Public Board of Directors

Thu 28 July 2022, 13:15 - 16:00

Freeman Boardroom (Board members only), all others to dial in via MS Teams

Agenda

13:15 - 13:15
0 min

Public Board of Directors Agenda

A0 Public Board Agenda 28 July 2022 KJ LB.pdf (4 pages)

Standing items:

13:15 - 13:15
0 min

1. Apologies for absence and declarations of interest

Verbal *John Burn*

13:15 - 13:15
0 min

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

Attached *John Burn*

A2 Public Board Minutes 31 May 2022 [DRAFT] GE KJ.pdf (19 pages)

13:15 - 13:15
0 min

3. Chairman's Report

Attached *John Burn*

A3 Chairman Report GE SJB KJ.pdf (6 pages)

13:15 - 13:15
0 min

4. Chief Executive's Report

Attached *Maurya Cushlow*

A4 Chief Executive Board Report July 2022 KJ LB.pdf (10 pages)

Strategic items:

13:15 - 13:15
0 min

5. Digital People Story

Attached *Maurya Cushlow*

A5 Digital People Story July 2022 KJ LB.pdf (4 pages)

13:15 - 13:15
0 min

6. Trust Recovery Programme:

Martin Wilson / Vicky McFarlane-Reid

a. General Update; and

Verbal

b. End of June Performance Position

Attached

- A6b Trust Performance Report Cover Sheet July 2022 KJ LB.pdf (3 pages)
- A6b. Public - Trust Performance Board Report July 2022 KJ LB.pdf (10 pages)

c. Performance Successes

Attached

- A6c Performance Success Stories July 2022 KJ LB.pdf (7 pages)

13:15 - 13:15
0 min

7. NIHR CRN NENC Annual Report [FOR APPROVAL] and Annual Plan

Attached *Andy Welch / Michael Wright*

- A7 CRN NENC Annual Business Plan (and Financial Plan) 2022-23 and Report 2021-22 LB KJ.pdf (8 pages)

13:15 - 13:15
0 min

8. Director reports:

a. Medical Director; including

Attached *Andy Welch*

- A8a Medical Director Report July 2022 KJ LB.pdf (8 pages)

i) Annual Guardian of Safe Working Report

ii) Consultant and Honorary Consultant Appointments

b. Executive Chief Nurse; including Freedom to Speak up Guardian update

Attached *Maurya Cushlow*

- A8b Executive Chief Nurse Report July 2022 KJ LB.pdf (13 pages)

i) Ockenden Update Report

Attached *Maurya Cushlow*

- A8b(i) Ockenden Update Report July 2022 KJ LB.pdf (31 pages)

c. Director of Quality & Effectiveness; including

Attached *Angela O'brien*

i) Quality Strategy;

Attached *Angela O'brien*

- A8c(i) QS Trust Board Cover Sheet KJ LB.pdf (1 pages)
- A8c(i) Quality Strategy July 2022 KJ GE.pdf (22 pages)

ii) CNST Quarterly report; and

Attached *Angela O'brien*

A8c(ii) CNST Quarterly Report July 2022 KJ LB.pdf (25 pages)

iii) Health and Safety Annual Report

Attached *Angela O'brien*

A8c(iii) Health and Safety Annual Report 2021-22 July 2022 KJ LB.pdf (23 pages)

Refreshment Break

d. Director of Infection Prevention & Control

Attached & BRP *Julie Samuel*

A8d Healthcare Associated Infections DIPC Report July 2022 KJ LB.pdf (9 pages)

e. Human Resources Director People Report; including:

Attached *Dee Fawcett*

A8e People Report July 2022 KJ LB.pdf (13 pages)

i) Trade Union Facility Time Report 2021/22

Attached *Dee Fawcett*

A8e(i) Trade Union Facility Time Report July 2022 KJ LB.pdf (5 pages)

f. Executive Director for Business, Development and Enterprise; including

Vicky McFarlane-Reid

i) Trust Strategy update

Attached *Vicky McFarlane-Reid*

A8f(i) Directorate strategy refresh July 2022 KJ LB.pdf (6 pages)

Items to approve

13:15 - 13:15
0 min

9. Provider Collaborative Governance Documents

Attached & BRP *Caroline Docking*

A9 NENC PvCv Governance Documents KJ LB.pdf (8 pages)

Items to receive and any other business:

13:15 - 13:15
0 min

10. Update from Committee Chairs

Attached *Committee Chairs*

A10 Update from Committee Chairs July 2022 LB KJ.pdf (7 pages)

13:15 - 13:15
0 min

11. Corporate Governance Update; including

Attached *Kelly Jupp*

A11 Corporate Governance Report July 2022 LB KJ.pdf (6 pages)

i) Committee Annual Reports, Terms of Reference and Schedules of Business [FOR APPROVAL];

BRP

ii) Annual Modern Slavery Declaration [FOR APPROVAL]; and

BRP

iii) Quarterly Declarations [FOR APPROVAL]

BRP

13:15 - 13:15
0 min

12. Integrated Board Report

BRP *Martin Wilson*

13:15 - 13:15
0 min

13. Public Consultation

BRP *Caroline Docking*

13:15 - 13:15
0 min

14. Meeting Action Log

BRP *John Burn*

13:15 - 13:15
0 min

15. Any other business

Verbal *All*

13:15 - 13:15
0 min

Date of next meeting: Thursday 29 September 2022

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Public Trust Board of Directors' Meeting

Thursday 28 July 2022, 1:15pm – 4.00pm

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

Agenda

Item		Lead	Paper	Timing
Standing items:				
1.	Apologies for absence and declarations of interest	Sir John	Verbal	13.15 – 13.16
2.	Minutes of the Meeting held on 31 May 2022 and Matters Arising	Sir John	Attached	13.16 – 13.20
3.	Chairman's Report	Sir John	Attached	13.20 – 13.23
4.	Chief Executive's Report	Maurya Cushlow	Attached	13.23 – 13.30
Strategic items:				
5.	Digital People Story	Maurya Cushlow	Attached	13.30 – 13.40
6.	Trust Recovery Programme: a. General Update; and b. End of June Performance Position c. Performance Successes	Martin Wilson and Vicky McFarlane-Reid	Verbal Attached Attached	13.40 – 14.00
7.	NIHR CRN NENC Annual Report [FOR APPROVAL] and Annual Plan	Andy Welch/Michael Wright	Attached & Board Reference Pack (BRP)	14.00 – 14.10
8.	Director reports:		Attached & (BRP)	
	a. Medical Director; including i) Annual Guardian of Safe Working Report ii) Consultant and Honorary Consultant Appointments	Andy Welch	 Attached	14.10 – 14.20
	b. Executive Chief Nurse; including Freedom to Speak up Guardian update i) Ockenden Update Report	Maurya Cushlow	Attached	14.20 – 14.30
	c. Director of Quality & Effectiveness; including i) Quality Strategy; ii) CNST Quarterly report; and iii) Health and Safety Annual Report	Angela O'Brien	Attached	14.30 – 14.40
	Refreshments break			*14.40 – 14.45*

Item			Lead	Paper	Timing
8.	d.	Director of Infection Prevention & Control	Julie Samuel	Attached & BRP	14.45 – 14.55
	e.	Human Resources Director People Report; including: i) Trade Union Facility Time Report 2021/22	Dee Fawcett	Attached	14.55 – 15.05
	f.	Executive Director for Business, Development and Enterprise; including i) Trust Strategy update	Vicky McFarlane-Reid	Attached	15.05 – 15.15
Items to approve:					
9.		Provider Collaborative Governance Documents	Caroline Docking	Attached & BRP	15.15 – 15.25
Items to receive and any other business:					
10.		Update from Committee Chairs	Committee Chairs	Attached	15.25 – 15.35
11.		Corporate Governance Update; including i) Committee Annual Reports, Terms of Reference and Schedules of Business [FOR APPROVAL]; ii) Annual Modern Slavery Declaration [FOR APPROVAL]; and iii) Quarterly Declarations [FOR APPROVAL]	Kelly Jupp	BRP	15.35 – 15.40
12.		Integrated Board Report	Martin Wilson	BRP	15.40 – 15.50
13.		Public Consultations	Caroline Docking	BRP	15.50 – 15.55
14.		Meeting Action Log	Sir John	BRP	15.55 – 15.57
15.		Any other business	All	Verbal	15.57 – 16.00

Date of next meeting: Thursday 29 September 2022

Professor Sir John Burn, Chairman

Mr Andy Welch, Medical Director/Deputy Chief Executive Officer

Ms Maurya Cushlow, Executive Chief Nurse [NB Deputising for Dame Jackie Daniel, CEO, on 28 July 2022]

Mr Martin Wilson, Chief Operating Officer

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

Mrs Angela Dragone, Finance Director

Mrs Caroline Docking, Assistant Chief Executive

Mrs Dee Fawcett, Director of Human Resources

Mrs Angela O'Brien, Director of Quality and Effectiveness

Ms Julie Samuel, Director of Infection Prevention and Control

Mrs Kelly Jupp, Trust Secretary

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

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

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

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

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PUBLIC TRUST BOARD OF DIRECTORS' MEETING

DRAFT MINUTES OF THE MEETING HELD 31 MAY 2022

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

In attendance:
Mrs C Docking, Assistant Chief Executive [ACE]
Mrs D Fawcett, Director of HR [HRD]
Ms L Sewell, Head of Digital Innovation & Delivery [HoDID] (for G King)
Mrs L Hall, Deputy Director of Quality and Effectiveness [DDQE] (for A O'Brien)
Mr R Smith, Estates Director [ED]
Mr B Boa, Strategic Financial Adviser [SFA]
Mrs L Pareja-Cebrian, Director of Infection Prevention and Control [DIPC]

Observers:
Mrs L Bromley, joining the Trust as a NED on 1 June 2022
Mrs P Yanez, Lead Governor
Mr E Valentine, Public Governor
Mr P Home, Public Governor
Dr A Dearges-Chantler, Public Governor
Mr S Volpe, Health Reporter
Mr M Discombe, HSJ Reporter *[from 15.00]*

Secretary: Mrs G Elsender — PA to Chairman and Trust Secretary

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

22/18 <u>STANDING ITEMS:</u>

i) Apologies for Absence and Declarations of Interest

Apologies for absence were received from Mr G King, Chief Information Officer, Mrs A O'Brien, Director of Quality and Effectiveness, Mrs K Jupp, Trust Secretary, and Associate NEDs (ANEDs) Professor D Burn and Mrs P Smith.

The Chairman welcomed observers to the meeting including Mrs Liz Bromley who would be commencing her role as Non-Executive Director the following day.

The Chairman declared an ongoing interest regarding matters pertaining to COVID-19 testing and the Integrated COVID Hub North East (ICHNE), due to his role as chairman of QuantuMDx. It was agreed that whilst the Chairman would observe any discussion regarding ICHNE, he would not take any part in such discussions.

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

It was resolved: to (i) **receive** the Chairman declaration and (ii) **note** no further declarations were made**.**

ii) Minutes of the Meeting held on 31 March and Matters Arising

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

There were no matters arising from the previous minutes.

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

iii) Chairman's Report

The Chairman presented his report, noting:

- Recent Governor activity including the Governor Elections and Council of Governors Workshop.
- The topics covered at the April Board development session.
- Recruitment of Mrs Liz Bromley as a new Trust Non-Executive Director.
- Regional engagement with Foundation Trust Chairs of the North Integrated Care Partnership (ICP), Local Authority and Voluntary Sector representatives.

The Chairman referred the recent Spotlight on Services with the Urology Team. Following a virtual presentation by the Team the Chairman, accompanied by NED colleagues conducted a Leadership Walkabout in the Urology Department based at the Freeman Hospital. The Lithotripsy Unit, The Emergency Assessment Unit and the Urology Treatment Suite were visited as part of the Leadership Walkabout.

The Chairman highlighted the positive team culture within the Directorate, with a strong multidisciplinary team approach. It was evident how staff have responded positively to the pandemic and adapted services to support the patient pathways, with new ways of working created.

The Chairman commended the work of the department.

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

iv) Chief Executive's Report

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

- The Trust has made steady progress in developing its activity and financial plans for 2022/23, with the formal planning submissions made, outlining anticipated activity levels, the elective recovery position and expected financial delivery. The CEO expressed her gratitude to everyone involved for their work in developing the Trust plans.
- The CEO noted the acute pressures on activity levels, particularly through Accident & Emergency (A&E) and paid tribute to the staff who had responded remarkably well.
- As well as pressures in activity the CEO noted increasing financial pressures.

  Being mindful of the current economic situation the Trust has been particularly conscious of the impact that high inflation is having on patients and staff personally. As such, the Trust has and will continue to take action to provide support to staff.
- The CEO referred to the importance of leadership and noted the development of the Trust Strategic Leaders Programme. The programme has provided ringfenced time for senior leaders to reflect, recover and look ahead to new and different ways of working in the NHS, while also ensuring the leaders have the tools required to lead successfully in the future. Feedback had been extremely positive.
- The CEO has supported Newcastle bids for National Institute for Health and Care Research (NIHR) funding. Alongside other Trust and Newcastle University colleagues, the CEO was interviewed as part of the assessment of the Biomedical Research Centre (BRC) and Patient Safety Research Collaborative (PSRC) applications. Whilst a positive experience the CEO noted that these funding processes were highly competitive, and the outcome of the applications was currently unknown.
- The CEO commended the work of the Diabetes Team and noted how, with the development of technology, peoples experience of living with diabetes had changed positively.
- The CEO congratulated Non-Executive Director, Steph Edusei, who was awarded the Transformational Leader award at the Northern Power Women Awards. She also paid tribute to the Trust Head of Occupational Therapy, Odeth Richardson, who had been elected as the new Chair of the British Association of Occupational Therapists (BAOT)/Royal College of Occupational Therapists (RCOT).

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

22/19 STRATEGIC ITEMS:

i) Digital People Story

The ECN introduced the digital people story, which shared the lived experience and career pathway of a member of staff who joined the Trust as a physiotherapy assistant. Róisín was

now a physiotherapist who had received funding from the NIHR to pursue her research as part of a prestigious pre-doctoral clinical academic fellowship.

The ECN advised that this story demonstrated the Nursing, Midwifery and Allied Health Professions (NMAHP) strategic commitment to strengthening academic links and research offers to NMAHP staff and highlighted links to the Trusts strategic objectives to ensure each staff member is able to liberate their potential.

The ECN expressed the importance of nurturing early career researchers whose research then translated back into practice, which had been clearly demonstrated by Róisín.

Mr Chapman noted that he was interested to learn of the outcome of Róisín's work. The ECN advised that Róisín work would be published. In addition to the publications, Róisín had also successfully applied for funding from the Council for Allied Health Professions Research (CAHPR) to co-design and produce a digital training resource to raise awareness of the benefits of adopting a coordinated multidisciplinary approach to promoting inpatient activity amongst nursing and therapy staff in response to the results of the survey.

The video was now included in the Trust's induction programme for all new starters including the training of healthcare assistants and volunteers as well as on the post-graduate doctors-in-training induction page.

The ECN highlighted that the video has also been shared and presented on competency frameworks, regional and national professional networks and had been supported by the Emergency Care Improvement Support Team within NHS Improvement and NHS England.

Mr MacLeod commended Róisín on her work and was pleased to learn from both the ECN and the Chairman that all health professionals were encouraged to take advantage of these research opportunities.

Ms Edusei was encouraged to note the participation of the patients in the video and recommended that going forward the friends and relatives of staff/patients also be included.

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

ii) <u>Trust Recovery Programme:</u>

a. General Update; and

b. End of April Performance Position

The EDBDE advised that a new performance report had been produced and shared with the Trust Board to illustrate the end of April position. The EDBDE thanked Joey Barton and Elliot Tame, Senior Performance Managers in her team who had worked tremendously hard to develop the report to such a high standard.

The EDBDE highlighted the following points:

- The new report consisted of three parts being:
    - NHS England (NHSE) Plan Requirements;
    - Operational Standards; and

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

The COO expressed his gratitude to the EDBDE and her team for the production of the new report. The COO reminded Board members of the importance of reading the new performance report together with the quality, people and finance sections in the Integrated Board Report to understand the collective position.

Whilst acknowledging not all targets were being met, Ms Edusei commented that the trend line was a useful addition which showed that performance was improving and noted the importance of recognising that measures were being taken to support improvement.

Mr MacLeod welcomed the revised report and the metrics included. Whilst appreciating the retrospective look back, Mr MacLeod questioned if the metrics could be analysed during the course of the month to identify any areas that may be under performing and provide a forecast position. The EDBDE advised that work was currently underway to construct a live digital dashboard which was a representation of the data included in the report and would be used as Mr MacLeod had suggested.

In response to a query from the Chairman, the COO advised that the weekly 'Stand-Up' meetings continued to take place virtually every Monday at 8:30am and invited Board members to attend one of the meetings in order to understand the content/matters discussed.

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

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

a. Medical Director: including:

- **Quarterly Guardian of Safe Working Report (GOSW)**

The MD presented the report, noting the following points:

- **National Patient Safety Strategy Update** – preparations for implementation continued. The two major threads under current development were the Patient Safety Incident Response Framework replacing the current Serious Incident Framework and the creation of the Patient Safety Partners roles.

  The Trust was considering how best it could genuinely involve patients and their families in how it builds the safest possible environment for all patients, whilst avoiding tokenistic or insubstantial contributions. As such, the Board would remain briefed as this part of the strategy developed.
- **Newcastle Improvement** – The MD noted that Róisín, who participated in the digital story, was an excellent example of the work/role of Newcastle Improvement. The Trust's partnership with the Institute for Healthcare Improvement (IHI) was nearing the end of its first year and had supported 15 teams comprising 85 individuals, 34 coaches and 30 senior leaders with improvement sponsorship roles, to develop skills and confidence in delivering improvements at both a local and Trust-wide level.
- **Infection Prevention & Control** – COVID rates were decreasing across the community which was reflected in hospital occupancy. Of the current 30 inpatients, 10 were admitted with COVID-19 diagnosis, 1 of which was ventilated, and the remaining 20 patients were incidental infection.

  The MD announced that this would be the last Board meeting attended by Lucia Pareja-Cebrian as DIPC as she would be stepping down from this role but would continue in her role as Associate Medical Director.
- **Monkeypox** – The MD advised that mortality from this infection was very low and the risk to patients, staff and visitors was lower than other viruses.
- **Heart Transplant Activity** – Over the duration of the Joint Innovation Fund (JIF) Donor Circulatory Death (DCD) heart pilot from 7 September 2020 to 28 April 2022, 225 DCD hearts were offered, and a National Organ Retrieval Services (NORS) team was mobilised to attend 107 of these.

  In 56 cases a heart transplant resulted after donor death within time criteria, reanimation of the heart in an organ care system and assessment. Prior to the trial none of these donors could or would have been used for transplantation to the patients on our waiting list and so this is a remarkable achievement. From the 7 transplant centres, Newcastle Hospitals carried out 15 transplants, second to Papworth who carried out 16. The MD commended the team on their work.

- **Quarterly Guardian of Safe Working Report (GOSW)**

The content of the report outlined the number and main causes of exception reports for the period 27 December 2021 to 26 March 2022. The report was also considered by the Trust People Committee on 19 April 2022, prior to submission to the Trust Board.

Ms Baker advised that she was looking forward to receiving updates in relation to the establishment of the Patient Safety Partners but highlighted the importance of ensuring that there was a diverse range of voices heard rather than the same individuals being utilised for multiple patient groups. As such she recommended linking in with voluntary and community sector as well as education partners where user involvement was well-developed.

Ms Baker referred to Patient Initiated Follow-Up (PIFU) and expressed concern that this method of follow-up may miss some patients in most need, being mindful of poverty levels within the North East and some patents not having access to the required technology for PIFU.

The MD noted the concerns of MS Baker and agreed that careful consideration would be given as to what patients would be chosen for PIFU rather than continuing with face to face follow up appointments, acknowledging that some patients may prefer the PIFU process.

Mr Jowett referred to the GOSW report and reiterated the importance of engaging with junior doctors to ensure they were comfortable in speaking out if necessary and fully endorsed the role.

Professor McCourt commended the work that had been undertaken with IHI. She noted that she had attended one of the Strategic Leadership Programme events and highlighted the positivity expressed during the session and looked forward to the evaluation.

Mr MacLeod noted his surprise at the level of Did Not Attends (DNA's) for cancer patients and queried if this was a procedural issue whereby patients were not aware of appointments. The MD advised that wherever possible cancer patients were contacted before an appointment via text or telephone call. He added that all DNA's for cancer patients were also followed up after the appointment to understand the reasons for non-attendance. The COO reiterated this and advised that the Outpatient Transformation Programme would also consider the issues that had been raised i.e. improving access for patients as well as educating patients how to access and get the best from the available services.

Ms Edusei noted that it was beneficial to follow up on DNA's, particularly in cancer as some non-attendance could be due to anxiety/stress.

It was resolved: to **receive** the report of the MD and the **note** the contents of the Guardian of Safe Working Quarterly Report.

b. Executive Chief Nurse; including:

The ECN drew attention to the following key points:

- This month's 'Spotlight' section outlined the work of the 'Harm Free Care Team', who were made up of a range of specialist staff providing services across the Trust. The teams covered both acute and community sites and worked collaboratively with clinical teams to support the delivery of harm free care to patients. An explanation of the work on Tissue Viability and Falls Prevention was provided.
- An update of Safeguarding and Learning Disability activity including analysis and review of the activity team was provided which outlined the factors which were

having an impact on the continued trend of increased activity and referrals into the team as well as the rising complexity of case management.

- The numbers of urgent Deprivation of Liberty Safeguards (DoLS) applications for 2021/22 were lower than in the previous years. In the previous two quarters, numbers have been significantly down (up to 30% less), compared to the same quarters in the previous year. Work was on-going to understand this change in activity.
- In terms of the Care Quality Commission (CQC) 2021 National Maternity survey results, it was encouraging to note the overall response rate. Areas for improvement identified in the results would be built into the Trust transformation work.

Referring to the results of the NHS Friends and Family Test (FFT) and specifically noting that 100% of people who responded to maternity services FFT would recommend the service, Mr Jowett highlighted this as a commendable outcome being mindful of the increased scrutiny and regulation and asked that his thanks be passed on to the department.

Ms Baker referred to the increase in safeguarding referrals for younger children and asked whether this was reflective of the national picture. From conversations within the Safeguarding Partnerships and Boards, the ECN advised the reason behind the increase was perceived to be the impact of the last two years of the pandemic.

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**].

Ms Edusei commented on the increased activity impact in terms of COVID-19, citing the increase in acuity of patients, rising safeguarding referrals and the increased need for mental health support and sought opinion as to whether this would increase further. Referring to the earlier discussions in relation to poverty, the CEO perceived activity would rise significantly. The ECN added that the impact of self-neglect and hidden harm was also being identified by the community teams.

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

I. Nursing & Midwifery Staffing

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

The following key points were noted:

- The staffing establishments remained broadly fit for purpose with the exception of specific adult and paediatric wards highlighted in the detail of the report. There was a demonstrable increase in acuity and dependency across many areas compared to pre-pandemic levels. This remained challenging and further investment may be required in the future if the increase in acuity and dependency continued.

- The Nurse Staffing and Clinical Outcomes Group continued to provide monthly oversight and assurance regarding safe staffing.
- Focused work continued to maximise recruitment and retention overseen by the Nursing and Midwifery Recruitment and Retention Group. The Trust position remained favourable compared to the national position and work was on-going to maximise international recruitment and Healthcare Support Worker recruitment in line with national work streams.
- The on-going requirement to mitigate staffing shortfalls due to the pandemic had been overseen by the Senior Nursing Team and based on existing evidence-based tools and assurance processes to ensure safer staffing levels.

The ECN drew attention to the conclusions noted in section 6 of the report and provided assurance around the risks, mitigations and deployment of staff to ensure that wards were the safest they could be with the resources available.

Mr Morgan sought opinion as to the percentage of international recruitment expected to be realised and questioned if there had been any specific feedback from patients being cared for by staff recruited internationally.

The ECN explained there was no target for international recruitment, but age profiling had been undertaken. The ECN advised that this would be the first cohort of international midwives, but the Trust already had many nurses recruited internationally who had been working wards historically. She noted that there had been a very small number of issues, but these were managed on a day-to-day basis.

Professor McCourt added that there were language tests which were required to be passed by prospective international employees and all internationally recruited staff were provided with a full orientation of the city.

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

II. Ockenden Final Report

The ECN presented the report, noting that it had been discussed in detail at a recent Board Development session and within the Quality Committee. The following points were noted:

- The final Ockenden report provided an additional 15 Immediate and Essential Actions, together with 92 recommendations, and acted as an immediate call to action for all commissioners and providers of maternity and neonatal services. A requirement to ensuring that lessons were rapidly learned and service improvements for women, babies, and their families were driven forward as quickly as possible, was a key priority. The ECN suggested taking a phased approach to reporting in view of the large number of recommendations.
- Workforce planning continued to be a key feature in the final publication, with a specific focus on Midwifery Continuity of Carer (MCoC).
- The Trust was currently undertaking detailed work in benchmarking against the Immediate and Essential Actions of the final report, to further identify any gaps and associated actions in relation to the recommendations. The publication had been

shared amongst the maternity and neonatal workforce, and it was recognised that further engagement and listening events were required.

- Reference was made to the core competency table on page 10 of the report. An increased training schedule had been implemented to support traction against the trajectory in meeting the 90% target, however, it should be noted that in times of escalation, due to high acuity and unexpected staff absence, it had at times been necessary to decrease the number of planned sessions.
- Preparation was underway for an Oversight Review Group visit on 17 June 2022.

Mr Chapman commended the ECN on the approach to this piece of work recognising the significant volume of change and requirements involved. A discussion ensued in relation to the external oversight and accountability arrangements.

The Chairman noted that he was encouraged by the level of compliance against the requirements and queried whether other Trusts who were less compliant could impact upon the Trust. The ECN advised that it was anticipated that most organisations would be moving to full compliance however further recommendations and actions may arise following the independent investigation into East Kent Maternity Services. The report was expected to be published in September 2022.

Ms Baker expressed her concern into the delay of implementing the Badgernet electronic system within Maternity, which was an online portal and app that allows mothers to access maternity records over the internet through electronic devices. For assurance Mr Chapman advised that this had been discussed regularly within the Quality Committee, with a Deep Dive planned for August 2022.

It was resolved: to i) **receive** the report; ii) **note** the current level of assurance, the identified gaps and associated risks; and iii) **recognise** that further detailed work is required to ensure full compliance regarding the final Ockenden report.

c. Director of Quality & Effectiveness

i. Quarterly CNST report;

The DDQE provided an update on the Trust's position against the Year 4 Clinical Negligence Scheme for Trusts (CNST) Maternity incentive scheme. The Year 4 CNST safety actions were effective from the 8 August 2021. Amendments were made to the safety actions in October and on the 23 December 2021 the Trust was informed that there would be a three month pause in the reporting period due to ongoing pressure on the NHS and maternity services, however the Trust continued with the work internally to progress with compliance.

After the report was written the Trust received notification on the 6 May 2022 of the amended 10 Safety Actions. The new submission date will be the 5 January 2023. As such, the Maternity department will be reviewing these actions as well as the Ockenden actions.

It was hoped that a detailed gap analysis report would be presented to the Board in July.

The DDQE highlighted three specific areas to note:

- Challenges regarding training for multi-disciplinary teams MDT and achievement of 90% compliance. Work was underway to try to understand the position against the trajectory that had been identified. A CNST Oversight Group was in place which meets fortnightly and reviews the position against each of the safety actions.
- The digital challenges present and the delay in the implementation of Badgernet which meant that submitting data was very time consuming using a manual process.
- The new submission date will be the 5 January 2023 with some specific changes being noted. The changes were currently being explored and would also be included in the report for the July Trust Board meeting.

It was resolved: to **note** the content of report **approve** the self-assessment to date.

ii. Learning from deaths quarterly report

The DDQE presented the report which had been scrutinised at the Quality Committee meeting held on 17 May 2022. The following key points were highlighted:

- The proportion of level 2 mortality reviews being undertaken compared to level 1 reviews had shown a downward trend. Whilst this can be a reassuring feature, a link had been identified between the reduction and the implementation of the Medical Examiner function, therefore suggesting a potential misunderstanding of the role of the Medical Examiner.

  Whilst the Medical Examiner did undertake a cursory review of the death, the review, was not akin to what a level 2 review would incorporate and would therefore not substitute a level 2 review. As such, some clear communication with regard to the role of the Medical Examiner was being prepared for staff by senior colleagues within the Quality and Effectiveness Directorate.

  It was noted that the Medical Examiner officers were very well established at both the Royal Victoria Infirmary (RVI) and the Freeman Hospital and positive feedback had been received from doctors and families who had been involved in the process.

- It was noted that the Learning Disability Team was under increasing pressure due to rising clinical workload and referrals. This had led to a delay in undertaking the LeDeR review of patient deaths and subsequent notification to the national database. Some additional support had been sought and it was hoped that all cases would be uploaded by the end of June 2022.

It was resolved: to (i) **receive** the report and (ii) **note** the actions taken to further develop the mechanisms for sharing learning across the Trust.

iii. Quality Account

The DDQE presented the report noting that updates on the Quality Priorities were presented throughout the course of the year to the Quality Committee.

The report included details of the developments and transformational work undertaken over the last year together with patient stories, which was acknowledged as an incredible achievement being mindful of the staff pressures.

During the last few months, the report had been presented to all of the local Clinical Commissioning Groups (CCGs), Overview and Scrutiny Committees (OSCs) as well as to Healthwatch to provide an update on progress against the quality priorities for the last year and also to consult on the quality priorities for the coming year.

Feedback had been positive with acknowledgement of the work undertaken by the Trust over the last 12 months, specifically around the mutual aid provided to other organisations both locally and nationally.

Quality priorities for 2022/23 would continue to focus on Healthcare Associated Infections (HCAI), the management of abnormal results and quality improvement initiatives. Focus would also continue on the Maternity Early warning score with expansion to a formal triage process within the maternity assessment unit, which will link into the work around deteriorating patients. Other priorities included digital developments, and day case pathways in relation to elective recovery.

The deadline for uploading the Quality Account to NHSE was 30 June 2022. Current progress indicated this deadline would be met.

Ms Baker commended all involved for the amount of work that had contributed to such a comprehensive document.

Mr Morgan questioned the process of how quality would be measured. The DDQE agreed it was difficult to define the immense amount of data contained within the report, however she added that the report was underpinned by a strong governance structure, therefore the achievements around national audits or compliance with NICE guidelines or HCAI data were reviewed at some of the management groups that feed into the Quality Committee which enables the Team to monitor progress against the quality metrics.

The ECN added that the report also follows a standardised format and is built up during the course of the year.

Referring to the Learning from Deaths report and specifically the deaths of patients with a recognised learning disability, the Chairman questioned if was possible to capture the data of those patients who may have a hidden disability. The DDQE admitted this was a difficult challenge and a key component to this was how the patients were identified on the digital system and electronic patient record. Work was ongoing with the digital, safeguarding and learning disability teams to try and improve the process for the planning and delivery of care. The ECN added there was a flag placed on a patient record if they had been diagnosed with a learning disability however it did not capture autism or complex learning disorders.

For assurance, Mr Chapman advised that the Quality Account was discussed in some detail at the Quality Committee, and he was meeting with Joanne Field, Senior Information Manager to discuss joint information and data sets.

It was resolved: to **note** progress against the 2021/22 quality priorities and **agree** the content of the document for publication.

d. Director of Infection Prevention & Control

The DIPC presented the report which provided bimonthly assurance to the Trust Board regarding HCAIs. It was noted that Monkeypox was not included in the report as was not included in the data capture at the time of writing the repot, however the DIPC assured the Board there were very robust pathways and procedures in place for identification of any suspicion of the disease in patients.

Key points to note included:

- Changes in COVID-19 screening of emergency and elective patients had not led to increases in periods of increased incidence or outbreaks.
- As we emerge from COVID-19, the focus for Infection Prevention and Control (IPC) is to enable and maximise clinical activity and reinvigorate projects that will lead to reductions in other HCAIs.
- Nationally set thresholds for Gram-negative Bloodstream Infections (GNBSI), were met for 2021/22. The new year trajectories have been set, with an internally set objective of a 10% reduction for all HCAIs. This includes MSSA for which there is no national threshold.
- There have been no MRSA bacteraemia's in 24 months.
- Funding has been approved for ICNET.
- No infections in hips or knees for surgical associated infections had been identified, however there had been an increase in surgical associated infections in spines.
- A new Clinical Director had been appointed for Sepsis and was currently working on a strategy.
- Antimicrobial Take 5 audits have been re-launched.
- Funding had been secured for an additional pharmacist to strengthen the IPC team.
- The IPC team have agreed the priorities for 2022/23 and have identified four key initiatives, being:
    - Use of Octenisan washes;
    - Glove use reduction;
    - Diarrhoea management and CDI initiative; and
    - Blood Stream Infections community initiative.

Mrs Pareja-Cebrian advised that she had felt very privileged to be the DIPC for the Trust for the last 5 years and during the pandemic and was pleased that she had helped make a difference and contributed to patient and staff safety for which she was very proud.

The CEO expressed her gratitude to the DIPC for her tireless and outstanding support, especially during the past two years during the pandemic, and her outstanding leadership. The MD concurred and added that Mrs Pareja-Cebrian had been brave in challenging national and region teams with regard to guidance and the Trust had been very successful in looking after both patients and staff during the pandemic. The MD added that Mrs Pareja-Cebrian had showed courage and leadership and as a result had made the Trust very successful.

The Chairman echoed the sentiments of both the CEO and the MD and added his own thanks.

It was resolved to: (i) **receive** the briefing, **note** and **approve** the content.

e. Human Resources Director – People Report

The HRD added her thanks for the work of the DIPC.

The HRD presented the report which provided an update on progress against the local People Plan and key national developments relevant to the people strategy. Key points to note included:

- The contract for the ICHNE ended in March 2022 and sadly some staff were made redundant from the Trust on 4 May 2022 following the formal consultation period. A number of the ICHNE staff had secured alternative employment.

  It was also noted that the recruitment campaign for the ICNHE was targeted at recruiting a diverse workforce.
- Sickness absence remained above pre-COVID levels.
- The majority of the Trust led COVID Vaccination sites would be closing next month.
- Further data was awaited regarding the staff survey results to develop and enhance improvement plans.
- The Equality and Diversity programme within the Trust provided an inspiring and informative set of events. Initial feedback had been excellent, and it was clear that the programme had initiated some great conversations and value-added change projects.
- Work continued on a range of developments to improve the staff experience and to support them through this challenging time.
- The Trust continued to expand its Apprenticeship offer with an increasing number of apprenticeship schemes in place.
- A wide range of education and training activities continues, and progress in upgrading the facilities continues at pace.
- International recruitment continued across the organisation. It was also noted that the changeover date for Junior Doctors was 3 August 2022.
- Robotic Process Automation (RPA) was currently being reviewed as the Trust looks to develop a trust wide delivery proposal. As part of this, an initial pilot has taken place in clinical areas which has produced two 'bots' to automate cancer information and national immunisation and vaccination data.

Mr Morgan sought an update on the recruitment to the Day Treatment Centre. The HRD was pleased to note that recruitment was on track advising there was also a weekly review meeting of progress against targets.

Mr Morgan queried if there would be any impact on other areas within the Trust as a result of recruitment to the Day Treatment Centre. The HRD assured Mr Morgan and the Board that the group involved in the recruitment were very cognisant of this.

Ms Edusei provided some feedback on the session she had participated in called 'Let's Talk Race' which offered a safe space for staff to have a full and frank discussion. The HRD advised that this session had been recorded and believed that it was readily available to all staff.

With regard to the Maximising Your Potential Programme, the initial feedback had been very positive with some good progress being made. She concurred with Ms Edusei who suggested that the effectiveness of the programme would provide a positive impact.

[Mr Jowett left the meeting at 14:43]

Ms Baker welcomed the update and questioned if staff absence was a result of 'the big COVID resign'. Whilst there was no specific evidence of this, the HRD was of the opinion that there may be increased numbers of retirements/early retirements as a consequence of the pandemic, adding that all employers were facing the same problems with workforce and attrition.

The HRD noted that it was currently a 'buyers' market'. As such, the HRD reiterated the importance of making the workforce feel valued and supported and to ensure that Newcastle Hospitals was a good place to work.

Ms Baker suggested focussing activities towards particular communities including care leavers and prisons to help with a pipeline of staff which may help with roles other than doctors and nurses. The HRD advised that this could be achieved via the apprenticeship route. She added that some links had also been made with prisons.

It was resolved: to **note** the content of report.

f. Chief Information Officer – Digital Update

The HoDID provided an update on both achievement of HIMSS Level 6 accreditation, formal closure of the Global Digital Exemplar (GDE) programme and delivery of the objectives outlined at the initiation of the programme. The following key points were noted:

- The GDE programme was initiated in March 2017 and concluded on 7 April 2022 with achievement of the HIMSS Level 6 accreditation. The programme had been delayed somewhat due to the impact of the COVID-19 pandemic.
- Newcastle Hospitals received the least amount of funding under the GDE programme however had the largest scale of delivery.
- The creation of electronic patient records across the Trust had contributed to more effective/efficient care delivery.
- The implementation of the electronic white boards and e-observation boards had provided a virtual and visible safety net and the Trust had received a regional award for the work around the deteriorating patient escalation. The work undertaken enabled the Trust to comply with the standards that are in place for the National Early Warning Score (NEWS).

  The functionality has been released into Paediatrics with positive feedback.
- The electronic patient record has allowed outreach teams to access directly into the clinical records.
- It was noted that the Create North Care Record (GNCR) and the Health Information Exchange (HIE) had been recognised as one of the most successful sharing initiatives across the UK and the 5th largest user of the HIE globally. On average 370,000 pieces of information are shared per month.

- The next piece of work planned was in relation to closed loop medicine management.

The HoDID stressed that this had been a whole Team effort and feedback from the accreditation team had been that there was a commitment to deliver on this programme which was welcomed by the Team.

The Chairman thanked the HoDID for a clear explanation of the report.

Mr Chapman congratulated the HoDID on achieving HIMSS Level 6 and questioned if there was any aspiration to reach HIMSS Level 7 which had a lot of data warehouse capability which he felt the Trust would have to undertake further transformational work to achieve.

The HoDID confirmed this was an aspiration however the criteria had not yet been published and until the criteria was known the Trust was unable to commit to delivery.

Following a question from Mr Morgan in relation to the value for money of the programme, Mr Chapman provided some clarity in relation to benefits of having electronic records in terms of patient safety.

The CEO noted that having access to good, connected data could only further enhance patient safety and fully supported the aspiration to reach HIMSS Level 7.

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

[M Discombe joined the meeting]

22/20 ITEMS TO RECEIVE AND ANY OTHER BUSINESS

i) Update from Committee Chairs

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

People Committee
No additional comments outside of the minutes were noted.

Finance Committee
Mr Morgan advised that the FD would be revising the Trust Financial Plan for the end of June. He noted that he had met with the SFA to discuss the development of the Trust Cost Improvement Programme (CIP) and felt his was an area of future focus for the Board.

Mr Morgan also referred to the challenges within the construction industry, with rising inflation and material costs, which would impact on the Trust Capital Programme.

Audit Committee
Mr MacLeod advised that both the Internal and External Auditors had attended the recent Audit Committee meeting, with positive representations made in relation to delivery of the timetable for the sign off of the Annual Report and Accounts 2021/22.

Charity Committee
Ms Baker referred to the digital story heard earlier in the meeting which highlighted the power of research. She noted that whilst the Charity could not fund core Trust business, it could support elements of research across all disciplines to enhance patient outcomes.

Quality Committee
Mr Chapman formally thanked Mrs L Pareja-Cebrian for her contributions to the Quality Committee during her time as the Trust DIPC.

Mr Chapman referred to the innovation and changes that had been made in how information was reported and presented to the Quality Committee. In noting the volume of information received by the Committee, he commended Mrs Angela O'Brien, Director of Quality and Clinical Effectiveness, who had been instrumental in making the changes to the agenda/reporting formats and ways of working. Mr Chapman added that Deep Dive sessions were also to be scheduled to take place in the months between the formal Quality Committees. The first session would be undertaken in August and would focus on Maternity, including the Badgernet system development, and Urology. Outpatient Transformation would be considered at a subsequent deep dive session.

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

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

In addition to the contents of the report, the ACE advised that the Trust was seeking to procure an external organisation to undertake a well-led review in line with NHS Improvement (NHSI) and CQC requirements. Following a tender evaluation exercise, PwC had been appointed to undertake the review.

The work would commence in June 2022 with regular updates to be provided to the Trust Board throughout the review.

- **Quarterly declarations [FOR APPROVAL]**

The quarterly NHSI declarations were included in the Board Reference Pack which were referenced and required Board approval prior to publication.

It was resolved: to (i) **receive** the report; and (ii) **approve** the NHSI quarterly declarations for publication.

ii) <u>Integrated Board Report</u>

The COO presented the update, noting that the Integrated Board Report was included in the BRP.

The FD added that month 1 was not reflective of the regular financial pattern, currently showing a deficit due to non-recovery of ERF income at this time.

It was resolved: to **receive** the report and note the contents within.

iii) Meeting Action Log

The Action log was received.

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

iv) Any other business

Whilst acknowledging how busy the Trust was, Professor McCourt informed Board members that she had welcomed the opportunity to receive some international visitors on behalf of the Trust.

22/21 DATE AND TIME OF NEXT MEETING

The next meeting of the Board of Directors was scheduled for **Thursday 28 July 2022.**

There being no further business, the meeting closed at 15:11.

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022						
Title	Chairman's Report						
Report of	Professor Sir John Burn, Chairman						
Prepared by	Gillian Elsender, PA to Sir John Burn						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☐	☒				

Summary	The content of this report outlines a summary of the Chairman's activity and key areas of focus since the previous Board of Directors meeting, including:
	• Governor Activity including:
	  ○ Governor Elections
	  ○ Council of Governors
	  ○ Attending a Quality of Patient Experience Working Group meeting
	• Board Development Session
	• Spotlight on Services – Urology and Hub and spoke model utilised for the Children and Families Newcastle Programme
	• Regional engagement with Foundation Trust Chairs of the North Integrated Care Partnership (ICP), Local Authority and Voluntary Sector representatives						

Recommendation	The Trust Board is asked to note the contents of the report.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. Pioneers – Ensuring that we are at the forefront of health innovation and research.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☒	☐
Impact detail	Provides an update on key matters.						
Reports previously considered by	Previous reports presented at each meeting.						

CHAIRMAN'S REPORT

EXECUTIVE SUMMARY

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

- Governor Activity including:
  - Governor Elections
  - Council of Governors
  - Attending a Quality of Patient Experience Working Group meeting
- Board Development Sessions
- Spotlight on Services – Urology and Hub and spoke model utilised for the Children and Families Newcastle Programme
- Regional engagement with Foundation Trust Chairs of the North Integrated Care Partnership (ICP), Local Authority and Voluntary Sector representatives

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

CHAIRMAN'S REPORT

Since our last Board meeting in May we have enjoyed a wonderful extended weekend in celebration of our Queen's Palatinum Jubilee who incidentally came to the throne on the day of my birth when her father died. As a result, my arrival sadly coincided with a period of national mourning!

Following our latest round of Governor Elections which closed on Monday 30 May 2022 I am pleased to welcome both new and re-elected Governors as noted below:

- **Newcastle upon Tyne:** Judy Carrick and David Forrester
- **Northumberland Tyne and Wear (excluding Newcastle):** Bob Wadell, Claire Watson and David Evans
- **Staff Medical and Dental:** John Hanley
- **Staff Health Professional Council:** Elizabeth Rowen
- **Appointed Governors:** Ian Tokell, Newcastle City Council and Professor Justin Durham, Newcastle University

We held our new Governor induction on Friday 10 June 2022 which covered the roles and responsibilities of being a Governor, Governor activities, the expectations as well as the support and tools in place to assist Governors in fulfilling their role.

Our Council of Governors also met in June. In addition to our regular updates from our Lead Governor and Working Group Chairs we were joined by Executive colleagues who provided a comprehensive update on the Trust's current performance and delivery. We were also joined by Dr Sarah Brown, Consultant Liaison Psychiatrist, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) and Honorary Associate Medical Director for Mental Health, Newcastle Hospitals, who delivered an excellent presentation on the journey so far in developing a Mental Health Strategy for the Trust.

I attended the Quality of Patient Experience Working Group, the date of which coincided with the Big Tea Event in celebration of NHS 74th Birthday. It would have been rude not to indulge in some Tea and Cake!

In terms of Board activity, I chaired an Extraordinary Board meeting on 21 June which was held to formally approve the Trust's Annual Report and Accounts and I would like to take this opportunity to thank everyone involved in the preparation of these two items as the work and effort involved should not be underestimated.

I also chaired a Board Development Session in June. The aims were:

- To discuss the latest developments in system work and the impact for Newcastle Hospitals.
- To discuss the impact of the National Patient Safety Strategy.
- To receive a position update on key Directorate Developments and progress on the well-led external review.
- To consider and agree the Trust capital development priorities and how we will prioritise actions/solutions to securing funding.

My annual appraisal was undertaken by Mr Jonathan Jowett, the Trust Senior Independent Director (SID) in early June and I have also completed the annual appraisal process for the Non-Executive Directors.

We have enjoyed two "Spotlight on Services" since the last Board meeting. The first was held in June 2022 with the Infection, Prevention and Control Team (IPC). Lucia Pareja-Cebrian, Director of Infection Prevention and Control (DIPC) was joined by her colleagues, Julie Samuel, Consultant Microbiologist, Angela Cobb, IPC Lead and Gill Lishman, Matron Infection Prevention & Control. It was noted that Lucia would be stepping down as DIPC with the role being succeeded by Julie Samuel in July 2022.

The IPC Team described their overall staffing structure covering the Freeman Hospital, Royal Victoria Infirmary (RVI), and the Community. Newcastle Hospitals was identified as having one of the lowest rates of COVID-19. The importance of ventilation was discussed in the early stages of the pandemic. Lucia went on to describe the successful processes put into place during the pandemic and also areas of learning and improvements.

An overview was given in relation to the management of outbreaks and how information is shared; acted upon and disseminated across the organisation; whilst reporting daily to NHS England (NHSE). The fantastic work of the test and trace service and laboratory services were highlighted. Keeping staff and patients safe through risk assessment reviews has been a major focus of all teams. This overview was followed by a physical walkabout in the IPC office area in Peacock Hall.

The second "Spotlight on Services" was a virtual session which focussed on the Hub and spoke model utilised for the Children and Families Newcastle Programme. We were joined by Jane Melvin, Directorate Manager for the Great North Children's Hospital and Community Services and Alison Priestly from Newcastle City Council. We enjoyed a short presentation which detailed the hub and spoke model which is based around family hubs and family partner roles.

We discussed the progress to date, the several funding sources and next steps, especially the development of a Multi-Disciplinary Team to support the work of Family Partners. This was followed by an interesting discussion about several issues including the role of the Voluntary and Community Sector (VCS) and potential to increase this and the need for robust evaluation.

At a regional level, I continue to engage with both Foundation Trust Chairs and Chairs of the Integrated Care Partnership (ICP) and participated in a meeting on 6 June which was also attended by Sam Allen, the new Chief Executive of the North East and North Cumbria Integrated Care System (NENC ICS). Discussion centred on the development of the Integrated Care Board (ICB) as well as sharing initiatives from respective Trusts to ease the impacts of the current cost of living crisis.

I was delighted to be invited to join the Bubble Foundation in celebrating their 30th year where I attended a celebration with patients, parents and staff both former and present.

RECOMMENDATION

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

Report of Professor Sir John Burn
Chairman
22 July 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022						
Title	Chief Executive's report						
Report of	Dame Jackie Daniel, Chief Executive Officer (CEO)						
Prepared by	Caroline Docking, Assistant Chief Executive Lewis Atkinson, Principal Advisor Alison Greener, Executive PA to the CEO						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	This report sets out the key points and activities from the Chief Executive. They include: • Working with partners in a changed NHS structure with the introduction of Integrated Care Boards (ICBs); • Renewing our high-performance culture and work as an anchor institution; and • Headlines from other key areas, including the Chief Executive Officer's networking activities, our awards and achievements.						
Recommendation	The Board of Directors are asked to note the contents of this report.						
Links to Strategic Objectives	This report is relevant to all strategic objectives and the direction of the Trust as a whole.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☒	☐	☒	☒
Impact detail	This is a high-level report from the Chief Executive Officer covering a range of topics and activities.						
Reports previously considered by	Regular report.						

CHIEF EXECUTIVE'S REPORT

EXECUTIVE SUMMARY

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

- The formation of the North East and North Cumbria Integrated Care Board (ICB);
- Challenges facing the NHS during the heatwave and summer;
- Renewing our high performance culture;
- Work on Greener NHS and child poverty;
- Networking and communication activity; and
- Recognition and awards for staff.

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

CHIEF EXECUTIVE'S REPORT

1. OVERVIEW

Working together on big challenges

The pressures that the whole NHS is facing this summer, with high levels of emergency demand exacerbated by waves of both heat and COVID, have brought into stark focus the challenge facing the new Integrated Care Boards (ICBs) which formally came into being on 1 July.

At this time of transition in organisational roles, I have found it useful to focus on the strategic aims of ICBs:

1. Improve outcomes in population health and healthcare;
2. Tackle inequalities in outcomes, experience and access;
3. Enhance productivity and value for money; and
4. Help the NHS support broader social and economic development.

The huge and complex nature of meeting these aims requires a different way of working than we have had in the past, especially across the North East and North Cumbria ICB which is the biggest in the country serving more than 3 million people. I believe we should use this opportunity to genuinely co-create an improved health and care system, and to unleash the passion and skills of our staff and communities to improve health outcomes in each place. With the NHS's budget under pressure from meeting rising demand and inflation, in my view we cannot afford to have focus and resources spent on centralising decision-making and performance-management arrangements.

I know that Sam Allen, the ICB CEO, is committed to working in a new way. As she and team continue to shape the ICB's leadership and governance, they will find allies here in Newcastle Hospitals. I continue to work every week to build and renew partnerships with ICB colleagues and others across the health and care system. I would particularly like to welcome the appointment of Joe Corrigan, appointed as the ICB's Director of Place for Newcastle. In the coming months we will be developing the arrangements to allow the ICB to delegate key parts of its decision-making down to Collaborative Newcastle, the core partnership we have between health and care organisations in the city. Joe's previous experience of working with us in the Newcastle Gateshead Clinical Commissioning Group (CCG) will be helpful in designing and implementing these delegation arrangements, and I know he will play a key role in the Collaborative Newcastle Joint Director team.

The only sustainable route to delivering better quality across the health and care system from existing resources is to further improve collaboration. That is why I was delighted this month to welcome more than 60 health and care leaders from across Collaborative Newcastle's organisations to the latest intake of the 'Learning to Lead together' joint development programme, which aims to develop collaborative leadership across organisational boundaries. Reflecting together with them and other CEOs about the challenges of system leadership renewed my optimism that, despite all challenges, we can continue to improve – together.

Renewing our high-performance culture

In June, NHS leaders from across the country gathered in Liverpool for the NHS Confederation Expo Conference – the first such event since 2019. In her excellent speech, NHS Chief Executive Amanda Pritchard focused on four 'r's that she wants us to have in mind as we work: recovery, reform, resilience and respect. With the Executive Team, I have been working on what these mean for us and how we can renew the high-performance culture that Newcastle Hospitals is renowned for, to ensure how we work is fit to meet the challenges of a post-pandemic world.

I continue to be proud of the resilience of our services and staff. Despite record urgent and emergency care demands, not to mention record temperatures, as an organisation we have continued to ensure that patients from arriving ambulances are received without undue delay. This means that patients get the hospital care they need, but also that ambulance crews can return to the road to respond to further emergency calls in a timely manner – an issue that has troubled significant parts of the NHS elsewhere in the country. There is a national focus on improving speed of discharge from hospital in order to create capacity for new patients to be received, and a refreshed national urgent and emergency care strategy is expected in the autumn.

We know that our services are only as resilient as our staff, and we continue to do whatever we can to support them with and the extraordinarily work they do in often difficult situations. Since the last Board meeting, our new staff bistro in the Leazes Wing at the Royal Victoria Infirmary (RVI) has opened seven days a week for staff with a range of hot foods, sandwiches, salads and cakes – ensuring there is 24/7 access to food. Thanks to the team who led that improvement, and also to the Newcastle Hospitals Charity who were fast to respond to the hottest day of the year, providing cooling ice-cream respite to staff. Providing a safe space for staff to share and talk about the personal impact of work is also an important part of supporting resilience, and this month I was honoured to join one of our programme of Schwartz Rounds to support this.

Our focus on recovery of elective waiting times also continues. I am pleased to report that we have now eliminated waits of above two years for all but a small number of specialist spinal patients, in line with national expectations. We are now focused on reducing elective waits of over 78 weeks, and on reducing the number of patients waiting more than 62 days on cancer pathways. Continued reform and improvement of services will be key to returning performance to where it was before the pandemic, so I was pleased to focus on our Newcastle Improvement learning and sharing events which showcased some of the excellent work going on.

Renewing our high-performance culture will also require us to renew our leadership and to ensure our management structures are fit for the future. It is the natural time to do this as we are expecting turnover in the Executive Team because of the retirements, in November, of Dee Fawcett (Director of Human Resources) and Angela Dragone (Finance Director), who leaves at the end of this month. As this is her last board meeting, I want to pay particular tribute to Angela for the work she has done over decades to ensure the financial strength of our organisation. Jackie Bilcliff will start with the Trust in September as Chief Finance Officer, and we are currently recruiting for the post of Chief People Officer with interviews scheduled to take place in late August. As the Executive Team changes, we will be taking

time to develop as a team together and to plan and communicate our roadmap to a high-performance future. This will complement Board-wide work currently underway as part of our 'well-led' review, which will help assure and further improve the robustness of our governance.

Working as an anchor institution to tackle climate change and improve life chances
The unprecedented heatwave we have just experienced is another reminder of the climate emergency and its significant impact on health and health services.

It has now been three years since Newcastle Hospitals become the first healthcare organisation in the world to declare a climate emergency. Over the last month I have had several opportunities to reflect on the progress the trust has made and talk about the current key constraint on us making significant further cuts to our emissions – the availability of capital to spend on decarbonising our estate. At the NHS Confederation Expo Conference in June, I spoke from the main stage about these constraints and our plans to reduce emissions that could be realised with capital - including building the New Specialist Hospital ('Richardson') wing at the RVI which would not just safeguard and improve our services, but also serve as the NHS exemplar of operating a net-zero facility.

The Conference also saw James Dixon, our Associate Director for Sustainability, speaking at the launch of the new clean air toolkit for Integrated Care Systems (ICSs) that we have helped develop along with partners Global Action Plan and Boehringer Ingelheim. We are leading work to tackle the challenge of air pollution across the North East and North Cumbria as we know that dirty air is estimated to kill between 28,000 and 36,000 people a year in the UK.

An equally shocking statistic featured in the news this month that the North East has the highest estimated rate of children living in poverty in the country, and Newcastle the highest proportion of any local authority in the region – with 42% of children here living in relative poverty after housing costs are taken into account. Staff often tell me about how conscious they are of the difficulties faced by families and children they work with who struggle financially, an issue that has been exacerbated by the impact of the cost-of-living crisis. There is a clear link between poverty and poor health outcomes, so we have a professional as well as a moral responsibility to act. This involves reducing the effects of being in poverty through the way we provide services, and also working to reduce poverty directly through our economic and employment impact.

Working with partners as part of Collaborative Newcastle, we have already created 'Children & Families Newcastle', bringing together health and support services in community hubs. This month we joined our partners from across the city at the launch of 'EVRY Child Newcastle', which has an ambition to empower young people and make Newcastle a place where every child and young person can achieve a successful future. As part of this we will be offering high quality paid traineeships to young people which will help young people, especially those from areas of the city with high levels of inequality, build high-quality careers. This latest initiative builds upon our strong record of apprenticeship and work experience, which includes ten years of commitment to Project Choice – a supported internship programme for young adults aged 16-24 with learning difficulties and/or disabilities, and/ or Autism. This month I was delighted to present certificates to the latest

intake at their graduation ceremony and to hear from the young people about how their hard work through the project has helped them become more confident and learn new work skills. Over 70% of our Project Choice graduates have gone on to achieve employment within the Trust and are contributing to caring for our patients – a fantastic example of how we can work as an anchor institution to have a positive social impact. In the coming months we will be looking for further opportunities to develop our anchor mission and I look forward to reporting progress to the Board.

2. NETWORKING ACTIVITIES

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

Visits
We have recently welcomed a number of national figures to the Trust and have had the opportunity to show them some of our services and discuss how we are addressing some key challenges. Visitors have included:

- Ian Trenholm, Chief Executive of the Care Quality Commission (CQC);
- Sir Chris Wormald, KCB Permanent Secretary at the Department of Health and Social Care and Dr Thomas Waite, Deputy Chief Medical Officer;
- Professor Sir Chris Whitty, Chief Medical Officer;
- Andrea Sutcliffe CBE, Chief Executive and Registrar, the Nursing and Midwifery Council.

I have also continued my programme of visits to a variety of areas across the Trust. Visiting critical care (ward 37) at the Freeman Hospital, I heard about the fundamentals of care that the team there are focused on. My visit coincided with the team finally working together again for the first time since the pandemic – a reminder of how all our staff have been required to work very differently in the last two years. They were a perfect example of how they supported each other, they could rely on each other and had a shared sense of focus to provide the best care that they could for their patients. The patients I spoke to felt that they were in safe, caring and expert hands.

I have also visited the Freeman Day Treatment Centre which is currently under construction and due to open in late Summer. I had the opportunity to go and see how the construction is progressing. It is a great example of how we are thinking differently about the future - it will create a state-of-the-art surgical hub to provide the best care and experience for our patients, as well as a fresh and inspiring work environment.

Research and Innovation
It continues to be a priority to promote and develop our research and innovation work.

In June, I spoke at the second anniversary celebration of our Academic Health Science Centre, Newcastle Health Innovation Partners (NHIP). As well as reflecting on the work done so far, I was delighted that we announced the appointment of Hannah Powell as NHIP's new Chief Operating Officer. Hannah has been working as our Directorate Manager for Clinical

Research and has been instrumental in delivering our research strategy. I know she will be equally effective in her new role, and I look forward to working closely with her as we look to further develop NHIP's impact.

We continue to work closely with our University partners through NHIP and other collaborative projects, and it was an honour earlier this month to attend the joyful inauguration of the new Chancellor of Newcastle University, Imtiaz Dhaker.

Last month's Shelford Group CEO meeting focused on life sciences, and we were pleased to be joined by Roz Campion, Director of the Office for Life Sciences, Lord David Prior and Sir Jonathan Symonds, Non-Executive Chair of GlaxoSmithKline plc. Our Executive Director of Business, Development and Enterprise, Victoria McFarlane-Reid presented a case study on the work of Diagnostics North East during the pandemic and the opportunity to play a leading role in the development of the diagnostic approaches needed to tackle future health challenges.

I am pleased to also report on work to lift the national ambitions around health research being undertaken by the Office for the Strategic Coordination of Health Research (OSCHR). I attended its steering group meeting which the new Chairman, Lord Ajay Kakkar, is effectively developing as an independent forum to link strategic partners together and to inform government policy and spending priorities.

Policy influencing

In a time of political uncertainty and change, I have participated in a number of formal and informal meetings with a range of health policy makers to help ensure Newcastle Hospitals' experience informs national decision-making. These events have included:

- A discussion on 'performance management in an age of integration' at the NHS Confederation Conference;
- A presentation to the Health Devolution Commission, chaired by Andy Burnham, on the role of Shelford Group organisations as anchor institutions;
- Roundtable events with NHS Providers and NHS England to inform work on refreshing the NHS Long Term Plan;
- The NHS Assembly, including discussion of the long-term workforce plan; and
- A joint event on reducing health inequalities with North of Tyne Combined Authority and Legal & General with Sir Michael Marmot.

I continue to maintain relationships across the national health and care policy-making community. When a new Prime Minister is in place in September, I expect there will be significant further activity to ensure our priorities and perspectives are heard.

3. RECOGNITION AND ACHIEVEMENTS

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

Jubilee Honours – Two of our staff were included in the Queen's Platinum Jubilee Honour's List, becoming Members of the British Empire (MBEs) in recognition of the huge contributions they have made beyond their already demanding day jobs. Congratulations to community midwife Diane Buggy and honorary consultant medical oncologist Ruth Plummer.

Lifetime Achievement Award – Huge congratulations to our recently retired hotel services manager, Jackie Thompson, who won an NHS Parliamentary Award for Lifetime Achievement and contribution. Jackie has been a real asset to Newcastle Hospitals and dedicated over 47 years to us – a truly remarkable achievement.

Celebrating Excellence Awards – At the end of May, nominations opened for our Celebrating Excellence Awards which were put on hold for the last couple of years due to the pandemic. The standard of entries has been extremely high, and our judging panel now has the difficult task of going through more than 350 of them in 14 categories! The awards will be held at Newcastle's Civic Centre on 30 September, and we are grateful to our sponsors who are supporting this event.

Nursing Times Awards – I'm delighted to share we have a number of finalists shortlisted in the following categories in the 2022 Nursing Times Awards. The winners will be announced on 26 October.

- Clinical research nursing – using patient and public involvement to improve the clinical pathway for cancer patients in clinical trials during the pandemic.
- Continence promotion and care – RUG: reducing urinary gram-negative blood stream infections.
- Theatre and surgical nursing – student theatre workshop project.

Digital champion – Consultant anaesthetist Dr Adnaan Querishi was also a finalist in this year's National BAME Health and Care Awards, which celebrate the unsung heroes of the NHS and specialist BAME services. He was recognised in the 'Digital Champion' category for his work on creating Newcastle PROMs – a custom online platform to collect, analyse and report patient-reported outcomes following surgery.

NHS Blood and Transplant (NHSBT) – Newcastle University is receiving almost £2million from NHSBT for a cutting-edge research unit focused on organ donation to help improve the outcomes for patients waiting for and receiving transplants. Collaboration between the University and the Trust will be a key part of delivering the unit's aims to increase the number of organs available, improve long-term outcomes and enhance quality of life after transplant.

Sarcoma research – Clinicians and researchers at the North of England Bone and Soft Tissue Tumour Service, which is part of the trust, secured £1.4million from the National Institute for Health and Care Research (NIHR), to trial a method that uses a harmless green dye to illuminate tumours under a special infrared camera. Consultant orthopaedic surgeon Mr Kenny Rankin is leading this research which, ultimately, could reduce the impact of sarcoma surgery on patients.

Community event – Our community teams recently joined together at a special event promoting staff wellbeing, inclusion and engagement. It was organised after staff highlighted, they wanted to feel more connected in their staff survey, with other teams in their directorate and their '*What Matters to You'* work and the event provided plenty of opportunities to share information, proud achievements and quality improvements.

Recognising our healthcare support workers – In June, we celebrated our healthcare support workers with a very special event to say thank you for all that they do and show how much they are valued. Staff were asked to nominate their colleagues for an award with five categories to choose from and you can find out more about the winners https://www.newcastle-hospitals.nhs.uk/news/celebrating-our-healthcare-support-workers/.

Patient milestone – North East and Cumbria's lifesaving 'Blood last on Board' service - a collaboration between the trust, Great North Air Ambulance and volunteers from Blood Bikes Cumbria and Northumbria Blood Bike – held a special reception at the RVI to celebrate treating 500 patients. The event was held for patients who have received blood and their loved ones.

Three decades and counting – Congratulations to the Bubble Foundation who marked their 30th anniversary of becoming a registered charity and thank you for your tireless support to our specialist 'bubble unit' on ward 3 at The Great North Children's Hospital.

4. RECOMMENDATION

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

Report of Dame Jackie Daniel
Chief Executive
19 July 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022		
Title	Digital People Story		
Report of	Maurya Cushlow, Executive Chief Nurse		
Prepared by	Tracy Scott, Head of Patient Experience Alistair Wilson, Hospital Carers Information and Advice Worker Role		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	This month's digital people story shares the lived experience of a visiting carer accessing healthcare services and the personal reflections of a staff carer. It describes: • How carers share their personal lived experiences; and • An introduction to the role of the Hospital Carers Information and Advice Worker (HCIAW). The digital story demonstrates the strategic commitment to supporting unpaid carers, personally and professionally.		
Recommendation	To listen and reflect on the personal experiences of the carers and acknowledge the positive impact of the role of the HCIAW.		
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. Partnerships • Our partnerships provide added value in all that we do.		

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

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

DIGITAL PEOPLE STORY

EXECUTIVE SUMMARY

Carers provide care and support to a family member, friend, partner or neighbour who cannot manage without their help or support because of disability, illness, frailty, mental health needs or alcohol or drug related problems. Carers are a vital and important part of healthcare for many vulnerable and complex patients and can be an essential part of the patient pathway. Well-informed and supported carers help to ensure the best possible health outcomes for patients as well as contributing to prevention and population health.

The NHS Long Term plan pledges to focus on identifying and supporting carers with a wider focus on social prescribing, a more joined up and coordinated approach to care, and improving flexibility and wellbeing of staff. Supporting the Carers agenda demonstrates the Trust's strategic commitment to supporting patients, people and partnerships.

Although the Trust had already signed up to and committed to John's Campaign (https://johnscampaign.org.uk/) we recognised there was additional support needed to help ensure carers and people being cared for were empowered during their healthcare journey.

The Hospital Carers Information and Advice Worker (HCIAW) role is a collaborative role developed in partnership with Newcastle Carers and funded by Newcastle Hospital Charity. It was successfully implemented in June 2021 with the aim to:

- Help identify Carers within hospital settings;
- Deliver timely information and support;
- Enable carers voices to be heard in discussions around care and discharge planning;
- Support better transition to the community; and
- Develop systems to support staff carers.

This month's digital people story shares the lived experience and personal reflections of a visiting carer and a staff carer.

- Bill's Experience

Bill is a full-time carer providing round the clock care for his wife. Bill often compares living and caring for his wife to Groundhog Day, reliving the same events day after day, but over time he has learned to adapt.

Bill was initially introduced to the HCIAW when his wife was admitted to the Freeman Hospital following a collapse at home. The HCIAW worked alongside the nursing team to enable a safe discharge from hospital. Bill explains the signposting information on a range of care agencies and the wide range of forward planning information offered has had a positive impact on their life's journey.

Bill values the ongoing well-being calls having someone at the end of a phone who can offer true empathy and helps him navigate through his journey caring for someone with dementia. Bill's wife, a retired nurse will only react positively to the instruction of nurses in uniform and Bill is so thankful for the excellent support he receives from nursing staff. Bill now has a robust care package in place to support with his wife's personal care and remains in regular contact with HCIAW.

- Michele's Experience

Michele is a practising staff nurse at the Royal Victoria Infirmary (RVI) in addition to being a carer for her mum who has dementia. Michele shares how juggling her responsibilities as a carer and nurse has been a difficult journey; however, she has never wanted to give up nursing. Michele loves her job and feels this has kept her focused and has helped her through some difficult times.

Michele is an active member of the Disability Staff Network and has registered as a carer champion. Being a carers champion has helped her to signpost colleagues and visiting carers to carer resources, promoting the staff carers passport and carer rights at 'Ask Me Anything' events. Michele also shares her experiences and offers carer support through a Facebook support group for people undergoing open heart surgery. Michele and the HCIAW have delivered 'Carer Awareness' sessions to RVI theatre staff.

The support of her line manager has been key to seeing the value of embracing the carer's agenda, which includes the adoption of the staff carer passport. Supporting Michele to attend network group meetings is having a positive impact; new staff carers have been identified, and appropriate support has been offered. Staff have fedback they are now more aware of the challenges carers face when coming into hospital and they now feel empowered to support and signpost to resources to help improve patient and carer experience.

The Trust is committed to maintaining and enhancing a network of carer champions across all directorates and department. A carers champion is a member of staff who is willing to act as a key contact for carer information for the team where they work and represents their department at the carer champion network and forums, bringing any queries or uncertainty for further discussion. Carer champions are active within the Freeman Hospital, the RVI, Regent Point, New Croft Centre and the Integrated COVID Hub North East.

RECOMMENDATION

To listen to Bill and Michele's experience and reflect on the positive impact the role of the HCIAW and carer champions is having on patient and carer outcomes.

Report of Maurya Cushlow
Executive Chief Nurse
28 July 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022						
Title	Trust Performance Report						
Report of	Martin Wilson – Chief Operating Officer & Vicky McFarlane-Reid – Director of Business, Development & Enterprise						
Prepared by	Joey Barton – Senior Performance Manager						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	This paper is to provide assurance to the Board on the Trust's elective recovery progress as well as performance against NHSE priorities for 2022/23 and key operational indicators.						
Recommendation	For assurance.						
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality. Performance – Being outstanding now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☒	☐
Impact detail	Details compliance against NHS England plan priorities for 2022/23. Details compliance against national access standards which are written into the NHS standard contract.						
Reports previously considered by	Regular report.						

TRUST PERFORMANCE REPORT

EXECUTIVE SUMMARY

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

- NHS England operational planning guidance for 2022/23 is target focused, with Newcastle Hospitals submitting trajectories including reducing the number of >104 week waits (ww) to 30 by the end of March 2023, the return of cancer patients waiting >62 days to February 2020 levels and promising substantial progress on the transformation of outpatients throughout 2022/23.
- Provisional data suggests Newcastle Hospitals delivered day case activity equivalent to 92.1% of June 2019 volumes, with overnight elective activity lower at 78.1%. Outpatient activity as a whole was delivered at 99.6% of the levels recorded in June 2019.
- June saw the Trust record an ambulance handover greater than 60 minutes for the first time since February. The Trust did not achieve the 95% Accident & Emergency (A&E) 4-hour standard in June, with performance of 81.2%. Positively, the Trust was compliant with the <2% 12-hour Emergency Department (ED) waits requirement in June.
- The 28-day Faster Diagnosis Standard (FDS) for cancer care has been achieved in each of the past four months, but seven of nine cancer standards fell short of target in May 2022.
- At the end of June, the Trust still had 41 patients waiting >104 weeks, but this represented a 27% reduction from the previous month, and the reduced volume was ahead of trajectory (63). Referral to Treatment (RTT) Compliance was 70.4%.

The Board of Directors is asked to receive the report.

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

Trust Performance Board Report

July 2022

Healthcare at its best with people at our heart

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

Purpose

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

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

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

Report Highlights

- NHS England operational planning guidance for 2022/23 is target focused, with Newcastle Hospitals submitting trajectories including reducing the number of >104 Week Waits (WW) to 30 by the end of March 2023, the return of cancer patients waiting >62 days to February 2020 levels and promising substantial progress on the transformation of outpatients throughout 2022/23.
- Provisional data suggests Newcastle Hospitals delivered day case activity equivalent to 92.1% of June 2019 volumes, with overnight elective activity lower at 78.1%.
  Outpatient activity as a whole was delivered at 99.6% of the levels recorded in June 2019.
- June saw the Trust record an ambulance handover greater than 60 minutes for the first time since February. The Trust did not achieve the 95% Accident & Emergency (A&E) 4-hour (hr) standard in June, with performance of 81.2%. Positively, the Trust was compliant with the <2% 12 hour Emergency Department (ED) waits requirement in June.
- The 28 day Faster Diagnosis Standard (FDS) for cancer care has been achieved in each of the past four months, but seven of nine cancer standards fell short of target in May 2022.
- At the end of June the Trust still had 41 patients waiting >104 weeks, but this represented a 27% reduction from the previous month, and the reduced volume was ahead of trajectory (63). Referral to Treatment (RTT) Compliance was 70.4%.
- A round of Activity Plan meetings were conducted with directorates throughout Quarter 1 (Q1) of 2022/23, led by the Chief Operating Officer and supported by the wider Executive Team. These reviews were focused around the 2022/23 NHSE Planning requirements and scrutinised current elective recovery achievement at specialty level, as well as discussing the support and transformation required to bridge the remaining gap and tackle elective and cancer long waits.

NHSE Plan Requirements 22/23 (1/4)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

2022/23 NHSE Plan Requirements

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

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

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

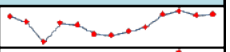
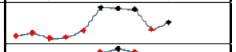
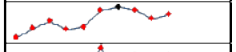
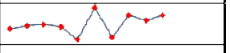
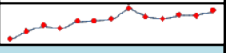
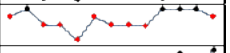
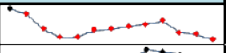
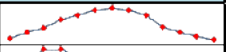
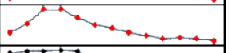
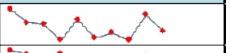
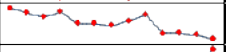
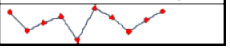
Newcastle Hospitals Response and Trajectories

In response the Trust submitted a draft plan in March 2022 and a final plan in April 2022, with key headlines from the submission including:

- An activity plan representing the combined total of 2019/20 activity baselines, subsequent service developments and planned independent sector usage.
- The most substantial increases compared to 2019/20 were projected in day case activity with the Campus for Ageing and Vitality (CAV) Cataract Centre, independent sector and the planned mobilisation of the new Day Treatment Centre all contributing significantly to this.
- Newcastle Hospitals submitted long waiter trajectories estimated 63 >104WW at the end of June 2022, with this comfortably achieved as there were 41 >104WW in reality. This is forecast to reduce to 30 >104WW by the end of March 2023, with these all expected to be spinal patients. The Trust expects to clear the >52WW backlog ahead of the target set in NHSE's planning guidance.
- MRI and CT are the diagnostic specialties expected to deliver the biggest proportional increase in activity compared to 2019/20 levels.
- Newcastle Hospitals is estimating that in March 2023 the number of cancer patients waiting >62 days will return to February 2020 levels. This is contingent on solving some of the long standing issues in certain tumour groups, such as Lower GI, Urology and Gynae. Compliance with the 28 Day FDS is expected throughout 2022/23 and has been achieved for 4 successive months between February and May 2022.
- Submitted trajectories also show Newcastle Hospitals anticipating substantial progress on the transformation of outpatients throughout 2022/23. The requirement to hold 25% of outpatient appointments virtually is expected to be met throughout 2022/23, and compliance with the 5% target set for patients seen and moved to patient initiated follow-up (PIFU) in March 2023 is also projected. Work continues to identify methods to reduce Outpatient (OP) reviews by 25%, however this target is not expected to be met in 2022/23.

NHSE Plan Requirements 22/23 (2/4)

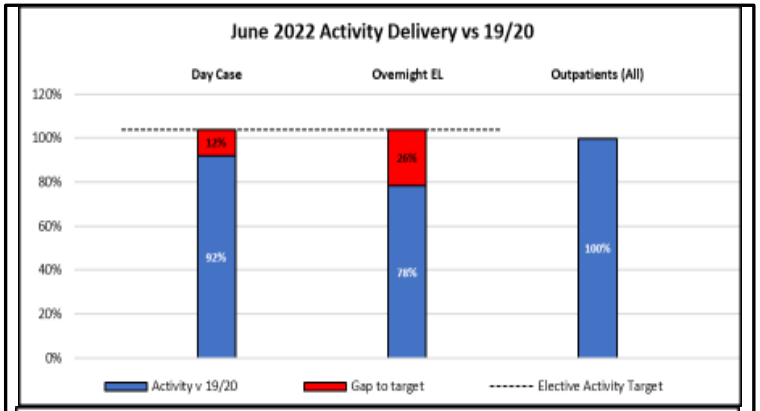
The Newcastle upon Tyne Hospitals NHS Foundation Trust

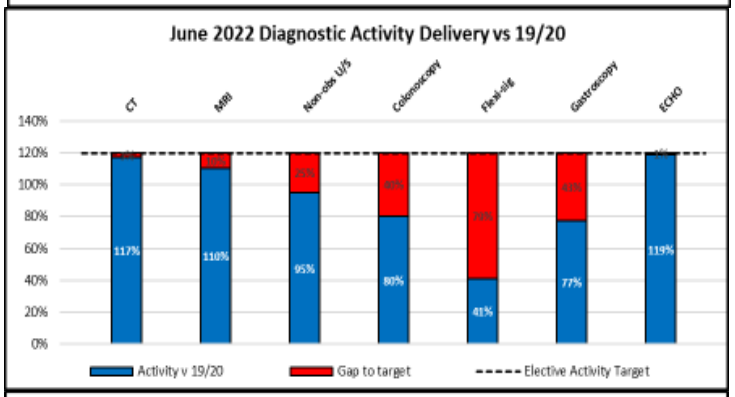
Metric	Requirement	RAG Rating		Mar-22	Apr-22	May-22	Jun-22	Trendline
		Trajectory	Target					
Activity Delivery								
Day Case	104% of 19/20 levels combined (Reviews fixed at 85% of 19/20)			91.8%	92.9%	91.6%	92.1%	
Elective Overnight				69.2%	84.9%	78.4%	78.1%	
Outpatient New				106.0%	97.7%	103.4%	99.6%	
Outpatient Procedures				101.2%				
Outpatient Reviews				104.2%				
Completed Treatments	110% of 19/20 levels			TBC	TBC	TBC	TBC	
Diagnostics*	120% of 19/20 levels			101.0%	103.3%	103.0%	105.8%	
Emergency Care								
Ambulance Handovers	>=65% under 15 mins	N/A		67.5%	68.5%	71.0%	70.0%	
	>=95% under 30 mins			95.9%	96.6%	97.1%	96.8%	
	100% under 60 mins			100.0%	100.0%	100.0%	100.0%	
A&E Arrival to Admission/Discharge	<2% over 12 hours			0.3%	0.5%	0.2%	0.5%	
Cancer Care								
>62 Day Cancer Waiters	Reduce to <=213 by e/o Mar-23			289	385	396	439	
28 Day Compliance	>=75%			83.4%	79.9%	77.6%	TBC	
Elective Care								
>104 Week Waiters	Zero by e/o Jun-22			117	84	56	41	
>78 Week Waiters	Zero by e/o Mar-23			662	722	678	595	
>52 Week Waiters	Reduction (Zero by e/o Mar-25)			3,535	3,636	3,760	4,122	
Outpatient Transformation								
Specialist Advice Requests	16 in every 100 New OP atts.	N/A		7.6%	TBC	TBC	TBC	
Virtual Attendances	>=25% Non-F2F			18.6%	18.7%	18.2%	17.4%	
PIFU Take-up	>=5% of all OP atts. by e/o Mar-23			N/A	0.1%	0.4%	0.8%	
Outpatient Reviews	<=75% of 19/20			110.6%	TBC	TBC	TBC	

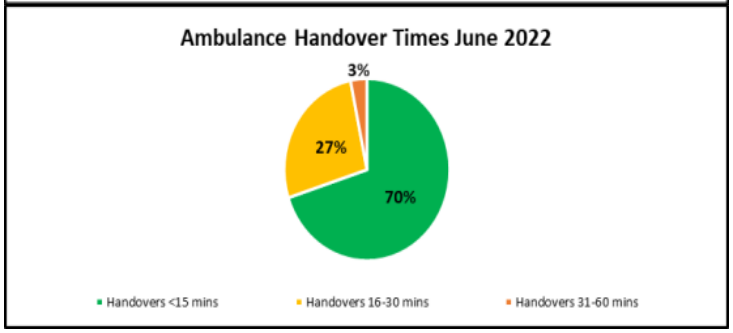
* Applicable to CT, MRI, Non-obs Ultrasound, Gastroscopy, Colonoscopy, Flexi-sigmoidoscopy and ECHO.

NHSE Plan Requirements 22/23 (3/4)

The Newcastle upon Tyne Hospitals NHS Foundation Trust







Activity Delivery

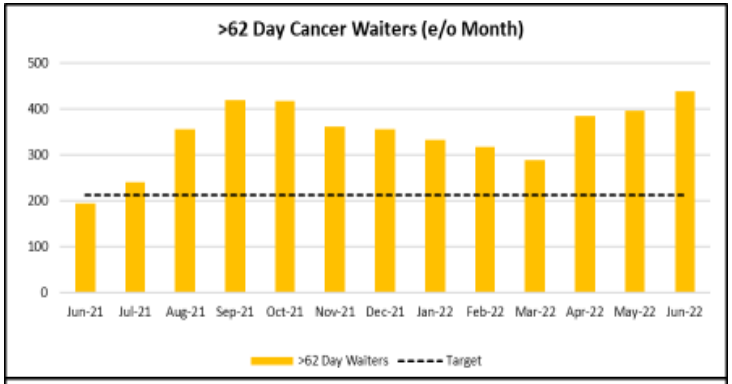
- Provisional data suggests Newcastle Hospitals delivered day case activity equivalent to 92.1% of June 2019 volumes, with overnight elective activity lower at 78.1%.
- Due to internal issues with outpatient activity data, we are currently unable to split outpatient procedure activity from new or review appointments. However for outpatient activity as a whole the Trust delivered 100% of the levels recorded in June 2019. These issues are anticipated to be resolved ahead of the next report.
- Activity delivery in both day case and overnight settings remained similar to May's levels, whilst outpatient recovery has consistently been at or above 100% for many months.
- Due to the aforementioned data issues we cannot state any indicative performance against the 104% value activity target at this time, however the data available is sufficient to be sure that the Trust did not achieve this overall requirement in June.
- Diagnostic activity has been at over 100% of pre-COVID levels for many months, and recovery rose to 106% in June, the highest level for 5 months. However, performance remains short of the 120% target. Whilst the extra capacity afforded by the Community Diagnostic Centre in Blaydon has helped increase activity, even the potential expansion to the Metro Centre is unlikely to provide sufficient capacity to consistently deliver the volume of tests as required by NHSE.
- A round of Activity Plan meetings were conducted with directorates throughout Q1 of 22/23, led by the Chief Operating Officer and supported by the wider Executive Team. These reviews were focused around the 2022/23 NHSE Planning requirements and scrutinised current elective recovery achievement at specialty level, as well as discussing the support and transformation required to bridge the remaining gap and tackle elective and cancer long waits.

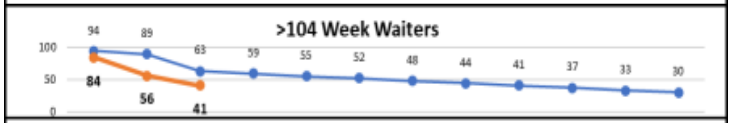
Emergency Care

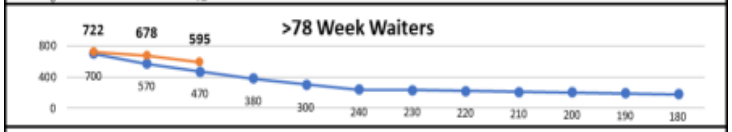
- All ambulance handover targets have been consistently met by the Trust in recent months. There are some data quality issues concerning handover times recorded by the North East Ambulance Service (NEAS) affecting all acute Trusts in the region, and Newcastle Hospitals emergency care team continue to raise these.
- The 12 hour ED wait is a new target measuring time from arrival to admission/discharge, and different to the 12 hour trolley wait target also monitored and for which breaches are very rare for the Trust (the last one was in October 2021). 12 hour ED waits averaged 3 per day in June. Although this is higher than May, Newcastle Hospitals remain compliant with the <2% target.

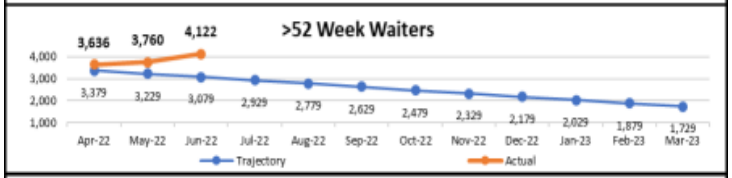
NHSE Plan Requirements 22/23 (4/4)

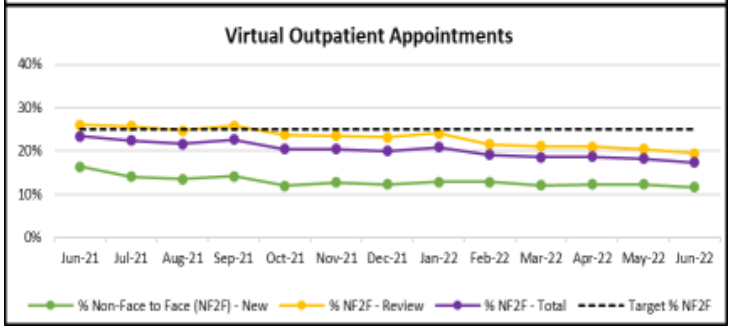
The Newcastle upon Tyne Hospitals NHS Foundation Trust











Cancer Care

- Progress was made in reducing the >62 day backlog in early 2022, largely due to reductions in skin cancer waiters through the use of teledermatology and weekend Waiting List Initiatives (WLIs). However the >62 day backlog snapshot has increased for three successive months, impacted by bank holidays and high staff sickness levels, as well as capacity exceeding demand in some areas. The tumour groups with the biggest backlog growth were Lower GI and Skin.
- The 28 day standard has been achieved in each of the past four months with performance above the Northern Cancer Alliance (NCA) average. Performance against this standard has also benefitted from the aforementioned skin cancer developments.

Elective Care

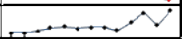
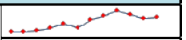
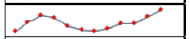
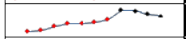
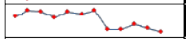
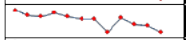
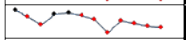
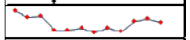
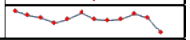
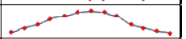
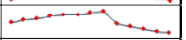
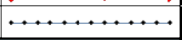
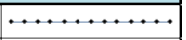
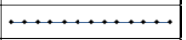
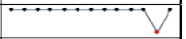
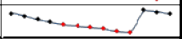
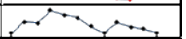
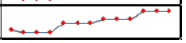
- The total number of >104WW reduced to 41 by the end of June, meaning the trajectory submitted to NHSE to have 63 at this time was comfortably achieved. Only 1 of these patients (an Ophthalmology patient) was in non-Spinal services. A business case is in the final stages of agreement with commissioners to fund an expansion in capacity of Spinal services, which had been severely lacking prior to the pandemic.
- >78WW volumes dropped to 595 in June, representing a 12% reduction in 1 month. However this remains well above trajectory of 470.
- The >52WW rose for the third successive month. This reverses the declining trend seen in Q3 and Q4 of 2021/22 and there are 4,122 >52 week waiters, which is above trajectory.

Outpatient Transformation

- Virtual attendances as a percentage of all outpatient attendances started 2021/22 at greater than 25%, but incrementally declined throughout the year. This trend has continued in Q1 of 2022/23, standing at 17.4% for June. To note, attendance type data for the Trust is currently being underreported nationally – a resolution is expected shortly.
- At 0.83%, PIFU take-up was above trajectory for the first time in 22/23 (0.75%), having increased considerably from 0.44% in May. PIFU outcomes became recordable from mid-April and it is anticipated that figures will continue to increase as services capture encounters where PIFU was already being implemented in all but name.
- Directorates have drawn up initial plans to contribute to the required reduction in review appointments, including wider adoption of advice and guidance provision and one stop clinics. It is recognised that it will not be appropriate for all services to reduce follow-ups at this stage, depending on patient cohorts and volumes of patients on non-RTT waiting lists.

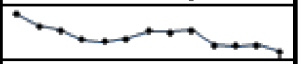
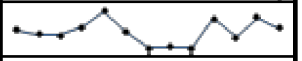
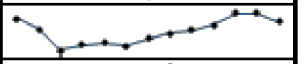
Operational Standards

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Metric	Standard	RAG Rating	Mar-22	Apr-22	May-22	Jun-22	Trendline
Emergency Care							
Ambulance Handovers	Zero >60 mins		0	0	0	1	
A&E Arrival to Admission/Discharge	95% <4 hours		82.2%	82.5%	82.5%	81.2%	
	<2% over 12 hours		0.3%	0.5%	0.2%	0.5%	
Cancer Care							
Two Week Wait (Suspected Cancer)	93%		84.1%	78.5%	79.5%	Cancer data runs one month behind	
Two Week Wait (Breast Symptomatic)	93%		38.0%	53.2%	68.9%		
28 Day FDS	75%		83.4%	79.9%	77.6%		
31 Days (First Treatment)	96%		86.9%	85.5%	83.8%		
31 Days (Subsq. Treat. - Surgery)	94%		66.7%	65.7%	60.2%		
31 Days (Subsq. Treat. - Drugs)	98%		96.4%	95.6%	95.5%		
31 Days (Subsq. Treat. - Radiotherapy)	94%		99.5%	97.6%	95.9%		
62 Days (Treatment)	85%		60.2%	62.4%	58.8%		
62 Days (Screening)	90%		81.0%	72.9%	46.3%		
Elective Care							
18 Weeks RTT	92%		70.1%	69.5%	71.6%	70.4%	
>104 Week Waiters	Zero		117	84	56	41	
>6 Weeks Diagnostic Waiters	1%		18.2%	16.9%	15.9%	15.2%	
Cancelled Ops. Rescheduled >28 Days	Zero		10	7	14	1	
Urgent Ops. Cancelled Twice	Zero		0	0	0	0	
IAPT							
Wait to First Appointment	75% <=6 weeks		98.8%	98.5%	98.0%	97.8%	
	95% <=18 weeks		99.0%	98.7%	99.8%	99.6%	
Movement to Recovery (Overall)	50%		43.7%	44.0%	33.5%	43.4%	
Other							
Duty of Candour	Zero		0	0	0	0	
Mixed Sex Acommodation Breach	Zero		0	0	0	0	
MRSA Cases	Zero		0	0	1	0	
C-Difficile Cases	<=153 (FY cumulative)		169	12	29	42	
VTE Risk Assessment	95%		95.9%	95.6%	95.0%	TBC	
Sepsis Screening Treat. (Emergency)	90% (of sample) <1 hour		90.0%	93.0%	93.0%	93.0%	
Sepsis Screening Treat. (All)			60.0%	63.0%	63.0%	63.0%	

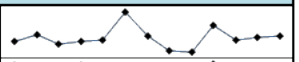
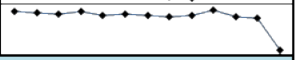
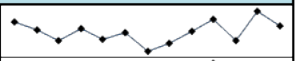
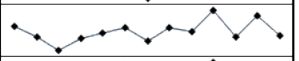
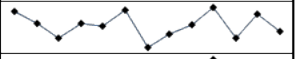
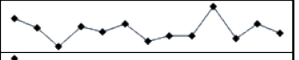
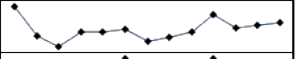
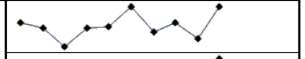
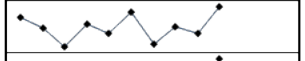
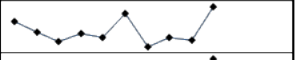
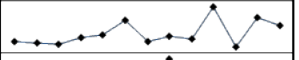
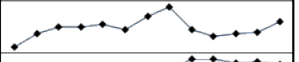
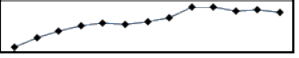
Other Metrics

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Metric		Mar-22	Apr-22	May-22	Jun-22	Trendline
Emergency Care						
Ambulance Arrivals		2,970	2,749	2,852	2,829	
Type 1 Performance (A&E 4 hour)		71.4%	71.0%	71.1%	68.7%	
Type 1 Attendances (Main ED)		13,035	11,716	13,130	12,386	
Type 2 Attendances (Eye Casualty)		1,563	1,446	1,563	1,440	
Type 3 Attendances (UTC)		5,670	5,880	6,624	6,087	
Patient Flow						
Covid Inpatients (average)		74	80	33	47	
Emergency Admissions		6,087	5,571	5,973	5,703	
G&A Bed Occupancy		86.0%	86.0%	86.0%	85.8%	
Critical Care Bed Occupancy		74.8%	79.1%	79.0%	76.1%	
Bed Days Lost (average)		143	114	64	78	
Medical Boarders		66	53	47	40	
Length Of Stay >7 Days		741	775	728	719	
Length Of Stay >21 Days		318	346	320	349	

Other Metrics

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Metric		Mar-22	Apr-22	May-22	Jun-22	Trendline
Cancer Care						
2WW Appointments		2,403	2,117	2,187	2,201	
Cancer First Treatments		541	456	441	TBC	
Planned Care						
2WW Referrals		2,733	2,243	2,924	2,600	
Urgent Referrals		6,286	5,024	6,052	5,107	
Routine Referrals		28,004	23,594	27,114	24,597	
Day Case Activity (Specific Acute (SA))		10,754	8,961	9,758	9,260	
Overnight Elective Activity (SA)		1,883	1,664	1,719	1,752	
New Outpatient Attendances (SA)		30,225	88,195	100,816	93,530	
Review Outpatient Attendances (SA)		77,977				
Outpatient Procedure Activity (SA)		18,077				
Diagnostic Tests		20,659	16,837	19,657	18,844	
Outpatient DNA Rate		7.9%	8.0%	8.1%	8.5%	
RTT Waiting List Size		97,447	96,321	96,526	95,901	

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Performance Success Stories

Trust Board

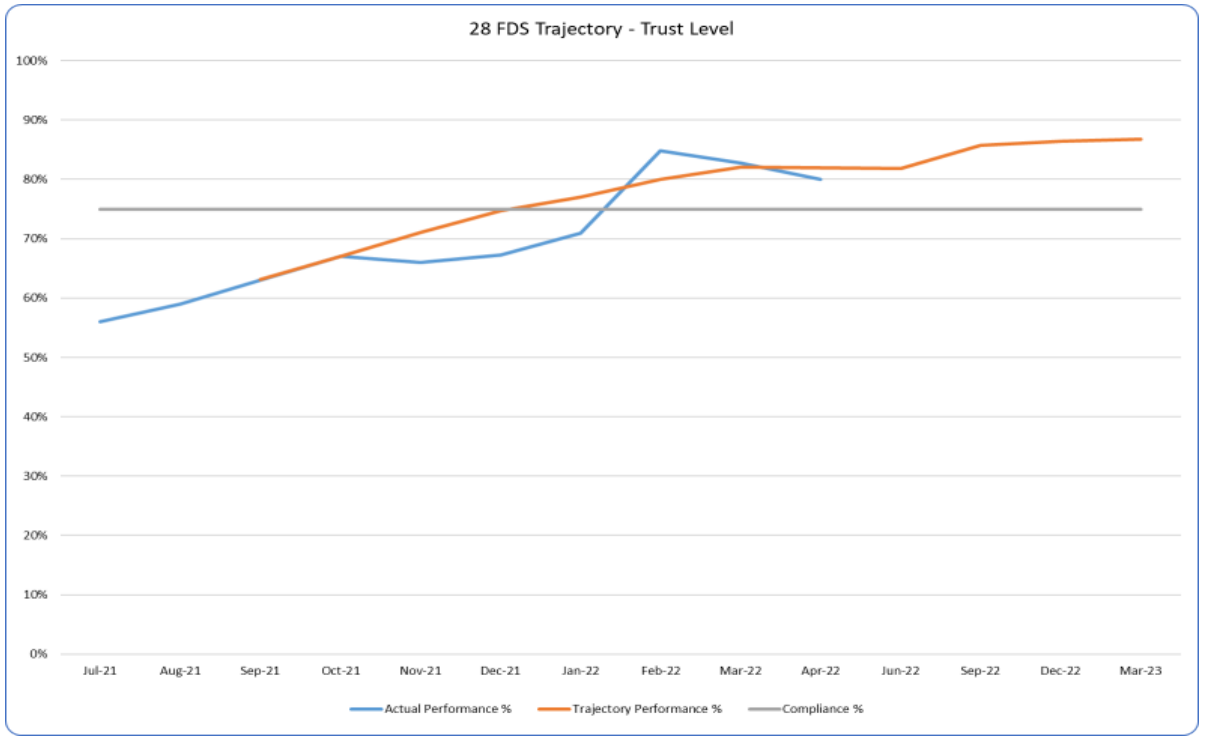
28 July 2022

Healthcare at its best
with people at our heart

28 Day Faster Diagnosis Standard (FDS)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

The Faster Diagnosis Standard is designed to ensure patients will be diagnosed or have cancer ruled out within 28 days of their referral. The Target for systems is to achieve 75% compliance.



SHELFORD BENCHMARKING – 28 DAY FDS – APRIL 2022			
Cambridge University Hosps	80.6%	Guy's and St Thomas'	67.5%
NUTH	79.9%	Sheffield Teaching Hospitals	64.8%
King's College Hospital	76.0%	UCL Hospitals	64.5%
Oxford University Hospitals	74.1%	University Hosps Birmingham	60.7%
Imperial College Healthcare	73.5%	Manchester University	53.4%

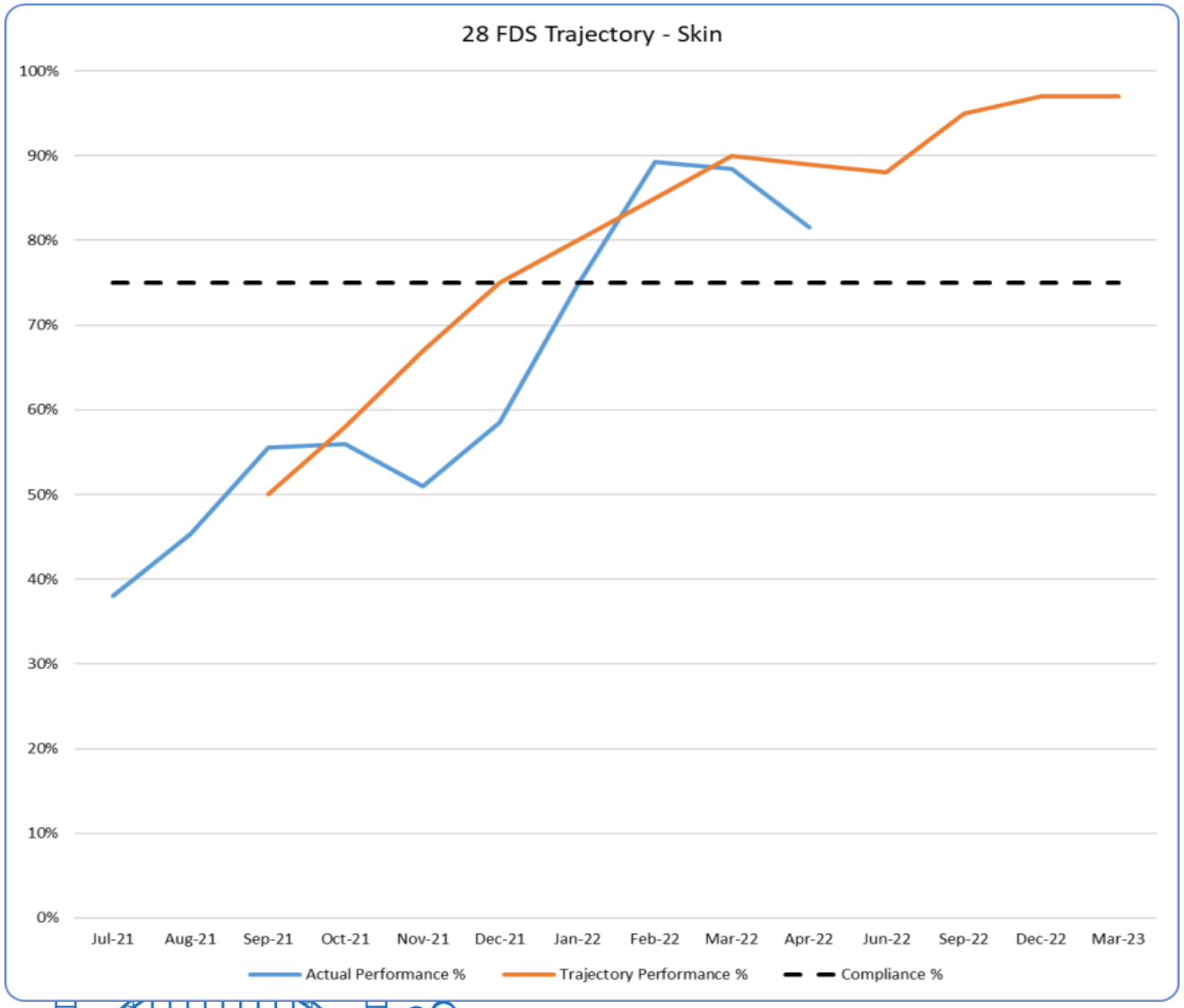
Newcastle Hospitals has exceeded the 75% compliance requirement since January 2022 and compares well against other Shelford Trusts.

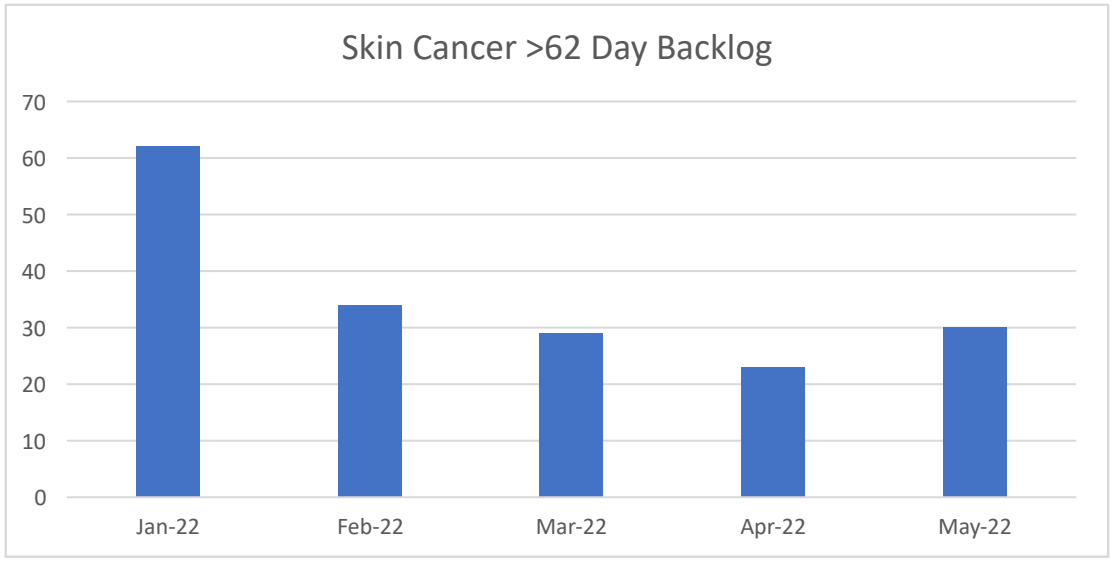
The highest performing tumour groups are breast and head and neck.

'The Corporate Cancer Services team have been working with tumour groups for the last couple of years to raise awareness and educate regarding the rules around the 28 day FDS' – Louise Hobson, Cancer Modernisation Lead.

Skin cancer performance

The Newcastle upon Tyne Hospitals
NHS Foundation Trust



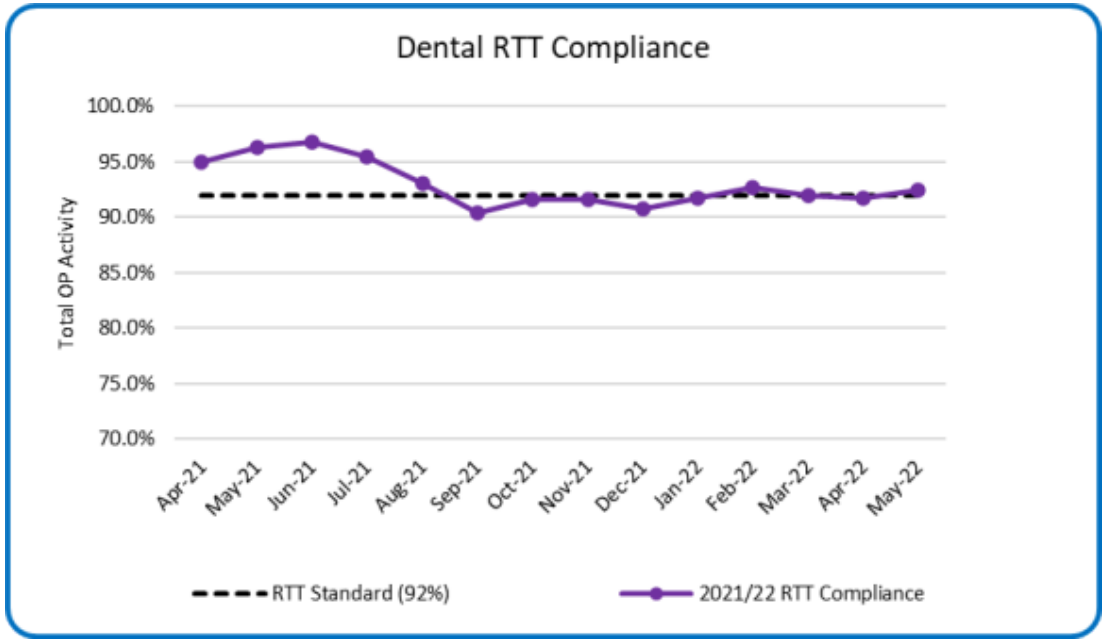


Skin cancer has been one of the most challenged tumour groups and has recently made huge improvements in its performance against the 28 day FDS and halved the backlog of patients on the 62 day cancer pathway since January 2022.

Referral to Treatment Times (RTT) - Dental

The Newcastle upon Tyne Hospitals NHS Foundation Trust

The NHS Referral to Treatment (RTT) target is for 92% of patients on an RTT pathway to be treated within 18 weeks of a GP referral. The overall Trust position in May 22 was 71.6%.



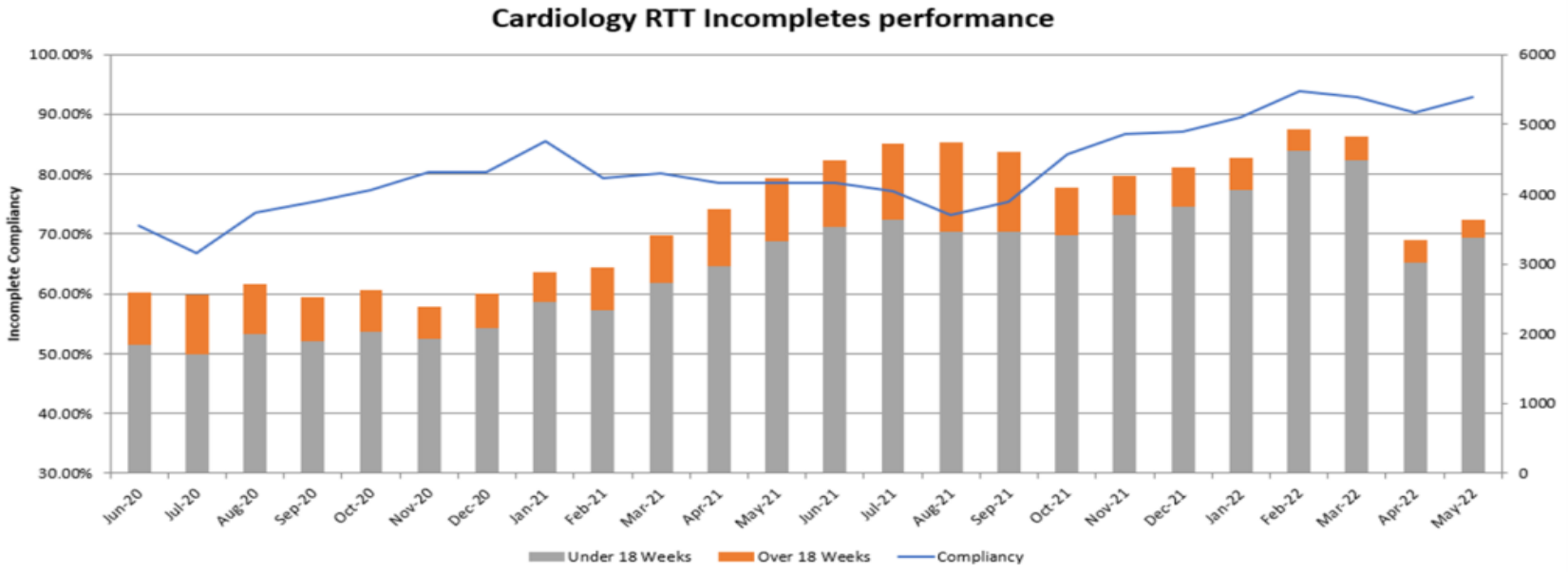
Dental services have stayed closer to this target than any other directorate during the pandemic, only marginally missing the 92% on a few occasions in the last 12 months. They also have no >52 week waiters.

'*The staff in the dental directorate have worked incredibly flexibly and collaboratively… to help us achieve and sustain our 18-week RTT position*' – Karen Parker, Assistant Directorate Manager for Dental Services.

May 2022 Dental Services Long Waiters		
	>40 Weeks	>52 Weeks
Oral Surgery	2	0
Restorative Dentistry	0	0
Paediatric Dentistry	0	0
Orthodontics	0	0
Maxillo-Facial Surgery	1	0
Dental Medicine Specialties	0	0
Dental Services Total	**3**	**0**

RTT – Catheter labs

The Newcastle upon Tyne Hospitals NHS Foundation Trust



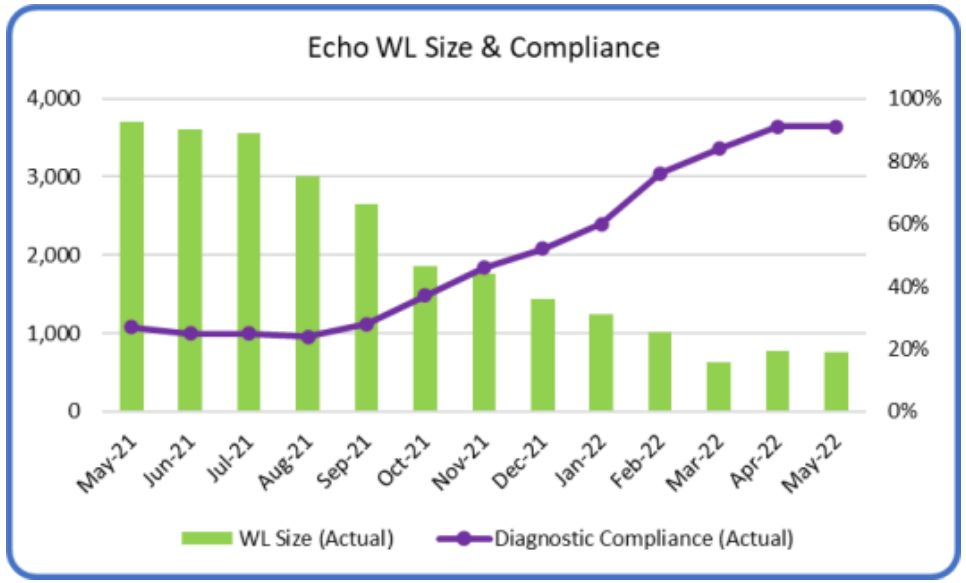
With the use of a mobile catheter lab the Cardiology Department have managed to reduce the waiting times for planned procedures, whilst maintaining an emergency service and with two of the Hospital cath labs under refurbishment. RTT compliance for May 2022 was slightly above 92%.

'With the additional support of InHealth mobile lab… they have established extremely good working relationships and seamless patient transitions to ensure a positive experience for our patients and staff… The feedback we have received from all visiting staff is they have loved working here and were warmly welcomed in the North East' – Leanne Dodd, Deputy Directorate Manager for Cardiothoracic Services.

Diagnostic waiting times - Echocardiogram

The Newcastle upon Tyne Hospitals NHS Foundation Trust

The diagnostic waiting time target is for 99% of patients to receive their diagnostic test with 6 weeks of referral.

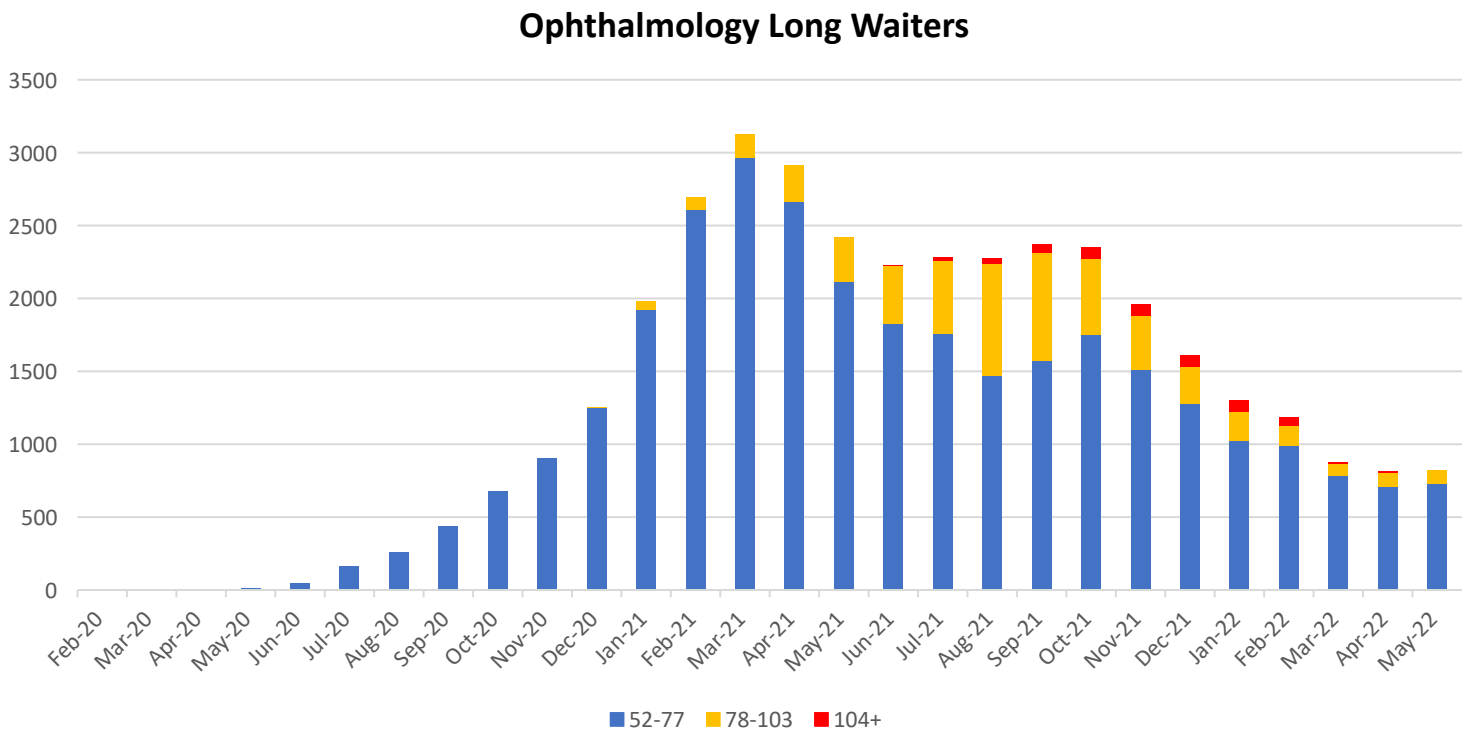


The cardio team saw a reduction in echo capacity due to recommended changes in the volume of work physiologists should carry out, coupled with a rise in demand for echo diagnostics.

Working with 4 insourcing companies, at weekends and evenings, the department have reduced the number of patients waiting from almost 4,000 to under 1,000 in the last 12 months and in May 2022 were 91% compliant with the diagnostic target, compared to just over 20% in May 2021.

'Echo continue to maintain waiting times with an excellent piece of capacity and demand work and have managed to reduce the volume of insourcing to two companies at a controlled number of additional patients to meet demand and are continuing to maintain the diagnostic target until recurrent investment can be confirmed' - Leanne Dodd, Deputy Directorate Manager for Cardiothoracic Services.

Long waiters



The Trust is managing the largest number of long waiters within the Integrated Care System (ICS). In Ophthalmology the number of long waiters has been reduced from >3,000 in March 2021 to <1,000 in May 2022.

Treating more than 2,000 of the longest waiters in 12 months.

'Through meticulous planning and joint working… the ophthalmology department has been able to make a significant difference to the backlog of patients waiting for care and treatment. This has been achieved by the total transformation of the delivery of cataract surgery and the commitment of the team involved' – Claire Pinder, Directorate Manager for EPOD.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022		
Title	NIHR CRN NENC Annual Business Plan (And Financial Plan) 2022-23 and Annual Report 2021-22		
Report of	Andrew Welch, Medical Director		
Prepared by	Chris Speed, NIHR CRN NENC Deputy Chief Operating Officer Morag Burton, NIHR CRN NENC Chief Operating Officer Caroline Wroe, NIHR CRN NENC Clinical Director		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☐
Summary	The Trust submits the National Institute of Health Research, Clinical Research Network North East and North Cumbria (CRN NENC) annual plan, annual financial plan (2022/23) and annual report (2021/22). CRN NENC has created a local plan. This plan identifies the activities to be carried out within the North East and North Cumbria region in accordance with the Performance and Operating Framework, CRN NENC Contract with the Department of Health and Social Care (DHSC). It also takes the priority areas/themes from the single national plan and aligns work to this. Also submitted to the Board and included in the Board Reference Pack is the CRN NENC annual report for 2021/22. The report on progress uses a national format and works to a national timeframe for submission to the Coordinating Centre. The annual report was submitted to NIHR CRN Coordinating Centre in Quarter 1 (Q1) 2022/23 as required, post submission approval for the report from Trust Board is sought. The CRN NENC Annual Business Plan and Financial Plan are no longer required to be approved by the Host Trust Board. However, the Trust feel that it is important that the Host Trust Board has sight of the planned activity and an opportunity to endorse it, therefore the Trust is submitting the plans for local approval. The Trust also submit the annual report detailing some of the areas of work completed in support of the annual plan approved by the Board of Directors in 2021.		
Recommendation	The CRN NENC Annual Business Plan and Financial Plan included in the Board Reference Pack are no longer required to be approved by the Host Trust Board. However, the Trust feel that it is important that the Host Trust Board has sight of the planned activity and an opportunity to endorse it, therefore the Trust is submitting the plans for local approval. The Trust also submit the annual report detailing some of the areas of work completed in support of the annual plan approved by the Board of Directors in 2021.		
Links to Strategic Objectives	N/A		

Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☒	☒	☒	☒
Impact detail	As detailed in the report.						
Reports previously considered by	Annual Plan - New report - for Trust Board approval. Annual Report - New report - for Trust Board approval.						

NATIONAL INSTITURE OF HEALTH RESEARCH CLINICAL RESEARCH NETWORK NORTH EAST AND NORTH CUMBRIA (NIHR CRN NENC) ANNUAL REPORT 2021/22

EXECUTIVE SUMMARY

This report provides a summary of the CRN NENC Annual Business Plan, Annual Business Plan and Annual Report which are included in the Board Reference Pack.

Annual Plan

Quality: A number of digital quality improvement initiatives are planned.

Finance: The report details the spend of the annual budget allocated to CRN NENC to best achieve value for money.

Human Resources: Almost 850 staff are employed using the budget of CRN NENC annually and the core team continues to grow the centralised research delivery function to expand wider into supporting research in settings outside of secondary care.

Equality & Diversity: Planned work to support this includes recruiting Research Champions from communities currently underserved by research & cultural competence training.

Reputation: CRN NENC funding and development work is significantly linked to the Host organisation. It gives it the opportunity to position itself as an innovator as well as an advocate for and deliverer of research. The continued partnership working of the LCRN with other regional and national NIHR infrastructure and local partners e.g. AHSN mirrors the Host Trust aspirations in relation to both Newcastle Health Innovation Partners and Collaborative Newcastle.

Sustainability: The CRN NENC contract ends in March 2024. Work is already underway to support the Trust retain its Host status for the Research Delivery Network which will replace the CRN. Continuity in this process will underpin the ongoing sustainability of research workforce in the region, and continued partnership with Life Sciences Industry and Small to Medium Enterprise result in further regional investment.

Annual Report

Quality: The first patient recruited into a study is taken as being a quality marker. To achieve a 'first' partner organisations need to have slick and streamlined processes in place. The Trust is pleased to report that it had several 'Commercial First Patients Recruited' (Study level) - 2 Global, 1 European and 13 in the UK.

Finance: As a region the Investigator Initiated Trials and MedTech Studies have once again been highly successful. The MedConnect North service supported funding applications totalling

£2,862,720.00. Over 90% of these funding applications were successful securing. This has secured an additional £2,581,222 of funding for the region.

Human Resources: The core Direct Delivery Team, increased staffing levels and now is on hand to offer support to deliver community based research activities.

Equality & Diversity: In a bid to support inclusive research that is of relevance to the local communities the Trust ran another successful call in the 'Targeting Health Needs Awards'.

Reputation: CRN NENC is once again seen as a leader in research in non-NHS settings and supported by the Host, achieved its operational ambition of setting up contracts with three Local Authorities.

Sustainability: Successful partnership between CRN NENC and Newcastle and Exeter Universities to develop the NIHR Academy of Medical Royal Colleges Clinician Researcher Credentials Framework. This has resulted in 2 Postgraduate Certificate courses which will assist in increasing research awareness for the future.

NATIONAL INSTITURE OF HEALTH RESEARCH CLINICAL RESEARCH NETWORK NORTH EAST AND NORTH CUMBRIA (NIHR CRN NENC) ANNUAL REPORT 2021/22

1. BACKGROUND

The National Institute for Health Research Clinical Research Network (NIHR CRN) is the clinical research delivery arm of the NHS in England and has been hosted by The Newcastle upon Tyne Hospitals since 2014. Its purpose is to ensure patients and healthcare professionals from all parts of the country can participate in and benefit from clinical research; integrate health research and patient care; improve the quality, speed and coordination of clinical research; increase collaboration with industry partners and ensure that the NHS can meet the health research needs of industry.

The CRN is intended to fund research infrastructure throughout the region - predominantly research delivery staff for example research nurses in all of the Partner Organisations and service support department staff e.g. pharmacy technicians. In the North East and North Cumbria, this currently funds approximately 798 people comprising 271 Nurses, Midwives and Allied Health Professionals (NMAHPs), 234 Medical Staff, 188 Research Delivery Support Staff and 104 Operational Management and Study Support Staff.

In January 2018, the remit of the CRN was widened by the new National Director to incorporate both Public Health and Social Care Research and in October 2018 it also took over the national payments administration of Excess Treatment Costs on behalf of NHS England. The staff the Trust fund have traditionally been NHS staff but increasingly this is branching into Local Authorities and the non-NHS sector. The Trust engages actively with local HEIs, Life Sciences Industry, including Small to Medium Enterprises (SME), and with other local research infrastructure for example NIHR Applied Research Collaborative (ARC), Academic Health Sciences Network (AHSN), NIHR Med Tech and Invitro Diagnostics Collaborative (MIC).

The Host holds contracts with providers in the NENC region of varying financial levels:

12 Category A Partners (>£50,000 annual funding)
3 Category B Partners (£10,000 - £50,000 annual funding)
280 Category C Partners (<£10,00 annual funding)

CRN NENC is governed by the Performance and Operating Framework (POF) contract which the Host has agreed to. This clearly outlines the areas of responsibility each year and the rules in relation to finance and operations. There are several sub-sections within this:

- Governance and Management
- Financial Management
- CRN Specialties
- Research Delivery
- Information and Knowledge

- Communications
- Patient and Public Involvement and Engagement (PPIE)
- NHS Engagement
- Workforce Learning and Organisational Development
- Business Development and Marketing

The Annual Business Plan and Finance Plan (CRN North East and North Cumbria 2022-23 Annual Financial Business Plan) outline all proposed activities to deliver the POF each year. Although submission of a local plan is no longer a requirement for CRN CC a local plan has been compiled to detail the planned work that supports the POF and states out local Operational Ambitions.

2. ANNUAL BUSINESS PLAN & FINANCE PLAN 2022-23

The Annual Plan is structured using the pervious national template with standardised sections and requirements. This year there are 3 distinct sections of note:

1. CRN NENC Operational Ambitions
2. LCRN Initiatives
3. Specialty Group Initiatives

Each of the entries in the plan aligns with the current Performance and Operating Framework, NIHR CRN Priorities Document, delivery of the NIHR CRN High Level Objectives and all relevant national Contract Support Documents (of which there are currently 55 in use).

The Annual Finance Plan has a separate document describing the financial allocations at a high level and for reference a more detailed document has been attached describing the monetary allocations to each of its Partners.

3. ANNUAL REPORT 2021/22

The Trust Board approved annual delivery plan for 2021/22 identified the activities that were to be carried out within the North East and North Cumbria region in accordance with the Performance and Operating Framework CRN NENC Contract with the Department of Health and Social Care.

During the annual cycle CRN NENC monitors progress on a quarterly basis against the annual plan and the agreed key performance indicators required (High Level Objectives (HLOs)). Historically the template mandated for the annual business plan formed the basis for the annual report, with each entry in the plan receiving its own commentary on status/progress at year end.

In addition to the HLOs the Trust set a number of local Operational ambitions to reflect the local priorities and achieved 100% compliance with these and submit them for information.

Since the COVID-19 Pandemic the Coordinating Centre agreed with the DHSC that a revised and streamlined reporting process be implemented, and it is that we share with you here along with the selected highlights below.

4. RECOMMENDATION

The Board is asked to approve the Annual Business Plan and Annual Financial Plan for CRN NENC for 2021-22.

Report prepared by Chris Speed, Morag Burton and Professor Caroline Wroe, on behalf of Dr Andrew Welch, Medical Director
30 June 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022						
Title	Medical Director's Report						
Report of	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Prepared by	Andy Welch, Medical Director/ Deputy Chief Executive Officer						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The Report highlights issues the Medical Director wishes the Board to be made aware of.						
Recommendation	The Board of Directors is asked to note the contents of the report.						
Links to Strategic Objectives	Putting patients at the heart of everything we do and providing care of the highest standard focusing on safety and quality.						
Impact (Please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☐	☐
Impact detail	Detailed within the report.						
Reports previously considered by	This is a regular report to Board. Previous similar reports have been submitted.						

MEDICAL DIRECTOR'S REPORT

EXECUTIVE SUMMARY

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

- Quality & Patient Safety Update;
- Cancer Update;
- Education and Training Update;
- Research Update; and
- Mental Health Update.

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

a) Quarterly Guardian of Safe Working Report; and
b) Consultant Appointments.

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

MEDICAL DIRECTOR'S REPORT

1. QUALITY AND PATIENT SAFETY

Recent activities include:

- Refreshment of the deteriorating patient strategy.
- Comprehensive presentation of the National Patient Safety Strategy (NPSS) at the Board Development Day held on 30 June - NPSS Steering Group has been established. Three major threads are:
    - Insight (replacing current Serious Incident (SI) framework);
    - Involvement (including patient safety partners); and
    - Improvement (implementing change).
- Digital – successful roll out of e-obs in Paediatrics; developments with industry on solutions to acting upon abnormal results in radiology; development of harm free care dashboards for ward; approaching conclusion of integration of internal guidance with BMJ Best Practice to provide outstanding decision support within e-record.
- NICE – improving position with respect to risk of non-compliant guidelines, including antimicrobial stewardship (previously the highest rated risk) and other longstanding risks following appointments to nurse specialist posts in young person's epilepsy and autism service.
- Quality Strategy interim extension to 2023 released by Clinical Governance and Risk Department (CGARD).
- Ockenden – covered under agenda item A8(b)(i).

2. COVID

Key points to note:

- 115 inpatients at time of writing with approximately half being treated for COVID.
- There has been an increase in COVID cases across the country, most of which due to infections with BA.4 and BA.5 strains. Whilst is it clear that new variants will continue to emerge, it is less clear what the impact of new waves will have in the wider population. Without a seasonal pattern of spread it will be difficult to plan ahead for shifts in prevalence.
- Now need to be proactive in ensuring that we can deliver activity during ongoing waves without seasonal predictability.
- Further COVID booster programme announced.
- The influenza vaccination programme will start in the autumn.

3. CANCER UPDATE

Key points to note:

- Cancer Waiting Time (CWT) referrals are above pre-Jan 2019 levels for first time which has presented significant challenges.
- Whilst there has a stabilisation in the majority of cancer performance targets, there has been a reduction in 62-day CWT performance – 65% to 58.5% (85%). This is due to multiple factors - staffing, beds, ITU capacity and delays in diagnostic tests particularly computerised tomography (CT) and Endobronchial ultrasound scan and biopsy (EBUS). Work is ongoing to improve the cancer pathways with weekly scrutiny via the trust Patient Tracking List (PTL) Group. There is a national focus on 62 day; performance and the National team have recently introduced a 3-tier oversight system. We have been informed that Newcastle Hospitals will be tier 2 which is regional oversight.
- The fall in the 62-day performance from 65% to 58.5% (85%) has been largely contributed to by pressure in Dermatology with 330 referrals in the last week alone. The teledermatology service is being fully utilised and the team continue to undertake Waiting List Initiatives (WLIs). The clinical capacity has been further reduced by the retirement of a senior experienced consultant. Neighbouring Trusts have no added capacity.
- There has been a reduction in the percentage of urgent cancer PTL beyond 62 days from 15.2% to 14.3% but further improvement is essential. There are currently significant delays in CT colonography. Extra capacity has been created to clear the backlog which will significantly improve our position. A regional task and finish group has been established to streamline Urology pathways.
- 14-day GP 2-week wait is 79.5% (85%).
- 31-day first treatment remains at 82.8% (95%).
- 31-day subsequent treatment - Surgery has fallen slightly from 63.5% to 61.0 % (94%).
- Chemotherapy has improved from 93.1% to 95.5% (98%).
- Radiotherapy continues to perform well at 96.2% (94%).
- The 28 FDS (Faster Diagnosis Standard) has been achieved at 77.7% (75%).
- The Corporate cancer team continue to work with each tumour group to enable performance recovery.

4. EDUCATION AND TRAINING

Key points to note:

- Requests were made from Health Education North East (HEE-NE) for additional Foundation doctors from August 2022 (oversubscription) as a result of expansion in medical school numbers. The Trust was unable to take up any posts due to lack of funding.
- Foundation expansion (i.e., permanent posts) will start from August 2023. It is likely that Trusts who have accepted 'oversubscribed' foundation trainees will be asked if these can be made permanent. However, there may be additional posts offered. Finance Directors have been made aware of this.
- Trainee expansion: The Trust has accepted training post numbers in the following specialities:

  - 2 radiology
  - 2 medical oncology
  - 2 clinical oncology
  - 1 respiratory medicine (12 months only)
  - 1 dermatology
  - 4 anaesthetic posts were declined due to lack of funding
- Trusts are often being given little notice about expansion in specialties.
- Changes to curricula in specialities will have service implications. Where changes are known, working groups have been established to work out these implications. This is happening in paediatrics with the "shape of training". There may be a need for additional trust doctors to fill any gaps created.
- Self-development time has been increased for Foundation Year 1 trainees with effect from August 2022. This will remove them from service for approximately 2 hours per week per trainee – increased from 1 hour per week. This affects 74 trainees. Self-development time for Foundation Year 2 doctors (x74) remains static at 3 hours per week. This has led to a reduction in the number of doctors in training on wards with consequent service pressures.
- Self-development time is being introduced for Internal Medicine trainees, again meaning less time on the ward. This is 2 hours per week.
- Self-development time has been suggested for Emergency Department (ED) trainees but is not yet compulsory. It is likely to be so in the future. A similar pattern is likely to follow for other specialities.
- Trusts are required to include prospective cover for study leave in rotas. Rotas currently allow for prospective cover for annual leave only. Including prospective cover for study leave will lead to additional staffing pressures.
- A working group is being set up to explore the implications in the medical directorate. This will involve representation from the Clinical Director, Directorate Finance Manager, Director of Medical Education, and Human Resources (HR).
- The General Medical Council (GMC) training survey 2022 has closed. Results are expected to be available in the latter half of July 2022.
- A Chief Medical Registrar has been appointed. This is a post linked with the Royal colleges and involves a 50% clinical role, and 50% quality improvement.
- The first directorate/specialty education quality meetings took place on Thursday 12 May with representation from the medical education quality team (undergraduate and postgraduate), and a Non-Executive Director. Obstetrics and gynaecology, and respiratory medicine at the Royal Victoria Infirmary were assessed. This involved a review of all GMC domains. A rolling programme has been established.

5. RESEARCH

Key points to note:

- In April and May 2022, 1,180, participants were reported as recruited to Trust studies.

- Two notable recruitment achievements since the last update include:
  - The Cardiovascular Research Team recruiting the first patient in the UK into the GOLDILOX-TIMI 69 study.
  - The Stroke Research Team recruiting the first patient in the EU into the MASTERS-2 study.
- The recently published *LCRN Commercial Portfolio Research Report for 21/22* highlights excellent performance with regards to Trust management of commercial research.
- News still awaited with regards the National Institute for Health and Care Research (NIHR) Patient Safety Research Collaboration bid.
- Research governance - we are still awaiting a date for a Medicines and Healthcare products Regulatory Agency (MHRA) inspection of us as a sponsor which we have been notified to expect before the end of September 2022. The main risk with regard to the lack of Paperlite implementation in research has been mitigated as much as possible (whilst still not having implementation) with the Trust Information Management & Technology department supporting several specific issues.
- New configuration for the NIHR Research Delivery Network confirmed - boundaries coterminous with NHS Regional Office boundaries.
- The selection process for organisations to host the regional networks, after the current contracts expire in March 2024, will commence this October. The process will be run by the NIHR Clinical Research Network Coordinating Centre.

6. MENTAL HEALTH

- New, honorary Associate Medical Director (AMD) role appointed 1 August 2021. Remit: to raise awareness and influence Trust developments in relation to mental health. Goals: to make Mental Health (MH) everyone's business, to develop a MH strategy for the Trust, to set gold standard for coproduction and involvement and develop a webpage to launch and showcase strategy and drawing together all existing resources coherently.
- Driven primarily by recommendations of National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Treat As One 2017 and Care Quality Commission (CQC) report on themed MH reviews, Assessment of Mental Health Services in Acute Trusts (AMSAT) 2020 advising every trust should have board level leadership.
- Current situation - multitude of unconnected services providing MH support in Newcastle Hospitals, including Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust psych liaison team, health psychology, alcohol liaison, staff wellbeing, Chaplaincy, research collaborations etc.
- Overarching Trust strategy touches on MH but could go further - steering group established to develop a collaborative coproduced strategy. Patient/carer involvement recruited to steering group and expert reference group established May 2022; next meeting July.
- Presentations to brief and engage colleagues to Executives, Board, Directorate Managers and Governors. Additional focus on inequalities. Excellent support for steering group and strategy gathered along the way.

- Next steps - focus groups for staff and patients co-facilitated by highly skilled patient carer representatives.
- Continued engagement with directorates to ensure MH considered for all developments (staff as well as patients).

7. BOARD REFERENCE PACK DOCUMENTS

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

c) Quarterly Guardian of Safe Working Report; and
d) Consultant Appointments.

8. RECOMMENDATION

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

A R Welch FRCS
Medical Director
19th July 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 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 Trust Catering Services; • Professional Nurse Advocate Implementation; • Nursing and Midwifery Staffing; • Freedom to Speak up Guardian; and • Nursing, Midwifery and Allied Health Professions (AHP) Strategy Launch						
Recommendation	The Board of Directors is asked to note and discuss the content of this report.						
Links to Strategic Objectives	• Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. • We will be an effective partner, developing and delivering integrated care and playing our part in local, national and international programmes. • Being outstanding, now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☐	☒	☐	☐
Impact detail	Putting patients first and providing care of highest standard.						
Reports previously considered by	The ECN Update is a regular comprehensive report bringing together a range of issues to the Trust Board.						

EXECUTIVE CHIEF NURSE REPORT

EXECUTIVE SUMMARY

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

Section 1: This month's 'Spotlight' section outlines the work of our Trust Catering Teams who provide services for both our patients and staff. The section provides an overview of the team's challenges and successes over the last 12 months.

Section 2: Provides an update on the development and implementation of the Professional Nurse Advocate (PNA) role. In March 2021, the PNA role was launched by the Chief Nursing Officer for England/NHS England/Improvement and this section provides an overview of Trust implementation to date.

Section 3: This is the regular nurse staffing report, which highlights any areas of risk and details actions and mitigation to assure safer staffing in line with the agreed escalation criteria. The Board of Directors have previously been informed of additional measures implemented in line with the Trust safer staffing escalation framework and these remain in place. COVID-19 related absences are increasing, and this is impacting on the ability to maintain safe staffing levels.

Section 4: Provides key issues from the Freedom to Speak Up Guardian. The full report was presented to the People Committee on 23 June 2022.

Section 5: Provides an overview of the launch of our new Nursing, Midwifery and Allied Health Professionals Strategy. This new strategy has been developed in collaboration with our workforce and there is an extensive communications and engagement plan to support embedding this new strategy in practice.

RECOMMENDATION

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

EXECUTIVE CHIEF NURSE REPORT

1. SPOTLIGHT

Facilities is made up of four key departments with 1,090 staff consisting of Hotel Services, Catering Services, Portering and Security staff. These staff are integral to the safe and effective delivery of care to patients and to staff in their daily work.

This spotlight section will focus on our Catering Services who support both patients and staff to have access to high quality catering services which meets individual needs. The catering team consists of 184 members of staff over three sites.

Like many parts of our Trust, the Catering department have been challenged by the impact of the pandemic but throughout this time the team has continued to deliver all core services. Staff have consistently demonstrated their loyalty and pride, even at the height of the pandemic when absence levels rose to around 24%. This was hugely challenging, yet the team continued to provide a full professional and outstanding service throughout ensuring patient safety and staff well-being was not compromised.

1.1 Patient meal service

The link between nutrition and hydration and a person's health is fundamental no matter what stage of life. This is particularly so during times of ill health and vulnerability where malnutrition and dehydration are both causes and consequences of ill health. Whilst the assessment of individual patients' nutrition and hydration requirements lies with our clinical staff, the catering team are vital in meeting the needs of our patients. The team provide over 3,400 patient meals across our sites every day, changing the meal choices to meet individual needs and religious requirements such as Ramadan. The catering team more recently catered afternoon tea for our patients in celebration of the Queens Platinum Jubilee which was enjoyed by many.

The catering team's goal is to remain at the forefront of nutritional food service delivery to patients - "food is medicine". The team are in the process of exploring how they can expand the existing food services and menu choices, working with the dietitians to ensure the correct requirements and calories are incorporated in the patient's diet. The team aim to introduce an electronic meal ordering (EMO) system, which will significantly improve the patient experience whilst reducing food waste by at least 10%. This is a key focus for the year ahead.

Working with the senior nursing team and our expert dietitians we are currently undertaking an end-to-end review of all aspects of food, hydration and nutrition to ensure we continue to meet all of our patient's needs.

1.2 Staff Catering

Staff well-being is of vital importance and a key aspect of this is ensuring staff, who are our most important asset, have their needs met whilst at work. This includes access to high quality and timely nutrition and hydration. The catering teams, along with other stakeholders in the Trust have been working hard over recent years to build on and extend the catering provision for our staff.

The catering teams have supported major off-site developments such as the Integrated COVID Hub North East (ICHNE) service at the Baltic Laboratory where bespoke hot catering facilities were required 24/7 for the staff on site.

The pandemic provided challenges in relation to social distancing and the team continued to use alternative space to support staff during rest periods. The Piano Room at the Royal Victoria Infirmary (RVI) and external seating areas were created at the Peacock Hall Bistro, adjacent to the Chapel and the Outpatient department. This has allowed staff space and fresh air during their well-deserved breaks which is crucial for their well-being

RVI Peacock Hall

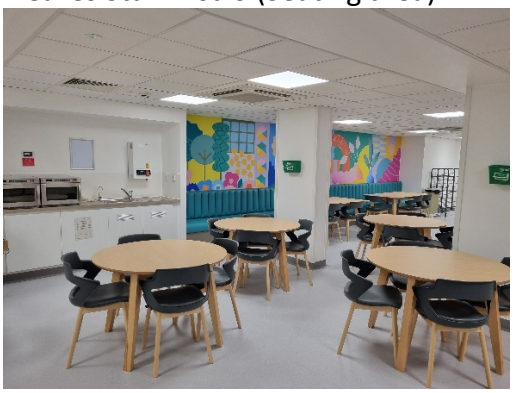
RVI Outpatient Department

One of the major achievements of the team this year has been the development of the new Leazes Wing Bistro at the RVI. This new staff only facility, is providing an extended hot food provision and the team are incredibly proud to be able to provide this service. Additional staff have been recruited to further extend this service to 24 hours a day in the coming weeks. This new facility will also be extended into the conservatory area once on-site estates work has been completed.

The team have also been exploring how we can make access to the Bistros as easy as possible. Over the last year we have launched the 'Food to Go' app for the Peacock Hall bistro, allowing staff to order in advance and pick up at a planned time to reduce their time queuing and maximise their rest period. It is planned that this will be extended to the Leazes Wing Bistro in the coming months.

Leazes Staff Bistro (Servery)

Leazes Staff Bistro (Seating area)



The Fruit and Vegetable stalls at the Freeman Hospital and RVI continue to support staff to eat healthily, providing fresh produce throughout the week. These two stalls are positively reviewed by our staff and are an important provision for staff health and wellbeing

RVI Fruit and Vegetable Stall

Freeman Fruit and Vegetable Stall

1.3 Summary

The last 12 months have been one of the most challenging for the Trust. Our catering team are fundamental in keeping patients and staff nourished in a safe and clean environment every day of the year. Over the last year there have been many achievements and successes despite the challenges and there are key pieces of work planned for the year ahead to continuously improve the catering provision for our patients and staff.

2. PROFESSIONAL NURSE ADVOCATE

In March 2021, the Professional Nurse Advocate (PNA) model was launched by the Chief Nursing Officer for England/NHS England/Improvement. The specific remit of the PNA model was to facilitate restorative clinical supervision to colleagues and teams in nursing and beyond. The training equips them to listen and to understand the challenges and demands of colleagues and to then lead, support and deliver quality improvement initiatives in response.

The PNA model is based on the A-EQUIP model of supervision used widely in midwifery, which embeds professional leadership and clinical supervision via the normative, formative and (in particular) restorative clinical supervision (RCS) model.

Current training to become a PNA involves completion of a 20-credit level 7 academic module. This is currently funded by NHS England / Improvement (NHSEI), albeit for a limited number of places. The Chief Nursing Officers ambition is to embed a model of supervision which provides a ratio of PNA to nurses of 1:20 (NHSEI, 2021). It is widely accepted that an incremental approach will be required in large organisations to build up the required number of PNAs as for Newcastle Hospitals this will require a minimum of around 250. This is a significant undertaking both to train and implement a model of supervision to this degree and we are currently working through how this will work in practice.

The national focus on rolling out the PNA model is reflected in recent changes to the NHS contract, which has mandated that organisations build upon the introduction of the PNA model and provide demonstrable evidence monthly and via the Provider Workforce Report (PWR) of the following:

- How many qualified PNAs in organisation;
- How many restorative supervisions provided;
- Number of improvement projects involving PNA; and
- Number of career conversations recorded.

2.1 Current Trust Position

Since 2021 the Trust has supported a number of nurses to complete the PNA Level 7 academic preparation, from specialties including paediatrics, theatres, Intensive Care, community and international recruitment.

We now have 21 PNAs who have completed training and feature on a regionally held list of PNAs. In addition, there are eight who are either on course, awaiting ratification, or due to start on programme. On International Nurses Day in May we were able to award our first cohort of qualified PNA with their certificates and badges. This event was supported by the North East and Yorkshire regional PNA lead.

Of those PNAs who have completed the course there have been challenges in implementing the PNA model and more broadly restorative supervision. Feedback from PNAs cite staffing issues and surge as reasons that have impeded PNA and supervision delivery, despite the clear rationale for PNA to support under such circumstances. However, where PNAs have been able to provide restorative clinical supervision sessions, or career conversations feedback from nurses has been incredibly positive, and in several cases PNA intervention has been cited as an effective retention tool, or an intervention that supports nurses in career progression.

The role is recognised and valued yet there will be challenges in reaching our ambition in embedding this model in clinical practice. To ensure the role is successfully embedded a PNA working group is being established to oversee this implementation

3. NURSING AND MIDWIFERY STAFFING UPDATE

3.1 Staffing Escalation

As previously reported to the Board, 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.

Workforce availability due to sickness absence (COVID-19 and Non-COVID) and vacancy has continued to impact on safe staffing levels. Consequently, the nurse staffing escalation remains at level 2 and has done since mid-February. This is due to the three following trigger criteria being met:

- Pre-emptive rosters demonstrate a significant shortfall in planned staffing.
- There is an increase in pandemic and non- pandemic related absence totalling between 6 and 10 % and this is impacting on workforce availability.
- Regular reporting of red flags and/or amber or red risk on safe care with reduced ability to move staff to mitigate risk.

In addition, the increased requirement for enhanced care continues, along with acuity and dependency remaining high across all service areas, which is mirrored across England.

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.

This level of escalation will remain in place until the de-escalation criteria has been met.

Staffing and bed capacity remains challenging. Focused workforce support continues for clinical areas where staffing levels are impacting on the ability to maintain commissioned bed capacity. Robust professional leadership from the Deputy Chief Nurse and Associate Directors of Nursing remains in place.

3.2 Nurse Staffing and Clinical Outcomes

It is important, to ensure monitoring of clinical outcomes/nurse sensitive indictors with explicit cross reference to safer staffing metrics, particularly considering the current level of staffing escalation. The Nurse Staffing and Clinical Outcomes Operational Group continues to meet monthly, reviewing all wards where there is an identified staffing or clinical outcome concern based on professional judgement, metrics and highlighted areas of risk. Wards reviewed by the group 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 quarter:

Month	No. of Wards Reviewed	Directorate	Low Level Support	Medium Level Support	High Level Support	Monitor	No support required
April	14	X1 Cardiothoracic Services x2 Internal Medicine x3 Urology and Renal Services x5 Covid/ RSV/Winter	2	4	2	6	0
May	20	x 1 Cancer Services x1 Cardiothoracic Services x 7 Internal Medicine x2 Musculoskeletal Services x1 EPOD x3 Urology and Renal Services x5 Covid/ RSV/Medicine	8	4	2	6	0
June	25	x2 Cardiothoracic Services x4 Children's Services x8 Internal Medicine x2 Musculoskeletal Services x3 Urology and Renal Services x1 Maternity Services x5 Covid/ RSV/Medicine	6	4	1	14	0

- In the last quarter, a number of wards have required support at medium or high level. This has been either due to a concern primarily in staffing or in the case of two wards, where it was felt this was impacting on 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. A process of weekly audit was put into place to monitor impact and in both areas a significant improvement has been noted. Support remains in place and will do so for a prolonged period to ensure improvement is sustained.
- Where beds have been closed due to staffing concerns, the process of 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:
    - April 15
    - May 11
    - June 15

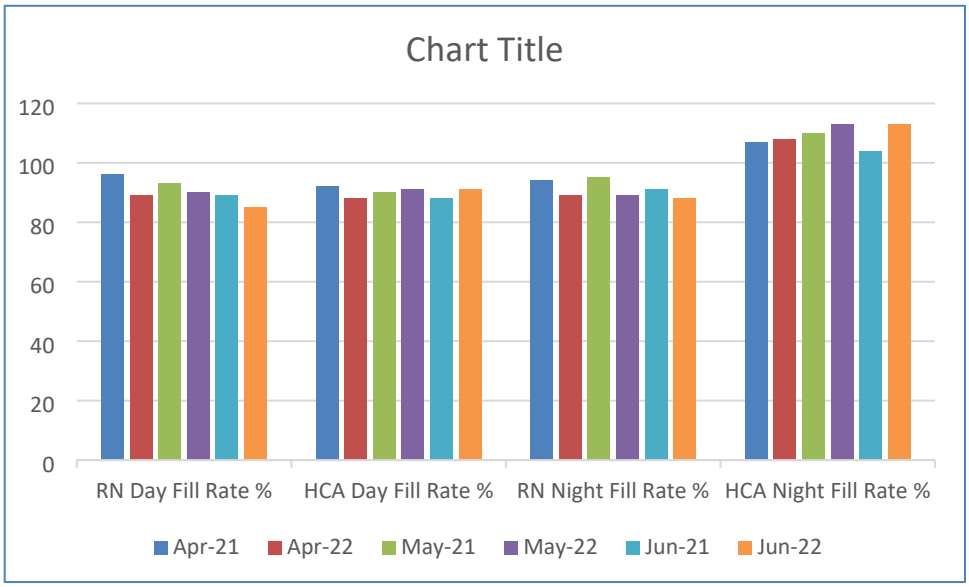
- Whilst this group provides oversight with high level monitoring and assurance, there continues to be a robust leadership and management framework led by the Matron team who manage the wards staffing, ensuring safety every day. It is noted however that the staffing picture remains fragile with staff well-being impacted by the sustained pressure and patient acuity.

3.3 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 %
April 2022	7.7	89%	88%	89%	108%	93.50%
May 2022	8.3	90%	91%	89%	113%	95.75%
June 2022	8.1	85%	91%	88%	113%	90%

- Below is the comparison data for this year and the same period last year. The lower Registered (RN) fill rate is due to vacancy, in addition to workforce who are 'away' for other reasons such as sickness, maternity leave as highlighted in the previous section. 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 higher fill rates were reflective of the temporary reduction to 4/5 beds in a bay on inpatient Wards.



- The Healthcare Assistant (HCA) fill rate on days and nights remains stable compared to this period in 2021. However, both day and night fill rates are augmented due to the increased use of temporary staffing to fulfil the increased requirement for enhanced care across both sites.

3.4 Recruitment and International Recruitment

3.4.1 Registered Nurse 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. This is linked to a reduction in the vaccination centres and service as a host provider.

Monthly generic recruitment for Band 5 RN continues with targeted bespoke recruitment. The Band 5 RN vacancy rate is 8.4% based on the financial ledger at Month 2 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 275.56 whole time equivalent (wte) staff across adult and paediatrics. This equates to approximately 14 wards worth of registered staff. Focused recruitment has taken place in May, June and July to respond to workforce requirements for new service developments and encourage applications from new registrants who will receive their NMC registration in October 2022.

The Trust commitment to supporting apprentices and growing our own workforce continues. The funded supernumerary apprenticeship model made it possible to successfully recruit 18 candidates to complete the Registered Nurse Degree Apprenticeship (RNDA) programme. All successful candidates were our own Nursing Associate or Assistant Practitioner staff. In turn significant recruitment to Trainee Nurse Associate posts will take place across the organisation.

3.4.2 International Recruitment

International recruitment has continued at pace to fulfil the ambition of recruiting 300 nurses and midwives this year. 24 internationally educated nurses were deployed in June with further planned deployments each month from the Philippines and India. The current international pipeline is 131wte, which includes 14 paediatric nurses and 1 midwife. This is in addition to the RN already in the recruitment pipeline outlined above. The two pipelines combined equate to approximately 20 wards worth of registered staff and this is required to keep pace with turnover.

We aim to close the shortfall in trajectory by the collaborative working of nursing and HR teams with NHSE/I and recruitment agents. Induction and pastoral support is provided for all recruits, with Midwifery candidates taking part in a regional OSCE bootcamp and Paediatric candidates being offered bespoke paediatric OSCE preparation in Trust. Adult Nursing candidates will now take their OSCE at the new Northumbria OSCE Test Centre. All international recruitment continues to be supported by additional funding from NHSEI.

3.4.3 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 but due to turnover, progression, service expansion and a competitive employment position, it remains challenging to maintain. There are currently 91.23wte candidates in pipeline providing a current vacancy rate of 23wte which represents 1.8% of the HCSW workforce.

3.4.5 Day Treatment Centre

Recruitment to the new Day Treatment Centre has progressed successfully with all 48.64wte of registered workforce recruited. 28.3wte support staff have been appointed with only 1.48wte vacancy remaining. An onboarding programme has commenced and will run regularly to accommodate deployment of the new staff. Of note there is a training lead in time required which will result in a flexible multiskilled workforce

Significant work continues via the Nursing and Midwifery Recruitment and Retention Group to improve the overall vacancy and turnover position. There are currently eight work streams including team rostering, internal rotation, preceptorship and progression pathways for Nursing Associates and Assistant Practitioners (NA/AP).

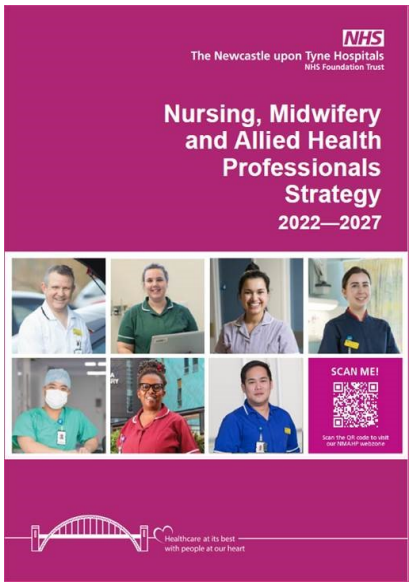
4. FREEDOM TO SPEAK UP GUARDIAN UPDATE

The Trust Freedom to Speak Up (FTSU) Guardian, Andy Pike, continues to provide a responsive service to staff across the organisation. Over the past three years, he has established the service as an integral part of the staff well-being offer, enhanced education and awareness of 'Speaking Up'. He has installed and nurtured a team of Champions, integrated the service into staff networks, forums and induction and engaged locally and nationally with FTSU teams to share best practice.

The past 12 months has seen a 30% increase in concerns raised, reflecting the development of a healthy speak up culture, awareness of the service and staff confidence that they will be listened to, and action taken. There has also been a significant increase in managers, Consultants and senior leaders accessing the service, as well as frontline staff, which supports the view of the service having more credibility. The vast majority of concerns raised relate to interpersonal relationships, particularly between line managers and staff. These do not necessarily equate to bullying allegations but perceptions of mismanagement, ineffective or unfair HR processes or inequity. This may align itself to the most recent Staff Survey results with a deterioration in Staff Engagement and a 6 out of 10 response to the question 'We are safe and healthy'.

There is evidence of the quality of service being provided to staff via the feedback forms each person accessing the service is invited to complete. Of all the responses received since January 2019, 98% of staff rated their experience of using the service 5 out of 5 'Very Satisfied' and the remaining 2%, 4 out of 5 'Satisfied'. 100% of respondents stated that they would recommend the service to colleagues.

5. NURSING, MIDWIFERY AND AHP STRATEGY



On the 26th of July we will be officially launching our new Nursing, Midwifery and Allied Health Professionals (NMAHP) strategy referenced in the BRP Appendix i.

From the outset it has been imperative that the NMAHP strategy is fully aligned to the Trust strategic priorities as well ensuring the Flourish principles and our core values are golden threads throughout. Over the last six months a small steering group has been meeting regularly to pull the content of the strategy together. Wide engagement and market research has been undertaken across the NMAHP workforce and we have used this feedback to strengthen and shape the strategy.

The strategy is split into six key priorities. These priorities outline what we are already achieving in the relevant domain with a clear "**We Are**" statement and contain between three to four high level **"We Will"** statements outlining our aspirations for the future. To ensure the strategy remains contemporaneous and fresh, each year it will be accompanied by a number of measurable high impact actions. The high impact actions will be led by the Executive Chief Nurse Team (ECNT), in partnership with directorates and departments where it is envisaged will agree their own high impact actions and there will be a method to collate and share achievements across the Trust.

To support the launch and culture of our strategy we have designed a new "NMAHP Zone" website as part of the Trust website. This site will hold our strategy and high impact actions but also pull together news stories, share examples of good practice to celebrate and learn, and be a place where our staff can engage. Alongside this we will be holding a number of high-profile events over six months. Each month will focus on one of the key priorities to ensure we help our staff understand the strategy and explore what it means for them and their teams. This will include a collection of launch videos, social media campaigns, face to face discussions and formal events.

We will continue to provide a regular update on progress to the Trust Board.

6. RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
28 July 2022

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022		
Title	Ockenden Update Report		
Report of	Maurya Cushlow, Executive Chief Nurse		
Prepared by	Jane Anderson, Associate Director of Midwifery		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	The Ockenden Report published on 30 March 2022, is the final report of an inquiry commissioned by the former Secretary of State, Jeremy Hunt, who requested an 'independent review of the quality of investigations and implementation of their recommendations of a number of alleged avoidable neonatal and maternal deaths, and harm, at The Shrewsbury and Telford NHS Trust'. The final report can be found at: https://www.gov.uk/government/publications/final-report-of-the-ockenden-review. The interim report published on 10 December 2020 outlined a number of Immediate and Essential Actions for providers of maternity services, and the Trust's progress against these have been systematically monitored and reported to members of the Trust Board since that time. The purpose of this paper is to provide members of the Trust Board with an overview and significance of the findings of the final Ockenden publication, intended actions for the Trust, together with an update on progress against both the interim and final report. Associated risks are identified and discussed, together with an updated high level Action Plan arising from the interim report. An overview of the findings of the Regional and System Insight Visit which took place on 17 June 2022 is also provided.		
Recommendation	The Trust Board is asked to i) Receive and discuss the report; ii) Note the current level of assurance and the identified gaps in assurance as benchmarked against the interim and final recommendations; iii) Recognise the significance of this final report for the Maternity Service and that further detailed work is required to ensure full compliance; and iv) Note the associated risks involved.		
Links to Strategic Objectives	Putting patients at the heart of everything we do. Providing care of the highest standards focussing on safety and quality.		

Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☒	☐	☒	☐
Impact detail	Detailed within the main body of the report.						
Reports previously considered by	Previous report presented to members of the Trust Board on 31 May 2022.						

OCKENDEN REPORT UPDATE

EXECUTIVE SUMMARY

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

The interim report published on 10 December 2020, outlined a number of Immediate and Essential Actions (IEA) for providers of maternity services, and the Trust has made positive progress against these which have been systematically monitored and reported to members of the Trust Board since that time.

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

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

The Trust has undertaken detailed work in benchmarking against the Immediate and Essential Actions of this final report, to further identify the gaps and associated actions in relation to the recommendations. This paper combines the interim and final Ockenden reports, taking a phased approach to reporting in view of the large number of recommendations, starting with the 7 non-compliant recommendations arising from the Trust's benchmarking. Future papers will provide details of partially compliant recommendations and relevant updates as indicated within the High-level Action Plan.

RECOMMENDATIONS

The Trust Board is asked to:

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

OCKENDEN REPORT UPDATE

1. INTRODUCTION

The purpose of this paper is to provide members of the Trust Board with an update on the Trust's position in relation to the interim Ockenden Report, published in December 2020, together with an overview of the findings of the Regional and System Insight Visit which took place on 17 June 2022.

This paper also provides background information and an overview of the final Ockenden Report; Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust, published 30 March 2022. Detail in relation to a comprehensive benchmarking exercise which has been undertaken by the Trust is provided, together with information on the next steps which are required in further progressing, monitoring, and reporting the recommendations.

2. BACKGROUND

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

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

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

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

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

As previously discussed, the report illustrates the importance of creating a culture where all staff feel safe and supported to speak up, with an expectation that every Trust Board will

have a robust freedom to speak up training programme for all managers and leaders, and a regular series of listening events. National policy and guidance on speaking up is awaited.

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

3. NEWCASTLE HOSPITALS MATERNITY SERVICES ASSESSMENT AND ASSURANCE

Members of the Trust Board will recall that the requirements in terms of the minimum evidence required to support compliance against the interim Ockenden recommendations evolved considerably throughout 2021, resulting in a total of 49 standards (Appendix 1) to be addressed by providers of maternity services. This second report further advises on an additional 15 Immediate and Essential Actions of which there are 92 recommendations (Appendix 2).

As is required, the Trust's position in relation to compliance on the interim actions has been reported to the LMNS, ICS, and NHS England's regional team, with submission of evidence being made in April 2022. A detailed breakdown of provider returns, and Trust compliance aligned to the initial Immediate and Essential Actions was reported to NHS England and Improvement's Public Board in May 2022 and published thereafter. Subsequent to the submission of evidence, a Regional and System Insight Visit was undertaken on 17 June 2022, the purpose of which was to provide assurance against the 7 Immediate and Essential Actions from the first Ockenden report.

3.1 Interim Report Update

The Insight Visiting Team used an appreciative enquiry and learning approach to foster partnership working, to ensure that the actions taken by the Trust to meet the Ockenden recommendations were embedded in practice. The visitors spent the day conversing with members of the senior leadership team, including Executive and Non-Executive Directors, and frontline staff from a range of job roles within the multi-professional team. Emerging themes from these conversations were organised under the 7 Immediate and Essential Action headings arising from the first report.

3.2 Key Headlines Arising from Insight Visiting Team

- The visitors described a culture of good working relationships both within the service and from ward to board, citing a demonstrable leadership team who are transparent, open, and responsive to all the support which has been offered.

- All grades of staff engaged positively with the insight team and were instrumental in being able to evidence a learning culture, demonstrating an ethos of quality improvement as being a high priority for the service. Examples of improving and learning from feedback from incidents, and actions relating to patient complaints, were received positively by the visiting team.

- Evidence to support patient involvement through the Maternity Voices Partnership (MVP) was reviewed and the visiting team particularly liked the patient feedback boards displayed within each area.

3.3 Insight Points for Consideration

- Continuous audit was a key theme running through the feedback and is a recommendation to further demonstrate the sustainability of interventions and to support quality improvement initiatives.

- Although the collaborative partnership working between the Trust and the MVP has been positively acknowledged, it is suggested that consideration should be given in involving the service user's voice in other forums. It was also recommended that further MVP involvement in the co-production of the development of the Trust website, with particular emphasis around the use of language, to enhance and support the provision of informed consent in personalised care planning. An increase in the use of audit to enable demonstrable evidence of 'true' informed consent and risk assessment should be taken.

- With regard to workforce planning, evidence supported the use of national guidance. A recommendation to consider the gaps in relation to the Royal College of Midwives (RCM) Leadership Manifesto in relation to the appointment of a Director of Midwifery was made.

The verbal report-out was positive, this was followed by receipt of a slide-pack confirming the above findings; the final written report is awaited, and any further findings will be considered and presented to members of the Trust Board in a future paper.

3.4 Final Ockenden Report Update

Detailed work has been undertaken within the Directorate benchmarking the Maternity Service against the 92 recommendations arising from the final publication. The report has been shared widely across the service and opportunity has been taken to present and disseminate the key messages amongst the multi-professional workforce.

The Senior Leadership Team have undertaken engagement events; however, it is acknowledged due to the large volume of work required in meeting with all recommendations within the final Ockenden report, that there is continuous and consistent work to do going forward. It is important to ensure that the findings of local benchmarking, together with required actions, are shared and discussed amongst the multi-professional team, and that staff are well supported as work progresses.

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

This paper details the Trust's position from both the interim and the final report, with a specific focus on the 7 non-compliant recommendations arising from the final report. To enable a more cohesive approach, future papers will continue to combine the two reports as one, taking a phased approach in providing the level of detail required to enable greater comprehension and clarity with regard to the Trust's progression.

4. HIGH LEVEL ACTION PLAN

Table 1 provides a revised and updated high level action plan, which amalgamates the residual actions from the interim report, together with those non-compliant actions as benchmarked against the final report. The 7 non-compliant recommendations benchmarked by the Trust as non-compliant are as follows:

IEA 1 (1.3) Minimum staffing levels must include a locally calculated uplift, representative of the three previous year's data, for all absences including sickness, mandatory training, annual leave, and maternity leave.

An uplift of 20% is broadly applied across the Trust with some specific local derogations in key areas. Work will be required in collaboration with key stakeholders within the organisation to scope and agree on an appropriate uplift going forward. In mitigation, the maternity service has approval to continuously over-recruit 20 whole-time-equivalent (wte) midwives to supplement the requirements for training and long-term absence.

IEA 1 (1.7) All trusts must ensure all midwives responsible for coordinating the Labour Ward attend a fully funded and nationally recognised Labour Ward Coordinator education module.

A local development package is currently in place within the organisation for newly appointed Labour Ward Coordinators. A national programme is currently unavailable and further information is awaited with regard to timeframes for implementation.

IEA 3 (3.1) All trusts must develop and maintain a conflict of clinical opinion policy to support staff members being able to escalate their clinical concerns where professional disagreement arises.

This policy does not currently exist; work will commence in developing a policy bespoke to Newcastle Hospitals.

IEA 5 (5.4) Change in practice arising from a Serious Incident (SI) investigation must be seen within 6 months after the incident occurring.

Changes to practice are routinely part of action plans following SI investigation. However, the application of robust Quality Improvement (QI) methodology, together with an appropriate audit schedule are required to provide greater assurance that changes in practice are embedded and have led to improvement.

IEA 5 (5.6) All maternity services must involve service users (MVP) in developing complaints response processes that are caring and transparent.

The MVP has not routinely been involved in the development of complaints processes within the Trust. Joint work is underway between the Directorate and the Trust Patient Experience team to ensure a collaborative approach in partnership with the MVP and other service users going forward.

IEA 5 (5.7) Complaints themes and trends must be monitored by the maternity governance team.

Work commenced by the Directorate on extracting themes and trends throughout 2021, however, further work is required to ensure a more robust strategy to ensure greater levels of assurance going forward. Complaints processes are regularly reviewed Trust-wide as part of the patient experience and engagement strategy.

IEA 10 (10.2) Midwifery-led units must complete yearly operational risk assessments.

Operational risk assessments have not been implemented within Newcastle Birthing Centre. A process is required to develop an appropriate risk assessment document, together with a schedule of routine auditing to ensure that this is undertaken and actions arising are completed.

Table 1

The Newcastle Upon Tyne Hospitals NHS Foundation Trust Maternity Services Assessment and Assurance Tool High Level Action Plan to support the requirements arising from the Ockenden Review; Updated July 2022 to include both the interim and the final Ockenden Report			
Immediate and Essential Action (IEA) Interim Report (Total)	**Updated action which is required to meet recommendation**	**Lead/s**	**Completion Date**
IEA 3 **Staff training and working together**	Required to ensure 90% of all specialties take part in multi-disciplinary training. This has been challenging for the reasons reported in the previous Trust Board reports; a mechanism is in place for regular monitoring and reporting and cross referenced to the requirements for the Clinical Negligence Scheme for Trusts (CNST). Close monitoring of the set trajectory is maintained with an anticipated compliance of 95% by October 2022.	Clinical Director (Training Lead) Lead Midwife for Quality and Clinical Effectiveness Practice Development Midwife	December 2022
IEA 4, 5 & 7 **Named Consultant and Risk assessment throughout pregnancy**	Continue to embed named consultant and continuous risk assessment through training, audit, and plan-do-study-act (PDSA). A task and finish group are established. Further enhance the current paper-based system as an interim whilst awaiting implementation of the Electronic Patient Record (EPR) with full audit schedule. Continue the work to progress the project plan and implementation of BadgerNet as the agreed electronic paper record.	Head of Obstetrics Midwifery Matrons Lead Midwife for Quality and Clinical Effectiveness Clinical Director Associate Director of Midwifery Digital Health Midwife	A repeat audit undertaken in June 2022 shows a 70% compliance – to maintain continuous audit schedule. EPR 6 months to implementation.

Immediate and Essential Action (IEA) Final Report Non-compliant elements (partial)	Action which is required to meet recommendation	Lead/s	Completion Date
IEA 1 Workforce Planning and Sustainability	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. Collaborative work with Executive Directors, Finance and Human Resources (HR) to work towards establishing a reflective uplift appropriate for Newcastle.	Directorate Manager Associate Director of Midwifery	December 2022
IEA 1 Workforce Planning and Sustainability: Training	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. Incorporate this training into the training passport for all Midwives coordinating the Delivery Suite. Further discussion with senior midwifery leaders across the region with a view to developing a bespoke accredited package which meets with the national standard.	Associate Director of Midwifery Matron for Intrapartum Care	To be confirmed (TBC) - Awaiting development of nationally recognised programme
IEA 3 Escalation and Accountability	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. Clinical leads to work collaboratively in creating a policy to meet with this recommendation.	Clinical Director Head of Obstetrics Associate Director of Midwifery	December 2022

IEA 5 Clinical Governance – Incident investigation and complaints	5.4 Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred. (Audit to commence) Audit schedule to be developed to enable evaluation of the Trust's position with regard to this recommendation. PDSA methodology to be applied in meeting with objective.	Clinical Director Associate Director of Midwifery Lead Midwife for Quality and Clinical Effectiveness	September 2022
IEA 5 Clinical Governance – Incident investigation and complaints	5.6 All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent. Task and finish group to be developed with key stakeholders enable progression on this recommendation.	Directorate Manager Associate Director of Midwifery Head of Patient Experience Chair of MVP	October 2022
IEA 5 Clinical Governance – Incident investigation and complaints	5.7 Complaint's themes and trends must be monitored by the maternity governance team. This work has already commenced; themes and trends to be monitored and reported through local governance assurance framework.	Directorate Manager Head of Obstetrics Lead Midwife for Quality and Clinical Effectiveness Patient Experience Coordinator	September 2022
IEA 10 Labour and Birth	10.2 Midwifery-led units must complete yearly operational risk assessments. Operational risk assessment to be developed and implemented with actions arising reported through local governance assurance framework.	Obstetric Lead for Intrapartum Care Matron for Intrapartum Care Lead Midwife for NBC	September 2022

5. DIGITAL HEALTH RECORDS

5.1 Implementation of BadgerNet

There is nothing further to update the members of the Trust Board on at this time; work continues to progress on the implementation of BadgerNet in line with a revised target date of December 2022; this is closely monitored through the BadgerNet Project Board. Any unanticipated issues which impact on a delay will be reported to members of the Trust Board in September 2022.

6. MATERNITY WORKFORCE PLANNING AND INVESTMENT

6.1 Midwifery Workforce

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

As requested by NHSE/I, the Trust duly submitted plans for MCoC by the required date of 15 June 2022, via the North East and North Cumbria LMNS.

Members of the Trust Board will recall that the final Ockenden publication advises that organisations must now take into account an immediate and essential action in ensuring safe midwifery staffing plans are in place, and Trusts must make one of 3 decisions with regard to MCoC:

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

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

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

The plan presented to the members of the Trust Board in January 2022 has been progressing through a formal organisational change process, with large scale workforce consultation to enable the implementation of plans for MCoC at Newcastle. This process, which commenced in February 2022, has extended beyond the original anticipated closure date of March 2022, to both facilitate additional robust engagement and to further clarify the Trust's position in light of the revised guidance in the final Ockenden report. Staff across all areas of

the maternity service, have engaged positively, and their feedback has been appreciated and of great value in supporting the plan for Newcastle.

Opportunity has been made available for individual 1:1 meetings, which have been undertaken with 200 members of staff. An additional programme of work has been undertaken with the Nursery Nurses across a 12-week period, offering a variety of different types of support. As part of the overarching work, an intense programme of engagement across a two-week period was undertaken by the Directorate Leadership Team, together with representatives of the Royal College of Midwifery (RCM), who visited the clinical areas on a daily basis covering the delivery suite, inpatient wards, antenatal outpatient services, the Birth Centre and community. The feedback received from staff has been collated into a thematic analysis, much of which reflected individual discussions; from this, further work is in progress to collate an additional 'you said, we did' response.

The consultation process formally closed on 6 June 2022 and initial written feedback, together with a slide pack summarising the key points, has been provided to staff groups. Staff are in the process of reviewing Job Descriptions upon which they will submit their preferences for roles within the service, to include a model associated with MCoC.

In line with the national picture, the Trust has seen attrition within the Midwifery workforce across the past four months; there are a number of reasons attributed to this and the position both Trust and system-wide is being closely monitored. The service has a current midwifery vacancy rate of 14.4%, half of which is recruited to, filled by newly qualified midwives due to commence in post in October 2022. The Directorate continues to actively advertise with further recruitment planned for late July 2022 to recruit to the remaining 17.8wte. A further, more detailed update on recruitment will be reported to members of the Trust Board in future papers, together with any identified risk.

Once all vacancies have been filled, a further staffing review is required to inform the Trust's position with regard to rollout of models associated with MCoC. However, it is likely that given the number of variable challenges, including ongoing vacancies, a delay in implementation may be necessary. Further review in August following July's recruitment will be made and presented in an update for consideration to the Executive Directors.

7. RISKS

All identified risks arising from the Trust's benchmarking of the final Ockenden report will be reported through future papers to members of the Trust Board.

A risk emerging from the non-compliant recommendations as detailed within this paper aligns to IEA 1 (1.3). A locally calculated uplift, representative of the three previous years data for all absences, including sickness, mandatory training, annual leave, and maternity leave must be agreed by the Trust. This will require detailed collaborative work with the Directorate, Executive Directors, Finance and Workforce Department, to establish the additional funding required to support this action. In mitigation, staff absence is currently closely monitored to support all absence and falls within the continuous routine monitoring and escalation plans within the Department. In addition, approval is in place to continuously over-recruit 20wte midwives to supplement training and long-term absence.

8. CONCLUSION

The Trust has made good progress against the Immediate and Essential Actions arising from the interim Ockenden report published in December 2020, and this has been reported systematically to the Executive Directors, the Trust and members of the Trust Board since that time. The outstanding actions of note relate specifically to risk assessment, personalised care planning, and the support which is required from a maternity specific electronic patient record. The feedback arising from the regional/system Insight Visit found similarities in their recommendations.

Donna Ockenden's final report brings further significant Immediate and Essential Actions for providers of maternity services. A detailed benchmarking exercise has been undertaken, the findings of which are illustrated in Table 3 (Appendix 2). Those areas which are partially compliant and outstanding from the interim report are also key areas discussed in the final Ockenden report and are amalgamated into a revised high-level action plan to be incorporated through a phased approach in future papers.

The findings of the final Ockenden publication are being shared widely throughout the maternity service and across the wider Trust, and further engagement and discussion will continue as the Trust progresses the work required to reach full compliance.

9. RECOMMENDATIONS

The Trust Board is asked to:

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

iv) Note the associated risks involved.

Report of Maurya Cushlow
Executive Chief Nurse
28 July 2022

APPENDIX 1

Table 2 – Interim Report			
Immediate Essential Action		Brief Descriptor	Compliance
Section 1		IEA 1-7	
IEA 1: Enhanced Safety	Q1	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 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 PMRT in use to required Ockenden standard (compliant with CNST).	Compliant
	Q13	Robust mechanism working with and gathering feedback from service users through 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 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

Table 3 – 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 Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	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.	Not applicable (n/a) Awaiting information on further funding
	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.	n/a Awaiting direction from National bodies
	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.	Partial compliance

. 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.	1.7	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.	Partial compliance
	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	Partial compliance
		All leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.	
	1.11	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.	Partial compliance

	2.4	All trusts must review and suspend if necessary, the existing provision and further roll out of 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.	Partial compliance
	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.	Partial compliance
	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.	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

If not resident there must be clear guidelines for when a consultant obstetrician should attend.	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. Clinical Governance: Leadership: Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	4.1	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
	4.2	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
	5.1	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. 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.	5.3	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
	7.1	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. Multidisciplinary Training Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	7.2	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
	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: The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	9.1	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	Compliant
	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. Neonatal Care: There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	14.1	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	Compliant
	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 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	92	100%
Non-applicable	11	n/a
Compliant	42	51.9%
Partial Compliance	32	39.5%
Non-compliance	7	8.6%

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

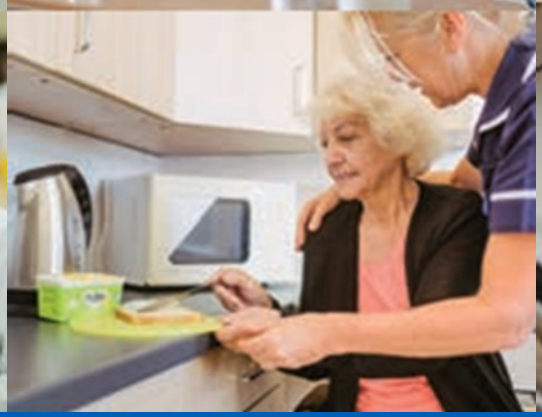
Date of meeting	28 July 2022						
Title	Quality Strategy (2018-2023) – High Level Review						
Report of	Angela O'Brien, Director of Quality and Effectiveness						
Prepared by	Louise Hall, Deputy Director Quality and Safety						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☒	☐	☐				
Summary	The key points of discussion: • The current Trust Quality Strategy was launched in 2018 and is now due for review. • The principles of this Strategy remain relevant and still apply however, in the coming year there are significant changes nationally and locally which will need to be included in the revised Quality Strategy. • The current Strategy has been extended to 2023 with a high-level review of the content, pending a full consultation and comprehensive re-write over the course of 2022-23.						
Recommendation	The Trust Board is asked to receive the report.						
Links to Strategic Objectives	Patients -Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☐	☐
Impact detail	Not applicable						
Reports previously considered by	New Report						

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Quality Strategy 2018—2023








Healthcare at its best
with people at our heart

Foreword: Medical Director

The Quality Strategy outlines our commitment to prioritise quality above all else. In this strategy, we continue to build on the progress made so far in line with the National Quality Board's (NQB) Shared Commitment to Quality (1). We outline our aims to continue to embed a culture of continuous improvement to increase and sustain the quality of our services for the people of Newcastle and beyond.

Quality Improvement (QI) has become an integral part of everyone's daily work. Learning, improving and innovation have always been the Newcastle way but we are now moving towards a culture which encourages innovation, experimentation and change and empowers staff to give improvement a go; to try it, take a risk, learn from what does and doesn't work. We have created a culture and environment in which staff are empowered to innovate and overcome the current challenges they face. Addressing these challenges requires real-world leaders who understand the systems they work in and who are motivated to make things better; nobody is better placed to come up with the solutions than those facing the problems. We recognise that all staff, regardless of role or experience, are capable of influencing change, either by offering suggestions for improvement or participating in initiatives to enhance services. As an organisation, we have committed to releasing frontline staff to facilitate time and attention to the work of quality improvement and learning across the Trust will help us deliver sustained improvement in the quality and experience of care.

In 2019, the Trust was graded as 'Outstanding' by the Care Quality Commission (CQC) for a second time. This incredible achievement was a fitting acknowledgement of the hard work and compassion of all of our 18,000 staff. Our ambition is to maintain this, build upon this achievement and continue to strive towards safe and effective, high-quality patient focused care.

Introduction

Delivering safe, effective, patient-centred care is the first strategic goal of the Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH).

We are committed to providing services which:

- Maintain patient safety at all times and in all respects
- Are clinically effective and lead to the best possible health outcomes for patients
- Provide a positive patient experience
- Are timely, equitable and efficient; responding to the needs of our population
- Are well-led, open and collaborative and are committed to learning and improvement across the system.

The COVID-19 pandemic is the biggest healthcare challenge this country has faced since World War 2. The demands of responding to the pandemic have changed over time from the urgent and immediate response to safely care for large numbers of patients with COVID-19, to starting our transition to 'living with COVID-19'. The Trust is facing the same challenges as healthcare services nationally; recovering our elective activity to pre-pandemic levels, improving patient flow in the context of unprecedented emergency admissions and increasing patient acuity. In order to sustain our NHS, we have to meet these challenges whilst embracing innovation and transformation, ensuring we improve the quality of service we provide. The National Quality Board (1) state "quality without efficiency is unsustainable, but efficiency without quality would be unthinkable" (p.2). In order to achieve this, we need to focus on continual learning and improvement at all levels and consider our role in the wider system, working collaboratively with the new Integrated Care Board and our partner organisations.

This strategy aligns our efforts as an organisation to the National Quality Board's Shared Commitment to Quality (1). However in the coming year there are some significant and transformational changes expected in the approach to quality and safety, both nationally and locally. Implementation of the new National Patient Safety Strategy is in the early stages and the CQC are changing how they regulate, taking a more dynamic and flexible approach. This will include assessing shared learning and improvement, with a focus on local systems and promoting equity of access, experience and outcomes. In the Trust we continue to build on our partnership with the Institute for Healthcare Improvement (IHI) to develop and strengthen our approach to transformation and continuous quality improvement. Following publication of the Ockenden Report the Trust has committed to fully implement all recommendations of the report, including installation of Badgernet, an end to end technological solution supporting all aspects of electronic recording for women through their pre-natal, labour, birth and post-natal period.

A new Quality Strategy reflecting all of these changes will be launched in 2023 setting out our vision, aims and objectives for the next 5 years.

Seven Steps to Improve Quality

This strategy follows the 'Seven Steps' to improving quality as outlined by the NQB (1, p.8) but have been modified to align with the Trust's own goals and expectations. The steps define what we need to do, to continually improve the quality of care we provide to our patients and ensure we have a skilled and motivated workforce for the future.

1. The Trust will continue to set a clear direction and identify quality priorities each year.
2. Bringing clarity to quality by defining what high quality care looks like.
3. Measuring and publishing quality to monitor standards and benchmark performance. We will aim to reduce duplication by measuring what matters.
4. Recognising and sharing quality and best practice to increase the pace of change and avoid duplication.
5. Maintaining and protecting quality to ensure we continue to deliver the best quality care. We will act quickly when this is not the case.
6. Building capacity in front line staff to ensure more staff have an understanding of quality improvement techniques and human factors.
7. Staying ahead by continuing to champion Innovation and research.

‘Putting patients at the heart of everything we do. Providing care of the highest standard, focusing on safety and quality’, is the first strategic goal of the Trust.

Quality and Safety are routinely placed on the top of the Trust’s agenda; both literally and figuratively. Key meetings always include a quality and patient safety item ensuring it is prioritised and emphasised alongside other key Trust objectives – this is our priority and we will ensure there is always time to discuss quality and safety issues. This commitment to quality and safety has also been demonstrated by the well-established role of Clinical Director for Patient Safety and Quality. These are senior and experienced consultants from a range of specialties across the Trust, who advocate, advise and steer the direction of the quality and safety agenda within the organisation. The Clinical Directors for patient Safety and Quality are highly motivated and clinically credible individuals who, by working closely alongside the Trust’s senior nursing leadership, act as ‘champions’ for the quality and safety agenda, offering strategic leadership on key priority areas and helping to develop a culture for continuous improvement by role modelling within the organisation.

Successfully managing quality relies on commitment, consultation and co-operation with all staff from the ward to the Board. Each year discussions with the Board of Directors, the Council of Governors, patient representatives, staff and public will take place in order to ensure quality priorities are identified to focus efforts for the coming 12 months. We will ensure the quality priorities are appropriate, meaningful, and resonate with all. Data and evidence will also play a vital role; each year we will ask where is there scope for improvement and in which areas is the quality gap the greatest?

The feedback from our front-line staff and our patients will help set core quality priorities that have an overarching impact across the organisation. Whilst these will change year in year, it is likely that the following will always focus in some guise:

Patient Safety:

- Reducing avoidable harm and early identification of deterioration
- Increasing incident reporting and learning from error
- Reducing healthcare acquired infections
- Safe staffing levels.

Clinical Effectiveness

- Enhancing capability in quality improvement
- Digital technology to improve safety, patient outcomes and experience
- Developments across the patient pathway encompassing recovery of elective activity.

Patient Experience:

- Acting on what patients tell us and co-creating solutions to challenges they face
- Improve health inequalities, particularly in relation to Mental Health and patients with Learning Disabilities and Autism.

2 . Bringing Clarity to Quality

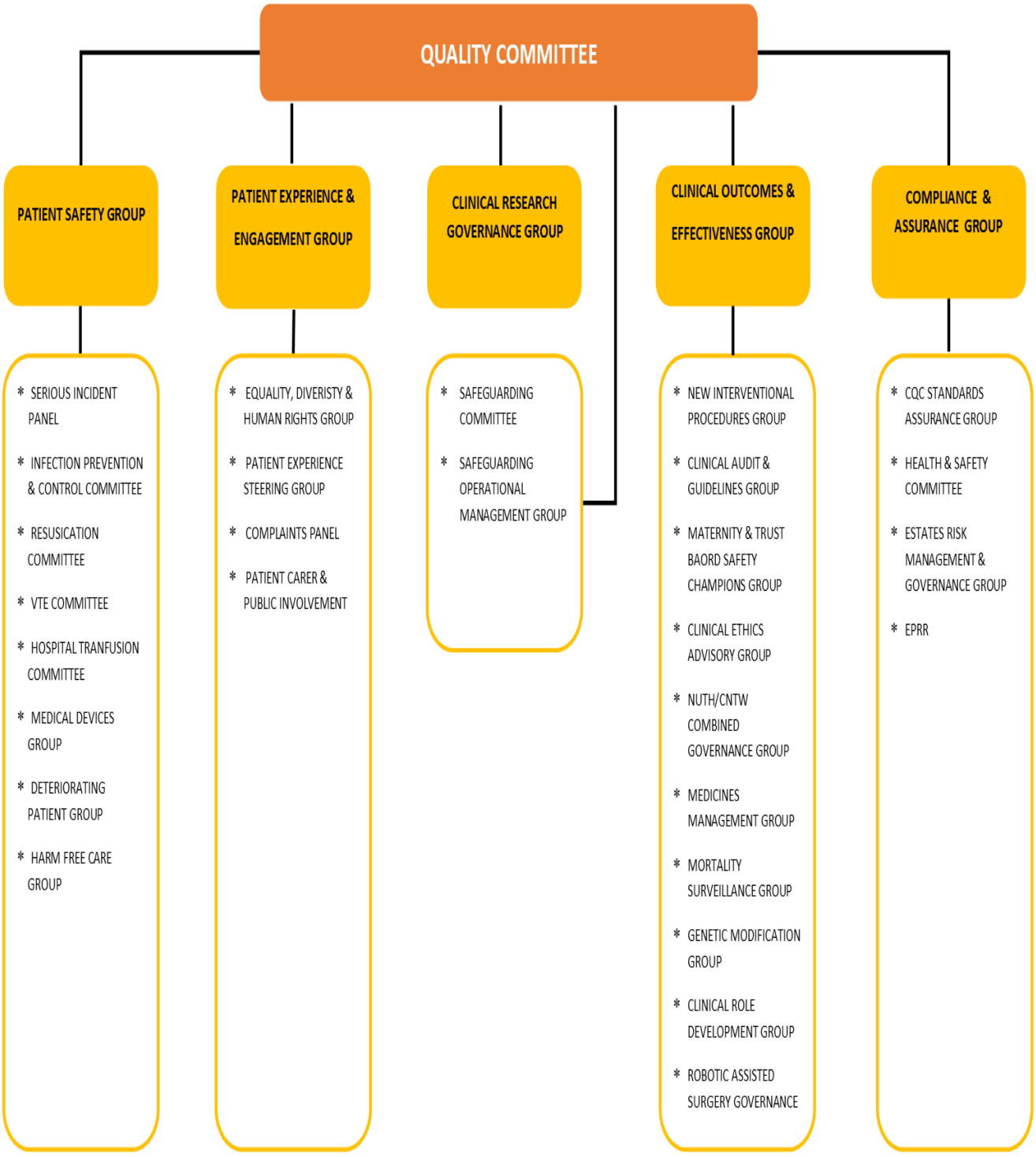
The Trust measures quality using the CQC's inspection framework which is based on the Francis, Berwick and Keogh reviews (2 - 4) and the outcome of a public consultation. We therefore routinely ask, are services safe, effective, caring, responsive and well-led?

Defining Quality

The quality domains are outlined here, together the descriptor of what these mean, the domains match those used by the CQC to ensure we are focused on making improvements which are aligned with their regulatory requirements.

The Trust's internal inspection and reporting processes have been aligned to these domains to bring consistency and clarity to the process. Our routine reporting and monitoring also follows these 5 domains to reiterate the message. Our internal processes will be adapted to reflect the change in CQC strategy and their approach to inspections.

The Trust has well-defined quality assurance processes for setting the standards for what high-quality care looks like across our services. A key part of this is a well-established committee framework which plays a vital role in providing quality assurance to the Board in a large and complex organi-sation.


QUALITY COMMITTEE
PATIENT SAFETY GROUP
PATIENT EXPERIENCE & ENGAGEMENT GROUP
CLINICAL RESEARCH GOVERNANCE GROUP
CLINICAL OUTCOMES & EFFECTIVENESS GROUP
COMPLIANCE & ASSURANCE GROUP
* SERIOUS INCIDENT PANEL
* INFECTION PREVENTION & CONTROL COMMITTEE
* RESUSICATION COMMITTEE
* VTE COMMITTEE
* HOSPITAL TRANFUSION COMMITTEE
* MEDICAL DEVICES GROUP
* DETERIORATING PATIENT GROUP
* HARM FREE CARE GROUP
* EQUALITY, DIVERISTY & HUMAN RIGHTS GROUP
* PATIENT EXPERIENCE STEERING GROUP
* COMPLAINTS PANEL
* PATIENT CARER & PUBLIC INVOLVEMENT
* SAFEGUARDING COMMITTEE
* SAFEGUARDING OPERATIONAL MANAGEMENT GROUP
* NEW INTERVENTIONAL PROCEDURES GROUP
* CLINICAL AUDIT & GUIDELINES GROUP
* MATERNITY & TRUST BAORD SAFETY CHAMPIONS GROUP
* CLINICAL ETHICS ADVISORY GROUP
* NUTH/CNTW COMBINED GOVERNANCE GROUP
* MEDICINES MANAGEMENT GROUP
* MORTALITY SURVEILLANCE GROUP
* GENETIC MODIFICATION GROUP
* CLINICAL ROLE DEVELOPMENT GROUP
* ROBOTIC ASSISTED SURGERY GOVERNANCE
* CQC STANDARDS ASSURANCE GROUP
* HEALTH & SAFETY COMMITTEE
* ESTATES RISK MANAGEMENT & GOVERNANCE GROUP
* EPRR

3. Measuring and Publishing Quality

The Trust maintains its commitment to delivering high quality services by monitoring effectiveness and studying outcomes. We will continue to be open and transparent, publishing progress against our quality priorities at public Board meetings and multiple staff forums. We will do this by producing a monthly Integrated Quality Report outlining the Trust's performance against a range of safety metrics and progress with the Quality Account priorities.

The new NHS Patient Safety Strategy is about maximizing the things that go right and minimizing things that go wrong for people experiencing healthcare. A core objective of the new strategy focuses on improved 'Insight' to help us understand safety across the whole system by triangulating data from multiple sources and a range of organisations. The emphasis will be on data for learning and measurable improvement to achieve sustained high quality care and reduce risk. We will continue to share our quality metrics to enable a responsive approach to our position, sharing excellence and also Identifying areas for improvement. By improving the ways we display data it will make it easier for staff, from the ward to the Board, to understand where we are making improvements and where we need to increase our efforts. Continual measurement will also help us to ensure that any improvements we do see are sustainable in the long term.

We will also continue to produce an annual Quality Account which will be our way of demonstrating to the public the progress we have made against our quality priorities each year and what we plan to improve in the succeeding year. This document will also demonstrate our commitment to participating in all relevant national audits, the outcomes of which provide another vital means of measuring the quality of our services.

4. Recognising and Sharing Quality

Moving forwards, we will strengthen our approach to recognising and sharing quality by building a network of staff throughout the organisation to improve patient care, work in a better way and build a sustainable future together.

A collaborative approach to enhance and promote QI across the Trust started with a network of staff based on the Health Foundation's Q initiative. 'Q' aims to connect people with improvement expertise across the UK, fostering continuous and sustainable improvement in health and care. This provided an excellent platform for us to build upon and in 2021, a partnership was established with the Institute for Healthcare Improvement (IHI) to develop and strengthen our approach as a Trust.

We are building a social movement around continuous quality improvement to increase knowledge and expertise through Newcastle Improvement learning & sharing events, development of an Improvement Coach Network and alignment with the Q-Network. Quality Improvement case studies are routinely shared in Dame Jackie's blog.

A connected community working together to improve health and care quality across the UK

Newcastle Improvement
Continuous Quality Improvement

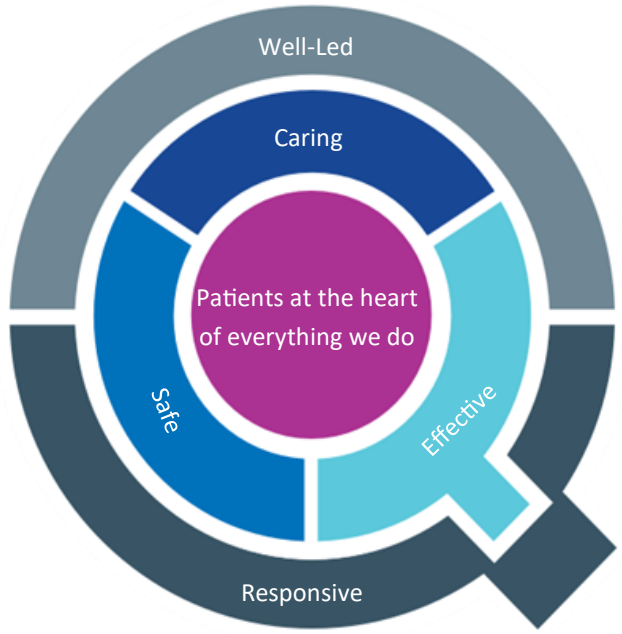
5. Maintaining and Protecting Quality

The Trust has developed and embedded a robust quality surveillance programme designed to provide assurance to the Board that high quality care is being delivered across all services and that areas requiring improvement can be quickly identified. The Patient Safety and Quality Review (PS&QR) process, is aligned to the CQC inspection approach. The framework has evolved since it was first launched in 2015 and delivers an

The PS&QR process involves an in-depth annual inspection using a framework aligned with the CQC inspection approach to help identify areas of care requiring improvement and to support more challenging issues that may be impacting on quality and patient safety.

In a change to previous annual reviews due to the impact of the pandemic, this process now includes a self-assessment tool. The clinical directorates, with support from Clinical Governance and Risk Department (CGARD), the Senior Nursing Team and Clinical Directors for Patient Safety and Quality are required to self-assess their performance related to the five CQC domains safe, effective, caring, responsive, well-led) and provide a rating for each domain. The evidence, including areas of achievement and areas for improvement are presented to a ratification panel, Chaired by the Medical Director. This then forms the basis of an action plan and opportunities for shared learning across directorates.

In 2022 we will concentrate our efforts on examining culture, leadership, governance, risk management, innovation and improvement across the organisation in the form of Well-Led reviews.



Well Led Review Process

Process

1. Well Led questionnaire and data slide sent to Directorate
2. Directorate respond to CGARD within 4 weeks
3. Panel receive completed Directorate questionnaire and data slide. Data slide linked with KLOE
4. Day of visit—Walkabout & Well Led discussion
5. CGARD collate information and rating
6. Ratification of rating
7. Feedback to Directorate
8. Directorate and CGARD link formulate action plan

People

Walkabout Team

- CGARD Representative
- Patient Safety CD
- Senior Nurse
- Estates Representative
- AHP Lead
- IPC
- Pharmacy Link
- Other Directorate Repre-

Walkabout team feedback to well led panel

Directorate Interview Team

- Patient safety CD
- Senior Nurse
- CGARD Representative
- Other Directorate Representative
- Other by exception as follows:-
- Performance review or Finance
- HR
- Estates

Directorate Well Led Review

Patient Experience

- People at our hearts awards
- Complaints
- CQC Patient Survey
- Patient Experience Forums
- Friends and Family Test

Quality Assurance

- NICE Guidelines awaiting baseline
- Local Guidelines for review
- Clinical Policies for review
- Clinical Effectiveness—Overdue projects
- National Clinical Audits
- GIRFT

- Serious Incident Reviews
- Never Events
- Near Misses
- Number of Incidents
- Outstanding Datix
- Risk Register
- Greatix

- Appraisal—all staff
- Mandatory Training
- Sickness/Absence
- Staff Turnover
- Staff Survey

Safety Culture

Human Resources

6. Building Capacity

We consider Quality Improvement to be an integral part of everyone's work through learning, improving and innovating. Building capacity in our front line staff is vital if the aims outlined in this strategy are to come to fruition. Whilst we want to create a movement, success will be limited if we are empowering and enabling staff to take control of these improvement projects without the skills to bring their plans to fruition. In order to achieve our aims, we therefore need to invest in the education and training of our workforce.

We will build capacity in the following three key areas:

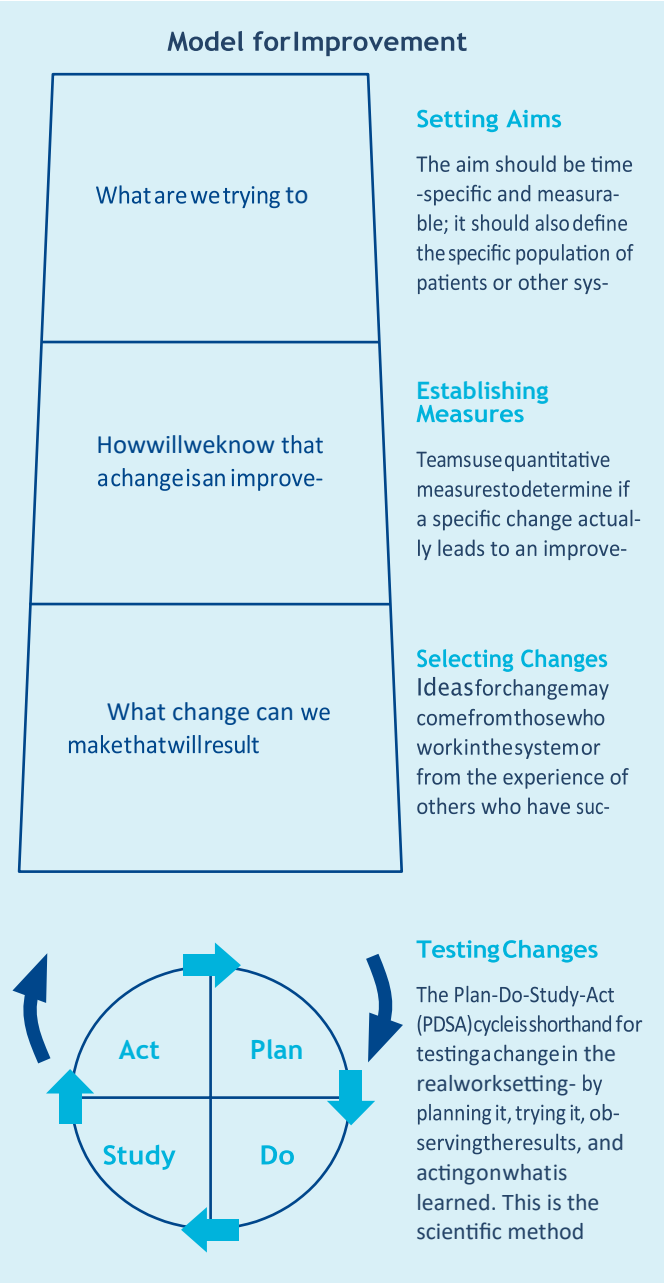
- ◊ Enhancing QI capabilities
- ◊ Human Factors
- ◊ Patient and Public Involvement in QI

Enhancing QI capabilities:

Our aim is to provide an opportunity for all 18,000 colleagues and relevant strategic partners to gain an understanding of the Newcastle Improvement approach, incorporating the Model for Improvement, and to have the confidence and ability to apply this learning to deliver improved outcomes for patients and enhanced staff experience.

An e-learning package and a new induction video has been launched on ESR, in addition to an enhanced induction session introducing staff to Newcastle Improvement and the role of continuous quality improvement. More formal QI training programmes including a selection of teams and coaches linked to Trust strategic and patient safety and quality priorities are also planned.

The Model for Improvement, developed by Associates in Process Improvement, is a simple, yet powerful tool for accelerating improvement. This model has been used very successfully by hundreds of health care organisations, in many countries, to improve many different health care processes and outcomes.



The work-plan for the coming year has been set in the context of the following core areas of focus:

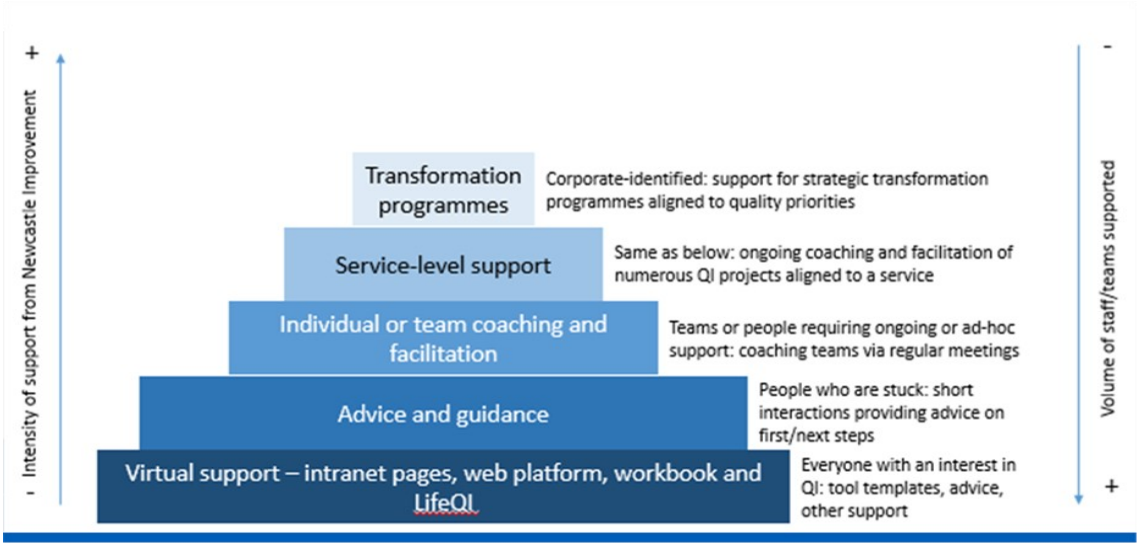
1. Workforce Expansion and Wellbeing

2. Operational Recovery for Delivery and Performance

3. Financial Stability

4. Transformation and Quality Improvement

5. Quality and Patient Safety



Human Factors:

Human factors is considered to be one of the core concepts underlying QI. The science behind the fundamental principles concerning the design of work systems , that match the needs of the people who work in them, is essential to understand if teams want to change them. The inclusion of Human Factors considerations in the design structure and process has the potential to improve outcomes for patients and families and to improve the comfort and usability of systems for staff. New technologies and continual change must be informed and designed through the application of Human Factors methods and principles to realise the full potential of QI.

Human Factors training enhances clinical performance through an understanding of the effects of team work, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings.

Patient and Public Involvement:

Don Berwick (3) states that ***"Patients and their carers should be present, powerful and involved at all levels in healthcare"*** (p.17).

The Trust has a long term commitment to listening and learning from the experience of patients and carers and well established forums and committees to lead this work (Public, Carer and Public Involvement Committee, a Community Advisory Panel, and an active Equality, Diversity and Human Rights Group.

Patient involvement is crucial to the delivery of appropriate, meaningful and safe healthcare and is essential at every stage of the care cycle: at the front line, the interface between patient and clinician and at the organisational level.

The aim of this strategy is not for patients and carers to be the passive recipients of increased engagement, but rather to achieve a pervasive culture that welcomes authentic patient partnership – in their own care and in the processes of designing and delivering care. This should include participation in decision-making, goal setting, care design, quality improvement, and the measuring and monitoring of patient safety. Patients should, when they wish, advise leaders and managers by offering their expert advice on how things are going, on ways to improve, and on how systems work best to meet the needs of patients.

The importance of the role of patients, their family and staff in improving quality is a core component of the Patient Safety Strategy. This includes appointment of Patient Safety Partners which will be key roles in helping us to co-design improvement initiatives, safety governance, strategy and policy. The Trust has already appointed Patient Safety Specialists who are key leaders and supporting the Trust's safety agenda.

7. Staying Ahead

NuTH has a rich history of research and innovation. We will continue to champion and spread innovation by making better use of our collective insight to inform research, adapting how we work so we can respond to and support innovative new models of care.

Our Clinical Research Strategy was launched in 2021. This strategy sets out our vision and plans to further advance Newcastle Hospitals' clinical research activities, embedding research into patient care in new and exciting ways. The collaborative approach already taking place within Newcastle Hospitals has shaped this new understanding, helping to show how a culture of embedded research can create a virtuous circle of improvement for patients, staff, organisations and ultimately, the wider population.

This collaborative approach and our partnership with Newcastle University is critical to our delivery of high calibre research and the strength of this relationship is evidenced by the Academic Health Science Centre (AHSC) status awarded to the partnership in April 2020 by the National Institute for Health Research (NIHR), NHS England and NHS Improvement. This partnership, Newcastle Health Innovation Partners (NHIP), includes in addition to the Trust and Newcastle University, Newcastle City Council, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and the Academic Health Science Network for the North East and North Cumbria. The collective vision is to become the most integrated and innovative AHSC in the world, working with innovators to discover, develop and deliver new solutions in healthcare to improve population health in the North East and North Cumbria.

The Trust also leads the way in developing a national CRN Research Patient Satisfaction Survey. We will collect regular feedback from patients who have experienced care as part of a research study through patient satisfaction surveys, friends and family initiatives and regular public engagement events. The Health Education England (HEE) Research & Innovation (R&I) strategy identifies the importance of a workforce that embraces R&I as being central to improving the quality of care and patient experience.

Historically, practice-based research has more commonly been developed by medical practitioners, with non-medical professionals predominantly supporting research delivery.

Since the launch of our first Nursing, Midwifery and Allied Health Professional (NMAHP) Research Strategy in 2015, significant work has been undertaken to continue to strengthen NMAHP research capability and capacity, ensuring we are at the forefront of this agenda nationally. This has been demonstrated by investing in a Trust Lead for NMAHP Research, appointing a Professorial Chair in Nursing and supporting over 135 individual NMAHP applications to externally competitive research related funding and training schemes over the last few years (from pre-to post doctoral). The Newcastle Hospitals Charity has recently supported a multi-million pound application to set up a NMAHP Research Institute which will benefit 100's of NMAHP in the years ahead.

The link between research active organisations and those that deliver the highest quality care is clear and so maintaining our longstanding commitment to research will be essential if we are to continually improve the quality of the services we deliver.

Newcastle Joint Research Office

Conclusion

We are confident that by implementing this strategy, and continuing to put *patients at the heart of everything we do,* we will continue to ensure that our services are safe, effective, caring, responsive and well-led. By working hard to foster a culture of continuous improvement, by empowering staff and patients to make the changes they want to see, we will continue to deliver the best possible care to the people of Newcastle and beyond. We will monitor the implementation of this strategy closely and look forward to working together to make the Newcastle upon Tyne Hospitals NHS Foundation Trust even better.

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 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 Year 4 CNST safety actions were effective from the 8 August 2021. Amendments were made to the safety actions in October and on the 23 December 2021 the Trust was informed that there would be a 3 month pause in the reporting period due to ongoing pressure on the NHS and maternity services. Trusts were informed to continue to apply the principles of the 10 safety actions in view of the overall aim which was to support the delivery of safer maternity care. The year 4 safety actions were amended during the pause period and re-published on 6 May 2022. The content of this report addresses all Year 4 Maternity Safety Actions since the amendments were published in May 2022. The new submission date is the 5 January 2023.						
Recommendation	The Trust Board are asked to note the contents of this report and approve the self-assessment to date to enable the Trust to provide assurance that the required progress with the standards outlined in the ten maternity safety actions are being met.						
Links to Strategic Objectives	Putting patients first and providing care of the highest standard focusing on safety and quality. Enhancing our reputation as one of the country's top, first class teaching hospitals, promoting a culture of excellence in all that we do.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☐	☐	☒	☐
Impact detail	Failure to comply with the standards outlined could impact negatively on maternity safety, result in financial loss to the Trust from the incentive scheme and from potential claims.						
Reports previously considered by	This is the sixth report for Year 4 of this Maternity Incentive Scheme. A previous report was presented to Trust Board on 26 May 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 and on the 23 December 2021 the Trust was informed that there would be a 3 month pause in the reporting period due to ongoing pressure on the NHS and maternity services. Trusts were informed to continue to apply the principles of the 10 safety actions in view of the overall aim which was to support the delivery of safer maternity care. Trusts were encouraged to continue reporting to MBRACCE-UK and eligible cases to the Healthcare Safety Investigation Branch (HSIB). Every reasonable effort should be made to make the Maternity Services Data Set submissions to NHS Digital.

The year 4 safety actions were amended during the pause period and re-published on 6 May 2022. The content of this report addresses all Year 4 Maternity Safety Actions since the amendments were published. The new submission date is 5 January 2023.

The content of this report addresses all Year 4 Maternity Safety Actions in order to report progress and ongoing compliance with the recommended standards and timescales for these respective safety actions.

The Board of Directors are asked to note the contents of this report and approve the self-assessment to date to enable the Trust to provide assurance that the required progress with the standards outlined in the ten maternity safety actions are being met.

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 should improve Trusts' performance on improving maternity safety and reduce incidents of harm that lead to clinical negligence claims.

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

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

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

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

The incentive scheme will run for a further year and new standards were published on 29th August 2021 outlining Year 4 requirements. The Standards were revised in October 2021 and May 2022. This report focuses on the third version published.

The Trust Board will receive a further report for consideration in September 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.

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

ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 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.

The Trust is compliant with this standard. All deaths of babies within the Trust, which require review, are reviewed within two months of each death using the PMRT and this process pre-dates the deadline date outlined in Standard A (08/08/2021). This process is well established and includes deaths after home births where care was provided by the Trust. There are no concerns regarding ongoing compliance with this standard and all cases either have a review in progress, or a completed review within the stipulated timeframe.

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.

The Trust is confident in exceeding the 50% target outlined in this standard for Year 4. The PMRT will only provide a completed (published) report after multidisciplinary case reviews have been fully completed and inputted into the system. In January 2022 there were 2 neonatal deaths and no stillbirths. Both (100%) of the neonatal deaths had reports in draft, and then final reports published, within the required timescale.

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.

The Trust continues to be compliant with this standard. It is a routine part of the discussion with families after the death of a baby that they are informed that a review will take place and their perspectives, and any questions or concerns are sought as part of the bereavement pathway. This is recorded clearly within the PMRT database and the Trust has achieved 100% compliance thus far. For each baby who has died, a bereavement lead is nominated who takes responsibility for maintaining contact with the parents. The PMRT can be externally accessed by NHS Resolution in verification of those standards which align.

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 has produced a quarterly PMRT report for Trust Board since 25/04/2019. The reports have previously been generated by MBBRACE and are quantitative only. For this Trust Board report a local report has been produced, cross referenced with the MBRRACE generated one. This is a new style report which is more informative and qualitative.

This report covers quarter 4 (01/01/2022 – 31/03/22). There were 15 perinatal deaths reported. 3 of these were terminations for abnormality and therefore do not require a PMRT review. The report includes: 3 stillbirths and 9 neonatal deaths.

Please refer to the Private Board Reference Pack for the PMRT report (agenda item A8(c)(iii)).

The Trust is confident in being fully compliant with this safety action and can provide evidence to support this standard.

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 Maternity Digital Strategy, which is aligned to the Trust Digital Strategy has been developed and will be ratified at the Obstetric Governance Group in August 2022. Once ratified it will be shared with the Local Maternity and Neonatal System (LMNS) and signed off by the Integrated Care Board (ICB). The lead midwife for digital health is part of the regional digital steering group and is fully engaged with the NHS England / Improvement (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" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022.

The Trust currently achieves 10 out of 11 CQIMS's. The 1 outstanding CQIM relates to a documented first feed of the baby; the Trust currently achieves a compliance rate of 65% regarding the documented first feed taken by the baby. To comply with this CQIM, compliance should be above 70%. The lack of 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 manually enter the data for the month of July to ensure this CQIM target is met.

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 at 91.7%. In February it was 92.7% and in March it was slightly below compliance at 89.3%. The Trust continues to monitor this compliance closely to ensure it remains consistently above the required 90%.

3.4 Standard 4

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

The Trust is 100% compliant with collection of this data set.

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 the April 2022 bookings was below the 95% threshold at 90.6%. This data requirement had previously been suspended and has just been re-introduced with the launch of the revised safety actions published in May 2022. The community midwives have been reminded to complete this data which will be closely monitored over the next few months. If compliance remains below 95% when the Trust receives the May and June data, there are plans in place to enter the data manually to increase compliance to the required 95%. Evidencing compliance in relation to this standard will be greatly supported through the implementation of BadgerNet.

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 April 2022 bookings was 91.7%. In February it was 92.7% and in March 91.7%. This standard was revised in May 2022 so that 'not stated, missing and not known' can no longer be accepted. The community midwives have been informed of the need to accurately complete this data entry requirement.

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.

The Trust is 91.7% compliant with this.

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.

Only 4% of the women booked to deliver at the Trust are placed on a Continuity of Care 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 44% and 100% respectively. The quality of the data submission is under review by the Trust Information Analysts and further analysis is required. The issue is in relation to Care Professional Local Identifier.

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 completed and submitted the Data Quality Submission Summary Tool for June 2022 and must do this 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 AVIODING TERM ADMISSIONS INTO NEONATAL UNITS PROGRAMME?

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

4.1 Standard A

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

The Trust is compliant with this standard as outlined in previous Board reports for Year 2 and Year 3 of the scheme and this pre-dates the deadline of 16 June 2022 for Year 4.

Pathways of care are outlined in the Care of the Vulnerable Neonatal Guideline and are based on the principles of the British Association of Perinatal Medicine (BAPM). This

pathway is business as usual and was jointly approved by maternity and neonatal teams, with a focus on minimising separation of mothers and babies and includes the Newborn Early Warning Trigger and Track (NEWTT) assessment from birth on Delivery Suite, Transitional and Postnatal 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.

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

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

4.3 Standard C

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

This is a new requirement in the revised standards published in May 2022. There has been a database in place since the introduction of the ATAIN meetings in 2018. The database has been amended to include babies admitted to the unit regardless of length of stay. Previously only babies admitted for longer than 4 hours were included in the database. The Trust is compliant with this standard.

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

Data is available on transitional care activity (regardless of place - which could be transitional care, postnatal ward, virtual outreach pathway etc.) and this data recording process pre-dates the deadline of 16 June 2022 outlined in Year 4 of the incentive scheme.

The Trust has a secondary recording process available for babies born between 34+0 - 36+6 weeks gestation at birth, who did not have surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered. This is already in place and pre-dates the deadline of 16 June 2022 outlined in the scheme.

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.

The Trust is compliant with this standard, coding is in place and commissioner returns are available to be shared more widely, on request, with the operational delivery network, Local Maternity and Neonatal System, Operational Delivery Network or commissioners as outlined in Year 4 of the scheme.

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.

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

Mechanisms are in the process of being agreed regionally to enable findings to be shared on a quarterly basis from the Trust's reviews of term admissions to the neonatal unit with LMNS and ICS. The Trust awaits clarification of this process.

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.

An action plan to address local findings was signed off by the Board at the November 2021 Board meeting. An updated action plan will be presented to the Maternity Board Level Safety Champions Group on the 10 August 2022 and included in the September Quality Committee report.

4.8 Standard H

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

This is a new requirement as part of Year 4 of the scheme to share progress with action plans with the LMNS and ICS quality surveillance meeting quarterly and a mechanism is being agreed regionally in order to be compliant with this standard, as outlined above.

The Trust is confident of being fully compliant with this safety action.

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

5.1 Standard A

Obstetric Medical Workforce

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

A paper was presented to the Maternity Board Level Safety Champions Group in December 2021 regarding a Medical Workforce Strategy. An update is required to be provided by the submission date of 5 January 2023 as outlined in the amended standards published in May 2022. This paper will be prepared and presented at the October 2022 Maternity Board Level Safety Champions Group.

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 LMNS.

Monthly audits of consultant attendance commenced in January 2022 as required. The results of these audits are shared at the Obstetric Governance group meeting and a six-month report will be presented at the next meeting in August 2022. The audits have also been shared at the April 2022 Maternity Board Level Safety Champions Group. The Trust is confident that attendance is good and in the absence of a Consultant, a senior trainee has been present. Overall, there are no concerns with Consultant attendance for the clinical situations listed in the RCOG document.

5.2 Standard B

Anaesthetic medical workforce

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

The Trust is confident in compliance with this standard as in previous years. Any gaps in the Trainee rota are covered by the Consultant. An audit of the rota was completed in February 2022 and the results of this were presented on the 13 April 2022 at the Maternity Board Level Safety Champions meeting. Additional rotas can be provided as further evidence if required.

5.3 Standard C

Neonatal medical workforce

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

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

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

The Neonatal unit did not meet the BAPM standards for year 3 of the scheme and the position remains the same for year 4. These deficiencies were addressed which led to a successful business case to increase the number of tier 2 neonatal trainee doctors. Despite a rigorous recruitment drive, the Trust has been unable to fill these posts. In the interim tier 1 neonatal trainee doctors have been recruited with a plan that they will progress to tier 2 level within a defined timeframe. An update regarding neonatal medical workforce will be included in the Medical Workforce paper presented to the Maternity Board Level Safety Champions Group in October 2022.

5.4 Standard D

Neonatal nursing workforce

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

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

A Staffing Report was presented to the Trust Board in November 2021 which included a position statement regarding the Neonatal Nursing Workforce. A staffing review using the Dinning Tool was undertaken in October 2020 which showed the establishment to be appropriate; a further review took place in May 2022. The outcome of this exercise is under review, with a plan to ensure actions are taken whereby deficiencies are identified. This action plan will be developed and presented in a subsequent Staffing Paper to the Trust Board before the 5 January 2023 (proposed MIS submission date).

The Trust is confident of being fully compliant with this safety action.

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.

Birthrate Plus (an external workforce review) was completed in October 2020. The review identified a shortfall in the Midwifery establishment which aligned to the Trust's bid for Ockenden funding in 2021, and which has been reported and regularly updated through the Trust Board Ockenden paper. Midwifery staffing is also presented regularly on a six-monthly basis to the Trust Board in the Nursing and Midwifery Staffing paper.

The Midwifery workforce is continuously monitored and reviewed, with immediate appropriate actions taken to support identified issues which arise. The Trust is currently in the process of reconfiguring the workforce to meet with plans aligned to Maternity Transformation. More detail is presented to the Quality Committee and Trust Board in the Ockenden and the Nursing and Midwifery staffing reports.

6.2 Standard B

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

The number of Midwives contracted to work within the organisation meets with the recommendations made by the Birthrate Plus review. This is subject to regular review and monitoring.

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

The Trust is compliant with Standards B and C as in previous years. As detailed in the May Board report between the period of 1 November 2021 and 28 February 2022, there were no occasions recorded where a midwife had been unable to provide continuous one-to-one care and support to a woman in established labour; and no occasions where the delivery suite coordinator had not remained supernumerary and has resulted in the coordinator being the named midwife for a woman. In the period 1 March and 30 June 2022 there were 5 occasions recorded when 1 midwife was not able to provide 1:1 care during established labour and 1 occasion where the delivery suite co-ordinator could not be supernumerary. This data is collected daily by completion of the Birthrate Plus Intrapartum acuity tool which is completed every 4hrs by the delivery suite co-ordinator.

It is recognised that this period posed significant challenge from the COVID-19 omicron variant wave of the pandemic from a staffing perspective, together with high levels of acuity. Qualified staff, included specialist midwives, were re-deployed to different clinical areas, there were some inpatient ward closures and relocation of triage services to ensure that safe staffing was maintained. The service did see some unavoidable delays in elective admissions for induction of labour due to the need to maintain one-to-one care in labour during this period, however, this has stabilised as the omicron wave and staff absence has improved.

There is a clear Maternity Services Escalation policy which is implemented in the event that acuity is as such that the coordinator cannot be supernumerary and/ or 1:1 care cannot be provided to women in active labour.

The standard states that a Trust can report compliance with this standard if this is a one-off event and the co-ordinator is not required to provide 1:1 care for a woman in established labour during this time. The Trust acknowledges that there has only been 1 occasion in an 8-month period whereby the co-ordinator has not been supernumerary and appropriate action has been taken in mitigation.

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.

Regular reporting on a six monthly basis is made to the Trust Board in relation to Midwifery staffing. A Nursing and Midwifery Staffing Report was submitted to the Trust Board in November 2021 and in May 2022. The contents of this paper are cross referenced as appropriate within the Ockenden paper to both the Quality Committee and the Trust Board.

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

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

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.

The quarterly care bundle was completed and submitted to the Clinical Network on the 26 May 2022 (see Public Board Reference Pack agenda item A8(c)(iii))

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 May showed 96% compliance.

CO monitoring of women at 36 weeks remains an ongoing challenge from Year 3 due to the lack of electronic maternity records for capturing this data. When the safety actions were amended this element has reduced the time frame which is now over 4 months instead of 6 months. Between September 2021 - December 2021 the compliance rate was 82%. Data is required to be entered manually in order to achieve compliance and this continues. Prior to manual data entry compliance has ranged from 61-77%. The Trust continues to address the lack of compliance and a report is produced monthly so that manual data entry can be commenced as soon as possible. Although the Trust has met this standard there remain ongoing challenges with maintaining compliance and progress will be reported in future papers.

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 with both these elements. There are three opportunities for women to receive this leaflet – 1) at the booking appointment 2) the NUTH pregnancy information booklet and 3) the 20-week anomaly scan. For compliance of this standard presence of the information leaflet shared at the 20-week scan has been audited.

An audit was undertaken in May 2022 showed 100% compliance with both A and B.

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 low figures is the difficulty in ensuring both doses of steroids are administered before delivery, when delivery occurs rapidly or unexpectantly. Some pre-term women attend in advanced labour and only one dose could be administered in time. 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 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.

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 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 is due to commence the post in August. This role will assist in the provision of care for the Pre-term birth women and they will be jointly responsible for monitoring compliance and delivering 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 has a firmly embedded Maternity Voices Partnership (MVP). The two new co-chairpersons are now settled into their roles and are working collaboratively in partnership with the Associate Director of Midwifery and key link Midwives within the service. The MVP continues the work in developing the work plan for 2022/23, ensuring key work streams are undertaken in a collaborative way and in partnership with service users.

Focus groups have been undertaken to obtain views of service users on two important elements relating to peri-natal mental health and bereavement pathways. Further work is planned to ensure that the Chairpersons are invited to triumvirate and safety champion meetings.

The Trust is confident of remaining fully compliant with this safety action.

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 annual '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 annual '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 remains a challenge due to staff absence as a result of the COVID-19 pandemic and other sickness 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 have subsequently been scheduled in addition to the planned sessions, to enable increased attendance throughout the next 6 months.

A task and finish group has been established to monitor and review ongoing compliance in relation to staff training. Compliance is improving and currently across standards B, C and D the range in the various staff groups is between 31 – 71%.

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	63%	90%
Maternity Support Worker/ Nursery Nurses/ HCA's	98	71%	90%
Theatre staff (includes DS)	11	70%	90%
Obstetric Consultants	14	50%	90%
Anaesthetic Consultants	16	31%	90%
Trainees	38	54%	90%
Total	**486**	**63%**	**90%**

A further 19 training days are scheduled up until the end of October. Providing all staff are able to attend their allocated session full compliance will be achieved by October. Additional sessions are also planned in the event of slippage and full compliance in all staff groups has not been achieved by the end of October 2022.

10. SAFETY ACTION 9: CAN YOU DEMONSTRATE THAT THERE ARE ROBUST PROCESSES IN PLACE TO PROVIDE ASSURANCE TO THE BOARD ON MATERNITY AND NEONATAL SAFETY AND QUALITY ISSUES?

10.1 Standard A

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

The pathway has been revised in light of the additional requirements and was presented at the Maternity Board Level Safety Champions Group in April 2022. The pathway is also displayed on the Safety Champions noticeboard outside the entrance to delivery suite. Further engagement work is required to ensure that all staff are aware of the pathway and updates will be reported through the Board-level Safety Champions Group.

10.2 Standard B

a) *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.*

A monthly Trust maternity data dashboard is submitted as part of the Integrated Board Report (IBR) data submission and this pre-dates the deadline date of 16 June 2022 outlined in the scheme. Themes identified and actions taken are outlined and presented quarterly.

Minimal staffing in maternity services is presented by the Executive Chief Nurse, also a Board-level Safety Champion, through the Nursing and Midwifery Staffing paper.

Training compliance is presented in detail in the Ockenden Board report which is submitted bi-monthly. A paper was presented in July 2022.

Monthly walkabouts continue to be undertaken by a member of the Board, with the Non-Executive Director (Maternity). Minutes of the walkabout are shared with the Executive / Non-Executive Director, the Directorate Manager, and Associate Director of Midwifery. Feedback from these walkabouts is shared with staff via the Improving Safety Together

newsletter produced twice a year (an example has been included within the Private Board Reference Pack under agenda item A8(c)(iii)).

The Trust's Claims Scorecard, alongside incident and complaint data was presented to the Maternity Board Level Safety Champions Group in February 2022. A second report will be presented at the October 2022 meeting, as outlined for the scheme.

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.

A proposal aligned to the Maternity Transformation Programme and the implementation of Continuity of Carer has been developed by the Women's Services Directorate and this was presented to the Trust Board in January 2022. Receiving Trust Board approval, the Trust has undertaken staff consultation through a formal organisational change process. This processed commenced in February 2022 and consultation closed on 6 June.

Plans have been developed to determine the proportion of Newcastle women that can be offered a Continuity of Carer pathway. A Birthrate plus (BR+) compliant staffing resource has been used and this has been modelled to achieve 63% of Newcastle women on a Continuity of Carer pathway. The Newcastle model retains a higher proportion of 'core staff' than BR+ indicates within acute service, in mitigation of the large number of out of area women and to preserve safety.

The proposal prioritises those women most likely to experience poorer outcomes and the timeline is in line with the requirements of this standard. Further work will be undertaken to clarify the additional investment which will be required to enable the Trust to offer Continuity of Carer as a default to 100% of Newcastle women.

It is important to acknowledge the recommendation made by the final Ockenden report which advises that Trusts must ensure minimum safe staffing levels prior to rollout of any further Midwifery Continuity of Carer. Further detail in relation to this and the Trust's position is presented within the Ockenden paper presented to the Quality Committee and Trust Board in July 2022.

10.4 Standard D

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

The Trust participate and engage with the relevant MatNeo Patient Safety Network events and have had representation at 4 events (16 September, 13 December 2021, 24 March and the 16 June 2022), as outlined in the scheme.

Evidence that insights from culture surveys undertaken have been used to inform local quality improvement plans by 5 January 2022

The Score survey (organisational culture) was undertaken in April 2019. The results were shared with staff and feedback sessions delivered by two external health professionals in January 2020. Themes identified were similar to those identified during the Trust Staff Survey undertaken at the same time and these were incorporated into the Directorate Quality Improvement plans for 2020/21. Ongoing work is planned in light of the final Ockenden report which asks providers of maternity services to ensure high levels of staff engagement, ensuring a culture which is transparent, open and honest, in which staff feel psychologically safe to speak up. Further updates will be provided in future papers cross-referenced to the Ockenden papers presented to Quality Committee and Trust Board.

The Trust is confident of being fully compliant with this safety action.

11. SAFETY ACTION 10. HAVE YOU REPORTED 100% OF QUALIFYING CASES TO HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB) AND TO NHS RESOLUTIONS EARLY NOTIFICATION (EN) SCHEME FROM 1 APRIL TO 5 DECEMBER 2022?

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

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

C) For all 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. For A and C – all qualifying cases have been reported to HSIB from 1 April 2021 and families involved in cases which qualify for a HSIB/ EN investigation meet with one of the Risk and Governance Midwives in the first 24-48hrs few days after birth. The process is fully explained to the parents and literature is provided to support the conversation. Thereafter, following discharge, a confirmation letter is sent to the family; this includes a written apology on behalf of the Trust in line with Duty of Candour Regulations.

Since 1 April 2022 there have been no qualifying EN cases (point B).

11. 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
28 July 2022

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022						
Title	Health and Safety Annual Report 2021-22						
Report of	Angela O'Brien, Director of Quality and Effectiveness						
Prepared by	Craig Newby, Health, Safety and Risk Lead						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	The purpose of this report is to provide the Trust Board with an update on health and safety activity across the organisation during 2021-22. It details: • Compliance with health and safety legislation. • Health and safety incidents remain relatively stable; however there have been increases in violence and aggression compared to previous years. • Lone worker devices successfully implemented across the organisation. • Increase in RIDDOR reportable incidents in 2021-22.						
Recommendation	The Trust Board are asked to note the content of the report and its findings.						
Links to Strategic Objectives	• Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. • Maintain compliance with all regulatory requirements.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☐	☐	☐	☒	☐
Impact detail	• Potential for harm to patients, staff and/or the public. • Enforcement action from regulatory bodies.						
Reports previously considered by	This report is an annual update on the activity associated with the Trust Board.						

HEALTH AND SAFETY ANNUAL REPORT 2021/2022

1. INTRODUCTION

The Health & Safety annual report covers the period 1 April 2021 to 31 March 2022. The annual report outlines key developments and the work that has been undertaken during this reporting period as well as a review of all health and safety related incidents. It reflects the Trust's compliance with the Board of Directors approved 'Statement of Intent' and Health & Safety Policy Statement, which requires those responsible for health and safety within the organisation and during Trust activities to:

- Comply with health and safety legislation;
- Implement health and safety arrangements;
- Comply with monitoring and reporting mechanisms appropriate to internal and external key stakeholders and statutory bodies; and
- Develop partnership working and to ensure health and safety arrangements are maintained for all.

In progressing the management strategy of health and safety throughout the Trust, the Compliance and Assurance Team continues to observe the HSG65 model "Managing for Health and Safety". The key components of the Plan, Do, Check, Act (PDCA) framework can be summarised, as follows:

Plan Determine policy, plan for implementation.
Do Profile health and safety risks, organise for health and safety management, and implement the plan.
Check Measure performance, investigate accidents and incidents.
Act Review performance, apply learning. This framework directly maps with the SASH+ methodology, Plan, Do, Study, Act

2. MEETINGS & ATTENDANCE

The Health and Safety Committee has met four times during the period 1 April 2021 to 31 March 2022. The Trust Health & Safety Committee achieved an attendance rate of 84% during the period of 1 April 2021 to 31 March 2022.

Members	13/05/21	12/08/21	11/02/21	23/02/22
Chairman: Head of Risk, Compliance and Assurance	X	X	X	X
Vice Chairman: Deputy Director of Quality & Safety	X	X	X	X
Director of Quality and Effectiveness	X		X	
Health Safety and Risk Lead	X	X	X	X
Associate Director of Nursing		X		X
Health and Safety Advisors	X	X	X	X
Health and Safety Administrator		X	X	X
Integrated Governance Manager	X	X	X	
Occupational Health Clinical Lead	X	X	X	X
Estates Compliance and Risk Manager	X	X	X	X
Portering and Security Manager	X	X	X	X
Strategic Fire Safety Lead	X	X	X	X
Senior Human Resources Manager	X	X	X	X
Workforce Development Manager	X	X		
Directorate Manager			X	X
Lead Moving and Handling Coordinator	X	X	X	X
Newcastle University Safety Advisor	X	X		
Contract Compliance Officer (Mitie)	X	X	X	X
Staff Side Representatives	X	X	X	X

3. TERMS OF REFERENCE

The Terms of Reference were reviewed and approved by the Committee on 23 February 2022 and now reflect key changes to the governance arrangements within Estates.

4. POLICIES & PROCEDURES

The policies below were ratified by the Health and Safety Committee during 1 April 2021 to 31 March 2022.

Policy/Procedure	Date Approved
Asbestos Management Policy	12/08/2021
Operational Control of Contractor Procedure	12/08/2021
Placing a Risk of Violence Alert on Patient Record Policy	12/08/2021
Health & Safety Operational Policy	12/08/2021
Personal Protective Equipment Policy	12/08/2021
Pregnancy Worker Policy	12/08/2021

Safe Use And Storage Of Liquid Nitrogen And Solid Carbon Dioxide (dry Ice) Policy	12/08/2021
Management of Violence and Aggression at Work Policy	12/08/2021
Transportation and Storage of Medical Gases	12/08/2021
Prevention of Non-Patient Related Slips Trips and Falls Policy	17/11/2021
Provision and Use of Work Equipment Policy	17/11/2021
LOLER (Lifting Operations and Lifting Equipment Regulations) Policy	17/11/2021
Display Screen Equipment Policy	17/11/2021
Radiation Safety Policy	17/11/2021
Electrical Safety Policy	17/11/2021
Management & Control of Pressure Systems Policy	17/11/2021
Lone Worker Policy	17/11/2021
Moving and Handling Policy	23/02/2022
Moving & Handling Bariatric Policy	23/02/2022
Management & Control of Pressure Systems Policy	23/02/2022
Electrical Safety Policy	23/02/2022

Quarterly and annual reports received at the Health and Safety Committee during 1 April 2021 to 31 March 2022.

Quarterly Reports	Annual Reports
Training Health and Safety Compliance Inspection Programme Health and Safety Incidents Sharps Incidents Estates Fire Safety Security Moving and Handling Health and Safety Risks Quarterly Mitie PFI Report	Radiation Protection Health and Safety Moving and Handling Sharps Electrical Safety Dental Health and Safety Lift System Annual Report Annual Pressure System Report Fire Safety Group Annual Report Asbestos Annual Report and management plan Benchmarking – Violence Reduction Standards

Minutes for the following committees and groups were reviewed quarterly in 1 April 2021 to 31 March 2022.

Related Committee Minutes
Trust Security Group
Stress in the Workplace Review Group
Radiation Protection Committee
Dental Health & Safety Committee
Laboratory Health and Safety Group
Slip, Trips and Falls Group

Violence and Aggression Prevention Group
Safe Sharps Group
Fire Safety Group
Water Safety Group
Asbestos Working Group
Electrical Safety Group
Pressure System Group
Datix User Group
Latex Awareness Advisory Group
Trust Security Group

5. TRAINING

The Health and Safety Team has successfully delivered 48 training course during 1 April 2021 to 31 March 2022.

Courses	Number of Sessions
Risk Assessor	9
COSHH Assessor	8
Datix E Learning Sessions	323
Stress Awareness	0
Stress Training for Managers	5
Lone Working LWS	830 individual staff members trained
Mental Health First Aid Courses	4

*COVID-19 had an impact on the training sessions available during 20-21

6. LEGAL COMPLIANCE

The table below outlines the main Health & Safety legislation and identifies the proactive work that the Trust has carried out in order to comply:

Legislation		Description of actions/compliance
Health & Safety at Work Act 1974		Compliant, specific areas of assurance are: • Competent persons in place to provide compliance advice. • Health and Safety Committee held 4 times a year – which are well attended. During 2021-22 the Committee met four times, in line with expectations. The scheduled meeting in May 2020 was cancelled due to COVID-19 restrictions. • Increased availability of induction training sessions for new recruits, both induction and update sessions include reminders of the requirement to risk assess.
Management of Health & Safety at Work Regulations 1999		Compliant, specific areas of assurance are: • H&S Audit programme, all clinical areas audited on a 2-year cycle, requires audit actions to be addressed at service level within given timescales in order to ensure full compliance.

		• Risk assessment training is provided to all clinical areas and risk assessment paperwork has been reviewed. Requirement for role specific risk assessments, production and quality of these is monitored via the audit / inspection programme. • Risk Assessor training provided for the Integrated Covid Hub North East (ICHNE). • Core risk assessments provided for ICHNE, Vaccination Centres and North Cumbria Cancer Services. • The most recent Health and Safety Compliance audit showed the number of departments that have a trained risk assessor at 91%.
Control of Substances Hazardous to Health (COSHH) 2005		Compliant, specific areas of assurance are: • COSHH policy has been revised with enhanced guidance on the risk assessment process e.g. DSEAR. • COSHH Risk assessment form simplified in order to improve compliance with Regulation 6. • COSHH awareness included in all H&S Awareness training, Induction Training. • COSHH compliance reviewed in Ward areas as part of health and safety audit / inspection programme. • COSHH training provided to ICHNE. • COSHH assessments completed for ICHNE and Vaccination Centres. • The most recent Health and Safety Compliance audit showed the number of departments that have a trained COSHH risk assessor at 89%.
Display Screen Equipment Regulations 1992		Compliance and specific areas of assurance are: • This policy aims to ensure that effective arrangements are in place for working with display screen equipment and to meet the requirements of the Display Screen Equipment Regulations 1992 (amended 2003). To safeguard staff safety and comfort whilst working with DSE. • Training Figures - The required standard is 95% compliance with the overall compliance for the year being 87.98%. • Office Chair Assessment Service - There have been a total of 306 referrals in 2021/2022 compared with 219 referrals in 2020/21. • Overall, 43.7% of all departmental assessments were completed. Compliance has been affected by the introduction of a new system for departmental risk assessments it is expected numbers will increase next year when system is embedded. • DSE compliance extended to cover ICHNE and Vaccination Centres.
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)		Minor non-compliance with reporting timeframes • 83% of the reported incidents are (Staff member off over 7 days). • Learning from all RIDDOR incidents is shared at the Trust Health & Safety Committee and other respective assurance meetings. • Further work identified to remind managers of reporting timeframes.

Health and Safety (Sharp Instruments in Healthcare) Regulations 2013		Compliance and specific areas of assurance are: • The Trust continues to monitor ordering practices to ensure compliance with the Regulations and use of safe sharps devices wherever reasonably practicable. Further work has been undertaken this year to "mask" non-safe sharps devices from the NHS Supply Chain Catalogue to reduce ordering practices where not supported by underlying risk assessment. • Where safe sharps are not reasonably practicable, we continue to ensure and have taken steps to enhance robust risk assessment and mitigation measures are in place. A new Medical Sharps risk assessment tool has been released this year to replace the generic Trust wide risk assessment tool. This new tool puts an emphasis on safe systems of work, training and monitoring to obviate risks from using non-safety devices. All new risk assessments are completed using this tool and older risk assessments are being transferred as they fall due for review. • Sharps disposal remains a priority and the Group continues to advocate the use of point of care disposal and use of SharpSmart sharps boxes. The new SharpSmart on wheels is now embedded in the Trust and our entire fleet of SharpSmarts continues to be updated systematically across all areas of the Trust. • Sharps Group meet Bi-monthly with representation from a variety of Trust departments including Clinical Education, Procurement, Supplies, Sustainability & Waste and Patient Safety. • The Trust is currently on the 7th edition of the Safer Sharps Inventory. This has been expanded to include safety lancets for capillary blood glucose monitoring and safety heel lancets for the Guthrie test in Maternity. Further work will be undertaken this year to expand the content of safety devices in addition to more closely aligning the Inventory.
Health & Safety (H&S) Information for Employees Regulations (Amendment) 2009		Compliance and specific areas of assurance are: • The H&S intranet page has been revised. • H&S Coordinators and TU H&S Reps in place. • Health and Safety Committee held four times a year is well attended by Managers, Trust Competent Persons, Trade Union Representatives and H&S Coordinators. • Reports on Audits, Action Plan progress, Key Performance Indicators (KPIs) and Risk Register. • Health and Safety Committee acts as consultative committee for H&S policies.
Health & Safety Consultation with Employees Regulations 1996		
Safety Representatives and Safety Committees Regulations 1977		

Lifting Operations and Lifting Equipment Regulations (LOLER) 1998		Compliance and specific areas of assurance are: • New Trust Lifting Operation and Lifting Equipment (LOLER) Policy introduced in November 2021. • Moving and Handling Team have introduced a new system related to gantry hoists that are assembled in a cubicle of a bariatric patient. • EME currently ensure all LOLER equipment meets the requirements of the regulations and are currently looking to introduce a new system, which would make them the first point of contact as opposed to the service company. • Estates have a comprehensive maintenance programme for all lifts ensuring this meets all LOLER requirements.
Provision and Use of Work Equipment Regulations (PUWER) 1998		Compliance and specific areas of assurance are: • New Trust Provision and Use of Work Equipment (PUWER) Policy introduced in November 2021. • The Health and Safety Compliance audit undertaken in quarter 3 of 21-22 includes a section for Estates around PUWER. The directorate scored 98% against the standards. • In May 2021 Estates commissioned Northern Safety Ltd to undertake an independent Safety Management System Review for the Estates Department. The result of the review was a 'Good' rating and the PUWER section of the report provided a high level of assurance other than some minor issues in relation to housekeeping. The associated action plan is currently being managed and updated. The outcome of this report will be utilised as part of the inspection programme.

7. HEALTH & SAFETY COMPLIANCE

Health & Safety Compliance audit results are reported quarterly to the Trust Health and Safety Committee for each Directorate. This compliance tool is an indicator of risk assessment completion across 12 common areas of health and safety which also include radiation and fire safety. The most recent report for Quarter 3 2021-2022 indicates that compliance across the Trust for the 12 general areas of health and safety is at 94% overall. There is ongoing work to further improve the quality of risk controls and close gaps in associated arrangements at service level.

All Departments have been subject to a health and safety Inspection since 2013 as part of a 24 month cycle to support local risk assessors and validate information collected under the compliance audit tool. Departments are provided with an action plan following each inspection. There have been 115 Health and Safety inspections undertaken during this period. The inspections have been undertaken in 9 Directorates in the current programme. Along with other measures, it is envisaged that the compliance and inspection arrangements will support an overall reduction in harm over the coming years. The

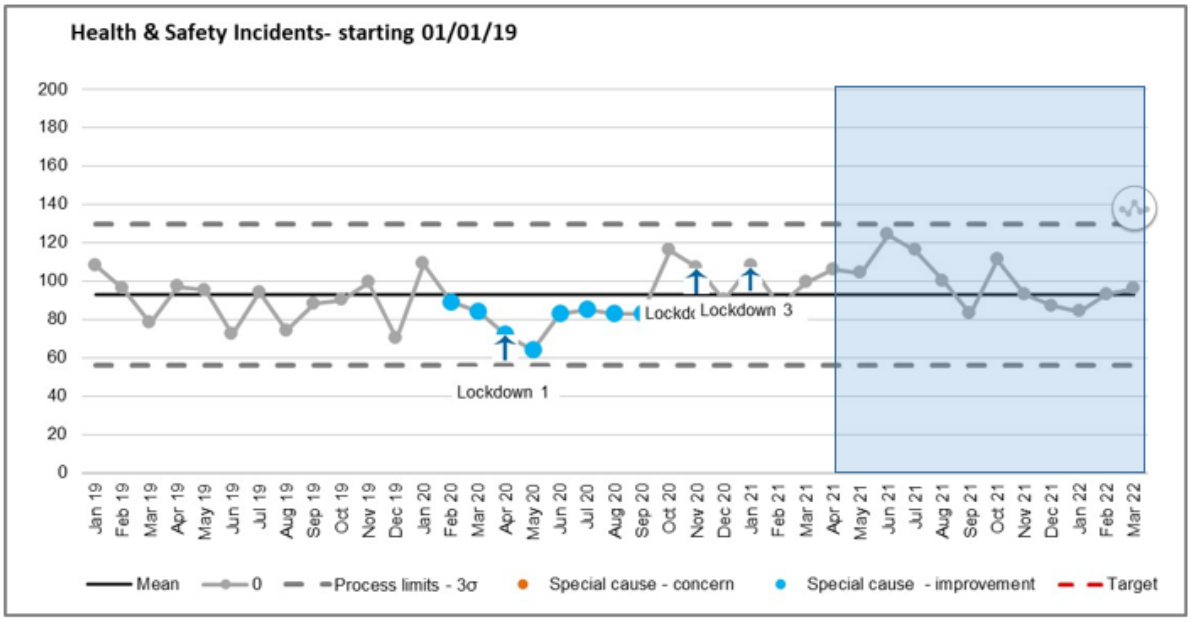
inspection programme plays an important role in validating compliance, the development of safe systems of work, leading to improved risk controls whilst supporting services.

The Compliance and Assurance department continue to work closely with the Estates department supporting the review of governance, monitoring and assurance measures around the estate related functions of the Trust. Those health and safety related risk register entries that have an estates related component and are shown below. Health and safety representation on key committees and groups continues to be provided.

8. HEALTH AND SAFETY INCIDENTS

The number and type of staff related incidents for each Directorate during the period of 1 April 2021 to 31 March 2022 is shown in table below. There is an overall 12.5% increase in reported health and safety incidents for 2021 – 2022 compared to the previous year.

Health and Safety Incidents by Type and Directorate 2021-22:



The above Statistical Process Chart (SPC) shows health and safety incidents to continue to track close to the mean more recently and there are no 'special cause' concern data trend over the previous 12 months.

Health and Safety Incidents by Category 21-22 (see below):

	Accident (staff, visitors etc.)	Buildings / Infrastructure	Exposure to Hazardous Substance	Facilities	Moving & Handling	Non-Patient Slip, Trip or Fall	Needlestick / Sharps	Total	Trend +/-
NCCC	7	0	6	3	1	0	15	32	+
Cardiothoracic	7	3	2	0	7	9	27	55	-
Chief Operating Officer	5	2	0	0	2	6	2	17	+
Children's Services	13	2	3	1	1	4	18	42	-
Clinical Research	3	3	0	1	0	0	1	8	=
Dental Services	5	3	2	0	1	1	26	38	+
Epod	6	2	4	2	1	6	28	49	+
Estates	30	71	4	5	1	17	1	129	+
Human Resources	2	0	0	0	0	1	0	3	-
IT	1	1	0	0	0	0	0	2	+
ILM	5	0	10	1	0	2	16	34	+
ICHNE	20	2	15	1	2	3	3	46	+
Medicine	28	11	7	1	15	11	38	111	-
Medical Director	1	0	0	0	0	2	0	3	-
Musculoskeletal Services	7	2	0	1	2	5	7	24	-
Neurosciences	6	0	3	0	1	2	12	24	-
NMPCE	8	0	1	1	0	0	0	10	+
Community Services	15	5	0	1	3	3	12	39	-
Patient Services	60	9	9	13	18	28	14	151	+
Peri-operative & Critical Care	28	2	10	2	9	10	81	142	-
Pharmacy	3	0	4	2	2	1	12	24	-
Radiology	7	1	8	1	0	2	3	22	=
Supplies	2	1	2	5	3	0	0	13	+
Surgical Services	8	1	3	0	1	6	12	31	+

Urology & Renal Services	7	0	5	0	3	2	12	29	-
Women's Services	21	6	3	4	1	5	33	73	-
Covid Vaccination Programme	8	7	5	0	0	6	32	58	+
External Trust / Organisation	0	0	1	0	0	0	0	1	-
Total	313	134	107	45	74	132	405	1210	+

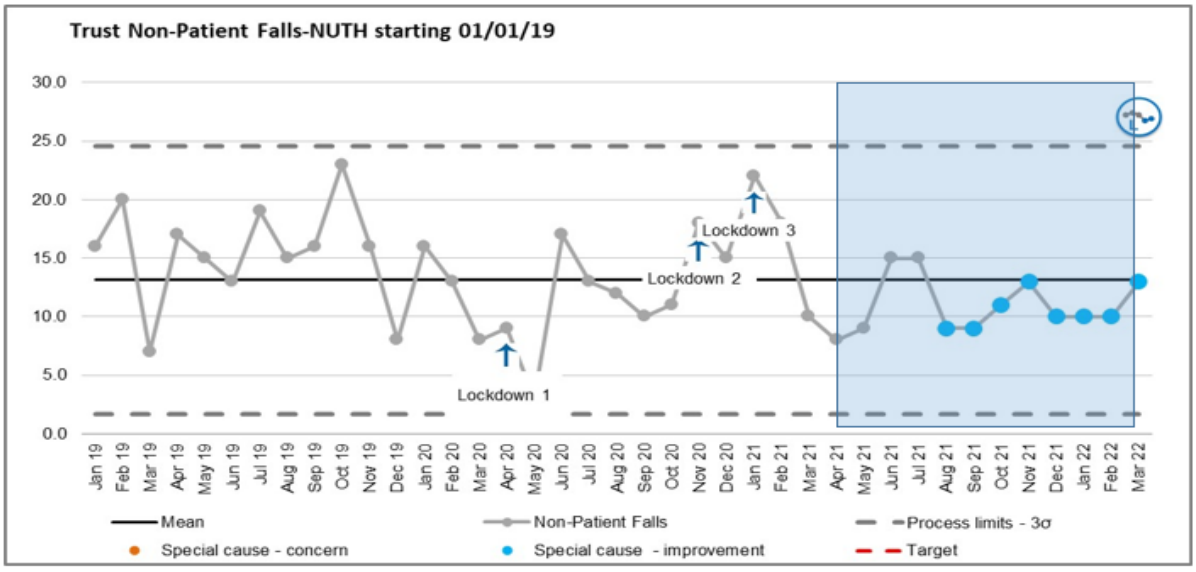
The number of incidents has increased in comparison to the previous year; however, during 2020-21 there were lock down periods which saw the level of clinical activity reduce significantly and a higher proportion of staff would have been working at home. Around 50% of Directorates saw a decrease in the number of health and safety incidents compared to the previous year.

A significant increase has been recorded in both COVID Vaccination Programme and ICHNE, which proportionately reflects the increase in workload during the previous 12-month period in comparison to last year.

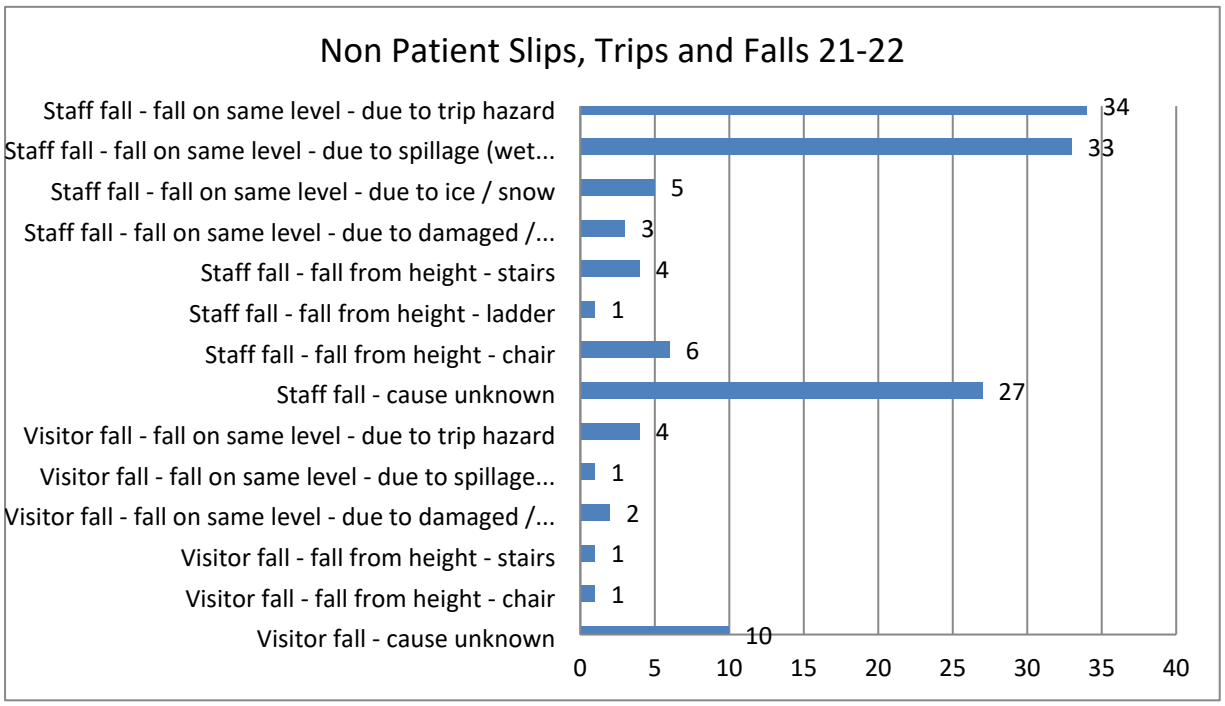
Estates incident rate has also increased on the previous year; however this is due to a re-alignment of incident coding in the new Datix Cloud IQ system, which was rolled out in April 2021. This included categorising 'buildings / infrastructure' incidents under health and safety.

9. SLIPS, TRIPS AND FALLS

A comparison of key slip, trip and fall types for staff and visitors for the period 2019 – 2022 is shown in the SPC chart below.



Non patient slips, trips and falls have reduced this year from 158 in 2020-21 to 132 in 2021-22. This continues a downward trend and more recently the rates in the SPC chart show eight continuous points of special cause improvement. During the period the Slips, Trips and Falls Group has been established to look at incident data, themes and assurance processes. External zonal inspections have been implemented and a Slips, Trips and Falls data dashboard has been developed. All RIDDOR reportable falls have been investigated fully and where necessary lessons have been shared.



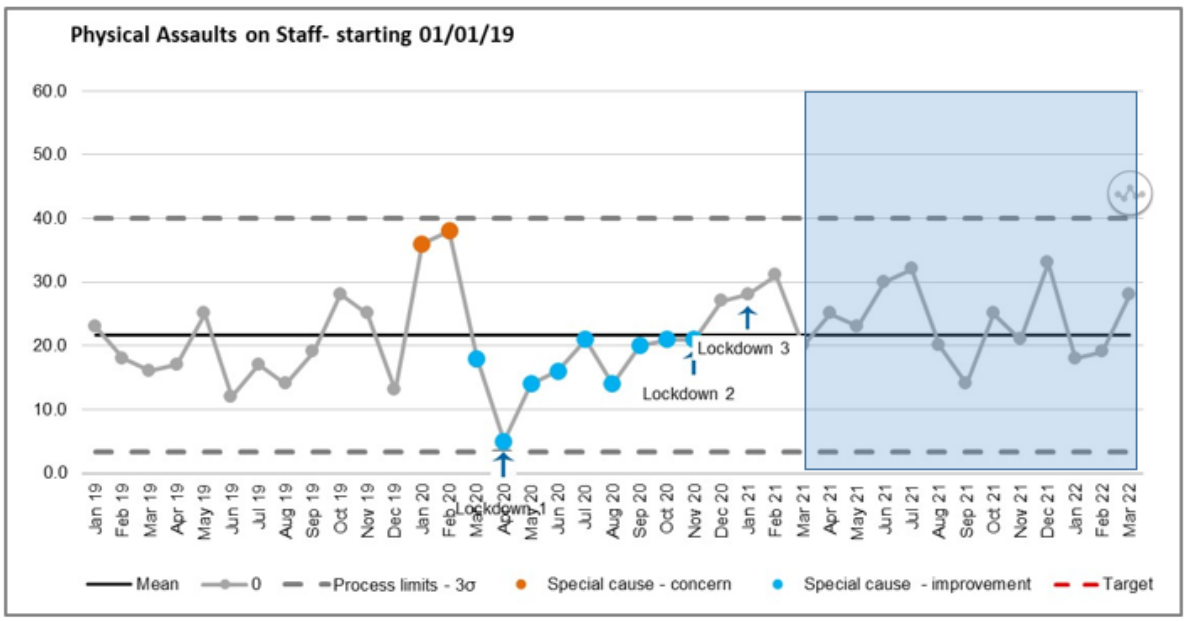
10. VIOLENCE AND AGGRESSION

Violence and aggression rates have continued to fluctuate over the period; however, incidents have increased by 18% this year in comparison to 2020-21. This reflects a difficult period as restrictions were lifted and hospital activity increased. There has been an increase in the amount of challenging behaviour both face to face and via telephone directly in relation to enforcing mask wearing, longer than normal waiting times and visitor restrictions. Emergency Department have also seen an unprecedented increase in demand for the service including a proportionate increase in those attending with challenging behaviour. It's clear that COVID has had a detrimental impact on the amount of violence and aggression towards staff.

	2017-18	2018-19	2019-20	2020-21	2021-22
Verbal	482	584	588	602	704
Racial	8	11	11	15	17
Sexual	8	9	13	11	18
Physical	247	259	273	257	298
Total	745	863	885	885	1037

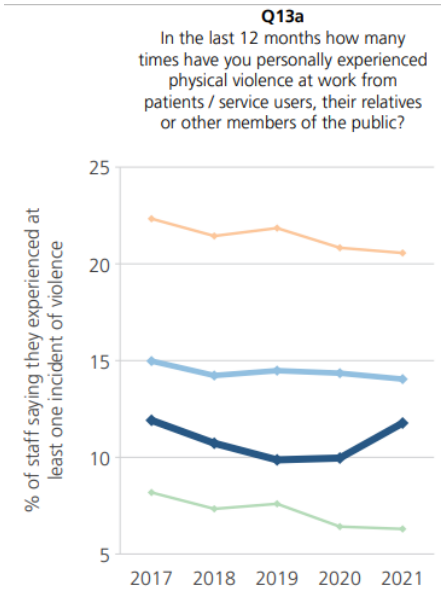
A huge amount of work has been undertaken this year to reduce restrictions and waiting times, where possible e.g. visiting arrangements. The Trust have undertaken a well evaluated training programme for staff around conflict resolution, focussing mainly for staff in reception areas and dealing with patients via telephone.

Assaults on staff have continued to fluctuate during the pandemic other than a significant reduction during lockdown 1.

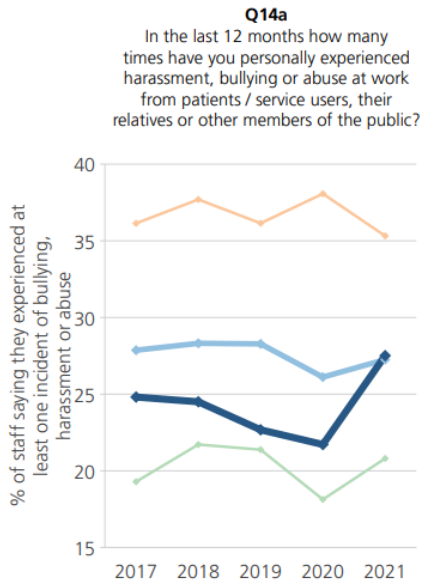


Data received from the NHS staff survey and shown in the extract below provides some indication of levels of violence and aggression experienced by staff. Q13a below suggests Trust staff are increasingly being exposed to violence which seems to be against national trends. Q14a suggests staff are being exposed to abuse, bullying and harassment from patients, relatives and the public at a higher rate than the national average.

Extract from 2021 NHS Staff Survey for NUTH



	2017	2018	2019	2020	2021
Worst	22.3%	21.4%	21.8%	20.8%	20.6%
Your org	11.9%	10.7%	9.9%	10.0%	11.8%
Average	15.0%	14.2%	14.5%	14.3%	14.0%
Best	8.2%	7.3%	7.6%	6.4%	6.3%
Responses	4,406	6,532	6,365	7,035	7,316



	2017	2018	2019	2020	2021
Worst	36.1%	37.7%	36.1%	38.1%	35.3%
Your org	24.8%	24.5%	22.7%	21.7%	27.5%
Average	27.9%	28.3%	28.3%	26.1%	27.3%
Best	19.3%	21.7%	21.4%	18.1%	20.8%
Responses	4,386	6,536	6,361	7,032	7,287

The Violent Marker Panel has approved the marking of 203 patient records during 2021/2022; this represents a 25% increase on the previous year. The conflict resolution training programme is a requirement for all staff with a regular patient facing role. This programme equips staff to recognise the ways that violence escalates, helps identify the behavioural and physical signs in people and provides a range of de-escalation techniques. At end of the period the training compliance for Conflict Resolution was 89% across the organisation.

A review of physical intervention (restraint) training provision for security staff was undertaken in 2018 and a more sustainable training model implemented (GSA). Due to COVID-19, training targets have been difficult to meet. Further work is currently underway to establish the best possible method to deliver this training.

One of the key objectives of the Compliance and Assurance team is the reduction of violence / aggression and restrictive interventions. A number of ongoing initiatives will feature within this work. For example:

- Datix system has been updated to Datix Cloud IQ with added business intelligence. In the later part of 2021-22 the Yellow Fin BI tool was used to develop a Violence and aggression dashboard, which has been shared at the Trust Security Group and plans are in place to analyse this data at the proposed Violence Reduction Group in early 2022-23.
- Restraint information is now captured on the Datix system. This was added in August 2020 and full year data will be presented as a separate report to the Health and Safety Committee. Since April 2021 221 restraints have been recorded. In terms of contributory factors mental health was recorded in 26% of restraints whilst drugs and alcohol was a factor in 35% of restraints. Restraints in the Emergency Department (ED) made up 48% of the incidents. A revised Restraint Policy is due to be introduced in early 2022-23 and will be rolled out in conjunction with revised guides around the use of rapid tranquilisation.
- Early 2022-23 will see the establishment of a Restrictive Intervention Reduction Panel, tasked with monitoring and discussing higher level interventions, which meet specific criteria (also highlighted in the revised Restraint Policy).
- Within the Emergency Department (ED) a form has been introduced to provide security with the legal rationale for restraint or detention within the department. This information is completed by the Consultant, shared with security staff and entered onto E-Record. This will become part of the Restraint Policy and therefore rolled out to all areas in early 22-23.
- The Children's Mental Health Group was established during 20-21. This group has been tasked with looking at the care pathway for children and young people with mental health or learning disabilities. This includes work around improvements to the environment on Ward 6 and ensuring appropriate psychiatric liaison is in place. The group has recently been bolstered by a range of staff from Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and input from carers.
- The Trust were successful in gaining Clinical Commissioning Group (CCG) funding to start the We Can Talk initiative, which provides support and training to Trust staff to improve their knowledge, skills and confidence when working with children and young people who are experiencing mental health difficulties whilst in hospital or attending Accident & Emergency (A&E) in a mental health crisis.

11. SHARPS INCIDENTS

The Safer Sharps Review Group met three times during 2021-22. The group work during 2021-22 includes assurance on the ongoing use of safer sharps devices in all appropriate clinical areas, ensuring risk assessments for use of non-safety devices (where reasonably practicable) reflect robust safety practice, review of sharps incidents including RIDDOR reports and introduction of a programme of staff education to enhance improvements in practice. The Group is working extensively with the waste team to bring down and properly stream our sharps related clinical waste to contribute to the Trust's sustainability

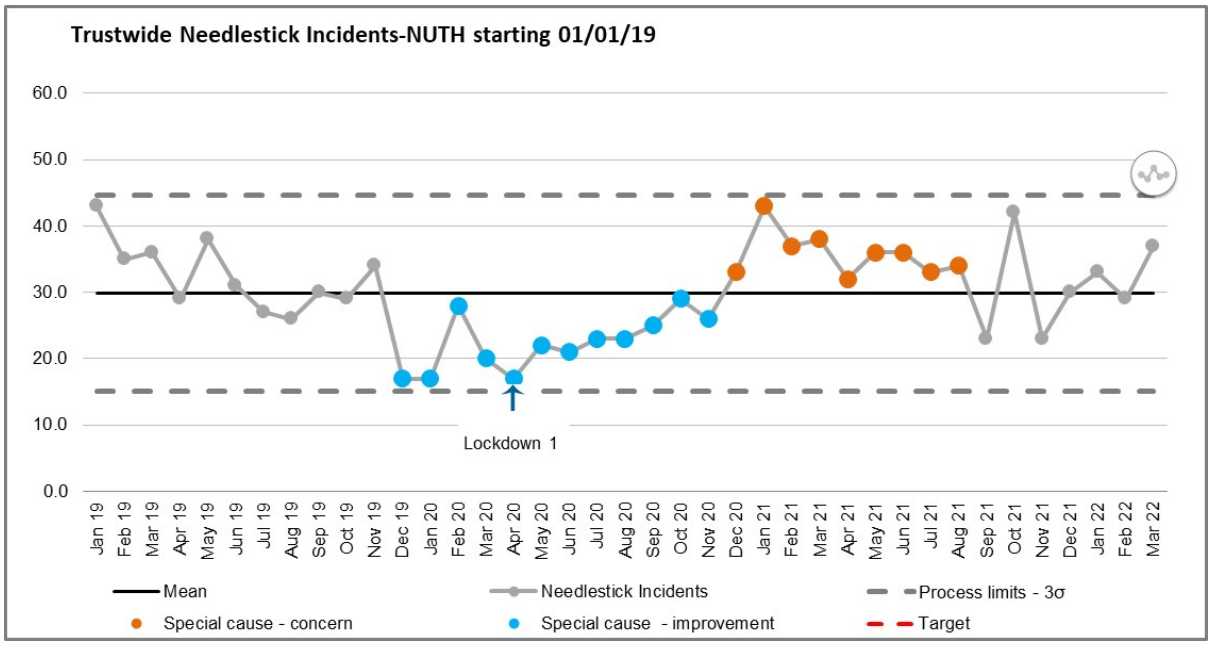
agenda. To that end a number of new products to market that will help the trust properly stream clinical waste and reclaim those metal components that can be recycled. Devices have been introduced to a number of areas for trialling purposes and this is supported by colleagues in NHS Supply Chain. Further collaborative working with the Occupational Health Service (OHS) continues to ensure accurate recording of incidents and that appropriate incident follow up actions are being undertaken. An inoculation incident report is presented quarterly to the Trust Health and Safety Committee.

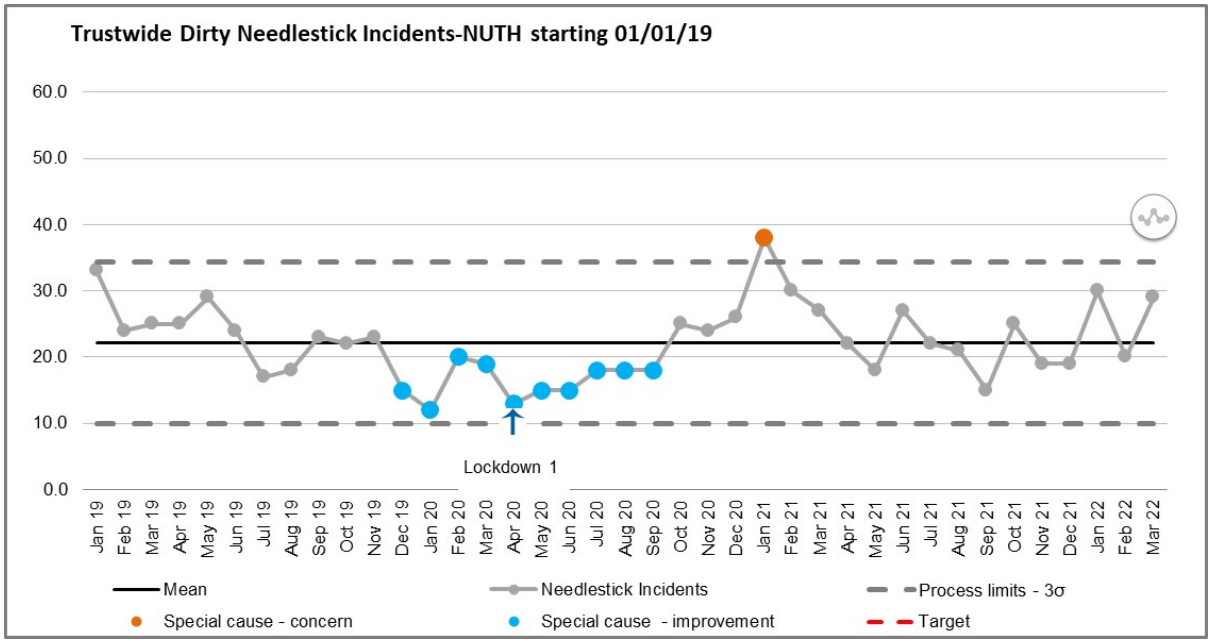
There were 378 sharps incidents during the period, of these 284 relate to dirty sharps with the remainder being clean or non-medical sharps incidents. Three of these incidents was reported to the HSE under RIDDOR requirements:

- During plastic surgery trauma clinic SHO went to open a glass vial of local anaesthetic, using a piece of gauze as protection, in order to carry a basic procedure in clinic. The glass broke / snapped awkwardly, resulting in a laceration to the finger. This required an operation and repair of the ulnar digital nerve on the plastics trauma list the next day. The SHO has required 2.5 weeks off work post-op for the wound to heal.
- I gave HIV +ve patient daltaparin injection, closed safety cap on needle. Went to put needle in sharps bin and caught safety cap on sharps bin lid and it opened and scratched my left thumb. Referred to Occupational Health.
- Venous blood sample taken from patient. Flicked plastic safety cover to cover needle and safety cover broke off. Tip of needle pierced through glove and broke skin on left thumb. Patient is newly diagnosed HIV positive. Referred to Occupational Health.

The Trust is on the 8th edition of the safer sharps inventory. Sharps incidents for the highest reporting Directorates are shown below:

Top 10 Needlestick Incidents 2021-22	
Peri-operative & Critical Care	76
Medicine	39
Women's Services	31
Covid Vaccination Programme	30
ENT, Plastics, Ophthalmology & Dermatology (ePOD)	28
Cardiothoracic	25
Children's Services	17
Dental Services	17
Integrated Laboratory Medicine	15
Cancer Services & Clinical Haematology	13





Further analysis of this data will be provided separately to the Health and Safety Committee and the Sharps Annual Report will be presented at the August 2021 meeting.

12. STRESS MANAGEMENT

The Stress in the Workplace Review Group (SWRG) met four times during 2021-22, which is in line with the Terms of Reference. During this period work progressed around a number of stress related areas such as risk assessment and training. Membership includes H&S, OHS, Human Resources (HR), Staff Development, Health Improvement, Chaplaincy and Staff

Side. It reports to the Trust Health and Safety Committee. Its role is to ensure that the requirements of the stress policy are met and progress the development of arrangements to prevent and manage stress. (The terms of reference for the group have been updated and amended, and all changes accepted by the group. The Stress Prevention Intranet site has been updated to include the up to date list of Mental Health first aid staff members and latest information. The stress risk assessment process remains the main mechanism to manage work related stress including areas of stress related sickness absence. The HR Department are actively involved in the process of supporting directorates in the completion of both service level and individual risk assessments. The Trust Stress risk assessment process is included in the manager induction programme. There has also been an ongoing series of monthly training sessions held across the Trust to instruct all mangers in the risk assessment process, run by the H&S team. The group continues to take account of the findings of the annual staff survey and incorporate any actions into the SWRG action plan. The SWRG action plan is a rolling plan designed to how best achieve set actions within an annual time frame. The plan is monitored and amended as actions are completed at the group meetings.)

Mental Health First Aid (MHFA) training was introduced in 2016 and work continued throughout 2021-22 to improve the service. Four training sessions were facilitated in 2021-22 bringing the total trained across the Trust as at May 2022 to 165. Further development work is planned for 2022 – 2023 including a further 6 training sessions and 5 refresher courses. The MHFA course teaches attendees to recognise the early signs of a mental health problem and the knowledge to provide help and support to staff across the organisation.

13. LONE WORKING

The Trust acknowledges the number of staff working in higher risk environments such as community based nursing teams. During 2020-21 a business case was submitted with a proposal to provide 800 LWS lone worker devices to replace the 'Lookout Call' system. This was approved and towards the end of the financial year information was gathered from Directorates to identify lone workers across the Trust that would benefit from a new device.

The LWS devices provide enhanced features, including roaming SIM cards, person down feature and GPS technology. Managers have the ability to monitor usage and update staff information via an interactive web-based portal.

The Compliance and Assurance Team have provided continued support during the mobilisation period and ensured the initial submission of user information was accurate and timely.

Staff continue to be reminded that a range of lone worker controls are available, highlighted in the new Lone Worker Policy, and that the new devices help to raise a response and reduce the risk to lone workers.

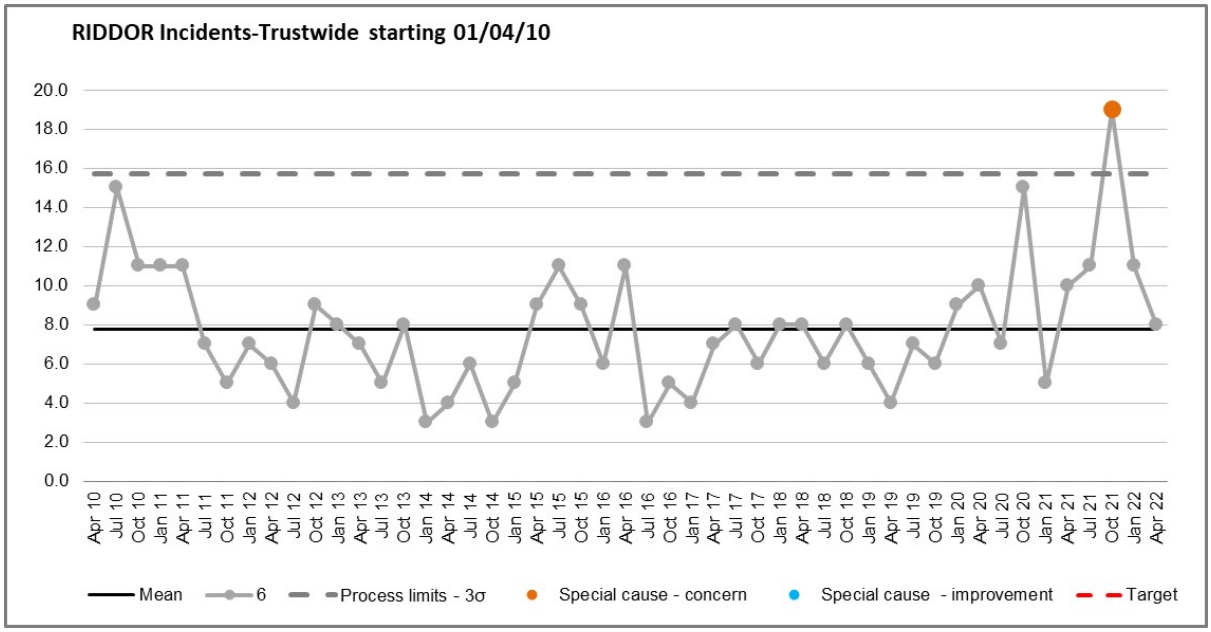
Once all of the devices have been deployed, further support will be provided to managers to ensure uptake of the online portal ensuring devices are used to their maximum capacity. Usage rates continue to be low; although work within the Community Directorate has now resulted in increasing numbers of staff using the devices. In the first 12 months of usage there have been in excess of 15,000 yellow alerts and 2 genuine red alerts. The genuine red alerts provided staff with support from the alarm receiving centre and a speedy response from the police. In both of these cases the staff were unharmed. A recent survey of all lone worker device users identified a number of smaller issues that we will look to resolve, for example some staff feel the devices are complicated to use and we are looking to provide additional training to help raise awareness and support staff.

14. REPORTING OF INJURIES DISEASES & DANGEROUS OCCURRENCES REGULATIONS

There has been an increase in the number of RIDDOR incidents compared to 2020 - 2021 from 37 to 49 incidents in 2021 - 2022. There were 4 specified (major) injuries reported to the Health and Safety Executive. All four where in relation to fractures following falls. There was one reportable exposure to blood borne virus. The remaining incidents reported were categorised as resulting in an over 7 day absence from work as a result of an injury. Eleven of these absences have resulted from moving and handling incidents (all of which have been investigated by the Trust Moving and Handling Team). Nine incidents where related to violence and aggression, which is almost doubled from the previous year and in line with incident increases noted above. All RIDDOR incidents are investigated by the reporting directorate and the followed up by the supporting Health and Safety Advisor under the continuous monitoring and support arrangements undertaken by the Health and Safety Team.

	Aggression & Violence	Accident (involving staff, visitors etc.)	Equipment / Medical Device	Exposure to Hazardous Substance	Moving & Handling	Non-Patient Slip, Trip or Fall	Security	Total
Cardiothoracic	1	1	0	0	1	1	0	4
EPOD	2	2	0	0	0	0	0	4
Medicine	2	2	0	0	5	0	0	9
Peri-Op	3	1	0	0	2	1	0	7
Urology & Renal Services	1	0	1	0	0	0	0	2
Clinical Research	0	1	0	0	0	0	0	1
Estates	0	1	0	0	0	0	0	1
Musculoskeletal Services	0	1	0	0	0	0	0	1
Patient Services	0	1	0	0	2	4	0	7
Pharmacy	0	2	0	0	0	0	0	2
Radiology	0	0	1	1	0	0	0	2
ILM	0	0	0	2	0	0	0	2
Children's Services	0	0	0	0	1	0	0	1
Supplies	0	0	0	0	2	0	0	2
Neurosciences	0	0	0	0	0	1	0	1
Surgical Services	0	0	0	0	0	1	0	1
Women's Services	0	0	0	0	0	0	0	0
Covid Vaccination Programme	0	0	0	0	0	1	0	1
NCCC	0	0	0	0	0	0	1	1
Total	9	12	2	3	13	9	1	49

The SPC chart below shows the trend around RIDDOR reporting since quarter one of 2010. It highlights that the number of reports for quarter three last year was at the upper control limit and therefore higher than normal. Further analysis of this quarter found a range of different types of incident across a number of Directorate. There were no significant themes or trends to indicate why numbers increased over this quarter. More generally post COVID activity has increased across the Trust and at the same time the Trust have taken on a number of additional services such as ICHNE and North Cumbria Cancer Services.



15. EXTERNAL INVESTIGATIONS

Following a RIDDOR reportable incident in Micro-biology at Freeman Hospital in June 2021, where a TB discard jar was spilled, the Health & Safety Executive (HSE) decided to make further enquiries. HSE involvement led to an extensive investigation looking into direct and indirect causation. This included a number of factors such as the impact of COVID-19 testing, specific TB process issues, staffing / capacity. The ability for the service to identify issues at an early stage, that impact on service delivery / safety was a key element of the action plan. Remedial work was undertaken by the Trust and shared with HSE, which in turn resulted in an enforcement letter and monitoring of comprehensive action plans. A huge amount of work was undertaken by Microbiology to complete the identified actions, and this helped to change practice and share lessons with other areas of the Integrated Laboratory Medicine (ILM) Directorate. The action plans were completed and signed off by the HSE in January 2022.

16. RISK REGISTER

As at 29th April 2022, the Trust held 463 open risks (previously 459).
Of the 463 risks, 243 (previously 235) were rated 12 or above.

Of these 243 risks, 10 (previously 19 *) are aligned to the interests of the Health and Safety Committee (4.1%).

(*) Following the Health and Safety Committee held on the 23 February 2022, reporting of a number of subgroups has been realigned to the Estates Risk Management and Governance Group (ERMGG), reflecting new reporting structures and monitoring arrangements – those subgroups who are now reporting into the ERMGG from the 1 April 2022 are as follows:

- Asbestos Working Group
- Pressure Systems Group
- Fire Safety Group
- Electrical/Lift Safety Group
- Mitie/PFI Safety Reporting

This transition is being monitored by the Trust's Compliance and Assurance Group.

17. COVID-19 – HEALTH AND SAFETY RESPONSE

The COVID-19 pandemic during 2021-2022 continued to have a profound impact on the day to day operation of the Compliance and Assurance department; however the team have continued to work responsively and adapted really well to the additional demands during this period. Restrictions during lockdown periods impacted on normal activities such as training and ward / department based inspections. At the same time, additional work-streams started to emerge, which required direct health and safety input. The commissioning of the ICHNE

Laboratory and Vaccination Hubs involved detailed work around operational risk assessments as well as wider involvement around Policy development and other assurance processes. This included development of the Datix Web system to ensure a robust incident reporting system was available to all staff. Staff welfare has also formed an important part of Health & Safety input into these areas.

During the pandemic the Compliance and Assurance Team supported internal groups such as Gold Command and the COVID Assurance Group.

COVID secure risk assessments were redeveloped by the team to support changes in national guidance and provide assurance around ongoing mitigation against COVID19.

18. DATIX DEVELOPMENTS

During 2021-22 the Compliance and Assurance Team have successfully planned, developed and rolled out three modules, incidents (April 2021), Safety Alerts (September 2021) and Claims (December 2021) and work is currently ongoing to roll out a fourth module on 1 April 2022 (Feedback). It is also planned that Enterprise Risk Manager (ERM) and Investigations will be developed and rolled out by the end of 2022.

The Datix System Lead is continuing to work through outstanding defects and enhancement requests with RLDatix to ensure these are available within Datix Cloud IQ as soon as possible.

Work has also started to develop a number of reports and dashboards within Yellowfin to enable reports to be broadcasted once this feature becomes available.

19. RECOMMENDATION

The Trust Board is requested to receive the report for information.

Report of Angela O'Brien
Director of Quality and Effectiveness
27 June 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022						
Title	Healthcare Associated Infections (HCAI) Director of Infection Prevention and Control Report						
Report of	Maurya Cushlow, Executive Chief Nurse						
Prepared by	Dr Julie Samuel, Director of Infection Prevention & Control (DIPC), Consultant Microbiologist Mr Ian Joy, Deputy Chief Nurse Mrs Angela Cobb, Infection Prevention & Control (IPC) Lead						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☐		
Summary	This paper is the bi-monthly report on Infection Prevention & Control (IPC). It complements the regular Integrated Board Report and summarises the current position within the Trust to the end of June 2022. Trend data (including number of COVID-19 Outbreaks within the Trust) can be found in Appendix 1 (HCAI Report and Scorecard June 2022), enclosed in the Public Board Reference Pack, which details the performance against targets where applicable.						
Recommendation	The Board of Directors is asked to (i) receive the briefing, note and approve the content and (ii) comment accordingly.						
Links to Strategic Objectives	Achieving local excellence and global reach through compassionate and innovative healthcare, education and research. Patients - Putting patients at the heart of everything we do and providing care of the highest standards focussing on safety and quality. Partnerships - We will be an effective partner, developing and delivering integrated care and playing our part in local, regional, national and international programmes. Performance - Being outstanding, now and in the future						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☐	☐	☐	☐	☐
Impact detail	Failure to effectively control infections may lead to patient harm, litigation against the Trust and loss of reputation. There are no specific equality and diversity implications from this paper.						
Reports previously considered by	This is a bimonthly update to the Board on Healthcare Associated Infections (HCAI).						

The Newcastle upon Tyne Hospitals NHS Foundation Trust

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

EXECUTIVE SUMMARY

This paper provides bimonthly assurance to the Trust Board regarding Healthcare Associated Infections (HCAIs).

Key points to note:

- Changes in mandatory mask usage has not led to an increase in COVID-19 periods of increased incidence or outbreaks.
- There has been 1 MRSA bacteraemia in May 2022.
- All other mandatory reporting organisms at the end of June 2022 are above the internal 10% reduction strategy.
- As we emerge from COVID-19, the focus for Infection Prevention and Control (IPC) is to enable and maximise clinical activity and reinvigorate projects that will lead to reduction in other HCAIs.

RECOMMENDATIONS

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

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

1. KEY POINTS FOR MAY/JUNE 2022

1.1 High Consequence Infectious Disease (HCID)

Newcastle HCID unit has been activated to manage Monkeypox (MPX) cases, support vaccination of staff and patient contacts whilst supporting the regional response. This has required a Trust response across our acute and community services. On 5 July 2022, national notification outlined that the current UK MPX outbreak will no longer be considered an HCID as per UK Health Security Agency (UKHSA) advice.

1.2 Coronavirus (COVID-19)

On the 1 June 2022, there was a change in national guidance which removed the mandatory use of facial masks in healthcare settings. The Trust risk assessed the implications of this change and issued updated respiratory guidance on 7 June 2022. The guidance outlined that mask were no longer mandated, with the exception of contact with patients on the respiratory pathway and high-risk areas.

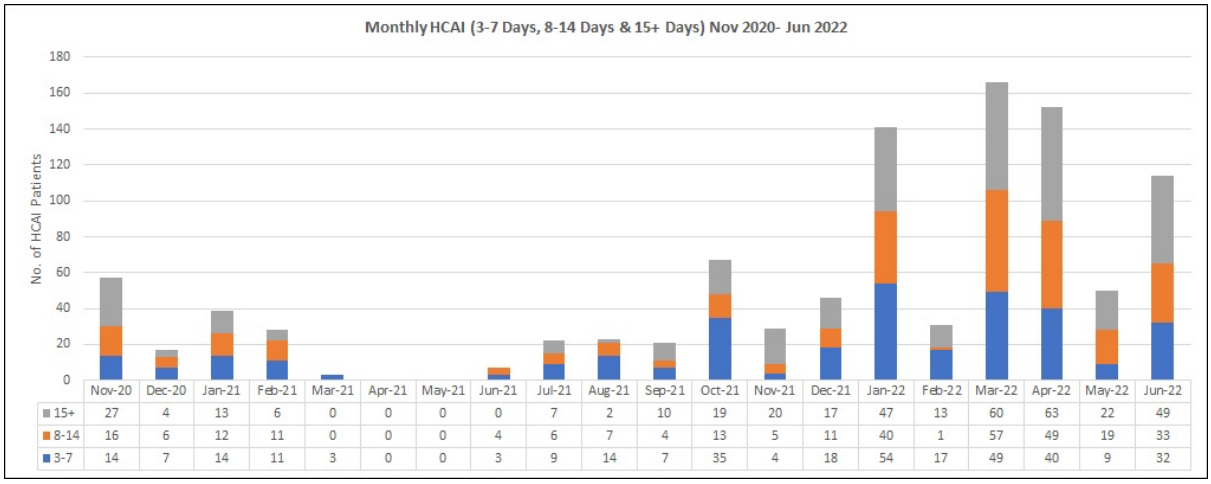
The guidance continues to advocate that all staff who have a personal preference to wear a face mask may continue to do so and all hospital onset COVID-19 cases continue to be closely monitored for the impact of any changes. The Trust have also been clear that if any patient would prefer staff to wear a mask, staff will do so. Whilst there has been an increase in declared patient COVID-19 outbreaks, this is mainly in high-risk areas and therefore not a direct consequence of the change in mask wearing guidance. The guidance is regularly reviewed and can be changed if data and local intelligence suggests this is required. This situation is regularly reviewed.

1.2.1 Managing HCAI COVID-19 cases

COVID-19 infections are classified as follows:

- Community-Onset (CO) – First positive specimen date <=2 days after admission to trust
- Hospital-Onset Indeterminate Healthcare-Associated (HO.iHA) – First positive specimen date 3-7 days after admission to Trust
- Hospital-Onset Probable Healthcare-Associated (HO.pHA) – First positive specimen date 8-14 days after admission to Trust
- Hospital-Onset Definite Healthcare-Associated (HO.dHA) – First positive specimen date 15 or more days after admission to Trust.

The graph below demonstrates the COVID-19 activity and category of detection. This takes into account the incubation period, which for most people is 5-7 days but can be up to 14 days.



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
15+	27	4	13	6	0	0	0	0	7	2	10	19	20	17	47	13	60	63	22	49
8-14	16	6	12	11	0	0	0	4	6	7	4	13	5	11	40	1	57	49	19	33
3-7	14	7	14	11	3	0	0	3	9	14	7	35	4	18	54	17	49	40	9	32

May 2022 saw a decline in the number of reported COVID-19 positive cases across all categories reflective of reduced community prevalence with only 55 patients tested positive for COVID-19 within 2 days of admission (defined as community onset). In June 2022, prevalence increased with 109 community onset cases declared, which is reflected of the subsequent increase in hospital onset cases. This may have coincided with the change in prevalence of Omicron sub-variants.

A COVID-19 outbreak is reported when there are 2 or more connected HO.dHA or HO.pHA case or connected staff member. There have been 2 COVID-19 outbreaks declared in May 2022 and 10 outbreaks declared in June which is representative of the reported hospital onset cases.

1.2.2 Test & Trace (T&T)

Lateral Flow Test (LFT), voluntary asymptomatic testing of staff continues to be encouraged across the Trust in line with national guidelines. The total number of reported LFT tests up to 30 June 2022 is 154,381 tests with 2,612 positive cases, and a positivity rate of 1.7%. Symptomatic staff continue to have access to PCR testing via the testing pod as required.

As previously reported, April 2022 saw a change in Trust guidance regarding staff COVID-19 contacts in line with revised NHS England/Improvement (NHSE/I) guidance. This guidance removed the mandate of requiring a vaccination to continue working during the incubation period and the need for a contact PCR test. The Trust continues to provide access to staff PCR testing, require daily LFT testing for close contacts and the test and trace team remain in place to support advice and guidance. These additional steps provide greater assurance than the national guidance.

The table below reflects the number of swabs performed from the beginning of the financial year 2022/23. There have been no recent changes to national guidance regarding swabbing requirements and discussions are on-going internally to confirm what testing requirements will be required in the medium to long term.

	RVI POD (Staff Swabbing)	FH POD (Patient Swabbing)	CNTW (Home Swabbing vulnerable patients)
April 2022	1126	859	86
May 2022	295	475	95
June 2022	273	314	65

	PCR Positive Cases	LFT Positive Cases
April 2022	171	184
May 2022	95	82
June 2022	83	395

The total number of performed PCR tests on staff up to 30 June 2022 is 1,694 tests with 349 positive cases which gives a positivity rate of 20.6%.

1.3 *Clostridioides difficile* Infections (CDI)

At the end of June 2022, a total of 42 cases were attributed to the Trust (31 case are Hospital Onset Healthcare Associated (HOHA); 11 cases are Community Onset Healthcare Associated (COHA)). The national threshold for the Trust has now been released with the aim of ≤166 cases; this is slightly higher than the Trust's internal 10% reduction trajectory of ≤153 which will continue our focus for reduction. As of 30 June 2022, we are currently over our internal trajectory by 4 cases (≤38) but on par with the national threshold (≤42).

A review of environmental contamination has been undertaken and the use of Hydrogen Peroxide Vapour (HPV) machines have been reinstated for the cleaning of all CDI and *Clostridioides difficile* carrier patient environments instead of Ultraviolet (UV) light. Themes from Post Infection Review (PIR) meetings includes: improve medical review of CDI and overall patient management and antimicrobial stewardship, improve documentation of diarrhoea to support early sample collection and timely isolation. The Infection Prevention and Control Team (IPCT) have commenced some focused educational sessions with clinical teams for correct management of patients with diarrhoea.

1.4 MRSA / MSSA Bacteraemias

The Trust had to record its first MRSA bacteraemia case in 24 months in May 2022. A review meeting has been undertaken and it was noted that the bacteraemia was unavoidable. The patient was known to be colonised with MRSA on admission and had been managed in line with Trust policies.

The Trust has now been advised that there continues to be no national set threshold set for MSSA in 2022/23 therefore we have continued to set a 10% reduction on the previous financial year's total number of cases (110) which is ≤99 cases for 2022/23. By the end of June 2022, a total of 26 cases were attributed to the Trust (18 HOHA cases; 8 COHA cases), which places the Trust over trajectory by 1 case. The IPC Team have commenced educational sessions with the clinical teams to support the correct use of Octenisan bodywash to reduce skin carriage thereby reducing the associated risks for bloodstream infections.

1.5 Gram Negative Bacteraemias (*E. coli,* Klebsiella, Pseudomonas aeruginosa)

The table below outlines the figures at the end of June 2022:

	E. coli	**Klebsiella**	**Pseudomonas aeruginosa**
Total number of Hospital attributed cases for June 2022	21	10	4
Cumulative No. cases for quarter one 2022/23	51 cases	35 cases	12 cases
National Threshold for end of quarter one 2022/23	≤50 Over by 1	≤39 Under by 4	≤10 Over by 2
Local 10% reduction Trajectory for June 2022	≤47 Over by 4	≤33 Over by 2	≤7 Over by 2

The Gram-Negative Bacteraemia Blood Stream Infections (GNBSI) Steering Group continue to monitor and review ongoing Quality Improvement (QI) projects.

The IPC Team have commenced the "Gloves off" education campaign across the Trust. This will promote best practice, improve hand hygiene compliance thereby resulting in a general HCAI reduction for all mandatory reporting organisms.

1.6 Outbreaks and Periods of Increased Incidence (PIIs)

There have been 5 *Clostridioides difficile* infections (CDI) periods of increased incidence (PII) during May / June 2022 within Surgical Services; Renal Services; Internal Medicine and Peri-operative & Critical Care. A CDI PII is defined as two cases within a 28-day period. The cases are being further investigated to establish if there are any learning from related themes.

In May and June 2022, there have been no other outbreaks declared.

1.7 Sepsis

The appointment of a new Clinical Director has focused the Deterioration and Sepsis team to develop a new strategy to review and refresh the whole approach to caring for the deteriorating patient, working in close collaboration with other initiatives to reduce patient harms.

The Deterioration and Sepsis mandatory training within the Electronic Staff Record (ESR) went live May 2022. Trust wide bespoke education sessions for directorates continues to be promoted though the ALERT Quality Improvements Projects. Monthly Data at directorate / ward level is produced to identify gaps in the identification and management of sepsis and deteriorating patients. The ambition is to strengthen education and training and provide feedback to teams as close as possible to real time, whilst achieving significant improvements in the response to alert rates.

1.8 Antimicrobials

The Antimicrobial Stewardship (AMS) team and the wider group which support AMS, namely Antimicrobial Leads, are working together more closely since the re-introduction of the antibiotic peer review. The use of electronic Synbiotix Take 5 audit has yielded a compliance of 30% participation; more work needs to be done to help engage leads now this has restarted, but the results have been interesting and highlight areas for improvement and areas of good practice. The peer review audit is designed as a click tool for prescribers, to audit antibiotics within inpatient wards. The audit is on current prescriptions, producing summary of results which are expected to be used by the Antimicrobial Leads to illustrate and discuss practice in their area within governance meetings and teaching opportunities. It is expected that formal plans are developed and acted on where areas of improvements are identified as a consequence of the audit. Compliance of the audit is included in directorate Serious Infection Review Meetings (SIRM).

The CQUIN target for appropriate prescribing and management with the Urinary Tract Infection (UTI) / Catheter Associated Urinary Tract Infection (CAUTI) is being progressed; to make this manageable we are focusing within the directorate of Internal Medicine for 2022-23 with the ambition to cascade lessons learnt and good practice from this CQUIN through the whole Trust later in the year.

Guideline reviews are necessary and constant; we have been further challenged to ensure we preserve the effectiveness of antibiotics, by reducing the broader antibiotics, that can be associated with development of significant resistance, by 4.5% this year and a further 6.5% in 2023-24. This will be huge undertaking as it will require significant reviews of all guidelines. This is now in the work plan for the Antimicrobial Stewardship Group (AMSG) over the next 6-9 months.

Successfully recruiting pharmacy staff, in the next few months, will help with these projects as will the introduction of the ICNET system, which is a surveillance tool to identify prescription-clinical indication mismatch and antibiotic-bug mismatch. This will enable better and more intelligent review of antibiotics in real time.

1.9 Water Safety

No exceptions to report.

Following discussion at the Strategic Water Safety Group the current version of the Water Safety Plan is to be reviewed and will be uploaded to the Policies and Guidelines section of the Intranet once ratified.

1.10 Ventilation

Royal Victoria Infirmary (RVI) Ventilation - there has been an inability to gain access to Ward 49 Air Handling Unit (AHU) to carry out planned preventative maintenance due to COVID positive patients. This increases risk of plant defective failures i.e. filter blockages, decreased air flow, fan failure etc.

The rolling programme of refurbishment and ventilation upgrades continues as planned.

Freeman Hospital (FH) wards 33,34 and 35 – planned fire remediation works are currently ongoing and intended to complete in September 2022.

1.11 Decontamination

Following the failure of the Niagara Washer Disinfector at the RVI (previously reported in last paper), this has been repaired and is now in service. Trust Primary plus backup machines have been re-established. Replacement endoscopy washers are being procured for FH with completion due March 2023.

2. RECOMMENDATIONS

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

Report of Maurya Cushlow
Executive Chief Nurse

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

28 July 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022						
Title	People Report						
Report of	Dee Fawcett, Director of HR						
Prepared by	Dee Fawcett, Director of HR						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The purpose of the report is to provide an update on developments across our People agenda. Reporting is aligned to our local People Plan themes and actions.						
Recommendation	Note the contents of this report.						
Links to Strategic Objectives	People – Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☒	☒	☒	☒
Impact detail	Impacts on all areas from a People perspective.						
Reports previously considered by	Routine update to the Board.						

PEOPLE REPORT

EXECUTIVE SUMMARY

This paper provides an update on progress against our local People Plan and key national developments relevant to our people strategy.
Key points:

- Sickness absence remains above 'pre' covid levels and continues to impact through creating gaps in workforce.
- Covid Vaccination sites are now closed.
- Staff Survey – Power BI dashboards have been made available to Directorates to enable them to access the data, recent trends and to develop their improvement plans.
- Aligned to 'growing our own' strategy, and creating good quality entry level employment, the 10th cohort of Project Choice interns graduated this month; further as part of a plan initiated by the City Council, and as a partner in Collaborative Newcastle, the Trust participated in the 'EVRY Child Can' launch on 19 July - a vast collaboration by a range of partners to pledge transformative commitments to make Newcastle a place where all under 25's can live, thrive and be heard.
- The Trust Leadership Development and Talent Management Strategy has been refreshed on an interim basis and shared at the People Committee. It has been presented for the Board to endorse.
- The first cohorts of the Strategic Leadership Programme have been completed.
- Work is well underway to welcome the next rotation of doctors into the Trust in August.

Dee Fawcett
Director of HR
20 July 2022

PEOPLE REPORT

1. COVID RECOVERY

Vaccination Hub:	As previously reported, NHS England (NHSE) issued a contract to NUTH to act as a COVID Vaccination Lead Provider for the North East and North Cumbria Integrated Care System (ICS) until 30 September 2022. Newcastle Hospitals Lead Provider and Lead Employer functions are not expected to change, however from the 1 July 2022 the Integrated Care Board (ICB) has a governance role in how the covid vaccination funds are allocated. There are several elements impacting on the lead provider and employer workforce strategy including retention of some people to facilitate an outreach base and vaccine mutual aid location for the system. The 'retained' team will work with system colleagues to identify areas of health inequalities, be able to deliver vaccination services, focus on severely immunocompromised patients, have immediate surge capability, should the need arise, and provide resilience where gaps appear due to provider opt out. Following the planned closure some 80 of the 220 staff were retained in the new team, with fixed term contracts of employment which run to 30 September 2022. Several staff have secured employment within the Trust, or in the wider NHS, or joined the staff bank. The steps taken to support the staff have resulted in no redundancies at this point. This will be kept under review.
Wellbeing:	**Sickness absence** • Sickness absence rates (6.58% full-time-equivalent (FTE) including COVID) and the reported level of sickness absence for anxiety and stress-related reasons (1.63% FTE) remains high and are of concern. We continue to focus on attendance management and support for staff. • COVID Sick Pay – national guidance issued on a temporary basis by the Department of Health and Social Care (DHSC) in 2020 for access to full pay for COVID sickness absence and self-isolation was withdrawn on 7 July 2022. From this date, staff who are off sick due to COVID will be paid their contractual sick pay entitlement; staff who are clinically well but are required by the Trust to self-isolate will be on 'authorised absence' with full pay. COVID sick pay (full pay) for long COVID which started before 7 July 2022 will end on 31 August 2022 and staff who continue to be unwell will be transitioned back to their contractual sick pay entitlement effective from 1 September 2022 unless they have returned to work. Following consultation with staff side colleagues and a paper to Executive Team in March 2022, the Trust had already moved staff with long COVID on to their contractual sick pay entitlement effective from 1 June 2022.

	• The Health and Wellbeing Policy has been refreshed and published and managers are being supported to implement. • The results from a staff survey on health needs are being collated and an action plan will be published in August.

2. SHAPING NEWCASTLE AS THE BEST PLACE TO WORK

Belonging feeling valued and recognised:	**NHS Staff Survey:** The following information has been provided to Directorate leaders to support long term staff experience action planning and implementation: • A Staff Experience dashboard using Power BI software and includes 5-year trends analysis of staff survey results. • Delivering supportive training in facilitations skills and using people data to help develop staff experience plans. • Developing longer term fluid 3 – 5-year local staff experience improvement plans. • An interactive staff experience leader's portal for key information linked to staff survey. • Quarterly Performance Reviews now include consideration of Staff experience improvement plans as a standard agenda item. • What Matters to You (WMTY) events are planned from September onwards to open discussions on current workstreams and the work to date in support the staff experience. **E-Job Planning:** Clinical Directors have been asked to ensure that job planning is completed by end of September. A refreshed policy reflecting the e-planning approach has been published.
Flourish/What Matters to You:	**Implementation of HIVE:** HIVE is a web-based dynamic staff engagement tool that enables conversations, surveys, and 'High Fives' as an informal staff recognition tool. Progress is as follows: • A task and finish group led by Staff Experience and Engagement Team, has been established. • An implementation plan to support the phased approach to the system developed. • 'Go live' will commence in September 2022 with the introduction of High Fives, coinciding with the Trust 'Thank You' month. **Focus on Flexible Working:**

	The Trust is promoting July as 'Flexible Working Month' to raise awareness around the range of opportunities for staff to work more flexibly, to proactively encourage and respond to requests as well as dispel some of the myths about working differently. Surgeries are being held throughout July and August to support managers to create more flexible working arrangements for our staff and to establish an approach where flexible working is embedded in our culture.
Inclusive and diverse workforce:	**Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES):** WRES and WDES are on target for completion and submission by 31 August 2022 with the action plans reviewed and published by October 2022. Improvements include: – WDES Metric 3 likelihood of entering formal capability processes has seen a significant improvement in the last 12 months. – WRES Metric Indicator 3 has improved to an equal likelihood of entering formal disciplinary processes. – Challenges remain regarding the differential staff experience of Bullying, Harassment, Abuse and discrimination. – Neurodiversity Managers Guide produced in partnership with the Disability Staff Network. – A WRES Improvement Team has been formed to use quality improvement methodology to improve differential experience. Cohort 1 of the **BME Leadership Development Programme 'Maximising your Potential'** completed this month, finishing off with an event at which participants shared presentations about their improvement projects. Plans are in place to roll a coaching offer to 60 BME staff, over the 4 cohorts. Our **staff networks groups** have decided to rename themselves, and this re-branding will be formally launched in September. In summary they are: BAME Staff Network is now the **Race Equalities Network**, contact: nuth.raceequalitiesnetwork@nhs.net Disability Staff Network is the **ENABLED Network**, contact: nuth.enablednetwork@nhs.net LGBT Staff Network is now the **Pride Network**, contact: nuth.pridenetwork@nhs.net **NHS Volunteering – task force:** A national NHS Volunteering Taskforce was set up in January 2022 to look at the strategic and practical steps needed to take to embed a culture of inclusive volunteering across Integrated Care Systems that delivers for patients, staff, and our diverse communities. The Trust is participating in

	this initiative to further develop its Trust volunteer service. New initiatives in development include: • St John Ambulance Partnership: A programme supporting young people (16-18) from hard-to-reach communities in gaining experience through volunteering. This is supported through a structured education programme delivered through St John Ambulance with experiential learning delivered through volunteering with the Trust. • NHS Volunteers to Careers: The development of supporting volunteering opportunities that provide a career pathway into employment across the Trust.

3. DELIVERING EXCELLENCE IN EDUCATION AND LEARNING

Leadership & Organisation Development; What Matters To You:	**Strategic Leaders Programme (SLP):** This programme has now concluded following 6 cohorts with a further two programmes in the planning stage for later in 2022. Evaluation has been extremely positive with several emerging themes currently being articulated in an evaluation report which will be shared with the Executive Team. Attendees at the programme were invited to a further session, a masterclass about 'Workforce Transformation' which was led by Tom Simons, NHSE/I Chief Human Resources & Organisational Development Officer, and John Drew, Director of Staff Experience and Engagement. The programme will culminate in a learning and sharing event in September 2022, hosted jointly by the Institute for Healthcare Improvement (IHI) and Newcastle Hospitals. This will provide the opportunity to share learning from the programme. **Leadership Development and Talent Management Strategy:** This has been refreshed on an interim basis, endorsed by the People Committee, and shared with the Board this month. Of note, the strategy incorporates the refreshed leadership behaviours, the 'Newcastle Leadership Way' as well as noting the recommendations of the recently published Messenger Review on leadership. A detailed implementation and awareness plan will be developed to raise awareness across the organisation. **WMTY:** Maternity and Dental Radiography continue with their improvement activities and additional leaders will attend Model for Improvement

	Training in late July. The IT team will join others who are continuing to progress. Scaling up of WMTY conversations is underway and Wave 4 will launch in early October. **Learning to Lead Together – Newcastle System Stewardship:** This new format of the Systems Leadership Development Programme. Applications to join the next two cohorts exceeded capacity so future programmes have been brought forward. This programme will support the recent transition of place-based leaders from the Clinical Commissioning Groups (CCGs) to the ICS and widen the participation from the local authority. Additional members from the Collaborative Newcastle 'Joint Directors Group' will join the programme Steering Group from July with the aim of increasing the value and learning of the collaborative activities between participants and organisations at system level.
Entry Level access to employment and training:	**EVRY Child Can: Traineeships:** Launched this month, this new city plan aims to make Newcastle a place where every child and young person can benefit from fantastic experiences, shape a path to a successful future, and find ways to foster happiness and wellbeing. The plan draws together commitments from partners that can positively transform a generation of young people's lives with the ambition to provide good quality jobs and training. As part of Collaborative Newcastle, the Trust will pilot a scheme to provide 'Traineeships' - paid work experience for up to three months, with the additional support of a mentor and help to achieve the required standard in maths and English to secure a place on an apprenticeship scheme. **Project Choice Graduation:** Earlier this month, the 10th cohort of Project Choice students graduated. This internship scheme, which continued throughout the pandemic, continues to make us very proud. Our workplace partners and mentors have been hugely inspirational in supporting the students to work hard, grow in confidence and secure employment having been given this opportunity. Our expectation this year, is that 100% will transition into employment. Both these programmes align with our 'grow our own' workforce strategy through enhancing supply and providing a great working experience enabling the Trust to improve its staff retention. **BTEC /T Levels:** The Department for Education have recently announced its intention to remove the BTEC qualifications in Health and Social Care from 2024 and

	replace them with the new Health T Level. The BTEC suite of qualifications are a well-established entry route into health care roles including Health Care Support Workers and as an alternative route to degree level nurse training. The T level alternative requires significant placement time with an employer and as such would create additional complexity and pressure to placement planning and supervision requirements for individual students. A national appeal by further education awarding bodies is currently ongoing with the aim of retaining the BTEC qualification as a well-established option that is trusted and recognised by employers. This position has also been explicitly supported by NHS Employers in a letter to the Secretary of State for Health stating that the Health T Level is not an equivalent option. Discussions are currently being held with local Further Education (FE) colleges to scope the scale of demand for T Level placement. Currently two local colleges have plans to offer this qualification but numbers in the first instance are expected to be low with a potential of 40 students across both providers.
Improvement Projects:	A number of improvement projects are ongoing including refreshing our **Study Leave** policy, revising the **Corporate Induction & Onboarding process** in response to evaluating the satisfaction rates for staff and managers who had attended a Corporate Induction for the core business, the Covid laboratories and Integrated Health Care Northeast in a 12-month period. **Resuscitation Training** - work is continuing to review requirements and increase compliance.
Virtual Learning Environment (VLE):	Work has commenced to build the trusts VLE. Data will continue to be submitted for upload over the next few weeks enabling the vendor to start constructing our catalogue of courses.
Statutory and Mandatory Training:	Overall, Trust compliance for statutory and mandatory training is 87.7%, below the target of 95%. Appraisal compliance is at 73% against the trust target of 95%. Responsibility for ensuring training compliance remains with directorates, and engagement is continuing to raise the awareness of the importance of compliance and offer support to address any barriers to completion. Clinical Directors have been advised of their access to the live performance 'dashboard' to enable them to identify and focus on areas for improvement. This matter is included on the organisational risk register because of its potential impact on patient and staff safety. The Executive Team reviews compliance collectively and via the Directorate Quarterly Performance Review process.
Medical Education:	Positive feedback was received following the Annual Deans' Quality Meeting in May we await the final report. The first collaborative **Medical Education Quality Panel** has now taken place, with an extremely positive outcome for both Respiratory Medicine and Obstetrics & Gynaecology. Introducing departmental quality

	meetings aligns with strategic priority to become the recognised employer and educator of choice in the North East, and to foster a culture of continuous improvement. These panels enable the Education Quality team to engage with departments to identify and disseminate good practice, as well as provide support for any emerging development areas. Consistent with our teaching hospitals status, the meetings also provided an opportunity to identify key challenges which impact on education and undertake action planning in relation to these. Further meetings are planned.
HEE Quality Framework:	A significant piece of work mapping Nursing, Midwifery and Allied Health Professional (NMAHP) Clinical Education to the Health Education England Quality Framework has been completed, with accompanying action plan which. Highlight key areas of focus and development for education quality assurance across the organisation, which will be communicated in future Learning and Education papers.
Education Space and Facilities:	Following some contractual delays, demolition work has now started at Eldon Court; work at Freeman Education Centre is progressing well. The deadline for completion of Freeman Education Centre remains Autumn 2022 with a slightly extended deadline of December 2022 for Eldon Court.

4. WORKING DIFFERENTLY

Clinical Directorate Proposed Reorganisation:	The engagement and consultation process regarding if and how our clinical management structure can be improved continues.
Recruitment – general:	The significant increase in recruitment activity continues throughout 2022, with over 788 candidates actively going through the recruitment process, of which 275 (35%) are Staff Nurses. A further 262 have confirmed future start dates. **Registered Staff Nurse:** Ongoing bespoke recruitment campaigns for staff nurse posts in the Day Treatment Centre, have been successful. In addition, social media promotions around Ophthalmology Theatres, 0-19 Service and Vascular services have been effective. **International Recruitment:** A cohort of around 50 international nurses from the Philippines and India arrived in the Trust in June 2022 and a further 123 nurses and midwifes are in the pipeline for deployment before 31 December 2022.

	The Trust continues to explore working with additional agencies to increase the supply of international staff for deployment. **Healthcare Support Worker:** There are currently 110 candidates going through the recruitment process and 32 candidates with future start dates. A Healthcare Assistant recruitment event took place on 13 July 2022. **Day Treatment Centre (DTC):** Candidates joining the DTC are being provided with a bespoke induction programme when they join the team; this is currently held at Newcastle College until the end of August 2022. Clinical DTC competency is signed off by the clinical educators. Regarding medical consultant posts there have been some delays and discussions are ongoing regarding how to address any potential gaps.
Recruitment – medical:	In August, the Trust will receive a cohort of approximately 560 Lead Employer Trust (LET) employed postgraduate doctors in training rotating in and approximately 80 Trust appointed doctors. Work schedules which detail generic working patterns and breakdown pay arrangements have now been issued and rotas checked for compliance. Due to Home Office delays in processing and issuing visas, we currently have a very small number of risks trust wide relating to candidates starting on time. Departments have been made aware. Other than this, we are anticipating a smooth changeover. Foundation Year 1 doctors also have a period of shadowing from 25 July 2022.
Technology enhancements:	**People Data Dashboards:** The first 'live' people data dashboards, including statutory and mandatory training and appraisal were introduced in April 2022. New dashboards include 'Staff in Post', 'Staff Survey' and newly released 'Role Specific Mandatory Training'. **Robotic Process Automation (RPA):** Review of a 2-year delivery roadmap is currently in development and a Strategic RPA Group is in development to understand the longer-term RPA delivery plan. The following 'bot 'developments are in progress: • Launch of Somerset Cancer Registration Bot to manage cancer referrals (400-500/week). • NIVS Bot (National Immunisation and Vaccination System). • Appraisal bot has updated 8000+ staff appraisal in 2022 to date.

	Medical Staff: Ongoing work continues to link SARD job planning into Rotamap to help populate patterns / to help check workload rostered matches job plan values. The Electronic Staff Record (ESR) integrates with Rotamap so all staff payroll number and basic demographics can be matched, additional sessions and awayness can flow between the two. Implementation of Rotamap is phased to assure quality assurance. Its hoped this roll out will be completed across the Trust by end December.

5. EMPLOYMENT TERMS & CONDITIONS

On 19 July 2022, the Government stated it was accepting the recommendations of the NHS Pay Review Bodies.

6. NHS PENSION SCHEME

NHS pension scheme member contribution rates are changing on 1 October 2022 and again in 2023 (date to be advised). This was communicated for the attention of staff earlier this month to raise awareness. Contribution rates will change for scheme members with some paying more and some paying less depending on the level of their pensionable earnings. The new salary thresholds will be uplifted in line with this year's Agenda for Change pay award once it is confirmed.

7. CERTIFICATION OF FIT NOTES

The Department for Work and Pensions amended legislation with effect from 1 July 2022 to enable nurses, occupational therapists, pharmacists and physiotherapists to certify fit notes in addition to doctors. These professional groups can legally certify a fit note, but they are not required to do so. The legislation is being considered to decide next steps including whether it is an acceptable part of the role of our staff and within their scope of practice, and whether there is the relevant knowledge, skills and experience to undertake health and work conversations and make decisions around certifying fit notes. Enabling a wider range of health professionals to certify fit notes aims to: provide a seamless, faster system for patients; reduce bureaucracy; avoid having to re-route requests to certify fit notes through doctors; and better utilise the skills of staff.

8. RECOMMENDATION

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

Report of Dee Fawcett
Director of HR
20 July 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Trust Board Meeting

Date of meeting	28 July 2022						
Title	Trade Union Facility Time Report						
Report of	Dee Fawcett, Director of Human Resources						
Prepared by	Donna Watson, Head of Workforce Engagement, and Information Systems						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☒	☒				
Summary	There is an annual legal requirement for public sector organisations to report and publish information on facility time for employees who are trade union representatives. This year the information is required by 31 July 2022. The purpose of this paper is to share the prescribed data with Trust Board and provide assurance the Trust will meet its obligation. Please note that the content was included in the Trust Annual Report approved by the Trust Board on 21 June 2022 and was discussed by the People Committee on 22 June 2022. Key information includes: • There are a total of 32 employees who were relevant union officials during the last financial year. • The full-time equivalent is 27.16. • The percentage of pay bill spent on facility time is 0.0075%. • The percentage of total paid facility time hours that were spent by employees who were relevant union officials on paid trade union activities was 27%.						
Recommendation	The Board is asked: a) To note the Trade Union Facility Time reporting information for 2021 – 2022. b) Endorse submission to the government portal and publication on the Trust website.						
Links to Strategic Objectives	Performance.						
Impact (Please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☐	☐	☒	☒	☐	☒	☐
Impact detail	Detailed within the report.						
Reports previously considered by	Annual Requirement.						

TRADE UNION FACILITY TIME REPORT

EXECUTIVE SUMMARY

The purpose of this paper is to update the Trust Board on the Trade Union Facility Time Reporting and provide assurance that the data will be submitted to the government portal and published on the Trust website by the due date of 31 July 2022.

Key information includes:

- There are a total of 32 employees who were relevant union officials during from 1 April 2021 until 31 March 2022.
- The full-time equivalent is 27.16.
- The percentage of pay bill spent on facility time is 0.0075%.
- The percentage of total paid facility time hours that were spent by employees who were relevant union officials on paid trade union activities was 27%.

The Board is asked to:

a) Note the Trade Union Facility Time reporting information for 2021-2022.
b) Support submission to the government portal.
c) Endorse publication of the data on the Trust website by 31 July 2022.

TRADE UNION FACILITY TIME REPORT

1. INTRODUCTION

There is a legal obligation for public sector employers to provide information to the Cabinet Office by 31 July 2022 and publish the data on the Trust website. The purpose of this paper is to update the Trust Board on Trade Union Facility Time for the reporting period 1 April 2021 to 31 March 2022.

2. RELEVANT UNION OFFICIALS

The total number of your employees who were relevant union officials during the relevant period:

Number of employees who were relevant union officials during the relevant period	Full-time equivalent (FTE) employee number
32	27.16 FTE

3. PERCENTAGE OF TIME SPENT ON FACILITY TIME

The total number of Trust employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time:

Percentage of time	Number of employees
0%	26
1-50%	3
51%-99%	0
100%	3

4. PERCENTAGE OF PAY BILL SPEND ON FACILITY TIME

The percentage of the Trusts total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period:

First Column	Figures
Provide the total cost of facility time	£57,330.95
Provide the total pay bill	£767,616,000 (Pending Audit)
Provide the % of total pay bill spent on facility time	0.0075%

5. PAID TRADE UNION ACTIVITIES

The percentage of total paid facility time hours that were spent by employees who were relevant union officials on paid trade union activities.

Time spent on paid trade union activities as a percentage of total paid facility time hours	27%

6. CONCLUSION

The Board is asked:

a) To note the Trade Union Facility Time reporting information for 2021 – 2022.
b) Confirm submission to the government portal.
c) Endorse publication on the Trust website.

Report of Donna Watson
Head of Workforce Engagement and Information Systems

Dee Fawcett,
Director of HR
28 July 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022						
Title	Directorate Strategy Refresh Programme						
Report of	Vicky McFarlane-Reid, Executive Director of Business, Development and Enterprise						
Prepared by	Lisa Jordan – Assistant Director of Business Strategy and Planning						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The purpose of this report is to update the Trust Board on the programme of work to refresh the Directorate Strategies, the work undertaken to date and the timelines for the next stages of the programme. In November 2021, the Trust began a 12–18-month programme of work to refresh the existing directorate strategies. The current directorate strategies were written in 2018 and helped to inform the current Trust Strategy. Much has happened since then; the COVID-19 pandemic, bringing with it unprecedented recovery challenges as well as the formation of the Integrated Care Board and system collaboration on a much broader scale. The current Trust strategy expires in 2024, these refreshed directorate strategies will help to inform the next Trust strategy. Work to date includes reviewing existing strategies, identifying achievements, what is still outstanding, and what has changed. A series of workshops have been held with directorates with guest speakers (internal and external) presenting information on topical issues to provoke discussion and consideration of local impact. The next stage is to provide the directorates with a template and supporting data and information for them to start drafting their refreshed strategies. We are conscious that the Trust Strategy runs for another 2.5 years, and whilst good progress has been made there is still much to do to achieve the objectives within the Strategy. We need to keep focus on this whilst encouraging the directorates to refresh and update their own strategies. The Strategies should all be published in April 2023.						
Recommendation	To receive the report.						
Links to Strategic Objectives							
Impact	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability

(please mark as appropriate)	☐	☐	☐	☐	☐	☒	☐
Impact detail							
Reports previously considered by	This is a new report to Board.						

UPDATE ON DIRECTORATE STRATEGY REFRESH PROGRAMME

1. INTRODUCTION

In November 2021, the Trust began a 12–18-month programme of work to refresh the existing clinical directorate strategies. The current Trust strategies were written in 2018 and helped to inform the current Trust Strategy. Much has happened since then; the COVID-19 pandemic, bringing with it unprecedented recovery challenges as well as the formation of the Integrated Care Board and system collaboration on a much broader scale. The current Trust strategy expires in 2024, these refreshed directorate strategies will help to inform the next Trust strategy.

2. PROGRESS TO DATE

In November and December 2021 all clinical directorates were asked to review their current strategies. A summary has been produced demonstrating what achievements have been made, what is still outstanding, and what has changed for each directorate. The directorates were also asked to consider what 'service lines' the new strategies should cover e.g., should there be a strategy for spinal services across the Trust instead of spinal services sitting across several directorates.

In January 2022, a series of workshops was launched to present information on topical issues to provoke discussion and consideration of local impact with the directorates. The first workshop was presented by Dame Jackie, and gave an overview of the Integrated Care System, its structure and what it will mean for our organisation. The subsequent workshops have covered topics such as:

- Clinical Developments
- Sustainability
- Research and Innovation
- Digital Strategy
- Health Inequalities
- Finance overview
- Newcastle Improvement
- Get It Right First Time (GIRFT)
- Estates Strategy

The workshops have been well attended with audiences of 50-70 Newcastle Hospitals staff, including directorate managers, clinical directors, Heads of Service, finance managers, Executive team members and non-Executives.

We plan to organise further workshops in the autumn to cover topics such as networks and 'place' systems once the future of these areas becomes a bit clearer.

3. NEXT STEPS

The next steps are to provide the directorates with a template document to complete, this will be based on an OGIM model (Objective Goal Initiatives Measures) to help focus the directorates on what they want to achieve.

The directorates will also be provided with an information pack which will provide details and signposting to information on patient demographics, epidemiology, inequalities and sustainability.

A detailed market review has also been carried out which demonstrates, at Treatment Function Code level, how many referrals and how much activity the Trust has undertaken in the last 3 years (excluding 2020-21). It also reviews levels of activity across the local and regional area across all CCGs and providers in terms of market share, gains, and losses. This information should help the directorates to look at areas they may wish to focus on.

The Business Development and Enterprise Team (BD&E) will meet with each directorate to talk through the template and information 'packs' and support them to develop their strategies.

When the 2018 strategies were developed the directorates all found it valuable to share their strategies with each other so they were aware of areas of conflict or cross-cutting and where they could work together. This process will be facilitated again so that they can feed this into the final versions of their strategies.

4. TIMELINES

When	What	Who
Early Aug	Data 'packs' and strategy template to be shared with directorates. Packs will include info on demographics, epidemiology and market share analysis as a minimum. A member of BD&E team will go through the packs with directorates and discuss what further information / data would be useful.	BD&E and directorate management teams
Aug-Oct	Directorates to draft their strategies / sub-strategies	Directorate management teams (with support available from BD&E)
Nov-Dec	'Workshops' for directorates to share their draft strategies with one another	Directorate management teams (facilitated by BD&E)
Jan-Mar 23	Finalise directorate strategies	Directorate management teams
April 23	Directorate Strategies 'published'	

5. SUSTAINING THE TRUST STRATEGY

We are conscious that the Trust Strategy runs for another 2.5 years, and whilst good progress has been made there is still much to do to achieve the objectives within the Strategy. We need to keep focus on this whilst encouraging the directorates to refresh and update their own strategies.

The basis of the directorate strategies will be the 5Ps from the Trust Strategy, Patients, People, Partnerships, Pioneers and Performance. These appear to be well embedded within the senior leadership team. Throughout the engagement with the directorates on drafting their new strategies we will use the opportunity to keep the Trust Strategy alive across the organisation and support the directorates to cascade this to their teams.

6. RECOMMENDATION

The Trust Board is asked to receive this report.

Report of
Victoria McFarlane-Reid
Director of Business, Development & Enterprise

Lisa Jordan
Assistant Director of Business Planning & Strategy

28 July 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022						
Title	North East and North Cumbria Provider Collaborative Governance: Update for NHS Foundation Trust Boards						
Report of	Caroline Docking, Assistant Chief Executive						
Prepared by	Matt Brown, Managing Director, North East and North Cumbria (NENC) Provider Collaborative						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☒	☐	☐				
Summary	As part of the new system structures NHS England (NHSE) required that by the 1 July all acute and mental health providers should form themselves into 'provider collaboratives'. These non-statutory bodies are intended to facilitate provider collaboration and co-operation at system level, tackling variation and contributing to wider Integrated Care System objectives. The 11 provider Trusts in NENC began to formal meet as a collaborative in September 2020. They have considered how they wished to formally work together, with a proposal that they will act as a 'provider leadership forum'. The Update paper provides a summary of this approach and is supported by three further enclosures: a). the Collaborative agreement (covering decision making, principles and overarching objectives); b). the Operating model, which describes how the collaborative will conduct its business and c). the Ambition documents which set out the overall aims and objectives for an external audience.						
Recommendation	The Board is asked to: 1. Note the progress made on the development of the NENC Provider Collaborative. 2. Note and formally approve the documents setting out the Collaboration Agreement, Operating Model and Our Ambition.						
Links to Strategic Objectives	Partnerships						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☐	☒	☐	☐	☐	☐	☐
Impact detail	Detailed within the report.						
Reports previously considered by	New report.						

PROVIDER COLLABORATIVE GOVERNANCE DOCUMENTS

EXECUTIVE SUMMARY

This report summarises the proposed formal work structure and governance for the North East and North Cumbria (NENC) Provider Collaborative, setting out how the 11 NHS Foundation Trusts (the Trusts) will operate, with the creation of a Provider Leadership Board (PLB), set out in the Ambition, Operating Model and Collaboration Agreement. There are separate arrangements for other collaboratives, such as those specifically for specialised mental health, learning disability and autism services.

Trust Boards are asked to note progress and confirm agreement to the proposed governance arrangements.

PROVIDER COLLABORATIVE GOVERNANCE DOCUMENTS

1. INTRODUCTION/PURPOSE

This report summarises the proposed formal work structure and governance for the North East and North Cumbria (NENC) Provider Collaborative, setting out how the 11 NHS Foundation Trusts (the Trusts) will operate, with the creation of a Provider Leadership Board (PLB), set out in the Ambition, Operating Model and Collaboration Agreement. There are separate arrangements for other collaboratives, such as those specifically for specialised mental health, learning disability and autism services.

2. CONTEXT

National policy required that by the 1 July 2022 all NHS acute and mental health trusts are working as a provider collaborative with a requirement that they:

- Are formally convened with a focus on collaborative working to deliver local and national requirements;
- Are established as a formal entity; and
- Have in place appropriate engagement and collective decision-making structures.

The intention of the legislation is that this supports closer system working and that it provides a basis for formal agreement between the Provider Collaborative and the Integrated Care Board (ICB) on jointly determined objectives and ways of working to deliver against those objectives.

Within NENC the 11 Foundation Trusts agreed to work together as a provider collaborative in September 2020. Since then, the Trusts have been developing working relationships, governance arrangements and determining areas for focus in the first instance. Though this work, the Provider Collaborative determined that this joint work would be underpinned by four key documents:

1. A formal memorandum of agreement to be made between the Trusts, setting out how the Provider Collaborative will work, the **"Collaboration Agreement"**
2. A document setting out the aspiration and ambition that Trusts have together, as a form of prospectus, particularly designed for partners and stakeholders, in **"Our Ambition"**
3. A work programme which will need to evolve over time, setting out priorities and the mechanisms for operational delivery such as capacity, workstreams and meeting structures, the **"Operating Model"**
4. A documented agreement between the Provider Collaborative and the ICB, setting out a shared view on priorities, work areas for the Provider Collaborative to take forward on behalf of the ICB, accountabilities and resourcing, the **"Responsibility Agreement"**.

Since Summer 2021, the 11 Trusts have worked together to develop their governance model and wider approach through a series of facilitated workshops and along with specialist

support from the legal firm Hill Dickinson to draft a governance structure. Documents 1 to 3 are included in the Board Reference Pack.

3. COLLABORATION AGREEMENT

The Collaborative Agreement includes as signatories all 11 Trust members of the Provider Collaborative, setting out the following key provisions:

- The overarching purpose and aims of the Collaborative and the status of the collaborative agreement;
- The proposed term of the agreement and arrangements for its regular review and updating;
- The principles of collaboration agreed between the Trusts, acknowledging each Trust's statutory duties and contractual obligations and the requirement for / ability of the Trusts to participate in other collaborative arrangements;
- The work programmes that have been agreed at the outset to be taken forward by the Collaborative and the resources the Trusts have agreed to commit (including to fund the Collaborative infrastructure (e.g. PMO)) etc;
- The governance arrangements to take forward the work programmes including the Provider Leadership Board and any sub-groups, together with terms of reference;
- A development plan setting out the key areas and priorities the Collaborative has agreed to focus on in further developing its governance and overall approach over the next 12-24 months;
- The process for resolving disagreements between the Trusts;
- The parameters of information sharing between the Trusts and dealing with conflicts of interest; and
- The process for members to terminate the arrangements, or for withdrawal of an individual Trust member and the process for admitting new members to the Collaborative.

The Collaboration Agreement sets out the governance approach, with a key vehicle for Provider Collaborative decision-making being the establishment of a 'Provider Leadership Board' (PLB). The Provider Leadership Board representation will be the Chief Executives of each of the 11 Trusts and is established as the overarching body, overseeing and directing the jointly agreed programme of work. Under this approach individual Trust Boards would retain final decision-making authority with each board giving their respective chief executive (or nominated organisational representative) delegated authority to make decisions as appropriate. Decisions would be made on a consensus basis.

A number of alternative approaches were considered that would see more formal delegation to the Provider Collaborative but were not felt to be appropriate at this point. For reference, the key alternatives considered were Committees in Common (CiC) and Joint Committee (which are now permissible under the Health Act). In these approaches, formal decision making is delegated to organisational representatives with decisions taken in the CiC or Joint Committee binding on constituent organisations. In the provider leadership approach, final decisions rest with the individual organisations and this works on the basis

that the partner trusts agree formally to work together but individual trust boards retain full decision-making powers.

The provider leadership model was felt to be appropriate as:

- It built from the existing model and work to date.
- Allowed for a formalised decision making without becoming overly bureaucratic.
- Was a flexible solution that could adjust to wider system working requirements as they evolve and emerge.
- Was not restrictive, in that it would allow for growth and development into approaches which allowed for greater delegated authority, should the Trusts wish to evolve in that way over time.

The Collaboration Agreement sets out that the chair of the Provider Leadership Board would be one of the Chief Executives with a 24-month term of office, with a potential extension of a further 24-month term of office. The PLB Chair would be one of the two Integrated Care Board Foundation Trust members and the tenure is aligned accordingly. A vice-chair would also be appointed, with the intention that the vice-chair is the successor to the chair, and a new vice-chair appointed by the Provider Leadership Board members. In January 2022, Ken Bremner was appointed as the Chair and Lyn Simpson as the Vice-Chair.

4. OUR AMBITION

Our Ambition is intended to be a document that is externally facing, summarising how the Provider Collaborative seeks to deliver system priorities and how it will link, interface and work with other partners and stakeholders.

This document describes who the Provider Collaborative is, its role and what it seeks to achieve and how it will facilitate horizontal collaboration between Trusts. It highlights that the focus is at system level and therefore will complement and support work at place-level and with nested collaboratives, such as on a sub-regional basis. It recognises that there will be different partnership and collaborations at different levels in this system.

The Provider Collaborative will be one of a number of partnerships that the ICB will work with and through to deliver its overall aims and objectives. The role of the Provider Collaborative will evolve over time in line with ICB requirements.

5. OPERATING MODEL

The Operating Model is intended to be a document that will evolve over time, setting out the key priorities for the Provider Collaborative and the way in which these will be taken forward operationally, including people, meeting and governance structures. The work programmes are structured around three broad areas of clinical, clinical support and corporate programmes, which is consistent with other, well-established provider collaboratives from around the country. The document sets out that the Provider Collaborative will have its own programmes and priorities as well as those agreed with the ICB.

The Provider Collaborative has set out to have a programme management approach with a particular focus over the next few months on:

- Clinical programmes, including
    - Elective and system recovery, reducing long waits for patients and taking forward the programme of transformation.
    - Urgent and emergency care, supporting colleagues in local systems with collaborative solutions to pressures.
    - Strategic approach to clinical services, tackling vulnerable services collectively such as issues with non-surgical oncology, supporting and leading clinical networks, and developing a strong model of clinical leadership.
- Clinical support programmes, not least the development of the NENC Provider Collaborative Aseptics Manufacturing Hub and continuing to focus on collaborative opportunities for pathology and diagnostics.
- Corporate programmes, where there are opportunities to make improvement by working together, particularly in seeking to take a more consistent, convergent approach to decisions affecting workforce and estates, while recognising the different circumstances for each organisation.

Programme reporting will be directly to the Provider Leadership Board, through Chief Executives taking on a Senior Responsible Officer role, supported by a programme management structure overseen by the Managing Director. Initial pump-priming resource to support the development of the collaborative and programme management capacity has come from NECS.

6. INTEGRATED CARE BOARD WORKING ARRANGEMENTS (RESPONSIBILITY AGREEMENT)

The Collaborative Agreement, Operating Model and Our Ambition documents have been shared with the Integrated Care Board (ICB) and formally supported by the ICB Executive Team, prior to seeking final approval by FT Boards. The Provider Collaborative and the ICB are aligned on the intended priorities, governance approach and ways of working set out in these documents. However, it has not yet been possible to formally reflect this into a Responsibility Agreement, given the ICB has only been established in July 2022.

It was determined that the Collaboration Agreement, Operating Model and Our Ambition documents should be shared with Trust Boards for support and approval, whilst the Responsibility Agreement is developed. The Responsibility Agreement will be shared with Trust Boards once concluded and will document clearly shared priorities, governance, escalation, accountability and resourcing.

7. RECOMMENDATIONS

The Foundation Trust Boards of the eleven NENC Provider Collaborative members are asked to:

- Note the progress made on the development of the NENC Provider Collaborative.
- Note and formally approve the documents setting out the Collaboration Agreement, Operating Model and Our Ambition.

Report of Matt Brown
North East and North Cumbria Provider Collaborative

8 July 2022

Enclosures [Board Reference Pack]

- **Enc. A: Collaborative Agreement (MoU)**
- **Enc. B: Operating Model**
- **Enc. C: Ambitions Document**

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 2022						
Title	Update from Committee Chairs						
Report of	Non-Executive Director Committee Chairs						
Prepared by	Kelly Jupp, Trust Secretary Lauren Brotherton, Governor and Membership Engagement Officer						
Status of Report	Public	Private	Internal				
	☒	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☐	☒				
Summary	The report includes updates on the work of the following Trust Committees that have taken place since the last meeting of the Trust's Board on 31 May 2022: • People Committee – 23 June 2022 • Finance Committee – 17 June 2022 (Extraordinary) and 27 July 2022 • Audit Committee – 20 June 2022 (Extraordinary) and 26 July 2022 • Charity Committee – 18 July 2022 (Extraordinary) • Quality Committee – 19 July 2022 • Board of Directors – 21 June 2022 (Extraordinary)						
Recommendation	The Board of Directors are asked to (i) receive the update and (ii) note the contents.						
Links to Strategic Objectives	Links to all.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☒	☒	☒	☐
Impact detail	Impacts on those highlighted at a strategic level.						
Reports previously considered by	Regular report.						

UPDATE FROM COMMITTEE CHAIRS

EXECUTIVE SUMMARY

This report provides an update to the Board on the ongoing work of the Trust's Committees for those meetings that have taken place since the last meeting of the Board of Directors in May 2022.

UPDATE FROM COMMITTEE CHAIRS

1. PEOPLE COMMITTEE

A formal meeting of the People Committee took place on 23 June 2022. During the meeting, the main areas of discussion to note were:

- An update on the Integrated COVID Hub North East (ICHNE) contract was provided by the Head of Human Resources and the Chief Operating Officer provided an update on the Vaccination Hub.
- A detailed update was received from the Associate Director of Education, Training and Workforce Development in relation to Statutory and Mandatory Training and Apprenticeships.
- The Leadership Development and Talent Management Strategy was presented by the Director of HR and approved.
- The people dashboard and Trade Union Working Time Report were received and discussed in detail.
- The Committee annual report, including the review of Terms of Reference and Schedule of Business was received and ratified.
- The Committee received the Guardian of Safe Working Annual Report, the Freeman to Speak Up Guardian Annual Report and the People Risks Board Assurance Framework (BAF) quarterly report.
- A Sustainability update was received.

The next formal meeting of the Committee will take place on 16 August 2022.

2. FINANCE COMMITTEE

An extraordinary meeting of the Finance Committee took place on 17 June 2022. During the meeting, the main areas of discussion included:

- The Interim Assistant Finance Director explained the rational for conducting earlier financial reporting from 2022/23 onwards.
- The Annual Accounts 2021/22 including the Trust Accounts Consolidation (TAC) schedules were received and approved.
- The Terms of Reference and Schedule of Business were received and ratified.

A formal meeting of the Finance Committee took place on 27 July 2022. During the meeting, the main areas of discussion included:

- An update on the financial plan sign off for 2022/23.
- The month 3 finance report including emerging risks regarding inflation and the removal of non-recurrent spend.
- An update on the Cost Improvement Programme (CIP) delivery and the activity and recovery programme.
- The Director of Estates provided an update on the capital strategy.
- The Month 3 2022/23 performance and delivery report was received.
- The Finance Director provided an update on the National Cost Collection Exercise.

The next formal meeting of the Committee will take place on 28 September 2022.

3. AUDIT COMMITTEE

An extraordinary meeting of the Audit Committee took place on 20 June 2022. During the meeting, the main areas of discussion to note were:

- Approval of the Annual Report and Accounts 2021/22 including the Annual Governance Statement and Trust Accounts Consolidation (TAC).
- AuditOne provided a progress report on the Trust's Internal Audit Programme and submitted the Draft Head of Internal Audit Opinion for 2021/22.
- Mazars LLP provided a progress report including the Trust ISA260 Audit Completion Report and Audit Opinion on the Annual Report and Accounts 2021/22.

A formal meeting of the Audit Committee took place on 26 July 2022. During the meeting, the main areas of discussion included:

- Committee Chairs provided updates relating to risk and assurance in relation to their specific areas of focus.
- The Head of Corporate Risk and Assurance presented the Board Assurance Framework (BAF) and the Standards of Business Conduct Annual Report including the Chairman Fit and Proper Persons Statement and the annual review of the register of gifts and hospitality.
- An update was received on the clinical audit process.
- The Finance Director provided an update on the review of performance of Internal Audit, External Audit and Counter Fraud.
- A Charity update was received including the Charity Annual Accounts and Charity Policy and Scheme of Delegation.
- AuditOne provided a progress report on the Trust's Internal Audit programme, the Internal Audit Operational Plan, and the Internal Audit Charter for 2022/23.
- Counter Fraud provided an update report and the Annual Anti-Fraud Report 2021/22.
- Mazars LLP provided an update on the Trust's Auditor's Annual Report.
- The Fit and Proper Persons Policy and Modern Slavery and Human Trafficking Act Annual Statement were submitted for approval.
- The Committee received a number of reports including:
    - Review of schedule of approval of single tender action and breaches and waivers exception report;
    - Review of debtors and creditors balances;
    - Review of schedule of losses and compensation;
    - Information Governance Update; and
    - Information Management & Technology Update.

The next formal meeting of the Committee will take place on 25 October 2022.

4. CHARITY COMMITTEE

An extraordinary meeting of the Charity Committee took place on 18 July 2022. The meeting was convened primarily to discuss a number of grant applications in advance of the next formal meeting in September.

The committee received an overview of the Charity's grant making approach and a summary of grants up to £25,000 that had been approved since the last meeting of the committee in May (these totalled £102,000).

The committee approved applications which totalled £396,981 and included the following:

- A neonatal MRI compatible transport ventilator.
- A cardiothoracic data development project.
- An uplift to a previously made grant to the Northern Region Functional Electrical Stimulation service.
- An uplift to a previously made grant for research into the clinical benefit of circulating tumour cell analyses for oesophageal adenocarcinoma patients.
- Support for Coping with Cancer North East's acupuncture and counselling service for NCCC patients.
- A Newcastle University study into socioeconomic inequalities in lung cancer treatment.
- Young Persons Advisory Group North East (YPAGne) and Engagement co-ordinator.

The next formal meeting of the Committee will take place on 2 September 2022.

5. QUALITY COMMITTEE

A formal meeting of the Quality Committee took place on 19 July 2022. During the meeting, the main areas of discussion to note were:

- An update on the Ockenden report and Assurance visit was provided.
- The Director of Quality and Effectiveness provided an update on the Trust's response and plan in relation to the National Patient Safety Strategy.
- The integrated quality and performance reports were received and discussed.
- A Royal College reviews update was provided.
- An update was provided on the Quality Strategy refresh.
- The Committee considered a number of reports including:
    - The Clinical Outcomes & Effectiveness Group;
    - Clinical Negligence Scheme for Trusts (CNST);
    - CQC Action Plan;
    - Health and Safety Annual Report; and
    - The Committee Annual Report 2021/22 including the schedule of business and review of the Committee Terms of Reference.
- An update was provided on the leadership walkabouts / spotlight on services.
- The Patient Safety Group and Clinical Outcomes and Effectives Group provided their annual reports.

- The Clinical Outcomes and Effectiveness Group provided an update on their activity and progress.

The next formal meeting of the Committee will take place on 20 September 2022.

6. PRIVATE BOARD OF DIRECTORS

An extraordinary private meeting of the Board of Directors took place on 21 June 2022. During the meeting, the main areas of discussion to note were:

- Approval of the:
    - Annual Report 2021/22; and
    - Annual Accounts 2021/22.

7. RECOMMENDATIONS

The Board of Directors is asked to (i) receive the update and (ii) note the contents.

Report of Kelly Jupp, Trust Secretary
Lauren Brotherton, Governor and Membership Engagement Officer
21 July 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 July 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; • Quarterly NHS Improvement Declarations; • Annual reviews of the Board Committees, Terms of Reference and Schedule of Business; • Annual Modern Slavery Act Declaration; • 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 quarterly declarations for publication; (iii) Approve the Committee Annual Reports; (iv) Approve the changes to the Committee Terms of Reference and Schedules of Business; and (v) Approve the Annual Trust Modern Slavery Act Statement for publication.						
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 16 June 2022;
  - Governor developments; and
  - Second Member's Event to be held on 9 August 2022.
- Submission of the Trust Annual Report and Accounts 2021/22;
- External Well-Led review;
- Quarterly NHS Improvement Declarations;
- Annual reviews of the Board Committees, Terms of Reference and Schedule of Business;
- Annual Modern Slavery Act Declaration;
- 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 quarterly declarations for publication;
(iii) Approve the Committee Annual Reports;
(iv) Approve the changes to the Committee Terms of Reference and Schedules of Business; and
(v) Approve the Annual Trust Modern Slavery Act Statement for publication.

CORPORATE GOVERNANCE UPDATE

1. COUNCIL OF GOVERNORS

1.1 Recent Meeting

A Council of Governors meeting was held on 16 June 2022. The meeting took place in person at the Dame Margaret Barbour Building, Medical School, Newcastle University and Governors received presentations and updates on:

- The Trust Integrated Quality, Performance, People and Finance Reports from Vicky McFarlane-Reid, Executive Director of Business, Development and Enterprise, Angela Dragone, Finance Director and Angela O'Brien, Director of Quality and Effectiveness.
- Making Mental Health Everyone's Business by Dr Sarah Brown, Consultant Psychiatrist.
- The 2022 Council of Governor Elections from Caroline Docking, Assistant Chief Executive.
- External Audit work on the Trust Annual Accounts and an Annual Accounts 2021/22 briefing from Mrs Angela Dragone, Finance Director.

The next formal meeting of the Council of Governors will be held on Thursday 18 August 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 member data is up to date.
- A meeting took place with the Deputy Chief Nurse, the new Quality of Patient Experience (QPE) Working Group Chair, the PA to the Chief Nurse and the Governor and Membership Engagement Officer to discuss the process to restart Governor ward/service visits from mid-September 2022. These visits had been paused during the COVID-19 pandemic.
- The newly elected Governors started their term of office on 1 June 2022 and have undertaken the New Governor Induction with the Chairman and Trust Secretary.
- Engagement continues to recruit Public and Staff members including Governors handing out leaflets outside the Medi Cinema at the Royal Victoria Infirmary (RVI) and working with Internal and Community Groups.

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

1.3 Members Event

The second Members Event for 2022 will take place on 9 August with a theme of Sustainability. This event will be held in person in the Lecture Theatre, Education Centre, Royal Victoria Infirmary (RVI). The programme has been advertised via the Trust website,

staff intranet, on the Trust's social media, direct email to Public Members and through internal groups.

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

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 intends to lay its ARA for 2021/22 before Parliament in tranche 2 of the ARA submissions, the first week after summer recess, being the week commencing the 5 September.

We are currently working with Potts to finalise the ARA design in order to achieve the Parliamentary laying date and in time for publication and presentation to the Annual Members Meeting, scheduled for 2.30pm – 4.30pm on 27 September 2022.

The thanks of the Corporate Governance Team are extended to all of those who contributed to the content.

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 will conclude in August 2022.

A progress update on the work undertaken to date has been included in the Private Board papers (agenda item B4).

4. QUARTERLY NHS IMPROVEMENT DECLARATIONS

The quarterly self-certifications provide assurance that NHS providers are compliant with the conditions of their NHS provider licence. They also provide a tool for the Trust to ensure it can continue to demonstrate effective systems are in place and adherence to the conditions of the NHS provider licence, NHS legislation and the NHS Constitution.

The certifications as appended cover the period from 1 April to 30 June 2022 and Board members are asked to approve the declarations.

5. ANNUAL REVIEWS OF THE BOARD COMMITTEES, TERMS OF REFERENCE AND SCHEDULE OF BUSINESS

The annual reviews of each Board Committee have now been completed with Committee Annual Reports produced. The Annual Reports set out Committee business undertaken during the year, membership and attendance, and areas of focus for 2022/23.

Further, the Terms of Reference and Schedules of Business of each Committee have been reviewed and minor changes proposed. The Charity Committee Terms of Reference are scheduled for review at the November 2022 Committee meeting.

The Annual Report of the Appointments and Remuneration Committee was developed as part of the production of the Trust Annual Report and Accounts 2021/22 and was reviewed by the Board of Directors at the extraordinary private meeting of the Trust Board in June 2022. Minor changes to the Terms of Reference were agreed at the 31 March 2022 Trust Board meeting, along with an updated Schedule of Business for the Appointments and Remuneration Committee. These documents will be further reviewed/updated following the conclusion of the work undertaken by Korn Ferry to consider best practice regarding remuneration governance/arrangements.

The Annual Reports, Terms of Reference, and Schedules of Business for each of the Committees are appended to this report for the approval of the Board.

6. ANNUAL MODERN SLAVERY ACT DECLARATION

Also appended to this report is the Annual Statement on behalf of the Trust in relation to the Modern Slavery and Human Trafficking Act 2015 for Board approval.

The report outlines the Trust's commitment to preventing modern slavery and human trafficking in its supply chain and demonstrates the Trust has reviewed and met its requirements in line with Section 54 of the Modern Slavery Act 2015.

7. PUBLICATIONS/CONSULTATION RESPONSES

During May 2022, NHS England (NHSE) published three key governance documents being:

1. Consultation on the new draft Code of governance for NHS Provider Trusts;
2. Consultation on the draft Addendum to your statutory duties – reference guide for NHS Foundation Trust Governors; and
3. NHS England – draft guidance on good governance and collaboration.

A detailed review of the documents was undertaken and shared with Executive Team members in early July 2022. Consultation responses were developed and submitted on behalf of the Trust in advance of the consultation response deadline.

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

As reported to the Trust Board in May 2022, Ms Liz Bromley commenced as a Trust NED on 1 June 2022. Ms Bromley is currently undergoing a tailored induction programme, including meetings with fellow Board members.

9. RECOMMENDATIONS

The Board of Directors are asked to

(i) Receive the report;
(ii) Approve the quarterly declarations for publication;
(iii) Approve the Committee Annual Reports;
(iv) Approve the changes to the Committee Terms of Reference and Schedules of Business; and
(v) Approve the Annual Trust Modern Slavery Act Statement for publication.

Kelly Jupp
Trust Secretary

Lauren Brotherton
Governor and Membership Engagement Officer
21 July 2022