Public Board of Directors

Tue 31 May 2022, 13:00 - 16:00

Freeman Hospital Board Room (for Board Members only)/MS Team for Public Members

Agenda

13:00 - 13:00
0 min

Public Board of Directors Agenda

Attached

00 A0 Public Board Agenda 31 May 2022 KJ GE - updated.pdf (2 pages)

Standing Items

13:00 - 13:01
1 min

1. Apologies for absence and declarations of interest

Verbal *Sir John*

NB: Apologies from Graham King and Kelly Jupp

13:01 - 13:05
4 min

2. Minutes of the Meeting held on 31 March 2022 and Matters Arising

Attached *Sir John*

A2 Public Trust Board of Directors Minutes 31 March 2022 [DRAFT] FD KJ.pdf (17 pages)

13:05 - 13:10
5 min

3. Chairman’s Report

Attached *Sir John*

A3 Chairman Board Report May 2022 GE KJ.pdf (6 pages)

13:10 - 13:20
10 min

4. Chief Executive's Report

Attached *Dame Jackie*

A4 Chief Executive Report May 2022 CD KJ.pdf (9 pages)

Strategic Items

13:20 - 13:30
10 min

5. Digital People Story

Attached *Maurya Cushlow*

A5 Digital Story May 2022 KJ.pdf (4 pages)

13:30 - 14:00
30 min

6. Trust Recovery Programme:

Verbal/Presentation *Martin Wilson, Vicky McFarlane-Reid and Angela Dragone*

a. General Update

Verbal *Martin Wilson, Vicky McFarlane-Reid and Angela Dragone*

b. End of April Performance Submission

Attached *Martin Wilson, Vicky McFarlane-Reid and Angela Dragone*

- A6b Trust Performance Report May 2022.pdf (3 pages)
- A6b Trust Performance Board Report May 2022 - PUBLIC.pdf (10 pages)

14:00 - 14:05
5 min

Refreshment Break

14:05 - 14:15
10 min

7. Director Reports:

a. Medical Director; including [NB to include Research Update]

Attached and BRP *Andy Welch*

- A7a Board Report May 2022 - Medical Director.pdf (7 pages)

i) Quarterly Guardian of Safe Working Report

BRP *Andy Welch*

14:15 - 14:35
20 min

b. Executive Chief Nurse; including

Attached *Maurya Cushlow*

- A7b Executive Chief Nurse Report May 2022 KJ.pdf (12 pages)

i) Nursing & Midwifery Staffing

Attached *Maurya Cushlow*

- A7b(i)Nursing & Midwifery Staffing May 2022 KJ.pdf (15 pages)

ii) Ockenden Final Report

Attached *Maurya Cushlow*

- A7b(ii) Ockenden Paper Trust Board May 2022 KJ.pdf (26 pages)

14:35 - 14:45
10 min

c. Director of Quality & Effectiveness

i) Quarterly CNST report; and

Attached *Angela O'Brien*

A7c(i) CNST Report May 2022 KJ.pdf (19 pages)

ii) Learning from deaths quarterly report

Attached *Angela O'Brien*

A7c(ii) Learning from Deaths May 2022 GE KJ.pdf (13 pages)

iii) Quality Account

Attached *Angela O'Brien*

A7c(iii) Quality Account May 2022 LB KJ.pdf (118 pages)

14:45 - 15:05
20 min

d. Director of Infection Prevention & Control

Attached and BRP *Lucia Pareja-Cebrian*

A7d Healthcare Associated Infections - DIPC Report May 2022 KJ.pdf (11 pages)

e. Human Resources Director - People Report

Attached *Dee Fawcett*

A7e People Board Report May 2022 GE KJ.pdf (12 pages)

f. Chief Information Officer - Digital Update

Attached *Lisa Sewell*

A7f Digital Update - HIMSS6 Accreditation and GDE Programme Closure May 2022 GE KJ.pdf (10 pages)

Items to receive and any other business

15:05 - 15:10
5 min

8. Update from Committee Chairs

Attached *Committee Chairs*

A8 Update from Committee Chairs May 2022 LB KJ GE.pdf (7 pages)

15:10 - 15:15
5 min

9. Corporate Governance Update; Including

BRP *Caroline Docking*

i) Quarterly Declarations

BRP *Caroline Docking*

15:15 - 15:25
10 min

10. Integrated Board Report

BRP *Martin Wilson*

15:25 - 15:30
5 min

11. Meeting Action Log

BRP *Sir John*

15:30 - **15:40**
10 min

12. Any other business

Verbal *Sir John*

Date of next meeting: Thursday 28 July 2022

15:40 - **15:40**
0 min

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Public Trust Board of Directors' Meeting

Tuesday 31 May 2022, 1:00pm – 4.00pm

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

Agenda

Item		Lead	Paper	Timing
Standing items:				
1.	Apologies for absence and declarations of interest	Sir John	Verbal	13.00 – 13.01
2.	Minutes of the Meeting held on 31 March 2022 and Matters Arising	Sir John	Attached	13.01 – 13.05
3.	Chairman's Report	Sir John	Attached	13.05 – 13.10
4.	Chief Executive's Report	Dame Jackie	Attached	13.10 – 13.20
Strategic items:				
5.	Digital People Story	Maurya Cushlow	Attached	13.20 – 13.30
6.	Trust Recovery Programme: a. General Update; and b. End of April Performance Position	Martin Wilson and Vicky McFarlane-Reid	Verbal / Presentation Attached	13.30 – 14.00
	Refreshments break			14.00 – 14.05
7.	Director reports:		Attached & Board	
	a. Medical Director; including i) Quarterly Guardian of Safe Working Report	Andy Welch	Reference Pack (BRP)	14.05 – 14.15
	b. Executive Chief Nurse; including i) Nursing & Midwifery Staffing; and ii) Ockenden Final Report	Maurya Cushlow		14.15 – 14.25
	c. Director of Quality & Effectiveness i) Quarterly CNST report; and ii) Learning from deaths quarterly report iii) Quality Account	Louise Hall		14.25 – 14.35
	d. Director of Infection Prevention & Control	Lucia Pareja-Cebrian		14.35 – 14.45
	e. Human Resources Director – People Report	Dee Fawcett		14.45 – 14.55

Item		Lead	Paper	Timing
	f. Chief Information Officer – Digital Update	Lisa Sewell		14.55 – 15.05
Items to receive and any other business:				
8.	Update from Committee Chairs	Committee Chairs	Attached	15.05 – 15.10
9.	Corporate Governance Update; including i) Quarterly declarations [FOR APPROVAL]	Caroline Docking	BRP	15.10 – 15.15
10.	Integrated Board Report	Martin Wilson	BRP	15.15 – 15.25
11.	Meeting Action Log	Sir John	BRP	15.25 – 15.30
12.	Any other business	All	Verbal	15.30 – 15.40

Date of next meeting: Thursday 28 July 2022

Professor Sir John Burn, Chairman

Dame Jackie Daniel, Chief Executive Officer

Mr Andy Welch, Medical Director/Deputy Chief Executive Officer

Ms Maurya Cushlow, Executive Chief Nurse

Mr Martin Wilson, Chief Operating Officer

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

Mrs Angela Dragone, Finance Director

Mrs Caroline Docking, Assistant Chief Executive

Mrs Dee Fawcett, Director of Human Resources

Mrs Louise Hall, Deputy Director of Quality and Effectiveness

Mrs Lisa Sewell, Head of Digital Innovation and Delivery

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

Mr Steven Morgan, Non-Executive Director/Chair of Finance Committee

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

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

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

PUBLIC TRUST BOARD OF DIRECTORS' MEETING

DRAFT MINUTES OF THE MEETING HELD 31 MARCH 2022

Present:	Professor Sir J Burn *[Chair]*	Chairman
	Dame J Daniel	Chief Executive Officer [CEO]
	Mrs M Cushlow	Executive Chief Nurse [ECN]
	Mrs A Dragone	Finance Director [FD]
	Dr V McFarlane Reid	Executive Director of Business, Development & Enterprise [EDBDE]
	Mr A Welch	Medical Director/Deputy Chief Executive Officer [MD/DCEO]
	Mr M Wilson	Chief Operating Officer [COO]
	Ms J Baker	Non-Executive Director [NED]
	Mr G Chapman	NED
	Ms S Edusei	NED
	Mr J Jowett *[until 2.59pm]*	NED
	Mr B Macleod	NED
	Professor K McCourt	NED
	Mr S Morgan	NED

In attendance:
Mrs C Docking, Assistant Chief Executive [ACE]
Mrs D Fawcett, Director of HR [HRD]
Mrs K Jupp, Trust Secretary [TS]
Mr G King, Chief Information Officer [CIO], *[until 3.13pm]*
Mrs A O'Brien, Director of Quality and Effectiveness [DQE]
Mr R Smith, Estates Director [ED]

Observers:
Mrs G Elsender, Corporate Governance Officer and PA to Chairman and TS
Mr P Home, Public Governor
Dr A Dearges-Chantler, Public Governor
Mr S Volpe, Health Reporter

Secretary: Mrs F Darville — Deputy Trust Secretary

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

22/15 STANDING ITEMS

i) Apologies for Absence and Declarations of Interest

Apologies were received from Associated NEDs (ANEDs), Professor D Burn and Mrs P Smith.

The Chairman declared an ongoing interest regarding matters pertaining to COVID-19 testing and the Integrated COVID Hub North East (ICHNE), due to his role as chairman of

QuantuMDx. It was agreed that whilst the Chairman would observe any discussion in the public session regarding ICHNE, he would not take any part in such discussions.

There were no additional declarations of interest made at this time.

It was resolved: to **note** the apologies for absence and the Chairman's declaration of interest.

ii) Minutes of the Meeting held on 27 January 2022 and Matters Arising

The minutes were agreed to be an accurate record of the meeting.

There were no matters arising from the previous minutes.

It was resolved: to **approve** the minutes.

iii) Chairman's Report

The Chairman presented his report, noting:

- The Council of Governors (CoG) meeting held virtually in February 2022 and the recent board development session.
- Recent activities, including the meeting of the regional foundation trust and chairs of the North Integrated Care Partnership (ICP) and the NHS Chairs roundtable event on the Health and Social Care Leadership Review.
- An update on the process for recruiting an additional NED.
- The virtual Members Event, which focussed on the work of the chaplaincy, the Trust's paediatric asthma service and the creation of the cataract centre at the Campus for Ageing and Vitality (CAV).

The Chairman highlighted the ongoing challenging social and geopolitical situation, impacted by the conflict in Ukraine and the cost-of-living crisis, as well as current challenges within the NHS including responding to the COVID-19 pandemic and the associated activity backlog.

The recent publication of the final Ockenden report was noted as a key area of focus for the Trust Board, with further detail to be shared by the Trust CEO. The Chairman highlighted the significance of the report and the importance of building on the work already progressed by Newcastle Hospitals in relation to the interim report.

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

iv) Chief Executive's Report

The CEO presented the report, firstly referring to the publication of the final Ockenden Report and offered the condolences of the Board to the circa 1,400 families impacted over the 19-year period. The report was the culmination of the review of a significant volume of records/evidence, and of the testimonies of staff and families. The outcomes of the report

would be pertinent to the ongoing and future delivery of maternity services throughout the country.

It was noted that circa £127m had been made available nationally for maternity services.

The CEO noted that the teams within maternity services, supported by the ECN, were carefully considering the final report to understand the implications for the Trust and a more formal response would be provided to the Trust Board at the May 2022 meeting.

The report contained updates on a number of areas, with the CEO noting the following points:

- At the time of the meeting, there were 96 COVID-19 positive inpatients and staff absence was currently at 8%. This absence level continued to challenge the organisation in meeting its activity requirements. The CEO expressed the gratitude of the Trust Board to all staff of Newcastle Hospitals for their continuing hard work.
- The UK Health Security Agency (UKHSA) had informed the Trust that they would be terminating their contract with Newcastle Hospitals for ICHNE, reflecting a national policy change regarding COVID-19 testing. The CEO acknowledged the significant achievements made to date, including that the main laboratory had processed over 8m tests, and the innovation laboratory continued to be at the forefront of new technological advances associated with testing, whilst also supporting education and training. The establishment of the ICHNE had resulted in the creation of significant job opportunities and training provision for individuals within the region.

  The CEO noted the organisation's disappointment that funding was not available on a longer-term basis.

  Tribute was paid to the 650 staff impacted by the contract termination, as well as to the COO, the HRD and their teams for their work in supporting the ICHNE staff. The CEO advised that the Trust was working closely with colleagues and partner organisations to do all that was reasonably practicable to avoid or reduce the number of staff at risk of redundancy.

  The innovation lab had been granted funding for a further 12 months from the Accelerated Access Collaborative and the Academic Health Science Centre (AHSC).
- Elective recovery continued to be an area of distinct focus for the Trust's Executive Team and the organisation was in a good position going into the start of a new financial year. However, risks remained in relation to elective recovery in terms of the continued prevalence of COVID-19 and associated staff absence.
- The Trust 10-year estates programme continued, with the construction of the Day Treatment Centre (DTC) progressing at pace. The DTC would assist the Trust's elective recovery and was on course to open in the summer.

  The consultation process to support the Trust planning application for the new dedicated Children's Heart Centre on the Royal Victoria Infirmary (RVI) site had commenced.
- Staff welfare and wellbeing continued to be of paramount importance to the Trust. Following feedback regarding staff catering facilities, particularly at the RVI, a new

staff bistro will be opened in the Leazes Wing in April 2022. The facility would be open from 7:30am to 2am, seven days a week. In addition, the opening hours in the bistro facility in Peacock Hall had been expanded to further expand the staff catering provision.

- The first cohort of the new Strategic Leaders Programme (SLP) has been held. The SLP was created and delivered in collaboration with the Institute of Healthcare Improvement (IHI) to further support and develop Trust leaders. Tribute was paid to the COO, ECN, and HRD in its development, and to the support of the NEDs for their involvement in the programme.

Professor McCourt noted her attendance at one of leadership development sessions and highlighted the positive collaboration amongst attendees. Mr Chapman concurred, noting in particular the enthusiasm amongst participants for change and improvement.

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

22/16 STRATEGIC ITEMS:

i) Digital People Story

The ECN introduced the digital people story, which highlighted the experience of Daniel who had been admitted to the Trust for day surgery. The story highlighted a good example of implementing the Trust's patient experience ambitions into personalised care and the work undertaken by the team involved to provide this for Daniel and his family.

The ECN thanked Daniel and his family for sharing his story.

Mr Jowett queried how the Trust might learn from such an experience and suggested use of technology to provide a 'virtual tour' for patients before their hospital visit. The ECN advised that this was being explored for key areas within the Trust.

Mr MacLeod noted the ongoing importance of continuing to receive such stories at board to highlight the unique nature of patient journeys, particularly in the context of discussions at the Trust Board and Committees regarding elective activity and backlog recovery.

It was resolved: to **receive** the report and the associated digital story.

ii) Trust Recovery Programme:

a. General Update
b. Performance Position; and
c. 2022/23 Plan headlines

The EDBDE presented the update, with the following key points noted:

- The report detailed the updated position following the presentation provided to the January 2022 meeting of the board. The COO advised that the organisation continued to be busy, with both ongoing COVID pressures and emergency demands, however the Trust was committed to delivering its Plan for the year ahead.

- **52 week waits (ww):** The H2 (second half of the 2021/22 financial year) target was to maintain the position as at October 2021. Significant progress had been made to reduce the number of 52wws, however there were still circa 3,764 patients waiting longer than 52 weeks for treatment. The Trust was ahead of the planned trajectory which demonstrated that this number would continue to reduce.
- **104ww:** The H2 target was to eliminate all 104ww by 31 March 2022. The Trust currently had 197 104ww patients. A significant improvement had been made to reduce the number of patients waiting for this time however pressures remained, particularly for spinal patients, which meant that the target would not be realised by 31 March 2022.
- **Cancer – 62-day performance:** The H2 target was to return the number of patients back to those experienced pre-pandemic. For the Trust, this was 213 patients. The current position was 269 patients waiting in excess of 62 days. The Trust continued to be on trajectory to improve this position.
- **Cancer – 28-day faster diagnosis:** The H2 target was to ensure 75% of patients had cancer diagnosed or ruled out within 28 days of referral for diagnostic testing. Compliance with this standard continued to increase and was now above 70%.
- Plan headlines and the submission timeline. The final draft Plan was due to be submitted nationally by 28 April.
- Key targets associated with long waiters (such as the elimination of over 104ww as a priority by July 2022), activity (such as to increase diagnostic activity to a minimum of 120% of pre-pandemic levels), and cancer (such as the return to pre-pandemic 62 day wait levels).
- The plan was based on 2019/20 activity outturn levels, which were higher than current levels. A number of assumptions were also included in the plan, such as that organisations would be able to return to pre-pandemic activity and levels of staff sickness and maintain low COVID inpatient numbers.
- Levels of activity within the organisation continued to be constrained by the current wave of COVID, which impacted both patient numbers and staff absence levels.

The CEO provided further context regarding the 104ww position, particularly for spinal patients, highlighting that the Trust was aiming to eliminate all 104wws by 31 July 2022.

It was noted that meeting the demand for complex spinal surgery was a national challenge, especially for patients with a spinal deformity, with the need for two clinicians to undertake a full day procedure due to the complexity of the procedure. A business case for investment was currently under review by the specialised commissioners.

The COO noted that some areas in the Trust were exceeding their targets. The Integrated Board Report contained within the Board Reference Pack (BRP) highlighted that referrals were up 7% and the Trust's emergency department were seeing 15% more patients than pre-pandemic levels.

Ms Edusei referred to the risk in focussing solely on addressing long waiting patients and health inequalities considerations e.g. prospective patients from disadvantaged communities who may not yet be on hospital waiting lists. The COO explained the way in which patients were prioritised on waiting lists and noted that the Trust was aware that many people from disadvantaged backgrounds (such as those experiencing poverty or

homelessness) often were referred later. The COO noted the inclusion of the health inequalities update report (under agenda item 22/10 iv) which outlined some of the programmes the Trust was involved in to work to address health inequalities and aid prevention. In addition, the Trust was working closely with the voluntary and community sector on a number of the programmes.

The Chairman queried how the Trust would ensure that there were no unintended consequences of the work undertaken e.g. potentially increasing the burden on primary care. The COO explained the social prescribers project, and the 'patient initiated follow up' programme via outpatients which would see patients return straight to hospitals rather than via primary care if required.

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

iii) <u>Director reports:</u>

a. Medical Director: including:

- **Quarterly Guardian of Safe Working Report**
- **Consultant Appointments**

The MD/DCEO presented the report, noting:

- Gratitude to the Trust's Associate Medical Directors for their contributions to the report and their ongoing commitment to the Trust.
- The national patient safety strategy (NPSS) remained an area of distinct focus for the organisation. A review of the Trust's own quality strategy was now underway following publication of the NPSS and an interim update would be presented to the Trust Board within the second quarter of 2022. A full quality strategy refresh would be undertaken in 2023.

  The NPSS introduced a new patient safety framework which would replace the current serious incident framework, which had been in place since 2015. The current framework stipulated organisations' responsibility for the reporting of serious harm to commissioners and for the receipt of a full report within 60 days. The new framework was more self-directed, reduced duplication and would allow for organisations to undertake thematic investigations to identify emerging trends.

  The NPSS also required the appointment of patient safety specialists in the organisation. The DQE and Dr Angus Vincent, Associate Medical Director, had been appointed into these roles.
- Recent clinical director appointments were outlined in section one of the report. There were now six quality and patient safety clinical directors within the Trust which would allow for additional focus on deteriorating patients and the avoidance of harm.
- The expansion of the medical examiner role into the community.
- There were currently 90-100 COVID positive inpatients, which the MD/DCEO noted had remained steady for some weeks. He noted that approximately half of such patients had been admitted for COVID, whilst the other half were found to have COVID upon admission. None of the inpatients with COVID-19 required admission to the intensive care unit or use of ventilation, and around one fifth of those being

treated for COVID-19 required oxygen. The Trust was currently experiencing circa 1-2 COVID related patient deaths per week.

The continuing requirement to treat COVID positive patients negatively impacted the Trust's ability to provide both elective and non-elective care for patients. The MD/DCEO added that despite this, the majority of planned elective surgery was able to go ahead and paid tribute to Trust staff for maintaining good patient flow through the organisation.

- Newcastle Improvement continued to progress, with training ongoing within the Trust for teams and coaches to deliver 'bottom up' quality improvement initiatives.
- The Trust's endoscopy team was congratulated on the recent joint advisory group (JAG) gastrointestinal endoscopy accreditation.
- The Trust's Sir Bobby Robson Unit (SBRU) had retained its status as a funded Cancer Research UK centre for the next five years. Additionally, the Trust's clinical research facility had also received circa £5.5m in funding for the next five years.

Ms Baker queried how the Trust would seek to link the work of Newcastle Improvement with the quality improvement elements of the NPSS. The DQE advised that improvement was an important component of the NPSS and the Trust was committed to strengthening the alignment between quality assurance and quality improvement through the development of a Quality Management System. Areas for opportunity would be identified going forward through audit, inspection, and incident reviews.

Ms Baker also queried whether there was any alignment between the Trust's SLP with IHI and the Collaborative Newcastle joint system leadership programme. It was noted that whilst there were commonalities, each programme was aimed at different cohorts of individuals within organisations (both internally and externally to the Trust) and had different delivery models. Ms Baker highlighted the importance of continuing to move away from leadership 'silos' when creating development programmes. The CEO concurred, noting that programmes were designed with collaboration and alignment in mind.

The quarterly guardian of safe working (GoSW) report and the consultant appointment report, contained within the BRP, were received.

In the GoSW report, Ms Baker requested examples of the identified local solutions to rota gaps and whether these learnings were shared with other wards and departments. The MD/DCEO agreed to request this information from the GOSW [**ACTION01].**

The Chairman noted that the Trust/SBRU being one of five fully funded centres in the country was a testament to the strength of cancer research at Newcastle Hospitals.

It was resolved: to (i) **receive** the MD/CEO report, (ii) to **action** the request from Ms Baker regarding the GoSW report, and (iii) to **receive** the GoSW report and the consultant appointments report for information.

b. Executive Chief Nurse

The ECN presented the report, noting the following key points:

- An update on the Trust's paediatric specialist community therapy teams was provided. A significant increase in demand for services had been observed and was anticipated to continue as the pandemic progressed. A higher number of referrals for speech and language therapy had been received which was believed to be as a consequence of children unable to access nursery and school support during lockdowns. Section 1.5 of the report particularly outlined the range of initiatives and innovations underway across the city.
- Safeguarding activity within the Trust continued to increase. In response to this an external review of the safeguarding team was commissioned to review working practices and a report generated. Work was ongoing to progress the recommendations identified within the report.
- In relation to nursing and midwifery staffing, enhanced scrutiny and oversight had been implemented as a result of increased COVID-related staff sickness and the associated staffing challenges. This was reduced at the end of January 2022, however, was reinstated in the previous two weeks due to the sustained staffing pressures. The ECN outlined the challenges in maintaining core staffing across the organisation and paid tribute to Mr Ian Joy, Deputy Chief Nurse, for the ongoing monitoring.
- A recruitment update was provided, which included detail regarding an upcoming virtual recruitment event and the ongoing healthcare support worker (HCSW) and international recruitment programmes.
- The Trust, in partnership with Northumbria University, opened the Nursing and Midwifery Council (NMC) Test of Competence centre. This was one of five opened nationally for the undertaking of observed structured clinical examinations (OSCEs) for international recruits.
- A summary of the quarter three patient experience and engagement position was outlined in the report. An increase in the number of complaints received by the Trust had started to emerge. This was in line with other organisations nationally.
- Feedback from national surveys was noted.

Ms Edusei requested further detail regarding one of the outcomes from the children and young people patient experience survey regarding distraction of children during treatment and whether this was considered to be a positive or negative indicator. The ECN agreed to feedback outwith the meeting with further context **[ACTION02].**

Noting the challenges in HCSW recruitment, Ms Baker queried whether the Trust had considered recruiting internationally for such roles to address the gap of 83 whole time equivalents (WTEs). The ECN noted that there was a rich talent pool in the region and work was underway with the Trust's civic partners to further address this. The ECN added the national 0% vacancy target for HCSW had proved challenging for NHS organisations to achieve due to competition with favourable terms and conditions in private sector organisations.

It was resolved: to **receive** the report and (ii) to **progress** the action regarding the provision of additional data to Ms Edusei for the children and young people's patient experience survey.

- **Ockenden Update Report**

The ECN presented the report, echoing the CEO's comments regarding the recent publication of the final Ockenden Report.

The Board report contained detail regarding the Trust's response to the interim publication and had been reviewed and discussed in detail at the recent Quality Committee meeting.

The ECN noted the work underway to address immediate and essential action three which related to training and other actions undertaken by the directorate. The actions of the maternity safety champions were outlined.

The next report to be received by the Trust Board would take into consideration the findings of the final Ockenden Report. The ECN advised that there were no areas of concern to note in relation to the immediate and essential actions identified in the final Ockenden Report.

The ECN noted that the implications of the Ockenden Report required consideration for the both the Trust and the wider region.

The current consultation underway with staff in relation to continuity of carer would be extended in light of the recent publication.

Professor McCourt commended the work of the ECN, DQE, and the senior maternity team for their ongoing diligence regarding maternity services.

It was resolved: to (i) **receive** the report and (ii) **note** the assurance provided as well as the identified gaps in the self-assessment.

c. Director of Quality & Effectiveness

- **Quarterly CNST Report**

The DQE presented the report. The Trust was now in its fourth year of the scheme, following the successful completion of year three. The report provided additional assurance to the Board regarding the Trust's self-assessment against the ten maternity safety actions. In acknowledgement of meeting the outlined actions, the Trust was in receipt of a rebate of its insurance payment as well as a portion of the unallocated funds from other organisations who were not compliant.

The following key points were noted by the DQE:

- Year four of the scheme commenced in August 2021, however, was paused in December 2021 in recognition of the ongoing pressures associated with the pandemic. The date of resumption was currently awaited; however, the Trust had continued to apply the maternity safety actions where possible.
- The DQE outlined areas of risk, including compliance with the 90% training standard. All staff were required to undertake a full day of mandatory training annually which had been difficult to achieve due to staffing pressures. A working group had been established to consider this further.
- A further area of risk was noted, being data extraction and submission. The incoming BadgerNet system would streamline the current misalignment with national systems therefore avoiding the need for future manual workarounds.

- Rebates received have been reinvested in maternity services.

It was resolved: to (i) **receive** the report and (ii) that the Board of Directors **approve** the self-assessment with the maternity safety actions to date.

- **Learning from deaths quarterly report**

The DQE presented the report, noting the following points:

- 2,044 deaths occurred within the Trust between January and December 2021. This was an increase on the previous year from 1,785. The cause for the increase was explained, noting that bed occupancy within the Trust had been lower during the peaks of the pandemic, elective admissions had ceased for a time, and the Trust had received a number of critically ill COVID-19 patients from other hospitals outside of the region.
- 45% of the in-hospital deaths in year were subject to a level two mortality review.
- During the period, there were 21 patients who died within the Trust who were identified as having a learning disability. On each occasion, the deaths were reviewed by the clinical team, followed by a further in-depth review by the Trust's Learning Disability Mortality Review Panel before being entered into the LeDeR national database. Going forward, patients with an autism diagnosis would also be included in the LeDeR process.
- The Trust's crude mortality was outlined in section four at between 1-2%. This compared to a regional average of between 2-6%. The Trust also performed well when compared to peers in relation to the Summary Hospital Mortality Indicator (SHMI) and the Hospital Summary Mortality Ratio (HSMR).
- The outcomes of serious incident investigations relating to unexpected deaths were outlined.

Mr Chapman queried the cause for the increase in level one reviews. The DQE noted that this was a positive indicator of the diligence surrounding mortality reviews in the Trust as key criteria were met which meant that a level 2 review was not required e.g. patient receiving palliative care, however, the CGARD Team would continue to monitor the trends and explore any other factors that may be impacting on the ratio of Level 1 to Level 2 reviews.

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

d. Director of Infection Prevention & Control

The DIPC presented the report, noting the following points:

- The ongoing high community prevalence of COVID-19 continued to impact the organisation, as a result of the BA2 omicron variant. It was noted that whilst the severity of patient illness was lower than in previous waves, January and February 2022 had the highest numbers of COVID outbreaks and hospital acquired COVID since the onset of the pandemic.
- The ways in which cases were recorded had been changed by the Government under the 'living with COVID' framework. This had also impacted testing and diagnosis definitions in the community. Infection prevention and control measures would

continue to be used in the Trust and the Trust had developed its own IPC policy to support the recovery programme.

- The Trust's test and trace teams continued to experience a high demand for services, with the difference in responsibilities over the pandemic outlined. Lateral flow testing (LFT) continued to be encouraged on a voluntary basis for asymptomatic staff. The total number of LFT to the end of February 2022 was 143,023, with a positivity rate of 1%. Symptomatic staff continued to have access to PCR testing via the testing pods which had undertaken over 23,800 PCR tests for staff over the course of the pandemic.

  The test and trace team continued to undertake a holistic approach to COVID management, by undertaking such activities as contact tracing and outbreak investigations.
- Staff uptake of the COVID and flu vaccinations was outlined, with the Trust having some of the highest rates of COVID booster vaccination in the country.
- The DIPC outlined the position in relation to the other healthcare associated infections monitored by the Trust. An increase in instances of c.difficile had been observed, which was in line with other providers. This was as a result of a variety of factors including increased patient acuity.
- There were no reported cases of MRSA bacteraemia in the Trust, a position held since April 2020.
- The Trust would achieve the national targets for HCAI reduction but not the Trust's self-imposed 10% reduction target.
- An additional sepsis nurse was appointed and commenced in post in late February. In addition, a Clinical Director had been appointed for deteriorating sepsis. This would allow for further review of Trust practice and enable a gap analysis to be undertaken.
- The launch of the Trust's 'Take Five' audit was noted for April and would allow for further monitoring of anti-microbial stewardship across the organisation.

Ms Edusei commended the Trust on its high rates of COVID vaccination amongst staff, however noted surprise at the lower uptake of the flu vaccination. She queried how this position compared to last year's flu campaign and what lessons had been learnt to inform next year's campaign. The ECN noted the difficulty in making year on year comparisons, noting the increase in eligible staff as a result of the larger headcount. The 69% uptake equated to circa 11,000 staff which was higher than elsewhere in the region. The ECN also advised improvements were required in relation to data collection, as circa 4-5% of staff received their vaccination elsewhere and this was not recorded.

Mr Morgan queried the likelihood of COVID variants becoming stronger rather than weaker and whether there was a long-term strategy in place for vaccination booster doses. The DIPC noted that whilst recent variants were milder, this was not always the case and highlighted that variants with higher transmissibility would be more successful in spreading amongst the population. In relation to boosters, the DIPC noted the focus on the development of longer lasting vaccines rather than more regular boosters.

The MD/DCEO noted that many in the population had received a fourth vaccination and a further dose next winter was likely.

The Chairman queried whether there had been any development in a combined COVID/flu vaccine. The DIPC advised that there had been no new developments on the matter.

Mr Chapman queried how the Trust would mitigate the risk of COVID in the organisation following the removal of free government testing. The DIPC advised that the Trust was developing plans for the future management of COVID and would move toward treating it the same as any other similar viruses. A comprehensive plan for PCR requirements going forward was required.

[Mr Jowett left the meeting]

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

e. Human Resources Director

- **People Report**

The HRD presented the report and reiterated the thanks of the CEO to ICHNE staff and commended the organisation's partners in assisting in the facilitation of identifying potential alternative employment. She noted that a number of ICHNE staff had applied for the Trust's HCSW apprenticeships which was an encouraging development.

The following key points were noted

- An update on sickness absence was provided. Despite a fall in overall absence following the peak in January 2022, the decline was not sustained. Of the 8% total sickness absence, 3.4% were COVID related.
- The Trust's wider wellbeing offer was outlined, which included a public transport subsidy.
- An update on the staff survey was provided. The HRD noted that the results were disappointing for some parts. The HRD reiterated that the Trust continued to be committed to listening to the thoughts and feelings of its workforce and would continue to utilise the 'What Matters to You' programme, in collaboration with IHI. This ongoing dialogue supported the Trust's overall wellbeing offer. Further analysis from Quality Health, the survey provider, had been requested.
- The receipt of a number of awards was outlined in the report, including a gold award as part of the Trust's Stonewall assessment and the shortlisting in the Recruitment Industry Diversity Initiative awards.
- An update on the local clinical excellence awards (LCEA) was provided.
- The report provided a comprehensive update on learning and development opportunities within the Trust, with the HRD paying tribute to Ms Gill Long, Associate Director of Education and Workforce Development for the coordination of the Trust's programmes.
- Apprentice activity was noted, as well as the anticipated resumption of face-to-face work experience. Further investment in the Trust's virtual learning environment was approved in February 2022, with work underway to implement the system.
- Developments in medical education were outlined, including the appointment of two new clinical educators.
- An update on the development of education space and facilities was provided, with work continuing at both the Freeman Education Centre and Eldon Court.

- The Trust had begun the process of consultation across the workforce regarding a potential reorganisation of the Directorate structure. Good levels of participation had been observed to date.
- Recruitment activity continued to be in high demand and further work was required to improve appraisal completion rates.

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

- **Gender Pay Gap Report 2021/22**

The HRD presented the report, noting its receipt and discussion at the February meeting of the People Committee. Organisations were required to publish the gender pay gap data on 31 March 2022 following approval by the Trust Board and signature by the CEO. The HRD advised that the data in the report presented the position as at 31 March 2021.

Mr Macleod referred to the 20% improvement in percentage terms and queried whether there were any one-off factors contributing to this improvement and whether it could be further sustained. The HRD advised that the Trust's positive action undertaken to increase diversity in local clinical excellence awards would assist in further accelerating this going forward.

Ms Edusei requested that the information contained within the report be disaggregated further to allow for greater interrogation of the data. This would allow for the review of medical and dental staff as separate groups, as well as other staff groups and via protected characteristics. The HRD advised that this information would be made available to Board members and advised that the contents of the report met with the requirements for national reporting **[ACTION03].**

The Chairman queried whether there had been an increase observed in staff retirements as a consequence of the pandemic. The HRD noted that 'the great resignation' had been reported in the press however this has yet to affect the Trust in substantial numbers.

The Trust Board agreed the report for publication.

It was resolved: to (i) **receive** the report, (ii) **approve** the report for publication, and (iii) for the HRD to **provide** disaggregated data to board members for further interrogation.

iv. Health Inequalities Update

The COO presented the report, noting that this was the second of such reports received by the Trust Board. In addition, the Board had received further update at a recent Board Development Workshop, as well as the recent NED participation national health inequalities workshop. The following points were noted:

- The report's appendix contained the NHS Providers health inequalities board assurance tool. The Trust's Health Inequalities Group were due to consider the tool at their next meeting.
- The report outlined the actions underway to strengthen the Trust's approach to tackling health inequalities. This included the appointment of two co-clinical directors

and three clinical leads for health inequalities. In addition, Dr Balsam Ahmed, a consultant in public health, had become part of the COO directorate. Dr Ahmed had responsibility for the coordination of the Trust's health inequalities work plan, as well as providing population health management advice across the organisation.

- The COO outlined the upcoming health inequality and levelling up event in late May for participants of the Collaborative Newcastle joint system leadership programme. This would provide opportunity for both staff and external participants.
- The report outlined the Trust's prevention programmes that reduced health inequalities, with the COO noting encouraging work in relation to reducing tobacco and alcohol consumption, as well as the COVID vaccination programme. Further development in relation to the way in which such data was presented was required, with the Newcastle Health Innovation Partnership (NHIP) to assist.

[Mr King left the meeting]

- The report also outlined the ways in which health inequalities were being positively impacted via Collaborative Newcastle. This included the Duplication to Personalisation programme (supported by Newcastle Hospitals Charity) and Children and Families Newcastle, with the hub and spoke model in place to allow for the co-location of some of the Trust's 0-19 services.
- The report detailed collaboration between the Trust and primary care for the pre-operative optimisation of patients with uncontrolled diabetes. This was developed by clinicians and discussion was underway with colleagues in the voluntary sector regarding further collaboration for healthier outcomes for patients.

Professor McCourt queried whether the recovery navigators in the emergency department, as referenced in section four, had commenced in post. The COO advised that he would ascertain this and feedback outwith the meeting **[ACTION04].**

The Chairman requested a future 'spotlight on services' on the hub and spoke model utilised for the Children and Families Newcastle programme. The TS agreed to schedule this **[ACTION05].**

It was resolved: to (i) **receive** the report, (ii) for the COO to **ascertain** the status of the recovery navigators, and (ii) for the TS to **schedule** a 'spotlight of services' for the Children and Families Newcastle programme.

22/17 ITEMS TO RECEIVE AND ANY OTHER BUSINESS

i) Update from Committee Chairs

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

People Committee
Professor McCourt noted the recent meeting which provided an update on the people implications of the COVID-19 pandemic and ICHNE, and a deep dive into recruitment for the

DTC. The committee received the quarterly Guardian of Safe Working report, as well as the Gender Pay Report, as well as a presentation on Safe Staffing.

Charity Committee
Ms Baker noted that the recent meeting of the Committee received an update regarding the work of the Charity Governance Working Group, a task and finish group convened to consider the actions required to ensure the requirements of the Charity Commission, as well as the NHS, were satisfied.

Mr Jon Goodwin, Head of Grant Programmes, presented the grants for approval. In total 12 grants were approved, totalling circa £1.3m. Of those, seven were in partnership with other organisations and accorded with the charity's ambition to collaborate with partners across the city. Ms Baker highlighted in particular the support for the Children's Cancer North charity and the Wolfson Childhood Cancer Research Centre as a result of the pandemic.

Quality Committee
Mr Chapman provided an update on the recent meeting, noting the good attendance and contribution of senior medical and nursing staff at meetings. The Committee received regular updates on the Trust's progress against the immediate and essential actions required as part of the Ockenden Report.

The Committee continued to focus on the importance of the delivery of harm free care, through deep dives and detailed discussion.

Finance Committee
Mr Morgan advised that the Trust was due to break even at the end of the financial year. He noted that the Committee have discussed in detail the challenges anticipated within the next financial year in relation to the finance regime and associated risks. An extraordinary meeting had been convened for late April to discuss the Trust's financial plan for 2022/23.

The committee continued to discuss the Trust's procurement plan and the financial position regarding the construction of the DTC. Mr Morgan commended the COO and team for the achievements regarding the ICHNE.

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

ii) <u>Corporate Governance Update; including:</u>

a. Updated Appointments and Remuneration Committee Terms of Reference and Schedule of Business

The TS presented the report, with the following points noted:

- Governor and membership activity was summarised within the report. This included recent meetings and progress regarding the governor elections.
- Minor amendments were requested to the terms of reference and schedule of business for the Appointments and Remuneration Committee, which required the approval of the Trust Board.
- NED recruitment activity and the procurement of an external well-led review continued.

- The quarterly NHS Improvement declarations, which also required the approval of the Trust Board.

The board **approved** both the terms of reference and schedule of business for the Appointments and Remunerations Committee and the quarterly declarations.

It was resolved: to (i) **receive** the report, (ii) **approve** the terms of reference and schedule of business, and (iii) **approve** the quarterly declarations.

iii) Integrated Board Report

The report was received.

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

iv) Meeting Action Log

The TS presented the action log position and confirmed that action 86 (data relating to onward destinations of staff leaving the ICHNE following the end of fixed term contracts) was now complete as the COO had shared the required information. In addition, a meeting had been scheduled next week between Ms Baker and the COO regarding action 80 (inclusion of voluntary and community groups representatives, as well as those with 'lived experience', within the Trust's Health Inequalities Group).

It was resolved: to **receive** the action log position.

v) Any other business

The Chairman expressed the gratitude of the Trust Board to the DTS at her last meeting.

DATE AND TIME OF NEXT MEETING

The next meeting of the Board of Directors was scheduled for **Tuesday 31 May 2022**.

There being no further business, the meeting closed at 15:28.

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	31 May 2022		
Title	Chairman's Report		
Report of	Professor Sir John Burn, Chairman		
Prepared by	Gillian Elsender, PA to Sir John Burn		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☐	☒

Summary	The content of this report outlines a summary of the Chairman's activity and key areas of focus since the previous Board meeting, including:
	• Governor Activity including:
	  ○ Governor Elections;
	  ○ Meeting with the Lead Governor and Working Group Chairs;
	  ○ Charing a Governor Task & Finish Group;
	  ○ Chairing our Council of Governors Workshop
	• Board Development Session.
	• Recruitment of a new Trust Non-Executive Director.
	• Spotlight on Services – Urology.
	• Attendance at one of our Strategic Leadership Programme cohorts.
	• Regional engagement with Foundation Trust Chairs of the North Integrated Care Partnership (ICP), Local Authority and Voluntary Sector representatives.		

Recommendation	The Board is asked to note the contents of the report.		
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. Pioneers – Ensuring that we are at the forefront of health innovation and research.		

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

Impact detail	Provides an update on key matters.
Reports previously considered by	Previous reports presented at each meeting.

CHAIRMAN'S REPORT

EXECUTIVE SUMMARY

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

- Governor Activity including:
  - Governor Elections;
  - Meeting with the Lead Governor and Working Group Chairs;
  - Chairing a Governor Task & Finish Group; and
  - Charing our Council of Governors Workshop.
- Board Development Session.
- Recruitment of a new Trust Non-Executive Director.
- Spotlight on Services – Urology.
- Attendance at one of our Strategic Leadership Programme cohorts.
- Regional engagement with Foundation Trust Chairs of the North Integrated Care Partnership (ICP), Local Authority and Voluntary Sector representatives

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

CHAIRMAN'S REPORT

I am writing my report today on what has been described by our meteorologists as the hottest day so far this year – long may it continue!

Since my last report earlier in the year my activity has been varied although a lot has been undertaken virtually due to having contracted COVID-19 from my wife, I am pleased to say we have made a full recovery.

There has been considerable Governor activity since our last meeting:

- **Governors Elections -** Our annual round of Governor elections is underway with voting closing at 5.00pm on Monday 30 May 2022 and the results being published on the Trust website the following day.

- **Lead Governor and Working Group Chairs -** I have met with the Lead Governor and Chairs of the People Engagement and Membership, Business and Development and Quality of Patient Experience Working Groups who provided an update from their respective areas.

- **Task and Finish Group -** I joined a number of Governors and Non-Executive Directors where we discussed the valuable relationship between the two Groups and how we can further improve the positive interaction in the future.

- **Council Of Governors Workshop -** We held our first Council of Governors Workshop of 2022 in April, and it was wonderful to finally welcome our Governors to attend in person. We were joined by a number of Board colleagues who delivered comprehensive presentations on a number of areas, including Operational and Financial Planning for 2022/23, as well as an update on our workforce including recruitment, retention, and challenges.

In terms of Board activity in April, I chaired a Board Development Session virtually which included:

- Discussion on the current Trust position in relation to the Well-Led Framework Key Line of Enquiry 5: Are there clear and effective processes for managing risks, issues and performance? We discussed the Trust Board Assurance Framework, the Risk Management Policy and risk management processes in place.
- A briefing on the headlines from the final Ockenden Report issued in March 2022 and feedback from recent Royal College Reviews.

Rounding off the session was a Leadership Walkabout to the Day Treatment Centre currently under construction at the Freeman Hospital site which I was unfortunately unable to join due to adhering to COVID-19 isolation requirements.

Following a robust recruitment process I am pleased to announce that we have appointed Liz Bromley as a new Non-Executive Director to the Board. She is Chief Executive Officer of NCG (formerly Newcastle College Group), one of the UK's largest national Further Education

College Groups. Throughout her career, Liz has led on a number of significant change programmes and service restructures and has a strong background in leadership and other professional development. She is a passionate advocate of education as the force behind genuine social mobility and cultural capital.

As part of our Spotlight on Services, I chaired a virtual meeting with the Urology Team. Jo Noble, Directorate Manager, Urology and Renal Services and Institute of Transplantation was joined by her colleagues Caroline Wroe, Clinical Director of Renal and Urology, Toby Page, Consultant Urologist and Sally Ridley, Matron who delivered a comprehension presentation via Teams covering:

- An overview of Newcastle Urology;
- Areas of excellence/key achievements;
- Key risks/issues; and
- Priorities for now and future development.

This was followed by a physical Leadership Walkabout to the Urology Department based at the Freeman Hospital visiting the Lithotripsy Unit, Emergency Assessment Unit as well as the Urology Treatment Suite. It was very clear from the Walkabout that there was a positive team culture within the Directorate with a strong multidisciplinary team approach. It was evident how staff have responded to the pandemic and adapted services to support the patient pathways, with new ways of working.

I was delighted to be invited to attend the Strategic Leadership Programme currently running for our Senior Managers and spoke alongside Graeme Chapman, Non-Executive Director. Upon completion the programme aims to enable participants to be able to apply new frameworks, mindsets, leadership behaviours and tools to lead advancement of Trust-wide priorities, take part in and lead collaborative coaching as well as planning how to incorporate NHS-wide changes into a local context. I was asked to share an element of my own leadership journey.

At a regional level, I continue to engage with both Foundation Trust Chairs and Chairs of the Integrated Care Partnership (ICP). We bid a virtual farewell to Alan Foster former CEO of the ICS at the end of March and welcomed Sam Allen as the new Chief Executive ahead of the ICS becoming a statutory organisation. Sam brings a wealth of experience which will be invaluable as we work together to tackle the issues that matter to our communities and deliver a shared ambition to reduce longstanding health inequalities, support people to live healthier lives, and deliver the highest standards of care.

Our most recent ICP meeting with Foundation Trust Chairs, Local Authority and Voluntary Sector representatives focused on ICS progress, Urgent Care Services as well as receiving a stakeholder update on the North East Transport Plan 2021-2035.

I also had the pleasure of meeting with Ms Allison Thompson, newly appointed Chair of South Tyneside and Sunderland NHS Foundation Trust. We hope to increase interaction between our organisations as part of the move to greater regional integration.

Our Trust leads one of England's seven Genomic Laboratory Hubs. I am pleased to continue to provide expert guidance in this area where I play a national and international role. This includes having agreed to be the Vice President Elect of the Human Genome Organisation. I am now a trustee of the European wing of this charitable organisation, headquartered in the United States. I will be attending its annual meeting, this year in Tel Aviv, prior to our Board Meeting. The charity is working to ensure global access to the health benefits of genomic medicine, addressing educational and ethical aspects, and are seeking to engage the World Health Organisation and UNESCO in these efforts.

RECOMMENDATION

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

Report of Professor Sir John Burn
Chairman
19 May 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 May 2022						
Title	Chief Executive's report						
Report of	Dame Jackie Daniel, Chief Executive Officer						
Prepared by	Caroline Docking, Assistant Chief Executive Lewis Atkinson, Principal Advisor Alison Greener, Executive PA to the CEO						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	This report sets out the key points and activities from the Chief Executive. They include: • An overview of the Trust's current performance and planning for 2022/23; • Work being carried out to support leadership, research and innovation; and • Headlines from key areas, including the Chief Executive's networking activities, our awards and achievements.						
Recommendation	The Board of Directors are asked to note the contents of this report.						
Links to Strategic Objectives	This report is relevant to all strategic objectives and the direction of the Trust as a whole.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☒	☐	☒	☒
Impact detail	This is a high-level report from the Chief Executive Officer covering a range of topics and activities.						
Reports previously considered by	Regular report.						

CHIEF EXECUTIVE'S REPORT

EXECUTIVE SUMMARY

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

- The finalisation and submission of plans for the 2022/23 financial year;
- An update on the delivery and performance of emergency and elective care;
- The economic and financial situation facing the Trust, its staff and patients;
- Work to develop and support leadership;
- National research funding applications;
- Networking and communication activity; and
- Recognition and awards for staff.

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

CHIEF EXECUTIVE'S REPORT

1. OVERVIEW

Planning and performing

Since the last Board meeting, the Trust has made steady progress in both developing our plans for the 2022/23 year and beginning to deliver upon them for the patients and population that we serve.

Like all other NHS organisations, we have now made our formal planning submissions outlining the waiting times, activity, and financial delivery we expect to see every month until March 2023. I want to thank everyone involved for their work in developing these alongside the work they do to care for our patients every day.

The last two months have still had periods of significant operational pressure within them – not least in late March and over Easter – but our services have been resilient and continued to offer good access to urgent and emergency care throughout. At a time when there has been a national and regional focus on ensuring timely handovers of patients from ambulances into Accident and Emergency (A&E), I am proud that this is something we have always consistently delivered for our patients at Newcastle.

We have also continued to make steady progress in reducing elective waiting times. In January, we had around 250 patients waiting more than 104 weeks for treatment, but we now have less than 80 patients in this situation, nearly all of whom are for highly specialist spinal procedures. We will continue to see the number of long waiting times fall as we mobilise the new investment in our spinal services that we have agreed with NHS England's Specialised Commissioners. We are also continuing to implement our plans to open the new Day Treatment Centre at the Freeman Hospital later in the year.

A key component of aligning the work of the organisation for the year ahead are the breakthrough objectives that we set ourselves to help achieve the strategic ambitions that we set out in our Trust strategy. We agreed this year's objectives by looking at the key areas that our patients and staff have highlighted as important to them, alongside what we need to do to deliver the goals that the Government sets for the NHS as a whole. The objectives we set have a laser focus on patient safety and quality, while also prioritising providing the best environment for our staff to work in. Each objective has specific, measurable deliverables but they are summarised as:

- **Patients**: We will continue to improve the quality of care that we offer to our patients;
- **People:** We will continue to improve our staff experience;
- **Partnerships:** We will continue to develop the anchor role for Newcastle Hospitals whilst developing a strong partnership with the Integrated Care Board;
- **Pioneers:** We will enhance patient pathways; and
- **Performance:** We will continue to deliver outstanding performance.

Financial pressures and support

No-one is unaffected by the current economic situation, and as a Trust we are particularly conscious of the impact that high inflation is having on patients and staff. We have taken action to provide further support to staff where we can, temporarily increasing mileage rates to recognise the current high cost of petrol and providing a discount on public transport passes. These measures sit alongside our existing offers of financial wellbeing guidance and support.

We also know from listening to staff that having consistent access to good, affordable food across all shifts is very important. Because of arrangements linked to the Private Finance Initiative (PFI) funded New Victoria Wing, consistent access to food has not always been available at the Royal Victoria Infirmary (RVI) site – a situation which has been a source of frustration to many staff. I am delighted to now report that our new Leazes Wing Bistro for staff has opened which provides much better facilities for staff and will soon offer 24-hour catering.

The current difficult economic situation also has implications for the organisation and NHS as a whole, with cost pressures impacting on the price of the goods and services we buy. After two years of financial arrangements and funding centred around responding to COVID-19, a new NHS financial regime and settlement is in place this year, and this requires all NHS organisations to identify and deliver efficiencies as part of their plan.

In the last month I am delighted we have appointed Jackie Bilcliff as the Trust's new Chief Financial Officer, who will join us at the end of the summer to replace Angela Dragone following her retirement. Jackie joins us from Gateshead Health NHS Foundation Trust, where she is Group Director of Finance and Deputy Chief Executive. To provide additional support at a time of financial transition, we have also recently welcomed Bill Boa who has joined as Interim Strategic Financial Advisor, with a particular focus on helping to identify and structure the efficiencies we need to deliver this year.

Leadership

Meeting the varied challenges that we face – from improving quality of care, to reducing waiting times or working more efficiently – requires the key ingredient of collective leadership.

Last month, the NHS England Chief Executive Amanda Prichard gathered Trust and Integrated Care System Chief Executives in London for the first in-person NHS national leadership meeting since the start of the pandemic. It was wonderful to reconnect with colleagues that I had only seen virtually for such a long time. Coming together was an opportunity to talk about how we can make the NHS that we collectively lead fit for the future, and how we would work together to meet shared responsibilities we have for the nation's care and treatment.

A key part of Flourish, the Trust's cornerstone programme to support staff to liberate their full potential, is our work to develop our leaders. Our opportunities to do this by bringing leaders together have increased with the lessening of pandemic restrictions, and I have

been delighted to hear positive feedback from a range of leadership programmes that we are running with support from partners such as the Institute of Health Improvement (IHI).

Our new Strategic Leaders Programme has been giving our senior leaders time together to reflect, recover and look ahead to new and different ways of working in the NHS, while also ensuring the leaders have the tools required to lead successfully in the future. This programme adds to the wider leadership offer we already have in place, such as the Leading an Empowered Organisation (LEO) programme for nurses, midwives and allied health professionals, and our Developing our Talent programme, which helps managers to maintain resilience while supporting their teams and deliver results.

Developing our leaders and embedding positive leadership behaviours is crucial because we know that well-led, supported and engaged people deliver better outcomes to patients. We will continue to focus on developing and strengthening leadership in the months ahead.

Research and Innovation

Developing our world-class research and innovation continues to be a priority, and since the last Board meeting a particular focus of my work has been in supporting Newcastle bids for National Institute for Health and Care Research (NIHR) funding. Alongside other Trust and Newcastle University colleagues, I was interviewed in London as part of the assessment of our Biomedical Research Centre (BRC) and Patient Safety Research Collaborative (PSRC) applications. The experiences were positive and showed the strength of Newcastle's collective partnerships and expertise in fields such as Long-Term Conditions. These funding processes are always very competitive, and we hope to hear the outcomes soon.

I am also delighted to report that funding has been confirmed from the Academic Health Science Network for the North East and North Cumbria (AHSN NENC) to continue the work of the North East Innovation Lab in assessing and validating the next generation of diagnostic testing. The Innovation Lab was originally set up as part of the Integrated Covid Hub North East (ICHNE) which looked at detecting and containing Coronavirus. The Innovation Lab is attracting national attention as a unique facility, and we expect it will continue to develop relationships and funding streams from industry partners as it plans for ongoing sustainability.

2. NETWORKING ACTIVITIES

In the last two months, I have continued a busy programme of meeting colleagues within and outside the organisation to maximise our collective understanding, reach and influence. I have also continued to visit a variety of areas across the Trust.

Diabetes Service Visit

Last month I had the pleasure of visiting our fantastic Diabetes team at the Campus for Ageing and Vitality (CAV). I met with some remarkable patients who have lived with type-1 diabetes for decades and who, during the pandemic, volunteered to take part in an NHS

England pilot study to trial innovative hybrid closed loop technology to manage their diabetes differently.

I heard how the development of technology has changed their experience of living with diabetes, meaning they no longer need to undergo the finger prick tests to measure blood glucose but are now monitored continually with automatic adjustments to the amount of insulin given through a pump, resulting in improvements in control of blood sugar levels.

There was an overwhelming sense of admiration and gratitude to the staff who helped them be 'part of the team' managing their own care. This was a great example of how we can combine care, expertise and innovation to enhance the quality of life for our patients.

North East & North Cumbria Integrated Care System (ICS) & Provider Collaborative

I have continued to meet with system colleagues across the North East and North Cumbria in a variety of forums ahead of the formal establishment of the Integrated Care Board (ICB) on 1 July.

Discussions have included the system's combined plan for finance, activity and performance in the year ahead, how we can collectively improve both waiting lists and emergency care access, as well as how we secure the future workforce we need in shortage specialties such as oncology.

We were delighted to welcome Sam Allen, the Chief Executive (Designate) of the ICB to our Trust at the beginning of April for a visit programme that included regional services such as children's cardiac, cancer, intensive care and maternity services. I and members of the Executive Team have also had discussions with Sam and her new team about the future approach to working at place, using learning from our experience through Collaborative Newcastle, as well as the ICB's future approach to population health and workforce.

National events and influencing

I have held a number of engagements with and on behalf of the Shelford Group, including welcoming Will Warburton, the new Managing Director, on his two-day introductory visit to Newcastle Hospitals earlier this month. With Shelford colleagues I also met with Roz Campion, the new Director of the Office for Life Sciences. We outlined the track record and capability of Shelford Trusts as a partner to government and industry, and discussed where best we could collaborate in the coming months.

In the last two months I have been involved in a number of meetings with Amanda Pritchard, CEO of NHS England, including one with Shelford colleagues where we discussed the respective future roles of Foundation Trusts, Provider Collaboratives and Integrated Care Systems. A further meeting with Amanda convened by NHS Providers discussed the approach to urgent and emergency care and post-Covid elective recovery.

Since my last Board report, I am proud to have been appointed as Vice-Chair and Trustee of the NHS Confederation, a role which will officially begin in July. I am currently undertaking several induction meetings with the rest of the Confederation board. I am sure this new role

will give new opportunities to contribute to and influence national policy, and I look forward to ensuring the continued national prominence of our Trust, its services and expertise.

3. RECOGNITION AND ACHIEVEMENTS

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

Major grant for antibiotic research – Dr Tom Hellyer, an honorary intensive care consultant and part of the Newcastle University Translational and Clinical Research Institute, has been awarded a £1.9million grant to determine whether antibiotic exposure in critically ill patients with sepsis can be safely reduced by shortening the duration of the initial course.

The funding - part of the Health Technology Assessment (HTA) grant from the NIHR - will deliver a large trial recruiting over 2,000 patients from 50 critical care units in the UK.

Digital excellence – Congratulations to our IT team and everyone who worked with them to help the Trust achieve HIMSS stage 6 accreditation across all our sites, becoming one of only eight NHS organisations to have achieved this level or higher. The Trust has also been officially accredited as a Global Digital Exemplar (GDE) for fulfilling our commitments as part of the GDE programme with NHS England.

200th anniversary – Newcastle Eye Infirmary – In March we marked 200 years since the Newcastle Eye Infirmary first opened its doors and I would like to thank all of our team, who currently perform around 65,000 procedures a year, as well as everyone who has contributed and developed these services.

Continence Nurse of the Year awards – The Newcastle Specialist Continence Service won at this year's British Journal of Nursing Awards for their Light Urinary Incontinence Project (LiP) with a core focus on good bladder healthcare and reducing the reliance on continence products whilst improving quality of life for patients and their loved ones.

Student Nursing Times Awards – Members of our Practice Education Team were finalists in this year's awards in recognition of their work with the North East and North Cumbria Covid vaccination hubs to rapidly create a unique placement allowing students to be involved in the response to the pandemic through the vaccination programme.

Transformational leader – Congratulations to our Non-Executive Director, Steph Edusei, who was awarded the Transformational Leader award at the Northern Power Women Awards. Steph leads the way in promoting equal rights, ensuring the voices of BME women are heard nationally and strategically.

National appointment – Head of occupational therapy, Odeth Richardson, has been elected as the new Chair of the British Association of Occupational Therapists (BAOT)/Royal College of Occupational Therapists (RCOT). Odeth will become the 21st Chair of BAOT/RCOT Council when she takes over from Professor Diane Cox at the end of June.

Heart transplants – Our cardiothoracic team have been part of the Joint Innovative Fund (JIF) UK wide DCD (donation after circulatory death) heart pilot, which has resulted in 56 patients nationally (including 15 in Newcastle which had higher numbers than most centres) receiving a transplant after donor death within the time criteria.

Prior to this trial, none of these organs could have been donated for transplantation for patients on the waiting list. This is a remarkable achievement for the team and, of course, we must acknowledge those patients – and their families – who made the decision to give the gift of life to others.

VAD nursing team – Congratulations also to our VAD (ventricular assisted devices) nursing team who were runners up in the 'Best Thoracic NAHP Team of the Year' category of the Society for Cardiothoracic Surgery Awards.

4. RECOMMENDATION

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

Report of Dame Jackie Daniel
Chief Executive
31 May 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 May 2022		
Title	Digital People Stories		
Report of	Maurya Cushlow, Executive Chief Nurse		
Prepared by	Tracy Scott, Head of Patient Experience		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	This month's digital people story shares the lived experience and career pathway of a member of staff who joined the Trust as a physiotherapy assistant. Róisín is now a physiotherapist with funding from the National Institute for Health and Care Research (NIHR) to pursue her research as part of a prestigious pre-doctoral clinical academic fellowship. This story demonstrates the NMAHP strategic commitment to strengthening academic links and research offers to NMAHP staff and demonstrates links to the Trusts strategic objectives to ensure each staff member is able to liberate their potential.		
Recommendation	To listen and reflect on the personal and professional career pathway and the positive impact this is having on patient outcomes.		
Links to Strategic Objectives	Patients • Putting patients at the heart of everything we do. • Providing care of the highest standard focusing on safety and quality. People • Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential. Pioneers • Ensuring that we are at the forefront of health innovation and research.		

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

Impact detail	Involving and engaging with staff, patients and relatives will help ensure we deliver the best possible health outcomes for our patients.
Reports previously considered by	This patient/staff story is a recurrent bi-monthly report.

DIGITAL PEOPLE STORY

EXECUTIVE SUMMARY

As the largest collective workforce, the nurses, midwives and allied health professionals (NMAHP) of Newcastle Hospitals are made up of approximately 7,000 individuals working across acute and community care settings. The uniqueness of their contribution is highly specialised and is delivered through the Trust's strategic framework in achieving local excellence and global reach through compassionate and innovative healthcare, education, and research.

This month's staff story shares the lived experience and career pathway of Róisín who started working at Newcastle hospitals as a physiotherapy assistant and qualified as a physiotherapist in 2018. As a rotational band 5 physiotherapist, Róisín had the unique opportunity to work across many different clinical areas, working alongside different staff groups and with a diverse range of patients with individual healthcare needs.

In 2019, Róisín began her clinical-academic journey by undertaking a service evaluation project to help design a seven-day activity diary to promote and monitor inpatient mobility following abdominal surgery The reason for this was that Róisín was aware from personal observation and research evidence that older adults are particularly vulnerable to poorer outcomes as a result of hospitalisation. Research literature indicated at this time that older patients spend approximately 83% of their hospital stay in bed and 12% of their time in a chair, therefore accelerating reductions in muscle mass and strength. Evidence suggests that hospital ward staff might encourage and contribute to these sedentary behaviours.

To understand more about the impact of hospital-acquired deconditioning (HAD) on patient outcomes and experience, Róisín was awarded the Newcastle Hospitals Band 5 NMAHP Research Internship. During the internship, Róisín discovered that there was no evidence-based intervention to prevent hospital-acquired deconditioning among older people. Therefore, Róisín developed a bespoke mixed-methods questionnaire to explore multidisciplinary healthcare professionals' views of promoting mobility in hospital.

The results of the survey highlighted staff's specific training needs about the risks and benefits of promoting physical activity in hospital and the impact of hospital-acquired deconditioning. The challenge with preventing HAD lies in breaking the habits of hospital clinical and nursing staff as staff's primary focus in hospital is generally on resolving the acute problem and therefore, less attention is given to the underlying risk of functional decline. Unintentionally, ward staff can sometimes encourage sedentary behaviours and 59% of nurses have reported that mobility was one of the most commonly neglected areas of their work owing to a lack of available time (BGS Healthier for Longer report, 2019). The service evaluation Róisín completed supported this evidence, and also highlighted professional-role boundaries that impacted patient outcomes and experience.

On completion of the Band 5 Internship, Róisín successfully applied for funding from the Council for Allied Health Professions Research (CAHPR) to co-design and produce a digital training resource to raise awareness of the benefits of adopting a coordinated

multidisciplinary approach to promoting inpatient activity amongst nursing and therapy staff in response to the results of the survey.

This video is now included in the Trust's induction programme for all new starters including the training of healthcare assistants and volunteers. It is also available on the post-graduate doctors-in-training induction page and the doctors on the assessment suite will receive this training in the coming weeks. The video has been shared and presented on competency frameworks, regional and national professional networks and is supported by the Emergency Care Improvement Support Team (NHS Improvement and NHS England).

Róisín has also been invited to present the video to the North East North Cumbria Allied Health Professional preceptorship group as part of the Integrated Care System, with the aim of developing a regional version of the video.

With encouragement and support from the Trust to continue a clinical academic career, Róisín was awarded Research Capability Funding (RCF) to help prepare a high quality, competitive National Institute for Health and Care Research pre-doctoral clinical-academic fellowship application in 2020.

Róisín is currently completing her pre-doctoral clinical academic fellowship that provides her with dedicated time to grow from a full-time clinician to an emerging clinical-academic leader while undertaking the research training needed to advance her programme of doctoral and post-doctoral research that will support older adults to live longer, healthier and more independent lives.

RECOMMENDATION

To listen and reflect on Róisín's personal and professional career pathway and the positive impact this is having on patient outcomes.

Report of Maurya Cushlow
Executive Chief Nurse
20 May 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 May 2022						
Title	Trust Performance Report						
Report of	Martin Wilson – Chief Operating Officer & Vicky McFarlane-Reid – Director of Business, Development & Enterprise						
Prepared by	Elliot Tame – Senior Performance Manager						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	This paper is to provide assurance to the Board on the Trust's elective recovery progress as well as performance against NHS England (NHSE) priorities for 2022/23 and key operational indicators.						
Recommendation	For assurance.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality. Performance – Being outstanding now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☒	☐
Impact detail	Details compliance against NHSE plan priorities for 2022/23. Details compliance against national access standards which are written into the NHS standard contract.						
Reports previously considered by	New report which will be submitted for every Trust Board meeting.						

TRUST PERFORMANCE REPORT

EXECUTIVE SUMMARY

This report provides an overview of the Trust's continuing recovery of elective activity as well as performance against both contracted national access standards and the priorities for the year outlined by NHSE as part of the 2022/23 planning round.

- NHS England operational planning guidance for 2022/23 is target focused, with Newcastle Hospitals submitting trajectories including reducing the number of >104WW to 30 by the end of March 2023, the return of cancer patients waiting >62 days to February 2020 levels and promising substantial progress on the transformation of outpatients throughout 2022/23.
- Provisional data suggests Newcastle Hospitals delivered day case activity equivalent to 93% of April 2019 volumes, with overnight elective activity slightly lower at 85%. Outpatient activity as a whole was delivered at 101% of the levels recorded in April 2019.
- No ambulance handovers greater than 60 minutes have been recorded for two months, whilst the Trust was compliant with the <2% 12-hour Emergency Department (ED) waits requirement in April. However, the Trust did not achieve the 95% Accident and Emergency (A&E) 4-hour standard in March, with performance of 82.5%.
- The 28-day Faster Diagnosis Standard (FDS) for cancer care has been comfortably exceeded in the past two months, but seven of nine cancer standards fell short of target in March 2022.
- At the end of April, the Trust still had 84 patients waiting >104 weeks, but this represented a 28% reduction from the previous month. Referral to Treatment (RTT) Compliance was 69.4%.

The Board of Directors is asked to receive the report.

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Trust Performance Board Report

May 2022

Healthcare at its best
with people at our heart

Contents

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Executive Summary

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Purpose

This report provides an overview of the Trust's continuing recovery of elective activity as well as performance against both contracted national access standards and the priorities for the year outlined by NHSE as part of the 2022/23 planning round. It has been established as a standalone report to provide more comprehensive scrutiny and accountability of operational performance as the Trust continues to strive to deliver higher volumes of treatments, reduce and eliminate the longest waits and transform the ways in which it delivers outpatient care. An overarching Delivery Board chaired by the Chief Executive also meets regularly to review and support further elective recovery and performance improvement.

The report is split into three sections, the first of which details the key access and delivery requirements highlighted by NHSE as national priorities for the forthcoming year as the NHS continues its operational recovery following the COVID-19 pandemic, alongside the Trust's trajectory responses. This is followed by a dashboard detailing current compliance with these requirements and subsequent narrative providing context for current performance against these metrics.

The second section provides an overview of the Trust's current performance against our contractual access standards and successive slides outlining the current position, underlying issues and actions being undertaken in relation to key waiting time standards within referral to treatment emergency care, cancer care and diagnostic pathways. The report concludes with current delivery against a list of metrics to provide additional operational context.

Report Highlights

- NHS England operational planning guidance for 2022/23 is target focused, with NuTH submitting trajectories including reducing the number of >104WW to 30 by the end of March 2023, the return of cancer patients waiting >62 days to February 2020 levels and promising substantial progress on the transformation of outpatients throughout 2022/23.
- Provisional data suggests NuTH delivered day case activity equivalent to 93% of April 2019 volumes, with overnight elective activity slightly lower at 85%. Outpatient activity as a whole was delivered at 101% of the levels recorded in April 2019.
- No ambulance handovers greater than 60 minutes have been recorded for two months, whilst the Trust was compliant with the <2% 12 hour ED waits requirement in April. However the Trust did not achieve the 95% A&E 4hr standard in March, with performance of 82.5%.
- The 28 day FDS for cancer care has been comfortably exceeded in the past two months, but seven of nine cancer standards fell short of target in March 2022.
- At the end of April the Trust still had 84 patients waiting >104 weeks, but this represented a 28% reduction from the previous month. RTT Compliance was 69.4%.
- Directorates are currently engaging in a round of Activity Plan meetings throughout April and May, focused on the support and transformation required to bridge the remaining gap to pre-pandemic activity delivery levels. They have also drawn up initial ideas to help contribute to the required reduction in review appointments.

NHSE Plan Requirements 22/23 (1/4)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

2022/23 NHSE Plan Requirements

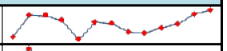
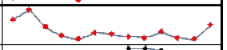
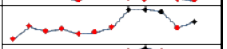
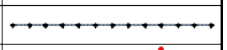
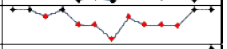
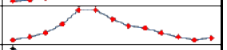
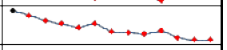
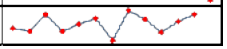
During the winter of 2021/22, NHS England released their 2022/23 operational planning guidance illustrating their priorities for the year ahead. Planning for 2022/2023 is target focused, with an ambition to deliver over 10% more completed pathways than prior to the pandemic through the delivery of >104% value based activity, as well as reduce and eliminate long waits. Specific targets established include:

- Eliminate waits of over 104 weeks by July 2022 and maintain this position through 2022/23 (except where patients choose to wait longer).
- Eliminate waits of over 78 weeks by April 2023, except where patients choose to wait longer or in specific specialties.
- Develop plans that support an overall reduction in 52 week waits where possible, in line with ambition to eliminate them by March 2025.
- Accelerate progress already made towards a more personalised approach to follow-up care in hospitals or clinics, reducing outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023.
- Return the number of cancer patients waiting over 62 days to levels observed in February 2020.

To support these ambitions, diagnostic activity should increase to a minimum of 120% of pre-pandemic levels across 2022/23 (for a specific group of tests). Overall activity should be delivered at 104% of 2019/20 levels, weighted for equivalent financial case mix value and with outpatient reviews capped at 85% of 2019/20 volumes. Overachievement against the 104% standard will deliver additional elective recovery fund finances to the ICS and in turn the Trust.

NHSE Plan Requirements 22/23 (2/4)

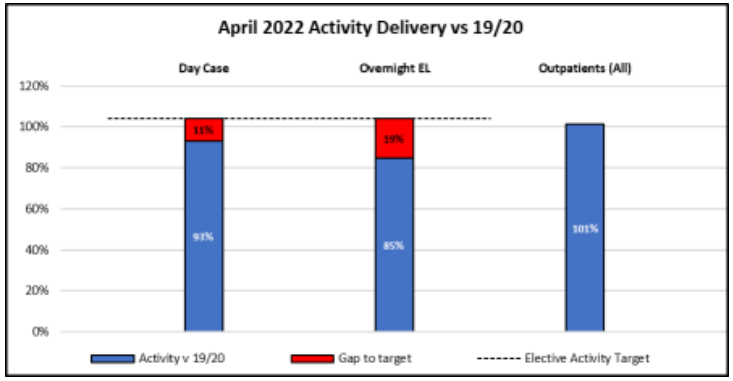
The Newcastle upon Tyne Hospitals NHS Foundation Trust

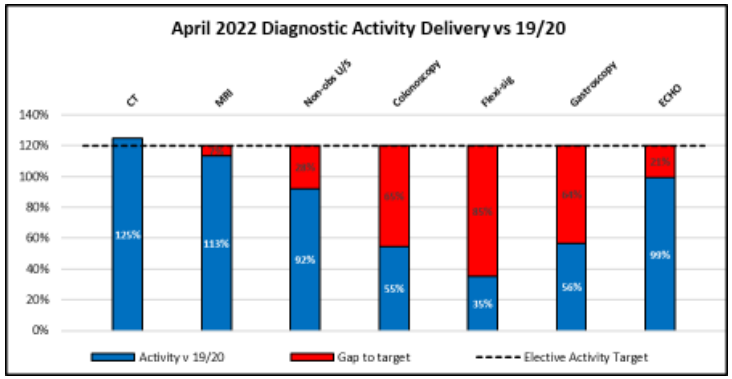
Metric	Requirement	RAG Rating		Jan-22	Feb-22	Mar-22	Apr-22	Trendline
		Trajectory	Target					
Activity Delivery								
Day Case	104% of 19/20 levels combined (Reviews fixed at 85% of 19/20)			87.5%	88.7%	91.7%	93.0%	
Elective Overnight				76.6%	71.0%	69.2%	84.8%	
Outpatient New				111.9%	101.6%	105.4%		
Outpatient Procedures				103.5%	99.2%	101.1%	101.4%	
Outpatient Reviews				103.7%	102.3%	103.0%		
Total (Value based)				TBC	TBC	TBC	TBC	
Completed Treatments	110% of 19/20 levels			TBC	TBC	TBC	TBC	
Diagnostics*	120% of 19/20 levels			107.6%	102.2%	101.0%	103.3%	
Emergency Care								
Ambulance Handovers	>=65% under 15 mins	N/A		66.8%	66.5%	67.5%	68.5%	
	>=95% under 30 mins			96.2%	96.9%	95.9%	96.6%	
	100% under 60 mins			99.9%	99.9%	100.0%	100.0%	
A&E Arrival to Admission/Discharge	<2% over 12 hours			0.2%	0.1%	0.3%	0.5%	
Cancer Care								
>62 Day Cancer Waiters	Reduce to <=213 by e/o Mar-23			334	318	289	385	
28 Day Compliance	>=75%			71.0%	84.8%	83.4%	TBC	
Elective Care								
>104 Week Waiters	Zero by e/o Jun-22			226	193	117	84	
>78 Week Waiters	Zero by e/o Mar-23			989	806	662	722	
>52 Week Waiters	Reduction (Zero by e/o Mar-25)			3,829	3,730	3,535	3,636	
Outpatient Transformation								
Specialist Advice Requests	16 in every 100 New OP atts.	N/A		7.0%	8.5%	7.5%	TBC	
Virtual Attendances	>=25% Non-F2F			20.9%	19.2%	18.6%	18.5%	
PIFU Take-up	>=5% of all OP atts. by e/o Mar-23			N/A	N/A	N/A	0.1%	
Outpatient Reviews	<=75% of 19/20			96.3%	104.5%	109.7%	TBC	

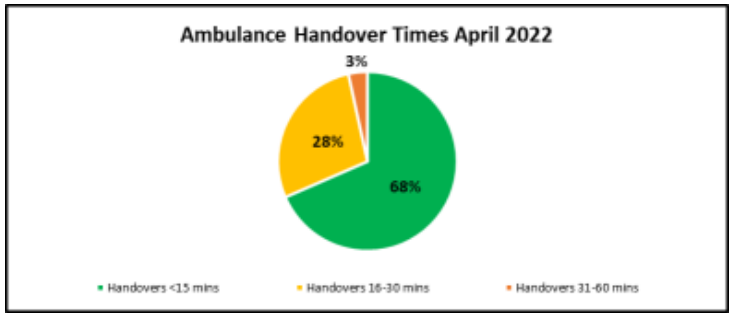
* Applicable to CT, MRI, Non-obs Ultrasound, Gastroscopy, Colonoscopy, Flexi-sigmoidoscopy and ECHO.

NHSE Plan Requirements 22/23 (3/4)

The Newcastle upon Tyne Hospitals NHS Foundation Trust







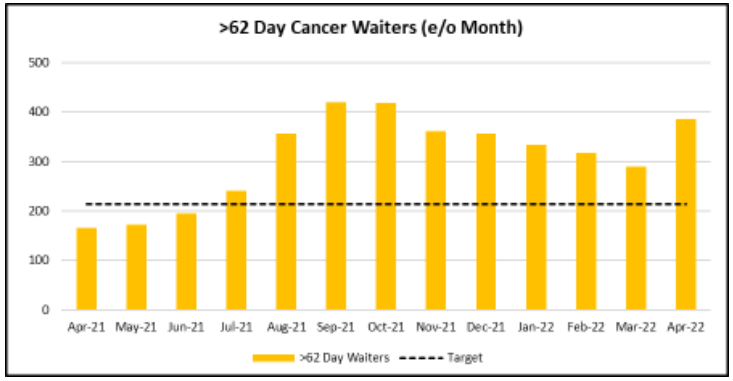
Activity Delivery

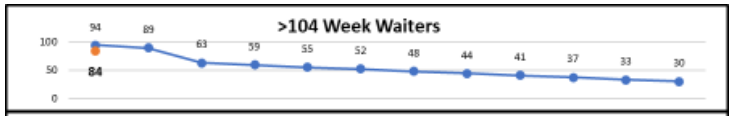
- Provisional data suggests NuTH delivered day case activity equivalent to 93% of April 2019 volumes, with overnight elective activity slightly lower at 85%.
- Due to internal issues with outpatient activity data, we are currently unable to split outpatient procedure activity from new or review appointments. However for outpatient activity as a whole the Trust delivered 101% of the levels recorded in April 2019. These issues are anticipated to be resolved ahead of the next report.
- Activity delivery in both day case and overnight settings represent an improvement on previous months, whilst outpatient recovery has consistently been above 100% recently.
- Due to the aforementioned data issues we cannot state any indicative performance against the 104% value activity target at this time, however the data available is sufficient to be sure that the Trust did not achieve this overall requirement in April.
- Diagnostic activity has been at over 100% of pre-COVID levels for months, but continues to fall short of the 120% target. Whilst the extra capacity afforded by the Community Diagnostic Centre in Blaydon has helped increase activity, even the potential expansion to the Metro Centre is unlikely to provide sufficient capacity to consistently deliver the volume of tests as required by NHSE.
- Directorates are currently engaging in a round of Activity Plan meetings throughout April and May, led by the Chief Operating Officer and supported by the wider Executive team. These reviews have focused on scrutiny of current elective recovery achievement at specialty level, with discussions on the support and transformation required to bridge the remaining gap as well as tackle elective and cancer long waits.

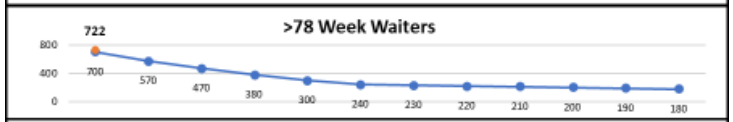
Emergency Care

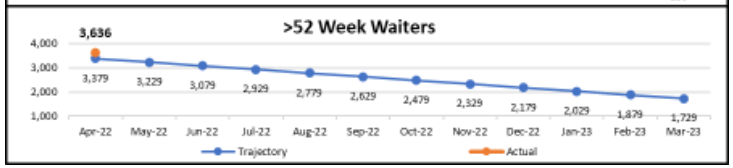
- All ambulance handover targets have been consistently met by the Trust in recent months. There are some data quality issues concerning handover times recorded by the North East Ambulance Service (NEAS) affecting all acute Trusts in the region, and NUTH's emergency care team continue to raise these.
- The 12 hour ED wait is a new target measuring time from arrival to admission/discharge, and different to the 12 hour trolley wait target also monitored and for which breaches are very rare for the Trust (the last one was in October 2021). 12 hour ED waits averaged three per day in April but NuTH were nonetheless compliant with the <2% target.

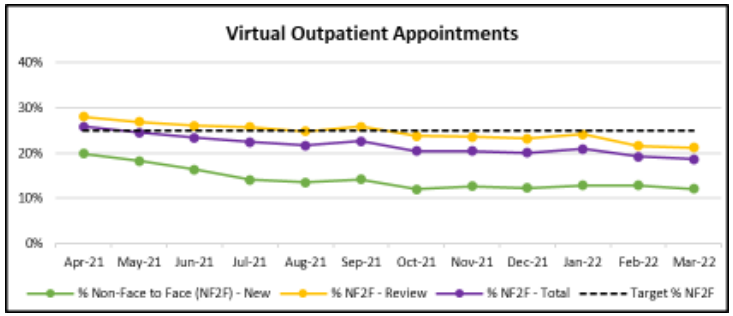
NHSE Plan Requirements 22/23 (4/4)











Cancer Care

- Progress had been made in reducing the >62 day backlog in early 2022, largely due to reductions in skin cancer waiters through the use of teledermatology and weekend WLIs. However the April >62 day backlog snapshot saw a significant increase, impacted by bank holidays and high staff sickness levels.
- The 28 day standard has been comfortably exceeded in the past two months with performance above the Northern Cancer Alliance (NCA) average. Performance against this standard has also benefitted from the aforementioned skin cancer developments.

Elective Care

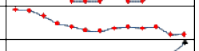
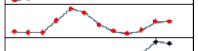
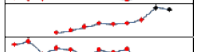
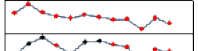
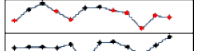
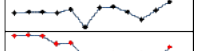
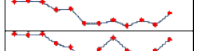
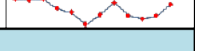
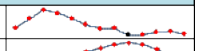
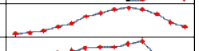
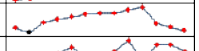
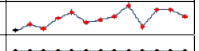
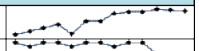
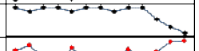
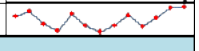
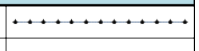
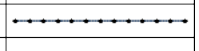
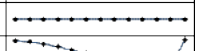
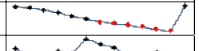
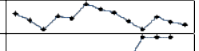
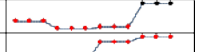
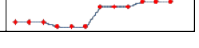
- The total number of >104WW reduced to 84 by the end of April, ahead of trajectory. Only 12 of these patients were in non-Spinal services, where there are anticipated to be zero waiters in this band by the end of June 2022.
- A business case as been agreed with commissioners to fund an expansion in capacity of Spinal services, which had been severely lacking prior to the pandemic.
- >78WW volumes increased for the first time in months to 722, slightly above trajectory, as did the total number of >52WW.

Outpatient Transformation

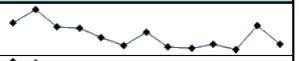
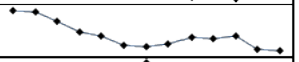
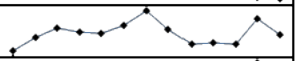
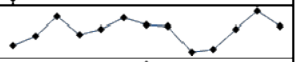
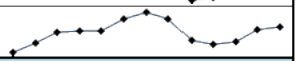
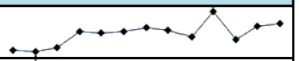
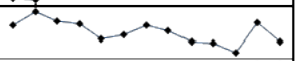
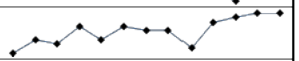
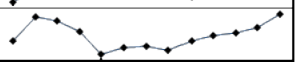
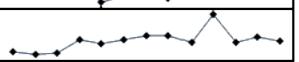
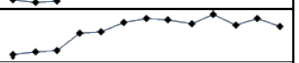
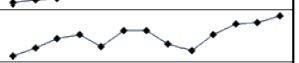
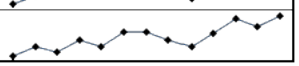
- Virtual attendances as a percentage of all outpatient attendances started 2021/22 at greater than 25%, but this incrementally declined throughout the year and stood at 18.5% for April. At 0.1%, PIFU take-up was below trajectory (0.25%), however such outcomes only became recordable mid-month and it is anticipated that figures will increase as services capture encounters where PIFU was already being delivered in all but name.
- All Directorates have drawn up initial plans and ideas to help contribute to the required reduction in review appointments, including wider adoption of advice and guidance provision and one stop clinics.

Operational Standards

The Newcastle upon Tyne Hospitals NHS Foundation Trust

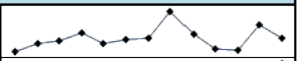
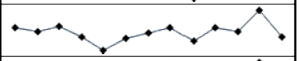
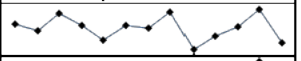
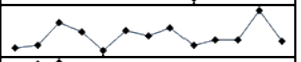
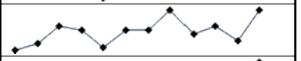
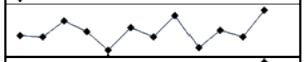
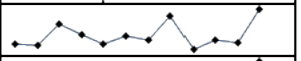
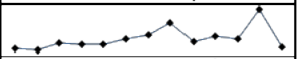
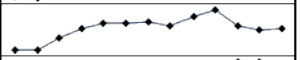
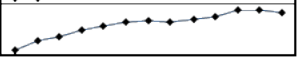
Metric	Standard	RAG Rating	Jan-22	Feb-22	Mar-22	Apr-22	Trendline
Emergency Care							
Ambulance Handovers	Zero >60 mins		2	1	0	0	
A&E Arrival to Admission/Discharge	95% <4 hours		84.8%	85.6%	82.2%	82.5%	
	<2% over 12 hours		0.2%	0.1%	0.3%	0.5%	
Cancer Care							
Two Week Wait (Suspected Cancer)	93%		82.8%	92.0%	84.1%	Cancer data runs one month behind	
Two Week Wait (Breast Symptomatic)	93%		24.8%	37.2%	38.0%		
28 Day FDS	75%		71.0%	84.8%	83.4%		
31 Days (First Treatment)	96%		85.0%	85.2%	86.9%		
31 Days (Subsq. Treat. - Surgery)	94%		59.1%	73.6%	66.7%		
31 Days (Subsq. Treat. - Drugs)	98%		94.1%	96.8%	96.4%		
31 Days (Subsq. Treat. - Radiotherapy)	94%		96.1%	97.9%	99.5%		
62 Days (Treatment)	85%		54.6%	50.3%	60.2%		
62 Days (Screening)	90%		69.0%	71.4%	81.0%		
Elective Care							
18 Weeks RTT	92%		69.4%	70.0%	70.1%	69.5%	
>104 Week Waiters	Zero		226	193	117	84	
>6 Weeks Diagnostic Waiters	1%		25.0%	19.4%	18.2%	16.9%	
Cancelled Ops. Rescheduled >28 Days	Zero		2	10	10	7	
Urgent Ops. Cancelled Twice	Zero		0	0	0	0	
IAPT							
Wait to First Appointment	75% <=6 weeks		98.4%	99.2%	98.8%	98.5%	
	95% <=18 weeks		100.0%	99.4%	99.0%	98.7%	
Movement to Recovery (Overall)	50%		37.8%	40.5%	43.7%	44.0%	
Other							
Duty of Candour	Zero		0	0	0	0	
Mixed Sex Acommodation Breach	Zero		0	0	0	0	
MRSA Cases	Zero		0	0	0	0	
C-Difficile Cases	<=113 (FY cumulative)		141	157	169	12	
VTE Risk Assessment	95%		95.0%	96.5%	95.9%	95.6%	
Sepsis Screening Treat. (Emergency)	90% (of sample) <1 hour			90.0%		TBC	
Sepsis Screening Treat. (All)				60.0%		TBC	

Other Metrics

Metric		Jan-22	Feb-22	Mar-22	Apr-22	Trendline
Emergency Care						
Ambulance Arrivals		2760	2699	2970	2749	
Type 1 Performance (A&E 4 hour)		76.2%	77.0%	71.4%	71.0%	
Type 1 Attendances (Main ED)		11,077	10,998	13,035	11,716	
Type 2 Attendances (Eye Casualty)		1,257	1,417	1,563	1,446	
Type 3 Attendances (UTC)		4,538	4,693	5,670	5,880	
Patient Flow						
Covid Inpatients (average)		113	36	74	80	
Emergency Admissions		5,540	5,293	6,087	5,571	
G&A Bed Occupancy		84.0%	85.0%	86.0%	86.0%	
Critical Care Bed Occupancy		72.0%	73.0%	74.8%	79.1%	
Bed Days Lost (average)		301	109	143	114	
Medical Boarders		73	56	66	53	
Length Of Stay >7 Days		684	740	741	775	
Length Of Stay >21 Days		303	339	318	346	

Other Metrics

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Metric		Jan-22	Feb-22	Mar-22	Apr-22	Trendline
Cancer Care						
2WW Appointments		1,907	1,898	2,403	2,120	
Cancer First Treatments		477	447	467	541	
Planned Care						
Outpatient Referrals (2WW)		2,189	2,472	2,733	2,209	
Outpatient Referrals (Urgent)		5,489	5,298	6,286	5,068	
Outpatient Referrals (Routine)		24,166	25,505	28,004	23,390	
Day Case Activity		9,083	9,112	10,754	8,976	
Elective Activity (Overnight)		1,518	1,608	1,883	1,661	
New Outpatient		27,672	25,210	30,225	91,560	
Review Outpatient		70,573	67,827	77,977		
Outpatient Procedures		15,775	15,499	18,077		
Diagnostic Tests		17,872	17,623	20,659	16,837	
DNA Rate		9%	8%	8%	8%	
RTT WL Size		94,495	97,270	97,447	96,321	

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31st May 2022						
Title	Medical Director's Report						
Report of	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Prepared by	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☐	☒				
Summary	The Report highlights issues the Medical Director wishes the Board to be made aware of.						
Recommendation	The Board of Directors is asked to note the contents of the report.						
Links to Strategic Objectives	Putting patients at the heart of everything we do and providing care of the highest standard focusing on safety and quality.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☐	☐
Impact detail	Detailed within the report.						
Reports previously considered by	This is a regular report to Board. Previous similar reports have been submitted.						

MEDICAL DIRECTOR'S REPORT

EXECUTIVE SUMMARY

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

- Quality & Patient Safety Update;
- Newcastle Improvement Update;
- Clinical Collaboration with Performance;
- Infection Prevention and Control (COVID 19 and Monkeypox)
- Cancer Performance;
- UK DCD Heart Transplant Pilot..

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

MEDICAL DIRECTOR'S REPORT

1. QUALITY AND PATIENT SAFETY

- There are two specific quality cases under consideration by the trust at present that are quite fundamental to how we function as an organisation and that merit oversight by the board. These will be discussed in private session.
- National Patient Safety Strategy Update - preparations for implementation continue. The two major threads under current development are the Patient Safety Incident Response Framework replacing the current Serious Incident Framework; and the Patient Safety Partners roles.
- Patient Safety Partners- the Trust is considering how best we can genuinely involve our patients and their families in how we build the safest possible environment for all our patients. This is more challenging than at first sight in particular to avoid tokenistic or insubstantial contribution from this key group and we will ensure the Board remain sighted as this part of our strategy develops.

2. NEWCASTLE IMPROVEMENT

Quality Improvement continues to be embedded throughout the organisation via a range of modalities including the launch of an e-learning package, continuation of improvement learning and sharing events, in-house and external training, and provision of advice and guidance to teams and individuals. The Trust's partnership with the Institute for Healthcare Improvement (IHI) is nearing the end of its first year and has supported 15 teams comprising 85 individuals, 34 coaches and 30 senior leaders with improvement sponsorship roles, to develop skills and confidence in delivering improvements at both a local and Trust-wide level.

In creating the aim for Newcastle Improvement, namely *'to provide an opportunity for all 18,000 colleagues and relevant strategic partners to gain an understanding of the Newcastle Improvement approach, incorporating the Model for Improvement, and to have the confidence and ability to apply this learning to deliver improved outcomes for patients, an enhanced staff experience, increases in productivity, contributions to financial stability and supporting the Trust's commitment to becoming a net-zero carbon organisation by 2040,'*we have worked with clinical and corporate teams to embed measurement within improvement initiatives and supported the creation of improvement networks.

Recognising the important role that Newcastle Improvement has in supporting operational recovery, assistance has been provided to Outpatient transformation programme - with a key achievement in the launch of Patient Initiated Follow-Up pathways – and the Day Case transformation programme with a focus on standardising processes and improving operational efficiencies and patient experience.

3. CLINICAL COLLABORATION WITH PERFORMANCE

The Associate Medical Directors (AMDs), as part of their portfolios, have specific oversight of specific Directorates. They are directly involved in collaborating with the business and finance teams to facilitate recovery.

4. INFECTION PREVENTION AND CONTROL

- **COVID 19 -** Covid rates are decreasing across the community which is reflecting on the hospital rates. Inpatients diagnosed with COVID-19 are roughly split half and half between those with a mild respiratory illness and those where COVID-19 is an incidental finding. Our screening policies and patient pathways have been designed to facilitate access to our clinical services rather than being an obstacle to patient treatment and we have been pioneers in the instigation of many of those protocols. At the time of writing there are 26 COVID 19 inpatients including 15 incidentals. No patients are currently ventilated.
- **Monkeypox -** Across the UK there is a cluster of cases of Monkeypox infection. This is not unique to the UK and cases are also appearing across Europe of what is otherwise a rare illness more often seen in the African continent. Infectious disease specialists, Microbiologists and Virologists have advised national and regional network teams on management pathways of these cases, one of which has been referred to our High Consequence Infectious Diseases Unit as per existing protocol. The mortality from this infection is very low and the risk to patients, staff and visitors is very small.

5. CANCER PERFORMANCE

Provisional May Position - Overall, there has been a general improvement in Newcastle Hospitals' cancer wait performance compared with previous reports particularly in terms of the Faster Diagnostic Standard (FDS) and 62-day Referral to Treatment (RTT) standard.

- 14-day GP Two Week Wait (WW) is 78.5% (85%)There has been a significant improvement in lower GI 2 WW performance from 40% in November to 90% in January. This has been achieved with a number of improvements in the lower GI pathway including use of the FIT test, endoscopy, and the appointment of an additional lower GI nurse endoscopist, funded by the Northern Cancer Alliance (NCA) for 3 years, and the new 2WW nurse led service for lower GI Cancer Waiting Time (CWT) referrals.
- 31-day first treatment remains at 85% (95%)
- 31-day subsequent treatment. Surgery has improved from 59.1% to 63.5 % (94%); Chemotherapy remains at 93.1% (98%); Radiotherapy continues to perform well at **97.1%** (94%); 28 FDS has improved further to **80.0.%** (75%).
- 62-day performance has improved to 65% (85%)
- It is anticipated that the 62-day performance will continue to improve. Upper GI, Lower GI, Lung and Urology make up the majority of the backlog.
- Lower GI - significant improvement in endoscopy performance with funding of additional endoscopy Clinical Nurse Specialist and fourth endoscopy room Radiology capacity for CT Colonography remains challenging.

- Did Not Attend (DNAs) have been a significant problem – a new cancer care coordinator is due to commence in post which will improve this and ensure that clinical capacity is optimally used.
- Increase in out of area referrals, particularly Cumbria.
- Now up to full complement of colorectal surgeons.
- Lung Cancer- Consultant new patient clinic slots have increased with the appointment of new lung cancer physicians at the Freeman Hospital. Endobronchial Ultra Sound slots remain an issue but new equipment now available. Awaiting outcome of Ward 25a business case to increase thoracic surgery capacity
- Urology – relatively high post 62-day backlog but on benchmarking, are in the middle of Shelford Group Trusts. Urology have access to additional theatre sessions from non-cancer lists on Freeman Hospital site, and work is ongoing with peri-ops to increase this. Radiology have provided ring fenced computerised tomography (CT) slots for Cancer Waiting Time (CWT) urology referrals as pilot.
- The Corporate cancer team continue to work with each tumour group to enable them to achieve their individual trajectories for performance recovery.
- Galleri Trial has resulted in a number of referrals with positive cancer signals for head and neck , breast, upper and lower Gastro Intestinal (GI) and prostate cancer.
- Rapid Diagnostic Service (RDS) and Non-Specific Symptom (NSS) pathway- Dave Nylander is the clinical lead with a Nurse Consultant and Care Coordinator. This new service is seeing an increase in referrals with positive feedback from patients and primary care colleagues. All of the positive GRAIL patients were referred into Newcastle Hospitals via the RDS and patient diagnostic and management pathways worked well.

6. UK DCD HEART TRANSPLANT ACTIVITY

Over the duration of the Joint Innovation Fund (JIF) Donor Circulatory Death (DCD) heart pilot in 07/09/2020 until 28/4/22, 225 DCD hearts were offered, and a National Organ Retrieval Services (NORS) team was mobilised to attend 107 of these.

In 56 cases a heart transplant resulted after donor death within time criteria, reanimation of the heart in an organ care system and assessment. Prior to the trial none of these donors could or would have been used for transplantation of the patients on our waiting list and so this is a remarkable achievement.

Individual unit activity is as follows :

- Birmingham -3
- Glasgow -3
- GOSH - 4
- Harefield – 14
- **Newcastle - 15**
- Papworth - 16
- Wythenshawe – 1

Outcomes are similar to using conventional DBD donor hearts.

7. BOARD REFERENCE PACK DOCUMENTS

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

a) Quarterly Guardian of Safe Working Report

8. RECOMMENDATION

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

A R Welch FRCS
Medical Director
23rd May 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 May 2022						
Title	Executive Chief Nurse (ECN) Report						
Report of	Maurya Cushlow, Executive Chief Nurse						
Prepared by	Ian Joy, Deputy Chief Nurse Diane Cree, Personal Assistant						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☐	☒				
Summary	This paper has been prepared to inform the Board of Directors of key issues, challenges, and information regarding the Executive Chief Nurse areas of responsibility. The content of this report outlines: • Harm Free Care Spotlight; • Clinical Assurance Toolkit update (CAT); • Safeguarding Quarter 4 (Q4) update; • Learning Disability Q4 update; • Patient Experience Q4 update; and • Palliative and End of Life Care Services.						
Recommendation	The Board of Directors is asked to note and discuss the content of this report.						
Links to Strategic Objectives	• Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. • We will be an effective partner, developing and delivering integrated care and playing our part in local, national and international programmes. • Being outstanding, now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☐	☒	☐	☐
Impact detail	Putting patients first and providing care of highest standard.						
Reports previously considered by	The ECN Update is a regular comprehensive report bringing together a range of issues to the Trust Board.						

EXECUTIVE CHIEF NURSE REPORT

EXECUTIVE SUMMARY

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

Section 1: This month's 'Spotlight' section outlines the work of the 'Harm Free Care Team'. The Harm Free Care Team is made up of a range of specialist staff who provide services across the Trust. The teams cover both acute and community sites and work collaboratively with clinical teams to support the delivery of harm free care to our patients.

Section 2: This section provides an update on the development and implementation of the new digital Clinical Assurance Toolkit.

Section 3 and 4 Provide a Q4 update of Safeguarding and Learning Disability activity including analysis and review of the activity team. The sections outline the factors which are having an impact on the continued trend of increased activity and referrals into the team as well as the increasing complexity of case management.

Section 5: This section gives a summary of Q4 patient experience data, which includes:

- Complaint Activity
- Feedback from national Maternity patient experience survey
- Patient Involvement and Engagement
- Patient equality, diversity, and inclusion update

Section 6: This section provides a brief update on the Palliative Care and End of Life Services. The team aim to support the delivery of high-quality best practice palliative and end of life care to patients and carers in Newcastle hospitals and community. Highlighted in this section are a number of key workstreams and achievements from the recent months.

RECOMMENDATIONS

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

EXECUTIVE CHIEF NURSE REPORT

1. HARM FREE CARE

Patients are at the centre of all that we do. We want to ensure patients receive the highest standard of care, have excellent outcomes and be free from avoidable harm when in our care. When patients experience avoidable harm the impact to them can be devastating. Whether this is a fall causing harm or pressure damage to their skin this can lead to increased time in hospital which can impact on their clinical outcome, can lead to unnecessary pain and long term injury, and negatively impact on their experience and pathway of care. The financial cost of avoidable harm and the impact on clinical effectiveness is also significant.

To truly deliver on the Trusts strategic objective 'Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality' we need to ensure there is unrelenting focus on the delivery of harm free care.

The Harm Free Care Team is comprised of 18 whole time equivalent (wte) members of staff (excluding Infection Prevention and Control (IPC)) who work singly and collectively across a range of complex clinical areas to support the delivery of harm free care. The staff focus on assessment, treatment, prevention, and managing risk in clinical conditions. The individuals lead complex work streams across the Trust including the management of tissue viability, falls prevention, management of the deteriorating patient, delivering of best practice dementia care, promotion of nutrition and hydration, and specialist continence advice including the reduction of infection. To lead the harm free care agenda across the Trust with 18wte staff is challenging but there continues to be evidence of continuous improvement of patient experience and the reduction in patient harm.

The rest of this section will focus on two aspects of work; Tissue Viability and Falls Prevention.

1.1 Tissue Viability Teams

Tissue Viability (TV) is a speciality that primarily focuses on all aspects of skin care and skin intergity which includes the prevention and management of acute wounds, pressure ulcers and skin ulceration. The TV of 6wte staff work across community and acute services and provide expert guidance and specialist support to clinical staff for all aspects of wound care and pressure ulcer prevention and treatement. The team is led professionally by the Clinical Academic Nurse Consultant (Tissue Viability) and supported by the Senior Nurse for Clinical Standards and Quality Improvement.

The last 12 months have seen an increased demand on the TV service. At present the team receive approximately 40-50 new referrals for community intervention per month on top of their existing caseload and the acute service dealt with 5,380 patient encounters last year. This is a 42% increase from the previous year. It is thought that as a direct consequence of COVID-19, patients have not accessed health care services, and have thus presented with

significant complex wounds, both within the community and acute settings. The skill and expertise of the TV team is paramount in providing timely expert advice, treatment and support.

In community, it was recognised that to ensure people with complex wounds can be cared for at home or closer to home the team needed to support staff to increase their knowledge, skills and experience in wound care. This led to the TV Team undertaking a proactive trial of increased input within one specific district nursing team in the city to better understand a typical caseload. The prevalence of wounds were high and wound care was recognised as the most demanding area of care delivery for the team. The project demonstrated that proactive input from TV can help reduce district nursing workload, significantly improve patient outcomes and reduce admission to hospital. As a result of the findings, work is underway to support increased education and training in community teams and explore the most effective utilisation of the TV teams expert skill and advice.

The increase in patient age, acuity and frailty means that the Trust is seeing more patients with a higher risk of acquiring pressure damage. In community, one of the Trust Quality Account priorities for 2021/22 was to reduce community acquired pressure damage in patients under the care of our District Nursing Teams. A Pressure Ulcer Prevention Pathway was developed and a programme of education delivered by the TV Team supported by colleagues from the wound care industry. This had led to improved early assessment and identificaton of those at risk of skin damage and improved care planning and treatement. Although the total numbers are small, there has been a 42.6% reduction in community acquired pressure damage for those under the care of the District Nursing Team. The role of the specialist staff in this improvement was key to its success.

Since 2020, the TV team has taken its acute service to the Royal Victoria Infirmary (RVI) Admission Suite. This is to ensure expert advice and proactive wound and skin care management is undertaken at the earliest opportunity. Patients are screened and if they have any wounds such as pressure ulcers, leg ulcers, skin tears, diabetic foot ulcers, then they are seen by the Nurse Consultant or by the TV specialist team. Patients are assessed, treated, referred to the appropriate team and a plan is put in place for staff to follow once patients are transferred to the wards. If the patient is discharged, the plan is communicated to the community team. Wound care in this setting is complex and requires high level expertise. During 2021-2022, 1,111 patients were seen and treated in the Assessment Suite; 20.6% of all patients seen in acute care were seen within 24-48 hours of admission.

Alognside direct clinical care, the TV service provides education to staff on pressure ulcer prevention as well as ad hoc sessions in wound care including wound bed preparation, surgical wound management and topical training sessions. The team deliver the ‘Short Course in Wound Healing’ and the course booklet is currently being updated to its fourth edition. Funding has been secured from the continuing professional development funding to further progress this work and provide an educational offer locally and regionally using the skills and expertise of the Trust teams.

1.2 Falls Prevention Coodinator

The role of the Falls Prevention Coordinator (FPC) is to work with clinical teams on all aspects of falls prevention and managment, including embedding falls best practice and leading the continuous improvement in falls reduction.

Evidence produced by the National Falls Audit (2021) illustrates rates of deconditioning in our elderly population as a result of periods of lockdowns and COVID-19 infection, has led to significant increases in both levels of patients at risk and incidents of falls as highlighted in the digital story to this Trust Board. Incidents within the Trust reflect this, whereby a high proportion of falls occur in our patients who are over 65.

Falls risk is assessed on admission, and those at risk have prevention measures put into place by nursing teams at ward level. The falls risk assessment is a formal assessment process based on best practice guidance. Training over the last two years has centred around the completion of this risk assessment in the electronic patient record which was adapted from the previous paper version. The electronic version supports greater consistency in application and allows real time reporting and auditing to be undertaken to highlight areas where improvements could be made which is a key aspect of the co-ordinator's role.

There has also been a focus on post falls care and the Trust has recently purchased further flat lifting equipment which is used to mitigate risk of further injury following a fall, a recommendation from the National Audit of Inpatient Falls (NAIPF).

Accurate measurement of lying and standing blood pressure is key in identifying those at increased risk of falls. A project has recently been completed, led by the Falls Prevention Co-ordinator, which has seen an average of 40% improvement in those patients over 65 who have had a lying and standing blood pressure on admission across four wards. Work is underway to understand the impact of this on falls reduction. The project will be re-audited in July 2022 and potentially rolled out Trust wide.

Future work streams for the Falls Co-ordinator include continued improvement in falls prevention work throughout the Trust. To maximise impact, work is underway to analyse the numbers of falls reported per Ward or Department to ensure attention is focused where it is most required. Working proactively with the Harm Free Care Leaders (HFCL) and Moving and Handling Facilitators (MHF) for the relevant areas, the falls prevention coordinator will enact focused training and education events in line with the themes identified from recent incidents or learning.

2. CLINICAL ASSURANCE TOOLKIT UPDATE (CAT)

The Clinical Assurance Toolkit (CAT) underpins the Trust commitment and vision for high quality patient care provided by nursing and midwifery staff. As previously reported to the Board of Directors, the CAT was suspended during the pandemic and an interim tool was used. It was recognised prior to the pandemic that the CAT required renewal and updating, and after reviewing several systems a digital solution was procured.

The tool was launched in March 2022 with two months of audits completed. Feedback from staff has been broadly positive, particularly from individual ward and departments as results are immediately available once the audit is complete. Work is on-going to refine the product, make any necessary further changes to the audit questions, finalise the reporting structure and ensure 100% completion compliance across all areas. It is planned that department and directorate results will be reported to the Trust Board in the coming months.

3. SAFEGUARDING Q4 2021/2022

This summary provides a Q4 update of safeguarding activity throughout the Trust and includes references to developments in practice as well as an overview of national practice developments and the Trust's compliance with these recommendations. The Q4 report also includes the 2021-2022 annual report which was discussed in detail at the Quality Committee.

3.1 Activity

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

- In adult safeguarding there have been 876 episodes of activity in the last quarter which is a 4% increase from the same quarter last year. Across the whole year there has a been a total rise in activity of 21% compared to 2020-2021.
- In children's safeguarding the episodes of activity were 1,045 which is a 10% increase compared to Q4 from the previous year, although overall comparing annual data from 2020-2021 there has been a small decrease of 6%. The highest categories of referrals continue to be self-harm/overdose, closely followed by neglect, domestic abuse and physical harm. It has been particularly concerning to continue to see younger children coming through our emergency department (ED) with intentional overdose, which has been seen across the region and nationally.
- In maternity safeguarding, overall activity has increased, with a significant rise in February to 89 cause for concern referrals. The predominant categories continue to be previous / current involvement of children's social care, domestic abuse, and mental health related issues although individual cases often report more than one category. Another category that is showing an increase relates to partner issues which include criminal history, previous domestic abuse, drug and alcohol misuse and mental health issues.

3.2 Mental Capacity Act (MCA) and Liberty Protection Standards (LPS)

In the 2021/22 year, the numbers of urgent Deprivation of Liberty Safeguards (DoLS) applications was 786. This number is lower than in the previous years (917: 2020-2021, 830: 2019-2020). It is particularly noted that in the last two quarters, numbers have been significantly down (up to 30% less), compared to the same quarters in the previous year. Work is on-going to understand this change in activity. Planning for staff information sessions is underway, alongside the planned launch of the newly uploaded e-learning MCA package to support improvements in practice.

The Code of Practice has now been released for consultation and this has been shared with members of the MCA Steering Group. It will be discussed at regional and local meetings with partner agencies to formulate a response. This amendment includes the transition to LPS.

3.3 Practice Developments

Work continues with ED colleagues to audit the recognition of safeguarding issues (particularly but not exclusive to the older age range) and a plan was implemented to visit both paediatric and Adult ED's two to three times per week to review admissions and identify any opportunities for further safeguarding intervention. This work has now concluded, with findings discussed in both areas. The benefits have included a decrease in cases where further exploration of safeguarding issues has been needed and the work to improve practice by the staff in both areas has been recognised and celebrated

3.4 Safeguarding Adults Partnerships and Boards

There has been initial work undertaken to re-launch the North Tyneside Safeguarding Adults Partnership in May 2022. The Trust have been approached to be part of this Partnership which recognises the wider working of the Trust outside of the Newcastle area.

The Trust also been invited to co-facilitate a Thematic Self-Neglect Workshop in May 2022. This workshop hosted by the Newcastle Safeguarding Adults Board aims to explore with front line staff the challenges, and existing strengths in responding to self-neglect in Newcastle. This workshop has arisen from local and regional Safeguarding Adults Reviews.

4. LEARNING DISABILITY Q4 2021/2022

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

In the last quarter the team received 643 referrals (adult, child and transition referrals combined). This demonstrates a 9% total increase in referrals compared to the same period last year. It is also noted that case complexity continues to increase. When reviewing the activity over the last year, the Trust has seen an increase of 34% in case facilitation from 1,425 to 1,921. The work to support access to acute services (classed as facilitation) is the most complex aspect of the team's work.

The Learning Disability Liaison Service scaffold and support staff and on occasions work directly with individuals to meet these measures and the trialling of "ward walking" is underway to increase the impact of the team. The team have completed almost five months of this outreach service and it has been very positively reviewed. The intention is to continue this alongside the launch and promotion of the Diamond Acute Care Pathways which has previously been reported to the Trust Board.

As part of the team's role in education, a masterclass has been held with Matrons to explore learning from complaints and learning from recent national high profile safeguarding adult reviews. The questions explored within the masterclass were the importance of the voice of

families, when individuals do not attend appointments what this may mean and stressed the importance of mental capacity assessments and professional curiosity.

5. PATIENT EXPERIENCE AND ENGAGEMENT SUMMARY Q4 2021-2022

5.1 Complaint activity

The Trust has opened 134 formal complaints in Q4, which is a decrease of 14% from the previous quarter. The Trust has received an average of 46 formal complaints per month, which is an 18% increase from the previous year.

Of the 134 complaints opened in this quarter, 49% had a primary concern with clinical treatment. This further breaks down in to sub-subjects, where the delay/failure to progress of care is the most common issue (n23), medical care (n18) and issues relating to medication (n7).

From the 113 resolved complaints in quarter four, 17 complaints were upheld. Internal Medicine and Neurosciences have 47% of the upheld complaints for this period. Communication and staff attitude subjects are responsible for 25% of complaints upheld across all clinical areas.

Complaint data, themes, trends, and actions plans continue to be monitored in the monthly complaints panel.

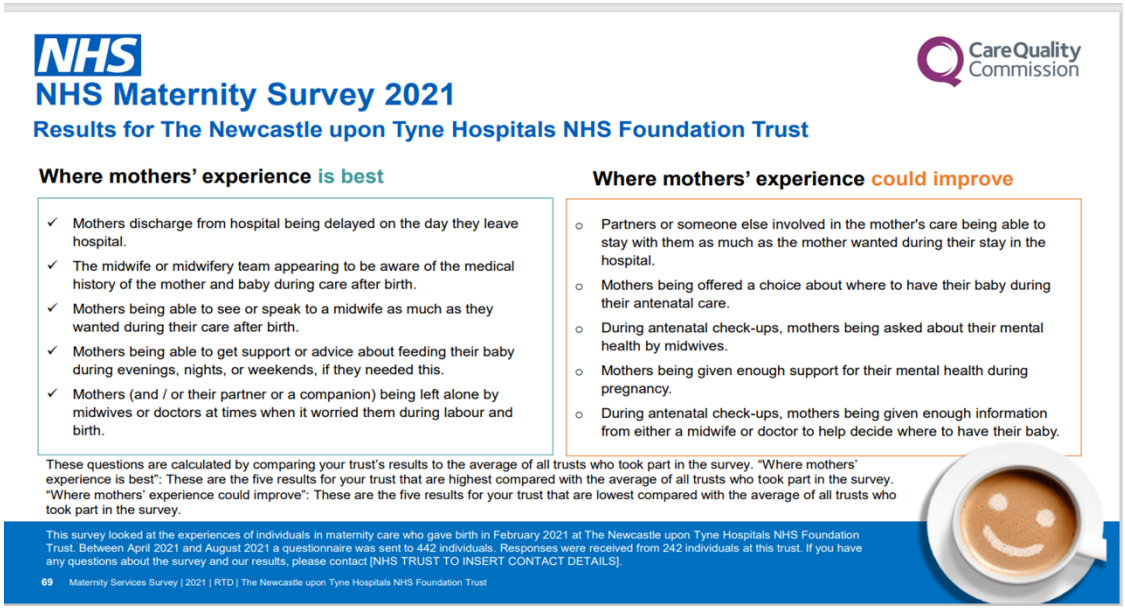
5.2 NHS Choices Feedback

The Trust received 30 items of feedback from NHS choices with most feedback in relation to the Medicine Directorate (n10) and Community (n4). The Trust received the maximum score rating of five stars from 87% (n26) of comments received.

Northern Centre for Cancer Care (NCCC) (5 Star) "*Throughout such a horrible, heart breaking and scary time the staff on both wards especially when I stayed overnight for an extended period on ward 3 were outstanding. They changed from medical staff to friends and I could not have had better care. They made a really tough time so much more bearable"*

5.3 National Patient Survey Programme 2020-2021

The Care Quality Commission (CQC) have published the national benchmark results for maternity services. The following infographic shows the key themes in regard to areas of good practice and areas for improvement.



NHS
NHS Maternity Survey 2021
Results for The Newcastle upon Tyne Hospitals NHS Foundation Trust

CareQuality Commission

Where mothers' experience is best

- ✓ Mothers discharge from hospital being delayed on the day they leave hospital.
- ✓ The midwife or midwifery team appearing to be aware of the medical history of the mother and baby during care after birth.
- ✓ Mothers being able to see or speak to a midwife as much as they wanted during their care after birth.
- ✓ Mothers being able to get support or advice about feeding their baby during evenings, nights, or weekends, if they needed this.
- ✓ Mothers (and / or their partner or a companion) being left alone by midwives or doctors at times when it worried them during labour and birth.

Where mothers' experience could improve

- ○ Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital.
- ○ Mothers being offered a choice about where to have their baby during their antenatal care.
- ○ During antenatal check-ups, mothers being asked about their mental health by midwives.
- ○ Mothers being given enough support for their mental health during pregnancy.
- ○ During antenatal check-ups, mothers being given enough information from either a midwife or doctor to help decide where to have their baby.

These questions are calculated by comparing your trust's results to the average of all trusts who took part in the survey. "Where mothers' experience is best": These are the five results for your trust that are highest compared with the average of all trusts who took part in the survey. "Where mothers' experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts who took part in the survey.

This survey looked at the experiences of individuals in maternity care who gave birth in February 2021 at The Newcastle upon Tyne Hospitals NHS Foundation Trust. Between April 2021 and August 2021 a questionnaire was sent to 442 individuals. Responses were received from 242 individuals at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

69 Maternity Services Survey | 2021 | RTD | The Newcastle upon Tyne Hospitals NHS Foundation Trust

Maternity services are currently analysing the survey results and will present findings to the wider teams in due course. Areas for improvement will be incorporated into service improvement plans in collaboration with maternity voice partnerships (MVP) and other service user forums. Plans are in place to display results in each area within the Maternity Service, together with the agreed actions for improvement. This will also cross-reference to the Ockenden Report.

5.4 NHS Friends and Family Test (FFT)

The published FFT data shows that there were 1,815 responses from the Trust in January 2022 (published March 2022).

The FFT data is encouraging in that:

- 100% of people who responded to maternity services FFT would recommend the service.
- 97% of people who responded to inpatient and day case areas FFT would recommend the service.
- The results for Accident and Emergency (A&E), walk in centres and minor injuries score are also encouraging at 92% which is considerably higher than the national average of 81%.

New Infographics have been designed to share the findings of the FFT which will be displayed across the Trust.

5.5 Patient Involvement and Engagement

The Advising on the Patient Experience Group have met in this quarter and discussed the following:

- APEX offered a warm welcome to the Newcastle Improvement team who shared the plans for the new day treatment centre at the Freeman Hospital. The team shared that, partly due to the COVID-19 pandemic there is a backlog of patients waiting for planned day surgery, which presents challenges to the Trust. APEX members were

invited to offer comments on the floor plans and visuals of the buildings. APEX queried what would happen to a patient if their condition deteriorated and they needed to be admitted to the main hospital and asked for assurance that car parking had been taken into consideration. APEX members also commented on the naming of the centre.

- An update on trust wide car parking has been shared with APEX including tariffs and concessionary charges from the Trust Travel and Transport Advisor. The group discussed the introduction of new concessions to try to make this fair and equitable and discussed public transport availability and the communications with patients and visitors. The issue of car parking is an ongoing concern but the limitations and increased pressure on spaces due to costs across the city was recognised.

5.6 Equality, Diversity, and Inclusion

With support from Newcastle Hospitals Charity, the Health Navigator Service for Deaf patients who use British Sign Language was launched in April 2022. This service will be delivered by Deaflink, a local Deaf charity, and will be piloted for one year. The service will support Deaf patients through their patient journeys, such as by explaining letters, helping prepare for appointments and liaising with trust staff to ensure interpreters are booked.

The Carers Information and Advice Worker project has also been extended for another year following a successful charity bid to Newcastle Hospitals Charity. The next year will focus on working with staff across the trust to improve the identification of carers, involvement of carers, signposting carers to resources and transition from hospital into the community.

6. PALLIATIVE AND END OF LIFE CARE SERVICES

The Palliative and End of Life Care Service are committed to following national and regional guidelines and achieving the Trust's Strategic Goals. The team aim to support the delivery of high-quality best practice palliative and end of life care to patients and carers in Newcastle hospitals and community. Highlighted below are a number of key workstreams and achievements over the recent months.

6.1 Freeman Haven

Following the positive feedback from relatives of dying patients about the comfort and support provided by the RVI Haven, the team have been working towards providing similar facilities at the Freeman site. Funding has been secured from the Newcastle Hospitals Charity, and the Estates department are currently identifying a suitable space on the Freeman site. The 'Gift of Kindness' Charitable Fund will provide comfort items such as toiletries, beverages, and towels for this new facility.

6.2 Palliative Care Support for Specialist Care Home Support Team

The Palliative Care Service obtained temporary funding for one day per week of consultant time (Dec 2021-Mar 2022) to work with the Specialist Care Homes Support Team to help them (through education, case reflection and joint review) to identify patients approaching the end of life and proactively promote discussions regarding advanced care planning.

Initial informal data has shown that through discussions and documentation of 43 Emergency Health Care Plans, care home staff have supported 42/43 of these residents to avoid inappropriate hospital admission and die comfortably in their care home.

6.3 Gold Standards Framework – Hospitals

Gold Standards Framework (GSF) provides training for generalist frontline staff in health and social care settings to enable the provision of 'gold standard' care for all people nearing end of life. GSF helps improve staff confidence, patient satisfaction and can reduce inpatient length of admission and assist in more rapid discharge. This programme of education is being funded by the Continuing Professional Development (CPD) funding. Nine wards across the Trust have agreed to participate in the GSF training programme this year. Once the wards have completed their training, they are required to embed their learning into practice for approximately six months then apply for accreditation. To be accredited each ward will be asked to submit their data collection and provide a portfolio of evidence. Following this the GSF team will visit the ward to observe the GSF in practice and produce a visit assessment report which is submitted to an independent panel who awards the Quality Hallmark Award.

This is an exciting development and will continue to report on progress as the framework is embedded and evaluated.

7. RECOMMENDATIONS

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

Report of Maurya Cushlow
Executive Chief Nurse
20 May 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 May 2022						
Title	Nursing and Midwifery Staffing						
Report of	Maurya Cushlow, Executive Chief Nurse						
Prepared by	Ian Joy, Deputy Chief Nurse Lisa Guthrie, Associate Director of Nursing						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☒	☐				
Summary	This report comprises the Nursing and Midwifery Staffing (2021/22) annual review and the quarterly safe staffing assurance report. It fulfils the recommendations of the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) and adheres to the recommendations set out by the National Quality Board (NQB 2016): How to ensure the right people, with the right skills, are in the right place at the right time. It updates the Board in relation to the following: • Actions agreed in the 2020/21 Nursing and Midwifery Staffing Six Month Interim Review (section 2). • Setting evidenced based staffing establishments (section 3). • In-patient Skill Mix (section 4). • Vacancy and turnover data for Nursing and Midwifery (section 5.1). • Red flags and Datix (section 5.2). • Planned and actual staffing fill rates (section 5.3). • Care Hours Per Patient Day (CHPPD) figures (section 5.4). • Three monthly staffing assurance review (section 5.5).						
Recommendations	The Board of Directors is asked to: • Receive and review the annual review from April 2021- March 2022. • Review and note the progress with the actions from the six-month interim review. • Comment on the content of this approach which has been prepared in line with national guidance. • Acknowledge and comment on actions outlined within the document. • Receive and review the quarterly staffing and outcomes review from January, February and March 2022.						
Links to Strategic Objectives	• To put patients at the heart of everything we do and providing care of the highest standard focussing on quality and safety. • Supported by Flourish, our cornerstone programme, we will ensue that each member of staff is able to liberate their potential performance. • Being outstanding, now and in the future.						
Impact	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability

(please mark as appropriate)	☒	☐	☒	☒	☐	☒	☒
Impact detail	• Failure to assure safer staffing levels may lead to patient harm, litigation against the Trust and loss of reputation. • Assurance of Safer Staffing based on Nurse and Midwifery Staffing Review process highlights the need to ensure alignment between base line establishment requirements and financial budget setting to meet safety and quality standards and comply with national guidance.						
Reports previously considered by	The Board has previously received the annual Nursing and Midwifery Staffing Review report, the six-month review report and quarterly safer staffing assurance reports.						

NURSING AND MIDWIFERY STAFFING ANNUAL REVIEW

EXECUTIVE SUMMARY

The purpose of this report is to provide the Trust Board with an overview of nursing and midwifery staffing, governance processes and advise upon compliance with national guidance. The 2021/22 Safer Nursing Care Tool (SNCT) reviews have been thoroughly and comprehensively undertaken with ongoing work and actions identified within this report. The Trust Board will be provided with a six-month review of progress in November 2022.

This report combines the Nursing and Midwifery Staffing (2021/22) annual review with quarter four (Q4) safe staffing report. The purpose is both to provide assurance that the Trust is compliant with national guidance in relation to safer staffing and to highlight where there are any risks, issues or concerns.

The following key points are noted:

- The staffing establishments remain broadly fit for purpose with the exception of specific adult and paediatric wards highlighted in the detail of this report. There is a demonstrable increase in acuity and dependency across many areas compared to pre-pandemic. This remains challenging and further investment may be required in the future if the increase in acuity and dependency continues.
- The Nurse Staffing and Clinical Outcomes Group continues to provide monthly oversight and assurance regarding safe staffing. Due to continued challenges from COVID-19 related absence and other contributory factors, additional support was required for four wards in the last quarter due to either primary staffing or clinical outcome concerns.
- Focused work continues to maximise recruitment and retention overseen by the Nursing and Midwifery Recruitment and Retention Group. The Trust position remains favourable compared to the national position and work is on-going to maximise international recruitment and Healthcare Support Worker recruitment in line with national work streams.
- The on-going requirement to mitigate staffing shortfalls due to the pandemic has been overseen by the Senior Nursing Team and based on existing evidence-based tools and assurance processes to ensure safer staffing levels.
- Based on this annual staffing review, five key actions are outlined for the year ahead in section 6.

The Board of Directors are asked to:

- Receive and review the annual review from April 2021- March 2022.
- Review and note the progress with the actions from the six-month interim review.
- Comment on the content of this approach which has been prepared in line with national guidance.
- Acknowledge and comment on actions outlined within the document.
- Receive and review the quarterly staffing and outcomes review from January, February and March 2022.

NURSING AND MIDWIFERY STAFFING REVIEW REPORT

1. INTRODUCTION/BACKGROUND

This report combines the Nursing and Midwifery Staffing (2021/22) annual review with the Q4 safe staffing report. The purpose is to provide assurance that the Trust is compliant with national guidance in relation to safer staffing and to highlight where there are any risks, issues or concerns. The National Quality Board (2016) and Developing Workforce Safeguards (2018) documents stipulate the requirement to undertake an in-depth nursing and midwifery staffing review annually with an interim review and update on actions highlighted to the Board at six months.

It is well recognised that over the last year, the pandemic has continued to have a significant impact on the deployment of staff across the Trust. Safe staffing governance frameworks remain in place with clear escalation criteria and associated actions. Escalation has been required since the last report and this has been supported by robust professional oversight and leadership. It is clear however that the staffing position remains challenging and the impact of the pandemic, high patient acuity, increased bed occupancy and increased COVID-19 related absence continues to impact our clinical staff and their deployment on a daily basis. As a result, additional professional oversight remains in place to maximise the safe and effective deployment of staff.

2. 2021/22 NURSING AND MIDWIFERY STAFFING REVIEW UPDATE

2.1 Progress since six month interim review

In line with national guidance, a comprehensive six-month interim review report of safe staffing was presented to the Board in November 2021. The report reviewed the progress against the actions outlined in the 2020/21 annual staffing review.

At the end of that review, actions were identified that required completion in the 2021/22 financial year. All actions were reviewed and actioned where possible. Exceptions to this are noted below:

- Undertake an in-depth nurse staffing review in the Emergency Department when the Safer Nursing Care Tool (SNCT) tool is available.
- Complete and review the acuity and dependency data within Community services to support staffing and skill mix requirements and to work with the Shelford Group in the development of Community evidence-based tool.

Both actions will be referenced and discussed in section 3.

3. SETTING OF EVIDENCED BASE ESTABLISHMENTS (Review of data April 21 – March 2022)

3.1 Adult and Paediatrics

3.1.1 Acuity and Dependency Tools

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

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

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

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

3.1.2 Outcome of the data review

The SNCT data capture was undertaken in May 2021 and November 2021 and completed in-line with national guidance. Data capture is usually March and September annually, but the decision was made to delay this by two months in 2021/22 due to the pandemic. This year the Trust has reverted to the normal time frames, and the March 2022 data capture has been undertaken. It should be noted that there will be some slight delays in process through the year as we revert back to the normal schedule of business.

The March 2022 data is in the process of being reviewed and meetings with Matrons, Ward Sisters/Charge Nurses and Directorate Managers have been scheduled to review, discuss the results, and agree actions. This discussion will include a review of SNCT data analysis alongside other safe staffing metrics including nurse sensitive indicators.

The following key points and actions have been noted from the review of the May and November 2021 data:

- Wards and departments which have altered from their primary function due to COVID-19 continue to be reviewed monthly at the Nurse Staffing and Outcomes Group. This is to ensure that any change in SNCT acuity and dependency can be monitored and a

change in staffing levels agreed if required. Two wards (Ward 5 RVI and Ward 44 RVI) remain under active review and temporary increased staffing numbers have been agreed based on acuity and dependency profiles.

- The acuity and dependency of patients across most wards has continued to rise when compared to pre- pandemic levels. This trend is replicated across the country when benchmarking with peers. This is noted specifically in Older People's Medicine (OPM) due to an increase in the requirement for enhanced care and Surgical disciplines due to increased case complexity. In 2019, additional investment was agreed in OPM to support increasing requirements for enhanced care. If this requirement increases further, additional resource may need to be considered. In the interim, temporary bank staff are requested to mitigate any risk. In surgery, bed capacity is reviewed regularly to mitigate risk from increased acuity and additional staff deployed when required.
- Work is ongoing with Ward 1a and 9 in the Great North Children's Hospital (GNCH) following the identification of a gap between the required versus actual establishment in the last SNCT data capture. Conclusion to the work on Ward 1a has been delayed due to the Respiratory Syncytial Virus (RSV) surge in September 2021 and the temporary closure of Ward 1a. This impacted on the accuracy of the SNCT data in November 2021. Reviews with the Matron is in progress following the March 2022 data capture to help conclude this work.
- Ward 9 GNCH remains under active review. There has been a pilot of bed reconfiguration to assess safe staffing and SNCT requirements and is being evaluated. It may be that further investment is required if SNCT metrics demonstrate a gap and this will be supported through the business planning process.
- All other areas were noted to be appropriately funded with rostering demand templates aligned to SNCT recommendations.

3.2 Urgent and Emergency Services

Since the last report, NHS England/Improvement (NHSE/I) have released the final version of the Emergency Department establishment setting tool. Training via the regional and national teams has recently commenced after being delayed nationally due to the pandemic. Staff in both Adults and Paediatrics successfully completed their training in May 2022 and will deliver cascade training in preparation for our first data capture which is planned for September 2022.

Additional investment has recently been agreed in the adult emergency department. This requirement was based on professional judgment and pre-launch data from the Emergency Department establishment setting tool which we received as part of the beta testing of the new tool. Recruitment to new posts is on-going and it is expected that the September data capture will confirm that the establishment is fit for purpose.

3.3 Community District Nursing Services

As noted in the previous report, in August 2021 the Trust district nursing services took part in primary data collection for the development of the National Community Safer Nursing Care Tool. Secondary testing of the tool was completed in November 2021. The final version of this tool is to be released imminently and it is expected the training programme will be similar to the Emergency Department tool. In the interim, the Senior Nurse (N&M Staffing)

has applied for a licence to use for this Trust; once the tool is released and training completed an in-depth review of community services will be undertaken.

3.4 Maternity Services Review

As reported to the Trust Board in previous papers, Maternity Services in England are under intense and increasing scrutiny due the findings of various governing bodies, and specifically the public inquiry and final report of Donna Ockenden (2022).

The key expectations of providers within NHS England's Maternity Transformation Programme and Better Births (2016), together with the Operational Guidance 2021/22 (NHS England and Improvement (NHSE/I)), lay down specific requirements with regard to workforce planning and changes which align to Midwifery Continuity of Carer (MCoC) and the reconfigured workforce models. A summary of the Trust position can be found in the Ockenden Update paper to this Board within agenda item A7b(ii).

Throughout the months of December 2021-March 2022, the service continued to see a significant impact on maternity staffing due to the effects of the COVID-19 pandemic, together with a moderate increase in sickness absence rates, averaging 6%. The Trust has in place a rigorous escalation and business continuity plan to ensure that staffing remains at optimum levels, maintaining patient safety within the maternity service.

The Directorate have taken the opportunity early this year to recruit student midwives who are expected to register in September 2022. The newly qualified midwives are expected to join the service in October 2022. There are currently increased levels of midwifery vacancy across the region and this early recruitment will support Newcastle in appointing midwives who currently have a greater choice of employer. A strategy has been implemented to ensure that the newly appointed midwives retain interest in working at Newcastle through planned regular engagement events, promoting positive working relationships prior to commencing employment; this work is being led by the Lead Midwife for Pastoral Support and Retention.

A combined projected vacancy rate of 9.5% until recruitment is complete in October 2022 is anticipated due to natural attrition and staff choosing to reduce hours. This shortfall in budgetary establishment is mitigated by the long-standing agreement to over-recruit at any one time by 20.0 whole time equivalent (wte), which is consistently utilised in balancing vacancy against the number of Midwives in post.

The Trust have been successful in receiving financial support to recruit five midwives through NHS England's International Recruitment initiative. To date one midwife has been recruited from the Philippines, who is due to be deployed in June 2022. It is anticipated that the four remaining Midwives will be recruited throughout May-July 2022.

A requirement of the Maternity Incentive Scheme (MIS), Year 4, Safety Action 5, is to report to the Trust Board on:

- The provision of 1:1 care for all women in labour; and
- Compliance with achieving 100% supernumerary status of the Labour Ward Co-ordinator.

From 1 November 2021 to 26 April 2022, there has been three occasions recorded where the midwife has been unable to provide continuous one-to-one care and support to a woman in established labour; and no occasions where the delivery suite coordinator has not remained supernumerary and has resulted in the coordinator being the named midwife for a woman.

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

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

4. IN-PATIENT SKILL MIX

Although there is national guidance relating to establishment setting there is no formal guidance regarding skill mix. Skill mix is based on professional judgment using the outputs of the acuity and dependency data. Our skill mix ratios are benchmarked locally and nationally and there has been no significant change in skill mix since the last staffing review.

Key points to note:

- All skill mix changes requested to demand templates are subjected to a quality impact assessment and costed by the directorate finance team. The updated demand template and subsequent costings are then shared with the Matron and Senior Sister prior to changes being made to the demand template or business case submission.
- Work has recommenced to accurately capture Nursing Associates in the national safe staffing returns via the allocate rostering system. The data is currently being assessed for accuracy and validity prior to publishing nationally. An update on progress will be provided in the November update.
- Maternity skill mix is reviewed as part of the Birthrate Plus tool. It is noted however that the percentage of specialist midwives in the Trust is currently 21.57% against a national recommendation of 27.73%. This is under review within the directorate and being addressed as part of the maternity transformation work.

5. NURSE STAFFING METRICS

5.1 Vacancy and Turnover Data

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

- The Nursing and Midwifery Recruitment and Retention Group continues to focus on improving the vacancy and turnover position with an agreed work plan. A virtual open day was held in April 2022 for Nursing, Midwifery and Operating Department Practitioner (ODP) students and qualified staff wishing to join the Trust.
- The current total nursing and midwifery workforce (Registered Nurse (RN), Registered Midwife (RM) and HCSW) turnover is 9.52%. This is based on data for April 2022.
- Monthly generic recruitment for Band 5 RN continues with bespoke recruitment agreed as required. The Band 5 RN vacancy rate sits at 7.9%. The total registered nursing vacancy rate is 5.8%. Whilst a favourable position, this does impact on the departments being able to staff to their full required demand.
- Since November 2021, 31 international recruits have been deployed from the Philippines. Following the agreed proposal to continue to recruit internationally, a further 101 candidates have been appointed. This includes eight paediatric nurses and one midwife with planned deployment due to commence in June 2022.
- There has been continued focus on recruitment of HCSWs from NHSE/I in the last year. It remains challenging to achieve a sustained operationally zero vacancy position. However, by the end of March 2022 following pro-active recruitment campaigns the Trust had successfully achieved a zero-vacancy position, albeit with approximately 100wte staff in pipeline.

5.2 Red Flags and Datix *(April 2021-March 2022)*

Red flags and datix are reviewed and acted upon where possible daily. Each month red flag and Datix incident data is reviewed by the Nurse Staffing and Clinical Outcomes Group to identify trends and areas of concern, at ward and directorate level. Themes identified from this data are used to inform responsive and planned nurse staffing reviews and shape future establishment requirement.

Key points to note:

- There were no notable trends in the submission of staffing related Datix with most reports relating to unpredictable shortfalls in staffing due to sickness or increased acuity.
- An update to the Datix system has improved data quality with regard to incidents where staffing was identified as a potential contributing factor.
- Red flags in the SafeCare system have been utilised effectively with a mix of red flags identifying shortfalls in staffing and increased acuity of the patients. This information is frequently supplemented by professional judgement allowing these incidents to be managed and mitigated responsively.
- Red flags are reviewed daily by the corporate senior nursing team and reported to the Chief Nurse and Deputy Chief Nurse and into silver command as required.

This is via the daily staffing review proforma and an example of which can be found in **Appendix 1** in the board reference pack.

5.3 Planned and Actual Staffing *(April 21-March 22)*

Planned staffing is the amount (in hours and minutes) of Registered Nurses, Midwives, and care support staff time that each ward plans to have on duty each shift. This is based on maximum utilisation of their funded establishment. Actual staffing is the amount of staff time (in hours) physically on duty each day.

The Nurse Staffing and Clinical Outcomes Group continue to triangulate ward fill rates with other staffing metrics monthly.

Key points to note:

- There has been a reduction in the fill rates across the last year from April 2021 (95.86%) to March 2022 (88.87%). The reason for this is multi-factorial and is a combination of continued COVID-19 related absence alongside existing vacancies. The fill rates remain a concern, though any impact is closely monitored.
- RN fill rates have decreased on days to an average fill rate of 87.20% and on night shift to an average fill rate of 87.01%. This is reviewed regularly with temporary bed closures employed to mitigate the risk and reviewed on a weekly basis.
- In March, 19 wards reported a fill rate of less than 85% which is similar to the previous year but an improvement from the position reported to the Trust Board in the November 2021 six month update. This is closely monitored by the senior nursing team.

5.4 Care Hours per Patient Day (CHPPD) *(April 21-March 22)*

Care hours per patient day (CHPPD) is the unit of measurement recommended in the Carter Report (2016) to record and report deployment of staff working on inpatient wards. It captures Registered Nurse and support worker hours. All acute Trusts are required to report their actual monthly CHPPD, based on the midnight census per ward to NHSE/I since May 2016. It is calculated using the formula below.

Key points to note:

- The Trust average CHPPD for December 2021 (last national data capture) is 8.6 with a national average 8.2. These figures are lower than last year both for the Trust and nationally highlighting the impact the pandemic has had on staffing levels.
- SafeCare enables the staffing team to review CHPPD required versus actual at ward level monthly. This facilitates the review of trend data for any ward, which falls below the 85% fill rate and help understand and mitigate any risk from staffing shortfalls. An example of such ward data can be found in **Appendix 2** in the board reference pack.
- Despite the data available in Model Hospital not being current, it does allow for benchmarking at peer and national level as per the NQB guidance. This is undertaken by the staffing team.
- Due to COVID-19, wards across the country have changed their primary function and this has altered the accuracy of ward level and speciality level benchmarking. The Trust broadly remains aligned with no areas of concern with all metrics reviewed as part of the nurse staffing review process.
- Specialist areas continue to demonstrate the greatest variance against the national average. This trend is well understood locally and nationally.

5.5 January to March 2022 Nurse Staffing and Clinical Outcomes Review

Any ward demonstrating a Registered Nurse day fill rate of less than 85% is reviewed by the Nurse Staffing and Clinical Outcomes Group alongside all other wards, which have been flagged due to a staffing or outcome risk; any ward requiring medium level support after review for two consecutive months will be highlighted to Board.

- It is evident that higher than normal levels of sickness absence alongside existing vacancies and high patient acuity and dependency are proving challenging in maintain a safe staffing position.
- Between January and March 2022, four wards required medium level support at some point. Additional support was provided to two wards in urology due to significant staffing shortfalls. Risk was mitigated by responsive bed closures and movement of staff from other areas. Twice weekly meetings have been held with the directorate management team and the senior nursing team to manage this situation.
- One ward in renal services and one in Internal Medicine have required additional support in addressing some complex infection prevention control concerns which were specific to their patient groups. This has now been addressed and de-escalated.
- Concerns regarding staffing and clinical outcomes for one ward in Musculo-skeletal Services has recently been highlighted. A deep dive review and action plan are in progress and will be reported to the Trust Board in July.
- All wards, which altered from their primary function due to COVID-19, were monitored monthly.

Month	No. of Wards Reviewed	Directorate	Monitor	Low Level Support	Medium Level Support	High Level Support	No support required
January	17	X1 NCCC	0	0	0	0	1
		x1 EPOD	0	1	0	0	0
		x1 MSK	0	1	0	0	0
		x5 Internal Medicine	3	2	0	0	0
		x2 Surgical Services	1	1	0	0	0
		x 1 Children's Services	0	1	0	0	0
		x 1Peri-Op and Critical Care	0	0	0	0	1
		x 3 Urology & Renal Services	1	0	2	0	0
		x 1 Women's Services	1	0	0	0	0
February	15	X2 EPOD	2	0	0	0	0
		x1 MSK	1	0	0	0	0
		x6 Internal Medicine	3	3	0	0	0
		x2 Surgical Services	2	0	0	0	0
		x 2 Children's Services	0	2	0	0	0
		x 2 Urology & Renal Services	0	0	2	0	0
March	19	x5 Children's Services	3	2	0	0	0
		x8 Internal Medicine	3	4	1	0	0
		x2 Surgical Services	2	0	0	0	0
		x1 Cancer Services	0	1	0	0	0
		x3 Urology and Renal Services	0	0	3	0	0

6. CONCLUSIONS AND ACTIONS

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

- In line with national guidance, the SNCT data capture has been completed and actions arising from the data analysis are in progress with the directorate teams.
- With the exception of the wards highlighted in this report, the establishments remain broadly fit for purpose. It is recognised that there are changes in the acuity and dependency profile of patients since the pandemic started and may impact future service requirements.
- Maternity workforce transformation and safer staffing management remains a high priority as outlined in this report and the Ockenden update report.
- New acuity and dependency tools have been recently released and will help inform future staffing requirements in these areas.
- The continued responsive movement of staff to respond to the pandemic and high patient volumes has been overseen by the Senior Nursing Team and is based on existing evidence-based tools and assurance processes.
- Safer staffing management continues to be extremely challenging due to existing vacancies, sickness absence levels and increased patient acuity and dependency. This has impacted on Trust level fill rates and CHPPD figures.

The following actions are proposed:

- Undertake a review of the Emergency Department in September 2022 using the new acuity and dependency tool.
- Undertake a review of Community services once the Community Nursing Services Safer Staffing Tool (CNSSST) is released and training is completed.
- Meet as planned in June with the directorate teams to discuss the November 2021 and March 2022 SNCT data.
- Continue to provide scrutiny and oversight regarding the re-deployment of staff to respond to continued service pressures.
- Continue with the recruitment of Internationally Educated nurses at pace.

7. RISK AND MITIGATION

This report describes the mandated nursing and midwifery annual review process which has been undertaken in accordance with national guidance. It highlights the ongoing challenges the pandemic has presented in providing safer staffing across our services. There are some highlighted areas which require further work to improve assurance and actions are outlined to address this. There will be challenges and risk in the year ahead in balancing recovery and re-design with safer staffing and financial efficiency whilst continuing to respond to the pandemic and elective waiting times. This is in part mitigated by the robust governance processes already in place but will require pro-active workforce planning and strong working relationships internally and externally to deliver this effectively.

It is evident from the nurse staffing metrics that there is a continued risk to the Trust due to the local and national shortage in the registered and support workforce, which is being closely monitored with proactive recruitment plans in place. It is therefore necessary to continue to explore mechanisms to maximise external recruitment, alongside retention strategies to reduce the total vacancy rate. Whilst this risk cannot be fully mitigated and remains a concern, a robust professional leadership framework is in place to actively support directorates in assuring safety and good progress across all work streams.

8. RECOMMENDATIONS

The Board of Directors are asked to:

i) Receive and review the annual review from April 2021- March 2022.
ii) Review and note the progress with the actions from the six-month interim review.
iii) Comment on the content of this approach which has been prepared in line with national guidance.
iv) Acknowledge and comment on actions outlined within the document.
v) Receive and review the quarterly staffing and outcomes review from January, February and March 2022.

Report of Maurya Cushlow

Executive Chief Nurse

Ian Joy
Deputy Chief Nurse

Lisa Guthrie
Associate Director of Nursing

20 May 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 May 2022		
Title	Ockenden Update Report		
Report of	Maurya Cushlow, Executive Chief Nurse		
Prepared by	Jane Anderson, Associate Director of Midwifery		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	The Ockenden Report published on 30 March 2022, is the final report of an inquiry commissioned by the former Secretary of State, Jeremy Hunt, who requested an 'independent review of the quality of investigations and implementation of their recommendations of a number of alleged avoidable neonatal and maternal deaths, and harm, at The Shrewsbury and Telford NHS Trust'. The final report can be found at: https://www.gov.uk/government/publications/final-report-of-the-ockenden-review The interim report published on 10 December 2020 outlined a number of Immediate and Essential Actions for providers of maternity services, and the Trust's progress against these have been systematically monitored and reported to the Trust Board since that time. The purpose of this paper is to provide the Board of Directors with an overview and significance of the findings of the final Ockenden publication, intended actions for the Trust, together with an update on progress against the interim report. A demonstration of workforce planning is required for all staff groups within the Maternity Service; this report provides a high-level update of the current position for the Midwifery workforce aligned to transformation and Midwifery Continuity of Carer, further referencing the recommendations made in the final Ockenden report. Associated risks are identified and discussed, together with an updated high level Action Plan. The impact of the final report for Newcastle as a regional tertiary centre is also considered in line with the final publication.		
Recommendation	The Trust Board is asked to i) Receive and discuss the report; ii) Note the current level of assurance and the identified gaps in assurance as benchmarked against the interim recommendations; iii) Recognise the significance of this final report for the Maternity Service and that further detailed work is required to ensure full compliance; and iv) Note the associated risks involved.		

Links to Strategic Objectives	Putting patients at the heart of everything we do. Providing care of the highest standards focussing on safety and quality.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☒	☐	☒	☐
Impact detail	Detailed within the main body of the report.						
Reports previously considered by	Previous report presented to the Trust Board on 31 March 2022.						

OCKENDEN REPORT UPDATE

EXECUTIVE SUMMARY

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

The interim report published on 10 December 2020, outlined a number of Immediate and Essential Actions for providers of maternity services, and the Trust has made positive progress against these which have been systematically monitored and reported to the Trust Board since that time. Key issues of note from outstanding actions are those associated with risk assessment, personalised care planning, and multi-disciplinary core competency training, and these elements are discussed in more detail within this paper.

The final publication provides an additional 15 Immediate and Essential Actions, together with 92 recommendations, and acts as an immediate call to action for all commissioners and providers of maternity and neonatal services, and an overview is provided to the Board of Directors within this paper. A requirement to ensuring that lessons are rapidly learned and service improvements for women, babies, and their families are driven forward as quickly as possible, must be a key priority.

Workforce planning continues to be a key feature in this final publication, with a specific focus on Midwifery Continuity of Carer (MCoC). This paper provides an overview of the Trust's current position in relation to MCoC, referencing the recommendation of Ockenden.

The Trust is currently undertaking detailed work in benchmarking against the Immediate and Essential Actions of this final report, to further identify the gaps and associated actions in relation to the recommendations. The publication has been shared amongst the maternity and neonatal workforce, and it is recognised that further engagement and listening events are required.

A sobering read, the scale of this review is unprecedented in the history of the NHS, and it is evident that this is a pivotal time for providers and systems of maternity services throughout England.

RECOMMENDATIONS

The Board of Directors is asked to:

i) Receive and discuss the report;
ii) Note the current level of assurance and identified gaps in assurance as benchmarked against the interim recommendations;
iii) Recognise the significance of this final report for the Maternity Service and that further detailed work is required to ensure full compliance; and
iv) Note the associated risks involved.

OCKENDEN REPORT UPDATE

1. INTRODUCTION

The purpose of this report is to provide the Board of Directors with background information and an overview of the final Ockenden Report; Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust, published 30 March 2022.

The report also provides an update of Newcastle Hospitals Maternity Service benchmarked against the initial Immediate and Essential Actions (IEA) to improve care and safety in maternity services across England, highlighted in the interim report, together with an updated High Level Action Plan.

2. BACKGROUND

The final Ockenden Report published on 30 March 2022, is the report of an inquiry commissioned by the former Secretary of State, Jeremy Hunt, who requested an independent review of the quality of investigations, and implementation of the recommendations of a number of alleged avoidable neonatal and maternal deaths, and harm, at The Shrewsbury and Telford NHS Trust. Providers of maternity services have been asked to present the Ockenden report at their next Public Board meeting and share widely with all relevant staff.

Following on from the initial interim report, published in December 2020, the final publication presents the findings, conclusions, and a number of essential actions for providers of maternity services across England. Endorsed by NHS England and Improvement (NHSE/I), the Immediate and Essential Actions complement and expand upon the Immediate and Essential Actions issued in the first Ockenden report. NHS England and Improvement are working with the Department of Health and Social Care in implementing the 15 Immediate and Essential Actions.

The report acts as an immediate call to action for all commissioners and providers of maternity and neonatal services, ensuring lessons are rapidly learned and service improvements for women, babies, and their families are driven forward as quickly as possible.

NHS England and Improvement have asked every Trust, Integrated Care System (ICS) and Local Maternity System (LMNS) Board to review the report, taking action to mitigate any risks identified and developing robust plans which pay particular attention to the report's four key pillars:

1. Safe Staffing
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up, with an expectation that every Trust Board will have a robust freedom

to speak up training programme for all managers and leaders, and a regular series of listening events. National policy and guidance on speaking up is expected to be published shortly.

As highlighted in the first report, the importance of listening to women and their families, taking action to support informed, personalised, safe decisions, is a key theme throughout this second publication.

An additional important recognition made within the report is that staff within maternity services may need enhanced health and wellbeing support following this harrowing publication.

A sobering read, the scale of this review is unprecedented in the history of the NHS, and this is a pivotal time for providers and systems of maternity services throughout England. That said, it is clear that the learning and actions arising from the findings of this report go beyond the maternity agenda for systems and providers of healthcare.

3. NEWCASTLE HOSPITALS MATERNITY SERVICES ASSESSMENT AND ASSURANCE

The Board of Directors will recall that since the initial submission of The Maternity Services Assessment and Assurance Tool published in December 2020, the requirements in terms of the minimum evidence required to support compliance against the interim Ockenden recommendations evolved considerably throughout 2021, resulting in a total of 49 standards to be addressed by providers of maternity services. This second report further advises on an additional 15 Immediate and Essential Actions of which there are 92 recommendations (Appendix 1).

As is required, the Trust's position in relation to compliance on the interim actions has been reported to the LMNS, ICS, and NHS England's regional team, with submission of evidence being made by the deadline of 15 April 2022. A detailed breakdown of provider returns, and Trust compliance aligned to the initial Immediate and Essential Actions will be reported to NHS England and Improvement's Public Board in May 2022.

Detailed work has commenced within the Directorate in benchmarking the Maternity Service against the 92 recommendations arising from the final publication. The report has been shared widely across the service and early opportunity has been taken to present and disseminate the key messages amongst the multi-professional workforce. The Senior Leadership Team acknowledge that there is further work to do in ensuring that through additional staff engagement, the findings are shared and discussed, and that staff are well supported along the way.

Areas of focus for Newcastle following an early initial review of the Immediate and Essential Actions arising from the final publication are as follows: -

- Workforce planning and sustainability for all professions
- Multi-disciplinary core competency training
- Learning from incidents and complaints and subsequent changes in practice
- Complex pre-conception care

- Personalised care planning and risk assessment
- Improved bereavement care
- Improved support for families with psychological and emotional care

A detailed analysis against Newcastle's benchmarking, together with revised high level action plan, will be reported to both the Quality Committee and Trust Board in July 2022.

As previously reported to the Board of Directors, the Trust is required to ensure that there are appropriate mechanisms in place for workforce planning across all professional groups with specific focus on the Midwifery leadership and non-executive support, together with Trust Board oversight. This remains a key area of focus within the final Ockenden report, with specific reference to Midwifery Continuity of Carer (MCoC). An update of the Midwifery workforce in line with Midwifery Continuity of Carer (MCoC) is provided and discussed within this paper.

As previously reported to the Trust Board, Table 1 illustrates Newcastle Hospitals current updated position against the minimum evidence required from the initial interim report.

Of the 47 applicable elements, full compliance is achieved against 42 equating to 86%, the remaining 5 (10%) demonstrate partial compliance. This illustrates good progress by the Trust throughout 2021 and the early part of 2022 in meeting with the recommendations arising from the interim Ockenden Report, and mirrors that reported externally to NHS England and Improvement for national publication.

The Directorate are currently preparing for an assurance visit by NHS England and Improvement's regional team, in partnership with the North East and North Cumbria LMNS, scheduled for 17 June 2022. The focus of the visit will be on the interim Ockenden report and forms part of a scheduled programme to include all services across England. The visitors will spend the day meeting with members of the multi-disciplinary, governance and leadership teams within the Maternity and Neonatal Units.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Table 1			
Immediate Essential Action		Brief Descriptor	Compliance
Section 1		IEA 1-7	
IEA 1: Enhanced Safety	Q1	Local Maternity System (LMNS) regional oversight to support clinical change - internal and external reporting mechanisms for key maternity metrics in place.	Compliant
	Q2	External clinical specialist opinions for mandated cases.	Compliant
	Q3	Maternity Serious Incident (SI) reports sent jointly to Trust Board (not sub board) & LMNS quarterly.	Compliant
	Q4	National Perinatal Mortality Review Tool (PMRT) in use to required standard.	Compliant
	Q5	Submitting required data to the Maternity Services Dataset.	Compliant
	Q6	Qualifying cases reported to HSIB & NHS Resolution's Early Notification scheme	Compliant
	Q7	A plan to fully implement the Perinatal Clinical Quality Surveillance Model (Trust/LMNS/ICS responsibility).	Compliant
	Q8	Monthly sharing of maternity SI reports with Trust Board, LMNS & HSIB.	Compliant
IEA 2: Listening to Women and Families	Q9	Independent Senior Advocate Role to report to Trust and LMNS.	n/a
	Q10	Advocate must be available to families attending clinical follow up meetings.	n/a
	Q11	Identify a non-executive director for oversight of maternity services – specific link to maternity voices and safety champions.	Compliant
	Q12	National Perinatal Mortality Review Tool (PMRT) in use to required Ockenden standard (compliant with CNST).	Compliant
	Q13	Robust mechanism working with and gathering feedback from service users through Maternity Voices Partnership (MVP) to design services.	Compliant
	Q14	Bimonthly meetings with Trust safety champions (obstetrician and midwife) & Board level champions.	Compliant
	Q15	Robust mechanism working with and gathering feedback from service users through MVP to design services.	Compliant
	Q16	Identification of an Executive Director & non-executive director for oversight of maternity & neonatal services.	Compliant
IEA 3: Staff Training & Working Together	Q17	Evidence of multidisciplinary team (MDT) training and working validated by LMNS 3 times a year. All professional groups represented at all MDT and core training.	Compliant

	Q18	Twice daily (over 24hrs), 7-days a week consultant-led multidisciplinary ward rounds.	Compliant
	Q19	Trust to ensure external funding allocated for the training of maternity staff is ring-fenced.	Compliant
	Q20	Effective system of clinical workforce planning (see section 2).	Compliant
	Q21	90% attendance for each staff group attending MDT maternity emergencies training session (with LMNS oversight and validation).	Partial Compliance
	Q22	Twice daily (over 24hrs), 7-days a week consultant-led multidisciplinary ward rounds	Compliant
	Q23	Evidence of multidisciplinary team (MDT) training and working validated by LMNS 3 times a year. All professional groups represented at all MDT and core training.	Compliant
IEA 4: Managing Complex Pregnancy	Q24	Maternal Medicine Centre (MMC) Pathway referral criteria agreed with trusts referring to NUTH for specialist input.	Compliant
	Q25	Women with complex pregnancies (whether MMC or not) must have a named consultant lead.	Partial Compliance
	Q26	Early specialist involvement and management plans must be agreed where a complex pregnancy is identified.	Compliant
	Q27	Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle (SBLCBv.2)	Compliant
	Q28	Continuation of Q25: mechanisms to regularly audit compliance.	Compliant
	Q29	Trust supporting the development of maternal medicine specialist centre.	Compliant
IEA 5: Risk Assessment Throughout Pregnancy	Q30	All women must be formally risk assessed at every antenatal contact.	Partial Compliance
	Q31	Risk assessment must include ongoing review of the intended place of birth.	Compliant
	Q32	Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle (V.2).	Compliant
	Q33	Regular audit mechanisms are in place to assess Personalised Care & Support Plan compliance.	Compliant
IEA 6: Monitoring Fetal Wellbeing	Q34	Dedicated Lead Midwife and Lead Obstetrician to champion best practice in fetal wellbeing.	Compliant
	Q35	Leads must be sufficiently senior with demonstrable expertise to lead on clinical practice, training, incident review and compliance of Saving Babies' Lives care bundle (V.2)	Compliant
	Q36	Demonstrate compliance with all five elements of the Saving Babies' Lives care bundle (V.2).	Compliant
	Q37	90% attendance for each staff group attending MDT maternity emergencies training session (with LMNS oversight and validation).	Partial Compliance
	Q38	Implement the Saving Babies Lives care bundle: identify a lead midwife and a lead obstetrician (as Q34)	Compliant
IEA 7: Informed Consent	Q39	Ensure women have access to accurate information, enabling informed choice for place and mode of birth.	Compliant
	Q40	Accurate evidence-based information for maternity care is easily accessible, provided to all women and MVP quality reviewed.	Compliant

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

Total Number of Questions	49	100%
Non-applicable (Q9 and 10)	2	n/a
Compliant	42	86%
Partial Compliance	5	10%

As has previously been reported to the Board of Directors, a natural plateau has been arrived at in relation to the outstanding key issues arising from the interim report, as follows:

IEA 3; The Trust continues to progress scheduled multi-disciplinary team training; as previously reported, there have been challenges in maintaining 90% attendance of all specialties which is a requirement of Ockenden and CNST.

As reported in January, all training was postponed in late December 2021 and throughout the month of January 2022, as a direct consequence of the impact of the Pandemic on staffing levels within the Service. Compliance as of 30 April 2022, as illustrated in the table below, ranges between 25-80% across each of the professional staff groups, with a combined figure of 41%.

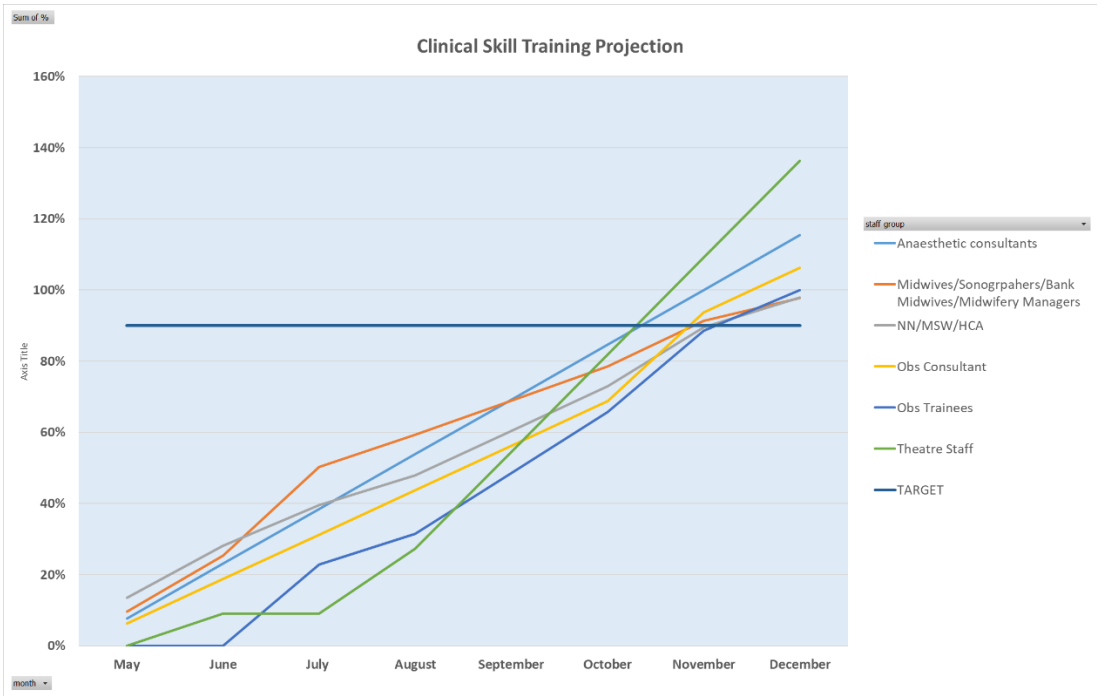
Directorate of Women's Services
Maternity Training Record for Core Competency Training

Staff Group	Number of staff in post	Number available to train	Number trained as of 30.04.22	Percentage trained as of the 30.04.22	Target by end of December 2022*
ADoM/Matrons/Lead MWs	5	5	4	80%	90%
Midwives/Sonographer	308	288	104	36.11%	90%
Nursery Nurse	21	21	14	67%	90%
Maternity Support Worker	53	53	22	42%	90%
Health care Assistant	26	24	18	75%	90%
Bank Midwives	21	19	8	42%	90%
Theatre staff (includes DS)	20	18	6	33%	90%
Obstetric Consultants	16	16	4	25%	90%
Anaesthetic Consultants	16	13	4	31%	90%
Trainees	38	35	17	49%	90%
Total	**524**	**492**	**201**	**41%**	**90%**

In mitigation, an increased training schedule has been implemented to support traction against trajectory in meeting a 90% target, however, it should be noted that in times of escalation, due to high acuity and unexpected staff absence, it has at times been necessary to decrease the number of planned sessions.

The Directorate continues to closely monitor and respond to the challenge which additional core competency training provides. Regular review is undertaken, and an update of compliance is reported locally within the Directorate to the bi-monthly CNST group, and thereafter through the Trust governance assurance framework. A revised date*, previously June 2022, for achievement of this CNST standard has been received from NHS Resolution in view of the challenges brought by the Pandemic, now extended to 5 January 2023.

Given the increased training schedule, the projection against a target of 90% of all staff groups is illustrated in the graph below.



IEA 4, 5; As the Board of Directors are aware from previous reports, the Trust is currently in the process of implementing a maternity specific electronic patient record (BadgerNet) which will provide greater levels of quality assurance and support compliance against personalised care planning and risk assessment.

4. DIGITAL HEALTH RECORDS

4.1 Implementation of BadgerNet

The implementation of BadgerNet will largely mitigate the current risks associated with paper-based records, and further enhance the level of assurance regarding the provision of the assessment of risk and contribute towards the enhancement of personalised care planning.

Significant progress has been made in the analysis of the future workflow which in turn drives the development and interfacing of Badgernet with existing systems. This work commenced following the appointment of the Digital Midwife and a Business Analyst was assigned to aid the process in March 2022. The analysis work which was scheduled to commence in January 2022 was delayed due to critical project work and other unanticipated factors.

Servers have been built to support the implementation of BadgerNet. The finalisation of the server set up was further delayed due to an incorrect configuration of a database which has since been rectified by Clevermed.

Given the unanticipated delays, the project launch date was forecast to fall in November 2022, however, due to other scheduled launches, Clevermed are unable to support the Newcastle launch until December 2022. The Project Board has been strengthened to ensure a greater level of oversight and support in meeting with a December launch and to avoid further delay. A further update for assurance will be provided to the Trust Board in July 2022.

5. MATERNITY WORKFORCE PLANNING AND INVESTMENT

NHS England and Improvement have announced investment of £127 million, in addition to the £95 million annual increase provided in 2021. The funding will support further workforce expansion, leadership development, capital to increase neonatal cot capacity, additional support to the LMNS, together with enhanced support for retention. It is expected that further information regarding investment will be published shortly.

The Trust is compliant in providing data to the regular provider workforce return (PWR) for the maternity service, together with those external periodic returns requested in addition to the PWR.

5.1 Midwifery Workforce

The key expectations of providers within NHS England's Maternity Transformation Programme and Better Births (2016), together with the Operational Guidance 2021/22 (NHS England and Improvement (NHSE/I)), lay down specific requirements with regard to workforce planning and changes which align to Midwifery Continuity of Carer (MCoC) and the reconfigured workforce models.

Furthermore, Trusts have been asked to submit plans for MCoC by 15 June 2022 to NHSE/I, however, the final Ockenden publication advises that this must now take into account an immediate and essential action in ensuring safe midwifery staffing plans are in place, and Trusts must make one of 3 decisions:

1. Trusts that can demonstrate that staffing meets safe minimum requirements can continue existing MCoC provision and continue to rollout.

2. Trusts that cannot meet safe minimum staffing requirements for further rollout of MCoC but can meet safe minimum staffing for existing MCoC provision, should cease further rollout.

3. Trusts that cannot meet safe minimum staffing requirements for further rollout of MCoC and for existing MCoC provision, should immediately suspend MCoC provision and transfer women to alternative pathways.

The Board of Directors will recall that the Trust has developed a workforce consultation plan to progress the implementation of MCoC at Newcastle, details of which were presented to the Trust Board in January 2022. The Directorate are currently part-way through this formal consultative process; in light of the revised guidance in the final Ockendon report, the intention is to complete this within the context of the revised guidance to ensure full

transparency and engagement with the maternity workforce, following which intended formal review of the Trust's position on further rollout of models associated with a Continuity of Carer pathway will be concluded. This further review will consider the immediate and essential action on MCoC arising from Ockenden, and the findings of this review will be updated to the Quality Committee in July 2022.

Of note is that the national workforce tool, Birthrate Plus, on which recommended midwifery establishments are based both at Newcastle and in other services across the country, is now subject to further independent methodological review as a recommendation of the final Ockenden report. The Trust awaits further information on this element but in the interim will use our own workforce measures which include Birthrate Plus, together with additional indicators in relation to staffing to inform our decision.

6. HIGH LEVEL ACTION PLAN

Table 2 provides a revised and updated high level action plan against the key issues to support the work required to facilitate progressing the Service towards full compliance with the interim Ockenden recommendations.

Table 2

The Newcastle Upon Tyne Hospitals NHS Foundation Trust Maternity Services Assessment and Assurance Tool High Level Action Plan to support the requirements arising from the Ockenden Review; Updated May 2022			
Immediate and Essential action (IEA)	**Updated action which is required to meet recommendation**	**Lead/s**	**Completion Date**
IEA 3 Staff training and working together	Required to ensure 90% of all specialties take part in multi-disciplinary training. This has been challenging for the reasons reported in the Trust Board and Quality Committee reports; a mechanism is in place for regular monitoring and reporting. A task and finish group has been established to ensure a more focussed strategy going forward.	Consultant Obstetrician (Training Lead) Practice Support Team Clinical Director Directorate Manager	Following pause, CNST Year 4 submission with Trust Board sign-off is delayed until 5 January 2023. Training compliance will now be taken over an 18-month period rather than the previous 12-month period to allow for challenges associated with the Pandemic.
IEA 4, 5 & 7 Named Consultant and Risk assessment throughout pregnancy	Continue to embed named consultant and continuous risk assessment through training, audit, and plan-do-study-act (PDSA). A task and finish group are established. Further enhance the current paper-based system as an interim whilst awaiting implementation of EPR with full audit schedule. Continue the work to progress the project plan and implementation of BadgerNet as the agreed electronic paper record.	Head of Obstetrics Midwifery Matrons Clinical Quality and Effectiveness Midwife Clinical Director Directorate Manager	An updated paper-based Risk Assessment has been implemented to support greater utilisation and increased compliance. A repeat comparison audit is to be undertaken in June 2022. EPR 8 months to implementation.

Actions to support Maternity Workforce planning				
		Action required to meet recommendation	**Lead/s**	**Completion Date**
Section 2 Midwifery workforce	A plan in place to meet the Birthrate Plus standard	The Midwifery workforce plan is contained within the wider work being undertaken aligned to transformation, Better Births and Continuity of Carer. Work is progressing against the proposal presented to the Trust Board in January 2022.	Associate Director of Midwifery Directorate Manager	Completed

7. STRATEGIC IMPLICATIONS

The final Ockenden publication raises a number of key issues and challenges, particularly for smaller providers of maternity services, which have the potential to impact on the regional tertiary service at Newcastle.

The Trust will continue to work with the North East and North Cumbria LMNS, and other NHS providers within the region, to more clearly establish and consider the wider strategic implications of meeting the Ockenden requirements published in the final report. Further updates will be provided to the Board of Directors in future papers.

8. RISKS

The risks identified in the January 2022 Trust Board report which align to the quality assurance issues arising from the use of paper-based records, will continue to exist until full implementation of a maternity specific electronic patient record. As previously reported, interim audit measures are in place to support monitoring and mitigation of risk.

As has been identified within this paper, workforce training is recognised as being at risk in terms of the sustainability of ensuring 90% compliance across all specialities. The pause and subsequent extension by NHS Resolution to the Maternity Incentive Scheme is welcomed and will undoubtedly support the Trust to meet with this essential requirement. Consistent monitoring is in place, and regular reporting on trajectory against the 90% target will be made to both the Trust's Quality Committee and the to the Trust Board.

9. CONCLUSION

The Trust has made good progress against the Immediate and Essential Actions arising from the interim Ockenden report. The outstanding actions of note relate specifically to risk assessment, personalised care planning, and the support which is required from a maternity specific electronic patient record. Work is progressing on the implementation of BadgerNet with a revised target date of December 2022.

The pause and subsequent extension to Year 4 of the Maternity Incentive Scheme is welcomed and will support the challenges which relate to multi-professional core-competency training within the maternity and neonatal services.

Donna Ockenden's final report brings further significant Immediate and Essential Actions for providers of maternity services. The Trust is currently in the process of undertaking a detailed benchmarking exercise, the analysis of which will be reported to both the Quality Committee and Trust Board in July 2022. The findings of the Ockenden publication are being shared widely throughout the maternity service and across the wider Trust.

It is expected that there will be further recommendations for maternity and neonatal services to consider later this year given other reviews which are underway. NHS England

and Improvement have committed to consolidating all actions to ensure a coherent national delivery plan, which is welcomed by the Trust.

10. RECOMMENDATIONS

The Board of Directors is asked to:

i) Receive and discuss the report;
ii) Note the current level of assurance and the identified gaps in assurance as benchmarked against the interim recommendations;
iii) Recognise the significance of this final report for the Maternity Service and that further detailed work is required to ensure full compliance; and
iv) Note the associated risks involved.

Report of Maurya Cushlow
Executive Chief Nurse
20 May 2022

Table 2 Immediate Essential Action		Brief Descriptor IEA 1-15	Compliance
1. Workforce Planning and Sustainability: **Financing a safe maternity workforce** The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	1.1	The investment announced following our first report was welcomed. However, to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.	
	1.2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	
	1.3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.	
	1.4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.	
1.21. Workforce Planning and Sustainability: **Training** We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.	1.21	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.	
	1.22	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	
	1.23	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.	
	1.24	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	
	1.25	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	
	1.26	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of	

		all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.	
	1.27	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	
2. Safe Staffing: All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels	2.1	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.	
	2.2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.	
	2.3	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	
	2.4	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.	
	2.5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction.	
	2.6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.	
	2.7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	
	2.8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	
	2.9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	
	2.10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.	

3. Escalation and Accountability: There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	3.1	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between professionals.	
	3.2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	
	3.3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	
	3.4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	
	3.5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	
4. Clinical Governance: Leadership: Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	4.1	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.	
	4.2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.	
	4.3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	
	4.4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	
	4.5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.	
	4.6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	
	4.7	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	
5. Clinical Governance – Incident investigation and complaints Incident investigations must be meaningful for families and staff and lessons must be learned and	5.1	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.	
	5.2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	
	5.3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.	
	5.4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	

implemented in practice in a timely manner.	5.5	All trusts must ensure that complaints which meet SI threshold must be investigated as such.	
	5.6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	
	5.7	Complaints themes and trends must be monitored by the maternity governance team.	
6. Learning from Maternal Deaths Nationally all maternal PM examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	6.1	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.	
	6.2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.	
	6.3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	
7. Multidisciplinary Training Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	7.1	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	
	7.2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	
	7.3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	
	7.4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	
	7.5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	
	7.6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	
	7.7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	

8. Complex Antenatal Care: Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	8.1	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	
	8.2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	
	8.3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	
	8.4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	
	8.5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	
9. Preterm Birth: The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	9.1	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	
	9.2	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	
	9.3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	
	9.4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	
10. Labour and Birth: Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.	10.1	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made	
	10.2	Midwifery-led units must complete yearly operational risk assessments.	
	10.3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	
	10.4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity	

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

unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times	12.4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	
13. Bereavement Care: Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	13.1	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.	
	13.2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	
	13.3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.	
	13.4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	
14. Neonatal Care: There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	14.1	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	
	14.2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.	
	14.3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	
	14.4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	
	14.5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	
	14.6	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	
	14.7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies	

		may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.	
	14.8	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	
15. Supporting Families: Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	15.1	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	
	15.2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	
	15.3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.	

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	31 May 2022		
Title	Maternity Incentive Scheme Year 4 (CNST)		
Report of	Angela O'Brien, Director of Quality and Effectiveness		
Prepared by	Rhona Collis, Quality and Clinical Effectiveness Midwife/ Jane Anderson, Associate Director of Midwifery		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☒	☐
Summary	The NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity incentive scheme invites Trusts, in this Year 4 scheme, to provide evidence of their compliance using self-assessment against ten maternity safety actions. The scheme intends to reward those Trusts who have implemented all elements of the 10 Maternity Safety Actions. The Year 4 CNST safety actions were effective from the 8 August 2021. Amendments were made to the safety actions in October and on the 23 December 2021 the Trust was informed that there would be a 3 month pause in the reporting period due to ongoing pressure on the NHS and maternity services. Trusts were informed to continue to apply the principles of the 10 safety actions in view of the overall aim which was to support the delivery of safer maternity care. Trusts were encouraged to continue reporting to MBRACCE-UK and eligible cases to HSIB. Every reasonable effort should be made to make the Maternity Services Data Set submissions to NHS Digital. A detailed report was submitted to the Trust Board in March 2022. The content of this report will focus on the 3 safety actions whereby compliance is not yet met but the Trust continues to work towards full compliance. After this report was written the Trust received notification on the 6 May 2022 of the amended 10 Safety Actions. The new submission date is the 5 January 2023. This report has been written to reflect the October 2021 safety actions. A full report updating the Board of Directors on the newly amended safety actions will be provided for the July 2022 Trust Board.		

Recommendation	The Trust Board are asked to note the contents of this report and approve the self-assessment to date to enable the Trust to provide assurance that the required progress with the standards outlined in the ten maternity safety actions are being met.						
Links to Strategic Objectives	Putting patients first and providing care of the highest standard focusing on safety and quality. Enhancing our reputation as one of the country's top, first class teaching hospitals, promoting a culture of excellence in all that we do.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☐	☐	☒	☐
Impact detail	Failure to comply with the standards outlined could impact negatively on maternity safety, result in financial loss to the Trust from the incentive scheme and from potential claims.						
Reports previously considered by	This is the fifth report for Year 4 of this Maternity Incentive Scheme. A previous summary report was presented to Trust Board on the 22 March 2022.						

MATERNITY INCENTIVE SCHEME YEAR 4 (CNST): MATERNITY SAFETY ACTION COMPLIANCE

1. BACKGROUND TO CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST) MATERNITY INCENTIVE SCHEME – YEAR 4

Maternity safety is an important issue for Trusts nationally as obstetric claims represent the scheme's biggest area of spend (£2,389.89 million in 2019/20). Of the clinical negligence claims notified to NHS Resolution in 2019/20, obstetric claims represented 9% of the volume and 50% of the value.

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

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

This scheme intends to reward those Trusts who have implemented all elements of the 10 maternity safety actions by enabling Trusts to recover the element of their contribution relating to the CNST incentive fund, and by receiving a share of any unallocated funds.

Failure to achieve compliance against the safety actions will result in the Trust not achieving the 10% reduction in maternity premium which NHS Resolution has identified.

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

The Trust Board declared full compliance with all 10 maternity safety actions for Year 1, Year 2 and Year 3 of this scheme. Confirmation of the Trust's achievement in fully complying with all 10 standards was confirmed by NHS resolution and the Trust was rewarded, for Year 1, Year 2 and Year 3, with £961,689, £781,550 and £877k respectively in recognition of this achievement.

The incentive scheme will run for a further year and new standards were published on 29 August 2021, amendments were published in October 2021 and this report focuses on the second version published.

Requirements for Year 4 were suspended for 3 months from 23 December 2021. The Trust received notification on the 6 May 2022 of the amended safety actions and the new submission date of the 5 January 2023.

The Trust Board will receive a further report for consideration in July 2022 as required by the scheme.

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

The following standards are required to be compliant with Safety Action 1:

2.1 Standard A

i. All perinatal deaths eligible to be notified to MBRRACE-UK from 1 September 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death.

The Trust maintains a database to record all eligible perinatal deaths and there is a robust system in place to ensure MBRRACE-UK are notified within the above time scales.

ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 August 2021 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.

The Trust is compliant with this standard as referenced in the March 2022 Trust Board report.

2.2 Standard B

At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 8 August 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.

The Trust is confident in exceeding the 50% target outlined in this standard for Year 4. A database is maintained to closely monitor progress of the report writing to ensure the appropriate reports are published within the six months timescales.

2.3 Standard C

For at least 95% of all deaths of babies who died in your Trust from 8 August 2021, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing

reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.

Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.

The Trust continues to be compliant with this standard as referenced in the March 2022 Trust Board report.

2.4 Standard D

Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.

The content of this report includes a summary of the deaths reported and reviewed for Quarter 3 (01/10/2021 – 31/12/2021) and Quarter 4 (01/01/2022 – 31/03/22). The Q3 report was presented in the March 2022 Trust Board report. However, as reviews are completed over a 4-to-6-month period, minimal detail is provided in the initial PMRT generated report.

In Quarter 3 there were 18 perinatal deaths reported in this time period. 15 have had a review completed, the remaining eligible cases have started the review process.

In Quarter 4 there were 10 perinatal deaths and the PMRT summary report acknowledges that 2 reports have been completed with 8 in progress.

The Trust has produced a quarterly PMRT report for the Trust Board since 25/04/2019. This report outlines data from PMRT for Quarter 3 and Quarter 4 2021/22 reviews. The reports have been included in the Private Board Reference Pack.

The Trust is confident of being fully compliant with this safety action as referenced in the March 2022 Trust Board report.

3. SAFETY ACTION 2: IS THE TRUST SUBMITTING DATA TO THE MATERNITY SERVICES DATA SET (MSDS) TO THE REQUIRED STANDARD?

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

3.1 Standard 1

Trust Boards to confirm that they have either:

already procured a Maternity Information System complying with the forthcoming commercial framework (to be published by NHSX) and are complying with Information Standard Notices DCB1513 and DCB3066
OR
have a fully funded plan to procure a Maternity Information System from the forthcoming commercial framework and comply with the above Information Standard Notices and attend at least one engagement session organised by NHSX.

The Trust is compliant with the actions outlined for this safety action to date. The implementation of BadgerNet, a maternity specific electronic patient record (EPR), is planned to be launched in December 2022, as detailed in the Trust Board Ockenden paper. In addition, the Maternity Digital Health Leads have attended various engagement sessions held by NHS Digital, as required by the scheme.

3.2 Standard 2

Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria on the national Maternity Services Dashboard for data submissions relating to activity in January 2022. The data for January 2022 will be available on the dashboard during April 2022.

Since the pause in MIS reporting the Trust has not received notification of the CQIM achievements via the Scorecard (usually produced by MSDS). Some of the CQIMS have since been removed and, therefore the Trust awaits confirmation of the exact requirements. Previously the Trust achieved 8 out of 11 CQIMs. The latest CNST report from NHS Digital in March 2022 showed that 2 out of the 3 outstanding are now passing the data quality criteria.

Work continues to improve the data quality for the remaining CQIM target. Data is entered manually to increase compliance, which presents a challenge and additional human resource. BadgerNet implementation will decrease the additional resource required and increase compliance in meeting with this standard.

3.3 Standard 3

January 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 14+1 weeks gestation for 90% of women reaching 14+1 weeks gestation in the month.

The Trust is not consistent in achieving full compliance. In February compliance was 92.7% but in March it fell slightly to 89.3%. The Trust will continue to monitor compliance monthly. Once the amended safety actions have been published and the exact month for

data submission is notified the Trust will have two months after the agreed month to ensure the data quality is above 90%.

3.4 Standard 4

January 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month.

The Trust is fully compliant with collection of this data set as reported in the March 2022 Trust Board report.

3.5 Standard 5

Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria on the national Maternity Services Dashboard for data submissions relating to activity in January 2022 for the following 5 metrics:

Continuity of carer (CoC)

1. *The proportion (%) of women placed on a CoC pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation*
2. *The proportion (%) of women receiving CoC*

This element of the safety action has now been removed from the amended October 2021 safety action. A further review of the newly revised technical guidance will be made and reported to the Trust Board in July 2022.

4. SAFETY ACTION 3: CAN THE TRUST DEMONSTRATE THAT IT HAS TRANSITIONAL CARE SERVICES IN PLACE TO MINIMISE SEPARATION OF MOTHERS AND THEIR BABIES AND TO SUPPORT THE RECOMMENDATIONS MADE IN THE AVOIDING TERM ADMISSIONS INTO NEONATAL UNITS PROGRAMME?

The following standards are required to be compliant with Safety Action 3:

4.1 Standard A

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

The Trust is compliant with this standard as reported in the March 2022 Trust Board report.

4.2 Standard B

The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.

The Trust is compliant with this standard and monthly ongoing audit of compliance with the agreed pathway into transitional care has continued from Year 3 as outlined in the incentive scheme.

A process is in place to share subsequent audit findings with the Neonatal Safety Champion on a monthly basis. Mechanisms are in the process of being agreed regionally for sharing audit findings quarterly with the Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting, to enable compliance with this requirement of the scheme for Year 4. In the interim the data collected is shared with the Network lead and Specialist Commissioner via e-mail.

4.3 Standard C

A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded.
If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.

Data is available on transitional care activity (regardless of place - which could be transitional care, postnatal ward, virtual outreach pathway etc.) and this data recording process pre-dates the deadline of 10 January 2022 outlined in Year 4 of the incentive scheme.

The Trust has a secondary recording process available for babies born between 34+0 - 36+6 weeks gestation at birth, who did not have surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered. This is already in place and pre-dates the deadline of 10 January 2022 outlined in the scheme.

The Trust is compliant with this standard.

4.4 Standard D

Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), Local Maternity and Neonatal System (LMNS) and commissioners, to inform capacity planning as part of the family integrated care

component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.

The Trust is compliant with this standard continuing the process from Year 3 of the Maternity Incentive Scheme.

4.5 Standard E

Reviews of term admissions to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. The reviews should report on the number of admissions to the neonatal unit that would have met current TC admissions criteria but were admitted to the neonatal unit due to capacity or staffing issues.

The review should also record the number of babies that were admitted to or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.

The review of term admissions to the neonatal unit have continued on a quarterly basis. The findings of these reviews were shared with the Maternity Board Level Safety Champions Group on the 13 October 2021, 10 February 2022 and 13 April 2022. A further report will be available for the proposed June 2022 meeting.

Mechanisms have now been agreed regionally to enable findings to be shared on a quarterly basis with the LMNS. The Trust submitted the Q4 report to the LMNS on the 29 April 2022.

4.6 Standard F

An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions into Neonatal units (ATAIN) reviews (point e) has been agreed with the maternity and neonatal safety champions and Board level champion.

The Trust is compliant with this standard.

4.7 Standard G

Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level champion and LMNS and ICS quality surveillance meeting each quarter.

The Trust is confident of being fully compliant with this safety action as outlined above (4.5).

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

5.1 Standard A

Obstetric Medical Workforce

The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service.

A paper was presented to the Maternity Board Level Safety Champions Group in December 2021 regarding a Medical Workforce Strategy. The group will receive this document bi-annually as agreed by MIS. A second paper will be presented at the June 2022 meeting.

Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS.

Monthly audits of consultant attendance commenced in January 2022. The results of the January and February audits were shared at the April 2022 Maternity Board Level Safety Champions Group. Audits for March, April and May 2022 will be shared at the Maternity Board Level Safety Champions Group on the 8 June 2022.

5.2 Standard B

Anaesthetic medical workforce

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

The Trust is confident in compliance with this standard as in previous years. As reported in the March 2022 Quality Committee and Trust Board report an audit in March demonstrated appropriate availability of the anaesthetist.

5.3 Standard C

Neonatal medical workforce

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

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

If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies.

The Neonatal unit did not meet the BAPM standards for year 3 of the scheme. These deficiencies were addressed which led to a successful business case to increase the number of tier 2 neonatal trainee doctors. Despite a rigorous recruitment drive, the Trust has been unable to fill these posts. In the interim tier 1 neonatal trainee doctors have been recruited with a plan that they will progress to tier 2 level within the next few years.

5.4 Standard D

Neonatal nursing workforce

The neonatal unit meets the service specification for neonatal nursing standards.
If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.

If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMS and Neonatal Operational Delivery Network (ODN) Lead.

A Staffing Report was presented to the Trust Board in November 2021 which included a position statement regarding the Neonatal Nursing Workforce. A further staffing review using the Dinning Tool is currently planned, a further update will be provided to the Trust Board with regard to the findings of this review.

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

6.1 Standard A

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

6.2 Standard B

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

and

6.3 Standard C

All women in active labour receive one-to-one midwifery care

6.4 Standard 4

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

Regular reporting on a six-monthly basis is made to the Trust Board through the Executive Chief Nurse staffing paper in relation to Midwifery staffing. A Nursing and Midwifery Staffing report was submitted to the Trust Board in November 2021 and a further paper will be presented in May 2022. The contents of this paper are cross referenced as appropriate within the Ockenden paper to both the Quality Committee and the Trust Board, together with the paper presented in relation to Maternity Transformation and Midwifery Continuity of Carer to the Trust Board in January 2022.

The Trust continues to be fully compliant with this safety action.

7. SAFETY ACTION 6: CAN YOU EVIDENCE COMPLIANCE WITH ALL FIVE ELEMENTS OF THE SAVING BABIES' LIVES CARE BUNDLE VERSION TWO?

7.1 Element 1

This element requires the following monitoring evidencing an average of 80% compliance over a six-month period:

A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.
B. Percentage of women where CO measurement at 36 weeks is recorded.

The Trust is compliant with point A. Data for January showed 94% compliance.

Evidence of CO monitoring of women at 36 weeks remains an ongoing challenge from Year 3 due to the lack of electronic maternity records for capturing this data. Data is required to be entered manually in order to achieve compliance. Between September 2021 - December 2021 the compliance rate was 82%. The Trust awaits confirmation of the exact month data will be extracted from for submission; appropriate audit mechanisms are in place to ensure consistent monitoring.

7.2 Element 2

This element requires the following monitoring evidencing at least 80%.

A. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan

The Trust is compliant with this element. Data extracted from the electronic maternity records at booking, for January 2022, showed 100% compliance.

7.3 Element 3

This element requires the following monitoring evidencing at least 80%.

A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy.
B. Percentage of women who attend with Reduced Fetal Movements who have a computerised CTG.

The Trust is compliant with both these elements as referenced in the March 2022 Trust Board and Trust Board report. Data for A) is extracted from the electronic maternity records at booking (82%) and for B) an audit of women attending the Maternity Assessment Unit was undertaken in March 2022 (100%).

7.4 Element 4

There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness.

The Trust board should specifically confirm that within their organisation:

- *90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above.*
- *A dedicated Lead Midwife (0.4 WTE) and Lead Obstetrician (0.1 WTE) per consultant led unit have been appointed by the end of 2021 at the latest.*

Compliance with training is presented in more detail in Safety Action 8.

A dedicated lead midwife and a lead Obstetrician for fetal monitoring are now in post, as reported in the March 2022 Trust Board report.

7.5 Element 5

This element requires the following monitoring evidencing at least 80%.

A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.
B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.
C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.
D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).

The Trust is compliant with A, C and D.

The Trust is not currently able to achieve standard B (above). However, the Trust can declare compliance with requirements of the scheme with an action plan being in place to address how the Trust will achieve at least 80% compliance for this standard and this is in place, together with a mechanism to monitor and report.

8. SAFETY ACTION 7: CAN YOU DEMONSTRATE THAT YOU HAVE A MECHANISM FOR GATHERING SERVICE USER FEEDBACK, AND THAT YOU WORK WITH SERVICE USERS THROUGH YOUR MATERNITY VOICES PARTNERSHIP (MVP) TO COPRODUCE LOCAL MATERNITY SERVICES?

8.1 Evidence should include:

Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems.

Minutes of MVP meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff.

Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme. Remuneration should take place in line with agreed Trust processes.

The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMS board that ratified it.

Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including childcare costs in a timely way.

Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given

the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.

The Trust remains fully compliant with this safety action with a well embedded, robust process working in collaborative partnership with the MVP and other key service users.

9. SAFETY ACTION 8: CAN YOU EVIDENCE THAT A LOCAL TRAINING PLAN IS IN PLACE TO ENSURE ALL SIX CORE MODULES OF THE CORE COMPETENCY FRAMEWORK WILL BE INCLUDED IN YOUR UNIT TRAINING PROGRAMME OVER THE NEXT 3 YEARS, STARTING FROM THE LAUNCH OF MIS YEAR 4?

IN ADDITION, CAN YOU EVIDENCE THAT AT LEAST 90% OF EACH RELEVANT MATERNITY GROUP HAS ATTENDED AN 'IN HOUSE', ONE DAY MULTI PROFESSIONAL TRAINING DAY WHICH INCLUDES A SELECTION OF MATERNITY EMERGENCIES, ANTENATAL AND INTRAPARTUM FETAL SURVEILLANCE AND NEWBORN LIFE SUPPORT, STARTING FROM THE LAUNCH OF MIS YEAR 4?

9.1 Standard A

A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4 in August 2021.

The Training Needs Analysis has been amended to include the six core modules of the Core Competency Framework and a plan is in place for implementation over the next 3 years.

9.2 Standard B

90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, to include maternity emergencies starting from the launch of MIS year four on 8 August 2021?

9.3 Standard C

90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four on 8 August 2021.

9.4 Standard D

Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four on 8 August 2021.

Achieving 90% compliance this year remains a challenge due to staff absence as a result of the COVID-19 pandemic.

Compliance across standards B, C and D currently range between 25-80% with an overall compliance of 41%. Further detail with a breakdown of compliance per staff group is contained within the Ockenden report presented to both the Quality Committee and the Trust Board.

Due to the current pause in Year 4 of the scheme, the Trust awaits confirmation of the exact time period required to evidence Year 4 compliance. In mitigation of the identified risk, the increased training schedule supports traction against trajectory, however, it should be noted that in times of escalation, due to high acuity and unexpected staff absence, it has at times been necessary to decrease the number of planned sessions.

10. 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?

10.1 Standard A

The pathway developed in Year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality surveillance-model.pdf (england.nhs.uk). The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.

The pathway has been revised in light of the additional requirements and was presented to the Maternity Board Level Safety Champions Group on 13 April 2022.

10.2 Standard B

Board level safety champions present a locally agreed dashboard to the Board on a quarterly basis including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 31 October 2021. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 31 December 2021.

The Trust is compliant with this safety action however, further work is ongoing to ensure that the process is robust and meaningful with the appropriate level of detail being presented to the Trust Board.

Changes to year 4 from 6 May 2022

In the newly amended technical guidance, the above date has changed, and the expectation is that the agreed dashboard should be presented to Trust Board by the 16 June 2022. In the July Trust Board report all the changes will be discussed in detail but in order to meet this deadline the most recent dashboard is included in the Private Board Reference Pack as part of this report.

10.3 Standard C

Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2023, prioritising those most likely to experience poor outcomes.

A proposal aligned to the Maternity Transformation Programme and the implementation of Continuity of Carer has been developed by the Women's Services Directorate and this was presented to the Trust Board in January 2022. Receiving approval, the Trust is currently in the process of staff consultation through a formal organisational change process.

The Directorate are currently part-way through this formal consultative process, following which it is intended that review will be undertaken with regard to the Trust's position on further rollout of models associated with a Continuity of Carer pathway. This further review will consider the immediate and essential action on MCoC arising from Ockenden, and the findings of this review will be updated to the Trust Board in July 2022.

10.4 Standard D

Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)

Evidence that insights from culture surveys undertaken have been used to inform local quality improvement plans by 30 April 2022

The Trust is confident of being fully compliant with this safety action as detailed in the March 2022 Trust Board report.

11. SAFETY ACTION 10. HAVE YOU REPORTED 100% OF QUALIFYING CASES TO HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB) AND TO NHS RESOLUTION'S EARLY NOTIFICATION (EN) SCHEME FOR 2021/22?

A) Reporting of all qualifying cases to HSIB for 2021/22.

B) For qualifying cases which have occurred during the period 1 April 2021 to 31 March 2022 the Trust Board are assured that:

1. the family have received information on the role of HSIB and the EN scheme;
2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

The Trust is fully compliant with this safety action.

12. RECOMMENDATIONS

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

Report of Angela O'Brien
Director of Quality & Effectiveness
20 May 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 May 2022						
Title	Learning From Deaths (January 2022 – March 2022)						
Report of	Angela O'Brien, Director of Quality and Effectiveness						
Prepared by	Pauline McKinney, Integrated Governance Manager-Quality; Victoria Smith, Patient Safety Manager						
Status of Report	Public		Private		Internal		
	☒		☐		☒		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	This paper aims to provide assurance to the Board that the processes for Learning from Deaths across the organisation are in line with best practice as defined in the National Quality Boards (NQB) National Guidance on Learning from Deaths (LFD) March 2017, and guidance on working with bereaved families and Carers (July 2018). This paper also summarises the processes that are in place to provide assurance to the Board that all deaths are reviewed including those with potentially modifiable factors. All deaths that require a more in-depth review (level 2) are recorded into the mortality review database to ensure lessons are learned and shared.						
Recommendation	The Board is asked to (i) receive the report and (ii) note the actions taken to further develop the mechanisms for sharing learning across the Trust.						
Links to Strategic Objectives	Putting patients first and providing care of the highest standard focusing on safety and quality: • Put patients and carers first and plan services around them; and • Maintaining our 'Outstanding' CQC rating.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☒	☒	☐
Impact detail	Provision of assurance that patient outcomes are reviewed and lessons learned to include deaths of people with learning disabilities.						
Reports previously considered by	This is a recurrent report and was previously presented to the Quality Committee on 17 May 2022.						

The Newcastle upon Tyne Hospitals NHS Foundation Trust

LEARNING FROM DEATHS

EXECUTIVE SUMMARY

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

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

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

LEARNING FROM DEATHS

1. BACKGROUND

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

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

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

The guidance released in July 2018 by the Department of Health and Social Care published the government's response to consultation on the "Introduction of Medical Examiners and Reforms to Death Certification in England and Wales". This guidance outlines the intention that the medical examiner system will be enshrined in statute and Medical Examiners will be based in all acute Trusts by 2021 with a view to scrutinise community deaths by 2022.

2. MORTALITY REVIEW DATABASE – DATA SUMMARY

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

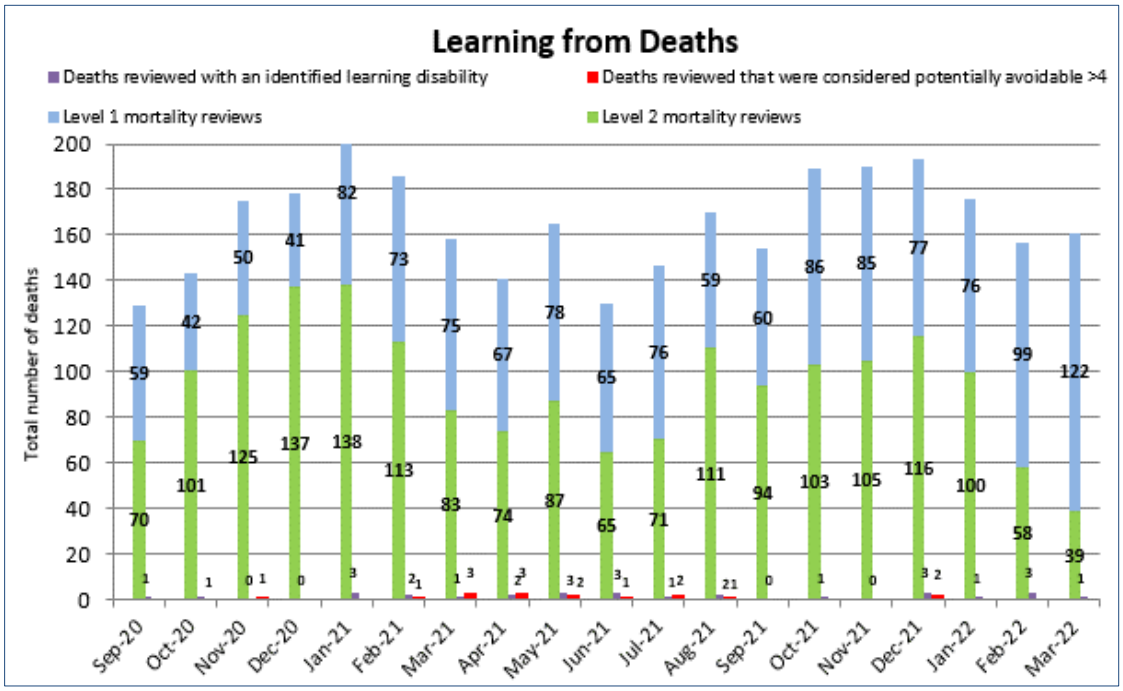
Level 1: The reviewer reviews the cause of death and discusses with the certifying doctor and medical examiner.

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

The Learning Disability Team (LDT) uses the database to record their investigations; this is in addition to the LDT recording into The National Learning Disabilities Mortality Review (LeDeR) National Database.

2.1 Inpatient Deaths

In the past 12 months (April 21 – March 22) 1,973 patients died within Newcastle Hospitals with a total of 1,034 patients having received a level 2 mortality review. It is likely that these mortality review figures will continue to rise due to ongoing M&M meetings being held over the forthcoming months. These figures will continue to be monitored and modified accordingly. The graph below shows total number of deaths each month from September 2020 as well as Trust mortality reviews, the graph clearly shows the peaks through the Covid-19 pandemic.



2.2 Patients identified with a Learning Disability

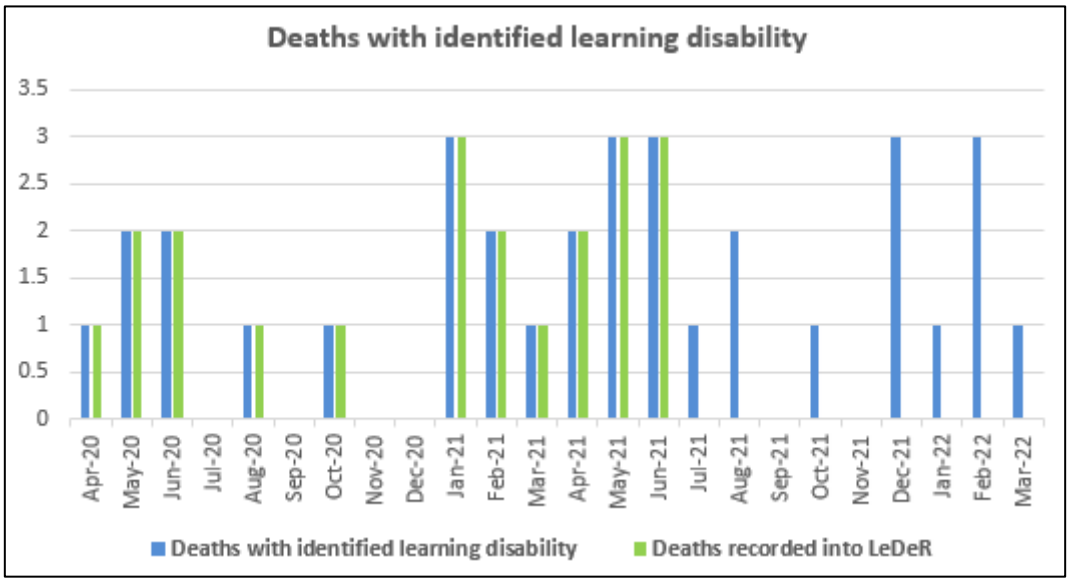
The National Learning Disabilities Mortality Review (LeDeR) Programme was established as a response to the recommendations from the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD 2013). CIPOLD reported that people with learning disabilities are three times more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

Between April 2021 – March 2022, 20 patients who died within Newcastle Hospitals were identified as having a learning disability. Within the Trust, whenever a patient with a learning disability dies, their death is reviewed by the clinical team and is supported by the Learning Disability Team. There is a further in-depth case review at the Learning Disability Mortality Review Panel and the case review is also entered onto the Trust Mortality Review Database, as well as into the LeDeR National Database. An update is provided from the Learning Disability Specialist Nurse at each quarterly Mortality Surveillance Group meeting

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

The graph below shows the data for the past 24 months (April 2020 – March 2022) and includes those patients who have been recorded into the national LeDeR database. However, due to the complexity of some cases and staffing constraints within the learning disability team, there has been a delay in cases being reviewed and updated into LeDeR. The backlog is envisaged to be submitted into the national LeDeR database by 30 June 2022.

The staffing constraints are currently being considered at Executive level in the Trust alongside a conditional mandatory requirement to include patients with a diagnosis of autism in the LeDeR process.



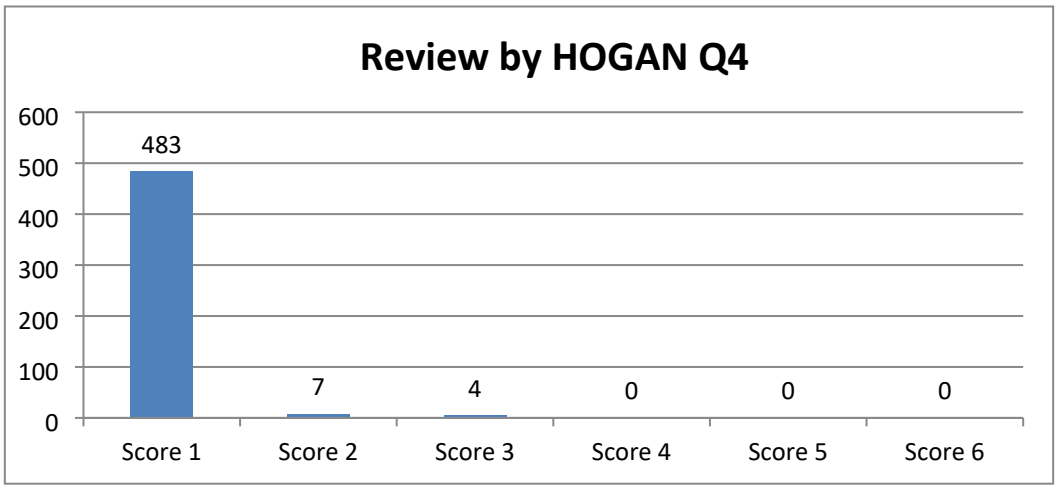
2.3 Outcome of Case Reviews – Hogan Score

Throughout Q4 (January 22 – March 22), 211 patients have received a full case note review (Level 2) which was undertaken by a multidisciplinary team and findings recorded into the Trust-wide mortality review database. This number will continue to rise as more M&M meetings go ahead over the forthcoming months.

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

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

A score of ≥4 suggests 'strong evidence of preventability' and an investigation is initiated to determine if a serious incident (SI) is to be reported, as well as being presented on an individual basis at quarterly mortality surveillance group. The outcomes of the cases reviewed in Q4 are summarised in the graph below:



3. KEY LEARNING POINTS

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

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

The learning points identified following M&M reviews in Q4 are detailed below, together with how learning has been shared and what action has been taken. Clinicians from each Directorate are also encouraged to share learning from local mortality reviews with any other Directorates throughout the Trust.

Learning points identified from case reviews undertaken in Q4:

Directorate	Speciality	Summary	Learning Point
Internal Medicine	Assessment Suite	Departmental staff were unable to contact relatives to inform them of their loved one's death. It appears the incorrect contact number was recorded in the electronic patient record (EPR).	The Trust is currently enhancing EPR functionality that enables the details of more than one next of kin to be accessible to staff, this will enable more timely communication with families.

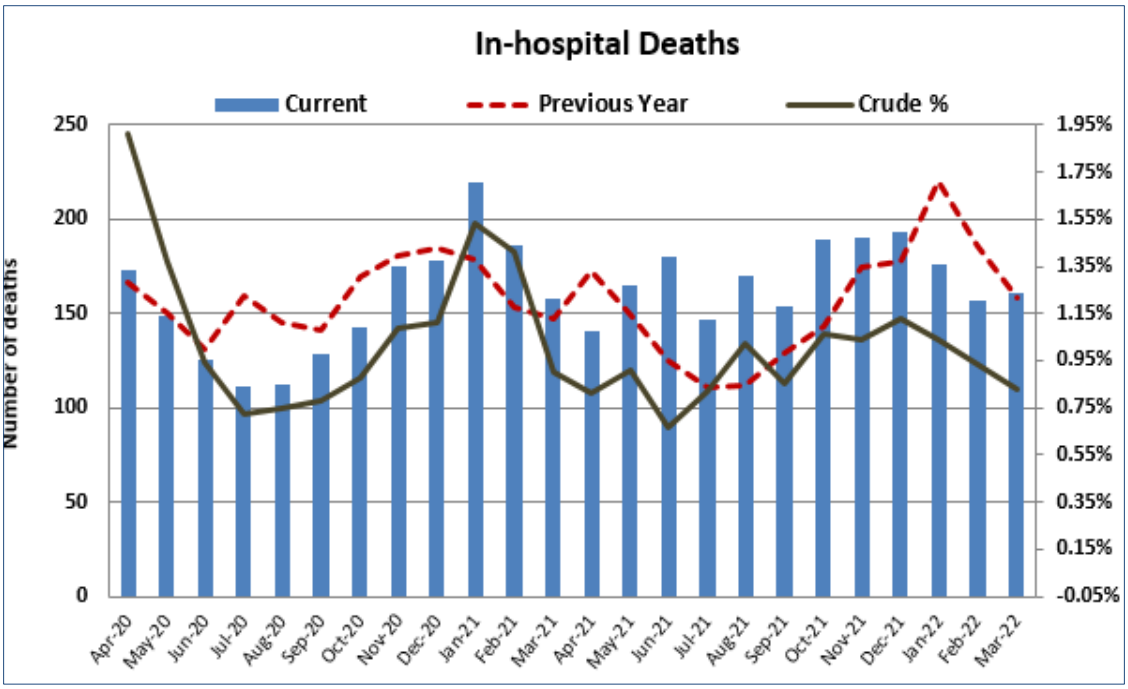
Directorate	Speciality	Summary	Learning Point
Internal Medicine	Respiratory	A patient was double vaccinated for COVID-19 but had not received their booster. A lack of access to booster vaccination for hospital inpatients has been raised with infection, prevention and control.	Access to booster vaccination for in-patients is now available on an ad-hoc basis.
Surgical Services	Vascular	An extremely frail patient was admitted due to critical limb ischaemia. The patient suddenly deteriorated six weeks after admission. Do not attempt cardio pulmonary resuscitation (DNACPR) was initiated with family involved but patient was too unwell to be involved in the discussion.	Advanced care planning is important for patients and their families, DNACPR decisions should be carefully considered, and where possible, discussed with patients at a time when they are able to contribute.
Internal Medicine	Assessment Suite	An extremely frail patient was admitted to hospital following a fall in their care home. In the weeks prior to this admission, the patient had attended on multiple occasions. Had an electronic healthcare plan been in place, the patient's care home may have been better supported to manage this patient at home, avoiding multiple trips to hospital.	The use of the Clinical Frailty Score and the importance of sharing this with patients GP's has been discussed in departmental forums. Staff have received training in this. This information, as part of an electronic healthcare plan, ensures joined-up care, improving the healthcare journey for the patient.
Internal Medicine	Gastroenterology FH	A critically ill patient was transferred from another Trust with a Gastrointestinal (GI) bleed. They were added to the waiting list for multi visceral transplant and began to improve clinically over the following few days. Sadly, they then deteriorated rapidly, and palliative care was initiated.	Timeliness of initiating palliative care is important for patients and their families. The palliative care team within the Trust is available to support clinical teams when a patient is deemed to require such care. Learning from this case was discussed at a local M&M meeting and shared with Gastroenterology colleagues.
Internal Medicine	Assessment Suite	A patient attended the Emergency Department (ED), via ambulance, after their carers found them unresponsive at home. When under the care of the paramedics the patient did regain consciousness for a short time and was able to describe a fall backwards. The patient also complained of chest and back pain. Palliative care was initiated, and the patient sadly died the following day. A Coronial referral was not made at this time in error.	All deaths involving a traumatic fall should be referred to the Coroner. Education has taken place in this regard to support all junior medical staff in this process.

4. CRUDE MORTALITY

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

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

The graph below shows the crude mortality rates since April 2020. The crude mortality shows a significant increase in April 2020. This is as a result of the COVID-19 pandemic first wave. At this time, the majority of elective surgical cases were postponed, dramatically reducing discharge rates. Although the deaths during this time period did not rise dramatically in comparison to the same time period the previous year, the reduced discharge rate increases the crude mortality percentage. A further significant rise can be seen in December 2020 to February 2021, which reflects more deaths than expected during the second wave of the COVID-19 pandemic. This is in part due to increased numbers of patients being admitted into the Intensive Treatment Unit (ITU) from other regional and national hospital Trusts as part of the second wave surge. More recently, the crude rate has reduced to less than 1%, which is in line with the expected rate for this Trust.



5. SHMI AND HSMR MORTALITY RATES

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

SHMI and HSMR data is scrutinised on publication to determine any areas that may raise concern. All groups within the data are individually monitored and all findings are presented

to the Trust Mortality Surveillance Group on a quarterly basis. Any group that flags as a concern is raised with the relevant Directorate to ensure an in-depth analysis is undertaken and findings recorded into the mortality review database. All learning from this analysis is shared with Directorates and presented to the Mortality Surveillance Group. The latest SHMI publication for October 20 – September 21 shows the Trust to be at 96, which is below the national average and within "expected levels".

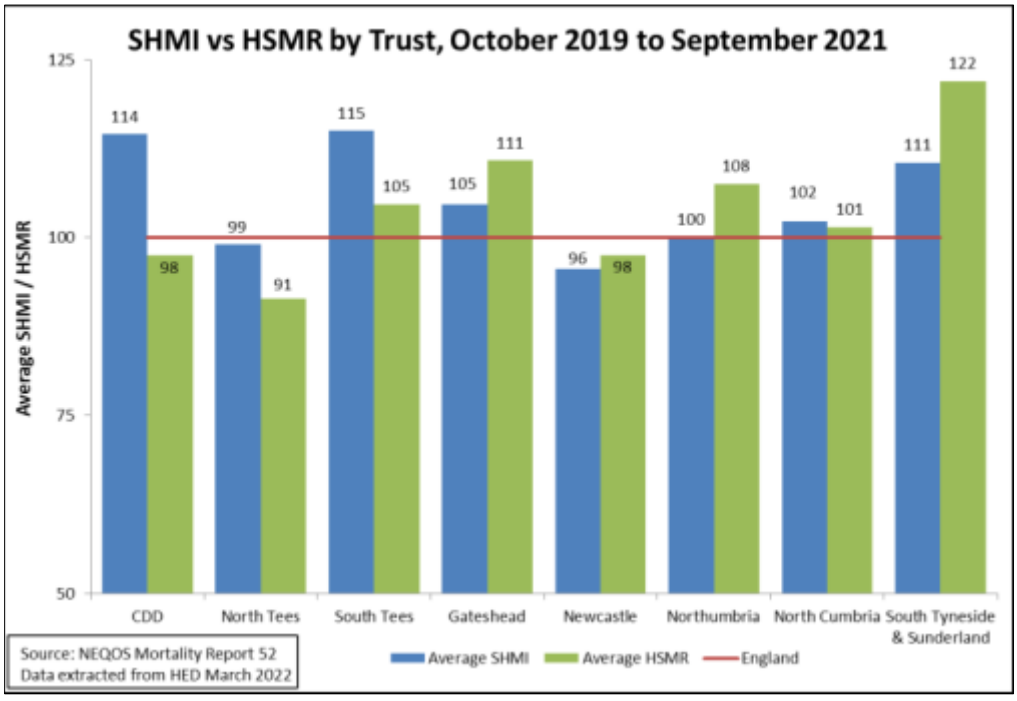
All mortality data including SHMI, HSMR and Variable Life Adjustment Displays (VLADS) are closely monitored.

6. NEQOS

The North East Quality Observatory Service (NEQOS) present analysis showing the SHMI and HSMR mortality indices including: a high level for Trusts identifying variation from the norm (outliers); showing trends through time; and using more granular analysis in order to describe contributing factors.

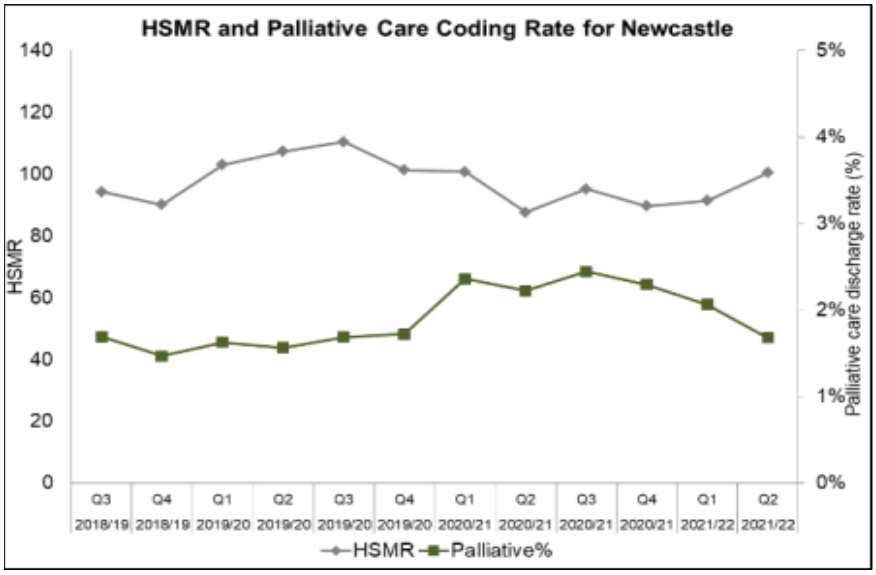
Overall, the graph below shows the Trust to be consistently below the national average for both SHMI and HSMR. The Trust SHMI average over a two-year period is 96 and the HSMR 98; both are below the national average. The Trust HSMR has lowered within recent months, with a main factor being due to new processes that were introduced into the Trust around palliative care coding, therefore as HSMR includes palliative care coding and is adjusted accordingly, the higher the palliative care coding the lower the HSMR.

SHMI vs HSMR for the last 2 years:

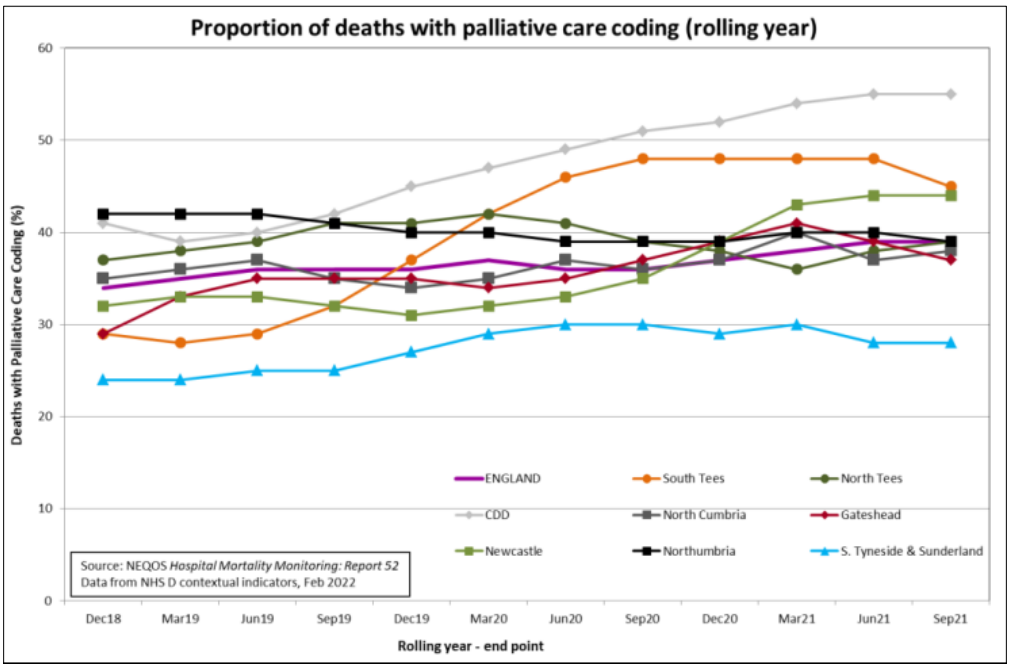


7. PALLIATIVE CARE CODING

The graph below shows that palliative care coding rate on discharge (including in-patient deaths) is historically reported below 2% within Newcastle upon Tyne Hospitals, which is one of the lowest in the region. The rise in palliative care coding throughout 2020/21 can be explained by the rise in deaths during the pandemic.



The graph below shows the percentage of deaths with a palliative care coding for regional Trusts, which includes those who have died within 30 days of discharge.



8. OUTCOME OF INVESTIGATIONS LINKED TO SERIOUS INCIDENTS

All unexpected patient deaths, or deaths with possible modifiable factors, are routinely escalated for review as potential SIs via the Trust incident reporting system (Datix). Deaths

of this nature are subject to a detailed review, facilitated by a Clinical Director and often involve members of the clinical team directly involved in the patient's care. For deaths identified and reported externally as an SI, a comprehensive investigation is undertaken, which includes an analysis of the care provided to identify any learning and determines whether any modifiable factors contributed to the patient's death. Key learning points are identified, and action plans generated. A summary of investigation outcomes linked to SIs in Q4 are shown below:

- During January 2022 – March 2022 (Q4) there were 54 SIs reported to Commissioners via the Strategic Executive Information System (STEIS).
- Of these 54, there were nine patient deaths, which identified potential modifiable factors.

The incidents that have resulted or contributed to a patient's death, that have been completed since the previous report submitted on 31 March 2022, are as follows:

2022/1839 – Patient Fall
This patient's death was investigated following an unwitnessed fall, resulting in a head injury. An in-depth review of the case identified areas of good practice in responding to the patient's fall. Improvement work has focused on exploring opportunities to improve signage across hospital premises in regard to reducing falls risk.

2021/14732 – Complication following interventional procedure
A patient sustained a complication during an interventional procedure and sadly passed away following this. The investigation into this case has identified the following learning: - All patients undergoing the procedure must have their case discussed with an appropriate Consultant prior to it taking place. - It is essential for medical staff undertaking this procedure to receive training both at induction and as part of a competency-based assessment package. Evidence of formal training must be demonstrated prior to undertaking this procedure.

9. MEDICAL EXAMINER

The Medical Examiner system for reviewing all patient deaths was introduced in 2019 by NHS England and was designed to strengthen safeguards for the public, improve the quality of death certification and to avoid unnecessary distress for the bereaved. The process aims to ensure all deaths are reviewed independently by the Medical Examiner, giving relatives of the deceased an opportunity to ask questions relating to their loved one's care.

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

Infirmary (RVI) in August 2021. The Medical Examiners do not currently scrutinise paediatric, maternal or deaths where the patient had a learning disability diagnosis, as these patients receive a full and in-depth case review, in line with national review processes.

The medical examiner process plans to incorporate community deaths in summer of 2022, with current work focussing on system development in regard to inclusion of these deaths. Two GP practices and two hospices have been identified to undertake a pilot before rolling out the process regionally. The Trust is currently expanding the number of medical examiners and medical examiner officer roles to incorporate the development of this service.

10. RECOMMENDATIONS

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

Report of Angela O'Brien
Director of Quality & Effectiveness
17 May 2022

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	31 May 2022						
Title	Quality Account						
Report of	Angela O'Brien Director of Quality and Effectiveness						
Prepared by	Anne Marie Troy-Smith Quality Development Manager						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☒		☒		☐		
Summary	Each year the Trust is required to produce and publish a Quality Account. Contained within this is a review of the previous 12-month performance against the agreed Quality Priorities, as well as a narrative detailing the identified priorities for the coming year. The Trust Board is asked to review and approve the Quality Account for publication. Continuing the revised arrangements put in place two years ago, NHS foundation trusts are no longer required to include a quality report in their annual report.						
Recommendation	The Board is asked to i) note progress against the 2021/22 quality priorities ii) agree content of the document for publication.						
Links to Strategic Objectives	Patients: Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality: - We deliver the best possible health outcomes for our patients.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☒	☒	☒	☒
Impact detail	If we fail to meet Quality and safety targets we put patient safety at risk.						
Reports previously considered by	Six monthly progress reports are taken to the Trust Board.						

QUALITY ACCOUNT

EXECUTIVE SUMMARY

Each year the Trust is required to produce and publish a Quality Account. Contained within this is a review of the previous 12-month performance against the agreed Quality Priorities, as well as a narrative detailing the identified priorities for the coming year.

The Trust Board is asked to review and approve the Quality Account for publication.

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

QUALITY ACCOUNT 2021/2022

Unconditionally registered with the
CQC since April 2010

CONTENTS

PART 1

CHIEF EXECUTIVE'S STATEMENT

Thank you for your interest in our 2021/2022 Quality Account.

This year's Quality Account sets out our key quality and patient safety priorities for 2022/2023 and it demonstrates how we have continued to deliver high quality, effective care for patients during the last year. We have continued to tackle the COVID-19 pandemic as well as continuing to provide a full range of community, general and specialist healthcare services to the North East and beyond.

Over the past year, we have not compromised our high standards or our desire to continually improve. Staff have continued to adapt so that we can provide the best care. Some of our achievements include:

- We opened a state-of-the-art theatre hub dedicated to cataract surgery
- We opened a new cancer centre on the site of the Cumberland Infirmary in Carlisle following an investment of £35million in north Cumbria. The Northern Centre for Cancer Care, North Cumbria – a partnership between Newcastle Hospitals and North Cumbria Integrated Care NHS Foundation Trust (NCIC) – brings all non-surgical cancer services under the same roof for the first time.
- We focussed on tackling the climate emergency and taking the voice of our young patients from the Great North Children's Hospital to COP26 in Glasgow – and mum Kaja Gersinska became the first person in the UK to use climate friendly pain relief during labour after giving birth to baby Rosie at the RVI.
- We became the first hospital in the region to launch a new self-service tool, in partnership with NHS Digital, to help everyone to use emergency care appropriately
- The National Institute for Health Research (NIHR) Newcastle Clinical Research Facility (CRF) has received over £5.47million to continue its research into a range of health conditions. The NIHR Newcastle CRF, a partnership between the trust and Newcastle University, is one of 28 in the country to receive funding which will support research into new treatments and early phase clinical trials which test treatments for the first time.
- Continued to roll out the regional vaccination programme for COVID-19.

I would like to thank all of our staff and volunteers for their incredibly hard work, dedication and compassionate care throughout the year.

Dame Jackie Daniel
Chief Executive
19 April 2022

To the best of my knowledge the information contained in this document is an accurate reflection of outcome and achievement.

WHAT IS A QUALITY ACCOUNT?

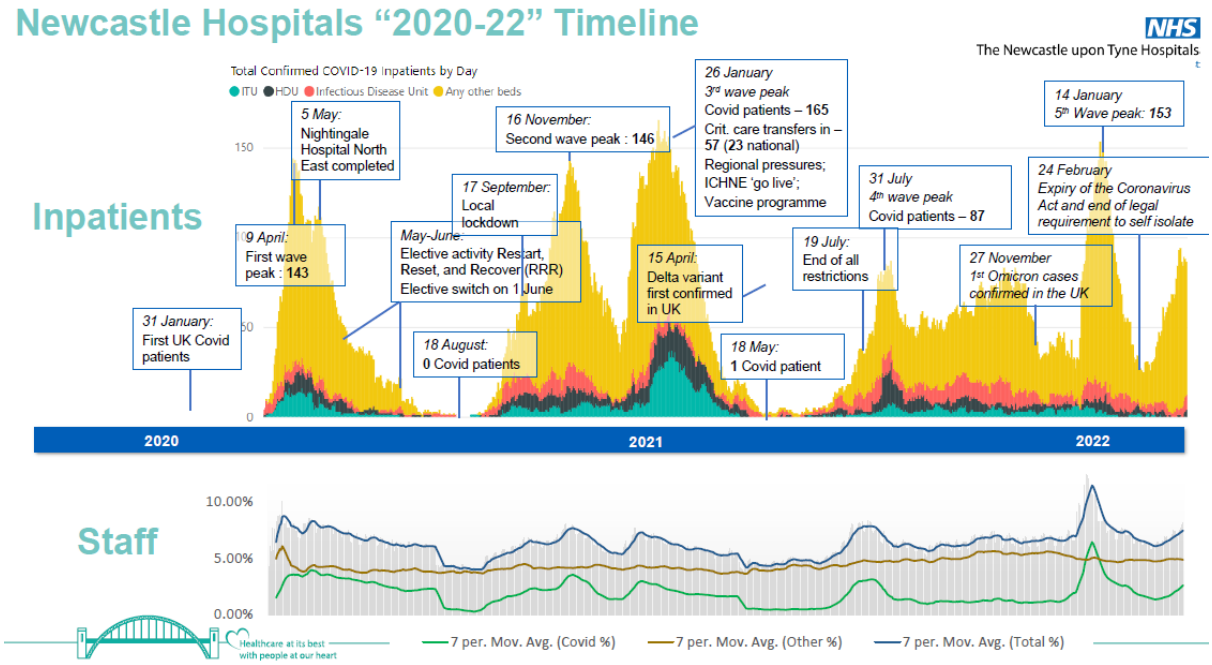
Quality Accounts are annual reports to the public from us about the quality of healthcare services that we provide. They are both retrospective and forward looking as they look back on the previous year's data, explaining our outcomes and, crucially, look forward to define our priorities for the next year to indicate how we plan to achieve these and quantify their outcomes.

RECOVERY and 'Living with COVID-19'

The COVID-19 pandemic is the biggest healthcare challenge this country has faced since World War 2. Since the first lockdown began in March 2020, the UK have experienced several national and local lockdowns. All restrictions and emergency COVID-19 regulations ended on March 31st 2022 as the nation started its transition into 'Living with COVID-19'. Publically funded Polymerase Chain Reaction (PCR) testing also ended on 31st March 2022.

Over the last year, COVID-19 has continued to have a significant impact upon the Trust:

- Staff sickness levels have been unprecedented, reaching over 12% in January 2022
- As of March 2022,COVID-19 inpatient numbers stood at 85, which is split between those that are 'being treated for COVID-19' and those that happen to 'have' COVID-19 but are not receiving treatment for the virus
- Activity levels have not recovered to pre COVID-19 percentages and we are tracking at 75% pre pandemic levels of elective activity
- Patient acuity has worsened due to delays in presentation
- Patient flow through the organisation has been challenged due to increased attendance at Accident & Emergency (A&E), increased length of stay (LOS) and increased occupancy. This has been exacerbated by delay to transfers and higher repatriations, all of which have impacted our elective programme
- Elective waiting lists numbers have increased by 49%
- For the first time in the history of the organisation, we have patients who have waited over two years for their treatment.



At the end of April 2020, and the first wave of COVID-19 infections started to decline, the 3 stage Restart, Reset and Recovery programme (3Rs programme) for clinical and enabling services at Newcastle Hospitals was established.

We are now two years on and Recovery is still our priority, but this is being conducted in parallel with COVID-19 and not in its absence, and therefore there are still significant challenges on our workforce and capacity. Focus also needs to shift to 'closing the gap' and returning the organisation to pre-COVID-19 levels of productivity and efficiency.

1.1 The Restart, Reset and Recovery Programme

The programme consists of three clear, but overlapping phases:

Restart - A short-term switch back on with minor alterations to pre-COVID-19. Completed.

Reset - Recommence but with adoption of new ways of working which are defined by the COVID-19 legacy constraints such as need for Personal Protection Equipment (PPE), testing, shielding, social distancing and workforce fatigue. Completed.

Recovery - A longer term programme, where we embed our new transformative ways of working, recover our performance and clear back logs. In progress and needs to continue as we learn to 'live with COVID-19'.

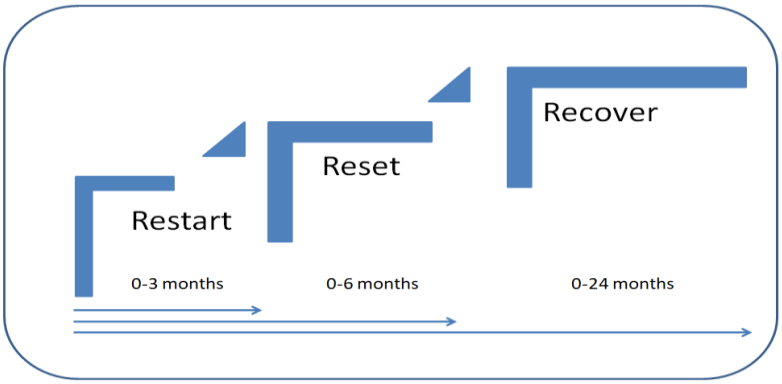


Figure 1. The 3Rs programme

1.2 Recovery progress

In April 2021, an Executive Team Operations Board was convened. This board has met on a weekly basis and its' focus has been to identify, fund and monitor schemes that could deliver increased activity and therefore enable the Trust to access Emergency Recovery Funds – non recurrent money which could be re invested on a temporary basis.

In order to transition into the next phase of recovery, from April 2022 the Operations Board has pivoted its focus to supporting the organisation to 'close the gap', return activity levels to pre-COVID-19 levels and then deliver more. The Board will still have a role in identifying and monitoring schemes that are aligned to correcting the pandemic consequences and delivering the 2022/2023 targets. Success will be measured on:

- Delivery of improved quality
- Delivery of improved productivity
- Delivery of improved efficiency

- Delivery of cost improvement.

Alongside the Operations Board, in order to apply more organisational grip to rectifying the unintended consequences of the pandemic, such as addressing the greater than 52 week, greater than 78 week and over 104 week long waiters, we convened the Newcastle Plan Delivery Board. This meeting is held fortnightly, it is chaired by Dame Jackie Daniel and attended by the full Executive Team.

Pathway Improvements

Cataract Theatres

Following the opening of a purpose built cataract centre (with patient flow improvements) at the Centre of Aging and Vitality on 6th April 2021, the feedback from both staff and patients has been extremely positive. More than 7,000 patients have been treated at the centre since the opening (circa 135 per week) which has exceeded the volume of cases in 2019/2020 (which relied heavily on waiting list initiatives and support from the independent sector). The centre has allowed the team to run high volume lists with a named nurse supporting the patient throughout their stay, thus reducing the time spent on site for patients from five hours to one hour. The waiting list for cataract surgery has reduced from 3000 to just over 1000 patients with the average wait reducing from 36 to 26 weeks.

However, given the ongoing pressures, the team would like to improve productivity in theatres and they are focussing their efforts on increasing the number of cases on lists in the coming months.

Endoscopy

Prior to the COVID-19 pandemic, endoscopy was a paper-based service and gathering an accurate count of waiting list demand was performed manually (based on the paper requests within the department, which was time consuming and open to human error).

The Endoscopy Department implemented Paperlite in June 2021, introducing electronic requesting for endoscopy outpatient procedures. The transition from paper to digital requesting has allowed for accurate waiting list management as well as the ability to measure wait times for patients against Key Performance Indicators such as two week wait cancer target and the six week diagnostic target; something that would have previously taken many hours to compile is now available at the click of a button.

The department can now robustly assess the demands placed upon Endoscopy, enabling the service to allocate capacity effectively, resulting in improved experience for patients as well as minimising delays in the diagnostic phase of the pathway.

Improving the digital maturity of the endoscopy service will continue throughout 2022, including expansion of electronic requesting for inpatients and implementation of a digital pre-assessment solution, which will reduce the need for some patients to come to hospital.

Outpatient Improvement Programme

Patient care delivery within the Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) outpatient setting accounts for approximately two-thirds of patient contacts per year. Working towards improving services and outpatient pathways for these patients, we launched our Outpatients Transformation Programme just prior to the COVID-19

pandemic. The impact of the pandemic necessitated an immediate shift in the Programme's plans and priorities and played a pivotal role in working alongside clinical services and corporate teams to enable this sector of service delivery to continue throughout the pandemic.

The main enabler for this has been the introduction, formalisation and adoption of Virtual Consultations, via both telephone and the introduction of our video consultation system, Attend Anywhere. At the height of the pandemic, we were delivering over 50% of our consultations virtually. Over the previous year as Face-to-Face appointments have become more available, we have continued to use this new way of working and the programme has continued to support clinical teams to utilise and optimise this consultation type. Through 2021/2022, there have been approximately 2,500 virtual consultations per month, enabling flexible working for our clinical staff and preventing patients travel to hospital; delivering both patient experience improvements as well as environmental benefits.

As we look ahead to 2022/2023 there are several, high-profile, Trust wide initiatives we will be implementing, positively impacting our patients as well as supporting National Planning Guidance.

Patient Initiated Follow Up (PIFU)
The PIFU outcome model allows clinicians to safely manage and ultimately discharge patients that would normally be given a routine follow-up appointment, but do not necessarily require one. It also allows patients greater control and encourages self-management of their condition through a shared decision making process. Additional benefits include a reduction in the total number of follow-ups required, a reduction in 'do not attends' (DNAs) and ensuring that follow up appointments for these patients are of high clinical value. Patients on the PIFU pathway will request an appointment when their symptoms change, rather than being given one in the future that they may not need or attend.

Improving Advice and Guidance (A&G)
Functionality available through the national E-Referral System (ERS) that allows GPs direct access to specialist services. GPs can request advice for the treatment of their patients in Primary Care, as opposed to sending in a referral for patients that may not necessarily need to be seen in secondary care. This reduces demand on our services and ensures that the most appropriate patients are referred and subsequently seen, positively impacting on demand and capacity. Many services across the Trust have participated in this service over previous years and we will be working with clinical teams to expand and optimise the service currently offered and work to include new services.

Electronic Outcome Form
Work continues to convert the current paper based form to an electronic version, enabling the accurate capture of outpatient attendance outcomes and improving on patient safety/'lost to follow up' concerns. This functionality will also significantly reduce the administrative time needed to investigate attendances where no outcome has been reported.

Working alongside clinical teams, scoping is currently underway to identify additional improvement initiatives as well as additional ways to reduce out-patient follow up appointments at a local service level, such as the development of 'One Stop Shops' to

combine multiple appointments into a single visit to hospital, service pathway redesigns and maximizing capacity through efficient clinic builds and booking procedures.

Day Case Improvement Project
Day surgery is a widely established practice with rates increasing around the world and has greatly evolved since the early days of the introduction of this technique, which saw minor procedures carried out on fit patients. Now due to advances in anaesthesia and surgical techniques, day surgery is the standard pathway of care for many complex patients and procedures previously treated through inpatient pathways.

The British Association of Day Surgery (BADS) data shows there is further opportunity to increase and broaden day case surgery across the Trust to improve patient and staff experience and support the recovery of elective care whilst reducing patient days away from home. This will also reduce elective surgical dependence on inpatient bed availability, allowing a greater proportion of elective surgery to continue despite traditional winter surge in admissions.

With this in mind, a Day Surgery Improvement Project launched in 2021 with two global aims:

- Redesign the current day case model (across the Trust) and develop a Universal Day Surgery Pathway (multi-specialty), identifying key components that can be applied to existing inpatient activity to convert to a day case approach (day case expansion);
- Create dedicated self-contained day surgery unit(s) (geographically discrete from inpatient activity) and establish dedicated day surgery teams who deliver (almost) the entire pathway and are fully committed to driving service improvement.

Whilst this is a strategic project, frontline staff are empowered to design the solutions (bottom-up delivery) with Quality Improvement training offered to ensure a legacy of continuous improvement. A number of improvement initiatives are ongoing across the Trust such as development of a universal waiting list addition/pre-assessment request form, 6-4-2 model, Saturday Day Case Pilots, development of enhanced pre-assessment model (incorporating optimisation). The new self-contained Day Treatment Centre (see below) will implement the universal day case pathway before we consider rolling out across the wider organisation.

Day Treatment Centre (DTC)

An exciting new development is taking place at our Freeman Hospital site, where we are investing £20 million in a purpose-built, dedicated facility for day case procedures. A self-contained Day Treatment Centre is currently under construction, with completion scheduled for August 2022 and the facility open to patients from September 2022 onwards.

Part of Newcastle Hospitals' ambitious day case improvement programme, the centre will house four new state-of-the-art theatres, along with a dedicated pre-operative ward and post–operative recovery areas, and will enable us to provide thousands of additional procedures in specialties such as musculoskeletal health, urology, surgery and cardiothoracic services. It will address some of the significant waiting list challenges and backlogs caused by the pandemic, through the transfer of suitable day cases from existing theatre lists to free up space for more complex work.

The DTC aims to:

- Improve patient experience and surgical outcomes
- Improve staff morale and retention
- Lower length of stay (bed day savings)
- Reduce waiting and pathway times
- Support recovery of elective backlog
- Lower emergency readmissions
- Reduce rates of hospital-acquired infection and venous thromboembolism (VTE)
- Reduce on the day surgical cancellations
- Align with other strategic programmes such as Getting It Right First Time (GIRFT) High Volume Low Complexity.

Prehabilitation/Perioperative Disease Management
With the deterioration in mental and physical health during the COVID-19 pandemic, this will place extra burden on overstretched resources and lead to complications, increased bed days and worse patient centric outcomes. Prehabilitation aims to improve the general health and wellbeing of the surgical population, reduce costs and improve success of the surgery. The Trust are currently focusing on a number of areas, with a mix of research and quality improvement projects for major surgery (pancreatic cancer, abdominal aortic aneurysm, upper gasto-intestinal, peripheral arterial disease) and also 'waiting well' programme for the elective surgery cohort targeting issues around smoking, obesity, diabetes and opiate dependency.

The programmes are designed to target those from socially deprived communities whilst embedding interventions that take into consideration health literacy and digital exclusion. To aid in the delivery, a collective approach with therapy services and third sector organisations (Healthworks, Ways to Wellness) has been developed and patient co-design will be a core principle. The evaluation of initiatives will be shared widely in the coming months with a view to piloting in other areas of surgery and oncology services. Sustainability of these initiatives will be considered alongside the results and impact of initiatives on the wider health and care system.

Enhanced Recovery after Surgery – Hepatobiliary and Pancreatic (HPB) Surgery
The Newcastle upon Tyne Hospitals NHS Foundation Trust is one of the UKs largest cancer resection centres for HPB undertaking > 200 liver and pancreas resections/year as well as offering a wide range of novel liver and pancreas directed therapies.

The unit outcomes in terms of mortality and cancer related outcomes are comparable with leading centres in Europe and internationally. However, the length of stay data has historically been an outlier when compared to similar centres in the Shelford Group.[1] In 2019, the team (in conjunction with Newcastle Improvement) started work to develop a new enhanced recovery after surgery (or ERAS) model for HPB surgery at the Freeman Hospital. ERAS launched during the first national lockdown, which made data collection within this period challenging.

However, 87% of patients are now accessing the pre-operative multi-disciplinary (MDT) ERAS clinic (December 2021-March 2022) and the service can demonstrate significant improvements in patient experience for over 300 cancer patients, with one patient commenting, “you must have had hundreds of patients, but I felt like I was your only one”. The liver programme launched in January 2020 and despite the pandemic, it delivered the target length of stay (a reduction of two days) for liver resections within two months. Whilst it has been challenging to deliver the pancreas length of stay reductions, the team have reported improvements. Furthermore, the richness of clinical data now collected is informing new ways of working and over time, this will start to shape the pathway and support the introduction of new technologies e.g. new approaches to regional analgesia.

Liver Transplant Assessment Service

A liver transplant assessment looks at people with chronic liver disease, who are heading towards transplantation. The assessment aims to review whether this is a suitable course of treatment for those patients as timing is critical with transplants, if they are left too late the person would be too unwell for the transplant or if they are too early, they won’t have any real benefit from transplantation.

Traditionally at the Freeman Hospital, the assessment process for liver transplant patients was three days with numerous tests spanning from Wednesday until Friday afternoon. Following extensive feedback from patients, the team wanted to use improvement techniques to reduce this assessment period to just one day, with no overnight stay. The COVID-19 pandemic presented a perfect opportunity to kick-start this development, particularly as there were challenges in getting patients admitted.

The assessment process for liver transplant patients is now one day and all test slots are now at fixed times, which has made it quicker for patients and much easier for staff to manage tests too. The improvement demonstrated a saving of 193 bed days in 2020/2021 and in most cases, patients will know if they are a suitable transplant candidate within a few days (reduced from three-four weeks).

A collaborative approach to reducing hospital admissions and amputations in diabetic patients

The Vascular Team at the Freeman Hospital has transformed care for patients with diabetic foot disease across Northumbria, North Tyneside, Newcastle and Gateshead. It is critical that patients with diabetic foot ulcerations have rapid access to vascular interventions as soon as possible to give them the best opportunity to heal. However, the team at the Freeman Hospital became increasingly concerned as they began to witness an increase in major amputations across their population. To improve care for this group of patients, the vascular team joined forces with stakeholders in the region to form the Newcastle Diabetic Foot Transformation Project.

[1] The Shelford Group is a collaboration between ten of the largest teaching and research NHS hospital trusts in England.

Resulting from this improvement project, all new diabetic foot referrals are now seen by community podiatry within 24 hours (additional podiatry capacity provided), community patients routinely receive a perfusion assessment, clinical reviews are available within 72 hours, specialist (Hot-Clinic) review is available within 72 hours supported by a weekly diabetic foot multi-disciplinary team (MDT). The service expects to see a significant reduction in major amputations in diabetic patients as well as an overall reduction in admissions and length of stay for patients with diabetic foot ulceration.

PART 2

QUALITY PRIORITIES FOR IMPROVEMENT 2022/2023

Following discussion with the Board of Directors, the Council of Governors, patient representatives, staff and public, the following priorities for 2022/2023 have been agreed. A public consultation event was held in January 2022 and presentations have been provided at various staff meetings across the Trust.

PATIENT SAFETY

Priority 1 - Reducing Healthcare Associated Infections (HCAI) – focusing on COVID-19, Methicillin-Sensitive Staphylococcus Aureus (MSSA)/Gram Negative Blood Stream Infections (GNBSI)/*C.difficile* infections.

Why have we chosen this?

Preventing healthcare acquired COVID-19 infections remains a priority whilst we adapt to living with COVID-19.

MSSA bacteraemias can cause significant harm. At The Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH), these are most commonly associated with lines and indwelling devices; achieving excellent standards of care and improving practice is essential to reduce these line infections in line with harm free care.

GNBSI constitute the most common cause of sepsis nationwide. Proportionally, at NUTH, the main source of infection is urinary tract infections, mostly catheter associated, and also line infections. An integrated approach, engaging with the multidisciplinary team across the whole patient journey, focusing on antibiotic stewardship, early identification of risks and timely intervention formulate the basis for our strategy to reduce these infections. The *GNBSI* Steering Group, created in 2021/2022, continue to review reduction strategies.

C. difficile infection is a potentially severe or life-threatening infection, which remains a national and local priority to continue to reduce our rates of infection in line with the national objectives.

What we aim to achieve?

- Prevent transmission and HCAI COVID-19 in patients and staff.
- Internal 10% year-on-year reduction of MSSA bacteraemias.
- National ambition to reduce *GNBSI* with an internal aim of a 10% year-on-year reduction.
- Sustain a reduction in *C.difficile* infections in line with national trajectory.

How will we achieve this?

- Review and update Infection Prevention and Control (IPC) practices in line with renewed national COVID-19 guidance. This is underpinned and supported by the national Board of Assurance Framework (BAF).
- Board level leadership and commitment to reduce the incidence of Health Care Associated Infection (HCAI).
- Quality improvement projects in key directorates running in parallel with Trust-wide awareness campaigns, education projects, and audit of practice, with a specific focus on:
    - Antimicrobial stewardship and safe prescribing.
    - Insertion and ongoing care of invasive and prosthetic devices.
- Ward monitoring of device compliance for peripheral intravenous (IV) and urinary catheters.

- Improve diagnosis and management of infection in all steps of the patient journey.
- Working with partner organisations to reduce infections throughout the Health Care Economy.
- Early recognition and management of suspected infective diarrhoea.
- Reintroduce Root Cause Analysis (RCA) meetings with Directorates (were suspended during the COVID-19 pandemic) to discuss and share learning and good practice.
- Directorate-led Serious Infection Review Meetings (SIRM) to share and support action plans to monitor/reduce HCAI and adherence to best practice.

How we will measure success?

- By ensuring and monitoring compliance with the BAF.
- Continuous monitoring of Hospital Onset COVID-19 prevalence.
- Sharing data with directorates whilst focusing on best practice and learning from clinical investigation of mandatory reporting organisms.
- Continue to report MSSA, *GNBSI* and *C.difficile* infections on a monthly basis, internally and nationally.

Where we will report this to?

- COVID-19 Assurance Group.
- Infection Prevention and Control Committee (IPCC).
- Infection Prevention and Control Operational Group.
- Patient Safety Group.
- Trust Board.
- The public via the Integrated Board Report.
- Public Health England.
- NHS England (NHSE)/NHS Improvement (NHSI).

Priority 2 – Management of Abnormal Results

Why have we chosen this?

The management of clinical tests from their request, through booking, performance, reporting, reviewing and acting on the results, is a major patient safety issue in all healthcare systems. We see evidence of patient harm caused by delays in tests, resulting in delays in treatment and aim to minimise those risks.

We currently lack assurance that investigation results, issued electronically, are appropriately approved in the electronic health record (EHR). Initially, we are going to focus on Radiology where failure to act can cause serious harm, especially in the outpatient setting.

Managing these problems will be a major undertaking, requiring successful completion of the Closed Loop Investigations project.

What we aim to achieve?

This project aims to improve electronic ordering by ensuring that all requests are filed against the 'correct' lead consultant. Results will be returned to the same 'correct' lead consultant for electronic approval.

How will we achieve this?

A list of 'lead' consultants must be defined and agreed.

- Providers must select the 'lead' consultant from a list in eRecord when they order a test.
- Results relating to electronic orders must be returned to the same 'lead' consultant, to be approved in eRecord.
- Where the 'lead' consultant is not available, the result must go back to other members of the 'lead' consultant's team.

How we will measure success?

- A reduction in the incidence of patient harm arising from delayed action on tests results.
- The proportion of results issued to eRecord that have been approved by the 'correct' lead consultant.
- A reduction in time between a report becoming available on eRecord and action being taken.

Where we will report this to?

- Clinical Policy Group.
- Trust Board.

CLINICAL EFFECTIVENESS

Priority 3 – Enhancing capability in Quality Improvement (QI)

Why have we chosen this?

COVID-19 continues to demonstrate the need for changes to made quickly to improve healthcare for patients and to recover from the impact of COVID-19. Throughout 2020/2021, we have established an infrastructure to build capability and capacity for improvement at scale with Newcastle Improvement. Our two-year partnership, with the Institute for Healthcare Improvement (IHI), will enable us to accelerate this improvement work. This is critical in maintaining our outstanding performance and the patient-focused high quality of care we deliver.

What we aim to achieve?

- Deliver IHI improvement-training programmes tailored to local teams working on Trust improvement priorities.
- Improvement teams will be led and supported by improvement coaches,in providing an organisational approach to enhance QI capability.
- Develop Newcastle Improvement staff towards being independent to deliver the IHI programmes in the future.

How will we achieve this?

- Train 15-20 improvement teams, each focused on a piece of improvement work and coach them through the work.
- Train 30 improvement coaches to build capability and support teams with their improvement work.
- Adapt the IHI training programme, following feedback from the training and evaluation.
- Newcastle Improvement team members to shadow and co-deliver the IHI delivery of programmes in 2022/2023.

How we will measure success?

- Measure completion of planned training programme comprising 15-20 teams of four-five multidisciplinary members through the 'Improvement for Teams' and 30 'Coaching for Improvement'.
- Evaluate the whole programme using the evaluation framework.
- Evaluate training programmes from learners' perspective and progression of improvement work.
- Staff survey results to identify improvement in involvement and ability to contribute to improvement domains.

Where we will report this to?

- Improvement Advisory Group.
- Trust Board.

Priority 4a - Introduction of a formal triage process on the Maternity Assessment Unit (MAU), in order to improve the recognition of the deteriorating pregnant or recently pregnant woman

Why have we chosen this?

The need for early recognition and management of deterioration of pregnant women has been highlighted by:

- Mothers and Babies, Reducing Risk by Audit and Confidential Enquiry (MBRRACE)
- The Ockenden Report.

To reduce the likelihood of avoidable harm to mothers and babies we need to improve early detection and rapid escalation of women at risk of deterioration on the Maternity Assessment Unit.

What we aim to achieve?

Within five minutes of arrival at the Maternity Assessment Unit (MAU) at the RVI, 95% of pregnant or recently pregnant women (within six weeks of birth), who don't receive immediate treatment, will have formal triage by a designated member of staff trained in triage.

How will we achieve this?

- Project looking at the environment/processes and roles and responsibilities of staff on MAU, one important aspect being the move of day care from MAU to the antenatal ward. This transition has been implemented with further plans to facilitate, 8am-8pm, seven days a week with two members of staff. In addition, an automated telephone system is urgently required, which is in process.
- On-going Plan Do Study Act (PDSA) as part of the IHI project
    - Pilot of triage proforma by triage at quiet times on MAU December 2021/January 2022.
    - Plan is for triage proforma to be used in busier periods from mid-March 2022.
- Staff experience survey – December 2020. Plan to re-do the survey when triage is fully introduced, and a patient experience survey is planned for the future.

How we will measure success?

Regular – monthly initially, audit of percentage of women having formal triage by a designated member of staff trained in triage, within five minutes of arrival at the Maternity Assessment Unit at the Royal Victoria Infirmary (RVI).

Where we will report this to?

- Obstetric Governance Group.
- Women's Services Quality & Safety.
- Trust Board.

Priority 4b - Modified Early Obstetric Warning Score (MEOWS)

Why have we chosen this?

In recent years there have been a number of maternal deaths within England where the lack of MEOWS systems for pregnant women in hospital but outside of a maternity setting played a significant part in their poor outcome.

What we aim to achieve?

Implementation of an electronic MEOWS system in areas of the Trust outwith the Maternity Unit would improve the quality and safety of patient care for those women and provide Obstetric Services with a daily list of pregnant/recently pregnant women regardless of their location throughout the Trust and therefore improve collaborative care.

How will we achieve this?

- Create an Information Technology (IT) solution for identification of a pregnant/recently pregnant women who are not cared for within Womens services by building"Are you/recently been pregnant" question into Electronic Patient Record (EPR) system.
- IT development of an electronic MEOWs system to replace National Early Warning Score/Paediatric Early Warning Score for this group of women.

How we will measure success?

- Identification of pregnancy question built into EPR System.
- Deployment of MEOWS Trust wide.
- Audit of compliance with MEOWS.

Where we will report this to?

- Womens Service Quality and Safety.
- Deteriorating Patients Group.
- Trust Board.

Priority 5 – Trust-wide Day Surgery Initiative

Why have we chosen this?

Day surgery is a widely established practice with rates increasing around the world and has greatly evolved since the early days of the introduction of this technique, which saw minor procedures carried out on fit patients. Now, due to advances in anaesthesia and surgical techniques, day surgery is the standard pathway of care for many complex patients and procedures previously treated through inpatient pathways.

The British Association of Day Surgery (BADS) data, shows there is further opportunity to increase and broaden day case surgery across the Trust to improve patient and staff experience and support the recovery of elective care whilst reducing patient days away from home.

This will also reduce elective surgical dependence on inpatient bed availability, allowing a greater proportion of elective surgery to continue despite traditional winter surge in admissions.

What we aim to achieve?

Initiate a Trust-wide Day Surgery Project.

The Day Surgery project has two global aims:

- Redesign the current day case model (across the Trust) and develop a Universal Day Surgery Pathway (multi-specialty), identifying key components that can be applied to existing inpatient activity to convert to a day case approach (day case expansion);
- Create dedicated self-contained day surgery unit(s) (geographically discrete from inpatient activity) and establish dedicated day surgery teams who deliver (almost) the entire pathway and are fully committed to driving service improvement.

How will we achieve this?

Given the size and complexity of the project, three priorities (key enablers) have been selected for the Quality Account:

- Surgical Assessment: Develop a universal waiting list process to ensure a consistent process across all specialties in order to progress the patient to surgery

- Pre-operative Assessment: Develop a universal request for day case patients to ensure patients get pre-assessed early in the pathway, ensuring any current health conditions are managed and the patients are at their fittest for surgery
- Implement the 6-4-2 method of theatre list planning in the Day Treatment Centre and two specialties on the main sites to ensure we use all of our theatre capacity and reduce the waiting list backlog.

How we will measure success?

- Delivery of three priorities above by March 2023.
- Reduce waiting times.
- Reduce on the day surgical cancellations.

Where we will report this to?

- Operations Board.
- Improvement Advisory Group.
- Trust Board.

PATIENT EXPERIENCE

Priority 6 – Mental Health in Young People

Why have we chosen this?

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Mental Healthcare in Young People and Young Adults report published recommendations in 2019, which are a beneficial tool to benchmark against.

Throughout 2021, there has been significant pressure on specialist mental health Tier 4 inpatient services across the North East and Yorkshire Region (NEY). There has been an increase in children and young people (CYP) presenting and is especially high in those presenting with eating disorders. This has resulted in some patients having delayed access to treatment in the right care environment.

In the NEY a CYP Mental Health Task and Finish Group has been established which has identified a number of work streams looking at the issue from different perspectives. With an overall aim of expediting delivery of a regional approach to manage the current significant challenges faced by children and young people in accessing appropriate mental health services. The Trust has representation within this work stream.

The overarching purpose of these recommendations is to improve the quality of care provided to young people and young adults with mental health conditions.

As an organisation, we will continue to review current service provision for children, young people and young adults in order to assure that we identify gaps, areas of good practice and plan to improve the care provided in the acute Trust for these patients.

What we aim to achieve?

- A dedicated and efficient pathway for assessment and treatment plan working in close conjunction with Cumbria, Northumbria, Tyne & Wear (CNTW) colleagues.
- Timely access to mental health services.
- Trained and skilled workforce.
- Appropriate environment for patients to be cared for.
- Efficient access to identify 'Advocates' for patients detained under the Mental Health Act.
- Clarity and improved pathways and support when patients detained under the Mental Health Act.

How will we achieve this?

- Dedicated group to identify gaps, areas of good practice and develop actions to support adherence to NCEPOD standards.
- Work collaboratively with regional colleagues in services for children and CNTW to access the "We Can Talk" training programme and ensure staff are trained.
- Review the impact of this training.
- Link in with Mental Health First Aider Course from Child Health Network.
- Updated policy outlining prevention of restrictive interventions and safe interventions for adults, children and young people within the organisation.
- Listen to patients and families and work with them to improve the service.

How we will measure success?

- More efficient pathways when patients present acutely.
- More efficient transfer to mental health services for inpatient management.
- Positive impact of training, increased numbers of staff and disciplines trained.
- 'Safe' area configured in Paediatric Emergency Department.
- Policy for patients under 18 years when detained under the Mental Health Act.
- Improved risk assessment and prevention of restrictive interventions.

Where we will report this to?

- Clinical Outcomes & Effectiveness Group.
- Trust Board.

Priority 7 – Ensure reasonable adjustments are made for patients with suspected, or known, Learning Disabilities

Why have we chosen this?

People (children, young people and adults) with a Learning Disability are four times more likely to die of something which could have been prevented than the general population. As a Trust, we are committed to ensuring patients with a learning disability and/autism have access to services that will help improve their health and wellbeing and provide a positive and safe patient experience for them and their families.

What we aim to achieve?

- Assurance that patients and their families have appropriate reasonable adjustments as required. That they are listened to, feel listened to and have a positive experience whilst in our care and appropriate follow-up.
- Assurance that patients are flagged appropriately and that these flags generate the appropriate response to care, treatment and communications.
- Ensure staff have received training in order to understand reasonable adjustments and the needs of patients with a learning disability and/autism.

How will we achieve this?

There are a number of workstreams to support ongoing work and developments to provide improved care for patients with learning disability and autism. The main priorities are;

Workforce

- Review of the existing Learning Disability Liaison Team, consider new roles and responsibilities within the team to better meet the needs.
- Temporary changes within the team to support the team to be more visible on the wards and departments.
- Temporary support to offer dedicated focus on identified priorities.

Training

- Implementation of Diamond Standards across the organisation to not only improve patient experience and pathways, but to educate the workforce.
- Ongoing consideration of joint training with simulation team and Northumbria University.

Skills and Support

- Review of the role of Learning Disability Champions across the organisation.
- Consider the concept of Autism Allies across organisation with appropriate training and support.
- Learning from Learning Disability Forums by showcasing and sharing the exemplary work some of the Trust's clinical teams do in terms of provision of reasonable adjustments.

Better Experience

- Work with patients and families to learn and improve.
- Review of pathways and e-Learning to determine if any adaptions required.
- Work in conjunction with North East and Cumbria Learning Disability Network and Great North Children Hospital (GNCH) anaesthetics to incorporate theatre attendance within passport for Children & Young People (CYP).
- Pathways to be developed for adult patients requiring Magnetic Resonance Imaging (MRI)/Computerized Tomography (CT) under sedation.
- Continue to ensure Learning Disability flags are visible for adults and children with a learning disability.
- Gather feedback from patients and service users and carers to identify gaps.

Learning Disabilties Mortality Review (LeDeR)

- Work to ensure mortality reviews for patients with a Learning Disability who die whilst in Trust care are timely.
- Identify risks in appropriately managing LeDeR reviews for patients with autism.

How we will measure success?

- Improved roles and responsibilities within the Learning Disability Liaison Team, with additional support to lead on autism.
- Diamond Standards embedded across the organisation.
- Staff have accessed and completed training.
- Patient with autism are flagged.
- Maintain timely Learning Disabilities Mortality Review Programme reviews.

Where we will report this to?

- Safeguarding Committee.
- Trust Board.

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN) INDICATORS

The CQUIN payment framework is designed to support the cultural change to place quality at the heart of the NHS. Local CQUIN schemes contain goals for quality and innovation that have been agreed between the Trust and various Commissioning groups. Listed below are the quality and/or innovation schemes which were agreed with the commissioners for 2022/2023.

2022/2023 - Specialised Commissioners, NHS England - CQUIN Schemes, Acute Hospital.	
PSS1	Achievement of revascularisation standards for lower limb ischaemia.
PSS2	Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery.
PSS3	Achieving progress towards Hepatitis C elimination within lead Hepatitis C.
PSS4	Delivery of Cerebral Palsy Integrated Pathway assessments for cerebral palsy patients in specialised children's services.
PSS5	Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines.

2022/2023 - Local Commissioning (CCG) - CQUIN Schemes, Acute Hospital.	
CCG1	Flu vaccinations for frontline healthcare workers- acute hospital.
CCG2	Appropriate antibiotic prescribing for UTI in adults aged 16+ years.
CCG3	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions.
CCG7	Timely communication of changes to medicines to community pharmacists via the discharge medicines services.
CCG9	Cirrhosis and fibrosis tests for alcohol dependent patients

2022/2023 - Local Commissioning (CCG) - CQUIN Schemes, Community	
CCG1	Flu vaccinations for frontline healthcare workers- community staff
CCG14	Assessment, diagnosis and treatment of lower leg wounds.

STATEMENT OF ASSURANCE FROM THE BOARD

During 2021/2022, Newcastle Hospitals provided and/or sub-contracted 22 relevant health services.

Newcastle Hospitals has reviewed all the data available to them on the quality of care in all 22 of these relevant health services.

The income generated by the relevant health services reviewed in 2021/2022, represents 100% of the total income generated from the provision of relevant health services by Newcastle Hospitals for 2021/2022.

Newcastle Hospitals aims to put quality at the heart of everything we do and to constantly strive for improvement by monitoring effectiveness. High level parameters of quality and safety have been reported monthly to the Board and Council of Governors. Activity is monitored in respect to quality priorities and safety indicators by exception in the Integrated Board Report, reported to Trust Board and performance is compared with local and national standards.

Leadership walkabouts across the Trust, coordinated by the Clinical Governance and Risk Department and involving Executive and Non-Executive Directors and members of the Senior Trust management team, were suspended at the start of the pandemic. As an alternative, the Chief Executive has been holding regular virtual check-ins with clinical and non-clinical teams to capture their experiences and feedback of working throughout the pandemic, whether caring for patients with COVID-19 or continuing to maintain other non-COVID-19 services.

In addition, the Trust Chair and Non-Executive Directors have been holding monthly virtual ‘Spotlight on Services’ sessions. These sessions provide an opportunity for the Chair and Non-Executive Directors to engage directly with staff, to learn more about the services themselves and any particular challenges arising. The virtual sessions provide an open forum for all involved to ask questions in a more informal setting, whether that be for staff to learn more about the role of the Chair and Non-Executive Directors or for the Chair and Non-Executive Directors to gain a better understanding of the quality of care provided to our patients within that particular service.

As the organisation takes steps towards recovery, further engagement work will take place with staff in a much deeper and more structured way so we can really focus on the wider ‘health and wellbeing agenda’, understand what has made our teams stronger and the positive changes we have made to support our patients.

The Trust Complaints Panel is chaired by the Executive Chief Nurse of the Trust and reports directly to the Patient Experience and Engagement Group, picking up any areas of concern with individual Directorates as necessary.

Clinical Assurance Toolkit (CAT) provides overall Trust clinical assurance via a six monthly report. With the advent of the COVID-19 pandemic, this Toolkit has been suspended since March 2020. Trust assurance was required and therefore in May 2020, a condensed Assurance Audit Check survey was commenced to ensure standards were maintained and essential information regarding COVID-19 requirements gathered. This audit survey is now sent out on a fortnightly basis to all Trust wards, outpatient departments, day units and clinics and questions are revised periodically in

line with NHSE/I and Public Health England (PHE) guidance. The Assurance Audit reflects the key lines of enquiry in the IPC Board Assurance Framework document. The Chief Nurse's team work plan, this year, includes an update and refresh of CAT, this is now in a trail phase with some clinical areas.

In September 2020, a multi-disciplinary COVID-19 Assurance Group was established. The purpose of this Group was to take collective ownership to provide oversight and scrutiny of the Infection Prevention and Control (IPC) Board Assurance Framework and associated standards. This included on-going assessment of risk, overseeing the implementation of emerging protocols and guidelines and, highlighting where there were gaps in evidence of compliance and limited assurance, facilitating a process of continual improvement and ensuring effectiveness. During the pandemic response, the Group has worked closely with the senior management team to support operational decision-making and provided assurance to Trust Board via the Director of Infection Prevention and Control.

PART 3

REVIEW OF QUALITY PERFORMANCE 2021/2022

The information presented in this Quality Account represents information which has been monitored over the last 12 months by the Trust Board, Council of Governors, Quality Committee and the Newcastle & Gateshead Clinical Commissioning Group (CCG).The majority of the Account represents information from all 22 Clinical Directorates presented as total figures for the Trust. The indicators, to be presented and monitored, were selected following discussions with the Trust Board. They were agreed by the Executive Team and have been developed over the last 12 months following guidance from senior clinical staff. The quality priorities for improvement have been discussed and agreed by the Trust Board and representatives from the Council of Governors.

The Trust has consulted widely with members of the public and local committees to ensure that the indicators presented in this document are what the public expect to be reported. Comments have been requested from the Newcastle Health Scrutiny Committee, Newcastle Clinical Commissioning Group and the Newcastle and Northumberland Healthwatch teams. Amendments will be made in line with this feedback.

PATIENT SAFETY

Priority 1 - Reducing Healthcare Associated Infections (HCAI) – focusing on COVID-19, Methicillin-Sensitive Staphylococcus Aureus (MSSA)/Gram Negative Blood Stream Infections (GNBSI)/C.Difficile Infections.

Why we chose this?

Preventing healthcare associated COVID-19 infections during the transition to "living with COVID-19" remains a priority, in line with the principles and framework of patient and staff safety.

MSSA bacteraemias can cause significant harm. At Newcastle upon Tyne NHS Foundation Trust (NUTH), these are most commonly associated with lines and indwelling devices; achieving excellent standards of care and improving practice is essential to reduce these line infections in line with harm free care.

GNBSI constitute the most common cause of sepsis nationwide. Proportionally, at NUTH, the main source of infection is urinary tract infections, mostly catheter associated, and also line infections. An integrated approach engaging with the multidisciplinary team across the whole patient journey, focusing on antibiotic stewardship, early identification of risks and timely intervention formulate the basis for our strategy to reduce these infections. A *GNBSI* Steering Group has been created to review reduction strategies.

C. difficile infection is a potentially severe or life threatening infection which remains a national and local priority to continue to reduce our rates of infection in line with the national objectives.

What we aimed to achieve?

- Prevent transmission and HCAI COVID in patients and staff.
- Internal 10% year on year reduction of MSSA bacteraemias.
- National ambition to reduce *GNBSI* with an internal aim of a 10% year on year reduction.
- Reduction in *C. difficile* infections in line with national trajectory.

What we achieved?

C. difficile – national threshold was for no more than 98 cases which was actually less than the Trust's local ambition to reduce cases by 10% of the previous year's total. Unfortunately the Trust has seen an increase of 58% as there have been 169 cases in total. The increase has been multifactorial, including the high acuity of patients and the previous suspension of multidisciplinary post infection review (PIR) meetings due to the additional COVID-19 workload and staffing pressures. Furthermore, antimicrobial Take 5 audits have not been completed due to the cessation of the previous electronic reporting platform whilst waiting for the implementation of the new Synbiotix electronic audit tool. A review of the PIR meetings are underway to establish an effective way to engage with the clinical teams to identify best practice and support any identified learning. Antimicrobial audits are planned to be reinstated from April 2022 with the introduction of an electronic audit system to enable directors to monitor prescribing practices. Other learning includes the need to improve documentation of diarrhoea to

support early sample collection and timely isolation. Some focused diarrhoeal management work is planned by 2022/2023.

MSSA bacteraemias – no more than 90 cases; unfortunately the Trust has seen a 10% increase as there have been 110 cases in total and predominately more cases during the second and third pandemic waves.

E. coli bacteraemias – no more than 176 cases; unfortunately, the Trust did not achieve its 10% reduction aim as 206 cases were assigned to NUTH, however the Trust was within the national threshold of no more than 228 cases.

Klebsiella bacteraemias – no more than 117 cases; NUTH had 146 cases assigned, which is an increase of 25%, however the Trust was within the national threshold of no more than 167 cases.

Pseudomonas aeruginosa bacteraemias – no more than 41 cases; NUTH had 43 cases assigned, which is a 5% increase. The Trust was also within the national threshold of no more than 54 cases.

COVID-19 - Healthcare associated COVID-19 cases (definite and probable) have remained below national and regional average throughout the pandemic.

How we measured success?

- Mandatory reporting of HCAI via Public Health England's Data Capture System.
- Benchmark Newcastle Hospitals' healthcare associated infection rates against other organisations.
- Incidence of declared outbreaks.
- Compliance to IPC practice via audits e.g. hand hygiene.
- Adherence to antimicrobial prescribing guidelines.

Priority 2 – Pressure Ulcer Reduction – Community Acquired Pressure Damage whilst under care of our District Nursing Teams

Why we chose this?

Reducing patient harm from pressure damage continues to be a priority, this year we have focused on reducing the rate of community pressure damage, specifically, community acquired pressure damage in patients under the care of our District Nursing Teams.

The increase in patient age, acuity and frailty means that the Trust is seeing more patients with a higher risk of acquiring pressure damage. It is therefore essential that the Trust identified this as a priority to ensure the risks of this are mitigated with accurate assessment and plans of care, together with the implementation of best practice care.

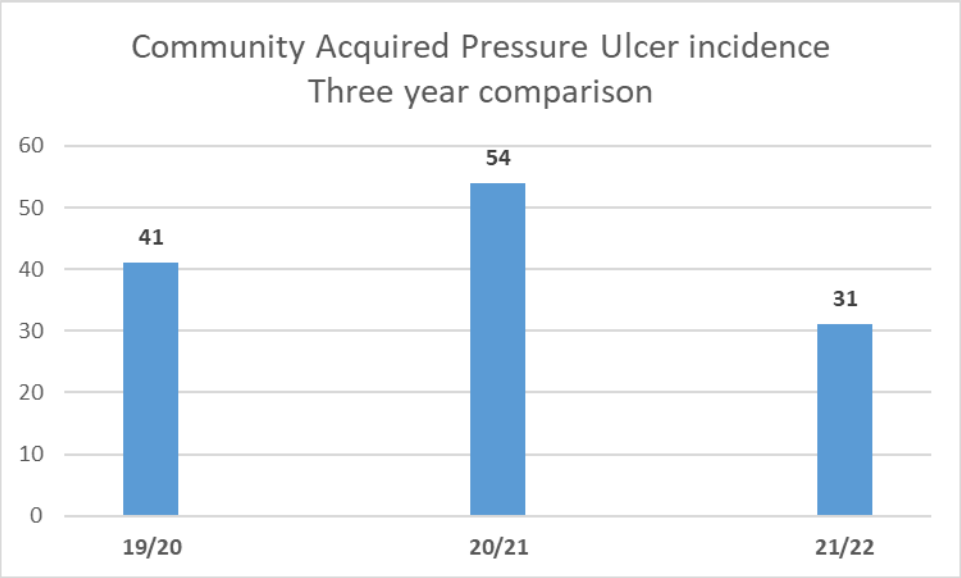
What we aimed to achieve?

- Significantly reduce community acquired pressure ulcers (specifically those graded category II, III and IV).

- Development of dashboards which allow community teams to have a visual aid of where pressure ulcers are occurring, allowing ownership and enabling these teams to make improvements.
- Undertake quality improvement work on targeted localities who report the highest number and rate of pressure damage.
- Increase the visibility and support provided by the Tissue Viability team to frontline clinical staff to assist in the prevention of pressure ulcers.
- Ensure we have a skilled and educated workforce with a sound knowledge base of prevention of pressure ulcers and quality improvement methodology.

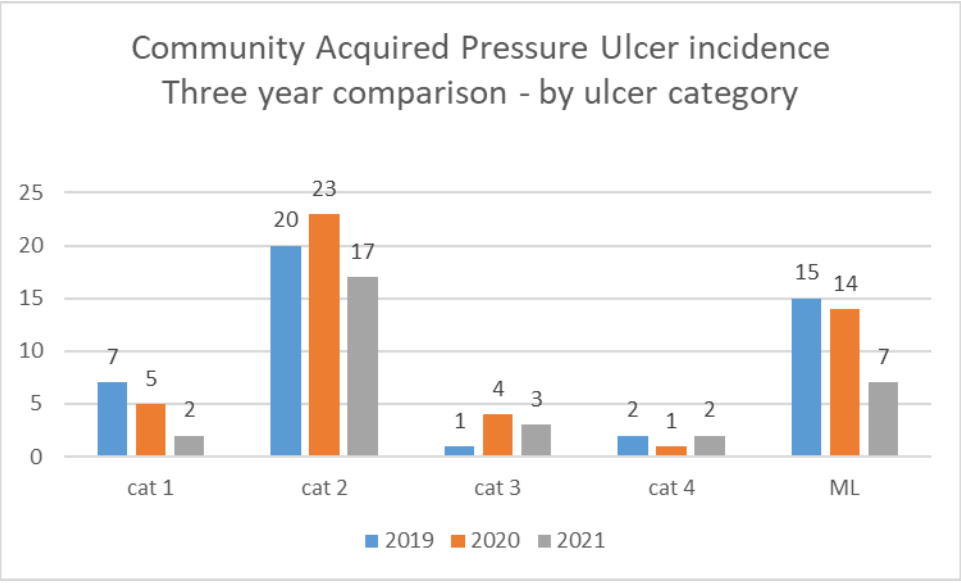
What we achieved?

- A new Pressure Ulcer Prevention Pathway was developed to guide and support staff. The pathway has been shared to all NHS Adult Community Services. Work is ongoing to ensure that this is fully embedded into practice.
- A robust programme of education was developed by the Tissue Viability Team delivering regular ‘Pressure Ulcer Prevention’ (PUP) updates across the city. Sessions were well attended by staff from community nursing and specialist services. Targeted pressure ulcer update sessions were implemented in teams reporting community acquired category III or IV pressure ulceration following Root Cause Analysis (RCA).
- Promotion of the ethos that PUP is the responsibility of all NHS staff regardless of where it was encountered by patients in their care journey.
- Inspired by Collaborative Newcastle, educational sessions were offered not only to Trust staff, but also to staff working in private organisations such as residential and nursing homes, and to domiciliary carers overseen by private care agencies and Local Authority. This promoted consistent messages across all care providers and ensured that preventative care interventions aligned with current best practice.
- Data collected over the previous three years (January 2019–December 2021) shows that pressure ulcer incidence in community is on a gradual downward trend (49, 47, 45). Data was then analysed by financial year (April 2019–March 2022) in alignment with the period set out for the Trust Quality Account and it is this that has been utilised to demonstrate the reduction in community acquired pressure ulceration. In the last 12 months we have attained a 42.6% overall reduction in community acquired pressure ulcers and a 24.4% reduction when using 2019 data as a pre-pandemic comparator.



There has been a reduction in Category I (60%), Category II (26%), Category III (25%) pressure ulcers and Moisture Lesions (ML) (50%).

The overall number of community acquired pressure ulceration remains small. Category IV pressure damage has increased by 100%, but this accounts for a very small proportion of community acquired pressure ulceration, two ulcers during the last 12 months.



Engagement with the RCA process from district nursing teams reporting community acquired category III and IV pressure ulceration has demonstrated improvements in the frequency of risk assessment and skin inspection, quality of nursing documentation and therefore patient care. Five RCA's have been undertaken in the last 12 months, with no RCA's being called since December 2021. The turnaround time of two weeks has been observed and aligns with the Trust's expectation for investigation. This has ensured that we are able to meet the timeline set by the commissioners with regards Serious Incident reporting.

How we measured success?

- Pressure Ulcer Incidence was measured through monthly analysis of Datix reporting. District Nursing Cluster Co-Ordinators reviewed all reported community acquired pressure ulceration to ensure accuracy in reporting. A final check was then undertaken by the Tissue Viability Team to validate accuracy. Incidence data was presented monthly at the Clinical Governance meeting.
- Dashboards produced weekly by the Quality Team using data submitted by District Nursing Teams via a weekly audit tool. These were circulated to District Nursing Cluster Co-ordinators for dissemination to their District Nursing Teams.
- The Community Tissue Viability Team monitored the amount of RCA's completed and create action plans in response to the findings of each RCA investigation.

Priority 3 – Management of Abnormal Results

Why have we chosen this?

The management of clinical tests from their request, through booking, performance, reporting, reviewing and acting on the results, is a major patient safety issue in all healthcare systems. We see evidence of patient harm caused by delays in tests, resulting in delays in treatment and aim to minimise those risks. This is a highly complex problem and nowhere in the world has an infallible system that can guarantee an important result cannot be missed, with an electronic patient record, paper, or a combination of both.

What we aimed to achieve?

To achieve this will require significant clinical input from the Digital Health Team, clinicians requesting investigations, staff performing the investigations and our technical team to make changes in our digital patient record.

What we achieved?

We have appointed a clinical lead for the management of abnormal results and reviewed our Trust investigations processes, starting with test ordering. We have agreed to progress this work as a top priority for the Digital Leadership Group and met with the Radiology Directorate to agree axial radiology as a pilot for the inclusion of a mandatory field for the lead consultant on their order entry forms. We have entered into a development partnership with 3M to use their "Follow-Up Finder" artificial intelligence technology to highlight the need for follow-up investigations indicated in free-text reports, and develop this functionality to identify gaps in the closed loop from requesting a test to taking appropriate actions for patient care, using the Trust's Clinical Data Warehouse and Document Store.

How we measured success?

Progress to date has comprised the mapping of current processes, agreement on a programme of design and development, and the identification of the resources required to complete the work. However, the success of this change must be measured by a reduction in the incidence of patient harm arising from delayed action on test results which will require long-term data collection. In the shorter term, other important metrics will include the proportion of digitally endorsed results and the time taken between a report becoming available and action being taken on its result.

CLINICAL EFFECTIVENESS

Priority 4 – Modified Early Obstetrics Warning Score (MEOWS)

Why we chose this?

In recent years there have been a number of maternal deaths in England where the lack of MEOWS systems for pregnant women in hospital but outside the maternity setting played a significant part. At present, pregnant/recently pregnant women outside the maternity unit are not monitored using a MEOWS system and observations taken follow the traditional model of NEWS monitoring for non-pregnant patients.

The need for early recognition and management of deterioration of pregnant women has been highlighted by:

- Mothers and Babies, Reducing Risk by Audit and Confidential Enquiry (MBRRACE)
- The Ockenden Report
- The Maternity and Neonatal Safety Improvement Programme (MatNeoSIP).
- Royal College of Physicians (RCP) guidance, which states that all medical pregnant/recently pregnant women should be monitored using a MEOWS system.

What is the aim?

Implementation of an electronic MEOWS system outside the Women's Services Directorate would improve the quality and safety of patient care for those women and provide Obstetric Services with a daily list of pregnant/recently pregnant women regardless of their location throughout the Trust and therefore improve collaborative care.

Our aim is therefore too:

- Create an IT solution for identification of a pregnant/recently pregnant woman outside Women's Services.
- Develop an electronic MEOWs system to replace National Early Warning System for this group of women.

What has been achieved?

- IT solution is ready to go live once tested.
- Newly appointed Clinical Director for Patient Safety to lead on this project.
- Raised change within IT for question to be added in relation to pregnancy status to assist automation of the maternity chart.

How we measured success?

Introduction of the identification of pregnant/recently pregnant woman outside Women's Services (in the rest of the Trust) and they are on the appropriate MEWS chart.

Priority 5 - Enhancing capability in Quality Improvement (QI)

Why we chose this?

Creating a culture of continuous improvement and learning across the Trust is important to deliver sustained improvement in the quality and experience of care. Change can be slow and inefficient if not supported by an improvement culture, a scientific approach and training. Therefore investing time for training on a scientific approach for improvement, to increase staff improvement capability is an important Trust priority. COVID-19 has demonstrated the need to make rapid changes and ongoing changes to recover from the impact of COVID-19, and enhancing QI improvement capability supports staff with this challenging time.

Our partnership with the Institute for Healthcare Improvement (IHI) will accelerate this work. This is critical in maintaining our outstanding performance and the patient-focused high quality of care we deliver in a sustainable way.

What we aimed to achieve?

We aimed to deliver improvement training programmes tailored to local teams working on Trust improvement priorities. The Improvement teams would then be supported by improvement coaches and leadership for improvement, to provide an organisational approach to enhance QI capability.

- Train 15-20 improvement teams, each focused on a piece of improvement work and coach them through the work.
- Train 30 improvement coaches to build capability and support teams with their improvement work.
- Train 30 senior leaders (Directorate Managers, Clinical Directors, Matrons or comparable senior level staff) in Leading for Improvement to provide the senior support for the improvement teams to effectively progress their improvement work.
- Develop a return on investment evaluation framework and assess the programme against this.
- Adapt the IHI training programme, following feedback from the training and evaluation, integrating sustainability tools linking the Sustaining Healthcare in Newcastle (SHINE) programme into improvement. Move towards being independent in ongoing delivery of training.
- Newcastle Improvement Team members to shadow the IHI delivery to learn in year two, to deliver the program after the IHI support period has finished.

What we achieved?

- The Newcastle Improvement Team has successfully recruited staff onto the three programmes.
- The IHI has delivered three training programmes:
    1. 15 improvement teams, involving 83 staff, each focused on a piece of improvement work on the IHI ‘Improvement for Teams’ Programme
    2. 37 improvement coaches to support teams with their improvement work on the IHI ‘Improvement Coach’ programme
    3. 30 senior leaders on the IHI ‘Leading for Improvement’ programme to provide the senior support for the improvement teams to effectively progress their improvement work.

An evaluation framework has been developed utilising ‘A Framework to Guide Evaluations of QI Capacity Building’ (Mery et al, 2017). The Framework has five core dimensions and within each dimension, key questions have been formulated. A variety of evaluation methods will be utilised to capture and analyse data with the purpose of answering key questions. The evaluation will provide information to assist in the assessment of the success of this novel approach, ahead of making any commitment for Year two of the partnership.

The first IHI training programmes are being adapted based on feedback from the training and evaluation. Sustainability tools have been shared with the improvement teams linking the SHINE programme into improvement. Newcastle Improvement staff have been shadowing the IHI Faculty and are moving towards joint deliver of programmes in year two.

How we measured success?

Each training session has been evaluated and subsequent sessions adapted based on participant feedback. Attendance at the training sessions was high.

The end of programme evaluation of the 37 coaches has shown an increase in confidence to apply improvement tools to their improvement work and to coach others on improvement. The skill level increased on many aspects of improvement for example; skills with organising effective team meetings, how to identify change ideas and using data to measure improvement.

Evaluation continues to capture feedback on the success of all training programmes and to inform the refinement of future programmes.

PATIENT EXPERIENCE

Priority 6 – Mental Health in Young People

Why we chose this?

In 2020, one in six (16.0%) children aged 5-16 years were identified as having a probable mental health disorder, increasing from one in nine (10.8%) in 2017. Greater impact for those with pre-existing mental health needs, young women and those at greater risk of social deprivation.

Nationally and regionally, there has been a surge in demand for specialist Tier 4 mental health inpatient beds for children and young people (CYP). We are currently seeing an increase in demand of up to one third compared to pre-COVID-19 times. The greatest pressure being seen is in the increase in the number of CYP presenting with either an eating disorder or disordered eating (associated with mental health co-morbidities). NHS Long Term Plan builds on the progress and learning from previous programmes and strategies going back to 2004 e.g. the National Service Framework, Every Child Matters, Choice and Partnership Approach, Targeted Mental Health in Schools, Children and Young People’s Improving Access to Psychological Therapies Change programme, Future in Mind, Five Year Forward View for Mental Health and

Transforming Children's and Young People's mental health Green Paper, The NCEPOD Mental Healthcare in Young People and Young Adults report published recommendations in 2019.

A National Transformation Programme of work has been established in recent months which is aligned to delivery of the CYP elements of the Long-Term Plan.

What we aimed to achieve?

- A dedicated and efficient pathway for assessment and treatment plan working in close conjunction with Cumbria, Northumbria, Tyne & Wear (CNTW) colleagues.
- Trained and skilled workforce.
- Appropriate environment for patients to be cared for.
- Efficient access to identify 'Advocates' for patients detained under the Mental Health Act.
- Learning from patient and parental experience

What we achieved?

- Multi-disciplinary Team Mental Health Strategy Group established and meet monthly and are joined by CNTW bi-monthly.
- Investment identified by We Can Talk Project.
- Online We Can Talk Training well utilised by staff.
- Ongoing review of environment in Paediatric Emergency to create a 'Safe space'.
- Much improved communications with colleagues at CNTW and collaborative work ongoing.
- Parent information leaflets now in use.
- Evidence of involving patient and parent to learn from experience.
- Policy for Detaining Patients under the Mental Health Act now includes under 18 years.
- Collaborative work with CNTW and Business case to seek investment for more efficient services for CYP nearly complete.
- Training delivered to CNTW staff by GNCH staff and CNTW delivering training to GNCH staff.
- Evidence of a very effective Multi-Disciplinary Team Support Hub including CNTW staff ahead of referral.

How we measured success?

- Review of staff training, staff feedback.
- More efficient communications between GNCH and CNTW.
- More efficient pathways when patients present acutely.
- More efficient transfer to mental health services for inpatient management.
- Review of impact of training.
- 'Patient and parental input in design of Safe' area in Paediatric Emergency Department.
- Policy for patients detained under the Mental Health Act now includes under 18 years.
- Policy for Reducing need for Restrictive Interventions for CYP.
- Improved risk assessment and prevention of restrictive interventions.

Priority 7 – Ensure reasonable adjustments are made for patients with suspected, or known, Learning Disability (LD)

Why we chose this?

People (children, young people and adults) with a Learning Disability are four times more likely to die of something that could have been prevented than the general population. As a Trust, we are committed to ensuring patients with a learning disability have access to services that will help improve their health and wellbeing and provide a positive and safe patient experience.

What we aimed to achieve?

Assurance that patients and their families have appropriate reasonable adjustments as required. That they are listened to, feel listened to and have a positive experience whilst in our care and appropriate follow up. Assurance that patients are flagged appropriately and that these flags generate the appropriate response to care, treatment and communications.

What we achieved?

- Medical support has ensured mortality reviews for patients with a Learning Disability who die whilst in Trust care are timely.
- Pathways continue to be developed for adult patients requiring MRI/CT under sedation.
- Continue to ensure Learning Disability flags are visible for adults and children with a learning disability.
- Audit documentation to provide evidence of best practice in relation to use of pathways of care, provision of reasonable adjustments to meet individual needs, appropriate use of hospital passports and application of the Mental Capacity Act including Deprivation of Liberty Safeguards.
- Learning Disability Liaison team to commence bi-monthly forums Trust wide to share learning and examples of good practise.
- Organisation registered for Improvement Standards 2021/2022.
- Review of pathways and e-learning to determine if any adaptions required.
- Work ongoing in conjunction with North East and Cumbria Learning Disability Network and Great North Children Hospital anaesthetics to incorporate theatre attendance within passport for Children & Young People.
- Review of role of ‘Champion’ commenced with a view to incorporating Autism.
- Collaborative work with University of Northumbria for development of simulation training.
- STOMP and STAMP project work resumed.
- Trust committed to ‘Weigh to Go’ and seek accreditation.
- Diamond Standards launched October 2021.

How we measured success?

- Diamond Standards embedded across the organisation.
- Increased staff training.
- Passports for CYP and adults updated and relaunched.
- Continued audit with regard to ‘flags’.

- Share learning and showcase examples of good practice.
- Maintain timely Learning Disabilities Mortality Review (LeDeR) Programme reviews.
- STOMP and STAMP embedded with organisation.
- Accreditation for ‘Weigh to Go’.
- Increased visibility of Learning Disability Liaison Team.

National guidance requires Trusts to include the following updates in the annual Quality Account:

Update on Duty of Candour (DoC)

Being open and transparent is an essential aspect of patient safety. Promoting a just and honest culture helps us to ensure we communicate in an open and timely way on those occasions when things go wrong. If a patient in our care experiences harm or is involved in an incident as a result of their healthcare treatment, we explain what happened and apologise to patients and/or their carers as soon as possible after the event.

There is a statutory requirement to implement Regulation 20 of the Health and Social Act 2008: Duty of Candour. Within the organisation we have a multifaceted approach to providing assurance and monitoring of our adherence to the regulation in relation to patients who have experienced significant harm.

The Trust's DoC Policy provides structure and guidance to our staff on the standard expected within the organisation. Our DoC compliance is assessed by the CQC; however, we also monitor our own performance on an ongoing basis. This ensures verbal and written apologies have been provided to patients and their families and assures that those affected are provided with an open and honest account of events and fully understand what has happened. An open and fair culture encourages staff to report incidents, to facilitate learning and continuous improvement to help prevent future incidents, improving the safety and quality of the care the Trust provides.

Duty of Candour requirements are regularly communicated across the organisation using a number of corporate communication channels. DoC is a standard agenda item at the Patient Safety Group, where clinical directorates' DoC compliance is monitored for assurance as part of a rolling programme. Staff learning and information sharing, in relation to DoC, also takes place at Trust-wide forums such as Clinical Policy Group, Clinical Risk Group as well as other directorate corporate governance committees.

DoC training is targeted at those staff with responsibility for leading both serious incident (SI) investigations and local directorate level investigations. DoC is included in Trust incident investigator training which is delivered to multidisciplinary staff once a month. In November 2021, an electronic DoC template to enable staff to accurately document DoC completion, went live as part of the electronic patient record. This acts as a prompt for clinicians to complete their DoC requirements correctly and enables the Trust to monitor compliance against this.

Statement on progress in implementing the priority clinical standards for seven day hospital services (7DS)

Due to the increasing pressures upon systems in responding to the COVID-19 pandemic, the Board Assurance Framework submissions since 2020/2021 have been deferred.

Gosport Independent Panel Report and ways in which staff can speak up

"In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS Foundation Trusts in England to report annually on staff who speak up (including whistleblowers). Ahead of such legislation, NHS trusts and NHS Foundation Trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust".

As part of its local People Plan, the Trust continues to focus efforts on shaping Newcastle Hospitals as 'the best place to work'; enable people to use their collective voice to develop ideas and make improvements to patient care and services; and create a healthy workplace.

Staff and temporary workers are informed from day one with the Trust, as part of their induction, via the e-handbook 'First Day Kit', and subsequently reminded regularly, that there are a number of routes through which to report concerns about issues in the workplace.

By offering a variety of options to staff, it is hoped that anyone working for Newcastle Hospitals will feel they have a voice and feel safe in raising a concern or making a positive suggestion. This includes the ability to provide information anonymously. Any of the reporting methods set out below can be used to log an issue, query or question; this may relate to patient safety or quality, staff safety including concerns about inappropriate behaviour, leadership, governance matters or ideas for best practice and improvements.

These systems and processes enable the Trust to provide high quality patient care and a safe and productive working environment where staff can securely share comments or concerns.

Work in confidence – the anonymous dialogue system

The Trust continues to use the anonymous dialogue system 'Work in Confidence', a staff engagement platform which empowers people to raise ideas or concerns directly with up to 20 senior leaders, including the Chief Executive and the Freedom to Speak Up Guardian. The conversations are categorized into subject areas, including staff safety.

This secure web-based system is run by a third-party supplier. It enables staff to engage in a dialogue with senior leaders in the Trust, safe in the knowledge that they cannot be identified. This is a promise by the supplier of the system.

Freedom to Speak up Guardian

The Trust Freedom to Speak up (FTSU) Guardian acts as an independent, impartial point of contact to support, signpost and advise staff who may wish to raise serious issues or concerns. This person can be contacted, in confidence, about possible wrongdoing, by telephone, email or in person.

To support this work, capacity has been increased to a network of FTSU Champions, spread across the organisation and sites, to ease access for staff.

Staff engagement to raise awareness about the roles and how to make contact have been undertaken via ‘drop in’ meetings, using poster campaigns and using a range of communications platforms.

In addition, the FTSU Guardian is expected to report bi-annually to the People Committee, a subcommittee of the Board, to provide assurance and ensure learning from cases.

Speak up – We Are Listening Policy (Voicing Concerns about Suspected Wrongdoing in the Workplace)

This policy provides employees who raise such concerns, assurance from the Trust that they will be supported to do so, and will not be penalised or victimised as a result of raising their concerns.

The Trust proactively fosters an open and transparent culture of safety and learning to protect patients and staff. It recognises that the ability to engage in this process and feel safe and confident to raise concerns is key to rectifying or resolving issues and underpins a shared commitment to continuous improvement.

Being open (Duty of Candour) Policy

Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. This policy involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment. It ensures communication is open, honest and occurs as soon as possible following an incident. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers.

Additional routes through which staff can voice concerns include Dignity and Respect at Work Policy and the Grievance Procedure.

Trust Contact Officer

The function of the contact officer is to act as a point of contact for all staff if they have work-related or interpersonal problems involving colleagues or managers in the working environment. Officers are contactable throughout the working day, with their details available under the A-Z index on the Trust Intranet.

Union and Staff Representatives

The Trust recognises a number of trade unions and works collaboratively in partnership with their representatives to improve the working environment for all. Staff are able to engage with these representatives to obtain advice and support if they wish to raise a concern.

Chaplaincy

The chaplaincy service is available to all staff for support and they offer one to one peer support for staff who require this. Chaplains are also able to signpost staff to appropriate additional resources.

Staff Networks

The staff networks have been established for a number of years. They provide support for Black and Minority Ethnic (BAME) staff, LGBTQ+ staff, and people with a disability or long standing health issue. Oversight rests with the Head of Equality, Diversity and Inclusion (People).

Each network has a Chair and Vice Chair and is supported in its function by the Human Resources Department. Each network has its own independent email account and staff can make contact this way, and/or attend a staff network meeting. The Staff Networks can either signpost staff to the best route for raising concerns, can raise a general concern on behalf of its members or can offer peer support to its members.

Cultural Ambassadors

Cultural Ambassadors, trained to identify and challenge cultural bias, were introduced into the Trust during 2020. These colleagues are an additional resource to support BAME colleagues who may be subjected to formal employment relations proceedings.

A summary of the Guardian of Safe Working Hours Annual Report

This consolidated Annual Report covers the period April 2021 – March 2022. The aim of the report is to highlight the vacancies in junior doctor rotas and steps taken to resolve these.

Rota gaps are present on a number of different rotas. This is due to both gaps in the regional training rotations and lack of recruitment of suitable locally employed doctors. Existing rota gaps have been exacerbated by both short term and long term sickness absence. The main areas of recurrent or residual concern for vacancies are Cardiothoracic Surgery, Ophthalmology, Acute Medicine and Histopathology. The Trust takes a proactive approach to minimise the impact of these by active recruitment; attempts to make the jobs attractive to the best candidates; utilisation of locums; and by rewriting work schedules to ensure that key areas are covered. In some areas, trainee shifts are being covered by consultants when junior doctor locums are unavailable.

In addition to the specific actions above, the Trust takes a proactive role in management of gaps with a coordinated monthly Junior Doctor Recruitment and Education Group meeting. Members of this group include the Director of Medical Education, Finance, Medical Education and Medical Staffing. In addition to recruitment into locally employed doctor posts, the Trust runs a number of successful trust-based training fellowships and a teaching fellow programme to fill anticipated gaps in the rota. These are 12 month posts aimed to maintain doctors in post and avoid the problem of staff retention. In specialties which are hard to recruit to, there has also been recruitment of advanced critical care practitioners and physician’s assistants.

Learning from deaths

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added new mandatory disclosure requirements relating to 'Learning from Deaths' to Quality Accounts from 2017/2018 onwards. These new regulations are detailed below:

1. During 2021/2022, 1973 of Newcastle upon Tyne Hospitals NHS Foundation Trust's patients died. This comprised the following number of deaths that occurred in each quarter of that reporting period: 436 in the first quarter; 471 in the second quarter; 572 in the third quarter; 494 in the fourth quarter.

2. During 2021/2022, 996 case record reviews and 28 investigations have been carried out in relation to 1973 of the deaths included in point one above. In 19 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 222 in the first quarter; 285 in the second quarter; 325 in the third quarter; 164 in the fourth quarter.

3. Twelve representing 0.61% of the patient deaths during the reporting period 2021/2022, are judged as more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of; three representing 0.15% deaths in the first quarter, four representing 0.20% in the second quarter, four representing 0.20% in the third quarter and one representing 0.05% in the fourth quarter. To date, not all incidents have been fully investigated. Once all investigations have been completed, any death found to have been due to problems in care will be reported in the 2022/23 quality account. All deaths will continue to be reported via the integrated quality report. These numbers have been estimated using the HOGAN evaluation score as well as root cause analysis and infection prevention control investigation toolkits.

Summaries from twelve completed cases judged to be more likely than not to have had problems in care, which have contributed to patient death:

Summary	Lessons learned from review	Action	Impact/Outcome
Patient fall	Investigation of this case found consistent areas of good practice in regards to nurse intentional rounding and falls assessments, with no omissions in care identified.	The good practice found in this investigation was shared with all staff members working in ward areas.	Staff are aware of the importance of fully completing falls assessment documentation and reviewing this regularly.
Patient fall	Local improvement has focused on consistently completing falls assessments in-line with Trust policy and the importance of strong leadership in driving positive changes in clinical practice.	An education programme has been delivered to senior ward staff in relation to the consistent completion of falls assessments.	All staff working in a ward environment are aware of the important link between robust falls assessment and prevention.

Summary	Lessons learned from review	Action	Impact/Outcome
Patient self-harm An in-patient receiving treatment, left the hospital and self-harmed, which sadly resulted in the patient's death	Screening mental health via structured mechanisms such as the patient electronic patient record is important in providing opportunities for staff to assess and communicate patient mental wellbeing.	The feasibility of increasing the visibility of current mental health screening questions is currently being explored.	Patients requiring mental health support may be identified and supported earlier in their care journey.
	Enhanced electronic patient record functionality that allows more than one next of kin and their contact details to be accessible to staff, will enable more timely communication with families.	The functionality of the electronic patient record to store additional next of kin details has been accepted as a priority by the digital team.	Staff will have increased opportunities to communicate critical information to families in a timely manner.
Medication Interaction	Increased pharmacist resource and the development of a medication acuity tool ensures that patients on high-risk medications are identified and prioritised for review as part of medicines reconciliation on discharge.	Business case approved for additional clinical pharmacy resource. Medicines acuity tool developed to help identify and manage patients taking high-risk medications.	Increased medicine reconciliation, especially in patients identified as high-risk will take place across the Trust.
		Dissemination of safety information communicated across multi-disciplinary clinical staff and clinical forums, to ensure learning from this medication interaction case is shared.	Staff have increased awareness of the medication interaction involved in this case.
	Reviewing patients' current medications on hospital admission is important, to support clinical decision making when prescribing new medications for acute treatment.	Medication reconciliation policy reviewed. Additional importance placed on reviewing appropriateness of admission medication in light of patient's current condition.	On admission, patients will have an appropriate review of their medication in relation to their acute presentation.
Medication Incident	Staff who manage patient anti-coagulation require a robust training package that is revisited at regular intervals.	An enhanced training and education package has been developed and is delivered regularly for medical, nursing and pharmacy staff.	Regular training of staff will ensure effective management of anticoagulation.
	The Trust warfarin guidance must be clear and easy to follow for clinical staff when re-introducing anticoagulation in complex post-operative patients.	Warfarin guidance has been reviewed by users in regards to readability and ease of interpretation	Increased awareness of safe warfarin management within the Trust.
	The development of a	Medicines acuity tool developed to help identify	Identification of high-

Summary	Lessons learned from review	Action	Impact/Outcome
	medication acuity tool (as above) would identify patients categorised as high risk in order to prioritise for pharmacist review.	and manage high-risk patients.	risk patients is essential to patient safety.
Medication Incident	Prescribing information within the electronic patient record (EPR) must be clear and concise for prescribers to easily interpret, for multiple clinical indications. An electronic 'flag' in the emergency department (ED) e-prescribing system would provide a digital solution that effectively communicates to nursing staff when medications are due for long stay patients. Enhanced training for all appropriate staff groups would improve understanding of steroid safety in acutely unwell steroid dependent patients.	Steroid prescribing 'alert' within the EPR reviewed & updated to ensure information clear to understand and usable in practice. Identify a digital solution in the ED e-prescribing system, which effectively alerts staff when a recurrent medication is required for a long stay patient. Explore training provided to staff groups to ensure provides appropriate level of education provision.	Staff provided with clear and concise EPR prescribing information to enable safe & appropriate steroid prescribing. An interim digital solution is now in place to alert staff to recurrent medications required. A longer-term plan to implement a permanent solution is in development.
Pressure Ulcer infection A patient developed an infection from a pressure ulcer, leading to sepsis.	Within the community, communication and handover of care between health and social care teams is essential; with named a nurse having oversight of each patient's care. Development and promotion of a pressure ulcer prevention pathway for community staff will drive consistent, high quality care for patients.	Increase staff knowledge of the risk of pressure damage and preventable measures needed, as part of an enhanced community staff training programme. Development of a community pressure ulcer pathway as well as preventative equipment guidance for community staff.	Staff will have increased knowledge and a clear pathway of care, which will improve handover and communication between teams.
Patient fall	It is important to have visual prompts on wheelchairs to remind users to apply brakes on wheelchairs whilst stationary, in order to promote safe use.	Put in place clear signage on all Trust wheelchairs to remind users of applying brakes at all times when stationary.	Patients/visitors choosing to use Trust wheelchairs will be better informed on wheelchair safety advice.
Four possible or probable Healthcare Acquired (Covid-19) Infections	Consistent compliance with Covid-19 screening, use of personal protective equipment (PPE) and hand hygiene is essential in reducing infections and protecting patients from harm.	The infection, prevention & control team to continue to robustly investigate all HCAI Covid-19 cases in order to identify learning to improve practice. All staff to continue to comply with all Covid-19 screening requirements.	The Trust infection prevention measures are shown to be robust in comparison to National peer organisations. National data demonstrates low HCAI rates within the Trust.

4. 174 case record reviews and 20 investigations were completed after April 2021, which related to deaths, which took place before the start of the reporting period.

5. 14 representing 7.22% of the patient deaths before the reporting period are judged more likely than not to have been due to problems in the care provided to the patient.

6. Four representing 0.3% of the investigations completed during 2020/2021 are judged more likely than not to have been due to problems in the care provided to the patient.

The Trust will monitor and discuss mortality findings at the Quarterly Mortality Surveillance Group and Serious Incident Panel, which will be monitored and reported to the Trust Board and Quality Committee.

Part 3 – Other Information - Overview of Board assurance 2021/2022

This is a representation of the Quality Report data presented to the Trust Board on a monthly basis in consultation with relevant stakeholders for the year 2021/2022. The indicators were selected because of the adverse implications for patient safety and quality of care should there be any reduction in compliance with the individual elements. In addition to the 13 local priorities outlined in section two, the indicators below demonstrate the quality of the services provided by the Trust over 2021/2022 has been positive overall.

Patient Safety	Data source	Standard	Actual 2020/21	Q1	Q2	Q3	Q4	Actual 2021/22
Number of MSSA bacteraemia cases	UKHSA Data Capture System	Mandatory reporting by NHSI/NHSE	HOHA* = 75 COHA* = 25	HOHA* = 15 COHA* = 8	HOHA* = 25 COHA* = 7	HOHA* = 19 COHA* = 6	HOHA* = 23 COHA* = 7	HOHA* = 82 COHA* = 28
Number of MRSA bacteraemia cases	UKHSA Data Capture System	Mandatory reporting by NHSI/NHSE	HOHA* = 1 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0
Number of *C. difficile* infection cases	UKHSA Data Capture System	Mandatory reporting by NHSI/NHSE	HOHA* = 85 COHA* = 26	HOHA* = 33 COHA* = 4	HOHA* = 39 COHA* = 16	HOHA* = 29 COHA* = 11	HOHA* = 34 COHA* = 3	HOHA* = 135 COHA* = 34
Number of *E. coli* bacteraemia cases	UKHSA Data Capture System	Mandatory reporting by NHSI/NHSE	HOHA* = 146 COHA* = 49	HOHA* = 42 COHA* = 14	HOHA* = 37 COHA* = 11	HOHA* = 36 COHA* = 16	HOHA* = 38 COHA* = 12	HOHA* = 153 COHA* = 53
Number of Klebsiella bacteraemia cases	UKHSA Data Capture System	Mandatory reporting by NHSI/NHSE	HOHA* = 94 COHA* = 35	HOHA* = 35 COHA* = 6	HOHA* = 39 COHA* = 3	HOHA* = 36 COHA* = 6	HOHA* = 15 COHA* = 6	HOHA* = 125 COHA* = 21
Number of Pseudomonas aeruginosa bacteraemia cases	UKHSA Data Capture System	Mandatory reporting by NHSI/NHSE	HOHA* = 32 COHA* =13	HOHA* = 7 COHA* = 3	HOHA* = 7 COHA* = 4	HOHA* = 12 COHA* = 1	HOHA* = 8 COHA* = 1	HOHA* = 34 COHA* = 9
Total number of patient incidents reported (Datix)	Internal Datix Incident reporting system	Local Incident Policy	17,515	4,543	4,543	4,618	4,736	18,440
Patient Incidents per 1000 bed days (Datix)	Internal Datix Incident reporting system	Local Incident Policy	44.0	37.9	37.1	37.7	37.9	37.5
% Patient incidents that result in severe harm or death	Internal Datix Incident reporting system	Local	0.5%	0.4%	0.7%	0.8%	1.0%	0.7%
Slip, trip and fall - patient (Datix)	Internal Datix Incident reporting system	N/A	2,391	617	580	634	715	2,546
Slip, trip and fall - patient (Datix) per 1,000 bed days	Internal Datix Incident reporting system	National definition	6.0	5.1	4.7	5.1	5.7	5.1
Inpatients acquiring pressure damage	Internal Datix Incident reporting system	National	706	214	234	241	219	908

Pressure Ulcers per 1000 bed days	Internal Datix Incident reporting system	Local	1.8	1.7	1.9	1.9	1.7	1.9
Total number of Never Events reported	Internal Datix Incident reporting system	National definition	3	3	0	1	2	6
Total number of Serious Incidents reported	Internal Datix Incident reporting system	Local SI Policy	151	61	64	76	79	280
Needlestick injury or other incident connected to sharps	Internal Datix Incident reporting system	Local Policy	319	100	84	85	100	369
Reporting of Injuries, Disease and Dangerous Occurances (RIDDOR)	Internal Datix Incident reporting system	Local Policy	39	11	18	11	8	48
Slip, Trip, Fall – Staff/Visitors/relatives	Internal Datix Incident reporting system	Local Policy	158	32	33	34	32	131

Clinical Effectiveness	Data Source	Standard	Q3 2020/21	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
Summary Hospital Mortality Index (SHMI)	CHKS	100	98	95	94	96	Not Published	Not Published
Learning from Deaths	Internal Mortality Review Database	Reviewing and Monitoring Mortality Policy	363	330	217	274	318	162

Patient Experience	Data source	Standard	Actual 2020/21	Q1	Q2	Q3	Q4	Actual 2021/22
Number of complaints received	Internal Datix Incident reporting system	Local Complaints Policy	467	134	130	156	134	554
National Inpatient Survey	CQC	National average	77.7% *	* This measure uses the results of a selection of five questions from the National Inpatient Survey focussing on the responsiveness to personal needs. Consultation feedback indicated that personalisation and service responsiveness are important issues for inpatients. This indicator aims to capture inpatients' experience of this.2021/2022 Data will not be available until 2023				
Friends and Family response rates (inpatients and A&E)	Locally collected and reported	Not applicable	Not published	98%	97%	96%	FFT results are 2 months in arrears and are not yet available to the Trust	TBC

*HOHA = Hospital Onset – Healthcare Associated
*COHA = Community Onset – Healthcare Associated

NHS Improvement (NHSI) changed the criteria for reporting C. difficile from 2020/2021. The reported figures are therefore not comparable to previous years as the change includes reporting COHA cases. This patient group includes those who have been discharged within the previous four weeks in addition to day-case patients and regular attenders.

Inconsistencies in data reported in the 2020/2021 report

There have been some slight variations in the reported 2020/2021 data – this is due to the fact that the Trust Incident reporting system is a live database which results in fluctuations in actual numbers of incidents reported as investigations are processed through the system.

OVERVIEW OF QUALITY IMPROVEMENTS

Pages 51-62 give some examples of other service developments and quality improvement initiatives the Trust has implemented, or been involved in, throughout the year.

Newcastle Hospitals opens regional ‘cataract centre’ to transform patient care

A state-of-the-art theatre ‘hub’, dedicated to cataract surgery, opened its doors to patients as part of a Newcastle Hospitals’ initiative.

Newcastle Westgate Cataract Centre a three-theatre, purpose-built clinical facility performs up to 1,000 cataract procedures a month, which is almost double the number undertaken before the coronavirus pandemic.

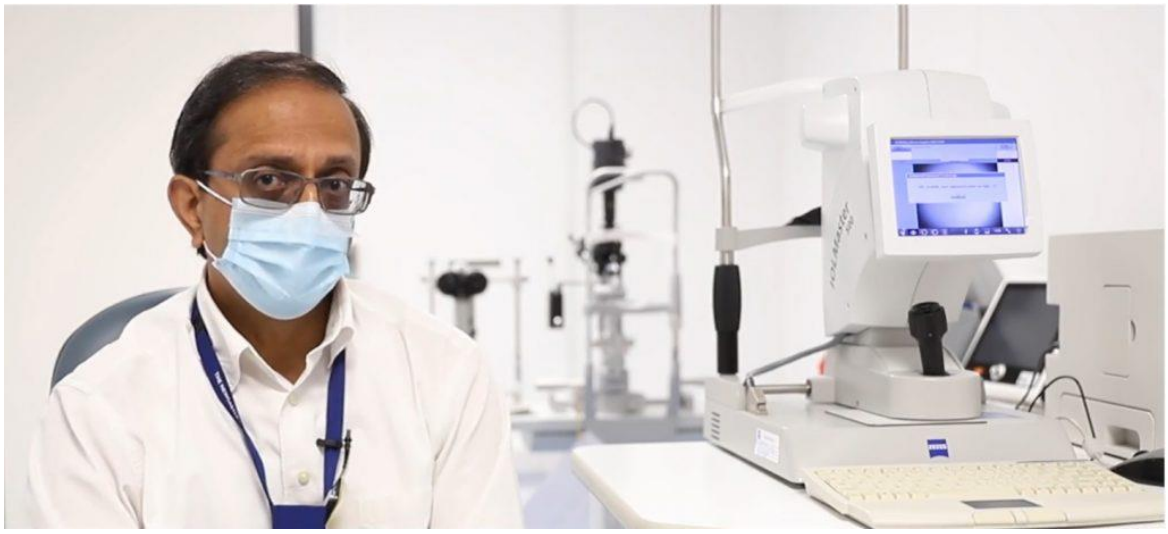
The centre has been designed to ensure that patients have exceptional clinical care from the expert team at the Trust. It has been streamlined to ensure that patients have no waiting meaning that each patient spends between just 40 minutes to an hour in the unit rather than the usual time of about three hours.

Personalised-care is provided throughout by a dedicated nurse who checks on the patient and remains with them throughout their journey. The patient sits in a special chair throughout and is wheeled into theatre for their day case procedure.

After being given information on aftercare, their nurse will escort them to their waiting transport just outside the Centre.

The ophthalmology team in Newcastle provide cataract surgery to patients across the region and every year receive hundreds of referrals. Just over a fifth of patients (21%) live within Newcastle, others come from across the North East.

Demand continues to increase year-on-year and cataract surgery is now the most commonly performed surgery in the NHS. The Royal College of Ophthalmologists estimate that demand will continue to rise by 25% over the next ten years and by 50% over the next 20 years.



Consultant Ophthalmologist and Clinical Lead, Krishnamoorthy Narayanan, said: “Prior to the pandemic, all patients were seen at the RVI and we were already seeing pressures on our waiting lists. Inevitably, waiting times have increased due to the pandemic.

“This is a very distressing situation for patients as cataracts can have a significant impact on quality of life and independence. It has been very difficult for the team to tell patients and their doctors that we couldn’t offer them surgery as quickly as they would wish”.

“Cataract surgery is a very quick, but a very highly technical operation which makes a huge impact on the quality of life as the improved vision means that the patient can go back to their normal activities.”

To find the best solution for patients, the ophthalmology team worked closely with estates colleagues and building contractors Vanguard, drawing up plans to secure a £7 million investment for the state-of-the-art cataract theatre centre on the Campus for Ageing and Vitality site (former Newcastle General Hospital).

To build something using traditional construction methods would have taken around two years to complete, but this build end-to-end, from conception to completion and including commissioning, has taken just seven months.

The team will only be operating on cataracts and will operate all through the working week. Some patients, including those who require a general anaesthetic, will still require their surgery at the Royal Victoria Infirmary.

“When the centre is fully operational we expect to operate between 200-250 cataract cases every week,” added Mr Narayanan.

“Due to the unique design, there is no waiting involved which is great for our patients. Appointment times are staggered so while we are seeing high patient numbers, their safety has been foremost when planning this service.

“A huge amount of preparation goes into getting the patient ready for the operation well before the operation date. We have also managed to cut out unnecessary waiting and delays on the day of surgery”.

“We are very excited and delighted to be able to provide our expertise and improved experience to the people of the North East.”

Chief Executive Dame Jackie Daniel said: “It’s fantastic that we can safely offer so many more patients the chance to have this important surgery and I am incredibly proud of the adaptability and creativity of the teams who have worked so hard to achieve this”.

“This is a great example of transformational thinking to provide a much swifter service with a clear focus on patient care and experience. It’s a model which I’m certain will be rolled out across the wider NHS.”

For Doris McGuire, 86, appearing in Geordie Hospital's final episode was a chance to celebrate for two reasons she was having her second cataract operation and it was also her birthday.

The Chapel House pensioner, and mother of two, said having her operations at the Newcastle Cataract Centre had been almost painless and she said they had made the "world of difference…It's wonderful, I would tell everyone to get it done."

Multi-million pound cancer centre at Cumberland Infirmary opens to patients

A new cancer centre on the site of the Cumberland Infirmary in Carlisle marks the culmination of two years' work with an investment of £35 million in North Cumbria to improve health outcomes for the local population.

The Northern Centre for Cancer Care, North Cumbria – a partnership between Newcastle Hospitals and North Cumbria Integrated Care NHS Foundation Trust (NCIC) brings all non-surgical cancer services under the same roof for the first time.

This means that patients no longer have to travel to different parts of the Infirmary for treatment.

The development of the centre will bring huge benefits to those people who need to access cancer services in North Cumbria as the majority of adult patients will be able to access the state-of-the-art facilities and receive their care closer to home.

Only patients with rare cancers, those requiring very specialist radiotherapy and children and young people with cancer, will continue to be referred to the Freeman Hospital in Newcastle.

Around 2,000 patients are already set to receive treatment or follow-up care at the new centre with approximately 1,200 new referrals each year.

The team also expects to deliver approximately 11,500 radiotherapy treatments and 8,000 chemotherapy treatments, as well as 4,000 supportive therapy treatments, a year.

The building will be managed by NCIC and services at the centre will be run by Newcastle Hospitals as part of the Northern Centre for Cancer Care. Around 80 members of staff, from North Cumbria's non-surgical oncology service, joined the Newcastle team. They will be supported by porters, housekeepers, estates and facilities staff from NCIC who will manage the maintenance of the building.

Together the trusts will be providing one of the biggest combined cancer treatment services in the country.

Dame Jackie Daniel, Chief Executive at Newcastle Hospitals said: "We're delighted to have welcomed our first patients at the Northern Centre for Cancer Care, North Cumbria".

"The centre looks fantastic and all of the teams involved have worked incredibly hard to make sure this is a calm and comfortable environment for our patients".

"The development of the centre demonstrates our commitment to providing high quality and sustainable cancer services to people across North Cumbria and supporting patients to receive care closer to home."

Lyn Simpson, Chief Executive at NCIC, said: "I know many people have closely watched the progress of the centre since construction began and it is excellent to see the building now complete and welcoming patients. The opening of the centre, in partnership with Newcastle Hospitals, is a real milestone in our journey to improve cancer services for patients across North Cumbria."

Newcastle doctor appointed first national speciality advisor for Long COVID

Dr Graham Burns, a consultant physician at Newcastle's Royal Victoria Infirmary, has been appointed as one of five new NHS clinical leads to help spearhead action to address some of the key issues facing the health service.

Dr Graham Burns is the NHS's first ever National Specialty Adviser for Long COVID, a role created to help the NHS meet the new demand for ongoing care from people suffering long-term physical and psychological after-effects from the virus.

He is joined in the role by Dr Melissa Heightman, respiratory physician and clinical lead for the post-COVID-19 clinic at University College London Hospital, and consultant lead for the post-COVID-19 network in North Central London. She has advised NHS England, National Institute of Clinical Excellence (NICE) and the National Institute for Health and care Research (NIHR) funded STIMULATE-ICP research program on care and treatment for patients experiencing Long COVID.

During the pandemic, Dr Burns, who is President of the British Thoracic Society, set up both a respiratory support unit and a post-COVID-19 assessment clinic, both of which became models replicated by other hospitals and in national NHS guidance.

The five new clinical leads, who also cover urgent and emergency care and elective care will provide expert advice to the NHS Medical Director, Professor Stephen Powis, and to the programme teams working to support local NHS teams improve services for patients in these areas.

Professor Julian Redhead has been appointed National Clinical Director for Urgent and Emergency Care, and will be responsible for helping the NHS to continue to improve 999, 111, A&E and other urgent care services, at the same time as the service faces record levels of pressure off the back of the pandemic. Professor Redhead is medical director and chief of service for emergency medicine at Imperial Healthcare and medical director for the North West London Integrated Care Partnership.

Joint National Clinical Directors have also been appointed for Elective Care, bringing a combined 60 years of experience to the NHS efforts to tackle the COVID-19 backlog for non-urgent treatment.

Ian Eardley is a Consultant Urological Surgeon in Leeds, and has held a range of national roles including Vice-Chair of the Royal College of Surgeons (England) and Chair of the Joint Committee for Surgical Training.

He is joined by Stella Vig, consultant in vascular and general surgery and Director of Elective Recovery at Croydon Health Services NHS Trust. Stella has also previously chaired the Joint Committee for Surgical Training, and is a current member of the Royal College of Surgeons of England Council.

NHS Medical Director, Professor Stephen Powis, said: “The fact that the NHS was able to respond so well to the greatest public health emergency in its history is, in large part because of our ability to draw on an unrivalled wealth of clinical experience, expertise and enterprise right the way from ward to board levels.

“So as the NHS works hard to tackle the COVID-19 backlog for non-urgent care, safely treat all those needing urgent and emergency care, particularly as we head into a difficult winter, and address the new challenge of Long COVID, I am delighted to welcome five senior clinicians to help lead this vital work.

“All of my new colleagues bring a wealth of experience and a strong track record of leading improvements in care and treatment for patients at a national level, and I know they are all eager to continue this in their new roles.”

Newcastle Hospitals become first in the UK to use climate-friendly gas and air during labour

Newcastle mum, Kaja Gersinska, has become the first person in the UK to use climate-friendly pain relief during labour after giving birth at Newcastle’s Royal Victoria Infirmary.

Entonox, also known as gas and air, is a mixture of nitrous oxide and oxygen and has been used to provide pain relief for women in labour for over a hundred years. However, nitrous oxide is a powerful greenhouse gas, almost 300 times more potent than carbon dioxide, and escapes into the atmosphere after being exhaled by a patient.

Kaja gave birth to her beautiful daughter, Rosie Martha O'Sullivan, who weighed 6lb 6oz, in the Newcastle Birthing Centre on 9 September 2021 and breathed the gas and air into a Mobile Destruction Unit (MDU), a machine designed to collect and destroy residual nitrous oxide from exhaled gas and air.

"I feel very privileged and proud actually, it's the little things you don't often think about and it's nice that someone thought about making these changes which will be better for the environment and for midwives who are working here all the time".

"I didn't expect this when I came here today I just came to have my baby but I started on the traditional machine and then swapped over. It was quieter and much more comfortable to hold, it's nice to make a little bit of history!"

Little Rosie, who was delivered by midwife Lindsay Craney, is Kaja and dad Craig's second child as they already have a two-year-old daughter Cassie.

The technology, developed by Medclair, is widely used in Sweden and collects the exhaled nitrous oxide and 'cracks' it into nitrogen and oxygen which are harmless.

The MDU purifies 99.6% of the nitrous oxide entering the unit, and as well having a huge benefit to the environment, it also benefits staff by reducing the amount of nitrous oxide they are exposed to while they work.

Chris Allen, Sustainable Anaesthesia Fellow at Newcastle Hospitals said "This is a really exciting day for the whole team involved in developing this project at Newcastle Hospitals. It has been a huge team effort including staff from maternity services and our sustainability and estates teams."

"Rolling this technology out across our maternity unit can help us to continue to support women to use gas and air during labour, whilst making it as environmentally friendly as possible."

"We have an ambitious plan to become a global leader in sustainable healthcare delivery and introducing innovative technology like this can help us to achieve that."

Newcastle Hospitals is well known for its award winning Shine (Sustainable Healthcare in Newcastle) programme and was the first healthcare organisation in the world to declare a climate emergency, in recognition that the climate emergency is a health emergency. The Trust is also committed to the ambitious goal of becoming a net-zero carbon organisation by 2030.

Chief Executive of Medclair Jonas Lundh said: “Working in the green medtech area I’m extremely impressed by the NHS Newcastle team, I’ve never seen such a display of action on the fact that there is a global climate crisis as we saw in Newcastle. We are delighted to be a supplier to the Trust and we look forward to Rosie’s generation being born in a climate friendly way.”

The Trust’s Associate Director Sustainability, James Dixon, added: “We’ve made significant progress in reducing the environmental impact of our anaesthetic care pathways in recent years, with a 23% reduction in anaesthetic gas carbon emissions last year alone”.

“All of this has been led by clinicians who are passionate about planetary, as well as patient health. Our use of Entonox (gas and air) is by far the biggest contributor to our anaesthetic gas carbon footprint and in adopting this innovative technology, we will see thousands of tonnes of carbon saved (or the equivalent annual carbon emissions of 150 UK citizens).”

“This is just one example of how we are embedding sustainability into our healthcare services, working hard to empower staff to make sustainable choices for the benefit of our patients and the planet.”

Geordie Hospital star Kit thrives after heart transplant and 'should inspire organ donation discussion'

Five-year-old Kit Matthews who featured in the first episode of Geordie Hospital.

“The little lad from Retford in the Midlands featured as he and his family prepared for him to be moved from one version of an artificial heart to another more flexible machine as he waits for a transplant”.

The show was filmed last year, and Kit has now had that transplant and is "going from strength to strength" but as his story is told on TV both his family and the consultant who looked after him at the Freeman Hospital are keen to highlight just how important organ donation is.

Kit's dad Joe is a heart-transplant recipient himself. "About April 16 was when it started. He wasn't feeling the best. Kit loves chocolate and we knew he wasn't right as he just wasn't interested," he said.

"Naturally we just thought he had a bad childhood cold like everyone else. Hannah, my wife, took him to the GP and they took some bloods but everything came back alright. He was still off his food."

After Joe and Hannah were told to take Kit to hospital, alarm bells began to ring for medics and they were quickly referred to hospital in Leeds. This was especially difficult as Kit's little brother Monty was just two at the time and the family had to spend lots of time apart, and Joe said he and Hannah were also incredibly proud of their younger son for coping with such upheaval.

Joe continued: "On the Saturday we got referred up to Leeds. Kit was just four and everyone wanted a piece of him to take bloods and do scans. It was awful for Hannah and myself, but clearly really horrible for him." Soon after, when it became clear quite how poorly Kit's heart was he, like his dad more than a decade ago was suffering from cardiomyopathy the family were told he would need specialist care rapidly. Space was available at the Freeman's world-renowned children's heart unit.

Joe added: "We arrived on the Monday evening and they operated to put him on the Ventricular Assist Device (VAD). We had gone from him wrestling with his brother to him in surgery in a critical condition, pretty much just like that. And we knew he might not survive the operation even."

Kit pulled through though, and was fitted with a Berlin Heart which kept him alive while he waited for a transplant. That transplant happened later in the year, the NHS is careful not to say exactly when so as not to identify the donor and by Christmas, Kit was at home with his family, "back to normal" and again playing like any kid should with his little brother.

Joe said: "Now, he's gone from strength to strength. He's shown how strong he really is and how resilient kids are. The majority of adults even would have given up."

"He knows exactly what's happened to him. I was on a VAD and he's seen pictures of me in a similar state to he was before. So he could see that as I'm doing so well now it was going to work and it made sense to him. He doesn't stop running. We have our Kit back. He's almost exactly the same, if anything, he's matured."

Speaking before the show aired, Joe said he was looking forward to seeing Geordie Hospital though he wasn't sure his eldest son felt the same. "For him, now it's something done," he said. "I don't think he really wants to revisit it. But for me, it's important I want everyone to see the benefit transplants can have. To spread that message and raise awareness."

Dr Emma Simpson, a paediatric intensive care consultant who looked after Kit agreed.

Recounting Kit's story and emphasising that it is similar for many children the unit sees, and sadly the outcome is not always a happy one, she added: "Kit, like many of our patients was in a very sick state when he came to us. His heart and circulatory system wasn't providing for his body's needs. He needed intensive care and was really sick and at risk of cardiac arrest and the body's organs failing.

"It was key to get him onto VAD. For someone of Kit's size there was only really one option of a pump and it requires a pretty big operation. The idea is to reduce the risk of cardiac arrest and hopefully put him in a better position for a transplant."

The staff at the Freeman Hospital work very closely with the company who creates Berlin Hearts and were among the first to use the new, smaller device which Kit is seen being fitted with on TV. That allows parents to take their child off the ward for several hours.

"He was very sick after the initial operation, but he got a little better and was able to move back to the ward and we were keen to get him onto the smaller Berlin Heart machine," Dr Simpson added. "It's a real help and we're always really keen to get families as much autonomy as they can”.

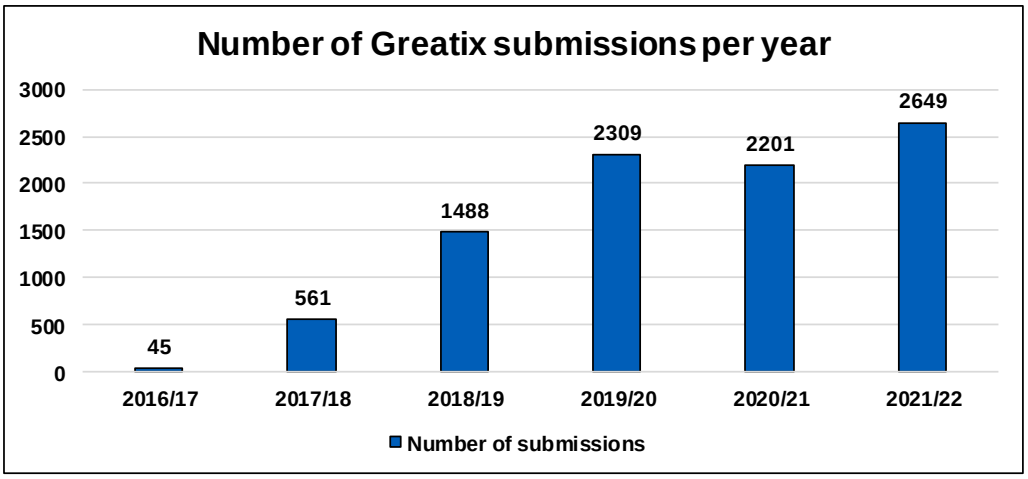
"Kit loved going to the park, or the family would take him around the hospital or to the fruit and veg seller." Echoing Joe, Dr Simpson said she hoped having featured on Geordie Hospital would have a positive impact. "I have no real interest in being on TV myself I did it to showcase the team's achievements and to also highlight that there is this group of patients”.

"Without the generosity of families at the most difficult time imaginable, there's no hope for children like Kit. Organ donation is something that needs to be discussed."

Greatix
Learning From Excellence

So often in healthcare we focus on when things go wrong and how to prevent them happening again. The introduction of Greatix at Newcastle Hospitals encouraged staff to look instead, at where things were going right, what we do well and how we could do more of it.

There are examples of excellence all around us every day. Colleagues are encouraged to recognise and share these examples, so that everyone can learn from them.



Newcastle Hospitals staff complete a simple online form, telling us who achieved excellence and what can be learnt.

By the end of March 2022, over five years after launching, the Trust has received over 9000 Greatix submissions. This is an outstanding achievement and one that reflects just how valued Greatix is by the staff working at Newcastle Hospitals.

The number of Greatix submissions has grown year on year, except 2020/2021 where the system was temporarily closed for a period of time due to upgrades. Since the summer of 2021 Greatix reporting to directorates has been improved with more focused feedback and promoted to all staff via the Trust communication team.

QUALITY STRATEGY UPDATE

When the Care Quality Commission (CQC) inspected The Newcastle upon Tyne NHS Foundation Trust in 2019, they awarded an outstanding rating overall. Peer review is Newcastle Hospital's internal inspection process. The aim of peer review is to strengthen the clinical quality assurance process that ensure patients receive the best experience and best possible care. As part of the usual peer review process, each directorate is reviewed on an annual basis to assess the quality of care delivered using the methodology of the CQC inspection framework.

For 2021/2022, in a change to the previous annual reviews, due to the impact of the pandemic, the directorates were invited to participate in a self-assessment process rather than the usual, comprehensive external peer review. The directorates, with support from the Clinical Governance and Risk Department (CGARD), the Senior Nursing Team and Clinical Directors for Patient Safety and Quality, were asked to self-assess their performance related to the five CQC domains (safe, effective, caring, responsive, well- led), and provide a rating for each domain. They then highlighted areas of achievement and areas for improvement.

The directorate self-assessment ratings were then reviewed and finalised by a ratification panel.

It is clear that the benefits of these reviews, promote learning and sharing of ideas for improvement across departments and individual directorates, whilst providing assurance. To ensure the review process continues to be effective, CGARD continues to align with the CQC inspection process and offers enhanced scrutiny and assurance. The Chief Operating Officer receives updated ratings, for all the Directorates, and a report is submitted to the Quality Committee annually.

Planning is underway for the 2022/2023 review process. In line with the CQC Strategy, the attention will move away from the core level service inspections and focus on the well-led domain.

INFORMATION ON PARTICIPATION IN NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

During 2021/2022, 58 national clinical audits and two national confidential enquiry reports / review outcome programmes covered NHS services that the Newcastle upon Tyne Foundation Hospitals NHS Foundation Trust provides.

During that period, the Newcastle upon Tyne Hospitals NHS Foundation Trust participated in 57 (98%) of the national clinical audits and 100% of the national confidential enquiries / review outcome programmes which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Newcastle upon Tyne Hospitals NHS Foundation Trust was eligible to participate in during 2021/2022 are as follows:

National Clinical Audits			National Confidential Enquiries
Case Mix Programme	National Audit of Breast Cancer in Older People	National Lung Cancer Audit	Child Health Outcome Review Programme
Chronic Kidney Disease Registry	National Audit of Cardiac Rehabilitation	National Maternity and Perinatal Audit	Medical and Surgical Clinical Outcome Review Programme
Cleft Registry and Audit Network	National Audit of Cardiovascular Disease	National Neonatal Audit Programme	
Elective Surgery – National PROMs Programme	National Audit of Care at the End of Life	National Paediatric Diabetes Audit	
Emergency Medicine QIPs – Pain in Children (care in emergency departments)	National Audit of Pulmonary Hypertension	National Perinatal Mortality Review Tool	
Emergency Medicine QIPs- Consultant Sign Off (in emergency departments)	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	National Prostate Cancer Audit	
Falls and Fragility Fracture Audit Programme – Fracture Liaison Service Database	National Cardiac Arrest Audit	National Vascular Registry	
Falls and Fragility Fracture Audit Programme – National Audit of Inpatient Falls	National Cardiac Audit Programme – Cardiac Rhythm Management	Neurosurgical National Audit Programme	
Falls and Fragility Fracture Audit Programme – National hip Fracture Database	National Cardiac Audit Programme – Myocardial Ischaemia	Paediatric Intensive Care Audit	
Inflammatory Bowel Disease Audit	National Cardiac Audit Programme – Adult Cardiac Surgery	Respiratory Audits – National Outpatient Management of Pulmonary Embolism	
Learning Disability Mortality Review	National Cardiac Audit Programme –	Respiratory Audits – National Smoking Cessation	

National Clinical Audits			National Confidential Enquiries
Programme	Percutaneous Coronary Interventions	Audit	
Maternal, Newborn and Infant Clinical Outcome Review Programme	National Cardiac Audit Programme – Heart Failure	Sentinel Stroke National Audit Programme	
National Adult Diabetes Audit – National Diabetes Core Audit	National Cardiac Audit Programme – Congenital Heart Disease in Children and Adults	Serious Hazards of Transfusion	
National Adult Diabetes Audit – National Pregnancy in Diabetes Audit	National Child Mortality Database	Society for Acute Medicine's Benchmarking Audit	
National Adult Diabetes Audit – National Diabetes Footcare Audit	National Comparative Audit of Blood Transfusion – 2021 Audit of Patient Blood Management & NICE Guidelines	Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	
National Adult Diabetes Audit – National Inpatient Diabetes Audit	National Early Inflammatory Arthritis Audit	Trauma Audit and Research Network	
National Asthma and COPD Audit Programme – Paediatric Asthma Secondary Care	National Emergency Laparotomy Audit	UK Cystic Fibrosis Registry	
National Asthma and COPD Audit Programme – Adult Asthma Secondary Care	National Gastro-intestinal Cancer Programme – National Oesophago-gastric Cancer	Urology Audits – Management of the Lower Ureter in Nephrouterectomy Audit	
National Asthma and COPD Audit Programme – COPD Secondary Care	National Gastro-intestinal Cancer Programme – National Bowel Cancer Audit		
National Asthma and COPD Audit Programme – Pulmonary Rehabilitation	National Joint Registry		

The national clinical audits and national confidential enquiries that the Newcastle upon Tyne Hospitals NHS Foundation Trust participated in during 2021/2022 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
Case Mix Programme	Intensive Care National Audit & Research Centre	This audit looks at patient outcomes from adult, general critical care units in England, Wales and Northern Ireland.	✓	Continuous data collection	Published report expected March 2023
Chronic Kidney Disease Registry	The Renal Association / The UK Renal Registry(UKRR)	The UKRR annual reports contain analyses about the care provided to patients with Chronic Kidney Disease (CKD)(including people pre- Kidney Replacement Therapy (KRT) and on KRT) at each of the UK's adult and paediatric kidney centres against the UK Kidney Association's guidelines.	✓	Continuous data collection	No publication date yet identified
Cleft Registry and Audit Network	Royal College of Surgeons - Clinical Effectiveness Unit	The CRANE Database collects information about all children born with cleft lip and/or cleft palate in England, Wales and Northern Ireland.	✓	Continuous data collection	No publication date yet identified
Elective Surgery - National Patient Reported Outcomes Measures (PROMs) Programme	NHS Digital	This audit looks at patient reported outcome measures in NHS funded patients eligible for hip or knee replacement.	✓	Continuous data collection	No publication date yet identified
Emergency Medicine QIPs - Pain in Children (care in emergency departments)	Royal College of Emergency Medicine	The purpose of the Quality Improvement and Patient Safety Competencies (QIP) is to improve patient care by reducing pain and suffering, in a timely and effective manner through sufficient measurement to track change but with a rigorous focus on action to improve.	✓	Data collection October 2021 – October 2022	No publication date yet identified
Emergency Medicine QIPs- Consultant Sign Off (in emergency departments)	Royal College of Emergency Medicine	The purpose of this QIP is to improve patient safety and quality of care as well as workspace safety by collecting sufficient data to track change but with a rigorous focus on actions to improve.	✓	Data collection April 2022 – October 2022	No publication date yet identified
Falls and Fragility Fracture Audit Programme –	Royal College of Physicians	Fracture Liaison Services are the key secondary prevention	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
Fracture Liaison Service Database		service model to identify and prevent primary and secondary hip fractures. The audit has developed the Fracture Liaison Service Database to benchmark services and drive quality improvement.			
Falls and Fragility Fracture Audit Programme – National Audit of Inpatient Falls	Royal College of Physicians	The audit provides the first comprehensive data sets on the quality of falls prevention practice in acute hospitals.	✓	Continuous data collection	No publication date yet identified
Falls and Fragility Fracture Audit Programme – National hip Fracture Database	Royal College of Physicians	The audit measures quality of care for hip fracture patients, and has developed into a clinical governance and quality improvement platform.	✓	Continuous data collection	No publication date yet identified
Inflammatory Bowel Disease (IBD) Audit	IBD Registry	The audit aims to improve the quality and safety of care for IBD patients throughout the UK.	✓	Continuous data collection	Published report expected July 2022
Learning Disability Mortality Review Programme	NHS England	The audit aims to improve the health of people with a learning disability and reduce health inequalities.	✓	Continuous data collection	No publication date yet identified
Maternal, Newborn and Infant Clinical Outcome Review Programme	University of Oxford / MBRRACE-UK collaborative	The aim of the audit is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, new-born and infant health services.	✓	Continuous data collection	No publication date yet identified
National Adult Diabetes Audit – National Diabetes Core Audit	NHS Digital	National Diabetes Audit collects information on people with diabetes and whether they have received their annual care checks and achieved their treatment targets as set out by NICE guidelines.	✓	Continuous data collection	No publication date yet identified
National Adult Diabetes Audit – National Pregnancy in Diabetes Audit	NHS Digital	The audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant.	✓	Continuous data collection	No publication date yet identified
National Adult Diabetes Audit – National Diabetes	NHS Digital	Patients referred to specialist diabetes foot care services for an	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
Footcare Audit		expert assessment on a new diabetic foot ulcer.			
National Adult Diabetes Audit – National Inpatient Diabetes Audit	NHS Digital	The National Diabetes Inpatient Audit is an annual snapshot audit of diabetes inpatient care in England and Wales and is open to participation from hospitals with medical and surgical wards. The audit allows hospitals to benchmark hospital diabetes care and to prioritise improvements in service provision that will make a real difference to patients' experiences and outcomes.	✓	Continuous data collection	No publication date yet identified
National Asthma and COPD Audit Programme – Paediatric Asthma Secondary Care	Royal College of Physicians	The audit looks at the care children and young people with asthma get when they are admitted to hospital because of an asthma attack.	✓	Continuous data collection	No publication date yet identified
National Asthma and COPD Audit Programme – Adult Asthma Secondary Care	Royal College of Physicians	The audit looks at the care of people admitted to hospital adult services with asthma attacks.	✓	Continuous data collection	No publication date yet identified
National Asthma and COPD Audit Programme – COPD Secondary Care	Royal College of Physicians	The aim of the audit is to drive improvements in the quality of care and services provided for COPD patients.	✓	Continuous data collection	No publication date yet identified
National Asthma and COPD Audit Programme – Pulmonary Rehabilitation	Royal College of Physicians	This audit looks at the care people with COPD get in pulmonary rehabilitation services.	✓	Continuous data collection	No publication date yet identified
National Audit of Breast Cancer in Older People	Royal College of Surgeons	This audit evaluates the quality of care provided to women aged 70 years and older by breast cancer services in England and Wales.	✓	Continuous data collection	No publication date yet identified
National Audit of Cardiac Rehabilitation	University of York	The audit aims to support cardiovascular prevention and rehabilitation services to achieve the best possible outcomes for patients with cardiovascular disease, irrespective of where they live.	✓	Continuous data collection	Published report expected December 2022
National Audit of	NHS	The audit will prioritise		Continuous	No publication

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
Cardiovascular Disease (CVD)	Benchmarking Network	working with system partners to drive CVD quality improvement at individual GP, Primary Care Network (PCN), Clinical Commissioning Group (CCG) and Integrated Care System (ICS) level.	✓	data collection	date yet identified
National Audit of Care at the End of Life	NHS Benchmarking Network	The National Audit of Care at the End of Life is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales and Northern Ireland.	✓	100%	No publication date yet identified
National Audit of Pulmonary Hypertension	NHS Digital	The audit measures the quality of care provided to people referred to pulmonary hypertension services.	✓	Continuous data collection	Published report expected October 2022
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Royal College of Paediatrics and Child Health	The audit aims to address the care of children and young people with suspected epilepsy who receive a first paediatric assessment within acute, community and tertiary paediatric services.	✓	Continuous data collection	No publication date yet identified
National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre / Resuscitation Council UK	The project audits cardiac arrests attended to by in-hospital resuscitation teams.	✓	Continuous data collection	Published report expected March 2023
National Cardiac Audit Programme – Cardiac Rhythm Management	Barts Health NHS Trust	The audit aims to monitor the use of implantable devices and interventional procedures for management of cardiac rhythm disorders in UK hospitals.	✓	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme – Myocardial Ischaemia	Barts Health NHS Trust	The Myocardial Ischaemia National Audit Project was established in 1999 in	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
		response to the National Service Framework for Coronary Heart Disease, to examine the quality of management of heart attacks (Myocardial Infarction) in hospitals in England and Wales.			
National Cardiac Audit Programme – Adult Cardiac Surgery	Barts Health NHS Trust	This audit looks at heart operations. Details of who undertakes the operations, the general health of the patients, the nature and outcome of the operation, particularly mortality rates in relation to preoperative risk and major complications.	✓	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme – Percutaneous Coronary Interventions(PCI)	Barts Health NHS Trust	The audit collects and analyses data on the nature and outcome of PCI procedures, who performs them and the general health of patients. The audit utilises the Central Cardiac Audit Database, which has developed secure data collection, analysis and monitoring tools and provides a common infrastructure for all the coronary heart disease audits.	✓	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme – Heart Failure	Barts Health NHS Trust	The aim of this project is to improve the quality of care for patients with heart failure through continual audit and to support the implementation of the national service framework for coronary heart disease.	✓	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme – Congenital Heart Disease in Children and Adults	Barts Health NHS Trust	The congenital heart disease website profiles every congenital heart disease centre in the UK, including the number and range of procedures they carry out and survival rates for the most common types of treatment.	✓	Continuous data collection	No publication date yet identified
National Child Mortality Database	University of Bristol	The National Child Mortality Database	✓	Continuous data	No publication date yet

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
		collates information nationally to ensure that deaths are learned from, that learning is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die.		collection	identified
National Comparative Audit of Blood Transfusion – 2021 Audit of Patient Blood Management (PBM) & NICE Guidelines	NHS Blood and Transplant	This audit aims to provide understanding of how to implement PBM and to measure their effectiveness in improving patient care.	✓	100%	Published February 2022. Action plan developed
National Early Inflammatory Arthritis Audit	British Society of Rheumatology	The audit aims to improve the quality of care for people living with inflammatory arthritis.	✓	Continuous data collection	No publication date yet identified
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	NELA aims to look at structure, process and outcome measures for the quality of care received by patients undergoing emergency laparotomy.	✓	Continuous data collection	No publication date yet identified
National Gastro-intestinal Cancer Programme – National Oesophago-gastric Cancer	NHS Digital	The audit aims to evaluate the quality of care received by patients with oesophago-gastric cancer in England and Wales.	✓	Continuous data collection	No publication date yet identified
National Gastro-intestinal Cancer Programme – National Bowel Cancer Audit (NBOCA)	NHS Digital	The NBOCA collects data on items that have been identified and accepted as good measures of clinical care. It compares regional variation in outcomes between English cancer alliances and Wales as a nation. It also compares local variation between English NHS trusts or hospitals, and Welsh MDTs.	✓	Continuous data collection	No publication date yet identified
National Joint Registry	Healthcare Quality Improvement Partnership	The audit covers clinical audit during the previous calendar year and outcomes including survivorship, mortality and length of stay.	✓	Continuous data collection	Published report expected September 2022
National Lung Cancer Audit	Royal College of Physicians	The audit was set up to monitor the introduction	✓	Continuous data	No publication date yet

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
		and effectiveness of cancer services.		collection	identified
National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists	A large scale audit of NHS maternity services across England, Scotland and Wales, collecting data on all registrable births delivered under NHS care.	✓	100%	No publication date yet identified
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health	To assess whether babies requiring specialist neonatal care receive consistent high quality care and identify areas for improvement in relation to service delivery and the outcomes of care.	✓	Continuous data collection	No publication date yet identified
National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health	The audit covers registrations, complications, care process and treatment targets.	✓	Continuous data collection	No publication date yet identified
National Perinatal Mortality Review Tool (PMRT)	University of Oxford / MBRRACE-UK collaborative	The aim of the PMRT programme is introduce the PMRT to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales.	✓	Continuous data collection	No publication date yet identified
National Prostate Cancer Audit	Royal College of Surgeons	The National Prostate Cancer Audit is the first national clinical audit of the care that men receive following a diagnosis of prostate cancer.	✓	Continuous data collection	No publication date yet identified
National Vascular Registry	Royal College of Surgeons	The National Vascular Registry collects data on all patients undergoing major vascular surgery in NHS hospitals in the UK.	✓	Continuous data collection	No publication date yet identified
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	This audit looks at all elective and emergency neurosurgical activity in order to provide a consistent and meaningful approach to reporting on national clinical audit and outcomes data.	✓	Continuous data collection	No publication date yet identified
Paediatric Intensive Care Audit (PICANet)	University of Leeds / University of	PICANet aims to continually support the improvement of	✓	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
	Leicester	paediatric intensive care provision throughout the UK by providing detailed information on paediatric intensive care activity and outcomes.			
Respiratory Audits – National Outpatient Management of Pulmonary Embolism	British Thoracic Society (BTS)	The BTS Audit of Outpatient Pulmonary Embolism Management in the UK seeks to identify where improvements can be made in this area to align practice to BTS Quality Standards and other guidance.	✓	100%	No publication date yet identified
Respiratory Audits – National Smoking Cessation Audit	British Thoracic Society	The aim of the BTS audit programme is to drive improvements in the quality of care and services for patients with respiratory conditions across the UK.	✓	100%	No publication date yet identified
Sentinel Stroke National Audit Programme	Kings College London	The audit collects data on all patients with a primary diagnosis of stroke, including any patients not on a stroke ward. Each incidence of new stroke is collected.	✓	Continuous data collection	No publication date yet identified
Serious Hazards of Transfusion	Serious Hazards of Transfusion	The scheme collects and analyses anonymised information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the United Kingdom.	✓	Continuous data collection	No publication date yet identified
Society for Acute Medicine's Benchmarking Audit	Society for Acute Medicine	SAMBA is a national benchmark audit of acute medical care. The aim is to describe the severity of illness of acute medical patients presenting to Acute Medicine, the speed of their assessment, their pathway and progress at seven days after admission and to provide a comparison for each participating unit with the national	The Trust did not participate in the programme due to local resourcing issues.		

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2021/22	Percentage Data completion	Outcome
		average.			
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	BURST Collaborative / British Urology Researchers in Surgical Training	The aim of BURST Research Collaborative is to produce high impact multi-centre audit and research that can improve patient care.	✓	Data collection 3rd May 2021 – 3rd April 2022	No publication date yet identified
Trauma Audit and Research Network	Trauma Audit & Research Network	The audit aims to highlight areas where improvements could be made in either the prevention of injury or the process of care for injured patients.	✓	Continuous data collection	Major Trauma Dashboards (quarterly), Clinical Feedback reports (3 per year), PROMs reports (quarterly).
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	This audit looks at the care of people with a diagnosis of cystic fibrosis under the care of the NHS in the UK.	✓	Continuous data collection	Published report expected August 2022.
Urology Audits – Management of the Lower Ureter in Nephrouterectomy Audit	British Association of Urological Surgeons	This audit aims to determine which surgical technique offers the best cancer control in terms of survival and recurrence.	✓	100%	No publication date yet identified
Child Health Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	The audit aims to assess the quality of healthcare and stimulate improvement in safety and effectiveness.	✓	Data collection period TBC	No publication date yet identified
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	The audit aims to assess the quality of healthcare and stimulate improvement in safety and effectiveness.	✓	Data collection period TBC	No publication date yet identified

An additional 12 audits have been added to the list for inclusion in 2022/2023 Quality Account, only eight of these audits are relevant to services provided by the Trust. The audits include:

- Breast and Cosmetic Implant Registry
- Assessing for cognitive impairment in older people (Emergency Medicine QIPs)
- Muscle Invasive Bladder Cancer Audit
- National Ophthalmology Audit Database
- Perioperative Quality Improvement Programme
- National Acute Kidney Injury Audit
- Adult Respiratory Support Audit
- UK Parkinson's Audit.

The reports of national clinical audits were reviewed by the provider in 2021/2022 and the Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- The Trust has firmly embedded monitoring arrangements for national clinical audits with the identified lead clinician asked to complete an action plan and present this to the Clinical Audit and Guidelines Group
- On an annual basis the Group receives a report on the projects in which the Trust participates and requires the lead clinician of each audit programme to identify any potential risk, where there are concerns action plans will be monitored on a regular basis
- In addition, each Directorate is required to present an Annual Clinical Audit Report to the Clinical Audit and Guidelines Group detailing all audit activity undertaken both national and local. Clinicians are required to report all audit activity using the Trust's Clinical Effectiveness Register
- Clinical Directorates are asked to include national clinical audit as a substantive agenda item at their Clinical Governance meetings in particular, to review any areas required for improvement
- Compliance with National Confidential Enquiries is reported to the Clinical Outcomes and Effectiveness Group and exceptions subject to detailed scrutiny and monitored accordingly
- Non-compliance with recommendations from National Clinical Audit and National Confidential Enquiries are risk assessed and considered for inclusion on the local risk register.

The reports of 762 local audits were reviewed by the provider in 2021/2022 and the Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following action to improve the quality of health care provided:

- Each Clinical Directorate is required to present an Annual Clinical Audit Report to the Clinical Audit and Guidelines Group detailing all audit activity undertaken both national and local.
- Any areas of non-compliance with standards are risk assessed and escalated as appropriate to the Clinical Outcomes and Effectiveness Group.

INFORMATION ON PARTICIPATION IN CLINICAL RESEARCH

In the last year 11,703 participants were recruited to Clinical Trials provided or hosted by The Newcastle upon Tyne Hospital's NHS Foundation Trust of which 10,846 enrolled on to UK National Institute for Health and Care Research (NIHR) Clinical Research Network (CRN) portfolio studies. These wide-ranging studies included common conditions such as migraines and irritable bowel syndrome, to dosing the first patient in Europe as part of a rare disease clinical trial and using robotics to carry out knee replacements.

Since the pandemic started in March 2020, clinical research at Newcastle has recruited 1,743 participants to 64 COVID-19 studies, contributing towards the approval of COVID-19 vaccines and new treatments that reduce COVID-19 related mortality. Despite the challenges brought on by the pandemic, research continued to see the positive impact clinical trials can have on patients' lives and the role it plays in tackling some of our greatest health challenges. The Newcastle upon Tyne Hospitals NHS Foundation Trust commitment to clinical research is demonstrated in our Clinical Research Strategy 2021-2026,which sets out how research will build on its national and international reputation for research excellence, whilst continuing to make a difference to local people.

INFORMATION ON THE USE OF THE CQUIN FRAMEWORK

In response to the COVID-19 pandemic, NHS England suspended healthcare contracting and introduced an emergency finance regime. That finance regime included provision for the funding of all Trusts via a “block envelope” paid over to Trusts regardless of activity, performance or quality.

In previous years, a proportion of The Newcastle upon Tyne Hospital’s NHS Foundation Trust income had been conditional upon achieving quality improvement and innovation, through Commissioning for Quality Innovation (CQUIN) payment framework. For 2021/2022, that is not the case and the suspension of healthcare contract implies the suspension of CQUIN as well.

INFORMATION RELATING TO REGISTRATION WITH THE CARE QUALITY COMMISSION (CQC)

The Newcastle upon Tyne Hospital's NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'Registered without Conditions'. The Newcastle upon Tyne Hospital's NHS Foundation Trust has no conditions on registration. The Newcastle upon Tyne Hospital's NHS Foundation Trust is registered with the CQC to deliver care from nine separate locations and for 10 regulated activities.

The Care Quality Commission has not taken enforcement action against The Newcastle upon Tyne Hospital's NHS Foundation Trust during 2020/21.

The Newcastle upon Tyne Hospital's NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Newcastle upon Tyne Hospital's Foundation Trust received a full inspection of all services during January 2019. Following this inspection, Newcastle Hospitals was graded as 'Outstanding'.

Overall Trust Rating - Outstanding

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

INFORMATION ON THE QUALITY OF DATA

The Newcastle upon Tyne Hospital's NHS Foundation Trust submitted records during 2021/2022 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data:

Which included the patients valid NHS number was:

- 99.6% for admitted patient care;
- 99.8% for outpatient care;
- 99.0% for accident and emergency care.

Which included the patients valid General Medical Practice Code was:

- 100% for admitted patient care;
- 100% for outpatient care;
- 100% for accident and emergency care.

Clinical Coding Information

Score for 2021/2022 for Information Quality and Records Management, assessed using the Data Security & Protection (DSP) Toolkit.

Our annual Data Security and Protection Clinical Coding audit for diagnosis and treatment coding of inpatient activity demonstrated an excellent level of attainment and satisfies the requirements of the Data Security and Protection Toolkit Assessment.

200 episodes of care were audited, covering the following three specialties:

- Vascular Surgery
- Cardiothoracic Surgery
- COVID-19 Infection.

The level attained for Data Security Standard 1 Data Quality – Standards Exceeded.
The level attained for Data Security Standard 3 Training – Standard Exceeded.

Table shows the levels of attainment of coding of inpatient activity

	Levels of Attainment		
	Standards Met	Standards Exceeded	NUTH Level
Primary diagnosis	>=90%	>=95%	98.0%
Secondary diagnosis	>=80%	>=90%	98.5%
Primary procedure	>=90%	>=95%	99.1%
Secondary procedure	>=80%	>=90%	95.8%

It was noted that previous audit recommendations have been taken on board to achieve quality improvements and that the organisation should be highly commended on its clinical coding accuracy.

KEY NATIONAL PRIORITIES 2021/2022

The key national priorities are performance targets for the NHS which are determined by the Department of Health and Social Care and form part of the CQC Intelligent Monitoring Report. A wide range of measures are included and the Trust's performance against the key national priorities for 2021/2022 are detailed in the table below. Please note that changes in performance are in all likelihood due to the impact of COVID-19.

Operating and Compliance Framework Target	Target	Annual Performance 2020/2021	Annual Performance 2021/2022
Incidence of Clostridium (*C .difficile:* variance from plan)	No more than 98 cases	111	169
Incidence of MRSA Bacteraemia	Zero tolerance	1	0
All Cancer Two Week Wait	93%	62.5%	65.7%
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%	50.7%	32.2%
31-Day (Diagnosis To Treatment) Wait For First Treatment	96%	93.0%	90.6%
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%	89.1%	74.6%
31-Day Wait For Second Or Subsequent Treatment: Drug treatment	98%	96.4%	97.1%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy	94%	97.5%	97.3%
All cancers: 62-day wait for first treatment from: • urgent GP referral for suspected cancer	85%	76.3%	58.9%
All cancers: 62-day wait for first treatment from: • NHS Cancer Screening Service referral	90%	63.7%	77.0%
RTT – Referral to Treatment - Admitted Compliance	90%	67.3%	64.4%
RTT – Referral to Treatment - Non-Admitted Compliance	95%	78.9%	82.1%
RTT – Referral to Treatment - Incomplete Compliance	92%	65.5%	71.4%
Maximum 6-week wait for diagnostic procedures	99%	80.7%	80.6%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	95%	91.9%	86.23%
Cancelled operations – those not admitted within 28 days	Offered a date within 28 days of none clinical cancellation	93.41% (789 cancelled ops with 52 breaching 28 day target)	Cancelled due to COVID reinstated 2022/23
Maternity bookings within 12 weeks and 6 days	Not defined	88.4%	86.9%

Details on Hospital-level Mortality Indicator please refer to page 82.

Rationale for any failed targets in free text please note below:

Cancer Performance Targets**:** Referral numbers have increased following an initial decline impacting performance. Outpatient capacity has been reduced during COVID-19 specifically impacting on Dermatology and Colorectal with a significant backlog of

patients waiting for first appointments/investigations. This has had a major impact on 14 day and 62-day compliance.

Implementation of a teledermatology service has had a significant impact in reducing the backlog of patients and has been extended to cover all suspected skin cancers. Diagnostic pressures (radiology and endoscopy) remain the biggest challenge with demand exceeding capacity.

In Endoscopy nurse led triage was implemented and has steadily improved the position, and more recently additional nurses appointed to support the expansion of the Department along with a new electronic scheduling system.

In radiology a number of actions are being progressed.

- Provision on site of additional MRI staffed mobile units to support recovery – two scanners initially six months.
- Access to private sector imaging centres – outsourcing of appropriate scans CT/MRI.
- Utilisation of Phase 1 CDC Centre – MRI & CT.
- International recruitment of appropriate radiographic and sonographic staff – project initiated.
- Further recruitment of radiologist agreed.
- Outsourcing of reporting – additional provider to be available within next six weeks.
- Working with universities to increase numbers of undergraduate radiographers.

Within the 31 day standard theatre capacity has been a major factor specifically in Urology and Breast. Workforce issues spanning all disciplines (COVID-19 and general sickness) has impacted across all standards. All tumour groups have a cancer improvement plan to support recovery, improved performance and patient experience. These will be regularly reviewed via the Cancer Steering Group.

Referral to Treatment Targets: Throughout the pandemic national guidance has prevailed with infection control measures to maximise safe patient treatments. This continues to be adhered to. Throughout this time, cancer and high clinical priority patients remained the priority to be treated.

The patients on the waiting list continue to be prioritised by clinical need and longest waits. There is intense scrutiny on the longest waiting patients to schedule their treatment as soon as possible. The performance details of long waiters are discussed and reported at Board level. Additional capacity is being utilised in the Independent sector, and measures to redesign patient pathways are proving successful in reducing the long waiters and as a result will improve performance.

Emergency Department (ED) Target: Type 1 attendances have increased by 14.45% compared to 2019/2020 this is an increase of 57 patients per day. Understandably, admissions via ED have increased by 10.57% compared to the same time scale and this is an increase of 13 emergency admissions per day. This increase in the number of emergency admissions coupled with significant gaps in the ED medical and nursing rotas due to vacancies and sickness contributed to achieving 86% performance. NUTH is still one of the best performing ED's in the country.

CORE SET OF QUALITY INDICATORS

Data is compared nationally when available from the NHS Digital Indicator portal. Where national data is not available the Trust has reviewed our own internal data.

Measure	Data Source	Target	Value	2021/22		2020/21				2019/20				
1. The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust	NHS Digital Indicator Portal https://indicators.ic.nhs.uk/webview/	Band 2 "as expected"		Oct 20 – Sept 21 **NUTH Value:** 0.9606	Jul 20 - Jun 21 **NUTH Value:** 0.9369	Apr 20 - Mar 21 **NUTH Value:** 0.9678	Jan20 - Dec 20 **NUTH Value:** 0.9536	Oct 19 – Sept 20 **NUTH Value:** 0.9795	Jul 19 - Jun 20 **NUTH Value:** 0.9948	Apr 19 - Mar 20 **NUTH Value:** 0.9791	Jan19 - Dec 19 **NUTH Value:** 0.9700	Oct 18 - Sep 19 **NUTH Value:** 0.9556	Jul 18 - Jun 19 **NUTH Value:** 0.9555	Apr 18 - Mar 19 **NUTH Value:** 0.9644
				NUTH Band 2	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**	**NUTH Band 2**
			National Average	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
			Highest National	1.1909	1.2017	1.2010	1.1845	1.1795	1.2074	1.1997	1.1999	1.1877	1.1916	1.2058
			Lowest National	0.7132	0.7195	0.6908	0.7030	0.6869	0.6764	0.6851	0.6889	0.6979	0.6967	0.7069
2. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust	NHS Digital Indicator Portal https://indicators.ic.nhs.uk/webview/	N/A	Trust	44%	44%	43%	39%	35%	33%	32%	31%	32%	33%	33%
			National Average	39%	39%	38%	37%	36%	36%	37%	36%	36%	36%	35%
			Highest National	63%	64%	63%	61%	60%	60%	58%	60%	59%	60%	60%
			Lowest National	12%	11%	8%	8%	9%	9%	9%	10%	12%	15%	12%

Measure 1. The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust.

The Newcastle upon Tyne Hospital's NHS Foundation Trust considers that this data is as described for the following reasons:
The Trust continues to perform well on mortality indicators. Mortality reports are regularly presented to the Trust Board. Newcastle Hospitals has taken the following actions to improve this indicator, and so the quality of its services by closely monitoring mortality rates and conducting detailed investigations when rates increase. We continue to monitor and discuss mortality findings at the Quarterly Mortality Surveillance Group; representatives attend this group from multiple specialities and scrutinise Trust mortality data to ensure local learning and quality improvement. This group complements the departmental mortality and morbidity (M&M) meetings within each Directorate.

Measure 2. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust.

The Newcastle upon Tyne Hospital's NHS Foundation Trust considers that this data is as described for the following reasons:
The use of palliative care codes in the Trust has remained static and aligned to the national average percentage over recent years. Newcastle Hospitals continues to monitor the quality of its services, by involving the coding team and End of Life team in routine mortality reviews to ensure accuracy and consistency of palliative care coding. We continue to monitor and discuss patients with a palliative care coding at the quarterly Mortality Surveillance Group.

Measure	Value	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16	2014/15
5. The patient reported outcome measures scores (PROMS) for primary hip replacement surgery (adjusted average health gain – EQ5D)	Trust Score	**0.52**	**0.46**	**0.50**	**0.47**	**0.44**	**0.43**	**0.43**
	National average:	0.47	0.46	0.47	0.47	0.44	0.44	0.44
	Highest national:	0.57	0.54	0.56	0.57	0.54	0.51	0.52
	Lowest national:	0.39	0.35	0.35	0.38	0.31	0.32	0.33
6. The patient reported outcome measures scores (PROMS) for primary knee replacement surgery (adjusted average health gain – EQ5D)	Trust Score	**0.35**	**0.36**	**0.31**	**0.33**	**0.33**	**0.31**	**0.32**
	National average:	0.32	0.34	0.34	0.34	0.32	0.32	0.31
	Highest national:	0.40	0.42	0.41	0.42	0.40	0.40	0.42
	Lowest national:	0.18	0.22	0.27	0.23	0.24	0.20	0.20

Please note that finalised PROMs data is now available for 2020/2021. Finalised 2021/2022 data will not be available until September 2022.

Measure 3. The Patient Reported Outcome Measures scores (PROMS) for groin hernia surgery.

Collection of groin procedure scores ceased on October 1st 2017.

Measure 4. The Patient Reported Outcome Measures scores (PROMS) for varicose vein surgery.

Collection of varicose vein procedure scores ceased on October 1st 2017.

Measure 5. The Patient Reported Outcome Measures scores (PROMS) for hip replacement surgery.

The Newcastle upon Tyne Hospital's NHS Foundation Trust considers that this data is as described for the following reasons:
Newcastle Hospitals PROMS outcomes are good and we are committed to increasing our participation rates going forward. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty Multidisciplinary team (MDT). Data for 2021/2022 has not yet been released, but data for 2020/2021 has been populated.

Measure 6. The Patient Reported Outcome Measures scores (PROMS) for knee replacement surgery.

The Newcastle upon Tyne Hospital's NHS Foundation Trust considers that this data is as described for the following reasons:
Newcastle Hospitals PROMS outcomes are good and we are committed to increasing our participation rates going forward. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty MDT. Data for 2021/2022 has not yet been released, but data for 2020/2021 has been populated.

7a. Emergency readmissions to hospital within 28 days of discharge from hospital: Children of ages 0-14.

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
2012/2013	31,841	2,454	7.7
2013/2014	32,242	2,648	8.2
2014/2015	34,561	3,570	10.3
2015/2016	38,769	2,875	7.4
2016/2017	35,259	1,983	5.6
2017/2018	35,009	2,077	5.9
2018/2019	36,387	2,003	5.5
2019/2020	42,238	4,609	10.9
2020/2021	29,319	2,643	9.0
2021/2022	34,099	3,039	8.9

7b. Emergency readmissions to hospital within 28 days of being discharged aged 15+.

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
2012/2013	173,270	8,788	5.1
2013/2014	177,867	9,052	5.1
2014/2015	180,380	9,446	5.2
2015/2016	182,668	10,076	5.5
2016/2017	186,999	10,219	5.5
2017/2018	182,535	10,157	5.6
2018/2019	185,967	10,461	5.6
2019/2020	192,365	12,648	6.6
2020/2021	142,629	10,730	7.5
2021/2022	184,032	11,923	6.5

Measure 7. The percentage of patients aged— (i) 0 to 15; and (ii) 16 or over readmitted within 28 days of being discharged from hospital.

This indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review. Therefore, the Trust has reviewed its own internal data and used its own methodology of reporting readmissions within 28 days (without Payment by Results exclusions). Newcastle Hospitals considers that this data is as described for the following reasons: The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement.

The Newcastle upon Tyne Hospital's NHS Foundation Trust intends to take the following actions to improve this indicator, and so the quality of its services, by continuing with the use of an electronic system.

Measure	Data Source	Value	2021/22*	2020/21	2019/20	2018/19	2017/18	2016/17
8. The trust's responsiveness to the personal needs of its patients	NHS Information Centre Portal https://indicators.ic.nhs.uk/	Trust percentage	Not available	77.7%	72.6%	73.1%	74.9%	74.6%
		National Average:	Not available	74.5%	67.1%	67.2%	68.6%	68.1%
		Highest National:	Not available	85.4%	84.2%	85.0%	85.0%	85.2%

		Lowest National:	Not available	67.3%	59.5%	58.9%	60.5%	60.0%
9. NB 2021 question changed to "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation" .	http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/Results/	Trust percentage	85.4%	91.3%	90%	90%	96%	95%
		National Average:	66.9%	74.3%	71%	70%	81%	80%
		Highest National:	89.5%	91.7%	95%	95%	100%	100%
		Lowest National:	43.6%	49.7%	36%	33%	43%	44%

Measure 8. The Trust's responsiveness to the personal needs of its patients.

The Newcastle upon Tyne Hospital's NHS Foundation Trust considers that this data is as described for the following reasons:
This measure uses the results of a selection of five questions from the National Inpatient Survey focussing on the responsiveness to personal needs. Consultation feedback indicated that personalisation and service responsiveness are important issues for inpatients. This indicator aims to capture inpatients' experience of this.
The historical data shows that the Trust consistently scores above the national average. As of the 2020/2021 survey, changes have been made to the working of the five questions used in this indicator as well as changes to the scoring regime. As a result, 2020/2021 results are not comparable with those of previous years.

The data shows that the Trust scores above the national average. Newcastle Hospitals intends to take the following actions to improve this indicator, and so the quality of its services, by continuing to implement processes to capture patient experience and improve its services. Data for 2021/2022 has not yet been released, but data for 2020/2021 published on March 17th 2022 has been populated.

Measure 9. The percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends changed to "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation" for 2021/2022 survey.

The Newcastle upon Tyne Hospital's NHS Foundation Trust considers that this data is as described for the following reasons:
The Trust score is well above the National average. Newcastle Hospitals has taken the following actions to improve this percentage, and so the quality of its services, by continuing to listen to and act on all sources of staff feedback. Data for 2019/2020 has been added as it was not available at time of publication last year.

Measure 10. The percentage of patients that were admitted to hospital who were risk assessed for Venous thromboembolism (VTE)

Due to COVID-19 National data collection has ceased and is not expected to resume until June 2022.

Measure	Data Source	Target	2021/22	2020/21	2019/20	2018/19
11. The number of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over	PHE Data Capture System	Trust number of cases	169 HOHA* = 135 COHA* = 34 (no appeals process this financial year)	111 HOHA* = 85 COHA* = 26 (no appeals process this financial year)	113 HOHA* = 95 COHA* = 18 National figure 89 (minus 24 successful appeals**)	77 National figure 48 (minus 29 successful appeals)
		National Average number of cases	HOHA* = 28 COHA* = 11	HOHA* = 23 COHA* = 10	HOHA* = 25 COHA* = 12	31
		Highest National number of cases	HOHA* = 185 COHA* = 76	HOHA* = 151 COHA* = 60	HOHA* = 163 COHA* = 77	130
		Lowest National number of cases	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	0

*HOHA = Hospital Onset – Healthcare Associated
*COHA = Community Onset – Healthcare Associated

Measure 11.The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over

The Newcastle upon Tyne Hospital's NHS Foundation Trust considers that this data is as described for the following reasons:
The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement. Newcastle Hospitals has taken the following actions to improve this rate, and so the quality of its services by having a robust strategy; Quarterly HCAI Report to share lessons learned and best practice from Serious Infection Review Meetings (see page 46).

Measure	Data Source	Target	2021/22	2020/21	2019/20		2018/19	
12. The number and rate per 100 admissions of patient safety incidents reported *NB: Changed to rate per 1000 bed days April 2014*	NHS Information Centre Portal https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/	Trust no.	April 2021 – March 2022 18440	April 2020 - March 2021 17915	Oct 2019-March 2020 9319	Oct 2018-March 2019 9707	Oct 2018-March 2019 9707	April-2018 Sept 2018 8661
		Trust %	37.5	50.3	41.5	39.8	39.8	38.3
		National Average	Not available	58.4	49.1	44.7	44.7	44.52
		Highest National	Not available	118.7	110.2	95.9	95.9	107.4
		Lowest National	Not available	27.2	15.7	16.9	16.9	13.1

Measure	Data Source	Target	2021/22		2020/21		2019/20			
13. The number and percentage of patient safety incidents that resulted in severe harm or death	NHS Information Centre Portal https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/	Trust no.	April-2021 March 2022 **Severe Harm** 85	April-2021 March 2022 **Death** 50	April 2020 - Mar 2021 **Severe Harm** 72	April 2020-Mar 2021 **Death** 49	Oct 2019-Mar 2020 **Severe Harm** 29	Oct 2019-Mar 2020 **Death** 5	April-2019 Sept 2019 **Severe Harm** 14	April-2019 Sept 2019 **Death** 4
		Trust %	0.5%	0.3%	0.3%	0.2%	0.3%	0.1%	0.2%	0.0%
		National Average	Not available	Not available	0.2%	0.2%	0.2%	0.1%	0.15%	0.04%
		Highest National	Not available	Not available	1%	1.3%	0.8%	0.6%	0.23%	0.08%
		Lowest National	Not available	Not available	0.0%	0.0%	0.0%	0.0%	1.22%	0.66%

Measure 12. The number and rate of patient safety incidents reported

The Newcastle upon Tyne Hospital NHS Foundation Trust considers that this data is as described for the following reasons:
The Trust takes the reporting of incidents very seriously and have an electronic reporting system (Datix) to support this. Newcastle Hospitals has taken the following actions to improve this number and rate, and so the quality of its services, by undertaking a campaign to increase awareness of incident/near misses reporting. Incidents are graded, analysed and, where required, undergo an investigation using a systems approach to inform actions, recommendations and learning. Incident data is reported to the Quality Committee to inform our organisational learning themes which are reported to the Board. From 2020/2021 the data is now reported annually, previously this was published bi-annually. The 2020/2021 data has now been updated where it was not available last year. The national data for 2021/22 is due for release in September 2022. 2021/2022 Trust data has been compared with all other organisations described as Acute Trusts in National Reporting and Learning System (NRLS).

Measure 13. The number and percentage of patient safety incidents that resulted in severe harm or death

The Newcastle upon Tyne Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:
The Trust takes incidents resulting in severe harm of death very seriously. The rate of incidents resulting in severe harm or death is consistent with the national average. This reflects a culture of reporting incidents which lead to, or have the potential to, cause serious harm or death. Newcastle Hospitals has taken the following actions to reduce this number and rate, and so the quality of its services, by the Board receiving monthly reports of incidents resulting in severe harm of death. From 2020/2021 the data is now reported annually, previously this was published bi-annually. The 2020/2021 data has now been updated where it was not available last year. The national data for 2021/2022 is due for release in September 2022. 2021/2022 Trust data has been compared with all other Organisations described as Acute Trusts in National Reporting and Learning System (NRLS).

WORKFORCE FACTORS

The tables below provide data on the loss of work days. The table directly below reports on the Trust and Regional position rate (data taken from the NHS Information Centre) and the next table provides an update on the Trust number of staff sick days lost to industrial injury or illness caused by work.

This table shows the loss of work days (rate).

	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
The Newcastle Upon Tyne Hospitals	5.10%	5.51%	4.76%	4.16%	4.32%	4.62%	4.76%	5.70%	5.77%	5.99%	6.51%	6.34%
South Tyneside and Sunderland	5.87%	5.88%	5.50%	4.65%	5.39%	5.78%	6.19%	6.41%	6.59%	7.15%	7.24%	7.25%
County Durham and Darlington	6.78%	7.22%	6.05%	5.06%	5.04%	5.44%	5.81%	6.21%	6.14%	6.95%	7.00%	6.56%
Gateshead Health	5.19%	4.96%	4.42%	4.34%	4.32%	4.60%	5.06%	5.70%	5.61%	6.06%	6.48%	5.89%
North Tees and Hartlepool	7.09%	7.07%	5.80%	5.09%	5.08%	5.52%	5.85%	6.16%	6.25%	6.42%	6.80%	6.50%
Northumbria Healthcare	5.49%	5.89%	5.21%	4.53%	4.77%	4.77%	5.08%	5.46%	5.99%	5.92%	6.01%	5.99%
South Tees Hospitals	5.59%	5.99%	5.25%	4.32%	4.28%	4.62%	5.23%	6.01%	5.99%	6.16%	6.69%	6.61%
England	5.09%	5.75%	4.65%	3.99%	4.06%	4.34%	4.63%	5.07%	5.14%	5.38%	5.66%	5.59%

The table below shows the number of staff sick days lost to industrial injury or illness caused by work.

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year Total
2010/11 no. of days	118	254	267	366	1005
2011/12 no. of days	253	299	247	153	952
2012/13 no. of days	154	138	174	209	675
2013/14 no. of days	489	331	785	147	1752
2014/15 no. of days	333	284	178	206	1001
2015/16 no. of days	360	194	365	219	1138
2016/17 no. of days	230	387	136	84	837
2017/18 no. of days	137	90	51	122	400
2018/19 no. of days	214	131	188	326	859
2019/20 no. of days	249	172	67	123	611
2020/21 no. of days	65	61	335	212	673
2021/22 no. of days	372	539	446	Not available	Not available

2021 NHS STAFF SURVEY RESULTS SUMMARY

The last couple of years have been exceptionally difficult for everyone working in the NHS. Now, more than ever, it is important to hear what colleagues think about working for us to help improve their working lives. A full census survey was sent via email to all employees of the Trust (via external post for those on maternity leave), giving all 16,071 members of our staff a voice. 7,336 staff participated in the survey, equalling a response rate of 46%, which is aligned to the sector average and was the largest number of respondents received when compared to other organisations in the region.

Providing the highest standard of care has always been our priority even more so during the pandemic and we know how important this is to all of our staff here at Newcastle. We were particularly proud to score higher than the national average (by 18.5%) when asked “If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.”

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the **People Promise,** the biggest re-design in over ten years. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:

- **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.**

Alongside the People Promise are two main themes**:**

- **Staff Engagement**
- **Morale.**

The reporting also includes new sub-scores, which feed into the People Promise elements and themes.

The Staff Engagement score is measured across three sub-themes:

- Advocacy: 7.5 out of 10, measured by Q21a, Q21c and Q21d (Staff recommendation of the trust as a place to work or receive treatment)
- Motivation: 6.8 out of 10, measured by Q2a, Q2b and Q2c (Staff motivation at work)
- Involvement: 6.6 out of 10, measured by Q3c, Q3d and Q3f (Staff ability to contribute towards improvement at work).

At The Newcastle upon Tyne Hospital’s NHS Foundation Trust Newcastle this score was:
Overall: rating of **staff engagement** 6.9 (out of possible 10).
This score was 0.5 below top position and 0.6 above worst position in the sector (Combined Acute & Community Trusts). It sits above sector average by 0.1.

Including Staff engagement, the Trust scored better on five of the nine people promises / themes when compared with 126 other Combined Acute & Community Trusts in England.

We are compassionate and inclusive
NuTH Score: 7.3 out of 10
Sector Score: 7.2 out of 10

We each have a voice that counts
NuTH Score: 6.8 out of 10
Sector Score: 6.7 out of 10

We are safe and healthy
NuTH Score: 6.0 out of 10
Sector Score: 5.9 out of 10

Morale
NuTH Score: 5.9 out of 10
Sector Score: 5.7 out of 10

The Trust scored equal to the sector in two of the people promises, which included:

We are always learning
NuTH Score: 5.2 out of 10
Sector Score: 5.2 out of 10

We are recognised and rewarded
NuTH Score: 5.8 out of 10
Sector Score: 5.8 out of 10

The Trust fell slightly behind sector average on two of the people promises, which included:
We work flexibly
NuTH Score: 5.6 out of 10
Sector Score: 5.9 out of 10

We are a team
NuTH Score: 6.4 out of 10
Sector Score: 6.6 out of 10

Additionally, the Trust scored favourably in a number of the questions in the survey. Some to note include:

- 90% feel trusted to do their job
- 86% feel their role makes a difference to patients
- 76% feel secure raising concerns about unsafe clinical practice. 2.5% increase from 2020
- 65% would recommend Newcastle Hospitals as a place to work. 6.6% higher than the sector average
- 80.9% enjoy working with the colleagues in our teams
- 69.1% believe the people we work with are understanding and kind to one another

- 70.0% think that people we work with are polite and treat each other with respect, 0.5% higher than sector average
- 71.7% of our staff believe our organisation respects individual differences, meaning we are 2.9% above the sector average.

There is unfortunately a national picture of staff experiencing burnout, which is no surprise, given the unprecedented demand over the last couple of years. Overall, the latest results show that we are in line with responses from other similar NHS organisations.

Ensuring that the voices of our staff continue to be heard continues to be a priority, and these survey results provide more depth to our understanding of the issues affecting staff and we will incorporate these findings into our ‘What Matters to You’ programme.

The issues highlighted in the staff survey are very much in line with the feedback given through ‘What Matters to You’ including flexible working and compassionate leadership. We are committed to building on improvements in these areas.

INVOLVEMENT AND ENGAGEMENT 2022/2023

Patients, staff and members of the public are at the heart of The Newcastle upon Tyne Hospital's NHS Foundation Trust values and ambitions, which helps to ensure we deliver the best care for everyone. By actively engaging and listening to people who use and care about our services, we can understand what matters most to them and at the same time respond to the diverse health and care needs of our patients

We want to embed engagement and involvement in everything we do and there are already many positive examples of the difference this has already made across the Trust. This includes having a range of supportive and effective mechanisms to feed back about services as well as systems and structures to ensure this experience is listened to, learnt from and acted upon to improve the services we provide to our patients. We want to build upon our progress to date and spread this good practice.

The Newcastle upon Tyne Hospital's NHS Foundation Trust has rapidly adapted to ensure we are able to actively involve and listen to our patients and local communities. The Advising on the Patient Experience (APEX), Young Persons Advisory Group (YPAGne), Maternity Voice Partnership (MVP) and Equality, Diversity and Humans Rights working group have continued to meet virtually, providing a sustainable and strong model of engagement with a diverse range of people.

The Newcastle upon Tyne Hospital's NHS Foundation Trust continues to have a good relationship with, and works in partnership with local communities and voluntary groups in order to ensure that equal and diverse opportunities are promoted to all. This year, we have worked with Deaflink, to develop the health navigator service which we hope to launch in the Spring.

In 2022/2023 the focus will be:

- Continue to work in partnership with local communities and voluntary groups
- Development of a Patient Experience Strategy
- Launch of the Deaf Health Navigator Project
- Improve our use of existing sources of feedback to inform continuous improvement and service transformation.
- Improve the health, wealth and wellbeing of our local population and reduce health inequalities through prevention, earlier diagnosis and by delivering outstanding care and treatment. The five priorities to enable this are:
  - Restore NHS services inclusively
  - Develop digitally-enabled pathways inclusively
  - Ensure datasets are complete & timely
  - Proactively engage people at greatest risk in prevention
  - Strengthen leadership & accountability.

The North East and North Cumbria (NENC) Integrated Care System (ICS) 5 year strategic plan includes the following key ambitions:

a) To raise average healthy life expectancy for men and women to 60.0 years by 2029;
b) To half the gap in average healthy life expectancy for both men and women between the NENC ICS and the England average by 2029; and
c) To reduce smoking prevalence to 5% or below by 2030.

The Trust is delivering on this work through both Collaborative Newcastle and internally through the appointment of a Health Inequalities Executive lead. The creation of a Health Inequalities Group (HIG) (diverse membership of clinicians, managers, support staff, together with experts with a deep knowledge of health inequalities from Newcastle City Council, Newcastle University, primary care and the local voluntary and community sector) which meets monthly and reports to the Executive team. This group utilises The NHS Providers Health Inequalities Board Assurance Toolkit and The NHS Health Inequalities Toolkit for Acute Foundation Trusts to develop a clear work programme and target investments.

In strengthening, the Trust's approach to tackle Health Inequalities the Trust has;

- Introduced a nationally innovative model of medical leadership for health inequalities, with the appointment of two co-clinical directors and three clinical leads. Their initial focus is on understanding health inequalities in patients' access, outcomes and experience and providing advice, education, and networking to enable the wider clinician body to embed a culture of tackling health inequalities in all aspects of work.
- In addition, a consultant in public health, has become part of the Chief Operating Officer directorate and is responsible for coordinating the HIG work plan and providing population health management advice across the Trust.

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. The COVID-19 pandemic has exacerbated existing health inequalities. There are marked differences in life expectancy between deprived and non-deprived areas but also among people living in more deprived areas. Newcastle is one of the 20% most deprived Local Authorities in England. Smoking is the principle driver of health inequalities and premature death.

Significant progress has been made in enhancing our existing range of prevention activities such as breast screening and targeted lung health checks with the following new developments:

- **Smoke Free NHS and the Trust Tobacco Dependency Treatment Service:** The Trust is establishing an onsite Tobacco Dependency Treatment Service for inpatients and maternity patients, supported by funding from NHS England and the ICS. The funding covers pharmacotherapy and staffing support to patients. The service will be provided in partnership with the local 'Healthworks' charity and delivered in conjunction with the Local Authority Commissioned stop smoking service. Five clinical Smoke Free Leads have been identified from across medical specialities and nursing to provide strategic support to the service. The Trust has agreed to take part in the Applied Research Collaborative /NIHR evaluation research project of the implementation and impact of NHS-funded tobacco dependence services.

- **Alcohol Care Team and recovery navigators in Emergency Department**: Similarly, the Trust has secured funding to implement an Alcohol Care Team (ACT) as part of the wider substance misuse team. The ACT is a rapidly expanding team supporting patients with Alcohol related liver disease working with them proactively to avoid lengthy admissions and providing support to the family/carers. Based in the emergency department they will provide early intervention of managing withdrawal and referring to community services and

give harm minimisation advice to reduce the length of stay or avoid an admission. An ICS funded research project will assess the impact of Recovery Navigators, based in hospitals, at supporting the needs of people who experience problems with alcohol and regularly seek emergency help.

- **COVID-19 Vaccination:** The Trust continues to lead the COVID Vaccine programme for the North East and North Cumbria with a significant focus on supporting local place based NHS and local authority teams to continue the implementation of plans to reduce inequality in uptake by ethnicity and deprivation. The NENC COVID Vaccination Equality Board is ensuring that interventions are data driven (e.g. in determining locations of community sites) and spreading best practice.

In addition to the direct impact we can have within the Trust to reduce health inequalities, we recognise that the greatest impact we can have is in working as a wider Newcastle place based system in addressing the wider determinants of health inequalities through Collaborative Newcastle. During the last six months, progress on these elements includes:

- **Duplication to Personalisation Programme:** This innovative programme has been established to collate and analyse health and care data for every person in Newcastle to help identify people whose care could be improved, and to re-design and improve services to reduce health inequalities.

- **Children and Families Newcastle**: This is an integrated provision of early intervention and prevention services across the city. It aims to; identify issues before crisis, ensure a smooth journey through services where children and families ‘only need to tell their story once’, recognise and build on community assets and reduce health inequalities.

- **Newcastle Hospitals and primary care pre-operative optimisation of patients with uncontrolled diabetes**: This innovative project is linking hospital waiting lists and primary care GP records to identify patients with uncontrolled diabetes on the elective surgery waiting lists and offer patients a personalised intervention plan. Delivered in partnership with three Primary Care Networks in Newcastle, patients are offered support from a Healthworks health improvement practitioner with the aim to increase exercise and improve diet potentially leading to improvements in their diabetic control.

Our work is demonstrating the huge potential of linking datasets and having the public health and analytical expertise to implement projects informed by a population health management approach. Opportunities to resource and develop this further are being explored including through Newcastle Health Innovation Partners.

ANNEX 1:

STATEMENT ON BEHALF OF THE NEWCASTLE HEALTH SCRUTINY COMMITTEE

17 May 2022

As Chair of the Health Scrutiny Committee, I welcome the opportunity to comment on your draft Quality Account for 2021/22, which we discussed at our meeting on 21 April 2022.

We recognise the importance of the Quality Account as a tool in ensuring that services are reviewed objectively and as a means of illustrating to patients, carers and partners the performance of the trust in relation to your quality priorities.

In relation to progress against your 2021/22 priorities:

- We are pleased to see that significant progress has been made in reducing incidence of community acquired pressure ulcers following an increase in this during the pandemic, and we hope to see this downward trend continue into the next year.

- We are concerned to see that there has been a 58% increase in C.difficile infections from the previous year. We note the link between this and increased use of antibiotics, alongside the suspension of multidisciplinary post infection review meetings during the pandemic and cessation of antimicrobial audits whilst a new reporting platform was being implemented. We are pleased to learn that this work is now recommencing, and that reduction of C.difficile infections is to remain a priority for 2022/23, and we hope to see progress against this in next year's report.

- We are pleased to learn more about the success of the Cataract Centre and the positive impact it is already having on both patient waiting times and patient experience, although the ambition of zero waiting times has not yet been achieved. We note that lessons learned from the success of the facility and processes that have been put in place around it are to be shared across the wider system, and we look forward to seeing more about that the impact of that in next year's report.

- We are pleased to lean that there has now been a complete transition to electronic ordering and results management, making results accessible in a much more timely manner and enabling information to be more easily shared between GPs and clinicians. We note that there is still some work to do with regards to staff engagement with the system, and that there are some areas of the system which require further improvement to make them more efficient. We hope to see further updates on this in future.

- We are pleased to hear that patient feedback on virtual care services has been positive and welcome the innovative work that is continuing to take place around this.

- We note that although there has been an increase in complaints compared to the previous year, this is in the context of there having been a large reduction in

complaints during the pandemic when public appreciation for the NHS was high and fewer patients were accessing services. We are reassured to learn that current complaint levels are comparable with those seen pre-pandemic and that the Trust compares well against other organisations of a similar size on this measure.

In relation to the 2022/23 priorities, we believe the document is a fair and accurate representation of the services provided by the trust and reflects the areas that are of high importance to Newcastle residents.

In relation to the Covid-19 pandemic we acknowledge the continuing significant impact that this is having on health care services.

- We note that staff absence has been high, in large part due to Covid, and that this has placed considerable pressure both on the workforce and on services. We are pleased to hear that investment in the physical, mental and financial wellbeing of staff is continuing.

- We are concerned that although there are now fewer patients with Covid in Newcastle hospitals, there are an increasing number of people presenting at A&E and an increased length of stay in hospital, both of which are putting pressure on the flow of patients through the system and impacting on the capacity to deliver elective services, with some patients currently waiting up to two years for operations. We note that mechanisms are in place to monitor this, and we hope to see an improvement in elective treatment waiting times in next year's report.

- We note that as part of the work towards recovery from Covid a workstream has been set up around outpatient transformation. We welcome the continuation of work to allow patients to access care virtually and reduce waiting times and the construction of a new day treatment centre scheduled to open in September of this year, and we look forward to hearing further updates on this area of work.

Finally, I would like to acknowledge and give thanks for the ongoing and open dialogue that the Trust has established with us over the past few years, and which has been particularly valuable during the pandemic. We look forward to seeing this continue.

Yours sincerely

Cllr Wendy Taylor
Chair, Health Scrutiny Committee

STATEMENT ON BEHALF OF NORTHUMBERLAND COUNTY COUNCIL

Northumberland
County Council

The Health and Wellbeing Overview and Scrutiny Committee (OSC) welcomes the opportunity to submit a commentary for inclusion in your Annual Plan and Quality Account for 2022/23.
The Committee always welcomes your attendance and input at their meetings and believe it is vital to effective scrutiny.

The Committee would like to first express their thanks to all the staff, both clinical and non- clinical, for the extraordinary work they have continued to do over the last year.

Over the last two meetings, our committee has heard the quality accounts from other local NHS trusts. Considering the accounts of our local NHS services together provides the committee with a holistic picture of the NHS services in Northumberland and their priorities.

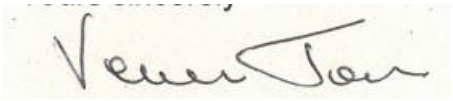
Following receipt of your Annual Quality Account 2021/22 and future priorities for 2022/23 the Committee would like to thank you for the comprehensiveness of this account. The Committee welcomed:

- The commitment to delivering local care for learning disabilities where appropriate.
- The continued work undertaken to support young people with mental health difficulties and their families. Members were pleased to hear about the We Can Talk project and the initiatives that have come from this project.
- The input from HealthWatch Northumberland and their suggestion of more localised communication and reflection of the Northumberland experience within the Quality Accounts.

We would also appreciate it if we could diarise when you will attend to give next year's equivalent Quality Account and future priorities presentation. I would be very grateful if you could confirm whether the OSC's meeting on Tuesday 2 May 2023 (beginning at 1.00pm) would be suitable please?

If I can be of any further assistance regarding the Committee's response, please do not hesitate to contact me.

Yours sincerely,



Councillor Veronica Jones
Chair of Health and Wellbeing Overview and Scrutiny Committee

STATEMENT ON BEHALF OF THE NEWCASTLE & GATESHEAD CLINICAL COMMISSIONING GROUP ALLIANCE

NHS Newcastle Gateshead Clinical Commissioning Group

NHS Northumberland Clinical Commissioning Group

NHS North Tyneside Clinical Commissioning Group

The Clinical Commissioning Groups (CCGs) welcome the opportunity to review and comment on the Annual Quality Account for the Newcastle Upon Tyne Hospitals NHS Foundation Trust for 2021/22 and would like to offer the following commentary:

As commissioners, Newcastle Gateshead, Northumberland and North Tyneside Clinical Commissioning Groups (CCGs) are committed to commissioning high quality services from the Newcastle Upon Tyne Hospitals NHS Foundation Trust. They take seriously their responsibility to ensure that patients' needs are met by the provision of safe, high quality services and that the views and expectations of patients and the public are listened to and acted upon.

Firstly, the CCGs acknowledge that 2021/22 has again been an extremely difficult year for the Trust and the entire NHS due to the unprecedented challenges of the pandemic. The CCGs would like to commend the Trust and all its staff for their exceptional response to the pandemic, for rapidly adapting and transforming services whilst delivering a wide range of pathways improvements to ensure that patient care continued to be delivered to a very high standard.

It is acknowledged that the pandemic has had a significant impact on the backlog of work and consequently increasing waiting times, which inevitably will have had an impact on patient experience and outcomes. The commissioners will continue to work collaboratively with the Trust to support and ensure delivery of the elective recovery programme as the NHS learns to live with COVID-19. We fully recognise the important work the Trust has undertaken, working in collaboration with other NHS organisations, CCGs and partner agencies to deliver a system wide approach to maintain the quality of commissioned services and improve the health outcomes for the local population.

The CCGs have remained sighted on the Trust's priorities for improving the quality of its services for its patients and have continued to provide robust challenge and scrutiny through the Quality Review Group (QRG) meetings. Due to social distancing restrictions, these meetings continued to be held on a virtual basis during 2021/22 which created significant efficiencies in terms of staff time and continued the improved attendance at meetings seen in 2020/21. QRG meetings are a helpful and constructive forum for discussing and reviewing quality issues and it is hoped this collaborative working relationship will continue as an integral part of the new Integrated Care Board (ICB) arrangements.

The Trust's quality account provides an open, transparent and comprehensive description of the improvement work undertaken. The CCGs welcome that quality remains a top priority for 2022/23.

The CCGs recognise the continuing initiatives to reduce health care acquired infections (HCAI) however it is noted that the Trust unfortunately did not achieve their internal aims in the reduction of C.Difficile, MSSA, E.Coli, Klebsiella or Pseudomonas

Aeruginosa bacteraemias, with increases recorded against each infection. However, it is encouraging to note there has been no cases of MRSA bacteraemias reported since April 2020 and the Trust remained within the national threshold for E.Coli, Klebsiella and Pseudomonas Aeruginosa bacteraemias. The 58% increase in C.Difficile cases is a particular concern however the CCGs acknowledge the reasons for this increase was multifactorial and are assured by the plans in place to restart the monitoring and management processes, which had been affected due to the additional COVID-19 workload and staffing pressures. Unfortunately, there was also a 10% increase in MSSA cases, however it is noted that more cases were seen during the second and third wave of the pandemic.

The CCGs commend the Trust for again remaining below national and regional averages for the number of nosocomial COVID-19 cases. The CCGs would like to thank the Trust and their Infection, Prevention and Control Team for the invaluable advice and support they have provided to partner organisations throughout the pandemic. The CCGs fully supports that reducing healthcare acquired infections remains a quality priority for 2022/23 with a continued focus on COVID-19, MSSA, gram-negative blood stream infections and C.difficile infections.

The CCGs recognise the Trust's commitment in reducing community acquired pressure damage whilst under the care of their District Nursing Teams. It is positive to see that through the development of a new pathway and robust education programme there was an overall 42.6% reduction in community acquired pressure damage. It is noted that the pathway has been shared with all adult community services and work is continuing to ensure this is fully embedded into practice. The CCGs were impressed by the Trust's approach in promoting the ethos that pressure ulcer prevention is the responsibility of all NHS staff and for implementing weekly dashboards to act as a visual prompt to promote ownership, understanding and monitoring for improvement. The CCGs would also like to commend the Trust for providing educational sessions to care homes and domiciliary care agencies, to ensure a consistent approach across the city and preventative care interventions are aligned with best practice.

The CCGs note that over the past eighteen months the incidence of hospital acquired pressure damage has been on an upward trajectory, with an increase in cases rising from 706 in 2020/21 to 908 in 2021/22. It is recognised that the acuity of patients is significantly higher than pre-pandemic levels and there has been an increase in patients presenting to the Trust with significant existing damage, or at risk of skin deterioration. The CCGs acknowledge that the Trust has implemented a number of quality improvement initiatives and pressure prevention education and it is hoped that this will help to support a significant reduction in cases.

The CCGs note the progress made in the quality priority to develop a long term electronic solution for the management of abnormal investigations. It is positive to see that a clinical lead is now in place, current processes have been mapped and an agreement reached on a programme of design and development, including identifying the resources needed to complete the work. It is also pleasing to note that the Trust has developed a partnership with 3M to use their 'follow-up finder' artificial intelligence technology and this functionality will be developed over the coming year, with the initial focus on radiology where failure to act on test results can result in serious harm, particularly in the outpatient setting. The CCGs recognise the importance of this quality priority in improving patient safety and patient experience and fully support this continuing as a quality priority in 2022/23.

It is positive to note the significant progress made in the Modifying Early Obstetrics Warning Score (MEOWS) quality priority, which included appointing a Clinical Director for Patient Safety to lead on this project and the creation of an IT solution for the identification of pregnant or recently pregnant women outside of Woman's Services, which is ready to go live once it has been tested. The CCGs welcomes the Trust's plans to continue with this important quality priority 2022/23, including the development of an electronic MEOWS system to replace the national early warning score/paediatric early warning score. In the light of the publication of the Ockenden Report, the CCGs also welcome the Trust's comprehensive action plan to ensure full compliance with the immediate and essential actions.

The CCGs congratulate the Trust on the excellent progress made in the Enhancing Capability in Quality Improvement priority, including the successful delivery of three Institute for Healthcare Improvement training programmes and the development of an evaluation framework. It is positive to see that attendance at each of the training session was high and subsequent sessions were adapted based on feedback received from the evaluation process. The CCGs recognise the importance of sustaining quality improvement at scale and fully support this continuing as a quality priority in 2022/23.

The CCGs congratulates the Trust on the fantastic progress made with the Mental Health in Young People quality priority and for the excellent collaborative working with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTWFT). The CCGs note that a wide range of work has taken place over the past year in developing dedicated and efficient pathways for the assessment and treatment of children and young people with mental health conditions, working in partnership with CNTWFT. It was very positive to note there has been an ongoing review of the paediatric emergency environment to create a 'safe space' with input from patients and parents. The CCGs recognise the Trust's continued commitment in improving the quality of care provided to young people and young adults with mental health conditions and fully support this important work continuing as a quality priority in 2022/23.

The CCGs recognise the excellent progress made with the ensuring reasonable adjustments are made for patients with suspected or a known learning disability quality priority. It is pleasing to note the number of achievements over the last year, including ensuring timely learning disability mortality reviews are undertaken, pathway improvements and the recommencement of the STOMP and STAMP project work. The ongoing work with the North East and Cumbria Learning Disability Network and Great North Children's Hospital anaesthetics team to incorporate theatre attendance within the hospital passport for children and young people is an excellent initiative. The CCGs acknowledges the Trust's commitment to ensuring patients with a learning disability have access to services that will help to improve their health and wellbeing, providing a positive and safe patient experience. The CCGs therefore fully support the Trust's plans to build further on this important work in 2022/23.

In 2021/22 the Trust reported six never events, which is an increase on the previous year when three were reported. All never events are managed through the serious incident process and the CCGs continue to work with the Trust to identify learning and appropriate actions; gaining assurance through the CCG SI Panels and QRG meetings. The CCGs were also pleased to note the increase in incident reporting rates alongside a decrease in the number of patient safety incidents per 1000 bed days, providing assurance of the positive reporting and safety culture within the Trust.

The emphasis that the Trust gives to national clinical audits and confidential enquiries demonstrates that they are focussed on delivering evidence-based best practice. The CCGs also commend the Trust for their continued commitment to clinical research, particularly with regards to their invaluable contribution towards the approval of COVID-19 vaccines and new treatments to reduce COVID-19 related mortality.

It is fully acknowledged that the NHS has faced huge pressures due to the COVID-19 pandemic and this has significantly impacted on the Trust's performance across a number of the key national priorities. The CCGs note the decline in performance for cancer and referral to treatment targets and the ongoing pressures in diagnostics, specifically Radiology and Endoscopy. The CCGs are encouraged by the progress being made through the implementation of the tele-dermatology service in reducing the backlog of patients, in endoscopy through nurse led triage, additional staff and electronic scheduling system and in the range of planned actions to improve the position in radiology. Commissioners will continue to work in partnership with the Trust and fully support the ongoing work and initiatives in place to improve cancer waiting times as well as other national key priorities.

The CCGs commend the Trust for the positive results received in the NHS Staff Survey; with 85% of staff stating they would be happy with the standard of care provided should a friend or relative need treatment and 86% agreeing that their role makes a difference to patients. Although some scores were lower than the previous year, the CCGs recognise that this is consistent with the national picture of NHS staff experiencing burn-out due to the pressures experienced over the past two years. It is acknowledged that where improvement areas have been identified appropriate action is taken to address these and the CCGs are assured that the Trust will continue to make hearing staff voices a priority.

The CCGs are also pleased to see the Trust's continued patient involvement and engagement work over the past year. This included working with Deaflink to develop the health navigator service and the continuing focus on partnership working with local communities and voluntary groups to ensure patients and local communities have been involved and listened to. The CCGs also note the Trust's strong performance in the National Patient Surveys, in particular the maternity survey which rated the Trust as better or somewhat better than expected across a number of categories.

The CCGs congratulates the Trust for the significant progress made in relation to transforming Ophthalmology Services, with the opening of Newcastle Westgate Cataract Centre following significant investment from commissioners. It is extremely positive to see that when fully operational the centre will be able to perform between 200-250 cataract operations each week. This is an excellent example of service transformation, which will undoubtedly reduce waiting times and improve patient experience. The CCGs look forward to continuing to receive regular updates on the progress of the ongoing transformation work in Ophthalmology Services at the QRG meetings.

The CCGs were impressed by the examples of service developments and quality improvements initiatives the Trust has implemented over the past year, as set out in the report. These are all fantastic achievements, and the CCGs would again like to thank the Trust and all its staff for their continued hard work and commitment in delivering high quality, effective and compassionate care to patients.

The CCGs welcome the specific quality priorities for 2022/23 highlighted in the Quality Account. These are appropriate areas to target for continuous evidence based quality improvement and link well with the commissioning priorities, which will be transferred to the new ICB. The CCGs can confirm that to the best of their ability the information provided within the Annual Quality Account is an accurate and fair reflection of the Trust's performance for 2021/22. It is clearly presented in the format required and contains information that accurately represents the Trust's quality profile and is reflective of quality activity and aspirations across the organisation for the forthcoming year.

The commissioners look forward to continuing to work in partnership with the Trust to assure the quality of services commissioned in 2022/23.

Julia Young
Executive Director of Nursing, Patient Safety & Quality

Dr Dominic Slowie
Medical Director

May 2022

For and on behalf of
NHS Newcastle Gateshead Clinical Commissioning Group NHS Northumberland Clinical Commissioning Group
NHS North Tyneside Clinical Commissioning Group

STATEMENT ON BEHALF OF HEALTHWATCH GATESHEAD, HEALTHWATCH NEWCASTLE AND HEALTHWATCH NORTH TYNESIDE

Thank you for sharing the draft quality account for our comment.

We would like to take this opportunity to thank your team for all its hard work during the COVID19 pandemic. The Trust has played a pivotal role in supporting the health and care system and leading elements of the vaccine programme in the North East and across the country during this difficult time.

It was good to read of the Trust's achievements over the last 12 months particularly the new cataract centre and work on long covid – something we have supported TyneHealth (North Tyneside's GP federation) to create resources to support local people experiencing long covid https://tynehealth.org.uk/long-covid/

We were pleased to see the progress with the 2021/22 priorities and that some of these will be developed in the priorities for 2022/23. We welcome the continued focus on maternity and support for people with learning disabilities and autism.

It is unclear from the quality account what progress has been made but we are reassuring that the Trust continues to recognise the impact caused by the delays in test results for the patient and continue to prioritise this as a quality objective.

As you are aware, the key issues people raise with us relate to waiting for treatment, backlogs and experiences of services. We note with interest the planned pathway improvements you highlight at the start of this this report. We welcome the approach to cataract centre and the Day treatment Centre dure to open later this year. We strongly encourage you to take co-production approaches and involve patients in developing your Outpatient Improvement Programme and Patient Initiated Follow Up (PIFU). Whilst it may be more efficient for service deliver, for some people regular check-ups offer peace of mind and confidence that their concerns will be heard. We in the Healthwatch Network could help you with this.

Healthwatch are aware of the negative impact of the pandemic on young people and echo the Trust concerns. We are pleased that there is a plan to improve the care provided in the acute Trust for these patients and that there is a collaborative approach with CNTW, patients and families. We look forward to seeing this develop. The confusion around pathways for professionals, VCS organisations and patients is a reoccurring theme for Healthwatch Gateshead and Healthwatch Newcastle.

In North Tyneside we have heard concerns about the audiology service where waiting times have been long for several years and people tell us they find it difficult to access follow up support. We will be going further work on this issue over the coming year wand would want to work with you on this.

We are pleased that the Trust has continued to recognise the health inequalities that exist within the learning disability community. While it is reassuring that patients with learning disabilities and their families have reasonable adjustment, we would recommend the trust look at the wider audience and the accessibility of the trust, including how these patients may be contacted and the systems that are in place to ensure they receive documents suitable for them.

In North Tyneside we have also been hearing issues around, keeping families/carers informed about the progress of their loved ones whilst in hospital (particularly when visiting is restricted) and also the experience of leaving hospital to home and the integration of health and social care services and are planning to further investigate these issues.

We look forward to building on our working relationship over the coming year and working together to ensure the voices people of Gateshead, Newcastle and North Tyneside is heard in the services the Trust provides.

STATEMENT ON BEHALF OF NORTHUMBERLAND HEALTHWATCH

Awaiting response from Northumberland Healthwatch.

ANNEX 2:

ABBREVIATIONS

Abbreviations	
3Rs	Restart, Reset and Recovery
7DS	Seven Day Service
A&E	Accident & Emergency
ACT	Alcohol Care Team
APEX	Advising on Patient Experience
BADS	British Association of Day Surgery
BAF	Board of Assurance Framework
BAME	Black, Asian and Minority Ethnic
BTS	British Thoracic Society
BURST	British Urology Researchers in Surgical Training
C.diff	Clostridium difficile
CAT	Clinical Assurance Tool
CCGs	Clinical Commissioning Group
CGARD	Clinical Governance and Risk Department
CKD	Chronic Kidney Disease
CNTW	Cumbria, Northumberland and Tyne and Wear
COHA	Community Onset – Healthcare Associated
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRANE	Cleft Registry and Audit Network
CRN	Clinical Research Network
CT	Computed Tomography
CVD	Cardiovascular Disease
CYP	Children and Young People
CYPMH	Children and Young People Mental Health
DoC	Duty of Candour
DSP	Data Security & Protection
DNA	Do Not Attend
DTC	Day Treatment Centre
E.coli	Escherichia coli
ED	Emergency Department
EHR	Electronic Health Record
EPR	Electronic Patient Record
ERAS	Enhanced Recovery After Surgery
ERS	E-Referral System
FTSU	Freedom to Speak up
GIRFT	Getting It Right First Time
GNBSI	Gram Negative Blood Stream Infections
GNCH	Great North Children's Hospital
GP	General Practitioner
HCAI	Healthcare Associated Infection
HES	Hospital Episode Statistics
HOHA	Hospital Onset – Healthcare Associated

Abbreviations	
HPB	Hepatobiliary and Pancreatic
HR	Human Resources
IBD	Inflammatory Bowel Disease
ICS	Integrated Care System
IHI	Institute for Healthcare Improvement
IPC	Infection Prevention & Control
IPCC	Infection Prevention & Control Committee
IT	Information Technology
IV	Intravenous
KRT	Kidney Replacement Therapy
LD	Learning Disability
LeDeR	Learning Disability Mortality Review
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer
LOS	Length of Stay
M&M	Mortality and Morbidity
MAU	Maternity Assessment Unit
MatNeoSIP	Maternity and Neonatal Safety Improvement Programme
MBRRACE	Mothers and Babies, Reducing Risk through Audits and Confidential Enquiries
MDT	Multi-Disciplinary Team
MDU	Mobile Destruction Unit
MEOWS	Modified Early Obstetrics Warning Score
ML	Moisture Lesion
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant *Staphylococcus aureus*
MSSA	Methicillin Sensitive *Staphylococcus Aureus*
MVP	Maternity Voice Partnership
N/A	Not Applicable
NCOBA	National Bowel Cancer Audit
NCEPOD	National Confidential Enquiries into Patient Outcome & Death
NELA	National Emergency Laparotomy Audit
NENC	North East and North Cumbria
NEY	North East and Yorkshire Region
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute for health and clinical excellence
NIHR	National Institute for Health & Care Research
NRLS	National Reporting & Learning System
NUTH	Newcastle upon Tyne Hospital NHS Foundation Trust
PCI	Percutaneous Coronary Interventions
PCM	Patient Blood Management
PCN	Primary Care Network
PCR	Polymerase Chain Reaction
PDSA	Plan Do Study Act

Abbreviations	
PHE	Public Heath England
PICANet	Paediatric Intensive Care Audit Network
PIFU	Patient Initiated Follow Up
PMRT	Perinatal Mortality Review Tool
PPE	Personal Protection Equipment
PROMS	Patient Reported Outcome Measures Scores
PUP	Pressure Ulcer Prevention
QI	Quality Improvement
QIPS	Quality Improvement and Patient Safety Competencies
RCA	Root Cause Analysis
RCP	Royal College of Physicians
RIDDOR	Reporting of Injuries, Disease and Dangerous Occurrences
RTT	Referral to Treatment
RVI	Royal Victoria Infirmary
SAMBA	Society for Acute Medicine's Benchmarking Audit
SHINE	Sustaining Healthcare in Newcastle
SHMI	Summary Hospital-level Mortality Indicator
SIs	Serious Incidents
UK	United Kingdom
UKRR	United Kingdom Renal Registry
VAD	Ventricular Assist Device
VTE	Venous thromboembolism
YPAGne	Young Persons Advisory Group

ANNEX 3:

GLOSSARY OF TERMS

1. C. *difficile* infection (CDI)

C. *difficile* diarrhoea is a type of infectious diarrhoea caused by the bacteria Clostridium difficile, a species of gram-positive spore-forming bacteria. While it can be a minor part of normal colonic flora, the bacterium causes disease when competing bacteria in the gut have been reduced by antibiotic treatment.

2. CQC

The Care Quality Commission (CQC) is the independent regulator of all health and adult social care in England. The aim being to make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere.

3. CQUIN – Commissioning for Quality and Innovation

The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of English healthcare provider's income to the achievement of local quality improvement goals.

4. DATIX

DATIX is an electronic risk management software system which promotes the reporting of incidents by allowing anyone with access to the Trust Intranet to report directly into the software on easy -to-use-web pages. The system allows incident forms to be completed electronically by all staff.

5. E.coli

Escherichia coli (E.coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of E.coli, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. E.coli bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. E.coli bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood.

6. Gram-negative Bacteria

Gram-negative bacteria cause infections including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis in healthcare settings. Gram-negative bacteria are resistant to multiple drugs and are increasingly resistant to most available antibiotics. These bacteria have built-in abilities to find new ways to be resistant and can pass along genetic materials that allow other bacteria to become drug-resistant as well.

7. Getting it Right First Time (GIRFT)

GIRFT is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking and presenting data-driven evidence to support change.

8. HOGAN evaluation score

Retrospective case record reviews of 1000 adults who died in 2009 in 10 acute hospitals in England were undertaken. Trained physician reviewers estimated life expectancy on admission, to identified problems in care contributing to death and judged if deaths were preventable taking into account patients' overall condition at that time. The Hogan scale, ranging from 1 (definitely not preventable) to 6 (definitely preventable), was used to determine if deaths were potentially avoidable, taking into account a patient's overall condition at the time.

Source: Dr Helen Hogan, Clinical Lecturer in UK Public Health,

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

9. IHI

The Institute for Healthcare Improvement (IHI) are committed to supporting all who aim to improve health and health care. They bring like-minded colleagues at global conferences, trainings, and career development programs to help grow the safety, improvement, and leadership skills of the health and health care workforce. They advance learning by leading collaborative initiatives that enrich, accelerate, and spread the latest improvement ideas and leadership strategies.

10. MRSA

Staphylococcus Aureus (S. aureus) is a bacterium that commonly colonises human skin and mucosa (e.g. inside the nose) without causing any problems. Although most healthy people are unaffected by it, it can cause disease, particularly if the bacteria enters the body, for example through broken skin or a medical procedure. MRSA is a form of S. aureus that has developed resistance to more commonly used antibiotics. MRSA bacteraemia is a blood stream infection that can lead to life threatening sepsis which can be fatal if not diagnosed early and treated effectively.

11. MSSA

As stated above for MSSA the only difference between MRSA and MSSA is their degree of antibiotic resistance: other than that there is no real difference between them.

12. Near Miss

An unplanned or uncontrolled event, which did not cause injury to persons or damage to property, but had the potential to do so.

13. Shelford Group

The Shelford Group is a collaboration between ten of the largest teaching and research NHS Trusts in Engla

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 May 2022						
Title	Healthcare Associated Infections (HCAI) Director of Infection Prevention and Control Report						
Report of	Maurya Cushlow, Executive Chief Nurse						
Prepared by	Dr Lucia Pareja-Cebrian, Associate Medical Director, Director of Infection Prevention & Control (DIPC), Consultant Microbiologist Mr Ian Joy, Deputy Chief Nurse Mrs Angela Cobb, Infection Prevention & Control (IPC) Lead						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	This paper is the bi-monthly report on Infection Prevention & Control (IPC). It complements the regular Integrated Board Report and summarises the current position within the Trust to the end of April 2022. The IPC Board Assurance Framework for COVID-19 can be found in the Private Board Reference pack; (BAF v1.8 - 2021-22 (NEW) working document. Updated 04.05.2022); trend data (including number of COVID-19 Outbreaks within the Trust) can be found in Appendix 1a (HCAI Report and Scorecard March 2022) and Appendix 1b (HCAI Report and Scorecard April 2022), enclosed in the Public Board Reference Pack, which details the performance against targets where applicable.						
Recommendation	The Board of Directors is asked to (i) receive the briefing, note and approve the content and (ii) comment accordingly.						
Links to Strategic Objectives	Achieving local excellence and global reach through compassionate and innovative healthcare, education and research. Patients - Putting patients at the heart of everything we do and providing care of the highest standards focussing on safety and quality. Partnerships - We will be an effective partner, developing and delivering integrated care and playing our part in local, regional, national and international programmes. Performance - Being outstanding, now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☐	☐	☐	☐	☐
Impact detail	Failure to effectively control infections may lead to patient harm, litigation against the Trust and loss of reputation. There are no specific equality and diversity implications from this paper.						
Reports previously considered by	This is a bimonthly update to the Board on Healthcare Associated Infections (HCAI).						

The Newcastle upon Tyne Hospitals NHS Foundation Trust

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

EXECUTIVE SUMMARY

This paper provides bimonthly assurance to the Trust Board regarding Healthcare Associated Infections (HCAIs).

Key points to note:

- Changes in COVID-19 screening of emergency and elective patients has not led to increases in periods of increased incidence or outbreaks.
- As we emerge from COVID-19, the focus for Infection Prevention and Control (IPC) is to enable and maximise clinical activity and reinvigorate projects that will lead to reduction in other HCAIs.
- Nationally set thresholds for Gram-negative Bloodstream Infections (GNBSI), were met for 2021/22. The new year trajectories have been set, with an internally set objective of a 10% reduction for all HCAIs. This includes MSSA for which there is no national threshold.
- There have been no MRSA bacteraemias in 24 months.

RECOMMENDATIONS

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

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

1. KEY POINTS FOR MARCH/APRIL 2022

1.1 Coronavirus (COVID-19)

Until March 2022, early detection of COVID-19 remained the focus through an asymptomatic screening programme aiming to identify all positive cases to reduce the risk of transmission. COVID-19 screening was completed in line with National Guidance on admission (or 72 hours prior for elective cases), day 3 and day 5 after admission. Both March and April brought operational challenges arising from changes in national guidance. The Trust responded quickly, proportionately and safely to these changes to maximise the benefit from the changes for patients and staff.

Due to the combined success of COVID-19 vaccination and antiviral treatments, as the severity of COVID-19 illness reduced there was a national recognition of the need to focus on recovery of other services to reduce waiting times and other potential patient harms. In line with the transition to "living with COVID" the Trust emergency pathway was changed on 17 March 2022. The main change was to use Polymerase Chain Reaction (PCR) testing for symptomatic patients only, with the exception of identified high risk areas. They continued to undertake a PCR test on admission and day 5 for all patients and a Lumira test was used for all maternity admissions.

A further change was implemented on 21 March 2022 for elective patients with the introduction of an additional PCR test for all high-risk patients / major surgery cases 72 hours prior to procedure. On 14 April 2022, additional national IPC guidance was issued which removed the need to isolate / test asymptomatic in-patient COVID-19 contacts; this significantly improves patient flow therefore Trust IPC respiratory guidance was amended to reflect this change. As expected, due to the change/reduction in testing for the general public nationally there was a decrease in Community-Onset (CO) and Hospital-Onset Indeterminate Healthcare-Associated (HO.iHA) cases. Reassuringly the increase in Hospital-Onset Definite Healthcare-Associated (HO.dHA) cases was minimal with an additional 3 cases declared in April 2022 in comparison to March 2022 and Hospital-Onset Probable Healthcare-Associated (HO.pHA) cases reduced by 8 cases. Cases continue to be monitored to ensure changes lead to no increases in Hospital-Onset Covid-19 (HOCI) infections.

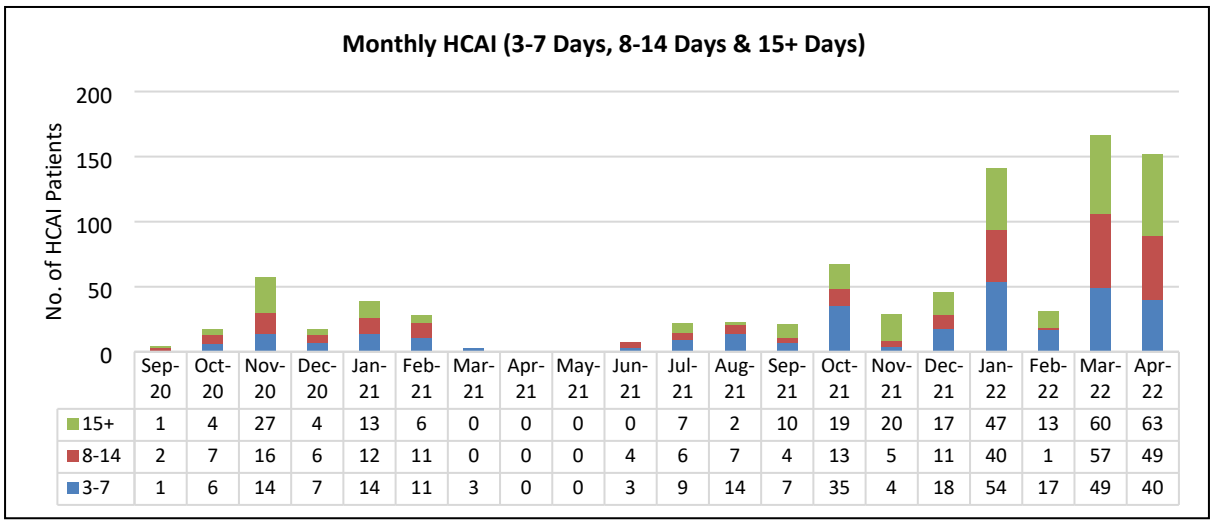
1.1.1 Managing HCAI COVID-19 cases

COVID-19 infections are classified as follows:

- Community-Onset (CO) – First positive specimen date <=2 days after admission to trust
- Hospital-Onset Indeterminate Healthcare-Associated (HO.iHA) – First positive specimen date 3-7 days after admission to Trust
- Hospital-Onset Probable Healthcare-Associated (HO.pHA) – First positive specimen date 8-14 days after admission to Trust
- Hospital-Onset Definite Healthcare-Associated (HO.dHA) – First positive specimen

date 15 or more days after admission to Trust.

The graph below demonstrates the COVID-19 activity and category of detection. This takes into account the incubation period, which for most people is 5-7 days but can be up to 14 days.



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
15+	1	4	27	4	13	6	0	0	0	0	7	2	10	19	20	17	47	13	60	63
8-14	2	7	16	6	12	11	0	0	0	4	6	7	4	13	5	11	40	1	57	49
3-7	1	6	14	7	14	11	3	0	0	3	9	14	7	35	4	18	54	17	49	40

In March 2022, 180 patients tested positive for COVID-19 within 2 days of admission (defined as community onset). This combination of high numbers of patients admitted with COVID-19 and the greater transmissibility contributed to the highest number of HO.pHA and HO.dHA cases declared by the Trust and an increased number of reported outbreaks. In the month of April there were no significant increase on the number of COVID infections acquired in hospital or outbreaks subsequent to the changes in COVID-19 guidance.

A COVID-19 outbreak is reported when there are 2 or more connected HO.dHA or HO.pHA case or connected staff member. There have been 10 COVID-19 outbreaks declared in March 2022 and a reduction in April 2022 to 4 outbreaks declared. Although national guidance continues to declare an outbreak open for 28 days from the last positive case, the North East and North Cumbria Integrated Care System (ICS) has agreed to reduce this time down to 10 days in line with the guidance for care homes, prisons and the ambulance service.

The message of 'Hands, Face and Space' (HFS) continues to be disseminated through Champions within Directorates to support staff compliance to COVID-19 precautions. The latest completed audit was undertaken in April 2022 with a lower response rate of 67% which is small reduction to the previous audit. Despite a lower response rate, an improvement has been noted in the lowest compliance for an individual element of the audit which is 94% for clinical areas. This relates to the identification of a HFS champion on a daily basis and non-clinical areas declared full compliance to all elements of the HFS initiative.

1.1.2 Test & Trace (T&T)

Lateral Flow Test (LFT), voluntary asymptomatic testing of staff continues to be encouraged

across the Trust in line with national guidelines. The total number of reported LFT tests up to 30 April 2022 is 151,286 tests with 2,395 positive cases, and a positivity rate of 1.6%. Symptomatic staff continue to have access to PCR testing via the testing pod as required.

In April 2022 Trust guidance regarding staff COVID-19 contacts changed in line with revised NHS England/Improvement (NHSE/I) guidance issued on 30 March 2022. This removed the mandate of requiring a vaccination to continue working during the incubation period and the need for contact PCR test. As a result, any known staff contacts can continue to work if they remain asymptomatic and undertake daily LFT before they commence work. This is an additional Trust step to provide greater assurance rather than the national guidance which recommends twice a week LFT in these circumstances.

The updated patient testing guidance introduced on 21 March 2022 has resulted in a significant decrease in FH POD activity for pre-assessment PCR testing in April. The table below reflects the number of swabs performed from the beginning of the financial year. Work is on-going to confirm what testing requirements will be required in the medium to long term.

	RVI POD (Staff Swabbing)	FH POD (Patient Swabbing)	CNTW (Home Swabbing vulnerable patients)
April 2021	336		
May 2021	439	1198	
June 2021	1414	2169	
July 2021	2400	1707	
August 2021	1330	1526	
September 2021	1825	1773	
October 2021	2153	1816	
November 2021	1781	2245	
December 2021	4994	1404	
January 2022	2816	2290	
February 2022	907	1951	122
March 2022	1594	2020	123
April 2022	1126	859	86

1.2 *C. difficile* Infections (CDI)

From April 2021 to the end of March 2022, a total of 169 cases were attributed to the Trust (135 case are Hospital Onset Healthcare Associated (HOHA); 34 cases are Community Onset Healthcare Associated (COHA)). This places the Trust over the national threshold number by 71 cases, which is an increase of 58% from no more than 98 cases The increase has been multifactorial, including the high acuity of patients and the previous suspension of multidisciplinary post infection review (PIR) meetings due to the additional COVID-19 workload and staffing pressures.

Furthermore, antimicrobial Take 5 audits have not been completed due to the cessation of the previous electronic reporting platform whilst waiting for the implementation of the new Synbiotix electronic audit tool. A review of the PIR meetings is underway to establish an effective way to engage with the clinical teams to identify best practice and support any identified learning. Antimicrobial audits are planned to be reinstated from April 2022 with the introduction of an electronic audit system to enable leaders to monitor prescribing practices.

Learning from PIR reviews include the need to improve documentation of diarrhoea to support early sample collection and timely isolation. Some focused management of diarrhoea work is planned through 2022/23.

At the end of April 2022, there has been a total of 12 CDI cases attributed to the Trust, which is in line with our internal reduction strategy. The national threshold for the Trust has not yet been released, therefore we are working to a local 10% reduction on the 2021/22 total with a target of no more than 153 cases in 2022/23 and no more than 12 cases in April 2022.

1.3 MRSA / MSSA Bacteraemias

There have been no MRSA bacteraemia cases since April 2020 thus the Trust has been "MRSA bacteraemia free" for 24 months which is a fantastic achievement. This is the Trust's longest MRSA bacteraemia free period (previously 16 months).

As previously reported, there was no national set threshold for MSSA in 2021/22 therefore the IPCC committee continued with setting a 10% reduction on the previous financial year's total number of cases (100) which is ≤90 cases for 2021/22. By the end of March 2022, a total of 110 cases were attributed to the Trust (82 HOHA cases; 28 COHA cases), which places the Trust over trajectory by 20 cases, a 22% increase overall.

By the end of April 2022, there has been a total of 12 MSSA cases attributed to the Trust which is higher than the month's trajectory of 9 cases and our commitment to achieve a local 10% reduction on the 2021/22 baseline, of no more than 99 cases in 2022/23. At the current time it is unknown if there will be a national MSSA 2022/23 threshold set for the Trust.

1.4 Gram Negative Bacteraemias (*E. coli,* Klebsiella, Pseudomonas aeruginosa)

From April 2021 to the end of March 20022, there have been:

- 206 *E. coli* bacteraemias,
- 146 Klebsiella bacteraemias, and
- 43 Pseudomonas aeruginosa bacteraemias

which places the Trust above all internally set GNBSI 10% reduction trajectories but is still within the national thresholds. Whilst acknowledging that the high and increasing acuity, dependency and complexity of our patients continues to be a contributing factor, Quality Improvement projects supported by the IHI have been undertaken to support a reduction in cases. Catheter Associated Urinary Tract Infections (CAUTI) prevention and prevention of Hepatobiliary (HPB) related sepsis continue to progress and are now at the evaluation phase.

By the end of April 2022, there has been a total of:

- 17 E. coli bacteraemias,
- 13 Klebsiella bacteraemias, and
- 5 Pseudomonas aeruginosa bacteraemias

attributed to the Trust. The national threshold for the Trust has not been released,

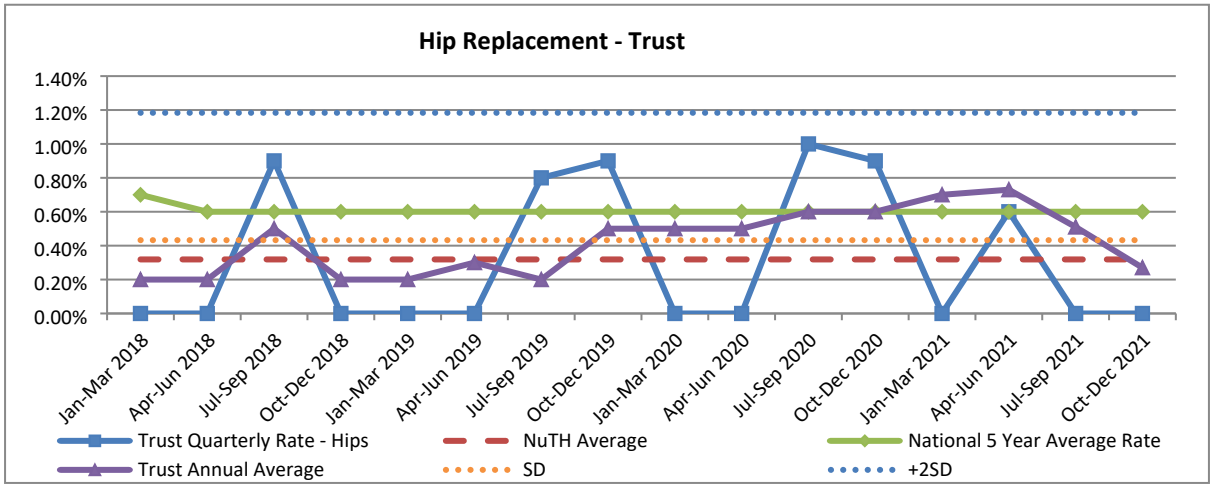
therefore we are continuing to work to a local 10% reduction on the 2021/22 baseline and are currently above the month's trajectory for all of the GNBSI by 1 or 2 cases.

1.5 SURGICAL SITE INFECTIONS (SSIs)

The Trust participates in UK Health Security Agency (UKHSA) surveillance of SSI for hip, knee and spinal surgery. The Trust received the reports for Quarter 4 (October - December 2021) which demonstrated that no SSIs were reported for hip and knee replacements for the second consecutive quarter.

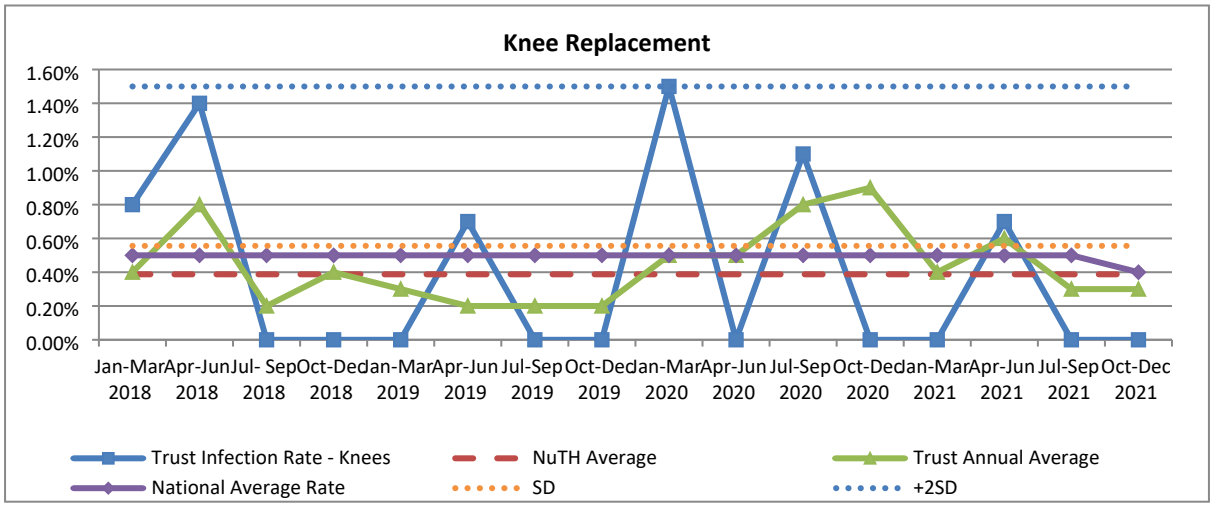
1.5.1 Hip Replacement

No SSIs have been reported for either the Royal Victoria Infirmary (RVI) or Freeman Hospital (FH) for Hip replacements in Quarter 4. The Trust SSI rate for the last 4 reported quarters now sits at 0.3%, significantly lower than the National 5-year average SSI rate of 0.6%.



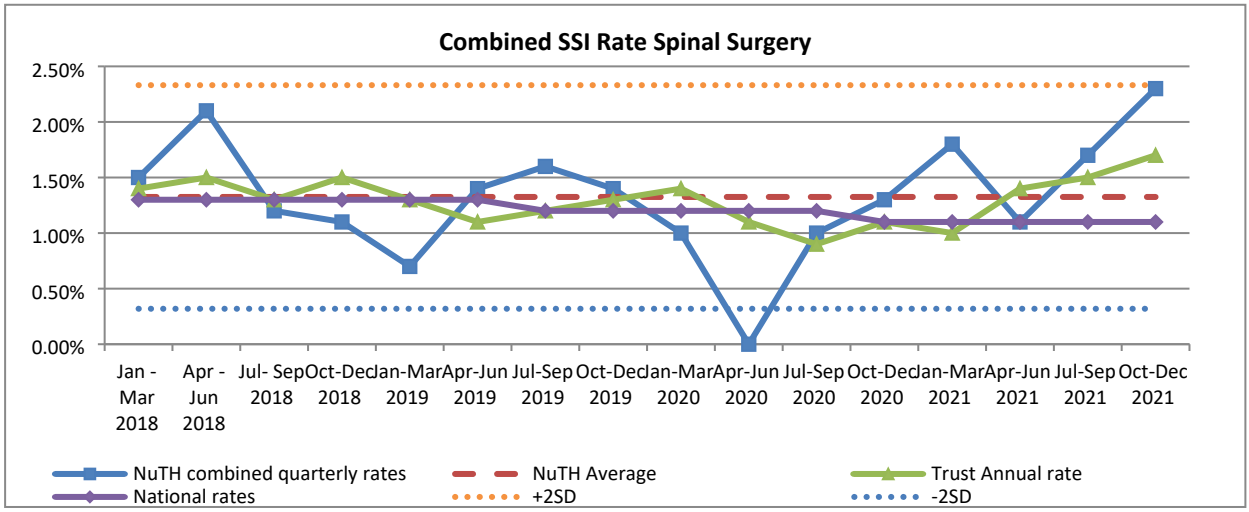
1.5.2 Knee Replacement

Quarter 4 once again saw no SSIs recorded. The Trust therefore continues to remain below the National 5-year average SSI rate of 0.4%. The Trust has remained below the National 5-year average SSI rate for 3 of the last 4 quarters.



1.5.3 Spinal Surgery

Quarter 4 saw an increase of SSIs with 7 cases recorded at the RVI, 4 from Orthopaedics and 3 from Neurosciences. This has led to a Trust quarterly SSI rate of 2.3% (comprised of a quarterly rate of 3.2% for Orthopaedics and 1.7% for Neurosciences.), which is double that of the national benchmark SSI rate of 1.1%. It has therefore resulted in an increased SSI rate for the Trusts last 4 reported quarters at a rate of 1.7% and as a result the Trust has received and responded to an outlier notification letter from UKHSA. The RCA process continues to identify any learning and promote good practice. A further multi-disciplinary team (MDT) meeting is planned to review all spinal infections and introduce any necessary changes to bring this back into normal reporting parameters.



1.6 Outbreaks and Periods of Increased Incidence (PIIs)

There have been 4 *Clostridium Difficile* infection (CDI) periods of increased incidence (PII) during March / April 2022 within Cancer Services and Clinical Haematology; Internal Medicine; Surgical Services and Peri-operative and Critical Care. A CDI PII is defined as two cases within a 28-day period. The cases are being further investigated to establish if there are any learning from related themes.

In March and April 2022, there have been 2 outbreaks declared, 1 for diarrhoea and vomiting and no organism was found, the other was an outbreak of influenza A.

1.7 Infection Prevention and Control Team (IPCT) Priorities for 2022/23

The IPCT have set the priorities for 2022/23 and have four key initiatives:

1. **Use of Octenisan washes** - the aim is to of improve compliance in Octenisan wash and correct application across the organisation and therefore reducing bloodstream infections (BSI).
2. **Glove use reduction**- supporting hand hygiene initiatives as high glove use impacts on the effectiveness of hand hygiene a key factor in all healthcare associated infections.
3. **Diarrhoea management and CDI initiative** - the aim is for early detection and management of diarrhoea to reduce CDI rates.
4. **BSI community initiative –** a project to understand the opportunities to implement

changes in practice to reduce the numbers of patients who develop community associated BSI.

1.8 Sepsis

The restructure of the team with the appointment of a new Clinical Director provides an opportunity to review and refresh our whole approach to caring for the deteriorating patient working in close collaboration with other initiatives to reduce other patient harms.

The Deterioration and Sepsis annual mandatory training pack which is to be included within the Electronic Staff Record (ESR) is currently still on track to be live on 16 May 2022 and Trust wide bespoke education sessions for directorates continues to be promoted. The data on the gaps identified on the identification and management of sepsis is shared with directorates as part of the education and improvement drive.

The responses to the deteriorating patient alerts by the clinical teams are analysed by the Sepsis nurse. The themes emerging from the data are discussed at the Infection Protection and Control Committee (IPCC) and the Harm Free Care Group (HFCG) and escalated to the Patient Safety Group along with a Gap Analysis and shared individually with directorates. The ambition is to strengthen education and training and provide feedback to teams as close as possible to real time, whilst achieving significant improvements in the response to alert rates.

1.9 Antimicrobials

Antimicrobial stewardship is the process that ensures appropriate antibiotic treatment for every patient every time. This improves outcomes for the patient and decreases the rate of antimicrobial resistance. In the trust, it is led by the Antimicrobial Stewardship Group (AMSG).

The AMSG is leading work to achieve improved antimicrobial stewardship (AMS). This will be achieved through a variety of different mediums including audits which have identified some useful Quality Improvement (QI) projects including the introduction of the 2 antibiotic dose order set within the Emergency Department (ED) Education will be an increased area of focus for the AMS Team to deliver.

The Trust continues to take part in the ePrescribing-based Antimicrobial Stewardship (ePAMS) which is a research project which aims to improve antimicrobial stewardship through electronic prescribing. We have identified pilot wards which include Respiratory and Cancer Services and are working to implement changes on these wards in April 2022.

The standard contract required the Trust make a 1% reduction on its use of antibiotics, compared to 2018. This was exceeded by 10%, achieving an 11% reduction. However, this is across all areas and most likely attributed to the varied patient cohorts due to COVID-19.

The monthly peer review ‘Take 5’ audits have been re-invigorated with a new improved platform successfully launched on 1 April 2022. The Take 5 audit tool will be useful for the

AMSG but especially for the wards to take ownership of their own audit tool with the ability to critically analyse antibiotic prescribing within their ward in snap shot monthly audit.

1.10 Water Safety

The enhanced legionella monitoring is still in place for FH Wards 24 and 27 following the remedial works carried out to the domestic water distribution. The results of the additional testing will be discussed with the site water safety group once received and suitable further measures agreed.

Following discussion at the Strategic Water Safety Group the current version of the Water Safety Plan is to be reviewed and will be uploaded to the Policies and Guidelines section of the Intranet once ratified.

1.11 Ventilation

No exceptions to report.

1.12 Decontamination

Following the failure of the Niagara Washer Disinfector at the RVI, a single point of failure has arisen in the decontamination of the DaVinci equipment which now has to be transferred to FH for processing. This is expected to be corrected with the arrival of the required replacement part week commencing 3 May 2022.

2. RECOMMENDATIONS

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

Report of Maurya Cushlow
Executive Chief Nurse

Dr Lucia Pareja-Cebrian
Director of Infection Prevention & Control (DIPC)

20 May 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 May 2022						
Title	People Report						
Report of	Dee Fawcett, Director of Human Resources						
Prepared by	Dee Fawcett, Director of Human Resources						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The purpose of the report is to provide an update on developments across our People agenda. Reporting is aligned to our local People Plan themes and actions.						
Recommendation	The Board is asked to note the contents of the report.						
Links to Strategic Objectives	People – Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☒	☒	☒	☒
Impact detail	Impacts on all areas from a People perspective.						
Reports previously considered by	Routine update to the Board.						

PEOPLE REPORT

EXECUTIVE SUMMARY

This paper provides an update on progress against our local People Plan and key national developments relevant to our people strategy.

Key points:

- The contract for the Integrated Covid Hub North East (ICHNE) ended in March 2022 and staff were made redundant from the Trust on 4 May 2022 following the formal consultation period.
- Sickness absence remains above pre covid levels.
- The majority of the Trust led Covid Vaccination sites are closing next month.
- Further data is awaited regarding the staff survey results to enhance improvement plans.
- The NHS Equality and Diversity programme within the Trust provided an inspiring and informative set of events. Work continues on a range of developments to improve the staff experience.
- Apprenticeships: The Trust continues to expand its offer with an increasing number of apprenticeship schemes in place.
- Education and Training: A wide range of activities continues, and progress in upgrading the facilities continues at pace.

Dee Fawcett
Director of Human Resources
18 May 2022

PEOPLE REPORT

1. COVID RECOVERY

ICHNE:	Following the decision of the United Kingdom Health Security Agency (UKHSA) on 4 March 2022 to end the contract for the ICHNE programme on 31 March 2022, a total of 650 staff covering three sites (Main lab, Coordination and Response Centre and Innovation lab) were put at risk of redundancy. During a statutory 45-day consultation period which ended on 4 May 2022, the Trust did it best to avoid or reduce the number of staff at risk and was successful in helping over 100 staff secure a new job. The final position was as follows: • No. of staff redundant with no redundancy payment = 434. • No. of staff redundant with a redundancy payment = 1. • No. of staff who were helped to secure new jobs within the NHS = 91 (of which 81 were at Newcastle Hospitals). • No. of staff who were helped to secure new jobs outside the NHS = 14 (all public sector). • No. of staff who left during the redundancy consultation process = 8 (excluding the above). Both the Coordination and Response Centre and the Innovation lab secured funding and were able to extend the employment of existing staff until 31 March 2023.
Vaccination Hub:	COVID Vaccination is an immunisation programme provided under NHS public health functions (Section 7a) agreement 2020 to 2021. NHS England (NHSE) issued a contract to Newcastle Hospitals to act as a COVID Vaccination Lead Provider for the North East and North Cumbria Integrated Care System (ICS) until 30 September 2022. As the programme transitions towards 'business as usual' (BAU) there is no longer a need for mass vaccination sites, and as such the centres will close on 30 June 2022. One site will be retained to support the local population, as a base for outreach work and to deliver some fixed site vaccination clinics. The programme team is fully committed to supporting staff in their next steps following the planned closure of the vaccination centres, and to ensure as reasonably as practicable, that they are not lost from the local healthcare economy.
Wellbeing:	**Sickness absence** • Sickness absence rates remain high (6.13%) and are of concern. There is a continued focus on attendance management and support for staff. The Department of Health and Social Care (DHSC) introduced Covid sick pay in March 2020 in response to pandemic legislation around statutory sick

	pay. It means staff off sick with Covid receive full pay as if at work on an ongoing basis. This is different to staff off sick for long periods for other reasons who receive NHS occupational sick pay for a specific period, reducing over time. Following consultation with staff side colleagues and endorsement from the Executive Team, the Trust will move staff who are off on long-term sick for a Covid-related reason to the standard occupational sick pay entitlement on 1 June 2022. Less than 60 staff are affected. • A new Health and Wellbeing Policy in in draft and will be going to the Employment Policies Consultation Group for review on 1 June 2022.

2. SHAPING NEWCASTLE AS THE BEST PLACE TO WORK

Belonging, feeling valued and recognised	**2021 NHS Staff Survey:** There has been a prolonged delay in receiving the Trust's local directorate results from the survey supplier. This has impacted on directorates receiving their full results and starting to understand areas of development and strengths. The results were due in May including a 'heatmap' of scoring across directorates to be developed to support improvement planning. The initial 'thematic qualitative' report has been received which has analysed the results in response to the Trust's bespoke questions based on the 'What Matters To You' (WMTY) programme: • Would you recommend the Trust as a place to work? ○ It would be great to understand why • What makes a good day at Newcastle Hospitals? • What gets in the way of a good day at Newcastle Hospitals? • How can we help you have a better day at Newcastle Hospitals? We continue to await further data to complete the report and following the receipt of the final data set for the directorates, the following information will be provided to Directorate leaders to support long term staff experience action planning and implementation: • A new Staff Experience dashboard using Power BI software and includes 5-year trends analysis of staff survey results (where questions are comparable). • Delivering supportive training in facilitations skills and using people data to help develop staff experience plans. • Developing longer term fluid 3 – 5-year local staff experience improvement plans. • A new interactive staff experience leader's portal for key information linked to staff survey.

	• Quarterly Performance Reviews (QPRs) will have Staff experience improvement plans as a standard agenda item and ownership on local staff experience will be through the QPR discussions. • WMTY events are planned from September onwards to open discussions on current workstreams and the work to date in support the staff experience. The next **NHS Pulse Survey** is due to go live in July 2022 however, to date, there has been limited uptake of the People Pulse surveys across the Trust, reflective nationally. Feedback has indicated that this is due to both frequency and that staff feel they have already fed back through the NHS Staff Survey as well as through their WMTY conversations. The results of the people pulse are incorporated into the WMTY programme to understand any key actions. A discussion on how we can further engage staff in the People Pulse survey will take place.
Flourish/What Matters to You	Included in the Trust's breakthrough 'People objectives' is the ambition to offer two-way dynamic conversations with staff as part of the wellbeing offer. To support this, HIVE, a staff engagement system has been purchased. This will support functions such as surveys,' high fives' recognition and messages which will provide key insights to the Trusts "What Matters to You" programme. A working group has been established with key partners to support both the implementation and ongoing developments of HIVE. An initial kick off meeting has taken place and the scoping of an outline of implementation plan is now underway.
Inclusive and diverse workforce	In partnership with the North East Ambulance Service NHS Foundation Trust, a full programme of sessions was advertised to staff for NHS Equality and Diversity Week. The programme covered many protected characteristics with key highlights: • 'Let's Talk Race' session with Dr Habib Naqvi – Director of the NHS Race and Health Observatory, Jacynth Ivery – Director Inspiring Hope, Stephanie Edusei – Non-Executive Director Newcastle Hospitals and Odeth Richardson Chair of the BAME staff network. • 'Why Inclusion Matters' with Paralympian Stephen Miller, MBE. • 'Disability in the Workplace: Let's stop wasting talent!' with Dr Hannah Barham Brown. Following the success of the Trust Disability Talent Development Programme and the BAME Maximising Your Potential an internal offer is in development with a roll out date of September 2022 ensuring disabled staff and staff from ethnic minorities continue to benefit from development opportunities. Funding from NHS Charities for a BAME Development activity is being used to develop an ILM 3 offer for staff. A 'Neurodiversity at Newcastle Hospitals Guide' has been developed with the support of our Disability Staff Network. The guide aims to better support our neurodiverse colleagues and will be available on the Trust Flourish Website. The guide includes input from neurodiverse staff and offers guidance for managers.

	The Workforce Race Equality Standard (WRES) Improvement Project has been agreed. It will be looking to improve the differences in experience between BME and White Staff.

3. DELIVERING EXCELLENCE IN EDUCATION AND LEARNING

Leadership & Organisation Development; What Matters To You (WMTY)	Organisational Development including: • Ongoing and new interventions include Paediatric Physiotherapy and Duplication to Personalisation. • Following a focus on Newcastle GP Services and Urgent Treatment Centres, Collaborative Newcastle is supporting a resource to take forward recommendations regarding the development of Multi-Disciplinary Team's in Newcastle – aimed to improve staff integration and better patient outcomes. WMTY: • The Institute for Healthcare Innovation (IHI) continue to deliver improvement coaching to increase capacity to support services and teams. • The education team is working with Newcastle Improvement to finalise the improvement support infrastructure and training curriculum. • The second wave of WMTY development has commenced. The Paediatric Intensive Care Unit and Human Resources leadership team will be well underway with their programmes by next month. • Guiding principles to measure WMTY activity is underway, testing and refining of the support infrastructure, and the refreshed leadership behaviours and approach are currently in development. Systems Programme: • Expressions of interest for cohorts 5 and 6 have been invited – with 31 places for each, and the Trust having 20 places across both cohorts. • Two induction events are being held in June 2022 for participants and their line managers. The 10-month programme commences 20 July 2022. Strategic Leaders Programme This continues to progress, and the foundations of the leadership behaviours that have been developed are being tested with colleagues participating in the programme. Leadership Behaviours • As previously advised, the draft 'Newcastle Leadership Way' has been developed based on extensive staff engagement - 'What Matters to you' and focus on the three themes which emerged from the WMTY engagement. • The formal launch will be implemented when all feedback has been reviewed, the behaviours finalised and agreed. • A detailed implementation and awareness plan will be developed to embed the behaviours across the organisation.

Apprenticeship activity	Year-end data for 2021/22: • 169 staff began an apprenticeship, a 72% increase on the previous year. 140 were 'employer only' and 29 were 'employer provider, which are those in scope for OFSTED inspection and Education and Skills Funding Agency (EFSA) Audit. • Staff began on 30 different apprenticeship standards from Level 2 to Level 7. Approximately 50% were on healthcare and nursing related apprenticeships. • Over £900k of levy was spent on apprenticeship training. • £1.6m was committed to fund the 169 staff who started during the year. Other activity: • 17 supernumerary Healthcare Support Worker (HCSW) apprentices are now in post, with a further 4 being processed through recruitment. The first 8 are now reaching the of the supernumerary phase and ready to transfer into substantive posts. • 6 former ICHNE staff and 2 other Trust staff from our 'Grow our Own' pool have been appointed to HCSW apprentice posts. • 20 Registered Nurse apprentices have been recruited and began this month. The next recruitment will commence next month for a cohort of Trainee Nurse Associate apprentices, due to commence in September. • An application for Centre Approval has been submitted to Pearson/Edexcel. Access to online initial Assessment and Diagnostic resources has been secured to offer a more thorough and bespoke service to users. • Four bespoke Maths sessions were delivered to ICHNE staff as part of their onboarding. • Formal training for both English and Maths will start once Centre Approval has been secured. • Funding agreements are in place with 6 employers, with 12 apprentice Pharmacy Technicians in County Durham and Teesside. These are being funded from the Trust's unused levy. • The Trust application to remain on the Register of Apprenticeship Training Providers was submitted in April. It is likely to be July when we learn whether we have been successful. Work Experience: Some Trust work experience activity will be introduced. Initially with controlled numbers until the risks with COVID 19 are deemed low enough to increase activity to capacity.
Improvement Projects:	• An improvement group has been created to identify and implement improvements to the Study Leave process to ensure closer alignment with organisational objectives, better accessibility for all staff groups to funding, and improved governance and visibility of use of finite resources. On an interim basis the Study Leave Policy will undergo a minimal review for ratification to ensure that current process is documented. • A separate group has been established to streamline Trust processes for booking travel, payment and invoicing of courses and events as well as claiming study leave expenses.

Virtual Learning Environment (VLE)	The implementation, installation and rollout of software will be overseen by a project board. A provisional 'soft launch' is planned for end July, allowing time to test the system with the new Foundation Doctor intake. Governance arrangements will be via the Trust Learning and Education Group (LEG).
Statutory and Mandatory Training	A statutory and mandatory training improvement plan has been presented to the LET, and includes targeted improvement plans to address compliance. The target remains 95% for both this training and appraisal completion. It is anticipated the planned introduction of the VLE will facilitate greater accessibility for staff. It is also anticipated that the sustained change required will be supported by the recent introduction of the Power BI dashboards which provide greater transparency to managers regarding compliance in their own areas.
Medical Education	Two Clinical Educators with a specific remit for Medical Education are now in post. The annual medical education event was delivered virtually on 28 April 2022 to over 200 participants. The keynote speaker was Dr Paul Redmond, and the topic was 'Mind the Generation Gap'. This was very well received. The Annual Deans' Quality Meeting is scheduled for 25 May 2022. This will focus on the quality assurance of multi-professional learning across the Trust.
Education Space and Facilities	Work at both the Freeman Hospital and Eldon Court continues at pace; procurement of IT/AV systems is underway. The 'Arts and Culture' strategy, currently in development, will inform and influence any art works which may be displayed in the new facilities. This is being supported by the Arts Programme Manager. A new Room Booking System will be implemented, to ensure efficient use of the new facilities.

4. WORKING DIFFERENTLY

Clinical Directorate Proposed Reorganisation	The engagement and consultation process regarding if and how our clinical management structure can be improved continues.
Recruitment - general	There has been a significant increase in the recruitment activity in throughout 2022, with over 760 candidates going through the recruitment process with a further 201 with a confirmed future start date. **Registered Staff Nurse Recruitment** There have been further bespoke recruitment campaigns for staff nurse posts in Cancer Services, Interventional Radiology, Medicine, and Surgery.

	International Recruitment In partnership with the Nursing Team, the international nursing recruitment programme for 2022 is underway and will be a key feature of the Day Treatment Centre recruitment activity. The Trust is recruiting for 305 overseas nurses/midwives who will commence in the Trust on a monthly basis from June 2022 throughout 2022. The first cohort of 22 nurses are planned to arrive on 9 June 2022. **HCSW Recruitment** The team are also working closely with the Nursing Team on HCSW recruitment to reduce the vacancy rate. There are currently 77 candidates going through the recruitment process and 38 candidates with future start dates. **Day Treatment Centre** A Trust wide recruitment campaign commenced in late April for the new Day Treatment Centre (DTC) at the Freeman Hospital and the transformation of services/pathways. The need is for around 200 whole-time equivalent (WTE) staff, mostly focused on Registered Nurses and Medical staff. A weekly SitRep has been designed to ensure full overview of progress is monitored and highlights any potential risks that may start to emerge. Further, a 2-day DTC onboarding programme has been developed which will commence in June 2022 to support all members of staff onboarding into the new facility. **Restricted Advertising Process (RAP)** A RAP was in place from 18 March 2022 to 9 May 2022 to support colleagues at ICHNE at risk to find an alternative post within the Trust. As a result of this colleagues found alternative employment in the Trust. **Support to ICHNE Colleagues** A bespoke microsite was designed to provide support and information on training, development, and events to help staff at risk to find alternative employment. Other partner organisations vacancies were advertised on the site and virtual recruitment presentations were delivered by organisations to support staff in finding opportunities in their organisations. Colleagues found alternative opportunities including the NHS. Both internal and external training and development sessions were provided. External support sessions were delivered by the Department for Work in Pensions and the National Careers Service and outplacement support provided by Renovo.
Recruitment - medical	**Recruitment – medical** • August's junior doctor 'changeover' falls, this year, on Wednesday 3 August 2022. • Preparation for the August's 'changeover' is well underway, with recent assessment days having taken place for the Trust's Teaching Fellows and Newcastle Surgical Rotations programmes, as well as recruitment to routine expected Trust Doctor vacancies at directorate level.

	• The high-quality calibre of applicants for the Teaching Fellow programme resulted in a 72% fill rate after the initial assessment day on 26 April, and a second round of advertising is underway to fill the remaining posts for August. • Initial information from the Lead Employer Trust relating to incoming August trainees has arrived but is expected to be refined and updated further in the lead-in period to August. • Assessment of additional recruitment needs in light of trainee vacancies is being assessed and closely managed through the Junior Doctor Recruitment and Education Group (JDREG). • The Medical Staffing Team are working on in excess of 400 work schedules for doctors-in-training rotating into/working within the Trust from 3 August, with a deadline of 15 days from receipt of information from the Lead Employer Trust, in order to meet the Code of Practice deadlines specified in the 2016 Terms and Conditions of Service. • Work on induction preparation for August 'changeover' has also commenced. • Information for September 'changeover' (Wednesday 7 September) is expected to arrive in mid-June, and will likely necessitate further recruitment to trainee gaps, and production of a significant volume of work schedules for trainees joining in September. • Consultant recruitment is ongoing, with focused work on recruitment for the Day Treatment Centre underway.
Technology enhancements	As part of the NHS People Plan and the HR Futures Report, there is a drive to ensure readily accessible data is available and innovative technology solutions are embedded to support our people. As part of this the following initiatives have been developed: • Live 'People Dashboards' (using Power BI technology) on the Trust's reporting Hub which provides real-time people data. The two dashboards that have recently gone live are Appraisal and Statutory and Mandatory Training dashboards. A people dashboard 'roadmap' has been developed that includes staff absence and staff in post dashboards planned for quarter 2 and 3. • Staff Survey people dashboard which provides an interactive platform to understand results. This includes the inclusion of 5-year historical data to understand trends across people's experiences as they help inform long term staff experience planning • Robotic Process Automation (RPA) is currently being reviewed as we look to develop a trust wide delivery proposal. As part of this, an initial pilot has taken place in clinical areas which has produced two 'bots' to automate cancer information and national immunisation and vaccination data. Both are the first bots to be created automating these clinical data services. This has released staffing capacity to ensure colleagues can concentrate on value adding tasks by eliminating the need for data input data into systems. A new RPA strategic group have formed which will scope new pilot areas to understand all processes that are available for automation and to understand long term planning and staffing investment required to use the technology across the Trust. • An interactive staff experience portal to provide live access to key support elements for leaders in engaging their teams.

5. NHS PENSION WEBINARS

The next round of locally hosted webinars to provide staff with an insight and information about the NHS Pension Scheme, commenced this month, and continue into June. The Webinars are intended to support staff with planning earlier in their professional careers and support financial planning.

6. EMPLOYMENT TERMS & CONDITIONS

McCloud and NHS pension scheme

The McCloud remedy removed the age discrimination that was judged to have arisen in public service pension schemes. All active members of the NHS pension scheme are now in the 2015 scheme with effect from 1 April 2022. Affected staff will be offered a choice about their pension benefits for the remedy period (1 April 2015 to 31 March 2022). Those who have retired before 1 October 2023 (the date when legislation is expected to be in place) will make a retrospective choice; those who retire after this date will make a choice at retirement.

National living wage

Agenda for Change pay rates for band 1 and band 2 (minimum point) have been uplifted with effect from 1 April 2022 to ensure pay is legally compliant with minimum wage regulations.

Queen's Platinum Jubilee public holiday

The Trust has agreed it will treat the extra public holiday falling on Friday 3 June 2022 as a normal public holiday for pay purposes.

7. RECOMMENDATIONS

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

Report of Dee Fawcett
Director of Human Resources
18 May 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 May 2022						
Title	Digital Update - HIMSS6 Accreditation and GDE Programme Closure Report						
Report of	Graham King, Chief Information Officer						
Prepared by	Holly Greenwell, Head of Projects Lisa Sewell, Head of Digital Innovation and Delivery						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	This report confirms both achievement of HIMSS Level 6 accreditation, formal closure of the Global Digital Exemplar (GDE) programme and delivery of the objectives outlined at the initiation of the programme.						
Recommendation	The Trust Bard is asked to note the contents of this report.						
Links to Strategic Objectives	Pioneers - We maximise the benefits from the use of technology.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☒	☐
Impact detail	Impact detail documented throughout the report.						
Reports previously considered by	New report.						

DIGITAL UPDATE – HIMSS6 ACCREDITATION AND GDE PROGRAMME CLOSURE

EXECUTIVE SUMMARY

In March 2017, the Global Digital Exemplar (GDE) programme was initiated in Newcastle Hospitals. Funding was awarded and matched by the Trust to support delivery of 15 objectives and outcomes; one of which was to achieve HIMSS6 accreditation.

HIMSS6 accreditation was achieved on 1 April 2022 and the GDE programme was completed and closed on 7 April 2022. The Board is asked to note the contents of this report.

DIGITAL UPDATE – HIMSS6 ACCREDITATION AND GDE PROGRAMME CLOSURE

1. THE GDE PROGRAMME

A Global Digital Exemplar (GDE) is an internationally recognised NHS provider delivering improvements in the quality of care, through the world-class use of digital technologies and information. Exemplars share their learning and experiences through the creation of blueprints to enable other trusts to follow in their footsteps as quickly and effectively as possible.

GDEs and "fast followers" are supported by NHS England and Department of Health and Social Care funding, matched locally, and enabling GDEs to establish proven models that can be rolled out across the NHS more broadly. In some cases, this could include sharing software or a common IT team. For others it could mean adopting standard care pathways, methodologies and processes.

In August 2016, NHS England invited the Trust to submit an Expression of Interest (EOI) to become a Centre of Global Digital Excellence. This invitation was based upon the high levels of digital maturity the Trust had achieved, evidenced through the Digital Maturity Assessment previously submitted by the Trust.

The GDE programme was initiated in March 2017. A funding agreement was put in place, objectives defined, and benefits identified. Following the delivery of 15 outcomes the programme was concluded in April 2022. It was noted that the GDE funding that Newcastle Hospitals received was the lowest level of funding per bed out of many GDE applicants, and the largest scope of change delivered for the investment across the GDE programmes.

1.1 GDE Programme Scope

The scope of the GDE programme is detailed in the 15 outcomes below.

The defined outcomes were delivered in a controlled manner and project and programme boards were established to ensure effective delivery.

Project	Outcomes
PAS Upgrade	Upgrade of the Patient Administration System (PAS). Key benefits: • Improve the patient experience through streamlined process • Release administrative staff time • Improvements to referral booking system • Reduced workflow/procedures for Outpatient Clerks Improve data quality and accuracy
Electronic Complex Medication Management	Digital Prescribing for complex medication pathways. Key Benefits:

Project	Outcomes
	• Increased patient safety through use of guided clinical decision support • Full electronic audit trail of medication processes • Increased adherence to medication protocols • Improved medication audit data • Patient medication record viewable and easily manipulated remotely if appropriate • Electronic transmission of discharge medication data to GP's • Alignment with digital strategies towards paper-light working
Patient Self Check-In Trial	The trial of self-check-in and consent in preparation for electronic patient communication utilising an Electronic Patient Record integrated kiosk-based system. Key Benefits: • Verified usage and proving of patient consent recording • Fully informed business case for a decision on whether expected take up is achieved
eObservations and Electronic Whiteboards	The deployment of a digital solution to spot vitals sign resulting in automated NEWS Score generation and alerting. Key Benefits: • Improves patient care by quicker escalation of deteriorating patient • Timely medical reviews • Improved patient observations and patient scores • Improved escalation to medical teams • Improved patient flow and reduction in length of hospital stay • Reduction in patient mortality • Reduction in critical care usage
Digital Support of 7 Day Working Standards	The Trust implemented a solution that tracks the time in line with national seven-day standard; from first admission for patients through acute care and provides decision support for the sequencing of patient reviews and Consultant handover. Key Benefits: • Deliver safer patient care through appropriate and timely reviews • Reduce the variation in appropriate clinical supervision across all days • Provide data to inform readmissions and mortality rates that associated with weekend admissions

Project	Outcomes
EPR – (Enhanced Electronic Patient Record)	This project introduced a digital patient record to replace paper-based systems. Key Benefits: • Substantially reduced reliance on paper records • Simultaneous access to patient records • Patient records available when required, and reduced risk of misplaced records • Enhanced decision support • Increased patient safety and quality of care • More time to care • Increased consistency of practice • Improved data quality and reporting • Reduced paper costs • Enables in-depth clinical record sharing across care providers • Alerts can improve accuracy of sepsis diagnosis coding • Helping clinicians quickly identify patients at risk for sepsis can decrease mortality • Reduction in length of stay • Reduction of ICU bed occupancy due to sepsis
Outpatient Ordering	Outpatient Ordering extended the ability to digitally order all patient tests across all Outpatient settings and standardised best practice. Key Benefits: • Reduction of risk to patient safety as orders are placed against patient's electronic record • Reduction in treatment delays associated with multiple treatments on same day notes in the wrong place at the wrong time • Reduction in clinic wait times associated with consultants waiting for notes/reviewing notes once received in clinic. Orders and results are available to be reviewed when Consultant wishes • Electronic Orders will ensure results are sent to correct requestor – removes errors resulting in labs being unable to allocate results • Electronic Outpatient prescriptions will reduce delays associated with poor or unclear prescribing, and reduce issues associated with controlled drug prescription • Electronic out-patient prescriptions will enable greater formulary control to prevent unnecessary non-urgent prescribing • Supports our robust record management procedures • All patient's orders and results are available on the patient's electronic record enabling Consultants to review other

Project	Outcomes
	treatment activity where patient is on multiple treatment pathways • Enable accurate coding and retrieval and recording of patient outcomes to inform public health planning, quality indicators and Trust performance. • Will also enable collection of patient demographics to inform planning
Digital Access to the Community Record	Digital access to the community record completes the automation and mobile working capability for all community units allowing all community staff to access clinical information in a timely manner. Key Benefits: • All community staff have access to current clinical information reducing the need for them to return to base and to facilitate record sharing between acute and community care settings.
Patient Portal	The ability for patients to receive appointments, correspondence, and information on their condition digitally. Provide the capability for patients to interact with their appointments to accept, amend or cancel their appointments. Key benefits: • Improve the patient experience and move to modern communication methods • Reduce Did Not Attend (DNA) rates • Provide assurance patients have received their information
Health Information Exchange	Health Information Exchange enables the capability to exchange health information with care organisations across the region. Key Benefits: • Sharing patient data across disparate systems in the healthcare economy for effective and better care coordination leading to improvements in safety, quality at a lower cost
Remote Patient Consultation	Remote Patient Consultation enables virtual consultations between patients and healthcare professionals without the need to visit NHS sites. Key Benefits: • Patients can self-manage within a supportive framework • Supports the delivery of healthcare to diverse and sometimes hard to reach groups • Working alliance between patients, caregivers and health care team is strengthened • Reduction in unscheduled in-clinic visits • Opportunity for structuring – clinicians and patients will interact differently making consultations efficient, effective and patient centred

Project	Outcomes
Closed Loop Medicines Management	Implementation of tools and systems to support the closed loop management of medicine. Key Benefits: • Improved patient safety • Reduced stock holding • Reduced medicines expenditure • Reduced omitted doses due to medicine unavailable • Improved medicines security • Auditable medicines management process • Improved stock management
Closed Loop Blood	Implementation of tools and systems to support the closed loop management of blood as part of the transfusion service. Key Benefits: • Improved patient safety • Reduced blood product waste • Reduced administration support in transfusion service • Reduction of staff required at transfusion from 2 to 1 releasing clinical care time • A requirement of HIMSS 6 accreditation
Closed Loop Milk	Implementation of tools and systems to support the closed loop management of expressed milk. Key Benefits: • Reduce errors in administering the wrong milk to the wrong baby • Reduce milk waste • Fulfil the commitment to NHS Digital to provide sufficient systems capability to allow NuTH to reach HIMSS level 6
HIMSS level 6	Achieving HIMSS6 Key Benefits: • Fulfil the commitment to NHS Digital to provide sufficient systems capability to allow NuTH to reach HIMSS level 6 • Improve patient safety • Reduce mistakes in administering Blood, Medication and Milk

1.2 HIMSS6 Overview

Healthcare Information and Management Systems Society (HIMSS) is a non-profit organisation whose goal is to promote the best use of IT and management systems in the healthcare industry. The organisation provides thought leadership, professional and workforce development and public policy.

HIMSS primary purpose is to provide assurance that digital systems are implemented to a global standard that is driven by patient safety.

Achieving HIMSS6 was one of the outcomes outlined as part of the scope of the GDE programme.

On 1 April 2022, the Trust was measured against the international standard for Electronic Medical Record Adoption Model (EMRAM), which consists of seven levels (0 progressing to 7), each of which must be implemented sequentially.

The assessment was led by HIMSS independent assessors, and the following departments participated in the assessment:

- Laboratory
- Medical Imaging
- Pharmacy
- Blood Bank
- Medical records
- Clinical coding
- The Emergency Department
- Project teams for Closed Loop Milk, Blood and Medication
- The IM+T Senior Management team

At the end of the assessment day the EMRAM accreditor confirmed that Newcastle Hospitals had achieved HIMSS6 accreditation, with the condition of achieving 50% delivery of scope roll out across in-patient wards for Medication, Blood, and Milk by end of Oct 2022. This achievement is significant no other Teaching Hospital similar in scale to Newcastle Hospitals has achieved all site accreditation. This is a significant achievement and sets the base to develop innovative use of advanced technologies to exploit the data collected in support of the Trust objectives.

The focus now moves to optimising the functionality of the systems to better support frontline staff.

The table below provides a summary of the benefits realised up to December 2021, non-cash releasing benefits have a monetary value applied for comparative purposes.

Benefits	**Total planned - 10 years**	**Planned to Date**	**Actuals to Date**
Cash Releasing	£8.67 M	£2.05 M	£2.23 M
Non-Cash Releasing	£17.48 M	£5.66 M	£4.33 M
Public	£0.02M	£.01 M	£.01 M
Total	***£26.16M***	***£7.71M***	***£6.57M***

2 RECOMMENDATION

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

Agenda item A7(f)

Report of Graham King, Chief Information Officer

Prepared by:
Holly Greenwell, Head of Projects
Lisa Sewell, Head of Digital Innovation & Delivery
12 May 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 May 2022						
Title	Update from Committee Chairs						
Report of	Non-Executive Director Committee Chairs						
Prepared by	Kelly Jupp, Trust Secretary Lauren Brotherton, Governor and Membership Engagement Officer Gillian Elsender, Corporate Governance Administrator and PA to Chairman and Trust Secretary						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The report includes updates on the work of the following Trust Committees that have taken place since the last meeting of the Trust's Board on 31 March 2022: • People Committee – 19 April 2022; • Finance Committee – 22 April 2022 (Extraordinary) and 25 May 2022 (Ordinary); • Audit Committee – 26 April 2022; • Charity Committee – 6 May 2022; and • Quality Committee – 17 May 2022.						
Recommendation	The Board of Directors are asked to (i) receive the update and (ii) note the contents.						
Links to Strategic Objectives	Links to all.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☒	☒	☒	☐
Impact detail	Impacts on those highlighted at a strategic level.						
Reports previously considered by	Regular report.						

UPDATE FROM COMMITTEE CHAIRS

EXECUTIVE SUMMARY

This report provides an update to the Board on the ongoing work of the Trust's Committees for those meetings that have taken place since the last meeting of the Board of Directors in March 2022.

UPDATE FROM COMMITTEE CHAIRS

1. PEOPLE COMMITTEE

A formal meeting of the People Committee took place on 19 April 2022. During the meeting, the main areas of discussion to note were:

- A detailed update was provided regarding the people impact of the termination of the Integrated COVID Hub (ICHNE) contract.
- A COVID-19 update was received in relation to the vaccination hub and vaccination as a condition of deployment.
- An update on the Flourish programme was received including:
    - 2021 final staff survey results;
    - Education and workforce development including statutory and mandatory training action plan; and
    - Flourish/What matters to you.
- The people dashboard was received and discussed.
- The Assistant Chief Executive provided an update on the Trust communication strategy.
- The Committee received the Guardian of Safe Working quarterly report and a legal update.

The next formal meeting of the Committee will take place on 23 June 2022.

2. FINANCE COMMITTEE

An extraordinary meeting of the Finance Committee took place on 22 April 2022. During the meeting, the main areas of discussion included:

- Month 12 and the year-end position.
- An update on the financial plan for 2022/23, with key risks highlighted.
- Key headlines from the draft Annual Accounts for 2021/22.
- The Trust Capital Programme.
- Agreement that future meetings would include deep dives on CIP and capital projects.

A formal meeting of the Finance Committee took place on 25 May 2022. During the meeting, the main areas of discussion included:

- An update on the draft Annual Accounts 2021/22.
- The Month 1 finance report and key risks.
- An update on the commercial strategy and the Commercial Enterprise Unit I&E.
- The Executive Director of Business, Development and Enterprise presented the activity for Month 1 2022/23.
- The Head of Corporate Risk and Assurance presented the Board Assurance Framework (BAF) report.
- Tenders and Business Cases presented for approval.
- An update from the Procurement and Supply Chain Director.
- The Committee Annual Report was received and approved.

The next extraordinary meeting of the Committee will take place on 17 June 2022, to approve the final accounts and annual report. The next ordinary meeting of the Committee will take place on 27 July 2022.

3. AUDIT COMMITTEE

A formal meeting of the Audit Committee took place on 26 April 2022. During the meeting, the main areas of discussion to note were:

- Committee Chairs provided updates relating to risk and assurance in relation to each of their committee's remit.
- The Head of Corporate Risk and Assurance presented the Board Assurance Framework Risk Management Annual Report.
- The Finance Director presented the draft annual accounts for 2021/22 and going concern statement for 2021/22.
- An update was received on the clinical audit process.
- AuditOne provided a progress report on the Trust's Internal Audit programme and Counter Fraud provided an update on the Trust's annual plan and annual fraud self-review tool.
- Mazars LLP provided an update on the Trust and Charity's external audit strategy memorandum.
- The Trust Secretary presented the Draft TCWG response, self-assessment checklist and the proposed updated terms of reference and schedule of business, which were approved.
- The Head of Corporate Risk and Assurance presented the draft annual governance statement.
- The Committee received a number of reports including:
    - Review of schedule of approval of single tender action and waivers exception report;
    - Review of debtors and creditors balances;
    - Review of schedule of losses and compensation;
    - Annual review of special severance payments/settlement agreements;
    - Information Governance update; and
    - Cyber update.

The next formal meeting of the Committee will take place on 26 July 2022.

4. CHARITY COMMITTEE

A formal meeting of the Charity Committee took place on 6 May 2022. During the meeting, the main areas of discussion to note were:

- The Charity Director provided an update on the operating cost benchmarking, charity risk statement and dashboard.
- The annual review of the Committee and schedule of business was received and approved.

- The Deputy Trust Secretary presented the charity audit strategy memorandum.
- A number of grants were considered for approval. Successful grants totalled circa £1.2m and included:
  - The purchase of Neonatal Bedside Resuscitation Equipment (Women's Services);
  - The purchase of Neonatal Delivery suite ventilators (Hamilton C1) (Women's Services);
  - Funding for a Haematology Clinical Trial Fellow (Cancer Services and Clinical Haematology);
  - Funding for support staff for the Enhanced Recovery programme in Abdominal Transplantation (Renal Services);
  - Imaging software and associated costs (Cardiothoracic Services) – Approved in principle pending confirmation of one matter**;**
  - Funding to provide open access to the Hospedia TV's for cancer patients (Cancer Services and Clinical Haematology);
  - Funds for EIDO Healthcare Informed Consent Patient Information leaflets (Patient Services);
  - Funding for a Physicians Associate Preceptorship in partnership with Health Education England (Cardiothoracic Services);
  - Funds for a clinical specialist physiotherapy in Children's Cancer (Children's Services) – Approved in principle pending agreement of the fund to be utilised**;**
  - Funding for a patient engagement in Continuous Improvement and Transformation project (Patient Services);
  - Funds for two Sir Bobby Robson Foundation training posts (Cancer Services / Clinical Haematology); and
  - Funding for a project called 'Establishing Effective Transition from Children's to Adult Services and Developing an 'Outreach' Service for Young People (YP) outwith GNCH' (Patient Services).
- A summary of grants approved since the last meeting was received.
- A number of finance reports were received, including a summary of investment report.

The next formal meeting of the Committee will take place on 02 September 2022.

5. QUALITY COMMITTEE

A formal meeting of the Quality Committee took place on 17 May 2022. During the meeting, the main areas of discussion to note were:

- An update on the Ockenden report and Maternity Incentive Scheme was provided.
- The integrated quality and performance report was received and discussed.
- A Royal College reviews update was provided.
- The chairs of the Patient Safety Group and Patient Experience & Engagement Group provided their report on activity and progress.
- Quarter four annual reports were received for Safeguarding, Learning Disability and Learning from Deaths.
- An end of life and palliative care biannual report was received.
- A Newcastle Improvement biannual report was received.

- An update on the leadership walkabout/spotlight on services was provided.

The next formal meeting of the Committee will take place on 19 July 2022.

6. RECOMMENDATIONS

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

Report of Kelly Jupp, Trust Secretary
Lauren Brotherton, Governor and Membership Engagement Officer
Gillian Elsender, Corporate Governance Administrator and PA to Chairman and Trust Secretary
19 May 2022

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