The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	29 September 2022						
Title	Guardian of Safe Working Quarterly Report (Q1 2022-23)						
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours						
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The terms and conditions of service of the new junior doctor contract (2016) require the Guardian of Safe Working Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant. The content of this report outlines the number and main causes of exception reports for the period 27 March to 26 June 2022 for consideration by the Trust Board.						
Recommendation	The Trust Board is asked to note the contents of this report.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☐	☐
Impact detail	In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.						
Reports previously considered by	Regular quarterly report of the Guardian of Safe Working Hours presented to the People Committee prior to Trust Board.						

The Newcastle upon Tyne Hospitals NHS Foundation Trust

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

This quarterly report covers the period 27 March to 26 June 2022.

There are now 811 postgraduate doctors in training on the New Junior Doctor Contract and a total of 1,012 postgraduate doctors in the Trust.

There were 97 exception reports in this period. This compares to 67 exception reports in the previous quarter.

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

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

2. INTRODUCTION / BACKGROUND

The 2016 New Junior Doctor Contract came into effect on 3rd August 2016 and was reviewed in August 2019, with changes implemented in a staggered approach from August 2019 to October 2020.

The TCS of the 2016 contract allows for exception reporting to raise reports on breaches of working hours and educational opportunities. These are ratified or rejected as appropriate by clinical supervisors and the process is overseen by the Guardian of Safe Working Hours.

The TCS require the Guardian of Safe Working Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant.

3. HIGH LEVEL DATA

		(Previous quarter data for comparison)
Number of Junior Doctors on New Contract	811	(800)
Total Number of Junior Doctors	1012	(1005)
Number of Exception reports	100	(69)
Number of Exception reports for Hours Breaches	97	(67)
Number of Exception reports for Educational Breaches	4	(5)
Fines	3	(1)

Admin Support for Role	Good
Job Planned time for supervisors	Variable

4. EXCEPTION REPORTS

4.1 Exception Report by Speciality (Top 5)

General Medicine	43
Ophthalmology	25
General Surgery	16
Haematology/Oncology	8
Cardiology	6

4.2 Exception Report by Rota/Grade

Ophthalmology ST3	21
Assessment Suite F1 RVI	13
Core Medical Training FH	10
General Surgery FH F1	9
Cardiology IMT/ST1/2	9
General Internal Medicine F1 FH	8
Intermediate Medical Training ST1/2 RVI	6

4.3 Example Themes from Exception Reports

General Medicine RVI/FH
"Asked to cross cover Ward XX (only 1 junior on the ward; minimum staffing 2 juniors); then at 10am asked to cover ward YY (which had no juniors on the ward; minimum staffing 2 juniors on the ward)"

Steps taken to resolve:
"Not possible due to below minimum staffing on multiple wards"

Medicine is under extreme pressure at the moment, due to staffing issues. These are due to multiple reasons, and are exacerbated by Covid related sickness absence. Discussions are underway to look for solutions.

General Surgery FH/RVI F1

"Busy department only 2 junior staff members (3 juniors minimum). Senior staff aware of difficulties."

Ophthalmology RVI

"Late finish in eye casualty plus additional corneal admin work. The extra work load is due to the two corneal fellows' change of role (but not replaced by anyone else)."

21/25 Exception Reports were submitted by the same doctor, highlighting this issue. The department and head of school are aware.

Haematology/Oncology

"I worked a busy day on STU. I was the only SHO covering the ward in the afternoon and due to clinical demand was unable to complete all my duties within my allocated hours."

5. EXCEPTION REPORT OUTCOMES

5.1 Work Schedule Reviews

One Work Schedule review has been requested and is underway in medicine following a request by a doctor.

5.2 Fines

3 fines have been issued:

- Ophthalmology: Rule breached "Unable to achieve minimum overnight continuous rest of five hours between 22:00 and 07:00 during a non-resident on-call (NROC)."
- Ophthalmology: Rule breached "Exceeding the maximum 13-hour shift length."
- Medicine: Rule breached "Exceeding the maximum 13-hour shift length."

6. ISSUES ARISING

6.1 Workforce and workload

The recurring theme as to when exception reports are raised is when there is a reduction of doctor numbers on the ward or high workloads due to multiple unwell patients. Some wards, particularly the medical wards, have experienced extreme pressures with gaps due to a combination of changes in doctors' working patterns and short-term sickness, as highlighted in my Annual Report.

6.2 Supervisor Engagement

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

6.3 Administrative Support

Administrative support is currently good.

7. ROTA GAPS

Specialties and rotas with vacancies are outlined below. A full breakdown of gaps has been added to the Private Board Reference Pack.

7.1 Locum Spend

LET Locum Spend

April to June (Q1 2022-23)	£446,907
January to March (Q4 2021-22)	£618,712

Comment from finance team:
"In terms of expenditure we rely on the invoices from the LET and so there are differences between the actual incidence of spend and the Trust being invoiced for it. "

Trust Locum Spend

April to June (Q1 2022-23)	£482,999
January to March (Q4 2021-22)	£589,740

Comment from finance team:
"Spend on Trust locums decreased by £107k of which £50k reduction related to a reduction in spend on locum to cover COVID and £58k to a reduction in locum cover related to covering on call and established vacancies."

8. RISKS AND MITIGATION

The main risk remains medical workforce coverage across a number of rotas. As previously highlighted, this is exacerbated by changes in working patterns due to alterations of the TCS of the Junior Doctor Contract, and changes in training requirements. Short term sickness is exacerbating these issues. Whereas previously exception reports were highlighting wards at minimum staffing, we are starting to see wards working below minimum staffing.

9. JUNIOR DOCTOR FORUM

The main areas of discussion were around the extreme pressures due to staffing issues in several different specialties. In addition, concerns regarding lack of parking provision, especially for doctors working long daytime shifts were highlighted.

Another issue that was again highlighted was lack of phlebotomy services for medical boarders, which increases workload for doctors when they are already stretched. Discussions are underway to address this.

10. RECOMMENDATIONS

I recommend that we reassess the workforce/workload balance with consideration to the changes in doctors' working patterns brought about by changes to the educational requirements and TCS of the Junior Doctor Contract.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
6 August 2022

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NB There is an embedded document within this report – please contact the Corporate Governance Team if you would like to view the embedded document

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	29 September 2022						
Title	NHS Emergency Preparedness, Resilience & Response (EPRR) Annual Report						
Report of	Andy Welch, Medical Director, Accountable Emergency Officer						
Prepared by	Michael Clark, Head of Business Continuity & Emergency Planning						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☒		☒		☐		
Summary	NHS England requires NHS organisations, and providers of NHS-funded care, to provide annual assurance of readiness against the Core Standards for Emergency Preparedness, Resilience & Response (EPRR). The content of this report outlines the Trust's position regarding the annual EPRR Core Standards self-assessment and progress with the EPRR Work Programme.						
Recommendation	The Board of Directors is asked to: i) Note progress made over the last year on the EPRR Work Programme and the successful response to incidents, delivery of training and exercises and plan updates as detailed within this paper; and ii) to approve the assessment of assurance against the 2022-23 EPRR Core Standards and the Trust's overall rating as Partially Compliant, with an action plan to achieve Full Compliance.						
Links to Strategic Objectives	Putting patients first and providing care of the highest standard focussing on safety and quality.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☐	☐	☐	☐	☐
Impact detail	Trust is required to meet legislative duties set out in the Civil Contingencies Act 2004.						
Reports previously considered by	The EPRR Report and Core Standards Self-Assessment is submitted annually to the Trust Board.						

EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE (EPRR) ANNUAL REPORT (APRIL 2021 to APRIL 2022)

1. INTRODUCTION

The Civil Contingencies Act 2004 (CCA) (UK Government, 2004) imposes a statutory duty on Newcastle Upon Tyne Hospitals NHS Foundation Trust (the Trust) to have in place arrangements to respond to incidents and emergencies. Under the terms of the CCA the Trust is a Category 1 Responder. This places a statutory duty upon the Trust to be able to respond to internal or external disruptive events that might impact on the Trust's ability to deliver its services.

The CCA also places other duties on Category 1 responders, including the requirement to:

- Assess the risk of emergencies occurring and use this knowledge to inform contingency planning.
- Ensure emergency plans and business continuity management arrangements are in place.
- Communicate with the public to ensure they are warned, informed and advised in the event of an emergency.
- Share information and cooperate with other local responders to enhance co-ordination and efficiency.

The NHS Emergency Preparedness, Resilience and Response (EPRR) Guidance (NHS England, 2015) requires the Trust to:

- Have suitable and up-to-date incident response plans which set out how the Trust would respond to and recover from a major incident/emergency which is affecting the wider community or the delivery of services; and
- Have business continuity plans that enable the Trust to maintain or recover the delivery of critical services in the event of a disruption.

The minimum requirements which the Trust must meet regarding EPRR are set out in the NHS England Core Standards for EPRR (Core Standards). These standards are in accordance with the CCA 2004 and the NHS Act 2006 (as amended). The standards are published annually, and the Trust undertakes a self-assessment against these standards as part of the annual national assurance process and submits results to the Board for approval along with a summary of EPRR activities in preceding 12 months.

1.1 Purpose of paper

This paper is intended to update the Board on progress with the Trust's compliance level with the NHS England's Emergency Preparedness, Resilience and Response (EPRR) Core Standards and other statutory requirements placed upon the Trust by the Civil Contingencies Act (CCA) (2004) and the NHS England EPRR Framework.

It will also provide the Board with an update on the progress made with the EPRR Work Programme and other activities undertaken by the department in the preceding 12 months. As such, it will summarise:

- The governance arrangements supporting EPRR;
- details of the meetings held to support EPRR;
- training & exercising undertaken to support the EPRR work programme;
- development and reviews of the Trust's emergency plans and business continuity plans;
- incidents of note; and
- the annual national assurance process for EPRR.

2.0 GOVERNANCE

2.1 Executive Director & Accountable Emergency Officer (AEO)

Mr Andy Welch, the Trust's Medical Director is the designated Accountable Emergency Officer for EPRR and has delegated responsibility for ensuring that the Trust is in a position to provide assurance that it has in place the necessary EPRR Framework. The Accountable Emergency Officer for EPRR is also a member of the Trust Board and chairs the EPRR Strategy Group.

2.2 Non-Executive Director

A non-executive director has been appointed by the board to endorse assurance to the board that the organisation is meeting its obligations with respect to EPRR and the Civil Contingencies Act. This supporting role also seeks assurance that the organisation has allocated appropriate resources to meet these requirements, including the support of properly trained and competent emergency planning officers and business continuity managers as appropriate.

The appointed non-executive director for EPRR is Mr Steven Morgan.

2.3 Resources

The Trust's EPRR function is delivered by the Business Continuity & Emergency Planning Team, made up of the Trust Head of Business Continuity & Emergency Planning and the EPRR Coordinator.

2.4 Emergency Preparedness, Resilience and Response (EPRR) Strategy Group

Designated leads, responsible for EPRR work programme of their respective committee, provide reports to the EPRR Strategy Group – see diagram below.

Diagram 1 – Newcastle Hospitals EPRR Committee Structure

The Emergency Preparedness, Resilience and Response (EPRR) Strategy Group meets quarterly to direct and oversee both Emergency Planning and Business Continuity Planning on behalf of the Trust Board.

There were no major changes to governance arrangements relating to EPRR during the year April 2021 to April 2022.

2.5 Policy Updates

The Trust EPRR Policy was updated in January 2022 to include provisions for managing acute supply chain disruptions. This formalised an ad-hoc group that was created to the manage these disruptions (the Medical Device Supply Group), outlining its membership, scope and governance arrangements.

The Trust Business Continuity Management Policy has been updated and ratified (February 2022). The latest version includes a clearer and more streamlined process for escalation of business continuity incidents.

2.6 Meetings & Groups

Through the year April 2021 to April 2022, all sub-groups for EPRR met as scheduled. The exception to this was a cancellation of one EPRR Strategy Group meeting in July 2021, owing to a short notice cancellation to accommodate a Gold Command meeting in response to staffing shortages caused by the Delta COVID variant.

	EPRR Strategy Group	Business Continuity Operational Group	Major Incident Planning Group
2021/22 – Q1	06/04/2021	18/05/2021	17/06/2021
2021/22 – Q2	Meeting Cancelled	17/08/2021	23/09/2021
2021/22 – Q3	14/10/2021	14/12/2021	16/12/2021
2021/22 – Q4	04/01/2022	15/02/2022	28/04/2022

2.7 External Visits

No external agency visit took place in during the year April 2021 to April 2022.

3.0 EMERGENCY & BUSINESS CONTINUITY PLANNING

As means of mitigation to items identified on the EPRR Risk Register, the Trust has developed both generic, all-hazard plans that cover a wide variety of potential disruptions, and hazard-specific plans for risks such as severe weather and downtime.

Documents	Objective of the Document	Status
All-Hazard Plans & Policies		
Emergency Preparedness, Resilience and Response (EPRR) Policy	Sets out an all-hazard EPRR framework and strategic direction for the Trust.	Version 3 – updated in February 2022.
Business Continuity Management Policy	Outlines how the Trust plans for and co-ordinates its response to a business continuity incident.	Version 6 – updated in February 2022.
EPRR Risk Register	Assesses the implications to the Trust of the EPRR threats and hazards.	Updated in January 2022.
Major Incident Plan	Outlines how the Trust co-ordinates its response to a Major Incident (mass casualty).	Version 7 – up to date as of February 2022.
Directorate/Department Business Continuity Plans	Outlines how critical services would be maintained in the event of a disruption.	See Section 3.2
Directorate Major Incident Plans	Outlines how directorates will respond to major incidents.	See Section 3.3
Hazard Specific Plans & Policies		
Lockdown Policy	Covers how a Trust owned and leased building / sites would be locked down and controlled.	Version 3 – updated in September 2020.
Full-site Evacuation Plan	Outlines the process for the evacuation and onward transfer of patients from an entire hospital site.	Version 1 – to be reviewed following issuance of new national guidance.
All Hazard Severe Weather Plan	Outlines procedures for the response to multiple severe weather hazards.	Version 1 – up to date as of June 2022.
eRecord Downtime Incident Response Plan	Outlines the process for planning for and responding to the loss of the electronic patient record system.	Version 1 currently under review.
Telephony Downtime Plan	Outlines the procedures for the management of a loss of any aspect of the Trust telephony system.	Version 1 currently under review.
Trust Pandemic Plan	Outlines the procedures required in planning for and responding to a pandemic.	Replaces Pandemic Flu Plan.

		Draft 0.1 – to be completed by December 2023.
High Consequence Infectious Disease (HCID) Policy & Action Cards	Outlines the procedures for the management of patients admitted to the Trust with a HCID.	Version 3.3 - Up to date as of April 2022.
Crisis Management & Incident Communications Plan	Outlines how the Trust will communicate internally and externally in the event of an incident or emergency.	Draft 0.1 – to be completed by March 2023.
Support Services Disaster Recovery Plans	Hazard & department specific plans for ensuring continuity upon the loss of a critical system or device.	Estates Emergency Manual currently under review.

3.2 Business Continuity Planning

Compliance for business continuity planning over the last 12 months has remained stable, increasing to a high of 70% in April of plans up to date.

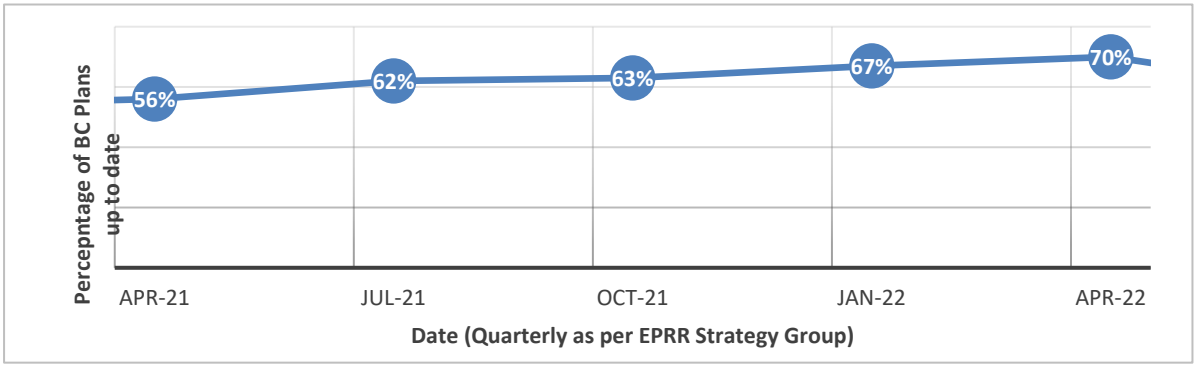

FIGURE 1 – RUN CHART OF BUSINESS CONTINUITY PLANNING COMPLIANCE (QUARTERLY)

In September 2021 the Head of Business Continuity & Emergency Planning was informed by IM&T that the existing Trust software for business continuity would no longer be supported due it being hosted on historic infrastructure. This expedited the need to identify and embed a new solution for managing the business continuity plans and business impact assessment. The analysis stage of this process in complete and a solution has been identified. The options are to be presented as a business case the executive in due course.

3.3 Major Incident Planning

The level of compliance with directorate level major incident plans has remained steady over the last 12 months. As of April 2022, the figure was 65% up to date, with 9 of the 26 plans still in need of a review.

3.4 Climate Change Adaptation Planning

Under the NHS Long Term Plan, and within the EPRR Core Standards, the Trust is required to hold and maintain a Climate Change Risk Assessment and Climate Change Adaptation Plan. These have been in place since 2017 but have not been updated since then. The BC/EP

Team has been working with the Sustainability Team to update both of these requirements, pending guidance from the Greener NHS Initiative.

Now that guidance has been received, an independent consultant has been instructed to undertake a review of the relevant legislation, guidance and Trust documentation and lead a workshop with stakeholders. This project presents an opportunity to the Trust to lead the way in developing a Climate Change Adaptation Plan.

4.0 RISKS

4.1 Risk Register

The EPRR Risk Register was updated in January 2022 to reflect the change in likelihood of a significant staffing shortage caused by a pandemic. The mitigation measures were also updated to reflect the processes that were implemented to manage this, particularly those relating to nurse staffing escalation.

5.0 INCIDENT RESPONSE

5.1 High Consequence Infectious Diseases

Through 2021 and early 2022, the Trust's HCID unit was put on alert for two potential HCID incidents - these included Lassa Fever and Crimean Congo Haemorrhagic Fever. No confirmed cases were admitted to the Trust, but the Infectious Diseases Team took the opportunity to train new staff and familiarise with procedures. Subsequent activations for Monkeypox have taken place, but these occurred in Summer 2022 and are out of scope of this report.

An OSCAR Alert system, similar to what is used in the Trust for Major Incidents has been embedded to ensure that appropriate individuals and departments around the Trust are alerted to potential or confirmed HCID in good time to improve the overall response.

5.2 Supply Chain Disruption

The Medical Device Supply Group was formed in March 2021 and met throughout the summer of 2021 to initially manage a shortage of blood bottles (vacutainers). Input was sought from the DIPC and other Corporate Clinical Directors to support a change in practice around ordering of blood tests only when these are clinically absolutely necessary. These changes were broadly successful as usage and ordering both markedly reduced.

The Medical Device Supply Group (MDSG) continue to meet on a weekly basis to manage the impact of ongoing disruption in the global supply chain as a result of disruptive global events. A number of issues are currently on the agenda, all of which are being actively supported by the relevant clinical speciality. Senior oversight continues to be provided by the appointed Associate Medical Director, with escalation is via the EPRR Strategy Group.

5.3 COVID-19

Throughout 2021 and in to early 2022, Silver Command (tactical) was in place to support the incident response to the COVID-19 Pandemic. As well as Silver, Gold (Strategic) Command meetings continued to take place weekly to maintain a consistent level of senior situational awareness across the organisation and approve major changes to operational policy.
In March 2022, following a consistent fall in COVID cases and changes in Government guidance, COVID Gold Command took the decision to stand down.

6.0 TRAINING & EXERCISING

As a Category 1 responder, the Trust must carry out training and exercising of our emergency plans and contribute towards collaborative exercising of local partner agencies' emergency plans. Exercises provide an opportunity for wards, departments, and clinical leaders at bronze, silver and gold to test readiness to respond to incidents.

The Trust is required under the NHS England EPRR Framework to undertake the following exercises:

TYPE OF EXERCISE	COMPLIANCE
An annual command post exercise	**FULL** ICC Training (Held on 08/12/2021)
An annual desktop exercise	**FULL** Cyber Security Exercise (Held on 09/03/2022)
Hold a six-monthly communication exercise	**FULL** Major Incident Comms Exercise (Held on 07/07/2022)
Hold a three yearly live or simulated exercise	Not required in 2021/22 Next iteration is scheduled for May 2023

In addition to the requirements of the NHS England EPRR Framework, the Trust EPRR Policy outlines internal exercising requirements. Under the NHS England EPRR Framework (2022), if an organisation activates its plan for response to a live incident, this replaces the need to run an exercise, providing lessons are identified and logged.

EXERCISE CATEGORY	COMPLIANCE
Directorate Level Business Continuity Exercise	**PARTIAL** (Managing the live impact of the COVID-19 Omicron Variant)
Directorate Level Major Incident Exercise	**PARTIAL** (Managing the live impact of the COVID-19 Omicron Variant)

Corporate Business Continuity Exercise	**FULL** Cyber Security Exercise (Held on 09/03/2022)
Corporate Major Incident Exercise	**FULL** ICC Training (Held on 08/12/2021)

6.1 Corporate On-call Training & Incident Coordination Centre (ICC) Familiarisation

The scenario for the 2021-22 round of ICC Exercises (Command Post) was also used as the scenario for the Corporate Major Incident Exercise. In this exercise, the Hospital Control Team (Silver Command) were given the task of managing a number of high-profile casualties contaminated with an unknown nerve agent. This exercised elements of the Trust Major Incident Plan, Emergency Department CBRN Plan and created some useful learning around patient VIP management.

6.2 Annual Business Continuity & Major Incident Exercises

In January 2021, the EPRR Strategy Group took the decision to defer the requirement to hold the annual directorate business continuity exercise in lieu of the ongoing staffing shortages and clinical response resulting from the Omicron variant of Covid. Directorates were asked to review their response to these staffing shortages as part of departmental meetings and include any relevant updated to staffing levels within the relevant plans.

The scenario developed for the 2021-22 cycle will be used to deliver the 2022-23 annual business continuity exercises.

6.3 Cyber Security Exercise

Following guidance issued by NHS Digital, in March 2022 the department developed and delivered an exercise for IM&T to test the Trust response and resilience to a large-scale and coordinated cyber-attack. The scenario explored the impact on the Trust of a move to ‘island-mode’ for an extended period of time. A report into the exercise with recommendations and actions is owned by IM&T.

7.0 EPRR WORK PROGRAMME FOR 2021 - 2023

7.1 Work Programme

- Address gaps in compliance with the EPRR Core Standards Self-assessment.
- Maintain regular tests of the OSCAR communication call cascade system.
- Work with MDSG and monitor our supply chain to ensure resilience.
- Debriefing & post-incident / Exercise Reports (as required).
- Attendance / engagement with LRF, LHRP & HSCRG (as required).
- Review Climate Change Risk Assessment following issue of national template.
- Rolling review of the Trust Major Incident (Mass Casualty) Plan.
- Develop & embed Trust (V)VIP Casualty Management Plan.

- Design & deliver business continuity & major incident exercises for the Directorates.
- Deliver the annual ICC familiarisation exercises for the Corporate On-call Team.
- Maintain Trust ICC Resources.
- Maintain and grow loggist pool & deliver familiarisation training.
- Continual monitoring of Directorate Business Continuity & Major Incident Plans.
- Annual review of compliance with Data Protection & Cyber Security Toolkit.
- Rolling ED Major Incident / CBRN Training & Estates Decontamination Tent Training.

7.2 Key Priorities for 2022 – 2023

- Review EPRR Training & Exercise Strategy & Programme as well as OLM Modules to align to MOS for EPRR and ensure compliance for on-call PDPs.
- Develop a generic Incident Response Plan, including an Escalation Framework (Critical Incident Plan).
- Finalise & embed the Incident Communications Plan.
- Update hazard-specific plans (telephony and eRecord downtime).
- Finalise and embed the Climate Change Adaptation Plan.
- Implement a new business continuity management system that aligns to international good practice through the procurement of new software.
- Embed Estates P1 Process through training and exercising.
- Embed the site-wide Evacuation Plan through the development of action cards, procurement of equipment, delivery of training and exercising.
- Audit and then roll out new structure for Ward & Department Emergency Files.

8.0 NATIONAL ASSURANCE PROCESS

8.1 EPRR Assurance 2022/23

For the 2021/22 version of EPRR Core Standards the trust was able to score Fully Compliant against all applicable standards. This was partly due to a successful work programme addressing gaps in compliance over a multi-year period and also due to the limited scope of the standards following the pandemic.

The 2022/23 Core Standards is more comprehensive following an extensive national consultation and review process since pre-pandemic versions. This has resulted in the creation of new standards, amendment to the evidence criteria for a number of standards, both of which have placed new requirements on Trusts in order to achieve full compliance.

The Head of Business Continuity & Emergency Planning has undertaken a thorough, fair and reflective self-assessment of the Trust's position in relation to compliance against this year's EPRR Core Standards. This has resulted in the compliance position changing from Fully Compliant to Partially Compliant. Details of the assessment against each standard, the impact of the relevant amendments and an action plan to achieve fully compliance are contained in the accompanying spreadsheet. A high-level outline is given below.

The NHS England & Improvement Regional Team has written to the Trust requesting that the organisation's final overall assurance rating be:

- Formally reported to, and signed off by, the organisation's Board.
- Presented at a public Board meeting.

A declaration of the overall level of compliance – see table below for criteria.

Overall EPRR Assurance Rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are required to achieve.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve.

8.2 Compliance Position

The tables below summarise the current Trust compliance position against all relevant domains within the 2022/23 Core Standards.

Following the completion of the self-assessment process, the Trust is **Partially Compliant.**

Percentage Compliance	**84%**
Overall Assessment	**Partially Compliant**

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant
Governance	5	5	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	7	4	0
Command and control	2	1	1	0
Training and exercising	4	2	2	0
Response	7	7	0	0
Warning and informing	4	2	2	0
Cooperation	4	3	1	0
Business continuity	10	10	0	0
CBRN	14	14	0	0
Total	**63**	**53**	**10**	**0**

NOTE: The Deep Dive Element (below) does not count towards the overall Trust compliance position.

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non-Compliant
Evacuation and Shelter	13	6	6	1
Total	**13**	**6**	**6**	**1**

9.0 RECOMMENDATIONS

The board are invited to:

- Note progress made over the last year on the EPRR Work Programme and the successful response to incidents, delivery of training and exercises and plan updates as detailed within this paper; and
- to approve the assessment of assurance against the 2022-23 EPRR Core Standards and the Trust's overall rating as Partially Compliant, with an action plan to achieve Full Compliance.

Report of
Mr Andy Welch
Accountable Emergency Officer
Medical Director

Prepared by
Mr Michael Clark
Head of Business Continuity & Emergency Planning
September 2022

Annex A – EPRR Core Standards Self-Assessment Spreadsheet

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	29 September 202						
Title	A framework of quality assurance for responsible officers and revalidation: Annex D – annual board report and statement of compliance						
Report of	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Prepared by	Michael Wright, Deputy Medical Director						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	The annual revalidation statement of compliance has been completed and included in this report.						
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							
Reports previously considered by	Submitted annually to the Trust Board.						

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2021 – 31 March 2022 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: Responsible Officer is in place and appropriately trained. Comments: The Medical Director is the Responsible Officer and is supported in this role by the Deputy Medical Director who is the Associate Responsible Officer and manages the operational delivery of the Appraisal and Revalidation programme. Action for next year: The Responsible Officer and Associate Responsible Officer will maintain appropriate training.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: Ensure ongoing support for the appraisal and Revalidation process. Complete training of new appraisers Comments: Medical appraisal and Revalidation is supported by 2 part time staff in the Medical Staffing Department (0.6 FTE Band 5 and 0.4 FTE Band 6) and the Head of Medical and Dental Staffing. The Associate Responsible Officer is supported by a Medical Appraisal Lead for the Trust who receives a responsibility allowance for this role. Appraisal of locally employed doctors (previously known as Trust doctors) is managed by the medical education team. A number of appraisers had retired during 2020/2021 and 2021/2022. Training of a new cohort of appraisers to support the existing experienced appraisers has now taken place and new appraisers have been appointed.

Action for next year: Continue to monitor the number of appraisers with particular emphasis on the loss of experienced appraisers through retirement.

Review the resources available to support appraisal and Revalidation for both senior and locally employed junior medical staff.

Review the process for support and monitoring of appraisal of locally employed doctors in training.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: To complete the implementation of SARD/GMC connect link. Continue work to develop SARD subsystem for appraisal and Revalidation of locally employed doctors.

Comments: The SARD system is now fully implemented with all consultant and SAS staff completing appraisal using this software. This ensures that an accurate record of all licenced practitioners with a prescribed connection to the organisation is available at all times. The prescribed connection links are regularly monitored. The final component of the SARD system is being implemented- a link to the GMC connect portal. This will provide automatic update in SARD of information on doctors' Revalidation held by the GMC.

Work was carried out with SARD to develop an online system for appraisal and Revalidation of locally employed doctors. This system was not as successful as had originally been hoped unfortunately and review of this will be undertaken as part of the work highlighted in section 2.

Action for next year: To complete the implementation of SARD/GMC connect link. Review the systems available for support of locally employed junior medical staff.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Complete review of Appraisal Policy for Senior Medical and Dental Staff before next expiration date in March 2022.

Comments: Policy expiration date was extended to until September 2022 to allow further review. Review underway and policy will be re-submitted for consideration for re-ratification. No significant changes are expected.

Action for next year: Complete resubmission and ratification of policy.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: To complete action plan from internal audit and to consider external audit with peer Trust.

Comments: The action plan derived from internal audit has been completed.

An external peer review has not been possible because of ongoing COVID related pressures.

Action for next year: To reconsider an external audit with a peer Trust.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: To re-consider development of a module within the SARD system for locally employed doctors.

Comments: Work has been carried out to improve supervision and professional development of locally employed junior doctors. Further work is planned with a formal review of existing processes underway.

Action for next year: To complete review of processes for supervision of junior doctors on short term contracts and implement findings.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change.

Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: To complete the full restart of appraisal and monitoring of completed appraisals.

Comments: Restart of appraisal has taken place although this was delayed by ongoing pressures associated with COVID. The Appraisal 2020 model has not been adopted however a pragmatic approach to the provision of supporting information is in place.

Action for next year: To reconsider the utility of the Appraisal 2020 model for future appraisals.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: To achieve levels of medical and dental appraisal seen prior to March 2020.

Comments: This has not been achieved however this is due to prolonged effects of the COVID pandemic. It was previously expected that this would have less effect in 2021/2022 than in 2020/2021 but this did not transpire.

Action for next year: To achieve levels of medical and dental appraisal seen prior to March 2020.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Appraisal policy should be reviewed.

Comments: Appraisal policy currently under review (see Section 1.4).

Action for next year: To complete review of appraisal policy and achieve ratification of policy.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: To complete training of additional appraisers as scheduled in November 2021 to ensure there are adequate appraisers.

Comments: Training of appraisers now complete and adequate numbers are now in place.

Action for next year: To continue to monitor appraisal numbers to ensure adequate appraisers are in place.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: To develop additional performance monitoring matrices using the SARD system.

Comments: This has not been possible due to ongoing COVID related pressures however it is expected that this will restart in Winter 2022.

Action for next year: Appraisers to participate in ongoing performance review and training.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: To consider external review with a peer Trust. Comments: This has not been possible due to ongoing COVID pressures however it is anticipated that this may be possible in 2022/2023. Action for next year: To consider external peer review.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2022	1212
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	961
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	262
Total number of agreed exceptions	76

Section 3 – Recommendations to the GMC

7. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: All recommendations to be made on time using appropriate protocol.

Comments: All recommendations were made on time in according with appropriate protocol.

Action for next year: All recommendations to be made on time using appropriate protocol.

8. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: All doctors to be contacted at time of recommendation.

Comments: All doctors are contacted when recommendation is made particularly if recommendation is for deferral.

Action for next year: To continue to contact all doctors when recommendation is made.

Section 4 – Medical governance

9. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: To maintain clinical governance structures.

Comments: A well-defined set of clinical governance structures is in place and operates effectively for all medical and dental staff. This is monitored through the appraisal and Revalidation group and the Medical Director's Group.

Action for next year: To maintain and further develop clinical governance structures.

10. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: To complete review of preparation of information for appraisal by CGARD.

Comments: A partial review of the preparation of information for appraisal by the CGARD team has been undertaken. Further discussion and consideration of alternative approaches is required.

Action for next year: To review preparation of information for appraisal by CGARD and performance monitoring of medical and dental staff.

11. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: To continue to manage concerns according to agreed process.

Comments: There is an agreed process for responding to concerns including arrangements for investigation and intervention for conduct and capability. There is close working with Occupational Health Services to monitor and respond to health concerns. Discussions have been held with a neighbouring Trust and consideration is being given to introduction of further monitoring processes.

Action for next year: To consider establishment of further responding to concerns and fitness to practice structures.

12. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: To consider further analysis and review of concerns reporting.

Comments: This has not been possible due to ongoing COVID pressures however further consideration is being given to the introduction of additional responding to concerns and fitness to practice monitoring structures

Action for next year: To consider establishment of further responding to concerns and fitness to practice structures.

13. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: All concerns to be transferred at RO to RO or Associate RO to RO level. Comments: Action for next year: To continue with existing processes for transfer of information between ROs.

14. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Ensure review of policies maintains freedom from bias and discrimination. Comments: All policies in the Trust are evaluated for freedom from bias and discrimination. Action for next year: To continue with current processes for review of policies.

Section 5 – Employment Checks

15. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: To maintain existing systems for pre-employment checking. Comments: All doctors employed undergo appropriate pre-employment checks prior to commencement. Action for next year: To continue existing systems for pre-employment checks.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

General review of actions since last Board report

- There has been ongoing significant clinical pressure across the organisation related to COVID during the most of 2021/2022 coupled with increasing pressure associated with clinical backlogs and the need to recover and limit potential patient harm. Despite this there has been a return to appraisal activity with significant focus on the pressures that COVID has placed on clinical staff.
- Additional appraisers have been trained demonstrating continuing interest in involvement in the delivery of appraisal.
- There is a need for further refinement and development of the appraisal system for locally employed doctors in training.

Actions still outstanding

- Further review of appraisal for locally employed doctors in training.
- External peer review of appraisal and Revalidation processes when possible.
- Further review and development of responding to concerns structures.

Current Issues

- Challenges with engaging doctors in training in the appraisal process.
- Ongoing difficulties in achieving patient feedback for some specialties.

New Actions

- Consideration of further responding to concerns monitoring structures as part of overall governance structures.

Overall conclusion:

There has been a satisfactory return to appraisal activity following major reduction in activity during the COVID pandemic. There is a need for ongoing focus on appraisal for locally employed doctors in training and consideration of additional monitoring or responding to concerns processes.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

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This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	29 September 2022						
Title	Consultant and Honorary Consultant Appointments						
Report of	Andy Welch, Medical Director						
Prepared by	Claudia Sweeney, Senior HR Advisor (Medical & Dental)						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The content of this report outlines recent Consultant Appointments.						
Recommendation	The Board of Directors is asked to review the decisions of the Appointments Committee.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. People – 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	Ensuring the Trust is sufficiently staffed to meet the demands of the organisation.						
Reports previously considered by	Consultant Appointments are submitted for information in the month following the Appointments Panel						

CONSULTANT APPOINTMENTS

1. APPOINTMENTS COMMMITTEE – CONSULTANT APPOINTMENTS

1.1 An Appointments Committee was held on 21 July 2022 and interviewed 1 candidate for 1 Consultant Rheumatologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Nishanthi Thalayasingam.

Dr Thalayasingam holds BM BCh (University of Oxford) 2004, MRCP (UK) 2007 and PhD (University of Newcastle) 2020. Dr Thalayasingam was previously employed as a Specialty Trainee in Rheumatology on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Thalayasingam took up the post of Consultant Rheumatologist on 12 September 2022.

1.2 An Appointments Committee was held on 2 August 2022 and interviewed 2 candidates for 2 Consultant Nephrologist posts.

By unanimous resolution, the Committee was in favour of appointing Dr Philip Thompson and Dr Scott Henderson.

Dr Thompson holds MBBS (Hull York Medical School) 2012 and MRCP (UK) 2015. Dr Thompson is currently employed a Specialty Trainee in Renal on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Thompson is expected to take up the post of Consultant Nephrologist post in October 2022.

Dr Henderson holds MBBS (University of Aberdeen) 2007, MRCP (UK) 2010 and PhD (University College London). Dr Henderson is currently employed as a National Institute for Health and Care Research (NIHR) Clinical Lecturer and Post-CCT Acting Consultant Nephrologist at Royal Free Hospital.

Dr Henderson is expected to take up the post of Consultant Nephrologist post in October 2022.

1.3 An Appointments Committee was held on 11 August 2022 and interviewed 1 candidate for 1 Consultant Medical Oncologist with an interest in Breast Cancers and Melanoma post.

By unanimous resolution, the Committee was in favour of appointing Dr Jenny Smith.

Dr Smith holds MBBS (University of Newcastle) 2012 and MRCP (UK) 2017. Dr Smith is currently employed as a Locum Consultant in Medical Oncology at the Freeman Hospital.

Dr Smith took up the post of Consultant Medical Oncologist with an interest in Breast Cancers and Melanoma on 12 September 2022.

1.4 An Appointments Committee was held on 11 August 2022 and interviewed 1 candidate for 1 Consultant Clinical Oncologist with an interest in Urological and Head and Neck Cancers post.

By unanimous resolution, the Committee was in favour of appointing Dr Malcolm Jackson.

Dr Jackson holds MBBS (University of Newcastle) 2013, MRCP (UK) 2016 and FRCR (UK) 2020. Dr Jackson was previously employed as a Specialty Trainee in Clinical Oncology on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Jackson took up the post of Consultant Clinical Oncologist with an interest in Urological and Head and Neck Cancers on 1 September 2022.

1.5 An Appointments Committee was held on 15 September 2022 and interviewed 3 candidates for 1 Consultant Anaesthetist post.

By unanimous resolution, the Committee was in favour of appointing Dr James Cameron.

Dr Cameron holds MBChB (University of Leeds) 2011, MRCS (Edinburgh) 2015 and FRCA (UK). Dr Cameron is currently employed Specialty Trainee in Anaesthetics on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Cameron is expected to take up the post of Consultant Anaesthetist in January 2023.

1.6 An Appointments Committee was held on 16 September 2022 and interviewed 2 candidates for 1 Consultant Cardiologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Matthew Williams.

Dr Williams holds MBBCh (University of Bristol) 2009, MRCP (UK) 2013 and PhD (University of Bristol) 2022. Dr Williams is currently employed as a Specialty Trainee in Cardiology at University Hospitals Bristol and Weston NHS Foundation Trust.

Dr Williams is expected to take up the post of Consultant Cardiologist post in April 2023.

1.7 An Appointments Committee was held on 16 September 2022 and interviewed 2 candidates for 1 Consultant Thoracic Surgeon post.

By unanimous resolution, the Committee was in favour of appointing Dr Joyce Thekkudan.

Dr Thekkudan holds MBBS (Calcutta University, India) 1996, FRCS (Edinburgh) 2000 and FRCS CTh (Edinburgh) 2016. Dr Thekkudan is currently employed as a Locum Consultant Thoracic Surgeon at Blackpool Teaching Hospital NHS Trust.

Dr Thekkudan is expected to take up the post of Consultant Thoracic Surgeon post as soon as possible.

2. RECOMMENDATION

1.1 – 1.7– For the Board to receive the above report.

Report of Andy Welch
Medical Director
29 September 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	29 September 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: • Spotlight on our Digital Health Team; • Nursing and Midwifery Staffing; • Flu/Covid Vaccination Overview including Department of Health and Social Care (DHSC) Healthcare Flu update; • Patient Experience Quarter 1 (Q1) 2022 – 2023; • Safeguarding Quarter 1 (Q1) 2022 – 2023; and • Learning Disability Quarter 1 (Q1) 2022 – 2023.						
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: Digital Health Team Spotlight

This month's 'Spotlight' section outlines the work of our Digital Health Team (DHT). The DHT are a team of Nursing, Midwifery and Allied Health Professionals who combine their expert professional and digital skills to support the implementation of digital solutions in practice. The DHT work as part of wider team including the Chief Medical Informatics Officer (CMIO) and other members of the Information Management and Technology (IM&T) Directorate. This newly formed team presently consists of six clinicians and has been in place for just over 13 months. As digital technology continues to progress and be a fundamental part of clinical processes and innovations, it is important to ensure implementation is clinically led and clinically driven. This helps ensure digital technology enhances professional practice synergistically and leads to sustainable improvements in patient care and experience

The report contains several examples of the workstreams the DHT are involved in contributing alongside the CMIO and IM&T colleagues to successful implementation. This includes projects such as:

- Revision of patient rounding documentation;
- High level support and visibility to support the implementation of closed loop medication practice in 17 wards, 2 intensive care units and one post-operative recovery area;
- Supporting the creation and implementation of clinical documentation for the new Day Treatment Centre; and
- Initial phase planning for review and optimisation of nursing assessment and discharge documentation.

The DHT is relatively unique and is being held up as an exemplar team locally, regionally, and nationally. Since its inception the team has been advising other organisations as they develop their digital maturity and the team have presented their work extensively. This is testament to their skills, expertise and leadership.

Section 2: Nursing and Midwifery Staffing Update

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

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

The monitoring of safer staffing metrics against clinical outcomes/nurse sensitive indicators as stipulated in national guidance continues via the Nurse Staffing and Clinical Outcomes Operational Group

The following key points from this group are noted below:

- A number of wards have required support at medium or high level since April. In July two wards were noted to require a high level of support given concerns regarding nurse staffing and the potential impact clinical outcomes for patients. Action plans were agreed for these areas in collaboration with the ward staff and additional clinical support, education and resources provided, overseen by the Executive Chief Nurse Team and Directorate Teams. Weekly audits are in place to monitor the impact of the interventions and significant improvements have been reported in both areas.
- Where beds have been closed due to staffing concerns, twice-weekly review with the Executive Chief Nurse Team remains in place and will continue until all commissioned bed capacity is safely opened.
- Red flags generated within the SafeCare module by the nursing staff in conjunction with professional judgement have provided valuable triangulation of data alongside DATIX reports. These alerts are responded to promptly by members of the Senior Nursing Team directly with the ward staff and the Matrons. All DATIX reports reviewed were graded no harm or low/minor. In the last quarter the number of DATIX and Red Flags submitted were:
  - July 20
  - August 17

Recruitment and Retention remain a priority workstream and the report provides an update on the current pipeline of Registered Nurses and Healthcare Support Workers. International Recruitment remains an important focus with the aspiration of deploying up to 300 nurses in this financial year, supported by funding from NHS England. The following key points are contained within the report:

- The combined turnover for Registered and Non-Registered staff is 10.65%;
- Registered Nurse turnover is 11.4% compared to 13.1% nationally;
- The Band 5 vacancy rate is 10.9% based on current staff in post. There is a pipeline of 294 (headcount) nurses across adult, paediatrics and operating department practitioners; and
- There are currently 72.55 whole time equivalent (wte) Healthcare Support Workers in the recruitment pipeline with 34.2wte posts unfilled. This equates to a 3% vacancy rate.

Section 3: Flu/Covid Vaccination Overview including DHSC Healthcare Flu update

The Joint Committee on Vaccination and Immunisation (JCVI) advises that any potential Covid-19 booster programme should begin in September 2022, to maximise protection in those who are most vulnerable to serious Covid-19 infection ahead of the winter months.

In the 2021/2022 program the uptake for the flu vaccine was 70% and the Covid Vaccine uptake was 98% first dose, 96% second dose with 90% uptake booster vaccination.

The aim is to meet and surpass the targets previously achieved with particular focus on flu uptake where there is an aspiration to achieve 90% (circa 11,000 staff) uptake for eligible staff.

The Trust has re-established the Vaccination Steering Group to lead on the delivery of this work and oversee the delivery of both programmes and has been in place since April. The anticipated delivery date of the flu vaccine is end of September 2022; therefore, the plan is to commence vaccinations via the peer vaccinator model from the 3 October 2022, similar to previous years.

Both vaccines will be monitored daily and reported weekly to Directorates via Trust meetings with high level data broken down to Directorate level and regular reporting to Exec Team and Trust Board. There is a requirement to report flu vaccination numbers weekly to Public Health England (PHE) and monthly to NHS England/ Improvement via the Immform database as was the case for previous years. It is assumed that Covid reporting requirements will remain as was during the initial programme with a monthly upload to Immform.

The Department of Health and Social Care (DHSC), together with PHE outlined their expectation to Trusts regarding Flu uptake. This includes completion of a 'self-assessment checklist' published in Board papers at the start of the flu season. This completed checklist is in the Board Reference Pack (BRP).

Section 4: Patient Experience Quarter One (Q1) Update

The Trust has opened 117 formal complaints in Q1, which is a decrease of 13% from the previous quarter.

Up to the end of March 2022, the highest percentage of complaints are within the Internal Medicine Directorate with seven complaints per 10,000 patient contacts (0.07%). The lowest number of complaints is within Dental Services who are still to receive a complaint this year.

From the 166 closed complaints in Q1, 20 complaints were upheld, 33 complaints were partially upheld and 113 were not upheld.

The report contains an overview of patient experience and engagement work with an overview of work undertaken by the Advising on the Patient Experience Group (APEX) and the Maternity Voice Partnership. This work of these groups remains fundamental in ensuring developments in services are patient led.

Section 5: Safeguarding Quarter One Update

This summary provides a Q1 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.

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

- In adult safeguarding, activity is marginally reduced compared to Q1 2021/22 but remains above pre pandemic levels.
- In children's safeguarding, the Trust has continued to see an increase in overall activity with more than double that of 2019/20 although a decrease (9%) in comparison to the same period last year. The highest categories of referrals are from neglect, followed by self-harm/overdose, domestic abuse and physical harm. We continue to see younger children coming through our emergency department (ED) with intentional overdose/self-harm, which has been seen across the region and nationally.
- In maternity safeguarding activity remains relatively stable. 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.

Section 6: Learning Disability Quarter One Update

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 623 referrals (adults, children, and transition referrals combined). This is broadly comparable to the same period last year though significantly greater than pre-pandemic levels. Whilst activity remains relatively static, the team continues to experience complex facilitation to ensure the experience for individuals and families is a positive and safe journey through Trust services.

Through a Trust wide Task and Finish Group, the Learning Disability week in June 2022 took the opportunity to utilise several events to relaunch the Learning Disability team, learn from practice and hear from families and patients on their experiences of care. There was significant support from the Trust Communication team to support messages through social media, asking for Trust staff to make a "pledge". This was an extremely positive event across the Trust and supported raising the profile of the team and the work required to continue to ensure all of patients receive the highest possible standard of care.

RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
29 September 2022

EXECUTIVE CHIEF NURSE REPORT

1. SPOTLIGHT

The Digital Health Team (DHT) are a team of Nursing, Midwifery and Allied Health Professionals who combine their expert professional and digital skills to support the implementation of digital solutions in practice. This newly formed team presently consists of six clinicians and has been in place for just over 13 months. The DHT work as part of wider team including the Chief Medical Informatics Officer and other members of the Information Management and Technology (IM&T) Directorate. As digital technology continues to progress and be a fundamental part of clinical processes and innovations, it is important to ensure implementation is clinically led and clinically driven. This helps ensure digital technology enhances professional practice synergistically and leads to sustainable improvements in patient care and experience.

1.1. Key Workstreams and Achievements

The DHT have been and continue to be involved in a number of small- and large-scale digital projects. As part of the optimisation of the Electronic Patient Record (EPR), the team have been undertaking work to amend the patient rounding section (the documentation of the regular checks the clinical team undertake on patients). Feedback from clinical teams demonstrated that this section of the EPR was not as efficient as it could be and there was unnecessary duplication in the documentation process. The DHT are key in engaging with front line clinical staff to ensure any changes are beneficial in practice and ensure optimisation is clinically led. The system has now been changed to ensure inputs into the record are where appropriate, automatically updated in other relevant sections. This improves patient care by improving clinical documentation and improves staff experience as it is more efficient and releases time to care. This has been recently implemented and positively reviewed by our front-line staff.

The Trust has recently been awarded Level 6 accreditation with the Healthcare Information Management Systems Society (HIMMS). As part of the HIMSS accreditation the DHT have been supporting the implementation of multiple closed loop projects (Medications, Milk and Blood) which is a prerequisite for achieving level 6 accreditation. The closed loop medication roll out is currently in progress.

Closed Loop Medication involves clinical staff scanning a patient's wristband during drug administration to identify them within the electronic system. The clinician then scans a barcode on the box of medication to identify the correct drug and this is cross referenced with their prescription chart. This process will enhance patient safety by ensuring positive patient identification, along with positive medication match prior to administration. At the time of writing the team have supported the roll out to 17 inpatient wards, 2 Intensive Care Units and 1 Recovery area at the Royal Victoria Infirmary (RVI). Roll out has now commenced at the Freeman Hospital. The team's presence and leadership on the relevant wards is key during implementation

ensuring concerns are addressed, the system is safely embedded, and clinical questions can be quickly answered.

In preparation for the opening of the new Day Treatment Centre, the DHT have been involved in supporting the clinical teams in the most efficient utilisation of the EPR from the outset. Work has been focused on developing bespoke clinical documents and tools to record accurate relevant data. This will support a seamless transition for the patient through the department from admission to theatre and to their discharge home. The knowledge of the DHT in relation to the EPR has been pivotal to relate the clinical need and aspirations into a product that will work for all the team, ensuring the patient has the best experience.

The DHT is relatively unique and is being held up as an exemplar team locally, regionally, and nationally. Over the last 13 months the team has been advising other teams as they develop their digital maturity and the team have presented their work extensively. This is testament to their skills, expertise, and leadership.

1.2 The Future

The team have started to plan and implement a number of other large-scale projects in the year ahead. Optimisation in the documentation of the nursing admission process is underway as this was a key priority identified by our front-line staff. During this process, the team have ensured that the opportunity of the EPR is maximised to support data transfer between documents to reduce the risk of duplication, whilst also providing more supporting documentation as reference tools for clinical staff when making clinical decisions.

Whilst the DHT have had a huge impact over the last year, the team remains small and is limited in what it can deliver. Since the pandemic we have seen a steep increase in the digitisation of clinical pathways and there is a backlog in planned work. The need for clinical leadership in the digital journey remains key. Additional investment has been agreed to further grow the team and the final details are being progressed. This will allow the DHT along with IT team to make a positive impact on patient safety as well as patient and staff experience in a timely manner.

1.3 Final Reflection

The DHT are clear that with any digital solution, the key is being able to provide expert knowledge of clinical practice to link into our IT solutions. Digital solutions should enhance patient and staff experience whilst not replacing clinical judgement and expertise in patient care. This is key to ensure as professions we develop in our digital maturity whilst not losing sight of clinical judgement.

2. NURSING AND MIDWIFERY STAFFING UPDATE

2.1 Staffing Escalation

The Trust continues to work within the framework of the Nursing and Midwifery Safe Staffing guidelines to ensure a robust process for safe staffing escalation and governance, as reported to the board in July.

The nurse staffing escalation level remains at level two due to the following triggers being met:

- Pre-emptive rosters demonstrate a significant shortfall in planned staffing.
- Regular reporting of red flags and/or amber or red risk on SafeCare with reduced ability to move staff to mitigate risk.

The increased requirement for enhanced care continues, in addition to acuity and dependency remaining high across all service areas.

The following actions remain in place:

- Daily staffing review by the corporate nursing team and reported into the Executive Chief Nurse.
- SafeCare (daily staffing deployment tool) utilised to deploy staff across directorates based on need.
- Daily review of staffing red flags and incident reports.

Level 2 escalation will remain in place until the de-escalation criteria has been met.

Workforce support remains in place from the senior nursing team for the clinical areas where staffing levels continue to impact on the ability to maintain commissioned bed activity. Staffing and bed capacity remains challenging across the organisation with robust professional leadership from the Deputy Chief Nurse and Associate Directors of Nursing in place.

2.2 Nurse Staffing and Clinical Outcomes

The monitoring of safer staffing metrics against clinical outcomes/nurse sensitive indicators as stipulated in national guidance continues via the Nurse Staffing and Clinical Outcomes Operational Group. Wards reviewed by the group at the monthly meeting are categorised as; requiring no support; monitoring; low level; medium level or high-level support. This is in line with the agreed escalation criteria when supportive actions are implemented. In addition, any wards which have altered from their primary function, are also reviewed.

Below is a summary of the wards reviewed and the level of escalation required for the last two months:

Month	No. of Wards Reviewed	Directorate	Low Level Support	Medium Level Support	High Level Support	Monitor	No support required
July	21	X 1 Cardiothoracic Services X 1 Children's Services X 1 EPOD X 9 Internal Medicine X 2 Musculoskeletal Services X 2 Urology and Renal Services X 5 Covid/RSV/Winter	7	3	2	8	0
August	9	X 2 Cardiothoracic Services X 3 Internal Medicine X 2 Musculoskeletal Services X 2 Urology Services X 5 Covid/RSV/Medicine	1	6	2	5	1

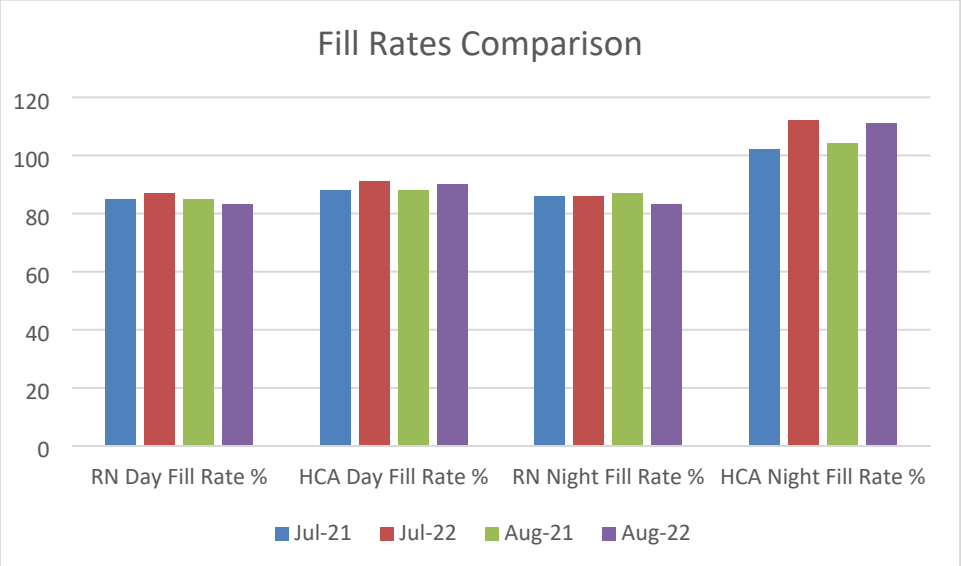
- A number of wards have required support at medium or high level since April. In July two wards were noted to require a high level of support given concerns regarding nurse staffing and the potential impact clinical outcomes for patients. Action plans were agreed for these three areas in collaboration with the ward staff and additional clinical support, education and resources provided, overseen by the Executive Chief Nurse Team and Directorate Teams. Weekly audits are in place to monitor the impact of the interventions and significant improvement have been reported in both areas.
- Where beds have been closed due to staffing concerns, twice-weekly review with the Executive Chief Nurse Team remains in place and will continue until all commissioned bed capacity is safely opened.
- Red flags generated within the SafeCare module by the nursing staff in conjunction with professional judgement have provided valuable triangulation of data alongside DATIX reports. All these alerts are responded to promptly by members of the Senior Nursing Team directly with the ward staff and the Matrons. All DATIX reports reviewed were graded no harm or low/minor. In the last quarter the number of DATIX and Red Flags submitted were:
    - July 20
    - August 17
- Despite the high-level monitoring, oversight and assurance provided by the group there continues to be a robust leadership and management framework led by the Matron team who manage the wards staffing. However, it is worth noting that the staffing picture remains challenging with the potential to impact staff wellbeing.

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

The Trust level fill rates and CHPPD are detailed below:

Month	CHPPD	RN day fill rate %	HCA Day fill rate %	RN Night fill rate %	HCA Night fill rate %	Trust fill rate %
July 2022	7.5	87%	91%	86%	112%	90%
August 2022	8.2	83%	90%	83%	111%	87%

- Below is the comparison data for this year and the same period last year. The lower registered nurse (RN) fill rate is due to vacancy, in addition to workforce who are "away" for other reasons such as sickness and maternity leave. Several wards have temporarily closed beds to mitigate the risk to patient safety. It is worth noting during the same time period last year the fill rates were reflective of the temporary reduction to 4/5 beds in a bay on a number of inpatient Wards.



- The Healthcare Assistant (HCA) fill rate on days and nights remains stable compared to the same period in 2021. However, both day and night fill rates are above plan due to the need for temporary staffing to fulfil the increased requirement for enhanced care across both sites and mitigate where possible, any registered staffing shortfall.

2.4 Recruitment and International Recruitment

2.4.1 Registered Nurse (RN) Recruitment

The current total Registered Nursing and Midwifery workforce and Healthcare Support Worker combined turnover is 10.65%. This is based on 2021-22 year-end data. Total RN turnover for this period was 11.4% which compares favourably with the national median of 13.1%, although this is higher than pre-pandemic levels. Improving the retention figure remains a key priority in the year ahead and beyond.

Monthly generic recruitment for Band 5 RN continues with targeted bespoke recruitment. The Band 5 RN vacancy rate is 10.9% based on the financial ledger at Month 4 and relates to current substantive staff in post. It does not include those nurses currently in the recruitment process, where there is a pipeline of 294 (head count) staff across adult and paediatrics and includes four Operating Department Practitioner apprentices. Focused recruitment has taken place in June, July and August to respond to workforce requirements for new service developments, encourage applications from experienced staff seeking new challenges in specialist services and new registrants who will receive their NMC registration in September/October 2022.

2.4.2 International Recruitment

International recruitment has continued despite challenges with the ambitious target of recruiting 300 adult and paediatric nurses and midwives this year. Since June 2022 we have seen the arrival of 80 internationally educated nurses. There are monthly deployments planned for the rest of the calendar year with a current pipeline of 177 internationally educated nurses. The total pipeline includes four paediatric nurses and two midwives. To help us achieve the recruitment of the remaining 43 nurses we have regular interview dates scheduled until the beginning of October and have contracted two extra recruitment agencies to deliver this.

To ensure that we achieve the target of recruiting 300 nurses the nursing workforce team and human resources teams work collaboratively updating NHSE regularly on progress. Induction and pastoral support are provided for all recruits, and we saw the first career conference for internationally educated recruits in July at the Great North Museum. All international recruitment continues to be supported by additional funding from NHSE with the remainder this year's funding being awarded at the end of August.

More recently, access to accommodation for our upcoming deployments of international recruits has become challenging and the team are exploring other options to ensure deployments are not unnecessarily delayed.

2.4.3 Healthcare Support Workers

There is continued focus on Healthcare Support Workers (HCSW) recruitment from NHSEI to achieve a zero-vacancy position, with the Trust successfully receiving additional funding to enhance pastoral support for our HCSW workforce. The zero-vacancy position was reached at the end Month 2 following successful recruitment campaigns. Due to staff turnover and service developments, maintaining a zero position is challenging and so retention work including career conversations is a priority along with proactive recruitment. There are currently 72.55 whole time equivalent (wte) staff in pipeline with a vacancy rate of 34.2wte (3%). This includes 25 additional posts which we have recently committed to recruiting to, in support of winter pressures.

3. WINTER INFLUENZA VACCINATION (FLU) AND COVID-19 BOOSTER CAMPAIGN

The Joint Committee on Vaccination and Immunisation (JCVI) advises that any potential Covid-19 booster programme should begin in September 2022, to maximise protection in

those who are most vulnerable to serious Covid-19 infection ahead of the winter months. Recent government announcements have confirmed the eligible cohorts for this programme which includes health and social care workers. Winter influenza vaccines are also to be delivered in the autumn in line with the normal yearly vaccination programme.

In the 2021/2022 program the uptake for the flu vaccine was 70% and the Covid Vaccine uptake was 98% first dose, 96% second dose with 90% uptake booster vaccination.
The aim is to meet and surpass the targets previously achieved with particular focus on flu uptake where there is an aspiration to achieve 90% (circa 11,000 staff) uptake for eligible staff.

The Trust has re-established the Vaccination Steering Group to lead on the delivery of this work and oversee the delivery of both programmes and has been in place since April.

Vaccine supply is still in the process of being finalised, though Covid-19 vaccinations are expected to start at the end of September and will be delivered in fixed clinics via booked appointment with flu vaccination being offered/co-administered where possible. Clinic locations at the Freeman Hospital will be Ward 12 with some clinics delivered via the screening pod. At the RVI, the screening pod will be used alongside additional satellite clinics. The Occupational Health Department will also have Covid-19/Flu clinics to vaccinate staff at Regent Point.

For flu, the anticipated delivery date is the end of September 2022, therefore, the plan would be to commence vaccinations via the peer vaccinator model from the 3 October 2022, similar to previous years.

Both vaccines will be monitored daily and reported weekly to Directorates via Trust meetings with high level data broken down to Directorate level and regular reporting to the Executive Team and Trust Board. There is a requirement to report flu vaccination numbers weekly to PHE and monthly to NHSEI (immform) database as was the case for previous years. It is assumed that Covid reporting requirements will remain as was during the initial programme with a monthly upload to immform.

As the main vaccination programme draws to a close, the “vaccinated elsewhere app” will be utilised to survey staff who have not received the vaccine according to our records. This will be a separate app for each vaccine as uptake may differ. This will collate staff vaccination information for those vaccinated outside of the Trust or will gain intelligence as to why an individual decided not to get vaccinated. Proposed time implementation is early December 2022.

The Department of Health and Social Care (DHSC), together with PHE outlined their expectation to Trusts regarding Flu uptake. This includes completion of a ‘self-assessment checklist’ published in Board papers at the start of the flu season. This completed checklist is in the Board Reference Pack (BRP).

4. PATIENT EXPERIENCE QUARTER 1 (Q1) REPORT

4.1 Complaints Activity

The Trust has opened 117 formal complaints in Q1, which is a decrease of 13% from the previous quarter. 25% of the complaints had a primary concern with regards to communication. This further breaks down into sub-subjects, communication failure with patient is the most common issue (n10), communication with relatives or carers (n5) and method or style of communication (n3).

Up to the end of March 2022, the highest percentage of complaints are within the Internal Medicine Directorate with seven complaints per 10,000 patient contacts (0.07%). The lowest number of complaints is within Dental Services who are still to receive a complaint this year.

From the 166 closed complaints in quarter 1, 20 complaints were upheld, 33 complaints were partially upheld and 113 were not upheld.

4.2 PALS

997 issues have been raised with PALS over this period. This compares to 979 in the previous quarter and 917 in the same quarter 2020-21. Issues continue to be raised relating to the impact of Covid-19 including delays to planned treatment and surgery; concerns about relatives and friends who are inpatients, and different appointment options and processes.

4.3. NHS Choices

The Trust received 30 items of feedback and received the maximum score rating of five stars from 48% (n15) of comments received.

Gynaecology (5 Star) – *"Having had the good fortune of not being too ill throughout my life, a recent stay in hospital on Ward 40, for emergency surgery then other medical appointments, has hugely rekindled my praise for the NHS, sending it soaring. After some issues I am truly delighted to be able to say that 95% in the main, my recent stay was beyond any anticipation.*

4.4 NHS Friends and Family Test (FFT)

The latest FFT data is encouraging in that, 98% of people who responded to inpatients and day cases FFT would recommend the service.

The results for A&E and walk in centres has considerably declined and is noted to be below the national average. This we believe is partly due to such low number of responses being received (n =less than 30) and unfortunately there is no narrative to help us understand this decline further.

4.5 Patient Involvement and Engagement

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

- APEX was pleased to receive the proposed plans for the new specialist hospital building at the RVI. This included what services would be housed, costs, and timeframes. APEX offered their feedback on the draft survey to help seek wider public and staff views, which went live in April 22; the results now need to be analysed and reported.
- APEX have also heard from the Deputy Chief Nurse about the national and trust position with regard to nurse recruitment and staffing. The Group discussed international recruitment and were encouraged by how the Trust helps new nurses settle into the local community as well as about the apprentice route into nursing. Following previous concerns regarding staffing levels on the ward, APEX members were reassured that work is continually ongoing to address this issue.
- The research team were keen to discuss with APEX a research project looking at the feasibility of a multimodal telehealth behaviour intervention to promote health benefits in low-grade abdominal aortic aneurysms. APEX gladly gave their views on how acceptable patients may find being asked to do this exercise and behaviour-change program.

4.5.1 Maternity voice Partnerships (MVP)/Connie Midwife

MVP has continued to nurture and build on established working relationships with Service Users and their associated communities and support networks, through focus groups and listening events. One focus group has reviewed the Obstetric emergency flash cards devised to enhance and improve communication with non-English speaking women in emergency situations. The group was well attended with diverse representation from Black and Mixed Ethnic communities who were able to bring crucial insights to shape the materials and ensure their efficacy.

The MVP, working closely with the MVP Professional Link Midwife and Consultant Obstetric Anaesthetist, have established a unified pathway for the reporting of service user feedback from all forums by way of a bi-monthly meeting with the Midwifery Matrons. The first Maternity Feedback Forum meeting was held in June and an associated work plan has commenced which seeks to 'close the loop' on feedback received ensuring arising themes are consistently identified and acted upon.

4.6 Equality, Diversity & Inclusion

Key Points to note:

- Healthwatch England have conducted deep dive analysis with people across the country who said they require communication support. Some of their key findings include people's health information not being provided to them in a way they understand, including different languages and formats. The Patient Experience Team, Outpatients and IT have discussed how appointment letters can include

wording if the patient requires their letter in a different language or format. The wording and placement on the letter have been agreed and this is in the process of being progressed.

- Various national reports have shown that asylum seekers and refugees, including recent Ukrainian refugees, are less likely to access healthcare due to a multitude of barriers. Local work with the Health and Race Equality Forum (HAREF) reveals that one of the key reasons asylum seekers and refugees are anxious of accessing healthcare is they are anxious about language barriers and unaware about professional interpretation services. In light of this feedback, we are working with HAREF to develop materials to help inform these local communities about their rights to healthcare and interpretation. It is planned to develop some community sessions to also help deliver this information and design some wallet cards for individuals to show hospital staff about their interpretation requirements.

5. SAFEGUARDING COMMITTEE QUARTER 1 (Q1) REPORT

This summary provides a Q1 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.

5.1 Activity

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

- In adult safeguarding, activity is marginally reduced compared to Q1 2021/22 but remains above pre pandemic levels. Despite a relatively stable activity position, Q1 has again been challenging due to high staff sickness and increasing case complexity.
- In Children's safeguarding, the Trust has continued to see an increase in overall activity with more than double that of 2019/20 although a decrease (9%) in comparison to the same period last year. The highest categories of referrals being from neglect, followed by self-harm/overdose, domestic abuse and physical harm. We continue to see younger children coming through our emergency department (ED) with intentional overdose/self-harm, which has been seen across the region and nationally.
- In maternity safeguarding activity remains relatively stable. 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.

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

The Mental Capacity Act (2005) was revised and amended in 2019. Chapters 12-22 of the resulting draft Code are concerned with the Liberty Protection Safeguards (LPS)as the replacement for the Deprivation of Liberty Safeguards. Central Government has given the public time to consult on the draft code with responses submitted in July 2022. A Trust response has been submitted after receiving extensive feedback a wide range of services, including children's services, psychiatry liaison, adult & children's safeguarding, legal and advocacy.

The implementation of the LPS will be a significant amount of work for providers. Once further detail is received, a comprehensive gap analysis will be undertaken with a proposed implementation plan and briefing shared with the relevant committees.

5.3 Safeguarding Training

The compliance relating to Safeguarding training has been closely monitored for the last two years. Compliance remains a concern regarding Level 3 Adult and Children. Significant work has been undertaken to improve this position across the Trust, with the introduction of new on-line training modules and an increase in general and bespoke staff training sessions. This has started to demonstrate an improvement in compliance across the Trust. This will continue to be closely monitored through the relevant committees.

6. LEARNING DISABILITY QUARTER 1 (Q1) REPORT

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 623 referrals (adults, children, and transition referrals combined). This is broadly comparable to the same period last year though significantly greater than pre-pandemic levels. Whilst activity remains relatively static, the team continues to experience complex facilitation to ensure the experience for individuals and families is a positive and safe journey through Trust services.

As previously reported, the Learning Disability Liaison Service scaffold and support staff and on occasions work directly with individuals to meet their needs. The trialling of “ward walking” continues with almost seven months completed. This outreach service has been very positively reviewed. By utilising ward walkers, the team can support staff to enhance their confidence and skills. This work also reflects the objectives of NHSE Improvement standards and work is underway how this can be embedded as core practice moving forward.

Through a Trust wide Task and Finish Group, the June 2022 Learning Disability week took the opportunity to utilise several events to relaunch the Learning Disability team, learn from practice and here from families and patients on their experiences of care. There was significant support from the Trust Communication team to support messages through social media and asking for Trust staff to make a “pledge”. This was an extremely positive event across the Trust and supported raising the profile of the team and the work required to continue to ensure all of patients receive the highest possible standard of care.

7. RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
29 September 2022

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Assurance Checklist

A	Committed leadership	Trust self-assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	X
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	X
A3	Board receive an evaluation of the flu programme 2020 to 2021, including data, successes, challenges and lessons learnt	X
A4	Agree on a board champion for flu campaign	X
A5	All board members receive flu vaccination and publicise this	X
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	X
A7	Flu team to meet regularly from September 2021	X
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	X
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	X
B3	Board and senior managers having their vaccinations to be publicised	X
B4	Flu vaccination programme and access to vaccination on induction programmes	X
B5	Programme to be publicised on screensavers, posters and social media	X
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	X
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	X
C2	Schedule for easy access drop in clinics agreed	X
C3	Schedule for 24 hour mobile vaccinations to be agreed	X
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	X
D2	Success to be celebrated weekly	X

OCKENDEN REPORT UPDATE

APPENDIX 1

Table 2 – Interim Report			
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 members of the 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 members of the 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

APPENDIX 2

Residual actions from Interim Report		
Immediate Essential Action	Brief Descriptor	Compliance
IEA 3: Staff Training & Working Together	90% attendance for each staff group attending MDT maternity emergencies training session (with LMNS oversight and validation).	Partial Compliance
IEA 4: Managing Complex Pregnancy	Women with complex pregnancies (whether MMC or not) must have a named consultant lead.	Partial Compliance
IEA 5: Risk Assessment Throughout Pregnancy	All women must be formally risk assessed at every antenatal contact.	Partial Compliance
IEA 6: Monitoring Fetal Wellbeing	90% attendance for each staff group attending MDT maternity emergencies training session (with LMNS oversight and validation).	Partial Compliance
Midwifery Leadership	Organisation meets the maternity leadership requirements set out by the Royal College of Midwives in "Strengthening midwifery leadership manifesto".	Partial Compliance

Final Report Immediate Essential Action		Brief Descriptor IEA 1-15	Compliance
1. Workforce Planning and Sustainability: Financing a safe maternity workforce The recommendations from the	1.1	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.	n/a Awaiting information on further funding

Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	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.	Compliant
	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.	Non- compliant
	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.	Not applicable (N/a) Awaiting direction from National bodies
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.	1.5	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.	Compliant
	1.6	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.	N/a National direction has changed since publication of Final report
	1.7	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.	Non-compliant
	1.8	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.	Compliant

	1.9	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.	Partial compliance
	1.10	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.	Partial compliance
	1.11	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.	N/a
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.	Compliant
	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.	N/a
	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.	Compliant
	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.	Compliant
	2.5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction.	N/a

	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.	Compliant
	2.7	All Trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	Partial compliance
	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.	Compliant
	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.	Compliant
	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.	Compliant
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.	Non-compliant
	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.	Compliant
	3.3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Compliant
	3.4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	Compliant
	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.	Compliant
	4.1	Members of the Trust Board 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.	Compliant

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.	4.2	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.	Partial compliance
	4.3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Compliant
	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.	Partial compliance
	4.5	All Trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis, and family engagement.	Partial compliance
	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.	Compliant
	4.7	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	Compliant
5. Clinical Governance – Incident investigation and complaints Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	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.	Compliant
	5.2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	Partial compliance
	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.	Partial compliance
	5.4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	Non- compliant
	5.5	All Trusts must ensure that complaints which meet SI threshold must be investigated as such.	Compliant
	5.6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	Non-compliant

	5.7	Complaint's themes and trends must be monitored by the maternity governance team.	Non-compliant
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.	N/a
	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.	N/a
	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.	To action once implemented by external stakeholder
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.	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.	Partial compliance
	7.2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all Trusts.	Partial compliance
	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.	Partial compliance
	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.	Partial compliance

Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	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.	Compliant
	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.	Compliant
	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.	Partial compliance
8. Complex Antenatal Care: Local Maternity Systems, Maternal Medicine Networks and Trusts must ensure that women have access to preconception 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.	Compliant
	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.	Compliant
	8.3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	Partial compliance
	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.	Partial compliance
	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).	Compliant
9. Preterm Birth:	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.	Compliant

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)	9.2	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.	Compliant
	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.	Compliant
	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.	Compliant
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. Centralised CTG monitoring systems should be mandatory in obstetric units	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	Compliance
	10.2	Midwifery-led units must complete yearly operational risk assessments.	Non-compliant
	10.3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	Partial compliance
	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	Partial compliance

		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.	Partial compliance
	10.6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	Compliant
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	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.	Compliant
	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.	Compliant
	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	Partial compliance
	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.	N/a
	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.	Compliant
	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.	Compliant
	11.7	The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments.	N/a

anaesthesia services throughout England must be developed.	11.8	Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.	Compliant
12. Postnatal Care: Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times	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	Compliant
	12.2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.	Partial compliance
	12.3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.	Partial compliance
	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.	Compliant
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.	Partial compliance
	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.	Compliance
	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.	Compliant
	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.	Partial compliance
	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.	Compliant

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.	14.2	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.	Compliant
	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.	Compliant
	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.	Compliant
	14.5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	N/a
	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.	Compliant
	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.	Partial Compliance
	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.	Partial compliance

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.	Partial compliance
	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.	Partial compliance
	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.	Compliant

Total Number of Recommendations (interim and final report combined)	97	100%
Non-applicable	12	N/a
Compliant	46	54.1%
Partial Compliance	32	37.6%
Non compliance	7	8.2%

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	29 September 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. A detailed report was submitted to the Quality Committee in July 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. The submission date is the 5 January 2023. A full report on all the safety actions will be provided for the November 2022 Quality Committee and Trust Board.						
Recommendation	The Trust Board is asked to note the contents of this report and approve the self-assessment to date to enable the Trust to provide assurance that the required progress with the standards outlined are being met.						
Links to Strategic Objectives	Putting patients first and providing care of the highest standard focusing on safety and quality. Enhancing our reputation as one of the country's top, first class teaching hospitals, promoting a culture of excellence in all that we do.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☐	☐	☒	☐
Impact detail	Failure to comply with the ten safety action standards could impact negatively on maternity safety, result in financial loss to the Trust from the incentive scheme and from potential claims.						
Reports previously considered by	This is the seventh report for Year 4 of this Maternity Incentive Scheme. A previous full report was presented to Trust Board on the 28 July 2022.						

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

EXECUTIVE 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 2021 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 advised 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. Providers of Maternity Services were encouraged to continue reporting to MBRACCE-UK and eligible cases to the Healthcare Safety Investigation Branch (HSIB). Every reasonable effort should be made to make the Maternity Services Data Set (MSDS) submissions to NHS Digital.

The year 4 safety actions were revised during the pause period and the revisions published on 6 May 2022. A full report with an update on all 10 safety actions was presented to the Quality Committee in July 2022 and subsequently thereafter to the Trust Board. This report provides an update on the 3 maternity Safety Actions where the Trust has not yet achieved full compliance but continues to work towards achieving full compliance by the submission date of 5 January 2023.

The Trust Board is 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 by the submission date.

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, 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.

This paper provides an update on the current position, reporting by exception those elements which have not as yet been achieved, namely Safety Actions 2, 6 and 8. The Trust Board will receive a further report for consideration in November 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 6th May 2022 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. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.

ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6th May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.

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 6th May 2022 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.

2.3 Standard C

For at least 95% of all deaths of babies who died in your Trust from 6th May 2022, 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.

2.4 Standard D

Quarterly reports will have been submitted to the Trust Board from 6th May 2022 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 Trust continues to be compliant with all four elements of this standard (A-D) as referenced in the July 2022 Quality Committee report and can provide evidence to support this standard.

A detailed PMRT report for Quarter 1 April to June 20022 will be submitted as part of the November 2022 Quality Committee report and discussed at the Maternity Board Level Safety Champions Group on 12 October 2022. The report has been commenced however, some cases have not yet been completed due to the deaths occurring in June.

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

By October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme.

The Trust Maternity Digital Strategy was submitted to the LMNS on the 5 September 2022 following sign off by the Trust CNIO. This was the agreed process by the LMNS. The Digital Health Specialist Midwife is engaged with the NHSEI Digital Child Health and Maternity Programme.

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 in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" on the for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022.

In June, the Trust achieved 9 out of 11 CQIMs. The Trust has previously achieved 10 out of 11 CQIMs (May 2022 data). The 1 ongoing outstanding CQIM relates to a documented first feed of the baby; the Trust currently achieves a compliance rate of 67% (electronic data entry) regarding the documented first feed taken by the baby. To comply with this CQIM, compliance should be above 70%. The reduced level compliance is in relation to the timing of the data entry. If the data is not entered whilst the baby is on delivery suite there is no other opportunity to enter this data at a later date. This will be resolved with the introduction of Electronic Paper Record, providing greater quality assurance. In the interim, the Trust will additionally add data manually for the month of July to ensure this CQIMs target is met.

In June, the additional CQIM that failed compliance appears to be due to a problem with extraction of data from the fields that contain the information, rather than failure to enter the required data. The data is evident in the maternity information system. This problem is being addressed by the Trust Information Analyst and will be corrected prior to submission of the July data.

The requirement is to ensure '*at least 9 out of 11'* pass the criteria. The Trust is therefore compliant with this data for June 2022 and is confident that the July data will be of sufficient quality to demonstrate compliance.

3.3 Standard 3

July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month.

Current compliance for this is 93.2% (June 2022 data).

3.4 Standard 4

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

Current compliance for this is 100% (June 2022 data).

3.5 Standard 5

July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2)

Current compliance for June 2022 data was 97.7%. Previously compliance was below the 95% threshold at 90.6% when this element was suspended during the 3-month pause. This is now a mandatory requirement which has resulted in the higher compliance rate in June.

3.6 Standard 6

July 2022 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)

Current compliance for the June 2022 bookings was 94.3%. The Trust is confident the July data will be compliant.

For the standards 2-6 the June data shows compliance. A provisional report for July has been requested and should be provided by mid-September allowing the Trust a two-week period to amend any problems identified.

3.7 Standard 7

Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics:

Midwifery Continuity of carer (MCoC)

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

In the Trust, 97.7% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed (June 2022 data).

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

Of the women booked to deliver at the Trust who are placed on a Continuity of Carer pathway, 100% of these women have both a Care Professional ID and Team ID.

Criteria i and ii are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation.

The Trust is compliant with both.

iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion.

Criteria iii are fundamental building blocks and a necessary step towards measuring whether or not women have received midwifery continuity of carer (though it is not the complete measurement).

Current compliance is 100% and 100% respectively (June 2022 data).

If the data quality for criteria 7 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information).

The Trust has submitted the Data Quality Submission Summary Tool for June and July 2022 and will submit for August 2022. The requirement is submission of the tool for at least 3 consecutive months in order to pass this criterion.

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.

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.

4.3 Standard C

*A data recording process (electronic and/or paper based) for capturing **all** term babies transferred to the neonatal unit, regardless of length of stay, is in place.*

4.4 Standard D

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.

4.5 Standard E

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.

4.6 Standard F

Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted 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.

4.7 Standard G

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 f) has been agreed with the maternity and neonatal safety champions and Board level champion.

4.8 Standard H

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

The Trust is confident of being fully compliant with all 8 elements (A-H) of this safety action as reported to the Quality Committee in the July 2022 report.

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.

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.

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.

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.

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.

The Trust is confident of being fully compliant with all four elements (A-D) of this safety action as reported to the Quality Committee in the July 2022 report.

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

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

6.3 Standard C

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

6.4 Standard D

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

6.5 Standard E

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.

The Trust continues to be fully compliant with the five elements (A-E) of this safety action as reported to the Quality Committee in the July 2022 report.

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

1. *Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019.*

   Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.

2. *Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.*

3. *The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements.*

The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net

from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.

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 July showed 94% compliance.

When the safety actions were amended this element changed to a time frame over 4 months instead of 6 months and there needed to be a consecutive 4-month period of 80% compliance. Between September 2021 – November 2021 (3 consecutive months) the compliance rate was above 80%, however, this reduced to 77% in December. The December 2021 data has recently been reviewed to ascertain if further manual entry of data could raise the compliance above 80%. This retrospective manual entry of data has been successful and increased the compliance rate to 83%. The Trust can now evidence compliance of this standard for the 4-month period September to December 2021. An action plan is required if compliance is below 95% but above 80%. This compliance rate is discussed monthly at the Saving Babies Lives meeting and an action plan can be evidenced in the minutes produced.

The Trust continues to monitor monthly compliance rates however until BadgerNet (Maternity Electronic Records) is implemented – scheduled to go live in November 2022 - this will remain a challenge.

7.2 Element 2

This element requires the following monitoring evidencing at least 80%. An action plan is required if compliance is less than 95%.

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 for May showed 100% compliance for risk assessment at booking. A separate audit was undertaken in June to review the 20-week scan assessment – this showed 97.5% 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 (100%) with both these elements as referenced in the July 2022 Quality Committee report.

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.*

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

7.5 Element 5

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

An audit was undertaken between 1 January to March 2022 and showed the following compliance.

A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.

Compliance is currently 43% for the above period. One of the reasons for reduced figures is the difficulty in ensuring both doses of steroids are administered before delivery, particularly when delivery occurs rapidly or unexpectantly. Some women attend in advanced labour and only one dose can be administered before the birth of the baby. Another issue is that some women are transferred to the Trust as an in-utero transfer from another Trust and delivery occurs in between both doses or they may not have received the first dose from the transferring Trust. This is being monitored and work continues as part of the Clinical Network Pre-term Group. Across the North East and North Cumbria (NENC) region compliance was 41%.

The Saving Babies Lives care bundle discusses giving antenatal steroids optimally 48hrs before a planned pre-term birth, for example induction for growth restriction, but the above data includes spontaneous onset of labour which is unpredictable.

B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.

Compliance is at 32%. The Saving Babies Lives (SBL) care bundle states 'a steroid to birth interval of greater than seven days should be avoided'. The 80% stated by the Maternity Incentive Scheme (MIS) does not reflect what SBL is trying to achieve - as the lower the figure, the better provision of service. The Trust has queried this discrepancy with MIS and awaits their response.

C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.

Compliance is at 94%.

D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).

Compliance is at 100%.

The Trust is partially compliant with element 5.

The Trust is not currently able to achieve compliance above 80% for standards A and B 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. An action plan has been developed to address non-compliance and this has been agreed as part of a regional group reviewing pre-term births. Diagnostic testing has been introduced to give a more accurate assessment of the likelihood of a woman going into pre-term labour, supporting the earlier administration of steroids. The Trust has also recently appointed a Specialist midwife for Pre-term birth who commenced in post in August 2022. This role will assist in the provision of care for the women at risk of or experiencing pre-term birth and will be jointly responsible for monitoring compliance and working towards navigating the issues outlined in the action plan.

Pre-term birth data was presented to the Maternity Board Level Safety Champions Group in February 2022 and an up-to-date report will be presented at the October 2022 meeting.

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 service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place 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 LMNS 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 travel, parking and 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.*
- *Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP.*

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.

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.

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.

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 annual in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four.

Achieving 90% compliance this year again remains a challenge due to staff absence as a result of the COVID-19 pandemic and other types of absence. The Trust was on target in line with trajectory until January 2022, at which point, due to significant shortage of staff in relation to the Omicron variant, it was necessary to postpone all training to ensure continuous safety within the Service. In mitigation, additional training sessions were subsequently re-scheduled in addition to the planned sessions. Training has been further suspended due to staffing challenges for six weeks between 31 August until 9 October 2022. This has had an impact on the trajectory; however, staff have been re-scheduled onto the remaining sessions and full compliance can be achieved providing there are no further unanticipated delays.

Of note, an additional challenge relates to the competing demands currently in place within the service with regard to the implementation of a number of digital platforms, BadgerNet and Closed Loop Milk, together with the Trust roll out of Closed Loop Blood training, which has a potential to further impact on the trajectory of this action. Close monitoring continues, with further escalation being made to the Executive Directors by exception if required.

Training compliance up to the 2 September 2022:

Staff Group	Number of staff in post	Percentage trained as of the 08.07.22	Target by the end of Dec 2022

Midwives/sonographer/ Midwifery Managers/ Bank Midwives	309	79%	90%
Maternity Support Worker/ Nursery Nurses/ HCA's	98	80%	90%
Theatre staff (includes DS)	11	80%	90%
Obstetric Consultants	14	71%	90%
Anaesthetic Consultants	16	31%	90%
Trainees	38	100%	90%
Total	**486**	**79%**	**90%**

A further 14 training days for all staff are scheduled up until mid-December. The anaesthetic Consultants have all been allocated a day to attend and are aware that their attendance at these sessions is essential. Providing all staff are able to attend their allocated session full compliance will be achieved by mid-December.

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.

10.2 Standard B

Board level safety champions present a locally agreed dashboard to the Board quarterly 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 16 June 2022. 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 16 June 2022.

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 2024, prioritising those most likely to experience poor outcomes.

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 5 January 2022

The Trust is confident of being fully compliant with the four elements (A-D) of this safety action as detailed in the July 2022 Quality Committee 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 FROM 1 APRIL TO 5 DECEMBER 2022?

A) Reporting of all qualifying cases to HSIB from 1st April 2021 to 5th December 2022.

B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 until 5 December 2022

C) For qualifying cases which have occurred during the period 1 April 2021 to 5 December 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 the self-assessment to date.

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

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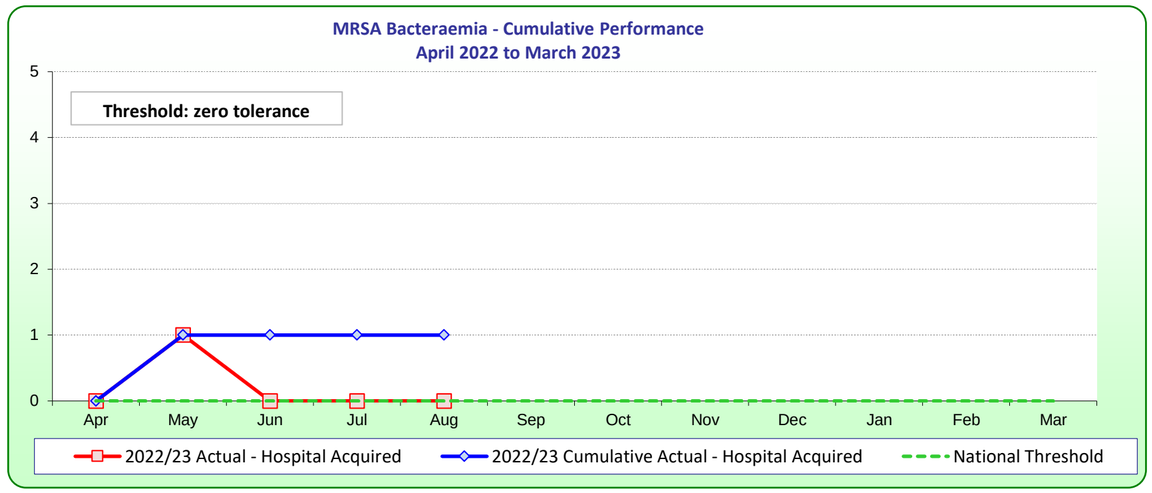
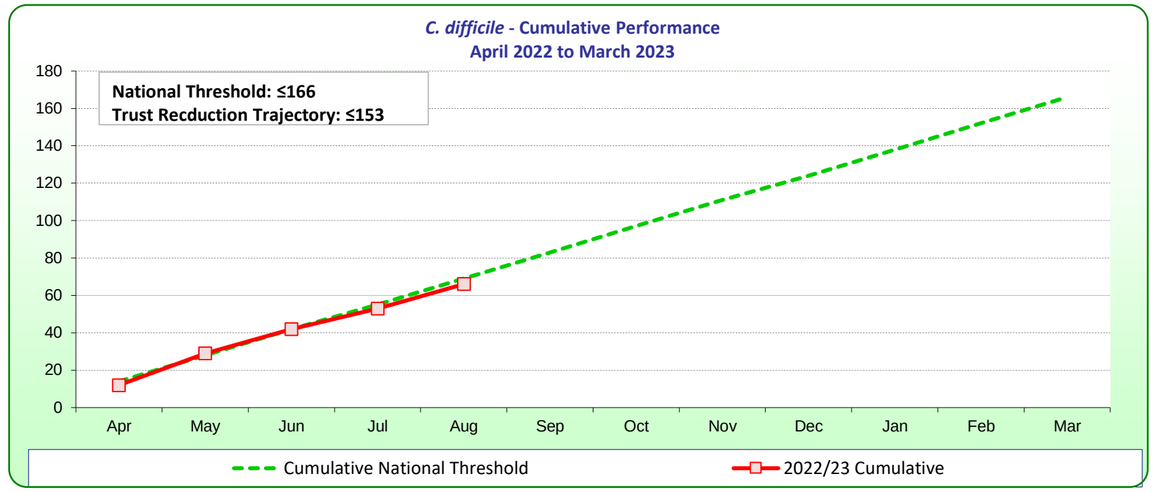
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

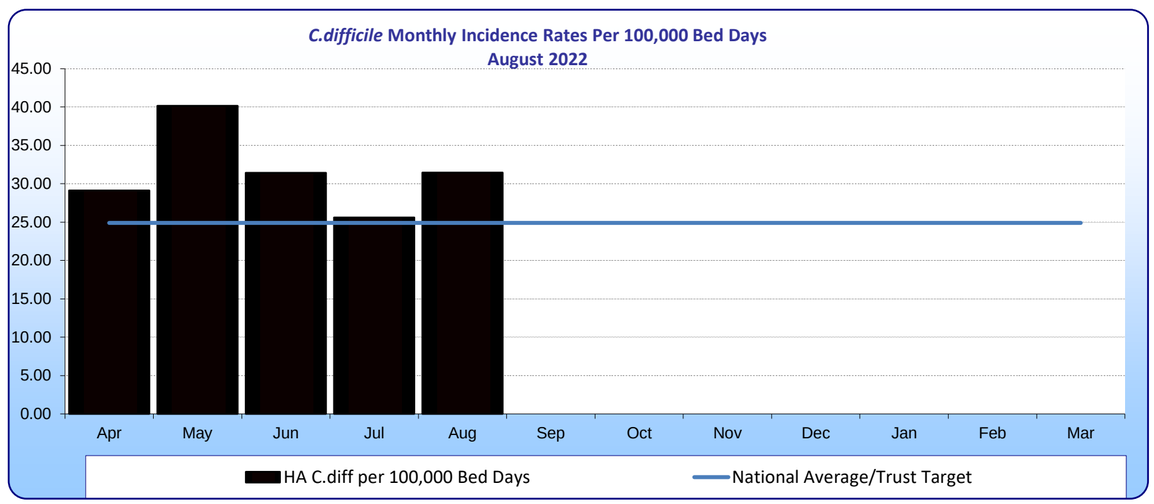
Healthcare-Associated Infections Report
August 2022

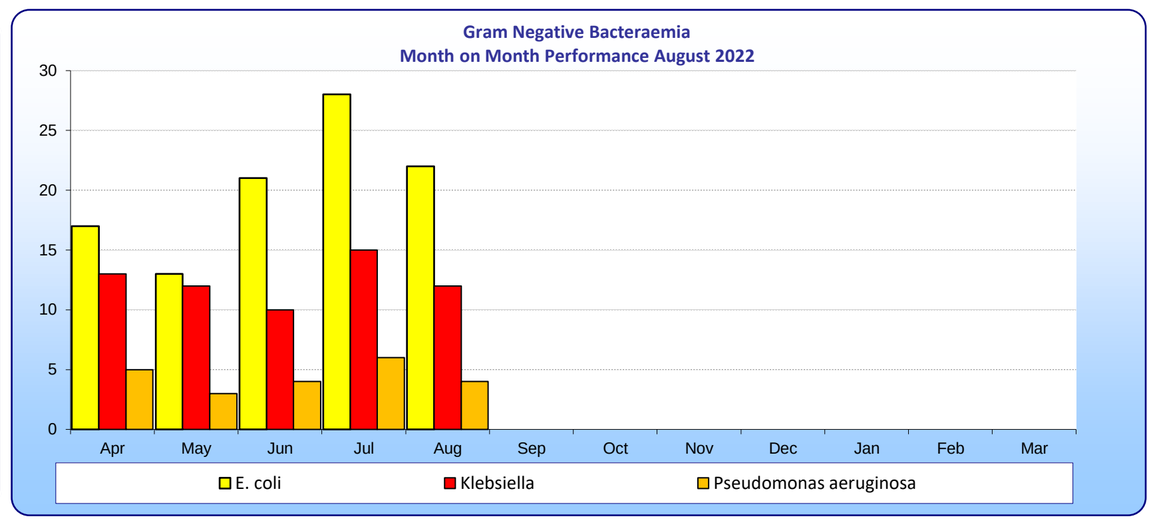
Healthcare-Associated Infection Report August 2022

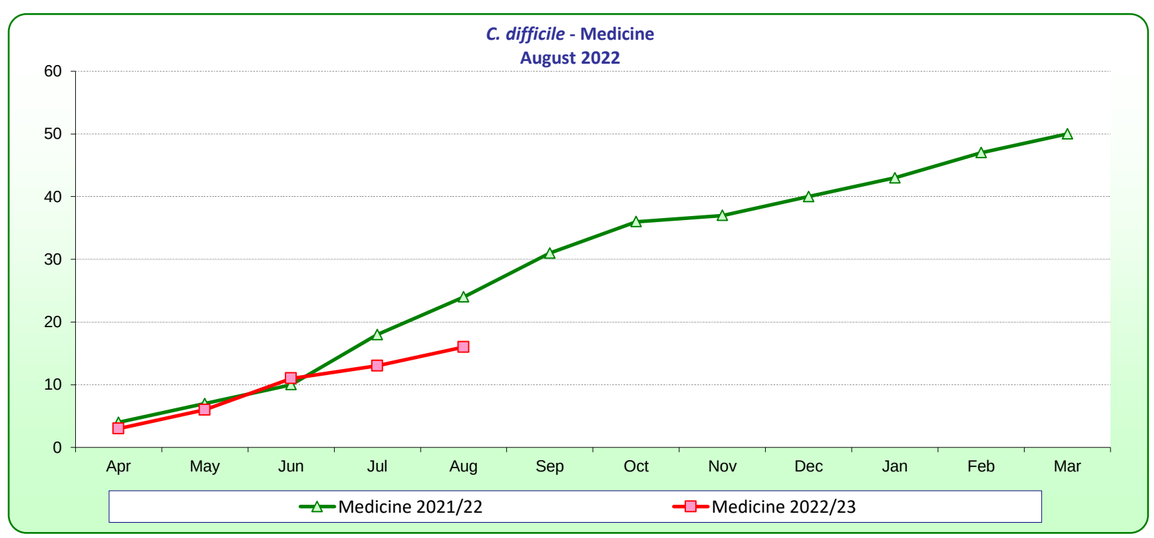
The Newcastle upon Tyne Hospitals NHS Foundation Trust

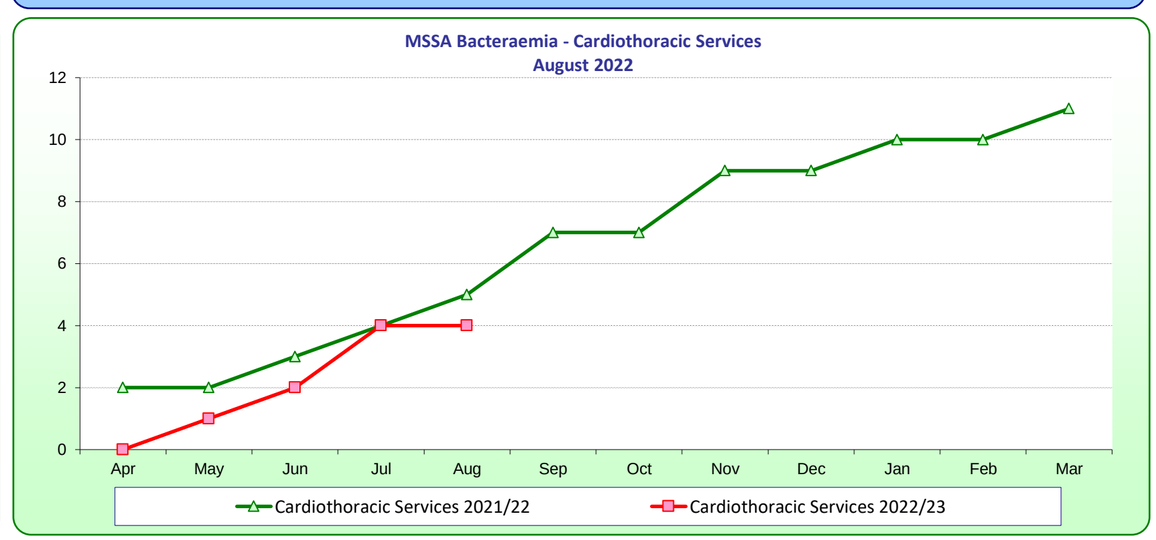






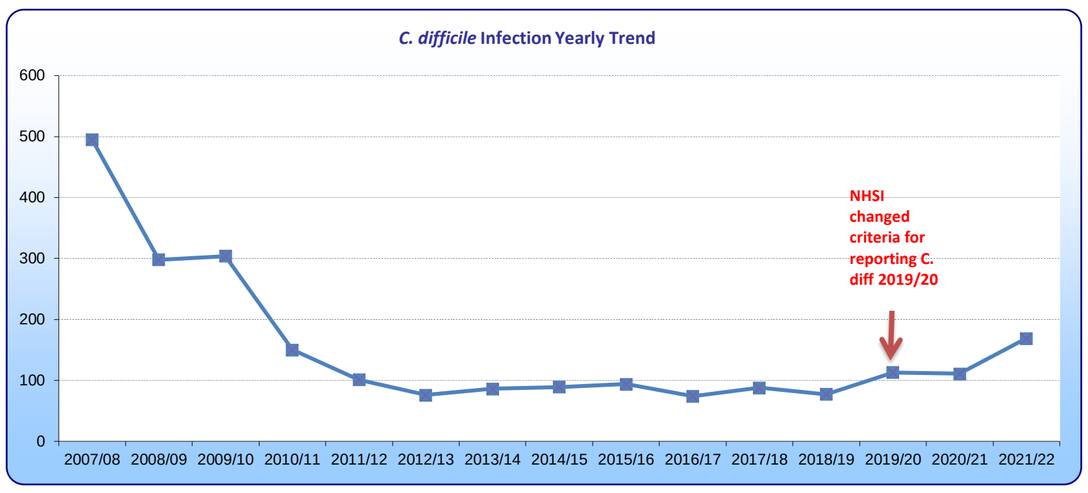


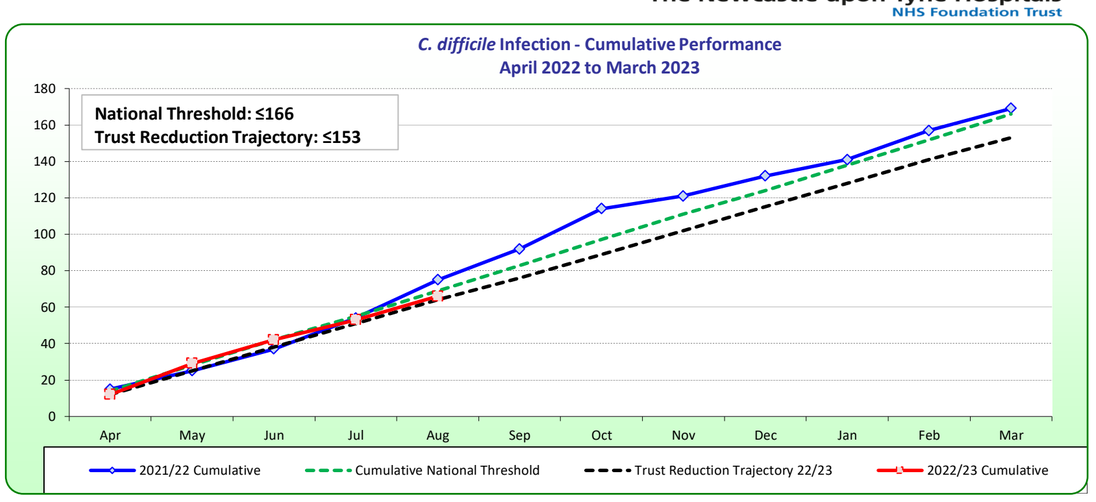


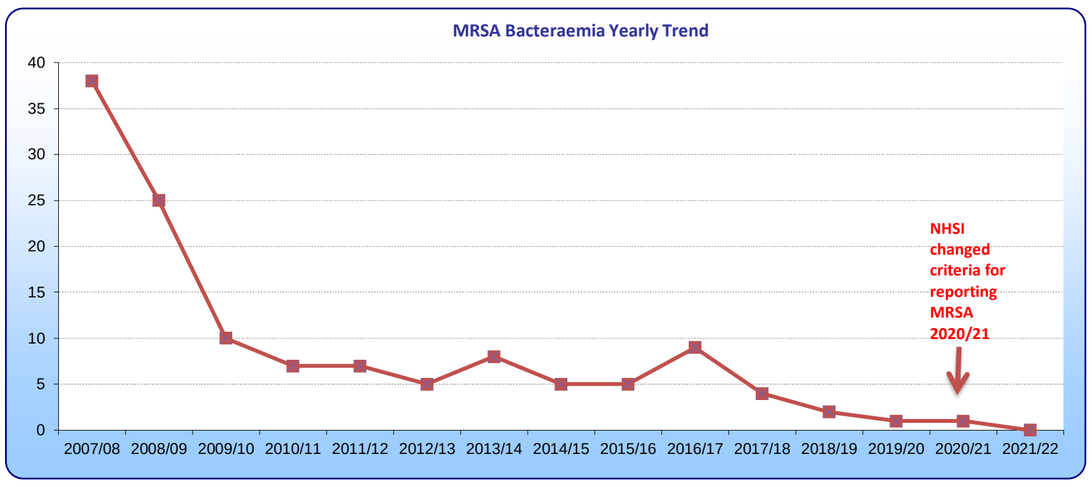


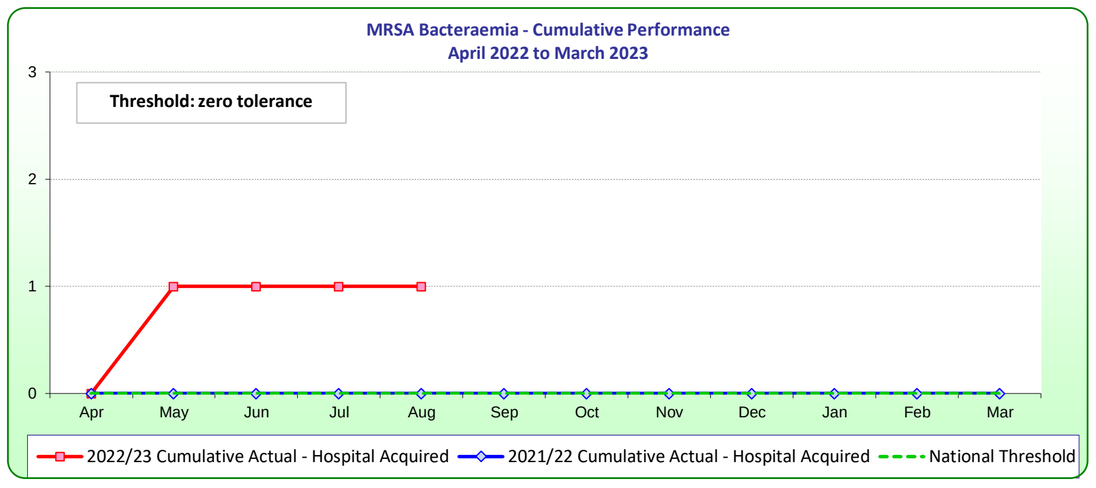
Healthcare-Associated Infection Report August 2022

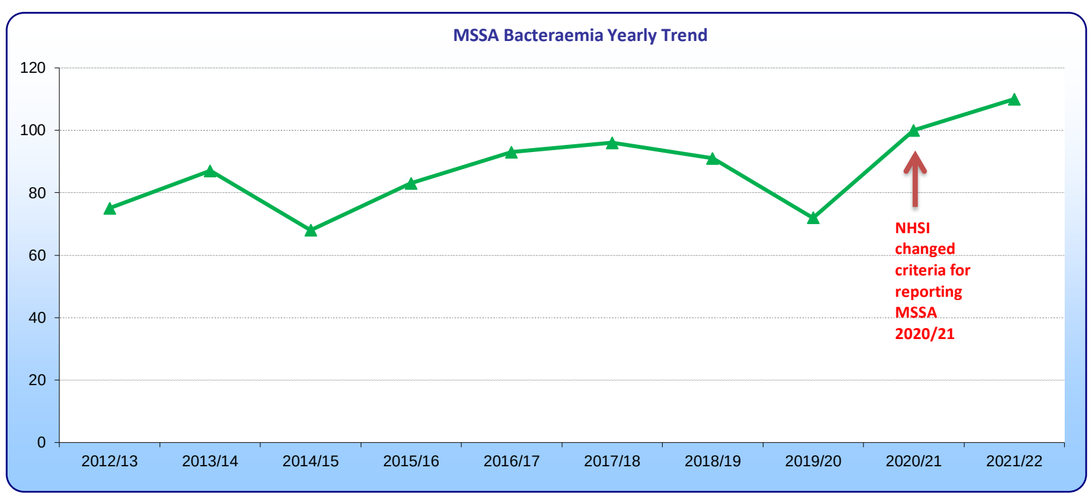
The Newcastle upon Tyne Hospitals NHS Foundation Trust

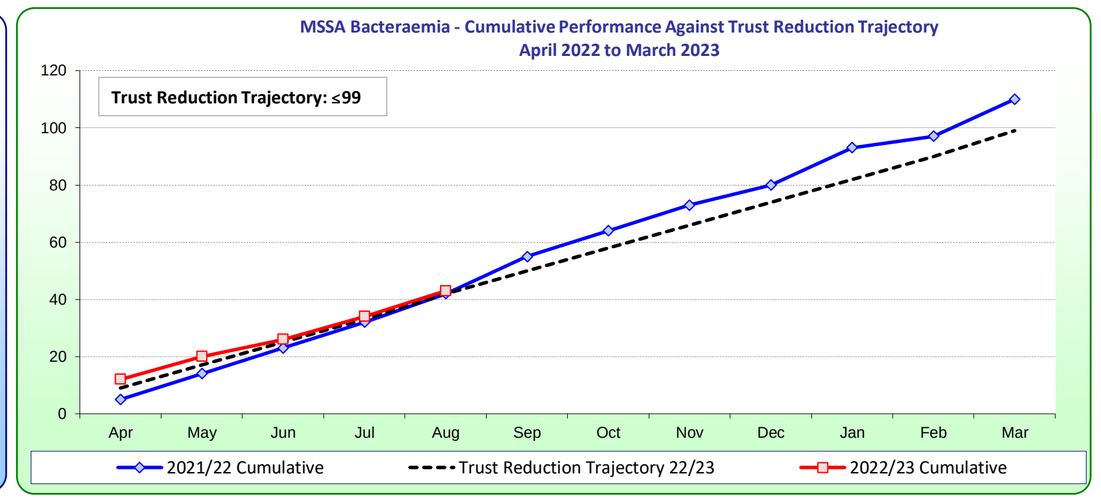


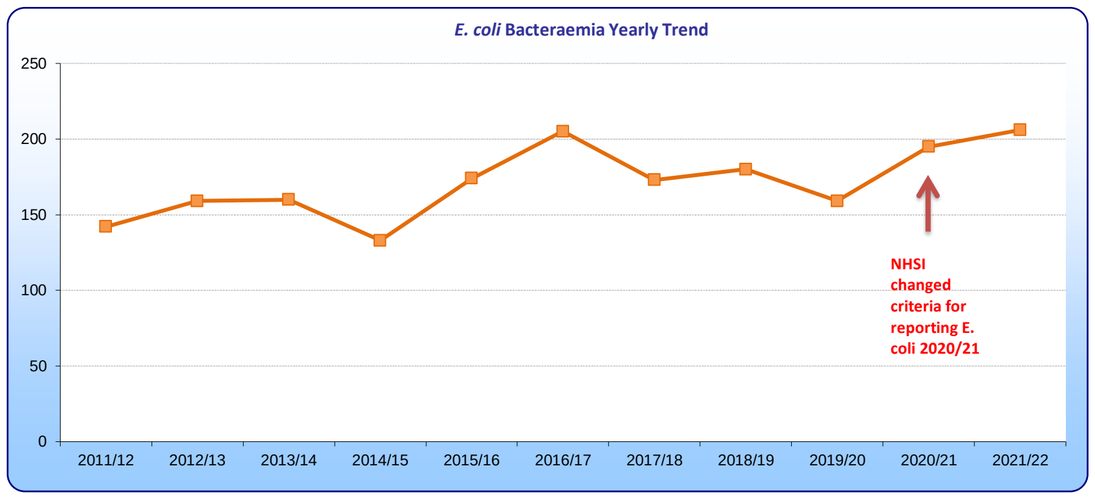


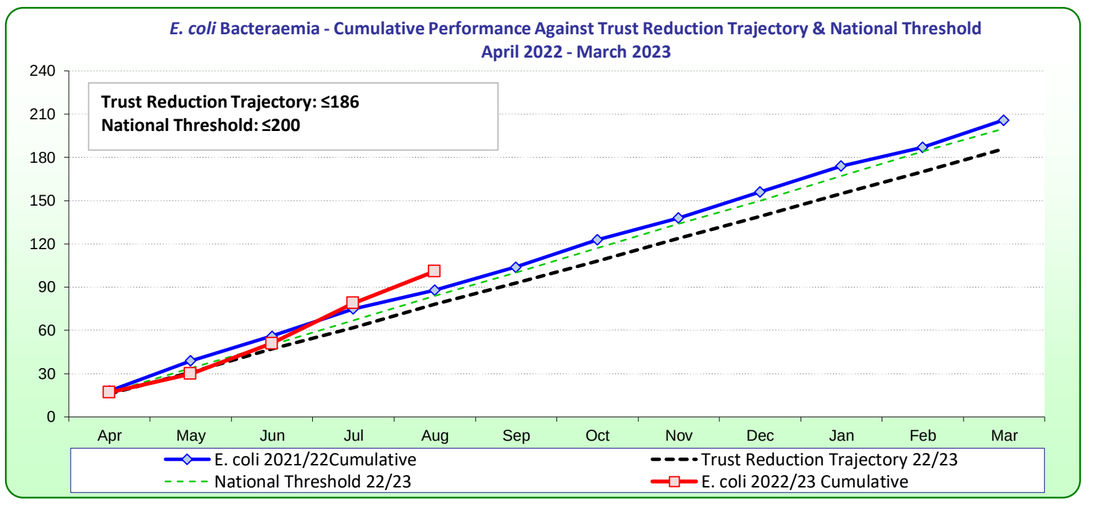


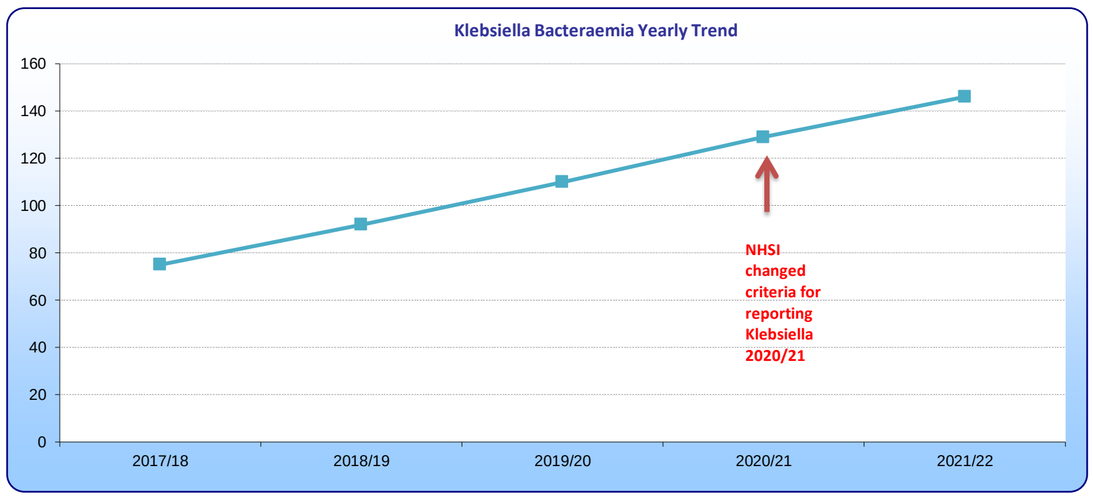


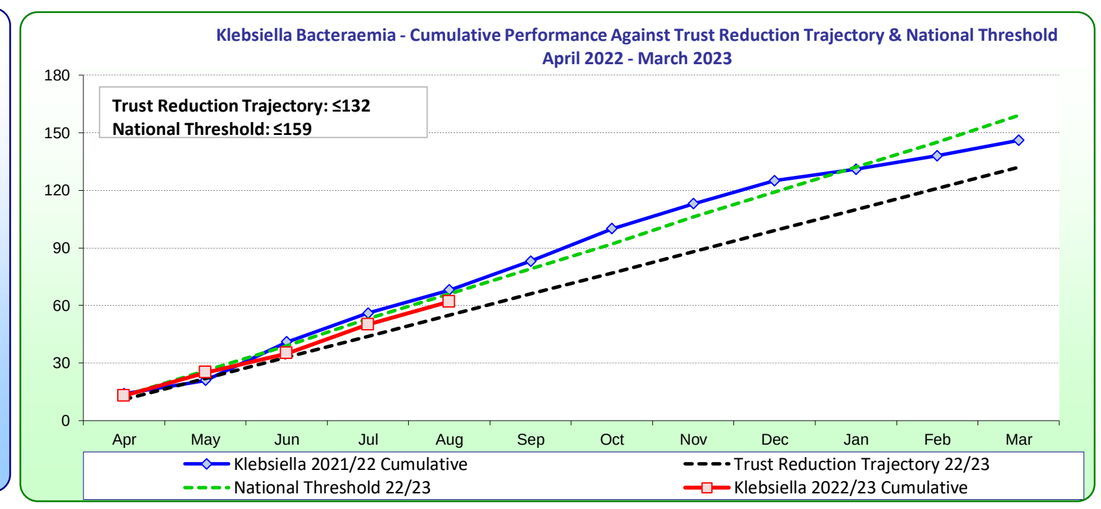


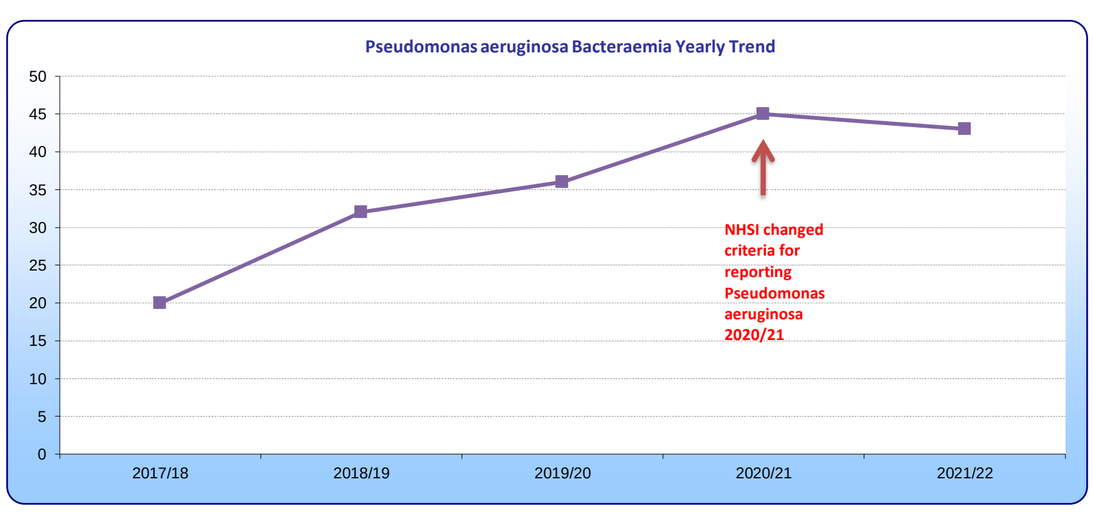


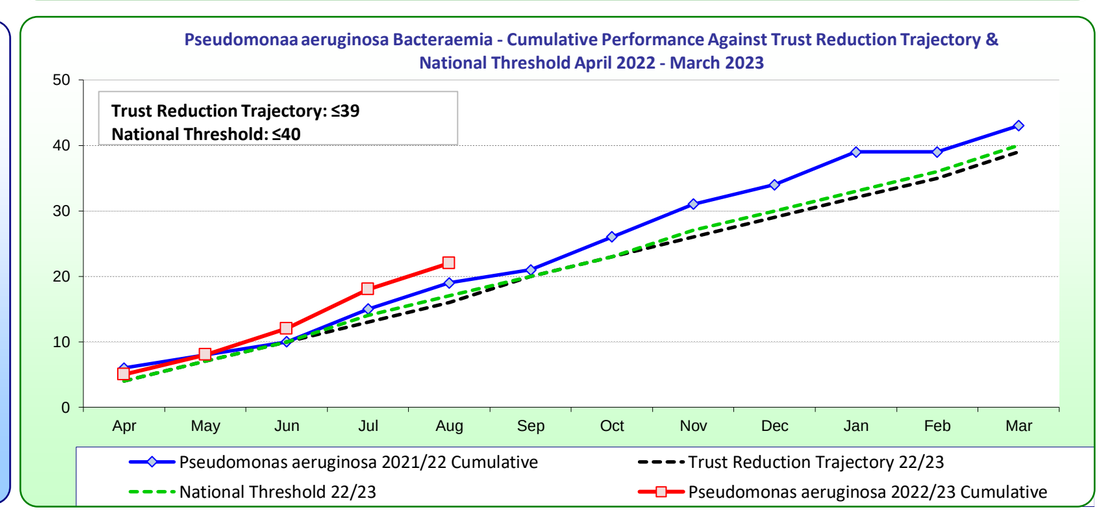












Healthcare-Associated Infection Report August 2022

The Newcastle upon Tyne Hospitals NHS Foundation Trust

IPC indicators (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA Bacteraemia - non-Trust	0	0	0	0	0								0
MRSA Bacteraemia - Trust-assigned (objective 0)	0	1	0	0	0								1
MRSA HA acquisitions	1	0	1	0	0								2
MSSA Bacteraemia - Healthcare Associated (local objective ≤99)	12	8	6	8	9								43
E. coli Bacteraemia - Healthcare Associated (local objective ≤186)	17	13	21	28	22								101
Klebsiella Bacteraemia - Healthcare Associated (local objective ≤132)	13	12	10	15	12								62
Pseudomonas aeruginosa Bacteraemia - Healthcare Associated (local objective ≤39)	5	3	4	6	4								22
C. diff - Hospital Acquired (national threshold not yet know; local objective ≤153)	12	17	13	11	13								66
C. diff related death certificates	-	-	2	3	0								
Part 1	-	-	1	0	0								
Part 2	-	-	1	3	0								

Periods of Increased Incidence (PIIs)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
C. diff - Hospital Acquired	2	4	1	0	0								7
Patients affected	5	8	3	0	0								16
COVID-19 - Hospital Acquired	7	1	2	1	1								12
Patients affected	22	2	4	4	6								38

Healthcare Associated COVID-19 cases (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Hospital onset Probable HC assoicated (8-14 days post admission)	49	19	33	56	15								172
Hospital onset Definite HC assoicated (≥15 days post admission)	63	22	49	84	13								231

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	-	-	-	-	-								0
Patients affected (total)	-	-	-	-	-								0
Staff affected (total)	-	-	-	-	-								0
Bed days losts (total)	-	-	-	-	-								0
Other Outbreaks	2	0	0	0	0								2
Patients affected (total)	16	0	0	0	0								16
Staff affected (total)	0	0	0	0	0								0
Bed days losts (total)	48	0	0	0	0								48
COVID Outbreaks	4	2	10	11	3								30
Patients affected (total)	32	15	92	110	12								261
Staff affected (total)	0	2	4	0	13								19

C.diff Transit and Testing Times Target <18hrs	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Trust Specimen Transit Time	12:36	12:44	14:41	11:50	11:27								12:39
Laboratory Turnaround Time	04:04	02:43	03:06	03:03	03:18								03:14
Total to Result Availability	16:40	15:27	17:47	14:53	14:45								15:54

Clinical Assurance Indicators/Audits (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Adult IP; Children's IP; Community HV/SN; Community Nursing; Critical Care; Dental; Maternity; OP; Theatres) Trust Total	58%	67%	67%	82%	83%								71%
Hand Hygiene Audit Trust Total	68%	85%	82%	81%	83%								80%
Invasive Device Care Audit Trust Total	64%	71%	69%	81%	80%								73%
Matron Checks (IP; OP/Community/Dental; Theatres) Trust Total	73%	78%	87%	73%	85%								79%

Infection Control Mandatory Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Infection Control	89%	90%	90%	89%	90%								90%

Aseptic Non Touch Technique Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
ANTT (M&D staff only)	55%	57%	57%	57%	58%								57%

ANTT compliance levels

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

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

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	29 September 2022						
Title	Corporate Governance Update						
Report of	Dame Jackie Daniel, Chief Executive						
Prepared by	Kelly Jupp, Trust Secretary Lauren Brotherton, Governor and Membership Engagement Officer						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☒	☐	☒				
Summary	The report includes an update on the following areas; • Updates on Council of Governors activities; • Submission of the Trust Annual Report and Accounts 2021/22; • External Well-Led review; • Appointments and Remuneration Committee Terms of Reference and Schedule of Business Review; • Minor proposed amendment to Committee Schedules of Business; • Recent publications/consultation responses; and • Non-Executive Director (NED) recruitment and induction.						
Recommendation	The Board of Directors are asked to: (i) Receive the report; (ii) Approve the minor amendment to the Committee Schedules of Business						
Links to Strategic Objectives	Performance – Being outstanding, now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☒	☐	☒	☐
Impact detail	Impacts on those highlighted at a strategic and reputational level.						
Reports previously considered by	Standing agenda item.						

CORPORATE GOVERNANCE UPDATE

EXECUTIVE SUMMARY

This report provides an update on a number of corporate governance areas, including:

- Council of Governors:
  - The recent Council of Governors meeting held on 18 August 2022;
  - Governor developments; and
  - Second Member's Event held on 9 August 2022.
- Submission of the Trust Annual Report and Accounts 2021/22;
- External Well-Led review;
- Appointments and Remuneration Committee Terms of Reference and Schedule of Business Review;
- Minor proposed amendment to Committee Schedule of Business;
- Recent publications/consultation responses; and
- Non-Executive Director (NED) recruitment and induction.

The Board of Directors are asked to:

(i) Receive the report;
(ii) Approve the minor amendment to the Committee Schedules of Business; and

CORPORATE GOVERNANCE UPDATE

1. COUNCIL OF GOVERNORS

1.1 Recent Meeting

A Council of Governors meeting was held on 18 August 2022. The meeting took place in person and via Microsoft Teams in the Boardroom, Freeman Hospital and Governors received presentations and updates on:

- Workforce Update including Staff Survey Results from Donna Watson, Head of Workforce Engagement & Information Systems.
- The Trust Integrated Quality, People and Finance Reports from Angela O'Brien, Director of Quality and Effectiveness.
- The Trust Performance Report from Vicky McFarlane-Reid, Director for Business, Development and Enterprise.
- The Annual Report and Annual Accounts by David Reynolds, Associate Director of Finance and Kelly Jupp, Trust Secretary.

The next formal meeting of the Council of Governors will be held on 8 December 2022.

1.2 Governor Developments

Since the last Trust Board meeting, the following activities have been undertaken:

- Regular data cleansing of the Trust's membership database, hosted by Civica, continues to take place to ensure membership data is up to date.
- The Quality of Patient Experience (QPE) Working Group department/ward visits have recommenced.
- Engagement continues to recruit Public and Staff members including Governors handing out leaflets at induction sessions and working with Internal and Community Groups.
- An order has been placed for two pop up banners which are the same design as the Membership Leaflets.
- A newsletter template has been drafted by the Governor and Membership Engagement Officer for a new quarterly Members' Newsletter.
- The Lead Governor and Working Group Chairs were involved in the Trust Well Led Review meetings.

Governors continue to be regularly updated on Trust developments via informal meetings, weekly emails, and 1:1 meetings with the Lead Governor.

1.3 Members Event

The second Members' Event for 2022 took place on 9 August with a theme of Sustainability. This event was held in person in the Lecture Theatre, Education Centre, Royal Victoria Infirmary (RVI).

Presentations were provided by Anna-Lisa Mills, Programme Manager and Odeth Richardson, Head of Service - Occupational Therapy.

The following positive feedback was received:

- *'Interesting topics';*
- *'Excellent presentations and gave us a lot to think about';*
- *'The venue and timings were convenient'; and*
- *'Lecture Theatre is an ideal venue'.*

Further feedback was received in relation to alternating the venue between the RVI and the Freeman Hospital for future events which can be facilitated once the refreshed Education Centre opens at the Freeman Hospital. A request was also received to learn more about 'Governor Activities' which will be incorporated into future Members' Events.

The Governor and Membership Engagement Officer is arranging the next event which will take place from 3pm on 1 December 2022.

2. SUBMISSION OF THE TRUST ANNUAL REPORT AND ACCOUNTS 2021/22

As detailed in previous Board updates, the Annual Report and Accounts (ARA) 2021/22 were approved by the Trust Board during a private extraordinary meeting on 21 June 2022.

The Trust Annual Report and Accounts for 2021/22 was laid before Parliament on Friday 9 September 2022.

The Annual Members' Meeting will be taking place in the Lecture Theatre, Education Centre, Royal Victoria Infirmary (RVI) at 2.30pm on Tuesday 27 September 2022. The event, hosted by the Chairman, will include a Review of the Year, and launch the Annual Report and Accounts for 2021/22. Prior to the Annual Members' Meeting, a number of our staff groups will be showcasing their innovative services at 1.30pm.

3. EXTERNAL WELL-LED REVIEW

As detailed in the previous Corporate Governance report, the Trust procured an external organisation (PwC) to undertake a well-led review in line with NHS Improvement and Care Quality Commission requirements.

The work commenced in June 2022 and is nearing completion. A draft report has been received and is currently undergoing factual accuracy checks. The final report will be shared with Board members in due course.

4. APPOINTMENTS AND REMUNERATION COMMITTEE TERMS OF REFERENCE AND SCHEDULE OF BUSINESS REVIEW

The Appointments and Remuneration Committee Terms of Reference have now been reviewed by the Committee Chair, the Director of Human Resources and the Trust Secretary following the external review undertaken by Korn Ferry, to consider best practice regarding remuneration governance/arrangements. Proposed changes will be presented to the Committee on 11 October 2022 for approval, and the final version will be brought to the November Trust Board meeting for agreement.

The Schedule of Business for the Committee has also been updated to reflect the changes proposed to the Terms of Reference and will also be brought to the November Board meeting for approval.

5. MINOR PROPOSED AMENDMENT TO COMMITTEE SCHEDULES OF BUSINESS

A request has been made by the Assistant Chief Executive for a minor amendment to rename a report included within some of the Committee Schedules of Business. The request being to rename the Board Assurance Framework (BAF) Report to the [Committee Name] Risk Report for the People Committee, Finance Committee and Quality Committee. The name will remain unchanged for the Audit Committee and Board of Directors.

The Board of Directors are asked to approve the minor amendment to the Committee Schedules of Business.

6. PUBLICATIONS/CONSULTATION RESPONSES

During August 2022, recent publications included:

- A new Patient Safety Incident Response Framework and supporting guidance was issued by NHS England;
- NHS England circulated a letter outlining the next steps to increase capacity and operational resilience in urgent and emergency care (UEC) ahead of winter;
- The Healthcare Safety Investigation Branch (HSIB) published a report covering a year in review of their maternity investigation programme; and
- Following the official launch of the COVID-19 Public Inquiry, the NHS England Inquiry Team has updated the FutureNHS page and FAQs to reflect latest developments.

Due to the national mourning period following the death of HM Queen Elizabeth II, publications have been minimal during September 2022.

7. NON-EXECUTIVE DIRECTOR (NED) RECRUITMENT AND INDUCTION

Ms Liz Bromley commenced as a Trust NED on 1 June 2022 and has now concluded her induction programme which included meetings with fellow Board members and completion of the Trust statutory and mandatory training.

8. RECOMMENDATIONS

The Board of Directors are asked to:

(i) Receive the report; and

(ii) Approve the minor amendment to the Committee Schedules of Business; and

Kelly Jupp
Trust Secretary

Lauren Thompson
Governor and Membership Engagement Officer
22 September 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	29 September 2022						
Title	Integrated Board Report						
Report of	Martin Wilson – Chief Operating Officer, Angela O'Brien- Director of Quality and Effectiveness.						
Prepared by	Louise Hall- Deputy Director of Quality and Safety, Peta Le Roux- Business Analysis.						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	This paper is to provide assurance to the Board on the Trust's performance against key Indicators relating to Quality and Finance.						
Recommendation	For assurance.						
Links to Strategic Objectives	Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. Supported by flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential. Performance – Being outstanding now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☒	☐	☐	☐
Impact detail	Details compliance against national access standards which are written into the NHS standard contract. Details compliance against key quality targets.						
Reports previously considered by	Regular report.						

INTEGRATED BOARD REPORT

EXECUTIVE SUMMARY

This report provides an integrated overview of the Trust's position across the domains of Quality, Workforce and Finance. In summary:

1. The Trust has had **no cases of MRSA bacteraemia in August 2022**.
2. There were **22 Serious Incidents (SIs) reported in August 2022** demonstrating a slight decrease back towards the mean between June 2022 – August 2022. **No Never Events were reported in August 2022**.
3. The Trust has received a total of **216 (210 with identified patient activity) formal complaints up to August 2022**, an increase of 53 on last month's opened complaints.
4. There were **1,481 responses to the Friends and Family test from the Trust in July 2022** (published September 2022) compared to 2,199 in the previous month.
5. The Trust **Violence Reduction Group met for the first time in July 2022.**
6. The **staff turnover figure has increased recently to 17.6%** due to the large number of staff leaving the Integrated Covid Hub North East (ICHNE) and the Covid Vaccination Programme (around 745 staff over the past 12 months). Excluding these two directorates reduces the overall turnover figure to 12% (from September 2021 to August 2022).
7. **To 31 August the Trust had spent £20.8 million capital, £13.7 million behind Plan** (the Trust submitted a Financial Plan to NHSE for 2022/23 in April, for a deficit of £5.5m for the year).

The Board of Directors is asked to receive the report.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

Quality, Workforce and Finance

September 2022

Healthcare at its best
with people at our heart

Executive Summary

Purpose

This report provides an integrated overview of the Trust's position across the domains of Quality, Workforce and Finance.

Current Operating Environment

The Trust experienced an increase in patients in hospital with COVID-19 during July in line with the increased incidence in the community. However, overall patients were less complex and did not need admission to Critical Care with approximately a third of patient's admitted for other reasons and with incidental COVID-19. The numbers are now falling and as at the 25th August are at 28, a reduction from 114 in early July. The numbers of staff testing positive has also dropped with COVID-19 staff absence rates reducing from 1.60% to 0.40%. There are still significant pressures being placed on the Trust's bed base due to the increase in emergency admissions and delayed discharges due to pressures in Social Care, with 90 patients currently awaiting discharge. Taking into account the permanent loss of beds, on average we have the same number of beds open as pre pandemic due to improved staffing levels, reduced COVID-19 outbreaks and IPC requirements. The overall position of the Trust remains challenged while balancing the focused effort of recovery, returning to 19/20 activity levels where possible, the Day Treatment Centre is on course to open on the 30th September, which will further support our recovery.

The Newcastle Plan

- In light of the COVID-19 pandemic and the commitment to address extended waits the Trust has developed The Newcastle Plan, and an overarching Delivery Board chaired by the Chief Executive.

Report Highlights

1. The Trust has had **no cases of MRSA bacteraemia in August 2022**.

2. There were **22 Serious Incidents (SIs) reported in August 2022** demonstrating a slight decrease back towards the mean between June 2022 – August 2022. **No Never Events were reported in August 2022**.

3. The Trust has received a total of **216 (210 with identified patient activity) formal complaints up to August 22**, an increase of 53 on last month's opened complaints.

4. There were **1,481 responses to the Friends and Family test from the Trust in July 2022** (published September 2022) compared to 2,199 in the previous month.

5. The Trust **Violence Reduction Group met for the first time in July 2022**

6. The **staff turnover figure has increased recently to 17.6%** due to the large number of staff leaving ICHNE and the Covid Vaccination Programme (around 745 staff over the past 12 months). Excluding these two directorates reduces the overall turnover figure to 12% (from September 2021 to August 2022).

7. **To 31 August the Trust had spent £20.8 million capital, £13.7 million behind Plan** (the Trust submitted a Financial Plan to NHSE for 2022/23 in April, for a deficit of £5.5m for the year).

Contents: September 2022

Quality

- Healthcare Associated Infections
- Harm Free Care – Pressure Damage
- Harm Free Care - Falls
- Incident Reporting
- Serious Incidents & Never Events
- Serious Incident Lessons Learned
- Mortality
- Friends and Family Test and Complaints
- Health and Safety
- Maternity
- Clinical Audit
- Quality Account Priorities Update

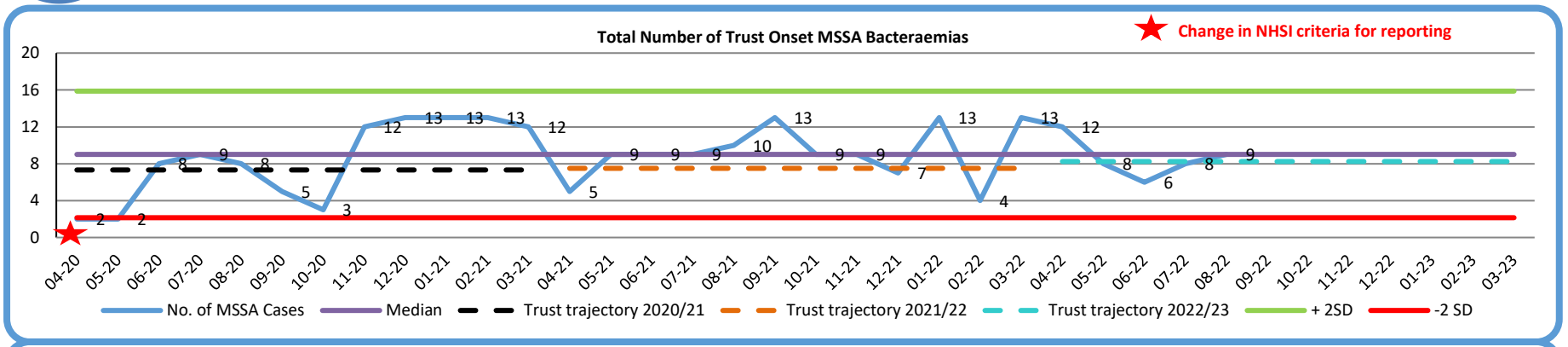
People

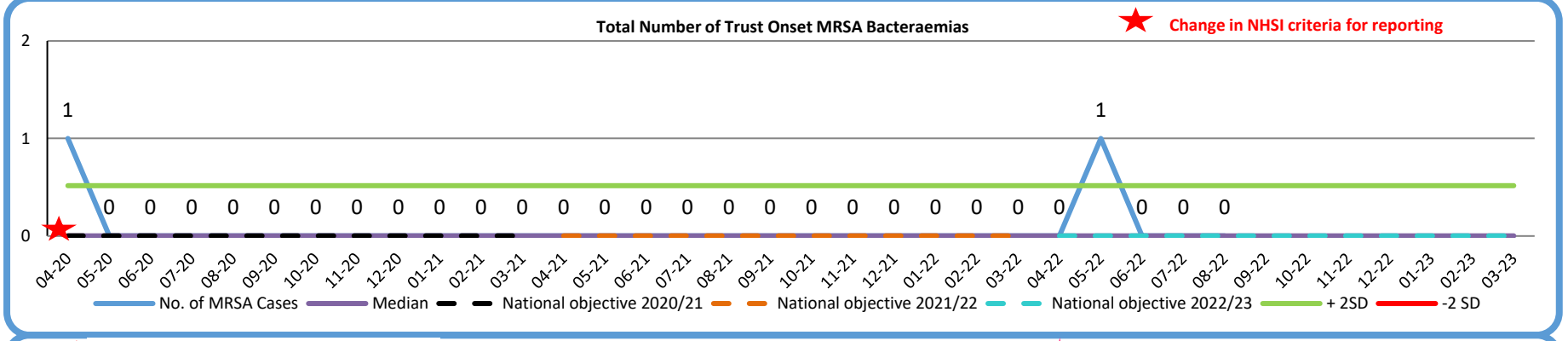
- COVID-19
- Well Workforce
- Equality and Diversity
- Sustainable Workforce Planning
- Excellence in Training and Education

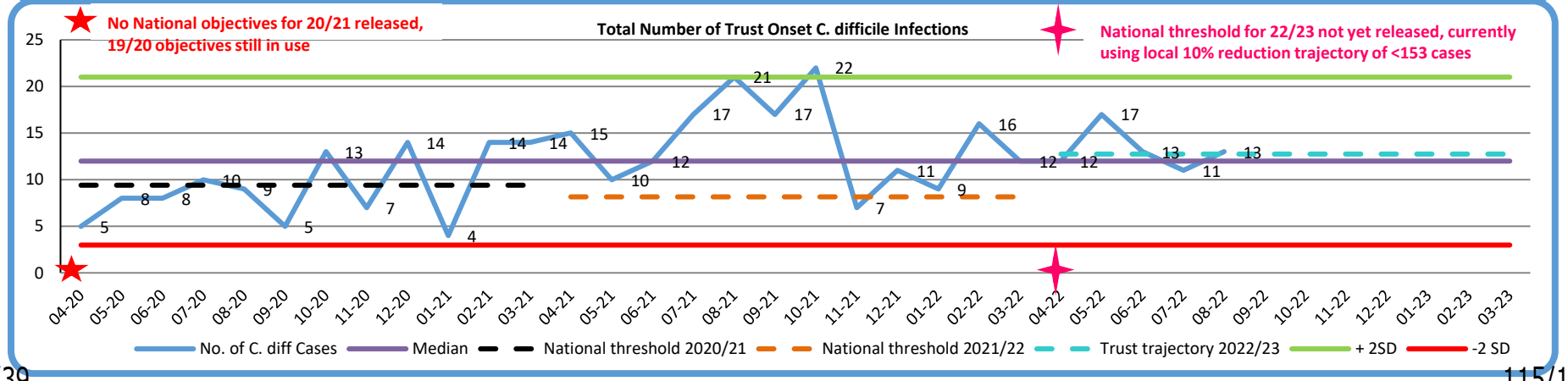
Finance

- Overall Financial Position

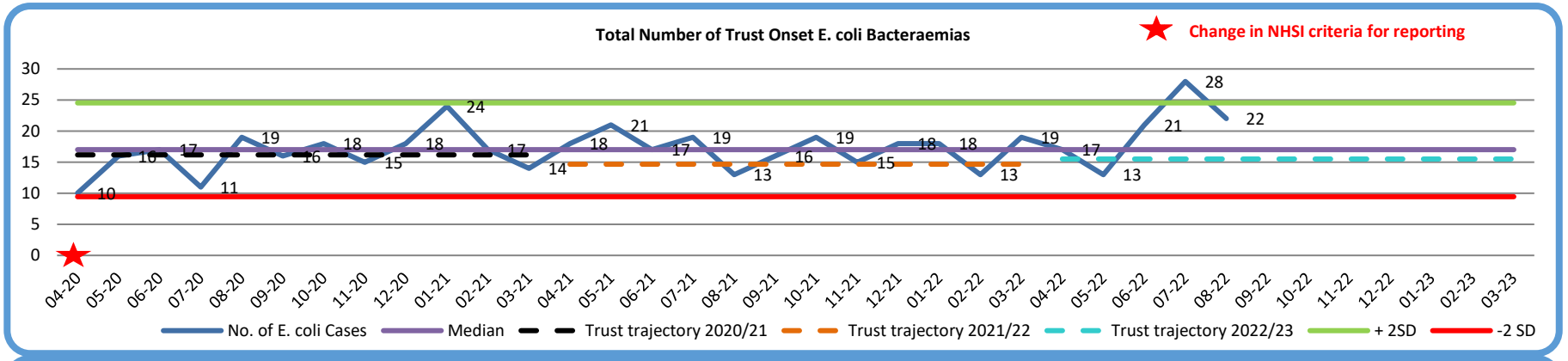
Quality: Healthcare Associated Infections 1/2

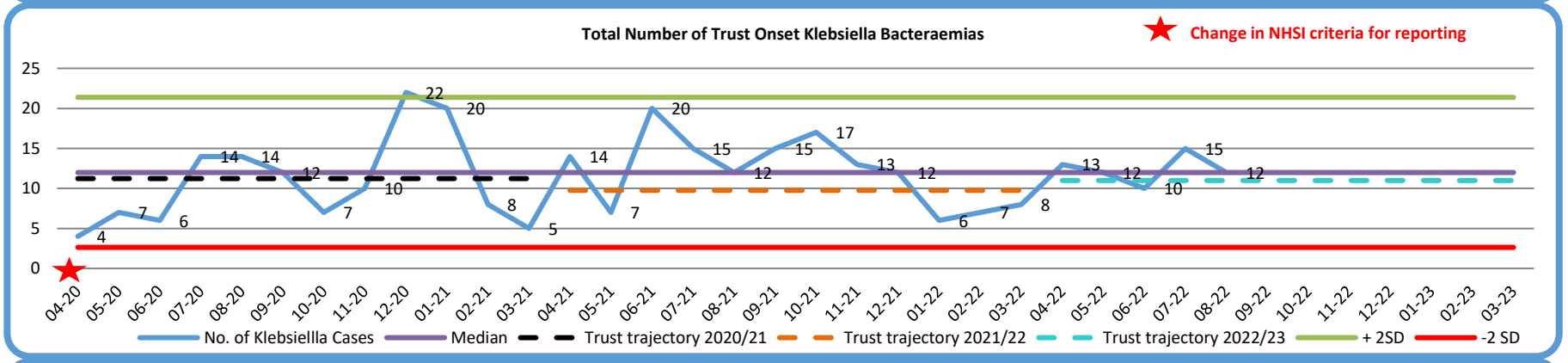


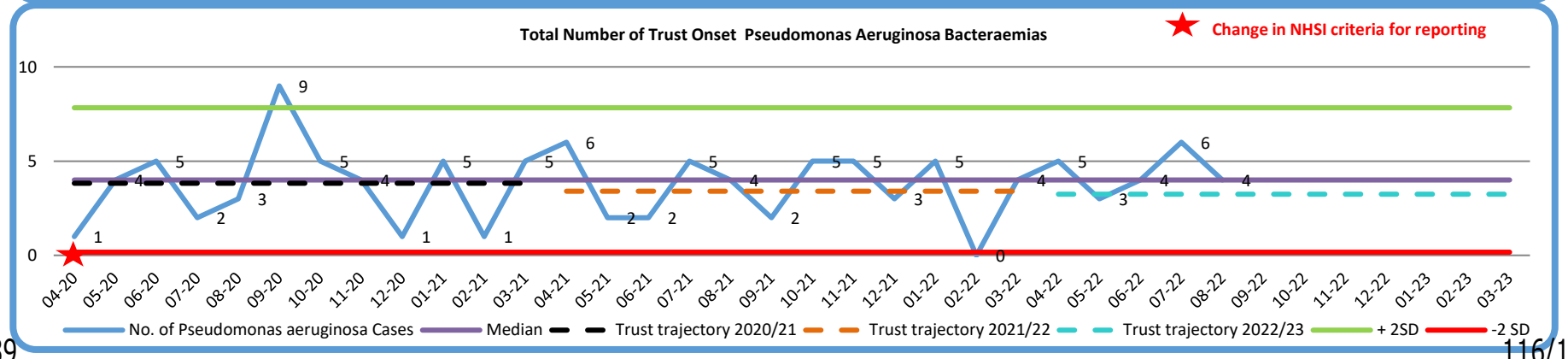




Quality: Healthcare Associated Infections 2/2



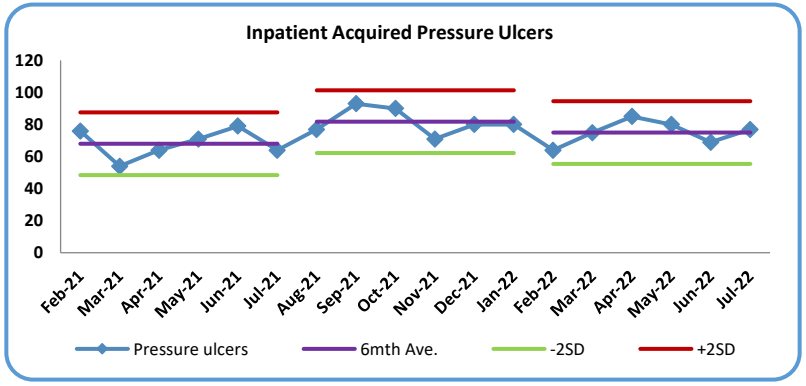


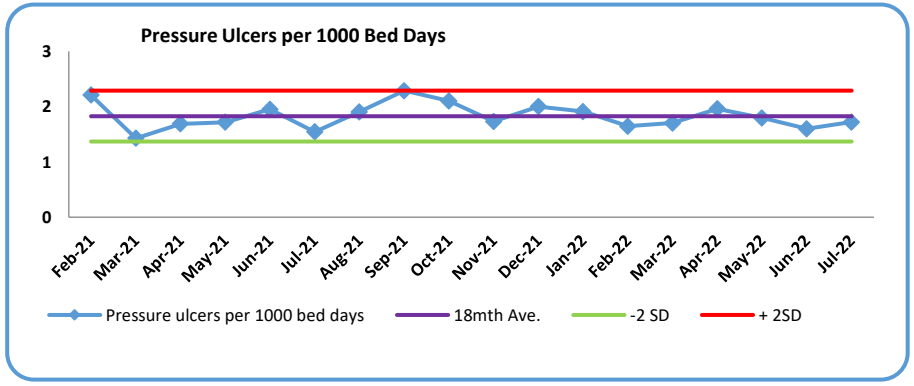


Quality: Harm Free Care – Pressure Damage

The graphs below indicates a slight reduction in overall incidence of pressure ulcers in the last 6 months, however overall rates remained higher than pre-pandemic levels. We did see a decrease in Pressure Ulcers in the month of June however July saw the number slightly increase again.

From August through to October 2021 a steep increase is evident, this directly correlates with surges in COVID-19 activity. This is also apparent in October 2020 through to February 2021, whereby waves two and three occurred. The Trust safe care data illustrates the acuity of patients is significantly higher than pre-pandemic levels. In addition, there has been an increase in patients presenting to the Trust with significant existing damage, or at risk of skin deterioration. This is consistent in both other Trusts in the Shelford group and indeed the National picture.



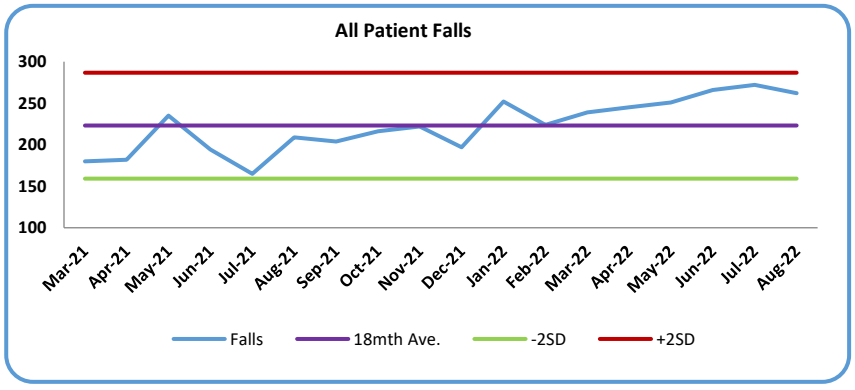


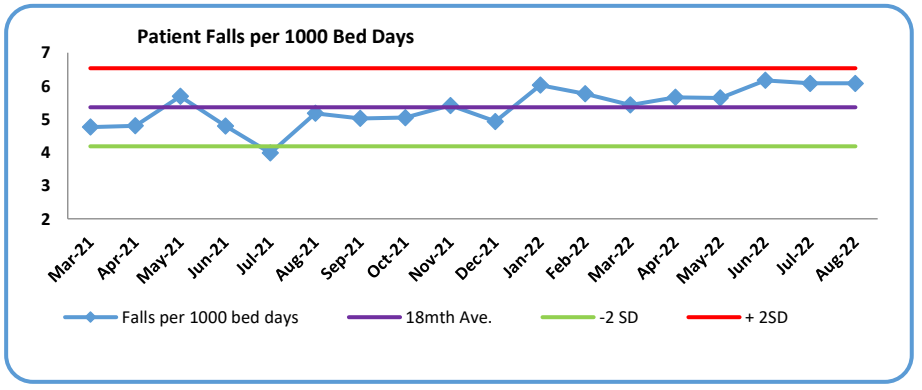
Quality: Harm Free Care - Falls

August has seen a reduction in falls for the first time since February 2022.

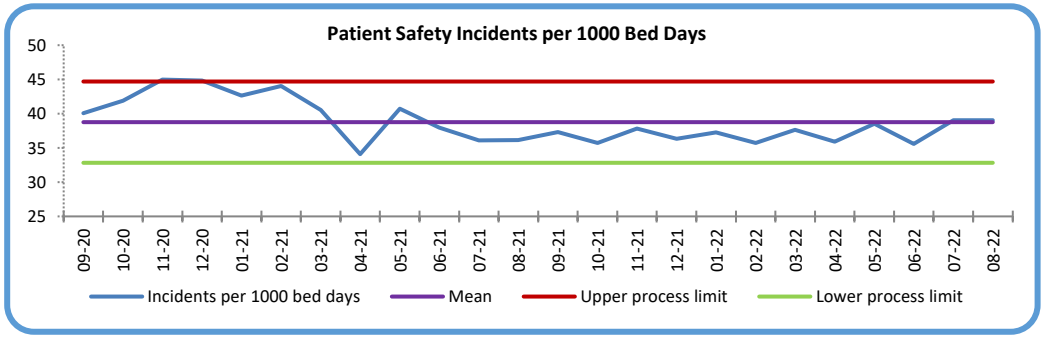
This year the Trust has experienced significant pressures, particularly in relation to bed occupancy levels, which have remained high throughout. Significant increases in the cohort of medical patients, particularly those over 65 are evident and did lead to the requirement to convert many surgical wards to medicine, and have remained so for the last two years. 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. Incidents within the Trust reflect this, whereby a high proportion of falls occur in our patients who are over 65.

The Falls Coordinator has commenced work identifying, on a monthly basis, the wards with the highest incidence of falls, identifying causes and looking at solutions with the aim to reduce numbers.

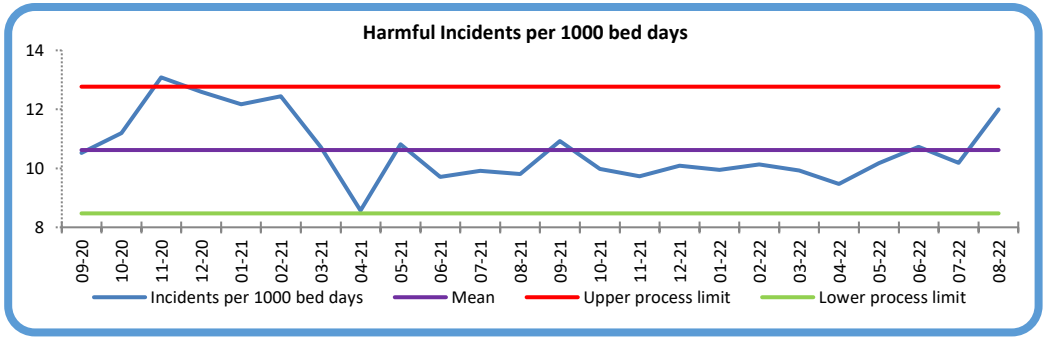




Quality: Incident Reporting

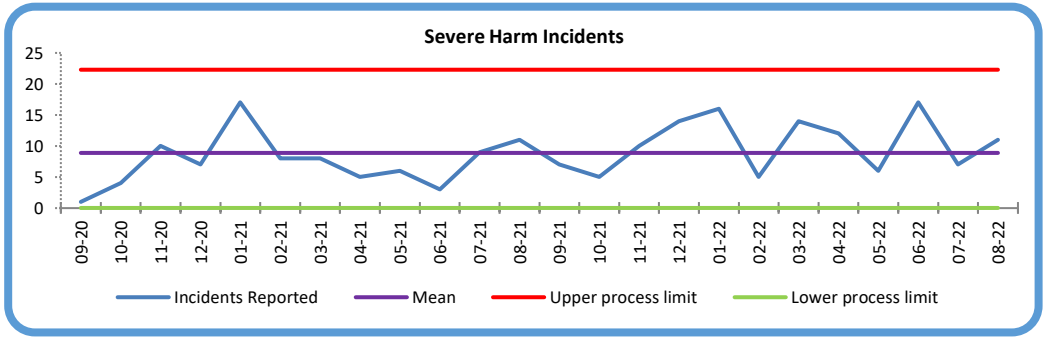


All patient incidents: The number of patient safety incidents per 1000 bed days continues to sit slightly above the mean for the month of August 2022. This however remains well within the expected common cause variation.



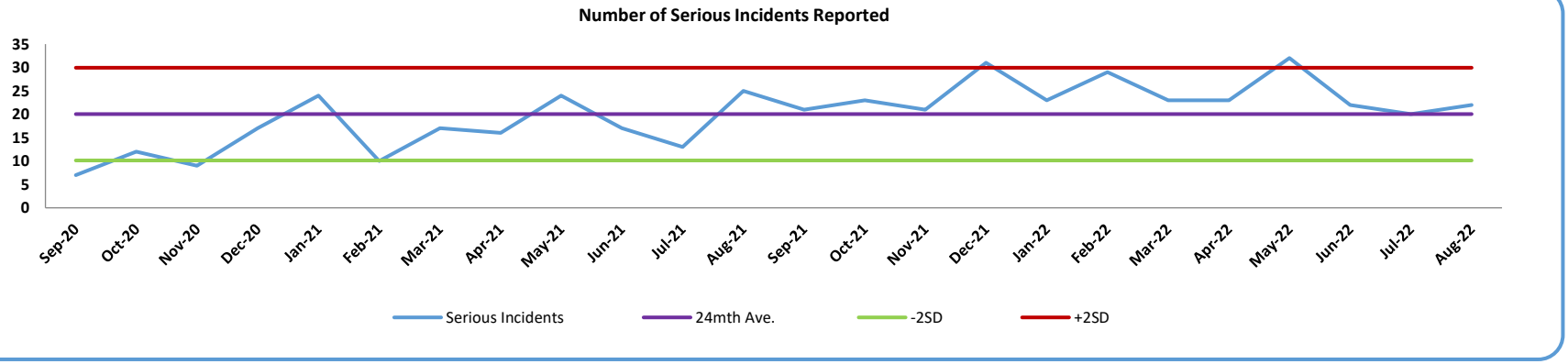
Harmful incidents: In August 2022 there has been an increase above the mean, in the number of *harmful patient safety incidents per 1000 bed days. This remains within the common cause variation expected however will be monitored closely for any further increase.
Severity grading of reported incidents may be modified following investigation and is therefore subject to change in future reports.

**includes all levels of harm from minor to catastrophic. Excludes patient safety incidents that resulted in no patient harm.*

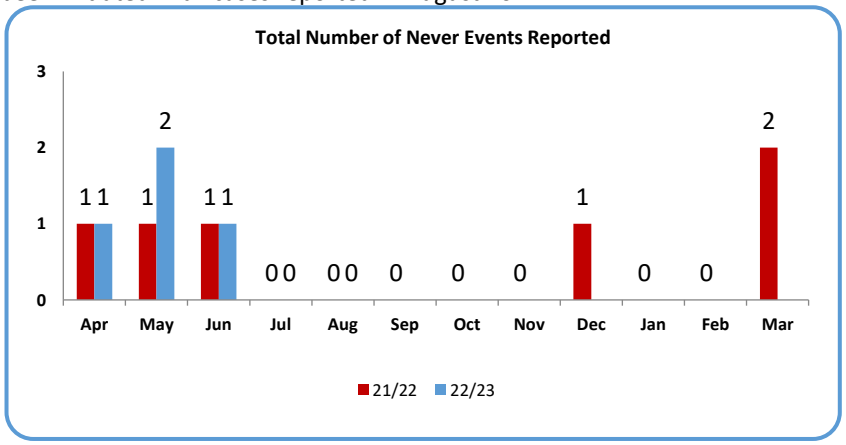


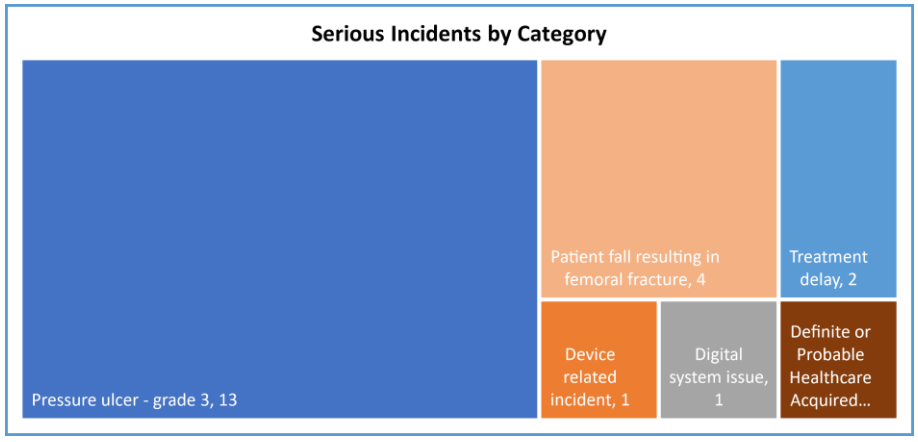
Severe harm incidents: There were 11 patient safety incidents reported which resulted in severe harm in August 2022. This is a slight increase above the mean in the number of severe harm incidents. This however remains within the common cause variation. Severity grading of reported incidents may be modified following investigation and is therefore subject to change in future reports.

Quality: Serious Incidents & Never Events



There were 22 Serious Incidents (SIs) reported in August 2022, demonstrating a slight decrease back towards the mean between June 2022 – August 2022. The increase in the numbers of SIs since July 2021 can be attributed to a return to pre-pandemic bed occupancy alongside higher acuity of patients in the Trust and an increase in COVID-19 prevalence. The statutory requirement Duty of Candour (DoC) applies to patient safety incidents that occur when providing care and treatment that results in moderate, severe harm or death and requires the Trust to be open and transparent with patients and their families. The DoC process has been initiated in all cases reported in August 2022.





*The Trust started reporting patients who have died with definite or probable hospital onset COVID-19 as serious incidents from 1st January 2021. This is following new NHSE reporting guidance which aims to standardise reporting by all trusts nationally.

Quality: Serious Incident Lessons Learned (1/2)

Learning identified from Serious Incident (SI) & Never Event (NE) investigations completed between 01.05.2022 – 31.08.2022

The following section outlines key learning from the 16 SI investigations completed between 1st May 2022 to 31st August 2022. This data excludes information on falls (with the exception of two inpatient falls where a more in-depth investigation was required), pressure ulcers, deaths as a result of definite or probable hospital acquired Covid-19 and any SI cases subsequently de-registered during this period.

Missed referral

- Patient information resource developed to better inform and involve the patient in relation to their own health condition.
- Enhanced induction programme for staff developed and agreed standardisation of the referral process.

Treatment delay – 2 cases

- Improved handover process to support better MDT communication.
- Development of a robust standard operating procedure to provide standardisation and safety-netting of patients across the pathway.
- Recruitment of Failsafe Officers and upskilling of existing staff to improve safety netting processes.

Delayed Diagnosis – 3 cases

- Mandated education for all clinical staff now in place with additional local training programmes developed.
- Use of digital decision-making aids to support staff to identify risk of patient deterioration and the need for early escalation.
- Enhanced governance processes, including implementation of a Trust-wide audit programme and compliance dashboards.
- Development of a robust training resource pack for staff new to the clinical areas.
- Redesign of the clinical pathway to ensure patients receive optimal care, depending on their individual needs.

Health Care Acquired Infection

- Procurement of a digital solution to better support staff when caring for patients at risk of complications.
- Enhanced governance processes, including monthly assurance audit and an enhanced education programme for staff.

Quality: Serious Incident Lessons Learned (2/2)

Inpatient Fall – 2 cases

- Strengthened processes in place, including the development of a falls safety bundle, refreshed guidance to support staff to minimise the risk of patient falls.
- Exploration and procurement of specialised patient beds to improve patient safety.

Surgical Incident – 2 cases

- Agreement of sub-specialty expert clinical rota for service provision, in line with national recommendations.
- Local and national sharing of learning from this case to reduce the risk of future occurrence.

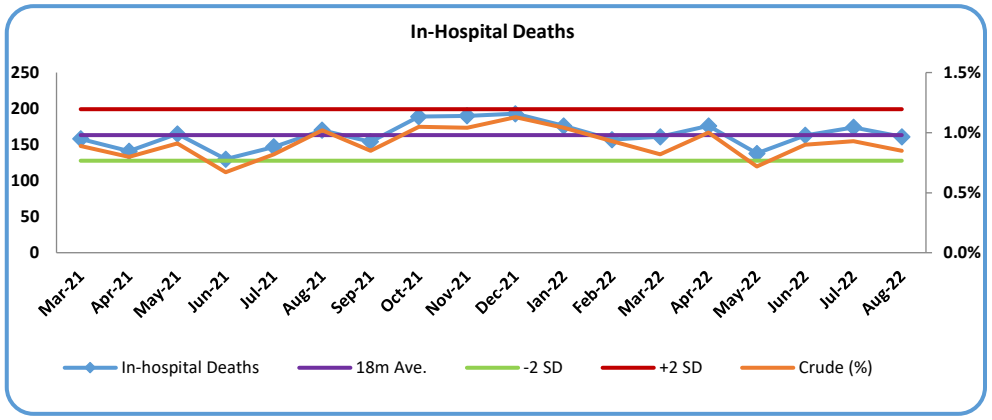
Maternity reportable cases - 5 cases

- Strengthened guidance to better dictate scan frequency for women with poor obstetric history.
- Raise awareness with staff regarding the importance of ensuring robust booking pathways are followed.
- Raise awareness of clinical pathways and guidance to ensure optimum fetal monitoring, aligned to national guidance.
- Opportunities to improve the cultural awareness for staff explored by Maternity Cultural Equality Group.
- Opportunities to improve communication with patients during complex labours.

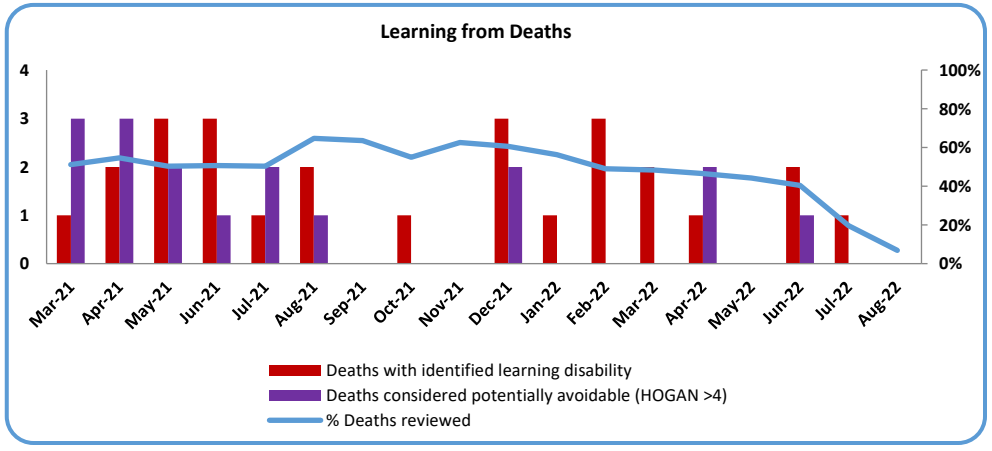
**Incidents involving babies are reported as SIs in line with the agreement of a regional 'trigger list' within the Northern Maternity Clinical Network group. This agreement is that all cases reported to the Royal College of Obstetrics & Gynaecology (RCOG) as fulfilling the criteria for the 'Each Baby Counts' national quality-improvement initiative should (by default) be notified as Serious Incidents.*

Quality: Mortality Indicators 1/2

In-hospital Deaths: In total there were 161 deaths reported in August 2022, which is slightly lower than the amount reported 12 months previously (n=170). Crude death rate is 0.85%. Historically, crude death rate has consistently remained under 1% with the exceptions of COVID-19 pandemic peaks.

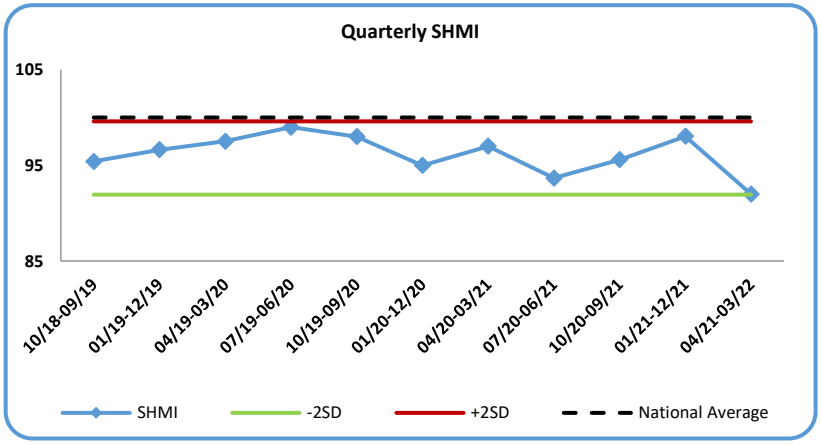


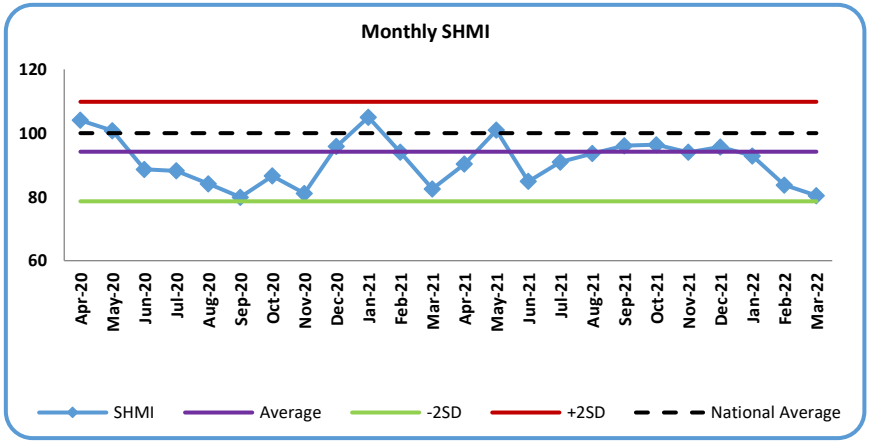
Learning from Deaths: Out of the 161 deaths reported in August 2022, 11 patients have, to date, received a level 2 mortality review. However, these figures will continue to rise due to ongoing M&M meetings held over the forthcoming months. All figures will continue to be monitored and modified accordingly.



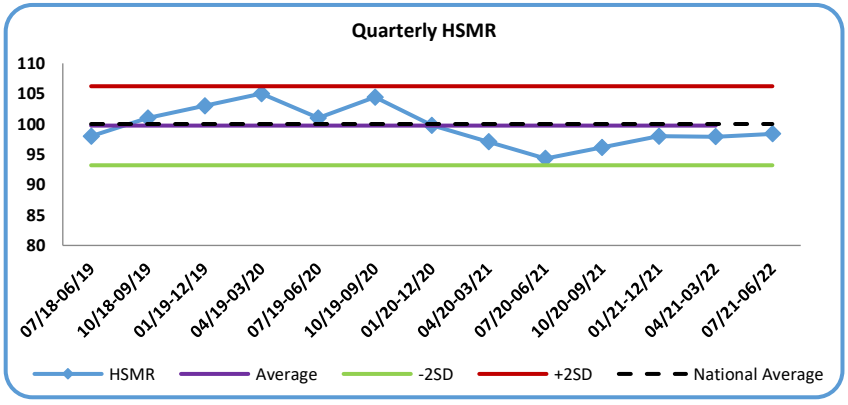
Quality: Mortality Indicators 2/2

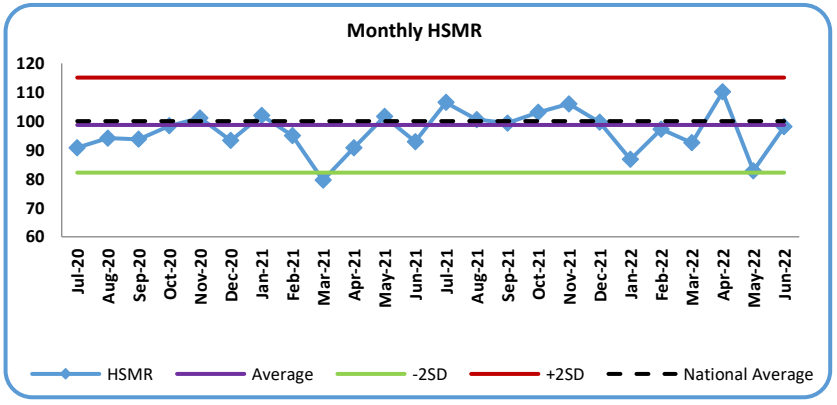
SHMI: The most recent published SHMI quarterly data from NHS Digital shows the Trust has scored 92 from months April 2021 – March 2022. This is below the national average and is within the "as expected" category. Monthly SHMI shows the Trust to be within the “as expected” category. COVID-19 data continues to be excluded from SHMI data published from NHS Digital.



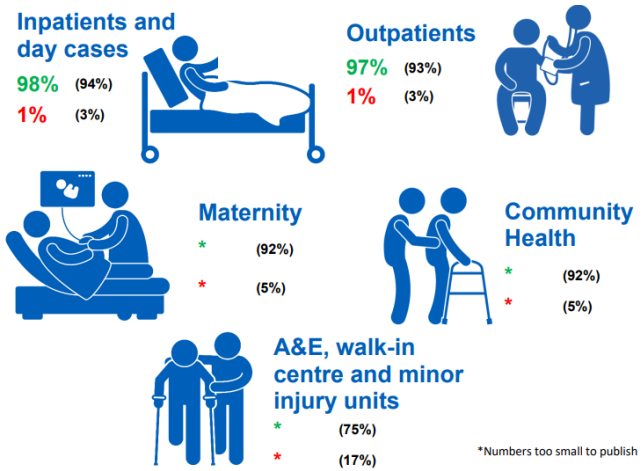


HSMR: The HSMR data shows a 12 month rolling HSMR score by quarter as well as monthly data. Monthly HSMR data is available up to June 2022, and is showing to be below the national average, however this number may rise or fall as the percentage of discharges coded increases. All figures will continue to be monitored and modified accordingly.





Quality: FFT and Complaints



Friends and Family Test

The published data shows that there were 1,481 responses to the Friends and Family test from the Trust in July 2022 (published September 2022) compared to 2,199 in the previous month.

The following infographic shows the proportion of responses that reflect a positive or negative experience from the feedback provided by our patients. The national average results are shown in brackets.

All data is available at: www.england.nhs.uk/fft/friends-and-family-test-data/

*numbers too small to publish

Trust Complaints 2022-23

The Trust has received a total of 216 (210 with identified patient activity) formal complaints up to August 22, an increase of 53 on last month's opened complaints.

The Trust has received an average of 43 new formal complaints per month, which is 3 complaints per month lower than the 46 per month average for the last full financial year 2021-22.

Taking into consideration the number of patients seen and areas with patient contact, the highest percentages of patients complaining to date are within Perioperative and Critical Care, Surgery and Neurosciences with 0.04% (4 per 10,000 contacts). The lowest complaint percentages are with Dental who are yet to receive a complaint.

	2022-23				
Directorates	Complaints	Activity	Patient % Complaints	Ratio (YTD)	21-22 Ratio (Full Year)
Cardiothoracic	6	46,069.00	0.013%	1:7678	1:3128
Children's Services	10	33,334.00	0.030%	1:3333	1:3275
Community Services	4	30,629.00	0.013%	1:7657	1:4546
Dental Services	0	43,416.00	0.000%	1:	1:10120
Medicine	23	81,753.00	0.028%	1:3554	1:3053
Medicine ED	8	73,302.00	0.011%	1:9163	1:4866
ENT, Plastics, Ophthalmology & Dermatolog	17	164,021.00	0.010%	1:9648	1:7356
Musculoskeletal Services	8	48,651.00	0.016%	1:6081	1:3505
Cancer Services & Clinical Haematology	13	89,004.00	0.015%	1:6846	1:6347
Neurosciences	19	44,231.00	0.043%	1:2328	1:3067
Patient Services	57	18,954.00	0.301%	1:333	1:1934
Peri-operative & Critical Care	7	15,937.00	0.044%	1:2277	1:3499
Surgical Services	13	34,375.00	0.038%	1:2644	1:1698
Urology & Renal Services	8	29,724.00	0.027%	1:3716	1:3090
Women's Services	17	62,795.00	0.027%	1:3694	1:3341
Trust (with activity)	**210**	**816,195.00**	**0.026%**	**1:3887**	**1:3994**

"Communication" is the highest primary subject area of complaints at 26% of all the subjects Trust wide.

Quality: Health and Safety

Overview

There are currently 1093 health and safety incidents recorded on the Datix system from the 1st September 2021 to 31st August 2022. This represents an overall rate of 64 per 1,000 staff. The Directorate with the highest number of incidents is Peri-operative & Critical Care reporting 144 health and safety incidents over this period. The highest reporting Directorates are Peri-operative & Critical Care (100), Internal Medicine (72.6) and Women's (72) at rates per 1,000 staff .

Incidents of Violence & Aggression to Staff

In addition to the health and safety incidents, there are 943 incidents of physical and verbal aggression against staff by patients, visitors or relatives recorded on the Datix system from the 1st September 2021 to 31st August 2022. This represents an overall rate of 55.3 per 1,000 staff during this period. The Trust Violence Reduction Group met for the first time in July 2022. A number of initiatives are already underway, for example 'We Can Talk' in Children's Directorate which is a training package used to upskill staff in effective communication skills with patient suffering from mental health issues. Staff in Reception areas have also received additional training in face to face and telephone conflict resolution.

Sharps Incidents

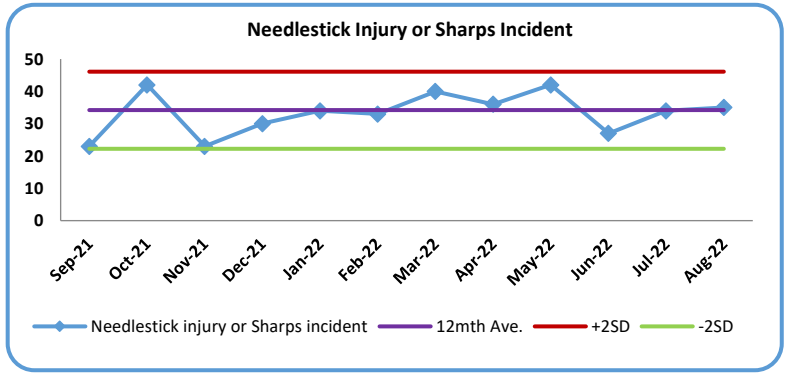
There have been 401 incidents during the period (average 33.4 incident per month 73% of these involve dirty needles). The recent sustained increase aligns with a number of factors, which are currently being discussed at the Trust Safer Sharps User Group. These factors include increased activity / acuity, supply issues meaning staff are using alternative devices and clinical educator vacancies.

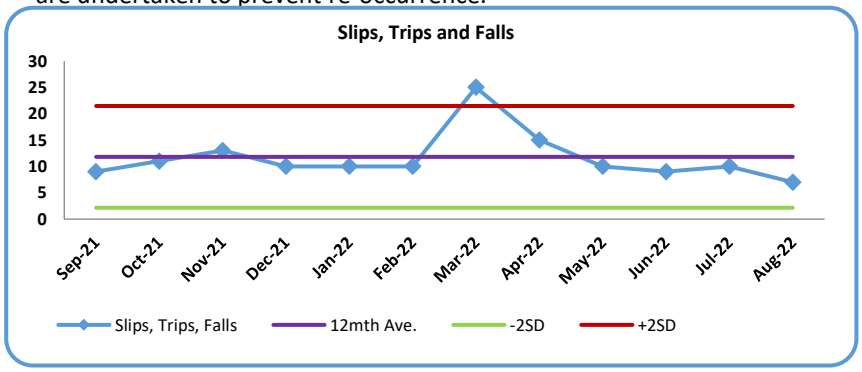
Slips, Trips and Falls

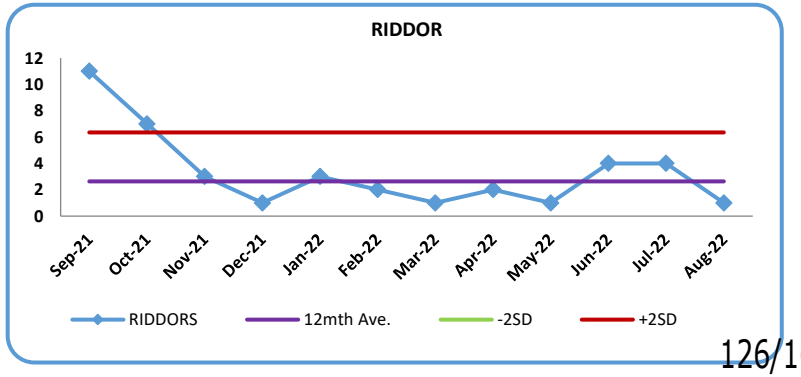
128 incidents reported between 1st September 2021 to 31st August 2022. 56% of these incidents were related to trips and slips on wet floors. Regular zonal inspections, on main hospital sites, takes place every month and regular data analysis is acted upon and feeds into the Slips, Trips and Falls Group, which meets quarterly.

RIDDOR

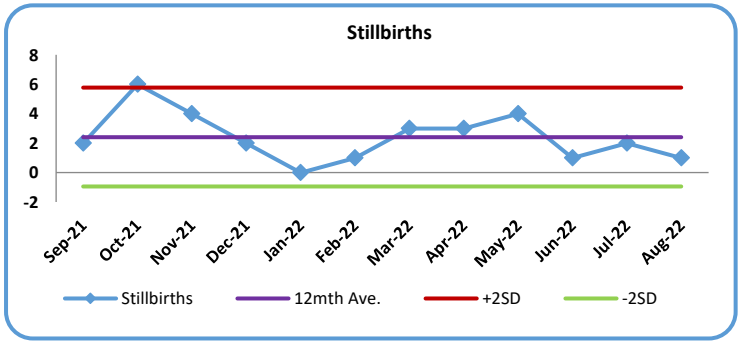
There have been 44 RIDDOR incidents reported between 1st September 2021 to 31st August 2022 The most common reasons of reporting accidents and incidents to the HSE within the period are Moving and Handling (14), Slips, Trips and fall (12), Accidents (involving staff, visitors etc.) (9) and Aggression & Violence (5). All RIDDOR reportable incidents are investigated fully and, where necessary, remedial actions are undertaken to prevent re-occurrence.





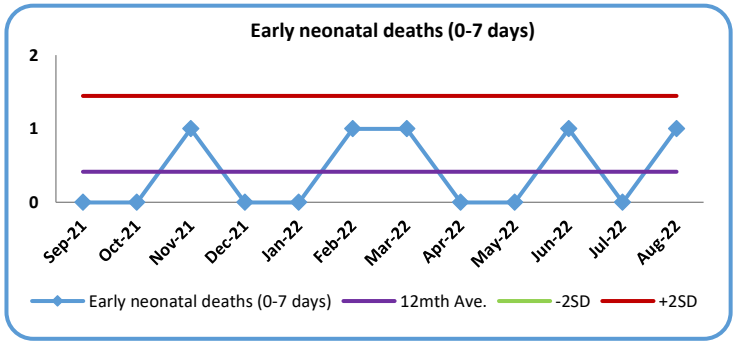


Quality: Maternity (1/3)

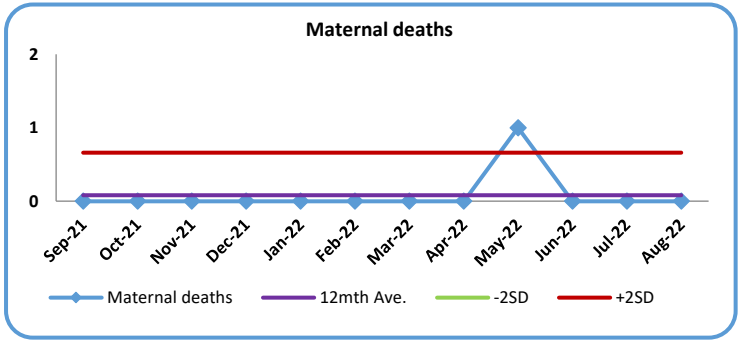


Perinatal deaths
All Perinatal deaths (Stillbirths and Neonatal Deaths) are reported to MBRRACE-UK who produce an annual National report which includes our local data.

Stillbirths
As we are a tertiary referral Fetal Medicine Unit often complex cases are referred to us from other units within the region and the women opt to deliver here rather than return to their local unit. This data includes termination for fetal anomalies > 24 weeks gestation. All cases undergo an initial local review and then a more detailed review including external input, once we have the investigation results.

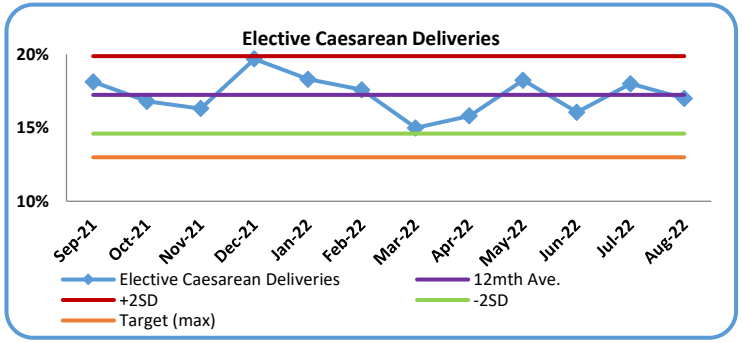


Early Neonatal Deaths
These figures are for term infants (born between 37 and 41 weeks) who delivered at the Trust but sadly died unexpectedly within the first week of life. These deaths are reported to the Child Death Review panel who will have oversight of the investigation and review process. These cases are also usually reported to the Coroner. A post mortem examination may be requested to try and identify the cause of death.



Maternal Deaths
Maternal deaths are reported to MBRRACE-UK and a national report is provided annually. Maternal deaths can be categorised as Direct or Indirect. It is rare to have a direct Maternal death in Newcastle. Tragically in May, a woman died after suffering complications shortly after delivery. The case has been reported to the Coroner, MBRRACE-UK and HSIB. HSIB have started their investigations. It is anticipated that the report will be available within 6 months. A local review to consider immediate actions was undertaken within 72hrs of the death.

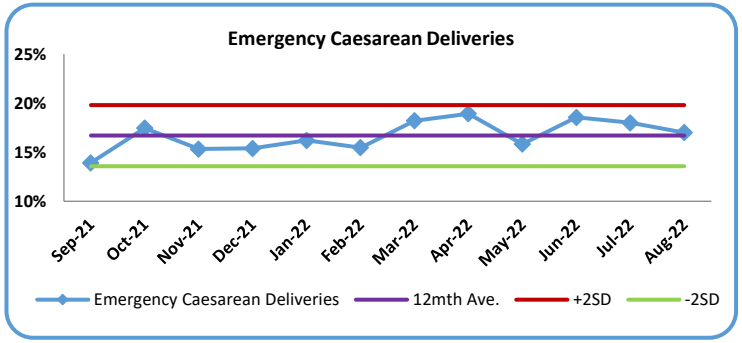
Quality: Maternity (2/3)



Elective Caesarean section

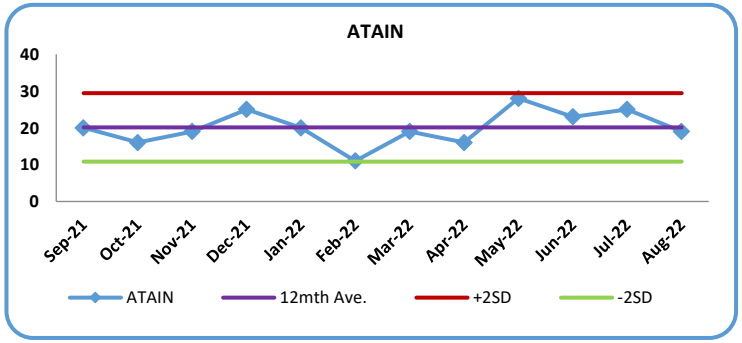
Maternity at the Trust is an outlier for elective Caesarean section compared to other UK Trusts. However, the rates are comparable to rates of other tertiary centres in the UK.

The service also has at its heart a shared decision making philosophy and offers informed, non-directive counselling for women over mode of delivery. There is an obstetrician/midwifery specialised clinic to facilitate this counselling and patient choice.



Emergency Caesarean section

The emergency Caesarean section rate is comparable to other Trusts. Maternity is a consultant led service with 98-hour dedicated consultant sessions for Delivery Suite (8am-10pm daily), twice daily consultant ward rounds and consultant obstetricians being involved with all decisions for emergency Caesarean section.



ATAIN

All unplanned admissions of term babies (37 – 41 weeks) into the neonatal unit are reviewed at a weekly multi-disciplinary meeting and a quarterly report is produced and shared. Some of these cases will be reviewed in more detail if they have been identified as a Serious Incident. The annual audit report will be presented at the Directorate Audit meeting in September with lessons learnt/ key themes/ change to practice being shared across obstetrics and neonatology.

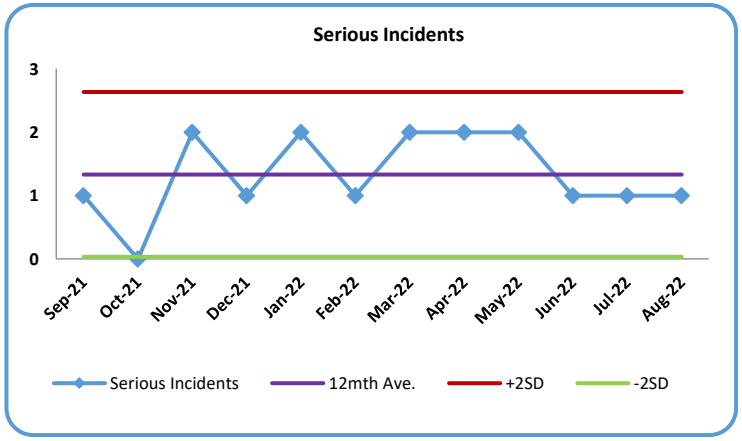
Quality: Maternity (3/3)

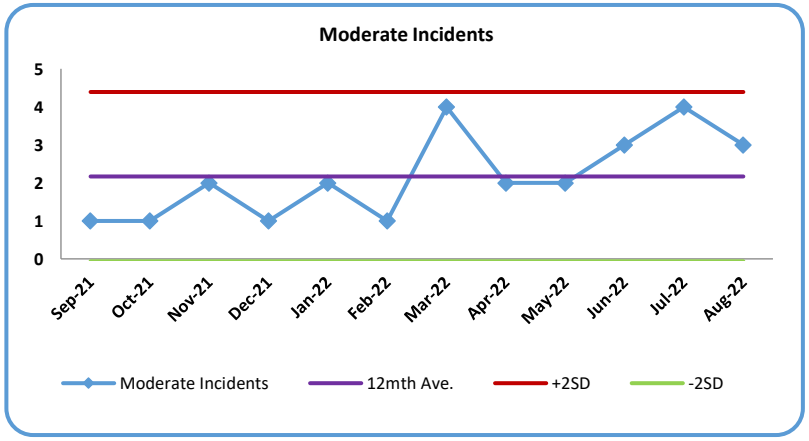
Serious Incidents

There have been 16 incidents escalated as Serious Incidents to the Trust in the past 12 months. These include 8 cases of potential Hypoxic Ischaemic Encephalopathy (HIE), 3 neonatal deaths, 1 bowel injury, 3 intrapartum stillbirths and 1 direct maternal death. The HIE, Intrapartum Stillbirths, Neonatal deaths and Maternal death were all reported to HSIB (Healthcare Safety Investigation Branch) for external review. A summary of the HSIB cases was presented to the Serious Incident Panel in May and an update to be provided in September.

Moderate incidents

All incidents are carefully reviewed by the Maternity Governance team and are graded appropriately after completion of a rapid review (48hr report). In the past 12 months the majority of the moderate graded incidents were babies that needed to receive 'therapeutic hypothermia' in order to minimise the risk of a brain injury. Although graded moderate these babies may have no long term injury but they require a two year follow up in order to assess their neurological status. Moderate incidents will be investigated as a Serious Learning Event and involve parental input to the investigation and follow up with a Consultant and Senior Midwife 6-8 weeks after the incident.





Quality and Performance: Clinical Audit (1/4)

Audit / NCEPOD	Date of Report	Areas of Good Practice	Recommendations for improvement	Action Plan Developed
National Asthma and COPD Audit Programme – Pulmonary Rehabilitation	10 December 2020	• 100% of patients offered discharge assessment received a written discharge exercise plan. • The Trust was rated as average or above average in all elements of the audit except one.	• Patients undertaking practice exercise test (for Incremental Shuttle Walk Test or 6 Minute Walk Test. 20% of Trust patients were recorded as having this undertaken compared to 98% nationally. However it is recognised that this was a very small sample. • The challenge relates to capacity for completion of the audit rather than the exercise test not being undertaken.	Discussed at May 2022 Clinical Audit and Guidelines Group
Sentinel Stroke National Audit Programme	9 December 2021	• Ranked joint first place with University College Hospital in London with a total key indicator score of 96. • Benchmarked fantastically across all key patient domains. The Trust scored 'A' which is the highest performance across all domains other than thrombectomy numbers and speech and language therapy. For those, the Trust scored B which is the next best performance category. The combined overall performance score was A. Scores range from A-E and the Trust is well above average in all domains.	• None, compliant with all recommendations.	Discussed at May 2022 Clinical Audit and Guidelines Group
Cleft Registry and Audit Network	23 December 2021	• The Newcastle Cleft Service has prioritised data submission to CRANE. Data collection has been embedded within the team at every level by supporting the full-time data co-ordinator who cross-checks all submissions. • Data submission and CRANE consent by the Newcastle Cleft Service reached positive outlier status in this report and the clinical lead was invited to share aspects of team working that supported this with the national cleft community. • The clinical outcomes achieved, by the Newcastle Cleft Service, stand highly within the UK, although the team strives to improve by collaborative working with multidisciplinary professionals across the region. This high delivery of care continued throughout the pandemic avoiding difficulties and delays in treatment for the patient cohort, whilst maintaining high standards of data completeness.	• None, compliant with all recommendations.	Discussed at June 2022 Clinical Audit and Guidelines Group

Quality and Performance: Clinical Audit (2/4)

Audit / NCEPOD	Date of Report	Areas of Good Practice	Recommendations for improvement	Action Plan Developed
National Maternity and Perinatal Audit	13 May 2021	• Woman are provided with information in antenatal clinic to aid decision making about mode of birth, including information on birth interventions and post-partum haemorrhage. • Annual audit of post-natal readmissions includes information on BMI. • Skin-to-skin contact, and breastfeeding is encouraged regardless of BMI.	• Ensuring that women with a BMI of 30 kg/m2 or above are given preconception and antenatal information tailored to their individual circumstances (including their BMI and whether this is their first birth, or they have previously had a caesarean birth). • Incorporating information on antenatal assessment of fetal growth status (suspected SGA or LGA) and on venous thromboembolism risk scores and prophylaxis in future trust/board and national maternity dataset specifications.	Discussed at July 2022 Clinical Audit and Guidelines Group
Maternal, Newborn and Infant Clinical Outcome Review Programme - National Perinatal Mortality Review Tool	13 October 2021	• Majority of the care women received was graded A. • Compliant with all recommendations including monthly MDT meeting held with external reviewers present. Parent engagement materials in use, parents fully informed of review process and have several opportunities to share their views. Parent engagement proforma in use.	• None, compliant with all recommendations	Discussed at July 2022 Clinical Audit and Guidelines Group
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	14 October 2021	• We have implemented all national initiatives to reduce stillbirth and neonatal deaths and monitoring the impact on reducing preterm birth. • Compliant with all 5 elements of Saving Babies Lives Care Bundle 2 (SBLCBV2) comprising preterm prevention, FGR, reduced FMs, Fetal monitoring training and champions. Dedicated Fetal Monitoring lead midwife focusing on each element of SBLCBV2. • Stillbirth rate very low compared to national average.	• Explore local variation in post-mortem uptake by different population groups, particularly by ethnicity and deprivation, and tailor training for consent takers based on the local population. • Undertake placental histology for all babies admitted to a neonatal unit, preferably by a specialist perinatal pathologist.	Discussed at July 2022 Clinical Audit and Guidelines Group

Quality and Performance: Clinical Audit (3/4)

Audit / NCEPOD	Date of Report	Areas of Good Practice	Recommendations for improvement	Action Plan Developed
Maternal, Newborn and Infant Clinical Outcome Review Programme - Saving Lives, Improving Mothers Care	11 November 2021	• Dedicated weekly 'Vulnerable Women' antenatal clinic for women with mental health issues and substance misuse. Named consultant obstetrician and specialist drug and alcohol misuse midwives and newly appointed Perinatal Mental Health midwife. Good model of care with close links/accessibility to named consultant psychiatrist and perinatal mental health services. • Robust bespoke electronic VTE risk assessment for Maternity and joint Obstetric Haematology ANC with Haematologist for MDT input and planning for women with VTE in pregnancy. • Maternal Medicine Specialists coordinate care of pregnant women with cancer. Individualised MDT planning.	• Ensure there are clear and explicit pathways into specialist perinatal mental health care, which take into account all other aspects of perinatal mental health provision, including specialist roles within midwifery and obstetric services, in order to avoid any confusion over roles and responsibilities. • Women with substance misuse are often more vulnerable and at greater risk of relapse in the postnatal period, even if they have shown improvement in pregnancy. Ensure they are reviewed for re-engagement in the early postpartum period where they have been involved with addictions services in the immediate preconception period or during pregnancy. • Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for women if, on examination, the appearance of their cervix is consistent with cervical cancer.	Discussed at July 2022 Clinical Audit and Guidelines Group
National Lung Cancer Audit	13 January 2022	Due to logistical complications (Covid 19 pandemic and change of audit provider), no Trust-level data was provided in this year's publication of the National Lung Cancer Audit. Due to the absence of Trust-specific data, the report does not contain any recommendations for the Trust or areas where the Trust is performing below the national average.		Discussed at July 2022 Clinical Audit and Guidelines Group

Quality and Performance: Clinical Audit (4/4)

Audit / NCEPOD	Date of Report	Areas of Good Practice	Recommendations for improvement	Action Plan Developed
UK Cystic Fibrosis Registry	1 December 2021	The 2020/2021 UK Cystic Fibrosis Registry report focused on patient demographics and does not contain any recommendations for the Trust or areas where the Trust is performing below the national average.		Discussed at August 2022 Clinical Audit and Guidelines Group
National Maternity and Perinatal Audit (NMPA)	14 October 2021	• Compliant with all key clinical findings. • Compliant with data collection as evidenced by successful CNST achievement 2021 in terms of MSDS. Badgernet will facilitate and enhance robustness of data collection for audit and CNST.	• Where data sources have been insufficiently complete to report results, or where results suggest there may be data quality issues, maternity service providers, maternity information system suppliers, NHSE&I and those responsible for collating and managing maternity datasets should work together to improve completeness and accuracy of the data items required.	Discussed at September 2022 Clinical Audit and Guidelines Group

Quality and Performance: Quality Account Priorities Update (1/4)

1. Reducing Healthcare Associated Infections

Progress to Date

- COVID-19 Trust guidance has been updated in response to national changes. COVID-19 hospital onset cases and declared outbreaks continue to be monitored.
- To the end of July 2022, the Trust has reported:
  - 1 MRSA bacteraemia.
  - 1 case over the internal 10% reduction for MSSA bacteraemia. There are no national thresholds for MSSA.
  - All *gram negative blood stream infection* rates were above internal and national trajectories with the exception of Klebsiella which is 3 cases under national threshold.
  - *C.difficile Infection* rates are within national trajectory.

Improvement focus

- "Gloves off" campaign focuses on correct PPE usage and effective hand hygiene. This will reduce the risk of cross-infection and minimise HCAI.
- *Blood stream infection* reduction initiatives to improve compliance with:
  - Skin decolonisation (Octenisan).
  - IV / Urinary Catheter device management.
- *C.difficile infection* reduction initiatives:
  - HPV cleaning.
  - Early recognition of diarrhoea for effective management.
  - Antimicrobial stewardship.
  - Audit process with Synbiotix .
  - All mandatory reported HCAI are reviewed by the IPCT.
  - Clinical MDT review is undertaken for all hospital onset C.difficile Infection.

2. Management of Abnormal Results

Progress to Date

- An MDT, involving colleagues in IT, clinical informatics, laboratory medicine, and radiology, has been organised to design a better system to track and display all investigations from request, to appointment, to completion, to reporting and then endorsement.
- Several large audits have been completed of this pathway.
- In February 2022, a review of electronic radiology orders returned to the correct 'lead' consultant was undertaken. Work is now ongoing to align lead consultant identifiers across Cerner Millennium, the Radiology RIS and the Laboratory LIMS.
- An audit in June 2022, demonstrated that 'lead' consultant information cannot pass digitally from eRecord to the LIMS or RIS, and results cannot pass digitally from the LIMS or RIS to each 'lead' consultant's 'message centre' in eRecord.
- Work is being finalised as part of a PDSA to redesign the existing radiology electronic order entry forms (eOEF).
- After 'go live', eOEFs will mandate selection of a 'Lead' Consultant for Radiology exam requests. Initially, this change will affect all MRI requests. If audit results show an improvement in the proportion of requests that include appropriate and correct 'lead' consultant identifiers, the plan is roll out this change to other areas.

Improvement focus

- The list of 'lead' consultants in eRecord/APEX/radiology systems will need to be updated on a regular basis, in order to correctly add new starters to each system and appropriately deactivate leavers.
- Once the new Cerner LIMS is implemented, we aim to use the same identifier for 'lead' consultants in the LIMS and eRecord.
- Further explore how and where best to implement the Future Orders module of Millennium in order to solve several problems resulting from the current implementation of eRecord Encounters, particularly in the outpatient setting.
- Further explore the future role of 3M's Follow-up Finder software & natural language processing (NLP) that enables understanding of free-text results. This enables Clinical Decision Support (CDS) that suggests appropriate actions, where necessary, in response to advisory comments included with free-text radiology reports.
- To explore the role of this software in suggesting appropriate actions in response to advisory comments included with free-text laboratory reports.

Quality and Performance: Quality Account Priorities Update (2/4)

3. Enhancing capability in Quality Improvement

Progress to Date

- Building on last years progress, cohort 2 of the Improvement for Teams has commenced and will be co-delivered by Newcastle Improvement and the Institute for Healthcare Improvement. There are 10 teams consisting of 5-6 people.
- Cohort 2 of the Improvement Coach Programme has now completed. In total 21 coaches completed the programme.
- The mid point check-in survey, reported these sessions to be valuable for staff taking part.

Improvement focus

- There has been challenges filling all the places available due to time pressures on clinical teams and the Newcastle Improvement team are co-designing future programmes for coaches, teams and leaders in conjunction with corporate and clinical departments. This should enable Newcastle Improvement to sustainably deliver the Improvement for Teams programme going forwards. It is expected this will improve course filling rates.
- A full evaluation of both the programmes will be undertaken to assess their contribution to enhancing capability in quality improvement. This has already started for the Improvement Coach Programme.

4a. Introduction of formal triage process on Maternity Assessment Unit

Progress to Date

- In July 2021, work started on the formal introduction of triage on the Maternity Assessment Unit (MAU) to improve safety with prompt recognition and management of the deteriorating pregnant or recently pregnant woman.
- Significant improvements have been made to MAU:
    - Triage documentation used on MAU that was developed with staff feedback as part of PDSA cycles.
    - Opening of a new 'Maternity Day- care Unit' with improved facilities at the end of ward 41. Not yet fully functional due to staffing challenges.
    - Consultant Obstetrician presence (80% of the time) on MAU 1-5pm.
    - A reduction in waiting times achieved through CAT (competency assessment tools) for midwives to undertake speculum examination in women < 37 weeks implemented.
    - Staff were previously concerned about how the process could be implemented but recent staff survey shows they are enthusiastic about the benefits this change could bring.
    - An automated telephone on MAU is planned and will reduce the number of phone calls, so that MAU staff can focus on patient care. This is due to start imminently .

Improvement focus

- Increasing staffing for the Maternity Day- care Unit to provide 2 midwives from 8am – 8pm.
- Minor modification to facilities on MAU.
- Planning to use BUSOTS (Birmingham Triage system) which is embedded in BadgerNet. Meetings are planned.
- Matron specifically for MAU (staffing review) approved - to be appointed.
- Considering bid (to AHSN NENC: up to £30,000 available for projects aligned to MatNeoSIP) for an additional Triage implementation midwife for 6 months.
- Additional admin and HCA support identified as required.
- Plan to expand Consultants presence on MAU in view of the successful pilot.

Quality and Performance: Quality Account Priorities Update (3/4)

4b.Modified Early Obstetric Warning Score (MEOWS) outside maternity

Progress to Date

- A digital solution has been added to admission (all Newcastle Hospitals) documentation that identifies if a patient is pregnant or has been pregnant within 42 day (6 weeks). This will enable staff to identify all patients that are outside maternity areas, allowing them to select the correct Maternity Early Warning Score Chart as appropriate.
- A digital maternity chart has been developed and tested. This has been recoded into the computer language called .NET. (implementation has been delayed – see below). Once tested, this will be implemented in all inpatient areas using eObs in both Adult and Paediatric areas within the Trust with adequate communication.

Improvement focus

- We are currently awaiting accurate testing of the digital maternity chart and code before it can be released. This will require support from the digital team to progress. It has been escalated through CGARD and added to the appropriate risk register.
- Further consideration needs to be given to how the placement of MEWS can be automated as this is currently a manual process.

5. Trust-wide Day Surgery Initiative

Progress to Date

- The best practice model has been agreed. This utilised key components of universal waiting list process;
  - Getting it Right First Time (GIRFT)
  - Centre for Peri-Operative Care (CPOC)
  - Day Case Delivery Pack
  - Standardised waiting list addition process
  - Combined form for adding to waiting list
  - PAC request (one referral route in),
  - Early pre-assessment to support patient optimisation
  - Smart scheduling
  - New PAC delivery model
  - New PAC outcome reporting encompassing RAG rating for surgical, medical & social criteria.
- An initial gap analysis of current theatre planning model in Directorates; Urology, Surgery and MSK completed, currently analysing data.
- Pilot Care Co-ordination System (CCS) in Urology, which will significantly support implementation of scheduling model called 6-4-2 ('go-live' September 22).
- 3rd PDSA Cycle on Day Treatment Centre (DTC) pre-assessment clinical criteria template completed.
- Ongoing PDSA cycles using Saturday Day Case Transformation Lists (testing out new initiatives and continuing to adapt existing cycles i.e., patient being pre-assessed before TCI, discrete cohorts of Laparoscopic Cholecystectomy patients to identify critical success factors and pre-assessment RAG rating for DTC appropriate patients).
- Weekly DTC Booking and Scheduling Meeting with Directorates focussing on 6-4-2 approach and actions.
- The outcome, process and balancing measures have been agreed.

Improvement focus

- To implement PDSA on waiting list addition and PAC request form (Sep 22)
- First CCS project meeting 15th September.
- Opening of DTC end September 2022.
- Recruitment of Improvement Facilitator to support implementation of CCS System.

Quality and Performance: Quality Account Priorities Update (4/4)

6. Mental Health in Young People

Progress to Date

- There is a dedicated Mental Health Strategy Group to review NCEPOD Standards and identify appropriate actions to ensure compliance.
- Collaborative work is ongoing with CNTW in terms of:
  - Training and support for staff.
  - The production of joined up patient information.
  - Developing links with KOOTH (Healthy Young Minds).
- 'We Can Talk' Programme complete, QI projects to improve experience for children young people (CYP) and adults achieved. Many staff have completed the Core Curriculum, a sizable proportion of which are non clinical. This will continue to be promoted across the organisation. This programme equips staff with the communication skills to better support CYP presenting with acute mental health issues.
- Ongoing work to provide a 'safe space' to improve the environment in Paediatric Assessment for CYP presenting in crisis is being progressed.
- Ongoing focused work aimed at preventing restrictive interventions has included reviewing the policy, equipment, debriefing and support for staff is almost complete.
- 'Safety Pod' training has been introduced and is ongoing. Safety Pods are available to use once staff trained.
- Ongoing work to support patients under 18 years old who are detained under the Mental Health Act (MHA).
- Working with families to hear experience and make improvements.

Improvement focus

- Training with regard to caring for CYP with eating disorders.
- Develop SOP for wards when CYP detained under the MHA.
- Ensure works complete for dedicated safe area within Paediatrics Assessment to manage patients awaiting acute mental health admission.
- Ratify Policy to support Reduction in Restrictive Interventions for CYP and CYP detained under MCA.
- Recruit mental health trained staff within workforce.

7 . Ensure reasonable adjustments are made for patients with suspected, or known, Learning Disabilities

Progress to Date

- Learning Disability Team fully staffed.
- Team supported by experienced bank staff.
- Profile of the Team raised during 'Learning Disability Week' June 2022.
- Autism awareness training to be delivered to adult ED staff.
- Forums to share learning continue.
- Deceased patients with a learning disability now have a review by medical examiner post death.
- Role of Champions' being refreshed.
- Pre-assessment within GNCH much improved for CYP with learning disability.

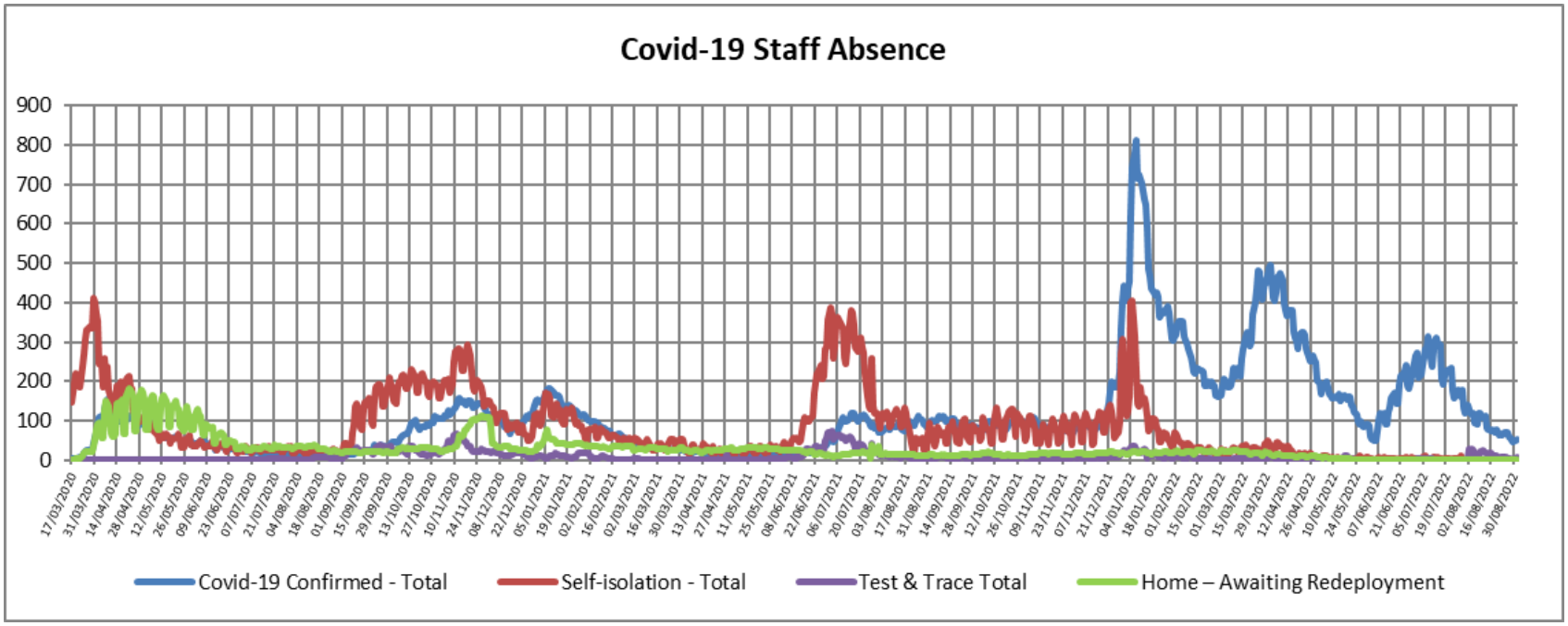
Improvement focus

- Implement 'Oliver McGown' training once released – Diamond Standards training will be incorporated within.
- Diamond Standards awareness raised across the organisation.
- Investment into the team with a focus on autism, processes are in place to ensure patients with autism are flagged on electronic patient records and have appropriate support.
- Introduce new adult passports.
- Ensure learning from lives and deaths of people with a learning disability and autistic people (LeDeR) review process efficient and timely.
- Improve pathway for patients requiring an MRI scan.

People – COVID-19

Figures quoted are by headcount

- The graph below identifies the number of COVID-19 related absences taken by Trust staff between 17h March 2020 and 31st August 2022. Some staff may have had more than one episode of COVID-19 related absence during this period.



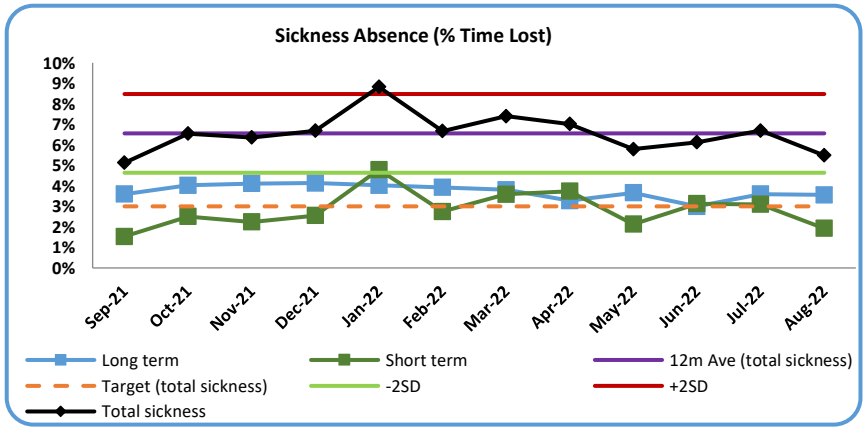
- Risk Assessments have been made available to all Trust staff – staff in 'high risk' category prioritised.

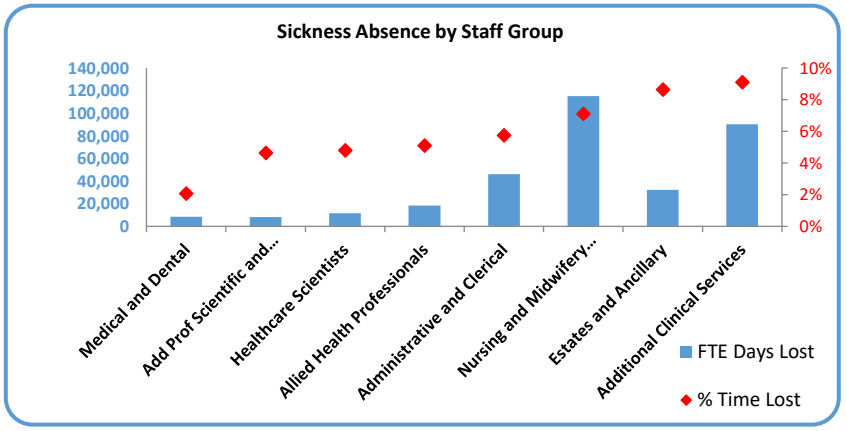
People – Sickness Absence 1/2

- Year to year comparison for sickness absence (including COVID-19 related sickness (rolling 12 months):

	Aug-21	Aug-22	
Long-term	3.56%	3.87%	↑
Short-term	1.41%	2.77%	↑
Total	4.98%	6.65%	↑

- 330,269 FTE working days were lost due to sickness (including COVID-19 related sickness) in the year to August 2022, compared to 260,868 for the previous year, 27% increase.
- Overall sickness absence (including COVID-19 related sickness) is 6.65%, which is down from end of Apr 2022 position of 7.02% (% FTE Time Lost).
- The top three reasons for non-COVID related sickness absence are Anxiety/stress/depression/other psychiatric illnesses (31%) Gastrointestinal problems (7.1%), and other musculoskeletal (10.4%).
- The top reason for "Other" absences is Maternity Leave (43% of total absence.
- Nursing and Midwifery have the highest number of Maternity Leave at 4% (%FTE Lost).

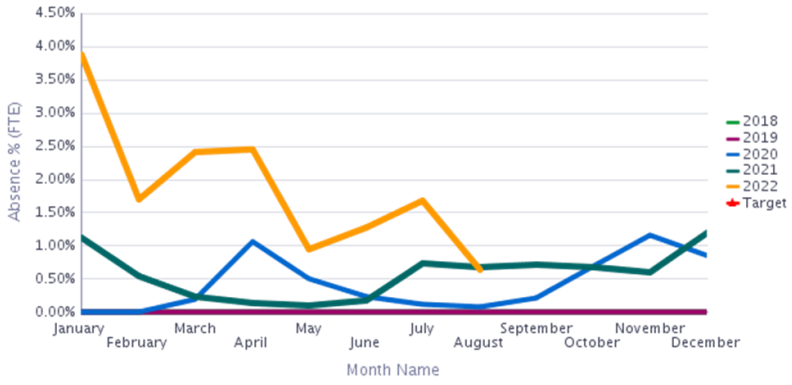




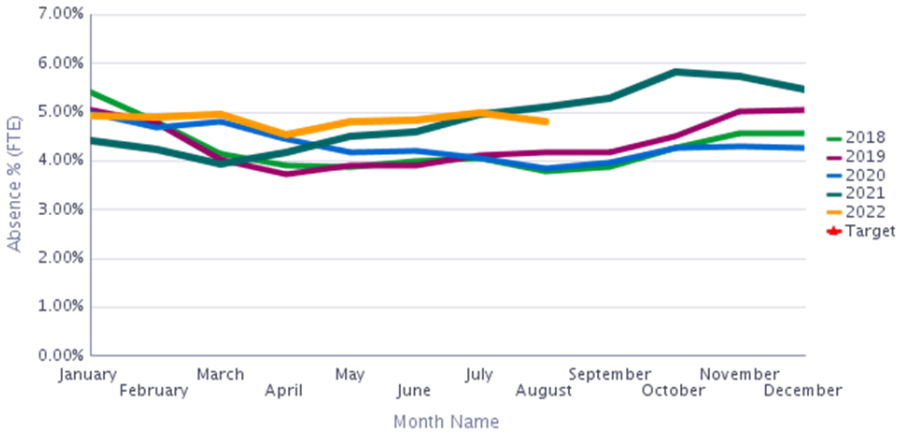
*COO Directorate includes Outpatients / ABC Service

People – Sickness Absence 2/2

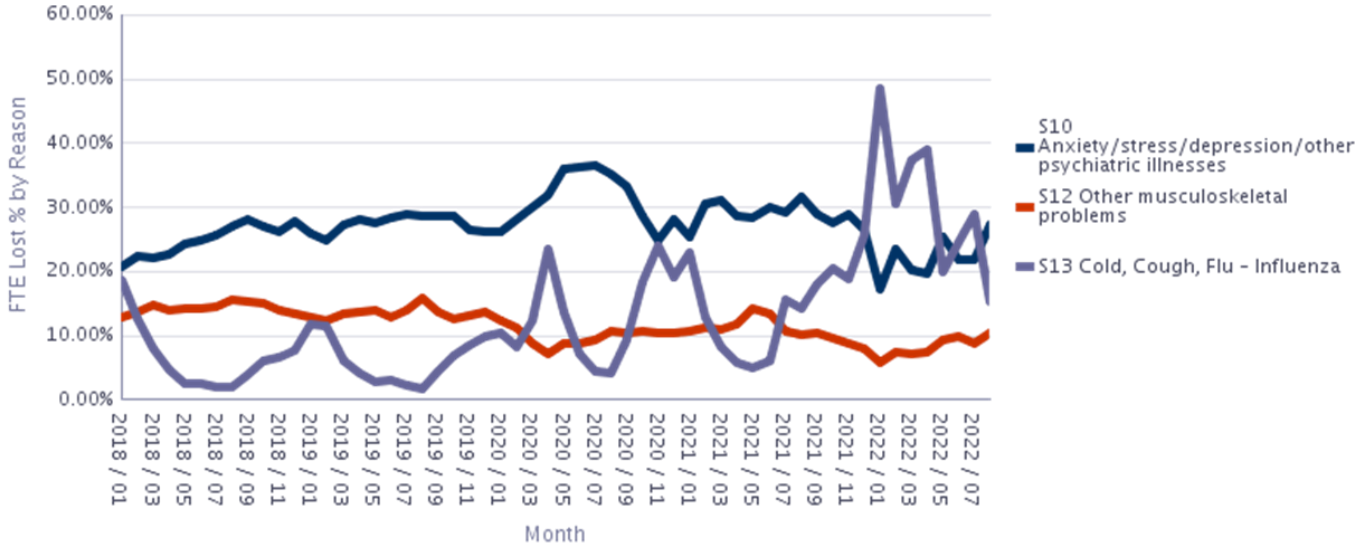
COVID-19 Related Sickness Jan 2018 - August 2022 (%FTE)



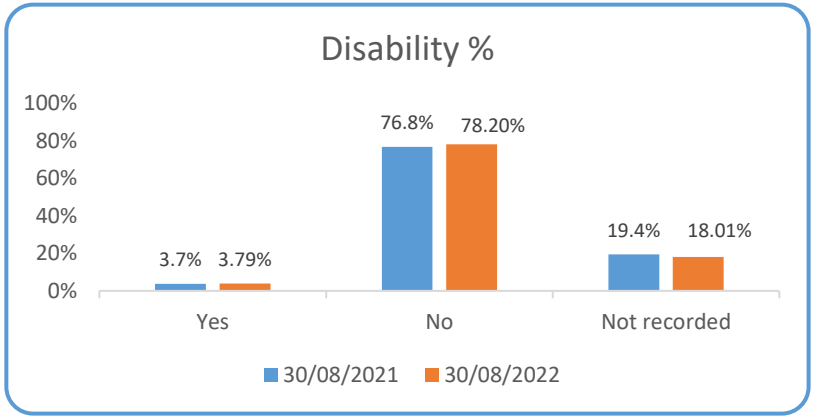
Non-COVID-19 Related Sickness Jan 2018 - August 2022 (%FTE)

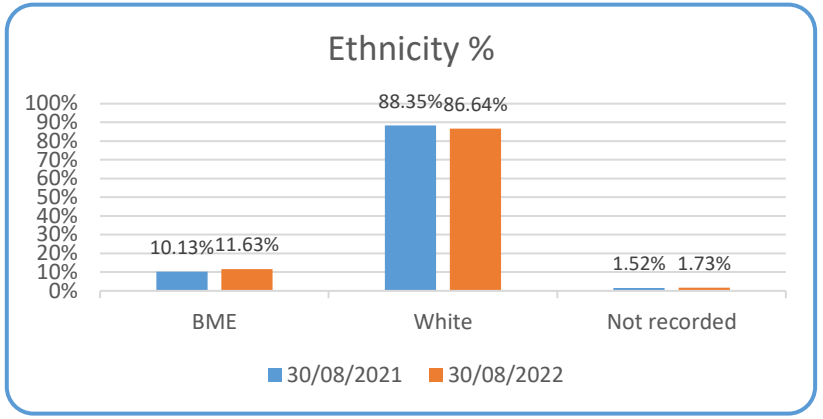


Top 3 Sickness Reasons Jan 2018 - Aug 2022 (%FTE)

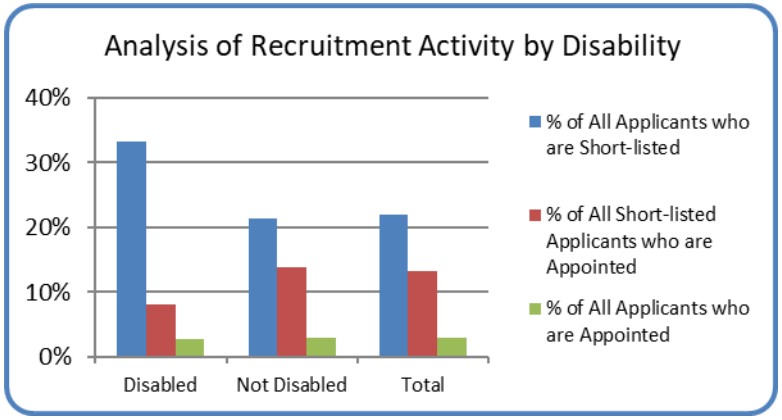


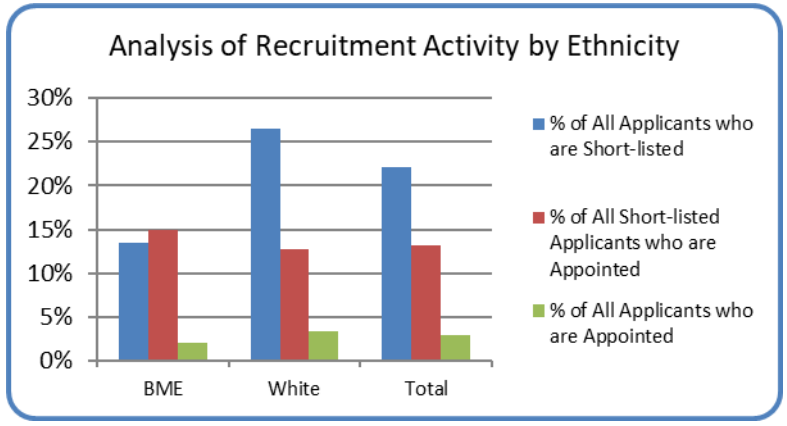
People – Equality and Diversity 1/2





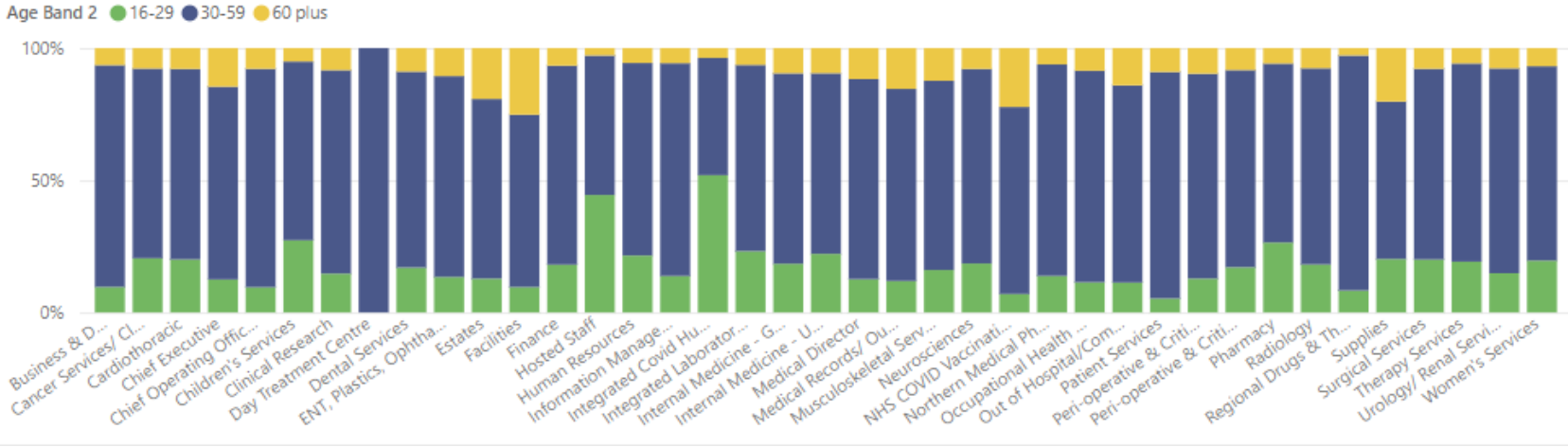
- The graphs above identify, by disability and ethnicity, the recruitment outcome of applicants during the twelve months ending August 2022.





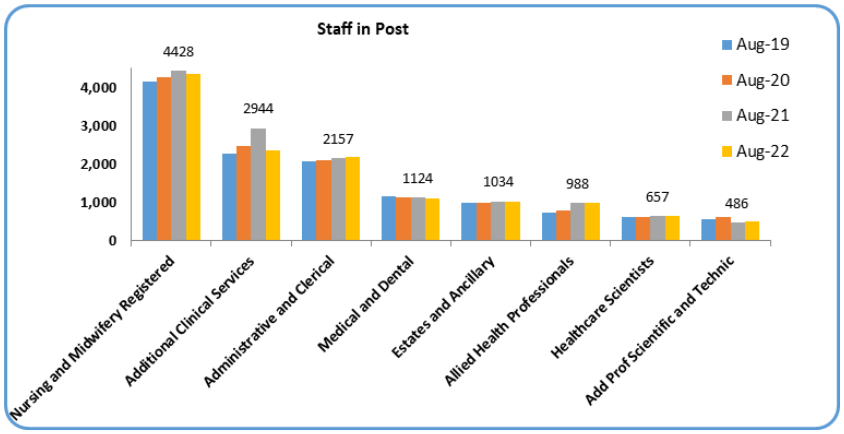
- The graphs above identify, by headcount, the percentage of staff in post in August 2021 and August 2022 by disability and ethnicity. The percentage of staff employed disclosing a disability has improved from 3.74% to 3.79% and the percentage of BAME staff has increased from 10.13% to 11.63%.

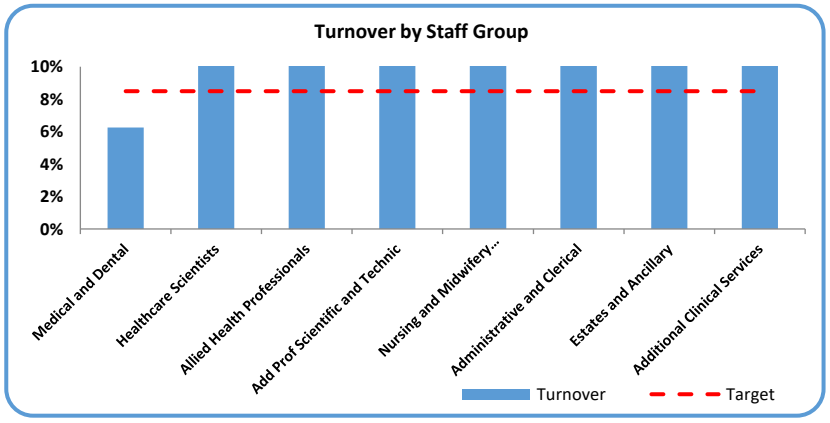
People – Equality and Diversity 2/2

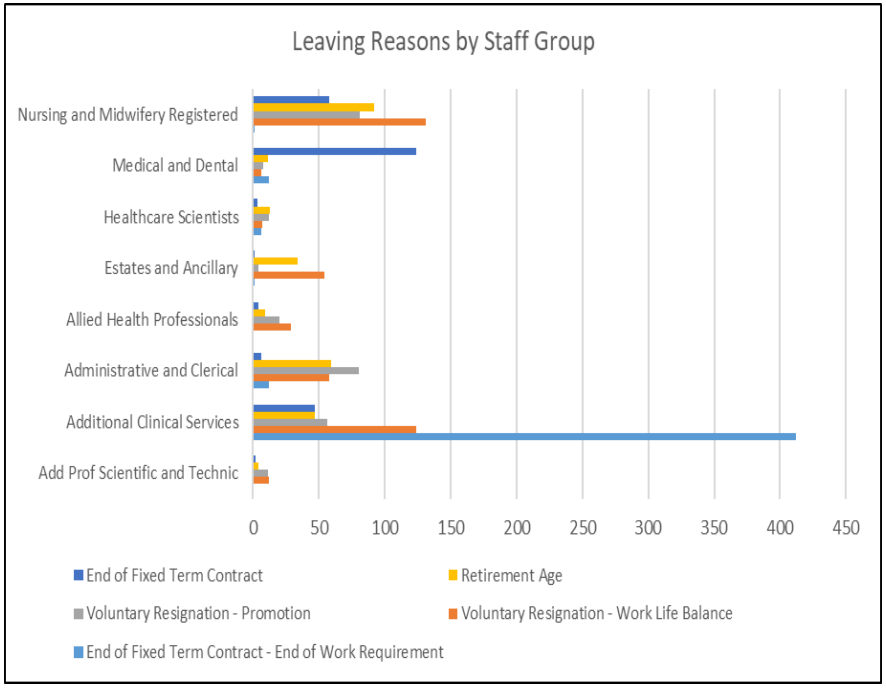


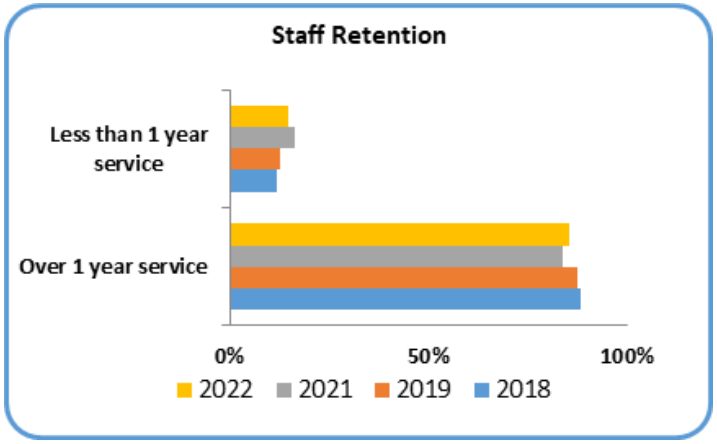
- Estates and Ancillary have the highest proportion of staff aged 55 and over (45%).
- Medical and Dental have 20% of staff aged 55 and above and 7% of staff aged 60 and above.

People – Workforce 1/4









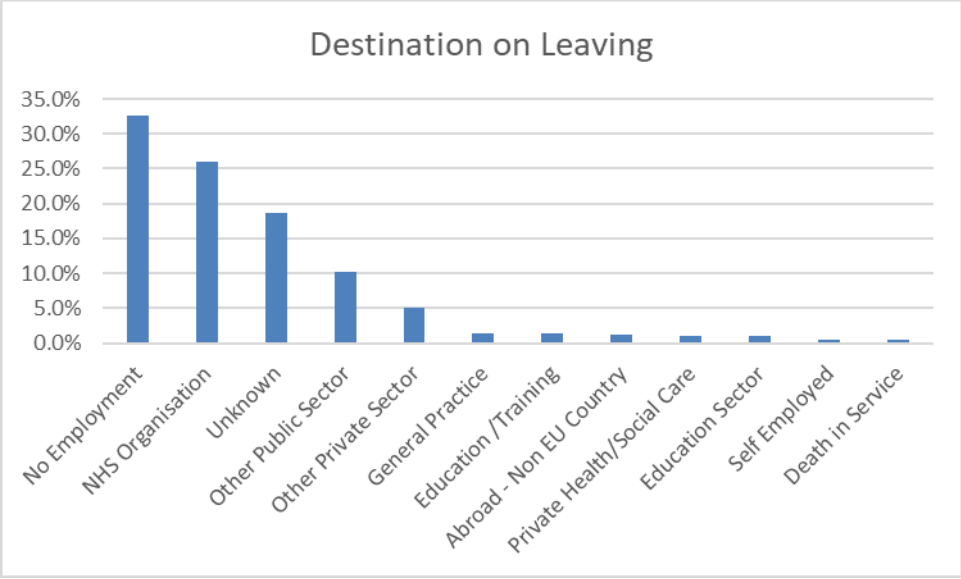
- Staff in post has increased by 4.52% since August 2019. The staff groups with the largest increase are Administrative and Clerical and Allied Health Professionals.
- Staff turnover has increased from 11.4% in August 2021 to 17.6% in August 2022, against a target of 8.5%.
- The total number of leavers in the period September 2021 to August 2022 was 2,528.
- Retention for staff over 1 year service is 87.04%, an increase from 83.6% in August 2021.

People – Workforce 2/4

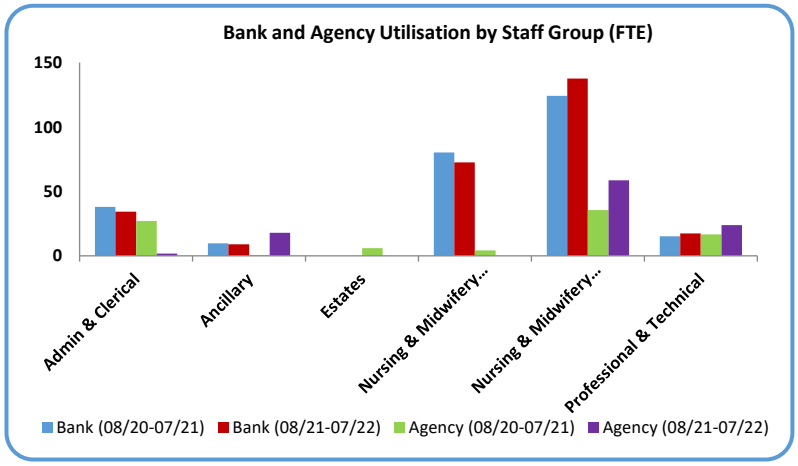
Turnover by Directorate

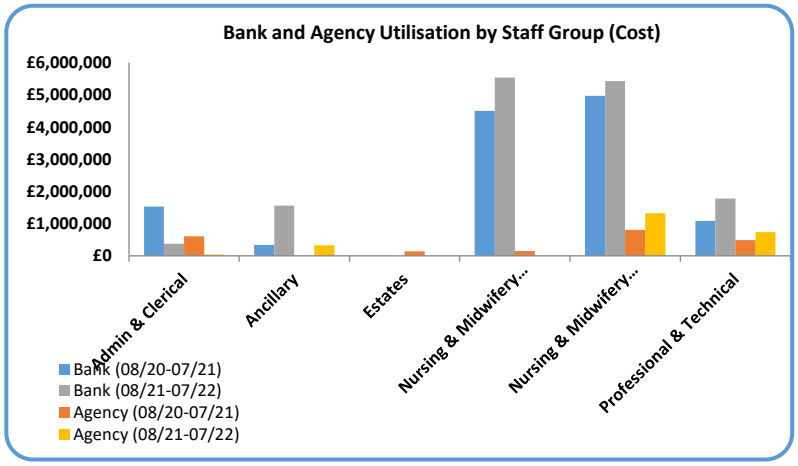
Directorate	Turnover
Day Treatment Centre	0.00%
Chief Executive	3.39%
Neurosciences	6.00%
Medical Director	8.78%
Peri-operative & Critical Care - FH	9.13%
Surgical Services	9.18%
Musculoskeletal Services	9.37%
Northern Medical Physics & Clinical Engineering	9.38%
Pharmacy	9.65%
Business & Development	9.68%
Urology/ Renal Services	10.19%
Internal Medicine/ED/COE	10.20%
Integrated Laboratory Medicine	11.14%
Chief Operating Officer	11.18%
ENT, Plastics, Ophthalmology & Dermatology	11.24%
Cardiothoracic	11.30%
Peri-operative & Critical Care - RVI	11.31%
Radiology	11.43%
Dental Services	11.53%
Cancer Services/ Clinical Haematology	11.69%
Information Management & Technology	11.72%
Clinical Research	12.17%
Women's Services	12.59%
Children's Services	12.86%
Out of Hospital/Community Services	12.90%
Finance	13.97%
Estates	14.08%
Patient Services	14.92%
Regional Drugs & Therapeutics	16.44%
Human Resources	22.17%
Supplies	25.15%
Grand Total	**18%**

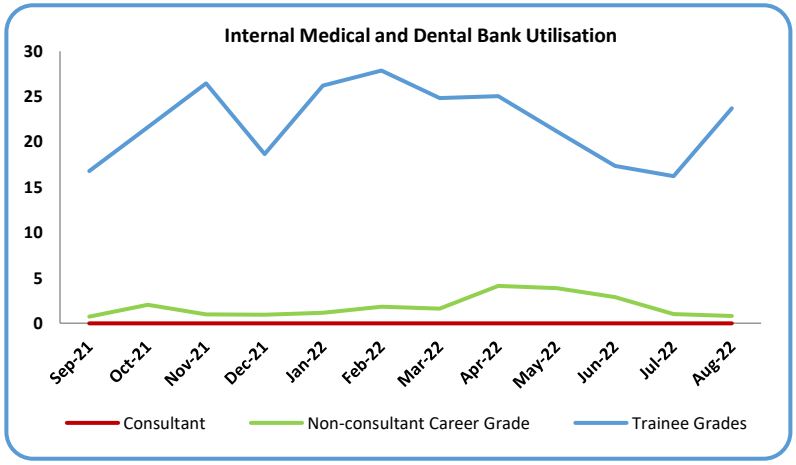
- The NHS Covid Vaccination Programme have had the highest turnover between August 2021 and August 2022, a total of 511 leavers.
- Only 26% of leavers across the Trust disclosed they were going to another NHS organisation.



People – Workforce 3/4

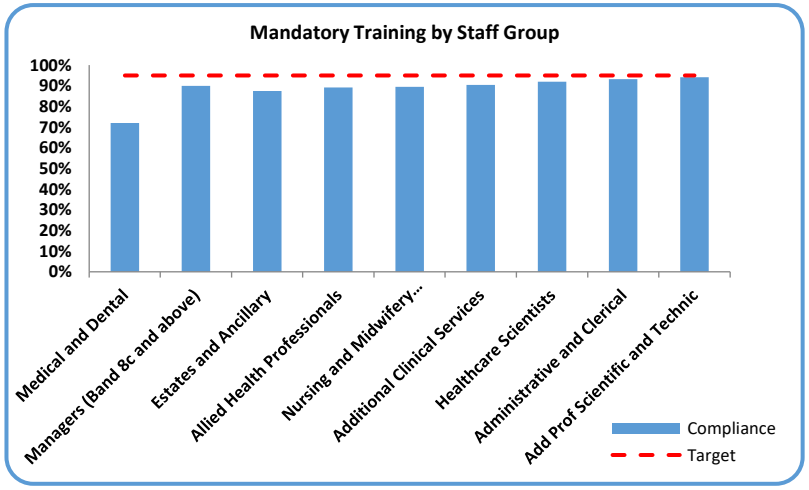


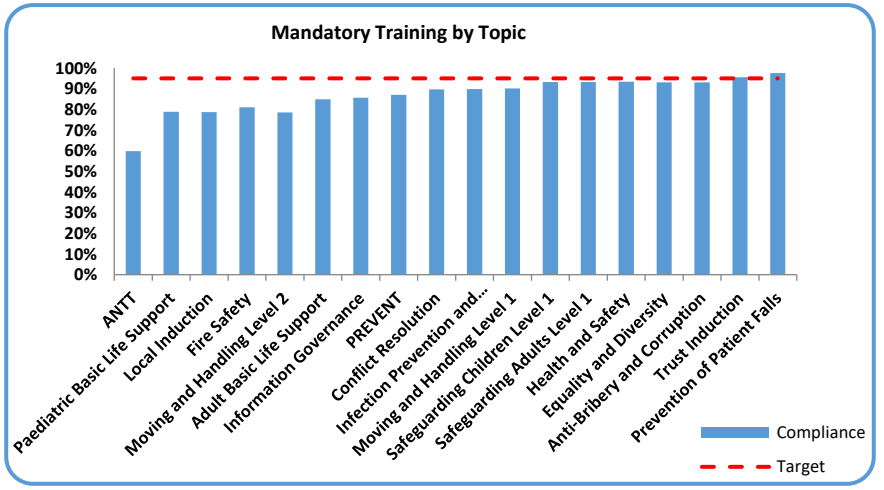


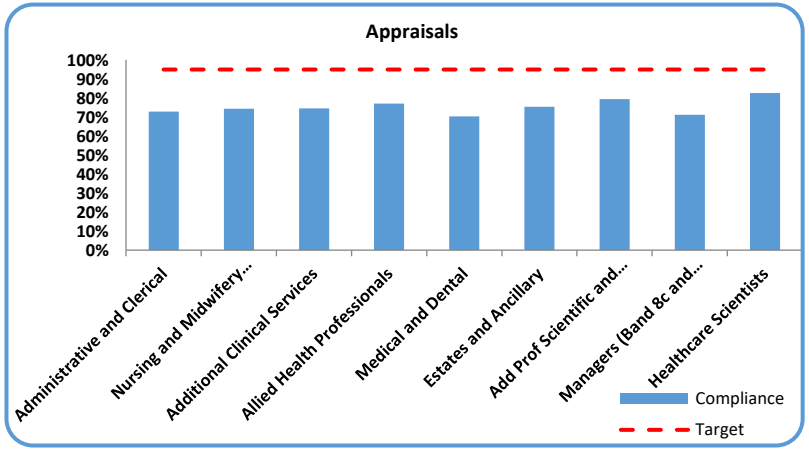


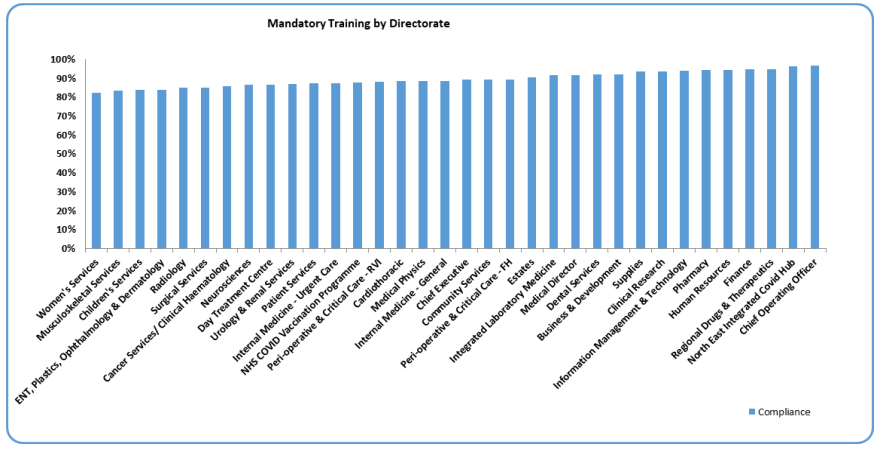
- Comparing the periods September 2020 – August 2021 to September 2021 – August 2022 , overall bank utilisation has increased from 267 wte to 270 wte and agency utilisation has increased from 89 wte to 102 wte.

People: Delivering Excellence in Education & Training









- Mandatory training compliance stands at 88.8% at end of August 2022, against an end of year target of 95%. The August 2021 position was 87.1%.
- Medical and Dental are the staff group with the lowest training compliance at 71.9% in August 2022 compared to 69.1% in August 2021.
- Appraisal compliance stands at 74.6%, at end of August 2022, against an end of year target of 95%. The August 2021 position was 76.6%. Interventions are in hand to improve this position.

Finance: Overall Financial Position

This page summarises the financial position of the Trust for the period ending 31st August 2022.

As stated in previous reports, a revised plan was submitted in June with a surplus of £10.7 million, which included additional funding available. There are a number of assumptions made, including the delivery of a challenging Cost Improvement Programme, delivery of the Elective Recovery Plan and reducing long waits.

In the period to 31st July August the Trust incurred expenditure of £566 million, and accrued income of £566.4 million on mainstream budgets and incurred expenditure of £3.3 million on the programmes outside the block envelope (vaccine roll-out programme), leading to a small surplus of £3.8 million. The Co-ordination and Response Centre and the Innovation Lab are included in the Trust's I&E position. ICHNE is being treated on an 'Agent Basis' and is excluded for both income and expenditure, the figure is £3.5 million and relates to the Lighthouse Laboratory only. It should be noted that all financial risk ratings are not being reported here, although the Trust has been included in NHS Provider Segmentation of 1 on the Use of Resources metrics (Oversight Framework). This means there are no specific support needs.

To 31st August the Trust had spent £20.8 million capital, £13.7 million behind Plan.

To note: the Trust submitted a Financial Plan to NHSE for 2022/23 in April, for a deficit of £5.5m for the year

	Month 5 Budget £'000	Month 5 Actual £'000	Month 5 Variance £'000
Income	563,022	566,380	3,358
Expenditure	562,673	566,031	3,358
I & E position (excl impairment) - (Deficit)/Surplus	349	349	0
Capital Programme	34,500	20,752	(13,748)

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BOARD MEETINGS - ACTIONS

Agenda item A11

Log No.	BOARD DATE	PRIVATE / PUBLIC	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
83	25/11/2021	PUBLIC	21/54 PIONEERS i) CIO Annual Report	The CIO noted that the Chair of the Audit Committee at Sunderland University had notified peers of a cyber-attack within their organisation and the CIO recommended undertaking a deep dive in relation to this. The CIO agreed to action and facilitate via the TS **[ACTION04].**	CIO/TS			12/01/22 - Date for the deep-dive to be agreed. 18/03/22 - Update requested. 24/03/22 - An update has been requested from the Chair of the Audit Committee at Sunderland University regarding the matter. 19/05/22 - Update requested from GK. 22/07/22 - Update requested from GK 29/07/22 - The CIO provided the following update: o It had been difficult to obtain the information requested. o There had been a number of recent cyber-attacks across the NHS and to date Newcastle Hospitals had not been affected. o The Trust is linked into the cyber centre with regular updates received and actioned. o The Trust was almost 100% compliant in terms of cyber defences and was confident the Trust was well protected. For assurance, the ACE added that the Trust was fully compliant with the Toolkits for data security and protection and cyber essentials. Action Closed.
89	31/03/2022	PUBLIC	iii) Director reports: e. Human Resources Director • Gender Pay Gap Report 2021/22	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].	HRD			19/05/22 - Update requested from DF. 22/07/22 - Call to be scheduled between DF and SE to clarify the action required. 25/07/22 - The HRD provided the following update: o Information relating to the gender pay gap has been reviewed internally by staff groups. Specific details with regard to Agenda for Change (AfC) staff and Medical and Dental staff have been incorporated into the next Gender Pay Report (for the year ending March 2022) to be considered by the People Committee in August. o A review has also taken place relating to the Local Clinical Excellence Awards (LCEA's) scheme by gender, and by gender and ethnicity (intersectionality) to better appreciate the potential dynamics of those characteristics. The data/analysis is included in the updated report. o Gender pay data has not yet been further interrogated by other protected characteristics and the ability to do so will require some additional reporting design work. Action Closed.
92	31/05/2022	PUBLIC	iii) Director Reports: Executive Chief Nurse	Being mindful of the results of the CQC 2021 National Maternity survey highlighting support for mental health as an area for improvement, Ms Baker questioned if any links had been established with the Maternal Mental Health Alliance. The ECN advised that work was being undertaken and agreed to include a summary in a future Board report [ACTION01].	MC			22/07/22 - Email circulated to MC as a reminder for the next Board Report. 23/09/22 - Update to be provided at the Board meeting.
93	28/07/2022	PUBLIC	22/235 STRATEGIC ITEMS: iv)a(ii) Consultant Report	The TS advised that one of the governors had raised a query in relation to the contents of the Consultant Appointments report. The TS agreed to note this as an action and provide an update at the next meeting. [ACTION01]	TS			01/08/22 - Email to Gail Haigh requesting clarification and confirmation of errors in report had been rectified 23/08/22 - Email to Gail Haig requesting confirmation errors had been rectified 22/09/22 - Email to Gail Haig requesting confirmation errors had been rectified 23/09/22 - Paper attached with amendments highlighted

KEY

NEW ACTION	To be included to indicate when an action has been added to the log.
ON HOLD	Action on hold.
OVERDUE	When an action has reached or exceeded its agreed completion date. Owners will be asked to address the action at the next meeting.
IN PROGRESS	Action is progressing inline with its anticipated completion date. Information included to track progress.
COMPLETE	Action has been completed to the satisfaction of the Committee and will be kept on the 'in progress' log until the next meeting to demonstrate completion before being moved to the 'complete' log.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Please note that this is the updated paper for action 93

TRUST BOARD

Date of meeting	28 July 2022						
Title	Consultant Appointments						
Report of	Andy Welch, Medical Director						
Prepared by	Claudia Sweeney, Senior HR Advisor (Medical & Dental)						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The content of this report outlines recent Consultant Appointments.						
Recommendation	The Board of Directors is asked to review the decisions of the Appointments Committee.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. People – 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	Ensuring the Trust is sufficiently staffed to meet the demands of the organisation.						
Reports previously considered by	Consultant Appointments are submitted for information in the month following the Appointments Panel						

CONSULTANT APPOINTMENTS

1. APPOINTMENTS COMMMITTEE – CONSULTANT APPOINTMENTS

1.1 An Appointments Committee was held on 21 March 2022 and interviewed 1 candidate for 1 Consultant Paediatric/Perinatal Pathologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Craig Platt.

Dr Platt holds MBChB (University of Leicester) 1984 and MRCPath (UK) 1993. Dr Platt is currently employed as a Locum Consultant Perinatal Pathologist at Nottingham University Hospital NHS Trust.

Dr Platt is expected to take up the post of Consultant Paediatric/Perinatal Pathologist in July 2022.

1.2 An Appointments Committee was held on 24 March 2022 and interviewed 1 candidate for 1 Consultant Plastic and Reconstructive Surgeon post.

By unanimous resolution, the Committee was in favour of appointing Mr Juan Enrique Berner Gomez.

Mr Berner Gomez holds Doctor of Medicine (Pontificia Universidad Catolica de Chile) 2012, MRCS (England) 2016 and FRCS (UK) 2021. Mr Berner Gomez is currently employed as a Locum Consultant Plastic Surgeon at Barts Health NHS Trust.

Mr Berner Gomez is expected to take up the post of Consultant Plastic and Reconstructive Surgeon post in September 2022.

1.3 An Appointments Committee was held on 24 March 2022 and interviewed 2 candidates for 1 Consultant Paediatric and ACHD Cardiologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Akintayo Adesokan.

Dr Adesokan holds MBBS (University of London) 2011 and MRCPCH (UK) 2014. Dr Adesokan is currently employed as an Interventional Catherisation Fellow at The Hospital for Sick Children, Canada.

Dr Adesokan is expected to take up the post of Consultant Paediatric and ACHD Cardiologist in August 2022.

1.4 An Appointments Committee was held on 31 March 2022 and interviewed 1 candidate for 1 Consultant Medical Oncologist (with interest in Gynaecological Cancers) post.

By unanimous resolution, the Committee was in favour of appointing Dr Sunita Gemmell.

Dr Gemmell holds MBChB (University of Liverpool) 2021 and MRCP (UK) 2016. Dr Gemmell was previously employed as a Specialty Trainee in Medical Oncology on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Gemmell took up the post of Consultant Medical Oncologist (with interest in Gynaecological Cancers) on 30 May 2022.

1.5 An Appointments Committee was held on 1 April 2022 and interviewed 1 candidate for 1 Consultant Otolaryngologist post.

By unanimous resolution, the Committee was in favour of appointing Mr Hassan Mohammed.

Mr Mohammed holds MD (University of Damascus) 2000, MRCS (England) 2008 and FRCS (England) 2014. Mr Mohammed is currently employed as a Senior Clinical Fellow (skull base surgery) at Cambridge University Hospital.

Mr Mohammed is expected to take up the post of Consultant Otolaryngologist in October 2022.

1.6 An Appointments Committee was held on 1 April 2022 and interviewed 1 candidate for 1 Consultant Otolaryngologist (Head and Neck/Laryngology) post.

By unanimous resolution, the Committee was in favour of appointing Mr Benjamin Cosway.

Mr Cosway holds MBBCh (Cardiff University) 2012 and FRCS (England) 2021. Mr Cosway is currently employed as a Training Interface Group Fellow in Head and Neck Surgical Oncology at the South Tees NHS Foundation Trust.

Mr Cosway is expected to take up the post of Consultant Otolaryngologist (Head and Neck/Laryngology in September 2022.

1.7 An Appointments Committee was held on 4 April 2022 and interviewed 2 candidates for 2 Consultant Geriatrician posts.

By unanimous resolution, the Committee was in favour of appointing Dr Clare Patchett and Dr Mayuri Madhra.

Dr Patchett holds MBBS (University of Newcastle) 2008 and MRCP (UK) 2013. Dr Patchett is currently employed as a Specialty Trainee in Geriatric Medicine on behalf of the Lead Employer Trust, at North Tyneside General Hospital.

Dr Patchett is expected to take up the post of Consultant Geriatrician in November 2022.

Dr Madhra holds MBBS (University of Newcastle) 2012 and MRCP (UK) 2016. Dr Madhra is currently employed as a Specialty Trainee in Geriatric Medicine on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Madhra is expected to take up the post of Consultant Geriatrician in September 2022.

1.8 An Appointments Committee was held on 6 April 2022 and interviewed 1 candidate for 1 Consultant Gastroenterologist (Endoscopy) post.

By unanimous resolution, the Committee was in favour of appointing Dr Jamie Catlow.

Dr Catlow holds MBChB (University of Glasgow) 2010, MRCP (UK) 2013 and Post-Graduate Diploma of Medical Education (University of Newcastle) 2018. Dr Catlow currently employed as a Specialty Trainee in Gastroenterology and Hepatology on behalf of the Lead Employer Trust, at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr Catlow is expected to take up the post of Consultant Gastroenterologist (Endoscopy) in October 2022.

1.9 An Appointments Committee was held on 6 April 2022 and interviewed 1 candidate for 1 Consultant Gastroenterologist (part-time [7 PAs]) post.

By unanimous resolution, the Committee was in favour of appointing Dr Suzanne Sweeney.

Dr Sweeney holds MBBS (University of Newcastle) 2009 and MRCP (UK) 2013. Dr Sweeney is currently employed as a Specialty Trainee in Gastroenterology and Hepatology on behalf of the Lead Employer Trust, at North Tyneside General Hospital.

Dr Sweeney is expected to take up the post of Consultant Gastroenterologist (part-time [7 PAs]) in July 2022.

1.10 An Appointments Committee was held on 6 April 2022 and interviewed 1 candidate for 1 Consultant Gastroenterologist-IBD post.

By unanimous resolution, the Committee was in favour of appointing Dr Andrew King.

Dr King holds MBBS (University of Newcastle) 2011, and MRCP (UK) 2017. Dr King is currently employed as a Specialty Trainee in Gastroenterology and Hepatology on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr King is expected to take up the post of Consultant Gastroenterologist-IBD in October 2022.

1.11 An Appointments Committee was held on 7 April 2022 and interviewed 2 candidates for 1 Consultant Haematologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Sajida Kazi.

Dr Kazi holds MBBS (University of Mumbai) 2003, MRCP (UK) 2010 and FRCPath (UK) 2018. Dr Kazi is currently employed as a Locum Consultant Haematologist at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr Kazi is expected to take up the post of Consultant Haematologist in July 2022.

1.12 An Appointments Committee was held on 25 April 2022 and interviewed 1 candidate for 1 Consultant in Neuromuscular Diseases -Northern Genetics Service post.

By unanimous resolution, the Committee was in favour of appointing Dr Maha El Seed.

Dr El Seed holds MBBS (University of Khartoum, Sudan) 1994 and MRCPCH (UK) 2002. Dr El Seed is currently employed as a Specialty Doctor in Clinical Neuromuscular Disorders at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr El Seed is expected to take up the post of Consultant in Neuromuscular Diseases-Northern Genetics Service in May 2023.

1.13 An Appointments Committee was held on 26 April 2022 and interviewed 2 candidates for 1 Consultant Cardiologist Advanced Heart Failure and Heart Transplantation post.

By unanimous resolution, the Committee was in favour of appointing Dr Oscar Gonzalez Fernandez.

Dr Gonzalez Fernandez holds LMS (Universidad Autonoma de Madid, Spain) 2011 and PhD in Medicine and Surgery (Universidad Autonoma de Madrid, Spain). Dr Gonzalez Fernandez was previously employed as a Consultant in Cardiology at Sistema Nacional de Salud, Madrid, Spain.

Dr Gonzalez Fernandez took up the post of Consultant Cardiologist Advanced Heart Failure and Heart Transplantation in July 2022.

1.14 An Appointments Committee was held on 10 and 11 May 2022 and interviewed 5 candidates for 2 Consultant Trauma and Orthopaedic Surgeon posts.

By unanimous resolution, the Committee was in favour of appointing Mr Philip Dobson and Mrs Sarah Rawlings.

Mr Dobson holds MBBS (University of Newcastle) 2007, MRCS (England) 2009, PhD (University of Newcastle) 2018 and FRCS (England). Mr Dobson is currently employed as an Orthopaedic Trauma Fellow at Hunter New England Health, Australia.

Mr Dobson is expected to take up the post of Consultant Trauma and Orthopaedic Surgeon in January 2023.

Mrs Rawlings holds MBBCh (Cardiff University) 2008, MRCS (Edinburgh) 2013 and FRCS (Edinburgh) 2019. Mrs Rawlings is currently employed as a Consultant Orthopaedic Surgeon at North Cumbria Integrated Care NHS Foundation Trust.

Mrs Rawlings is expected to take up the post of Consultant Trauma and Orthopaedic Surgeon in September 2022.

1.15 An Appointments Committee was held on 18 May 2022 and interviewed 1 candidate for 1 Consultant in Community Paediatrics post.

By unanimous resolution, the Committee was in favour of appointing Dr Kim Barrett.

Dr Barrett holds MBChB (University of Glasgow) 1988 and RCPCH (UK) 1996. Dr Barrett is currently employed as a Consultant Community Paediatrician at South Tyneside and Sunderland NHS Foundation Trust.

Dr Barrett is expected to take up the post of Consultant in Community Paediatrics in October 2022.

1.16 An Appointments Committee was held on 23 May 2022 and interviewed 2 candidates for 1 Consultant Dermatologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Remus Winn.

Dr Winn holds MBBS (Imperial College London) 2013 and MRCP (UK) 2015. Dr Winn is employed as a Specialty Trainee in Dermatology on behalf of the Lead Employer Trust, at the Royal Victoria Infirmary.

Dr Winn is expected to take up the post of Consultant Dermatologist in September 2022.

1.17 An Appointments Committee was held on 23 May 2022 and interviewed 1 candidate for 1 Consultant Dermatologist and Mohs Surgeon post.

By unanimous resolution, the Committee was in favour of appointing Dr Dominic Tabor.

Dr Tabor holds MBChB (University of Leeds) 2011 and MRCP (UK) 2015 and MRCP-Dermatology (UK) 2016. Dr Tabor was employed as a Locum Consultant Dermatologist and Mohs Surgeon at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr Tabor took up the post of Consultant Dermatologist and Mohs Surgeon in July 2022.

1.18 An Appointments Committee was held on 9 June 2022 and interviewed 3 candidates for 3 Consultant Anaesthetist posts.

By unanimous resolution, the Committee was in favour of appointing one candidate, Dr Anna Louise Wahed.

Dr Wahed holds MBBS (University of Newcastle) 2009 and FRCA (UK) 2014. Dr Wahed is currently employed as a Specialty Trainee in Anaesthetics on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Wahed is expected to take up the post of Consultant Anaesthetist in September 2022.

1.19 An Appointments Committee was held on 13 June 2022 and interviewed 3 candidates for 1 Consultant Hepatologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Laura Jopson.

Dr Jopson holds MBChB (University of Sheffield) 2007 and MRCP (UK) 2010. Dr Jopson is employed as a Consultant Gastroenterologist at Northumbria Healthcare Foundation Trust.

Dr Jopson is expected to take up the post of Consultant Hepatologist in October 2022.

1.20 An Appointments Committee was held on 16 June 2022 and interviewed 1 candidate for 1 Consultant Radiologist (Diagnostic) Upper GI post.

By unanimous resolution, the Committee was in favour of appointing Dr Ishaana Munjal.

Dr Munjal holds MBBS (University of Newcastle) 2014 and FRCR (UK) 2021. Dr Munjal is currently employed as a Specialty Trainee in Clinical Radiology on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Munjal is expected to take up the post of Consultant Radiologist (Diagnostic) Upper GI in October 2022.

1.21 An Appointments Committee was held on 16 June 2022 and interviewed 1 candidate for 1 Consultant Radiologist (Paediatrics) post.

By unanimous resolution, the Committee was in favour of appointing Dr Thomas McDonald.

Dr McDonald holds MBBS (University of Newcastle) 2013 and FRCR (UK) 2020. Dr McDonald is currently employed as a Specialty Trainee in Clinical Radiology on behalf of the Lead Employer Trust, at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr McDonald is expected to take up the post of Consultant Radiologist (Paediatrics) in September 2022.

1.22 An Appointments Committee was held on 16 June 2022 and interviewed 1 candidate for 1 Consultant Radiologist (ENT) post.

By unanimous resolution, the Committee was in favour of appointing Dr Khaled Kallas.

Dr Kallas holds MD (University of Latvia) 2009 and FRCR (UK) 2021. Dr Kallas is currently employed as Specialty Trainee in Clinical Radiology on behalf of the Lead Employer Trust, at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr Kallas is expected to take up the post of Consultant Radiologist (ENT) in November 2022.

1.23 An Appointments Committee was held on 16 June 2022 and interviewed 1 candidate for 1 Consultant Radiologist (HPB) post.

By unanimous resolution, the Committee was in favour of appointing Dr Kimsien Lang Ping Nam.

Dr Lang Ping Nam holds MBBS (University of Newcastle) 2013, MRCP (UK) 2016 and FRCR (UK) 2021. Dr Lang Ping Nam is currently employed as a Specialty Trainee in Clinical Radiology on behalf of the Lead Employer Trust, at the Freeman Hospital.

D Lang Ping Nam is expected to take up the post of Consultant Radiologist (HPB) post in October 2022.

1.24 An Appointments Committee was held on 22 June 2022 and interviewed 1 candidate for 1 Consultant in Respiratory Medicine and Home Ventilation Service post.

By unanimous resolution, the Committee was in favour of appointing Dr Nicholas Lane.

Dr Lane holds MBBS (University of Newcastle) 2010, MRCP (UK) 2013 and PhD (University of Newcastle) 2021. Dr Lane is currently employed as a Locum Consultant Respiratory Physician at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr Lane is expected to take up the post of Consultant in Respiratory Medicine and Home Ventilation Service post in August 2022.

1.25 An Appointments Committee was held on 22 June 2022 and interviewed 1 candidate for 1 Consultant Urological Surgeon (Newcastle and Gateshead).

By unanimous resolution, the Committee was in favour of appointing Mr Jonathan Barclay.

Mr Barclay holds MBBS (University of Newcastle) 2009 and FRCS (England) 2021. Mr Barclay is currently employed as a Consultant Urologist at South Tees Hospitals NHS Foundation Trust.

Mr Barclay is expected to take up the post of Consultant Urological Surgeon (Newcastle and Gateshead) in October 2022.

1.26 An Appointments Committee was held on 22 June 2022 and interviewed 2 candidates for 1 Consultant Urological Surgeon (Newcastle and Northumbria).

By unanimous resolution, the Committee was in favour of appointing Mr Angus Luk.

Mr Luk holds MBBS (University of Sheffield) 2013, MRCS (Edinburgh) 2016 and FRCS (Edinburgh) 2021. Mr Luk is currently employed as a Fellow in Endo-urology and Stone Surgery at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Mr Luk is expected to take up the post of Consultant Urological Surgeon (Newcastle and Northumbria) in January 2023.

1.27 An Appointments Committee was held on 24 June 2022 and interviewed 1 candidate for 1 Consultant in Acute Medicine (part-time [7 PAs]) post.

By unanimous resolution, the Committee was in favour of appointing Dr Lynsey Threlfall.

Dr Threlfall holds MBBS (University of Newcastle) 2008 and MRCP (UK) 2011. Dr Threlfall is currently employed as a Specialty Trainee in Acute Medicine on behalf of the Lead Employer Trust, at Sunderland Royal Hospital.

Dr Threlfall is expected to take up the post of Consultant in Acute Medicine (part-time [7 PAs]) post in September 2022.

1.28 An Appointments Committee was held on 28 June 2022 and interviewed 1 candidate for 1 Consultant Medical Virologist (part-time [5 PAs]) post.

By unanimous resolution, the Committee was in favour of appointing Dr Helena Christi-Anne Ellam.

Dr Ellam holds BMBCh (University of Oxford) 2004 and FRCPath (UK) 2014. Dr Ellam is employed as a Locum Consultant Virologist at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Dr Ellam is expected to take up the post of Consultant Medical Virologist (part-time [5 PAs]) post in August 2022.

1.29 An Appointments Committee was held on 28 June 2022 and interviewed 1 candidate for 1 Consultant Gynaecologist with subspecialty in Urogynaecology post.

By unanimous resolution, the Committee was in favour of appointing Dr Priyanka Krishnaswamy.

Dr Krishnaswamy holds MBBS (Rajiv Gandhi University of Health Science, India) 2011 and MRCOG (UK) 2017. Dr Krishnaswamy is currently employed as a Subspecialty Trainee in Urogynaecology at the Queen Elizabeth University Hospital, Glasgow.

Dr Krishnaswamy is expected to take up the post of Consultant Gynaecologist with subspecialty in Urogynaecology post in August 2022.

1.30 An Appointments Committee was held on 30 June 2022 and interviewed 1 candidate for 1 Consultant Diagnostic Neuroradiologist (part-time [7.5 PAs]) post.

By unanimous resolution, the Committee was in favour of appointing Dr Mudassara Munir.

Dr Munir holds MBBS (University of Punjab, Pakistan) 2004 and FRCR (UK) 2020. Dr Munir is currently employed as a Specialty Trainee in Radiology on behalf of the Lead Employer Trust, at the Royal Victoria Infirmary.

Dr Munir is expected to take up the post of Consultant Diagnostic Neuroradiologist (part-time [7.5 PAs]) in September 2022.

1.31 An Appointments Committee was held on 6 July 2022 and interviewed 1 candidate for 1 Consultant Anaesthetist with special interest in Intensive Care post.

By unanimous resolution, the Committee was in favour of appointing Dr Gavin Hardy.

Dr Hardy holds MBBS (University of Newcastle) 2010, FRCA (UK) 2018 and FFICM (UK) 2018. Dr Hardy is currently employed as a Specialty Trainee in Anaesthesia and Intensive Care Medicine on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Hardy is expected to take up the post of Consultant Anaesthetist with special interest in Intensive Care in September 2022.

1.32 An Appointments Committee was held on 8 July 2022 and interviewed 4 candidates for 2 Consultant Cardiologist with an interest in Cardiac Electrophysiology posts.

By unanimous resolution, the Committee was in favour of appointing Dr Kadhim Kadhim and Dr Hanney Gonna.

Dr Kadhim holds MBChB (Baghdad University, Iraq) 2007, MRCP (UK) 2013 and PhD (University of Adelaide) 2022. Dr Kadhim is currently employed as a Specialty Trainee in Cardiology on behalf of the Lead Employer Trust, at James Cook University Hospital.

Dr Kadhim is expected to take up the post of Consultant Cardiologist with an interest in Cardiac Electrophysiology post in September 2022.

Dr Gonna holds MBBS (University of London) 2003 and MRCP (UK) 2006. Dr Gonna is currently employed as a Cardiac Electrophysiology Fellow at Toronto General Hospital, Canada.

Dr Gonna is expected to take up the post of Consultant Cardiologist with an interest in Cardiac Electrophysiology post in September 2022.

1.33 An Appointments Committee was held on 14 July 2022 and interviewed 1 candidate for 1 Consultant Breast Surgeon post.

By unanimous resolution, the Committee was in favour of appointing Miss Jane Carter.

Miss Carter holds MBChB (University of Bristol) 2007, MRCS (England) 2010, PhD (University of Louisville) 2016 and FRCS (England) 2021. Miss Carter is employed as a Specialty Trainee in General Surgery on behalf of the Lead Employer Trust, at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Miss Carter is expected to take up the post of Consultant Breast Surgeon post in September 2022.

1.34 An Appointments Committee was held on 14 July 2022 and interviewed 1 candidate for 1 Consultant Colorectal Surgeon post.

By unanimous resolution, the Committee was in favour of appointing Mr Kamran Khatri.

Mr Kharti holds MBBS (University of Karachi, Pakistan) 2002, MRCS (Edinburgh) 2009 and FRCS (Edinburgh) 2021. Mr Kharti is currently employed as a Specialty Trainee in General Surgery at Queen Elizabeth University Hospital, Glasgow.

Mr Kharti is expected to take up the post of Consultant Colorectal Surgeon post in September 2022.

1.35 An Appointments Committee was held on 14 July 2022 and interviewed 1 candidate for 1 Consultant Hepato-Pancreatic Biliary (HPB) Surgeon post.

By unanimous resolution, the Committee was in favour of appointing Mr Rohan Thakkar.

Mr Thakkar holds MBBS (University of Navi Mumbai, India) 2002, MRCS (Edinburgh) 2014 and FRCS (Edinburgh) 2017. Mr Thakkar is currently employed as a Locum Consultant in HPB and Transplant Surgery at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Mr Thakkar is expected to take up the post Consultant Hepato-Pancreatic Biliary Surgeon post in September 2022.

1.36 An Appointments Committee was held on 15 July 2022 and interviewed 1 candidate for 1 Consultant Paediatric Gastroenterologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Sally Buxton.

Dr Buxton holds MBBS (University of Newcastle) 2011 and MRCPCH (UK) 2016. Dr Buxton is currently employed as a Specialty Trainee in General Paediatrics on behalf of the Lead Employer Trust, at the Great North Children's Hospital.

Dr Buxton is expected to take up the post Consultant Paediatric Gastroenterologist post in November 2022.

2. RECOMMENDATION

1.1 – 1.36 – For the Board to receive the above report.

Report of Andy Welch
Medical Director
28 July 2022

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