The Newcastle upon Tyne Hospitals
NHS Foundation Trust

# TRUST BOARD

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date of meeting | 26 January 2023 | | | | | | |
| Title | Consultant Appointments | | | | | | |
| Report of | Andy Welch, Medical Director | | | | | | |
| Prepared by | Claudia Sweeney, Senior HR Advisor (Medical & Dental) | | | | | | |
| Status of Report | Public | | Private | | Internal | | |
| | ☒ | | ☐ | | ☐ | | |
| Purpose of Report | For Decision | | For Assurance | | For Information | | |
| | ☐ | | ☐ | | ☒ | | |
| Summary | The content of this report outlines recent Consultant Appointments. | | | | | | |
| Recommendation | The Board of Directors is asked to review the decisions of the Appointments Committee. | | | | | | |
| Links to Strategic Objectives | Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality.<br>People – Supported by Flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential. | | | | | | |
| Impact (please mark as appropriate) | Quality | Legal | Finance | Human Resources | Equality & Diversity | Reputation | Sustainability |
| | ☐ | ☐ | ☐ | ☒ | ☐ | ☐ | ☐ |
| Impact detail | Ensuring the Trust is sufficiently staffed to meet the demands of the organisation. | | | | | | |
| Reports previously considered by | Consultant Appointments are submitted for information in the month following the Appointments Panel | | | | | | |

# CONSULTANT APPOINTMENTS

## 1. APPOINTMENTS COMMMITTEE – CONSULTANT APPOINTMENTS

1.1 An Appointments Committee was held on 18 November 2022 and interviewed 3 candidates for 1 Consultant Paediatric Orthopaedic Surgeon post.

By unanimous resolution, the Committee was in favour of appointing Mr Richard Hutchinson.

Mr Hutchinson holds MBChB (University of Manchester) 2008, MRCS (UK) 2012, MSc in Orthopaedic Engineering (University of Cardiff) 2015 and FRCS (UK) 2020. Mr Hutchinson is currently employed as a Senior Orthopaedic Trauma Fellow at Nottingham University Hospitals.

Mr Hutchinson is expected to take up the post of Consultant Paediatric Orthopaedic Surgeon in April 2023.

1.2 An Appointments Committee was held on 7 December 2022 and interviewed 1 candidate for 1 Consultant Cardiologist (Adult Congenital Heart Disease) post.

By unanimous resolution, the Committee was in favour of appointing Dr Justyna Rybicka.

Dr Rybicka holds a Doctor of Medicine (Ludwik Rydygier Collegium Medicum in Bydgoszcz, Poland) 2008, and PhD (Institute of Cardiology in Warsaw, Poland) 2015. Dr Rybicka was previously employed as a Locum Consultant Cardiologist in Adult Congenital Heart Disease at the Royal Brompton and Harefield Hospitals.

Dr Rybicka took up the post of Consultant Cardiologist (Adult Congenital Heart Disease) on 3 January 2023.

1.3 An Appointments Committee was held on 12 December 2022 and interviewed 1 candidate for 1 Consultant Cellular Pathologist with an interest in Hepatopathology post.

By unanimous resolution, the Committee was in favour of appointing Dr Sam Cook.

Dr Cook holds MBChB (University of Manchester) 2014, and FRCPath (UK) 2022. Dr Cook is currently employed as a Specialty Trainee in Histopathology on behalf of the Lead Employer Trust, at the Royal Victoria Infirmary.

Dr Cook is expected to take up the post of Consultant Cellular Pathologist with an interest in Hepatopathology in February 2023.

1.4 An Appointments Committee was held on 20 December 2022 and interviewed 1 candidate for 1 Consultant Community Paediatrician post.

By unanimous resolution, the Committee was in favour of appointing Dr Sharan Romberg.

Dr Romberg holds MBBS (University of Newcastle) 2007, and MRCPCH (UK) 2013. Dr Romberg is currently employed as a Specialty Trainee in Paediatrics on behalf of the Lead Employer Trust, at the University Hospital of North Durham.

Dr Romberg is expected to take up the post of Consultant Community Paediatrician in April 2023.

1.5 An Appointments Committee was held on 9 January 2023 and interviewed 1 candidate for 1 Consultant in Obstetrics and Fetal Medicine post.

By unanimous resolution, the Committee was in favour of appointing Dr Fung Lin Foo.

Dr Foo holds BM (University of Southampton) 2009 and PhD (Imperial College, London) 2019. Dr Foo is currently employed as a Sub-specialist Trainee in Maternal-Fetal Medicine on behalf of the Lead Employer Trust, at the Royal Victoria Infirmary.

Dr Foo is expected to take up the post of Consultant in Obstetrics and Fetal Medicine in April 2023.

1.6 An Appointments Committee was held on 11 January 2023 and interviewed 2 candidates for 1 Consultant Anaesthetist post.

By unanimous resolution, the Committee was in favour of appointing Dr Ashley Scott.

Dr Scott holds MBBS (University of Newcastle) 2011, MRCP (UK) 2013, and FRCA (UK) 2018. Dr Scott is currently employed as a Specialty Trainee in Anaesthesia on behalf of the Lead Employer Trust, at the Royal Victoria Infirmary.

Dr Scott is expected to take up the post of Consultant Anaesthetist in May 2023.

1.7 An Appointments Committee was held on 12 January 2023 and interviewed 4 candidates for 3 Consultant Cardiologist posts.

By unanimous resolution, the Committee was in favour of appointing Dr Mohamed Farag, Dr Bilal Bawamia and Dr Timothy Cartlidge.

Dr Farag holds MBBCh (Ain Shams University, Egypt) 2008, MRCP (UK) 2012, and PhD (University of Hertfordshire) 2018. Dr Farag is currently employed as a Locum Consultant at East and North Hertfordshire NHS Trust and Imperial College Healthcare.

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

Dr Bawamia holds MBBS (University of Newcastle) 2010, MRCP (Edinburgh) 2013, PGDip in Clinical Research (University of Newcastle) 2014 and MD (University of Newcastle) 2022. Dr Bawamia is currently employed as a Locum Consultant Interventional Cardiologist at the Freeman Hospital.
Dr Bawamia is expected to take up the post of Consultant Cardiologist in February 2023.

Dr Cartlidge holds MBChB (University of Edinburgh) 2009, MRCP (Edinburgh) 2011, and PhD (University of Edinburgh) 2021. Dr Cartlidge is currently employed as a Locum Consultant Interventional Cardiologist at the Freeman Hospital

Dr Cartlidge is expected to take up the post of Consultant Cardiologist in February 2023.

1.8 An Appointments Committee was held on 13 January 2023 and interviewed 3 candidates for 1 Consultant Congenital Cardiothoracic Anaesthetist post.

By unanimous resolution, the Committee was in favour of appointing Dr Simon Hill.

Dr Hill holds MBChB (University of Birmingham) 2012, and FRCA (UK) 2019. Dr Hill is currently employed as a Trust Fellow in Paediatric Cardiothoracic Anaesthesia, at the Freeman Hospital.

Dr Hill is expected to take up the post of Consultant Cardiothoracic Anaesthetist post in February 2023.

## 2. RECOMMENDATION

1.1 – 1.8 – For the Board to receive the above report.

**Report of Andy Welch**
**Medical Director**
26 January 2023

THIS PAGE IS INTENTIONALLY BLANK

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

# TRUST BOARD

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date of meeting | 26 January 2023 | | | | | | |
| Title | Guardian of Safe Working Quarterly Report (Q2 2022-23) | | | | | | |
| Report of | Dr Henrietta Dawson, Trust Guardian of Safe Working Hours | | | | | | |
| Prepared by | Dr Henrietta Dawson, Trust Guardian of Safe Working Hours | | | | | | |
| Status of Report | Public | | Private | | Internal | | |
| | ☒ | | ☐ | | ☐ | | |
| Purpose of Report | For Decision | | For Assurance | | For Information | | |
| | ☐ | | ☐ | | ☒ | | |
| Summary | The terms and conditions of service of the new junior doctor contract (2016) require the Guardian of Safe Working Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant.<br><br>The content of this report outlines the number and main causes of exception reports for the period 27 June to 26 September 2022 for consideration by the Trust Board. | | | | | | |
| Recommendation | The Trust Board is asked to note the contents of this report. | | | | | | |
| Links to Strategic Objectives | Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. | | | | | | |
| Impact (please mark as appropriate) | Quality | Legal | Finance | Human Resources | Equality & Diversity | Reputation | Sustainability |
| | ☒ | ☐ | ☐ | ☒ | ☐ | ☐ | ☐ |
| Impact detail | In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training. | | | | | | |
| Reports previously considered by | Quarterly report of the Guardian of Safe Working Hours. | | | | | | |

# GUARDIAN OF SAFE WORKING QUARTERLY REPORT

## 1. EXECUTIVE SUMMARY

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

There are now 850 postgraduate doctors in training on the New Junior Doctor Contract and a total of 1,043 postgraduate doctors in the Trust.

There were 138 exception reports in this period. This compares to 97 exception reports in the previous quarter.

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

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

## 2. INTRODUCTION / BACKGROUND

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

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

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

## 3. HIGH LEVEL DATA

| | | (Previous quarter data for comparison) |
|---|---|---|
| Number of Junior Doctors on New Contract | 850 | (811) |
| Total Number of Junior Doctors | 1,043 | (1,012) |
| Number of Exception reports | 143 | (100) |
| Number of Exception reports for Hours Breaches | 138 | (97) |
| Number of Exception reports for Educational Breaches | 9 | (4) |
| Fines | 7 | (3) |
| | | |
| Admin Support for Role | Good | |
| Job Planned time for supervisors | Variable | |

## 4. EXCEPTION REPORTS

### 4.1 Exception Report by Speciality (Top 5)

| | | (Previous quarter for comparison) |
|---|---|---|
| General Medicine | 64 | (43) |
| Ophthalmology | 36 | (25) |
| General Surgery | 11 | (16) |
| Haematology/Oncology | 17 | (8) |
| Neurosurgery | 7 | (0) |

### 4.2 Exception Report by Rota/Grade

| | |
|---|---|
| General medicine RVI | |
| F1 | 15 |
| F2 | 4 |
| General Medicine FH | |
| F1 | 26 |
| F2/ Core medical training | 13 |
| Intermediate medical training | 6 |
| Ophthalmology | |
| F2/ST1&2 | 8 |
| ST3+ | 28 |
| General Surgery | |
| RVI (F1/F2) | 8 |
| FH (F1) | 3 |
| Neurosurgery | |
| F2 | 7 |

### 4.3 Example Themes from Exception Reports

**General Medicine RVI/FH**
"Late finish + no breaks due to below minimum staffing for doctors. I was on call that night too so stayed after my shift to complete ward work until 11pm."

42/64 exception reports for medicine were in the 1st 5 weeks (up to August changeover of medical staff.) Medicine was under extreme staffing pressures. There are ongoing issues with staffing and high workloads.

**Neurosurgery**

"I had to hand over 2 ill patients one of which I reviewed right before handover. Required documentation to be performed on my end and time to handover to night staff. Work schedule states 2-8 and there does not seem to be anytime included for handover when on lates.."

This work schedule has been amended to allow time for handover.

**Ophthalmology RVI**

"Due to eye casualty being busy; late finish at 18:30 - Lots of patients; not enough senior staff to review patients."

"Busy on call; worked onsite 9am to 8pm; then trauma call so worked 9.30pm-11.30pm; then trauma call again 1.30am - worked until 2.50am."

The workload in eye casualty and the workload of the on call for ophthalmology are being reviewed by the directorate with steps taken to address these issues.

**Haematology/Oncology**

"Stayed 1.5hrs late on ward doing routine day jobs due to rota below minimum staffing"

## 5. EXCEPTION REPORT OUTCOMES

### 5.1 Work Schedule Reviews

One Work Schedule review has been undertaken to include handover time in neurosurgery (see earlier.)

### 5.2 Fines

1 fine has been issued:

Haematology/Oncology: £100.78. Rule breached "Exceeding the maximum 13-hour shift length."

6 fines are being calculated for Ophthalmology:
Rule breached "Unable to achieve minimum overnight continuous rest of five hours between 22:00 and 07:00 during a non-resident on-call (NROC)."

## 6. ISSUES ARISING

### 6.1 Workforce and workload

The recurring theme as to when exception reports are raised is when there is a reduction of doctor numbers on the ward or high workloads due to multiple unwell patients.
The non-resident on call working pattern in ophthalmology is also under scrutiny.

### 6.2 Supervisor Engagement

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

### 6.3 Administrative Support

Administrative support is currently good.

## 7. ROTA GAPS

Specialties and rotas with vacancies are outlined below.

| Specialty/Subspecialty | Grade | No required on rota (at full complement) | Sep-22 | Aug-22 | Jul-22 |
|---|---|---|---|---|---|
| **Cancer Services** | | | | | |
| Oncology | ST3+ | 14 | 3 | 3 | 0.8 |
| Palliative Medicine | F2/ST1+ | 13 | 1.5 | 1.5 | 2.1 |
| Haematology / Oncology | F2/ST1/ST2 | 10 | 2 | 2 | 2 |
| Haematology / Oncology | CMT | 4 | 0.4 | 0.4 | 0.2 |
| Haematology | ST3+ | 10 (from Jan 2021) | 2 | 2 | 2 |
| **Cardiothoracic Services** | | | | | |
| Cardiology | F2/ST1-2 | 5 | 1.2 | 1.2 | 1.2 |
| Cardiology | CMT | 2 (from Dec 20) | 1 | 1 | 1 |
| Cardiothoracic Anaesthesia | ST3+ | 9 | 4 | 4 | 3 |
| Cardiothoracic Surgery | F2/ST1-2 | 2 | 1 | 1 | 0 |
| Cardiothoracic Surgery | ST3+ | 11 | 3 | 4 | 2 |
| Cardiothoracic Transplant | ST3+ | 3 | 1 | 1 | 1 |
| PICU | ST3+ | 9 (inc day cover with GNCH & Paeds Cardiology | 1.4 | 0.4 | 0.2 |
| Paediatric Cardiology 1st | F2/ST1/ST2 | 7 | 2 | 1 | 1 |
| Paediatric Cardiology 2nd | ST3+ | 9 (from Jan 2021) | 0.4 | 0.2 | 0 |
| Respiratory Medicine | CMT/ST1-2 | 4 | 1 | 1 | 1 |
| Respiratory Medicine | ST3+ | 11 (rotate with RVI) | 1.4 | 0.4 | 0.4 |
| **Children's Services** | | | | | |
| Paediatric Surgery 2nd | ST3+ | 9 (8 from Nov 20) | 2.4 | 2.4 | 1.4 |
| Paediatrics 1st - ST1/ST2 (now inc Paeds Surgery) | F2/ST1/ST2 | 30 | 3 | 2.6 | 1.6 |
| General Paediatrics | ST3+ | 21 | 2 | 2 | 2 |
| Paediatric Oncology | ST3+ | 6 | 2 | 2 | 2 |
| Paediatric ICU (PICU) | ST3+ | 9 (8 from May 2021) | 2 | 2 | 1.4 |

| | | | | | |
|---|---|---|---|---|---|
| **Dental** | | | | | |
| OMFS | ST1/ST2 | 8 | 1 | 2 | 2 |
| DCT | DCT | 12 | 0 | 1 | 1 |
| **EPOD** | | | | | |
| ENT | F2 / CST / ST1-2 | 6 | 1 | 1 | 0.2 |
| ENT | ST3+ | 9 | 1.4 | 1.4 | 0.4 |
| Plastic Surgery | F2/ST1/ST2 | 10 | 2 | 2 | 1 |
| Plastic Surgery | ST3+ | 13 | 0 | 0 | 1 |
| Ophthalmology | F2/ST1/ST2 | 6 | 1.4 | 2.4 | 1.4 |
| Ophthalmology | ST3+ | 24 | 1.4 | 1.4 | 0.4 |
| Dermatology | ST3+ | 9 | 0.4 | 1.4 | 0.8 |
| Dermatology | CMT | 2 | 1 | 1 | 1 |
| Dermatology | GPSTR | 1 | 0.4 | 0.4 | 0.4 |
| **Integrated Lab Medicine** | | | | | |
| Histopathology | ST3+ | 13 | 0.8 | 0.8 | 2.8 |
| Forensic Histopathology | ST3+ | 2 | 2 | 2 | 2 |
| Histopathology | ST1/2 | 8 | 2 | 2 | 2 |
| Genetics | ST3+ | 4 | 0.4 | 0.4 | 0.4 |
| MM rota integrated with ID and MV and GIM | ST1+ | 21 | 1 | 1 | 0.8 |
| **Medicine** | | | | | |
| General Internal Medicine | F2/GPVTS/CMT/TF | 21 | 1 | 1 | 2 |
| CMT BOH and FOH Combined (August 2019) | CMT | 11 | 1 | 1 | 1 |
| CMT Acute- ACU (August 2019) | CMT | 2 | 1 | 1 | 2 |
| ACCS on Assessment Suite Only | ACCS | 2 | 0 | 0 | 0.2 |
| General Internal Medicine | ST3+ | 25 | 2 | 3.6 | 3.1 |
| Care of the Elderly | ST3+ | 5 | 1.2 | 1.2 | 0.2 |
| Accident & Emergency 1st | ACCS/ST1-2/CT1-2 | 20 | 6 | 6 | 1.6 |
| Accident & Emergency 2nd | ST3+ | 15 (14 from Nov 20) | 3 | 5.2 | 4.3 |
| **Musculoskeletal** | | | | | |
| Rheumatology | ST3+ | 5 | 2.4 | 1.4 | 1.4 |
| Rheumatology | CMT1-2 | 4 | 1 | 1 | 2 |
| Orthopaedics | F2/ST1/ST2 | 6 | 2 | 1 | 0 |
| Orthopaedics | F2/ST1/ST2 | 5 | 1 | 0 | 0 |
| Orthopaedics | ST3+ | 19 | 1.2 | 1.2 | 0.3 |
| **Neurosciences** | | | | | |
| Neurosurgery | F2/ST1/ST2 | 5 | 1 | 1 | 0 |
| Neurosurgery | ST3+ | 13 | 1 | 1 | 0 |
| Neurology | ST3+ | 13 | 1.6 | 1.6 | 1.6 |
| Neurology | F2/ST1/ST2 | 2 | 0 | 0.2 | 0.2 |
| Neurophysiology | All grades | 3 | 0.2 | 0.2 | 0.2 |
| **Peri-operative FH** | | | | | |
| Critical Care | F2 ST1-7 | 11 | 2.8 | 2.8 | 2 |
| Anaesthetics General | ST1-7 CT1-2 | 29 | 2 | 2 | 1.8 |
| **Peri-operative RVI** | | | | | |
| Critical Care | ST1+ | 18 (14 from Aug 22) | 1.2 | 1.4 | 2.8 |
| Anaesthetics | ST1-2 / ST3 + | 44 (40 From Aug 22) | 2.8 | 2.8 | 4.6 |

| | | | | | |
|---|---|---|---|---|---|
| **Radiology** | | | | | |
| Radiology On Call | ST2 / ST3+ | 33 | 1.4 | 1.4 | 1.4 |
| Neuroradiology | All grades | 4 | 0.2 | 1 | 1 |
| **Surgical Services** | | | | | |
| General Surgery | F2/ST1/ST2/ST3+ | 7 | 2 | 2 | 1 |
| Vascular | ST3+ | 10.5 (11 from May 2021) | 2 | 2 | 0 |
| General Surgery | F2/ST1/ST2 | 7 | 1 | 1 | 0 |
| General Surgery | ST3+ | 17 | 3 | 3.2 | 1.6 |
| IoT - NSR & Teaching Fellows | ST1-2 NSR TFs | 4 | 1 | 1 | 0 |
| **Urology & Renal** | | | | | |
| Renal Medicine | F2/ST1/ST2 | 5 | 0 | 0 | 1 |
| Renal Medicine | ST3+ | 9 | 0.4 | 0.4 | 1 |
| Urology | F2/ST1/ST2 | 7 | 0 | 0 | 0.4 |
| **Women's' Services** | | | | | |
| Obstetrics & Gynaecology | F2/ST1/ST2 | 14 | 0 | 0 | 1 |
| Obstetrics & Gynaecology | ST3+ | 22 | 2 | 2 | 0 |
| Neonates | F2/ST1/ST2 | 7 | 1.4 | 1.4 | 1.4 |
| Neonates | ST3+ | 13 | 2.6 | 1.6 | 0 |

### 7.1 Locum Spend

**LET Locum Spend**

| | |
|---|---|
| July to September (Q2 2022-23) | £683,260.67 |
| April to June (Q1 2022-23) | £446,907 |
| January to March (Q4 2021-22) | £618,712 |

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

**Trust Locum Spend**

| | |
|---|---|
| July to September (Q2 2022-23) | £673,665 |
| April to June (Q1 2022-23) | £482,999 |
| January to March (Q4 2021-22) | £589,740 |

Comment from finance team:
"Spend on Trust locums increased by £190k, this was made up in the most part of a £234k increase to cover established vacancies and a £26k increase for sickness offset by a decrease of £72k related to Covid. With regard to directorates the biggest increases seen were an increase of £38k in A&E, £53k across Cardiac specialties and £33k in General Medicine."

## 8. RISKS AND MITIGATION

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

## 9. JUNIOR DOCTOR FORUM

There is a new JDF postgraduate doctor chair.

The main areas of discussion were again around the issues of staffing and extreme clinical pressures. In addition, concerns regarding lack of changing facilities and inequity of locum pay were discussed.

## 10. RECOMMENDATIONS

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

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

THIS PAGE IS INTENTIONALLY BLANK

The Newcastle upon Tyne Hospitals NHS Foundation Trust

# TRUST BOARD

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date of meeting | 26 January 2023 | | | | | | |
| Title | Executive Chief Nurse (ECN) Report | | | | | | |
| Report of | Maurya Cushlow, Executive Chief Nurse | | | | | | |
| Prepared by | Ian Joy, Deputy Chief Nurse<br>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:<br>• Spotlight on our Learning Disability Team<br>• Nurse and Midwifery Staffing update<br>• Nursing, Midwifery and Allied Health Professional Strategy – Research update<br>• Royal College of Nursing Industrial action | | | | | | |
| 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.<br>• We will be an effective partner, developing and delivering integrated care and playing our part in local, national and international programmes.<br>• 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: Learning Disability Team

This month's 'Spotlight' section outlines the work of our Learning Disability Liaison Team.

The Learning Disability Liaison Team work across the organisation (maternity, children and adults) offering specialist advice and support to clinical teams with regard to learning disability and the understanding of reasonable adjustments to support their clinical care. The team provide guidance throughout the patient journey, supporting with elective and acute presentations. A key aspect of the liaison teams work is facilitation, which includes planning and support to access care, which can range from attending an outpatient appointment to day case attendance to support admission to hospital.

The team currently consists of 2.2 whole time equivalent (wte) nursing staff who have a breadth of skills and qualifications to support this work across the organisation. Following a recent workforce review new investment has been agreed to increase the infrastructure in the team and recruitment to this new investment is in progress.

The report includes an overview of the work the team are involved in including:

- **Activity** - Referrals to the team are increasing in number and complexity. In November and December 2021, the team received a total of 425 referrals with this increasing to 510 for the same period in 2022 – a 17% increase.
- **Workstreams** - The Liaison Team have a 'virtual ward' to identify patients with a learning disability who have been admitted to the Trust which is reviewed daily, and the team offer support to the clinical teams. This is particularly the case for more complex patients that require large multi-disciplinary teams to come together to discuss the individualised care for patients with the support and input from their families / carers. Specific actions are being developed by the team and wider Trust to consider how to improve support to patients with a diagnosis of autism in isolation of a learning disability diagnosis across the organisation and how better to identify them when they have been admitted.
- **Education** - In July, the Health and Care Act 2022 introduced a requirement that regulated service providers ensure their staff receive training on learning disability and autism which is appropriate to the person's role. Nationally, The Oliver McGowan Mandatory Training on Learning Disability and Autism is standardised training that has been developed for this purpose. The training has recently been released and work is underway to explore if this can be implemented across the Trust.

In December 2021, the CQC undertook a focused inspection to review our approach and care for and with patients who have a Learning Disability or Mental Health needs.

The team were included in this focussed inspection, and we await formal feedback from this review to combine any recommendations with Trust action plans to ensure we have a clear focus for the year ahead.

## Section 2: Nursing and Midwifery Staffing Update

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

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

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

The following key points from this group are noted below:

- A number of wards have required support at medium or high level since the last report to Board. Action plans are in place for three specific wards 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 impacting on staff wellbeing.
- Red flags generated within the SafeCare module by the nursing staff in conjunction with professional judgement have provided valuable triangulation of data alongside DATIX reports. All these alerts are responded to promptly by members of the Senior Nursing Team directly with the ward staff and the Matrons. All DATIX reports reviewed were graded no harm or low/minor.

In the last quarter the number of DATIX submitted were:

- November 19
- December 36

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

- Nursing and Midwifery (N&M) turnover is 12.7% against a national average of 13.5%. Improving the retention figure remains a key priority with completion of the NHSE/NHS Improvement (NHSI) N&M retention self-assessment tool looking at gap analysis against high impact outcomes being submitted to the Integrated Care System (ICS).
- The Band 5 Registered Nurse (RN) vacancy rate is 5.76% based on current staff in post. There is a pipeline of 124 (head count) Band 5 RN staff across adult and paediatrics.
- Since June 2022 we have seen the arrival of 204 internationally educated nurses. There are monthly deployments planned up to May 2023 with a current pipeline of 100 nurses.
- The Healthcare Support Workers (HCSW) vacancy currently sits at 6.7%. There are currently 113 candidates in the recruitment pipeline.

**Section 3: Nursing, Midwifery and Allied Health Professional (NMAHP) Strategy – Research update**

On the 26 July 2022 the Trust launched its new NMAHP Strategy. As previously highlighted to Board, the strategy is split into six key priorities. These priorities outline what we are already achieving in the relevant domain with a clear "We Are" statement and contain between three to four high level "We Will" statements outlining our aspirations for the future.

Since the launch, there has been a monthly deep dive to help culture the key priorities and this commenced with a focus on priority five – *Increasing research opportunities and impact, whilst strengthening our academic links*. This section of the report provides an update on this priority with a specific focus following on the launch of our NMAHP Research Development Institute.

The following key achievements have realised since the launch of the strategy. Further information is provided within the report:

- In August, following the completion of a rigorous and robust selection process, we awarded the first three NMAHP Research Development Institute (RDI) fellowships. One Fellowship was awarded at Masters level and two at Doctoral level.
- The second Round of Doctoral Fellowships is currently open, closing March 2023.
- The 1st Chief Nurse Post-Doctoral Fellowship has been awarded and the individual is due to commence imminently.
- There is a Research Capacity Building and Futures Group meeting now established and reporting into the RDI Leadership Board.
- During 2021, a collaboration between the Newcastle Hospitals, The James Paget University Hospitals and the ImpACT Research Group at University of East Anglia led to the development of an innovative practice led Embedded Researcher (ER) model to contribute to the range of work going on to support research capacity building for the NMAHP workforce. The Embedded Researcher Fellowship Pilot in the Trust has just recently been appointed after a competitive process with a number of high calibre applications.
- Mapping work to start to identify career opportunities aligned with growing research capability will form part of the workplan for this next year.

It is exciting to see this work progress and to see the aspirations of the strategy come to fruition. There has already been a tangible benefit to those individuals who were successful in being awarded fellowships in feeling valued, supported, and encouraged to develop.

We will be able to see the impact and direct benefit of their work in the years ahead as they shape professional practice and improve patient care.

## Section 4: Royal College of Nursing (RCN) Industrial Action

In early November 2022, the Trust was informed by the RCN that members in the Trust had voted in favour of industrial action and the necessary thresholds had been met. At the end of November, the Trust was informed by the RCN that it would be involved in the first wave of industrial action, planned for the 15 and 20th December.

Collaborative working across Nursing, Medical, Operational, HR and Directorate Teams was undertaken to ensure effective and controlled management of the industrial action, ensuring safe care was maintained and staff supported to strike. The Trust negotiated closely with the RCN via the Industrial Dispute Strike Committee which was set up to manage the industrial action between both parties.

On the 15 December 25% of staff planned to work on that day went out on strike with 28% on the 20 December. Clinical and operational leaders and front-line staff from across the Trust worked hard to ensure any risk was mitigated. Post-strike debrief has been undertaken to ensure any lessons learned are understood and shared to prepare for any future strike action.

At the time of writing, we are actively preparing for one day strike by the Chartered Society of Physiotherapists and a further two days of strike by RCN members.

## RECOMMENDATION

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

**Report of Maurya Cushlow**
**Executive Chief Nurse**
26 January 2023

# EXECUTIVE CHIEF NURSE REPORT

## 1. SPOTLIGHT


People (children, young people, and adults) with a Learning Disability are four times more likely to die of something which could have been prevented than the general population. One of our Trust's strategic priorities is Patients – *Putting Patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality*. As a Trust, we are committed to ensuring patients with a learning disability have timely access to services that will help improve their health and wellbeing. We want to provide assurance that patients and their families have appropriate reasonable adjustments put into place as required and that they are listened to, feel listened to, and have a positive experience whilst in our care and appropriate follow up.

### 1.1 The Learning Disability Liaison Team

The Learning Disability Liaison Team work across the organisation (maternity, children and adults) offering specialist advice and support to clinical teams with regard to learning disability and the understanding of reasonable adjustments to support their clinical care. The team provide guidance throughout the patient journey, supporting with elective and acute presentations. A key aspect of the liaison teams work is facilitation, which includes planning and support to access care, which can range from attending an outpatient appointment to day case attendance to support admission to hospital.

The team currently consists of 2.2 whole time equivalent (wte) nursing staff who have a breadth of skills and qualifications to support this work across the organisation. Following a recent workforce review new investment has been agreed to increase the infrastructure in the team and recruitment to this new investment is in progress.

### 1.2 Key Workstreams

The team take referrals from clinical teams within the organisation and from Community Teams and GP's. The number of referrals to the team are increasing in number and complexity. In November and December 2021, the team received a total of 425 referrals with this increasing to 510 for the same period in 2022 – a 17% increase.

Separate to referrals, it is important to ensure that there are processes in place to ensure patients with a learning disability who attend the Trust are highlighted to the team to ensure support can be provided to ensure reasonable adjustments. The Liaison Team have a 'virtual ward' to identify patients with a learning disability who have been admitted to the Trust which is reviewed daily and the team offer support to the clinical teams. This is particularly the case for more complex patients that require large multi-disciplinary teams to come together to discuss the individualised care for patients with the support and input from their families / carers.

Specific actions are being developed by the team and wider Trust in order to consider how to improve support to patients with a diagnosis of autism in isolation of a learning disability diagnosis across the organisation and how better to identify them when they have been admitted. Currently these patients are not routinely 'flagged' on the system and there is discussion regionally regarding how this can best be managed in the best way for these patients. Work is underway to explore how this system can be further expanded to identify elective admissions in advance and highlight patient with a learning difficulty including autism.

**1.3 Reasonable Adjustments**

As previously mentioned, a key focus for the team is ensuring reasonable adjustments are in place. There skills, experience and expertise are of paramount importance in ensuring as a Trust we get this right for our patients. When this is done well and the impact on the individual and their family is significant not just on this occasion but also in preparation for future attendance. It is important to ensure adjustments are specific to the individual and agreed with the patient, their family/carer. The team are key in leading this work.
Examples of adjustments recently have included:

- Visit from transfer crews the evening prior admitting to hospital so the patient could see and understand the vehicle and team who were transferring into hospital the following day.
- Route through hospital agreed and lifts held to avoid delays and reduce anxiety.
- Transfer home at night-time as this was more beneficial for the patient and their sleep pattern.
- Bespoke 'play sessions' for children in advance and during the hospital attendance.
- Care delivered in different locations across the Trust to ensure the most appropriate environment of care delivery for individuals.

**1.4 Training and Education**

A key aspect of work for the team is the delivery of training and education.
In July the Health and Care Act 2022 introduced a requirement that regulated service providers ensure their staff receive training on learning disability and autism which is appropriate to the person's role. Nationally, The Oliver McGowan Mandatory Training on Learning Disability and Autism is standardised training that has been developed for this purpose. It is named after Oliver McGowan, whose death shone a light on the need for health and social care staff to have better training. The training has recently been released and will be in two parts which will require all staff to complete 'Tier 1' and specific staff to complete 'Tier 2'. Work is underway supported to explore if this can be implemented across the Trust.

**1.5 Moving Forward**

The importance of this team and their work cannot be underestimated as we strive to deliver the highest standard of care and experience for all patients. The team has worked tirelessly to improve care and the application of reasonable adjustments and continue to do so, supported by new investment into the team.

In December 2021 the CQC undertook a focused inspection to review our approach and care for and with patients who have a learning disability, and we await formal feedback from this review to combine any recommendations with Trust action plans to ensure we have a clear focus for the year ahead, aligned to our existing Quality Strategy priority.

## 2. NURSING AND MIDWIFERY STAFFING UPDATE

### 2.1 National Guidance

In November 2022, NHSE/I released guidance "Key actions - winter 2022 preparedness: nursing and midwifery safer staffing". This guidance has a focus on preparedness, decision making and escalation processes to support safer nursing and midwifery staffing in responding to challenges over the winter period. This guidance builds on the existing frameworks already outlined in the National Quality Board (NQB) Safe, sustainable, and productive staffing guidance.

The guidance outlines four key themes:

- Staffing Escalation/Surge and Super Surge Plans
- Operational Delivery
- Daily Governance (via EPRR route when required)
- Board oversight and assurance

A gap analysis has been undertaken to ensure our existing "Nursing and Midwifery Safe Staffing Guidelines" and escalations are aligned to national expectations.
It is clear from a nursing perspective that existing guidelines and process are aligned to national guidance. The Trust is broadly complaint with no concerns noted. Where there are areas which could be further strengthened, this is being explored.

### 2.2 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 November.

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.
- Sickness absence sustained between 5 and 7% for the nursing and midwifery workforce

The increased requirement for enhanced care continues, in addition to acuity and dependency remaining high across all service areas. This along with increased sickness absence has led to significant challenges in maintaining a safer staffing provision.
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.

Alongside the formal escalation actions there are other key points and actions to note:

- Nurses and midwives in corporate roles and non-ward areas have been deployed where possible to support clinical areas. Additional refresher training and education is in place to support staff.
- To future support this escalation, Matron cover on site at weekends is provided to support safer staffing and ensure increased senior professional oversight in complex decision making alongside existing processes.

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. Whilst a framework for safer staffing remains in place, it is acknowledged that the current staffing challenges are having a significant impact on staff well-being.

## 2.3 Nurse Staffing and Clinical Outcomes

In view if the current staffing escalation 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 is particularly important. Each month wards are reviewed by the group and 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. Any ward requiring medium support for two consecutive months or any ward requiring high-level support will be highlighted to the Board in this report.

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 |
|---|---|---|---|---|---|---|---|
| November | 20 | X2 Musculoskeletal Services<br>X7 Internal Medicine<br>X1 Cardiothoracic Services<br>X2 Children's Services<br>X2 Urology and Renal Services<br>X1 Peri – Op and Critical Care<br>X1 EPOD | 6 | 2 | 6 | 2 | 0 |
| December | 12 | X1 Musculoskeletal Services | 5 | 1 | 6 | 1 | 0 |

| Month | No. of Wards Reviewed | Directorate | Monitor | Low Level Support | Medium Level Support | High Level Support | No Further Support |
|---|---|---|---|---|---|---|---|
| | | X8 Internal Medicine<br>X1 Cardiothoracic Services<br>X2 Urology and Renal Services<br>X1 Children's Services | | | | | |

- A number of wards have required support at medium or high level since the last report to Board. Action plans are in place for three specific wards 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 impacting on staff wellbeing.
- Red flags generated within the SafeCare module by the nursing staff in conjunction with professional judgement have provided valuable triangulation of data alongside DATIX reports. All these alerts are responded to promptly by members of the Senior Nursing Team directly with the ward staff and the Matrons. All DATIX reports reviewed were graded no harm or low/minor.

In the last quarter the number of DATIX submitted were:

  - November 19
  - December 36

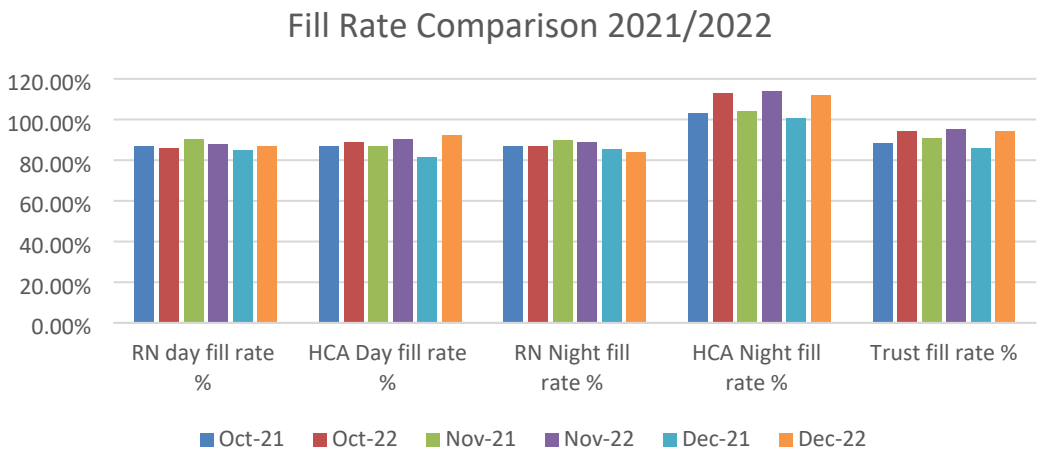
- Whilst the group provides high-level monitoring, oversight and assurance there continues to be a robust leadership and management framework led by the Matron team.

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

The Trust level fill rates and CHPPD are detailed below:

| Month | CHPPD | RN day fill rate % | HCA Day fill rate % | RN Night fill rate % | HCA Night fill rate % | Trust fill rate % |
|---|---|---|---|---|---|---|
| October 22 | 7.6 | 86% | 89% | 87% | 113% | 94% |
| November 22 | 7.5 | 88% | 90% | 89% | 114% | 95% |
| December 22 | 7.9 | 87% | 92% | 84% | 112% | 94% |

- Below is the comparison data for this year and the same period last year. The registered nurse (RN) fill rate is due to vacancy, in addition to workforce who are "away" for other reasons such as sickness and maternity leave but has remained stable. Several wards have temporarily closed beds to mitigate the risk to patient safety. It is worth noting during the same time period last year the fill rates were reflective of the temporary reduction of 48 adult beds to mitigate risk due to staffing. There are currently now only 16 beds closed due to staffing but there are 8 surge beds opened in other areas.




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

## 2.5 Recruitment and International Recruitment

### 2.5.1 Registered Nurse Recruitment

The current total Registered Nursing and Midwifery workforce combined turnover is 12.7%. This is based on month six Model Health System data. Whist the turnover has increase it compares favourably with the national median of 13.5%. The increased turnover is a national picture and includes those staff who are leaving following a delay in planned retirement following the pandemic. Improving the retention figure remains a key priority with completion of the NHSE/I N&M retention self-assessment tool looking at gap analysis against high impact outcomes being submitted to the ICS.

Monthly generic recruitment for Band 5 RN continues with targeted bespoke recruitment. The Band 5 RN vacancy rate is 5.76% based on the financial ledger at Month 7 and relates to current substantive staff in post. It does not include those nurses currently in the recruitment process, where there is a pipeline of 124 (head count) Band 5 RN staff across adult and paediatrics. Focused recruitment has taken place to respond to workforce requirements for new service developments, encourage applications from experienced staff seeking new challenges in specialist services and for winter preparedness.

### 2.5.2 International Recruitment

International recruitment has continued despite challenges with the ambitious target of recruiting 300 adult and paediatric nurses and midwives this year. Since June 2022 we have seen the arrival of 204 internationally educated nurses which includes 19 paediatric nurses and two midwives. There are monthly deployments planned up to May 2023 with a current pipeline of 100 internationally educated nurses. The total pipeline includes 15 paediatric nurses and three midwives. The deployments run beyond the end of this financial year due to challenges recognised nationally in identifying suitable rental accommodation for our new staff.

NHSE have recently confirmed funding to support international recruitment into 2023/24 financial year. The Executive Chief Nurse Team, supported by colleagues in HR and Finance are reviewing the requirements for next year and will submit a proposal in due course. It is expected that we will need to continue to recruit internationally to further reduce the vacancy gap.

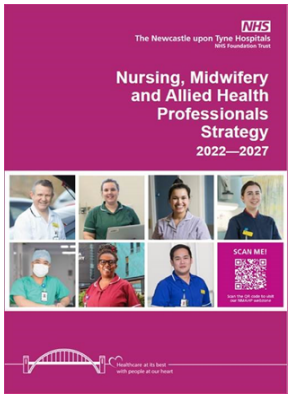
### 2.5.3 Healthcare Support Workers

There is continued focus on Healthcare Support Workers (HCSW) recruitment from NHSE to achieve a zero-vacancy position. Due to staff turnover and service developments, maintaining a zero position is challenging and so retention work including career conversations is a priority along with proactive recruitment. The current vacancy rate sits at 6.7%

There are currently 113 (headcount) staff in pipeline. We have successfully recruited to 15 additional posts in support of winter pressures. A HCSW steering group takes place monthly to review and monitor performance and has a focus on retention, professional development, and pastoral support of Healthcare Support Workers across the organisation. This includes the provision of a career conversation for all HCSWs and the provision of high-quality induction and training.

The HCSW retention work was showcased during a week of celebrations in November 2022 for Health Care and Maternity Support Workers Day. The Trust submitted a proposal to NHSE 'Widening Access Transformational project' which was successful in obtaining £40,000. This will fund a large-scale community event utilising innovative recruitment solution, working with community partners with the aim of having a representative workforce which impacts health inequalities.

## 3. NURSING, MIDWIFERY AND ALLIED HEALTH PROFESSIONAL (NMAHP) STRATEGY SPOTLIGHT – RESEARCH PILLAR



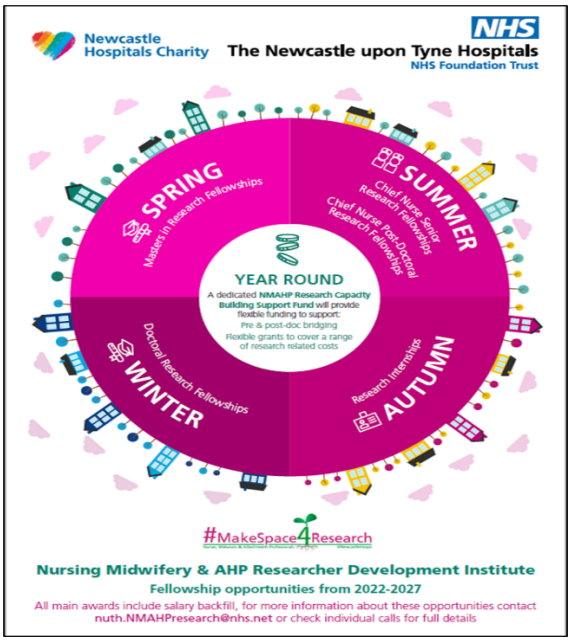

On the 26th of July 2022 the Trust launched its new NMAHP Strategy. As previously highlighted to Board, the strategy is split into six key priorities. These priorities outline what we are already achieving in the relevant domain with a clear "We Are" statement and contain between three to four high level "We Will" statements outlining our aspirations for the future.

Since the launch, there has been a monthly deep dive to help culture the key priorities. This has included in person and virtual events as well as sharing or practice via the new NMAHP website and social media platforms. The first focus was on priority five – *Increasing research opportunities and impact, whilst strengthening our academic links.* This section provides an update on this priority with a specific focus on the launch of our NMAHP Research Development Institute.

**3.1 Progress**

The Newcastle Hospitals Charity Committee agreed a grant of up to £3.2m to fund a five-year programme of work to help develop the Nursing, Midwifery and AHP Researcher Development Institute (NMAHP RDI).

On August the 3rd 2022, as part of a wider launch of the NMAHP strategy, the NMAHP RDI was officially launched via a large Teams event including the Head of Nursing (Research Transformation) at NHSE. The event included the sharing of a video animation about the various funding available as part of the RDI and incorporated our wider aspirations to be seen as leaders in NMAHP Research.




The infographic provides an instant visual of the awards and funding available as part of the RDI.

Since the launch six months ago – the following key achievements have been recognised:

- In August, following the completion of a rigorous and robust selection process, we awarded our first three NMAHP RDI fellowships. One Fellowship was awarded at Masters level and two at Doctoral level. The successful individuals and their research focus are outlined below:

  **MRes fellowship**:
  Sarah Hogg (Clinical Research Nurse): To determine the acceptability and feasibility of motivational interviewing in alcohol related liver disease.

  **Doctoral Fellowships:**
  1) Sarah Stephen (Speech & Language Therapist) An exploration of how transoral surgery affects swallowing and communication in the first 6-weeks after surgery in oropharyngeal cancer.

2) Raya Vinogradov (Clinical Research Radiographer) To develop resources to support women in making informed decisions about the use of aspirin during pregnancy to reduce the risk of preeclampsia.

- The second Round of Doctoral Fellowships is currently open, closing March 2023.
- The 1st Chief Nurse Post-Doctoral Fellowship has been awarded and the individual is due to commence imminently.
- There is a Research Capacity Building and Futures Group meeting now established and reporting into the RDI Leadership Board.
- During 2021, a collaboration between the Newcastle Hospitals, The James Paget University Hospitals and the ImpACT Research Group at University of East Anglia led to the development of an innovative practice led Embedded Researcher (ER) model to contribute to the range of work going on to support research capacity building for the NMAHP workforce. The Embedded Researcher Fellowship Pilot has just recently been appointed after a competitive process with a number of high calibre applications.
- Mapping work to start to identify career opportunities aligned with growing research capability will form part of the workplan for this next year.

It is exciting to see this work progress and to see the aspirations of the strategy come to fruition. There has already been a tangible benefit to those individuals who were successful in being awarded fellowships in feeling valued, supported and encouraged to develop. We will be able to see the impact and direct benefit of their work in the years ahead as they shape professional practice and improve patient care. This also ensures NMAHP's at Newcastle remain at the forefront in developing and improving evidence based clinical practice.

## 4. ROYAL COLLEGE OF NURSING INDUSTRIAL ACTION

In early November 2022, the Trust was informed by the RCN that members in the Trust had voted in favour of industrial action and the necessary thresholds had been met. At the end of November, the Trust was informed by the RCN that it would be involved in the first wave of industrial action, planned for the 15 and 20 December.

Collaborative working across Nursing, Medical, Operational, HR and Directorate Teams was undertaken to ensure effective and controlled management of the industrial action, ensuring safe care was maintained and staff supported to strike. The Trust negotiated closely with the RCN via the Industrial Dispute Strike Committee which was set up to manage the industrial action between both parties.

On the 15 December 25% of staff planned to work on that day went out on strike with 28% on the 20 December. Clinical and operational leaders and front-line staff from across the Trust worked hard to ensure any risk was mitigated. Post-strike debrief has been undertaken to ensure any lessons learned are understood and shared to prepare for any future strike action.

It is important to acknowledge that whether staff went out on strike or supported the strike by continuing to provide patient care, this was a difficult time for staff both personally and professionally and will continue to be challenging if further dates are announced.

At the time of writing, we are actively preparing for one day strike by the Chartered Society of Physiotherapists and a further two days of strike action by RCN members.

## 5. RECOMMENDATION

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

**Report of Maurya Cushlow**
**Executive Chief Nurse**
26 January 2023

THIS PAGE IS INTENTIONALLY BLANK

The Newcastle upon Tyne Hospitals NHS Foundation Trust

# TRUST BOARD

| | | | |
|---|---|---|---|
| Date of meeting | 26 January 2023 | | |
| Title | Ockenden Update Report | | |
| Report of | Maurya Cushlow, Executive Chief Nurse | | |
| Prepared by | Jane Anderson, Associate Director of Midwifery<br>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<br><br>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.<br><br>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.<br><br>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<br><br>An updated high level Action Plan combining outstanding actions from the interim report together with those arising within the final report is presented detailing current Trust compliance. | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Recommendation | The Trust Board is asked to<br>i) Receive and discuss the report;<br>ii) Note the current level of assurance and the identified gaps in assurance as benchmarked against the interim and final recommendations;<br>iii) Recognise the significance of this final report for the Maternity Service and that further detailed work is required to ensure full compliance; and<br>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 24 November 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 (Appendix 1), and the Trust has continued to progress, monitor, and systematically report these to members of the Trust Board since that time. There are 4 partially compliant Immediate and Essential Actions (IEAs) which remain outstanding for the Trust (Appendix 2).

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 (Appendix 2). 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 3.0:** Provides an update on the Interim Report progress, with reference to the feedback received from the Regional Insight Team Visit, of which there is nothing further to update at present. The outstanding actions of note relate to evidencing and auditing compliance for risk assessment throughout pregnancy, managing complex pregnancies and supporting informed consent, all of which are dependent on the assurance gained from electronic patient records.

**Section 4.0:** Reports on the High-Level Action Plan (Appendix 3), 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 Appendix 3 illustrates the Trust's progress on these actions. Progress has been made and partial compliance achieved for 4 of these 7 recommendations.

4.1: A process is in place to ensure complaints themes and trends are now monitored by the Governance Team, whilst the Maternity Voices Partnership (MVP) have been offered greater involvement in understanding and appraising the complaints process.

4.2: The Trust is progressing work on an operational risk assessment for the Newcastle Birthing Centre. A regional training programme for Delivery Suite coordinators has now been developed and the first module delivered by Teesside University commences in January 2023. Ongoing work will ensure progress/compliance for these standards is achieved by the next reporting period.

4.3: There remain 3 non-compliant recommendations from the final report which the Trust continues to work toward. These include workforce planning and sustainability, developing staff conflict of opinion guidance and auditing change to practice as a result from serious incidents.

4.4: 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. The second group of partially compliant recommendations were reported to the Trust Board in November 2022. This paper presents the final group of partially compliant recommendations taken from the 32 of the final report, along with relevant updates for previously reported partially compliant recommendations as indicated within the High-level Action Plan (Appendix 3). Due to the phased approach taken to report all partially compliant elements, progress on the final group has been made during the interim and therefore some are now compliant.

4.5: Of note is the success in achieving the Ockenden and Clinical Negligence Scheme for Trusts (CNST) requirement of reaching and maintaining 90% multi-disciplinary obstetric core competency training for all specialities; this was previously highlighted to the Trust Board as an identified risk. The Trust achieved this target for the 12-month training period between December 2021 and December 2022 and is thereby compliant.

4.6: As previously reported to the Trust Board in November 2022, additional work has been identified to support the provision of complex antenatal care for women with diabetes. The Trust is not yet aligned to NICE guidance, work continues on updating local guidance and toward resourcing the diabetic service with a dietician.

4.7: Of note from the final group of partially compliant recommendations is the Trust's requirement to audit postnatal care against the recommended standards, whereby women who are readmitted to a postnatal ward, and all those unwell, have timely consultant review. The Trust has processes in place to ensure postnatal women are identified and receive timely consultant review. Audits are underway to provide the evidence and assurance that these processes are robust and embedded within practice. And a further update will be provided to the Trust Board in March 2023.

4.8: Neonatal medical staffing is also identified as an area that continues to present a challenge for the Trust. Funding has been received to resource additional Middle Grade posts to enable the Neonatal unit to be staffed as per the British Association of Perinatal Medicine (BAPM) national guidance. This will result in 2 Tier 2 (middle grades) and 1 Tier 1 for night shifts. Due to training and recruitment difficulties in appointing to these posts, the Trust continues to be challenged in meeting the required standards, resulting in gaps in rotas mitigated by rostering an additional Tier 1 overnight.

4.9: Mental Health and Wellbeing is highlighted in the Final Ockenden report as a focus for Maternity Services. Trusts are expected to have robust mechanisms to identify psychological distress, whilst having clear pathways for women and their families to access emotional and psychological support. Trust Guidance for mental health and wellbeing has been updated and a standardised referral tool has been implemented. BadgerNet further supports this requirement with routine mental health questioning for care encounters and

includes a new patient information leaflet regarding mental health and contact details for support. The Trust is aligned to the Local Maternity and Neonatal System (LMNS) pathway for maternal psychosocial support. Work is ongoing in developing service improvement in collaboration with service user representation and the wider Perinatal Health team. A strategy is being developed to ensure partners and families are integral to mental health and wellbeing service provision as care currently focuses on women as the key service user. The partner and family strategy is scheduled to be implemented in June 2023 when full compliance of this recommendation will be achieved.

Overall progress to date in relation to the Ockenden recommendations is detailed in the amalgamated Action Plan (Appendix 2) as summarised in the table below.

| | Nov 22 | Nov 22 | Jan 23 | Jan 23 |
|---|---|---|---|---|
| Total Number of Recommendations (interim and final report combined) | 97 | 100% | 98 * | 100% |
| Non-applicable | 12 | n/a | 12 | n/a |
| Compliant | 46 | 54.1% | 56 | 65.1% |
| Partial Compliance | 36 | 41.4% | 27 | 31.4% |
| Non compliance | 3 | 3.5% | 3 | 3.5% |

*additional IEA added following Insight Visit Feedback

**Section 5.0:** Reports on the implementation of the electronic patient record; at the time of writing the Trust Board paper, the Directorate are on track to implement BadgerNet by the revised 'go-live' date of 10th January, and there are no issues to report.

**Section 6.0:** 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. Members of the Trust Board will recall that this 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 with 4 recommendations.

6.1: As reflected in the recommendations, targets for change are mainly directed at system-wide and national levels and therefore fall beyond the scope of individual Trusts until further direction is provided from system and national drivers of Maternity Services.

6.2: Of note is the single set of Maternity Standards expected to be published by NHS England (NHSE) in Spring 2023. The anticipated aim is to combine current standards and recommendations from the Maternity Incentive Scheme (CNST), the Ockenden Report and East Kent Report into one set of standards for Maternity Services to report against. Also expected to be published and considered alongside the single set of standards are the findings resulting from the current ongoing review of maternity services at The Nottingham University Hospitals NHS Trust, another review being chaired by Donna Ockenden, and publication of this report is awaited.

Work will continue to progress and report against all Immediate and Essential Actions in relation to the Ockenden Report and a further update will be provided to the Trust Board in March 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 on 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 national single set of maternity standards expected to be published in Spring 2023 by NHS England and Improvement (NHSE/I), the aim is to combine current standards and recommendations from the Maternity Incentive Scheme (Clinical Negligence Scheme for Trusts/CNST), the Ockenden Report and the East Kent Report into one set of reporting requirements for Maternity Services to report against. Also expected to be published and considered alongside the single set of standards are the findings resulting from the current ongoing review of maternity services at The Nottingham University Hospitals NHS Trust, this is another review being chaired by Donna Ockenden and publication of this report is awaited.

## 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 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.

## 3. NEWCASTLE HOSPITALS MATERNITY SERVICES ASSESSMENT AND ASSURANCE

### 3.1 Interim Report Update

As previously reported to the Trust Board, written feedback received by the Trust in August arising from the Regional Maternity System Insight visit in June 2022, was largely aligned with the Trust's self-assessment for meeting or partially meeting the Immediate and Essential actions from the Interim Report (2020). There were 10 standards highlighted by the visiting team that were regraded from 'compliant' to 'partially compliant'. The regraded standards are detailed in Appendix 1 and are largely attributed to the requirement for audit to provide evidence and assurance.

A key theme running throughout the feedback, particularly for the regraded standards, was the need to strengthen audit in relation to quality improvement and intervention processes. Work is ongoing and a process is now in place to enable the triangulation of complaints, incidents, and claims. The implementation of electronic patient records through BadgerNet will greatly enhance audit capabilities within the maternity service.

The Trust was advised to improve access for information to support informed choice through development of the Trust Website and that this work should be undertaken in collaboration with the Maternity Voices Partnership (MVP). This work will commence following a further scoping exercise following BadgerNet implementation.

As previously reported, the Trust was also guided to consider strengthening the profile and staff awareness of the role of the Non-Executive Director (NED) safety champion, "to improve effectiveness and reporting of safety concerns directly to Board". Preliminary work has been undertaken to explore ways of supporting this recommendation and an update will be provided in future papers.

As reported in November 2022, 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 (ISAs). The Ockenden Interim report recommended that ISAs must be available to parents-to-be, new parents and families, to ensure they are listened to and heard by their care providers. ISAs will support women and their families navigating the healthcare system and provide advocacy when they have a concern about their care. ISAs will also be available to families attending follow up meetings with clinicians, where concerns about care are discussed. The ISA can also support people to navigate through formal complaints processes where an adverse outcome has occurred. The NENC ISAs will be appointed as part of a national pilot which will serve to evaluate and further develop the role with a view to full England-wide implementation in 2023/24 onwards. The outcome of the appointments is still awaited.

## 4. HIGH LEVEL ACTION PLAN

Appendix 3 provides an updated high level action plan incorporating both the interim and final Ockenden reports.

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

**IEA 11 (11.3) Obstetric Anaesthesia: 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**

This partially compliant element has been regraded compliant following the initial benchmarking exercise. Obstetric Anaesthetic encounters will be recorded within the electronic patient record; at the time of writing this report BadgerNet 'go-live' expected 10th January.

**IEA 12 (12.2) Postnatal Care: Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.**

The Postnatal Wards have a standard operating procedure (SOP) which identifies women requiring Consultant review by a Red/Amber/Green labelling system for the daily ward rounds. Consultants are timetabled to perform these reviews as part of the Postnatal Ward Round. The Trust are in the process of performing an audit to assess the efficacy of this system and will report results from this in March 2023. Postnatal patients who are so unwell they remain in acute care settings such as delivery suite, intensive care or high dependency units automatically have Consultant review as part of the ward round for the Delivery Suite On-Call Consultant which includes outliers on other wards.

**IEA 12 (12.3) Postnatal Care: Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.**

Postnatal readmissions for Maternal reasons are reviewed firstly on the Maternity Assessment Unit (MAU) by a member of the Obstetric Team before being readmitted to the most appropriate ward depending on severity and ongoing care requirements. The Trust is in the process of performing an audit to assess current compliance against this recommendation the results of which will be reported to Trust Board in March 2023.

**IEA 13 (13.1) Bereavement Care: Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.**

The Trust is compliant with this recommendation; all women and families who require Bereavement Care have access to this 24/7 within the Maternity Service.

**IEA 13 (13.4) Bereavement Care: 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.**

The Trust considers this recommendation to be compliant as there are clear pathways of care and guidance for staff caring for families experiencing perinatal loss. Local guidance is aligned to the National Bereavement Care Pathway. There are a core team of Delivery Suite Midwives who have a special focus for Bereavement care. The team are highly experienced in caring for families suffering perinatal loss and also support colleagues to develop these skills. All staff receive annual training updates for bereavement care and this training is

delivered by members of the bereavement team. The Trust are in the process of further strengthening the service provided for bereaved families by appointing a Specialist Lead Bereavement Midwife.

**IEA 14 (14.7) Neonatal Care: 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.**

The Trust guidance is aligned to the Resuscitation Council UK Newborn Life Support (NLS G2021 update) algorithm which identifies the consideration of increasing inflation pressures to achieve adequate chest rise. All Neonatal Practitioners are trained in accordance with the NLS teaching and algorithm as part of their mandatory training and regular skills updates. The Trust use NLS as the model for newborn assessment, stabilisation and resuscitation and are therefore fully compliant with this recommendation.

**IEA 14 (14.8) Neonatal Care: 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.**

The Trust have funded additional Middle Grade posts to enable the Neonatal unit to be staffed as per the British Association of Perinatal Medicine (BAPM) national guidance. This will result in two Tier 2 (middle grades) and one Tier 1 for night shifts. Due to training and recruitment difficulties in appointing to these posts, the Trust continues to be challenged in meeting the required standards, resulting in gaps in rotas or mitigated by having an additional Tier 1 overnight.

**IEA 15 (15.1) Supporting Families: 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.**

The Trust has recently appointed a Mental Health Specialist Midwife who has implemented a Mental Health and Wellbeing reporting form to standardise assessment, reporting and referral to services. Local guidance for Perinatal Mental Health and Wellbeing has also been updated to include routine questions for mental health at every scheduled antenatal and postnatal visit. This has been incorporated into BadgerNet along with a new patient information leaflet. Work is ongoing in developing service improvement and collaboration with MVP and wider Perinatal Health MDT involvement. A strategy is in development to ensure partners and families are integral to service provision as care currently focuses on women as the key service user. The partner and family strategy is scheduled to be implemented in June 2023 when full compliance of this recommendation will be achieved.

**IEA 15 (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.**

The Trust are compliant with this recommendation; there are clear processes in place for easy referrals into the Birth Reflections service, Health Visiting, Health Psychology, Bereavement Counselling, Improving Access to Psychological Therapies (IAPT) and the Perinatal Mental Health Team.

## 5. DIGITAL UPDATE

At the time of compiling this paper, the Directorate are on track to implement the end-to-end electronic patient record, BadgerNet, by the revised 'go-live' date of 10th January. There are no anticipated challenges in being able to meet with this date. BadgerNet will align the Trust to the Region and facilitate Ockenden assurance for enhanced safety, managing complex pregnancies, assessing risk throughout pregnancy, supporting informed consent, and providing personalised care plans. BadgerNet will also enable greater quality assurance, increased audit capability and, therefore, more readily evidence care provision. BadgerNet is fully aligned and compliant with mandatory reporting systems.

## 6. ITEMS OF RELEVANCE OUT-WITH OCKENDEN

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

As previously reported to the Trust Board, 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 with 4 high level recommendations.

Targets for change in the report's recommendations are mainly directed at system-wide and national levels and therefore fall beyond the scope of individual Trusts until further direction is provided from system and national drivers of Maternity Services.

Of note is the single set of Maternity Standards expected to be published by NHSE/I in Spring 2023. The aim is to combine current standards and recommendations from the Maternity Incentive Scheme (CNST), the Ockenden Report and the East Kent Report into one set of Standards for Maternity Services to report against. The Trust therefore await the single standards to be published before undertaking further work in response to East Kent. Also expected to be published and considered alongside the single set of standards are the findings resulting from the current ongoing review of maternity services at The Nottingham University Hospitals NHS Trust, this is another review being chaired by Donna Ockenden and publication of this report is awaited.

## 7. 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 to evidencing and auditing compliance for risk assessment throughout pregnancy, managing complex pregnancies and supporting informed consent.

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 the final group of the original benchmarked 32 partially-compliant recommendations for the Trust. Work is progressing and status updates are provided on previously reported non and partially compliant recommendations that were detailed in the July, September and November Ockenden update reports.

This paper also revisits the publication of the East Kent Report, highlighting the system-wide and national-level recommendations for change. Further National direction is expected in Spring 2023 with the publication of a single set of maternity reporting standards which will combine the CNST requirements and the findings from the Ockenden and East Kent reports.

## 8. 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**
**26 January 2023**

**APPENDIX 1**

| 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). | Compliant |
| | 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). | Compliant |
| **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). | Compliant |
| **IEA7: Informed consent** | Ensure women have easy access to accurate, evidence-based information to support informed choice and informed consent. | Partial Compliance<br>(added following Insight visit feedback) |
| **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**<br><br>**Immediate Essential Action** | | Brief Descriptor<br>IEA 1-15 | Compliance |
|---|---|---|---|
| 1. Workforce Planning and Sustainability: | 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 |

| | | | |
|---|---|---|---|
| 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. | | | 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 | 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. | Partial compliance |
| | 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 |

| | | | |
|---|---|---|---|
| every maternity unit should be implemented. | 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:** | 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 |

| | | | |
|---|---|---|---|
| Trust boards must have oversight of the quality and performance of their maternity services.<br>In all maternity services the Director of<br>Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems. | 4.2 | All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board. | Partial compliance |
| | 4.3 | Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services. | Compliant |
| | 4.4 | All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities. | Partial compliance |
| | 4.5 | All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis, and family engagement. | Partial compliance |
| | 4.6 | All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research. | Compliant |
| | 4.7 | All maternity services must ensure they have midwifery and obstetric co-leads for audits. | Compliant |
| **5. Clinical Governance – Incident investigation and complaints**<br><br>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 a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings. | 6.1 | NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death. | n/a |
| | 6.2 | This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff, and seek external clinical expert opinion where required. | n/a |
| | 6.3 | Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS. | To action once implemented by external stakeholder |
| **7. Multidisciplinary Training** Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. | 7.1 | All members of the multidisciplinary team working within maternity should attend regular joint training, governance, and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored. | Partial compliance |
| | 7.2 | Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts. | Compliant |
| | 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. | Compliant |
| | 7.4 | There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient. | Partial compliance |

| | | | |
|---|---|---|---|
| Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training | 7.5 | There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care. | Compliant |
| | 7.6 | Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills. | Compliant |
| | 7.7 | Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory. | Compliant |
| **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 accommodating 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 (Regraded non-compliant) |
| | 8.4 | When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records. | Partial compliance |
| | 8.5 | Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019). | Compliant |
| **9. Preterm Birth:** | 9.1 | Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability. | Compliant |

| | | | |
|---|---|---|---|
| The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.<br>Trusts must implement NHS Saving Babies Lives Version 2 (2019) | 9.2 | Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered. | Compliant |
| | 9.3 | Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability. | Compliant |
| | 9.4 | There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit. | Compliant |
| **10. Labour and Birth:**<br>Women who choose birth outside a hospital setting must receive accurate<br>advice with regards to transfer times to an obstetric unit should this be necessary.<br>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**: | 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 |

| | | | |
|---|---|---|---|
| A pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed. | 11.2 | 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 | Compliant |
| | 11.4 | Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance. | n/a |
| | 11.5 | The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave. | Compliant |
| | 11.6 | The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity. | Compliant |
| | 11.7 | The competency required for consultant staff who cover obstetric services out-of-hours, but who have no regular obstetric commitments. | n/a |
| | 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. | Compliant |
| | 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. | Compliant |
| **14. Neonatal Care:** There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce, and enhance the experience of families. This work must now progress at pace. | 14.1 | 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. | Compliant |
| | 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. | Compliant |
| | 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 |

| | Nov 22 | Nov 22 | Jan 23 | Jan 23 |
|---|---|---|---|---|
| Total Number of Recommendations (interim and final report combined) | 97 | 100% | 98 * | 100% |
| Non-applicable | 12 | n/a | 12 | n/a |
| Compliant | 46 | 54.1% | 56 | 65.1% |
| Partial Compliance | 36 | 41.4% | 27 | 31.4% |
| Non compliance | 3 | 3.5% | 3 | 3.5% |

*additional IEA added following Insight Visit Feedback

**APPENDIX 3: High Level Action Plan**

| **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**<br>**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.<br><br>Achievement now reached for 12-month period of December 2021-December 2022. This is an ongoing requirement and therefore close monitoring required to continue trajectory towards achievement in next reporting period. | Clinical Director (Training Lead)<br>Lead Midwife for Quality and Clinical Effectiveness<br>Practice Development Midwife | December 2022 |
| **IEA 4, 5 & 7**<br>**Named Consultant and Risk assessment throughout pregnancy** | Named consultant and continuous risk assessment achieved through implementation of BadgerNet as the agreed electronic paper record. | Clinical Director<br>Associate Director of Midwifery<br>Digital Health Midwife | EPR – implementation date 10.01.23 |
| **IEA 7**<br>**Informed Choice & Consent (added following Insight Visit Feedback evaluation)** | Women have access to accurate information, enabling informed choice for place and mode of birth. Accurate evidence-based information is easily accessible, provided to all women and MVP quality reviewed. Enable equal participation in decision-making and method of recording this. Clearly described pathways of care to be posted on the Trust website and MVP quality reviewed.<br><br>BadgerNet EPR will support above however further development of the Trust's Maternity Services Website required. | Clinical Director<br>Associate Director of Midwifery<br>Digital Health Midwife | EPR – implementation date 10.01.23<br><br>Website redevelopment 2023-2024 |

| **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.<br><br>Collaborative work with Executive Directors, Finance and HR to work towards establishing a reflective uplift appropriate for Newcastle. In mitigation continue to use over established workforce (20 WTE midwives). | Directorate Manager<br>Associate Director of Midwifery | March 2023 |
| **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.<br><br>A regional maternity Coordinator's Programme has now been developed in collaboration with the NENC Clinical Network, North Tees and Hartlepool NHS Trust and Teesside University. The course aligns with Ockenden and provides academic credits at level 6 or 7. NUTH have initially been requested to nominate 2 Labour Ward Coordinators to attend the first programme commencing in January 2023. Modules are expected to run in May and September 2023 with further places made available for NUTH staff to access. Funding for course attendance is still being explored. | Associate Director of Midwifery<br>Matron for Intrapartum Care | Regional module in place and first 2 NUTH Labour Ward Coordinators attending January 2023. |

| Immediate and Essential Action (IEA) Final Report Non-compliant elements | Action which is required to meet recommendation | Lead/s | Completion Date |
|---|---|---|---|
| **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.<br><br>Policy written – awaiting Directorate Quality and Safety approval. | Clinical Director<br>Head of Obstetrics<br>Associate Director of Midwifery<br>Lead Midwife for Clinical Effectiveness | February 2023 |
| **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)<br><br>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.<br><br>Of note: HSIB reports containing Trust safety recommendations are often not received until 6 months after the incident. In addition, the implementation of the Patient Safety Incident Response Framework (PSIRF) removes the SI classification. National direction is awaited for further advice regarding the impact of PSIRF on existing Maternity service recommendations and reporting systems. | Clinical Director<br>Associate Director of Midwifery<br>Heat of Obstetrics<br>Lead Midwife for Quality and Clinical Effectiveness | Audit Schedule 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.<br><br>MVP have had oversight and understanding of complaints process. MVP to meet with Head of Patient Experience in January 2023 to further explore complaints process. | Directorate Manager<br>Associate Director of Midwifery<br>Head of Patient Experience<br>Chair of MVP<br>Link Midwife for MVP | 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 5 Clinical Governance – Incident investigation and complaints** | 5.7 Complaint's themes and trends must be monitored by the maternity governance team.<br><br>This work has already commenced; to be monitored and reported through local governance assurance framework. The process for monitoring themes and trends from complaints has been agreed. | Directorate Manager<br>Head of Obstetrics<br>Lead Midwife for Quality and Clinical Effectiveness<br>Patient Experience Coordinator | January 2023 |
| **IEA 10 Labour and Birth** | 10.2 Midwifery-led units must complete yearly operational risk assessments.<br><br>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<br>Matron for Intrapartum Care<br>Lead Midwife for NBC | January 2023 |
| **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.<br><br>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<br>Matron for Intrapartum Care<br>Delivery Suite Coordinators<br>Practice Development midwife | May 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** | 1.10 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.<br><br>Maternity specific workforce strategy in development. | Clinical Director<br>Associate Director of Midwifery | March 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.<br><br>Currently only available for Delivery Suite. Further work is ongoing to explore expansion into all settings. Maternity specific workforce strategy in development. | Associate Director of Midwifery<br>Midwifery Matrons<br>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. Benchmarking exercise expected completion Q4. | Clinical Director<br>Associate Director of Midwifery<br>Head of Obstetrics<br>Lead Midwife for Quality and Clinical Effectiveness | Present to Board March 2023 |

| **Immediate and Essential Action (IEA) <u>Final Report</u> 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.<br><br>Scoping and job planning complete, business case submitted. Governance and leadership roles identified for increased PA allocation from 11.5 (2022) to 15.25 (2023). | Clinical Director<br>Directorate Manager | TBC - Awaiting Business Case Review |
| **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.<br><br>Work ongoing, ensure senior leadership access suitable programs. | Clinical Director<br>Associate Director of Midwifery<br>Quality & Clinical Effectiveness Midwife<br>Head of Obstetrics | Training plan to be in place by 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.<br><br>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<br>Associate Director of Midwifery<br>Quality & Clinical Effectiveness Midwife<br>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.<br><br>Audit process under development, first audit planned January 2023. | Clinical Director<br>Associate Director of Midwifery<br>Quality & Clinical Effectiveness Midwife<br>Head of Obstetrics | Audit Schedule commencing 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: 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.<br><br>>90% achievement for 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<br>Associate Director of Midwifery<br>Head of Obstetrics<br>Quality & Clinical Effectiveness Midwife<br>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.<br><br>Training with inclusion of SBAR ongoing. | Quality & Clinical Effectiveness Midwife<br>Practice Development Midwife<br>Intrapartum Obstetric Lead<br>Head of Neonatology<br>Obstetric Anaesthetic Lead | January 2023 |
| **Immediate and Essential Action (IEA) Final Report** | **Action which is required to meet recommendation** | **Lead/s** | **Completion Date** |

| | | | |
|---|---|---|---|
| **Partial-compliant part 2.** | | | |
| **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.<br><br>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<br>Associate Director of Midwifery<br>Quality & Clinical Effectiveness Midwife<br>Practice Development Midwife<br>Intrapartum Obstetric Lead | January 2023 |
| **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.<br><br>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. 6 unannounced/unanticipated drills held in last 12 months. | Clinical Director<br>Associate Director of Midwifery<br>Practice Development Midwife<br>Lead for Obstetric Skills Drills<br>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.<br><br>Achievement of >90% of staff attendance of mandatory MDT training (which includes obstetric emergencies and CTG training). Work to support staff completion of K2 CTG training programme ongoing. | Clinical Director<br>Associate Director of Midwifery<br>Practice Development Midwife<br>Matron for Intrapartum Care<br>Lead Midwife for Fetal Monitoring | 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 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.<br><br>Scoping for Dietician to support GDM clinic underway – service provision currently by Specialist Diabetic Midwives and Obstetricians. Local Guidance under review. | Clinical Director<br>Obstetric Consultants specialising in Diabetes<br>Diabetic Specialist Midwife | April 2023 |
| **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.<br><br>Will be supported through implementation of BadgerNet electronic patient record. | Clinical Director<br>Obstetric Consultants specialising in Diabetes<br>Lead Diabetic Support Midwife | January 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.<br><br>Newcastle Birthing Centre (NBC) is included within the programme of monthly unanticipated/unannounced MDT drills. 6 unannounced/unanticipated drills held in last 12 months, NBC included in 1. | Clinical Director<br>Lead Obstetrician for Skills Drills<br>Intrapartum Matron<br>NBC Manager | January 2023 |

| **Immediate and Essential Action (IEA) Final Report Partial-compliant part 3.** | **Action which is required to meet recommendation** | **Lead/s** | **Completion Date** |
|---|---|---|---|
| **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.<br><br>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<br>Lead Midwife for Quality and Clinical Effectiveness<br>Community Team Leads | Awaiting collaborative discussion with NEAS March 2023 |
| **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.<br><br>Local guidance under review to reflect this recommendation. | Clinical Director<br>Head of Obstetrics<br>Intrapartum Obstetric Lead<br>Intrapartum Matron | April 2023 |
| **IEA 11 Obstetric Anaesthesia** | 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.<br><br>Will be supported through implementation of BadgerNet electronic patient record. | Clinical Director<br>Obstetric Anaesthetic Lead | January 2023 |

| **Immediate and Essential Action (IEA) Final Report Partial-compliant part 3.** | **Action which is required to meet recommendation** | **Lead/s** | **Completion Date** |
|---|---|---|---|
| **IEA 12 Postnatal Care** | 12.2 Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.<br><br>Process in place to identify and ensure Consultant review for unwell postnatal women – audit underway for compliance against this standard with expected completion and reporting by March 2023. | Clinical Director<br>Associate Director of Midwifery<br>Postnatal Matron<br>Postnatal Obstetric Lead | March 2023 |
| **IEA 12 Postnatal Care** | 12.3 Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.<br><br>Audit underway for compliance against this standard with expected completion and reporting by March 2023. | Clinical Director<br>Associate Director of Midwifery<br>Postnatal Matron<br>Postnatal Obstetric Lead | March 2023 |
| **IEA 13 Bereavement Care** | 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.<br><br>Regraded compliant following initial benchmarking exercise. | Clinical Director<br>Associate Director of Midwifery<br>Bereavement Midwife (on appointment) | December 2022 |
| **IEA 13 Bereavement Care** | 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.<br><br>Regraded compliant following initial benchmarking exercise. | Clinical Director<br>Associate Director of Midwifery<br>Bereavement Midwife (on appointment) | December 2022 |

| Immediate and Essential Action (IEA) Final Report Partial-compliant part 3. | Action which is required to meet recommendation | Lead/s | Completion Date |
|---|---|---|---|
| **IEA 14 Neonatal Care** | 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.<br><br>Regraded compliant following initial benchmarking exercise. | Clinical Director<br>Associate Director of Midwifery<br>Head of Neonatology<br>Practice Development Midwife | December 2022 |
| **IEA 14 Neonatal Care** | 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.<br><br>Middle Grade post funding in place to enable staffing to meet national guidance. Due to training and recruitment difficulties in appointing to these posts, still challenges meeting the standards, resulting in gaps in rotas or mitigated by having an additional Tier 1 overnight. On Risk Register. | Directorate Manager<br>Clinical Director<br>Head of Neonatology | December 2023 |

| **Immediate and Essential Action (IEA) Final Report Partial-compliant part 3.** | **Action which is required to meet recommendation** | **Lead/s** | **Completion Date** |
|---|---|---|---|
| **IEA 15 Supporting Families** | 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.<br><br>Ongoing improvements - Specialist Mental Health Lead Midwife working with MVP and wider MDT, strategy in development to ensure partners and families integral to service provision. | Clinical Director<br>Associate Director of Midwifery<br>Perinatal Mental Health Lead Midwife | June 2023 |
| **IEA 15 Supporting Families** | 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.<br><br>Regraded compliant following initial benchmarking exercise. | Clinical Director<br>Associate Director of Midwifery<br>Perinatal Mental Health Lead Midwife | December 2022 |

THIS PAGE IS INTENTIONALLY BLANK

The Newcastle upon Tyne Hospitals NHS Foundation Trust

# TRUST BOARD

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date of meeting | 26 January 2023 | | | | | | |
| Title | Maternity Incentive Scheme (MIS) Year 4 (CNST) | | | | | | |
| Report of | Angela O'Brien, Director of Quality and Effectiveness | | | | | | |
| Prepared by | Rhona Collis, Quality and Clinical Effectiveness Midwife/ Jane Anderson, Associate Director of Midwifery | | | | | | |
| Status of Report | Public | | Private | | Internal | | |
| | ☒ | | ☐ | | ☐ | | |
| Purpose of Report | For Decision | | For Assurance | | For Information | | |
| | ☐ | | ☒ | | ☐ | | |
| Summary | The NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity incentive scheme invites Trusts, in this Year 4 scheme, to provide evidence of their compliance using self-assessment against ten maternity safety actions. The scheme intends to reward those Trusts who have implemented all elements of the 10 Maternity Safety Actions.<br><br>A detailed report was submitted to the Trust Board in November 2022. This report is a full progress report on all 10 safety actions and was discussed in detail at the Extraordinary Board of Directors meeting held on 17 January 2023. It will be the final report prior to the Trust declaration submission on the 2 February 2023. | | | | | | |
| Recommendation | The Trust Board are asked to note the contents of this report and to note that a declaration of full compliance against the Maternity CNST Year 4 Safety Actions was made and endorsed at the Extraordinary Board of Directors meeting held on 17 January 2023. | | | | | | |
| Links to Strategic Objectives | Putting patients first and providing care of the highest standard focusing on safety and quality. Enhancing our reputation as one of the country's top, first class teaching hospitals, promoting a culture of excellence in all that we do. | | | | | | |
| Impact (please mark as appropriate) | Quality | Legal | Finance | Human Resources | Equality & Diversity | Reputation | Sustainability |
| | ☒ | ☐ | ☒ | ☐ | ☐ | ☒ | ☐ |
| Impact detail | Failure to comply with the ten safety action standards could impact negatively on maternity safety, result in financial loss to the Trust from the incentive scheme and from potential claims. | | | | | | |
| Reports previously considered by | This is the ninth report for Year 4 of this Maternity Incentive Scheme. A previous report was presented to Trust Board on the 24 November 2022 and 17 January 2023. | | | | | | |

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

## EXECUTIVE SUMMARY

The NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme invites Trusts, in this Year 4 scheme, to provide evidence of their compliance using self-assessment against ten maternity safety actions. The scheme intends to reward those Trusts who have implemented all elements of the 10 Maternity Safety Actions.

The Year 4 CNST safety actions were effective from the 8 August 2021. Amendments were made to the safety actions in October 2021 and on the 23 December 2021 the Trust was informed that there would be a 3 month pause in the reporting period due to ongoing pressure on the NHS and maternity services. Trusts were advised to continue to apply the principles of the 10 safety actions in view of the overall aim which was to support the delivery of safer maternity care.

The year 4 safety actions were revised during the pause period and the revisions published on 6 May 2022. Further amendments were published in October 2022. A full report with an update on all 10 safety actions was presented to the Trust Board in November 2022. This report focuses on the fourth and final version published and was discussed in detail at an extraordinary Board of Directors meeting held on the 17 January 2023. At that meeting the Head of Midwifery and Clinical Director for Women's Services presented the status against each of the 10 Safety Actions to Board members present. Board members agreed that full compliance against the 10 Safety Actions be declared, with two areas of note discussed. It was agreed that the declaration form be completed and submitted, signed by the Chief Executive, to the North East and North Cumbria Integrated Chair Board Chief Executive for final sign-ff prior to submission to NHS Resolution before the 2 February 2023.

The Trust is able to meet the requirements for all 10 Safety Actions. The Trust Board is asked to note the contents of this report.

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

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

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

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

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

This scheme intends to reward those Trusts who have implemented all elements of the 10 maternity safety actions, enabling Trusts to recover the element of their contribution relating to the CNST incentive fund, and by receiving a share of any unallocated funds. Failure to achieve compliance against the safety actions will result in the Trust not achieving the 10% reduction in maternity premium which NHS Resolution has identified.

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

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

This paper provides an update on the final position of all the standards outlined in each of the 10 safety actions.

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

The Trust is fully compliant with all 5 standards of this safety action.

## 2.1 Standard A

*i. All perinatal deaths eligible to be notified to MBRRACE -UK from 6th May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.*

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

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

The Trust is 100% compliant with this standard. All deaths of babies within the Trust, which require review, are reviewed within two months of each death using the PMRT and this process pre-dates the deadline date outlined in Standard A (06/05/2022). This process is well established and includes deaths after home births where care was provided by the Trust. There are no concerns regarding ongoing compliance with this standard and all cases either have a review in progress, or a completed review within the stipulated timeframe.

## 2.2 Standard B

*At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6th May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.*

The Trust is 95% compliant with this standard. The PMRT will only provide a completed (published) report after multidisciplinary case reviews have been fully completed and inputted into the system. One report was published after the six-month time frame.

## 2.3 Standard C

*For at least 95% of all deaths of babies who died in your Trust from 6th May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.*

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

The Trust is 100% compliant with this standard. It is a routine part of the discussion with families after the death of a baby that they are informed that a review will take place and their perspectives, and any questions or concerns are sought as part of the bereavement pathway. The PMRT can be externally accessed by NHS Resolution in verification of those standards which align.

**Compliance from 6 May to 5 December 2022**

| Standard | Required % | Stillbirths/ late fetal loss | Neonatal deaths |
|---|---|---|---|
| **Standard A** Notified within 7 working days | 100% | 100% | 100% |
| Surveillance completed within 1 month | 100% | 100% | 100%* |
| PMRT started within 2 months | 95% | 100% | 100% |
| **Standard B** MDT review and PMRT draft report generated within 4 months | 50% | 100% | 100% |
| PMRT report published within 6 months | 50% | 90% | 100% |
| **Standard C** Parental involvement | 95% | 100% | 100% |

*There was one surveillance form that was not submitted within 1 month. It was fully completed within the timescale but in error, the form was not submitted to MBRRACE. When the omission was identified (3 weeks after the submission date) MBRRACE were contacted for advice. An audit trail can demonstrate the form was completed within the timescale but accidentally not submitted. The Trust will declare full compliance with this safety action. MBRRACE will be informed via e-mail that the Trust supports the decision to declare full compliance so that they have a record of this decision when asked by MIS to provide external validation.

## 2.4 Standard D

*Quarterly reports will have been submitted to the Trust Board from 6th May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly*

*reports should be discussed with the Trust maternity safety and Board level safety champions.*

The Trust is compliant with this standard. The Trust has produced a quarterly PMRT report for the Trust Board since 25/04/2019. For this Trust Board report a local report has been produced, cross referenced with that generated from MBRRACE. This is a new style report which is more informative and qualitative. The PMRT report for Quarter 1 April to June 2022 was also presented to the Maternity Board Level Safety Champions Group on 12 October 2022. Quarter 2 July to September is included within the Private Board Reference Pack (BRP).

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

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

The Trust is fully compliant with all 7 standards of this safety action. The data was required to be compliant for the month of July only.

### 3.1 Standard 1

*By 31st October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme.*

The Trust Maternity Digital Strategy was signed off by the Trust Chief Information Officer and submitted to the Local Maternity and Neonatal System (LMNS) on the 5 September 2022. The Trust has received confirmation that the LMNS has signed this off on behalf of the Integrated Care Board.

### 3.2 Standard 2

*Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022.*

The Trust has successfully achieved compliance for this standard. The Trust has received confirmation, via the NHS Digital CNST Scorecard, of compliance with all 11 CQIM's for the month of July 2022.

### 3.3 Standard 3

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

The Trust has successfully achieved compliance for this standard. Compliance for July was 97.1%.

### 3.4 Standard 4

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

The Trust has successfully achieved compliance for this standard. Compliance for July was 100%.

### 3.5 Standard 5

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

The Trust has successfully achieved compliance for this standard. Compliance for July was 98%.

### 3.6 Standard 6

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

The Trust has successfully achieved compliance for this standard. Compliance for July was 90.2%. Although this is just above the required compliance the Trust has confirmation from NHS Digital that this has passed the criteria for July 2022 data submission. Compliance for August was recorded as 91.8%.

### 3.7 Standard 7

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

***Midwifery Continuity of carer (MCoC)***

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

The Trust is 100% compliant with this.

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

Only 5.3% of the women booked to deliver at the Trust are placed on a Continuity of Care pathway. 100% of these women have both a Care Professional ID and Team ID.

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

The Trust is compliant with both.

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

The Trust has successfully achieved compliance for this standard. Compliance for July was 100% (MSD202) and 100% (MSD302).

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

The Trust has completed the Data Quality Submission Summary Tool from June 2022 onwards and must do this for at least 3 consecutive months in order to pass this criterion.

The Trust received compliance of standards 2-7 (above), via the NHS Digital CNST Scorecard, published in October 2022.

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

The Trust is fully compliant with all 8 standards of this safety action.

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

### 4.1 Standard A

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

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

Pathways of care are outlined in the Care of the Vulnerable Neonatal Guideline and are based on the principles of the British Association of Perinatal Medicine (BAPM). This pathway is business as usual and was jointly approved by maternity and neonatal teams, with a focus on minimising separation of mothers and babies and includes the Newborn Early Warning Trigger and Track (NEWTT) assessment from birth on Delivery Suite, Transitional and Postnatal care.

### 4.2 Standard B

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

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

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

### 4.3 Standard C

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

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

### 4.4 Standard D

*A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has*

*been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered*

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

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

### 4.5 Standard E

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

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

### 4.6 Standard F

*Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.*

The review of term admissions to the neonatal unit have continued on a quarterly basis. The findings of these reviews were shared with the Maternity Board Level Safety Champions Group on the 13 October 2021, 10 February 2022, 13 April 2022, 10 August 2022, 12

October 2022 and 14 December 2022. The quarterly report is also shared at the bi-monthly Obstetric Governance Group meeting and circulated for staff to read via an infographics poster.

The ATAIN reports have been shared with the LMNS and ICS since July 2022 following agreement of a process for receipt of these.

### 4.7 Standard G

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

An action plan to address local findings was signed off by the Board at the November 2021 Board meeting. This was reviewed and an updated action plan was presented to and agreed by the Maternity Board Level Safety Champions Group on the 14 December 2022.

### 4.8 Standard H

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

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

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

The Trust is fully compliant with all 4 standards of this safety action.

### 5.1 Standard A

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

A paper was presented to the Maternity Board Level Safety Champions Group in December 2021 regarding a Medical Workforce Strategy. An update was also provided on the 12 October 2022.

*Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where*

*attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS.*

Monthly audits of consultant attendance commenced in January 2022 as required. The results of these audits are shared at the Obstetric Governance group meeting bi-monthly. An initial report and action plan was presented to the Maternity Board Level Safety Champions Group on 13 April 2022. A report covering the periods between January and August 2022 was also presented on the 12 October 2022. The report was shared with the LMNS at the end of October 2022. The Trust's position has been shared regularly with the Board via previous Board reports.

The Trust is confident that attendance has been exemplary and in the absence of a Consultant, a senior trainee, who has been signed off as competent (which is acceptable) has been present. Overall, there are no concerns with Consultant attendance for the clinical situations listed in the RCOG document. A full report covering January to December 2022 will be shared with the Obstetric Governance group on the 10 February 2023.

### 5.2 Standard B

**Anaesthetic medical workforce**

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

The Trust is fully compliant with this standard as in previous years. Any gaps in the Trainee rota are covered by the Consultant. An audit of the rota was completed in April 2022 which reviewed the rota's for March and April. The results of this were presented on the 13 April 2022 at the Maternity Board Level Safety Champions meeting. An additional audit was presented at the December 2022 meeting which covered a six-month period, as required by the amended May 2022 safety actions.

### 5.3 Standard C

**Neonatal medical workforce**

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

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

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

The Neonatal unit did not meet the BAPM standards for year 3 of the scheme. The position however progressed for year 4. The Trust supported a business case to increase the number of tier 2 neonatal trainee doctors to allow for two tier 2 doctors in the 'out of hours' period. Despite a rigorous recruitment drive, the Trust had been unable to fill these posts due to their specialised nature. In the interim, tier 1 neonatal trainee doctors were recruited, allowing for two tier 1 and one tier 2 out of hours, with a plan that they will progress to tier 2 level within a defined timeframe. This has now led the service to a position where the 'out of hours' period has three members of medical staff on duty made of a mix of tier 1 and tier 2 with a proportion of these shifts having two tier 2 clinicians. The aim is to continue to increase the proportion of shifts as staff gain the appropriate experience.

An update regarding neonatal medical workforce has been included in previous Board reports since the start of year 4.

### 5.4 Standard D

**Neonatal nursing workforce**

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

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

A Staffing Report was presented to the Trust Board in November 2021 which included a position statement regarding the Neonatal Nursing Workforce. A staffing review using the Dinning Tool was undertaken in October 2020 which showed the establishment to be appropriate; a further review took place in May 2022. The outcome of the most recent Neonatal Nursing Workforce review was the same as the findings of the review in October 2020. The review recommended a greater number of band 6 nurses as compared to band 5. No action plan was required as the total establishment was agreed to be broadly fit for purpose. There were no changes to report to the Nursing and Midwifery Staffing Trust Board report for November 2022.

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

The Trust is fully compliant with all 5 standards of this safety action.

### 6.1 Standard A

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

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

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

### 6.2 Standard B

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

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

The Trust is compliant with Standards A and B.

### 6.3 Standard C

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

As previously reported in July and November 2022 to the Trust Board there have been occasions whereby the midwifery co-ordinator has not had supernumerary status.

The time period for standard C is between the 6 May 2022 and the 5 December 2022. There were 5 occasions recorded where the co-ordinator has not been supernumerary. These 5 occasions have been reviewed in more detail and all relate to a short-term period whereby the co-ordinator had to cover and provide midwifery care. There was one occasion in June, one occasion in October and 3 occasions in November. The standard states 'if this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance'. Having reviewed the 5 occasions that have occurred over a 7-month period the Trust is confident this should not be regarded as a 'recurrent event' and

that compliance should be declared. The position for December 2022 was also reviewed – although not required for this standard – to provide assurance that the number of occasions when the co-ordinator had not been supernumerary was not on the increase. In December there were no occasions recorded, which demonstrated that the 3 occasions in November was unusual but non-recurring.

### 6.4 Standard D

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

As previously reported in July and November 2022 to the Trust Board there have been occasions whereby the midwife had been unable to provide continuous one-to-one care and support to a woman in established labour. This data is collected daily by completion of the Birthrate Plus Intrapartum acuity tool which is completed every 4hrs by the delivery suite co-ordinator.

The time period for standard D is between the 6 May 2022 until the 5 December 2022. There were 11 occasions recorded where we have not been able to achieve 1 to 1 care in labour during this period.

In accordance with this standard an action plan detailing how the maternity services intends to achieve 100% compliance with 1:1 care in active labour has been written and was submitted with the Board report in November 2022.

### 6.5 Standard E

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

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

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

The Trust is fully compliant with all standards of this safety action.

1. *Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019.*
   *Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.*
2. *Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been*

*agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.*

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

*The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.*

The quarterly care bundle for October 2022 was submitted to the Clinical Network and was also provided as part of the November 2022 Trust Board report.

**7.1 Element 1**

*This element requires the following monitoring evidencing an average of 80% compliance over a consecutive four month period:*

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

Between February 2022 and May 2022 the compliance average was 95.7%.

*B. Percentage of women where CO measurement at 36 weeks is recorded.*

Between September 2021 - December 2021 the compliance average was 82%.

The data for both was obtained via the current Maternity Information System.

An action plan is required if compliance is above 80% but below 95%. An action plan was produced and shared with the Obstetric Governance Group. An audit undertaken in September 2022 demonstrated an increase in compliance to above 85%, showing a slight improvement. It was acknowledged that greater compliance will be achieved with the introduction of Badgernet was implemented in January 2023.

*In addition, the Trust board should specifically confirm that within their organisation they:*

1) *Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric.*

The Trust has passed this CQIM for every month of 2022 so far. The Dashboard currently goes up to September 2022.

2) *Have a referral pathway to smoking cessation services (in house or external).*

The Trust referral pathway is currently an inhouse referral to the outpatient smoking cessation services managed by Care Grow Live (CGL). The Public Health Midwife is notified of these referrals.

3) *Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service.*

An audit of all 31 cases of women who had a CO measurement ≥4ppm at booking in April 2022 was undertaken. Cross referencing with the Care Grow Live audit revealed that 46.8% of women had been referred (n=15).

4) *Have generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period:*

The data for bookings in the four-month period September 2021 – December 2021 have been generated and reviewed.

- *Percentage of women with a CO measurement ≥4ppm at booking.*
  At booking there was a range of 13.8%-17.6%.

- *Percentage of women with a CO measurement ≥4ppm at 36 weeks.*
  At 36 weeks these rates had reduced to a range of 5.5%-8.5%.

- *Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment.*
  The range for this group of women was 18%-31%.

All this data has been shared with the community and hospital midwives and will continue to be monitored by the Public Health Midwife.

### 7.2 Element 2

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

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

The Trust is compliant with this element. Data for May 2022 showed 100% compliance for risk assessment at booking. A separate audit was undertaken in June 2022 to review the 20-week scan assessment – this showed 97.5% compliance.

*In addition, the Trust board should specifically confirm that within their organisation:*
*2. Women with a BMI>35 kg/m$^2$ are offered ultrasound assessment of growth from 32 weeks' gestation onwards*

The Trust is compliant with this requirement. Women with a BMI >40 have always been offered growth scans from 32 weeks. Due to capacity issues, there was a delay in introducing growth scans from 32 weeks for women with a BMI between 35 and 40, as an alternative they were offered growth scans at 36 and 38-39 weeks. The Trust is now able to offer growth scans from 32 weeks for all women with a BMI >35.

*3. In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation*

The Trust is compliant with this requirement. An audit in June 2022 demonstrated 100% compliance.

*4. There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.*

The Trust has a monthly review meeting to audit babies born <3rd centile. Birthweight data is submitted following the birth of each baby to the Perinatal Institute via the GROW (Gestational Related Optimal Weight) software which generates a birthweight centile using a customized growth chart. The Perinatal Institute then provide quarterly data to the Trust relating to the number of babies that are small and the relevant gestation. The Trust is well below the national average. This data is subsequently reviewed at the monthly meeting and appropriate action taken if required.

*5. They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT).*

Using the Perinatal Mortality Review Tool (PMRT) the above data has been generated and reviewed. In 2021, 4.3% of cases were identified where the identification and/or management of FGR was relevant in relation to the outcome for the baby.

*6. Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network.*

T

he Trust's multiple pregnancy guidance closely follows NICE guidance, with wording in the Trust guideline taken directly from the NICE guideline.

*7. They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation <u>for quarter 3 of this financial year (2021/22)</u> if staffing is critical and this directly frees up staff for the provision of clinical care.*

A monthly review is undertaken, and a quarterly report written which identifies any themes identified and actions taken. Individual feedback is given if appropriate and general lessons learnt are shared via e-mail with the staff. An annual audit of the outcomes was presented at the Directorate audit meeting in January 2022 and a further presentation of audits is scheduled for the 17 January 2023. A detailed report will be presented at the Obstetric Governance group meeting in February 2023. To date the number of missed fetal growth restricted babies is minimal however the Trust has implemented several quality improvement initiatives to strengthen the training to identify and recognise small babies at the earliest opportunity.

**Quality improvement initiatives**

Below is a brief summary of the quality improvement initiatives that have been implemented within the Trust:

- Aim for new community midwives to undertake GROW training (Perinatal Institute training on screening and management of fetal growth restriction, referral protocols and use of the CGCs) prior to moving from hospital to the community – this was facilitated by an extra session to help target those staff who had not completed it, as well as a 1-2-1 session.
- The Lead Midwife for Fetal Surveillance has now undertaken the Perinatal Institute's training in order that she can deliver the GROW training to help expand capacity.
- The GROW training has been revamped (adapted from the perinatal institute) to be more accessible and relevant to local guidelines and referral protocols.
- The new spreadsheet is in use to enable better data collection and monitoring of trends and themes.
- To improve accuracy of plotting, rulers were purchased and provided to community midwives to keep with their equipment.
- A practice support package was put in place for an individual sonographer, where issues were identified during a case review.

### 7.3 Element 3

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

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

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

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

## 7.4 Element 4

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

*The Trust board should specifically confirm that within their organisation:*

- *90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above.*

**CTG training**

| **Staff Group** | Number of **eligible** staff in post | Percentage trained |
|---|---|---|
| Midwives/sonographer/ Midwifery Managers/ Bank Midwives | 264 | 90% |
| Obstetric Consultants | 13 | 92% |
| Trainees | 32 | 91% |
| **Total** | **309** | **91%** |

## 7.5 Element 5

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

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

An audit undertaken between July and September 2022 demonstrated 46% compliance. Across the Region in August, it was just under 30%. One of the reasons for low figures is the difficulty in ensuring both doses of steroids are administered before delivery, when delivery occurs rapidly or unexpectantly. Some pre-term women attend in advanced labour and only one dose could be administered in time. Another issue is that some women are transferred to the Trust as an in-utero transfer from another Trust and delivery occurs in between both doses or they may not have received the first dose from the transferring Trust. This is being monitored and work continues as part of the Clinical Network Pre-term Group.

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

*B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. (The percentage should be as low as possible).*
An audit undertaken between July and September 2022 demonstrated 7.6% compliance.

The Saving Babies Lives (SBL) care bundle states 'a steroid to birth interval of greater than seven days should be avoided'.

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

An audit undertaken between July and September 2022 demonstrated 93% compliance. This data has been obtained from the Trust local database which is monitored by the lead Consultant for Pre-Term birth.

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

Compliance is at 100% because the Trust is co-located with a level 3 neonatal unit.

The Trust is not currently able to achieve compliance above 80% for standard A, however the Trust can declare compliance with element 5 as the requirements of the scheme is that an action plan is in place to address how the Trust will achieve at least 80% compliance for this standard. An action plan has been developed to address non-compliance and this has been agreed as part of a regional group reviewing pre-term births. Diagnostic testing has been introduced to give a more accurate assessment of the likelihood of a woman going into pre-term labour, supporting the earlier administration of steroids. The Pre-term birth specialist midwife and lead Consultant will be jointly responsible for monitoring compliance and delivering the issues outlined in the action plan.

Pre-term birth data was presented to the Maternity Board Level Safety Champions Group in February and October 2022.

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

### 8.1 Evidence should include:

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

The Newcastle Maternity Voices have had Terms of Reference reflecting the core principles since 2021. They were updated in November 2022.

- *Minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has*

*taken place and evidence of service developments resulting from coproduction between service users and staff.*

Minutes are available for the meetings held throughout 2021/2022 and include evidence of all the above.

- *Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme. Remuneration should take place in line with agreed Trust processes.*
- *Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way.*

The Trust has confirmation that the service user chairs (joint role) are being renumerated as agreed.

- *The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it*

The Trust has evidence of the MVP Workplan and the agreed MVP minutes which support the workplan. The LMNS minutes for November 2022 demonstrates ratification of the work plan.

- *Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.*
- *Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP.*

The Trust has a firmly embedded Maternity Voices Partnership (MVP). There are two co-chairpersons who work collaboratively in partnership with the Associate Director of Midwifery and key link Midwives within the service. The MVP continues the work in developing the work programme for 2022/23, ensuring key work streams are undertaken in a collaborative way and in partnership with service users.

The MVP continue to forge new connections and build on existing relationships with service users from within our Black and Minority Ethnic communities. The MVP attend monthly at the Mother and baby coffee mornings held at the Angelou centre and there have been visits to a women's health group at a local mosque. There is ongoing work to develop service user feedback for non-English speaking women. A summary report regarding the MVP involvement with BAME groups throughout 2022 has been written to capture the activities undertaken to date. This work will continue to be a focus for the MVP going forward.

The chairperson attends the bi-monthly Obstetric Governance group meeting. Further work is in progress regarding triangulation of incidents, complaints and claims and once this has been agreed within the Directorate the process for sharing complaint responses, including trends and themes will be shared with the MVP. In the interim complaint numbers and themes are discussed at the Governance meeting which the MVP co-chair is invited to attend.

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

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

The Trust is fully compliant with all 4 standards of this safety action.

### 9.1 Standard A

*A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years*

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

### 9.1 Standard B

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

### 9.2 Standard C

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

Achieving 90% compliance in year 4 was a challenge due to continuing workforce pressures, together with high levels of activity and acuity within the Department. The Trust was on target in line with trajectory until January 2022, at which point, due to significant shortage of staff in relation to the Omicron variant, it was necessary to postpone all training to ensure continuous safety within the Service. In mitigation, additional training sessions were subsequently re-scheduled in addition to the planned sessions. Training was further

suspended due to ongoing staffing challenges for six weeks between 31 August until 9 October 2022, whilst awaiting newly appointed staff to commence in role. Training sessions recommenced on 7 November 2022. The pressures experienced have had an impact on the trajectory however, staff were re-scheduled onto the remaining sessions and full compliance could have been achieved providing there were no further cancellation of sessions.

When the safety actions were amended in October 2022 the relevant time period was changed from '90% in 18 months in order to declare compliance acknowledging Covid-19 pressure' to 'any 12 consecutive months within the year 4 period, August 2021 until 5th December 2022'. This amendment led to a loss of 4 months of training attendance and achieving compliance before the 5th December was considered to be a significant challenge.

In order to meet with this revision and to achieve 90% compliance in all relevant staff groups, additional training days were arranged, with maximum attendance at all 6 sessions rostered for the final two weeks of the training compliance period. Staff that had been rostered to attend in December and January were re-scheduled to attend one of the six sessions before the 5th December. This required significant adjustments to staff rotas, together with deployment of non-clinical staff in backfilling, however, compliance was achieved as demonstrated in the table overleaf, whilst simultaneously ensuring the maintenance of safe services.

Training for standards B, C and D is achieved by attendance at the Clinical Skills training day which is 'an in-house' multiprofessional training day.

The table below shows training compliance in the 12-month period 3rd December 2021 to 2nd December 2022.

| **Staff Group** | Number of **eligible** staff in post | Percentage trained |
|---|---|---|
| Midwives/sonographer/ Midwifery Managers/ Bank Midwives | 264 | 90% |
| Maternity Support Worker/ Nursery Nurses/ HCA's | 82 | 90% |
| Theatre staff (includes Delivery Suite) | 7 | 100% |
| Obstetric Consultants | 13 | 92% |
| Obstetric trainees | 32 | 91% |
| Anaesthetic Consultants | 13 | 92% |
| Anaesthetic trainees | 14 | 93% |
| **Total** | **425** | **92%** |

The Trust has continued to provide training to all staff groups throughout the 12-month period. Despite training being cancelled for 3 of those months the Trust is able to

demonstrate compliance in all 7 staff groups. This has been extremely challenging, but compliance has been met as the staff demonstrated commitment to attending the training sessions which they value and appreciate.

### 9.3 Standard D

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

**Neonatal Life Support training compliance** 3rd December 2021 to 2nd December 2022.

| **Staff Group** | Number of **eligible** staff in post | Percentage trained |
|---|---|---|
| Midwives/sonographer/ Midwifery Managers/ Bank Midwives | 264 | 90% |
| Obstetric Consultants | 82 | 92% |
| Obstetric Trainees | 32 | 91% |
| Neonatal Consultants | 8 | 100% |
| Neonatal Trainees | 21 | 100% |
| Neonatal Nurses | 135 | 90% |
| Advanced Neonatal Nurse Practitioners | 6 | 100% |
| **Total** | **548** | **95%** |

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

The Trust is fully compliant with all 4 standards of this safety action.

### 10.1 Standard A

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

The pathway has been revised in light of the additional requirements and was presented at the Maternity Board Level Safety Champions Group in April 2022. The pathway is also displayed on the Safety Champions noticeboard outside the entrance to delivery suite.

## 10.2 Standard B

a) *Board level safety champions present a locally agreed dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.*

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

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

Training compliance is presented in in the Ockenden Board report which is submitted bi-monthly. A paper was presented in November 2022, and a further paper was presented to the Quality Committee in January 2023 which will subsequently be presented to the Trust Board in the same month.

Monthly walkabouts continue to be undertaken by a member of the Board, with the Non-Executive Director (Maternity). Key themes arising from the discussions with staff are verbally reported back to the Associate Director of Midwifery to ensure that issues arising can be managed appropriately in a timely manner. Feedback from these walkabouts is shared with staff via the Improving Safety Together newsletter produced twice a year (this will be shared with the Trust Board in March 2023).

The Trust's Claims Scorecard, alongside incident and complaint data was presented to the Maternity Board Level Safety Champions Group in February and December 2022. The Maternity Board Level Safety Champions were briefed about a new 'Triangulation of Incidents, Complaints and Claims' process that the Directorate are developing which would result in a more detailed local dashboard, as outlined for the scheme.

## 10.3 Standard C

This was amended in the October 2022 revision of the Maternity Incentive Scheme.

*Trust Boards have reviewed current staffing in the context of the letters to systems on 1 April 2022 and 21 September 2022 regarding the roll out of Midwifery Continuity of Carer as the default model of care. A decision has been made by the Board as to whether staffing meets safe minimum requirements to continue rollout of current or planned MCoC teams, or whether rollout should be suspended.*

As previously reported, following a formal organisational change process which occurred between January 2022-August 2022, the Trust undertook a further staffing review to inform the position with regard to the implementation of a model associated with Continuity of Carer. The findings of this review, together with the feedback from staff, steered a change in direction and a revised proposal which reduced the number of Teams to be rolled out. This change was presented to the Trust Board in September 2022, and is in line with the recommendations made in the letter from NHSEI in September 2022.

The Trust's focus is on ensuring that workforce metrics are optimised and sustainable before any further rollout associated with Continuity of Carer, aligned to national and regional workforce strategies and, therefore, plans are currently paused with a further review to be made in Quarter 1 2023.

### 10.4 Standard D

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

The Trust participate and engage with the relevant MatNeo Patient Safety Network events and have had representation at 6 events (16th September, 13th December 2021, 24th March, 16th June, 21 September and 14 December 2022), as outlined in the scheme.

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

The Score survey (organisational culture) was undertaken in April 2019. The results were shared with staff and feedback sessions delivered by two external health professionals in January 2020. Themes identified were similar to those identified during the Trust Staff Survey undertaken at the same time and these were incorporated into the Directorate Quality Improvement plans for 2020/21.

Ongoing work is in progress in light of the final Ockenden report which asks providers of maternity services to ensure high levels of staff engagement, ensuring a culture which is transparent, open, and honest, in which staff feel psychologically safe to speak up. This work continues at a local level and, combined with further engagement work arising from the 2022 staff survey, will form an integral part of the Directorate Strategy for 2023. Plans are in place to ensure staff engagement is prioritised with the intention to provide a variety of options for staff to discus, collaborate and feedback on matters of importance to them.

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

The Trust is fully compliant with all 3 standards of this safety action.

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

There were 19 qualifying cases during this time period all of which were reported to HSIB.

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

There have been no Early Notification cases that required notifying to NHS Resolution Early Notification Scheme since 1 April 2022.

*C) For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that:*

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

The families of all qualifying cases have been informed about the role of HSIB and the Early Notification scheme. The family – usually the mother – will be informed by one of the Risk and Governance Midwives in the first 24-48hrs days after birth. The process is fully explained to the parents and literature is provided to support the conversation. Thereafter following discharge from hospital, a confirmation letter is sent to the family; this includes a written apology on behalf of the Trust in line with Duty of Candour Regulations.

## 12. RECOMMENDATIONS

To note the content of this report, and to note that a declaration of full compliance against the Maternity CNST Year 4 Safety Actions was made and endorsed at the Extraordinary Board of Directors meeting held on 17 January 2023. The completed declaration form and presentation are appended to this report. The declaration form will be signed accordingly prior to submission.

**Report of Angela O'Brien**
**Director of Quality & Effectiveness**
26 January 2023

NHS Resolution

## Section A : Maternity safety actions - The Newcastle Upon Tyne Hospitals NHS Foundation Trust

| Action No. | Maternity safety action | Action met? (Y/N) |
|---|---|---|
| 1 | Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard? | Yes |
| 2 | Are you submitting data to the Maternity Services Data Set to the required standard? | Yes |
| 3 | Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? | Yes |
| 4 | Can you demonstrate an effective system of clinical workforce planning to the required standard? | Yes |
| 5 | Can you demonstrate an effective system of midwifery workforce planning to the required standard? | Yes |
| 6 | Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle V2? | Yes |
| 7 | Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services? | Yes |
| 8 | Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?<br>In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4? | Yes |
| 9 | Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues? | Yes |
| 10 | Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022? | Yes |

NHS Resolution

## Maternity incentive scheme - Board declaration Form

**Trust name** The Newcastle Upon Tyne Hospitals NHS Foundation Trust
**Trust code** T467

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

| | Safety actions | Action plan | Funds requested | Validations |
|---|---|---|---|---|
| Q1 NPMRT | Yes | | - | |
| Q2 MSDS | Yes | | - | |
| Q3 Transitional care | Yes | | - | |
| Q4 Clinical workforce planning | Yes | | - | |
| Q5 Midwifery workforce planning | Yes | | - | |
| Q6 SBL care bundle | Yes | | - | |
| Q7 Patient feedback | Yes | | - | |
| Q8 In-house training | Yes | | - | |
| Q9 Safety Champions | Yes | | - | |
| Q10 EN scheme | Yes | | - | |
| **Total safety actions** | **10** | **-** | | |
| **Total sum requested** | | | **-** | |

**Sign-off process:**

**Electronic signature**

**For and on behalf of the board of** The Newcastle Upon Tyne Hospitals NHS Foundation Trust

**Electronic signature**

**For and on behalf of the board of** The Newcastle Upon Tyne Hospitals NHS Foundation Trust

**Confirming that:**
The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

**Electronic signature**

**For and on behalf of the board of** The Newcastle Upon Tyne Hospitals NHS Foundation Trust

**Electronic signature**

**For and on behalf of the board of** The Newcastle Upon Tyne Hospitals NHS Foundation Trust

**Confirming that:**
The content of this form has been discussed with the commissioner(s) of the trust's maternity services

**Electronic signature**

**For and on behalf of the board of** The Newcastle Upon Tyne Hospitals NHS Foundation Trust

**Electronic signature**

**For and on behalf of the board of** The Newcastle Upon Tyne Hospitals NHS Foundation Trust

**Confirming that:**
There are no reports covering either **this year (2020/21) or the previous financial year (2019/20)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.

**Electronic signature**

**For and on behalf of the board of** The Newcastle Upon Tyne Hospitals NHS Foundation Trust

**Electronic signature**

**For and on behalf of the board of** The Newcastle Upon Tyne Hospitals NHS Foundation Trust

**Confirming that:**
If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering

**Name:**
**Position:**
**Date:**

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

# NHS Resolution
# Maternity Incentive Scheme

Position and Progress Report January 2023

Jane Anderson, Associate Director of Midwifery and
Paul Moran, Clinical Director

Healthcare at its best
with people at our heart

# NHS Resolution

# Maternity Incentive Scheme Year 4

## August 2021 to December 2022

# 10 Safety Actions

- Each safety action has a nominated lead
- Fortnightly CNST progress meetings since August 2021
- Bi-monthly updates reports to Quality Committee and Trust Board
- Amendments to the safety actions in view of changing circumstances / Covid 19 / pressure from other NHS Trusts
- Subtle changes each time – now working towards version 4
- Requires full compliance with all 10 safety actions to declare and receive rebate
- Final submission date 2nd February 2023
- Self declaration signed off by the Chief Executive Officer for the Trust and Accountable Officer for the Integrated Care Board

# Self Declaration



- All ten safety actions must be met in full.
- The declaration form does not allow additional free text to explain any issues of concern.
- 3 of the safety actions – 1 National Perinatal Mortality Review,  2 Maternity Safety Data Sets and 10 HSIB and Early Notification Scheme – are externally validated by cross referencing with the appropriate reporting body.
- All 10 of the safety actions have now met full compliance.

# Safety Action 1

# Perinatal Mortality Review (PMRT)

- A previously reported to the Trust board there was one delay in submitting a Perinatal surveillance form to MBRRACE-UK in September 2022.
- This safety action requires 100% compliance.
- Of the 46 cases reported to MBRRACE between 6th May and the 5th December, 45 of them had the surveillance form completed within the one month timeframe. There is a robust system in place to ensure these are completed within a month however the missed case was unusual in that it was a sudden neonatal death at home – the majority of our deaths are in hospital – and hence the oversight process was slightly different. The surveillance form was fully completed within a month but the form was not submitted. The person completing the form thought they had submitted it hence the omission was not discovered until the case was reviewed again 3 weeks later after the multi-disciplinary review.
- On identifying the omission MBRRACE were contacted for advice. They informed us that it may be possible to see through an audit trail that the form was fully completed but not submitted timely. They advised that this should be discussed with Trust at the time of declaration.
- As a tertiary referral unit we record the highest number of cases to MBRRACE each month and have been able to demonstrate exemplary reporting in 45 out of 46 cases. Failure to submit the form was simply down to human error.
- The Trust believes full compliance should be declared with this safety action in view of an auditable trail by MBRRACE.

# Safety Action 8

## Training '90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day, that includes maternity emergencies'.

- As previously reported to the Trust Board achieving compliance with this safety action has been extremely challenging due to high acuity and staffing pressures during the pandemic and thereafter.
- The Trust has now achieved full compliance of all 7 staff groups.
- This is a great achievement despite 3 months of training being cancelled during the 12 month period.
- In 2 of the staff groups compliance was just 90%, however, these groups have a large number of staff (total 346).
- The average was 92% across the total staff groups.

# In Summary

- Challenges experienced with regard to Safety Action 8 in relation to training requirements, however, through consistent review and further rescheduling compliance has now been met with this standard.

- There is one PMRT submission in relation to Safety Action 1 which was completed but not submitted due to human error; MBRRACE believe that this is auditable in terms of the timeframe being within the required month, therefore recommend that this is declared as compliant.

- All 10 safety actions are assessed as being fully compliant thereby supporting monetary rebate and upholding the reputation of the Trust.

- With special thanks to all members of the Maternity Team and our colleagues in CGARD who have made this possible.

THIS PAGE IS INTENTIONALLY BLANK

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

# TRUST BOARD

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date of meeting | 26 January 2023 | | | | | | |
| Title | Learning from Deaths (July 2022 – September 2022) | | | | | | |
| Report of | Angela O'Brien, Director of Quality and Effectiveness | | | | | | |
| Prepared by | Pauline McKinney, Integrated Governance Manager – Quality,<br>Jo Ledger, Head of Patient Safety & Risk | | | | | | |
| Status of Report | Public | | Private | | Internal | | |
| | ☒ | | ☐ | | ☒ | | |
| Purpose of Report | For Decision | | For Assurance | | For Information | | |
| | ☐ | | ☒ | | ☐ | | |
| Summary | This paper aims to provide assurance to the Trust Board that the processes for Learning from Deaths across the organisation are in line with best practice as defined in the National Quality Boards (NQB) National Guidance on Learning from Deaths (LFD) March 2017, and guidance on working with bereaved families and Carers (July 2018).<br><br>This paper also summarises the processes that are in place to provide assurance to the Committee that all deaths are reviewed including those with potentially modifiable factors. All deaths that require a more in-depth review (level 2) are recorded into the mortality review database to ensure lessons are learned and shared. | | | | | | |
| Recommendation | The Board of Directors is asked to (i) receive the report and (ii) note the actions taken to further develop the mechanisms for sharing learning across the Trust. | | | | | | |
| Links to Strategic Objectives | Putting patients first and providing care of the highest standard focusing on safety and quality<br>• Put patients and carers first and plan services around them.<br>• Maintaining our 'Outstanding' CQC rating. | | | | | | |
| Impact (please mark as appropriate) | Quality | Legal | Finance | Human Resources | Equality & Diversity | Reputation | Sustainability |
| | ☒ | ☐ | ☐ | ☐ | ☒ | ☒ | ☐ |
| Impact detail | Provision of assurance that patient outcomes are reviewed, and lessons learned to include deaths of people with learning disabilities. | | | | | | |
| Reports previously considered by | This is a recurrent report and was previously presented to Quality Committee and Trust Board in November 2022. | | | | | | |

# LEARNING FROM DEATHS

## EXECUTIVE SUMMARY

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

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

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

# LEARNING FROM DEATHS

## 1. BACKGROUND

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

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

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

The guidance released in July 2018 by the Department of Health and Social Care published the government's response to consultation on the "Introduction of Medical Examiners and Reforms to Death Certification in England and Wales". This guidance outlined the intention that the Medical Examiner system would be enshrined in statute and Medical Examiners would be based in all acute Trusts by 2021 with a view to start scrutinising community deaths by 2022. It is envisaged all deaths (both internal and community based) will receive scrutiny by April 2023, this deadline is endorsed by Department of Health and Social Care.

## 2. MORTALITY REVIEW DATABASE – DATA SUMMARY

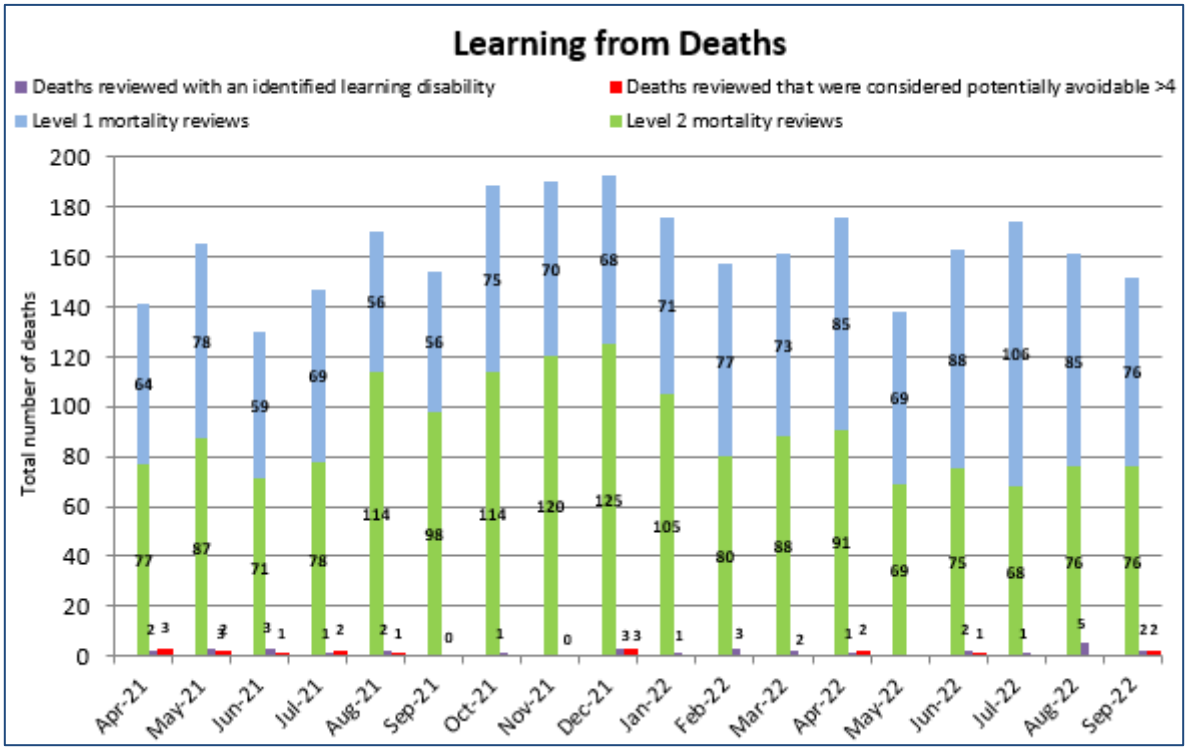
Current Morbidity and Mortality (M&M) meetings provide a robust forum for multidisciplinary discussion of each patient death. The mortality review database was launched in June 2017 and has improved the ease at which lessons identified within M&M meetings can be shared between Directorates. The database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

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

Level 2: In addition to the level 1 actions, the reviewer also considers documents and health records associated with the death and records findings into the Trust-wide mortality review database, in-line with Trust Mortality Policy.

### 2.1 Inpatient Deaths

In the 12 months period (October 2021 – September 2022) 2,030 patients died within Newcastle Hospitals with a total of 1,087 patients having received a level 2 mortality review. It is likely that these mortality review figures will continue to rise due to ongoing M&M meetings being held over the forthcoming months. These figures will continue to be monitored and modified accordingly. The graph below shows total number of deaths each month from April 2021 as well as level 2 mortality reviews.

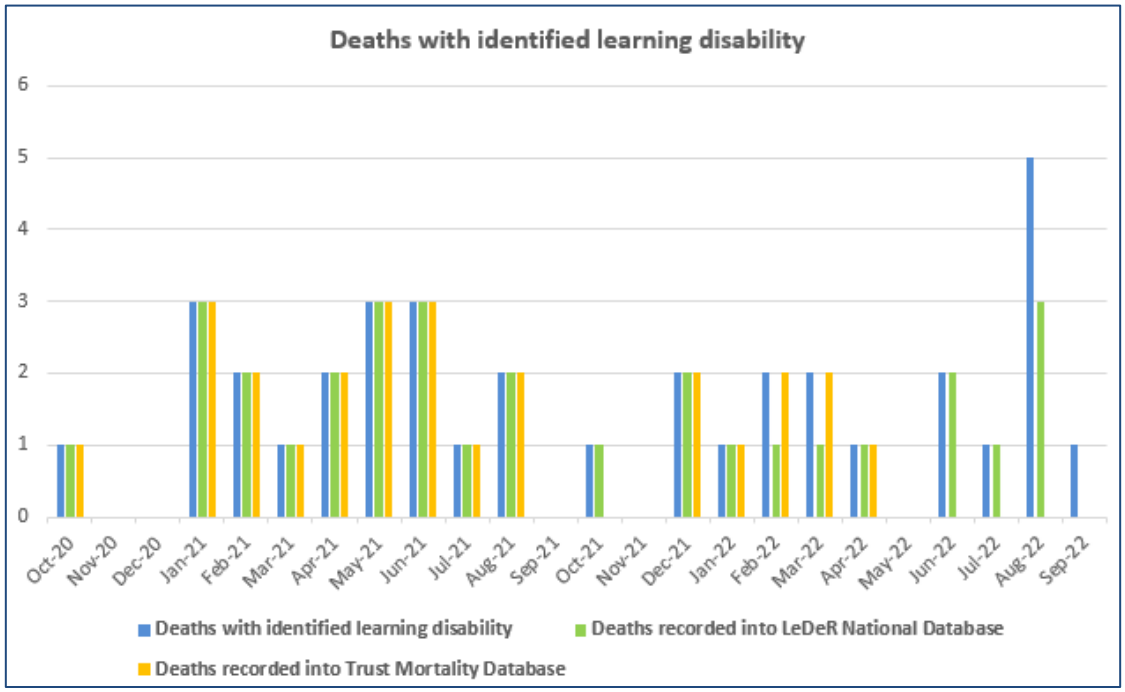



## 2.2 Patients identified with a Learning Disability

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

Over the preceding 12 months (October 2021 – September 2022), 21 patients who died within Newcastle Hospitals were identified as having a learning disability. Within the Trust, whenever a patient with a learning disability dies, their death is reviewed by the clinical team and is supported by the Learning Disability Team. There is a further in-depth case review at the Learning Disability Mortality Review Panel and the case review is also entered onto the Trust Mortality Review Database, as well as into the LeDeR National Database. An update is provided from the Learning Disability Specialist Nurse at each quarterly Mortality Surveillance Group meeting and lessons learned are shared using various methods, which includes presenting at the Clinical Risk Group and via Patient Safety Bulletins.

The graph below shows the data for the past 24 months (July 2020 – June 2022) and includes those patients who have been recorded into the national LeDeR database and Trust mortality database.



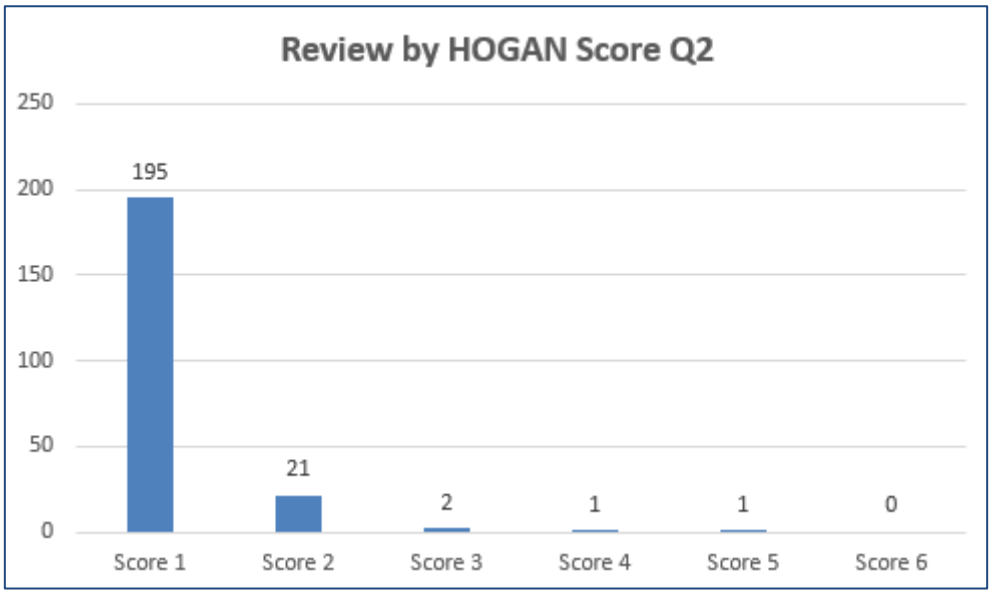

## 2.3 Outcome of Case Reviews – Hogan Score

Throughout Q2 (July 2022 – September 2022), 220 patients have received a full case note review (Level 2) which was undertaken by a multidisciplinary team and findings recorded into the Trust-wide mortality review database. This number will continue to rise as more M&M meetings go ahead over the forthcoming months.

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

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

A score of ≥4 suggests 'strong evidence of preventability'. Trust processes mandate that an investigation is initiated to determine if serious harm has occurred and a subsequent incident (SI) is to be reported, as well as being presented on an individual basis at quarterly mortality surveillance group. The outcomes of the cases reviewed in Q2 are summarised in the graph below:




The graph shows two patients recorded as HOGAN 4 or above. Both cases are under review by the Serious Incident Triage Panel.

**Amendment to initial HOGAN Gradings**

As part of a review of cases within adult cardiac surgery between 2018-2021, initial mortality reviews and assigned Hogan scores were considered. The investigation panel concluded that three cases previously graded 1 or 2, should be increased to Hogan 5. This has been actioned and the database amended accordingly. The Duty Of Candour process has been completed in all cases.

## 3. KEY LEARNING POINTS

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

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

The learning points identified following M&M reviews in Q2 are detailed below, together with how learning has been shared and what action has been taken. Clinicians from each Directorate are also encouraged to share relevant learning from local mortality reviews with any other Directorates throughout the Trust.

**Learning points identified from case reviews undertaken in Q2**

| Directorate | Speciality | Summary | Learning Point | Outcome |
|---|---|---|---|---|
| Surgical Services | Vascular | A vascular surgery patient was boarded onto a different speciality ward due to clinical activity pressures. The patient required intensive vascular input due to a deterioration in their condition, which was difficult to provide on the non-specialty ward. | At the first sign of deterioration in their condition, patients should be repatriated to a specialty ward for ongoing management. | Discussions are now taking place weekly between Vascular Consultants on-call and Patient Services Co-ordinators.<br><br>The focus of discussions will be to repatriate priority patients back to base wards for timely speciality input. |
| Surgical Services | HPB Transplant | A patient was admitted for an elective investigative procedure. During and after the procedure the patient developed complications, requiring a prolonged hospital admission. During the patient's treatment it was agreed that active intervention was no longer appropriate, and they sadly passed away. | Several handovers between consultants were recorded within the patient's medical records. This affected the quality of communication with the patient. On reflection better communication with the patient, led by their named consultant would have improved the experience for the patient. | The criteria for remaining on an acute patient list versus transfer onto named consultant care is to be discussed at the next consultant meeting (in February 2023). |
| EPOD | Dermatology | An elderly patient received multiple diagnoses and treatment for their presenting condition. The patient was eventually diagnosed with a rare autoimmune condition. Treatment for this was initiated 13 days after diagnosis. | Although it was agreed the delay in treatment did not contribute to the death of this patient, learning should focus on timely review of blood results in order to initiate prompt patient treatment. | Discussion at the departmental governance meeting focused on strengthening mechanisms available to review and act on blood results in a timely manner. |
| Cardiothoracic | Surgery/Anaesthetics/ICU | Patient successfully resuscitated following cardiac arrest. However, specialist equipment was not immediately available with the patient at the time of the arrest. | Ensure specialist equipment is readily available on specialist wards at all times.<br><br>Staff training package to be updated. | Discussed and learning shared at Directorate governance meeting and is under review by the serious incident triage panel. |
| Cardiothoracic | Surgery/Anaesthetics/ICU | The patient was admitted as an emergency and was transferred to a ward following the surgical procedure, however they deteriorated. A DNACPR was in place, the patient sadly died two days post operatively. | On reviewing the patient record during the mortality review, it was noted that the patient's cause of death was not recorded within the electronic patient record. | Learning re-enforced via directorate governance meeting to ensure accurate documentation in the patient electronic record. This is due to be disseminated to all clinicians. |

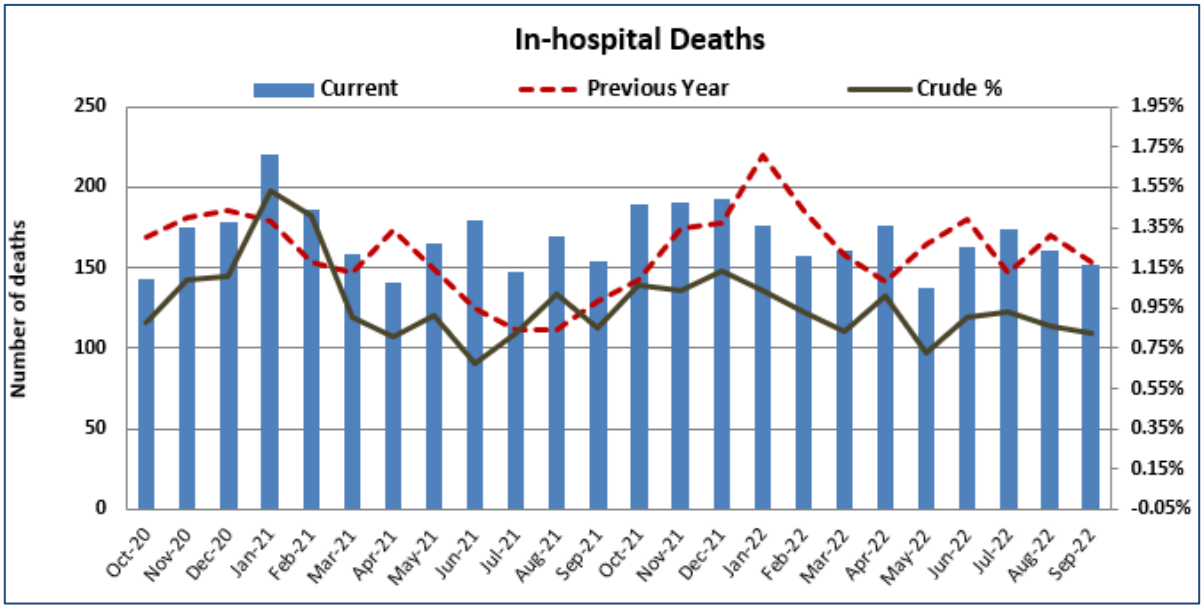
## 4. CRUDE MORTALITY

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

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

The graph below shows the crude mortality rates since October 2020. The crude mortality shows a significant increase in January 2021. Although historically deaths during this time period do rise in comparison to warmer months, the Trust also recorded an increase in Covid-19 deaths within this time period due to the second wave of the pandemic.

More recently, the crude rate has reduced to less than 1%, which is in line with the expected rate for this Trust.




## 5. SHMI AND HSMR MORTALITY RATES

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

SHMI and HSMR data is scrutinised on publication to determine any areas that may raise concern. All groups within the data are individually monitored and all findings are presented to the Trust Mortality Surveillance Group on a quarterly basis. Any group that

flags as a concern is raised with the relevant Directorate to ensure an in-depth analysis is undertaken and findings recorded into the mortality review database. All learning from this analysis is shared with Directorates and presented to the Mortality Surveillance Group.

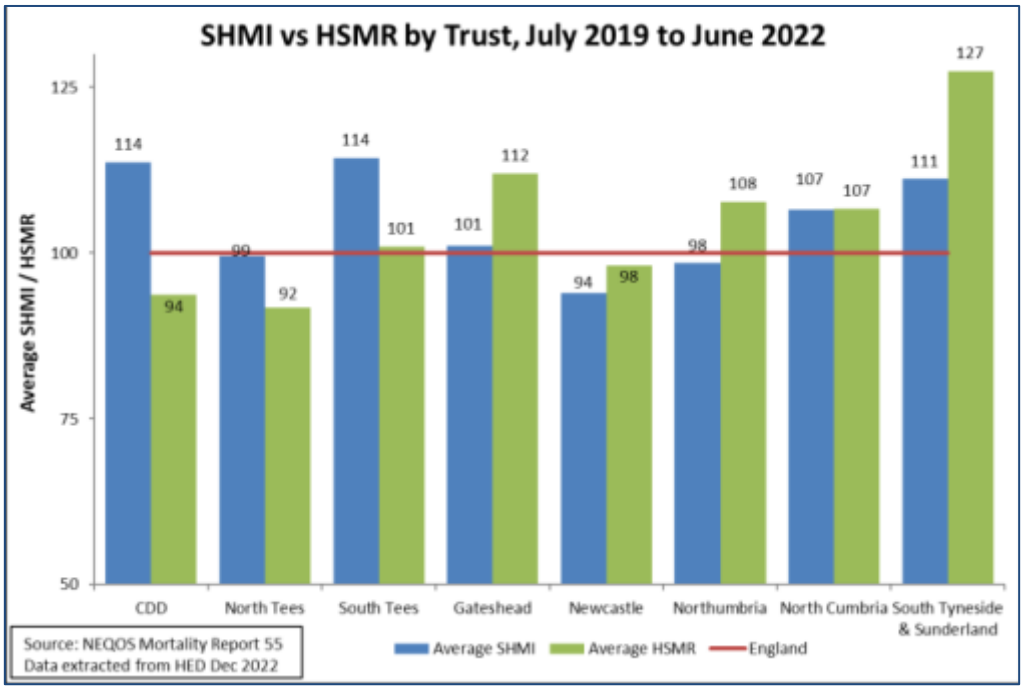
The latest SHMI publication for July 2021 – June 2022 shows the Trust to be at 91, which is below the national average and within "expected levels".

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

## 6. NEQOS

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

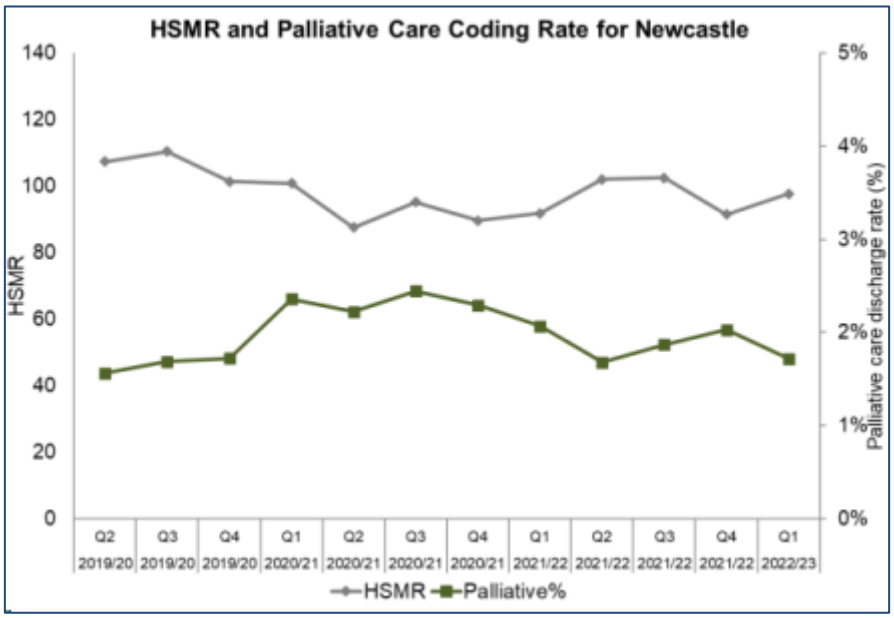
Overall, the graph below shows the Trust to be consistently below the national average for both SHMI and HSMR. The Trust SHMI average over a three-year period is 94 and the HSMR 98; both are below the national average.



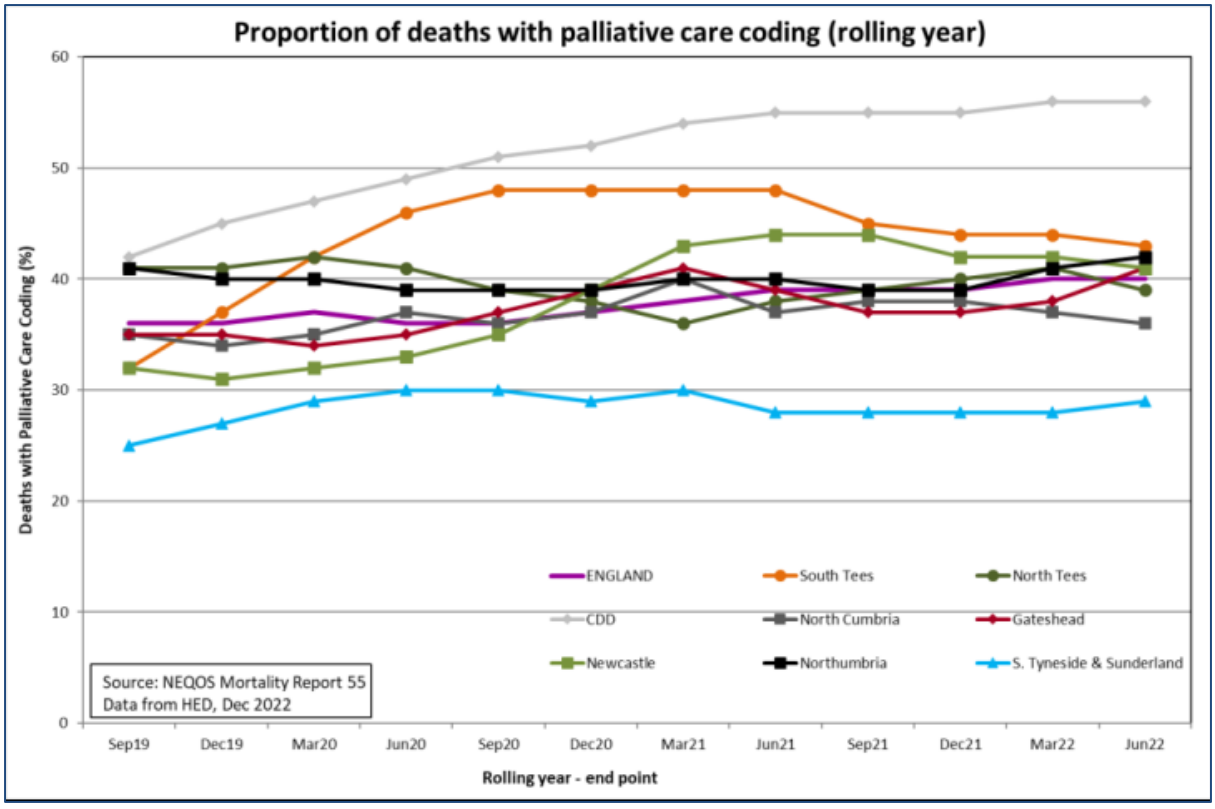

## 7. PALLIATIVE CARE CODING

The graph below shows that palliative care coding rate on discharge (including in-patient deaths) is historically reported below 3% within Newcastle Hospitals. The rise in palliative care coding throughout 2020/21 can be explained by the rise in deaths during the pandemic. HSMR (unlike SHMI) is adjusted for discharges with a specialist palliative care

code, therefore it a common theme if palliative care rate shows a downward trend the HSMR rate will show an upward trend.




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




## 8. OUTCOME OF INVESTIGATIONS LINKED TO SERIOUS INCIDENTS

All unexpected patient deaths, or deaths with possible modifiable factors, are routinely escalated for review as potential serious incidents (SI) via the Trust incident reporting system (Datix). Deaths of this nature are subject to a detailed review, facilitated by a Clinical Director and often involve members of the clinical team directly involved in the patients care. For deaths identified and reported externally as an SI, a comprehensive investigation is undertaken, which includes an analysis of the care provided to identify any learning and determines whether any modifiable factors contributed to the patient's death. Key learning points are identified, and action plans generated. A summary of investigation outcomes linked to SIs in Q2 are shown below:

- During July 2022 – September 2022 (Q2) there were 59 SIs reported to Commissioners via the Strategic Executive Information System (STEIS).
- Of these 59, there were seven patient deaths, which identified potential modifiable factors which contributed to the death.

The incidents that have resulted or contributed to a patient's death, that have completed their investigation since the previous report submitted in September 2022, are as follows:

| **2021/10166 – Deteriorating Patient** |
|---|
| • Guidance strengthened to ensure consistency of temperature management during spontaneous rupture of membranes in term babies.<br>• Clinical pathways and guidance re-enforced to encourage staff to discuss immediate induction of labour where pre-labour rupture of membranes has occurred.<br>• Re-enforced the actions required by staff during an emergency response.<br>• Clinical pathways and guidelines strengthened to align to national guidance in relation to difficult airway management. Additional simulation training also added to staff training package.<br>• Staff resources strengthened to support holistic interpretation of cardiotocograph. |

| **2021/20647 – Unexpected Death** |
|---|
| • Local learning shared widely to raise awareness of specific complications of treatment and how to reduce the risk of future occurrence. |

| **2021/24737 – Deteriorating Patient** |
|---|
| • Re-enforced the importance to staff of ensuring important clinical information is documented in handheld and hospital notes, as per local guidance.<br>• Clinical guidance and staff training strengthened to align to national guidance in relation to contemporaneous Apgar assessments.<br>• Increased practice support implemented to strengthen staff knowledge of the actions required in recognition and escalation of a deteriorating patient. This includes 'skills and drills' sessions and MDT training scenarios based on the learning from this case. |

| **2022/10332 – Medication Error** |
|---|
| • Review of discharge documentation to facilitate strengthened communication across the local healthcare system.<br>• Implementation of Trust-wide audit and quality improvement programmes to safety-net patients discharged from hospital with changes to their medications. |

- Strengthened links between secondary and primary care regarding sharing of learning from medication related incidents.

## 9. MEDICAL EXAMINER

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

The Medical Examiners roles went live in January 2021 as part of an initial test period, scrutinising patients' medical notes and discussing the care pathway with the ward clinician for all patients who died within two specified wards at the Freeman Hospital (FH). As the test period was considered a success, the project moved to the next stage in March 2021, which involved scrutinising all deaths at FH and finally including all deaths at Royal Victoria Infirmary (RVI) in August 2021. In addition to usual processes, the Medical Examiners have also recently (October 2022) started to scrutinise maternal deaths and patients with a learning disability. Paediatric deaths do not currently get scrutinised by the medical examiner as these patients receive a full and in-depth case review, in line with national review processes. However, communication is ongoing with Paediatric Directorate to start the Medical Examiner process for paediatric deaths by April 2023.

The Medical Examiner process plans to incorporate all community deaths by April 2023 and are currently trialling this in two local hospices. System development of the current mortality database, regarding inclusion of community deaths is ongoing. The development team are able to give a completion deadline for January 2023.

## 10. RECOMMENDATIONS

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

**Report of Angela O'Brien**
**Director of Quality & Effectiveness**
**17 January 2023**

THIS PAGE IS INTENTIONALLY BLANK

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

# TRUST BOARD

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date of meeting | 26 January 2023 | | | | | | |
| Title | National Patient Safety Strategy Steering Group (NPSSSG) – Bi-annual report | | | | | | |
| Report of | Angela O'Brien, Director of Quality & Effectiveness | | | | | | |
| Prepared by | Jo Ledger, Head of Patient Safety | | | | | | |
| Status of Report | Public | Private | Internal | | | | |
| | ☒ | ☐ | ☐ | | | | |
| Purpose of Report | For Decision | For Assurance | For Information | | | | |
| | ☐ | ☒ | ☒ | | | | |
| Summary | This is the first National Patient Safety Strategy Steering Group bi-annual report to the Quality Committee and Trust Board, which outlines current status and progress with work underway to meet the requirements of the national strategy.<br><br>The report provides information on progress with key priorities workstreams identified by the Trust including; the implementation of the Patient Safety Incident Response Framework (PSIRF), introduction of new key roles of Patient Safety Specialists, Patient Safety Partners and an outline of requirements in relation to increasing staff capability and links to quality improvement apparatus. | | | | | | |
| Recommendation | The Trust Board is asked to receive this paper for assurance. | | | | | | |
| Links to Strategic Objectives | Putting patients first and providing care of the highest standard focusing on safety and quality<br>• Put patients and carers first and plan services around them.<br>• Maintaining our 'Outstanding' CQC rating. | | | | | | |
| Impact (please mark as appropriate) | Quality | Legal | Finance | Human Resources | Equality & Diversity | Reputation | Sustainability |
| | ☒ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ |
| Impact detail | Potential reputational risk. | | | | | | |
| Reports previously considered by | This is a new bi-annual report to the Quality Committee and Trust Board. Previous NPSS updates to the Trust Board have been provided in presentation format and a previous report has been presented to the Executive Team in November 2021 | | | | | | |

# NHS PATIENT SAFETY STRATEGY (NPSS) & PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) UPDATE

## 1. INTRODUCTION

The NHS Patient Safety Strategy, published in July 2019 (updated in February 2021), describes how the NHS will continuously improve patient safety over the next five to ten years.

The strategy outlines the national ambition to fundamentally change the way the NHS responds to, learns from and improves patient safety. The strategy is transformational and far reaching in relation to quality and safety and is inclusive of all healthcare systems, regulators and safety partners; e.g. Care Quality Commission (CQC), Healthcare Safety Investigation Branch (HSIB), Get It Right First Time (GIRFT), NHS Digital, Integrated Care Boards (ICBs). The strategy requires action at a national, regional and local organisational level. The whole strategy is under-pinned by trying to address health inequalities.

Implementation of the national strategy has started, and the time-period extends currently to 2023/24.

There are reputational risks of not implementing the key deliverables of the national strategy and it is anticipated that there will be considerable scrutiny of the Trust's system improvements to support strategy requirements, from regulators and commissioning bodies.

This report outlines the Trust key priorities and progress to date.

### 1.1. Main objectives of the NHS Patient Safety Strategy

There are five main objectives as follows:

Patient safety culture – supporting and embedding a measurable safety culture that is open to learning and system change, which incorporates leadership and behaviours that promote an inclusive and compassionate climate.

Patient safety system – developing safe systems across all provider organisations, national & regional bodies, networks, commissioning and regulatory bodies, including digital developments to enable transformational improvements in safety, with a shared understanding of safety across all organisations.

Insight – identifying metrics, triangulation of data for learning and **measurable improvement** from a range of organisations e.g. HSIB, NHS Resolution (NHSR), GIRFT, Medicines and Healthcare products Regulatory Agency (MHRA). Development of the new national 'Learning from patient safety events' (LFPSE) system for reporting, analysis and learning.

Involvement – includes the introduction of the Patient Safety Specialist (PSS) role across the networks and partner organisations – five have been appointed for the Trust.

Improvement – development of local safety improvement programmes underpinned by the national improvement priorities; building on the MatNeo model.

The Trust, alongside other healthcare providers, is expected to implement all key strategic requirements of the national strategy within the timescales outlined.

## 2. TRUST PRIORITIES AND PROGRESS TO DATE

### 2.1. Trust NPSS Steering Group

The Trust's NPSS Steering Group (NPSSSG) held its inaugural meeting on 13 June 2022, meeting monthly thereafter, and is led by the Trust's identified Senior Responsible Officer (SRO); the Director of Quality & Effectiveness, with support from identified deputies and strategic team. The steering group core membership includes representation from the Associate Medical Directors (AMDs) and Clinical Directors (CDs) for Quality & Patient Safety, Senior Patient Safety Leads, Clinical Digital Lead, Trust Education Lead and Medication Safety Lead. Stakeholders are co-opted to the group for targeted workstreams, and engagement as required.

The NPSSSG has responsibility for overseeing the implementation of the Strategy, supporting the three strategic aims of improving understanding of safety (**insight**), equipping patients, staff and partners with the skills and opportunities to improve patient safety (**involvement**) and designing and supporting programmes that deliver effective and sustainable change (**improvement)**.

Terms of Reference have been scoped and key objectives of the group include a focus on data collection and digital developments to enable transformational improvements in safety, ensuring meaningful patient and staff involvement, as well as addressing inequalities and promoting a shared understanding of safety across the whole organisation.

The NPSSSG also recognises the opportunity to consider how quality and safety governance mechanisms, aligned to national patient safety strategy requirements, can be strengthened and integrated as part of the transformation to new divisional structures within the Trust.

### 2.2. Patient Safety Specialists

As part of the NHS Patient Safety Strategy ambition, the new role of Patient Safety Specialist (PSS) has been introduced across all national provider and commissioning organisations. PSSs are identified as integral to, providing visible, senior expert support to the patient safety work of healthcare organisations and seen as key drivers of change for national strategy implementation.

The Trust appointed five named PSSs in March 2019, in line with contractual requirement within the NHS Standard Contract 2021/22, and these individuals cover key roles across the

Trust wide patient safety agenda, with a direct link to the named executive director lead for patient safety.

PSSs are active and visible, involved in national NHS England & Improvement (NHSEI) and regional networking, attending national PSS webinars and collaborating with Shelford trusts and local patient safety networks.

Two of the PSSs presented to the Trust Board of Directors on 30 June 2022, outlining the key Trust requirements for aligning to the national strategy and providing key information and raising awareness of the PSS role within the Trust.

### 2.3. Patient Safety Incident Response Framework (PSIRF)

The new PSIRF is a key priority of the national strategy and represents a fundamental shift in how the NHS will respond to patient safety incidents, how we understand the systems factors that contribute to adverse incidents occurring and how we develop and maintain effective systems for learning & improvement. Adoption of PSIRF is mandated by Autumn 2023.

PSIRF will replace the current Serious Incident Framework (SIF) which has been in place since 2015), however PSIRF is not simply a replacement reporting framework with defined criteria, rather is designed to be flexible and adapt to enable organisations to learn and improve local patient safety incident profiles, risks and safety priorities. PSIRF encourages a proportionate data driven incident response, using range of tools in order to balance effort between investigating individual incidents (relevant to local context) and exploring issues and undertaking improvement work activity. Implementation of PSIRF is supported by the provision of supporting frameworks, documents and tools for organisations to consider (see Figure 1).

Compassionate engagement with those affected by patient safety incidents i.e. patients, families and staff, as well as addressing inequalities in patient safety, is key to PSIRF. Under PSIRF, supportive regulatory/ICB oversight is promoted, with a focus on consideration of the effectiveness of Trust systems for responding, learning & improving, rather than on provider performance and compliance targets and individual incident sign off.

A PSIRF working group has been established, overseen by the NPSSSG, which has started to outline key drivers required for implementation. The working group has completed an investment proposal which was presented to the Executive Team on 11 January 2022. The investment proposal identifies the resource needed to support implementation of the PSIRF.

Effective implementation of PSIRF requires a significant amount of work and represents organisational change, in order to ensure the structures, mechanisms and defined roles are in place in order to adopt PSIRF within the Trust by Autumn 2023.

In addition, further engagement with the ICB, PSIRF Lead is underway, with a collaborative approach required to understand the oversight role of the ICB as required as part of PSIRF implementation. Communication is in the early stages and work is in progress in order for

the Trust to understand expectations in relation to system wide mechanisms and cross organisational working required.

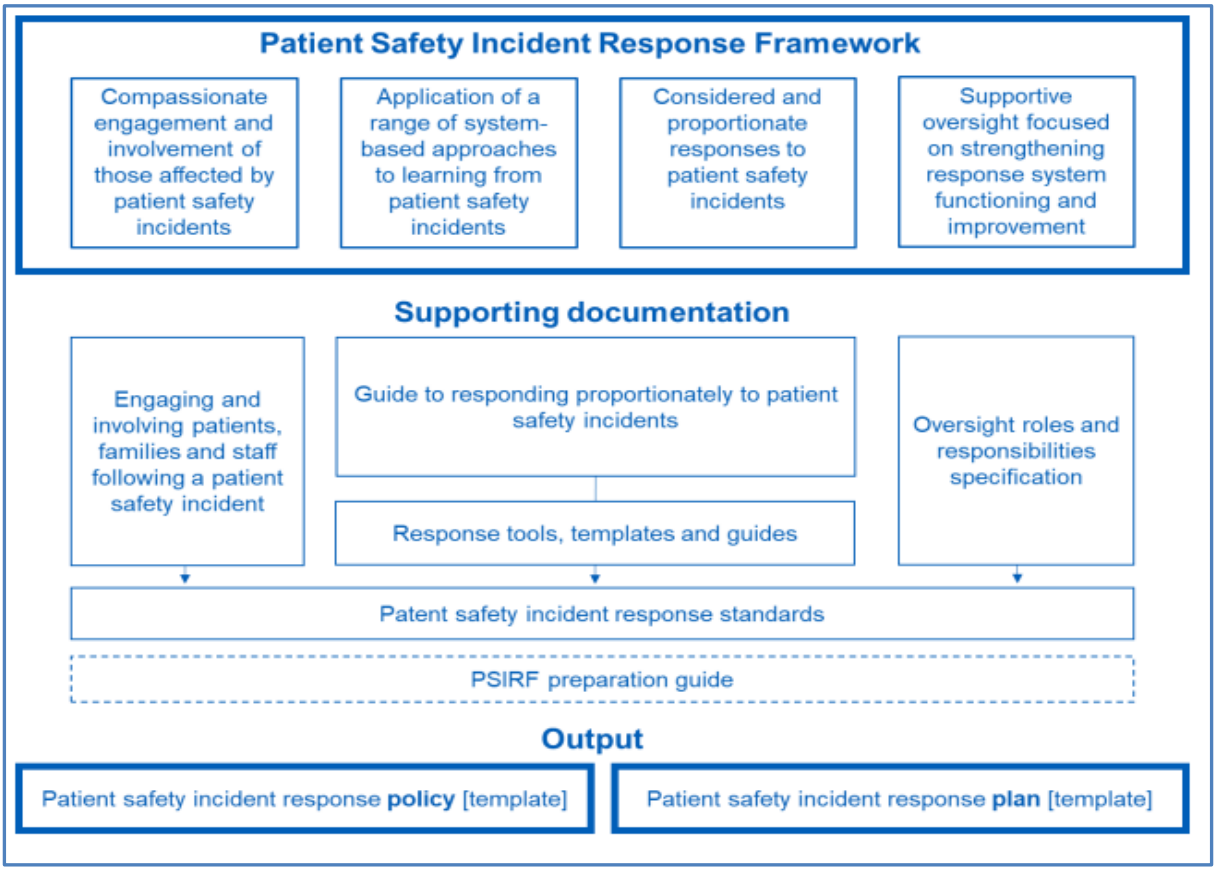



**Figure 1 – PSIRF and supporting documentation**

## 2.4. Introduction of the Patient Safety Partner (PSP) role

The *Framework for Involving Patients in Patient Safety* (2021) and is a key priority for implementation by all NHS healthcare providers, as part of the national strategy. This framework highlights the importance of involving patients in their own safety and includes the introduction of a new role; the PSP, responding to Don Bewick's call for patients and their carers to be present, powerful and involved at all levels of healthcare organisations from wards to the boards of trusts.

PSPs are patients, carers, family members or other lay people, who are recruited to work in partnership with staff in order to influence and improve the governance and leadership of safety within an NHS organisation. PSP are not employees however they are expected to have agreed job descriptors and to be renumerated for their time and contribution to the Trust's patient safety agenda. Provider trust's are required to recruit at least two PSPs, to sit on trust safety governance groups and for them to have received the required training and support in order to enable them to undertake this role.

An application for charitable funds was submitted in July 2022 to request support for the introduction of four PSP roles within the Trust (two for each main site), unfortunately this application was unsuccessful. The PSIRF investment proposal (outlined in PSIRF section

above) also incorporates an assessment of the resource required for the introduction of the Patient Safety Partner role within the Trust and it is hoped that this will be supported.

There is a recognised gap in patient involvement/engagement in the Trust and the investment proposal outlines a QI project for proof of concept, working towards the ambition of having a 'patient safety board', in order to strengthen our partnership with patients, improve patient involvement in a meaningful way (across the new divisional Trust structures) and to clearly align to the NHS Patient Safety Strategy requirements.

### 2.5. National Patient Safety Syllabus

As part of the NHS Patient Safety Strategy's objective to increase staff capacity and capability, Health Education England in partnership with the Academy of Royal Colleges, have published the first NHS-wide Patient Safety Syllabus, which applies to all NHS employees and aims to result in enhanced patient safety training for all staff in every role, creating a step change in thinking about and understanding patient safety proactively.

Training providers, for example E-learning for Health, HSIB, are developing and publishing training courses and modules, as part of a national training procurement framework, in order to provide additional higher level staff training including; understanding safety in complex systems, human factors and systems incident investigation training.

The Trust was asked to pilot HSIB's systems incident investigator training programme in 2022, prior to this training being rolled out to the national early adopter sites for PSIRF, with a number of directorate Quality & Safety Leads (Consultants) benefiting from receiving this training. In addition, a number of Trust directorate Quality & Safety Leads have also received systems incident investigator training, led by a Clinical Director for Quality & Patient Safety in collaboration with an external safety science expert and Trust faculty. This training is being used currently to support incident investigation practice in a number of directorates and supports the transition from the current national Serious Incident (SI) Framework to PSIRF.

### 2.6. Links with Improvement apparatus

Measuring continuous improvement is a key driver in the NHS Patient Safety Strategy. Newcastle Improvement and existing strong links with the Institute for Healthcare Improvement (IHI) will be pivotal in enabling the Trust to integrate patient safety learning with quality improvement (QI) activity and capacity, as part of an integrated quality management system.

## 3. RECOMMENDATIONS

The Trust Board is asked to receive this report for information and assurance on status and progress with expected system-wide requirements of the national strategy.

**Report of Angela O'Brien**
**Director of Quality & Effectiveness**
6 January 2023

THIS PAGE IS INTENTIONALLY BLANK

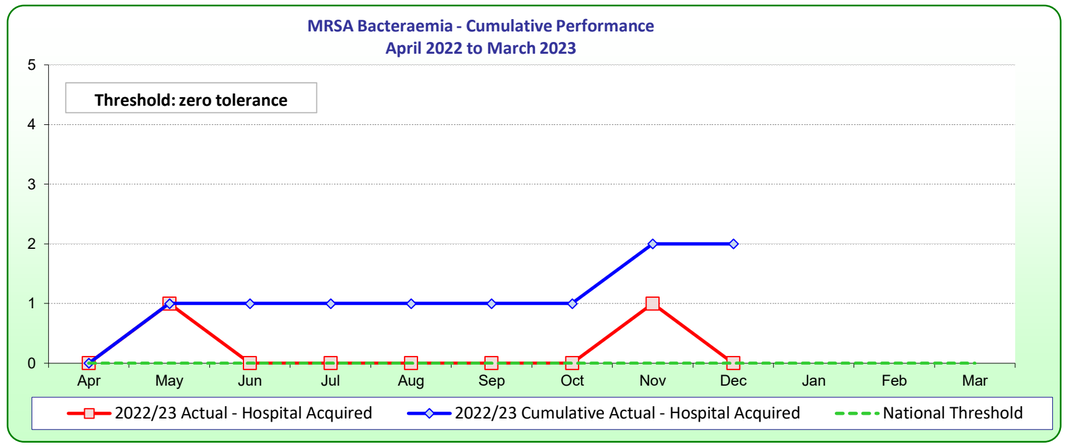
Agenda item A8(d)

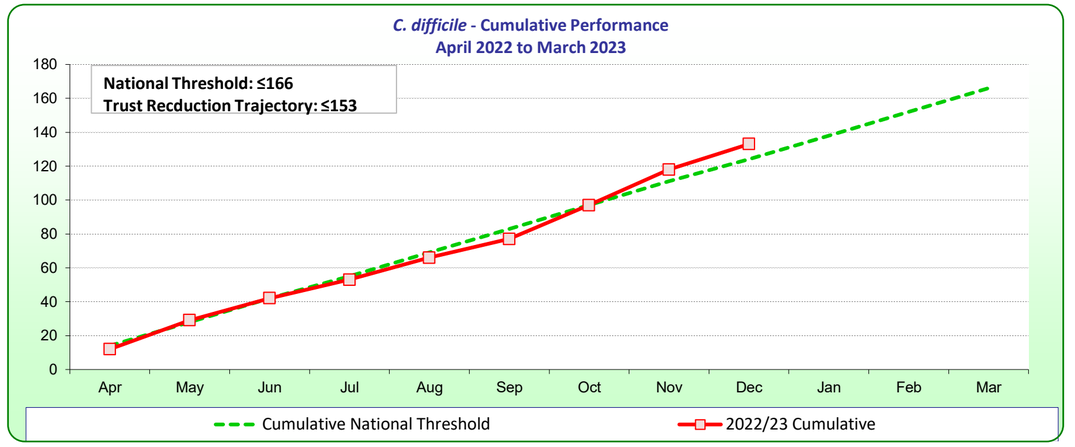
The Newcastle upon Tyne Hospitals NHS Foundation Trust

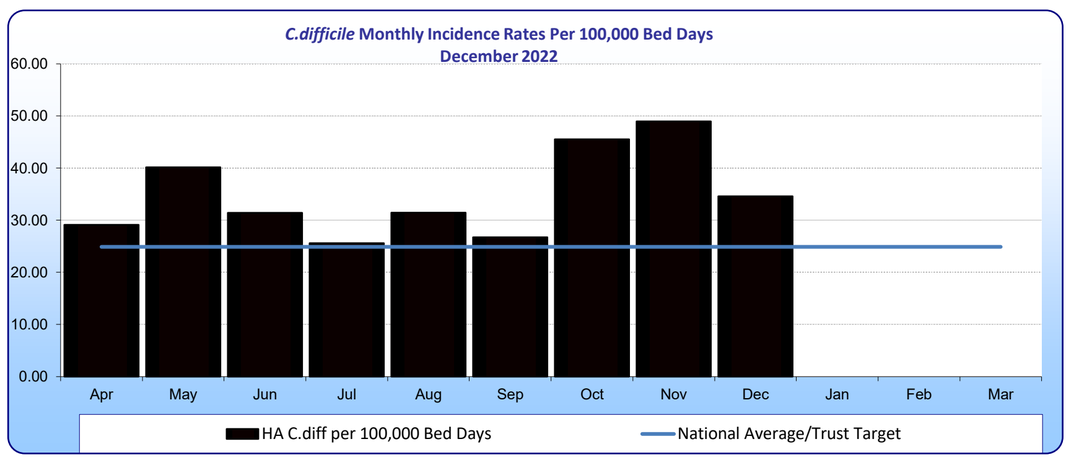
# Healthcare-Associated Infections Report
# December 2022

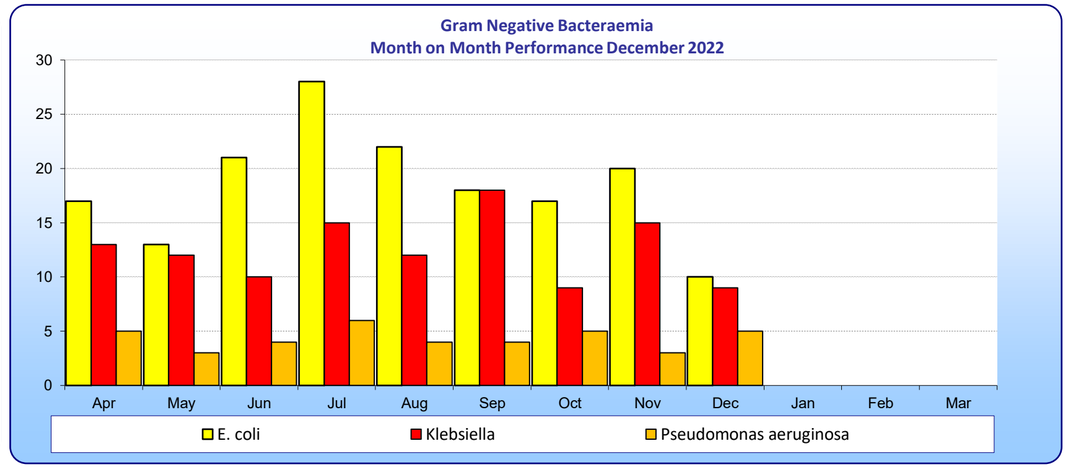
**Agenda item A8(d)**
**Healthcare-Associated Infection Report December 2022**

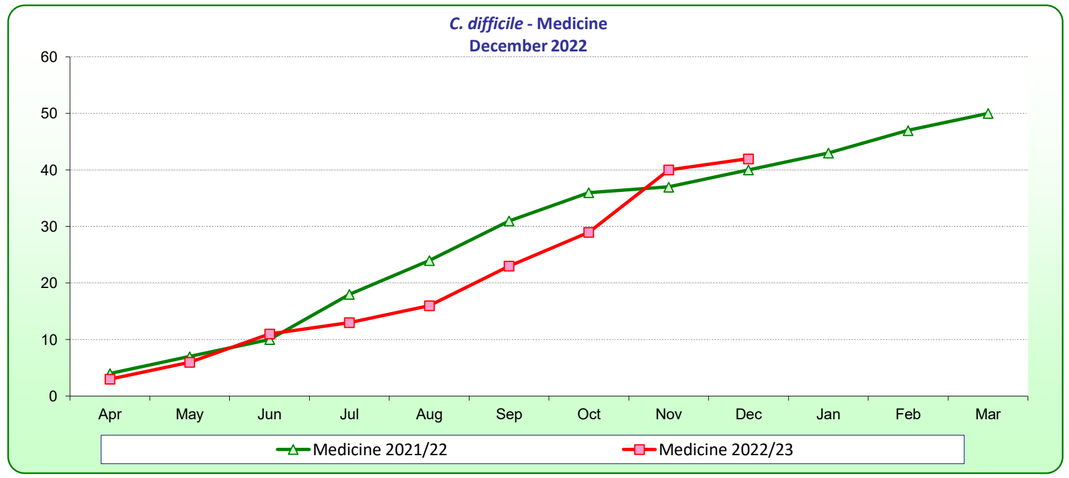
The Newcastle upon Tyne Hospitals NHS Foundation Trust

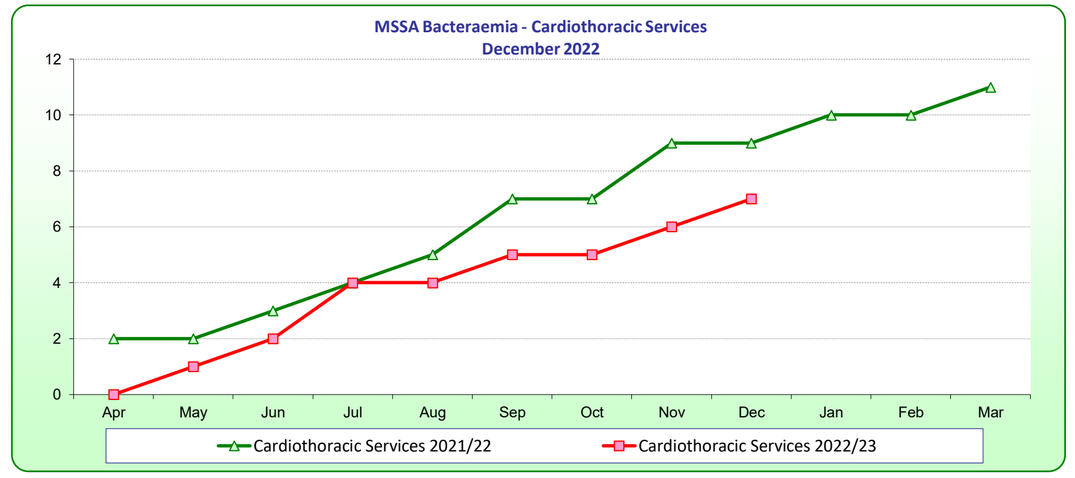


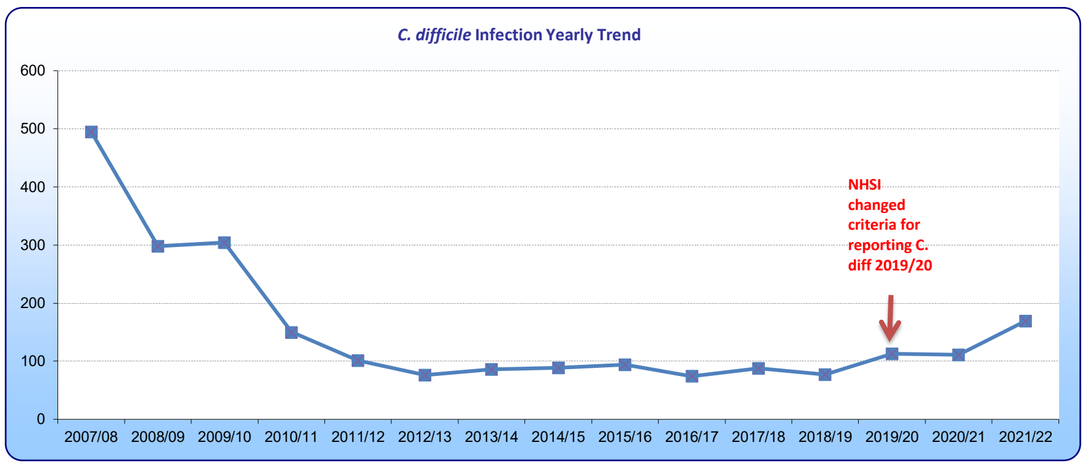



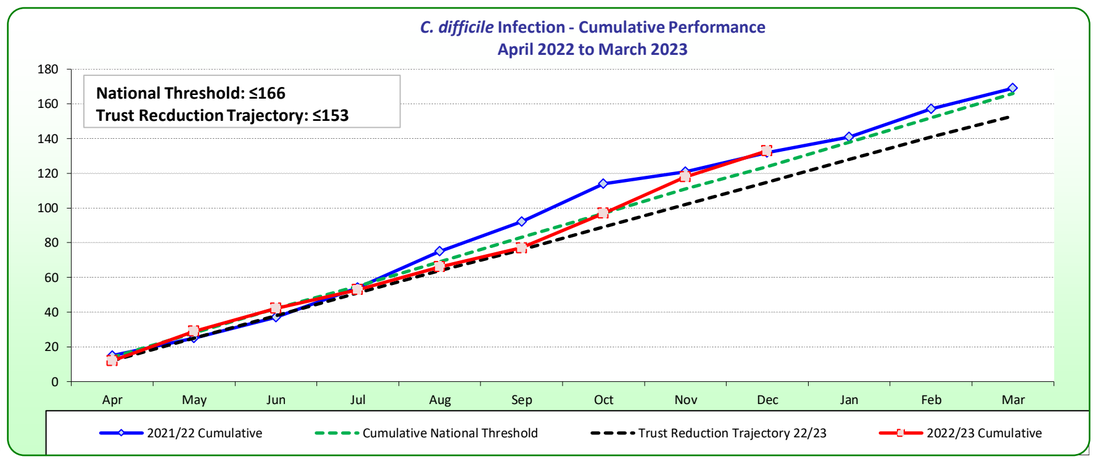



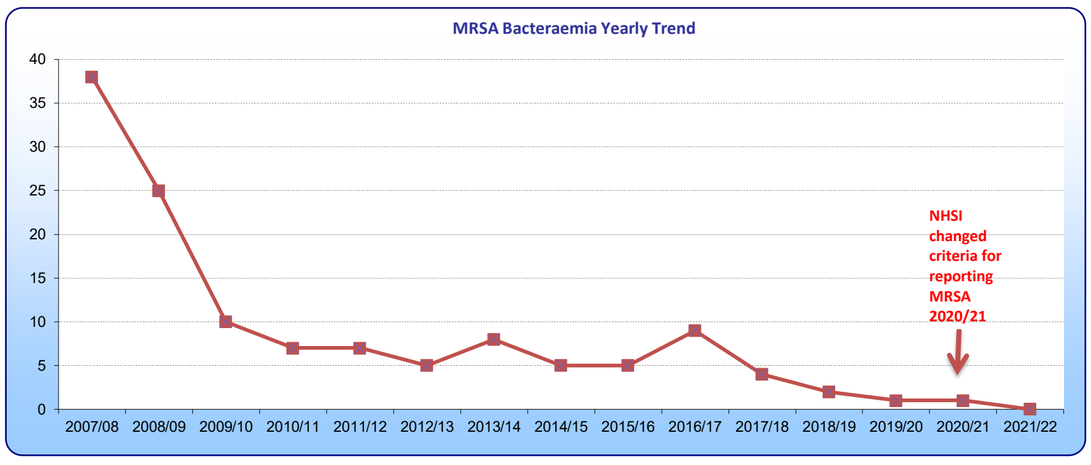



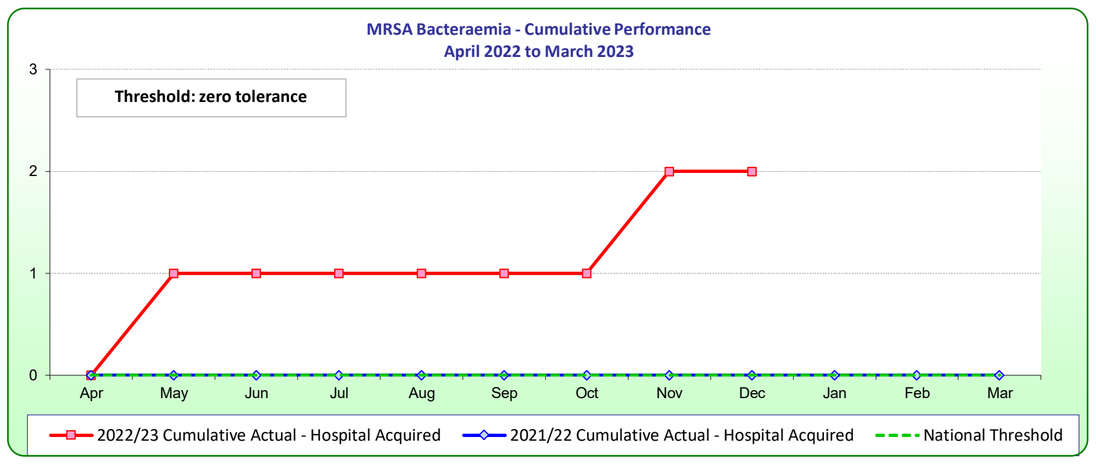
**Agenda item A8(d)**
**Healthcare-Associated Infection Report December 2022**

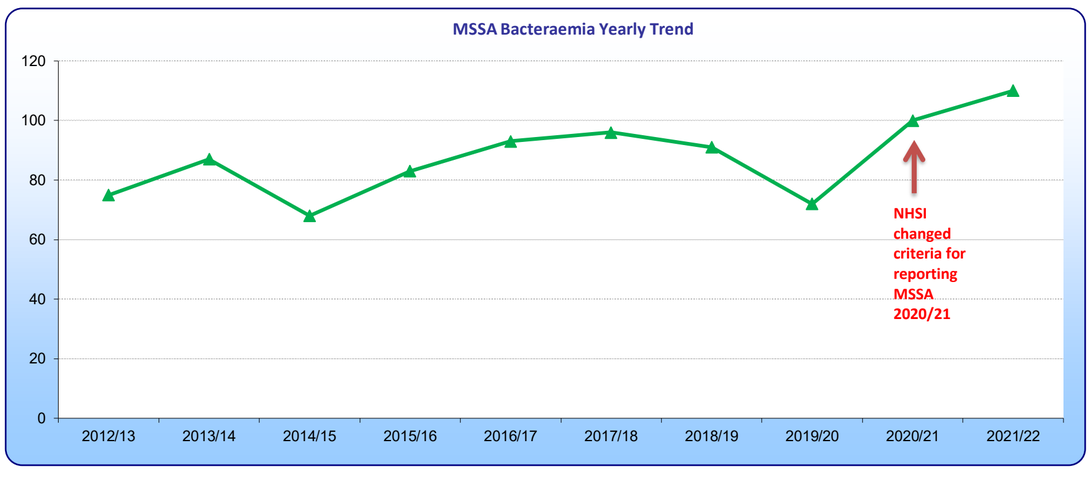
The Newcastle upon Tyne Hospitals NHS Foundation Trust

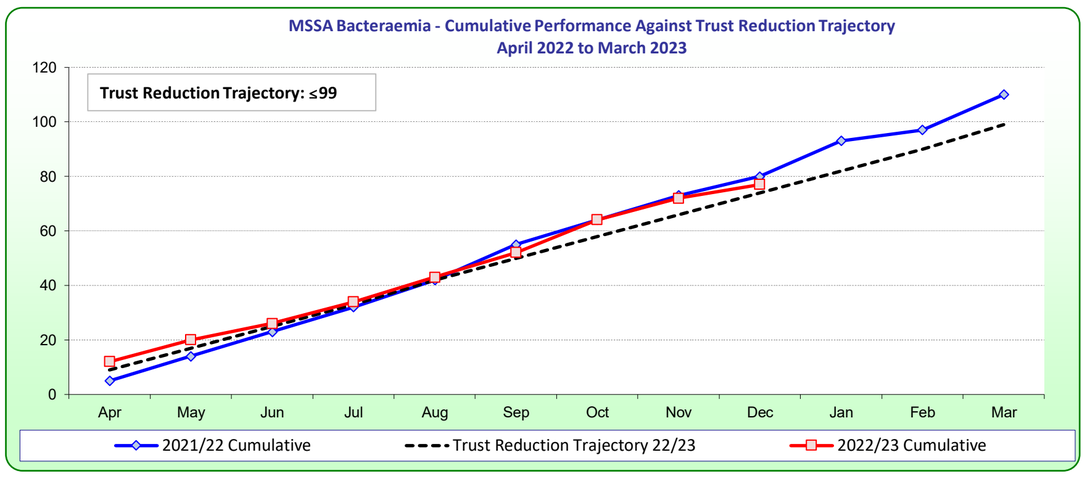


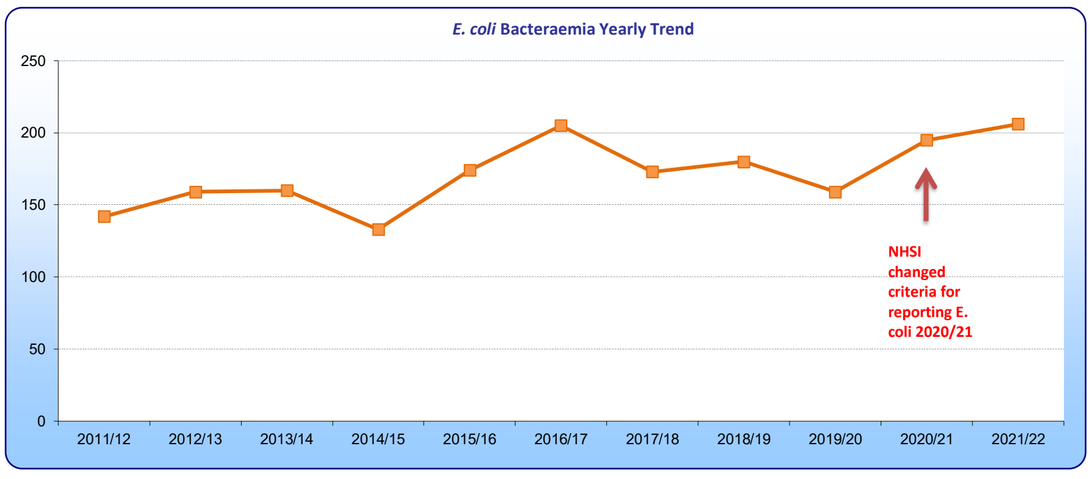



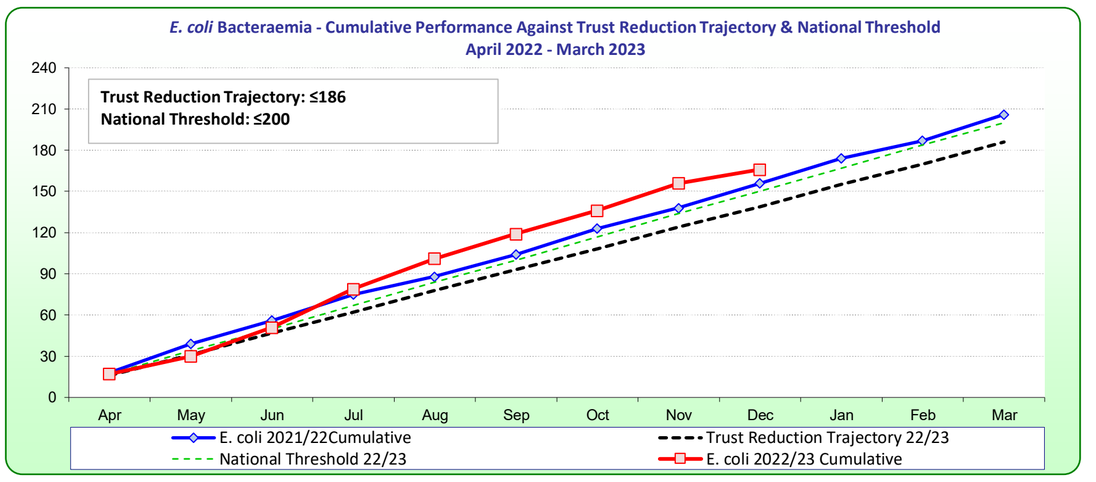



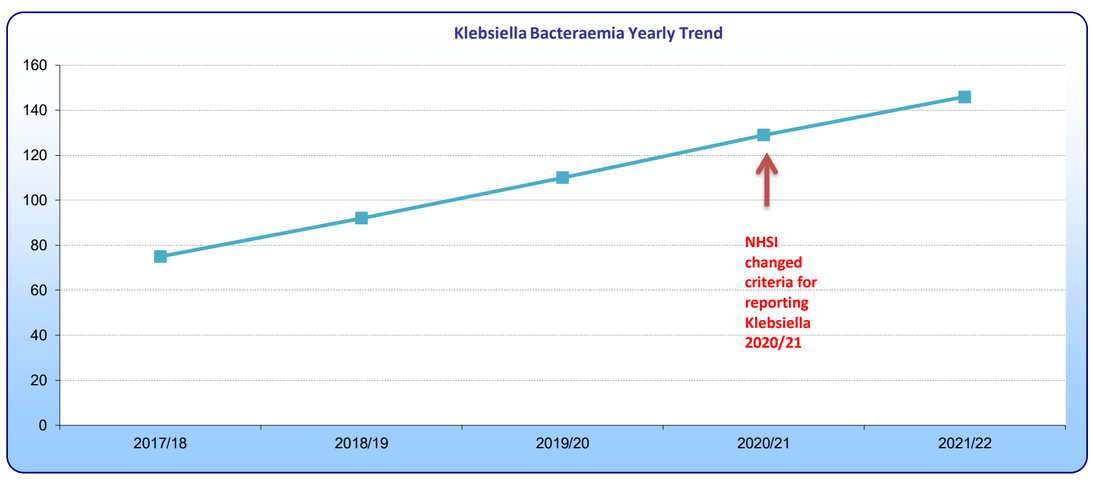



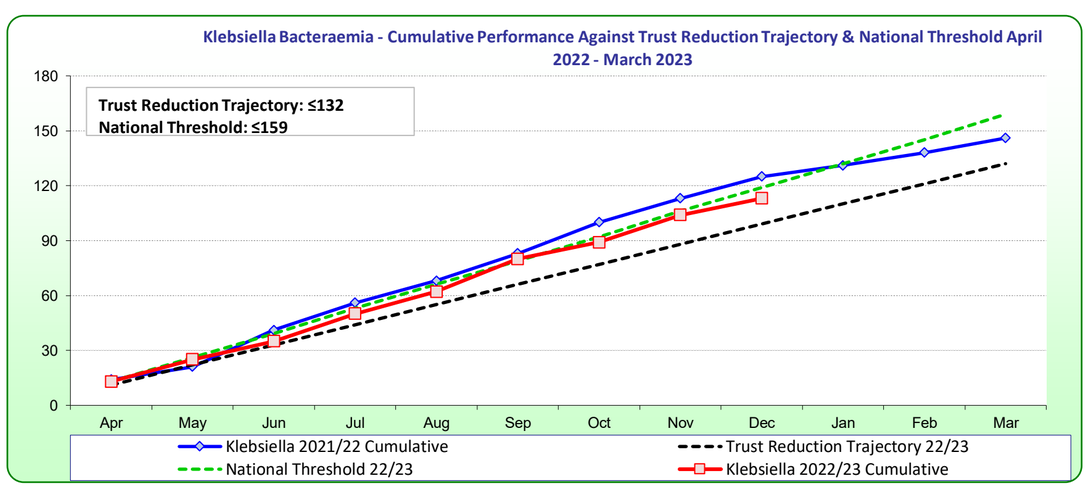



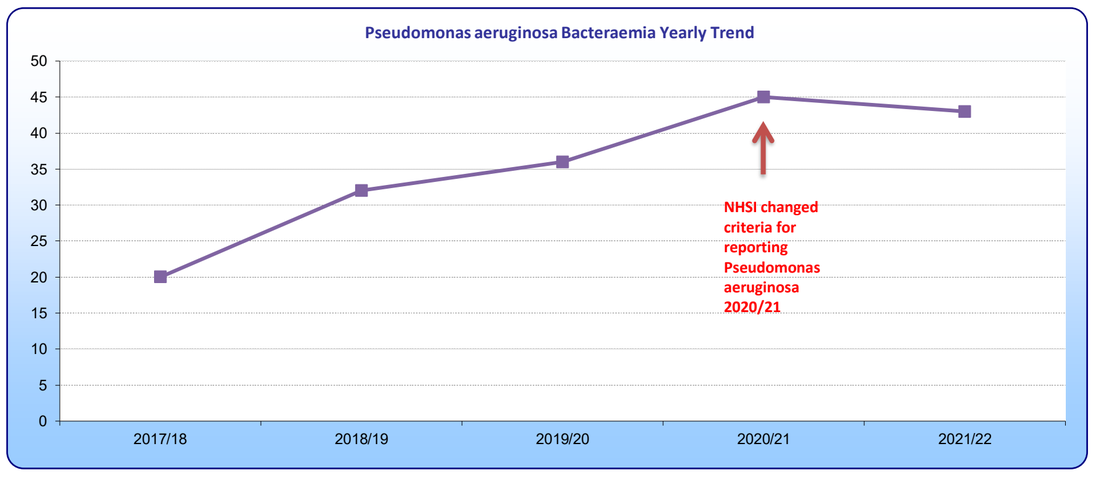



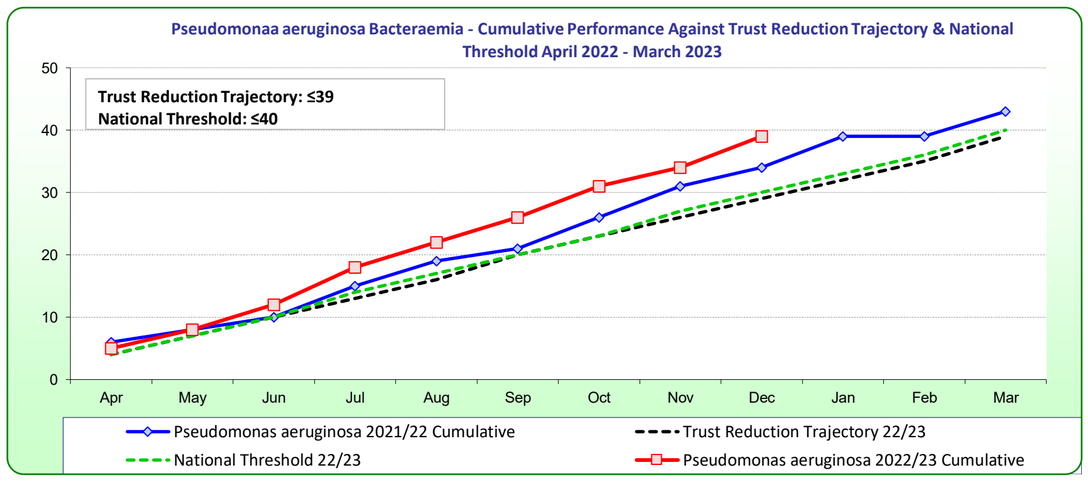



**Agenda item A8(d)**
**Healthcare-Associated Infection Report December 2022**

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 | 0 | 0 | | | | 1 |
| MRSA Bacteraemia - Trust-assigned (objective 0) | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | | | | 2 |
| MRSA HA acquisitions | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | | | | 2 |
| MSSA Bacteraemia - Healthcare Associated (local objective ≤99) | 12 | 8 | 6 | 8 | 9 | 9 | 12 | 8 | 5 | | | | 77 |
| *E. coli* Bacteraemia - Healthcare Associated (local objective ≤186) | 17 | 13 | 21 | 28 | 22 | 18 | 17 | 20 | 10 | | | | 166 |
| Klebsiella Bacteraemia - Healthcare Associated (local objective ≤132) | 13 | 12 | 10 | 15 | 12 | 18 | 9 | 15 | 9 | | | | 113 |
| Pseudomonas aeruginosa Bacteraemia - Healthcare Associated (local objective ≤39) | 5 | 3 | 4 | 6 | 4 | 4 | 5 | 3 | 5 | | | | 39 |
| *C. diff* - Hospital Acquired (national threshold not yet know; local objective ≤153) | 12 | 17 | 13 | 11 | 13 | 11 | 20 | 21 | 15 | | | | 133 |
| *C. diff* related death certificates | - | - | 2 | 3 | 0 | 0 | 0 | 2 | 0 | | | | |
| Part 1 | - | - | 1 | 0 | 0 | 0 | 0 | 2 | 0 | | | | |
| Part 2 | - | - | 1 | 3 | 0 | 0 | 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 | 5 | 6 | 2 | | | | 23 |
| Patients affected | 5 | 8 | 3 | 0 | 1 | 4 | 8 | 14 | 11 | | | | 54 |
| COVID-19 - Hospital Acquired | 7 | 1 | 2 | 1 | 1 | 1 | 2 | 3 | 0 | | | | 18 |
| Patients affected | 22 | 2 | 4 | 4 | 6 | 2 | 7 | 7 | 0 | | | | 54 |

| 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 | 19 | 27 | | | | 257 |
| Hospital onset Definite HC assoicated (≥15 days post admission) | 63 | 22 | 49 | 84 | 13 | 36 | 62 | 41 | 53 | | | | 423 |

| Outbreaks | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Cumulative |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Norovirus Outbreaks | - | - | - | - | - | - | - | - | 1 | | | | 1 |
| Patients affected (total) | - | - | - | - | - | - | - | - | 9 | | | | 9 |
| Staff affected (total) | - | - | - | - | - | - | - | - | 4 | | | | 4 |
| Bed days losts (total) | - | - | - | - | - | - | - | - | 1 | | | | 1 |
| Other Outbreaks | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | | | | 6 |
| Patients affected (total) | 16 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 24 | | | | 40 |
| Staff affected (total) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12 | | | | 12 |
| Bed days losts (total) | 48 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | | | | 51 |
| COVID Outbreaks | 4 | 2 | 10 | 11 | 3 | 6 | 9 | 5 | 7 | | | | 57 |
| Patients affected (total) | 32 | 15 | 92 | 110 | 12 | 41 | 59 | 34 | 32 | | | | 427 |
| Staff affected (total) | 0 | 2 | 4 | 0 | 13 | 9 | 4 | 2 | 5 | | | | 39 |

| *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 | 12:20 | 13:48 | | | | 12:47 |
| Laboratory Turnaround Time | 04:04 | 02:43 | 03:06 | 03:03 | 03:18 | 03:05 | 03:19 | 03:30 | 04:03 | | | | 03:21 |
| Total to Result Availability | 16:40 | 15:27 | 17:47 | 14:53 | 14:45 | 16:22 | 15:47 | 15:50 | 17:51 | | | | 16:09 |

| 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% | 86% | 84% | | | | 76% |
| Standard IPC Precautions (incl HH, ANTT, PPE) Audit Trust Total | 68% | 85% | 82% | 81% | 85% | 81% | 80% | 86% | 83% | | | | 81% |
| Invasive Device Care Audit Trust Total | 64% | 71% | 69% | 81% | 80% | 80% | 83% | 80% | 86% | | | | 77% |
| Matron Checks (IP; OP/Community/Dental; Theatres) Trust Total | 73% | 78% | 87% | 73% | 86% | 85% | 88% | 90% | 90% | | | | 83% |

| 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% | 91% | | | | 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% | 61% | 66% | | | | 59% |

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

The Newcastle upon Tyne Hospitals NHS Foundation Trust

# TRUST BOARD

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date of meeting | 26 January 2023 | | | | | | |
| Title | Corporate Governance Update | | | | | | |
| Report of | Caroline Docking, Assistant Chief Executive | | | | | | |
| Prepared by | Kelly Jupp, Trust Secretary<br>Lauren Thompson, Deputy Trust Secretary / Corporate Governance Manager | | | | | | |
| Status of Report | Public | Private | Internal | | | | |
| | ☒ | ☐ | ☐ | | | | |
| Purpose of Report | For Decision | For Assurance | For Information | | | | |
| | ☒ | ☐ | ☒ | | | | |
| Summary | The report includes an update on the following areas;<br>• Updates on Council of Governors activities;<br>• Appointments and Remuneration Committee Terms of Reference and Schedule of Business Review;<br>• Recent publications/consultation responses;<br>• Non-Executive Director (NED) recruitment;<br>• Annual Report and Accounts 2022/23 Planning; and<br>• Quarterly NHS Improvement Declarations. | | | | | | |
| Recommendation | The Board of Directors is asked to:<br>(i) Receive the report;<br>(ii) Approve the Appointments and Remuneration Committee Terms of Reference and Schedule of Business; and<br>(iii) Approve the Quarterly NHS Improvement Declarations. | | | | | | |
| Links to Strategic Objectives | Performance – Being outstanding, now and in the future. | | | | | | |
| Impact (please mark as appropriate) | Quality | Legal | Finance | Human Resources | Equality & Diversity | Reputation | Sustainability |
| | ☒ | ☒ | ☒ | ☒ | ☐ | ☒ | ☐ |
| Impact detail | Impacts on those highlighted at a strategic and reputational level. | | | | | | |
| Reports previously considered by | Standing agenda item. | | | | | | |

# CORPORATE GOVERNANCE UPDATE

## EXECUTIVE SUMMARY

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

- Governor Developments;
- Appointments and Remuneration Committee Terms of Reference and Schedule of Business Review;
- Recent publications/consultation responses;
- Non-Executive Director (NED) recruitment;
- Annual Report and Accounts 2022/23 Planning; and
- Non-Executive Director (NED) recruitment.

The Board of Directors is asked to:

(i) Receive the report;
(ii) Approve the Appointments and Remuneration Committee Terms of Reference and Schedule of Business; 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 second quarterly Members' Newsletter (Winter edition) has been drafted for circulation to all Members.
- A group of Governors were invited to Newcastle Sixth Form College to explain the Governor Role and to promote Trust Membership.
- A Members' Event – Innovation took place on 1 December 2022.
- Discussions are underway with Governor members of the People, Engagement and Membership Working Group to plan the first Trust Discussion Forum for both members and prospective members.

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

## 2. APPOINTMENTS AND REMUNERATION COMMITTEE TERMS OF REFERENCE (ToR) AND SCHEDULE OF BUSINESS REVIEW

The Appointments and Remuneration Committee Terms of Reference were reviewed and updated at the Committee meeting on 11 October 2022.

In summary the following changes were made:

- Updates to reflect the change in name of the Local Clinical Excellence Awards (to the National Clinical Impact Awards).
- Minor changes to reflect duplicated points and suggestions recommended within the external Korn Ferry review report e.g. amendments to clarify the role of the Committee.
- Consistent use of role titles e.g. 'Chief Executive' and 'Chief People Officer' throughout the ToR.
- Changes to provider greater clarity over the Very Senior Manager (VSM) population.
- An update to reference the annual review of the succession plan.

A new Schedule of Business has been drafted to cover the full financial year 2022/23 and to include further updates to reflect the changes made to the Terms of Reference.

Board members are asked to approve the updated ToR and Schedule of Business.

Going forwards, the annual review of the Appointments and Remuneration Committee Terms of Reference will be aligned to the July annual review cycle for all Board Committees.

## 3. PUBLICATIONS/CONSULTATION RESPONSES

During December 2022 and January 2023, recent publications included:

- NHS Providers published a briefing on Community Network: Making the most of urgent community response services.
- The Care Quality Commission (CQC) published a report on monitoring the Mental Health Act.
- NHS England published the NHS 2023/24 priorities and operational planning guidance.

## 4. NON-EXECUTIVE DIRECTOR (NED) RECRUITMENT

Board members are aware that Mr Morgan will be leaving his role as a Trust Non-Executive Director at the end of January 2023.

The Nominations Committee met on 13 January 2023 to commence the process for the recruitment of a new Non-Executive Director to replace the post currently held by Mr Morgan.

The Trust Board wish to thank Mr Morgan for his commitment and dedication during his time as a Non-Executive Director within Newcastle Hospitals and wish him success in his future role

## 5. ANNUAL REPORT AND ACCOUNTS 2022/23

Preparations have commenced for the collation of information for the Annual Report and Accounts 2022/23. An initial meeting has been scheduled on 27 January 2023 with representatives from a number of teams across the organisation.

Whilst the publication of the Annual Reporting Manual (ARM) is awaited and the dates for parliamentary laying are currently unknown, a number of key dates have been announced:

- Draft submission of the annual accounts: 27 April 2023; and
- Final/audited submission of the annual report and accounts: 30 June 2023.

As such, extraordinary meetings of the Finance Committee, Audit Committee, and Board of Directors meeting to approve the report and accounts are being scheduled.

## 6. 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 October 2022 to 31 December 2022 and Board members are asked to approve the declarations.

## 7. RECOMMENDATIONS

The Board of Directors is asked to:

(i) Receive the report;
(ii) Approve the Appointments and Remuneration Committee Terms of Reference and Schedule of Business; and
(iii) Approve the Quarterly NHS Improvement Declarations.

**Kelly Jupp**
**Trust Secretary**

**Lauren Thompson**
**Deputy Trust Secretary / Corporate Governance Manager**

**12 January 2023**

**Worksheet "FT4 declaration"**

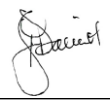
**Financial Year to which self-certification relates** **Dec-22**

## 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.<br>No material risks identified.<br>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.<br>No material risks identified.<br>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:<br>(a) Effective board and committee structures;<br>(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and<br>(c) Clear reporting lines and accountabilities throughout its organisation. | | No material risks identified.<br>The CQC reviewed the effectiveness of the Board and confirmed Committee structure as part of the 'Well Led' review, assessed as 'Outstanding'.<br>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:<br><br>(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;<br>(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;<br>(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;<br>(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);<br>(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;<br>(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;<br>(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<br>(h) To ensure compliance with all applicable legal requirements. | | Confirmed.<br>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:<br>- Trust Board meetings.<br>- Routine Integrated Board Reports and focussed performance reports.<br>- Regular meetings of the Trust Executive Team, Executive Risk Group, Finance, Quality, Audit and People Committees.<br>- Board approved terms of references and schedules of business.<br>- Board approved Annual Plan.<br>- Regular detailed Board finance report.<br>- Board Assurance Framework and Risk Registers.<br>- 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:<br><br>(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;<br>(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;<br>(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;<br>(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;<br>(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<br>(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.<br>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:<br>- Trust Board composition includes Chief Executive Officer, Chief Operating Officer, Medical Director, Director for Business, Development and Enterprise, Finance Director and Executive Chief Nurse<br>- Annual Quality Account produced<br>- Patient/staff stories digital presented at Board meetings as a regular agenda item<br>- Board line of sight as part of Leadership Spotlight on Services / Walkabouts<br>- Positive external stakeholder feedback (re Quality Account)<br>- Routine Integrated Report to Trust Board (including SIRI reporting)<br>- Quality Committee meetings to seek assurance over quality of care including scrutiny of SIRIs and Never Events<br>- 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**  **Signature** 

**Name** Dame Jackie Daniel **Name** Sir John Burn

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

A

# Worksheet "Training of governors"

**Financial Year to which self-certification relates** Dec-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** | 26.01.2023 | **Date** | 26.01.2023 |

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** Dec-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

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** | 26.01.2023 | **Date** | 26.01.2023 |

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

# TERMS OF REFERENCE – APPOINTMENTS AND REMUNERATION COMMITTEE

## 1. Constitution of the Committee

1.1 The Appointments and Remuneration Committee is a statutory Committee established by the Board of Directors to oversee, on behalf of the Trust Board, the appointment and remuneration of the Chief Executive, Executive Directors, and other Very Senior Managers at the Trust.

1.2 The Committee is constituted in line with the requirements of the NHS Codes of Conduct and Accountability and the Higgs report. The Higgs report recommends the Committee be comprised exclusively of Non-Executive Directors, a minimum of three, who are independent of management.

1.3 The Board of Directors approved the establishment of the Appointment and Remuneration Committee, formerly the 'Terms of Service and Remuneration Committee' (known as "the Committee" in these Terms of Reference) for the purpose of:

a) the nomination of the Chief Executive and other Executive Directors for the Trust;
b) the determination of the remuneration, contracts and terms of service and allowances for the Chief Executive and other Executive Directors and Very Senior Managers for the Trust;
c) oversight of remuneration and allowances for Trust Senior Staff (TSS) and
d) overseeing the process for allocation of the National Clinical Impact Awards.

1.4 The Committee is a formal sub-committee of the Board of Directors. It is appointed and authorised by the Board of Directors to act within its Terms of Reference. All members of staff are directed to co-operate with any request made by the Committee.

## 2. Purpose and function

2.1 The purpose of the Committee will be to determine the appropriate level and composition of remuneration, and terms of service for the Chief Executive, other Executive Directors and Very Senior Managers, including:

a) all aspects of salary (including any performance-related elements / bonuses);
b) provisions for other benefits for senior staff, including pensions and annual leave allocations at variance with standard NHS terms and conditions;
c) arrangements for the recruitment of the Chief Executive, other Executive Directors and Very Senior Managers; and
d) arrangements for termination of employment and other contractual terms.

2.2 In all deliberations pertaining to the Chief Executive and all other Executive Directors, the Committee shall take into account the Fit and Proper Persons requirements, required by the Care Quality Commission (CQC).

2.3 The Committee shall consider the recommendations arising from the National Clinical Impact Awards Programme before making recommendation(s) to the Trust Board on such awards.

## 3. Authority

The Committee is:

3.1 a statutory Non-Executive Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference;

3.2 authorised by the Board of Directors to:

I. investigate any activity within its Terms of Reference;
II. seek any information it requires from any officer of the Trust; and
III. invite any employee including the Chief Executive (except where the pay and conditions of the Chief Executive are under consideration) and the Director of Human Resources/Chief People Officer, to provide information, advice and guidance by request at a meeting of the Committee to support its work, as and when required;

3.3 authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for, or expedient to, the exercise of its functions, including instructing professional advisors on whatever professional advice it requires (as advised by the Executive Lead of the Committee and / or the Trust Secretary).

## 4. Membership and quorum

### Membership

4.1 Members of the Committee will be appointed by the Board of Directors and will be made up of at least four members.

4.2 The Committee's membership will comprise the Chair of the Board and a minimum of two other Non-Executive Directors.

4.3 The Chief Executive, Director of Human Resources/Chief People Officer and Trust Secretary will attend the Committee. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.4 The Trust Board will agree a Non-Executive Director to chair the Committee. A further Non-Executive member of the Committee will be appointed as Vice-Chair by the Trust Board as required. In the absence of the Chair of the Committee, the Vice-Chair will chair the meeting. Members are expected to attend all meetings of the Committee.

4.5 The Trust Secretary, or their designated deputy, will act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, will attend all meetings of the Committee.

4.6 All members of the Committee will receive training and development support as required before joining the Committee and on a continuing basis to ensure their effectiveness as members, supported by the process of annual appraisal, as agreed by the Board of Directors.

4.7 An attendance record will be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

**Quorum**

4.8 The quorum necessary for the transaction of business will be three members.

4.9 A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

## 5. Duties

### 5.1 Appointment of the Chief Executive

The Committee will:

5.1.1 evaluate the existing skills, knowledge and experience of the Board of Directors and oversee the preparation of a description of the role and capabilities required for the appointment of a Chief Executive;

5.1.2 ensure a process is in place to identify suitable candidates to fill the Chief Executive vacancy as it arises and to make recommendations to the Chair and Committee members in respect of a Chief Executive appointment;

5.1.3 ensure that sufficient procedures are undertaken to verify that the Chief Executive meets the fit and proper persons tests in line with the statutory fitness requirements set out in the NHS Improvement provider licence for directors of NHS foundation trusts;

5.1.4 make a recommendation to the Non-Executive Directors who are not members of the Committee on the appointment of the Chief Executive;

5.1.5 make a recommendation to the Council of Governors, for approval by them, on the appointment of the Chief Executive;

5.1.6 upon appointment, confirm the individual's level and composition of remuneration is within the range agreed by the Committee for the Chief Executive; and

5.1.7 give full consideration to succession planning, taking into account the challenges and opportunities facing the organisation and the skills and expertise required upon the Board of Directors.

### 5.2 Appointment of Executive Directors

The Committee will:

5.2.1 when considering the appointment of an Executive Director, evaluate the existing skills, knowledge and experience of the Board of Directors and oversee the preparation of a description of the role and capabilities required for the appointment of an Executive Director;

5.2.2 be assured that a robust recruitment process is established to identify suitable candidates to fill Executive Director vacancies as they arise, making recommendations to the Chair, Chief Executive and Committee members in respect of Executive Director appointments;

5.2.3 ensure that sufficient procedures are undertaken to verify that the Executive Director meets the fit and proper persons tests of the general conditions of the NHS Improvement provider licence;

5.2.4 be assured that an appropriate Interview Panel is convened with responsibility for determining whether the Executive Director should be appointed;

5.2.5 prior to appointment, endorse the level and composition of remuneration for an Executive Director and confirm on appointment that the remuneration level is within the specified range; and

5.2.6 give full consideration to succession planning, taking into account the challenges and opportunities facing the organisation and the skills and expertise required upon the Board of Directors.

**5.3 Remuneration**

The Committee will:

5.3.1 taking account of ensuring value for money for the organisation, determine the range of remuneration and allowances for the appointment and retention of the Chief Executive and / or Executive Directors and VSM's. No Director or the Chief Executive shall be involved in any decisions relating to his or her own remuneration;

5.3.2 subject to receipt of a report on the annual performance of the Chief Executive (from the Chair of the Board of Directors), and taking account of such national pay determinants, comparative data, performance against objectives and other matters considered appropriate by the Committee, review the remuneration of the Chief Executive on an annual basis;

5.3.3 subject to receipt of a report on the annual performance of individual Executive Directors (from the Chief Executive), and taking account of such national pay determinants, comparative data, performance against objectives and other matters considered appropriate by the Committee, review the remuneration of individual Executive Directors/VSM's an annual basis;

5.3.4 taking account of value for money requirements for the organisation, ensure that remuneration is sufficient to recruit retain and motivate the Chief Executive / Executive Directors with the level of skills appropriate for the proper and robust management of the organisation;

5.3.5 approve any termination or severance payments that are proposed for the Chief Executive or other Executive Directors, for other Very Senior Managers (VSMs) and others as may be required by NHSI/E and the Department of Health and Social Care;

5.3.6 monitor levels of remuneration across the organisation, particularly in relation to those 'high earning' members of staff. Responsibility for the determination of the salaries of VSMs, other than Executive Directors, is delegated to the Chief Executive and advised by the Director of

Human Resources/Chief People Officer. The Committee Chair will review annually the earnings of the VSMs including senior clinicians (being the Deputy Medical Director and Associate Medical Directors) with corporate responsibilities; and

5.3.7 undertake its business in accordance with the approved Remuneration Policy, having regard to the rest of the workforce.

**5.4 Succession Planning**

The Committee will:

5.4.1 ensure that the Trust has a detailed succession plan in place, which is reviewed annually, for all Executive Team members, other Trust Directors and 'mission critical' posts.

**5.5 Performance Review**

The Committee will:

5.5.1 oversee the annual performance review process for the Chief Executive, Executive Team members, Associate Medical Directors and very senior managers across the Trust. In addition to ensure that the outcome of the process being to result in the generation of a single performance rating from measuring the achievement of objectives and alignment to the Trust behaviours framework;

5.5.2 ensure that the performance appraisals of the Chief Executive, Executive Team members, Associate Medical Directors and very senior managers are undertaken in accordance with the Trusts performance review policy; and

5.5.3 from time to time review the Chief Executive and Executive Directors objectives.

5.5.4 The Committee has authority to commit financial resources in respect of matters identified in these Terms of Reference. The Director of Finance must be informed of any decision requiring the use of resources and the Director of Human Resources/Chief People Officer informed to ensure the appropriate changes are made to the Chief Executive's / Executive Director's contract of employment and remuneration.

5.5.4 In carrying out this role the Committee may form sub committees for the performance of roles within any Trust processes as it thinks fit. Further, it may authorise the Chair or Vice Chair of the Committee to liaise with such Trust officers or others as circumstances dictate to ensure that Trust processes are adhered to including delegating functions under such processes so that any formal determinations can be made by the Committee in a reasonable way.

## 6. Reporting and Accountability

6.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Terms of Reference will be reviewed by the Committee and approved by the Board of Directors on a minimum basis of every two years.

6.3 The Committee will review its effectiveness and compliance with these Terms of Reference each year and report the outcomes of this review to the Board.

## 7. Committee Administration

7.1 The Committee shall meet as frequently as it may determine to meet its purpose, but not less than once per calendar year. A meeting shall be called by the Trust Secretary at the request of any member.

7.2 The Chair of the Committee may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The agenda will be set in advance by the Chair, with the Trust Secretary and Director of Human Resources/Chief People Officer.

7.4 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, will be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers will be made available no later than three working days before the date of the meeting.

7.5 Committee papers will include an outline of their purpose and key points in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

7.6 The Chair will establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure these are recorded in the minutes accordingly.

7.7 The Committee secretary will minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings will be made available promptly to all members of the Committee, normally within ten working days of the meeting.

**Procedural control statement:** 14 September2022
**Date approved:** Committee [11 October 2022] and Board [26 January 2023 **TBC**]
**Approved by:** Board of Directors **[TBC]**
**Review date:** July 2023 *[NB to be reviewed earlier in order to align with the annual cycle for the review of the other Board Committee Terms of Reference]*

PUBLIC BRP - Agenda item A10(ii)

| **Remuneration** | May-22 | Oct-22 | Dec-22 | Mar-23 |
|---|---|---|---|---|
| Minutes | X | X | X | X |
| Action Log | X | X | X | X |
| Review of VSM Remuneration Policy | X | | | X |
| Review of VSM and Senior Clinican Pay | | X | | |
| National Clinical Impact Awards programme (formerly the LCEA progarmme) | | X | | X |
| Annual Report of the Committee/Review of Committee effectiveness | X | | | |
| Appointments | X [as required] | X [as required] | X [as required] | X [as required] |
| Sucession planning | X | | | X |
| VSM performance review | X | | | |
| CEO appraisal | X | | | |
| Terms of reference review | | X | | |
| Pensions Update/Policy Review | | X | | X |

*NB - Fit and proper persons review undertaken as part of the Standards of Business Conduct report presented to the Audit Committee annually in July.*

THIS PAGE IS INTENTIONALLY BLANK

The Newcastle upon Tyne Hospitals NHS Foundation Trust

# TRUST BOARD

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Date of meeting | 26 January 2023 | | | | | | |
| Title | Integrated Board Report | | | | | | |
| Report of | Martin Wilson – Chief Operating Officer, Angela O'Brien- Director of Quality and Effectiveness. | | | | | | |
| Prepared by | Louise Hall- Deputy Director of Quality and Safety, Peta Le Roux- Business Analysis. | | | | | | |
| Status of Report | Public | | Private | | Internal | | |
| | ☒ | | ☐ | | ☐ | | |
| Purpose of Report | For Decision | | For Assurance | | For Information | | |
| | ☒ | | ☒ | | ☐ | | |
| Summary | This paper is to provide assurance to the Board on the Trust's performance against key Indicators relating to Quality, People and Finance. | | | | | | |
| Recommendation | For assurance. | | | | | | |
| Links to Strategic Objectives | Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality.<br>Supported by flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential.<br>Performance – Being outstanding now and in the future. | | | | | | |
| Impact (please mark as appropriate) | Quality | Legal | Finance | Human Resources | Equality & Diversity | Reputation | Sustainability |
| | ☒ | ☐ | ☒ | ☒ | ☐ | ☐ | ☐ |
| Impact detail | Details compliance against national access standards which are written into the NHS standard contract.<br>Details compliance against key quality targets. | | | | | | |
| Reports previously considered by | Regular report. | | | | | | |

# INTEGRATED BOARD REPORT

## EXECUTIVE SUMMARY

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

1. The Trust has had **no cases of MRSA bacteraemia in December 2022.** The numbers of Trust onset C.difficile infections, and Pseudomonas Aeruginosa bacteraemias are higher than the Trust trajectory.
2. In December there has been a **decrease in the incidence of inpatient acquired pressure ulcers (n=89). The number of falls across the Trust (n=294) increased by one following a significant increase seen in November.**
3. There were **22 Serious Incidents (SIs) reported in December 2022** demonstrating a decrease towards the mean. **No Never Events were reported in December 2022**.
4. The Trust has received a total of **409 (393 with identified patient activity) formal complaints up to December 2022**, an increase of 48 on last month's opened complaints.
5. There were **1,623 responses to the Friends and Family test from the Trust in October 2022** (published December 2022) compared to 1,560 in the previous month.
6. There was **an increase in deaths reported in December 2022 (n=251).** This is subject to further analysis.
7. In the period to 31st December the Trust incurred expenditure of £1,042.3 million and accrued income of £1,046.8 million on mainstream budgets. An expenditure was incurred of £5.5 million on the programmes outside the block envelope (vaccine roll-out programme), leading to a surplus of £4.2 million.

The Board of Directors is asked to receive the report.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

# Integrated Board Report

## Quality, People and Finance

**January 2023**

Healthcare at its best
with people at our heart

# Executive Summary

## Purpose

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

## Current Operating Environment

The reported December pressure has continued into early January. System wide pressures, delayed discharges and patients requiring repatriation to their local hospital continue to put additional pressure on bed availability and patient flow remains compromised, with the added complication of needing to isolate and/or cohort patients with COVID, patients with Flu (which peaked in December), and more recently there has been an increased incidence of Norovirus leading to a temporary loss of beds. Industrial Action continues to take place in our region also impacting on general system pressure.

Throughout the month there has been increased frequency in needing to escalate due to operational pressure, including our own escalation to OPEL 4, the highest level, and the inpatient elective programme has consequently been reduced to only priority and cancer cases. Daycase activity continues which enables us to continue to schedule many of our long waiting patients.

## Report Highlights

1. The Trust has had **no cases of MRSA bacteraemia in December 2022.** The numbers of Trust onset C.difficile infections, and Pseudomonas Aeruginosa bacteraemias are higher than the Trust trajectory.

2. In December there has been a **decrease in the incidence of inpatient acquired pressure ulcers (n=89). The number of falls across the Trust (n=294) increased by one following a significant increase seen in November.**

3. There were **22 Serious Incidents (SIs) reported in December 2022** demonstrating a decrease towards the mean. **No Never Events were reported in December 2022**.

4. The Trust has received a total of **409 (393 with identified patient activity) formal complaints up to December 2022**, an increase of 48 on last month's opened complaints.

5. There were **1,623 responses to the Friends and Family test from the Trust in October 2022** (published December 2022) compared to 1,560 in the previous month.

6. There was **an increase in deaths reported in December 2022 (n=251).** This is subject to further analysis.

7. In the period to 31st December the Trust incurred expenditure of £1,042.3 million and accrued income of £1,046.8 million on mainstream budgets. An expenditure was incurred of £5.5 million on the programmes outside the block envelope (vaccine roll-out programme), leading to a surplus of £4.2 million.

# Contents: January 2023

## Quality


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

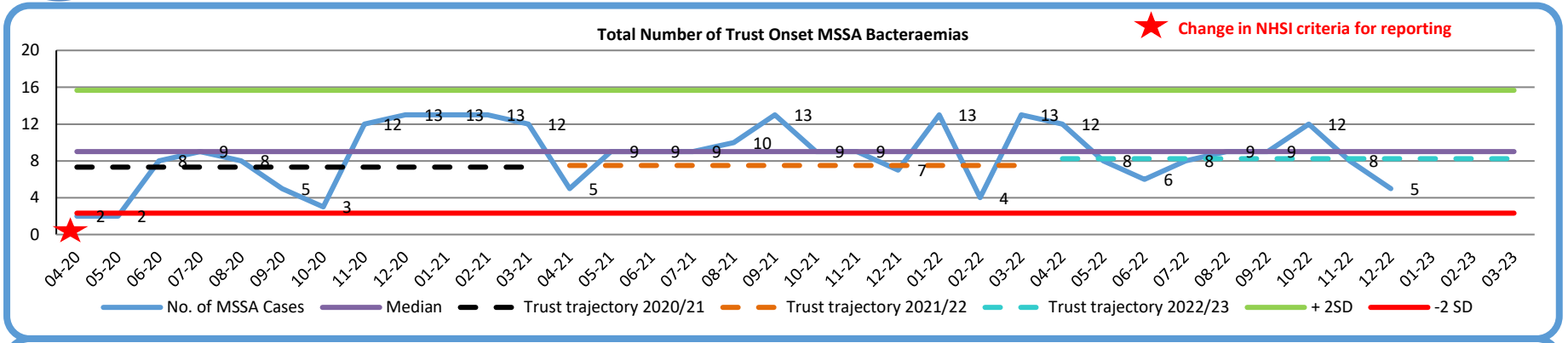

## People

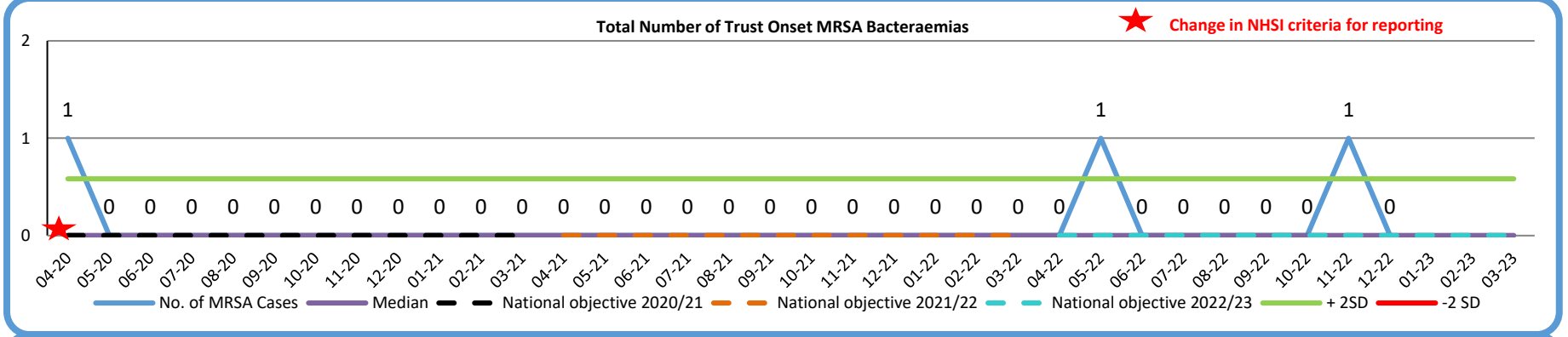

- COVID-19
- Well Workforce
- Equality and Diversity
- Sustainable Workforce Planning
- Excellence in Training and Education

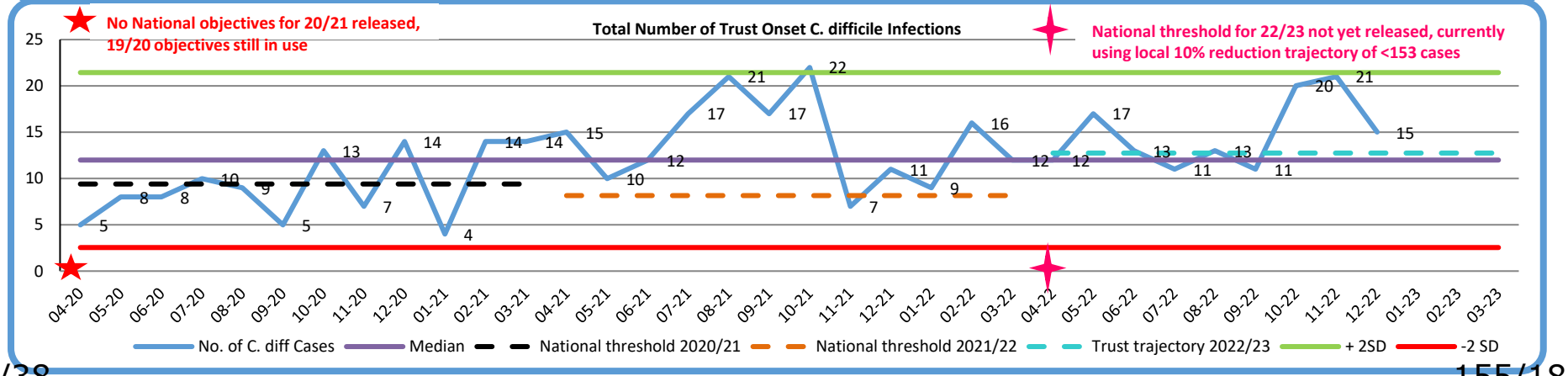

## Finance


- Overall Financial Position

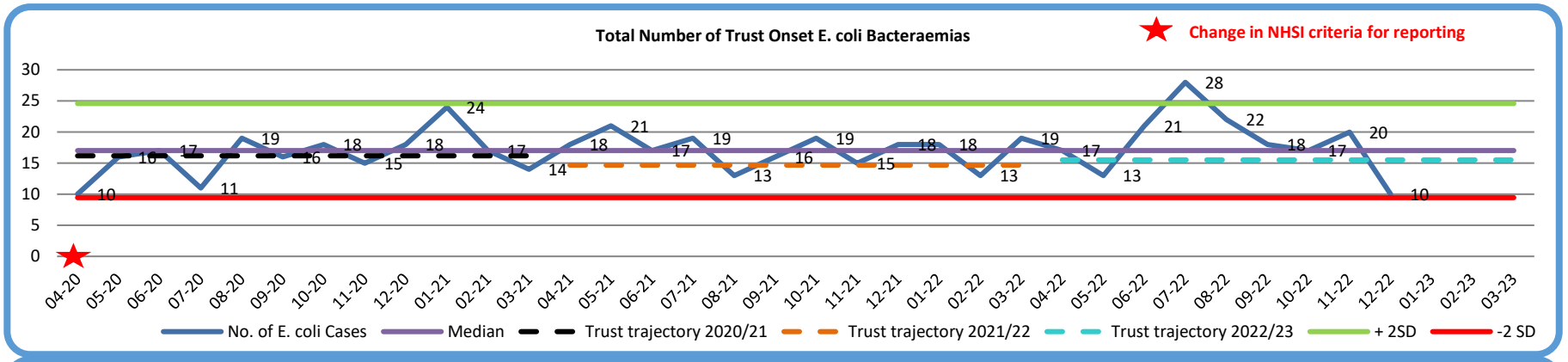
# Quality: Healthcare Associated Infections 1/2

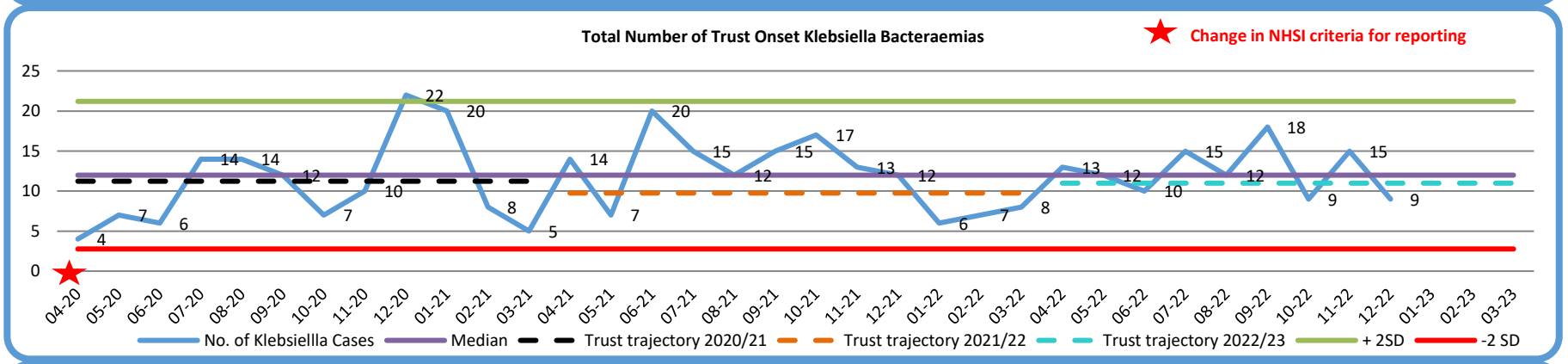


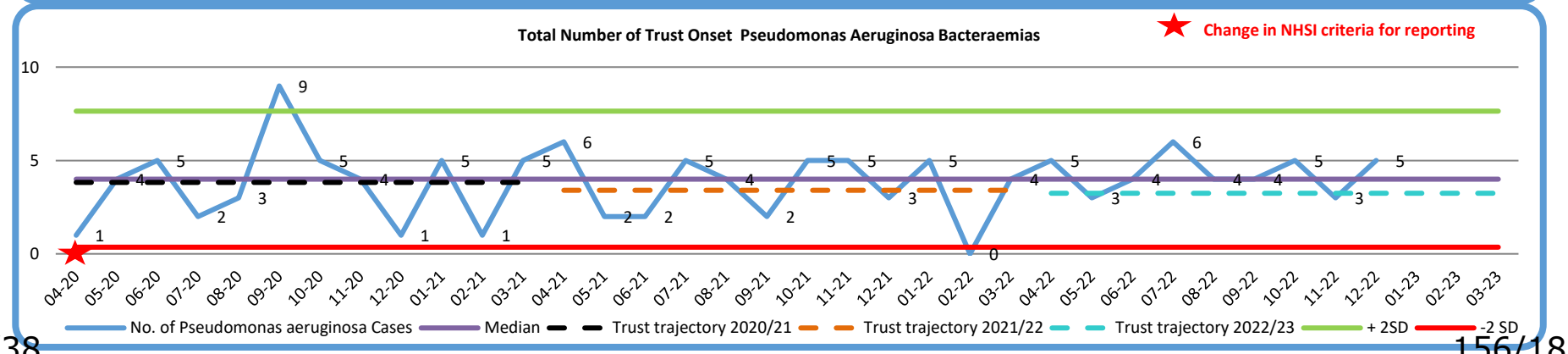



# Quality: Healthcare Associated Infections 2/2



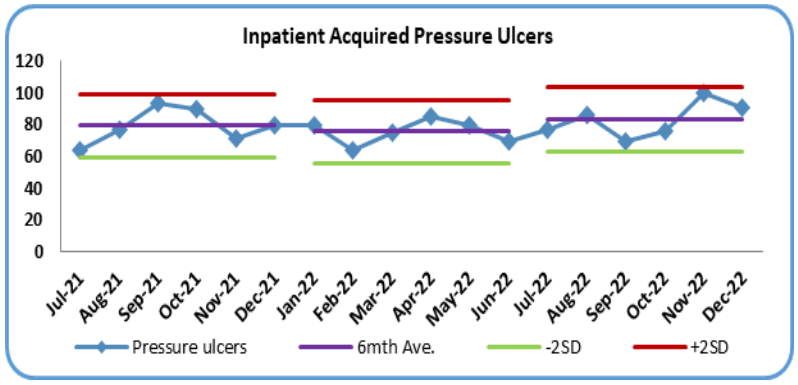
# Quality: Harm Free Care – Pressure Damage

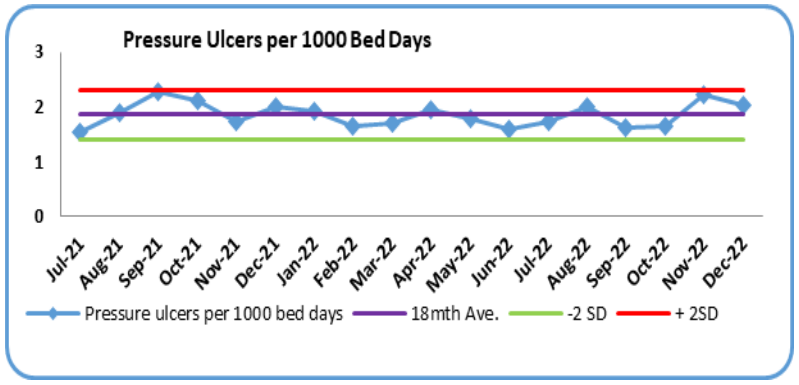
The incidence of inpatient acquired pressure ulcers has decreased in December from 100 in November to 89 in the month.

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. There has been and continues to be a high number of medical borders across the Trust.

The tissue viability team are doing some focussed work with wards and departments with the highest incidence of pressure damage, focussing on education .

A pilot has been started to introduce a new risk assessment tool called PURPOSE T, this would replace Braden and help staff identify and plan care for those patients at risk of pressure damage.



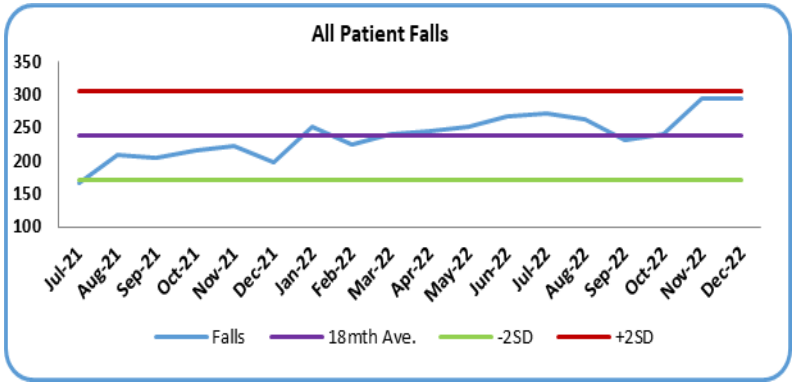



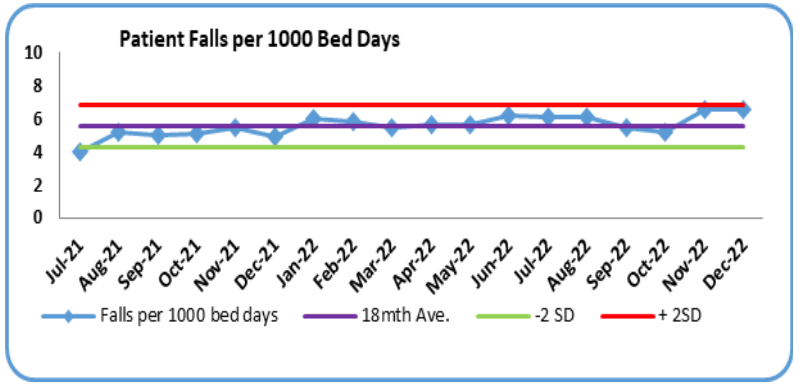
# Quality: Harm Free Care - Falls

There was a significant increase in falls across the Trust in November showing 293 falls in the month the highest number this year despite on going prevention work with wards and departments this has continued into December with 294 falls.

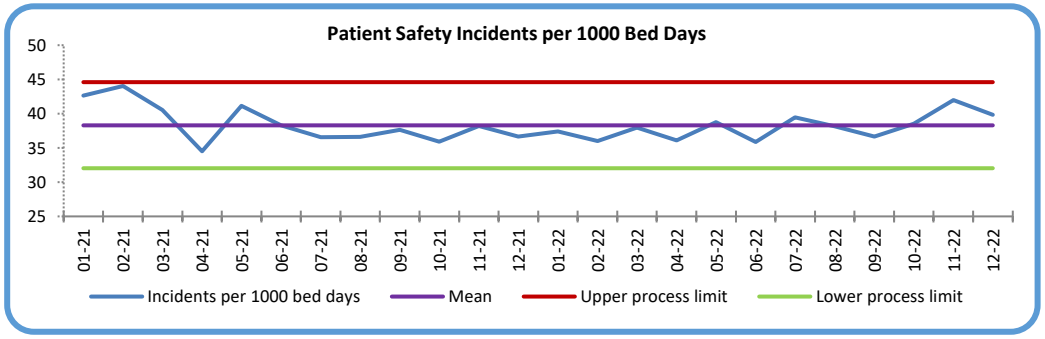
In 2022 the Trust has experienced significant pressures, particularly in relation to bed occupancy levels, which have remained high throughout. Significant increases in the cohort of medical patients, particularly those over 65 are evident and did lead to the requirement to convert many surgical wards 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 continued with 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.

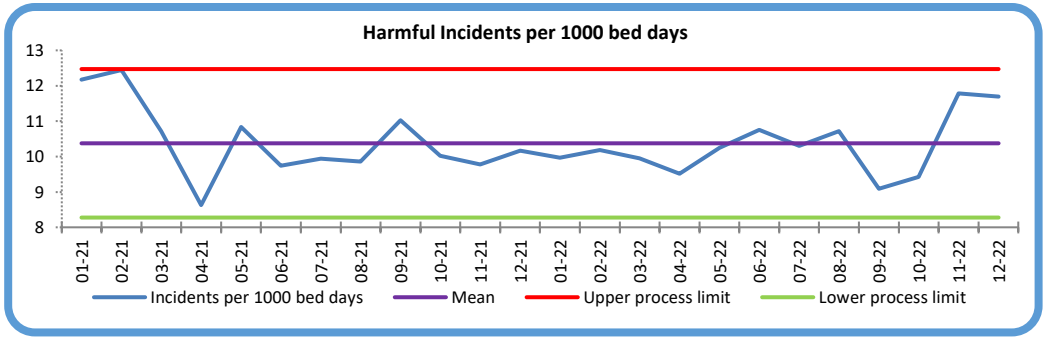


# Quality: Incident Reporting

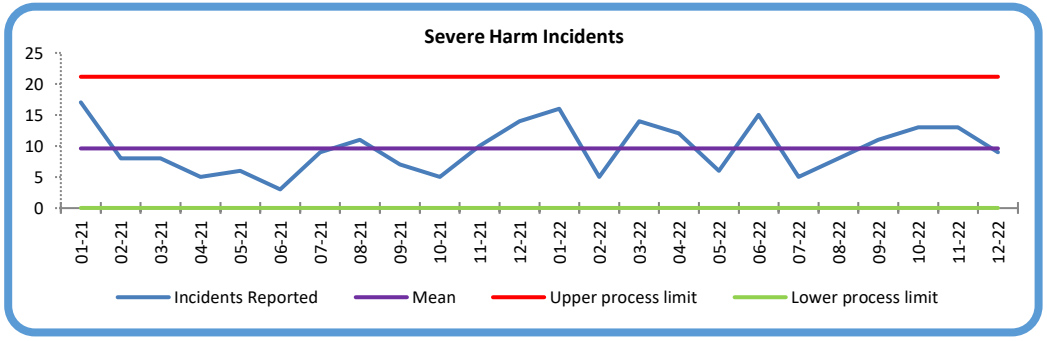



**All patient incidents:** The number of patient safety incidents per 1,000 bed days decreased slightly toward the mean for December 2022. This remains well within the expected common cause variation.



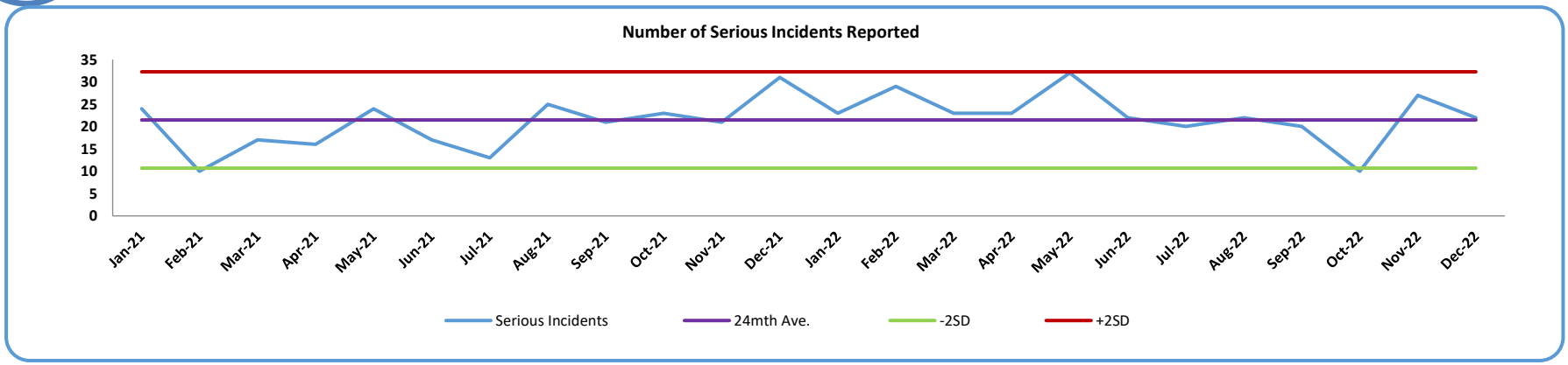

**Harmful incidents:** The number of *harmful patient safety incidents per 1,000 bed days decreased slightly for December 2022. This remains within the expected common cause variation. Severity grading of reported incidents may be modified following investigation and is therefore subject to change in future reports.

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

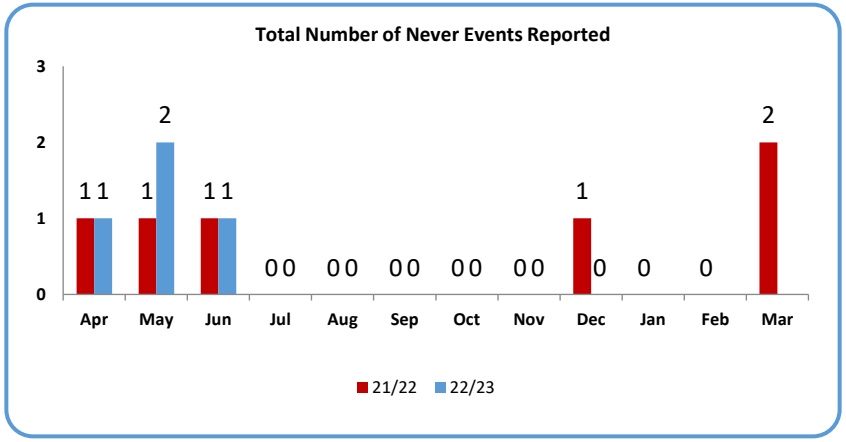


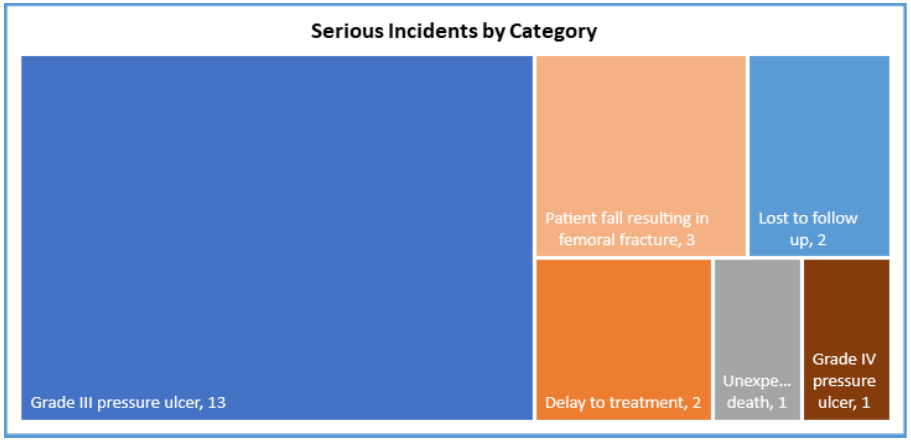

**Severe harm incidents:** There were 9 patient safety incidents reported which resulted in severe harm in December 2022. This demonstrates a decrease below the mean and remains within the common cause variation. Severity grading of reported incidents may be modified following investigation and is therefore subject to change in future reports.

# Quality: Serious Incidents & Never Events




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



# Quality: Serious Incident Lessons Learned

**Learning identified from Serious Incident (SI) & Never Event (NE) investigations completed between 01.09.2022 – 31.12.2022**

The following section outlines key learning from the 27 SI investigations completed between 1st September 2022 to 31st December 2022. This data excludes information on falls, pressure ulcers, deaths as a result of definite or probable hospital acquired Covid-19 and any SI cases subsequently de-registered during this period.

**Maternity reportable cases - 5 cases**

- Strengthened safety netting processes to ensure clear and robust follow-up plans in place after each clinic appointment
- Strengthened simulation training on difficult airway scenarios provided and guidance strengthened to reflect national guidance
- Consistent use of medical history alerts re-enforced, whilst improved digital functionality awaited as part of e-patient record implementation
- Real time assessments strengthened in line with national practice frameworks and learning integrated within clinical skills training
- Decision tool for mode of delivery improved to provide clearer information for women, to better inform decision making
- Pathways of care and wellbeing assessments strengthened for surveillance in multiple pregnancies
- Wider MDT discussion in place to improve communication and ensure that planned tasks and defined roles are clear
- Re-enforced timely resuscitation team escalation requirement to ensure appropriate senior response
- Fetal monitoring guidelines and training strengthened in line with national guidance, to re-enforce escalation and management pathways
- Provision of debriefing sessions to offer staff additional support and refection following learning events

**Unexpected death - 3 cases**

- Targeted education sessions to upskill staff for managing patients with complex mental health conditions
- Standardised local procedure developed and agreed to guide staff for when patients are disclosing potential self-harm
- Rare but recognised complication re-enforced to doctors in training and learning shared at local governance forums
- Appointment of new Clinical Educators, creation of device Super Users and creation of workbook to strengthen training provision & audit
- Liaison with device manufacturer to review functionality to explore enhanced and improved usability

**Medication incidents – 2 cases**

- Collaborative work with GPs and junior doctors, to review discharge process and documentation to inform pathway improvements
- Pharmacy Hub reconciliation processes strengthened to improve medicine safety netting for patients discharged in the community
- Digital e-Record solutions explored, to better alert staff to anomalies or extreme changes in height and weight measurements

**Missed abnormal results – 2 cases**

- Use of digital functionality for critical notifications re-enforced to ensure requesting clinicians are consistently alerted to abnormal radiological results
- Solutions to strengthen specialty processes identified to enable timely Consultant review and actioning of all results
- Senior Quality and Patient Safety leadership oversight of proposed digital solutions to ensure sustainable improvements are identified

# Quality: Serious Incident Lessons Learned

**Delayed diagnosis – 2 cases**

- Urgent referral pathway re-enforced through strengthened staff training and learning shared to ensure timely escalation & comprehensive documentation of decision making
- Bespoke mental health training programmes delivered to support and upskill staff caring for patients with complex mental health conditions
- Urinary catheter management guidance strengthened in collaboration with frontline staff, to provide clarity of expected practice
- Programme of local training and monthly audit in place for ongoing assurance of best practice in NEWS2 risk scoring.
- Digital solutions explored to identify opportunities for e-Record & NEWS2 e-system integration to better alert staff to urine output concerns

**Incorrect treatment**

- Specialist training and technical support made available for all staff to ensure wider familiarity with the design of newly installed systems
- Liaison with manufacturer to ensure improvements to engineer hand overs, to provide assurance of robust assessments

**Lost to follow-up**

- MDT 'outcome' processes strengthened to ensure that follow up appointment and onward referral (if required) are checked for robust onward planning, with audit of process to provide ongoing assurance

**Complication of treatment**

- There was no local learning identified in this case and the patient received an outstanding standard of care

**Complication of treatment**

- Training and standardised equipment set-up and safety checks strengthened in line with national guidance and audited for assurance of compliance
- Learning regarding equipment design improvements shared with manufacturer and MHRA to contribute to national learning

**Complications of high risk surgery – 8 cases**

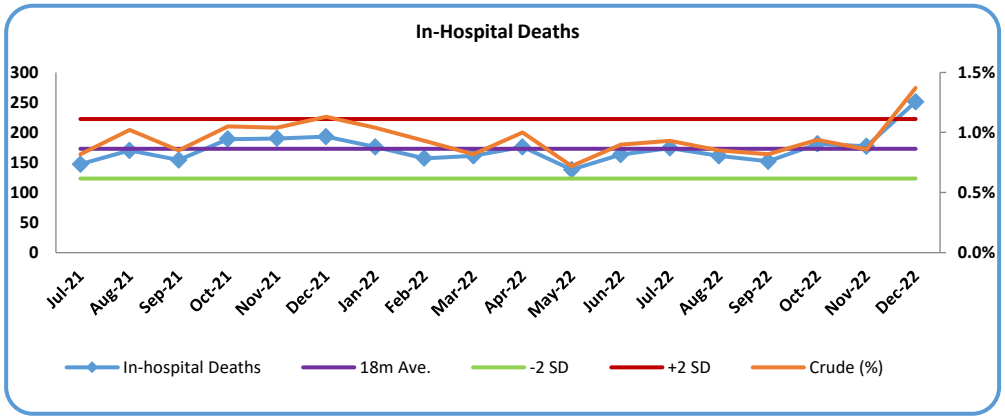
- Strengthen communication processes between specialist teams to support clinical decision making and ensure accurate documentation
- Develop more robust governance processes including MDT and M&M review, to promote effective communication and strengthen assurance processes

**Healthcare Acquired Infection**

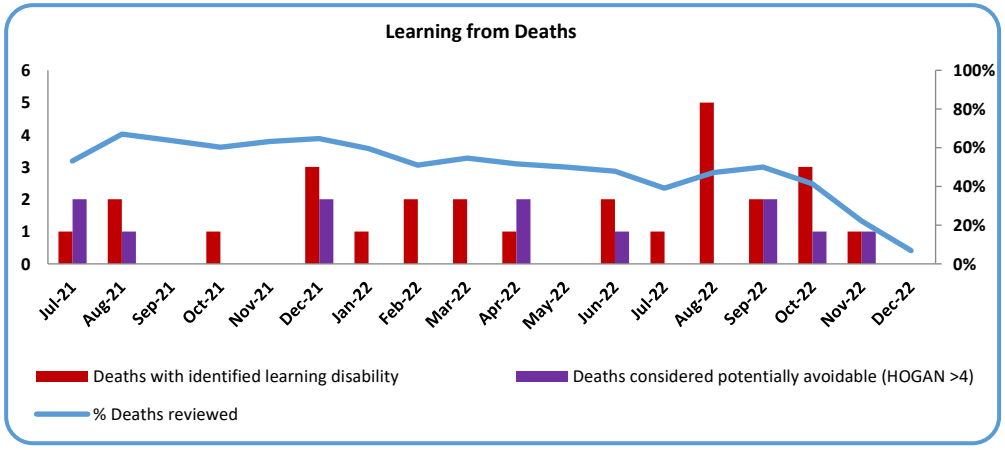
- Ongoing improvement work in relation to cannula care, with robust staff education and nominated Harm Free Care Lead support in place, to ensure consistent best practice

# Quality: Mortality Indicators 1/2

**In-hospital Deaths:** In total there were 251 deaths reported in December 2022, which is considerably higher than the amount reported 12 months previously (n=193). The high increase in deaths in December 2022 has been noted and will be subject to further analysis. Due to the increase in deaths, the crude death rate is 1.37%.

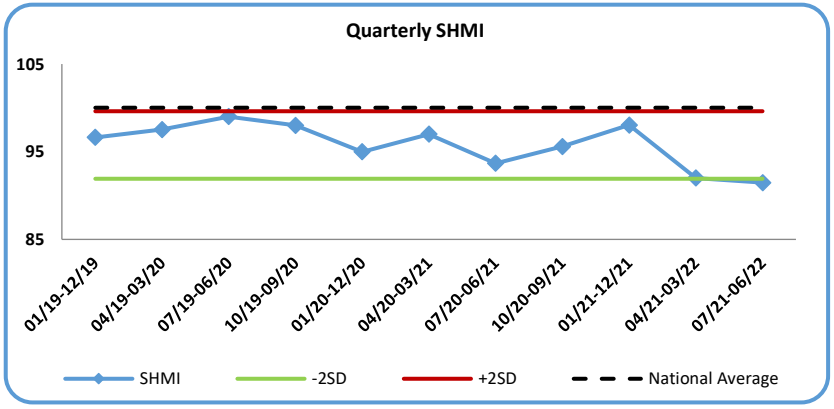


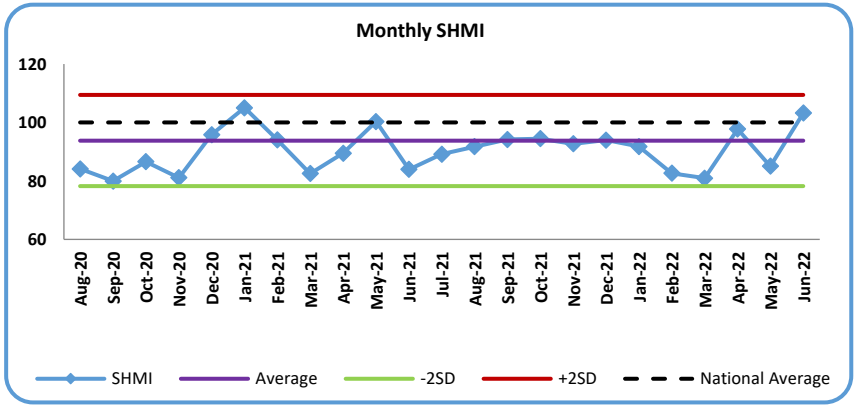

**Learning from Deaths:** Out of the 251 deaths reported in December 2022, seventeen patients have, to date, received a level 2 mortality review. However, these figures will continue to rise due to ongoing M&M meetings held over the forthcoming months. All figures will continue to be monitored and modified accordingly.



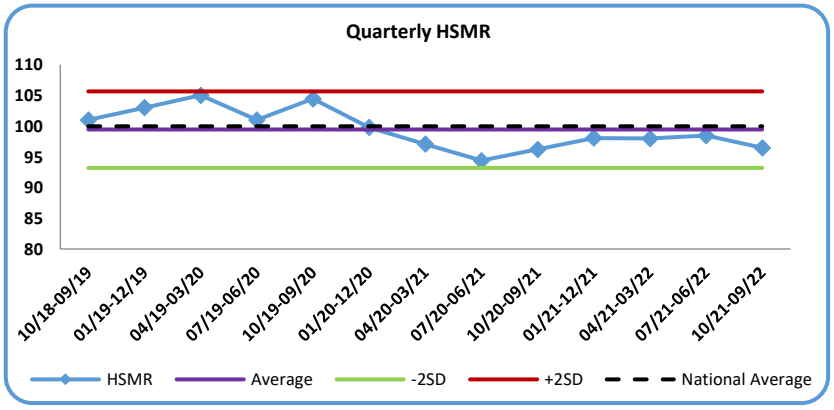
# Quality: Mortality Indicators 2/2

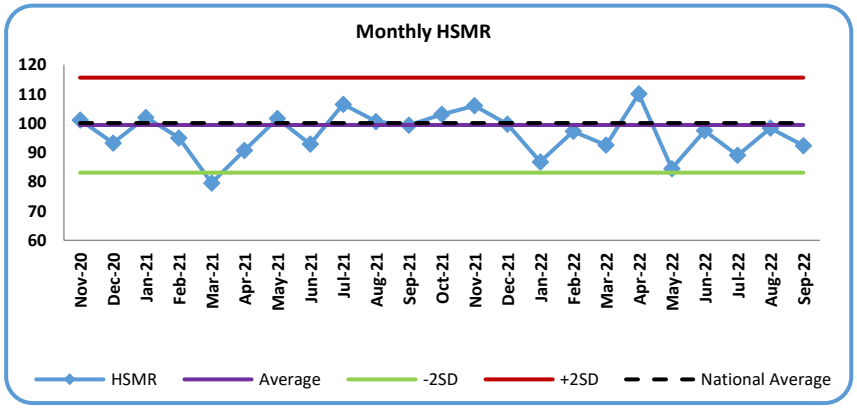
**SHMI:** The most recent published SHMI quarterly data from NHS Digital shows the Trust has scored 91 from months July 2021 – June 2022. This is below the national average and is within the "as expected" category. Monthly SHMI shows the Trust to be above the national average for June 22, however, is still within the “as expected” category. COVID-19 data continues to be excluded from SHMI data published from NHS Digital.



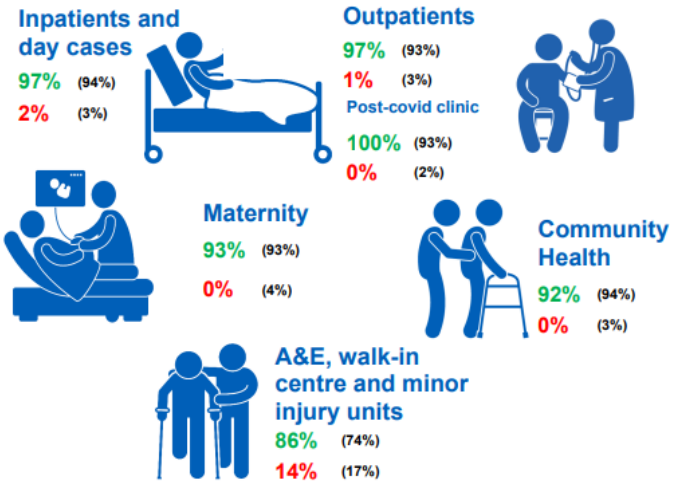




**HSMR:** The HSMR data shows a 12 month rolling HSMR score by quarter as well as monthly data. HSMR data is available up to September 2022, and is showing below the national average, however this number may rise or fall as the percentage of discharge coding increases. All figures will continue to be monitored and modified accordingly. Unlike SHMI data, HSMR data does not include deaths within 30 days of discharge.



# Quality: FFT and Complaints




**Friends and Family Test**

The published data to date shows that there were 1,623 responses to the Friends and Family test from the Trust in October 2022 (published December 2022) compared to 1,560 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 409 (393 with identified patient activity) formal complaints up to December 22, an increase of 48 on last month's opened complaints.

The Trust has received an average of 45 new formal complaints per month, which is one less than the 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 0.05% (5 per 10,000 contacts). The lowest complaint percentages are with Dental, community, NCCC and EPOD who have 0.01%.

| | 2022-23 | | | | |
|---|---|---|---|---|---|
| ates | Complaints | Activity | Patient % Complaints | Ratio (YTD) | 21-22 Ratio (Full Year) |
| Cardiothoracic | 16 | 74,492.00 | 0.021% | 1:4656 | 1:3128 |
| Children's Services | 24 | 54,334.00 | 0.044% | 1:2264 | 1:3275 |
| Community Services | 7 | 54,854.00 | 0.013% | 1:7836 | 1:4546 |
| Dental Services | 5 | 73,267.00 | 0.007% | 1:14653 | 1:10120 |
| Medicine | 37 | 107,626.00 | 0.034% | 1:2909 | 1:3053 |
| Medicine (ED) | 24 | 134,434.00 | 0.018% | 1:5601 | 1:4866 |
| ENT, Plastics, Ophthalmology & Dermatolog | 29 | 267,662.00 | 0.011% | 1:9230 | 1:7356 |
| Musculoskeletal Services | 22 | 74,978.00 | 0.029% | 1:3408 | 1:3505 |
| Cancer Services & Clinical Haematology | 21 | 154,322.00 | 0.014% | 1:7349 | 1:6347 |
| Neurosciences | 28 | 75,839.00 | 0.037% | 1:2709 | 1:3067 |
| Patient Services | 95 | 31,051.00 | 0.306% | 1:327 | 1:1934 |
| Peri-operative & Critical Care | 10 | 26,661.00 | 0.038% | 1:2666 | 1:3499 |
| Surgical Services | 26 | 54,766.00 | 0.047% | 1:2106 | 1:1698 |
| s | 14 | 46,932.00 | 0.030% | 1:3352 | 1:3090 |
| Women's Services | 35 | 106,039.00 | 0.033% | 1:3030 | 1:3341 |
| **Trust (with activity)** | **393** | **1,337,257.00** | **0.029%** | **1:3403** | **1:3994** |

"Communication" is the highest primary subject area of complaints at 24% of all the subjects Trust wide.

# Quality: Health and Safety

**Overview**

There are currently 1,102 health and safety incidents recorded on the Datix system from the 1st January 2022 to 31st December 2022. This represents an overall rate of 71 per 1,000 staff. The Directorate with the highest number of incidents is Peri-Op reporting 156 health and safety incidents over this period. The highest reporting Directorates per capita are Peri-Operative & Critical Care (108) Internal Medicine (86), ENT (61) at incident rates per 1,000 staff.

**Incidents of Violence & Aggression to Staff**

In addition to the incidents above, there are 980 incidents of physical and verbal aggression against staff by patients, visitors or relatives recorded on the Datix system from 1st January 2022 to 31st December 2022. This represents an overall rate of 63 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:

- The Trust Violence Reduction Strategy has been developed and will be ratified at February's Health and Safety Committee
- Further improvements to the overall compliance of the National Violence Reduction Standards
- Violence data dashboards have been further developed to provide improved analysis
- Agreement in principle, with Police and Crime Commissioner, to introduce ED Navigators

**Sharps Incidents**

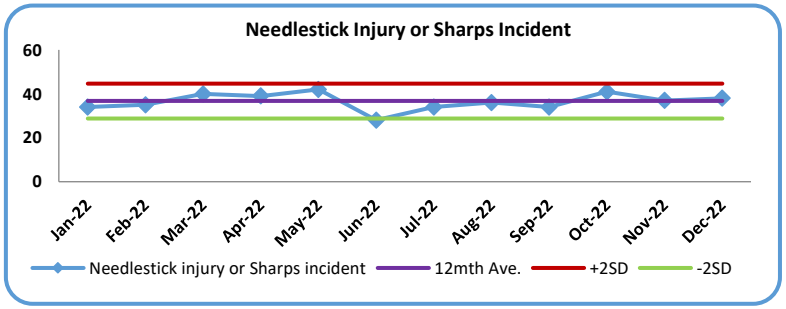
There have been 438 incidents during 1st January 2022 to 31st December 2022 (average 37 incident per month, 79% of these involve used needles). The recent sustained increase aligns with a number of factors, which are currently being discussed at the Trust Safer Sharps User Group. These include increased 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.

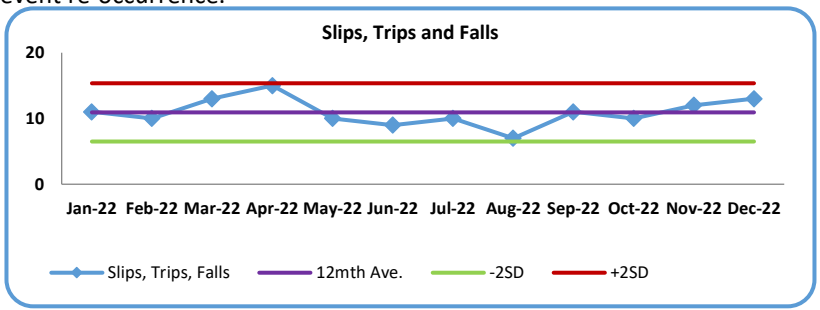
**Slips, Trips and Falls**

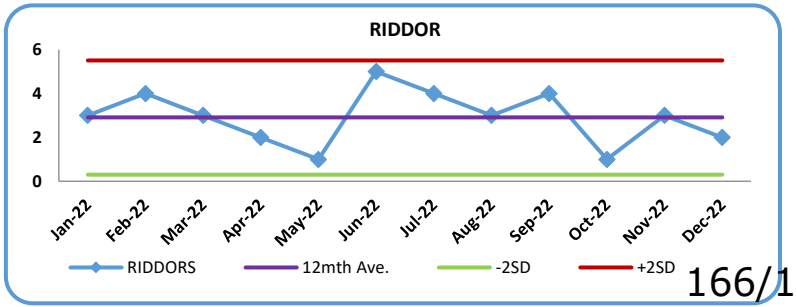
129 incidents were reported between 1st January 2022 to 31st December 2022. 64% of these incidents were related to trips and slips on wet floors. Regular zonal inspections take place every month and data analysis is acted upon, feeding into the Slips, Trips and Falls Group, which meets quarterly. For example, issues were raised following incidents within Catering at Freeman and following this further work has been identified around housekeeping and control of contractors.

**RIDDOR**

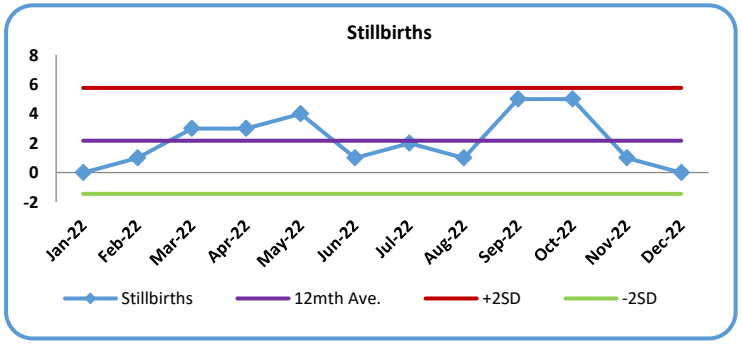
There have been 35 RIDDOR incidents reported between 1st January 2022 to 31st December 2022. The most common reasons of reporting accidents and incidents to the HSE are Moving and Handling (11), Slips, Trips and falls (11), Accidents involving staff, visitors etc. (7) and Aggression & Violence (4). All RIDDOR reportable incidents are investigated fully and, where necessary, remedial actions are undertaken to prevent re-occurrence.

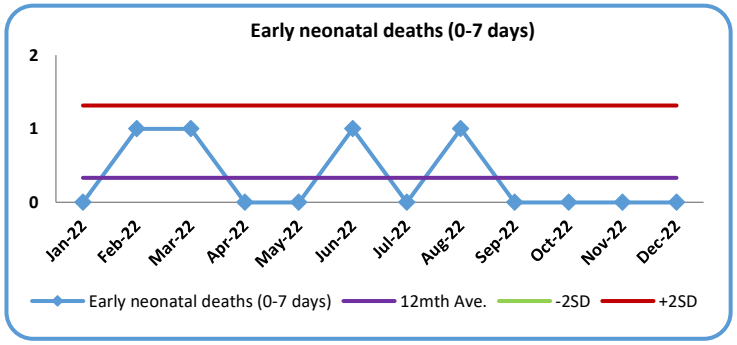


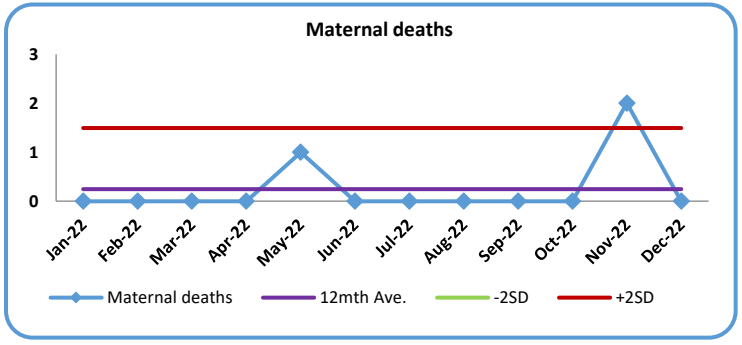



# Quality: Maternity (1/3)



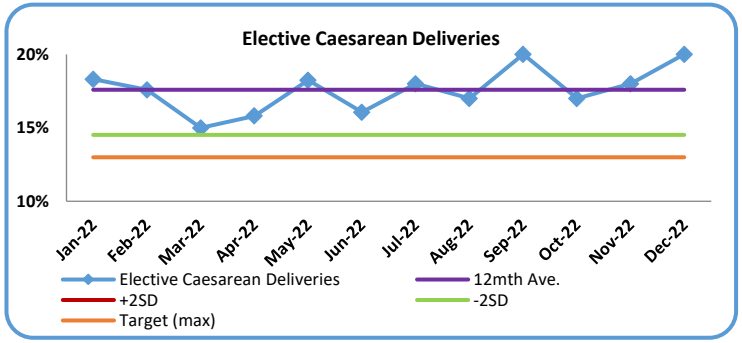

**Perinatal deaths**
All Perinatal deaths (Stillbirths and Neonatal Deaths) are reported to MBRRACE-UK who produce an annual National report which includes our local data.

**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 December there were no stillbirths to report. 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 December.

**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. Sadly there were two indirect maternal deaths in November which have been reported to MBRRACE-UK and HSIB. Both cases were pregnancies of less than 20 weeks gestation. There have been no cases of maternal death in December.

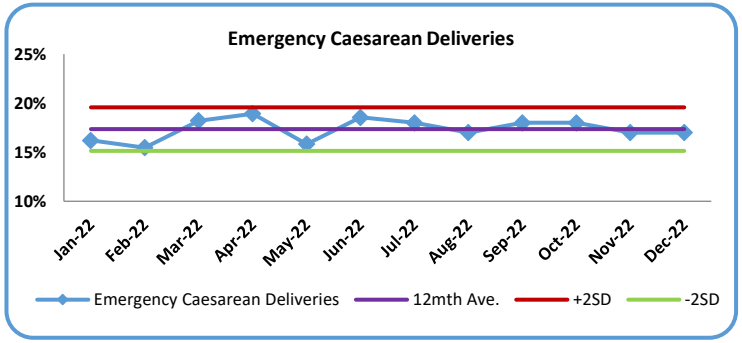
# Quality: Maternity (2/3)




**Elective Caesarean section**

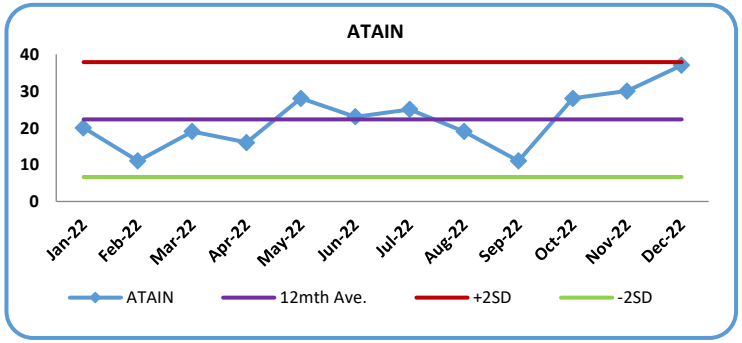
Maternity at the Trust is an outlier for elective Caesarean section compared to other UK Trusts. However, the rates are comparable to that of other tertiary centres in the UK.

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. For the past 3 months there has been an increase in the number of term admissions. There were 37 in December, 30 in November and 28 in October. The average prior to this was 22 per month. This increase will be reviewed and a report available for the next Obstetric Group meeting in February 2023.

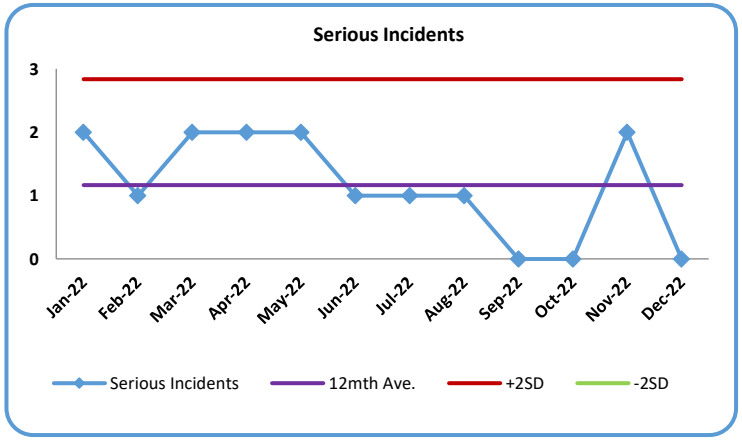
# Quality: Maternity (3/3)

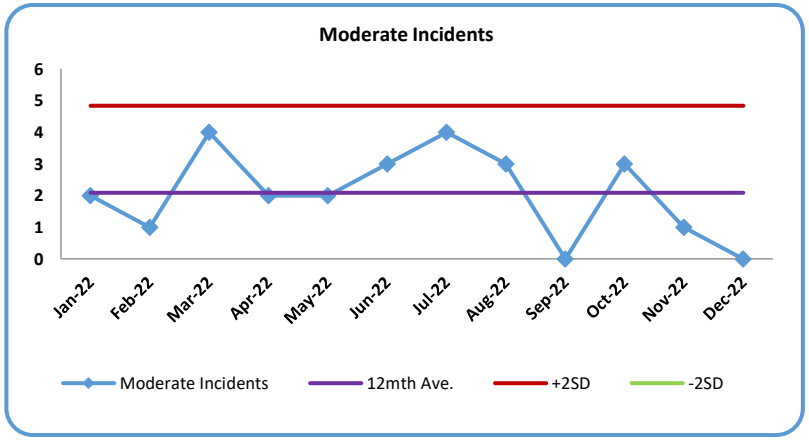
**Serious Incidents**

There have been 14 incidents escalated as Serious Incidents in the Trust in the past 12 months. These include six cases of potential Hypoxic Ischaemic Encephalopathy (HIE), two neonatal deaths, one bowel injury, two intrapartum stillbirths and three maternal deaths. The HIE, Intrapartum Stillbirths, Neonatal deaths and Maternal death were all reported to HSIB (Healthcare Safety Investigation Branch) for external review.

**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: Clinical Audit 1/7

| Audit / NCEPOD | Date of Report | Areas of Good Practice | Areas for improvement | Action Plan Developed |
|---|---|---|---|---|
| Paediatric Intensive Care Audit Network (PICANet) | 11 February 2021 & 13 February 2022 | • 100% GNCH admission records completed within three months of discharge (National Average 89.2%, 2020)<br>• Level 2 resource benchmarking and capacity inventory led by Operational Delivery Network & GIRFT resulted in money being identified to increase level 2 capacity<br>• Risk adjusted mortality within expected range despite staffing shortages & one of the most complex patient bases in the UK<br>• Paediatric ODN and Adult Critical Care Network agreed on mutual aid process, meaning the region remained a fully functioning unit despite pandemic. | • Don't have required nursing and administrative staff therefore often breach time limits for data submission to PICANet<br>• Do not meet 30-minute retrieval target 70% of the time due to staffing challenges | Discussed at December 2022 Clinical Audit and Guidelines Group |
| National Emergency Laparotomy Audit (NELA) | 12 November 2020 | • Rapid access to CT examinations (ED & Radiology)<br>Better than the national average in regard to:<br>• Mortality rate<br>• Case ascertainment<br>• Arrival in theatre timescale<br>• Preoperative input (Surgery & Anaesthetics) | • No out of hours consultant led service (only supervisory)<br>• Embed NELA pathway in all services throughout the Trust.<br>• Requirement for increased elderly care input (including MDT discussion) and access to ED Physician | Discussed at December 2022 Clinical Audit and Guidelines Group |
| National Audit of Pulmonary Hypertension | 20 January 2022 | • 98% of patients had a timely diagnosis<br>• 88% of patients seen or discharged within 30 days<br>• 100% of patients receiving a PH drug had a PH diagnosis recorded<br>• 100% of first line drug therapy for Pulmonary Arterial Hypertension was a PDE5 inhibitor<br>• 97% of patients had quality of life recorded<br>• 98% of patients receiving a PH drug had an annual consultation | • Nil identified | Discussed at December 2022 Clinical Audit and Guidelines Group |
| National Ophthalmology Database | 20 May 2022 | • Case ascertainment 100%<br>• Complication rate 0.82% (National Average 1.1%) | • Nil identified | Discussed at December 2022 Clinical Audit and Guidelines Group |

# Quality: Clinical Audit 2/7

| Audit / NCEPOD | Date of Report | Areas of Good Practice | Areas for improvement | Action Plan Developed |
|---|---|---|---|---|
| **Perioperative Quality Improvement Programme (PQIP)** | 1 September 2022 | • No recommendations or Trust level data published, national data only. Nil identified for the Trust to assess. | | Discussed at December 2022 Clinical Audit and Guidelines Group |
| **British Spine Registry** | 1 November 2022 | • No recommendations or Trust level data published, national data only. Nil identified for the Trust to assess. | | Discussed at December 2022 Clinical Audit and Guidelines Group |
| **National Hip Fracture Database** | 8 September 2022 | KPI Performance:<br>• Admission to specialist ward: 18% vs 7% (National Average)<br>• Prompt orthogeriatric review: 97% vs 86% (National Average)<br>• Prompt surgery: 78% vs 59% (National Average)<br>• NICE compliant surgery: 79% vs 69% (National Average)<br>Top quartile in the following:<br>• Admitted to orthopaedic ward within four hours<br>• Perioperative medical assessment<br>• Surgery on day of, or day after admission<br>• Surgery supervised by consultant surgeon and anaesthetist<br>• Spinal anaesthetic and nerve block (of all spinal anaesthetics)<br>• Acute length of stay (days)<br>• Documented final discharge destination | • Mental test score recorded on admission<br>• Number of patients mobilised out of bed by the day after surgery<br>• Nutritional risk assessment<br>• Subtrochanteric fractures treated with an Intra Medullary nail<br>• Overall hospital length of stay<br>• Documented not to have developed a pressure ulcer | Discussed at December 2022 Clinical Audit and Guidelines Group |
| **National Maternity and Perinatal Audit** | 16 June 2022 | • A lower percentage of small for gestational age babies born after 40 weeks | • Higher than average for induction of labour<br>• Higher than average maternal postnatal readmission after birth<br>• Slightly lower than average episiotomy rate<br>• Lower than average for birth intervention without augmentation | Discussed at December 2022 Clinical Audit and Guidelines Group |

# Quality: Clinical Audit 3/7

| Audit / NCEPOD | Date of Report | Areas of Good Practice | Areas for improvement | Action Plan Developed |
|---|---|---|---|---|
| **National Adult Asthma Secondary Care Audit** | 16 June 2022 | • 100% of patients reviewed within 24 hours of arrival in hospital<br>• 88% of patients received steroids at discharge<br>• 38% of patients administered systemic steroids within one hour of arrival at hospital (26% nationally) | • Nil identified | Discussed at December 2022 Clinical Audit and Guidelines Group |
| **National Diabetic Inpatient Harms (NaDIA)** | 12 November 2020 & 8 July 2021 | • Early adopter of e-Record, highlighting anyone admitted with Type 1 diabetes to all healthcare professionals<br>• Submitted data to NaDIA Harms audit since inception (some Trust's do not participate) | • Nil identified | Discussed at December 2022 Clinical Audit and Guidelines Group |
| **National Diabetes Audit: Care processes and treatment targets** | 12 August 2021 & 14 July 2022 | • Trust has regular MDT meetings between secondary and primary care staff working in Diabetes care<br>• Innovative integrated care model called Newcastle Integrated Diabetes Care led by Diabetes Specialist Nurses. This ensures there is access to specialist teams for patients across the city. | • Nil identified | Discussed at December 2022 Clinical Audit and Guidelines Group |
| **National Type 1 Diabetes Audit** | 12 August 2021 | • Highlight specialist Type 1 MDT service<br>• NHS England pilot site of insulin pump closed loop studies | • Nil identified | Discussed at December 2022 Clinical Audit and Guidelines Group |

# Quality: Clinical Audit 4/7

| Audit / NCEPOD | Date of Report | Areas of Good Practice | Areas for improvement | Action Plan Developed |
|---|---|---|---|---|
| **National Diabetes Foot Care Audit** | 11 May 2022 | • Dedicated band 7 inpatient podiatrist<br>• Hub and spoke model for diabetes podiatry – shared learning across podiatry team | • Nil identified | Discussed at December 2022 Clinical Audit and Guidelines Group |
| **National Pulmonary Rehabilitation Audit** | 14 July 2022 | • Completion rate numbers for COPD patients.<br>• Repeat walk tests started in August 2022.<br>• The team now has one phone number; it is a central contact with a voicemail attached and linked to laptops so can be picked up on all locations.<br>• Taxi initiative is improving completion rates and evidence of good practice.<br>• Standardisation of education programme across all classes.<br>• Reinstated live MDT input.<br>• Collaborating with other services for onward maintenance and giving patients a menu of current community exercise/activity options.<br>• Home exercise programme has been developed and being administered.<br>• Discharge appointments for patients is currently under review. | • Nil identified | Discussed at December 2022 Clinical Audit and Guidelines Group |
| **National Early Inflammatory Arthritis Audit (NEIAA)** | 13 October 2022 | Trust was compliant with six of the quality standards in this audit:<br>• Patients referred to specialist within three working days<br>• Time to initiation of cDMARD therapy<br>• Provision of patient education within first three months<br>• Treatment target agreed with patient<br>• Access to emergency care<br>• Treatment response information documented at follow up appointments | • NuTH flagged as an outlier. 31% of patients were seen within three weeks, compared with a national average reported by the NEIAA of 48%. Following early insight, necessary actions have been taken and 2022/23 data shows improvement (88%). | Discussed at December 2022 Clinical Audit and Guidelines Group |

# Quality: Clinical Audit 5/7

| Audit / NCEPOD | Date of Report | Areas of Good Practice | Areas for improvement | Action Plan Developed |
|---|---|---|---|---|
| **National Perinatal and Mortality Review Tool (PMRT)** | 30 September 2022 | • PMRT review group in neonates exceeds national averages for representation | • No capacity to provide external review to regional colleagues | Discussed at December 2022 Clinical Audit and Guidelines Group |
| **National Audit of Breast Cancer in Older Patients (NABCOP)** | 12 May 2022 | • Breast reoperation rates below national average (18% vs 22% National Average)<br>• Higher surgical rates of breast cancer (90% vs 89% national average)<br>• Higher rates of women receiving triple diagnostic assessment in breast clinic (85% vs 70% national average)<br>• Higher number of women reviewed by clinical nurse specialist (99% vs 96% National average)<br>• Data capture via NABCOP is better than national average across all domains | • Improve recurrence information on patients with breast cancer in cancer registration datasets. No specific part of data capture that looks at whether cancer is a recurrence. | Discussed at December 2022 Clinical Audit and Guidelines Group |
| **Sentinel Stroke National Audit Programme (SSNAP)** | 10 November 2022 | • The service is scoring above national average across all key indicators and is the second best performing service on a national ranking.<br>Well above national average in regard to:<br>• patients directly admitted to stroke unit, specialist stroke nurse assessments, time to CT scan, occupational and physiotherapy compliance against therapy targets.<br>• Our speech and language therapy service is performing above national average but occasionally below level A (highest performing)on SSNAP indicators, due to staffing issues.<br>• Improvements in dietician input over the past few years. | • Nil identified | Discussed at December 2022 Clinical Audit and Guidelines Group |

# Quality: Clinical Audit 6/7

| Audit / NCEPOD | Date of Report | Areas of Good Practice | Areas for improvement | Action Plan Developed |
|---|---|---|---|---|
| **National Heart Failure Audit** | 16 June 2022 | • 84% case ascertainment<br>• 66.5% Cardiology Inpatients (48% nationally)<br>• 65.1% receive input from Cardiologist (47% nationally)<br>• High level of prescribing of ACE/ARB/ARNI and Beta-blockers | • Improve access to echo within 48 hours of admission<br>• Improve access to early specialist follow-up | Discussed at December 2022 Clinical Audit and Guidelines Group |
| **National Adult Cardiac Surgery Audit** | 10 December 2020,<br>14 October 2021<br>& 16 June 2022 | • Proportion of first time Coronary Artery Bypass Graft (CABG) performed as an urgent case - 2019/20 & 2020/21: Expectation that at least 50% of CABG operations should be performed urgently, Freeman Hospital (FH) performed 56% urgently.<br>• Post-op length of stay following first time CABG – 2019/20: mean days 7.2, FH in upper-quartile.<br>• Post-op bleeding following CABG – 2020/21: FH in upper-quartile.<br>• New post-op Cerebrovascular Accident or Transient Ischaemic Attack following CABG – 2020/21: FH in upper-quartile.<br>• Waiting times for elective CABG – 2021/22: Less than target of 84 days, improved performance, FH in upper-quartile.<br>• Mean target of 7 days to urgent CABG after diagnostic angiography met - 2021/22. | • Urgent CABG performed within 7 days of coronary angiography National Target 75%, NUTH 53%<br>• Day of surgery admission for elective CABG National Target 50%, NUTH 19% | Discussed at January 2023 Clinical Audit and Guidelines Group |
| **Young people with type 2 diabetes** | 12 August 2021 | • Dedicated young patient clinic<br>• Trust recently awarded significant bid for improving transition care in diabetes, includes extra funding for psychology support workers and diabetes educators | • Newcastle Integrated Model looking at how to engage people from ethnic minority groups, particular from west end of Newcastle where there is a higher need | Discussed at January 2023 Clinical Audit and Guidelines Group |
| **National Pregnancy in Diabetes Audit** | 14 October 2021 | • Audit outcomes in National Pregnancy Audit favourable in comparison to Shelford Hospitals including need for neonatal special care admission and rates of Large for Gestational Age | • MDT team exploring how preconception service can reach people with Type 2 diabetes in more deprived areas. Integrated Care Model means this issue is being highlighted regularly at a practice level. Diabetes Master Classes for Primary Care staff to highlight preconception care | Discussed at January 2023 Clinical Audit and Guidelines Group |

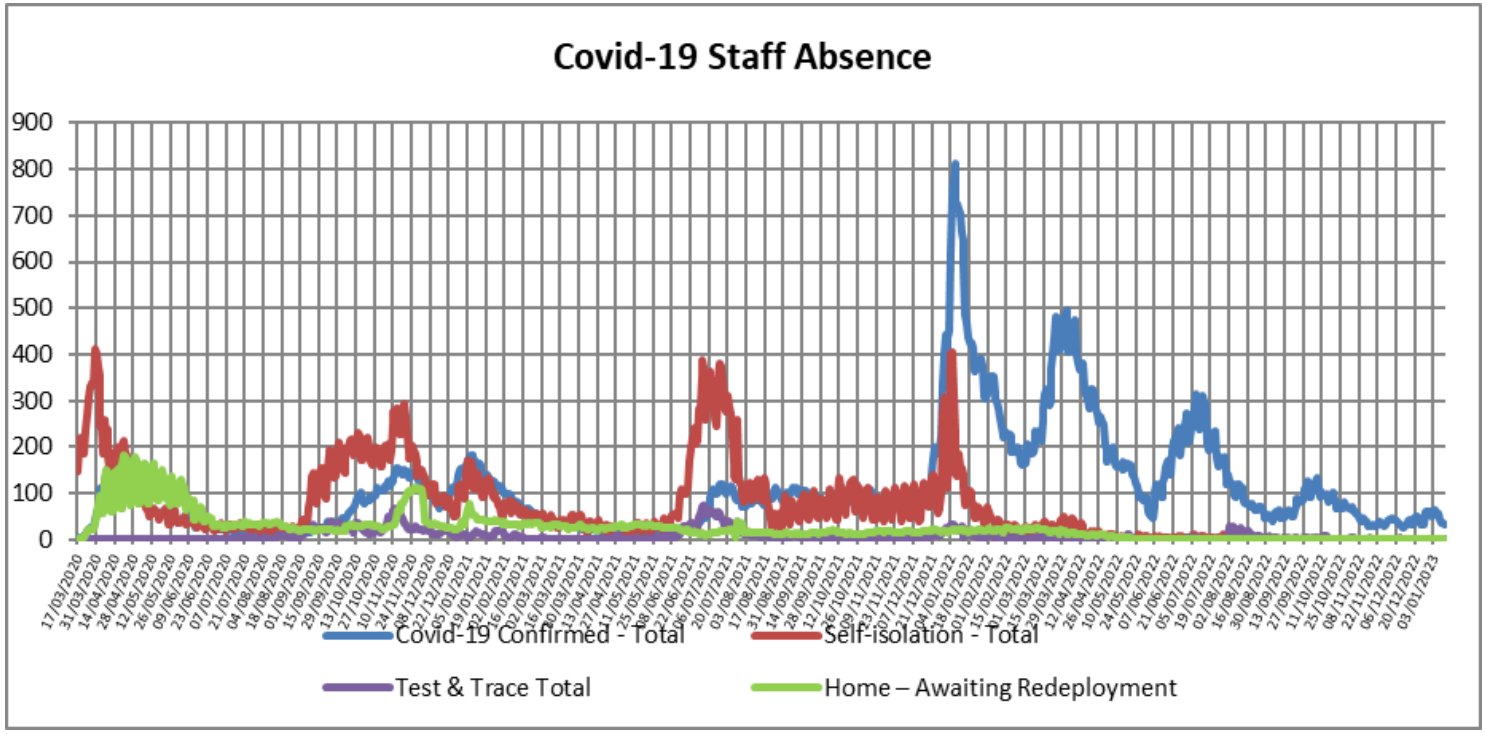
# Quality: Clinical Audit 7/7

| Audit / NCEPOD | Date of Report | Areas of Good Practice | Areas for improvement | Action Plan Developed |
|---|---|---|---|---|
| **Antenatal and Newborn National Audit Protocol 2019-2021** | 1 November 2022 | • Fetal anomaly ultrasound – 99% (National Standard 90%)<br>• HIV – 99.8% (National Standard 95%)<br>• Hepatitis B – 99.8% (National Standard 95%)<br>• Syphilis – 99.8% (National Standard 95%)<br>• Antenatal screening – 99.9% (National Standard 95%)<br>• Timeliness of antenatal screening – 62.9% (National Standard 50%)<br>• Coverage of CCG responsibility at birth – 98.4% (National Standard 95%) | • Completion of family origin questionnaire 93.1% (National Standard 95%) | Discussed at January 2023 Clinical Audit and Guidelines Group |
| **National Smoking Cessation Audit** | 1 March 2022 | • In 2021 the Trust documented smoking status in 93.4% of patients, compared to 88.0% in 2019 (the 2021 national average 78.6%)<br>• The smoking rate in 2021 was 17.5% compared to 22.1% in 2019 (the national average in 2021 was 20.9%)<br>• In 2021 we offered 80% of patient's nicotine products to support a cessation attempt, compared to 42.9% in 2019 (the national average in 2021 was 32.4% | • Ensure the Trust adheres to standards set in NG209<br>• Review Smoking Cessation Forms in e-record to reflect the changes in national and ICS data collection guide<br>• Undertake all necessary steps to build a system for data reporting and schedule submissions to NHSEI and NECS (ICS) on a quarterly basis<br>• Ensure ongoing referrals to the community stop smoking service for all smokers in all inpatient wards<br>• Recruitment of additional tobacco advisors in the service to ensure that the service covers all inpatient wards across the two hospital sites | Discussed at January 2023 Clinical Audit and Guidelines Group |
| **Muscle Invasive Bladder Cancer Audit** | 19 August 2022 | • Time from referral to Trans urethral removal of bladder tumour | • Nil identified | Discussed at January 2023 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 17h March 2020 and 31st December 2022. Some staff may have had more than one episode of COVID-19 related absence during this period.



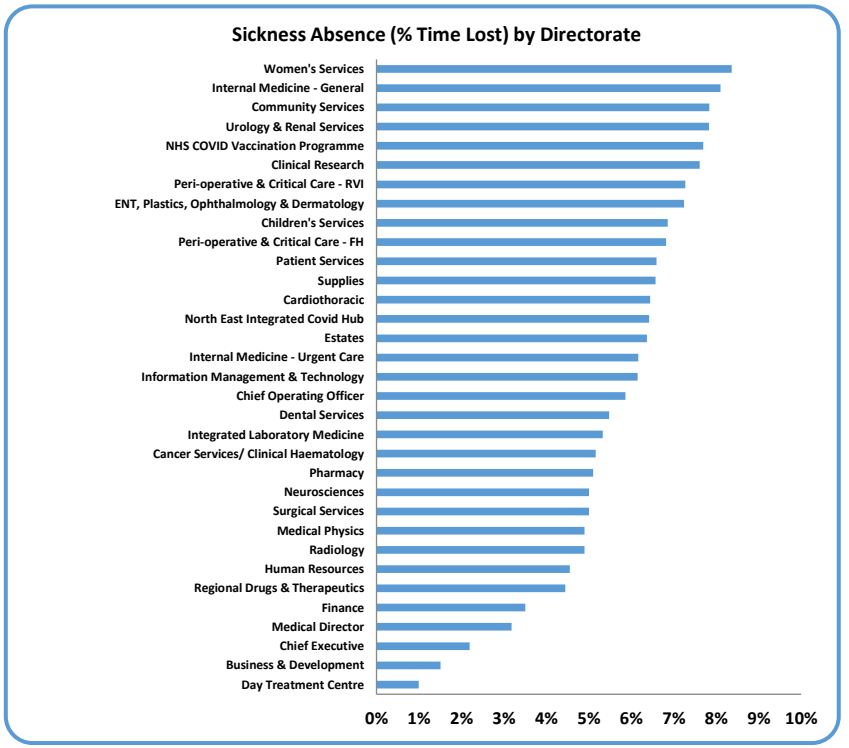

- Risk Assessments have been made available to all Trust staff – staff in 'high risk' category prioritised.

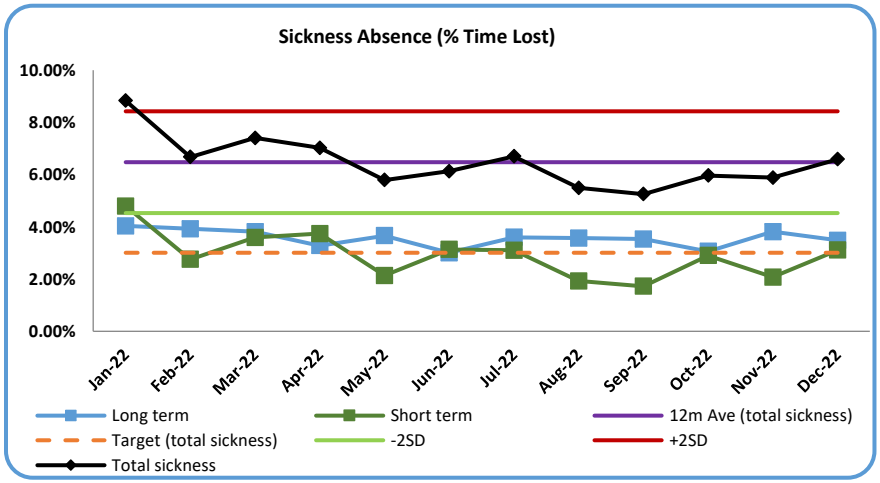
# People: Sickness Absence 1/2

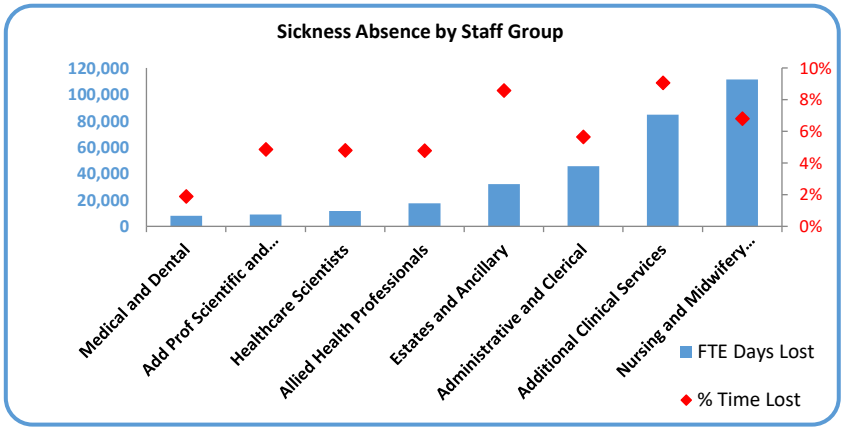
- Year to year comparison for sickness absence (including COVID-19 related sickness (rolling 12 months):

| | Dec-21 | Dec-22 | |
|---|---|---|---|
| Long-term | 1.67% | 3.69% | ↑ |
| Short-term | 3.78% | 2.78% | ↓ |
| Total | 5.45% | 6.47% | ↑ |

- 320,981 FTE working days were lost due to sickness (including COVID-19 related sickness) in the year to December 2022, compared to 275,267 for the previous year.
- Overall sickness absence (including COVID-19 related sickness) is 6.47%, which is down from end of Oct 2022 position of 6.50% (% FTE Time Lost).
- The top three reasons for non-COVID related sickness absence are Anxiety/stress/depression/other psychiatric illnesses (24%) Gastrointestinal problems (7%), and other musculoskeletal (9%).
- The top reason for "Other" absences is Maternity Leave (50% of total absence.
- Nursing and Midwifery have the highest number of Maternity Leave at 4% (%FTE Lost).



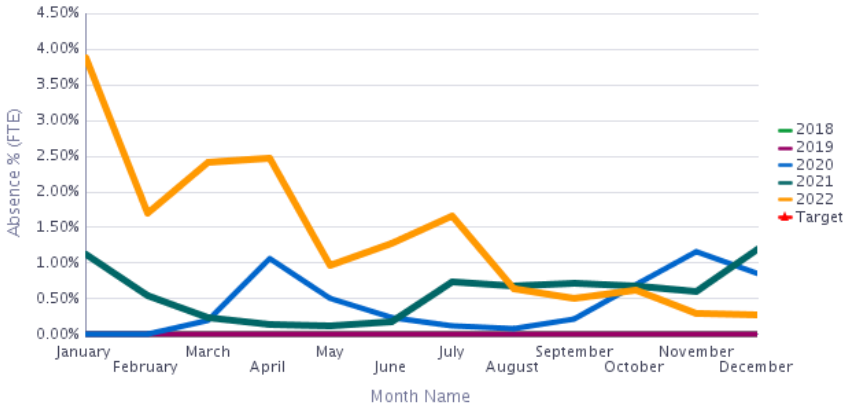



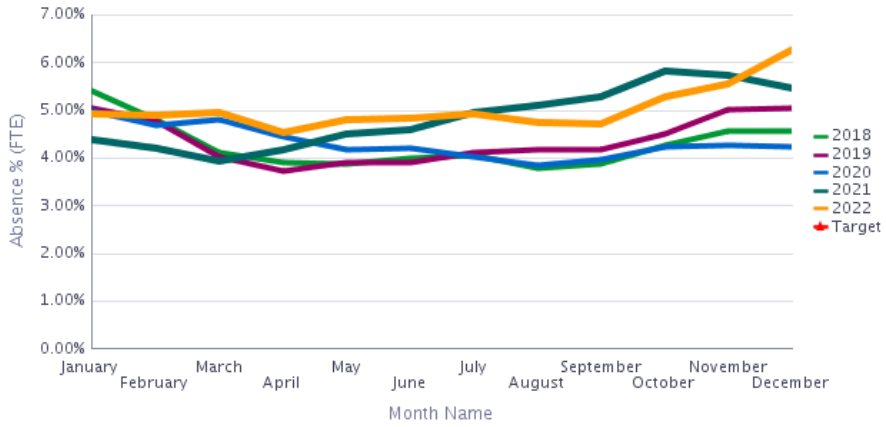

*COO Directorate includes Outpatients / ABC Service

# People: Sickness Absence 2/2

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

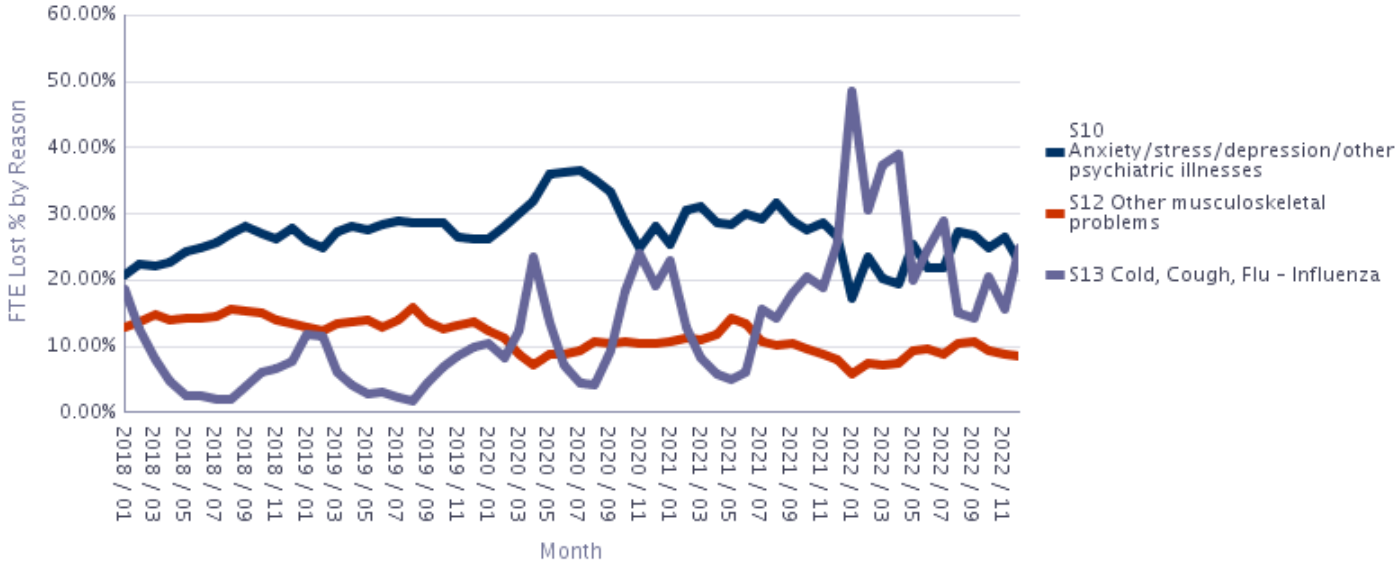



Non-COVID-19 Related Sickness Jan 2018 - December 2022 (%FTE)

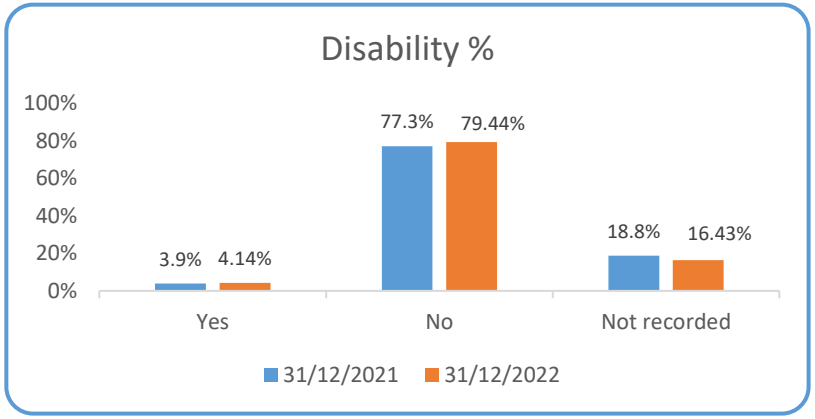


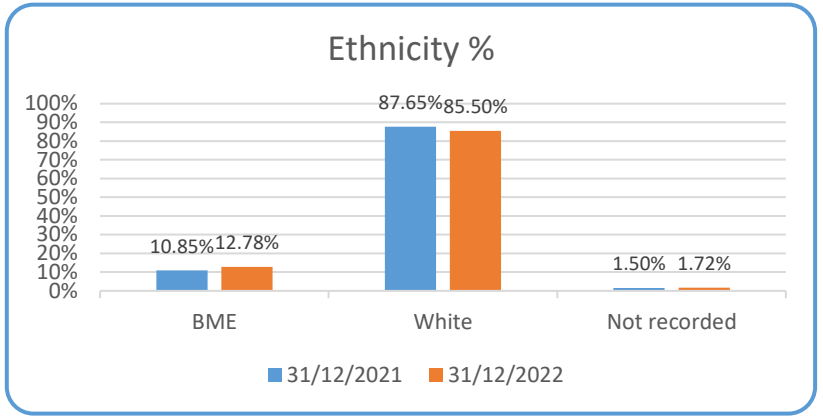

Top 3 Sickness Reasons Jan 2018 - Dec 2022 (%FTE)

*S13 includes Covid sickness*

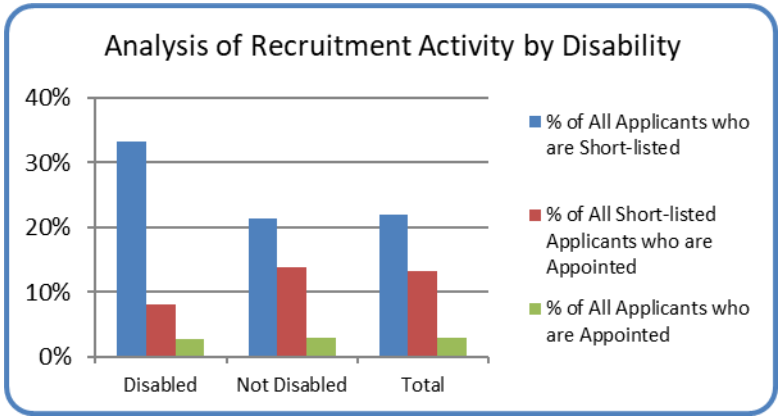


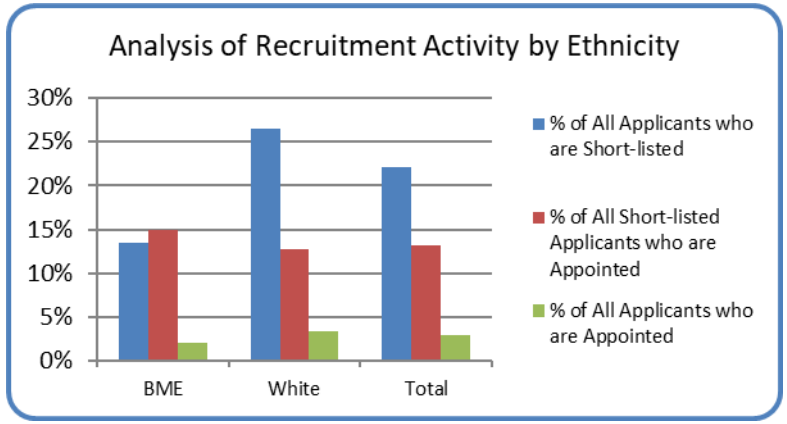
# People: Equality and Diversity 1/2



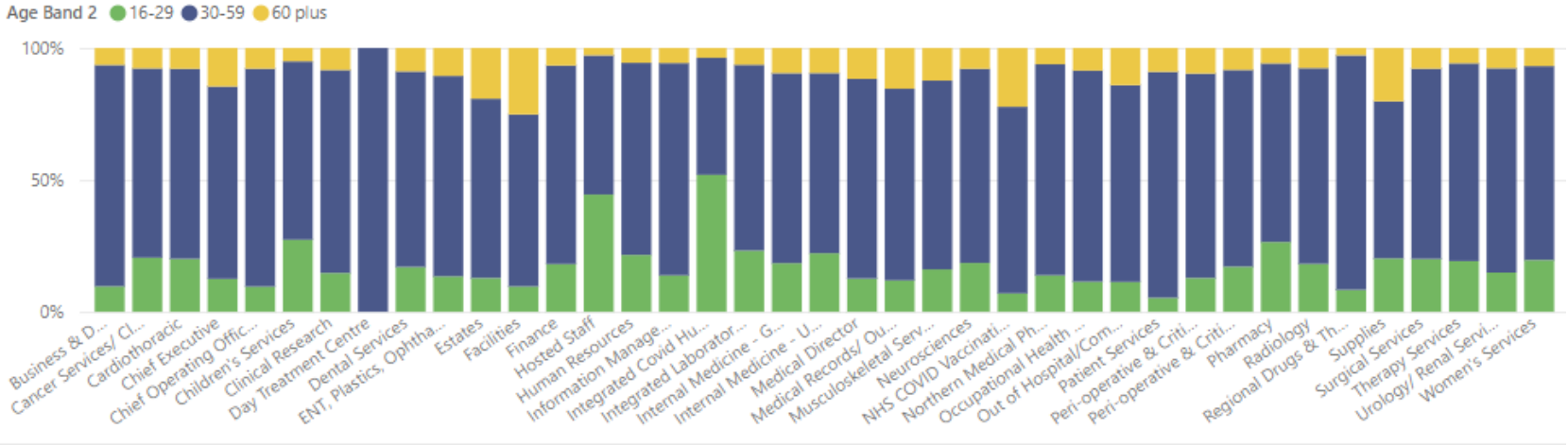

- The graphs above identify, by disability and ethnicity, the recruitment outcome of applicants during the twelve months ending December 2022.




- The graphs above identify, by headcount, the percentage of staff in post in December 2021 and December 2022 by disability and ethnicity. The percentage of staff employed disclosing a disability has improved from 3.94% to 4.14% and the percentage of BAME staff has increased from 10.85% to 12.78%.

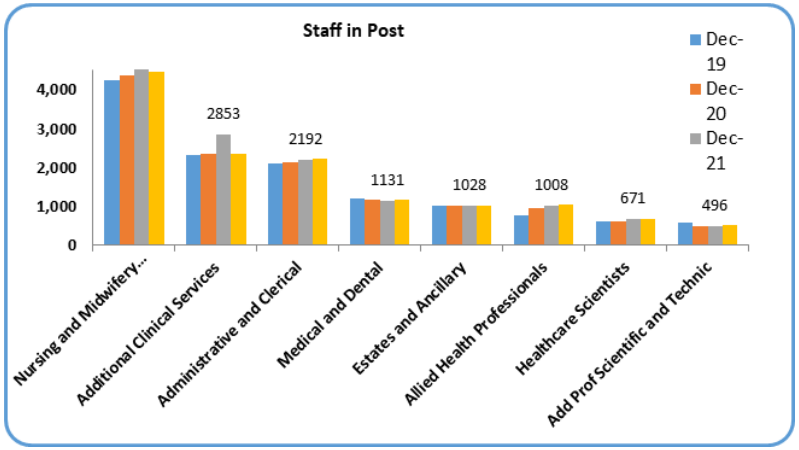
# People: Equality and Diversity 2/2

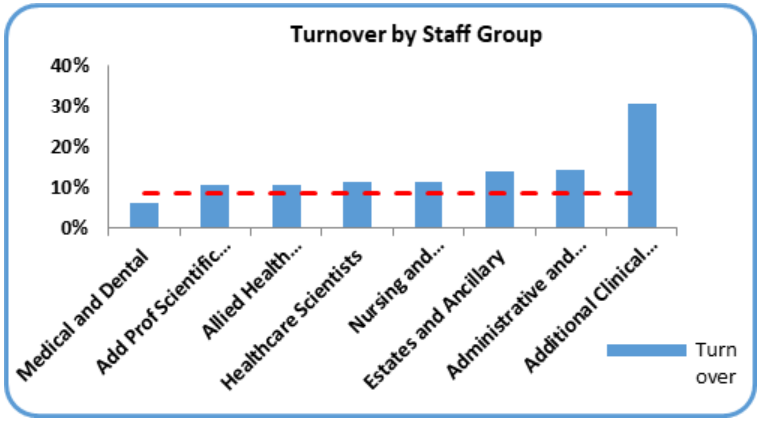


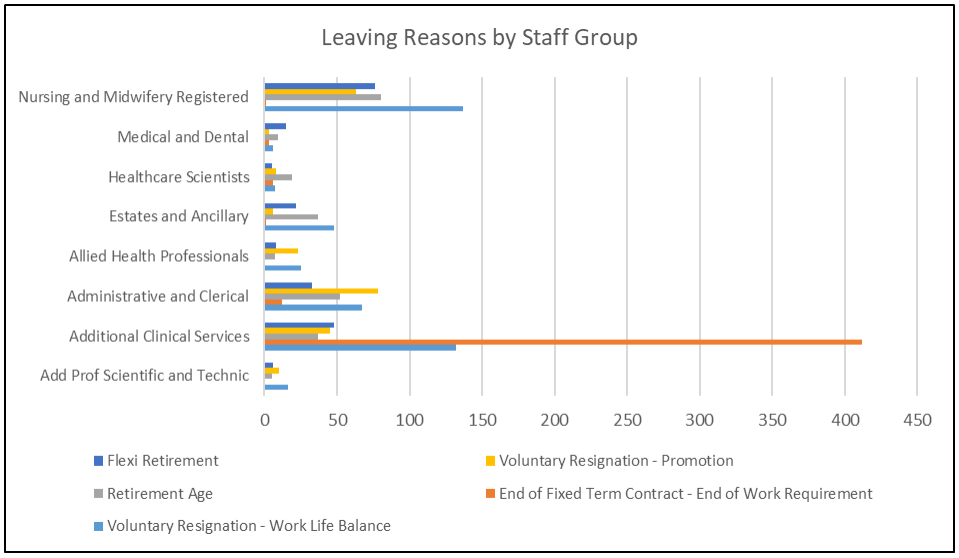


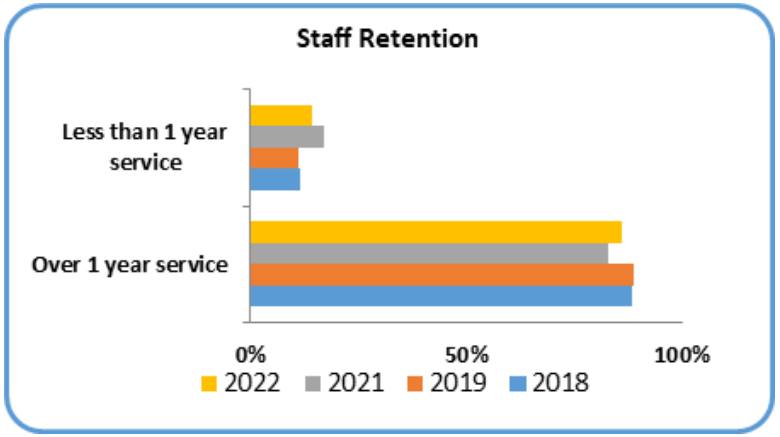
- Estates and Ancillary have the highest proportion of staff aged 55 and over (45%).
- Medical and Dental have 20% of staff aged 55 and above and 7% of staff aged 60 and above.

# People: Workforce 1/3



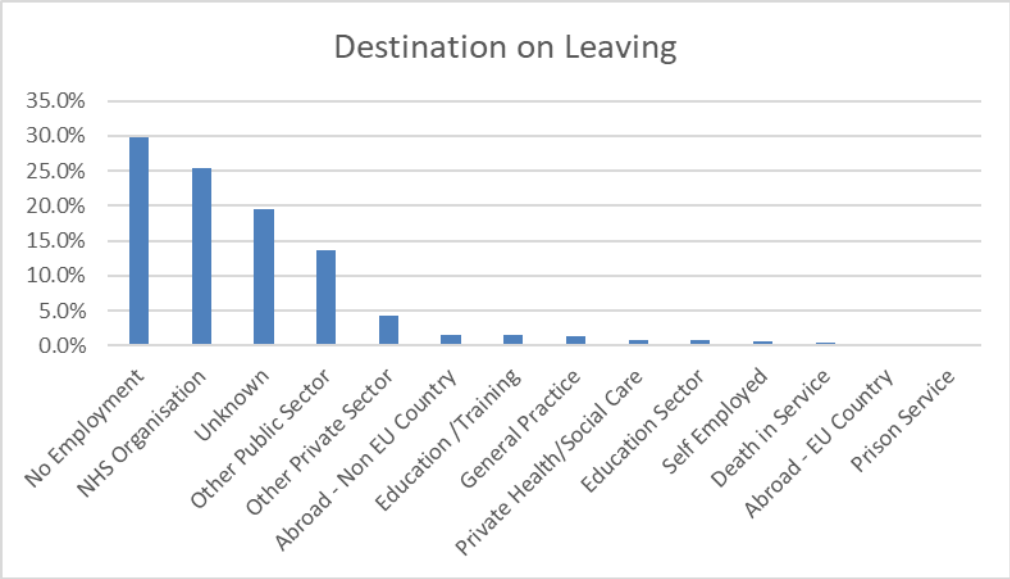

- Staff in post has increased by 4.88% since October 2019. The staff groups with the largest increase are Administrative and Clerical and Allied Health Professionals.
- Staff turnover has increased from 11% in December 2021 to 15.4% in December 2022, against a target of 8.5%.
- The total number of leavers in the period January 2022 to December 2022 was 2,432.
- Retention for staff over 1 year service is 85.89%, an increase from 82.94% in December 2021.

# People: Workforce 2/3

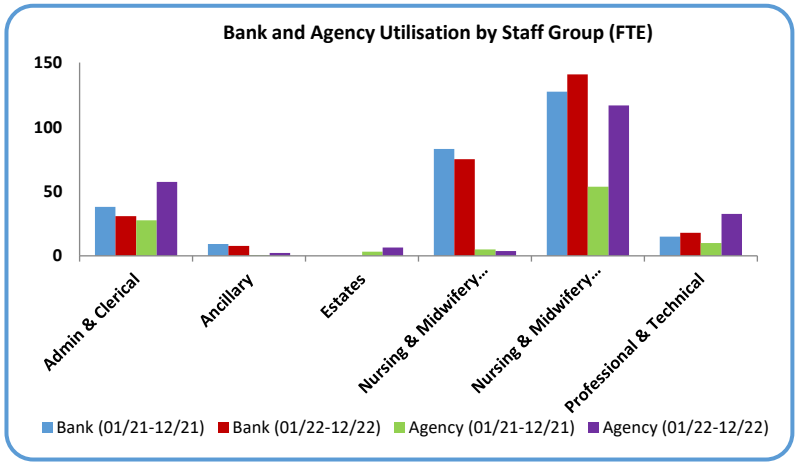
Turnover by Directorate

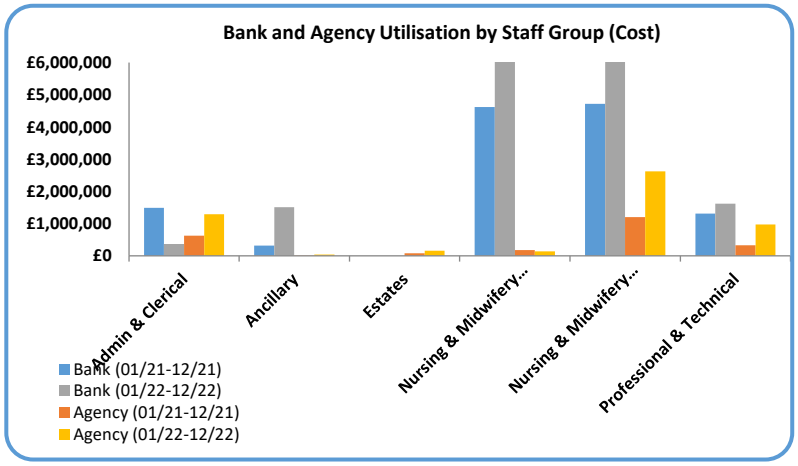
| Directorate | Turnover |
|---|---|
| Day Treatment Centre | 0.00% |
| Chief Executive | 4.72% |
| Neurosciences | 6.44% |
| Urology & Renal Services | 7.53% |
| Medical Director | 7.73% |
| Peri-operative & Critical Care - FH | 8.13% |
| Medical Physics | 8.43% |
| Surgical Services | 9.22% |
| Internal Medicine - Urgent Care | 9.71% |
| Business & Development | 10.17% |
| Children's Services | 10.34% |
| Cancer Services/ Clinical Haematology | 10.52% |
| Internal Medicine - General | 10.57% |
| Pharmacy | 10.57% |
| ENT, Plastics, Ophthalmology & Dermatology | 10.69% |
| Musculoskeletal Services | 10.84% |
| Clinical Research | 11.06% |
| Radiology | 11.17% |
| Chief Operating Officer | 11.56% |
| Dental Services | 11.78% |
| Peri-operative & Critical Care - RVI | 11.79% |
| Cardiothoracic | 12.05% |
| Women's Services | 12.09% |
| Integrated Laboratory Medicine | 12.09% |
| Community Services | 13.45% |
| Patient Services | 13.76% |
| Regional Drugs & Therapeutics | 14.29% |
| Estates | 14.39% |
| Information Management & Technology | 15.53% |
| Finance | 17.54% |
| Human Resources | 23.71% |
| Supplies | 25.15% |

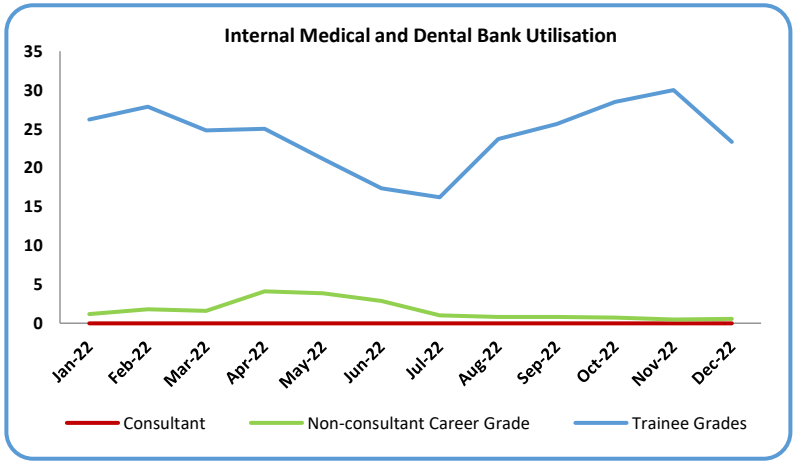
- Only 25% of leavers across the Trust disclosed they were going to another NHS organisation.



# People: Workforce 3/3

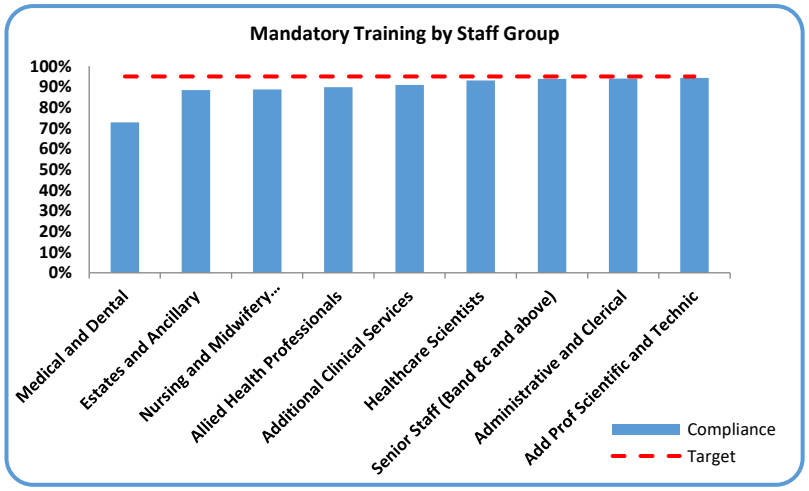


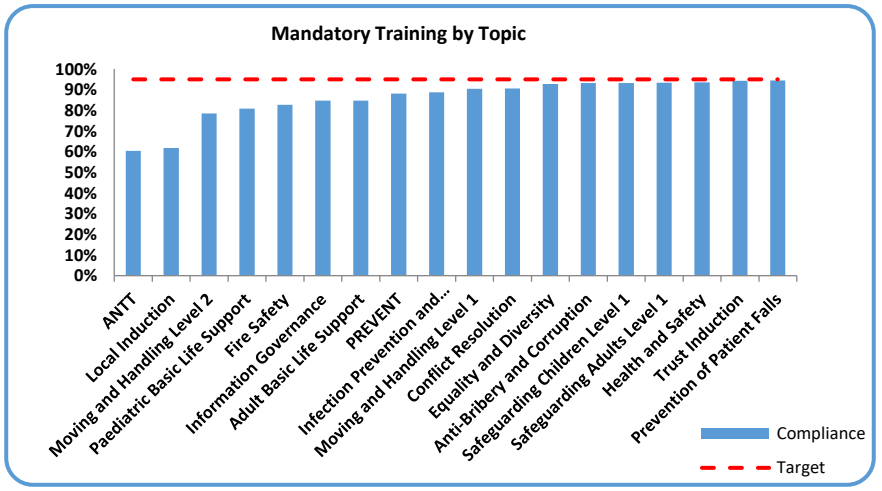



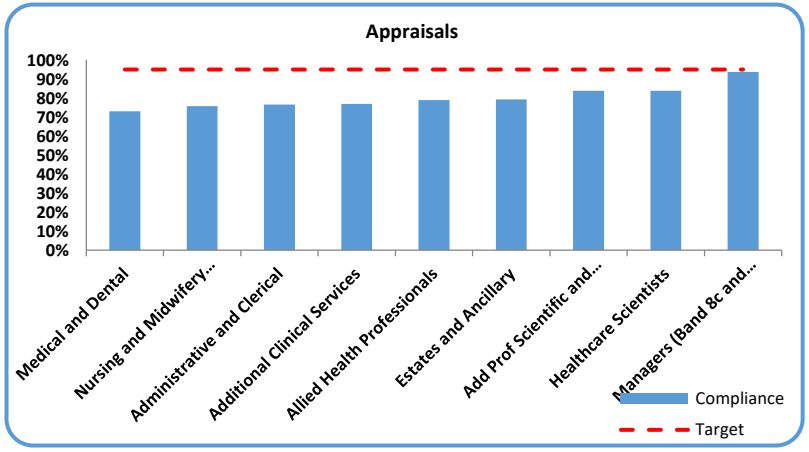



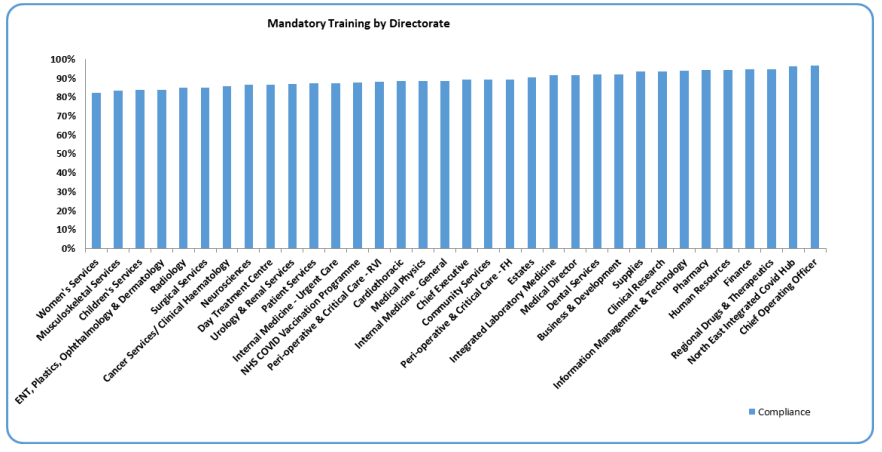

- Comparing the periods January 2021 – December 2021 to January 2022 – December 2022 , overall bank utilisation has remained the same at 272.08 wte and agency utilisation has increased from 99 wte to 218 wte.

# People: Delivering Excellence in Education & Training




- Mandatory training compliance stands at 88.8% at end of December 2022, against an end of year target of 95%. The December 2021 position was 87.8%.
- Medical and Dental are the staff group with the lowest training compliance at 72.7% in December 2022 compared to 68.9% in December 2021.
- Appraisal compliance stands at 77.3%, at end of December 2022, against an end of year target of 95%. The December 2021 position was 76.9%. 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 December 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 December the Trust incurred expenditure of £1,042.3 million, and accrued income of £1,046.8 million on mainstream budgets and incurred expenditure of £5.5 million on the programmes outside the block envelope (vaccine roll-out programme), leading to a surplus of £4.2 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 £4.2 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 December the Trust had spent £38.6 million capital, £10.8 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 9 Budget £'000 | Month 9 Actual £'000 | Month 9 Variance £'000 |
|---|---|---|---|
| Income | 1,016,593 | 1,046,774 | 30,181 |
| Expenditure | 1,010,690 | 1,042,584 | 31,894 |
| I & E position (excl impairment) - (Deficit)/Surplus | 5,902 | 4,189 | (1,713) |
| | | | |
| Capital Programme | 49,409 | 38,569 | (10,840) |

THIS PAGE IS INTENTIONALLY BLANK