The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 March 2023						
Title	Guardian of Safe Working Quarterly Report (Q3 2022-23)						
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours						
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	The terms and conditions of service of the new junior doctor contract (2016) require the Guardian of Safe Working Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant. The content of this report outlines the number and main causes of exception reports for the period 27 September to 26 December 2022 for consideration by the Trust Board.						
Recommendation	The Board of Directors 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 and previously presented at the February People Committee.						

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

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

There are now 836 postgraduate doctors in training on the New Junior Doctor Contract and a total of 1,036 postgraduate doctors in the Trust.

There were 124 exception reports in this period. This compares to 138 exception reports in the previous quarter.

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

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	836	(850)
Total Number of Junior Doctors	1036	(1,043)
Number of Exception reports	124	(143)
Number of Exception reports for Hours Breaches	122	(138)
Number of Exception reports for Educational Breaches	7	(9)
Fines	2	(7)
Admin Support for Role	Good	
Job Planned time for supervisors	Variable	

4. EXCEPTION REPORTS

4.1 Exception Report by Speciality (Top 4)

		(Previous quarter for comparison)
General Surgery	56	(11)
General Medicine	42	(64)
Ophthalmology	13	(36)
Haematology/Oncology	6	(17)

4.2 Exception Report by Rota/Grade

General Surgery	
FH (F1)	55
○ Hepatobiliary	36
○ Vascular	10
○ Colorectal	6
○ Unspecified	3
RVI (F1)	1
General medicine RVI	
F1 ward 48/52 (respiratory)	24
F1/F2 back of house	11
General Medicine FH	
F1 Older person's medicine	7
Ophthalmology	
SHO	6
ST3+	7
Haematology/Oncology	
ST3+	6

4.3 Example Themes from Exception Reports

General Surgery FH

The ward today was below minimum levels of staffing; I was the only HPB F1 scheduled to work but the SHO ""stepped down"" and assisted on the ward with neither PA being in; no other general surgery F1s were able to cover as they were also on minimum levels of staffing. In addition; in the afternoon; two F1s had a compulsory BDBP session taking the total number general surgery juniors to 3 (minimum of 5). I stayed an hour late to complete

all the ward round jobs and handed over the jobs that were appropriate for the on-call team at 6pm.

The high workload and staffing issues within general surgery F1 at Freeman are well known and have been escalated to the Executive Team. The increase in exception reports is due to a positive change in exception reporting culture, with doctors now encouraged to exception report for extra work carried out.

General Medicine RVI/FH

"Unable to take a lunch break and had to stay 1 hour late due to clinical pressures on the ward."

Ophthalmology RVI

"Busy day for on call and EED; so late finish in EED. I was the EED reg. The PM session we were down a consultant and SHO."

Issues with workload, especially in the eye emergency department (EED), and on call work intensity are being addressed by the department.

Haematology/Oncology

"I had a late finish from the ward. There were multiple patients to be seen; clerking of new admissions and outstanding jobs from other teams; who interrupted intermittently. I was by myself as my Registrar was stuck in radiotherapy. I really hope tomorrow would be better!"

High workload and staffing issues are well documented within this department.

5. EXCEPTION REPORT OUTCOMES

5.1 Work Schedule Reviews

No work schedule reviews were conducted on the back of exception reports.

5.2 Fines

2 fines have been issued:

Ophthalmology. Rule breached "Unable to achieve minimum overnight continuous rest of 5 hours between 22.00 and 07.00 during a non resident on-call (NROC.)"

Medicine. Rule breached "Exceeded the maximum 13 hour shift length, unable to achieve minimum 11 hours rest between resident shifts."

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.

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.

Directorate	Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Dec-22	Nov-22	Oct-22
		Cancer Services					
Cancer Services	FH	Oncology	ST3+	14	4	4	3.4
Cancer Services	FH	Palliative Medicine	F2/ST1+	13	1.2	1.2	1.5
Cancer Services	FH	Haematology / Oncology	F2/ST1/ST2	10	3	2	2
Cancer Services	FH	Haematology / Oncology	CMT	3	1.4	0	0.2
Cancer Services	FH	Haematology	ST3+	10 (from Jan 2021)	1	1	2
		Cardiothoracic Services					
Cardiothoracic Services	FH	Cardiology	F2/ST1-2	5	0.2	0.2	0.2
Cardiothoracic Services	FH	Cardiology	CMT	2 (from Dec 20)	1	1	1
Cardiothoracic Services	FH	Cardiothoracic Anaesthesia	ST3+	9	2	2	5
Cardiothoracic Services	FH	Cardiothoracic Surgery	ST3+	11	4	4	4
Cardiothoracic Services	FH	Cardiothoracic Transplant	ST3+	3	1	1	1
Cardiothoracic Services	FH	PICU	ST3+	8	2.4	2.4	2.4
Cardiothoracic Services	FH	Paediatric Cardiology 1st	F2/ST1/ST2	7	1	1	2

Directorate	Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Dec-22	Nov-22	Oct-22
Cardiothoracic Services	FH	Paediatric Cardiology 2nd	ST3+	9 (from Jan 2021)	0.4	0.4	0.4
Cardiothoracic Services	FH	Respiratory Medicine	CMT/ST1-2	5 (from Sept 2022)	1	1	1
Cardiothoracic Services	FH	Respiratory Medicine	ST3+	11 (rotate with RVI)	1	1	1.4
		Children's Services					
Children's Services	RVI	Paediatric Surgery 2nd	ST3+	9 (8 from Nov 20)	1.4	1.4	1.4
Children's Services	RVI	Paediatrics 1st - ST1/ST2 (now inc Paeds Surgery)	F2/ST1/ST2	25 (From Sept 22)	3	3	2
Children's Services	RVI	General Paediatrics	ST3+	21	1.4	1.4	2
Children's Services	RVI	Paediatric Oncology	ST3+	6	3	3	3
Children's Services	RVI	Paediatric ICU (PICU)	ST3+	9 (8 from May 2021)	1	1	1.4
		Dental					
Dental	RVI	OMFS	ST1/ST2	8	1	1	1
		EPOD					
EPOD	FH	ENT	F2 / CST / ST1-2	6	1.4	1.4	0.4
EPOD	FH	ENT	ST3+	9	0.4	0.4	0.4
EPOD	RVI	Plastic Surgery	F2/ST1/ST2	10	0	0	1
EPOD	RVI	Ophthalmology	F2/ST1/ST2	6	2	2	1.4
EPOD	RVI	Ophthalmology	ST3+	24	2.64	2.64	0.4
EPOD	RVI	Dermatology	ST3+	5 (from Sept 2022)	0.8	0.8	0.4
EPOD	RVI	Dermatology	CMT	2	1	1	1
EPOD	RVI	Dermatology	GPSTR	1	0.4	0.4	0.4
		Integrated Lab Medicine					
Integrated Lab Medicine	RVI	Histopathology	ST3+	13	0.8	0.8	0.8
Integrated Lab Medicine	RVI	Forensic Histopathology	ST3+	2	2	2	2
Integrated Lab Medicine	RVI	Histopathology	ST1/2	8	2	2	2
Integrated Lab Medicine	C4L	Genetics	ST3+	4	1	1	0.4
Integrated Lab Medicine	RVI	MM rota integrated with ID and MV and GIM	ST1+	21	1	1	1
		Medicine					
Medicine	FH	General Internal Medicine	F2/GPVTS/CMT/TF	21	2.6	2	2
Medicine	RVI	CMT BOH and FOH Combined (August 2019)	CMT	11	1	1	1

Directorate	Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Dec-22	Nov-22	Oct-22
Medicine	RVI	CMT Acute- ACU (August 2019)	CMT	2	1	1	1
Medicine	RVI	General Internal Medicine	ST3+	25	2	3.6	3.1
Medicine	FH	Care of the Elderly	ST3+	5	1.2	1.2	1.2
Medicine	RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	20	4	4	4
Medicine	RVI	Accident & Emergency 2nd	ST3+	15 (14 from Nov 20)	2	2	3
		Musculoskeletal					
Musculoskeletal	FH	Rheumatology	ST3+	5	0	0	0.4
Musculoskeletal	FH	Rheumatology	CMT1-2	4	1	1	1
Musculoskeletal	FH	Orthopaedics	F2/ST1/ST2	6	0	1	1
Musculoskeletal	RVI	Orthopaedics	F2/ST1/ST2	5	1	0	0
Musculoskeletal	RVI/ FRH	Orthopaedics	ST3+	19	1.4	1.4	1.2
		Neurosciences					
Neurosciences	RVI	Neurosurgery	F2/ST1/ST2	5	1	1	0
Neurosciences	RVI	Neurosurgery	ST3+	13	1	1	1
Neurosciences	RVI	Neurology	ST3+	13	1.1	1.1	1.1
Neurosciences	RVI	Neurology	IMT/CMT	3	1	1	1
		Peri-operative FH					
Peri-operative & Critical Care	FH	Critical Care	F2 ST1-7	11	1.2	1.6	2
Peri-operative & Critical Care	FH	Anaesthetics General	ST1-7 CT1-2	29	2	2	2
		Peri-operative RVI					
Peri-operative & Critical Care	RVI	Critical Care	ST1+	18 (14 from Aug 22)	2.2	2.2	1.2
Peri-operative & Critical Care	RVI	Anaesthetics	ST1-2 / ST3 +	44 (40 From Aug 22)	2.4	2.4	2.8
		Radiology					
Radiology	RVI / FH	Radiology On Call	ST2 / ST3+	33	1.2	1.2	1.4
Radiology	RVI / FH	Neuroradiology	All grades	4	0.2	0.2	0.2
		Surgical Services					
Surgical Services	FH	General Surgery	F2/ST1/ST2/ ST3+	7	2.2	2.2	2
Surgical Services	FH	Vascular	ST3+	10.5 (11 from May 2021)	2	2	2
Surgical Services	RVI	General Surgery	F2/ST1/ST2	7	1	1	1

Directorate	Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Dec-22	Nov-22	Oct-22
Surgical Services	RVI	General Surgery	ST3+	17	3.4	3.4	3
Surgical Services	FH	IoT - NSR & Teaching Fellows	ST1-2 NSR TFs	4	1	1	1
		Urology & Renal					
Urology	FH	Renal Medicine	F2/ST1/ST2	5	1	1	0
Urology	FH	Renal Medicine	ST3+	9	0.4	0.4	0.4
Urology	FH	Urology	F2/ST1/ST2	7	0.2	0.2	0
		Women's Services					
Women's Services	RVI	Obstetrics & Gynaecology	ST3+	22	2	2	2
Women's Services	RVI	Neonates	F2/ST1/ST2	7	0.4	0.4	0.4
Women's Services	RVI	Neonates	ST3+	13	1.8	2	2.6

7.1 Locum Spend

LET Locum Spend

October to December (Q3 2022-23)	£367,761
July to September (Q2 2022-23)	£683,260
April to June (Q1 2022-23)	£446,907

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, as Q3 covers the Christmas period it is likely claim forms have been delayed and will be evidenced by an increase in January spend. The decrease from Q2 to Q3 was across the Trust with Internal Medicine reducing by £183k, Women's by £101k, EPOD by £83k and Peri-Op increasing by £76k."

Trust Locum Spend

October to December (Q3 2022-23)	£646,204
July to September (Q2 2022-23)	£673,665
April to June (Q1 2022-23)	£482,999

Comment from finance team:
"Spend on Trust locums decreased by £27k, this was made up of a £20k reduction in on-call cover and a £6k reduction in sickness offset by a £7k increase in workload. COVID-19 additional dependency reduced by £97k with Established Vacancies increasing by £90k indicating a change in given reason rather than change in spend. With regard to directorates there was minimal change, within medicine A&E reduced by £12k but this was offset by an Increase in General Medicine (RVI) £45k and General Medicine (FRH) £25k,

within Cardiology there was an £14k increase in Cardiology FRH offset by a £21k reduction in Cardio Anaesthesia and £20k reduction in Cardio Surgery."

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. Work is underway to assess this.

9. JUNIOR DOCTOR FORUM

The main areas of discussion were again around the issues of staffing and clinical pressures. In addition, there was discussion around the need for improvement of mess facilities at the Royal Victoria Infirmary (RVI).

10. RECOMMENDATIONS

I recommend that we continue to review the workforce workload balance to ensure safe and sustainable staffing.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
13 January 2023

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	23 March 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. 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 1 February 2023 and interviewed 4 candidates for 3 Consultant in Critical Care and Anaesthesia (Adult) posts.

By unanimous resolution, the Committee was in favour of appointing Dr Claire Mitchell, Dr Louise Swan, and Dr James Lennard.

Dr Mitchell holds MBBS (University of Newcastle) 2008, FRCA (UK) 2017, and FFICM (UK) 2022. Dr Mitchell is currently employed as a Specialty Trainee in Intensive Care Medicine on behalf of the Lead Employer Trust, at James Cook University Hospital.

Dr Mitchell is expected to take up the post of Consultant in Critical Care and Anaesthesia (Adult) in June 2023.

Dr Swan holds MBBS (University of Newcastle) 2007, FRCA (UK) 2012, and FFICM (UK) 2020. Dr Swan is currently employed as a Specialty Trainee in Intensive Care Medicine on behalf of the Lead Employer Trust, at the Royal Victoria Infirmary.

Dr Swan is expected to take up the post of Consultant in Critical Care and Anaesthesia (Adult) in June 2023.

Dr Lennard holds MBBS (University of Newcastle) 2009, FRCA (UK) 2017, and FFICM (UK) 2021. Dr Lennard is currently employed as a Specialty Trainee in Intensive Care Medicine on behalf of the Lead Employer Trust, at the Freeman Hospital.

Dr Lennard is expected to take up the post of Consultant in Critical Care and Anaesthesia (Adult) in August 2023.

1.2 An Appointments Committee was held on 10 February 2023 and interviewed 1 candidate for 1 Consultant Radiologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Jonathan Hacking.

Dr Hacking holds MBBS (University of Newcastle) 2013, MRCP (Edinburgh) 2017, and FRCR (UK) 2021. Dr Hacking is currently employed as a Specialty Trainee in Clinical Radiology on behalf of the Lead Employer Trust, at the Royal Victoria Infirmary.

Dr Hacking is expected to take up the post of Consultant Radiologist in April 2023.

1.3 An Appointments Committee was held on 1 March 2023 and interviewed 1 candidate for 1 Consultant Paediatric Endocrinologist post.

By unanimous resolution, the Committee was in favour of appointing Dr Rachel Boal.

Dr Boal holds MBChB (University of Manchester) 2011, and MRCPCH (UK) 2015. Dr Boal is currently employed as a Specialty Trainee in Paediatrics on behalf of the Lead Employer Trust, at The Great North Children's Hospital.

Dr Boal is expected to take up the post of Consultant Paediatric Endocrinologist in March 2023.

1.4 An Appointments Committee was held on 1 March 2023 and interviewed 5 candidates for 3 Consultant Paediatrician posts.

By unanimous resolution, the Committee was in favour of appointing Dr Elizabeth McLellan, Dr Laura Astall, and Dr Rachel Lee.

Dr McLellan holds MBBS (University of Newcastle) 2008, and MRCPCH (UK) 2014. Dr McLellan is currently employed as a Specialty Trainee in Paediatrics on behalf of the Lead Employer Trust, at The Great North Children's Hospital.

Dr McLellan is expected to take up the post of Consultant Paediatrician in March 2023.

Dr Astall holds MBChB (University of Liverpool) 2008, and MRCPCH (UK) 2020.
Dr Astall is currently employed as a Locum Consultant General Paediatrician at The Great North Children's Hospital.

Dr Astall is expected to take up the post of Consultant Paediatrician in March 2023.

Dr Lee holds MBChB (University of Aberdeen) 2012, and MRCPCH (UK) 2016. Dr Lee is currently employed as a Specialty Trainee in General Paediatrics on behalf of the Lead Employer Trust, at The Great North Children's Hospital.

Dr Lee is expected to take up the post of Consultant Paediatrician in April 2024.

1.5 An Appointments Committee was held on 1 March 2023 and interviewed 1 candidate for 1 Consultant Paediatrician with an interest in Diabetes post.

By unanimous resolution, the Committee was in favour of appointing Dr Islay Clark.

Dr Clark holds MBBS (The University of Hull and the University of York) 2008, and MRCPCH (UK) 2013. Dr Clark is currently employed as Locum Consultant Paediatrician at The Great North Children's Hospital.

Dr Clark is expected to take up the post of Consultant Paediatrician with an in interest in Diabetes in March 2023.

1.6 An Appointments Committee was held on 8 March 2023 and interviewed 1 candidate for 1 Consultant Plastic Surgeon post.

By unanimous resolution, the Committee was in favour of appointing Mr Iain Anderson.

Mr Anderson holds MBBS (University of Newcastle) 2012, MRCS (UK) 2015, and FRCS (Edinburgh) 2021. Mr Anderson is currently employed as a Microsurgical Reconstruction Fellow in Sarcoma and Lower Limb Trauma at Greater Glasgow and Clyde NHS Foundation Trust.

Mr Anderson is expected to take up the post of Consultant Plastic Surgeon in August 2023.

2. RECOMMENDATION

1.1 – 1.6 – For the Board to receive the above report.

Report of Andy Welch
Medical Director
23 March 2023

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 March 2023						
Title	Executive Chief Nurse (ECN) Report						
Report of	Maurya Cushlow, Executive Chief Nurse						
Prepared by	Ian Joy, Deputy Chief Nurse Diane Cree, Personal Assistant						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	This paper has been prepared to inform the Board of Directors of key issues, challenges, and information regarding the Executive Chief Nurse areas of responsibility. The content of this report outlines: • Spotlight on our Hospital at Night Team • Nurse and Midwifery Staffing update • Safeguarding Quarter 3 (Q3) update • Learning Disability Q3 update • Patient Experience Q3 update						
Recommendation	The Board of Directors is asked to note and discuss the content of this report.						
Links to Strategic Objectives	• Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. • We will be an effective partner, developing and delivering integrated care and playing our part in local, national and international programmes. • Being outstanding, now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☐	☒	☐	☐
Impact detail	Putting patients first and providing care of highest standard.						
Reports previously considered by	The ECN Update is a regular comprehensive report bringing together a range of issues to the Trust Board.						

EXECUTIVE CHIEF NURSE REPORT

EXECUTIVE SUMMARY

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

Section 1:

This month's 'Spotlight' section outlines the work of our Hospital at Night Team Nurse Practitioners.

The team is made up of 16 Nurse Practitioners who, working alongside our medical teams, provide a pivotal role in the safe functioning of the Royal Victoria Infirmary (RVI) and Freeman Hospital out of hours. The team was introduced as part of an NHS initiative to ensure optimum patient safety during the "out of hours" period when medical cover had reduced following implementation of the European Working Time Directive. The team have now been in place for 15 years and we have recently taken the opportunity to recognise and celebrate the excellent work of this safety critical team since its inception.

The report contains and overview of the role of the Nurse Practitioners and the service they provide out of hours. The following key points are noted:

- The practitioners are highly skilled and are supported in developing competence and confidence through formal education and competency sign off and the development of skills in practice through mentorship and supervision. The individual team members have substantial shadowing prior to practicing independently and work as a collective and supportive team during clinical shifts.
- The majority of Hospital at Night Nurse Practitioners are Independent Nurse Prescribers, with newly appointed practitioners due to complete the training. This is necessary as prescribing remains a significant competency of the role with 27% of all calls received by the Team relating to prescribing requests.
- The Hospital at Night Team is co-ordinated by a nurse practitioner within each team. The wards call the nurse practitioner as the first point of contact with any patient concerns. This prevents the junior medical staff having to take numerous calls whilst simultaneously reviewing patients. The nurse practitioner triages all calls and either manages them directly or if required, passes them on to the most appropriate member of the team. This ensures the patient needs are met by the right person at the right time and includes escalation to critical care outreach, on call physiotherapists and senior medical professionals.
- The service is regularly audited to ensure demand is understood and the practitioner role in practice is reviewed when required. A recent audit of one month demonstrated that the team received over 4,500 calls, responded to over 350 deterioration alert calls – of which 100% were appropriately documented by the Nurse Practitioners, and prescribed over 1,300 medications. The role is a safety critical function out of hours.

The team are extremely well respected by all staff and regularly receive compliments and have recently been nominated for personal touch awards and Greatix by both patients and staff.

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. This has been recently reviewed and agreed by the Executive Chief Nurse Team. 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:

- It is noted that three wards have required high-level support over the last two months. All three wards have action plans in place, overseen by the Nurse Staffing and Clinical Outcomes Group and overseen by the Executive Chief Nurse Team. An overview of the three wards including current factors influencing the need for high level support and current performance have been discussed and presented at the Trust's Quality Committee for scrutiny and oversight.
- Where beds have been closed due to staffing concerns, weekly documented review with the Executive Chief Nurse Team remains in place and will continue until all commissioned bed capacity is safely opened.
- Red flags generated within the SafeCare module by the nursing staff in conjunction with professional judgement have provided valuable triangulation of data alongside DATIX reports. These alerts are responded to promptly by members of the Senior Nursing Team directly with the ward staff and the Matrons.
- Red flags reported in wards are reviewed in the Nurse Staffing and Clinical Outcomes Group:
    - January meeting: (December red flags) 86 flags
    - February meeting: (January red flags) 47 flags
- All DATIX reports reviewed were graded no harm, low/minor or moderate. In the last quarter the number of DATIX submitted were:
    - December 36
    - January 15
    - February 5

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

- The current total Registered Nursing and Midwifery workforce combined turnover is 10.05%. This is based on Month 10 data and demonstrates a reduction from 12.7% previously reported. Its compares favourably with the national median of 13.05% and improving retention remains a key priority.
- The Registered Nurse (RN) vacancy rate is 5.3% based on the financial ledger at Month 10 and relates to current substantive staff in post. This is a favourable position and is slightly below the March 2022 vacancy rate of 5.9%. It does not include those nurses currently in the recruitment process, where there is a pipeline of 99 (head count) staff across adult and paediatrics. The figure also does not include International Recruits due to be deployed.
- Since June 2022 we have seen the arrival of 252 internationally educated nurses which includes 24 paediatric nurses and four midwives. There are monthly deployments planned up to May 2023 with a current pipeline of 47 nurses and more interview dates booked.

Section 3: Safeguarding Quarter 3 (Q3)

Section 3 of the report provides a Q3 summary update of safeguarding activity throughout the Trust and includes references to developments in practice as well as an overview of national practice developments and the Trust's compliance with these recommendations.

Safeguarding activity for Q3 evidences the following key high-level points:

- In adult safeguarding activity remains relatively static compared to the previous two quarters with activity levels remaining above those prior to the pandemic. Case complexity remains high, requiring close work with the Mental Capacity Act (MCA) Lead Practitioner and legal services.
- In children's safeguarding, it is noted that the Trust has continued to see an increase in overall activity from 2019/20 (pre-pandemic period) and a small increase in referrals for Q3 compared to 2021/22. There has been a marked increase in gang related activity and incidents of knife crime (including carrying but not using knives) this quarter. This has been seen particularly in those groups of children where possible exploitation is a risk factor (children in care/those who go missing). Work continues to raise awareness around these issues both with ongoing work with our Emergency Department (ED) colleagues and throughout training and supervision, working closely with our safeguarding partners to monitor this.
- In Q3 there has been an increase in the numbers of urgent Deprivation of Liberty applications (DoLS) overseen by the MCA Lead Practitioner. It is positive to see this increase in referrals as it ensures patients are appropriately cared for in line with the Mental Health Act.

The compliance relating to Safeguarding training continues to be closely monitored. Compliance with Level 3 Safeguarding Children stands at 73% and Level 3 Adults at 76% which is lower than the Trust expected standard and remains a concern. A number of actions are in place to improve compliance with staff being provided both face to face training and eLearning to maximise the flexibility in training options. The impact of actions is overseen and monitored by the Safeguarding Committee.

Recent investment has been agreed into the Safeguarding Teams on the back of a workforce review and recruitment is in progress with a number of posts appointed to with some staff in post.

Section 4: Learning Disability Q3

This section of the report provides a Q3 summary update regarding the work of the Learning Disabilities Liaison Team. The team continues to develop practice to improve care for people with Learning Disabilities, building on the existing infrastructure and the dedicated expertise of the Learning Disability Liaison Team.

In December 2021, the Care Quality Commission (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 Learning Disability team were included in this focussed inspection, and a specific workstream has been established to ensure recommendations are implemented in practice. This will include a focus on the documentation and evidencing of reasonable adjustments in practice. The detailed CQC inspection report is presented separately to the Board of Directors as item A6.

In the last quarter the team have received 737 referrals, an increase of 50 from Q2. The Learning Disability Team currently have several highly complex cases, requiring support from the MCA Lead Practitioner and legal services. There have been 288 inpatients and 297 Accident & Emergency (A&E) attendances in Q3.

The report contains an overview of the recent national discussions regarding Learning Disability training for all staff. Recently, the Trust has launched the Diamond Standards which is a regional eLearning education package for staff regarding Learning Disabilities and reasonable adjustments and has been mandated for all clinical and patient facing staff.

Section 5: Patient Experience Q3

The report contains a Q3 summary of the work of the Patient Experience team.

The Trust has opened 144 formal complaints in Q3, which is a decrease of 2% from the previous quarter. The Trust has received on average 45 formal complaints per month, which is an 2% decrease from the previous year where the average was 46 complaints per month.

Up to the end of December 2022, the highest number of complaints are with the Medicine directorate with 61 complaints. The lowest number are with the Dental directorate with five complaints.

Of the 144 complaints opened in this quarter, 20% had a primary concern with regards to communication. This further breaks down into sub-subjects; communication failure with patient is the most common issue (n13), communication with relatives or carers (n6), incorrect information given and Communication with GP (n2), access to interpreting services, patient not listened to, breakdown between departments, breaking bad news, conflicting information, and breakdown regarding appointments (n1).

Included within the report is an overview of national maternity survey published by the CQC on 11 January 2023. The survey took place in February 2022 and asked women about their experiences of care at three different stages of their maternity journey, antenatal care, labour and birth and postnatal care. 247 women who accessed maternity care at the Royal Victoria Infirmary took part.

Those who responded to the survey said they were confident in the midwife or midwifery team they saw and that they were treated with respect and dignity.

Results show maternity services at Newcastle Hospitals were rated much better than most trusts for **5** questions, better than most trusts for **22** questions, somewhat better than most trusts for **5** questions. Results were about the same as other trusts for **19** questions.

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

RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
23 March 2023

EXECUTIVE CHIEF NURSE REPORT

1. SPOTLIGHT

The Hospital Night team is made up of 16 Nurse Practitioners who, working alongside our medical teams, provide a pivotal role in the safe functioning of the Royal Victoria Infirmary (RVI) and Freeman Hospital out of hours. The team was introduced as part of an NHS initiative to ensure optimum patient safety during the "out of hours" period when medical cover had reduced following implementation of the European Working Time Directive. The team has just celebrated fifteen years of practice this year.

1.1 The Hospital at Night Team

Since the inception of the Hospital at Night team the service has continued to expand and the 16 practitioners now cover around 1,000 beds, split into five teams. The Nurse Practitioners bring differing experience to the team ranging from Renal Medicine, Intensive Care, Medical Education, Medical Admissions, High Dependency and Sepsis Management expertise. The teams provide care overnight for Freeman Surgery (including orthopaedics, ENT, vascular and urology), Northern Centre for Cancer Care, Neurosurgery and Orthopaedic Services at the RVI all medical specialities at both RVI and FH sites.

The practitioners are highly skilled and are supported in developing competence and confidence through formal education and competency sign off and the development of skills in practice through mentorship and supervision. The individual team members have substantial shadowing prior to practicing independently and work as a collective and supportive team during clinical shifts.

The majority of Hospital at Night Nurse Practitioners are Independent Nurse Prescribers, with newly appointed practitioners due to complete the training. This is necessary as prescribing remains a significant competency of the role with 27% of all calls received by the Team relating to prescribing requests.

1.2 The Role of the Hospital at Night Practitioner

The Hospital at Night Team is co-ordinated by nurse practitioner within each team. The wards call the nurse practitioner as the first point of contact with any patient concerns. This prevents the junior medical staff having to take numerous calls whilst simultaneously reviewing patients. The nurse practitioner triages all calls and either manages them directly or if required, passes them on to the most appropriate member of the team. This ensures the patient needs are met by the right person at the right time and includes escalation to critical care outreach, on call physiotherapists and senior medical professionals.

As a contact within the hospital at night team, the practitioner is also a resource for other team members for supervision and support as well as providing essential professional advice and support to ward and department based teams out of hours. It is therefore

important that the practitioner is not just clinically competent but has the breadth of knowledge and expertise to provide senior nursing professional advice.

The practitioners also undertake audit and improvement work, supporting the improvement of clinical standards in practice.

1.3 Nurse Practitioner Demand

The service is regularly audited to ensure demand is understood and the practitioner role in practice is reviewed when required. A recent audit of one month demonstrated that the team received over 4,500 calls, responded to over 350 deterioration alert calls – of which 100% were appropriately documented by the Nurse Practitioners, and prescribed over 1,300 medications. The role is a safety critical function out of hours.

The Nurse Practitioners are also required to support staff members with regards to their health and wellbeing. As mental health first aiders they offer staff impartial support - listening and offering guidance.

The team are extremely well respected by all staff and regularly receive compliments and have recently been nominated for personal touch awards and Greatix by both patients and staff.

1.4 Recognising and Celebrating 15 years

It is important to recognise and celebrate 15 years of excellent work by this important team. Over the last two months via our Nursing, Midwifery and Allied Health Professionals website, twitter zone and intranet, we have been able to share the work of the team. As part of this we have been able to share quotes from staff across the Trust, thanking the team for their hard work, dedication and innovation.

It is clear the team have paved the way for this role over the last 15 years and will continue to do so in the years ahead.

2. NURSING AND MIDWIFERY STAFFING UPDATE

2.1 Staffing Escalation

The Trust continues to apply the Nursing and Midwifery Safe Staffing guidelines to ensure a robust process for safe staffing escalation and governance, as reported to the board in January.

In December 2022 and January 2023 there was increased nursing and midwifery sickness absence reaching 6.57% in January. This resulted in significant challenges in maintaining safe staffing across all clinical areas and therefore 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.

This has recently been reviewed by the Executive Chief Nurse Team and it has been agreed to remain in Level 2 escalation until the de-escalation criteria has been met.

Additional actions continue which include:

- A daily staffing review of planned, actual and required demand by the corporate nursing team reported to the Executive and Deputy Chief Nurse daily and into the operations command centre.
- SafeCare (daily staffing deployment tool) continues to be utilised to deploy staff across directorates based on need.
- Increased senior nursing cover at weekends with a Matron on site.
- Daily contact with staff bank to co-ordinate deployment based on need.

Despite all mitigations remaining in place, the increased requirement for enhanced care continues and it is recognised that this cannot be met on all occasions, in addition to acuity and dependency remaining high across all service areas.

Staffing and bed capacity remains challenging across the organisation with weekly support in place for clinical areas where staffing levels continue to impact on the ability to maintain commissioned bed activity. Whilst a framework for safer staffing is in place, it is acknowledged that the current staffing situation impacts on staff well-being with resources and support available which are promoted at an individual, ward and Trust level.

2.2 Acuity and Dependency Scoring

In line with national guidance, the Safer Nursing Care Tool (SNCT) data capture for this six-month period commenced in March and for the first time will also include Emergency Departments for adults and paediatrics with Community District Nursing commencing in April. The outputs of this will be reported to the Trust Board in May.

The validation of dependency scoring is an ongoing process across all areas to maintain data assurance. In particular there has been training for those in leadership roles emphasising the importance of the validation process through face-to-face learning supported by reference videos and online packages to promote the tool and its benefits.

2.3 Nurse Staffing and Clinical Outcomes

It is important, particularly with the current level of staffing escalation, to ensure monitoring of clinical outcomes and nurse sensitive indictors are triangulated with safer staffing metrics. The Nurse Staffing and Clinical Outcomes Group continues to meet monthly, reviewing all wards where there is a staffing or clinical outcome concern based on identified risk and professional judgement. The wards reviewed are classified as requiring low level, medium level or high-level support. 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 three months:

Month	No. of Wards Reviewed	Directorate	Monitor	Low Level Support	Medium Level Support	High Level Support	No Further Support
December	13	x1 Musculoskeletal Services x8 Internal Medicine x1 Cardiothoracic Services x2 Urology and Renal Services x1 Children's Services	5	1	6	1	0
January	14	x1 Musculoskeletal Services x4 Internal Medicine x2 Cardiothoracic Services x2 Urology and Renal Services x5 Children's Services	4	2	5	3	0
February	16	x1 Musculoskeletal Services x6 Internal Medicine x2 Cardiothoracic Services x2 Urology and Renal Services x5 Children's Services	5	2	6	3	0

- It is noted that three wards have required high-level support over the last two months. All three wards have action plans in place, overseen by the Nurse Staffing and Clinical Outcomes group and overseen by the Executive Chief Nurse Team. An overview of the three wards including current factors influencing the need for high level support and current performance have been discussed and presented at the Trust Quality Committee.
- Where beds have been closed due to staffing concerns, a weekly documented review with the Executive Chief Nurse Team remains in place and will continue until all commissioned bed capacity is safely opened.
- DATIX reports for staffing are reviewed and feedback provided to encourage escalation of issues appropriately. Themes are analysed to promote learning and for audit purposes.
- Red flags generated within the SafeCare module by the nursing staff in conjunction with professional judgement have provided valuable triangulation of data alongside DATIX reports. These alerts are responded to promptly by members of the Senior Nursing Team directly with the ward staff and the Matrons.
- Red flags reported in wards reviewed in the Nurse Staffing and Clinical Outcomes Group:
    - January meeting: (December red flags) 86 flags
    - February meeting: (January red flags) 47 flags
- All DATIX reports reviewed were graded no harm, low/minor or moderate. In the last quarter the number of DATIX submitted were:
    - December 36
    - January 15
    - February 5

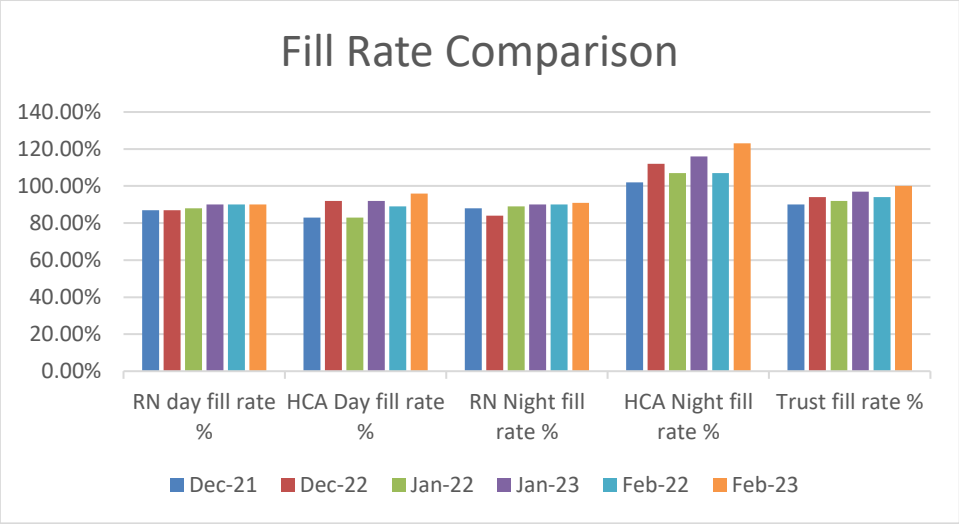
- Whilst the group provides high-level monitoring, oversight and assurance there continues to be a robust leadership and management framework led by the Matron team.

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 %
December 22	7.9	87%	92%	84%	112%	94%
January 23	7.9	90%	92%	90%	116%	97%
February 23	8.1	90%	96%	91%	123%	100%

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.



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 28 adult 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 2022. 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 10.05%. This is based on Month 10 data and demonstrates a reduction from 12.7% previously reported. Its compares favourably with the national median of 13.05% and improving retention remains a key priority.

The centralised and bespoke recruitment for Band 5 registered nurses continues with the next interviews taking place in March with a planned careers open day on 18th March 2023 to attract both new registrants qualifying in September and experienced staff. The Band 5 RN vacancy rate is 5.3% based on the financial ledger at Month 10 and relates to current substantive staff in post. This is a favourable position and is slightly below the March 2022 vacancy rate of 5.9%. It does not include those nurses currently in the recruitment process, where there is a pipeline of 99 (head count) staff across adult and paediatrics. Oversight and analysis of the staffing data is maintained to identify further requirements in the short to medium term and longer-term workforce strategy.

2.5.2 International Recruitment

Since June 2022 we have seen the arrival of 252 internationally educated nurses which includes 24 paediatric nurses and four midwives. This is in line with the ambitious target of recruiting 300 adult/paediatric nurses and five midwives. There are monthly deployments planned up to May 2023 with a current pipeline of 47 nurses and more interview dates booked. The deployments run beyond the end of this financial year, with agreement from NHSE due to challenges recognised nationally in identifying suitable rental accommodation for our new staff.

The Trust has submitted a successful bid to NHS England for additional funding to support a further 150 internationally educated nurses into 2023/24 financial year to be deployed by the end of November 2023. Added to the NSHE funded deployment the Trust will recruit a further 74 nurses between December 2023 and March 2024 to effectively manage the RN turnover. The proposal for future international recruitment has also been agreed by the Executive team. The proposal to recruit 224 in the next financial year will be robustly managed by the International Recruitment team with a deployment and training schedule arranged to meet the targets. The challenges encountered with securing rental accommodation will be avoided as a contract has been agreed for student accommodation in the city centre. This provides quality accommodation whilst allowing the nurses an opportunity to socialise and for peer support during their induction and OSCE preparation.

2.5.3 Healthcare Support Workers

The Trust continues to be part of the national Healthcare Support Worker (HCSW) programme which has a target achieve a zero-vacancy HCSW position. Due to staff turnover and service innovations, maintaining a zero position is challenging and so retention work including career conversations is a priority along with proactive recruitment. There are currently 80 (headcount) staff in pipeline. The 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 high-quality induction and training. The programme of education and training delivered by the Health Care Academy will be reviewed and updated in April to reflect the changing needs of our patients, to include those requiring mental health support.

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 based at the Beacon Centre in the west of the city, utilising innovative recruitment solutions, working with community partners with the aim of having a representative workforce which impacts health inequalities.

Following presentation at the regional NHSE HCSW Roadshow showcasing our HCSW Celebration week, we have provided information for a case study to be shared on Future NHS Collaboration Platform.

3. SAFEGUARDING Q3 UPDATE

This summary provides a Q3 update of safeguarding activity throughout the Trust and includes references to developments in practice as well as an overview of national practice developments and the Trust's compliance with these recommendations.

Safeguarding activity for Q3 evidences the following key high-level points:

- In adult safeguarding activity remains relatively static compared to the previous two quarters with activity levels remaining above those prior to the pandemic. Case complexity remains high, requiring close work with the MCA Lead Practitioner and legal services.
- In children's safeguarding, it is noted that the Trust has continued to see the increase in overall activity from 2019/20 (pre-pandemic period) and a small increase in referrals for Q3 compared to 2021/22. There has been a marked increase in gang related activity and incidents of knife crime (including carrying but not using knives) this quarter. This has been seen particularly in those groups of children where possible exploitation is a risk factor (children in care/those who go missing). Work continues to raise awareness around these issues both with ongoing work with our ED colleagues and throughout training and supervision, working closely with our safeguarding partners to monitor this
- In Q3 there has been an increase in the numbers of urgent Deprivation of Liberty applications (DoLS) overseen by the MCA Lead Practitioner. It is positive to see this increase in referrals as it ensures are appropriately cared for in line with the Mental Health Act.

The compliance relating to Safeguarding training continues to be closely monitored. Compliance with Level 3 Safeguarding Children stands at 73% and Level 3 Adults at 76% which is lower than the Trust expected standard and remains a concern. A number of actions are in place to improve compliance with staff being provided both face to face training and eLearning to maximise the flexibility in training options.

Recent investment has been agreed into the Safeguarding Teams on the back of a workforce review and recruitment is in progress with a number of posts appointed to with some staff in post.

4. LEARNING DISABILITY QUARTER 3 UPDATE

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

In 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 Learning Disability team were included in this focussed inspection, and a specific workstream has been established to ensure recommendations are implemented in practice. This will include a focus on the documentation and evidencing of reasonable adjustments in practice.

In the last quarter the team have received 737 referrals, an increase of 50 from Q2. The Learning Disability Team currently have several highly complex cases, requiring support from the MCA Lead Practitioner and legal services. There have been 288 inpatients and 297 A&E attendances in Q3.

The number of patients with complex needs that are referred to the learning disability team remain significant. The liaison team continue to support the clinical teams in planning and delivering safe and appropriate admission, inpatient care and discharge planning. Often this planning requires the support of the Trust MCA Lead, Safeguarding and the Trust legal teams in that process. Following the workforce review last year, investment has been agreed into the Learning Disability Liaison Team and the team are currently recruiting. These posts are welcome additions to the team offering a different skill set.

Consideration for how reasonable adjustments are captured in patient records will be a significant piece of work moving forward. The team are working closely with the digital team and piloting a potential solution.

Nationally, The Oliver McGowan training, in part has now been launched. Oliver was a young man whose death highlighted the need for health and social care staff to have better skills, knowledge and understanding of the needs for autistic people and people with a learning disability. The training was developed because of *Right to be Heard* the Government's response to the consultation on mandatory training on learning disability and autism for health and social care staff. The training requires both an on-line and in person element.

Health Education England (HEE) is working with partners to arrange trainer's training that will prepare people with a learning disability and autistic people to co-deliver the online interactive and face to face sessions of The Oliver McGowan Mandatory Training. The estimated numbers of staff for a Trust our size and the time it will take to complete is

currently being worked through and further discussion is required regarding its implementation.

Recently, the Trust has launched the Diamond Standards which is a regional eLearning education package for staff regarding Learning Disabilities and reasonable adjustments. This has been mandated for all clinical and patient facing staff and will remain in place until a long-term strategy has been agreed regarding which training and education packages to implement in practice.

5. PATIENT EXPERIENCE Q3 UPDATE

5.1 Complaints Activity

The Trust has opened 144 formal complaints in Q3, which is a decrease of 2% from the previous quarter. The Trust has received on average 45 formal complaints per month, which is an 2% decrease from the previous year where the average was 46 complaints per month.

Up to the end of December 2022, the highest number of complaints are with the Medicine directorate with 61 complaints. The lowest number are with the Dental directorate with five complaints.

Of the 144 complaints opened in this quarter, 20% had a primary concern with regards to communication. This further breaks down into sub-subjects; communication failure with patient is the most common issue (n13), communication with relatives or carers (n6), incorrect information given and Communication with GP (n2), access to interpreting services, patient not listened to, breakdown between departments, breaking bad news, conflicting information, and breakdown regarding appointments (n1).

From the 126 closed complaints in Q3, 22 complaints were upheld, 23 complaints were partially upheld and 81 were not upheld. Women's Services, Children's and Medicine account for 50% of the upheld complaints for this period. The Communication primary subject category accounts for 36% of complaints upheld in the Trust across 7 directorates.

5.2 PALS

924 issues have been raised with PALS over this period. This compares to 833 in the previous quarter, which is an 11% increase and 877 in the same quarter 2021-22, a 5.5% increase. 48 enquiries were from carers. There has been an increase in the number of enquiries regarding access to medical records 31 this quarter compared to 15 in Q2.

5.3 NHS Choices

The Trust received 34 items of feedback with most comments being in relation to Dental (n7) and Medicine (n5) directorates. The Trust received the maximum score rating of five stars from 82% (n28) of comments received.

5.4 National Adult Maternity Survey 2022 – Care Quality Commission (CQC) Benchmark Data

The CQC published results of its national maternity survey on 11 January 2023. The survey took place in February 2022 and asked women about their experiences of care at three different stages of their maternity journey: antenatal care, labour and birth and postnatal care. 247 women who accessed maternity care at the Royal Victoria Infirmary took part.

Those who responded to the survey said they were confident in the midwife or midwifery team they saw and that they were treated with respect and dignity.

Results show maternity services at Newcastle Hospitals were rated much better than most trusts for **5** questions, better than most trusts for **22** questions, somewhat better than most trusts for **5** questions. Results were about the same as other trusts for **19** questions.

The Trust was rated as:

- 'Much better' than others at listening to women and taking any concerns raised seriously.
- 'Much better' than others at providing help or advice to women about feeding their baby in the first six weeks after giving birth.
- 'Better' than others at providing information about recovery and any changes in mental health that might be experienced after giving birth.
- 'Better' than others at providing help when needed.
- 'Somewhat better' than others in asking about mental health, providing advice about a baby's health and progress and making sure women were involved in decisions about their care during labour and birth.

This is the ninth survey of its kind that CQC has carried out to help Trusts better understand the experiences of women using maternity services and involved 121 NHS acute Trusts. The results are used by CQC as part of its wider monitoring of hospital services and will feed into the regulators current maternity inspection programme.

5.5 NHS Family and Friends Test

The latest published FFT data shows that there were 1,847 responses from the Trust in November 2022 (published January 2023). This data remains encouraging in that 96% of people who responded to the inpatient and day case survey and 98% of outpatients would recommend the service to family and friends.

The patient experience team continue to work with the directorate teams and the Patient Experience Monitoring Group to review the results, identify areas for improvement and opportunities to increase the number of responses, particularly in areas who get fewer responses such as the Emergency Department and the Maternity wards.

5.6 Advising on the Patient Experience (APEX)

The APEX group have met and discussed the following:

- The Nurse Consultant for Vulnerable Older Adults who presented the Dementia Care Plan for 2022-2026 and priorities for patient care and ongoing work to ensure wards are dementia friendly.
- The group also heard about the potential plans for the introduction of a smart-phone app (Good Maps Explore) which would provide an indoor digital wayfinding system. If implemented the Trust would be the first in the UK to introduce this although it is used in healthcare services in the United States. APEX felt the availability of the app would be beneficial to patients and visitors, especially those with individual needs.
- Apex have also contributed valuable ideas to the re-development of the shop for patients, visitors and staff on the main concourse at the Freeman which is due to be refurbished during 2023.
- Group members have also supported the idea of allowing the charging of mobile phone devices within the Emergency Department as this is often a query from people attending the Department and felt it would improve the experience whilst freeing up staff time.

5.7 Maternity voice Partnerships (MVP)/Connie

MVP hosted a stand at the annual Teakisi 'Women Talk' event which was a valuable opportunity to forge new connections and build on existing relationships. The theme of the event was 'inclusive communities for all' and provided important insight into the challenges faced by communities.

MVP online meeting took place with an emphasis on the 'fourth trimester' with a particular focus on perinatal mental health. The meeting catalysed some excellent discussion around service user experiences in the postnatal period and was a valuable opportunity to raise awareness of perinatal mental health in the postnatal period, the challenges often experienced by women, and provided the opportunity to sign post service users to available information and support.

2023 will see emphasis on MVP reaching the four corners of the city and the demographics represented within each area with quarterly meetings held in the North, East, West and Central community hubs. Interim listening events are also planned which will target the most socially and economically deprived communities in our city, alongside the continuation of monthly drop ins at the Angelou Centre.

The Connie E-Midwife service has maintained a steady presence on social media providing responsive service updates around the adjustments to service provision in light of acuity pressures, strike action and technical issues. Connie has been instrumental in information sharing regarding the introduction of Badgernet to Maternity, all of which have been gratefully received by her following.

Pregnancy and Infant Loss Week was marked with a series of features highlighting the impact of pregnancy loss and the important work of our bereavement team and the

charities that support families and their care givers. The week culminated in the wave of light remembering all those touched by pregnancy and infant loss.

In 2023, aligned with MVP priorities and workstreams, Connie will continue to seek new and innovative ways of reaching service users and providing a responsive service that equips and informs women with what they want to know and celebrates all that is good about Newcastle Hospitals Maternity Services.

5.8 Young Persons Advisory Group Northeast (YPAG NE)

During this quarter, three PPI meetings took place, reviewing five research projects and three quality improvement projects. YPAGne have welcomed 16 new people to the group.

The Great North Youth Forum have reviewed three quality improvement projects and continue to work on the youth led project looking at exam access requirements for young people with long term conditions.

5.9 Equality, Diversity, and Inclusion (EDI)

Interpretation and Translation Contract Tender

In November 2022 suppliers on the NOECPC and the NEPO procurement frameworks were invited to bid for the spoken language and British Sign Language contract, with the current contract with The Big Word ending in April 2023. All suppliers were asked to provide detailed information against seven areas for the quality domain, including:

- Implementation of contract
- Service delivery
- Service improvements and efficiencies
- Management information and reports
- Social values
- Business Contingency and continuity
- Booking platform

In January 2023, all bidders were invited to present their service(s) and booking platform to the evaluation panel in-person. After the presentations, the evaluation panel came to an agreed score for all areas within the quality domain. The scoring for the pricing domain was done using a fixed algorithm for the costings provided by each supplier.

It has been agreed the Trust will begin to work with the new provider; Language Empire and we look forward to embedding new processes and systems in the new financial year.

Deaflink Health Navigator Service

The BSL Navigator Service for Deaf patients, which is delivered by the local charity Deaflink, is funded jointly by NUTH, CNTW and Northumbria Healthcare from each Trust's respective hospital charity until the end of FY 22/23.

The pilot service has demonstrated the need to continue with real added value to Deaf patients. The service has had over 400 referrals to date and has supported Deaf patients and advocated for them when they have otherwise struggled with current hospital systems and communications. The Health Navigator service has also supported NUTH staff and services in making reasonable adjustments when they have cared for Deaf patients.

To continue the funding for this service, a charitable application has been submitted for another year and both CNTW and Northumbria Healthcare have also committed to seeking equivalent funding. In addition, the newly appointed Director of Health Equity at the ICB will be joining the monthly steering group to support a sustainable business case to the ICS that could also incorporate primary care.

6. RECOMMENDATION

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

Report of Maurya Cushlow
Executive Chief Nurse
21 March 2023

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 March 2023		
Title	Ockenden Update Report		
Report of	Maurya Cushlow, Executive Chief Nurse		
Prepared by	Jane Anderson, Director of Midwifery Jeanette Allan, Senior Risk Management Midwife		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	The Ockenden Report published on 30 March 2022, is the final report of an inquiry commissioned by the former Secretary of State, Jeremy Hunt, who requested an 'independent review of the quality of investigations and implementation of their recommendations of a number of alleged avoidable neonatal and maternal deaths, and harm, at The Shrewsbury and Telford NHS Trust'. The final report can be found at: https://www.gov.uk/government/publications/final-report-ofthe-ockenden-review The interim report published on 10 December 2020 outlined a number of Immediate and Essential Actions for providers of maternity services, and the Trust's progress against these have been systematically monitored and reported to members of the Trust Board since that time. The purpose of this paper is to provide members of the Trust Board with an overview and significance of the findings of the final Ockenden report published in March 2022. Actions for the Trust following internal benchmarking have been updated to reflect the external feedback from the Regional Maternity Insight Visit. An update on progress against both the interim and final report recommendations is provided. 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 the Trust has commenced a focus on culture and organisational behaviour through a schedule of workforce engagement whereby the voices of staff can be listened to and heard. 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 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.		

<table>
<tr><td>Recommendation</td><td colspan="7">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.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="7">Putting patients at the heart of everything we do. Providing care of the highest standards focussing on safety and quality.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Reputation</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☒</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Impact detail</td><td colspan="7">Detailed within the main body of the report.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="7">Previous report presented to members of the Trust Board on 17 January 2023.</td></tr>
</table>

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 remain four 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 ninety-two 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 which going forward can be provided through the newly implemented electronic patient record.

Section 4.0: Reports on the High-Level Action Plan (Appendix 3), combining the interim and final Ockenden reports, a phased approach has been taken to reporting in view of the substantial number of recommendations. The seven 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 resulting in two recommendations remaining non-compliant, three partially compliant and two fully compliant.

4.1 Details the two remaining non-compliant recommendations and associated actions from the final report:

- Calculating a local uplift for midwifery staffing.
- Implementing and monitoring change in practice as a result of a Serious Incident (SI).

4.2 Reports on the remaining three recommendations which are now graded partially compliant:

- Labour Ward Coordinators attending role specific Maternity System endorsed training course.
- Conflict of Clinical Opinion Escalation Guidance.
- Newcastle Birthing Centre Completion of Yearly Operational Risk Assessment.

It is anticipated that all three of these outstanding actions will be completed and reported as such in the update provided to the Trust Board in May 2023.

4.3 Highlights the Trust's achievement for the following two recommendations:

- Maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.
- Complaint's themes and trends must be monitored by the maternity governance team.

4.4: The first group of eight from a total of thirty-two 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. The final group of partially compliant recommendations were presented to the Trust Board in January 2023.

This paper presents relevant updates for all previously reported partially compliant recommendations as indicated within the High-level Action Plan (Appendix 3). There remain fifteen partially compliant recommendations from this group and notable progress is reported against the following, details of which are presented within this paper:

- IEA 10 (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.
- IEA 12 Postnatal Care.
- IEA 13 Bereavement Care.

4.5: As previously reported to the Trust Board one partially compliant recommendation has been regraded to non-compliant due to the additional work which is required to support the provision of complex antenatal care for women with diabetes. The Trust is not yet aligned to NICE guidance, work is near completion for updating local guidance and work is ongoing toward resourcing the diabetic service with a dietician. It is anticipated that dietetic support will be in place by July 2023.

Overall progress to date in relation to the Ockenden recommendations is detailed in the amalgamated Action Plan (Appendix 2) as summarised in the Table 1 below.

Table 1

	Nov 22	Nov 22	Jan 23	Jan 23	March 23	March 23
Total Number of Recommendations (interim and final report combined)	97	100%	98	100%	98	100%
Non-applicable	12	n/a	12	n/a	12	n/a
Compliant	46	54.1%	56	65.1%	64	74.4%
Partial Compliance	36	41.4%	27	31.4%	20	23.2%
Non-compliant	3	3.5%	3	3.5%	2	2.3%

Section 5.0: Reports on the implementation of the electronic patient record; BadgerNet was successfully implemented on 10th January. Work continues to ensure that staff are supported to use BadgerNet, and to ensure the system is continuously embedded both within the maternity service and to wider internal and external stakeholders. Work will focus on fully using the electronic patient record for reporting and auditing purposes and updates will be provided in future papers to the Trust Board.

Section 6.0: Reports on reconfigurations of workforce which have taken place and specifically in relation to the impact on the Newcastle Birthing Centre (NBC). Due to elevated levels of activity and acuity across the maternity service which have coincided with staffing pressures, in preserving safe services for all the Directorate have been required to make intermittent temporary closures of the NBC, redeploying staff to the Delivery Suite and Postnatal Services.

The Directorate performed a Quality Impact Assessment (QIA) at the time of closure and identified no impact to patient safety and/or clinical effectiveness. The QIA has identified that patient experience is likely to have been affected due to the environmental impact on the experience of service users. Due to the constraints of the estate and in safeguarding all patients, the service is unable to offer overnight stays to partners on the postnatal ward, contrary to what is possible on the Birthing Centre.

Section 7.0: Reference is made with regard to 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 four key areas for system-wide action.

7.1: Those areas of the report which relate to culture and organisational behaviour are key to ensuring that maternity services are safe. It is essential that providers act and accept the essence of Kirkup's report on 'reading signals amongst the noise,' and that this is brought clearly into focus, whilst simultaneously progressing the detail of the must do recommendations of Ockenden.

Work to this effect has commenced starting with a schedule of workforce engagement whereby the voices of staff can be listened to and heard.

7.2: 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 (Clinical Negligence Scheme for Trusts/CNST) the Ockenden Report and the East Kent Report, into one set of standards for Maternity Services to report against.

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 May 2023.

RECOMMENDATIONS

The Trust Board is asked to:

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

OCKENDEN REPORT UPDATE

1. INTRODUCTION

This paper provides background information and an overview of the final Ockenden Report; Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust, published 30 March 2022, providing members of the Trust Board with an update on the Trust's position in relation to both the interim Ockenden Report, published in December 2020, and the final publication in March 2022.

As previously discussed, due to the substantial number of recommendations arising from the final publication, a phased approach has been taken in reporting to the Trust Board. All recommendations assessed as non or partially compliant have now been reported in detail since July 2022. This paper provides an update on progress and outstanding recommendations that continue to be worked on by the Directorate.

Also referenced for discussion is the national single set of maternity standards expected to be published in Spring 2023 by NHS England, the aim is to combine current standards and recommendations from the Maternity Incentive Scheme (Clinical Negligence Scheme for Trusts/CNST) Ockenden Report and East Kent Report into one set of reporting requirements for Maternity Services to report against. The findings from the current ongoing review of maternity services at The Nottingham University Hospitals Trust, chaired by Donna Ockenden, are 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 NHS England and Improvement (NHSE/I), the Immediate and Essential Actions complement and expand upon the Immediate and Essential Actions issued in the first Ockenden report.

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

3. NEWCASTLE HOSPITALS MATERNITY SERVICES ASSESSMENT AND ASSURANCE

3.1 Interim Report Update

Work continues toward Trust compliance for the Immediate and Essential Actions (IEAs) from the Interim Report (2020) that were evaluated by the Regional Maternity System Team insight visit in June 2022. As previously reported to the Trust Board, written feedback from the visit received in August 2022 regraded ten standards from 'compliant' to 'partially compliant' and these are detailed in Appendix 1, illustrating progress.

A key focus of the written feedback and regraded standards was the need for evidence to provide assurance of compliance. January's successful implementation of BadgerNet will provide greater quality assurance through accessible audit processes. A minimum time period of three-six months is now required to ensure that sufficient data is available within the BadgerNet system to enable audit and analysis. The Maternity service is currently revising the overall audit programme to strengthen quality assurance frameworks within the department.

Of note, the Regional Maternal Medicine Centre (MMC) have been working with BadgerNet developers to create a solution that will enable audit to demonstrate compliance of IEA4 'Managing Complex Pregnancies'. Referral pathways are established and embedded throughout all regional maternity units, all but one of these units uses BadgerNet. The MMC require a robust system to identify and audit MMC patients across the region to ensure those who should be referred are referred. The solution will integrate the MMC service specification categories within BadgerNet to ensure meaningful audit and data collection is available in demonstrating compliance. The MMC update to BadgerNet is scheduled for May 2023 and therefore subsequent auditing of this data is anticipated following a three-six month period thereafter.

As previously reported, 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). The MVP have provided feedback to the Trust following appraisal of the website. Work will commence following a further scoping exercise; website development is expected to progress throughout 2023-2024.

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

4. HIGH LEVEL ACTION PLAN

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

4.1: Outstanding Non-Compliant Final Report Recommendations

The two non-compliant recommendations from the final report which the Trust continues to work toward are:

- **(1.3) A locally calculated uplift of midwifery staff based on previous 3 years.**

The Trust has recently appointed to a non-substantive post of Senior Midwife (Workforce) to further support workforce planning within the Directorate. This post holder will support the Director of Midwifery in working towards innovative sustainable workforce strategies fit for the future direction of maternity services. As part of this work, a three-year review will be undertaken to include the increasing requirements in relation to speciality specific training, which will inform what is required regarding adequate uplift. Once completed, this will be presented to the Trust Board for consideration. In the interim, an over-recruitment agreement remains in place to partially mitigate any risk from a lower than required establishment uplift.

- **(5.4) Change in practice as a result of a Serious Incident (SI) to be seen within 6 months and audited to ensure a change has occurred**

Work is ongoing to strengthen the Maternity services audit programme which will include evidencing changes to practice as a result of a serious incident occurring. The six-month timescale remains challenging for all Serious Incidents due to that previously reported issue that those SIs are often also investigated by HSIB, whose reports and safety recommendations regularly fall outside the six-month timeframe. However, improvement work is in progress for those SIs that are within the remit of the Trust to investigate to enable regular audit in demonstrating a change in practice.

4.2: Progress for Non-Compliant Final Report Recommendations

The remaining three recommendations that are now graded partially compliant (from the original group of seven non-compliant) which the Trust continues to work toward are:

- **(1.7) Labour ward coordinators to attend Nationally Recognised Course (including advanced decision making, human factors, psychological safety etc)**

As previously reported, the newly developed course held by Teesside University and developed with the LMNS has commenced, and the first two of Newcastle's labour ward coordinators began the module in January 2023. Further training dates are awaiting upon which all midwives with responsibility for coordinating the labour ward will be allocated.

- **(3.1) Conflict of clinical opinion escalation policy**

The Newcastle upon Tyne Hospitals NHS Foundation Trust Maternity Conflict of Clinical Opinion policy is now written and awaiting ratification, confirmation of which will be made in the paper presented to the Trust Board in May 2023.

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

Newcastle's Birthing Centre (NBC) operational risk assessment is currently in development with members of the local leadership team working collaboratively with the national task and finish group. Once agreement has been made, this document will be ratified through the maternity governance assurance framework and an update provided to the Trust Board in future papers.

4.3: Compliance for original Non-Compliant Final Report Recommendations

Of note compliance has now been achieved for:

- **(5.6) All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.**

The MVP have had detailed oversight of the complaints process with greater understanding provided through meeting with the Head of Patient Experience. The MVP now have a link to the Maternity lead for Patient Experience to enable direct dialogue and discussion.

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

The Maternity Governance team now have a process for monitoring themes and trends from complaints alongside claims and serious incidents. The key themes arising from claims and serious incidents are captured and triangulated with those from complaints, discussed at Directorate Management meetings, and learning arising from this shared across the wider multi-professional team. Any changes to practice are subject to audit as described in 5.4 above.

4.4: Previously reported Partial Compliant recommendations:

There remain twelve partially compliant recommendations from the original group of thirty-two which the Trust continue to progress, and notable progress has been achieved for:

IEA 10 (10.5) Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.

The Newcastle upon Tyne Hospitals NHS Foundation Trust guidance for IOL has now been updated to reflect this recommendation. A process for the monitoring delays has now been implemented and this will be monitored by the Maternity Intrapartum Group, incorporating changes to practice and actions arising. High level oversight will be gained through a reporting mechanism to the Obstetric Governance Group.

IEA 12 Postnatal Care

Audits of postnatal care began in January 2023 in order to provide assurance that unwell women receive timely Consultant involvement in their' care, and readmissions are seen urgently if necessary or within 14 hours. The audits have required further development to ensure they are designed to provide robust and sufficient evidence/assurance of the recommendations. Reporting of postnatal audit outcomes has been revised to May 2023.

IEA 13 Bereavement Care

Newcastle have recently appointed to the specialist post of Bereavement Midwife to ensure high quality bereavement services in line with national standards, together with those

recommendations of Ockenden. This role will support both staff and service users in ensuring pathways meet with identified needs and that opportunity for service development and improvement is optimised into the future. Matters arising will be reported to the Trust Board by exception in future papers.

4.5: Complex care - Diabetes

As previously reported to the Trust Board, one partially compliant recommendation was regraded non-compliant as additional work was identified to support the provision of complex antenatal care for women with diabetes.

The Trust is not yet aligned to NICE guidance, work is near completion for updating local guidance and progress is being made towards resourcing the diabetic service with a dietician. It is anticipated that dietetic support will be in place by July 2023 and progress will be updated in future papers.

5. DIGITAL UPDATE

The Directorate successfully implemented the end-to-end electronic maternity patient record BadgerNet, on the revised 'go-live' date of 10th January. BadgerNet has been implemented in all other regional providers, with the exception of one, and will facilitate greater assurance for enhanced safety, managing complex pregnancies, assessing risk throughout pregnancy, supporting informed consent, and providing personalised care plans.

BadgerNet will also enable greater assurance processes through increased audit capability and, therefore, the Trust will more readily be able to evidence the quality-of-care provision. BadgerNet is fully aligned and compliant with national mandatory reporting systems. The staff have embraced this change and continued to be supported in the use of a new electronic platform. Service users have the ability to access their own notes through the App and benefit from the advanced features that this brings.

The Maternity service is now reporting key dashboard data sets from BadgerNet, and the Trust has been working with software providers CleverMed, to further develop the system for reporting and audit purposes, with particular focus for the Regional Maternal Medicine Centre (MMC). A system update is anticipated in May 2023 which will ensure MMC Patients can be regionally identified through the referral criteria that will be built into BadgerNet. This will create a robust system to identify and audit MMC patients across the region, ensuring those with complex needs who should be referred are referred. The solution will ensure meaningful audit and data collection is achieved to demonstrate compliance of 'Managing Complex Pregnancies' and auditing of this data is anticipated to follow a three-six month period following implementation.

6. WORKFORCE

Due to periods of increased activity and acuity across the maternity service throughout January and February, which have coincided with acute staffing pressures, in line with the

internal escalation plan the Directorate have been required to make intermittent temporary closures of the NBC, redeploying staff to the Delivery Suite and postnatal services.

In mitigating risk, the NBC was temporarily closed on five occasions between 14 January and 3 March 2023. Two of these occasions were for a period of twelve hours, one for twenty-four hours and one for thirty-six hours. During the half-term school holiday, additional staffing pressures, together with increased levels of activity were experienced, resulting in the Birthing Centre closing for seven continuous days.

Against a backdrop of nine hundred and fifty births in this period of time, the five closures affected seventeen women in total, all of whom received 1:1 care on the Delivery Suite. Of these seventeen women, seven would have ordinarily required transfer from the Birthing Centre to the Delivery Suite at some point throughout their labour/birth due to emerging clinical complications.

The decision to close this area of the service was taken following clinical risk assessment by senior midwifery and obstetric leads, and careful consideration in preserving the safety of all mothers and babies across the service both within the acute and community settings. This change was escalated through the usual Trust governance pathways at the time, notifying the senior manager/director on-call, to ensure wider organisational awareness.

The Directorate performed a Quality Impact Assessment (QIA) at the time of closure and identified no impact to patient safety and/or clinical effectiveness. The QIA has identified that patient experience is likely to have been affected due to the environmental impact on the experience of service users. Due to the constraints of the estate and in safeguarding all patients, the service is unable to offer overnight stays to partners on the postnatal wards, contrary to what is possible on the Birthing Centre.

A process has been developed to capture NBC closures and monitor the numbers of service users affected and the related outcomes; this will be regularly reported to the Trust Board forward.

7. ITEMS OF RELEVANCE OUT-WITH OCKENDEN

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

Members of the Trust Board will recall that the report of Dr Bill Kirkup is different in that it has not sought to make detailed recommendations to practice or management, in contrast to Ockenden; instead, the report highlights four key areas for action with four 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.

However, those areas of the report which relate to culture and organisational behaviour are key to ensuring that maternity services are safe. It is essential that providers act and accept the essence of Kirkup's report on 'reading signals amongst the noise,' and that this is brought clearly into focus, whilst simultaneously progressing the detail of the must do recommendations of Ockenden.

Work to this effect has commenced within the Maternity Service, starting with a schedule of workforce engagement whereby the voices of staff can be listened to and heard. The feedback from this engagement will support the foundations for bespoke cultural improvement work within the service. The intention is that this work will be against a backdrop of a quality improvement framework, with support provided from both internal and external sources. Further updates will be provided in future papers.

7.2 As previously reported to the Trust Board NHS England's (NHSE) publication of a single set of Maternity Standards is anticipated to be released in Spring 2023. Current standards and recommendations from the Maternity Incentive Scheme (Clinical Negligence Scheme for Trusts/CNST) Ockenden Report and East Kent Report are expected to be combined into one set of Standards for Maternity Services. The Trust also await the findings resulting from the current ongoing review of maternity services at The Nottingham University Hospitals NHS Trust, this is another review chaired by Donna Ockenden and publication of this report will be considered alongside the single set of standards.

7.3 The CQC, as part of their national maternity inspection programme, carried out a short notice unannounced focused inspection of the maternity service at Newcastle Hospitals in January. Key lines of enquiry were those within the safe and well-led domains. The Trust is awaiting final publication of the inspection report and updates will be made in future papers.

8. CONCLUSION

The Trust has continued to make 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 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. The successful implementation of the electronic patient record 'BadgerNet' will support the Trust to meet and evidence compliance in many of the recommendations. Further digital improvement is required to develop the Trust website throughout 2023-2024.

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 provides a detailed update on progress and compliance on the original bench-marked seven non-compliant recommendations from the final report, of which there remain two non-compliant, and the original benchmarked thirty-two partially

compliant recommendations for the Trust, of which there remain fifteen. Work is progressing and status updates are provided on all previously reported non and partially compliant recommendations which were detailed in the July, September, November (2022) and January (2023) Ockenden update reports.

This report also presents the Quality Impact Assessment of NBC closures aligned to workforce and service pressures; a process is in place for monitoring and reporting which will continue through the maternity governance framework to Trust Board.

This paper also revisits the publication of the East Kent Report, highlighting the system-wide and national-level recommendations for change. Further to this, the Trust has commenced a focus on culture and organisational behaviour starting with a schedule of workforce engagement whereby the voices of staff can be listened to and heard.

Further National direction is awaited, anticipated in Spring 2023, with the publication of a single set of maternity reporting standards which will combine CNST, Ockenden and East Kent.

9. RECOMMENDATIONS

The Trust Board is asked to:

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

Report of Maurya Cushlow
Executive Chief Nurse
21 March 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
	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).	Compliant
	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".	Compliant
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 (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".	Compliant

Final Report **Immediate Essential Action**		Brief Descriptor IEA 1-15	Compliance
1. Workforce Planning and Sustainability: Financing a safe maternity workforce The recommendations from the Health and Social Care Committee	1.1	To fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.	n/a Awaiting information on further funding

Report: The safety of maternity services in England must be implemented.	1.2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	Compliant
	1.3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave, and maternity leave.	Non- compliant
	1.4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.	n/a Awaiting direction from National bodies
Workforce Planning and Sustainability: Training We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.	1.5	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.	Compliant
	1.6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	n/a National direction has changed since publication of Final report
	1.7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision making, learning through training in human factors, situational awareness, and psychological safety, to tackle behaviours in the workforce.	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
	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.	Partial compliance
	3.2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	Compliant
	3.3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Compliant
	3.4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	Compliant
	3.5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	Compliant
4. Clinical Governance: Leadership: Trust boards must have oversight of the quality and performance of their maternity services.	4.1	Members of the Trust Board must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.	Compliant
	4.2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.	Partial compliance

In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	4.3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Compliant
	4.4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	Partial compliance
	4.5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis, and family engagement.	Partial compliance
	4.6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	Compliant
	4.7	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	Compliant
5. Clinical Governance – Incident investigation and complaints Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	5.1	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.	Compliant
	5.2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	Partial compliance
	5.3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.	Partial compliance
	5.4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	Partial compliance
	5.5	All trusts must ensure that complaints which meet SI threshold must be investigated as such.	Compliant
	5.6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	Compliant
	5.7	Complaint's themes and trends must be monitored by the maternity governance team.	Compliant
	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. 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.	6.2	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. Rotas & Job planning need to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	7.1	All members of the multidisciplinary team working within maternity should attend regular joint training, governance, and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	Partial compliance
	7.2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	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.	Compliant
	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 accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Compliant
	8.3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	Partial compliance (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.	Compliant (to audit)
	8.5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	Compliant
9. Preterm Birth: The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving	9.1	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	Compliant
	9.2	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	Compliant
	9.3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	Compliant

Babies Lives Version 2 (2019)	9.4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	Compliant
10. Labour and Birth: Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	10.1	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made	Compliant
	10.2	Midwifery-led units must complete yearly operational risk assessments.	Partial compliance
	10.3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	Partial compliance
	10.4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.	Partial compliance
	10.5	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	Compliant
	10.6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	Compliant
11. Obstetric Anaesthesia: A pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address	11.1	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain, and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.	Compliant
	11.2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	Compliant

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.	11.3	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
	13.1	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. Bereavement Care: Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	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	March 23	March 23
Total Number of Recommendations (interim and final report combined)	97	100%	98 *	100%	98	100%
Non-applicable	12	n/a	12	n/a	12	n/a
Compliant	46	54.1%	56	65.1%	64	74.4%
Partial Compliance	36	41.4%	27	31.4%	20	23.2%
Non compliance	3	3.5%	3	3.5%	2	2.3%

*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 March 2023 to include both the interim and the final Ockenden Report			
Immediate and Essential Action (IEA) Interim Report (Total)	**Updated action which is required to meet recommendation**	**Lead/s**	**Completion Date**
IEA 3 **Staff training and working together**	Required to ensure 90% of all specialities take part in multi-disciplinary training. This has been challenging for the reasons reported in the Trust Board reports; a mechanism is in place for regular monitoring and reporting and cross referenced to the requirements for CNST. 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) Lead Midwife for Quality and Clinical Effectiveness Practice Development Midwife	December 2022
IEA 4, 5 & 7 **Named Consultant and Risk assessment throughout pregnancy**	Named consultant and continuous risk assessment achieved through implementation of BadgerNet as the agreed electronic paper record. Assurance through audit required following embedding of BadgerNet. BadgerNet solution being sought for MMC regional audit and assurance purposes.	Clinical Director Director of Midwifery Digital Health Midwife	EPR – implemented 10.01.23
IEA 7 **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.	Clinical Director Director of Midwifery Digital Health Midwife	EPR – implemented 10.01.23

	BadgerNet EPR will support above however further development of the Trust's Maternity Services Website required.		Website redevelopment 2023-2024
Immediate and Essential Action (IEA) <u>Final Report</u> Non-compliant elements	**Action which is required to meet recommendation**	**Lead/s**	**Completion Date**
IEA 1 Workforce Planning and Sustainability	1.3 Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave, and maternity leave. Collaborative work with Executive Directors, Finance and HR to work towards establishing a reflective uplift appropriate for Newcastle. In mitigation continue to use over established workforce (20 WTE midwives). Maternity Service has recently appointed to post of Senior Midwife (Workforce) to further support the Director of midwifery in working towards sustainable workforce strategies fit for the future direction of maternity services.	Directorate Manager Director of Midwifery	July 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. 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	Director of Midwifery Matron for Intrapartum Care	Regional module in place and first 2 NUTH Labour Ward Coordinators commenced January 2023.

	aligns with Ockenden and provides academic credits at level 6 or 7. 2 NUTH Labour Ward Coordinators commenced the first programme 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.		
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. Policy written – awaiting Directorate Quality and Safety approval.	Clinical Director Head of Obstetrics Director of Midwifery Lead Midwife for Clinical Effectiveness	May 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 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. Plan for 2023 to maintain monitoring and audit for all SI report actions recommending a change to practice on a rolling basis. 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. NUTH Clinical Governance senior staff attended LMNS PSIRF implementation support day 28/02/2023. National expectation for Trust to implement PSIRF by September 2023.	Clinical Director Director of Midwifery Heat of Obstetrics Lead Midwife for Quality and Clinical Effectiveness	Audit Schedule May 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. MVP have had oversight and understanding of complaints process. MVP met with Head of Patient Experience in January 2023 to further explore complaints process, future plans for MVP liaison with Maternity lead from Patient Experience Team.	Directorate Manager Director of Midwifery Head of Patient Experience Chair of MVP Link Midwife for MVP	January 2023
IEA 5 Clinical Governance – Incident investigation and complaints	5.7 Complaint's themes and trends must be monitored by the maternity governance team. This work has 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 Head of Obstetrics Lead Midwife for Quality and Clinical Effectiveness Patient Experience Coordinator	January 2023
IEA 10 Labour and Birth	10.2 Midwifery-led units must complete yearly operational risk assessments. Operational risk assessment in development (this is in alignment with existing Maternity and Trust Wide Risk Assessments as Newcastle Birthing Centre is 'in-hospital' unit). Any actions arising reported through local governance assurance framework.	Obstetric Lead for Intrapartum Care Matron for Intrapartum Care Lead Midwife for NBC	April 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 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.	Director of Midwifery Matron for Intrapartum Care Delivery Suite Coordinators Practice Development midwife	May 2023

	Training plan in place to achieve 100% for existing core staff by May 2023. Further training planned for new core team members 2023.		
IEA 1 Workforce Planning and Sustainability	1.10 All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience. Maternity specific workforce strategy in development. Maternity Service has recently appointed to post of Senior Midwife (Workforce) to further support the Director of midwifery in working towards sustainable workforce strategies fit for the future direction of maternity services.	Clinical Director Director of Midwifery	May 2023
IEA 2 Safe staffing	2.7 All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings. Currently available for Delivery Suite. Further work is ongoing to explore expansion into all settings. Maternity specific workforce strategy in development. Newly appointed 'Senior Midwife (Workforce)' will support the ongoing development and implementation of this strategy.	Director of Midwifery Midwifery Matrons Practice Development midwife	July 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 Director of Midwifery Head of Obstetrics Lead Midwife for Quality and Clinical Effectiveness	Present to Board in May 2023
IEA 4 Clinical Governance: Leadership	4.4 All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities. Scoping and job planning complete, business case submitted. Governance and leadership roles identified for increased PA allocation from 11.5 (2022) to 15.25 (2023).	Clinical Director 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. Work ongoing, ensure senior leadership access suitable programs.	Clinical Director Director of Midwifery Quality & Clinical Effectiveness Midwife 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. 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 Director of Midwifery Quality & Clinical Effectiveness Midwife Head of Obstetrics	May 2023

IEA 5 Clinical Governance: Incident investigation and complaints	5.3 Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred. Audit process under development, first audit planned May 2023.	Clinical Director Director of Midwifery Quality & Clinical Effectiveness Midwife Head of Obstetrics	Audit commencing May 2023
Immediate and Essential Action (IEA) <u>Final Report</u> 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. >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.	Clinical Director Director of Midwifery Head of Obstetrics Quality & Clinical Effectiveness Midwife Practice Development Midwife	Ongoing throughout 2023
IEA 7 Multidisciplinary Training	7.2 Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts. Training with inclusion of SBAR ongoing.	Quality & Clinical Effectiveness Midwife Practice Development Midwife Intrapartum Obstetric Lead Head of Neonatology Obstetric Anaesthetic Lead	January 2023

IEA 7 Multidisciplinary Training	7.3 All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMNS. Human factors training is included within mandatory MDT training day as part of Training Needs Analysis plan which has LMNS oversight. Requires further review aligned to this IEA.	Clinical Director Director of Midwifery Quality & Clinical Effectiveness Midwife Practice Development Midwife 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. 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 2022 months. 2 unannounced/unanticipated drills held in 2023 to date.	Clinical Director Director of Midwifery Practice Development Midwife Lead for Obstetric Skills Drills Matron for Intrapartum Care	January 2023
IEA 7 Multidisciplinary Training	7.7 Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory. 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 Director of Midwifery Practice Development Midwife Matron for Intrapartum Care Lead Midwife for Fetal Monitoring	December 2022
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.	Clinical Director Obstetric Consultants specialising in Diabetes Diabetic Specialist Midwife	July 2023

	Work is near completion for updating local guidance and work is ongoing toward resourcing the diabetic service with a dietician. It is anticipated that dietetic support will be in place by July 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. Compliant with implementation of BadgerNet electronic patient record. For Audit in 3 months to provide evidence and assurance.	Clinical Director Obstetric Consultants specialising in Diabetes Lead Diabetic Support Midwife	January 2023 (Audit for assurance scheduled June 2023)
IEA 10 **Labour and Birth**	10.3 Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan. Newcastle Birthing Centre (NBC) is included within the programme of monthly unanticipated/unannounced MDT drills. 6 unannounced/unanticipated drills held in 2022, NBC included in 1.	Clinical Director Lead Obstetrician for Skills Drills Intrapartum Matron NBC Manager	January 2023
IEA 10 **Labour and Birth**	10.4 It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Written leaflet in development. Completion of BadgerNet Risk Assessment for Homebirth will detail this information and electronic version of leaflet can be attached within Badger Notes.	Matron for Community Services Lead Midwife for Quality and Clinical Effectiveness Community Team Leads	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.	Clinical Director Head of Obstetrics Intrapartum Obstetric Lead Intrapartum Matron	April 2023

	Local guidance has been updated to reflect this recommendation.		
Immediate and Essential Action (IEA) <u>Final Report</u> Partial-compliant part 3.	**Action which is required to meet recommendation**	**Lead/s**	**Completion Date**
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. Will be supported through implementation of BadgerNet electronic patient record.	Clinical Director Obstetric Anaesthetic Lead	January 2023
IEA 12 Postnatal Care	12.2 Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum. 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 May 2023.	Clinical Director Director of Midwifery Postnatal Matron Postnatal Obstetric Lead	May 2023
IEA 12 Postnatal Care	12.3 Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary. Audit underway for compliance against this standard with expected completion and reporting by May 2023.	Clinical Director Director of Midwifery Postnatal Matron Postnatal Obstetric Lead	May 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. Regraded compliant following initial benchmarking exercise. NUTH have recently appointed to post of Specialist Bereavement Midwife which will support development of the service.	Clinical Director Director of Midwifery 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. Regraded compliant following initial benchmarking exercise. NUTH have recently appointed to post of Specialist Bereavement Midwife which will support development of the service.	Clinical Director Director of Midwifery Bereavement Midwife (on appointment)	December 2022
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. Regraded compliant following initial benchmarking exercise.	Clinical Director Director of Midwifery Head of Neonatology 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. 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 Clinical Director Head of Neonatology	December 2023
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. 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 Director of Midwifery 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. Regraded compliant following initial benchmarking exercise.	Clinical Director Director of Midwifery Perinatal Mental Health Lead Midwife	December 2022

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Healthcare-Associated Infections Report
February 2023

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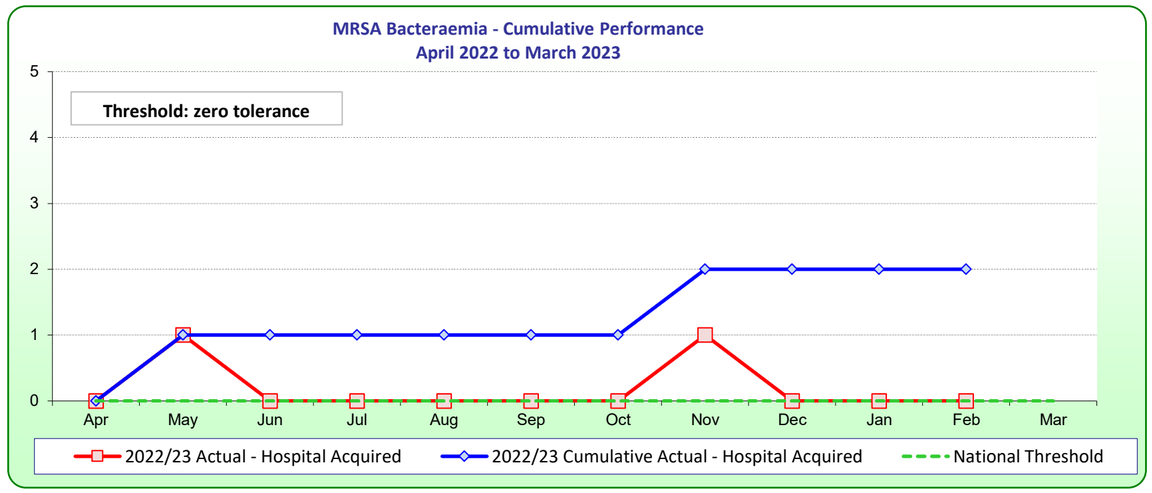
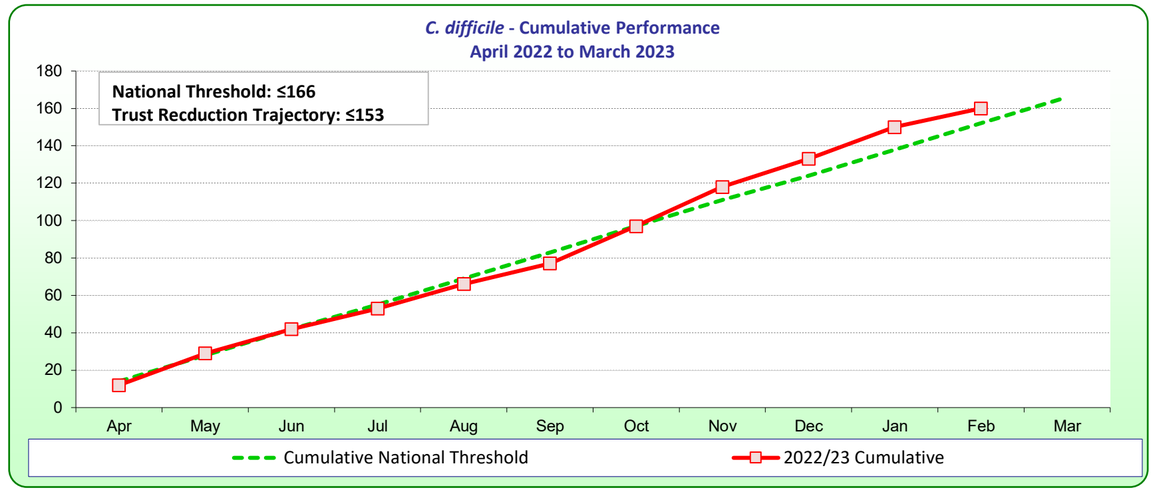
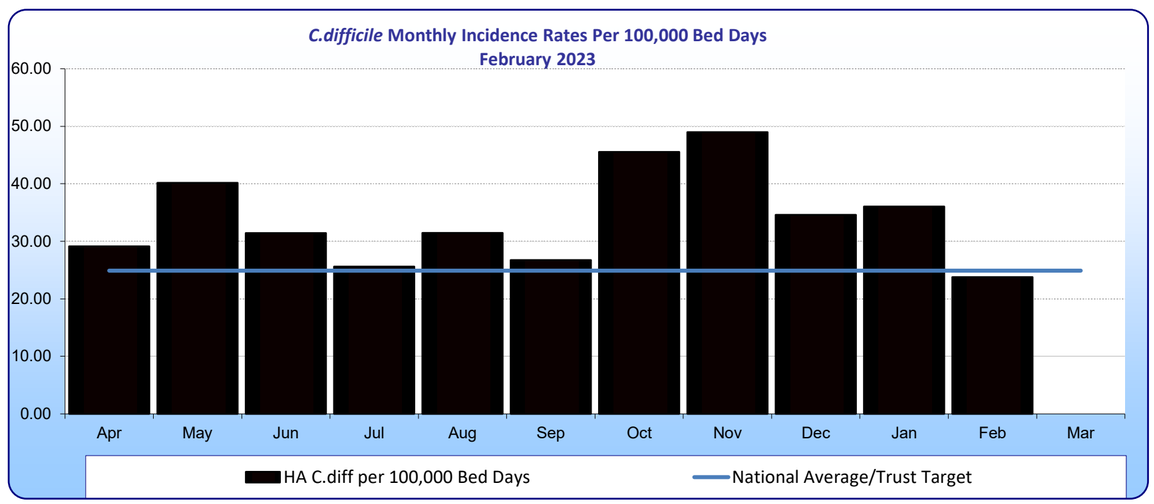
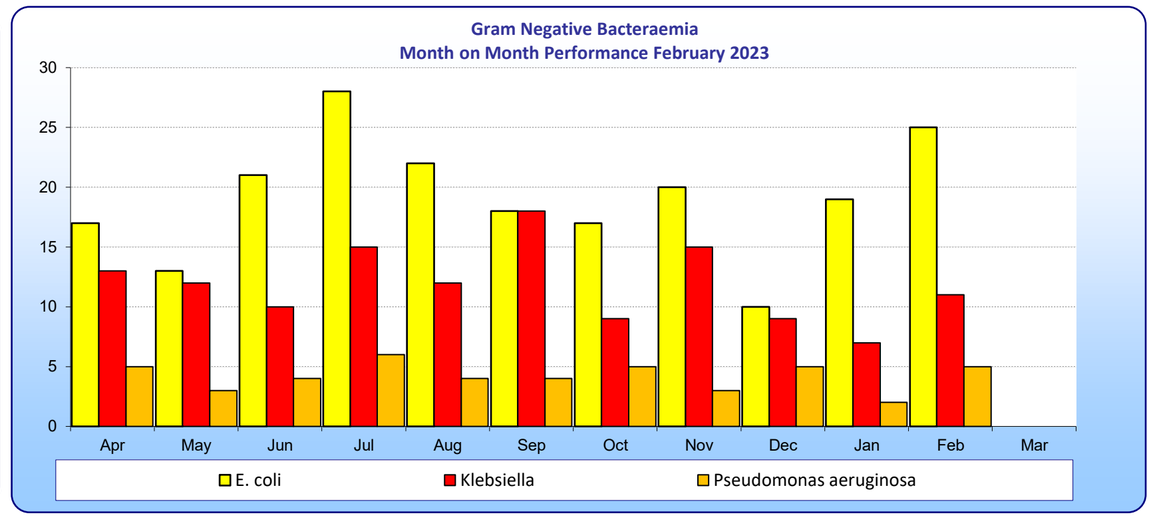
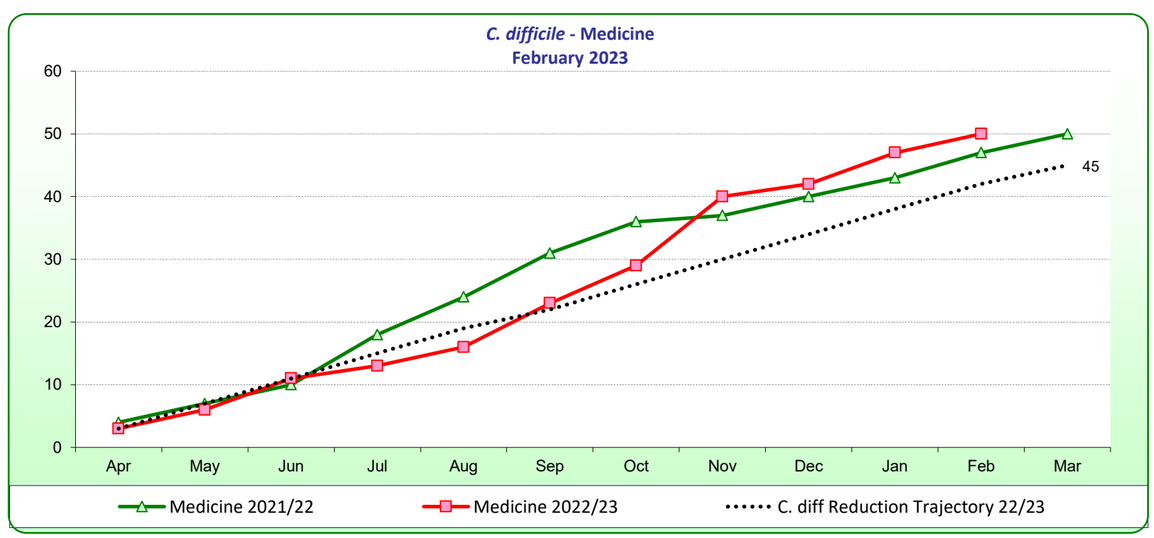
The Newcastle upon Tyne Hospitals NHS Foundation Trust

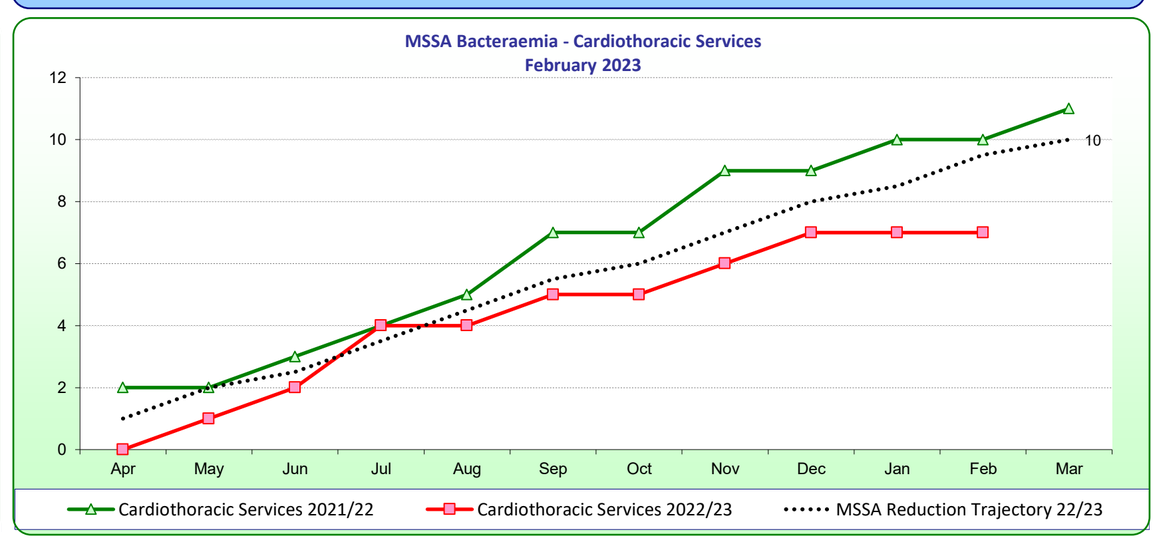






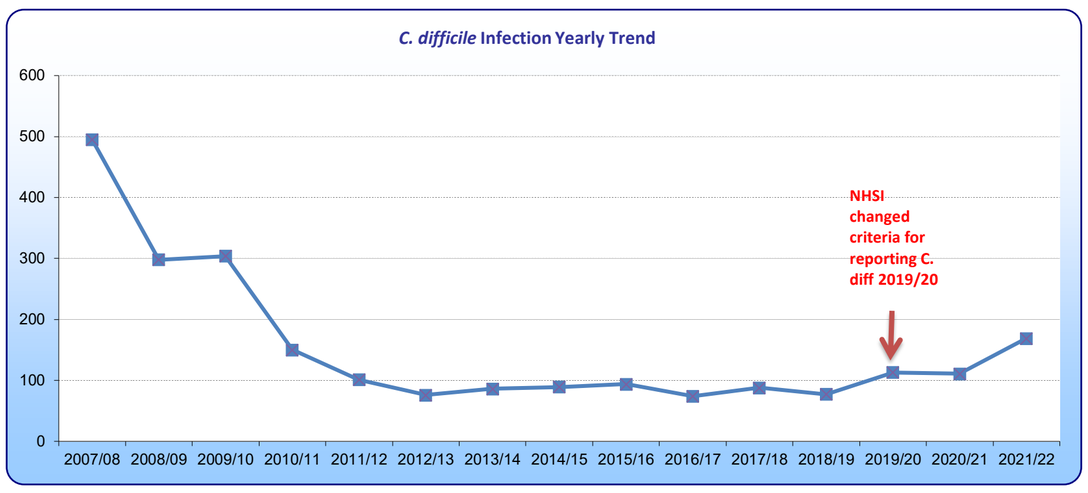


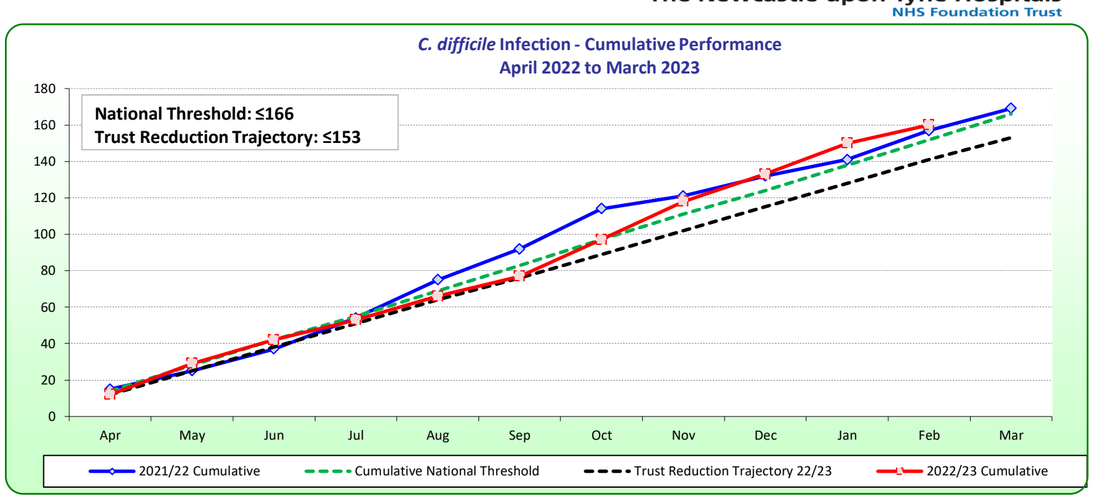


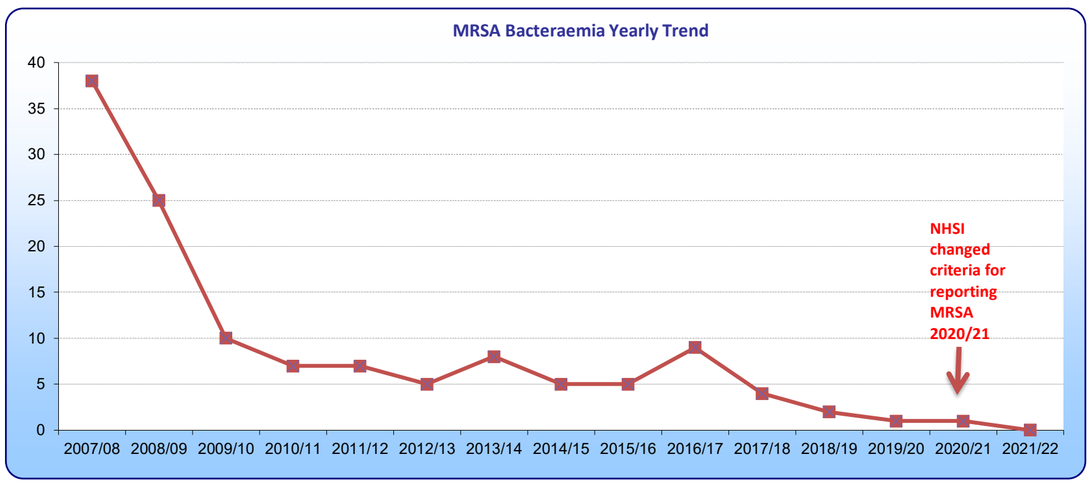


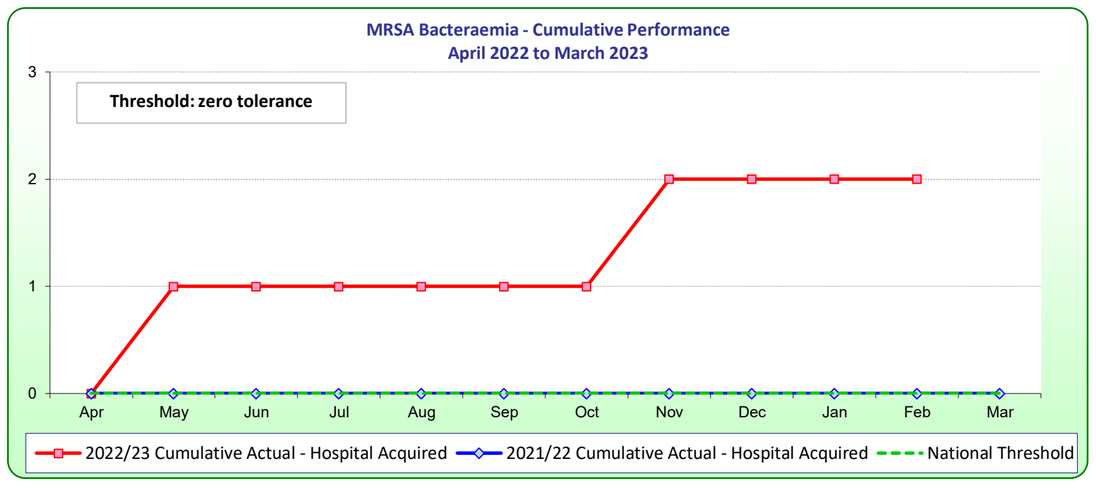
Healthcare-Associated Infection Report February 2023

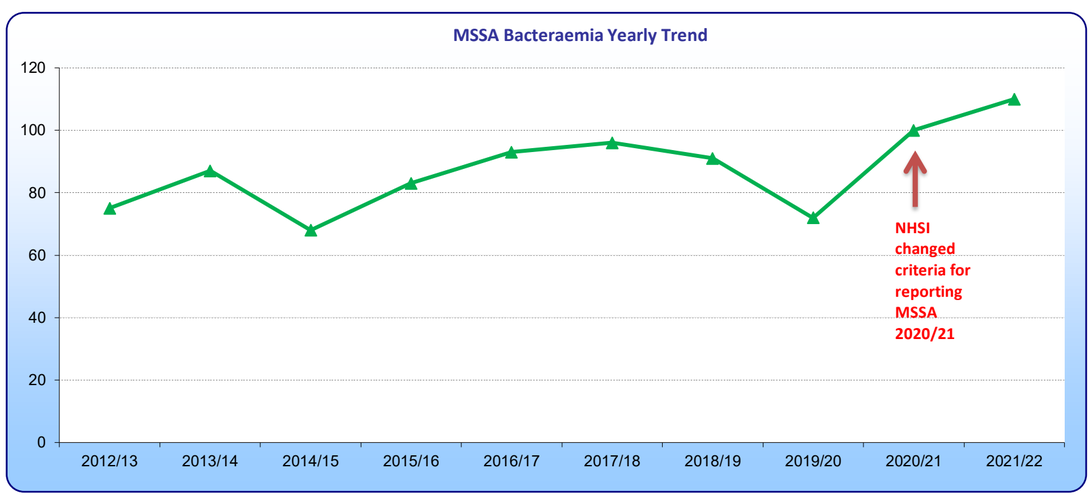
The Newcastle upon Tyne Hospitals NHS Foundation Trust

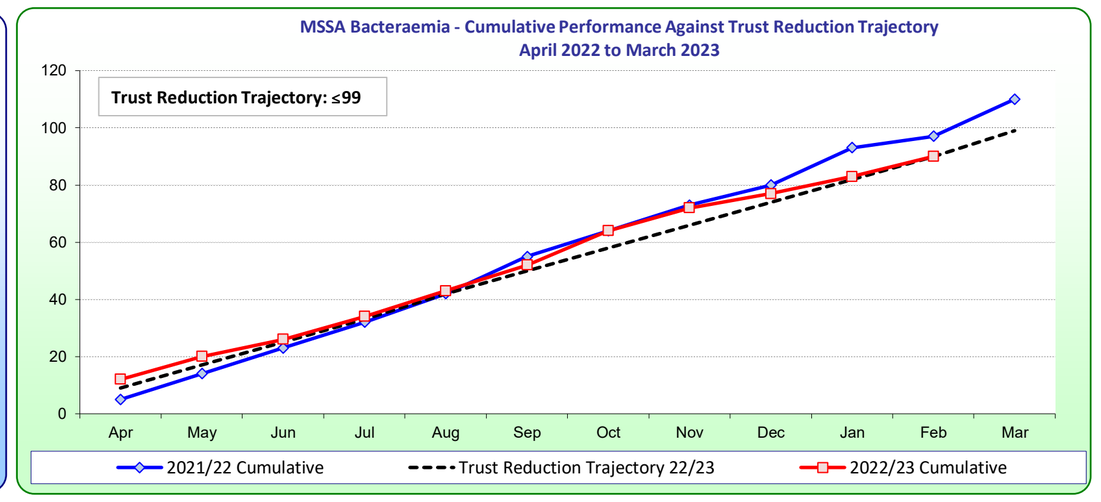


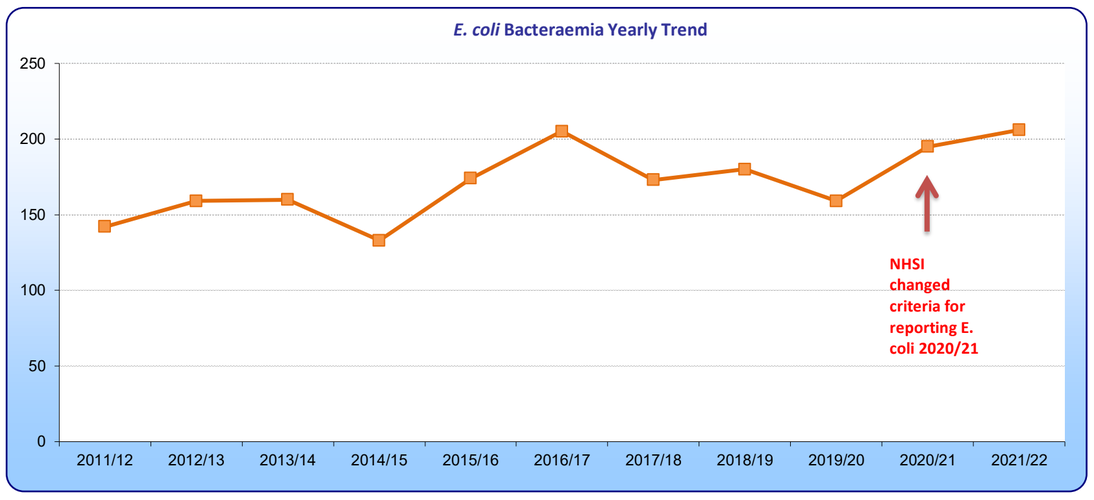


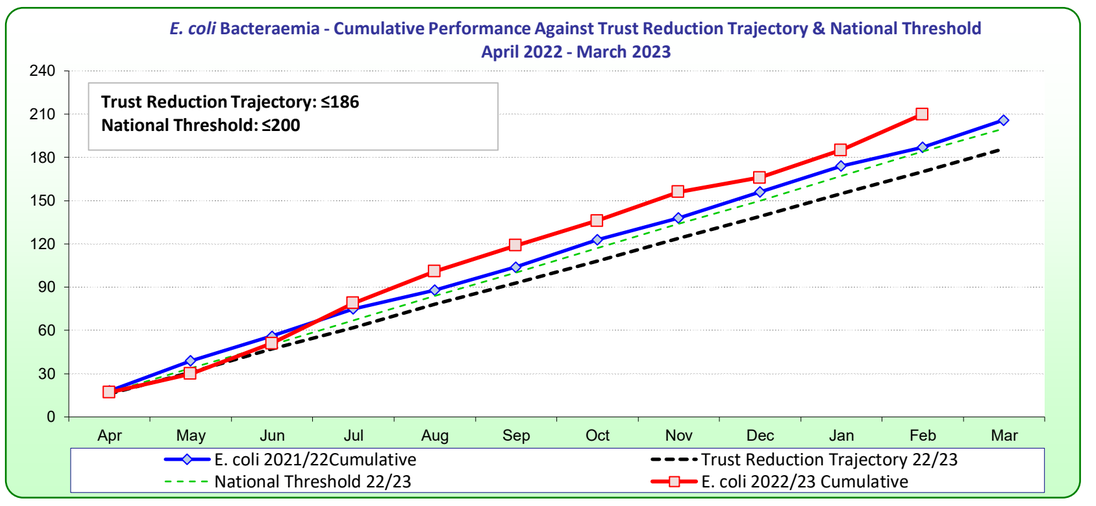


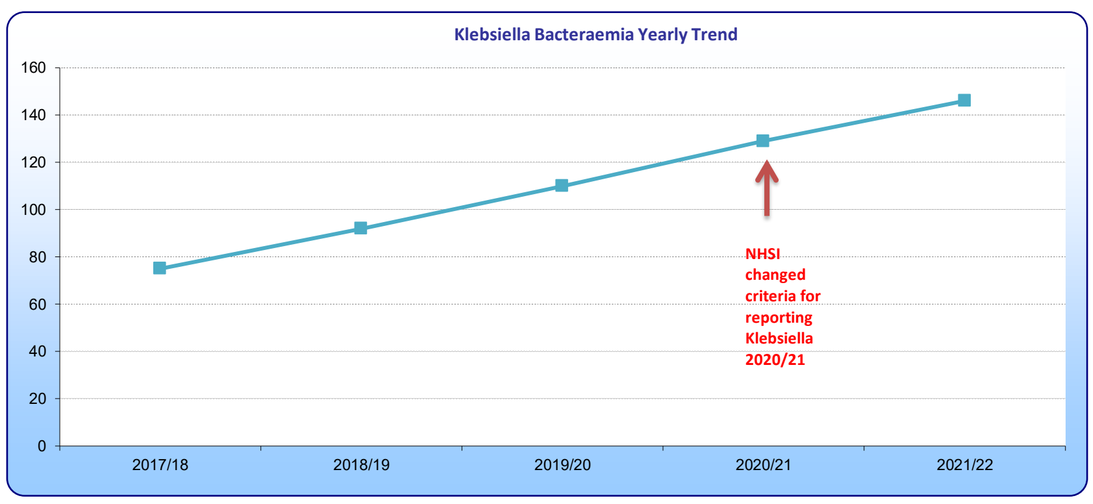


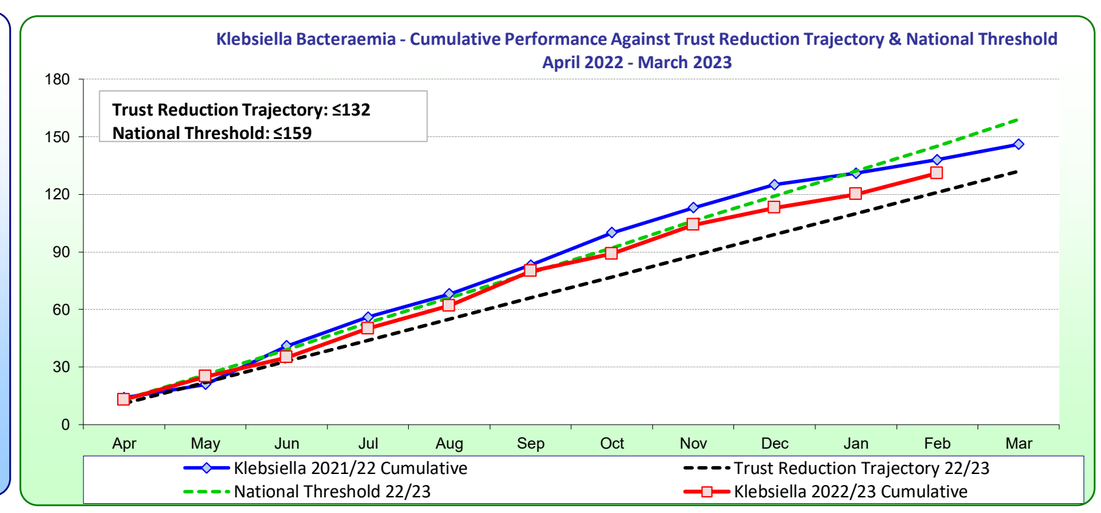


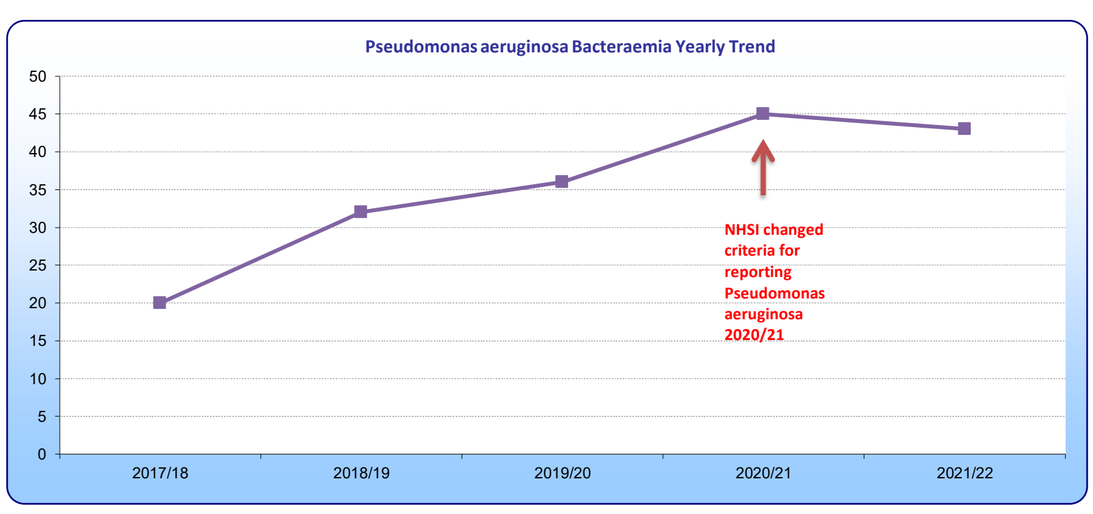


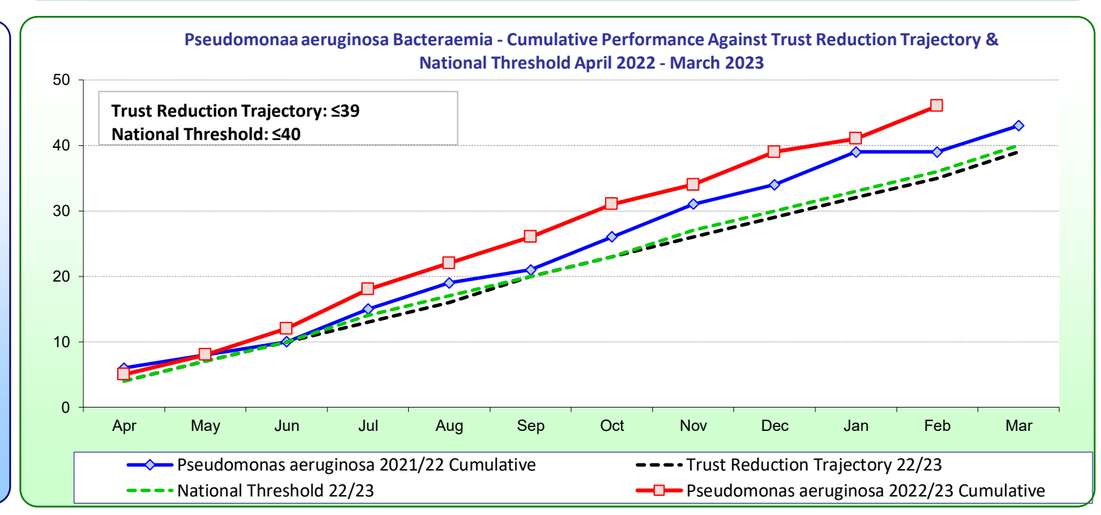












The Newcastle upon Tyne Hospitals NHS Foundation Trust

Bacteraemia / Infections

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	0	0		1
MRSA Bacteraemia - Trust-assigned (objective 0)	0	1	0	0	0	0	0	1	0	0	0		2
MRSA HA acquisitions	1	0	1	0	0	0	0	0	0	0	1		3
MSSA Bacteraemia - Healthcare Associated (local objective ≤99)	12	8	6	8	9	9	12	8	5	6	7		90
E. coli Bacteraemia - Healthcare Associated (local objective ≤186)	17	13	21	28	22	18	17	20	10	19	25		210
Klebsiella Bacteraemia - Healthcare Associated (local objective ≤132)	13	12	10	15	12	18	9	15	9	7	11		131
Pseudomonas aeruginosa Bacteraemia - Healthcare Associated (local objective ≤39)	5	3	4	6	4	4	5	3	5	2	5		46
C. diff - Hospital Acquired (national threshold ≤166; local objective ≤152)	12	17	13	11	13	11	20	21	15	17	10		160
C. diff related death certificates	-	-	2	3	0	0	0	2	0	2	0		9
Part 1	-	-	1	0	0	0	0	2	0	2	0		5
Part 2	-	-	1	3	0	0	0	0	0	0	0		4

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	4	1		28
Patients affected	5	8	3	0	1	4	8	14	11	7	4		65
COVID-19 - Hospital Acquired	7	1	2	1	1	1	2	3	0	0	0		18
Patients affected	22	2	4	4	6	2	7	7	0	0	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	22	35		314
Hospital onset Definite HC assoicated (≥15 days post admission)	63	22	49	84	13	36	62	41	53	38	40		501

Outbreaks	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cumulative
Norovirus Outbreaks	-	-	-	-	-	-	-	-	1	6	1		8
Patients affected (total)	-	-	-	-	-	-	-	-	11	54	3		68
Staff affected (total)	-	-	-	-	-	-	-	-	5	29	1		35
Bed days losts (total)	-	-	-	-	-	-	-	-	1	99	0		100
Other Outbreaks	2	0	0	0	0	0	0	0	5	3	1		11
Patients affected (total)	16	0	0	0	0	0	0	0	28	23	5		72
Staff affected (total)	0	0	0	0	0	0	0	0	12	2	0		14
Bed days losts (total)	48	0	0	0	0	0	0	0	3	17	0		68
COVID Outbreaks	4	2	10	11	3	6	9	5	7	5	10		72
Patients affected (total)	32	15	92	110	12	41	59	34	32	47	47		521
Staff affected (total)	0	2	4	0	13	9	4	2	5	0	0		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	13:31	11:37		12:45
Laboratory Turnaround Time	04:04	02:43	03:06	03:03	03:18	03:05	03:19	03:30	04:03	03:48	02:44		03:20
Total to Result Availability	16:40	15:27	17:47	14:53	14:45	16:22	15:47	15:50	17:51	17:19	14:21		16:05

Clinical Assurance Tool (CAT)

Clinical Assurance Indicators/Audits (%) - Trust as a whole	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; Day Procedure; Dental; Maternity; OP; Theatres) Trust Total	58%	67%	67%	82%	83%	79%	81%	86%	84%	82%	92%		78%
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Trust Total	68%	85%	82%	81%	85%	81%	80%	86%	83%	87%	90%		83%
Invasive Device Care Audit Trust Total	64%	71%	69%	81%	80%	80%	83%	80%	86%	89%	91%		79%
Matron Checks (IP; OP/Community/Dental; Theatres) Trust Total	73%	78%	87%	73%	86%	85%	88%	90%	90%	91%	89%		85%

Clinical Assurance Indicators/Audits (%) - Acute side only	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Adult IP; Children's IP; Critical Care; Day Procedure; Dental; Maternity; OP; Theatres) Acute only Total	57%	68%	62%	77%	81%	85%	88%	89%	83%	82%	93%		79%
Standard IPC Precautions (incl HH, ANTT, PPE) Audit Acute only Total	71%	86%	83%	81%	86%	83%	84%	87%	82%	88%	89%		84%
Invasive Device Care Audit Acute only Total	63%	70%	68%	80%	80%	81%	87%	79%	87%	90%	90%		80%
Matron Checks (IP; OP/Community/Dental; Theatres) Acute only Total	73%	80%	83%	74%	86%	87%	91%	90%	91%	93%	91%		85%

Clinical Assurance Indicators/Audits (%) - Community side only	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
CAT (Community HV/SN; Community Nursing; OP) Community only Total	39%	73%	86%	98%	91%	74%	74%	83%	91%	87%	99%		81%
Standard IPC Precautions (incl HH, ANTT, PPE) Community only Total	37%	68%	69%	75%	82%	62%	50%	73%	90%	81%	99%		71%
Invasive Device Care Audit Community only Total	86%	94%	88%	100%	68%	60%	20%	100%	60%	58%	100%		76%
Matron Checks (OP/Community/Dental) Community only Total	48%	61%	92%	80%	89%	72%	46%	87%	79%	40%	95%		72%

Education & Training

Infection Control Mandatory Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
Infection Control (Level 1)	89%	90%	90%	89%	90%	88%	89%	89%	91%	97%	88%		90%

Aseptic Non Touch Technique Training (%)	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
ANTT (M&D staff only)	55%	57%	57%	57%	58%	58%	60%	61%	66%	67%	65%		60%

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.

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 March 2023						
Title	Update from Committee Chairs						
Report of	Non-Executive Director Committee Chairs						
Prepared by	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 updates on the work of the following Trust Committees that have taken place since the last meeting of the Trust Board in January 2023: • People Committee – 21 February 2023; • Charity Committee – 16 February 2023 and 10 March 2023; • Quality Committee – 21 March 2023; and • Finance Committee – 22 March 2023.						
Recommendation	The Board of Directors is asked to (i) receive the update and (ii) note the contents.						
Links to Strategic Objectives	Links to all strategic objectives						
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	Regular report.						

UPDATE FROM COMMITTEE CHAIRS

EXECUTIVE SUMMARY

This report provides an update to the Board on the ongoing work of the Trust's Committees for those meetings that have taken place since the last meeting of the Board of Directors in January 2023.

UPDATE FROM COMMITTEE CHAIRS

1. PEOPLE COMMITTEE

A meeting of the People Committee took place on 21 February 2023. During the meeting, the main areas of discussion included:

- An Industrial action status update was provided.
- The People Committee Risk report was received and discussed.
- A deep dive into staff turnover and the General Medical Council (GMC) training survey / training and education which were comprehensive updates.
- The Assistant Chief Executive provided an update in relation to communications and engagement which included the new Trust communications strategy.
- The Chief People Officer shared the latest position regarding the People Strategy Workplan.
- The People Dashboard was received and discussed.
- The Guardian of Safe Working Quarterly report and Sustainability Quarterly update were received.

The next formal meeting of the Committee will take place on 18 April 2023.

2. CHARITY COMMITTEE

A meeting of the Charity Committee took place on 16 February 2023. During the meeting, the main areas of discussion included:

- The Charity Director provided a general Charity update.
- Guidance in relation to the principles/approach to developing an Investment Strategy/Policy was discussed.
- The following grant was approved which totalled £15,000:
    - Children's Services: Collaborative Newcastle – Children and Families Newcastle – Integrated Early Years Centre (uplift to existing).
- The Charity Finance reports were received and discussed.
- The Committee discussed the Summary of Investment to 31 December 2022 including the Quarterly Summary Investment reports from:
    - Newton's; and
    - CCLA.
- A verbal update was provided by the Finance Manager regarding the Financial Processes initial findings/priorities.
- The Committee received the Dashboard of Operational Key Performance Indicators (KPI's) and Communication, the Charity Risk Statement and the £1m Donor Due Diligence Form.

A meeting of the Charity Committee took place on 10 March 2023. The meeting was convened primarily to discuss several grant applications in advance of the next formal meeting.

During the meeting, the Committee approved applications which totalled £618,889 as follows:

- SA1228 – Surgical Services Directorate: The Northern Oesophago-gastric Unit Data Analyst and Support Analyst - up to £153,940;
- SA1244 – Perioperative and Critical Care Directorate: Robotic Table - £86,731;
- EXT011 – Blue Sky Trust, 'Living Well with HIV' project - £75,000 with HoGP given flexibility to approve more in line with Full Cost Recovery principles;
- EXT015 – Northumbria Blood Bikes, Volunteer training and development programme - £30,000;
- EXT016 – Citizens Advice Gateshead, 'A Helping Hand: Social Welfare Advice for Trust Staff - £59,796;
- EXT018 – Citizens Advice Gateshead, 'Direct access to social welfare advice for families at GNCH - £188,422; and
- EXT017 – Children's Foundation, 'The baby box – supporting first time mothers' – up to £25,000.

The next meeting of the Committee will take place on 11 May 2023.

3. QUALITY COMMITTEE

A meeting of the Quality Committee took place on 21 March 2023. During the meeting, the main areas of discussion included:

- The Quality Committee Risk Report was received and discussed.
- The Committee received two management group reports for consideration:
  - Clinical Outcomes & Effectiveness Group; and
  - Patient Experience and Engagement Group.
- A comprehensive assurance update was received regarding Clinical Research.
- An update was provided in relation to the Trust's response to the recent Care Quality Commission (CQC) inspections.
- The Director of Infection, Prevention and Control, the Director of Quality and Effectiveness, and the Chief Operating Officer presented the quality and performance elements of the Integrated Board Report.
- The Director of Quality and Effectiveness providing an update regarding learning disability.
- A comprehensive maternity update was given by the Chief Nurse which included a report on Ockenden.
- The Committee received and discussed three quarter 3 reports:
  - Safeguarding
  - Learning Disability
  - Mortality/Learning from Deaths

- The Committee received an update on the leadership walkabouts / spotlight on services and a Royal College Review update.

The next meeting of the Committee will take place on 16 May 2023.

4. FINANCE COMMITTEE

A meeting of the Finance Committee took place on 22 March 2023. During the meeting, the main areas of discussion included:

- The Head of Corporate Risk and Assurance presented the Committee Risk Report.
- An update on the financial position was provided including the following:
  - Financial Position Update - Month 11 Finance report;
  - Productivity & Efficiency Programme delivery;
  - Finance Plan, Capital Plan and Budget 2023/24;
  - Capital Programme 2022/23 update; and
  - Activity Recovery including the month 11 Performance Report and Operational Planning Guidance.
- Tenders and Business Cases were presented for approval.
- The Committee received a verbal update on the Private Finance Initiative (PFI).

Extraordinary meetings of the Finance Committee took place on 23 February, 9 March and 16 March 2023 to approve Business Cases and Tenders prior to Trust Board submission before the year end.

The next meeting of the Committee will take place on 24 May 2023.

5. RECOMMENDATIONS

The Board of Directors is asked to (i) receive the update and (ii) note the contents.

Report of Lauren Thompson
Corporate Governance Manager / Deputy Trust Secretary
16 March 2023

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 March 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. Supported by flourish, our cornerstone programme, we will ensure that each member of staff is able to liberate their potential. Performance – Being outstanding now and in the future.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☒	☐	☐	☐
Impact detail	Details compliance against national access standards which are written into the NHS standard contract. Details compliance against key quality targets.						
Reports previously considered by	Regular report.						

INTEGRATED BOARD REPORT

EXECUTIVE SUMMARY

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

1. The Trust has had no cases of MRSA bacteraemia in February 2023. The numbers of Trust onset E.coli bacteraemias and Pseudomonas Aeruginosa Bacteraemias are higher than the Trust trajectory.
2. In February 2023 there has been a reduction in the number of falls across the Trust (n= 283) and pressure ulcers (n=95).
3. There were 24 Serious Incidents (SIs) reported in February 2023 including two Never Events were reported in February 2023.
4. The Trust has received a total of 477 (460 with identified patient activity) formal complaints up to February 2023
5. There were 1,240 responses to the Friends and Family test from the Trust in January 2023 (published March 2023) compared to 1,301 in the previous month.
6. The year-to-year comparison for sickness absence from February 22 with February 23 shows an increase from 5.90% to 6.12%.
7. Mandatory training compliance stands at 87.2% in February 23 and appraisal compliance was 73.1%
8. In the period to 28th February the Trust incurred expenditure of £1,277.7 million, and accrued income of £1,282.9 million on mainstream budgets, including expenditure of £5.8 million on the programmes outside the block envelope (vaccine roll-out programme), leading to a surplus of £5.2 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

March 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

Over the last month pressure overall continues to ease, but fluctuate, and there is a new COVID wave and peak being experienced early March. We are still experiencing delayed discharges but these are lower than when they peaked during the Christmas period.

Work is ongoing with Northumbria Healthcare NHS Foundation Trust to directly transfer appropriate patients to Hexham hospital, as well as work within the region to improve the timeliness of transfers for patients for their next stage of care.

We continue to have escalation beds open where workforce allows which helps to maintain safe flow, minimise overcrowding in the Emergency Department (ED) and ensure timely handovers of ambulance patients.

The elective programme has been sustained throughout the last month, with only on the day cancellations occurring, which have also been fewer in number, and the strike disruptions. Further disruption is being planned for with the Junior Doctor Industrial Action in March. However, all cancer and urgent cases will continue alongside a high proportion of long wait patients.

Report Highlights

1. The Trust has had **no cases of MRSA bacteraemia in February 2023.** The numbers of Trust onset E.coli bacteraemias and Pseudomonas Aeruginosa Bacteraemias are higher than the Trust trajectory.

2. In February 2023 there has been a **reduction in the number of falls across the Trust (n= 283) and pressure ulcers (n=95).**

3. There were **24 Serious Incidents (SIs) reported in February 2023 including two Never Events were reported in February 2023**.

4. The Trust has received a total of **477 (460 with identified patient activity) formal complaints up to February 2023.**

5. There were **1,240 responses to the Friends and Family test from the Trust in January 2023** (published March 2023) compared to 1,301 in the previous month.

6. The year to year comparison for sickness absence from February 22 with February 23 shows an increase from 5.90% to 6.12%.

7. Mandatory training compliance stands at 87.2% in February 23 and appraisal compliance was 73.1%.

8. In the period to 28th February the Trust incurred expenditure of £1,277.7 million, and accrued income of £1,282.9 million on mainstream budgets, including expenditure of £5.8 million on the programmes outside the block envelope (vaccine roll-out programme), leading to a surplus of £5.2 million.

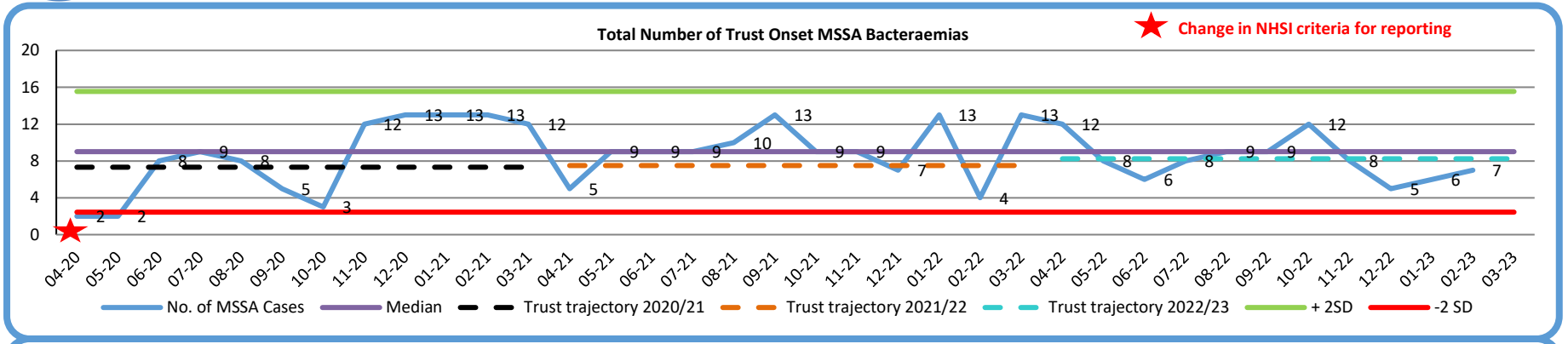
Contents: March 2023

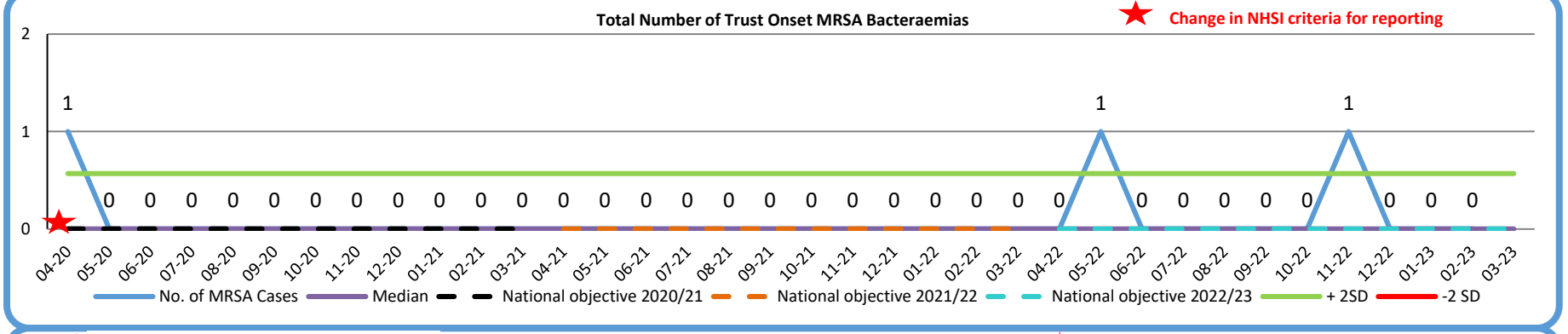
Quality

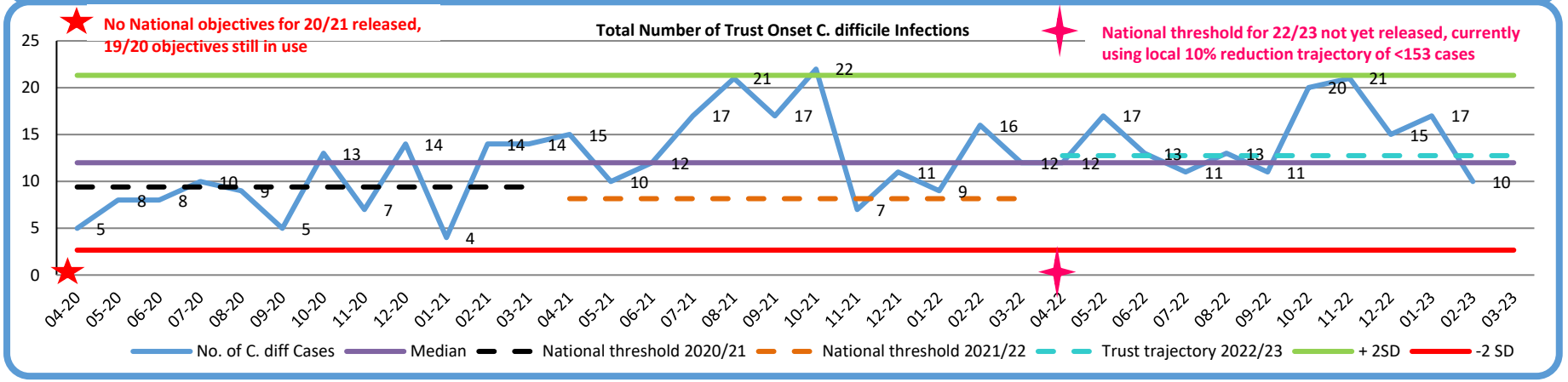
People

Finance

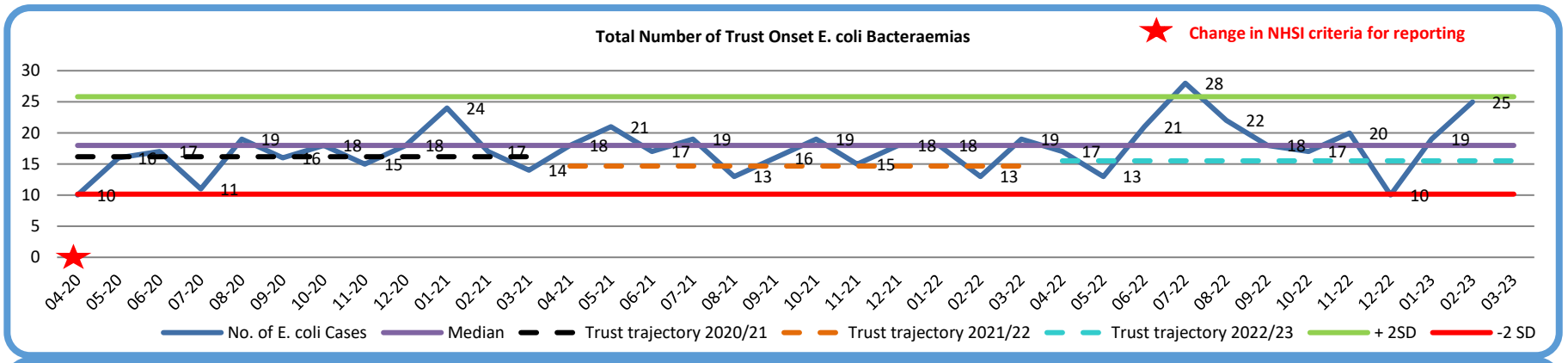
Quality: Healthcare Associated Infections 1/2

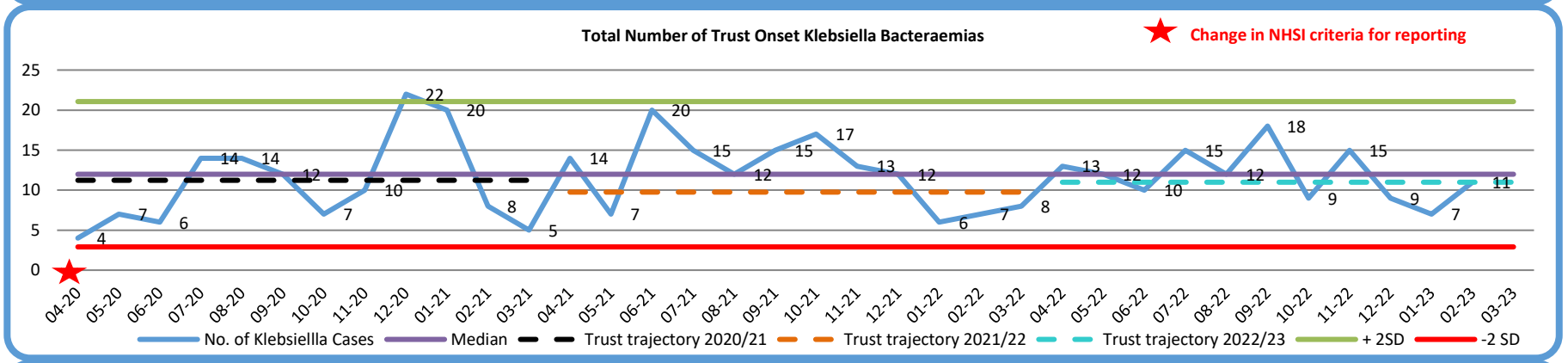


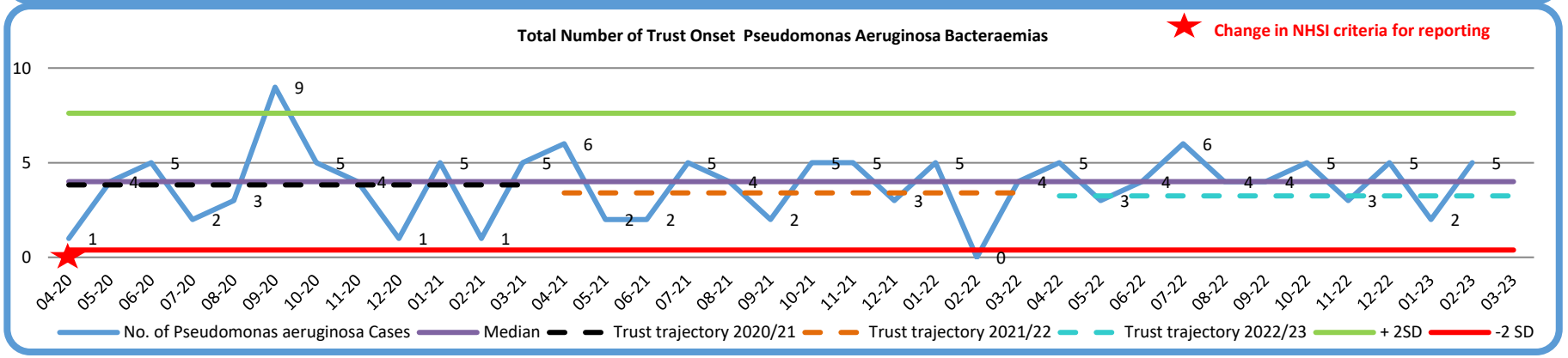




Quality: Healthcare Associated Infections 2/2







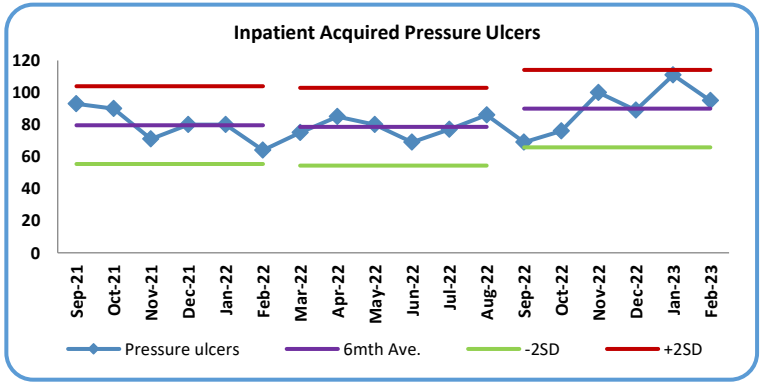
Quality: Harm Free Care – Pressure Damage

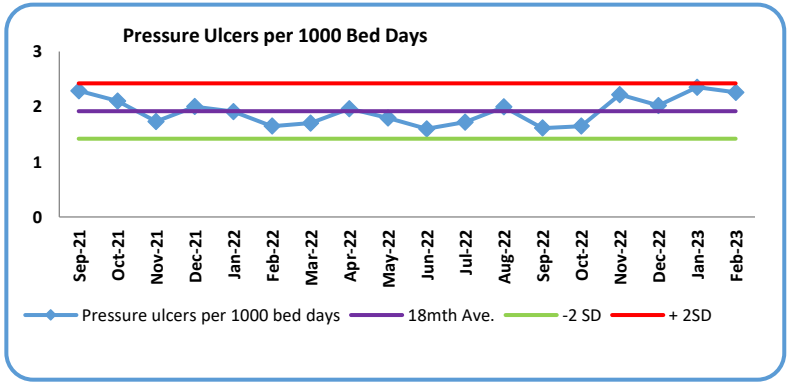
In February there has been a fall in inpatient pressure ulcers to 95 in the month. However this is still significantly higher than the February 2022. There was however only 6 requiring a Root Cause Analysis (RCA) as opposed to 9 in February 2022.

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.



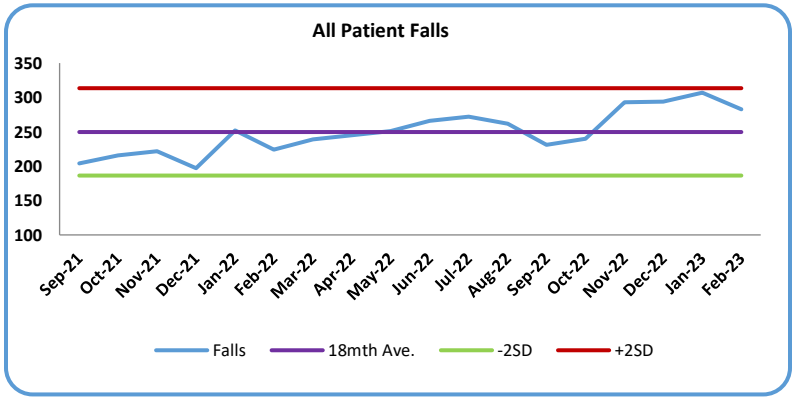


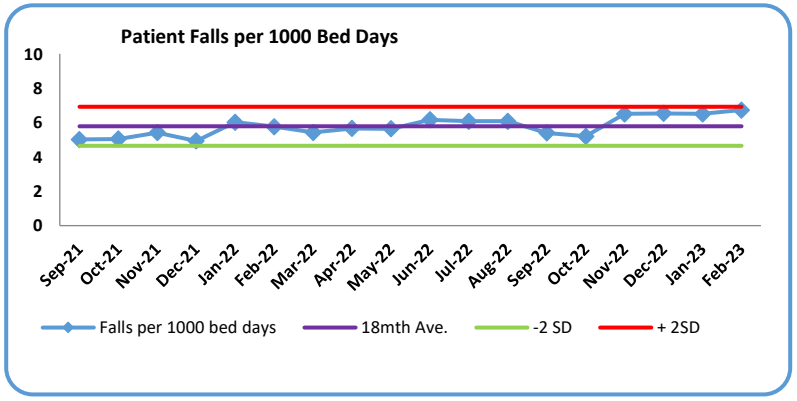
Quality: Harm Free Care - Falls

There has been a reduction in February 2023 of inpatient falls for the first time in four months. Despite the ongoing prevention work with wards and departments patient falls had increased in November (293), December (294) and January (307). In February this reduced to 283.

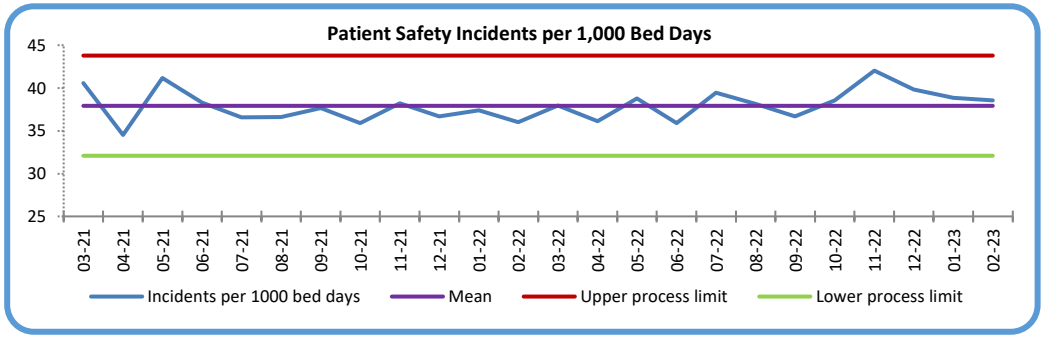
In 2022 the Trust experienced significant pressures, particularly in relation to bed occupancy levels, which have remained high throughout. Significant increases in the cohort of medical patients, particularly those over 65 were evident and led to the requirement to convert many surgical wards to medicine, 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, recognising contributing factors and identifying learning and solutions, with the aim to reduce numbers of falls in the Trust.

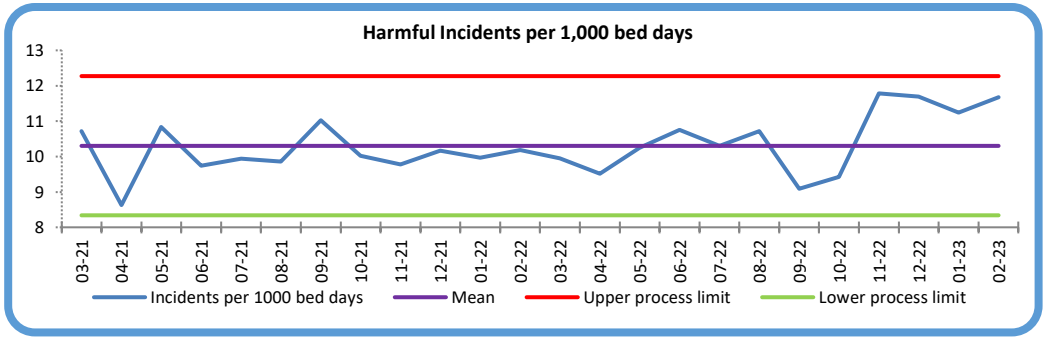




Quality: Incident Reporting

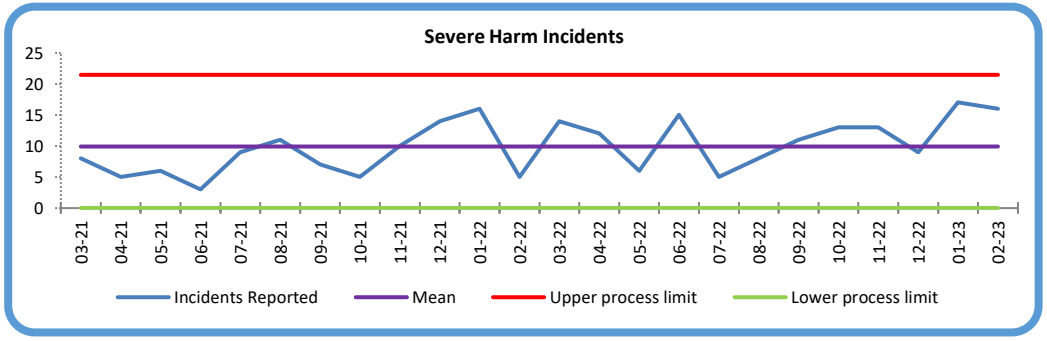


All patient incidents: The number of patient safety incidents per 1,000 bed days continues to be in close proximity to the mean for February 2023. This remains well within the expected common cause variation.



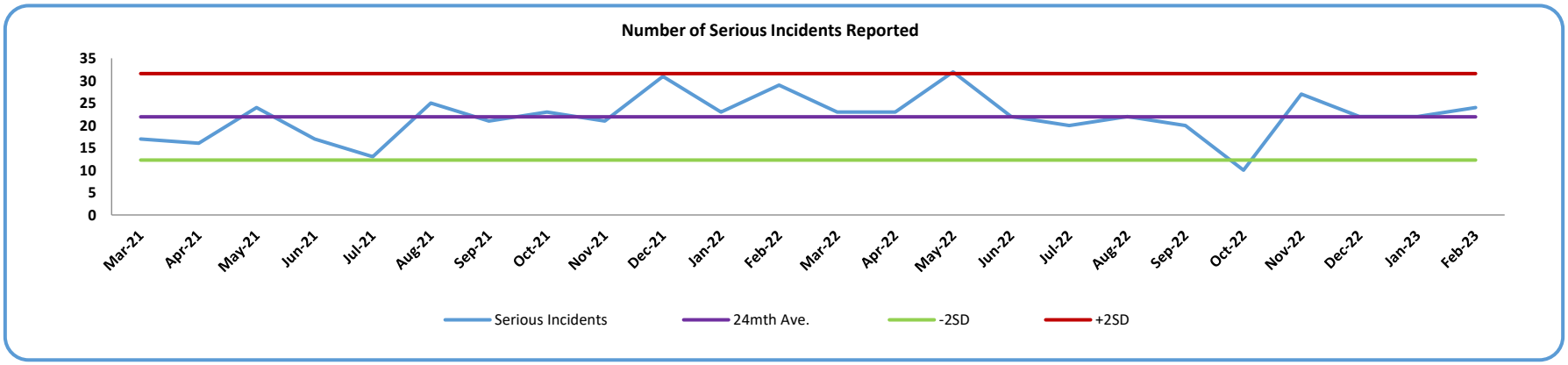
Harmful incidents: The number of *harmful patient safety incidents per 1,000 bed days showed a slight increase for February 2023, but remains within the expected common cause variation.
Severity grading of reported incidents may be modified following investigation and is therefore subject to change in future reports.

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

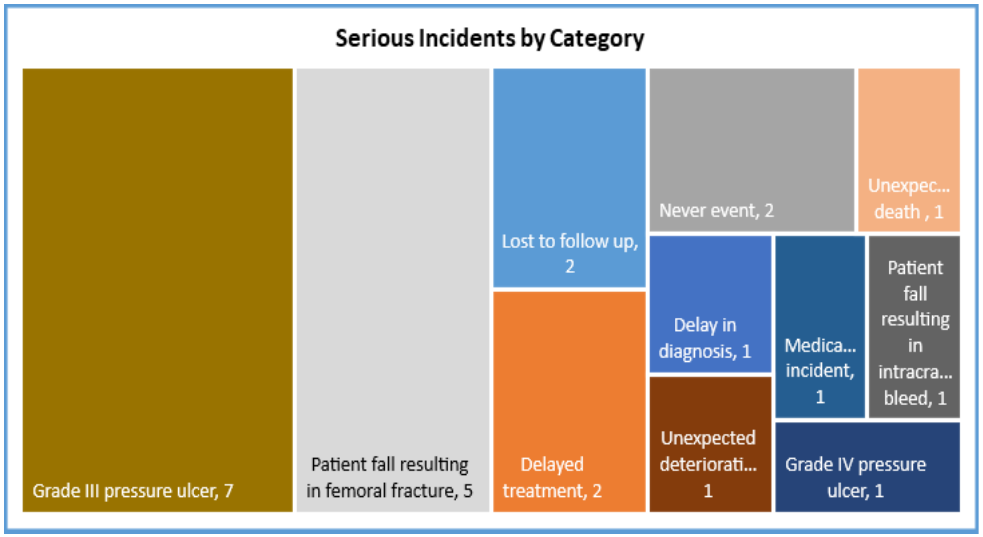


Severe harm incidents: There were 16 patient safety incidents reported that resulted in severe harm in February 2023. This is a slight decrease from the previous month, but remains within the common cause variation. Severity grading of reported incidents may be modified following investigation and is therefore subject to change in future reports.

Quality: Serious Incidents

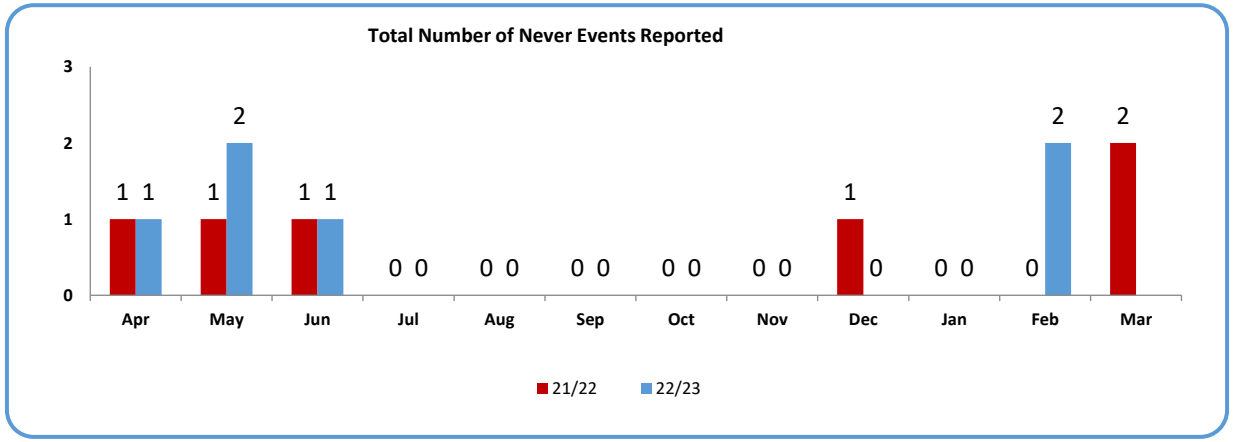


There were 24 Serious Incidents (SIs) reported in February 2023, which indicates that there has been minimal deviation from the mean since January 2023. The statutory requirement Duty of Candour (DoC) applies to patient safety incidents that occur when providing care and treatment that results in moderate, 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 February 2023.

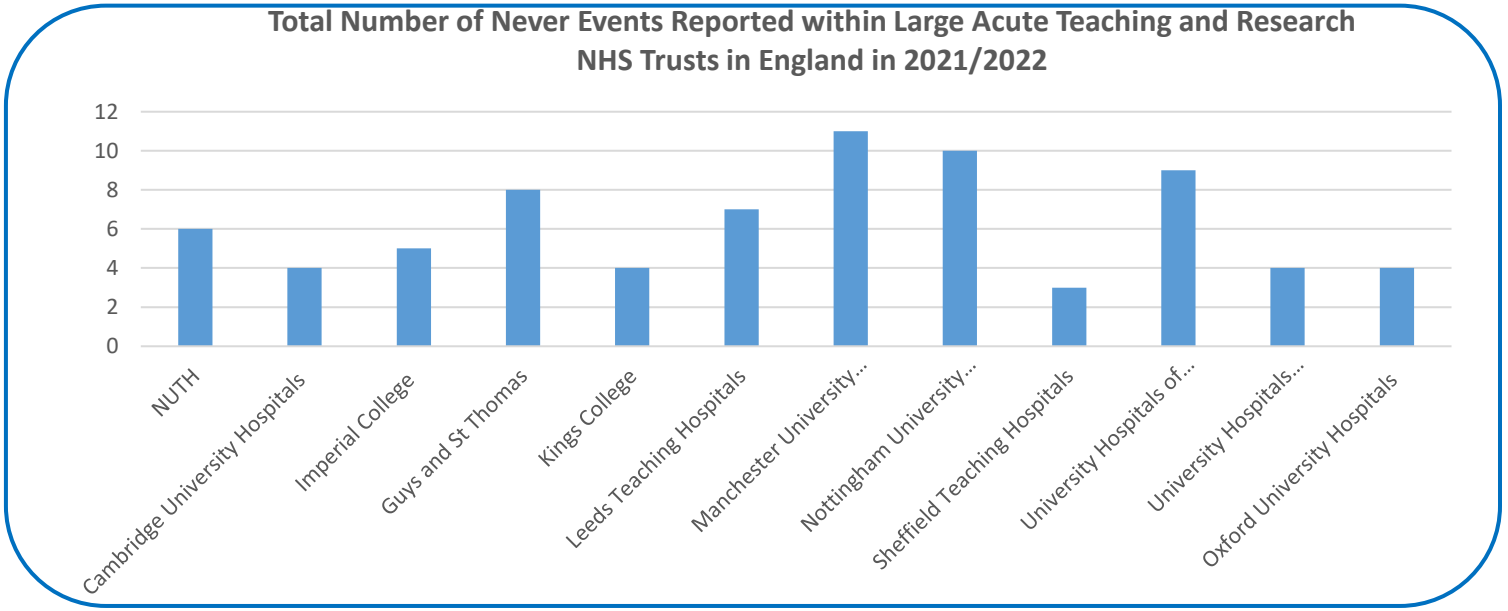


The categories of reported SIs for February are displayed in the table to the left. The highest number of SIs related to grade III pressure damage, followed by patient falls resulting in femoral fracture.

Quality: Never Events

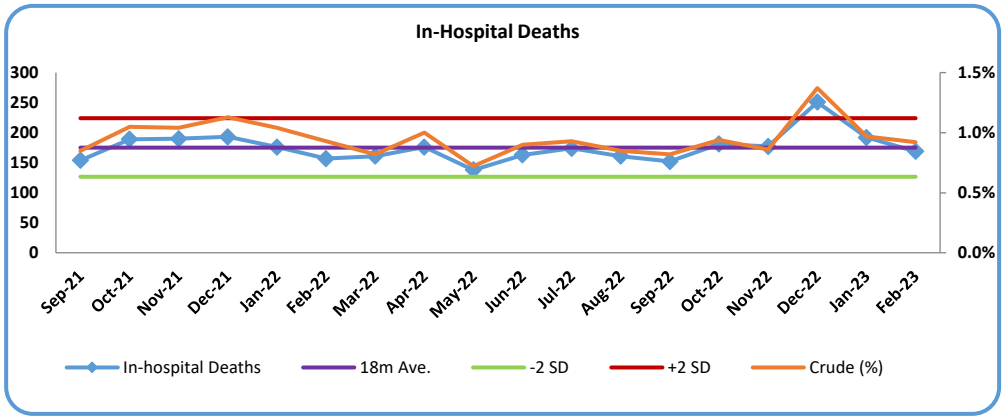


There were 6 Never Events reported in the Trust in 2021/2022. The average number of Never Events reported across Shelford and other large teaching/research NHS Trusts in England within the same reporting period (2021/22), is 6.25, which indicates that the Trust is not an outlier in relation to the number of Never Events reported nationally. It is noteworthy that the Trust performs a wider range of, and significantly higher number of surgical procedures, than most other Trusts nationally. There have been 6 Never Events reported in the Trust to date during 2022/2023 (11 month period).

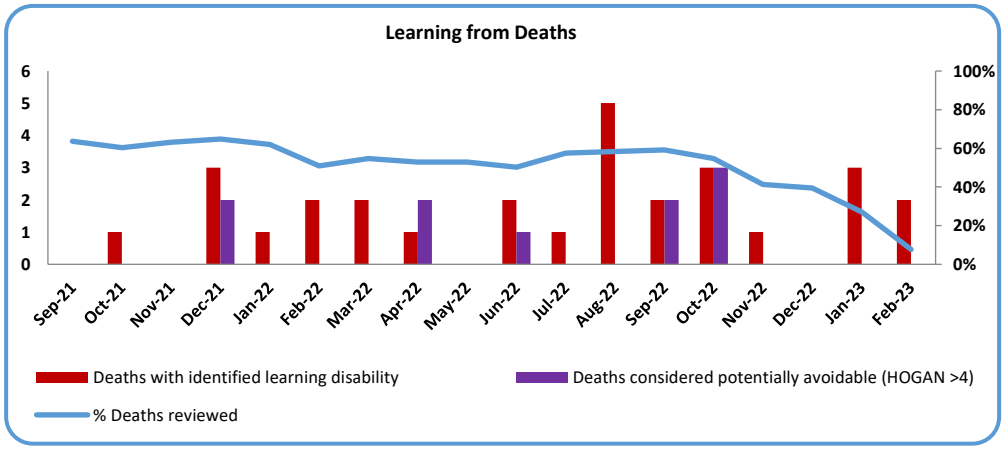


Quality: Mortality Indicators 1/2

In-hospital Deaths: In total there were 169 deaths reported in February 2023, which is higher than the amount reported 12 months previously (n=157). The crude death rate is 0.92%. Nationally the deaths were high in December 2022, indications are highlighting influenza to be the main cause of death.

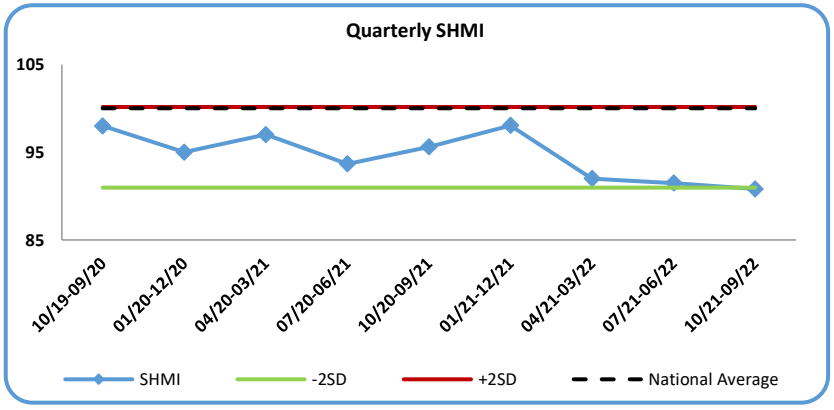


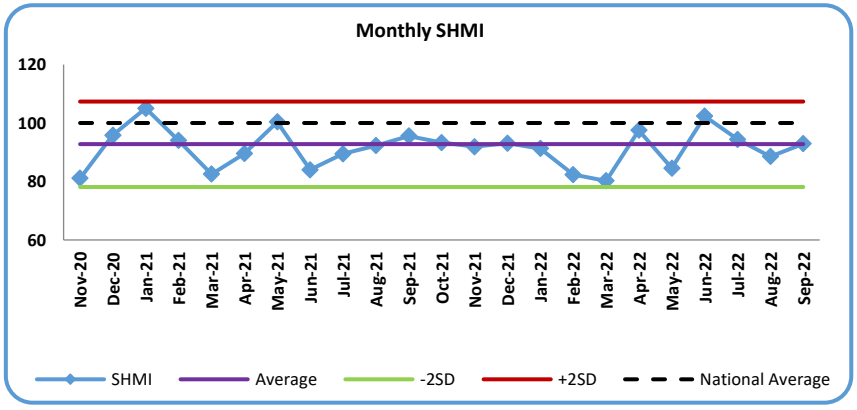
Learning from Deaths: Out of the 169 deaths reported in February 2023, 13 patients have, to date, received a level 2 mortality review. However, these figures will continue to rise due to ongoing M&M meetings held over the forthcoming months. All figures will continue to be monitored and modified accordingly.



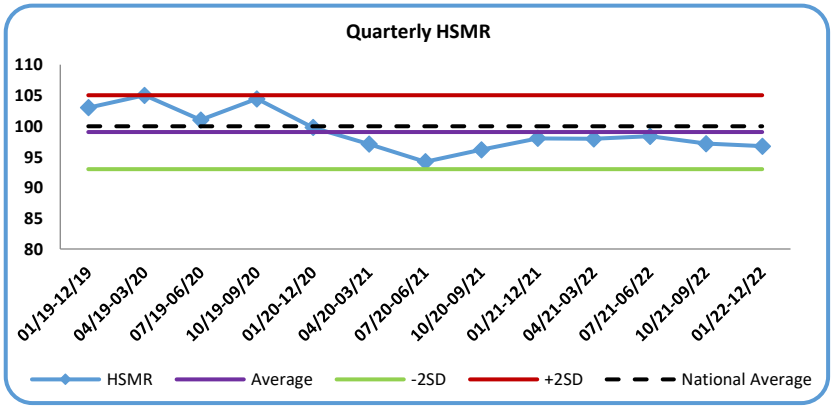
Quality: Mortality Indicators 2/2

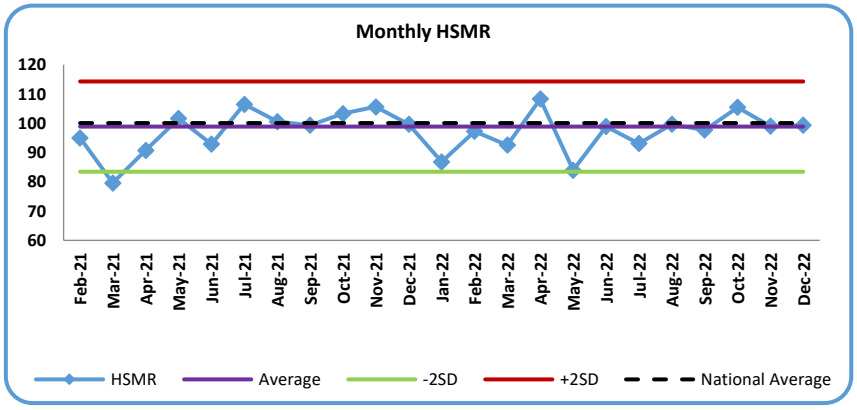
SHMI: The most recent published SHMI quarterly data from NHS Digital shows the Trust has scored 91 from months October 2021 – September 2022. This is below the national average and is within the "as expected" category. Monthly SHMI is published up to September 2022 and shows the Trust to be below the national average and within the “as expected” category. COVID-19 data continues to be excluded from SHMI data published from NHS Digital.



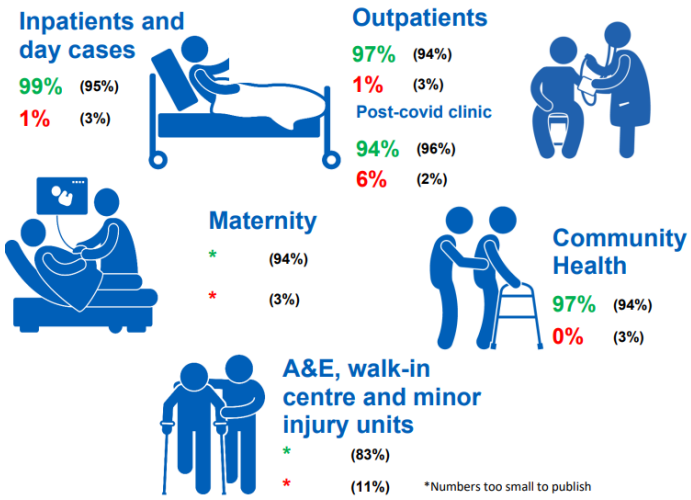


HSMR: The HSMR data shows a 12 month rolling HSMR score by quarter as well as monthly data. HSMR data is published up to December 2022, and is showing just below the national average, however this number may rise or fall as the percentage of discharge coding increases. All figures will continue to be 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 1,240 responses to the Friends and Family test from the Trust in January 2023 (published March 2023) compared to 1,301 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 opened a total of 477 (460 with identified patient activity) formal complaints up to February 23, with 40 new complaints opened last month.

The Trust has opened an average of 43 new formal complaints per month, which is three less than the average complaints for the last full financial year 2021-22.

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

	2022-23				
Directorates	Complaints	Activity	Patient % Complaints	Ratio (YTD)	21-22 Ratio (Full Year)
Cardiothoracic	23	92,648.00	0.025%	1:4028	1:3128
Children's Services	31	67,126.00	0.046%	1:2165	1:3275
Community Services	8	65,321.00	0.012%	1:8165	1:4546
Dental Services	6	92,983.00	0.006%	1:15497	1:10120
Medicine	52	131,878.00	0.039%	1:2536	1:3053
Medicine (ED)	33	161,309.00	0.020%	1:4888	1:4866
ENT, Plastics, Ophthalmology & Dermatolog	39	328,378.00	0.012%	1:8420	1:7356
Musculoskeletal Services	26	91,301.00	0.028%	1:3512	1:3505
Cancer Services & Clinical Haematology	26	196,937.00	0.013%	1:7575	1:6347
Neurosciences	31	92,734.00	0.033%	1:2991	1:3067
Patient Services	75	38,310.00	0.196%	1:511	1:1934
Peri-operative & Critical Care	12	32,994.00	0.036%	1:2750	1:3499
Surgical Services	39	66,740.00	0.058%	1:1711	1:1698
ıgy & Renal Services	20	57,896.00	0.035%	1:2895	1:3090
Women's Services	39	128,874.00	0.030%	1:3304	1:3341
Trust (with activity)	460	1,645,429.00	0.028%	1:3601	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 1,140 health and safety incidents recorded on the Datix system from the 1st March 2022 to 28th February 2023. This represents an overall rate of 73 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 (79), Cardiothoracic (61) at incident rates per 1,000 staff.

Incidents of Violence & Aggression to Staff

In addition to the incidents above, there are 1,025 incidents of physical and verbal aggression against staff by patients, visitors or relatives recorded on the Datix system from 1st March 2022 to 28th February 2023. This represents an overall rate of 65 per 1,000 staff during this period. 399 of these incidents involved physical assaults on staff. 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

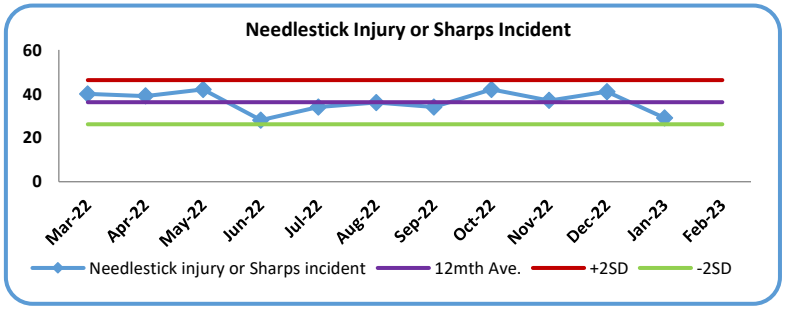
There have been 436 incidents during 1st March 2022 to 28th February 2023 (average 36 incident per month, 79% of these involve used needles). The recent sustained increase aligns with a number of factors, which are currently being discussed at the Trust Safer Sharps User Group. These include increased 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.

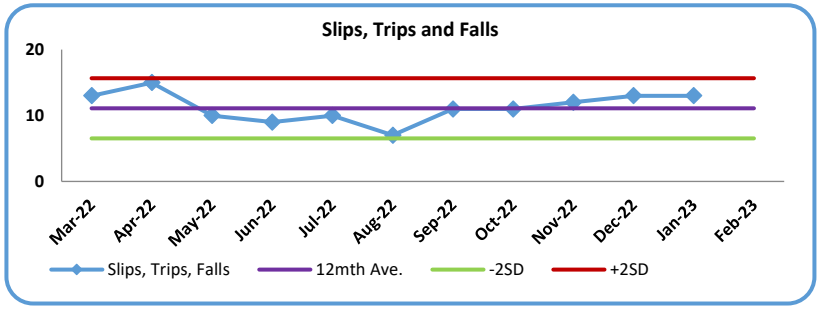
Slips, Trips and Falls

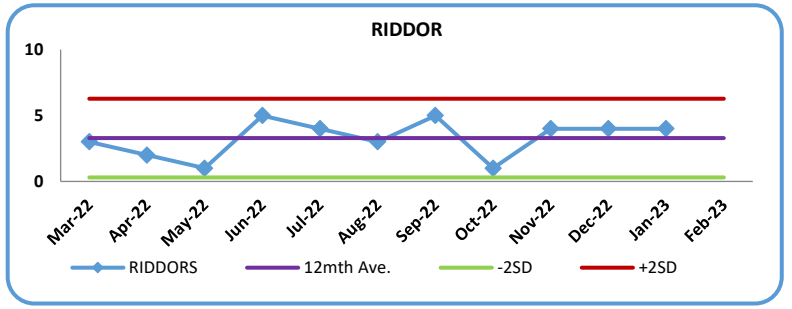
134 incidents were reported between 1st March 2022 to 28th February 2023. 61% of these incidents were related to trips and slips. Regular zonal inspections take place every month and data analysis is acted upon, feeding into the Slips, Trips and Falls Group, which meets quarterly. For example, issues were raised following incidents within Catering at Freeman and following this further work has been identified around housekeeping and control of contractors.

RIDDOR

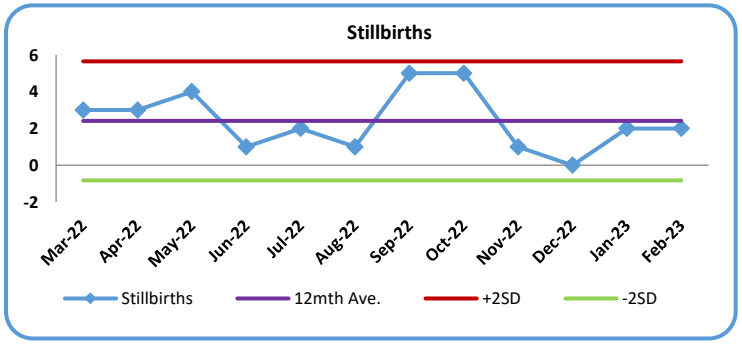
There have been 36 RIDDOR incidents reported between 1st March 2022 to 28th February 2023. The most common reasons of reporting accidents and incidents to the HSE are, Slips, Trips and falls (12), Moving and Handling (11), Accidents involving staff, visitors etc. (6) and Aggression & Violence (5). All RIDDOR reportable incidents are investigated fully and, where necessary, remedial actions are undertaken to prevent re-occurrence





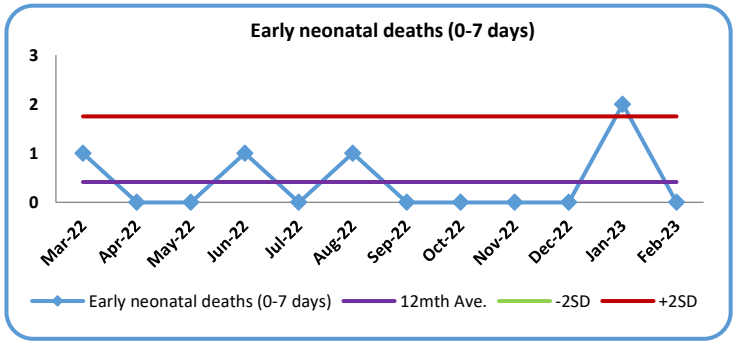


Quality: Maternity (1/3)

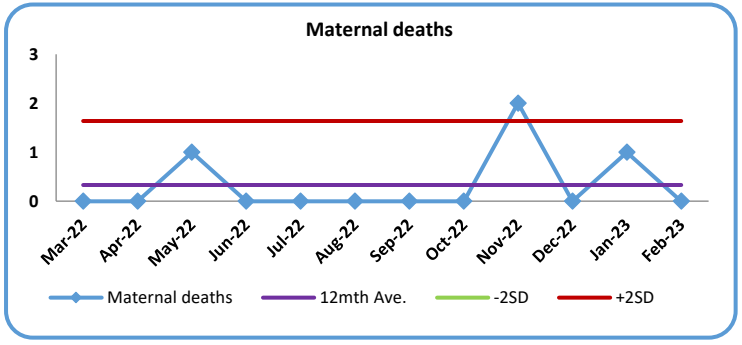


Perinatal deaths
All Perinatal deaths (Stillbirths and Neonatal Deaths) are reported to MBRRACE-UK who produce an annual National report which includes our local data.

Stillbirths
As Newcastle Hospitals 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 February there were 2 stillbirths to report. All cases undergo an initial local review and then a more detailed multidisciplinary team review including external input. Findings and actions required as a result of reviewing each case are then shared with the family involved.

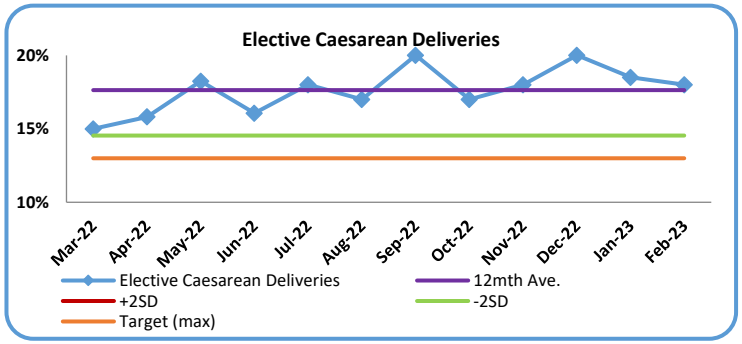


Early Neonatal Deaths
These figures are for term infants (born between 37 and 41 weeks) who delivered at the Trust but sadly died within the first week of life. These deaths are reported to the Child Death Review panel who will have oversight of the investigation and review process. These cases are also 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 February.



Maternal Deaths
Maternal deaths are reported to MBRRACE-UK and a national report is provided annually. They are also reported to HSIB and investigation is dependant on certain criteria. Maternal deaths can be categorised as Direct or Indirect. It is rare to have a direct Maternal death in Newcastle. There have been no Maternal deaths to report in February.

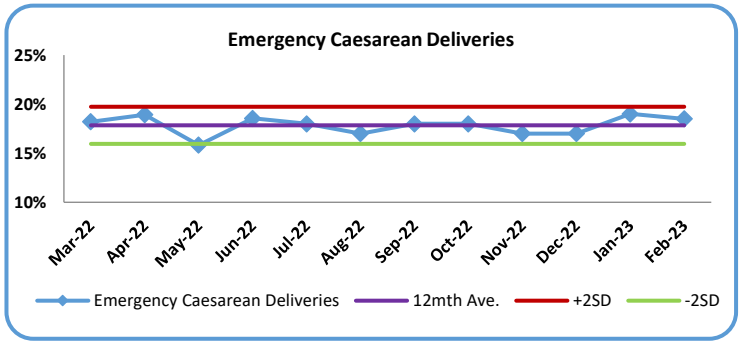
Quality: Maternity (2/3)



Elective Caesarean section

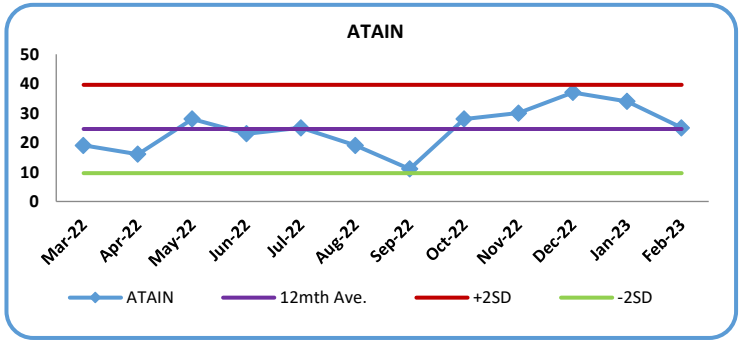
Maternity at the Trust is an outlier for elective Caesarean section compared to other UK Trusts. However, the rates are comparable to that of other tertiary centres in the UK.

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. In the last quarter (Oct-Dec) an increase in the number of term admissions was noted and has been reviewed. In February there were 25 admissions, which shows a reduction from the previous month (n34). Thematic review of these cases is currently ongoing.

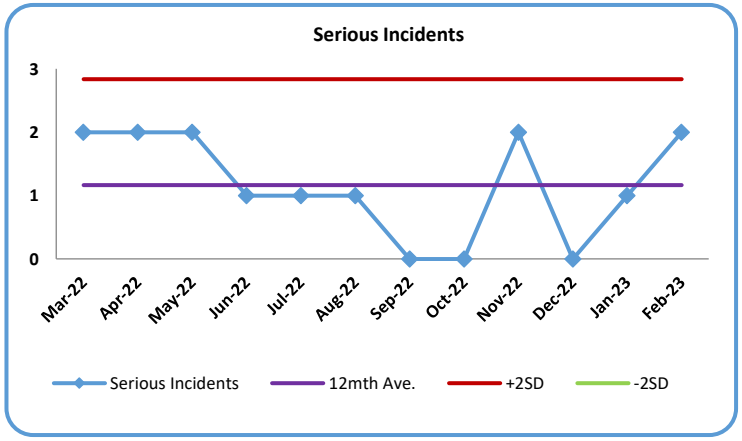
Quality: Maternity (3/3)

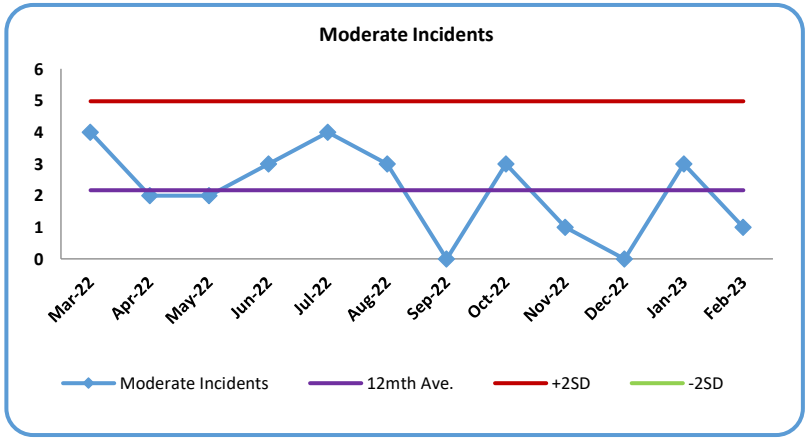
Serious Incidents

There were 14 incidents escalated as Serious Incidents in the last 12 months. These included four cases of potential Hypoxic Ischaemic Encephalopathy (HIE), one case of confirmed HIE, three neonatal deaths, one bowel injury, two intrapartum stillbirths, two antepartum intrauterine deaths and two maternal deaths. The HIE, Intrapartum Stillbirths, Neonatal deaths and Maternal deaths were all reported to HSIB (Healthcare Safety Investigation Branch) for external review. In February there was one intrapartum stillbirth and one case of neonatal kernicterus (rare brain injury resulting from severe jaundice).

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: Audit 1/4

Audit / NCEPOD	Date of Report	Areas of Good Practice	Areas for improvement	Action Plan Developed
UK Registry of Endocrine and Thyroid Surgery	12 January 2021	• The Trust produced above average outcomes in all measures with the exception of thyroid, adrenal and parathyroid cancers.	• Compliance with cancer standards in thyroid, adrenal and parathyroid cancers requires review and further improvements to be implemented including additional CNS nurse resource.	Discussed at February 2023 Clinical Audit and Guidelines Group
National Joint Registry (NJR)	1 November 2022	• 96% of records entered onto the NJR included a valid patient NHS number (RVI). National Standard 95%. • 90-day mortality and revision rate was within the expected range for both Hip and Knee replacement, across both sites (RVI & FH)	• Consent rates documented on NJR below national standard for both RVI & FH (national standard 95%): FH 1%, RVI 46%. An electronic solution has been implemented in October 2022 which will improve compliance rates with this standard. This will be reflected in the next audit cycle. • 45% of records entered onto the NJR included a valid patient NHS number (FH). National Standard 95%.	Discussed at February 2023 Clinical Audit and Guidelines Group
National Comparative Audit of Blood Transfusion	1 February 2022	• 100% of patients who were known to have iron deficiency anaemia prior to being admitted for surgery were treated with iron before surgery (59% nationally). • 100% of patients undergoing surgery with expected moderate blood loss received tranexamic acid (67.5% nationally). • 90% of transfused patients had evidence of receiving written or verbal information about the risks, benefits, and alternatives to transfusion (64% nationally). • 80% of patients received both written and verbal information (26% nationally).	• 30% of patients receiving elective red blood cell transfusions had both their Hb checked and a clinical re-assessment after a unit of red cells was transfused (58% nationally). An action plan to increase awareness is in place.	Discussed at February 2023 Clinical Audit and Guidelines Group

Quality: Audit 2/4

Audit / NCEPOD	Date of Report	Areas of Good Practice	Areas for improvement	Action Plan Developed
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	14 July 2022	• 100% data completion for audit (79% average for England and Wales) • NuTH is one of 126 out of 144 Trusts with a defined paediatric epilepsy lead • NuTH is one of 13 out of 144 Trusts able to facilitate a review location within the Trust for Vagus Nerve Stimulation (VNS) and one of 23 out of 144 trusts to do so for ketogenic diet. • NuTH offers a full range of investigations (different types of EEG, MRI, and telemetry) • There was 0% prescribing of Sodium Valproate (teratogenic anti-epilepsy drug) to girls aged nine years old and over • 76% of patients obtained their EEG within four weeks of request (compared to 54% Nationally)	• Paediatric Epilepsy Specialist Nurse (PESN) is currently undertaking a review of all patients to ensure discussion about Sudden Unexpected Death in Epilepsy has taken place and a prolonged seizure care plan is in place for all children. • PESN is liaising with schools who have children with epilepsy to facilitate training and care planning. • PESN has been in post since September 2022 and has more children on their caseload than is recommended (n=250). Data is currently being gathered regarding accurate caseload numbers. • Consultant staff and Paediatric Epilepsy Lead do not have dedicated time within their job plan to take part in the Epilepsy12 audit, which is a national requirement. • All children and young people with an epilepsy diagnosis should have ongoing screening for mental health illness using a validated tool as part of their routine epilepsy care. NuTH are reviewing the current approach to Mental Health assessment in children and young people with an epilepsy diagnosis. • Clear shared care pathways between secondary care and paediatric neurology do not follow national guidance. Instead NuTH use informal referral pathways that are inconsistently used. This work requires allocated time for the clinical lead and PESN to be able to take this forwards.	Discussed at February 2023 Clinical Audit and Guidelines Group

Quality: Audit 3/4

Audit / NCEPOD	Date of Report	Areas of Good Practice	Areas for improvement	Action Plan Developed
National Emergency Laparotomy Audit (NELA)	11 November 2021	• Good communication between ED and Radiology allowing rapid access to CT examinations 24 hours a day. • Risks documented before surgery (92% vs National Average 85%) • Consultant Surgeon in theatre (99% vs National average 96%) • Reduction in adjusted mortality rate from 6% to 5.4% (national average 8.7%)	• Negative Laparotomies to be audited quarterly in line with guidance.	Discussed at March 2023 Clinical Audit and Guidelines Group
Cleft Registry and Audit Network Database	12 December 2022	The Trust was a positive outlier for: • Registered children with verified consent • Consented 5-year-olds who had facial growth data reported • Consented 5-year-olds who had dental outcomes reported • Consented 5-year-olds with ratings suggesting speech within the normal range • Consented 5-year-olds with ratings suggesting no structurally related speech difficulties • Consented 5-year-olds who had complete psychology data reported, (according to cleft service)	• No areas for improvement were identified	Discussed at March 2023 Clinical Audit and Guidelines Group
National Outpatient Management of Pulmonary Embolism	31 October 2022	• Time from presentation to CT Pulmonary Angiogram (CTPA) significantly higher than national average (42.9% within 2 hours compared to 18.5% nationally, 100% within 12 hours compared to 45% nationally) • 100% reporting of evidence of right heart strain on CTPA • 92.9% of patients were given verbal contact details compared to 58.6% nationally • Organisational structure in place with regards to seven-day access to CTPA as part of a formalised PE pathway • Significant improvement from 2020 NCEPOD data	• All patients should receive written information including emergency contact details and follow-up within seven days of discharge: Trust scored 0% (national average 40%) Patient information leaflet has been created and now given to patients. The Trust is recruiting a Pulmonary Embolism Nurse Specialist who will be responsible for contacting patients within seven days of discharge.	Discussed at March 2023 Clinical Audit and Guidelines Group

Quality: Audit 4/4

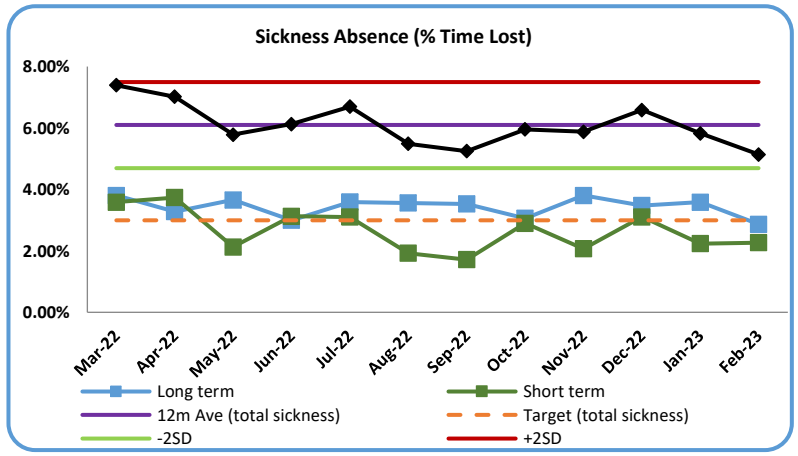
Audit / NCEPOD	Date of Report	Areas of Good Practice	Areas for improvement	Action Plan Developed
National Audit of Inpatient Falls	10 November 2022	• Cases where patients were checked for injury before being moved from site of fall (95% vs 74% National Average). • Cases where a safe manual handing method was used to move a patient from floor (57% vs 33% National Average) • Cases that received a medical assessment within 30 minutes of a fall (86% vs 72% National Average) • High-quality Multi-factorial falls risk assessment (MFRA)prior to the fall (95% vs 76% National Average)	• No areas for improvement were identified	Discussed at March 2023 Clinical Audit and Guidelines Group
National Cardiac Rhythm Management Audit	14 October 2021 & 16 June 2022	• Hospital activity volumes are above recommended targets for device implants, complex device implants, simple catheter ablation & AF ablation • Data validity >95% in 6/7 key components • 98.3% of pacemaker implants were dual chamber (pacing for sinus node disease in the absence of atrial fibrillation) • 91% of pacemaker implants were dual chamber (pacing for atrioventricular block in the absence of atrial fibrillation) • 95.6% of Implantable Cardioverter Defibrillators (ICD) implants for primary prevention were documented to meet at least one of the NICE criteria • 97% of ICD implants for secondary prevention were documented to meet at least one of the NICE criteria • Simple pacemaker re-interventions within first year following implant – 4.52% (target 95%). • Complex pacemaker re-interventions within first year following implant – 8.36% (target 95%)	• No areas for improvement were identified	Discussed at March 2023 Clinical Audit and Guidelines Group

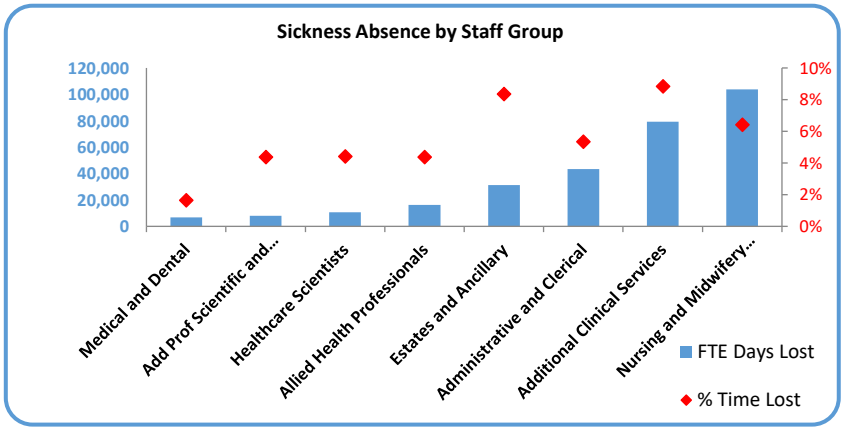
People: Sickness Absence 1/2

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

	Feb-22	Feb-23	
Long-term	3.80%	3.63%	↑
Short-term	2.1%	2.49%	↑
Total	5.90%	6.12%	↑

- 301,231 FTE working days were lost due to sickness (including COVID-19 related sickness) in the year to February 2023, compared to 298,826 for the previous year.
- Overall sickness absence (including COVID-19 related sickness) is 6.12%, which is down from end of Dec 2022 position of 6.45% (% FTE Time Lost).
- The top three reasons for non-COVID related sickness absence are Anxiety/stress/depression/other psychiatric illnesses (27%) Cold, Cough, Flu (9%), and other musculoskeletal (10%).
- 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).

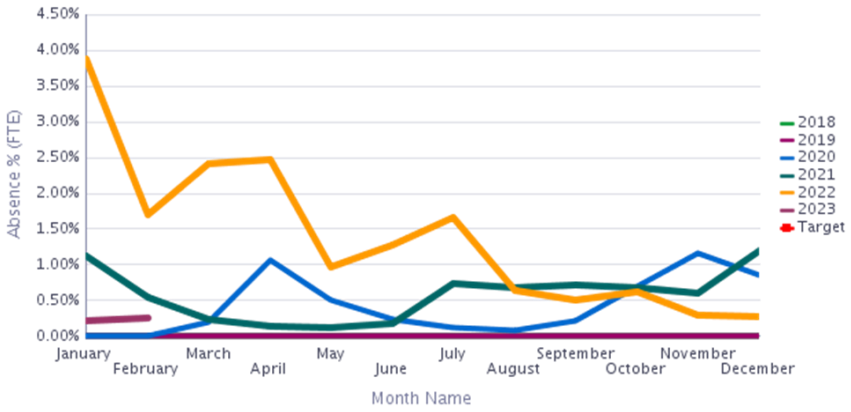




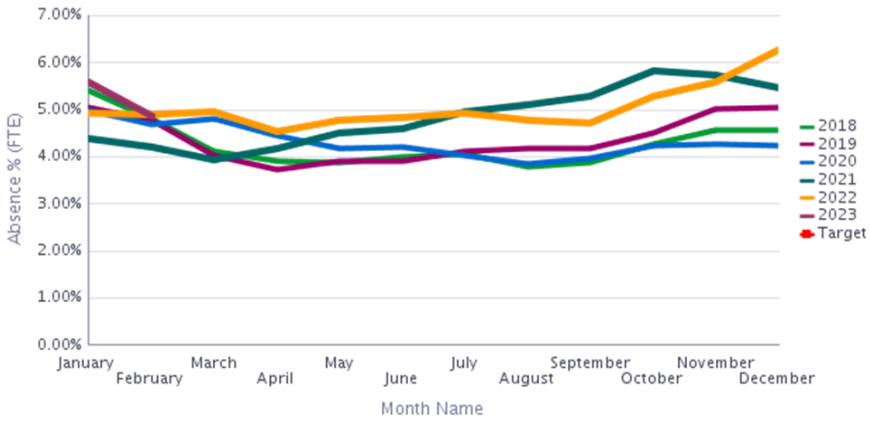
*COO Directorate includes Outpatients / ABC Service

People: Sickness Absence 2/2

COVID-19 Related Sickness Jan 2018 – February 2023 (%FTE)

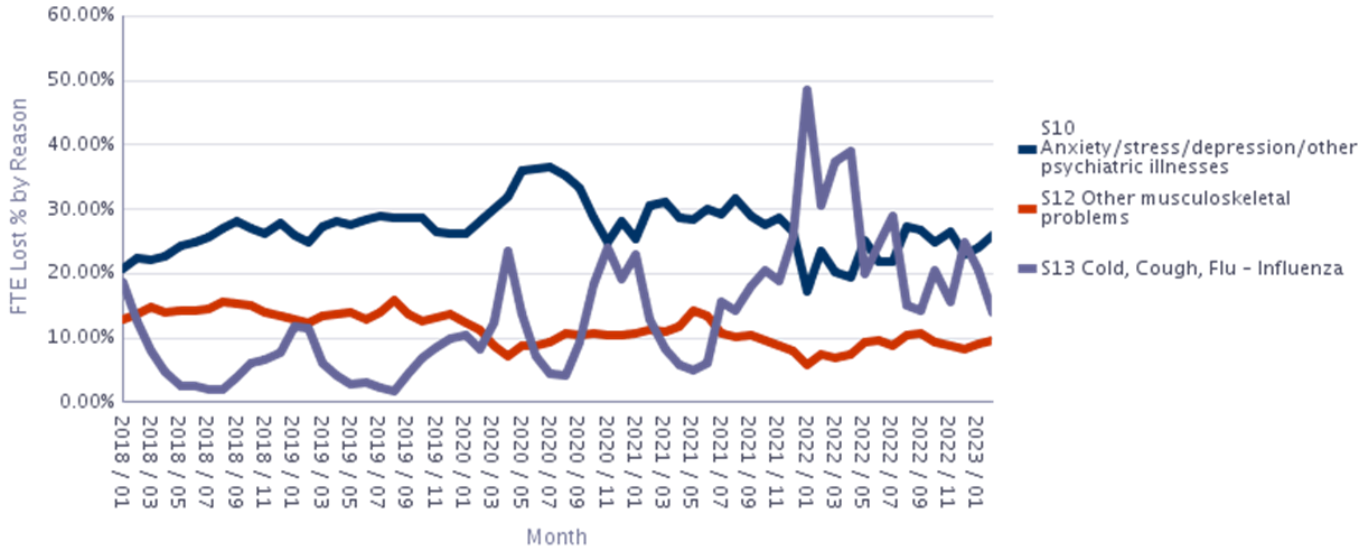


Non-COVID-19 Related Sickness Jan 2018 – February 2023 (%FTE)

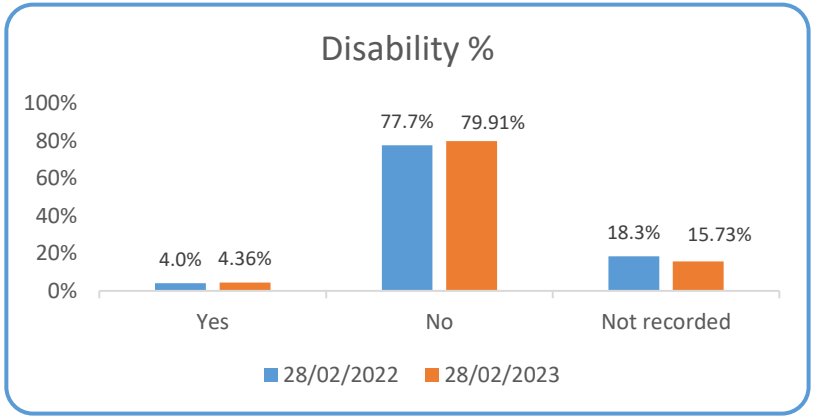


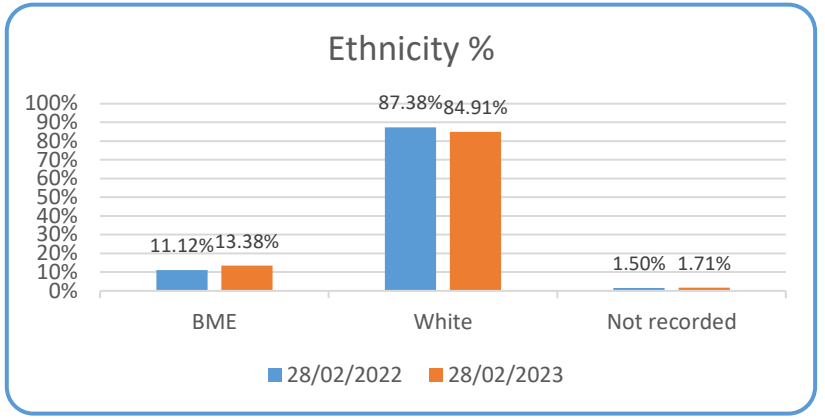
Top 3 Sickness Reasons Jan 2018 - Feb 2023 (%FTE)

S13 includes Covid sickness

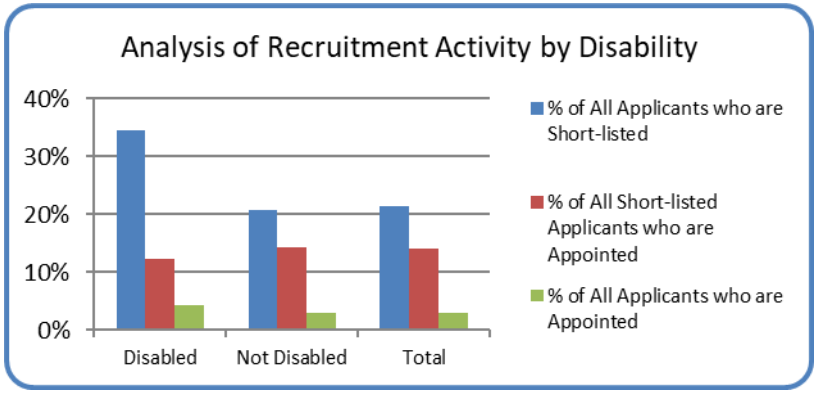


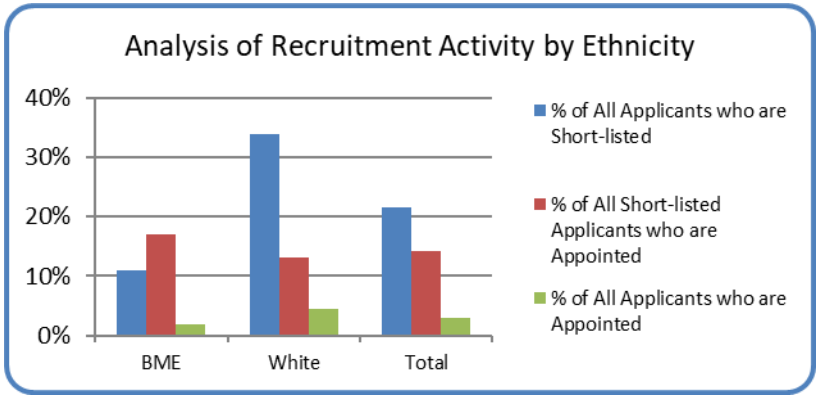
People: Equality and Diversity





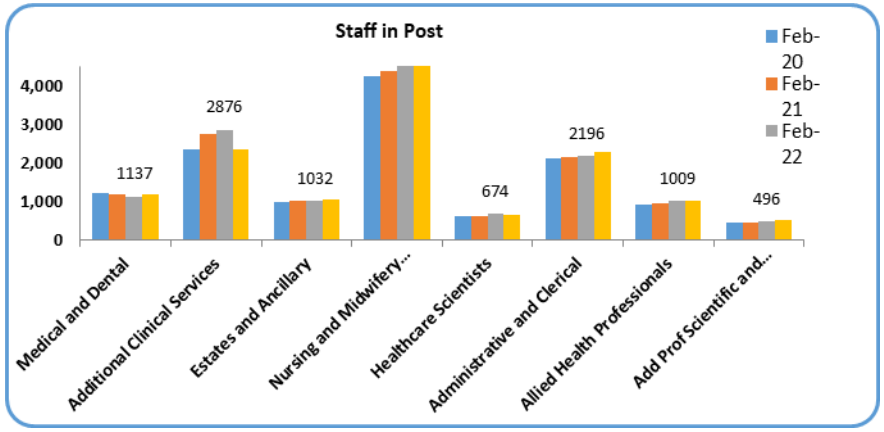
- The graphs above identify, by disability and ethnicity, the recruitment outcome of applicants during the twelve months ending February 2023.

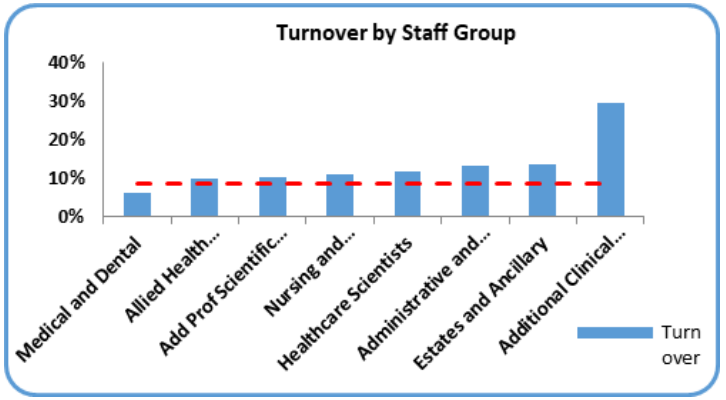


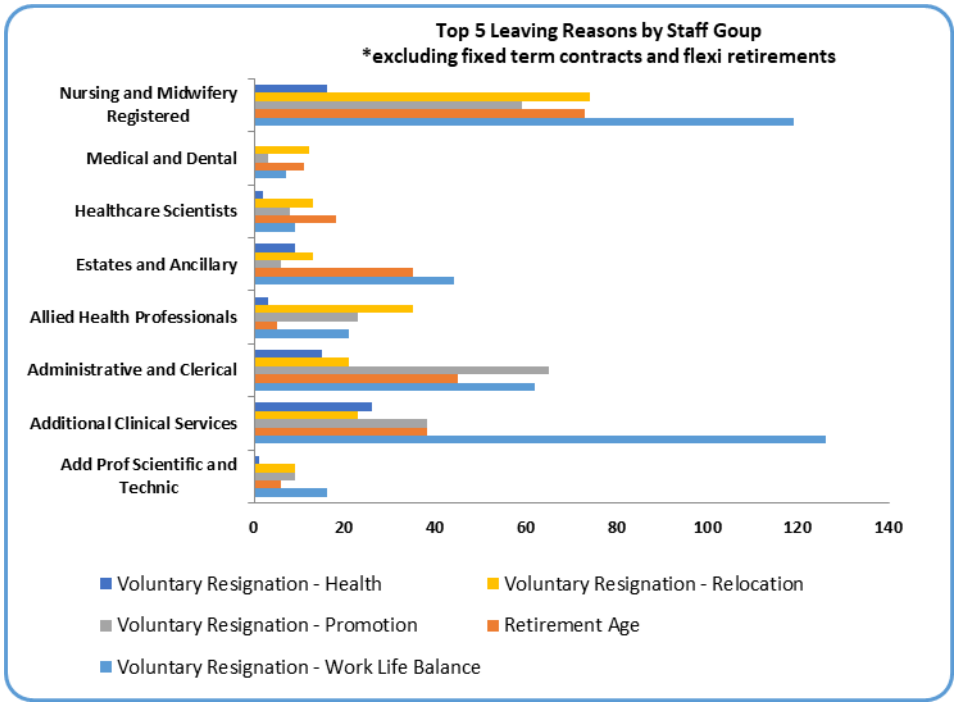


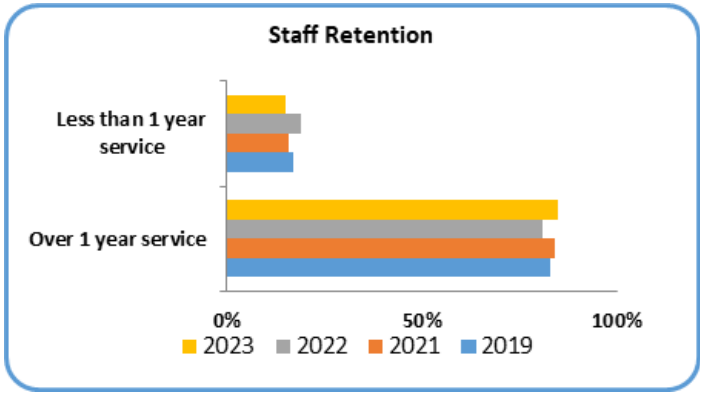
- The graphs above identify, by headcount, the percentage of staff in post in February 2022 and February 2023 by disability and ethnicity. The percentage of staff employed disclosing a disability has improved from 3.98% to 4.36% and the percentage of BAME staff has increased from 11.12% to 13.38%.

People: Workforce 1/3









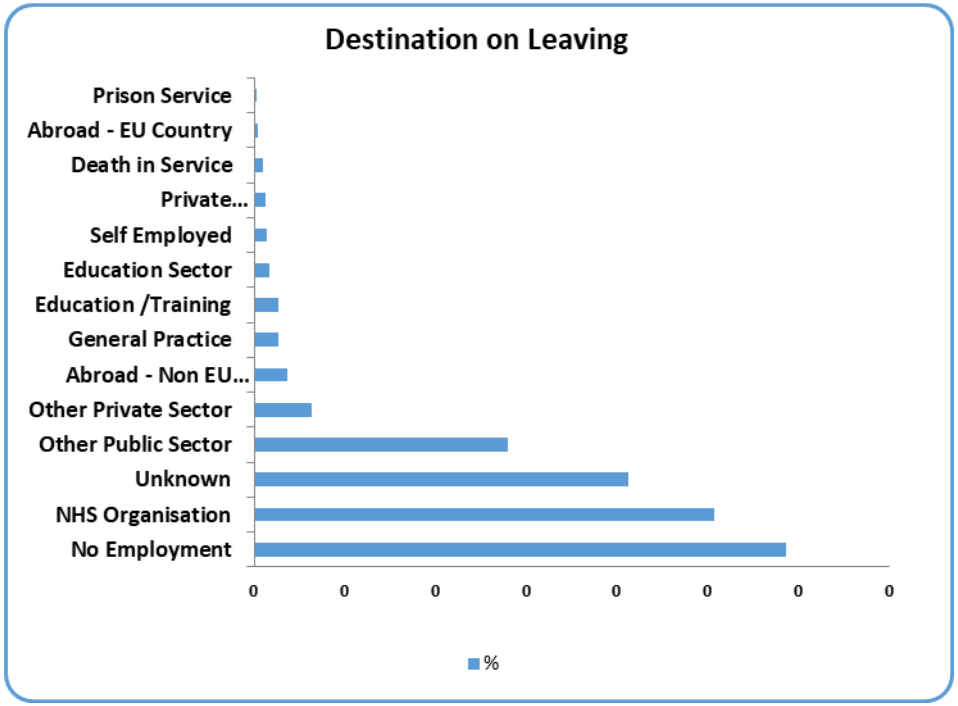
- Staff in post has increased by 5.64% since February 2020. The staff groups with the largest increase are Additional Scientific and Allied Health Professionals.
- Staff turnover has increased from 11% in February 2022 to 13.6% in February 2023, against a target of 8.5%.
- The total number of leavers in the period March 2022 to February 2023 was 2,335.
- Retention for staff over 1 year service is 85.06%, an increase from 81.11% in February 2022.

People: Workforce 2/3

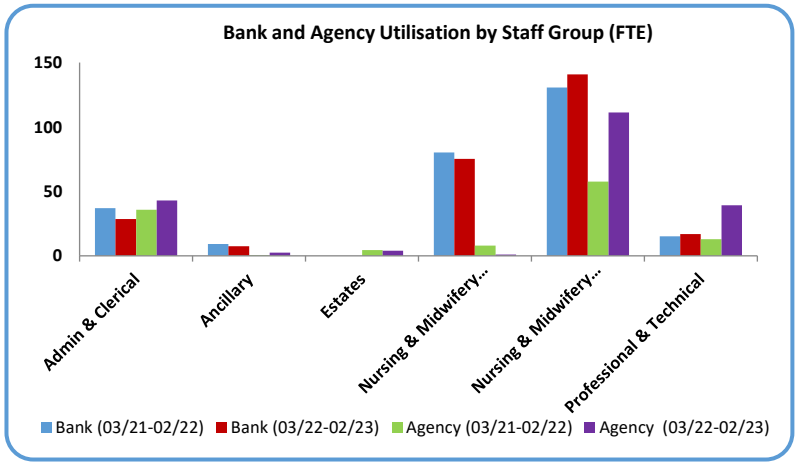
Turnover by Directorate

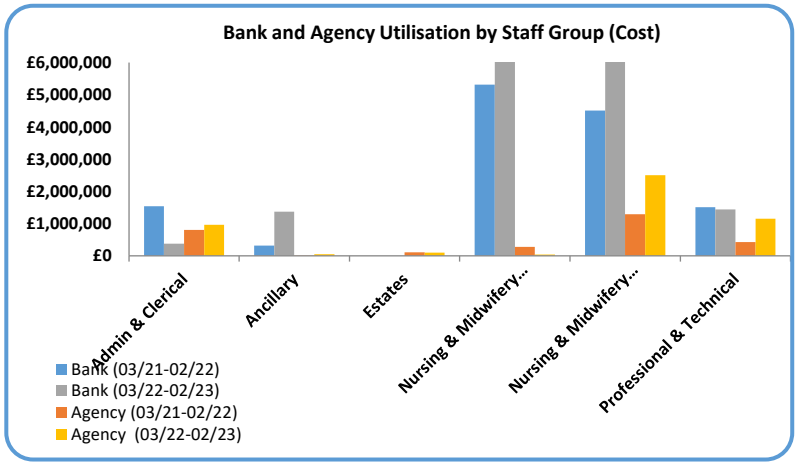
Day Treatment Centre	0.00%
Business & Development	3.23%
Medical Director	6.48%
Urology & Renal Services	7.63%
Neurosciences	7.81%
Chief Executive	7.87%
Peri-operative & Critical Care - FH	7.94%
Surgical Services	8.46%
Regional Drugs & Therapeutics	8.70%
Medical Physics	9.20%
Children's Services	9.39%
Internal Medicine - Urgent Care	9.55%
ENT, Plastics, Ophthalmology & Dermatology	9.94%
Radiology	10.18%
Cancer Services/ Clinical Haematology	10.21%
Dental Services	10.43%
Musculoskeletal Services	10.55%
Clinical Research	10.80%
Cardiothoracic	10.84%
Internal Medicine - General	10.95%
Peri-operative & Critical Care - RVI	11.09%
Pharmacy	11.21%
Women's Services	11.68%
Integrated Laboratory Medicine	11.76%
Community Services	12.62%
Chief Operating Officer	12.84%
Patient Services	12.97%
Information Management & Technology	14.91%
Estates	16.79%
Finance	17.47%
Human Resources	20.39%
Supplies	24.24%

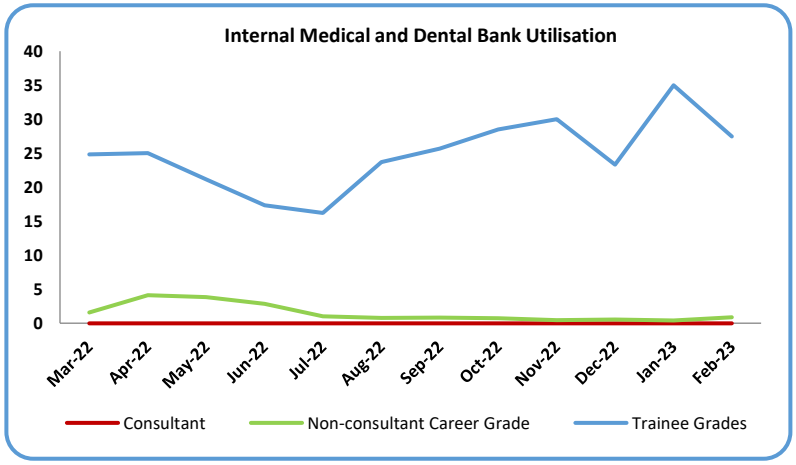
- Only 25% of leavers across the Trust disclosed they were going to another NHS organisation.



People: Workforce 3/3

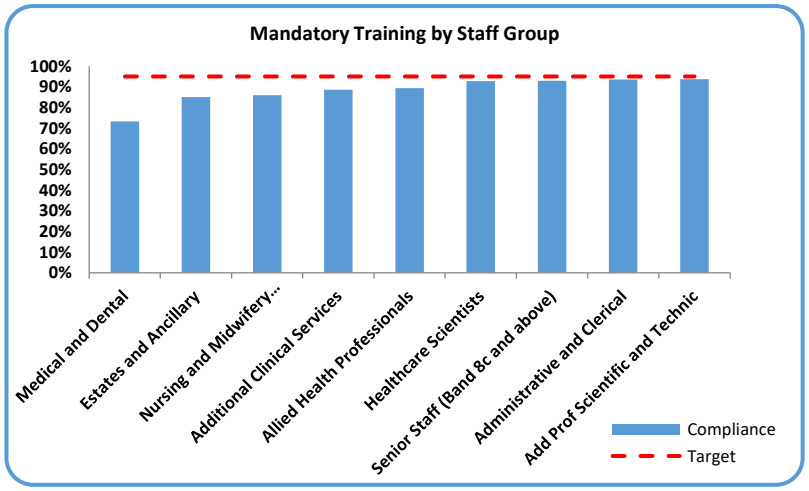


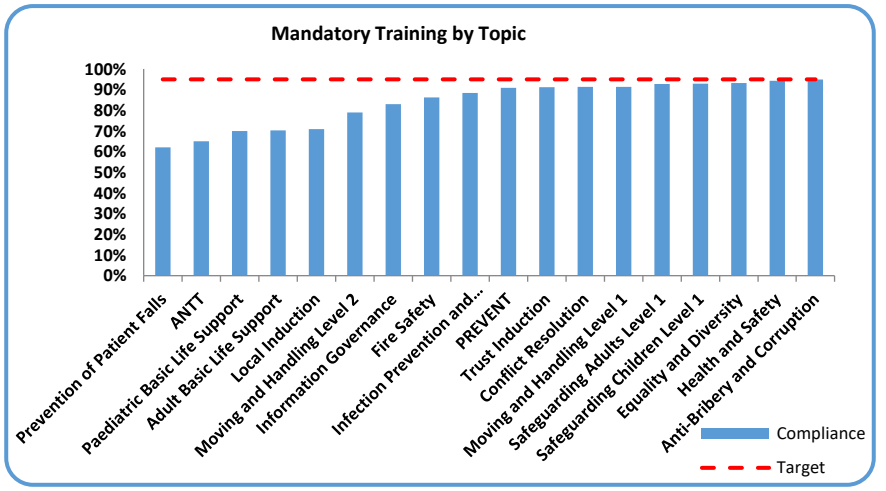


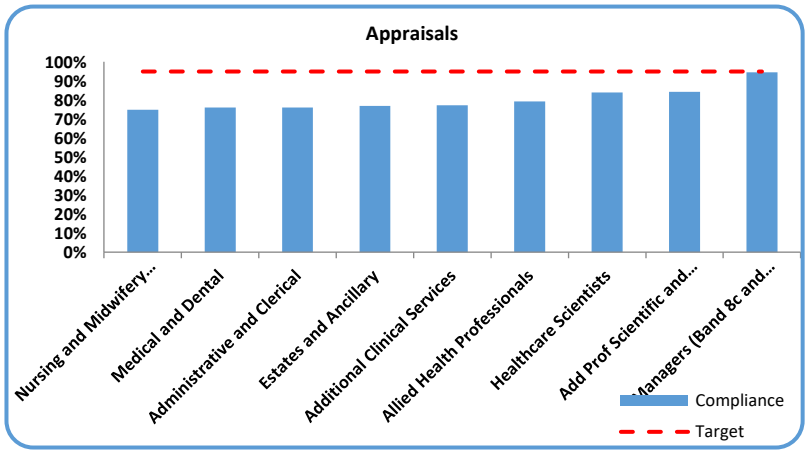


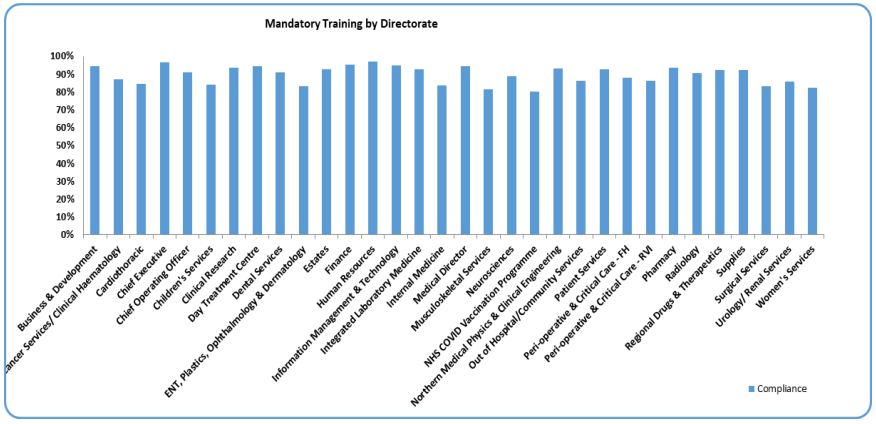
Comparing the periods March 2021 – February 2022 to March 2022 – February 2023, overall bank utilisation decreased from 272 wte to 269 wte and agency utilisation has increased from 119 wte to 200 wte.

People: Delivering Excellence in Education & Training









- Mandatory training compliance stands at 87.2% at end of February 2023, against an end of year target of 95%. The February 2022 position was 87.6%.

- Medical and Dental are the staff group with the lowest training compliance at 73.1% in February 2023 compared to 68.8% in February 2022.

- Appraisal compliance stands at 77.03%, at end of February 2023, against an end of year target of 95%. The February 2022 position was 73.8%. 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 28th February 2023.

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. There have been recent discussions and negotiations with NHSE and the ICB, to review the forecast out-turn position and agreement has been reached to a revised figure of £3.7million.

In the period to 28th February the Trust incurred expenditure of £1,277.7 million, and accrued income of £1,282.9 million on mainstream budgets, including expenditure of £5.8 million on the programmes outside the block envelope (vaccine roll-out programme), leading to a surplus of £5.2 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 £4.4 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 28th February the Trust had spent £47.5 million capital, £15.6 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 11 Budget £'000	Month 11 Actual £'000	Month 11 Variance £'000
Income	1,243,541	1,282,918	39,377
Expenditure	1,238,401	1,277,668	39,266
I & E position (excl impairment) - (Deficit)/Surplus	5,140	5,250	110
Capital Programme	63,067	47,477	(15,590)

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	23 March 2023						
Title	Communications Strategy						
Report of	Caroline Docking, Assistant Chief Executive & Director of Communications & Engagement						
Prepared by	Amanda Marksby, Head of Communications Julie Marsh, Head of Communications – Special Projects & Commercial						
Status of Report	Public	Private	Internal				
	x	☐	☐				
Purpose of Report	For Decision	For Assurance	For Information				
	☐	☐	x				
Summary	This communications strategy provides a framework for external and internal communications and stakeholder engagement at Newcastle Hospitals. This framework is 'owned' by the Board of Directors who set the direction for communications across the organisation. The Executive Lead for the strategy is the Director of Communications, and it will be implemented by the Communications Team. This document outlines: 1. Strategy Overview 2. Context and challenges 3. SWOT Analysis 4. Objectives 5. Audiences and positioning 6. Comms Channels and tactics from 2023 7. Evaluation process 8. Resources						
Recommendation	The Committee are asked to note the contents of this strategy.						
Links to Strategic Objectives	This strategy links to each of the 5 Ps within the organisation's strategic framework.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☐	☐	☐	☒	☐
Impact detail	Impact detailed in report.						
Reports previously considered by	People Committee - October 2022						

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Communications & Stakeholder Engagement Strategy

1. STRATEGY OVERVIEW

This communications strategy provides a framework for external and internal communications and stakeholder engagement at Newcastle Hospitals.

This framework is 'owned' by the Board of Directors who set the direction for communications across the organisation. The lead member of the Executive team is the Director of Communications/Assistant Chief Executive.

It is implemented by the communications team.

Our overarching aim is to sustain and build on the positive and growing profile of Newcastle Hospitals within the framework of the trust's vision and values – with quality and patient safety at the heart of everything we do.

Our vision: Newcastle Hospitals – Achieving local excellence and global reach through compassionate and innovative healthcare, education, and research.

Our values were developed wholly by our staff and guide everything that we do as we grow to achieve our vision.

We care and are kind

We care for our patients and their families, and we care for each other as colleagues.

We have high standards

We work hard to make sure that we deliver the very best standards of care in the NHS. We are constantly seeking to improve.

We are inclusive

Everyone is welcome here. We value and celebrate diversity, challenge discrimination and support equality. We actively listen to different voices.

We are innovative

We value research. We seek to learn and to create and apply new knowledge.

We are proud

We take huge pride in working here and we all contribute to our ongoing success.

The communications team's role is to:

- Enhance and preserve Newcastle Hospital's reputation as an organisation that provides the highest quality patient care, research, and associated services.
- Support the delivery of our trust strategy and breakthrough objectives (through the five P's), as well as operational priorities.
- Provide expert communications and engagement advice.
- Enhance staff engagement.
- Work in a way which exemplifies our trust values.
- Understand and enhance the ways that different stakeholders will interact with us and what we need and want from them (and vice versa).

2. CONTEXT AND CHALLENGES

Economic

- There is increased economic uncertainty in the UK.
- The cost-of-living increase is having an impact on NHS staff and the communities we care for.
- This will have an impact on NHS budgets and will require a different approach to the cost improvement programme.

Political

- Political change, due to recent changes in Government, means there is no clear political strategy for the NHS as yet.
- Political demands - because of the scale of impact on the NHS through the pandemic and action needed on waiting lists and urgent demand.
- Need to demonstrate the impact of investment e.g. virtual wards, transformation.
- Important to create hope and pride in a challenging environment.
- The next general election is scheduled to be held in May 2024.
- Potential strike action from multiple workforce groups.

Partners

- New opportunities and challenges from the new Integrated Care Board and System, Collaborative Newcastle, and other key partner organisations.
- The Northern Cancer Alliance is working with us to transform pathways.
- We work closely with sector colleagues to support a full range of specialist services for the region and beyond.
- As an Academic Health Science Centre, we continue to work across health, academic and social care organisations to improve the quality of healthcare.
- Ensuring we are at the forefront of health innovation and research with our partners, integrating research into every-day care, facilitating research and publicising research opportunities for patients.
- Our charity has grown in strength and profile and works with a range of other partners.

3. COMMUNICATIONS STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS (SWOT)

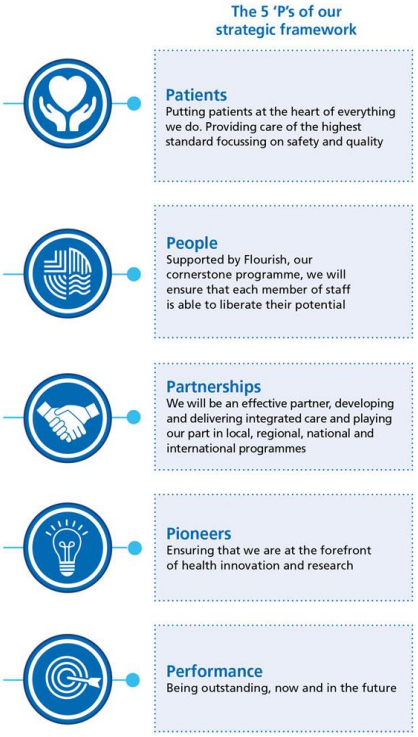
Strengths	**Weaknesses**
We have skills that cover all communications 'disciplines' (journalism, PR, digital, internal comms, engagement, integrated campaigns, design, video production, research, and evaluation). We have a good reputation for supporting the organisation, working with partners in and outside the healthcare system and delivering high quality, effective work. The trust has a clear brand, and a clear strategy, vision, and values. The trust has some of the most respected clinicians and academics in the world. We have a fantastic heritage and pioneering research, with lots of examples of our services and care having a profound and positive impact on people's lives. We are CQC outstanding and perform highly. We have invested in new facilities and services.	Communications team capacity vs expectation. Our communications team is relatively small compared to many other Trusts, with no non-pay funding. Succession planning and career development is difficult in a small team. Individual staff members are under a huge amount of pressure and regularly work significant extra hours. We have a poor intranet that requires significant development / ongoing maintenance. Digital activity is mainly one way, sharing information rather than meaningful engagement or information gathering e.g. patient experience, service improvement. We have a huge, dispersed workforce that can make communication and engagement challenging. The wider workforce is under huge pressure.
Opportunities	**Threats**
New ways of working - MS Teams all staff briefings and 'town hall' events. Developing and implementing more digital communications and engagement – resource dependent. Taking a combined approach to communicating CIP, organisational restructure, and efficiency/service improvement initiatives – 'Fit for the Future' TV profile – national news/documentaries. Research developments and the AHSC. Our partnership with the IHI - Quality Improvement projects and What Matters to You. Partnership working at place. VIP visits.	COVID-19, flu, plus winter pressures and impact on patient and staff experience. Ongoing pressures on the NHS make it more difficult to meet requirements and expectations of regulators. Potential national economic stressors. Impact of cost-of-living crisis on staff and patients. Negative publicity/reputational damage from individual cases. Workforce unrest across the NHS.

4. Objectives

Being led by our vision and values, the trust's communications service will work to deliver the following overarching objectives, to position Newcastle Hospitals as:

- One of the best hospitals in the UK and the world to receive compassionate, expert and high-quality patient care
- The best place in the NHS to work through our #Flourish Programme
- Somewhere that values partnerships and looks to challenge health inequalities, especially through Collaborative Newcastle
- A beacon of research and innovation, developing cutting-edge practice
- A leader in digital technology
- At the forefront of sustainability and a greener NHS
- A national exemplar in all we do, with a sound financial platform

We will also ensure our communications objectives are embedded in the organisation's strategic framework – the 5 'P's – to help us measure our progress and success in the delivery of our vision and ambitions and, ultimately, the trust's objectives and strategy.



In all our communications we will be:

- Clear, concise, and consistent with a shared corporate narrative
- Clinically led where appropriate
- Inclusive and accessible
- Timely and accurate
- Honest, authentic, and transparent
- Targeted and relevant
- Multi-channel and two-way
- Evidence-based
- Human - sharing stories which engage our audiences by showing real people and the difference they make or have experienced

We will do this by:

- Positioning Newcastle Hospitals as the healthcare provider of choice for GPs and patients
- Actively engaging staff through a high-quality internal communications programme
- Positioning Newcastle Hospitals as a credible, influential, and prominent voice in the media
- Continuing to build and develop our digital and online communications to enhance our reputation and service offer to the public, staff, and wider stakeholders
- Engaging external stakeholders in our work
- Ensuring consistent branding and visual identity in line with previous board agreement. A clear brand hierarchy, with associated guidance, is under development, to ensure all Newcastle hospitals services and projects are clearly and appropriately identified within a consistent corporate framework

Case study – Day Treatment Centre

A fast-track elective recovery and estates project, the day treatment centre was constructed in less than 10 months on the Freeman Hospital site to help tackle waiting list challenges caused by the COVID-19 pandemic.

The trust's programme management office played a significant role in the delivery of the initiative, with a dedicated communications and engagement lead and workstream forming a key component of this. Throughout the programme and construction, internal and external communications requirements and activity formed a key part of strategy and delivery.

Key communications outputs included:

- Developing and targeting a recruitment campaign 'out of area', with the aim of attracting new staff into the DTC workforce. This utilised social media to reach certain geographical locations identified by the senior nursing team.
- Local media coverage, highlighting jobs available and messages about the importance of investing in a dedicated day treatment centre.
- An internal bulletin for trust managers, updating progress with the project and sharing information about patient suitability criteria.
- Sending update letters to local residents and ward councillors.
- Social media content for LinkedIn, Facebook and Twitter, highlighting key messages and milestones.
- Organising launch event for official opening, incorporating VIP tours, official photography and media visits/coverage.
- Open days/tours for key stakeholders in advance of opening to patients.
- Official photography to showcase the facility.
- Ongoing media relations before, during and after construction, reinforcing investment decision and key messages about elective recovery.
- Producing a range of communications materials – including patient information film and leaflet to accompany appointment letters.

5. AUDIENCES AND POSITIONING

External audiences

External audiences should see us as:

- An organisation that lives its vision and values
- An organisation that focuses on patients
- Providing high quality patient care and pioneering specialist services
- Easy to access, an efficient, caring, and clean place to get treated
- An employer that cares about its staff and provides a great place to work and train
- An anchor organisation in the NHS and in the region
- A centre of world class research, providing cutting edge treatments for patients
- A local hospital, a national centre of excellence and an international organisation
- A financially successful organisation which spends public funds wisely
- A leading, innovative NHS organisation that works collaboratively with partners

Case study (External Audience) – Geordie Hospital evaluation

After a lot of discussion and planning and as the country came out of lockdown last summer (2021), we granted production company Curve Media access to our hospitals, our staff, and patients for the Channel 4 series Geordie Hospital.

This six-part series, which first aired in January 2022, followed our incredible staff through a shift, from world class medics saving and transforming lives, to the support teams who make it possible. In summary, here is an evaluation of series 1:

- **Viewing figures** - average 1.1m viewers over the series – 6% viewing share with 1.23 million views at its peak
- **Market share** - premier episode came in with a 6.42% share vs Channel 4's average for that transmission time of 5.56%
- **Audience demographic** - Highest audience demographic - older, 65+, female, with a reach of 5.5m unique views but good demographic across the board
- **Website –** over half a million page views (540,600) with 437.5K unique
- **Facebook –** 539,400 views, 1.9m reach
- **Twitter –** 1.2million impressions (13.8K per day), 3,500 link clicks, 1,200 retweets, 6,500 likes, 109K profile visits
- **New followers -** we generated 919 new followers during the time the series was aired
- **Instagram** – 21,600 reach, 2,400 views, 300 new followers
- **Recruitment** – 18,018 new users to recruitment site (19,414 in total) with almost 66,000 page views
- **Reputation -** Generated local and national media interest – circa 50 articles with extensive coverage in the Chronicle. Patient stories picked up by television (BBC / Tyne Tees) despite it being a Channel 4 production
- **Reputation** - Parliamentary Questions – mention from Newcastle MP Chi Onwurah
- **Reputation** – Excellence feedback from the cast, our patients, and the public

Internal Audiences

Internal audiences should see us as:

- An employer that cares about, listens to, and positively responds to staff
- An excellent place to train and learn throughout your career
- An organisation that focuses on patients
- A place to be proud of
- An organisation they would recommend working at to others and receive care
- A responsible organisation the supports our staff in their desire to improve, develop and enhance services, patient, and staff experiences

Although specific messages will be tailored to each audience, the core principles underpinning our communication are:

- Newcastle Hospitals is a high-quality organisation.
- We focus on delivering for our patients.
- We are innovative, translating cutting-edge research into excellent patient care.
- Our hospitals provide treatment for the local community alongside highly specialised services for patients from all over the North East and beyond.
- Newcastle is a clean, friendly, and efficient place to be treated.
- We respect patients and staff members as individuals and welcome diversity.
- We care about our staff and strive to make Newcastle a great place to work. We care about what matters to you.
- Each member of staff is able to be 'their best selves', unlock their potential and help deliver the very best services to the population we serve.
- Any changes we make to services will make the best use of our excellent staff and facilities to provide better health care for the benefit of patients.
- We play an important role in our community and want to enhance the Health, Wealth and Wellbeing of the North East.
- We take the climate crisis seriously and will take decisive action, even when it is hard.

Through engagement with staff, we have identified six overarching key themes – Continuous Quality Improvement, Leadership and Lifelong Learning, SHINE – sustainable healthcare, Staying Well, Celebrating Diversity, Valued and Heard - which form part of our Flourish framework and are all part of the way we work together.

The trust's communications service will continue to work with corporate and clinical teams to actively engage staff on key projects / workstreams which form part of this framework through a high-quality internal communications programme.

Case study (Internal Audience) – Celebrating Excellence Awards / Thank You Month

The trust's annual Celebrating Excellence Awards – which are planned, managed and delivered by the communication team - recognise the exceptional work of our teams, individuals, volunteers and charity supporters. This year they formed part of a wider 'Thank You' Month to acknowledge and say thank you to staff for everything they do.

Key communications outputs included:

Awards

- Generating over £35,000 in awards sponsorship
- Design and production of a range of communication and promotional materials – including a video celebrating our staff, photography, nomination forms, finalists' brochure and certificates, presentations, sponsorship package, scriptwriting
- Complete project management of the awards – from concept to completion
- Organising evening dinner event for over 400 guests with official photography
- Production of all internal / external communications including social media content
- Co-ordination of 'Fruity Friday' and 'Treat Yourself' days for staff where they could help themselves to a free piece of fruit and a drink / cake
- Production of materials and communication / promotion for 'Thank You' month which included 'Newcastle Bake Off', launch of Hive staff engagement tool, Leadership Matters Event, People at Our Heart Awards, Great North 5K

6. BREAKDOWN OF TARGET AUDIENCES AND WHO IS RESPONSIBLE FOR THEM

Key audiences	Current roles and responsibilities of the communications unit
Staff	The communications team: Manages and delivers the weekly operational update, In Brief and the Chief Executive's fortnightly blog, as well as occasional additional updates. Jointly manages the intranet with IT. Provides content for screen savers on Trust computers and digital noticeboards. Manages and monitors all the trust's e.communications including corporate social media channels, which are followed by people who work for us. Produce high standard in-house video content which are used for internal (and external) communications. Manages and updates the Flourish website with information for staff including events, news, and resources. Oversee, plan, and manage the trust's annual Celebrating Excellence Awards for staff. Works closely with the recently expanded staff experience team, particularly in relation to the staff survey, Hive platform and the What Matters to You programme. Provides dedicated support to the Quality Improvement team, research, digital and our nursing, midwives, and allied health professionals. Is responsible for operational / strategic communications in event of serious untoward incidents, major incidents. Produces ongoing materials, campaigns, and content for 'core internal business' such as staff survey and the staff flu and COVID-19 vaccination programme. Guardians for the organisation's brand and identity. Responsible for the design of key corporate documents / communication materials for staff including the annual report, COVID-19 staff handbook, CQC materials.

Patients, public, carers and families	The communications team developed the new external website and is responsible for its ongoing maintenance and ensuring content is up to date. The team produces content and monitors all social media channels (twitter, Facebook, YouTube, Instagram, LinkedIn). Patient information is managed outside the team by the Chief Nurse and the Patient Experience Team, although the team has a key role (particularly during the pandemic) in the production of trust-wide patient information, such as visiting information, service changes and patient information videos. www.nhs.uk – the communications unit is responsible for corporate copy. Day to day responses to patient feedback is managed by patient relations.
GPs and other referrers	The communications team have access to GP Net and share urgent operational updates to GPs through a communication network but most communication with GPs is managed through the business development team.
Media	The communications team responds to queries from the media about positive and negative news stories and deals with filming requests from news organisations, documentary makers and other organisations that we work with. It issues positive proactive press releases, reactive statements and devises individual media campaigns aligned to service developments, VIP visits, key events, patient stories, awareness campaigns etc. This regularly involves supporting / guiding patients, families, and staff through high profile stories (and ensuring they are fully aware of the potential impact a media story can have)
Governors and Members	Communication with members and the governing body is managed outside the team by the Corporate Governance Team. Governors receive Dame Jackie's Blog, and a membership strategy (2022-2024) has been developed.

Stakeholder management	Stakeholder management is currently considered on a case-by-case basis, given the size and complexity of the trust. The commercial unit, covid vaccination programme and major estates programmes all have clear stakeholder engagement plans.
PPI	Is managed by the Patient Relations Team and the executive director lead is the Executive Chief Nurse.
Staffside	Staffside relationships are led by the Chief People Officer.
Staff Networks	Relationships with our staff equality networks are led by the trust equalities team in HR.
Community and voluntary sector	Through Collaborative Newcastle, Governors, and clinical services.

7. OUR ROLE AND AMBITIONS

As a major NHS provider and highly successful teaching hospital, we will maximise opportunities that support the trust's aspirations to excel at a number of levels:

In our organisation – to be an outstanding organisation, now and in the future, providing strong foundations to support our regional, natoinal and global reach

In Newcastle – to be a full civic partner, contributing to the health, weatlh and wellbeingof the city, and delivering integrated services

In the region – to be an anchor organisation in the North East and Cumbria as a clinical systems leader and a regional provider of services, creating and supporting a sustainable system

Nationally – to be a beacon organisation in the UK, leading and influencing service delivery and policy

Globally – to realise our capability internationally using our oustanding foundations, enhancing our global reach

We work with other organisations in the North East and North Cumbria to improve the care we provide for local people and are part of the North East and North Cumbria **Integrated Care System (ICS)** - a partnership of organisations including local councils, voluntary and community services that provide health and care across our region.

Members of the communication team are also part of the regional NHS Communications Network, as well as NHS England and Improvement regional and national networks. The Assistant Chief Executive is also a member of the Shelford Communications Directors Group.

As an anchor organisation, the Trust is also part of Collaborative Newcastle – an innovative partnership that brings together the NHS, local government, higher education and the voluntary and community sector in Newcastle and aims to improve the health, wealth and wellbeing of everyone in the City.

collaborative NEWCASTLE

Working collaboratively and creatively, the aim is to reduce inequalties, tackle some of the big things that hold people back and provide better opportunities for all. There are three pillars which underpin the Collaborative:

- Health and care
- Growth and prosperity
- Net Zero Newcastle

Case study – North East Innovation Lab

The North East Innovation Lab was created in January 2021, as part of the Integrated Covid Hub North East, with an initial focus on evaluating cutting-edge Covid testing technologies, in order to bring new and accessible diagnostics into mainstream use.

The lab is now part of Newcastle Hospitals and operates on a commercial basis with developers across industry, academia, and health service, testing the performance of new diagnostics and offering specialist support for methodology and protocol development.

Since opening in January 2021, the lab has built a client base ranging from university spin-outs to large multi-national corporations, including UK and international organisations, with a portfolio that now includes assessment of diagnostics for a range of viruses and diseases, including sepsis and cancer. Over the last two years, the team has engaged with over 100 test developers and worked on over 45 projects with 21 companies across the globe.

A dedicated communications and marketing resource has been instrumental in this success, forming a key component of the business development approach. From the start, communications has been a central consideration, with weekly meetings between the head of the lab, the business development manager and dedicated communication lead.

The head of lab has confirmed this strategic communications approach plays a central role in building the lab's brand and generating numerous sales leads and enquiries.

Communications activity and expertise has included:

- Media relations - for initial lab launch and key milestones, for example, VIP visits and anniversary dates, and targeting specialist outlets, including international industry websites.
- Conducting a stakeholder and industry mapping exercise to identify target audiences and individuals, and appropriate ways to reach.
- Building a brand for the lab, including visual identity, clarification of offer/key message development, production of communications content and materials.
- Establishing and managing content for social media accounts on LinkedIn and Twitter, including routine posts, blogs and opinion pieces.
- Strategic social media content planning to maximise reach and engagement and capitalise on beneficial links with industry and partner activity.
- Liaising with communication leads in industry bodies and partner organisations, e.g. BIVDA and Invest Newcastle, to maximise opportunities to amplify communications reach.
- Producing video to showcase the lab offer to potential clients and partners.
- Organising VIP visits, including representatives from UKHSA, NENC ICB and local MP.
- Content planning and production of materials, for example exhibition stands and leaflets, to support attendance at industry events and conferences.

8. WHAT DO TARGET AUDIENCES THINK OF OUR COMMUNICATIONS?

Staff

We conducted two internal communications surveys during the pandemic – feedback was very positive from staff.

- The Trust Intranet, In Brief, Trust-wide emails (the COVID-19 update which is now the operational update) and the Chief Executive's Blog had the highest frequency as the 'most useful' communications channels to staff.
- The COVID-19 update was regarded as the main and trusted source of information for staff throughout the pandemic.
- The Trust intranet is frequently used (most often for policies and procedures, training and development and staff directory) by staff but very difficult to navigate. Staff wanted easier access (from other devices or from home) a better user experience, up-to-date information, and a search feature.
- Majority of staff felt informed about what is happening across the organisation.
- Staff were aware of the Trust's offers of support with health and wellbeing.
- Staff would like to be involved in more staff engagement events.

When asked what the communications team could do to help to improve communications, there were some consistent themes that emerged:

- **More timely information –** information should be held centrally on the intranet and only urgent information emailed out to reduce the number of emails
- **Engagement with staff –** Focus on two-way communication with staff and engagement with staff groups
- **Simplified communication**
- **Layout and design –** Clearer design of the bulletins and consistency, clearer headings, shorter and more engaging
- **Managerial communication and engagement –** messages are often not filtered down from clinical directors or directorate managers to staff
- **Access to information from personal devices –** Not all staff work 9 – 5 or have access to a computer whilst at work and would prefer to access information from home on another device
- **Improved intranet –** Information should be held on intranet than through email attachments. It should be user friendly, accessed remotely, easier to find information
- **Opt-in information for different areas:** Option to opt into email bulletins. For example, separate groups for RVI / Freeman or departmental issues

Stakeholders

Newcastle Hospitals has not undertaken a broader stakeholder management survey. This will be considered as part of the resource scoping for the strategy.

9. ALIGNMENT AND CO-DEPENDENCIES

There are other strategies and plans that interact with this communications strategy, most notably the major incident plan, staff engagement strategy, leadership strategy, research strategy, digital strategy, commercial team strategy and charity strategy.

Individual communication plans and processes are developed by the communication team for specific projects throughout the year.

Over the next six months, we will work with colleagues in those teams to ensure alignment of action plans and ensure that we are using our resources to the best effect.

10. COMMUNICATIONS CHANNELS AND TACTICS (FROM JANUARY 2023)

Key activities	Initial milestones	Rational/success criteria
Tactic 1: To actively engage staff through a high-quality internal communications programme		
Audit internal communications regularly and review the internal communications activities in light of the results	Ongoing	To ensure that the communications team provides the highest possible quality internal communications by reviewing the programme in light of the results from the staff survey, What Matters to You programme and learning from other organisations.
Align internal communications with trust corporate objectives	Ongoing	To have a communication plan in place for the corporate objectives. To ensure that we are sharing a clear narrative which is consistently owned and shared by the executive team.

Key activities	Initial milestones	Rational/success criteria
Deliver key internal communication activity	Ongoing	To ensure the intranet and Flourish website are up to date with relevant information for colleagues. To maintain regular briefings for staff with the continuation of In Brief, weekly operational updates, Dame Jackie's fortnightly blog. As well as operational updates as required. To use other tools including screen savers, posters, screens in staff bistros etc to reach our diverse workforce in a plethora of different ways.
Intranet	TBC	Supported by the IT team, seek funds for and develop a new staff intranet which is fit for purpose. This will ensure the site is easier to use, has up to date information and is more accessible for staff by being mobile enabled.
Develop and deliver a communications approach for key strategic functions – research, NMAPS, digital etc	Ongoing	Successful engagement in these key areas, clear plans, and associated evaluation
Tactic 2: To work with other NHS organisations and engage stakeholders		
Make best use of VIP visits	Ongoing	

Key activities	Initial milestones	Rational/success criteria
		To work with Department of Health and Social Care, NHS England / Improvement, charities, and others on requests for visits to ensure we show Newcastle at its best while prioritising services and safety.
Deliver quarterly stakeholder bulletin to political stakeholders and other organisations who are interested in our work	Quarterly	Deliver quarterly bulletin.
North East and North Cumbria Cancer Alliance	Quarterly	Public Engagement re new models of care for non-surgical oncology.
Ensure that the communications team delivers core corporate communications	Ongoing	Deliver Annual Report design, content, and staff / member summary Help provide content for the for the chief executive Annual Members MM presentation and Video.
Website	Ongoing	Custodians of the trust website, supporting clinical services to provide high quality information.
Tactic 3: To raise the profile of Newcastle Hospital services in the media		

Key activities	Initial milestones	Rational/success criteria
To manage reactive media	Ongoing	To respond to requests from journalists, delivering proactive press releases, identifying, and handling risk and developing relationships with journalists. Preparing media statements, internal and stakeholder briefings on issues that are likely to attract media attention, for example, court cases
Manage proactive media relations	Ongoing	To deliver positive media coverage about significant milestones – new buildings, service developments, achievements, activity, etc To deliver positive media coverage in key strategic areas such as research, recovery, and climate action etc.
To manage and develop our corporate social media accounts and to develop our social media content	Ongoing	To use Twitter, LinkedIn, Instagram, Youtube and Facebook as part of our communications and to focus our efforts on these channels for maximum effect for fundraising and recruitment. To support staff teams with the safe use of social media.
Tactic 4: To communicate our strategy – where we are going and how we are going to get there		

Key activities	Initial milestones	Rational/success criteria
To deliver the communications plan for new estates builds – children's heart centre and the new specialist hospital building at the RVI	Ongoing	Internal and external communications to ensure staff and patients are aware of changes and supportive.
Tactic 5: To position Newcastle as an organisation that collaborates to improve patient care locally and to help communities and the NHS understand the uniqueness of our specialist services		
Support Collaborative Newcastle Communications	Ongoing	Internal and external communications to ensure staff, patients and partner organisations are aware of the work of the Collaborative.
The Great North Children's Hospital	Ongoing	To deliver positive news stories and support internal and external communications to continue to position the hospital as a centre of excellence for children.
Tactic 6: To develop our fundraising communications (in partnership with Newcastle Hospitals Charity)		
Support Charity fundraising and align, where possible, with trust communications	Ongoing	To provide recognition for Charity-funded projects. To have a clear plan for Major donors and schemes.

Key activities	Initial milestones	Rational/success criteria
		To align the Charity with the Flourish framework so all joint ventures are appropriately branded and recognised by colleagues.

10. REVIEW AND EVALUATION

The strategy will be reviewed at two team business planning half days each year to assess progress and review activity. It is reflected in the individual objectives of staff members. A quarterly communications dashboard is prepared for Executive team and the People Committee.

11. RESOURCES

Communications as a strategic function was established in Newcastle in 2018 with the creation of the Director of Communications post following Board approval.

The core communications team has an establishment of 5 wte staff (with a current vacant post due to a secondment) so there needs to be a balance between what we would like to achieve and what the communications team can deliver.

Six posts are funded by external teams and professionally managed by the communications team (four currently on fixed-term contracts or secondment). They are:

- Communications manager for digital healthcare (permanent)
- Communications manager for research (permanent)
- Communications manager for NMAHPs (temporary / secondment)
- Internal Comms lead (temporary)
- Head of Communications - Commercial and special projects (temporary)
- Communications manager - Commercial and special projects (temporary)

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BOARD MEETINGS - ACTIONS

Log No.	BOARD DATE	PRIVATE / PUBLIC	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
101	26 January 2023	PUBLIC	23/03 BUSINESS ITEMS: iii) National Patient Safety Bi-Annual Report	The work is currently in the orientation stage and there is an expectation to deliver training to all staff in the organisation against the national curriculum. Ms Edusei noted the importance of working with all staff and partners to ensure diverse representation. The DQE confirmed that she would share the evidence circulated to CQC with Ms Edusei regarding patient involvement [ACTION01].	AOB			16/03/2023 - AOB confirmed that the requested information has been sent to Ms Edusei. Action closed.

KEY

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