The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	24th November 2022						
Title	Honorary Consultant Appointments						
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 content of this report outlines recent requests for Honorary Consultant Contracts						
Recommendation	The Board of Directors is asked to note the award of/ extension to the Honorary Consultant Contracts						
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	Honorary Consultant Appointment requests are submitted as and when requests are received.						

HONORARY CONSULTANT APPOINTMENTS

1. HONORARY CONSULTANT APPOINTMENT REQUESTS

1.1 Mr Jonathan Forty

Mr Forty, Batchelor of Arts (Honours) 1978 Cambridge, Batchelor of Medicine 1980 Cambridge, Batchelor of Surgery 1980 Cambridge, Master of Arts 1982 Cambridge, FRCS(Edinburgh) 1986, FRCS(England) 1987, Doctor of Medicine 1999 Cambridge. Mr Forty currently holds the post of National Programme Director for Advanced Trauma and Life Support (ATLS) and a 1PA contract with the Trust.

After 5 years, the ATLS post is due to come to an end in December 2022 and therefore also his 1 PA Contract with the Trust. An Honorary Contract has been requested to allow Mr Forty to carry out clinical service provision and also assist with investigations and mediations. The contract would commence as soon as possible and would be reviewed on an annual basis.

There are no financial implications for the Trust.

1.2 Dr Subhan Christudas

Dr Christudas, MRCPCH March 2011, FRCPCH 2021, MBBS January 2000 is currently employed by North Tees University Hospital as a Consultant Paediatrician.

An Honorary Contract has been requested to allow Dr Christudas to run joint parallel clinics with Newcastle Hospitals Paediatric Cardiologists to maintain skills and the good links between the Congenital Heart Disease Network. The contract would end on 31 September 2024

There are no financial implications for the Trust

1.3 Dr Kenneth Frank Baker

Dr Baker, PhD Doctor of Philosophy Newcastle 2018, PGCert Postgraduate Certificate in Medical Education Dundee 2016, MRCP(UK) Royal College of Physicians 2011, BM BCh distinction 2008 Oxford, BA(Hons) Medical Sciences 1st Class, 2005 Oxford is appointed to the position of Senior Clinical Fellow Newcastle University.

I confirm that the Musculoskeletal Services Directorate of The Newcastle upon Tyne Hospitals NHS Foundation Trust agrees to host Dr Kenneth Baker as an honorary consultant and to pay Newcastle University for five PAs of clinical work. This has been approved through Medical Directors Group.

2. RECOMMENDATIONS

The Board is asked to note:

1.1 Mr Forty be awarded Contract as a Consultant Cardiothoracic Surgeon with immediate effect and to be reviewed on an annual basis.
1.2 Dr Christudas be awarded an Honorary Contract as a Consultant Paediatrician with immediate effect and to be reviewed on an annual basis.
1.3 Dr Baker be awarded an Honorary Contract as a Consultant Rheumatologist with immediate effect and to be reviewed on an annual basis.

Report of Andy Welch
Medical Director
15th November 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

<table>
<tr><td>Date of meeting</td><td colspan="7">24 November 2022</td></tr>
<tr><td>Title</td><td colspan="7">Consultant Appointments</td></tr>
<tr><td>Report of</td><td colspan="7">Andy Welch, Medical Director</td></tr>
<tr><td>Prepared by</td><td colspan="7">Claudia Sweeney, Senior HR Advisor (Medical & Dental)</td></tr>
<tr><td rowspan="2">Status of Report</td><td colspan="3">Public</td><td colspan="2">Private</td><td colspan="2">Internal</td></tr>
<tr><td colspan="3">☒</td><td colspan="2">☐</td><td colspan="2">☐</td></tr>
<tr><td rowspan="2">Purpose of Report</td><td colspan="3">For Decision</td><td colspan="2">For Assurance</td><td colspan="2">For Information</td></tr>
<tr><td colspan="3">☐</td><td colspan="2">☐</td><td colspan="2">☒</td></tr>
<tr><td>Summary</td><td colspan="7">The content of this report outlines recent Consultant Appointments.</td></tr>
<tr><td>Recommendation</td><td colspan="7">The Board of Directors is asked to review the decisions of the Appointments Committee.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="7">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.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Reputation</td><td>Sustainability</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☒</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Impact detail</td><td colspan="7">Ensuring the Trust is sufficiently staffed to meet the demands of the organisation.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="7">Consultant Appointments are submitted for information in the month following the Appointments Panel</td></tr>
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CONSULTANT APPOINTMENTS

1. APPOINTMENTS COMMMITTEE – CONSULTANT APPOINTMENTS

1.1 An Appointments Committee was held on 04 October and interviewed 1 candidate for 1 Consultant General Paediatrician with special interest in HDU/Transport post.

By unanimous resolution, the Committee was in favour of appointing Dr Natasha Bell.

Dr Bell holds MBBS (University of Newcastle) 2008, and MRCPCH (UK) 2015. Dr Bell was previously employed as a Locum Consultant Paediatrician at the Great North Children's Hospital.

Dr Bell took up the post of Consultant General Paediatrician with special interest in HDU/Transport on 17 October 2022.

1.2 An Appointments Committee was held on 26 October 2022 and interviewed 2 candidates for 1 Consultant in Paediatric Dentistry post.

By unanimous resolution, the Committee was in favour of appointing Dr Oliver Sumner.

Dr Sumner holds BDS (University of Newcastle) 2011, MFDS (Edinburgh) 2013, MPaedDent (Edinburgh) 2018, and FDS (Edinburgh) 2021. Dr Sumner is currently employed as a Locum Consultant in Paediatric Dentistry at the Newcastle Dental Hospital.

Dr Sumner is expected to take up the post of Consultant in Paediatric Dentistry in November 2022.

1.3 An Appointments Committee was held on 27 October 2022 and interviewed 1 candidate for 1 Consultant Cellular Pathologist with a special interest in Dermatopathology.

By unanimous resolution, the Committee was in favour of appointing Dr Rana Salem.

Dr Salem holds MBBCh (Alexandria University, Egypt) 2010, FRCPath (UK) 2021. Dr Salem is currently employed as a Specialty Trainee in Histopathology on behalf of the Lead Employer Trust, at the Royal Victoria Infirmary.

Dr Salem is expected to take up the post of Consultant Cellular Pathologist with a special interest in Dermatopathology in February 2023.

1.4 An Appointments Committee was held on 03 November 2022 and interviewed 1 candidate for 1 Consultant in Paediatric Intensive Care (Cardiac & General) post.

By unanimous resolution, the Committee was in favour of appointing Dr Louise Woodgate.

Dr Woodgate holds MBChB (University of Liverpool) 2008, and MRCPCH (UK) 2012, FRCPath (UK) 2021. Dr Woodgate is currently employed as a Post CCT Fellow in Paediatric Heart Failure and Mechanical Support at the Freeman Hospital.

Dr Woodgate is expected to take up the post of Consultant in Paediatric Intensive Care (Cardiac & General) in January 2023.

1.5 An Appointments Committee was held on 14 November 2022 and interviewed 1 candidate for 1 Consultant Clinical Oncologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Caroline Dobeson.

Dr Dobeson holds MBChB (University of Aberdeen) 2012, and MRCP (UK) 2016, FRCPath (UK) 2020. Dr Dobeson is currently employed as a Specialty Trainee in Clinical Oncology on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Dobeson is expected to take up the post of Consultant Clinical Oncologist in December 2022.

1.6 An Appointments Committee was held on 14 November 2022 and interviewed 1 candidate for 1 Consultant Medical Oncologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Ajay Sudan.

Dr Sudan holds MBChB (University of Manchester) 2012, and MRCP (UK) 2017. Dr Sudan was previously employed as a Specialty Trainee in Medical Oncology on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Sudan is expected to take up the post of Consultant Medical Oncologist post in January 2023.

1.7 An Appointments Committee was held on 14 November 2022 and interviewed 3 candidates for 2 Consultant Neonatologist posts.

By unanimous resolution, the Committee was in favour of appointing Dr Claire Granger and Dr Tom Sproat.

Dr Granger holds MBBS (University of Newcastle) 2007, MRCPCH (UK) 2011, and PhD (University of Glasgow) 2013. Dr Granger is currently employed as a Specialty Trainee in Neonatal Medicine on behalf of the Lead Employer Trust, at the Royal Victoria Infirmary.

Dr Granger is expected to take up the post of Consultant Neonatologist in April 2023.

Dr Sproat holds MBChB (University of Sheffield) 2010, MRCPCH (UK) 2012 and MD (Newcastle University) 2020. Dr Sproat is currently employed as a Clinical Fellow in Neonatal-Perinatal Medicine at Alberta Children's Hospital, Canada.

Dr Sproat is expected to take up the post of Consultant Neonatologist in September 2023.

2. RECOMMENDATION

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

Report of Andy Welch
Medical Director
24 November 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Appendix i

Trust Board

Date of meeting	24 November 2022		
Title	Equality Delivery System – Annual Report		
Report of	Mauyra Cushlow, Executive Chief Nurse		
Prepared by	Tracy Scott – Head of Patient Experience Fardeen Choudhury – Equality, Diversity & Inclusion Manager (Patient Services)		
Status of Report	Public	Private	Internal
	☒	☐	☒
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☐
Summary	The Equality Delivery System (EDS) is a mandatory NHS improvement tool from NHS England to help NHS organisations improve their performance for individuals and groups protected by the Equality Act 2010. This report fulfils the annual EDS requirement to produce a report that grades the Trust's performance against set goals by NHS England, review Trust objectives and establish new objectives. The report is then required to be published online on the trust website. This report also fulfils the trust's legal Public Sector Equality Duties set out in the Equality Act 2010.		
Recommendation	The Trust Board is asked to read and acknowledge the content of this paper.		
Links to Strategic Objectives	We deliver the best possible health outcomes for our patients. Learning and continuous improvements is embedded across the organisation. We focus on prevention and population health. 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	This report fulfils the Equality Delivery System obligations set out by NHS England. This report fulfils the trust' legal Public Sector Equality Duties set out in the Equality Act 2010 Ensuring we have robust reporting of Equality and Diversity is of utmost importance, providing assurance that we are responsive to some of our most vulnerable patients and families.						
Reports previously considered by	Annual Report						

EQUALITY DELIVERY SYSTEM 2022 – Patients
2022 ANNUAL REPORT

1. INTRODUCTION TO THE EQUALITY DELIVERY SYSTEM 2022

The Equality Delivery System for the NHS is a mandatory improvement tool from NHS England to help NHS organisations, in partnership with local stakeholders, to review and improve their performance for individuals and groups protected by the Equality Act 2010 and to support them in meeting the Public Sector Equality Duty (PSED). The protected characteristics include age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The EDS can also be applied to other groups that can face inequalities, such as people on low incomes and asylum seekers.

The EDS has recently been refreshed from the previous EDS2 to the EDS2022. This new version streamlines the domains from four goals to three and places more emphasis on working with local organisations, stakeholders and patients to review and improve services. This annual report aims to demonstrate how the Trust meets the requirements of the Equality Act 2010 and the General and Public Sector Equality Duties associated with the Act. The Trust is mandated to use the EDS2022 toolkit to demonstrate how it meets these requirements and sets out our commitments to taking equality into account in everything we do.

The EDS2022 has 11 outcomes grouped into three goals. The three overarching goals are:
- Commissioned or provided services (Patient Services)
- Workforce health and well-being (Workforce)
- Inclusive leadership (Workforce)

The patient focused EDS2022 objectives have been developed through a process of:
- Profiling demographic information on the population of Newcastle from Census data
- Collating qualitative and quantitative data in relation to equality issues
- Involvement with the third sector, voluntary organisations, patient representatives, Trust staff and neighbouring NHS organisations.
- Considering what the Trust currently does to meet needs

Workforce objectives and progress will be reported separately by human resources.

2. PUBLIC SECTOR EQUALITY DUTY

As a public sector organisation, the Trust must, in the exercise of its functions, have due regard to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act

- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

The Equality Act 2010 explains that having "due regard" for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low

This general duty is also underpinned by other specific duties which places responsibilities on the Trust to:

- Publish equality objectives at least every four years
- Publish information to demonstrate we have complied with the general equality duty on an annual basis

3. EDS2022 GRADING

3.1 Monitoring and Reviewing the EDS2022

The Executive Chief Nurse has Executive responsibility for Equality, Diversity and Inclusion for Patients. The implementation, monitoring and reviewing of the EDS2022 (patient focused) is overseen by the Equality, Diversity and Human Rights Groups (EDHR) which is chaired by the Associate Director of Nursing. This group meets quarterly and monitors progress of the EDS2022 work plan.
The EDHR group membership includes representatives from: Elders Council, West End Youth Enquiry Service, Be-North, Chaplaincy, MESMAC/SHINE, Newcastle Disability Forum, The National Association of Laryngectomies Club, Deaflink, Newcastle Vision Support, Launchpad, Newcastle Carers Centre, HAREF, Healthwatch, PALS, Outpatients and Staff Networks.

3.2 EDS2022 Grading

Grading of objectives has involved:

- Collating qualitative and quantitative data in relation to the needs of people with protected characteristics
- Collating evidence of work within the Trust to address needs
- Working in partnership with third sector and voluntary organisations to review trust performance and evidence

There are four possible grades:

- Excelling

- Achieving
- Developing
- Undeveloped

The grading criteria is in Appendix 1. The tables in the pages below set out the objectives and the grades agreed for The Newcastle upon Tyne Hospitals NHS Trust.

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	- Established Carer's Champions network to empower local areas in identifying and supporting carers - Carers packs with signposted resources to support carers - Audit of hospital grounds from AccessAble and publicly available online to support disabled patients coming into hospital - Uptake of telephone interpreting and purchase of additional devices for virtual BSL interpretation - Audits being undertaken to identify inequalities in appointment attendance - Patient feedback supporting interpretation contract tender	**1 – Developing**	- Patient Experience Team
	1B: Individual patients (service users) health needs are met	- Development of Disability Awareness Training in partnership with disabled service users - Development of an Accessible Information Standard policy and training toolkit - Pilot of BSL Health Navigator Service to support Deaf patients through their patient journey	**2 – Achieving**	- Patient Experience Team
		- Co-production of a Mental Health Strategy in partnership with patients and staff		- Psychiatric Associate Medical Director
		- Development of sensory friendly areas for children with sensory differences		- Children's
		- Multi-faith chaplaincy team		- Chaplaincy

<table>
<tr><td rowspan="9"></td><td rowspan="5">1C: When patients (service users) use the service, they are free from harm</td><td>- Refreshed Dementia strategy that focuses on training, and working with families and carers</td><td rowspan="5">2 – Achieving</td><td>- Dementia team</td></tr>
<tr><td>- Validation exercise during COVID to prioritise patients and manage waiting lists
- Schwartz Rounds to support trust wide learning
- Equality analysis on policies and service developments
- Communication assessment on electronic admission form</td><td>- Trust wide</td></tr>
<tr><td>- Specialist roles, such as learning disability sexual health nurse</td><td>- Sexual health/LD</td></tr>
<tr><td>- Dedicated safeguarding policies for adults, children and maternity</td><td>- Safeguarding/ Children’s/ Maternity</td></tr>
<tr><td>- SI panel to review incidents and events and share learnings</td><td>- Clinical governance</td></tr>
<tr><td rowspan="4">1D: Patients (service users) report positive experiences of the service</td><td>- Equality monitoring of complaints and offering flexibility in the complaints process
- Working with local community organisations to gather insight and feedback into services and develop improvement work
- Equality monitoring on surveys</td><td rowspan="4">2 – Achieving</td><td>- Patient Experience</td></tr>
<tr><td>- Patient Experience Monitoring Group to review patient feedback to services and establish action plans and share learnings</td><td>- Trust wide</td></tr>
<tr><td>- Local services have dedicated patient engagement forums e.g. Maternity Voices Partnership/YPAG</td><td>- Women’s, Children’s</td></tr>
<tr><td>- New day case pathway gathering feedback from patients who have gone through the pathway</td><td>- Day case surgery</td></tr>
<tr><td colspan="3">Domain 1: Commissioned or provided services overall rating</td><td>7</td><td></td></tr>
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4. PATIENT FOCUSED EQUALITY OBJECTIVES

4.1 Progress on Current Objectives

Patient focussed equality objectives for 2021 – 2022 were developed in partnership and agreed with stakeholders from the Equality, Diversity and Human Rights Working Group. Progress on these objectives is reported below:

Completed actions from previous year	
Action/activity	**Related equality objectives**
- Equality analysis conducted and reviewed on all new and revised policies, incorporating learnings from the COVID pandemic - Shared information and good practice with local and national partner organisations throughout the pandemic - Reviewing complaints with equality issues - Working with local organisations to keep up to date about the impact of COVID 19 on different groups of people - English Unlocked training (e-learning to support staff communicating with non-English speaking patients) implemented. The training was completed by 254 people across all staffing groups. 81% of staff found the learnings easy to apply, with 91% of staff found they have improved the way they speak to patients who don't speak English. 76% of staff found it has had a positive impact on patient experience. 95% rated the learning as Good or Excellent and would recommend the course to colleagues	Incorporate EDI into changes and developments relating to COVID 19
- In collaboration with Newcastle Carers, a Hospital Carers Information and Advice Worker was recruited and extended for another year with support from Newcastle Hospital Charity. The project continues to promote the recognition and support of carers, deliver training, develop tools for staff and implement process changes	Enhance the support for Carers and people being cared for
- PALS, complaints and feedback in relation to AIS reviewed. Feedback gathered from local charities and Healthwatch. Gap analysis exercise conducted with outpatients and IT. AIS policy developed with IT, outpatients, IG and reviewed by EDHR group	Review and improve the experience for patients in relation to the Accessible Information Standard

Completed actions from previous year	
Action/activity	**Related equality objectives**
- Four new pieces of equipment for British Sign Language Virtual Remote Interpretation was purchased and will soon be available for staff to use. Virtual interpretation services for spoken and BSL interpretation has been promoted across the Trust, receiving good feedback from staff - The contract has been monitored and helped highlight improvement areas, such as languages requiring more recruitment and improving processes. Staff feedback and DATIX incidents have also been reviewed. This monitoring will support the upcoming tender for the interpretation contract.	Review interpretation and translation services
- Focus groups were held with Disability North and We Are All Disabled to help gather themes and feedback about being in hospital - Video idea generation and planning is underway with a video production company	In collaboration with local charities, produce a Disability Awareness training video
- The pilot service went live in April 2022 and has received a high volume of referral supporting Deaf patients through their patient journey. Monthly reports support the monitoring of the project and has highlighted further improvements areas for Deaf patients. - The service has received good feedback from Deaf patients who have accessed the service and has also supported staff across the Trusts.	In collaboration with Northumbria Healthcare, and Cumbria, Northumberland and Tyne and Wear Trust, pilot a BSL Health Navigator Service delivered by Deaflink

4.2 2022 – 2024 Equality Objectives

EDS Action Plan	
EDS Lead	**Year(s) active**
Fardeen Choudhury – Patient Services	2022 - 2024
EDS Sponsor	**Authorisation date**
(Patients) Maurya Cushlow – Executive Chief Nurse	24/10/2022

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	1. Support patients who face language barriers to access health services	- Conduct tender exercise for interpretation contract and implement provider - Continue BSL Health Navigator pilot and explore further funding avenues for extension - Work with local community organisations to raise awareness of interpreting services	October 2023 April 2024 December 2023
		2. Engage with local communities and underrepresented groups for service developments and improvement work	- Engage with communities and patients to understand access barriers to services - Analyse and review attendance and non-attendance data broken down by groups (e.g. ethnicity, gender, age, postcode)	October 2024

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1B: Individual patients (service users) health needs are met	1. Support patients to be involved in their healthcare needs and support shared decision making	- Develop guidelines for writing letters to patients - Pilot guidelines in selected service(s) and gather feedback	October 2024
		2. Identify and support carers and young carers, and empower appropriate social prescribing	- Implement and monitor carers pathway in pre-assessment and share learnings trust-wide	October 2023
	1C: When patients (service users) use the service, they are free from harm	1. Support staff caring for patients and visitors from protected characteristic groups, including disabled, LGBT and religious groups	- Implement and monitor the new Accessible Information Standard policy, and support staff training - Develop training tools and guidance to support staff in caring for patients from certain protected characteristic groups	October 2024
		2. Establish a better picture of inequalities in waiting lists	- Data analysis and audits of waiting lists disaggregated by postcode, ethnicity and other protected characteristic groups	October 2024
	1D: Patients (service users) report positive experiences of the service	1. Reach diverse communities for patient engagement activities	- Development and rollout of a patient engagement strategy which will include engagement with local communities - Monitor service user protected characteristics when analysing satisfaction from surveys, complaints and engagement activities - Use patient feedback to influence processes and interventions	October 2024

Appendix 1 – Grading Criteria

Outcome 1A: Patients (service users) have required levels of access to the service

Rating	Score	Description	Evidence
Underdeveloped	0	No or little activity taking place	Organisations/systems have little or nothing in place to ensure patients with protected characteristics have adequate and appropriate access to the services they require. Feedback from patients is not acted upon. Organisations have not identified barriers facing patients.
Developing	1	Minimal/basic activities taking place	Data and evidence to show some protected characteristics (50%) have adequate access to the service. Patients consistently report fair or good when asked about accessing services. Demonstration that the organisation has identified barriers to accessing services.
Achieving	2	Required level of activity taking place	Data to show those with protected characteristics (100%), and other groups at risk of health inequalities, have adequate access to the service. Patients consistently report food or very good when asked about accessing services. Demonstration that the organisation has identified barriers to accessing services.
Excelling	3	Activity exceeds requirements	Data to show those with protected characteristics (100%), and other groups at risk of health inequalities, have tailored access to the service. Patients consistently report very or excellent when asked about accessing services. Demonstration that the organisation has knowledge of barriers and have changed outcomes for people who experience those barriers in accessing services.

Outcome 1B: Individual patient's (service user's) health needs are met

Rating	Score	Description	Evidence
Underdeveloped	0	No or little activity taking place	Patients with higher risks due to a protected characteristic receive little or no support to self-manage care needs. The organisation does little or no engagement surrounding services.
Developing	1	Minimal/basic activities taking place	Patients at higher risk due to protected characteristic needs are met in a way that work for them. The organisation often consults with patients and public to commission, de-commission and cease services provided.
Achieving	2	Required level of activity taking place	Patients at higher risk due to protected characteristic needs are met in a way that works for them. The organisation often consults with patients with higher risk due to a protected characteristic to commission, design, increase, decrease, de-commission and cease services provided. The organisation signposts to VCSE organisations and social prescribing. Personalised care is embedded into the care delivered for those with higher risks due to a protected characteristic by the organisation.
Excelling	3	Activity exceeds requirements	Patients at higher risk due to a protected characteristic and other groups at risk of health inequalities needs are met in a way that works for them. The organisation fully engages with patients, community groups, and the public, to commission, design, increase, decrease, de-commission and cease services provided. The organisation works in partnership with VCSE organisations to support community groups identified as seldom heard. The organisation uses social prescribing, where relevant. Personalised care is embedded into the care delivered for those with higher risks due to a protected characteristic. The organisation works with, and influences partners, to improve outcomes for people with a protected characteristic and other groups at risk of health inequalities, across the system or where services connect.

Outcome 1C: When patients (service users) use the service, they are free from harm

Rating	Score	Description	Evidence
Underdeveloped	0	No or little activity taking place	The organisation may or may not have mandated/basic procedures/initiatives in place to ensure safety in services. Staff and patients are not supported when reporting incidents and near missed. The organisation holds a blame culture towards mistakes, incidents and near missed.
Developing	1	Minimal/basic activities taking place	The organisation has mandated/basic procedure/initiatives in place to ensure safety in services. The organisation has procedures/initiatives in place to enhance safety in services for patients in protected characteristic groups.
Achieving	2	Required level of activity taking place	The organisation has procedures/initiatives in place to enhance safety in services for patients in all protected characteristic groups where there is known H&S risks. Staff and patients feel confident, and are supported to, report incidents and near misses/ The organisation encourages an improvement culture giving consideration to equality and health inequality themes in safety incidents and near misses.
Excelling	3	Activity exceeds requirements	The organisation has procedures/initiatives in place to enhance safety in service for all patients in protected characteristic groups where there is known H&S risks. Staff and patients are supported and encouraged to report incidents and near misses. The organisation encourages and promotes an improvement culture actively including equality and health inequality themes in safety incidents and near misses. The organisation works with system and community partners to improve safety outcomes for people, using existing data and driven by service need/risk

Outcome 1D: Patients (service users) report positive experiences of the service

Rating	Score	Description	Evidence
Underdeveloped	0	No or little activity taking place	The organisation does not engage with patients about their experience of the service. The organisation does not recognise the link between staff and patient treatment. The organisation does not act upon data or monitor progress.
Developing	1	Minimal/basic activities taking place	The organisation collates data from patients with protected characteristics about their experience of the service. The organisations creates actions plans and monitors progress.
Achieving	2	Required level of activity taking place	The organisation collates data from patients with protected characteristics about their experience of the service. The organisation creates evidence-based action plan in collaboration with patients and relevant stakeholders, and monitors progress. The organisation shows understanding of the link between staff and patient treatment and demonstrate improvement in patient experiences.
Excelling	3	Activity exceeds requirements	The organisation engages with patients with protected characteristics and other groups at risk of health inequalities about their experience of the service. The organisation actively works with the VCSE to ensure all patient voices are hears. The organisation creates data driven/evidence-based action plans, and monitors progress. The organisation shows understanding of the link between staff and patient treatment. The organisations use patient experience data to influence the wider system and build interventions in an innovative way.

Appendix 2 – Equality & Diversity Access Data

Equality & Diversity Statistics for Patients Treated

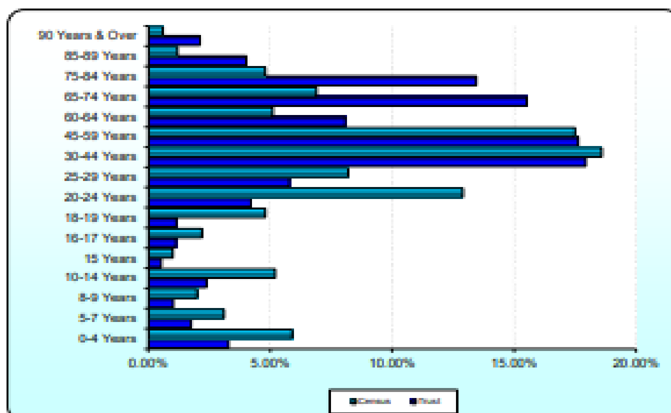
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Patients treated between 01/04/2021 and 31/03/2022

1. Age.

Compares the age of patients seen by the Trust during the period to the age of Newcastle residents as collected in the 2011 census.

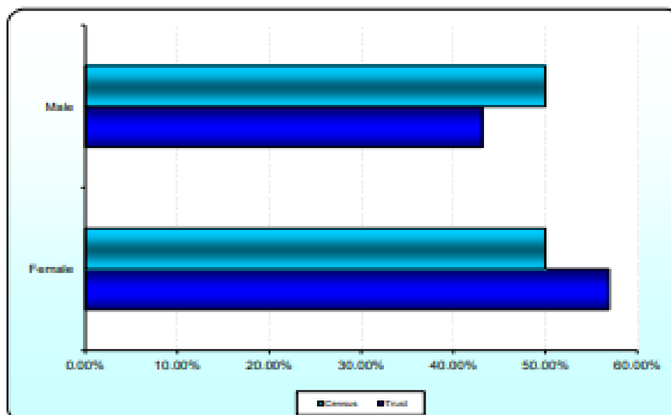
Age Band	Trust	Census
0-4 Years	3.29%	5.90%
5-7 Years	1.75%	3.10%
8-9 Years	1.02%	2.00%
10-14 Years	2.39%	5.20%
15 Years	0.53%	1.00%
16-17 Years	1.13%	2.20%
18-19 Years	1.15%	4.80%
20-24 Years	4.20%	12.90%
25-29 Years	5.78%	8.20%
30-44 Years	17.94%	18.60%
45-59 Years	17.63%	17.50%
60-64 Years	8.08%	5.10%
65-74 Years	15.52%	6.90%
75-84 Years	13.45%	4.80%
85-89 Years	4.02%	1.20%
90 Years & Over	2.12%	0.60%
Total	**100.0%**	**100.0%**



2. Gender

Compares the gender of patients seen by the Trust during the period to the gender of Newcastle residents as collected in the 2011 census.

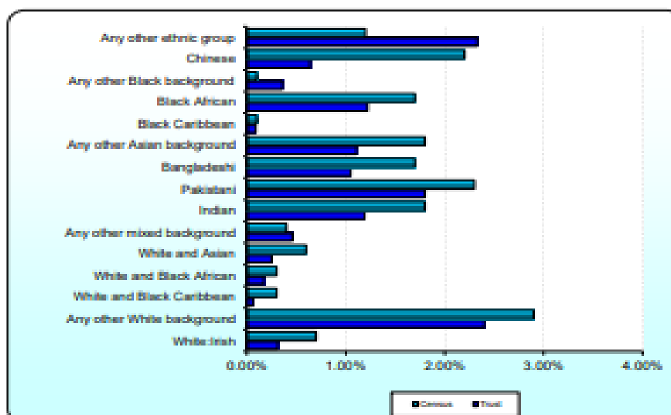
Gender	Trust	Census
Female	56.91%	50.00%
Male	43.09%	50.00%
Total	**100.0%**	**100.0%**



3. Ethnic Origin

Compares the ethnic origin of patients seen by the Trust during the period to the ethnic origin of Newcastle residents as collected in the 2011 census.

Ethnic Group	Trust	Census
White:British	80.01%	81.90%
White:Irish	0.31%	0.70%
Any other White background	2.40%	2.90%
White and Black Caribbean	0.06%	0.30%
White and Black African	0.17%	0.30%
White and Asian	0.25%	0.60%
Any other mixed background	0.46%	0.40%
Indian	1.19%	1.80%
Pakistani	1.80%	2.30%
Bangladeshi	1.05%	1.70%
Any other Asian background	1.11%	1.80%
Black Caribbean	0.09%	0.10%
Black African	1.22%	1.70%
Any other Black background	0.36%	0.10%
Chinese	0.64%	2.20%
Any other ethnic group	2.33%	1.20%
Blank/Not Stated	6.55%	0.00%
Total	**100.0%**	**100.0%**



The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	24 November 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 International Recruitment • Patient Experience Quarter 2 (Q2) 2022 - 2023 • Safeguarding Quarter 2 (Q2) 2022 – 2023 including Newcastle Safeguarding Adults Board Annual Report and • Learning Disability Quarter 2 (Q2) 2022 – 2023						
Recommendation	The Board of Directors is asked to note and discuss the content of this report.						
Links to Strategic Objectives	• Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. • We will be an effective partner, developing and delivering integrated care and playing our part in local, national and international programmes. • Being outstanding, now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☐	☒	☐	☐
Impact detail	Putting patients first and providing care of highest standard.						
Reports previously considered by	The ECN Update is a regular comprehensive report bringing together a range of issues to the Trust Board.						

EXECUTIVE CHIEF NURSE REPORT

EXECUTIVE SUMMARY

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

Section 1: International Recruitment

This month's 'Spotlight' section outlines the work of our International Recruitment (IR) Team. Due to the nursing workforce challenges locally, regionally, and nationally, International Recruitment has, and continues to be an important part of our recruitment strategy to ensure we have enough nurses to provide the highest possible standard of care. We cannot underestimate the courage of our international recruits to leave their homes and families to come and live and work in Newcastle. It is therefore of paramount importance that we ensure they have the best possible experience both inside and outside of work. Our International Recruitment Team, working closely with colleagues in HR recruitment, Finance and colleagues from across the Trust are key in delivering the best experience for our recruits. This spotlight focuses on the work of this team.

Since 2015 the Trust has deployed 308 internationally recruited nurses and two midwives. Of the 310, 127 are nurses and midwives that have been deployed since June 2022 as part of our ambition to deploy 305 nurses and midwives over 2022 and into early 2023.

This report contains many examples of how the team support a positive pastoral experience for our IR recruits - from pre-deployment to full integration into the clinical teams. This includes examples such as:

- Ensure bedding, cutlery, domestic essentials, and fresh provisions have already been purchased and provided in preparation for their arrival.
- The recruits are provided with UK sim cards for phones and offered appointments to set up UK bank accounts
- The team also support a bespoke induction with support from chaplaincy team, our Staff Networks, previous recruits, local police, and other members of the community to support them personally as well as professionally.
- A high quality OSCE preparation programme designed and delivered by the team
- When the nurse or midwife is ready to take their OSCE Test of competence (ToC) they team liaise with test centres, and they accompany all registrants to their test at a number of national OSCE test centres.
- The pastoral offer extends beyond the OSCE ToC and the team regularly provide advice and guidance to wards and departments in relation to the support of nurses in practice

Over the previous months the IR team have had several challenges and successes, and these are outlined within the report. Of note, the team have successfully submitted robust evidence for a nationally acclaimed pastoral award whilst Audrey Tapang, the Senior Nurse

for International Recruitment has successfully been shortlisted for International Nurse of the Year in the Nursing Times Workforce Awards later in November 2022. This is testament to the teams' hard work and dedication.

Section 2: Patient Experience Quarter Two (Q2) Update

The Trust has opened 147 formal complaints in Q2, which is an increase of 26% from the previous quarter. The Trust has received on average 44 formal complaints per month, which is a 4% decrease from the previous year where the average was 46 complaints per month.

Up to the end of September 2022, the highest number of complaints are with the Medicine Directorate with 42 complaints. The lowest number are with the Dental directorate with two complaints.

Of the 147 complaints that opened in this quarter, 28% had a primary concern with regards to communication. This further breaks down into sub-subjects; communication failure with patient is the most common issue (n19), communication with relatives or carers (n8) and access to interpreting services (n3).

The report contains an overview of the CQC National Adult Inpatient Survey 2021. Historically, the Trust performs very well in this survey and this year's results continue to reflect this. Analysis of the benchmarked data confirms the Trust has performed much better, better than most and somewhat better than most Trusts in 12 questions. The Trust did not perform much worse, worse or somewhat worse than most trusts in any questions. The CQC also compare results from the previous year, which demonstrated that the Trust had five areas where scores have slightly declined. The report includes further detail on these areas and actions to address areas for improvement.

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

Finally, the report contains an overview of the Equality Delivery System which is a mandatory improvement tool from NHS England to help NHS organisations, in partnership with local stakeholders, to review and improve their performance for individuals and groups protected by the Equality Act 2010 and to support meeting the Public Sector Equality Duty (PSED).

It is noted that standard 1A has been downgraded to 'developing' based on our internal review. This is due to concerns raised by patients regarding interpreter availability and ensuring access to information in different formats. There is active work on-going to address both issues which is overseen by the Patient Experience and Engagement Group. Further detail of key actions is included in the report and a copy of the full annual report and published equality and diversity access data can be found separately in (Appendix i) in the board reference pack.

Section 3: Safeguarding Quarter Two (Q2) Update

This summary provides a Q2 update of safeguarding activity throughout the Trust and includes references to developments in practice as well as an overview of national practice developments and the Trust's compliance with these recommendations.

Safeguarding activity for Q2 evidences the following key high-level points

- In adult safeguarding it is noted that whilst activity fluctuates, the current trend matches the pattern over the last two years. There was a notable reduction in activity in September which was unexpected. This has been reviewed by the team and the reasons for this are multi-factorial including some issues due to data accuracy which have been reviewed and rectified and is not a reflection of reduced activity.
- In Children's safeguarding, it is noted that the Trust has continued to see an increase in overall activity with almost triple that of 2019/20 (pre-pandemic). The Trust has also seen an increase of 19.6 % in referrals over Q1 and Q2 compared to comparable period over the last three years. The highest categories of referrals being for Neglect, followed by self-harm/overdose, Parental self-harm/overdose, domestic abuse and physical harm. The Trust continues to see younger children coming through our emergency department (ED) with intentional overdose/self-harm, which has been seen across the region and nationally. There is also an increase in gang related crime/incidents of knife crime (including carrying but not using knives).
- In Maternity safeguarding, activity over the first two quarters has shown an average 40% increase compared to the same time last year with 75 CfC (cause for concerns) received in September 2022, the highest number for this period. The predominant categories continue to be previous / current involvement of children's social care, domestic abuse and mental health related issues although individual cases often report more than one category

A workforce review of the Safeguarding, Learning Disability Liaison Team and Mental Capacity Act function was commissioned late in 2021 and the report has subsequently been reviewed and shared with the team. A number of actions have been identified which included the need to increase the infrastructure across the teams. A business case has been agreed and recruitment to the new posts is in progress.

The report also includes an overview of work relating the application of the Mental Capacity Act in practice which remains of high importance across the Trust.

Section 4: Learning Disability Quarter One Update

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

In the last quarter the team have received 683 referrals which is an increase of 60 from Q1 and is a slight increase compared to the same period last year. Whilst activity has only marginally increased, the team continues to employ complex facilitation to ensure the experience for individuals and families is a positive and safe journey through Trust services.

At present the Learning Disability Liaison Team have 22 very complex cases, requiring coordination between multiple services.

The Learning Disability liaison service are working alongside clinicians to improve practice and focus on the importance of understanding urgency and time frames to ensure effective and efficient care co-ordination. There is ongoing work to ensure more efficient pathways for patients referred into the organisation for imaging without an admitting clinician. This piece of work covers child and adult pathways and is near completion following wider circulation and feedback.

RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
24 November 2022

EXECUTIVE CHIEF NURSE REPORT

1. SPOTLIGHT

Due to the nursing workforce challenges locally, regionally and nationally, International Recruitment has, and continues to be an important part of our recruitment strategy to ensure we have enough nurses to provide the highest possible standard of care. We cannot underestimate the courage of our international recruits to leave their homes and families to come and live and work in Newcastle. It is therefore of paramount importance that we as a Trust ensure our recruits the best possible experience both inside and outside of work. Our International Recruitment Team, working closely with colleagues in HR recruitment, Finance and colleagues from across the Trust are key in delivering this experience. This spotlight focuses on the work of this team.

1.1. Background

Since 2015 the Trust has deployed 308 internationally recruited nurses and two midwives. Of the 310, 127 are nurses and midwives that have been deployed since June 2022 as part of our ambition to deploy 305 nurses and midwives over 2022 and into early 2023.

The international nurses that we have recruited have offered high calibre nursing expertise and a breadth of diversity of skills and experience that have complemented the teams that they work in. We are able to successfully deploy and retain international nurses demonstrating the significance to the organisation of international recruitment as a key workforce strategy, but also the importance of the pastoral support offered to nurses to ensure that they can work within the Trust and integrate into the local community.

1.2. The International Recruitment Nursing Team

The International Recruitment team currently comprises of 1.0 whole time equivalent (wte) Senior Nurse for International Recruitment and 3.6wte Clinical Educators. As previously mentioned, this team is supported by colleagues in HR and Finance. All of the international nursing team are themselves international recruits who joined the Trust in previous cohorts, and who have demonstrated passion to support new nurses, and recognise the anxieties that they may face. It has been a privilege to watch this team grow and develop their careers in this way.

On a day to day basis the team are largely responsible for the following:

- Interviewing and recruitment of international registrants.
- Planning the deployment of recruits with support from recruitment agents
- Observed Structured Clinical Examination (OSCE) timetabling and the delivery of OSCE bootcamps for both adult and children’s nursing with support from educators from across the Trust
- Supporting the integration into clinical teams

The pastoral offer starts as soon as the international nurse reaches the UK and the team ensure that they are escorted from their flight to accommodation which has been sourced for the first six months on their behalf. The team ensure bedding, cutlery, domestic essentials and fresh provisions have already been purchased and provided in preparation for their arrival. The recruits are provided with UK sim cards for phones and offered appointments to set up UK bank accounts, uniform fitting and Occupational Health clearance as part of the induction process. The team also support a bespoke induction with support from chaplaincy team, our Staff Networks, previous recruits, local police and other members of the community to support them personally as well as professionally.

When the nurse or midwife is ready to take their OSCE Test of competence (ToC) the team liaise with test centres and they accompany all registrants to their test at a number of national OSCE test centres. The pastoral offer extends beyond the OSCE ToC and the team regularly provide advice and guidance to wards and departments in relation to the support of nurses in practice.

A key focus for the Executive Chief Nurse Team, aligned to our Nursing, Midwifery and AHP (NMAHP) strategy is to ensure a clear career framework is in place for our international recruits to ensure they develop professionally and are represented at all levels in the Trust. The team have recently delivered an international recruitment career and development and event which was well attended by our nurses.

1.3 Current Challenges

There continues to be challenges with the deployment of international recruits which the team continue to manage and escalate on a day by day basis.

Due to accommodation shortages in the city, there have been challenges with sourcing enough accommodation to meet the demand of the recruitment pipeline. The team, supported by the Commercial and Senior Nursing Team, have been working tirelessly to source extra accommodation to deliver on our aspirations and this work remains in progress.

There have also been recent changes to the OSCE requirements with additional examination scenarios introduced at short notice nationally. The team have been extremely responsive in redesigning the education programme and supporting our recruits with any anxieties they may have regarding the test process and ensure they have a good experience in the Trust.

1.4 Good Practice and Successes

Despite these challenges the Team continue to provide an excellent support offer to our recruits which has been recognised regionally and nationally. The team have successfully submitted robust evidence for a nationally acclaimed pastoral award. Audrey Tapang, the Senior Nurse for International Recruitment has successfully been shortlisted for International Nurse of the Year in the Nursing Times Workforce Awards later in November 2022. This is testament to the teams' hard work and dedication.

2. PATIENT EXPERIENCE QUARTER 2 (Q2) REPORT

2.1 Complaints Activity

The Trust has opened 147 formal complaints in quarter 2, which is an increase of 26% from the previous quarter. The Trust has received on average 44 formal complaints per month, which is a 4% decrease from the previous year where the average was 46 complaints per month.

Up to the end of September 2022, the highest number of complaints are with the Medicine Directorate with 42 complaints. The lowest number are with the Dental directorate with two complaints.

Of the 147 complaints that opened in this quarter, 28% had a primary concern with regards to communication. This further breaks down into sub-subjects; communication failure with patient is the most common issue (n19), communication with relatives or carers (n8) and access to interpreting services (n3).

2.2 PALS

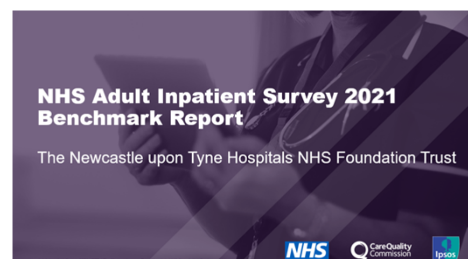
828 issues have been raised with PALS over this period. This compares to 997 in the previous quarter and 977 in the same quarter 2020-21. There continues to be an increase in the number of issues relating to outpatient appointment delays with 8.4% of total issues last quarter compared to 10% of issues raised this quarter. The Directorates with the most enquiries in relation to this theme are Cardiothoracic and EPOD.

2.3 NHS Choices

The Trust received 37 items of feedback with most comments being in relation to the ePOD (n8) and Community (n7). The Trust received the maximum score rating of five stars from 81% (n29) of comments received.

2.4 National Adult Inpatient Survey 2021 – Care Quality Commission (CQC) Benchmark Data

The CQC have published the results of the National Inpatient Survey, which provides benchmarking data for all Trust participating in the survey. The Trust submitted a sample of 1250 patients who met the eligibility criteria and were discharged from hospital during November 2021 with fieldwork taking place between January and May 2022.



The CQC use the results from this survey to build an understanding of the risk and quality of services across 134 acute and specialist NHS trusts.

Historically, the Trust performs very well in this survey and this year's results continue to reflect this. Analysis of the benchmarked data confirms the Trust has performed much

better, better than most and somewhat better than most Trusts in 12 questions. Key themes included that patients reported they received enough help from staff to wash themselves, felt confident in the nurses and doctors caring for them and felt included in discussions about their care. The Trust did not perform much worse, worse or somewhat worse than most trusts in any questions.

The CQC also compare results from the previous year, which demonstrated that the Trust had five areas where scores have slightly declined:

- Were you ever prevented from sleeping at night by noise from other patients?
- How clean was the hospital room or ward that you were in?
- If you brought medication with you to hospital, were you able to take it when you needed to?
- In your opinion, were there enough nurses on duty to care for you in hospital?
- To what extent did staff looking after you involve you in decisions about your care and treatment?

And one area had an improved score:

- Before you left hospital, were you given any information about what you should or should not do after leaving hospital?

These results are presented and scrutinised by the Patient Experience Monitoring Group to identify areas for action. In addition, specific results will be presented to relevant Groups within the Trust for example, results regarding food and nutrition to the Trust Catering Group.

2.5 NHS Friends & Family Test

The latest published FFT data shows that there were 1,481 responses from the Trust in July 2022 (published September 2022). This data remains encouraging in that 98% of people who responded to the inpatient and day case survey and 97% of outpatients would recommend the service to FFT.

Regrettably, the number of responses received for maternity services, community health and A &E walk in centre and minor injury units were too small to publish. The patient experience (PE) team are working closely with the services to encourage participation in the FFT survey.

2.6 Advising on the Patient Experience (APEX)

The APEX group met in this quarter and discussed the following:

- APEX heard about the progress of the plans for a new Children’s Heart Centre, RVI, key elements of the building and what it would look like, how patients and the public have been engaged to date and plans for further engagement. APEX highlighted issues of accessibility such as signposting which needs to be put in place.

- APEX members gave their views on the information given to patients who are required to use Octenisan wash and commented on how they would prefer to receive information and instructions about this type of treatment.
- A specialist dietitian has updated the group on her research project looking at personalised nutrition in non-alcoholic fatty liver disease (NAFLD). APEX had previously suggested that patients could be provided with pre-packaged ready meals which are home delivered to help ensure they were able to adhere to research criteria, which has been successfully implemented.

2.7 Maternity voice Partnerships/Connie Midwife

This quarter has seen the welcome reintroduction of in-person-engagement opportunities for Newcastle Maternity Voices Partnership. This quarter's MVP was hosted by Health Works at the Lemington Centre, the meeting facilitated rich discussion and suggestions from service users surrounding labour and birth experiences.

Forging connections that nurture trusting relationships and meaningful engagement with Black and Minority Ethnic communities has taken central priority this quarter with the commencement of monthly MVP attendance at mother and baby coffee mornings at the Angelou centre and an introductory visit to a women's health group at a local mosque.

The MVP and Connie E-midwife team have continued a close collaborative relationship with the MVP overseeing the annual evaluation of the Connie service. This year's survey saw the greatest number of participants and gathered resoundingly positive feedback. 100% of respondents agreed or strongly agreed that Connie provides relevant and interesting information, questions and queries are well answered and addressed, the service enables greater service user engagement with Maternity Services, and they would recommend Connie's service to family and friends – a fantastic achievement.

2.8 Young Persons Advisory Group Northeast (YPAG NE)

YPAG NE had the pleasure in presenting and raising awareness of their fantastic work at the Great North Children's Research Community (GNCRC) webinar.
The Great North Youth Forum are currently discussing what was important to them and what the focus for the coming year would be. Forum members have chosen to explore exam provisions for young people with long term conditions and will work on creating guidance for engaging young people in staff recruitment for the Great North Children's Hospital.

2.9 Carers Pathway

Identifying and supporting carers and young carers is one of the NHS Long Term Plan commitments. To support the achievement of this commitment, a carer's pathway has been finalised to be piloted in pre-assessment. This pathway will allow staff to ask the appropriate questions to identify carers and young carers and provide them with the necessary resources and signpost them to the appropriate services they can access to support their own health and wellbeing.

2.10 BSL Health Navigator Service

In conjunction with Northumbria Healthcare Foundation Trust and Cumbria, Northumberland Tyne and Wear (CNTW), the Trust has been piloting a BSL Health Navigator Service since April 2021 delivered by Deaflink, a local Deaf charity.

The pilot has come to its mid-point and has already received over 300 referrals. The service has received outstanding feedback from Deaf patients who would otherwise struggle to navigate the hospital systems and understand written letters. We have also been collecting feedback from patients about the hospital services, and one of the key issues identified is supporting staff to have more Deaf awareness. As a result, the three Trusts are working with Deaflink to develop Deaf Awareness e-learning for staff.

2.11 Appointment Attendance from Patients in Deprived Areas

Data analysis on appointment Did Not Attend (DNAs) within radiology has shown that patients from the most deprived areas in Newcastle have a significantly high rate of DNA and this is disproportionately higher than patients from areas that have higher Index of Multiple Deprivation (IMD). Whilst we know some of the barriers patients may face when attending appointments, we need to further understand the main barriers faced by the most deprived. Radiology and the EDI Manager are working together to develop a patient engagement plan to hear directly from these patients of the barriers and issues they face and develop some recommendations.

2.12 Equality Delivery System 2 (EDS2) Patients Annual Report

The Equality Delivery System is a mandatory improvement tool from NHS England to help NHS organisations, in partnership with local stakeholders, to review and improve their performance for individuals and groups protected by the Equality Act 2010 and to support meeting the Public Sector Equality Duty (PSED).

The EDS2 has 11 outcomes grouped into three goals. The three overarching goals are:

- Commissioned or provided services (Patient Services)
- Workforce health and well-being (Workforce)
- Inclusive leadership (Workforce)

The provisional patient services gradings based on the evidence presented have been agreed:

- Outcome 1A – patients (service users) have required levels of access to the service, has been downgraded to ‘Developing’ due to increasing feedback from patients, carers, local charities, the EDHR Group and data showing concerns and issues such as lack of interpreter availability, lack of access to information in different formats and difficulties in being able to contact services. Significant work is already underway to address areas for improvement and progress overseen by the Patient Experience and Engagement Group. Further detail can be found in the annual report in the board reference pack.
- Outcome 1B Individual patients (service users) health needs are met were graded as ‘Achieving’
- Outcome 1C: When patients (service users) use the service, they are free from harm were graded as ‘Achieving’

- Outcome 1D: Patients (service users) report positive experiences of the service were graded as 'Achieving'

The following EDS2 objectives have been approved for 2022/2024:

- Support patients who face language barriers to access health services
- Engage with local communities and underrepresented groups for service developments and improvement work
- Support patients to be involved in their healthcare needs and support shared decision making
- Identify and support carers and young carers, and empower appropriate social prescribing
- Support staff caring for patients and visitors from protected characteristic groups, including disabled, LGBT and religious groups
- Establish a better picture of inequalities in waiting lists
- Reach diverse communities for patient engagement activities

Each of the objectives have a professional lead, work plan, and completion date and will be monitored quarterly via the EDHR meetings. A copy of the full annual report and published equality and diversity access data can be found in the board reference pack.

3. SAFEGUARDING COMMITTEE QUARTER 2 (Q2) REPORT

This summary provides a Q2 update of safeguarding activity throughout the Trust and includes references to developments in practice as well as an overview of national practice developments and the Trust's compliance with these recommendations.

3.1 Activity

Safeguarding activity for Q2 evidences the following key high-level points

- In adult safeguarding it is noted that whilst activity fluctuates, the current trend matches the pattern over the last two years. There was a notable reduction in activity in September which was unexpected. This has been reviewed by the team and the reasons for this are multi-factorial including some issues due to data accuracy which have been reviewed and rectified and is not a reflection of reduced activity.
- In Children's safeguarding, it is noted that the Trust has continued to see an increase in overall activity with almost triple that of 2019/20 (pre-pandemic). The Trust has also seen an increase of 19.6 % in referrals over Q1 and Q2 compared to comparable period over the last three years. The highest categories of referrals being for neglect, followed by self-harm/overdose, parental self-harm/overdose, domestic abuse and physical harm. The Trust continues to see younger children coming through our emergency department (ED) with intentional overdose/self-harm, which has been seen across the region and nationally. There is also an increase in gang related crime/incidents of knife crime (including carrying but not using knives).
- In Maternity safeguarding, activity over the first two quarters has shown an average 40% increase compared to the same time last year with 75 CfC (cause for concerns)

received in September 2022, the highest number for this period. The predominant categories continue to be previous / current involvement of children's social care, domestic abuse and mental health related issues although individual cases often report more than one category

A workforce review of the Safeguarding, Learning Disability Liaison Team and Mental Capacity Act function was commissioned late in 2021 and the report has subsequently been reviewed and shared with the team. A number of actions have been identified which included the need to increase the infra-structure across the teams. A business case has been agreed and recruitment to the new posts in progress.

3.2 Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS)

There has been a growing number of cases where staff have raised concerns around Mental Capacity and Best Interests that require involvement of legal services and Court of Protection. This work may often include an individual who has a learning disability, or/and where there are complex health and social care needs. This work is critical to ensure that there is oversight of the MCA and that we have approached care and support holistically. A number of audits are regularly undertaken in line with policy and we have commissioned responsive audits as required. This work is overseen by the MCA Steering group and there are a number of workstreams in place to ensure all staff understand and have the necessary support to effectively apply the MCA in practice.

An additional post has been agreed to support the Mental Capacity Act lead in the work and recruitment is in progress.

3.3 Safeguarding Adults Week (November 2022)/Newcastle Safeguarding Adults Board Annual Report

The Trust are contributing to work with Newcastle Council for this week of awareness and sharing of practice. The team are specifically contributing to the 'Making Safeguarding Personal Agenda' and highlighting the need to ensure the voice of the individual affected is heard. As a Trust we have also linked with 'Your Voice Counts' who provide Independent Mental Capacity Advocates for the Trust where referrals are made, so we can begin to review activity and assurance of their involvement for relevant cases.

The Trust also continues to be an active partner in the wider Newcastle Safeguarding Adults Board (NSAB) and a copy of the Annual Report can be found in (appendix ii) in the Board Reference Pack.

4. LEARNING DISABILITY QUARTER 2 (Q2) REPORT

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

In the last quarter the team have received 683 referrals which is an increase of 60 from Q1 and is a slight increase compared to the same period last year. Whilst activity has only

marginally increased, the team continues to employ complex facilitation to ensure the experience for individuals and families is a positive and safe journey through Trust services. At present the Learning Disability Liaison Team have 22 very complex cases, requiring coordination between multiple services.

There have been several particular complex cases to support over this Q2 across adults and children's services, many requiring the support and input from Mental Capacity Act lead and Adult Named Nurse Safeguarding.

The team continue to support staff and on occasions work directly with individuals to support reasonable adjustments for the individual whilst supporting the staff involved. The newly established process of "ward walking" continues to evaluate well and is seen as a positive way of working to support staff face to face. The team has successfully recruited an experienced Registered Learning Disability Nurse and have recently received confirmation of additional investment from the recent workforce review.

Awareness has been raised across the organisation regarding the Diamond Standards but no further electronic work regarding training is progressing until the Oliver McGowan training has been fully released in practice.

The Learning Disability liaison service are working alongside clinicians to improve practice and focus on the importance of understanding urgency and time frames to ensure effective and efficient care co-ordination. There is ongoing work to ensure more efficient pathways for patients referred into the organisation for imaging without an admitting clinician. This piece of work covers child and adult pathways and is near completion following wider circulation and feedback.

5. RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
24 November 2022

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

<table>
<tr><td>Date of meeting</td><td colspan="7">24 November 2022</td></tr>
<tr><td>Title</td><td colspan="7">Nursing and Midwifery Staffing</td></tr>
<tr><td>Report of</td><td colspan="7">Maurya Cushlow, Executive Chief Nurse</td></tr>
<tr><td>Prepared by</td><td colspan="7">Ian Joy, Deputy Chief Nurse
Lisa Guthrie, Associate Director of Nursing</td></tr>
<tr><td rowspan="2">Status of Report</td><td colspan="3">Public</td><td colspan="2">Private</td><td colspan="2">Internal</td></tr>
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<tr><td rowspan="2">Purpose of Report</td><td colspan="3">For Decision</td><td colspan="2">For Assurance</td><td colspan="2">For Information</td></tr>
<tr><td colspan="3">☐</td><td colspan="2">☒</td><td colspan="2">☐</td></tr>
<tr><td>Summary</td><td colspan="7">This report comprises of the Nursing and Midwifery Staffing (202/23) six-month review and the quarterly safe staffing assurance report. It fulfils the recommendations of the NHS Improvement ‘Developing Workforce Safeguards’ guidance (October 2018) and adheres to the recommendations set out by the National Quality Board (NQB 2016): How to ensure the right people, with the right skills, are in the right place at the right time. It updates the Board in relation to the following:
• Actions agreed in the 2021/22 Nursing and Midwifery Staffing Annual Review
• Setting evidenced based staffing establishments
• Maternity Safe Staffing update
• In-patient Skill Mix
• Vacancy and turnover data for Nursing and Midwifery
• Red flags and Datix
• Planned and actual staffing fill rates
• Care Hours Per Patient Day (CHPPD) figures
• Three monthly staffing assurance review</td></tr>
<tr><td>Recommendations</td><td colspan="7">The Board of Directors is asked to:
• Receive and review the six-month review from April 2022- October 2022.
• Review and note the progress with the actions from 2021/22 annual review.
• Comment on the content of this approach which has been prepared in line with national guidance.
• Acknowledge and comment on actions outlined within the document.
• Receive and review the quarterly staffing and outcomes review from August, September, October 2022.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="7">• To put patients at the heart of everything we do and providing care of the highest standard focussing on quality and safety.
• Supported by Flourish, our cornerstone programme, we will ensue that each member of staff is able to liberate their potential performance.
• Being outstanding, now and in the future.</td></tr>
<tr><td>Impact</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Reputation</td><td>Sustainability</td></tr>
</table>

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

NURSING AND MIDWIFERY STAFFING SIX MONTH REVIEW

EXECUTIVE SUMMARY

This report combines the Nursing and Midwifery staffing six-month review report with the quarterly safe staffing assurance report. The purpose is to provide assurance that the Trust remains compliant with national guidance in relation to safer staffing

The on-going impacts of the Covid-19 pandemic combined with the current challenges faced across the NHS continues to influence some of the detailed actions and outcomes contained within the report. There is robust professional leadership in place, supported by safer staffing governance frameworks and clear escalation guidance and accompanying actions. It is clear however that the staffing situation remains extremely challenging due to high bed occupancy, increased patient acuity and dependency, balancing emergency and elective capacity and the need to continue to deliver the highest possible standard of care. As such safe staffing escalation in line with our governance processes has remained in place since the last report.

Section 2 of the report highlights progress on agreed actions as outlined in the annual review presented to the Trust Board in May 2022. All actions have been addressed where possible and an update on progress is provided within the report. There is nothing outstanding to escalate from that time period.

Section 3 highlights the outcome of the recent acuity and dependency data capture undertaken across in-patient areas in September 2022. The Trust uses the Safer Nursing Care Tool (SNCT) and the Safer Nursing Care Tool Children and Young People (SNCT C&YP) as the evidence-based establishment-staffing tool. The normal Trust process (aligned to national guidelines) is to triangulate these results with professional judgment and clinical outcomes with Ward Sisters, Charge Nurses and Matrons as part of the nurse staffing review process. These meetings are planned throughout November and December and then the Senior Nursing Team will meet with the Directorate Management Team early in 2023 to understand and areas of risk and agree where investment may be required through the business case process.

Whilst this is in progress, it is important to highlight key themes from a review of the September data capture.

Key points to note:

- Across a significant number of in-patient medical, general surgical and orthopaedic wards, SNCT data has highlighted a consistent increase in the acuity and dependency of patients and that the funded establishment is not sufficient. In most areas this is between 2 to 5wte equating to around one person per shift
- Three wards in Paediatrics are demonstrating a deficit in funded establishment. Due to recent bed closure and temporary service reconfigurations this requires further analysis which is being undertaken by the staffing team

Further analysis and actions will be presented to the Trust Board in May 2023 once the above process has been completed. A review of other key services utilising newly released tools (Emergency Department and Community District Nursing) is in progress.

Section 3.4 includes an update regarding the Midwifery workforce position which continues to be challenging (in line with the national picture). The Trust has seen increasing attrition within the Midwifery workforce throughout 2022. A total of 36 midwives left the organisation within the 12-month period to October 2022, equating to 27.35wte, increasing the 12-month rolling turnover rate to 12.4%, which is broadly in line with the nationally reported rate (NHSEI). 47% of leavers are of retirement age.

New starters expected to join the organisation between November and January will provide an over-recruited position of 6.75wte, 3wte above that recommended by the Birthrate Plus review. The Trust has approved a permanent over-recruitment of 20wte to allow for increased levels of maternity leave and to ensure a consistent, sustainable position within the large Midwifery workforce.

Sickness absence rates have increased throughout the course of 2022 with a combined sickness absence rate currently of 8% benchmarked against a Shelford peer rate of 6.5%. A significant number of absences are attributed to psychological and anxiety related disorders following what has been an extremely challenging 2 years for staff. This is closely monitored by the Directorate and work is in progress to ensure that the retention of staff is improved, with particular focus on measures to increase the support offered with regard to the health and wellbeing. A Specialist Midwife has been appointed to lead on this work.

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

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

From 1 May 2022 to 31 October 2022, there have been eleven occasions recorded where the midwife has been unable to provide continuous one-to-one care and support to a woman in established labour; and two occasions where the delivery suite coordinator has not remained supernumerary and has resulted in the coordinator being the named midwife for a woman.

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

The review of Birth rate plus data has demonstrated that in the months of September and October, the staffing numbers have not met the acuity of patients on more frequent

occasions than the months prior; a total of 74 episodes in September and 93 in October compared to 40 episodes in March and 55 episodes in April. This has led to more prolonged periods of internal escalation to safely manage the service, including on some occasions, the diversion of low-risk women in labour who would have attended the Birthing Centre, to be cared for on the main Delivery Suite. It should be noted that September and October are consistently high activity months for providers of maternity services.

Section 5 of the report provides an overview of Nurse Staffing Metrics (Recruitment, Retention, Red Flags and Datix, Staffing Fill Rates, Care Hours Per Patient Day) between April 2022 and October 2022. The following key points are noted:

- The Trust has completed the NHSE Nursing and Midwifery Retention Self-assessment in September and this has been shared with the Integrated Care Board (ICB) lead. This will facilitate development of high impact actions and inform future work plans.
- The Band 5 RN vacancy rate sits at 5.8%, compared to 6.05% for this period last year. This figure is based on the financial ledger and relates to current substantive staff in post and does not include those staff currently in the recruitment process.
- The total registered nursing turnover rate is 10.88%. which compares favourably with the national median of 13.6%. Whilst a favourable position, this does impact on the departments being able to staff to their full required demand
- Since December 2021, 146 international recruits have been deployed from the Philippines and India. A further 129 candidates have been appointed and are in recruitment pipeline, with further interviews booked. This deployment has been prolonged due to the nationally recognised challenge in gaining suitable rental accommodation.
- Datix submission related to staffing incidents remain on average 25 per month. The majority relating to unfilled shifts, staff sickness and high acuity and dependency of patients.
- Red flags in the SafeCare application continue to be utilised effectively in conjunction with professional judgement. Red Flags are reviewed daily and acted upon/mitigated where possible in real time.
- There has been an increase in the staffing fill rates from April (89%) to September (95%). The reason for this is a reduction in absence and the increased requirement for enhanced care leading to increased Healthcare Assistant (HCA) deployment.
- Fill rates for RN's remain a concern and have decreased on days to an average fill rate of 86% and on night shift to and average fill rate of 89%. This gap however cannot be fully mitigated and impacts on both staff and patient experience
- The Trust average CHPPD for August 2022 is 8.2 which is higher than the peer average of 7.2 and the national average 8.0. These averages are marginally lower than our last report for the Trust and nationally.
- The staffing team continue to monitor CHPPD in SafeCare to enable the mitigation of risks form staffing shortfalls.

This section also contains the quarterly update from the Nurse Staffing and Clinical Outcomes group. The Trust remains in level 2 safe staffing escalation, as has been the case for over a year.

A number of wards have required support at medium or high level since the last report to Board and the detail has been highlighted via the Quality Committee. Action plans are in place 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.

Where beds have been closed due to staffing concerns, twice-weekly review with the Executive Chief Nurse Team remains in place and will continue until all commissioned bed capacity is safely opened.

CONCLUSION AND ACTIONS

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

- Complete the nurse staffing review meetings across the Trust and sign off 2023/24 staffing requirements in quarter 4
- Complete the review of the Emergency Department in November using the new acuity and dependency tool and provide data analysis in the May 2023 report.
- Complete staff training in the new Community Nursing Services Safer Staffing Tool and undertake the first data capture
- Continue to provide scrutiny and oversight regarding the re-deployment of staff to respond to continued service pressures based on the level of staffing escalation

RECOMMENDATIONS

The Board of Directors are asked to:

i) Receive and review the mid-year six monthly staffing review update
ii) Review and note the progress with the actions from annual review.
iii) Comment on the content of this approach which has been prepared in line with national guidance.
iv) Acknowledge and comment on actions outlined within the document.
v) Receive and review the quarterly staffing and outcomes review from August, September and October 2022.

Report of Maurya Cushlow
Executive Chief Nurse
24 November 2022

NURSING AND MIDWIFERY STAFFING REVIEW REPORT
SIX MONTHLY REVIEW

1. INTRODUCTION/BACKGROUND

This report combines the Nursing and Midwifery staffing six-month review report with the quarterly safe staffing assurance report. The purpose is to provide assurance that the Trust remains compliant with national guidance in relation to safer staffing. The Developing Workforce Safeguards (2018) guidance clearly communicates the requirement to undertake an in-depth nursing and midwifery staffing review annually with a review and update on actions highlighted to the Board at six months.

The on-going impacts of the Covid-19 pandemic combined with the current challenges faced across the NHS continues to influence some of the detailed actions and outcomes contained within this report. There is robust professional leadership in place, supported by safer staffing governance frameworks and clear escalation guidance and accompanying actions. It is clear however that the staffing situation remains extremely challenging due to high bed occupancy, increased patient acuity and dependency, balancing emergency and elective capacity and the need to continue to deliver the highest possible standard of care. As such safe staffing escalation in line with our governance processes has remained in place since the last report.

2. 2021/22 NURSING AND MIDWIFERY STAFFING REVIEW UPDATE

2.1 Progress since 2021/2022 Annual review

A comprehensive and thorough staffing review was presented to the Trust Board in May 2022. A number of actions were proposed and an update on relevant actions is provided below:

- **Undertake a review of the Emergency Department in September 2022 using the new acuity and dependency tool** – update can be found in section 3.3

- **Undertake a review of Community services once the Community Nursing Services Safer Staffing Tool (CNSSST) is released and training is completed –** update can be found in section 3.4

- **Continue to provide scrutiny and oversight regarding the re-deployment of staff to respond to continued service pressures** – update can be found in section 5.5

- **Continue with the recruitment of Internationally Educated nurses at pace** - update can be found in section 5.6

3. SETTING EVIDENCED BASE ESTABLISHMENTS (April 2022 - October 2022)

3.1 Adult and Paediatrics

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

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

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

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

3.1.2 Outcome of the data review

In line with national guidance a minimum 21 day data SNCT capture was undertaken across all in-patient areas (adult and paediatrics) in September 2022. The normal Trust process (aligned to national guidelines) is to triangulate these results with professional judgment and clinical outcomes with Ward Sisters, Charge Nurses and Matrons as part of the nurse staffing review process. These meetings are planned throughout November and December and then the Senior Nursing Team will meet with the Directorate Management Team early in 2023 to understand and areas of risk and agree where investment may be required through the business case process.

Whilst this is in progress, it is important to highlight key themes from a review of the September 2022 data capture. It is also important to note that any analysis is based on the funded establishment and not the current staff in post. Therefore, any ward budget which is fit for purpose may not be represented in practice due to staffing gaps and any ward requiring additional workforce may represent staff currently operating at a significant deficit.

Key points to note:

- With the investment previously agreed in Cancer Services, these wards remain broadly fit for purpose

- Cardiothoracic Surgery, Neurosurgery, Gynaecology, ENT, Plastics and Ophthalmology all remain broadly fit for purpose and aligned to SNCT recommendations
- Across a significant number of in-patient medical, general surgical and orthopaedic wards, SNCT data has highlighted a consistent increase in the acuity and dependency of patients and that the funded establishment is not sufficient. In most areas this is between 2 to 5wte equating to around one person per shift
- Three wards in Paediatrics are demonstrating a deficit in funded establishment. Due to recent bed closure and temporary service reconfigurations this requires further analysis which is being undertaken by the staffing team

Further analysis and actions will be presented to the Trust Board in May 2023 once the above process has been completed.

3.2 Emergency Department

In 2022 substantial investment was agreed to increase the number of nursing staff in the adult emergency services, particularly at Band 5 RN. In lieu of a nationally endorsed acuity and dependency tool for Emergency Departments (ED), this was based on professional judgment. These posts have been actively recruited to.

Subsequent to this, the national team have released the ED Safer Nursing Care Tool to support accurate establishment setting. Training of the staff in the new tool has been completed and the first data capture is being undertaken in November 2022. This data will be ready for analysis for the nurse staffing review process at the start of 2023

Attendances in ED remain at unprecedented levels and the November data will capture the impact of this on staffing levels to help review the impact of the new investment and future workforce requirements. An update will be provided in the full year review in May 2023.

3.3 Community District Nursing Services

The new national acuity and dependency tool for community district nursing services was launched this summer and is in the process of being rolled out regionally. Trust staff are in the process of attending training in the tool. Due to the number of staff requiring training to employ the tool the first data collection will take place in 2023.

3.4 Maternity Review

As reported to the Trust Board in previous papers, Maternity Services in England are under intense and increasing scrutiny due the findings of various governing bodies, and specifically the public inquiries of Donna Ockenden (2022), together with the recently published report of Dr Bill Kirkup (October 2022) on the findings of the East Kent inquiry.

Workforce is a core feature of the final Ockenden report and members of the Trust Board will recall that the final publication advises that organisations must now consider an immediate and essential action in ensuring safe midwifery staffing plans are in place, particularly in relation to any further rollout associated with a model of Continuity of Carer.

Staff were consulted on proposals for Continuity of Carer through a formal organisational change process, which concluded in August 2022. Following this, a further staffing review was undertaken to inform the Trust's position in relation to further rollout and based on this review, a revised recommendation was presented to the Trust Board in September. It is imperative that workforce remains a focus in relation to the overall quality and safety of the maternity service, and a further review will be undertaken in Spring 2023 with regard to the next steps in relation to progressing Continuity of Carer.

In line with the national picture, the Trust has seen increasing attrition within the Midwifery workforce throughout 2022; there are a number of reasons attributed to this and the position has been closely monitored by the Directorate. A total of 36 midwives left the organisation within the 12-month period to October 2022, equating to 27.35wte, seeing an increased 12 month rolling turnover rate of 12.4%, which is broadly in line with the nationally reported rate (NHSEI). 22 of those leaving have been since May 2022. Of note is that the 47% of leavers are of retirement age.

Table 1 illustrates the current position with regard to Midwifery staffing, including frontline clinical staff, and those in specialist and management positions. New starters expected to join the organisation November-January will provide an over-recruited position of 6.75wte, 3wte above that recommended by the Birthrate Plus review. The Trust has approved a permanent over-recruitment of 20wte to allow for increased levels of maternity leave and to ensure a consistent, sustainable position within the large Midwifery workforce.

Table 1

Funded Establishment	**Actual Establishment as at 31.10.22**	**New Starters November-January**	**Birthrate Plus Recommendation**
250.20wte (+ 20wte allowance to over-recruit)	245.15wte -5.05wte (2.0%)	11.8wte +6.75 over establishment (2.69%)	254wte
Sickness Absence (long term)	**Sickness Absence (short term)**	**Sickness Absence (total)**	**Maternity Leave**
7.0wte 2.8%	13.1wte 5.2%	20.1wte 8.0%	10.31wte 4.1%

Sickness absence rates have increased throughout the course of 2022 with a combined sickness absence rate currently of 8%, benchmarked against a Shelford peer rate of 6.5%; a significant number of absences are attributed to psychological and anxiety related disorders following what has been an extremely challenging 2 years for staff. This is closely monitored

by the Directorate and work is in progress to ensure that the retention of staff is improved, with particular focus on measures to increase the support offered with regard to the health and wellbeing. A national offer of support has been accessed and engagement work has commenced in collaboration with NHSEI in supporting the health and wellbeing of all staff within the Maternity Service.

The Trust have been successful in receiving financial support to recruit 5 midwives through NHS England's International Recruitment (IR) initiative. To date 1 midwife has commenced in post, 1 has withdrawn in favour of another provider, and 2 who will be in post on completion of successful OSCE. The Trust has received an offer of national 'go-further' funding and have declared interest in recruiting to a maximum of 8wte international midwives to support workforce expansion plans into the future.

The challenge for Newcastle, like many providers of maternity services, is that 26% of Midwives are aged 50 and above, a proportion of whom will be at retirement age in the not too distant future. A growing concern is that the number of newly registered midwives will not meet the demand going forward despite an increase in undergraduate programmes by HEIs. Newcastle is exploring alternative workforce strategies to meet with anticipated further attrition throughout the coming months and years.

There are currently increased levels of midwifery vacancy across the region. A strategy has been implemented to ensure that the newly appointed midwives retain interest in working at Newcastle through planned regular engagement events, promoting positive working relationships prior to commencing employment; this work is being led by the Lead Midwife for Pastoral Support and Retention. Further updates on retention will be provided in future papers.

Support staff are a crucial and valuable element in maximising the workforce, and an important part of the workforce review is optimising skill-mix and further developing our non-registered workforce with education and training offers aligned to the national framework. MSW training plans are currently in development and are due to be submitted to the NENC LMNS in December 2022. An update will be provided in future papers.

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

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

From 1 May 2022 to 31 October 2022, there has been eleven occasions recorded where the midwife has been unable to provide continuous one-to-one care and support to a woman in established labour; and two occasions where the delivery suite coordinator has not remained supernumerary and has resulted in the coordinator being the named midwife for a woman.

On the occasions described above, this was escalated to the senior team and managed through internal redeployment within the service. Where red flags and shortfalls against plan were noted, a review of the acuity and activity has been undertaken. Together with

professional judgement, the most appropriate utilisation of the available workforce resource has been made, thereby preserving, and maintaining safety.

The review of Birth rate plus data has demonstrated that in the months of September and October, the staffing numbers have not met the acuity of patients on more frequent occasions than the months prior; a total of 74 episodes in September and 93 in October compared to 40 episodes in March and 55 episodes in April. This has led to more prolonged periods of internal escalation to safely manage the service, including on some occasions, the diversion of low-risk women in labour who would have attended the Birthing Centre, to be cared for on the main Delivery Suite.

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

Of note is the increased demand in core competency training for all members of the multi-disciplinary team and this will impact further on the available resource for both registered and non-registered staff to meet with the mandated requirements. A recommendation from Ockenden is that the uplift for staff working within Maternity Services is reviewed in line with the additional training requirements. The Directorate is currently undertaking a comprehensive review of the Training Needs Analysis, to further inform the Trust's position in relation to uplift; the finding of this review will be presented to the Trust Board in January 2023.

4. IN-PATIENT SKILL MIX

Skill mix requirements form part of the triangulation of data as recommended by the Developing Workforce Safeguards (2018) guidance gathered from the evidence-based tools used for establishment setting and professional judgement. Skill mix reviews are conducted as part of the annual nurse staffing reviews or if a ward has altered from their primary function.

***Key points to note**:*

All skill mix changes requested to demand templates are subjected to a quality impact assessment and costed by the directorate finance team. The updated demand template and subsequent costings are then shared with the Matron and Senior Sister prior to changes being altered to the demand template or business case submission.

No significant skill mix changes have been undertaken since the previous review

5. NURSE STAFFING METRICS

5.1 Vacancy and Turnover Data

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

- Significant work continues via the Nursing and Midwifery Recruitment and Retention Group with a focus on improving the vacancy and turnover position with an agreed work plan in line with NHS retention guidance. A careers open day was held in October 2022 with Nursing, Midwifery and Operating Department Practitioner representation.
- The Trust has completed the NHSE Nursing and Midwifery Retention Self-assessment in September and this has been shared with the Integrated Care Board (ICB) lead. This will facilitate development of high impact actions and inform future work plans.
- Monthly generic recruitment for Band 5 RN continues with bespoke recruitment agreed as required. The Band 5 RN vacancy rate sits at 5.8%, compared to 6.05% for this period last year. This figure is based on the financial ledger and relates to current substantive staff in post and does not include those staff currently in the recruitment process.
- The total registered nursing turnover rate is 10.88%. which compares favourably with the national median of 13.6%. Whilst a favourable position, this does impact on the departments being able to staff to their full required demand. A recruitment and retention masterclass/consultation was led by the Associate Director of Nursing (Workforce) and HR colleagues in November with Matrons to review current recruitment processes for RN and Healthcare Support Workers (HCSW/Maternity Support Workers (MSW) and recruitment and retention workstreams consulted upon. priority will be given to internal transfer for staff to ensure flexible working options and career development.
- Since December 2021, 146 international recruits have been deployed from the Philippines and India. A further 129 candidates have been appointed and are in recruitment pipeline, with further interviews booked. This deployment has been prolonged due to the nationally recognised challenge in gaining suitable rental accommodation. Significant work is undertaken by the International Recruitment Team, HR and Business colleagues to ensure the quality of experience for new nurses is not compromised.
- There has been continued focus on recruitment of HCSWs. It remains challenging to achieve a sustained operationally zero vacancy position. However, with pro-active recruitment campaigns the Trust has approximately 140 wte staff in pipeline. With widening participation workstreams being prioritised.

5.2 Red Flags and Datix *(April 22-October 22)*

Red flag and Datix incident data are reviewed daily by the Senior Nursing Team and reported as part of the daily staffing briefing. Red flags also continue to be presented to the Nurse Staffing and Clinical Outcomes Group monthly to observe trends and highlight areas of concern. This data is available at a Ward, Directorate and Trust level. Frequency and themes inform responsive and planned nurse staffing reviews and inform future establishment requirement.

Key points from the last 6 months:

- Datix submission related to staffing incidents remain on average 25 per month. The majority relating to unfilled shifts, staff sickness and high acuity and dependency of patients.
- Red flags in the SafeCare application continue to be utilised effectively in conjunction with professional judgement. Red Flags are reviewed daily and acted upon/mitigated where possible in real time.
- Datix in the near future will become integrated with SafeCare to improve data quality and safe staffing. The senior nursing team, Datix team and ERA team are working with Allocate to ensure data quality and accuracy.

5.3 Planned and Actual Staffing *(April 22 - October 22)*

Planned staffing is the amount (in hours and minutes) of RN, Midwives, and HCA staff time that each ward plans to have on duty each day. This is based on maximum utilisation of their funded establishment. Actual staffing is the amount of staff time (in hours) actually on duty each day. These are broken down by day and night shift.

The senior nurse, nursing and midwifery staffing reviews the ward fill rates monthly and presents the wards of concern to the Nurse Staffing and Clinical Outcomes group. Data from these wards is triangulated with other staffing metrics.

Key points to note:

- There has been an increase in the staffing fill rates from April (89%) to September (95%). The reason for this is a reduction in absence and the increased requirement for enhanced care leading to increased Healthcare Assistant (HCA) deployment.
- The fill rates remain a concern particularly relating to RN fill rates. RN fill rates have decreased on days to an average fill rate of 86% and on night shift to and average fill rate of 89%. This is reviewed regularly with some temporary bed closures employed to mitigate the risk, which are reviewed on a weekly basis. This gap however cannot be fully mitigated and impacts on both staff and patient experience
- In September, 27 wards reported a fill rate of less than 85% which is a decrease of 3 from the previous year. This is closely monitored by the senior nursing team.
- The senior nursing team and ERA team are working with the matrons in surgery and two pilot wards in surgery to download the nursing fill rate data from SafeCare. It is envisaged this will provide improved data collection for the fill rates.

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

Care hours per patient day (CHPPD) is the unit of measurement recommended in the Carter Report (2016) to record and report deployment of staff working on inpatient wards. As stated previously, this is to become the primary benchmarking metric from September 2019. It is made up of Registered Nurses and support worker hours. All acute Trusts have been required to report their actual monthly CHPPD, based on the midnight census per ward to NHS Improvement since May 2016. It is calculated using the formula below.

Key points to note:

- The Trust average CHPPD for August 2022 is 8.2 which is higher than the peer average of 7.2 and the national average 8.0. These averages are marginally lower than our last report for the Trust and nationally.
- The staffing team continue to monitor CHPPD in SafeCare to enable the mitigation of risks form staffing shortfalls.
- Due to Covid-19, wards across the country have changed their primary function and reduced bed capacity. This has altered the accuracy of ward level and speciality level benchmarking via Model Hospital. We broadly remain aligned with no areas of concern with all metrics reviewed as part of the nurse staffing review process.
- Specialist areas continue the re-occurring theme of demonstrate the greatest variance against the national average. This trend is well understood locally and nationally.

5.5 August 2022 to October 2022 Nurse Staffing and Clinical Outcomes Review

5.5.1 Staffing Escalation

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

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

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

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

The following actions remain in place:

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

- Daily review of staffing red flags and incident reports.

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

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

5.5.2 Nurse Staffing and Clinical Outcomes

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

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

Month	No. of Wards Reviewed	Directorate	Monitor	Low Level Support	Medium Level Support	High Level Support	No Further Support
August	9	x2 MSK x3 Internal Medicine x 2 Cardiothoracic Services x2 Urology and Renal Services	5	1	6	2	0
September	20	X2 Musculoskeletal Services X8 Internal Medicine X3 Cardiothoracic Services X4 Children's Services X2 Urology and Renal Services X1 Peri – Op and Critical Care	6	8	5	1	0
October	12	X7 Internal Medicine X 2 Cardiothoracic Services X 2 Urology and Renal Services X1 Children's Services	4	3	3	2	0

Key points to note:

- A number of wards have required support at medium or high level since the last report to Board and have been highlighted via the Quality Committee. Action plans are in place 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.

- Where beds have been closed due to staffing concerns, twice-weekly review with the Executive Chief Nurse Team remains in place and will continue until all commissioned bed capacity is safely opened.
- Despite the high-level monitoring, oversight and assurance provided by the group there continues to be a robust leadership and management framework led by the Matron team who manage the wards staffing. However, it is worth noting that the staffing picture remains challenging with the potential to impact staff wellbeing.

6. CONCLUSIONS AND ACTIONS

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

- In line with national guidance, the SNCT data capture has been completed. These results need to be triangulated with professional judgment. From initial data review, there is an increasing patient acuity and dependency across a number of areas which may necessitate additional investment
- Maternity workforce transformation and safer staffing management remains a high priority as outlined in this report and the Ockenden update report.
- New acuity and dependency tools have been recently released for the Emergency Department and Community District Nursing and training and implementation is in progress
- The continued responsive movement of staff to respond to the pandemic and high patient volumes has been overseen by the Senior Nursing Team and is based on existing evidence-based tools and assurance processes.
- Safer staffing management continues to be extremely challenging due to existing vacancies, sickness absence levels and increased patient acuity and dependency. This has impacted on Trust level fill rates and CHPPD figures and is impacting on patient care and staff wellbeing

The following actions are proposed:

- Complete the nurse staffing review meetings across the Trust and sign off 2023/24 staffing requirements in quarter 4
- Complete the review of the Emergency Department in November using the new acuity and dependency tool and provide data analysis in the May 2023 report.
- Complete staff training in the new Community Nursing Services Safer Staffing Tool and undertake the first data capture
- Continue to provide scrutiny and oversight regarding the re-deployment of staff to respond to continued service pressures based on the level of staffing escalation.

7. RISK AND MITIGATION

This report describes the mandated nursing and midwifery staffing review process which has been undertaken in accordance with national guidance. It highlights the ongoing challenges the pandemic has presented in providing safer staffing across our services. The most recent SNCT data capture has highlighted and increase in the acuity and dependency

across some core services and this is being triangulated with professional judgment. It is likely that further investment will be required in some areas. In the interim, the risk is mitigated through additional bank staff/overtime/additional hours requests based on patient acuity and dependency.

There are some highlighted areas which require further work to improve assurance and actions are outlined to address this. There will be challenges and risk in the year ahead in balancing patient demand and capacity, workforce availability and the need to deliver high quality patient care. This is in part mitigated by the robust governance processes already in place but will require pro-active workforce planning and strong working relationships internally and externally to deliver this effectively.

It is evident from the nurse staffing metrics that there is a continued risk to the Trust due to the local and national shortage in the registered and support workforce, which is being closely monitored with proactive recruitment plans in place. It is therefore necessary to continue to explore mechanisms to maximise external recruitment, alongside retention strategies to reduce the total vacancy rate. International recruitment remains a key part of the overall workforce plan and continues at pace.

8. RECOMMENDATIONS

The Board of Directors are asked to:

i) Receive and review the mid-year six monthly staffing review update
ii) Review and note the progress with the actions from annual review.
iii) Comment on the content of this approach which has been prepared in line with national guidance.
iv) Acknowledge and comment on actions outlined within the document.
v) Receive and review the quarterly staffing and outcomes review from August, September and October 2022.

Report of Maurya Cushlow
Executive Chief Nurse
24 November 2022

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newcastle safeguarding adults board

CONTENTS

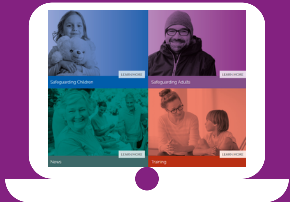
Introductions from our Chair and Cabinet Member	Pages 3-4
Who we are and what we do	Page 5
Looking ahead to 2022-23	Page 6
What our local data tells us	Pages 8-9
Update from our sub-committees	Pages 11 - 18
Partner agency perspectives	Pages 21 - 28
Board members 2021-22	Page 29

Spotlights on safeguarding adults and...

Financial abuse	Page 7
Homelessness	Page 10
Care Homes	Page 20

For more information on safeguarding adults in Newcastle visit our website:

www.newcastlesafeguarding.org.uk



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@newcastle_sab

No excuse for adult abuse, report it:
0191 278 8377 or report online

INTRODUCTIONS

Once again, I am privileged to introduce the Newcastle Safeguarding Adults Board's (NSAB) Annual Report for 2021-22.

In writing a similar introduction 12 months ago, it was hard to envisage that Covid-19 would continue to impact on the work of the NSAB, both directly and indirectly. However, the challenges of the pandemic have not deterred the commitment, determination and ongoing contributions of partner organisations to the safeguarding of adults at risk in Newcastle. All agencies are "learning to live" with the virus and its implications and have embedded both new ways of working and good practice shared over the Pandemic period.

A significant area of Board focus in 2021-22 has been responding to the continued increase in safeguarding adults activity and closely monitoring the impact that this has had on the multi-agency safeguarding system. Board members are rightly concerned about the volume of safeguarding adults referrals that are being reported. All agencies continue to ensure that these referrals are being referred via the right pathways and that there are sufficient resources to meet demand . I pay tribute to the front-line staff who are responding effectively and resiliently. The NSAB will continue to carefully scrutinise the position into next year and take any further actions required. **Find out more about local data on pages 8-9.**

In the last year the NSAB finalised a Safeguarding Adults Review (SAR) about Adult L. The death of an adult linked to abuse or neglect is always a tragedy, however the SAR gives agencies an opportunity to learn. The published report highlights both strengths in practice and areas where developments and improvements can be made. The NSAB is robustly monitoring an action plan which responds to the recommendations from the SAR and a lot of progress has already been made. **Find out more about the Adult L SAR on page 11.**

The Board has four sub committees who are critical in helping deliver the key objectives in the NSAB's Strategic Annual Plan. They have continued to make significant progress which includes:

- The Improving Practice Committee producing guidance around financial abuse and work on responding to poverty.
- The Learning and Development Committee managing a successful transition to a new e-learning provider.
- The Missing, Slavery, Exploited Trafficked (MSET) Sub-Committee assisting in the development of resources and training around criminal exploitation.
- The Safeguarding Adults Review Committee co-ordinating a number of reviews which will enable further learning and improvement.

I am most grateful to the members of the sub-committees who dedicate their time, experience and enthusiasm, often in addition to their day-to-day roles. **Find out more about the work of our sub-committees on pages 11-18.**

The Board's Strategic Annual Plan for 2022-23 details what the NSAB aims to achieve in the coming year. Work will include updating multi-agency policy and procedures, an integral part of ensuring agencies work together to safeguard adults with care and support needs. Further clarifications around the introduction of the Liberty Protection Safeguards are eagerly awaited, this new national guidance will impact on several member agencies. The NSAB see these new safeguards as a lever for enhancing Mental Capacity Act practice more generally, all too often highlighted as an area of learning in SARs. The Board will continue to have a focus on Making Safeguarding Personal (MSP), ensuring that adults at risk are at the centre of all safeguarding adults enquiries.

An area of focus in Newcastle (and regionally) will be self-neglect – considering the findings of a local thematic review in this area, updating local practice guidance and working with North East colleagues to raise awareness of self-neglect and what can be done to help those at risk. The NSAB has a busy year ahead and remains ambitious in delivering on key priorities. **Find out more about our plans for 2022-23 on page 6**.

I would like to reiterate my thanks to all those who continue to make safeguarding adults happen in Newcastle – senior leaders, the NSAB and sub group members, front-line practitioners and volunteers – each and every one of you continue to prioritise safeguarding adults in your work. Your desire to ensure the safety and wellbeing of adults with care and support needs in Newcastle remains apparent.

I commend this Annual Report to you and encourage you to share it within your organisations and networks.
Vida Morris
NSAB Independent Chair

As Cabinet Member for a Healthy, Caring City, it is my ambition that Newcastle residents are supported to live healthy, safe, independent lives. The Newcastle Safeguarding Adults Board's annual report documents the work done by the partnership, and it's member agencies, in support of this priority.

The lifting of Covid-19 restrictions did not result in a reduction in safeguarding adults activity in the City. It is reassuring to see that the NSAB is closely monitoring this position and it's impact on the safeguarding adults system.

I continue to take a keen interest in the link between poverty and adult safeguarding. I see this continuing to be an area of importance for the Board in the coming year given the anticipated cost-of-living crisis and continued impact of government austerity cuts and welfare reforms. Poverty is more effectively mitigated by coordinated partnership responses; the NSAB is well placed to ensure there is a shared understanding of the complex challenges that residents face and help bridge the gap between financial advice, support, care, health and safeguarding.

I would like to finish by offering my deepest thanks to all those who continue to work determinedly and compassionately to keep the residents of Newcastle safe from abuse and neglect.
Councillor Karen Kilgour
Deputy Leader, Newcastle City Council and Cabinet Member for Healthy, Caring City

WHO WE ARE AND WHAT WE DO

The Newcastle Safeguarding Adults Board (NSAB) is the statutory multi-agency partnership responsible for safeguarding adults from abuse and neglect. There are a number of agencies represented on the Board, including the Council, Health Services and the Police (see page 29 for membership).

OUR VISION

"To ensure Newcastle is a safer city for adults at risk of abuse and neglect"

OUR PURPOSE

To help and protect adults with care and support needs.

Empowerment
Proportionality
Protection

Partnership
Prevention
Accountability

To do this we have to make sure that:

Local safeguarding arrangements are in place.

Our safeguarding practice is person-centred and outcome focussed.

We work together to prevent abuse and neglect.

We give timely and proportionate responses.

We continuously learn and improve our practice.

The NSAB is supported by a number of sub committees, one of which is jointly overseen by the Newcastle Safeguarding Children Partnership (NSCP). The NSAB also works closely with Safe Newcastle (the Community Safety Partnership) and the Youth Justice Partnership Board.

STRATEGIC ANNUAL PLAN

The Care Act 2014 requires all Safeguarding Adults Board's to produce an annual plan that details how we will meet our objectives and how our member and partner agencies will contribute.

The achievements against our plan for 2021-22 are detailed in this annual report. Looking forward to our 2022-23 plan, we have used a variety of information sources to ensure our priorities reflect the needs related to safeguarding adults at risk. This has included using our local data, learning from cases and audit, results of agency self-assessments, and responding to national policy, guidance or legislation.

Delivery on some of our priorities for 2021-22 were impacted upon by Covid-19; where this was the case, actions have been carried forward into our 2022-23 plans.

ACTION AREAS FOR 2022-23

- **Audit referrals to ensure Making Safeguarding Personal information is being included.**
- **Develop training and resources around domestic abuse and older people.**
- **Consider the local implications of ADASS/LGA Briefing on Carers and Safeguarding.**
- **Use creative methods of sharing key messages and resources with practitioners.**
- **Undertake a thematic review around self-neglect and update guidance and training in this area.**
- **Further understand MCA practice in Newcastle; share good practice and address any challenges highlighted.**
- **Maintain an overview of the implementation of Liberty Protection Safeguards (LPS).**
- **Work with Public Health to improve safeguarding adults responses to adults who use alcohol and drugs problematically.**
- **Understand and address the increased and sustained demand within the safeguarding adults system.**
- **Finalise the update of multi-agency NSAB policy and procedures.**
- **Addressing learning from Safeguarding Adults Reviews and any other relevant review processes e.g. Domestic Homicide Reviews.**

FINANCIAL ABUSE

Financial abuse can be wide-ranging and complex. It can be difficult to identify and knowing where to go for help might be confusing for both the person at risk and those supporting them. Financial abuse accounts for a significant amount of the safeguarding adults enquiries undertaken in Newcastle. Financial abuse can have a serious impact upon a person, not only on their money or property but also on their overall wellbeing, physical and mental health.

With this in mind, the Improving Practice Committee set up a multi-agency group of practitioners to explore the issue further and produce guidance on **identifying, preventing and responding to financial abuse**. The guidance was launched in November 2021 as part of Safeguarding Adults Week.

The group also produced a **poster** and a **short film** which highlighted the key points from the guidance.

KEY POINTS IN THE FINANCIAL ABUSE GUIDANCE

- Financial abuse includes having money, property, benefits or possessions stolen or misused; being defrauded or scammed.
- There are many different signs and indicators, and lots of professionals will have the opportunity to identify it, not just those working with people's finances.
- Being aware of some of the risk factors can assist practitioners in taking proactive steps to prevent financial abuse occurring.
- Finances can be a sensitive and private topic but practitioners should try to talk to the person about concerns and what they want to happen next.
- We should be empowering and enabling people to use and manage their own finances and property safely. There are services and support available. The guidance includes a service directory of local and national services and support.
- Responding to financial abuse might involve taking immediate action to keep someone or their finances safe.
- Safeguarding adults procedures can be used where the person who is experiencing or at risk of financial abuse is an adult at risk.

OUR LOCAL SAFEGUARDING ADULTS DATA

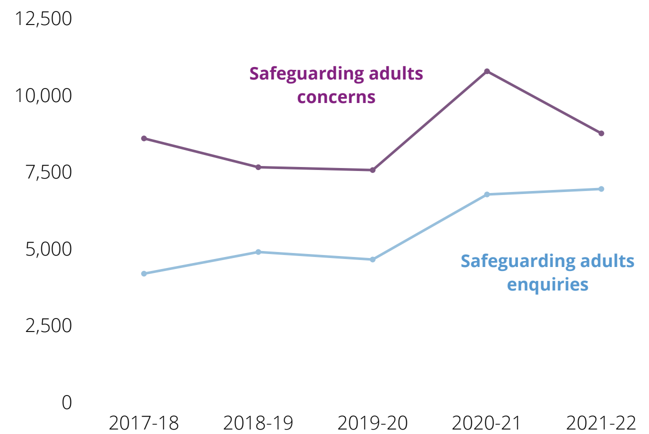
The publication of national guidance around what constitutes a safeguarding adults concern and enquiry has led to what appears to be a reduction in safeguarding adults concerns. However, the NSAB continues to monitor the overall volume of initial safeguarding adults referrals made, which in 2021-22 was 14,861 (a 38% increase on the previous year).

Whilst the interpretation of some key measures has changed, overall activity required to respond to referrals remains the same. Addressing this increased and sustained activity within the safeguarding adults system is an important focus for the Board, particularly as a significant proportion of referrals do not meet the criteria for action under safeguarding adults procedures.

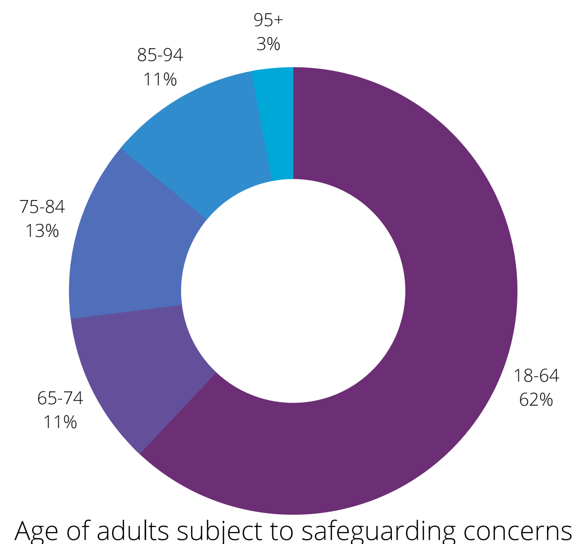
Whilst the highest number of safeguarding adults concerns were about people aged 18-64, when this data is compared to population totals for each age group, the prevalence of abuse/neglect increases the older a person is. The breakdown of age groups remains largely unchanged from the position reported in 20/21.

There was a high proportion of safeguarding adults concerns relating to adults whose Primary Support Reason (PSR) was unknown. This is felt to reflect the high number of concerns being referred about adults who do not have care and support needs or who were not known to Adult Social Care.

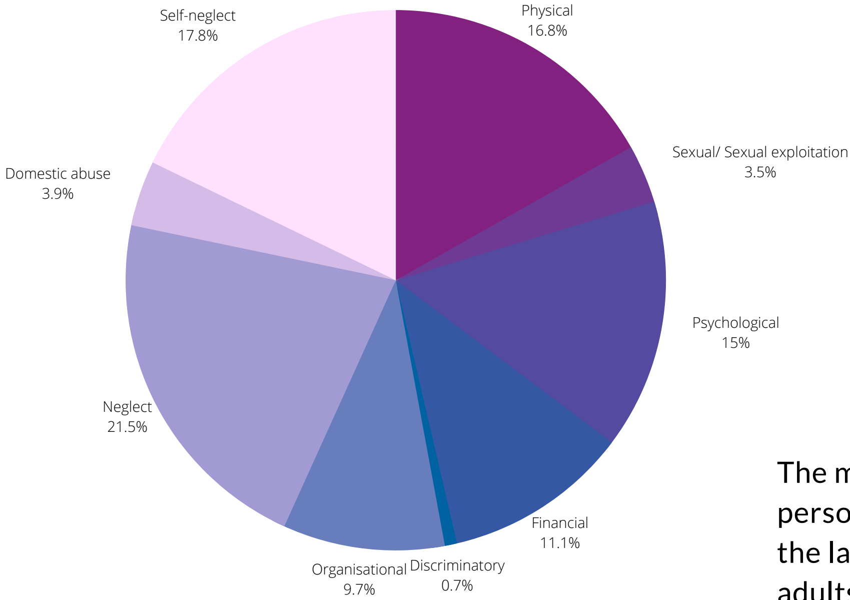
There is a slightly higher proportion of safeguarding concerns raised about women than men. This is reflected nationally and is consistent with historic reporting.



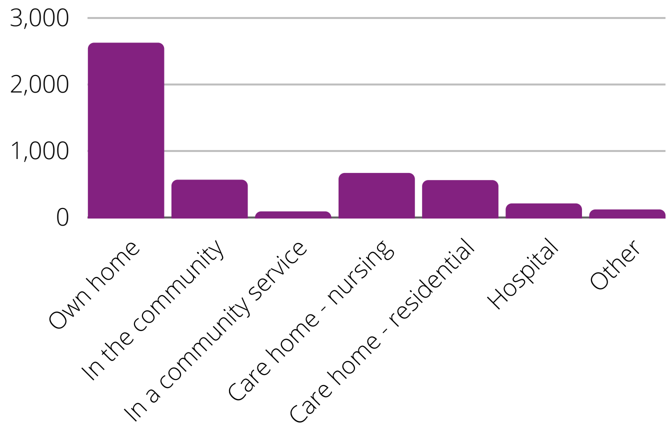
14,861	Safeguarding adults **referrals** received
8,751	Referrals which met the **safeguarding adult concern** criteria
6,941	Safeguarding adults concerns which progressed to a **safeguarding adults enquiry**



Age of adults subject to safeguarding concerns



Neglect featured in 1,181 safeguarding adults enquiries and was the most common type of abuse that safeguarding adults enquiries were undertaken about. This was closely followed by self-neglect which featured in 979 enquiries.



The most common location of abuse remains the persons own home, however this decreased by 16%. In the last year, there have been increases in safeguarding adults enquiries related to abuse or neglect that was happening in a care home setting. It is important to highlight however that the location of risk is different to the source of risk and an increase in care home as a location does not necessarily equate to an increase in care staff as a source of risk. Service Providers were identified as the source of risk in 24% of enquiries compared to 19% in 2020-21.

In 87% of safeguarding adults enquiries risk was either removed or reduced. Audits have identified that the majority of cases where risk remains relate to cases involving adults who are presumed or assessed to have capacity to make decisions not to engage with an enquiry or to accept a level of risk.

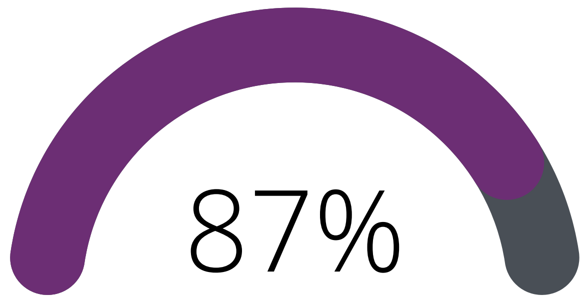
In 72% of safeguarding adults enquiries, the adult at risk or their representative was asked what they wanted to happen as a result of a safeguarding adults concern being made. Improving this percentage and other Making Safeguarding Personal indicators remains a key priority for the NSAB.

72%

Proportion of safeguarding adults enquiries where the adult at risk (or their representative) expressed their desired outcomes.

35%

Proportion of safeguarding adults enquiries about an adult lacking in mental capacity



Safeguarding adults enquiries where risk was either removed or reduced

HOMELESSNESS AND ADULT SAFEGUARDING

The Local Government Association and Association of Directors of Adult Social Services published **"Adult safeguarding and homelessness: a briefing on positive practice"** in 2020. This briefing highlighted that this was a complex area of safeguarding adults practice, requiring an integrated whole system response. The briefing highlighted the important role that Safeguarding Adults Boards have in seeking assurance on local policy and practice around safeguarding adults who are at risk of or experiencing multiple exclusion homelessness. In November 2021, the NSAB received a report from Newcastle City Council's Active Inclusion and Commissioning Teams that provided such assurance.

There are a range of services and support available to people who are homeless or at risk of becoming homeless in Newcastle. Through partnership working it is the aim that there is: no rough sleeping; no B&B use; and no evictions into homelessness in Newcastle. Good quality accommodation and additional support have had positive results. Newcastle won the prestigious **World Habitat Gold Award in 2020** for preventing homelessness and presented to the United Nations on the **rights-based approach to preventing homelessness**.

There are good relationships between those working in homelessness services and those working in safeguarding adults, this is both on the front-line and at a senior level. The workforce are well informed around safeguarding adults meaning that appropriate concerns are being raised and enquiries undertaken where required. There is a focus on prevention, including strong multi-agency working to keep improve a person's safety and wellbeing with the aim of negating the need for action under safeguarding adults procedures. These key safeguarding principles will be used in the application of additional funding the city has secured to respond to homelessness.

Newcastle has a **Homeless and Rough Sleeping Strategy 2020-2025** which is signed off at a Cabinet Level and progress is monitored via Quarterly Homelessness Reviews chaired by the Housing Portfolio Holder. Homelessness prevention has been agreed as priority by Collaborative Newcastle, further demonstrating the emphasis on joint working and accountability in this area.

Safeguarding Adults Manager insights....

"Adults who are homeless can be very vulnerable, often having multiple and complex health and social care needs and being at risk of things like self-neglect, domestic abuse, criminal exploitation and physical abuse. There can also be cross-boundary complications. Cases involving homelessness are about so much more than resolving the person's housing needs and we are lucky in Newcastle to have good relationships between agencies such as the Housing Advice Centre, YHN, supported accommodation providers, the Police's Harm Reduction Team, CNTW's Harm Minimisation Team, Changing Lives' Multiple Exclusion Team and Community Safety. The safeguarding adults framework provides a robust multi-agency process for sharing information about risks and agreeing a plan to reduce or remove risk. "

ADULT L SAR

In 2021-22, the Safeguarding Adults Review (SAR) Committee finalised and published a SAR in relation to Adult L. Adult L was a 75-year-old woman who died from Covid-19 in 2020. The Review focussed on the care and events leading up to her death. Adult L had increasing care and support needs with several agencies involved to meet those needs. Adult L sometimes refused care which created concerns for agencies.

The report highlighted that there were many areas of good multi-agency working and good systems in place to safeguard and offer safe and effective care to Adult L. The author also highlighted the challenges that practitioners faced – the complexities of Adult L's multiple health needs and her difficulty in accepting support in the context of a global pandemic. The Safeguarding Adults Review report includes the following areas for strengthening practice:

- Identifying and working with people who are alcohol dependent.
- Working with older couples where there is domestic abuse.
- Working with people who self-neglect, ensuring the promotion of and use of guidance and frameworks in this area.
- Multi-agency working, communication and the impact of the Covid-19 pandemic.

The NSAB have published the full report, an Easy Read version, a practitioner briefing and a briefing about learning from Covid-19 related to safeguarding adults. These can all be downloaded from the **SAR pages** of the NSAB website.

All of the recommendations made in the SAR have been accepted by the NSAB and an action plan has been developed in response. The SAR Committee will oversee progress against the action plan and report progress to the NSAB.

The SAR Committee continues to progress two further SARs which were referred in 2020-21. The first is anticipated to be published in Autumn 2022 and the second in 2023.

Two additional SAR referrals were received by the SAR Committee in 2021-22. Both referrals related to cases of significant self-neglect. The SAR Committee considered these cases and decided that they did not meet the criteria for a SAR. However, given the increasing number of self-neglect concerns being reported via local safeguarding adults procedures, as well as these and previous SAR referrals, the Committee proposed undertaking a thematic review into self-neglect. The review would look at what was working in well in identifying and responding to self-neglect, as well as what was challenging and if there was anything further that could be done to support front-line practitioners in this area.

Finally, SAR Committee members have been participating in a number of the Care and Health Improvement Programme (CHIP) webinars about SARs. The programme is a sector-led improvement initiative with the aim of sharing good practice. Newcastle were involved in delivering one of the webinars, highlighting the work of our regional SAR Champions who meet regularly to develop and improve practice around SARs. In 2021-22 the SAR Champions set-up the North East SAR Library (an online, searchable platform for SARs undertaken locally) and produced a North East SAR Quality Markers Checklist (a checklist to support SABs in undertaking good quality SARs).

SAR COMMITTEE PRIORITIES FOR 2022-23

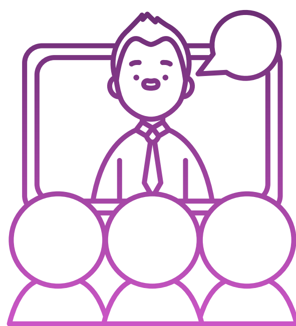
- Oversee the action plan in relation to the Adult L Safeguarding Adults Review.
- Progress the two ongoing Safeguarding Adults Reviews.
- Co-ordinate a thematic review around self-neglect.
- Continue to implement the local action plan in response to the national Analysis of Safeguarding Adults Reviews. This will include a development session for SAR Committee members.

IMPROVING PRACTICE COMMITTEE

This year the Committee set up a task and finish group about financial abuse. This was following feedback from practitioners who said this was a complex and wide-ranging area where additional guidance and support would be welcomed. The group had representatives from across different agencies who worked together to produce guidance on **identifying, preventing and responding to financial abuse**. The guidance is primarily in relation to adults with care and support needs and is intended to complement the over-arching Newcastle Safeguarding Adults Board multi-agency safeguarding adults policy and procedures. However, many of the services, support and information detailed are universal and are available to all adults. The guidance was successfully launched in November 2021 during Safeguarding Adults Week. See page 7 for further information.

Safeguarding Adults Week is a national week of activity and awareness raising. For the last 3 years, the Improving Practice Committee have co-ordinated a programme of webinars. The webinars this year covered: the Disclosure and Barring Service; Financial Abuse; Newcastle Treatment and Recovery Service; Identification and Brief Advice (drugs and alcohol); Liberty Protection Safeguards; Cyber Protect; Self-Neglect and Criminal Exploitation. Key safeguarding messages were also co-ordinated across NSAB member agencies on social media. The week received so much positive feedback and interaction – we aim to replicate the same in November 2022.

SAFEGUARDING ADULTS WEEK STATS



439

people attended 8 webinars delivered by 17 presenters.

300%

increase in Twitter mentions and 200% increase in profile visits.

2,349

hits on our website during the week with 657 hits on 17th November alone - our best day ever.

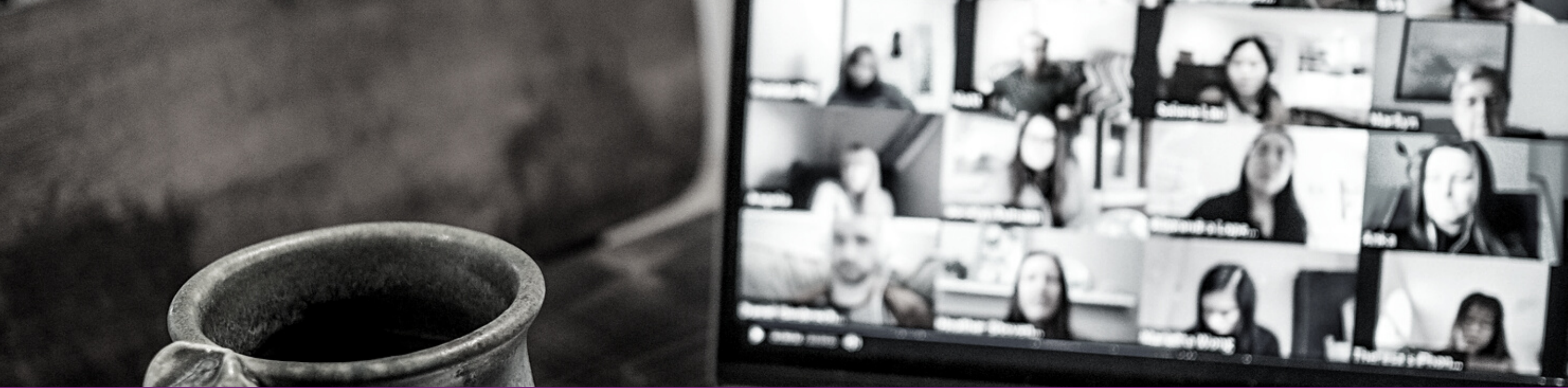
The NSAB have a wealth of guidance available on safeguarding adults. The Improving Practice Committee has a key role in ensuring the guidance is regularly reviewed and up to date. This year the Committee updated the **Abuse between Adults with Care and Support Needs Guidance**. This review coincided with a case presentation involving an allegation of sexual assault by one care home resident to another. Case presentations are an important way for the Committee to understand key issues in front-line practice. Following on from the case presentation, the Committee invited the Sexual Assault Referral Centre (SARC) to discuss the services and support they offer. This helped inform the update to the Abuse between Adults with Care and Support Needs guidance.

The Committee has continued to focus on Making Safeguarding Personal (MSP). A dedicated performance scorecard in relation to MSP helps the Committee to delve deeper into some of the challenges for practitioners. It was good to find out that there was improved performance in key areas compared to previous years. In particular, the asking of a person or representative's desired outcomes has improved to place Newcastle above national, regional and other statistical comparators. The Committee's Audit Sub-Group are planning an audit around desired outcomes in early 2022-23.

Committee members began a review of the over-arching multi-agency procedures. This is in line with the three-year review period and will reflect any changes to operational practice due to Covid-19. This work will continue into 2022-23.

IMPROVING PRACTICE COMMITTEE PRIORITIES FOR 2022-23

- Finalise review and update of multi-agency policy and procedures.
- Contribute to the review and update of self-neglect practice guidance.
- Continued focus on Making Safeguarding Personal which will involve audit work and work alongside the Learning and Development Committee.
- Promotion of best practice in the application of the Mental Capacity Act (MCA), considering any changes brought about by the new MCA and Liberty Protection Safeguards (LPS) Code of Practice.
- Hold a best practice week to coincide with Safeguarding Adults Week.
- Consideration of updated **ADASS/LGA Briefing on Carers and Safeguarding** and implications for policy, practice and training in Newcastle.
- Continue work on safeguarding and poverty - including involvement in a project with West End Foodbank and exploring how routine conversations about finances can be built into safeguarding adults procedures.



LEARNING AND DEVELOPMENT COMMITTEE

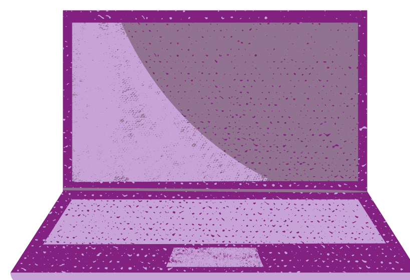
The Learning and Development Committee continued with their successful virtual multi-agency training programme in 2022. In line with public health guidelines and the continued prevalence of COVID -19 in our communities, there was no multi-agency face-to-face training delivered in the last year.

One key area of work has been further collaboration between the Committee and the work of the NSCP's Learning & Improvement Group. This closer working relationship has facilitated the sharing of ideas, continuity of approach in appropriate areas and promoted access of staff to training provided by both partnerships. In the last year, the NSAB and NSCP re-commissioned the safeguarding e-learning offer available to the Newcastle workforce. Me Learning were selected as the new provider in December 2021. Five courses are offered (free of charge to anyone working or volunteering in Newcastle) - Safeguarding Adults Level 1 Basic Awareness; Safeguarding Children Level 1; Safeguarding Children Level 2; Mental Capacity Act Basic Awareness and Deprivation of Liberty Safeguards Basic Awareness.

The Committee has had an array of guest speakers over the year. Northumbria Police provided a short presentation on online safety, for staff within organisation's and members of the public. This has led to a Task and Finish Group being set up to look at developing training in this area.

2,553

participants on NSAB training courses.



1,467

people who have completed our e-learning courses in the last year. The most popular was Safeguarding Adults Basic Awareness (877 completions).

95%

of participants on NSAB training rate it as good or excellent. 93% of learners felt that training would influence their practice.

As a result of learning from cases, the content of the Self-Neglect Workshop has been revised by colleagues from Adult Social Care, Your Homes Newcastle (YHN) and Tyne and Wear Fire and Rescue Service (TWFRS). In 2021-22, the revised workshop has been delivered to YHN staff and will be re-launched as part of the multi-agency programme in 2022-23. The training will be further reviewed in light of the ongoing work by the SAR Committee, and regionally, on self-neglect.

The Learning and Development Committee continues to seek assurance from partner agencies on the uptake of safeguarding adults training. Some agencies have needed to suspend aspects of their safeguarding adults training programmes during Covid-19. Agencies are aware of the need for their staff to access regular and up-to-date safeguarding adults training and hope to recommence their usual training strategies as soon as possible.

A further action has been to embed the York Judgement (PC & NC v City of York Council) and its impact on assessing mental capacity into all levels of safeguarding and MCA training. This judgement places an emphasis on assessing a person's ability to make a decision first (the functional test) before confirming whether the inability to make a decision is as a result of an impairment or disturbance of the mind or brain (diagnostic test). It is important that our training reflects current case law and it will place us in a good position for changes brought about by the updated MCA Code of Practice when this is finalised.

The Committee continue to promote financial inclusion/anti-poverty training, supporting work to break the link between safeguarding and poverty.

LEARNING & DEVELOPMENT COMMITTEE PRIORITIES FOR 2022-23

- Developing bite-size training resources using different approaches, including recorded webinars and short animations.
- Reviewing our MCA training offer to ensure it supports front-line practice and reflects changes brought about by the updated MCA Code of Practice and introduction of the Liberty Protection Safeguards (LPS).
- Continue with a task and finish group work to design and delivery a training course on online safety for adults.
- Offer training on domestic abuse and older people and financial abuse.
- Continue to quality assure single-agency safeguarding training and look to assist single-agency trainers by sharing resources and offering peer support.

MISSING, SLAVERY, EXPLOITED, TRAFFICKED COMMITTEE

The year began with a reset of the Committee's work and a review of the Strategic Delivery Plan. The plan reflects emerging trends around missing, slavery, exploitation and trafficking and aligns with the City's Criminal Exploitation and Serious Violence Strategy.

One of the Committee's key objectives is to increase practitioner confidence in recognising and responding to missing, slavery and exploitation concerns. Over the course of the last year, the Committee has produced a **Criminal Exploitation and Serious Violence Flowchart**. This two-page document outlines the different referral pathways and services available to support people at risk. It also gives key information about signs and indicators, good practice when responding to a person experiencing criminal exploitation and how concerns can be reported anonymously.

Another way in which practitioner confidence can be increased is via training opportunities. The Violence Reduction Unit (VRU) funded a training post within Adult Social Care for 2021-22 which allowed a greater co-ordination and delivery of multi-agency training around criminal exploitation, adversity and trauma-informed practice. There were just over 500 practitioners trained in the year, from a variety of different sectors including housing, care providers, children's and adult social workers and community and voluntary organisations. Some of the training was co-delivered with presenters from Children's Social Care, Northumbria Police and Edge North East adding their knowledge and experience to the content. The Committee have also promoted a number of nationally available online training e.g., on County Lines and the National Referral Mechanism.

> **"It was a really informative course. With working in Children's Social Care so long, I feel I had an awareness of adult safeguarding, but a very limited knowledge and a limited knowledge of the organised crime and exploitation. I found it very helpful in respect of a current case I have whereby I am involved with a very vulnerable young mum, and I have arranged a meeting tomorrow morning to discuss this with other professionals and agree a plan of support and referral to adult safeguarding."**

Evaluation from participant on criminal exploitation training

The Committee have considered several national reports and briefings and considered their implications for Newcastle. This has included the **Bridging the Gap report** about transitional safeguarding. Newcastle featured in this report, highlighting the good practice that happens here as well as shining a light on how important the transition period from childhood to adulthood is in terms of safeguarding people at risk of exploitation. Another national report considered was **The Multi-Agency Response for Adults Missing from Health and Care Settings, A National Framework for England**. The Committee had already been involved in the development of a regional **Missing Adults Protocol for Adult**s; the national framework was used as part of the annual review of the regional protocol which was updated in February 2022.

The Committee understood that online exploitation was becoming an increasing concern, particularly as a result of the lockdowns. Northumbria Police had done work with schools and parents about keeping safe online in October 2021 which included information about cyber bullying and harassment, sharing of nude images and sexting and also sources of support. It was noted that the further work could be done with adults at risk in this area and this will be an area of work for next year.

1,794

missing adult incidents in Newcastle in 2021-22. These related to

1,133

individuals.

The Exploitation Hub is key to the multi-agency response for those at risk. The work of the Hub was more closely aligned to MSET this year with the lead Detective Chief Inspector becoming a member of the Committee and regular reports being received on its continued development. The Hub also featured in a short video to promote Exploitation Awareness Day on 18 March 2022.

M-SET COMMITTEE PRIORITIES FOR 2022-23

- Refine the data and intelligence available to Strategic MSET so that this helps to inform priorities.
- Have a greater understanding of the link between peer crime groups and missing, exploitation and trafficking.
- Continue to promote and offer training in this area.
- Increase awareness and understanding of missing, slavery, exploitation and trafficking with children, young people, adults at risk and more generally within the communities of Newcastle.
- Ensure online safety initiatives also include adults at risk. This will involve contributing to the work of the NSAB Learning and Development Committee task and finish group on online safety (see page 16).
- Develop and maintain links between MSET and other partnerships and sub-committees. In particular, the Domestic Abuse Local Partnership Board.
- Explore the vulnerability of children and adults with a learning disability.
- Influence the commissioning of services for children, young people and adults at risk of going missing, slavery, exploitation and trafficking. In particular, the accommodation available to those at risk.

CRIMINAL EXPLOITATION CASE STUDY

NORTHUMBRIA POLICE

Northumbria Police’s Missing from Home Coordinators have played an active role in multi-agency safeguarding over the last 12 months in respect of young adults missing and linked to criminal exploitation and county lines. Last year saw the introduction of a Safeguarding Adults Manager into the Multi Agency Operational MSET (Missing, Slavery, Exploitation, Trafficked) meetings for children and young people. This has been a positive step to ensure a greater early awareness of young people as they transition into adulthood.

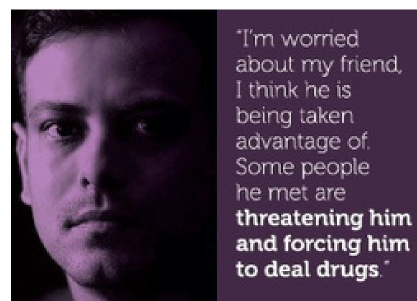
One such example involved a young male involved in criminal exploitation and county lines. He was picked up as an early transition case and professionals were introduced to his family at an early stage to build trust and a rapport. Mental Capacity Act assessments were completed by Adult Social Care completed MCA assessments and it was subsequently identified that he had an undiagnosed Learning Disability. These assessments informed subsequent agency responses in supporting the young person and keeping him safe from harm.

Agencies have worked together to ensure he has appropriate accommodation that meet his care and support needs. He also has a mentor and is participating in sporting activity. Whilst it has been difficult to remove all risks to the individual, there are now significant harm reduction plans and support in place. This example highlights the benefits of safeguarding adult representation in the operational MSET process and the importance of robust safeguarding transitions from childhood to adulthood.

No excuse, this is **abuse**

Report it: **0191 278 8377**

For more information visit: **newcastlesafeguarding.org.uk**



No excuse, this is **abuse**

Report it: **0191 278 8377**

For more information visit: **newcastlesafeguarding.org.uk**

As part of the NSAB's poster and leaflet review, two posters now depict criminal exploitation scenarios.

SAFEGUARDING ADULTS IN CARE HOMES

In February 2021, the National Institute of Care Excellence (NICE) published guidance on **Safeguarding Adults in Care Homes**. The guidelines included recommendations on policy, training and culture. Care homes, commissioners and Safeguarding Adults Boards were encouraged to raise awareness of the guidelines, evaluate their current position and make improvements where required.

The Safeguarding Adults Unit and Commissioners from Health and Social Care undertook a benchmarking exercise based on the recommendations made in the guidelines. There was strong assurance around the arrangements in place in Newcastle:

- Care home providers demonstrate a high level of knowledge of awareness of abuse and neglect and an openness and transparency in reporting concerns on a multi-agency basis.
- Care home providers are a high referrer of safeguarding adults concerns and this is seen as a positive.
- Safeguarding is a core part of the standard contract.
- There are good relationships and networks between providers, commissioners, the Care Quality Commission (CQC) and safeguarding adults specialists.
- Care homes have access to free multi-agency safeguarding training and can have their in-house training quality assured.
- 89% of care homes in Newcastle have a good or outstanding CQC rating.

A presentation was given at the Care Home Provider Forum about the guidelines and managers were encouraged to use the baseline assessment tool to identify any areas where improvements could be made. Many of the recommendations in the guidelines are already covered within CQC regulations, contracts and local multi-agency safeguarding adults policies and procedures.

Alongside the guidelines, NICE published two quick guides:

- Creating a safeguarding culture and
- Good practice in safeguarding training.

These guides were promoted with care home managers.

PARTNER AGENCY PERSPECTIVES

NORTHUMBRIA POLICE

Protecting Vulnerable People is a force priority. To support this a Force Vulnerability Strategy was launched this year with four key pillars: Working Together, Our People, Leadership and Early Intervention and Prevention. The key aim is to protect and safeguard our vulnerable people and ensure perpetrators are targeted and prevented from re-offending and causing further harm within our communities. Harm Reduction Teams are now embedded across the force area and they will play a key role in tackling emerging issues identified with vulnerability, working with partners to adopt a problem solving approach.

Within the last twelve months a Force Harm Reduction Team have been appointed. They will oversee the implementation of our Force Early Intervention Strategy. The Strategy focusses on Building Community Resilience, Partnerships, Preventative Intervention and Our People.
In support of our strategy the force has a new out of court disposal team (TREAD team) who are looking at pathways to divert adult offenders from the criminal justice system. The team have pathways around training and education, substance misuse, 18-24 year olds and veterans.

To ensure that Protecting the Vulnerable is front and centre of our force response, force wide "Vulnerability Matters" training has been rolled out in the first quarter of 2022. This training will support officers to take a trauma informed approach to dealing with vulnerability and assist officers to identify vulnerable adults in the community.

The training focusses on equipping officers to better understand vulnerability by looking for clues, applying curiosity and ensuring our communications are in a supportive and empathetic way. The training includes an input from one of our MASH managers with specific guidance about how to submit a quality Adult Concern Notification (ACN) referral.

Bespoke training sessions are also being delivered in force around Vulnerability to our force control room call takers to enable them to recognise and respond to vulnerability at the first point of contact. In addition our newly appointed Sergeant and Inspectors in force are given an input on the Care Act and the categories of abuse so they can apply this learning in their team supervisions.

This year has seen the re-launch of the Multi-Agency Exploitation Hubs and the commitment of all six Local Authorities and Health to provide a coordinated approach to protect and safeguard those at risk of sexual, criminal exploitation and all aspects of Modern Day Slavery. Work in this area has been further enhanced by utilising a consistent force wide chair at the MSET Committee, allowing the sharing and join up of best practice in respect of all forms of exploitation. This chair has built links with both the Violence Reduction Unit and the Regional County Lines Coordinator who can build learning from national and regional practice into the local response.

NEWCASTLE CITY COUNCIL

The Adult Social Care workforce continue to be front and centre of responding to the increased safeguarding adults activity in Newcastle. Social Workers and their Team Managers are responsible for screening all 14,861 safeguarding adults referrals received and co-ordinating the 6,941 Section 42 Enquiries that were undertaken in the year; assessing risks and ensuring there are plans in place to reduce or eliminate those identified risks. Additional resource has been put into the Adult MASH to assist with the continued increase in safeguarding adults concerns being referred.

In 2021-22, the Violence Reduction Unit funded a Social Care Assessment Officer post within the multi-agency Exploitation Hub to deliver awareness raising and training around criminal exploitation and serious violence. The post had a particular focus around sharing best practice and improving approaches to safeguarding young adults transitioning from children's services. In total, 505 people received training, from a variety of different organisations and sectors. 176 Adult and Children's Social Workers received a full-day's Criminal Exploitation Training, which also included input from Northumbria Police and Edge North East. Training sessions also brought in trauma-informed practice and adverse childhood experiences.

There was cross-Directorate involvement in the development of the NSAB's Financial Abuse Guidance. This included contributions from Adult Social Work, Trading Standards, Active Inclusion and Finance and Debt Recovery colleagues.

Newcastle City Council (alongside colleagues in YHN) celebrated getting White Ribbon accreditation in November 2021. White Ribbon is the global campaign to end male violence against women and girls. The Council has a series of goals and an associated action plan to change the behaviour and culture that leads to abuse and violence. New domestic abuse duties were placed on local authorities in 2021-22 which resulted in the establishment of the Domestic Abuse Local Partnership Board (DALPB). The Board has key duties around assessing and making arrangements for relevant accommodation-based services. The DALPB has also agreed a two-year strategy which includes some priorities that contribute to the safeguarding of adults with care and support needs.

Newcastle City Council played an active part in Safeguarding Adults Week. Public Health delivered a webinar on Identification and Brief Advice (drugs and alcohol), the Deprivation of Liberty Safeguards (DoLS) Team gave a presentation on the new Liberty Protection Safeguards (LPS) and there was a webinar on Criminal Exploitation. Messages were also shared via Newcastle City Council social media feeds and via internal communications.

The Association of Directors of Adult Social Services (ADASS) North East region have been pro-active around adult safeguarding in 2021-22. In April 2021 they funded a **radio campaign** about safeguarding adults. The campaign broadcast key messages on Metro Radio and TFM. The ADASS network have also been working hard on self-neglect, with a series of 7-minute guides and an animation planned for publication in 2022-23.

NEWCASTLE CITY COUNCIL CONTINUED

Across the wider Council workforce, the Corporate Safeguarding Training Group (CSTG) is responsible for ensuring that colleagues across Newcastle City Council have the knowledge, skills and confidence in relation to their safeguarding responsibilities. Over the past two years the CSTG embarked upon a programme of work to review the corporate safeguarding training offer and in doing so launched the Keeping Everyone Safe (KES) training modules. For the first time in the corporate safeguarding training programme the KES course brought together key messages in relation to safeguarding children, safeguarding adults, community safety, domestic abuse and Prevent under one banner. As of March 2022, 94% of colleagues who are required to undertake the training have done so.

NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

Despite the continued challenges the pandemic has presented and an overall increase in activity of 23%, high quality safeguarding practice has remained a priority for the Trust.

Multi-agency working remains a constant and important aspect of the team's work, with cases continuing to demonstrate evidence of self-neglect, substance use and complex health needs. The team have continued to contribute to Multi-agency (MASH) discussions and multi-agency meetings throughout the region which is a fundamental and important part of the team's work. Our involvement is not limited to the Newcastle Area and referrals/safeguarding activity supports individuals who live across the North East.

Over the last year we have focused on the sharing of learning which is key factor in continuously improving safeguarding practice. Safeguarding Communication Forums continue within the Trust which offer opportunities to share learning and openly discuss and debate practice. The sessions have evaluated well and have focused on a wide range of subjects and included the concept of professional curiosity, which remains an essential approach to safeguarding practice across the teams.

We have also been focusing on providing additional pro-active outreach work to some of our wards and departments. The purpose is to address any current concerns or questions, to provide informal teaching through conversation and provide monthly safeguarding supervision session. A pilot is in place across several areas but is evaluating well and this work will shape future Trust safeguarding practice in the year ahead.

Key contributions to the NSAB priorities have been the continued commitment to multi-agency working and participation in the NSAB Multi-agency Audit.

The Trust continues the further development of the application of the Mental Capacity Act. Work around this has included a service improvement project to explore challenges and enablers to the use of the Act and the development of local learning and outreach. The Trust has continued to recognise the challenges in the utilisation of the Mental Capacity Act and has linked with several regional agencies to focus on the transition to Liberty Protection Safeguards. This work has continued internally through the development and launch of an e-learning package and examination of challenges through action research.

SELF-NEGLECT CASE STUDY

NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

Miss B lives in extra care accommodation, she has a learning disability and a number of physical health needs. Over several months, there are attempts to support Miss B to attend reviews as there are concerns she needs more urgent treatment and care. Miss B is now referred to safeguarding adults procedures. This is due to the following concerns:

- her health interventions have a growing urgency and Miss B has been unable to attend planned appointments and treatments.
- her tenancy is breaking down as there is evidence of self-neglect.
- there are concerns that Miss B is no longer engaging with services and spend very little time at home.
- the police are frequently called as the public are concerned for her safety and well-being.
- Staff at her accommodation are seeing less and less of her and are reporting Miss B missing on many occasions.

Miss B requires two surgical procedures. Discussions focus on whether this can be planned together, which is agreed. This required coordination and planning in terms of support pre and post operatively. Through discussions, it becomes apparent that the key challenge to facilitating access to care, is locating Miss B and bringing her safely and respectfully to hospital. The team around Miss B are worried that there have been changes in her behaviour and a query around whether physical health needs may be causing Miss B discomfort or worry. The teams within the Hospitals Trust are contributing to the safeguarding process and linking with other partners to support attendance. Mental Capacity Assessments are conducted and Best Interest Meetings are held, with support from an Independent Mental Capacity Advocate (IMCA). Legal services are supporting Court of Protection Procedures and the very complex process of conveyance (transport) to hospital. The team recognizes that locating Miss B and transporting her to hospital from a public place, may lead to increased distress and there is a working hypothesis of options to ensure safety and dignity. The conveyance to hospital is the far greatest challenge as there are dilemmas for all involved. Ultimately Miss B was admitted to hospital, with a coordinated response and extensive reasonable adjustments. Flexible, supportive care and treatment was completed. The admission was longer than planned, however this allowed for continued multi-agency working to ensure safe discharge. Support to Miss B demonstrated the effective use of the Mental Capacity Act and Equality Act, and a flexible and tenacious response to self-neglect.

In 2021-22, the NSAB worked hard to increase awareness of self-neglect both with the public and professionals. A new self-neglect poster was designed and there an article published in CityLife in November 2021. CityLife is delivered to all houses in Newcastle.

Work to increase awareness of, and responses to, self-neglect will continue into next year.

NEWCASTLE GATESHEAD CLINICAL COMMISSIONING GROUP

In July 2021, the NGCCG Safeguarding Team secured funding from NHS England to develop an Integrated Care System (ICS) wide pilot to develop forensic examination services for adults who present with unexplained or non-accidental injuries. The bid was successful and has been taken forward during 2021-22 and through to 2023. The funding has been used to:

- Develop Forensic Awareness training for GPs and clinical staff
- Fund a Forensic Examination Conference
- Deliver training for staff to undertake Forensic examination.
- Develop a knowledge hub /Resource hosted by the Faculty of Forensic and Legal Medicine.

During 2021 the NGCCG safeguarding team were instrumental in establishing and ICS wide Safeguarding Professionals Network. This has developed as the only forum in our area that is open to safeguarding (health) staff from both provider and commissioning organisations across health agencies. The Network is well established and well attended and has been recognised by NHSE and a key forum to support the development of safeguarding practice across the ICS.

A key achievement during 2021 was the implementation of a Local Enhanced Service Agreement (LES) with Primary Care which has been developed to ensure that GP Practices are appropriately reimbursed for the cost associated with support to multi agency working and safeguarding. This represents a step change in development of engagement and information sharing to support safeguarding practice with NGCCG being an early adopter of this approach within the region.

The Safeguarding Team have continued to develop online approached to training which has included building and developing an online resource of recorded training for Primary Care staff to access via the CCG's intranet.

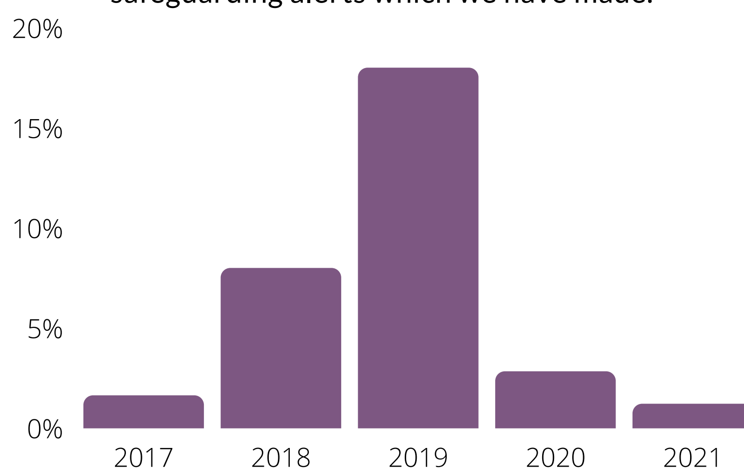
The NGCCG safeguarding team have been instrumental in establishing and ICS wide Safeguarding Professionals Network. This has developed as the only forum in our area that is open to safeguarding (health) staff from both provider and commissioning organisations across health agencies. The Network is well established and well attended and has been recognised by NHSE and a key forum to support the development of safeguarding practice across the ICS.

SEARCH (Services for Older People)

As a small grass roots organisation providing support to local older people, we focus our attention on one area each year to try and make the a significant impact on prevalent issues. Over the past year we have worked with staff to raise awareness of self-neglect, our staff now have a new approach to working with people who have self-neglect issues and a pro-active approach to prevent missed health appointments. We secured a small grant to provide pamper and self-care packs to people which helped us start difficult conversations around self-care and washing.

The areas which Search has made the most significant contribution to NSAB priorities are

- Partnership- Close working with Social Care, Mental Health, and Hospitals to provide local solutions for older people in Newcastle's West End.
- Prevention – at Search we have focused on prevention this year and we have seen a significant reduction in the number of safeguarding alerts which we have made.



'The percentage of people receiving a support service from Search who have had safeguarding alerts raised over the past five years.

Connected Voice

Connected Voice's Advocacy service won the overall Outstanding Advocacy Service again at the National Advocacy Awards 2022. We were nominated by Gateshead Council for our safeguarding work to protect people from harm and abuse and Northumbria Police and Crime Commissioner for our Hate Crime Advocacy service. We have been awarded the national Quality Performance Mark and were assessed as excellent (including in the key area of safeguarding).

An in-depth Annual Report is provided for the Connected Voice Trustee Board on statistics and demographic data on people safeguarded in the year. For the period October 2020-September 2021, 95 people were supported around safeguarding. This related to 67 alerts, 28 concerns and 40 Section 42 enquiries.

Connected Voice's On the Hoof News Bulletin has a specific section for safeguarding matters for people working in the voluntary, community and social enterprise (VCSE) sectors. Connected Voice deliver an **Introduction to Safeguarding** session for VCSE organisations in Newcastle and Gateshead. We have also been helping community groups adapt to online services and ensure continuity of delivery.

Connected Voice Advocacy have continued to campaign nationally around key legislation (Mental Health Act and Mental Capacity Act) and to ensure people's Human Rights are upheld. This has been particularly important during lockdowns.

The service have contributed to a number of pieces of national research and consultations, including: Adult Social Care Reform, Equality and Human Rights Commission Review on Adult Social Care complaints and research into inpatient settings for people with a Learning Disability and Autism.

The Advocacy Charter includes ten commitments, one of which is safeguarding. Advocates play a key role in ensuring many of the key principles of safeguarding are met. Advocates work shoulder to shoulder with people to ensure decisions are person centred, person led and compliant with the Mental Capacity Act. They also have a scrutiny role, ensuring that service providers are acting lawfully when working with vulnerable people.

CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST (CNTW)

During COVID-19 pandemic, there was a directive from NHS England for all crisis services to provide a 24/7 universal crisis response. In direct response to this, CNTW reviewed current working practices and introduced a Universal Crisis Team (UCT) model across Newcastle and Gateshead. The development of the UCT is part of the national long term plan and Community Mental Health Transformation agendas, and will provide parity of service provision across the age range for those experiencing a mental health crisis.

The Individual Placement and Support (IPS) Employment Support service works across Newcastle, supporting people receiving community care and treatment from the CTT and EIP teams to pursue their paid employment ambitions.

Historically people with Serious Mental Illness (SMI) have lacked evidence-based support in relation to employment, often assuming their only option is to claim benefits. However CNTW and CCG's have invested heavily in the IPS Service in order to address this, viewing unemployment as a serious risk to long-term health and good employment as a health outcome to which we all aspire and to which everyone should have access as a fundamental right.

Support provided from the IPS team includes:

- help getting or keeping a job
- employment rights
- benefit entitlement
- employment opportunities

In addition to supporting people into sustainable, good employment the Trust has been working with the Money and Pensions Service (MAPS) to create a financial wellbeing tool that can be used by any healthcare professional to assess the impact of finance circumstances on a person's health and then facilitate accredited, independent financial support for the person.

The hypothesis is that financial health has a significant impact on physical and mental health, so by understanding financial health we will be better able to assess and treat mental health difficulties.

Development of this tool began in 2020 but it has never been more pertinent given the accelerating cost of living crisis and the demand for mental health treatment and support.

The Trust are currently engaged in an evaluation of the tool and will publish the findings once the trial concludes. The ambition is that financial wellbeing tool will form part of core assessments across health services, supporting people using services and the teams providing care and treatment to build a holistic picture and rapidly involve accredited, independent financial experts or direct to high quality self-help.

CHANGING LIVES

One of the key developments this year at Changing Lives has been developing a Peer led Reflective Practice model to help staff emotionally manage complex safeguarding cases. The Gibbs Reflective Cycle is central to our model.

Being a trauma informed and trauma responsive organisation means we care and support for our staff as we care for and support the people accessing our services. At Changing Lives we want to work towards a culture where all staff understand the importance of self-reflection and that everyone has access to a reflective space on a regular basis. Accessing Reflective Practice should be a core and fundamental part of how we operate across Changing Lives services and departments, and it should be made accessible on a consistent basis, to all staff.

"Well, for me this is about the organisation stating we want to encourage you to take time out and use reflection as not only a learning tool. But also as a safe space to try and make sense of some of the complexities we work with, so that we don't carry that baggage around...self-care is how you survive!"

"Reflective practice gives not only us as individuals the tools to help respond to the many changes we face during our working day, it also helps us with decision making, managing our emotions, creating productive relationships. It also demonstrates that Changing Lives is taking the opportunity and embracing the view, that if you take care of your staff, they will take care of your business"
Changing Lives Peer Led Reflective Practitioners

The Changes Lives Safeguarding Annual Plan has just been drafted and covers all of the six safeguarding principles, and they are the key headings in our plan.

The Safeguarding Governance group receives performance reports at each meeting with more frequent exception reporting if concerning patterns or trends are identified. These include Serious Untoward Incidents, training reports and regular updates about the MASH developments.

NSAB MEMBERS

In 2021-22, the NSAB was chaired by Vida Morris. The NSAB would like to offer thanks to Neil Baird, Mick Mangan, Natalie Caush and Sue Kirkley for their contributions to safeguarding adults and who all stepped down as NSAB members this year.

Changing Lives (VCS representative)	Laura McIntyre
Connected Voice Advocacy (VCS representative)	Jane Kingston
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	Karen Whorton
Newcastle City Council	Alison McDowell
	Jonathan Jamison
	Samantha Keith
	James Steward
	Michelle Stamp
	Councillor Karen Kilgour
NHS Newcastle Gateshead Clinical Commissioning Group	Julia Young
	Richard Scott
Northumbria Police	Lynne Colledge
Northumbria Community Rehabilitation Company (former)	Natalie Caush
Newcastle upon Tyne Hospitals NHS Foundation Trust	Maurya Cushlow
Search (VCS representative)	Simon Luddington
The Probation Service	Paul Weatherstone
Tyne and Wear Fire and Rescue Service	Mick Mangan
	Alan D'Arcy
Your Homes Newcastle	Helen Neal
Newcastle Safeguarding Children Partnership	Sue Kirkley
Chair of Improving Practice Committee	Dr Clare Abley
Chair of Learning and Development Committee	Dr Carole Southall
Legal Adviser to NSAB	Peter Larkham
NSAB Coordinator	Claire Nixon

No excuse for **adult abuse.** **Report it.**

To report abuse or neglect, please contact:

Community Health and Social Care Direct
Telephone: 0191 278 8377
Textphone: 0191 278 8359
Email: scd@newcastle.gov.uk
Online report: www.newcastlesafeguarding.org.uk

Outside of office hours, please call:
Telephone: 0191 278 7878
In an emergency always call 999.

All agencies in Newcastle work together to protect adults at risk from abuse. If you want to tell somebody else that you trust, like a GP, nurse, police office or care worker, than they will pass on your concerns.

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	24th November 2022		
Title	Ockenden Update Report		
Report of	Maurya Cushlow, Executive Chief Nurse		
Prepared by	Jane Anderson, Associate Director of Midwifery Jeanette Allan, Senior Risk Management Midwife		
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-ofthe-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 report published in March 2022. Actions for the Trust following internal benchmarking have been updated to reflect the external feedback from the Regional Maternity Insight Visit. A summary of the feedback from the Regional Insight Visit is provided, together with an update on progress against both the interim and final report. Publication of the East Kent Maternity Report (Reading the signals - Maternity and neonatal services in East Kent – the Report of the Independent Investigation, 2022) is also acknowledged and key actions presented for future consideration. The East Kent Report can be found at: https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report Associated risks are identified and discussed, together with an updated high level Action Plan combining outstanding actions from the interim report together with those arising within the final report.		

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 29 September 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 (IEAs) for providers of maternity services, and the Trust has continued to progress, monitor, and systematically report these to members of the Trust Board since that time. There are 5 partially compliant Immediate and Essential Actions (IEAs) which remain outstanding for the Trust.

As previously reported the final publication provided an additional 15 IEAs comprising 92 recommendations highlighting an urgency for essential change and improvement to maternity and neonatal services. Specific focus on listening to families is a key driver of both the interim and final reports, with Trusts expected to investigate, learn, and embed improvements to ensure the safety of women, babies, and families in their care.

Section 3.1 highlights the written feedback received from the visiting Insight Team in August 2022. The feedback was largely aligned with the Trust's self-assessment for meeting or partially meeting the immediate and essential actions from the interim report (2020). Positive feedback described evidence of good working relationships, transparency within the leadership team, together with the good ward to board pathways, with evidence of a positive learning culture.

Further work is required to ensure that the Trust can evidence through audit, quality improvement and intervention, providing explicit assurance that learning, actions, and improvements have been made.

Section 4 reports on the High Level Action Plan, combining the interim and final Ockenden reports, taking a phased approach to reporting in view of the large number of recommendations. The 7 non-compliant recommendations arising from the Trust's benchmarking of the final report were presented to the Trust Board in July 2022 and Table 1 (BRP) illustrates the Trust's progress on these actions.

The first group of 8 from a total of 32 partially compliant recommendations from the final report were reported to the Trust Board in September 2022. This paper provides detail for the second group (numbering 10) of partially compliant recommendations taken from the 32 of the final report, along with relevant updates for previously reported recommendations as indicated within the High-level Action Plan (Table 1, BRP).

Of note is an identified risk which has previously been highlighted to the Trust Broad which relates to achieving and maintaining 90% multi-disciplinary obstetric core competency training for all specialities, which is a requirement of both Ockenden and CNST. Workforce pressures throughout September and October resulted in all training being suspended until November 7th which has impacted on trajectory against plan. In addition, the compliance metrics for CNST have been restricted to a 12 month consecutive period, reducing the amount of time that providers have been afforded to enable the target to be met.

Close monitoring will continue, with further escalation being made to the Executive Directors by exception if required and whereby it is envisaged that the Trust will be unable to meet with a 90% target.

The Trust continues to work with the competing demands currently within the service with regard to the implementation of a number of digital platforms, BadgerNet and Closed Loop Milk, together with the Trust roll out of Closed Loop Blood training, with a potential to further impact on the trajectory of this action. This identified risk is discussed in more detail in section 7 of this paper.

Additional work has been identified in relation to the provision of complex antenatal care, specifically, diabetes, and the requirement for providers to follow NICE guidance. The Trust is compliant in this regard, with the exception of the provision of a dietician; work has commenced to secure the resource required within the diabetes clinic.

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. The Trust currently provide this information in discussion with women but do not have a formal process for providing this detail in writing. Work is currently underway to produce an information leaflet based on data collated from transfers over the past 12 months. The implementation of BadgerNet will provide enhanced information for women across the pregnancy, birth and postnatal continuum.

Section 5 of this report provides an update on the implementation of BadgerNet. A ‘go-live’ implementation date is planned for 5th December 2022. There are a number of competing demands which are currently being worked through to ensure that this launch date is achieved, including the testing of key technical elements of the platform. Training is currently progressing well and, on a trajectory to meet with the 90% target of the workforce having received their training by the ‘go-live’ date.

The launch of other digital platforms is also planned simultaneously, both Closed Loop Milk and Closed Loop Blood, the Directorate continues to work closely with the digital project team to ensure that plans remain on track. Issues which may arise which place a risk to the intended launch date will be reported by exception to the Executive Directors.

Section 6 reports on the Trust’s position in relation to the midwifery workforce and the implementation of Continuity of Carer. Midwifery staffing is discussed in more detail within the Nursing and Midwifery Staffing Paper which is presented to Trust Board.

Section 7.1 of this report discusses the CQC Survey (2021), reported through Picker in 2022, which outlined a number of areas for the Trust associated with the provision of emotional and maternal mental health, which could be improved upon. A task and finish group, in partnership with the MVP, has been working closely on the findings, creating actions to support improvements in these areas. This paper outlines the work which is in progress to meet with those areas identified as requiring improvement.

Section 7.2 of this report references the independent investigation lead by Dr Bill Kirkup, CBE, 'Reading the signals: maternity and neonatal services in East Kent' report of a public inquiry published 19 October 2022. The report is different in that it has not sought to make detailed recommendations to practice or management, in contrast to Ockenden, instead the report highlights 4 key areas for action:

1. **Monitoring safe performance – finding signals among noise: -**
   - The report is critical of the usefulness of the information currently collected and reported by maternity services and highlights issues using league tables.
   - The report proposes that measuring key outcomes improves scope to improve effectiveness and patient safety. It therefore recommends:

> **Recommendation 1:**
> The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.

2. **Standards of clinical behaviour – technical care is not enough: -**
   - The report highlighted patterns of unprofessional behaviour amongst staff and toward families, describing care lacking kindness, compassion, and empathy.
   - The report also stresses the importance of listening to patients and families.

> **Recommendation 2:**
> Those responsible for undergraduate, postgraduate, and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.
>
> Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.

3. **Flawed teamworking – pulling in different directions**
   a. The report found dysfunctional teamworking within and across professional groups resulting in lack of trust, conflict, lack of sharing information and tendency toward blame.

b. The report also highlighted the lack of common purpose and diverging objectives between midwives and obstetricians, and also poor morale amongst obstetric trainees.

Recommendation 3:
Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how team working in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives, and training from the outset.

Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, team working and development.

4. Organisational behaviour – looking good while doing badly

- The report is critical of East Kent's denial, deflection, and concealment in prioritising the management of its reputation whilst denying opportunity to learn and improve when things went wrong.
- This behaviour also led to parents and families experiencing further trauma and harm by denying them knowledge and truth about what went wrong.

Recommendation 4:
The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.

Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.

NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.

The Directorate is further considering the findings arising from the East Kent Report, the work which is required at provider level, system-wide, and nationally, and the impact of this for the Trust. Further updates will be provided in future papers.

Work will continue to report and progress against all Immediate and Essential Actions in relation to the Ockenden Report and a further detailed review of the East Kent Inquiry and provide an update to the Trust Board in January 2023.

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

This paper 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, providing members of the Trust Board with an update on the Trust's position in relation to both the interim Ockenden Report, published in December 2020, and the final publication in March 2022. As previously discussed, due to the large number of recommendations arising from the final publication, a phased approach is taken in reporting to the Trust Board.

Also referenced for discussion is the publication of Dr Bill Kirkup, CBE, published on 19th October 2022, 'Reading the signals' which reports on the investigation into 202 cases within the Maternity and Neonatal services at East Kent Hospitals.

2. BACKGROUND

As members of the Trust Board are aware, 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 System (LMNS) Board to review the report, taking action to mitigate any risks identified and developing robust plans which pay particular attention to the report's four key pillars:

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

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

As previously reported, subsequent to the submission of evidence, a Regional and System Insight Visit was undertaken on 17th June 2022, the purpose of which was to provide assurance against the 7 Immediate and Essential Actions from the first (interim) Ockenden report. The Trust received a written feedback report on 26th August and has completed a benchmarking exercise against the updated self-assessment. A summary of the key comments, themes and observations from the Interim Report insight visit is discussed in section 3.1.

3.1 Interim Report Update

Written feedback received by the Trust in August arising from the Regional Maternity System Insight visit in June 2022, has now been reviewed. The feedback was largely aligned with the Trust's self-assessment for meeting or partially meeting the Immediate and Essential actions from the Interim Report (2020). Indeed, some of the partially met self-assessed elements were identified as being met following the visit.

Of particular note is the positive feedback from the insight team describing evidence of good working relationships, transparency within the leadership team, good ward to board relations, evidence of a learning culture, evidence of improvements and learning from incidents and complaints. The Team also regarded the Maternity Voices Partnership (MVP) involvement within the Governance forum to be positive.

There were 10 standards highlighted by the visiting team that were regraded from 'compliant' to 'partially compliant'. The regraded standards are detailed in Table 2 referenced in the board reference pack (BRP) and are largely attributed to the requirement for audit to provide evidence and assurity.

A key theme running throughout the feedback, particularly for the regraded standards, was the need to strengthen audit, quality improvement and intervention processes. The feedback stressed the need for evidence to provide "explicit assurance" that learning, action and improvement is embedded and ongoing within the service. Further work is underway in this regard, for example a process has been developed to enable the triangulation of complaints, incidents and claims, and it is anticipated that the implementation of electronic patient records through Badgernet will enhance audit capabilities.

The Trust are also developing a system and process for greater oversight of learning, action plans and improvement initiatives in response to Serious Incidents, complaints and claims as

advised by the insight team. The system was presented to the Directorate Quality and Safety Group on 04th November 2022.

A further theme from the insight recommendations involved greater service user feedback and consideration for widening the involvement of the Maternity Voices Partnership (MVP) with a view to co-production and service development. The Trust was advised to improve access to information to support informed choice for women and families. The Trust anticipate that Badgernet will enhance this provision. Recommendations were also made to improve the maternity services website in collaboration with the MVP which will further support informed choice.

MVP involvement within Triumvirate and Safety Champions meetings was also highlighted for Trust consideration so that "service user voice can be heard at more senior levels within the organisation".

The Trust was also guided to consider strengthening the profile and staff awareness of the role of the NED safety champion, "to improve effectiveness and reporting of safety concerns directly to Board".

The feedback from the insight visit was shared with the Regional Chief Nurse, the Local Maternity and Neonatal System (LMNS) the MVP and Integrated Care Board (ICB), with a plan to collate key findings to support shared learning and collaborative working across the region. Insight visit findings will also be reported to the national maternity team.

An item of note in relation to IEA2, 'Listening to Women and families' the LMNS, as part of the North East North Cumbria Integrated Care Board (NENC ICB), is to appoint two Independent Senior Advocates. The Ockenden Interim report recommended that Independent Senior Advocates must be available to families attending clinical follow up meetings and will report to Trust Boards and the LMNS. The outcome of the appointments is awaited, and an update will be provided in future papers.

As previously reported, IEA3 'Staff working together must train together' has continued to be a challenge for the Trust due to ongoing workload pressures and competing training demands of implementing Badgernet, Closed Loop Milk and Closed Loop Blood. Maternity multidisciplinary core competency training resumed on 7th November after being postponed throughout September and October. In addition, increasing the challenge further, the compliance metrics for CNST have been restricted to a 12 month consecutive period, reducing the amount of time that providers have been afforded to enable the target to be met. The trajectory for meeting 90% compliance of staff attending MDT training for the 12 month period of 6th December 2021 to 5th December 2022 is being closely monitored and mitigated for, however continues to represent a risk to the Trust.

4. HIGH LEVEL ACTION PLAN

Table 1 referenced in the Board Reference Pack (BRP) provides an amalgamated action plan comprising the residual actions from the interim report, the non-compliant actions as benchmarked against the final report, in addition to the first and second groups of partially compliant actions from the final report.

As previously reported to the Trust Board, referred to in Section 3.1, there is one outstanding partially compliant action from the interim report which continues to present ongoing challenges for the Directorate, as follows:-

IEA 3 (Interim) All Trusts are required to ensure 90% of all specialities take part in multi-disciplinary training.

There are ongoing challenges in achieving and maintaining 90% attendance of all specialities which is a requirement of both Ockenden and CNST as detailed above.

Work is underway to review the additional resource which is required to ensure that the uplift afforded to the Midwifery workforce, is sufficient to meet with the requirements of mandated obstetric core competency training and this will be reported in future papers.

The second group of partially compliant actions as benchmarked by the Trust against the final report are as follows: -

IEA 7 (7.1) Multidisciplinary Training, Staff who work together must train together
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.

All midwives, nurses and non-registered maternity staff are allocated time to attend an annual multidisciplinary core competency clinical skills training day as supported by the 'Maternity Services Training Needs Analysis'. Obstetric Consultants and Trainees are also allocated to attend this training within their rota, as are Anaesthetic Consultants. Multidisciplinary attendance at clinical skills is monitored weekly and is a key requirement for CNST compliance as well as Ockenden.

The recently updated Medical Workforce Strategy includes consideration for the ongoing and expanding demands of governance and audit within the Directorate. If successful, the business case would see expansion of the Consultant body, allowing sufficient allocation of time for those with governance and leadership roles within job plans.

The maternity department holds a variety of specific governance and audit meetings which range in frequency. Multidisciplinary attendance at these events is monitored to ensure they remain quorate as per their terms of reference.

The Trust recognises however that wider multidisciplinary attendance and access to these events is limited due to staffing and activity. Clinical staff are not allocated time within their rotas to attend governance and audit events and therefore attendance relies on workload acuity to enable staff to be released from duty. The Trust are exploring ways of enabling clinical staff to have improved access to governance and audit output through possible electronic/intranet solutions.

IEA 7 (7.2) Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.

The multidisciplinary clinical skills training day attended by all staff includes the use of SBAR (Situation, Background, Assessment, Recommendation) handover and is detailed in the Maternity Services Training Needs Analysis, this is further embedded within the multidisciplinary skills drills/simulations

IEA 7 (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 LMNS.

Human Factors has been included within maternity training since 2014. It forms a key consideration in the mandatory clinical skills day and is also a focus within skills drills/simulations. Content has developed in response to local incidents, national guidance and reports. The Maternity Services Training Needs Analysis has been updated to reflect the Ockenden recommendation stipulating the inclusion of psychological safety and civility, and these principles are now within the revised programme. The LMNS has oversight of the Trust's Training Needs Analysis and has therefore accepted the human factor training content.

IEA 7 (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.

The 'Maternity Training Needs Analysis' details a 3-year plan to include the emergency scenarios identified in NHS England's Core Competency Framework and also aligns with CNST and Ockenden requirements within the Clinical Skills day training programme. These scenarios are tailored to respond to learning from local cases and include changes to policies and guidelines.

The Trust has developed a programme of 'live' or 'in-situ' emergency drills. These are monthly, unanticipated and unannounced multidisciplinary simulations involving Maternity, Neonatal and Anaesthetic input. They are conducted following an assessment to ensure they are safe to proceed. The simulations help the Trust to test systems, processes and ergonomics and also address locally identified learning needs following incidents (for

example opening a third theatre and transfer to Delivery Suite from Newcastle Birthing Centre).

IEA 7 (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.

The mandatory clinical skills training day includes emergency skills and CTG training. The current trajectory is that all clinical staff available to work (not absent due to maternity or sickness absence) will have attended their annual mandatory clinical skills training by December 2022.

Supplementary CTG training is available to all clinical staff via the external online 'K2' training system. All clinical staff are encouraged to complete this prior to their attendance at clinical skills training and prior to their rotation to Delivery Suite. This is not currently mandatory, unlike the clinical skills training, however, work is ongoing to further embed this as a quality improvement initiative within the Department. Completion of the full K2 CTG training package takes 7.5 hours and currently stands at 49% for Midwives (71% for Delivery Suite Core Team) and 47% Medical staff.

IEA 8 (8.3) <u>Complex Antenatal Care</u>
NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.

The trust are mainly compliant with NICE Guidance with the exception of the Gestational Diabetes Mellitus (GDM) Clinic which does not currently have Dietitian support. Dietetic advice is currently provided by the Specialist Diabetic Support Midwives and Obstetricians. The Directorate are currently in the process of scoping the required Dietitian support for the GDM clinic.

The Trust are also in the process of updating Local Pregnancy and Diabetes Guidance with expected completion early 2023. Of note, the Trust offers additional service provision of colostrum harvesting for women with diabetes and diabetic screening for all pregnancies affected by Polyhydramnios (raised amniotic fluid levels) and Suspected Macrosomia (significantly large Fetus), this is additional to NICE guidance.

IEA8 (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.

It is anticipated that the implementation of Badgernet electronic maternity record will enable improved access and signposting to electronic sources of evidence-based information, while also enabling the sharing of information and advice to be more easily captured for evidence of joint discussion and audit purposes.

IEA 10 (10.3) Labour and Birth
Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.

As previously discussed, the Newcastle Birthing Centre (NBC) is included within the programme of unanticipated/unannounced MDT drills.

The NBC also run their own birth-centre specific drills, particularly when there is a new rotation of staff, a new cohort of students or in response to learning from local incidents. These are dependent on staffing and workload; a total of 3 have been undertaken in 2022, the last being in March 2022 which simulated a transfer from the Birth Centre to the obstetric theatre

(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.

The Trust currently provide this information in discussion with women but do not have a formal process for providing this detail in writing. Work is currently underway to produce an information leaflet based on data collated from transfers over the past 12 months.

The implementation of Badgernet electronic patient record ensures transfer time to obstetric unit will be discussed and documented as part of the 'Homebirth Risk Assessment' for parents requesting a homebirth. It will also be possible to attach an electronic version of the information leaflet to the patient record in Badger Notes.

(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.

The Trust Induction of Labour (IOL) Pathway has been developed to align with National Guidance (NICE Guideline 207 Inducing Labour) however this does not include guidance on pathways for delays to IOL. The Trust is currently reviewing the local guideline to incorporate this recommendation.

The Trust currently manages any delays to IOL due to staffing or high activity on an individual shift basis with oversight from the Delivery Suite Coordinator and Obstetric Consultant on Call. Prioritisation of workload is dependent on the expert knowledge and experience of the Coordinator and Consultant and the continuously changing nature of activity on Delivery Suite where IOL takes place.

5. DIGITAL HEALTH RECORDS

5.1 Implementation of BadgerNet

A 'go-live' implementation date is planned for 5th December 2022. There are a number of competing demands which are currently being worked through to ensure that this launch date is achieved, including the testing of key technical elements of the platform. Training staff is a significant undertaking both with regard to the number of staff the service can release for training at any one time, together with the available capacity of digital trainers within the Trust. However, robust plans are in place with a planned trajectory to meet the target date. Training is currently progressing well and on a trajectory to meet with the 90% target of the workforce having received their training.

The launch of other digital platforms is also planned simultaneously, both Closed Loop Milk and Closed Loop Blood, the Directorate continues to work closely with the digital project team to ensure that plans remain on track. Issues which may arise which place a risk to the intended launch date will be reported by exception to the Executive Directors.

6. MATERNITY WORKFORCE PLANNING AND INVESTMENT

6.1 Midwifery Workforce

Workforce is a core feature of the final Ockenden report and members of the Trust Board will recall that the final publication advises that organisations must now consider an immediate and essential action in ensuring safe midwifery staffing plans are in place, particularly in relation to any further rollout associated with a model of Continuity of Carer.

Staff were consulted on the proposal for Continuity of Carer through a formal organisational change process, which concluded in August 2022. Following this, a further staffing review was undertaken to inform the Trust's position in relation to further rollout and based on this review, a revised recommendation was presented to the Trust Board in September, reducing the proposal initially presented. This revised proposal aligned to the change in direction and recommendations by NHSEI which were notified to the Trust in September 2022.

Whilst it is difficult to predict with accuracy what the position will be throughout 2023, it is likely that staffing within the maternity service will continue to be a challenge given that the number of available midwives currently undergoing programmes of training will be insufficient to meet the demand both across the region and nationally. This coupled with a potential higher turnover, sickness absence, and poor staff morale makes for an increasingly challenging picture. Midwifery staffing is discussed in more detail within the Nursing and Midwifery Staffing Paper which is presented to Trust Board.

7. ITEMS OF RELEVANCE OUT-WITH OCKENDEN

7.1 CQC survey 2021

The CQC Survey (2021), reported through Picker in 2022, outlined a number of areas for the Trust associated with the provision of emotional and maternal mental health, which could be improved upon. A task and finish group, in partnership with the MVP, has been working closely on the findings, creating actions to support improvements in these areas.

A number of the actions align with key areas which are also a focus for the Maternal Mental Health Alliance (MMHA) in their 'Make All Care Count' campaign. The Service appointed a Specialist Midwife for Perinatal Mental Health earlier this year, which will support the strengthening of pathways and bring a greater spotlight to holistic care and specifically those areas associated with maternal emotional and psychological health.

7.2. Reading the signals - Maternity and neonatal services in East Kent – the Report of the Independent Investigation, Dr Bill Kirkup, CBE

The Report was published on 19th October 2022, following a review of the care of 202 cases which occurred between 2009 and 2020. The report is different in that it has not sought to make detailed recommendations to practice or management, in contrast to Ockenden, instead the report highlights 4 key areas for action:

1. **Monitoring safe performance – finding signals among noise: -**
    - The report is critical of the usefulness of the information currently collected and reported by maternity services and highlights issues using league tables.
    - The report proposes that measuring key outcomes improves scope to improve effectiveness and patient safety. It therefore recommends:

i. Producing a meaningful set of clinically relevant outcome measures (related directly to outcomes that are risk adjustable, already available, and timely) that are national and mandatory.

ii. The outcome measures are analysed and presented to show the "noise" attributable to the random variation in all measures and occurrences but highlight trends and outlying events that are not attributable to random variation known as the "signal".

Recommendation 1: The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.

2. Standards of clinical behaviour – technical care is not enough: -

- The report highlighted patterns of unprofessional behaviour amongst staff and toward families, describing care lacking kindness, compassion, and empathy.
- The report also stresses the importance of listening to patients and families.

Recommendation 2:
Those responsible for undergraduate, postgraduate, and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.

Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.

3. Flawed teamworking – pulling in different directions

- The report found dysfunctional teamworking within and across professional groups resulting in lack of trust, conflict, lack of sharing information and tendency toward blame.
- The report also highlighted the lack of common purpose and diverging objectives between midwives and obstetricians, and also poor morale amongst obstetric trainees.

Recommendation 3:
Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how team working in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives, and training from the outset.

Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, team working and development.

4. Organisational behaviour – looking good while doing badly

- The report is critical of East Kent's denial, deflection, and concealment in prioritising the management of its reputation whilst denying opportunity to learn and improve when things went wrong.
- This behaviour also led to parents and families experiencing further trauma and harm by denying them knowledge and truth about what went wrong.

Recommendation 4:
The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.

Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.

NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.

The Directorate is further considering the findings arising from the East Kent Report, the work which is required at provider level, system-wide, and nationally, and the impact of this for the Trust. Further updates will be provided in future papers.

8. RISKS

As discussed in point 4 above, due to a number of competing demands, together with a change in the requirement in relation to CNST compliance, an ongoing risk is identified in relation to achieving 90% of multi-disciplinary core competency training across each speciality within the service.

BadgerNet and Closed Loop Milk training has been modified to reduce the burden on staff in their preparedness for digital readiness, and to support ongoing core competency training. However, staffing pressures have significantly increased the challenge in meeting with a 90% training compliance which currently stands at 77%, and detailed work is in progress to mitigate the emergent risk and achieve the required 90% by December 2022.

Close monitoring of staffing resource is a continuous process and escalation plans have been made to ensure the continued provision of safe services, whilst simultaneously working towards achieving the agreed targets of these competing demands. The Service continues to work on revised training plans and any further identified risk in relation to training and/or digital implementation will be reported in a timely manner to the Executive Directors by exception.

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

9. CONCLUSION

The Trust has continued to make 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 Quality Committee, and members of the Trust Board since that time.

There remain outstanding actions of note, which relate specifically to risk assessment, personalised care planning, and the support which is required from a maternity specific electronic patient record.

Formal feedback arising from the regional/system insight visit has been reported within this paper and a summary of key points presented. Key themes arising from the insight visit include the need to strengthen audit, quality improvement and intervention processes. The need for audit to evidence and embed learning and change from serious incidents, complaints and claims. Further work has been advised to involve the Maternity Voices Partnership in co-production of the Trust website and to ensure service user voice representation at triumvirate and safety champion meetings. The insight visit also recommended improving the profile and visibility of the NED Safety Champion to enable staff reporting of safety concerns directly to board. The Directorate continues to work toward achieving the recommendations made from the Interim report and insight visit.

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. This paper continues a phased reporting approach providing detail and required actions on a further ten of the 32 partially-compliant recommendations for the Trust. Status updates are provided on previously reported non and partially compliant recommendations that were detailed in the July and September Ockenden update reports.

This paper also acknowledges the publication of the East Kent Report, highlighting the 4 Key Areas for Action that require consideration and incorporation into ongoing quality improvement work within maternity services.

10. 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
24 November 2022

The Newcastle upon Tyne Hospitals NHS Foundation Trust

APPENDIX 1

Table 2 – Interim Report			
Immediate Essential Action		Brief Descriptor	Compliance
Section 1		IEA 1-7	**(added regrading from regional insight visit feedback)**
IEA 1: Enhanced Safety	Q1	Local Maternity System (LMNS) regional oversight to support clinical change - internal and external reporting mechanisms for key maternity metrics in place.	Compliant
	Q2	External clinical specialist opinions for mandated cases.	Compliant (regraded partial compliance)
	Q3	Maternity Serious Incident (SI) reports sent jointly to members of the Trust Board (not sub board) & LMNS quarterly.	Compliant
	Q4	National Perinatal Mortality Review Tool (PMRT) in use to required standard.	Compliant
	Q5	Submitting required data to the Maternity Services Dataset.	Compliant
	Q6	Qualifying cases reported to HSIB & NHS Resolution's Early Notification scheme	Compliant
	Q7	A plan to fully implement the Perinatal Clinical Quality Surveillance Model (Trust/LMNS/ICS responsibility).	Compliant
	Q8	Monthly sharing of maternity SI reports with members of the Trust Board, LMNS & HSIB.	Compliant
IEA 2: Listening to Women and Families	Q9	Independent Senior Advocate Role to report to Trust and LMNS.	n/a Awaiting appointment
	Q10	Advocate must be available to families attending clinical follow up meetings.	n/a Awaiting appointment
	Q11	Identify a non-executive director for oversight of maternity services – specific link to maternity voices and safety champions.	Compliant
	Q12	National Perinatal Mortality Review Tool (PMRT) in use to required Ockenden standard (compliant with CNST).	Compliant
	Q13	Robust mechanism working with and gathering feedback from service users through Maternity Voices Partnership (MVP) to design services.	Compliant

	Q14	Bimonthly meetings with Trust safety champions (obstetrician and midwife) & Board level champions.	Compliant
	Q15	Robust mechanism working with and gathering feedback from service users through MVP to design services.	Compliant
	Q16	Identification of an Executive Director & non-executive director for oversight of maternity & neonatal services.	Compliant
IEA 3: Staff Training & Working Together	Q17	Evidence of multidisciplinary team (MDT) training and working validated by LMNS 3 times a year. All professional groups represented at all MDT and core training.	Compliant
	Q18	Twice daily (over 24hrs), 7-days a week consultant-led multidisciplinary ward rounds.	Compliant
	Q19	Trust to ensure external funding allocated for the training of maternity staff is ring-fenced.	Compliant
	Q20	Effective system of clinical workforce planning (see section 2).	Compliant
	Q21	90% attendance for each staff group attending MDT maternity emergencies training session (with LMNS oversight and validation).	Partial Compliance
	Q22	Twice daily (over 24hrs), 7-days a week consultant-led multidisciplinary ward rounds	Compliant
	Q23	Evidence of multidisciplinary team (MDT) training and working validated by LMNS 3 times a year. All professional groups represented at all MDT and core training.	Compliant
IEA 4: Managing Complex Pregnancy	Q24	Maternal Medicine Centre (MMC) Pathway referral criteria agreed with trusts referring to NUTH for specialist input.	Compliant (regraded partial compliance due to need for audit)
	Q25	Women with complex pregnancies (whether MMC or not) must have a named consultant lead.	Partial Compliance (regraded compliant)
	Q26	Early specialist involvement and management plans must be agreed where a complex pregnancy is identified.	Compliant (regraded partial compliance due to need for audit)
	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 (regraded partial compliance due to need for audit)
	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 (regraded compliant)
	Q31	Risk assessment must include ongoing review of the intended place of birth.	Compliant (regraded partial compliance due to need for audit)
	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 (regraded partial compliance due to need for audit)
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 (regraded partial compliance due to need for website review)
	Q40	Accurate evidence-based information for maternity care is easily accessible, provided to all women and MVP quality reviewed.	Compliant (regraded partial compliance as above)
	Q41	Enable equal participation in all decision-making processes and Trust has method of recording this.	Compliant (regraded partial compliance – need for audit of

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

APPENDIX 2

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

Final Report **Immediate Essential Action**		Brief Descriptor IEA 1-15	Compliance
1. Workforce Planning and Sustainability: Financing a safe maternity workforce The recommendations from the 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.	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
. Workforce Planning and Sustainability: Training We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.	1.5	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.	Compliant
	1.6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	n/a National direction has changed since publication of Final report
	1.7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision making, learning through training in human factors, situational awareness, and psychological safety, to tackle behaviours in the workforce.	Non-compliant (no national module)
	1.8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Compliant
	1.9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	Partial compliance
	1.10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.	Partial compliance

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

	2.10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.	Compliant
3. Escalation and Accountability: There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	3.1	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between professionals.	Non-compliant
	3.2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	Compliant
	3.3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Compliant
	3.4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	Compliant
	3.5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	Compliant
4. 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. Clinical Governance – Incident investigation and complaints Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	5.1	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.	Compliant
	5.2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	Partial compliance
	5.3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.	Partial compliance
	5.4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	Partial compliance
	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.	Partial compliance
	5.7	Complaint's themes and trends must be monitored by the maternity governance team.	Partial compliance
6. Learning from Maternal Deaths Nationally all maternal PM examinations must be conducted by	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

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.	6.3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	To action once implemented by external stakeholder
7. Multidisciplinary Training Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	7.1	All members of the multidisciplinary team working within maternity should attend regular joint training, governance, and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	Partial compliance
	7.2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	Partial compliance
	7.3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	Partial compliance
	7.4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Partial compliance
	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	Compliant
	10.2	Midwifery-led units must complete yearly operational risk assessments.	Partial compliance
	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 services must prepare this information working together and in agreement with the local ambulance trust.	Partial compliance
	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	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

must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	11.5	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
	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.	Compliant
	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 (LMS/LMNS) quarterly.	Compliant
	14.3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	Compliant
	14.4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	Compliant
	14.5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	n/a
	14.6	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	Compliant
	14.7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.	Partial Compliance

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

Total Number of Recommendations (interim and final report combined)	97	100%
Non-applicable	12	n/a
Compliant	46	54.1%
Partial Compliance	36	41.4%
Non compliance	3	3.5%

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

APPENDIX 3

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 September 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 specialities take part in multi-disciplinary training. This has been challenging for the reasons reported in the Trust Board reports; a mechanism is in place for regular monitoring and reporting and cross referenced to the requirements for CNST. Close monitoring of the set trajectory continues; however, this is an area of increasing risk.	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 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 August 2022 showed a 71% compliance for named consultant. Completion of paper-based risk assessment remained low at 33%. EPR – implementation date 05.12.22

Immediate and Essential Action (IEA) Final Report Non-compliant elements	**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 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	TBC following further review and scoping exercise
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 Lead Midwife for Clinical Effectiveness	December 2022

Immediate and Essential Action (IEA) Final Report Non-compliant elements	Action which is required to meet recommendation	Lead/s	Completion Date
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 Heat of Obstetrics Lead Midwife for Quality and Clinical Effectiveness	January 2023
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. Work underway to ensure MVP have oversight and understanding of complaints process, consideration for annual complaints update to MVP group to be explored.	Directorate Manager Associate Director of Midwifery Head of Patient Experience Chair of MVP Link Midwife for MVP	January 2023
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; to be monitored and reported through local governance assurance framework. The process for monitoring themes and trends from complaints was presented to the Directorate Quality and Safety Group on 04th November 2022.	Directorate Manager Head of Obstetrics Lead Midwife for Quality and Clinical Effectiveness Patient Experience Coordinator	Review January 2023
IEA 10 Labour and Birth	10.2 Midwifery-led units must complete yearly operational risk assessments. Operational risk assessment in development (this is in alignment with existing Maternity and Trust Wide Risk Assessments as Newcastle Birthing Centre is 'in-hospital' unit). Any actions arising reported through local governance assurance framework.	Obstetric Lead for Intrapartum Care Matron for Intrapartum Care Lead Midwife for NBC	January 2023

Immediate and Essential Action (IEA) Final Report Partial-compliant part 1.	Action which is required to meet recommendation	Lead/s	Completion Date
IEA 1 Workforce Planning and Sustainability	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. Training plan in place to achieve 100% for existing core staff by May 2023. Further training planned for new core team members 2023.	Associate Director of Midwifery Matron for Intrapartum Care Delivery Suite Coordinators Practice Development midwife	May 2023
IEA 1 Workforce Planning and Sustainability	1.10 All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience. Maternity specific workforce strategy in development.	Clinical Director Associate Director of Midwifery	February 2023
IEA 2 Safe staffing	2.7 All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings. Currently only available for Delivery Suite. Further work is ongoing to explore expansion into all settings.	Associate Director of Midwifery Midwifery Matrons Practice Development midwife	April 2023
IEA 4 Clinical Governance: Leadership	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.	Clinical Director Associate Director of Midwifery Head of Obstetrics Lead Midwife for Quality and Clinical Effectiveness	Present to Board March 2023

	Benchmarking exercise expected completion Q4.		
Immediate and Essential Action (IEA) Final Report Partial-compliant part 1.	**Action which is required to meet recommendation**	**Lead/s**	**Completion Date**
IEA 4 Clinical Governance: Leadership	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. Scoping and job planning in progress, business case to be submitted.	Clinical Director Directorate Manager	TBC following scoping exercise
IEA 4 Clinical Governance: Leadership	4.5 All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis, and family engagement. Work ongoing, ensure senior leadership access suitable programs.	Clinical Director Associate Director of Midwifery Quality & Clinical Effectiveness Midwife Head of Obstetrics	May 2023
IEA 5 Clinical Governance: Incident investigation and complaints	5.2 Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan. Work ongoing within Training Needs Analysis. Professional leads for training involved in SI action plans, further work required to embed and monitor through audit.	Clinical Director Associate Director of Midwifery Quality & Clinical Effectiveness Midwife Head of Obstetrics	May 2023

IEA 5 Clinical Governance: Incident investigation and complaints	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. Audit process under development, first audit planned January 2023.	Clinical Director Associate Director of Midwifery Quality & Clinical Effectiveness Midwife Head of Obstetrics	December 2022
Immediate and Essential Action (IEA) Final Report Partial-compliant part 2.	**Action which is required to meet recommendation**	**Lead/s**	**Completion Date**
IEA 7 Multidisciplinary Training: Staff work together must train together. Staff should attend regular mandatory training. Rotas & Job planning needs to ensure all staff can attend.	7.1 All members of the multidisciplinary team working within maternity should attend regular joint training, governance, and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored. Ongoing monitoring of mandatory MDT training attendance. Further work required to enable wider accessibility and sharing of audit/governance outputs for staff not allocated this within their roles. Awaiting Business Case submission/approval for increase in Consultant Body.	Clinical Director Associate Director of Midwifery Head of Obstetrics Quality & Clinical Effectiveness Midwife Practice Development Midwife	April 2023
IEA 7 Multidisciplinary Training	7.2 Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts. Training with inclusion of SBAR ongoing.	Quality & Clinical Effectiveness Midwife Practice Development Midwife Intrapartum Obstetric Lead Head of Neonatology Obstetric Anaesthetic Lead	January 2023

IEA 7 Multidisciplinary Training	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 LMNS. Human factors training is included within mandatory MDT training day as part of Training Needs Analysis plan which has LMNS oversight. Requires further review aligned to this IEA.	Clinical Director Associate Director of Midwifery Quality & Clinical Effectiveness Midwife Practice Development Midwife Intrapartum Obstetric Lead	January 2023
Immediate and Essential Action (IEA) Final Report Partial-compliant part 2.	**Action which is required to meet recommendation**	**Lead/s**	**Completion Date**
IEA 7 Multidisciplinary Training	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. Monitoring of staff attendance of mandatory MDT training (which includes obstetric emergencies) ongoing. Monthly unannounced/unanticipated skills drills ongoing with 12 month plan in place.	Clinical Director Associate Director of Midwifery Practice Development Midwife Lead for Obstetric Skills Drills Matron for Intrapartum Care	January 2023
IEA 7 Multidisciplinary Training	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. Monitoring of staff attendance of mandatory MDT training (which includes obstetric emergencies and CTG training) ongoing. Work to support staff completion of K2 CTG training programme ongoing.	Clinical Director Associate Director of Midwifery Practice Development Midwife Matron for Intrapartum Care Lead Midwife for Fetal Monitoring	April 2023

IEA 8 Complex Antenatal Care	8.3 NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes. Scoping for Dietician to support GDM clinic underway – service provision currently by Specialist Diabetic Midwives and Obstetricians. Local Guidance under review.	Clinical Director Obstetric Consultants specialising in Diabetes Diabetic Specialist Midwife	February 2023
Immediate and Essential Action (IEA) Final Report Partial-compliant part 2.	**Action which is required to meet recommendation**	**Lead/s**	**Completion Date**
IEA 8 **Complex Antenatal Care**	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. Will be supported through implementation of Badgernet electronic patient record.	Clinical Director Obstetric Consultants specialising in Diabetes Lead Diabetic Support Midwife	April 2023
IEA 10 **Labour and Birth**	10.3 Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan. Newcastle Birthing Centre (NBC) is included within the programme of monthly unanticipated/unannounced MDT drills.	Clinical Director Lead Obstetrician for Skills Drills Intrapartum Matron NBC Manager	January 2023
IEA 10 **Labour and Birth**	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. Written leaflet in development. Completion of Badgernet Risk Assessment for Homebirth will detail this information and electronic version of leaflet can be attached within Badger Notes.	Matron for Community Services Lead Midwife for Quality and Clinical Effectiveness Community Team Leads	December 2022

IEA 10 **Labour and Birth**	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. Local guidance under review to reflect this recommendation.	Clinical Director Head of Obstetrics Intrapartum Obstetric Lead Intrapartum Matron	April 2023

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Appendix i

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The Newcastle upon Tyne Hospitals
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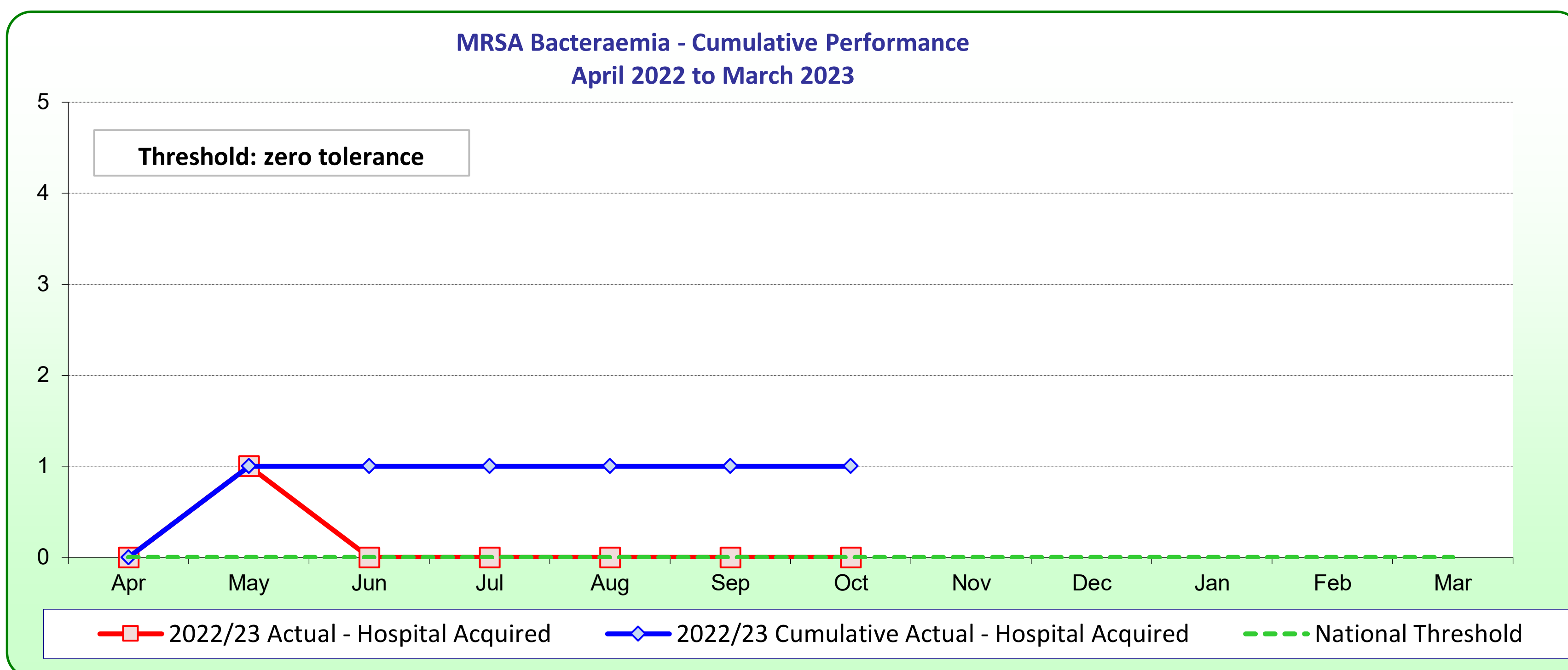
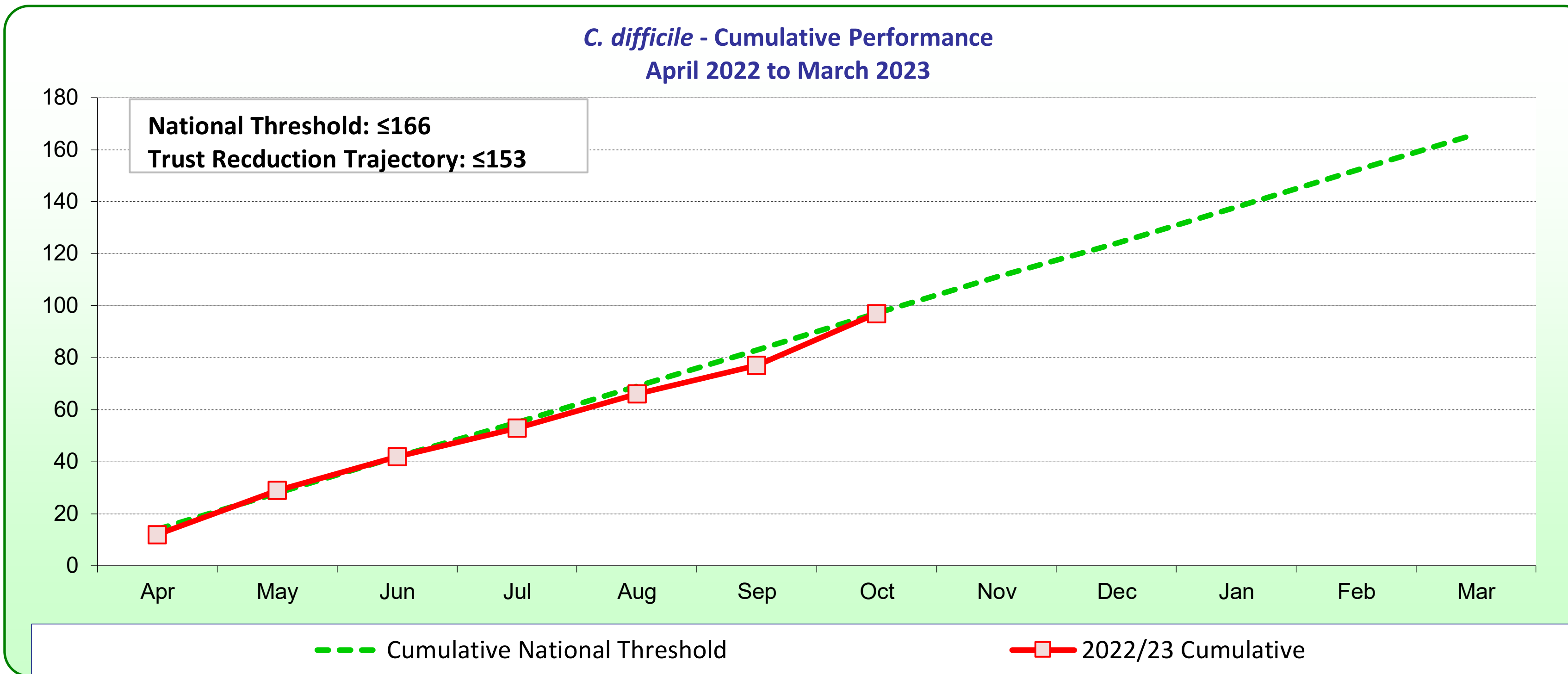
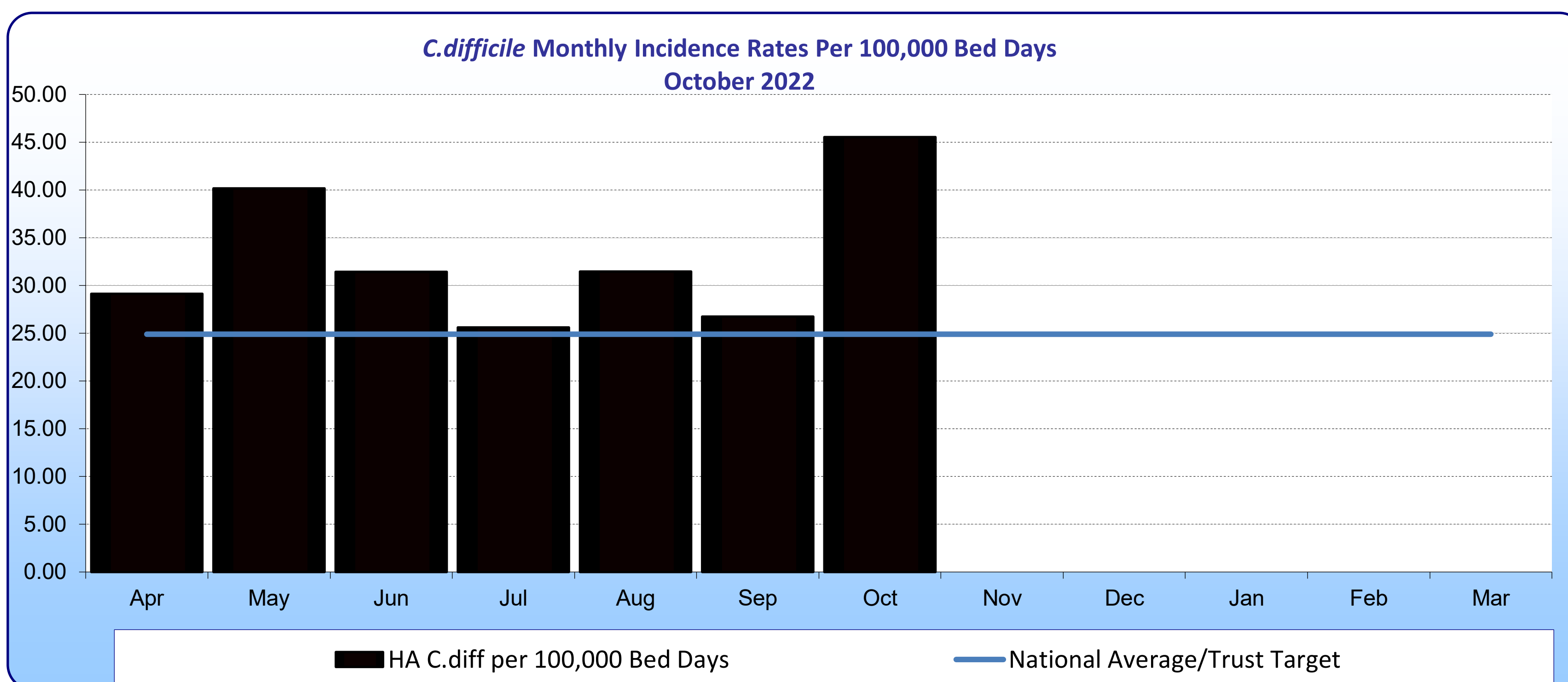
Healthcare-Associated Infections Report
October 2022

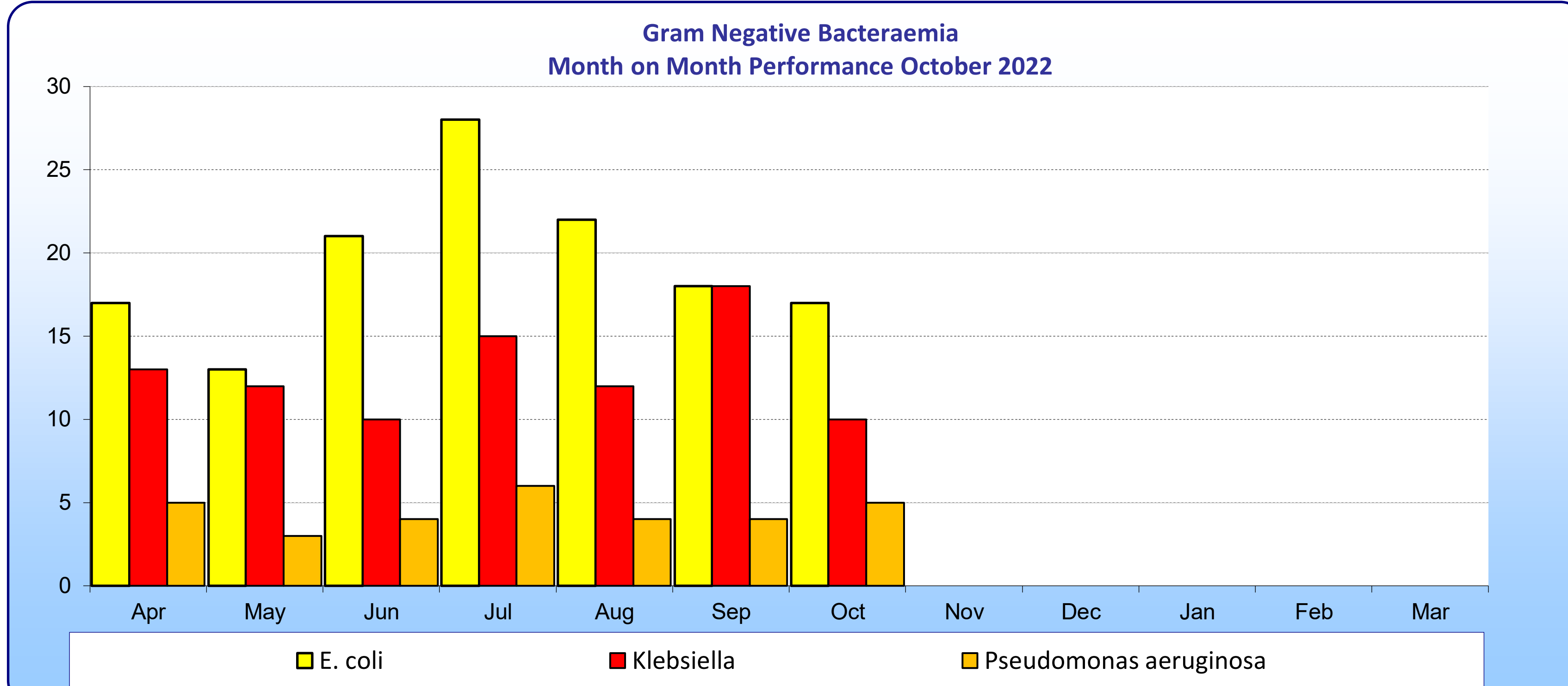
Healthcare-Associated Infection Report October 2022

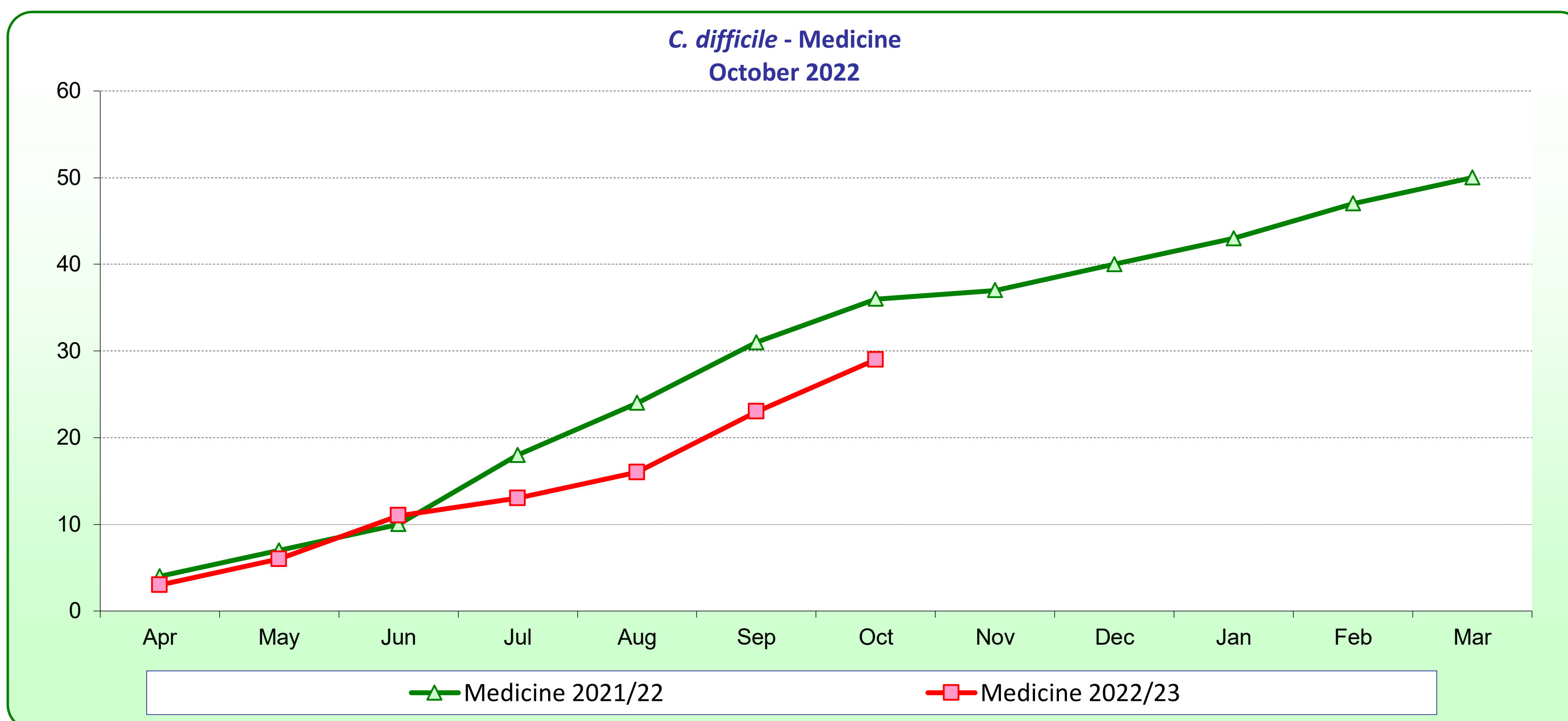
The Newcastle upon Tyne Hospitals NHS Foundation Trust

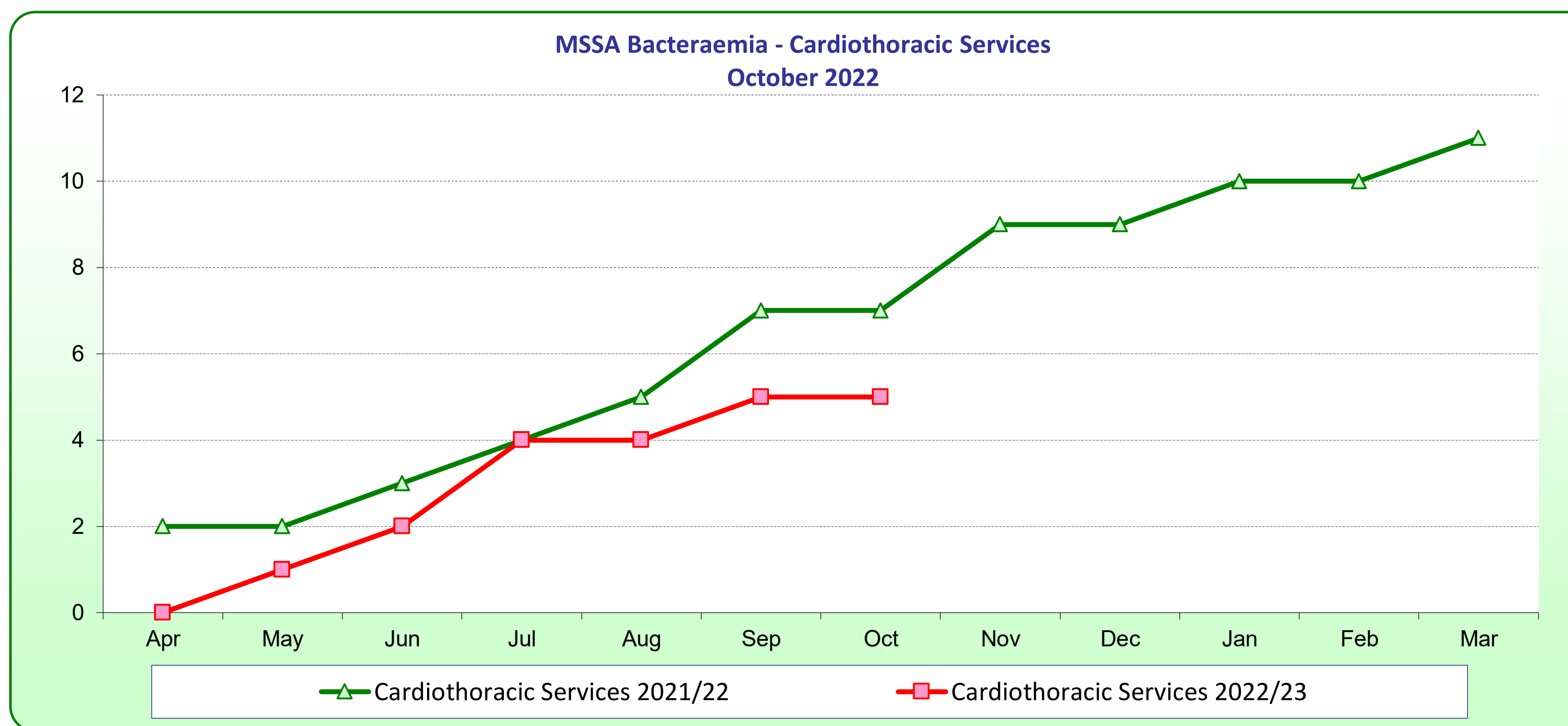






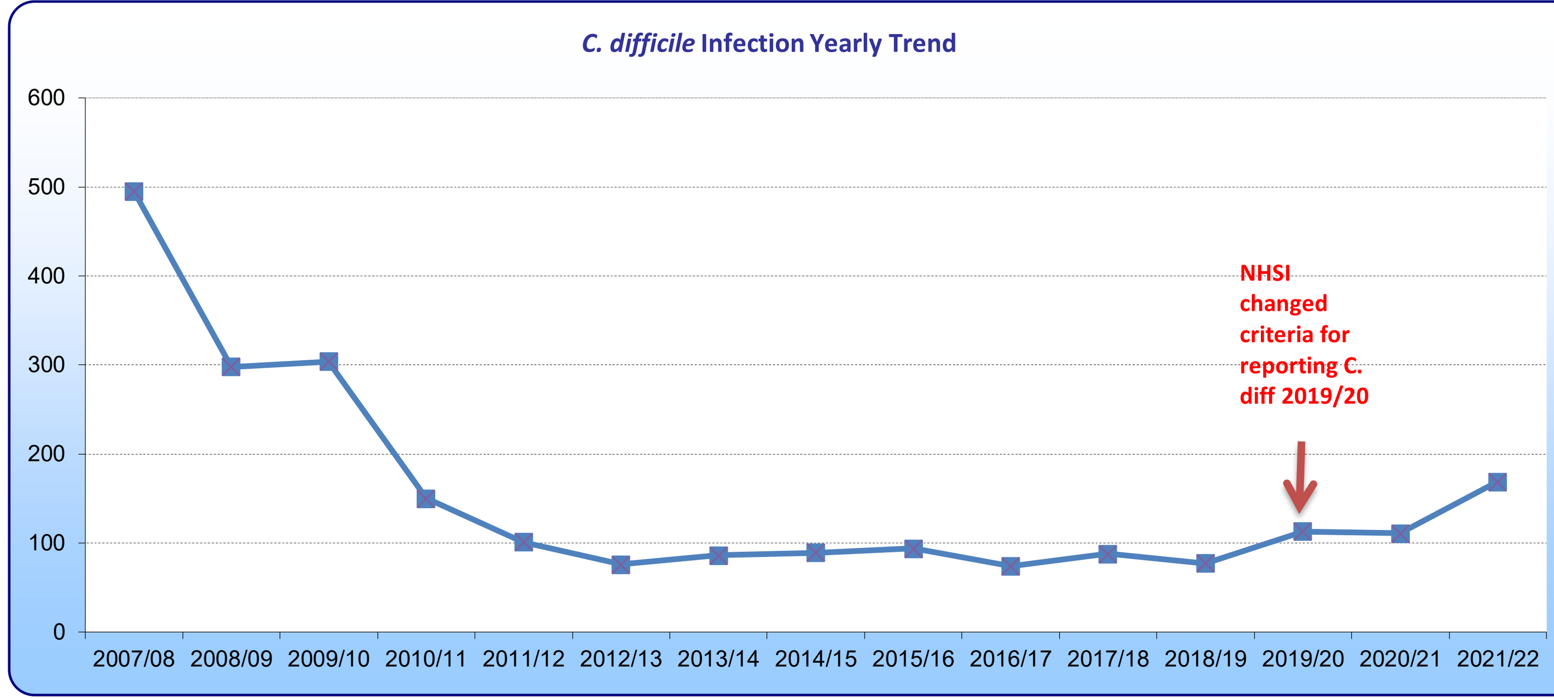


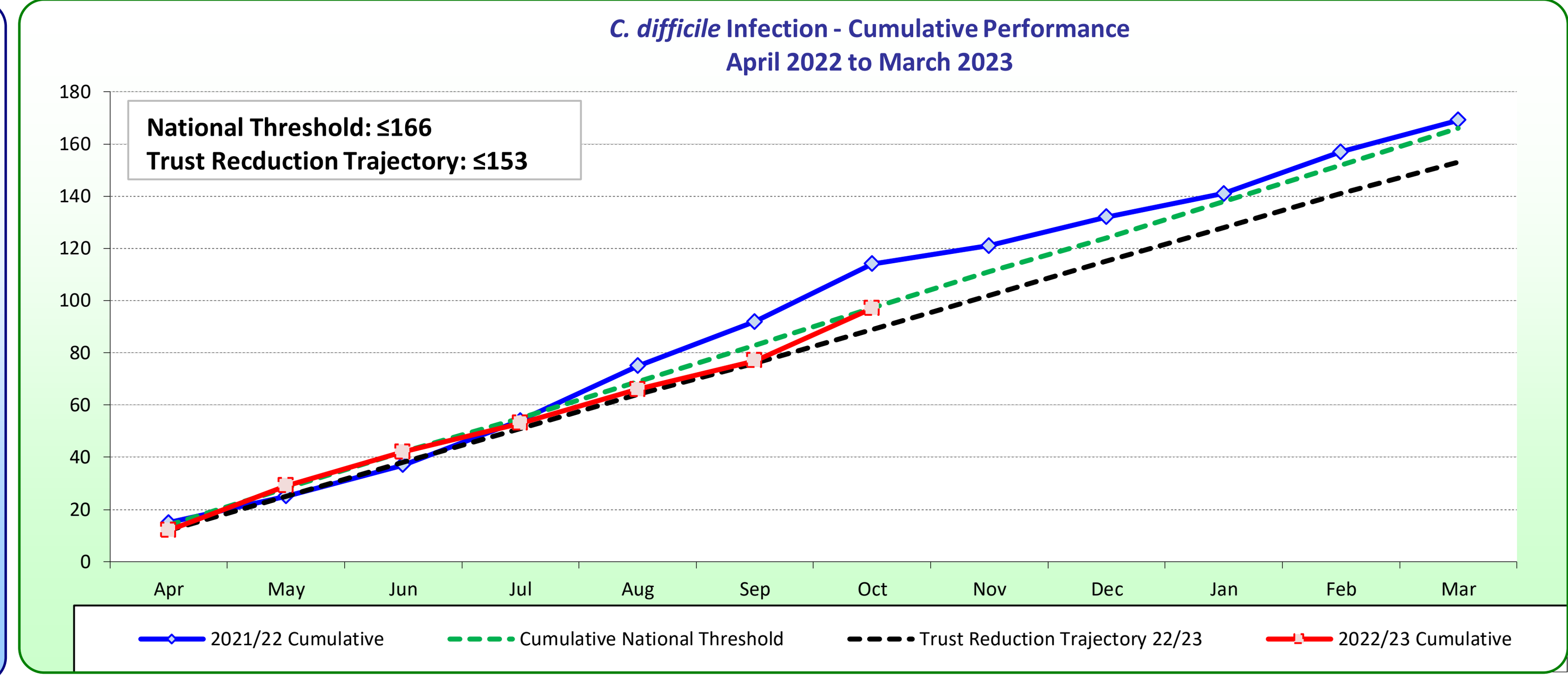


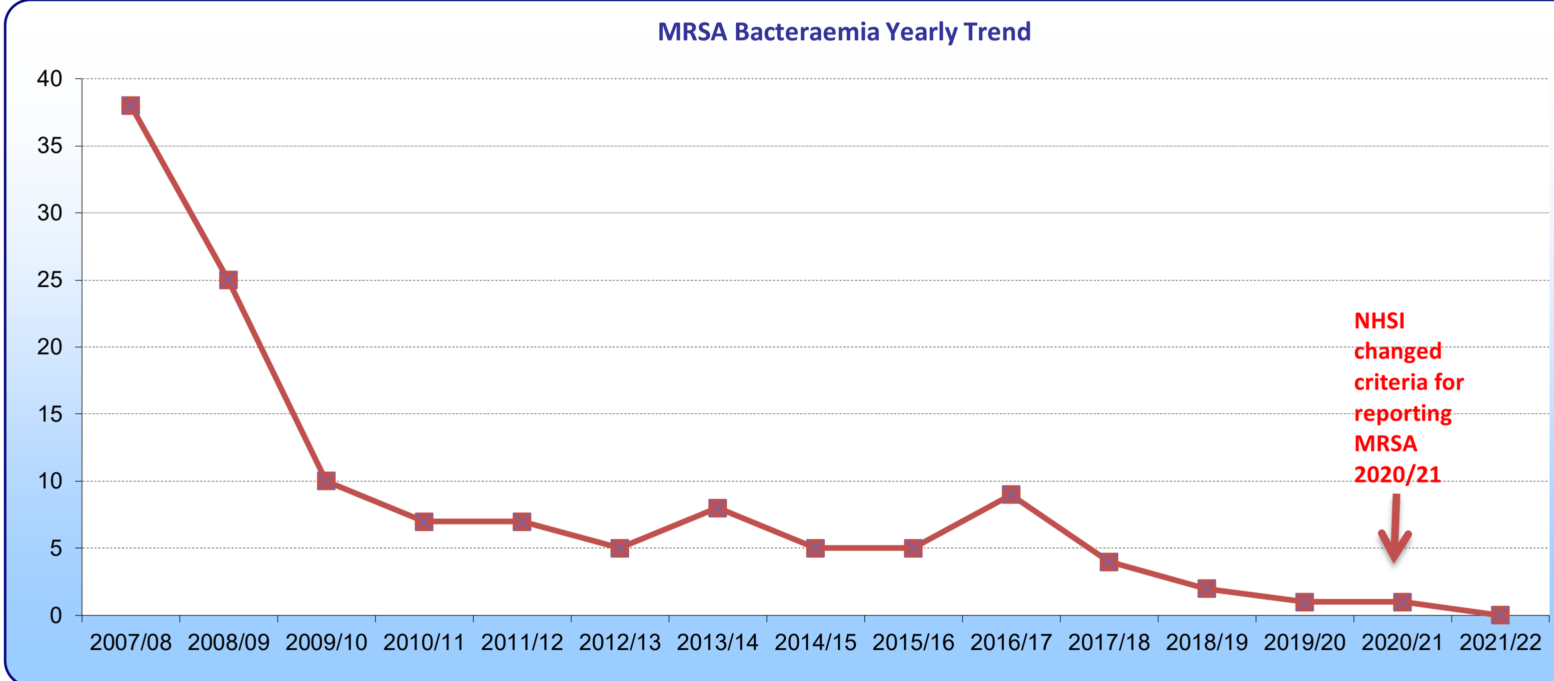


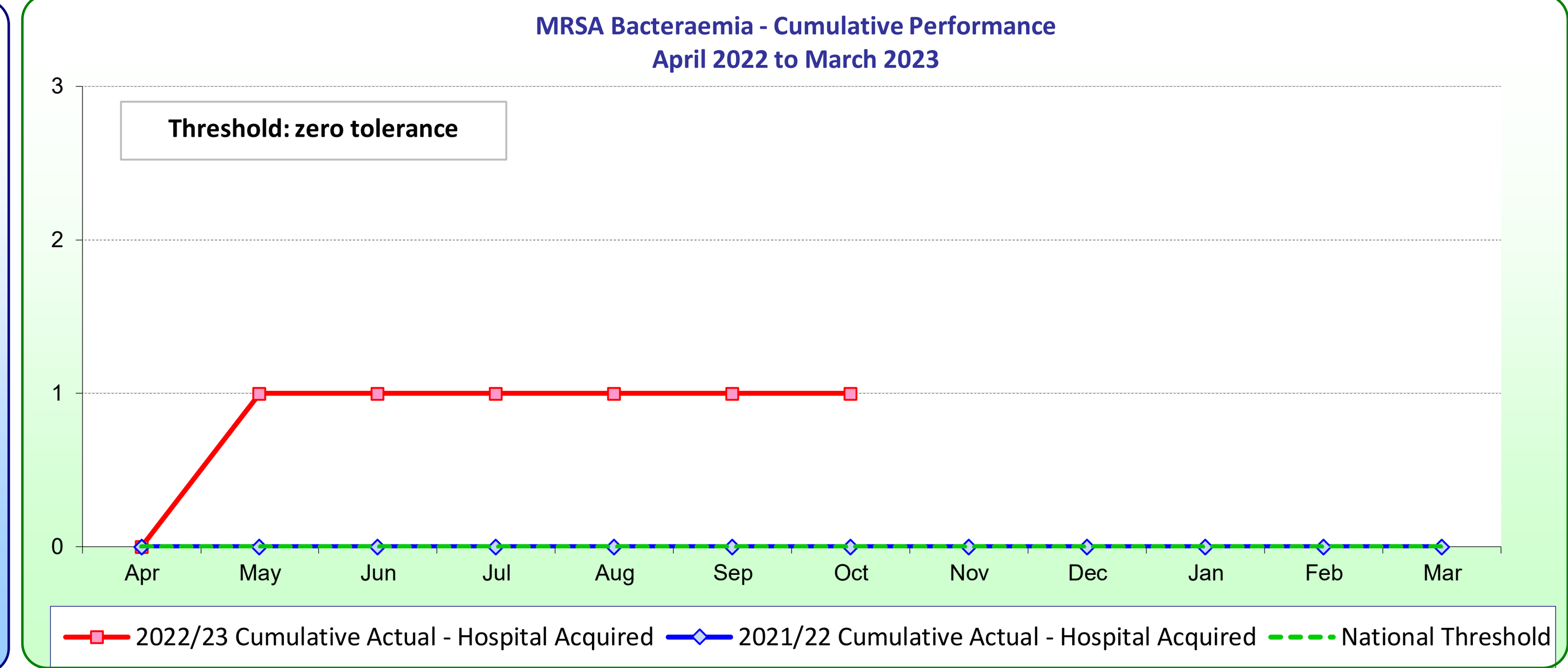
Healthcare-Associated Infection Report October 2022

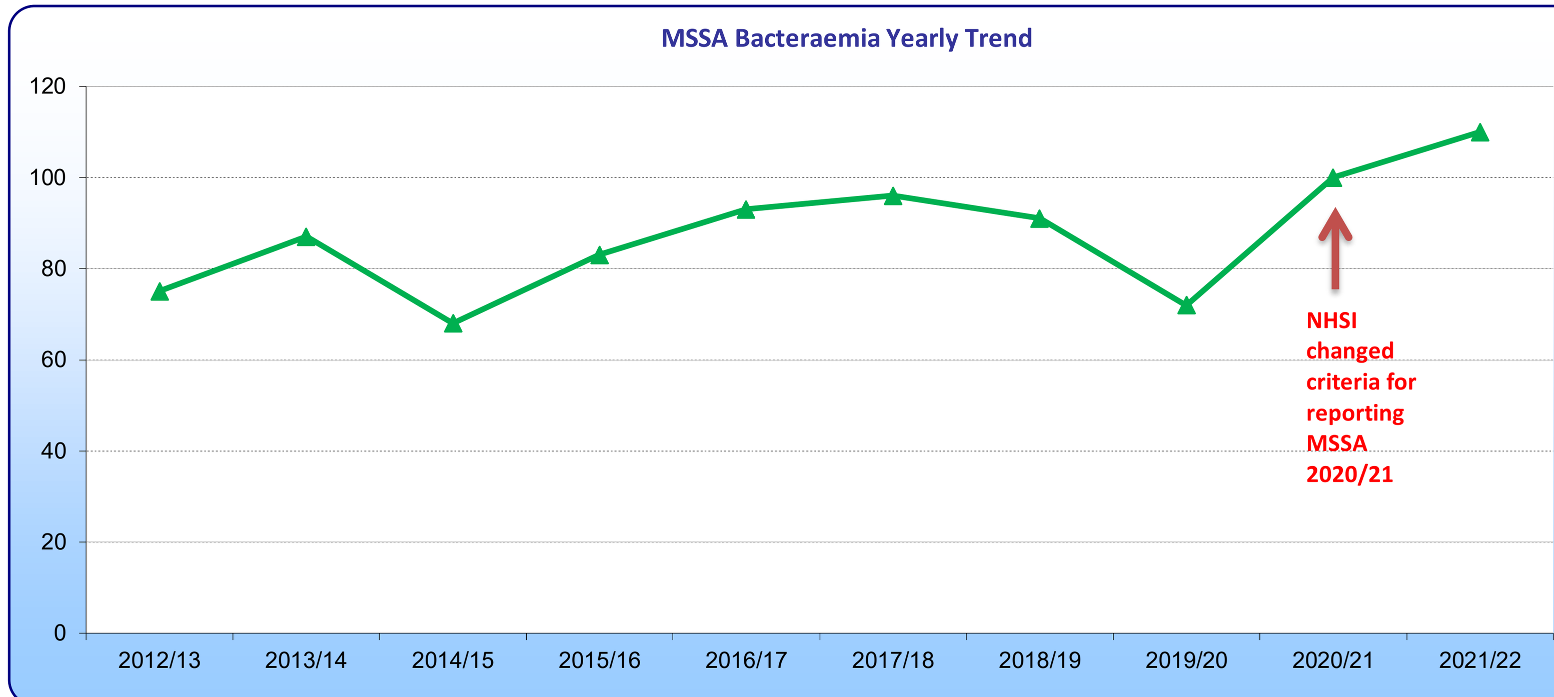
The Newcastle upon Tyne Hospitals NHS Foundation Trust

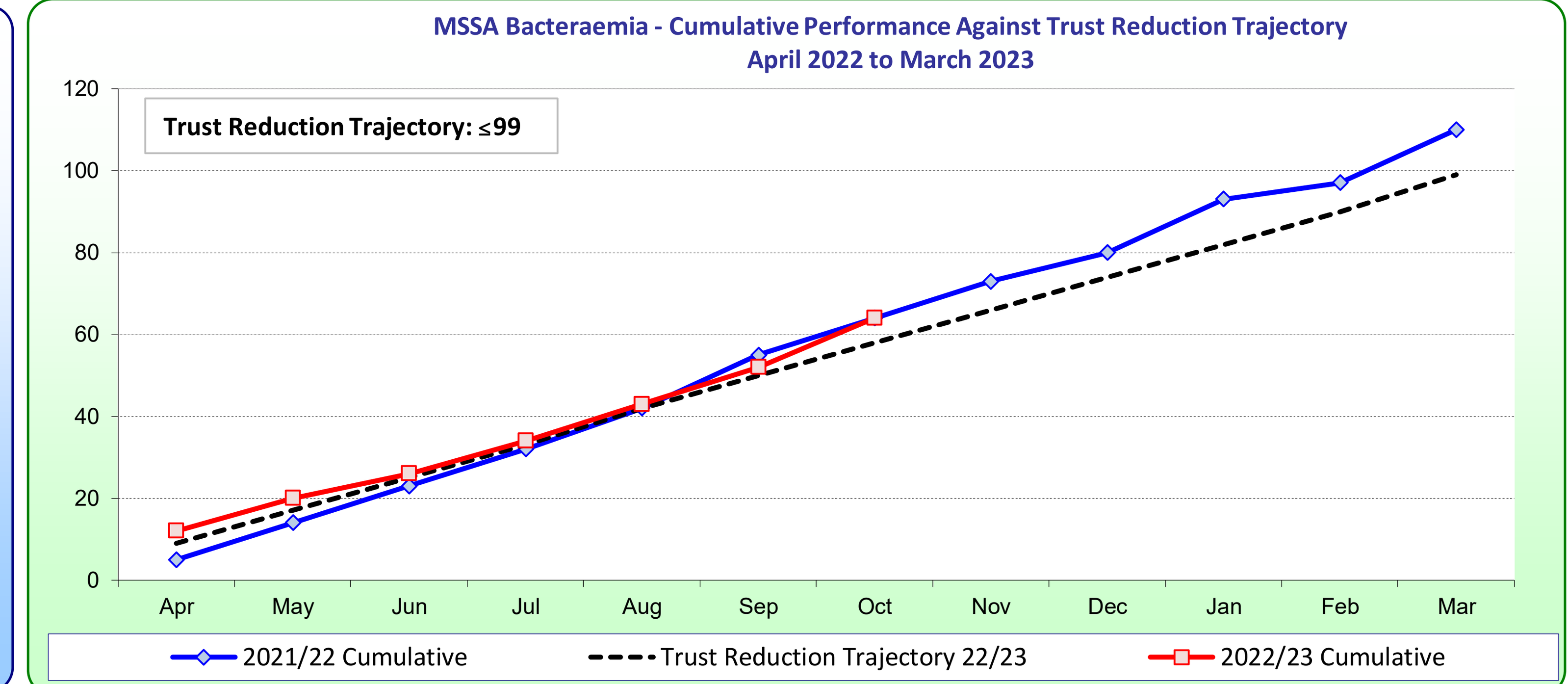


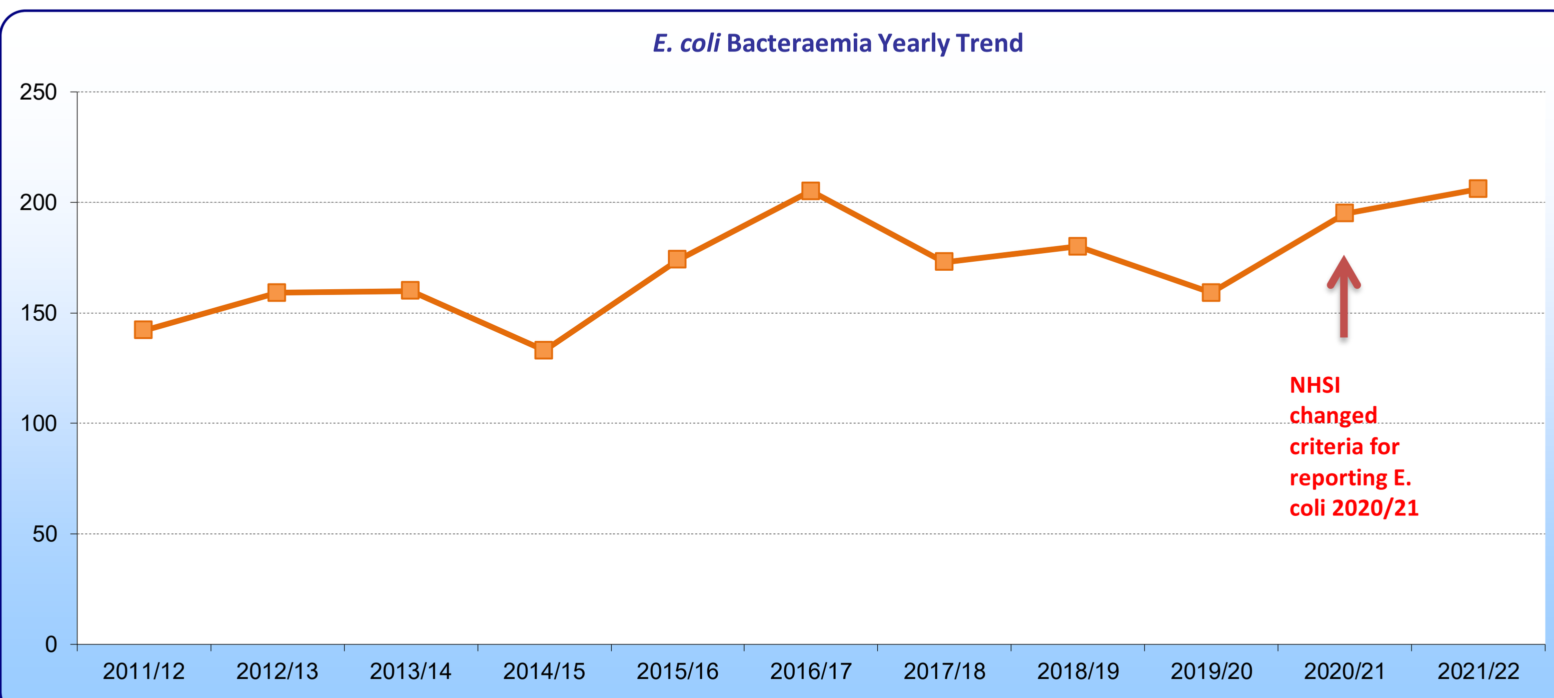


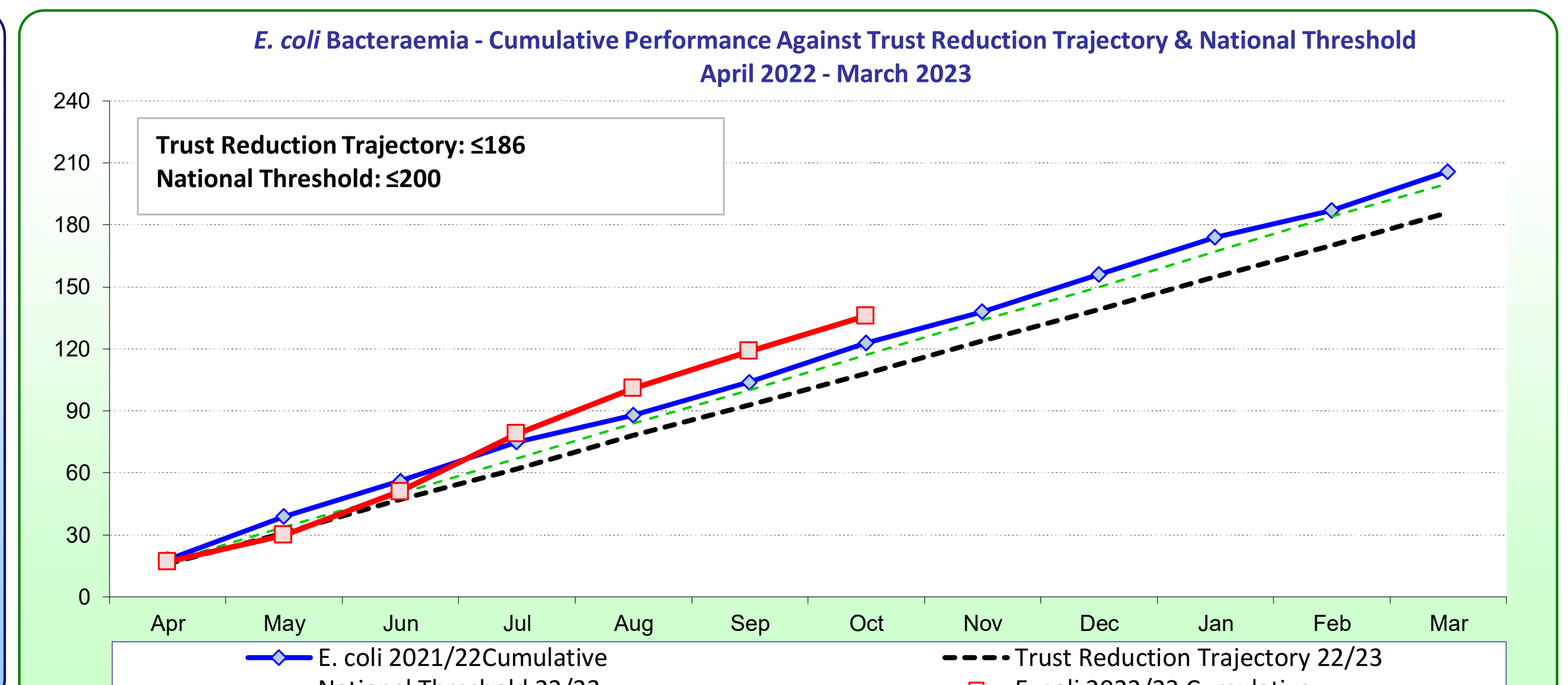


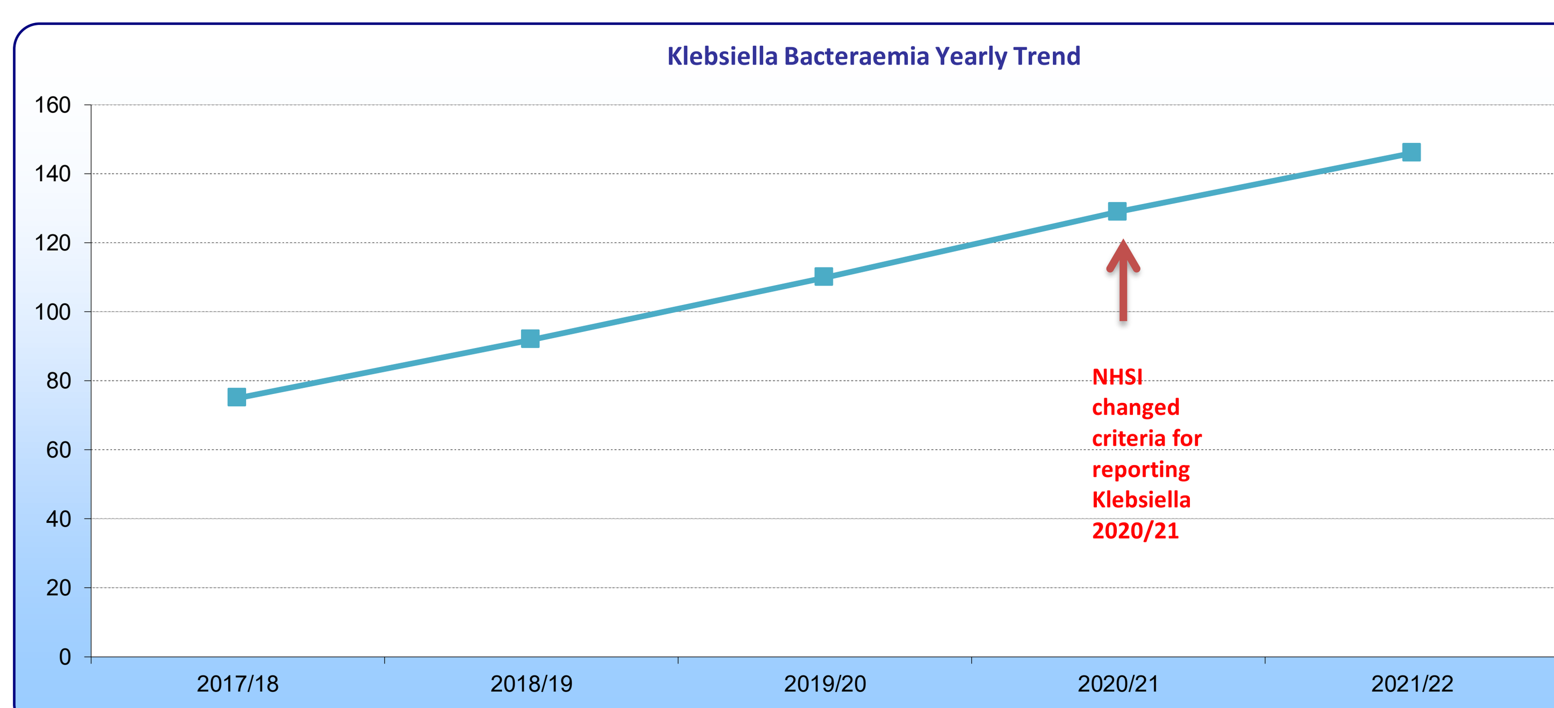


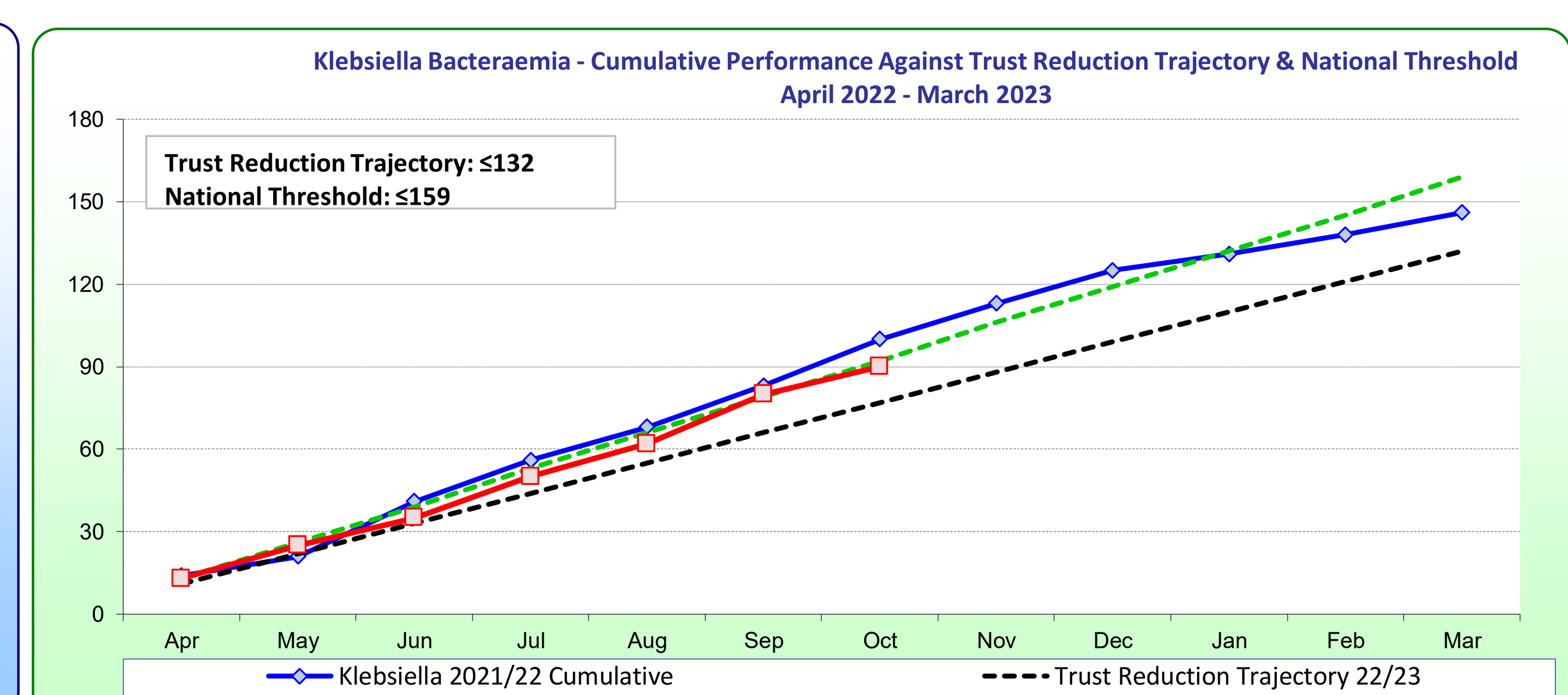


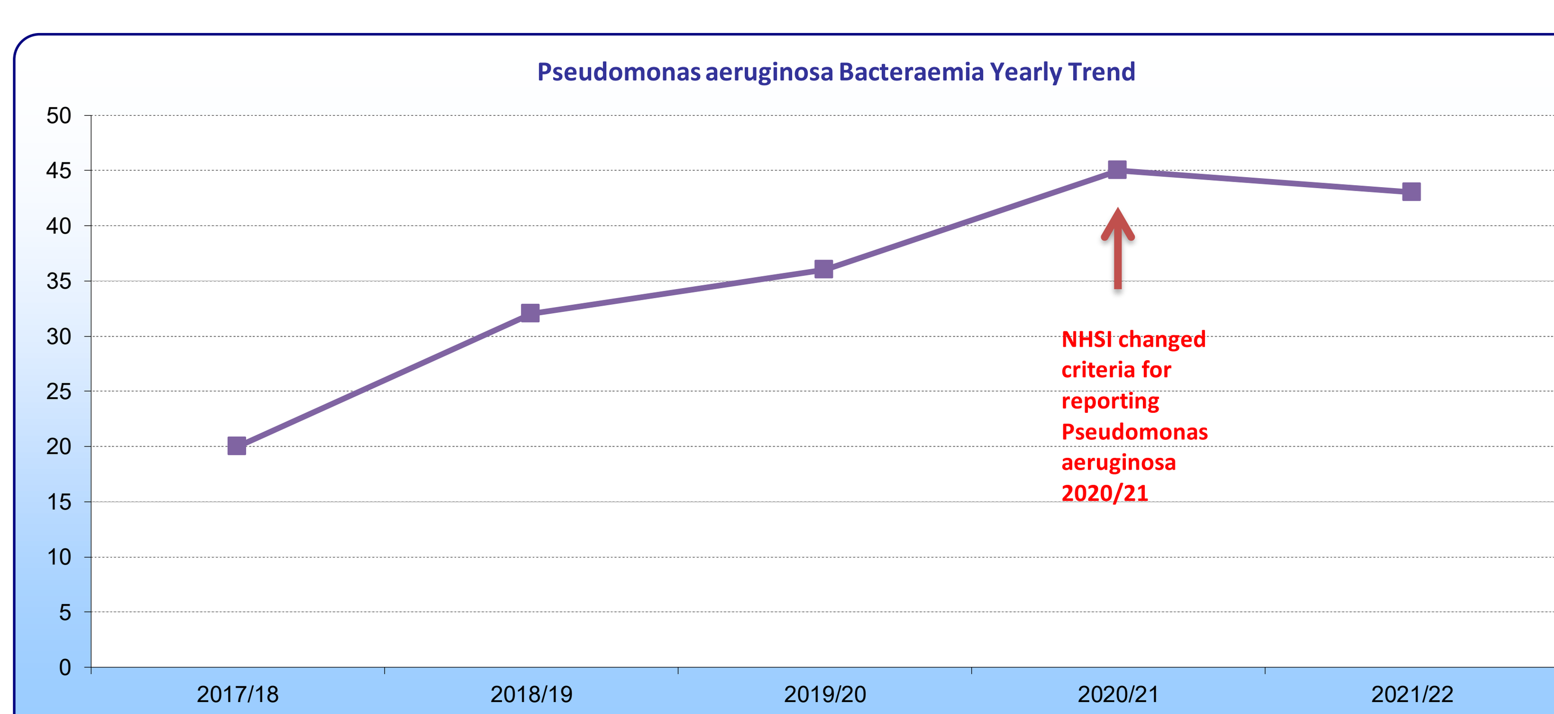


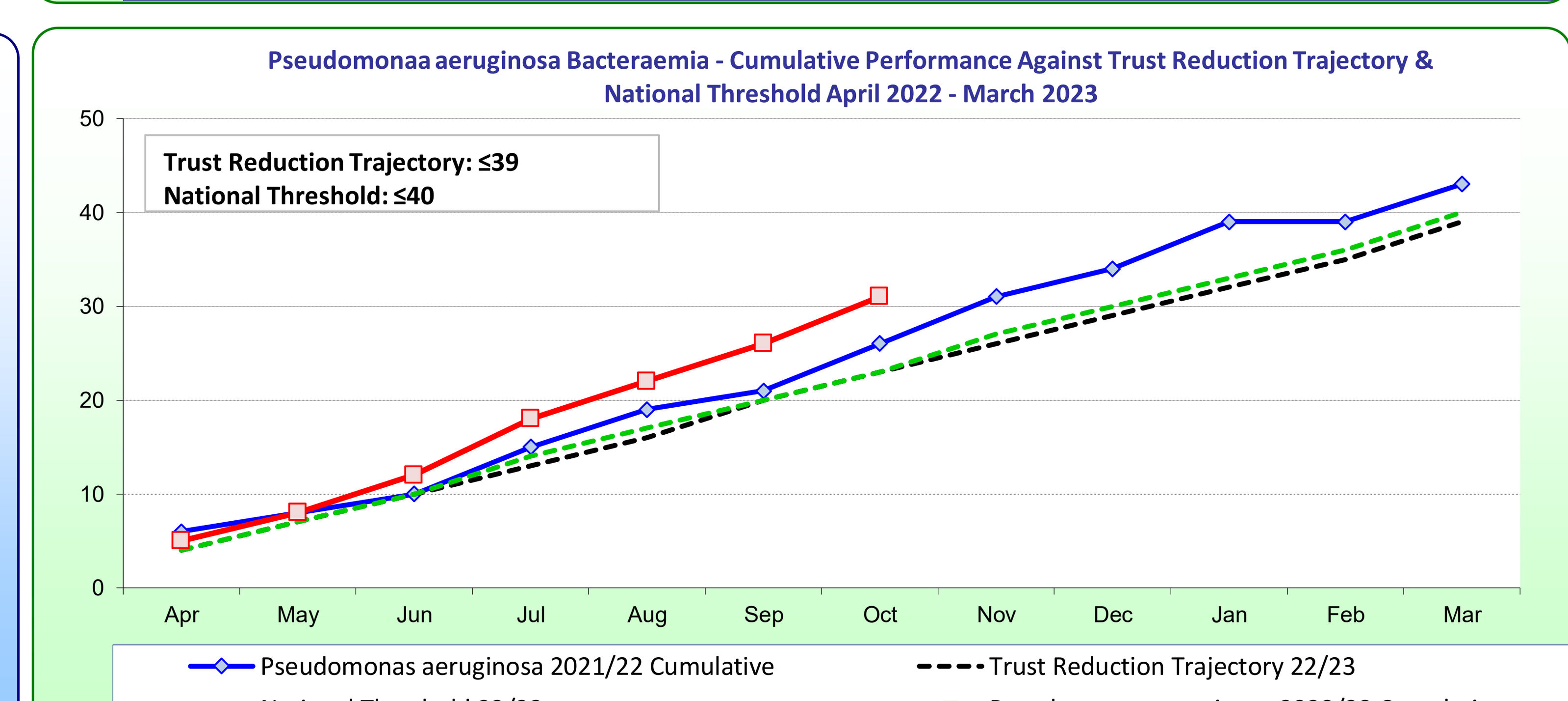












Healthcare-Associated Infection Report October 2022

The Newcastle upon Tyne Hospitals NHS Foundation Trust

IPC indicators (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
MRSA Bacteraemia - non-Trust	0	0	0	0	0	0	1						1
MRSA Bacteraemia - Trust-assigned (objective 0)	0	1	0	0	0	0	0						1
MRSA HA acquisitions	1	0	1	0	0	0	0						2
MSSA Bacteraemia - Healthcare Associated (local objective ≤99)	12	8	6	8	9	9	12						64
E. coli Bacteraemia - Healthcare Associated (local objective ≤186)	17	13	21	28	22	18	17						136
Klebsiella Bacteraemia - Healthcare Associated (local objective ≤132)	13	12	10	15	12	18	10						90
Pseudomonas aeruginosa Bacteraemia - Healthcare Associated (local objective ≤39)	5	3	4	6	4	4	5						31
C. diff - Hospital Acquired (national threshold not yet know; local objective ≤153)	12	17	13	11	13	11	20						97
C. diff related death certificates	-	-	2	3	0	0	0						
Part 1	-	-	1	0	0	0	0						
Part 2	-	-	1	3	0	0	0						

Periods of Increased Incidence (PIIs)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
C. diff - Hospital Acquired	2	4	1	0	1	2	3						13
Patients affected	5	8	3	0	1	4	6						27
COVID-19 - Hospital Acquired	7	1	2	1	1	1	2						15
Patients affected	22	2	4	4	6	2	7						47

Healthcare Associated COVID-19 cases (reported to DH)	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Hospital onset Probable HC assoicated (8-14 days post admission)	49	19	33	56	15	13	26						211
Hospital onset Definite HC assoicated (≥15 days post admission)	63	22	49	84	13	36	62						329

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	-	-	-	-	-	-	-						0
Patients affected (total)	-	-	-	-	-	-	-						0
Staff affected (total)	-	-	-	-	-	-	-						0
Bed days losts (total)	-	-	-	-	-	-	-						0
Other Outbreaks	2	0	0	0	0	0	0						2
Patients affected (total)	16	0	0	0	0	0	0						16
Staff affected (total)	0	0	0	0	0	0	0						0
Bed days losts (total)	48	0	0	0	0	0	0						48
COVID Outbreaks	4	2	10	11	3	6	9						45
Patients affected (total)	32	15	92	110	12	41	59						361
Staff affected (total)	0	2	4	0	13	9	4						32

C.diff Transit and Testing Times Target <18hrs	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Trust Specimen Transit Time	12:36	12:44	14:41	11:50	11:27	13:17	12:28						12:43
Laboratory Turnaround Time	04:04	02:43	03:06	03:03	03:18	03:05	03:19						03:14
Total to Result Availability	16:40	15:27	17:47	14:53	14:45	16:22	15:47						15:57

Clinical Assurance Indicators/Audits (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Adult IP; Children's IP; Community HV/SN; Community Nursing; Critical Care; Dental; Maternity; OP; Theatres) Trust Total	58%	67%	67%	82%	83%	79%	81%						74%
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Trust Total	68%	85%	82%	81%	85%	81%	80%						80%
Invasive Device Care Audit Trust Total	64%	71%	69%	81%	80%	80%	83%						75%
Matron Checks (IP; OP/Community/Dental; Theatres) Trust Total	73%	78%	87%	73%	86%	85%	88%						81%

Infection Control Mandatory Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Infection Control	89%	90%	90%	89%	90%	88%	89%						89%

Aseptic Non Touch Technique Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
ANTT (M&D staff only)	55%	57%	57%	57%	58%	58%	60%						57%

ANTT compliance levels

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

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

The Newcastle upon Tyne Hospitals
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TRUST BOARD

<table>
<tr><td>Date of meeting</td><td colspan="7">24 November 2022</td></tr>
<tr><td>Title</td><td colspan="7">Corporate Governance Update</td></tr>
<tr><td>Report of</td><td colspan="7">Caroline Docking, Assistant Chief Executive</td></tr>
<tr><td>Prepared by</td><td colspan="7">Lauren Thompson, Corporate Governance Manager / Deputy Trust Secretary</td></tr>
<tr><td rowspan="2">Status of Report</td><td colspan="3">Public</td><td colspan="2">Private</td><td colspan="2">Internal</td></tr>
<tr><td colspan="3">☒</td><td colspan="2">☐</td><td colspan="2">☐</td></tr>
<tr><td rowspan="2">Purpose of Report</td><td colspan="3">For Decision</td><td colspan="2">For Assurance</td><td colspan="2">For Information</td></tr>
<tr><td colspan="3">☒</td><td colspan="2">☐</td><td colspan="2">☒</td></tr>
<tr><td>Summary</td><td colspan="7">The report includes an update on the following areas:
• Update on Governor developments;
• Confirmed Board of Directors, Board Committees and Council of Governors dates for 2023;
• Recent publications/consultation responses; and
• Quarterly NHS Improvement Declarations.</td></tr>
<tr><td>Recommendation</td><td colspan="7">The Board of Directors are asked to:
(i) Receive the report;
(ii) Note the Board of Directors, Board Committees and Council of Governors dates for 2023; and
(iii) Approve the Quarterly NHS Improvement Declarations.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="7">Performance – Being outstanding, now and in the future.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Reputation</td><td>Sustainability</td></tr>
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<tr><td>Impact detail</td><td colspan="7">Impacts on those highlighted at a strategic and reputational level.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="7">Standing agenda item.</td></tr>
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CORPORATE GOVERNANCE UPDATE

EXECUTIVE SUMMARY

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

- Update on Governor developments;
- The scheduling of the 2023 meetings of the Board of Directors, the Board Committees, and the Council of Governors;
- Recent publications/consultation responses; and
- Quarterly NHS Improvement Declarations.

The Board of Directors are asked to:

(i) Receive the report;
(ii) Note the Board of Directors, Committee meetings and Council of Governors dates for 2023; and
(iii) Approve the Quarterly NHS Improvement Declarations.

CORPORATE GOVERNANCE UPDATE

1. GOVERNOR DEVELOPMENTS

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

- Regular data cleansing of the Trust's membership database, hosted by Civica, continues to take place to ensure membership data is up to date.
- The first Members' Newsletter (Autumn edition) was distributed to all Members.
- Engagement continues to recruit public and staff members including working with the internal staff networks, local charities, colleges and universities.
- A Members' Event has been planned for 1 December 2022.

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

2. BOARD OF DIRECTORS MEETING DATES FOR 2023

Committee meeting dates for 2023 have been scheduled and are listed below:

Board of Directors

Board meeting	Thursday 26 January 2023
Board workshop	Thursday 23 February 2023
Board meeting	Thursday 23 March 2023
Board workshop	Thursday 27 April 2023
Board meeting	Thursday 25 May 2023
Board workshop	Thursday 29 June 2023
Board workshop	Thursday 27 July 2023
Board meeting	Thursday 27 September 2023
Board workshop	Thursday 26 October 2023
Board meeting	Thursday 30 November 2023
Board workshop	Thursday 14 December 2023

Council of Governors

Thursday 16 February 2023
Thursday 20 April 2023 (workshop)
Thursday 15 June 2023
Thursday 17 August 2023
Thursday 19 October 2023 (workshop)
Thursday 7 December 2023

Board Committees

Committee	Frequency per Terms of Reference	2023 Meeting Dates
Audit Committee	5 x per year (min)	24 January, 25 April, [TBC May*], 25 July, 24 October *Dependent upon the Annual Reporting Manual deadline for the submission of the Annual Report and Accounts.
Quality Committee	6 x per year (min)	17 January, 21 March, 16 May, 18 July, 19 September, 21 November
Finance Committee	6 x per year (min)	25 January, 29 March, 24 May, 26 July, 27 September, 29 November
Newcastle Hospitals Charity Committee	4 x per year (min)	16 February, 11 May, 10 August, 16 November
People Committee	6 x per year (min)	21 February, 18 April, 22 June, 22 August, 17 October, 19 December
Appointments & Remuneration Committee	Min. 1 per year	16 March, 4 May, 3 October, 12 December

3. PUBLICATIONS/CONSULTATION RESPONSES

During October and November 2022, recent publications included:

NHS Providers published a number of briefings including:

- Maternity and neonatal services in East Kent;
- A letter sent to the new Chancellor;
- An announcement of their new Chief Executive, Julian Hartley; and
- The Operational Framework for NHS England.

NHS Providers also commenced a provider licence consultation held from 28 October 2022 to 9 December 2022.

The Care Quality Commission (CQC) published their Annual State of Care report for 2021/22 as well as an update on how it is implementing its new strategy.

4. QUARTERLY NHS IMPROVEMENT DECLARATIONS

The quarterly self-certifications provide assurance that NHS providers are compliant with the conditions of their NHS provider licence and 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 included in the BRP cover the period from 1 July 2022 to 30 September 2022 and Board members are asked to approve the declarations.

5. RECOMMENDATIONS

The Board of Directors are asked to:

(i) Receive the report;

(ii) Note the Board of Directors, Board Committees and Council of Governors dates for 2023; and

(iii) Approve the Quarterly NHS Improvement Declarations.

Lauren Thompson
Corporate Governance Manager / Deputy Trust Secretary

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Worksheet "FT4 declaration"

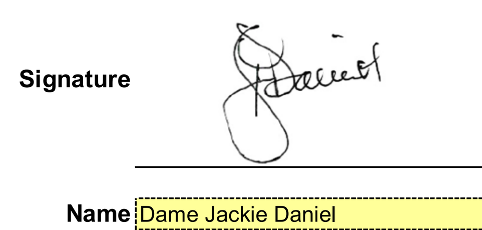
Financial Year to which self-certification relates Sep-22

Corporate Governance Statement (FTs and NHS trusts)

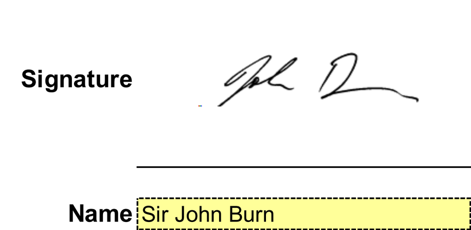
The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.		Confirmed. No material risks identified. Assurances include Annual Report (declaration of compliance with Code of Governance and Annual Governance Statement, both are subject to independent review and scrutiny by External Audit as part of the year end external audit). CQC Inspection of 'Well Led' Domain assessed as 'Outstanding'.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time		Confirmed. No material risks identified. Key documents are highlighted/circulated to the Board through the Chief Executive Update report, items to note and agenda items.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.		No material risks identified. The CQC reviewed the effectiveness of the Board and confirmed Committee structure as part of the 'Well Led' review, assessed as 'Outstanding'. There are a wide range of controls in place, including: an approved Scheme of Delegation, Standing Financial Instructions, Board approved committee structure and terms of reference in place, a Board member appraisal process is in place, agreed Executive portfolios and clear organisational structure/reporting lines.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		Confirmed. No material risks identified. There are a range of systems and/or processes in place which evidence the Trust's on-going compliance with this requirement, including: - Trust Board meetings. - Routine Integrated Board Reports and focussed performance reports. - Regular meetings of the Trust Executive Team, Executive Risk Group, Finance, Quality, Audit and People Committees. - Board approved terms of references and schedules of business. - Board approved Annual Plan. - Regular detailed Board finance report. - Board Assurance Framework and Risk Registers. - External and Internal audit annual opinion and Internal Audit annual plan approved by the Audit Committee.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		Confirmed. No material risks identified. There are a range of systems and/or processes in place which evidence the Trust's on-going compliance with this requirement, including: - Trust Board composition includes Chief Executive Officer, Chief Operating Officer, Medical Director, Director for Business, Development and Enterprise, Finance Director and Executive Chief Nurse - Annual Quality Account produced - Patient/staff stories digital presented at Board meetings as a regular agenda item - Board line of sight as part of Leadership Spotlight on Services / Walkabouts - Positive external stakeholder feedback (re Quality Account) - Routine Integrated Report to Trust Board (including SIRI reporting) - Quality Committee meetings to seek assurance over quality of care including scrutiny of SIRIs and Never Events - Mortality Surveillance Group
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.		There are a range of controls in place to mitigate staffing risks, including: Directorate Ward staffing reviews and a single centralised bank for nursing and midwife posts.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature 

Name Dame Jackie Daniel

Signature 

Name Sir John Burn

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

PUBLIC BRP A14

Worksheet "Training of governors"

Financial Year to which self-certification relates **Sep-22**

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

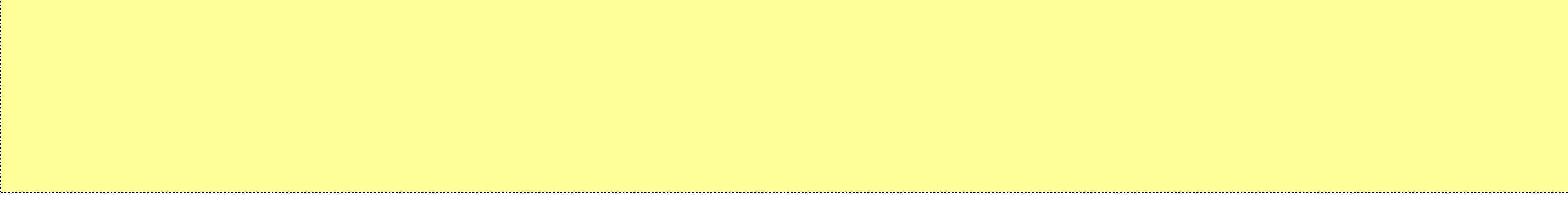
Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	**Confirmed**

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Dame Jackie Daniel	**Name**	Professor Sir John Burn
Capacity	Chief Executive Officer	**Capacity**	Chairman
Date	14.11.2022	**Date**	14.11.2022

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A 

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates Sep-22

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. — **Confirmed** — OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. — **Confirmed**

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

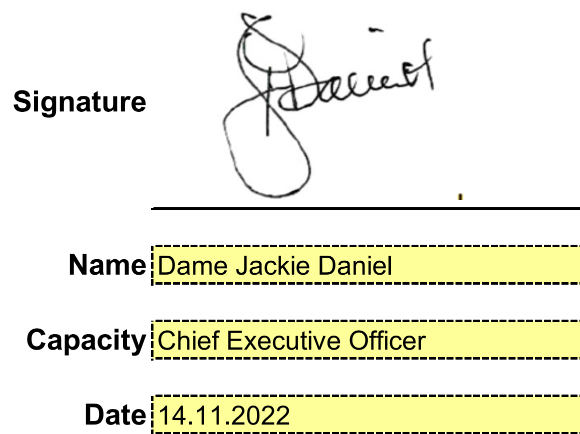
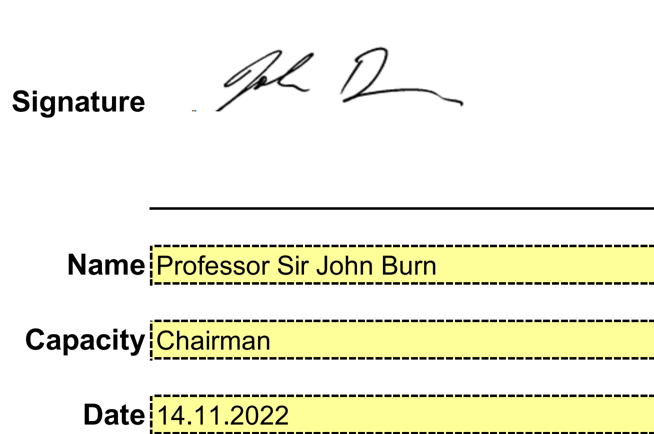
3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust has taken all necessary precautions as were necessary to comply with the conditions.
Transformation/Quality Improvement, performance and financial management arrangements are in place to support the delivery of the Trust plans, overseen through the Trust governance structure. Specific reports on the Trust Activity and Financial Plans are presented routinely to the Finance Committee, with updates to the Trust Board.
The Newcastle Improvement, Performance and Finance Teams continue to work on the Trust's long-term recovery programme.
The annual going concern assessment was presented to the Audit Committee in April 2022 and considered by the Trust Board members in May 2022. This is updated annually.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Dame Jackie Daniel	**Name**	Professor Sir John Burn
Capacity	Chief Executive Officer	**Capacity**	Chairman
Date	14.11.2022	**Date**	14.11.2022

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

<table>
<tr><td>Date of meeting</td><td colspan="7">November 2022</td></tr>
<tr><td>Title</td><td colspan="7">Integrated Board Report</td></tr>
<tr><td>Report of</td><td colspan="7">Martin Wilson – Chief Operating Officer, Angela O'Brien- Director of Quality and Effectiveness.</td></tr>
<tr><td>Prepared by</td><td colspan="7">Louise Hall- Deputy Director of Quality and Safety, Peta Le Roux- Business Analysis.</td></tr>
<tr><td rowspan="2">Status of Report</td><td colspan="3">Public</td><td colspan="2">Private</td><td colspan="2">Internal</td></tr>
<tr><td colspan="3">☒</td><td colspan="2">☐</td><td colspan="2">☐</td></tr>
<tr><td rowspan="2">Purpose of Report</td><td colspan="3">For Decision</td><td colspan="2">For Assurance</td><td colspan="2">For Information</td></tr>
<tr><td colspan="3">☒</td><td colspan="2">☒</td><td colspan="2">☐</td></tr>
<tr><td>Summary</td><td colspan="7">This paper is to provide assurance to the Board on the Trust's performance against key Indicators relating to Quality, People and Finance.</td></tr>
<tr><td>Recommendation</td><td colspan="7">For assurance.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="7">Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality.
Supported by flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential.
Performance – Being outstanding now and in the future.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Reputation</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☒</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Impact detail</td><td colspan="7">Details compliance against national access standards which are written into the NHS standard contract.
Details compliance against key quality targets.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="7">Regular report.</td></tr>
</table>

INTEGRATED BOARD REPORT

EXECUTIVE SUMMARY

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

1. The Trust has had no cases of MRSA bacteraemia in September 2022. However, there has been an increase in the number of Klebsiella Bacteraemias in September 2022 (n=18), this is the highest number recorded since June 2021.

2. There were 10 Serious Incidents (SIs) reported in October 2022 demonstrating a noticeable decrease below the mean. No Never Events were reported in October 2022.

3. The Trust has received a total of 319 (308 with identified patient activity) formal complaints up to October 2022, an increase of 54 on last month's opened complaints.

4. There were 1,560 responses to the Friends and Family test from the Trust in September 2022 (published October 2022) compared to 1,802 in the previous month.

5. Staff turnover has increased from 10.5% in October 2021 to 15.5% in October 2022, against a target of 8.5%.

6. In the period to 31 October the Trust incurred expenditure of £808 million, and accrued income of £810 million on mainstream budgets and incurred expenditure of £4.4 million on the programmes outside the block envelope (vaccine roll-out programme), leading to a small surplus of £2.2 million.

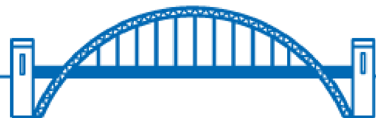
The Board of Directors is asked to receive the report.

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

Quality, People and Finance

November 2022



Executive Summary

Purpose

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

Current Operating Environment

The Trust is experiencing increasing pressure in emergency and urgent care which has been sustained throughout this year and has increased as we move into winter. There has been an ever-present number of COVD-19 patients in the organisation throughout the 3rd quarter, with 44 patients in the Trust in November, in line with the increased incidence in the community. However, overall patients were less complex and did not need admission to Critical Care with approximately two thirds of patient's admitted for other reasons and with incidental COVID-19. The numbers of staff testing positive had decreased over the summer months, and this is reflected in the reduction in COVID-19 staff absence rates from 0.36% to 0.19%. The rate has remained low due to modified IPC guidelines and requirements to isolate. There continues to be significant pressures placed on the Trust's bed base due to the increase in emergency admissions and delayed discharges due to pressures in Social Care, with an average of 85 patients currently awaiting discharge and 35 patients awaiting repatriation to another organisation. Taking into account the permanent loss of beds due to the maternity reconfiguration, on average we have the same number of beds open as pre-pandemic due to improved staffing levels, reduced COVID-19 outbreaks and IPC requirements. However, it should be noted that staffing across the Organisation remains challenging both clinically and in supporting departments where recruitment is difficult with reducing numbers of applications. This has been particularly noticeable in administration roles. The overall position of the Trust remains challenged while balancing the focused effort of recovery, returning to 2019/20 activity levels where possible. The Day Treatment Centre has increased its capacity.

Report Highlights

1. The Trust has had **no cases of MRSA bacteraemia in September 2022.** However, there has been an **increase in the number of Klebsiella Bacteraemias** in September 2022 (n=18), **this is the highest number recorded since June 2021**.

2. There were **10 Serious Incidents (SIs) reported in October 2022** demonstrating a noticeable decrease below the mean. **No Never Events were reported in October 2022**.

3. The Trust has received a total of **319 (308 with identified patient activity) formal complaints up to October 2022**, an increase of 54 on last month's opened complaints.

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Contents: November 2022

Quality

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

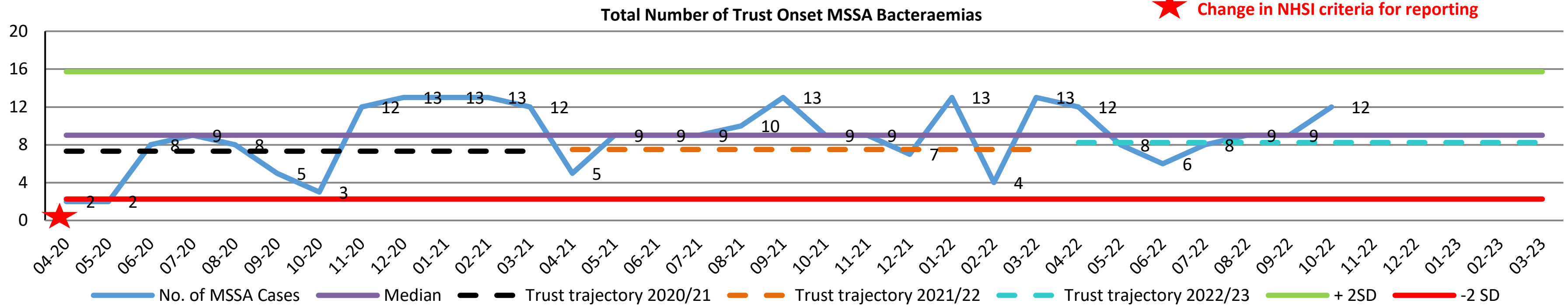
People

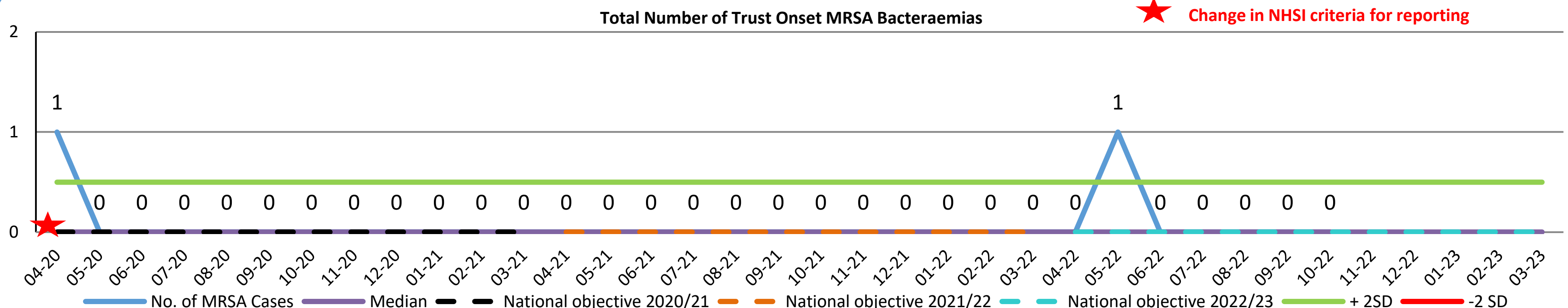
- COVID-19
- Well Workforce
- Equality and Diversity
- Sustainable Workforce Planning
- Excellence in Training and Education

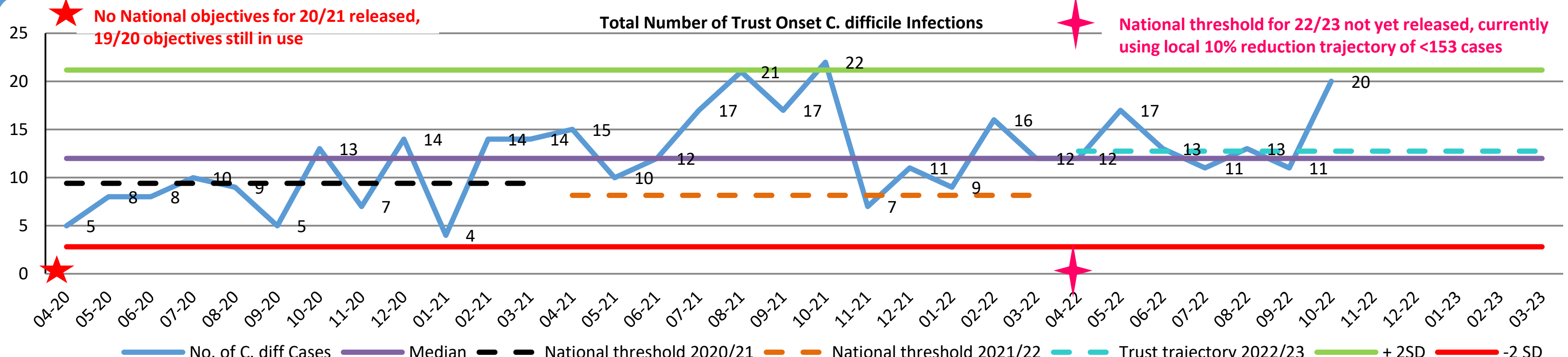
Finance

- Overall Financial Position

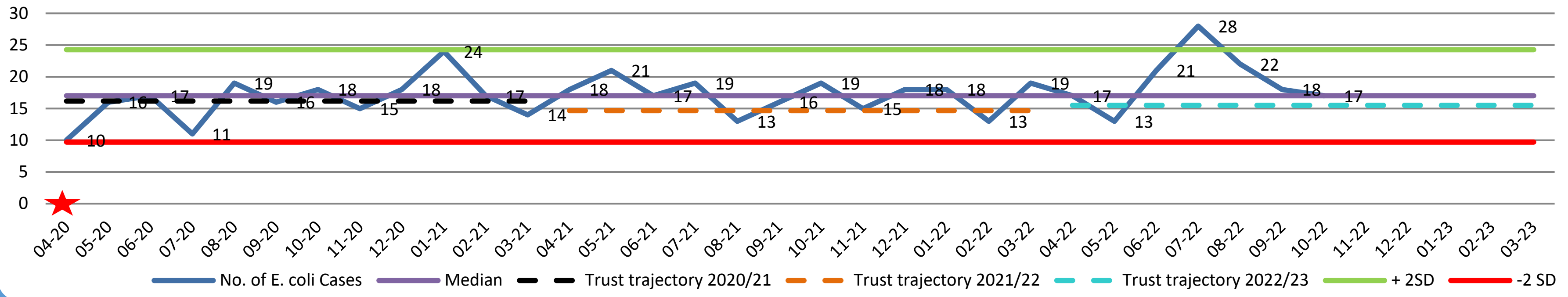
Quality: Healthcare Associated Infections 1/2

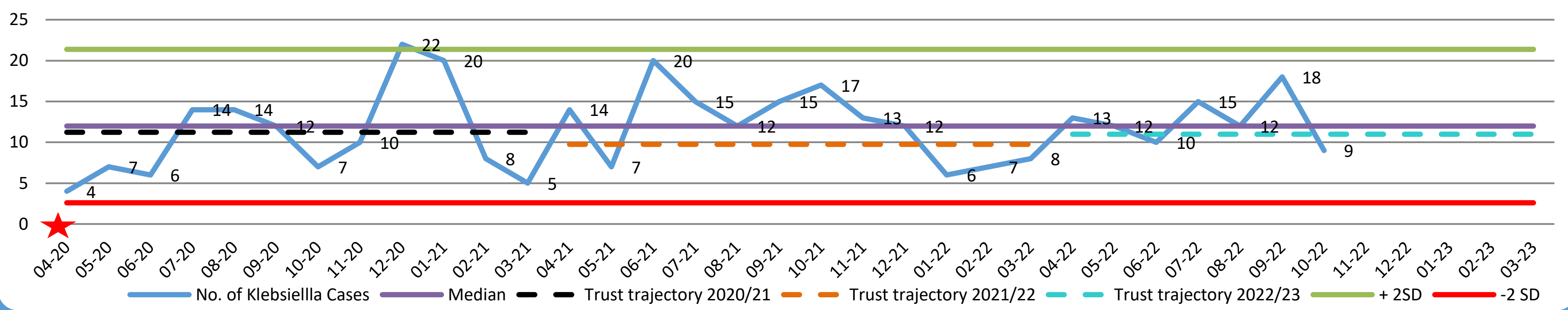


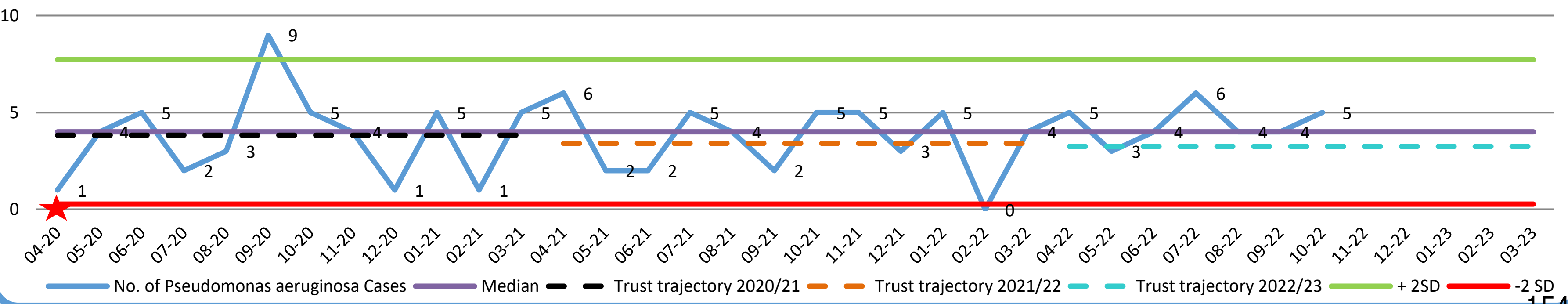




Quality: Healthcare Associated Infections 2/2





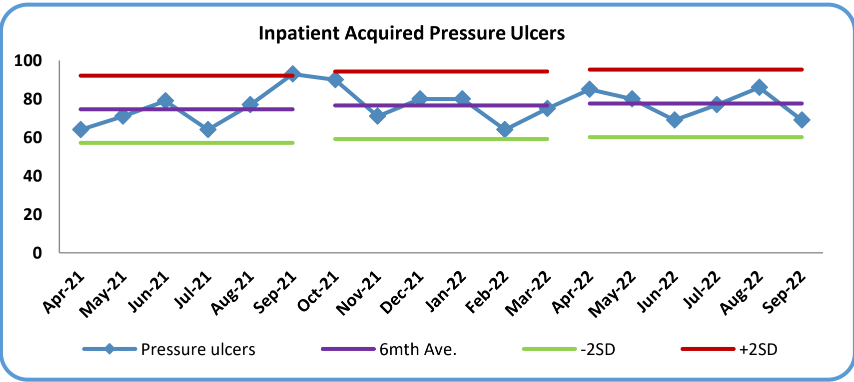


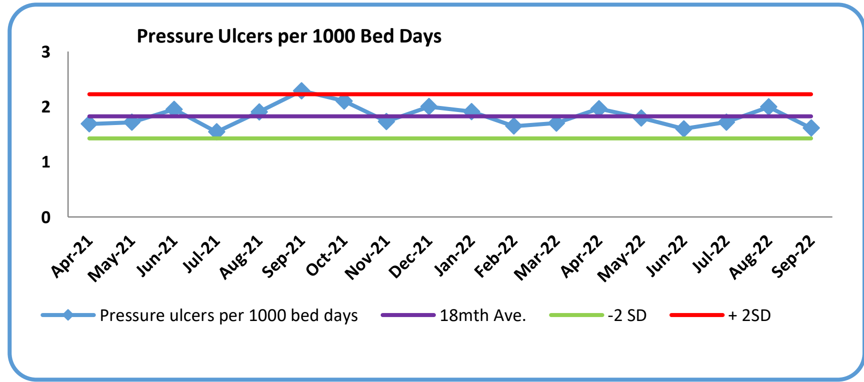
Quality: Harm Free Care – Pressure Damage

In the month of September 2022 a decrease can been seen in the number of pressure ulcers across the Trust. This is the second lowest monthly number throughout 2022. However, between April to September 2022 there has been an increase in the number of pressure ulcers (n=18) compared to the same time period in 2021.

From August to October 2021 a steep increase in pressure ulcers is evident. This directly correlates with surges in COVID-19 activity. This is also apparent in October 2020 to February 2021, whereby COVID-19 waves two and three occurred.

The Trust safe care data illustrates that the acuity of patients is significantly higher than pre-pandemic levels. In addition, there has been an increase in patients presenting to the Trust with significant existing damage, or that are at risk of skin deterioration. This is consistent in both other Trusts in the Shelford group and indeed is representative of the National picture.



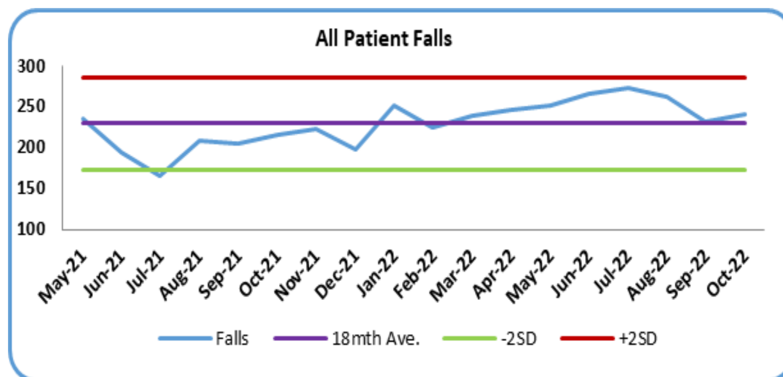


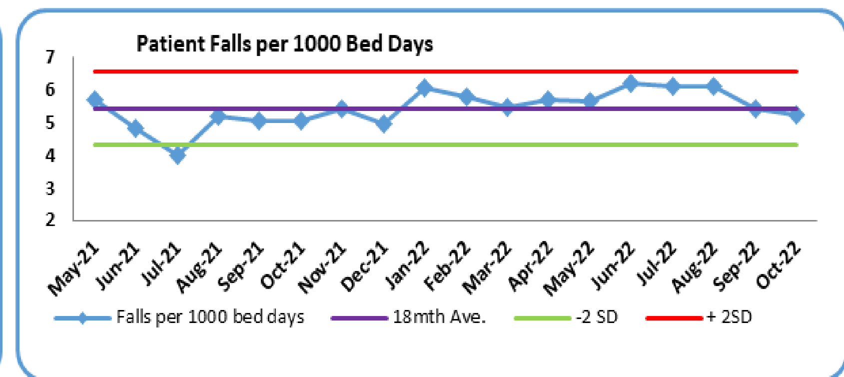
Quality: Harm Free Care - Falls

In October 2022 a slight increase in falls can been seen (n=240).

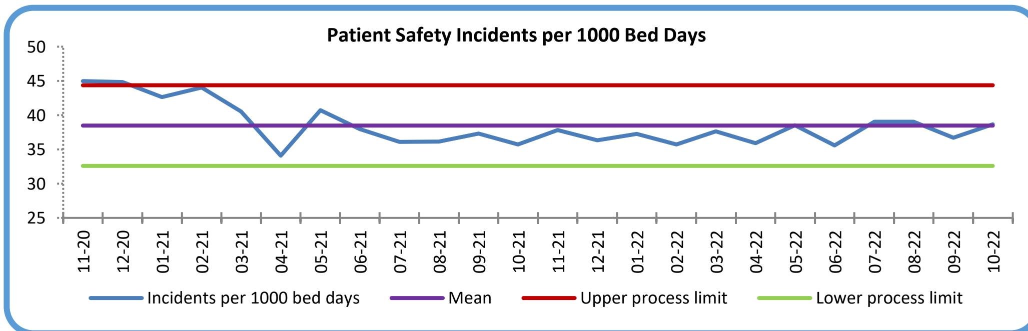
In 2022 the Trust has experienced significant pressures, particularly in relation to bed occupancy levels, which have remained high throughout. Significant increases in the cohort of medical patients, particularly those over 65 are evident and did lead to the requirement to convert many surgical wards to medicine, and have remained so for the last two years. Evidence produced by the National Falls Audit (2021) illustrates rates of deconditioning in our elderly population as a result of periods of lockdowns and COVID-19 infection. This has led to significant increases in both levels of patients at risk and incidents of falls. Incidents within the Trust reflect this, whereby a high proportion of falls occur in our patients who are over 65.

The Falls Prevention Coordinator has commenced work identifying, on a monthly basis, the wards with the highest incidence of falls, identifying contributing factors and identifying learning and solutions, with the aim to reduce numbers of falls in the Trust.

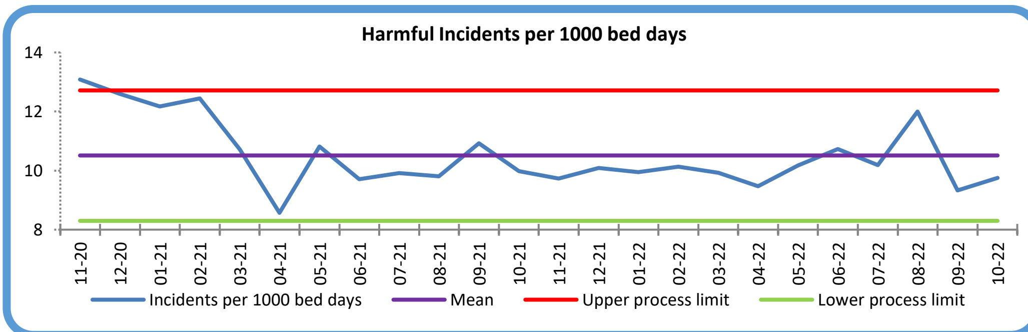




Quality: Incident Reporting

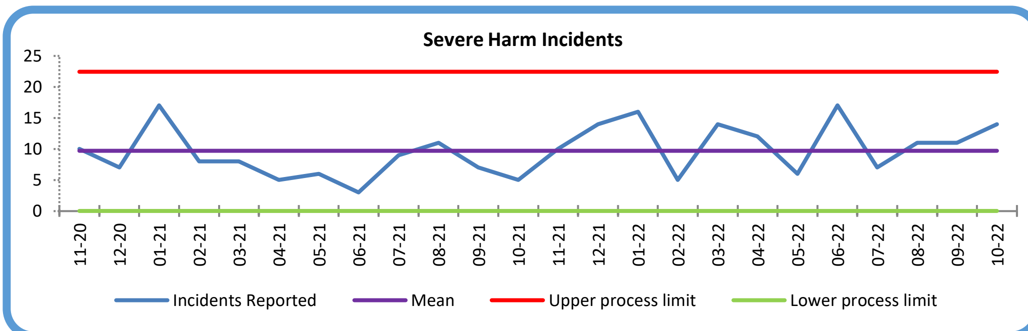


All patient incidents: The number of patient safety incidents per 1000 bed days remains at the mean for October 2022. This remains well within the expected common cause variation.



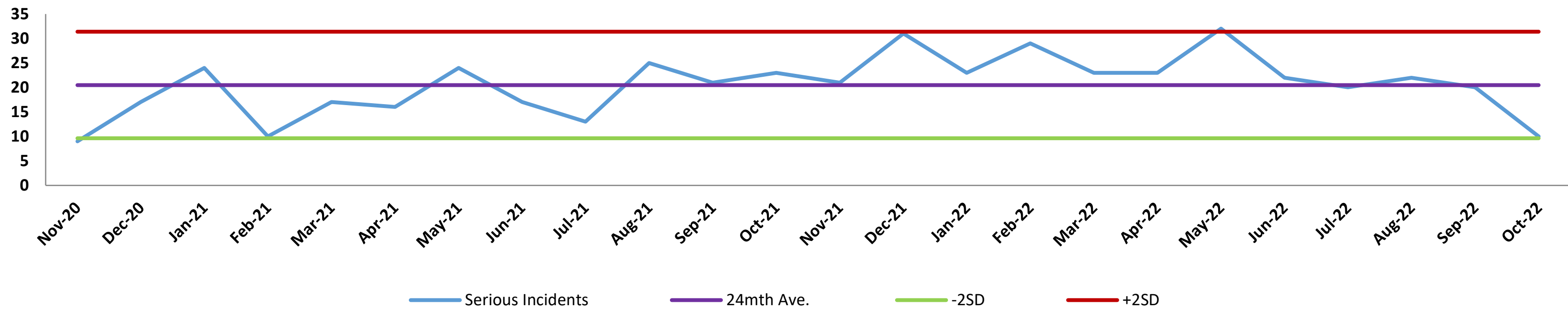
Harmful incidents: The number of *harmful patient safety incidents per 1000 bed days remains below the mean for October 2022. This remains within the common cause variation expected. Severity grading of reported incidents may be modified following investigation and is therefore subject to change in future reports.

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

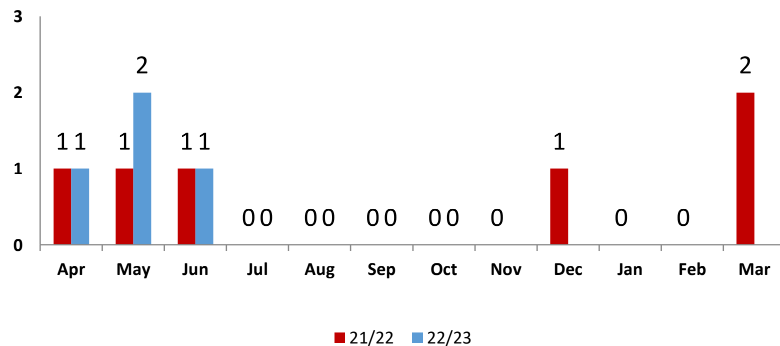


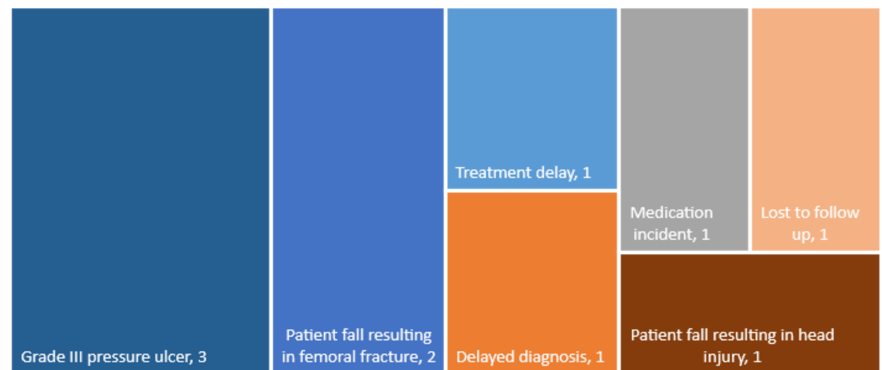
Severe harm incidents: There were 14 patient safety incidents reported which resulted in severe harm in October 2022. This is a slight increase above the mean, however remains within the common cause variation. Severity grading of reported incidents may be modified following investigation and is therefore subject to change in future reports.

Quality: Serious Incidents & Never Events



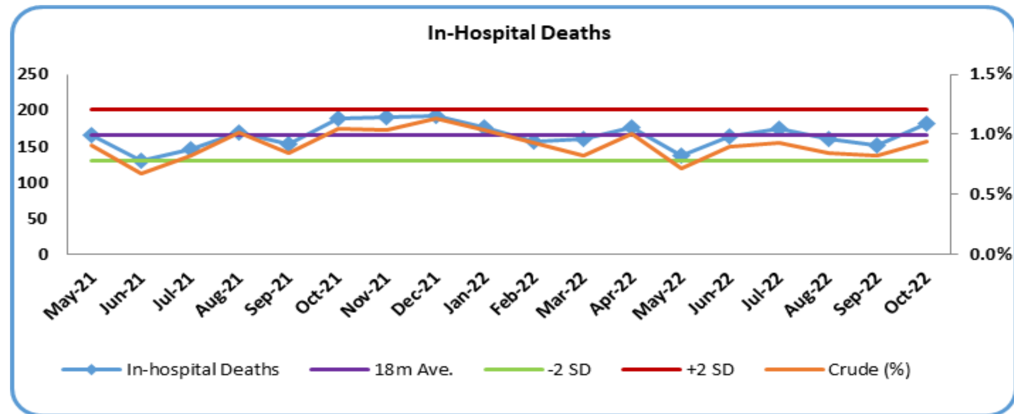
There were 10 Serious Incidents (SIs) reported in October 2022, demonstrating a notable decrease below the mean since September 2022. This is in part due to no reported definite or probable Covid related deaths and a reduction in the number of reported pressure ulcers & falls. The increase in the numbers of SIs since July 2021 can be attributed to a return to pre-pandemic bed occupancy alongside higher acuity of patients in the Trust and an increase in COVID-19 prevalence. The statutory requirement Duty of Candour (DoC) applies to patient safety incidents that occur when providing care and treatment that results in moderate, severe harm or death and requires the Trust to be open and transparent with patients and their families. The DoC process has been initiated in all cases reported in October 2022.



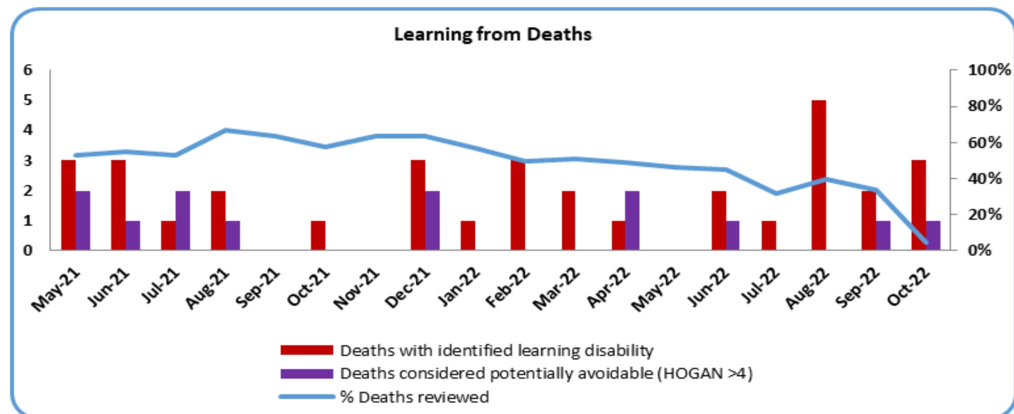


Quality: Mortality Indicators 1/2

In-hospital Deaths: In total there were 181 deaths reported in October 2022, which is slightly lower than the amount reported 12 months previously (n=189). Crude death rate is 0.94%.

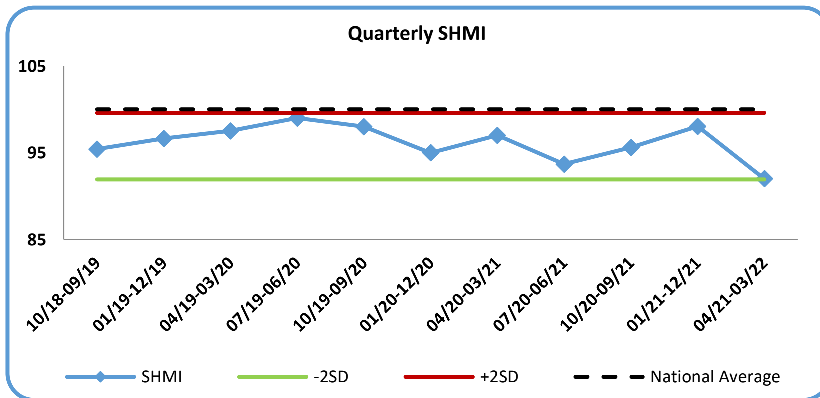


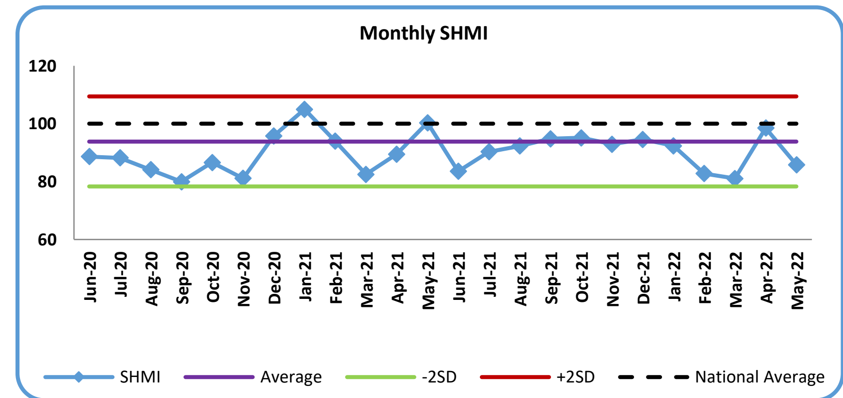
Learning from Deaths: Out of the 181 deaths reported in October 2022, eight patients have, to date, received a level 2 mortality review. However, these figures will continue to rise due to ongoing M&M meetings held over the forthcoming months. All figures will continue to be monitored and modified accordingly.



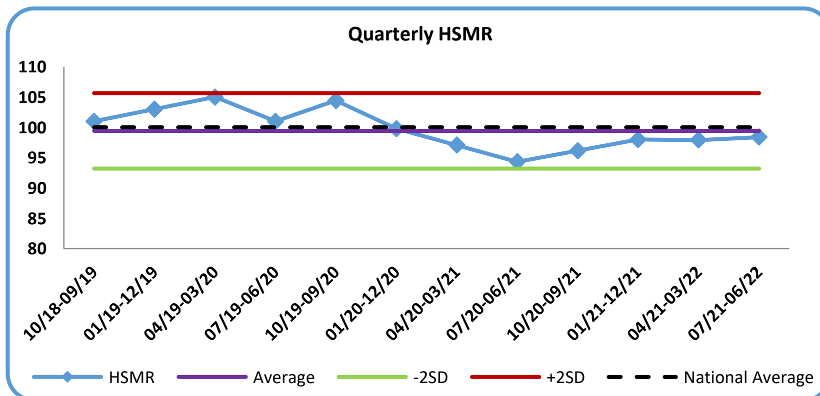
Quality: Mortality Indicators 2/2

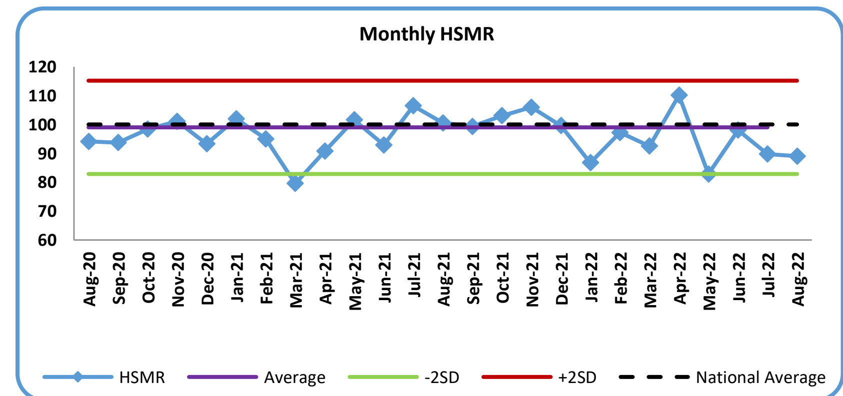
SHMI: The most recent published SHMI quarterly data from NHS Digital shows the Trust has scored 92 from months April 2021 – March 2022. This is below the national average and is within the "as expected" category. Monthly SHMI shows the Trust to be below the national average and within the "as expected"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





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





Quality: FFT and Complaints

Inpatients and day cases
98% (94%)
1% (3%)

Outpatients
97% (93%)
1% (3%)

Maternity
100% (92%)
0% (4%)

Community Health
98% (94%)
2% (3%)

A&E, walk-in centre and minor injury units
* (77%)
* (16%)

*Numbers too small to publish

Friends and Family Test

The published data to date shows that there were 1,560 responses to the Friends and Family test from the Trust in September 2022 (published October 2022) compared to 1,802 in the previous month.

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

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

*numbers too small to publish

Trust Complaints 2022-23

The Trust has received a total of 319 (308 with identified patient activity) formal complaints up to October 22, an increase of 54 on last month's opened complaints.

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

Taking into consideration the number of patients seen and areas with patient contact, the highest percentages of patients complaining to date are within Surgery with 0.06% (6 per 10,000 contacts). The lowest complaint percentages are with Dental, community and EPOD who have 0.01%.

	2022-23				
Directorates	Complaints	Activity	Patient % Complaints	Ratio (YTD)	21-22 Ratio (Full Year)
Cardiothoracic	13	48,942.00	0.027%	1:3765	1:3128
Children's Services	18	35,306.00	0.051%	1:1961	1:3275
Community Services	6	43,197.00	0.014%	1:7200	1:4546
Dental Services	3	45,840.00	0.007%	1:15280	1:10120
Medicine	31	71,985.00	0.043%	1:2322	1:3053
Medicine ED	16	102,930.00	0.016%	1:6433	1:4866
ENT, Plastics, Ophthalmology & Dermatolog	22	180,111.00	0.012%	1:8187	1:7356
Musculoskeletal Services	17	49,749.00	0.034%	1:2926	1:3505
Cancer Services & Clinical Haematology	16	105,173.00	0.015%	1:6573	1:6347
Neurosciences	24	53,007.00	0.045%	1:2209	1:3067
Patient Services	76	20,630.00	0.368%	1:271	1:1934
Peri-operative & Critical Care	9	17,733.00	0.051%	1:1970	1:3499
Surgical Services	22	36,720.00	0.060%	1:1669	1:1698
rology & Renal Services	11	30,491.00	0.036%	1:2772	1:3090
Women's Services	24	71,162.00	0.034%	1:2965	1:3341
Trust (with activity)	**308**	**912,976.00**	**0.034%**	**1:2964**	**1:3994**

"Communication" is the highest primary subject area of complaints at 25% of all the subjects Trust wide.

Quality: Health and Safety

Overview
There are currently 1094 health and safety incidents recorded on the Datix system from the 1st November 2021 to 31st October 2022. This represents an overall rate of 64 per 1,000 staff. The Directorate with the highest number of incidents is Peri-operative & Critical Care reporting 144 health and safety incidents over this period. The highest reporting Directorates per capita are Peri-Operative & Critical Care (100) Internal Medicine (77), Cardio (63.7) at incident rates per 1,000 staff.

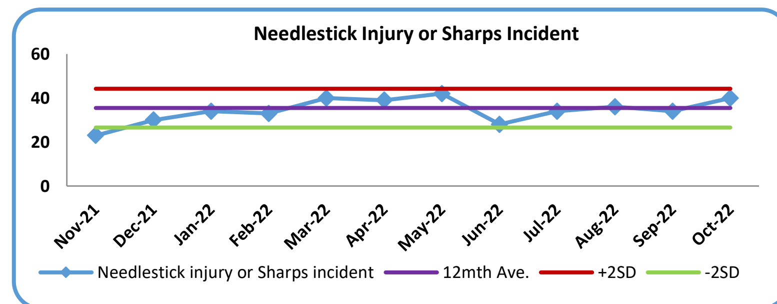
Incidents of Violence & Aggression to Staff
In addition to the incidents above, there are 975 incidents of physical and verbal aggression against staff by patients, visitors or relatives recorded on the Datix system from 1st November 2021 to 31st October 2022. This represents an overall rate of 57.1 per 1,000 staff during this period. The Trust Violence Reduction Group met for the first time in July 2022. A number of initiatives to reduce these incidents are already underway, for example:

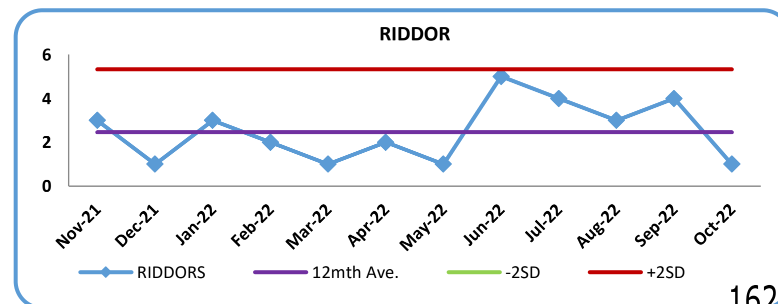
- 'We Can Talk' in the Children's Directorate; a training package used to upskill staff in effective communication skills with patients suffering from mental health issues.
- 35 clinical staff have now received training in the use of Safety Pods for the safe and therapeutic holding of patients.
- Bespoke conflict resolution training is currently being evaluated with clinical staff.

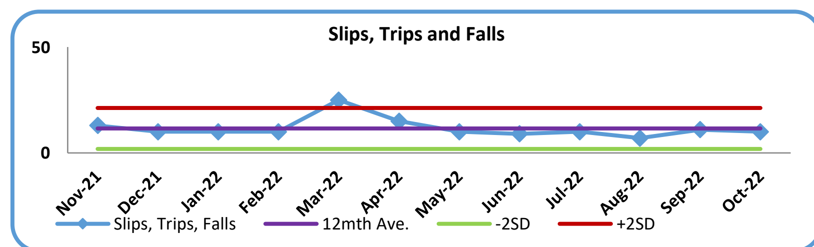
Sharps Incidents
There have been 421 incidents during 1st Nov 2021 to 31st October 2022 (average 35 incident per month, 75.5% of these involve used needles). The recent sustained increase aligns with a number of factors, which are currently being discussed at the Trust Safer Sharps User Group. These include increased activity / acuity, supply issues meaning staff are using alternative devices and clinical educator vacancies. Further work is underway to expand the Datix Cloud IQ system to incorporate further details on the types of sharps incidents.

Slips, Trips and Falls
129 incidents were reported between 1st November 2021 to 31st October 2022. 58% of these incidents were related to trips and slips on wet floors. Regular zonal inspections take place every month and data analysis is acted upon, feeding into the Slips, Trips and Falls Group, which meets quarterly. For example, issues were raised following incidents on the external staircase next to ED and this has resulted in remedial work being undertaken and the risk removed.

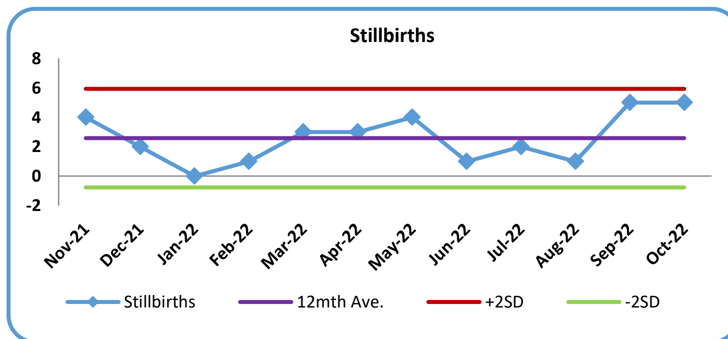
RIDDOR
There have been 34 RIDDOR incidents reported between 1st November 2021 to 31st October 2022. The most common reasons of reporting accidents and incidents to the HSE are Moving and Handling (11), Slips, Trips and falls (11), Accidents involving staff, visitors etc. (5) and Aggression & Violence (5). All RIDDOR reportable incidents are investigated fully and, where necessary, remedial actions are undertaken to prevent re-occurrence.







Quality: Maternity (1/3)

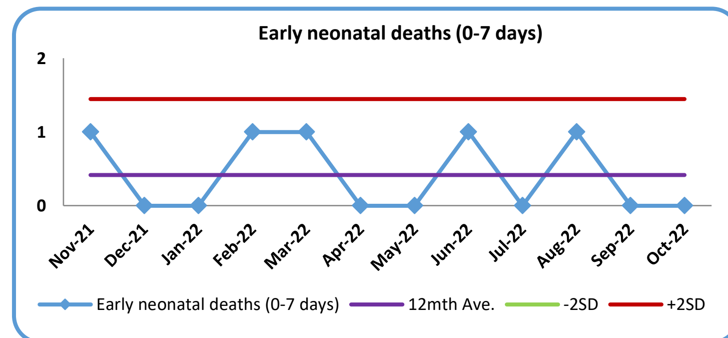


Perinatal deaths

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

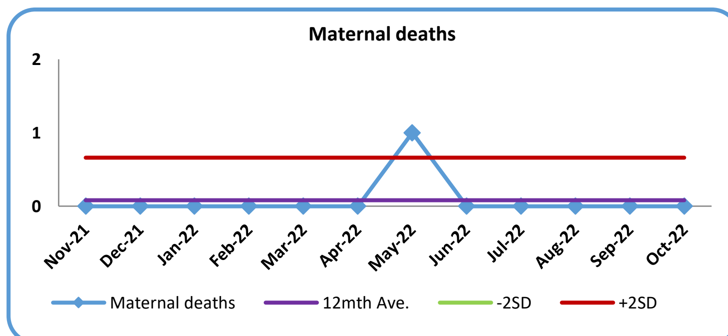
Stillbirths

As NuTH is a tertiary referral Fetal Medicine Unit, complex cases are often referred to the Trust from other units within the region, with women opting to deliver here rather than return to their local unit. This data includes termination for fetal anomalies > 24 weeks gestation. In October, two of the cases had known fetal anomalies. All cases undergo an initial local review and then a more detailed review including external input, once we have the investigation findings.



Early Neonatal Deaths

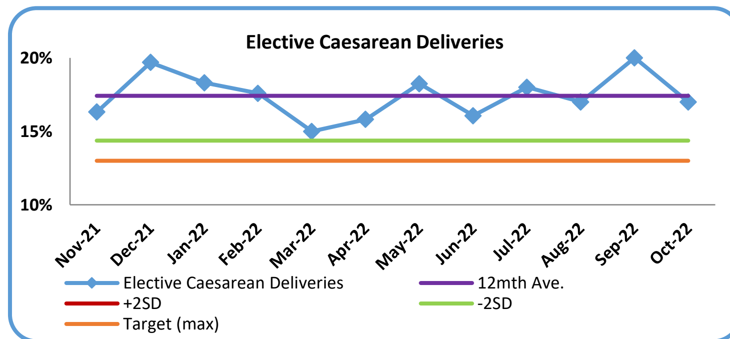
These figures are for term infants (born between 37 and 41 weeks) who delivered at the Trust but sadly died unexpectedly within the first week of life. These deaths are reported to the Child Death Review panel who will have oversight of the investigation and review process. These cases are also usually reported to the Coroner and HSIB. A post mortem examination may be requested to try and identify the cause of death. There were no term, early neonatal deaths reported in October.



Maternal Deaths

Maternal deaths are reported to MBRRACE-UK and a national report is provided annually. Maternal deaths can be categorised as Direct or Indirect. It is rare to have a direct Maternal death in Newcastle. Tragically in May, a woman died after suffering complications shortly after delivery. The case has been reported to the Coroner, MBRRACE-UK and HSIB. HSIB have almost completed their investigation and the Trust have returned comments for the draft report. The Final report is dependant on the Coroner's Post Mortem Report which is expected November-December 2022. The Trust has continued to engage with the family whilst the report is awaited.

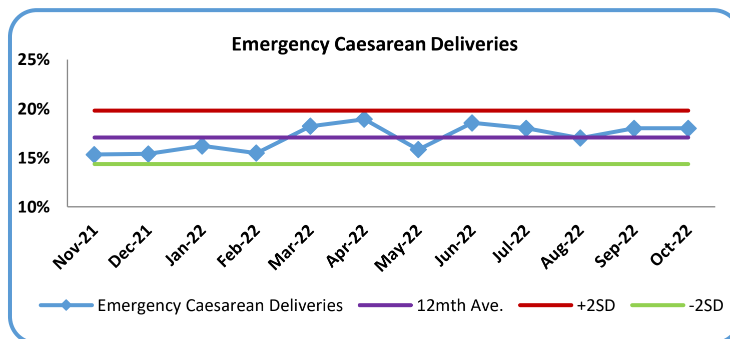
Quality: Maternity (2/3)



Elective Caesarean section

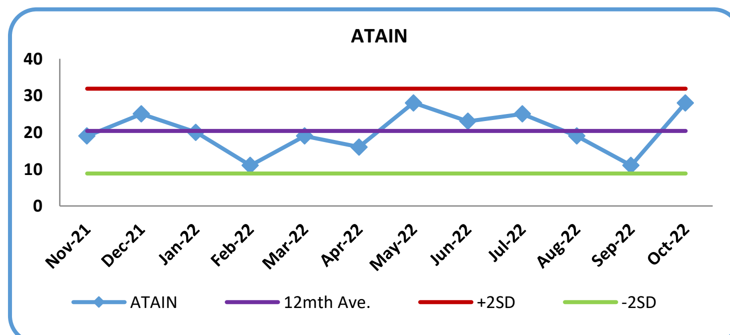
Maternity at the Trust is an outlier for elective Caesarean section compared to other UK Trusts. However, the rates are comparable to that of other tertiary centres in the UK.

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



Emergency Caesarean section

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



ATAIN

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

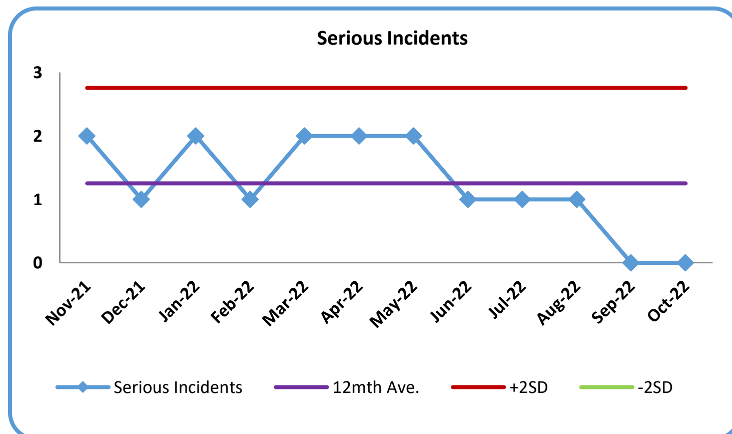
Quality: Maternity (3/3)

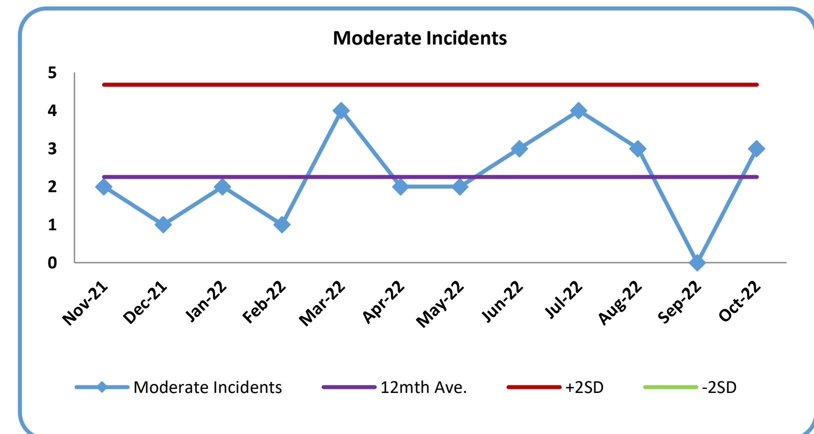
Serious Incidents

There have been 15 incidents escalated as Serious Incidents in the Trust in the past 12 months. These include seven cases of potential Hypoxic Ischaemic Encephalopathy (HIE), three neonatal deaths, one bowel injury, three intrapartum stillbirths and one direct maternal death. The HIE, Intrapartum Stillbirths, Neonatal deaths and Maternal death were all reported to HSIB (Healthcare Safety Investigation Branch) for external review. A summary of the HSIB cases was presented to the Serious Incident Panel in September. There are currently six patient safety incidents awaiting further local review and analysis before returning to Trust SI panel for consideration.

Moderate incidents

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





Quality and Performance: Clinical Audit (1/4)

Audit / NCEPOD	Date of Report	Areas of Good Practice	Recommendations for improvement	Action Plan Developed
National Audit of Seizure Management in Hospitals (NASH3)	1 November 2020	• Higher proportion of patients receiving emergency medications prior to assessment in the Emergency Department (ED) • High proportion of patients assessed in ED received appropriate baseline observations • Higher % of patients received Specialist Neurology input • Higher % of patients were cared for by a Neurologist as an inpatient	• None	Discussed at October 2022 Clinical Audit and Guidelines Group
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	10 March 2022	• Provision of antenatal steroids to mothers who deliver babies between 23 and 33 weeks gestation (national average 91%, RVI 93%) • Term admissions: number of separation days from mother (national average 2.8%, RVI 1.8%) • Moderate preterm admissions (34-36wks): number of separation days from mother (national average 6.3%, RVI 3.6%) • Babies born at less than 30 weeks gestational age receive medical follow-up at two years (corrected age) (national average 68%, RVI 81%)	• Admission temperature within normal range (36.5-37.5%) (national average 71%, RVI 65%) • Consultation with parents within 24 hours of admission (national average 95%, RVI- 89%) • Babies born at less than 33 weeks gestational age receive any of their own mother's milk at discharge to home (national average 58%, RVI 43%)	Discussed at October 2022 Clinical Audit and Guidelines Group
National Paediatric Diabetes Audit	3 December 2021	• Proportion of patients receiving required HbA1c, BMI, BP checks • Health check completion rate for patients aged 12 years and over • Provision of Flu vaccine, sick day rule and blood ketone testing advice • Thyroid and Coeliac disease screening within 90 days of diagnosis • Continue year on year improvement in clinic average HbA1c measurements • Proportion of patients with HbA1c below NICE target is above national average	• Proportion of patients receiving annual psychology assessment was significantly below regional and national average (42.9% vs 80% regional and 71.6% national).	Discussed at October 2022 Clinical Audit and Guidelines Group
National Cardiac Arrest Audit	26 March 2021	• The rates of cardiac arrest per 1000 admissions in the RVI and FRH were 0.21 and 0.62. These are well below the national average of 1.0. • Survival to hospital discharge rates in the RVI and FRH were 19% and 13%. • Ratios of observed to predicted mortality for the RVI and FRH were 1.13 and 0.58.	• Survival to hospital discharge following cardiac arrest at the FRH	Discussed at November 2022 Clinical Audit and Guidelines Group

Quality and Performance: Clinical Audit (2/4)

Audit / NCEPOD	Date of Report	Areas of Good Practice	Recommendations for improvement	Action Plan Developed
BAUS Urology Audits	30 May 2020 & 6 September 2022	• No recommendations were published, only national data and consultant specific data was provided. Due to this the Trust is unable to compare Trust data to National Data. This applies to the following audits listed in the 2019/20 & 2021/22 Quality Account list. Female Stress Urinary Incontinence, Nephrectomy, Percutaneous Nephrolithotomy, Radical Prostatectomies & Radical Cystectomies and Management of the Lower Ureter in Nephroureterectomy Audit.		Discussed at November 2022 Clinical Audit and Guidelines Group
National Prostate Cancer Audit	14 January 2021 & 13 January 2022	• Local anaesthetic transperineal biopsy service is well established • The Trust remains high volume radical prostatectomy centre (243 & 174 operations completed in audit periods, nationally there was a reduction of 48% of men undergoing prostatectomy due to the COVID-19 pandemic)	• None	Discussed at November 2022 Clinical Audit and Guidelines Group
Myocardial Ischaemia National Audit Programme	10 December 2020, 14 October 2021 & 16 June 2022	• 85% of eligible patients should receive magnetic resonance angiography at time of discharge from hospital following STEMI – 89% for FH • 90% of relevant patients should receive all secondary prevention drugs (for which they are eligible) at time of discharge from hospital following STEMI and NSTEMI – 93% for FH	• 90% of patients should have an echocardiogram prior to being discharged (FH 40%) • Freeman Hospital performed <60% of PCI procedures for patients with NSTEMI within 72 hours	Discussed at November 2022 Clinical Audit and Guidelines Group
Learning Disabilities Mortality Review Programme	10 June 2021	• Identification of a specific clinical lead for LeDeR, ensuring consistent reviews are undertaken • Monthly LeDeR review panel meetings take place • Patients who have died and have a learning disability now have their care scrutinised by the medical examiner	• Continue to a develop a robust process to ensure LeDeR representation at all child death review meetings • Patients with autism, in the absence of a learning disability are now required to go through LeDeR process	Discussed at November 2022 Clinical Audit and Guidelines Group

Quality and Performance: Clinical Audit (3/4)

Audit / NCEPOD	Date of Report	Areas of Good Practice	Recommendations for improvement	Action Plan Developed
National Audit of Cardiac Rehabilitation	1 November 2021	• Use of digital technology improved over past 12 months including review of existing material, with a view to producing own resources. • More high risk and complex patients treated compared peers	• Improved coding via SystmOne to ensure data accuracy	Discussed at November 2022 Clinical Audit and Guidelines Group
National Cardiac Arrest Audit	2 September 2022	• The rates of cardiac arrest per 1000 admissions in the RVI and FRH were 0.28 and 0.72. These are well below the national average. • Risk adjusted survival to hospital discharge rates in the RVI and FRH were 35% and 44%. • Ratios of observed to predicted mortality for the RVI and FRH were 1.3 and 1.13.	• None	Discussed at November 2022 Clinical Audit and Guidelines Group
Neurosurgical National Audit Programme	18 October 2022	No national data published, only hospital specific, no recommendations or data was provided.		Discussed at November 2022 Clinical Audit and Guidelines Group
National Hip Fracture Database	5 October 2021	• Admitted to orthopaedic ward within 4 hours • Surgery within 36 hours of presentation • Surgery supervised by consultant surgeon and anaesthetist • Surgery under spinal anaesthetic and nerve block • Eligible displaced fractures treated with total hip replacement • Sub trochanteric fractures treated with Intra-medullary nail • Acute length of stay	• RVI is in the lowest quartile for Mental test score on admission • RVI is in the lowest quartile for Nutritional risk assessment	Discussed at November 2022 Clinical Audit and Guidelines Group

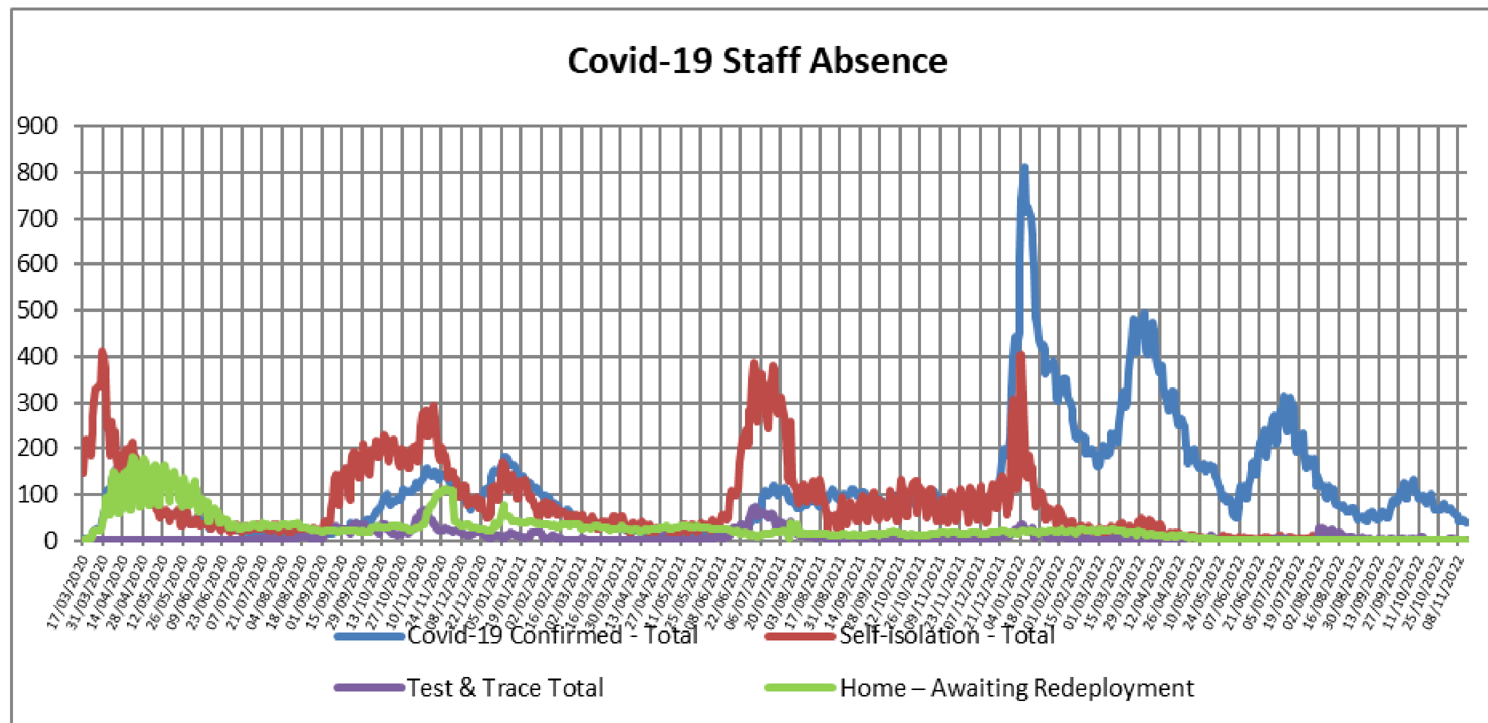
Quality and Performance: Clinical Audit (4/4)

Audit / NCEPOD	Date of Report	Areas of Good Practice	Recommendations for improvement	Action Plan Developed
Percutaneous Coronary Intervention	14 October 2021 & 16 June 2022	• Freeman Hospital performed >80% of door to balloon procedures within 60 minutes • Freeman Hospital performed 90% of PCI procedures using radial artery access • Freeman Hospital used DES in >99% of PPCI procedures requiring a stent	• Freeman Hospital performed <60% of PCI procedures for patients with NSTEMI within 72 hours • Need to reduce unnecessary overnight stays	Discussed at November 2022 Clinical Audit and Guidelines Group
National Congenital Heart Disease Audit	14 October 2021 & 16 June 2022	• Quality of data submitted to audit was excellent >98% for Freeman	• Procedures with prenatal diagnosis rate of at least 75% for all abnormalities where an intervention is undertaken in the first year of life: 2020/21 – 43.8% for Northeast. 2021/22 – 53.5% for Northeast. Very few regions achieved standard of 75%, National average 53%	Discussed at November 2022 Clinical Audit and Guidelines Group
Renal Colic Audit	18 October 2021	• Primary ureteroscopy rates (National 6.4% vs FH 19%) • Primary shockwave lithotripsy rates (National 8.1% vs FH 23.8%) • Serum Calcium checked (National 87.4% vs FH 97.5%) • Primary shockwave lithotripsy done within 48 hours (National 41% vs FH 72.22%)	None	Discussed at November 2022 Clinical Audit and Guidelines Group
National Audit of the Care at the End of Life	14 July 2022	• NUTH have scored above the national average in all but one domain. NUTH scored the same as the national score for 'families' and others' experience of care' and were one of the few Trusts to be allocated a summary score across all domains through participation and adequate family/staff engagement in all audit elements	None	Discussed at November 2022 Clinical Audit and Guidelines Group

People – COVID-19

Figures quoted are by headcount

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



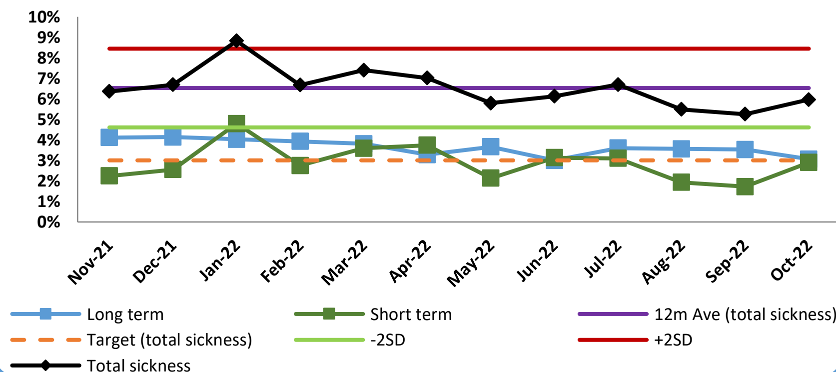
- Risk Assessments have been made available to all Trust staff – staff in 'high risk' category prioritised.

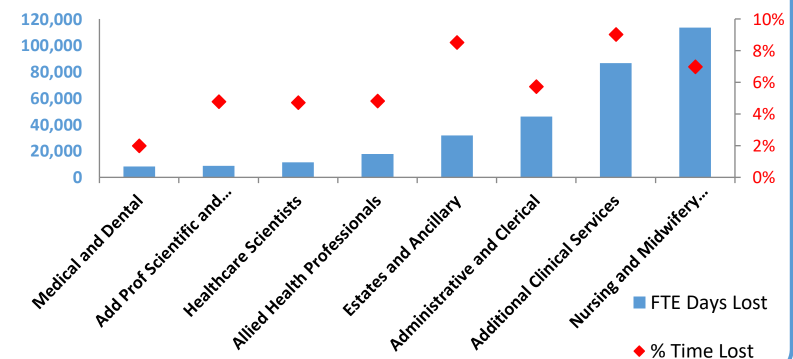
People – Sickness Absence 1/2

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

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

- 387,730 FTE working days were lost due to sickness (including COVID-19 related sickness) in the year to October 2022, compared to 310,021 for the previous year, 25% increase.
- Overall sickness absence (including COVID-19 related sickness) is 6.51%, which is down from end of Sep 2022 position of 6.65% (% FTE Time Lost).
- The top three reasons for non-COVID related sickness absence are Anxiety/stress/depression/other psychiatric illnesses (28%) Gastrointestinal problems (9%), and other musculoskeletal (10.6%).
- The top reason for "Other" absences is Maternity Leave (42% of total absence.
- Nursing and Midwifery have the highest number of Maternity Leave at 4% (%FTE Lost).

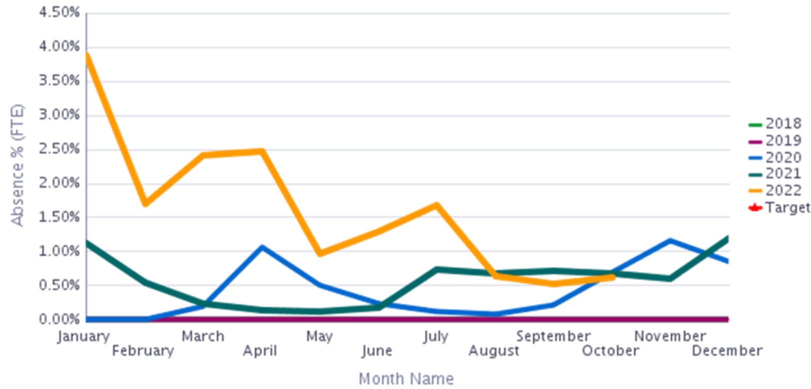




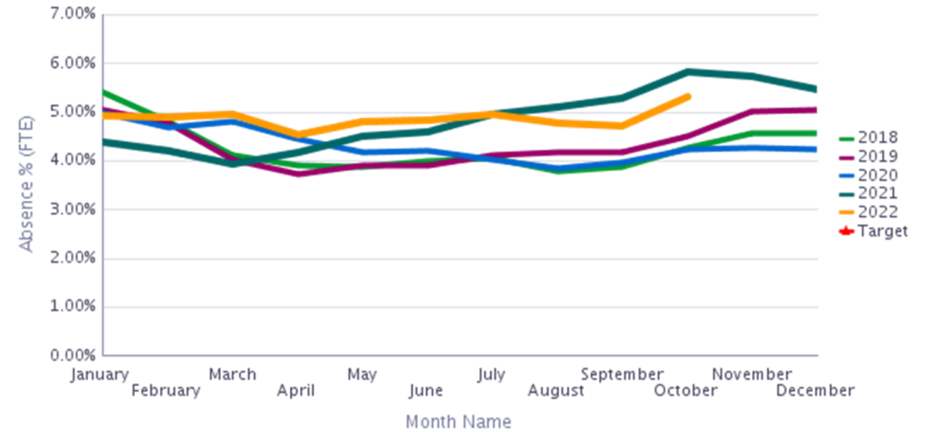
*COO Directorate includes Outpatients / ABC Service

People – Sickness Absence 2/2

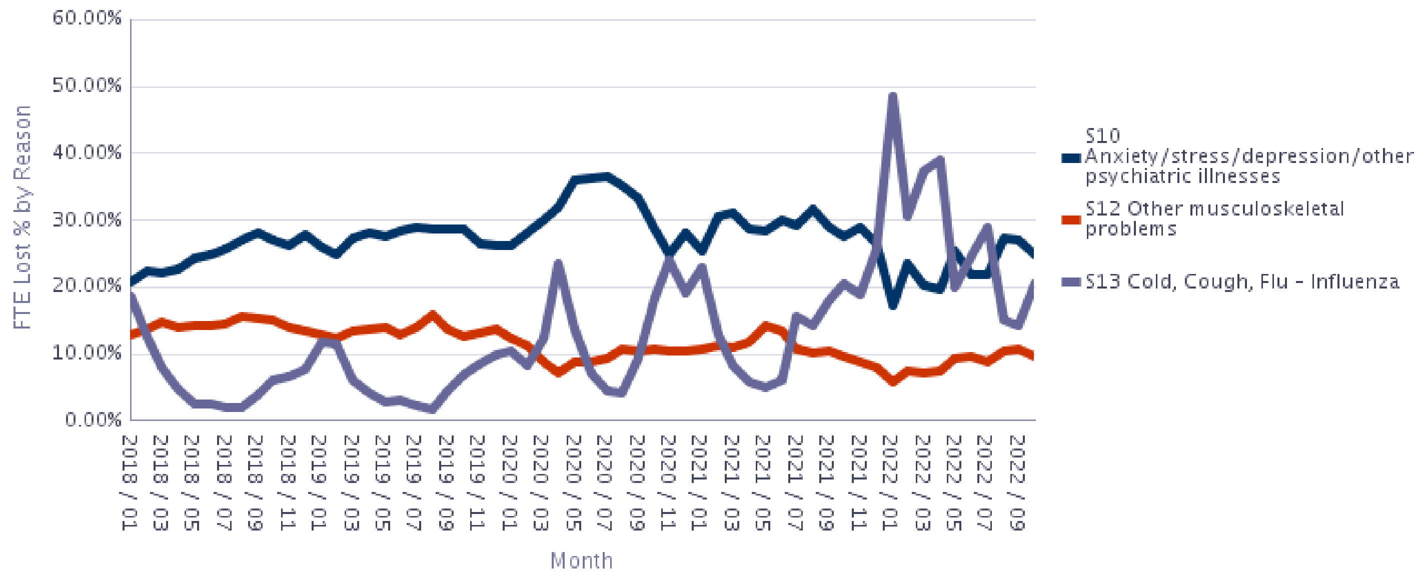
COVID-19 Related Sickness Jan 2018 - October 2022 (%FTE)



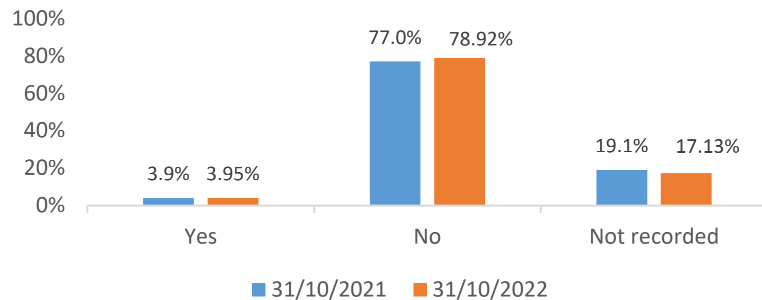
Non-COVID-19 Related Sickness Jan 2018 - October 2022 (%FTE)

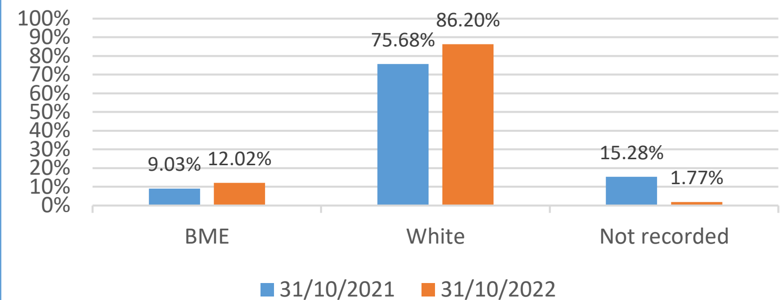


Top 3 Sickness Reasons Jan 2018 - Oct 2022 (%FTE)

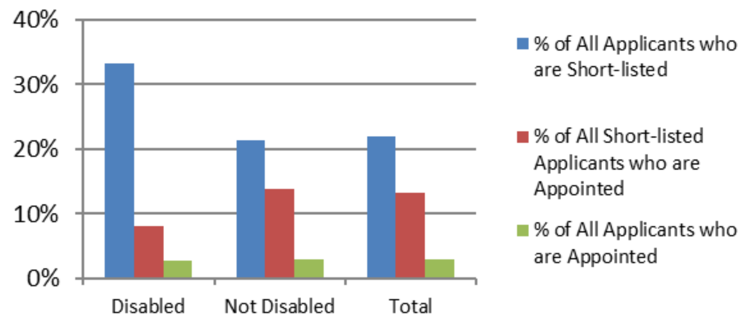


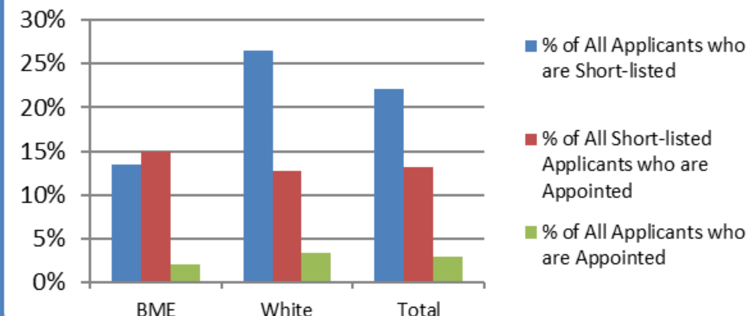
People – Equality and Diversity 1/2





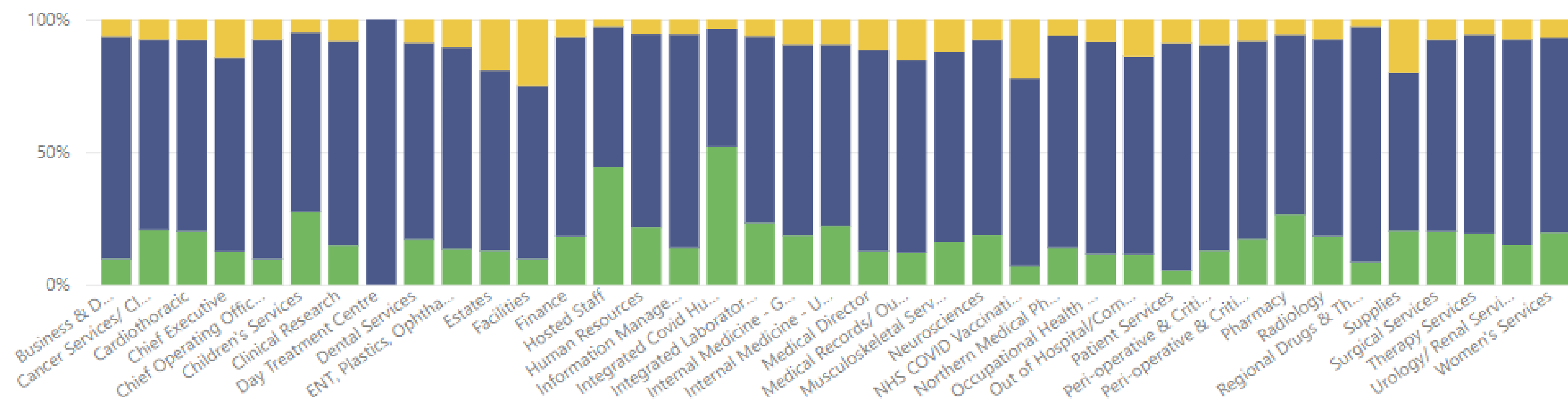
- The graphs above identify, by disability and ethnicity, the recruitment outcome of applicants during the twelve months ending October 2022.

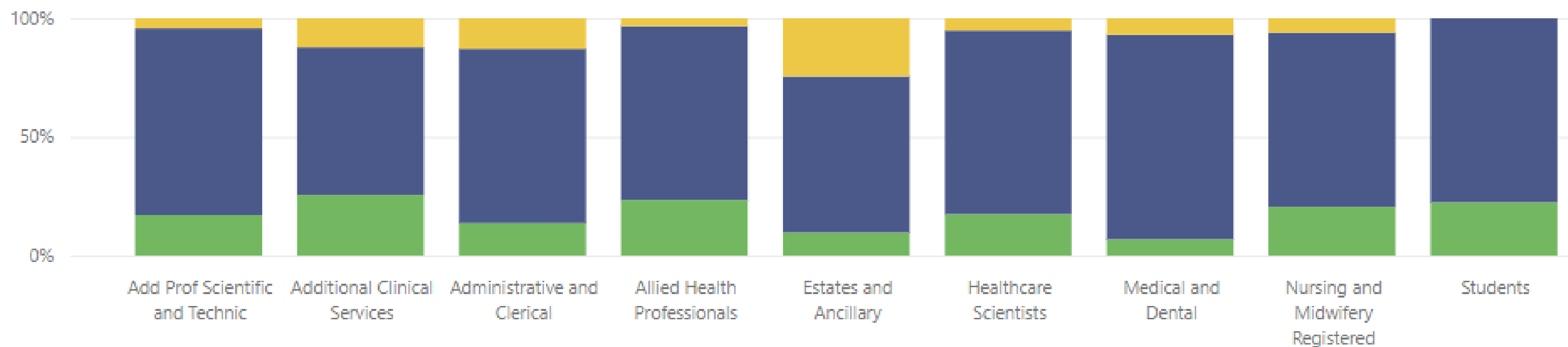




- The graphs above identify, by headcount, the percentage of staff in post in October 2021 and October 2022 by disability and ethnicity. The percentage of staff employed disclosing a disability has improved from 3.86% to 3.95% and the percentage of BAME staff has increased from 9.03% to 12.02%.

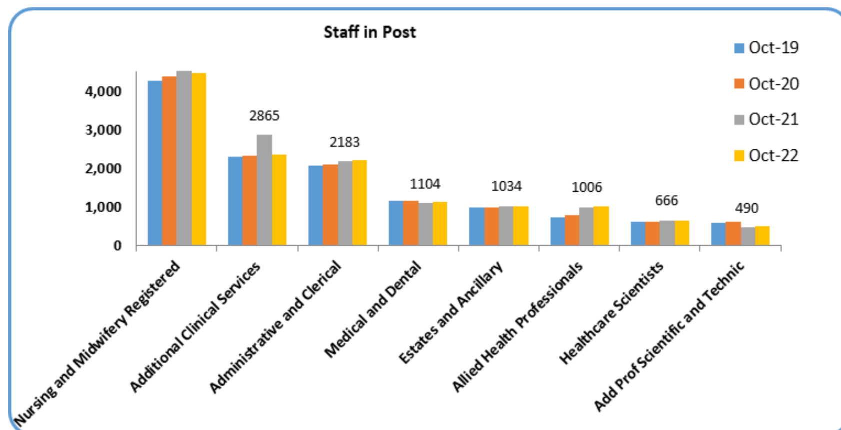
People – Equality and Diversity 2/2

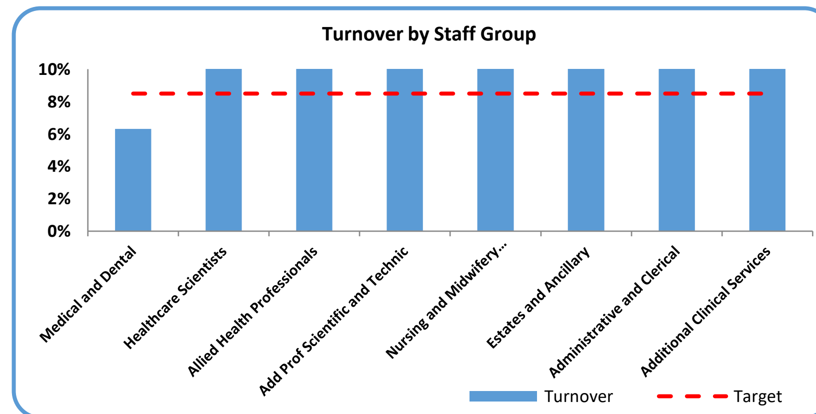


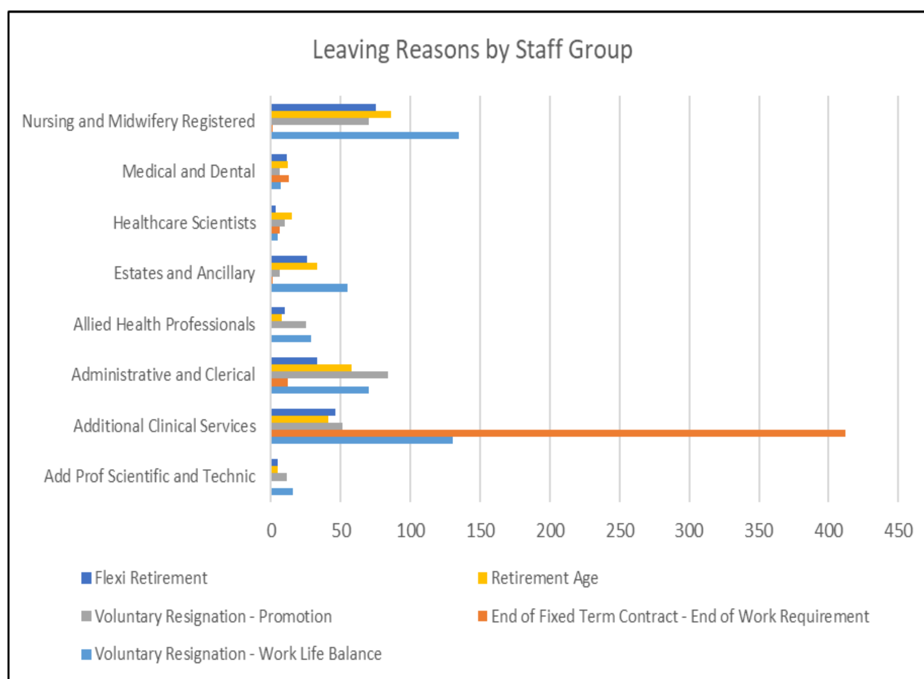


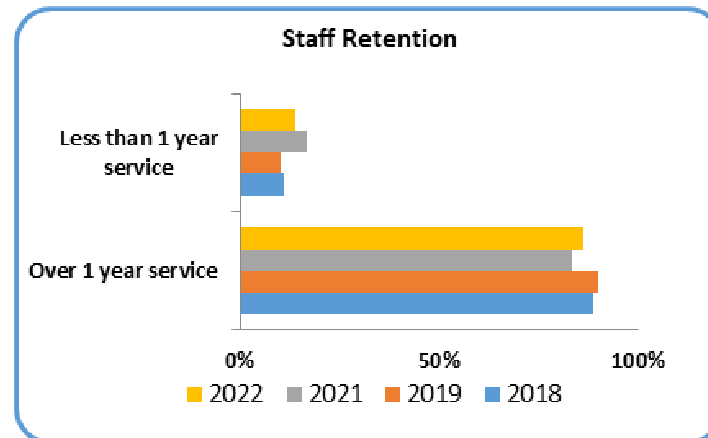
- Estates and Ancillary have the highest proportion of staff aged 55 and over (45%).
- Medical and Dental have 20% of staff aged 55 and above and 7% of staff aged 60 and above.

People – Workforce 1/4









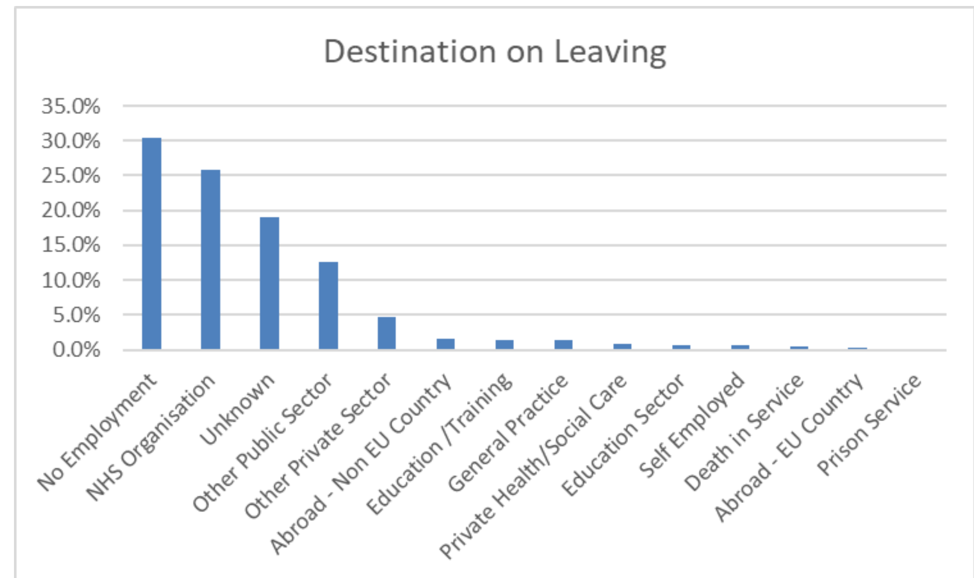
- Staff in post has increased by 4.95% since October 2019. The staff groups with the largest increase are Administrative and Clerical and Allied Health Professionals.
- Staff turnover has increased from 10.5% in October 2021 to 15.5% in October 2022, against a target of 8.5%.
- The total number of leavers in the period November 2021 to October 2022 was 2,464.
- Retention for staff over 1 year service is 86.18%, an increase from 83.41% in October 2021.

People – Workforce 2/4

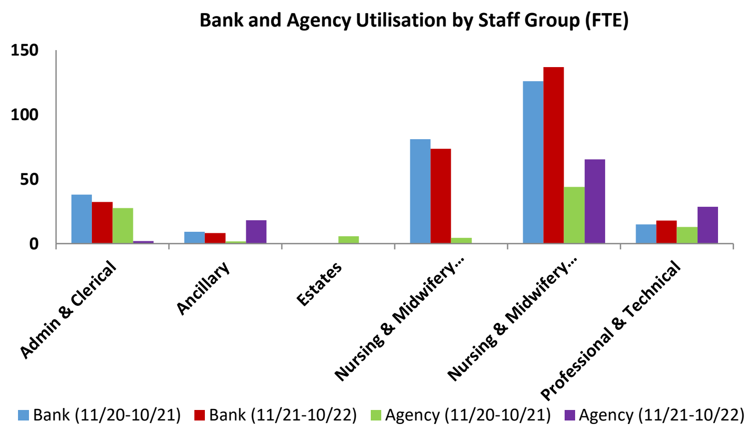
Turnover by Directorate

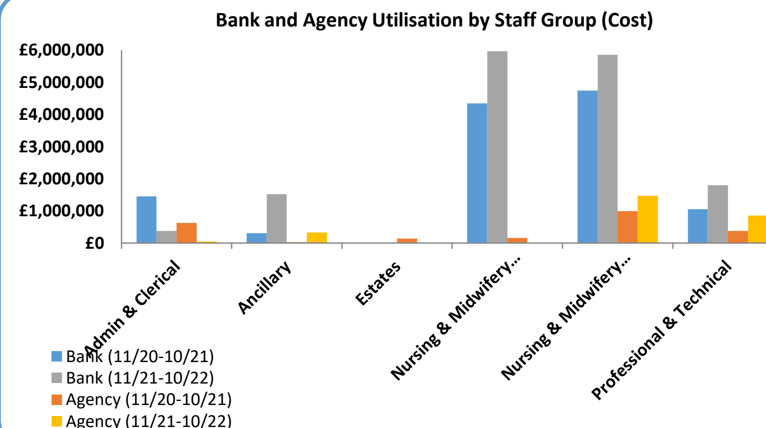
Directorate	Turnover
Day Treatment Centre	0.00%
Chief Executive	3.23%
Neurosciences	6.15%
Medical Physics	6.95%
Medical Director	7.66%
Surgical Services	8.59%
Urology & Renal Services	8.64%
Peri-operative & Critical Care - FH	8.65%
Internal Medicine - Urgent Care	9.32%
Business & Development	9.68%
Musculoskeletal Services	9.97%
Clinical Research	10.51%
Cancer Services/ Clinical Haematology	10.70%
Pharmacy	10.88%
Children's Services	10.95%
ENT, Plastics, Ophthalmology & Dermatology	11.30%
Internal Medicine - General	11.35%
Cardiothoracic	11.38%
Radiology	11.51%
Dental Services	11.54%
Peri-operative & Critical Care - RVI	11.58%
Women's Services	11.71%
Chief Operating Officer	11.94%
Community Services	12.87%
Integrated Laboratory Medicine	13.22%
Information Management & Technology	13.52%
Estates	14.21%
Patient Services	14.26%
Regional Drugs & Therapeutics	16.44%
Finance	17.24%
Human Resources	22.75%
Supplies	24.39%
Grand Total	**15.5%**

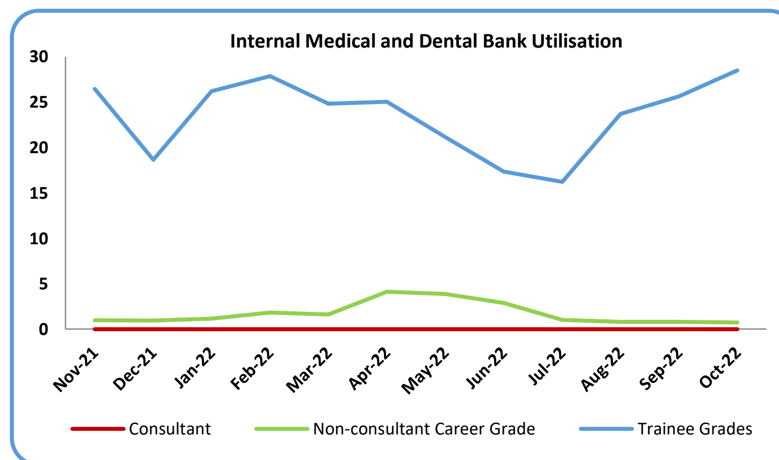
- Only 26% of leavers across the Trust disclosed they were going to another NHS organisation.



People – Workforce 3/4

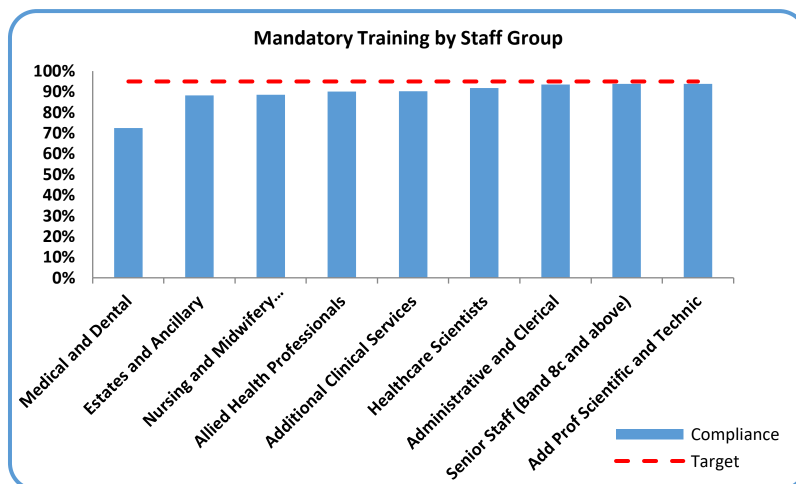


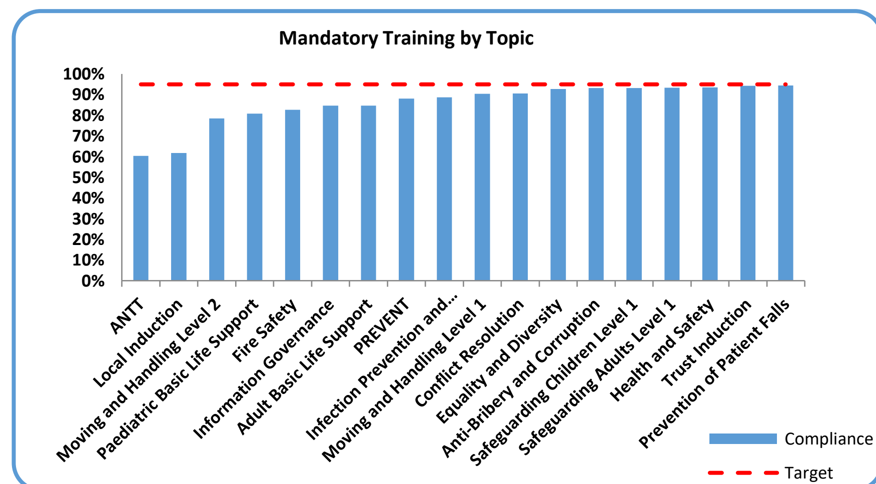


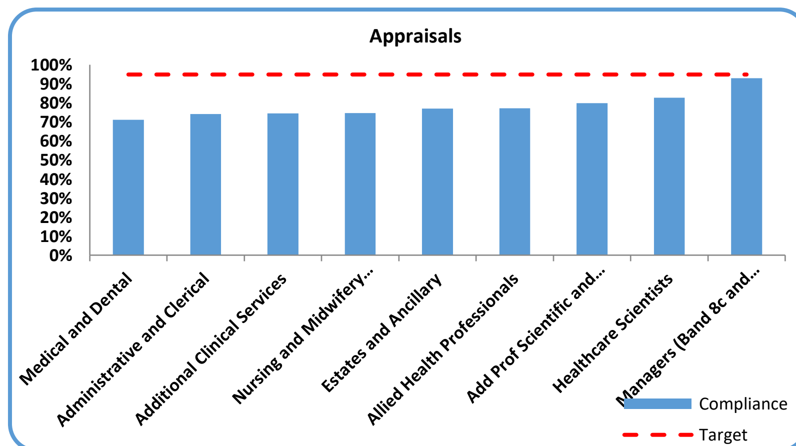


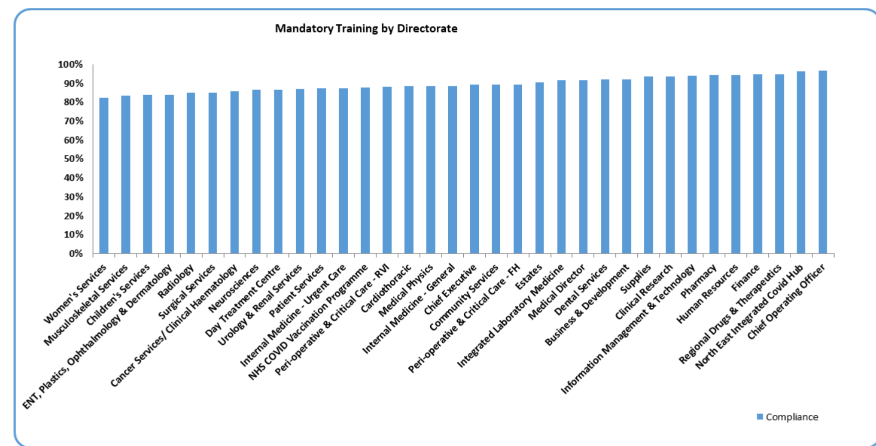
- Comparing the periods September 2020 – August 2021 to September 2021 – August 2022 , overall bank utilisation has remained the same at 268 wte and agency utilisation has increased from 95 wte to 114 wte.

People: Delivering Excellence in Education & Training









- Mandatory training compliance stands at 88.4% at end of October 2022, against an end of year target of 95%. The October 2021 position was 86.8%.
- Medical and Dental are the staff group with the lowest training compliance at 72.4% in October 2022 compared to 68.2% in October 2021.
- Appraisal compliance stands at 75.5%, at end of October 2022, against an end of year target of 95%. The October 2021 position was 75.2%. Interventions are in hand to improve this position.

Finance: Overall Financial Position

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

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

In the period to 31st October the Trust incurred expenditure of £808 million, and accrued income of £810 million on mainstream budgets and incurred expenditure of £4.4 million on the programmes outside the block envelope (vaccine roll-out programme), leading to a small surplus of £2.2 million. The Co-ordination and Response Centre and the Innovation Lab are included in the Trust's I&E position. ICHNE is being treated on an 'Agent Basis' and is excluded for both income and expenditure, the figure is £3.9 million and relates to the Lighthouse Laboratory only. It should be noted that all financial risk ratings are not being reported here, although the Trust has been included in NHS Provider Segmentation of 1 on the Use of Resources metrics (Oversight Framework). This means there are no specific support needs.

To 31st October the Trust had spent £30.6 million capital, £9.1 million behind Plan.

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

	Month 7 Budget £'000	Month 7 Actual £'000	Month 7 Variance £'000
Income	790,002	810,479	20,478
Expenditure	785,567	808,254	22,687
I & E position (excl impairment) - (Deficit)/Surplus	4,435	2,226	(2,209)
Capital Programme	39,703	30,575	(9,128)

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BOARD MEETINGS - ACTIONS

Agenda item A11

Log No.	BOARD DATE	PRIVATE / PUBLIC	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
92	31/05/2022	PUBLIC	iii) Director Reports: Executive Chief Nurse	Being mindful of the results of the CQC 2021 National Maternity survey highlighting support for mental health as an area for improvement, Ms Baker questioned if any links had been established with the Maternal Mental Health Alliance. The ECN advised that work was being undertaken and agreed to include a summary in a future Board report [ACTION01].	MC			22/07/22 - Email circulated to MC as a reminder for the next Board Report. 23/09/22 - Update to be provided at the Board meeting. 15/11/22 - ECN has confirmed that engagement is included in routine reports in relation to maternity services. Action closed.

KEY

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