff in recommending the service for others (100% reporting they would recommend the service to others rating it 5/5). Free text feedback highlighted the value of the service to staff in need. Staff reported initial apprehension about accessing the service but reported feeling safe, supported and heard. To simplify and improve feedback, a new QR code and feedback questionnaire have been designed to enhance accessibility.

Staff also continue to access the service via the anonymous 'Work in Confidence' portal. These concerns range from individual issues to concerns raised on behalf of departments.

Initial conversations via the portal are used to create a sense of trust to allow further, more meaningful face to face discussion.

2. RECURRENT THEMES IN CONCERNS RAISED

Interpersonal relationships remain the focus in an overwhelming majority of the concerns raised, particularly between staff and their direct line manager. These do not equate to bullying allegations but perceptions of mismanagement, ineffective or unfair application of HR processes or inequity. Recurrent issues in concerns raised include:

- Inappropriate attitudes and behaviours.
- Worker safety and wellbeing.
- Inadequate exit interviews (either not being proactively offered to staff or not being taken due to issues with the staff member offering the interview).
- The misapplication of policy relating to health and wellbeing, change management, flexible working, stress risk assessments.
- Allocate – misapplication of policy, weaponisation of rota, and under-utilisation of functionality.
- Ineffective management of incidents of aggression or conflict between staff.
- Large organisational change process (particularly transparency and staff engagement).
- The length of time for formal HR processes to take place and conclude, and timeliness and quality of feedback to complainants.
- Feeling that no action will be taken and nothing will change, despite staff speaking up.
- Interpersonal relationships between senior colleagues leading to reticence to address poor behaviours, as well as it influencing process such as promotion.
- Management of neurodiversity and the initiation of reasonable adjustments to support these staff.
- Transphobic behaviour in the form of ‘banter’.
- Inhibited escalation due to ongoing confusion for staff regarding the Clinical Board structure. Only a very small minority of contacts could identify their Clinical Board, with limited knowledge about town hall or engagement events, or if any are held.

During the reporting period, there have only been 3 contacts related to patient safety. This proportionately low number resonates with the national data and is tangible evidence that the Freedom to speak up service has changed dramatically from its inception (focused on patient safety) to the majority of contacts relating to interpersonal relationships and behaviours.

Ongoing mention of ‘What Matters to You’ discussions continue; however, senior teams should be mindful that these discussions must be facilitated in a constructive manner by willing managers. There have been contacts from staff who have described such sessions as significantly detrimental to wellbeing as they were facilitated by staff who were unwilling to listen to any uncomfortable, but essential, issues being raised and who were perceived to be central to the problems. Staff reported not being comfortable in speaking out safely at such events.

This theme has also been raised about the application of stress risk assessments. Staff have reported that risk assessments performed by the main stressor are unhelpful and increase stress meaning staff cannot express themselves honestly. This was also mirrored in team stress risk assessments where staff felt they were unable to be honest due to the staff either facilitating or in the session.

3. TEAM INTERVENTIONS & AWARENESS RAISING

Targeted work has been undertaken in recent months with staff across Microbiology and Radiology. The FTSU service has been integral to this multifaceted intervention and facilitated active and productive engagement with staff in these areas, supplemented by staff experience questionnaires.

The collaborative approach of intervention by colleagues in FTSU, Staff Experience and HR has been demonstrably successful.

4. SERVICE DEVELOPMENT

The National Freedom To Speak Up Policy is in Appendix 1 and has been adopted by the Trust.

The Trust is required to complete the self-assessment and reflection tool and the template is in Appendix 2, however, due to changes in personnel, this will need to be reviewed, and a Board development session is booked in August with the National Guardians office.

A range of promotional activities have been undertaken, such as Town Hall attendances and attending service meetings and team staff meetings. During the National Freedom to speak up month (October 2024) a significant amount of awareness work was undertaken. In partnership with Gateshead Health NHS Foundation Trust we arranged for the Millennium bridge to be turned Green to mark the start of the month and the FTSUG attended multiple staff engagement events.

In addition, several stakeholder engagement events were held in late 2024 to explore barriers to speaking up. They were moderately well attended, and the results were not unexpected with perceived detriment a strong theme along with a lack of trust in confidentiality or action from speaking up. We continue to try and tackle this across the Trust but a focus on broader organisational learning will be key in the next 12 months.

We have launched the Speak up Champions network with 11 champions recruited across several Clinical Boards and corporate services. The FTSUG has trained all the Champions, and their role is to raise awareness and signpost staff appropriately for help. Champions do not take any case work.

A significant improvement in the service has been the very recent development of a data collection tool. This will significantly improve the accuracy and reporting efficiency of data collection and ensure standardisation of for future reporting. There has been further

development in the reporting mechanisms to include a dashboard tool for ease of reporting and allow accountability for organisational learning.

5. FUTURE DEVELOPMENTS

The FTSUG is leaving the Trust following successfully gaining employment within the union sector. The work that has been developed over the last 12 months has created a strong foundation to build upon however whilst we recognise the increased use of the service; we acknowledge the need to review our model. The FTSUG was created on the premise of supporting patient safety concerns, to help us further embed this we will be aligning FTSUG to the quality and safety directorate with an increase in capacity long term.

It is acknowledged some areas of speaking up link to civility and inter-personal relationships. The development of this service will also include the wider focus on the supporting framework of signposted areas such as People and OD to support where required.

6. RECOMMENDATIONS

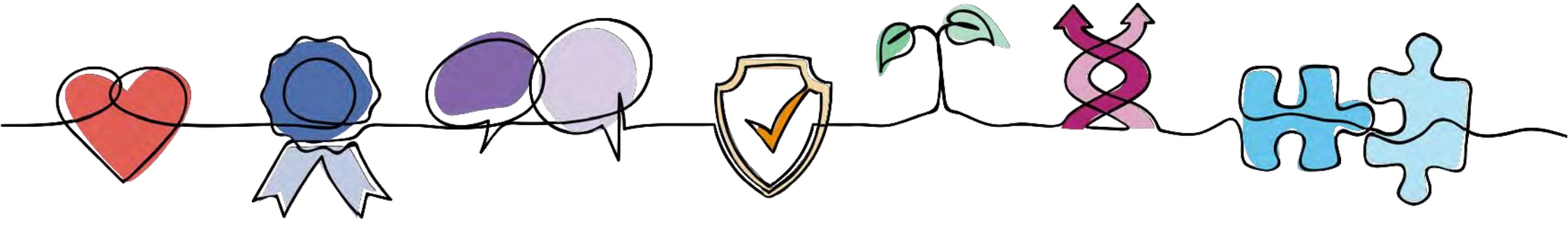
The Board is asked to receive the report and support the ongoing development of the Freedom to Speak Up Guardian role and service.

Report of Vicky McFarlane-Reid
Executive Lead of People and OD

Agenda item A8 – Appendix 1
Publication approval reference: PAR1245_i

Freedom to Speak Up policy for the NHS

Version 2, August 2024



Contents

Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Speak up – we will listen

We welcome speaking up and we will listen. By speaking up at work you will be playing a vital role in helping us to keep improving our services for all patients and the working environment for our staff.

This policy is for all our workers. The NHS People Promise (https://www.england.nhs.uk/our-nhs-people/online-version/lfaop/our-nhs-people-promise/the-promise/#we-each-have-a-voice-that-counts) commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words".

We want to hear about any concerns you have, whichever part of the organisation you work in. We know some groups in our workforce feel they are seldom heard or are reluctant to speak up. You could be an agency worker, bank worker, locum or student. We also know that workers with disabilities, or from a minority ethnic background or the LGBTQ+ community do not always feel able to speak up.
This policy is for all workers and we want to hear all our workers' concerns.

We ask all our workers to complete the online training (https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/) on speaking up. The online module on listening up is specifically for managers to complete and the module on following up is for senior leaders to complete.

You can find out more about what Freedom to Speak Up (FTSU) is in these videos (https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/)

This policy

All NHS organisations and others providing NHS healthcare services in primary and secondary care in England are required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. Its aim is to ensure all matters raised are captured and considered appropriately.

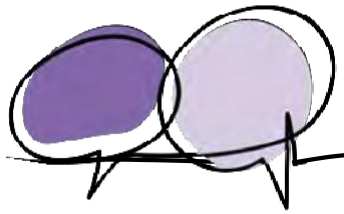
What can I speak up about?

You can speak up about anything that gets in the way of patient care or affects your working life. That could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviours of others is affecting your wellbeing, or that of your colleagues or patients.

Speaking up is about all of these things.

Speaking up, therefore, captures a range of issues, some of which may be appropriate for other existing processes (for example, HR or patient safety/quality) • a Trade Union or Staff Representative, Contact Officer or Chaplain • the Trust 'Freedom to Speak Up Guardian': newcastle.speakupguardian@nhs.net • the 'Speak in Confidence' anonymous dialogue system: https://speak2us.at/nuth • Whistleblowing Helpline advice from NHS and Social Care T: 08000 724 725 or enquiries@wbhelpline.org.uk • Public Concern at Work (Now called Protect): Contact our Advice Line - Protect - Speak up stop harm (protect-advice.org.uk) or T: 020 3117 2520 • Whistleblowing Advice

Line | NSPCC or T: 0800 028 0285 That's fine. As an organisation, we will listen and work with you to identify the most appropriate way of responding to the issue you raise.



We want you to feel safe to speak up

Your speaking up to us is a gift because it helps us identify opportunities for improvement that we might not otherwise know about.

We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up.

Who can speak up?

Anyone who works in NHS healthcare, including pharmacy, optometry and dentistry. This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers, and former workers.

Who can I speak up to?

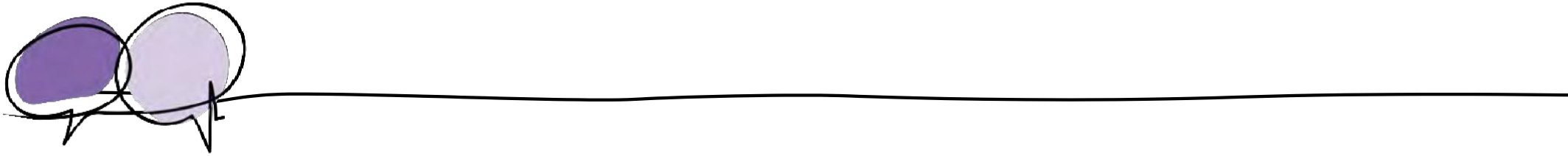
Speaking up internally

Most speaking up happens through conversations with supervisors and line managers where challenges are raised and resolved quickly. We strive for a culture where that is normal, everyday practice and encourage you to explore this option – it may well be the easiest and simplest way of resolving matters.

However, you have other options in terms of who you can speak up to, depending on what feels most appropriate to you and depending on the size of the organisation you work in (some of the options set out below will only be available in larger organisations).

- Senior manager, partner or director with responsibility for the subject matter you are speaking up about.
- The patient safety team or clinical governance team (where concerns relate to patient safety or wider quality) – Patient Safety Incident Response Framework for Newcastle Hospitals https://intranet.newcastle-hospitals.nhs.uk/services/patient-safety/patient-safety-incident-response-framework/
- Local counter fraud team (where concerns relate to fraud) https://policies.app/policies/Policies/CorporateGov/FraudBriberyandCorruptionPolicy202305.pdf (Policies app)
- Our Freedom to Speak Up Guardian Jill Taylor (newcastle.speakupguardian@nhs.net 0191 2448128) who can support you to speak up if you feel unable to do so by other routes. The guardian will ensure that people who speak up are thanked for doing so, that the issues they raise are responded to, and that the person speaking up receives feedback on the actions taken. You can find out more about the guardian role here: https://nationalguardian.org.uk/for-guardians/job-description/.
- Our HR team https://intranet.newcastle-hospitals.nhs.uk/services/human-resources/
- Our senior lead responsible for Freedom to Speak Vicky McFarlane-Reid (Staff directory - Newcastle upon Tyne Hospitals NHS Foundation Trust - Intranet (newcastle-hospitals.nhs.uk))- they provide senior support for our speaking-up guardian and are responsible for reviewing the effectiveness of our FTSU arrangements.
- Our non-executive director responsible for Freedom to Speak Up Bernie McCardle Staff directory https://intranet.newcastle-hospitals.nhs.uk/staff-directory/?staff_forename=B&staff_surname=McCardle&staff_role&staff_departmentName&staff_directorate&staff_email&u= – this role is specific to organisations with boards and can provides more independent

support for the guardian; provide a fresh pair of eyes to ensure that investigations are conducted with rigor, and help escalate issues, where needed].



Speaking up externally

If you do not want to speak up to someone within your organisation, you can speak up externally to:

- Care Quality Commission (CQC) (http://www.cqc.org.uk/content/who-we-are) for quality and safety concerns about the services it regulates – you can find out more about how the CQC handles concerns here: https://www.cqc.org.uk/contact-us/report-concern/report-concern-if-you-are-member-staff.
- NHS England for concerns about:
  - GP surgeries
  - dental practices
  - optometrists
  - pharmacies
  - how NHS trusts and foundation trusts are being run (this includes ambulance trusts and community and mental health trusts)
  - NHS procurement and patient choice
  - the national tariff.

  (https://www.england.nhs.uk/ourwork/freedom-to-speak-up/how-to-speak-up-to-us-about-other-nhs-organisations/

NHS England may decide to investigate your concern themselves, ask your employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles.

Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.

- NHS Counter Fraud Authority (http://www.nhsbsa.nhs.uk/3350.aspx) for concerns about fraud and corruption, using their online reporting form https://reportfraud.cfa.nhs.uk/or calling their freephone line **0800 028 4060**.

If you would like to speak up about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council, Nursing and Midwifery Council, Health & Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.

Appendix B contains information about making a 'protected disclosure'.

How should I speak up?

You can speak up to any of the people or organisations listed above in person, by phone or in writing (including email).

Confidentiality

The most important aspect of your speaking up is the information you can provide, not your identity.

You have a choice about how you speak up:

- **Openly:** you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.
- **Confidentially:** you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent.
- **Anonymously:** you do not want to reveal your identity to anyone. This can make it difficult for others to ask you for further information about the matter and may make it more complicated to act to resolve the issue. It also means that you might not be able to access any extra support you need and receive any feedback on the outcome.

In all circumstances, please be ready to explain as fully as you can the information and circumstances that prompted you to speak up.

Advice and support

You can find out about the local support available to you at [either link to organisation intranet or reference other locations where this information can be found]. Your local staff networks [include link to local networks] can be a valuable source of support.

You can access a range of health and wellbeing support via NHS England:

- Support available for NHS people https://www.england.nhs.uk/supporting-our-nhs-people/support-now/
- Looking after you: https://www.england.nhs.uk/supporting-our-nhs-people/support-now/looking-after-you-confidential-coaching-and-support-for-the-primary-care-workforce/care workforce.

NHS England has a Speak Up Support Scheme

https://www.england.nhs.uk/ourwork/whistleblowing/whistleblowers-support-scheme/ that you

can apply to for support. You can also contact the following organisations:

- Speak Up Direct (https://speakup.direct/) provides free, independent, confidential advice on the speaking up process.
- The charity Protect (https://protect-advice.org.uk/) provides confidential and legal advice on speaking up.
- The Trades Union Congress (https://www.tuc.org.uk/joinunion) provides information on how to join a trade union.
- The Law Society (https://www.lawsociety.org.uk/for-the-public/) may be able to point you to other sources of advice and support.
- The Advisory, Conciliation and Arbitration Service (https://www.acas.org.uk/) gives advice and assistance, including on early conciliation regarding employment disputes.

What will we do?

The matter you are speaking up about may be best considered under a specific existing policy/process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you. If you speak up about something that does not fall into an HR or patient safety incident process, this policy ensures that the matter is still addressed.

What you can expect to happen after speaking up is shown in Appendix B.

Resolution and investigation

We support our managers/supervisors to listen to the issue you raise and take action to resolve it wherever possible. In most cases, it's important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation.

Where an investigation is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside your organisation or from a different part of the organisation) and trained in investigations. It will reach a conclusion within a reasonable timescale (which we will notify you of), and a report will be produced that identifies any issues to prevent problems recurring.

Any employment issues that have implications for you/your capability or conduct identified during the investigation will be considered separately.

Communicating with you

We will treat you with respect at all times and will thank you for speaking up. We will discuss the issues with you to ensure we understand exactly what you are worried about. If we decide to investigate, we will tell you how long we expect the investigation to take and agree with you how to keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others and recognising that some matters may be strictly confidential; as such it may be that we cannot even share the outcome with you).

How we learn from your speaking up

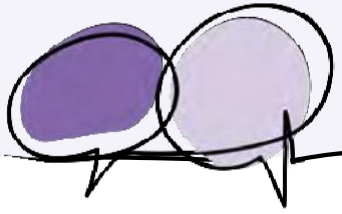
We want speaking up to improve the services we provide for patients and the environment our staff work in. Where it identifies improvements that can be made, we will ensure necessary changes are made and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

Review

We will seek feedback from workers about their experience of speaking up. We will review the effectiveness of this policy and our local process annually, with the outcome published and changes made as appropriate.

Senior leaders' oversight

Our most senior leaders will receive a report at least annually providing a thematic overview of speaking up by our staff to our FTSU guardian(s).



Appendix A:
What will happen when I speak up?

We will:

Thank you for speaking up

•

Help you identify the options for resolution

•

Signpost you to health and wellbeing support

•

Confirm what information you have provided consent to share

•

Support you with any further next steps and keep in touch with you

→

Steps towards resolution:

Engagement with relevant senior managers (where appropriate)

•

Referral to HR process

•

Referral to patient safety process

•

Other type of appropriate investigation, mediation, etc

→

Outcomes:

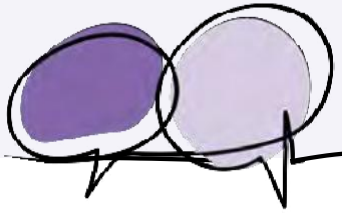
The outcomes will be shared with you wherever possible, along with learning and improvement identified

→

Escalation:

If resolution has not been achieved, or you are not satisfied with the outcome, you can escalate the matter to the senior lead for FTSU or the non-executive lead for FTSU (if you are in an NHS trust)

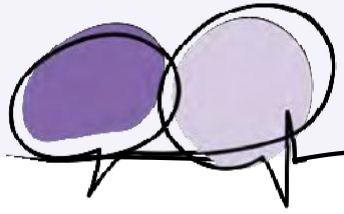
• Alternatively, if you think there are good reasons not to use internal routes, speak up to an external body, such as the CQC or NHS England



Appendix B:
Making a protected disclosure

Making a 'protected disclosure'

A protected disclosure is defined in the Public Interest Disclosure Act 1998. This legislation allows certain categories of worker to lodge a claim for compensation with an employment tribunal if they suffer as a result of speaking up. The legislation is complex and to qualify for protection under it, very specific criteria must be met in relation to who is speaking up, about what and to whom. To help you consider whether you might meet these criteria, please seek independent advice from the charity Protect (https://protect-advice.org.uk/) or a legal representative.



Agenda item A8 - Appendix 2

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up (FTSU)

A reflection and planning tool

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	
I have led a review of our speaking-up arrangements at least every two years	
I am assured that our guardian(s) was recruited through fair and open competition	
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	
I am regularly briefed by our guardian(s)	
I provide effective support to our guardian(s)	
Enter summarised commentary to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	
I am confident that the board displays behaviours that help, rather than hinder, speaking up	
I effectively monitor progress in board-level engagement with the speaking-up agenda	
I challenge the board to develop and improve its speaking-up arrangements	
I am confident that our guardian(s) is recruited through an open selection process	
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	
I am involved in overseeing investigations that relate to the board	
I provide effective support to our guardian(s)	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	
We regularly and clearly articulate our vision for speaking up	
We can evidence how we demonstrate that we welcome speaking up	
We can evidence how we have communicated that we will not accept detriment	
We are confident that we have clear processes for identifying and addressing detriment	
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	
We regular discuss speaking-up matters in detail	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)	
1	
2	

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	
We support our guardian(s) to make effective links with our staff networks	
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	
We have reviewed the ringfenced time our Guardian has in light of any significant events	
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	
We can evidence that our staff know how to find the speaking-up policy	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	
We have an annual plan to raise the profile of Freedom to Speak Up	
We tell positive stories about speaking up and the changes it can bring	
We measure the effectiveness of our communications strategy for Freedom to Speak Up	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	
Our HR and OD teams measure the impact of speaking-up training	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	
All managers and senior leaders have received training on Freedom to Speak Up	
We have enabled managers to respond to speaking-up matters in a timely way	
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	
We use triangulated data to inform our overall cultural and safety improvement programmes	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	
We use this information to add to our Freedom to Speak Up improvement plan	
We share the good practice we have generated both internally and externally to enable others to learn	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	
Our guardian(s) has been trained and registered with the National Guardian Office	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	
Our guardian(s) has access to a confidential source of emotional support or supervision	
There is an effective plan in place to cover the guardian's absence	
Our guardian(s) provides data quarterly to the National Guardian's Office	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	
We are assured that confidentiality is maintained effectively	
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	
We know who isn't speaking up and why	
We are confident that our Freedom to Speak Up champions are clear on their role	
We have evaluated the impact of actions taken to reduce barriers?	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	
We monitor whether workers feel they have suffered detriment after they have spoken up	
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	
Our improvement plan is up to date and on track	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	
Our plan follows a recognised ‘plan, do, study, act’ or other quality improvement approach	
Our speaking-up arrangements have been evaluated within the last two years	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	
We have we evaluated the content of our guardian report against the suggestions in the guide	
Our guardian(s) provides us with a report in person at least twice a year	
We receive a variety of assurance that relates to speaking up	
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

Development areas to address in the next 12–24 months	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

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Agenda item A9

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025					
Title	Great North Healthcare Alliance					
Report of	Martin Wilson, Director Great North Healthcare Alliance and Strategy					
Prepared by	Martin Wilson and other members of the Alliance Formation Team					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	This paper provides an update on the work undertaken and ongoing to form and develop the Great North Healthcare Alliance (GNHA), which brings together: ○ Gateshead Health NHS Foundation Trust; ○ North Cumbria Integrated Care NHS Foundation Trust; ○ Northumbria Healthcare NHS Foundation Trust; and ○ The Newcastle upon Tyne Hospitals NHS Foundation Trust. There are clear opportunities and benefits for patients from closer working, whilst recognising there are also benefits that come from each individual Trust's identities and integrity as separate organisations. Specific deliverables from the Alliance work plan have begun to demonstrate these benefits, and the improved experiences and outcomes for patients. We have established the Alliance with a Collaboration Agreement signed by each of the four organisations. This agreement underpins meetings of Trust Board Committees in Common to steer and govern the Alliance work plan, as well as a Joint Committee between three of the trusts to focus work in certain areas, and bilateral discussions between trusts.					
Recommendation	The Trust Board is asked to note the progress made.					
Links to Strategic Objectives	Patients, People, Performance, Partnerships, Pioneering					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☐	☒
Link to Board Assurance Framework [BAF]	Risk 7.1 - Inability to sufficiently influence priorities of key partnerships (including the GNHA, the Integrated Care Board (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.					

Reports previously considered by	New report.

GREAT NORTH HEALTHCARE ALLIANCE

1. OVERVIEW AND VISION

The Newcastle upon Tyne NHS Foundation Trust (FT), Gateshead NHS FT, Northumbria Healthcare NHS FT and North Cumbria Integrated Care NHS FT have been working together as the Great North Healthcare Alliance since January 2024.

An overview of the Alliance and our guiding objectives are as follows:

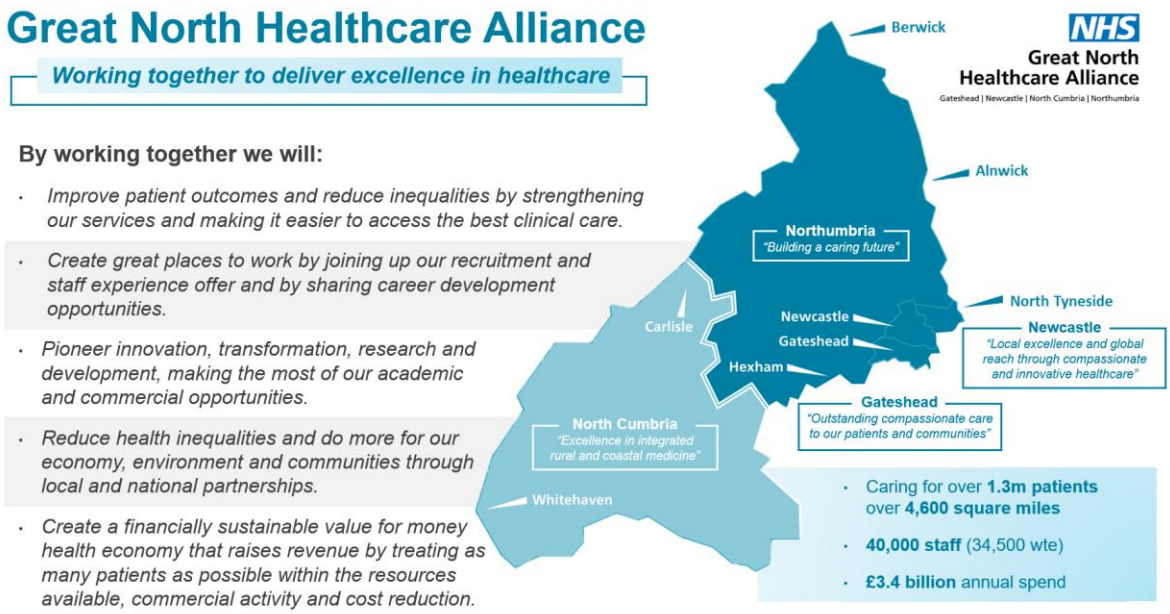

Figure 1 – Alliance overview

The Alliance is intended in large part to change ways of working across the four trusts, supplementing existing practice and working more closely in partnership with neighbouring organisations to drive better decision making for the benefit of patients, staff and external partners.

Our Alliance vision is therefore based on how we should work – both individually and together – and what we will aim to achieve. This vision has been developed and approved by each of the Alliance Trust Boards and there has been positive engagement and feedback on it from partners including the Integrated Care Board (ICB), local authorities, and NHS and University partners.

How we will work – our foundations:

Our purpose is to deliver high quality, safe and reliable care to our population, with fairer outcomes for all and equal access regardless of geography.	**Our patients are at the centre of our decision making but our staff are key to success.**
Our Alliance is based upon creating energy, engagement and innovation within our workforce, to enable them to deliver what we aspire to.	**We believe that working together at scale across our different leadership domains will breed cultural and clinical change.**

How we will work – our principles:

Acting together	• **Patients see us as 'one NHS'**, so we must work and design our services to meet this. • We will speak with **one voice to influence collectively** and ensure our communities get the investment and support we deserve. • We will keep focused on the fact that we are **first and foremost healthcare delivery organisations:** ➢ We exist to serve patients with rapid access to care, positive experiences, the best possible outcomes, and preventing illness in the first place. • **Excellence** – our ambition is to achieve the highest possible standards in healthcare, national and global leaders, supported by technology, commercial, innovation, education, research and development.
Subsidiarity	• We understand the value in care being delivered locally – we will take every opportunity to **provide the widest range of services in local settings**, whilst recognising that services need the appropriate infrastructure to be safe. • The **identities** of and sense of belonging in our individual organisations must be retained and built on – no Trust wants to lose what is special about them, and what is good for one Trust is good for all. • We will **leverage the best of each organisation for the benefit of all**, building on the distinct strengths of each organisation. • We will **trust, empower and give permission to all leaders** to work across the Alliance to co-design services, feeling both accountable for and supported to deliver, under pinned by our ICB-wide leadership compact.

Effective planning	• Our Alliance activities will be made **where opportunities to do so arise, and to an agreed plan**. We will plan and deliver jointly where possible and desirable, and work with commissioners jointly. • We want to **grow the support and opportunities our teams have**, and our work plan will have this at its heart. • We want to **put as much money as possible into frontline care treating and preventing** illness, which is why our planning will seek to maximise value for the Alliance £ ensuring affordability, productivity, minimal waste and duplication, and maximising external investment. • Our collective planning and decision making will be supported by **strong governance processes** that are shared where desirable and possible.
Accountability and engagement	• In delivering our work plan and ways of working we want to **maintain and increase our lines of local accountability**, to our staff, communities and our local partners. • We will retain **accountability within our individual places** and the visibility of local leaders in local places. Alongside this, we want to improve the accountability that local places have over issues that are greater, multi-place scale. • Our principles of partnership working and behaviours will be led by our ICB-wide **leadership compact.** • We want **genuine and honest engagement** with partners both within our organisations and externally. • Local partners will **have a say in the decisions** that affect them, and we will continue to develop our Alliance work plan and vision with their input.

What we aim to deliver in the next five years:

Clinical pathways	• CQC 'good' or above rating in each organisation, exceeding the constitutional standards, simplified patient flow using all available resources, and a reputation for being best in the country once again. • Improved and sustainable footing for fragile and vulnerable services, starting with urology, oral and maxillofacial surgery, urgent and emergency care, cancer, and women's services. • Brought together clinical teams from across the Trusts to jointly review each clinical specialty and to prioritise a programme of clinical pathway redesigns to improve services for patients. This will be informed by rich access, experience and outcomes insights and data, demographic pressures that we know are coming, and the views of patients, staff and partners. • Improved local access to all constituent parts of specialised service pathways and clinical research – from tertiary settings, to acute and community, so that more patients can benefit.

	• Boosted and prioritised primary and community care, we will work closely with primary care networks, and provide a strong, dedicated strategic leadership with supporting corporate infrastructure to deliver integration with community and secondary care. • Made a positive step change in tackling health inequalities - including in reducing poverty by helping local people not at work due to sickness to get healthcare support to get back to work as fast as possible. • Ensure individuals are treated in the right place at the right time by working with social care partners in local government and private providers to maximise our delivery of social care integration and respond to national policy.
People and processes	• Remove the barriers and annoyances for our people that stop them from making full use of their professional skills, creating new opportunities, delegating power and responsibility so they work to their potential level. • Opportunities for joined up recruitment, brand and workforce development programmes that supports local people into stretching careers, with succession and that recognises specific fragile staffing areas. • Community promise that supports local growth - including promotion of health careers, social value, and a healthy green environment. • Single point of contact for local and regional partners to raise and discuss issues and opportunities – including the ICB, Local Government, Universities and Primary Care Networks. • Innovation, research and development that helps design and deliver improvements to patients and local services, reaches its commercial potential, is led by our centres of excellence, and is internationally recognised. • NHS England Oversight Framework segment 2 or better positions for each organisation, with financial sustainability across the Alliance. • Explore joined up corporate services to support value for money and reduce outliers – for instance, coordinated procurement. • Commercial strategy delivery that takes rapid decisions, moves first, and is based on our combined assets. • Single, unified governance structure for decision-making across the Alliance, supported by a collaboration model that is in itself, innovative.
Physical assets	• Coordinated estates strategies and decisions with 'big build' developments in each Alliance trust that is supported by external investment. • Because 20% of our patients already flow between our hospitals, deliver: ➢ Digital interoperability across the Alliance trusts, ➢ Seamless service pathways, whilst not risking system resilience,

	➢ A clear & accessible interface for patients that supports patient choice. • Prioritise money for patient care by ensuring organisations maximise the benefits from subsidiaries.

Taking together the foundations and principles for how we will work, and the ambitions of what we will do provides a clear framework for delivering the objectives set out in figure 1 and the benefits that comes from these.

2. PROGRESS TO DATE

Since the previous update to Trust Boards held in public, we have had a number of notable successes that demonstrate progress against the objectives and vision outlined above. A few highlights include:

- **Community Diagnostic Centre** (CDC) – the Metro Centre CDC opened in October 2024, and has already enabled over 16,000 people, mostly from Newcastle and Gateshead, to have a diagnostic test more quickly and/or closer to home. Another CDC will be opened in Workington, North Cumbria in the coming months.
- **Cardiology** – positive engagement between clinical teams has supported a 30% reduction in the waiting time for patients with Acute Coronary Syndromes (ACS) to be transferred between the Royal Victoria Infirmary, and Queen Elizabeth Hospital and Northumbria Specialist Emergency Care Hospital for revascularisation. This has also reduced occupied hospital bed days for patients.
- **Audiology** – improvements in the service provided by Newcastle Hospitals means many more patients are now having their hearing assessments done within the 6 week national waiting time standard. This is creating resource to improve local provision across Northumberland and North Tyneside, with further improvements expected in the coming months.
- **Paediatrics** – this joint workstream has built positive relationships between the four Trust teams, leading to increased hospital capacity being opened compared to the past ten years and better sharing of best practice. Issues that affect patient services are being tackled together.
- **Urology** – honest and positive discussions between the trusts has agreed joint solutions to issues in these patient services. Although performance is still not where any trust would want it to be, positive progress has been seen for instance the elimination of >52 week waits for Gateshead. We expect substantive improvements to be increasingly demonstrated over the coming year.
- **Interstitial Lung Disease** (ILD) – changing pathways for patients with ILD to transfer to more local provision for them in Northumbria. Part of these changes include Northumbria clinicians being able to prescribe key drugs for patients in a timelier manner than previously. Around 120 patients are being offered the opportunity to transfer their care.
- **Hepato-pancreato-biliary** (HPB) – Northumbria are taking on appropriate patients to share capacity more evenly, and Northumbria surgeons looking to use the Freeman Hospital Day Treatment Centre to increase capacity.

- **Community outpatients** – supporting local services provided by Newcastle to move to a local, newly refurbished site alongside Northumbria services – providing services from neighbouring organisations in a 'one NHS' site.
- **Digital** – Agreeing a longer-term plan to deliver an interoperable set of digital services to enable information and data to exchange across the Alliance to effectively support patients and frontline services. We have appointed a lead Chief Digital Officer to coordinate this work across Newcastle, Gateshead and Northumbria, working closely with North Cumbria. This work, which will increase in pace, has led to some early quick wins from projects including shared Wi-Fi, use of cloud services, and joint procurement opportunities for certain core services.
- **Research and Innovation** – hosting an Alliance-wide session to agree priority areas for our combined research and innovation experience, expertise and assets to work together for the benefit of the Alliance.
- **Estates planning** – a shared business case looking at long-term estates opportunities across the four trusts has been developed, for discussion on possible investment sources to deliver this.
- **Financial planning** – open engagement between Finance Directors to support short and medium-term financial planning in particular, in order to plan a path for the Alliance trusts to return to a balanced financial position, and for this to be sustainable.

3. GOVERNANCE ARRANGEMENTS

Relationships across the four organisations have developed at pace to support joint working on Alliance priorities. The Alliance Steering Group of the Chairs and CEOs from the four organisations meets monthly as Committees in Common. Since our previous update to Public Boards, these arrangements have been strengthened through a Joint Committee and three sets of bilateral arrangements.

- **Joint Committee**: a tighter form of governance, with delegations from Trust Boards, has been established between Newcastle Hospitals, Northumbria Healthcare and Gateshead Health as members, and with North Cumbria colleagues attending. The Joint Committee has a specific focus initially on certain financial planning for 2025/26, digital interoperability, and research and innovation.
- **Bilateral arrangements**: in order to progress work bilaterally between organisations, more formal arrangements have been put in place between Newcastle Hospitals and North Cumbria. Sub-Committees in Common will drive progress on ensuring high quality tertiary service provision across North Cumbria alongside other clinical and corporate workstreams. Other bilateral arrangements have also been established between other organisations, for instance Newcastle and Northumbria who meet regularly to work through shared clinical service issues and improve service delivery for patients. A similar Newcastle and Gateshead bilateral group is about to be set up.

4. DEVELOPING AND DELIVERING THE WORK PLAN IN COLLABORATION

We have sought to develop the work plan – be it clinical services, corporate approaches and Alliance governance – in collaboration with Trust Boards and Governing Bodies across the trusts, as well as external partners where appropriate.

The members of the four Trust Boards have met together twice for half day workshops looking at progress made and future opportunities – positive feedback overall was received for both events. A joint event for Governors from the organisations is being held in April to supplement the invaluable input that they have made through the respective Councils of Governor meetings.

In addition, we have ensured that the ICB for the North East and North Cumbria has been involved in informing the vision, work plan and governance arrangements for the Alliance. Most recently, a supportive session was held in December 2024 with the ICB Chair and Chief Executive – at this session the ICB provided an update on some stakeholder engagement work on the Alliance vision and work plan that they had supported with external partners. This included important and helpful feedback from local universities, primary care groups, and local authorities. This has informed the work plan workstreams and deliverables and is something that we will build on in the next 12 months.

In accordance with the principles for Alliance working set out earlier in this paper, the governance arrangements are intended to be as *de minimus* as possible and support collaborative working relationships across all levels of the Alliance partners, be it Executives, Non-Executives, Governors, Clinical Leads, Operational Leads, and frontline staff. Equally, they have been established and agreed by Trust Boards in such a way to not change the independence of Trust Boards and Governing Bodies, or the delegations, powers and authorities that Chief Executive Officers already have.

5. SUMMARY ASSESSMENT

Looking back over the first year of the Alliance, progress has been good. Enthusiasm for working together across organisations has been evident, a number of tangible benefits have already been delivered, and there is momentum in support of greater collaboration. Trust and relationships between the organisations have never been in such a positive position.

Although there has been variation in progress between workstreams, we have learnt lessons from these instances to ensure that we are delivering benefits from Alliance working.

Leadership and communication have been critical parts of our work at different levels throughout our organisations. We have also recognised that there is a strong need to measure and celebrate progress, and that project governance and management works best for the Alliance where it is kept as light touch as possible.

6. RECOMMENDATION

The Trust Board is asked to note the progress made.

Report of Martin Wilson
Director - Great North Healthcare Alliance & Strategy
13 March 2025

Report prepared by Great North Healthcare Alliance Formation Team: Andrew Edmunds, Northumbria, Martin Wilson, Newcastle; Nicola Bruce, Gateshead; Steve Park, North Cumbria

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Agenda item A10

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025		
Title	Care Quality Commission (CQC) Update		
Report of	Ian Joy, Executive Director of Nursing		
Prepared by	Ian Joy, Executive Director of Nursing		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	This report to the Trust Board provides an overview on progress with CQC action plans and the current process of enhanced scrutiny and oversight which remains in place with external partners. The following key points are noted for the Trust Boards attention: • Progress against the Phase 2 Improvement Plan can be found in the report. There are 47 actions excluding Section B (Service Improvement Plans) of which 18 are completed and 3 behind plan. Those behind plan aim to be resolved in April. • The process of undertaking rapid Quality and Safety Peer Reviews remain in place and updates are provided regularly to the Quality Committee. 89 areas have been reviewed since December. There are no new areas for escalation. A programme of reviews has been agreed for quarter one. • We have commissioned The Value Circle to undertake an independent review of progress with embedding improvement actions in the Cardiothoracic Clinical Board. Key lines of Enquiry have been agreed, shared with external partners, and the review commenced on the 25th March. An overview of findings will be provided in future reports. • Additional oversight remains in place through CQC Engagement Meetings and the Integrated Quality Improvement Group (IQIG). The most recent IQIG meeting led to a request for a follow up meeting to review progress with assurance measures relating to Section B action plans. This meeting took place on the 20th March and there are no points for escalation at this time. • NHSE and the ICB are working collaboratively to review the de-escalation criteria relating to additional oversight. This will be discussed further at the next IQIG meeting at the end of April. • The CQC Delivery Group remains in place to provide scrutiny and oversight on priority actions and support preparation for future inspection. With the change in role for the Deputy Chief Executive Officer to Acting Chief Executive Officer, the Executive Director of Nursing will assume responsibility for this group, its function and CQC inspection preparedness. The Phase 2 Improvement Plan will be available in the Trust Board 'Reading Room'.		
Recommendation	The Trust Board is asked: To note: • Progress against the Phase 2 Improvement Plan.		

<table>
<tr><td></td><td colspan="6">• The current position regarding additional oversight from external partners.
• Current position relating to understanding potential de-escalation criteria.
• The change in Executive oversight of the CQC Delivery Group.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Performance – Being outstanding now and in the future.</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">1.2 - Failure to implement effective governance systems and processes across the Trust to assess, monitor and drive improvements in quality and safety.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Regular report.</td></tr>
</table>

Agenda item A10

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

CQC Update

28th March 2025

Healthcare at its best
with people at our heart

Overview of progress with Action Plans

The Newcastle upon Tyne Hospitals NHS Foundation Trust

- A phase two action plan which relates to Effective Governance and Well Led is in place and focuses on testing embeddedness of systems and process in practice now that the transactional elements of the action plan are complete.

- There are 47 actions in total of which 18 are complete. Of those which remain open, 3 are behind plan and are planned to be resolved by April. All other actions remain on target.

- Section B service specific action plans have either been reviewed and refreshed, or are in the process of being reviewed, to ensure they have clear actions to test embeddedness in practice as part of phase two. Oversight and scrutiny continues through local improvement or oversight groups and into the Quality Committee.

Quality and Safety Peer Review Progress

The Newcastle upon Tyne Hospitals NHS Foundation Trust

- The Quality and Safety Peer Review process has been developed to provide Trust-wide oversight on the level of compliance to quality and safety standards. It highlights areas for improvement as well as those areas achieving high quality standards.
- 89 clinical areas/services were reviewed between December 2024 and February 2025.
- Results demonstrate continued improvement with continued focus required across some fundamental quality and safety checks and medicines management to ensure consistent application of standards in practice.
- Compliance remains high in many areas of the organisation.
- Collaboration between the Compliance Team leading the Quality and Safety Review process, the Accrediting Excellence (ACE) programme and Medicines Management Team has widened the support being given to clinical teams.
- A programme of reviews for quarter one 2025/26 has been agreed.

Additional internal oversight and scrutiny

The Newcastle upon Tyne Hospitals NHS Foundation Trust

- To ensure we review progress independently, The Value Circle (TVC) have been undertaking improvement review assessments across a number of departments who have service specific action plans in place. The Trust Board have been appraised of the reviews undertaken in our Emergency Department, NECTAR and across our Surgical Services. Action plans have been amended accordingly.

- A review commenced across Cardiothoracic Services on Tuesday 25th March and concludes on 28th March. Key lines of enquiry have been agreed and shared with external partners. An update on findings, the report and areas for review and development will be shared through the relevant governance processes once received.

Oversight and Engagement with External Partners

- A CQC engagement meeting was held on 27th March to agree oversight processes for this next phase of engagement. Monthly meetings between the CQC and the Executive Director of Nursing remain in place to manage business as usual processes.

- Oversight remains in place through the Integrated Quality Improvement Group (IQIG) (NHS England (NHSE) including Specialised Commissioning/CQC/Integrated Care Board (ICB)). Last meeting 27th February. It was agreed at that meeting that a deeper dive into service specific action plans would be beneficial to understand assurance processes for specific services.

- Deep dive meeting between the Executive Director of Nursing, NHSE and the ICB completed on the 20th March. No concerns were raised for escalation and sign off from this exercise to be discussed in the next IQIG on the 25th April. This will include a discussion regarding the framework for future IQIG meetings.

- NHSE and ICB colleagues are reviewing the de-escalation criteria and will provide an update at the next meeting.

Preparation for any future inspection

The Newcastle upon Tyne Hospitals NHS Foundation Trust

- The CQC delivery group remains in place meeting fortnightly to review progress with priority actions and support preparation for future inspection. With the change in role for the Deputy Chief Executive Officer to Acting Chief Executive Officer, the Executive Director of Nursing will assume responsibility for this group, its function and CQC inspection preparedness.

- Trust wide communication packages and standard operating procedures are in the process of being finalised and will be distributed imminently. This will ensure staff can be prepared and supported for whenever a future inspection may occur.

- Well Led preparation interviews undertaken with Ellen Armistead, Interim Quality Support Director, have now been completed for all Clinical Board Triumvirates to support their own personal development. Feedback is in the process of being collated to identify any cross cutting themes to focus future improvement actions.

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Agenda item A11

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025		
Title	Integrated Board Report		
Report of	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. **Quality** • January saw a significant reduction in *Clostridioides difficile* infections compared to the previous month (9 v 18), returning to no special cause concerning variation. There were 2 community-onset healthcare-associated (COHA) cases and 7 hospital-onset, healthcare associated (HOHA) cases, 3 are unavoidable and 4 awaiting investigation/pending review. • In January there was a slight increase in adult falls compared to the previous month (236 v 234), in line with trends from previous years – this total remains below the mean and an overall sustained reduction has been maintained. Falls per 1,000 bed days is at 4.9 therefore remains significantly under the Trust target of 6.0. **Performance** • In December the 77% 28 Day Faster Diagnosis Standard (FDS) was failed for the fifth successive month (76.1%). This is within the level of natural variation to be expected given recent historical trends. 31 Day performance has continued to deteriorate (75.0%) with performance outside the control limits for four successive months. 62 Day compliance was 64.0%, reflecting improving special cause variation despite an overall consistent failure to hit the target. • Diagnostic performance has improved for five successive months – 17.9% of patients were waiting over six weeks at the end of January. The target continues to be consistently failed but there is now special cause variation of an improving nature. **People** • Total sickness absence remained at 5.47% in January 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 identify and agree priorities linked to the gap analysis undertaken as part of the Better Health at Work Award assessment, especially in relation to psychological wellbeing. A new policy is also being finalised.		

<table>
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- Appraisal compliance declined again in January (84.4%) and rates are consistently failing the target. A new appraisal process is to launch from April 2025 and will include a reminder system, whilst discussions are being held in monthly performance reviews conducted with Clinical Boards to ensure accountability.

Finance

- As at Month 10 the Trust is reporting an overspend of £3.7 million against the planned deficit of £4.8 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) element and includes a number of non-recurrent factors.

Health Inequalities

- The next Health Inequalities update, focused on elective care waiting time inequalities, will be provided in the April 2025 report.

</td></tr>
<tr><td>Recommendation</td><td colspan="6">For assurance.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">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.</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 is a regular paper provided to Trust Board.</td></tr>
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Agenda item A11

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

Quality, Performance, People, Finance, Health Inequalities

March 2025

Healthcare at its best
with people at our heart

Contents

SPC Assurance Matrix

VARIATION	P	?	F	No Target	↑
H / L	• Trust BSOTS Midwifery Care Yellow - within 1 hour • Mandatory Training	• Adult Patient Falls • Trust BSOTS Midwifery Care Orange - within 15 minutes • Trust BSOTS Midwifery Care Green - within 4 hours • Trust BSOTS Medical review Yellow - within 2 hours • Trust BSOTS Medical review Green - within 2 hours • Trust Turnover	• RTT >65 Week Waits • Cancer 62 Day Referral to Treatment Standard • Diagnostic 6 Week Performance	• Falls per 1,000 bed days • Maternal deaths • Serious incidents • BSOTS Initial Triage within 15 minutes • RTT Waiting List Size • Diagnostic Waiting List Size • EDI - Disability • EDI - Ethnicity	• Total number of inpatient deaths
—	• BSOTS Initial triage within 15 minutes • Infectious Diseases • FA2 20 week Anomaly scan • ST2 Timeliness of Antenatal Screening	• Number of C. diff Cases • Number of MSSA Cases • Number of E. coli Cases • Number of Klebsiella Cases • Number of Pseudomonas aeruginosa Cases • Never Events • Inpatient Acquired Pressure Ulcers • ATAIN • Trust BSOTS Medical review Red - Seen Immediately • ST3 Completion of FOQ • S01 - % screen compliant <72hrs of age • S03 - % hip USS attended between 4-6 weeks • S05 - % suspected bi-lateral undescended testes seen <24 hrs • CQC/MSNI/CQC concern or request for action • Regulation 28 made directly to the Trust • ED Performance - All Types (%) • ED Trolly Waits >12 hours • Cancer 28 Day Faster Diagnosis Standard	• Trust & LMNS BSOTS Medical review Orange - within 15 minutes •NB2 Avoidable NBBS repeats • RTT 18 Weeks Performance (%) • Appraisal Compliance	• Pressure ulcers per 1,000 bed days • Patient Safety Incidents per 1,000 bed days • Severe/Fatal Patient Safety Incidents per 1,000 bed days • Number of Verbal Duty of Candour Not Complete within 10 Days • Proportion of inpatient admissions where death occurred • Registerable Births • Stillbirths • Early neonatal deaths (0-7 days) • Perinatal Mortality cases • Caesarean section Deliveries (Total) • Elective Caesarean Deliveries • Emergency Caesarean Deliveries • Overall "Induction Of Labour" • Blood Loss >1500ml (per 1,000 deliveries)	• Neonatal Re-admissions (Total) • Moderate incidents • Pregnancy Bookings • ST4a • ST4b • S04 - % of hip referral outcome decision made (<6wks corrected age) • Short-term Sickness Absence • Long-term Sickness Absence
H / L		• Number of MRSA Cases • Percentage of Verbal Duty of Candour Completed • ED Arrival to Admission / Discharge >12 hours	• Cancer 31 day Combined Decision to Treat to Treatment Standard • Trust Sickness Absence	• Percentage of Written Duty of Candour Completed • Number of level 2 mortality reviews undertaken • Maternal Re-admissions (Total) • FA3 T21, T18, T13 Screening	↓ • Registerable (Maternal) Deliveries • S02 - % eye abnormality suspected/seen <14 days of examination

ASSURANCE

Quality

Quality Overview

Metric	Period	Actual	Target	Variation	Assurance
HCAI - MSSA	Jan-25	11	8		
HCAI – C. Diff	Jan-25	9	11		
Harm Free Care – Inpatient (IP) Acquired Pressure Ulcers	Jan-25	63	69		
Harm Free Care – Adult Patient Falls	Jan-25	236	203		
Stillbirths	Jan -25	4			
Blood Loss >1500ml (per 1,000)	Jan -25	38			
ATAIN	Jan - 25	10%	5%		

Health Care Acquired Infections (HCAI)

- January saw a significant decrease in Clostridioides difficile infection (CDI) cases compared to the previous month (9 v 18), a return of no special cause concern variation.
- The number of Meticillin-Sensitive Staphylococcus aureus (MSSA) cases decreased to 11 in January, however this remains above the monthly target (10% reduction on previous year) and has now exceeded the target overall (100 v 81).

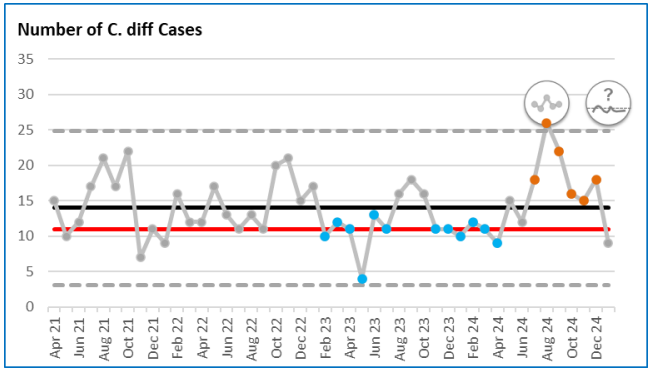
Harm Free Care

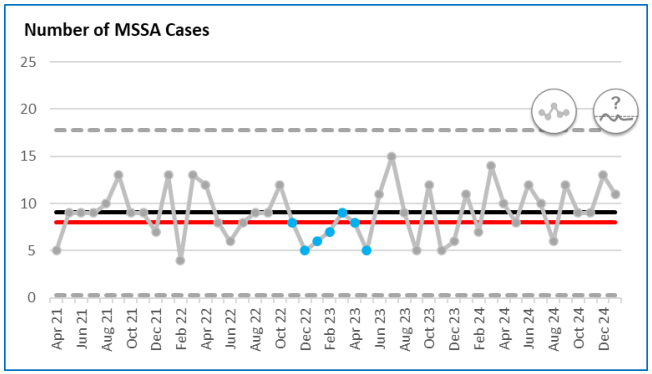
- The number of acute pressure ulcers decreased slightly in January (63 v 64). Following a sustained reduction, no special cause variation has been highlighted.
- In January there was a slight increase in falls in comparison to December (236 v 234), this is over the monthly target of 203, however remains below the mean and a sustained reduction has been maintained.

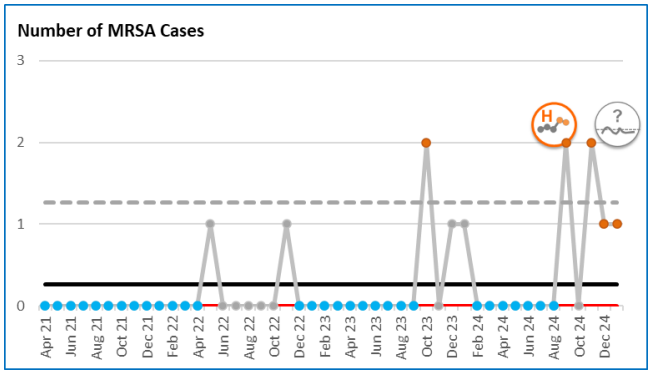
Perinatal Quality Surveillance

- The avoiding term admissions into neonatal units (ATAIN) rate is 10%. The Trust is benchmarking against other Tertiary services, but a deep dive has commenced as hypothermia is the second most common reason for admission, with infants of diabetics with respiratory distress being the most common reason.
- The average Postpartum hemorrhage (PPH) rate for England is 33 per 1000 and North East North Cumbria (NENC) average is 32 per 1000. PPH rate in January was 38 per 1000, this is indicative of the complexities of the high-risk patient group and provision of the Placenta Accreta Spectrum service as confirmed by the previous review.

Healthcare Associated Infections (1/2)







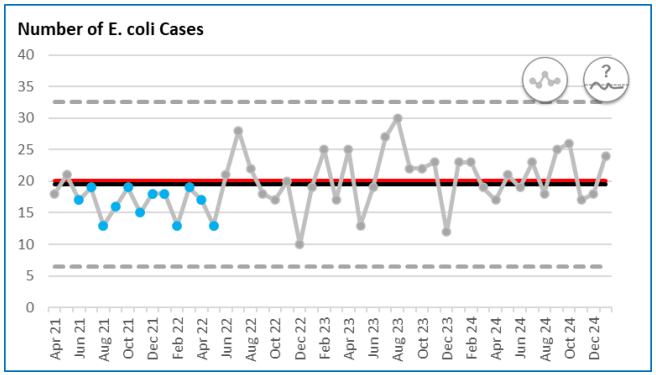
Standards

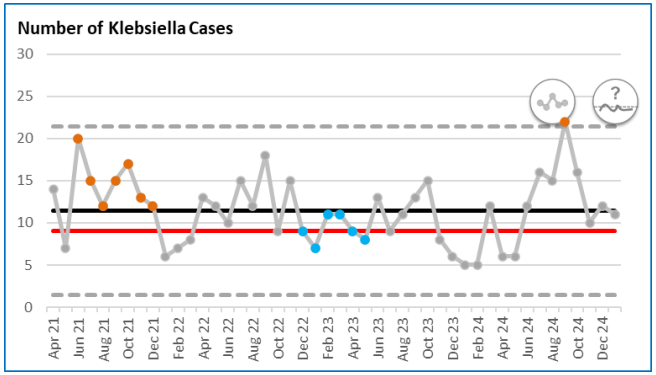
- **Zero MRSA** cases.
- **No more than 98 MSSA** cases across the financial year (local target - 10% reduction from 2023/24).
- **No more than 136 CDIs, 247 E. coli** cases, **108 Klebsiella** cases or **39 Pseudomonas aeruginosa** cases across the financial year.

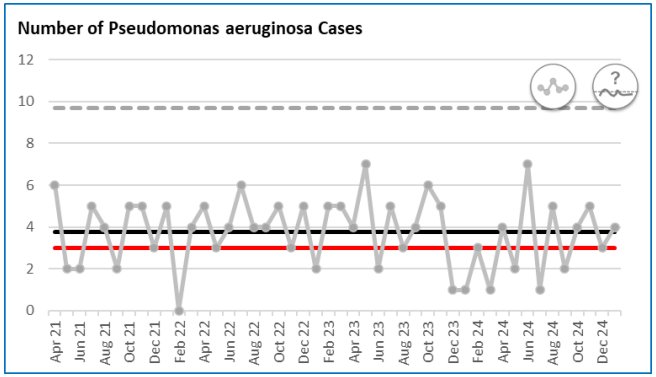
Current Position

- January saw a decrease in CDI cases compared to the previous month (9 v 18) returning to no special cause concerning variation. There were 2 community-onset healthcare-associated (COHA) cases and 7 hospital-onset, healthcare associated (HOHA) cases of which in 3 are unavoidable and 4 awaiting investigation/pending review.
- The number of MSSA cases have slightly decreased to 11 this month. Of these there were 7 HOHAs and 4 COHA. Of the HOHA cases 3 were deemed unavoidable, and 4 are pending review.
- There was 1 MRSA case in January attributed to Surgical and Associated Services Clinical Board, the patient was known to be colonised with MRSA on admission. Themes identified were issues with decolonisation, line documentation and antibiotic stewardship.
- There was an increase in *E. coli* bacteraemia cases compared to the previous month (24 v 18) , however cases remain under the national trajectory. There were 5 COHA cases and 19 HOHA, of which of the HOHA 15 were deemed unavoidable, and 4 under review. There was 1 avoidable case attributed to one of the COHA cases in relation to Surgical Site Infection.
- The number of Klebsiella bacteraemia have slightly decreased to 11 this month. Of these there were 7 HOHAs and 4 COHAs. Of the HOHA cases 4 were deemed unavoidable and 3 are pending review.
- Cases of Pseudomonas aeruginosa cases slightly increased in January to 4 and remain in line with common cause variation. All of which were HOHAs, 3 have been deemed unavoidable and 1 is under review.

Healthcare Associated Infections (2/2)



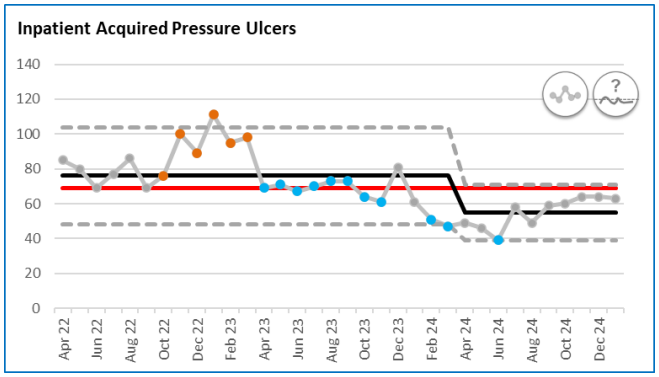


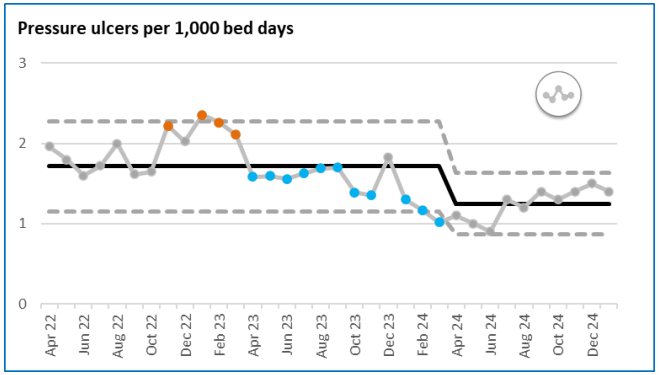


Action taken

- Methicillin-resistant Staphylococcus aureus (MRSA) Quality Improvement pilot commenced within Surgical and Associated Services (SAS) Clinical Board due to high incidence; to improve MRSA screening compliance and management. Weekly compliance report reviewed by clinical teams. Work has commenced with digital health to explore a dashboard within Power BI.
- Clinical Informatics Microbiology Lead is providing the Clinical Boards with patient level data on inappropriate antibiotic prescriptions for MRSA.
- The Antimicrobial Stewardship (AMS) Team are working with digital health to initiate a flag to alert clinicians that patients have a history of MRSA.
- Infection Prevention Control (IPC), Facilities Teams, Patient Service Coordinator (PSC) Teams and clinical leaders continue to work together in periods of high incidence of infection to facilitate safe and timely patient placement and prompt specialised cleaning when required.
- The digital dashboard to monitor invasive devices is now live and improvement work has commenced with clinical areas to increase compliance. This is strengthened through the relaunch of Aseptic Non-Touch Technique (ANTT) training.
- The Quality Improvement project continues in Older People's Medicine to decrease avoidable urinary catheters by 5% in collaboration with the clinical teams, IPC and the Bladder and Bowel Specialist Nursing Team.
- An action plan reflects the work on increased visibility of IPC Nurses on wards to improve collaboration between front line staff and IPC. In addition to the provision of education, and increased observation of IPC precautions.
- IPC are working collaboratively with the Accrediting Excellence (ACE) programme with the support of an IPC coach to those areas who are considering/preparing for accreditation.
- Increased collaboration between clinical infection specialists, the wider Trust and Antimicrobial Pharmacists, and Medicines Management Optimisation Group. Learning from incidents disseminated through Patient Safety bulletin has generated positive feedback and engagement from medical staff.
- The Director of IPC continues to chair AMS strategic and operational group.

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.

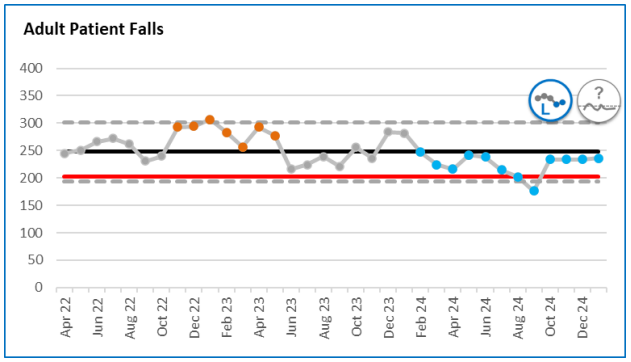
Current position

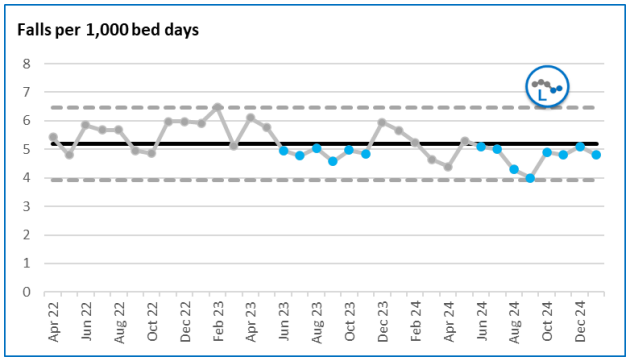
- The number of acute pressure ulcers (PU) reported in January decreased slightly to 63. The chart has been adapted to reflect a sustained reduction, therefore highlighting no special cause variation.
- The number of Cat III pressure ulcers in January increased to 4 from 3 in December. Investigations into these are underway.

Action taken

- Some themes and trends from recent investigations show mis-categorisation of pressure ulcers has been key in several investigations. Documentation had not been well completed, and images had not been taken in a timely manner.
- Training has taken place, which has been well attended. This includes mattress training, Pressure Ulcer prevention and aSSKING, Pressure Ulcer categorisation, Wound Assessment and Dressing Selection and Advanced Practical Bandage Training. Further sessions have been planned and advertised, and staff are booking in.
- Trust mattress audit planned for early 2025.
- The Tissue Viability Team (TVT) are working with the ACE team to support wards through their accreditation process, with a focus upon increasing awareness, and reducing harm in line with reduction trajectory.

Harm Free Care: Falls





Standard

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

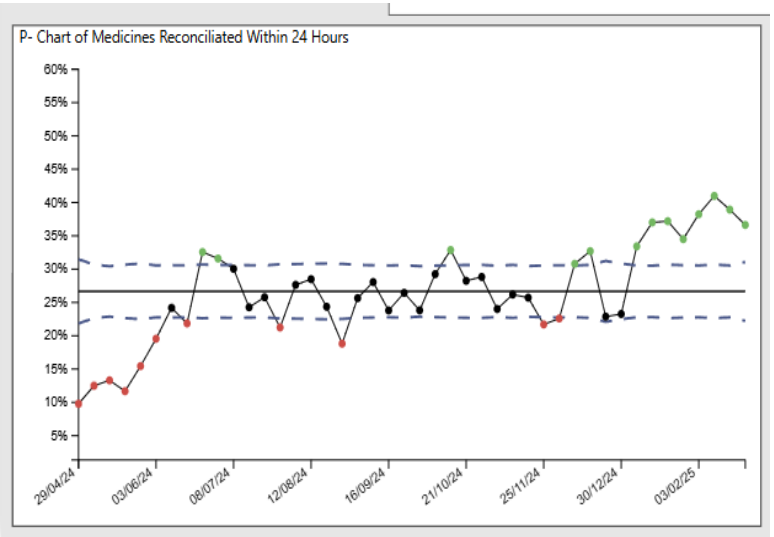
Current position

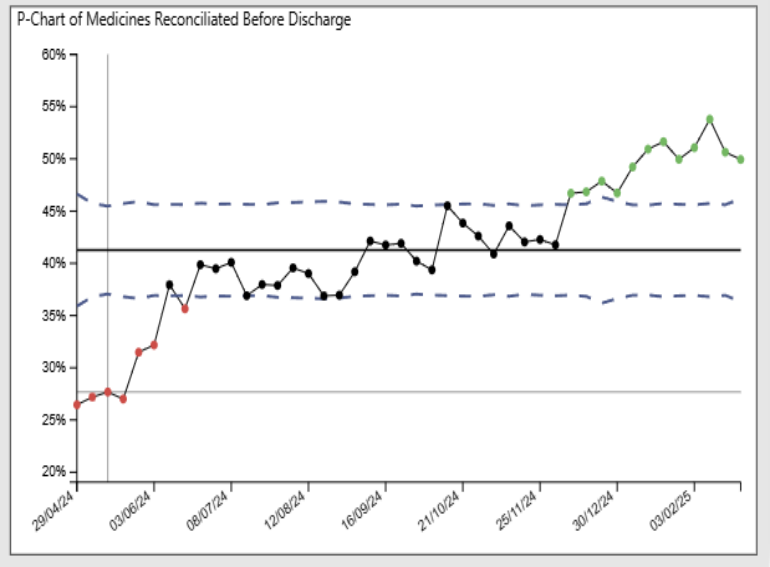
- In January, there was a slight increase in falls compared to the previous month (236 vs 234).
- Falls with moderate or above harm were recorded as 4.24% of falls (10).
- The 10 major harm incidents resulted in 3 fatalities, 4 severe harms and 3 moderate harms.
- Injuries sustained were 5 fractured necks of femurs, 2 head injuries, 2 pelvic ring fractures and 1 humeral prosthesis dislocation.
- All 3 fatalities involved neck of femur fractures, all of which are undergoing a Patient Safety Incident Response Framework (PSIRF) review.

Action taken

- The improvement and learning themes created were around the quality of the multi-factorial assessment to optimise safe activity (specifically lying-standing blood pressure test, 4AT Delirium screen and vision assessments), adherence to Trust protocols (Falls Risk Assessments and Enhanced Care Observations), the training of Moving & Handling Facilitators and providing prompt analgesia after falls with injury .
- The Falls Prevention Coordinator has incorporated vision assessments in staff falls training and has opened discussions regarding whose responsibility this should be.
- The Falls Prevention Coordinator is collaborating with the Dementia / Delirium and Deteriorating Patient Teams regarding the improvement of 4AT and lying-standing blood pressure completion within the Trust.
- The Trust guideline for the inpatient use of non-slip slipper socks has been widely distributed alongside educational resources that includes footwear advice.
- Enhanced Care Observation and Moving & Handling Facilitator training remains being rolled out Trust wide.

Medicines Reconciliation





Standards

- Target 40% (with existing staffing); 60% after approval of phase 1 of staffing business case; 80% after approval of phase 3 of the staffing business case

Action taken

- Quality Improvement (QI) project being undertaken to test different ways of working that aim to improve medicines reconciliation rates without adversely impacting other core services (e.g. patient flow, medicine supply, operational duties).
- Phase 1 of the staffing business case to be submitted February 2025.

Current Position

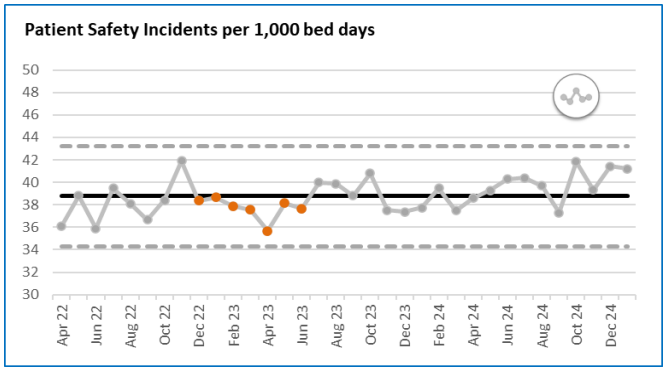
- Improvements visible, nearing towards 40% target within 24 hours.
- Continuing increase in med rec before discharge.

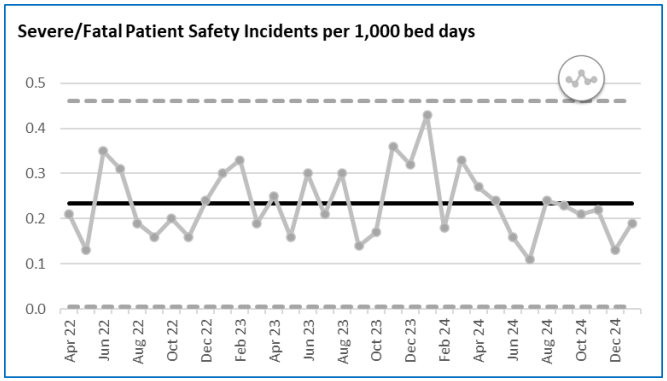
	Med rec within 24 hours	Total Med Rec before discharge
May 2024	**13%**	28%
June 2024	**24%**	36%
July 2024	**27%**	38%
Aug. 2024	**25%**	38%
Sept. 2024	**26%**	41%
Oct. 2024	**29%**	43%
Nov 2024	**24%**	42%
Dec 2024	**27%**	46%
Jan 2025	**34%**	51%
Feb 2025	**39%**	52%

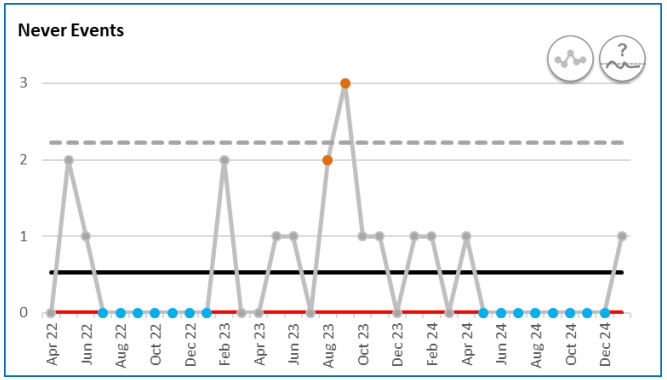
Narrative February

- Continued rise in figures due to continued targeting of surgical patients pre-admission before elective surgery at the Freeman Hospital (FRH).
- Have also rolled out to target elective cardio patients pre-admission at FRH.

Incident Reporting







Standards

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

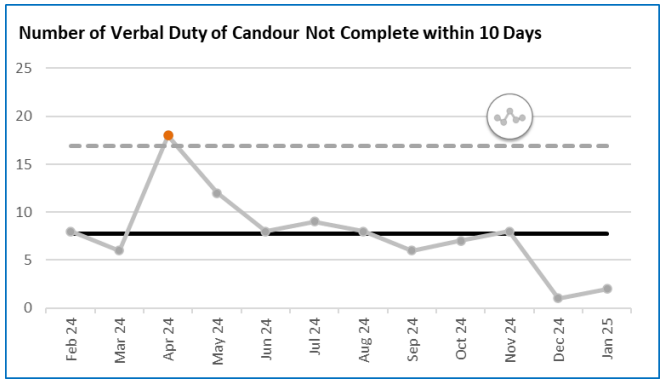
Current Position

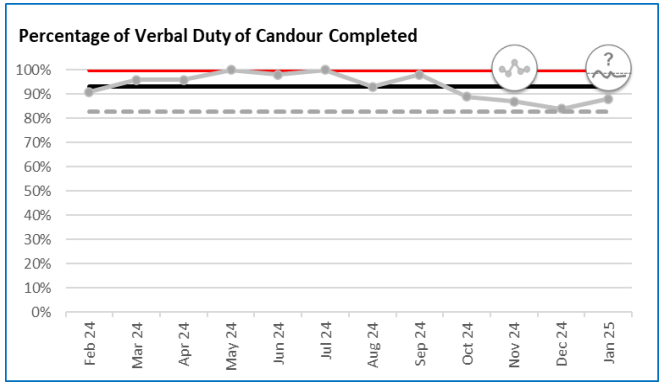
- The total number of patient safety incidents per 1,000 bed days reported in January 2025 remains similar to that of December 2024.
- The number of severe/fatal safety incidents per 1,000 bed days increased in January 2025.
- One Never Event were declared in January 2025 – retained foreign object post procedure (peri-ops).
- Two After Action Reviews were declared in January 2025.
- One Patient Safety Incident Investigation were declared in January 2025 (the no harm Never Event above).
- Two PSIRF Priority incidents were identified in January 2025. Both were Lost internal referrals.

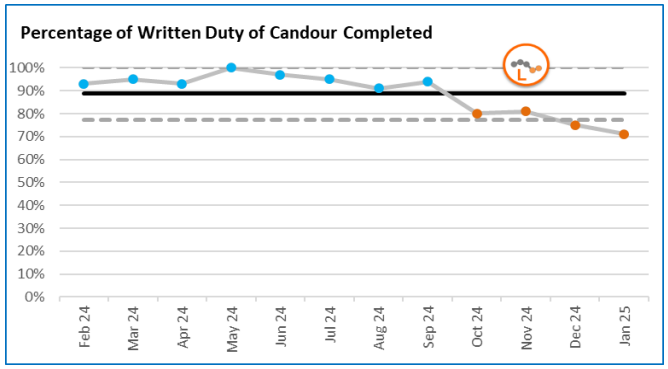
Action taken

- Clinical Boards have access to incident reporting rates and have identified areas of low reporting, implementing targeted plans to address this.
- Most Clinical Boards have employed a Patient Safety and Clinical Governance Lead. The patient safety team are providing education around incident management for these new colleagues at a formal monthly meeting in addition to offering support on an ad-hoc basis where required.
- Raising awareness of incidents and dissemination the learning continues to take place through the Patient Safety Bulletin, Patient Safety Briefings and Clinical Risk Group.
- Bespoke patient safety teaching sessions are being offered to clinical areas, e.g. ASU, RVI.
- 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.

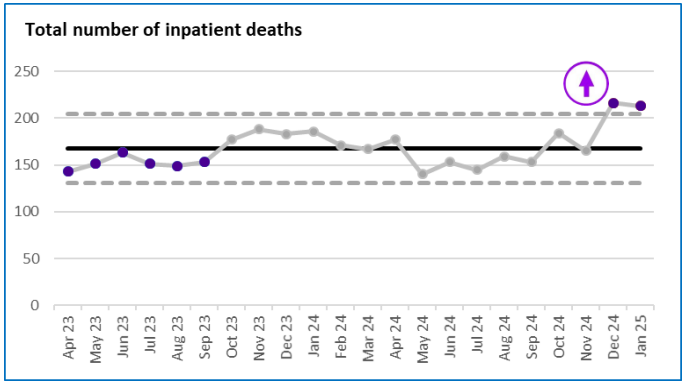
Current Position

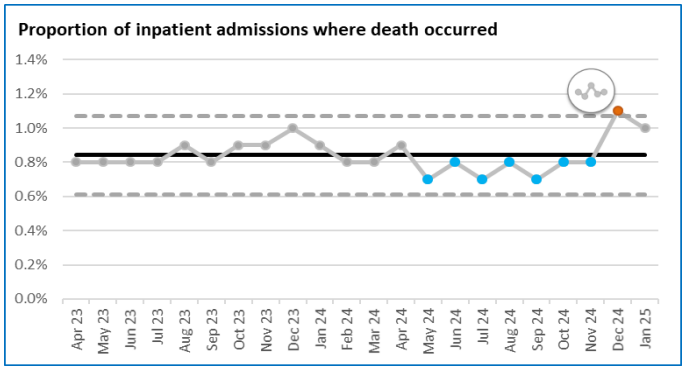
- Overall trust compliance for verbal duty of candour had increased to 93% for the reporting period compared with 85% the previous month.
- Overall trust compliance for written duty of candour had increased to 89% for the reporting period compared with 79% the previous month.
- Compliance will continue to improve as incidents are reviewed, and apologies provided to patients and their families.

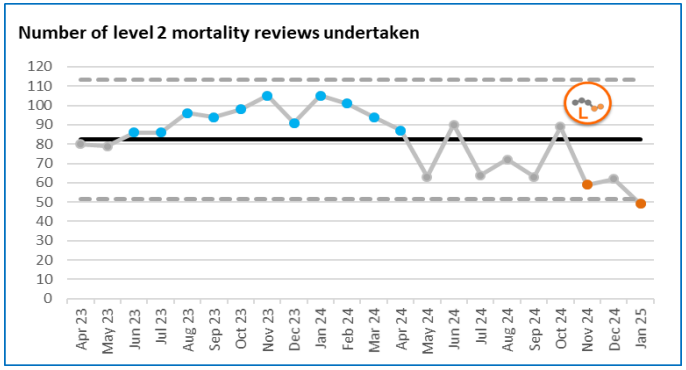
Action taken

- Learning Lab module on Duty of Candour being developed in conjunction with TEL team.
- The development of a digital guide to support DoC documentation.
- Ongoing monitoring and oversight of DoC compliance including the inclusion of Clinical Board level compliance within the quality focused performance reviews.

Mortality Indicators (1/2)







Standards

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

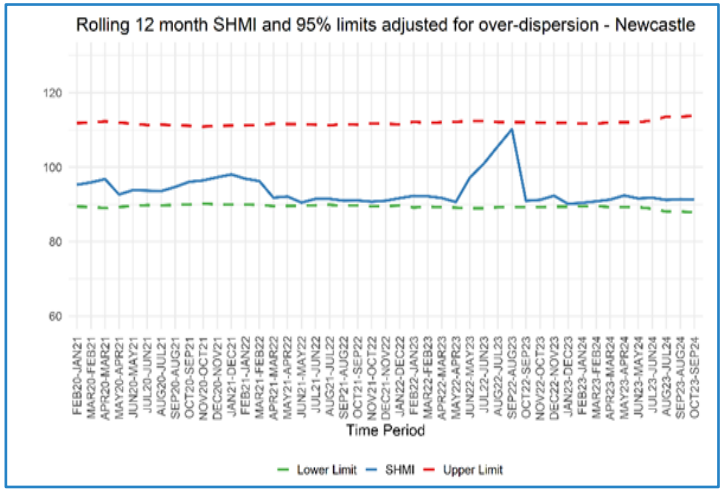
Current Position

- There were 213 inpatient deaths in total reported in January 2025, which is an increase of 27 on the figure reported 12 months previously and above the parameters of common variation. This likely reflects a higher rate of admissions during this flu season, expected to be similar to 2022/23, and to be considerably higher than last winter when rates were low (as per UKHSA published early indications, 12 December 2024).
- The crude rate in January 2025 is 1%. This is a decrease on the previous month by 0.1%, and an increase on the figure reported 12 months previously by 0.1% (0.9% in January 2024).
- Out of the 213 inpatient deaths reported, there are 49 completed level 2 mortality reviews entered into the Trust mortality review database to date.
- None of the level 2 reviews completed in January 2025 to date have been scored with a high HOGAN or NCEPOD grading.
- In January 2025, there were 3 patient deaths with an identified learning disability.

Action taken

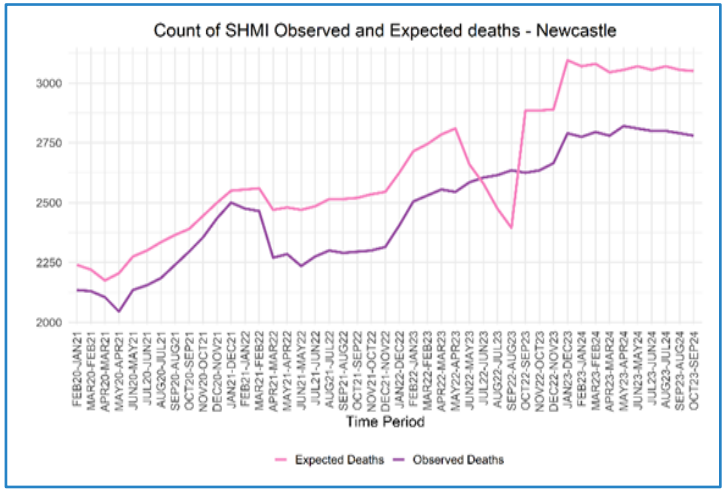
- All inpatient deaths are continually monitored.
- Planned thematic review of adult in-patient deaths during December 2024 – January 2025.
- The number of level 2 mortality reviews will rise significantly over the coming months as Morbidity & Mortality (M&M) meetings continue to take place.

Mortality Indicators (2/2)



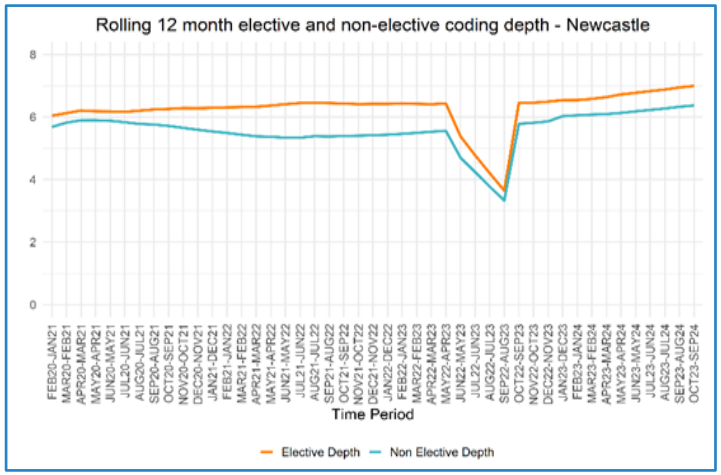
Hospital-level Mortality Indicator (SHMI)
Within the latest published SHMI data (October 2023 – September 2024) the Trust SHMI is at 0.91. This is within the "as expected" category.

Observed & Expected deaths
Between October 2023 – September 2024, the Trust has 2,780 observed deaths and 3,050 expected deaths.



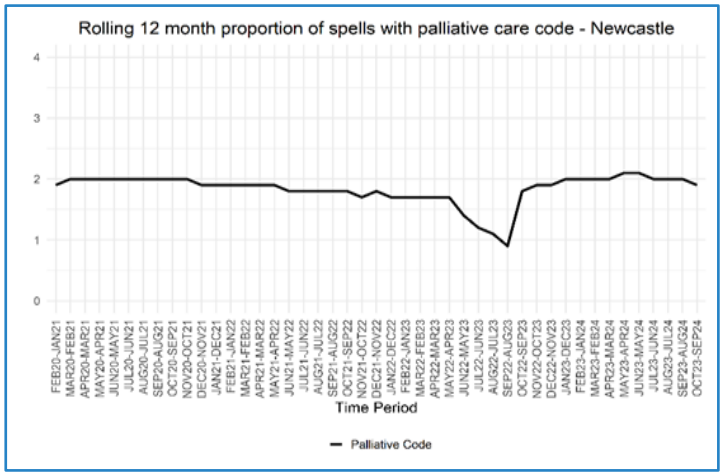
All data rolling 12 month periods. Data as reported by NHS England.

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

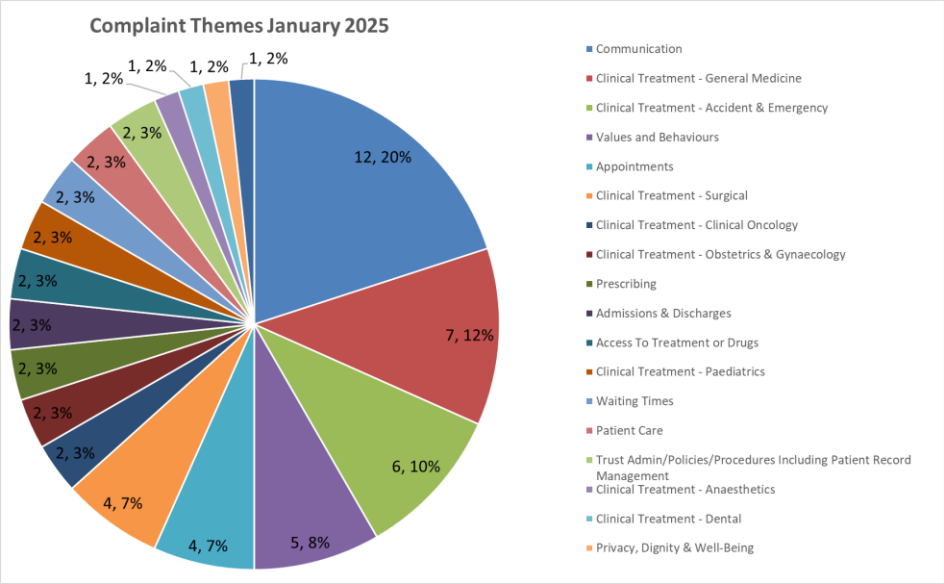


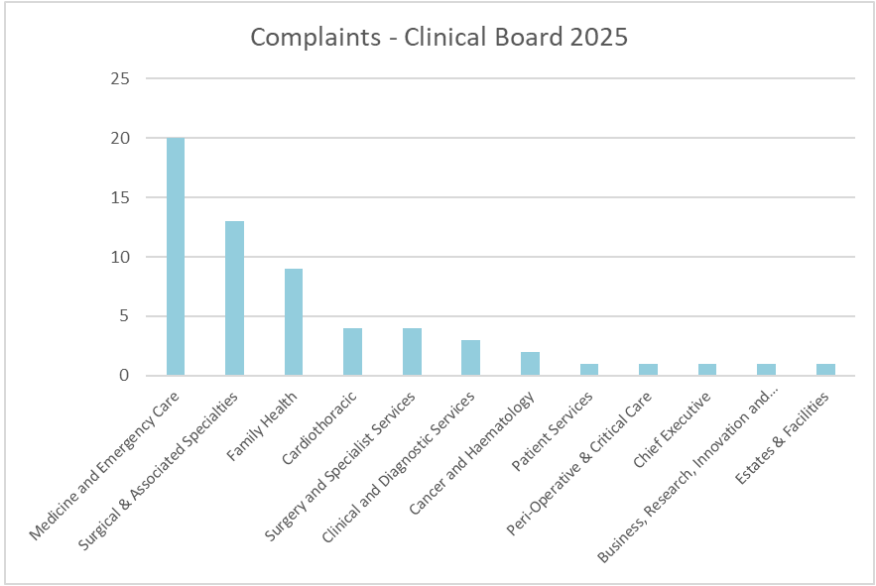
Coding Depth
Coding depth has a substantial impact on mortality indicators. Within the latest published SHMI data the Trust has an elective coding depth of 7.0 and a non-elective coding depth of 6.4*.

Spells with palliative code
Between October 2023 – September 2024, the Trust has a 1.9% palliative care coding rate.



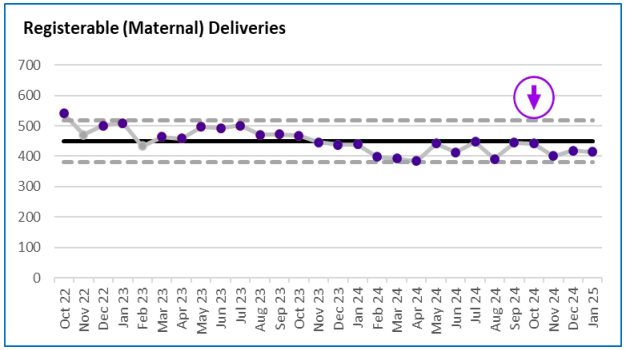
Formal Complaints

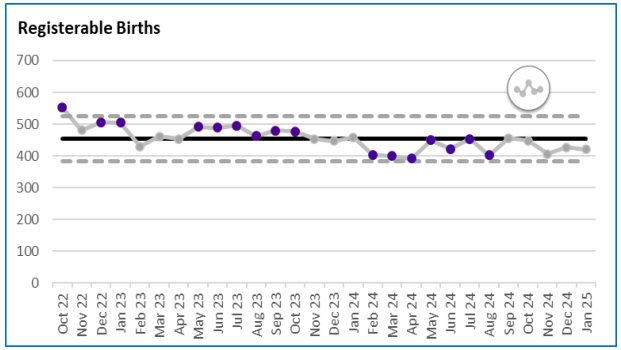


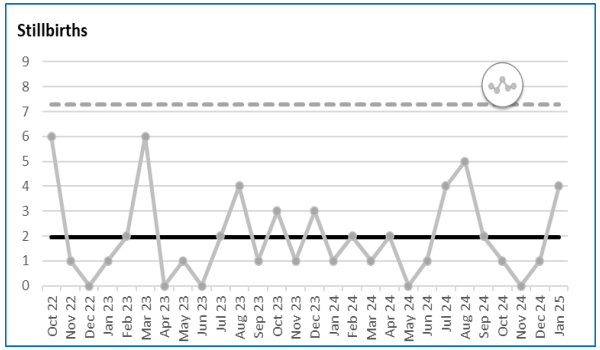


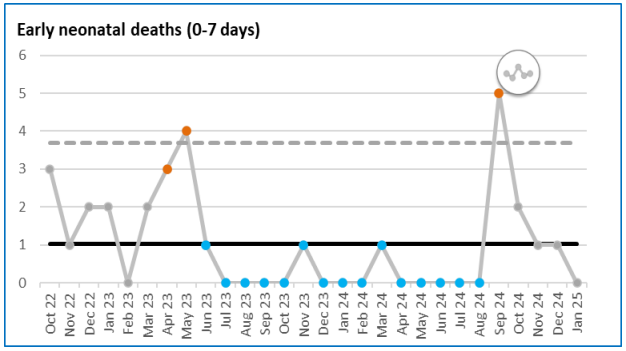
- The Trust has had 60 formal complaints In February 2025. The average number of complaints opened this financial year is currently 53, which is five complaints higher than the Trust average for the previous financial year.
- The main theme for complaints continues to be Communication accounting for 20% of the complaints (12).
- Clinical treatment accounts for the most complaints collectively with 42% of complaints opened this month (25).
- The most complaints were opened for the following clinical boards:
    - Medicine 20 (33%)
    - Surgical & Associated Specialties 13 (22%)
    - Family Health 9 (15%)

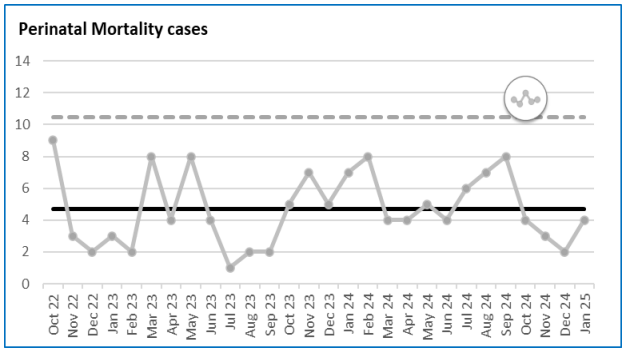
Perinatal Quality Surveillance: Births











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 on the 2 December 2024. There were 36 births on NBC in December and 30 in January. Activity will continue to be closely monitored.

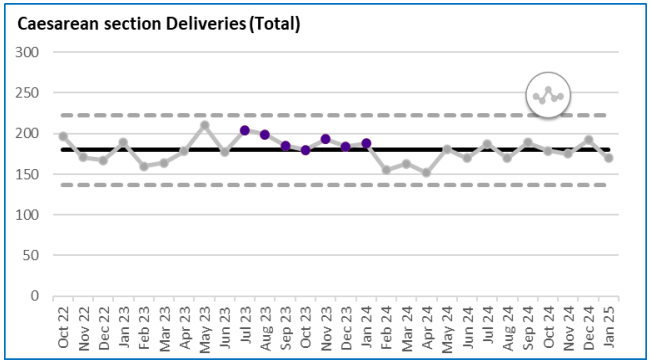
Stillbirths

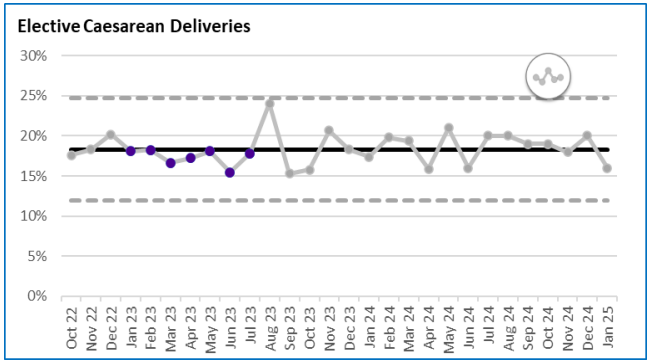
- Newcastle is a tertiary referral Fetal Medicine Unit, providing care to the most complex cases from across NENC. This data includes termination for fetal anomalies >24 weeks gestation. There were 4 stillbirths in January 2025. All will be reviewed via the Perinatal Mortality Review process. Two cases underwent a rapid review / Multi-Disciplinary Team (MDT) with some initial learning identified and shared with staff (Average per 1000 births: England 3.2, NENC 3.6).

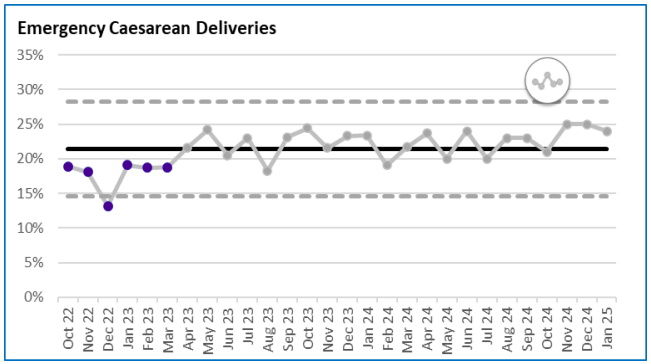
Early Neonatal Deaths

- 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. There were no early neonatal deaths in January 2025.

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 41% in January 2025.

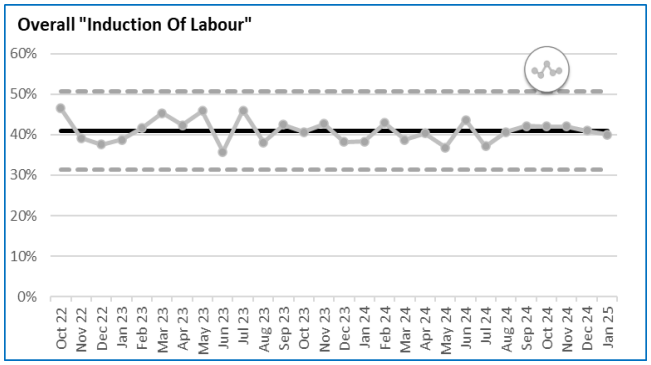
Elective Caesarean section

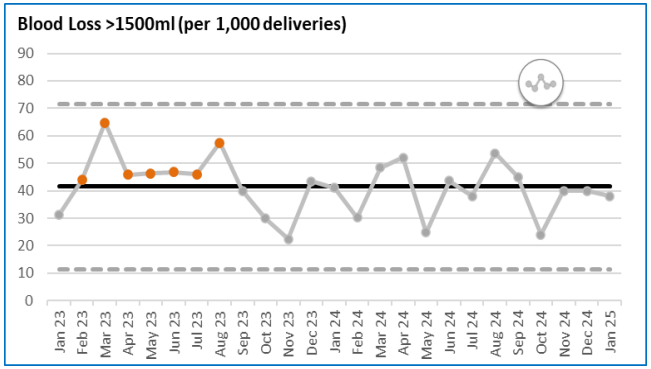
- The average England elective caesarean rate is 18.2%.
- The Trust elective caesarean rate was 16.6% in January compared to 20% in December.
- The rise in elective caesarean rates is partially due to an increasing proportion being undertaken due to maternal request in accordance with the National Institute for Health and Care Excellence (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.

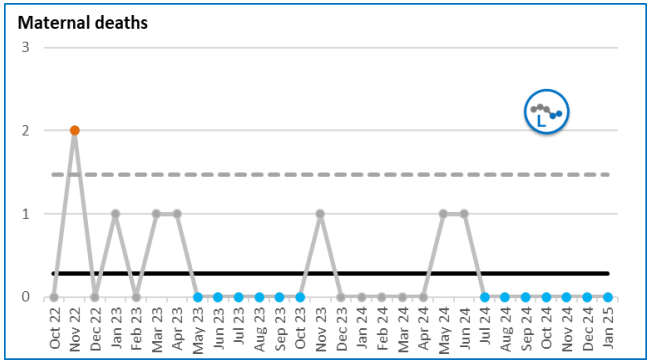
Emergency Caesarean section

- 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 January was 24.4% which is slightly lower than December 2024.
- 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% between October to December. In January it reduced slightly to 40.1%. There is currently an Induction of Labour Quality Improvement Plan (QIP) reviewing pathways and patient experience.

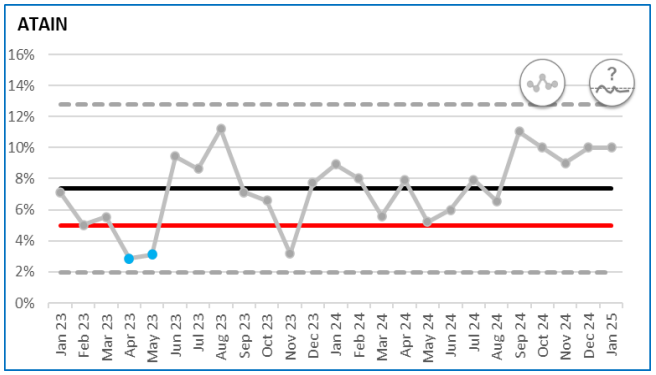
Blood Loss >1500ml

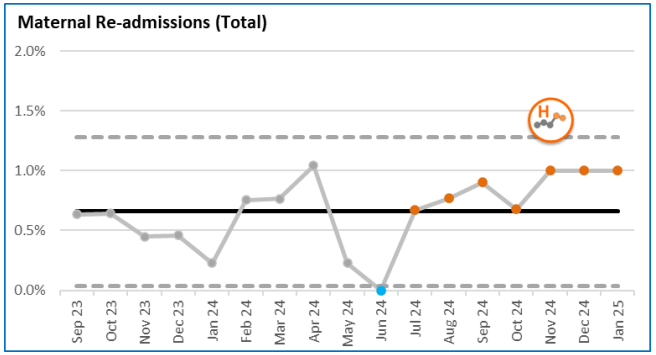
- In 2023 the Trust triggered a safety signal for postpartum haemorrhage >1500ml per 1000 births on the NENC clinical dashboard, which instigated a deep dive and audit. The recommendations of the review were enacted and resulted in a reduction in the PPH rate. The average PPH rate for England is 33 per 1000 and NENC average is 32 per 1000. PPH rate in January was 38 per 1000, this is indicative of the complexities of the high-risk patient group and provision of the Placenta Accreta Spectrum service as confirmed by the previous review.

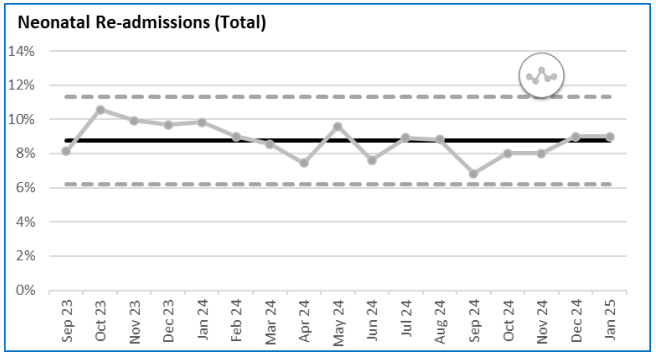
Maternal Deaths

- 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 2024 and January 2025.

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 Neonates Intensive Care Unit (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. The LMNS have been asked to agree a NENC definition of unplanned admission.

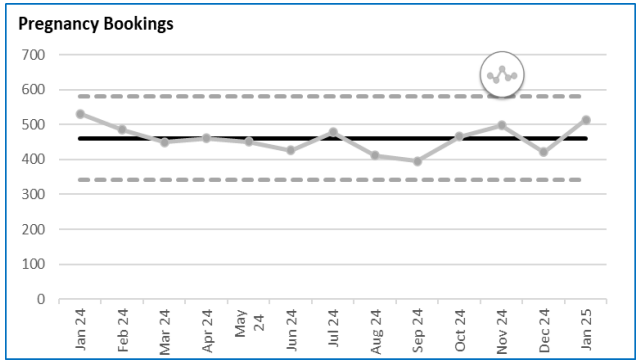
Maternal Readmissions

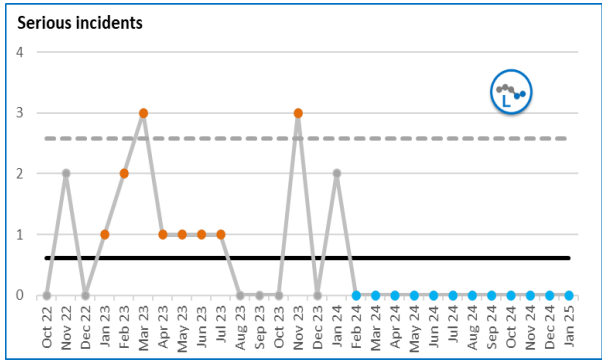
- This is a new metric; work is ongoing to benchmark performance with national parameters. From National Maternity & Perinatal Audit (NMPA) Report (2022) the maternal postnatal readmission rate for England was 3.3%, with rates being higher following caesarean section compared with vaginal birth (4.3% vs 2.9%). The LMNS are working to agree a NENC KPI for this metric. Maternal readmission rate for January remained at 1%, significantly less than the England average.

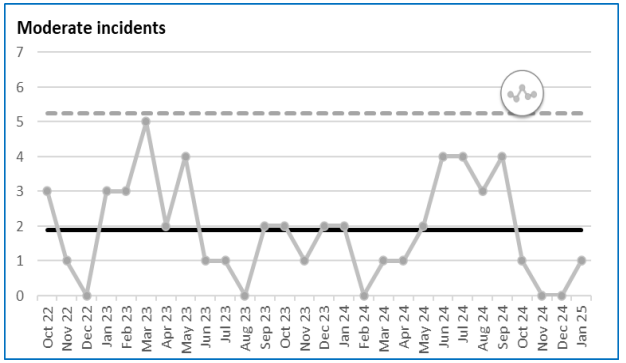
Neonatal Readmissions

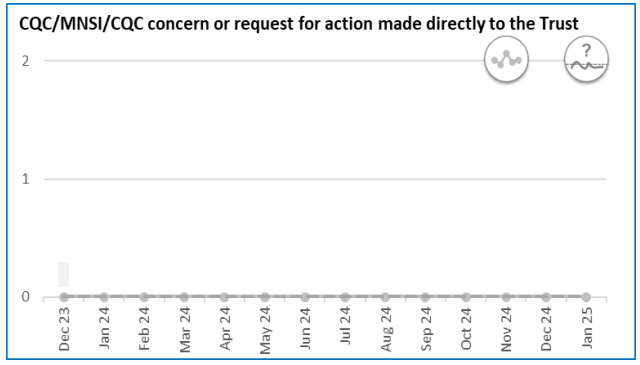
- This is a new metric; work is ongoing to benchmark performance with national parameters. Clinical Quality Improvement Metrics (CQIM) for 'Babies readmitted to hospital who were under 30 days old' data is available for this indicator from March 2024- June 2024. The national rate for this period ranges from 5.3- 5.5%. Neonatal readmission rate for January is 9%. This will be explored further once the LMNS agree the NENC KPI for this metric.

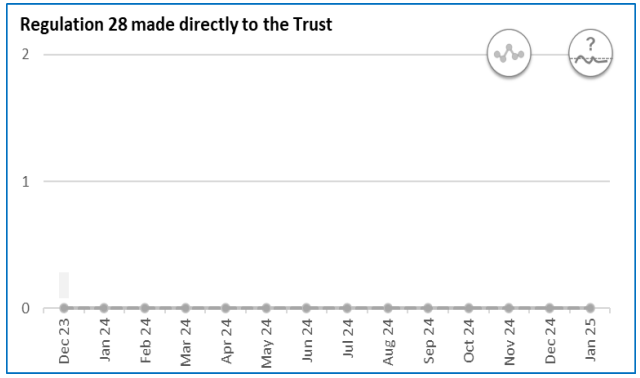
Perinatal Quality Surveillance: Incidents & Bookings











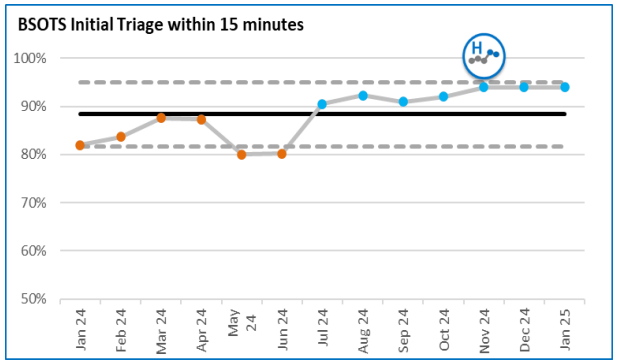
Incidents

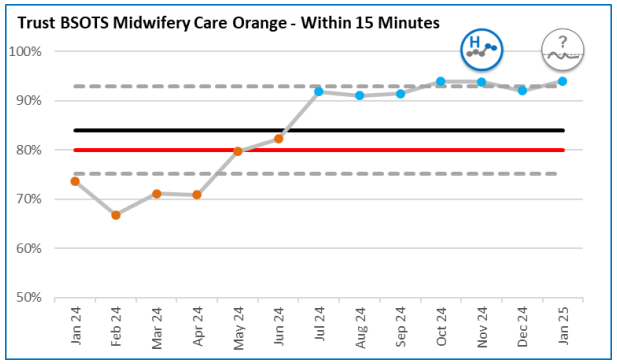
- There was one moderate (and above) incidents reported in maternity in January 2025. An 'After Action Review' is underway and initial learning from this incident has been shared with staff. The theme was failure to recognise a deteriorating patient and escalate earlier for senior medical review.
- The 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.
- There have been no CQC/MNSI concerns or requests for action in last 12 months.
- There have been no regulation 28 notices in the last 12 months.

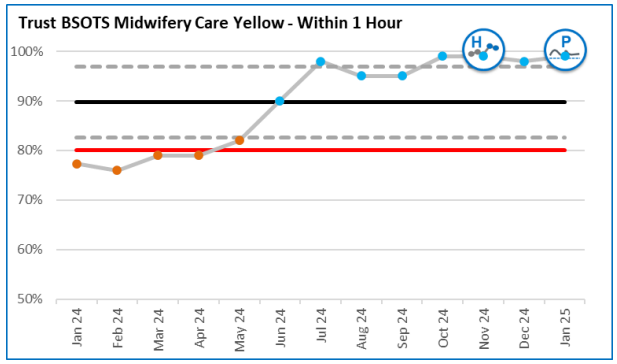
Pregnancy Bookings

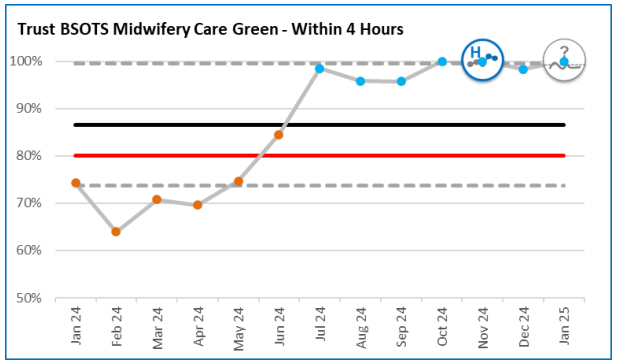
- The number of women choosing to book for care and delivery at the Trust had fallen steadily since January 2024. The Trust is aware that this decision was influenced by the closure of the Newcastle Birthing Centre. However, the number of bookings in January has increased to 514, in December there were 421. This metric will continue to be monitored closely but the service are optimistic this is in response to the opening of the birthing centre.

Perinatal Quality Surveillance: Triage - Midwifery Care Timings





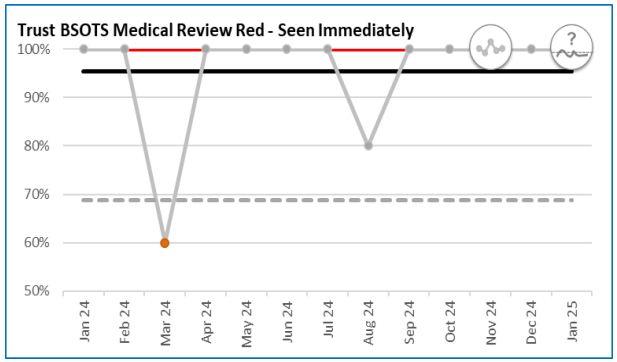


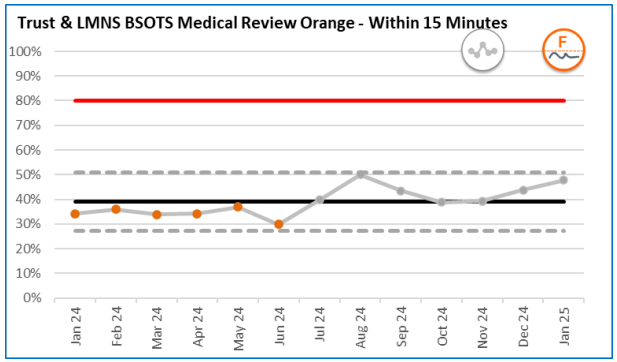


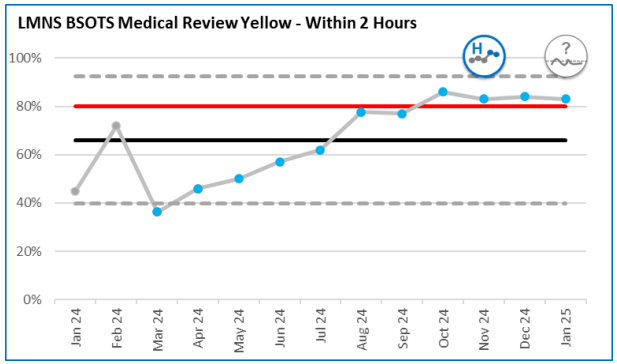
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

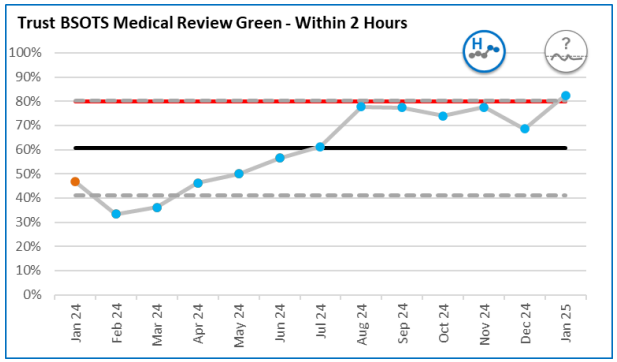
- The Trust implemented the BSOTS triage system in January 2024. Midwifery triage and subsequent review has improved considerably and has exceeded the Trust and LMNS target.

Perinatal Quality Surveillance: Triage - Medical Review Timings





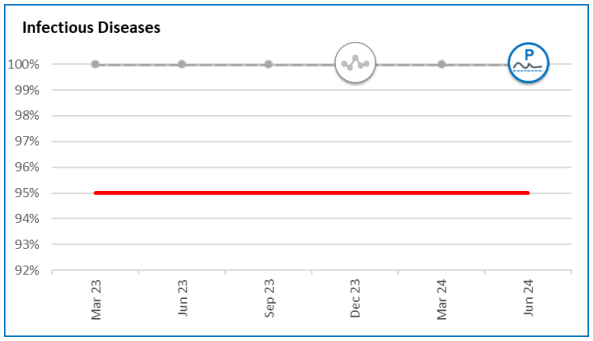


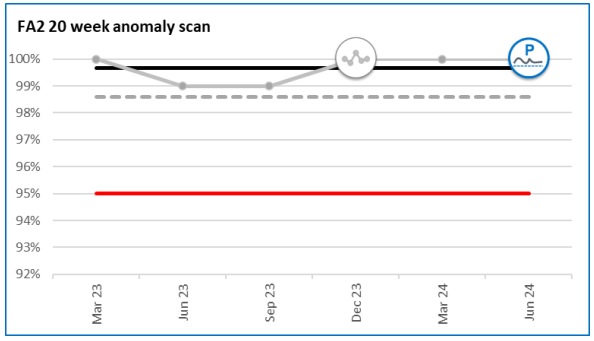


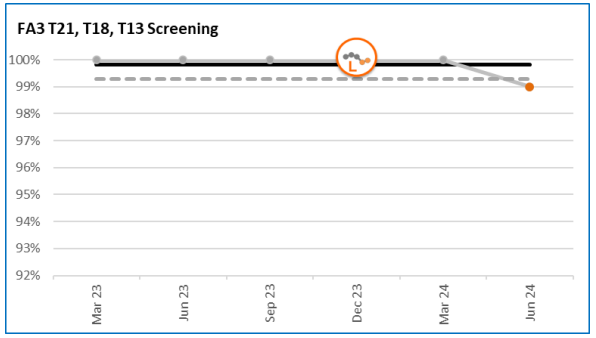
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

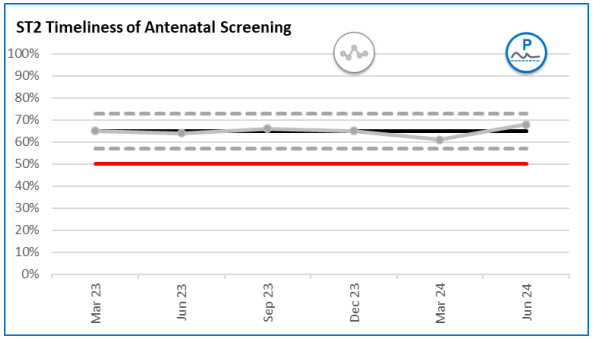
- The Trust has now bench marked performance against the NENC LMNS target for each of the categories. It is worth noting that the timescales for review are longer for women in the yellow category (2 rather than 1 hour) and the targets for compliance lower than those previously set internally.
- The service will continue to aspire to reach the Trust performance target but will be benchmarked against the LMNS target on the NENC Triage Dashboard.
- There is still work to do to improve performance will reviews within 15 minutes however there has been significant improvements in performance in the last 12 months.

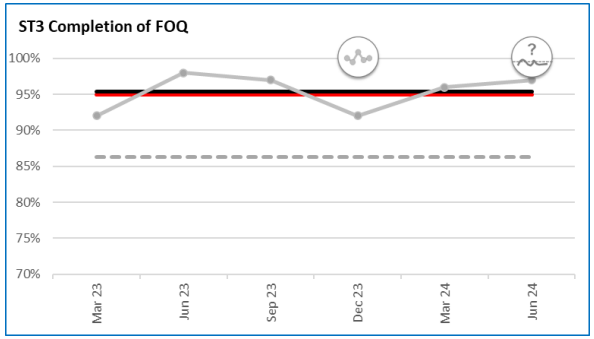
Perinatal Quality Surveillance: Antenatal Screening

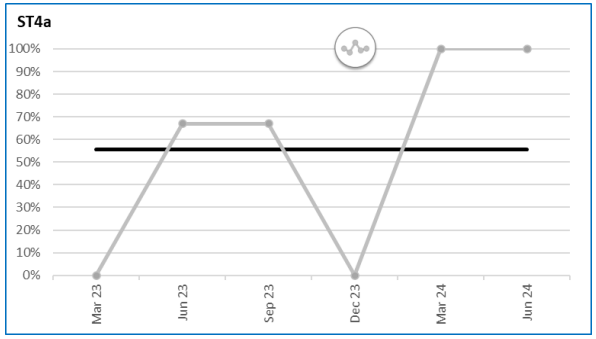


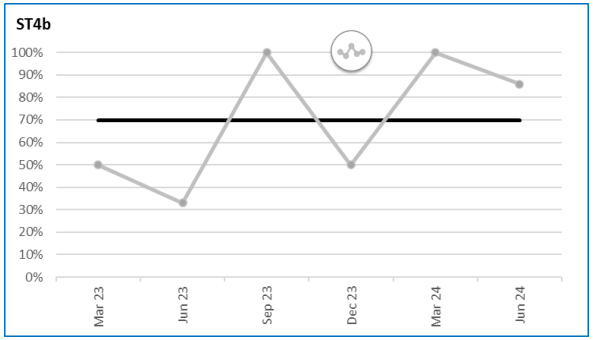


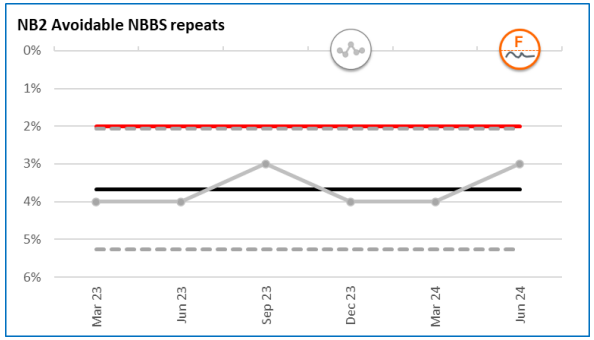








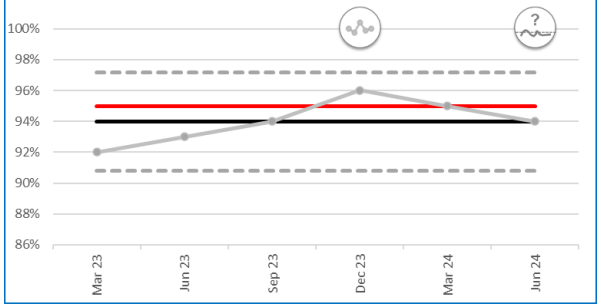




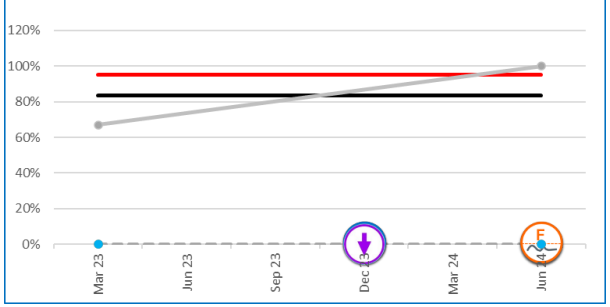
- 1 patient safety incident investigation (PSII) underway, 2 completed.
- Comprehensive action plan in place. Incident oversight group with NHSE & Integrated Care Board (ICB) colleagues meeting fortnightly.
- QIP to review antenatal clinic patient flow, failsafe and administration processes underway.

Perinatal Quality Surveillance: NIPE Screening

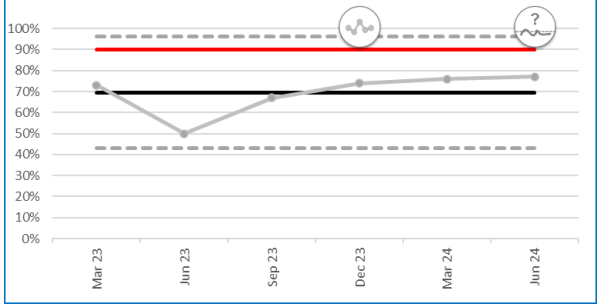
S01 - % screen compliant <72 hrs of age



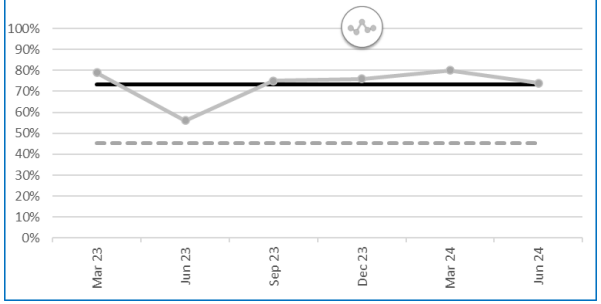
S02 - % eye abnormality suspected/seen <14 days of examination



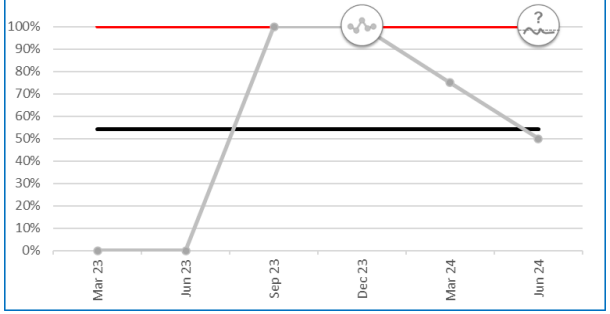
S03 - % hip USS attended between 4-6 weeks



S04 - % of hip referral outcome decision made (<6 weeks corrected age)



S05 - % suspected bi-lateral undescended testes seen <24 hrs



Perinatal Quality Surveillance: Patient Experience

Your labour and the birth of your baby						
Question	Question Text	2024 11	2024 12	2025 01	Change	
C4	Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?	80%	93%	84%	-9%	Top 20%
C5	Were you involved in the decision to be induced?	85%	77%	81%	5%	Top 20%
C6	At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	91%	94%	100%	6%	Top 20%
C7	During your labour, were you ever sent home when you were worried about yourself or your baby?	100%	100%	98%	-2%	Top 20%
C8	Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth?	88%	91%	86%	-5%	Top 20%
C9	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	98%	97%	97%	0%	Top 20%
C10	Did the staff treating and examining you introduce themselves?	94%	98%	93%	-6%	Middle 60%
C11	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you	86%	94%	90%	-4%	Top 20%
C12	If you raised a concern during labour and birth, did you feel that it was taken seriously?	91%	100%	87%	-13%	Top 20%
C13	During labour and birth, were you able to get a member of staff to help you when you needed it?	91%	95%	95%	-1%	Top 20%
C14	Thinking about your care during labour and birth, did you feel that the midwives and / or doctors looking after you worked well together?	94%	94%	92%	-2%	Top 20%
C15	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	97%	98%	96%	-2%	Top 20%
C16	Thinking about your care during labour and birth, were you involved in decisions about your care?	93%	95%	90%	-5%	Top 20%
C17	Thinking about your care during labour and birth, were you treated with respect and dignity?	96%	98%	94%	-4%	Top 20%
C18	Did you have confidence and trust in the staff caring for you during your labour and birth?	93%	94%	89%	-4%	Top 20%
C19	After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	77%	73%	81%	8%	Top 20%
C20	During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	87%	88%	85%	-3%	Top 20%
C21	Thinking about your care during labour and birth, were you treated with kindness and compassion?	96%	97%	92%	-5%	Middle 60%
	Average	**91%**	**93%**	**91%**	**-3%**	

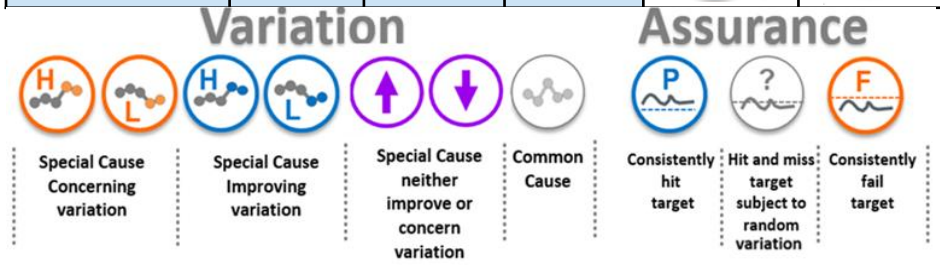
Patient perspective

- 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 Care Quality Commission (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.
- This report includes all responses from women during January 2025, 407 surveys were delivered, with 77 responding, 19%
- The Trust is in the top 20% of Trusts overall. It is in the top 20% on 38 questions, middle 60% on 18 questions and bottom 20% on 1 question. Overall, results are good in these areas, communication with staff at all stages of pregnancy, cleanliness, help with feeding, not leaving alone at a worrying time. Results could be improved in, asking women about their mental health, elements of postnatal care in the hospital, and staff introducing themselves. The postnatal quality improvement action plan is making good progress.

Performance

Performance Overview

Metric	Period	Actual	Target	Variation	Assurance
A&E Arrival to Admission / Discharge	Jan-25	75.4%	78%		?
Referral to Treatment (RTT) 18 Weeks	Jan-25	69.8%	92%		F
>65 Week Waiters	Jan-25	138	0	L	F
Cancer 28 Day FDS	Dec-24	76.1%	77%		?
Cancer 31 Day	Dec-24	75.0%	96%	L	F
Cancer 62 Day	Jan-25	63.7%	70%	H	F
Diagnostic 6 Weeks	Jan-25	17.9%	5%	L	F



Emergency Care

- Type 1 and overall performance improved for the second consecutive month in January, remaining in line with common cause variation.
- In January, 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 3%.

Elective Waits

- January witnessed a 6% increase in the number of >52 week waits at Newcastle Hospitals, rising to 1,780, however remaining 56% lower than January 2024 levels.
- The number of >65 week waits increased marginally from December to 138 (+8) as the Trust managed a significant volume of tip-ins within the month. 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 notably and is showing special cause variation of an improving nature.

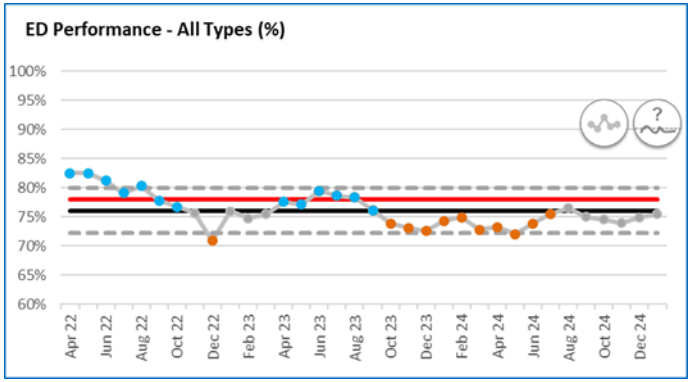
Cancer Care

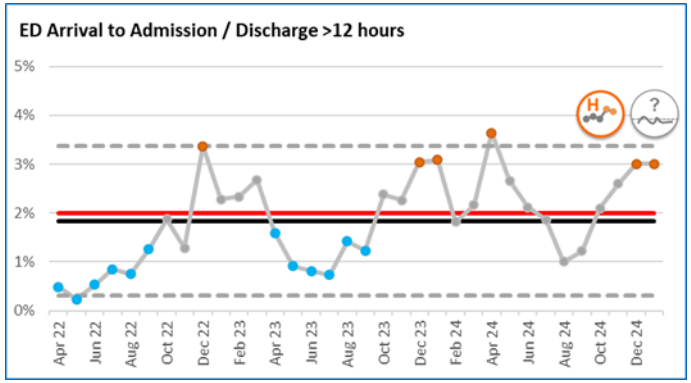
- In December, the 77% 28 Day Faster Diagnosis Standard (FDS) was failed for the fifth successive month (76.1%). This is within the level of natural variation to be expected given recent historical trends
- 31 Day performance has continued to deteriorate (75.0% for December) with performance outside the control limits for four successive months.
- 62 Day compliance for December was 64.0%, reflecting improving special cause variation despite an overall consistent failure to hit the target.

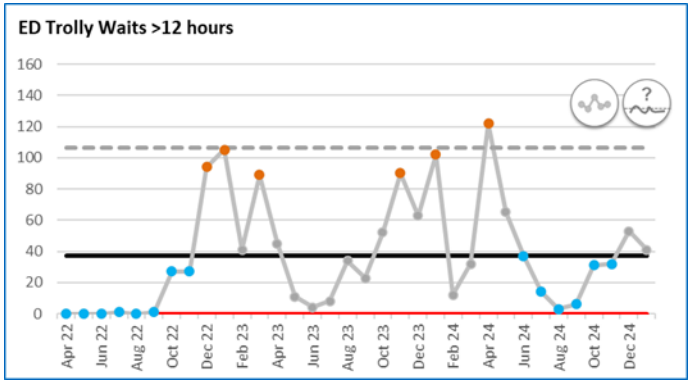
Diagnostics

- Performance has improved for five successive months – 17.9% of patients were waiting over six weeks at the end of January. The target continues to be consistently failed but there is now special cause variation of an improving nature.

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.

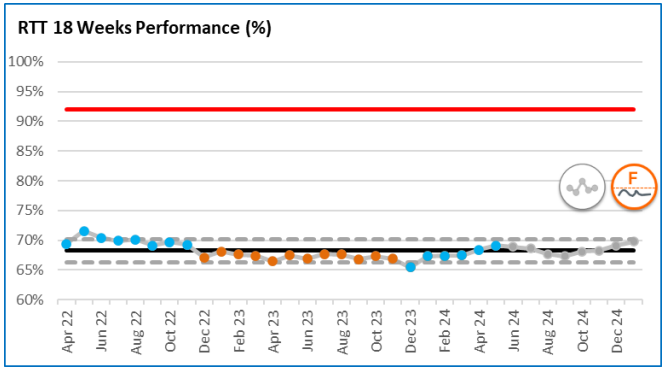
Current position

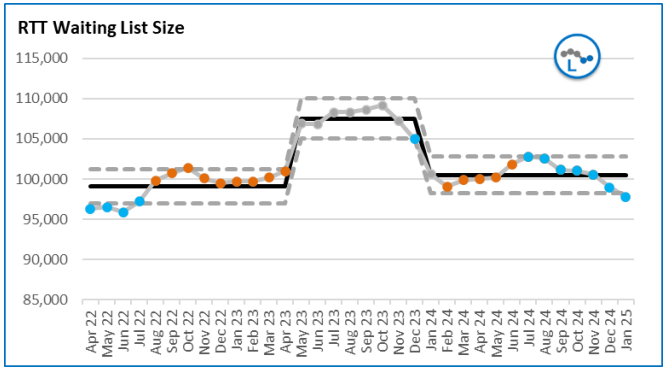
- Type 1 and overall performance improved for the second consecutive month in January, increasing to 60.8% (+1.7%) and 75.3% (+0.4%), remaining in line with common cause variation.
- Emergency Department (ED) attendances (All Types) were at their lowest since August 2024, at 19,138. This was a 1,128 decrease from December 2024.
- Ambulance handovers > 60 minutes saw a reduction in January with a total of 91, a 25% reduction from December 2024.
- ED Discharges increased to 8,829, the highest since October 2024, and a 4% increase compared to January 2024.
- ED Arrival to Discharge remained consistently high at 3%, failing for the fourth successive month. Performance against this metric is deteriorating and the target lies within the process limits, so achievement is sporadic and unpredictable.

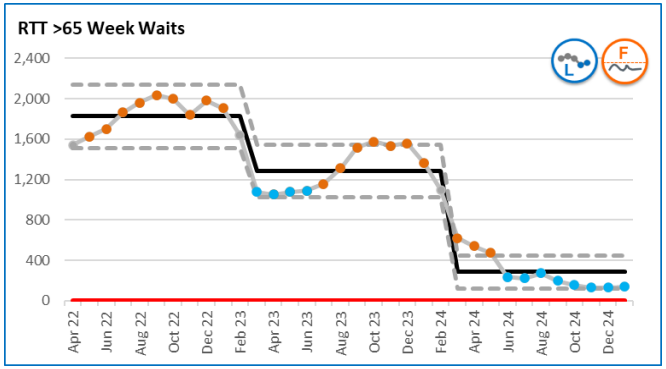
Action taken

- Front Door Frailty Service launched on Monday 13th January with therapy nurse practitioners, Senior House Officers (SHO) and consultant geriatrician support. This has supported reducing unnecessary admissions and increasing the visibility of frailty and increased screening.
- Winter ward is open and functioning, and both discharge lounges are open. Utilisation has overall picked up, and there are plans to energise and promote the discharge lounge at the RVI.
- There has been a change in discharge hub process, with a joint site hub meeting now for complex patients/troubleshooting only, improving patient discharge.
- Same day emergency care (SDEC) footprint has been extended onto Ward 1 to include vascular and urology. Additional Nurse Practitioners are coming into post with the aim to decompress emergency admissions suite.
- ED Oversight Group has been established, meetings are fortnightly to integrate quality and performance workstreams.

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).

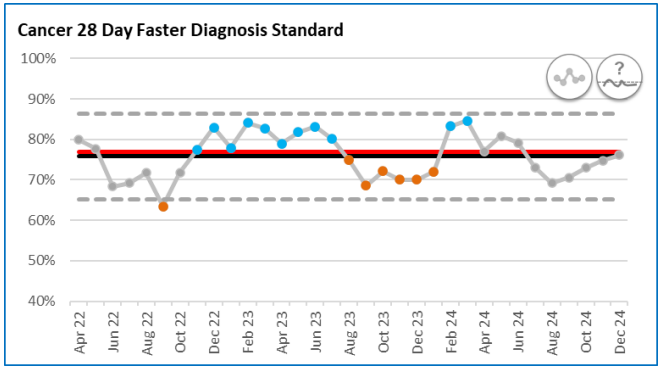
Current position:

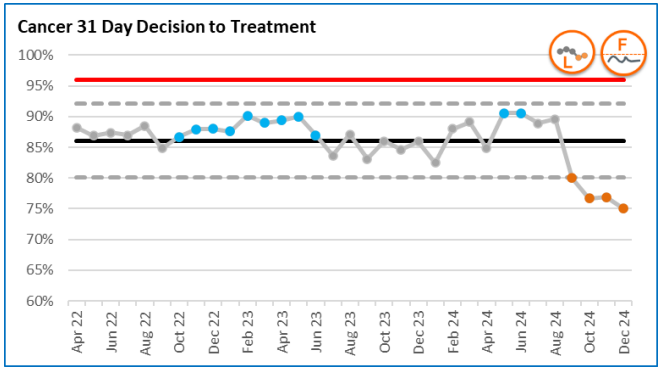
- January witnessed a 6% increase in the number of >52 week waits at Newcastle Hospitals, rising to 1,780, however remaining 56% lower than January 2024 levels. The number of >65 week waits increased marginally from December to 138 (+8) as the Trust managed a significant volume of tip-ins within the month.
- The total number of patients waiting >78 weeks remained static at 22 with breaches centred in specialties in Spinal Surgery, T&O and Ophthalmology corneal graft patients.
- While excellent progress has been made in reducing long waiters throughout 2024/25, challenges remain at both 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 exacerbated by a pause in the service.
- The total waiting list (WL) size decreased notably in January and now displays improving variation. The total number of patients waiting >18 weeks dropped to 29,535, with RTT 18-week performance recorded at an improving 69.8%.

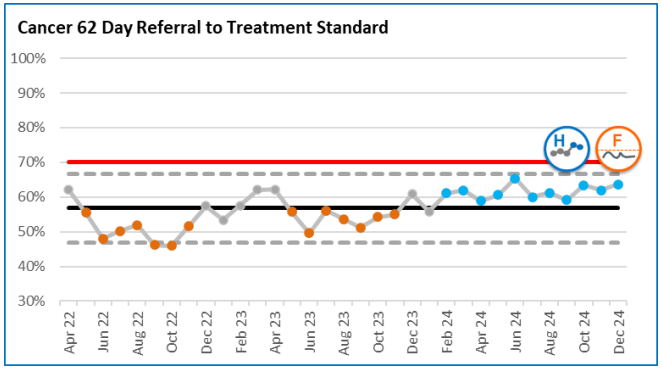
Action taken

- Mutual aid is in place with Gateshead for Foot and Ankle (F&A), with further regional mutual aid on repatriation of patients and re-directing referrals at source agreed in principle.
- Early discussions commenced with Northumbria regarding F&A surgeons operating at Newcastle.
- The Trust continues to send appropriate patients to the regional spinal MDT for Adult Deformity Service for review to accelerate their treatment.
- Weekend Waiting List Initiative (WLI) lists remain in place across specialties, including T&O Foot and Ankle and Spinal Neuro.
- The Trust's access policy has been thoroughly reviewed against NHSE guidance and continues to be rigorously and appropriately applied.

Cancer Care







Standards

Please note – January cancer performance unavailable at the time of the production of this report.

- 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).

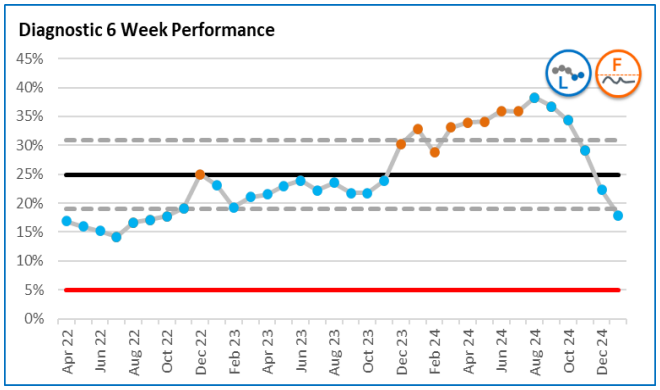
Current position:

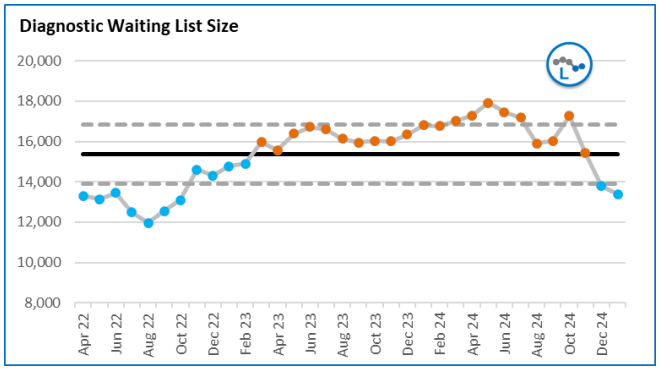
- In December, the 77% 28 Day Faster Diagnosis Standard (FDS) was failed for the fifth successive month (76.1%). This is within the level of natural variation to be expected given recent historical trends. Skin cancer performance has the largest impact of any singular tumour group on overall achievement – issues with engagement in teledermatology from primary care have resulted in empty digital clinics and longer waits for face-to-face appointments.
- 31 Day performance has continued to deteriorate – 75.0% for December, with performance now outside the control limits for four 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 December was 64.0%, 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 – January 2025			
MRI	21.5%	CT	9.9%
Non-obs US	12.9%	DEXA	12.4%
Audiology	8.5%	ECHO	53.0%
Electrophysiology	53.3%	Neurophysiology	3.6%
Sleep Studies	88.7%	Urodynamics	20.0%
Colonoscopy	9.8%	Flexi-Sig	20.0%
Cystoscopy	25.3%	Gastroscopy	14.0%
Newcastle Hospitals Total			**17.9%**

Standards

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

Current position:

- Performance against the 5% standard has improved for 5 successive months. 17.9% of patients were waiting over six weeks at the end of January - the highest performance achieved in over 2 years and compares to 38.3% as recently as August 2024. The target continues to be consistently failed but there is special cause variation of an improving nature. Audiology has improved most significantly with performance of 8.5% in January compared to 53.8% in December.
- The waiting list (WL) fell by 405 patients in January meaning the WL has reduced by 3,882 patients since October - the biggest drop in a three-month period for many years. Consequently, the special cause variation of a concerning nature has been eliminated and conversely special cause variation of an improving nature is now present. Aligned to the increased activity, the Audiology WL alone fell by 1,543 patients with a particular reduction in those waiting >6 weeks.
- There was another drop in the volume of patients waiting >13 weeks to 574 (reduced from 1,043 in December and 2,390 in November) with this improvement also attributable to Audiology. MRI now have the most >13 week waiters (266).

Action taken

- Since November 2024, Audiology have used insourcing, overtime and direct access clinic sessions to work through their backlog. Consequently, the monthly average for tests undertaken in the past 3 months (2,743) is more than double the average (1,232) in the first 7 months of 24/25.
- Numerous actions are also being taken to increase Audiology efficiency. Changes have been made to clinic templates, a new screening tool has been piloted since December 2024 and booking processes altered to ensure any cancelled clinics/patients are rescheduled sooner.
- The Trust is working with suppliers to ensure IT issues at The Community Diagnostic Centre (CDC) at the Metrocentre are resolved, which will particularly benefit Echo performance.
- Radiology are working with the Trust's Communications Department to highlight the CDC provides services for Newcastle patients, to try and reduce the reluctance of patients to travel.
- Deepresolve Acceleration software is being installed on Neuroradiology scanners in early March to reduce scanning times.
- A working group has been established to deal with the issue of particularly long waits for certain complex MRI scans, in order to reduce over 13 week waiters.

Contractual & Planning Standards (1/2)

Theme	Standard	Oct-24	Nov-24	Dec-24	Jan-25	Num.	Den.	24/25 YTD
Activity & Elective Care								
Day Case	**100%** of 24/25 Plan (equivalent to 107% of 19/20 value-weighted activity)	100.0%	99.0%	**100.5%**	**102.8%**	11,737	11,420	**89.0%**
Elective Overnight		100.5%	102.1%	**105.0%**	**91.6%**	1,667	1,820	**89.5%**
Outpatient New		97.8%	98.1%	**99.7%**	**101.5%**	27,249	26,839	**87.1%**
Outpatient Procedures		108.4%	109.1%	**106.4%**	**103.7%**	20,938	20,182	**95.7%**
Outpatient Review	**N/A**	115.7%	117.9%	**123.7%**	**123.3%**	71,313	57,841	**103.3%**
Non-Elective		95.2%	88.4%	**95.1%**	**94.1%**	1,022	1,086	**89.4%**
Emergency		110.3%	107.0%	**106.4%**	**106.9%**	6,415	6,001	**94.6%**
RTT 18 Week Wait	**92%**	68.1%	68.4%	**69.1%**	**69.8%**	68,263	98,980	**68.6%**
>78 Week Waiters	**Zero**	23	19	**22**	**22**	22		
>65 Week Waiters	**Zero** (by Sep-24)	158	130	**130**	**138**	138		
>52 Week Waiters	As per submitted trajectory	2,130	2,048	**1,683**	**1,780**	1,780		
RTT Waiting List Size	As per submitted trajectory	101,025	100,553	**98,980**	**97,798**	97,798		
Diagnostic Activity	**120%** of 19/20 activity	111.1%	120.7%	**126.8%**	**126.9%**	24,410	19,326	**114.8%**
Diagnostic 6 week wait	<=**5%** (local target of <=15%)	34.3%	29.1%	**22.3%**	**22.3%**	2,402	13,794	**32.2%**
Day case rates (BADS procedures)	**85%**	**87.0%**	TBC	TBC	TBC			
Capped Theatre Utilisation	**85%**	77.9%	78.7%	**75.5%**	**80.0%**			
Urgent Ops. Cancelled Twice	**Zero**	0	0	**0**	**0**	0		**0**
Cancelled Ops. Rescheduled >28 Days	**Zero**	18	7	**15**	**13**	13		**119**
OP Activity Ratio: New/Procedure	**46%**	42.5%	42.0%	**41.5%**	**40.9%**	46,130	94,823	**41.6%**
>12 Week Waiters Validated	**90%**	75.6%	72.7%	**74.4%**	**77.4%**	21,390	28,910	**70.4%**
Outpatient Review Reduction	**25%** reduction vs 19/20 baseline	110.2%	114.9%	**114.0%**	**111.1%**	93,928	79,058	**109.1%**
PIFU Take-up (%)	>=**5%** of all OP atts. (by Mar-25)	2.3%	2.4%	**2.2%**	**2.4%**	3,072	107,127	**2.2%**

Contractual & Planning Standards (2/2)

Theme	Standard	Oct-24	Nov-24	Dec-24	Jan-25	Num.	Den.	24/25 YTD
Cancer Care								
28 Day Faster Diagnosis	**77%** (by Mar-25)	73.1%	**74.7%**	**76.1%**	TBC	1,811	2,986	**74.8%**
31 Days (DTT to Treatment)	**96%**	76.7%	**76.9%**	**75.0%**	TBC	984	1,401	**83.7%**
62 Days (Referral to Treatment)	**70%** (by Mar-25)	63.4%	**62.0%**	**63.7%**	TBC	264	473	**61.6%**
>62 Day Cancer Waiters		221	196	**217**	**197**	197		
Urgent & Emergency Care								
A&E Arrival to Admission/Discharge	**>=78%** under 4 hours (by Mar-25)	74.5%	73.9%	74.9%	**75.4%**	14,428	20,266	**74.4%**
	<=2% over 12 hours	2.2%	2.6%	2.7%	**2.1%**	407	20,266	**2.3%**
A&E Decision to Admit to Admission	**Zero** over 12 hours	31	32	53	**41**	41		**404**
Adult General & Acute Bed Occupancy	**<=92%**	92.1%	93.2%	88.0%	**90.4%**	1,319	1,422	**89.2%**
Ambulance Handovers <15 mins	**65%**	55.7%	49.8%	45.8%	**47.6%**	1,554	3,256	**52.9%**
Ambulance Handovers <30 mins	**95%**	84.2%	82.0%	80.1%	**82.7%**	2,704	3,256	**84.3%**
Ambulance Handovers >60 mins	**Zero**	114	68	114	**91**	91		**757**
Urgent Community Response Standard	**>=70%** under 2 hours	87.6%	88.5%	89.5%	**75.1%**	346	505	**82.2%**
Safe, High Quality Care								
Mixed Sex Acommodation Breach	**Zero**	71	86	72	**76**	76		**849**
VTE Risk Assessment	**95%**	**92.2%**			TBC			
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour	**55.0%**			TBC			
Sepsis Screening Treat. (All)		**89.0%**			TBC			

People

People Overview

Metric	12-Month Rolling	Actual	Target	Variation	Assurance
Sickness	Jan-25	5.47%	4.5%	H	F
Short-term	Jan-25	2.25%			
Long term	Jan-25	3.89%			
Turnover	Jan-25	9.02%	10%	L	?
Mandatory training	Jan-25	92.87%	90%	H	P
Appraisal	Jan-25	84.43%	90%		F
Disabled staff	Jan-25	5.69%		H	
Ethnicity (BAME staff)	Jan-25	17.42%		H	

Staff in post (Whole Time Equivalent ((WTE))

- January 15,268 wte: 1,839 wte (13.7%) above pre-Covid; and 651 wte (4.5%) above plan of 14,617 wte.
- Clinical staff (excluding Medical & Dental) highest increase +1,214 wte (14%).

Sickness

- Total sickness absence remained at 5.47% (consistently failing target).
- Top reasons for sickness: anxiety/stress/depression 31%; cold/cough/flu 15%; gastrointestinal 8%.
- Short-term sickness increased in January to 2.25%, long term down to 3.9%.

Retention & Turnover

- Total turnover improved by -0.19% to 9.02%.
- Top reason for leaving: work-life balance 16.66%. Top destinations: no employment 39%; other NHS organisation 32.5% (includes retire-return).

Mandatory training

- Performance improved by 0.35% to 92.87%.
- Lowest performance in Medical and Dental at 81.72%.
- Paediatric basic life support is the only mandatory training below 80%.

Appraisal

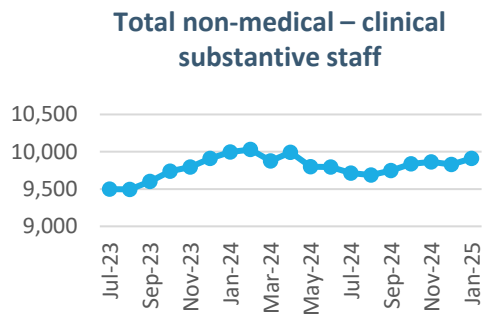
- Performance decreased by -1.18% to 84.43%.

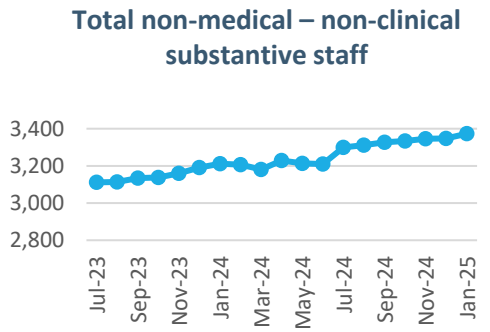
Equality & Diversity

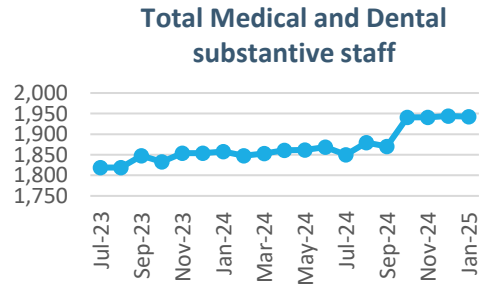
- Disabled staff increased by +0.04% to 5.69%.
- BAME staff increased by +0.11% to 17.42%.

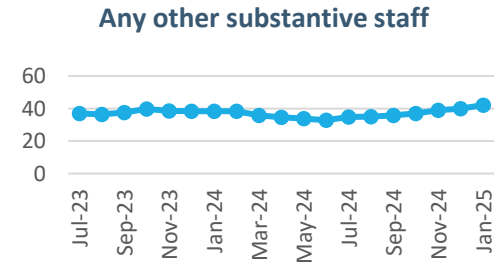
Provider Workforce Return (PWR)

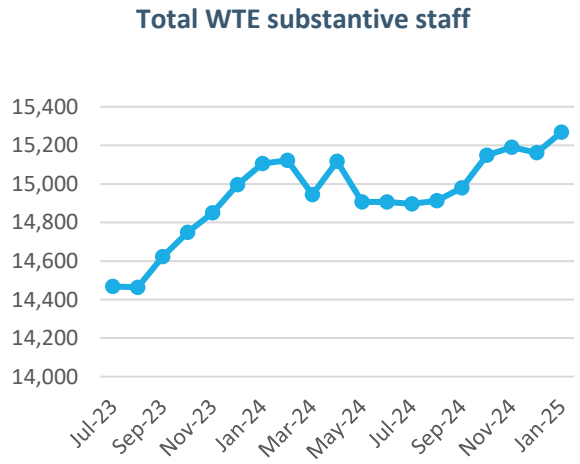
Metric	Benchmark January 2020	Plan (WTE) January 2025	Actual (WTE) January 2025	Difference Jan 20 Actual v Jan 25 Actual	Difference Jan 25 Plan v Jan 25 Actual
Total non-medical - clinical substantive staff	8,696	9,719	9,910	**+ 1,214**	**+191**
Total non-medical - non-clinical substantive staff	2,875	2,957	3,373	**+ 498**	**+416**
Total Medical and Dental substantive staff	1,722	1,902	1,943	**+ 220**	**+41**
Any other staff (substantive total)	135	39	42	**- 93**	**+3**
Total Whole Time Equivalent (WTE) Substantive Staff	**13,429**	**14,617**	**15,268**	**+ 1,839 (13.70%)**	**+651 (4.46%)**







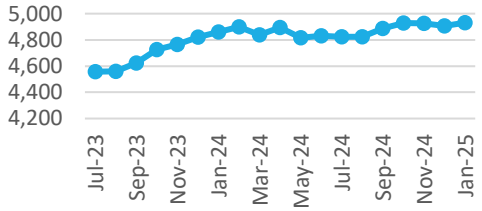




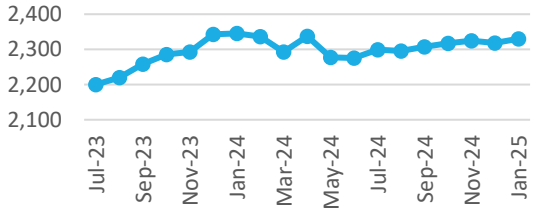
Provider Workforce Return (PWR) - Staff Groups

Metric	Benchmark January 2020	Plan (WTE) January 2025	Actual (WTE) January 2025	Difference Jan 20 v Jan 25
Registered nursing, midwifery and health visiting staff (substantive total)	4,214	4,768	4,931	+ 717
Registered/qualified scientific, therapeutic and technical staff (substantive total)	1,993	2,278	2,330	+ 337
Support to clinical staff (substantive total)	2,489	2,674	2,650	+ 160
Total NHS infrastructure support (includes Admin & Clerical, estates, managers) (substantive total)	2,875	2,957	3,373	+ 498
Medical and Dental (substantive total)	1,722	1,902	1,943	+ 220
Any other staff (substantive total)	135	39	42	- 93
Total WTE Substantive Staff	**13,429**	**14,617**	**15,268**	**+ 1,839 (13.70%)**

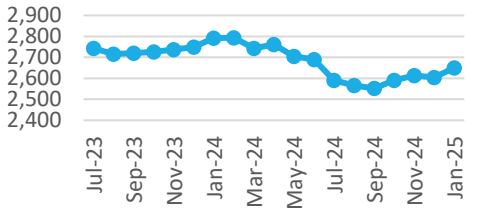
Registered nursing, midwifery and health visiting staff



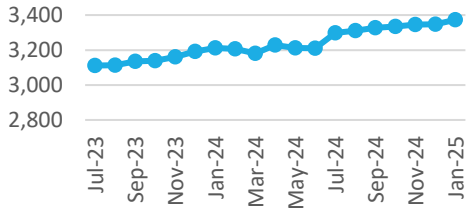
Registered/qualified scientific, therapeutic and technical staff



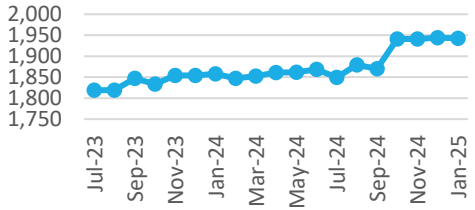
Support to clinical staff



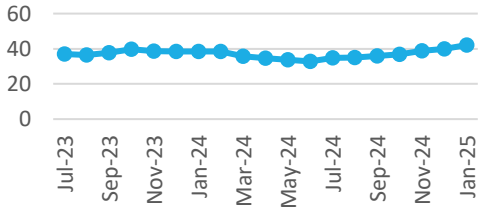
Total NHS infrastructure support



Medical and Dental

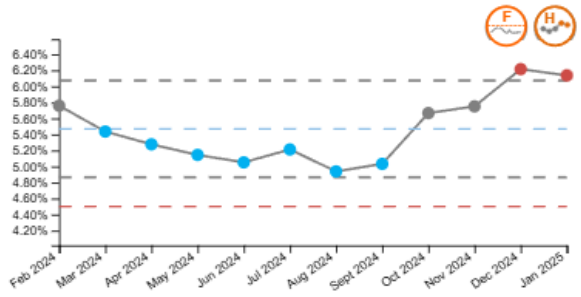


Any other staff



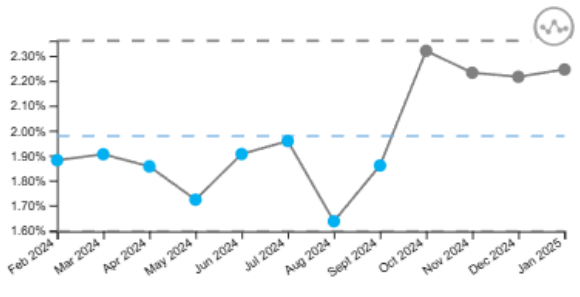
Sickness Absence

Trust Sickness %	12-Month Rolling	Value	Target
	Jan 25	5.47%	4.50%



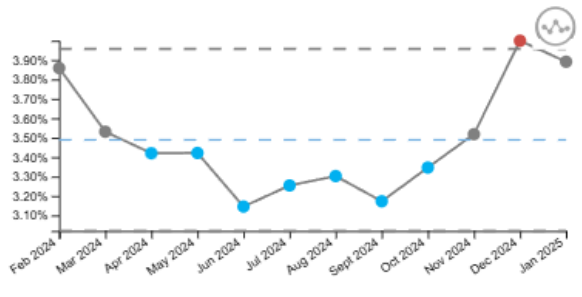
Variation: Assurance:

Metric	Value
Short Term Sickness %	2.25%



Variation:

Metric	Value
Long Term Sickness %	3.89%



Variation:

Current Position:

- 12-month average to January 5.47%.
- January total sickness: 6.14%; short-term 2.25%; long-term 3.89%.
- Top reasons for sickness:
  - Anxiety/stress/depression 31%
  - cold/cough/flu 15%
  - Gastrointestinal problems 8%

Underlying Issues

- Main reason for staff sickness is anxiety/ stress/depression which accounts for 31% of all sickness absence and has an upward underlying trend since May 2023.
- Total full time equivalent days lost: 286,507.
- Average days lost per person: 19.
- Total cost of sick pay: £31.2m.
- Variation in sickness rates across Clinical Boards for the month of January:
  - lowest is Clinical and Diagnostic Services 4.90%; short-term sick 2.01%; long term sick 2.89%
  - highest is Medicine and Emergency Care 6.96%; short-term sick 2.35%; long term sick 4.61%

Actions Undertaken:

- Health and Wellbeing (HAWB) offer – work in progress to identify and agree priorities linked to gap analysis especially in relation to psychological wellbeing.
- New HAWB policy – being finalised in conjunction with Staff Side.
- Sickness absence – a target reduction in sickness absence of 0.5% and a cost reduction in sick pay of £5m have been set for 2025/26.
- Accountability – monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards/Corporate Services. All areas to be asked to renew focus and double-down on non-compliance.

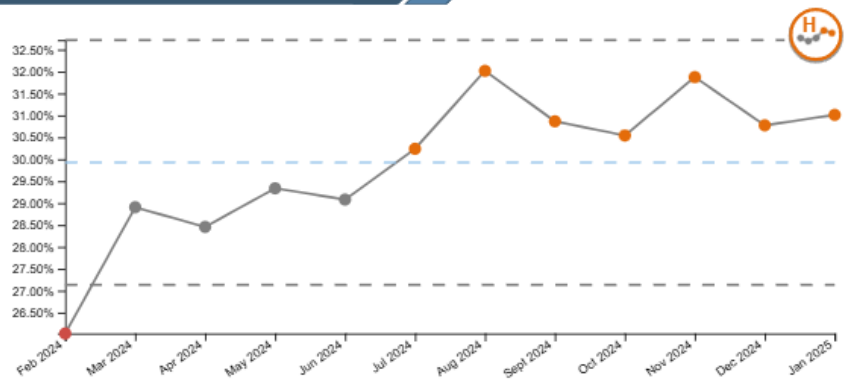
Sickness Absence – Absence reasons (1/2)

Trust Sickness %	12-Month Rolling	Value	Target
	Jan 25	5.47%	4.50%

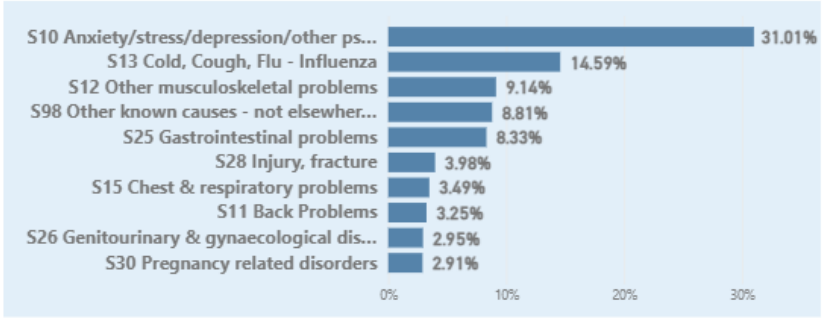
Sickness Reasons - SPC

S10 - Anxiety/stress/depression/ other psychiatric illness

31.01%

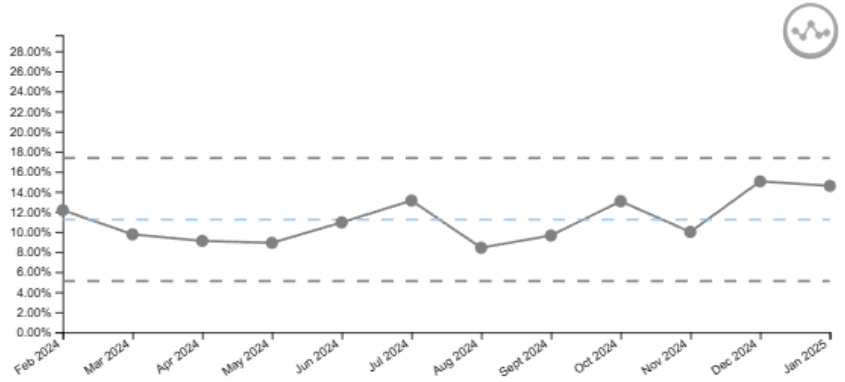


Top 10 Sickness Abscences



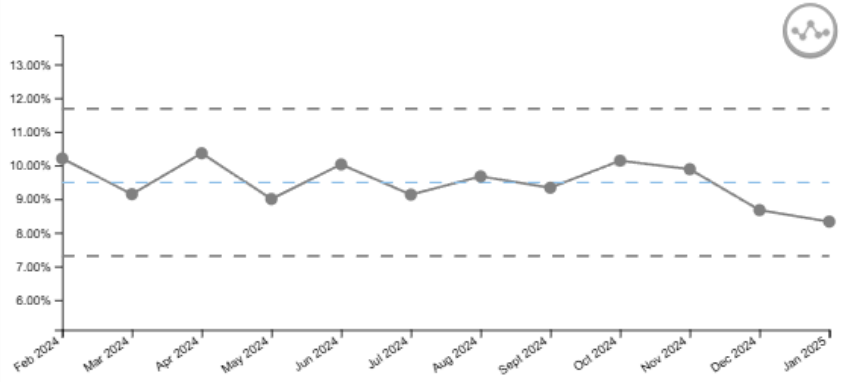
S13 - Cold, Cough, Flu - Influenza

14.59%

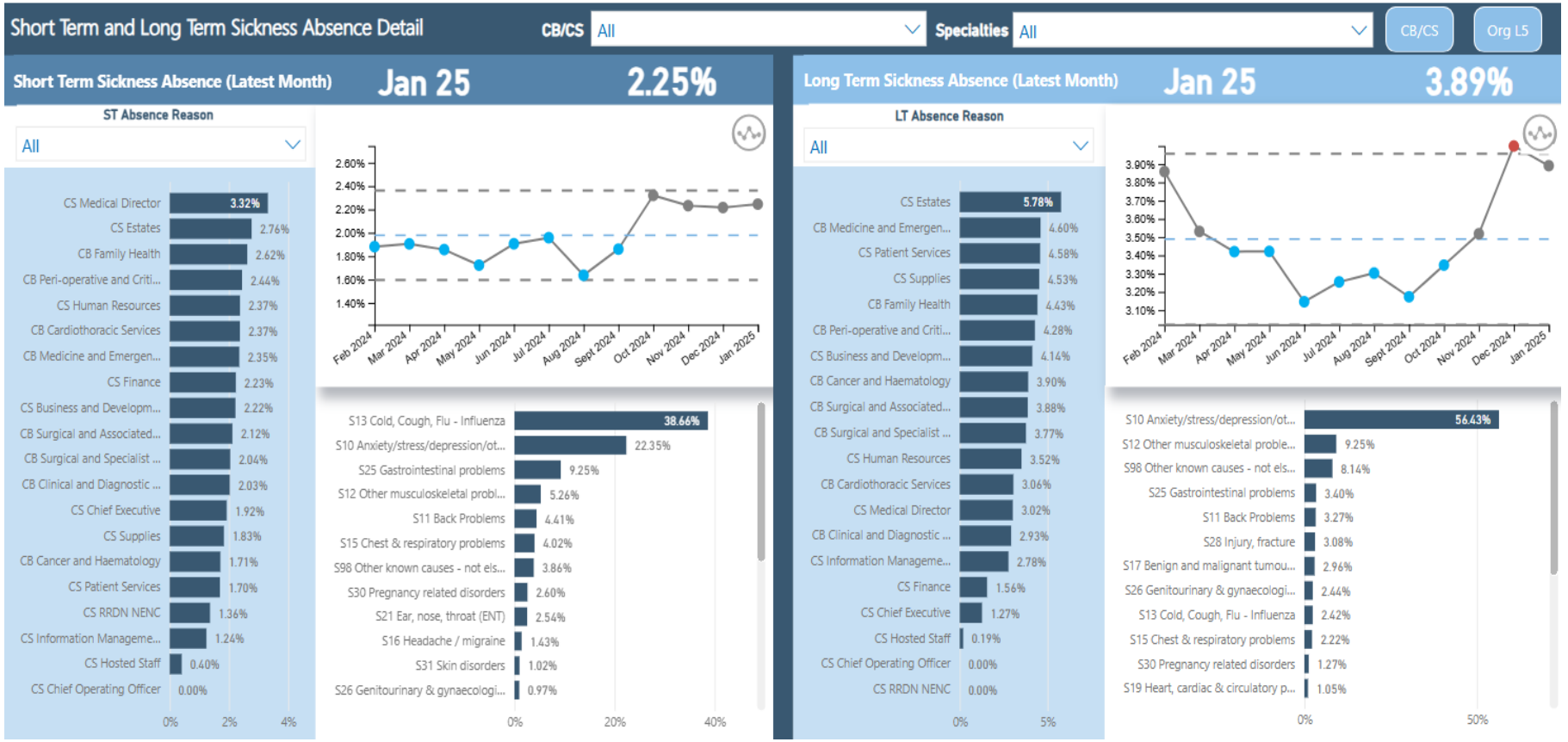


S25 - Gastrointestinal problems

8.33%



Sickness Absence – Absence reasons (2/2)



Sickness – Full Time Equivalent working days lost & Formal Action

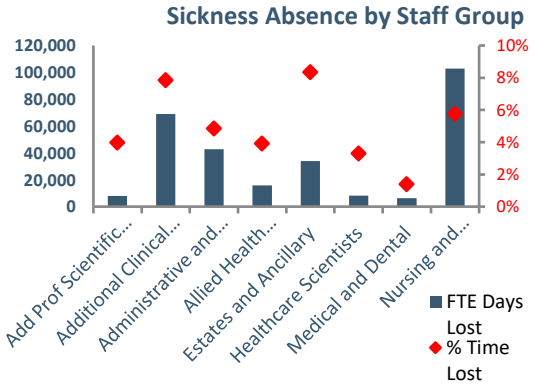
Sickness - FTE working days lost

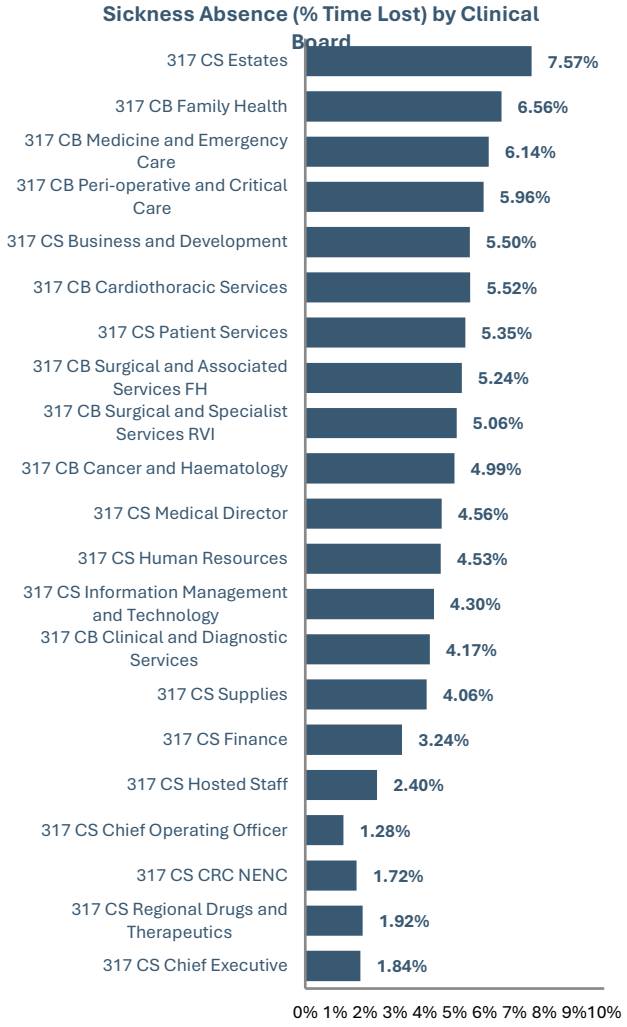
FTE Working Days Lost due to sickness

286,507

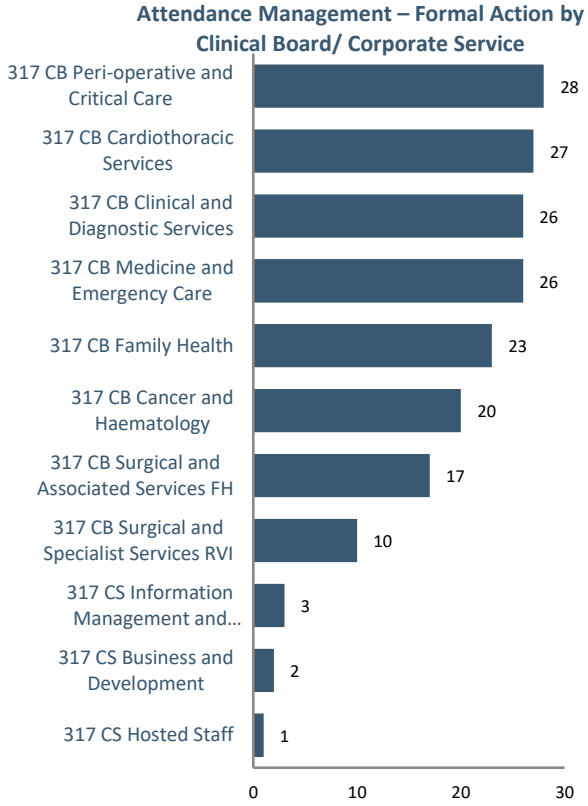
262,049

Compared to the previous year.



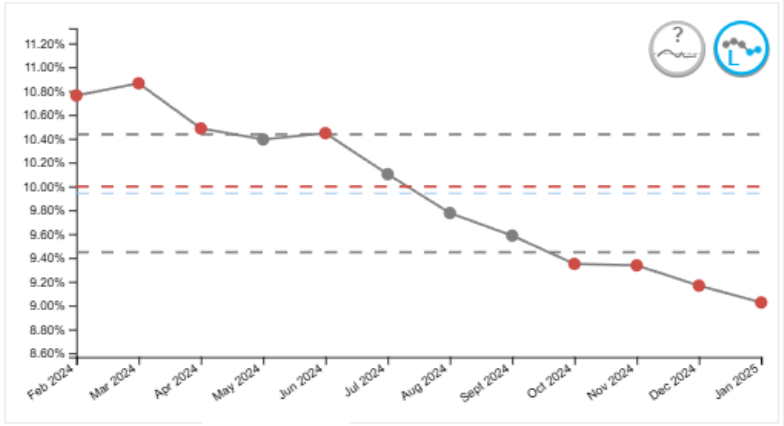


Sickness - Formal Action



Turnover (1/2)

Trust Turnover %	12-Month Rolling	Value	Target
	Jan 25	9.02%	10



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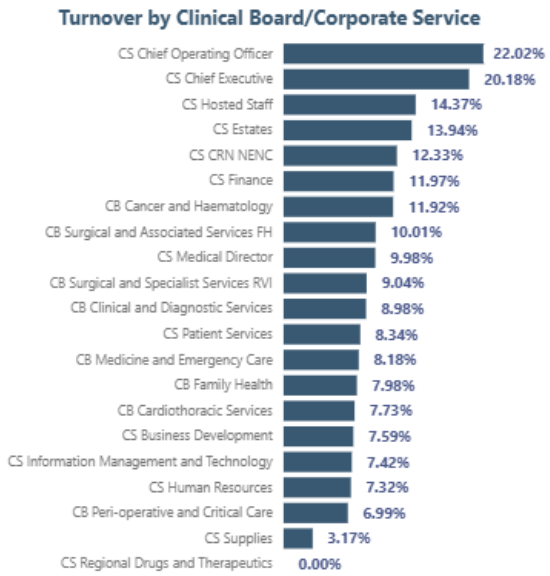
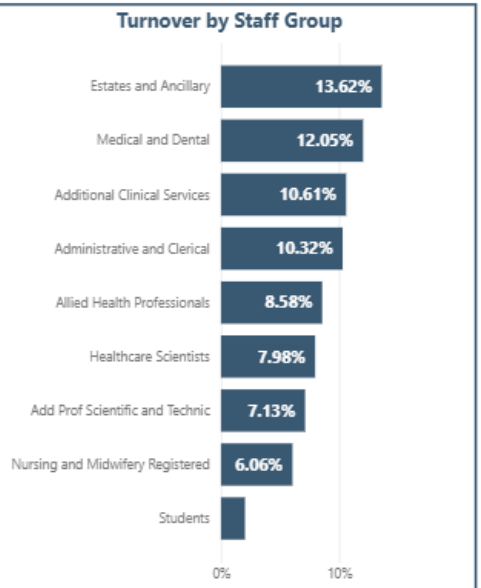




Current Position:	Underlying Issues	Actions Undertaken:
• 12-month average to January 9.02%. • Chart shows performance is now meeting target with consistent downward trajectory.	• 1,507 leavers in 12-months to January 2025: 22% were Nursing & Midwifery (333) and Additional Clinical Services 20% (303). • Top destinations – No Employment (589, 39%); Other NHS organisation (490, 33%). • Top reasons – Work life Balance (251, 17%); Relocation (203, 13%) Retirement Age (201, 13%)	• Flexible working – supported and encouraged across the Trust. • Exit process – work on-going to act on reasons and trends why staff leave. • 'Stay conversations' – being explored. • Monitoring – daily information available to managers via People Dashboard; monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards/Corporate Services.

Turnover (2/2)

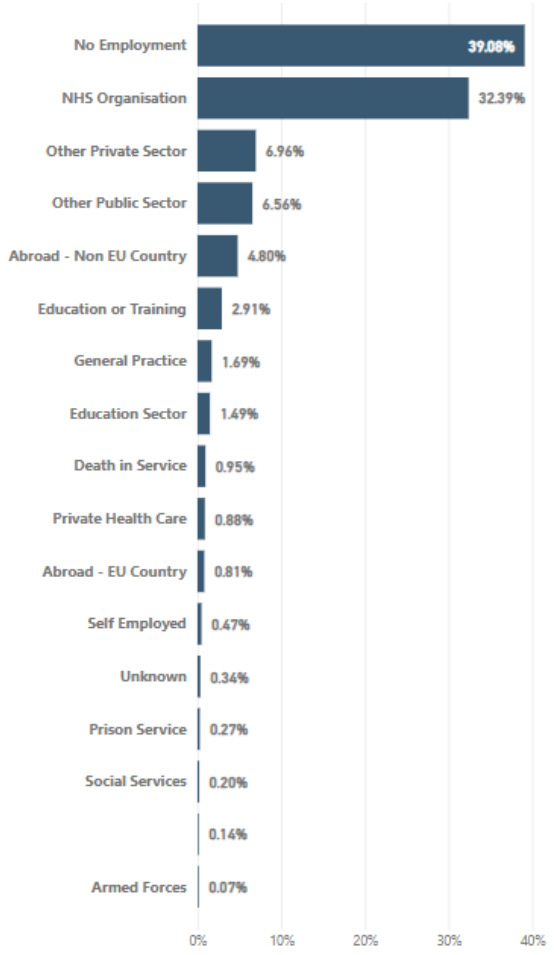
Trust Turnover %	12-Month Rolling	Value	Target
	Jan 25	9.02%	10.00%

Leaving Reasons

Leaving Reasons

Leaving Reason	Leaving Reason %
Voluntary Resignation - Work Life Balance	16.77%
Voluntary Resignation - Relocation	13.46%
Retirement Age	13.39%
Voluntary Resignation - Promotion	9.26%
Flexi Retirement	9.06%
Voluntary Resignation - Health	5.95%
End of Fixed Term Contract	5.75%
Voluntary Resignation - To undertake further education or training	4.39%
Voluntary Resignation - Incompatible Working Relationships	4.06%
Voluntary resignation - Pay and Reward Related	3.25%
Voluntary Resignation - Lack of Opportunities	2.30%
Voluntary Resignation - Child Dependants	1.89%
Dismissal - Capability	1.69%
End of Fixed Term Contract - Other	1.62%
End of Fixed Term Contract - Completion of Training Scheme	1.22%
Death in Service	1.08%
Voluntary Resignation - Other/Not Known	1.08%
Retirement - Ill Health	0.74%
Dismissal - Conduct	0.68%
Voluntary Resignation - Adult Dependants	0.54%
Voluntary Early Retirement - with Actuarial Reduction	0.47%
Voluntary Early Retirement - no Actuarial Reduction	0.34%
Dismissal - Statutory Reason	0.27%
End of Fixed Term Contract - End of Work Requirement	0.27%
End of Fixed Term Contract - External Rotation	0.20%
Redundancy - Voluntary	0.14%
Bank Staff not fulfilled minimum work requirement	0.07%
Employee Transfer	0.07%

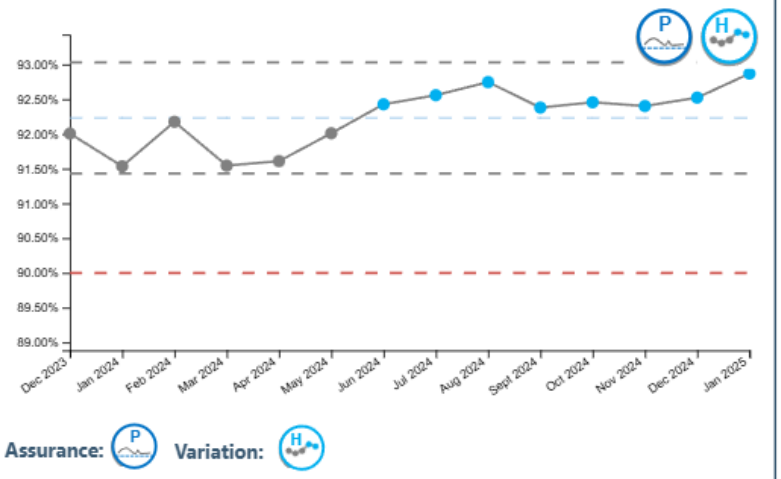
Destination on Leaving



Destination On Leaving	Destination On Leaving %
No Employment	39.08%
NHS Organisation	32.39%
Other Private Sector	6.96%
Other Public Sector	6.56%
Abroad - Non EU Country	4.80%
Education or Training	2.91%
General Practice	1.69%
Education Sector	1.49%
Death in Service	0.95%
Private Health Care	0.88%
Abroad - EU Country	0.81%
Self Employed	0.47%
Unknown	0.34%
Prison Service	0.27%
Social Services	0.20%
	0.14%
Armed Forces	0.07%

Mandatory Training (1/2)

Mandatory Training Compliance	Month	Value	Target
	Jan 25	92.87%	90.00%



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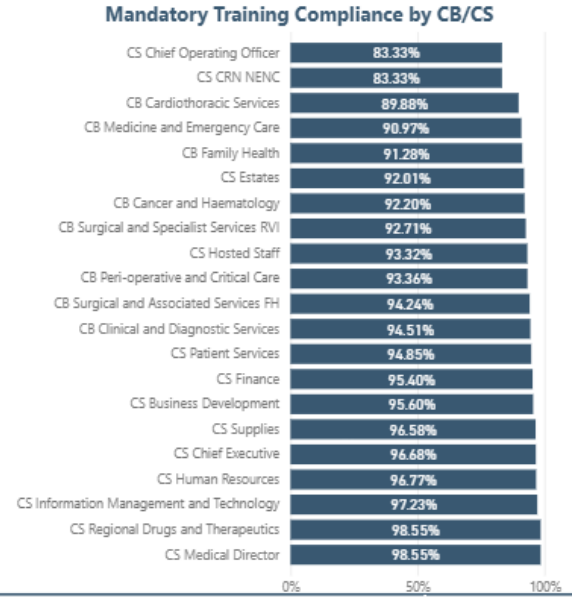
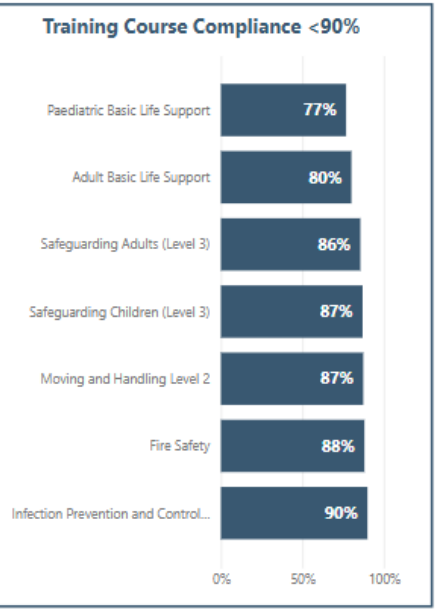




Current Position:

- Chart shows improvement with overall target consistently hit.

Underlying Issues

- Medical and Dental – have lowest overall compliance (82%) with low compliance in Adult Basic Life Support (63%), Paediatric Basic Life support (64%); Fire Safety (74%).
- Paediatric Life Support – overall compliance low at 77% for January 2025.
- Safeguarding Level 3 – e-learning package currently being prepared for launch next month.
- Oliver McGowan – still subject to much debate nationally; working with partners and key stakeholders to develop an Alliance-wide alternative training programme.

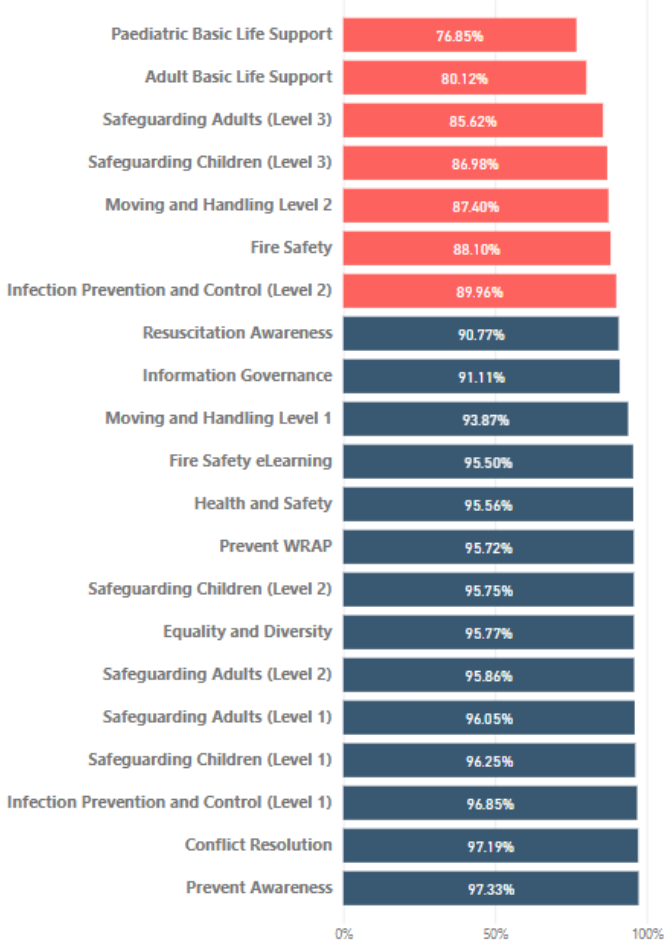
Actions Undertaken:

- Resus – changes made to delivery model and an increased number of cascade trainers are now actively involved in delivering training.
- Statutory & mandatory national review – National SMEs now appointed; nationally agreed statutory and mandatory policy due in Spring; work continues with digital passport.
- New requirement for annual reporting to be introduced March 2026.
- Accountability – monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards / Corporate Services. All areas to renew focus and double-down on non-compliance.

Mandatory Training (2/2)

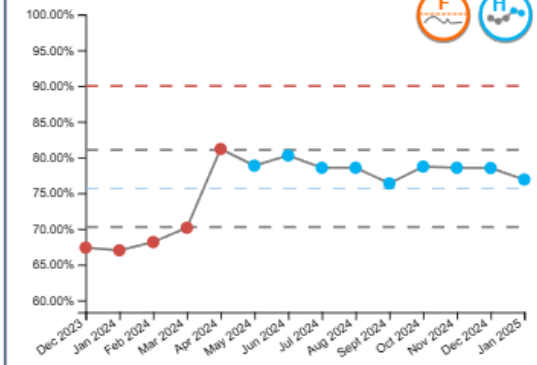
Mandatory Training Compliance	Month	Value	Target
	Jan 25	92.87%	90.00%

Training Course Compliance %

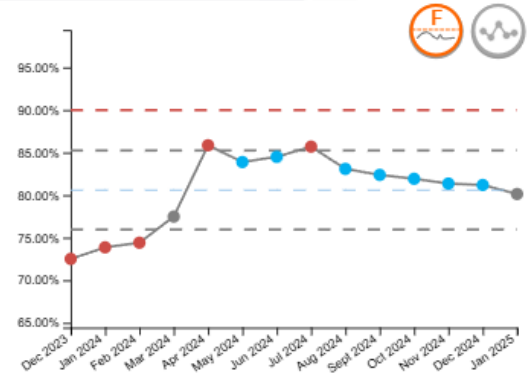


Lowest 4 Mandatory Training Compliance %

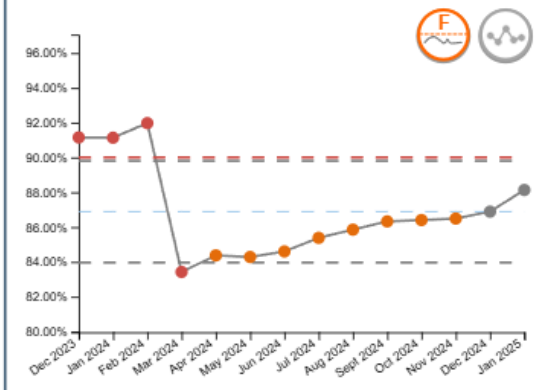
Paediatric Life Support 77%



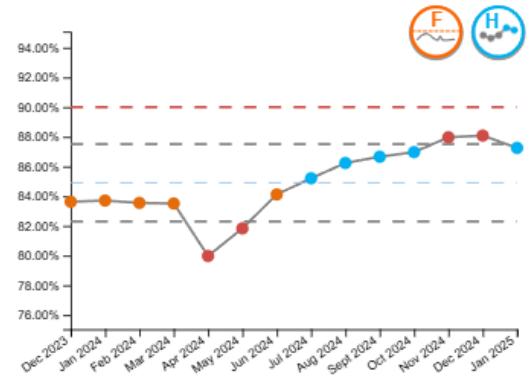
Adult Life Support 80%



Fire Safety 88%

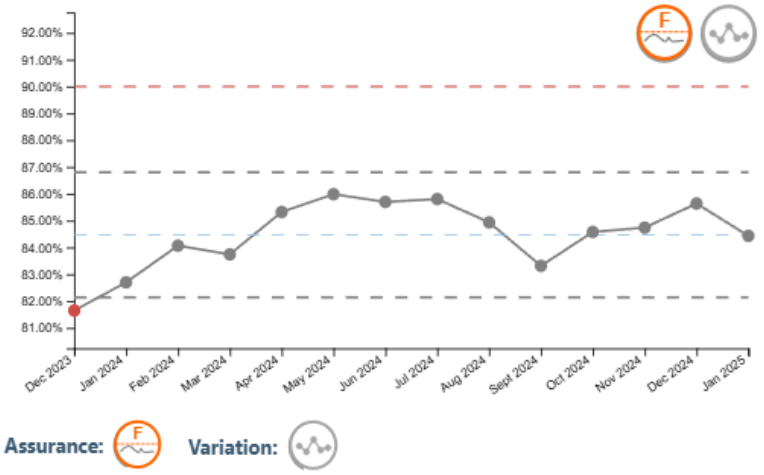


Moving and Handling Level 2 87%

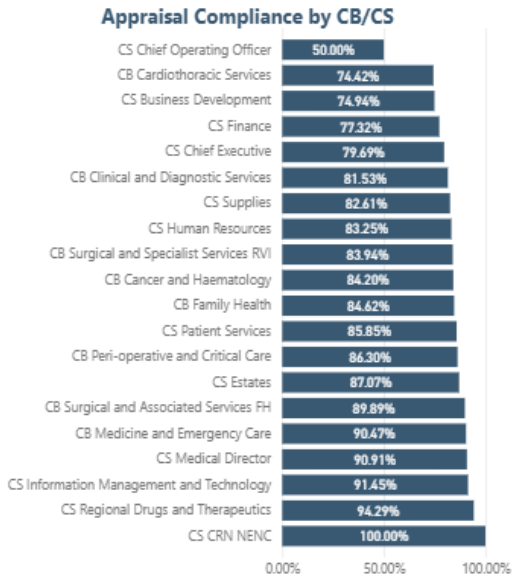


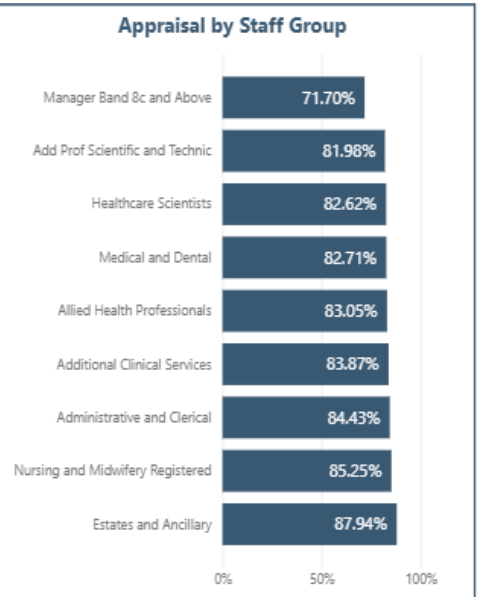
Appraisal Compliance

Appraisal Compliance	Month	Value	Target
	Jan 25	84.43%	90.00%



Assurance: 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 has shown improvement since October with a slight dip in January 2025.
- The vast majority of areas have not met the target.

Underlying Issues

- 2,191 appraisals are overdue with highest numbers in Nursing and Midwifery (686) and Additional Clinical Services (374).
- Clinical Board percentage compliance ranges from 74.76% to 90.46%.
- Corporate Service percentage compliance ranges from 50.00% to 100.00%.

Actions Undertaken:

- New appraisal process due to launch next month.
- Monitoring – daily information available to managers via People Dashboard.
- Accountability – monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards/Corporate Services. All areas to be asked to renew focus and double-down on non-compliance.

Bank use – (£)

Bank Utilisation (£)	12-Month period ending	Total Bank Expenditure (£)	Total Bank Difference (£)
	Jan 25	£16,828,769	-£1,147,745

Bank Utilisation (£)

Staff Group	Feb 23 - Jan 24	Feb 24 - Jan 25	Difference
Admin & Clerical	£1,139,633	£267,295	-£872,338
Ancillary	£377,207	£1,089,933	£712,726
Estates			
Nursing & Midwifery (Registered)	£6,287,302	£5,501,119	-£786,183
Nursing & Midwifery (Unregistered)	£9,088,784	£9,155,422	£66,638
Professional & Technical	£1,083,588	£815,000	-£268,588
Total	£17,976,514	£16,828,769	-£1,147,745

Current Position:	Underlying Issues	Actions Undertaken:
• Bank Usage has continued to reduce in the 12 months to January 2025 (£16,828,769) compared with the previous period ending January 2024 (£17,976,514).	• Notable reductions in Nursing & Midwifery (registered), Admin & Clerical and Professional & Technical. • Notable increases in Ancillary due to recruitment, retention and sickness absence.	• Work continues to reduce bank usage with effective rostering and direction. • Aiming to reduce agency use for Health Care Assistants (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 use – (£)

Agency Utilisation (£)	12-Month period ending	Total Agency Expenditure (£)	Total Agency Difference (£)
	Jan 25	£3,488,953	-£1,125,142

Agency Utilisation (£)

Staff Group	Feb 23 - Jan 24	Feb 24 - Jan 25	Total Hours
Admin & Clerical	£499,544	£200,924	-£298,620
Ancillary	£11,202	£23,760	£12,558
Estates	£62,131	£18,736	-£43,396
Nursing & Midwifery (Registered)	£214,517	£283,817	£69,299
Nursing & Midwifery (Unregistered)	£3,157,056	£1,674,639	-£1,482,417
Professional & Technical	£669,643	£1,287,076	£617,434
Total	£4,614,095	£3,488,953	-£1,125,142

Current Position:

- Agency Usage has continued to reduce in the 12 months to January 2025 (£3,488,953) compared with the previous period ending January 2024 (£4,614,095).

Underlying Issues

- Notable reductions in Nursing & Midwifery (unregistered) and Admin & Clerical.
- Significant increase in Professional & Technical due to recruitment in radiology and pathology.
- Registered nurse agency use – hotspots in Theatres and Cardiothoracic Services for scrub and anaesthetic nurses. Pressures also continue for Nurse Practitioners.

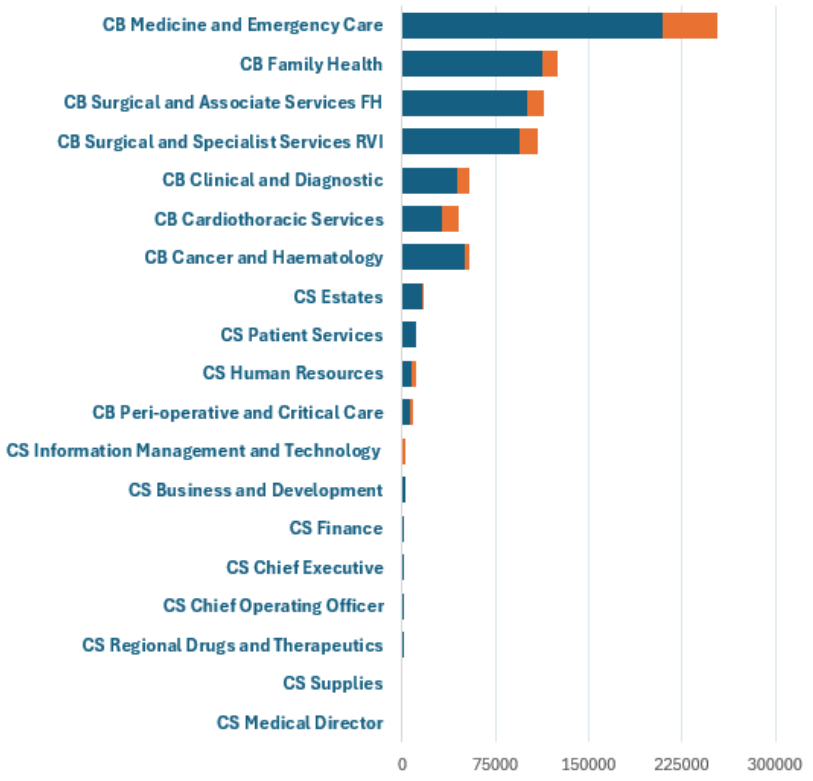
Actions Undertaken:

- Agency cost – a target reduction of £2m has been set for 2025/26.
- Increasing bank availability to reduce agency use.
- Agency usage reviewed and challenged monthly.

Bank & Agency Utilisation - Hours

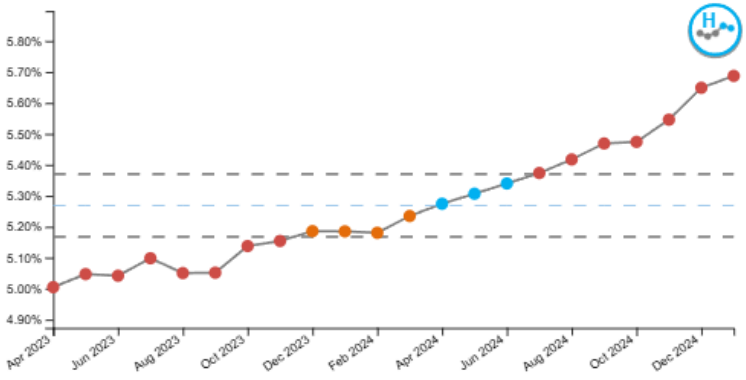
Bank & Agency	12-Month period ending	Total Bank and Agency Hours
	Jan 25	808,351

Clinical Board	Bank Hours	Agency Hours	Total Hours
CB Medicine and Emergency Care	208,967	44,748	253,716
CB Family Health	112,606	12,192	124,798
CB Surgical and Associate Services FH	100,627	13,264	113,891
CB Surgical and Specialist Services RVI	94,201	15,215	109,416
CB Clinical and Diagnostic	44,147	10,359	54,505
CB Cancer and Haematology	49,669	4,508	54,177
CB Cardiothoracic Services	31,542	13,432	44,973
CS Estates	15,820	588	16,408
CS Patient Services	10,998	0	10,998
CS Human Resources	7,876	2,909	10,785
CB Peri-operative and Critical Care	5,732	2,610	8,341
CS Business and Development	2,728	0	2,728
CS Information Management and Technology	0	2,011	2,011
CS Chief Executive	838	0	838
CS Finance	567	0	567
CS Chief Operating Officer	185	0	185
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
	Jan 25	5.69%	16,545



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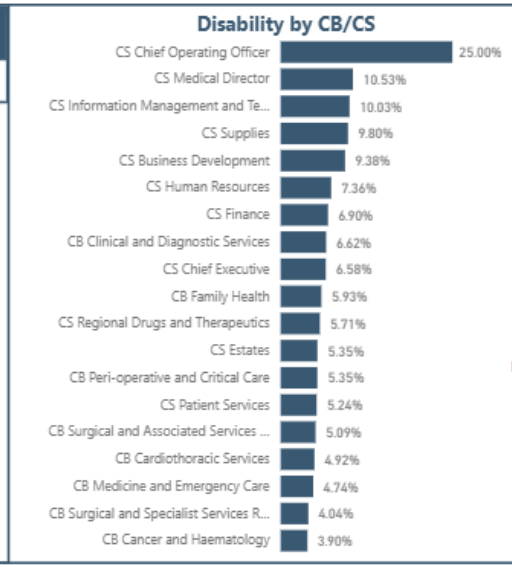
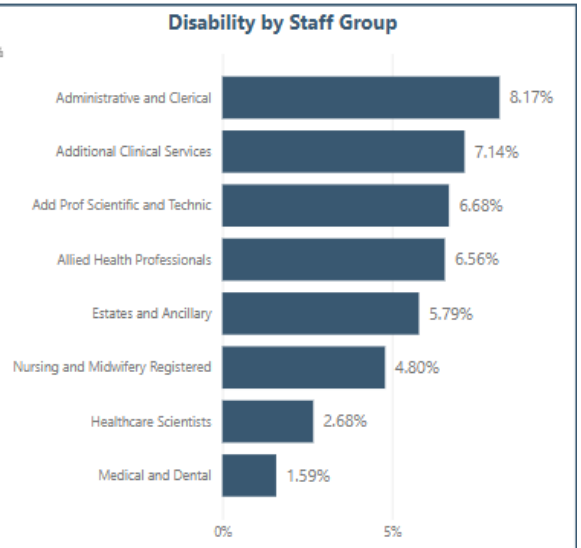
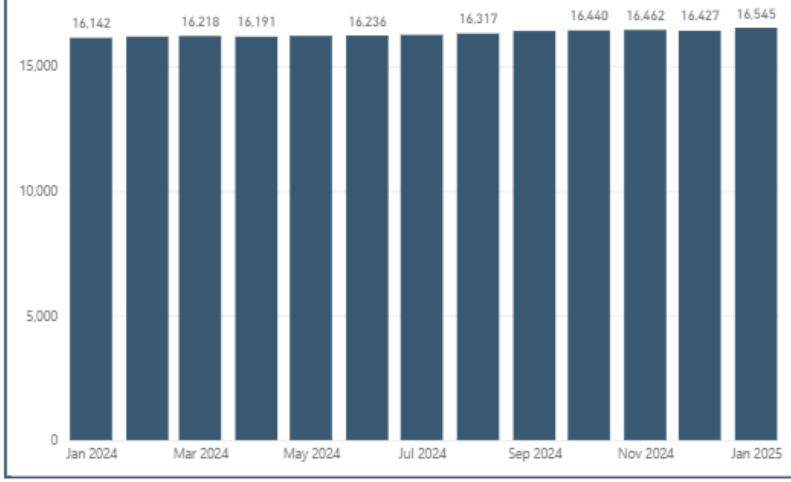




Trust Headcount Trend



Age Band

	Age Band	Disability %
1	<=20 Years	9.33%
2	21-25	11.06%
3	26-30	7.14%
4	31-35	5.64%
5	36-40	4.49%
6	41-45	4.56%
7	46-50	4.27%
8	51-55	4.68%
9	56-60	5.60%
10	61-65	5.43%
11	66-70	2.95%
12	>=71 Years	4.69%

Current Position:

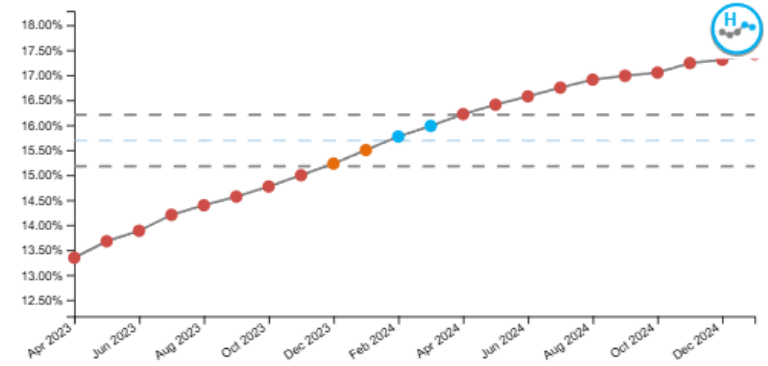
Charts show percentage of staff in post each month by those disclosing a disability.

Percentage of staff employed disclosing a disability continues to demonstrate a month-on-month increase with the latest reporting period increasing to 5.69%.

Percentage of staff who have not disclosed their status is 10%. An 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
	Jan 25	17.42%	16,545



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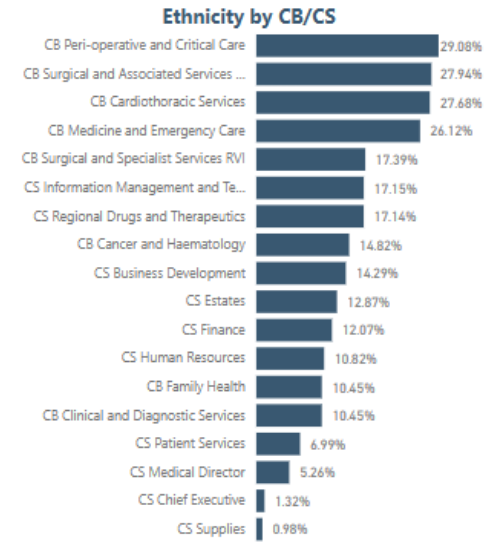
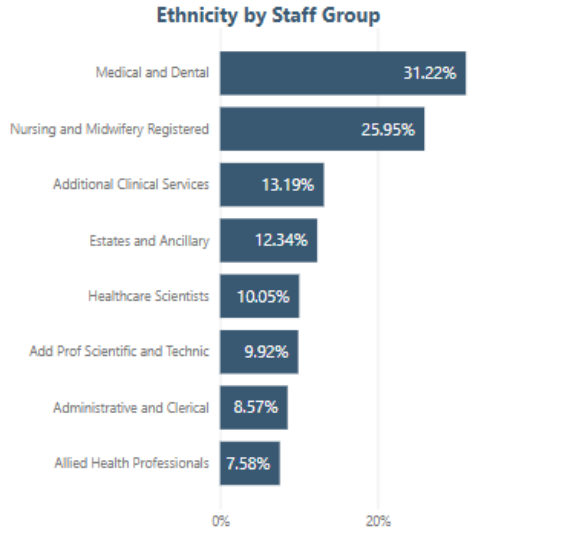
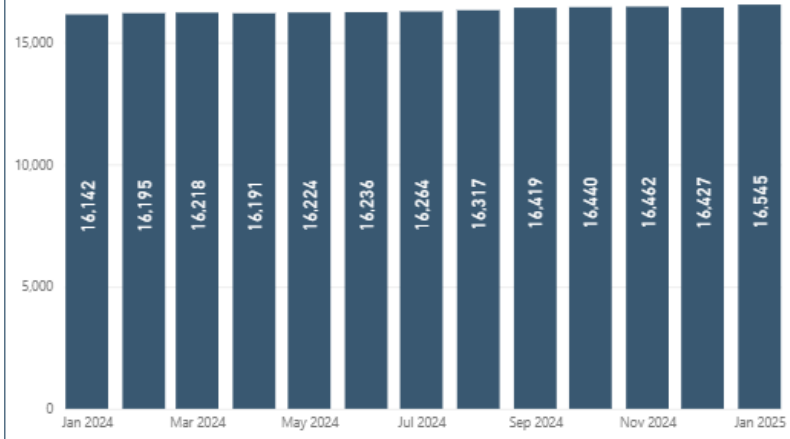




Trust Headcount Trend



Age Band

	Age Band	BME %
1	<=20 Years	14.00%
2	21-25	19.08%
3	26-30	24.20%
4	31-35	24.25%
5	36-40	22.00%
6	41-45	13.01%
7	46-50	20.21%
8	51-55	15.46%
9	56-60	8.11%
10	61-65	4.67%
11	66-70	5.49%
12	>=71 Years	3.13%

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 17.42% 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	Jan-25	£1,413.5m	£1,367.3m
Expenditure	Jan-25	£1,422.0m	£1,372.1m
Surplus /(Deficit)	Jan-25	(£8.5m)	(£4.8m)
Income & Expenditure Margin	Jan-25	(0.6%)	(0.4%)
Cost Improvement – Recurrent	Jan-25	£29.8m	£54.8m
Cost Improvement – Non-Recurrent	Jan-25	£47.5m	£27.3m
Elective Income	Jan-25	£267m	£265m
Capital (CDEL)	Jan-25	£21.3m	£26.9m

Income & Expenditure

- Total income is £46 million ahead of plan, with pass through drugs, devices and deferred income at £17.7 million ahead of plan.
- Total expenditure is £49.9million ahead of plan, off-set by income above and pressure of Industrial Action, drugs growth and Cost Improvement Programme (CIP).

Cost Improvement

- There is reliance on non-recurrent measures to bridge the recurrent CIP gap of £21.7 million.

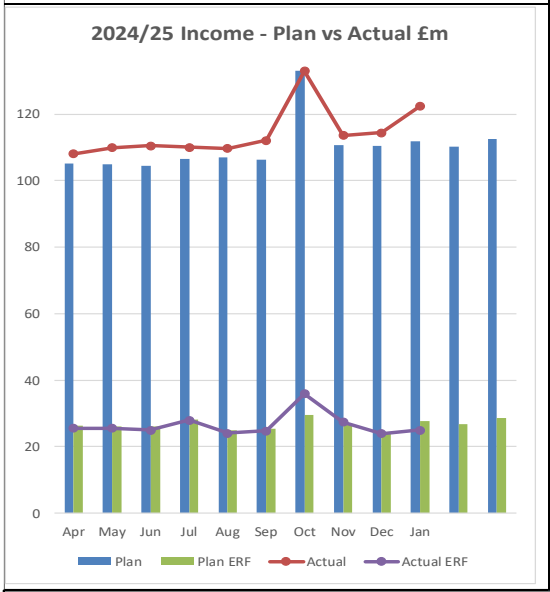
Elective Income

- The trust is ahead on the Elective Recovery Fund (ERF) income by around £1.9 million.

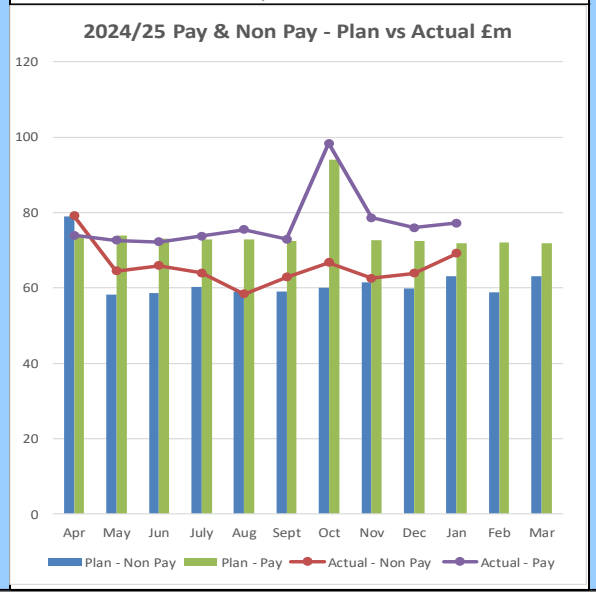
Overall Finance Position (1/4)

Financial Overview as at 31st January 2025

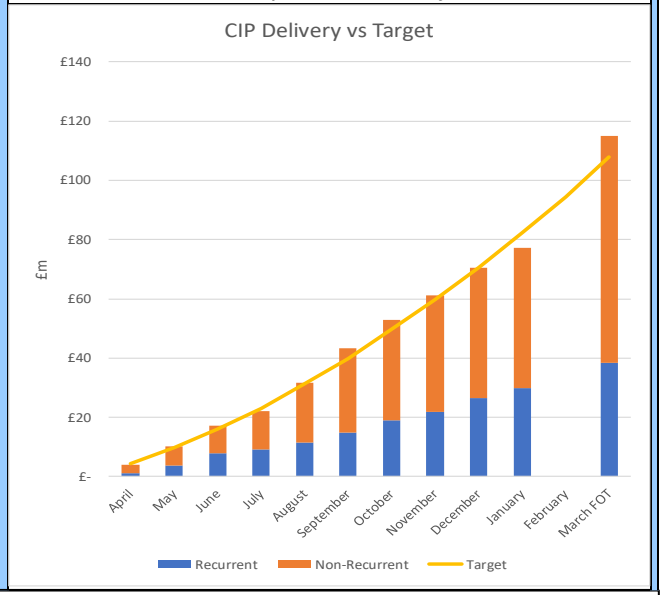
Income



Expenditure



Cost Improvement Analysis



This page summarises the financial position of the Trust for the period ending 31st January 2025. The Trust has agreed a Financial Plan for 2024/25 with a break-even position. As at Month 10 the Trust is reporting an overspend of £3.7 million against the planned deficit of £4.8 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 paid in October.

Capital Expenditure - The Plan for January is £26.9 million and the year to date expenditure is £21.3 million creating a variance of £5.6 million to date.

Risks -

- Delivery of the required levels of activity compared with 2019/20 activity levels - Green
- 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 (January 2024)			Year To Date (January)		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Operating income from patient services	120,617	127,044	6,427	1,184,853	1,213,253	28,400
Other Patient Care - & Non NHS	2,315	3,620	1,305	23,155	26,563	3,408
Non Patient Care - Other Income	16,413	16,480	68	156,815	165,643	8,828
TOTAL OPERATING INCOME (WITHIN EBITDA)	**139,345**	**147,145**	**7,799**	**1,364,823**	**1,405,459**	**40,636**
Employee expenses	74,210	77,196	2,987	757,039	771,340	14,301
Drugs	25,641	25,089	(552)	235,669	239,888	4,218
Supplies & Services Clinical	14,045	15,382	1,337	134,658	150,321	15,663
Operating expenses excl. employee expenses	18,264	23,314	5,051	176,822	194,910	18,088
TOTAL OPERATING EXPENSES (WITHIN EBITDA	**132,159**	**140,982**	**8,823**	**1,304,189**	**1,356,459**	**52,270**
NET FINANCE COSTS	**5,474**	**4,643**	**(831)**	**74,056**	**60,999**	**(13,057)**
OPERATING SURPLUS/(DEFICIT)	**1,712**	**1,520**	**(193)**	**(13,422)**	**(11,999)**	**1,423**
Control Total & IFRS16 PFI Adjustments	1,136	1,243	107	(8,633)	(3,510)	5,123
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR - CONTROL TOTAL	**576**	**276**	**(299)**	**(4,789)**	**(8,489)**	**(3,700)**

The reported performance for January 2025 is as follows:-

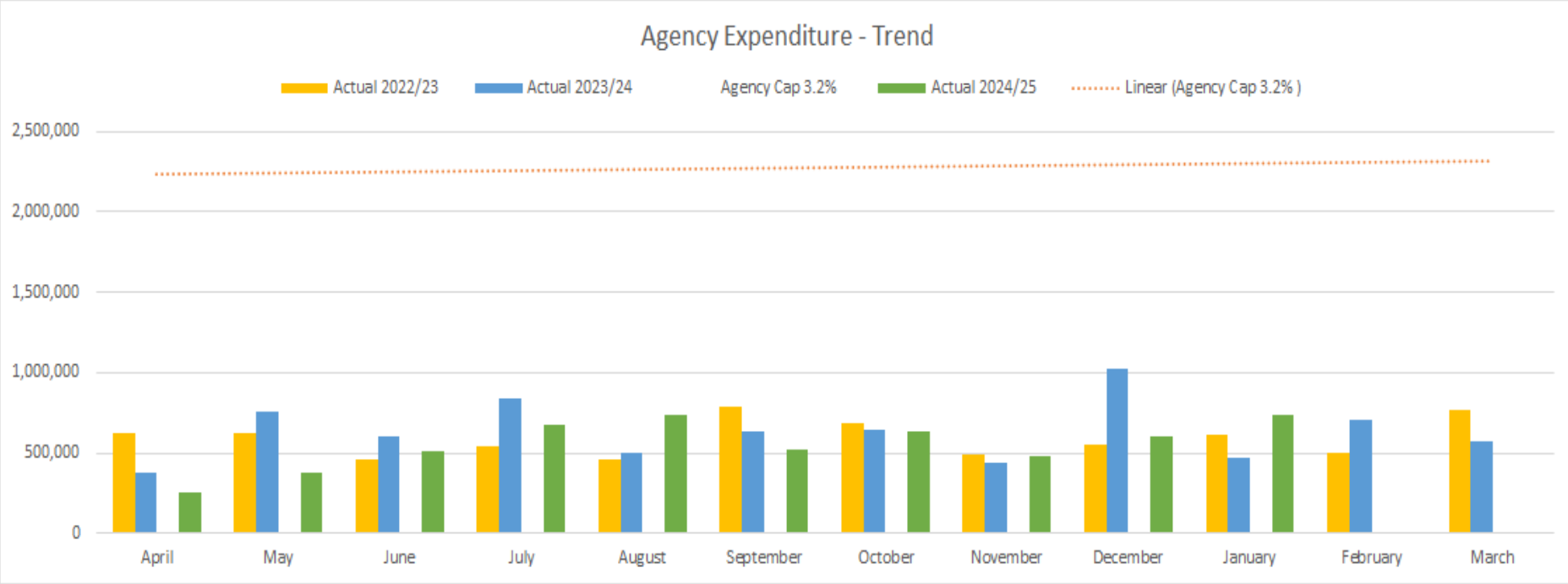
Income

- The in-month position is an overall favourable variance of £7,799 partly due to over-performance on matched drugs and devices and an over achievement on Non-recurrent income CIP. Elective Recovery Funding (ERF) income is on plan despite the impact of industrial action.

Expenditure

- Pay costs are £14.3m over plan at month 9 and include the costs associated with industrial action. Total operating expenditure is £38m above plan due to increased costs relating to drugs and clinical supplies (including circa £17.4m that is matched with income) and unachieved CIP (£21.7m behind on expenditure).

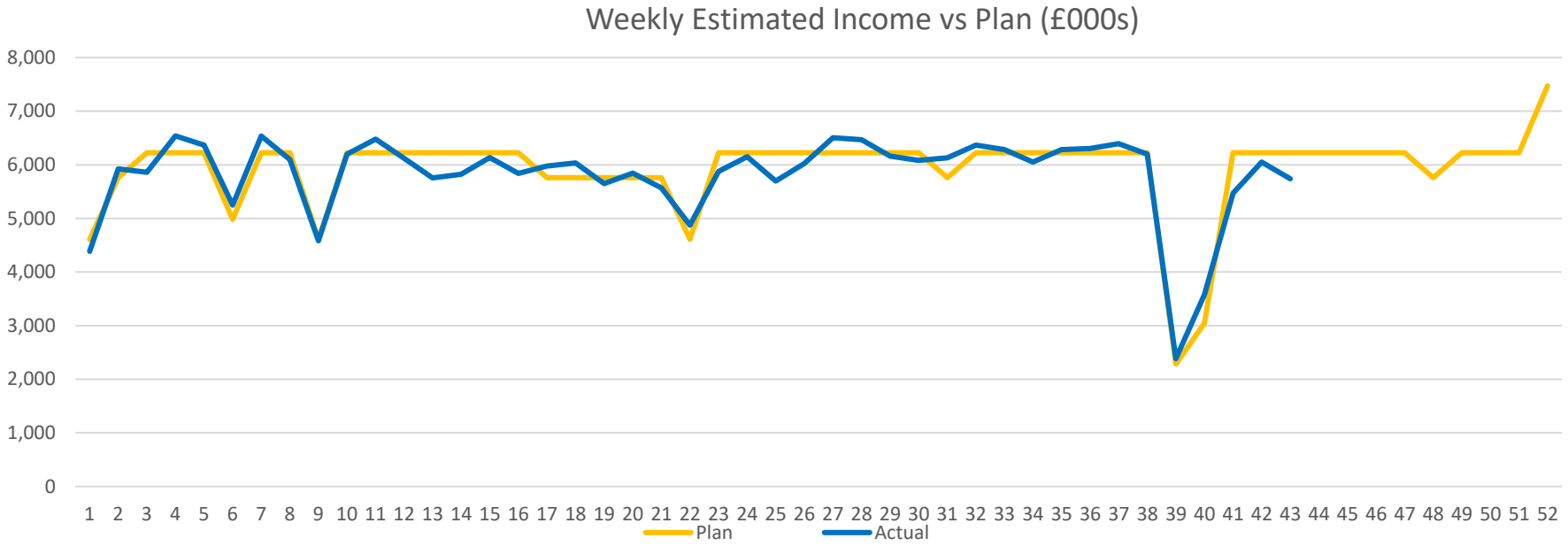
Overall Finance Position (3/4)



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 an increase in January (Month 10) 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 43, total delivery is £1,090k 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

The next Health Inequalities update, focused on elective care waiting time inequalities, will be provided in the April 2025 report.

A Guide to Statistical process control (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 A12

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025					
Title	Shine (Sustainable Healthcare in Newcastle) – Interim Update					
Report of	Vicky McFarlane Reid, Director for Commercial Development & Innovation (Executive Director Board Lead for Sustainability)					
Prepared by	James Dixon, Associate Director – Environmental Sustainability					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☐	☒			
Summary	In 2019 Newcastle Hospitals became the first healthcare organisation in the world to publicly declare the climate emergency as a health emergency, committing to fast-tracking decarbonisation of our services a decade ahead of government targets. The 'Delivering a Net Zero NHS' report was published in October 2020, making the NHS the first healthcare system in the world to commit to net zero carbon. Our own Climate Emergency Strategy was subsequently published on 22 October 2020 (https://bit.ly/CEStrategy_NUTH) clearly setting out our vision, long-term goals and action plan for 2020-25. This report presents an interim six-monthly update to Trust Board on progress towards the targets in our strategy, national developments with regards to Green Plan guidance and an update on mitigating the three challenges/risks highlighted to Trust Board in September 2024.					
Recommendation	The Trust Board of Directors is recommended to: i) Receive this report for information, noting progress to date; and ii) Approve the proposal to continue with our Climate Emergency Strategy 2020-25 into the final year of its action plan meanwhile developing a new strategy for 2025-30 to be published for next year (considering the new Trust strategy and NHS England (NHSE) Green Plan guidance).					
Links to Strategic Objectives	**Pioneering** – first healthcare organisation in the world to declare a Climate Emergency, ambitious aim for net zero by 2030 for our footprint and 2040 for our footprint plus. **Performance** – continuing as leaders in healthcare environmental sustainability. **People** – sustainable healthcare is a priority for our staff (99% rate it as important).					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☐	☒	☐	☐	☐	☒
Link to Board Assurance Framework [BAF]	None (*Previous Board Assurance Framework Risk ID - SO5.6: Climate Emergency (Rated 20)*)					
Reports previously considered by	Interim six-monthly update (previous full report to Board on 27 September 2024).					

SHINE (SUSTAINABLE HEALTHCARE IN NEWCASTLE) – INTERIM UPDATE

1. PROGRESS UPDATE

Progress towards the targets and actions in our Climate Emergency Strategy 2020-25 is summarised in our newly developed **Sustainability High-level Dashboard** (see Appendix 1). The dashboard is based on the Trust High-level Dashboard presented at the Chief Executive Officer (CEO) Business Briefings and presents data up to the end of December 2024 alongside strategic updates in Shine priority action areas. This was first presented to the Sustainable Healthcare Committee (SHC) in February 2025 and recommended for sharing with Trust Board. The following sections outline the detail to support the high-level dashboard.

1.1 Energy

Transitioning from fossil-fuel derived heat and power for our building energy remains our biggest challenge. Significant investment is required to de-steam our hospital heat networks so we are heavily reliant on securing external funding for this. Our new Estates Net Zero Team helped deliver the decarbonisation of Regent Point (saving 120 tonnes of carbon/year) and developed a bid for a £40m Salix grant to do the same at the Freeman Hospital (FH) (which is going through the final stages of technical evaluation). Our first successful bid to the National Energy Efficiency Fund (NEEF) was announced in January, with a grant of £750,000 for LED lighting at the Royal Victoria Infirmary (RVI) and Solar PV on the roof of the Day Treatment Centre at the FH. The Estates Net Zero Team were also successful in securing £85,000 in charity funding to upgrade patient environment lighting in Ward 21 (RVI) and Disablement Services Centre (DSC) (FH) – with this work to start in Quarter 1 2025/26.

1.2 Journeys (Transport Carbon Emissions)

Our operational transport carbon emissions are now creeping above our carbon reduction target, against a period of reduced emissions during Covid. The electric hopper bus is saving 144 tonnes of carbon per year but elective recovery demand has seen an increase in grey fleet (staff mileage claims), taxi and courier emissions.

1.3 Care (Anaesthetic Gas Carbon Emissions)

Anaesthetic gas emissions continue to track below our carbon reduction target. There has been a 61% reduction in emissions since our baseline year of 2019/20. This has been achieved by local clinician-led projects to ban desflurane (the most environmentally damaging anaesthetic gas), introduce Entonox cracking technology (to safe use of this pain-relieving gas in Maternity) and to decommission the unused nitrous oxide pipeline at FH.

1.4 Waste

Whilst the total amount of waste disposed of continues to be higher than our pre-Covid baseline, our segregation performance benchmarks as one of the best in the country. Ward waste audits, corporate induction training and regular engagement/awareness raising

events have helped to Trust to maintain legal compliance, reduce the cost of waste treatment and the environmental impact of waste disposal. 2024 marked the 20th anniversary of Newcastle Hospitals first using reusable Sharpsmart boxes and bringing this innovation to Europe, avoiding thousands of tonnes of plastic being incinerated over the last two decades. And in October, at the inaugural NHS Waste Awards, the **Waste Management Champion of the Year** was awarded to our Waste Manager, Jason Mitchell, acknowledging his efforts to maintain our Trust's leadership position in the sector.

1.5 People

There are now almost **700 staff Green Champions** in the Trust (up from 580 in Quarter 2). Engagement by the Sustainability Team at the corporate induction Market Place events is resulting in a surge of interest and support to work on environmental improvement projects. Over 50% of staff have completed the 'Building a Net Zero NHS' e-learning module in the Learning Lab, since it was added to our mandatory training package at the request of our Green Champion network.

1.6 Other Achievements

In September, the Trust Management Group approved the proposal to embed sustainability into our organisational culture by using the **Shine 10-Step framework in each Clinical Board**. Progress towards this has been limited over winter, but Clinical Diagnostic Services and Cardiothoracic Services have now appointed Sustainability Leads (Step 1) and our hope is that other Boards will swiftly follow. At the request of the Trust Board the Executive Team considered the sustainability risks presented at the September 2024 Board meeting (*see Section 4 for risk updates*) and agreed to refreshed governance arrangements with Sustainable Healthcare Committee reporting into the Finance & Performance Committee rather than People Committee.

Our work to engage with our suppliers has increased support for our **5 Step Net Zero Supply Chain** work, leading to 1,300 of our suppliers actively supporting this work and more accurate procurement carbon emissions calculations. Each new Trust tender requires the successful bidder to deliver a Carbon Reduction Plan for the services they deliver to us. Our **Born Green Generation** partnership with other European hospitals has led to the reduction of single use plastics using in Maternity and Obstetric Theatres. We have also been successful in a bid to secure external charity funding to host a **Nature Recovery Ranger** at our sites to enhance biodiversity and support access to our green spaces for patients, visitors and staff (who in turn will benefit from the positive health & wellbeing affects this brings).

2. PLANNING GUIDANCE 2025/26 (REQUIREMENT FOR GREEN PLAN REFRESH)

2.1 National Statutory Guidance

In 2020, the NHS became the world's first health system to commit to reaching net zero emissions. The Health and Care Act 2022 reinforced this commitment, placing new duties on NHS trusts to consider statutory emissions and environmental targets in their decisions. Trusts and Integrated Care Board (ICBs) are expected to meet these duties through the

delivery of board-approved green plans. These trust Green Plans now need to be refreshed in line with this statutory guidance (https://www.england.nhs.uk/long-read/green-plan-guidance/#:~:text=This%20updated%20guidance%20supports%20systems,change%20and%20broader%20sustainability%20issues), approved by Trust Board and published on the organisation's website by 31 July 2025.

1.2 Newcastle Hospitals' Position

Newcastle Hospitals published a Board approved green plan in the form of our Climate Emergency Strategy 2020-2025. This sets out our long-term goals and a five-year action plan, covering each of our eight Shine action areas. This strategy and action plan runs until the end of the financial year 2025/26 with planned consultation, co-production and publication of our new 2025-2030 strategy and action plan due to take place in Quarter (Q) 3 & Q4 of 2025/26 (considering the development and publication of the new Trust Strategy). The Sustainability Team have reviewed our current strategy and action plan against the national guidance and believe we are compliant with: taking into account the national targets, setting out actions & Key Performance Indicators (KPIs) for each area of focus and ensuring governance and reporting processes are in place (in the form of our https://www.newcastle-hospitals.nhs.uk/about/sustainable-healthcare/shine-annual-reports/).

3. RISKS

The last report presented to Trust Board (September 2024) highlighted that the previous Board Assurance Framework risk entry for Climate Emergency (Ref SO5.6: Rated 20) was moved onto the Estates Risk Register, given the dominance of challenges to decarbonise our hospital heat and power. Following Executive Team authorisation to recruit an in-house Estates Net Zero Team, each of the three posts has been filled and they have been instrumental in securing additional grant funding to begin mitigating this risk. However, one of the project leads will leave in March and the recruitment authorisation is awaited. This gap in capacity may put the delivery of our £40m Salix decarbonisation grant project at FH at risk (if we are successful in the bid).

The last report to Board also highlighted three challenges/risk that hinder progress towards achieving the goals and targets in our Climate Emergency Strategy. The following sections provide a brief update on progress to mitigate these.

3.1 Lack of Dedicated Capacity

The NHS financial position and Trust projected deficit for 2025/26 will not allow for further investment in the additional capacity needed to mitigate this risk. This was confirmed during an Executive Team discussion on these three risks subsequent to the Board meeting in September. The CEO was keen to ensure that sustainability became business as usual and not an add-on to operational activities. In support of this, the Sustainability Team included targeted capacity building in the Newcastle Hospitals charities bid for the £500,000 strategic allocation to support Shine projects across the Trust. Approval has been received to trial a one-year Clinical Sustainability Lead position as well as the final year of charity support for a Clinical Sustainability Fellowship. This enhanced capacity will work with the appointed

Sustainability Leads in each Clinical Board to deliver projects that will improve patient care, save money and reduce carbon.

3.2 Lack of Dedicated Finance

As with 4.1, above, the Trust financial position will not allow for dedicated internal finance to be ringfenced for delivering Climate Emergency Strategy projects. Support from the Executive Team secured a £750,000 allocation of Trust 2024/25 Capital Plan to Net Zero projects (which helped to match fund the Regent Point decarbonisation project as well as some smaller energy saving projects in the hospitals). Despite this challenging context the combined efforts of the Sustainability Team and Estates Net Zero Team have worked to secure the following:

- A bid of **£40m** for Salix grant funding to decarbonise heat at the FH (technical evaluation stage, news awaited).
- A grant of **£750,000** for installing LED lighting at the RVI and Solar PV at the FH.
- Approval to fund Shine projects totalling **£343,000** of the £500,000 of Newcastle Hospitals charity funding allocated to this strategic priority (£85,000 of which is dedicated to patient-area energy saving lighting improvements).

3.3 Significant Increases in Energy Costs

This financial year (2024/25) has seen a significant increase in the cost of gas and electricity to heat and power our sites. Our long-term energy procurement strategy has limited our exposure to global energy market volatility in recent years, but this deal ended in March 2024 and we are now paying similar rates to our NHS peers (taking our annual spend from £16m to nearer £30m). Investing in energy demand reduction projects will generate recurring revenue budget savings, though no internal funding has been ringfenced to support this to date (*see Section 4.2 above*). The Sustainability Team & Estates Net Zero Team will continue to apply for external funding to deliver energy saving projects and work with Estates Operational colleagues to identify low/no-cost interventions that will realise recurring cost savings.

4. RECOMMENDATIONS

The Trust Board of Directors is recommended to:

i) Receive this report for information, noting progress to date; and

ii) Approve the proposal to continue with our Climate Emergency Strategy 2020-25 into the final year of its action plan meanwhile developing a new strategy for 2025-30 to be published for next year (considering new Trust strategy and NHSE green plan guidance).

Report of
James Dixon
Associate Director – Environmental Sustainability
18 March 2025

On Behalf of

Dr Vicky McFarlane Reid
Director for Commercial Development & Innovation (Executive Lead for Sustainability)

Appendix 1: Sustainability High-level Dashboard

Sustainability High-level Dashboard – March 2025

Data: December 2024

Shine – Sustainable Healthcare in Newcastle

The Newcastle upon Tyne Hospitals NHS Foundation Trust

STRATEGIC UPDATE

- **Capacity**: vacancies filled in Sustainability & Estate Net Zero
- **Funding**: won £750k grant for LED & Solar PV, bid £40m for heat decarbonisation at Freeman (PSDS4) – *news awaited*, allocated £500k by charities for SHINE initiatives (**£343k approved so far**)
- **Culture**: working with Clinical Boards to embed Shine 10-steps
- **Governance**: SHC refresh, reporting to Board via F&P committee
- **Procurement**: 1,300 suppliers engaged, more accurate CO_2 data
- **Biodiversity**: successful in bid for Nature Recovery Ranger
- **Born Green**: reduced plastics in MAU & Obs theatre (c-sections)
- **Estates Net Zero**: RP fully decarbonised (**saving 120 tCO_2e/yr**)

ENERGY

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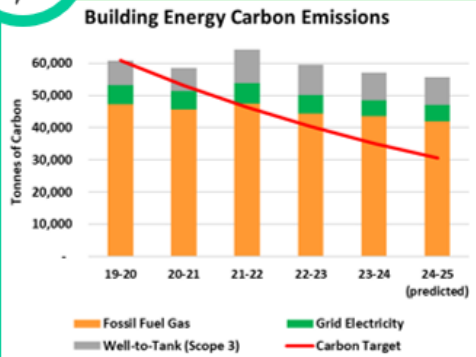

- Minor reduction in energy CO2 predicted for 24-25 (still off target)
- PSDS4 £40m bid (*news awaited*)
- **£750k government grant** awarded for LED & PV
- **£85K charity funding** for LED in R21 and DSC at FH

PEOPLE

- **699 Green Champions** (*580 in Q2,* ↑21%)
- Sustainability & Waste included in corporate induction
- **Over 50% of staff have completed sustainability training** *('Net Zero NHS' e-module)*
- CEO attended Green Champion meeting

WASTE

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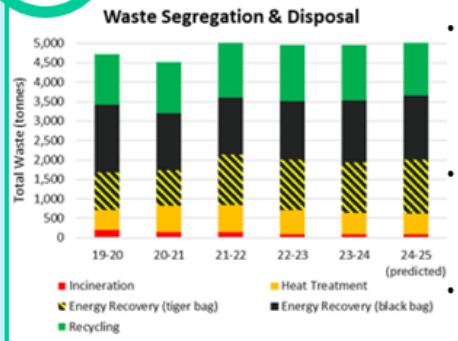

- Incineration waste **down to 1.7%** (*was 4% in 19-20*)
- **Recycling rate at 46%** (*non-clinical*)
- Zero to Landfill

JOURNEYS

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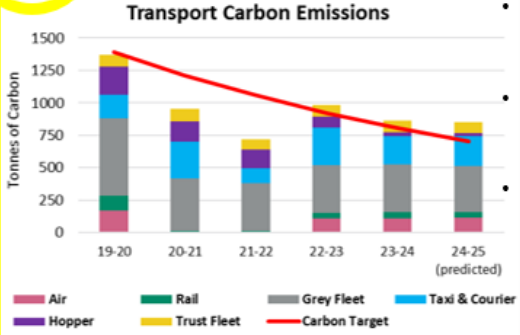
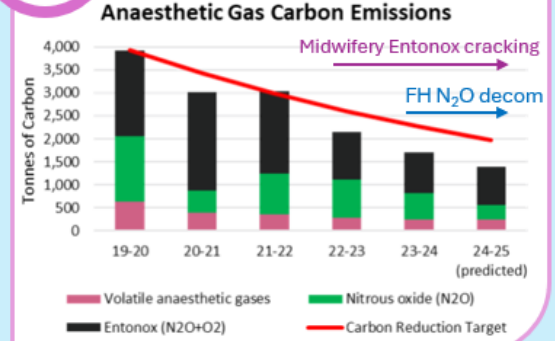


- Now above CO_2 target
- **EV hopper saving 144 tCO_2e/yr**
- Grey fleet, taxis & courier = biggest challenge

CARE

RAG =



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Agenda item A13

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025					
Title	Equality, Diversity and Inclusion update					
Report of	Caroline Docking, Director of Communications and Corporate Affairs, Annie Laverty, Chief Experience Officer					
Prepared by	Caroline Docking, Director of Communications and Corporate Affairs, Annie Laverty, Chief Experience Officer					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	This presentation provides an update on activity to support Equality, Diversity and Inclusion activity in the trust following a change to leadership/oversight responsibility. This is a vital area for us to demonstrate impact and improvement to tackle inequalities effectively and support staff. This presentation was considered at the People Committee, and is shared in the public meeting to demonstrate transparency and commitment. Future progress will also be reported in the public domain.					
Recommendation	For information and support.					
Links to Strategic Objectives	'We want this to be a great place to work where everyone feels supported', and 'Quality of care will be our main priority'.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☐	☒	☒	☐
Link to Board Assurance Framework [BAF]	Not applicable.					
Reports previously considered by	New report.					

Agenda item A13

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality, Diversity and Inclusion (EDI) Improvement Plan

Initial actions

Trust Board - March 2025

Healthcare at its best with people at our heart

6 High Impact Actions

High impact action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

High impact action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

High impact action 3: Develop and implement an improvement plan to eliminate pay gaps.

High impact action 4: Develop and implement an improvement plan to address health inequalities within the workforce.

High impact action 5: Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.

High impact action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Source document: NHS England » NHS equality, diversity, and inclusion improvement plan

6 High Impact Actions

High impact action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

- The Chairman and all Non-Executive Directors share an EDI specific action to 'oversee, and seek assurance on, the development and delivery of the Newcastle People Programme, which includes a specific focus on improving performance regarding EDI, and support demonstrable leadership in relation to EDI within Newcastle Hospitals. To be evidenced through discussion in Board and Committee meetings (documented in the minutes of the meetings) in relation to updates on the delivery of the People Programme and key people metrics on EDI.'
- All Executive Team Members have an agreed EDI objective in draft (to be agreed by Acting Chief Executive Officer (CEO)) these include for example, Executive Sponsorship of the staff networks, an EDI lens on health inequality and associated performance measures, specific directorate improvement focus, baseline understanding of standards relating to EDI and compliance with statutory requirements.

Also:

- Review of EDI Steering Group.
- Discussion with staff network chairs about the year 2 people plan objectives, so that there is meaningful and demonstrable action to support those with protected characteristics.
- Deep dive into Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data (alongside staff survey).
- Ongoing opportunities to highlight and celebrate our communities of interest, led by those communities and supported corporately.
- Engagement with the wider organisation to understand the experience of staff with protected characteristics and what they want to see change.

Recent activities

International Women's Day Celebrations
Hearing from and celebrating inspirational women

Iftar Celebration
Colleagues coming together to break fast together

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Agenda item A14

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025					
Title	Update on a Public Health / Health Inequality Strategy					
Report of	Lucia Pareja-Cebrian, Joint Medical Director					
Prepared by	Balsam Ahmad, Consultant in Public Health					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☐		☒	
Summary	The purpose of this report is to provide the Trust Board with an update on progress on a Public Health/Health Inequality Strategy and governance for the Trust as well as to give assurance regarding progress relevant to various public health work streams. In doing so this paper highlights key challenges, potential risks and gaps but also opportunities around delivery of the public health and health inequality programmes of work. It also makes a number of recommendations.					
Recommendation	Trust Board is asked to i. Receive and discuss the report. ii. Note progress in relation to the development of a Trust Public Health Strategy iii. Note the proposed governance structure in relation to health inequalities.					
Links to Strategic Objectives	Putting patients at the heart of everything we do.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☒	☒
Link to Board Assurance Framework [BAF]	Not applicable.					
Reports previously considered by	Bi-annual report to Trust Board. A detailed report was presented to the Quality Committee on 18 March 2025.					

UPDATE ON A PUBLIC HEALTH / HEALTH INEQUALITIES STRATEGY

1. INTRODUCTION

This report aims to provide the Trust Board with an update on progress made in relation to public health and addressing health inequalities in the Trust. A more detailed paper describing the plans on a strategy and changes regarding oversight and governance was submitted to the Quality Committee meeting on 18th March.

2. PROGRESS UPDATE

2.1 Strategy Development

The strategy is anticipated to be based on 6 key pillars on which to build quality improvement projects, aims and objectives and Key Performance Indicators (KPIs) targeting Health Inequalities (HI) for people who access Newcastle Hospitals. The proposed pillars are:

1. Prevention
2. Elective Care
3. Maternity
4. Children and Young People
5. Urgent and Emergency Care
6. Research and Innovation

The HI strategy will outline plans that will enable a clear vision of priorities, Board Committee oversight, appropriate regular reporting at Board level, clear lines of accountability, and appropriate routes for the escalation of risks.

The aim is to bring the final strategy to the next Quality Committee meeting in April for sign off together with a high level action plan and metrics to enable monitoring progress.

2.2 Governance arrangements

A new bi-monthly 'Promoting Equity in Health Group' (PHEG) is currently being established. The Terms of Reference and membership are being finalised, with Quality Committee approval required.

In Maternity a Perinatal Public Health and Prevention Group (PPHPG) is already in place and will report by exception into the PHEG.

2.3 Progress in the previous 6-months

Examples include:

a) Smoke Free Hospitals and Patient Facing in-house Tobacco Dependency Treatment Service:

A collaborative quality improvement project researching air quality on Trust sites was conducted. This included a smoke free survey carried out during the summer of 2024

with responses from over 1,800 staff, patients and visitors. Findings were analysed and included:

- 87% of respondents agree or strongly agree that Newcastle Hospitals should be smoke free.
- 39% of respondents are aware of our hospital-based Tobacco Dependency Treatment Service (TDTS).

Some of the outcomes from the QI project included: expanding the remit of our in-house TDTS, to deliver very brief advice to people who are smoking and vaping at hospital entrances.

A targeted smoke-free campaign to move smokers away from outside the maternity department at the RVI has been launched and two patient safety bulletins on smoking have been published to raise awareness of the safety issues for patients.

b) Embedding social prescribing in care pathways

Social prescribing is a way to address people's needs holistically by connecting them to non-clinical services in their community.

SPACE CYP (Children and Young People) is a collaboration between the Great North Children's Hospital, Newcastle, and Ways to Wellness. This innovative service allows children with chronic complex conditions and their families to be supported by social prescribing link workers with expert local knowledge, right from within the hospital. Support extends beyond discharge into the community, for 6 months.

2.4 Challenges

Challenges and threats have been highlighted in the report to the Quality Committee. These are the result of the extensive scope of the HI programme with services and interventions falling under different Clinical Boards as well as the cross-cutting nature of the programme, be it in acute and community services and across partnerships at place and the Integrated Care System. Built into the strategy there will be a self-assessment tool for each Clinical Board to identify development work and target opportunities for improving Health Inequalities.

Running in parallel to this, the Trust will work with partner organisations and others seeking opportunities to collaborate going further on those aims.

3. RECOMMENDATION

The Trust Board are asked to receive this progress report as an assurance for the Trust's progress in relation to public health and addressing health inequalities.

Report of Lucia Pareja-Cebrian,
Joint Medical Director
March 2025

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Agenda item A15(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025					
Title	Joint Medical Directors Trust Board Report					
Report of	Lucia Pareja-Cebrian / Michael Wright					
Prepared by	Lucia Pareja-Cebrian / Michael Wright					
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: • Urgent and Emergency Care Update • Cancer Update • Quality & Safety • County Durham & Darlington NHS Foundation Trust (CDDFT) – Breast Service • Medical Education Update • Remote Hosting Organisation (RHO) Update					
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 related to front door frailty in order 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.					
Links to Strategic Objectives	Not applicable.					
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.					

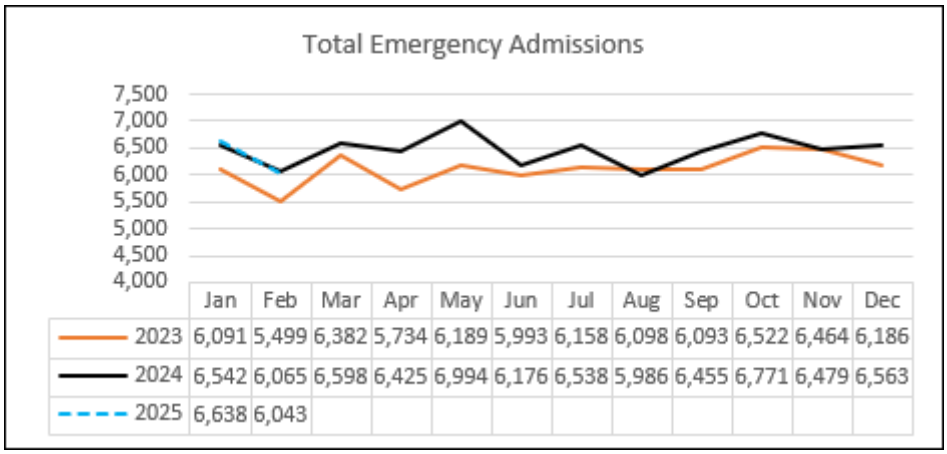
JOINT MEDICAL DIRECTORS TRUST BOARD REPORT

1) URGENT & EMERGENCY CARE

The Trust performance against the standard of assessing, discharging or admitting 78% of arrivals into the Emergency Department (ED) within 4 hours has increased steadily from 73.2% in April 2024 to 76.75% in February 2025.

Performance of Type 1 ED attendances has increased from 57.7% in April 2024 to 62.37% in February 2025. The trajectory for March 2025 is a little under the February performance but has been impacted by widespread Norovirus outbreaks across the Trust.

Total emergency admissions continue to run at slightly higher levels in 2024.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	6,091	5,499	6,382	5,734	6,189	5,993	6,158	6,098	6,093	6,522	6,464	6,186
2024	6,542	6,065	6,598	6,425	6,994	6,176	6,538	5,986	6,455	6,771	6,479	6,563
2025	6,638	6,043										

Recent initiatives to reduce congestion in ED to both improve performance and facilitate improvements in care include:

- Development of a frailty service front of house with strong links to community services.
- New pathways for acute cardiology to manage arrhythmia patients via Same Day Emergency Care (SDEC) and direct access to the Rapid Access Chest Pain Clinic (RACPAC) from ED.
- Direct streaming to the Surgical Assessment Unit from the ED for specific conditions
- Broadening streaming to medical SDEC from the ED.
- Improvements in the discharge process for pathway 1 and 2 patients to reduce overall length of stay.

As of 13 March, the national comparisons show that we have the 20th highest ED performance of any Trust in the Country, and the top performer of all the Shelford Group Trusts.

2) CANCER UPDATE

2.1 Performance

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
28-day (28D) Faster Diagnosis Standard (FDS) %	77	80.8	79.2	73	68.4	68.9	71.8	73	75	69
Number of Patients	2620	3005	2831	2842	2727	2421	2962	2487	2548	2746
62-day (62D) %	58.9	60.6	65.3	60	64.8	68.9	64.3	65.7	68.1	67.6
62D by Tumour										
Breast	89.9	93.8	97.8	89.7	90.8	92.2	86.7	90.6	90	86.5
Lung	29.3	46	48.3	34.8	33.8	34.9	38.7	48.3	63.3	47.5
Head & Neck	80	66.7	79.4	80	78.6	75.7	77.4	75.4	63.5	84.9
Lower GI	25.3	46.4	28.8	49.3	49	50	34.3	49.1	32.2	52.9
Upper GI	37.9	29.3	40.4	36.7	64.8	47.5	48.9	51.2	47.8	51.3
Urology	46	36.1	50	46.9	42.5	48.1	53.9	55.3	64.7	56.9
Skin	80.5	87.9	87.9	83.5	89	81.6	87.2	77	78.7	80.7

Cancer performance is clearly still below the standard required and below what we would want to see. Significant improvement has been seen in the number of patients currently beyond day 62 on a cancer pathway. The level is currently 149, down from just over 300 at its peak. Dealing with patients who are waiting for treatment is the key to moving to working in real time which is where we need to be with cancer pathways.

The most consistently challenged tumour groups in terms of 62D performance remain, lower GI, upper GI, lung and urology.

All tumour groups are preparing updated action plans to detail how this performance can be improved. The improvement team members are fully involved in this work. The biggest focus to date has been on colorectal cancer, bladder cancer, lung cancer and hepatobiliary (HPB) cancer as there are the areas of highest patient risk.

2.2 Harm Review (patients beyond 104 days on a cancer pathway)

A paper was presented at the Quality Committee meeting on 18 March 2025.

Key Messages: All Cases Except Those Assessed for Lung Cancer Surgery 1 April 2024 - 7 October 2024

100% of captured cases reviewed

Cases Reviewed	439
Harm Found	1

Harm in 1 HPB patient with co-morbidities which initially delayed surgery then repeat scan showed progression which precluded surgery.

Lung Cancer Surgery Cases 1 January 2024 – 31 January 2025

100% of captured cases reviewed

Cases Reviewed	160
Harm Found	24

Nature of Harm for Lung Patients

For the most part stage migration was the concern.

Breakdown of impact is listed below:

Surgery remained curative	4
Adjuvant chemo recommended for cure	12
Changed from surgery to curative chemo option	2
Palliative or Best Supportive Care (BSC) Approach	6

These data underscore the need for a specific and continued focus on lung cancer treatment.

2.3 Job Planning for Tumour-specific Cancer Lead Roles and Clinical Board Alignments

Roles and responsibilities of the tumour group cancer leads have been agreed. These encompass clarity around Clinical Board accountability for pathways even when patients need to pass through the care of multiple Clinical Boards for their treatment. The overarching nature of tumour lead roles is highlighted and there is formalisation of the advisory nature of this role to Clinical Board senior management teams

In summary, there has been some improvement in number of patients waiting over 104 days, continued improvement in this area should facilitate real time working and thus impact time to treatment and target achievement.

3) QUALITY AND SAFETY (Q&S)

The first Q&S focused Quality Performance Reviews (QPRs) were held with all the Clinical Boards in February. These were positive meetings overall that provided an opportunity to oversee Quality Oversight Group (QOG) activity and gather assurance on Q&S governance structures, clinical effectiveness, dissemination of learning and actions following incident reporting and investigations and clinical risk. Each Clinical Board shared their Q&S priorities.

Call for Concern (Martha's rule) is now on week 2 of its implementation in adults. A total of six calls have been received to the service in that period of time. One of those represents true deterioration in a patient with pain control issues while the rest were a variety of predominantly communication-based issues dealt with by the Outreach team. A detailed report into the activity arising from this service will be shared in due course.

Implementation in children of this service has been slightly behind mostly due to the absence of a critical care outreach service in paediatrics. A finalised process for how this service is provided within paediatrics is expected imminently.

The annual Patient Safety Incident Response Framework (PSIRF) review is currently in progress and highlights patient safety incident reporting has increased in the Trust since implementation of PSIRF by 4.8%. 28 Patient Safety Incident Investigations have been declared over the course of the year and Clinical Board ownership of investigations and actions is improving. This has been underpinned by the delivery of an in-house training programme with 80 senior staff completing this.

The Trust Patient Safety Group will receive an update from the three PSIRF priority leads on 21 March and is summarised below. This discussion will also contribute to informing proposed PSIRF priorities for the coming year. However, the limitations of the digital infrastructure has impacted on the ability to successfully achieve the current priorities and must be considered for any future priorities.

Reduction in hospital acquired thrombosis – compliance with completing the Venous thromboembolism (VTE) risk assessment on admission has increased from 30% to 96% and a dashboard to allow clinical areas to view their own data is being finalised. There has also been in an increase in compliance from 4% to 80% with completing the VTE online training, and training is now also delivered face to face. Finally, Artificial Intelligence (AI) has been developed to identify all new blood clot diagnoses, meaning each case can be identified and appropriately reviewed. The focus is now turning to embedding the changes and establishing appropriate data oversight mechanisms.

Lost internal referrals – stakeholders identified and have agreed the Care Optimisation Committee (COC) will hold operational authority. The COC have agreed to the digital build required to support this priority and this build is expected to start in April 2025.

Management of abnormal results (closed loop investigation project) – The IT build needed to enable a safe system with capacity for audit and oversight is being completed. The draft Results to Endorse (RTE) Policy has been shared and Digital leaders for each Clinical Board have been consulted on this policy. Newcastle Hospitals staff are attending Oracle Health's Special Interest Group to learn from other organisations how to implement a robust RTE process. Locality based RTE pools have been shared with IT and a new reporting workstream has been tasked with ensuring appropriate audit can be undertaken.

The proposed Quality Account priorities continue to be refined and developed with the identified leads and are highlighted below:

- Incident reporting and learning from incidents including expansion of learning resources, 'hits' on Patient Safety briefings and bulletins. May include development of a Community focused Patient Safety Briefing.
- Medicines Management ward-based compliance with Care Quality Commission (CQC) standards.
- Accrediting Excellence (ACE) programme staff experience and clinical standards relating to CQC findings.

- Waiting Safely consideration for review of patient experience in ED, cancer pathways and elective waits.
- Mental Capacity Act (MCA) Deprivation of Liberty Safeguards (DoLs) focus on best interest decision making improving the application for inpatients with Learning Disabilities.
- Substantive launch of the Patient Experience real time surveys expansion to 40 wards.

There was a Physical Health summit hosted by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) on 7 February at Newcastle Racecourse that Newcastle Hospitals representatives attended. The aim of the day was to build on partnerships between CNTW and acute trusts to improve joint working and greater integration of physical and mental health care and consideration was given to how CNTW can support acute Trusts to care for patients with Mental Health conditions, as well as how acute Trusts can support CNTW to manage the physical health needs of detained patients, such as completion of VTE risk assessments and care plans in relation to pressure ulcers. There were also discussions about how acute providers could work differently to in-reach into CNTW and provide physical healthcare support if needed, to avoid patient transfer out of CNTW. Newcastle Hospitals were highlighted as an area that do this well, and Rachael Gregory, Associate Director of Nursing has supported a couple of wards from CNTW and Newcastle Hospitals to buddy up, so the nursing staff develop strong working relations in order to improve patient and staff experience.

4) COUNTY DURHAM & DARLINGTON FOUNDATION TRUST (CDDFT) - BREAST SERVICE

Routine reviews of CDDFT breast service, alongside findings from national surveys, have identified areas of practice where CDDFT has been an outlier. CDDFT has worked with stakeholders – in particular, the North East and North Cumbria Integrated Care Board (ICB). Newcastle Hospitals is currently supporting the service delivery for this group of patients in several ways.

5) MEDICAL EDUCATION UPDATE

There continues to be an increase in support required from the Postgraduate team due to the increase in International Medical Graduate doctors in the organisation. This support includes but is not limited to supernumerary placement on rotas, coaching & mentoring, and additional teaching in subjects such as prescribing.

The Postgraduate team are in the initial stages of looking at the possibility of creating in-house alternative training routes for those who are unsuccessful or not eligible for national training. The benefits to the organisation would include keeping doctors for longer and developing their skills across specialities and provide an opportunity to grow our own clinical staff in areas we struggle to recruit too.

The annual medical education event will be held on the 18 September at The Catalyst, Newcastle. There will be a mixture of speakers and workshops including supporting neurodiversity in doctors, trauma informed working and cultural safety.

We have been successful in our bids for the additional tariff funded posts from August in the following specialties:

- Renal medicine = 1 (from February 2026)
- Rheumatology = 1
- Obstetrics and Gynaecology = 1
- Ophthalmology = 2
- Clinical radiology = 1
- Oral and maxillofacial surgery = 1

Undergraduates

Key Achievements

- 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 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 & Risks

- The undergraduate administration team continues to operate over capacity. 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. This is having an impact on workload and productivity. There have also been vacancies within the Senior Clinical Team that are currently being advertised which is having a similar impact.
- The current teaching fellow cohort needs reviewing to ensure it reflects curriculum and clinical demand.

Newcastle University's recent decision to pause all Medical Electives was unexpected. As a team, we are looking to explore how we can continue to support this activity as a Trust. This will likely add to current capacity issues within the Undergraduate Medical Education Team though the team remain committed to finding a way to deliver this service.

6) REMOTE HOST ORGANISATION (RHO) UPDATE

The CQC report recognised dysfunctionality around the Trust Electronic Patient Records (EPR) (OracleCerner, SystmOne, BadgerNet, Medisoft). Subsequent surveys undertaken by Cerner and KLAS (a healthcare research company) groups highlighted responsiveness of EPR,

training and functionality issues. Additional patient safety issues including clinical incidents from internal referral letters and letter printing have arisen from patient safety process / investigations.

The newly created Care Optimisation Group (COpG) seeks to prioritise and oversee delivery of improvements and enhancements to EPR to improve user experience and manage safety issues. To date, COpG has prioritised projects for delivery, however changes in IT leadership and workload in the IT department related to the transfer of OracleCerner to a managed hosting service has delayed progress and delivery. A workplan for delivery is being re-assessed by the new Chief Digital Officer.

The EPR move to a Remote Hosting Organisation (RHO) was planned for the beginning of February 2025. The move will enable the some of the improvements and efficiency changes we need from EPR. Safety issues identified within the downtime processes associated with drug prescribing prevented this to go ahead. A rescheduled date is awaited and will be shared with the organisation so that wards and departments can be appropriately prepared.

Report of
Dr Lucia Pareja-Cebrian/ Dr Michael Wright
Joint Medical Directors

March 2025

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Agenda item A15

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 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. This is a revised and shortened report compared to previous, including some reference items in the reading room. The Trust Board is asked to review and comment on this revised approach. • Section 1: Nursing and Midwifery Staffing Update • Section 2: Flu and Covid Vaccination update • Section 3: Safeguarding and Mental Capacity Act/Deprivation of Liberty Safeguards (DoLS) Quarter 3 highlight report • Section 4: Learning Disability Quarter 3 highlight report The following key points/risks are noted for the Trust Board's attention: • 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 and there are no new escalations to the Trust Board in this regard. • Several wards have required support at medium and one at high level. 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. • There are several nurse staffing metrics included in the report with additional detail included in the reading room. There is no significant variation and no new escalations to note. • Flu and Covid vaccination uptake was lower than in previous years and this pattern was reflected locally and nationally. The Trust figures are included in the report for reference and planning is in place for this year's campaign. • Staffing capacity in the Safeguarding Team is affecting the ability to deliver on all aspects of good practice, this has been added to the risk register. Patient care is prioritised, and oversight of mitigations is provided by the Safeguarding Committee. This is impacting on compliance with Safeguarding Policy audits and a policy audit compliance report is submitted to the Safeguarding Committee to ensure progress. • Safeguarding training compliance continues to be monitored. Level 1 and 2 adult and children compliance is above Trust target. Level 3 adult and children compliance is below the 90% threshold with actions in place to improve this. • Capacity to respond to the increased demand in the Learning Disability Liaison Team, results in a risk to patient safety and staff experience. Additionally, there is no dedicated		

<table>
<tr><td></td><td colspan="6">resource for the development work around caring for those who are autistic. This is logged on the risk register, and work is underway to increase team capacity. Interim mitigations are in place and detail is contained within the report.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Board of Directors is asked
i) Receive and discuss the report.
ii) Note the oversight and reporting of safe staffing which has been prepared in line with national guidance.
iii) Note the risks and mitigations in relation to the Safeguarding and Learning Disability Liaison Teams.
iv) Comment on the revised structure of this report and agree next steps.</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>
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EXECUTIVE DIRECTOR OF NURSING REPORT

1. NURSE STAFFING UPDATE

A guidance document providing an overview of nursing safe staffing metrics and the Ward and Department Monthly Safe Staffing Dashboard can both be found in the Trust Board reading room to complement the detail contained within this report.

1.1 Nurse Staffing Escalation

The Trust Nursing Safe Staffing Guidelines provide a robust framework to ensure safe nurse staffing governance and identifies a clear process for safe staffing escalation. The Trust staffing escalation is currently operating at level two due to the following thresholds being met:

- Sustained sickness absence greater than 6% for the registered nursing and midwifery workforce.
- Surge beds remain utilised, which creates an increased staffing requirement.

The following actions remain in place and are overseen by the EDoN:

- 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 cover continues, which enhances staffing and professional oversight out of hours. Level two escalation will remain in place until the de-escalation criteria has been met.

1.2 Nurse Staffing and Clinical Outcomes (NSCO)

The monitoring of safer staffing metrics against clinical outcomes/nurse sensitive indicators as mandated in national guidance continues via the NSCO Group. Below is an overview for the last quarter:

Month	Total	Clinical Board	High level support	Medium level support	Low level support
Nov-24		Family Health Services	3, 4 Great North Children's Hospital (GNCH)		2a, 9, 12 GNCH 40 Royal Victoria Infirmary (RVI)
		Surgical & Specialist Services RVI		22 RVI	16 RVI
		Perioperative Services			18 RVI
		Cardiothoracic Services		Paediatric Intensive Care Unit (PICU) FH	23, 24, 25, 29 Freeman Hospital (FH)
		Medicine & Emergency Care Services			30, 31, 42, 48, 52, Assessment Suite (AS) RVI, 14, 15, 17 FH

Month	Total	Clinical Board	High level support	Medium level support	Low level support
		Surgical & Associated Services FH		44 RVI	6, 8 FH
		Cancer & Clinical Haematology Services		34 Northern Centre for Cancer Care (NCCC)	35 NCCC
Total	**28**		**2**	**4**	**22**
Dec-24		Family Health Services	GNCH 3	GNCH 2a, 4	GNCH 9, 12. RVI 40
		Surgical & Specialist Services RVI			FH 19, RVI 16
		Perioperative Services			
		Cardiothoracic Services		FH PICU	FH 23, 24, 25, 29
		Medicine & Emergency Care Services		RVI AS, 30	FH 17, RVI 42
		Surgical & Associated Services FH		FH 8, RVI 44	
		Cancer &Clinical Haematology Services		NCCC 34	NCCC 33
Total	**21**		**1**	**8**	**12**
Jan-25		Family Health Services	GNCH 3	GNCH 2a	GNCH 4, 9, 12. RVI 40
		Surgical & Specialist Services RVI			FH19, RVI 16, 20
		Perioperative Services			
		Cardiothoracic Services		FH PICU	FH23, 24
		Medicine & Emergency Care Services		RVI AS, 30	FH13, 16, 18 RVI 42
		Surgical & Associated Services FH			FH 8, RVI 44
		Cancer &Clinical Haematology Services		NCCC 34	NCCC 33
Total	**22**		**1**	**5**	**16**

Key points to note:

- Two wards (GNCH 3 & 4) have required high-level support over the last three months. Ward 4 GNCH had a peer review with a staff survey in December 2024 and has been stepped down through medium to low support.
- Ward 3 GNCH has staffing concerns which are unlikely to fully resolve until recruited staff commence employment and successfully complete their supernumerary period. This is being mitigated by closed beds and a supportive action plan. The multiple vacancies have been recruited to with staff commencing employment in March 2025.

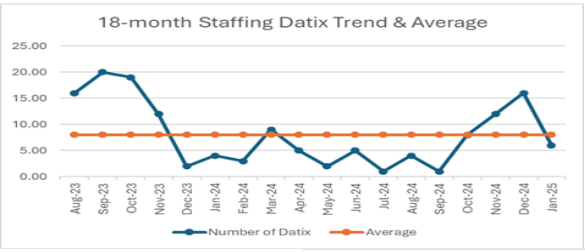
1.3 Datix and Red Flag data

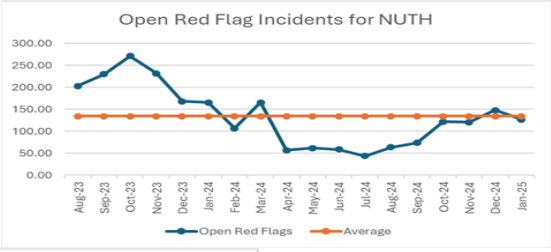
Red flag and Datix incident data are reviewed daily (Monday-Friday) by the senior nursing team and reported as part of the daily staffing briefing and presented to the NSCO Group monthly.

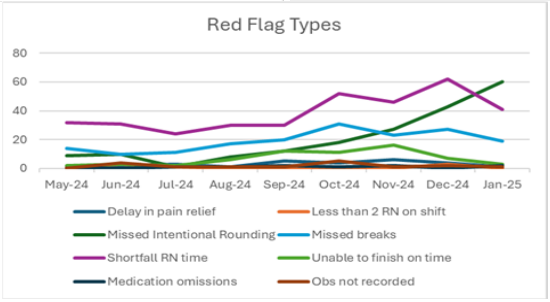
Key points to note:

- The reporting of staffing related datix incidents continues to be encouraged across the Trust. There has been no statistically significant variation in the reporting of incidents in this quarter.
- Staffing Datix are being reported most frequently in Medicine and Emergency Care. This is the Clinical Board with the highest requirement for enhanced care observation and includes front of house services. Local oversight of safe staffing remains in place. No new trends for escalation have been noted.
- There has been a reduction in red flag incidents reported since March 2024, with the number of reports largely remaining below the 18-month average. This is expected based on improved fill rates and a reduced vacancy and turnover position.

- The most reported reg flag type was “shortfall in Registered Nurse (RN) time”, until January 2025, when “missed intentional rounding” became the most frequently reported. This continues to be closely monitored.







1.4 Care Hours Per Patient Day (CHPPD) data

The staffing team monitor Ward-specific CHPPD on the Safer Staffing Dashboard and it is reviewed at the NSCO Group every month. The Trust CHPPD remains above average and despite increased bed capacity and higher sickness rates, CHPPD has risen in December 2024 and January 2025 to 9.0. This is largely due to the number of critical care areas within the Trust which impact on the overall position.

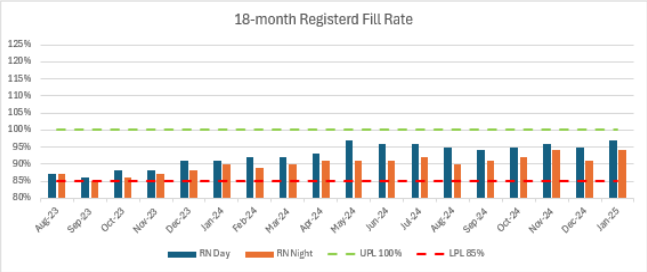
Non-specialist in-patient wards benchmark lower than the Model Hospitals Dashboard comparator in most services but direct benchmarking is difficult. There are no new areas for escalation.

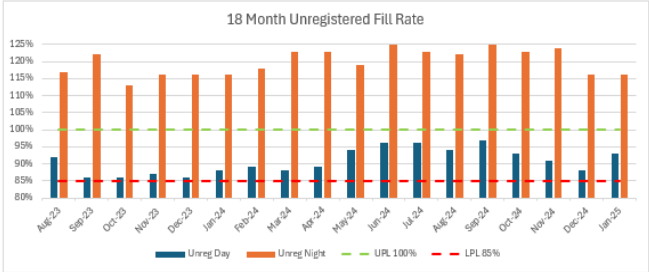
1.5 Planned versus actual hours (fill rates)

The planned and actual staffing hours are converted into percentage “fill rates” which are entered onto the safer staffing dashboard, rag rated and reviewed monthly by the NSCO group. RN fill rates <85% are reported to the EDoN every month.

Key points to note:

- In January 4 wards reported less than a 85% RN fill rate for days and 10 on nights (2 being the same as those reported on days) based on planned versus actual data.
- 4 of those areas were critical care areas where bed capacity and management of patient acuity mitigated risk on a day-by-day basis. Of those other areas, no concerns were raised, and local staffing mitigations remained in place.
- There has been a change in those areas reporting less than an 85% RN fill rates which is now heavily weighted to nightshift. Rostering practice is being reviewed in relevant areas.





1.6 Temporary Staffing

Newcastle Hospitals Staff Bank supply temporary staffing to wards and departments to fill short-term vacancies or absence. Additional oversight is provided by temporary staffing reports and agency usage reports which are distributed to the senior corporate nursing team and heads of nursing every week.

Key points to note:

- Temporary staffing spend has fluctuated month-to-month with a gradual increasing trend. This is influenced by pay increases and back-dated pay awards. However, unregistered agency spend has a decreasing trajectory and this is evidenced through a reduced temporary staffing spend.
- The number of requested temporary staffing shifts for both registered and unregistered staff has continued to reduce and has been on a downward trend over the past 18 months. This is expected based on improvement in vacancy rates but is reassuring to note.

1.7 Registered Nurse (RN) Recruitment

Key points to note:

- The current RN turnover is 6.06%. This demonstrates a further reduction from the previously reported 8.05% in the same period last year.
- The current RN vacancy rate is 1.69%. This is a slight increase however it still remains stable from the 1.07% reported previously and is slightly above the figure of 0.91% 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.
- A proposal to devolve elements of the Band 3 and 5 Recruitment process is progressing with a pilot being undertaken in Perioperative Services.
- The clinical educator/support for Internationally Educated Nurses will end in March and will not be replaced, this work transfer to the Senior Nurse (Workforce).

1.8 Healthcare Support Worker (HCSW) Recruitment

Key points to note:

- The HCSW vacancy rate is currently 8.52% and remains largely static. It should be noted that the Trust Workforce report contains non-HCSW staff such as house keepers and so with those staff manually removed the HCSW vacancy rate is lower. The unallocated posts for HCSW or ‘live vacancies’ is 35.17 whole-time-equivalent (WTE) which would equate to a vacancy rate 2.72%.

- The current HCSW turnover rate was 8.67% compared to 11.28% the previous year. For Healthcare Assistants specifically this is 7.73% compared to 9.35% the previous year.
- Our monthly centralised recruitment was paused for February and March due to the low numbers of vacancies. The April recruitment will be for HCSW Apprenticeships as well as a bespoke opportunity for Newcastle College.
- The Senior Nurse for HCSW Development has retired and the post will not be replaced. This work will be undertaken by the Senior Nurse (Workforce).

2. FLU VACCINATION PROGRAMME UPDATE

The Trust Staff Vaccination Programme encouraged staff to take up vaccination to protect themselves, family and patients. It commenced in early October 2024 with the Flu vaccine, shortly followed by the Covid vaccine. A mixed delivery model was adopted consisting of peer vaccination and fixed clinic delivery. Vaccination uptake was monitored daily and against uptake in the previous year. Uptake was lower than in previous years and this pattern was seen in peer organisations and nationally. Consequently, the Department of Health and Social Care extended the offer of vaccination until the end of January 2025.

At the end of January 2025, the number of staff who have received the Flu vaccine was 7,281 (54.3% of staff). This is the highest percentage both regionally and nationally for Trusts with more than 10,000 staff. The total number of staff vaccinated against Covid was 3,888 (29.0% of staff). Although low this compares favourably against both regional and national data. Work is underway to plan the programme for the year ahead.

3. SAFEGUARDING AND MENTAL CAPACITY ACT QUARTER 3 (Q3)

This summary of key points provides a Q3 update of Safeguarding (Adult, Children's and Maternity) and Mental Capacity activity throughout the Trust. This detail was presented to the Safeguarding Committee (January 2025) and the Quality Committee (February 2025).

The following key points are noted for the Trust Board's attention:

3.1 Activity and Audit

- The complexity within adult safeguarding remains significant and unchanged. This is reflected in several Local Authorities who are developing a Multi-Agency Risk Management (MARM) process to further enhance safeguarding procedures.
- Children's Safeguarding and Maternity activity remains largely unchanged.
- Staffing capacity in the Safeguarding Team is affecting the ability to deliver on all aspects of good practice with patient care being prioritised. This has been added to the risk register with key actions to be agreed and implemented. Oversight of mitigating actions is provided by the Safeguarding Committee.
- In Q3 there were 161 reported Mental Capacity Act (MCA) and DoLS related enquiries, with some regarded as complex and duly escalated within the Trust. This is an increase from 137 in Q2.

- Compliance with policy audits remains challenging due to capacity in the adult team. A policy audit compliance report which is monitored as part of the agenda for the Safeguarding Committee, ensures progress.
- Routine audit has been gathered and shared at the MCA Steering Group. Results demonstrate that staff do carry out assessments of capacity and there are examples of good assessments when making decisions in best interests. Further work is required to ensure this is consistent in all areas.

3.2 Education and Training

- Safeguarding Adults training compliance is closely monitored at the Safeguarding Committee. Currently Level 1 training demonstrates good compliance with 96.07% and Level 2 96.04%. Safeguarding Adult Level 3 compliance is 85% and below the Trust 90% standard. All staff have been contacted to prioritise their Level 3 training.
- Safeguarding Children Level 1 compliance rates are 96.28% and Level 2 95.86%. Level 3 Children's safeguarding sits at 86% which is below the required target. The Safeguarding Adults/Children Training Development Manager is progressing work to improve statutory mandatory compliance rates across the Trust.
- The comprehensive training needs analysis aligned to the intercollegiate guidelines has been completed and the final recommendations were presented to and endorsed by the Learning and Education Group in November 2024. Planning to implement the roll out is underway. A risk/benefit analysis has been undertaken and agreed at Safeguarding Committee.
- Level 1 MCA mandatory training for all clinical and patient facing staff is in place. Compliance currently sits at 96%. The Level 2 MCA and DoLS e-learning package has now been completed and was launched on 9 December 2024. The aim is to achieve 90% compliance by the end of June 2025. Current compliance rate sits at 48% which is on target based on planned percentage uptake per month.

4. LEARNING DISABILITY QUARTER 3 (Q3)

This summary of key points provides a Q3 update of Learning Disabilities activity throughout the Trust. This detail was presented to the Safeguarding Committee (January 2025) and the Quality Committee (February 2025).

The following key points are noted for the Trust Board's attention:

4.1 Activity and Service Pressures

- There continues to be an increase in referrals and contact with the Learning Disability Liaison Team. Q3 figures demonstrate that there were 99 new patients referred. The Liaison Team continue to prioritise clinical care and Multi-Disciplinary Team (MDT) planning meetings.
- Additional resource has been identified to increase team capacity, but further work is required to identify dedicated funding to support a post to lead on caring for those who are Autistic. Mitigations are in place overseen by the Associate Director of

Nursing. The service risks have been evaluated, and two risks (Risk IDs 4424 and 4272) have been entered onto the risk register and continue to be closely monitored.

4.2 Mandatory training for Learning Disability and Autism

- Current compliance for all clinical and non-clinical patient facing staff with the Diamond Standard Mandatory Training is at 95% and this includes the Maternity Diamond Standard training.
- The Trust is currently reviewing the training plans in line with national expectation, this will in turn need discussing with the Integrated Care Board (ICB) alongside funding implications. The Trust is also meeting with regional acute provider colleagues to determine the benefits of working more collaboratively with the delivery of training.
- Two introductory Tier 2 Oliver McGowan Training for Learning Disability and Autism sessions have been funded with the first having 22 attendees on 10 January 2025. This builds on the previous pilot work undertaken by the Trust.
- Six one-hour sessions which focus on managing distressed behaviours and autism will be delivered by the Northeast Autism Society between February and July 2025.

4.3 CQC Action Plan and Improvement Workstreams

- The Learning Disability CQC Action Plan is overseen by the Learning Disability Steering Group at bi-monthly meetings. This is in the process of being reviewed to transition to a wider improvement plan and will be presented to the Quality Committee in due course.
- A key part of this improvement work involves working with those with lived experience to improve and shape our services. Skills for People have been supporting a number of workstreams including a plan for quality checking services, improving written communication and working to improve the use of hospital passports. Skills for People have helped us produce a training video recorded by people with lived experience which will be launched in late March ahead of the pilot of the new reasonable adjustment form.

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
28 March 2025

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 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. Key points/risks to note: • The Trust triggered a safety signal from the North East North Cumbria (NENC) clinical indicator dashboard for postpartum haemorrhage (PPH) of over 1500mls in Quarter 1 and 2 2023/24 which instigated a deep dive review and audit. The recommendations of the review were enacted, and the Trust has not subsequently triggered a safety signal. Postpartum haemorrhage rates are within the expected range. • The maternity service maintained Operational Pressures Escalation Level (OPEL) 1 and 2 in December 2024 and January 2025. Phase 1 of the staffing review will be maintained in April 2025 due to maternity leave, with further evaluation of the intrapartum midwifery staffing. It is likely that there will be a requirement to increase the staffing in this area alone. The revised timeline for phase 2 and 3 of the staffing review will be discussed at the People and Culture Group in April 2025. • The Year 7 Maternity Incentive Scheme document is due for publication on 2 April 2025. The requirement for evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set has been reduced from monthly to at least quarterly. • The Trust has volunteered to be a pilot site for the testing and validation processes for the Maternity Outcome Signal System. • An overview of the findings and recommendations of the recent Local Maternity and Neonatal System (LMNS) 2024 Perinatal Quality Surveillance Annual Assurance Peer Review Visit, which includes the actions required to address any areas of improvement. There are 11 recommendations, of which 10 have existing associated internal actions and reporting and monitoring arrangements. Action 4 requires discussion at the People and Culture Group, with escalation to Family Health Clinical Board and Trust Estates and Car Parking Group if indicated. • Work has continued to conclude the Patient Safety Incident Investigations reports and develop the required antenatal and newborn screening improvement plan. The Incident Oversight Group, with Integrated Care Board (ICB) and NHS England (NHSE)		

<table>
<tr><td></td><td colspan="6">representation, which was meeting fortnightly, has been stood down and moved to business as usual oversight via the Operational Antenatal and Newborn Screening Board.
• There have been no further Glycopeptide Resistant Enterococcus (GRE) infections in February 2025 in the Neonatal Intensive Care Unit (NICU), however, there has subsequently been an outbreak of Carbapenemase Producing Enterobacteriaceae (CPE) resulting in the long-term closure of a cot.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The 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 requirement for a revised timeline for phase 2 of the staffing review in response to the impact of maternity leave over the summer.
iv. Note the findings of the LMNS peer review visit, recommendations and governance oversight arrangements.
v. Note the current risk and mitigations in place.
vi. Agree the frequency of future Perinatal Quality Surveillance reports.</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 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>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">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="6">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>
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PERINATAL QUALITY SURVEILLANCE REPORT

1. INTRODUCTION

This report provides the Trust Board members with an overview of the Maternity Service compliance with the 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 final self-assessed position against the Year 6 Maternity Incentive Scheme 10 Safety Actions and outlines applicable changes to the Year 7 scheme.

2. MINIMUM DATA MEASURES

The 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 Postpartum haemorrhage >1500ml

The Trust triggered a safety signal from the NENC clinical indicator dashboard for postpartum haemorrhage (PPH) of over 1500mls in Quarter 1 and 2 2023/24 which instigated a deep dive review and audit. The Trust is commissioned to provide the Placental Accreta Spectrum (PAS) service and provides complex maternal and fetal medicine care to a high-risk population. It was important to ascertain if the rate was reflective of the complexities of care, or if there was opportunity for quality improvement.

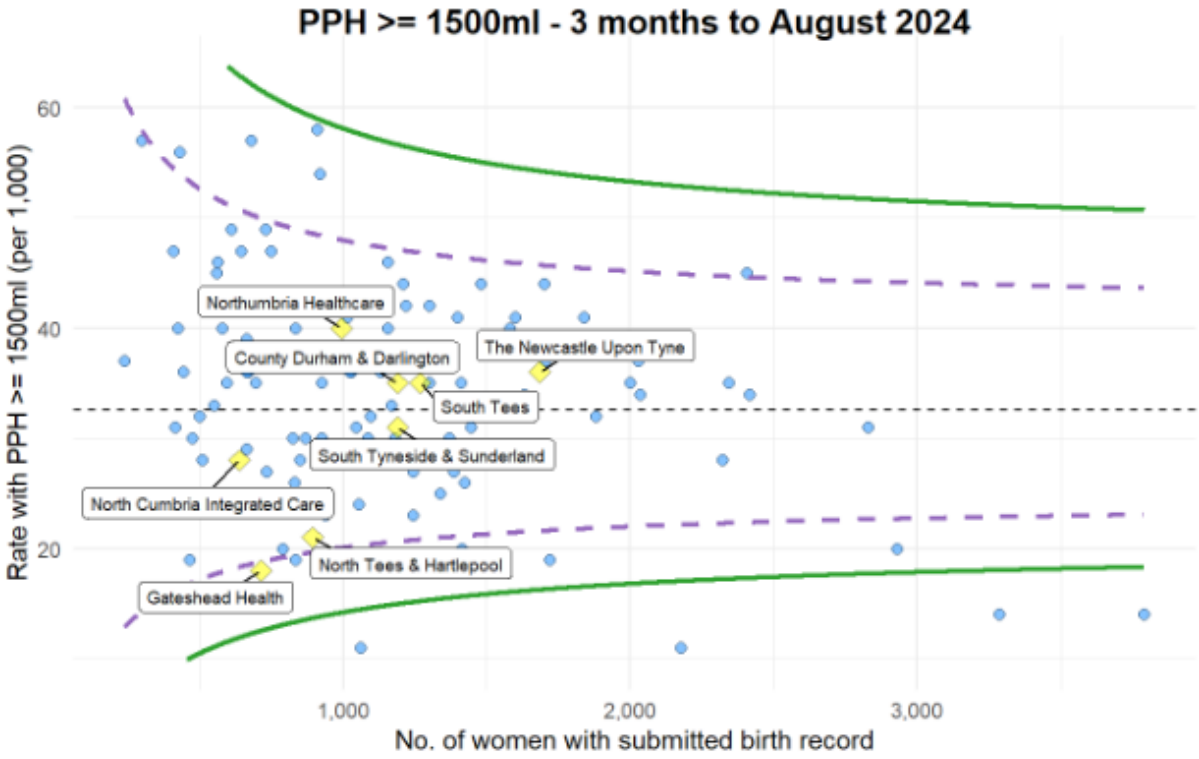
The review considered data quality, patient risk factors, guidance compliance and areas for improvement. 140 cases (1 January 2023- 31 June 2023) were reviewed. 13 cases were excluded due to double data entry. 56 women were delivered by caesarean section, of those 13 women received blood transfusions (6 were under the care of the PAS team). The review demonstrated that data input was an issue, the use of measured rather than estimated blood loss should be embedded and that the high-risk patient group had impacted on the PPH rates. Documentation was noted to be poor throughout the review.

The recommendations were shared with the LMNS in November 2023, in summary:

- Data quality and ensuring no dual entry of the blood loss.
- Embedding of measured blood loss rather than estimation.
- Ensure early consultant attendance for high-risk cases.
- Embed use of the PPH documentation proforma.

The recommendations of the review were enacted, and the Trust has not subsequently triggered a safety signal for PPH. A repeat audit of documentation was completed in February 2025 which demonstrated higher quality documentation and use of the PPH proforma.

The NENC Q2 2024/25 dashboard demonstrates the Trusts current position in comparison with local and national Trusts, noting that these include all units without PAS and tertiary services. We are awaiting publication of the NENC Q3 dashboard, local data indicates the position will be unchanged with a PPH rate of 38 per 1000 deliveries in January 2025.



2.2 Midwifery staffing

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings. Midwifery staffing is reported separately to the Quality Committee and Trust Board biannually to meet the requirements of the Maternity Incentive Scheme.

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).

The staffing position has been reviewed to evaluate the impact of enacting phase 1 of the staffing review and opening of the Newcastle Birthing Centre. To note:

- Phase 1 of the staffing review requires 190.34 whole-time-equivalent (WTE).
- Phase 2 of the staffing review requires 204.17WTE.
- Current establishment is 185WTE.
- Interviews conducted 28th January; 9.2 WTE recruited, this will include 4 Internationally Educated Midwives who currently reside in the UK with Nursing and Midwifery Council (NMC) pin.

The service is currently tracking maternity leave which is expected to significantly increase over the summer (11.2WTE from April, peaking at 16.26WTE in August 2025) therefore further recruitment is required. There will be a specific student advert when the current recruitment cycle is complete.

Phase 2 of the staffing review is due to be enacted in April 2025 and requires 204.17WTE. The impact of maternity leave means this will not occur as planned, and a revised timeline is required.

Assessment of impact of Phase 1 staffing enacted December 2024

Maternity Assessment Unit
Midwifery initial triage within 15 minutes is 93% and Birmingham Symptom Specific Obstetric Triage System (BSOTS) ongoing midwifery care across all categories is above LMNS targets. Overall, the midwifery staffing establishment is adequate to maintain safe midwifery triage times.

Antenatal inpatient ward and Day Care Unit
The daily BirthRate Plus acuity tool assessment demonstrated that the phase 1 midwifery staffing met acuity 76% in January 2025, however the confidence factor in completion was only 75.81%. There will be a focus on improving the BirthRate Plus daily acuity tool scoring compliance to increase the confidence factor.

There were five red flags recorded in December 2024 relating to delayed or cancelled time critical activity and delay in pain relief. There were no red flags on the antenatal ward in January 2025. Based on this assessment it is acceptable to maintain the phase 1 midwifery staffing.

Intrapartum care (Delivery Suite and Newcastle Birthing Centre)
The daily BirthRate Plus acuity tool assessment demonstrated that the phase 1 staffing met acuity 74% for Delivery Suite and 99% for Newcastle Birthing Centre (NBC) in January 2025. The confidence factor is completion is good, 82% and 90%, respectively.

There were two red flags in December 2024 for intrapartum care recorded, one relating to delayed or cancelled time critical activity and one related to delay in admission and commencement of induction of labour. There was only one red flag on Delivery Suite in January 2025, for a delayed time critical procedure, and no red flags for NBC. There were no occasions when one to one care could not be provided, and no occasions during the shift when the coordinator was not supernumerary. This demonstrates a significant reduction in the number of red flags, with no women experiencing delays in their induction of labour care pathway. There were thirty-eight babies born on NBC during January. Further work is required to assess the staffing requirements for the intrapartum services as to whether additional midwifery staffing is required.

Postnatal and transitional care wards
The daily BirthRate Plus acuity tool assessment demonstrated that the phase 1 midwifery staffing met acuity 100% in January 2025. There were no red flags on the postnatal ward. There is an ongoing review of the neonatal nursing establishment for the transitional care

ward, but the midwifery staffing was adequate. Based on this assessment it is acceptable to maintain the phase 1 staffing.

Community midwifery teams
Phase 1 midwifery staffing is adequate to maintain safe caseloads across the 4 community teams. Work is ongoing to realign caseloads and case mix at an individual midwife level to support equity of caseload, with a focus on safeguarding complexity.

The maternity service maintained Operational Pressures Escalation Level (OPEL) 1 and 2 in December 2024 and January 2025. Phase 1 of the staffing review will be maintained in April 2025 due to maternity leave, with further evaluation of the intrapartum midwifery staffing. It is likely that there will be a requirement to increase the staffing in this area alone.
There is a midwifery open day in April 2025 with targeted student recruitment in April and May 2025.

The revised timeline for phase 2 and 3 of the staffing review will be discussed at the People and Culture Group in April 2025.

2.3 Staff experience

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 discussed 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 multidisciplinary representation from across the maternity and neonatal teams. A service wide Teams channel has been established to share all key documents in an open and inclusive manner, to encourage participation and transparency. The action plan will be revisited following the publication of the Staff Survey results.

3. MATERNITY INCENTIVE SCHEME

The Trust Board supported the self-assessed position in February 2025. The Trust declared compliance with the Safety Actions 1, 2, 3, 4, 5, 7, 9, and 10 and non-compliance with safety actions 6 and 8. An action plan and associated funding plan was submitted to NHS Resolution on the 3 March 2025, the Trust awaits the outcome of this request for funding for an administration officer and senior midwife post. In line with reporting requirements, the Quarter 3 Perinatal Mortality Review Report (PMRT) can be found in the Trust Board reading room for noting.

The Year 7 Maternity Incentive Scheme document is due for publication on 2 April 2025. In advance of publication NHS Resolution have provided a very brief overview of any significant changes to the scheme. Whilst most of the changes relate to clinical practice, there are amendments to Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal

safety and quality issues?

- Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM at least quarterly (previously every meeting).
- Perinatal leadership team - Evidence of collaboration with Safety Champions and the LMNS/Operational Delivery Network (ODN)/ICB lead(s) and including the Maternity and Neonatal Voices Partnership (MNVP) Lead.

The Trust has developed the Perinatal Quality Surveillance minimum data set, reported in the Integrated Board Report, and a Perinatal Quality Surveillance Report to Quality Committee and Trust Board monthly during 2024/25. This report also provides a comprehensive overview of quality and safety issues within the perinatal services, and progress with the Maternity Incentive Scheme and more broadly ensures visibility of risks and escalations. The Trust Board are asked to consider the frequency of reports in 2025/26 in accordance with the Year 7 guidance, whilst acknowledging the service would support continuing monthly reporting.

4. MATERNITY OUTCOMES SIGNAL SYSTEM (MOSS)

In response to Dr Bill Kirkup's recommendation from 'Reading the Signals' the NHSE national Maternity and Neonatal Outcomes Group are developing the Maternity Outcomes Signal System (MOSS). This system is being developed to provide a method to identify potential critical safety issues in maternity care that may lead to adverse outcomes in real time, improving early identification of trusts requiring additional support to improve safety and reduce harm. The Trust has volunteered to be a pilot site for the testing and validation processes which are due to commence in Q1 2025/26. Any safety signals will be reported and escalated to the Quality Committee and Trust Board and Regional Perinatal Quality Surveillance Oversight Group.

5. LOCAL MATERNITY AND NEONATAL SYSTEM (LMNS) PERINATAL QUALITY SURVEILLANCE VISIT REPORT

In response to the need to proactively identify trusts that require support before serious issues arise and to fulfil the LMNS requirements of principle 2 of the perinatal quality surveillance model and strengthen the LMNS and ICB role in quality oversight, the LMNS introduced annual assurance visits.

The assurance visit highlighted both areas of excellence and opportunities for improvement. The report contained 11 recommendations of which 10 have existing associated internal actions and reporting and monitoring arrangements. The full report is available in the Trust Board reading room.

6. ANTENATAL AND NEWBORN SCREENING

Following the previous update, work has continued to conclude the Patient Safety Incident Investigations reports and develop the required improvement plan. The Incident Oversight Group, with ICB and NHSE representation, which was meeting fortnightly, has been stood down and moved to business as usual oversight via the Operational Antenatal and Newborn Screening Board.

7. ESCALATION

Neonatal Intensive Care Unit (NICU) Infection Outbreaks

There has been no further Glycopeptide Resistant Enterococcus (GRE) infections in February 2025 in the Neonatal Intensive Care Unit (NICU), however, there has subsequently been an outbreak of Carbapenemase Producing Enterobacteriaceae (CPE).

The index case was identified on 25 February 2025 and in response all babies on NICU were screened, this identified two further confirmed CPE cases. One of the babies had direct contact to the index case however the second baby did not.

An initial senior team meeting was undertaken involving Microbiology Consultant, Infection Prevention and Control (IPC) and Neonatal Senior Team and immediate actions were completed. This includes:

- Cohort the confirmed cases in a bay, resulting in one long term cot closure.
- HPV clean to cubicle and enhanced cleaning.
- Weekly screening for 4 weeks after the last positive case is discharged.
- Red PCR screens for all babies admitted to the Special Care Baby Unit (SCBU), all internal and external transfers.
- Await PCR results prior to transferring patients to other wards/hospitals.
- Personal protective equipment (PPE) requirements agreed for staff and parents.
- Parents will be asked to express at bedside to avoid using communal breast feeding room.

The IPC, microbiology and neonatology senior team note that the lack of isolation rooms, inadequate number of toilet facilities and risks associated with expressed breast milk storage and poor expressing facilities are a concern and contributory factor. To mitigate the existing estates risks the senior team are exploring which high risk patients should be offered admission screening to reduce the risk of further outbreaks which will require senior support to progress.

8. 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 the final Year 6 Maternity Incentive Scheme submission and changes to the Year 7 scheme.

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, and the risk associated with the infection outbreaks on NICU.

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.

9. RECOMMENDATIONS

The 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 requirement for a revised timeline for phase 2 of the staffing review in response to the impact of maternity leave over the summer.
iv. Note the findings of the LMNS peer review visit, recommendations and governance oversight arrangements.
v. Note the current risk and mitigations in place.
vi. Agree the frequency of future Perinatal Quality Surveillance reports.

Report of Ian Joy
Executive Director of Nursing
20 March 2025

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Agenda Item A15(c)(ii)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025					
Title	Maternity Safety Champion Report					
Report of	Liz Bromley, Non-Executive Director (NED) and Trust Maternity Safety Champion					
Prepared by	Liz Bromley, NED and Trust Maternity Safety Champion					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	This report summarises feedback from the Maternity Safety Champion since the last report shared at the November Board meeting.					
Recommendation	The Trust Board is asked to receive the report and consider/discuss the content.					
Links to Strategic Objectives	Performance: Being outstanding now and in the future.					
Impact (Please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework (BAF)	No direct link. Risks are detailed within the main body of the report.					
Reports previously considered by	Last report presented at the Public Board meeting on 29 November 2024.					

MATERNITY SAFETY CHAMPION REPORT FOR MARCH 2025

I was delighted to be accompanied by Nini Adetuberu, Associate NED, on the walk round we undertook on 7 March. We were able to talk to a number of colleagues from the Maternity department, with something of a focus on Neonates.

Challenges prevalent in the department, other than the ongoing accommodation issues, included more than 25 midwives being pregnant themselves and 3 sonographers being off sick; the great news about three new consultants coming in being muted by 3 emigrating or heading for retirement. However, 3 matrons are back from long-term sick leave which has taken a lot of strain off the one colleague remaining on site.

There is some concern that colleagues are not engaging in the communication pathways (primarily a Microsoft Teams channel) as positively as had been hoped; the information is there for them but low numbers log on.

Neonatal Intensive Care Unit (NICU) is very busy at the moment with some babies at risk of having to be sent out of area on the day of the walk round. This is because of the lack of space – an issue that was so obvious in every area visited and covered in more detail later on. In very positive news though, the re-opening of the Birthing Centre has significantly improved the levels of patient interest in Maternity Services at Newcastle Hospitals.

The Maternity Assessment Unit (MAU) continues to offer great value under trying circumstances. There is still no dedicated consultant which would be a game changing addition to the team. This means that medical screenings remain a huge problem and does not enhance the patient experience. There is a shared consultant on call, a Senior House Officer (SHO) and a Registrar who are very helpful but without a dedicated consultant everyone is stretched. All rooms are in use meaning that delivery suites were having to be used for examinations. To give the Board an idea of capacity / usage, on the day of our walk round there had been 40 women using the service, with around 1,200 patient users over the month. This is a huge footfall for such a tiny area. Some women had to wait for up to 4 hours, exacerbating the accommodation issue. As ever, the team has found a stop gap solution by midwifery roles being extended to cover a range of associated services to ensure that resource keeps moving.

In Neonates the space issue was at its most challenging. One tiny baby had a bowel infection (Carbapenemase Producing Enterobacteriaceae (CPE)) which, as well as being extremely serious for the baby, was creating a major issue with infection control within the very confined space being used by the team. With only one isolation cubicle and one chair for the baby's mother, both patient experience and safety have been severely challenged. The staff toilet had to be given up for the family. (There are too few toilets on Level 4 due to the inadequate plumbing system which suffers from backflows including up through showers, leaking through ceilings and into offices). Three babies were being cared for in the bay because intensive care beds had to be closed. When the department has to take patients who cannot go anywhere else because of the specialist services they need, the issue of bed closures caused major problems. Infection control makes management of such a confined

space much harder. This is a clear example of where the poor estate has a direct and damaging impact on patient outcomes.

As well as speaking to the clinicians managing the baby's care, we spoke with colleagues working on the desk. The first and foremost concern they wanted to share was SPACE, no space for the necessary number of computers, making for a poor working environment; no space for the families of sick babies; tiny cubicles giving no privacy or space, creating a poor family / carer experience. Corridors are clearly too narrow and working space per patient bed is below standard with health building notes showing that the department is working at less than 50% of the recommended space levels. Additionally, equipment is too big for the areas in which it is needed because it is manufactured against the standard meterage per bed space rather than the restricted space available in Neonates.

There is also a worrying issue about the sourcing of life saving equipment post-Brexit. Equipment takes longer to get into the UK and in the cases of some equipment (e.g. Endotracheal tubes) there is no appropriate substitute, so clinicians are spending a lot of time waiting for critical equipment. The cause seems to be a lack of profitability on manufacturing specialist healthcare equipment, making UK companies reliant on overseas components (this is a national issue, not specific or confined to Newcastle Hospitals).

The Clinical Board is aware of these issues and awaits specificity on the Big Build project in terms of the plans for Maternity. Jenna Wall, Director of Midwifery, is also aware of the challenges, and will continue to make the case for more cots for sick babies.

Staff also need more bedspace so that they can keep equipment in drawers to ensure that babies have their own thermometers and blood pressure control. More sinks are needed. These would be practical ways of managing infection better.

One of the doctors we spoke to explained that the heating system is not doing what is needed. Babies get cold and have to be admitted for care because they have got too cold. The theatres are cold, as are the recovery corridors. Rooms that are on the outside of the building are roughly 2% colder than the rest of the building.

In other conversations we heard about the lack of experience that some trainees have, and how the skills mix will take time to settle down. There is a national issue of medical training with few hours being offered in training, meaning staff are being promoted with less experience than expected. There were discussions about whether in house trainees are a viable option in the current market. Nursing staff and junior doctors are still paying £18 per day for parking. However, retention is good and the improved, healthier, subsidised bistro was 'great'. Free breakfasts have been much appreciated.

This has been a rather negative report for the Board because on the day we visited there were such challenges being managed in Neonates. Yet the colleagues we spoke to were enthusiastic, stoic, friendly and open in their conversations, and all seemed to be happy working in the department, despite the challenges. If we could address, as a matter of urgency, the accommodation and environmental issues which are pressing and having a

negative impact on both staff and patients' experience, the department would be a much more vibrant, committed and very professional example of the best of Newcastle Hospitals.

Report of
Liz Bromley, Non-Executive Director
18 March 2025

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Agenda item A15(d)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025					
Title	Learning from Deaths, Quarter 3 (October 2024 – December 2024)					
Report of	Rachel Carter, Director of Quality and Safety (DQ&S)					
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 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 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 2 mortality reviews. • Detail of level 2 mortality reviews requested by the Medical Examiner (ME). • Completed level 2 reviews for patients with a recognised learning disability. • Detail of HOGAN and NCEPOD scoring from completed level 2 mortality reviews in Quarter (Q) 3 2024/25. • Any new cases for investigation under the Patient Safety Incident Response Framework (PSIRF) where Learning from Death criteria has been met. • Summary of learning and actions from any completed investigations during the quarter. The report is correct as of 28 February 2025 and covers data for Q3 of 2024/25.					
Recommendation	The Trust Board are asked to note: (i) The content of the report; and (ii) 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 A15(d)

Reports previously considered by	This report forms part of the regular quarterly reporting cycle for Learning from Deaths.

LEARNING FROM DEATHS

1. INTRODUCTION

In April 2017, following the Care Quality Commission's (CQC's) recommendations on how the NHS investigates patient deaths, the 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.

Newcastle Hospitals 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. The policy is currently subject to review and update, to incorporate the statutory changes to the ME scrutiny process from September 2024, in addition to changes made to mortality review processes since the Trust's transition to the PSIRF from January 2024. The revised policy will be presented to the Trust's Mortality Surveillance Group (MSG) for approval in April 2025.

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 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 raised during the level 1 scrutiny in relation to the care provided are required to undergo a level 2 review. Patients may have more than one level 2 review recorded within the database if during the course of their final admission, 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.

For patients under the age of 18, all 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 2 Reviews

Figure 1, below, provides a breakdown of the number of completed level 2 reviews by month over the previous 12 months up until the end of Q3 2024/2025. These are shown by the date the patient died and in some cases, include multiple level two reviews for the same patient. The number of deaths that require a level two review will vary each month and there is no outlined target for this.

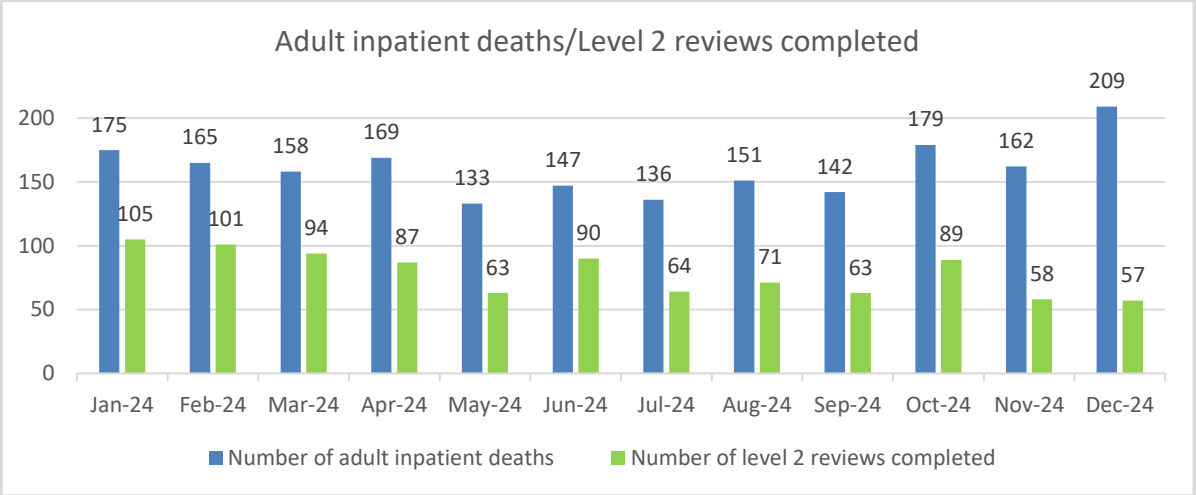

Figure 1: Number of Completed Level 2 Reviews, Jan 24 - Dec 24

Although the later part of Q3 2024/2025 (November/ December) shows a lower number of completed level 2 reviews compared to the preceding period, these figures are expected to rise as more Morbidity & Mortality (M&M) reviews are completed.

2.2 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 or where a concern is identified in the provision of care during the patient's admission. Many level 2 reviews are completed each month within the Trust, however only a small number of these are initiated by the ME review process.

Figure 3 details the number of level 2 reviews requested by the ME and subsequently completed by the relevant clinical board:

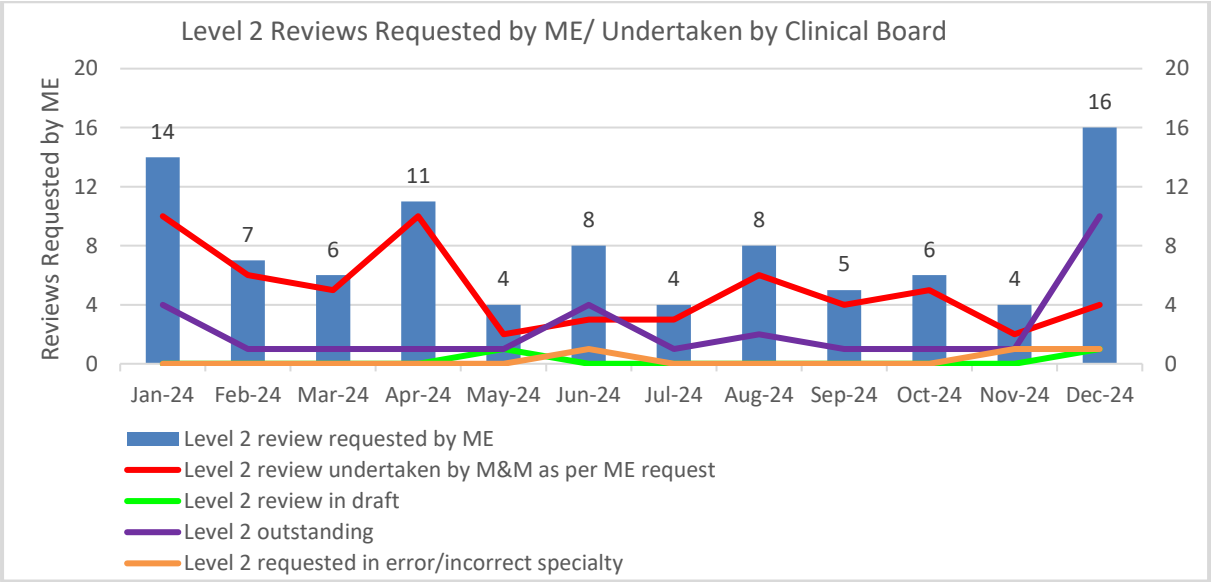

Figure 2: L2 Reviews Requested by ME and Undertaken by the Clinical Board

2.3 Patients with Learning Disability

Trust policy states that 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 specialty, 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 the Learning Disability Mortality Review Programme (LeDeR) commissioned by NHS England.

Since January 2024, there have been 19 recorded deaths of adult patients with a recognised learning disability. Of these, 10 have received a Level 2 review by the LeDeR panel. The data excludes children who are reviewed by the Child Death Overview Panel (CDOP), as was agreed nationally to avoid duplication.

Figure 3 below provides a month by month breakdown of the deaths and completed reviews. Work is ongoing, led by the Executive Director of Nursing (EDoN), the DQ&S and the Associate Director of Nursing (Learning Disability) to support clearance of the backlog of cases identified and ensure that the outstanding LeDeR reviews are completed and uploaded to the Trust's mortality database.

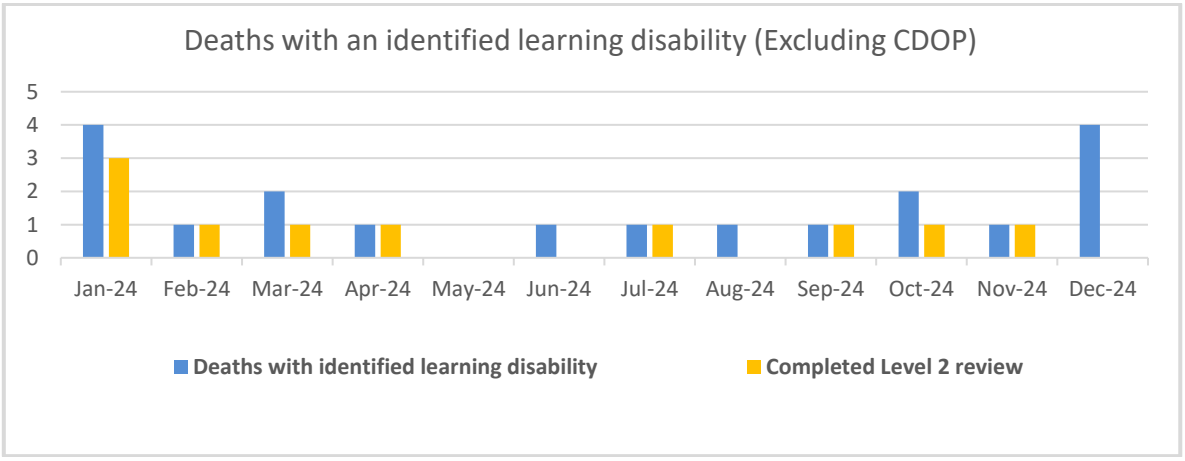

Figure 3: LeDeR Level 2 Reviews

3. LEARNING FROM DEATHS Q3 2024/2025

Under the Learning from Death criteria, where the patient's death is more likely than not due to problems with the delivery of care, these cases should be reported as a Patient Safety Incident Investigation (PSII). 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 NCEPOD score of 3, this may potentially meet the requirements for incident reporting and investigation. 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 MSG, whilst all HOGAN ≥4 and NCEPOD 3 are discussed by the group on an individual basis.

3.1 HOGAN Scores

HOGAN scores are a guide as to the preventability of the patient's death and 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 Q3 2024/2025, 204 level 2 reviews were undertaken of the 550 adult inpatient deaths recorded in the Trust. This equates to 37% of all adult deaths recorded in the quarter however it should be noted that one patient may have more than one level 2 review recorded.

Figure 4 provides a breakdown of reviews by HOGAN scores for the quarter. No deaths in Q3 2024/2025 that underwent L2 review received a HOGAN ≥4.

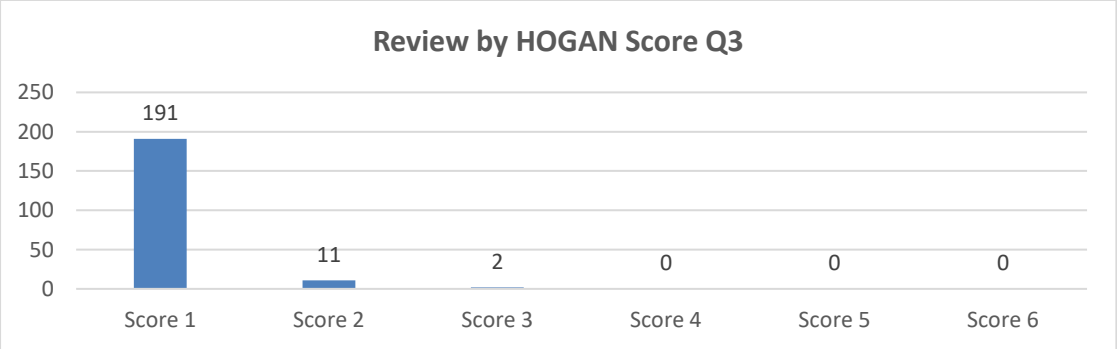

Figure 4: All Q3 Level 2 Reviews with HOGAN Scores

3.2 NCEPOD Scores

NCEPOD scores are a guide as to the quality of care provided to the patient during their final admission, and are defined as per the following scale:

NCEPOD 1	Good practice: A standard you would accept from yourself, your trainees and your institution
NCEPOD 2A	Room for improvement: Aspects of clinical care that could have been better
NCEPOD 2B	Room for improvement: Aspects of organisational care that could have been better
NCEPOD 2C	Room for improvement: Aspects of clinical and organisational care that could have been better
NCEPOD 3	Less than satisfactory: Several aspects of clinical and/ or organisational care that were well below what you would accept from yourself, your trainees and your organisation

Figure 5 details the breakdown of reviews by NCEPOD scores for the quarter. No deaths in Q3 2024/2025 that underwent L2 review received a score of NCEPOD 3.

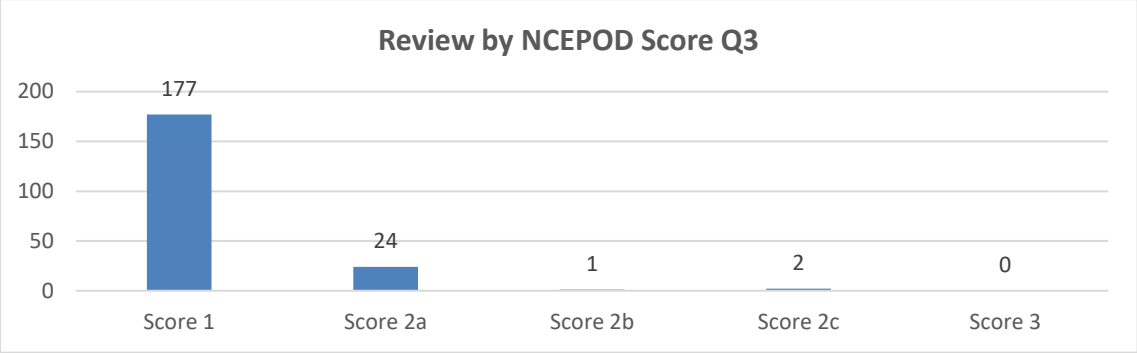

Figure 5: All Q3 Level 2 Reviews with NCEPOD Scores

3.3 Other Cases Meeting Learning from Death Criteria

The Trust's Response Action Review Meeting (RARM) panel reviews any patient deaths recorded as a patient safety event via Datix, in addition to cases escalated via the mortality review process. In Q3 2024/25, the RARM panel reviewed a death that occurred in May 2024, but was reported on Datix in October 2024 following the release of the coronial post-mortem report. The case was deemed to meet Learning from Death criteria and a PSII declared. The investigation is currently ongoing. A level 2 review was undertaken by the clinical board prior to the PSII being declared, with a HOGAN score of 1 and NCEPOD score of 2a being given.

3.4 Completed Investigations and Learning

Completed PSII investigations are presented to the Trust's monthly Patient Safety Incident Forum (PSIF) for scrutiny and final report approval. In Q3 2024/25, two completed PSIIs that were declared under Learning from Death criteria were presented to PSIF. The summary of the case and learning is detailed in the below table:

Case Summary	Date Presented at PSIF	Key Learning Points	Actions
Major bleed from arteriovenous fistula (AVF) at home	04/10/2024	• The review identified good practice around the documented discussions on patient's capacity to cancel surgical intervention and understanding of risk.	To undertake audit of patient knowledge and awareness. To be repeated every 3 years.

Case Summary	Date Presented at PSIF	Key Learning Points	Actions
		• Evaluate patients' awareness of the immediate actions they should take if they have an AVF bleed.	
Inadvertent major vascular injury during spinal surgery	06/12/2024	• Surgery carried out in line with national guidelines and local agreement for vascular presence (for anterior lumbar interbody fusion (ALIF)). • Limited knowledge among the scrub team as to the location of a particular set of instruments (did not impact on outcome). • Major vascular injury is a well-recognised complication of spinal surgery. Exploration of extending agreement with Vascular Surgery to include attendance at oblique lumbar interbody fusions (OLIF).	• Local arrangements in place for the presence of the vascular team for both ALIF and OLIF. • Review location and number of vascular emergency trays in Royal Victoria Infirmary (RVI) Theatres. • Continuous audit of outcomes of complex spinal surgery. • The Getting It Right First Time (GIRFT) team have been approached to consider supporting super-regional Multi-Disciplinary Teams (MDTs).

4. RECOMMENDATIONS

The Trust Board are asked to note:

(i) The contents of the report.

(ii) 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
28 February 2025

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Agenda item A16

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 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 January 2025: • Finance and Performance Committee – 27 January 2025 and 25 February 2025 • Quality Committee – 21 January 2025 and 11 February 2025 • Digital and Data Committee – 12 December 2024 • People Committee – 21 January 2025 and 11 February 2025 • Charity Committee – 10 February 2025 • Audit, Risk and Assurance Committee – 28 January 2025 and 20 February 2025					
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	Public Board meeting - January 2025.					

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**: 27 January 2025
Connecting to: Audit, Risk and Assurance Committee Trust Board	**Date of Meeting**: 20 February 2025 28 March 2025
Key topics discussed in the meeting	

- In relation to the month 9 finance report, there is a reported variance against plan of £3.4m which relates to unfunded industrial action costs and more significantly the in-year pay award. Further work is being undertaken in partnership with the Integrated Care Board (ICB).
- At month 9, the total capital expenditure to date was £23.6m against a plan of £28.1m. However, this included donated assets of £2.8m therefore the Trust is currently £1.7m ahead of plan from a Capital Departmental Expenditure Limit (CDEL) perspective.
- The first iteration of the Medium Term Financial Plan was submitted to the ICB on 19 December 2024. Once the National Planning Guidance is received, an assessment of the impact of the revised guidance and production of further finance models will be carried out.
- PwC were commissioned by the Integrated Care Board (ICB) in the Autum to complete a review of financial sustainability and infrastructure available to support the delivery of the financial recovery. The Committee discussed the action plan from the review in detail with most of the recommendations already in progress.
- The Clinical and Diagnostics Services Clinical Board presented an update on their financial position, Cost Improvement Programme (CIP) and elective recovery performance. The Clinical Board CIP target of 1.5% has been achieved in year.
- The Committee received a comprehensive update on the Integrated Board Report (IBR). The 31 day cancer standard performance has continued to deteriorate (76.7%) with performance outside the control limits for three successive months. Diagnostic performance against the 5% standard has improved for three successive months with 29.1% of patients waiting over six weeks at the end of November 2024. A deep dive took place into Elective Waits, Children and Young People Key Performance Indicators (KPI)s and Winter Performance. It was noted that Emergency Department (ED) performance is being sustained and Paediatric ED performance is improving.
- 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 January Audit, Risk and Assurance Committee and Trust Board meetings.
- The Finance and Performance Committee Internal Audit Report was presented for the Committee to monitor and seek assurance relating to the internal audit plan and

associated recommendations aligned to the Finance and Performance Committee area of focus. There are 13 internal audits within the Trust's 2024/25 Internal Audit Plan that relate to the Committee.

- A Data Partnerships update was provided to update the Committee on the developments in relation to the data partnerships workstream and the Alliance vision.
- A business case and a tender were ratified for Trust Board approval.
- The Committee received the following documents:
  - Minutes of the Capital Management Group in December.
  - The month 9 Financial Recovery Report.

Actions agreed in the meeting	Responsibility / timescale
1. In relation to the month 9 Finance report, it was agreed that the finance team would carry out further work with the Clinical Boards to review recurrent and non-recurrent spend.	1. The Chief Finance Officer (CFO) / Deputy Chief Finance Officer (DCFO) / January 2025
2. The Director of Performance and Governance (DPG) to circulate the updated version of the Winter Performance slides which include the most recent figures.	2. DPG / January 2025
3. A number of actions were agreed in relation to the Data Partnership item regarding contract reviews, communications and ethical considerations. The Executive Director for Commercial Development and Innovation (EDCDI) agreed to action.	3. EDCDI / January to February 2025
4. The Deputy Chief Executive Officer (DCEO) agreed to share an update at the next meeting on external consultancy costs for a specific piece of work.	4. DECO/ February 2025
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**
• 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

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

Meeting: Finance and Performance Committee	**Date of Meeting**: 25 February 2025
Connecting to: Audit, Risk and Assurance Committee (ARAC) Trust Board	**Date of Meeting**: 25 March 2025 28 March 2025
Key topics discussed in the meeting	

- In relation to the month 10 finance report, there is a reported variance against plan of £3.7m which relates to unfunded industrial action costs and more significantly the in-year pay award. Further work is being undertaken in partnership with the Integrated Care Board (ICB).
- At month 10, the total capital expenditure to date was £26.6m against a plan of £32.6m. However, this included donated assets of £3m therefore the Trust is currently £9m behind plan from a Capital Departmental Expenditure Limit (CDEL) perspective.
- The Committee received the headline submission of the 2025/26 Annual Plan to North East North Cumbria (NENC) Integrated Care Board (ICB), which will form part of their wider submission to NHS England. The final planning submission is due by 21 March 2025 to the ICB, with a national submission due 27 March 2025.
- The Medicine and Emergency Care Clinical Board provided a comprehensive financial update. As of 31 December 2024, the Clinical Board was overspent by £5,403k (2.9%). The forecast overspend is down from last year's outturn position of circa £17m to £7.2m. The Cost Improvement Plans (CIP) to date is overachieved at month 9 by £489k.
- The Committee received a comprehensive update on the Integrated Board Report (IBR). It was noted in November the 77% 28 Day Faster Diagnosis Standard (FDS) was failed for the fourth successive month (74.7%) however Diagnostic performance has improved for four consecutive months. A deep dive took place with regards Cancer and Diagnostic performance. In relation to cancer, current performance against 28-day FDS, 31 day and 62-day standards and the perfect cancer pathway was discussed. In relation to diagnostics, Trust level performance is improving particularly in relation to Audiology however there are challenges within specific services due to staffing capacity and increased capacity.
- The Committee received and noted the Board Assurance Framework (BAF) recommendations approved by the Audit, Risk and Assurance Committee and Trust Board relating to the Committees area of focus.
- The Director of Performance and Governance presented the draft headline submission for 2025/26 which included an update on national priorities, key actions for delivery and timescales. It was noted that both the flash return and the headline submission reflect the Trusts ambitious activity plans to deliver 115% of 2019/20 activity. The final submission will be presented at the March Committee meeting.
- The Committee received a comprehensive update in relation to the utilisation and capacity of the Clinical Diagnostic Centre (CDC) at the Metro Centre.

- The Procurement and Supply Chain Director provided a verbal update on the new Procurement Act 2023. Further detail will be presented at the March Committee meeting.
- A number of tenders and business cases were approved.
- The Committee approved the Committee Terms of Reference and Schedule of Business 2025/26.
- The Committee received the following documents:
    - Minutes of the Capital Management Group in January and Supplies and Service Procurement Group in December.
    - The month 10 Financial Recovery Report.

Actions agreed in the meeting	Responsibility / timescale
There were no actions agreed at the meeting.	Not applicable.

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
• 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**: 21 January 2025
Connecting to: Audit Risk & Assurance Committee and Trust Board	**Date of Meeting**: 28 March 2025
Key topics discussed in the meeting	

- Care Quality Commission (CQC) – A general update on progress within the following areas were received:
  - Cardiac Oversight Group Update
  - Medicines Oversight Group
  - NECTAR Action Plan
  - Emergency Department
  - Duty of Candour
  - Feedback from thevaluecircle Improvement Review
- Management Group Reports for the following were presented:
  - Patient Safety Group (PSG) the most recent meeting focussed on Patient Safety Incident Response Framework priorities all three of which are making good progress.
  - Clinical Outcomes and Effectiveness Group (COEG) focussed on the relationship between Clinical Board Quality Oversight Groups (QOGs) and Getting It Right First Time (GIRFT) reports and the associated recommendations, New Interventional Procedures and Support for Clinical Ethics Advisory Group.
- Mortality/Learning from Deaths. The process for review and escalation of cases where concerns in the delivery of care are identified was noted. A summary of cases considered to meet Learning from Death reporting criteria in Quarter 2 2024/2025 was provided with any learning arising from the subsequent investigation.
- Patient Experience and Complaints Update. The presentation provided an update on learning about the care experience from patient, carer, and family feedback. Results for November/December 2024 were shared.
- Perinatal Quality Surveillance Report including Maternity Incentive Scheme Update and Maternity Deep Dive Staffing Paper. An update 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 was shared. The report details the Trust's self-assessed position against the Maternity Incentive Scheme 10 Safety Actions, compliance, any areas of risk and the mitigations in place. Two areas remain non-complaint. The Maternity Staffing Deep Dive paper provided an overview of future investment requirements to remain aligned to

BirthRate+ recommendations. The committee supported these recommendations in principle pending further modelling and costings.

- Wards of concern. An update was provided highlighting wards of concern as raised via the Trusts established professional Nurse Staffing and Clinical Outcomes Group.
- Audiology Update - An update on the review from the Integrated Care Board (ICB) focussing on governance & culture, paediatric waiting times and Auditory Brainstem Response (ABR) was provided. Assurance meetings with the ICB have reduced to monthly with good progress being made against the action plan. The historic 'look back' exercise of ABR screening for 2,015 patients was underway, no harm had been identified to date. Governance and leadership have been strengthened, and waiting times for paediatric patients has reduced significantly and are ahead of trajectory.
- Serious Incident Close Out Report. The update provided an overview of the work undertaken since the previous report in July 2024 to finalise and complete the outstanding Serious Incident (SI) action plans following transition from the SI framework to the Patient Safety Incident Response Framework (PSIRF) in January 2024.
- The Integrated Board 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.
- Quality Committee Internal Audit Report. The update report aimed to support the Quality Committee to monitor and seek assurance relating to the internal audit plan and associated recommendations aligned to the Quality Committee area of focus.
- Revised Quality Committee Governance. To ensure there are effective governance systems and processes in place to drive improvements in quality and safety, a review of the Tier 2 groups (and feeder groups) reporting into Quality Committee has taken place. The Terms of Reference for all Tier 2 groups will be revised/written and will be submitted to Quality Committee, alongside the Committee Schedule of Business for ratification in March 2025.
- The Terms of Reference for the Transplantation Committee were reviewed and approved.
- Trust Participation in National Clinical Audits. The Healthcare Quality Improvement Partnership (HQIP) release a list of National Clinical Audits (NCA) every year that all NHS Trusts are required to participate in (if eligible). The Trust Clinical Audit and Guidelines Group (CAGG) is responsible for monitoring Trust performance in each audit, making recommendations and escalating issues of non-compliance where appropriate. Out of the 122 published National Clinical Audits, 99 were applicable to secondary care.
- Legal Cases Update. The report outlined any legal matters arising in the next 3 months which the Quality Committee should be aware of.

Actions agreed in the meeting	Responsibility / timescale
1. Elective Recovery Funding (ERF) being ring fenced in quarter 4. An update to be provided on the impact in terms of quality and safety on patient waiting lists for 2025/26.	• The Deputy Chief Executive to provide an update once impact is sought.

2. Work on understanding outcomes for Cancer patients. Currently would need extensive resource to manually trawl data, therefore considering alternative options such as Artificial Intelligence and/or possible outsourcing.	• Update to be provided by Joint Medical Director – March Quality Committee.
3. Terms of Reference for the Cardiac Oversight Group to be reviewed and brought to Quality Committee in February for consideration and approval.	• Cardio Clinical Board Chair – February Committee.
4. Numbers and level of harm following harm reviews for lung cancer to be included in the update noted under action 2 above.	• Update to be provided by Joint Medical Director – March Quality Committee.
5. Deep Dive report on Duty of Candour to be provided for Quality Committee.	• Director of Quality and Safety – April Committee meeting.
6. To determine a process to provide robust assurance that Duty of Candour has been enacted and any subsequent actions.	• Joint Medical Director / Director of Quality & Safety / Clinical Director for Quality & Safety/Chair of Patient Safety Group – February Quality Committee meeting.
7. GIRFT (Getting Right First Time) reports to be added to the Quality Committee Reading room and a 6 monthly update to be provided to the Committee.	• Director of Quality and Safety / meeting secretariat.
8. Clinical Ethics Advisory Group – discussion to be undertaken at Executive Team to determine the remit and resource required being mindful of the complexity of the organisation.	• Deputy Chief Executive/ Joint Medical Director / Executive Director of Nursing.
9. Level 2 Mortality Reviews - assurance to be provided that the right number of level 2 reviews are undertaken. A report to be prepared for Quality Committee prior to submission to Trust Board.	• Joint Medical Director / Director of Quality & Safety.
10. To provide assurance that the process for Level 2 mortality reviews is robust. Process to be described and data to be incorporated into the next report.	• Joint Medical Director / Director of Quality & Safety.
11. To determine if it would be feasible to survey bereaved families on their experience.	• Chief Experience Officer.
12. To provide assurance around the 'failsafe' process. A comprehensive action plan to be provided including the learning from all Patient Safety Incident Investigations (PSII).	• Director of Midwifery – March Quality Committee.
13. To provide a six-month review of the revised Quality Governance Structure from when the new arrangements are commenced in April.	• Executive Director of Nursing

Escalation of issues for action by connecting group/Trust Board	Responsibility / timescale
• There were no issues for escalation to ARAC however the Chair wished to note the Cancer performance and the ongoing work to improve the position.	• Committee Chair.
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Detailed within the BAF.	• Not applicable.

Agenda item A16

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Quality Committee
Chair's Log

Meeting: Quality Committee	**Date of Meeting**: 11 February 2025
Connecting to: Audit Risk & Assurance Committee and Trust Board	**Date of Meeting**: 28 March 2025
Key topics discussed in the meeting	

- Care Quality Commission (CQC) – A general update on progress within the following areas were received:
    - Cardiac Oversight Group Update
    - Medicines Oversight Group
    - NECTAR Action Plan
    - Emergency Department
    - Duty of Candour
    - Update from CQC Delivery Group and phase 2 action plan Management Group Reports for the following were presented:
- Quarter 3 Reports including Quality Account Priority 3
    - Safeguarding and Mental Capacity Act – it was noted that the complexity within adult safeguarding remains, with staffing capacity affecting the ability to deliver on all aspects of good practice. Patient care is therefore being prioritised. Compliance with policy audits has been challenging due to capacity in the adult team. Safeguarding training compliance is closely monitored. Whilst there has been an improvement in the application of the Mental Capacity Act in practice, focused education is required.
    - Learning Disabilities – the report provided evidence of action relating to the Quality Account Priority - To ensure reasonable adjustments are made for patients with suspected or known Learning Disability &/or Autism. Appropriate and consistent use of Mental Capacity Assessment & Deprivation of Liberty Safeguards for patients with vulnerabilities. It was noted that there continues to be an increase in both activity and complexity of patients being referred to the Learning Disability Liaison Team.
- Quality Account Priorities Proposals 2025/26. The proposed priorities together with the rationale behind the proposal was presented. Following the Public Consultation Event held on 20 January 2025 together with internal stakeholder engagement, the 6 proposals are:
    - Incident reporting and learning from incidents
    - Medicines Management ward-based compliance with CQC standards.
    - Accrediting Excellence (ACE)
    - Waiting Well

- Mental Capacity Act / Deprivation of Liberty
- Substantive launch of the Patient Experience real time surveys expansion to 40 wards

- Perinatal Quality Surveillance Report including Maternity Incentive Scheme Update. The report informed the Quality Committee 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 detailed the Trusts self-assessed position against the Maternity Incentive Scheme 10 Safety Actions, compliance, any areas of risk and the mitigations in place.
- National Clinical Audits - The Healthcare Quality Improvement Partnership (HQIP) release a list of National Clinical Audits (NCA) every year that all NHS Trusts are required to participate in (if eligible). The Trust Clinical Audit and Guidelines Group (CAGG) is re-sponsible for monitoring Trust performance in each audit, making recommendations and escalating issues of non-compliance where appropriate. Out of the 122 published National Clinical Audits, 99 were applicable to secondary care.
- Privacy & Dignity Update. The Executive Director of Nursing has responsibility to ensure the highest standards of privacy and dignity for all patients who access Trust services and sites. This includes those who are deceased, with a specific requirement to ensure where bodies of the deceased are kept, and to provide assurance that their security, privacy and dignity has been safeguarded. The report contained an overview of recent assurance visits undertaken in December and January of the Freeman and Royal Victoria Infirmary (RVI) Mortuaries and the Newcastle Surgical Training Centre (NSTC).
- The Integrated Board 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.
- Infection Prevention Control (IPC) Deep Dive and (IPC) BAF. The report informed the Quality Committee of the Trust's current position in relation to Infection Prevention & Control (IPC). The report detailed current rates of Health Care Associated Infections (HCAIs), and the IPC Board Assurance Framework (BAF), highlighting, compliance, areas of risk, and the mitigations in place. It complemented the regular Integrated Board Report (IBR) and summarised the current position for the Trust up to the end of December 2024.
- Revision of the Cardiac Oversight Group Terms of Reference which were recommended for approval by Trust Board.
- Transplantation Committee Chairs Log was received from the meeting held on 15 January 2025 where an update was provided in relation to the Assessment and Repair Centre (ARC), Capacity and Organisational Constraints and agreement to receive Chairs Logs from Operational Transplantation Group and the Institute of Transplantation Governance Group going forward.

Actions agreed in the meeting	Responsibility / timescale
1. To provide an update from the ICB in relation to the commissioning for end-of-life services following the cessation of contract with Bluebird Care.	• Director of Nursing, NENC ICB – as soon as possible.

2. Cardiac Oversight Group update in CQC update - frequency reduced to bi-monthly. The schedule of business would be updated to reflect this.	• Secretariat for meeting. Next report due April 2025.
3. NECTAR Action Plan update in CQC update - frequency reduced to bi-monthly. The schedule of business would be updated to reflect this.	• Secretariat for meeting. Next report due April 2025.
4. Level 3 Safeguarding Training compliance. Targeted focus on those who are non-compliant and be tracked through the Quality Performance Reviews in Clinical Boards.	• Executive Director of Nursing.
5. To discuss the options in relation to staff training regarding to patients with Learning Disabilities.	• Executive Director of Nursing / Director of Communications & Corporate Affairs.
6. Inclusion of details of post-partum hemorrhage in the next Perinatal Quality Surveillance Report.	• Director of Midwifery – March report.
7. To discuss the possibility of including Care Optimisation – Care Planning as a future agenda item from a quality & safety perspective.	• Executive Director of Nursing.
Escalation of issues for action by connecting group/Trust Board	**Responsibility / timescale**
• There were no issues for escalation to ARAC. • Escalation to Trust Board that the Committee noted the Trust to be an outlier in relation to Infection Protection Control (IPC) but the Committee has sought assurance with regard to processes which will be monitored through the Committee. • Escalation to People Committee to undertake a training need analysis.	• Committee Chair
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Detailed within the BAF	• Not applicable.

Agenda item A16

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Digital and Data Committee
Chair's Log

Meeting: Digital and Data Committee	**Date of Meeting**: 12 December 2024
Connecting to: Audit, Risk and Assurance Committee Board Meeting	**Date of Meeting**: 28 January 2025 28 March 2025
Key topics discussed in the meeting	

- The roadmap of work has been started and the steps have been taken to do a digital strategy refresh. Ideally would be done after the organisational and clinical strategies are completed, however there has been substantial feedback to enable a brief digital strategy to be rewritten this year.
- There has been very good uptake of the move to standardised templates for care plans in Nursing and Midwifery including the successful education and training programme that has underpinned the shift in practice.
- Carry forward lesson learned from care plan template usage. Some of the work requires the ability for staff to attend and learn and the ongoing requirements need to be reviewed with the Chief People Officer and Deputy Chief Executive Officer (DCEO).
- Development of roadmap for digital programme for next agenda.
- Roadmap to be produced for digitised dictation project.
- There was a positive discussion about cyber security breaches/risks currently occurring across the healthcare sector, with a review of what the NHS and Newcastle Hospitals are doing to continue to monitor. These are noted on the Board Assurance Framework (BAF) with the assurance and progress rating showing green.
- There was an item on the risk register regarding paediatric Audiology and was noted as a digital risk. On further investigation it related to 2 consultants leaving and the impact on the service. It was noted and agreed this was not a digital risk and more appropriate for the People Committee to as it relates to staffing. Decision to remove from action list.
- High take up of the Electronic Patient Record (EPR) useability and staff survey with 1,056 surveys returned compared to 226 the last time the survey was done.
- Good progress against this year's Cost Improvement Programme (CIP) but concerns about the reliance on non-recurrent savings to deliver the target.
- A positive overview of the digital change projects that are ongoing across the Trust was shared.
- There was a full account of the potential and real commercial partnership opportunities, including how they are being assessed and decisions being taken,

giving the Committee a positive picture of potential income streams that could come from commercial use of our digital assets.

Actions agreed in the meeting	Responsibility / timescale
1. **EPR Useability and Staff Survey:** Digital Services completed the NHS EPR Useability survey. Results to be reviewed next week and once available these will be provided to the January Committee meeting **[Action41]**	1. Chief Nursing Information Officer (CNIO)– Timescale: Next Committee meeting 23/1/2025.
2. **CQC Actions:** DCEO asked if there was any learning opportunity for the Cerner relaunch from this care planning work. It was noted that DCEO would meet with DCNIO outside of the Committee to create a lessons learned document with actions. **[Action42]**	2. Deputy CNIO/DCEO – Timescale: Next Committee meeting 23/1/2025.
3. **Strategic Digital and Data Priorities/Updates:** CIO informed the Committee that Digital IT are currently working on the Roadmap and a refresh review of the Digital Strategy will start in the New Year. CIO to meet with DCEO next week to look through the roadmap and will be brought back to the next Committee meeting. To be added as Agenda item **[Action43]**	3. Chief Information Officer (CIO) - Timescale: Update at next Committee meeting 23/1/2025.
4. **NENC - Connect Link:** Now Live. Newcastle has been asked to support the development of a Blueprint for NHS England to share approach, learning and benefits achieved. Chief Clinical Information Officer (CCIO) confirmed this will good collaboration with other Trusts and will report back at future meeting **[Action44]**	4. CCIO - Timescale: To report back at future Committee meeting with progress.
5. **Patient Engagement Platform (PEP)/Letters:** In response to Director of Performance and Governance question on PEP and letters, it was confirmed that data is too immature to benchmark against. It was agreed to add as an agenda item at a future Committee meeting for Head of Innovation & Delivery to provide an update **[Action45]**	5. Head of Innovation & Delivery – Timescale: To provide update at future Committee meeting.
6. **BAF:** It was discussed and agreed that the Cardio KOKO risk is a capital equipment replacement risk, not a Digital risk. It will be removed from Digital risks. **[Action46**]	6. Head of Risk Management – Timescales: Next Committee meeting 23/1/2025.
7. **Commercial Opportunities:** The commercial team following the technology assessment	

recommended two opportunities that the Trust would proceed with. These were supported by the committee. The Trust will then get to a commercial position which will be verified and approved by Finance & Performance Committee. The revenue expected was presented. This committee will look at the technology, partnerships and the appropriateness of due diligence and finance will look at the contract implications and an update will be done at a future Committee meeting. **[Action47]**	7. Commercial Innovation Lead – Timescale: Future committee meeting.
Escalation of issues for action by connecting group	Responsibility / timescale
Not applicable	Not applicable
Risks (Include ID if currently on risk register)	Responsibility / timescale
It was discussed and agreed that the Cardio KOKO risk is a capital equipment replacement risk, not a Digital risk and will be removed from the digital risks.	Head of Risk Management

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

People Committee - Chair's Log

Meeting: People	**Date of Meeting**: 21 January 2025
Connecting to: Audit, Risk and Assurance Committee (ARAC) Trust Board	**Date of Meeting**: 20 February 2025 28 March 2025
Key topics discussed in the meeting	

- An update was provided in relation to the People Plan overview of year 1 deliverable actions. Actions are regularly reviewed and are on track for completion. The Chief People Officer (CPO) advised that discussions are ongoing to align Occupational Health and the wider Health and Wellbeing offer including the Psychological support offer to staff.
- A Valued and Health update was received which included an update on the Speak up 8-point plan and a staff survey 2024 update. The importance of ensuring staff know how to speak up safely and the promotion of the Freedom to Speak Up Guardian (FTSUG) and Freedom to Speak Up (FTSU) Champion roles was highlighted. In terms of the 2024 staff survey, early data has been received with work taking place to develop further analysis and actions.
- The Joint Medical Director provided an update on the new job planning guidance which has been developed to address inconsistencies and ensure transparency and fairness across Newcastle Hospitals in line with local and national targets for job planning in 2025/26.
- An update was received with regards to the People internal audit plan and the associated recommendations. It was noted that detailed discussions have taken place at ARAC in relation to People internal audits with assurance being sought.
- The Guardian of Safe Working (GoSW) presented the GoSW Quarterly Report from the period of 27 September to 26 December 2024. It was noted that the main cause of exception reports is when there is a high clinical workload or low staffing levels. The GoSW recommended to continue to review the workforce workload balance to ensure safe and sustainable staffing.
- The Committee received and noted the Board Assurance Framework (BAF) recommendations and a review of the People BAF risks is currently taking place.
- The Committee received a performance and delivery update which included the People Integrated Board Report (IBR) and a deep dive into recruitment and retention. A detailed discussion took place with regards to staff in post, sickness absence rates, mandatory training and appraisals. It was noted that the new appraisal pilot has been well received. In relation to recruitment and retention, vacancy hotspots were an area of discussion, and it was noted that a dashboard has been created to provide Clinical Boards and Corporate Services with staff in post/vacancy data.
- The minutes from the November Sustainable Healthcare Committee and the December Equality, Diversity and Inclusion (EDI) Steering Group were received for information.

Actions agreed in the meeting	Responsibility / timescale
1. The FTSUG, CPO and Director of Communications and Corporate Affairs (DCCA) to discuss offline the communications in relation to the roll out of the FTSU Champions to ensure there is maximum awareness [ACTION01]. 2. The Clinical Boards to review and actively monitor statutory and mandatory training data [ACTION02].	1. The FTSUG, CPO and DCCA / January 2025 2. The Clinical Board Chairs & Directors of Operations / January 2025
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.	Not applicable.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

People Committee - Chair's Log

Meeting: People	**Date of Meeting**: 11 February 2025
Connecting to: Audit, Risk and Assurance Committee (ARAC) Trust Board	**Date of Meeting**: 20 February 2025 28 March 2025
Key topics discussed in the meeting	

- The Executive Director of Nursing provided a Nursing, Midwifery and Allied Healthcare Professions (AHP) update and it was agreed that in the future, specific reports can be requested based on issues arising to the People Committee as concerns are raised through the Quality Committee and the Professional Practice Oversight Group.
- A comprehensive Deep Dive took place with regards to the General Medical Council (GMC) Training Survey results and the Committee were provided with further detail into two departments. Actions are progressing and being followed up however it was noted that some changes may take time. Regular meetings take place with trainees including the Resident Doctors Forum, which is well attended, and robust conversations take place.
- An update was provided in relation to the People Plan overview of year 1 deliverable actions. Two actions are now under review to understand potential collaborations across the Alliance.
- The Committee received an update on the development of a tiered approach to Health and Wellbeing and staff psychological support. It was agreed that further discussions would take place outside of the meeting to progress this work.
- An update was provided with regards to the Self-Assessment Report and Quality Improvement Plan 2023/24 which is due to be submitted to NHS England (NHSE) on 28 February 2025. Key areas of improvement have been identified as time for training, job planning and financial transparency with detailed action plans for each of these areas currently in development.
- The Gender Pay Gap report was presented which included data from the 'snapshot' date of 31 March 2024 and actions to reduce the Gender Pay Gap. The Committee ratified for Public Trust Board approval at the end of March 2025.
- The Committee received and noted the Board Assurance Framework (BAF) recommendations approved by the Trust Board relating to the Committees area of focus. The BAF is currently being reviewed and updated.
- The People Integrated Board Report was discussed in detail which included sickness absence rates including support for managers and staff, vacancy rates, staff appraisals and statutory and mandatory training.
- The minutes from the January Learning and Education Group, the January Equality, Diversity and Inclusion (EDI) Steering Group and the January Health and Wellbeing Group were received.

Actions agreed in the meeting	Responsibility / timescale
1. Mrs Bromley, Non-Executive Director (NED) noted that it would be useful to have an infographic created to explain the current governance arrangements detailed within the report to which the Executive Director of Nursing (EDN) agreed to take this forward and to ensure it ties in with the Quality Committee reporting.	1. EDN / March 2025
2. The Deputy Chief Executive Officer (DCEO) agreed to arrange a meeting outside of the People Committee to progress the Health and Wellbeing and staff psychological support work.	2. DECO / March 2025
3. The Chair said that it would be useful for the Committee to have more sight on the progress in relation to the apprenticeship levy to which the Corporate Governance Manager/Deputy Trust Secretary (CGM/DTS) agreed to add regular updates to the People Committee Schedule of Business [ACTION03].	3. CGM/DTS / March 2025
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.	Not applicable.

Agenda item A16

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Charity Committee - Chair's Log

Meeting: Charity Committee	**Date of Meeting**: 10 February 2025
Connecting to: ARAC Trust Board	**Date of Meeting**: 25 March 2025 28 March 2025
Key topics discussed in the meeting	

- An update on the Sir Bobby Robson Institute Fundraising Campaign was given.
- A presentation on the development of the Funding Criteria and Guidance was received and discussed.
- Management accounts to 31 December 2024 were received.
- The summary investment reports were shared.
- The funds committed and not yet drawn down quarterly report was discussed.
- Updates on previous funding applications were discussed.
- A discussion took place regarding spend against the Funding Programmes 2024/25.
- Funding proposals were discussed in relation to:
  - Sustainable Health:
    - GA072 - Implementation of a 30-year biodiversity management plan - £12,000 – Approved / Green the Grey projects - £12,000 – Approved.
    - GA073 – Bike Maintenance sessions - £4,500 – Approved.
    - GA074 - Clinical Sustainability Lead - £15,000 – Approved / Clinical sustainability fellowships £140,000 approved.
  - MUSICaL Study: MSI Urine Surveillance to Identify Cancers in Lynch syndrome - £74,344 – Approved.
  - Transperineal Ultrasound Scanning - £32,043 – Approved.
  - MacroVIEW Equipment – Mortuary - £38,684 – Approved.
  - Medicinema – deferred.
  - Device Repurposing Programme across the North East and North Cumbria - £18,733 – Approved.
  - XVIVO Child Heart Transplant Procedure - £118,750 – Approved.
  - Tricuspid Valve Intervention - £52,000 – Approved.
- The summary of funding agreed since the last meeting was reviewed (bids up to £20k).
- The Charity Risk Statement was received.
- The Terms of Reference (ToR) and 2025/26 Schedule of Business were received. PK asked for ToR to be sent to Committee for further comment.
- A funding monitoring and evaluation report was received.
- An Arts programme update was received.
- A future draft proposal for the expansion of the Robotics Programme was received.
- The minutes of associated meetings were received.

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Actions agreed in the meeting	Responsibility / timescale
1. Charity Operations Manager (COM) to contact Trust Secretary (TS) regarding a Board Development Session on Charity Governance. 2. Charity Head of Finance to update the Committee on the figure for unrestricted funds at the next meeting. 3. The Committee Chair requested that the Terms of Reference was shared with all Committee members for comment and returned to the COM by 28 February 2025. 4. An external Charity Strategy Planning Away Day to be arranged in June. 5. The Director of Communications and Corporate Affairs (DCCA) to discuss Expansion of Robotics Programme proposal with the Chief Finance Officer (CFO). 6. Robotics Strategy to be developed.	1. COM 2. Charity Head of Finance 3. COM 4. COM 5. DCCA 6. Charity Director / Head of Grants Programmes
Escalation of issues for action by connecting group	**Responsibility / timescale**
There are no documents requiring escalation.	
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
The Charity Risk Statement was discussed – one tolerated risk and a further three new risks have been identified.	

Agenda item A16

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Audit, Risk and Assurance Committee (ARAC) - Chair's Log

Meeting: ARAC	**Date of Meeting**: 28 January 2025
Connecting to: Board	**Date of Meeting**: 28 March 2025
Key topics discussed in the meeting	

- The meeting action log was discussed, with brief updates shared on:
  - The work ongoing to improve pharmacy stock management systems in Wards and Theatres.
  - Back up/recovery of data from hard drives.
  - The two different types of risk management training.
- Escalation from other Board Committees to ARAC:
  - Quality Committee held on 21 January 2025 – the Committee reviewed a report on compliance with national clinical audits and requested further work to be conducted on the process for justification when a national clinical audit is not progressed. Committee members also agreed that cancer performance be escalated to the Trust Board for further consideration/action.
  - Finance & Performance Committee held on 27 January 2025 – progress with internal audits relating to the Committees remit was discussed, with an action to raise for further discussion at the ARAC meeting. ARAC members therefore discussed the current audit status.
  - People Committee held on 21 January 2025 – no matters for escalation but it was highlighted that Committee members were focussing on improving appraisal and statutory and mandatory training compliance.

- 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. New actions have been added to both the finance, quality and Digital and Data BAF risks. Two assurance ratings had improved for the better (maternity services and financial recovery) which were agreed. Committee members discussed and agreed BAF risk ID 1.2 with some minor amendments to be made regarding the narrative on risk management training.

- Clinical Audit report – The Executive Director of Nursing (EDON) added further context to the discussion held in the Quality Committee meeting (as referenced above), and the work under development to improve governance processes.

- ICB external review of Financial and Workforce controls Report – the Internal Audit Manager shared an overview of the AuditOne work for the ICB external review. Two high-rated recommendations were identified regarding the policy/guidance for waiting list initiative payments, and for controls in relation to discretionary account code usage. Controls regarding agency and bank staff usage was also discussed.

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- Internal Audit progress report – the current position regarding internal audits was shared, with performance similar to the same time in the prior year. A brief overview of the recommendations regarding the three reasonable assurance rated reports was provided. Part 1 of the CQC internal audit report received a substantial assurance rating.

  Committee members discussed the Trust No Purchase Order No Pay policy and scope.

- Activity Report including Fraud Response Log / Fraud register – an update was provided on recent guidance issued and the new legislation creating a Corporate Offence of failing to prevent fraud. Committee members discussed the national increase in use of artificial intelligence to conduct recruitment fraud and an update on cases in progress was shared.

- Review of Standing Financial Instructions (SFIs), Standing Orders (SOs) and Scheme of Delegation (SoD) – the Trust Secretary advised that minor amendments had been proposed to the three documents to reflect the establishment of the Pharmacy subsidiary company, updates to Committee names and Terms of Reference, changes to guidance & legislation, changes in role titles and responsibilities, and changes to policy names. The changes were approved with some minor additional updates agreed. A further review of the documents was scheduled to take place during February/March to reflect changes to accountability and autonomy arrangements for Clinical Boards and Corporate Departments.

- The following items were received for information:
  a. Schedule of approval of single tender action and breaches and waivers exception report
  b. Debtors and creditors balances – Committee members were updated on the position regarding the PFI balances.
  c. Schedule of losses and Compensation – the process regarding cost recovery for private patients and international patients was discussed.
  d. Financial statements timetable for 2024/25

- The Committees Chairs Logs were received for the following Committee meetings:
  - Finance and Performance Committee – 25 November and 16 December
  - People Committee – 19 November and 17 December
  - Quality Committee – 19 November and 10 December
  - Charity Committee – 13 January 2025
  - Digital & Data Committee – 12 December

In addition the minutes of the Compliance and Assurance Group meeting held on 14 January 2025 were received.

Actions agreed in the meeting	Responsibility / timescale
1. It was agreed that action 317 (pharmacy stock losses) be transferred to the Finance and Performance Committee action log for progressing.	1. Trust Secretary (TS) / January 2025
2. The Deputy Chief Executive Officer (DCEO) agreed to liaise with the Chief Information Officer (CIO) to share an update at the next Committee meeting on back up/recovery arrangements for hard drives.	2. DCEO / February 2025
3. The TS agreed to identify a date for training for Board members on the BAF and risk management.	4. TS / February 2025

5. a. Narrative for action 263 (risk training) in the action log to be updated. b. Narrative for action 308 (capital risks) in the action log to be updated.	5. a. Head of Corporate Risk and Assurance (HCRA) / February 2025 b. DCEO / February 2025
6. Narrative for BAF risk ID 1.2 to be updated to separate out the two different types of risk management training.	6. HCRA / February 2025
7. It was agreed that the Clinical Audit report be taken to the Quality Committee in February and then an update be shared at ARAC thereafter. The EDON also agreed to the risks section of the report with the HCRA and to consider the sequencing of the reports to the Quality Committee and ARAC.	7. EDON / February 2025
8. Committee Schedule of Business to be updated to include twice yearly updates on the SoD, SFIs and SOs.	8. TS / March 2025
9. The TS agreed to obtain the report on International Patients shared at a previous Finance and Performance Committee meeting to ascertain whether it included case study information and process details which could be shared with ARAC members.	9. TS / February 2025
Escalation of issues for action by connecting group	**Responsibility / timescale**
There were no escalations.	Not applicable
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
All BAF risks were detailed in the BAF report. Committee members discussed risk ID 1.2 Failure to implement effective governance systems and processes across the Trust to assess, monitor and drive improvements in quality and safety.	Not applicable

Agenda item A16

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Audit, Risk and Assurance Committee (ARAC) - Chair's Log

Meeting: ARAC	**Date of Meeting**: 20 February 2025
Connecting to: Board	**Date of Meeting**: 28 March 2025
Key topics discussed in the meeting	

- The meeting action log was received, and it was pleasing to note that many of the outstanding actions had been completed.

- No matters were identified for escalation from other Board Committees to ARAC.

- Clinical Board Risk Deep Dive – Cancer and Haematology – The Clinical Board Chair and Director of Operations provided an overview of their risk profile and mitigating actions for the highest scoring risks. The following points were noted:
  - 6 risks are included on the risk register, of which 3 are rated as moderate and 3 as low.
  - The 6 risks relate to:
    - Staffing - national shortage of oncology consultants (a review programme is in place with multiple workstreams), shortage of radiotherapy staff (action plan in place with performance monitored), shortage of systematic anti-cancer therapy staff (staff in training are being rotated and staffing levels monitored).
    - Capacity issues – several actions are in place to mitigate against the risk including learning from the Perfect Pathway exercise, clinical prioritisation and harm review processes.
    - Estates/space - ventilation requirements. Estates colleagues are engaged, and proposals being sought.
    - Digital - the need for an automated solution to be identified to enable the interoperability of two digital systems. A manual workaround is in place in mitigation.
  - 2 of the 6 risks are over two years old.
  - The interdependencies of the 6 risks.

- Board Assurance Framework (BAF) Report – The BAF was presented for receipt, having been approved by the Trust Board on 31 January 2025. Further work was noted to be needed in relation to the People and Digital risks on the BAF. A meeting is scheduled on 26 March for Board members to agree the 2025/26 BAF risks.

- Risk Register Report – an overview of the Trust risk profile and the recent activity of the Risk Validation Group (RVG) was shared. In summary:
  - The Clinical Boards and Corporate Directorates have opened 21 new risks between November 2024 and January 2025. 17 were scored less than 15 and 4 were scored 15+.

- There are 75 risks with a current risk score of 15+ held on risk registers across the Trust. This has reduced by 2 since November 2024.
- The Clinical Boards and Corporate Directorates have closed 20 risks between November 2024 and January 2025.
- There has been 7 tolerated risks between November 2024 and January 2025.

The RVG ensures that any risks which have not been fully validated are actioned accordingly. Committee members discussed:
- The planned implementation of the new Risk Management System (InPhase) and associated training.
- The importance of developing/agreeing the Trust Board Risk Appetite for 2025/26.

- The Committee Terms of Reference (ToR) were reviewed and changes made to reflect the Compliance and Assurance Group (CAG) reporting into the Committee, the updated process for Governor observers and some minor amendments to job titles. Two further amendments were agreed:
  - Clarity of the reporting route to receive assurance on claims and litigations, with associated learnings, and therefore that the ToR be updated to reflect this.
  - That the Counter Fraud references are updated as Counter Fraud activity is reported directly into the Committee rather than through CAG.

  Committee members agreed the changes to the Terms of Reference, subject to the final amendments being made as per above. In addition, the Schedule of Business for 2025/26 was approved.

- An update on national clinical audits was received for information.

- The Committees Chairs Logs were received for the following Committee meetings:
  - Finance and Performance Committee – 28 January 2025
  - People Committee – 21 January 2025
  - Quality Committee – 21 January 2025

Actions agreed in the meeting	Responsibility / timescale
1. The Executive Director of Nursing (EDN) agreed to discuss with the Integrated Care Board (ICB) how cancer prevention/awareness campaigns can be communicated/notified to NHS cancer care providers in advance to allow better planning for the impact of such campaigns.	1. EDN / March 2025
2. It was agreed that an action be taken forward by the Quality Committee to receive an update on the implementation plan/rollout of the new InPhase system.	2. EDN / April 2025
3. The Director of Performance and Governance (DPG) agreed to discuss the timeline for the development of the Board Risk Appetite Statement with the Head of Corporate Risk and Assurance	3. DPG and HCRA / March 2025

(HCRA), with a preference noted by Committee members to be actioned as soon as practically possible.	
4. Claims and litigations reporting is discussed between the Quality Committee Chair, the EDN, the HCRA and the Director of Quality & Safety (DQ&S), with feedback shared with the Trust Secretary (regarding the ToR).	4. Quality Committee Chair and EDN / March 2025.
5. The Committee ToR be updated by the TS for the two amendments identified.	5. TS / March 2025
Escalation of issues for action by connecting group	**Responsibility / timescale**
There were no escalations.	Not applicable
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
All BAF risks were detailed in the BAF report. The Cancer and Haematology Clinical Board risks were discussed – IDs: 4648 3645 4548 4549 4213 4645	Not applicable

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025		
Title	Board Assurance Framework (BAF) Report.		
Report of	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 provide the Trust Board with assurance that strategic risks 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: • All current risk scores have remained unchanged. • Assurance level ratings have changed on 3 threats relating to Elective Recovery Funding (ERF), Capital Departmental Expenditure Limit (CDEL) and financial recovery for 2024/25. • 25 action timescales have been adjusted. • 6 new actions have been added. • 11 controls have been added. • For Risk ID 1.2 - The Audit, Risk and Assurance Committee (ARAC) are asked to review updates/amendments, discuss the recommended assurance rating and agree an assurance level for each threat. • A compliance and risk based internal audit has been completed to review the policy, process, reporting and escalation of risk management and the Board assurance framework, we are pleased to report that good levels of assurance have been received for both audits.		
Recommendation	The Trust Board are asked to: • Receive assurance that strategic risks are being managed effectively; that risks have an appropriate action plan in place to mitigate them; and that risk scores are realistic and achievable. • Provide any feedback/comments on the content of the report.		
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	Standard agenda item at every ARAC and Public Board meeting.

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 (ARAC) and reported to the Trust Board, as well as identify any further actions required to mitigate risk.

The key elements of the 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 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 ARAC.
	The ARAC receive a BAF risk report including the full BAF and recommendations proposed by Committee Chairs. The ARAC 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 the ARAC.

3. BAF RISK REVIEW

Below aims to give an overview of the Executive review and updates for each Committee.

3.1 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, the 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).
- Action timescales have been adjusted on 3 actions relating to development of ICNET, completion of maternity service wide staffing review and report to Quality Committee and development of duty of candour action plan and report to Quality Committee.
- 2 actions have been added relating to the Patient Safety Incident Response Framework (PSIRF) annual report and the development of a dashboard for Clinical Boards.
- 2 new controls have been added relating to patient correspondence audits and system functionality reviews in relation to patient correspondence – providing positive assurance relating to processes in place.
- Assurance has been updated in relation to Mental Capacity Act (MCA) Quarter 3 audit data and compliance with MCA training.

- Action progress indicators have remained unchanged.
- Assurance ratings have remained unchanged.

3.2 People Committee

There are three strategic risks aligned to the People Committee, these relate to capacity and capability of our workforce, embedding and maintaining organisational culture and the development and implementation of a new approach to leadership and organisational development.

These risks has been reviewed by 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).
- Action timescales have been adjusted for 6 actions relating to development of the anti-racism policy, review of Human Resources (HR) policies, health and wellbeing funding bid, analysis of Freedom to Speak Up (FTSU) staff survey data, embedding of behaviours and civility charter and action plan to improve the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).
- 3 actions have been completed relating to introduction of value/leadership competencies into recruitment processes, development of local people dashboards, dignity and respect policy and people committee internal audit reporting.
- Three controls have been added relating to introduction of value/leadership competencies, local people dashboards, dignity and respect policy and people committee internal audit reporting.
- Action progress indicators have remained unchanged.
- Assurance ratings have remained unchanged.

3.3 Finance and Performance 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 have been reviewed by the Director of Performance and Governance, Director of Estates, Chief Finance Officer and Head of Corporate Risk and Assurance.

Following the risk review the key points to note are as follows:

- All current risk scores remain unchanged.
- 12 actions timescales have been adjusted, these mainly relate to risk 5.1, failure to maintain the standards of the Trust Estate, Environment, and infrastructure.
- 2 new actions have been added relating to executive settlement agreements.
- Relating to risk 6.1 failure to manage our finances, threats relating to ERF, CDEL, unplanned emerging costs and financial recovery for 2024/2025 have been moved to green level of assurance, notes are added in the assurance box to provide the rationale.

- Relating to risk 5.1 failure to maintain the standards of Trust Estate, the threat relating to CDEL has moved to green assurance for delivery of CDEL 2024/25.
- 3 controls have been added relating to estates condition surveys, targeted cancer improvement plans and financial deep dives.

3.4 Digital and Data Committee

There is one strategic risk aligned to the Digital and Data Committee, this relates to failure to deliver digital systems, processes, and infrastructure to support the provision of safe effective patient care and our digital aspirations for the future.

This risk has been reviewed by the Chief Information Officer and the Head of Corporate Risk and Assurance. Following the risk review the key points to note are as follows:

- The current risk score has remained unchanged.
- 4 action timescales have been redefined since the last review, these actions relate to the implementation of the Oracle/Cerner Remote hosting project, the removal of devices over 5 years old, development of the digital strategy and 3-year digital financial plan.
- Assurance ratings remain the same, 2 red, 1 green.
- Action progress indicators remain unchanged.

3.5 ARAC

There is one strategic risk aligned to the ARAC, this relates to the failure to implement effective governance systems and processes (1.2). 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 unchanged.
- 2 new actions have been added relating to Delivery of Care Quality Commission (CQC) phase 2 action plan, development of risk induction video.
- 3 new controls has been added relating to development of CQC phase 2 action plan, BAF and Risk Management risk and compliance based internal audit reports – good level of compliance received for both.

5. RECOMMENDATIONS

The Trust Board are asked to:

- Receive assurance that strategic risks are being managed effectively; that risks have an appropriate action plan in place to mitigate them; and that risk scores are realistic and achievable.
- Provide any feedback/comments on the content of the report.

Report of:

Agenda Item A17

Natalie Yeowart
Head of Corporate Risk and Assurance
20 March 2025

Agenda item A17

BOARD ASSURANCE FRAMEWORK (BAF)
2024/2025 – MARCH 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	04.03.2025	**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 – Actions on track to be completed by deadline, please see CQC phase 2 action plan document for exact timescales – 25% of phase 2 action plan completed as of 27th January 2025. • Development of Duty of Candour action plan to ensure compliance against Duty of Candour standards– Paper to Quality Committee Meeting April 2025. • Development of 25/26 Quality Priorities – April 2025. • Development of Trust-Wide Patient Safety Strategy – July 2025. • PSIRF Annual Report to Quality Committee April 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, along with areas of high risk. • 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. – Q3 data – 85% of patients requiring MCA had documented evidence (97% in Q2) • Increase in DOL's referrals represented of expected volume. • Compliance with MCA mandatory training 96.4% Feb 25 (96% January 2025) 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. • Bi-annual Reports to Quality Committee. • Bi-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 Clinical Board's (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.	• 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.	• 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.**

	• Medicine Management Policies and procedures. • 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 (MMOG) to ensure delivery of improvements • Increased nursing infrastructure to support medicines safety.	• Peer review and external review reports and audit data. • 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. • Midwifery staffing and red flags monitored and reported to quality Committee.	• Completion of service wide staffing review and enact the recommendations by – Paper to Quality Committee March 2025 with update on phase 2. • Maternity Services phase 3 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	• Cardiac Oversight 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	• 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.**

	• Review infrastructure of quality oversight and local governance groups.	• Compliance and Assurance Group Reports and Minutes.	• Development of dashboard framework for Clinical Board oversight of actions/areas for improvement by Jul 2025.	
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 Quality Improvement (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 • Patient correspondence/letters audit to validate Clinical Board processes to maintain oversight of timeliness of completion of correspondence • Secondary review of all systems functionality in relation to patient correspondence/letters.	• 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. • Power BI report provided to all clinical boards to all routine validation to take place. • Secondary review of all system functionality in relation to patient correspondence and letters provided positive assurance relating to processes in place.	• 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) • EPR induction training – review of post roll out training has commenced. Two sessions have been completed with more planned in 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 (IPCC) and subgroups. • Clinical Board Governance Meetings and Quality Oversight Group. • Local and National Benchmarking. • IPC policies. • Clinical Board Improvement plans. • Clinical Assurance Toolkit Audits. • Accrediting Excellence (ACE) Programme. • Antimicrobial Stewardship Policy and Framework.	• 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.	• ICNET system development underway improve surveillance and timely intervention - Sept 2025 • Review and revise central IPC Team roles and responsibilities to maximise visibility and engagement - by March 2025	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

Risk ID	1.1

Comments:

Agenda item A17

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	18.03.2025	**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. • CQC phase one action plan. • CQC phase two action plan.	• 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 • Internal audit of CQC phase one action plan – substantial assurance received. • CQC phase two action plan developed, presented and supported by IQIG.	• Evaluate the implementation of revised integrated governance structure – Clinical Board Governance Internal Audit starting in November – audit report expected by April 2025. • Delivery of CQC phase 2 action plan – December 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. • Clinical Board update report presented to Trust Board.	• Review issue escalation through new governance route to Exec, through Clinical Board Governance. • Compliance and Risk based internal audit of operational risk management governance and BAF governance including processes, policy, oversight and	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

		• The value circle report on QPR process • The value circle report on effective governance	escalation – Reports to ARAC March 2025.	

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 April 2025.	**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 for risk system users. • 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 and Board Assurance Framework Risk and compliance based internal audit.	• 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 • Risk management and Board Assurance Framework risk and compliance based internal audit – good level of assurance.	• 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. • Development of risk management induction video for all staff – April 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	18.03.2025	**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.	**1.Fully on plan across all actions.** **ERF is 1.9m ahead of plan and therefore achieved for 24/25.**
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.	Financial Grip and Control internal audit action plan – April 2025.	**1.Fully on plan across all actions.**

	• 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. • Financial communications strategy.	• NHSE/I monthly finance monitoring • Going concern and financial controls audit. • Mazars external audit – satisfactory assurance, no issues re going concern. • First financial specific coms issued in January 2025.		
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) • Financial deep dives.	• 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. • Financial deep dives, all schemes reviewed, and mitigation plans in place, although mainly through non recurrent measures.		**1.Fully on plan across all actions.** **Threat mitigated for 2024/25 albeit through non recurrent measures.**
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	• 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 – April 2025. • Await national planning guidance following budget – March 2025.	**1-Fully on plan across all actions.**

	• Business case process. • Financial Recovery Steering Group. • Long Term Plan.			
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.		**1.Fully on plan across all actions.** **Threat mitigated for 2024/25 albeit through non recurrent measures.**
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.	• CDEL Action Plan in place to hit year-end target – March 2025. – Trust is currently forecasting to spend 10.7m more than its capital plan through additional CDEL income allocation.	**1.Fully on plan across all actions.** **Trust is currently forecasting to spend 10.7m more than its capital plan through additional CDEL income allocation.**
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.	• 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.	• Strengthen commercial contracts and templates – April 2025. • IP Policy – April 2025. • Strengthen governance relating to IP protection and data access – May 2025. • Strengthen our job descriptions for senior staff to include data access alongside IP - 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 A17

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	18.03.2025	**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. • Targeted cancer improvement plans.	• 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. • Targeted cancer improvement plans – two tumour groups reported via F&P March 2025.	• Develop Clinical Board Level reports – challenges identified in completing – June 2025. • Review current information and performance reports to ensure they are fit for purpose – June 2025 • 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. • Develop Service Review methodology and reviews, to start in April 25. • 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 • 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 – trial underway positive feedback received.	**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 A17

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 – delayed to March 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) • 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 • Cyber Security Policy. • Asset Inventory management process.	• 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.	• Replace/update outdated systems and software, legacy hardware, and unsupported systems -dependent on funds, opportunity to consolidate at contract end periods – Update provided via ITSM report to Digital and Data, - April 2025. • 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 – April 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 A17

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	18.03.2025	**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 national capital funding allocation 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. • Alignment of condition surveys.	• 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. • Condition surveys now aligned on CAFM system.	• Develop a risk-based asset report for Clinical Boards to inform risk-based prioritisation of backlog maintenance programme -July 2025. • Develop a detailed 5-year Backlog Maintenance plan to feed into the Estates Strategy -July 2025.	**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. – remaining areas are RVI Leazes wing theatres 1,2,2a all in theatres refurbishment plan. • Tender/award contract for phase 3 of passive fire remediation works -delayed retender now May 2025. • Complete 24/25 upgrade programme of active fire system May 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

			• Tender/award contract for 2025/26 upgrade of active fire systems -May 2025.	
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).	• Develop a risk-based asset report for Clinical Boards to inform risk-based prioritisation of backlog maintenance programme -July 25. • Develop a detailed 5-year Backlog Maintenance plan to feed into the Estates Strategy -July 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**
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. • 3-year lifecycle replacement plan.	• 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. • Lifecycle replacement plan and programme in place.	• CDEL Action Plan in place to hit year-end target – March 2025. – Trust is currently forecasting to spend 10.7m more than its capital plan through additional CDEL income allocation.	**1-Fully on plan across all actions.** **Trust is currently forecasting to spend 10.7m more than its capital plan through additional CDEL income allocation.**
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.	• **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 and Facilities Operational Management Structures. • Estates Risk Management & Governance Group minutes and action logs. • Quarterly report to Compliance & Assurance Group. • PLACE Assessments.	• 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–	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

	• Estates Strategy. • Trust Policies and Procedures	• NHS Premises Assurance Model (PAM). • IPCC oversight. • CQC Delivery Group. • CQC Standards Assurance Group. • Trust Internal Audit Programme (AuditOne).	24-month programme). Review at August 2025. • Compliance with Self Harm Risk Assessment recommendations 18–24-month programme. April 2025. • 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 – July 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 – March 2025. • Adherence to outlined performance parameters – March 2025. • Execute Settlement Agreement 2 – due April 2025. • Execute Settlement Agreement 3 – due May 2025	**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. • Deed of variation being prepared for HSN direct delivery – due April 2025. • HSN Project management resource now appointed. • Implementation planned June 2025.	**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.	• Independent certification for each zone when completed. • Ongoing compliance requirements contained within PFI Project Agreement.	• Regular reviews of requirements and progress with the remedial works -April 2026.	**4-Actions defined -but largely behind plan.**

	• Maintain meetings structures to manage progress with the works.	• PFI Fire Steering Group.		
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 delivering remedial works to programme -March 2025.	**3-Action defined-work started but behind plan.**
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 July 2025	**5- Actions not yet fully defined.**

Risk ID	5.1
Comments:	

Agenda item A17

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	Director of Commercial Development and Innovation.	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	People
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	12.03.2025	**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**
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. • People dashboards.	• 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. • Local People dashboards developed for CD/CBs.	• 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. – Phase 1 to build establishment control within staffing system (ESR) to be completed by April 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 – Phase 1 to build establishment control within staffing system (ESR) to be completed by April 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 Commercial Development and Innovation.	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	12.03.2025	**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**
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. • Staff Survey.	• 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. • Staff Survey response rate 63%	• Promotion of behaviours and civilities charter across the Trust including bespoke training to be completed by June 2025. • Embedding a staff and patient experience improvement programme March 2026.	**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. • Dignity and Respect 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 – Review action plan by April. • Anti racism policy to be produced April 2025.	**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 – June 2025.	**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. • Anonymised, real time staff feedback piloted in summer 2024.	• Implement speaking up 8-point plan programme from October 2024 – March 25. • Analysis of staff survey feedback understanding and analysing speaking up– June 2025.	**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	Director of Commercial Development and Innovation.	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	12.03.2025	**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. • Leadership Development Training pilot • People Committee Internal Audit Report. • Introduction of value/leadership competency into our recruitment 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. • Report now in place, reporting quarterly to People Committee, tracking progress with recommendations and assurance levels.	• 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.	**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.	• Development of Health and Wellbeing funding bid based on gap analysis – April 2025 • Delivery of people plan action plan – 25 of year one actions delivered, 1 due to be completed by 31st March and 2 under review to enable alliance approach.	**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. • Leadership Development Training pilot.	• 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. • Introduction of value/leadership competency into our recruitment processes – incrementally from June 2024, fully implemented by April 2025. • Review of key HR policies and processes aimed at supporting staff – Ongoing from Sept- April 2025. • Anti-racism policy to be produced – April 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**

Risk ID	2.3

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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 sustainable 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, Director Great North Healthcare Alliance and Strategy	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	Finance/VfM
Date Added	01.05.2024	**Likelihood**	**4**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	07.03.2025	**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 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 • Great North Healthcare Alliance Joint Committee established. 3 lead directors in place for delegated functions of financial planning, digital and research and innovation. • Bilateral group between Northumbria and Newcastle established. • Bilateral sub-committee between North Cumbria and Newcastle 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 Vision, Workplan and Milestones. • Alliance Performance Dashboard. • Approval of Boards, Governors, ICB and NHSE to appoint a shared chair across Newcastle, Northumbria and Gateshead.	• Chair and CEO member of Great North Healthcare Alliance Steering Group Committees in common and Joint Committee. • CEO member of Provider Collaborative Leadership Board. • Lead director as part of Alliance Formation Team • Executive Directors leading appropriate Alliance work streams with peers. • CEO chairs Newcastle Place ICB Sub-Committee. • Alliance vision and 3-year work plan approved by Trust Board and supported by Council of Governors and NENC ICB. • Great North Healthcare Alliance Steering Group Committees in Common and Joint Committee 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 approval of Alliance Case for Change. • ICB led stakeholder engagement assurance of Alliance plan very positive. • NHSE assured Alliance shared leadership arrangements • Alliance updated Collaboration Agreement.	• Clinical Board quality and performance reviews to include focus on Alliance working – March 2025. • Establishment of bilateral group between Gateshead and Newcastle – April 2025. • Development of Alliance pathway transformation and big build project scope – May 2025. • Recruitment of shared chair across Newcastle, Northumbria and Gateshead – June 2025. • Development of NUTH Clinical Strategy – autumn 2025.	**1-Fully on plan across all actions.**

Risk ID	7.1

Comments:

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Agenda item A18

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025					
Title	Gender Pay Gap					
Report of	Vicky McFarlane-Reid - Director for Commercial Development and Innovation & Executive Lead People Directorate					
Prepared by	Karen Pearce Head of Equality, Diversity and Inclusion (People)					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☐	☐			
Summary	Under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 the Trust is required to produce and publish an annual report of gender pay gap information. This paper includes the Trust's gender pay gap report for the 'snapshot' date of 31 March 2024 plus a supporting narrative and action plan. The report must be published on the government's gender pay gap service website and the Trust's website within a year of the snapshot date (i.e. before 30 March 2025).					
Recommendation	To agree the contents of the paper and the publication of the data on the government's gender pay gap service website and the paper on the Trust's website before 30th March 2025.					
Links to Strategic Objectives	People Strategy and Equality Diversity and Inclusion (EDI) Improvement Plan					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☒	☒
Link to Board Assurance Framework [BAF]	Not applicable.					
Reports previously considered by	Gender Pay Gap Report - March 2024					

GENDER PAY GAP REPORT 2024/25

1. EXECUTIVE SUMMARY

1.1 INTRODUCTION

The Trust's overall gender pay gap remains strongly influenced by the pay and gender make-up of the medical and dental staff group. This group is predominantly male and their higher pay relative to other staff increases the level of male average pay compared to females. A review of the data set demonstrates the mean pay gap for Agenda for Change staff is -0.18% and the median pay gap for Agenda for Change is -8.76%.

1.2 PAY GAP DATA

The gap in the average [mean] hourly pay rate between males (£24.57) and females (£19.26) is 21.59%. The gap has decreased slightly by 0.85 percentage points since 2023 when the Trust reported a mean pay gap of 22.44%.

When the data is reviewed by staff group with the highest gender pay gap is within Administrative and Clerical at 14.75%, followed by Estates and Ancillary (8.22%) and Medical and Dental (7.30%). The report provides a detailed breakdown of the gender pay gap across different pay bands and roles within the Trust. It demonstrates that the pay gap emerges in the higher pay bands with significant gaps starting to appear in the higher bands (8C 4.48%, band 8D 6.53%). Within the Medical and Dental workforce, a 5.25% gap exists but there is also a significant gap with trainees employed by the Trust (11.98%). In the 'other' category (ad-hoc appointments, apprentice, Trust doctors) men earn 7.45% more indicating potential equity issues in less structured and or flexible senior positions.

1.3 BONUS PAY GAP DATA

The gap in average [mean] bonus pay between males (£9,363.65) and females (£3,683.95) is 60.66%. The gap has decreased by 18.7 percentage points from 2023. The average [median] gap in bonus pay decreased from 96.68% to 0.0%; this is due to the impact of equal distribution of Clinical Excellence Awards (CEA's) for 2022/23 and 2023/24.

Like the Trust's mean gender pay gap, the mean gender bonus pay gap is also strongly influenced by the pay and gender make-up of the medical and dental staff group. In this reporting period the total value of CEAs paid by the Trust by gender was:

- male £2,794,923
- female £535,607

1.4 ADDITIONAL ANALYSIS

Analysis demonstrates that female employees are overrepresented in the lower two quartiles, particularly in Nursing and Midwifery and administrative roles. Male staff dominate the highest paying quartile, especially on Medical and Dental and Scientific roles. Representation disparities suggest occupational segregation and potential barriers for females transitioning to higher paid positions.

1.5 ACTION TO REDUCE THE GENDER PAY GAP

People Plan: Last year the Trust established a People Programme Board to guide and ensure the success of our People Plan. There are four key themes forming our people plan for 2024-2027. The year 1 action plan covers a number of elements impacting indirectly on gender equity including:

- Equality and Diversity Steering Group: The establishment of our Equality and Diversity Steering Group has provided a platform to engage a diverse representation of staff, to ensure a comprehensive and supportive plan.
- Equality, Diversity and Inclusion (EDI) Improvement Plan: Alongside our People Plan our EDI Improvement plan focuses on 6 High Impact National Actions.
- Growth Opportunities: Initiatives such as the revised person-centred appraisal process and the 'Scope for Growth' career conversations focus on tailoring development plans to individual aspirations and potential. This allows for more targeted learning pathways and personal growth opportunities. Pay gap data also plays a crucial role in informing our Leadership and Development (L&D) Strategy by identifying systematic barriers, giving a focus on career progression to reduce disparities and developing compassionate and inclusive leadership that values diversity.
- The Establishment of the Women's Network: will create opportunities to amplify women's voices, challenging stereotypes, raise awareness of gender disparities and the additional impact of intersectionality.

2. INTRODUCTION

The gender pay gap measures the difference between the pay rates of all male and female staff across the Trust irrespective of their role and seniority. It should not be confused with equal pay where males and females performing similar roles or work of equal value must be paid equally. Under the Equality Act 2010 it is unlawful to pay people unequally because they are male or female. This report shows the Trust's gender pay gap data for the 'snapshot' date of 31 March 2024 and includes a supporting narrative and action plan. Gender pay reporting is about showing the difference in average pay and bonus payments between male and female staff. Currently 22% of our workforce are male, 78% are female.

The gap in the average [mean] hourly pay rate between males (£24.57) and females (£19.26) is 21.59%. The gap has decreased slightly by 0.85 percentage points since 2023 when the Trust reported a mean pay gap of 22.44%.

The gap in average [mean] bonus pay between males (£9,363.65) and females (£3,683.95) is 60.66%. The gap has decreased by 18.7 percentage points from 2023. The average [median] gap in bonus pay decreased from 96.68% to 0.0%; this is due to the impact of equal distribution of CEA's for 2022/23 and 2023/24.

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

There are other staff groups (admin and clerical) identified within the detail of the report that require further exploration. Within the Trust proportionally more males hold senior positions within the when compared to females.

This report provides and in-depth analysis of the Trust's gender pay gap, highlighting key findings from the most recent reporting period and the actions we are taking to address any disparities. We continue to be committed to fostering a fair, equitable and inclusive workplace. While our gender pay gaps don't indicate unequal pay for equal work it does reflect broader structural areas of focus such as proportional representation in senior roles, and potential barriers to career progression. We view addressing our gender pay gap not only as a legal obligation but also as a fundamental part of our core values and our broader commitment to diversity and inclusion, aligning both with our People Plan and our EDI Improvement Plan.

3. OUR COMMITMENT TO EQUALITY, DIVERSITY, AND INCLUSION

As a Trust we are committed to supporting staff to succeed to enable us to provide the best possible service to our patients.

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

Salaries within the Trust for staff employed on Agenda for Change are determined through the NHS Job Evaluation Scheme and NHS terms and conditions of service. Salaries for Medical and Dental Staff are in accordance with NHS terms and conditions of service for this staff group. Staff undertaking the same job are paid the same irrespective of gender. We are an equal pay employer.

4. DECLARATION

I confirm this report is accurate to the best of my knowledge and belief. It reflects a snapshot of our organisation on 31 March 2024. We have a number of actions in place which are intended to address our gender pay gap. We will publish our data by 30 March 2025.

Signed: Date:

Name: Rob Harrison

Designation: Acting Chief Executive

5. OUR GENDER PAY GAP DATA

5.1 Gender profile

Profile	Male 2024	Female 2024	Male 2023	Female 2023	Male 2022	Female 2022
All staff	**22%**	**78%**	**22%**	**78%**	23%	77%

5.2 Gender pay gap

Profile	Male 2024	Female 2024	Pay Gap 2024	Male 2023	Female 2023	Pay Gap 2023	Male 2022	Female 2022	Pay Gap 2022
Mean hourly pay rate (all staff)	**£24.57**	**£19.26**	**21.59%**	**£23.34**	**£18.10**	**22.44%**	£22.29	£17.30	22.42%
Median hourly pay rate (all staff)	**£18.10**	**£17.68**	**2.29%**	**£17.24**	**£16.84**	**2.29%**	£16.39	£15.12	1.65%

The mean hourly pay gap has decreased by 0.85 percentage points to 21.59%. The median hourly pay rate gap remains unchanged at 2.29%

The Trust's overall mean gender pay gap remains strongly influenced by the pay and gender make-up of the medical and dental staff group which is predominantly male. Their higher pay relative to other staff increases the level of male average pay compared to females. A review of the data set demonstrates the mean pay gap for Agenda for Change staff is -0.18% and the median pay gap for Agenda for Change is -8.76%. When we take Medical and Dental Staff out females, on average earn more than males.

5.2.1 Gender pay gap by staff group.

Staff Group	Male	Female	Difference	Pay gap
Add Prof Scientific and Technic	£22.94	£21.31	£1.63	7.10%
Additional Clinical Services	£13.41	£13.47	-£0.05	-0.39%
Administrative and Clerical	£18.70	£15.95	£2.76	14.75%
Allied Health Professionals	£20.70	£20.96	-£0.26	-1.26%
Estates and Ancillary	£14.59	£13.39	£1.20	8.22%
Healthcare Scientists	£23.58	£22.04	£1.54	6.53%
Medical and Dental	£51.51	£47.75	£3.76	7.30%
Nursing and Midwifery Registered	£20.23	£20.49	£0.26	1.28%
Students	£13.33	£14.45	-£1.12	-8.39%

The staff group with the highest gender pay gap is Administrative and Clerical at 14.75%, followed by Estates and Ancillary (8.22%) and Medical and Dental (7.30%).

5.3 Bonus pay

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

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

Gender bonus pay gap.

Profile	Male 2024	Female 2024	Bonus pay gap 2024	Male 2023	Female 2023	Bonus pay gap 2023	Male 2022	Female 2022	Bonus pay gap 2022
Mean bonus pay	**£9,363.65**	**£3,683.95**	**60.66%**	**£12,038.50**	**£2,484.38**	**79.36%**	£1,009.03	£205.24	79.66% (* 77.24% without thank you bonus)
Median bonus pay	**£4,298.00**	**£4,298.00**	**0.00%**	**£6,032.04**	**£200.00**	**96.68%**	£147.05	£147.05	0% (* 90.78% without thank you bonus)
Proportion of staff in receipt of bonus	**12.92%**	**3.93%**		**7.27%**	**2.35%**		92.41%	94.06%	

The mean bonus pay gap has reduced by 18.7 percentage points.
The median bonus gap has decreased by 96.68% to 0%. This is as a consequence of CEA's being equally distributed across the medical workforce.

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

Staff Group	Gender	Staff paid bonus	Total relevant staff	%
Add Prof Scientific and Technic	**Female**	41	524	6.87%
	Male	24	148	14.19%
Additional Clinical Services	**Female**	36	2,695	1.34%
	Male	17	597	2.18%
Administrative and Clerical	**Female**	40	1,962	1.99%
	Male	14	685	2.04%
Allied Health Professionals	**Female**	12	1,008	1.19%
	Male	3	222	1.35%
Estates and Ancillary	**Female**	14	664	2.11%
	Male	10	579	1.73%

Healthcare Scientists	**Female**	6	445	1.35%
	Male	4	277	1.44%
Medical and Dental	**Female**	352	578	39.37%
	Male	538	732	47.27%
Nursing and Midwifery Registered	**Female**	95	5,147	1.85%
	Male	6	462	1.30%
Totals	**Female**	596	13,023	3.57%
	Male	616	3,702	11.26%

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

In this reporting period the total value of CEAs paid by the Trust by gender was:

- male £2,794,923
- female £535,607

The number of consultants by gender in receipt of a national platinum, gold or silver CEA is male 30; female 5 the values of which are identified below and can be seen to impact on gender pay.

Bonus Type	Female	Male	Female (value)	Male (value)
CEA 1-10	56	116	£392,649	£1,534,509
CEA Bronze	5	13	£142,958	£462,570
CEA Silver	0	13	£	£557,908
CEA Gold	0	3	£	£171,507
CEA Platinum	0	1	£	£68,492

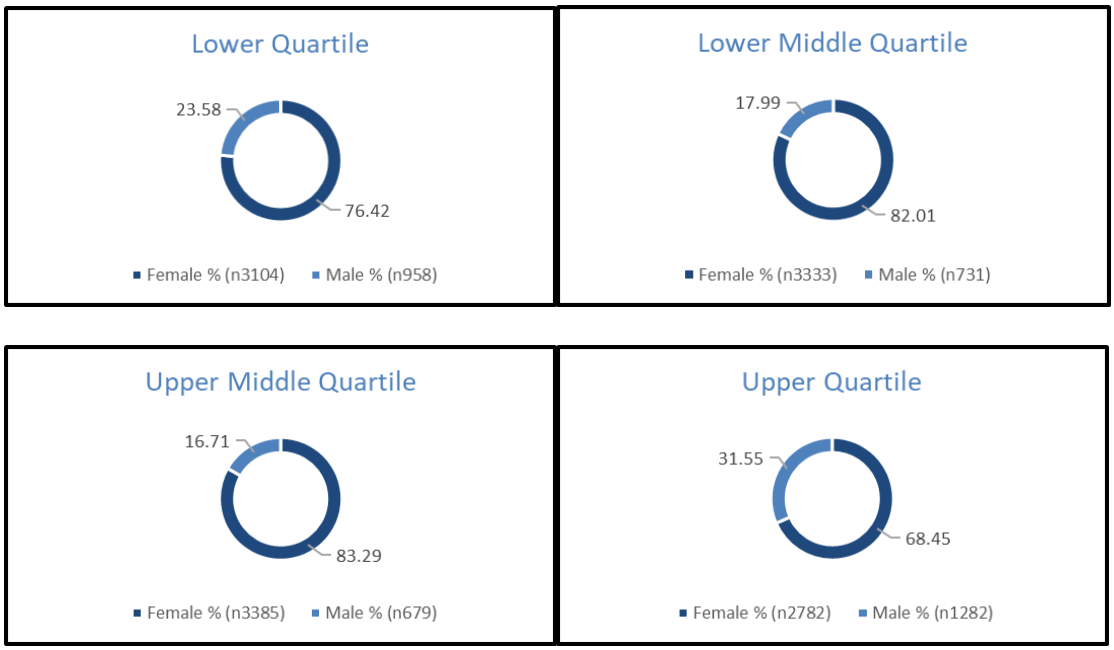
5.4 Bonus paid 1 April 2023 - 31 March 2024

Bonus Type	Female	Male	Total
Clinical Excellence Awards	341	522	863
Excellence Award	0	0	0
Performance Related Pay	0	0	0
Performance	39	37	76
Long Service Awards	206	41	247
TOTALS	586	600	1186

5.5 Pay distribution by quartiles.

The data below is achieved by dividing the workforce into four equal parts (quartiles). All staff are ranked from the lowest hourly rate of pay to the highest. The rank order is then divided into four sections with an equal number of staff in each. With a female workforce of 78%, females should ideally make up 78% of each quartile. Females are under-represented

in the upper quartile and over-represented in the lower and upper middle quartiles. The medical and dental workforce is predominantly in the upper quartile and has a higher percentage of males (728) compared to females (575).

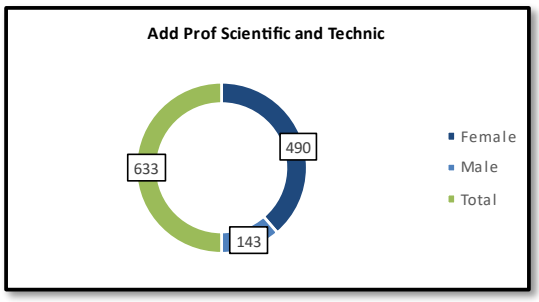


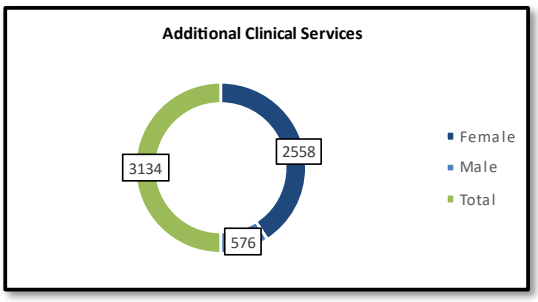
- 79.2% (6,437) of all staff in the lower and lower middle quartiles are female – a positive decrease of 0.24% compared to last year (79.4%).
- 75.9% (6,167) of all staff in the upper middle and upper pay quartiles are female – a negative decrease of 0.5% compared to last year (76.3%).
- 20.8% (1,689) of all staff in the lower and lower middle quartiles are male – a negative decrease of 1.44% compared to last year (20.8%).
- 24.1% (1,961) of all staff in the upper middle and upper pay quartiles are male – a positive decrease of 2.12% compared to last year (23.6%).

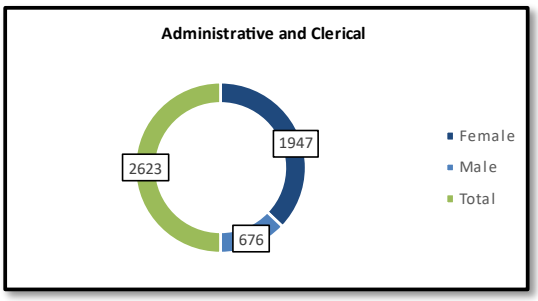
Proportionally more males hold senior positions than females:

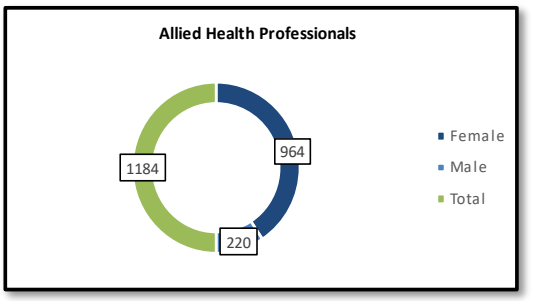
	Percentage of total male in upper quartile	Percentage of total female in upper quartile
March 2022	34.70%	22.13%
March 2023	36.09%	22.54%
March 2024	35.12%	22.07%

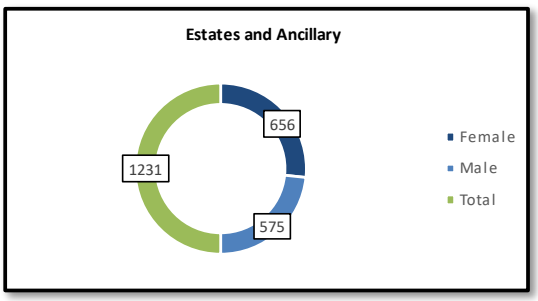
5.6 Gender profile by staff group

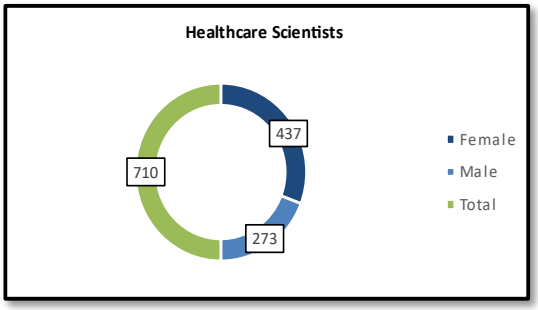


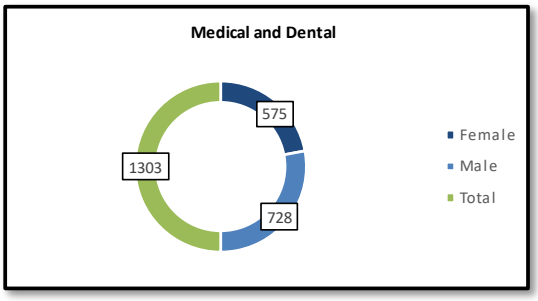


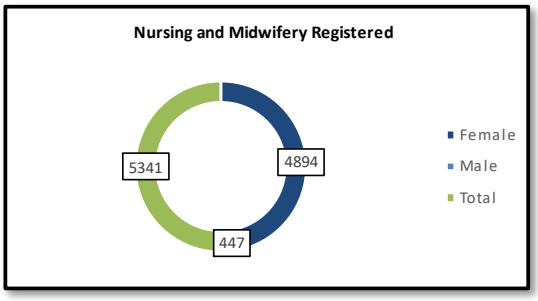


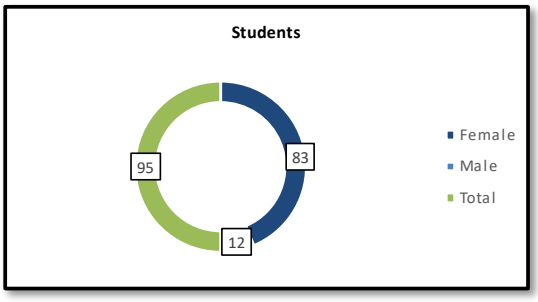












- The majority of females are in nursing and midwifery (4894), additional clinical services (2,558) and admin and clerical (1947).

- The majority of males are in medical and dental (728), admin and clerical (676) and additional clinical services (576).

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

	lower quartile	lower quartile	lower middle quartile	lower middle quartile	upper middle quartile	upper middle quartile	upper quartile	upper quartile
staff group	male	female	male	female	male	female	male	female
Add Prof Scientific and Technic	0.04%	0.28%	0.16%	0.85%	0.31%	0.71%	0.38%	1.18%
Additional Clinical Services	2.41%	9.70%	0.88%	5.42%	0.25%	0.60%	0.01%	0.01%
Administrative and Clerical	1.58%	6.17%	0.94%	3.48%	0.71%	1.05%	0.92%	1.28%
Allied Health Professionals	0.01%	0.01%	0.27%	1.10%	0.68%	2.73%	0.39%	2.10%
Estates and Ancillary	1.73%	2.31%	1.22%	1.22%	0.44%	0.49%	0.15%	0.01%
Healthcare Scientists	0.04%	0.07%	0.23%	0.53%	0.56%	0.88%	0.84%	1.21%
Medical and Dental	0.00%	0.00%	0.00%	0.00%	0.03%	0.09%	4.45%	3.45%
Nursing and Midwifery Registered	0.02%	0.26%	0.78%	7.73%	1.20%	14.24%	0.76%	7.88%
Students	0.06%	0.30%	0.01%	0.18%	0.00%	0.03%	0.00%	0.00%

Female employees are overrepresented in the lower two quartiles, particularly in Nursing and Midwifery and administrative roles. Male staff dominate the highest paying quartile, especially on Medical and dental and scientific roles. Representation disparities suggest occupational segregation and potential barriers for females transitioning to higher paid positions.

5.8 Gender pay gap by band/pay scale as-at March 2024

PayScale	Male	Female	Pay Gap
	mean average hourly rate	mean average hourly rate	
Band 1	£11.45	£13.84	-20.92%
Band 2	£12.74	£12.39	2.69%
Band 3	£13.31	£13.37	-0.43%
Band 4	£13.72	£13.86	-0.99%
Band 5	£17.10	£17.78	-3.97%
Band 6	£20.14	£20.59	-2.21%
Band 7	£23.94	£24.29	-1.49%
Band 8a	£27.22	£26.98	0.86%

Band 8b	£32.18	£31.60	1.81%
Band 8c	£39.51	£37.73	4.48%
Band 8d	£48.78	£45.59	6.53%
Band 9		£58.78	-100%
Other	£48.26	£44.66	7.45%
M&D Consultant	£56.86	£53.87	5.25%
M&D SAS	£36.69	£36.66	0.07%
M&D Trainee	£36.55	£32.17	11.98%

The data presented above provides a detailed breakdown of gender pay gap across different pay bands and roles within the Trust. It demonstrates that the pay gap emerges in the higher pay bands with significant gaps starting to appear in the higher bands (8C 4.48%, band 8D 6.53%). Within the medical and dental workforce, a 5.25% gap exists but there is also a significant gap with trainees employed by the Trust (11.98%). In the 'other' category (ad-hoc appointments, apprentice, Trust doctors) men earn 7.45% more indicating potential equity issues in less structured and or flexible senior positions.

6. ACTION TO REDUCE THE GENDER PAY GAP

6.1 PEOPLE PLAN

Last year the Trust established a People Programme Board to guide and ensure the success of our People Plan. We now have an agreed People Plan and EDI Improvement Plan with a governance structure to ensure delivery. The four key themes forming our people plan for 2024-2027 are:

- Health and wellbeing
- Behaviours and civilities
- Valued and heard.
- Leadership and management

The year 1 action plan covers a number of elements impacting indirectly on gender equity including.

- **Equality and Diversity Steering Group** The establishment of our Equality and Diversity Steering Group in 2023 has provided a platform to engage a diverse representation of staff, to ensure a comprehensive and supportive plan. Beyond coordinating the Trust's approach to equality, diversity and inclusion, the Steering Group facilitates discussions and responses on relevant issues, emphasising key requirements and assessing effectiveness. Going forward the group will actively drive delivery and improvement by evaluating performance through key performance indicators, determining action plans and prioritising initiatives and interventions.

- **EDI Improvement Plan** – Alongside our People Plan our EDI Improvement plan focuses on 6 High Impact National Actions.

- *High impact action 1:* Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
- *High impact action 2:* Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
- *High impact action 3:* develop and implement an improvement plan to eliminate pay gaps.
- *High impact action 4:* develop and implement an improvement plan to address health inequalities within the workforce.
- *High impact action 5:* implement a comprehensive induction, onboarding and development programme for internationally recruited staff.
- *High impact action 6:* create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Growth Opportunities: Initiatives such as the revised person-centred appraisal process and the 'Scope for Growth' career conversations focus on tailoring development plans to individual aspirations and potential. This allows for more targeted learning pathways and personal growth opportunities. Pay gap data also plays a crucial role in informing our L&D Strategy by identifying systematic barriers, giving a focus on career progression to reduce disparities and developing compassionate and inclusive leadership that values diversity.

- **The Establishment of the Women's Network** will create opportunities to amplify women's voices, challenging stereotypes, raise awareness of gender disparities and the additional impact of intersectionality.

6.2 ADDITIONAL ANALYSIS

To further understand the impact outside of CEA's the following will be incorporated into next year's reporting.

- The likelihood of appointments in all senior roles band 8a and above by gender.
- A review of promotion data to understand whether women progress as frequently as men into senior positions.
- Gaining an understanding where and why women leave the Trust.
- Working with the newly formed Women's network to identify what additional support can be offered.

7. RECOMMENDATION

To agree the contents of the paper and the publication of the data on the government's gender pay gap service website and the paper on the Trust's website before 30th March 2025.

Karen Pearce
Head of EDI (People)

Agenda item A18

Vicky McFarlane-Reid
Director for Commercial Development and Innovation & Executive Lead People Directorate
19 March 2025

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025		
Title	Committee Terms of Reference and Schedule of Business Review for 2025/26		
Report of	Kelly Jupp, Trust Secretary		
Prepared by	Lauren Thompson, Corporate Governance Manager and Deputy Trust Secretary		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☐
Summary	The annual review of the Board Committee Terms of Reference (ToR) has been conducted. The Committee ToRs and Schedules of Business (SoB) have been discussed at each respective Committee meeting. Minor changes have been made to the ToRs and SoBs to reflect: - Updated responsibilities, governance arrangements and strategic priorities. - Changes to Director role titles and membership. - The People Committee ToR have been streamlined to better align with the People Plan. - Changes to the frequency of meetings for the People Committee. - To incorporate the reporting for Newcastle Hospitals Pharmaservices Limited (NHPL). - The updated process for Governor observers to each Committee. - The Sustainability (Shine Report) and the Sustainable Healthcare Committee Chairs Log/Minutes were originally reported into the People Committee. From April, these will report into the Finance and Performance Committee. - The Digital and Data Committee meeting months have changed to match the Public Trust Board meetings. The Digital and Data Committee ToR and SoB will be further reviewed once the new Committee Chair commences in the role. The Charity Committee ToR and SoB will be submitted to the Trust Board in May 2025.		
Recommendation	The Trust Board is asked to approve the updated Terms of Reference and 2025/26 Schedules of Business.		
Links to Strategic Objectives	Performance – Being outstanding, now and in the future.		

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

Link to Board Assurance Framework [BAF]	No direct link.

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Reports previously considered by	Annual Review. Submission to the relevant Committee meetings has taken place in advance of the March Trust Board.

TERMS OF REFERENCE – AUDIT, RISK AND ASSURANCE COMMITTEE

1. CONSTITUTION OF THE COMMITTEE

The Audit, Risk and Assurance Committee (ARAC) is a statutory Committee established by the Board of Directors to monitor, review and report to the Board on the suitability and efficacy of the Trust's provisions for governance, risk management and internal control. In addition the Committee will provide assurance to the Trust Board regarding compliance with standards, policies and procedures relating to clinical governance, corporate governance and risk management.

2. PURPOSE AND FUNCTION

The purpose and function of the Committee is to:

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

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

2.3 gain assurance that the Trust risk management strategy, associated policies and processes are in place, fit for purpose, working effectively and are regularly reviewed;

2.4 ensure that the Trust, and Group, has appropriate policies in place to seek assurance over compliance with relevant legislation (e.g. Health and Safety, and Emergency Planning), regulatory standards and the conditions of its licences e.g. Care Quality Commission (CQC) and Human Tissue Authority (HTA), via the Compliance and Assurance Group (CAG);

2.5 seek assurance from the CAG that the findings from any External Reviews are reviewed, and the delivery of any required actions is monitored;

2.6 ensure that the process for responding to clinical litigation claims, as reported to/monitored by the CAG, is robust and that appropriate actions are taken to address any areas for improvement, including the identification of any themes and the sharing of lessons learned;

2.7 ensure that the CAG seeks assurance that processes are in place to verify that policies are regularly reviewed and compliance is monitored, in accordance with the Trust policy on writing policies;

2.8 review the effectiveness of the Trust and Group internal audit function, counter fraud services and external audit function;

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

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

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

3. AUTHORITY

The Committee is:

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

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

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

4. MEMBERSHIP AND QUORUM

MEMBERSHIP

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

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

Committee and a second member will be appointed as Vice-Chair by the Trust Board of Directors.

4.03 The Committee Chair will have recent relevant financial experience, assessed as being appropriate to the role by the Nominations Committee, on behalf of the Board of Directors. It is expected that at least one member will have a formally recognised professional accountancy qualification.

4.04 The membership will include, but is not limited to:

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

4.05 Meeting attendees for specific agenda items will include:

- Chief Finance Officer;
- Deputy Chief Executive Officer;
- Joint Medical Directors;
- Executive Director of Nursing;
- Director of Quality and Safety;
- Chief People Officer;
- Chief Information Officer;
- Director of Communications and Corporate Affairs;
- Trust Secretary;
- Head of Corporate Risk and Assurance;
- Assistant Finance Director – Financial Services; and
- Directors of Operations.

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

4.07 The Senior Independent Director of the Board of Directors will not be Chair of the Audit, Risk and Assurance Committee.

4.08 Only members of the Committee have the right to attend Committee meetings. Alternate, or substitute, members may be agreed in advance with the Chair of the Committee for a specific meeting but not for more than one and will not count towards the quorum. Other non-Committee members may be invited to observe Committee meetings, or to attend and assist the Committee from time to time, according to particular items being considered and discussed.

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

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

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

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

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

4.14 The Council of Governors may nominate one Governor to attend Committee meetings on a quarterly cycle by rotation to observe proceedings. The observation of Board assurance Committees by Governors will be subject to conditions agreed by the Board of Directors. The Chair of the Committee may in exceptional circumstances exclude Governors from being present for specific items.

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

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

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

QUORUM

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

4.19 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will count towards the quorum.

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

5. DUTIES

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

6. FINANCIAL REPORTING

The Committee will:

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

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

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

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

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

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

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

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

7. GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL

The Committee will:

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

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

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

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

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

7.6 review any changes to the profile and scoring of risks included in the Board Assurance Framework, as well as any proposed new risks or risks proposed for closure, as determined by the Board and the Board Committees;

7.7 seek assurance on behalf of the Board of Directors that risks of all types are identified, and managed to an acceptable level, and to undertake a deep dive of

significant risks (those with a residual score of 20 or above)/review Clinical Board governance reports;

7.8 seek assurance that risk management systems and processes are continually developed and monitored to support high standards of clinical care;

7.9 ensure that there is an effective mechanism for reporting, managing and escalating risks to the Board or senior management in accordance with the agreed Risk Management Policy;

7.10 receive a report to identify any approved changes to the Board Assurance Framework, as well as summarising assurances received/gaps in assurance in relation to the identification, management and escalation of risks;

7.11 advise the Trust Board on defining 'acceptable' risk in terms of the Trust Boards risk appetite;

7.12 ensure the risk management process is underpinned by a culture of open and honest reporting and management of any situation that may threaten the quality of the patient experience, staff, visitor, or public safety;

7.13 ensure there are mechanisms in place for training and the dissemination of information on risk management and issues, to all stakeholders, to raise awareness and understanding of risk management for all Trust employees;

7.14 seek assurance from CAG that the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, any related reporting and self-certifications. Work related to counter fraud and security, as required by the NHS Counter Fraud Authority will be reported directly into the Committee;

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

7.16 seek assurance that a process is in place to update the Register of Directors' Interests; and Register of Gifts and Hospitality on a regular basis, and not less than annually.

8. INTERNAL CONTROL AND COUNTER FRAUD

The Committee will:

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

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

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

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

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

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

8.07 consider the effectiveness of Counter Fraud services annually;

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

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

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

9. EXTERNAL AUDIT

The Committee will:

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

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

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

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

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

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

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

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

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

10. OTHER BOARD ASSURANCE FUNCTIONS

The Committee will:

10.01 seek assurance from the CAG on policy compliance and on the maintenance of the policy framework of the Trust and review any significant breaches of the policies (non-financial);

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

raised for the attention of the Audit, Risk and Assurance Committee by the People Committee Chair;

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

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

10.05 seek assurance from the CAG that the findings from External reviews are acted upon (where required) and that any lessons learned are disseminated;

10.06 ensure that the CAG receives regular reports regarding compliance with Business Continuity, Emergency Preparedness and Health and Safety standards/legislation;

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

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

10.09 receive assurance in relation to work of the Clinical Audit function;

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

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

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

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

10.14 In fulfilling its responsibilities, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated

governance, risk management and internal control, together with indicators of their effectiveness.

10.15 Consider matters referred to the Audit, Risk and Assurance Committee by the Board, any Board Committee or any Audit, Risk and Assurance Committee sub-committee; and

10.16 Refer matters to any committee of the Trust for further consideration/review.

11. REPORTING AND ACCOUNTABILITY

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

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

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

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

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

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

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

11.7 The Committee will approve the terms of reference and membership of any of its reporting sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee the work of those sub-committees, receiving reports from them as specified by the ARAC in the sub-committees' terms of reference for consideration and action as necessary;

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

12. COMMITTEE ADMINISTRATION

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

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

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

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

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

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

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

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

Procedural control statement: 11 February 2025
Date approved: [TBA] [Board]
Approved by: Audit, Risk and Assurance Committee 20 February 2025 and Trust Board [TBC]
Trust Board Review date: March 2026

Committee / Group:	**Audit, Risk and Assurance Committee (ARAC)**
Chair:	**David Weatherburn**
Annual Cycle Covered:	**2025/26**

Agenda item A19(i)

Focus:			Audit	R & A	Audit	Audit	R & A	Audit	R & A	Audit	R & A	R & A	
	Lead	**Authors / contacts of the report**	**Apr-25**	**May-25**	**June-25 EXTRAORDINARY**	**Jul-25**	**Sep-25**	**Oct-25**	**Nov-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Notes**
Standing Items													
Apologies for absence	David Weatherburn		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Declaration of interests	David Weatherburn		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	David Weatherburn	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Action log	David Weatherburn	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Committee minutes - Finance & Performance - Quality - People - Charity - Compliance and Assurance Group - Digital & Data	Committee Chairs/members	Kelly Jupp / Lauren Thompson	✓			✓		✓		✓			
Escalations from other Board Committees to ARAC/Escalations from ARAC to other Committees	Committee Chairs	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Escalations to TB	David Weatherburn	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Assurance and Risk Management													
Compliance and Assurance Group Chairs Log	Patrick Garner	Patrick Garner		✓	✓		✓		✓		✓	✓	
Risk Register report	Patrick Garner	Natalie Yeowart		✓	✓		✓		✓		✓	✓	
Risk profile by Clinical Board and Corporate Departments (annual)	Patrick Garner	Natalie Yeowart	✓										
Risk Appetite	Patrick Garner	Natalie Yeowart										✓	
Clinical Board risk deep-dive	Patrick Garner	Natalie Yeowart		✓ SAS CB		✓ MEC CB	✓ SSS CB CS CB		✓ C&D CB	✓ FH CB		✓ C&H CB PO&CC CB	1 or 2 Boards per meeting - risk profile by Board to be used to decide order of attendance. To cover: - focus on risks scored 20+ - training, approach, scoring, effectiveness of controls/actions to mitigate risks - to ask the Clinical Boards to provide in advance
New guidance or mandatory documents	Kelly Jupp	Kelly Jupp											As an when required
Scheme of Delegation/SFIs/SOs	Jackie Bilcliff	Chris Haynes / Kelly Jupp					✓					✓	Bi annual review from July 2024 meeting
Modern Slavery Act Statement	Dan Shelley / Kelly Jupp	Dan Shelley / Kelly Jupp				✓							Review annually as a minimum
Annual Board Assurance Framework and Risk Management Report	Patrick Garner	Natalie Yeowart	✓										
Board Assurance Framework (BAF) and Risk Register Report	Patrick Garner	Natalie Yeowart	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Review findings of other significant assurance functions (outwith internal and external audit)	Kelly Jupp/Patrick Garner	Kelly Jupp/Patrick Garner											As and when required - for example the CQC, NHSI and NHS Resolution
Committee Self-Assessment of effectiveness and Audit Committee Annual Report	Kelly Jupp	Kelly Jupp / Lauren Thompson	✓										
Committee Terms of Reference and Schedule of Business	Kelly Jupp	Kelly Jupp / Lauren Thompson	✓										
Committee Annual Report	Kelly Jupp	Kelly Jupp / Lauren Thompson		✓									
Annual Governance Statement	Patrick Garner	Natalie Yeowart	✓(Draft)		✓(Final)								
Review of the Clinical Audit Process	Rachel Carter	Gavin Snelson				✓				✓			

Financial reporting systems	Jackie Bilcliff	Chris Haynes / Jo Mason	✓										
Assurance from the People Committee as to whether arrangements by which staff may raise concerns are operating effectively	Bernie McCardle	Christine Brereton						✓					Annual - in accordance with the Trust policy on raising concerns
SIRO Report	Shauna McMahon	Shauna McMahon				✓				✓			Six-monthly
Designated Individual Mortuary update including: a. Regulatory Compliance b. Mortuary services improvement plans	Nigel Cooper	Nigel Cooper					✓					✓	
Fuller and HTA reporting	Ian Joy / Michael Wright	Ian Joy / Michael Wright											[Dates to be agreed]
Financial Governance													
Financial Statements timetable and plans	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓(Update)							✓			
Review Accounting issues raised as part of the Financial Statements audit	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓		✓								
Trust Annual Financial Statements and TACs	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓(Draft/Update)		✓(Final)								Prior to Board approval
Charity Annual Financial Statements	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity				✓(Draft)		✓(Final)					Prior to Board approval
Annual Report (including Quality Account)	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity			✓								Prior to Board approval
Corporate Governance Manual update	Kelly Jupp	Kelly Jupp											As and when required
Schedule of Losses and Compensation report	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓			✓		✓		✓			
Standards of Business Conduct Annual Report, including the Chairman's fit & proper persons declaration	Natalie Yeowart, Kelly Jupp and Christine Brereton	Natalie Yeowart, Kelly Jupp and Christine Brereton				✓							
Annual Report - Register of Directors' Interests	Kelly Jupp	Kelly Jupp / Lauren Thompson			✓ (As part of the Annual Report)								
Annual Review of Special Severance Payments / Settlement Agreements	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓										
Debtors and Creditors balances report	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓			✓		✓		✓			
Schedule of Approval of Single Tender Action	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓			✓		✓		✓			
External/Internal Audit Protocol	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity				✓							
Financial Statements Accounting Policies, Estimates and Judgements	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓		✓								
Going Concern Position	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓										
Internal Audit													
Annual Plan	Internal Audit	Internal Audit	✓(Draft)	✓(Final)						✓			
Outcome of Audit Work / Progress Update	Internal Audit	Internal Audit	✓		✓	✓		✓		✓			
Head of Internal Audit Opinion	Internal Audit	Internal Audit	✓(Draft)		✓(Final)								Verbal update at April meeting

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

✓	On agenda and discussed
✓	Item deferred

Terms of Reference – Digital and Data Committee

1. Constitution of the Committee

The Digital and Data Committee is a non-statutory Committee established by the Trust Board of Directors to:

- Provide assurance to the Board on the development and implementation of the Digital Strategy, including the delivery of associated roadmaps;
- Oversee the delivery of significant digital transformation projects, procurement of major or critical digital systems or equipment and the development of the Trust's digital infrastructure; and
- Assure the Trust Board on compliance with legislation/relevant regulations for information governance, cyber security and information security, as well as on the governance of the Trust's data quality.

2. Purpose and function

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

2.01 that the Digital Strategy enables improvements in the efficiency and safety of patient and staff experience, as well as in corporate processes;

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

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

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

2.05 that the Trust's digital resources and assets are being used and maintained effectively and efficiently to ensure value for money;

2.06 on the Trust's compliance with current digital statutory and external reporting standards and requirements;

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

2.08 on the robustness of systems and processes for prioritisation of investments related to the Digital Strategy, including digital infrastructure;

2.09 on compliance with legislation/relevant regulations for information governance and information security, as well as on the governance of the Trust's data quality; and

2.10 on the robustness of processes for review of any Digital and/or Data incidents.

3. Authority

The Committee is:

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

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

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

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

3.5 The Terms of Reference must be approved by the Board of Directors and be reviewed on an annual basis.

4. Membership and quorum

Membership

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

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

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

4.04 In addition to the Non-Executive Chair and Vice Chair of the Committee, the membership of the Committee shall include the:

- Chief Digital Information Officer (Executive Lead);
- Deputy Chief Executive Officer;
- Joint Medical Directors;
- Associate Medical Director – Digital
- Senior Information Risk Owner (SIRO);
- Chief Finance Officer;

- Director for Commercial Development and Innovation;
- Chief Experience Officer;
- Director of Performance and Governance;
- Deputy Chief Nurse;
- Chief Clinical Information Officer;
- Chief Nursing Information Officer;
- Director of Operations – Clinical & Diagnostic Services Clinical Board;
- Head of Digital Innovation & Delivery;
- Head of Corporate Risk & Assurance; and
- Head of IT Service Management.

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

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

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

4.08 The Chief Digital Information Officer shall act as Executive Lead for the Committee.

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

4.10 The Council of Governors may nominate one governor to attend Committee meetings on a quarterly cycle by rotation to observe proceedings. The observation of Board assurance committees by governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may, in exceptional circumstances, exclude governors from being present for specific items.

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

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

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

Quorum

4.14 The quorum necessary for the transaction of business shall be four members as defined in 4.01 and 4.04 above, including the Chair or Vice Chair.

4.15 Members unable to attend a meeting of the Committee may nominate a suitably qualified deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will count towards the quorum.

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

5. Duties

5.1 Cycle of Business

The Committee will:

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

5.2 Strategies and policies

The Committee will:

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

5.2.2 review guidance for the development and delivery of the digital aspects of the annual planning round;

5.2.3 review, and recommend to the Board of Directors, the Digital Strategy, including key digital performance indicators;

5.2.4 provide advice and support on significant digital policies and transformation programmes prior to their recommendation for approval;

5.2.5 seek assurance that digital policies and plans are aligned to the Trust's agreed approach to the development of place-based, systems and regional working; and

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

5.3 Digital Roadmap

The Committee will:

5.3.1 review the Trust's Digital Roadmap; and

5.3.2 review progress and performance against the approved roadmap and any significant supporting plans and targets and analyse the robustness of any corrective action required.

5.4 Risk

The Committee will:

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

5.4.2 To receive the Executive Oversight Report for information.

5.5 Performance and progress reporting

The Committee will:

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

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

- the Trust's strategic digital priorities;
- cyber security;
- exceptions to compliance with national data targets; and
- risk mitigation.

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

5.5.4 provide regular reports to the Board on assurance around key areas of digital strategy performance, risk, and corrective actions, both retrospectively and prospectively;

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

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

5.5.7 ensure the alignment and consistency of Board assurances, use of data and intelligence, by working closely with the other Board Committees;

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

- Digital Roadmap; and
- Digital Strategy Update Reports to Trust Board.

5.5.9 review and approve the Terms of Reference for, and receive the minutes of, the:
- Digital & Technology Service Delivery Group;
- TBC

5.5.10 receive for information and assurance any Internal Audit reports and external review reports pertaining to the remit of the Committee.

5.6 New technologies and digital innovations

The Committee will:

5.6.1 seek assurance on the development and implementation of new technologies and digital innovations, including Artificial Intelligence (AI).

5.6.2 provide support and advice on the policies and strategies associated with the development and implementation of new technologies and digital innovations for the Trust.

5.6.3 seek assurance over the implementation of digital transformation/change programmes and associated outcomes/benefits.

5.6.4 assure the Trust Board, on a regular basis, of the effectiveness of, and compliance with, any new technologies and innovation strategies and related policies, including the effective prioritisation of innovation projects, the robustness of processes and rigour of decision-making regarding innovations, and report on this as part of the Committee's Annual Report to the Board.

5.7 **Data Quality and Security, Cyber Security and Information Governance**

The Committee will:

5.7.1 seek assurance that the Trust has in place appropriate arrangements for ensuring that technology is secure and up-to-date and that digital systems are protected from cyber threats in accordance with national requirements;

5.7.2 seek assurance on data quality relating to the Trust's systems and processes, including the data quality of mandated and local datasets, Data Protection Impact Assessments, Information Assets and the effectiveness of digital clinical systems;

5.7.3 seek assurance over performance against key information governance standards and requirements, including Freedom of Information requests, data breaches and mandatory information governance training;

5.7.4 provide assurance to the Trust Board that the Trust is compliant with the relevant Data Security and Protection Toolkit standards and national requirements; and

5.7.5 seek assurance over the appropriate storage and processing of records across the Trust including compliance with the General Data Protection Regulation requirements, local policy and subject access requests.

5.8 Investment Prioritisation

The Committee will:

5.8.1 consider and review the priorities for digital investment to align with delivery of the Digital Strategy to be included in the 3-year investment plan (to be considered by the Capital Management Group).

5.9 Statutory compliance

The Committee will:

5.9.1 ensure, on behalf of the Board, that current digital statutory and regulatory compliance and reporting requirements are met;

5.9.2 ensure future digital legislative and regulatory and reporting requirements are identified and appropriate action taken;

5.9.3 consider any proposed changes to Trust Standing Financial Instructions, Standing Orders and Scheme of Delegation in relation to the Digital Strategy prior to their approval by the Audit, Risk and Assurance Committee; and

5.9.4 consider any reports/correspondence from the Information Commissioner relating to digital technology and information governance.

6. Reporting and accountability

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

6.2 The Committee will provide an Annual Report to the Board to inform and / or accompany the Trust's Annual Report. This shall include an assessment of compliance with the Committee's Terms of Reference and a review of the work and effectiveness of the Committee.

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

6.4 The terms of reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

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

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

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

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

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

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

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

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: 12 March 2025
Date approved: 20 March 2025 [D&D Committee] and Trust Board [TBC]
Approved by: Trust Board
Trust Board Review date: March 2026

Committee / Group:	**Data and Digital Committee**
Chair:	**Hassan Kajee**
Annual Cycle Covered:	**2025/26**

Agenda item A19(i)

	Lead	Authors / contacts of the report	May-25	Jul-25	Sep-25	Nov-25	Jan-25	Mar-25	Notes
Standing Items									
Apologies for absence and Declarations of interest	Lead		✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Hassan Kajee	Angela Halliday	✓	✓	✓	✓	✓	✓	
Action log	Hassan Kajee	Lauren Thompson/Kelly Jupp	✓	✓	✓	✓	✓	✓	
Meeting debrief	Hassan Kajee		✓	✓	✓	✓	✓	✓	
Matters requiring escalation and AOB	Hassan Kajee	Lauren Thompson/Kelly Jupp	✓	✓	✓	✓	✓	✓	
Regular Reports									
CIO Report, including digital performance report and partnerships update	Dave Elliott	Angela Halliday	✓	✓	✓	✓	✓	✓	To cover any data quality matters by exception.
Data Security & Protection (DSPT), Information Governance and Cyber Security	Natalie Yeowart	Natalie Yeowart	✓		✓	✓		✓	To cover any IG breaches/reports to the ICO, any significant sharing agreements etc.
BAF/risk report & emerging risks	Natalie Yeowart	Natalie Yeowart	✓(Emerging risks only)	✓(Emerging risks only)	✓	✓	✓(Emerging risks only)	✓	
Digital financial plan/position/investments	David Byrom	David Byrom	✓	✓	✓	✓	✓	✓	
Digital Transformation Update (projects by rotation)	Dave Elliott	Angela Halliday	✓(Digital Change Projects overview)	✓(Tech & AI initiatives)	✓(Tech /Digital Achievements & Challenges)	✓(Updates on two Digital Change Projects)	✓(Updates on two Digital Change Projects)	✓(Examples/ evidence of projects impact on quality, safety, employee/patient experience/digital inclusion)	
Digital/Data incident review	Dave Elliott	Angela Halliday	✓	✓	✓	✓	✓	✓	As and when required
Annual Reports (AR) or updates									
Strategic Digital & Data Priorities/Updates	Dave Elliott	Angela Halliday	✓	✓	✓	✓	✓	✓	
Annual Digital Workplan/Annual Digital Strategy	Dave Elliott	Angela Halliday			✓			✓	
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Dave Elliott / Kelly Jupp / Lauren Thompson	Kelly Jupp / Lauren Thompson	✓					✓	To include effectiveness consideration. ToR and SoB in March and Committee Annual Report in May
Ad Hoc reports (tabled as required)									
Draft standing agenda	Dave Elliott / Kelly Jupp	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	
External/Internal audit/review reports related to Digital & Data	Dave Elliott	Angela Halliday	✓	✓	✓	✓	✓	✓	E.g. data quality, penetration testing etc

✓	On agenda and discussed
	Item deferred

Terms of Reference – Finance & Performance Committee

1. Constitution of the Committee

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

2. Purpose and function

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

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

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

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

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

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

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

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

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

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

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

- Investment Strategy (regarding investments in services and business cases);
- Commercial Strategy;
- Procurement Strategy; and

- Sustainability (Shine Report).

3. Authority

The Committee is:

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

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

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

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

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

4. Membership and quorum

Membership

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

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

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

4.04 The membership of the Committee shall include:

- a Non-Executive member;
- the Chief Finance Officer;
- the Deputy Chief Executive Officer;
- the Chief Information Officer;

- the Director of Estates, Facilities and Strategic Partnerships; and
- the Director for Commercial Development and Innovation.

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

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

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

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

4.09 The Council of Governors may nominate one Governor to attend Committee meetings on a quarterly cycle by rotation to observe proceedings. The observation of Board assurance Committees by Governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may, in exceptional circumstances, exclude governors from being present for specific items.

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

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

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

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

Quorum

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

4.15 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will count towards the quorum.

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

5. Duties

5.1 Cycle of Business

The Committee will:

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

5.2 Strategies and policies

The Committee will:

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

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

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

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

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

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

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

5.3 Annual Financial Plan

The Committee will:

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

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

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

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

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

5.4 Risk

The Committee will:

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

5.4.2 To receive the Executive Oversight Report for information.

5.5 Performance and progress reporting

The Committee will:

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

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

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

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

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

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

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

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

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

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

5.5.9 review and approve the Terms of Reference for, and receive the Chairs Logs and minutes of, the:

i) Supplies and Services Procurement Group;
ii) Capital Management Group;
iii) Strategy, Planning and Capital Investment Group;
iv) Financial Recovery Steering Group;
v) Sustainable Healthcare Committee; and
vi) Any time-limited Strategic Oversight Groups created which are aligned to the Committee.

5.6 Capital, investments, acquisitions and disposals

The Committee will:

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

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

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

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

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

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

5.7 Commercial strategy

The Committee will:

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

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

5.8 Subsidiary company reporting

The Committee will:

5.8.1 monitor the effectiveness of subsidiary company/companies financial and operational performance reporting systems, ensuring that the Board is assured of continued compliance through its annual reporting processes, reporting by exception where required to the Board.

5.9 Statutory compliance

The Committee will:

5.9.1 ensure, on behalf of the Board, that current statutory and regulatory compliance and reporting requirements are met, including compliance with treasury policies and procedures and the appropriate safeguards for security of the Trust's funds as an NHS Foundation Trust;

5.9.2 ensure the proper reporting of actions deemed "high-risk" by regulators, or actions with an equity component, which entail a potentially significant risk to reputation or to the stability of the business of the Trust, or which create material contingent liabilities;

5.9.3 ensure future legislative and regulatory and reporting requirements are identified and appropriate action taken; and

5.9.4 consider, and recommend for approval by the Audit, Risk & Assurance Committee, any proposed changes to Trust Standing Financial Instructions, Standing Orders and Scheme of Delegation.

6. Reporting and accountability

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

6.2 The Committee will provide an Annual Report to the Board to inform and / or accompany the Trust's Annual Report. This shall include an assessment of compliance with the Committee's Terms of Reference and a review of the work and effectiveness of the Committee.

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

6.4 The terms of reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

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

7.2 The Chair may at any time convene additional meetings, or Extraordinary meetings of the Committee to consider business that requires urgent attention.

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

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

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

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

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

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: February 2025
Date approved: 25 February 2025 [Finance & Performance Committee] and [TBC] [Board]
Approved by: Finance & Performance Committee and Board
Trust Board Review date: March 2026

Committee / Group:	**Finance & Performance Committee**
Chair:	**Bill MacLeod**
Annual Cycle Covered:	**2025/26**

	Lead	Authors / contacts of the report	Apr-25	May-25	Jun-25	Jul-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Notes
Standing Items														
Apologies for absence	Bill MacLeod		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Declaration of interests	Bill MacLeod		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Bill MacLeod	Kelly Jupp / Lauren Thompson		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Action log	Bill MacLeod	Kelly Jupp / Lauren Thompson		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Meeting debrief, matters requiring escalation and AOB	Bill MacLeod	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Regular Reports														
Finance report [Including KPIs, CIP, cquins, risks, capital summary, balance sheet updates]	Jackie Bilcliff	Claire Garrity / Jo Mason / Chris Haynes	✓	✓	✓		✓	✓	✓		✓	✓	✓	
Finance Committee Risk Report and New/emerging risks	Natalie Yeowart	Natalie Yeowart		✓			✓				✓		✓	Committee members will discuss any new and emerging risks at each meeting where relevant
Financial Recovery Plan	Jackie Bilcliff	Claire Garrity / Jo Mason / Chris Haynes		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Capital Plan and capital projects update (4 x a year)	Rob Smith / Jackie Bilcliff	Claire Garrity / Lynsey Allen		✓			✓			✓			✓	
Focused Performance updates	Patrick Garner / Rob Harrison	Hannah Morrison	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	M1 - Elective waits and Children & Young People KPIs M2 - Cancer and Diagnostics M3 - Emergency Care and other supporting updates as required
Procurement Plan/Update [4 x a year]	Dan Shelley	Dan Shelley			✓			✓			✓		✓	
Summary of Internal Audit reports relating to the F&P Committee	Natalie Yeowart	Natalie Yeowart	✓			✓		✓			✓			
Management Group Minutes:														
- Supplies & Service Procurement Group (SSPC) minutes [when available]	Bill MacLeod	Dan Shelley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
- Sustainable Healthcare Committee	Bill MacLeod	James Dixon	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
- Capital Management Group (CMG) minutes [when available]	Bill MacLeod	Lynsey Allen	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
- Strategy, Planning and Capital Investment Group (SPCIG) minutes [when available]	Bill MacLeod	Lynsey Allen	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
- Financial Recovery Steering Group minutes	Jackie Bilcliff	Claire Garrity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
- Any Strategic Oversight Group minutes as required	Bill MacLeod	Kelly Jupp	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Review of Commercial Schemes	Vicky McFarlane-Reid	Wayne Elliott				✓		✓			✓			Quarterly
Clinical Board / Corporate Service Updates	Rob Harrison	Hannah Morrison		✓	✓ FH CB	✓ PO&CC CB	✓ C&H CB	✓ SAS CB	✓ CS CB	✓	✓ C&D CB	✓ MEC CB	✓ SSS CB	
Sustainability (Shine Report)	James Dixon	James Dixon				✓					✓			JD to attend twice a year. Report to Board twice a year.
Annual Reports (AR) or updates														
Annual Report & Accounts Draft/Final	Jackie Bilcliff	Claire Garrity / Jo Mason / Chris Haynes		✓	✓									
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Kelly Jupp	Kelly Jupp / Lauren Thompson	✓										✓	
Revenue and budget setting	Jackie Bilcliff	Claire Garrity	✓										✓	
Capital expenditure deep dive, including PFI	Rob Smith / Jackie Bilcliff	Claire Garrity / Lynsey Allen / Russell Jones / Chris Haynes					✓				✓			
Month 12/year-end report	Jackie Bilcliff	Claire Garrity / Jo Mason	✓											
National Cost Collection	Jackie Bilcliff	Claire Garrity / Jo Mason					✓							
Plan /Plan updates (Finance and Activity)	Jackie Bilcliff Vicky McFarlane Reid	Claire Garrity / Kerry Leonard	✓								✓		✓	
Subsidiary company updates														
NHPL Report (twice a year)	Julie Swaddle	Julie Swaddle					✓						✓	
Ad-hoc reports to be considered														
Waiting List Size Activity and Finance Considerations	Jackie Bilcliff Vicky McFarlane Reid	Claire Garrity / Kerry Leonard			✓									
Commercial strategy / Updates [twice a year]	Vicky McFarlane-Reid	Kerry Leonard		✓					✓					
Briefing on the new Procurement Act 2023	Dan Shelley	Dan Shelley					✓							
Policies and procedures e.g. Treasury management, Investment management as required in accordance with the SFIs/SoD	All	Kerry Leonard / Dan Shelley / Chris Haynes / Kelly Jupp												

	Lead	Authors / contacts of the report	Apr-25	May-25	Jun-25	Jul-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Notes
Business cases / investment proposals [as and when required in accordance with the SoD/SFIs/SoD]	Vicky McFarlane-Reid / All	Kerry Leonard / Dan Shelley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Schedule of Business Cases to be shared at the March 2025 Committee meeting for 2025/26
GIRFT/Model Hospital [to report by exception as required]	Rob Harrison	Hannah Morrison		✓										
Finance and Investment strategies	Jackie Bilcliff	Claire Garrity / Jo Mason / Chris Haynes					✓							
Business Cases not approved	Vicky McFarlane-Reid	Kerry Leonard	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
ED Business Case Update	Vicky McFarlane-Reid	Kerry Leonard					✓							
Estates Capital Schemes														
[Capital items to be added once Capital Programme finalised]														
Contracts														Contracts schedule for 2025/26
Medicines Manufacturing Centre	Vicky McFarlane-Reid	Kerry Leonard	✓											
Taxi Services	Dan Shelley	Procurement team members			✓									
Orthotics Services	Dan Shelley	Procurement team members				✓								
Caresite Cannulation Packs	Dan Shelley	Procurement team members				✓								
Bespoke Membrane Oxygenator Kits	Dan Shelley	Procurement team members				✓								
Neuroradiology Consumables	Dan Shelley	Procurement team members				✓								
Radiology Consumables	Dan Shelley	Procurement team members				✓								
CISCO Licence Support	Dan Shelley	Procurement team members				✓								
Catering - Meals to Go and prepared meals	Dan Shelley	Procurement team members				✓								
NECTAR Specialist Critical Care Ambulance	Dan Shelley	Procurement team members					✓							
Internal & External Fixation (Trauma)	Dan Shelley	Procurement team members					✓							
Linen	Dan Shelley	Procurement team members					✓							
Radiology PACS	Dan Shelley	Procurement team members				✓								
Minimally Invasive Surgical Consumables, Surg. Stapling and Sutures	Dan Shelley	Procurement team members							✓					
Home Delivery, Enteral Feeds	Dan Shelley	Procurement team members							✓					
Document Management System	Dan Shelley	Procurement team members							✓					
Pharmacy Isolators	Dan Shelley	Procurement team members							✓					
Endoscopy Consumables	Dan Shelley	Procurement team members									✓			
Renal Dialysis	Dan Shelley	Procurement team members									✓			
Prosthetics Service	Dan Shelley	Procurement team members											✓	
Manual Wheelchairs	Dan Shelley	Procurement team members											✓	

✓	On agenda and discussed
	Item deferred

Terms of Reference – People Committee

1. Constitution and Authority

1.1. The People Committee is a non-statutory Committee (the Committee) constituted as a standing committee of the Trust Board of Directors (the Board). The Terms of Reference shall be reviewed by the Committee and any changes to these must be approved by the Board of Directors, at least annually.

1.2. The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference and to seek any information it requires from any officer of the Trust to support its work, as and when required.

1.3. The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

2. Purpose

2.1. The purpose of the Committee is to seek assurance, on behalf of the Board that the Trust's People agenda is aligned to the strategic priorities and is delivered through the people plan which includes, but is not limited to:

- equality, diversity and inclusion (EDI)
- culture and staff experience
- workforce plans, recruitment retention
- health and well-being
- education and training
- learning and development
- communications and engagement

3. Duties

3.1. The Committee will provide support and challenge on the development and review of the Trust's People Plan and related workforce strategies to achieve it. Its duties will include, but are not limited to:

a. Receiving regular reports to scrutinise the delivery of the People Plan and related people priorities.

b. Reviewing risks held on the Board Assurance Framework (BAF) pertaining to the Committees area of focus and seeking assurance that these are effectively managed. The Committee will provide assurance to the Audit, Risk and Assurance Committee on the effectiveness of these risks.

c. Reviewing the Trust's priorities and plans against the Workforce Race Equality Standards (WRES); Workforce Disability Standards (WDES); the NHS EDI Improvement Plan; Gender Pay Gap; and the Equality Delivery System.

d. Receiving reports to review performance against key people performance indicators.

e. Monitoring staff experience through staff surveys, pulse surveys and the performance dashboard from the Freedom to Speak Up Guardian.

f. Reviewing the Trust's education strategies and plans and seek assurance on the requirements, reporting and recommendations from external partners, professional bodies and regulators in relation to the standards of education and training provided by or at the Trust.

g. Providing support and challenge on the development of the Trust's engagement and communications strategies and related programmes of work and reviewing the effectiveness of communications and engagement.

h. Reviewing workforce related Internal and External Audit reports/findings and the implementation of any associated audit recommendations.

i. Monitoring Trust compliance against legislative and other regulatory workforce requirements including the NHS People Promise.

j. Reviewing and approving the Terms of Reference for, and receive the Chairs Logs and minutes of, the People Programme Board.

3.2. The Committee will set an annual Cycle of Business and will report to the Board on its progress, escalating issues of concern where necessary.

4. Membership and quorum

4.1. Members of the Committee shall be appointed by the Trust Board of Directors and include at least three Non-Executive Directors and three Executive Team members.

4.2. One of the non-executive members will be appointed by the Trust Board of Directors as the Chair of the Committee and another as Vice Chair (who will chair the meeting in the absence of the Committee Chair if required).

4.3. The membership of the Committee shall be:

- Three Non-Executive Directors
- The Deputy Chief Executive (The Deputy Chief Executive, or other designated executive lead for People shall act to fulfil the role of Executive lead for the Committee)
- The Executive Director of Commercial Development and Innovation
- The Executive Director of Nursing
- A Joint Medical Director
- The Director of Communications & Corporate Affairs
- The Chief Experience Officer
- The Associate Director of People and Organisational Development

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

4.5. Members are expected to attend all meetings. Members unable to attend a meeting of the Committee may by exception nominate a deputy to attend on their behalf, agreed in advance with the Chair of the Committee.

4.6. Only members of the Committee have the right to make decisions in relation to Committee business. Other non-Committee members may be invited attend, with agreement of the Chair, to assist the Committee from time to time, according to particular items being considered and discussed.

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

4.8. The Council of Governors may nominate one Governor to attend Committee meetings on a quarterly cycle by rotation to observe proceedings. The observation of Board assurance Committees by Governors will be subject to conditions agreed by the Board of Directors. The Chair of the Committee may in exceptional circumstances exclude Governors from being present for specific items.

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

Quorum

4.10. The quorum necessary for the transaction of business shall be four members, as defined in 4.3 above, with at least two Non-Executive Directors present. Nominated deputies will count towards the quorum.

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

5. Committee Administration, Reporting and Accountability

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

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

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

5.4. Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less

than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than three working days before the date of the meeting.

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

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

5.7. The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten working days of the meeting. A Chairs Log will be produced which will be included in the Public Board of Directors papers.

5.8. The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors, and produce an Annual Committee Report outlining how the Committee has discharged its responsibilities and met its Terms of Reference.

5.9. The Committee Chair will report formally to the Trust Board of Directors on matters requiring escalation after each People Committee meeting.

Procedural control statement: March 2025
Date approved: 18 March 2025 [People Committee] and [TBC] [Trust Board]
Approved by: People Committee and Board
Trust Board review date: March 2026

Agenda item A19(i)

Committee / Group:	**People Committee**
Chair:	**Bernie McCardle**
Executive Lead:	**Vicky McFarlane-Reid**
Year:	**2025/26**

	Lead	Authors / contacts of the report	May-25	Jul-25	Sep-25	Nov-25	Jan-26	Mar-26	Notes
Standing Items									
Apologies for absence and Declarations of interest	Bernie McCardle		✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Bernie McCardle	Lauren Thompson / Gillian Elsender	✓	✓	✓	✓	✓	✓	
Action log	Bernie McCardle	Lauren Thompson / Gillian Elsender	✓	✓	✓	✓	✓	✓	
Meeting debrief	Bernie McCardle		✓	✓	✓	✓	✓	✓	
Matters requiring escalation and AOB	Bernie McCardle	Lauren Thompson / Gillian Elsender	✓	✓	✓	✓	✓	✓	
New and emerging risks	Bernie McCardle		✓	✓	✓	✓	✓	✓	
Integrated Board Report (IBR) including People and Culture Dashboard - Headlines	Paul Turner	Deb Stuart	✓	✓	✓	✓	✓	✓	The full IBR will be included in the Reading Room.
People Plan - Year 2 Delivery Plan - Overview	Donna Watson	Donna Watson	✓	✓	✓	✓	✓	✓	Incorporate CQC updates as required
People Plan - Deep dive on themes	Vicky McFarlane-Reid	Donna Watson	✓	✓	✓	✓	✓	✓	Each meeting will focus on x2 themes of the people plan: Health and Wellbeing, Valued and Heard, Behaviours and Civilities and Leadership and Management
Board Assurance Framework Report	Vicky McFarlane-Reid	Natalie Yeowart	✓	✓	✓	✓	✓	✓	Committee to approve the BAF for ratification at Audit, Risk and Assurance Committee and Trust Board
Regular Reports									
Employee Relations	Paul Turner	Deb Stuart	✓			✓			Biannual updates scheduled - further updates to be shared if required.
Summary of Internal Audit reports relating to the People Committee	Patrick Garner / Natalie Yeowart	Natalie Yeowart		✓	✓		✓	✓	
Equality, Diversity and Inclusion Update	Vicky McFarlane-Reid	Karen Pearce	✓	✓		✓	✓		4x per year
NHS Staff survey, staff engagement and culture plans/updates	Vicky McFarlane-Reid	Donna Watson	✓		✓		✓	✓	4x per year To include: - Culture - Annual staff experience survey - Annual staff survey
Guardian of Safe Working	Henrietta Dawson	Henrietta Dawson		✓	✓	✓	✓	✓	HD to attend twice a year (July & January). Quarterly Reports. Reports go to Trust Board.
Freedom To Speak Up (FTSU) Guardian	Jill Taylor	Jill Taylor	✓		✓		✓		FTSUG is incorporated in the Valued and Heard update. Report to Board twice a year.
People learning development update	Donna Watson	Donna Watson		✓			✓		
Communications strategy/strategic communications and external engagement update	Caroline Docking	Cerys Bodey			✓			✓	2x per year
Deep Dive Reports (New category added - some were in Ad Hoc)									
Violence & Aggression to staff	Ian Joy	Tim White	✓			✓			
Sickness Absence	Vicky McFarlane-Reid	Paul Turner		✓			✓		
Retention, Turnover and Workforce Plans	Vicky McFarlane-Reid	Paul Turner			✓			✓	
Recruitment and Selection	Vicky McFarlane-Reid	Paul Turner		✓			✓		
Ad hoc Clinical Board Deep Dives as required	Vicky McFarlane-Reid	Donna Watson/Paul Turner		✓	✓	✓	✓		
Ad hoc as identified by Chair / committee (if required)	Vicky McFarlane-Reid	Donna Watson	✓	✓	✓	✓	✓	✓	
Annual Reports (AR) or updates									
People Strategy and Year priorities	Vicky McFarlane-Reid	Donna Watson	✓						
Development of the Trust Workforce Plan (New item)	Vicky McFarlane-Reid /Donna Watson	Donna Watson						✓	
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Kelly Jupp / Lauren Thompson /Vicky McFarlane-Reid/Donna Watson	Kelly Jupp / Lauren Thompson	✓					✓	To include effectiveness consideration Terms of Reference and Schedule of Business to be approved at March Committee Annual Report of Committee to be presented at May Committee
GMC training survey	Michael Wright / Ifti Haq	Ifti Haq				✓			
Gender Pay Report	Vicky McFarlane-Reid	Karen Pearce						✓	
WRES & WDES	Vicky McFarlane-Reid	Karen Pearce	✓						
Workforce Profile & Demographics update	Vicky McFarlane-Reid	Paul Turner				✓			
Legal Update	Vicky McFarlane-Reid	Deb Stuart	✓						
Annual Conversation with Executive Directors	Michael Wright / Ian Joy	Ruth Hall / Diane Cree		✓			✓		
Trade Union Faculty Time Report	Vicky McFarlane-Reid	Paul Turner		✓					
Ad Hoc reports (tabled as required)									
People Programme Board Chairs Log and minutes	Donna Watson	Deb Stuart	✓	✓	✓	✓	✓	✓	To incorporate updates from the Learning and Education Group, HWB Group and EDI Steering Group. The People Programme Board minutes will be received in the Reading Room.

Terms of Reference – Quality Committee

1. Constitution of the Committee

The Quality Committee is a non-statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience.

2. Purpose and function

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

2.1 that the Trust has appropriate quality governance structures, systems, processes and controls in place to achieve consistently safe high-quality care and to meet the Trust's legal and regulatory obligations;

2.2 on the Trust's approach to, and delivery of, continuous quality improvement so that is a hallmark of the way the Trust and its people work, recognised by stakeholders, including partners and the public;

2.3 that any shortcomings in the quality and safety of care against agreed standards are being identified and addressed in a systematic and effective manner;

2.4 on the Trust's research and development activities and its clinical practice, acting as a guardian and advocate; and to seek assurance that the Trust has a robust mechanism of research governance which is subject to regular scrutiny and monitoring;

2.5 on the quality impact of changing professional and organisational practices, including those involved in increased system-based and partnership working (in collaboration with the People Committee);

2.6 that the Trust fulfils its leadership and influencing role on service quality, standards and practice, as an organisation of national importance, as a significant service provider and as a partner in training, education and development of health and care capacity in the region (in collaboration with the People Committee) and beyond;

2.7 around current and future statutory and mandatory quality and patient safety standards, such as Care Quality Commission (CQC) Fundamental Standards, and the actions needed to meet them;

2.8 on the effectiveness of mechanisms used for the involvement of patients and the public, staff, partners and other stakeholders in improving quality assurance and patient safety at the Trust, and report on their value and impact to the Board; and

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

3. Authority

The Committee is:

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

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

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

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

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

4. Membership

4.01 Members of the Committee shall be appointed by the Board of Directors and shall be made up of least seven members drawn from Non-Executive Directors (three members minimum) and members of the Executive team (four members).

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

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

4.04 The membership shall include:

- the Joint Medical Directors;
- the Executive Director of Nursing;
- the Deputy Chief Executive Officer or nominated Executive Lead ;
- the Director of Quality and Safety;
- the Associate Medical Director, Patient Safety and Quality;
- the Chief Experience Officer;
- the Deputy Director of Nursing;
- the Director of Midwifery;

- Associate Director of AHP's and Therapy Services;
- Single Clinical Board Representation at each meeting responsible for Quality and Safety; and the Chairs of the Tier 2 committees reporting to Quality Committee if not previously mentioned above.

4.05 The Chair of the Board of Directors and the Chief Executive shall not be members of the Committee, but may be in attendance.

4.06 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed. This may include representatives from the North East & North Cumbria Integrated Care Board.

4.07 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings.

4.08 The Executive Director of Nursing shall act as the Executive Lead for the Committee.

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

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

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

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

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

Quorum

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

4.15 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will count towards the quorum.

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

5. Duties

5.1 Cycle of Business

The Committee will:

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

5.2 Strategy

The Committee will:

5.2.1 advise and contribute to the strategic quality priorities and investments needed to support high-quality clinical outcomes and improve clinical effectiveness in the Trust, and advise the Board accordingly;

5.2.2 review the Trust's Quality Strategy, Quality Account and related delivery plans and programmes, and provide informed advice to the Board on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact;

5.2.3 take note of international intelligence and research evidence on clinical safety and practice and distil their relevance to the Trust's strategic quality priorities (including where necessary commissioning research to inform its work);

5.2.4 be assured around the monitoring of the Trust's suite of quality-assurance policies against benchmarks to ensure they are comprehensive, up-to-date and reflect best practice; and

5.2.5 scrutinise and triangulate advice on the development of significant clinical and quality policies prior to their adoption.

5.3 Risk

The Committee will:

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

5.3.2 to receive the Executive Oversight Report for information.

5.4 Outcomes and processes

The Committee will:

5.4.1 review the Quality Account to be assured it reflects the integration of clinical quality and patient safety improvement processes;

5.4.2 be assured of the integrity of the Trust's control systems, processes and procedures relating to critical areas, to include:

- high quality care (through the Trust's quality review processes);
- compliance with fundamental standards of quality and safety;
- patient safety and harm reduction;
- safeguarding – adults and children
- infection prevention and control;
- clinical audit;
- introduction of new clinical pathways and procedures;
- introduction of new clinical roles (in conjunction with the People Committee);
- dissemination and implementation of statutory guidance;
- escalation and resolution of quality concerns; and
- patient and carer involvement and engagement.

5.4.3 ensure the effective operation of processes relating to clinical practice and performance, including early detection of issues and problems, escalation, corrective action and learning.

5.5 Learning and communication

The Committee will:

5.5.1 be assured of the effectiveness of systems and processes used for continuous learning, innovation and quality improvement, establishing ways of gaining assurance that appropriate action is being taken;

5.5.2 be assured that the robustness of procedures ensure that adverse incidents and events are detected, openly investigated, with lessons learned being promptly applied and appropriately disseminated in the best interests of patients, of staff and of the Trust;

5.5.3 be assured that evidence-based practice, ideas, innovations and statutory and best practice guidance are identified, disseminated and applied within the Trust;

5.5.4 develop and oversee a programme of activities to engage Board members directly in quality assurance processes and to ensure that such processes include the establishment of a procedure to review, distil and implement the learning from these activities, including 'walk-abouts' and informal visits, reviews, focus groups and deep-dives; and

5.5.5 be assured of the effectiveness of communication, engagement and development activities designed to support patient safety and improve clinical governance.

5.6 Patient and public engagement

The Committee will:

5.6.1 be assured of the effectiveness of a credible process for assessing, measuring and reporting on the 'patient experience' in a consistent way over time, including the appropriateness and effectiveness of processes for patient engagement in support of the Trust's strategic goals and programmes of work.

5.8 Progress and performance reporting

The Committee will:

5.8.1 review a range of evidence and data from multiple sources, including management and executive committees and groups, on which to arrive at informed opinions on:

- the standards of clinical, service quality and patient safety in the Trust;
- compliance with agreed standards of care and national targets and indicators; and
- organisational quality performance measured against specified standards and targets;

5.8.2 review a succinct set of key performance and progress measures relating to the full purpose and function of the Committee;

5.8.3 review progress against these measures on a regular basis and seek assurance around any performance issues identified, including proposed corrective actions and reporting any significant issues and trends to the Board of Directors;

5.8.4 review and shape the quality-related content of the Quality and Performance Reports to the Board of Directors;

5.8.5 agree the programme of benchmarking activities to inform the understanding of the Committee and its work;

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

5.8.7 ensure alignment of the Board assurances and consistent use of data and intelligence, by working closely with the Audit, Risk and Assurance Committee, People Committee and the Finance & Performance Committee;

5.8.8 review the following formal reports prior to submission to the Board of Directors as part of the Annual Cycle of Business:

- an Annual Quality Report to inform and / or accompany the Trust's Annual Report;
- Infection Prevention and Control Annual Report;
- Safeguarding Annual Report; and
- the process for management review of specific service reports.

5.9 Statutory and regulatory compliance

The Committee will:

5.9.1 be assured of the arrangements for ensuring maintenance of the Trust's compliance standards specified by the Secretary of State, the CQC, NHS England, and statutory regulators of health care professionals.

6. Reporting and Accountability

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

6.2 The Committee will provide an Annual Report to the Board to inform and / or accompany the Trust's Annual Report. This shall include an assessment of compliance with the Committee's Terms of Reference and a review of the effectiveness of the committee.

6.3 The Chair of the Committee shall provide an annual update to the Council of Governors on the work of the Committee.

6.4 The Terms of Reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

7. Committee Administration

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

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

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

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

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

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

7.7 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of

Committee meetings shall be made available promptly to all members of the Committee, normally within ten days of the meeting.

7.8 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors.

Procedural control statement: 18 March 2025
Date approved: 18 March 2025 [Quality Committee] and [TBC] [Board]
Approved by: Quality Committee and Board
Trust Board Review date: March 2026

Committee / Group:	**Quality Committee**
Chair:	**Committee Chair**
Annual Cycle Covered:	**2025/26**

	Lead	Authors / contacts of the report	Apr-25	May-25	Jun-25	Jul-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Notes
Standing Items														
Apologies for absence	Committee Chair		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Declaration of interests	Committee Chair		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Committee Chair	Lauren Thompson / Gill Elsender	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Action log	Committee Chair	Lauren Thompson / Gill Elsender	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Meeting debrief and matters requiring escalation	Committee Chair	Lauren Thompson / Gill Elsender	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Regular Reports														
Chairs Logs of Tier 2 Committees	Mike Clarke /Gus Vincent / Ian Joy/Julie Swaddle/Lucia Pareja-Cebrian	As below	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Management Group Chair Reports / Chairs Log														
• Patient Safety Group (PSG)	Mike Clarke	Steve Stoker	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
• Experience of Care Group	Ian Joy	Ian Joy / Diane Cree		✓		✓		✓		✓		✓		
• Clinical Outcomes & Effectiveness Group (COEG)	Gus Vincent	Steve Stoker		✓		✓	✓		✓		✓		✓	
• Medicines Management Group	Ian Joy	Julie Swaddle												Julie Swaddle to update
• Care for all Group	Lucia Pareja-Cebrian													Group to be established, no dates yet
• Transplantation Committee (for receipt only)	Lucia Pareja-Cebrian	Cerys Bodey	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Safeguarding	Ian Joy	Diane Cree			✓(Q4 AR)		✓(Q1)		✓(Q2)				✓(Q3)	
Learning from Deaths	Rachel Carter	Danielle Smith/ Pippa Breakspear-Dean	✓(Q4 AR)			✓(Q1)				✓(Q2)			✓(Q3)	
Learning Disability	Ian Joy	Diane Cree			✓(Q4)		✓(Q1)		✓(Q2)				✓(Q3)	
Perinatal Quality Surveillance Report, including Maternity Incentive Scheme update	Ian Joy	Jenna Wall	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Integrated Board Report	Rob Harrison	Hannah Morrison / Patrick Garner	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
CQC Updates	Rachel Carter / Ian Joy / Rob Harrison / Others	Pippa Breakspear-Dean/Hannah Morrison/Diane Cree	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Patient and Staff Experience	Annie Laverty	Cerys Bodey		✓		✓		✓		✓		✓		Bi-Monthly
Quality Committee Board Assurance Framework	Natalie Yeowart	Natalie Yeowart	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Legal Update & Learning from Claims	Rachel Carter	Emma Stonehouse / Pippa Breakspear-Dean	✓					✓						Changed to biannually in agreement with Ian and A
Wards of concern & Accrediting Excellence (ACE) Progress Report	Ian Joy	Diane Cree		✓		✓		✓		✓		✓		
Summary of Internal Audit Reports relating to the Quality Committee	Natalie Yeowart	Natalie Yeowart	✓			✓		✓			✓			
Cancer Patient Harm Reviews	Lucia Pareja-Cebrian	Gail Jones					✓						✓	Biannually
Duty of Candour	Rachel Carter	Jo ledger	✓					✓						Biannually
Infection Prevention Control Update (IPC)	Julie Samuel	Cheryl Teasdale				✓					✓			
Equality Impact Assessment (EIA)	Ian Joy	Jo McCallum					✓						✓	Biannually
Quality Performance Reviews	Ian Joy	Rachel Carter			✓		✓			✓			✓	Q&S focused QPRs occur quarterly (May, Jul, Nov & Feb) therefore scheduled a report for the following month to Quality Committee.
Annual/Biannual Reports														
PLACE Inspection Update Report	Paul Hanson	Lynsey Allen			✓									
End of Life and Palliative Care	Ian Joy	Diane Cree		✓					✓					
Quality Account Priorities	Rachel Carter	Louise Hall / Pippa Breakspear-Dean		✓					✓					
Equality Delivery System Annual Report	Ian Joy	Diane Cree							✓					
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Kelly Jupp / Lauren Thompson	Kelly Jupp / Lauren Thompson		✓									✓	ToR & SoB in March Committee Annual Report in May
Clinical Audit / Guidelines Report	Rachel Carter	Gavin Snelson / Pippa Breakspear-Dean					✓						✓	

Agenda item A19(i)

Committee / Group:	**Quality Committee**
Chair:	**Committee Chair**
Annual Cycle Covered:	**2025/26**

	Lead	Authors / contacts of the report	Apr-25	May-25	Jun-25	Jul-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Notes
Strategy														
PSIRF/PSIRF Updates	Rachel Carter	Louise Hall / Pippa Breakspear-Dean		✓			✓			✓			✓	
Quality Priorities Updates	Rachel Carter	Louise Hall / Pippa Breakspear-Dean			Quality Priority 1	Quality Priority 2		Quality Priority 3	Quality Priority 4		Quality Priority 5	Quality Priority 6		
Ad Hoc reports to be considered														
Policies/Internal audit reports [as and when required]	Exec Lead	Exec PA												
Clinical Strategy – AD HOC	Michael Wright/Lucia Pareja-Cebrian	Kerry Leonard												
Patient Safety - update on Marthas rule	Lucia Pareja-Cebrian	Gus Vincent												
Alliance developments	Committee Chair/Others	Committee Chair/Others												
Progress Reports from Any External Reviews i.e. Fuller, GIRFT, RCS	Executive Lead	Executive Leads												

✓	On agenda and discussed
✓	Item deferred

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025					
Title	Public, Private and Charity Trust Board Schedules of Business for 2025/26					
Report of	Kelly Jupp, Trust Secretary					
Prepared by	Lauren Thompson, Corporate Governance Manager and Deputy Trust Secretary					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☐	☐			
Summary	The Public and Private Trust Board Schedules of Business (SoB) have been drafted for 2025/26 and shared for review with the Executive Team and the Interim Shared Chair. Minor changes have been made to reflect: - Updated responsibilities, governance arrangements and strategic priorities. - Changes to Director role titles. - To incorporate updates from the Newcastle Hospitals Pharmaservices Limited (NHPL) including the approval of the Board Terms of Reference, annual report and annual accounts. - Bi-annual update will be received from the Freedom to Speak Up Guardian [FTSUG]. A new SoB for the Corporate Trustee of Newcastle Hospitals Charity Private Charity Board of Directors has been drafted for 2025/26 and shared for review with the Director of Communications and Corporate Affairs and the Charity Director.					
Recommendation	The Trust Board is asked to review and approve the updated 2025/26 Schedules of Business for Public, Private and Charity Trust Board meetings.					
Links to Strategic Objectives	Performance – Being outstanding, now and in the future.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link.					
Reports previously considered by	Annual Review.					

Committee / Group:	**Public Board of Directors**
Chair:	**Sir Paul Ennals**
Annual Cycle Covered:	**2025/26**

Meeting date	**23/05/2025**	**25/07/2025**	**26/09/2025**	**28/11/2025**	**TBC 2026**	**TBC 2026**		
Deadline for papers	**13/05/2025**	**15/07/2025**	**16/09/2025**	**18/11/2025**	**TBC 2026**	**TBC 2026**		

	Lead	Authors / contacts of the report	May-25	Jul-25	Sep-25	Nov-25	Jan-26	Mar-26	Notes
Standing items									
Apologies for absence	Paul Ennals		✓	✓	✓	✓	✓	✓	
Declaration of interests	Paul Ennals		✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Paul Ennals	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	
Action log	Paul Ennals	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	
Any other business	Paul Ennals		✓	✓	✓	✓	✓	✓	
Chair Report	Paul Ennals	Vic Champion	✓	✓	✓	✓	✓	✓	
Chief Executive Report (Dashboard)	Jim Mackey	Jackie Sutherland / Cerys Bodey	✓	✓	✓	✓	✓	✓	
Quality									
Patient and Staff Story	Annie Laverty	Cerys Bodey	✓	✓	✓	✓	✓	✓	
Joint Medical Directors Report	Michael Wright/Lucia Pareja-Cebrian	Kerry Leonard	✓	✓	✓	✓	✓	✓	
Guardian of Safe Working	Michael Wright/Lucia Pareja-Cebrian	Henrietta Dawson	✓	✓		✓	✓		Quarterly reports go to People Committee (April, July, October and January)
Annual Emergency Preparedness, Resilience and Response (EPRR) Report	Michael Wright/Lucia Pareja-Cebrian	Kerry Leonard			✓				
Annual Mental Health Update	Michael Wright/Lucia Pareja-Cebrian/Sarah Brown	Sarah Brown					✓		
Executive Director of Nursing Report including safe staffing	Ian Joy	Diane Cree	✓	✓	✓	✓	✓	✓	
Perinatal Quality Surveillance (formerly named the Maternity Update report) and Maternity Incentive Scheme update Report	Ian Joy / Jenna Wall	Diane Cree / Jenna Wall	✓	✓	✓	✓	✓	✓	From Quality Committee
Nurse Staffing Deep Dive	Ian Joy	Diane Cree	✓			✓			
Annual flu checklist	Ian Joy	Diane Cree			✓		✓		
Care Quality Commission (CQC) update	Rob Harrison	Elle Marshall	✓	✓	✓	✓	✓	✓	Annual Report on Governance (CQC Regulation 17) into this report
Learning from Deaths Report	Rachel Carter	Pippa Breakspear-Dean				✓		✓	From Quality Committee
Health and Safety Annual Report	Rachel Carter	Pippa Breakspear-Dean				✓			From Quality Committee
Quality Account update	Rachel Carter	Pippa Breakspear-Dean / Anne-Marie Troy-Smith	✓						From Quality Committee
Patient Safety Strategy Bi-annual reports	Rachel Carter	Pippa Breakspear-Dean			✓				From Quality Committee
Strategy/Planning									
Plan 2025/26	Jackie Bilcliff	Claire Garrity	✓					✓	
Strategy / Strategy update / Objectives 2025/26	Patrick Garner	Lisa Jordan	✓			✓			
Quality & Safety Strategy update	Rachel Carter	Pippa Breakspear-Dean			✓				
Winter Planning	Rob Harrison	Hannah Morrison			✓	✓			From Finance & Performance Committee
Performance									
Integrated Board Report	Rob Harrison / Patrick Garner	Elliott Tame	✓	✓	✓	✓	✓	✓	From all Committees
Sustainability update	Vicky McFarlane- Reid	James Dixon			✓			✓	From People Committee Annual Shine Report - September
People									
Gender Pay Gap Report	Vicky McFarlane-Reid / Donna Watson	Karen Pearce / Deb Stuart						✓	From People Committee
Freedom to Speak Up update	Vicky McFarlane-Reid / Donna Watson	Deb Stuart			✓			✓	From People Committee

Staff Survey Results	Vicky McFarlane-Reid / Donna Watson	Deb Stuart						✓	From People Committee
Equality, Diversity and Inclusion (EDI) and health inequalities – patients and people	Lucia Pareja-Cebrian / Vicky McFarlane-Reid	Kerry Leonard / Deb Stuart						✓	
Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report	Vicky McFarlane-Reid / Donna Watson	Karen Pearce / Deb Stuart	✓						From People Committee
Annual Revalidation Report	Michael Wright	Kerry Leonard			✓				
Annual Report of the Trust Employer Based Awards Committee	Vicky McFarlane-Reid / Donna Watson	Deb Stuart				✓			
Business Items / Governance									
Committee Chairs Logs	Committee Chairs	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	
Committee Terms of Reference and Schedules of Business	Kelly Jupp	Kelly Jupp / Lauren Thompson						✓	
Subsidiary Board Terms of Reference	Kelly Jupp	Kelly Jupp / Gillian Elsender						✓	
Committee Annual Reports	Kelly Jupp	Kelly Jupp / Lauren Thompson	✓						
Board Assurance Framework	Rob Harrison	Natalie Yeowart	✓	✓	✓	✓	✓	✓	
Modern Slavery Declaration	Kelly Jupp	Kelly Jupp		✓					From Audit, Risk and Assurance Committee
Annual Governance Statement	Jim Mackey	Natalie Yeowart							From Audit, Risk and Assurance Committee Includes annual declarations
Fit and proper persons statement	Paul Ennals	Rachel Cockburn			✓				
Standards of business conduct	Paul Ennals	Natalie Yeowart			✓				
Pioneers									
Chief Digital Officer Quarterly Report	Shauna McMahon / Dave Elliott	Angela Halliday				✓	✓		
Research and Innovation	Vicky McFarlane-Reid	John Isaacs and Neil Watson							TBC
Partnerships									
Alliance update	Martin Wilson	Martin Wilson					✓		
NB Collaborative Newcastle/Provider Collab and other Partnership Updates	Martin Wilson	Martin Wilson				✓		✓	
NIHR CRN NENC Annual Report / Research updates	Vicky McFarlane-Reid	John Isaacs				✓			

✓	On agenda and discussed
	Item deferred

Committee / Group:	**Private Board of Directors**
Chair:	**Sir Paul Ennals**
Annual Cycle Covered:	**2025/26**

		Meeting date	**24/04/2025**	**23/05/2025**	**26/06/2025**	**15/07/2025**	**26/09/2025**	**23/10/2025**	**28/11/2025**	**18/12/2025**	**TBC 2026**	**TBC 2026**	**TBC 2026**	
		Deadline for papers	**15/04/2025**	**13/05/2025**	**17/06/2025**	**25/07/2025**	**16/09/2025**	**14/10/2025**	**18/11/2025**	**09/12/2025**	**TBC 2026**	**TBC 2026**	**TBC 2026**	
	Lead	**Authors / contacts for the reports**	**April**	**May**	**June**	**July**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**Notes**
Standing items														
Apologies for absence	Paul Ennals		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Declaration of interests	Paul Ennals		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Paul Ennals	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Action log		Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Any other business	Paul Ennals		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Chair update	Paul Ennals	Vic Champion	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Chief Executive update	Jim Mackey	Jackie Sutherland	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Quality														
Cardiac Oversight Group update	Michael Wright	Ellspeth Marshall	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Maternity Incentive Scheme Sign Off Report	Ian Joy	Jenna Wall										✓		
Safeguarding Serious Case Review	Ian Joy	Diane Cree				✓			✓				✓	
Legal Update	Rachel Carter	Pippa Breakspear-Dean		✓		✓					✓			
Finance & Planning														
New Drug Approvals	Michael Wright / Lucia Pareja-Cebrian	Neil Watson / June Howey	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	When required
Finance Report	Jackie Bilcliff	Claire Garrity		✓		✓	✓				✓		✓	
Tenders & Business Cases	Jackie Bilcliff / Vicky McFarlane Reid	Claire Garrity / Kerry Leonard		✓		✓	✓				✓		✓	When required
Operational & Financial Planning 2024/25:														
- Monthly Finance Report	Jackie Bilcliff	Claire Garrity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
- Financial Recovery Plan	Jackie Bilcliff	Claire Garrity		✓							✓			
- Capital Programme	Jackie Bilcliff / Rob Smith	Claire Garrity / Lynsey Allen					✓							
Performance														
Key Clinical Board Updates	Patrick Garner	Patrick garner	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Executive Director for Commercial, Development and Innovation Report	Vicky Mcfarlane-Reid	Vicky Mcfarlane-Reid		✓		✓					✓			
Commercial Strategy	Vicky McFarlane- Reid	Wayne Elliott					✓							
People														
People Legal Cases	VIcky McFarlane- Reid / Donna Watson	Deb Stuart		✓		✓	✓				✓		✓	When required
Business items / Governance														
Annual Report and Accounts	Jackie Bilcliff / Kelly Jupp	Kelly Jupp / Lauren Thompson		✓										
Risk Appetite and Risk Management Policy	Rob Harrison	Natalie Yeowart												
Review of Board effectiveness	Paul Ennals	Kelly Jupp / Lauren Thompson				✓								
Subsidiary updates	Rob Harrison / Jackie Bilcliff / Patrick Garner	Ali Greener / Claire Garrity		✓					✓					Business plan - May Update - November
Subsidiary annual report and annual accounts	Rob Harrison / Jackie Bilcliff	Chris Haynes					✓							
By exception														
Estates Director Report (by exception)	Paul Hanson	Lynsey Allan												
Reading room														
Committee minutes: - Finance and Performance - Audit, Risk and Assurance - Quality - People - Charity - Digital and Data	Committee Chairs	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

✓	On agenda and discussed
	Item deferred

Committee / Group:	**Corporate Trustee of Newcastle Hospitals Charity Private Charity Board of Directors**
Chair:	**Sir Paul Ennals**
Annual Cycle Covered:	**2025/26**

Meeting date	**25/07/2025**	**TBC Jan 2026**
Deadline for papers	**15/07/2025**	**TBC Jan 2026**

Agenda item A19(ii)

	Lead	Authors / contacts of the report	Jul-25	Jan-26	Notes
Standing items					
Apologies for absence	Paul Ennals		✓	✓	
Declaration of interests	Paul Ennals		✓	✓	
Minutes and matters arising	Paul Ennals	Kelly Jupp / Lauren Thompson	✓	✓	
Action log	Paul Ennals	Kelly Jupp / Lauren Thompson	✓	✓	Actions go onto the Private Board action log
Any other business	Paul Ennals		✓	✓	
Charity Governance					
Charity Update / Charity Governance recommendations	Caroline Docking	Teri Bayliss		✓	
Review of Corporate Trustee Handbook	Caroline Docking	Teri Bayliss	✓		
Fundraising priorities: Sir Bobby Robson Institute Campaign	Caroline Docking	Teri Bayliss	✓	✓	
Charity Annual Report and Accounts	Caroline Docking	Teri Bayliss	✓		
Annual Funding Programme update	Caroline Docking	Teri Bayliss	✓	✓	
Risk Statement	Caroline Docking	Teri Bayliss		✓	
Charity Funding Programmes	Caroline Docking	Teri Bayliss	✓		

✓	On agenda and discussed
	Item deferred

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Agenda item A19(iii)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 March 2025					
Title	Accountability Framework					
Report of	Kelly Jupp, Trust Secretary					
Prepared by	Kelly Jupp, Trust Secretary					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☐	☐			
Summary	The Accountability Framework requires review as part of the annual process. It has therefore been reviewed by the Trust Secretary, the Director of Performance and Governance, the Executive Director of Nursing and the Director of Quality and Safety. Changes include: • Updated references to reflect changes in role titles and Clinical Board names. • Information added/changes made in relation to the discussions with the Trust Management Group and Executive Team members on Autonomy and Accountability. • Updated structure and other charts. • Updated references to the Big Signals/Interim Strategy as appropriate. • Removed the reference to Newcastle Way as this is no longer used. • The reference to the Quality and Safety Framework has been removed as a Quality and Safety Strategy is currently being developed and will be available later in the year.					
Recommendation	The Trust Board is asked to review and approve the changes to the Accountability Framework.					
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]	Not applicable.					
Reports previously considered by	Annual review. Last presented to the Trust Board, and approved, in March 2024. The Framework will be presented at the Audit, Risk and Assurance Committee on 25 March 2025. A verbal update will be given at the Board meeting on 28 March 2025 with any further changes suggested by the Committee.					

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Performance and Accountability Framework

Version: 3.0

This version issued: 19 March 2025

Executive Team approved: [TBA]

Trust Board approved: [TBA]

Review date: [TBA]

Owner: Patrick Garner, Director of Performance and Governance

Contents: **[Section/page numbers to be updated once content finalised]**

Scope

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

Purpose and key aims

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

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

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

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

Introduction

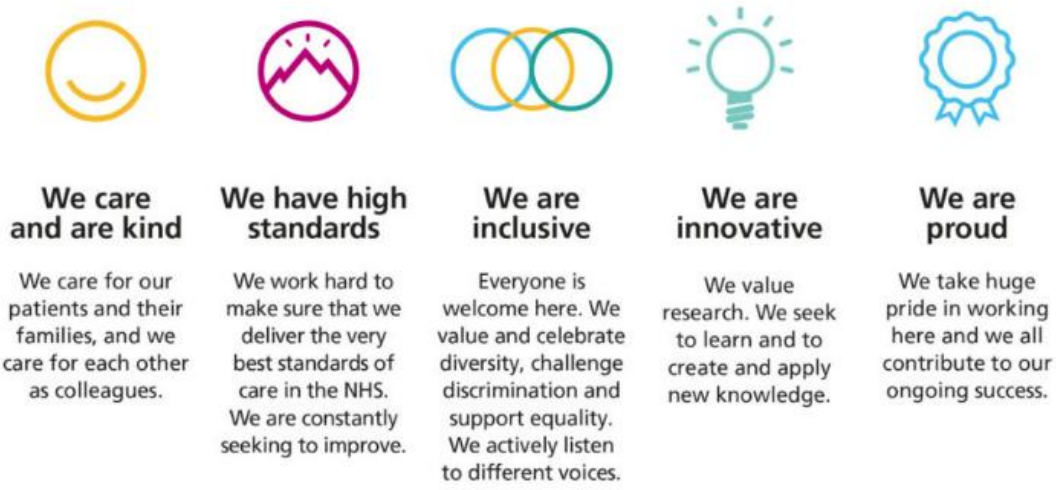
1.5 At Newcastle Hospitals our vision is **'achieving local excellence and global reach through compassionate and innovative healthcare, education and research'**. This is supported by the four themes included within the 'Big Signals' for 2024/25; being:

1. Improving Safety and Experience
2. Performance Delivery
3. Effective governance

4. Systems and Partnerships

The four themes above will form the basis of the Trust's Interim Strategy for 2025/26

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



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

1.7 The Trust's Interim Strategy will be underpinned by Truste-wide goals that describe the areas of focus for 2025/26, what success will look like and how we will get there. During 2025/26 an engagement exercise will be undertaken to develop a longer term strategy for the Trust.

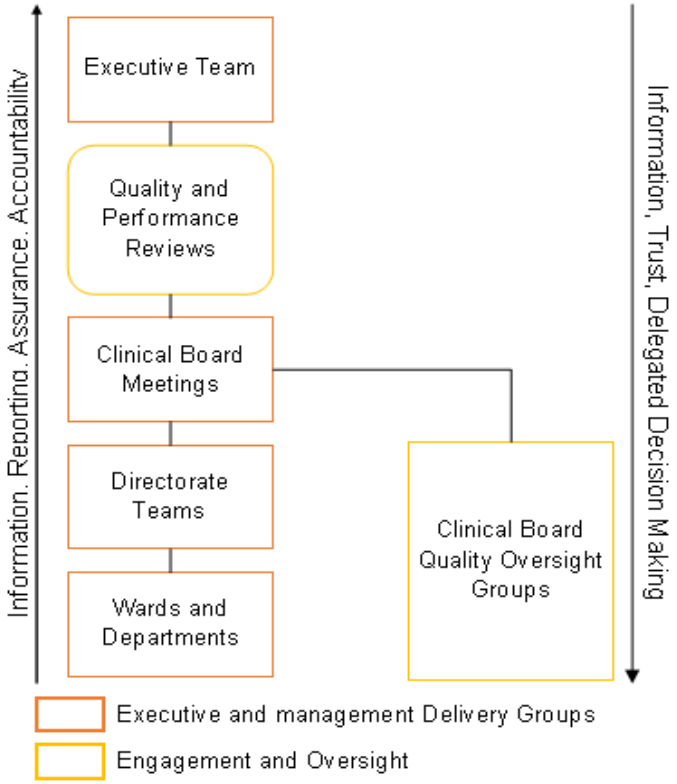
1.8 A key element of the Framework is distributed leadership which is supported through accountability and autonomy – being clear about where there is authority to make decisions independently within Clinical Boards and Corporate Departments, where decisions must be escalated to the Executive Team and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

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

Organisational and governance structure

1.10 As part of the Trust's planning cycle the Trust Board sets the strategic direction and the annual objectives for the organisation, utilising a range of intelligence including current performance. The diagram below shows the accountability structure. There

should be a clear alignment to the strategic direction of what teams and individuals are required to do.



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

1.12 The organisational structure is included in Appendix 1 and Appendix 2 shows the governance structure.

1.13 The Terms of Reference of the Clinical Boards, the QPR meetings and the Trust Management Group are included in appendices 3 to 5.

Trust Board of Directors

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

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

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

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

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

Council of Governors

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

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

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

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

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

Chief Executive Officer (CEO)

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

Executive Team

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

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

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

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

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

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

Trust Management Group (TMG)

1.28 The TMG meets every 2-weeks to bring together senior leaders of the Trust (as defined in the Terms of Reference in Appendix 5) to maintain the overall effectiveness of the Trust by ensuring the robust, effective and efficient operational management.

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

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

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

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

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

Risk Validation Group

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

Strategic command

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

Tactical command

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

Clinical Policy Group

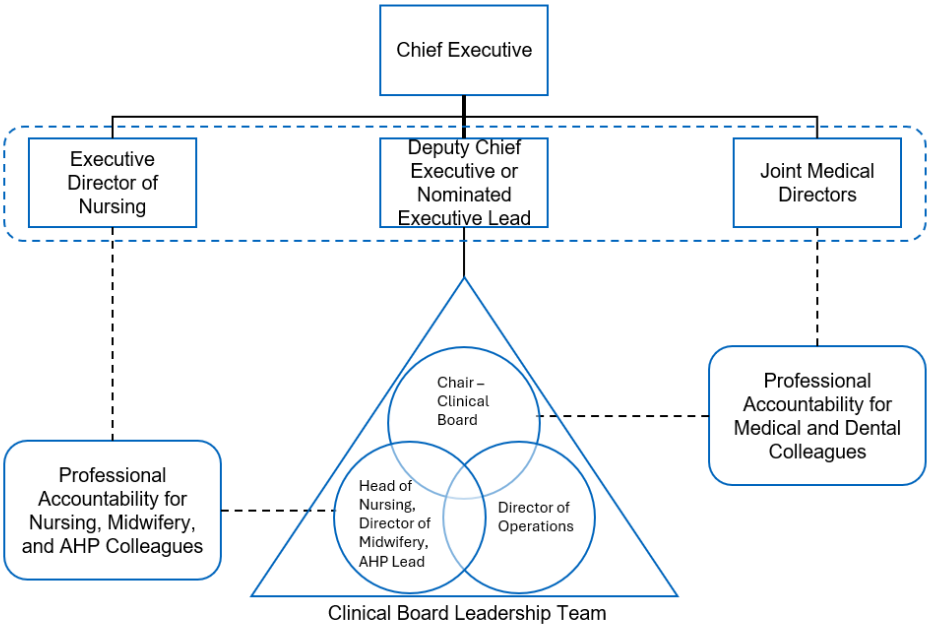
1.35 A regular monthly meeting chaired by the Joint Medical Directors and including all Associate Medical Directors, Clinical Board Chairs, Corporate Clinical Directors, Senior Nursing Teams and selected senior clinical leaders. Attended by Executive Team members. Responsible for developing and implementing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

Clinical Boards and directorates

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

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

1.38 Clinical Board Accountability Structure:



1.39 The Clinical Board Chair is responsible for leadership of the Clinical Board to support the delivery of patient care according to the Trust vision and strategy and is responsible for ensuring that quality and safety of patient care remains the primary objective of all staff of the Clinical Board. The Clinical Board Chair is also responsible for ensuring robust quality and safety arrangements are in place,.

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

1.41 The Clinical Board Chair is accountable for all aspects of the performance of the Clinical Board and chairs the Clinical Board meetings. They also have line management responsibility for the Director of Operations and Clinical Directors.

1.42 Reporting to the Clinical Board Chair and Deputy Chief Executive Officer/Nominated Executive Lead, the Director of Operations is responsible for overall operational delivery, interpreting and delivering overall health service policy and strategy, and has a key role in supporting the Clinical Board Chair in the leadership of a group of

Specialties and Directorates. The Director of Operations is also responsible for providing high-level operational and strategic business planning and leadership to ensure that the Clinical Board provides high quality patient care and achieves its performance objectives.

1.43 The Clinical Board Director of Operations has line management responsibility for the Head of Nursing (with professional accountability to the Executive Director of Nursing).

1.44 The Clinical Directors within each Clinical Board are accountable to the Clinical Board Chair for the performance of the Specialties and Directorates in their sphere of responsibility. The Clinical Directors, who are members of the Clinical Board, have line management responsibility for the specialty leads within their clinical directorate and have access to appropriate resources to support necessary performance and governance outputs. This includes responsibility for the budget of the clinical directorate.

1.45 The Clinical Board triumvirate (the Clinical Board Chair, the Director of Operations and the Head of Nursing/AHP leadership) is responsible for overseeing effective operation and delivery of services across all the Clinical Board's activities including operational performance, quality, workforce and finance. It is also responsible for ensuring that there are robust governance arrangements in place throughout the Clinical Board (including within clinical directorates and specialties) to ensure that key issues and risks are identified, managed and escalated as necessary in an effective way.

1.46 Each Clinical Board is managed in accordance with a common governance framework, specifically in relation to arrangements for quality governance. The following section outlines how the Clinical Boards are held to account for the delivery of their business plans.

Corporate directorates

1.47 Each member of the Executive Team leads a corporate directorate comprising teams with functional responsibilities for providing corporate support on decisions to the organisation as a whole. The Executive Team is accountable to the CEO for the performance of their corporate directorates.

1.48 While this Framework focuses on the levels of the organisational structure outlined above, it is important to recognise that clarity of accountability is vital at all levels of the organisation, including teams and individuals within Newcastle Hospitals who should all have clear objectives which are linked to the organisational objectives.

1.49 Corporate Directorates have organised their teams to align to each of the Clinical Boards to ensure that the Clinical Boards have support to deliver their functions.

Holding to account

1.50 The primary means by which the Executive Team holds the Clinical Board and corporate directorates to account for progress against contractual and national performance requirements is through regular QPRs (up to 10 per year depending on the autonomy level assigned to the Clinical Board). These meetings are equally an important mechanism through which Clinical Board and corporate directorates can escalate issues to and seek support from the management executive.

1.51 QPR meetings take place with each of the eight Clinical Boards. They are chaired, and administered, by the Deputy Chief Executive Officer/Nominated Executive Lead, with an expectation that the following Executive Directors are present as a minimum: Executive Director of Nursing, Joint Medical Directors, Chief Finance Officer, Director of Performance and Governance, Director of Quality & Safety, Associate Director of People and Organisational Development and Director for Commercial Development and Innovation. From each Clinical Board, it is expected that the Clinical Board representation will be led by the Clinical Board Chair and will comprise of the Director of Operations, Head of Nursing/AHP Lead, as well as the quality and safety, finance, information, performance and workforce leads. Clinical Directors and Associate Directors of Operations /General Managers will also be invited to attend as appropriate. Other members of the clinical leadership team are also free to attend where appropriate.

1.52 Other members of the Executive Team are free to attend all meetings. Core attendees should prioritise these meetings but, if they are not available, they should send a representative who is appropriately briefed in order to participate fully in the meeting. It is expected that core members of each QPR (as outlined above) should attend a minimum of 70% of meetings a year.

1.53 The Clinical Board QPRs focus on five domains (including any risks associated with each):

- Quality and safety.
- Performance – including activity and access targets.
- People merits and progress in the implementation of the People Plan.
- Finance including current year position and financial recovery.
- Strategy and service developments.

1.54 Key summary metrics within each of these domains are used to track progress. This underpins the key principle of distributed leadership and autonomy.

1.55 The focus of the Clinical Board QPRs is on issues and metrics that need to be raised by exception for discussion, with the information and data provided for reference at the meeting taken as read. To get the most from QPRs, the Clinical Board leadership team are required to prepare a pack of information circulated 3 working days in

advance to enable the QPR attendees to have the information required to undertake the review to the appropriate depth. This is supported by Corporate Teams as required and covers all aspects of the agenda. Notes and action points are circulated in a timely way by the Corporate Performance Team and the nominated action owners are responsible for following up their actions ahead of the next meeting.

1.56 A comprehensive action log is maintained and this is supported by an active risk register for each Clinical Board.

1.57 It is expected that each Clinical Board will have in place a formal structure for regular QPR review meetings with their directorates and this should report directly into their Clinical Board.

1.58 For the QPRs, Clinical Boards will:

- Report on recruitment decisions
- Report Clinical Board Business Case decisions (including updates on consultation where appropriate)
- Provide assurance on establishment changes (within allocated budget) to transfer resources between budget lines, skill mix
- Be prepared to unwind decisions if required

1.59 Following each round of QPRs with the Clinical Boards, the key quality and performance issues arising from the meetings will be drawn together by the Chair of the QPRs and discussed by the Executive Team. This provides an opportunity for key issues to be escalated, particularly where they might involve or impact on more than one Clinical Board. This in turn will help inform the discussion of quality and performance by the relevant Board Committees, and/or the Trust Board. A Chairs action log from the QPRs will be produced/maintained which will be included with the papers for the Quality and Finance and Performance Committees.

1.60 The Executive Team will monitor and review the need for additional training, support and capacity to facilitate the effective operation of the Performance and Accountability Framework.

Performance Management and Reporting

1.61 A Trust-wide Integrated Board Report (IBR) providing data at Board level, with selective key performance indicators (KPIs) forms the basis for the QPRs with the Clinical Boards. These reports are regularly updated as performance expectations change, and new targets set. The KPIs and thresholds for performance success are agreed and set by the Executive Team in consultation with TMG.

1.62 Where Clinical Boards demonstrate an ability to maintain high levels of performance, the principle of maximum autonomy will apply. The levels of autonomy are outlined below:

Autonomy level	Assessment criteria	Level of Support	Autonomy level
1. Maximum autonomy	Consistently high performing across the review domains.	No specific support needs	Full autonomy within the scope of the Framework, Standing Financial Instructions and Standing Orders.
2. Enhanced autonomy	Majority of the review domains are high performing and improvement plans are in place for the other domains	Specific support needs on request of the Clinical Board	Additional oversight on specific domains of concern. This may include escalation to corporate oversight of recruitment and investment decisions.
3. Reduced autonomy	Where a Clinical Board is under delivering on most domains, or where underperformance on a specific domain is having a significant impact on overall Trust performance	Mandated additional support from relevant Corporate Teams	Additional support and oversight across all domains with enhanced input from improvement teams, finance and performance teams, with additional oversight of recruitment, establishment changes, investment proposals and quality oversight.

Principles of Autonomy and Accountability

1.63 The following are principles that the Clinical Board teams should have regard to when decision making:

- Consider the impact on other Clinical Boards, as well as on Patients and Staff.
- Determine who are the relevant stakeholders and identify whether they have been consulted.
- Act in the overall interests of the organisation.
- Ensure effective resource management.

- Avoid setting new precedent without Executive level agreement.
- Put in place good governance arrangements locally.
- Commit to sharing learning to improve wider organisational decision making.
- Contribute to external reporting assurance as necessary.
- Ensure compliance with the Trust Standing Orders, Scheme of Delegation and Standing Financial Instructions.

Triggering and managing performance escalations

1.64 There are several layers and routes of escalation:

1.65 Stepping up of QPRs:

- Clinical Board to escalate in-month of any deterioration across the IBR that impacts on their level of autonomy.
- Trust-wide oversight and performance monitoring identifies a Clinical Board concern.
- IBR identifies a need for a focussed review of finance, workforce, quality and patient safety or operational performance. These meetings will be scheduled in between QPR meetings with members of the corporate team and the Clinical Board Triumvirate.

1.66 To the Executive Team:

- Specific items of escalation for the Executive Team to note i.e. breach of a national requirement however assurance can be provided that a recovery action plan is place and will no longer be an issue within a specified time-frame.
- Specific items of escalation for the Executive Team to action i.e. breach of a national requirement and there is no credible recovery plan in place and support is required. The Executive Team will agree the next course of action directly with the Clinical Board.
- Clinical Boards and other corporate leadership teams can make a direct escalation to an appropriate forum, i.e. a Senior Leadership Forum or directly into the Executive Team rather than wait for a QPR.
- If there is ongoing slippage against the action plan, there will be a further escalation to the Deputy Chief Executive Officer/Nominated Executive Lead and the relevant Executive Director pending the nature of the escalation.
- A further escalation can be made to include the CEO to mediate a resolution or set out the next steps.

1.67 As the framework relies on robust governance arrangements being in place, any governance concerns can and should be highlighted through other routes including, the Risk Validation Group and Clinical Effectiveness and Audit Group as examples. Members in attendance are expected to triangulate information and raise concerns if there is contradictory information presented. In this instance, the Executive Team will review and determine whether a governance review of the Clinical Board is required.

Reserved Matters for the Executive Team

1.68 The following matters are reserved for Executive Team discussion and decision:

- Capital spend to be centrally controlled given the Capital Departmental Expenditure Limit (CDEL) and cash flow.
- Minimum Performance and Quality ambitions.
- Pay Terms and Conditions, the regrading and job evaluation process, and the job planning policy.
- Use of the Very Senior Manager (VSM) grade.
- Redundancy.
- Changes to ward based Safer Nursing Care Toolkit (SNCT) levels.
- Use of Agency staff for non-clinical roles, above cap and off framework.
- Business cases where there is no funding / income available.
- Procurement of Digital Systems.
- Overall decision making on financial requirements and Trust wide policy decisions.

Risk Management

1.69 This Framework aims to align with the Risk Management Policy and Strategy. The Trust recognises that there are unavoidable and inherent risks to providing healthcare services and are committed to supporting a dynamic, proactive, and transparent approach to risk management throughout the organisation.

1.70 The Board of Directors with the support from its Committees of the Board have a key role in ensuring robust risk management systems and processes are effectively implemented, and maintained, as well as to promote a culture whereby risk

management is fully embedded across all Trust activities through its policy, strategy and management plans.

1.71 All Clinical Board leadership teams are responsible for ensuring the implementation of the Risk Management Policy within their clinical boards including establishing effective risk management governance to support the continual management of risks and risk registers as set out within the Risk Management Policy which can be found in the Trust policy directory.

1.72 All staff play a vital role in considering risk and helping to ensure it does not prevent the delivery of care. Effective risk management is the responsibility of every member of staff and the escalation of risk should be encouraged and managed separately using an appreciative enquiry approach.

Monitoring compliance with and the effectiveness of this document

1.73 The Framework will be reviewed annually.

Equality and diversity statement

1.74 This document complies with the Newcastle Hospitals equality and diversity statement.

Disclaimer

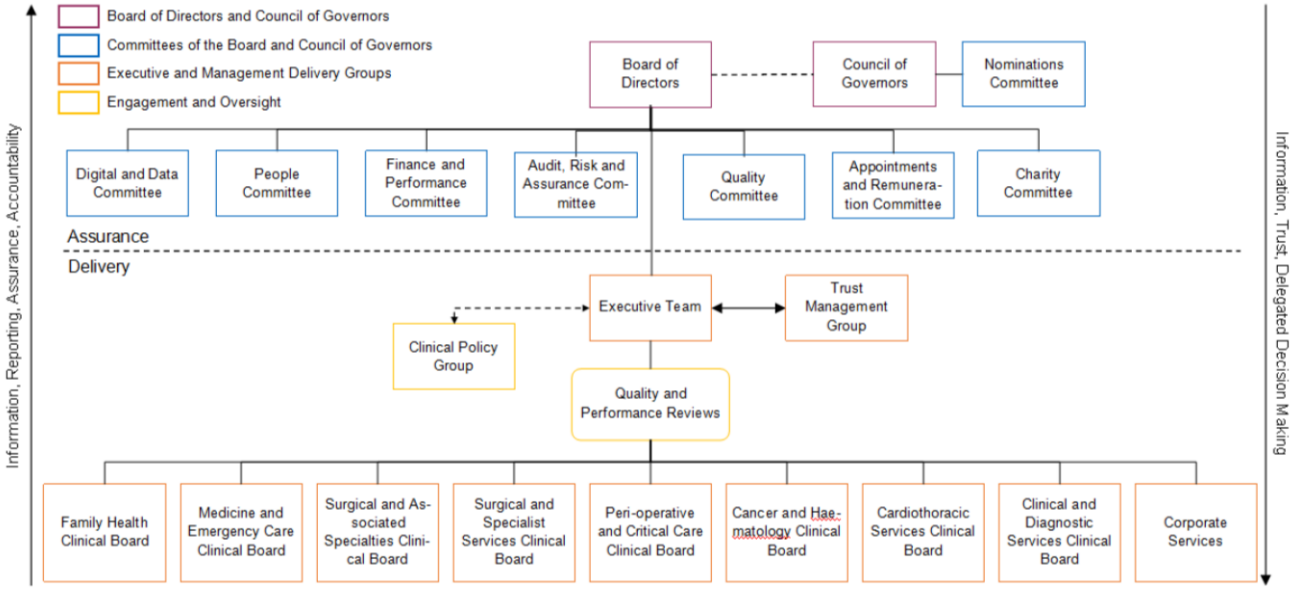
It is the responsibility of the individual to ensure that the most recent version of this document is being used. This can be checked in the electronic library version control section.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Appendix 1 – Leadership and Clinical Board organisational structure chart [Awaiting updated chart as at March 2025]

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Appendix 2 – Governance structure



Appendix 3 – Clinical Board Terms of Reference

CLINICAL BOARD

TERMS OF REFERENCE

1. CONSTITUTION

1.1 All clinical services in the Trust are part of one of eight Clinical Boards, which is led by a Clinical Board Chair (a senior clinician), a Director of Operations (a senior manager) and a Head of Nursing (referred to as the leadership triumvirate). Each of these Clinical Boards have been established for the purpose of bringing together its most senior leaders to create a culture of collective leadership, to role model the Trust values and to work in an integrated way to deliver conditions that support staff to deliver the strategic objectives of the Trust.

1.2 The Clinical Board is accountable to the Executive Team through the Clinical Board Chair and Director of Operations who are accountable to the Deputy Chief Executive Officer/Nominated Executive Lead. The Joint Medical Directors and the Executive Director of Nursing have professional accountability in relation to all aspects of medical and nursing care.

2. DUTIES

2.1 In particular the Clinical Board will:

a) Oversee and facilitate delivery of Trust objectives, incorporating the annual objectives/goals set each year along with the Clinical Board and Directorate / specialty business plans by:
   - Delivering the agreed Clinical Board strategy.
   - Providing assurance on action plans for variances that are either serious in extent or common across the Clinical Board.
   - Maintaining and reviewing an action tracker.
   - Identifying, managing and escalating (as appropriate) risks in line with the risk management policy.

b) Facilitate learning across Clinical Boards from successful initiatives and the review of adverse events utilising the Patient Safety Incident Response Framework.

c) Ensure robust management and monitoring of performance metrics, quality and safety issues within the Clinical Board until they are resolved.

d) Discuss the Clinical Board's quality and performance and agree actions where necessary to address any issues arising.

e) Ensure the Clinical Board's financial position remains within the agreed budget, delivering the Cost Improvement target set and take action where necessary when variances occur to minimise the impact.
f) Manage key workforce issues and agree actions where necessary.
g) Collaborate with clinical and corporate teams on developments in the wider Trust to deliver the Trust strategic objectives.
h) Agree and implement research and education priorities and activities within the Clinical Board.
i) Report to the Executive Team matters by exception (noting that performance and finance are routinely reported through Trust information packs).
j) Agree a communication plan within the Clinical Board on significant matters and initiatives.

3. MEMBERSHIP & ATTENDANCE

5.3 The Clinical Board will include the following members:

a) Clinical Board Chair (Chair)
b) Director of Operations
c) Associate Directors of Operations
d) Associate Medical Director
e) Head of Nursing
f) Clinical Directors (CD)
g) Clinical Board finance lead
h) Clinical Board workforce lead
i) Clinical Board information lead
j) Quality and Safety lead

3.2 The members will meet monthly, and an appropriate member of the admin team will be in attendance to take notes of the Clinical Board meetings. Other personnel may be invited by the Chair to attend the meetings on an ad-hoc basis as appropriate.

3.3 Deputies may be nominated to attend prior to the meeting, with the Chair's approval.

4. RESPONSIBILITY OF MEMBERS AND ATTENDEES

Members of the Clinical Board have a responsibility to:

a) attend meetings, having read all papers beforehand;
b) when matters are discussed in confidence at the meeting, to maintain such confidences;

c) at the start of the meeting, declare any conflicts of interest / potential conflicts of interest in respect of specific agenda items (even if such a declaration has previously been made in accordance with the Trust's policies and procedures);

d) produce and maintain a Clinical Board Chairs log to be used as part of the QPRs.

5. QUORUM

5.1 Quorum for the monthly Clinical Board meetings will be six members. Of which, two should be members of the triumvirate and there should be at least three Senior Clinical Leaders e.g. CD and Q&S lead in attendance.

5.2 When considering if the meeting is quorate, only those individuals who are voting members as listed in 3.1 above can be counted.

5.3 Meetings will normally take place monthly on a [day to be inserted].

6. AUTHORITY

The Clinical Board is authorised to: i) act within the Standing Orders, Standing Financial Instructions and Scheme of Delegation, ii) carry out activities and receive assurance on any activity within these terms of reference, iii) make recommendations to the Executive Team; iv) seek any information is requires from any member of staff and v) promote a learning culture, which is open and transparent.

7. REVIEW

The Terms of Reference will be reviewed at least every three years by the Trust Secretary and Managing Director, with recommendations on changes submitted to the Executive Team for approval.

Date Approved and issued	[TBA]
Version Number:	Draft Version 3
Next Review:	[TBA]
To be approved by:	Executive Team
Executive Responsibility: Lead	Deputy Chief Executive/Nominated Executive

Appendix 4 – Quality & Performance Review Meetings Terms of Reference

QUALITY AND PERFORMANCE REVIEW MEETINGS

TERMS OF REFERENCE

1. PURPOSE

1.1 The purpose of Quality and Performance Reviews (QPRs) are to ensure that Clinical Boards and Directorates are progressing in line with their strategic aims and objectives, national and local reporting requirements, as well as addressing areas of under-performance and acknowledging areas of strong performance.

1.2 The Clinical Board leadership team will prepare a pack of information circulated 3 working days in advance to enable the QPR attendees to have the information required to undertake the review to the appropriate depth. This will be supported by Corporate Teams as required and cover all aspects of the agenda. The process will ensure that key issues and risks are being appropriately managed.

1.3 As well as playing an important role in the overall Accountability Framework for the Trust, the QPR process provides Clinical Boards an opportunity to discuss and escalate updates and concerns to members of the Executive Team and other Senior Managers as part of the review.

2. DUTIES

2.1 QPR meetings take place (at a frequency determined in accordance with the autonomy level assigned) with each of the eight Clinical Board.

2.2 The Clinical Board QPRs focus on five domains:

- Quality and safety.
- Performance – including activity and access targets.
- People merits and progress in the implementation of the People Plan.
- Finance including current year position and financial recovery.
- Strategy and service developments.

3. MEMBERSHIP & ATTENDANCE

3.1 QPR Meetings will include the following members:

a) Deputy Chief Executive/Nominated Executive Lead (Chair)
b) Joint Medical Directors
c) Executive Director of Nursing

d) Chief Finance Officer
e) Director of Performance & Governance
f) Director of Quality & Safety
g) Associate Director for People and Organisational Development
h) Director for Commercial Development & Innovation
i) Clinical Board Chair
j) Director of Operations
k) Head of Nursing
l) Associate Directors of Operations (optional)
m) Clinical Directors (optional)
n) Clinical Board finance lead
o) Clinical Board workforce lead
p) Clinical Board information lead
q) Clinical Board quality lead
r) Performance Lead

3.2 An appropriate member of the performance team will be in attendance to take notes of the meetings.

3.3 Deputies may be nominated to attend prior to the meeting, with the Chair's approval.

3.4 The Deputy Chief Executive/Nominated Executive Lead will chair all QPRs in the first instance, with a member of the Executive Team nominated to act as Vice Chair. Additionally, the Deputy Chief Operating Officer will endeavour to attend in these circumstances to ensure consistency and representation from the Deputy Chief Executive Officer team across all reviews.

4 RESPONSIBILITY OF MEMBERS AND ATTENDEES

4.1 Members of the QPR Meetings have a responsibility to:

- attend meetings, having read all papers beforehand;
- when matters are discussed in confidence at the meeting, to maintain such confidences; and
- at the start of the meeting, declare any conflicts of interest / potential conflicts of interest in respect of specific agenda items (even if such a declaration has previously been made in accordance with the Trust's policies and procedures).

4.2 If unable to attend, members must inform the Chair and the Corporate Performance team, as well as assigning a Deputy to attend on their behalf.

4.3 Meeting Chairs will ensure there is a consistent approach to QPRs by following the issues specified in the agenda, as approved by the Executive Team.

5 RELATIONSHIPS AND REPORTING ARRANGEMENTS

5.1 Reviews will be scheduled at least 6 weeks prior to the proposed date.

5.2 Reports for the meeting should be submitted by the agreed deadlines.

5.3 Information providers must secure sign-off from the Directors of Operations before providing the document to the Performance Team - once a document is received it will be assumed that it has been signed-off.

5.4 The Performance Team will then collate, check, clarify and format documents with the aim of distributing a complete ahead of the review date to all attendees. Post-review, it will be the responsibility of the performance team to circulate draft minutes and action logs in a timely manner.

5.5 The Clinical Board will provide a presentation pack 3 working days in advance to lead the review meeting attendees through the exception reports.

5.6 To co-ordinate QPRs, flexibility will be required on behalf of all members and administration teams should make every effort to ensure these are a priority.

6 REPORTING OUTCOMES AND BOARD FEEDBACK

6.1 It is expected that each Clinical Board will have in place arrangements for similar review meetings with their clinical directorates ahead of the Clinical Board performance review meeting.

6.2 Following each round of QPR meetings with the Clinical Boards, the key performance issues arising from the meetings will be drawn together by the Deputy Chief Executive/Nominated Executive Lead and discussed by the Executive Team. This provides an opportunity for key issues to be escalated, particularly where they might involve or impact on more than one Clinical Board. This in turn informs the discussion of performance by the Board of Directors' Committees, and the Board itself. The Chairs log from the QPR meetings will be included with the papers for the Quality and Finance Committees, and Trust Board.

7. QUORUM

7.1 Quorum will be six members. Of which, at least two should be Executive Team members and at least two should be Clinical Board members.

7.2 The frequency of meetings will depend on which autonomy level the Clinical Board is assigned to.

8. REVIEW

8.1 The Terms of Reference will normally be reviewed at least every three years, with recommendations on changes submitted to the Executive Team for approval.

Date Approved and issued	[TBA]
Version Number:	Draft Version 2
Next Review:	[TBA]
To be reviewed by:	Trust Management Group
To be approved by:	Executive Team
Executive Responsibility: Lead	Deputy Chief Executive/Nominated Executive

Appendix 5 – Trust Management Group Terms of Reference

TRUST MANAGEMENT GROUP

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Trust Management Group is a forum which has been established for the purpose of bringing together clinical and senior leaders to maintain the overall effectiveness of the Trust by ensuring robust, effective and efficient operational management.

1.2 The Trust Management Group operates within the Trust Corporate Governance Framework established by the Board of Directors and acts as a forum:

a) To provide scrutiny and challenge on significant reports, business cases, service developments, organisational decisions and future plans before they are presented to the Trust Board or relevant Committee.
b) To discuss key risks to the Trust e.g. achievement of the Trust Plan and the Recovery Programme;
c) To provide assurance on Clinical Board performance and any significant service issues or service changes;
d) To consider performance against key targets and any remedial actions required;
e) For discussing progress on key corporate metrics and the Trust overarching strategy;
f) To consider transformation and improvement plans which will drive improvement across the Trust;
g) For group members to bring significant matters/issues to the attention of the Executive Team;
h) For sharing feedback from Board members and Board Committees; and
i) To ensure that staff are kept up to date on Trust wide issues.

1.3 Meetings will normally take place fortnightly on a Wednesday.

2. DUTIES

2.1 In particular the Trust Management Group will:

a) ensure the robust, effective and efficient operational management of the Trust;
b) support the development of, and improvements to, services across the Trust including the adoption of new technologies and innovations;
c) contribute to the review and development of the Trust's vision, purpose and strategic direction;

d) consider operational risk and related quality & patient safety issues, ensuring that any emerging risks are identified, assessed and managed appropriately;
e) contribute to creating a positive Trust culture by upholding the agreed Trust values and behaviours;
f) support improvement of communication and involvement of staff; and
i) consider the overarching Trust performance against key performance indicators.

3. MEMBERSHIP & ATTENDANCE

3.1 The Trust Management Group will include the following members:

a) Chief Executive Officer (CEO) (Chair);

b) All Executive Team members and some deputies (as agreed with the Chair);

c) All Clinical Board Chairs;

d) All Associate Medical Directors;

e) All Associate Directors of Nursing, Midwifery and Allied Health Professionals;

f) All Directors of Operations; and

g) All Heads of Nursing.

3.2 The Trust Secretary, or a member of the Corporate Governance Team, will be in attendance to take notes and capture key actions arising from the meetings. Other personnel may be invited by the Chair to attend the meetings as appropriate.

3.3 Attendees should not send deputies unless there are exceptional circumstances or acting up arrangements have been put in place. Where this is the case, approval must be sought from the Chair.

4. RESPONSIBILITY OF MEMBERS AND ATTENDEES

Members of the Trust Management Group have a responsibility to:

e) attend meetings, having read all papers beforehand;
f) when matters are discussed in confidence at the meeting, to maintain such confidences.
g) at the start of the meeting, declare any conflicts of interest / potential conflicts of interest in respect of specific agenda items (even if such a declaration has previously been made in accordance with the Trust's policies and procedures).

5. QUORUM

TMG is not a decision-making forum and therefore a quorum is not required.

6. AUTHORITY

The Trust Management Group is authorised to: i) carry out activities within its terms of reference, ii) make recommendations to the Executive Team.

7. REVIEW

The Terms of Reference will normally be reviewed at least every two years, with recommendations on changes submitted to the Executive Team for approval.

Date Approved and issued:	October 2018 (V1), June 2023 (V2)
	January 2024 (V3), March 2024 (V4), March (V5)
Version Number:	Version 5
Next Review:	March 2027
To be reviewed by:	Trust Management Group
To be approved by:	Executive Team
Executive Responsibility:	CEO

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PUBLIC BOARD MEETINGS - ACTIONS

Agenda item A20

Log No.	BOARD DATE	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
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. 20.03.25 - Update requested from AL.
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. 31.01.25 - JW advised that she would continue to try and obtain the required information from finance colleagues. 21.03.25 - JW has been unable to get the data via the Head of Midwifery network however IJ will discuss with the regional Directors of Nursing during our April forum.
133	31 January 2025	iv) Integrated Board Report (IBR)	Mr Kane sought clarification with regards to recruitment and retirement challenges for Dosimetrists and the Royal College of Radiology Accreditation Programme. The JMD-PC advised that she would find out further information with regards to the Royal College of Radiology Accreditation Programme however highlighted that the teams involved were aware of the importance of recruitment and retirement planning [ACTION01].	LPC			20.03.25 - Response shared with Mr Kane. Propose to close action.
134	31 January 2025	v) Research update including: a) Home-Grown Research b) Clinical Research Network Update	The DCDI highlighted the importance of increasing the visibility of ongoing research activities, through regular presentations to the Board, and that support was given to positively embed research as part of everyone's role and an option for care. It was agreed that the governance and reporting would be discussed separately outside of the meeting [ACTION02].	VMR			17.03.25 - VMR advised that a paper was presented to Private Board in February in relation to the governance and reporting. This work is ongoing and an update will be provided once available. An action is currently open on the Private Board action log. Propose to close action.
135	31 January 2025	b. Executive Director of Nursing Report; including: i) Spotlight on ACE Programme	Information was included with regards to the Accrediting Excellence (ACE) Programme and it was agreed that the website link would be shared with Trust Board members [ACTION03].	IJ			17.03.25 - ACE programme link circulated to Board members for information. Propose to close action.

KEY

NEW ACTION	To be included to indicate when an action has been added to the log.
ON HOLD	Action on hold.
OVERDUE	When an action has reached or exceeded its agreed completion date. Owners will be asked to address the action at the next meeting.
IN PROGRESS	Action is progressing inline with its anticipated completion date. Information included to track progress.
COMPLETE	Action has been completed to the satisfaction of the Committee and will be kept on the 'in progress' log until the next meeting to demonstrate completion before being moved to the 'complete' log.